WEIGHTED SCORES - Original Weights

State	City	Population	CON	Need	10%	unmet	23%	Comp	22%	Medicaid	5%	Comm	12%	Staff Ratio	8%	Staff Cost	8%		Waiver	2%	High Ed	5%	Building	5%		SCORE
		294,000	N	88	0.8	100%	20.0	0	22.0	588	3.1	650	6.5	6	3.2	130	2.5	0.7	N	0	8	5.0	16.8	4.4	0.1	67.5
		1,104,000	Y	257	4.9	78%	13.1	5	15.5	420	0.3	675	7.4	9	8.0	117	4.9	0.4	N	0	7	4.4	17.6	3.7	0.3	62.3
		784,000	Y	169	2.8	72%	11.3	5	15.5	468	1.1	700	8.3	9	8.0	108	5.5	0.3	N	0	6	3.8	16.2	5.0	0.0	61.2
		926,000	Y	164	2.6	59%	7.2	3	18.1	550	2.5	650	6.5	9	8.0	112	4.9	0.4	Y	2	8	5.0	17.6	3.7	0.3	60.5
		832,000	Y	151	2.3	60%	7.5	3	18.1	600	3.3	775	11.1	9	8.0	126	3.1	0.6	N	0	8	5.0	20.2	1.2	0.8	59.6
		428,000	N	91	0.8	71%	10.9	3	18.1	588	3.1	650	6.5	6	3.2	89	8.0	0.0	N	0	5	3.1	16.8	4.4	0.1	58.2
		2,231,000	Y	433	9.2	65%	9.1	9	10.4	468	1.1	700	8.3	9	8.0	135	1.9	0.8	N	0	8	5.0	17.0	4.2	0.2	57.2
		1,716,000	N	372	7.7	72%	11.3	6	14.2	588	3.1	650	6.5	6	3.2	135	1.9	0.8	N	0	8	5.0	17.4	3.9	0.2	56.8
		866,000	Y	180	3.0	69%	10.3	7	12.9	550	2.5	650	6.5	9	8.0	107	5.6	0.3	Y	2	3	1.9	17.4	3.9	0.2	56.6
		250,000	N	59	0.0	79%	13.4	3	18.1	588	3.1	650	6.5	6	3.2	96	7.1	0.1	N	0	0	0.0	16.8	4.4	0.1	55.9
		3,448,000	N	752	10.0	73%	11.6	17	0.0	700	5.0	800	12.0	9	8.0	149	0.0	1.0	Y	2	8	5.0	21.4	0.1	1.0	53.7
		611,000	Y	77	0.5	42%	1.9	3	18.1	468	1.1	700	8.3	9	8.0	113	4.8	0.4	N	0	8	5.0	16.5	4.7	0.1	52.4
		808,000	Y	181	3.0	75%	12.2	3	18.1	550	2.5	725	9.2	4	0.0	124	3.3	0.6	?		6	3.8	21.3	0.2	1.0	52.4
		1,009,000	N	155	2.4	51%	4.7	4	16.8	588	3.1	650	6.5	6	3.2	104	6.0	0.3	N	0	8	5.0	16.7	4.5	0.1	52.2
TN	Tri-Cities	668,000	Y	117	1.5	45%	2.8	7	12.9	550	2.5	650	6.5	9	8.0	105	5.9	0.3	Y	2	7	4.4	17.0	4.2	0.2	50.7
		491,000	Y	116	1.4	79%	13.4	1	20.7	550	2.5	625	5.5	5	1.6	118	4.1	0.5	N	0	0	0.0	21.5	0.0	1.0	49.4
		342,000	N	57	0.0	55%	5.9	4	16.8	588	3.1	650	6.5	6	3.2	113	4.8	0.4	N	0	7	4.4	16.8	4.4	0.1	49.2
		659,000	Y	130	1.8	60%	7.5	5	15.5	550	2.5	675	7.4	9	8.0	138	1.5	0.8	N	0	7	4.4	21.4	0.1	1.0	48.6
		838,000	Y	129	1.8	51%	4.7	8	11.6	550	2.5	650	6.5	9	8.0	124	3.3	0.6	Y	2	6	3.8	17.3	4.0	0.2	48.1
		639,000	N	98	1.0	51%	4.7	4	16.8	588	3.1	650	6.5	6	3.2	105	5.9	0.3	N	0	1	0.6	16.8	4.4	0.1	46.2
		713,000	Y	127	1.7	59%	7.2	5	15.5	420	0.3	575	3.7	9	8.0	141	1.1	0.9	N	0	6	3.8	17.2	4.1	0.2	45.3
		529,000	Y	66	0.2	41%	1.6	4	16.8	550	2.5	725	9.2	6	3.2	108	5.5	0.3	N	0	3	1.9	17.0	4.2	0.2	45.1
		2,206,000	Y	464	10.0	70%	10.6	11	7.8	550	2.5	625	5.5	4	0.0	130	2.5	0.7	N	0	7	4.4	20.0	1.4	0.7	44.8
		1,395,000	Y	152	2.3	36%	0.0	8	11.6	550	2.5	650	6.5	9	8.0	124	3.3	0.6	Y	2	7	4.4	17.8	3.5	0.3	44.1
		746,000	Y	122	1.6	54%	5.6	5	15.5	550	2.5	775	11.1	4	0.0	136	1.7	0.8	?		8	5.0	21.4	0.1	1.0	43.2
		556,000	Y	66	0.2	39%	0.9	4	16.6	550	2.5	675	7.4	6	3.2	118	4.1	0.5	N	0	6	3.8	17.2	4.1	0.2	43.0
		1,349,000	Y	277	5.4	68%	10.0	14	3.9	550	2.5	575	3.7	4	0.0	111	5.1	0.4	N	0	5	3.1	17.4	3.9	0.2	37.5

Assumptions & Notes
Average Medicaid Pmt is 550
Average Commercial Pmt is 650
Population significance is realized in other metrics
Ohio ratio includes techs
Staff salaries are the sum of RN, LCSW, and CNA
Florida Ratio: One rep said none, other said 1:10
GA ratio: Adult is 6:1 Adolescent is 4.5:1, Gero is 4:1

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PENGAD 800-631-6989
EXHIBIT
7/27/15
SBH-Kingsport

WEIGHTED SCORES - Chris's Weights

State	City	Population	CON	Need	8.3%	unmet	16.6%	Comp	30.0%	Medicaid	16.6%	Comm	8.3%	Staff Ratio	7.5%	Staff Cost	3.0%	Waiver	0.0%	High Ed	3.8%	Building	5.0%	SCORE
[redacted]		284,000	N	88	0.6	100%	16.6	0	30.0	585	10.4	650	4.5	6	3.0	130	1.2	N	0	8	3.8	16.8	4.4	74.5
		832,000	Y	151	1.9	69%	6.2	3	24.7	600	11.1	775	7.7	9	7.5	126	1.5	N	0	0	3.8	20.2	1.2	65.6
		428,000	N	91	0.7	71%	9.1	3	24.7	585	10.4	650	4.5	6	3.0	89	3.8	N	0	5	2.4	16.8	4.4	63.0
		926,000	Y	164	2.2	59%	6.0	3	24.7	550	8.3	650	4.5	9	7.5	112	2.3	Y	0	8	3.8	17.6	3.7	62.9
		1,716,000	N	372	6.4	72%	9.3	6	19.4	588	10.4	650	4.5	6	3.0	135	0.9	N	0	8	3.8	17.4	3.9	61.6
		250,000	N	59	0.0	79%	11.2	3	24.7	588	10.4	650	4.5	6	3.0	96	3.4	N	0	0	0.0	16.8	4.4	61.6
		784,000	Y	169	2.3	72%	9.3	5	21.2	468	3.8	700	5.7	9	7.5	108	2.6	N	0	6	2.9	16.2	5.0	60.3
		1,104,000	Y	257	4.1	78%	10.9	5	21.2	420	1.1	675	5.1	9	7.5	112	2.3	N	0	7	3.3	17.6	3.7	59.2
		1,009,000	N	155	2.0	51%	3.9	4	22.9	588	10.4	650	4.5	6	3.0	104	2.9	N	0	8	3.8	16.7	4.5	57.9
		666,000	Y	180	2.5	69%	8.6	7	17.6	550	8.3	650	4.5	9	7.5	107	2.7	Y	0	3	1.4	17.4	3.9	56.9
		808,000	Y	181	2.5	75%	10.1	3	24.7	550	8.3	725	6.4	4	0.0	124	1.6	?	0	6	2.9	21.3	0.2	56.7
		491,000	Y	116	1.2	79%	11.2	1	28.2	550	8.3	625	3.8	5	1.5	118	2.0	N	0	0	0.0	21.5	0.0	56.2
		342,000	N	57	0.0	55%	4.9	4	22.9	588	10.4	650	4.5	6	3.0	113	2.3	N	0	7	3.3	16.8	4.4	55.8
		2,231,000	Y	433	7.7	65%	7.5	9	14.1	466	3.8	700	5.7	9	7.5	135	0.9	N	0	8	3.8	17.0	4.2	55.2
		611,000	Y	77	0.4	42%	1.6	3	24.7	468	3.8	700	5.7	9	7.5	113	2.3	N	0	8	3.8	16.5	4.7	54.5
		3,448,000	N	752	8.3	73%	9.6	17	0.0	700	16.6	500	8.3	9	7.5	149	0.0	Y	0	8	3.8	21.4	0.1	54.2
		659,000	Y	130	1.5	60%	6.2	5	21.2	550	8.3	675	5.1	9	7.5	138	0.7	N	0	7	3.3	21.4	0.1	53.9
		639,000	N	98	0.8	51%	3.9	4	22.9	588	10.4	650	4.5	6	3.0	105	2.8	N	0	1	0.5	16.8	4.4	53.2
TN	Tri-Cities	668,000	Y	117	1.2	45%	2.3	7	17.6	550	8.3	650	4.5	9	7.5	105	2.8	Y	0	7	3.3	17.0	4.2	51.8
[redacted]		529,000	Y	66	0.2	41%	1.3	4	22.9	550	8.3	725	6.4	6	3.0	108	2.6	N	0	3	1.4	17.0	4.2	50.4
		838,000	Y	129	1.5	51%	3.9	8	15.9	550	8.3	650	4.5	9	7.5	124	1.6	Y	0	6	2.9	17.3	4.0	49.9
		556,000	Y	66	0.2	39%	0.8	4	22.9	550	8.3	675	5.1	6	3.0	118	2.0	N	0	6	2.9	17.2	4.1	49.2
		746,000	Y	122	1.3	54%	4.7	5	21.2	550	8.3	775	7.7	4	0.0	136	0.8	?	0	8	3.8	21.4	0.1	47.8
		713,000	Y	127	1.4	59%	6.0	5	21.2	420	1.1	575	2.6	9	7.5	141	0.5	N	0	6	2.9	17.2	4.1	47.1
		1,385,000	Y	152	1.9	36%	0.0	8	15.9	550	8.3	650	4.5	9	7.5	124	1.6	Y	0	7	3.3	17.8	3.5	46.5
		2,206,000	Y	464	8.3	70%	8.8	11	10.6	550	8.3	625	3.8	4	0.0	130	1.2	N	0	7	3.3	20.0	1.4	45.8
		1,349,000	Y	277	4.5	68%	8.3	14	5.5	550	8.3	575	2.6	4	0.0	111	2.4	N	0	5	2.4	17.4	3.9	37.6

Assumptions & Notes
Average Medicaid Pmt is 550
Average Commercial Pmt is 650
Population significance is realized in other metrics
Ohio ratio includes techs
Staff salaries are the sum of RN, LCSW, and CNA
Florida Ratio: One rep said none, other said 1:10
GA ratio: Adult is 6:1 Adolescent is 4.5:1, Geri is 4:1

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P-3144

SBH-KINGSPORT 001548

MARKET DEMAND

State	City	Population	CON	Need	33.3%	unmet	66.6%	SCORE
[redacted]		3,448,000	N	752	56.9	73%	38.5	95.4
		294,000	N	88	2.5	100%	66.6	69.1
		2,206,000	Y	464	33.3	70%	35.4	68.7
		1,716,000	N	372	25.8	72%	37.5	63.2
		2,231,000	Y	433	30.8	65%	30.2	60.9
		1,104,000	Y	257	16.4	78%	43.7	60.1
		1,349,000	Y	277	18.0	68%	33.3	51.3
		808,000	Y	181	10.1	75%	40.6	50.7
		491,000	Y	116	4.8	79%	44.7	49.6
		784,000	Y	169	9.2	72%	37.5	46.6
		250,000	N	59	0.2	79%	44.7	44.9
		866,000	Y	180	10.1	69%	34.3	44.4
		428,000	N	91	2.8	71%	36.4	39.2
		926,000	Y	164	8.8	59%	23.9	32.7
		832,000	Y	151	7.7	60%	25.0	32.7
		659,000	Y	130	6.0	60%	25.0	30.9
		713,000	Y	127	5.7	59%	23.9	29.7
		746,000	Y	122	5.3	54%	18.7	24.0
		1,009,000	N	155	8.0	51%	15.6	23.6
		838,000	Y	129	5.9	51%	15.6	21.5
		342,000	N	57	0.0	55%	19.8	19.8
		639,000	N	98	3.4	51%	15.6	19.0
TN	Tri-Cities	868,000	Y	117	4.9	45%	9.4	14.3
[redacted]		611,000	Y	77	1.6	42%	6.2	7.9
		1,395,000	Y	152	7.8	36%	0.0	7.8
		529,000	Y	66	0.7	41%	5.2	5.9
		556,000	Y	66	0.7	39%	3.1	3.9

COMPETITION

State	City	Population	CON	Comp	100.0%	SCORE
[redacted]		294,000	N	0	100.0	100.0
		491,000	Y	1	94.1	94.1
		832,000	Y	3	82.4	82.4
		926,000	Y	3	82.4	82.4
		428,000	N	3	82.4	82.4
		250,000	N	3	82.4	82.4
		808,000	Y	3	82.4	82.4
		611,000	Y	3	82.4	82.4
		1,009,000	N	4	76.5	76.5
		342,000	N	4	76.5	76.5
		639,000	N	4	76.5	76.5
		529,000	Y	4	76.5	76.5
		556,000	Y	4	76.5	76.5
		784,000	Y	5	70.6	70.6
		1,104,000	Y	5	70.6	70.6
		659,000	Y	5	70.6	70.6
		746,000	Y	5	70.6	70.6
		713,000	Y	5	70.6	70.6
		1,716,000	N	6	64.7	64.7
		866,000	Y	7	58.8	58.8
TN	Tri-Cities	868,000	Y	7	58.8	58.8
[redacted]		838,000	Y	8	52.9	52.9
		1,395,000	Y	8	52.9	52.9
		2,231,000	Y	9	47.1	47.1
		2,206,000	Y	11	35.3	35.3
		1,349,000	Y	14	17.6	17.6
		3,448,000	N	17	0.0	-

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BUILDING

State	City	Population	CON	Building	100.0%	SCORE
[redacted]		784,000	Y	16.2	100.0	100.0
		611,000	Y	16.5	94.3	94.3
		1,009,000	N	16.7	90.6	90.6
		294,000	N	16.8	88.7	88.7
		428,000	N	16.8	88.7	88.7
		250,000	N	16.8	88.7	88.7
		342,000	N	16.8	88.7	88.7
		639,000	N	16.8	88.7	88.7
		2,231,000	Y	17.0	84.9	84.9
TN	Tri-Cities	868,000	Y	17.0	84.9	84.9
[redacted]		529,000	Y	17.0	84.9	84.9
		556,000	Y	17.2	81.1	81.1
		713,000	Y	17.2	81.1	81.1
		838,000	Y	17.3	79.2	79.2
		1,716,000	N	17.4	77.4	77.4
		866,000	Y	17.4	77.4	77.4
		1,349,000	Y	17.4	77.4	77.4
		926,000	Y	17.6	73.6	73.6
		1,104,000	Y	17.6	73.6	73.6
		1,395,000	Y	17.8	69.8	69.8
		2,206,000	Y	20.0	28.3	28.3
		832,000	Y	20.2	24.5	24.5
		808,000	Y	21.3	3.8	3.8
		3,448,000	N	21.4	1.9	1.9
		659,000	Y	21.4	1.9	1.9
		746,000	Y	21.4	1.9	1.9
		491,000	Y	21.5	0.0	(0.0)

STAFFING

State	City	Population	CON	Staff Ratio	50.0%	Staff Cost	25.0%	High Ed	25.0%	SCORE
[redacted]		926,000	Y	9	50.0	112	15.4	8	25.0	90.4
TN	Tri-Cities	868,000	Y	9	50.0	105	18.3	7	21.9	90.2
[redacted]		611,000	Y	9	50.0	113	15.0	8	25.0	90.0
		1,104,000	Y	9	50.0	112	15.4	7	21.9	87.3
		784,000	Y	9	50.0	108	17.1	6	18.8	85.8
		832,000	Y	9	50.0	126	9.6	8	25.0	84.6
		1,395,000	Y	9	50.0	124	10.4	7	21.9	82.3
		2,231,000	Y	9	50.0	135	5.8	8	25.0	80.8
		838,000	Y	9	50.0	124	10.4	6	18.8	79.2
		866,000	Y	9	50.0	107	17.5	3	9.4	76.9
		659,000	Y	9	50.0	138	4.6	7	21.9	76.5
		3,448,000	N	9	50.0	149	0.0	8	25.0	75.0
		713,000	Y	9	50.0	141	3.3	6	18.8	72.1
		1,009,000	N	6	20.0	104	18.8	8	25.0	63.8
		428,000	N	6	20.0	89	25.0	5	15.6	60.6
		342,000	N	6	20.0	113	15.0	7	21.9	56.9
		294,000	N	6	20.0	130	7.9	8	25.0	52.9
		556,000	Y	6	20.0	118	12.9	6	18.8	51.7
		1,716,000	N	6	20.0	135	5.8	8	25.0	50.8
		529,000	Y	6	20.0	108	17.1	3	9.4	46.5
		250,000	N	6	20.0	96	22.1	0	0.0	42.1
		639,000	N	6	20.0	105	18.3	1	3.1	41.5
		1,349,000	Y	4	0.0	111	15.8	5	15.6	31.5
		746,000	Y	4	0.0	136	5.4	8	25.0	30.4
		2,206,000	Y	4	0.0	130	7.9	7	21.9	29.8
		808,000	Y	4	0.0	124	10.4	6	18.8	29.2
		491,000	Y	5	10.0	118	12.9	0	0.0	22.9

REIMBURSEMENT

State	City	Population	CON	Medicaid	66.6%	Comm	33.3%	SCORE
[redacted]		3,448,000	N	700	66.6	800	33.3	99.9
		832,000	Y	600	44.4	775	30.7	75.1
		746,000	Y	550	33.3	775	30.7	64.0
		294,000	N	588	41.7	650	17.9	59.7
		428,000	N	588	41.7	650	17.9	59.7
		1,716,000	N	588	41.7	650	17.9	59.7
		250,000	N	588	41.7	650	17.9	59.7
		1,009,000	N	588	41.7	650	17.9	59.7
		342,000	N	588	41.7	650	17.9	59.7
		639,000	N	588	41.7	650	17.9	59.7
		808,000	Y	550	33.3	725	25.6	58.9
		529,000	Y	550	33.3	725	25.6	58.9
		659,000	Y	550	33.3	675	20.5	53.8
		556,000	Y	550	33.3	675	20.5	53.8
		926,000	Y	550	33.3	650	17.9	51.2
		866,000	Y	550	33.3	650	17.9	51.2
TN	Tri-Cities	868,000	Y	550	33.3	650	17.9	51.2
[redacted]		838,000	Y	550	33.3	650	17.9	51.2
		1,395,000	Y	550	33.3	650	17.9	51.2
		491,000	Y	550	33.3	625	15.4	48.7
		2,206,000	Y	550	33.3	625	15.4	48.7
		1,349,000	Y	550	33.3	575	10.2	43.5
		784,000	Y	468	15.1	700	23.1	38.1
		2,231,000	Y	468	15.1	700	23.1	38.1
		611,000	Y	468	15.1	700	23.1	38.1
		1,104,000	Y	420	4.4	675	20.5	24.9
		713,000	Y	420	4.4	575	10.2	14.7

New Scores That Jim Thinks Will Be Different But Are Actually The Same

State	City	Population	CON	Mkt Demand	25.0%	Competition	30.0%	Reimbursement	25.0%	Staffing	15.0%	Building	5.0%	SCORE
[redacted]		294,000	N	69.1	17.3	100.0	30.0	59.7	14.9	52.9	7.9	88.7	4.4	74.6
		832,000	Y	52.5	13.1	82.4	24.7	75.1	18.8	84.6	12.7	24.5	1.2	70.5
		428,000	N	39.2	9.8	82.4	24.7	59.7	14.9	60.6	9.1	88.7	4.4	63.0
		926,000	Y	32.7	8.2	82.4	24.7	51.2	12.8	90.4	13.6	73.6	3.7	62.9
		1,716,000	N	63.2	15.8	64.7	19.4	59.7	14.9	50.8	7.6	77.4	3.9	61.6
		250,000	N	44.9	11.2	82.4	24.7	59.7	14.9	42.1	6.3	88.7	4.4	61.6
		784,000	Y	46.6	11.7	70.6	21.2	38.1	9.5	85.8	12.9	100	5.0	60.2
		3,448,000	N	95.4	23.9	0.0	0.0	99.9	25.0	75	11.3	1.9	0.1	60.2
		1,104,000	Y	60.1	15.0	70.6	21.2	24.9	6.2	87.3	13.1	73.6	3.7	59.2
		1,009,000	N	23.6	5.9	76.5	23.0	59.7	14.9	63.8	9.6	88.7	4.4	57.8
		866,000	Y	44.4	11.1	58.8	17.6	51.2	12.8	76.9	11.5	77.4	3.9	56.9
		808,000	Y	50.7	12.7	82.4	24.7	58.9	14.7	29.2	4.4	3.8	0.2	56.7
		491,000	Y	49.6	12.4	94.0	28.2	48.7	12.2	22.9	3.4	0	0.0	56.2
		342,000	N	19.8	5.0	76.5	23.0	59.7	14.9	56.9	8.5	88.7	4.4	55.8
		2,231,000	Y	60.9	15.2	47.1	14.1	38.7	9.7	80.8	12.1	84.9	4.2	55.4
		611,000	Y	7.9	2.0	82.4	24.7	38.1	9.5	90	13.5	94.3	4.7	54.4
		659,000	Y	30.9	7.7	70.6	21.2	53.8	13.5	76.5	11.5	1.9	0.1	53.9
		639,000	N	19	4.8	76.5	23.0	59.7	14.9	41.5	6.2	88.7	4.4	53.3
TN	Tri-Cities	868,000	Y	14.3	3.6	58.8	17.6	51.2	12.8	90.2	13.5	84.9	4.2	51.8
[redacted]		529,000	Y	5.9	1.5	76.5	23.0	58.9	14.7	46.5	7.0	84.9	4.2	50.4
		838,000	Y	21.5	5.4	52.9	15.9	51.2	12.8	79.2	11.9	79.2	4.0	49.9
		556,000	Y	3.9	1.0	76.5	23.0	53.8	13.5	51.7	7.8	81.1	4.1	49.2
		746,000	Y	24	6.0	70.6	21.2	64.0	16.0	30.4	4.6	1.9	0.1	47.8
		713,000	Y	29.7	7.4	70.6	21.2	14.7	3.7	72.1	10.8	81.1	4.1	47.2
		1,395,000	Y	7.8	2.0	52.9	15.9	51.2	12.8	82.3	12.3	69.8	3.5	46.5
		2,206,000	Y	68.7	17.2	35.3	10.6	48.7	12.2	29.8	4.5	28.3	1.4	45.8
		1,349,000	Y	51.3	12.8	17.6	5.3	43.5	10.9	31.5	4.7	77.4	3.9	37.6

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Bed Need Ranking - All Cities

Page	State	Build city, surrounding cities within 60 mi., and weight of populations.	Population	Need	Notes
1		[redacted]	8,292,000	1231	
2			4,156,000	782	
3			3,448,000	752	73% unmet demand.
4			5,405,000	744	
5			5,117,000	734	
6			3,444,000	536	
7			3,936,000	466	
8			2,206,000	464	Only 10 gero beds.
9			4,249,000	459	
10			2,550,000	454	
11			2,122,000	433	65% unmet demand.
12			2,101,000	391	
13			5,564,000	357	Not much PRTF comp.
14			3,050,000	296	
15			1,349,000	277	No PRTF or gero. 20 youth
16			1,104,000	257	
17			866,000	250	Only 10 beds. No PRTF.
18			697,000	181	No beds in 30ml. No Gero
19			2,220,000	171	
20			784,000	169	No youth, geriatric, PRTF
21			926,000	164	All medsurg. 10 youth
22			1,395,000	152	
23			1,618,000	152	
24			954,000	151	No PTRF.
25			2,288,000	143	
26			1,003,000	138	
27			659,000	130	No Youth or PRTF.
28			838,000	129	No Gero.
29			704,000	127	No PRTF or acute in 30ml
30			1,638,000	126	No PRTF
31			959,000	125	
32			1,534,000	123	
33			746,000	122	
34	TN	Johnson City/Kingsport/Boone/Morristown/Greenville/ ,25 Asheville	868,000	117	
35			1,343,000	116	
36			491,000	116	
37			1,304,000	113	
38			972,000	113	No PRTF
39			970,000	106	
40			1,098,000	105	No PRTF
41			1,370,000	100	
42			2,812,000	99	
43			1,010,000	98	No PRTF.
44			611,000	77	
45			717,000	70	
46			556,000	66	
47			529,000	66	
48			1,858,000	63	
49			857,000	60	
50			366,000	58	No youth beds.
51			465,000	57	
52			908,000	53	
53			1,942,000	51	
54			462,000	50	
55			1,671,000	47	
56			367,000	45	
57			1,249,000	45	
58			600,000	42	
59			497,000	40	
60			329,000	39	
61			341,000	35	
62			551,000	33	No Gero.
63			1,321,000	29	

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64	[redacted]	738,000	24	
65		1,258,000	23	
66		649,000	22	
67		772,000	14	No PRTF w/in 60 mi.
68		398,000	9	
69		549,000	8	
70		470,000	5	No youth or PRTF in 30mi
71		279,000	-3	
72		518,000	-6	No Gero? No PRTF?
73		473,000	-10	
74		354,000	-26	
75		519,000	-38	
76		499,000	-44	
77		504,000	-56	No PRTF.
78		1,057,000	-59	
79		711,000	88	
80		934,000	-126	
81		1,283,000	-242	

NOTES
Acute need based on 30 beds per 100,000 people.
Beds over 50 mi away are NOT included in competition analyses
MI (save Detroit) consider beds w/in 30 mi, so need is adjusted up by 10%

% Unmet Ranking - All Cities

Page	State	Build city, cities within 60 mi., and weight of populations	Population	Need	% unmet	Notes
1			250,000	75	100%	
2			866,000	228	88%	Only 10 beds. No PRTF.
3			491,000	116	79%	No gero
4			1,104,000	257	78%	
6			808,000	181	75%	No beds in 30mi. No Gero
7			3,448,000	752	73%	
8			784,000	169	72%	No youth, geriatric, PRTF
9			2,206,000	464	70%	Only 10 gero beds.
10			1,349,000	277	68%	No PRTF or gero. 20 youth.
11			2,231,000	433	65%	
12			4,156,000	782	63%	
13			2,101,000	391	62%	
5			832,000	151	60%	No PTRF.
14			659,000	130	60%	No Youth or PRTF.
15			2,550,000	454	59%	
16			926,000	164	59%	All medsurg. 10 youth
17			713,000	127	59%	No PRTF. No acute in 30mi
18			746,000	122	54%	
19			366,000	58	53%	No youth beds.
20			3,479,000	536	51%	
21			8,292,000	1231	49%	
22			5,405,000	744	46%	
23			1,003,000	138	46%	
24			5,443,000	734	45%	
25	TN	Johnson City/Kingsport/Boone/Morristown/Greenville/ .25 Asheville	868,000	117	45%	
26			959,000	125	43%	
27			611,000	77	42%	
28			529,000	66	41%	
29			465,000	57	41%	No gero
30			3,936,000	466	39%	
31			972,000	113	39%	No PRTF
32			556,000	66	39%	
33			329,000	39	39%	
34			4,249,000	459	36%	
35			1,395,000	152	36%	
36			970,000	106	36%	
37			462,000	50	36%	No gero
38			3,050,000	324	35%	
39			438,000	45	35%	
40			341,000	35	35%	No gero
41			539,000	56	34%	
42			717,000	70	33%	
43			1,098,000	105	32%	No PRTF
44			1,010,000	98	32%	No PRTF.
45			1,618,000	152	31%	
46			1,343,000	116	29%	
47			1,304,000	113	29%	
48			474,000	40	28%	
49			1,534,000	123	27%	
50			2,220,000	171	26%	
51			1,638,000	126	26%	No PRTF
52			1,285,000	91	24%	
53			857,000	60	23%	
54			5,564,000	357	21%	Not much PRTF comp.
55			2,288,000	143	21%	
56			660,000	41	21%	
57			908,000	53	20%	
58			554,000	33	20%	No Gero.
59			2,812,000	99	12%	
60			1,858,000	63	11%	

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61	[redacted]	738,000	24	11%	
62		614,000	22	11%	
63		298,000	9	11%	
64		1,942,000	51	9%	
65		1,671,000	47	9%	
66		1,321,000	29	7%	
67		1,258,000	23	6%	
68		772,000	14	6%	No PRTF w/in 60 mi.
69		549,000	8	5%	
70		470,000	5	4%	No youth or PRTF in 30mi
71		838,000	129		No Gero.
72		279,000	-3		
73		518,000	-6		No Gero? No PRTF?
74		473,000	-10		
75		519,000	-36		
76		601,000	-44		
77		504,000	-56		No PRTF.
78		1,057,000	-59		
79		711,000	-88		
80		934,000	-126		
81		1,009,000			
82		342,000			
83		334,000			
84		1,716,000			
85		388,000			
86		428,000			
87		491,000			
88		6,371,000			
89		639,000			
90		5,946,000			
91		895,000			
92		2,142,000			
93		1,283,000	-242		
94		9,461,000			
95		354,000	-26		

NOTES
Acute need based on 30 beds per 100,000 people.
Beds over 50 mi away are NOT included in competition analyses
MI (save Detroit) consider beds w/in 30 mi
Wisconsin doesn't allow locked PRTF's

TRI-CITIES AREA - 868,000

Population Breakdown				
Johnson City	Kingsport	Boone/Morristown/Greenville	Asheville(60mi)(.25)	Total
198,000	309,000	255,000	424,000	868,000

BED CAPACITY AND NEED

# Beds Should Have	# Beds Has	# Beds Needs	% Unmet Demand	
260	143	117	45%	

ACUTE COMPETITION

Facility	Beds	Patient Group	notes	Phone
Stand-alone				
Woodridge Hospital	85			(423) 928-7111
MedSurg				
Wellmont Bristol	15	15a		(423) 844-6000
Ridgeview	15	15a		
Tacoma Regional	16	16a		(423) 636-2446
Sycamore Shoals	12	12a		(423) 542-1300

PRTF COMPETITION

Facility	Beds	Patient Group	notes	Phone
Mountain City				423-727-9898

SIMILAR PROGRAMS

Facility	Beds	Patient Group	notes	Phone

COMPETITION SCORE

Stand-alone	MedSurg	Weighted Score		
1	4	7		

HIGHER EDUCATION SCORE

ETSU

Psych	Nursing	Social Work	Enrollment	Score
2	2	2	1	7

Higher Ed Scoring Methodology: 1 pt for undergrad relevant degree and 1 pt for grad relevant degree.
1 pt for over 10k enrollment, 2 pts for over 20k enrollment.

ADDITIONAL INFORMATION

CON?	Yes
Medicaid Rate	550
Commercial Rate	650
Required Staffing Ratio	9
Staffing Cost Percentile	30%
Adult IMD Waiver?	Yes
Building Cost Percentile	20%

Note* Percentiles are relative to the other top 25 cities. The higher the percentile, the more expensive.

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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.	)	
	)	

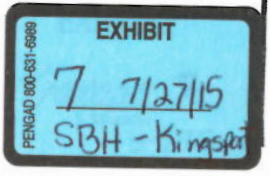
SBH-KINGSPORT, LLC'S RESPONSES TO MOUNTAIN STATES HEALTH ALLIANCE'S FIRST SET OF INTERROGATORIES

Petitioner SBH-Kingsport, LLC (hereinafter "Petitioner") hereby responds to Intervenor Mountain States Health Alliance's ("Intervenor" or "MSHA") First Set of Interrogatories as set forth herein. These Responses have been made subject to the following General Objections:

GENERAL OBJECTIONS

GENERAL OBJECTION NO. 1

Petitioner objects to Intervenor's interrogatories to the extent each seeks information protected by the attorney-client privilege or the attorney work product privilege. As used herein, the term "non-privileged" refers to documents not subject to these privileges.



GENERAL OBJECTION NO. 2

Petitioner objects to Intervenor's interrogatories to the extent that they seek the disclosure of confidential, proprietary and/or sensitive business information, commercially private data, or confidential information pertaining to third persons not parties to this action absent an appropriate protective order or agreement.

GENERAL OBJECTION NO. 3

Petitioner objects to these interrogatories insofar as they seek information that prejudices the privacy interests of Petitioner's employees, former employees, and third parties.

GENERAL OBJECTION NO. 4

Petitioner reserves all objections at any hearing, trial, or other proceeding to the admissibility of any information provided in these responses to Intervenor's Interrogatories. Petitioner submits these interrogatory responses without conceding the relevance or materiality of the subject matter of any information which may be disclosed and without prejudice to Petitioner's rights to object to the admissibility of any evidence regarding such information. Petitioner reserves the right to change or supplement any response that may subsequently appear to be incomplete or incorrect. Petitioner reserves the right to object at such later time that any response given hereunder is protected by the attorney/client privilege or any other privilege, is attorney work product or trial preparation material, and/or that the disclosure of such information was inadvertent.

GENERAL OBJECTION NO. 5

In responding to these interrogatories, Petitioner has conducted a reasonable search of those records where information requested would most likely be maintained and has made a reasonable inquiry of those persons most likely to possess information responsive thereto. To the extent Intervenor seeks Petitioner to respond further, Petitioner objects on the grounds these interrogatories are overbroad, unduly burdensome, unreasonable and oppressive.

GENERAL OBJECTION NO. 6

Petitioner objects to these interrogatories insofar as they seek information not in the possession, custody or control of Petitioner on the grounds that said requests are overbroad, unreasonable, unduly burdensome, improper, and their scope is not limited to information known to Petitioner.

GENERAL OBJECTION NO. 7

With respect to these interrogatories and objections made herein, Petitioner expressly reserves the right to supplement any such response/answer or objection. Each of the specific responses/answers and objections below is expressly made subject to the foregoing general objections.

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GENERAL OBJECTION NO. 8

Petitioner objects to the definitions and instructions accompanying the interrogatories to the extent definitions and instructions contradict, are inconsistent with, or impose any obligations beyond those required by applicable provisions of the Tennessee Rules of Civil Procedure, the local rules, or orders of this Court.

GENERAL OBJECTION NO. 9

Petitioner's specific objections to each request are in addition to the General Objections set forth in this section. These General Objections form a part of each discovery response, and they are set forth here to avoid duplication and repetition of restating them for each discovery response. The absence of a reference to a General Objection in response to a particular request does not constitute a waiver of any General Objection with respect to that discovery request. All responses are made subject to and without waiver of Petitioner's general and specific objections.

GENERAL OBJECTION NO. 10

The Petitioner objects to the definitions specified by the Intervenor for "you," "yours" and "Strategic Behavioral Health, LLC" in the Interrogatories and Requests for Production served upon it by the Intervenor. Strategic Behavioral Health, LLC and its affiliates, subsidiaries and other related entities are not, with the sole exception of the Petitioner, SBH-Kingsport, LLC, parties to this proceeding. Therefore, only the Petitioner, SBH-Kingsport, LLC, is subject to the duty to respond to the Interrogatories and Requests for Production served upon it by the Intervenor in this matter. Any Interrogatories or Requests to Produce sought by the Intervenor to be imposed on any non-parties are improper because they are not within the scope of Rule 33 or Rule 34 of the Tennessee Rules of Civil Procedure. On this basis, the Petitioner, without waiver of this general objection, has responded to the Interrogatories and Requests for Production served upon it by the Intervenor.

Responses to Interrogatories

1. *Identify each person (whether your employee or not) whom you may call as an expert* witness to testify at the hearing of this matter. With respect to each such person, state:

(a) the specific subject matter on which the witness is expected to testify;

RESPONSE: Petitioner has not yet retained an expert witness, but is in the process of doing so. Petitioner will supplement its responses to this Interrogatory once it has retained an expert.

(b) the substance of the facts, opinions and conclusions to which the witness is expected to testify;

RESPONSE: See response to Interrogatory 1.(a) above.

(c) a summary of the factual grounds for each opinion or conclusion;

RESPONSE: See response to Interrogatory 1.(a) above.)

(d) the witness's qualifications (including a list of all publications authored in the ten previous years) and a list of all other cases in which the witness has testified in the previous four years;

RESPONSE: See response to Interrogatory 1.(a) above.

(e) the compensation paid or to be paid to the witness for work on the case; and

RESPONSE: See response to Interrogatory 1.(a) above.

(f) whether any such person has prepared or provided you with a written or recorded statement or report concerning their investigation, review, or analysis of the Project.

RESPONSE: See response to Interrogatory 1.(a) above.

2. Identify each person who participated in any way in preparing the answers to these Interrogatories and the Requests for Production that MSHA has propounded and for each such person, identify the Interrogatory or Request the person participated in answering and describe the nature of the person's participation.

RESPONSE: Mike Garone and Jim Shaheen prepared and reviewed the responses to *these Interrogatories and Requests for Production. They also consulted with SBH-Kingsport, LLC's* Tennessee legal counsel with regard to all discovery. The responses to the Interrogatories have been finally reviewed and executed hereinbelow by Mike Garone.

3. With respect to the conception, origin, or initiation of the Project, state the following:

(a) The date and means by which the Project was conceived, originated, or initiated;

RESPONSE: Petitioner objects to this Interrogatory because it seeks discovery of proprietary information constituting trade secrets of the Petitioner. Without waiver of the foregoing objection, Petitioner provides the following information. In the summer of 2012, Jim Shaheen directed an SBH market analysis project to identify markets throughout the United States where the development of new psychiatric hospitals was needed. The Upper East Tennessee area was one of those so identified. The criteria utilized in this analysis are proprietary, confidential and constitute a trade secret of SBH. Thus, the Petitioner objects to the production or disclosure of these criteria or documents which utilize them. Without waiver of the foregoing objection, these documents, if produced, are stamped "Highly Confidential" subject to the Protective Order signed by the parties' respective counsel in this matter.

(b) Identify each person who participated in any way in the conception, origin, initiation, and/or development of the Project.

RESPONSE: Jim Shaheen and Mike Garone performed the tasks described in this Interrogatory.

4. For each meeting that was held concerning the decision to apply for the CON for the Project, including meetings of your employees and/or meetings between your employees and other persons, provide the following information:

(a) Identify each person who was present at the meeting;

RESPONSE: Jim Shaheen, in consultation with Mike Garone and Mike Orians, decided in October 2013 to file the CON application at issue. He also consulted with SBH's Tennessee legal counsel concerning this decision. After filing the CON application at issue in December 2013, Jim Shaheen and Mike Garone met with Mike Orians, Doug Ginn, Edward Dobbs and Chris Cosby to inform the Dobbs Management Services company executives about the filing of this CON application. This meeting with Dobbs personnel took place on January 10, 2014.

(b) The date and location of the meeting; and

RESPONSE: The meeting with Dobbs Management Services executives occurred on January 10, 2014, at the offices of Dobbs Management Services, 1000 Ridgeway Loop Road, Memphis, Tennessee 38120.

(c) The general nature of the meeting and the substance of any matters discussed at the meeting.

RESPONSE: At the January 10, 2014 meeting with the Dobbs executives, Jim Shaheen and Mike Garone discussed the SBH-Kingsport hospital project with regard to rationale, opportunity and stakeholder feedback.

5. Were any alternative facilities, services, or sites considered with respect to the Project other than the facilities, services, and site set forth in the CON application? If so, with respect to each such facility, service, or site provide the following information:

(a) Identify each person involved in the consideration or evaluation of the proposed facility, service, or site;

RESPONSE: The only alternative that was discussed for this Project was an alternative site in Kingsport, Sullivan County. The Petitioner looked at a site that is situated just off intersection of Highway 11W and I-26 at Exit 1 in Kingsport, but it was more land than the Petitioner needed and the cost was higher than the Petitioner wanted to pay.

(b) Identify each facility, service, or site and the date(s) when it was considered;

RESPONSE: The site identified above was considered in late October 2013.

(c) Describe any written evaluation, consideration, or determination of the proposed facility, service, or site; and

RESPONSE: Jim Shaheen and Mike Garone decided to utilize the site set forth in the CON project at issue; the selected site was less expensive and smaller.

(d) Summarize why the facilities, services, and site set forth in the CON application were chosen instead of the alternatives.

RESPONSE: The selected site set forth in the CON application at issue was less expensive and the right size for the Project.

6. With respect to the area to be served by the Project:

(a) Describe with particularity the area to be served;

RESPONSE: The service area for this Project is comprised of Hawkins and Sullivan counties in Tennessee, and Wise, Scott and Lee counties in Virginia.

(b) State the date and means by which the determination of the service area was made;

RESPONSE: The determination of the service area was made by Jim Shaheen and Mike Garone in October 2013, prior to the filing of the CON application at issue.

(c) Identify each person who assisted or participated in any way in determining the service area;

RESPONSE: Jim Shaheen and Mike Garone participated in this determination, and they consulted with SBH's Tennessee counsel regarding the identification of the service area.

(d) Identify with particularity any alternative service areas that were considered for the Project; and

RESPONSE: Prior to filing the CON application at issue, Mike Garone considered the entire northeast Tennessee and southwest Virginia area. He determined on further analysis that the greatest need for the Project lay in the counties identified as the Project's service area in the CON application at issue.

(e) Provide a detailed description of every written evaluation, analysis, study, and/or review of any type that you performed, caused to be performed, reviewed, and/or obtained concerning the proposed service area or any alternative service areas.

RESPONSE: In addition to Mike Garone's analysis of service area issues and the summer 2012 market identification analysis, Mike Garone and Jim Shaheen provided a report based on prior data from the summer 2012 market need analysis as to the Kingsport, Tennessee area to the Dobbs Management Services Company personnel on January 10, 2014.

7. Identify every person who participated in drafting or providing information used in the application for the CON or in the responses to the supplemental questions in support of such application. For each person identified, explain his or her involvement and identify those questions he or she assisted in answering or for which he or she provided information. Persons should be identified whether they were involved in the actual preparation or writing of the application or responses, or whether they supplied information for or reviewed drafts of the application or responses, or provided other assistance or advice relating to the preparation of the application or responses.

RESPONSE: The Petitioner objects to this Interrogatory because it seeks discovery of privileged information covered by the attorney/client privilege. Without waiver of the foregoing objection, Petitioner responds as follows: Mike Garone was involved with all areas of the application; Jim Shaheen was involved with all aspects of the application; Doug Ginn was involved with all aspects of the application; and James Cagle was involved with financial aspects of the application. Mike Garone and Jim Shaheen also consulted with the Petitioner's legal counsel regarding various aspects of the CON application and the HSDA filing process.

Other individuals who assisted in preparation of aspects of the CON application include: Laura Miller and David Benham of the architecture firm LS3P, who assisted with the drawings and architectural issues; Thomas Construction Group employees Chris Reid and Jill Sullivan, who assisted with construction and construction cost issues; Steve Taylor, assistant vice-president of Fifth Third Bank, who provided the financing letter; and Mike Orians and Linda Harrington of Dobbs Management Services, Inc., who assisted with corporate documentation issues.

8. With respect to the projected patient volumes set forth in your CON application, provide the following information:

(a) Identify each person who participated in generating, was consulted about, or provided information in connection with the proposed utilization rates; and

RESPONSE: Mike Garone consulted with Jim Shaheen and the other individuals as set forth in the produced spreadsheet concerning utilization issues with the Project.

(b) Identify any written studies, projections, pro formas, estimates, or analyses of any type supporting the utilization rates set forth in the application and/or which were consulted or relied upon in generating those rates.

RESPONSE: Utilization rate projections were not driven by formal written studies, estimates or analyses. A pro forma projection leading to the Projected Data Chart data in the CON application was developed and is being produced. The projected utilization rates set forth therein were developed by Mr. Garone based on data analysis based on population/bed need formula; projections made based off of number of service area stakeholders expressing overwhelming need for additional services as well as difficulty accessing services because of bed unavailability; Sullivan County Sheriff's department Mental Health transports; and Youth Villages Out of Area Percentages. SBH built its projected utilization in this Project 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.

9. Describe in detail all of the psychiatric programs and services that you or any physician or physician group will make available as part of the Project.

RESPONSE: As set forth in the CON application and supplemental responses herein, the Project will make available the following psychiatric programs and services; inpatient acute psychiatric hospitalization, all ages; medically managed detoxification, adult; partial psychiatric hospitalization, all ages; intensive psychiatric outpatient services, all ages.

10. For each program or service identified in your response to Interrogatory No. 9, provide the average length of stay for patients enrolled in the same (or similar) programs or services at each of the other Strategic Behavioral Health, LLC locations.

RESPONSE: The average length of stay for the categories of inpatient psychiatric services provided by SBH at its current facilities is as follows: Acute Adult - 8.9 days; Acute Adult Chem Dep - 9.9 days; Acute Child - 9.5 days; Acute Geropsych - 9.2 days.

11. With respect to inpatient psychiatric admissions, provide annual projections for each of the first three years of operation of the Project for the following categories of information:

(a) Number of Patients;

RESPONSE: See also Responses to Interrogatory No. 29 below. Year 1 - 946; Year 2 - 1859; Year 3 - projections have been done only through year 2 of operations.

(b) Gross Revenue;

RESPONSE: Year 1 - 13,728,600; Year 2 - 26,983,800; Year 3 - projections have been done only through year 2 of operations.

(c) Net Reimbursement;

RESPONSE: Year 1 - 5,207,385; Year 2 - 10,235,205; Year 3 - projections only through year 2 of operations.

(d) Percentage of projected patients in each of the following payor categories:

(i) Commercial Insurance - Year 1 - 35%; Year 2 - 35%; Year 3 - projections only through year 2 of operations.

(ii) TennCare/Medicaid - Year 1 - 38%; Year 2 - 38%; Year 3 - projections only through year 2 of operations.

(iii) Medicare - Year 1 - 20%; Year 2 - 20%; Year 3 - projections only through year 2 of operations.

(iv) Self-Pay - Year 1 - 5%; Year 2 - 5%; Year 3 - projections only through year 2 of operations.

(v) Charity/Indigent - Year 1 - 5; Year 2 - 5; Year 3 - projections only through year 2 of operations.

(vi) Other; and - Year 1 - 2; Year 2 - 2; Year 3 - projections only through year 2 of operations.

(e) Percentage of projected patients by geographic county and state of origin.

RESPONSE: The Petitioner objects to this interrogatory because it asks for projections *not made or performed by the Petitioner, and thus not in the Petitioner's possession, custody, or control.* Without waiver of the foregoing objection, Petitioner states as follows: Neither Mr. Garone nor Mr. Shaheen, nor anyone else, performed this analysis for the Project. No such projections were made.

12. With respect to the estimated distribution of revenues by payor source contained in your application, provide the following information:

(a) Identify any written analyses of projected revenues by payor source at the Project;

RESPONSE: A spreadsheet of projected revenues by payor source was developed by Mr. Garone; it is being produced.

(b) Identify all persons who were involved in preparing any such analyses (written or otherwise) and/or who provided information for such analyses.

RESPONSE: Doug Ginn, Jim Shaheen and Mike Garone provided information for the spreadsheet specified in the response to Interrogatory No. 12(a) above.

13. With respect to any consideration, analysis, or determination of the effect of the Project on Woodridge Hospital or any other existing provider, whether such consideration, analysis, or determination was conducted before or after the filing of the CON application, state the following:

(a) The date and a general description of each such consideration, analysis, or determination;

RESPONSE: Prior to the filing of the CON application, Mike Garone analyzed the potential effect of the Project on Woodridge. He continued to do so while the CON application at issue was being deemed complete and also in preparation for the HSDA meeting on June 25, 2014.

(b) Identify each person who assisted or participated in any way in such consideration, analysis, or determination; and

RESPONSE: Mr. Garone carried out the analysis on his own, although he also consulted with Jim Shaheen and legal counsel for SBH on these issues.

(c) Identify each document setting forth, referencing or discussing the results of the consideration, analysis, or determination.

RESPONSE: The Petitioner objects to this Interrogatory because it seeks discovery of privileged information covered by the attorney/client privilege. Without waiver of the foregoing objection, Petitioner responds as follows: Mr. Garone utilized the available JAR data for Woodridge and other facilities in carrying out his analysis. In addition to the CON application and supplemental responses, PowerPoint slides he prepared for the presentation of the CON application at issue at the June 25, 2014 meeting of the HSDA discuss the results of his analysis.

14. With regard to any consideration, analysis, or determination as to the special needs of the population to be served by the Project, including accessibility to consumers, particularly women, racial and ethnic minorities, and low-income groups, whether such consideration, analysis, or determination was conducted before or after the filing of the CON application, state as follows:

(a) The date and a general description of the nature of each such consideration, analysis, or determination;

RESPONSE: The matters covered by this Interrogatory were addressed and analyzed by Mr. Garone and Mr. Shaheen during the preparation of the CON application at issue, responses to HSDA staff requests for supplemental information, and in preparation for the June 25, 2014 HSDA meeting.

(b) Identify each person who assisted or participated in any way in such consideration, analysis, or determination; and

RESPONSE: Mr. Garone and Mr. Shaheen consulted with legal counsel for SBH in carrying out the consideration and analysis of the issues raised by this Interrogatory.

(c) Identify each document setting forth, referencing or discussing the results of the consideration, analysis, or determination.

RESPONSE: The Petitioner objects to this Interrogatory because it seeks discovery of privileged information covered by the attorney/client privilege. Without waiver of the foregoing objection, Petitioner responds as follows: the consideration and analysis of the issues addressed by this interrogatory are set forth in the CON application at issue, in the responses to the HSDA's requests for supplemental information, and in the PowerPoint presentation prepared by Mr. Garone for use at the June 25, 2014 HSDA Meeting.

15. With regard to any consideration, analysis, or determination as to the extent to which the Project will serve TennCare, Medicare, Medicaid, and/or medically indigent patients, whether such consideration, analysis or determination was conducted before or after the filing of the CON application, state as follows:

(a) The date and a general description of the nature of each such consideration, analysis, or determination;

RESPONSE: The matters covered by this Interrogatory were addressed and analyzed by Mr. Garone and Mr. Shaheen during the preparation of the CON application at issue, in responding to the requests for supplemental information from the HSDA staff and in the Powerpont presentation prepared by Mr. Garone for use at the June 25, 2014 HSDA meeting.

(b) Identify each person who assisted or participated in any way in such consideration, analysis, or determination; and

RESPONSE: Mr. Garone and Mr. Shaheen also consulted with legal counsel for SBH in carrying out the consideration and analysis of the issues raised by this Interrogatory.

(c) Identify each document setting forth, referencing or discussing the results of the consideration, analysis, or determination.

RESPONSE: The Petitioner objects to this Interrogatory because it seeks discovery of privileged information covered by the attorney/client privilege. Without waiver of the foregoing objection, Petitioner responds as follows: the consideration and analysis of the issues addressed by this interrogatory are set forth in the CON application at issue, in the responses to the HSDA's requests for supplemental information and in the Powerpont presentation prepared by Mr. Garone for use at the June 25, 2014 HSDA meeting.

16. With regard to any consideration, analysis, or determination as to the relationship of the Project to existing facilities in the service area proposed by the application, whether such consideration, analysis, or determination was conducted before or after the filing of the CON application, state as follows:

(a) The date and a general description of the nature of each such consideration, analysis, or determination;

RESPONSE: *There is only one such existing facility in the Project's proposed service area: a 12-bed adult and geropsychiatric unit at Bristol Regional Medical Center. This unit, unlike the proposed project, does not appear to serve child and adolescent patients or have any dedicated chemical dependency beds. Prior to the filing of the CON application at issue, Mike Garone considered and analyzed the matters covered by this Interrogatory. He also considered and analyzed these issues in preparation for the presentation of the CON application at issue to the HSDA at its June 25, 2014 meeting.*

(b) Identify each person who assisted or participated in any way in such consideration, analysis, or determination; and

RESPONSE: Mr. Garone consulted on these issues covered by this Interrogatory with Jim Shaheen and legal counsel for SBH.

(c) Identify each document setting forth, referencing or discussing the results of the consideration, analysis, or determination.

RESPONSE: The Petitioner objects to this Interrogatory because it seeks discovery of privileged information covered by the attorney/client privilege. Without waiver of the foregoing objection, Petitioner responds as follows: in addition to the CON application at issue and SBH's responses to HSDA staff requests for additional information, documents responsive to this Interrogatory include: PowerPoint slides prepared by Mr. Garone for use at the June 25, 2014 HSDA meeting, and Mr. Garone's analyses of the various reports on this Project by the Tennessee Department of Mental Health and Substance Abuse Services ("MHSAS").

17. With regard to any consideration, analysis, or determination as to the relationship of the Project to existing facilities in the service area to include the Tennessee counties of Hawkins, Green, Washington, Carter and Johnson and the Virginia counties of Wise, Scott and Lee, whether such consideration, analysis, or determination was conducted before or after the filing of the CON application, state as follows:

(a) The date and a general description of the nature of each such consideration, analysis, or determination;

RESPONSE: SBH objects to this interrogatory -- it misstates the service area utilized by SBH in the CON application at issue: SBH's proposed service area did not include the Tennessee counties of Green, Washington, Carter and Johnson, but did include the non-listed Tennessee county of *Sullivan. SBH did not perform the analysis set forth in this Interrogatory; thus, said analysis is not in* SBH's possession, custody or control.

(b) Identify each person who assisted or participated in any way in such consideration, analysis, or determination; and

RESPONSE: SBH objects to this interrogatory -- it misstates the service area utilized by SBH in the CON application at issue: SBH's proposed service area did not include the Tennessee counties of Green, Washington, Carter and Johnson, but did include the non-listed Tennessee county of Sullivan. The analysis described in this Interrogatory was not performed by SBH; thus, no person assisted or participated in it.

(c) Identify each document setting forth, referencing or discussing the results of the consideration, analysis, or determination.

RESPONSE: SBH objects to this interrogatory -- it misstates the service area utilized by SBH in the CON application at issue: SBH's proposed service area did not include the Tennessee counties of Green, Washington, Carter and Johnson, but did include the non-listed Tennessee county of Sullivan. The analysis described in this Interrogatory was not performed by SBH; thus, no responsive document exists.

18. With regard to any consideration, analysis, or determination of the patient volume trends for inpatient psychiatric patients offered by other already existing healthcare providers in the service area as defined in the application, whether such consideration, analysis, or determination was conducted before or after the filing of the CON application, state as follows:

(a) The date and a general description of the nature of each such consideration, analysis, or determination;

RESPONSE: Prior to and during the drafting of the application at issue and the preparation of responses to requests for supplemental information from the HSDA staff, Mike Garone considered and analyzed the patient volume issues set forth in this Interrogatory for BRMC, the single other provider of inpatient psychiatric services in the Project's service area. He also did so in preparing his PowerPoint presentation for the June 25, 2014 HSDA meeting.

(b) Identify each person who assisted or participated in any way in such consideration, analysis, or determination; and

RESPONSE: Mr. Garone carried out the described consideration and analysis, and consulted with Jim Shaheen and legal counsel for SBH regarding the same.

(c) Identify each document setting forth, referencing or discussing the results of the consideration, analysis, or determination.

RESPONSE: The Petitioner objects to this Interrogatory because it seeks discovery of privileged information covered by the attorney/client privilege. Without waiver of the foregoing objection, Petitioner responds as follows: the results of the consideration, analysis and determination specified in this Interrogatory are set forth in the CON application at issue and in SBH's responses to the requests for additional information if received from HSDA staff. Other responsive documents include PowerPoint slides Mr Garone prepared for use at the June 25, 2014 HSDA meeting.

19. With regard to any consideration, analysis, or determination of the patient volume trends for inpatient psychiatric patients offered by other already existing healthcare providers in the service area to include the Tennessee counties of Hawkins, Green, Washington, Carter and Johnson and the Virginia counties of Wise, Scott and Lee, whether such consideration, analysis, or determination was conducted before or after the filing of the CON application, state as follows:

(a) The date and a general description of the nature of each such consideration, analysis, or determination;

RESPONSE: SBH objects to this interrogatory -- it misstates the service area utilized by SBH in the CON application at issue: SBH's proposed service area did not include the Tennessee counties of Green, Washington, Carter and Johnson, but did include the non-listed Tennessee county of Sullivan. SBH did not perform the consideration, analysis or determination set forth in this Interrogatory.

(b) Identify each person who assisted or participated in any way in such consideration, analysis, or determination; and

RESPONSE: SBH objects to this interrogatory -- it misstates the service area utilized by SBH in the CON application at issue: SBH's proposed service area did not include the Tennessee counties of Green, Washington, Carter and Johnson, but did include the non-listed Tennessee county of Sullivan. SBH did not perform the consideration, analysis or determination set forth in this Interrogatory. Thus, no person participated in it.

(c) Identify each document setting forth, referencing or discussing the results of the consideration, analysis, or determination.

RESPONSE: SBH objects to this interrogatory -- it misstates the service area utilized by SBH in the CON application at issue: SBH's proposed service area did not include the Tennessee counties of Green, Washington, Carter and Johnson, but did include the non-listed Tennessee county of Sullivan. SBH did not perform the consideration, analysis or determination set forth in this *Interrogatory. Thus, no responsive documents exist.*

20. With regard to any consideration, analysis, or determination as to whether the projected costs of completing the Project are reasonable, whether such consideration, analysis, or determination was conducted before or after the filing of the CON application, state as follows:

(a) The date and a general description of the nature of each such consideration, analysis, or determination;

RESPONSE: SBH has extensive experience in carrying development budgets for inpatient psychiatric hospital projects at the hospitals it has developed. It based its projected costs in the CON application at issue on that experience. Items considered included, but were not limited to, the price of the land for the project, soft construction costs, FFE, hard construction costs, permitting fees, architectural fee, engineering fees, land due diligence, and operating losses during the build year for the Project.

(b) Identify each person who assisted or participated in any way in such consideration, analysis, or determination; and

RESPONSE: Mike Garone, Jim Shaheen, Laura Miller, and Chris Reid participated in these matters.

(c) Identify each document setting forth, referencing or addressing the results of the consideration, analysis, or determination.

RESPONSE: The projected Development Budget for the Project is such a document and is being produced.

21. With regard to any consideration, analysis, determination, projection, or forecast of anticipated revenue from the Project, whether such consideration, analysis, or determination was conducted before or after the filing of the CON application, state as follows:

(a) The date and a general description of the nature of each such consideration, analysis, or determination;

RESPONSE: Prior to and during the preparation of the CON application at issue and the responses to requests for supplemental information from the HSDA staff, Mike Garone developed a proforma spreadsheet which included projected revenues for the build year and years one and two of the project's operation. It is being produced. The version of this spreadsheet presented to the SBH stakeholders on January 10, 2014, is also being produced.

(b) Identify each person who assisted or participated in any way in such consideration, analysis, or determination; and

RESPONSE: Mike Garone, Jim Shaheen and Doug Ginn had input into the referenced spreadsheet.

(c) Identify each document setting forth, referencing or addressing the results of the consideration, analysis, or determination.

RESPONSE: In addition to the spreadsheet itself, the PowerPoint presentation Mike Garone made to the Dobbs Management Company interest holders on January 10, 2014 made reference to the spreadsheet. That PowerPoint presentation is being produced.

22. With regard to any consideration, analysis, or evaluation of the positive or negative effects attributed to duplication or competition resulting from the Project, whether such consideration, analysis, or determination was conducted before or after the filing of the CON application, state as follows:

(a) The date and a general description of the nature of each such consideration, analysis, or determination;

RESPONSE: In preparing the CON application at issue in December 2013, and January 2014, and in responding to supplemental requests for information from the HSDA staff, Mike Garone considered, analyzed and evaluated the positive or negative effects attributed to duplication or completion resulting from the project. He also did so in preparation for the presentation of the CON application at issue at the June 25, 2014 HSDA meeting. He also did so in June 2014 in response to the multiple reports on the CON application at issue prepared by the Tennessee Department of Mental Health and Substance Abuse Services ("MHSAS").

(b) Identify each person who assisted or participated in any way in such consideration, analysis, or determination; and

RESPONSE: Mr. Garone was assisted in this consideration, analysis, and evaluation by Jim Shaheen. He also consulted on these matters with SBH's Tennessee legal counsel.

(c) Identify each document setting forth, referencing or addressing the results of the consideration, analysis, or determination.

RESPONSE: The Petitioner objects to this Interrogatory because it seeks discovery of privileged information covered by the attorney/client privilege. Without waiver of the foregoing objection, Petitioner responds as follows: the documents which set forth, refer to, or address the results of this consideration, analysis or determination include the CON application at issue and the responses to HSDA staff supplemental requests for additional information, as well as the PowerPoint presentation prepared by Mr. Garone for presentation at the June 25, 2014 HSDA meeting.

23. With regard to any consideration, analysis, or evaluation of the human resources required by the Project and the availability and accessibility of such human resources, whether such consideration, analysis, or determination was conducted before or after the filing of the CON application, state as follows:

(a) The date and a general description of the nature of each such consideration, analysis, or determination;

RESPONSE: In preparing the CON application at issue in December 2013, and January 2014, and in responding to supplemental requests for information from the HSDA staff, Mike Garone considered, analyzed and evaluated the human resources required by the Project and the availability and accessibility of such human resources. He also did so in preparation for the presentation of the CON application at issue at the June 25, 2014 HSDA meeting. He also did so in June 2014 in response to the multiple reports on the CON application at issue prepared by the Tennessee Department of MHSAS.

(b) Identify each person who assisted or participated in any way in such consideration, analysis, or determination; and

RESPONSE: Mr. Garone has assisted in this consideration, analysis, and evaluation by Jim Shaheen. He also consulted on these matters with SBH's Tennessee legal counsel.

(c) Identify each document setting forth, referencing or addressing the results of the consideration, analysis, or determination.

RESPONSE: The Petitioner objects to this Interrogatory because it seeks discovery of privileged information covered by the attorney/client privilege. Without waiver of the foregoing objection, Petitioner responds as follows: the documents which set forth, refer to, or address the results of this consideration, analysis or determination include the CON application at issue and the responses to HSDA staff supplemental requests for additional information, as well as the PowerPoint presentation prepared by Mr. Garone for presentation at the June 25, 2014 HSDA meeting. The January 10, 2014 PowerPoint presentation Mr. Garone made to the Dobbs Management stakeholders also references these issues.

(d) Identify the number of physicians, by specialty, who will be employed by the Project.

RESPONSE: The Project will not employ any physicians. Physicians who work at the Project will be independent contractors.

24. State all pricing assumptions relied on in determining projected revenues for the Project.

RESPONSE: The Petitioner utilized the following per day projected reimbursement rates for the respective payors. Medicaid - $550; Medicare - $750; Commercial - $650; Other - $600.

25. Are there any statements or information in the CON application which you no longer believe to be accurate or complete? If so, identify the statements or information that you no longer believe to be accurate or complete and state the basis for your belief.

RESPONSE: Yes, as set forth herein. While, as set forth elsewhere in these Interrogatory Responses, we believe the projections of patient days in Year 1 and Year 2 of the Project remain accurate, further analysis of SBH data cause us to believe now that the average length of stay at the Project will be approximately 9.2 days and that admissions in Year 1 will be 946, and for Year 2 admissions will be 1,859. Related data is found in the SBH responses to Question 23 of the HSDA staff's requests for supplemental information.

26. Identify all persons who currently have any equity, ownership, financial rights or governance rights in SBH and/or any other associated entities, including, but not limited to, Strategic Behavioral Health, LLC.

RESPONSE: The following persons or entities own interests in SBH-Kingsport, LLC and Strategic Behavioral Health, LLC: Jim Shaheen, Doug Ginn, Chris Crosby, Mike Orians, Bill Lawson, John Hull Dobbs, Jr. 1985 Trust, John Hull Dobbs Grantor Trust, Edward J. Dobbs Grantor Trust, Edward J. Dobbs 2009 Trust, Caroline Kirby Dobbs 1985 Trust, Caroline Kirby Dobbs Floyd 2012 Trust, Juliette C. Dobbs 1985 Trust, and Jackson Dobbs Allen 2012 Trust.

27. Identify all persons, other than your employees or the HSDA, to whom you have provided information about or whom you have directly or indirectly asked to support the Project.

RESPONSE: Mike Garone has identified the following list of persons respective to this Interrogatory:

Alexis Carson	Doug Messer	Judy Salyer	Randall Jessee
Amy Gregory	Erika Phillips	Julie Johnson	Richard Baxter
Andy Kitzmiller	Gary Parsons	Justin Quillin	Robin Foreman
Angela Jackson	Glenda Collins	Kandi Shearer	Scott Fink
Brenda Robinette	Greg Jones	Kelie Gambrel	Scott Flemmer
Brian Cinnamon	Hal Elliott	Kristy Beach-Callebs	Spring Thompson
Callie Faircloth	Harold Leonard	Lenore Kilgore	Sue Lindenbusch
Cheri Baird	James Woods	Lisa Christian	Sybil Smith
Chris Beach	Janie Snyder	Lois Agnew	Taylor Scott
Chuck Thompson	Jason Bellamy	Luanne McMurray	Teresa Kidd

Clay Walker	Jason Smith	Lucretia Sanders	Todd Jablonski
Dale Phipps	Jeff Fleming	Lyle Ailshie	Troy Funkhouser
Daniel Boyd	Jeff Thacker	Mark Johnson	Vickie Brown
David Quillin	Jessica Woodward	Mary Shelton	Wandaleen Adams
Dawn Puster	Jill McCarley	Michele Gamble	Wayne Anderson
Deborah Fahr	Jill McCarley	Michele Moser	
Denise Tynes	John Arredondo	Misty Keller	
Dennis Phillips	John Campbell	Mitch Perry	
Donna Souder	John Ferguson	Paul Stanton	
Dory Creech	John Puckett	Preston Adams	

28. If you contend that the Project is "necessary to provide needed health care in the area to be served," as required in Tenn. Code Ann. § 68-11-1609(b), or satisfies any or all of the criteria contained in HSDA Rule 0720-11.-01(1), then:

(a) *State the factual basis for your contention;*

Response: The Petitioner contends that the Project is necessary to provide needed healthcare in the area to be served, as required by T.C.A. § 68-11-1609(b), and that it satisfies all of the criteria contained in HSDA Rule 0720-11-.01(1). The bases for this contention are set forth immediately below.

The Petitioner contends that the Project is "necessary to provide needed healthcare in the area to be served, as required in T.C.A. § 68-11-1609(b), and that the Project satisfies all of the criteria set forth in HSDA Rule 0720-11-.01(1). The factual bases for these contentions the Petitioner makes in this answer to this Interrogatory are set forth below.

1. In addition to the comments made in support of this Project and the CON application at issue in the Petitioner's responses to requests for supplemental information from the HSDA staff, application of the Tennessee State Health Plan, the *Guidelines for Growth*, indicates that this Project is necessary, is required by the statute and rules cited in the Interrogatory. On the basis of the *Guidelines for Growth*'s 30 beds per 100,000 population, there is a need in the service area described in the application for *92.8* psychiatric beds. See page 3 of the staff summary of the CON application. There is a supply of only 12 beds in the proposed service area, located at Bristol Regional Medical Center. This means that there is a net need for psychiatric beds in the service area, as determined by the *Guidelines for Growth* formula, of 80.8 beds. The Project proposes to *establish only 72 psychiatric hospital beds in the service area. Therefore, the Project is* needed and will not even satisfy the need for initial psychiatric beds in the service area.

2. The state of Tennessee closed the Lakeshore Mental Health Institute in Knox County, Tennessee in 2012. This institution, which had been licensed for 160 beds, had Hawkins and Sullivan County in its service area.

3. Mountain States Health Alliance, the Intervenor in this matter, closed Indian Path Pavilion in Kingsport, in 2009. Indian Path Pavilion had 61 psychiatric beds at the time; nine of these were moved to Woodridge, and the remainder were closed by MSHA, and have remained closed. Therefore, there was a net loss in the service area of 52 beds from the closure of Indian Path Pavilion.

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 for Growth* psychiatric bed need formula, there will remain a need for 68 additional psychiatric beds within the applicant's two-state service area.

5. Woodridge's "two-state service area" described above includes, but is not limited to, all of the counties claimed by the applicant in the project's at issue service area, with the exception of Lee County, Virginia. Therefore, the HSDA staff recognized that there would be a significant continuing need for beds in the northeast Tennessee southwest Virginia service area after the closure of Indian Path Pavilion by MSHA.

6. Furthermore, other inpatient psychiatric hospital beds in the service area were closed by Indian Path Medical Center in either the late 1990s or the first decade of the 21st Century. Outside the service area, but elsewhere in East Tennessee, in 2009, Peninsula Psychiatric Hospital in Blount County also closed 145 psychiatric hospital beds.

7. The documents supporting the issuance of interim final rule by the U.S. Department of Health and Human Services concerning the applicability of the Mental Health Parity and the Addiction Equity Act of 2008, as further expanded by the Affordable Care Act to apply to Medicaid non-managed care benchmark and benchmark equivalent state plan benefits, also support the conclusion that there is a significant need for additional psychiatric hospital beds in the service area proposed by the applicant.

8. There is a complete absence of child and adolescent service beds currently in the applicant's proposed service area; the 12 beds at Bristol Regional Medical Center do not report providing child adolescent services on the BRMC JAR. In fact, in the entire upper east Tennessee southwest Virginia area, there are only 12 dedicated child adolescent beds, all of which are located in Woodridge Hospital in Washington County, Tennessee.

9. Several of the counties in the service area proposed by SBH report, according to MSHA's own data, that chemical dependency services and behavioral health services are within the top five or six healthcare needs in their areas.

10. As a number of witnesses testified at the June 25, 2014 HSDA meeting, there are significant problems in access to services, especially for children and adolescents, at Woodridge Psychiatric Hospital for individuals in the proposed service area.

11. Dr. Hal Elliott, an associate professor of psychiatry at East Tennessee State University's College of Medicine stated in his June 24, 2014 letter to Melanie Hill, that there was a "huge need for psychiatric services in the Tri-Cities area" and that SBH's "proposed clinical services will not only benefit the area in terms of services and training offering, they will do so without significant overlap or competition of services offered at Woodridge 30 minutes away in Johnson City."

12. Dr. Jill McCarley, a psychiatrist who formerly practiced at Woodridge Psychiatric Hospital, also there was significant demand present in the service area for inpatient psychiatric that the existing providers in east Tennessee haven't been able to meet. This is particularly true for child and adolescent services.

13. The National Association of Psychiatric Health Systems reported in its 2011 annual survey, published in 2012, that in 2010 one in five adults experienced mental illness in the past year, and 5% of the adult population lived with serious mental illness in the past year. Therefore, the applicant asserts that this is true for the population in its proposed service area as well.

14. As noted by Chairman Johnson of the HSDA at the June 25, 2014 meeting, the Washington County, Virginia psychiatric facility, owned by Wellmont, was basically nearly full when he personally checked on its utilization level. Therefore, as he indicated, the presence of that 28-bed psychiatric unit outside the proposed service area is not a significant factor in alleviating the need within the service area.

15. The applicant also cites as the basis for its assertion that there is significant need for 72 psychiatric hospital beds in the proposed service area the stakeholder comments recorded by Mike Garone in his spreadsheets listing the results of his contacts with various stakeholders in the service area. These are being produced in these discovery responses as requested.

16. The Project's service area set forth in the CON application is reasonable and proper. When HCA filed a previous CON application, CN9606-042, involving Indian Path Pavilion, it described its primary service area as Hawkins and Sullivan Counties in Tennessee, and Wise, Scott and Lee Counties in Virginia. Similarly, MSHA itself has described the service area of its Kingsport, Tennessee acute hospital, Indian Path Medical *Center, as Hawkins and Sullivan Counties in Tennessee, and Wise, Scott, Lee and* Dickenson Counties in Virginia. See MSHA 2012 Social Responsibility Plan, p. 175.

(b) Identify each person who has knowledge supporting this contention and describe the general nature of each such person's knowledge;

RESPONSE: Mike Garone and Jim Shaheen have knowledge that support this contention. This knowledge extends to all the factors listed. Supporters of the Project who filed letters of support of the Project at the June 25, 2014 HSDA meeting also have such knowledge. Outside counsel for SBH also has such knowledge. Legal counsel for Petitioner also has such knowledge.

(c) Provide a detailed description of each projection, evaluation, estimate, review or study of any type which you contend demonstrates that the Project is "necessary to provide needed health care in the area to be served";

RESPONSE: The projections, evaluations, estimates and reviews demonstrating that the Project is necessary to provide needed healthcare in the area to be served are set forth in the CON application at issue, the responses to requests for supplemental information from the HSDA staff, and in the PowerPoint presentation prepared by Mr. Garone for presentation at the HSDA meeting on June 25, 2014. The HSDA staff report on the application at issue and on CON application CN0908-043 also demonstrate that the Project is necessary to provide needed health care in the area to be served, as do the area stakeholder comments recorded by Mr. Garone in the documents being produced.

(d) Identify each person who assisted or participated in any way in obtaining, preparing or supplying any information included in any such projection, evaluation, estimate, review, or study.

RESPONSE: Mark Garone, and Jim Shaheen participated in the efforts listed in this Interrogatory. Mr. Garone also consulted with SBH's outside legal counsel on these issues.

29. If you contend that the Project can be "economically accomplished and maintained," as required in Tenn. Code Ann. § 68-11-1609(b), or satisfies any or all of the criteria contained in HSDA Rule 0720-11.-01(2), then:

(a) State the factual basis for your contention;

RESPONSE: The Project can be economically accomplished and maintained, as required by T.C.A. § 68-11-1609(b). The Project also satisfies all of the criteria listed in HSDA Rule *0720-11-.01(2). As the Department of Mental Health and Substance Abuse Services ("MHSAS")* repeatedly found in the three reports it generated on this Project, the Project has reasonable costs and can be completed in a timely manner. Furthermore, adequate funds are available for the development of the Project through the assistance of Dobbs Management Services, LLC, bank credit lines, and cash flows from existing operations. As the MHSAS reports indicate, adequate funding is available and projected gross revenues in Years 1 and 2 appear to be sufficient to ensure the economic feasibility of the Project. Furthermore, the Project will participate in state and federal revenue programs. As noted in the application, communications with the Tennessee Bureau of TennCare have led the applicant to believe that it will be able to participate in the TennCare program, not only for children and adolescents, but also *for adults even though it is classified as an institute of mental disease (IMD). At the MHSAS reports* indicate, there are no other free-standing psychiatric hospital facilities in the proposed service area. Therefore, sharing the facilities is not likely to occur or be available to the applicant in the service area. In order to meet the needs for inpatient psychiatric facilities in this service area, there are no alternatives

other than to construct a new facility in Kingsport, in Sullivan County, in order to serve the five counties of the service area.

Even though the projected average length of stay for the Project will be (as earlier set forth above) an ALOS of 9.2 days, the Project will be economically feasible. The applicant projects that the number of patient days will remain the same as projected in Years 1 and 2. However, due to the alterations of projected ALOS, the number of admissions is projected to rise in Year 1 to approximately 946 and in 1,859 in Year 2. As noted, the number of patient days each year for the first two years of operation, 8,700 patient days in Year 1 and 17,100 patient days in Year 2 remain as originally projected in the certificate of need application and its supplements.

SBH built its projected utilization in this Project 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.

(b) Identify each person who has knowledge supporting this contention and describe the general nature of each such person's knowledge;

RESPONSE: Mike Garone and Jim Shaheen have the knowledge specified in this Interrogatory, as does Michael Orians, the vice president and treasurer of Strategic Behavioral Health, LLC. Legal counsel for Petitioner also has such knowledge.

(c) Provide a detailed description of each projection, evaluation, estimate, review, or study of any type which you contend demonstrates that the Project can be "economically accomplished and maintained"; and

RESPONSE: The "Project Cost Chart" and "Projected Data Chart" in the CON application at issue, the CON application itself, and the responses to requests for supplemental information from the HSDA staff demonstrate that the Project can be economically accomplished and maintained, as do the HSDA staff summary and the MHSAS reports.

(d) Identify each person who assisted or participated in any way in obtaining, preparing, or supplying any information included in any such projection, evaluation, estimate, review, or study;

RESPONSE: The requested individuals are: Mike Garone, Jim Shaheen and Mike Orians.

30. If you contend that the Project will "contribute to the orderly development of adequate and effective health care facilities and/or services" as required in Tenn. Code Ann. § 68-11-1609(b), then:

(a) State the factual basis for your contention;

RESPONSE: The Project will contribute to the orderly development of adequate and effective healthcare facilities and/or services as required by T.C.A. § 68-11-1609(b). It will also satisfy all the criteria set forth in HSDA Rule 0720-11-.01(3). As noted in the application and supplementals, there is no significant competition for this Project in the service area proposed, other than the 12 beds located at Bristol Regional Medical Center in Bristol, Tennessee. Therefore, there is no negative effect due to duplication or competition arising by this Project. The relationship of the Project to the existing healthcare system, such as satisfaction of the requirements of the *Guidelines for Growth* and TennCare involvement, are also indications that it contributes to the orderly development of adequate and effective healthcare facilities and/or services. The applicant has already had discussions with schools of nursing and physicians in Sullivan County with regard to physicians in east Tennessee regarding assisting the medical school at ETSU and the nursing programs at local area colleges regarding training opportunities for their students. The applicant is confident of the availability and accessibility of human resources required by the proposal, as set forth in the application and supplemental responses. Representatives of the applicant have already been approached by healthcare professionals in east Tennessee seeking employment at the Project upon its completion. The Project will satisfy all applicable governmental professional standards; Strategic Behavioral Health, LLC has significant experience in developing and operating numerous inpatient psychiatric facilities in other states, and will utilize that experience and those skills in developing and operating the Project.

(b) Identify each person who has knowledge supporting this contention and describe the general nature of each such person's knowledge;

RESPONSE: *Mike Garone and Jim Shaheen have knowledge supporting this contention* generally and as set forth in the CON application, supplemental responses, and these Responses to Interrogatories. The individuals who submitted letters of support for the Project or spoke in support thereof at the June 25, 2014 HSDA meeting also have such knowledge, as does counsel for the Petitioner. Legal counsel for Petitioner also has such knowledge.

(c) Provide a detailed description of each projection, evaluation, estimate, review or study of any type which you contend demonstrates that the Project will "contribute to the orderly development of adequate and effective health care facilities and/or services"; and

RESPONSE: The specific projections, evaluations, estimates, reviews or studies are set forth in the CON application at issue, the responses to HSDA staff's requests for supplemental information, the HSDA staff summary on the Project, the MHSAS reports on the Project, and the Powerpont presentation prepared by Mr. Garone for the June 25, 2014 HSDA meeting.

(d) Identify each person who assisted or participated in any way in obtaining, preparing, or supplying any information included in any such projection, evaluation, estimate, review, or study.

RESPONSE: The persons specified in this Interrogatory are Mike Garone and Jim Shaheen. They also consulted with SBH's outside legal counsel on these issues.

31. Please identify the Vanderbilt University statistician referenced on pg. 11 of the June 25, 2014 hearing transcript. With respect to this individual, provide the following information:

(a) When and by whom this statistician was retained; and

RESPONSE: Petitioner objects to this Interrogatory because the information it seeks is proprietary, highly confidential and constitutes a trade secret of SBH. Without waiver of the foregoing objection, Petitioner states that the information sought herein will be provided subject to an appropriate protective order.

(b) The dates of any written analysis, specific data or statistics, consideration or estimation provided by this statistician.

RESPONSE: The referenced report was done in the summer of 2012.

32. Please identify all "developmentally delayed" programs offered by SBH referenced on pg. 74 of the June 25, 2014 hearing transcript.

RESPONSE: SBH operates such a program at the Strategic Behavioral Center in Garner, North Carolina.

33. During the HSDA meeting on June 25, 2014, a representative of SBH claimed that "there is an overwhelming belief by clinicians in the area that don't believe Woodridge offers a quality of care." (See page 15 of the hearing transcript.) With respect to this claim, provide the following information:

(a) The factual basis for the claim;

RESPONSE: The Petitioner objects to this Interrogatory because it does not accurately quote the HSDA June 25, 2014 hearing transcript. Without waiver of the foregoing objection, the Petitioner further asserts as follows: The quote specified in this Interrogatory is itself a quote from the support letter submitted by Harold Leonard, Regional Chair of the Tennessee Suicide Prevention

Network. The transcript's language specifically states as follows, on page 15: "He goes on to state that there is an overwhelming belief by clinicians in the area that they don't believe Woodridge offers a quality of care." The "quality of care" language is quoted text from Mr. Leonard's letter of support for the Project.

(b) If you have conducted or caused to be conducted or have reviewed or are relying on any written analysis, specific data or statistics, consideration or estimation in support of this argument, identify each such analysis, consideration or estimation; and

RESPONSE: The HSDA meeting transcript text quoted in this interrogatory is drawn from comments by a person in the mental health field in East Tennessee. It was quoted by Mr. Garone for the purpose of showing views held in East Tennessee about Woodridge. Letters expressing similar sentiments were also submitted to the HSDA in support of this position: see pages 115-116 and 118 of the HSDA mailout package.

(c) Identify each person who has knowledge of the facts supporting these statements.

RESPONSE: See the letters referred to by Mr. Garone which are contained in the letters of support submitted to the HSDA in support of the Project, especially the letter of Harold Leonard, contained at page 117 in the CON application mailout package.

34. Identify the payor mix (Medicare, Medicaid, commercial insurance, charity care/indigent, private pay, etc.) for all Strategic Behavioral Health, LLC facilities from January 1, 2011, to the date of your response.

RESPONSE: The payor mix at all current SBH facilities is as follows, except for psychiatric residential treatment facilities, whose data are not included in the analysis below:

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)

35. Identify the average length of stay for each payor identified in your response to Interrogatory No. 34 for all Strategic Behavioral Health, LLC facilities from January 1, 2011, to the date of your response.

RESPONSE: The requested average length of stay data for all current SBH facilities is as follows, except for psychiatric residential treatment facilities, whose data are not included in the analysis below:

Payor	ALOS
Medicaid	9.8 days
Medicare	12.2 days
Commercial	7.5 days
HMO/PPO	7.7 days
Self pay	6.7 days

36. Identify the number of involuntary admissions accepted at all Strategic Behavioral Health, LLC facilities, per year, from January 1, 2011, to the date of your response. For each involuntary admission accepted, please identify the payor type (Medicare, Medicaid, commercial insurance, charity care/indigent, private pay, etc.).

RESPONSE: Strategic Behavioral Center - Wilmington: 2011 - N/A; 2012 - N/A; 2013 - 113; 1/1/14 to 10/1/14 - 359

Strategic Behavioral Center - Raleigh: 2011 - N/A; 2012 - N/A; 2013 - 380; 1/1/14 to 10/1/14 - 517

Strategic Behavioral Center - Charlotte: 2011 - N/A; 2012 - N/A; 2013 - N/A; 1/1/14 to 10/1/14 - N/A

Peak View Behavioral Health: 2011 - N/A; 2012 - N/A; 2013 - 1,493; 1/1/14 to 10/1/14 - 1,999

Montevista Hospital: 2011 - data not available; 2012 - data not available; 2013 - 929; 1/1/14 to 10/1/14 - 356

Red Rock Behavioral Health: 2011 - data not available; *2012* - data not available; *2013* - 422; 1/1/14 to 10/1/14 - 216

Rock Prairie Behavioral Health: 2011 - N/A; 2012 - N/A; 2013 - N/A; 1/1/14 to 10/1/14 - 203

Peak Behavioral Health: 2011 - do not have; 2012 - do not have; 2013 - do not have; 1/1/14 to 10/1/14 - do not have

37. State whether you have policies and procedures governing information management, document retention or destruction, or related matters, and identify all documents that evidence, reflect, refer or relate to such policies and procedures that have been in effect since January 1, 2011.

RESPONSE: The Petitioner has not yet promulgated such policies and procedures.

38. Have any documents relating to the Project been destroyed? Identify each such destroyed document, indicate when and how it was destroyed and identify the person who destroyed the document or caused it to be destroyed.

RESPONSE: The Petitioner is not certain; however, documents relating to the Project have never been intentionally destroyed to avoid discovery.

39. Identify all Strategic Behavioral Health facilities currently operational or under construction and provide the following information:

(a) For all operational facilities, please provide the date of opening.

RESPONSE:

a) Strategic Behavioral Center – Wilmington
   i) Date of Opening – Acute – 9/2013 --- PRTF - 10/2008
   ii) Semi-Private Rooms – Acute – 10 / PRTF - 36
   iii) Private Rooms – 0
   iv) Co-Ed Adolescent Units – Acute – 2 / PRTF - 1
   v) Same Sex Adolescent Units – Acute – 0 / PRTF - 3
   vi) Question does not specify the date range

b) Strategic Behavioral Center – Raleigh
   i) Date of Opening – Acute – 2/2013 --- PRTF 10/2012
   ii) Semi-Private Rooms – 46
   iii) Private Rooms – 0
   iv) Co-Ed Adolescent Units – 8
   v) Same Sex Adolescent Units – 0
   vi) Question does not specify the date range

c) Strategic Behavioral Center – Charlotte
   i) Date of Opening – 7/2013
   ii) Semi-Private Rooms – 30
   iii) Private Rooms – 0

iv) Co-Ed Adolescent Units – 1
v) Same Sex Adolescent Units – 4
vi) Question does not specify the date range

d) Peak View Behavioral Health
i) Date of Opening – 2012
ii) Semi-Private Rooms – 46
iii) Private Rooms – 0
iv) Co-Ed Adolescent Units – 0 or potential (2) as needed
v) Same Sex Adolescent Units – 2
vi) Question does not specify the date range

e) Montevista Hospital
i) Date of Opening – 1985
ii) Semi-Private Rooms – 42
iii) Private Rooms – 0
iv) Co-Ed Adolescent Units – 1
v) Same Sex Adolescent Units – 0
vi) Question does not specify the date range

f) Red Rock Behavioral Health
i) Date of Opening – 2006
ii) Semi-Private Rooms – 10
iii) Private Rooms – 1
iv) Co-Ed Adolescent Units – N/A
v) Same Sex Adolescent Units – N/A
vi) Question does not specify the date range

g) Rock Prairie Behavioral Health
i) Date of Opening – 4/2013
ii) Semi-Private Rooms – 36
iii) Private Rooms – 0
iv) Co-Ed Adolescent Units – 2
v) Same Sex Adolescent Units – 0
vi) Question does not specify the date range

h) Peak Behavioral Health
i) Date of Opening – 2002
ii) Semi-Private Rooms – 59
iii) Private Rooms – 1
iv) Co-Ed Adolescent Units – 1 acute
v) Same Sex Adolescent Units – 4 PRTF
vi) Question does not specify the date range

i) Clear View Behavioral Health
   i) Expected Date of Opening – November 2016
   ii) Projected Capitol Cost – Approx. $16.5 million
   iii) Semi-Private Rooms – N/A
   iv) Private Rooms – N/A
   v) Co-Ed Adolescent Units – N/A
   vi) Same Sex Adolescent Units – N/A

(b) For each facility not yet in operation, please provide the expected open date and the projected capital cost for each facility.

RESPONSE: The answer to this subpart is set forth in the response to Interrogatory 39(a) above.

(c) For all facilities, whether operational or under construction, identify the number of semi-private versus private rooms.

RESPONSE: The answer to this subpart is set forth in the response to Interrogatory 39(a) above.

(d) For all facilities, whether operational or under construction, identify the number of coed *adolescent units versus same-sex units.*

RESPONSE: The answer to this subpart is set forth in the response to Interrogatory 39(a) above.

(e) For operational facilities, the patient days and average length of stay for all patients for ages 0-17, 18-64, and 65 and above.

RESPONSE: ALOS data for SBH facilities is set forth in the response to Interrogatory 10 above.

40. Provide SBH's projected charge for DRG 751 (Major Depressive Disorder) and DRG 753 (Bi-polar disorder).

RESPONSE: Projected charges for DRG 751 and DRG 753 are both $1,578.

41. Provide the salaries and number of full time equivalents by each proposed employment position for the first three years of the Project's operation.

RESPONSE: The Petitioner responds to this Interrogatory as set forth below with the proviso that the requested data are only available for first two years of operation.

			Year 1	Year 2
Clinical				
	rate		FTE's	FTE's
day	$10.00	Techs	5.6	12.2
even	$11.00	Techs	5.6	11.2
night	$12.00	Techs	5.6	11.2
	$45.00	Clinical Director	1.0	1.0
	$35.00	Program Director	1.0	2.0
	$22.00	Milieu Manager	0.0	1.0
day	$25.00	R.N.'s/U.M.	4.2	7.0
even	$27.00	R.N.'s/U.M.	4.2	7.0
night	$30.00	R.N.'s/U.M.	4.2	7.0
	$18.00	L.V.N.	4.2	8.4
	$25.00	Therapist	4.0	6.0
	$18.00	RT	2.0	2.0
		Totals	**41.6**	**76.0**
Non-Clinical				
	rate		FTE's	FTE's
	$72.12	Administrator	1.0	1.0
	$20.00	Administrative Secretary	1.0	2.0
	$40.00	Controller	1.0	1.0
	$30.00	BO Manager	1.0	1.0
	$17.50	*BO Clerks*	*1.0*	*1.0*
	$17.50	BO Biller	0.0	1.0
	$25.00	Medical Records Supervisor	1.0	1.0
	$15.00	Medical Records	1.0	1.0
	$24.00	Marketing	3.5	3.5
	$10.00	Receptionist	2.8	2.8
	$40.00	Nurse Administrator	1.0	1.0
	$23.00	OP Director	0.0	1.0
	$12.00	Dietary	4.0	4.0
	$30.00	Utilization Review	1.0	2.0
	$24.00	Admissions	3.5	3.5

	$25.00	HR Manager	1.0	1.0
	$12.50	HR	1.0	1.0
	$30.00	QA/Infection Control	1.0	1.0
	$15.00	Maintenance	1.0	1.0
	$12.00	Maintenance	1.0	1.0
		Totals	**27.8**	**31.8**

42. For all FTEs identified in response to Interrogatory No. 41, state how many will be providing outpatient services/therapy. Please also provide the Project's projected volume of outpatient services by type of service.

RESPONSE: Outpatient programing will share services and support with all departments/positions listed in Interrogatory #41. In Year 2 an OP Director will be hired. Detailed projected volume of outpatient services by type of service has not been conducted.

VERIFICATION

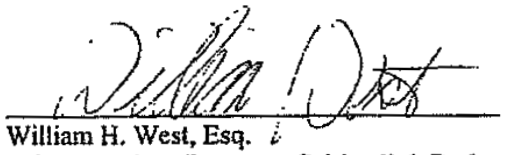
I have read the foregoing responses to interrogatories and declare under penalty of perjury that they are true and correct to the best of my present knowledge.

Executed on the 21st day of November, 2014.

Mike Garone

SBH-KINGSPORT 001593

AS TO OBJECTIONS:



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Counsel for Petitioner, SBH-Kingsport, LLC

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 hand delivery to the addresses below:

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

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

this 21 day of November, 2014.

HEALTH SERVICES AND DEVELOPMENT AGENCY MEETING
APRIL 23, 2014
APPLICATION SUMMARY

NAME OF PROJECT:	SBH-Kingsport, LLC
PROJECT NUMBER:	CN1312-050
ADDRESS:	Unaddressed property at the end of Executive Park Blvd. Kingsport (Sullivan County), TN 37660
LEGAL OWNER:	SBH-Kingsport, LLC 8295 Tournament Drive, Suite 201 Memphis (Shelby County), TN 38125
OPERATING ENTITY:	N/A
CONTACT PERSON:	Mike Garone (901-969-3100)
DATE FILED:	December 13, 2013
PROJECT COST:	$11,717,915.00
FINANCING:	Cash Reserves, Revolving Credit, Net Cash Flows
REASON FOR FILING:	Establishment of a new 72 bed free-standing mental health hospital and initiation of inpatient psychiatric services

DESCRIPTION:

SBH-Kingsport, LLC is seeking approval for the establishment of a new 72 bed free standing mental health hospital and initiation of inpatient psychiatric and substance abuse services. The proposed mental health hospital will consist of 28 inpatient beds for psychiatric care for children ages 5-17, 18 inpatient beds for adult psychiatric care for adults ages 18-64, 16 inpatient beds for geropsychiatric care for ages 55+, and 10 adult chemical dependency beds. The proposed project will accept voluntary and/or involuntary admissions. If approved, the applicant plans to initiate services in November 2015.

SERVICE SPECIFIC CRITERIA AND STANDARD REVIEW:

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).

Using the population estimates prepared by the Department of Health, the Guidelines for Growth Bed Need Formula calculate the following total bed need for inpatient psychiatric services:

TN counties (Hawkins, Sullivan)
2014 Population:
Total 216,484 X 30 beds/100,000 = 64.9 Beds

2018 Population:
Total 219,300 X 30 beds/100,000 = 65.8 Beds

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

2014 Population:
Age 18+ 175,764 X 30 beds/100,000 = 52.7 Beds
Age 65+ 44,484 X 30 beds/100,000 = 13.3 Beds

2018 Population:
Age 18+ 184,934 X 30 beds/100,000 = 55.5 Beds
Age 65+ 50,355 X 30 beds/100,000 = 15.1 Beds

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

2018 Population:
Age 0-17 34,366 X 30 beds/100,000 = 10.3Beds

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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.

Service Area	Population (2018)	Need Pop. x(30 beds/100,000)	Current Beds	Net Need
Hawkins and Sullivan County (TN)	219,300	65.8	12	53.8
Wise Scott, Lee (Va.)	89,174	27	0	27
Total Proposed Service Area	**308,474**	**92.8**	**12**	**80.8**
Contiguous Washington, Greene	209,964	63	100	Surplus 37
Total	518,438	155.80	112	43.80

It would appear the application meets this criterion, when considering only the applicant's declared service area. When including contiguous Washington and Greene Counties, there is a net need of 43.8 beds.

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.

The geographic area includes Hawkins and Sullivan counties located in Tennessee. The proposed project will be located in Kingsport (Sullivan County). The applicant has also included the contiguous counties of Wise, Scott and Lee in Virginia.

It would appear the application meets this criterion.

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.

The applicant states there is a need for chemical dependency services for low-income age groups and individuals. In addition, involuntary psychiatric inpatient admissions will be accepted.

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It would appear the application meets this criterion.

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.

There are no identified state, city, county or regional planning documents provided by the Tennessee Department of Mental Health and Substance Abuse Services.

This criterion does not apply to this application.

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.

There are no identified state, city, county or regional plans that require consideration.

This criterion does not apply to this application.

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

According to a memo dated May 17, 2012 from the Tennessee Department of Mental Health and Substance Abuse Services, Lakeshore Mental Health Institute (LMHI) closed on June 30, 2012. Lakeshore Mental Health Institute is the Regional Mental Health Institute previously designated to serve a 24 county catchment area in East Tennessee that included the counties of Hawkins and Sullivan. The Tennessee Department of Mental Health and Substance Abuse Services expanded its contracts with 3 private psychiatric hospitals to provide services to uninsured persons, which would accommodate most of the uninsured patient who would have been served by LMHI. The 3 inpatient psychiatric facilities are Woodridge Hospital located in Johnson City (Washington County), Ridgeview Psychiatric Hospital and Center in Oak Ridge (Anderson County), and Peninsula Hospital in Louisville (Blount County). Moccasin Bend Mental Health

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Institute, located in Chattanooga, TN is currently the designated Regional Mental Health Institute to serve the 24 counties previously served by LMHI.

The proposed 72 bed psychiatric inpatient facility will be classified as an IMD (Institute for Mental Disease). For TennCare admissions (ages 21-64), TennCare will not receive matching federal funds. The cost of patient care for TennCare enrollees for age 21-64 will be reimbursed using 100% state funds.

It is not possible to determine what, if any, impact this proposal may have on similar services supported by state appropriations from the limited data that is currently available.

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.

   The applicant will accept involuntary admissions.

   It would appear the application meets this criterion.

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

   The applicant plans to contract with all area TennCare managed care organizations and participate in Medicare.

   It would appear the application meets this criterion.

D. Relationship to Existing Similar Services in the Area

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

   Bristol Regional Medical Center (BRMC), a 12 bed inpatient psychiatric facility (ages 18+), is the only inpatient psychiatric inpatient provider in the proposed 2 county Tennessee service area of Hawkins and Sullivan Counties. The psychiatric inpatient occupancy rate for BRMC was 72.8% in 2010, 55.8% in 2011 and 62.7% in 2012.

SBH-KINGSPORT 001600

Woodridge Psychiatric Hospital (84 beds-accepts all ages) in contiguous Washington County experienced a 65% occupancy rate in 2011, 70% in 2012, and 72.3% in 2013.

Takoma Regional Hospital (16 beds gero-psych) in contiguous Green County experienced an occupancy rate of 30.6% in 2011, 38% in 2012, and 35% in 2013.

It would appear the application meets this criterion.

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

Charity care will account for approximately 4.8% of total gross revenue in Year One and Year Two equaling to $686,430 (421.9 days) and $1,349,190 (823.3 days), respectively.

It would appear the application meets this criterion.

E. Feasibility

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

The applicant is aware and understands the licensing and certification as required by the State of Tennessee for medical and clinical staff.

It appears the application meets this criterion.

STAFF SUMMARY

Note to Agency members: This staff summary is a synopsis of the original application and supplemental responses submitted by the applicant. Any HSDA Staff comments will be presented as a "Note to Agency members" in bold italic.

SBH-Kingsport, LLC will be designated an IMD (Institution for Mental Disease).* Federal matching payments for Medicaid are not available to states for reimbursement to IMDs for patients ages 21-64. In the supplemental response, the applicant indicates SBH-Kingsport, LLC will be able to accept TennCare admissions if SBH is successful in becoming a contracted TennCare provider. However, it appears the TennCare cost for a patient stay to an IMD will be reimbursed from State funds only.

Note Agency Members: As part of the Medicare Catastrophic Act of 1988 (Pub.L. 100-360), Congress defined an IMD as a facility with more than 16 beds. This was apparently added to promote small, community-based group living arrangements as an alternative to large institutions. The result of these amendments is that Medicaid currently provides mental health treatment coverage for a large percentage of people with Medicaid, but that coverage is excluded for inpatient treatment of adults aged 21 to 64 in any acute or long-term care institutions with 17 or more beds that are primarily engaged in providing treatment for mental illnesses. This payment exclusion became known as the Medicaid IMD exclusion. Source: http://www.medicaid.gov.

History
The following is a timeline of events that have impacted SBH-Kingsport, LLC's proposed service area of Hawkins and Sullivan counties.

- 2008-The Mental Health Parity and Addiction Equity Act of 2008 is approved. The parity law aims to ensure that when coverage for mental health and substance use conditions are provided, it is generally comparable to coverage for medical and surgical care. *Source: U.S Dept. of health and Human Services, http://aspe.hhs.gov/health/reports/2013/mental/rb_mental.cfm.*
- 2009-MSHA, Woodridge Psychiatric Hospital (satellite of Johnson City Medical Center), CN0908-043A, located in adjacent Washington County, is approved at the November 18, 2009 Agency meeting for the addition of 9 psychiatric beds increasing the hospital bed complement from 75 to 84.
- 2009-As a result of the approval of CN0908-043A, MSHA agrees to delicense 61 psychiatric beds at Indian Path Pavilion located 24.6 miles in adjoining Sullivan County.

- June 30, 2012- Lakeshore Mental Health Institute, a licensed 250 bed State operated Regional Mental Health Institute (RMHI) serving 26 East Tennessee counties closed.
- May 2012- The Tennessee Department of Health expands existing contracts with the following three private psychiatric facilities to provide services to uninsured patients who would have been served by LMHI: Woodridge Psychiatric Hospital (Washington County) Ridgeview Psychiatric Hospital & Center in Oak Ridge (Anderson County), and Peninsula Hospital in Louisville (Blount County).
- 2014-According to a US Department of Health and Human Services, Assistant Secretary for Planning and Evaluation (ASPE) Office of Health Policy Research Brief, the Affordable Care Act, building on the Mental Health Parity and Addiction Equity Act, will expand coverage of mental health and substance use disorder benefits and federal parity protections in three distinct ways (1) Essential Health Benefits (2) Parity in Individual and Small Group Markets (3) Increasing Access to Quality Health Care. The Brief is attached at the end of this summary.

Note to Agency members: The number of applications for psychiatric inpatient beds has increased (most likely due to the increased coverage for mental health services under the ACA). The following five applications totaling 192 beds have been or will be heard in 2014.

- *Rolling Hills Hospital, (Williamson County), CN1312-051A, approved for the addition of 40 psychiatric beds to its existing 80 bed mental health hospital at the March 26, 2014 Agency meeting.*
- *Woodridge of West Tennessee, (Madison County), CN1309-035A, approved for the establishment of a 16 bed geriatric inpatient psychiatric facility at the January 22, 2014 Agency meeting.*
- *Crestwyn Behavioral Health, (Shelby County), CN1310-040, request for the establishment of 60 bed mental health hospital located in Shelby County to be heard at the April 23, 2014 Agency meeting.*
- *SBH-Kingsport, (Sullivan County), CN1312-050, (this applicant) request for the establishment of a 72 bed mental health hospital.*
- *Athens Regional, (McMinn County), filed a LOI April 1, 2014 for the addition of (4) gero-psychiatric beds to its existing 10 bed unit.*

Need

The applicant provides the following justification in the original application:

- Indian Path Pavilion closed their 61 bed inpatient psychiatric unit.
- Lakeshore Mental Health Institute, a 250 licensed bed state operated Regional Mental Health Institute (RMHI) serving Northeast Tennessee, closed its doors.
- Only 12 inpatient psychiatric beds in the proposed service area are currently operational.

Ownership

SBH-Kingsport, LLC is wholly owned by Strategic Behavioral Health, LLC. Strategic Behavioral Health, LLC is a company based in Memphis, Tennessee that operates 7 psychiatric hospitals in Colorado, Nevada, New Mexico, and North Carolina and has one under development in College Station, Texas. If approved, SBH-Kingsport, LLC will be its first psychiatric hospital based in Tennessee.

A list of inpatient chemical dependency and psychiatric units owned by Strategic Behavioral Health is listed in Supplemental One.

Facility Information

- The proposed SBH-Kingsport, LLC facility will be a 52,263 SF one story building located on 9.7 acres.

Inpatient Areas

- The inpatient area consist of 27,044 SF.
- Each patient room is double occupancy with an adjacent restroom.
- The sixteen (16) bed geriatric unit contains a living room, group room, doctor office, seclusion room, and a centrally located nurse's station.
- The additional fifty-six beds are separated into four units (two with 18 beds and two with 10 beds).
- Two acute care units share a nurse's station, med room and seclusion room.
- There are two (2) classrooms for child and adolescent patients.
- A 2,223 SF gymnasium is available for all patients.
- A 552 SF pharmacy is on-site.

Outpatient and Assessment Areas

- Outpatient and Assessment areas are individually secure from each other and the rest of the building

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- The assessment suite includes rooms for patient assessment, financial counseling, and private family waiting.
- The outpatient suite houses individual and group therapy rooms.

Service Area Demographics

SBH-Kingsport, LLC declared primary service area is Hawkins and Sullivan Counties in Tennessee, and the counties of Wise, Scott, and Lee in Virginia.

Tennessee Total Population

- The total population of the service area is estimated at 216,484 residents in calendar year 2014 increasing by approximately 1.3% to 219,300 residents in CY 2018.
- The total population of the State of Tennessee is expected to grow 3.7% during the same timeframe.

13-17 Population

- The total 13-17 population is estimated at 13,326 residents in 2014 decreasing approximately 7.2% to 12,358 residents in 2018.
- The age 13-17 population in the State of Tennessee overall is expected to increase 0.8% during the same timeframe.

18-64 Population

- The total 18-64 population is estimated at 175,764 residents in 2014 increasing approximately 12.9% to 50,355 in 2018.
- The total 18-64 population in the State of Tennessee overall is expected to increase by 4.4% during the same timeframe.

65+ Population

- The total 65 and older population is estimated at 44,484 residents in 2014 increasing approximately by 5.2% to 184,934 in 2018.
- The age 65+ population in the State of Tennessee overall is expected to increase 12.3% during the same timeframe.

TennCare

- The latest 2013 percentage of the proposed service area population enrolled in the TennCare program is approximately 18.1%, as compared to the statewide enrollment proportion of 18.2%.

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

Virginia Total Population

The following table reflects population statistics for SBH-Kingsport's 3 proposed service area counties in Virginia.

County	0-18	65+	2010	2012	%change
Wise	8,429	6,015	41,452	40,918	-1.3%
Scott	4,306	4,647	23,177	22,782	-2.3%
Lee	5,044	4,458	25,587	25,474	-0.4%
Total	**17,779**	**15,120**	**90,216**	**89,174**	**-1.2%**

Source: http://quickfacts.census.gov/qfd/states/51/51195.html

- Overall, the proposed three county service area in Virginia will experienced a 1.2% decrease in population from 2010 to 2012.

Service Area Historical Utilization

Migration of patients from the proposed Tennessee service area

	County	Age 5-11	% of total	Age 12-17	% of total	Age 18-54	% of total	Age 55+	% of total	Total	% of total service area patients
Acute Care Hospitals											
Peninsula Hospital	Blount	7	33.3%	32	23.2%	174	13.8%	26	8.1%	239	13.8%
Sycamore Shoals Hospital	Carter	0	0	0	0	3	0.23%	42	13.1%	45	2.6%
Vanderbilt University Hospital	Davidson	0	0	0	0	6	0.47%	0	n/a	6	0.34%
Parkridge Valley Child and Adolescent	Hamilton	1	4.7%	6	4.3%	0	n/a	0	n/a	7	0.40%
Wellmont Regional Medical Center	Sullivan	0	0	0	n/a	157	12.5%	86	26.9%	243	14%
Woodridge Psychiatric Hospital	Washington	13	92%	100	72.5%	862	68.5%	150	46.9%	1,125	65%
Other providers		0	n/a	0	n/a	11	0.87%	16	5.0%	27	1.6%
State Mental Health Hospitals											
Mocassin Bend Mental Health Institute	Hamilton	0	n/a	0	n/a	42	3.3%	0	n/a	42	2.4%
*Lakeshore Mental Health Institute	Knox	0	n/a	0	n/a	0	0	0	n/a	0	n/a
Middle Tennessee Mental Health Institute	Davidson	0	n/a	0	n/a	4	0.31%	0	n/a	4	0.23%
Total		21		138		1,259		320		1,738	

Source: Department of Health, Hospital Discharge Data based on select diagnostic related groups (DRGs) found in Major Diagnostic Category (MDC) 19-Mental Disease Disorder.

**There was no Joint Annual Report filed by Lakeshore Mental Health for 2012. The 2011 LMHI Joint Annual Report indicated there were 35 patients admitted from Hawkins County and 135 patients admitted from Sullivan County.*

- Woodridge Psychiatric Hospital has the overall highest percentage of patients from the proposed Tennessee service area totaling 65% or 1,125 patients in 2012. In addition, WPH also has the overall highest percentage of patients for the following age categories in 2012: 5-11 (92%), 12-17 (71%), 18-54 (67.6%), and 55+ (42.8%).

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Note to Agency members: Since WPH has a 65% market share in the Tennessee portion of the applicant's service area, the following will assess the impact of the proposed project on WPH.

The counties of Sullivan and Hawkins are currently in WPH's service area. If SBH-Kingsport, LLC is approved, the counties of Sullivan and Hawkins will be shared between Woodridge and SBH. An analysis of Woodridge Psychiatric Hospital's 5 county service area, need, and historical utilization would provide an overview of the possible impact on WPH, if SBH-Kingsport, LLC is approved.

The following is the migration of patients from Virginia to Woodridge Psychiatric Hospital in 2012.

Facility	COUNTY	Wise	Scott	Lee	Virginia Total	Out of State Total	Tennessee Total	Grand Total
Woodridge Psychiatric Hospital	Washington	0	74	0	274	351	3,222	3,573

Source; 2012 Joint Annual Report

- The above table indicates only 2.1% of all of Woodridge Psychiatric Hospital's admissions came from the counties of Wise, Scott and Lee Counties.

According to a previously filed application by Woodridge Psychiatric Hospital (WPH), CN0908-043A in 2009, WPH's primary service area is Washington, Sullivan, Carter, Greene and Hawkins Counties in Tennessee. Eighty-five percent (85.2%) of Woodridge patients come from these five counties. The following is an analysis of Woodridge's current primary service area.

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WPH 5 County Service Area Facilities

Bed Need			Facility located in service area		
County	2018 Population	Multiply 30/100,000	Facility	Beds	Distance to applicant (SBH)
Sullivan	161,136	48.33	Wellmont Regional Medical Center	12 Beds Ages 18+	16.1 miles
Washington	138,370	41.51	MSHA: Woodridge Psychiatric Hospital	84 Beds All Ages	21 miles
Carter	57,680	17.30	MSHA: Sycamore Psych Hospital	12 Beds Gero-Psych	30.2 miles
Greene	71,594	21.47	Wellmont Health Alliance: Takoma Regional Hospital	16 Beds gero-psych	37.2 miles
Hawkins	58,164	17.44	No psych facility		
Total	486,944	146 beds		124 beds	

- The above table indicates there is a net need of 22 psychiatric beds in Woodridge's 5 county service area applying current Guidelines for Growth need standards of 30 beds per 100,000 population.
- There appears to be one (1) twelve (12) bed psychiatric unit for children ages 1-17 located at WPH. This represents 10% of total available beds in the service area. The bed need formula for the 0-17 age group for the Woodridge 5 county service area (88,638 pop.) for 2018 indicates a need of 27 child and adolescent beds resulting in a need of 15 additional beds.
- The range of distances from SBH to existing providers in WPH's 5 county service area ranges from 16.1 miles to 37.2 miles.

Woodridge Historical Utilization Trends

Facility	County	Beds (2012)	2011 Patient Days	2012 Patient Days	*2013 Patient Days	'10-'13% Change	2011 Occup	2012 Occup.	2013 Occup.
Woodridge Psychiatric Hospital	Washington	84	19,827	21,329	22,182	+11.9%	65%	70%	72.3%

**2013 Provisional JAR*

- The above chart indicates Woodridge Psychiatric Hospital's inpatient utilization in their five county service area increased 11.9% from 19,827 patient days in 2011 to 22,182 patient days in 2013.

Service Area Historical Utilization and Overall Market Share

Facility	County	Beds (2012)	2010 Patient Days	2011 Patient Days	2012 Patient Days	'10-'12 % Change	2010 Occup	2011 Occup.	2012 Occup.	Service Area Inpatients	Service Area Patients as a % of Total
Bristol Regional Medical Center	Sullivan	12	3,189	2,448	2,745	-13.9%	72.8%	55.8%	62.7%	243	13.7%

Source: Tennessee Department of Health, Joint Annual Reports - 2010, 2011, and 2012

- The above chart indicates inpatient psychiatric utilization at the one psychiatric unit in the proposed service area decreased 13.9% from 3,189 patient days in 2010 to 2,745 patient days in 2012.

Applicant Projected Utilization

SBH-Kingsport, LLC's projected utilization for the first two years after project completion is presented in the table below:

Beds	Year 1 Admits	Year 1 Patient Days	Year 1 ALOS	Year 1 % Occupancy	Year 2 Admits	Year 2 Patient Days	Year 2 ALOS	Year 2 % Occupancy
72	725	8,700	12 days	33%	1,425	17,100	12 days	65%

Project Cost

Major costs are:

- Construction Cost- $8,000,002, or 68.3% of cost.
- Acquisition of Site- $925,000, or 7.9% of the total cost.
- Preparation of Site-$675,000, or 5.8% of cost.
- For other details on Project Cost, see the Project Cost on page 20.

- The applicant expects the construction cost per square foot to be $153.00. This falls below the 1st quartile for hospital construction of $234.64/sq. for projects previously approved between 2010 and 2012.

Financing
A December 11, 2013 letter from Michael A. Orians, CFO, confirms that Strategic Behavioral Health, LLC (parent company of SBH-Kingsport, LLC) has the necessary financial resources through cash balances, access to a revolving credit loan, and cash net flows to fund the project. Cash balances on hand total $4.1 million and cash flow equals $917,915. A December 12, 2013 letter from Stephen C. Taylor of Fifth Third Bank confirms the availability of a $15.5 million revolving credit loan with a current variable rate of 3.75%.

Historical Data Chart
Since this is a new facility, a historical data chart was not provided.

Projected Data Chart
The applicant projects $14,154,600.00 in total gross revenue on 8,700 days during the first year of operation and $28,023,800 on 17,100 days in Year Two (approximately $1,639 per day). The Projected Data Chart reflects the following:

- Net operating income less capital expenditures for the applicant will equal a loss of ($1,334,340) in Year One increasing to $676,853 in Year Two.
- Net operating revenue after contractual adjustments is expected to reach $9,603,359 or approximately 34.3% of total gross revenue in Year Two.
- Charity care at approximately 4.8% of total gross revenue in Year One and Year Two equaling to $686,430 (422 days) and $1,349,190 (823 days), respectively.

Strategic Behavioral Health, LLC and Subsidiaries consolidated Statement for the period ending December 31, 2012 indicates $2,820,508 in cash and cash equivalents, total current assets of $11,825,136, total current liabilities of $6,338,091, and a current ratio of 1.87:1.

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

Charges
In Year One of the proposed project, the average charges are as follows:

- The proposed average gross charge is $1,627/day in 2016.
- The average deduction is $1,077/day, producing an average net charge of $550/day.

Medicare/TennCare Payor Mix

- Medicare- Charges will equal $1,305,000 in Year One representing 27% of total net operating revenue.
- TennCare- Charges will equal $1,818,300 in Year One representing 38%.

Staffing
The applicant's proposed direct patient care staffing in Year Two includes the following:

- 1.0 Clinical Director
- 1.0 Program Director
- 16.8 Psychiatric Techs
- 2.0 Recreational Therapist
- 4.0 Therapist
- 12.6 Registered Nurses
- 1.0 Registered Nurse/Utilization Management
- 4.2 Licensed Vocational Nurse
- **42.6 Total FTE's**

Licensure/Accreditation
SBH-Kingsport, LLC will be licensed by the Tennessee Department of Mental Health and Substance Abuse Services and certified by Medicare.

SBH-Kingsport, LLC will seek accreditation from The Joint Commission.

The applicant has submitted the required information on corporate documentation and title and deeds. Staff will have a copy of these documents available for member reference at the meeting. Copies are also available for review at the Health Services and Development Agency's office.

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

CERTIFICATE OF NEED INFORMATION FOR THE APPLICANT:

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

CERTIFICATE OF NEED INFORMATION FOR OTHER SERVICE AREA FACILITIES:

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

PLEASE REFER TO THE REPORT BY THE DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES FOR A DETAILED ANALYSIS OF THE STATUTORY CRITERIA OF NEED, ECONOMIC FEASIBILITY, AND CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE IN THE AREA FOR THIS PROJECT. THAT REPORT IS ATTACHED TO THIS SUMMARY IMMEDIATELY FOLLOWING THE COLOR DIVIDER PAGE.

PME (4/4/14)

ASPE
RESEARCH BRIEF

Affordable Care Act Will Expand Mental Health and Substance Use Disorder Benefits and Parity Protections for 62 Million Americans

By Kirsten Beronio, Rosa Po, Laura Skopec and Sherry Glied

The Affordable Care Act will provide one of the largest expansions of mental health and substance use disorder coverage in a generation. Beginning in 2014 under the law, all new small group and individual market plans will be required to cover ten Essential Health Benefit categories, including mental health and substance use disorder services, and will be required to cover them at parity with medical and surgical benefits. The Affordable Care Act builds on the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA, or the federal parity law), which requires group health plans and insurers that offer mental health and substance use disorder benefits to provide coverage that is comparable to coverage for general medical and surgical care.

While almost all large group plans and most small group plans include coverage for some mental health and substance use disorder services, there are gaps in coverage and many people with some coverage of these services do not currently receive the benefit of federal parity protections. The final rule implementing the Essential Health Benefits directs non-grandfathered[1] health plans in the individual and small group markets to cover mental health and substance use disorder services as well as to comply with the federal parity law requirements beginning in 2014.[2]

Mental Health and Substance Use Disorder Benefits Prior to the Affordable Care Act

About one-third of those who are currently covered in the individual market have no coverage for substance use disorder services and nearly 20 percent have no coverage for mental health services, including outpatient therapy visits and inpatient crisis intervention and stabilization.[3] In addition, even when individual market plans provide these benefits, the federal parity law does not apply to these plans to ensure that coverage for mental health and substance use disorder services is generally comparable to coverage for medical and surgical care.

[1] "Grandfathered" plans are plans that were in place when the Affordable Care Act was enacted that have not been changed in certain specified ways.
[2] The Essential Health Benefits, Actuarial Value, and Accreditation Final Rule was released February 20, 2013.
[3] ASPE Issue Brief, "Essential Health Benefits: Individual Market Coverage," ed. U.S. Department of Health & Human Services (2011).

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In the small group market, coverage of mental health and substance use disorder treatment is more common than in the individual market. We estimate that about 95 percent of those with small group market coverage have substance abuse and mental health benefits.[4] Again, the federal parity law does not apply to small group plans. In many states, state parity laws offer those covered in this market some parity protection, but most state parity laws are narrower than the federal parity requirement.

In addition, 47.5 million Americans lack health insurance coverage altogether,[5] and 25 percent of uninsured adults have a mental health condition or substance use disorder or both.[6]

The Affordable Care Act: Better Coverage for Mental Health and Substance Use Disorders

The Affordable Care Act and its implementing regulations, building on the Mental Health Parity and Addiction Equity Act, will expand coverage of mental health and substance use disorder benefits and federal parity protections in three distinct ways: (1) by including mental health and substance use disorder benefits in the Essential Health Benefits; (2) by applying federal parity protections to mental health and substance use disorder benefits in the individual and small group markets; and (3) by providing more Americans with access to quality health care that includes coverage for mental health and substance use disorder services.

1. Essential Health Benefits

- First, under the statute, treatment for mental health and substance use disorders is a benefit category covered as part of the package of Essential Health Benefits available to all Americans in non-grandfathered plans in the individual and small group markets as of January 1, 2014. The Essential Health Benefits final rule, released today, ensures that consumers purchasing insurance can be confident that their health plan will provide the care they need if they get sick. Including mental health and substance use disorder treatment in this package means—

  - About 3.9 million people currently covered in the individual market will gain either mental health or substance use disorder coverage or both;[7]

  - Also, we estimate that 1.2 million individuals currently in small group plans will receive mental health and substance use disorder benefits under the Affordable Care Act.[8]

[4] ASPE Issue Brief, "Essential Health Benefits: Comparing Benefits in Small Group Products and State and Federal Employee Plans," ed. U.S. Department of Health & Human Services (2011).
[5] Estimated based on the US Census Bureau's 2011 American Communities Survey.
[6] Garfield RL, Lave JR, Donahue JM, "Health reform and the scope of benefits for mental health and substance use disorder services." Psychiatric Services 61:1081-1086 (2010).
[7] Estimate based on 2011 Medical Loss Ratio filings indicating that 11 million people are covered in the individual market, and 35% lack mental health coverage, substance use coverage, or both. This estimate includes some individuals currently enrolled in grandfathered coverage.
[8] Estimate based on the finding that approximately 95% of small group plans cover mental health and substance use disorder services. See Issue Brief, "Essential Health Benefits: Comparing Benefits in the Small Group Products and State and Federal Employee Plans," ed. U.S. Department of Health and Human Services (2011). This estimate includes some individuals currently enrolled in grandfathered coverage.

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2. Parity in the Individual and Small Group Markets

Second, HHS finalized regulations that apply federal parity rules to mental health and substance use disorder benefits included in Essential Health Benefits. As a result, Americans accessing coverage through non-grandfathered plans in the individual and small group markets will now be able to count on mental health and substance use disorder coverage that is comparable to their general medical and surgical coverage.

- Under this approach, 7.1 million Americans currently covered in the individual market who currently have some mental health and substance use disorder benefits will have access to coverage of Essential Health Benefits that conforms to federal parity protections as provided for under the Affordable Care Act and the Mental Health Parity and Addiction Equity Act.[9]

- In addition, because the application of parity to Essential Health Benefits will also apply to those currently enrolled in non-grandfathered plans in the small group market, 23.3 million current enrollees in small group plans will also receive the benefit of having mental health and substance use disorder benefits that are subject to the federal parity law.[10,11]

3. Increasing Access to Quality Health Care

Finally, the Affordable Care Act will expand insurance coverage to a projected 27 million previously uninsured Americans through access to private health insurance in the individual and small group markets, the Marketplaces, and Medicaid.[12] Essential Health Benefits, including mental health and substance use disorder services subject to parity requirements, will be available to this newly covered population.

In total, through the Affordable Care Act, 32.1 million Americans will gain access to coverage that includes mental health and/or substance use disorder benefits that comply with federal parity requirements and an additional 30.4 million Americans who currently have some mental health and substance abuse benefits will benefit from the federal parity protections. By building on the structure of the Mental Health Parity and Addiction Equity Act, the Affordable Care Act will extend federal parity protections to 62 million Americans.

[9] Estimate based on 2011 Medical Loss Ratio filings indicating that 11 million people are covered in the individual market. This estimate includes some individuals currently enrolled in grandfathered coverage.
[10] State parity laws often already apply to these small group plans.
[11] Estimate based on ASPE internal analysis of the 2012 Current Population Survey indicating that 24.5 million people are enrolled in employer-sponsored insurance and work in a firm with fewer than 50 employees. This analysis excluded anyone who also reported Medicare, Medicaid, CHIP, or military coverage. This estimate includes some individuals currently enrolled in grandfathered coverage.
[12] Congressional Budget Office, "Effects of the Affordable Care Act on Health Insurance Coverage – February 2013 Baseline," (2013).

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Individuals currently in individual plans	3.9 million	7.1 million	11 million
Individuals currently in small group plans	1.2 million	23.3 million	24.5 million
Individuals currently uninsured	27 million	n/a	27 million
Total	32.1 million	30.4 million	62.5 million

NOTE: These estimates include individuals and families who are currently enrolled in grandfathered coverage. Grandfathered plans are not required to comply with the Essential Health Benefits provisions of the Affordable Care Act. We note that, as the Affordable Care Act is implemented, we expect grandfathered coverage to diminish, particularly in the individual market.

SBH-KINGSPORT 001617

LETTER OF INTENT

DEC 10 '13 PM3:1

LETTER OF INTENT
TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY

The Publication of Intent is to be published in the Kingsport Times News (Name of Newspaper) which is a newspaper of general circulation in Sullivan County (County), Tennessee, on or before December 10 (Month / day), 2013 (Year), for one day.

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

SBH-Kingsport, LLC (Name of Applicant) N/A (Facility Type-Existing)

owned by: SBH-Kingsport, LLC with an ownership type of limited liability company and to be managed by: itself intends to file an application for a Certificate of Need for:

establishment of a new inpatient psychiatric hospital in Kingsport, Sullivan County, Tennessee 37660. This project will be located on unaddressed property at the end of Executive Park Boulevard in Kingsport, Tennessee. This property extends south and west of Executive Park Boulevard, and is south of the intersection of Executive Park Boulevard and East Stone Drive in Kingsport, Tennessee. This project will involve the initiation of inpatient psychiatric hospital services. This new psychiatric hospital will have 18 adult beds, 16 geropsychiatric beds, 28 child and adolescent beds, and 10 chemical dependency beds. These 72 beds will all be new beds licensed as psychiatric hospital beds. The estimated project costs for this project are projected to be approximately $12,000,000.00.

The anticipated date of filing the application is December 13, 2013.

The contact person for this project is Mike Garone (Contact Name) Director of Development (Title)

who may be reached at: Strategic Behavioral Health, LLC (Company Name) 8295 Tournament Drive, Suite 201 (Address)

Memphis (City) Tennessee (State) 38125 (Zip Code) 901 / 969-3100 (Area Code / Phone Number)

Mike Garone (Signature) by [illegible], as authorized 12/10/13 (Date) mgarone@strategicbh.com (E-mail Address)

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

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

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

COPY

-Application

SBH-Kingsport, LLC

CN1312-050

DEC 13 '13 PM 1:32

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

SBH - Kingsport, LLC
Name

unaddressed property at the end of Executive Park Boulevard, south of the intersection of Executive Park Boulevard and East Stone Drive — Sullivan
Street or Route — County

Kingsport — TN — 37660
City — State — Zip Code

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

Mike Garone — Director of Development
Name — Title

Strategic Behavioral Health, LLC — mgarone@strategicbh.com
Company Name — E-mail address

8295 Tournament Drive, Suite 201 — Memphis — TN — 38125
Street or Route — City — State — Zip Code

Director of Development — 901-969-3100 — 901-969-3120
Association with Owner — Phone Number — Fax Number

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

SBH-Kingsport, LLC — 901-969-3100
Name — Phone No.

8295 Tournament Drive, Suite 201 — Shelby
Street or Route — County

Memphis — TN — 38125
City — State — Zip Code

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

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

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

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

Name

Street or Route | County

City | State | Zip Code

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

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

A. Ownership	___	D. Option to Lease	___
B. Option to Purchase	X	E. Other (Specify) _____	___
C. Lease of ___ Years	___		

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

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

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

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

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

9. ***Bed Complement Data***
Please indicate current and proposed distribution and certification of facility beds.

		Current Beds Licensed	*CON	Staffed Beds	Beds Proposed	TOTAL Beds at Completion
A.	Medical					
B.	Surgical					
C.	Long-Term Care Hospital					
D.	Obstetrical					
E.	ICU/CCU					
F.	Neonatal					
G.	Pediatric					
H.	Adult Psychiatric				18	18
I.	Geriatric Psychiatric				16	16
J.	Child/Adolescent Psychiatric				28	28
K.	Rehabilitation					
L.	Nursing Facility (non-Medicaid Certified)					
M.	Nursing Facility Level 1 (Medicaid only)					
N.	Nursing Facility Level 2 (Medicare only)					
O.	Nursing Facility Level 2 (dually certified Medicaid/Medicare)					
P.	ICF/MR					
Q.	Adult Chemical Dependency				10	10
R.	Child and Adolescent Chemical Dependency					
S.	Swing Beds					
T.	Mental Health Residential Treatment					
U.	Residential Hospice					
	TOTAL				72	72

*CON-Beds approved but not yet in service

10. **Medicare Provider Number** to be applied for
Certification Type inpatient psychiatric hospital

11. **Medicaid Provider Number** to be applied for
Certification Type inpatient psychiatric hospital

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

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

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

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NOTE: ***Section B*** is intended to give the applicant an opportunity to describe the project and to discuss the need that the applicant sees for the project. ***Section C*** addresses how the project relates to the Certificate of Need criteria of Need, Economic Feasibility, and the Contribution to the Orderly Development of Health Care. **Discussions on how the application relates to the criteria should not take place in this section unless otherwise specified.**

SECTION B: PROJECT DESCRIPTION

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

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

RESPONSE: SBH-Kingsport, LLC ("SBH") proposes to establish a 72-bed, free-standing psychiatric hospital located in Kingsport, Sullivan County, Tennessee. It is requesting CON permission to construct 18 adult psychiatric beds, 16 geropsychiatric beds, 28 child and adolescent psychiatric beds, and 10 chemical dependency beds for a total of 72 beds.

SBH will be owned and operated by a limited liability company, SBH-Kingsport, LLC. This limited liability company is a wholly-owned subsidiary of Strategic Behavioral Health, LLC, which is an inpatient psychiatric hospital company based in Memphis, Tennessee. It currently operates seven psychiatric hospitals through subsidiaries in the states of Colorado, Nevada, New Mexico and North Carolina. It has another facility under development in College Station, Texas. SBH will be its first hospital based in its home state of Tennessee.

The service area for SBH is projected to be the counties of Sullivan and Hawkins in Tennessee, and the counties of Wise, Scott and Lee in southwestern Virginia. Currently, in this service area there are only twelve inpatient psychiatric beds, located at Bristol Regional Medical Center in Bristol, Tennessee, at the eastern end of the service area. Thus, as far as the applicant is able to ascertain, in its proposed service area, which has a population of more than 300,000 people, there are only 12 inpatient psychiatric beds (located in Bristol). Thus, there is a significant need for additional inpatient psychiatric bed resources in this service area, particularly as it pertains to children and adolescents. Sullivan County is the most populous county in upper East Tennessee, and Kingsport is the biggest municipality in the service area.

The projected project costs for this hospital development are approximately $12,000,000. The funding for this project will be developed with the assistance of Dobbs Management Services, LLC, the owners of which represent the majority ownership of Strategic Behavioral Health, LLC. Furthermore, as of December 31, 2012, SBH itself had consolidated annual net revenue of approximately $50.7 million and employed approximately 745 employees. Thus, Strategic Behavioral Health, LLC, the parent

company of SBH-Kingsport, LLC, is a well-capitalized, financially successful psychiatric hospital development and management company.

SBH, the parent company of the applicant, is experienced in the development and operation of inpatient psychiatric facilities. Therefore, it has access to sufficient resources to assure proper staffing and financial feasibility for this facility, SBH-Kingsport, LLC, in Kingsport, Tennessee, the subject of this CON application.

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

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

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

RESPONSE: SBH-Kingsport, LLC, the applicant for this project, is requesting a certificate of need for the construction, development and establishment of a 72-bed free-standing psychiatric hospital to be located at unaddressed property at the end of Executive Park Boulevard, Kingsport, Tennessee 37660.

The requested chart for square footage and cost per square foot is attached. This project is projected to cost approximately $12,000,000, and is further projected to contain approximately 52,260 square feet of psychiatric hospital and related space. The construction costs are projected to be approximately $153 per square foot.

The proposed SBH-Kingsport will be a one-story, 52,263 SF facility serving acute psychiatric and chemical dependency patients. The structure is type VA construction with the following occupancies: Institutional (I-2) at patient units, Assembly (A-2) at the Dining Room, Assembly (A-3) at the Gym, Education (E) at the classrooms, and Business (B) at the administrative, assessment and outpatient suites. The building structure consists of spread footings (unless the soil report dictates otherwise), concrete slab-on-grade, load-bearing steel studs, and pitched wood roof trusses. The exterior walls are clad in two colors of brick, the roof is asphalt shingles, and the glazing is frosted in patient areas to protect patient privacy. On-site parking is provided per local zoning guidelines. A covered ambulatory entrance is also included.

Each patient room is double-occupancy and is served by an adjacent bathroom with shower, toilet and lavatory. The 16-bed geriatric unit contains a living room, group room, doctor office, seclusion room with dedicated toilet room, and a centrally-located nurses' station. The additional 56 inpatient beds are separated into four units – two with 18 beds and two with 10 beds. Each unit houses a dayroom and consultation office. Two acute units share a nurses' station, med room, and seclusion room with dedicated toilet room. The nurses' station is located so that the nursing staff can maintain visual control over both units while preserving acoustic separation to protect patient privacy.

Child and Adolescent patients are served by two classrooms. There is a full-service kitchen and adjacent dining room that can be divided into two separate spaces. A gymnasium with basketball goal is available for all patients.

The administrative, assessment and outpatient suites are individually secure from each other and the rest of the building. The assessment suite includes rooms dedicated to patient assessment, financial counseling, and private family waiting. The outpatient suite houses therapy offices, and group rooms. The administrative suite includes offices and a large conference area.

All fixtures, hardware and finishes have been selected with patient safety as the critical factor. Plumbing fixtures, door hardware, shower curtain hangers, and furniture are specified to be anti-ligature. All patient room windows are protected from the interior with polycarbonate. Corridor and patient room walls are protected below the chair rail with FRP panels. Even with these measures in place, great care has been taken to create a welcoming, comfortable environment with a residential feel for patients and staff.

The design meets local building codes as well as regulations set forth by the Tennessee Department of Health.

No major medical equipment will be purchased for this project.

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

RESPONSE: This project involves development of an inpatient psychiatric hospital that is projected to contain 18 adult psychiatric beds, 16 geropsychiatric beds, 28 child and adolescent psychiatric beds, and 10 chemical dependency beds. Thus, it will have a total of 72 licensed inpatient psychiatric hospital beds when the project is completed. It does not have any existing services in this service area.

The applicant has chosen to seek the establishment of 28 child and adolescent psychiatric beds because, to the best of its knowledge, there are no dedicated child and adolescent psychiatric beds reported for this service area. Thus, these beds will, in a dedicated fashion, meet the extensive need which exists in the service area for such dedicated resources to serve the inpatient behavioral health needs of children and adolescents in the service area.

Furthermore, until 2009, a 61-bed psychiatric hospital existed in Kingsport, Tennessee. This was Indian Path Pavilion, which was closed down in approximately 2009 as part of a CON project whereby an additional nine adult psychiatric beds were opened at the Woodridge Psychiatric facility in Johnson City, in Washington County, which is not in this service area. The owner of Woodridge, Mountain States Health Alliance ("MSHA"), having acquired Indian Path Pavilion a number of years earlier, closed it sometime around 2009. Thus, for a number of years, there have been no sizeable provider of inpatient psychiatric beds anywhere in this five-county service area that is proposed for this project.

SQUARE FOOTAGE AND COST PER SQUARE FOOTAGE CHART

A. Unit / Department	Existing Location	Existing SF	Temporary Location	Proposed Final Location	Proposed Final Square Footage			Proposed Final Cost/ SF		
					Renovated	New	Total	Renovated	New	Total
Administration						5,338	5,338		$153.07	$153.07
Assessment						2,704	2,704		$153.07	$153.07
Outpatient Treatment						2,078	2,078		$153.07	$153.07
Inpatient Unit						27,044	27,044		$153.07	$153.07
Lab						0	0		0	0
Dietary						2,467	2,467		$153.07	$153.07
Educational						909	909		$153.07	$153.07
Gym						2,223	2,223		$153.07	$153.07
Building Support						1,112	1,112		$153.07	$153.07
Materials Management						568	568		$153.07	$153.07
Pharmacy						552	552		$153.07	$153.07
B. Unit/Depart. GSF Sub-Total						44,992	44,992		$6,887,015	$6,887,015
C. Mechanical/ Electrical GSF						340	340		$52,044	$52,044
D. Circulation /Structure GSF						6,931	6,931		$1,060,942	$1,060,942
E. Total GSF						52,263	52,263		$8,000,002	$8,000,002

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

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

RESPONSE: The applicant, SBH, proposes to initiate adult psychiatric as well as child and adolescent psychiatric services, along with beds for each, at this proposed new facility. As noted above, Indian Path Pavilion does not provide inpatient psychiatric bed services now, and has not done so for a number of years.

Also, the applicant is informed that northeast Tennessee, unlike most of the other regions of the state, does not have a government owned and operated mental health facility. Thus, SBH will be contributing additional resources, personnel and funding to meeting the need for inpatient behavioral services, especially for children and adolescents, in this service area, after this proposal is approved and the project is completed.

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

RESPONSE: Not applicable.

E. Describe the acquisition of any item of major medical equipment (as defined by the Agency Rules and the Statute) which exceeds a cost of $1 .5 million; and/or is a magnetic resonance imaging (MRI) scanner, positron emission tomography (PET) scanner, extracorporeal lithotripter and/or linear accelerator by responding to the following:

1. For fixed-site major medical equipment (not replacing existing equipment):

a. Describe the new equipment, including:

1. Total cost; (As defined by Agency Rule).
2. Expected useful life;
3. List of clinical applications to be provided; and
4. Documentation of FDA approval.

RESPONSE: Not applicable.

b. Provide current and proposed schedules of operations.

RESPONSE: Not applicable.

2. For mobile major medical equipment:

a. List all sites that will be served;

b. Provide current and/or proposed schedule of operations;

c. Provide the lease or contract cost.

d. Provide the fair market value of the equipment; and

e. List the owner for the equipment.

RESPONSE: Not applicable.

3. Indicate applicant's legal interest in equipment (i.e., purchase, lease, etc.) In the case of equipment purchase include a quote and/or proposal from an equipment vendor, or in the case of an equipment lease provide a draft lease or contract that at least includes the term of the lease and the anticipated lease payments.

RESPONSE: Not applicable.

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

1. Size of site (*in acres*);

2. Location of structure on the site; and

3. Location of the proposed construction.

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

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

RESPONSE: The requested plot plan is attached. Executive Park Boulevard dead-ends at the site, which lies south of the Executive Park Boulevard

intersection with East Stone Drive in Kingsport, Tennessee. The site's acreage is approximately 9.7 acres.

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

RESPONSE: SBH-Kingsport, LLC will be located on undeveloped land at the end of Executive Park Boulevard in Kingsport, Tennessee. The site is very close to one of the major highway intersections in Kingsport – the intersection of East Stone Drive and North John B. Dennis Highway.

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

RESPONSE: The requested floor plans are attached.

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

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

A. Existing service area by County;

B. Proposed service area by County;

C. A parent or primary service provider;

D. Existing branches; and

E. Proposed branches.

RESPONSE: Not applicable.

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SECTION C: GENERAL CRITERIA FOR CERTIFICATE OF NEED

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

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

QUESTIONS
NEED

1. Describe the relationship of this proposal toward the implementation of the State Health Plan and Tennessee's Health: Guidelines for Growth.

   A. Please provide a response to each criterion and standard in Certificate of Need Categories that are applicable to the proposed project. Do not provide responses to General Criteria and Standards (pages 6-9) here.

   RESPONSE: The applicant's responses to the individual criteria for this project in the *Guidelines for Growth* are set forth below.

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).

   RESPONSE: The total population of the five-county service area, Sullivan and Hawkins Counties Tennessee and Wise, Scott and Lee Counties in Virginia, is approximately 305,657, according to recent Census Bureau and Tennessee Department of Health data. At the rate of 30 beds per 100,000 population, there is a need for approximately 90 beds and in this five-county service area.

   Sullivan County is by far the most populous county in the service area, with a 2014 population of nearly 159,000 people. If the need for Sullivan and Hawkins Counties only were considered separately, there would be approximately 216,484 people in that service area. These two counties alone would generate a need for more than 62

inpatient psychiatric beds, according to the *Guidelines for Growth* formula (excluding the population 4 years of age and under).

In the service area, according to the applicant's best information, there are only 12 inpatient psychiatric beds located at Bristol Regional Medical Center. Thus, there is a need for 78 additional inpatient psychiatric hospital beds for this service area, as calculated by the 30 beds per 100,000 general population need formula in the *Guidelines for Growth*.

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

RESPONSE: Available population data charts break out the population according to the chart below, in age brackets that run from 15 to 19 for adolescents. The applicant has analyzed the need for adult beds for the population cohorts age 19 through 64, as shown on the chart below. As this chart indicates, there are approximately 186,000 adults in the service area. When the need standard in *Guidelines for Growth* of 30 beds per 100,000 population is applied, the needed beds figure amounts to 55.8 adult beds, which would be 56 beds rounded off. Currently, as noted above, there are 12 inpatient psychiatric adult beds at Bristol Regional Medical Center in Bristol, Tennessee. Therefore, according to this formula, there are 44 additional adult inpatient psychiatric beds needed for the service area. This application seeks 16 such beds; therefore, this application satisfies this criterion. The population data in the cart below are from two sources; the Tennessee data for Sullivan and Hawkins County are from the Tennessee Department of Health's 2013 Population Projections 2010-2020, while the data for the Virginia counties of Wise, Scott and Lee are from the U.S. Census Bureau's 7/1/2012 County Characteristics Resident Population Estimates.

This application also plans to establish 16 geropsychiatric beds. The age 65 and over population of the service is approximately 60,650 individuals. This yields a need for 18.2 geropsychiatric beds, according to the need formula. The applicant seeks 16 geropsychiatric beds, thus the need for those beds in this service area is justified under the *Guidelines for Growth*.

Age Brackets: Population of Service Area

County	Ages 5-14	Ages 15-19	Ages 19-64	Ages 65+	Totals
Sullivan	16,775	9,398	92,651	33,325	152,149
Hawkins	6,597	3,617	33,582	11,259	55,055
Wise, VA	4,683	2,682	26,117	6,028	39,510
Scott, VA	2,422	1,213	18,175	4,656	26,466
Lee, VA	1,475	1,355	15,537	5,382	23,749
Totals:	31,952	18,265	186,062	60,650	296,929

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

RESPONSE: Given the way the population data is available, the applicant has examined the population service area in two age ranges as shown in the chart above: ages 5 through 14 and ages 15 through 19. The ages 5 through 14 yields a total

population of the service area for this age group as 31,952, which yields a need of 9.6 beds.

Similarly, the adolescent age group of ages 15 through 19 yields a population total of 18,265 individuals. This yields, under the *Guidelines for Growth* need formula, a need for 5.5 beds. Thus, for children and adolescents there is a net need of 15.1beds, which yields a practical need of 16 beds in this service area. The applicant believes that, given the paucity of dedicated adolescent psychiatric hospital beds in the upper east Tennessee, southwestern Virginia area, it will draw additional utilization for this service from counties outside the primary service area.

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.

RESPONSE: As shown in the above responses, there are only 12 existing inpatient psychiatric hospital beds in the service area, according to the applicant's best information. Therefore, there is a significant need for the additional beds as set forth in this application.

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.

RESPONSE: As noted above, the Tennessee counties of Sullivan and Hawkins account for more than 70% of the population in the service area. Given Kingsport's prominence in the service area as the largest city in this region as well as the service area, and Sullivan County's status as the most populous county in the service area, it is entirely appropriate for this hospital to be based in the most densely populated area of the service area, in Kingsport, Tennessee. Furthermore, Kingsport shares geography and economic links with the counties to its north and west in southwestern Virginia. Therefore, the population area is reasonable, given the mountainous nature of this region.

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.

RESPONSE: The applicant will accept involuntary and voluntary admissions to its inpatient psychiatric beds. There is also a great need for service to low income groups and individuals suffering from chemical dependency. People needing chemical dependency inpatient services are a group for whom there are no other dedicated beds in the service area, to the best of the information of the applicant. The socio demographics of the service area are shown in the attached population reports.

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.

RESPONSE: As shown above, this project is consistent with the *Guidelines for Growth*'s numerical and need analysis. It will provide much needed investment in inpatient psychiatric facilities in the northeastern Tennessee area, given the closure of the Indian Path Pavilion psychiatric hospital in 2009, and the closure of Lakeshore Mental Health Institute in Knoxville in 2012, which had included Sullivan and Hawkins Counties in its service area.

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.

RESPONSE: As noted above, this mountainous area of northeastern Tennessee and southwestern Virginia is underserved in terms of inpatient psychiatric hospital beds. The applicant has received significant support from individuals in the area who believe there is a need for additional inpatient psychiatric services. That there are only 12 inpatient psychiatric beds in the service area also indicates that it is an underserved area with an underserved population.

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

RESPONSE: The applicant will accept TennCare patients and referrals. However, because of certain restrictions in the Medicaid program, the applicant will not be able to accept adult TennCare admissions, until as the applicant hopes will occur soon, the Medicare regulations preventing such acceptance are altered. However, the majority of TennCare patients are under 21.

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.

RESPONSE: As indicated above, the applicant will accept voluntary and involuntary admissions. It is familiar with the involuntary admission process and issues; its parent company supports similar processes in other states at its other inpatient psychiatric hospitals.

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

RESPONSE: The applicant does intend to accept all available TennCare admissions, and will accept Medicare admissions as well. Therefore, the applicant anticipates significant Medicare and TennCare utilization and financial participation. Its TennCare utilization is projected to be 38% of charges while its projected Medicare utilization is projected to be 20% of charges.

D. Relationship to Existing Similar Services in the Area

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

RESPONSE: As noted above, there is only one other location in the service area which provides inpatient psychiatric services: Bristol Regional Medical Center in Bristol, Tennessee. Bristol is located at the eastern end of Sullivan County, whereas Kingsport is on the western side of Sullivan County. The applicant does not foresee significant impact on this project on the Bristol BRMC inpatient psych beds given the complete absence of these services in the Kingsport area currently, or in any of the other counties in the projected service area.

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

RESPONSE: As noted, the applicant will accept involuntary admissions. Therefore, the mentally infirm will be eligible to receive treatment at this facility.

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.

RESPONSE: The applicant will meet all applicable licensure regulations of the Tennessee Department of Mental Health and Substance Abuse Services, as well as any required by the Department of Health. It also intends to be accredited by the Joint Commission. It will meet all applicable licensure for all applicable personnel and staffing requirements for inpatient psychiatric facilities.

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

RESPONSE: Not applicable.

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

RESPONSE: This is a new facility. However, it is the first facility in Tennessee to be sought to be developed by Strategic Behavioral Health, LLC, which is a provider of mental health services in a number of other states. Strategic Behavioral Health, LLC is based in Memphis, Tennessee, and considers the development of a Tennessee facility to be essential to its long-range development plan.

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

RESPONSE: The proposed service area consists of the Tennessee counties of Sullivan and Hawkins, and the Virginia counties of Wise, Scott and Lee. The proposed service

area maps are attached. The applicant plans to establish this facility in this most populous town in the most populous county in the service area. Its location is convenient to residents of Hawkins County, as well as to residents of Wise, Scott, and Lee Counties in Virginia. These counties form a service area which looks to facilities in Kingsport for service. It also constitutes an area that has very few inpatient psychiatric beds. It needs this project.

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

RESPONSE: The demographics of the service area are as demonstrated in the attached population data tables.

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

RESPONSE: See the responses to the *Guidelines for Growth* criteria above. Also, according to the publication of the National Institute of Mental Health ("NIMH") entitled "The Numbers Count: Mental Disorders in America", over 26% of Americans 18 and older suffer from a diagnosable mental disorder in any given year. Furthermore, NIMH states that 6% of the population suffers from a serious mental illness, and mental disorders are the leading cause of disability in the U.S. These same conditions apply to the population of this project's service area.

5. Describe the existing or certified services, including approved but unimplemented CONs, of similar institutions in the service area. Include utilization and/or occupancy trends for each of the most recent three years of data available for this type of project. Be certain to list each institution and its utilization and/or occupancy individually. Inpatient bed projects must include the following data: admissions or discharges, patient days, and occupancy. Other projects should use the most appropriate measures, e.g., cases, procedures, visits, admissions, etc.

RESPONSE: As noted above, there is only one other provider of inpatient psychiatric services in the service area: Bristol Regional Medical Center in Bristol, Tennessee. It reports having 12 adult psychiatric beds. According to the DOH Office of Health Statistics, in 2011, BRMC had 335 psychiatric admissions, which generated 2,448 patient days.

Its reported utilization for the past three years as shown in BRMC's Joint Annual Reports for the respective years, differs significantly, and apparently does not reflect the utilization of its 12 psychiatric beds:

Year	Drug/Alcohol Admissions	Drug/Alcohol Patient Days	Psychiatric Admissions	Psychiatric Patient Days
2012	57	200	44	184
2011	42	146	62	266
2010	43	116	40	195

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

RESPONSE: This project is for the establishment of a new inpatient psychiatric hospital. There is no historical utilization. The utilization projected for the first two years following the completion of this project is as set forth below:

Month	Year 1	Year 2
January	3.9	38.7
February	6.4	40.3
March	11.6	40.6
April	16.0	44.0
May	19.4	44.5
June	24.0	48.4
July	27.1	48.4
August	31.0	50.3
September	34.0	51.2
October	34.8	50.3
November	38.0	52.6
December	38.7	52.3
Total Average ADC	**23.8**	**46.8**

ECONOMIC FEASIBILITY

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

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

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

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

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

RESPONSE: The projected cost report is attached. The documentation from the architect and contractor requested are attached hereto.

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PROJECT COSTS CHART

A.	Construction and equipment acquired by purchase:		
	1. Architectural and Engineering Fees		$267,000
	2. Legal, Administrative (Excluding CON Filing Fee), Consultant Fees		$75,000
	3. Acquisition of Site		$925,000
	4. Preparation of Site		$675,000
	5. Construction Costs		$6,000,682
	6. Contingency Fund		$200,000
	7. Fixed Equipment (Not included in Construction Contract)		$660,000
	8. Moveable Equipment (List all equipment over $50,000)		$100,000
	9. Other (Specify)	N/A	N/A
B.	Acquisition by gift, donation, or lease:		
	1. Facility (inclusive or building and land)		N/A
	2. Building only		N/A
	3. Land only		N/A
	4. Equipment (Specify) Copier		$2,000
	5. Other (Specify)		N/A
C.	Financing Costs and Fees:		
	1. Interim Financing		$150,000
	2. Underwriting Costs		$75,000
	3. Reserve for One Year's Debt Service		N/A
	4. Other (Specify) Build Year Operating Cost		$562,607
D.	Estimated Project Cost (A+B+C)		$11,691,609
E.	CON Filing Fee		$26,306
F.	Total Estimated Project Cost (D+E)		$11,717,915
		TOTAL	$11,717,915

JAN 29 '14 PM3:01

SUPPLEMENTAL- # 1
January 29, 2014
3:10pm

2. Identify the funding sources for this project.

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

   ☐A. Commercial loan - Letter from lending institution or guarantor stating favorable initial contact, proposed loan amount, expected interest rates, anticipated term of the loan, and any restrictions or conditions;

   ☐B. Tax-exempt bonds - Copy of preliminary resolution or a letter from the issuing authority stating favorable initial contact and a conditional agreement from an underwriter or investment banker to proceed with the issuance;

   ☐C. General obligation bonds--Copy of resolution from issuing authority or minutes from the appropriate meeting.

   ☐D. Grants--Notification of Intent form for grant application or notice of grant award; or

   ☒E. Cash Reserves--Appropriate documentation from Chief Financial Officer.

   ☒F. Other--Identify and document funding from all other sources.

   RESPONSE: The funding source letter for this project is attached hereto.

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

   RESPONSE: The project costs for establishing this new inpatient psychiatric facility are reasonable. The cost per square foot of construction is approximately $153. This compares favorably with recent projects approved by the Health Services and Development Agency.

4. Complete Historical and Projected Data Charts on the following two pages--Do not modify the Charts provided or submit Chart substitutions! Historical Data Chart represents revenue and expense information for the last three (3) years for which complete data is available for the institution. Projected Data Chart requests information for the two (2) years following the completion of this proposal. Projected Data Chart should reflect revenue and expense projections for the Proposal Only (i.e., if the application is for additional beds, including anticipated revenue from the proposed beds only, not from all beds in the facility).

   RESPONSE: As noted, this is a new facility, therefore, there is no historical data for it. The requested Projected Data Chart is attached hereto.

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

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RESPONSE: The project's average gross charge is $1,578; its average deduction from operating revenue is $979, and its average net charge is $599.

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HISTORICAL DATA CHART

N/A

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

	Year____	Year____	Year____
A. Utilization Data (Specify unit of measure)			
B. Revenue from Services to Patients			
1. Inpatient Services	$	$	$
2. Outpatient Services			
3. Emergency Services			
4. Other Operating Revenue (Specify)_____			
Gross Operating Revenue	$	$	$
C. Deductions from Gross Operating Revenue			
1. Contractual Adjustments	$	$	$
2. Provision for Charity Care			
3. Provisions for Bad Debt			
Total Deductions	$	$	$
NET OPERATING REVENUE	$	$	$
D. Operating Expenses			
1. Salaries and Wages	$	$	$
2. Physician's Salaries and Wages			
3. Supplies			
4. Taxes			
5. Depreciation			
6. Rent			
7. Interest, other than Capital			
8. Management Fees:			
a. Fees to Affiliates			
b. Fees to Non-Affiliates			
9. Other Expenses (Specify) _____			
Total Operating Expenses	$	$	$
E. Other Revenue (Expenses) -- Net (Specify)	$	$	$
NET OPERATING INCOME (LOSS)	$	$	$
F. Capital Expenditures			
1. Retirement of Principal	$	$	$
2. Interest			
Total Capital Expenditures	$	$	$
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES	$	$	$

SUPPLEMENTAL- # 1
January 29, 2014
3:10pm

PROJECTED DATA CHART

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

		Year 1	Year 2
A.	Utilization Data (Specify unit of measure) patient days	8,700	17,100
B.	Revenue from Services to Patients		
	1. Inpatient Services	$13,728,600	$26,983,800
	2. Outpatient Services	426,000	1,040,000
	3. Emergency Services	0	0
	4. Other Operating Revenue (Specify) N/A	0	0
	Gross Operating Revenue	$14,154,600	$28,023,800
C.	Deductions from Gross Operating Revenue		
	1. Contractual Adjustments	$8,521,215	$16,748,595
	2. Provision for Charity Care	686,430	1,349,190
	3. Provisions for Bad Debt	162,612	322,656
	Total Deductions	$9,370,257	$18,420,441
NET OPERATING REVENUE		$4,784,343	$9,603,359
D.	Operating Expenses		
	1. Salaries and Wages	$3,388,492	$5,628,936
	2. Physician's Salaries and Wages	150,000	150,000
	3. Supplies	405,000	786,600
	4. Taxes	60,000	60,000
	5. Depreciation	414,056	414,056
	6. Rent	24,000	24,000
	7. Interest, other than Capital	N/A	N/A
	8. Management Fees:		
	a. Fees to Affiliates	N/A	N/A
	b. Fees to Non-Affiliates	N/A	N/A
	9. Other Expenses (Specify) Utilities/ins/travel/repairs/ advertising/purchased serv	843,108	1,057,692
	Total Operating Expenses	$5,284,656	$8,121,284
E.	Other Revenue (Expenses) -- Net (Specify)	N/A	N/A
NET OPERATING INCOME (LOSS)		$<500,313>	$1,482,075
F.	Capital Expenditures		
	1. Retirement of Principal	$380,000	$366,879
	2. Interest	454,027	438,343
	Total Capital Expenditures	$834,027	$805,222
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES		$<1,334,340>	$676,853

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

RESPONSE: There is no current charge schedule for this facility since it has not been constructed yet. Its proposed charges are as follows:

Adult psychiatric average inpatient charge per day: $1,578

Geropsychiatric average inpatient charge per day: $1,578

Child and adolescent average inpatient charge per day: $1,578

Chemical dependency average inpatient charge per day: $1,578

These charges compare favorably with charges for other inpatient psychiatric facilities that can be ascertained from the records of the HSDA.

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

RESPONSE: See response to Question A above.

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

RESPONSE: Given the need for additional psychiatric inpatient services in the service area, especially for children, the applicant projects that its utilization rates are sufficient to maintain cost effectiveness of the facility. The applicant has significant experience in starting and establishing inpatient psychiatric facilities in other states. The number of psychiatric beds it proposes to build here (72) take into account economies of scale superior to those of smaller-scale units in general acute-care hospitals. This has been Strategic Behavioral Health's experience in its numerous other hospitals.

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

RESPONSE: As noted above, given the applicant's experience in other states, it is confident that financial viability will be ensured within two years and positive cash flow will develop in the second year. The applicant's financial analysis has taken into account any short-term losses that may occur during ramp-up. Strategic Behavioral Health has a corporate philosophy of patient capital investment, as evidenced by the numerous startup hospital projects it has completed over the last eight years.

9. Discuss the project's participation in state and federal revenue programs including a description of the extent to which Medicare, TennCare/Medicaid, and medically indigent patients will be served by the project. In addition, report the estimated dollar amount of revenue and percentage of total project revenue anticipated from each of TennCare, Medicare, or other state and federal sources for the proposal's first year of operation.

RESPONSE: The applicant plans to participate in Medicare and TennCare. It also will provide services to medically indigent patients. The applicant projects that in its first year of operations, its estimated actual revenue received from TennCare will be approximately $1,818,300 which constitutes approximately 38% of its revenue for that year. It further projects that in its first year of operation, its estimated actual revenue received from Medicare will be $1,305,000 which constitutes approximately 27% of its revenue for that year.

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

RESPONSE: SBH-Kingsport, LLC is a new entity. Its corporate documentation is attached. The requested financial documentation for its parent company, Strategic Behavioral Health, is attached.

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

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

RESPONSE: The applicant has reviewed the closing of psychiatric beds in the broader East Tennessee area that has gone on for a number of years, including at Indian Path Pavilion in 2009. Given that, the applicant is confident that there are no less costly, more effective, more efficient ways of providing the benefits of inpatient psychiatric beds other than by constructing a new facility. Strategic Behavioral Health has analyzed this issue in other contexts, and found that freestanding psychiatric hospitals operate on a significantly lower cost per patient day than acute hospital psychiatric units or state-run psychiatric facilities.

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

RESPONSE: The applicant has no facilities in east Tennessee to modernize. It does not believe that any other providers in east Tennessee would engage in sharing arrangements with it, since it is a new provider in the area. Further, sharing facilities is not likely to occur, since there are no other freestanding psychiatric hospital facilities in its service area.

(III.) CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE

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

RESPONSE: The applicant plans to have transfer agreements with local area hospitals, such as Wellmont Holston Valley Medical Center in Kingsport. Strategic Behavioral Health, the parent company of the applicant, reports that in every community in which it provides care, it has a history of working with all agencies and other providers to provide a collaborative process to analyze and reduce barriers to access and service delivery. In this service area, there are currently no freestanding psychiatric hospital beds, a critical component of the mental and behavioral health continuum of care.

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

   RESPONSE: The applicant has noted repeatedly in this application, other than the 12 inpatient geropsychiatric beds at BRMC in eastern Sullivan County, Tennessee, there are no other inpatient psychiatric beds, to the applicant's best knowledge, in this service area. Furthermore, the population of the service area, when analyzed in terms of the *Guidelines for Growth*'s numerical formula, demonstrates a need for additional inpatient psychiatric beds. Therefore, the applicant does not project that its project will have significant impact on the utilization rates of any existing providers in the service area for the project. Furthermore, by offering dedicated chemical dependency and child and adolescent beds to the service area, the applicant will have a positive effect on the behavioral healthcare system in the service area.

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

   RESPONSE: The requested staffing pattern information is attached hereto.

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

   RESPONSE: The applicant, as a subsidiary of a successful, Tennessee-based, psychiatric hospital company, will have sufficient access to human resources required by the proposal adequate to meet the requirements of the Mental Health and Substance Abuse Services Department, or the Tennessee Department of Health, as applicable.

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

   RESPONSE: The applicant understands and has reviewed all licensing and certification requirements of the State of Tennessee for medical or clinical staff.

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

RESPONSE: The applicant is plans to participate in the training of students in the area of behavioral healthcare. It is open to collaborating with area nursing schools and other healthcare training and education providers.

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

   RESPONSE: The applicant has reviewed and understands the licensure requirements of the Tennessee Department of Mental Health and Substance Abuse Services and the Department of Health, as applicable.

   B. Provide the name of the entity from which the applicant has received or will receive licensure, certification, and/or accreditation.

   Licensure: The applicant anticipates licensure from the Department of Mental Health and Substance Abuse Services.

   Accreditation: The applicant intends to obtain accreditation by the Joint Commission.

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

   RESPONSE: Not applicable.

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

   RESPONSE: Not applicable.

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

   RESPONSE: No such orders or judgments exist.

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

   RESPONSE: There are no such civil or criminal judgments.

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

    RESPONSE: If approved, the applicant will provide the Tennessee Health Services and Development Agency and any other reviewing agency with the requested information.

DEC 13 '13 PM 1:32

PROOF OF PUBLICATION

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

DEVELOPMENT SCHEDULE

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

1. **Please complete the Project Completion Forecast Chart on the next page. If the project will be completed in multiple phases, please identify the anticipated completion date for each phase.**

2. **If the response to the preceding question *indicates that the applicant does not anticipate completing the project within the period of validity as defined in the preceding paragraph*, please state below any request for an extended schedule and document the "good cause" for such an extension.**

Form HF0004
Revised 05/03/04
Previous Forms are obsolete

SBH-KINGSPORT 001649

DEC 13 '13 PM 1:33

Legals

NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED

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

Stratiola Kingsport, LLC (Name of Applicant) owned by: Stratiola Kingsport, LLC with an ownership type of limited liability company, and to be managed by: Itself

intends to file an application for a Certificate of Need for: establishment of a new inpatient psychiatric hospital in Kingsport, Sullivan County, Tennessee 37660. This project will be located on undetermined property at the end of Executive Park Boulevard in Kingsport, Tennessee. This property extends south and west of Executive Park Boulevard, and is south of the intersection of Executive Park Boulevard and East Stone Drive in Kingsport, Tennessee. This project will involve the initiation of inpatient psychiatric hospital services. This new psychiatric hospital will have 16 adult beds, 16 geropsychiatric beds, 20 child and adolescent beds, and 10 chemical dependency beds. These 72 beds will all be new beds licensed as psychiatric hospital beds. The estimated project costs for the project are projected to be approximately $12,000,000.00.

The anticipated date of filing the application is: December 12, 2013.

The contact person for this project is:
Mike Garone (Contact Name) Director of Development (Title)
who may be reached at: Stratiola Behavioral Health, LLC (Company Name)
6398 Tournament Drive, Suite 201 (Address)
Memphis (City) Tennessee (State) 38125 (Zip Code)
901/360-3100 (Area Code / Phone Number)

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

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

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

PUB 12/10/13

Legals

SUBSTITUTE TRUSTEE'S SALE

Sale at public auction will be on January 16, 2014 at 10:00AM local time, at the main door, Sullivan County Courthouse, 140 Blountville Bypass, Blountville, Tennessee, conducted by Shapiro & Kirsch, LLP Substitute Trustee, pursuant to Deed of Trust executed by Tony Wayland Vines, unmarried, to Lenders Title & Escrow, LLC, Trustee, on October 29, 2004 at Book 2161C, Page 702; all of record in the Sullivan County Register's Office.
Party entitled to enforce security interest: PNC Bank, National Association, its successors and assigns

The following real estate located in Sullivan County, Tennessee, will be sold to the highest cash bidder subject to all unpaid taxes, prior liens and encumbrances of record:
SITUATE in the 11th Civil District of Sullivan County, Tennessee; to-wit:

LOT 13, BLOCK 61 (erroneously stated as Block 01 in prior deed), CITY OF KINGSPORT, as shown on map of record in the Register's Office for Sullivan County at Blountville, Tennessee, in Deed Book 107, at Page 406; and being the same property conveyed to Tony Wayland Vines from Everette R. Collins and Sherry G. Crawford by deed dated October 29, 2004 of record in the Register's Office for Sullivan County at Blountville, Tennessee in Deed 2161C, Page 700.
Street Address: 729 Boone Street, Kingsport, Tennessee 37660
Parcel Number: 046J-K-024.00
Current Owner(s) of Property: Tony Wayland Vines
Other Interested parties: Lenders Title & Escrow LLC and First Franklin Financial, a division of National City Bank of Indiana
The street address of the above described property is believed to be 729 Boone Street, Kingsport, Tennessee 37660, but such address is not part of the legal description of the property [illegible] herein and in the event of any [illegible]

410 Garage & Yard Sales

****HAVING A**** GARAGE SALE?
Let people know by placing an ad in the Kingsport Times-News Classifieds.
TimesNews
Place your ad online www.timesnews.net/classifieds or call 423-302-1311 for more information.

Take our Garage Sale Map on your Mobile Device. Scan the QR Code or go to ishoptheirmaps.com

421 Clothing

WOMEN'S 3X Burgundy Leather Jacket. Also, 3X name brand jeans. All new. 423-747-7141

430 Household & Antiques

Dining room set, 6 chairs, table w/leaf, china cabinet. Antique claw foot bathtub. 423-247-8330

431 Furnishings

!!! $200 10" Thick Full Size Pillowtop Mattress SET.. Never used. Still in factory sealed plastic. 423-765-8014

!!! $225 13" Thick Queen Size Pillowtop Mattress SET. Never Used. Still in factory sealed plastic. 423-765-8014

!!! $80 Full Size Mattress SET. Never Used. Still in Factory Sealed Plastic. Call 423-765-8014.

!!! $90 Queen Size Mattress SET, Never Used, Still in Factory Sealed Plastic, Call 423-765-8014

KING Pillow top Mattress set Never used, still in factory sealed plastic. $260 423-765-8014

ROLL TOP DESK Very good condition dark oak finish $250 423-247-4368

Legals

431 Furnishings

MATTRESS STORE CLOSING SELLING DUE TO HEALTH BUY AT DEALER COST Remaining inventory consists of Queen Mattress Sets Only! Open by Appointment Only! phone (423) 367-4478 For Details Johnson City

440 Computers & TV's

TOSHIBA 47" LED, full 1080p 3D, smart HD TV $570 OBO 7 mos. old 423-967-3081

XBOX ONE OR PLAYSTATION 4! SOLD OUT EVERYWHERE! Brand New in Box. Factory Sealed. Ready to Pickup Now! No Waiting! $450 Cash /Credit Card.. Call or Text 423-791-2570.

470 Building Materials

LIQUIDATION EVERYTHING GOES. All windows & doors 50% off 835 W. Sullivan St. 423-612-0002

490 Sports Equipment

ALUM. TACKLE BOX, with 3 trays 70 Bass plugs. Most never used. $300 423-239-3056

GUN SHOW DEC 14-15 SAT 9-6 & SUN 9-4 KNOXVILLE EXPO CENTER (5441 CLINTON HWY) EXIT 106 OFF I-75N BUY-SELL-TRADE INFO: (563) 927-5170

HORIZON Series Evolve Treadmill, would make an excellent gift, no more than 3 hrs used, $300 245-2540

510 Bicycles

BICYCLE, Trek 820 MounTain Track 21" $150 423-480-0191

520 Boats & Marine Equipment

CLOSEOUT sale at dealers cost, South Bay 2013 Pontoon 524CR, 115 hp Mercury. Lakeview Marina 423-323-1054

PONTOON - 1985 Riviera Cruiser 24 ft, hard top, 2001 Tandem axle trailer 70 hp Johnson motor, needs work, good winter project, asking $3,000. 423-418-5700

540 Musical Merchandise

AN older VIOLIN made in german very nice, ready to play in orchestra, case & bow included. $750 OBO local 765-9024

GUITAR - Fender Lebron Acoustic w/built-in pick-up. Black w/white pin stripe $450 423-747-7141

KING Silver Flare Trumpet, like new, case and mouth piece included. w/ thumb trigger & finger. 423-883-1066 $575 OBO

Legals

110

550

SBH-KINGSPORT 001650

DEC 13 '13 PM1:33

PROJECT COMPLETION FORECAST CHART

Enter the Agency projected Initial Decision date, as published in T.C.A. § 68-11-1609(c): 3/26/14

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

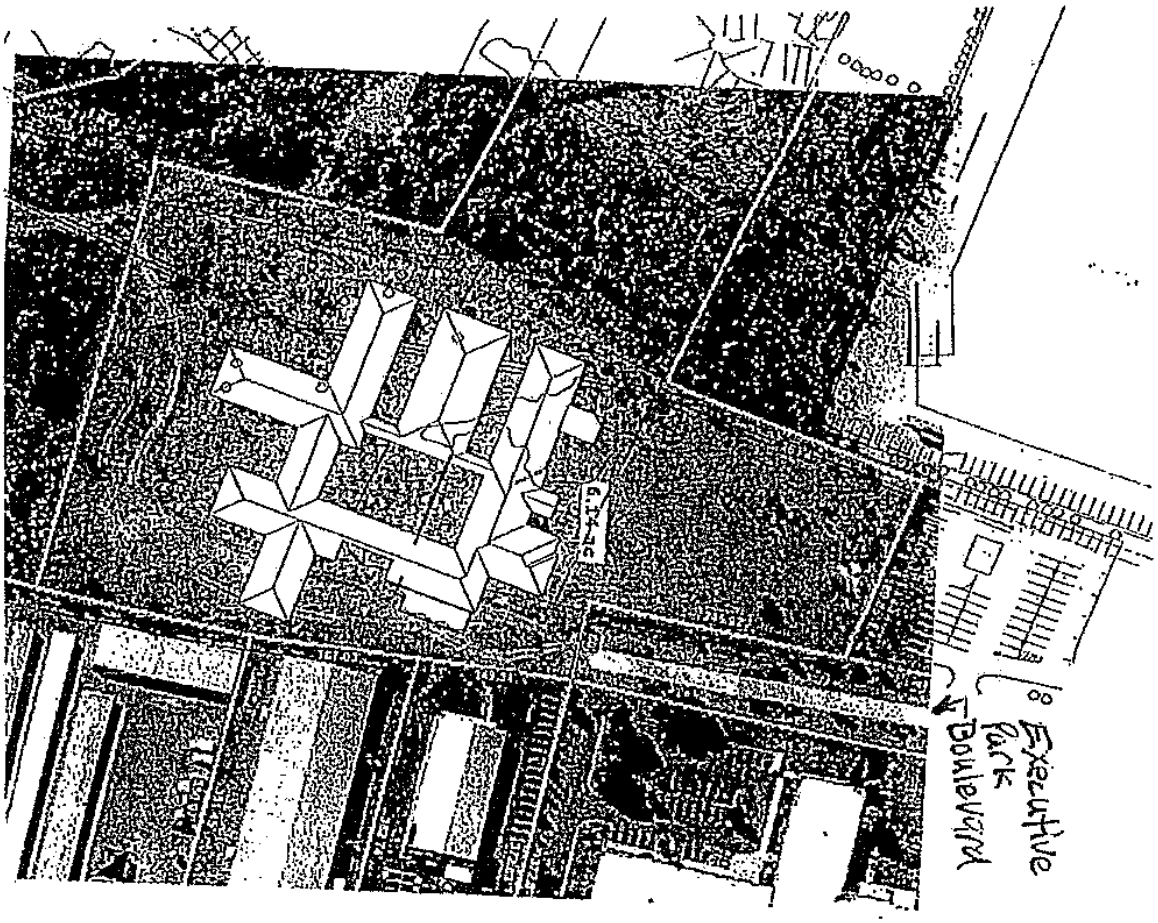
Phase	DAYS REQUIRED	Anticipated Date (MONTH/YEAR)
1. Architectural and engineering contract signed	0	3/26/14
2. Construction documents approved by the Tennessee Department of Health	214	10/26/14
3. Construction contract signed	61	5/26/14
4. Building permit secured	153	8/26/14
5. Site preparation completed	214	10/26/14
6. Building construction commenced	220	11/1/14
7. Construction 40% complete	371	4/1/15
8. Construction 80% complete	524	9/1/15
9. Construction 100% complete (approved for occupancy	585	11/1/15
10. *Issuance of license	599	11/15/15
11. *Initiation of service	600	11/16/15
12. Final Architectural Certification of Payment	615	12/1/15
13. Final Project Report Form (HF0055)	629	12/15/15

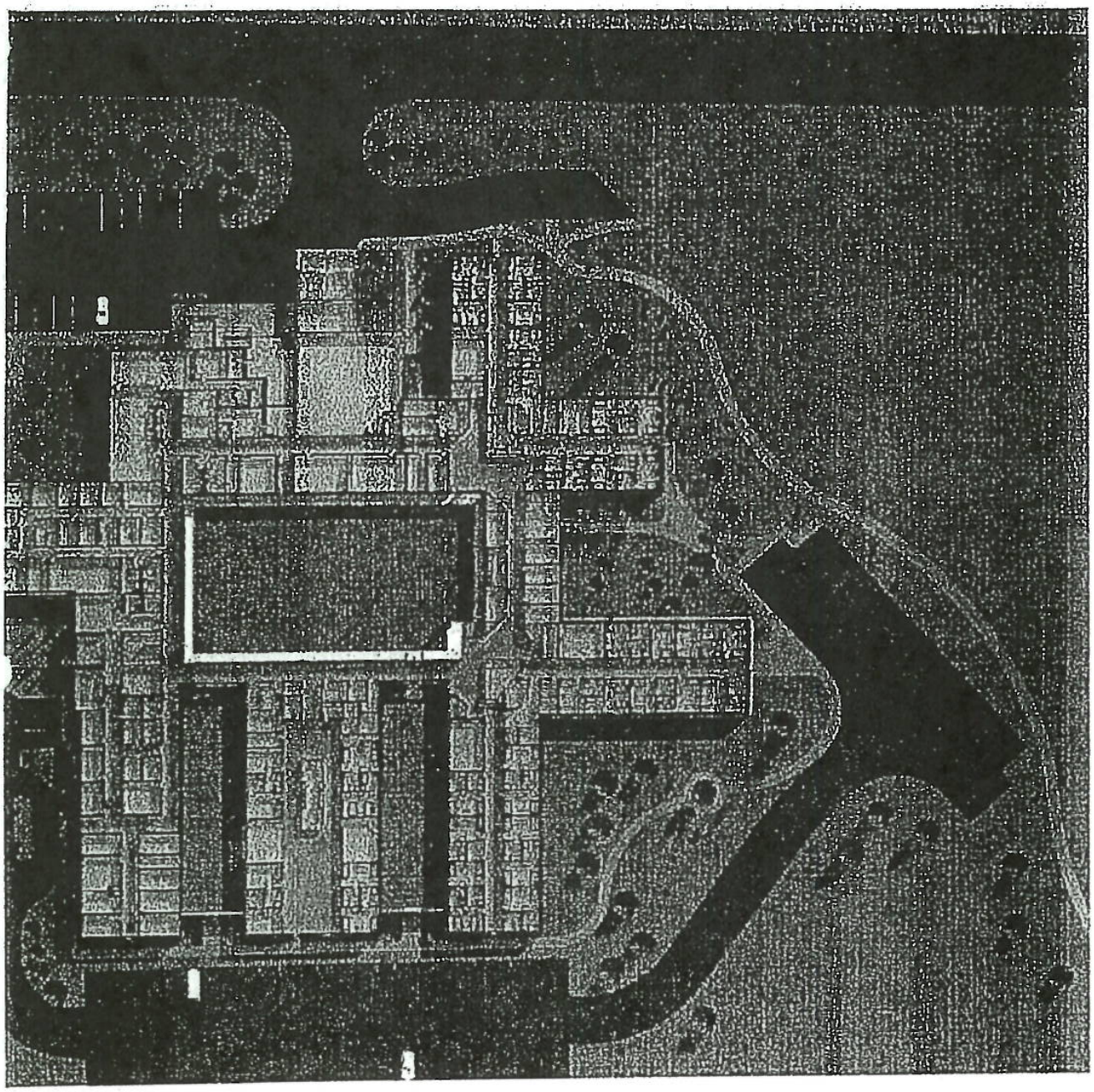
* For projects that do NOT involve construction or renovation: Please complete items 10 and 11 only.

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

B.III.A. - Plot Plan

SUPPLEMENTAL- # 1
January 29, 2014
3:10pm

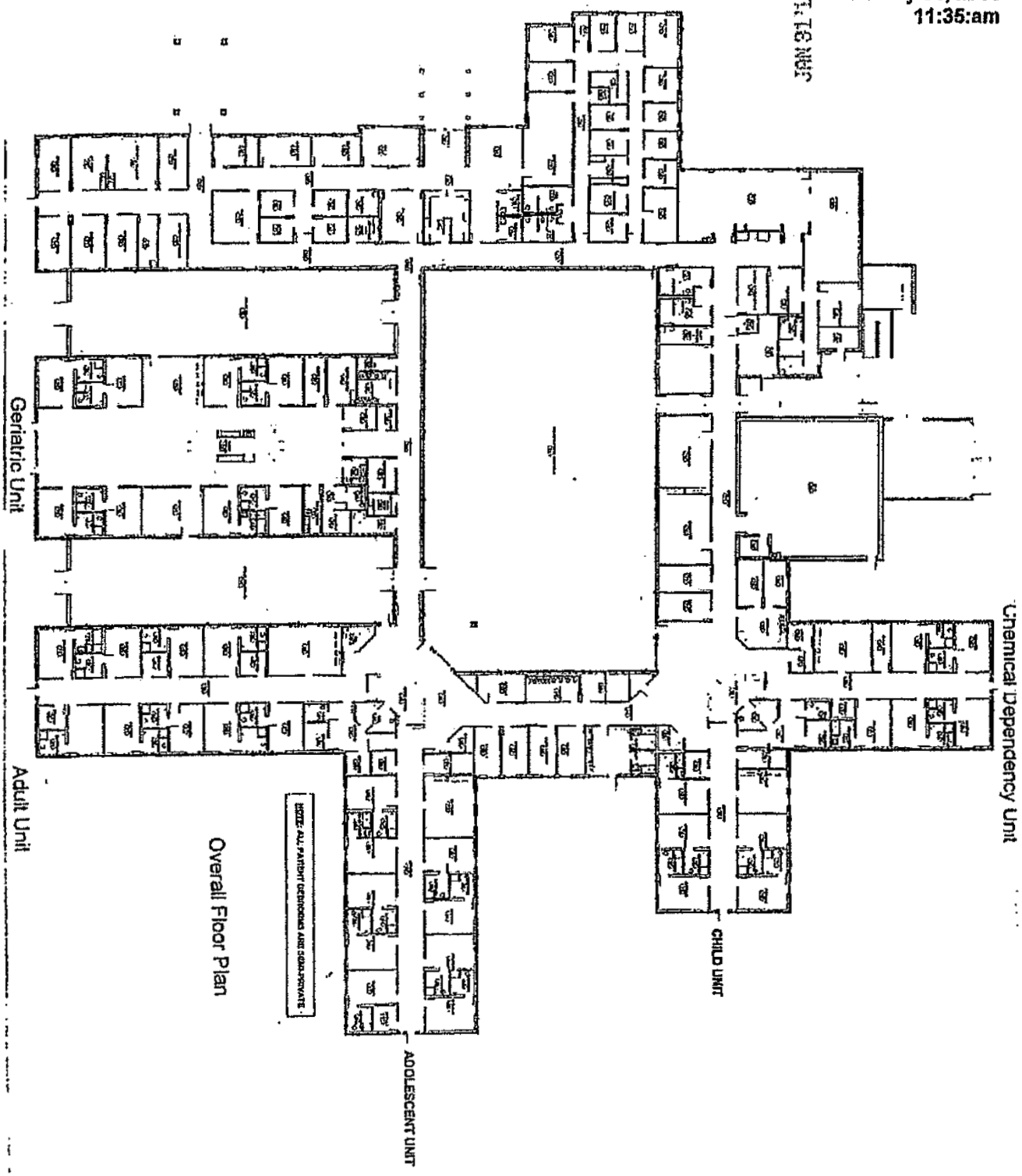




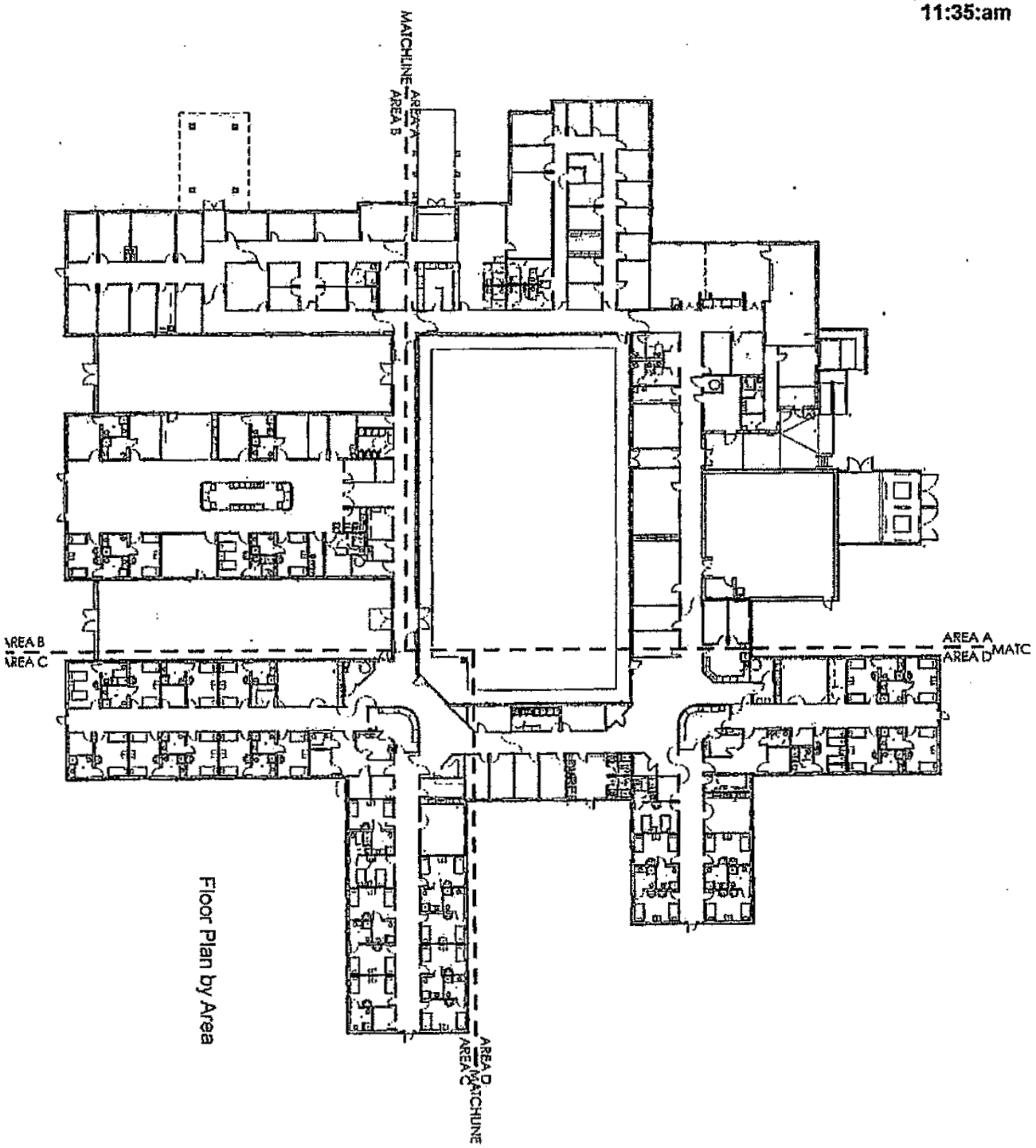
B.IV. - Floor Plan

SUPPLEMENTAL- # 2
January 31, 2014
11:35:am

JAN 31 '14 AM 11:25

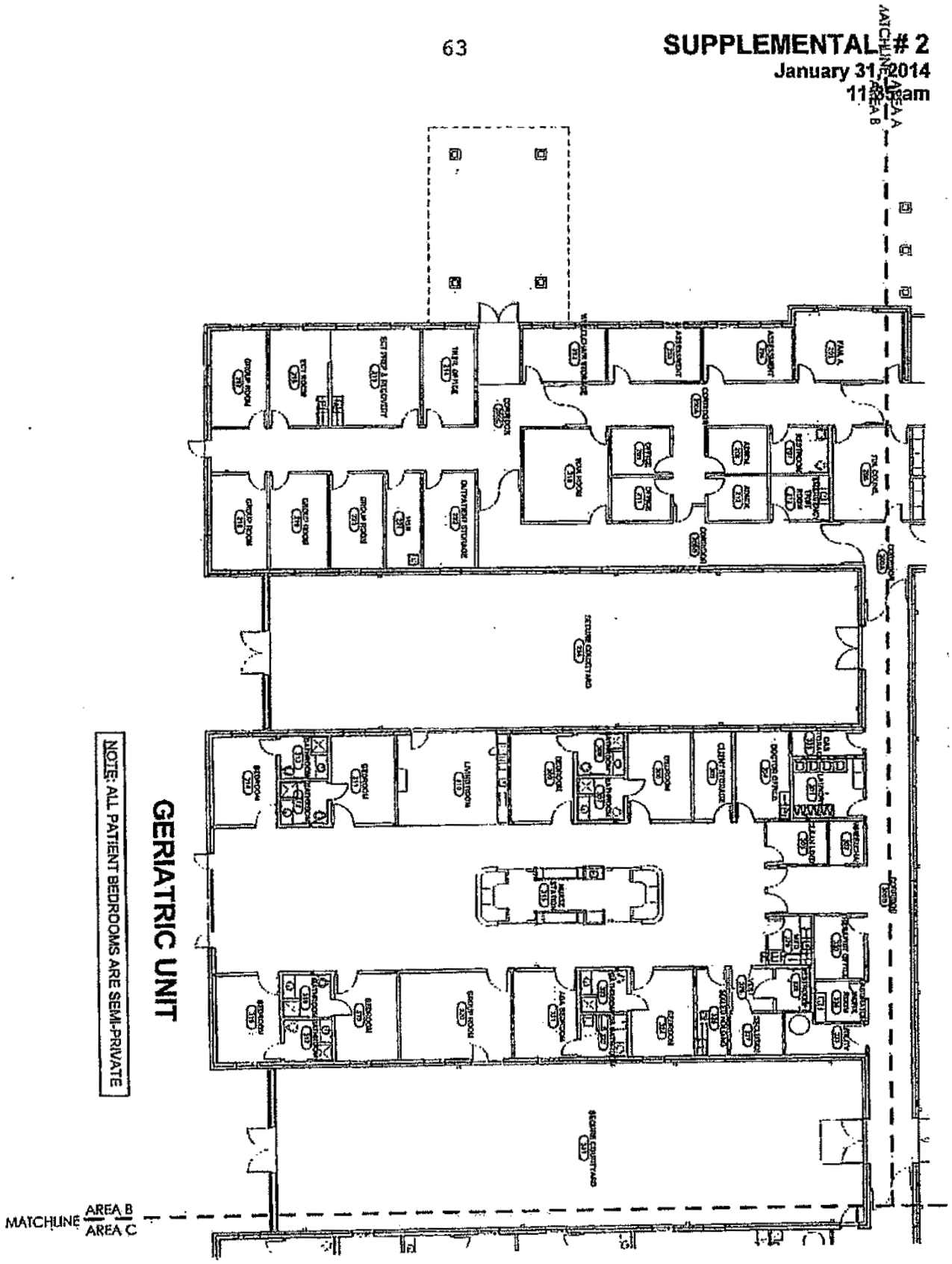


SUPPLEMENTAL- # 2
January 31, 2014
11:35:am



Floor Plan by Area

SUPPLEMENTAL # 2
January 31, 2014
11:15am



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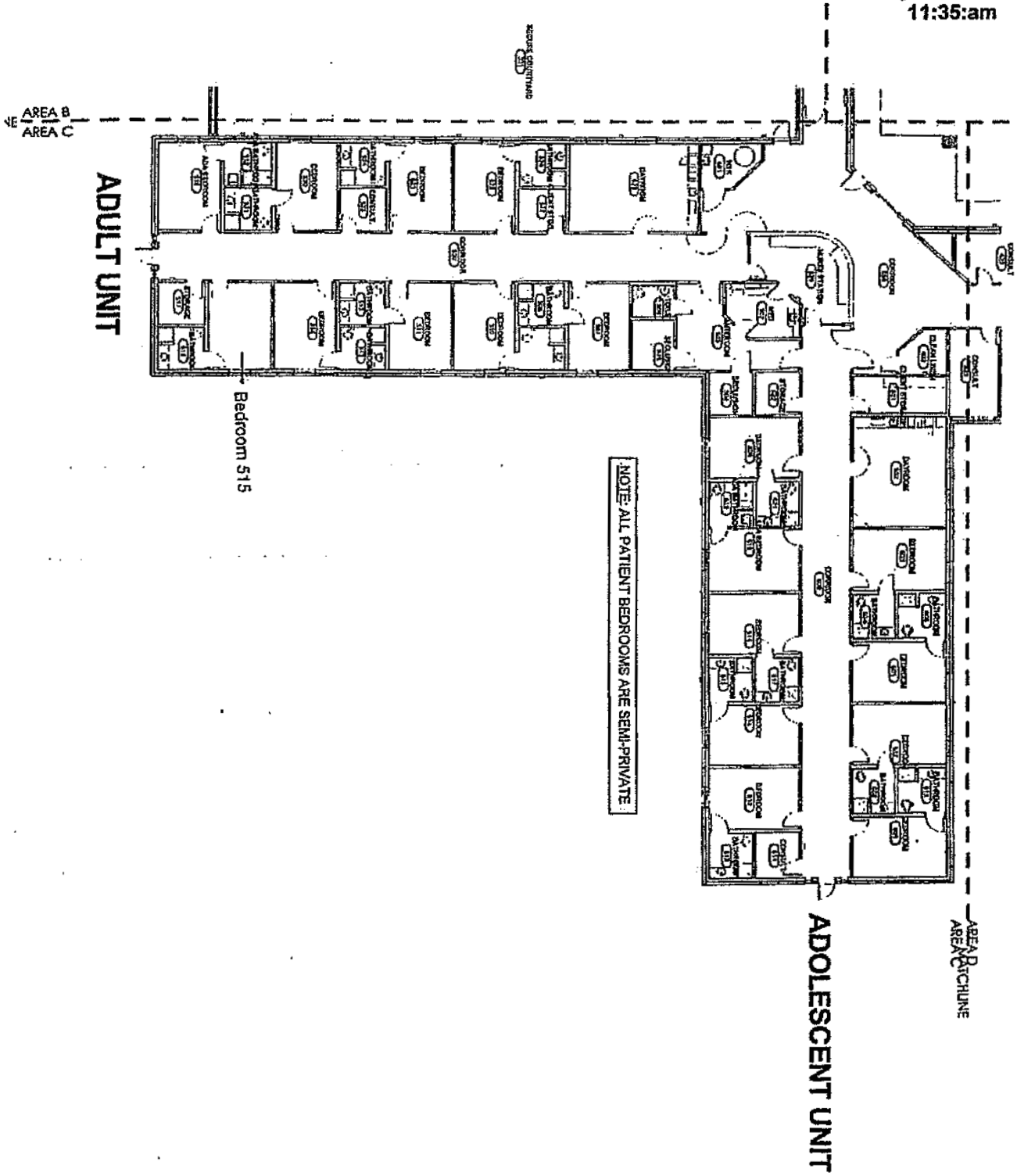
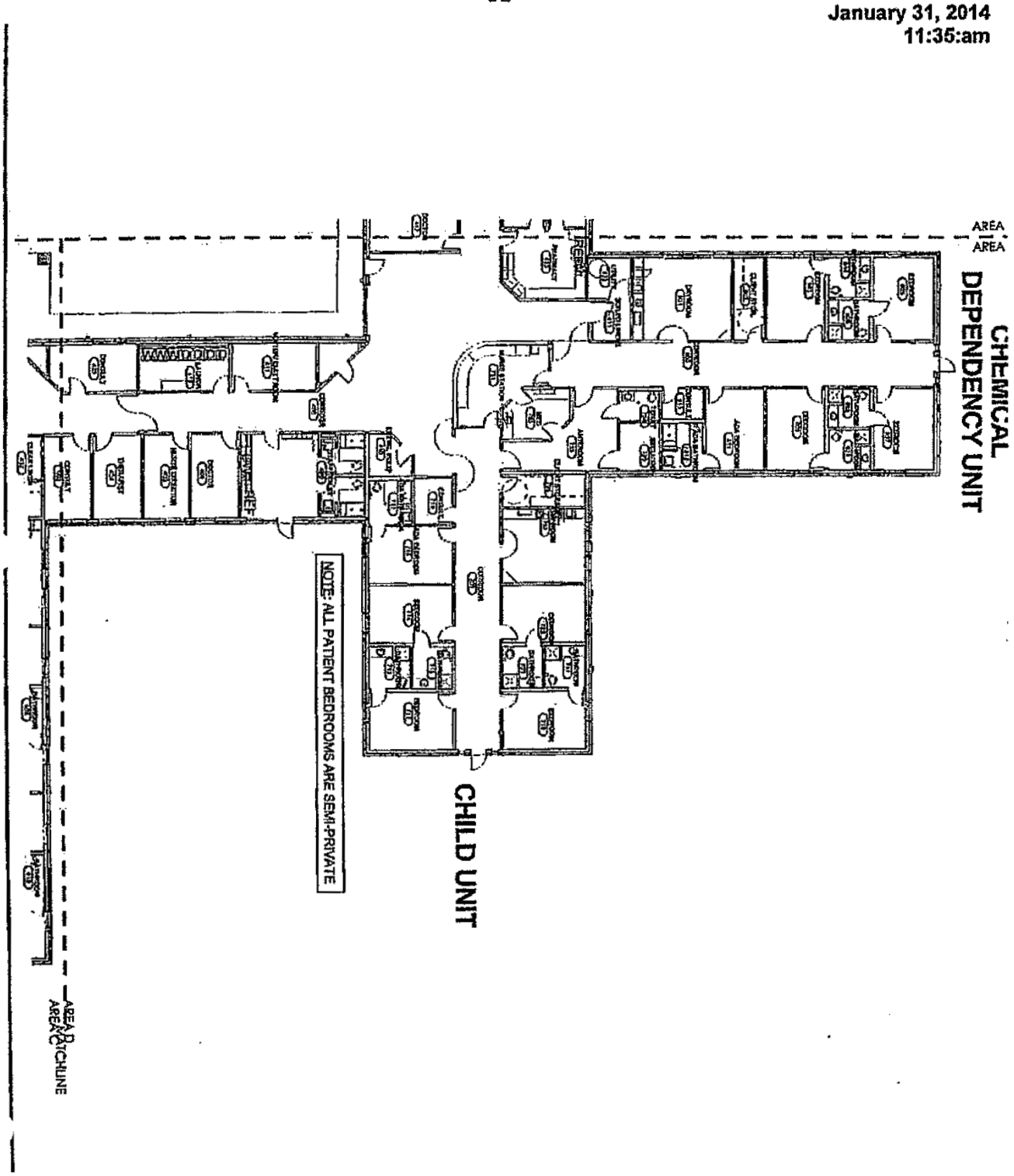
January 31, 2014
11:35:am



SUPPLEMENTAL- # 2
January 31, 2014
11:35:am



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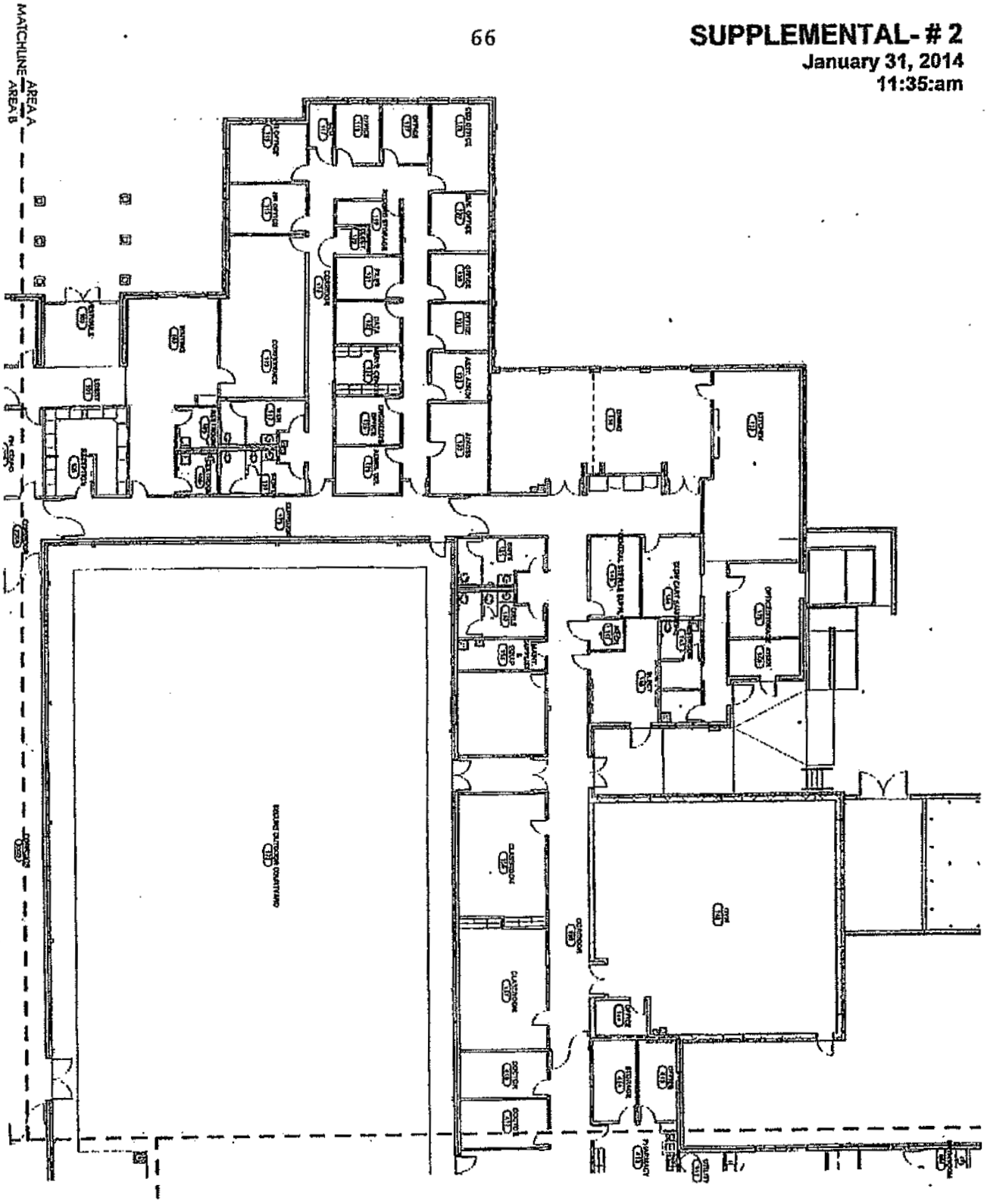
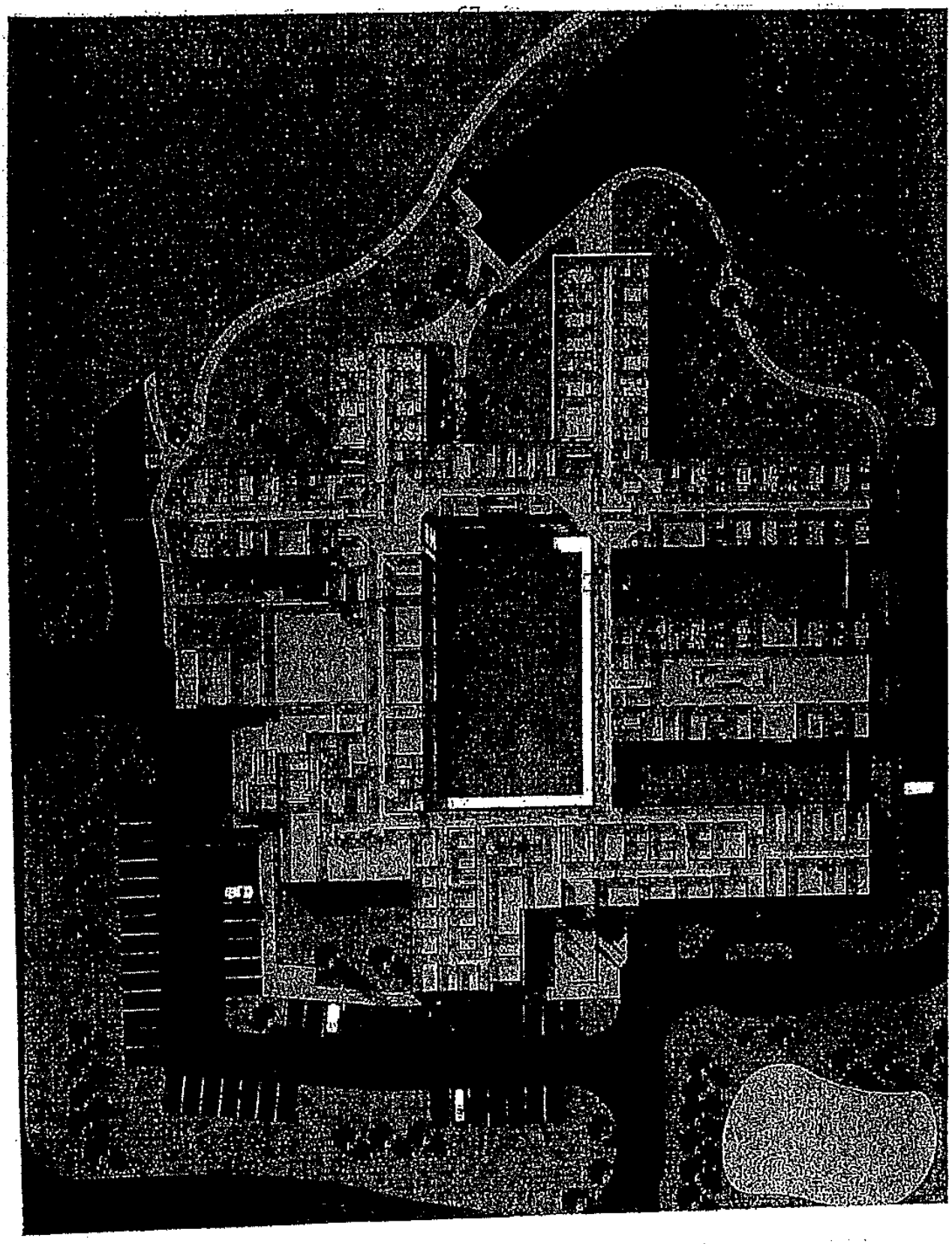
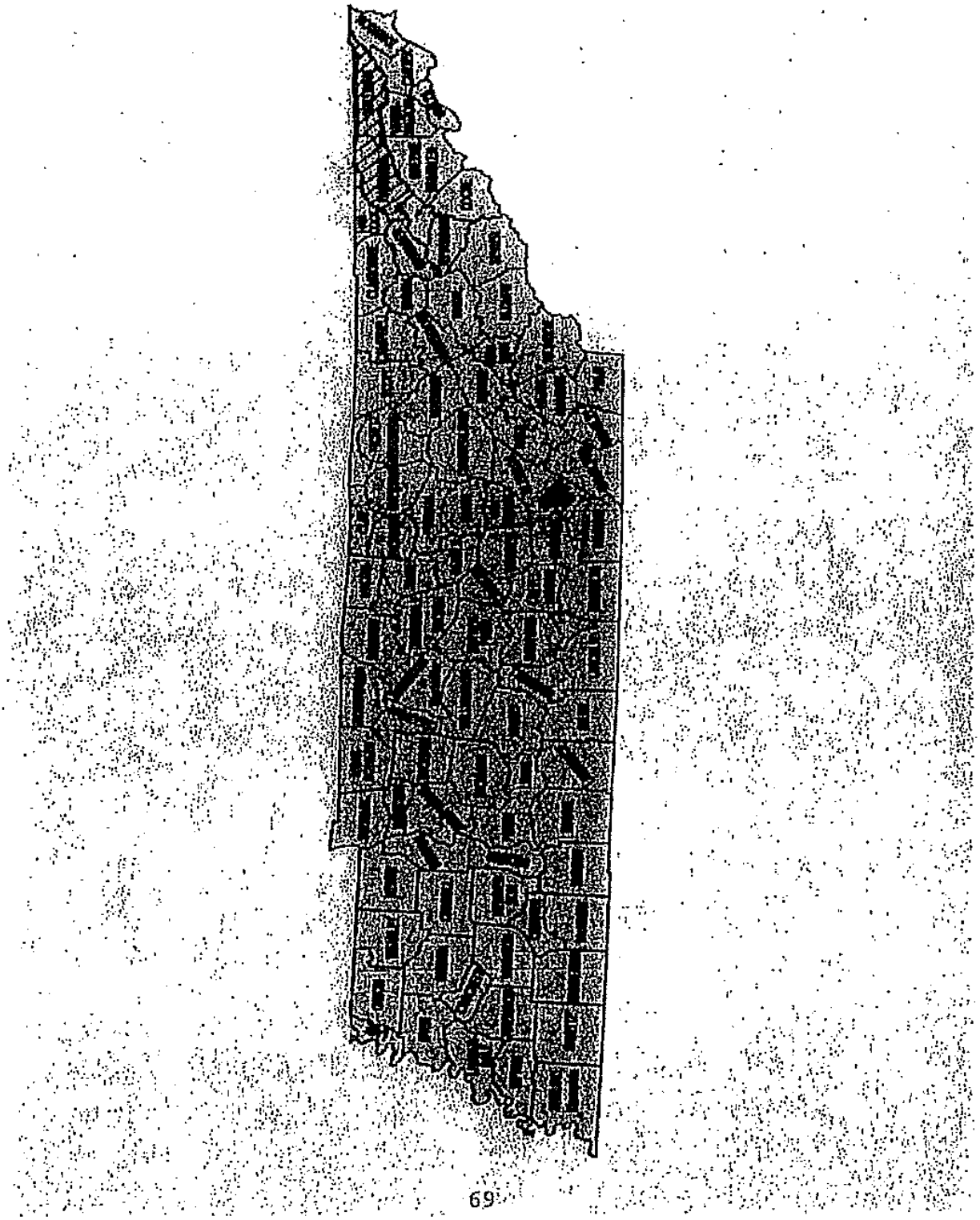
January 31, 2014
11:35:am

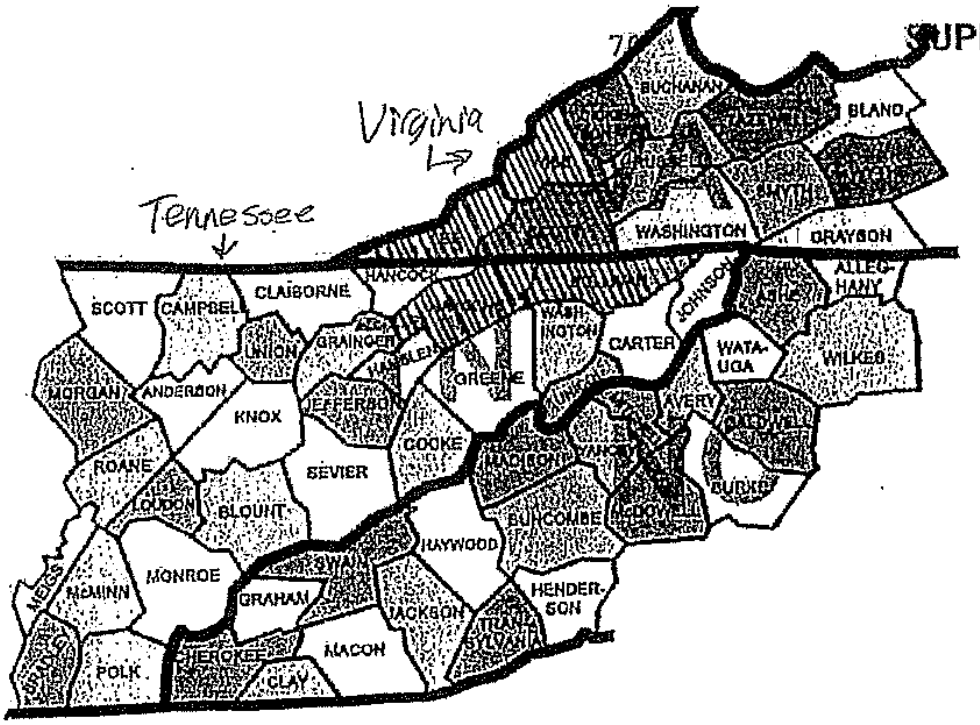




C.3. - Service Area Map



SUPPLEMENTAL- # 1
January 29, 2014
3:10pm



C. Economic Feasibility 1. - Construction Documentation

THOMAS
CONSTRUCTION GROUP

December 9, 2013

Mr. Jim Shaheen
Strategic Behavioral Health
6295 Tournament Drive, Suite 201
Memphis, TN 38125

Re: Strategic Behavioral Health Facility – Kingsport, Tennessee

Dear Jim:

As your construction partner, Thomas Construction Group has extensive experience building your behavioral health centers over the past 5 years. We are currently constructing projects for SBH in Las Vegas, Nevada, and College Station, Texas.

We have reviewed the preliminary information prepared by LS3P for the proposed Kingsport, TN project, and the "Project Costs Chart" contained in the Certificate of Need application for the above referenced project, specifically Part A ("Construction and Equipment acquired by Purchase"). Based upon the information provided to us, the amounts set forth in Part A of the "Project Costs Chart" (attached) appear appropriate at today's costs.

Sincerely,

THOMAS CONSTRUCTION GROUP

Christopher N. Reid
President

CNR/js

cc: Mike Garone, SBH .

Building on a Strong Foundation
1111 Military Cutoff Road · Suite 191 · Wilmington, NC 28405
(O) 910.799.2295 · (F) 910.799.2072
www.thomasconstructiongroup.com

C. Economic Feasibility 2. - Finance Letter

SUPPLEMENTAL- # 1
January 29, 2014
3:10pm

STRATEGIC
BEHAVIORAL HEALTH, LLC

December 11, 2013

Melanie M. Hill, Executive Director
Tennessee Health Services and Development Agency
Andrew Jackson State Office Building, Ninth Floor
500 Deaderick Street
Nashville, TN 37243

RE: SBH – Kingsport, LLC Psychiatric Hospital Project

Dear Ms Hill:

The Kingsport, LLC Hospital project will be funded by a combination of cash, accumulated earnings from operations and availability under our revolving line of credit. As of November 30, 2013 Strategic Behavioral Health, LLC (parent company of SBH – Kingsport, LLC) had $4.1 million in cash balances and $6.7 million available under its $15.5 million revolving credit facility syndicated through Fifth Third Bank.

The current borrowing rate under this credit facility is LIBOR plus 3.50% and the facility matures on May 20, 2018.

The combination of cash, availability under the credit facility and net cash flows from existing operations are more than sufficient to provide the funding required for SBH – Kingsport, LLC Psychiatric Hospital Project.

Please feel free to call me if you have any questions regarding this letter or if you need any additional information.

Sincerely,

Michael A. Orians
Vice President, Treasurer
Strategic Behavioral Health, LLC

8295 Tournament Drive, Suite 201 ♦ Memphis, TN 38125
(901) 969-3100 ♦ Fax (901) 969-3120

SUPPLEMENTAL- # 1
January 29, 2014
3:10pm

FIFTH THIRD BANK

December 12, 2013

Melanie M. Hill, Executive Director
Tennessee Health Services and Development Agency
Andrew Jackson State Office Building, Ninth Floor
500 Deaderick Street
Nashville, TN 37243

RE: SBH – Kingsport, LLC Psychiatric Hospital Project (the "Project")

Dear Ms Hill:

Fifth Third Bank, as Agent for Strategic Behavioral Health, LLC ("SBH"), and its affiliates including SBH – Kingsport, LLC, recently expanded its credit facility and entered into an $80 million dollar syndicated credit facility in May 2013. Under the new credit facility, SBH has a $15.5 million revolving credit loan available to fund, among other things, future development projects such as this Project.

This letter is to provide assurance that Fifth Third Bank is familiar with the Project being proposed for CON approval to better serve Kingsport and the surrounding communities.

Fifth Third Bank has a high degree of interest in financing the proposed Project. The Bank anticipates providing both construction and permanent financing for the Project through its revolver. It is the understanding of the Bank that the overall Project and financing request will not exceed $12,000,000.

The interest rate on the loan would be based on LIBOR plus an applicable spread. The current variable rate on the loan is approximately 3.75%.

Please feel free to call or email me directly if you have any questions regarding this letter or if you need any additional information. We very much look forward to working with you and SBH on the financing and completion of this Project.

Sincerely,

Stephen C. Taylor
Assistant Vice President
Fifth Third Bank – Healthcare Division
Phone: 615.687.3003
Email: stephen.taylorjr@53.com

C. Economic Feasibility 10. - Balance Sheet and Income Statement

CONFIDENTIAL

STRATEGIC BEHAVIORAL HEALTH, LLC AND SUBSIDIARIES
Consolidated Statements of Assets, Liabilities and Members' Equity -
Modified Cash Basis
December 31, 2012 and 2011

	2012	2011
ASSETS		
Current assets		
Cash and cash equivalents	$ 2,820,508	$ 4,103,586
Accounts receivable, net of allowance for doubtful accounts of $915,540 at 2012 and $264,197 at 2011	8,195,262	1,668,921
Inventories	67,931	26,138
Prepaid expenses	741,435	324,626
Total current assets	11,825,136	6,123,271
Property and equipment	48,843,897	31,722,773
Less accumulated depreciation	(2,181,981)	(985,673)
Property and equipment, net	46,661,916	30,737,100
Deposit on acquisition	-	32,063,791
Goodwill	28,616,112	-
Other assets, net	1,080,521	723,794
Total other assets	29,696,633	32,787,585
Total assets	$ 88,183,685	$ 69,647,956
LIABILITIES AND MEMBERS' EQUITY		
Current liabilities		
Current maturities of long-term debt	$ 1,703,039	$ 1,334,616
Accounts payable	923,373	930,106
Accrued expenses	3,272,283	1,216,459
Accrued distributions to members	439,396	531,111
Total current liabilities	6,338,091	4,012,292
Long-term debt, less current maturities	40,739,559	34,481,765
Total liabilities	47,077,650	38,494,057
Members' equity		
Members' contributions	36,915,034	31,915,034
Note receivable for members' contributions	(71,616)	(76,616)
Accumulated earnings (deficit)	4,262,617	(684,519)
Total members' equity	41,106,035	31,153,899
Total liabilities and members' equity	$ 88,183,685	$ 69,647,956

See accompanying notes.

CONFIDENTIAL

STRATEGIC BEHAVIORAL HEALTH, LLC AND SUBSIDIARIES
Consolidated Statements of Revenues and Expenses -
Modified Cash Basis
Years Ended December 31, 2012 and 2011

	2012	2011
Revenues		
Patient service revenue (net of contractual allowances and discounts)	$ 50,630,683	$ 19,290,243
Provision for bad debts	(748,305)	(404,798)
Net patient service revenue less provisions for bad debts	49,882,378	18,885,445
Expenses		
Salaries and benefits	28,084,047	9,835,300
Professional fees	3,204,772	1,154,667
Supplies	2,632,128	893,950
Management and incentive fees	1,030,560	532,895
Depreciation and amortization	1,211,918	345,972
Rent	880,575	294,540
Utilities	900,441	231,381
Insurance	409,614	138,293
Interest	1,604,292	410,697
Acquisition costs	51,263	610,448
Other expenses	2,640,170	749,981
Total expenses	42,649,780	15,198,124
Excess of revenues over expenses - modified cash basis	$ 7,232,598	$ 3,687,321

See accompanying notes.

C. Contribution to the Orderly Development of Health Care 3 - Current and/or Anticipated Staffing Patterns

BUILD YEAR

Clinical

	rate		FTE's
day	$10.00	Techs	1.4
even	$11.00	Techs	1.4
night	$12.00	Techs	1.4
day	$10.00	Techs	1.4
even	$11.00	Techs	1.4
night	$12.00	Techs	1.4
day	$10.00	Techs	0.0
even	$11.00	Techs	0.0
night	$12.00	Techs	0.0
addon	$45.00	Clinical Dir	1.0
	$35.00	Program Dir	1.0
day	$25.00	R.N.'s/U.M.	1.4
even	$27.00	R.N.'s/U.M.	1.4
night	$30.00	R.N.'s/U.M.	1.4
day	$18.00	L.V.N.	0.0
even	$18.00	L.V.N.	0.0
night	$18.00	L.V.N.	0.0
day	$25.00	Therapist	1.0
day	$25.00	Therapist	0.0
day	$25.00	Therapist	0.0
day/even	$25.00	Therapist	0.0
day/even	$25.00	Therapist	0.0
day	$18.00	RT	1.0
day	$18.00		0.0
day	$0.00	Teachers	0.0

YEAR 2

Clinical

	rate		FTE's
day	$10.00	Techs	1.4
even	$11.00	Techs	1.4
night	$12.00	Techs	1.4
day	$10.00	Techs	1.4
even	$11.00	Techs	1.4
night	$12.00	Techs	1.4
day	$10.00	Techs	1.4
even	$11.00	Techs	1.4
night	$12.00	Techs	1.4
day	$10.00	Techs	1.4
even	$11.00	Techs	1.4
night	$12.00	Techs	1.4
addon	$45.00	Clinical Dir	1.0 ✓
	$35.00	Program Dir	1.0
day	$25.00	R.N.'s/U.M.	1.4
even	$27.00	R.N.'s/U.M.	1.4
night	$30.00	R.N.'s/U.M.	1.4
day	$25.00	R.N.'s/U.M.	1.4
even	$27.00	R.N.'s/U.M.	1.4
night	$30.00	R.N.'s/U.M.	1.4
day	$25.00	R.N.'s/U.M.	1.4
even	$27.00	R.N.'s/U.M.	1.4

SBH-KINGSPORT 001676

day	$0.00	Teachers	0.0
day	$0.00	Teachers	0.0
		Totals	16.6

Non-Clinical

	rate		FTE's
day	$72.12	Admin	1.0
day	$20.00	Admin Sec	1.0
day	$30.00	BOM	1.0
day	$17.50	BO Clerks	1.0
day	$25.00	med rec supr	1.0
day	$24.00	Marketing	2.0
day	$10.00	Recept	2.8
day	$40.00	Nurse Admin	1.0
day	$12.00	Dietary	4.0
day	$30.00	Utilization Rev	1.0
day	$24.00	Admissions	3.0
	$0.00		
day	$20.00	HR	1.0
day	$30.00	QA/infctr	1.0
day	$15.00	Maint	1.0
			21.8

night	$30.00	R.N.'s/U.M.	1.4
day	$18.00	L.V.N.	1.4
even	$18.00	L.V.N.	1.4
night	$18.00	L.V.N.	1.4
day	$18.00	L.V.N.	1.4
even	$18.00	L.V.N.	1.4
night	$18.00	L.V.N.	1.4
			2.0
day	$18.00	L.V.N.	1.4
even	$18.00	L.V.N.	1.4
night	$18.00	L.V.N.	1.4
day	$25.00	Therapist	1.0
day	$25.00	Therapist	1.0
day	$25.00	Therapist	1.0
day/even	$25.00	Therapist	1.0
day/even	$25.00	Therapist	0.0
day	$18.00	RT	1.0
day	$18.00	RT	1.0
day	$15.00	Teachers	0.0
day	$15.00	Teachers	0.0
day	$0.00	Teachers	0.0
		Totals	52.0

Non-Clinical

	rate		FTE's
day	$72.12	Admin	1.0

SBH-KINGSPORT 001677

DEC 13 '13 PM1:32

AFFIDAVIT

STATE OF Tennessee

COUNTY OF Shelby

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

SIGNATURE/TITLE Director of Development

Sworn to and subscribed before me this 12 day of December (Month) 2013 (Year) a Notary Public in and for the County/State of Shelby

NOTARY PUBLIC

My commission expires Oct 9 (Month/Day) 2016 (Year)

RENEE E. KLEIN
STATE OF TENNESSEE NOTARY PUBLIC
SHELBY COUNTY
MY COMMISSION EXPIRES: October 9, 2016

COPY-
SUPPLEMENTAL-1

SBH-Kingsport, LLC

CN1312-050

85

JAN 29 1 PM 3:0

SUPPLEMENTAL- # 1
January 29, 2014
3:10pm

January 28, 2014

Mr. Phillip M. Earhart
Health Planner III
Tennessee Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

Via Hand Delivery

Re: Certificate of Need Application CN1312-050
SBH-Kingsport, LLC

Dear Mr. Earhart:

Set forth below are the responses of SBH-Kingsport, LLC, the applicant in Certificate of Need Application CN1312-050 to the request for information dated December 20, 2013. We have filed these in triplicate, as you directed, along with an affidavit regarding the responses. If you have any questions or need additional information, please advise.

1. **Section A, Applicant Profile, Item 6**

The Purchase and Sale Agreement is noted. Please provide a clearer and legible copy of Exhibit A of the document.

RESPONSE: The requested documentation is attached hereto.

2. **Section A, Applicant Profile, Item 13**

Please identify all TennCare MCOs in the applicant's service area and the TennCare MCOs with which the applicant intends to contract.

RESPONSE: The applicant expects to contract with BlueCare, TennCare Select and United Healthcare Community Plan.

3. **Section B, Project Description, Item 1**

Your response is noted. Please provide an executive summary not to exceed two (2) pages. Please list the following areas as headers and address each area under the header: proposed services and equipment, ownership structure, service area, need, existing resources, project cost, funding, financial feasibility and staffing.

RESPONSE:

SUPPLEMENTAL- # 1
January 29, 2014
3:10pm

Mr. Phillip M. Earhart
January 28, 2014

Proposed Services and Equipment:

SBH-Kingsport, LLC ("SBH") proposes to establish a 72-bed, free-standing psychiatric hospital located in Kingsport, Sullivan County, Tennessee. It is requesting CON permission to construct 18 adult psychiatric beds, 16 geropsychiatric beds, 28 child and adolescent psychiatric beds, and 10 chemical dependency beds for a total of 72 beds.

Ownership Structure:

SBH will be owned and operated by a limited liability company, SBH-Kingsport, LLC. This limited liability company is a wholly-owned subsidiary of Strategic Behavioral Health, LLC, which is an inpatient psychiatric hospital company based in Memphis, Tennessee. It currently operates seven psychiatric hospitals through subsidiaries in the states of Colorado, Nevada, New Mexico and North Carolina. It has another facility under development in College Station, Texas. SBH will be its first hospital based in its home state of Tennessee.

Service Area:

The service area for SBH is projected to be the counties of Sullivan and Hawkins in Tennessee, and the counties of Wise, Scott and Lee in southwestern Virginia.

Need:

Currently, in this service area there are only twelve inpatient psychiatric beds, located at Bristol Regional Medical Center in Bristol, Tennessee, at the eastern end of the service area. Thus, as far as the applicant is able to ascertain, in its proposed service area, which has a population of more than 300,000 people, there are only 12 inpatient psychiatric beds (located in Bristol). Thus, there is a significant need for additional inpatient psychiatric bed resources in this service area, particularly as it pertains to children and adolescents. Sullivan County is the most populous county in upper East Tennessee, and Kingsport is the biggest municipality in the service area.

Existing Resources:

There are no other free-standing inpatient psychiatric hospitals within the service area. There are only twelve inpatient psychiatric beds in this service area, located at Bristol Regional Medical Center in Bristol, Tennessee.

Project Cost:

The projected project costs for this hospital development are approximately $12,000,000.

Funding:

The funding for this project will be developed with the assistance of Dobbs Management Services, LLC, the owners of which represent the majority ownership of Strategic Behavioral

Health, LLC. The proposed project will be funded through cash, a credit line with Fifth Third Bank and net cash flows from existing operations.

Financial Feasibility:

As of December 31, 2012, SBH itself had consolidated annual net revenue of approximately $50.7 million and employed approximately 745 employees. Thus, Strategic Behavioral Health, LLC, the parent company of SBH-Kingsport, LLC, is a well-capitalized, financially successful psychiatric hospital development and management company.

Staffing:

Strategic Behavioral Health expects no difficulty in attracting staff to the proposed new hospital. There are several teaching institutions within Strategic Behavioral Health's service area. These colleges and universities offer programs in nursing, counseling & human services, psychology, psychiatry and many offer programs in medical practice management, medical billing, and other healthcare service related fields. Graduates of these colleges and universities will have an opportunity to work at Strategic Behavioral Health's Kingsport facility.

Strategic Behavioral Health also has prior experience building and staffing new hospitals across the United States. The company uses an employee search service should it become necessary to look outside the service area for employees, and Strategic Behavioral Health has found no difficulty staffing its hospitals in smaller markets like Wilmington, North Carolina and College Station, Texas. Strategic Behavioral Health will be able to attract qualified, well-trained professionals who will live and work in the service area.

Please describe the classes and curriculum that is part of the proposed project.

RESPONSE:

Clinical Program Description

The Strategic Behavioral Health (SBH) philosophy of care is based upon a therapeutic model. All clinical disciplines work together to produce positive outcomes. Using the CORE (Clinical Outcomes in Routine Evaluation) we consistently reevaluate our acute care outcomes and strive to improve our programming through research.
Fundamentals of treatment include being good community partners where comprehensive care starts with the first referral call to follow-up care post discharge. Clinical services begin with an initial no cost assessment. Upon admission, a psychiatrist conducts an initial psychiatric assessment within 24 hours along with a therapist treatment plan meeting. A family therapy session is required within 72 hours. Throughout treatment, safety is paramount and supported by around the clock 15 minute safety checks by direct care staff. Discharge planning includes a safety plan with follow-up appointments or step-down level of care assignment.

SUPPLEMENTAL- # 1
January 29, 2014
3:10pm

Mr. Phillip M. Earhart
January 28, 2014

We offer several specialty programs for all ages. Each program is individualized to meet the cultural and strength based needs taking into special consideration multiple factors such as acuity, age, gender, development, and family support. We believe that family involvement, when possible, is the foundation for care. All programming includes individual, process and psychoeducation groups, and family therapy. Below is a summary of our programs.

Child & Adolescent:

- *Character Counts:* Psychoeducation program developed by the Josephson Institute Center for Youth Ethics incorporated into the daily routine to emphasize elements of good character.
- *Trauma-Focused Cognitive-Behavioral Therapy*: TF-CBT is the most well-supported and effective treatment for children who have been abused and traumatized. Multiple clinical research studies consistently have found it to help children with PTSD and other trauma-related problems.
- *Level System:* Reward based system to promote positive development based on General Behaviors (GB) and Target Goals (TG). General behavior is defined as following the rules of the facility and staying focused on the posted values and demonstrating appropriate behaviors. Target goal points are earned when the patient is working toward the goal he or she chose from his or her individual treatment plan that morning.
- *The Seven Challenges Program:* Designed specifically for adolescents with drug problems, to motivate a decision and commitment to change - and to support success in implementing the desired changes. The Program simultaneously helps young people address their drug problems as well as their co-occurring life skill deficits, situational problems, and psychological problems.
- *Clear Path:* Specialized treatment for sexual offenders in a residential setting.

Adult & Geriatric:

- *Illness Management & Recovery Model*: Illness management is an evidence based treatment from SAMHSA with a broad set of strategies designed to help individuals with serious mental illness collaborate with professionals, reduce their susceptibility to the illness, and cope effectively with their symptoms. Research on illness management for persons with severe mental illness, including 40 randomized controlled studies, indicates that psychoeducation improves people's knowledge of mental illness; that behavioral tailoring helps people take medication as prescribed; that relapse prevention programs reduce symptom relapses and re-hospitalizations; and that coping skills training using cognitive-behavioral techniques reduces the severity and distress of persistent symptoms.
- *Chemical Dependency Treatment:* Accompanied with IMR model, we offer medical detoxification and additional support groups utilizing the AA recovery model. Partnerships with local agencies provide a transition upon discharge for support groups.
- *Trauma Therapy:*
    - *EMDR* (Eye Movement Desensitization and Reprocessing) has been shown to be effective in reducing the intensity of subjective distress related to traumatic memories. We offer 3 day intensive trauma focused programming led by EMDR certified therapists.

- *Cognitive Processing Therapy (CPT)* is a 12-session therapy that has been found effective for both PTSD and other corollary symptoms following traumatic events supported by the Veterans Administration.

- *Geriatric Programs*:
  - Illness Management & Recovery Model continues to be the foundation for treatment for our senior population. Special consideration is given to address any additional medical concerns and physical mobility demands. Psychoeducation is also geared toward grief and loss, life transitions, and overall wellness. This includes medical health and physical evaluations with medical consults, special dietary concerns, and trained nursing aides. The program is geared to be sensitive to transitions in residence upon discharge with community partnerships.

What type of outpatient programs are a part of this proposed project.

RESPONSE: SBH – Kingsport, LLC intends to offer Partial Hospitalization and Intensive Outpatient for adults, children and adolescents. This level of programing will allow for direct admissions as well as being available as a step down level of care.

Please clarify if the proposed seventy (72) bed inpatient psychiatric hospital will be classified as an Institution for Mental Disease (IMD).

RESPONSE: SBH – Kingsport, LLC intends for this seventy two (72) bed inpatient psychiatric hospital to be classified as an Institution for Mental Disease (IMD).

Please describe the applicant's experience in operating the following:

- An Adult Inpatient Chemical Dependency Unit
- An Adult Psychiatric Unit
- An Child and Adolescent Inpatient Psychiatric Unit
- A Gero-Inpatient Psychiatric Unit

RESPONSE: Strategic Behavioral Health, parent company of SBH – Kingsport, LLC operates seven psychiatric and chemical dependency hospitals across the United States, providing quality behavioral healthcare for children, adolescents, adults, and seniors. The company has either built or acquired a variety of programs, including acute, residential, and outpatient services, with a focus on compassion, empathy, and perseverance for patients and their families. All of Strategic Behavioral Health's facilities are accredited by either the Joint Commission or The Commission on Accreditation of Rehabilitation Facilities (CARF), and are in good standing with the department of licensure within their respective state. SBH – Kingsport, LLC has the advantage of utilizing the expertise of its sister facilities in the areas of clinical program development and operations.

An Adult Inpatient Chemical Dependency Unit

Strategic Behavioral Health operates an Adult Inpatient Chemical Dependency Unit at the following facilities:

- Montevista Hospital in Las Vegas, NV – 20 beds
- Peak View Behavioral Health Hospital in Colorado Springs treats Chemical Dependency and mental health disorders in a combined 40 beds

An Adult Psychiatric Unit

Strategic Behavioral Health operates an Adult Psychiatric Unit at the following facilities:

- Montevista Hospital in Las Vegas, NV – 40 beds
- Peak View Behavioral Health Hospital in Colorado Springs, CO - 40 Beds
- The Peak Hospital in Santa Teresa, NM - 44 Beds

A Child and Adolescent Inpatient Psychiatric Unit

Strategic Behavioral Health operates a Child and Adolescent Inpatient Psychiatric Unit at the following facilities:

- Montevista Hospital in Las Vegas, NV – 38 beds
- Peak View Behavioral Health Hospital in Colorado Springs, CO - 20Beds
- The Peak Hospital in Santa Teresa, NM – 12 Beds
- Strategic Behavioral Center – Wilmington in Leland, NC – 20 Beds
- Strategic Behavioral Center – Raleigh in Garner, NC – 20 Beds

A Gero-Inpatient Psychiatric Unit

Strategic Behavioral Health operates a Gero-Inpatient Psychiatric Unit at the following facilities:

- Red Rock Hospital in Las Vegas, NV – 21 beds
- Peak View Behavioral Health Hospital in Colorado Springs, CO – 32 Beds

4. Section B, Project Description, Item II.A

Please clarify which two (2) units will share a nurse's station and med room, seclusion room and dedicated toilet.

RESPONSE: The facility has been specifically designed to accommodate various patient populations and census levels. Each unit is securely locked and has window access to the nurse's station. In additions, each unit has its own medication window for easy and secure med distribution. The units that will share a nurse's station are the adult unit with the adolescent unit and the child unit with the chemical dependency unit. The seclusion room and

bathroom area is a securely locked area, but is a shared area between units. Use of the seclusion room and bathroom are coordinated based on need.

Please clarify if the twenty-eight (28) adolescent and child unit will be coed. If so, how and when will females and males be segregated?

RESPONSE: The twenty-eight (28) bed adolescent and child units will be coed. All males and females patients will be placed in rooms with same gender. Based on acuity, and clinical appropriateness there will be coed programming in an attempt to replicate real life environments, assisting in generalizing skills. All units are supervised to clinical need, including q15 minute checks.

Please describe the outpatient suites.

RESPONSE: SBH – Kingsport, LLC has designed a state of the art 72 bed free standing psychiatric hospital with much attention to both patient care areas as well as administrative space. Our outpatient programing will be held in our outpatient suite which is located within the facility but completely separated from our inpatient patient care areas, including a separate entrance so that our inpatient and outpatient populations never mix.

Please clarify if all the proposed psychiatric units will be locked.

RESPONSE: All psychiatric units will be locked.

What are the proposed ages ranges for each of the four (4) proposed psychiatric units?

RESPONSE: The ages for the four (4) proposed psychiatric units are as follows:

- Child – ages 5 – 11
- Adolescent – ages 12 – 17
- Adult – ages 18 – 54
- Gero – ages 55 and up

Please provide a clearer and legible copy of the square footage and cost per square footage chart.

RESPONSE: The requested copy is attached hereto.

5. **Section B, Project Description, Item II.B**

The applicant states there are no existing services in the service area. Please clarify if the following providers have declared Hawkins or Sullivan counties in Tennessee, or Wise, Scott, and Lee counties in Virginia as part of three service area:

Magnolia Ridge (Washington County)-Alcohol and Drug,
Wellmont Bristol Regional Medical Center (Sullivan County)
Woodridge Psychiatric Facility (Washington County)
Wellmont Pavilion (Bristol, Virginia)

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RESPONSE: The applicant has no information as to whether Magnolia Ridge or Wellmont Pavilion have claimed any of the listed counties as being in their service area. Neither is covered by Tennessee CON law. Woodridge has claimed Sullivan and Hawkins Counties to be in its primary service area, and has claimed Scott and Wise Counties in Virginia to be in its secondary service area in CON filings. BRMC is in Sullivan County and claims Hawkins County in its service area. The applicant assumes that it also claims Wise and Scott Counties in Virginia as being in its service area; the applicant does not so assume as to Lee County, Virginia.

If the above providers are part of the proposed service area of the applicant, please provide a summary of services provided, number of licensed beds and age range for each inpatient service.

RESPONSE: With the exception of Wellmont Bristol Regional Medical Center, none of these providers are located in the proposed service area of the applicant.

6. **Section B, Project Description, Item II.C**

Please indicate if the applicant has discussed the need for this proposed 72 bed facility with the Tennessee Department of Mental Health and Substance and Abuse Services. If so, please summarize including the date and person contacted.

RESPONSE: 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. On January, 2 2013 a representative from Strategic Behavioral Health contacted Mr. John Arredondo, Assistant Commissioner of Hospital Services Division, to fulfill the requirement of discussing the proposed 72 bed facility. During the conversation, Mr. Arredondo said that the HSDA will get a copy of the application over to his office and that they would provide their analysis and response directly to the HSDA.

Please clarify of the applicant has contacted the Bureau of TennCare, or the contracted TennCare managed care organizations in the proposed service area regarding the need for additional inpatient psychiatric and chemical dependency units. If so, please provide a summary of the contact including the date and person contacted. If not, please contact the Bureau of TennCare and the contracted Managed Care Organizations to determine if there is a need for additional inpatient and chemical dependency services. Please provide a summary of the contact including the date and person contacted.

RESPONSE: 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.

TennCare

On January, 9 2013 a representative from Strategic Behavioral Health contacted Mrs. Mary Shelton, Director of Behavioral Health Operations and Mr. William Aaron, Deputy CFO, to

fulfill the requirement of discussing the proposed 72 bed facility with the Bureau of TennCare. During the conversation, it was stated that the applicant should seek a contract with the MCO's to become a contracted TennCare provider. As a contracted provider the applicant would be able to treat TennCare members of all ages, including the adult (ages 18 – 64) population. At the time of the call, Mrs. Shelton was unable to go on record confirming a need for additional inpatient psychiatric beds in Eastern Tennessee.

BlueCare

On December 27, 2013 a representative from Strategic Behavioral Health was told that behavioral health contracting is managed through Value Options. The SBH representative attempted to contact Mrs. Rhonda Roper (UM Clinical Care Manager Supervisor) and Brooke McCully (Care Manager). A message was left for both individuals however Strategic Behavioral Health is still waiting on a response.

United Healthcare Community Plan

On December 27, 2013 a representative from Strategic Behavioral Health attempted to contact United Healthcare to inquire about the need for additional inpatient and chemical dependency services. A message was left with the credentialing department. On January 13, 2014 a follow up call was made and an SBH representative was able to discuss the inpatient psychiatric project with Mrs. Kimberly Averitt, Contract Manager. Mrs. Averitt requested that an email be sent with the project overview and scope of services in order to do an internal evaluation. The email fulfilling Mrs. Averitt's request was sent and Strategic Behavioral Health is waiting on a response.

TennCare Select

On December 27, 2013 a representative from Strategic Behavioral Health unsuccessfully attempted to contact TennCare Select to inquire about the need for additional inpatient and chemical dependency services. Strategic Behavioral Health is still waiting on a response.

Please contact the mobile crisis team serving the proposed service area. Please indicate if the mobile crisis teams are experiencing difficulty in referring patients and placing patients into inpatient psychiatric facilities. Please provide the date of the contact, person contacted and summary of the contact.

RESPONSE: Strategic Behavioral Health has a vast experience in the area of mobile crisis evaluation in its other markets and would be open to helping to facilitate the coordination of care throughout the service area. Frontier Health was identified as the mobile crisis team providing level of care assessments within our service area. A representative from Strategic Behavioral Health initially called and spoke with a member of the Frontier Health Crisis Response Team, who indicated that the only resource they really have is Woodridge Hospital and they sometimes have to send patients as far as Chattanooga for inpatient hospitalization. As a follow up to that conversation a meeting was set with Teresa Kidd (Senior VP of Operations) and Randall Jessee (Senior VP of Specialty Services) on Thursday, October 10, 2013. During the meeting it was noted that Frontier does not believe that there is a problem

getting patients placed; however at the time of the meeting Strategic Behavioral Health had not excluded Washington County from its service area as we were still very early in the planning process. It should also be noted that Frontier did say that if we were able to complete our project and provide quality clinical programing that they would work with us. .

7. **Section B, Project Description Item III.A.(Plot Plan)**.

Please provide a legible plot plan.

RESPONSE: The requested plot plan is attached.

8. **Section B, Project Description, Item B.IV**

The floor plans submitted are noted. Please a clearer and legible copy that includes labeling of patient care rooms (noting private or semi-private), ancillary areas, equipment areas, etc.

RESPONSE: The requested floor plan is attached.

9. **Section C, Need, Item 1 a., (Project Specific Criteria-Psychiatric Inpatient Services A. Need, 1)**

Please reference the year of the recent Census Bureau and Tennessee Department of Health population data the applicant used to determine the bed need in the proposed five (5) county service areas.

RESPONSE: The applicant employed the July 1, 2012 Census Bureau population data for the population projection for the Virginia counties. It utilized the Tennessee Department of Health 2010-2020 population projections as published by the TDOH in 2010.

Please clarify which Virginia inpatient psychiatric facilities claim Wise, Lee and Scott counties in there proposed service area.

RESPONSE: Representatives of the applicant have not been able to determine this information. To the best of the applicant's knowledge, there are no inpatient psychiatric providers located in those three counties.

10. **Section C, Need, Item 1 a., (Project Specific Criteria-Psychiatric Inpatient Services**

The applicant has provided responses to the Project Specific Criteria for Psychiatric Inpatient Services with the assumption Bristol Regional Medical Center is the only inpatient provider covering Hawkins and Sullivan County. It appears Woodridge Psychiatric Hospital located in adjoining Washington County includes Hawkins and Sullivan counties in their service area. Please revise all responses to the Project Specific Criteria for Psychiatric Inpatient Services that includes inpatient facilities that has Hawkins and Sullivan counties in their designated service area as reflected in the Joint Annual reports. This will impact the bed need for the proposed service area.

RESPONSE: The request incorrectly states the applicant's position in its CON application. The *Guidelines for Growth* do not require the applicant to analyze data of providers not located in its proposed service area. The Joint Annual Reports also do not specify a service area for any reporting hospital.

11. Section C, Need, Item 1 a., (Project Specific Criteria-Psychiatric Inpatient Services A. Need, 2)

The applicant states there is a need for 16.8 gero-psychiatric beds in the proposed service area according to the bed need formula. Please clarify how that was determined if the bed need formula does not break out gero-psychiatric bed need.

RESPONSE: As directed by the *Guidelines for Growth*, the applicant applied the 30 beds per 100,000 population standard to the portion of the service area population aged 65 and over.

12. Section C, Need, Item 1 a., (Project Specific Criteria-Psychiatric Inpatient Services A. Need, 4)

Please indicate if the applicant will have a psychiatric unit for age 5-14 and a unit for ages 15-19.

RESPONSE: We intend to have a child psychiatric unit for patient's ages 5 – 11 and have an adolescent psychiatric unit for patients ages 12 – 17.

13. Section C, Need, Item 1 a., (Project Specific Criteria-Psychiatric Inpatient Services B.1. (Service Area)

Please complete the following chart. The chart will determine where patients of the proposed service area migrate to for psychiatric services. Please contact Mr. George Wade at the Tennessee Department of Health, Division of Health Statistics (615-741-1954) and request patient discharge utilization data (inpatient day or discharge patient days) from January 1, 2012 to December 31, 2012 by MCD19 (Mental Diseases and Disorders) and MCD 20 (Alcohol/Drug Abuse & Alcohol/Drug-Induced Organic Mental Disorders).

Patient Origin by County
Number of Inpatient Days or Discharge Patient Days

Facility	Hawkins	Sullivan	Lee	Scott	Wise
Magnolia Ridge (Alcohol and Drug)					
Wellmont Bristol Regional Hospital					

Wellmont Pavilion (Va.)					
Woodridge Psychiatric Hospital					
Moccasin Bend					
Ridgeview Psychiatric Hospital and Center in Oak Ridge					
Peninsula Hospital in Louisville (Blount County)					
Total					

RESPONSE: A representative of the applicant conferred with Mr. Wade on December 26, 2013, and emailed him the table below with a request for assistance from his office. He replied via email on that date stating that he had forwarded applicant's email request on to his office's director. Since that time, the applicant has not received any response from Mr. Wade's office, or from his director.

Facility	Hawkins	Sullivan	Lee	Scott	Wise
Magnolia Ridge (Alcohol and Drug)	not available	not available	not available	not available	not available
Wellmont Bristol Regional Hospital	not broken out**	not broken out**	not listed	not listed	not listed
Wellmont Pavilion (Va.)	not available	not available	not available	not available	not available
Woodridge Psychiatric Hospital	1,520	5,886	not listed	443	not listed
Moccasin Bend	172	14	0	0	0
Ridgeview Psychiatric Hospital and Center in Oak Ridge	5	5	0	0	0
Peninsula Hospital in Louisville (Blount County)	494	967	not listed	not listed	not listed
Total***	2,191	6,872	0	443	0

*Source - 2012 JARs

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**Not broken out in JAR by location and mental disease/A&D diagnoses
***Totals of available data

14. Section C, Need, Item 1 a., (Project Specific Criteria-Psychiatric Inpatient Services B. 1. Service Area and Section C. Need. Item 3 Service Area

Your response is noted. Please complete the following table indicating the travel times and distances to existing facilities, and the proposed SBH-Kingsport, LLC.

Facility		Hawkins Co. (Rogersville, TN)	(Sullivan Co. Kingsport, TN	Wise County (Wise, VA)	Lee County (Jonesville, VA)	Scott County (Gate City, VA)
Magnolia Ridge (Washington County)	Time					
	Distance					
Wellmont Regional Medical Center (Sullivan Co.)	Time					
	Distance					
Woodridge Psych Hospital (Washington Co.)	Time					
	Distance					
Wellmont Pavilion (Bristol, VA)	Time					
	Distance					
Ridgeview Psychiatric Hospital and Center in Oak Ridge (Anderson County)	Time					
	Distance					

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Peninsula Hospital in Louisville (Blount County)	Time					
	Distance					
Moccasin Bend Mental Health Institute (Hamilton County)	Time					
	Distance					
Proposed SBH-Kingsport, LLC	Time					
	Distance					

RESPONSE: The requested chart is set forth below. Driving times and distances given by MapQuest.

Facility	[redacted]	Hawkins Co. ** (Rogersville, TN)	(Sullivan Co. *** Kingsport, TN	Wise County (Wise, VA)**	Lee County** (Jonesville, VA)	Scott County** (Gate City, VA)
Magnolia Ridge (Washington County)	Time	1 hr	30 min	1 hr 29 min	1 hr 25 min	39 min
	Distance	50.8 mi	25.2 mi	73.7 mi	68.4 mi	31.5 mi
Wellmont Regional Medical Center (Sullivan Co.)*	Time	1 hr	19 min	1 hr 23 min	1 hr 16 min	31 min
	Distance	46.8 mi	15.6 mi	64.1 mi	59.6 mi	22.7 mi
Woodridge Psych Hospital (Washington Co.)	Time	1 hr	30 min	1 hr 29 min	1 hr 25 min	28 min
	Distance	49.8 mi	24.1 mi	72.7 mi	67.3 mi	31.5 mi
Wellmont Pavilion (Bristol, VA)	Time	1 hr	22 min	1 hr 27 min	1 hr 20 min	35 min

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	Distance	49.3 mi	18 mi	69.3 mi	62 mi	25.2 mi
Ridgeview Psychiatric Hospital and Center in Oak Ridge (Anderson County)	Time	1 hr 55 min	2 hr 9 min	3 hr 8 min	2 hr 9 min	2 hr 19 min
	Distance	95.7 mi	123.1 mi	173.3 mi	99.8 mi	130.9 mi
Peninsula Hospital in Louisville (Blount County)	Time	1 hr 47 min	2 hr 1 min	3 hr 1 min	2 hr 21 min	2 hr 11 min
	Distance	87.1 mi	112.6 mi	162.4 mi	97.9 mi	120.4 mi
Moccasin Bend Mental Health Institute (Hamilton County)	Time	1 hr 47 min	3 hr 35 min	4 hr 34 min	3 hr 52 min	3 hr 45 min
	Distance	188.4 mi	244.4 mi	264.6 mi	197.8 mi	222.1 mi
Proposed SBH-Kingsport, LLC	Time	40 min		1 hr 6 min	1 hr 1 min	15 min
	Distance	31.2 mi		52 mi	46.4 mi	9.6 mi

* Assumes Wellmont Bristol Regional Medical Center
** Drive times and distances given from local county courthouses, respectively
***Drive time and distance given from SBH-Kingsport site.

15. **Section C, Need, Item 1 a., (Project Specific Criteria-Psychiatric Inpatient Services) B. 2. Service Area Demographics and Section C. Need. Item 4.A Service Area Demographics**

Please complete the following chart.

Demographic Data	Hawkins County	Sullivan County	Service Area Total	State of TN Total
Total 2013 Population				
Total Population-				
Total 2017 Population % Change				
65+ Pop. - 2013				
65+ Pop. - 2017				
65+ Population % Change				
65+ Population % of Total Population				
Median Age				
Median Household Income				
TennCare Enrollees				

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TennCare Enrollees as % of Total Population				
Persons Below Poverty Level				
% of Total Population below Poverty Level				

RESPONSE: The requested chart is set forth below:

Demographic Data	Hawkins County	Sullivan County	Service Area Total	State of TN Total
Total 2013* Population	60,131	154,387	214,518	6,414,297
Total Population- 2017	61,865	154,946	216,811	6,623,114
Total 2017 Population % Change	2.9%	.4%	1.1%	3.3%
65+ Pop. - 2013	10,211	29,471	39,682	904,587
65+ Pop. - 2017	11,333	31,683	43,016	1,014,889
65+ Population % Change	11%	7.5%	8.4%	12.2%
65+ Population % of Total Population	18%	19.5%	19.1%	14.2%
Median Age**	42.3 yrs	43.5 yrs	43.2 (est.)	38 yrs
Median Household Income	$36,419	$40,025	$39,124 (est.)	$44,140
TennCare Enrollees***	11,668	27,446	39,114	1,198,663
TennCare Enrollees as % of Total Population	19.4%	17.8%	18.2%	18.7%
Persons Below Poverty Level**	9,861	26,091	35,952	1,109,673
% of Total Population below Poverty Level	16.4%	16.9%		17.3%

* Source: Tenn. Dept. of Health
** Source: U.S. Census Bureau
*** Source: Bureau of TennCare, September 2013 enrollment data
****Sullivan and Hawkins Counties only

Please clarify the reason the applicant did not include Washington County in its service area since it appears Sullivan and Washington counties share economic links and are closely in proximity.

RESPONSE: The applicant seeks to serve the area with the most need since Mountain States Health Alliance, owner of Indian Path Pavilion, closed that inpatient psychiatric hospital several years ago, and the state psychiatric hospital facility in Knoxville recently closed also. The need for the applicant's project is greatest where there are no other facilities. Washington County has Woodridge Hospital in Johnson City to serve its needs.

Please indicate the counties included in the service area of Woodridge Hospital in Johnson City, Ridgeview Psychiatric Hospital and Center in Oak Ridge, and Peninsula Hospital in Louisville (Blount County)?

RESPONSE: Woodridge Hospital has claimed these counties as its primary service area: Washington, Carter, Sullivan, Hawkins and Greene. Peninsula Hospital has outpatient centers in Blount, Knox, Loudon and Sevier Counties; thus, the applicant assumes that those

comprise its service area. According to p. 22 of its 2009 JAR, on 11/2/09 it surrendered 145 inpatient psychiatric hospital beds.

According to its 2012 JAR, Ridgeview Psychiatric Hospital in Anderson County has 16 beds and draws the greatest majority of its patients from Anderson County and the counties contiguous to it: Campbell, Knox, Roane, Scott and Morgan (91% of its admissions or discharges in 2012).

Please review and provide a copy of the letter from the Tennessee Department of Mental Health dated May 17, 2012 regarding Lakeshore Mental Health Institute (LMHI) from the following web address: http://tn.gov/mental/mhs/Catchment%20Area%20Letter-DV.pdf Please respond to the following question:

- Has the applicant discussed with the Tennessee Department of Mental Health the possibility of providing services for uninsured persons? If so, please discuss.

RESPONSE: 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. On January 2, 2013, a representative from Strategic Behavioral Health contacted Mr. John Arredondo, Assistant Commissioner of Hospital Services Division. During the conversation, Mr. Arredondo stated that he did not wish to comment on the project, and said that the HSDA will get a copy of the application over to his office and that they would provide their analysis and response directly to the HSDA. Strategic Behavioral Health would be open to exploring the possibility of providing services for uninsured persons with the Tennessee Department of Mental Health.

- How will the expansion of existing contracts with the three mentioned private inpatient psychiatric hospitals impact utilization at the applicant's proposed inpatient facility?

RESPONSE: The expansion of the state's contracts with the listed providers should not impact the applicant's utilization. Many of the patients subject to those contracts will be adult Medicaid, for which, as shown below, the applicant will have to deal with the IMD issue prior to serving.

16. **Section C, Need, Item 1 a., (Project Specific Criteria-Psychiatric Inpatient Services C. 1. Relationship to existing applicable plans (State, City, County, Regional Plans)**

The applicant states Strategic Behavioral Health, LLC does not have any inpatient psychiatric facilities in Tennessee. Please indicate if the applicant has reviewed Tennessee Title 33 Laws specific to inpatient psychiatric facilities.

RESPONSE: The applicant has reviewed Title 33 of the Tennessee Code Annotated.

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17. **Section C, Need, Item 1 a., (Project Specific Criteria-Psychiatric Inpatient Services C. 3. Relationship to existing applicable plans State appropriations).**

The applicant states the proposed inpatient facility will not be able to accept adult TennCare admissions. Please clarify why this is so and reference any rules and regulations.

RESPONSE: Institutions for Mental Disease (IMDs) are inpatient facilities of more than 16 beds whose patient roster is more than 51% people with severe mental illness. Federal Medicaid matching payments are prohibited for free standing IMDs with a population between the ages of 22 and 64. IMDs for persons under age 22 or over age 64 are permitted, at state option, to draw federal Medicaid matching funds. See 42 CFR §435.100a as attached hereto. Initially the applicant was under the impression that the proposed inpatient facility would not be able to accept adult TennCare admissions based on the aforementioned. Upon further investigation, the applicant was able to confirm with representatives from TennCare that, if SBH – Kingsport, LLC is successful in becoming a contracted TennCare provider, it will be able to accept adult TennCare admissions. SBH – Kingsport, LLC has every intention to becoming a contracted TennCare provider and would be more than happy to treat this population within its facility.

18. **Section C, Need, Item 1 a., (Project Specific Criteria-Psychiatric Inpatient Services C. 4. Relationship to existing applicable plans (Involuntary Admissions)**

Does the applicant expect to accept all involuntary admissions (all ages)? Will the applicant have the expertise and staff to monitor patients who may require one to one observation or may require special treatment?

RESPONSE: SBH – Kingsport, LLC will accept involuntary admissions starting at 5 years of age. The applicant will have the expertise and staff to monitor patients who may require one to one observation or may require special treatment. All staff will be thoroughly trained in proper observation monitoring and special treatment procedures to include Restraint and Seclusion techniques. In addition, the applicant will have access to additional staff through a PRN pool of Mental Health Technicians as staffing demands change due to one to one observation.

Please discuss if involuntary admissions and the uninsured would be transferred to private psychiatric hospitals that have expanded contracts with the Tennessee Department of Mental Health.

RESPONSE: SBH – Kingsport, LLC would be open to contracting directly with the Tennessee Department of Mental Health to accommodate this patient population. The applicant does plan to accept involuntary admissions and the uninsured.

The applicant states SBH-Kingsport, LLC will accept involuntary and voluntary admissions. Since Lakeshore Mental Health Institute closed on June 30, 2012, does the applicant plan to accept uninsured persons that would have been served by LMHI?

RESPONSE: As indicated above, SBH – Kingsport, LLC would be open to contracting directly with the Tennessee Department of Mental Health to accommodate those individuals who are no longer able to receive treatment at Lakeshore Mental Health Institute.

Please discuss examples of when the applicant could not accept an "Involuntary Admission." In a situation where the applicant could not take an "Involuntary Admission", what protocols would the applicant enact to assure the patient could receive proper treatment?

RESPONSE: An example of when we would not be able to accept an involuntary admission would be if we do not have a bed available, or if the patient's medical status is beyond our scope of care. In this case a full assessment would be completed and an admission specialist would coordinate with other community resources to assist in proper placement.

19. **Section C, Need, Item 1 a., (Project Specific Criteria-Psychiatric Inpatient Services C. 5. Relationship to existing applicable plans**

The applicant states the proposed facility will not be able to accept adult TennCare admissions. If this is so, does the projected TennCare utilization of 38% of charges seem reasonable? Please discuss.

RESPONSE: As previously indicated, prior to submitting the application the applicant was not aware that they would be able to accept adult TennCare admissions. As such, the projected utilization of 38% of charges does seem reasonable. We believe that the projected utilization is reasonable given the number of child and adolescent patients we intend to treat, as well as the number of duel eligible Medicare/Medicaid patients that are anticipated.

20. **Section C, Need, Item 1 a., (Project Specific Criteria-Psychiatric Inpatient Services D.1. (Relationship to Existing Similar Services)**

Please complete the following table indicating the licensed beds and occupancies of existing facilities that have Hawkins and Sullivan Counties in their existing service area.

Facility	Total Psychiatric Licensed Beds	Geriatric Beds	Adult Psych Beds	Total Child and Adolescent Beds	Total Chemical Dependency Beds	2010 Occup.	2011 Occup	2012 Occup.	Accept Involuntary Admissions
Magnolia Ridge (Washington County)									
Wellmont Regional Medical Center (Sullivan Co.)									
Woodridge Psych Hospital (Washington Co.)									

Total									

RESPONSE: Mr. Wade's office has not made Magnolia Ridge's utilization available to the applicant. Publicly available data for the other 2 facilities is set forth below.

Facility	Total Psychiatric Licensed Beds	Geriatric Beds	Adult Psych Beds	Total Child and Adolescent Beds	Total Chemical Dependency Beds	2010 Occup.	2011 Occup	2012 Occup.	Accept Involuntary Admissions
Magnolia Ridge (Washington County)	0	0	0	0	0	Not avail-able	Not avail-able	Not avail-able	Not for psychiatric inpatient
Wellmont Regional Medical Center (Sullivan Co.)	12	0	12	0	0	Not avail-able	Not avail-able	Not avail-able	Yes
Woodridge Psych Hospital (Washington Co.)	84	0	84	0	0	63.8%	64.7%	69.6%	Yes
Total*	96	0	96	0	0	63.8%	64.7%	69.6%	

*Based on available information

Please indicate if there are existing psychiatric intensive outpatient or partial hospitalization programs in the proposed service area.

RESPONSE: The applicant is not aware of any psychiatric intensive outpatient or partial hospitalization programs ongoing in the service area.

Will the applicant provide any intensive outpatient or partial hospitalization programs in the proposed service areas?

RESPONSE: The applicant intends to provide both intensive outpatient as well as partial hospitalization. Strategic Behavioral Health has significant experience operating both intensive outpatient and partial hospitalization programs for mental health and substance abuse in its other markets.

21. **Section C, Need, Item 1 a., (Project Specific Criteria-Psychiatric Inpatient Services D.2. (Relationship to Existing Similar Services-Access/Special Needs Groups)**

The applicant states involuntary patients will be accepted. If an uninsured individual is admitted involuntarily and is then is enrolled in TennCare, will be applicant need to transfer the patient to another facility since adult TennCare patients cannot be accepted?

RESPONSE: SBH – Kingsport, LLC does not believe that this scenario is likely given the time it would take for enrollment and eligibility verification. It is our belief that there is a very high probability that the individual would be stabilized and no longer be involuntary in the time that it would take to enroll in TennCare.

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22. **Section C, Need, Item 3.**

Please provide a clearer county level map of the proposed service area.

RESPONSE: The requested service area map is attached.

23. **Section C, Need, Item 6**

Please also complete the following chart:

Facility	Beds	Year 1	Year 1	Year 1	Year 1	Year 2	Year 2	Year 2	Year 2
[redacted]	[redacted]	Admits	Pat. Days	ALOS	%Occ.	Admits	Pat. Days	ALOS	%Occ.
SBH-Kingsport, LLC									

RESPONSE:

Facility	Beds	Year 1	Year 1	Year 1	Year 1	Year 2	Year 2	Year 2	Year 2
[redacted]	[redacted]	Admits	Pat. Days	ALOS	%Occ.	Admits	Pat. Days	ALOS	%Occ.
SBH-Kingsport, LLC	72	725	8,700	12	33	1,425	17,100	12	65

Please provide the details regarding the methodology used to project 8,700 patient days during the first year of operation and 17,100 patient days during the second year of operation. The methodology must include detailed calculations or documentation from referral sources.

RESPONSE: Mental illness effects a large portion of the United States population, with 44.7 million adults experiencing some mental illness in 2011- 2012, and another 10.4 million adults experiencing serious mental illness, such as schizophrenia, chronic depression, or bipolar disorder. (Data from the Substance Abuse and Mental Health Administration's National Survey on Drug Use and Health, published May 31, 2012) The Substance Abuse and Mental Health Administration (SAMHSA) provides data on mental illness in the United States. According to SAMHSA estimates, the following percentages of people in the United States and Tennessee suffer from mental illness (These tables are based on National Survey on Drug Use and Health surveys conducted in 2008 and 2009.):

[redacted]	[redacted]
Tennessee	**21.46%**
Nation	**19.77%**

[redacted]	[redacted]
Tennessee	**5.01%**
Nation	**4.62%**

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Tennessee has mental illness rates higher than the national average. With such large portions of Tennessee's population suffering from mental illness, it is important for the state to ensure adequate availability of mental health services so this population can receive needed psychiatric treatment.

Strategic Behavioral Health has extensive experience in the ramp up of psychiatric hospitals. The applicant has looked at the population of the service area, prevalence of mental illness and serious mental illness and has taken into account the ramp up pattern of other SBH facilities as its methodology and to form its projections.

The total average daily census of 23.8 in Year One and 46.8 in Year Two of the proposed project is noted. Please break-out the proposed average daily census by unit:

	Year One-ADC	Year Two-ADC
Adult Psychiatric Unit (18 beds)		
Gero Psychiatric Unit (16 Beds)		
Child and adolescent beds (28 beds)		
Chemical Dependency Unit (10 beds)		
Total	23.8	46.8

RESPONSE:

	Year One-ADC	Year Two-ADC
Adult Psychiatric Unit (18 beds)	6	11.7
Gero Psychiatric Unit (16 Beds)	5.3	10.4
Child and adolescent beds (28 beds)	9.2	18.2
Chemical Dependency Unit (10 beds)	3.3	6.5
Total	23.8	46.8

Please provide letters of referral from Community Mental Health Centers, Private Psychiatrists and Primary Care Physicians, etc.

RESPONSE: At this time, the applicant has met with a wide sample of community mental health stakeholders; including private practice clinicians, law enforcement, medical/surgical hospitals, skilled nursing facilities, teaching institutions, Department of Children's Services and local government officials. The applicant has attached the Letters of Support that are already in receipt, validating the need for additional inpatient psychiatric services discussed during the meetings. In addition, the applicant anticipates receiving letters of support from several community stakeholders.

Please also provide letters from the service area's Community Mental Health Agency's mobile crisis teams that express the need for the proposed psychiatric inpatient facility in Sullivan County.

RESPONSE: A Strategic Behavioral Health Representative has made contact with Frontier Health, who is not willing to write a letter expressing the need for our proposed facility. In a meeting on October 10, 2013 with Lucretia Sanders, Regional Administrator for the Department of Children's Services, a representative from Strategic Behavioral Health was told that there is definitely a need for additional inpatient psychiatric beds. Mrs. Sanders indicated that if DCS is unable to get a youth placed at Woodridge Hospital they have to send the youth to Knoxville, which puts a tremendous strain on continuity of care and is not desirable. Additionally, in a meeting with Sullivan County Sheriff's Office Chief Deputy Lisa Christian a representative from Strategic Behavioral Health was shown data reflecting mental health transports conducted by the department. In 2012 there were 1,107 transports that had to leave Sullivan County to receive services. In 2013 there were 1,168 transports that had to leave Sullivan County to receive services. On 1/14/2014 a representative from Strategic Behavioral Health met with several key stakeholders from Kingsport City Schools. During this meeting it was stated that the school district takes a proactive role in responding to the mental health needs of its students and would be encouraged to work with Strategic Behavioral Health as a community partnership to place an emphasis on continuity of care and transitional re-entry into schools.

24. **Section C. Economic Feasibility Item 1 (Project Cost Chart)**

The letter from Thomas Construction Group dated December 9, 2013 is noted. Please submit the referenced attached "Part A of the Project Costs Chart" the letter is referencing.

RESPONSE: This reference refers to "Part A" of the Project Cost Chart itself, which specifies that the projected construction costs are approximately $8,000,000.

Please clarify $562,607 assigned to C.4. "Build Year Operating Cost".

RESPONSE: These are costs, such as personnel and benefit costs, that accrue as operating costs as the applicant brings the project through construction completion and licensure prior to accepting the first patient. A list of these costs is attached.

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25. Section C. Economic Feasibility Item 2 (Funding)

The applicant has checked box F-"Other Funding" to document funding for this proposed project. The letter dated December 11, 2013 for Strategic Behavioral Health, LLC notes the proposed project will be funded through cash, availability under the credit facility and net cash flows from existing operations. Please clarify how much of the $11,717,915 project cost will be assigned to cash, revolving credit and net cash flows. Also, please check all applicable funding sources for the project and resubmit a replacement page.

RESPONSE: SBH – Kingsport, LLC anticipates that the breakdown of funding for the project is as follows:

- Cash - $4,100,000
- Revolving Credit - $6,700,000
- Additional Net Cash Flows - $917,915

The requested replacement page, indicating all applicable funding sources is attached.

26. Section C. Economic Feasibility Item 3 (Reasonableness of Project Cost)

Please compare the cost per square foot of construction to similar projects recently approved by the Health Services and Development Agency.

RESPONSE: The applicant's construction cost per square foot of $153.00 compares favorably with that projected by the applicant in the following CON applications: Rolling Hills Hospital, CN1312-051: $337 per square foot; Woodridge of West Tennessee, CN1309-035: $114 per square foot (renovation only).

The latest HSDA Hospital Construction Cost per Square Foot analysis for projects approved by the HSDA 2010-2012 is provided at the following web-site:
http://tennessee.gov/hsda/applicants_tools/docs/Construction%20Cost%20Per%20Square%20Foot%20charts-0911.pdf

RESPONSE: See the attached chart for the requested historic costs per square foot. The median cost per square foot for new hospital construction projects for 2010-2012 was $259.66 per square foot. The applicant projects that its construction costs are approximately $153.00 per square foot. This project's projected construction costs are thus below the 2010-2012 median cost.

27. Section C. Economic Feasibility Item 4. (Historical Data Chart and Projected Data Chart)

Please indicate if there are management fees associated with this project. Please note that "Management Fees to Affiliates" should include management fees paid by agreement to the parent company, another subsidiary of the parent company, or a third party with common ownership as the applicant entity. "Management Fees to Non-Affiliates" should also include

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any management fees paid by agreement to third party entities not having common ownership with the applicant. Management fees should not include expense allocations for support services, e.g., finance, human resources, information technology, legal, managed care, planning marketing, quality assurance, etc. that have been consolidated/centralized for the subsidiaries of a parent company.

RESPONSE: There are no management fees associated with this project.

There appears to be a calculation error for the total of Gross Operating Revenue in Year 2 on the Projected Data Chart. Please verify and resubmit a replacement page if needed.

RESPONSE: The Gross Operating Revenue in Year 2 on the Project Data Chart had a typo and should have been $28,023,800 and not $26,023,800. A corrected Project Data Chart is attached.

The applicant projects 8,700 patients in Year One. What is the census of patients needed to breakeven?

RESPONSE: The census of patients that is needed to break even is twenty four (24).

Please complete the following for D.9 of the Projected Data Chart:

PROJECTED DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Year____	Year___
1.	$_____	$_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____
7.	_____	_____
Total Other Expenses	$_____	$_____

RESPONSE:

OTHER EXPENSES CATEGORIES	Year__1__	Year__2_
1. Advertising	$_120,000_	$_120,000_
2. Purchased Services	$_366,708_	$_550,542_
3. Recruitment	$_36,000__	$_36,000__
4. Travel	$_90,000__	$_90,000__
5. Repairs	$_17,400__	$_34,200__
6. Insurance	$_48,000__	$_48,000__
7. Utilities	$_144,300_	$_149,850__

8.	Misc. Expenses	$_20,700__	$_29,100__
	Total Other Expenses	**$_843,108_**	**$_1,057,692_**

28. Section C. Economic Feasibility Item 5

Please calculate average gross charge, average deduction from operating revenue and average net charge Year One. The applicant should divide each area by the total of patient days.

RESPONSE: The applicant projects that its average gross charge per inpatient day in year 1 is approximately $1,578, and that its average net charge per inpatient day is approximately $550 per day. Its average deduction from gross operating revenue is approximately $1,028.

29. Section C, Economic Feasibility, Item 6.A. and 6.B.

Please provide comparative charges to Woodridge Psychiatric Hospital in adjoining Washington County.

RESPONSE: As indicated by data on p. 18 of its 2012 JAR, the Woodridge Psychiatric Hospital average charges per day appear to be approximately $2,214 per patient day. This figure was derived by dividing its reported gross charges for inpatient ($47,218,094) care by the number of its reported 2012 inpatient days (21,329).

30. Section C, Economic Feasibility, Item 9.

How will the medically indigent be served?

RESPONSE: Appropriate medical care will be provided to all patients, regardless of their ability to pay. That care will be limited to the appropriate scope of a psychiatric hospital. Emergency medical or life threatening medical will be transferred to the appropriate medical hospital.

31. Orderly Development, Item 1

Does the applicant plan to have a working relationship with area mobile crisis teams?

RESPONSE: Yes, the applicant intends to have a working relationship with the area mobile crisis teams. As indicated in question 6, Frontier Health did say that if we were able to complete our project and provide quality clinical programing that they would work with us.

32. Orderly Development, Item 2

It appears there are other inpatient psychiatric providers such as Woodridge Psychiatric Hospital that also claims Hawkins and Sullivan counties in their service area. How will this proposal impact the utilization of similar providers such as Woodridge?

RESPONSE: Utilization of Woodridge and other inpatient psychiatric providers not in the service area has already been accounted for in the projections for this project. The

elimination over recent years of inpatient psychiatric beds at Indian Path Pavilion and Lakeshore Mental Health Institute in Knoxville demonstrate the continuing need for additional inpatient psychiatric beds in this service area.

33. **Section C, Contribution to Orderly Development, Item 3**

The applicant has assigned 1.4 techs and 1.4 R.N/UM per shift. This staffing pattern appears to be underestimated by the applicant in staffing a 72 bed psychiatric facility that may have high acuity patients. How will 1.4 techs and 1.4 RN/UM cover four (4) units? If there is a suicide watch how will this be handled with limited staff? Please clarify.

RESPONSE: The hospital will be staffed based on clinical acuity and staffing levels will increase to accommodate the need if special observation is required. The staffing pattern previously submitted was calculated by taking averages of FTE's per unit per shift over the ramp up census levels. The following ratios should provide more clarity on staffing:

Nursing – 1:10

Mental Health Tech – 1:8

Recreation Therapist – 1:30

Therapist – 1:12

In addition to fifteen (15) minute checks, line of sight observations and one-to-one observations will be used as needed. A PRN pool will be established to support the need for additional staff for special observations.

How will one therapist cover four (4) psychiatric units in Year One and Year Two, and be specialized in child and adolescent, chemical dependency, adult psych and gero-psych areas?

RESPONSE: The applicant will have appropriate therapist coverage for each patient population. There is a one (1) to twelve (12) therapist ratio. Therapists will be educated and trained in all specialized areas and populations.

Why are there no FTEs assigned to teachers?

RESPONSE: Children in acute psychiatric hospital care are on medical homebound from local schools and education is not the focus of acute stabilization; however the applicant will, upon the guardian's request, communicate with the school in order to avoid administrative disenrollment due to attendance.

What will be the patient to tech and nurse ratio for each of the four units? Will this meet staffing requirements of the Tennessee Department of Mental Health?

RESPONSE: The applicant will meet the staffing requirements of the Tennessee Department of Mental Health (Rule 0940-5-16-.14). All units will be staffed to acuity.

Staffing will increase to cover special observations. The tech to patient ratio will be one (1) to eight (8), and the nurse to patient ratio will be one (1) to twelve (12).

Please compare clinical staff salaries in the proposal to prevailing wage patterns in the service area as published by the Tennessee Department of Labor and Workforce Development and/or other documented sources.

RESPONSE: Wage patterns for these positions in this service area, as published by the Tennessee Department of Labor and Workforce Development, are set forth below for the Kingsport-Bristol MSA:

Position	Median Wage
RN	$48,630
Mental Health Counselor	$34,740
Healthcare Support Workers	$33,600

If necessary, please resubmit the staffing pattern for the 72 bed psychiatric facility that will meet licensure standards.

34. **Section C, Contribution to Orderly Development, Item 7**

Please provide the latest results of a state licensure survey of an existing inpatient psychiatric inpatient facility owned by Strategic Behavioral Health, LLC along with the applicant's responses.

RESPONSE: The requested documentation is attached hereto.

35. **Proof of Publication**

Please submit a copy of the full page of the newspaper in which the notice of intent appeared with the mast and dateline intact or submit a publication affidavit which is supplied by the newspaper as proof of the publication of the letter of intent.

RESPONSE: The requested documentation is attached hereto.

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January 29, 2014
3:10pm

Mr. Phillip M. Earhart
January 28, 2014

Sincerely,

Mike Garone

Contact Person for Certificate of Need
Application CN1312-050
SBH-Kingsport, LLC

Attachments

Ambulatory Surgical Treatment Center Construction Cost Per Square Foot

Years: 2010 – 2012

	Renovated Construction	New Construction	Total Construction
1st Quartile	$50.00/sq ft	$200.00/sq ft	$78.42/sq ft
Median	$100.47/sq ft	$252.74/sq ft	$166.28/sq ft
3rd Quartile	$166.28/sq ft	$292.61/sq ft	$244.26/sq ft

Source: CON approved applications for years 2010 through 2012

Hospital Construction Cost Per Square Foot

Years: 2010 – 2012

	Renovated Construction	New Construction	Total Construction
1st Quartile	$99.12/sq ft	$234.64/sq ft	$167.99/sq ft
Median	$177.60/sq ft	$259.66/sq ft	$235.00/sq ft
3rd Quartile	$249.00/sq ft	$307.80/sq ft	$274.63/sq ft

Source: CON approved applications for years 2010 through 2012

Nursing Home Construction Cost Per Square Foot

Years: 2010 – 2012

	Renovated Construction	New Construction	Total Construction
1st Quartile	$19.30/sq ft	$164.57/sq ft	$73.23/sq ft
Median	$35.76/sq ft	$167.31/sq ft	$164.57/sq ft
3rd Quartile	$55.00/sq ft	$181.72/sq ft	$167.61/sq ft

Source: CON approved applications for years 2010 through 2012

Outpatient Diagnostic Center Construction Cost Per Square Foot

Years: 2010 – 2012

Due to insufficient sample size, Construction ranges are not available.

4390. INSTITUTIONS FOR MENTAL DISEASES

A. Statutory and Regulatory Provisions.--The statutory provisions relating to institutions for mental diseases (IMDs) include two categories of covered services and a broad payment exclusion that can preclude payment for services provided to certain individuals in both participating and non-participating facilities.

1. IMD Coverage.--The original Medicaid legislation (P.L. 89-97) included a benefit for individuals 65 years of age or older who are in hospitals or nursing facilities that are IMDs. This provision is in §1905(a)(14) of the Act and regulations relating to this benefit are in Subpart C of 42 CFR 441.

In 1972, the Medicaid program was expanded (P.L. 92-603) to include inpatient psychiatric hospital services for individuals under age 21, or, in certain circumstances, under age 22. This provision is in §1905(a)(16) of the Act. Authority for using additional settings was enacted in P.L. 101-508. This benefit is currently being provided in a wide variety of psychiatric facilities. Regulations for this benefit are in Subpart D of 42 CFR 441.

Both IMD benefits are optional, except that inpatient psychiatric services for individuals under age 21 must be provided in any State as early and periodic screening, diagnosis and treatment (EPSDT) services if they are determined to be medically necessary.

2. IMD Exclusion.--The IMD exclusion is in §1905(a) of the Act in paragraph (B) following the list of Medicaid services. This paragraph states that FFP is not available for any medical assistance under title XIX for services provided to any individual who is under age 65 and who is a patient in an IMD unless the payment is for inpatient psychiatric services for individuals under age 21. This exclusion was designed to assure that States, rather than the Federal government, continue to have principal responsibility for funding inpatient psychiatric services. Under this broad exclusion, no Medicaid payment can be made for services provided either in or outside the facility for IMD patients in this age group.

3. IMD Definition.--In 1988, P.L. 100-360 defined an institution for mental diseases as a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. This definition is in §1905(i) of the Act and in 42 CFR 435.1009. The regulations also indicate that an institution is an IMD if its overall character is that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases.

Facilities with fewer than 17 beds that specialize in treating persons with mental disorders can provide the types of services discussed in item 1 if they meet the regulatory requirements to provide these institutional benefits, but these facilities are not technically IMDs. Because IMDs are defined to be institutions with more than 16 beds, the IMD exclusion applies only to institutions with at least 17 beds.

B. Guidelines for Determining What Constitutes an Institution.--When it is necessary to determine whether an institution is an IMD, the IMD criteria listed in subsection C must be applied to the appropriate entity. In most cases, there is no difficulty in determining what entity to apply the criteria to. But in cases in which multiple components are involved, it may be necessary for the HCFA regional office (RO) to apply the following guidelines

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to identify the institution to be assessed. Components that are certified as different types of providers, such as NFs and hospitals, are considered independent from each other.

1. Are all components controlled by one owner or one governing body?

2. Is one chief medical officer responsible for the medical staff activities in all components?

3. Does one chief executive officer control all administrative activities in all components?

4. Are any of the components separately licensed?

5. Are the components so organizationally and geographically separate that it is not feasible to operate as a single entity?

6. If two or more of the components are participating under the same provider category (such as NFs), can each component meet the conditions of participation independently?

The RO may also use other guidelines that it finds relevant in a specific situation. If the answer to items 1, 2, or 3 is "no," or the answer to items 4, 5, or 6 is "yes," for example, there may be a separate facility/component. If it is determined that a component is independent, the IMD criteria in subsection C are applied to that component unless the component has 16 or fewer beds.

C. Guidelines for Determining Whether Institution Is an IMD.--HCFA uses the following guidelines to evaluate whether the overall character of a facility is that of an IMD. If any of these criteria are met, a thorough IMD assessment must be made. Other relevant factors may also be considered. For example, if a NF is being reviewed, reviewers may wish to consider whether the average age of the patients in the NF is significantly lower than that of a typical NF. A final determination of a facility's IMD status depends on whether an evaluation of the information pertaining to the facility establishes that its overall character is that of a facility established and/or maintained primarily for the care and treatment of individuals with mental diseases.

1. The facility is licensed as a psychiatric facility;

2. The facility is accredited as a psychiatric facility;

3. The facility is under the jurisdiction of the State's mental health authority. (This criterion does not apply to facilities under mental health authority that are not providing services to mentally ill persons.);

4. The facility specializes in providing psychiatric/psychological care and treatment. This may be ascertained through review of patients' records. It may also be indicated by the fact that an unusually large proportion of the staff has specialized psychiatric/psychological training or that a large proportion of the patients are receiving psychopharmacological drugs; and

5. The current need for institutionalization for more than 50 percent of all the patients in the facility results from mental diseases.

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D. Assessing Patient Population.--The review team applying the guidelines must include at least one physician or other skilled medical professional who is familiar with the care of mentally ill individuals. No team member may be employed by or have a significant financial interest in the facility under review.

In applying the 50 percent guideline (see §4390.C.2), determine whether each patient§s current need for institutionalization results from a mental disease. It is not necessary to determine whether any mental health care is being provided in applying this guideline.

For purposes of determining whether a facility is subject to the IMD exclusion, the term "mental disease" includes diseases listed as mental disorders in the International Classification of Diseases, 9th Edition, modified for clinical applications (ICD-9-CM), with the exception of mental retardation, senility, and organic brain syndrome. The Diagnostic and Statistical Manual of Mental Disorders (DSM) is a subspecification of the mental disorder chapter of the ICD and may also be used to determine whether a disorder is a mental disease.

If it is not possible to make the determination solely on the basis of an individual's current diagnosis, classify the patient according to the diagnosis at the time of admission if the patient was admitted within the past year. Do not include a patient in the mentally ill category when no clear cut distinction is possible.

To classify private patients when review of their records is not possible, rely on other factors such as the surveyor's professional observation, discussion with staff of the overall character and nature of the patient's problems, and the specialty of the attending physician.

When the 50 percent guideline is being applied in a NF, the guideline is met if more than 50 percent of the NF residents require specialized services for treatment of serious mental illnesses, as defined in 42 CFR 483.102(b). Facilities providing non-intensive care for chronically ill individuals may also be IMDs. All NFs must provide mental health services which are of a lesser intensity than specialized services to all residents who need such services. Therefore, in applying the 50 percent guidelines, it is important to focus on the basis of the patient's current need for NF care, rather than the nature of the services being provided.

E. Chemical Dependency Treatment Facilities.--The ICD-9-CM system classifies alcoholism and other chemical dependency syndromes as mental disorders.

There is a continuum of care for chemical dependency. At one end of the spectrum of care, treatment follows a psychiatric model and is performed by medically trained and licensed personnel. If services are psychological in nature, the services are considered medical treatment of a mental disease. Chemically dependent patients admitted for such treatment are counted as mentally ill under the 50 percent guideline. Facilities with more than 16 beds that are providing this type of treatment to the majority of their patients are IMDs.

At the other end of the spectrum of care are facilities that are limited to services based on the Alcoholics Anonymous model, i.e., they rely on peer counseling and meetings to promote group support and encouragement, and they primarily use lay persons as counselors. Lay counseling does not constitute medical or remedial treatment. (See 42 CFR 440.2(b).) Do not count patients

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admitted to a facility only for lay counseling or services based on the Alcoholics Anonymous model as mentally ill under the 50 percent guideline. If psychosocial support provided by peers or staff without specialized training is the primary care being provided in the facility, the facility is not an IMD. The major factor differentiating these facilities from other chemical dependency treatment facilities is the primary reliance on lay staff.

Federal matching funds may not be claimed for institutional services when lay/social treatment is the primary reason for the inpatient stay. Facilities may not claim Medicaid payment for providing covered medical or remedial services in a nursing facility or hospital to patients admitted for treatment of chemical dependency and simultaneously claim that they are providing only lay or social services to those same patients when the 50 percent guideline is being applied. Facilities also may not avoid having their chemically dependent patients counted as mentally ill under the 50 percent guideline by withholding appropriate treatment from those patients. Facilities failing to provide appropriate treatment to patients risk termination from the program.

In determining whether a facility has fewer than 17 beds, it is not necessary to include beds used solely to accommodate the children of the individuals who are being treated. Children in beds that are not certified or used as treatment beds are not considered to be patients in the IMD and therefore are not subject to the IMD exclusion if they receive covered services while outside the facility.

4390.1 Periods of Absence From IMDs.--42 CFR 435.1008(c) states that an individual on conditional release or convalescent leave from an IMD is not considered to be a patient in that institution. These periods of absence relate to the course of treatment of the individual's mental disorder. If a patient is sent home for a trial visit, this is convalescent leave. If a patient is released from the institution on the condition that the patient receive outpatient treatment or on other comparable conditions, the patient is on conditional release.

If an emergency or other need to obtain medical treatment arises during the course of convalescent leave or conditional release, these services may be covered under Medicaid because the individual is not considered to be an IMD patient during these periods. If a patient is temporarily transferred from an IMD for the purpose of obtaining medical treatment, however, this is not considered a conditional release, and the patient is still considered an IMD patient.

The regulations contain a separate provision for individuals under age 22 who have been receiving the inpatient psychiatric services benefit defined in 42 CFR 440.160. This category of patient is considered to remain a patient in the institution until he/she is unconditionally released or, if earlier, the date he/she reaches age 22.

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would ordinarily be paid to a family of two without income or resources may use an amount based upon a reasonable relationship to such an AFDC standard for a family of two.

(g) FFP is not available in expenditures for services provided to categorically needy and medically needy beneficiaries subject to the FFP limits if their annual income, after the cash assistance income deductions and any income disregards in the State plan authorized under section 1902(r)(2) of the Act are applied, exceeds the 133⅓ percent limitation described under paragraphs (b), (c), and (d) of this section.

(f) A State may use the less restrictive income methodologies included under its State plan as authorized under §435.601 in determining whether a family's income exceeds the limitation described in paragraph (b) of this section.

[59 FR 1033, Jan. 19, 1994, as amended at 66 FR 2321, 2327, Jan. 11, 2001]

§ 435.1008 FFP in expenditures for medical assistance for individuals who have declared United States citizenship or nationality under section 1137(d) of the Act and with respect to whom the State has not documented citizenship and identity.

Except for individuals described in §435.406(a)(1)(iv), FFP will not be available to a State with respect to expenditures for medical assistance furnished to individuals unless the State has obtained satisfactory documentary evidence of citizenship or national status, as described in §435.407 that complies with the requirements of section 1903(x) of the Act.

[72 FR 38694, July 13, 2007]

§ 435.1009 Institutionalized individuals.

(a) FFP is not available in expenditures for services provided to—

(1) Individuals who are inmates of public institutions as defined in §435.1010; or

(2) Individuals under age 65 who are patients in an institution for mental diseases unless they are under age 22 and are receiving inpatient psychiatric services under §440.160 of this subchapter.

(b) The exclusion of FFP described in paragraph (a) of this section does not apply during that part of the month in which the individual is not an inmate of a public institution or a patient in an institution for tuberculosis or mental diseases.

(c) An individual on conditional release or convalescent leave from an institution for mental diseases is not considered to be a patient in that institution. However, such an individual who is under age 22 and has been receiving inpatient psychiatric services under §440.160 of this subchapter is considered to be a patient in the institution until he is unconditionally released or, if earlier, the date he reaches age 22.

[43 FR 45204, Sept. 29, 1978, as amended at 50 FR 15169, Apr. 9, 1985; 50 FR 35317, Sept. 25, 1985. Redesignated and amended at 71 FR 49228, July 12, 2006]

§ 435.1010 Definitions relating to institutional status.

For purposes of FFP, the following definitions apply:

Active treatment in intermediate care facilities for individuals with intellectual disabilities means treatment that meets the requirements specified in the standard concerning active treatment for intermediate care facilities for persons with Intellectual Disability under §483.440(a) of this subchapter.

Child-care institution means a nonprofit private child-care institution, or a public child-care institution that accommodates no more than twenty-five children, which is licensed by the State in which it is situated, or has been approved by the agency of the State responsible for licensing or approval of institutions of this type, as meeting the standards established for licensing. The term does not include detention facilities, forestry camps, training schools or any other facility operated primarily for the detention of children who are determined to be delinquent.

In an institution refers to an individual who is admitted to live there and receive treatment or services provided there that are appropriate to his requirements.

SBH-KINGSPORT 001714

SUPPLEMENTAL- # 1
January 29, 2014
3:10pm

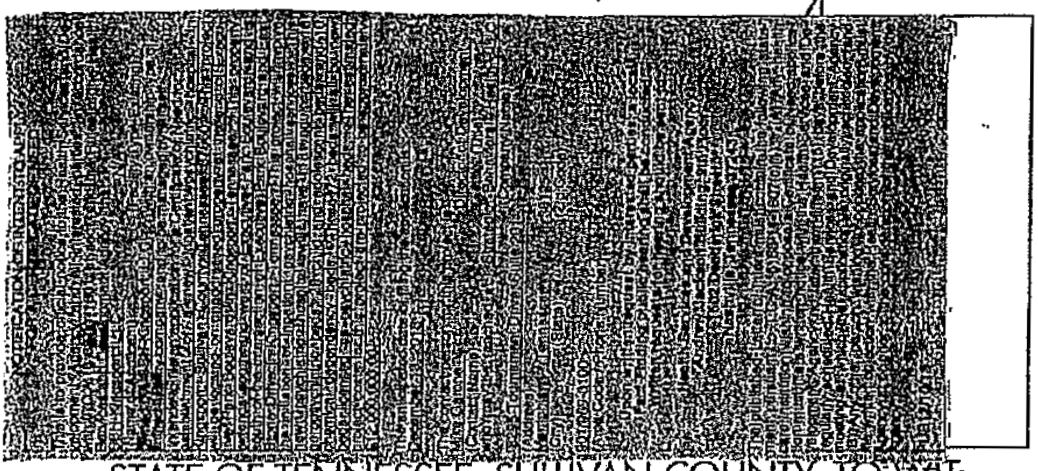
KINGSPORT TIMES-NEWS

PUBLICATION CERTIFICATE

Kingsport, TN 12/10/13

This is to certify that the Legal Notice hereto attached was published in the Kingsport Times-News, a daily newspaper published in the City of Kingsport, County of Sullivan, State of Tennessee, beginning in the issue of December 10, 2013, and appearing 1 consecutive weeks/times, as per order of Baker, Donelson, Bearman

Signed Sheryl Edwards



STATE OF TENNESSEE, SULLIVAN COUNTY, TO WIT:

Personally appeared before me this 10th day of December, 2013, Sheryl Edwards of the Kingsport Times-News and in due form of law made oath that the foregoing statement was true to the best of my knowledge and belief.

JANICE P. REESER NOTARY PUBLIC AT LARGE WASHINGTON COUNTY, TN

Janice P. Reeser
Notary Public

My commission expires 3-2-2016

SUPPLEMENTAL- # 1
January 29, 2014
3:10pm

JAN 29 '14 15:08

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF Shelby

NAME OF FACILITY: SBH - KINGSPORT, LLC

I, MICHAEL GARONE, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

DIRECTOR OF DEVELOPMENT
Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 28th day of January, 2014, witness my hand at office in the County of Shelby, State of Tennessee.

Renee E. Klein
NOTARY PUBLIC

My commission expires Oct. 19, 2016.

HF-0043

Revised 7/02

RENEE E. KLEIN
STATE OF TENNESSEE
NOTARY PUBLIC
SHELBY COUNTY

MY COMMISSION EXRIRES:
October 9, 2016

COPY-
SUPPLEMENTAL-2

SBH- Kingsport, LLC

CN1312-050

SUPPLEMENTAL- # 2
January 31, 2014
11:35:am

January 31, 2014

Mr. Phillip M. Earhart
Health Planner III
Tennessee Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

Via Hand Delivery

Re: Certificate of Need Application CN1312-050
SBH-Kingsport, LLC

Dear Mr. Earhart:

Set forth below are the responses of SBH-Kingsport, LLC, the applicant in Certificate of Need Application CN1312-050 to the request for information dated January 30, 2014. We have filed these in triplicate, as you directed, along with an affidavit regarding the responses.

1. Section B, Project Description, Item II.A

Please clarify the reason each psychiatric unit will not have their own dedicated seclusion room and bathroom. Does this arrangement meet best practice guidelines in life/safety?

RESPONSE: The applicants President, a seasoned Mental Health Professional spent considerable time with the architect and design team to design the building specifically to accommodate the patient population. In our years of experience, we have learned that when a patient is in need of seclusion or restraint, it is extremely important to remove them from the stimulus of the current unit. Our design has these seclusion rooms directly adjacent to the unit, but far enough away to reduce stimulus. Additionally, we have a clinical philosophy of seclusion and restraint as a last resort and we believe providing too many seclusion areas could encourage additional use. The current design provides for maximum dignity and respect for each client with the bathrooms being attached to the seclusion area.

How many seclusion rooms will there be per psychiatric unit?

RESPONSE: There are a total of three (3) seclusion rooms and bathrooms for the facility. Each nurse's station has a seclusion room behind them for better clinical oversight and support. This equates to three (3) seclusion rooms for five distinct hallways or one (1) per nurse's station.

The applicant states the twenty-eight (28) adolescent and child units are coed. What experience does the applicant have in operating an adolescent and child inpatient psychiatric unit with high risk patients?

RESPONSE: Strategic Behavioral Health currently operates a total of 387 child / adolescent inpatient beds in North Carolina, Colorado, New Mexico and Nevada. In each of these facilities, we have built a reputation of taking the most high-risk, most "acute", and most violent and aggressive children in each of these markets. In fact, our clinical outcomes have shown significant improvement in these particular patients. Our staffing models and clinical program design allow us to appropriately manage co-ed as well as different clinical presentations in each unit.

The square footage and cost per square footage chart is noted. However, the last three columns of the chart should be the final cost per sq. ft. for each unit/department, not project cost assigned to each area. Please revise.

RESPONSE: The requested documentation is attached hereto. Please note that the price per sq/ft is the same for each unit/department because we do not have the level of detail that breaks out the pricing by unit.

2. **Section B, Project Description, Item II.B**

The applicant states Woodridge has claimed Sullivan and Hawkins counties in their service area, which the applicant is also proposing to claim in their service area. Please provide a brief summary of inpatient psychiatric services provided by Woodridge Psychiatric Hospital and number of licensed beds assigned to each unit.

RESPONSE: According to its 2012 JAR, Woodridge has 84 psychiatric beds. Its 2012 JAR does not list any psychiatric hospital beds assigned "specifically for children and youth under age 18" or specifically for "geriatric patients". Also, its 2012 JAR does not assign any beds to "chemical dependency" services.

3. **Section B, Project Description Item III.A.(Plot Plan)**

The plot plan is noted. Please describe the four businesses that border the site.

RESPONSE: To the best of the applicant's knowledge the surrounding businesses are as follows:

1. Kmart
2. Gregory Corradino, MD
3. Mountain Region Family Medicine
4. Frank Merendino, DDS

5. Wellmont Health System

6. Grace Covenant Church

7. Stowaway Self Services Storage

It appears the proposed structures will be close to two existing structures. What are the two structures and the distance to the proposed facility?

RESPONSE: To the best of the applicant's knowledge one of the buildings is a self-storage building and it is unclear what the other building is. The building footprint is not drawn to scale on the plot plan, so we are unable to verify the distance to the two existing structures. As indicated in the letter from our architect, all aspect of the project will be in accordance with city building codes.

4. **Section B, Project Description, Item B.IV**

The floor plans submitted are noted. Please provide floor plans that include labeling of psychiatric units, seclusion rooms, patient care rooms (noting private or semi-private), ancillary areas, equipment areas, etc.

RESPONSE: The requested documentation is attached hereto.

5. **Section C, Need, Item 1 a., (Project Specific Criteria-Psychiatric Inpatient Services A. Need, 1)**

The use of Tennessee Department of Health 2010-2020 projections published by the TDOH in 2010 is noted. However, the most recent revision published by the Tennessee Department of Health is 2013. Please revise all need calculations using population statistics incorporating the Tennessee Department of Health Populations revised 2013 at the following web-site address: http://health.state.tn.us/statistics/pdffiles/CertNeed/Population_Projections_2010-20.pdf

Please submit replacement pages with the revised changes.

RESPONSE: The requested revisions have been done, and the respective replacement pages are attached.

6. **Section C, Need, Item 1 a., (Project Specific Criteria-Psychiatric Inpatient Services B.1. (Service Area)**

The chart of the patient origin by county is noted. The chart notes the following number of inpatient/discharge days for Woodridge Hospital in the two counties that is included in the applicant's proposed service area: Sullivan County: 5,886 inpatient/discharge days; and Hawkins County: 1,520 inpatient/discharge days. The 2012 Joint Annual Report indicates there were a total 19,306 Tennessee inpatient/discharge days in 2012 for Woodridge Hospital.

Woodridge depends on 38% of their psychiatric inpatient patient/discharge days (7.9% from Hawkins County and 30.1% from Sullivan County) from the applicant's proposed service area. Please clarify and discuss the impact the proposed project will have on Woodridge Psychiatric Hospital while Woodridge depends on 38% of their patient days/discharges from Hawkins and Sullivan counties.

RESPONSE: The SBH-Kingsport CON project plans to have only 18 beds dedicated to adult psychiatric hospital services. As noted on its 2012 JAR, Woodridge allocates all 84 of its beds to general adult psychiatric services, while not specifically reserving any for child and adolescent inpatient psychiatric hospital services, geropsychiatric hospital services, or as dedicated chemical dependency beds. Thus, the corporate mission of SBH-Kingsport, as set forth in this CON application, differs significantly from that of Woodbridge. Therefore, the applicant projects that its project will have relatively little impact on Woodridge. Woodridge also claims to serve counties such as Greene, Washington, and Carter counties, which SBH-Kingsport does not claim as being in its service area.

7. **Section C, Need, Item 1 a., (Project Specific Criteria-Psychiatric Inpatient Services) B. 2. Service Area Demographics and Section C. Need. Item 4.A Service Area Demographics**

Please complete the following chart using population statistics revised 2013 by the Tennessee Department of Health at the following web-site address http://health.state.tn.us/statistics/CertNeed.shtml

Demographic Data	Hawkins County	Sullivan County	Service Area Total	State of TN Total
Total 2014 Population				
Total Population-				
Total 2018 Population % Change				
65+ Pop. - 2014				
65+ Pop. - 2018				
65+ Population % Change				
65+ Population % of Total Population				
Median Age				
Median Household Income				
TennCare Enrollees				
TennCare Enrollees as % of Total Population				

Persons Below Poverty Level				
% of Total Population below Poverty Level				

RESPONSE:

Demographic Data	Hawkins County	Sullivan County	Service Area Total	State of TN Total
Total 2014 Population	57,509	158,975	216,484	6,588,698
Total Population- 2018	58,164	161,136	219,300	6,833,509
Total 2018 Population % Change	1.1%	1.4%	1.3%	3.7%
65+ Pop. - 2014	11,259	33,325	44,484	981,984
65+ Pop. - 2018	12,990	37,365	50,355	1,102,413
65+ Population % Change*	15.4%	12.1%	12.9%	3.7%
65+ Population % of Total Population*	19.6%	21.0%	20.3%	14.9%
Median Age**	42.3 yrs	43.5 yrs	43.2 yrs (est.)	38 yrs
Median Household Income**	$36,419	$40,025	$39,163	$1,197,412
TennCare Enrollees***	11,711	27,452	39,163	1,197,412
TennCare Enrollees as % of Total Population	20.4%	16.9%	18.1%	18.2%
Persons Below Poverty Level**	9,431	26,867	36,298	981,716
% of Total Population below Poverty Level	16.4%	16.9%	16.8%	14.9%

*2014 DOH Population Projection
**Census Bureau data
***Bureau of TennCare October 2013 data

8. **Section C. Economic Feasibility Item 1 (Project Cost Chart)**

A referenced list of $562,607 assigned to C.4. "Build Year Operating Cost" could not be located in the supplemental. Please provide.

RESPONSE: Please reference the table below for breakdown of Build Year Operating Cost.

Build Year Operating Expenses	
Salaries	$310,085
Benefits	$77,521
Professional Fees	$12,500
Advertising	$45,000

Purchased Services	$0
Recruitment	$36,000
Food & Supplies	$25,000
Travel	$37,000
Repairs	$0
Rental Expense	$7,500
Insurance	$0
Utilities	$3,000
Bad Debt Expense	$0
Property Taxes	$0
Other Expenses	$9,000
Total Hospital Expenses	**$562,607**

9. Section C. Economic Feasibility Item 5

The calculation of average gross charge, average deduction from operating revenue and average net charge Year One is noted. However, please recalculate average deduction from gross operating revenue. It appears to be $1,077 not $1,028. Please clarify.

RESPONSE: The average deduction from gross operating revenue is $1,077, when calculated by dividing the total deductions of $9,370,257 by the total number of projected patient days (8,700).

10. Section C, Contribution to Orderly Development, Item 3

Please complete the following table for total FTE's that will be employed in the first year that will be providing patient care:

Position Type	FTE's
Clinical Director	
Program Director	
Registered Nurses	
RN/UM	
Techs	
Licensed Vocational Nurse	
Therapist	
RT	
Teacher	
Total	

RESPONSE:

Position Type	FTEs
Clinical Director	1.0
Program Director	1.0
Registered Nurses	12.6
RN/UM	1.0
Techs	16.8
Licensed Vocational Nurse	4.2
Therapist	4.0
RT	2.0
Teacher	0
Total	42.6

Please clarify of there will be assessment/referral and aftercare positions involved with this proposed project.

RESPONSE: The applicant intends to have an assessment and referral department. The aftercare positions would consist of those Inpatient Therapy Staff that are involved with discharge planning as well as those staff working in our Partial Hospitalization Program (PHP) and Intensive Outpatient Program (IOP).

[Remainder of page intentionally left blank]

Mr. Phillip M. Earhart
January 31, 2014

SUPPLEMENTAL- # 2
January 31, 2014
11:35:am

Sincerely,

Mike Garone

Contact Person for Certificate of Need
Application CN1312-050
SBH-Kingsport, LLC

Attachments

DEC 10 '13 PM3:11

LETTER OF INTENT
TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY

The Publication of Intent is to be published in the Kingsport Times News (Name of Newspaper) which is a newspaper of general circulation in Sullivan County (County), Tennessee, on or before December 10 (Month / day), 2013 (Year), for one day.

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

SBH-Kingsport, LLC (Name of Applicant) N/A (Facility Type-Existing)

owned by: SBH-Kingsport, LLC with an ownership type of limited liability company and to be managed by: itself intends to file an application for a Certificate of Need for:

establishment of a new inpatient psychiatric hospital in Kingsport, Sullivan County, Tennessee 37660. This project will be located on unaddressed property at the end of Executive Park Boulevard in Kingsport, Tennessee. This property extends south and west of Executive Park Boulevard, and is south of the intersection of Executive Park Boulevard and East Stone Drive in Kingsport, Tennessee. This project will involve the initiation of inpatient psychiatric hospital services. This new psychiatric hospital will have 18 adult beds, 16 geropsychiatric beds, 28 child and adolescent beds, and 10 chemical dependency beds. These 72 beds will all be new beds licensed as psychiatric hospital beds. The estimated project costs for this project are projected to be approximately $12,000,000.00.

The anticipated date of filing the application is December 13, 2013.

The contact person for this project is Mike Garone (Contact Name) Director of Development (Title)

who may be reached at: Strategic Behavioral Health, LLC (Company Name) 8295 Tournament Drive, Suite 201 (Address)

Memphis (City) Tennessee (State) 38125 (Zip Code) 901 / 969-3100 (Area Code / Phone Number)

Mike Garone (Signature) by [illegible] as authorized 12/10/13 (Date) mgarone@strategicbh.com (E-mail Address)

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

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

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

STATE OF TENNESSEE
DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
ANDREW JACKSON BUILDING, 6TH FLOOR
500 DEADERICK STREET
NASHVILLE, TENNESSEE 37243

BILL HASLAM
GOVERNOR

E. DOUGLAS VARNEY
COMMISSIONER

MEMORANDUM

TO: Melanie Hill, Executive Director
Health Services and Development Agency

FROM: Sandra Braber-Grove, Assistant General Counsel
Director, Office of Contracts and Privacy/Division of General Counsel

DATE: June 13, 2014; **AMENDED June 20, 2014 (calculations on Pages 9-11 and Conclusions About Applying the Bed Need Formula on Page 12); SECOND AMENDMENT on June 20, 2014 (calculations on Pages 9-11)**

RE: Review and Analysis of Certificate of Need Application
Strategic Behavioral Health (SBH) - Kingsport -- CN1312-050

Pursuant to and in accordance with Tennessee Code Annotated (TCA) § 68-11-1608 and Rules of the Health Services and Development Agency including the Criteria and Standards for Certificate of Need (2000 Edition, Tennessee's Health Guidelines for Growth, prepared by the Health Planning Commission) [hereinafter Guidelines for Growth], staff of the Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS), the licensing agency, have reviewed and analyzed the above-referenced application for a Certificate of Need.

Attached is the TDMHSAS report. At a minimum and as noted in TCA § 68-11-1608, the report provides:

(1) Verification of application-submitted information;

(2) Documentation or source for data;

(3) A review of the applicant's participation or non-participation in Tennessee's Medicaid program, TennCare or its successor;

(4) Analyses of the impact of a proposed project on the utilization of existing providers and the financial consequences to existing providers from any loss of utilization that would result from the proposed project;

(5) Specific determinations as to whether a proposed project is consistent with the state health plan; and

(6) Further studies and inquiries necessary to evaluate the application pursuant to the rules of the agency.

If there are any questions, please contact me at (615) 532-6520.

cc: E. Douglas Varney, Commissioner, TDMHSAS
Marie Williams, Deputy Commissioner, TDMHSAS
John Arredondo, Assistant Commissioner, Hospital Services, TDMHSAS

REVIEW AND ANALYSIS
CERTIFICATE OF NEED APPLICATION
CN1312-050

Opening Remarks on the Project

Pursuant to and in accordance with Tennessee Code Annotated (TCA) § 68-11-1608 and Rules of the Health Services and Development Agency including the Criteria and Standards for Certificate of Need (2000 Edition, Tennessee's Health Guidelines for Growth, prepared by the Health Planning Commission) [hereinafter Guidelines for Growth], staff of the Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS), the licensing agency, have reviewed and analyzed the application for a Certificate of Need submitted by Mr. Mike Garone, Director of Development (Strategic Behavioral Health, LLC) on behalf of SBH-Kingsport, LLC, a wholly owned subsidiary of Strategic Behavioral Health, LLC, an inpatient psychiatric hospital company based in Memphis, Tennessee with seven (7) psychiatric hospitals through subsidiaries in Colorado, Nevada, New Mexico, and North Carolina. The Applicant reports that the owners of Dobbs Management Services, Inc., who will assist with the funding for this project, represent the majority ownership of Strategic Behavioral Health, LLC. The application is for the establishment of a new, freestanding, seventy-two (72)-bed psychiatric (mental health) hospital to be located at unaddressed property at the end of Executive Park Boulevard, south of the intersection of that street and East Stone Drive in Kingsport, Sullivan County, Tennessee. The Applicant reports that the proposed facility, if approved, will be Strategic Behavioral Health's first hospital in its home state. The Applicant also reports that there is a "significant need for additional inpatient psychiatric bed resources in this service area, particularly as it pertains to children and adolescents." The Applicant's proposed service area is a two-county area of Tennessee: Hawkins and Sullivan; and a three-county area of Virginia: Lee, Scott, and Wise.

The report has three (3) parts:

A. Summary of Project
B. Conclusions
C. Analysis - in three (3) parts:

Need	Economic Feasibility	Contribution to the Orderly Development of Health Care
Evaluated by the following general factors: a. Relationship to any existing applicable plans; b. Population to be served; c. Existing or Certified Services or Institutions; d. Reasonableness of the service area; e. Special needs of the service area population (particularly women, racial and ethnic minorities, and low-income groups); f. Comparison of utilization/ occupancy trends and services offered by other area providers; g. Extent to which Medicare, Medicaid, and medically indigent patients will be served; and h. Additional factors specified in the Tennessee's Health Guidelines for Growth publication for this type of facility.	Evaluated by the following general factors: a. Whether adequate funds are available to complete the project; b. Reasonableness of costs; c. Anticipated revenue and the impact on existing patient charges; d. Participation in state/federal revenue programs; e. Alternatives considered; f. Availability of less costly or more effective alternative methods; and g. Additional factors specified in the Tennessee's Health Guidelines for Growth publication.	Evaluated by the following general factors: a. Relationship to the existing health care system (i.e., transfer agreements, contractual agreements for health services, and affiliation of the project with health professional schools); b. Positive or negative effects attributed to duplication or competition; c. Availability and accessibility of human resources required; d. Quality of the project in relation to applicable governmental or professional standards; and e. Additional factors specified in the Tennessee's Health Guidelines for Growth publication.

A. SUMMARY OF PROJECT

Submission of Application

Mr. Mike Garone, Director of Development (Strategic Behavioral Health, LLC) has submitted, on behalf of SBH-Kingsport, LLC, a wholly owned subsidiary of Strategic Behavioral Health, LLC, whose majority ownership are the owners of Dobbs Management Services, Inc., an application for a Certificate of Need seeking to establish a new, freestanding seventy-two (72)-bed psychiatric (mental health) hospital (SBH-Kingsport, LLC) to be located at unaddressed property at the end of Executive Park Boulevard, south of the intersection of that street and East Stone Drive in Kingsport, Sullivan County, Tennessee. The distribution of proposed beds is as follows: eighteen (18) adult psychiatric beds (for those 18-64 years of age); sixteen (16) geriatric psychiatric (gero-psych) beds (for those 65+ years of age); twenty-eight (28) child and adolescent beds (for those 5-17 years of age); and ten (10) chemical dependency beds (for adults).

Applicant Profile, Ownership, Management, and Licensure

The Applicant Profile indicates that the Legal Interest in the Site of the Institution (Item 6.) is "Option to Purchase" (Item 6.B.). The Applicant submitted a Purchase and Sale Agreement in Supplemental #1. The type of institution is "Mental Health Hospital" (Item 7.F.) and the purpose of review is "New Institution" (Item 8.A.) and "Initiation of Health Care Service as defined in TCA § 68-11-1607(4) of Psychiatric Services" (Item 8.D.).

The Applicant Profile also shows that the Owner of the Facility, Agency or Institution is SBH-Kingsport, LLC (Item 3.). Item 9. of the Applicant Profile shows the bed complement as noted previously eighteen (18) adult psychiatric beds (for those 18-64 years of age); sixteen (16) geriatric psychiatric (gero-psych) beds (for those 65+ years of age); twenty-eight (28) child and adolescent beds (for those 5-17 years of age); and ten (10) chemical dependency beds (for adults); all of which are proposed beds since this project is for a new facility.

There is no separate management/operating entity (Item 5.). In Supplemental #1, the Applicant confirms that there are no management fees associated with this project.

Since the Applicant is applying for a new facility, there is no current license. If the project is approved, the facility would be licensed by the Department of Mental Health and Substance Abuse Services.

The Proposed Project

As noted, the Applicant seeks to establish a new, freestanding, seventy-two (72)-bed psychiatric (mental health) hospital, which would be, as the Applicant reports, the Applicant's first in its home state of Tennessee. As explained in Supplemental #1, the focus is on providing quality behavioral healthcare for children, adolescents, adults, and seniors with a program focus on compassion, empathy, and perseverance for patients and their families. Existing facilities are accredited by

either the Joint Commission or the Commission on Accreditation of Rehabilitation Facilities (CARF) and are in good standing with the department of licensure within their respective state (names and locations of these facilities are in Supplemental #1). As explained on Pages 5-6 of the application, the proposed facility will follow the company's philosophy of care and be a one-story, 52,263 square foot facility with patient units, a gymnasium, classrooms, administrative suites, and assessment and outpatient suites. The patient rooms are double-occupancy and served by an adjacent bathroom. The gero-psych unit will have a living room, group room, doctor office, seclusion room, and a centrally-located nurses' station. Other inpatient beds are separated into four (4) units: two with eighteen beds each and two with ten beds each. Each of these units will house a dayroom and a consultation office. The two acute units will share a nurses' station, medication room, and seclusion room. The child and adolescent patients will be served by two classrooms. A full-service kitchen is planned with an adjacent dining room that can be divided into two separate spaces. The gymnasium will be available to all patients. The administrative, assessment, and outpatient suites will be individually secure from each other and the rest of the facility. The administrative suite will also include offices and a large conference area. The Applicant reports that fixtures, hardware, and finishes have been selected with patient safety as the critical factor. On Pages 4 and 6, the Applicant explains that there is a "significant need" for additional inpatient psychiatric beds in the proposed service area, particularly as it pertains to children and adolescents because there are only twelve (12) existing inpatient psychiatric beds (in Bristol) and Sullivan County is the most populous county in upper East Tennessee and Kingsport is the biggest municipality in the service area. Further, the Applicant reports that, to the best of its knowledge, there are no dedicated child and adolescent psychiatric beds reported for the proposed service area. On Page 7, the Applicant notes the closure of Indian Path Pavilion (sometime in 2009), which resulted in "no sizeable provider of inpatient psychiatric beds" in the proposed service area. It is also noted that the closure of Indian Path Pavilion was related to a Certificate of Need project of Mountain States Health Alliance and the Woodridge psychiatric facility in Johnson City, Washington County, Tennessee. On Page 14 of the application, the Applicant reports that Sullivan and Hawkins counties account for more than seventy percent (70%) of the population in the service area, and it is appropriate for the proposed facility to be based in the most densely populated area of the proposed service area. Further, in Supplemental #1 the Applicant explains that it seeks to serve the area with the most need and where there are no other facilities, especially since the closure of Indian Path Pavilion and the State's Lakeshore Mental Health Institute (Knoxville). Also in Supplemental #1, the Applicant was asked to clarify why it did not include Washington County in its service area, especially since Sullivan and Washington Counties share economic links and are close in proximity to each other. The Applicant responded that it seeks to serve the area with the most need and where there are no other facilities and that "Washington County has Woodridge Hospital in Johnson City to serve its needs." The potential impact of this project on existing resources will be discussed later in this report.

The Applicant reports that there is no major medical equipment involved in the project.

The Applicant reports a total estimated project cost (Application, Page 20) of $11,717,915.00 (excluding the CON application filing fee); with construction costs of $8,000,002.00; preparation of site costs of $675,000.00, architectural and engineering fees of $267,000.00, acquisition of site costs of $925,000.00; moveable equipment costs of $100,000.00; fixed equipment costs of $660,000.00; and financing costs and fees of $787,607.00. The anticipated date the project will be 100% complete (approved for occupancy) is November 1, 2015. The issuance of a license is expected to occur on November 15, 2015 and the initiation of services is expected to occur on November 16, 2015 (Application, Page 22).

Service Areas

The Applicant's proposed service area is a two-county area of Tennessee: Hawkins and Sullivan; and a three-county area of Virginia: Lee, Scott, and Wise.

B. CONCLUSIONS

As previously stated, if the application is approved, the facility would be licensed by the TDMHSAS. Several staff members of TDMHSAS have been consulted and contributed to this report. We have concerns supporting approval of the scope and size of the proposed project for the following reasons:

1. A note about inpatient psychiatric beds. As mentioned in reports for other CON applications, the Guidelines for Growth publication specifies a formula of thirty (30) beds per a population of one hundred thousand (100,000) to determine the need for inpatient psychiatric beds. As also mentioned in those reports, in practice, application of the formula has often resulted, but does not always result, in an underestimation of the number of inpatient psychiatric beds needed due to the impact of other factors on bed utilization, including: the willingness of the provider to accept emergency involuntary admissions; the extent to which the provider serves the TennCare population and/or the indigent population; and the number of beds designated as "specialty" beds (gero-psychiatric units or units established to treat patients with specific diagnoses). These factors limit the availability of beds for the general population, as well as for specialty populations, depending on how the beds are distributed. Additional factors include taking into consideration not only the number of existing beds in the proposed service area, but the utilization of those beds and the TDMHSAS' strong support for serving people, if and when possible, in the community in which they live to increase the potential involvement of family, the individual's support system, and access to other needed services, including aftercare services.

2. There may not be a Need for all proposed beds as described in further detail in Section C.1. As noted, the Guidelines for Growth publication specifies a formula of thirty (30) beds per a population of one hundred thousand (100,000) to determine the need for inpatient psychiatric beds. The Applicant's proposed service area consists of a two-county area in Tennessee: Hawkins and Sullivan and a three-county area in Virginia: Lee, Scott, and Wise. As we have seen before, there are many ways to assess

need: different service areas (primary service areas, secondary service areas, and so on); different population numbers (U.S. Census, state population numbers, current, projected future, and so on); and different numbers of existing resources. Each of these calculations frequently has a different result. As we have also seen, numbers alone are not the full picture of need. One has to consider the composition of existing inpatient psychiatric beds and the utilization of existing inpatient psychiatric beds. If existing inpatient psychiatric beds are underutilized, even though the numbers might show a need, there may not be a need. There may be a need for one type of bed, but not another. There might be a need for additional resources in the proposed service area, but not of the scope and size being proposed. As will be shown in Section C.1., several calculations were performed, each showing a different result, but all showing less of a need than what is being proposed. The Applicant indicates that it will serve voluntary and involuntary, uninsured, and indigent, but there are some concerns about the Applicant's understanding of involuntary commitments.

3. Economic Feasibility has been established as described in further detail in Section C.2. The cost of the proposed project appears to be reasonable and the project can be completed in a timely manner. The Applicant indicates that funding for the project will be developed with the assistance of Dobbs Management Services, LLC and the project will be funded through cash, a credit line with Fifth Third Bank (documentation submitted in Supplemental #1) and net cash flows from existing operations (documentation submitted in Supplemental #1). It is reported that Strategic Behavioral Health, LLC, the parent company of the Applicant, is a "well-capitalized, financially successful psychiatric hospital development and management company" who had a consolidated annual net revenue of approximately $50.7 million as of December 31, 2012. As noted earlier, Strategic Behavioral Health, LLC, the parent company of the Applicant, operates seven (7) psychiatric hospitals through subsidiaries in Colorado, Nevada, New Mexico, and North Carolina and has another facility under development in College Station, Texas. Overall, adequate funding appears to be available and projected gross operating revenue of $14,154,600.00 in Year 1 and $28,023,800.00 in Year 2, and adjusted Net Operating Income of $676,853.00 in Year 2 (a loss of $1,334,340.00 is reported for Year 1) appear to be sufficient to ensure the economic feasibility of the project. The Applicant reports that its financial analysis has taken into account any short-term losses that may occur during ramp-up and it is confident that financial viability will be ensured within two years and positive cash flow will develop in the second year. The Applicant attributes this to the parent company's experience in its numerous other hospitals and the hospital projects it has completed over the last eight years.

4. The project may not contribute to the orderly development of healthcare as described in further detail in Section C.3. Since this application is for a new facility, the Applicant has indicated that it will seek appropriate licensure, certification, and accreditation for the proposed facility. The Applicant states that it will meet all applicable licensure regulations of the licensing agency (TDMHSAS) as well as any required by the Department of Health. Further, the Applicant reports that it intends to be accredited by the Joint Commission.

The Applicant also states that it will meet all applicable licensure for personnel and staffing requirements for inpatient psychiatric facilities and understands and has reviewed all licensing and certification requirements of the State of Tennessee for medical or clinical staff. The Applicant submitted Anticipated Staffing Patterns for "Build Year" and "Year 2" on unnumbered pages of the main part of the application and a staffing chart submitted in Supplemental #2 that shows FTEs by position type. The Applicant reports that it will have sufficient access to human resources needed for the project. While it is difficult to follow the staffing pattern due to formatting and the use of some acronyms, it does appear that the reported staffing plan would meet the TDMHSAS licensing requirements for this type of facility. Department staff were not able to find the requested comparison of clinical staff salaries in the proposal to prevailing wage patterns in the service area as published by the Tennessee Department of Labor and Workforce Development and/or other documented sources (#3 on Page 27 of the application). While the submitted Anticipated Staffing Patterns for "Build Year" and "Year 2" do show what appear to be hourly rates per position type, there is no corresponding comparison to prevailing wage patterns. The Projected Data Chart shows total expenses for "Salaries and Wages" of $3,388,492.00 (Year 1) and $5,628,936.00 (Year 2) with $105,000.00 listed for "Physician's Salaries and Wages" for Year 1 and the same in Year 2. This data is insufficient to make the requested comparison, so it is not clear if the proposed salaries are reasonable in comparison to prevailing wage patterns. Since this is an application for a new facility, there are no transfer agreements in place and there is no current participation in the training of students through internships, residencies, and other such programs, but the Applicant reports that it has plans to have transfer agreements with local area hospitals such as Wellmont Holston Medical Center in Kingsport and the parent company has a history of working with all agencies and other providers to provide a "collaborative process to analyze and reduce barriers to access and service delivery" and it plans to participate in the training of students and is open to collaborating with area nursing schools and other healthcare training and education providers. As noted in the HSDA Staff summary and the application, the proposed facility will be classified as an Institute for Mental Disease (IMD), which means that the cost of patient care for TennCare enrollees aged 21-64 years will be reimbursed using 100% state funds. The full impact on similar services supported by state appropriations has not been determined. As will be explained later in this report, there are concerns that the scope and size of the proposed project will have a negative impact on existing resources in contiguous counties that are economically linked to those of the proposed project.

C. ANALYSIS

1. Need

There may not be a need for all proposed beds

As has been previously stated, the application of the formula (30 beds per 100,000 population) has often resulted in an underestimation of the number of inpatient

psychiatric beds needed due to the impact of other factors on bed utilization, including: the willingness of the provider to accept emergency involuntary admissions; the extent to which the provider serves the TennCare population and/or the indigent population; and the number of beds designated as "specialty" beds (gero-psychiatric units or units established to treat patients with specific diagnoses). These factors limit the availability of beds for the general population, as well as for specialty populations, depending on how the beds are distributed. Additional factors include taking into consideration not only the number of existing beds in the proposed service area, but the utilization of those beds and the TDMHSAS' strong support for serving people, if and when possible, in the community in which they live to increase the potential involvement of family, the individual's support system, and access to other needed services, including aftercare services.

Reviewing and taking into consideration the factors noted above, some calculations show an apparent need for fewer inpatient psychiatric beds than the number proposed by the Applicant and some calculations show a surplus, so no need.

Number Of Existing Beds

The Applicant reports that there are only twelve (12) inpatient psychiatric beds in the proposed service area. Staff of the TDMHSAS found that Ridgeview Pavilion located in Bristol, Virginia has twenty-eight (28) adult inpatient psychiatric beds. These beds should be included because the proposed service area includes areas of Virginia, bringing the total number of existing beds to forty (40). Furthermore, due to the close proximity of Washington and Greene Counties (Tennessee) and the economic links of those Counties to the proposed service area, existing resources in those areas should also be taken into consideration. There is a sixteen (16)-bed gero-psych unit at Takoma Regional Hospital in Greene County, Tennessee and an eighty-four (84)-bed psychiatric hospital (Woodridge Psychiatric Hospital) in Washington County, Tennessee. This would add one hundred (100) inpatient psychiatric beds to the number in existence, bringing the total number to one hundred forty (140).

Tennessee Population Numbers (as reported in the HSDA Staff Summary)

As shown in the HSDA Staff Summary, using the population estimates prepared by the Department of Health and applying the bed need formula (population x 30 ÷ 100,000), bed need is as follows --- **without** adjusting for existing beds:

Total Tennessee Counties (Hawkins and Sullivan) Population - CY2014 and CY2018

2014 Total Population for Tennessee Counties (Hawkins and Sullivan):

216,484 x 30 ÷ 100,000 = 65 (64.9 rounded)

2018 Total Population for Tennessee Counties (Hawkins and Sullivan):

219,300 x 30 ÷ 100,000 = 66 (65.8 rounded)

Factoring in the Applicant's Submitted Virginia Population Numbers

The Applicant submitted QuickFacts from the U.S. Census Bureau for the three-county area in Virginia which show population numbers as follows:

Lee County, VA: 25,474 (2012 estimate);
Scott County, VA: 22,781 (2012 estimate); and
Wise County, VA: 40,918 (2012 estimate)

for a total Virginia service area population of 89,173. However, when the numbers presented on Page 13 of the application (the same as those in Supplemental #2) are added together, the total is 89,725.

The 89,173 number was used for all calculations shown below.

The Applicant also submitted a chart on Page 13 of the application showing "Population of Service Area" which shows totals for the five-county service area (both Tennessee and Virginia). In the narrative part of that same page, the Applicant indicates that only twelve (12) inpatient psychiatric beds exist in the proposed service area, at Bristol Regional Medical Center in Bristol, Tennessee. As discussed above, there are an additional twenty-eight (28) beds (those in Bristol, VA) that should be included since the Applicant includes Virginia in the proposed service area. When doing so, the total number of existing inpatient psychiatric beds in the proposed five-county service area (Tennessee and Virginia) is forty (40). When applying the Tennessee criteria of 30 beds per 100,000 population to the total (TN and VA) population numbers used by the Applicant (281,133 x 30 ÷ 100,000), there is a need of 84 inpatient psychiatric beds for all ages used on the Applicant's chart.

If using the number of existing beds reported by the Applicant -- 12, and 84 are needed [282,133 x 30 ÷ 100,000], then it does appear that there is an unmet need of 72 beds and the proposed project would meet that need.

AMENDED June 20, 2014
If 40 beds exist, the population number needs to increase by the population of Bristol, VA (17,728 in 2013 [estimated]), then 90 [89.6 rounded] beds would be needed [281,133 + 17,728 = 298,861 x 30 ÷ 100,000], and there would be an unmet need of 50 beds; however, the project is proposing 72 total beds, a number greater than the apparent unmet need.

SECOND AMENDMENT June 20, 2014
If 140 beds exist, the population number needs to increase by the populations of both Greene and Washington Counties (200,773 in 2014), then 150 [149.89 rounded] beds would be needed [281,133 + 17,728 + 200,773 = 499,634 x 30 ÷ 100,000], and there would be an unmet need of 10 beds; however, the project is proposing 72 total beds, a number greater than the apparent unmet need.

Applicant's Updated Population Numbers

In Supplemental #2, in response to a request from HSDA staff, the Applicant submitted an updated chart and a revised narrative using updated population numbers. It is noted that only the Tennessee numbers were updated, the Virginia numbers remained the same. When using the updated TN and VA population numbers (296,929 x 30 ÷ 100,000), the result is a need of 89 inpatient psychiatric beds for all ages used on the Applicant's updated chart.

If using the number of existing beds reported by the Applicant -- 12, and 89 are needed [296,929 x 30 ÷ 100,000], then it does appear that there is an unmet need of 77 beds and the proposed project would come close to meeting that need.

AMENDED June 20, 2014
If 40 beds exist, the population number needs to increase by the population of Bristol, VA (17,553 in 2018 [estimated]), then 94 [94.3 rounded] beds would be needed [296,929 + 17,553 = 314,482 x 30 ÷ 100,000], and there would be an unmet need of 54 beds; however, as noted, the project is proposing 72 total beds, a number greater than the apparent unmet need.

SECOND AMENDMENT June 20, 2014
If 140 beds exist, the population number needs to increase by the populations of both Greene and Washington Counties (209,964 in 2018), then 157 [157.33 rounded] beds would be needed [296,929 + 17,553 + 209,964 = 524,446 x 30 ÷ 100,000], and there would be an unmet need of 17 beds; however, as noted, the project is proposing 72 total beds, a number greater than the apparent unmet need.

Using the University of Tennessee Center for Business and Economic Research Population Project Data Files' Population Numbers and Factoring in the Virginia Population Numbers

When using the 2014 and 2018 population numbers from the University of Tennessee Center for Business and Economic Research Population Projection Data Files (2010-2020), combined with the Virginia population numbers noted above, the calculations tell a different story:

2014 TN population 216,484 + VA population 89,173 = 305,657 x 30 ÷ 100,000 = 92 (91.69 rounded)

If using the number of existing beds reported by the Applicant -- 12, and 92 are needed [216,484 + 89,173 = 305,657 x 30 ÷ 100,000], then it does appear that there is an unmet need of 80 beds and the proposed project would come close to meeting that need.

AMENDED June 20, 2014
If 40 beds exist, the population number needs to increase by the population of Bristol, VA (17,728 in 2013 [estimated]), then 97 [97.01 rounded] beds would be needed [216,484 + 89,173 + 17,728 = 323,385 x 30 ÷ 100,000], and there would be an unmet need of 57 beds; however, as noted, the project is proposing 72 total beds, a number greater than the apparent unmet need.

SECOND AMENDMENT June 20, 2014
If 140 beds exist, the population number needs to increase by the populations of both Greene and Washington Counties (200,773 in 2014), then 157 [157.24 rounded] beds would be needed [216,484 + 89,173 + 17,728 + 200,773 = 524,158 x 30 ÷ 100,000], and there would be an unmet need of 17 beds; however, as noted, the project is proposing 72 total beds, a number greater than the apparent unmet need.

2018 TN population 219,300 + VA population 89,173 = 308,473 x 30 ÷ 100,000 = 93 (92.54 rounded)

If using the number of existing beds reported by the Applicant -- 12, and 93 are needed [219,300 + 89,173 = 308,473 x 30 ÷ 100,000], then it does appear that there is an unmet need of 81 beds and the proposed project would come close to meeting that need.

AMENDED June 20, 2014
If 40 beds exist, the population number needs to increase by the population of Bristol, VA (17,553 in 2018 [estimated]), then 98 [97.80 rounded] beds would be needed [219,300 + 89,173 + 17,553 = 326,026 x 30 ÷ 100,000], and there would be an unmet need of 58 beds; however, as noted, the project is proposing 72 total beds, a number greater than the apparent unmet need.

SECOND AMENDMENT June 20, 2014
If 140 beds exist, the population number needs to increase by the populations of both Greene and Washington Counties (209,964 in 2018), then 161 [160.79 rounded] beds would be needed [219,300 + 89,173 + 17,553 + 209,964 = 535,990 x 30 ÷ 100,000], and there would be an unmet need of 21 beds; however, as noted, the project is proposing 72 total beds, a number greater than the apparent unmet need.

Tennessee Population Numbers by Age Category -- 18+ and 65+ -- CY2014 and CY2018

2014 18+ Population for Tennessee Counties (Hawkins and Sullivan):

175,764 x 30 ÷ 100,000 = 53 (52.7 rounded)

2018 18+ Population for Tennessee Counties (Hawkins and Sullivan)

184,934 x 30 ÷ 100,000 = 56 (55.5 rounded)

2014 65+ Population for Tennessee Counties (Hawkins and Sullivan)

44,484 x 30 ÷ 100,000 = 13 (13.3 rounded)

2018 65+ Population for Tennessee Counties (Hawkins and Sullivan)

50,355 x 30 ÷ 100,000 = 15 (15.1 rounded)

Tennessee Population Numbers by Age Category -- 0-17 years -- CY2018

2018 0-17 Population for Tennessee Counties (Hawkins and Sullivan)

34,366 x 30 ÷ 100,000 = 10 (10.3 rounded)

Since the category of existing beds is not clear; in other words, it is not exactly known if the existing beds are adult psychiatric beds, gero-psych beds, child and adolescent beds, or chemical dependency beds; the calculations conducted above will not be conducted on these specific age category numbers.

Applicant's Submitted Virginia Population Numbers (for the three-county area) by Age Category (date unknown) and Applying the Tennessee Bed Need Formula [population x 30 ÷ 100,000 [without adjusting for existing beds]

Ages 5-14: 8,580 x 30 ÷ 100,000 = 3 (2.57 rounded)

Ages 15-19: 5,250 x 30 ÷ 100,000 = 2 (1.57 rounded)

Ages 19-64: 59,829 x 30 ÷ 100,000 = 18 (17.94 rounded)

Ages 65+: 16,066 x 30 ÷ 100,000 = 5 (4.81 rounded)

For these Virginia Counties, applying the Tennessee bed need formula, a bed need would be a total of 28 (after rounding), without adjusting for existing beds. The Applicant reports that there are no known existing beds in these Virginia Counties.

AMENDED June 20, 2014
Conclusions About Applying the Bed Need Formula

As you can see, many calculations, many different results. The bottom line is not clear -- depending on which numbers and calculations are used when applying the bed need formula, there is either a need for additional beds equal to the number being proposed, slightly above the number being proposed, or much less than the number being proposed. It should also be noted that if the Virginia population numbers changed or were adjusted based on estimated projections, rather than remaining constant as reported, there would more likely than not be additional differences in the calculations.

Calculating Need By Looking at Statistics -- Applicant's Methodology and Department Findings

When asked to provide the details regarding the methodology used to project 8,700 patient days in Year 1 and 17,100 patient days in Year 2, the Applicant submitted (in Supplemental #1) statistical information from the Substance Abuse and Mental Health Administration's (SAMHSA's) National Survey on Drug Use and Health [published May 31, 2012] in which it was reported, from surveys conducted in 2008 and 2009, that Tennessee has mental illness rates higher than the national average (21.46% versus 19.77%; 5.01% versus 4.62%). The Applicant reports that it looked at the population of the service area, prevalence of mental illness and serious

mental illness to form its projections. The Applicant states that it is important for the state to ensure adequate availability of mental health services so this population can receive needed psychiatric treatment. The charts do not contain table headers, so it is not exactly clear to what these percentages refer; however, Department staff report that in 2010, only 5.26% of adults over the age of 18 were diagnosed with a serious mental illness in Hawkins and Sullivan Counties, a mid-range number in comparison to the rest of Tennessee's rural areas. Further, Department staff report that in 2010, only 7.92% of adults over the age of 18 were diagnosed with a substance abuse disorder in Hawkins and Sullivan Counties, a mid-range number in comparison to the rest of the state. Department staff also reported that in 2013, there were 44 admissions to a Regional Mental Health Institute (state-owned and operated) from Hawkins and Sullivan Counties combined while there were 642 treatment admissions for substance abuse/addiction disorders. Department staff researchers conclude that there is no need for adult inpatient beds in the proposed service area (including Virginia), there is no need for gero-psych beds in the proposed service area (including Virginia), there is a need for child and adolescent beds, but fewer than what is being proposed (18, not 28), and it appears that substance abuse treatment needs are higher in the proposed Tennessee service area.

Utilization of Existing Resources

Please see the discussion in Section C.3.

Serving Voluntary, Involuntary, Uninsured, and Indigent

As noted in Supplemental #1, the Applicant expects to contract with BlueCare, TennCare Select, and United Healthcare Community Plan. Such relationships are not yet in place since this application is for a new facility. Also in Supplemental #1, the Applicant clarified its earlier statement that it would not be able to accept adult TennCare admissions by noting that its belief that the IMD (Institutions for Mental Disease) provisions would keep it from being able to accept adult TennCare admissions was incorrect, and the Applicant confirmed with representatives from TennCare that it will be able to accept adult TennCare admissions. Further, in Supplemental #1, the Applicant was asked to discuss if involuntary admissions and the uninsured would be transferred to private psychiatric hospitals that have expanded contracts with the Department. The Applicant reports that it would be open to contracting directly with the Department to accommodate this patient population. When asked if it would accept uninsured persons that would have been served by the State's now-closed Lakeshore Mental Health Institute, the Applicant responded that it would be open to contracting directly with the Department to accommodate these individuals. Question #21 in Supplemental #1 asks if an uninsured individual is admitted involuntarily and is then enrolled in TennCare, will the Applicant need to transfer the patient to another facility since adult TennCare patients cannot be accepted. The Applicant's response of "It is our belief that there is a very high probability that the individual would be stabilized and no longer be involuntary in the time that it would take to enroll in TennCare" raises some concern about the Applicant's understanding of 'involuntary' and the involuntary commitment process. The Applicant reports that it will provide appropriate care to all patients

regardless of their ability to pay and that the care will be limited to the appropriate scope of a psychiatric hospital.

2. Economic Feasibility

The cost of the proposed project appears to be reasonable and the project can be completed in a timely manner. The Applicant indicates that funding for the project will be developed with the assistance of Dobbs Management Services, LLC and the project will be funded through cash, a credit line with Fifth Third Bank (documentation submitted in Supplemental #1) and net cash flows from existing operations (documentation submitted in Supplemental #1). It is reported that Strategic Behavioral Health, LLC, the parent company of the Applicant, is a "well-capitalized, financially successful psychiatric hospital development and management company" who had a consolidated annual net revenue of approximately $50.7 million as of December 31, 2012. As noted earlier, Strategic Behavioral Health, LLC, the parent company of the Applicant, operates seven (7) psychiatric hospitals through subsidiaries in Colorado, Nevada, New Mexico, and North Carolina and has another facility under development in College Station, Texas. Since the application under review is for a new facility, there is no historical data for revenue and expenses. Overall, adequate funding appears to be available and projected gross operating revenue of $14,154,600.00 in Year 1 and $28,023,800.00 in Year 2, and adjusted Net Operating Income of $676,853.00 in Year 2 (a loss of $1,334,340.00 is reported for Year 1) appear to be sufficient to ensure the economic feasibility of the project. The Applicant reports that its financial analysis has taken into account any short-term losses that may occur during ramp-up and it is confident that financial viability will be ensured within two years and positive cash flow will develop in the second year. The Applicant attributes this to the parent company's experience in its numerous other hospitals and the hospital projects it has completed over the last eight years.

Ownership and Management

As noted, the Applicant, SBH-Kingsport, LLC, is a wholly owned subsidiary of Strategic Behavioral Health, LLC, whose majority ownership are the owners of Dobbs Management Services, Inc. Strategic Behavioral Health, LLC, is an inpatient psychiatric hospital company based in Memphis, Tennessee with seven (7) psychiatric hospitals through subsidiaries in Colorado, Nevada, New Mexico, and North Carolina and another facility under development in College Station, Texas.

Expected Cost and Alternatives

The Applicant reports a total estimated project cost (Application, Page 20) of $11,717,915.00 (excluding the CON application filing fee); with construction costs of $8,000,002.00; preparation of site costs of $675,000.00, architectural and engineering fees of $267,000.00, acquisition of site costs of $925,000.00; moveable equipment costs of $100,000.00; fixed equipment costs of $660,000.00; and financing costs and fees of $787,607.00. The Applicant reports that it reviewed the closing of psychiatric beds in the broader East Tennessee area, including Indian Path Pavilion, and is "confident that there are no less costly, more effective, more

efficient ways of providing the benefits of inpatient psychiatric beds other than by constructing a new facility." The Applicant reports that freestanding psychiatric hospitals operate on a "significantly lower cost per patient day than acute hospital psychiatric units or state-run psychiatric facilities." The Applicant also reports that since there are no other freestanding psychiatric hospital facilities in the proposed service area, sharing facilities is not likely to occur.

Revenue and Expense Information (including Projected Utilization Numbers and the Methodology Used to Calculate Utilization Numbers)

Since the application under review is for a new facility, there is no historical data to review. The Applicant reports, on Page 24, that projected utilization data in Year 1 is 8,700 patient days and 17,100 patient days. There is no current charge schedule since this application is for a new facility. The Applicant submitted (Page 25) a proposed gross charge for the average inpatient charge per day of $1,578.00. The charge is the same for adult psychiatric, gero-psych, child and adolescent, and chemical dependency. In Supplemental #1 it is reported that the average net charge per inpatient day is approximately $550.00, with the average deduction from gross operating revenue of approximately $1,028.00. Upon request to provide comparative charges to Woodridge Psychiatric Hospital (Washington County, Tennessee), in Supplemental #1 the Applicant reports that the 2012 Joint Annual Report (JAR) shows that Woodridge's per day charge appears to be $2,214.00, derived by dividing its reported gross charges for inpatient care ($47,218,094.00) by the number of reported inpatient days (21,329).

Applicant's Methodology and Department Findings

When asked to provide the details regarding the methodology used to project 8,700 patient days in Year 1 and 17,100 patient days in Year 2, the Applicant submitted (in Supplemental #1) statistical information from the Substance Abuse and Mental Health Administration's (SAMHSA's) National Survey on Drug Use and Health [published May 31, 2012] in which it was reported, from surveys conducted in 2008 and 2009, that Tennessee has mental illness rates higher than the national average (21.46% versus 19.77%; 5.01% versus 4.62%). The Applicant reports that it looked at the population of the service area, prevalence of mental illness and serous mental illness to form its projections. The Applicant states that it is important for the state to ensure adequate availability of mental health services so this population can receive need psychiatric treatment. The charts do not contain table headers, so it is not exactly clear to what these percentages refer; however, Department staff report that in 2010, only 5.26% of adults over the age of 18 were diagnosed with a serious mental illness in Hawkins and Sullivan Counties, a mid-range number in comparison to the rest of Tennessee's rural areas. Further, Department staff report that in 2010, only 7.92% of adults over the age of 18 were diagnosed with a substance abuse disorder in Hawkins and Sullivan Counties, a mid-range number in comparison to the rest of the state. Department staff also reported that in 2013, there were 44 admissions to a Regional Mental Health Institute (state-owned and operated) from Hawkins and Sullivan Counties combined while there were 642 treatment admissions for substance abuse/addiction disorders. Department staff researchers conclude that there is no need for adult inpatient beds in the proposed service area (including Virginia), there is no need for gero-psych beds in the proposed service

area (including Virginia), there is a need for child and adolescent beds, but fewer than what is being proposed (18, not 28), and it appears that substance abuse treatment needs are higher in the proposed Tennessee service area.

3. Contribution to the Orderly Development of Health Care

Licensure

Since the Applicant is applying for a new facility, there is no current license. If the project is approved, the facility would be licensed by the Department of Mental Health and Substance Abuse Services. The Applicant has indicated that it will seek appropriate licensure, certification, and accreditation for the proposed facility. The Applicant states that it will meet all applicable licensure regulations of the licensing agency (TDMHSAS) as well as any required by the Department of Health. Further, the Applicant reports that it intends to be accredited by the Joint Commission. The Applicant also states that it will meet all applicable licensure for personnel and staffing requirements for inpatient psychiatric facilities and understands and has reviewed all licensing and certification requirements of the State of Tennessee for medical or clinical staff.

Staffing and Reported Salaries

The Applicant submitted Anticipated Staffing Patterns for "Build Year" and "Year 2" on unnumbered pages of the main part of the application and a staffing chart submitted in Supplemental #2 that shows FTEs by position type. The Applicant reports that it will have sufficient access to human resources needed for the project. In Supplemental #1, the Applicant explains that the parent company has prior experience building and staffing new hospitals across the United States and will use an employee search service should it become necessary to look outside the service area for employees and will be able to attract qualified, well-trained professionals who will live and work in the service area. While it is difficult to follow the staffing pattern due to formatting and the use of some acronyms, it does appear that the reported staffing plan would meet the TDMHSAS licensing requirements for this type of facility. Department staff were not able to find the requested comparison of clinical staff salaries in the proposal to prevailing wage patterns in the service area as published by the Tennessee Department of Labor and Workforce Development and/or other documented sources (#3 on Page 27 of the application). While the submitted Anticipated Staffing Patterns for "Build Year" and "Year 2" do show what appear to be hourly rates per position type, there is no corresponding comparison to prevailing wage patterns. The Projected Data Chart shows total expenses for "Salaries and Wages" of $3,388,492.00 (Year 1) and $5,628,936.00 (Year 2) with $105,000.00 listed for "Physician's Salaries and Wages" for Year 1 and the same in Year 2. This data is insufficient to make the requested comparison, so it is not clear if the proposed salaries are reasonable in comparison to prevailing wage patterns. In response to Question #33 in Supplemental #1, a chart showing "Position" and "Median Wage" for three (3) positions [RN, Mental Health Counselor, and Healthcare Support Workers] was provided, but the "Median Wage" is an annual amount, so is an inappropriate comparison to the hourly wage supplied by the Applicant and a full comparison for each position type was not submitted, so it is not

clear if the proposed salaries are reasonable in comparison to prevailing wage patterns. Supplemental #1 contains several questions and Applicant responses related to staffing. A review of those questions and the Applicant's responses show that the Applicant does intend to meet the staffing requirements of the Department (TDMHSAS) and staff all units as appropriate for patient acuity levels and that staffing will increase to cover special observations.

Upon request, the Applicant submitted in Supplemental #1 a licensure survey report on one of its facilities. The Applicant submitted a "Statement of Deficiencies and Plan of Correction" document, dated January 13, 2014, from the Nevada Department of Health and Human Services, Division of Public and Behavioral Health in which a deficiency related to having unqualified or unlicensed personnel was substantiated after an investigation in November, 2013. The deficiency was later corrected, but it is hoped that similar staffing issues do not occur in Tennessee.

Effect on Existing Providers and Resources

Please see the HSDA Staff Summary for an assessment of the impact of the proposed project on Woodridge Psychiatric Hospital, a facility in Washington County, Tennessee that has a 65% market share in the Tennessee portion of the Applicant's service area. Department staff agree with those findings.

As noted previously, there are concerns that the scope and size of the proposed project will have a negative impact on existing resources in contiguous counties that are economically linked to those of the proposed project, which would be disruptive to the overall delivery of services in the area. If existing resources are not being used to their fullest, in other words are underutilized, it raises the question of whether additional resources are needed.

The Applicant reports that there are no freestanding inpatient psychiatric facilities in the proposed service area, particularly since the closure of Indian Path Pavilion (sometime in 2009). The Department does not disagree. However, this does not mean that there aren't any resources or services available to those with mental illness and/or substance abuse disorders. The Department's understanding of the closure is that it closed because of underutilization and lack of demand for inpatient psychiatric services and that there were, and are, sufficient other resources and services to meet the mental health needs of the individuals in the Upper East Tennessee region.

The Applicant was asked to revise its responses to the Project Specific Criteria for Psychiatric Inpatient Services to include data on other inpatient facilities that have Hawkins and Sullivan Counties in their designated service area since that will impact the bed need for the proposed service area. In Supplemental #1, the Applicant responded that it is not required to analyze data of providers not located in its proposed service area. Department staff respectfully disagree with the Applicant's response. In order to assess the extent and true impact on existing resources and providers, it is important to review the data of those whose patient population comes from the counties in which one seeks to establish new services or build a new facility. If there are existing providers and resources that also serve the proposed service area, there will more likely than not be an impact on those providers and

resources. The extent of that impact should be evaluated and assessed. Asked another way in Question #32 of Supplemental #1, the Applicant was asked how the project will impact the utilization of similar providers, especially those who claim Hawkins and Sullivan Counties in their service area. The Applicant responded that "Utilization of ... other inpatient psychiatric providers not in the service area has already been accounted for in the projections for this project. The elimination over recent years of inpatient psychiatric beds ... demonstrate[s] the continuing need for additional inpatient psychiatric beds in this service area." Department staff respectfully disagree with the Applicant's response -- the elimination of inpatient psychiatric beds does not necessarily "demonstrate the continuing need for additional inpatient psychiatric beds", but may indicate that other services are sufficiently addressing the need and there may be alternatives for those with mental illness and/or substance abuse disorders.

On Page 16 of the application, the Applicant reports that the proposed project will not have an impact on the existing twelve (12) beds (at Bristol Regional Medical Center in Bristol, TN) given the "complete absence of these services in the Kingsport area currently, or in any of the other counties in the projected service area."

Letters of Support or Opposition

TDMHSAS staff is aware of letters of support as well as letters of opposition. Several letters of support are in favor of the project because there are waiting lists at the existing mental health resources; the location of existing resources are outside the community, which makes family involvement more difficult; and services are being provided in, in their words, inappropriate places (emergency rooms, jails). The opposition will present its views at the June meeting.

Working Relationships with Existing Health Care Providers and Participation in the Training of Students (Internships, Residencies, Etc.)

Since this is an application for a new facility, there are no transfer agreements in place, no working relationships with existing health care providers, and there is no current participation in the training of students through internships, residencies, and other such programs, but the Applicant reports that it has plans to have transfer agreements with local area hospitals such as Wellmont Holston Medical Center in Kingsport and the parent company has a history of working with all agencies and other providers to provide a "collaborative process to analyze and reduce barriers to access and service delivery". In Supplemental #1, the Applicant reports that it intends to have a working relationship with the area mobile crisis teams such as those at Frontier Health, but notes that in a meeting in October 2013 members of Frontier Health indicated that there is not a problem getting patients placed. The Applicant points out that at that time, Washington County was included in the proposed service area, and has since been excluded from the proposed service area, and that members of Frontier Health also indicated that if the project were completed and quality clinical programming would be provided, Frontier Health would work with the Applicant. The Applicant reports that it plans to participate in the training of students and is open to collaborating with area nursing schools and other healthcare training and education providers.

Ms. Hill provided a brief summary of the application and recommended approval for the change of site of the approved but unimplemented project based upon the application meeting the established criteria as follows: 1) Need – The need to relocate is justified based upon the problems found at the existing site. The development of the existing site would require significant blasting, grading, and building substantial retaining walls, which would significantly increase the original project cost; 2) Economic Feasibility – The project will be funded by cash reserves of the parent company and is projected to have positive net operating income less capital expenditures by year 2. The relocation will not result in greater cost to patients or a higher reimbursement for the applicant; and 3) Contribution to the Orderly Development of Health Care – In addition to the cost savings, the relocation will help contribute to the orderly development of health care because the new site is closer to Summit Hospital, which will be a major referral source for skilled nursing care.

Dan H. Elrod, Esq., was present to address the Agency, and Bruce K. Duncan, Assistant Vice President, NHC was present on behalf of the project.

Mr. Doolittle moved for approval of the project by accepting the Executive Director's determination. Dr. Flora seconded the motion. The motion CARRIED [8-0-0]. **APPROVED.** Ms. Hill noted the project included a three year expiration date instead of the usual two.

AYE: Jordan, Mills, Flora, Gaither, Doolittle, Wright, Hodge, Johnson
NAY: . None

CERTIFICATE OF NEED APPLICATIONS

Mark Farber summarized the following CON Applications:

Ms. Burns left meeting.

SBH-Kingsport, LLC - (Kingsport, Sullivan County), TN - Project No. CN1312-050

Establishment of a new 72-bed mental health hospital and the initiation of inpatient psychiatric services. The hospital will contain 18 adult, 16 geropsychiatric, 28 child and adolescent, and 10 chemical dependency beds. The facility will be located at an unaddressed site at the end of Executive Park Boulevard. The estimated project cost is $11,717,915.00.

William H. West, Esq., addressed the Agency on behalf of the applicant, and speaking on behalf of the project was Mike Garone, Director of Development, Strategic Behavioral Health. Speaking in support were: Jason Smith, Supervisor of Personnel, Scott County Schools; Jeff Thacker, Sgt. Deputy Sheriff, Scott County Virginia Sheriff's Office; Robin Ann Foreman, Assistant Professor, King University; Scott Fink, Chief of Police, Gate City Police Department; Greg Jones, Town Manager, Gate City Virginia; David Quillin, Chief of Police, Kingsport Police Department; Jill D. McCarly, M.D.; Chris Beach, COO, Camelot Care Centers, Inc.; Taylor Scott, Lee County Virginia Sheriff's Department; Callie Faircloth; Jim Shaheen, President, Strategic Behavioral Health.

Speaking in opposition were: Dan H. Elrod, Esq. representing Woodridge Psychiatric Hospital; Marlene Bailey, Director, Behavioral Services, Woodridge Psychiatric Hospital; Terry Borel, M.D., Woodridge Psychiatric Hospital; and Hetal Brahmbhatt, M.D., Woodridge Psychiatric Hospital. Present in opposition were: Shane Hilton, Regional CFO/VP, Mountain States Health Alliance; Kasey McDevitt, Director, Strategic Planning, Mountain States Health Alliance; Allison Rogers, VP, Strategic Planning, Mountain States Health Alliance; and Dru Malcolm, Assistant Administrator, CNO, Woodridge Psychiatric Hospital.

Mr. West rebutted.

Mr. Elrod provided opposition summation.

Mr. West provided applicant summation.

Chairman Johnson called for a motion; after no other member offered a motion, Chairman Johnson turned the meeting over to Vice-Chairman Wright. Then, to move the application to a vote, he moved for approval of the project to establish a new 72-bed mental health hospital and the initiation of inpatient psychiatric services with 18 adult, 16 geropsychiatric, 28 children and adolescent, and 10

chemical dependency beds based on: 1) Need – The data clearly shows there is a need for those beds; 2) Economic Feasibility – The economic feasibility is available through the financing that is available through the organization; and 3) The project does contribute to the orderly development of adequate and effective health care as it will provide health care in a region that drastically needs this service, and can't really use the health care services that are available, conveniently, in the area where they are. Mr. Doollittle seconded the motion. The motion FAILED [4-4-0]. **DENIED -- the motion failed because it was not supported by a majority of members present and voting ***

AYE: Doolittle, Wright, Hodge, Johnson
NAY: Jordan, Mills, Flora, Gaither

**Mr. Gaither stated that he voted against the approval of the project because it doesn't contribute to the orderly development of health care services as it will be detrimental to the delivery system in the region.*

Ms. Burns returned to meeting and Mr. Doolittle left meeting.

Wharton Nursing Home - (Pleasant Hill, Cumberland County), TN - Project No. CN1403-006

Relocation of 31* of the existing 62 dually certified nursing home beds to an adjacent building on the campus of Uplands Village, a continuing care retirement community. The 31 beds will be relocated from an existing building at 878-880 W. Main Street to 55 West Lake Road. The project includes construction and renovation. All 62 beds will be operated under Wharton Nursing Home's license. The estimated project cost is $5,100,000.00.

*These beds are not subject to the 2013-2014 Nursing Home Bed Pool.

Richard Woodard, Executive Director, Uplands Village, addressed the Agency on behalf of the project. Present in support were: Al Griffin, Director of Financial Services, Uplands Village and Anita Croinex, Health Services Director, Uplands Village.

Mr. Wright moved for approval of the project for the renovation of their existing space by actually moving a part of their patient care population to another adjacent building on the same campus based on: 1) Need – Since this project adds no beds to the existing service area, the need has been previously established; 2) Economic Feasibility – The project's economic feasibility is established by an approved government loan; and 3) The project's contribution to the orderly development of adequate and effective health care is met by renovation and reallocation of resources, to better serve the senior population of the community, and modern accommodations with enhanced services. Mr. Mills seconded the motion. The motion CARRIED [8-0-0]. **APPROVED**

AYE: Jordan, Mills, Flora, Gaither, Wright, Burns, Hodge, Johnson
NAY: None

Dyersburg Regional Medical Center - (Dyersburg, Dyer County), TN - Project No. CN1403-007

The expansion of cardiac catheterization services to include interventional (therapeutic) cardiac catheterization procedures. Catheterization services are currently limited to diagnostic-only. The estimated project cost is $367,763.00.

DEFERRED TO JULY 2014 MEETING

West Tennessee Imaging d/b/a Outpatient Diagnostic Center of Memphis - (Memphis, Shelby County), TN - Project No. CN1403-008

Establishment of an outpatient diagnostic center (ODC), acquisition of MRI equipment, and initiation of MRI services in 8,258 SF of space at 7600 Wolf River Blvd. In addition to MRI, CT, X-ray, and ultrasound services will be provided. This project will not add additional capacity to the market because a new joint venture has been established to own this ODC which will in effect relocate an existing ODC with MRI from 5130 Stage Road, a distance of 10 miles. The existing facility will relinquish its license and cease MRI services once this facility is operational. The estimated project cost is $10,123,989.00.

SBH-KINGSPORT 001746

STRATEGIC
BEHAVIORAL HEALTH, LLC

Psych Hospital Opportunity
72 Beds / 53 Census
Kingsport, Tennessee

1/10/14

PENGAD 800-631-6989
EXHIBIT
SBH-Kingsport
10
7/27/15

SBH-KINGSPORT 001748

Financial Summary – Kingsport New Building

Kingsport represents a great opportunity for SBH to grow our number of current Acute Hospitals. Returns exceed our requirements and provide for growth in multiple business lines.

FINANCIAL SUMMARY

	72 Beds/53 Census
Capital Investment	
- Equity (40%)	$4.6 MM
- Debt (60%)	$6.8 MM
Total Capital	$11.4 MM
Adj. Net Inc. to Equity (1)	$2.25 MM (EBITDA - capital expenditures & interest)
Simple Return to Equity (2)	50% (Adjusted Net income / Equity)

Note:

1) Adjusted Net Income to Equity = Net Income Plus Depreciation Less Capital Expenditures
2) Returns are simple returns and illustrative. Does not factor in time element of returns in calculation.

P-0539

SBH-KINGSPORT 001749

Kingsport Opportunity Rationale

Key Elements of Kingsport Opportunity:

- Tennessee is a CON State – provides barrier to market entry for additional competition
- Kingsport Market ranks #15 on the list of the Top 27 Markets according to the Intern Project
- Limited competition
  - Only 2 facilities (40 beds) within 25 miles and 3 facilities (112) beds within 50 miles
  - Only 1 substance abuse provider (19 beds) in the entire market
- Kingsport Market is "under bedded"
  - National statistics show 30-50 beds per 100,000 population
  - Entire Kingsport Market has a need for 81 additional beds (at 30/100k)
  - Significant need for Child / Adolescent, Geriatric and Substance Abuse services
  - Patients are traveling all the way to Knoxville (100 miles) and Chattanooga (210 Miles) to access services
  - State facilities are operating at or over capacity
  - State recently (June 2012) closed Lakeshore Mental Health Institute which had 250 beds
- TennCare
  - Has confirmed that there is additional need for inpatient psych. services in Eastern TN
  - Only current SBH Market that would allow for Adult (21 – 65) Medicaid reimbursement

SBH-KINGSPORT 001750

Kingsport Opportunity Rationale - Continued

- Community Support
  - Law Enforcement / Department of Children's Services / SNIF's / School District
  - Community is tired of only having one major provider in town
  - Rural communities in need of services and willing to travel
- Partnership Opportunities
  - ETSU Department of Psychiatry
  - Wellmont Health System
- Accessibility to staff
  - Ranked # 2 for staffing on the Intern Project
  - East Tennessee State University (Johnson City)
    - Psychiatry & Behavioral Sciences
    - Nursing
    - Psychology
    - Social Work
  - King University (Bristol / Kingsport)
    - Nursing
    - Psychology
- Community Mental Health Providers
  - Tremendous opportunity to have multiple feeder relationships throughout the market

SBH-KINGSPORT 001751

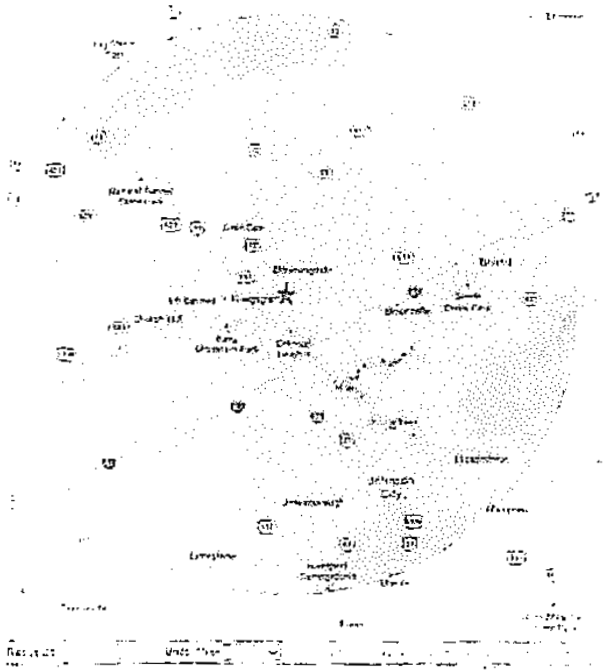
Kingsport Opportunity - Rationale

Criteria	Comments	Poor	Average	Good	Excellent
Rate of Pay	➢ $650 PPD - Commercial				
Adult Medicaid as additional payor	➢ Will be able to contract for TennCare ages 21 – 65 ➢ Only current SBH market to allow for this reimbursement				
C.O.N.	➢ CON required ➢ Providers determine their own service area ➢ Limits future competition				
Degree of Competition / Supply & Demand	➢ Additional demand for 81 beds				
Staffing Requirements	➢ No set ratio requirements for acute other then 2 direct care per unit at all times				
Staffing	➢ Overall #2 on Intern Project ➢ Staff cost low / Higher Ed. high ➢ Catchment area has over 300k ➢ ETSU (Nursing / Psychiatry)				
Community Support	➢ Support from TennCare, mental health providers, police and med/surg hospitals				

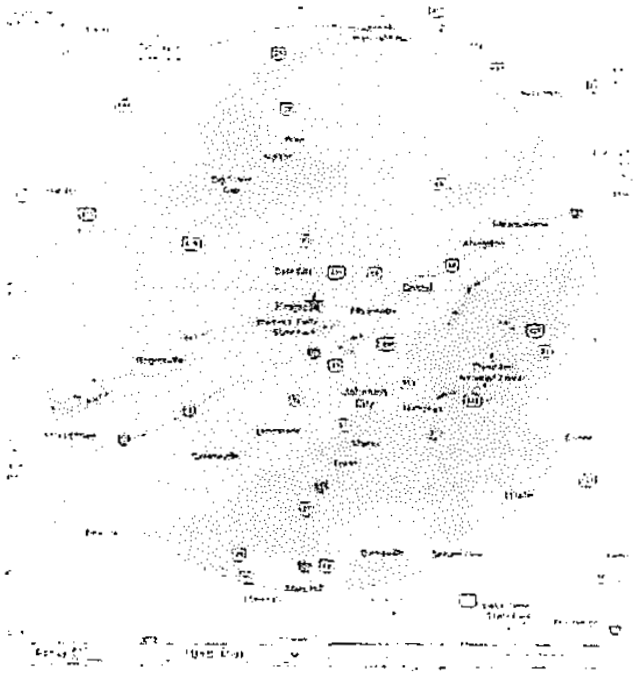
SBH-KINGSPORT 001752

Kingsport Catchment Area

25 Mile Radius ☆



50 Mile Radius ☆



SBH-KINGSPORT 001753

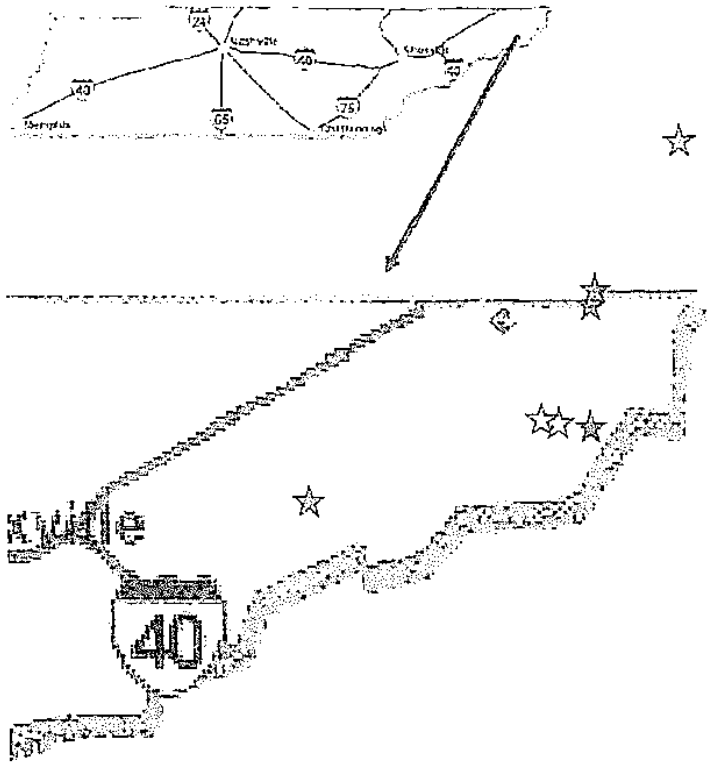
Kingsport Population Data & Bed Need

County	Weight	Actual Population	Weighted Population
Hawkins (TN)	1	56,587	56,587
Greene (TN)	1	68,819	68,819
Sullivan (TN)	1	156,786	156,786
Washington (TN)	1	125,094	125,094
Unicoi (TN)	1	18,235	18,235
Carter (TN)	1	57,355	57,355
Johnson (TN)	1	18,095	18,095
Hancock (TN)	1	6,720	6,720
Hamblen (TN)	0.75	62,746	47,060
Grainger (TN)	0.25	22,706	5,677
Cocke (TN)	0.25	35,571	8,893
Wise (VA)	1	40,918	40,918
Scott (VA)	1	22,781	22,781
Washington (VA)	1	55,190	55,190
Russell (VA)	1	28,445	28,445
Lee (VA)	0.75	25,474	19,106
Dickenson (VA)	0.75	15,690	11,768
Buchanan (VA)	0.25	23,859	5,965
Smyth (VA)	0.25	31,718	7,930
Avery (NC)	0.75	17,635	13,226
Mitchell (NC)	0.75	15,368	11,526
Yancey (NC)	0.75	17,630	13,223
Watauga (NC)	0.5	51,871	25,936
Madison (NC)	0.5	20,742	10,371
Ashe (NC)	0.25	27,097	6,774
Total		**1,023,132**	**842,477**
Bed Need		307	253
Existing Beds		172	172
Additional Need		**135**	**81**

SBH-KINGSPORT 001754

Eastern Tennessee Area Psych Hospital Beds

	SBH Kingsport (proposed) • 72 beds
	Senior Reflections (Wellmont Bristol Regional Medical Center) • 12 beds
	Ridgeview Pavilion • 28 beds
	Woodridge Hospital • 84 beds
	Magnolia Ridge • 19 beds (CD)
	New Leaf Senior Care (Sycamore Shoals Hospital) • 12 beds
	Takoma Regional Hospital • 16 beds
	Clearview Psychiatric Center (Russell County Medical Center) • 20 beds



P-0545

SBH-KINGSPORT 001755

Kingsport Competition

Immediate Market (0-25 miles) | Secondary Market (25-50 miles) | Surrounding Market (50+ Miles)

Name of Facility	City / County	Miles Away	Type of Facility	Private / State	# of Adult Beds	# of Older Adult Beds	# of Child-Adolescent Beds	# of CD Beds
Senior Reflections (Wellmont Bristol Regional Medical Center)	Bristol / Sullivan (TN)	15.8	Med / Surg	Private	0	12	0	0
Ridgeview Pavilion	Bristol / Washington (VA)	17.6	Free Standing	Private	28	0	0	0
TOTAL - 40					28	12	0	0
Woodridge Psychiatric Hospital	Johnson City / Washington (TN)	25.2	Free Standing	Private	58	14	12	0
Magnolia Ridge	Johnson City / Washington (TN)	25.9	Free Standing	Private	0	0	0	19
New Leaf Senior Care (Sycamore Shoals Hospital)	Elizabethton / Carter (TN)	31.3	Med / Surg	Private	0	12	0	0
Takoma Regional Hospital	Greenville / Greene (TN)	43.3	Med / Surg	Private	0	16	0	0
TOTAL - 131					58	42	12	19
Clearview Psychiatric Center (Russell County Medical Center)	Lebanon / Russell (VA)	52.6	Med / Surg	Private	20	0	0	0
TOTAL - 20					20	0	0	0

SBH-KINGSPORT 001756

Market Research

We have determined significant need for Geriatric, Adult and Child/Adolescent service lines. We have already met face-to-face with over 10 people to evaluate the psychiatric hospital demand. We will be meeting with over 15 additional stakeholders now that the CON Application has been filed. Below is the summary of who we met with and the information they presented.

Market Information Source	Comments
TennCare ➢ Director of Behavioral Health Operations	➢ There is a need for additional IP mental health services in Eastern TN, especially in the area of children & adolescents ➢ TennCare would be able to contract with you to provide services to adult members (21 – 65)
Tennessee Department of Children's Services ➢ Regional Administrator, East TN ➢ Clinical Psychologist	➢ We would love to have more beds here and would definitely support you ➢ We would want to get a contract with you for custodial kids ➢ We currently have 20 kids in care ➢ If we can't get a kid into Woodridge we have to send them all the way to Knoxville
Johnson City Police Department ➢ CIT Sargent	➢ There is definitely a need for additional services in this area ➢ MSHA has a monopoly. They push everyone out who tries to enter market and the ones that suffer is the community ➢ Frontier's CSU is more of a headache then an asset for us ➢ My officers can't legal someone, only Frontier MAT can (title 33) ➢ We average 35 mental health transports per month ➢ Closest state facility is in Chattanooga ➢ Lots of need for substance abuse services ➢ SBH would have no problem staffing the place

SBH-KINGSPORT 001757

Market Research - Continued

Market Information Source	Comments
NHC Healthcare (SNIF) ➢ Administrator ➢ Director of Nursing	➢ We have a hard time getting patients placed in psych ➢ We would utilize psych services more and not try to manage in house if we had a good partner ➢ We get most of our patients from MSHA so I am reluctant to write a LOS but if they didn't get cranky I would write and essay
The Journey Center (outpatient therapy) ➢ Therapist	➢ There is a great need for additional services, especially for youth ➢ Woodridge only does walk-ins 8am-4pm M-F ➢ My patients tell me that it is very scary to walk into Woodridge ➢ Frontier is the only TennCare provider ➢ All of SW Virginia comes to Kingsport for treatment and occasionally gets clients from Kentucky ➢ Would be happy to write LOS
Frontier Health ➢ Crisis Response Team ➢ Senior VP of Operations ➢ Senior VP of Specialty Services	➢ We only have Woodridge to work with and sometimes we have to send patients all the way to Chattanooga, which is not what's best for them ➢ We have a contract to do all the psych evals in the ER's within 2 hours ➢ They have a CSU and IP CD Program, so they are not an advocate
Johnson City Schools ➢ Director of Student Services	➢ We do not need someone to come in a replicate what Frontier is doing (she sits on Frontier's Board) ➢ Frontier gets our kids from crisis to placement very fast
Welmont Health System ➢ Vice President ➢ General Counsel	➢ Welmont management has been trying to work out an "internal solution" for psych ➢ We would welcome a psych provider that could take people out of our emergency room but would be concerned about a provider who would not take indigent patients ➢ I doubt Welmont would oppose a new psych facility

SBH-KINGSPORT 001758

Market Research - Continued

Market Information Source	Comments
Kingsport Police Department - Operations Captain	➢ We are always glad to have another provider ➢ We are very interested in exploring how we can work with your facility
Wellington Place of Colonial Heights (SNIF) - Administrator - Director of Nursing	➢ We need more resources close to this community ➢ We have had no help with psych since everything closed ➢ Woodridge will not take our incontinent patients so we are forced to send them all the way to Greenville
King University – School of Nursing - Professor (Mental Health Courses) - Clinical Rotation Coordinator	
King University – Counseling Center - Counseling Center Director - Student Intern	
Kingsport City Schools - Assistant Superintendent	
City of Kingsport - Mayor	
Kingsport Economic Development - Assistant City Manager	
Cognitive Behavioral Therapists of Tri-Cities - 3 Therapists	

SBH-KINGSPORT 001759

Market Research - Continued

Market Information Source	Comments
ETSU – School of Psychiatry - Psychiatric Residency Program Director	
GracePointe Counseling Center - Owner	
Tri-Cities Therapy - Owner	
Private Practice - Multiple Therapists	
Brookhaven Manor (SNF) - Director of Nursing	
Ashbury Place at Kingsport (SNF) - Director of Nursing	

SBH-KINGSPORT 001760

Pro Forma Financials

- Detailed Financials

SBH-KINGSPORT 001761

Reimbursement

- Per diem reimbursement estimates

- 37% Commercial @ $650 PPD
- 20% Medicare @ $750 PPD
- 38% Medicaid @ $550 PPD
- 5% True Indigent @ $0 PPD

SBH-KINGSPORT 001762

Key Assumptions

- Build 55,000 square foot facility for $175 per foot.
- Building sits on 9.7 acres with ability to treat 72 patients.
- Pro-forma assumes the following IP ADC
  - 20 Child / Adolescent
  - 15 Adults
  - 11 Geriatrics
  - 7 Chemical Dependency
- Pro-forma assumes 15 IOP/Partial ADC
- Staffing ratio's of 1-to-6 for Direct Care & Nursing staff

SBH-KINGSPORT 001763

Kingsport

13-Oct-14

BUILD YEAR

P & L		MONTH 1	2	3	4	5	6	7	8	9	10	11	12	annual
ADC		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Month														
Gross Revenue		0	0	0	0	0	0	0	0	0	0	0	0	0
Gross Patient Rev		0	0	0	0	0	0	0	0	0	0	0	0	0
Revenue Deductions		0	0	0	0	0	0	0	0	0	0	0	0	0
Net I/P Patient Revenue		0	0	0	0	0	0	0	0	0	0	0	0	0
OP		0	0	0	0	0	0	0	0	0	0	0	0	0
Net Revenue		0	0	0	0	0	0	0	0	0	0	0	0	0
Net Revenue PPD														
Operating Expenses														
Salaries		0	0	0	13,250	13,250	13,250	16,996	16,996	16,875	20,742	47,327	151,399	310,085
Benefits		0	0	0	3,312	3,312	3,312	4,249	4,249	4,219	5,186	11,832	37,850	77,521
Professional Fees		0	0	0	0	0	0	0	0	0	0	0	12,500	12,500
Advertising		0	0	0	0	0	0	0	0	0	15,000	15,000	15,000	45,000
Purchased Services		0	0	0	0	0	0	0	0	0	0	0	0	0
Recruitment		0	0	0	0	0	0	0	0	3,000	20,000	10,000	3,000	36,000
Food & Supplies		0	0	0	0	0	0	0	0	0	0	0	25,000	25,000
Travel		1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	5,000	5,000	5,000	10,000	37,000
Repairs		0	0	0	0	0	0	0	0	0	0	0	0	0
Rental Expense		0	0	0	0	0	0	1,250	1,250	1,250	1,250	1,250	1,250	7,500
Insurance		0	0	0	0	0	0	0	0	0	0	0	0	0
Utilities		0	0	0	0	0	0	500	500	500	500	500	500	3,000
Bad Debt Expense		0	0	0	0	0	0	0	0	0	0	0	0	0
Property Taxes		0	0	0	0	0	0	0	0	0	0	0	0	0
Other Expenses		0	0	0	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	9,000
Total Hospital Expenses		1,500	1,500	1,500	19,063	19,063	19,063	25,495	25,495	31,844	68,678	91,909	257,499	562,607
Operating Expenses PPD		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
EBITDA		(1,500)	(1,500)	(1,500)	(19,063)	(19,063)	(19,063)	(25,495)	(25,495)	(31,844)	(68,678)	(91,909)	(257,499)	(562,607)
Annualized														
Contribution		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
Depreciation		0	0	0	0	0	0	0	0	0	0	0	0	0
ADC		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Days in Period		31	28	31	30	31	30	31	31	30	31	30	31	365
Admissions														0
ALOS		12	12	12	12	12	12	12	12	12	12	12	12	12
ADC		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Patient Days		0	0	0	0	0	0	0	0	0	0	0	0	0
Payer Mix														
Tenn Medicaid		0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Medicare		0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	51%	51%

EXHIBIT
tabbies
11 7/27/15
SBH-Ringsport

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Commercial			0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	38%	38%
Self Pay			0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	11%	11%
Other 1				0%	0%	0%	0%	0%	0%	0%	0%	0%	0%		0%
Other 2				0%	0%	0%	0%	0%	0%	0%	0%	0%	0%		0%
Other 3			100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	0%	0%
Gross Charges PPD			0	0	0	0	0	0	0	0	0	0	0	1,578	1,578
Net Per Diem															
Tenn Medicaid			0	0	0	0	0	0	0	0	0	0	0	550	550
Medicare			0	0	0	0	0	0	0	0	0	0	0	750	750
Commercial			0	0	0	0	0	0	0	0	0	0	0	650	650
Self Pay			0	0	0	0	0	0	0	0	0	0	0	2	2
Other 1			0	0	0	0	0	0	0	0	0	0	0	0	0
Other 2			0	0	0	0	0	0	0	0	0	0	0	0	0
Other 3			0	0	0	0	0	0	0	0	0	0	0	0	0
Gross Revenue			0	0	0	0	0	0	0	0	0	0	0	0	0
Net Revenue															
Tenn Medicaid			0	0	0	0	0	0	0	0	0	0	0	0	0
Medicare			0	0	0	0	0	0	0	0	0	0	0	0	0
Commercial			0	0	0	0	0	0	0	0	0	0	0	0	0
Self Pay			0	0	0	0	0	0	0	0	0	0	0	0	0
Other 1			0	0	0	0	0	0	0	0	0	0	0	0	0
Other 2			0	0	0	0	0	0	0	0	0	0	0	0	0
Other 3			0	0	0	0	0	0	0	0	0	0	0	0	0
Total			0	0	0	0	0	0	0	0	0	0	0	0	0

				ADC		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
Clinical		regular hours				R.N./Tech	R.N./Tech	R.N./Tech	R.N./Tech	R.N./Tech	R.N./Tech	R.N./Tech	R.N./Tech	R.N./Tech	R.N./Tech	R.N./Tech	R.N./Tech	
	rate		FTE's		Staffing													
day	$10.00	Techs	1.4	Acute													2,474	
even	$11.00	Techs	1.4	Acute													2,721	
night	$12.00	Techs	1.4	Acute													2,969	
day	$10.00	Techs	1.4	Acute													2,474	
even	$11.00	Techs	1.4	Acute													2,721	
night	$12.00	Techs	1.4	Acute													2,969	
day	$10.00	Techs	0.0	Acute				0	0	0	0	0	0	0	0	0	0	0
even	$11.00	Techs	0.0	Acute				0	0	0	0	0	0	0	0	0	0	0
night	$12.00	Techs	0.0	Acute				0	0	0	0	0	0	0	0	0	0	0
				Acute														
addon	$45.00	Clinical Dir	1.0	Acute												7,695	7,952	
	$35.00	Program Dir	1.0														6,185	
day	$25.00	R.N.'s/U.M.	1.4	Acute													6,185	
even	$27.00	R.N.'s/U.M.	1.4	Acute													6,679	
night	$30.00	R.N.'s/U.M	1.4	Acute													7,421	
day	$18.00	L.V.N	0.0	Acute		0	0	0	0	0	0	0	0	0	0	0	0	0
even	$18.00	L.V.N.	0.0	Acute		0	0	0	0	0	0	0	0	0	0	0	0	0
night	$18.00	L.V.N.	0.0	Acute		0	0	0	0	0								
day	$25.00	Therapist	1.0	Acute													4,418	
day	$25.00	Therapist	0.0	Acute		0	0	0	0	0	0	0	0	0	0	0	0	0
day	$25.00	Therapist	0.0	Acute				0	0	0	0	0	0	0	0	0	0	0
day/even	$25.00	Therapist	0.0	Acute					0	0	0	0	0	0	0	0	0	0
day/even	$25.00	Therapist	0.0	Acute						0								
day	$18.00	RT	1.0	Acute													3,181	
day	$18.00		0.0	Acute		0	0	0	0	0	0	0	0	0	0	0	0	0

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day	$0.00	Teachers	0.0	Acute		0	0	0	0	0	0	0	0	0	0	0	0	0
day	$0.00	Teachers	0.0	Acute				0	0	0	0	0	0	0	0	0	0	0
day	$0.00	Teachers	0.0	Acute												0	0	0
		Totals	16.8			0	0	0	0	0	0	0	0	0	0	0	7,695	58,346
				PTO's	6.00%	0	0	0	0	0	0	0	0	0	0	462	3,501
						0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
				FTE's	worked	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	15.6
				EPOB													#DIV/0!	#DIV/0!
Non-Clinical																		
	rate		FTE's															
day	$72.12	Admin	1.0						12,500	12,500	12,500	12,500	12,500	12,500	12,500	12,500	12,743	
day	$20.00	Admin Sec	1.0									3,534	3,534	3,420	3,534	3,420	3,534	
day	$30.00	BOM	1.0														5,301	
day	$17.50	BO Clerks	1.0															
day	$25.00	med rec supr	1.0														4,418	
day	$24.00	Marketing	2.0													6,208	6,482	
day	$10.00	Recept	2.8														4,948	
day	$40.00	Nurse Admin	1.0													6,840	7,068	
day	$12.00	Dietary	4.0														8,482	
day	$30.00	Utilization Rev	1.0														5,301	
day	$24.00	Admissions	3.0														12,722	
	$0.00					0	0	0	0	0	0	0	0	0	0	0	0	0
day	$20.00	HR	1.0												3,534	3,420	3,534	
day	$30.00	OA/nfctr	1.0														5,301	
day	$15.00	Maint	1.0													2,565	2,851	
			21.8			0	0	0	12,500	12,500	12,500	16,034	16,034	15,920	19,568	36,953	84,483	
									2FTES	2FTES								
				PTO's	6.00%	0	0	0	750	750	750	962	962	955	1,174	2,217	5,069	
				FTE's	worked	0.0	0.0	0.0	1.0	1.0	1.0	2.0	2.0	2.0	3.0	7.0	20.8	
			Total	FTE's	paid				#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	6.5	38.6	
			Total	FTE's	worked	0.0	0.0	0.0	1.0	1.0	1.0	2.0	2.0	2.0	3.0	8.0	36.4	
			Total	EEPOB	paid	#VALUE!	#VALUE!	#VALUE!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
			Total	EEPOB	worked				#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
				Hourly rate paid		#VALUE!	#VALUE!	#VALUE!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	$32.64	$22.21	
				ADC		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
Employee Benefits																		
include Workers Comp		25.0%				0	0	0	3,312	3,312	3,312	4,249	4,249	4,219	5,186	11,832	37,850	
Professional Fees																		
H & P's		Per Admit	1			0	0	0	0	0	0	0	0	0	0	0	0	
						0	0	0	0	0	0	0	0	0	0	0	0	
	0.0	All Inclusives				0											0	
	$0	RTC rounds				0											0	
Medical Dir.		$0.00	per ADC														12,500	
Total Prof Fees						0	0	0	0	0	0	0	0	0	0	0	12,500	
Advertising/Media															15,000	15,000	15,000	
Purchased Services																		
Lab		$7.00	PPD			0	0	0	0	0	0	0	0	0	0	0	0	
E/R, X-Rays, EKG etc...		$4.25	PPD			0	0	0	0	0	0	0	0	0	0	0	0	

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Linen	$7.00	PPD		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Housekeeping	$9.00	PPD		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Transcription																							
Dietary	$35.00	PPD		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Grounds																							
Dietician																							
Legal																							
Audit																							
PhD																							
ADP/Accounting Fees																							
Other				0	0	0	0	0															0
				0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Recruitment																				3,000	20,000	10,000	3,000
			ADC		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Food and Supplies $																							
- General Supplies	$12.00	PPD		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	25,000
- Food	$0.00	PPD		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
- Pharmaceuticals	$20.00	PPD		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
- Linen	$0.00	PPD		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
- Other	$0.00	PPD		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total				0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	25,000
Travel				1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	5,000	5,000	5,000	10,000				
Repairs	Van & Building	$2.00	PPD	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Rent / Lease																							
- Buildings	$0	a year		0	0	0	0	0	0	0	0	0	0	0	0	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
- Equipment	Copiers & Fax			0	0	0	0	0	0	0	0	0	0	0	0	250	250	250	250	250	250	250	250
Total				0	0	0	0	0	0	0	0	0	0	0	0	1,250	1,250	1,250	1,250	1,250	1,250	1,250	1,250
Insurance																							
-Prof. Liab	$14.00	PPD		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
-Auto/Buildings/General				0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total				0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Utilities	includes Gas - Vans & Mobile phones															500	500	500	500	500	500	500	500
Bad Debt	3.0%	% GR		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Property Taxes	Building, Van & Equipment																						
Other Expenses																							
-Patient Awards	$0.00	PPD		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
-Field Trips	$0.00	PPD		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
-Clothing	$0.00	PPD		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
-Other	$0.00	PPD		0	0	0	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Dues																							
Total				0	0	0	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000

Kingsport Proforma

13-Oct-14

YEAR 1

MONTH

P & L		1	2	3	4	5	6	7	8	9	10	11	12	annual
ADC		3.9	6.4	11.6	16.0	19.4	24.0	27.1	31.0	34.0	34.8	36.0	38.7	23.8
Month														
Gross Revenue		189,360	284,040	568,080	757,440	946,800	1,136,160	1,325,520	1,514,880	1,609,560	1,704,240	1,798,920	1,893,600	13,728,600
Gross Patient Rev		189,360	284,040	568,080	757,440	946,800	1,136,160	1,325,520	1,514,880	1,609,560	1,704,240	1,798,920	1,893,600	13,728,600
Revenue Deductions		117,534	176,301	352,602	470,136	587,670	705,204	822,738	940,272	999,039	1,057,806	1,116,573	1,175,340	8,521,215
Net I/P Patient Revenue		71,826	107,739	215,478	287,304	359,130	430,956	502,782	574,608	610,521	646,434	682,347	718,260	5,207,385
OP		0	0	0	5,000	10,000	15,000	20,000	25,000	30,000	36,000	36,000	36,000	213,000
Net Revenue		71,826	107,739	215,478	292,304	369,130	445,956	522,782	599,608	640,521	682,434	718,347	754,260	5,420,385
Net Revenue PPD		599	599	599	609	615	619	622	625	628	632	630	629	623
Operating Expenses														
Salaries		148,669	143,854	203,399	204,516	210,891	229,856	249,101	252,378	262,809	271,127	262,809	271,385	2,710,793
Benefits		37,167	35,963	50,850	51,129	52,723	57,464	62,275	63,095	65,702	67,782	65,702	67,846	677,698
Professional Fees		12,500	12,500	12,500	12,500	12,500	12,500	12,500	12,500	12,500	12,500	12,500	12,500	150,000
Advertising		10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	120,000
Purchased Services		14,758	16,033	21,525	24,075	26,625	29,175	33,725	36,275	39,217	40,492	41,767	43,042	366,708
Recruitment		3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	36,000
Food & Supplies		5,520	8,280	16,560	22,080	27,600	33,120	38,640	44,160	46,920	49,680	52,440	60,000	405,000
Travel		7,500	7,500	7,500	7,500	7,500	7,500	7,500	7,500	7,500	7,500	7,500	7,500	90,000
Repairs		240	360	720	960	1,200	1,440	1,680	1,920	2,040	2,160	2,280	2,400	17,400
Rental Expense		2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	24,000
Insurance		4,000	4,000	4,000	4,000	4,000	4,000	4,000	4,000	4,000	4,000	4,000	4,000	48,000
Utilities		8,000	9,000	10,000	11,000	12,000	13,000	13,550	13,550	13,550	13,550	13,550	13,550	144,300
Bad Debt Expense		2,155	3,232	6,464	8,769	11,074	13,379	15,683	17,988	19,216	20,473	21,550	22,628	162,612
Property Taxes		5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	60,000
Other Expenses		1,120	1,160	1,360	1,480	1,600	1,720	1,840	1,960	2,020	2,080	2,140	2,200	20,700
Total Hospital Expenses		261,630	261,903	354,878	368,009	387,713	423,153	460,494	475,326	495,473	511,344	506,238	527,050	5,033,212
Operating Expenses PPD		2,180	1,455	986	767	646	588	548	495	466	473	444	439	579
EBITDA		(189,804)	(154,164)	(139,400)	(75,705)	(18,583)	22,803	62,288	124,282	145,048	171,090	212,109	227,210	387,173
Annualized		(2,277,646)	(1,849,966)	(1,672,801)	(908,455)	(222,993)	273,632	747,452	1,491,380	1,740,573	2,053,081	2,545,308	2,726,515	
Contribution		-264%	-143%	-85%	-26%	-5%	5%	12%	21%	23%	25%	30%	30%	
Depreciation														0

	ADC	3.9	6.4	11.6	16.0	19.4	24.0	27.1	31.0	34.0	34.8	36.0	38.7	23.8
Days In Period		31	28	31	30	31	30	31	31	30	31	30	31	365
Admissions		10	15	30	40	50	60	70	80	85	90	95	100	725
ALOS		12	12	12	12	12	12	12	12	12	12	12	12	12
ADC		3.9	6.4	11.6	16.0	19.4	24.0	27.1	31.0	34.0	34.8	36.0	38.7	23.8
Patient Days		120	180	360	480	600	720	840	960	1,020	1,080	1,140	1,200	8,700
Payor Mix														
Tenn Medicaid		38%	38%	38%	38%	38%	38%	38%	38%	38%	38%	38%	38%	38%
Medicare		20%	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%
Commercial		35%	35%	35%	35%	35%	35%	35%	35%	35%	35%	35%	35%	35%
Self Pay		5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%
Other 1			0%	0%	0%	0%	0%	0%	0%	0%	0%	0%		0%
Other 2			0%	0%	0%	0%	0%	0%	0%	0%	0%	0%		0%

Other 3	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%
Gross Charges PPD	1,578	1,578	1,578	1,578	1,578	1,578	1,578	1,578	1,578	1,578	1,578	1,578	1,578	1,578
Net Per Diem														
Tenn Medicaid	550	550	550	550	550	550	550	550	550	550	550	550	550	550
Medicare	750	750	750	750	750	750	750	750	750	750	750	750	750	750
Commercial	650	650	650	650	650	650	650	650	650	650	650	650	650	650
Self Pay	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Other 1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other 2	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other 3	600	600	600	600	600	600	600	600	600	600	600	600	600	600
Gross Revenue	189,360	284,040	568,080	757,440	946,800	1,136,160	1,325,520	1,514,880	1,609,560	1,704,240	1,798,920	1,893,600	13,728,600	
Net Revenue														
Tenn Medicaid	25,080	37,620	75,240	100,320	125,400	150,480	175,560	200,640	213,180	225,720	238,260	250,800	1,818,300	
Medicare	18,000	27,000	54,000	72,000	90,000	108,000	126,000	144,000	153,000	162,000	171,000	180,000	1,305,000	
Commercial	27,300	40,950	81,900	109,200	136,500	163,800	191,100	218,400	232,050	245,700	259,350	273,000	1,979,250	
Self Pay	6	9	18	24	30	36	42	48	51	54	57	60	435	
Other 1	0	0	0	0	0	0	0	0	0	0	0	0	0	
Other 2	0	0	0	0	0	0	0	0	0	0	0	0	0	
Other 3	1,440	2,160	4,320	5,760	7,200	8,640	10,080	11,520	12,240	12,960	13,680	14,400	104,400	
Total	71,826	107,739	215,478	287,304	359,130	430,956	502,782	574,608	610,521	646,434	682,347	718,260	5,207,385	

					ADC		3.9	6.4	11.6	16.0	19.4	24.0	27.1	31.0	34.0	34.8	38.0	38.7
Clinical		regular hours					R.N./Tech	R.N./Tech	R.N./Tech	R.N./Tech	R.N./Tech	R.N./Tech	R.N./Tech	R.N./Tech	R.N./Tech	R.N./Tech	R.N./Tech	R.N./Tech
	rate		FTE's		Staffing													
day	$10.00	Techs	1.4	Acute			2,474	2,234	2,474	2,394	2,474	2,394	2,474	2,474	2,394	2,474	2,394	2,474
even	$11.00	Techs	1.4	Acute			2,721	2,458	2,721	2,633	2,721	2,633	2,721	2,721	2,633	2,721	2,633	2,721
night	$12.00	Techs	1.4	Acute			2,969	2,681	2,969	2,873	2,969	2,873	2,969	2,969	2,873	2,969	2,873	2,969
				Acute														
day	$10.00	Techs	1.4	Acute					2,474	2,394	2,474	2,394	2,474	2,474	2,394	2,474	2,394	2,474
even	$11.00	Techs	1.4	Acute					2,721	2,633	2,721	2,633	2,721	2,721	2,633	2,721	2,633	2,721
night	$12.00	Techs	1.4	Acute					2,969	2,873	2,969	2,873	2,969	2,969	2,873	2,969	2,873	2,969
				Acute														
day	$10.00	Techs	1.4	Acute					2,474	2,394	2,474	2,394	2,474	2,474	2,394	2,474	2,394	2,474
even	$11.00	Techs	1.4	Acute					2,721	2,633	2,721	2,633	2,721	2,721	2,633	2,721	2,633	2,721
night	$12.00	Techs	1.4	Acute					2,969	2,873	2,969	2,873	2,969	2,969	2,873	2,969	2,873	2,969
						open 2nd wing												
day	$10.00	Techs	1.4	Acute									2,474	2,474	2,394	2,474	2,394	2,474
even	$11.00	Techs	1.4	Acute									2,721	2,721	2,633	2,721	2,633	2,721
night	$12.00	Techs	1.4	Acute									2,969	2,969	2,873	2,969	2,873	2,969
addon	$45.00	Clinical Dir	1.0	Acute			7,952	7,182	7,952	7,695	7,952	7,695	7,952	7,952	7,695	7,952	7,695	7,952
	$35.00	Program Dir	1.0	Acute			6,185	5,586	6,185	5,985	6,185	5,985	6,185	6,185	5,985	6,185	5,985	6,185
day	$25.00	R.N.'s/U.M.	1.4	Acute			6,185	5,586	6,185	5,985	6,185	5,985	6,185	6,185	5,985	6,185	5,985	6,185
even	$27.00	R.N.'s/U.M.	1.4	Acute			6,679	6,033	6,679	6,464	6,679	6,464	6,679	6,679	6,464	6,679	6,464	6,679
night	$30.00	R.N.'s/U.M.	1.4	Acute			7,421	6,703	7,421	7,182	7,421	7,182	7,421	7,421	7,182	7,421	7,182	7,421
day	$25.00	R.N.'s/U.M.	1.4	Acute					6,185	5,985	6,185	5,985	6,185	6,185	5,985	6,185	5,985	6,185
even	$27.00	R.N.'s/U.M.	1.4	Acute					6,679	6,464	6,679	6,464	6,679	6,679	6,464	6,679	6,464	6,679
night	$30.00	R.N.'s/U.M.	1.4	Acute					7,421	7,182	7,421	7,182	7,421	7,421	7,182	7,421	7,182	7,421
day	$25.00	R.N.'s/U.M.	1.4	Acute								5,985	6,185	6,185	5,985	6,185	5,985	6,185
even	$27.00	R.N.'s/U.M.	1.4	Acute								6,464	6,679	6,679	6,464	6,679	6,464	6,679
night	$30.00	R.N.'s/U.M.	1.4	Acute								7,182	7,421	7,421	7,182	7,421	7,182	7,421
day	$18.00	L.V.N.	1.4	Acute											4,309	4,453	4,309	4,453
even	$18.00	L.V.N.	1.4	Acute											4,309	4,453	4,309	4,453
night	$18.00	L.V.N.	1.4	Acute											4,309	4,453	4,309	4,453

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day	$16.00	L.V.N.	1.4	Acute													
even	$16.00	L.V.N	1.4	Acute													
night	$16.00	L.V.N.	1.4	Acute													
			2.0														
day	$18.00	L.V.N.	1.4	Acute													
even	$18.00	L.V.N.	1.4	Acute													
night	$18.00	L.V.N.	1.4	Acute													
day	$25.00	Therapist	1.0	Acute		4,418	3,990	4,418	4,275	4,418	4,275	4,418	4,418	4,275	4,418	4,275	4,418
day	$25.00	Therapist	1.0	Acute			3,990	4,418	4,275	4,418	4,275	4,418	4,418	4,275	4,418	4,275	4,418
day	$25.00	Therapist	1.0	Acute					4,275	4,418	4,275	4,418	4,418	4,275	4,418	4,275	4,418
day/even	$25.00	Therapist	1.0	Acute							4,275	4,418	4,418	4,275	4,418	4,275	4,418
day/even	$25.00	Therapist	0.0	Acute													
day	$16.00	RT	1.0	Acute		3,181	2,873	3,181	3,078	3,181	3,078	3,181	3,181	3,078	3,181	3,078	3,181
day	$16.00	RT	1.0	Acute								3,181	3,181	3,078	3,181	3,078	3,181
		Totals	52.0			50,183	49,316	91,213	92,545	95,630	116,451	131,677	131,677	140,357	145,035	140,357	145,035
				PTO's	6.00%	3,011	2,959	5,473	5,553	5,738	6,987	7,901	7,901	8,421	8,702	8,421	8,702
						0.0	0.0	0.0	0.0	0.0	0.0	1.0	1.0	1.0	1.0	1.0	1.0
				FTE's	worked	11.4	12.4	20.8	21.8	21.8	22.8	23.8	23.8	25.6	26.6	25.6	26.6
				EPOB		2.95	1.93	1.79	1.36	1.13	0.95	0.88	0.77	0.78	0.76	0.70	0.69
Non-Clinical																	
	rate		FTE's														
day	$72.17	Admin	1.0			12,500	12,500	12,500	12,500	12,500	12,500	12,500	12,500	12,500	12,500	12,500	12,743
day	$20.00	Admin Sec	1.0			3,534	3,192	3,534	3,420	3,534	3,420	3,534	3,534	3,420	3,534	3,420	3,534
day	$40.00	Controller	1.0			7,068	6,384	7,068	6,840	7,068	6,840	7,068	7,068	6,840	7,068	6,840	7,068
day	$30.00	BO mgr	1.0			5,301	4,788	5,301	5,130	5,301	5,130	5,301	5,301	5,130	5,301	5,130	5,301
day	$17.50	BO Clerks	1.0										3,092	2,993	3,092	2,993	3,092
day	$25.00	med rec supr	1.0			4,418	3,990	4,418	4,275	4,418	4,275	4,418	4,418	4,275	4,418	4,275	4,418
day	$15.00	Medical Rec	1.0						2,565	2,651	2,565	2,651	2,651	2,565	2,651	2,565	2,651
day	$15.00	Medical Rec	0.0										0	0	0	0	0
day	$24.00	Marketing	3.5			14,843	13,406	14,843	14,364	14,843	14,364	14,843	14,843	14,364	14,843	14,364	14,843
day	$24.00	Marketing							0	0	0	0	0	0	0	0	0
day	$24.00	Marketing										0	0	0	0	0	0
day	$10.00	Receipt	2.8			4,948	4,469	4,948	4,788	4,948	4,788	4,948	4,948	4,788	4,948	4,788	4,948
day	$40.00	Nurse Admin	1.0			7,068	6,384	7,068	6,840	7,068	6,840	7,068	7,068	6,840	7,068	6,840	7,068
day	$12.00	Dietary	4.0			8,482	7,661	8,482	8,208	8,482	8,208	8,482	8,482	8,208	8,482	8,208	8,482
day	$30.00	Utilization Rev	1.0			5,301	4,788	5,301	5,130	5,301	5,130	5,301	5,301	5,130	5,301	5,130	5,301
day	$24.00	Admissions	1.0			4,241	3,830	4,241	4,104	4,241	4,104	4,241	4,241	4,104	4,241	4,104	4,241
day	$24.00	Admissions	1.0				3,830	4,241	4,104	4,241	4,104	4,241	4,241	4,104	4,241	4,104	4,241
day	$24.00	Admissions	1.5					6,361	6,156	6,361	6,156	6,361	6,361	6,156	6,361	6,156	6,361
	$25.00	HR	1.0			4,418	3,990	4,418	4,275	4,418	4,275	4,418	4,418	4,275	4,418	4,275	4,418
day	$12.50	HR	1.0											2,138	2,209	2,138	2,209
day	$30.00	QA/infctr	1.0			5,301	4,788	5,301	5,130	5,301	5,130	5,301	5,301	5,130	5,301	5,130	5,301
day	$15.00	Maint	1.0			2,651	2,394	2,651	2,565	2,651	2,565	2,651	2,651	2,565	2,651	2,565	2,651
day	$12.00	Maint	1.0											2,052	2,120	2,052	2,120
			27.8			90,071	86,395	100,673	100,394	103,324	100,394	103,324	106,416	107,576	110,745	107,576	110,988
									2FTES	2FTES							
				PTO's	6.00%	5,404	5,184	6,040	6,024	6,199	6,024	6,199	6,385	6,455	6,645	6,455	6,659
				FTE's	worked	17.3	17.3	17.3	17.3	17.3	17.3	17.3	18.3	20.3	20.3	20.3	20.3
			Total	FTE's	paid	30.4	31.5	40.4	41.4	41.4	42.5	43.6	44.6	49.7	49.7	49.7	49.7
			Total	FTE's	worked	28.7	29.7	38.1	39.1	39.1	40.1	41.1	42.1	46.9	46.9	46.9	46.9
			Total	EEPOB	paid	7.86	4.90	3.48	2.59	2.14	1.77	1.61	1.44	1.46	1.43	1.31	1.28
			Total	EEPOB	worked	7.41	4.62	3.28	2.44	2.02	1.67	1.52	1.36	1.38	1.35	1.23	1.21
				Hourly rate paid		$27.66	$28.63	$28.50	$28.86	$28.80	$31.62	$32.36	$32.01	$30.91	$30.86	$30.91	$30.89
				ADC		3.9	6.4	11.6	16.0	19.4	24.0	27.1	31.0	34.0	34.8	36.0	36.7
Employee Benefits																	
include Workers Comp		25.0%				37,167	35,963	50,850	51,129	52,723	57,464	62,275	63,095	65,702	67,782	65,702	67,846

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Professional Fees														
H & P's	Per Admit	1		0	0	0	0	0	0	0	0	0	0	0	0
				0	0	0	0	0	0	0	0	0	0	0	0
	0.0 All Inclusives			0											0
	$0 RTC rounds			0											0
Medical Dir.	$0.00	per ADC		12,500	12,500	12,500	12,500	12,500	12,500	12,500	12,500	12,500	12,500	12,500	12,500
Total Prof Fees				12,500	12,500	12,500	12,500	12,500	12,500	12,500	12,500	12,500	12,500	12,500	12,500
Advertising/Media				10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000
Purchased Services														
Lab	$10.00	PPD		1,200	1,800	3,600	4,800	6,000	7,200	8,400	9,600	10,200	10,800	11,400	12,000
E/R, X-Rays, EKG etc ..	$4.25	PPD		510	765	1,530	2,040	2,550	3,060	3,570	4,080	4,335	4,590	4,845	5,100
Linen	$7.00	PPD		840	1,260	2,520	3,360	4,200	5,040	5,880	6,720	7,140	7,560	7,980	8,400
Housekeeping	$9.00	PPD		2,083	2,083	3,750	3,750	3,750	3,750	3,750	3,750	5,417	5,417	5,417	5,417
Transcription															
Dietary	$0.00	PPD		0	0	0	0	0	0	0	0	0	0	0	0
Grounds				1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Pharmacist				3,000	3,000	3,000	3,000	3,000	3,000	5,000	5,000	5,000	5,000	5,000	5,000
Legal				2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000
EMR				2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000
PhD															
ADP/Accounting Fees				2,125	2,125	2,125	2,125	2,125	2,125	2,125	2,125	2,125	2,125	2,125	2,125
Other				0	0	0	0	0							0
				14,758	16,033	21,525	24,075	26,625	29,175	33,725	36,275	39,217	40,492	41,767	43,042
Recruitment				3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000
		ADC		3.9	6.4	11.6	18.0	19.4	24.0	27.1	31.0	34.0	34.6	36.0	36.7
Food and Supplies $															
- General Supplies	$10.00	PPD		1,200	1,800	3,600	4,800	6,000	7,200	8,400	9,600	10,200	10,800	11,400	12,000
- Food	$10.00	PPD		1,200	1,800	3,600	4,800	6,000	7,200	8,400	9,600	10,200	10,800	11,400	12,000
- Pharmaceuticals	$26.00	PPD		3,120	4,680	9,360	12,480	15,600	18,720	21,840	24,960	26,520	28,080	29,640	31,200
- Linen	$0.00	PPD		0	0	0	0	0	0	0	0	0	0	0	0
- Other	$0.00	PPD		0	0	0	0	0	0	0	0	0	0	0	4,800
Total				5,520	8,280	16,560	22,080	27,600	33,120	38,640	44,160	46,920	49,680	52,440	60,000
Travel				7,500	7,500	7,500	7,500	7,500	7,500	7,500	7,500	7,500	7,500	7,500	7,500
Repairs	Van & Building	$2.00	PPD	240	360	720	960	1,200	1,440	1,680	1,920	2,040	2,160	2,280	2,400
Rent / Lease															
- Buildings	$0 a year			0	0	0	0	0	0	0	0	0	0	0	0
- Equipment	Copiers & Fax			2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000
Total				2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000
Insurance															
-Prof. Liab			PPD	4,000	4,000	4,000	4,000	4,000	4,000	4,000	4,000	4,000	4,000	4,000	4,000
-Auto/Buildings/General				0	0	0	0	0	0	0	0	0	0	0	0
Total				4,000	4,000	4,000	4,000	4,000	4,000	4,000	4,000	4,000	4,000	4,000	4,000
Utilities	Includes Gas - Vans & Mobile phones			8,000	8,000	10,000	11,000	12,000	13,000	13,550	13,550	13,550	13,550	13,550	13,550

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Bad Debt	3.0%	% net revenue	2,155	3,232	6,464	8,769	11,074	13,379	15,683	17,988	19,216	20,473	21,550	22,628
Property Taxes	Building, Van & Equipment		5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000
Other Expenses														
-Patient Awards	$1.00	PPD	120	180	360	480	600	720	840	960	1,020	1,080	1,140	1,200
-Field Trips	$0.00	PPD	0	0	0	0	0	0	0	0	0	0	0	0
-Clothing	$0.00	PPD	0	0	0	0	0	0	0	0	0	0	0	0
-Other	$0.00	PPD	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Dues														
Total			1,120	1,180	1,360	1,480	1,600	1,720	1,840	1,960	2,020	2,080	2,140	2,200

Kingsport Proforma

YEAR 2

13-Oct-14

P & L		MONTH 1	2	3	4	5	6	7	8	9	10	11	12	annual
	ADC	38.7	40.3	40.6	44.0	44.5	48.4	48.4	50.3	51.2	50.3	52.8	52.3	46.8
	Month													
Gross Revenue		1,893,600	1,779,984	1,988,280	2,082,960	2,177,640	2,291,256	2,367,000	2,461,680	2,423,808	2,461,680	2,499,552	2,556,360	26,983,800
Gross Patient Rev		1,893,600	1,779,984	1,988,280	2,082,960	2,177,640	2,291,256	2,367,000	2,461,680	2,423,808	2,461,680	2,499,552	2,556,360	26,983,800
Revenue Deductions		1,175,340	1,104,820	1,234,107	1,292,874	1,351,641	1,422,161	1,469,175	1,527,942	1,504,435	1,527,942	1,551,449	1,586,709	15,748,595
Net I/P Patient Revenue		718,260	675,164	754,173	790,086	825,999	869,095	897,825	933,738	919,373	933,738	948,103	969,651	10,235,205
OP		36,000	40,000	42,000	42,000	45,000	45,000	45,000	45,000	45,000	45,000	45,000	45,000	520,000
Net Revenue		754,260	715,164	796,173	832,086	870,999	914,095	942,825	978,738	964,373	978,738	993,103	1,014,651	10,755,205
Net Revenue PPD		629	634	632	630	631	630	629	627	628	627	627	626	629
Operating Expenses														
Salaries		344,376	311,050	349,059	359,876	371,872	388,685	402,028	402,028	389,059	402,028	389,059	402,028	4,503,149
Benefits		66,094	77,762	87,265	89,969	92,968	95,171	100,507	100,507	97,265	100,507	97,265	100,507	1,125,767
Professional Fees		12,500	12,500	12,500	12,500	12,500	12,500	12,500	12,500	12,500	12,500	12,500	12,500	150,000
Advertising		10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	120,000
Purchased Services		43,942	36,178	40,650	41,925	43,200	44,730	47,750	49,025	50,182	50,692	51,202	51,967	550,542
Recruitment		3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	36,000
Food & Supplies		55,200	51,888	57,960	60,720	63,480	66,792	69,000	71,760	70,656	71,760	72,864	74,520	786,600
Travel		7,500	7,500	7,500	7,500	7,500	7,500	7,500	7,500	7,500	7,500	7,500	7,500	90,000
Repairs		2,400	2,256	2,520	2,640	2,760	2,904	3,000	3,120	3,072	3,120	3,168	3,240	34,200
Rental Expense		2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	24,000
Insurance		4,000	4,000	4,000	4,000	4,000	4,000	4,000	4,000	4,000	4,000	4,000	4,000	48,000
Utilities		13,550	9,000	10,000	11,000	12,000	13,000	13,550	13,550	13,550	13,550	13,550	13,550	149,850
Bad Debt Expense		22,628	21,455	23,885	24,963	26,130	27,423	28,285	29,382	28,931	29,382	29,793	30,440	322,656
Property Taxes		5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	60,000
Other Expenses		2,200	2,128	2,260	2,320	2,380	2,452	2,500	2,560	2,536	2,560	2,584	2,620	29,100
Total Hospital Expenses		613,490	555,717	617,599	637,413	658,790	677,157	710,620	715,912	699,251	717,579	703,485	722,871	8,029,884
Operating Expenses PPD		511	493	490	483	477	466	474	459	455	460	444	446	470
EBITDA		140,770	159,447	178,574	194,673	212,209	236,937	232,205	262,826	265,122	261,159	289,618	291,780	2,725,321
Annualized		1,689,241	1,913,368	2,142,890	2,336,075	2,546,504	2,843,250	2,786,465	3,153,912	3,181,463	3,133,912	3,475,420	3,501,359	
Contribution		19%	22%	22%	23%	24%	26%	25%	27%	27%	27%	29%	29%	
														0

RTC	ADC	38.7	40.3	40.6	44.0	44.5	48.4	48.4	50.3	51.2	50.3	52.8	52.3	46.8
Days in Period		31	28	31	30	31	30	31	31	30	31	30	31	365
Admissions		100	94	105	110	115	121	125	130	128	130	132	135	1425
ALOS		12	12	12	12	12	12	12	12	12	12	12	12	12
ADC		38.7	40.3	40.6	44.0	44.5	48.4	48.4	50.3	51.2	50.3	52.8	52.3	46.8
Patient Days		1,200	1,125	1,260	1,320	1,380	1,452	1,500	1,560	1,536	1,560	1,584	1,620	17,100
Payor Mix														
Tenn Medicaid		38%	38%	38%	38%	38%	38%	38%	38%	38%	38%	38%	38%	38%
Medicare		20%	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%
Commercial		35%	35%	35%	35%	35%	35%	35%	35%	35%	35%	35%	35%	35%
Self Pay		5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%
Other 1			0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Other 2			0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

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Other 3	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%
Gross Charges PPD	1,578	1,578	1,578	1,578	1,578	1,578	1,578	1,578	1,578	1,578	1,578	1,578	1,578	1,578
Net Per Diem														
Tenn Medicaid	550	550	550	550	550	550	550	550	550	550	550	550	550	550
Medicare	750	750	750	750	750	750	750	750	750	750	750	750	750	750
Commercial	650	650	650	650	650	650	650	650	650	650	650	650	650	650
Self Pay	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Other 1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other 2	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other 3	600	600	600	600	600	600	600	600	600	600	600	600	600	600
Gross Revenue	1,893,600	1,779,984	1,988,280	2,082,960	2,177,640	2,291,256	2,367,000	2,461,680	2,423,808	2,461,680	2,499,552	2,556,360	26,983,800	
Net Revenue														
Tenn Medicaid	250,800	235,752	263,340	275,880	288,420	303,468	313,500	326,040	321,024	326,040	331,056	338,580	3,573,900	
Medicare	180,000	169,200	189,000	198,000	207,000	217,800	225,000	234,000	230,400	234,000	237,600	243,000	2,565,000	
Commercial	273,000	256,620	286,650	300,300	313,950	330,330	341,250	354,900	349,440	354,900	360,360	368,550	3,890,250	
Self Pay	60	56	63	66	69	73	75	78	77	78	79	81	855	
Other 1	0	0	0	0	0	0	0	0	0	0	0	0	0	
Other 2	0	0	0	0	0	0	0	0	0	0	0	0	0	
Other 3	14,400	13,536	15,120	15,840	16,560	17,424	18,000	18,720	18,432	18,720	19,008	19,440	205,200	
Total	718,260	675,164	754,173	790,086	825,999	869,095	897,825	933,738	919,373	933,738	948,103	969,651	10,235,205	

Clinical		regular hours		ADC		38.7	40.3	40.6	44.0	44.5	48.4	48.4	50.3	51.2	50.3	52.8	52.3
	rate		FTE's		Staffing	R.N./Tech	R.N./Tech	R.N./Tech	R.N./Tech	R.N./Tech	R.N./Tech	R.N./Tech	R.N./Tech	R.N./Tech	R.N./Tech	R.N./Tech	R.N./Tech
day	$10.00	Techs	5.6	Acute		9,895	8,938	9,895	9,576	9,895	9,576	9,895	9,895	9,576	9,895	9,576	9,895
even	$11.00	Techs	5.6	Acute		10,885	9,831	10,885	10,534	10,885	10,534	10,885	10,885	10,534	10,885	10,534	10,885
night	$12.00	Techs	5.6	Acute		11,874	10,725	11,874	11,491	11,874	11,491	11,874	11,874	11,491	11,874	11,491	11,874
				Acute													
day	$10.00	Techs	2.8	Acute		4,948	4,469	4,948	4,788	4,948	4,788	4,948	4,948	4,788	4,948	4,788	4,948
even	$11.00	Techs	2.8	Acute		5,442	4,918	5,442	5,267	5,442	5,267	5,442	5,442	5,267	5,442	5,267	5,442
night	$12.00	Techs	2.8	Acute		5,937	5,363	5,937	5,746	5,937	5,746	5,937	5,937	5,746	5,937	5,746	5,937
				Acute													
day	$10.00	Techs	1.4	Acute					2,394	2,474	2,394	2,474	2,474	2,394	2,474	2,394	2,474
even	$11.00	Techs	1.4	Acute					2,633	2,721	2,633	2,721	2,721	2,633	2,721	2,633	2,721
night	$12.00	Techs	1.4	Acute					2,873	2,969	2,873	2,969	2,969	2,873	2,969	2,873	2,969
day	$10.00	Techs	1.4	Acute								2,474	2,474	2,394	2,474	2,394	2,474
even	$11.00	Techs	1.4	Acute								2,721	2,721	2,633	2,721	2,633	2,721
night	$12.00	Techs	1.4	Acute								2,969	2,969	2,873	2,969	2,873	2,969
addon	$45.00	Clinical Dir	1.0	Acute		7,952	7,182	7,952	7,695	7,952	7,695	7,952	7,952	7,695	7,952	7,695	7,952
	$35.00	Program Dir	2.0	Acute		12,369	11,172	12,369	11,970	12,369	11,970	12,369	12,369	11,970	12,369	11,970	12,369
day	$25.00	R.N.'s/U.M.	4.2	Acute		18,554	16,758	18,554	17,955	18,554	17,955	18,554	18,554	17,955	18,554	17,955	18,554
even	$27.00	R.N.'s/U.M.	4.2	Acute		20,038	18,099	20,038	19,391	20,038	19,391	20,038	20,038	19,391	20,038	19,391	20,038
night	$30.00	R.N.'s/U.M.	4.2	Acute		22,264	20,110	22,264	21,546	22,264	21,546	22,264	22,264	21,546	22,264	21,546	22,264
day	$25.00	R.N.'s/U.M.	1.4	Acute		6,185	5,586	6,185	5,985	6,185	5,985	6,185	6,185	5,985	6,185	5,985	6,185
even	$27.00	R.N.'s/U.M.	1.4	Acute		6,679	6,033	6,679	6,464	6,679	6,464	6,679	6,679	6,464	6,679	6,464	6,679
night	$30.00	R.N.'s/U.M.	1.4	Acute		7,421	6,703	7,421	7,182	7,421	7,182	7,421	7,421	7,182	7,421	7,182	7,421
day	$25.00	R.N.'s/U.M.	1.4	Acute							5,985	6,185	6,185	5,985	6,185	5,985	6,185
even	$27.00	R.N.'s/U.M.	1.4	Acute							6,464	6,679	6,679	6,464	6,679	6,464	6,679
night	$30.00	R.N.'s/U.M.	1.4	Acute							7,182	7,421	7,421	7,182	7,421	7,182	7,421
day	$18.00	L.V.N.	1.4	Acute		4,453	4,022	4,453	4,309	4,453	4,309	4,453	4,453	4,309	4,453	4,309	4,453
even	$18.00	L.V.N.	1.4	Acute		4,453	4,022	4,453	4,309	4,453	4,309	4,453	4,453	4,309	4,453	4,309	4,453
night	$18.00	L.V.N.	1.4	Acute		4,453	4,022	4,453	4,309	4,453	4,309	4,453	4,453	4,309	4,453	4,309	4,453

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day	$18.00	L.V.N.	1.4	Acute					4,309	4,453	4,309	4,453	4,453	4,309	4,453	4,309	4,453
even	$18.00	L.V.N.	1.4	Acute					4,309	4,453	4,309	4,453	4,453	4,309	4,453	4,309	4,453
night	$18.00	L.V.N.	1.4	Acute					4,309	4,453	4,309	4,453	4,453	4,309	4,453	4,309	4,453
	$25.00	OP Therapist	1.0	OP		4,418	3,990	4,418	4,275	4,418	4,275	4,418	4,418	4,275	4,418	4,275	4,418
	$22.00	Mktg Mgr	1.0	Acute		3,887	3,511	3,887	3,762	3,887	3,762	3,887	3,887	3,762	3,887	3,762	3,887
	$10.00	OP Tech	1.0	Acute		1,767	1,596	1,767	1,710	1,767	1,710	1,767	1,767	1,710	1,767	1,710	1,767
day	$25.00	Therapist	1.0	Acute		4,418	3,990	4,418	4,275	4,418	4,275	4,418	4,418	4,275	4,418	4,275	4,418
day	$25.00	Therapist	1.0	Acute		4,418	3,990	4,418	4,275	4,418	4,275	4,418	4,418	4,275	4,418	4,275	4,418
day	$25.00	Therapist	1.0	Acute		4,418	3,990	4,418	4,275	4,418	4,275	4,418	4,418	4,275	4,418	4,275	4,418
day/even	$25.00	Therapist	1.0	Acute		4,418	3,990	4,418	4,275	4,418	4,275	4,418	4,418	4,275	4,418	4,275	4,418
day/even	$25.00	Therapist	1.0	Acute				4,418	4,275	4,418	4,275	4,418	4,418	4,275	4,418	4,275	4,418
day	$18.00	RT	1.0	Acute		3,181	2,873	3,181	3,078	3,181	3,078	3,181	3,181	3,078	3,181	3,078	3,181
day	$18.00	RT	1.0	Acute		3,181	2,873	3,181	3,078	3,181	3,078	3,181	3,181	3,078	3,181	3,078	3,181
		Totals	76.0			197,904	178,752	202,322	216,623	223,844	236,254	252,292	252,292	244,154	252,292	244,154	252,292
				PTO's	6.00%	11,874	10,725	12,139	12,997	13,431	14,175	15,138	15,138	14,649	15,138	14,649	15,138
						1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
				FTE's	worked	47.6	47.6	47.6	51.8	51.8	56.8	51.8	51.8	51.8	51.8	51.8	51.8
				EPOB		1.23	1.18	1.17	1.18	1.16	1.07	1.07	1.03	1.01	1.03	0.98	0.99
Non-Clinical																		
	rate		FTE's															
day	$72.12	Admin	1.0			12,743	11,510	12,743	12,332	12,743	12,332	12,743	12,743	12,332	12,743	12,332	12,743
day	$20.00	Admin Sec	1.0			3,534	3,192	3,534	3,420	3,534	3,420	3,534	3,534	3,420	3,534	3,420	3,534
day	$40.00	Controller	1.0			7,068	6,384	7,068	6,840	7,068	6,840	7,068	7,068	6,840	7,068	6,840	7,068
day	$30.00	BO mgr	1.0			5,301	4,788	5,301	5,130	5,301	5,130	5,301	5,301	5,130	5,301	5,130	5,301
day	$17.50	BO Clerks	1.0			3,092	2,793	3,092	2,993	3,092	2,993	3,092	3,092	2,993	3,092	2,993	3,092
day	$25.00	med rec supr	1.0			4,418	3,990	4,418	4,275	4,418	4,275	4,418	4,418	4,275	4,418	4,275	4,418
day	$15.00	Medical Rec	1.0			2,651	2,394	2,651	2,565	2,651	2,565	2,651	2,651	2,565	2,651	2,565	2,651
day	$17.50	Bo Biller	1.0			3,092	2,793	3,092	2,993	3,092	2,993	3,092	3,092	2,993	3,092	2,993	3,092
day	$24.00	Marketing	3.5			14,843	13,406	14,843	14,364	14,843	14,364	14,843	14,843	14,364	14,843	14,364	14,843
day	$20.00	Admin Sec	1.0			3,534	3,192	3,534	3,420	3,534	3,420	3,534	3,534	3,420	3,534	3,420	3,534
day	$23.00	OP Director	1.0			4,064	3,671	4,064	3,933	4,064	3,933	4,064	4,064	3,933	4,064	3,933	4,064
day	$10.00	Recept	2.8			4,948	4,469	4,948	4,788	4,948	4,788	4,948	4,948	4,788	4,948	4,788	4,948
day	$40.00	Nurse Admin	1.0			7,068	6,384	7,068	6,840	7,068	6,840	7,068	7,068	6,840	7,068	6,840	7,068
day	$12.00	Dietary	4.0			8,482	7,661	8,482	8,208	8,482	8,208	8,482	8,482	8,208	8,482	8,208	8,482
day	$30.00	Utilization Rev	2.0			10,602	9,576	10,602	10,260	10,602	10,260	10,602	10,602	10,260	10,602	10,260	10,602
day	$24.00	Admissions	1.0			4,241	3,830	4,241	4,104	4,241	4,104	4,241	4,241	4,104	4,241	4,104	4,241
day	$24.00	Admissions	1.0			4,241	3,830	4,241	4,104	4,241	4,104	4,241	4,241	4,104	4,241	4,104	4,241
day	$24.00	Admissions	1.5			6,361	5,746	6,361	6,156	6,361	6,156	6,361	6,361	6,156	6,361	6,156	6,361
	$25.00	HR	1.0			4,418	3,990	4,418	4,275	4,418	4,275	4,418	4,418	4,275	4,418	4,275	4,418
day	$12.50	HR	1.0			2,209	1,995	2,209	2,138	2,209	2,138	2,209	2,209	2,138	2,209	2,138	2,209
day	$30.00	OAfinfctr	1.0			5,301	4,788	5,301	5,130	5,301	5,130	5,301	5,301	5,130	5,301	5,130	5,301
day	$15.00	Maint	1.0			2,651	2,394	2,651	2,565	2,651	2,565	2,651	2,651	2,565	2,651	2,565	2,651
day	$12.00	Maint	1.0			2,120	1,915	2,120	2,052	2,120	2,052	2,120	2,120	2,052	2,120	2,052	2,120
			31.8			126,979	114,691	126,979	122,883	126,979	122,883	126,979	126,979	122,883	126,979	122,883	126,979
									2FTES	2FTES							
				PTO's	6.00%	7,619	6,881	7,619	7,373	7,619	7,373	7,619	7,619	7,373	7,619	7,373	7,619
				FTE's	worked	22.3	22.3	22.3	22.3	22.3	22.3	22.3	22.3	22.3	22.3	22.3	22.3
			Total	FTE's	paid	74.1	74.1	74.1	78.5	78.5	78.5	78.5	78.5	78.5	78.5	78.5	78.5
			Total	FTE's	worked	69.9	69.9	69.9	74.1	74.1	74.1	74.1	74.1	74.1	74.1	74.1	74.1
			Total	EEPOB	paid	1.91	1.84	1.82	1.79	1.76	1.62	1.62	1.56	1.53	1.56	1.49	1.50
			Total	EEPOB	worked	1.81	1.74	1.72	1.68	1.66	1.53	1.53	1.47	1.45	1.47	1.40	1.42
				Hourly rate paid		$26.30	$26.30	$26.66	$26.79	$26.79	$28.34	$28.97	$28.97	$28.97	$28.97	$28.97	$28.97
				ADC		36.7	40.3	40.6	44.0	44.5	48.4	48.4	50.3	51.2	50.3	52.8	52.3
Employee Benefits																		
Include Workers Comp		25.0%				86,094	77,762	87,265	89,989	92,968	95,171	100,507	100,507	97,265	100,507	97,265	100,507

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Professional Fees														
H & P's	Per Admit	1	0	0	0	0	0	0	0	0	0	0	0	0
			0	0	0	0	0	0	0	0	0	0	0	0
	0.0 All Inclusives		0											0
	$0 RTC rounds		0											0
Medical Dir.	$0.00 per ADC		12,500	12,500	12,500	12,500	12,500	12,500	12,500	12,500	12,500	12,500	12,500	12,500
Total Prof Fees			12,500	12,500	12,500	12,500	12,500	12,500	12,500	12,500	12,500	12,500	12,500	12,500
Advertising/Media			10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000
Purchased Services														
Lab	$10.00	PPD	12,000	11,280	12,600	13,200	13,800	14,520	15,000	15,600	15,360	15,600	15,840	16,200
E/R, X-Rays, EKG etc....	$4.25	PPD	5,100	4,794	5,355	5,610	5,865	6,171	6,375	6,630	6,528	6,630	6,732	6,885
Linen	$7.00	PPD	8,400	7,896	8,820	9,240	9,660	10,164	10,500	10,920	10,752	10,920	11,088	11,340
Housekeeping	$9.00	PPD	5,417	2,083	3,750	3,750	3,750	3,750	3,750	3,750	5,417	5,417	5,417	5,417
Transcription														
Dietary	$0.00	PPD	0	0	0	0	0	0	0	0	0	0	0	0
Grounds			1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Pharmacist			5,000	3,000	3,000	3,000	3,000	3,000	5,000	5,000	5,000	5,000	5,000	5,000
Legal			2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000
EMR			2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000
PhD														
ADP/Accounting Fees			2,125	2,125	2,125	2,125	2,125	2,125	2,125	2,125	2,125	2,125	2,125	2,125
Other			0	0	0	0	0							0
			43,042	36,178	40,650	41,925	43,200	44,730	47,750	49,025	50,182	50,692	51,202	51,967
Recruitment			3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000
		ADC	38.7	40.3	40.6	44.0	44.5	48.4	48.4	50.3	51.2	50.3	52.8	52.3
Food and Supplies $														
- General Supplies	$10.00	PPD	12,000	11,280	12,600	13,200	13,800	14,520	15,000	15,600	15,360	15,600	15,840	16,200
- Food	$10.00	PPD	12,000	11,280	12,600	13,200	13,800	14,520	15,000	15,600	15,360	15,600	15,840	16,200
- Pharmaceuticals	$26.00	PPD	31,200	29,328	32,760	34,320	35,880	37,752	39,000	40,560	39,936	40,560	41,184	42,120
- Linen	$0.00	PPD	0	0	0	0	0	0	0	0	0	0	0	0
- Other	$0.00	PPD	0	0	0	0	0	0	0	0	0	0	0	0
Total			55,200	51,888	57,960	60,720	63,480	66,792	69,000	71,760	70,656	71,760	72,864	74,520
Travel			7,500	7,500	7,500	7,500	7,500	7,500	7,500	7,500	7,500	7,500	7,500	7,500
Repairs	Van & Building	$2.00 PPD	2,400	2,256	2,520	2,640	2,760	2,904	3,000	3,120	3,072	3,120	3,168	3,240
Rent / Lease														
- Buildings	$0 a year		0	0	0	0	0	0	0	0	0	0	0	0
- Equipment	Copiers & Fax		2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000
Total			2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000
Insurance														
-Prof. Liab		PPD	4,000	4,000	4,000	4,000	4,000	4,000	4,000	4,000	4,000	4,000	4,000	4,000
-Auto/Buildings/General			0	0	0	0	0	0	0	0	0	0	0	0
Total			4,000	4,000	4,000	4,000	4,000	4,000	4,000	4,000	4,000	4,000	4,000	4,000
Utilities	Includes Gas - Vans & Mobile phones		13,550	9,000	10,000	11,000	12,000	13,000	13,550	13,550	13,550	13,550	13,550	13,550

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Bad Debt	3.0%	% net revenue	22,628	21,455	23,885	24,963	26,130	27,423	28,285	29,362	28,931	29,362	29,793	30,440
Property Taxes	Building, Van & Equipment		5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000
Other Expenses														
-Patient Awards	$1.00	PPD	1,200	1,128	1,260	1,320	1,380	1,452	1,500	1,560	1,536	1,560	1,584	1,620
-Field Trips	$0.00	PPD	0	0	0	0	0	0	0	0	0	0	0	0
-Clothing	$0.00	PPD	0	0	0	0	0	0	0	0	0	0	0	0
-Other	$0.00	PPD	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Dues														
Total			2,200	2,128	2,260	2,320	2,380	2,452	2,500	2,560	2,536	2,560	2,584	2,620

SBH-KINGSPORT 001777

Market: Kingsport, TN

	Agency	Contact Name	Contact Title	Meeting Date	Notes
Med/Surg	Wellmont Health System	Sue Lindenbusch	VP	10/10/2013	10/10 we have been looking for an internal solution for psych - would like to find a way to get psych patients out of the ERs - didn't say this, but anything that hurts MSHA helps Wellmont
SNF	Brookhaven Manor	Jessica Woodward	DON		1/6 LM for Jessica Woodward with Rebecca Taylor
	The Wexford House	Amy Gregory	DON		1/6 spoke to Amy Gregory (DON) and she said they are owned by Wellmont and she will need to run it past her administrator
	Ashbury Place at Kingsport	Lois Agnew?	DON		1/6 LM for Lois Agnew (DON)
	Holston Manor		DON		1/6 LM for DON
	Wellington Place of Colonial Heights	Spring Thompson / Donna Souder	Administrator / DON	1/15/2014	1/6 set mtg with Spring and Donna for 1/15 at 1pm -- Spring told me "we have no help with psych since everything closed" and "Woodridge won't take our treatment patients so we have no options except to send out to Greenville" -- 1/15 called and said there was a outbreak and needed to cancel - told me to email her and she would try to get her corporate to allow her to write LOS - I emailed on 1/15 --- 1/22 LM for Spring --- 1/27 she is waiting to hear back from corporate and should know by wednesday, 1/29 - said if I dont hear from her by wednesday afternoon to call her for an update. -- 1/30 LM -- 2/4 LM -- 2/11 LM
	NHC Healthcare	Preston Adams / Scott Flemmer	Administrator / DON	10/9/2013	10/9 we have a hard time getting patients placed in psych - we would utilize psych services more and not try to manage in house if we had a good partner - they get most of their patients from MSHA so he is reluctant to write a LOS but if they didn't get cranky he would write and essay
Private Practice	GracePointe Counseling Center	Denise Tynes	Owner		1/6 LM --- 1/8 LM
	Cognitive Behavioral Therapists of Tri-Cities	Cheri Baird	Therapist	1/14/2014	1/6 Meeting set with Claudell Williams for 1/14 at 2:15pm -- 1/14 confirmed need and said she would write LOS
	Cognitive Behavioral Therapists of Tri-Cities	Kristy Beach-Collebs	Therapist	1/14/2014	1/6 Meeting set with Claudell Williams for 1/14 at 2:15pm -- 1/14 confirmed need and said she would write LOS
	Cognitive Behavioral Therapists of Tri-Cities	Harold Leonard	Therapist	1/14/2014	1/6 Meeting set with Claudell Williams for 1/14 at 2:15pm -- 1/14 confirmed need and said he would write LOS
	The Journey Center	Sybil Smith	Therapist	10/9/2013	10/9 said that there is a great need for additional services, especially for youth - Woodridge only does walk ins 8am-4pm M-F - her patients tell her that it is very scary to walk into Woodridge - said Frontier is the only TennCare provider - said that all of SW Virginia comes to Kingsport for treatment and occasionally gets clients from Kentucky - would be happy to write LOS
Mental Health Centers	King University Counseling Center	Chuck Thompson		1/15/2014	1/6 mtg was set with Diane for 1/15 at 9:30am will have an intern from ETSU Johnson -- 10/15 had to reschedule - call to do overview and ask for LOS
	Frontier Health	Stephanie	Crisis Response Team	10/10/2013	10/10 said they really only have Woodridge to work with and they sometimes need to send patients as far as Chatanooga
	Frontier Health	Teresa Kidd / Randall Jessee	VP / VP	10/10/2013	10/10 they are on contract to have MAT to ER's within 2 hours - they have a 15 bed CSU and a IP CD program so they are not an advocate of ours - they must take all payors
State Mental Health Division	TN Department of Mental Health & Substance Abuse	John Arapedondo	Assistant Commissioner of Hospital Services Division	1/2/2014	1/2 Phone Call - discussed our project and he said that the Department's response will do to the HSDA
Medicaid	TennCare	Mary Shelton	Director of Behavioral Health Operations	1/9/2014	1/9 said that they need additional resources especially in youth - will be able to contract with us for adult Medicaid
State Licensing					
Social Services	TN Department of Children's Services	Lucretia Sanders / Deborah Fabr	Regional Administrator / Psychologist	10/10/2013	10/10 we would love to have more beds here - we would definitely support you - we would want to get a contract with you for custodial kids - if we can't get a kid into Woodridge we need to send them all the way to Knoxville - they currently have 30 kids in care -- 1/22 said she was at a conference and would call me back --- 1/23 said to email her the template and she would try to get the letter written and sent by tomorrow - I emailed -- 1/27 said I would have it today
Juvenile Justice					
Economic Development	City of Kingsport - Development	John Campbell	City Manager	1/15/2014	1/15 met with him and he agrees there is a need - also confirmed we have picked a great site -- 1/22 LM with Joy for him to call me to talk about discussing our project with the Police Chief for the LOS --- 1/27 LM about his meeting with the police chief this afternoon - called me back and said that he would like to see our indigent care data for the company and that Andy Hall (government relations with Wellmont) said they they are neutral on our CON
	City of Kingsport - Development	Jeff Fleming	Assistant City Manager	1/15/2014	1/3 LM with his assistant (Paige Jeffers) -- 1/6 left VM -- 1/7 will join the meeting with the Mayor on 1/15 at 2:30pm -- 1/15 met with him and he confirmed the need - said he would promise to expedite our process of approvals
Law Enforcement	Johnson City Police Department	Mitch Perry	CIT Sgt	10/10/2013	10/10 MSHA has a monopoly - they push everyone out who tries to enter market - Frontier's CSU is more of a headache than an asset for us - there is definitely a need for additional services in this area - his officers can not legal someone, only the Frontier MAT can (title 33) - they avg 35 mental health transports per month - we would need to be in city limits for them to write LOS closest state facility is in Chatanooga - lots of need for substance abuse services - we would have no problem staffing the place
	Kingsport Police Department	Dale Phipps	Deputy Chief		1/3 - left VM -- has me meeting with Jason Bellamy instead

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14 7/27/15
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	Kingsport Police Department	Jason Buchanan	Operations Captain	1/14/2014	1/3 set meeting for 1/14 at 11:30am -- confirmed need and will write LOS -- 1/20 LM -- 1/22 emailed and said he has given all the info to his Chief and he will write the letter after he talks to the City Manager - LM with him saying I called John Campbell and still need the data from Lt. Quillin -- 1/23 confirmed that the chief is writing the letter and should have it to me in the next few days -- 1/27 LM -- he emailed to say the chief has a meeting with John Campbell this afternoon and will discuss the LOS - also said he would update me after -- received letter from the Chief
	Kingsport Police Department	Justin Quillin	Lieutenant - Jail	1/14/2014	1/3 set meeting for 1/14 at 11:30am -- confirmed need and will write LOS
	Sullivan County Sheriff's Office	Lisa Christian	Chief Deputy	1/15/2014	1/16 confirmed the need and will write LOS -- 1/22 LM -- 1/23 confirmed she will have the letter signed today and out in the mail to me by the end of the week. -- 1/27 called me back and said it is on the Sheriff's desk for signature. -- 1/31 emailed Lisa for an update -- 2/4 LM -- 2/10 received LOS
Courts					
School District	Johnson City Schools	Linda Snyder	Director of Student Services	10/10/2013	10/10 phone call - says that there are 17 thera putic counselors contracted through Frontier (federal grant) - the site on the board of Frontier and they do not need someone to replicate what Frontier is doing - says they get kids from crisis to placement very fast
	Kingsport City Schools	Lenore Kilgore	Director of Special Education	1/14/2014	1/14 met with the team and they confirmed need and said that we could get a LOS from the School District -- 1/20 LM -- 1/22 emailed and said I need to call Dory Creech to set call with her to discuss project and LOS
	Kingsport City Schools	Helen Cheuvront	Early Childhood & Special Ed Coordinator	1/14/2014	1/14 met with the team and they confirmed need and said that we could get a LOS from the School District
	Kingsport City Schools	Kathy Keller	School Health Coordinator	1/14/2014	1/14 met with the team and they confirmed need and said that we could get a LOS from the School District
	Kingsport City Schools	Dory Creech	Assistant Superintendent	1/14/2014	1/3 - Left message with Vivian Ahlum (assistant to superintendent) and requested a call back and a meeting -- set meeting with Nancy Green (assistant) for 1/14 at 1pm -- 1/22 LM to set up call with her and the superintendent -- 1/24 said her attorney said they couldn't do the letter but will support us without being formal about it. -- I emailed her to make sure my statement was ok.
Local Government	City of Kingsport	Dennis Phillips	Mayor	1/15/2013	1/3 - LM with Renee McArthur asking for meeting -- 1/6 set mtg with Renee for 1/15 at 2:30pm - she will invite Jeff Fleming -- 1/15 met with Mrs and discussed the project - he confirmed the need and said he needs to make sure the police and sheriff agree before he writes the LOS -- 1/20 LM -- 1/22 LM -- 1/23 Renee called me back to say that she is drafting the letter and should have it signed today. - 1/29 received letter
County Psych Hospitals					
Colleges / Universities	ETSU - School of Psychiatry	Dr. Hal Elliott	Psychiatric Residency Program Director		1/3 - LM with Shana Price asking for meeting -- 1/7 VM for Shana Price and another VM for Dr. Elliott -- 2/11 spoke to Dr. Elliott and Dr. McCarley - they said there is definitely a need and they are interested in finding an additional place to send residents - Dr. McCarley said she is the medical director over the cba unit at Woodridge and she is still wanting to support us. they said Indian Path closed not due to a lack of need but due to joint commission problems. Both are willing to write a LOS after they go through their certification in March - didnt want to do anything prior to that because they dont want MSHA to sabotage their survey. -- 3/25 emailed to ask for the LOS
	ETSU - School of Psychiatry	Dr. JD McCarley	Associate Program Director in the Psychiatry Residency Program		2/11 spoke to Dr. Elliott and Dr. McCarley - they said there is definetely a need and they are interested in finding an additional place to send residents - Dr. McCarley said she is the medical director over the cba unit at Woodridge and she is still wanting to support us. they said Indian Path closed not due to a lack of need but due to joint commission problems. Both are willing to write a LOS after they go through their certification in March - didnt want to do anything prior to that because they dont want MSHA to sabotage their survey. -- 3/25 emailed to ask for the LOS
	ETSU - School of Psychiatry	Dr. Paul Stanton	Chair		Meeting scheduled for 5/1
	ETSU Center of Excellence for Children in State Custody	Dr. Michele Mercer	Director		4/15 emailed to set up meeting -- 4/30 LM and emailed
	King University - School of Nursing	Robin Foreman	Professor for M+I Courses / Set up clinical rotations	1/15/2014	1/6 LM with Trish Sale (assistant in nursing office) -- 1/7 VM -- 1/8 set mtg for 1/15 at 9am -- 10/15 met with Robin and she said she definitely believes there is a need -- said that she would write a personal LOS and ask the university if it is ok to put another LOS on King letterhead -- 1/29 said she will work on in tomorrow and get it to me ASAP -- 1/31 received the LOS and she is mailing me the signed copy

LOS	Agency	Contact Name	Contact Title	Notes
Y	Cognitive Behavioral Therapists of Tri-Cities	Cheri Bond	Therapist	3/28 LM & emailed -- 4/1 responded to say that they couldn't make it -- 5/8 talked with Claudele and she will have them call me next week -- 5/29 Claudele said they will not be able to come but wish us good luck
Y	Cognitive Behavioral Therapists of Tri-Cities	Kristy Roach-Collebs	Therapist	3/28 LM & emailed -- 4/1 responded to say that they couldn't make it -- 5/8 talked with Claudele and she will have them call me next week -- 5/29 Claudele said they will not be able to come but wish us good luck
Y	Cognitive Behavioral Therapists of Tri-Cities	Harold Leonard	Therapist	3/28 LM & emailed -- 4/1 responded to say that they couldn't make it -- 5/8 talked with Claudele and she will have them call me next week -- 5/29 Claudele said they will not be able to come but wish us good luck
Y	The Journey Center	Sybil Smith	Therapist	3/28 emailed -- 4/1 responded to say that she couldn't make it -- 5/8 LM -- 5/29 LM -- 6/2 said she wants to come and will let me know by the end of this week if she will be able to make it.
Y	TN Department of Children's Services	Lucretia Sanders / Deborah Fehr	Regional Administrator / Psychologist	3/28 emailed -- 5/8 asked me to call her back tomorrow -- 5/9 said she cant come and that nobody within the Department will be able to due to possible conflict of interest.
	Kingsport Police Department	Jason Bellamy	Operations Captain	5/8 LM
	Kingsport Police Department	Justin Quillin	Lieutenant - Jail	
Y	Kingsport Police Department	David Quillin	Police Chief	5/8 LM with Terrie and emailed Terrie asking for a phone call with the Chief -- 5/29 Terrie said he was out of the office and I emailed her to forward to him -- 6/9 talked to Chief Quillin and he said he is coming to Nashville and he will pay his own way - I just need to email him the details of where it is and when - emailed
	Sullivan County Sheriff's Office	Lisa Christian	Chief Deputy	5/8 LM -- 5/27 LM
Y	Sullivan County Sheriff's Office	Wayne Anderson	Sheriff	5/29 John Campbell told me he talked to Sheriff Anderson and he told him he probably wont come because Elliott Moore asked him not to
Y	Kingsport City Schools	Dory Creech	Assistant Superintendent	5/8 LM -- 5/29 LM
Y	City of Kingsport	Dennis Phillips	Mayor	3/28 emailed -- Can not come but suggested I talk to John Campbell about getting others to come
	City of Kingsport	John Campbell	City Manager	3/28 emailed -- 5/8 LM -- 5/29 told me he gave police chief approval to come and heard that sheriff was told by Elliott Mobre not to come - he will call the superintendent - also suggested I call Clay Walker from economic development 615-878-5182
	City of Kingsport	Jeff Fleming	Assistant City Manager	5/28 emailed -- 5/8 LM - 5/27 LM
	Networks Sullivan Partnership	Clay Walker	CEO	3/29 he will call me back today - called back and said he will try to encourage the community stakeholders to come to Nashville -- 6/9 LM to get update if he made any progress
	ETSU - School of Psychiatry	Dr. Hal Elliott	Psychiatric Residency Program Director	3/28 LM with Shana Price - she will call me on my cell on Monday and let me know if they can do a call on Tuesday
	ETSU - School of Psychiatry	Dr. Jill McCarley	Associate Program Director in the Psychiatry Residency Program	5/27 she changed her mind and said she doesn't start with the VA until July so she might be able to come to Nashville and speak for us. Touch base with her next week -- 6/2 LM -- 6/5 text her and she said to call Dr. Stanton just as a routine check in and that she is going to talk to Hal Elliott and make a decision if she will come
	ETSU - School of Psychiatry	Dr. Paul Stanton	Chair	Meeting scheduled for 5/1 -- 6/3 LM with Janice to see if he would be open to a call - she responded and said they are still neutral
	ETSU - Center of Excellence for Children in State Custody	Dr. Michele Moser	Director	4/15 emailed to set up meeting
Y	King University - School of Nursing	Robin Foremen	Professor for MH Courses / Sets up clinical rotations	3/28 emailed -- 5/29 LM and emailed -- called back to confirm she will come and testify (will bring her husband) and call me tomorrow to confirm after she talks to her husband -- 6/2 called me to confirm she is coming to the CON meeting
	NAMI of TN	Richard Baxter	President	4/1 emailed -- 5/8 would be willing to come but suggested I get a local person (Todd Jablonski) to come
	NAMI of TN	Todd Jablonski	Regional Contact	5/8 emailed overview and LOS's - will be willing to come but wants to make sure it is ok with the NAMI board first -- 5/29 said he talked to board and founder and they said he cant testify and need to stay neutral
	NAMI of VA	Judy Salyer	Regional Contact	5/8 emailed overview and LOS's - will be willing to come but wants to make sure it is ok with the NAMI board first
Y	Town of Gate City	Greg Jones	Town Manager	5/21 had dinner with him and he said that he would get a city decree and be at the hearing -- 5/27 give him a call on Tuesday 6/3 and he should have more info -- 6/3 emailed to say he will have the resolution tomorrow afternoon and I asked him to confirm that he and Chief Fink are still coming to Nashville -- 6/4 said he will have the signed decree today and confirmed that both him and Scott Fink are coming to Nashville - I need to email him the details -- 6/10 will have the resolution signed tonight and sent to me tomorrow
	Gate City Police Department	Scott Fink	Police Chief	5/21 had dinner with him and he said that he would get a city decree and be at the hearing -- 5/29 LM -- 6/4 Greg Jones confirmed that he and Scott Fink are coming to Nashville - need to email him the details
Y	Scott County Department of Social Services	Luanna McMurray	Interim Director	5/21 wrote LOS but said that she probably wont be able to make it to Nashville
Y	Scott County Sheriff's Office	John Puckett	Sheriff	5/21 will write LOS and either him or a representative will come to Nashville -- 5/29 will have me the LOS either tomorrow or Monday and will have Jeff Thacker (423) 863-3100 come to Nashville -- 6/1 received LOS
	Scott County Sheriff's Office	Jeff Thacker	Deputy	5-29 Jeff confirmed he will be there and asked that we email him the hotel reservation
Y	Scott County Public Schools	Jason Smith	Personnel & Middle School Director	5/21 will check with superintendent to get approval to write LOS and try to attend meeting in Nashville -- 5/29 emailed me to say that he is trying to get permission from superintendent to come to Nashville -- 6/3 received the LOS from the Superintendent and confirmed with Jason that he will be attending the meeting - need to send him hotel info
	Scott County Public Schools	Brenda Robinette	Supervisor of Special Education	5/21 will check with superintendent to get approval to write LOS and try to attend meeting in Nashville -- 6/3 she said she is getting the letter and will email me with who is going to attend the CON meeting
Y	Youth Villages	Randi Shearer	Program Supervisor - Specialized Crisis Services	5/21 will write LOS and either her or a representative will come to Nashville -- 5/29 LM -- 6/2 said she will have the LOS to me by tomorrow and that the Youth Villages Rep that will come to the hearing will be from Nashville and she will get me that info too -- 6/9 she said she will reach out again to Dawn and let me know at some point tomorrow

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	Touch Villages	Dawn Punter	Program Director	6/4 wait to see if she calls by Friday and if not then call her - 6/11 LM and emailed
Y	Hawkins County Schools	Erika Phillips	Coordinator of School Health	5/22 will write LOS and try to come to Nashville -- 5/29 LM -- 6/3 said she should have an answer on the LOS by Friday and if I haven't heard from her to call her Friday - I also emailed her the LOS from Kingsport, Eze, Scott -- 6/6 she will not be able to make the COH meeting but is waiting to get the LOS approved and will mail it to me. -- 6/10 talked with director Britton's assistant who said she will track down the letter and call me back. - 6/11 emailed me the LOS
	Hawkins County Schools	Angela Jackson	Director of Special Education	
Y	Hawkins County Sheriff's Department	James Woods	Lieutenant - Courts / Transportation	5/21 wrote LOS -- 5/2 LM
Y	Church Hill PoSee Department	Mark Johnson	Police Chief	5/29 wrote LOS -- 6/2 LM
Y	Hawkins County Juvenile Judge	Daniel Boyd	Juvenile Judge	5/29 LM -- 6/2 no answer -- 6/3 told to call back tomorrow at 7:30am -- 6/4 LM with his assistant -- 6/6 said he will write a LOS and try to get a representative from the court to come to Nashville -- 6/10 his assistant will have him call me -- received LOS
Y	Family Advocate	Callie Faircloth	Mother of MH Patient	5/23 will write LOS and try to come to Nashville -- 5/29 will get me LOS by Monday -- her and her husband (Green) will be coming to Nashville and I told her I would email her the hotel reservation and would reimburse for mileage and food -- 6/10 said she would email me to letter tonight and that I should respond with comments so she can scan me the signed copy by 6/11
Y	Lee County Schools	Michele Gamble	School Psychologist	5/22 will write LOS and try to come to Nashville -- 5/29 received LOS -- 6/2 will let me know by Friday if she can come -- 6/3 said she can not make it to Nashville and I responded to ask if there is anyone else from the district that can come
	Lee County Schools	Vickie Brown	Special Education Director	6/16 emailed to ask if she could come to the hearing and she said she can not
Y	Scott / Lee County Juvenile Justice	Troy Funkhouser	Court Service Unit Supervisor	6/4 has made the request to write LOS through JJS headquarters in Richmond - if I don't hear back from him then call on 6/11 -- 6/10
	Lee County Department of Social Services	Julie Johnson		5/22 they support us and will look into writing LOS -- 6/3 out today but call back tomorrow -- 6/3 LM
Y	Lee County Department of Social Services	Kelle Gambrel		5/22 they support us and will look into writing LOS -- 5/27 said she will call me tomorrow to let me know after she talks to Julie -- 6/5 received the LOS -- 6/9 thanked her for LOS and she said neither her or Julie Johnson can not make it to Nashville
	Lee County CMH Board	Dr. Wandaleen Adams		
	Lonesome Pine Office on Youth	Glenda Collins		5/22 met at Lee County Stakeholder Meeting -- 6/3 LM
Y	Lee County Sheriff's Office	Gary Parsons	Sheriff	5/22 will write LOS -- 6/2 his assistant said he wrote the letter and will make sure it got mailed and will have him call me to talk about coming to Nashville -- 6/3 traded voicemails -- 6/4 told me he cant not come but is going to see if he can send someone else from the department and will get back to me by the end of the week -- 6/10 had one of his deputy's call me and he will call me back tomorrow to let me know if they are coming
	Lee County Sheriff's Office	Taylor Scott	Captain	
	Lee County Protective Services	Alexis Carson		5/22 met at Lee County Stakeholder Meeting - she can not come to COH because of her dissertation
	Camelot Care	Andy Kitzmiller	VP	6/3 said he will call me later this week to set up a conference call with his team for next week and said he is in support of additional MH services in East TN -- 6/9 LM -- 6/10 LM and emailed -- set call for 6/13 at 3pm CST -- 6/11 said he will get the LOS written -- 6/16 LM to see about coming to Nashville
Y	Camelot Care	Chris Beach	COO	6/11 received LOS
	Family Advocate	Doug Messer	Family Advocate / Pastor	6/11 Angela Jackson with Hawkins County Schools suggested I call her pastor as a family advocate - LM - 6/16 LM

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PATIENT FLOW SHEET

CENSUS: 68

DATE: 8/1/14

TIME: 8:30 am

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16 (1 c-bed)	25	8	5
Blocked Rooms	~~0~~	~~0~~	1 private	~~0~~	1 private
Beds Available	~~0~~	1 male	~~0~~	6	6

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
~~0~~						

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PATIENT FLOW SHEET

CENSUS: 62

DATE: 8-2-14

TIME: 8:30

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	10	14	24	8	4
Blocked Rooms	0	1	0	0	1
Beds Available	2	1	2	6	7

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
0						

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PATIENT FLOW SHEET

CENSUS: 65

DATE: 8-3-14

TIME: 7:45

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	13	15	24	8	5
Blocked Rooms	~~0~~	513B-1	~~0~~	~~0~~	317B 1
Beds Available	1	~~0~~	2	6	6

Name of Patient Waiting ~~0~~	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)

MSHA-001443

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PATIENT FLOW SHEET

CENSUS: 67

DATE: 8/4/14

TIME: 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	11	15	25	10	6
Blocked Rooms	613A	513B	Q	Q	317B
Beds Available	2	Q	1F	4	5

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
	Takoma	M	27	8 hrs	Cedar	

MSHA-001444

SBH-KINGSPORT 001785

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PATIENT FLOW SHEET

CENSUS: 68

DATE: 8/5/14

TIME: 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	13	16	17	14	8
Blocked Rooms	613B	513B	0	0	317B, 318B
Beds Available	0	0	9	0	2

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)

MSHA-001445

SBH-KINGSPORT 001786

PATIENT FLOW SHEET

CENSUS: 65

DATE: 8/6/14

TIME: 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	13	15	19	12	6
Blocked Rooms	613B	513B	Ø	Ø	317B
Beds Available	1F	Ø	7	2	5

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
Ø						

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PATIENT FLOW SHEET

CENSUS: 69

DATE: 8/07/14

TIME: 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	13	12	24	11	9
Blocked Rooms	0	0	230B	0	313B 317B
Beds Available	1	4	0	3	1

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
0						

MSHA-001447

SBH-KINGSPORT 001788

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PATIENT FLOW SHEET

CENSUS: 74

DATE: 8/8/14

TIME: 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	13	16	24	12	9
Blocked Rooms	Ø	Ø	230 A B	Ø	3
Beds Available	1F	Ø	Ø	412B m 413B m	Ø

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)

MSHA-001448

SBH-KINGSPORT 001789

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 59

DATE: 08/09/14

TIME: 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	9	14	19	8	9
Blocked Rooms	~~0~~	~~0~~	~~0~~	~~0~~	3
Beds Available	5	2	7	6	~~0~~

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult *	Potential Unit	Comments: (Admitted/Unit)
	UT Hospital	M	44	Retracted Referral	Poplar	Pending acceptance to another facility
	Lakeway	F	68		Cedar	
	Horizon ER	F	32		Laurel Cedar	

MSHA-001449

SBH-KINGSPORT 001790

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PATIENT FLOW SHEET

CENSUS: 72

DATE: 8-10-14

TIME: 0740

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	13	16	25	9	9
Blocked Rooms	1 med	~~0~~	~~0~~	~~0~~	3
Beds Available	~~0~~	~~0~~	1	5	~~0~~

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
~~0~~						

MSHA-001450

SBH-KINGSPORT 001791

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PATIENT FLOW SHEET

CENSUS: 71

DATE: 8/11/14

TIME: 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	12	17	21	12	9
Blocked Rooms	616B	0	0	0	313B 317B 318B
Beds Available	1	0	0	2	0

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
0						

MSHA-001451

SBH-KINGSPORT 001792

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PATIENT FLOW SHEET

CENSUS: 66

DATE: 8/12/14

TIME: 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	11	16	18	13	8
Blocked Rooms	616B	0	0	0	313B, 317B 318B
Beds Available	2	0	8	1	1

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
0						

MSHA-001452

SBH-KINGSPORT 001793

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PATIENT FLOW SHEET

CENSUS: 70

DATE: 8/13/14

TIME: 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	12	16	18	13	10
Blocked Rooms	616B	Ø	Ø	Ø	313B 317B
Beds Available	1	Ø	8	1F	Ø

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[illegible]	ED	F	13	13 hrs	Willow	
Laughlin		F	17	14 hrs	Willow	
[illegible]	PEDS	F	16	6 hrs	Willow	

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SBH-KINGSPORT 001794

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PATIENT FLOW SHEET

CENSUS: 67

DATE: 8/14/14

TIME: 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	10	14	22	11	10
Blocked Rooms	616B	0	0	410B	313B, 317B
Beds Available	1	2	4	2	0

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
	ED	F	15	2 hrs	Willow	

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SBH-KINGSPORT 001795

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PATIENT FLOW SHEET

CENSUS: 69

DATE: 8-15-14

TIME: 0720

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	12	13	22	13	10
Blocked Rooms	1	Ø	Ø	1	2
Beds Available	1F	3	4	1	Ø

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
	HVER	F	57		Poplar	holding, pt OD represent @ HAM

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PATIENT FLOW SHEET

CENSUS: 78

DATE: 8-16-14

TIME: 730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	13	16	26	13	10
Blocked Rooms	1	Ø	Ø	1	2
Beds Available	Ø	Ø	Ø	Ø	Ø

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
Ø						

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SBH-KINGSPORT 001797

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PATIENT FLOW SHEET

CENSUS: 79

DATE: 8-17-14

TIME: 7:45

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	13	16	26	14	10
Blocked Rooms	1	~~0~~	~~0~~	~~0~~	2
Beds Available	~~0~~	~~0~~	~~0~~	~~0~~	0

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
	PICU	F	14	9 hrs	Willow	No beds available
	HVMC	M	35	10½ hrs	Cedar only	no beds

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SBH-KINGSPORT 001798

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PATIENT FLOW SHEET

CENSUS: 81

DATE: 8/18/14
TIME: 7:30

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	13	17	27	14	10
Blocked Rooms	1	Ø	Ø	Ø	3
Beds Available	Ø	Ø	Ø	Ø	Ø

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
	PICU	F	14	32 hrs	Willow	
	HVMC	F	36	39 hrs	any	
	Laughlin	F	30	12 hrs	Poplar	
	CSU	M	34	12 hrs	Poplar	
	BRMC	M	55	7½ hrs	any	
	JPMC ED	F	46	8 hrs	Spruce	
	JPMC ED	M	39	4 hrs	any	
	JCMC ED	F	54	1½ hrs	Laurel	

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SBH-KINGSPORT 001799

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PATIENT FLOW SHEET

CENSUS: 82

DATE: 8/19/14

TIME: 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	17	26	14	11
Blocked Rooms	616B	0	0	0	317B
Beds Available	0	0	0	0	0

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
	JMC ED	M	61	14hrs	Cedar	
	Wallmont	F	51	16 hrs	Laurel/Cedar	
	Takoma	F	54	2hrs	Laurel/Cedar	

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SBH-KINGSPORT 001800

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PATIENT FLOW SHEET

CENSUS: 78

DATE: 8/20/14

TIME: 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	13	16	25	14	10
Blocked Rooms	616B	0	0	0	0
Beds Available	0	0	1	0	2

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
	FMC 2307	F	60	13hrs	Laurel/Cedar	
	BMC	M	40	8hrs	Poplar	

MSHA-001460

SBH-KINGSPORT 001801

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PATIENT FLOW SHEET

CENSUS: 74

DATE: 8/21/14

TIME: 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	13	16	25	10	10
Blocked Rooms	616B	0	0	0	0
Beds Available	0	0	1	4	2

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
0						

MSHA-001461

SBH-KINGSPORT 001802

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PATIENT FLOW SHEET

CENSUS: 69

DATE: 08/22/2014

TIME: 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	13	16	20	10	10
Blocked Rooms	616 B	~~0~~	~~0~~	~~0~~	~~0~~
Beds Available	~~0~~	~~0~~	6	4	2

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
~~0~~						

MSHA-001462

SBH-KINGSPORT 001803

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PATIENT FLOW SHEET

CENSUS: 71

DATE: 08/25/2014

TIME: 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	13	15	20	12	11
Blocked Rooms	~~0~~	~~0~~	~~0~~	408B 1-Bed	~~0~~
Beds Available	1	1	6	1	1

New Leaf 12 Full

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
~~0~~						

MSHA-001463

SBH-KINGSPORT 001804

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PATIENT FLOW SHEET

CENSUS: 75

DATE: 8-24-14

TIME: 7:50

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	22	12	11
Blocked Rooms	~~0~~	~~0~~	~~0~~	1 408	~~0~~
Beds Available	~~0~~	~~0~~	4	1F	1 male appropriate

Now less full

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
	~ IPMC 426	F		24hr.	New Leaf	
	HVMC ED	m			Laurel/Cedar	
	JCMC ED	F		7hr.	Cedar only	
	JCMC ED	m			Laurel/Cedar	
	VAMC	M		2hr.		

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SBH-KINGSPORT 001805

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PATIENT FLOW SHEET

CENSUS: 82

DATE: 8/25/14

TIME: 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	17	27	13	11
Blocked Rooms	Ø	Ø	Ø	408B	Ø
Beds Available	Ø	Ø	Ø	Ø	1M

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
	PACU floor	F	78	8/23/14 1213	New Leaf	
	7 one floor	M	62	8/24/14 1605	Poplar	
	7 one CPC	F	48	8/24/14 1725	Poplar	
	7 one floor	M	45	8/24/14 1856	Cedar	
	HVMC	M	70	8/24/14 2308	New Leaf	
	5SH floor	F	87	8/24/14 2344	New Leaf	
	Takeoma	F	93	8/25/14 0700	Willow	

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PATIENT FLOW SHEET

CENSUS: 78

DATE: 8/26/14

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	17	26	13	8
Blocked Rooms	0	0	0	408b	318b
Beds Available	0	0	0	0	3

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
	IPMC ED	M	61	9 hrs	Spruce/Laurel	
	SSH Floor	F	87	8/24/14 2344	New Leaf	
	JCMC ED	F	19	6 hrs	Poplar	
	Laughlin	M	30	7 hrs	Poplar	
	Laughlin	M	48	3 hrs	Poplar	

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SBH-KINGSPORT 001807

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PATIENT FLOW SHEET

CENSUS: 77

DATE: 8/27/14

TIME: 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	26	13	8
Blocked Rooms	0	0	0	408B	318B
Beds Available	0	0	0	0	3

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
~~ZMC ED~~	F	82	3 hrs	Spruce		
CSU	M	37	6 hrs	Laurel		
CSU	F	32	5 hrs	Poplar		
UCMH	F	41	2 hrs	Laurel		
Laughlin	M	30	8/26/14 1607	Poplar		

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SBH-KINGSPORT 001808

PATIENT FLOW SHEET

CENSUS: 72

DATE: 8/28/14
TIME: 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	12	15	24	13	8
Blocked Rooms	Ø	Ø	Ø	408B	312A, 318B
Beds Available	2	1	2	Ø	2

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
	SC jail	F	27	12 hrs	Cedar	labs 8/28/14
	TMC PEDS	M	7	8 hrs	Willow	
	JCCH 8	M	7	7 hrs	Willow	
	Ridgeview NH	M	63	6 hrs	New Leaf	

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SBH-KINGSPORT 001809

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PATIENT FLOW SHEET

CENSUS: 73

DATE: Aug. 29, 2014

TIME: 725

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	11	14	24	12	10
Blocked Rooms	Ø	Ø	Ø	1	2
Beds Available	3	2	2	1	Ø

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
	IPMC 4th	F	65	15 hrs	Newleaf	

MSHA-001469

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PATIENT FLOW SHEET

CENSUS: 03

DATE: 8-30-14

TIME: 730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	12	12	23	9	7
Blocked Rooms	Ø	0	Ø	1	1
Beds Available	2	4	3	4	4

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)

MSHA-001470

SBH-KINGSPORT 001811

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PATIENT FLOW SHEET

CENSUS: 74

DATE: 8/31/14

TIME: 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	12	16	25	13	8
Blocked Rooms	~~0~~	~~0~~	~~0~~	1	1
Beds Available	1 Room	~~0~~	1F	~~0~~	1 Room 1 M

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
~~0~~						

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SBH-KINGSPORT 001812

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PATIENT FLOW SHEET

CENSUS: _74_____ DATE: _10/01/14_____

TIME_0730 _____

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	13	16	22	13	10
Blocked Rooms	0	0	0	0	313b
Beds Available	1	0	4	1	1

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
	HVMC	F	73	10 hrs	Spruce	
	JCMC PEDS	F	15	9 hrs	Willow	
	JCMC PEDS	F	17	8 hrs	Willow	

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PATIENT FLOW SHEET

CENSUS: _70_____ DATE: _10/2/14_____

TIME__0730_____

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	13	14	19	14	10
Blocked Rooms	0	0	0	0	313b
Beds Available	1f	2	7	0	1m

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
	HVMC	F	73	9/30/14 2109	Spruce	
	Hawkins	F	13	10 hrs	Willow	

MSHA-001473

SBH-KINGSPORT 001815

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PATIENT FLOW SHEET

CENSUS: 70

DATE: 10-3-14

TIME: 0735

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	12	13	21	14	10
Blocked Rooms	⊘	⊘	⊘	⊘	1
Beds Available	1m 1F	3	5	⊘	1m

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
	SSH ICU	F	25	10+	Poplar	
	Home	F	13	10+	Willow	
	Laughlin ED	F	16	10+	Willow	Psychosis
	JCMC 4224	M	23	10+	Laurel	

MSHA-001474

SBH-KINGSPORT 001816

PATIENT FLOW SHEET

CENSUS: 76

DATE: 10-4-14

TIME: 0640

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	13	16	27	12	8
Blocked Rooms	0	0	0	0	1
Beds Available	1F	0	0	2	3

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)

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PATIENT FLOW SHEET

CENSUS: _77_____ DATE: _10/7/14_____

TIME_0730 _____

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	25	13	9
Blocked Rooms	0	0	228b	411a	313b 317b
Beds Available	0	0	0	0	1 f

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
	JCMC ED	M			Laurel/Cedar	
	JCMC ICU	F			Poplar	
	JCMC PEDS	M			Willow	
	IPMC ED	M			Laurel	
	JCMC ED	M			Laurel	
	JCMC ED	M			Poplar	
	Gibson Place	M			Cedar	
	HVMC ED	M			Poplar	
	HVMC ED	M			Poplar	
	Laughlin Ed	F			Cedar	

MSHA-001476

SBH-KINGSPORT 001818

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PATIENT FLOW SHEET

CENSUS: 75

DATE: 10/8/14

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	14	24	13	10
Blocked Rooms	0	1 room	228b	0	317b
Beds Available	0	0	1m	1f	1f

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
	JCMC floor	M	75	8 hrs	Spruce	
	HVMC ED	F	66	6 hrs	New Leaf	MRSA
	JCMC PEDS	M	17	6 hrs	Willow	
	HVMC	F	39	1 hr	Laurel	

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PATIENT FLOW SHEET

CENSUS: 78

DATE: 10/09/14

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	25	13	10
Blocked Rooms	0	0	228b	0	317b
Beds Available	0	0	0	1	1

	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
	BRMC ED	M	50	6 hrs	Poplar	
	HVMC ED	F	12	3 hrs	Willow	

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PATIENT FLOW SHEET

CENSUS: 79

DATE: 10-12-14

TIME: _____

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	26	14	9
Blocked Rooms	0	0	0	0	1
Beds Available	0	0	0	0	2

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
	JCMC ED	F	57	10+	Poplar	
	EPH ED	M	29	10+	Poplar/Laurel	
	HVH ED	F	36	3hr	Poplar	

MSHA-001479

SBH-KINGSPORT 001821

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PATIENT FLOW SHEET

CENSUS: _79_____ DATE: _10/13/14_____

TIME_0730 _____

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	26	14	10
Blocked Rooms	0	0	0	0	313b
Beds Available	0	0	0	0	1m

	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
	HVMC ED	F	72	15 hrs	Spruce	
	Laughlin	M	63	9 hrs	Spruce/Laurel	
	JCMC floor	M	22	15 hrs	Laurel	

MSHA-001480

SBH-KINGSPORT 001822

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PATIENT FLOW SHEET

CENSUS: 78

DATE: 10/14/14

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	15	26	14	9
Blocked Rooms	0	515a	0	0	317b
Beds Available	0	0	0	0	2

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
	JCMC ED	F	22	10/13/14	Poplar	
	FWCH ED	M	39	10/13/14	Laurel/Poplar	
	SSH ED	M	26	10/13/14	Cedar	
	JCMC floor	M	54	10/13/14	Poplar/Laurel	
	JCMC ED	F	58	10/13/14	Laurel	
	JCMC ED	M	61	10/13/14	Poplar/Spruce	
	IPMC ED	M	60	10/14/14	Poplar/Spruce	
	HVMC ED	F	72	10/12/14	Spruce	

MSHA-001481

SBH-KINGSPORT 001823

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PATIENT FLOW SHEET

CENSUS: 72

DATE: 10/15/14

TIME: 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	15	22	13	8
Blocked Rooms	0	515A	224B	0	317B
Beds Available	0	0	3	1	3

Name of Patient Waiting	Location	M/F	Age	LCS Since Consult	Potential Unit	Comments: (Admitted/Unit)
0						

MSHA-001482

SBH-KINGSPORT 001824

Highly Confidential

PATIENT FLOW SHEET

CENSUS: _77_____ DATE: _10/16/14_____

TIME__0730 _____

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	15	25	13	9
Blocked Rooms	0	515a	224b	409a	317b
Beds Available	0	0	0	0	2

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
	SSH ED	M	65	12 hrs	New Leaf	
	Hawkins Co	M	22	7 hrs	Cedar	
	HVMC ED	F	69	5 hrs	New Leaf	

MSHA-001483

SBH-KINGSPORT 001825

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PATIENT FLOW SHEET

CENSUS: 74

DATE: 10/17/14

TIME: 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14 Full	15 Full	24	11	10
Blocked Rooms	~~0~~	515A Med	2248 Med	~~0~~	317B
Beds Available	~~0~~	~~0~~	1F	3	1F

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
	HVMC ICU	F	30	10+	Cedar	
	MMC ER	F	60	2+	Cedar	

MSHA-001484

SBH-KINGSPORT 001826

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PATIENT FLOW SHEET

CENSUS: 72

DATE: 10-18-14

TIME: 0800

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	13	15	24	11	9
Blocked Rooms	0	0	1	0	1
Beds Available	1	1	1	3	2

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)

MSHA-001485

SBH-KINGSPORT 001827

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PATIENT FLOW SHEET

CENSUS: 71

DATE: 10-19-14

TIME: 0800

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	13	16	19	12	11
Blocked Rooms	0	0	0	2	0
Beds Available	1	0	7	0	1

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)

MSHA-001486

SBH-KINGSPORT 001828

Highly Confidential

PATIENT FLOW SHEET

CENSUS: _79_____ DATE: _10/20/14_____

TIME_0730 _____

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	26	12	11
Blocked Rooms	0	0	0	407b 413b	0
Beds Available	0	0	0	0	1

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
	IPMC ED	M	22	11 hrs	Poplar	
	FWCH ED	F	23	11 hrs	Poplar/Laurel	
	JCMC floor	M	20	12 hrs	Cedar	
	BRMC	F	45	18 hrs	Laurel/Cedar	
	HVMC	F	60	8 hrs	Laurel/Cedar	
	HVMC	F	50	6 hrs	Laurel/Cedar	

MSHA-001487

SBH-KINGSPORT 001829

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PATIENT FLOW SHEET

CENSUS: _75_____ DATE: _10/21/14_____

TIME__0730 _____

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	13	16	12	25	9
Blocked Rooms	0	0	413b	0	0
Beds Available	1	0	1	1	3

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
None						

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SBH-KINGSPORT 001830

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PATIENT FLOW SHEET

CENSUS: 76

DATE: 9/1/14

TIME: 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	13	16	25	13	9
Blocked Rooms	0	0	0	0	3B 3/8B
Beds Available	1	0	1	1	1

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
	HVMC	F	59	2hrs	New Leaf	

MSHA-001489

SBH-KINGSPORT 001831

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PATIENT FLOW SHEET

CENSUS: 77

DATE: 9/2/14

TIME: 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	25	13	9
Blocked Rooms	0	0	0	0	317B 318B
Beds Available	0	0	1F	1F	1M

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
None						

MSHA-001490

SBH-KINGSPORT 001832

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 72

DATE: 9/3/14

TIME: 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	11	15	26	13	7
Blocked Rooms	0	0	0	0	313B, 318B
Beds Available	3	1	0	1	3

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
None						

MSHA-001491

SBH-KINGSPORT 001833

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 74

DATE: 9/4/14

TIME: 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	15	23	13	9
Blocked Rooms	0	0	0	0	313B, 318B
Beds Available	0	1	3	1	1

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
	TCR PED ICU	F	15	13hrs	Willow	

MSHA-001492

SBH-KINGSPORT 001834

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PATIENT FLOW SHEET

CENSUS: 72

DATE: 9/5/14

TIME: 730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	22	10	10
Blocked Rooms	Ø	Ø	0	Ø	2
Beds Available	Ø	Ø	4	4	Ø

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
	JCMC ED	F	15	13 hrs	Willow	Willow
	BRMC ED	M	43	9 hrs	Cedar	Cedar

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SBH-KINGSPORT 001835

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PATIENT FLOW SHEET

CENSUS: 75

DATE: 9-6-14

TIME: 730a

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	26	9	10
Blocked Rooms	Ø	Ø	Ø	Ø	2
Beds Available	Ø	Ø	Ø	5	Ø

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
	SSH ED	F	40	3	Laurel	

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SBH-KINGSPORT 001836

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PATIENT FLOW SHEET

CENSUS: 76

DATE: 9-7-14

TIME: 0735

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	25	11	10
Blocked Rooms	~~0~~	~~0~~	~~0~~	~~0~~	2 beds 313B & 318B
Beds Available	~~0~~	~~0~~	1F	3	~~0~~

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
	Takoma	M	29	7 hrs.	Cedar	

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SBH-KINGSPORT 001837

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PATIENT FLOW SHEET

CENSUS: 79

DATE: 9/8/14

TIME: 0230

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	26	13	10
Blocked Rooms	0	0	0	408A	313B, 318B
Beds Available	0	0	0	0	0

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
	HVMC	M	44	4 hrs	Poplar	
	Hawkins	M	25	3 hrs	Poplar	
	Takoma	M	34	6 hrs	Poplar	
	BRMC	F	52	12 hrs	Laurel/Cedar	
	Hawkins	F	28	7 hrs	Laurel/Cedar	
	Hawkins	M	38	2 hrs	Laurel	
	Takoma	M	29	27 hrs	Cedar	
	Hancock	M	62	15 hrs	Cedar	

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SBH-KINGSPORT 001838

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PATIENT FLOW SHEET

CENSUS: 72

DATE: 9/9/14

TIME: 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	15	22	11	10
Blocked Rooms	0	0	0	0	318B
Beds Available	0	1	4	3	

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
Tacoma		M	29	9/7/14 0450	Cedar	
Hancock		M	62	9/7/14 1611	Cedar	

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PATIENT FLOW SHEET

CENSUS: 76

DATE: 9/10/14

TIME: 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	12	16	25	12	11
Blocked Rooms	0	0	0	412B	318B
Beds Available	2	0	1	1	0

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
	H/NC ED	M	18	2hrs	Laurel/Cedar	
	BRMC ED	F	13	2 hrs	Willow	
	Hawkins	F	17	8hrs	Willow	
	BRMC ED	M	31	2hrs	Cedar	

MSHA-001498

SBH-KINGSPORT 001840

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PATIENT FLOW SHEET

CENSUS: 69

DATE: 9/11/14

TIME: 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	21	9	9
Blocked Rooms	0	0	228A	412B	313B 318B
Beds Available	0	0	4	4	1

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
	Laughlin ED	M	16	9/10/14 2021	Willow	
	TCH ED	F	12	9/10/14 2032	Willow	
	BRMC ED	F	13	9/10/14 1725	Willow	
	BRMC ED	F	29	8 hrs	Cedar	
	SSH ED	M	42	5 hrs	Laurel	
	Laughlin	M	39	10 hrs	Laurel	

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PATIENT FLOW SHEET

CENSUS: 78

DATE: 09/12/14

TIME: 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	13	16 Full	26 Full	13 Full	10 Full
Blocked Rooms	0	0	0	410B - Med	313 B - Med
Beds Available	1F	0	0	0	0

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
	xmc PEDS	M	15	15+ hrs	Willow	
	5SH ICU	F	26	14+hrs	Poplar	
	Hawkins COER	M	21	4+hrs	Poplar	
	HawkinsCOER	F	19	4+hrs	Poplar	
	Hawkins Co ER	F	15	7+ hrs	Willow	
	Hawkins ER	M	63	2+		

MSHA-001500

SBH-KINGSPORT 001842

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PATIENT FLOW SHEET

CENSUS: 80

DATE: 09/13/14

TIME: 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14 Full	16 Full	26 Full	12 Full	12 Full
Blocked Rooms	0	0	0	410B-med 411A-med	0
Beds Available	0	0	0	0	0

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
	HVMCER	F	42	10+	Cedar	
	XMCER	F	65	4+	Spruce	
	HVMCER	M	44	2+	Laurel/Cedar	

MSHA-001501

SBH-KINGSPORT 001843

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PATIENT FLOW SHEET

CENSUS: 79

DATE: 9/14/14

TIME: 7:40

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	13	16	26	12	12
Blocked Rooms	~~0~~	~~0~~	~~0~~	410	~~0~~
Beds Available	1F	~~0~~	~~0~~	1M	~~0~~

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
	SCMC 6411	F	71	8hrs	~~spruce~~ New leaf	
	HVMCER	F	42	8hrs	Cedar	
	HVMC ER	M	44	14hrs	Laurel	
	HVMCER	M	21	24hrs	Poplar	
	JCHC	M	31	7hrs	Laurel/Poplar	
	PICU -	F	12	4 days	Willow	

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PATIENT FLOW SHEET

CENSUS: 81

DATE: 09-15-2014

TIME: 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14 Full	16 Full	26 Full	13 Full	12 Full
Blocked Rooms	0	0	0	410B medical	0
Beds Available	0	0	0	0	0

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
	IPMC ER	F	21	16+	Poplar	12 Rebecca Jacobs- PICU willow
	FWBH ER	F	59	3+	Poplar / Spruce	
	Xmc 6400	F	71	24+	Spruce/New Leaf	
	Xmc PICU	F	13	48+	Willow	13 Connor Mathes- PICU willow
	Xmc 6200	M	39	10+	Laurel / Cedar	
	HVMC	F	42	48+	Cedar	
	BRMC ER	M	32	1+	Laurel	
	Takoma	F	45	18+	Laurel	
	BRMC	F	81	20+	New Leaf	
	HVMC ER	F	33	12+	Poplar	
	HVMC ICU	F	23	16+	Laurel / Cedar	

MSHA-001503

SBH-KINGSPORT 001845

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PATIENT FLOW SHEET

CENSUS: 77

DATE. 09-16-14

TIME: 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14 Full	16 Full	25 Full	12	10
Blocked Rooms	~~0~~	~~0~~	228 A Med	410 B med	312 A- Med
Beds Available	~~0~~	~~0~~	~~0~~	1M	1M

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
	WMC ICU	F	32yo	15+	?	will require PVT room Medical Complex MRSA, Breast wound
	PMC ER	F	50yo	7+	Laurel	
	JCMC ER	M	33yo	3a+	Laurel	
	HMC ICU	F	23yo	30+	Laurel	
25.	Tekoma	F	30yo	7+	Cedar	
	Russell CO MC	M	17yo	2+	Willow	
	Calm Center	M	45yo	7+	Poplar	g.f. also may present Intoxicated
	JCMC PICU	F	12yo	5+days	Willow	
	JCMC ER	M	39yo	1hr	Poplar	? awaiting crisis consult

MSHA-001504

SBH-KINGSPORT 001846

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PATIENT FLOW SHEET

CENSUS: 78

DATE: 09-17-2014

TIME: 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14 Full	16 Full	26 Full	13 Full	9
Blocked Rooms	0	0	0	410B Med	312B-Med 313B-Bed
Beds Available	0	0	0	0	1F

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
	JCMC ER	F	32	7+hrs	Laurel	
	BRMC ER	M	28	5+hr	Poplar	

MSHA-001505

SBH-KINGSPORT 001847

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PATIENT FLOW SHEET

CENSUS: 76

DATE: 09-18-2014

TIME: 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14 Full	16 Full	26 Full	13	7
Blocked Rooms	0	0	0	0	3128-med 3138-?
Beds Available	0	0	0	1M	3

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
	XMC PICU	M	16	10+	Willow	
	XMC ER	M	37	10+	Cedar	
	HVMC ER	M	18	10+	Willow	Senior in H-S
	Laughlin	M	28	8+	Cedar	
	BRMC	M	49	6+	Poplar	
	NewLeaf	M		—	Spruce	per Dr S Patel request + transfer to Spruce

MSHA-001506

SBH-KINGSPORT 001848

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PATIENT FLOW SHEET

CENSUS: 80

DATE: 9-19-14

TIME: 0745

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	15 Full	16 Full	25	14 Full	10
Blocked Rooms	Ø	Ø	Ø	Ø	1
Beds Available	Ø	Ø	1F	Ø	1m

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
	JCMC Floor	M	53	10+	Poplar	
	BRMC ER	M	41	10+	Poplar	
	BRMC ER	M	64	10+	Laurel/Cedar	
	Takoma ER	M	42	10+	Poplar	
	Vail HVHEP	F	13	9	Willow	

MSHA-001507

SBH-KINGSPORT 001849

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PATIENT FLOW SHEET

CENSUS: 81

DATE: 9-20-14

TIME: 0720

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	26	14	11
Blocked Rooms	0	0	0	0	1
Beds Available	0	0	0	0	0

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
	SSH ED	F	25	10+	Laurel/Cedar	
	JCMC 6302	F	44	10+	Any	Needs Private Room
	JCMC ED	M	28	7	Laurel	
	BCMC ED	M	56	10+	Pop/Spruce	
	Hawkins ED	M	72	10+	New Leaf	
	HVH ED	M	22	10+	Laurel	

MSHA-001508

SBH-KINGSPORT 001850

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PATIENT FLOW SHEET

CENSUS: 80

DATE: 9-21-14

TIME: 0700

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	25	14	11
Blocked Rooms	Ø	Ø	Ø	Ø	1
Beds Available	Ø	Ø	1m	Ø	Ø

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
	JCMC ED	F	45	6	Cedar	
	JCMC B502	F	44	10+	Any	Needs Private Room
	Hawkins ED	M	72	10+	New Leaf	
	HVH ED	M	22	10+	Laurel	
	Jcmc	M	59	10+	Pop/Laurel	
	CSU	M	44	10+	Poplar	
	HVH ED	M	18	8	Poplar	
	HVH ED	F	80	10+	New Leaf/Spruce	

MSHA-001509

SBH-KINGSPORT 001851

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PATIENT FLOW SHEET

CENSUS: 81

DATE: 9/22/2014

TIME: 730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	26	14	11
Blocked Rooms	Ø	Ø	Ø	Ø	1
Beds Available	Ø	Ø	Ø	Ø	Ø

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
1)	HVMC	M	22	9 days	Laurel	
	JCMC	F	16	19 hrs	Willow	
1	HVMC	F	32	13 hrs	Laurel/Cedar	
	JCCH	F	31	6 hrs	Cedar	
	BRMC	F	41	7 hrs	Cedar	
	HVMC	F	21	2 hrs	Poplar	

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PATIENT FLOW SHEET

CENSUS: 78

DATE: Sept 23, 14

TIME: 730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	13	15	25	14	11
Blocked Rooms	Ø	Ø	Ø	Ø	1
Beds Available	1 F	1 M	1 M	Ø	Ø

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult-	Potential Unit	Comments: (Admitted/Unit)
	JCMC Peds	F	16	9/21/14	Willow	
	JCMC	M	27	4 hrs	Cedar	

PATIENT FLOW SHEET

CENSUS: 76

DATE: 9/24/14

TIME: 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	23	13	11
Blocked Rooms	Ø	Ø	Ø	Ø	312B
Beds Available	Ø	Ø	3	1m	Ø

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
	JCMC PED ICU	F	16	14 hrs	Willow	
	Takoma	F	16	15 hrs	Willow	
	JCMC PED ICU	M	17	8 hrs	Willow	
	JCMC ED	F	37	8 hrs	Laurel/Cedar	

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MSHA-001512

SBH-KINGSPORT 001854

PATIENT FLOW SHEET

CENSUS: 75

DATE: 9/25/14

TIME: 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	25	12	8
Blocked Rooms	0	0	23OA	0	0
Beds Available	0	0	0	2	4

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
	MMC ED	F	45	8 hrs	Laurel/Cedar	

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MSHA-001513

SBH-KINGSPORT 001855

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PATIENT FLOW SHEET

CENSUS: 76

DATE: 9-26-14

TIME: 0800

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	13	16	25	13	9
Blocked Rooms	Ø	Ø	1	Ø	Ø
Beds Available	1 F	Ø	Ø	1 M	3

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
	JCMC ED	M	42	8	Cedar/Laurel	
	HVH ED	F	45	10 +	Poplar	
	Hawkins ED	M	58	10	Cedar	

MSHA-001514

SBH-KINGSPORT 001856

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PATIENT FLOW SHEET

CENSUS: 75

DATE: 9/27/14

TIME: _____

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	15	25	10	11
Blocked Rooms	0	1	0	0	1
Beds Available	0	0	1m	4	0

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
	Hawkins Co ED	M	58	24+	Cedar/Laurel	

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PATIENT FLOW SHEET

CENSUS: 80

DATE: 9/29/14

TIME: 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	15	26	14	11
Blocked Rooms	0	511B	0	0	313B
Beds Available	0	0	0	0	0

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult-	Potential Unit	Comments: (Admitted/Unit)
	FHNC ED	M	56	29hrs	Cedar	
	ZANC ED	M	59	12hrs	Cedar	
	[illegible] ED	M	28	9hrs	Laurel	
	[illegible] ED	M	23	8hrs	Poplar	
	[illegible] ED	M	24	6hrs	Poplar	
	FWCH ED	M	30	10hrs	Cedar	
	[illegible] ED	F	29	8hrs	Poplar	
	HVNC ED	F	15	4hrs	Willow	
	BRNC ED	F	16	1hr	Willow	
	Ridgeview	M	60	8hrs	Cedar	
	BRNC	M	39	12hrs	Laurel	
	HVNC	M	41	7hrs	Poplar	

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PATIENT FLOW SHEET

CENSUS: _75_____ DATE: _9/30/14_____

TIME__0730 _____

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	23	11	11
Blocked Rooms	0	0	0	0	313b
Beds Available	0	0	3	3	0

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
None						

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5/17/12
2 Originals to Contract Services

GRANT CONTRACT

(cost reimbursement grant contract with an individual, business, non-profit, or governmental entity of another state)

Begin Date	End Date	Agency Tracking #	Edison ID
April 1, 2012	June 30, 2014	33901-55512	

Contractor Legal Entity Name	Edison Vendor ID
Mountain States Health Alliance	91846

Subrecipient or Vendor	CFDA #
☐ Subrecipient ☒ Vendor	

Service Caption (one line only)

Inpatient Psychiatric Services

Funding —

FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
2012	$629,180.00				$632,060.00
2013	$2,528,240.00				$2,528,240.00
2014	$2,528,240.00				$2,528,240.00
TOTAL:	$5,686,540.00				$5,686,540.00

American Recovery and Reinvestment Act (ARRA) Funding: ☐ YES ☒ NO

Ownership/Control

☐ African American ☐ Asian ☐ Hispanic ☐ Native American ☐ Female
☐ Person w/Disability ☐ Small Business ☐ Government ☒ NOT Minority/Disadvantaged
☐ Other:

Selection Method & Process Summary (mark the correct response to confirm the associated summary)

☐ Alternative Competitive Method	The predefined, competitive, impartial, procurement process was completed in accordance with the associated, approved procedures and evaluation criteria.
☐ Non-Competitive Negotiation	The non-competitive contractor selection was completed as approved, and the procurement process included a negotiation of best possible terms & price.
☒ Other	The contractor selection was directed by law, court order, settlement agreement, or resulted from the state making the same agreement with all interested parties or all parties in a predetermined "class."

Budget Officer Confirmation: There is a balance in the appropriation from which obligations hereunder are required to be paid that is not already encumbered to pay other obligations.

OCR USE - GR

Speed Chart (optional)	Account Code (optional)

EXHIBIT 7/29/15
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SBH-Kingsport

GRANT CONTRACT
BETWEEN THE STATE OF TENNESSEE,
DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
AND
MOUNTAIN STATES HEALTH ALLIANCE

This Grant Contract, by and between the State of Tennessee, Department of Mental Health and Substance Abuse Services, hereinafter referred to as the "State" and Mountain States Health Alliance, hereinafter referred to as the "Grantee," is for the provision of Inpatient Psychiatric Services, as further defined in the "SCOPE OF SERVICES."

The Grantee is a Non-Profit Corporation.
Grantee Place of Incorporation or Organization: Tennessee
Grantee Edison Vendor ID # 91846

A. **SCOPE OF SERVICES:**

A.1. The Grantee shall provide all service and deliverables as required, described, and detailed herein and shall meet all service and delivery timelines as specified by this Grant Contract.

A.2. Service Definitions:

a. Inpatient Psychiatric Services shall include: assessment; treatment planning; active treatment; and discharge planning, but shall not include partial hospitalization.

b. An uninsured individual, for purposes of this Grant Contract, shall be an individual who:

(1) Does not have an identified third party health benefits payor source (i.e., Tennessee's Medicaid program, TennCare; Medicare; or any Private Insurance); or

(2) Has insurance, but the insurance does not cover Inpatient Psychiatric Services as described herein; or

(3) Has insurance but has exhausted the benefits for Inpatient Psychiatric Services as described herein; or

(4) Does not have any other financial means to pay for Inpatient Psychiatric Services as described herein.

c. "Patient Day" is calculated using the midnight-to-midnight method. The day of admission is considered a full day regardless of the time of admission; the day of discharge is not an authorized day and shall not be reimbursed.

d. The terms "Referred" and "Referral", for purposes of this Grant Contract, mean a request made to the Grantee by a State-designated crisis service provider seeking Inpatient Psychiatric Services as described herein. Such requests can be made via telephone, tele-health, or in-person.

A.3. Provision of Services. The Grantee shall provide inpatient psychiatric services, at its Woodridge Hospital facility, as follows:

a. Inpatient psychiatric services shall be provided to uninsured adult individuals, and a small number of uninsured juvenile individuals as noted in Section A.5.a., in Tennessee who have been referred to the Grantee by a State-designated crisis service provider and admitted in accordance with the provisions of Tennessee Code Annotated (TCA) Title 33,

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Chapter 6. Proof that a State-designated crisis service provider was an active participant in the determination for inpatient psychiatric hospitalization shall be submitted to the State, in a format and template prescribed by the State, along with other supporting documentation and the invoice as described in Section C.5.

b. The Grantee shall conduct due diligence and make reasonable efforts to avoid refusing to consider or admit an uninsured adult individual solely on the basis of acuity level or treatment history. In the event that the Grantee is unable to admit an uninsured adult individual determined to need inpatient psychiatric hospitalization after an on-site assessment by the Grantee, the Grantee shall contact the other State-contracted private inpatient psychiatric hospitals providing inpatient psychiatric services as described herein to determine if they would consider the uninsured adult individual **prior** to referring the uninsured adult individual on to one of the State's Regional Mental Health Institutes (RMHIs).

c. **After exhausting all other options**, if a referral to one of the State's RMHIs is being considered, the Grantee shall follow State-specified procedures to refer the uninsured adult individual to one of the State's RMHIs.

d. If at any point during the inpatient psychiatric hospitalization of an uninsured adult individual, a transfer to one of the State's RMHIs is being considered, the Grantee shall follow State-specified procedures to request the transfer of the uninsured adult individual to one of the State's RMHIs.

A.4. Documentation and Reporting. The Grantee shall create and maintain all appropriate documentation related to the provision of inpatient psychiatric services, including but not limited to a patient medical record and other documentation described herein. The Grantee shall submit the following reports as indicated. It is expressly understood and agreed the obligations set forth in this section shall survive the termination of this Grant Contract as specifically indicated herein.

a. A Monthly Report on Uninsured Individuals Served. The Grantee shall submit, in a format and template specified by the State, a monthly report containing information about any uninsured individuals served under this Grant Contract. The report is due by the fifteenth (15th) of the following month for the preceding month. Information to be collected and reported includes, but is not limited to:

(1) Social Security number;

(2) Last Name;

(3) First Name;

(4) Date of birth;

(5) County of Residence;

(6) State of Residence;

(7) Date of admission;

(8) Time of admission;

(9) Date of discharge;

(10) Number of Uninsured Adult Patient Days;

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(11) Number of Eligible Uninsured Juvenile Patient Days;

(12) Gender;

(13) Race;

(14) Ethnicity;

(15) Marital Status;

(16) Military Status;

(17) Primary language (English, Spanish, American Sign Language, other);

(18) Job/employment status;

(19) Amount of income;

(20) Living arrangement at admission;

(21) Number of people in household;

(22) Referral source (name of specific State-designated crisis service provider);

(23) Legal status at admission (voluntary, emergency involuntary, other);

(24) Primary admission diagnosis (Axis I or II);

(25) Secondary admission diagnoses (all other Axis I and II diagnoses);

(26) Primary discharge diagnosis (Axis I or II);

(27) Secondary discharge diagnoses (all other Axis I and II diagnoses);

(28) Living arrangement at discharge; and

(29) Aftercare arrangements.

A.5. Reimbursement for Services. The Grantee shall be reimbursed, at an established rate which is only a portion of the total cost of these services, for inpatient psychiatric services provided to uninsured adult individuals, and a small number of eligible juvenile individuals as noted in Section A.5.a., admitted for inpatient psychiatric services under this Grant Contract with the following understandings:

a. One goal of this Grant Contract is to ensure that eligible uninsured adult individuals receive inpatient psychiatric services as described herein when those services are needed. To that end, the Grantee agrees to provide inpatient psychiatric services to eligible uninsured adult individuals as follows: for the period April 1, 2012 through June 30, 2013 for Four Hundred Sixty-Eight (468) uninsured adult patient days per month and for the period July 1, 2013 through June 30, 2014 for Four Hundred Fifty-Four (454) uninsured adult patient days per month. Included in these numbers are Thirty-Two (32) uninsured juvenile patient days for eligible uninsured juvenile individuals. Each month the numbers may be adjusted based on variances in utilization (see Budget, Attachment 01). Another goal of this Grant Contract is to distribute the total funds available in this Grant Contract across the full term of this Grant Contract; therefore, the Grantee shall

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consult with the State, on a quarterly basis, regarding any necessary adjustments to meet these goals.

b. This Grant Contract shall be considered the payor of last resort. The Grantee shall conduct due diligence and make reasonable efforts to determine eligibility for public or private insurance payors and bill those payors if they are available. The Grantee shall also conduct due diligence and make reasonable efforts to enroll eligible uninsured individuals in public insurance programs. The Grantee shall also determine if the individual has any financial means to pay for inpatient psychiatric services described herein. The Grantee shall submit proof of such efforts upon request of the State. If there is payment received from a public or private insurance payor, or from the individual or other private party, for the same inpatient psychiatric services after payment has been received through this Grant Contract, the Grantee agrees to return such payment, in its entirety, to the State or the State shall withhold future payments until the amount is repaid. Further, if the State finds that payment could have been received from a public or private insurance payor, or from the individual or other private party, for the same inpatient psychiatric services after payment has been made under this Grant Contract, the Grantee shall return such payment, in its entirety, to the State or the State shall withhold future payments until the amount is repaid.

c. Up to seven (7) uninsured patient days are authorized for an eligible uninsured adult individual during any one (1) continuous inpatient psychiatric hospitalization. The day of admission is considered a full day of inpatient psychiatric services, regardless of the time of admission. The day of discharge is not an authorized day of inpatient psychiatric services and shall not be reimbursed. The midnight-to-midnight method shall be used in reporting days of inpatient psychiatric services.

d. If additional uninsured patient days, beyond the authorized up to seven (7) uninsured patient days, are needed for an eligible uninsured adult individual during any one (1) continuous inpatient psychiatric hospitalization, up to an additional three (3) uninsured patient days (resulting in up to a ten (10)-day continuous stay) may be requested only if the State is provided with a brief one (1)-page summary detailing the medical necessity for the up to three (3) additional uninsured patient days. The one (1)-page brief summary shall be faxed to the State's Medical Director or designee no later than Noon Central Time on the business day **prior to** the seventh (7th) uninsured patient day. The State's Medical Director's or designee's decision shall be faxed to the Grantee.

e. If up to ten (10) uninsured patient days have been approved for an eligible uninsured adult individual during any one (1) continuous inpatient psychiatric hospitalization and even more uninsured patient days are needed, reimbursement will not be provided for more than the approved ten (10) uninsured patient days for an eligible uninsured adult individual during any one (1) continuous inpatient psychiatric hospitalization **without prior written approval** from the State. To request approval for days beyond an approved up to ten (10) uninsured patient days for an eligible uninsured adult individual during any one (1) continuous inpatient psychiatric hospitalization, the Grantee or designee shall contact the State's Medical Director or designee by telephone no later than Noon Central Time on the business day **prior to** the tenth (10th) uninsured patient day to provide clinical information to support the request. The State's Medical Director's or designee's decision and, if applicable, the number of additional uninsured patient days for an eligible uninsured adult individual during any one (1) continuous inpatient psychiatric hospitalization being approved, shall be faxed to the Grantee. This process may be repeated as needed.

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B. **CONTRACT PERIOD:**

This Grant Contract shall be effective for the period beginning April 1, 2012, and ending on June 30, 2014. The Grantee hereby acknowledges and affirms that the State shall have no obligation for Grantee services or expenditures that were not completed within this specified contract period.

C. **PAYMENT TERMS AND CONDITIONS:**

C.1. Maximum Liability. In no event shall the maximum liability of the State under this Grant Contract exceed Five Million Six Hundred Eighty-Eight Thousand Five Hundred Forty Dollars ($5,688,540.00). The Grant Budget, attached and incorporated hereto as Attachment 01, shall constitute the maximum amount due the Grantee for all service and Grantee obligations hereunder. The Grant Budget line-items include, but are not limited to, all applicable taxes, fees, overhead, and all other direct and indirect costs incurred or to be incurred by the Grantee.

C.2. Compensation Firm. The maximum liability of the State is not subject to escalation for any reason unless amended. The Grant Budget amounts are firm for the duration of the Grant Contract and are not subject to escalation for any reason unless amended, except as provided in section C.6.

C.3. Payment Methodology. The Grantee shall be reimbursed for actual, reasonable, and necessary costs based upon the Grant Budget, not to exceed the maximum liability established in section C.1. Upon progress toward the completion of the work, as described in section A of this Grant Contract, the Grantee shall submit invoices prior to any reimbursement of allowable costs.

C.4. Travel Compensation. Reimbursement to the Grantee for travel, meals, or lodging shall be subject to amounts and limitations specified in the "State Comprehensive Travel Regulations," as they are amended from time to time, and shall be contingent upon and limited by the Grant Budget funding for said reimbursement.

C.5. Invoice Requirements. The Grantee shall invoice the State, on an invoice supplied by the State, no more often than monthly by the fifteenth (15th) of the month for the preceding month, with all necessary supporting documentation, and present such to:

Department of Mental Health and Substance Abuse Services
Division of Fiscal Services
10th Floor, Andrew Johnson Tower
710 James Robertson Parkway
Nashville, TN 37243

a. Each invoice shall clearly and accurately detail all of the following required information (calculations must be extended and totaled correctly).
   (1) Invoice/Reference Number (assigned by the Grantee).
   (2) Invoice Date.
   (3) Invoice Period (to which the reimbursement request is applicable).
   (4) Grant Contract Number (assigned by the State).
   (5) Grantor: Department of Mental Health and Substance Abuse Services;
   (6) Grantor Number (assigned by the Grantee to the above-referenced Grantor).
   (7) Grantee Name.
   (8) Grantee Tennessee Edison Registration ID Number Referenced in Preamble of this Grant Contract.
   (9) Grantee Remittance Address.
   (10) Grantee Contact for Invoice Questions (name, phone, and/or fax).
   (11) Itemization of Reimbursement Requested for the Invoice Period— it must detail, at minimum, all of the following:

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i. The amount requested by Grant Budget line-item (including any travel expenditure reimbursement requested and for which documentation and receipts, as required by "State Comprehensive Travel Regulations," are attached to the invoice);
ii. The amount reimbursed by Grant Budget line-item to date;
iii. The total amount reimbursed under the Grant Contract to date;
iv. The total amount requested (all line-items) for the Invoice Period;
v. The total number of uninsured adult patient days billed for the Invoice Period;
vi. The total number of eligible uninsured juvenile patient days as noted in Section A.5.a. billed for the Invoice Period;
vii. The following supporting documentation **must** accompany the invoice:
(a) A report containing the following information on each uninsured individual served. The report described in Section A.4.a. satisfies this requirement:
1. Social Security Number;
2. Last Name;
3. First Name;
4. Date of Birth;
5. Date of Admission;
6. Time of Admission;
7. Date of Discharge;
8. Number of Uninsured Adult Patient Days;
9. Number of Eligible Uninsured Juvenile Patient Days as noted in Section A.5.a.; and
10. Referral Source (name of specific State-designated crisis service provider);
(b) Proof that a State-designated crisis service provider was an active participant in the determination for inpatient psychiatric hospitalization as described in Section A.3.a.; and
(c) The document received by the Grantee showing approval by the State's Medical Director or designee for any additional uninsured adult patient days beyond seven (7) as described in Sections A.5.d. and A.5.e.

b. The Grantee understands and agrees to all of the following.

(1) An invoice under this Grant Contract shall include only reimbursement requests for actual, reasonable, and necessary expenditures required in the delivery of service described by this Grant Contract and shall be subject to the Grant Budget and any other provision of this Grant Contract relating to allowable reimbursements.
(2) An invoice under this Grant Contract shall not include any reimbursement request for future expenditures.
(3) An invoice under this Grant Contract shall initiate the timeframe for reimbursement only when the State is in receipt of the invoice, and the invoice meets the minimum requirements of this section C.5.

C.6. Budget Line-items. Expenditures, reimbursements, and payments under this Grant Contract shall adhere to the Grant Budget. Reimbursable expenditures may NOT vary from the Grant Budget line-item amount(s) detailed.

C.7. Disbursement Reconciliation and Close Out. The Grantee shall submit any final invoice and a grant disbursement reconciliation report within sixty (60) days of the Grant Contract end date and inform and substance acceptable to the State.

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a. If total disbursements by the State pursuant to this Grant Contract exceed the amounts permitted by the Section C, Payment Terms and Conditions of this Grant Contract, the Grantee shall refund the difference to the State. The Grantee shall submit said refund with the final grant disbursement reconciliation report.

b. The State shall not be responsible for the payment of any invoice submitted to the state after the final invoice and grant disbursement reconciliation report. The State will not deem any Grantee costs submitted for reimbursement after the final invoice to be allowable and reimbursable by the State, and such invoices will NOT be paid.

c. The Grantee's failure to provide a final grant disbursement reconciliation report to the state as required shall result in the Grantee being deemed ineligible for reimbursement under this Grant Contract, and the Grantee shall be required to refund any and all payments by the state pursuant to this Grant Contract.

d. The Grantee must close out its accounting records at the end of the grant period in such a way that reimbursable expenditures and revenue collections are NOT carried forward.

C.8. Indirect Cost. Should the Grantee request reimbursement for indirect cost, the Grantee must submit to the State a copy of the indirect cost rate approved by the cognizant federal agency and the State. The Grantee will be reimbursed for indirect cost in accordance with the approved indirect cost rate to amounts and limitations specified in the attached Grant Budget. Once the Grantee makes an election and treats a given cost as direct or indirect, it must apply that treatment consistently and may not change during the contract period. Any changes in the approved indirect cost rate must have prior approval of the cognizant federal agency and the State. If the indirect cost rate is provisional during the period of this agreement, once the rate becomes final, the Grantee agrees to remit any overpayment of funds to the State, and subject to the availability of funds the State agrees to remit any underpayment to the Grantee.

C.9. Cost Allocation. If any part of the costs to be reimbursed under this Grant Contract are joint costs involving allocation to more than one program or activity, such costs shall be allocated and reported in accordance with the provisions of Department of Finance and Administration Policy Statement 03 or any amendments or revisions made to this policy statement during the contract period.

C.10. Payment of Invoice. A payment by the State shall not prejudice the State's right to object to or question any reimbursement, invoice, or matter in relation thereto. A payment by the State shall not be construed as acceptance of any part of the work or service provided or as approval of any amount as an allowable cost.

C.11. Unallowable Costs. Any amounts payable to the Grantee shall be subject to reduction for amounts included in any invoice or payment theretofore made, which are determined by the State, on the basis of audits or monitoring conducted in accordance with the terms of this Grant Contract, not to constitute allowable costs.

C.12. Deductions. The State reserves the right to deduct from amounts, which are or shall become due and payable to the Grantee under this or any contract between the Grantee and the State of Tennessee any amounts, which are or shall become due and payable to the State of Tennessee by the Grantee.

C.13. Prerequisite Documentation. The Grantee shall not invoice the State under this Grant Contract until the State has received the following documentation properly completed.

a. The Grantee shall complete, sign, and present to the State an "Authorization Agreement for Automatic Deposit (ACH Credits) Form" provided by the State. By doing so, the Grantee acknowledges and agrees that, once said form is received by the State, all

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payments to the Grantee, under this or any other contract the Grantee has with the State of Tennessee shall be made by Automated Clearing House (ACH).

b. The Grantee shall complete, sign, and present to the State a "Substitute W-9 Form" provided by the State. The taxpayer identification number detailed by said form must agree with the Federal Employer Identification Number or Social Security Number referenced in this Grant Contract or the Grantee's Tennessee Edison Registration.

D. STANDARD TERMS AND CONDITIONS:

D.1. Required Approvals. The State is not bound by this Grant Contract until it is signed by the contract parties and approved by appropriate officials in accordance with applicable Tennessee laws and regulations (depending upon the specifics of this contract, said officials may include, but are not limited to, the Commissioner of Finance and Administration, the Commissioner of Human Resources, and the Comptroller of the Treasury).

D.2. Modification and Amendment. Except as specifically provided herein, this Grant Contract may be modified only by a written amendment signed by all parties hereto and approved by both the officials who approved the base contract and, depending upon the specifics of the contract as amended, any additional officials required by Tennessee laws and regulations (said officials may include, but are not limited to, the Commissioner of Finance and Administration, the Commissioner of Human Resources, and the Comptroller of the Treasury).

D.3. Termination for Convenience. The State may terminate this Grant Contract without cause for any reason. Said termination shall not be deemed a breach of contract by the State. The State shall give the Grantee at least one hundred eighty (180) days written notice before the effective termination date. The Grantee shall be entitled to compensation for authorized expenditures and satisfactory services completed as of the termination date, but in no event shall the State be liable to the Grantee for compensation for any service which has not been rendered. The final decision as to the amount, for which the State is liable, shall be determined by the State. Should the State exercise this provision, the Grantee shall not have any right to any actual general, special, incidental, consequential, or any other damages whatsoever of any description or amount.

D.4. Termination for Cause. If the Grantee fails to properly perform its obligations under this Grant Contract in a timely or proper manner, or if the Grantee violates any terms of this Grant Contract, the State shall have the right to immediately terminate the Grant Contract and withhold payments in excess of fair compensation for completed services. Notwithstanding the above, the Grantee shall not be relieved of liability to the State for damages sustained by virtue of any breach of this Grant Contract by the Grantee.

D.5. Subcontracting. The Grantee shall not assign this Grant Contract or enter into a subcontract for any of the services performed under this Grant Contract without obtaining the prior written approval of the State. If such subcontracts are approved by the State, each shall contain, at a minimum, sections of this contract pertaining to "Conflicts of Interest," "Lobbying," "Nondiscrimination," "Public Accountability," "Public Notice," and "Records" (as identified by the section headings). Notwithstanding any use of approved subcontractors, the Grantee shall be the prime contractor and shall be responsible for all work performed.

D.6. Conflicts of Interest. The Grantee warrants that no part of the total Grant Amount shall be paid directly or indirectly to an employee or official of the State of Tennessee as wages, compensation, or gifts in exchange for acting as an officer, agent, employee, subcontractor, or consultant to the Grantee in connection with any work contemplated or performed relative to this Grant Contract.

The Grantee acknowledges, understands, and agrees that this Grant Contract shall be null and void if the Grantee is, or within the past six months has been, an employee of the State of

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Tennessee or if the Grantee is an entity in which a controlling interest is held by an individual who is, or within the past six months has been, an employee of the State of Tennessee.

D.7. Lobbying. The Grantee certifies, to the best of its knowledge and belief, that:

a. No federally appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

b. If any funds other than federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this contract, grant, loan, or cooperative agreement, the Grantee shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

c. The Grantee shall require that the language of this certification be included in the award documents for all sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into and is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, *U.S. Code*.

D.8. Nondiscrimination. The Grantee hereby agrees, warrants, and assures that no person shall be excluded from participation in, be denied benefits of, or be otherwise subjected to discrimination in the performance of this Grant Contract or in the employment practices of the Grantee on the grounds of handicap or disability, age, race, color, religion, sex, national origin, or any other classification protected by Federal, Tennessee State constitutional, or statutory law. The Grantee shall, upon request, show proof of such nondiscrimination and shall post in conspicuous places, available to all employees and applicants, notices of nondiscrimination.

D.9. Public Accountability. If the Grantee is subject to *Tennessee Code Annotated*, Title 8, Chapter 4, Part 4, or if this Grant Contract involves the provision of services to citizens by the Grantee on behalf of the State, the Grantee agrees to establish a system through which recipients of services may present grievances about the operation of the service program, and the Grantee shall display in a prominent place, located near the passageway through which the public enters in order to receive Grant supported services, a sign at least twelve inches (12") in height and eighteen inches (18") in width stating:

NOTICE: THIS AGENCY IS A RECIPIENT OF TAXPAYER FUNDING. IF YOU OBSERVE AN AGENCY DIRECTOR OR EMPLOYEE ENGAGING IN ANY ACTIVITY WHICH YOU CONSIDER TO BE ILLEGAL, IMPROPER, OR WASTEFUL, PLEASE CALL THE STATE COMPTROLLER'S TOLL-FREE HOTLINE: 1-800-232-5454

D.10. Public Notice. All notices, informational pamphlets, press releases, research reports, signs, and similar public notices prepared and released by the Grantee shall include the statement, "This project is funded under an agreement with the State of Tennessee." Any such notices by the Grantee shall be approved by the State.

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D.11. Licensure. The Grantee and its employees and all sub-grantees shall be licensed pursuant to all applicable federal, state, and local laws, ordinances, rules, and regulations and shall upon request provide proof of all licenses.

D.12. Records. The Grantee (and any approved subcontractor) shall maintain documentation for all charges under this Contract. The books, records, and documents of the Grantee (and any approved subcontractor), insofar as they relate to work performed or money received under this Contract, shall be maintained for a period of three (3) full years from the date of the final payment and shall be subject to audit at any reasonable time and upon reasonable notice by the state agency, the Comptroller of the Treasury, or duly appointed representatives. The records of not-for-profit entities shall be maintained in accordance with the *Accounting and Financial Reporting for Not-for-Profit Recipients of Grant Funds in Tennessee*, published by the Tennessee Comptroller of the Treasury and found at http://www.comptroller1.state.tn.us/ma/finreptmanual.asp. The records for local governments shall be maintained in accordance with the *Internal Control and Compliance Manual for Tennessee Municipalities*, published by the Tennessee Comptroller of the Treasury and found at http://www.comptroller1.state.tn.us/ma/citymanual.asp and in accordance with GFOA's publication, *Governmental Accounting, Auditing and Financial Reporting*.

D.13. Prevailing Wage Rates. All grants and contracts for construction, erection, or demolition or to install goods or materials that involve the expenditure of any funds derived from the State require compliance with the prevailing wage laws as provided in *Tennessee Code Annotated*, Section 12-4-401 *et seq.*.

D.14. Monitoring. The Grantee's activities conducted and records maintained pursuant to this Grant Contract shall be subject to monitoring and evaluation by the State, the Comptroller of the Treasury, or their duly appointed representatives.

D.15. Progress Reports. The Grantee shall submit brief, periodic, progress reports to the State as requested.

D.16. Annual Report and Audit. The Grantee shall prepare and submit, within nine (9) months after the close of the reporting period, an annual report of its activities funded under this Grant Contract to the commissioner or head of the Granting agency, the Tennessee Comptroller of the Treasury, and the Commissioner of Finance and Administration. The annual report for any Grantee that receives five hundred thousand dollars ($500,000) or more in aggregate federal and state funding for all its programs shall include audited financial statements. All books of account and financial records shall be subject to annual audit by the Tennessee Comptroller of the Treasury or the Comptroller's duly appointed representative. When an audit is required, the Grantee may, with the prior approval of the Comptroller, engage a licensed independent public accountant to perform the audit. The audit contract between the Grantee and the licensed independent public accountant shall be on a contract form prescribed by the Tennessee Comptroller of the Treasury. Any such audit shall be performed in accordance with generally accepted government auditing standards, the provisions of OMB Circular A-133, if applicable, and the *Audit Manual for Governmental Units and Recipients of Grant Funds* published by the Tennessee Comptroller of the Treasury. The Grantee shall be responsible for reimbursement of the cost of the audit prepared by the Tennessee Comptroller of the Treasury, and payment of fees for the audit prepared by the licensed independent public accountant. Payment of the audit fees of the licensed independent public accountant by the Grantee shall be subject to the provisions relating to such fees contained in the prescribed contract form noted above. Copies of such audits shall be provided to the designated cognizant state agency, the State Granting Department, the Tennessee Comptroller of the Treasury, and the Department of Finance and Administration and shall be made available to the public.

D.17. Procurement. If other terms of this Grant Contract allow reimbursement for the cost of goods, materials, supplies, equipment, and/or contracted services, such procurement(s) shall be made

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on a competitive basis, including the use of competitive bidding procedures, where practical. The Grantee shall maintain documentation for the basis of each procurement for which reimbursement is paid pursuant to this Grant Contract. In each instance where it is determined that use of a competitive procurement method is not practical, supporting documentation shall include a written justification for such decision and non-competitive procurement. Further, and notwithstanding the foregoing, if such reimbursement is to be made with funds derived wholly or partially from federal sources, the determination of cost shall be governed by and reimbursement shall be subject to the Grantee's compliance with applicable federal procurement requirements.

The Grantee shall obtain prior approval from the State before purchasing any equipment under this Grant Contract.

D.18. Strict Performance. Failure by any party to this Grant Contract to insist in any one or more cases upon the strict performance of any of the terms, covenants, conditions, or provisions of this agreement shall not be construed as a waiver or relinquishment of any such term, covenant, condition, or provision. No term or condition of this Grant Contract shall be held to be waived, modified, or deleted except by a written amendment signed by the parties hereto.

D.19. Independent Contractor. The parties hereto, in the performance of this Grant Contract, shall not act as employees, partners, joint venturers, or associates of one another. It is expressly acknowledged by the parties hereto that such parties are independent contracting entities and that nothing in this Grant Contract shall be construed to create an employer/employee relationship or to allow either to exercise control or direction over the manner or method by which the other transacts its business affairs or provides its usual services. The employees or agents of one party shall not be deemed or construed to be the employees or agents of the other party for any purpose whatsoever.

The Grantee, being an independent contractor and not an employee of the State, agrees to carry adequate public liability and other appropriate forms of insurance, including adequate public liability and other appropriate forms of insurance on the Grantee's employees, and to pay all applicable taxes incident to this Grant Contract.

D.20. State Liability. The State shall have no liability except as specifically provided in this Grant Contract.

D.21. Force Majeure. The obligations of the parties to this Grant Contract are subject to prevention by causes beyond the parties' control that could not be avoided by the exercise of due care including, but not limited to, natural disasters, riots, wars, epidemics, or any other similar cause.

D.22. State and Federal Compliance. The Grantee shall comply with all applicable state and federal laws and regulations in the performance of this Grant Contract.

D.23. Governing Law. This Grant Contract shall be governed by and construed in accordance with the laws of the State of Tennessee. The Grantee agrees that it will be subject to the exclusive jurisdiction of the courts of the State of Tennessee in actions that may arise under this Grant Contract. The Grantee acknowledges and agrees that any rights or claims against the State of Tennessee or its employees hereunder, and any remedies arising there from, shall be subject to and limited to those rights and remedies, if any, available under *Tennessee Code Annotated*, Sections 9-8-101 through 9-8-407.

D.24. Completeness. This Grant Contract is complete and contains the entire understanding between the parties relating to the subject matter contained herein, including all the terms and conditions of the parties' agreement. This Grant Contract supersedes any and all prior understandings, representations, negotiations, and agreements between the parties relating hereto, whether written or oral.

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D.25. Severability. If any terms and conditions of this Grant Contract are held to be invalid or unenforceable as a matter of law, the other terms and conditions hereof shall not be affected thereby and shall remain in full force and effect. To this end, the terms and conditions of this Grant Contract are declared severable.

D.26. Headings. Section headings are for reference purposes only and shall not be construed as part of this Grant Contract.

E. **SPECIAL TERMS AND CONDITIONS:**

E.1. Conflicting Terms and Conditions. Should any of these special terms and conditions conflict with any other terms and conditions of this Grant Contract, these special terms and conditions shall control.

E.2. Communications and Contacts. All instructions, notices, consents, demands, or other communications required or contemplated by this Grant Contract shall be in writing and shall be made by certified, first class mail, return receipt requested and postage prepaid, by overnight courier service with an asset tracking system, or by EMAIL or facsimile transmission with recipient confirmation. Any such communications, regardless of method of transmission, shall be addressed to the respective party at the appropriate mailing address, facsimile number, or EMAIL address as set forth below or to that of such other party or address, as may be hereafter specified by written notice.

The State:

John R. Arredondo, Assistant Commissioner
Division of Hospital Services
Department of Mental Health and Substance Abuse Services
11th Floor, Andrew Johnson Tower
710 James Robertson Parkway
Nashville, TN 37243
John.Arredondo@tn.gov
Telephone #: (615) 532-6515
FAX #: (615) 532-6514

The Grantee:

Candace Jennings
Senior Vice President, TN Operations
Mountain Sates Health Alliance – Corporate
303 Med Tech Parkway, #300
Johnson City, TN 37604
JenningsCA@msha.com
Telephone #: (423) 302-3374
FAX #: (423) 302-3446

All instructions, notices, consents, demands, or other communications shall be considered effectively given upon receipt or recipient confirmation as may be required.

E.3. Subject to Funds Availability. The Grant Contract is subject to the appropriation and availability of State and/or Federal funds. In the event that the funds are not appropriated or are otherwise unavailable, the State reserves the right to terminate the Grant Contract upon written notice to the Grantee. Said termination shall not be deemed a breach of contract by the State. Upon receipt of the written notice, the Grantee shall cease all work associated with the Grant Contract. Should such an event occur, the Grantee shall be entitled to compensation for all satisfactory and

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authorized services completed as of the termination date. Upon such termination, the Grantee shall have no right to recover from the State any actual, general, special, incidental, consequential, or any other damages whatsoever of any description or amount.

E.4. Insurance. The Grantee shall carry adequate liability and other appropriate forms of insurance.

a. The Grantee shall maintain, at minimum, the following insurance coverage:

(1) Workers' Compensation/ Employers' Liability (including all states coverage) with a limit not less than the relevant statutory amount or one million dollars ($1,000,000) per occurrence for employers' liability whichever is greater.

(2) Comprehensive Commercial General Liability (including personal injury & property damage, premises/operations, independent contractor, contractual liability and completed operations/products) with a bodily injury/property damage combined single limit not less than one million dollars ($1,000,000) per occurrence and two million dollars ($2,000,000) aggregate.

(3) Automobile Coverage (including owned, leased, hired, and non-owned vehicles) with a bodily injury/property damage combined single limit not less than one million dollars ($1,000,000) per occurrence.

(4) Professional Malpractice Liability with a limit of not less than one million dollars ($1,000,000) per claim and two million dollars ($2,000,000) aggregate.

b. At any time State may require the Grantee to provide a valid Certificate of Insurance detailing Coverage Description; Insurance Company & Policy Number; Exceptions and Exclusions; Policy Effective Date; Policy Expiration Date; Limit(s) of Liability; and Name and Address of Insured. Failure to provide required evidence of insurance coverage shall be a material breach of this Grant Contract.

E.5. Charges to Service Recipients Prohibited. The Grantee shall not collect any amount in the form of fees or reimbursements from the recipients of any service provided pursuant to this Grant Contract.

E.6. No Equipment Acquisition. This Grant Contract does not involve the acquisition and disposition of equipment acquired with funds provided under this Grant Contract.

E.7. Confidentiality of Records. Strict standards of confidentiality of records and information shall be maintained in accordance with applicable state and federal law. All material and information, regardless of form, medium or method of communication, provided to the Grantee by the State or acquired by the Grantee on behalf of the State shall be regarded as confidential information in accordance with the provisions of applicable state and federal law, state and federal rules and regulations, departmental policy, and ethical standards. Such confidential information shall not be disclosed, and all necessary steps shall be taken by the Grantee to safeguard the confidentiality of such material or information in conformance with applicable state and federal law, state and federal rules and regulations, departmental policy, and ethical standards.

The Grantee's obligations under this section do not apply to information in the public domain; entering the public domain but not from a breach by the Grantee of this Grant Contract; previously possessed by the Grantee without written obligations to the State to protect it; acquired by the Grantee without written restrictions against disclosure from a third party which, to the Grantee's knowledge, is free to disclose the information; independently developed by the Grantee without the use of the State's information; or, disclosed by the State to others without restrictions against disclosure. Nothing in this paragraph shall permit Grantee to disclose any information that is confidential under federal or state law or regulations, regardless of whether it has been

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disclosed or made available to the Grantee due to intentional or negligent actions or inactions of agents of the State or third parties.

It is expressly understood and agreed the obligations set forth in this section shall survive the termination of this Grant Contract.

E.8. HIPAA Compliance. The State and the Grantee shall comply with obligations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its accompanying regulations.

a. The Grantee warrants to the State that it is familiar with the requirements of HIPAA and its accompanying regulations, and will comply with all applicable HIPAA requirements in the course of this Grant Contract.

b. The Grantee warrants that it will cooperate with the State, including cooperation and coordination with State privacy officials and other compliance officers required by HIPAA and its regulations, in the course of performance of this Grant Contract so that both parties will be in compliance with HIPAA.

c. The State and the Grantee will sign documents, including but not limited to business associate agreements, as required by HIPAA and that are reasonably necessary to keep the State and the Grantee in compliance with HIPAA. This provision shall not apply if information received by the State under this Grant Contract is NOT "protected health information" as defined by HIPAA, or if HIPAA permits the State to receive such information without entering into a business associate agreement or signing another such document.

E.9. Rule 2 Compliance. The State and the Grantee shall comply with obligations under Rule 2 of the Confidentiality of Alcohol and Drug Abuse Patient Records, and its accompanying regulations as codified at 42 CFR § 2.1 et seq.

a. The Grantee warrants to the State that it is familiar with the requirements of Rule 2 of the Confidentiality of Alcohol and Drug Abuse Patient Records, and its accompanying regulations, and will comply with all applicable requirements in the course of this Grant Contract.

b. The Grantee warrants that it will cooperate with the State, including cooperation and coordination with State privacy officials and other compliance officers required by Rule 2 of the Confidentiality of Alcohol and Drug Abuse Patient Records, and its regulations, in the course of performance of the Grant Contract so that both parties will be in compliance with Rule 2 of the Confidentiality of Alcohol and Drug Abuse Patient Records.

c. The State and the Grantee will sign documents, including but not limited to business associate agreements, as required by Rule 2 of the Confidentiality of Alcohol and Drug Abuse Patient Records, and that are reasonably necessary to keep the State and the Grantee in compliance with Rule 2 of the Confidentiality of Alcohol and Drug Abuse Patient Records. This provision shall not apply if information received by the State under this Grant Contract is NOT "protected health information" as defined by Rule 2 of the Confidentiality of Alcohol and Drug Abuse Patient Records, or if Rule 2 of the Confidentiality of Alcohol and Drug Abuse Patient Records permits the State to receive such information without entering into a business associate agreement or signing another such document.

E.10. Printing Authorization. The Grantee agrees that no publication coming within the jurisdiction of *Tennessee Code Annotated*, Section 12-7-101, *et seq.*, shall be printed unless a printing authorization number has been obtained and affixed as required by *Tennessee Code Annotated*, Section 12-7-103 (d).

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E.11. State Furnished Property. The Grantee shall be responsible for the correct use, maintenance, and protection of all articles of nonexpendable, tangible, personal property furnished by the State for the Grantee's temporary use under this Grant Contract. Upon termination of this Grant Contract, all property furnished shall be returned to the State in good order and condition as when received, reasonable use and wear thereof excepted. Should the property be destroyed, lost, or stolen, the Grantee shall be responsible to the State for the residual value of the property at the time of loss.

E.12. Environmental Tobacco Smoke. Pursuant to the provisions of the federal "Pro-Children Act of 1994" and the Tennessee "Children's Act for Clean Indoor Air of 1995," the Grantee shall prohibit smoking of tobacco products within any indoor premises in which services are provided to individuals under the age of eighteen (18) years. The Grantee shall post "no smoking" signs in appropriate, permanent sites within such premises. This prohibition shall be applicable during all hours, not just the hours in which children are present. Violators of the prohibition may be subject to civil penalties and fines. This prohibition shall apply to and be made part of any subcontract related to this Grant Contract.

E.13. Debarment and Suspension. The Grantee certifies, to the best of its knowledge and belief, that it, its current and future principals, its current and future subcontractors and their principals:

a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any federal or state department or agency;

b. have not within a three (3) year period preceding this Grant Contract been convicted of, or had a civil judgment rendered against them from commission of fraud, or a criminal offence in connection with obtaining, attempting to obtain, or performing a public (federal, state, or local) transaction or grant under a public transaction; violation of federal or state antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification, or destruction of records, making false statements, or receiving stolen property;

c. are not presently indicted or otherwise criminally or civilly charged by a government entity (federal, state, or local) with commission of any of the offenses detailed in section b. of this certification; and

d. have not within a three (3) year period preceding this Grant Contract had one or more public transactions (federal, state, or local) terminated for cause or default.

The Grantee shall provide immediate written notice to the State if at any time it learns that there was an earlier failure to disclose information or that due to changed circumstances, its principals or the principals of its subcontractors are excluded or disqualified.

E.14. Hold Harmless. The Grantee agrees to indemnify and hold harmless the State of Tennessee as well as its officers, agents, and employees from and against any and all claims, liabilities, losses, and causes of action which may arise, accrue, or result to any person, firm, corporation, or other entity which may be injured or damaged as a result of acts, omissions, or negligence on the part of the Grantee, its employees, or any person acting for or on its or their behalf relating to this Grant Contract. The Grantee further agrees it shall be liable for the reasonable cost of attorneys for the State in the event such service is necessitated to enforce the terms of this Grant Contract or otherwise enforce the obligations of the Grantee to the State.

In the event of any such suit or claim, the Grantee shall give the State immediate notice thereof and shall provide all assistance required by the State in the State's defense. The State shall give the Grantee written notice of any such claim or suit, and the Grantee shall have full right and obligation to conduct the Grantee's own defense thereof. Nothing contained herein shall be deemed to accord to the Grantee, through its attorney(s), the right to represent the State of

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Tennessee in any legal matter, such rights being governed by *Tennessee Code Annotated*, Section 8-6-106.

E.15. Drug-Free Workplace. The Grantee agrees that it shall provide a drug-free workplace pursuant to the Drug-Free Workplace Act of 1988, Title 41 of the United States Code (41 USC) §§ 701 et seq., and the regulations in Title 45 of the Code of Federal Regulations (45 CFR) Part 82.

E.16. Professional Practice. The Grantee shall assure that there is a code of conduct in place and applicable to all employees that covers, at minimum, business practices, clinical practices, and service recipient/staff interaction/fraternization. Further, Grantee's personnel shall conduct their practice in conformity with all applicable statutes, rules and regulations, and recognized ethical standards of their profession. Procedures for reporting violations of the ethical standards shall be developed and communicated to staff upon hire and annually thereafter, which shall include a non-reprisal approach for persons reporting suspected violations, as well as a description of possible sanctions for violating the standards. Failure to implement a code of conduct in accordance with this section and to adequately address suspected violations of the code of conduct may be cause for termination of this Grant Contract.

E.17. Additional Subcontracting Requirements. If subcontracts are approved by the State, they shall contain, in addition to those sections identified in D.5., sections on "Confidentiality of Records", "HIPAA Compliance", and "Rule 2 Compliance" (as identified by the section headings). Notwithstanding any use of approved subcontractors, the Grantee shall be the prime contractor and shall be responsible for all work performed.

IN WITNESS WHEREOF,

MOUNTAIN STATES HEALTH ALLIANCE:

APPROVED BY MSHA LEGAL DEPARTMENT

GRANTEE SIGNATURE **DATE**

PRINTED NAME AND TITLE OF GRANTEE SIGNATORY (above)

DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES:

E. DOUGLAS VARNEY, COMMISSIONER **DATE**

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ATTACHMENT 01

GRANT BUDGET

(BUDGET PAGE 1)

GRANTEE: Mountain States Health Alliance
PROGRAM: Inpatient Psychiatric Services (at the Woodridge Hospital facility)

APPLICABLE PERIOD: The grant budget line-item amounts below shall be applicable only to expense incurred during the period beginning April 1, 2012 and ending June 30, 2014.

POLICY 03 Object Line-Item Reference	EXPENSE OBJECT LINE-ITEM CATEGORY [1] (detail schedule(s) attached as applicable)	GRANT CONTRACT	GRANTEE PARTICIPATION	TOTAL PROJECT
1	Salaries	0.00	0.00	0.00
2	Benefits & Taxes	0.00	0.00	0.00
4, 15	Professional Fee/ Grant & Award [2]	$5,688,540.00	0.00	$5,688,540.00
5	Supplies	0.00	0.00	0.00
6	Telephone	0.00	0.00	0.00
7	Postage & Shipping	0.00	0.00	0.00
8	Occupancy	0.00	0.00	0.00
9	Equipment Rental & Maintenance	0.00	0.00	0.00
10	Printing & Publications	0.00	0.00	0.00
11, 12	Travel/ Conferences & Meetings	0.00	0.00	0.00
13	Interest [2]	0.00	0.00	0.00
14	Insurance	0.00	0.00	0.00
16	Specific Assistance To Individuals	0.00	0.00	0.00
17	Depreciation [2]	0.00	0.00	0.00
18	Other Non-Personnel [2]	0.00	0.00	0.00
20	Capital Purchase [2]	0.00	0.00	0.00
22	Indirect Cost	0.00	0.00	0.00
24	In-Kind Expense	0.00	0.00	0.00
25	GRAND TOTAL	$5,688,540.00	0.00	$5,688,540.00

[1] Each expense object line-item shall be defined by the Department of Finance and Administration Policy 03, *Uniform Reporting Requirements and Cost Allocation Plans for Subrecipients of Federal and State Grant Monies, Appendix A.* (posted on the Internet at: www.state.tn.us/finance/rds/ocr/policy03.pdf).

[2] Applicable detail attached if line-item is funded.

ATTACHMENT 01 (continued)

GRANT BUDGET LINE-ITEM DETAIL

(BUDGET PAGE 2)

GRANTEE: Mountain States Health Alliance PROGRAM: Inpatient Psychiatric Services (at the Woodridge Hospital facility)	
PROFESSIONAL FEE/ GRANT & AWARD	AMOUNT
Reimbursement for Inpatient Psychiatric Services to eligible uninsured individuals for the period April 1, 2012 through June 30, 2012 for Four Hundred Sixty-Eight (468) uninsured adult patient days per month. Included in this number for this time period is Eight (8) uninsured juvenile patient days for eligible uninsured juveniles, not to exceed a maximum of $3,600.00 for this time period. Each month may be adjusted based on variances in utilization.	$632,060.00
Reimbursement for Inpatient Psychiatric Services to eligible uninsured individuals for the period July 1, 2012 through June 30, 2013 for Four Hundred Sixty-Eight (468) uninsured adult patient days per month. Included in this number for this time period is Thirty-Two (32) uninsured juvenile patient days for eligible uninsured juveniles, not to exceed a maximum of $14,400.00 for this time period. Each month may be adjusted based on variances in utilization.	$2,528,240.00
Reimbursement for Inpatient Psychiatric Services to eligible uninsured individuals for the period July 1, 2013 through June 30, 2014 for Four Hundred Fifty-Four (454) uninsured adult patient days per month. Included in this number for this time period is Thirty-Two (32) uninsured juvenile patient days for eligible uninsured juveniles, not to exceed a maximum of $14,400.00 for this time period. Each month may be adjusted based on variances in utilization.	$2,528,240.00
TOTAL	$5,688,540.00

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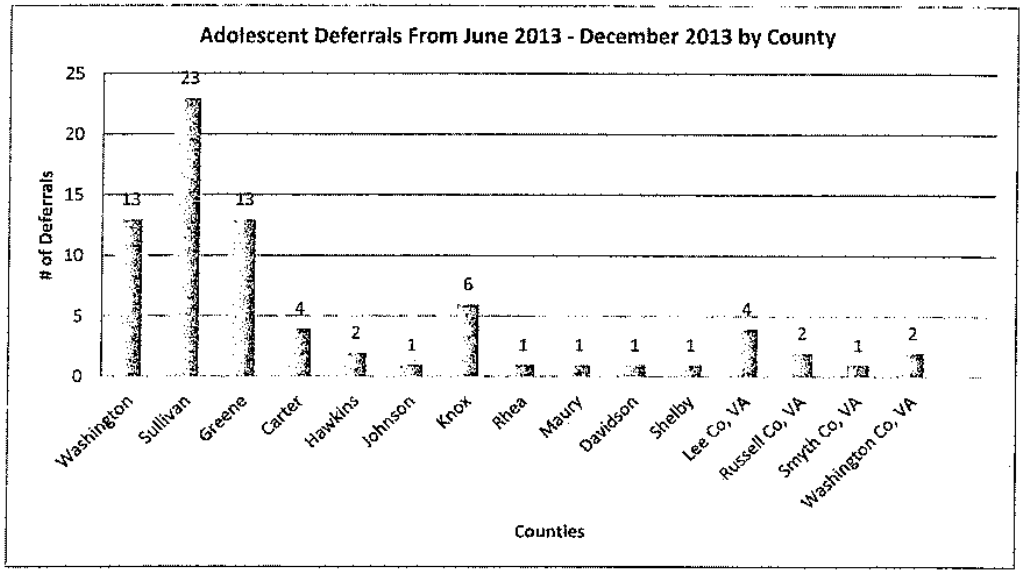
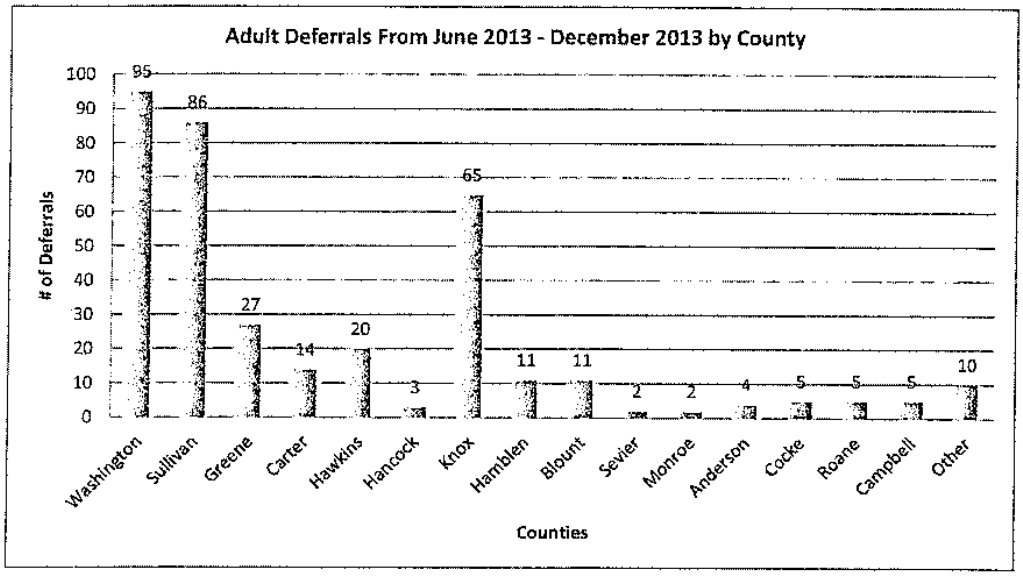
Adolescent Deferrals from June 2013 - December 2013 by County

Washington	Sullivan	Greene	Carter	Hawkins	Johnson	Knox	Rhea	Maury	Davidson	Shelby	Lee Co, VA	Russell Co, VA	Smyth Co, VA	Washington Co, VA	TOTAL
13	23	13	4	2	1	6	1	1	1	1	4	2	1	2	75



Adult Deferrals from June 2013 - December 2013 by County

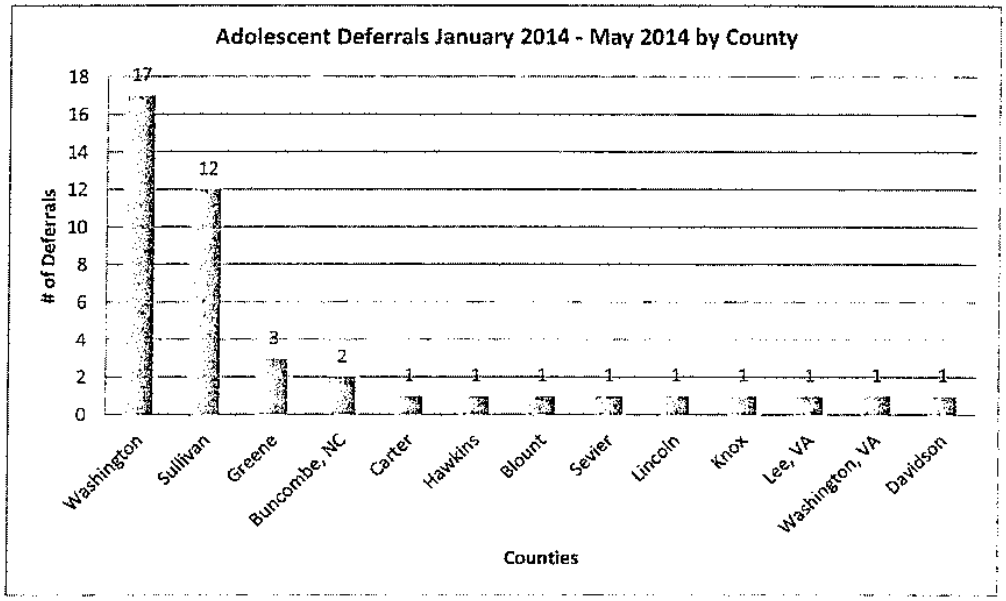
Washington	Sullivan	Greene	Carter	Hawkins	Hancock	Knox	Hamblen	Blount	Sevier	Monroe	Anderson	Cocke	Roane	Campbell	Other	TOTAL
95	86	27	14	20	3	65	11	11	2	2	4	5	5	5	10	365



The following counties had one deferral each during the time frame from June 1, 2013 - December 31, 201:
The counties are Unicoi, Johnson, Jefferson, Jackson, Morgan, Shelby, Loudon, Putnam, Russell, VA, and Scott, VA

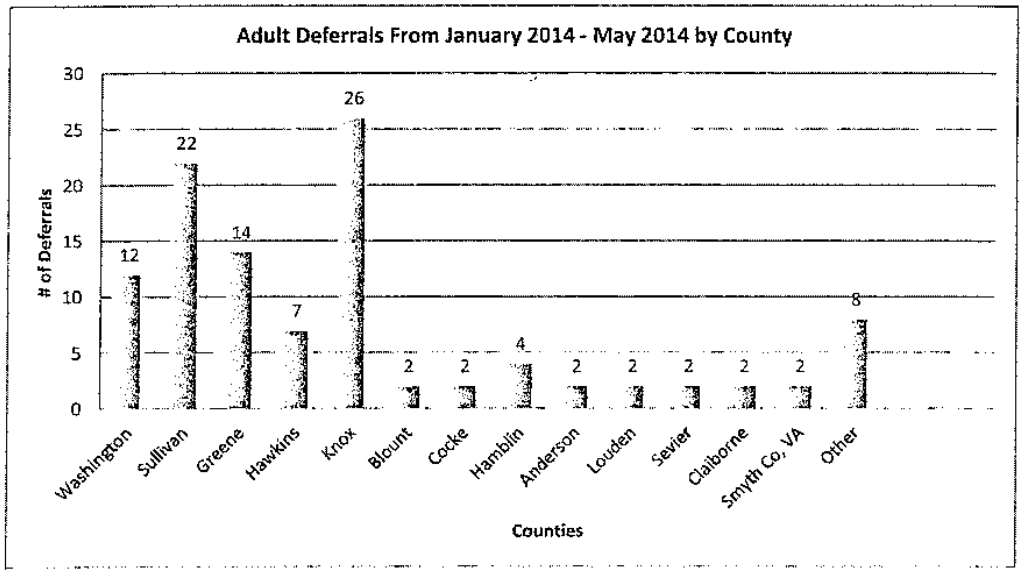
Adolescent Deferrals from January 2014-May 2014 by County

Washington	Sullivan	Greene	Buncombe, NC	Carter	Hawkins	Blount	Sevier	Lincoln	Knox	Lee, VA	Washington, VA	Davidson	TOTAL
17	12	3	2	1	1	1	1	1	1	1	1	1	43



Adult Deferrals from January 2014 - May 2014 by County

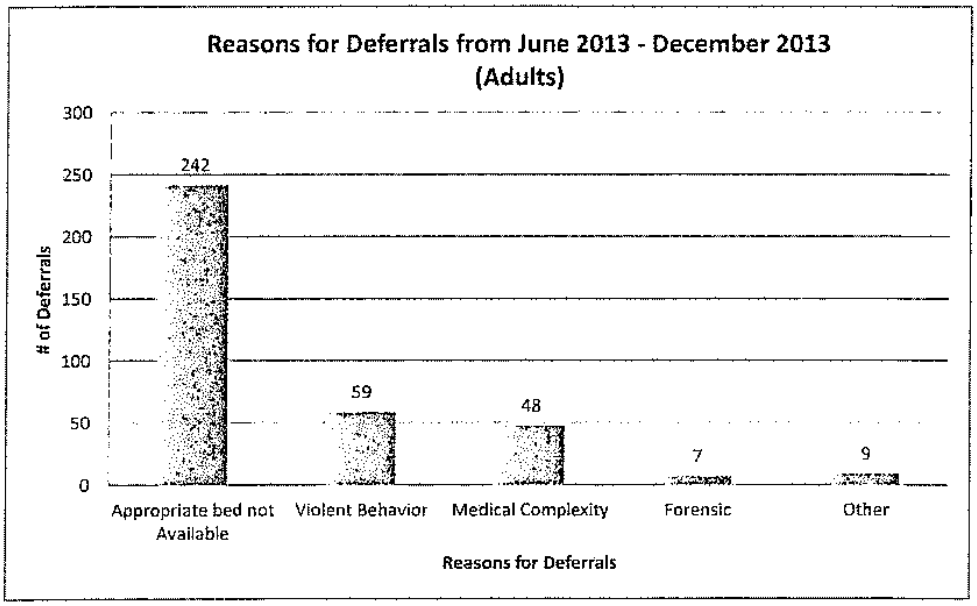
Washington	Sullivan	Greene	Hawkins	Knox	Blount	Cocke	Hamblin	Anderson	Louden	Sevier	Claiborne	Smyth Co, VA	Other	TOTAL
12	22	14	7	26	2	2	4	2	2	2	2	2	8	107



The following counties had one deferral each during the time frame from January 1, 2014 through May 31, 201
The counties are Carter, Unicoi, Jefferson, Monroe, Rutherford, Shelby, Roane, and Buncombe, NC

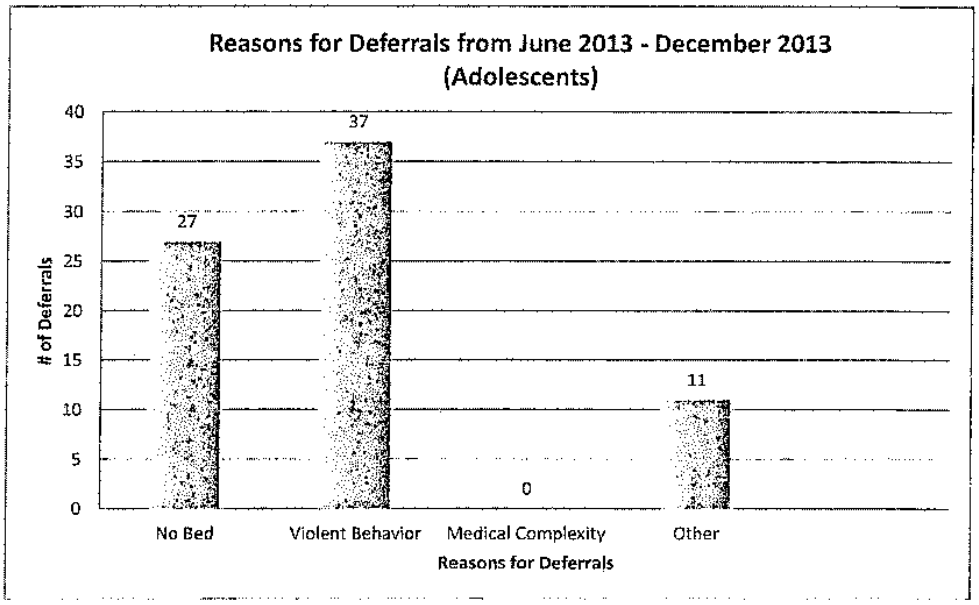
Reasons for Deferrals from June 2013 - December 2013

	Appropriate bed not Available	Violent Behavior	Medical Complexity	Forensic	Other	TOTAL
ADULTS	242	59	48	7	9	365



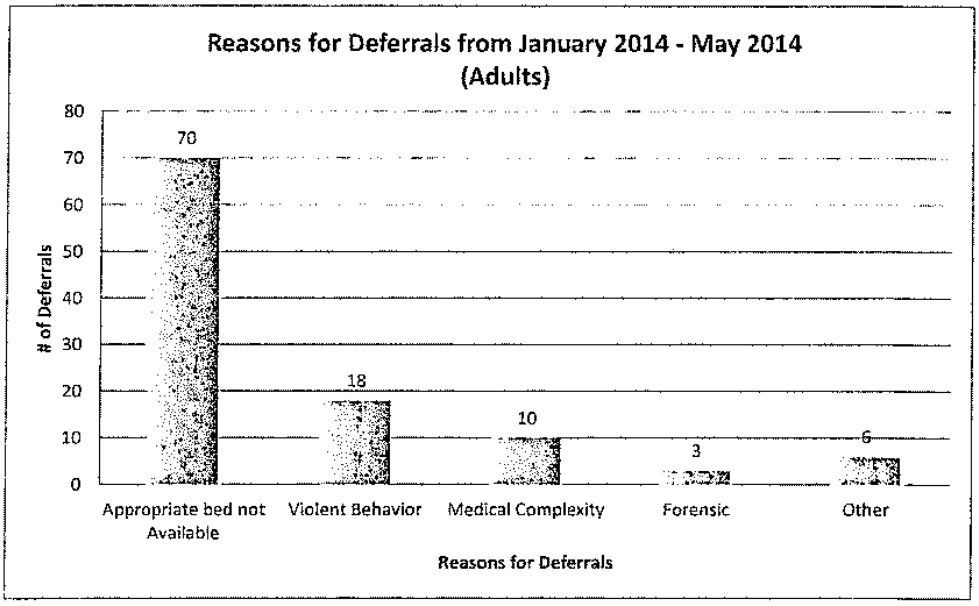
Reasons for Deferrals from June 2013 - December 2013

	No Bed	Violent Behavior	Medical Complexity	Other	TOTAL
ADOL	27	37	0	11	75



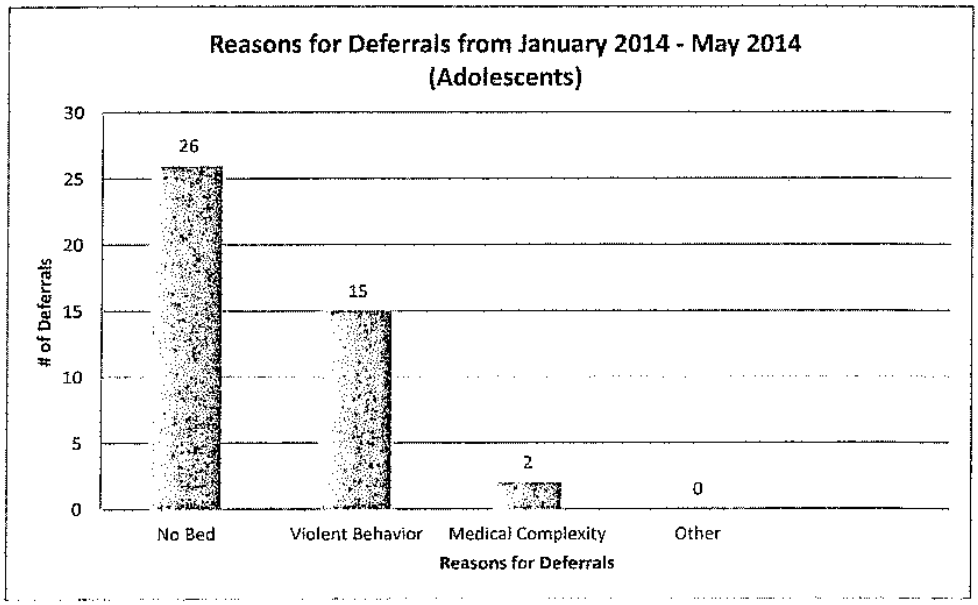
Reasons for Deferrals from January 2014 - May 2014

	Appropriate bed not Availabl	Violent Behavior	Medical Complexity	Forensic	Other	TOTAL
ADULTS	70	18	10	3	6	107



Reasons for Deferrals from January 2014 - May 2014

	No Bed	Violent Behavior	Medical Complexity	Other	TOTAL
ADOL	26	15	2	0	43



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Inpatient Psychiatric Services Data Dictionary			
Item #	ENC - REDACTED	Data Item Definition	Data Description
1		**Social Security Number**	Identifies the patient's social security number.
		9- Digit Number	
2		**Last Name**	Identifies the patient's last name.
3		**First Name**	Identifies the patient's first name.
4		**Date of Birth**	Identifies the patient's date of birth.
		MMDDYYYY	
5		**County of Residence**	Identifies the patient's county of residence.
		Anderson	
		Bedford	
		Benton	
		Bledsoe	
		Blount	
		Bradley	
		Campbell	
		Cannon	
		Carroll	
		Carter	
		Cheatham	
		Chester	
		Claiborne	
		Clay	
		Cocke	
		Coffee	
		Crockett	
		Cumberland	
		Davidson	
		Decatur	
		DeKalb	
		Dickson	
		Dyer	
		Fayette	
		Fentress	
		Franklin	
		Gibson	
		Giles	
		Grainger	
		Greene	
		Grundy	

Inpatient Psychiatric Services Data Dictionary			
m #	ENC - REDACTED	Data Item Definition	Data Description
		Hamblen	
		Hamilton	
		Hancock	
		Hardeman	
		Hardin	
		Hawkins	
		Haywood	
		Henderson	
		Henry	
		Hickman	
		Houston	
		Humphreys	
		Jackson	
		Jefferson	
		Johnson	
		Knox	
		Lake	
		Lauderdale	
		Lawrence	
		Lewis	
5		**County of Residence (Cont.)**	Identifies the patient's county of residence.
		Lincoln	
		Loudon	
		Macon	
		Madison	
		Marion	
		Marshall	
		Maury	
		Meigs	
		Monroe	
		Montgomery	
		Moore	
		Morgan	
		McMinn	
		McNairy	
		Obion	
		Overton	
		Perry	
		Pickett	
		Polk	
		Putnam	
		Rhea	
		Roane	
		Robertson	
		Rutherford	

Inpatient Psychiatric Services Data Dictionary			
n #	ENC - REDACTED	Data Item Definition	Data Description
		Scott	
		Sequatchie	
		Sevier	
		Shelby	
		Smith	
		Stewart	
		Sullivan	
		Sumner	
		Tipton	
		Trousdale	
		Unicoi	
		Union	
		Van Buren	
		Warren	
		Washington	
		Wayne	
		Weakley	
		White	
		Williamson	
		Wilson	
		Out of State	

Inpatient Psychiatric Services Data Dictionary			
m #	ENC - REDACTED	Data Item Definition	Data Description
6		**State of Residence**	Identifies the patient's state of residence.
		Tennessee	
		Kentucky	
		North Carolina	
		Virginia	
		Other State	
7		**Date of Admission**	Identifies the patient's date of admission.
		MMDDYYYY	
8		**Time of Admission**	Identifies the patient's time of admission.
		HH:MM AM or PM	
9	DD	**Date of Discharge**	Identifies the patient's date of discharge.
		MMDDYYYY	
10	NU	**Number of Uninsured Adult Patient Days**	Identifies the number of uninsured patient days.
		Valid number of days	
11	GE	**Gender**	Identifies the patient's reported sex.
	1	Male	
	2	Female	
12	RA	**Race**	Specifies the patient's reported race.
	2	American Indian and Alaska Native	
	13	Asian	
	23	Native Hawaiian or Other Pacific Islander	
	4	Black or African American	
	5	White	
	20	Some Other Race Alone	
	21	Two or More Races	
13	ETH	**Ethnicity**	Identifies whether or not the patient is of Hispanic or Latino origin.
	1	Hispanic Origin	
	2	Not of Hispanic Origin	

Inpatient Psychiatric Services Data Dictionary			
n #	ENC - REDACTED	Data Item Definition	Data Description
14	MS	**Marital Status**	Identifies patient's reported marital status.
	1	Never Married	
	2	Married/Living as a Couple	
	3	Separated	
	4	Divorced	
	5	Widowed	

Inpatient Psychiatric Services Data Dictionary			
n #	ENC - REDACTED	Data Item Definition	Data Description
15	MIS	**Military Status**	Identifies the condition of being active or non-active, an honorably or dishonorably discharged veteran in the armed forces, no military participation or unknown status.
	1	Active Military	
	2	None	
	3	Veteran	
	4	Unknown	
16	PL	**Primary Language**	Identifies language that patient uses most comfortably to communicate.
	1	English	
	2	Spanish	
	3	American Sign Language	
	4	Other	
17	EMP	**Job/ Employment Status**	Specifies the patient's employment status at admission.
	1	Full time	
	2	Part time	
	3	Unemployed	
	14	Homemaker	
	24	Student	
	34	Retired	
	44	Disabled	
	54	Hospital patient or resident of other institutions (e.g., correctional facilities, nursing homes, mental health care facilities, etc.)	
	64	Other Reported Classification (e.g. volunteers)	
	74	Sheltered/Non-Competitive employment	
	98	Not Collected	
18	AI	**Amount of Income**	Specifies the patient's income in the last 12 months. "Income" means gross income and is the total of earned and unearned income used by the Internal Revenue Service of the United States of America to determine whether an income tax return shall be filled.

Inpatient Psychiatric Services Data Dictionary			
n #	ENC - REDACTED	Data Item Definition	Data Description
19	LAA	**Living Arrangement at Admission**	Specifies patient's residential status at time of admission.
	1	Homeless	
	2	Foster Home/Foster Care	
	3	Residential Care	
	4	Crisis residence	
	5	Institutional Setting	
	6	Jail/Correctional Facility	
	17	Private Residence – Independent Living	
	27	Private Residence – Dependent Living	
	87	Private Residence – Living Arrangement Not Available	
	8	Other Residence Status	
	37	With family/extended family or with non-relative	Should only be used for children

Inpatient Psychiatric Services Data Dictionary			
m #	ENC - REDACTED	Data Item Definition	Data Description
20	NPH	Number of People in Household	Specifies the number of persons in a patient's household at admission. A household includes all the people who occupy a housing unit. A housing unit is a house, an apartment, a mobile home, a group of rooms, or a single room occupied as separate living quarters.
21	RS	Referral Source	Identifies entity that referred patient for hospitalization.
	1	Crisis team	
	2	Emergency department	
	3	Family	
	4	Self	
	5	Other	
22	LS	Legal Status at Admission	Identifies the patient's legal status at the time of admission.
	1	Voluntary – Self	
	2	Voluntary – Others (by guardian, parents, etc.)	
	3	Involuntary – Civil	
	4	Involuntary – Criminal	
23	PAD	Primary Admission Diagnosis (Axis I or II)	Specifies the patient's current diagnoses at admission.
	XXX.XXXX	Diagnosis Code	
24	SAD	Secondary Admission Diagnosis (All Other Axis I or II Diagnoses)	Specifies the patient's current diagnoses at admission.
	XXX.XXXX	Diagnosis Code	
25	PDD	Primary Discharge Diagnosis (Axis I or II)	Specifies the patient's current diagnoses at discharge.
	XXX.XXXX	Diagnosis Code	
26	SDD	Secondary Discharge Diagnosis (All Other Axis I or II Diagnoses)	Specifies the patient's current diagnoses at discharge.
	XXX.XXXX	Diagnosis Code	

Inpatient Psychiatric Services Data Dictionary			
m #	ENC - REDACTED	Data Item Definition	Data Description
27	LAD	**Living Arrangement at Discharge**	Specifies patient's residential status at time of discharge.
	1	Homeless	
	2	Foster Home/Foster Care	
	3	Residential Care	
	4	Crisis residence	
	5	Institutional Setting	
	6	Jail/Correctional Facility	
	17	Private Residence – Independent Living	
	27	Private Residence – Dependent Living	
	87	Private Residence – Living Arrangement Not Available	
	8	Other Residence Status	
	37	With family/extended family or with non-relative	Should only be used for children
28	AFT	**Aftercare Arrangements**	Identifies number of days from discharge that an appointment with a community-based provider was scheduled for patient.
		Valid number of days (*Use "0" if no appointment was scheduled for patient prior to discharge.)	
29	DR	**Discharge Reason**	Identifies the reason for discharge.
	1	Completed inpatient mental health or substance abuse treatment	
	2	Released by or to courts	
	3	Left against medical advice ('AMA')/ Eloped or failed to return from leave/ Non Compliance with treatment and/ or policy	
	4	Client Choice	
	5	Extended placement	
	6	Death	
	7	Discharged to other psychiatric inpatient provider	
	8	Discharged to an acute medical facility for medical services	

Woodridge Psychiatric Hospital Report

Sort by MCRT	Hospital Encounter Number	Social Security Number	Last Name	First Name	Date of Birth	County of Residence	State of Residence	Date of Admission	Time of Admission	Date of Discharge	Number of Unsecured Adult Patient Days	Gender	Race	Ethnicity	Marital Status	Military Status	Primary Language	Job/ Employment Status	Amount of Income	Living Arrangement at Admission	Number of People in Household	Referral Source	Legal Status at Admission	Primary Admission Diagnosis (Axis I or II)	Secondary Admission Diagnosis (All Other Axis I or II Diagnoses)	Primary Discharge Diagnosis (Axis I or II)	Secondary Discharge Diagnosis (All Other Axis I or II Diagnoses)	Living Arrangement at Discharge	Aftercare Arrangements	Discharge Reason	Per Diem Rate	Total Amount for Stay
MCRT	ENC - REDACTED	SSN	LN	FN	DOB	CO	ST	DA	TA	DD	NU	GE	RA	ETH	MS	MIS	PL	EMPS	AI	LAR	NPH	RS	LS	PAD	SAD	PDD	SDD	LAD	AFT	DR	Per Diem	Totals
A					2/11/1997	82	1	7/20/14	12:25 AM	8/19/14		2	5	2			1						1	3								450.00	$450.00
X					1/2/1976	37	1	7/22/14	6:15 AM	8/2/14	1	1	5	2			1						1	3								477.00	$477.00
X					12/1/1980	37	1	7/28/14	8:45 PM	8/2/14	1	1	5	2			1						1	3								477.00	$477.00
X					10/20/1963	30	1	7/28/14	8:24 AM	8/4/14	3	2	5	2			1						1	3								477.00	$1,431.00
X					1/19/1981	98	4	7/28/14	2:17 PM	8/4/14	3	1	5	2			1						1	3								477.00	$1,431.00
X					11/2/1992	96	3	7/28/14	9:33 AM	8/5/14	4	1	5	2			1						1	3								477.00	$1,908.00
X					1/2/1968	90	1	7/29/14	5:58 AM	8/5/14	4	2	5	2			1						1	3								477.00	$1,908.00
X					1/25/1983	90	1	7/29/14	12:54 PM	8/6/14	4	2	5	2			1						1	3								477.00	$1,908.00
X					12/27/1985	30	1	7/29/14	7:25 PM	8/3/14	2	1	5	2			1						1	1								477.00	$954.00
X					4/18/1971	37	1	7/29/14	4:34 PM	8/4/14	3	2	5	2			1						1	1								477.00	$1,431.00
X					2/27/2002	86	1	7/29/14	9:10 PM	8/5/15	4	2	5	2			1						1	3								450.00	$1,800.00
X					1/5/1988	98	4	7/30/14	9:05 AM	8/6/14	5	2	5	2			1						1	3								477.00	$2,385.00
X					5/31/1972	10	1	7/30/14	5:29 PM	8/4/14	3	2	5	2			1						1	3								477.00	$1,431.00
X					3/8/1975	96	5	7/30/14	10:10 PM	8/6/14	5	2	5	2			1						1	3								477.00	$2,385.00
X					9/23/1963	90	1	7/30/14	9:15 PM	8/4/14	3	1	5	2			1						1	1								477.00	$1,431.00
X					4/3/1982	82	1	7/30/14	3:12 PM	8/2/14	1	2	5	2			1						1	3								477.00	$477.00
X					12/25/1981	98	4	7/31/14	4:30 AM	8/7/14	6	2	5	2			1						1	3								477.00	$2,862.00
X					8/17/1984	82	1	7/31/14	7:35 PM	8/7/14	6	1	5	2			1						1	3								477.00	$2,862.00
X					3/23/1990	30	1	7/31/14	3:20 PM	8/2/14	1	1	5	2			1						1	1								477.00	$477.00
X					3/4/1984	82	1	7/31/14	11:30 PM	8/4/14	3	1	5	2			1						1	3								477.00	$1,431.00
X					3/22/1998	82	1	8/1/14	10:08 AM	8/6/14	5	1	5	2			1						1	3								477.00	$2,385.00
X					7/22/1970	82	1	8/2/14	4:00 AM	8/13/14	8	1	5	2			1						1	3								477.00	$3,816.00
X					11/29/1964	37	1	8/2/14	11:25 AM	8/7/14	5	2	5	2			1						1	3								477.00	$2,385.00
X					12/21/1981	90	1	8/2/14	5:40 PM	8/5/14	3	2	5	2			1						1	3								477.00	$1,431.00
X					7/28/1987	90	1	8/4/14	1:30 AM	8/8/14	4	1	5	2			1						1	3								477.00	$1,908.00
X					2/1/1971	30	1	8/4/14	10:39 PM	8/10/14	6	2	5	2			1						1	3								477.00	$2,862.00
X					4/19/1992	20	1	8/5/14	5:39 PM	8/10/14	5	1	5	2			1						1	3								477.00	$2,385.00
X					9/18/1979	98	4	8/5/14	1:39 PM	8/6/14	1	1	5	2			1						1	3								477.00	$477.00
X					7/23/1965	82	1	8/6/14	4:03 AM	8/12/14	6	1	5	2			1						1	3								477.00	$2,862.00
X					3/7/1954	90	1	8/6/14	4:46 PM	8/8/14	2	1	5	2			1						1	3								477.00	$954.00
X					3/17/1963	90	1	8/6/14	5:10 PM	8/11/14	5	1	5	2			1						1	1								477.00	$2,385.00
X					4/9/1986	90	1	8/8/14	3:55 PM	8/10/14	4	1	5	2			1						1	1								477.00	$1,908.00
X					9/22/1965	90	1	8/7/14	6:23 PM	8/11/14	4	1	5	2			1						1	1								477.00	$1,908.00
Y					9/23/1963	90	1	8/7/14	9:45 PM	8/14/14	7	1	5	2			1						1	3								477.00	$3,339.00
X					6/17/1977	90	1	8/7/14	8:09 PM	8/13/14	6	2	5	2			1						1	3								477.00	$2,862.00
X					6/22/1979	30	1	8/7/14	9:15 PM	8/12/14	5	2	5	2			1						1	3								477.00	$2,385.00
X					9/18/1979	90	1	8/7/14	3:15 PM	8/10/14	3	1	5	2			1						1	1								477.00	$1,431.00
X					9/20/1962	90	1	8/8/14	1:40 AM	8/13/14	5	1	5	2			1						1	3								477.00	$2,385.00
X					8/23/1967	82	1	8/8/14	2:27 PM	8/11/14	3	2	5	2			1						1	3								477.00	$1,431.00
					9/5/1984	37	1	8/8/14	1:30 AM	8/11/14	3	1	5	2			1						1	3								477.00	$1,431.00
					9/2/1979	90	1	8/8/14	5:59 PM	8/14/14	6	1	5	2			1						1	3								477.00	$2,862.00
					6/26/1988	90	1	8/8/14	1:25 PM	8/13/14	4	1	5	2			1						1	3								477.00	$1,908.00
					3/4/1972	82	1	8/9/14	4:55 PM	8/13/14	4	2	5	2			1						1	3								477.00	$1,908.00
					12/25/1981	98	4	8/10/14	4:45 AM	8/22/14	10	2	5	2			1						1	3								477.00	$4,770.00
					11/12/1980	82	1	8/10/14	1:10 AM	8/13/14	3	2	5	2			1						1	3								477.00	$1,431.00
					10/22/1983	90	1	8/11/14	2:55 AM	8/18/14	7	1	5	2			1						1	3								477.00	$3,339.00
					1/5/1969	82	1	8/11/14	8:45 PM	8/13/14	2	1	5	2			1						1	2								477.00	$954.00
					7/20/1986	90	1	8/11/14	7:35 PM	8/18/14	7	1	5	2			1						1	1								477.00	$3,339.00
					6/13/1976	82	1	8/11/14	6:32 PM	8/18/14	7	1	5	2			1						1	3								477.00	$3,339.00
					5/12/1955	10	1	8/12/14	5:41 PM	8/19/14	7	1	5	2			1						1	3								477.00	$3,339.00
					8/24/1999	47	1	8/12/14	7:43 PM	8/19/14	7	1	5	2			1						1	3								477.00	$3,339.00
					11/4/1990	37	1	8/12/14	4:43 AM	8/16/14	4	1	5	2			1						1	3								477.00	$1,908.00
					1/18/1980	90	1	8/13/14	2:17 PM	8/18/14	5	1	5	2			1						1	3								477.00	$2,385.00
					4/21/1976	37	1	8/13/14	11:30 PM	8/16/14	3	2	5	2			1						1	3								477.00	$1,431.00
					4/23/1988	30	1	8/13/14	1:56 PM	8/19/14	6	2	5	2			1						1	3								450.00	$2,700.00
					10/20/1993	90	1	8/14/14	9:20 PM	8/19/14	5	1	5	2			1						1	1								477.00	$2,385.00
					9/23/1958	82	1	8/14/14	11:50 PM	8/22/14	8	1	5	2			1						1	1								477.00	$3,816.00
					8/2/1953	90	1	8/15/14	11:34 PM	8/25/14	6	1	5	2			1						1	1								477.00	$2,862.00
					12/16/1994	96	4	8/15/14	11:47 PM	8/25/14	10	2	5	2			1						1	3								477.00	$4,770.00
					10/29/1962	82	1	8/15/14	5:33 PM	8/25/14	10	2	5	2			1						1	3								477.00	$4,770.00
					10/7/1984	90	1	8/15/14	10:30 PM	8/20/14	5	2	5	2			1						1	3								477.00	$2,385.00
					3/15/1979	37	1	8/15/14	1:10 PM	8/19/14	4	1	5	2			1						1	1								477.00	$1,908.00
					7/5/1978	82	1	8/16/14	11:40 PM	8/19/14	3	1	5	2			1						1	3								477.00	$1,431.00
					5/7/1987	90	1	8/16/14	4:01 PM	8/21/14	5	1	5	2			1						1	1								477.00	$2,385.00
					2/14/1979	82	1	8/17/14	5:10 PM	8/20/14	3	1	5	2			1						1	3								477.00	$1,431.00
					3/11/1975	10	1	8/17/14	7:45 AM	8/23/14	4	2	5	2			1						1	3								477.00	$1,908.00
					8/8/1959	98	4	8/18/14	3:42 PM	8/23/14	5	1	5	2			1						1	3								477.00	$2,385.00
					8/2/1979	90	1	8/18/14	3:34 PM	8/22/14	4	1	5	2			1						1	1								477.00	$1,908.00
					10/28/1968	98	4	8/19/14	4:00 AM	8/23/14	3	1	5	2			1						1	3								477.00	$1,908.00
					8/29/1984	37	1	8/19/14	9:45 PM	8/22/14	3	1	5	2			1						1	1								477.00	$1,431.00
					4/17/1977	90	1	8/19/14	9:01 AM	8/20/14	1	1	5	2			1						1	3								477.00	$477.00
					4/30/1984	37	1	8/19/14	7:30 PM	8/21/14	2	1	5	2			1						1	1								477.00	$954.00
					9/24/1963	90	1	8/19/14	6:52 PM	8/21/14	2	1	5	2			1						1	1								477.00	$954.00
					12/23/1989	30	5	8/20/14	6:25 PM	8/27/14	7	1	5	2			1						1	3								477.00	$3,339.00
					9/2/1980	10	1	8/20/14	2:05 PM	8/26/14	6	1	5	2			1						1	3								477.00	$2,862.00
					8/31/1973	82	1	8/20/14	5:41 PM	8/23/14	3	1	5	2			1						1	3								477.00	$1,431.00
					12/3/1961	90	1	8/20/14	1:03 PM	8/25/14	5	1	5	2			1						1	3								477.00	$2,385.00
					10/9/1989	82	1	8/21/14	3:05 AM	8/25/14	4	1	5	2			1						1	3								477.00	$1,908.00
					5/29/1991	82	1	8/21/14	3:25 AM	8/27/14	6	1	5	2			1						1	3								477.00	$2,862.00
					10/1/1974	37	1	8/21/14	2:55 AM	8/27/14	6	1	5	2			1						1	3								477.00	$2,862.00
					9/23/1963	90	1	8/21/14	12:55 AM	8/22/14	1	1	5	2			1						1	1								477.00	$477.00
					4/20/1985	90	1	8/21/14	3:41 PM	8/24/14	3	2	5	2			1						1	1								477.00	$1,431.00
					6/15/1978	98	5	8/22/14	5:15 AM	8/29/14	7	1	5	2			1						1	3								477.00	$3,339.00
					3/12/1990	30	1	8/22/14	5:07 AM	8/28/14	6	1	5	2			1						1	3								477.00	$2,862.00
					8/25/1958	48	1	8/22/14	6:56 PM	8/29/14	7	2	5	2			1						1	3								477.00	$3,339.00
					9/13/1954	37	1	8/22/14	2:39 PM	8/29/14	7	2	5	2			1						1	3								477.00	$3,339.00
					12/11/1980	98	4	8/23/14	3:30 AM		9	1	5	2			1						1	3								477.00	$4,293.00
					9/7/1975	90	1	8/23/14	5:55 PM	8/28/14	5	1	5	2			1						1	3								477.00	$2,385.00
					10/30/1954	96	4	8/23/14	4:40 AM	8/29/14	6	2	5	2			1						1	3								477.00	$2,862.00
					7/28/1987	90	1	8/23/14	8:45 PM	8/27/14	4	1	5	2			1						1	3								477.00	$1,908.00
					5/27/1965	90	1	8/23/14	8:55 PM	8/27/14	4	2	5	2			1						1	3								477.00	$1,908.00
					1/21/1986	34	1	8/23/14	12:25 AM	8/27/14	4	1	5	2			1						1	3								477.00	$1,908.00
					7/16/1959	37	1	8/24/14	8:32 PM	8/30/14	6	1	5	2			1						1	3								477.00	$2,862.00
					11/19/1992	90	1	8/24/14	1:40 PM	8/29/14	5	2	5	2			1						1	3								477.00	$2,385.00
					7/26/1967	96	4	8/24/14	12:00 PM	8/27/14	3	1	5	2			1						1	1								477.00	$1,431.00
					5/3/1980	29	4	8/24/14	7:55 AM	8/29/14	5	1	5	2			1						1	3								477.00	$2,385.00

x					2/11/1995	10	1	8/24/14	8:40 AM	8/27/14	3	2	5	2			1						1	3								477.00	$1,431.00
x					11/17/1999	82	1	8/24/14	3:00 PM	8/27/14	3	1	5	2			1						1	1								477.00	$1,431.00
x					7/22/1967	90	1	8/25/14	6:51 PM	8/28/14	3	1	5	2			1						1	3								477.00	$1,431.00
					12/30/1975	10	1	8/25/14	4:06 PM	8/30/14	5	1	5	2			1						1	3								477.00	$2,385.00
					1/4/1988	90	1	8/25/14	9:45 PM	9/1/14	7	1	5	2			1						1	3								477.00	$3,339.00
					11/16/1989	90	1	8/25/14	2:46 PM		6	1	5	2			1						1	3								477.00	$2,862.00
x					5/7/1967	82	1	8/26/14	10:32 PM	8/27/14	1	1	5	2			1						1	3								477.00	$477.00
x					5/23/1981	10	1	8/26/14	1:15 PM	8/31/14	5	1	5	2			1						1	1								477.00	$2,385.00
x					1/25/1983	12	1	8/26/14	7:30 AM		6	2	5	2			1						1	3								477.00	$2,862.00
x					6/24/1964	90	1	8/27/14	11:45 PM		5	2	5	2			1						2	3								477.00	$2,385.00
x					12/11/1989	60	1	8/28/14	12:10 AM		4	1	5	2			1						1	3								477.00	$1,908.00
x					2/10/1958	90	1	8/29/14	2:30 AM		3	2	5	2			1						1	3								477.00	$1,431.00
x					9/2/1979	90	1	8/29/14	4:24 AM	8/29/14	1	1	5	2			1						1	3								477.00	$477.00
x					9/16/1973	5	1	8/29/14	11:09 PM		3	1	5	2			1						1	3								477.00	$1,431.00
x					6/3/1966	6	1	8/29/14	11:35 PM		3	1	5	2			1						1	3								477.00	$1,431.00
x					4/10/1969	10	1	8/29/14	5:07 PM		3	1	5	2			1						1	3								477.00	$1,431.00
x					3/4/1984	82	1	8/30/14	12:50 AM	9/1/14	2	1	5	2			1						1	3								477.00	$954.00
x					11/27/1997	47	1	8/30/14	12:00 AM		2	1	5	2			1						1	3								477.00	$954.00
x					8/13/1970	82	1	8/30/14	1:00 AM		2	1	5	2			1						1	3								477.00	$954.00
x					2/9/1979	30	1	8/31/14	2:48 AM		1	2	5	2			1						1	1								477.00	$477.00
x					7/28/1987	90	1	8/31/14	2:45 AM		1	1	5	2			1						1	1								477.00	$477.00
x					4/19/1980	90	1	8/31/14	5:55 AM		1	1	5	2			1						1	3								477.00	$477.00
x					5/15/1989	37	1	8/31/14	4:38 AM		1	1	5	2			1						1	3								477.00	$477.00
x					4/20/1966	98	4	8/31/14	1:58 AM		1	2	5	2			1						1	3								477.00	$477.00
x					5/5/1983	96	4	8/31/14	2:48 AM		1	1	5	2			1						1	3								477.00	$477.00

Total $ Remaining First of Month:	$210,668.67	Adult Per Diem:	$464.00
Total $ Used This Month	$244,404.00	Child Per Diem	$450.00
Total $ Remaining End of Month:	$33,717.33	Total Patient Days:	512
		Average LOS:	4.27

Document produced in native format

Highly Confidential

MSHA-001208

SBH-KINGSPORT 001900

Woodridge Psychiatric Hospital Report

Cert by MCRT	Hospital Encounter Number	Social Security Number	Last Name	First Name	Date of Birth	County of Residence	State of Residence	Date of Admission	Time of Admission	Date of Discharge	Number of Uninsured Adult Patient Days	Gender	Race	Ethnicity	Marital Status	Military Status	Primary Language	Job/ Employment Status	Amount of Income	Living Arrangement at Admission	Number of People in Household	Referral Source	Legal Status at Admission	Primary Admission Diagnosis (Axis I or II)	Secondary Admission Diagnosis (All Other Axis I or II Diagnoses)	Primary Discharge Diagnosis (Axis I or II)	Secondary Discharge Diagnosis (All Other Axis I or II Diagnoses)	Living Arrangement at Discharge	Aftercare Arrangements	Discharge Reason	Per Diem Rate	Total Amount for Stay
MCRT	ENC - REDACTED	SSN	LN	FN	DOB	CO	ST	DA	TA	DD	NU	GE	RA	ETH	MS	MIS	PL	EMP	AI	LAA	NPH	RS	LS	PAD	SAD	PDD	SDD	LAD	AFT	DR	Per Diem	Total
X					9/7/1925	90	1	6/25/14	1:40 AM	7/2/14	1	2	5	2	2	2	1	3	50	17	3	1	1	296.30	304.80	296.33	309.51	4	0	5	477.00	$477.00
X					8/18/1954	82	1	6/27/14	8:50AM	7/15/14	14	2	5	2	1	2	1	3	50	17	4	1	3	296.64	301.90	294.64	301.90	17	1	1	477.00	$6,678.00
X					7/20/1986	90	1	6/27/14	11:38PM	7/4/14	3	1	5	2	1	2	1	3	50	1	1	1	3	296.34	303.90	296.33	300.00	1	4	1	477.00	$1,431.00
X					4/19/1955	90	1	6/28/14	3:55AM	7/14/14	4	1	5	2	1	2	1	3	58,500	17	1	1	3	296.36	799.90	296.33	304.10	17	4	1	477.00	$1,908.00
X					2/16/1978	90	1	6/28/14	12:30PM	7/4/14	3	1	5	2	1	2	1	3	50	1	1	1	3	296.36	301.90	296.33	300.00	3	4	1	477.00	$1,431.00
X					3/16/1989	90	1	6/29/14	12:15AM	7/3/14	2	2	5	2	1	2	1	3	52,264	87	1	3	3	296.30	304.80	296.33	304.80	3	0	5	477.00	$1,908.00
X					9/1/1966	90	1	6/29/14	2:20AM	7/4/14	3	1	5	2	1	2	1	3	52,264	1	1	1	1	311.00	303.90	296.33	303.90	1	5	1	477.00	$1,431.00
X					8/31/1978	90	1	6/29/14	1:15AM	7/3/14	2	2	5	2	1	2	1	3	50	17	3	1	3	311.00	799.90	311.00	799.90	17	5	1	477.00	$954.00
X					12/25/1981	76	4	6/29/14	2:33AM	7/3/14	2	2	5	2	1	4	1	98	50	87	1	1	1	296.90	305.00	296.90	305.00	87	0	8	477.00	$954.00
X					9/15/1976	82	1	6/29/14	2:10PM	7/4/14	3	2	5	2	1	3	1	3	50	17	3	1	1	296.63	799.90	296.93	292.84	17	6	1	477.00	$1,431.00
X					9/9/1934	90	1	6/29/14	6:54PM	7/8/14	2	1	5	2	1	3	1	3	50	17	3	1	1	296.30	799.90	296.30	728.00	1	7	1	477.00	$954.00
X					11/22/1982	90	1	6/30/14	1:26pm	7/8/14	2	1	5	2	1	4	1	3	51,644	1	1	1	3	296.33	300.00	296.33	300.00	1	0	5	477.00	$954.00
X					5/27/1984	90	1	7/1/14	1:25pm	7/4/14	3	1	5	2	1	2	1	3	52,000	17	1	1	3	296.96	0.00	296.93	293.83	8	3	1	477.00	$1,431.00
X					12/25/1981	76	4	7/1/14	5:54pm	7/3/14	2	1	5	2	1	2	1	3	55,000	17	1	1	3	296.90	0.00	296.90	0.00	17	7	1	477.00	$954.00
X					12/8/1979	82	1	7/1/14	5:15pm	7/3/14	2	1	5	2	1	2	1	3	52,264	17	1	1	3	311.00	304.80	304.80	292.84	17	6	1	477.00	$954.00
X					10/8/1987	90	1	7/1/14	2:50pm	7/2/14	1	1	5	2	1	2	1	3	52,000	17	3	1	1	311.00	304.80	311.00	304.80	3	0	5	477.00	$477.00
X					1/5/1968	90	1	7/1/14	3:58pm	7/8/14	8	1	5	2	1	2	1	3	50	17	2	1	3	296.30	301.90	296.90	292.84	17	3	1	477.00	$1,908.00
X					5/29/1977	90	1	7/2/14	9:49 PM	7/7/14	5	1	5	2	1	4	2	1	44	2	1	1	3	296.99	300.00	296.63	301.90	3	3	1	477.00	$2,385.00
X					6/7/1977	82	1	7/2/14	1:45 PM	7/10/14	4	1	5	2	1	4	2	1	55,000	1	1	1	3	311.00	304.80	296.33	292.84	1	4	1	477.00	$1,908.00
X					8/31/1987	90	1	7/2/14	7:02am	7/7/14	5	2	5	2	1	2	1	3	50	17	1	1	3	296.53	304.60	296.53	292.84	17	8	1	477.00	$1,385.00
X					9/7/1957	95	1	7/3/14	7:30pm	7/9/14	6	1	5	2	1	3	1	3	50	1	1	1	3	296.33	303.90	296.33	303.90	1	6	1	477.00	$2,862.00
X					3/24/1968	10	1	7/3/14	5:15am	7/7/14	4	2	5	2	1	2	1	3	50	17	2	1	3	311.00	305.00	311.00	306.00	17	9	1	477.00	$1,908.00
X					4/30/1944	82	1	7/3/14	10:10am	7/8/14	5	1	5	2	1	3	1	3	50	17	3	1	3	296.33	304.80	296.33	304.80	17	3	1	477.00	$2,385.00
X					10/27/1963	96	4	7/3/14	10:55pm	7/14/14	11	1	5	2	1	4	2	1	3	50	17	3	1	3	296.90	303.90	311.00	298.90	17	3	1	477.00	$5,247.00
X					3/8/1977	82	1	7/4/14	5:54am	7/6/14	4	2	5	2	1	2	1	3	50	17	4	1	3	296.30	0.00	296.33	311.00	17	3	1	477.00	$1,908.00
X					1/31/1989	10	1	7/4/14	4:20am	7/7/14	3	1	5	2	1	2	1	3	50	17	5	1	3	296.99	304.00	296.53	304.80	17	5	1	477.00	$1,431.00
X					9/23/1963	90	1	7/4/14	3:15pm	7/10/14	6	1	5	2	2	2	1	3	59	1	1	1	1	296.33	303.90	296.33	303.90	1	7	1	477.00	$2,862.00
X					6/13/1976	82	1	7/4/14	4:06pm	7/15/14	7	1	5	2	1	3	1	3	52,268	1	1	1	3	296.53	292.84	296.33	292.84	1	7	1	477.00	$3,339.00
X					12/6/1975	82	1	7/5/14	6:00am	7/18/14	3	2	5	2	1	2	1	1	518,000	17	6	1	3	296.20	0.00	311.00	300.00	17	2	1	477.00	$1,431.00
X					9/7/1975	90	1	7/5/14	4:20am	7/10/14	5	1	5	2	1	2	1	3	5400	17	1	1	3	296.30	304.00	296.33	299.10	17	4	1	477.00	$2,385.00
X					5/16/1979	36	1	7/5/14	2:10am	7/10/14	5	1	5	2	1	3	2	1	5500	17	2	1	2	296.33	292.84	296.33	292.84	17	7	1	477.00	$2,385.00
X					12/19/1966	34	1	7/5/14	2:58pm	7/10/14	5	1	5	2	1	2	1	3	5455	17	4	1	3	296.63	604.80	296.33	297.84	17	11	1	477.00	$2,385.00
X					1/3/2000	76	4	7/5/14	4:30PM	7/31/04	6	2	5	2	1	2	1	3	50	17	4	1	1	296.33	307.23	296.33	307.23	17	5	1	450.00	$2,700.00

x					5/15/1970	90	1	7/5/14	8:46pm	7/10/14	5	2	5	2	3	2	1	3	$0	17	1	1	3	296.30	304.80	296.90	303.90	17	8	1	477.00	$2,385.00
x					9/5/1971	90	1	7/5/14	10:10pm	7/11/14	6	2	5	2	3	2	1	3	$300	1	1	1	3	296.53	304.80	296.53	304.80	1	6	1	477.00	$2,862.00
x					8/23/1983	90	1	7/6/14	8:12 PM	7/8/14	2	1	5	2	1	2	1	3	$4,325	17	8	1	3	296.80	327.01	296.53	327.01	17	7	1	477.00	$954.00
x					2/13/1961	82	1	7/6/14	9:30 AM	7/10/14	4	2	5	2	2	2	1	3	$2,268	17	2	1	3	296.33	292.84	296.33	304.80	17	4	1	477.00	$1,908.00
x					3/21/1959	90	1	7/6/14	6:45am	7/16/14	10	2	5	2	3	2	1	1	$7,000	17	2	1	3	296.60	303.90	296.80	296.30	17	5	1	477.00	$4,770.00
x					2/6/1980	90	1	7/7/14	9:45am	7/7/14	1	1	5	2	2	2	1	3	$0	17	2	1	3	296.30	0.00	296.33	300.01	17	0	1	477.00	$477.00
x					6/23/1954	46	1	7/8/14	7:42 PM	7/15/14	7	1	5	2	3	2	1	3	$0	17	2	1	3	303.90	291.00	296.33	303.90	17	6	1	477.00	$3,339.00
x					10/4/1976	90	1	7/8/14	2:43 PM	7/15/14	7	1	5	2	1	2	1	3	$2,280	17	1	1	3	296.90	304.80	296.33	291.90	17	7	1	477.00	$3,339.00
x					11/4/1990	37	1	7/8/14	5:39 PM	7/15/14	7	1	5	2	1	2	1	3	$0	17	3	1	3	296.33	309.60	296.53	292.84	17	8	1	477.00	$3,339.00
x					12/27/1980	82	1	7/8/14	2:30 PM	7/12/14	4	2	5	2	4	2	1	3	$0	17	3	1	1	296.90	0.00	296.33	296.53	17	6	1	477.00	$1,908.00
x					4/23/1960	96	3	7/8/14	11:04 AM	7/10/14	2	2	5	2	3	2	1	2	$2,050	17	2	1	3	296.80	305.00	303.90	0.00	17	0	3	477.00	$954.00
x					8/1/1970	90	1	7/9/14	1:00 AM	7/11/14	2	1	5	2	4	2	1	3	$0	1	1	1	1	311.00	303.90	296.33	292.84	1	0	1	477.00	$954.00
x					1/25/1983	90	1	7/9/14	4:46 PM	7/25/14	10	2	5	2	3	2	1	3	$0	1	1	1	3	296.80	304.80	296.44	309.80	1	15	1	477.00	$4,770.00
x					3/5/1968	90	1	7/9/14	8:00 PM	7/12/14	3	1	5	2	1	2	1	3	$0	17	2	1	1	295.30	304.80	295.30	304.80	17	4	1	477.00	$1,431.00
x					8/30/1990	90	1	7/9/14	2:05 PM	7/16/14	7	1	5	2	2	2	1	3	$0	17	2	1	1	296.80	0.00	296.33	301.90	17	7	1	477.00	$3,339.00
x					12/9/1970	46	1	7/9/14	8:37 AM	7/10/14	1	1	5	2	2	2	1	1	$1,000	17	2	1	3	296.33	292.84	296.33	304.80	17	0	8	477.00	$477.00
x					12/14/1954	90	1	7/10/14	6:48 PM	7/17/14	7	2	5	2	1	2	1	3	$0	1	1	1	3	311.00	300.00	296.33	304.80	3	0	5	477.00	$3,339.00
x					9/2/1978	30	1	7/10/14	6:22 PM	7/16/14	6	1	5	2	1	2	1	3	$700	17	3	1	3	296.80	0.00	296.53	300.21	17	6	1	477.00	$2,862.00
x					7/27/1974	82	1	7/10/14	5:00 PM	7/11/14	1	1	5	2	4	3	1	1	$25,000	17	2	1	1	296.80	303.90	296.80	303.90	3	0	5	477.00	$477.00
x					9/23/1963	90	1	7/11/14	2:28 PM	7/17/14	6	1	5	2	4	2	1	3	$0	1	1	1	1	295.33	303.90	296.33	303.90	1	6	1	477.00	$2,862.00
x					1/2/1976	37	1	7/11/14	12:20 PM	7/18/14	7	1	5	2	3	2	1	3	$2,268	17	2	1	3	296.80	309.80	296.53	0.00	87	4	1	477.00	$3,339.00
x					9/7/1975	90	1	7/11/14	11:15 PM	7/17/14	6	1	5	2	2	2	1	3	$400	17	1	1	1	296.33	292.84	296.33	292.84	17	4	1	477.00	$2,862.00
x					9/3/1998	86	1	7/11/14	4:50 PM	7/18/14	7	2	5	2	1	2	1	24	$0	17	4	1	3	311.00	0.00	296.33	296.53	17	4	1	450.00	$3,150.00
x					12/16/1994	90	1	7/12/14	7:50 PM	7/21/14	9	2	5	2	1	2	1	3	$0	17	3	1	3	298.90	293.83	298.90	311.00	17	3	1	477.00	$4,293.00
x					7/25/1987	30	1	7/12/14	5:50 AM	7/18/14	6	2	5	2	1	2	1	44	$7,740	17	1	1	3	296.80	0.00	296.33	300.21	17	6	1	477.00	$2,852.00
x					9/2/1979	90	1	7/12/14	12:14 PM	7/14/14	2	1	5	2	2	2	1	2	$17,500	17	8	1	3	296.80	303.90	296.53	292.84	3	0	5	477.00	$954.00
x					3/1/1980	46	1	7/13/14	7:55 PM	7/20/14	7	2	5	2	3	2	1	2	$5,400	17	2	1	3	298.90	0.00	298.90	304.00	17	1	1	477.00	$3,339.00
x					12/17/1995	96	4	7/13/14	1:08 AM	7/18/14	5	2	5	2	1	2	1	3	$0	17	5	1	1	311.00	0.00	296.53	0.00	17	3	1	477.00	$2,385.00
x					6/13/1976	82	1	7/14/14	8:39 AM	7/21/14	7	1	5	2	3	3	1	3	$2,268	1	1	1	1	296.53	304.80	296.53	304.80	1	4	1	477.00	$3,339.00
x					5/18/1971	90	1	7/14/14	4:38 PM	7/19/14	5	1	5	2	4	2	1	3	$0	1	1	1	3	311.00	304.80	296.33	304.80	1	7	1	477.00	$2,385.00
x					10/21/1956	46	1	7/14/14	12:24 PM	7/17/14	3	1	5	2	4	3	1	34	$24,000	17	2	1	3	298.90	309.80	298.90	0.00	17	7	1	477.00	$1,431.00
x					10/24/1979	37	1	7/14/14	9:20 PM	7/18/14	4	2	5	2	3	2	1	3	$2,268	17	3	1	3	311.00	300.00	296.33	300.00	17	7	1	477.00	$1,908.00
x					2/28/1979	96	4	7/16/14	3:50 AM	7/18/14	2	1	5	2	2	3	1	1	$23,000	17	6	1	3	296.90	303.90	311.00	303.90	17	4	1	477.00	$954.00
x					3/9/1976	82	1	7/16/14	4:00 AM	7/21/14	5	2	5	2	3	2	1	3	$0	17	2	1	3	296.80	304.80	296.33	304.80	17	2	1	477.00	$2,385.00
x					9/30/1989	90	1	7/16/14	7:50 PM	7/18/14	2	1	5	2	1	2	1	3	$2,268	17	5	1	3	298.90	304.80	296.64	309.80	17	4	1	477.00	$954.00
x					8/13/1970	82	1	7/16/14	4:32 PM	7/19/14	3	1	5	2	5	2	1	3	$0	17	1	1	3	296.80	303.90	296.33	303.90	17	0	1	477.00	$1,431.00
x					3/8/1979	96	4	7/17/14	3:50 AM	7/20/14	3	1	5	2	4	2	1	3	$0	17	5	1	3	296.33	292.84	295.70	304.80	17	10	1	477.00	$1,431.00
x					10/20/1993	90	1	7/17/14	2:46 PM	7/23/14	6	1	5	2	1	2	1	3	$0	1	1	1	3	311.00	0.00	296.33	300.00	1	2	1	477.00	$2,862.00
x					9/7/1975	90	1	7/17/14	9:10 PM	7/18/14	1	1	5	2	2	2	1	3	$450	17	1	1	1	296.33	304.00	304.80	0.00	17	2	1	477.00	$477.00
x					5/27/1972	82	1	7/17/14	8:50 PM	7/21/14	4	2	5	2	3	2	1	3	$2,040	17	3	1	1	296.80	0.00	296.53	300.00	17	8	1	477.00	$1,908.00
x					9/20/1962	90	1	7/18/14	12:20 AM	7/19/14	1	1	5	2	5	3	1	3	$0	1	1	1	3	298.90	0.00	290.42	295.70	1	0	8	477.00	$477.00
x					9/21/1989	90	1	7/18/14	3:40 PM	7/27/14	4	1	5	2	1	2	1	3	$3,500	1	1	1	1	296.80	0.00	311.00	327.10	1	7	1	477.00	$1,908.00
x					5/16/1980	10	1	7/18/14	5:06 PM	7/22/14	4	2	5	2	2	2	1	3	$0	17	2	1	3	295.30	311.00	295.30	311.00	17	12	1	477.00	$1,908.00
x					4/13/1985	82	1	7/19/14	11:00 AM	7/22/14	3	1	5	2	1	2	1	1	$18,000	17	2	1	3	296.33	303.90	296.33	304.80	17	1	1	477.00	$1,431.00
x					12/18/1986	30	1	7/19/14	6:25 AM	7/22/14	3	1	5	2	1	2	1	3	$2,268	1	2	1	1	311.00	304.80	304.80	296.33	1	0	1	477.00	$1,431.00
x					10/20/1998	78	1	7/19/14	1:10 AM	7/25/14	6	2	5	2	1	2	1	24	$0	17	3	1	3	311.00	0.00	296.33	0.00	17	16	1	450.00	$2,700.00
x					9/23/1963	90	1	7/20/14	1:10 AM	7/24/14	4	1	5	2	4	2	1	3	$0	1	1	1	1	311.00	303.90	296.33	305.00	1	4	1	477.00	$1,908.00
x					11/30/1993	96	4	7/20/14	2:50 AM	7/23/14	3	2	5	2	1	2	1	3	$0	17	4	1	3	296.30	309.80	311.00	300.00	17	7	1	477.00	$1,431.00

x					2/11/1997	82	1	7/20/14	12:25 AM	8/19/14	7	2	5	2	1	2	1	3	$0	17	4	1	3	296.90	305.20	296.30	309.80	3	0	5	450.00	$3,150.00
x					11/12/1980	82	1	7/21/14	12:17 PM	7/27/14	6	2	5	2	3	2	1	3	$0	17	2	1	3	296.44	0.00	296.44	304.80	17	5	1	477.00	$2,862.00
x					11/19/1974	47	1	7/21/14	3:55 PM	7/25/14	4	1	5	2	3	2	1	3	$2,268	1	1	1	1	311.00	304.00	296.33	304.80	1	3	1	477.00	$1,908.00
x					8/23/1973	90	1	7/22/14	10:00 PM	7/26/14	4	2	5	2	3	2	1	3	$4,800	17	6	1	3	296.33	309.80	296.33	309.80	17	3	1	477.00	$1,908.00
x					3/2/1983	82	1	7/22/14	8:54 PM	7/28/14	6	1	5	2	4	2	1	3	$0	17	2	1	3	295.70	0.00	295.70	327.01	17	2	1	477.00	$2,862.00
x					4/6/1986	90	1	7/22/14	8:44 PM	7/30/14	8	2	5	2	1	2	1	3	$2,264	1	1	1	3	296.34	304.00	296.34	304.10	1	5	1	477.00	$3,816.00
x					1/2/1976	37	1	7/22/14	6:15 AM	8/2/14	10	1	5	2	3	2	1	3	$2,268	1	1	1	3	298.90	0.00	296.90	300.00	1	2	1	477.00	$4,770.00
x					7/28/1997	90	1	7/22/14	4:20 PM	7/25/14	3	1	5	2	1	2	1	2	$1,400	17	3	1	3	296.30	0.00	296.33	296.53	17	4	1	477.00	$1,431.00
x					10/24/1959	63	1	7/22/14	10:21 AM	7/25/14	3	1	5	2	1	2	1	3	$0	17	1	1	3	296.34	303.90	298.33	296.53	17	8	1	477.00	$1,431.00
x					9/20/1962	90	1	7/22/14	4:02 AM	7/28/14	6	1	5	2	5	3	1	3	$0	1	1	1	3	298.90	309.81	295.70	309.81	1	1	1	477.00	$2,862.00
x					8/12/1990	30	1	7/23/14	8:47 AM	7/25/14	2	1	5	2	1	2	1	2	$12,000	17	2	1	3	296.64	0.00	296.44	0.00	17	5	1	477.00	$954.00
x					11/16/1976	90	1	7/23/14	5:01 PM	7/29/14	6	2	5	2	3	2	1	3	$1,764	17	2	1	3	311.00	304.80	296.33	300.00	17	9	1	477.00	$2,862.00
x					8/24/1986	90	1	7/23/14	11:37 AM	7/26/14	3	1	5	2	1	2	1	3	$1,200	17	1	1	3	311.00	303.90	296.33	292.84	17	3	1	477.00	$1,431.00
x					10/8/1987	82	1	7/23/14	4:13 PM	7/28/14	5	1	5	2	1	2	1	3	$4,000	17	3	1	3	311.00	304.80	296.33	292.84	3	0	5	477.00	$2,385.00
x					11/17/2000	10	1	7/23/14	5:05 AM	7/30/14	7	2	5	2	1	2	1	24	$0	17	3	1	3	296.33	0.00	296.33	0.00	17	10	1	450.00	$3,150.00
x					7/17/1970	10	1	7/24/14	4:35 AM	7/27/14	3	1	5	2	4	2	1	3	$5,268	17	3	1	3	296.33	292.34	304.80	292.00	17	9	1	477.00	$1,431.00
x					12/18/1980	47	1	7/24/14	7:10 AM	7/28/14	4	1	5	2	1	2	1	3	$24,000	17	2	1	3	295.70	304.80	296.53	304.80	17	2	1	477.00	$1,909.00
x					2/11/1980	82	1	7/25/14	8:32 AM	7/28/14	3	1	5	2	3	2	1	1	$1,200	17	2	1	3	296.33	292.84	296.33	292.84	17	2	1	477.00	$1,431.00
x					10/21/1956	46	1	7/25/14	11:16 PM	8/1/14	7	1	5	2	4	3	1	34	$23,000	17	2	1	3	295.30	30.81	295.70	0.00	17	6	1	477.00	$3,339.00
x					4/12/1990	90	1	7/25/14	4:27 PM	7/29/14	4	1	5	2	1	2	1	3	$2,268	1	1	1	3	311.00	0.00	296.33	300.00	1	6	1	477.00	$1,908.00
x					4/16/1979	90	1	7/25/14	5:06 PM	7/30/14	5	1	5	2	1	2	1	24	$0	17	2	1	3	296.80	300.01	296.64	309.81	17	4	1	477.00	$2,385.00
x					3/3/1961	30	1	7/25/14	4:24 PM	7/29/14	4	1	5	2	2	2	1	3	$2,268	17	2	1	3	296.80	303.90	296.33	292.84	17	0	1	477.00	$1,908.00
x					3/4/1972	90	1	7/25/14	4:35 PM	7/29/14	4	2	5	2	4	2	1	3	$2,268	17	1	1	3	296.80	0.00	296.53	301.90	17	5	1	477.00	$1,908.00
x					6/3/1983	82	1	7/26/14	2:30 AM	8/1/14	6	1	5	2	2	2	1	3	$0	17	5	1	3	296.80	0.00	295.70	300.00	17	6	1	477.00	$2,862.00
x					2/14/1977	37	1	7/26/14	1:14 AM	7/30/14	4	1	5	2	2	2	1	3	$600	17	3	1	3	300.00	303.90	296.33	292.84	17	1	1	477.00	$1,908.00
x					12/1/1980	37	1	7/26/14	3:45 PM	8/2/14	6	1	5	2	3	2	1	3	$0	17	3	1	3	296.80	304.00	296.33	292.84	17	3	1	477.00	$2,862.00
x					10/20/1966	30	1	7/28/14	8:24 AM	8/4/14	4	2	5	2	4	2	1	3	$2,268	1	1	1	3	296.53	300.00	296.53	309.81	1	1	1	477.00	$1,908.00
x					1/19/1981	96	4	7/28/14	2:17 PM	8/4/14	4	1	5	2	1	2	1	2	$4,000	1	1	1	1	296.80	300.00	296.53	314.90	1	2	1	477.00	$1,908.00
x					11/2/1992	96	3	7/28/14	9:11 AM	8/5/14	4	1	5	2	1	2	1	44	$8,400	17	3	1	3	312.30	317.00	312.30	317.00	17	3	1	477.00	$1,908.00
x					1/2/1968	90	1	7/29/14	5:58 AM	8/5/14	3	1	5	2	3	2	1	3	$1,228	1	1	1	3	296.30	305.00	296.33	292.84	4	0	5	477.00	$1,431.00
x					1/25/1983	90	1	7/29/14	12:54 PM	8/6/14	3	2	5	2	4	2	1	3	$0	1	1	1	3	296.90	304.80	296.44	309.81	1	5	1	477.00	$1,432.00
x					12/27/1985	30	1	7/29/14	7:23 PM	8/3/14	3	1	5	2	1	2	1	1	$13,000	17	2	1	1	296.90	304.80	296.33	304.80	3	0	5	477.00	$1,431.00
x					4/18/1971	37	1	7/29/14	4:34 PM	8/4/14	3	2	5	2	4	2	1	3	$0	17	2	1	1	311.00	0.00	296.33	300.00	17	4	1	477.00	$1,431.00
x					2/27/2002	86	1	7/29/14	9:10 PM	8/5/14	3	2	5	2	1	2	1	24	$0	17	3	1	3	311.00	0.00	296.33	300.00	17	2	1	450.00	$1,350.00
x					1/9/1988	96	4	7/30/14	3:05 AM	8/6/14	2	2	5	2	1	2	1	3	$0	1	1	1	3	298.90	0.00	295.70	0.00	1	0	1	477.00	$954.00
x					5/31/1972	10	1	7/30/14	5:29 PM	8/4/14	2	2	5	2	4	2	1	3	$0	17	2	1	3	296.33	327.10	296.33	300.00	17	4	1	477.00	$954.00
x					3/8/1975	96	5	7/30/14	10:10 PM	8/6/14	2	2	5	2	1	2	1	3	$0	84	1	1	3	311.00	309.30	309.81	311.00	84	6	1	477.00	$954.00
x					9/23/1953	90	1	7/30/14	9:15 PM	8/4/14	2	1	5	2	4	2	1	3	$2,268	1	1	1	3	296.33	303.90	296.33	303.90	1	2	1	477.00	$954.00
x					4/3/1982	82	1	7/30/14	3:12 PM	8/2/14	2	2	5	2	4	2	1	3	$0	17	2	1	3	296.33	0.00	296.33	300.00	17	5	1	477.00	$954.00
x					12/25/1981	96	4	7/31/14	4:40 AM	8/7/14	1	2	5	2	1	2	1	2	$1,000	17	1	1	3	296.53	296.33	296.53	304.80	17	1	1	477.00	$477.00
x					8/17/1984	82	1	7/31/14	7:35 PM	8/7/14	1	1	5	2	1	2	1	3	$0	17	3	1	3	298.90	0.00	296.64	312.30	17	7	1	477.00	$477.00
x					3/22/1990	30	1	7/31/14	3:20 PM	8/2/14	1	1	5	2	1	2	1	3	$500	17	2	1	1	311.00	304.80	296.33	292.84	3	0	5	477.00	$477.00
x					3/4/1984	82	1	7/31/14	11:30 PM	8/4/14	1	1	5	2	1	2	1	3	$2,268	1	1	1	3	295.70	303.90	295.70	303.90	1	1	1	477.00	$477.00

Total $ Remaining First of Month: $210,886.67
Total $ Used This Month: $250,884.00
Total $ Remaining End of Month: $40,197.33

Adult Per Diem: $464.00
Child Per Diem: $450.00
Total Patient Days: 528
Average LOS: 4.26

STRATEGIC BEHAVIORAL HEALTH, LLC AND SUBSIDIARIES

Memphis, Tennessee

Consolidated Financial Statements – Modified Cash Basis

Years Ended December 31, 2014 and 2013

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HORNE
CPAs & Business Advisors

INDEPENDENT AUDITOR'S REPORT

Members
Strategic Behavioral Health, LLC
Memphis, Tennessee

Report on the Consolidated Financial Statements – Modified Cash Basis

We have audited the accompanying consolidated financial statements of Strategic Behavioral Health, LLC and Subsidiaries (the "Company"), which comprise the consolidated statements of assets, liabilities and members' equity on a modified cash basis as of December 31, 2014 and 2013, and the consolidated statements of revenues and expenses, changes in members' equity and cash flows on a modified cash basis for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Consolidated Financial Statements – Modified Cash Basis

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with the modified cash basis of accounting described in Note 1; this includes determining that the modified cash basis of accounting is an acceptable basis for the preparation of the consolidated financial statements in the circumstances. Management is also responsible for the design, implementation and maintenance of internal control relevant to the preparation and fair presentation of the consolidated financial statements on a modified cash basis that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

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

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk

assessments, the auditor considers internal control relevant to the Company's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

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

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the assets, liabilities and members' equity of the Company as of December 31, 2014 and 2013, and its revenues and expenses, changes in members' equity and cash flows for the years then ended in accordance with the modified cash basis of accounting described in Note 1.

Basis of Accounting

We draw attention to Note 1 of the consolidated financial statements, which describes the basis of accounting. The consolidated financial statements are prepared on the modified cash basis of accounting, which is a basis of accounting other than accounting principles generally accepted in the United States of America. Our opinions are not modified with respect to this matter.

Horne LLP

Memphis, Tennessee
May 8, 2015

STRATEGIC BEHAVIORAL HEALTH, LLC AND SUBSIDIARIES
Consolidated Statements of Assets, Liabilities and Members' Equity -
Modified Cash Basis
December 31, 2014 and 2013

	2014	2013
ASSETS		
Current assets		
Cash and cash equivalents	$ -	$ 2,271,076
Patient accounts receivable, net of allowance for doubtful accounts of $908,652 at 2014 and $2,544,167 at 2013	14,677,544	13,593,272
Due from third-party payors	776,604	215,868
Inventories	102,971	86,741
Prepaid expenses	1,376,727	1,221,325
Total current assets	16,933,846	17,388,282
Property and equipment	94,518,057	73,426,065
Less accumulated depreciation	(7,555,502)	(4,331,553)
Property and equipment, net	86,962,555	69,094,512
Goodwill	45,326,774	45,326,774
Other assets, net	1,813,441	1,470,620
Total other assets	47,140,215	46,797,394
Total assets	$ 151,036,616	$ 133,280,188
LIABILITIES AND MEMBERS' EQUITY		
Current liabilities		
Book overdraft	$ 864,940	$ -
Current maturities of long-term debt	4,666,667	3,072,422
Accounts payable	4,130,616	3,294,809
Accrued expenses	6,046,970	4,694,081
Accrued distributions to members	1,026,371	155,942
Total current liabilities	16,735,564	11,217,254
Long-term debt, less current maturities	69,053,333	65,527,959
Total liabilities	85,788,897	76,745,213
Members equity		
Members contributions	45,915,034	45,915,034
Note receivable for members contributions	(63,255)	(161,878)
Retained earnings	19,395,940	10,781,819
Total members' equity	65,247,719	56,534,975
Total liabilities and members' equity	$ 151,036,616	$ 133,280,188

See accompanying notes.

SBH-KINGSPORT 001908

STRATEGIC BEHAVIORAL HEALTH, LLC AND SUBSIDIARIES
Consolidated Statements of Revenues and Expenses -
Modified Cash Basis
Years Ended December 31, 2014 and 2013

	2014	2013
Revenues		
Patient service revenue (net of contractual allowances and discounts)	$ 106,680,067	$ 84,341,797
Provision for bad debts	(2,100,378)	(3,849,410)
Net patient service revenue, less provisions for bad debts	104,579,689	80,492,387
Expenses		
Salaries and benefits	60,619,766	47,276,225
Professional fees	8,870,831	6,129,697
Supplies	6,016,083	4,668,386
Management and incentive fees	1,034,914	754,517
Depreciation and amortization	3,242,843	2,169,598
Rent	1,085,786	967,683
Utilities	1,713,589	1,264,783
Insurance	801,419	618,143
Interest	3,202,997	2,693,906
Property tax	480,990	547,467
Travel	1,387,043	1,304,452
Acquisition costs	110,847	619,877
Other expenses	3,412,473	2,512,386
Total expenses	91,979,581	71,527,120
Excess of revenues over expenses - modified cash basis	$ 12,600,108	$ 8,965,267

See accompanying notes.

STRATEGIC BEHAVIORAL HEALTH, LLC AND SUBSIDIARIES
Consolidated Statements of Changes in Members' Equity -
Modified Cash Basis
Years Ended December 31, 2014 and 2013

	Members Contributions	Note Receivable for Members Contributions	Retained Earnings (Deficits)	Total
Balance, January 1, 2013	$ 36,915,034	$ (71,616)	$ 4,262,617	$ 41,106,035
Excess of revenues over expenses - modified cash basis			8,965,268	8,965,268
Contributions	9,000,000	-	-	9,000,000
Note receivable from members	-	(103,185)	-	(103,185)
Payment on note receivable from members	-	12,923	-	12,923
Distributions to members	-	-	(2,446,066)	(2,446,066)
Balance, December 31, 2013	45,915,034	(161,878)	10,781,819	56,534,975
Excess of revenues over expenses - modified cash basis	-	-	12,600,108	12,600,108
Contributions	1,000,000	-	-	1,000,000
Redemption of equity	(1,000,000)	-	-	(1,000,000)
Payment on note receivable from members	-	98,623	-	98,623
Distributions to members	-	-	(3,985,987)	(3,985,987)
Balance, December 31, 2014	$ 45,915,034	$ (63,255)	$ 19,395,940	$ 65,247,719

See accompanying notes.

SBH-KINGSPORT 001910

STRATEGIC BEHAVIORAL HEALTH, LLC AND SUBSIDIARIES
Consolidated Statements of Cash Flows -
Modified Cash Basis
Years Ended December 31, 2014 and 2013

	2014	2013
Cash flows from operating activities		
Excess of revenues over expenses - modified cash basis	$ 12,600,108	$ 8,965,268
Adjustments to reconcile excess of revenues over expenses (modified cash basis) to net cash provided by operating activities		
Depreciation and amortization	3,242,843	2,169,598
Amortization of debt issue costs	231,754	203,496
Provision for bad debts	2,100,378	3,849,410
Change in assets and liabilities		
Patient accounts receivable	(3,184,650)	(6,857,732)
Due from third-party payors	(560,736)	(524,786)
Inventories	(16,230)	1,859
Prepaid expenses	(155,402)	(455,713)
Other assets	(192,667)	(109,971)
Accounts payable	835,807	2,286,127
Book overdraft	864,940	-
Accrued expenses	1,352,889	1,442,932
Net cash provided by operating activities	17,119,034	10,970,488
Cash flows from investing activities		
Acquisitions of property and equipment	(21,110,886)	(18,613,606)
Acquisition of SBH-El Paso, LLC	-	(24,764,177)
Net cash used by investing activities	(21,110,886)	(43,377,783)
Cash flows from financing activities		
Debt proceeds received	73,720,000	77,030,626
Repayment of long-term debt	(68,600,381)	(50,872,843)
Cash contributions from members	1,000,000	8,896,815
Payments of debt issuance costs	(381,908)	(482,874)
Proceeds received on members note receivable for contributions	98,623	12,923
Redemption of members equity	(1,000,000)	-
Cash distributions to members	(3,115,558)	(2,726,784)
Net cash provided by financing activities	1,720,776	31,857,863
Net decrease in cash and cash equivalents	(2,271,076)	(549,432)
Cash and cash equivalents, beginning of year	2,271,076	2,820,508
Cash and cash equivalents, end of year	$ -	$ 2,271,076
Supplemental disclosure of cash flow information		
Cash paid during the year for interest	$ 3,060,969	$ 2,706,591
Supplemental disclosure of non-cash investing and financing activities		
Accrued distributions to members	$ 1,026,371	$ 155,942
Purchase of members contribution by issuance of note receivable	$ -	$ 103,185

See accompanying notes.

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NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – MODIFIED CASH BASIS

Note 1. Nature of Business and Significant Accounting Policies

Nature of Business

Strategic Behavioral Health and its subsidiaries (collectively "SBH" or the "Company") provide a variety of services for individuals with psychiatric disorders, including emotional and behavioral disorders. Services provided include but are not limited to therapy, education, nursing and medical services, treatment planning, social skills training and substance abuse counseling. At December 31, 2014, SBH operated 8 behavioral healthcare facilities, with over 600 beds, located in the states of Colorado, Nevada, New Mexico, North Carolina, and Texas.

The Company's significant accounting policies are summarized below:

Basis of Presentation

The Company's policy is to prepare its consolidated financial statements on a modified cash basis of accounting. Except as described below, the Company records amounts due from patients and third-party payors at the time services are rendered and costs and expenses associated with providing services as they are incurred. If an expenditure results in the acquisition of an asset having an estimated useful life which extends substantially beyond the year of acquisition, the expenditure is capitalized and depreciated or amortized over the estimated useful life of the asset. Due to the uncertainty regarding the realization of certain enhanced revenue payments received from governmental payors, these payments are recorded as revenues when the cash is received without considering the potential uncertainties pertaining to any subsequent review by the governmental payors. Additionally, the Company has entered into interest rate swap agreements (see Note 3) with a third party, which are recorded on an accrual basis whereby cash flows are included in interest expense during the period. However, the interest swap agreement is not recorded at fair value at the end of each period as required by accounting principles generally accepted in the United States of America.

Principles of Consolidation

The accompanying consolidated financial statements include SBH and its wholly-owned subsidiaries. All significant intercompany accounts and transactions have been eliminated in the consolidation.

Use of Estimates

The preparation of consolidated financial statements in accordance with the modified cash basis of accounting requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements and the reported amounts of revenue and expenses during the reporting period.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – MODIFIED CASH BASIS

Note 1. Continued

Actual results could differ from those estimates. The amounts recorded as revenues from certain governmental payors are subject to future reviews that could result in refunds of the amounts previously received. Should any refunds of these amounts occur, they will be presented as a reduction of net revenues in the period that the amounts are refunded.

Cash and Cash Equivalents

For purposes of reporting cash flows, SBH considers all cash accounts and all highly liquid debt instruments with an original maturity of three months or less to be cash equivalents.

Accounts Receivable, Net

SBH reports patient accounts receivable at net realizable value after deduction of allowances for doubtful accounts. Management determines the allowance for doubtful accounts based on historical losses, aging of accounts and current economic and regulatory conditions. On a continuing basis, management analyzes delinquent receivables and, once these receivables are determined to be uncollectible, they are written off through a charge against an existing allowance account or against earnings. For receivables associated with services provided to patients who have third-party coverage, SBH analyzes contractually due amounts and provides an allowance for doubtful accounts and a provision for bad debts predominately based on the aging of accounts, if necessary. For receivables associated with self-pay patients (which includes both patients without insurances and patients with deductible and copayment balances due for which third-party coverage exists for the part of the bill), SBH records a provision for bad debts based on the age of the accounts. The difference between the standard rates (or the discounted rates if negotiated) and the amounts actually collected after all reasonable collection efforts have been exhausted is charged off against the allowance for doubtful accounts.

The Company's allowance for doubtful accounts was 6 percent and 16 percent of patient accounts receivable at December 31, 2014 and 2013, respectively. The Company has not changed its charity care polices related to discounts for certain uninsured patients during fiscal years 2014 or 2013.

Inventories

Inventories consist primarily of pharmaceutical supplies and are stated at the lower of cost using the first-in, first-out method, or market.

Prepaid Expenses

Prepaid expenses are amortized over the period of benefit using the straight-line method.

Property and Equipment

Property and equipment is stated at cost. Depreciation is computed using the straight-line method over the useful lives of the assets. Assets under capital leases are recorded at the present

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – MODIFIED CASH BASIS

Note 1. Continued

value of the future minimum rentals at the lease inception and are amortized over the shorter of the lease term or the useful life of the related asset. Amortization of assets under capital lease obligations is included in depreciation and amortization expense.

Debt Issue Costs

Debt issue costs, which include underwriting, legal and other direct costs related to the issuance of debt, are capitalized and amortized to interest expense over the contractual term of the debt using the effective interest method.

Long-Lived Assets

Long-lived assets, such as property and equipment, are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount of an asset may not be recoverable from the estimated future cash flows expected. The Company will recognize an impairment loss when the carrying amount of a long-lived asset is not expected to be recoverable from its undiscounted cash flows. Such a charge is measured by the amount by which the carrying amount exceeds the estimated fair value of the asset. No such impairment losses have been recognized during 2014 or 2013.

Goodwill

The Company's goodwill was recorded as a result of the Company's business combinations. The Company has recorded these business combinations using the acquisition method of accounting. In 2013, the Company recorded the purchase of SBH-El Paso, which resulted in an addition of $16,710,662 to previously existing goodwill. During 2012, the Company recorded the acquisitions of SBH-Red Rock and SBH-Montevista which resulted in $ 28,616,112 of goodwill. There were no business combinations that occurred in 2014. The Company tests its recorded goodwill for impairment on an annual basis, or more often if indicators of potential impairment exist. The Company first assesses qualitative factors to determine whether the existence of events or circumstances leads to a determination that it is more likely than not that the fair value of a reporting unit is less than its carrying amount. If, after assessing the totality of events or circumstances, the Company determines it is not more- likely-than-not that the fair value of a reporting unit is less than its carrying amount, then performing the two-step impairment test is unnecessary. Because it was determined that it was not more-likely-than-not that impairment existed, the two-step impairment test was not performed and no impairment loss was recognized during the years ended December 31, 2014 and 2013. Changes to goodwill for 2014 and 2013 are outlined below.

	Balance at 1/1	Additions to Goodwill	Balance at 12/31
2014	$ 45,326,744	$ -	$ 45,326,774
2013	$ 28,616,112	$ 16,710,662	$ 45,326,774

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NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – MODIFIED CASH BASIS

Note 1. Continued

Compensated Absences

SBH employees are granted both vacation and sick leave. Accumulated time off is accrued at the balance sheet date because the employees' right to receive the compensation for the future absences is vested.

Net Revenues

Other than certain enhanced revenue payments received from governmental payors, net revenues are reported at the estimated net realizable amounts from patients, third-party payors and others for services rendered. A summary of the basis of reimbursement with major third-party payors follows:

Medicare

Medicare reimbursement generally is based on the Inpatient Psychiatric Facility Prospective Payment System ("IPF PPS"). Under this methodology, the facility is paid on the basis of a Federal per diem base rate, limited by a specific target amount per discharge, and adjusted annually for such factors as wage index, DRG assignment, rural location and other facility-level adjustments. These annual adjustments are subject to frequent changes and could impact future reimbursement. In addition to the per diem rate, the IPF PPS provides additional payment policies for outlier cases, stop-loss protection, Electroconvulsive Therapy ("ECT") treatments and interrupted stays.

Medicaid

Services rendered to Medicaid beneficiaries are generally reimbursed on a per-diem rate set by each state's division of Medicaid.

Other

SBH has also entered into payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations. The basis for payment to SBH under these agreements includes prospectively determined rates per discharge, discounts from established charges and prospectively determined daily rates.

The laws and regulations under which the Medicare and Medicaid programs operate are complex and subject to interpretation and frequent changes. As a part of operating under these programs, there is a possibility that government authorities may review SBH's compliance under these laws and regulations. Such reviews may result in adjustments to program reimbursement previously received and subject SBH to fines and penalties. Although no assurance can be given, management believes that it has complied with the requirements of these programs. Due to the uncertainty regarding the realization of certain enhanced payments received from governmental payors, these payments are recorded as revenues when the cash is received. As of December 31, 2014, cost reports for fiscal years 2011 and forward have not been settled.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – MODIFIED CASH BASIS

Note 1. Continued

Charity Care

SBH provides medical care without charge or at a reduced charge to patients that meet certain criteria. Because SBH does not pursue collection of amounts determined to qualify as charity, these charges are not reported as revenue.

Advertising Costs

Advertising costs are charged to operations as incurred. For the years ended December 31, 2014 and 2013, advertising costs totaled approximately $327,000 and $305,000, respectively.

Income Taxes

SBH files a consolidated federal income tax return with its subsidiaries. SBH is structured as a limited liability company and therefore does not incur federal income taxes. The federal taxable earnings are reported by and taxed to the members of SBH individually. SBH also files composite tax returns in several states and makes payments for state income taxes to each of those states on behalf of its members. The state payments are reflected as distributions to members on the accompanying consolidated financial statements. The Company is subject to excise taxes on earnings allocated to the State of Tennessee. The amount of Tennessee excise tax is not considered material and accordingly no deferred or current income taxes are reflected in the accompanying consolidated financial statements.

Reclassifications

Certain reclassifications have been made in the 2013 consolidated financial statements to conform with the 2014 presentation. There was no impact in members' equity or changes in members' equity, as previously reported.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – MODIFIED CASH BASIS

Note 2. Long-Term Debt

Long-term debt consists of the following at December 31:

	2014	2013
Credit Facility (See below)		
Term Loan	$ 70,000,000	$ 55,670,000
Construction Loan	-	6,126,709
Revolver Loan	3,720,000	6,800,000
Total Credit Facility	73,720,000	68,596,709
Other Debt		
Capital lease obligation	-	3,672
Total long-term debt	73,720,000	68,600,381
Less current maturities	4,666,667	3,072,422
Long-term debt, less current maturities	$ 69,053,333	65,527,959

In December 2014, SBH entered into a $130 million Credit Facility (the "Credit Facility") with a syndicated group of lenders with a maturity date of December 2019. The Credit Facility consists of an initial Term Loan of $70 million, a Development Loan (the "Development Loan") of up to $50 million and a Revolving Line of Credit (the "Revolver Loan") of up to $10 million. The Revolver Loan provides for a sublimit of $2 million for standby letters of credit, of which $245,000 was outstanding at December 31, 2014. The Credit Facility also has an accordion option in which borrowing limits can be increased by up to $20 million. The purpose of the Credit Facility was to increase funds available for growth, as well as refinance substantially all existing debt. There is also a commitment fee charged on all unused borrowing capacity equal to a range of .25% up to.5% dependent upon amounts of total indebtedness less cash on hand in excess of $2.5 million (not to exceed $10 million) factored by adjusted EBITDA ("net leverage ratio").

Provisions of the Development Loan require monthly interest payments on advances. Advances taken during the year must be aggregated each December 31 (commencing December 31, 2016) and converted to term loans in tranches. The term loans will begin amortization on the last day of the first quarter following the anniversary of the closing date. Each term loan will be payable in quarterly installments of 1.25% of the respective tranche amount. There were no amounts outstanding on the Development Loan as of December 31, 2014.

The Revolver Loan requires monthly interest only payments through maturity with all principal due at the maturity date of December 31, 2019.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – MODIFIED CASH BASIS

Note 2. Continued

The interest rates on all the loans under the Credit Facility are based on the net leverage ratio as follows:

Net Leverage Ratio	Spread
Less than 2.50	30-Day LIBOR + 250 basis points
Greater than or equal to 2.50 but less 3.00	30-Day LIBOR + 275 basis points
Greater than or equal to 3.00 but less 3.50	30-Day LIBOR + 300 basis points
Greater than or equal to 3.50	30-Day LIBOR + 350 basis points

The interest rate at December 31, 2014 was at 3.67 percent.

The previous debt outstanding at December 31, 2013 required interest on the loans at a variable rate equal to the 30-Day LIBOR plus a certain amount of basis points beginning at 350 (3.75 percent at December 31, 2013).

The Credit Facility is secured by substantially all of the assets of the Company.

The terms of the Credit Facility described above requires certain affirmative and negative debt covenants including the maintenance of a minimum fixed charge coverage ratio and a maximum net leverage ratio. At December 31, 2014 and 2013, SBH was in compliance with all required covenants.

The maturities of long-term debt are as follows:

Year Ending December 31,	Amount
2015	$ 4,666,667
2016	4,666,667
2017	4,666,667
2018	4,666,667
2019	55,053,332
Total	$ 73,720,000

Note 3. Interest Rate Swaps

The Company has entered into various interest rate swap agreements to manage interest costs and risks associated with changes in interest rates. These agreements effectively convert underlying variable-rate debt based on the 30-Day LIBOR to fixed-rate debt through the exchange of fixed and floating interest payment obligations without the exchange of underlying principal amounts.

At December 1, 2014 and 2013, the following interest rate swap agreements were in effect:

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – MODIFIED CASH BASIS

Note 3. Continued

	Description	Notional Value	Maturity	Pay Index	Receive Index	Fair Value
Swap 1						
December 31, 2014	Fixed payer	$ 4,768,166	June 2017	4.29%	30-Day LIBOR	$ (367,155)
December 31, 2013	Fixed payer	5,069,966	June 2017	4.29%	30-Day LIBOR	(530,785)
Swap 2						
December 31, 2014	Fixed payer	19,188,000	June 2017	1.06%	30-Day LIBOR	(51,348)
December 31, 2013	Fixed payer	20,340,000	June 2017	1.06%	30-Day LIBOR	(67,942)
Swap 3						
December 31, 2014	Fixed payer	$ 6,080,000	June 2017	.87%	30-Day LIBOR	$ 11,601
December 31, 2013	Fixed payer	6,362,000	June 2017	.87%	30-Day LIBOR	19,585
Swap 4						
December 31, 2014	Fixed payer	5,337,000	June 2017	.87%	30-Day LIBOR	10,161
December 31, 2013	Fixed payer	5,581,500	June 2017	.87%	30-Day LIBOR	17,162
Swap 5						
December 31, 2014	Fixed payer	18,911,565	June 2017	.90%	30-Day LIBOR	250
December 31, 2013	Fixed payer	19,931,973	June 2017	.90%	30-Day LIBOR	7,790
Swap 6						
December 31, 2014	Fixed payer	45,410,000	May 2018	2.96%	30-Day LIBOR	(309,020)
December 31, 2013	Fixed payer	45,410,000	May 2018	2.96%	30-Day LIBOR	59,507
					Fair value 2014	$ (705,511)
					Fair value 2013	$ (494,683)

Swap 6 is a forward interest rate swap that becomes effective on July 1, 2017.

As a result of the interest rate swap agreements, interest expense increased by $590,560 and $343,003 in relation to the required debt service for the years ended December 31, 2014 and 2013, respectively.

Note 4. Property and Equipment

A summary of property and equipment follows:

	December 31, 2014	2013
Land and improvements	$ 11,753,592	$ 8,739,753
Building and improvements	67,254,093	45,839,068
Fixed and major moveable equipment	9,050,777	7,124,183
	88,058,462	61,703,004

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NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – MODIFIED CASH BASIS

Note 4. Continued

Less accumulated depreciation and amortization	(7,555,502)	(4,331,553)
	80,502,960	57,371,451
Construction in progress	6,459,595	11,723,061
Property and equipment, net	$ 86,962,555	$ 69,094,512

Depreciation expense related to these assets for the years ended December 31, 2014 and 2013 amounted to $3,242,843 and $2,169,598, respectively. The amount of interest capitalized by the Company was $89,726 and $223,277 for the years ended December 31, 2014 and 2013, respectively.

At December 31, 2014, the Company had outstanding construction commitments related to construction in progress of $8,156,569.

Note 5. Other Assets

Other assets at December 31, 2014 and 2013 consisted of the following:

	2014	2013
Debt issue costs, net of accumulated amortization of $545,431 and $313,677 at December 31, 2014 and 2013, respectively	$ 1,389,672	$ 1,229,820
Other	423,769	240,800
	$ 1,813,441	$ 1,470,620

Note 6. Leases

SBH leases certain property and equipment from third parties and related parties under long-term operating leases. Total rental expense for all operating leases for the years ended December 31, 2014 and 2013 was $1,085,786 and $967,683, respectively. Minimum future rental payments under non-cancelable operating leases having remaining terms in excess of one year as of December 31, 2014 are as follows:

Year Ending December 31,	Amount
2015	$ 659,147
2016	531,872
2017	305,215
2018	358,015
Thereafter	308,861
Total	$ 2,163,110

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – MODIFIED CASH BASIS

Note 7. Patient Accounts Receivable and Net Patient Service Revenue

Patient Accounts Receivable, Net

SBH grants credit without collateral to its patients. The percentage mix of receivables from patients and third-party payors is as follows:

	December 31,	
	2014	2013
Medicare	15%	20%
Medicaid	30	39
Commercial	47	35
Self Pay	8	6
Total	100%	100%

A summary of the activity in the allowance for doubtful accounts for 2014 and 2013 is as follows:

	Balance at Beginning of Year	Additions to Allowance	Accounts Written Off, Net of Recoveries	Balance End of Year
Allowance for doubtful accounts year ended December 31, 2014	$ 2,544,167	$ 2,100,378	$ (3,735,893)	$ 908,652

	Balance at Beginning of Year	Additions to Allowance	Accounts Written Off, Net of Recoveries	Balance End of Year
Allowance for doubtful accounts year ended December 31, 2013	$ 915,540	$ 3,849,410	$ (2,220,783)	$ 2,544,167

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – MODIFIED CASH BASIS

Note 7. Continued

A summary of net revenue, net of the provision for bad debts, for patient services rendered for the years ended December 31, 2014 and 2013 is as follows:

	2014		2013	
	Amount	Percentage	Amount	Percentage
Medicare	$ 20,754,781	20%	$ 15,839,812	20%
Medicaid	41,051,140	39%	29,150,783	36%
Commercial	41,920,355	40%	34,713,653	43%
Self Pay	853,413	1%	788,139	1%
	$ 104,579,689	100%	$ 80,492,387	100%

Patient service revenue, net of contractual allowances and discounts (but before the provision for bad debts), recognized in the period from these major payor sources, is as follows:

	Year Ended December 31, 2014		
	Third-Party Payors	Self-pay	Total All Payors
Patient service revenue (net of contractual allowances and discounts)	$ 105,809,514	$ 870,553	$ 106,680,067

	Year Ended December 31, 2013		
	Third-Party Payors	Self-pay	Total All Payors
Patient service revenue (net of contractual allowances and discounts)	$ 83,515,967	$ 825,830	$ 84,341,797

Note 8. Charity Care

The Company maintains records to identify and monitor the level of charity care it provides. These records include the amount of charges foregone for services and supplies furnished under its charity care policy. The direct and indirect cost, which includes all operating expenses excluding the provision for bad debts, associated with these services cannot be identified to specific charity care patients. Therefore, management estimated the costs of these services by calculating a ratio of cost to gross charges and multiplying that ratio by the gross charges associated with providing care to charity patients. The estimated direct and indirect cost incurred is approximately $491,000 and $485,000 for the years ended December 31, 2014 and 2013, respectively.

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NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – MODIFIED CASH BASIS

Note 9. Insurance Programs

SBH purchases professional and general liability insurance to cover medical malpractice claims. Management believes that any claims would be substantially covered under its insurance program and would not have a significant effect on the consolidated financial statements. Nevertheless, the future assertion of claims for occurrences prior to year-end is possible and may occur, although not anticipated.

Note 10. Related Party Transactions

Dobbs Management Service, LLC ("Dobbs") is a related party entity due to common ownership by certain members of SBH. SBH's business formation agreement requires a base management fee to Dobbs in an amount not to exceed $5,000 per month. Management fees incurred to Dobbs $60,000 for each of the years ended December 31, 2014 and 2013.

The business formation agreement also requires that guaranteed payments be made to certain SBH's members. For the years ended December 31, 2014 and 2013, the amounts of guaranteed payments totaled $447,510 and $418,636, respectively, and are included in salaries and benefits on the accompanying consolidated financial statements.

Additionally, the business formation agreement requires that an incentive fee based on a percentage of net income be paid to certain members of SBH and Dobbs, respectively. The incentive fees for the years ended December 31, 2014 and 2013 were $974,670 and $754,517, respectively. Accrued incentive fees at December 31, 2014 and 2013 were $95,175 and $58,868, respectively.

SBH has declared certain distributions payable to its members as of December 31, 2014 and 2013 related to income tax distributions. Total accrued distributions to members as of December 31, 2014 and 2013 were $1,026,371 and $155,942, respectively.

The Company allows members from time to time to transact equity transactions in the form of secured promissory notes. At December 31, 2014 and 2013 outstanding amounts receivable from members were $63,255 and $161,878, respectively. Interest is charged at a variable rate with the principal to be paid in full in May 2015. The Company received $98,623 and $12,923 of principal payments related to the notes receivable during 2014 and 2013, respectively. Note receivable balances due from members are presented as a component of members' equity on the accompanying consolidated financial statements.

The Company purchases property, casualty, and malpractice insurance coverage from a company which is owned by Dobbs. During 2014 and 2013, the Company paid insurance premiums of approximately $1,800,000 and $1,500,000, respectively to this party.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – MODIFIED CASH BASIS

Note 11. Employee Benefits

SBH participates in a multi-employer defined contribution 401(k) plan sponsored by Dobbs for its eligible employees. Contributions by the Company to the plan for the years ended December 31, 2014 and 2013 were $325,859 and $249,221, respectively.

SBH also provides health insurance benefits to its eligible employees. Health insurance benefits provided were $3,635,125 and $2,972,148 for the years ended December 31, 2014 and 2013, respectively.

Note 12. Risks and Uncertainties

SBH is involved in litigation in the normal course of business. Management is of the opinion that likelihood of any financial impact to SBH would be minimal and would be covered by insurance.

The amounts of certain enhanced revenues received from certain governmental payors are subject to future reviews that could result in refunds of the amounts previously received. Should any refunds of these amounts occur, they will be presented as a reduction of net revenues in the period that the amounts are refunded.

SBH maintains cash deposits that are at times in excess of FDIC insurance limits. The Company has not experienced any losses as a result of this concentration.

Note 13. Acquisition

On May 19, 2013, the Company entered into an asset purchase agreement with Universal Health Services, Inc. ("UHS") for the purchase of substantially all of the net assets and assumption of certain liabilities of Peak Behavioral Hospital. The Company's acquisition was based on management's belief that the Santa Teresa, New Mexico location is complementary to the Company's existing business and provides a base for further growth. The total original purchase price was $24,000,000.

The Company's acquisition was recorded by allocating the cost of the acquisition to the assets acquired, including intangible assets and liabilities assumed based on their estimated fair values at the acquisition date. The excess of the cost of the acquisitions over the net amounts assigned to the fair value of the assets acquired, net of liabilities assumed, was recorded as goodwill. The following table summarizes the valuation:

Assets	
Accounts receivable	$ 2,389,688
Inventory	20,669
Prepaid expenses and other assets	24,927
Property and equipment	5,988,588
Goodwill	16,710,662
Assets acquired	25,134,534

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – MODIFIED CASH BASIS

Note 13. Continued

Liabilities		
Accounts payable	$	85,309
Accrued expenses		285,048
Total liabilities		370,357
Net assets acquired	$	24,764,177

The difference between the original consideration paid of $24,000,000 and assets acquired of $24,764,177 was $764,177 and represented a subsequent working capital adjustment paid to UHS.

During 2014 and 2013, the Company recorded expenses of approximately $111,000 and $620,000, respectively, related to costs incurred in this and other potential acquisitions. The acquisition costs were primarily related to legal and professional fees and other costs incurred in performing due diligence.

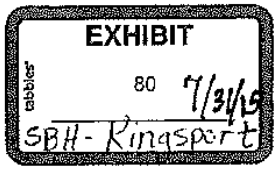
Note 14. Subsequent Events

SBH has evaluated, for consideration of recognition or disclosure, subsequent events that have occurred through May 8, 2015, the date the consolidated financial statements were available to be issued and has determined that no significant events have occurred subsequent to December 31, 2014 but prior to May 8, 2015, that would have a material impact on its consolidated financial statements.

SBH-Kingsport, LLC
CN1312-050

Report
Of
Daniel J. Sullivan
Sullivan Consulting Group, Inc.

June 2015



Overview

On December 13, 2013, SBH-Kingsport, LLC ("SBH") submitted a Certificate of Need ("CON") application to Tennessee Health Services and Development Agency ("HSDA") seeking approval for the establishment of a new 72 bed free standing mental health hospital and initiation of inpatient psychiatric and substance abuse services in Kingsport, Sullivan County, Tennessee. The proposed mental health hospital will include 28 inpatient beds for psychiatric care for children ages 5-17, 18 inpatient beds for adult psychiatric care for adults ages 18-64, 16 inpatient beds for geropsychiatric care for ages 55+, and 10 adult chemical dependency beds. SBH also proposes partial hospitalization and outpatient programs. The total project cost is $11,717,915.00.

SBH's proposed service area includes the counties of Sullivan and Hawkins in Tennessee, and Wise, Scott and Lee in southwestern Virginia.

The following considerations support approval of the SBH project:

- Tennessee has an inadequate supply of state-funded behavioral health beds, which places additional demands on private hospitals to meet the needs of residents.

- Inpatient behavioral health resources for children and adolescents are particularly scarce throughout the state and in Northeastern Tennessee where SBH proposes to locate its project.

- Eastern Tennessee, generally, and Sullivan County, specifically, have seen a significant reduction in the number of available psychiatric beds.

    - Lakeshore Mental Health Institute, the state operated facility with 250 licensed beds serving a multicounty area in Eastern Tennessee, which included Hawkins and Sullivan Counties, closed on June 30, 2012.

    - Indian Path Pavilion, which was licensed for 61 psychiatric beds, was closed by Mountain States Health Alliance ("MSHA") in 2009, with 9 of its beds transferred to Woodridge Hospital in Johnson City, Washington County. Both Indian Path Pavilion and Woodridge Hospital were part of the Mountain States Health Alliance.

- There are no inpatient psychiatric beds in Hawkins County or the three Virginia Counties in SBH's service area. Sullivan County, which is Tennessee's ninth largest county, is served by single 12-bed acute hospital based adult psychiatric unit at Wellmont Bristol Regional Medical Center in Bristol, which is located at the northeastern edge of Sullivan County.

- The SBH project is consistent with the Tennessee *Guidelines for Growth* for Psychiatric Inpatient Services. The proposed 72 psychiatric and chemical dependency beds are needed under the quantitative methodology set forth in the *Guidelines for Growth*, and the project satisfies the other service-specific criteria.

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- The SBH project is needed to address the limited availability behavioral health treatment services in the service area, as described in the letters of support accompanying the SBH application and in testimony at the HSDA Meeting at which the SBH project was considered.

- The SBH project is consistent with the Five Principles for Achieving Better Health in Tennessee's Comprehensive Health Plan.

- The SBH project demonstrates economic feasibility in the short and long term.

- The SBH project will contribute to the orderly development of adequate and effective health care services and facilities.

The HSDA denied the SBH CON application (based on a tie vote) on June 25 2014. SBH is appealing its denial and is being opposed by Mountain States Health Alliance ("MSHA"), which operates Woodridge Hospital ("Woodridge). An administrative hearing is scheduled for July 2015.

SCOPE OF THIS REPORT

I am the President of Sullivan Consulting Group, Inc., which was retained by Baker Donelson to evaluate independently the need for the SBH project and the consistency of the project with Tennessee CON review statutory criteria and the applicable provisions in the *Guidelines for Growth*.

I was not involved in the preparation of the original CON application or supplemental information submitted by SBH in connection with this project. A copy of my resume is included as **Exhibit 1** to this report. A listing of the information that I have reviewed in the preparation of this report is included as **Exhibit 2**.

In addition, I also have been engaged to respond to the reports of any expert(s) retained by MSHA that relate to health planning issues. As of this date, no such report has been produced by MSHA.

BACKGROUND

Access to appropriate mental health treatment is a significant problem nationally and in Tennessee. According to the National Alliance on Mental Illness, approximately 60 percent of adults and almost one-half of youth ages 8 to 15 with a mental illness received no mental health services in the previous year. See **Exhibit 3**. Many local officials in Northeastern Tennessee, including the MSHA's Chief Executive Officer Alan Levine, agree that access to mental health and addiction treatment services are a major problem in Northern Tennessee and Southwestern Virginia. See Deposition of Alan Levine, pp. 11-16 and **Exhibit 24**.

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Based on data from the Substance Abuse and Mental Health Services Administration ("SAMSHA"), Tennessee has a rate of serious mental illness that is above the national average. See **Exhibit 4**. Tennessee ranked 44th among states for the rate of adults with mental illness and 42nd for children with emotional behavioral developmental issues. Tennessee also ranked 43rd with respect to adults with mental illness who are uninsured. See **Exhibit 4**.

Historically, a core element of mental health treatment has been state run facilities that serve patients with the most serious mental illness; however, the resources at the state level have declined precipitously over the last several decades as a result of budgetary pressures and efforts to avoid long-term institutionalization of severely mentally patients.

A report by the Treatment Advocacy Center highlights the extent of this decline and its consequences. See **Exhibit 5**. Among the findings from this report:

- The number of state psychiatric beds decreased by 14% from 2005 to 2010. In 2005, there were 50,509 state psychiatric beds available nationwide. By 2010, the number had shrunk to 43,318.

- Tennessee closed 462 psychiatric beds between 2005 and 2010 and has a rate of 9.7 public psychiatric beds per 100,000 population, which is only 69% of the national rate of 14.1. The ratio today is even lower because Lakeshore Mental Health Institute (LMHI) and its 250 psychiatric beds closed on June 30, 2012.

The consequences of these bed closures include the following.

- Nationwide, closures reduced the number of beds available in the combined 50 states to 28% of the number considered necessary for minimally adequate inpatient psychiatric services.

- A minimum of 50 beds per 100,000 population, nearly three times the current bed population, is a consensus target for providing minimally adequate treatment. (Tennessee has less than 20% of this target ratio.) See **Exhibit 6**.

- In the absence of needed treatment and care, individuals in acute or chronic disabling psychiatric crisis increasingly gravitate to hospital emergency departments, jails, and prisons, which experience significant negative impacts including.

    - Hospital emergency departments are so overcrowded that some acutely ill patients wait days or even weeks for a psychiatric bed to open so they can be admitted; some eventually are released to the streets without treatment.

    - Law enforcement agencies find service calls, transportation, and hospital security for people in acute psychiatric crisis creating significant, growing demands on their officers and straining public safety resources.

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- Jails and prisons are increasingly populated by individuals with untreated mental illness with some facilities reporting that one-third or more of their inmates are severely mentally ill.

- A statistically significant inverse association emerged between lower state-hospital spending and higher rates of arrest-related deaths.

- A statistical trend emerged between public hospital bed populations and certain violent crimes, including homicide. States that closed more public psychiatric beds between 2005 and 2010 experienced higher rates of violent crime generally and of aggravated assault in particular (2010 data). A trend-level association between lower per capita hospital expenses and higher rates of aggravated assault also was found.

The National Alliance on Mental Illness conducted an analysis in 2009 to "grade" each state in terms of resources available to treat patients with serious mental illness, which updated a previous report card performed in 2006. The grades were based on 65 factors divided into four categories. See **Exhibit 7**. Tennessee's grade actually fell from a "C" to a "D" between 2006 and 2009, which was before the closure of LMHI in 2012.

The National Health Policy Forum undertook a study of the decreasing supply of acute mental health services in this United States. Institution-based treatment resources are, in fact, contracting, but this reduction in inpatient psychiatric services is not being balanced by the development of strong, comprehensive community-based systems of care. The number of dedicated psychiatric hospital beds has dropped dramatically over the last decade, and many communities report serious constraints in inpatient psychiatric capacity. New outpatient models are being developed, but they have not been implemented at the scale necessary to compensate for the decrease in inpatient beds. See **Exhibit 8**.

This National Health policy Forum study defines "acute mental health care" as "a short-term response to the urgent needs of an individual experiencing a mental health crisis." These patients are most often treated in psychiatric units of general acute care hospitals or private freestanding psychiatric hospitals. The study documents a significant decline in the number of psychiatric beds in both of these settings beginning in the 1990s due to a variety of factors including reimbursement limitations, governmental policy changes, and the availability of psychiatrists to attend inpatients receiving treatment.

SBH's proposed service area mirrors this national trend of a decreasing supply of inpatient psychiatric bed supply. LMHI, prior to its closure, was the Regional Mental Health Institute designated to serve a 24 county catchment area in East Tennessee that included the counties of Hawkins and Sullivan. After LMHI closed, the Tennessee Department of Mental Health and Substance Abuse Services ("TDMHSAS") expanded its contracts with three private psychiatric hospitals to provide services to uninsured persons in the region. Only one of these, Woodridge, is located in Northeastern Tennessee, and none of these facilities is located in service area proposed for this project. These three inpatient psychiatric facilities are Woodridge located in Johnson City (Washington County), Ridgeview Psychiatric Hospital and Center in Oak Ridge (Anderson

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County), and Peninsula Hospital in Louisville (Blount County). No inpatient psychiatric facility in Sullivan County has a contract with TDMHSAS.

Moccasin Bend Mental Health Institute, located in Chattanooga, TN, is currently the designated Regional Mental Health Institute to serve the 24 counties previously served by LMHI. The distance from Kingsport to Chattanooga is more than 200 miles, which makes accessing state mental health facilities extremely difficult for residents of Sullivan and surrounding counties. As a result, Tennessee residents, generally, and residents of Northeastern Tennessee, specifically, are more dependent on private psychiatric hospitals than many other states. While Woodridge has a contract to serve some of the patients previously treated by LMHI, it has only 84 beds to serve uninsured patients who previously were treated in state facilities as well as private patients in Northeastern Tennessee.

The TennCare Program is seeking to fill part of this gap in state mental health resources by expanding its "Patient Centered Medical Home" concept to incorporate patients with severe and persistent mental illness requiring long-term treatment. This program seeks to emphasize outpatient and community-based resources that may address some of the needs of patients requiring long-term treatment; however, it will not eliminate the needs of behavioral health patients requiring acute inpatient admission during crisis or when short-term intensive interventions are necessary.

Frontier Health, which provides crisis response and community-based psychiatric and addiction treatment services throughout Northeast Tennessee and Southwestern Virginia, has an adult crisis stabilization unit in the SBH service area may be considering opening a similar unit for adolescent patients. While such a center would provide another needed resource in the community, these facilities are designed to hold patients for up to 72 hours while waiting for placement in a psychiatric hospital facility. These crisis centers do not supplant the need for the more comprehensive and intensive services that a psychiatric hospital provides.

In addition to the loss of state sponsored beds, the inventory of private psychiatric beds has also declined in recent years specifically in Sullivan County where SBH proposes to locate its project. In 2009, Indian Path Pavilion, a psychiatric facility in Kingsport with 61 licensed psychiatric beds closed.[1] With this closure, Wellmont Bristol Regional Medical Center ("Wellmont BRMC") is the only provider of inpatient psychiatric services in SBH's service area, but it operates a single, 12-bed adult psychiatric unit. There are no psychiatric beds in SBH's service area that are designated for children, adolescents, older patients, or those with chemical dependency.

The HSDA staff noted in the Staff Summary prepared in connection with the SBH application, "According to a US Department of Health and Human Services, Assistant Secretary for Planning and Evaluation (ASPE) Office of Health Policy Research Brief, the Affordable Care Act, building on the Mental Health Parity and Addiction Equity Act, will expand coverage of mental health and substance use disorder benefits and federal parity protections in three distinct ways (1) Essential Health Benefits (2) Parity in Individual and Small Group Markets (3) Increasing

[1] As noted previously, MSHA, which operated Indian Path Pavilion, received CON approval to transfer 9 of the closed beds to WH.

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Access to Quality Health Care." See Application Summary, p.8. The ASPE Brief states specifically: "The Affordable Care Act will provide one of the largest expansions of mental health and substance use disorder coverage in a generation. Beginning in 2014 under the law, all new small group and individual market plans will be required to cover ten Essential Health Benefit categories, including mental health and substance use disorder services, and will be required to cover them at parity with medical and surgical benefits." See **Exhibit 9**. Lack of insurance has been a significant barrier to utilization of mental health services. The expansion of insurance coverage will positively impact demand for all types of treatment, including the inpatient psychiatric and chemical dependency services proposed by SBH.

The picture that emerges from these facts is that Northeastern Tennessee has seen a significant decline in available psychiatric inpatient bed capacity, and a limited number of psychiatric beds remain to address the behavioral health needs of its large and growing number of residents with behavioral health problems.

The Framework for Tennessee's Comprehensive State Health Plan
Five Principles for Achieving Better Health

The following Five Principles for Achieving Better Health serve as the basic framework for the State Health Plan. After each principle, the applicant states how this application supports the principle, if applicable.

1. Healthy Lives
The purpose of the State Health Plan is to improve the health of Tennesseans. Every person's health is the result of the interaction of individual behaviors, society, the environment, economic factors, and our genetic endowment. The State Health Plan serves to facilitate the collaboration of organizations and their ideas to help address health at these many levels.

The primary purpose of SBH's project is to improve access to behavioral health services, and as a result, improve the overall health of its service area residents. Mental illness is often a debilitating condition and can often result in other comorbid conditions. SBH will offer a comprehensive treatment setting to provide direct treatment as needed and coordinate with other resources in the community to ensure that patients receive ongoing care in the most appropriate setting.

2. Access to Care
Every citizen should have reasonable access to health care. Many elements impact one's access to health care, including existing health status, employment, income, geography, and culture. The State Health Plan can provide standards for reasonable access, offer policy direction to improve access, and serve a coordinating role to expand health care access.

As noted in the prior response, SBH's project is intended to improve access both from a geographic and a programmatic standpoint. There is a single 12-bed psychiatric unit in Sullivan County in Bristol, Tennessee. Since the closure of Indian Path Pavilion, neither Kingsport nor any other county in the service area has an inpatient psychiatric provider. Most patients are

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traveling outside the service area for inpatient psychiatric care. This project will significantly enhance geographic access.

Wellmont Bristol Regional Medical Center, the only service area provider, offers only adult psychiatric services. SBH proposes to offer services for all age groups as well as a chemical dependency unit. Access to child and adolescent services, in particular, is limited with only a 12-bed unit at Woodridge in Johnson City, Washington County, Tennessee. SBH's 28-bed child and adolescent unit will provide a needed expansion in capacity in the region's largest county.

3. Economic Efficiencies

The state's health care resources should be developed to address the needs of Tennesseans while encouraging competitive markets, economic efficiencies and the continued development of the state's health care system. The State Health Plan should work to identify opportunities to improve the efficiency of the state's health care system and to encourage innovation and competition.

The SBH project directly advances this goal by providing a comprehensive facility under the direction of an experienced operator. Competition is severely lacking in Northeastern Tennessee, with all of the psychiatric beds controlled by either the Wellmont or the MSHA organizations. Wellmont and MSHA have announced plans to pursue a merger, which will further decrease the competitive market for behavioral health care. SBH has the experience and resources to compete effectively in this market.

4. Quality of Care

Every citizen should have confidence that the quality of health care is continually monitored and standards are adhered to by health care providers. Health care providers are held to certain professional standards by the state's licensure system. Many health care stakeholders are working to improve their quality of care through adoption of best practices and data-driven evaluation.

SBH describes in its application the quality of its services at other facilities it operates and its commitment to offer quality services at its proposed Kingsport facility.

5. Health Care Workforce

The state should support the development, recruitment, and retention of a sufficient and quality health care workforce. The state should consider developing a comprehensive approach to ensure the existence of a sufficient, qualified health care workforce, taking into account issues regarding the number of providers at all levels and in all specialty and focus areas, the number of professionals in teaching positions, the capacity of medical, nursing, allied health and other educational institutions, state and federal laws and regulations impacting capacity programs, and funding.

SBH's project will contribute to this goal by bringing a number of needed behavioral health professionals to staff its facility. Child/Adolescent psychiatrists are in particularly short supply in Tennessee and nationally. SBH proposes to recruit Child/Adolescent psychiatrists to its facility along with a number of clinical professionals that will enhance availability of quality workforce.

CRITERIA USED FOR REVIEW.

I. 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 (e.g., the State Health Plan);

The applicable State Health Plan is *Tennessee's Health Guidelines for Growth, Criteria and Standards for Certificate of Need, 2000 Edition (Guidelines for Growth)*, which, among other things, sets forth service-specific standards and criteria for inpatient psychiatric services. The Preface to the *Guidelines for Growth* states:

> *Certificate of Need applications are reviewed by the Health Facilities Commission in accordance with three major criteria: need, economic feasibility, and contribution to the orderly development of adequate and effective health care. **The following criteria and standards do not supersede the code section in any way and are meant to provide additional guidance to assist the Commission in its review of CON applications.*** [p.1] [Emphasis added.]

The Health Facilities Commission has been replaced by the HSDA, but the purpose of the *Guidelines for Growth* remains clear: the criteria and standards assist in the evaluation of applications, but are not mandatory.

Regardless, it is undisputed that, on several occasions in recent years, the HSDA has approved projects that were not in conformity with the determination of beds need calculated under the *Guidelines for Growth*, including projects for psychiatric beds, and that these approvals either went unchallenged or have been upheld on appeal. A June 13, 2014 memorandum from Sandra Braber-Grove of TDMHSAS regarding the SBH project stated:

> *"As mentioned in reports for other CON applications, the Guidelines for Growth publication specifies a formula of thirty (30) beds per a population of one hundred thousand (100,000) to determine the need for inpatient psychiatric beds. As also mentioned in those reports, in practice, application of the formula has often resulted, but does not always result, in an underestimation of the number of inpatient psychiatric beds needed due to the impact of other factors on bed utilization, including: the willingness of the provider to accept emergency involuntary admissions; the extent to which the provider serves the TennCare population and/or the indigent population; and the number of beds designated as "specialty" beds (gero-psychiatric units or units established to treat patients with specific diagnoses). These factors limit the availability of beds for the general population, as well as for specialty populations, depending on how the beds are distributed. Additional factors include taking into consideration not only the number of existing beds in the proposed service area, but the utilization of those beds and the TDMHSAS' strong support for serving people, if and when possible, in the community in which they live to increase the potential involvement of family, the*

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individual's support system, and access to other needed services, including aftercare services." See TDMHSAS Memorandum, p. 5.

With this foundation, the following discussion evaluates the need for, economic viability of, and contribution to the orderly development of health care by the SBH project. Among other relevant considerations are the Guidelines for Psychiatric Inpatient Services.

SERVICE SPECIFIC CRITERIA AND STANDARD REVIEW: 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).*

The guideline of 30 beds per 100,000 total population was established many years ago, prior to the closure of the Tennessee psychiatric beds described above, and as noted by TDMHSAS, it does not consider the unique needs of various age groups in the population for inpatient psychiatric services. SBH's application seeks to develop a comprehensive behavioral health hospital that will serve individuals across the age spectrum with both psychiatric and substance abuse disorders. This report will address need using the 30 beds per 100,000 guideline as well as other considerations that impact the need for the services proposed.

Service Area

The *Guidelines for Growth* do not define designated planning areas for the determination of need for inpatient psychiatric services. As a result, the starting point for need determination is the service area that the applicant presents for its proposal. The SBH application describes a five-county service area that includes Hawkins and Sullivan County in Tennessee and Lee, Scott, and wise Counties in Virginia. SBH will be located in Sullivan County and the remaining counties adjoin Sullivan County and do not have an inpatient psychiatric provider. See **Exhibit 10**.

MSHA has asserted that SBH should have included at least Washington County, Tennessee, in its service area. MHSA noted that Woodridge was the largest provider of inpatient psychiatric services to residents in Sullivan and Hawkins Counties, and Washington County, Tennessee also shares economic ties with Sullivan County. At the HSDA Meeting a MSHA representative proposed using a 35-mile radius around Kingsport to define SBH's service area. See Transcript, pp. 53-54.

TDMHSAS in its reviewing agency report noted that because SBH was including some Virginia counties in its service area it therefore should have included the City of Bristol, Virginia and its 28-bed psychiatric facility in its service area, although not the population of Bristol and the surrounding Washington County, Virginia. The HSDA Staff analyzed need from the perspective of Woodridge's current service area based on the fact that Woodridge was the principal facility serving psychiatric patients from SBH's service area. Woodridge's draw from SBH's service

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area is not surprising given that it is the only facility offering a comprehensive range of psychiatric services in the Northeastern Tennessee region. The HSDA Staff calculated the need for psychiatric beds in Woodridge's service area, which included Sullivan, Washington, Greene, Carter, and Hawkins County in Tennessee, but it gave no consideration to Virginia counties which SBH proposes to serve. Most importantly, the HSDA analysis did not consider whether SBH would in fact draw material numbers of patients from all of these counties.

All of these attempts to redefine SBH's service area are problematic. A service area must be defined from the perspective of the applicant's proposal, i.e., what is the area from which the project will draw the significant majority of the patients it proposes to serve. Geography alone does not establish a service area. It is not uncommon for a hospital's service area to exclude one or more contiguous counties based on a number of factors including the presence of a large provider in a contiguous county, relationships with referring health professionals, travel access, and historical health care migration patterns, among others

Some of these factors are relevant to SBH's project. SBH's location in Kingsport is not as readily available to most residents in Washington County as Woodridge's Johnson City location. Moreover, Woodridge is an 84-bed freestanding hospital that has been long established with defined referral patterns. Woodridge offers programs serving the same age groups that SBH proposes to serve. More importantly, Woodridge is part of MSHA, which is a major provider of health care services in Washington County and throughout Northeastern Tennessee and Southwestern Virginia.[2] MSHA operates Johnson City Medical Center, which is the major provider of acute care services in Washington County and the source of a significant number of inpatient psychiatric referrals. MSHA also has employed physicians located through the region. For all of these reasons, it is not likely that significant numbers of psychiatric patients will leave Washington County for services in Kingsport. SBH will be a new facility in a different location that will establish relationships with a different set of referral sources than Woodridge. It would not be reasonable to expect that SBH's service area to be identical to Woodridge's service area.

The experience of other hospital providers in Sullivan County also supports SBH's proposed service area definition. HealthSouth Rehabilitation Hospital in Kingsport is a specialty hospital that in 2013 received 91.0% of its admissions from residents of Sullivan, Hawkins, and certain Virginia counties. Only 32 patients, which was 3.8% of HealthSouth's total patients, were Washington County, Tennessee residents, which is likely due to the fact that MSHA operated Quillen Rehabilitation Hospital in Johnson City, a situation analogous to what SBH will face. See **Exhibit 11.**

Indian Path Medical Center in Kingsport was previously owned by HCA. In a CON application for Indian Path Medical Center (CN 9606-042) HCA defined Indian Path's primary service area as the same five counties that SBH identified as its proposed service area. See **Exhibit 11A.**

Indian Path Medical Center, which is now the MSHA acute care hospital located in Kingsport, had similarly limited reliance on Washington County, Tennessee. In 2013, Indian Path Medical

[2] As discussed in more detail below, MSHA is seeking a merger with the other large health system in Northeastern Tennessee, Wellmont Health System. If consummated, this merger will create an organization with significant presence in all aspects of health care delivery in the area.

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Center received 92.1% of its admissions from residents of Sullivan, Hawkins, and Virginia counties. Washington County, Tennessee residents represented only 4.7% of its total inpatient discharges. See **Exhibit 12**. Indian Path Medical Center's service area was defined in MSHA's 2012 Social Responsibility Plan as Sullivan and Hawkins County in Tennessee, and Wise, Scott, Lee, and Dickenson Counties in Virginia. See p. 175 of MSHA's 2012 Social Responsibility Plan, which is included as **Exhibit 12A.**

Wellmont Holston Valley Medical Center, the largest acute care provider in Kingsport, received 86.5% of its 2013 admissions from Sullivan and Hawkins Counties in Tennessee, and Scott, Wise, and other counties in Virginia. Only 5.7% of its inpatients were residents of Washington County, Tennessee. See **Exhibit 13.**

Wellmont Bristol Regional Medical Center (Wellmont BRMC"), the only provider of psychiatric services in Sullivan County, is located on the county's northeastern edge near the Virginia border. Based on patient origin data obtained from MSHA in discovery, Wellmont BRMC's psychiatric and substance abuse patient origin data indicate how service areas vary even within the same county. The largest source of psychiatric patients for BRMC in 2013 was Washington County, Virginia, which represented 31.1% of its 2013 total discharges. Sullivan County, where it is based, provided only 21.9% of its 2013 psychiatric discharges. Of Wellmont BRMC's total psychiatric discharges, only 42.1% were residents of any of the five counties in SBH's service area. Washington County, Tennessee provided only 0.8% of its total psychiatric and substance abuse patients. See **Exhibit 14**.

The HSDA has accepted applicants' service area definitions that excluded contiguous counties in recent CON reviews that resulted in CON approvals. As an example, TrustPoint Hospital in Rutherford County, Tennessee, which is an existing provider of psychiatric and rehabilitation hospital services, recently applied for an expansion of its psychiatric bed capacity, which the HSDA approved. A copy of this CON application is included as **Exhibit 15**. TrustPoint defined its service area as Rutherford and Bedford Counties and excluded the contiguous counties of Davidson and Williamson. Both Williamson and Davidson have large existing psychiatric providers. In fact, TrustPoint's application presented historical patient origin data that indicated that Davidson County was the second largest source of its admissions, yet its defined service area was employed by the HSDA in assessing need. Both Bedford and Rutherford Counties were also included as part of Rolling Hills Hospital's primary service area in CON application CN 1312-051. See **Exhibit 15A**. Rolling Hills is a psychiatric hospital located in Williamson County, Tennessee, which is contiguous to Rutherford County as well as Davidson County.

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.

Population

SBH's service area comprises a large population base to support a new behavioral health hospital. Sullivan County, with an estimated 2015 population of 159,494, has the ninth largest county population in Tennessee. See **Exhibit 16**. The SBH service area has an estimated 2015

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total population of 305,755, which is projected to increase to 308,830 by 2019. See **Exhibit 17.** Approximately 71% of the service area population resides in the two Tennessee counties. The specific demographic trends in the service area population are addressed in more detail below.

Planning Horizon

2015 will serve as the base year in my analysis and 2019 will be the end of projection period for purposes of need determination.

Total Psychiatric Bed Need

Exhibit 18 presents the need for total psychiatric beds in the SBH service area based on the *Guidelines for Growth's* 30 beds per 100,000 formula applied to the total service area population. Based on this approach, there is a need for a total of 92 psychiatric beds in 2015 increasing to 93 in 2019 in the SBH service area. Subtracting the 12 existing psychiatric beds at Wellmont BRMC results in a net need for 80 additional psychiatric beds in 2015 and 81 additional psychiatric beds in 2019. The SBH request for a total of 72 beds is consistent with this need calculation.

The following responses identify the need by various age groups that SBH proposes to serve. There is no reason to expect that need for inpatient psychiatric services will be evenly distributed across all groups in the population. These quantitative age-specific calculations must be supplemented by consideration of specific needs in each community identified by qualitative analysis.

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

Exhibit 19 provides the psychiatric bed need projections for the service area population age 18 to 64 years. In 2015 the total adult need is 56 beds, which increases to 57 beds in 2019. Subtracting the 12 beds at Wellmont BRMC, which are dedicated to adult services, results in net need for 44 adult beds in 2015 and 45 adult beds in 2019. SBH proposes a total of 28 adult beds (18 psychiatric and 10 chemical dependency beds), which is consistent with this calculated need.

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

Given that SBH proposes to serve children and adolescents, the population under age 18 was included in this need determination. As reflected in **Exhibit 20**, there is a projected need for 17 child and adolescent psychiatric beds in 2015 and 15 beds in 2019. SBH is proposing 28 child and adolescent beds. Despite the quantitative determination under the formula, the development of 28 child and adolescent beds appears appropriate for several reasons.

First, the only psychiatric beds for child and adolescent patients in Tennessee north and east of Knoxville are in a 12-bed unit at Woodridge in Johnson City. Based on documents produced by MSHA, utilization of this unit has been increasing over the last two years and on several days in 2014 no beds were available to admit child and adolescent patients. See MSHA 1441-1517 and

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1571, which are discussed in more detail below. In addition, there are alternative providers of adult psychiatric services including Wellmont BRMC within the service area and other providers located outside the services area but the needs of children and adolescents have not been substantially addressed in the region.

Dr. Jill McCarley, a child and adolescent psychiatrist and previously a professor at ETSU and the Medical Director of the child and adolescent unit at Woodridge, spoke in favor of the SBH project at the HSDA Meeting. See Transcript, pp. 31-33, included as Exhibit 20A. She described limitations with Woodridge's child and adolescent unit that support the development of the proposed 28-bed child and adolescent unit at SBH. See stated: "Woodridge offers a combined child "and" adolescent unit. So when you take an eight-year-old or a nine-year-old you can't take a violent 16-year-old. You can't put the younger ones in danger. They share the same milieu." Marlene Bailey, Director of Behavioral Health Programs at Woodridge, noted in her deposition that Woodridge often must "block" beds (i.e., not allow an admission to that beds on a particular day) in the child and adolescent unit because of concerns with clinical compatibility of patients, infections, or other health concerns. See Deposition of Marlene Bailey, pp. 31-37. These blocked beds constrain Woodridge's ability to utilize all 12 of its child and adolescent beds. SBH, in contrast, proposes separate units for children and adolescents, which will reduce the types of limitations on bed utilization that Woodridge now confronts.

Dr. McCarley noted that there are limited psychiatric inpatient beds throughout Tennessee for children and adolescents. "When the state hospital closed its beds for children and adolescents a few years ago, that put a huge demand on our system. It's a demand that we haven't been able to meet, across this state, quite yet. Strategic Behavioral Health has a plan that could help ease the burden on the community and on the state." (See Transcript, p. 32.

Certain of the letters of support presented in SBH's application, summarized below, specifically discuss the great need for additional resources for children and adolescents in the communities that SBH proposes to serve. Based on the information in the SBH application and the qualitative evidence in terms the observations of SBH's representatives and the letters of support from the community, the need for SBH's 28 child and adolescent beds is demonstrated.

This need is confirmed by the practical limitations of Woodridge's 12-bed child and adolescent unit, detailed above.

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.*

As noted above, the only existing psychiatric beds are the 12 adult beds at Wellmont BRMC located in eastern Sullivan County. These beds were appropriately subtracted from the appropriate need calculations in the preceding responses to the criteria.

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.*

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The definition of SBH's primary service areas is reasonable appropriate for the reasons discussed above.

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.*

The target population for SBH includes all individuals age 5 and older with mental health disorders requiring treatment in an inpatient, partial hospital, or outpatient setting.

Population growth in SBH's service area is expected to be modest. As shown in **Exhibit 17**, the population under age 18 is expected to decline between 2015 and 2019, but there will remain nearly 50,000 young residents in the service area who can benefit from the services SBH proposes. The fastest growing segment of the population will be individuals age 65 and older, consistent with statewide and national trends. This growing elderly population readily supports the inclusion of geropsychiatric unit at SBH.

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*

Not applicable.

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.*

Not applicable.

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

There are no state-funded inpatient governmental mental health institutes located in Eastern Tennessee north of Chattanooga after the closure of LMHI. Given the distances to the remaining state facilities in Chattanooga as well as Middle and Western Tennessee, there should be no impact on facilities directly supported by state appropriations, such as Moccasin Bend in Chattanooga. As discussed above, Woodridge does have a contract with TDMHSAS to serve some uninsured patients previously served by LMHI. These grants that Woodridge receives are not likely to be affected by the approval of SBH's project. In any event, Woodridge is a facility supported primarily by revenues from Medicare and TennCare as well as private insurers and therefore would not be considered under this guideline.

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As discussed in more detail below, there are a number of reasons why Woodridge will not be materially impacted by SBH's approval. Among the reasons are Woodridge is part of MSHA, which is large health system that has hospitals and health care providers throughout Northeastern Tennessee and Southwestern Virginia. It is likely that MSHA will continue to receive referrals from its affiliated organizations regardless of SBH's presence in Sullivan County. More importantly, the need for inpatient behavioral health treatment in SBH's service area is greater than the historical numbers of patients served by Woodridge and other providers. The significant loss of inpatient psychiatric bed capacity has constrained access to care. Woodridge itself has seen its utilization rise dramatically in recent years after it reduced constraints on access to its beds, as addressed below. Given the size of the population base in Northeastern Tennessee and Southwestern Virginia, there is ample need for SBH's 72 beds in addition to Woodridge's existing 84-bed facility.

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.*

SBH will accept both voluntary and involuntary admissions. It will focus on short-term acute care services with an expected length of stay of 10 days.

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

This project seeks to serve all individuals appropriate for care including Medicare and TennCare patients. In Year 1 of operation, SBH projects that 38% of its revenues will be attributable to TennCare patients and 27% to Medicare patients.

D. Relationship to Existing Similar Services in the Area

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

The only providers that are relevant to the evaluation of SBH's application are Wellmont BRMC and Woodridge. Wellmont BRMC operates a 12-bed adult psychiatric unit in Bristol, Tennessee. Its occupancy has increased from 55.9% in 2011 to 65.8% in 2013. See **Exhibit 21**. Wellmont BRMC serves primarily patients from Virginias with a smaller percentage of patients from Sullivan County, as discussed above. With its small unit size and its 2013 occupancy level, Wellmont BRMC has few beds available to meet the needs of residents in the SBH service area.

Woodridge is the largest provider of behavioral health services to the SBH service area. MSHA took the position before the HSDA in opposing the SBH project that its existing 84 beds are underutilized, an assertion which it claims is an indicator that additional behavioral health beds are not needed in Northeastern Tennessee. While Woodridge's beds have not been fully utilized in years prior to 2014, there is significant evidence from MSHA's own documents that its historical utilization was a function of Woodridge's own policies and practices rather than a lack of need and demand for the beds.

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In late 2013, MSHA undertook what it termed a "Value Stream Analysis ('VSA')" to evaluate how Woodridge's beds were being underutilized and identify "gaps" in Woodridge's historical operations that limited effective utilization of its resources. See Bailey Deposition, pp. 37-42. This analysis indicated that Woodridge was not fully utilized previously due to a variety of factors not related to need or demand for services, as outlined in this excerpt drawn from MSHA's VSA for Behavioral Health:

Description of Gap	Root Cause "WHY"
Patients being held greater than 24 hours	Not enough adult acute care beds due to MDs not discharging early enough and closure of state hospital which increased census
Culture change	Nursing manager and supervisor dictating the flow of the patient instead of MDs
No urgent care type setting	The need has not been realized to divert pts from the Eds
Blocked beds	Ties up free beds due to policies that need to be reviewed. (cant room two people together for certain medical reasons)
No Respond tracking system	There is not indicator to let respond know that 2 hours has passed since crisis has been contacted
Transportation	Wings Ground is the best option but they are lacking resources because it is a nonfunded service
Lack of medical community knowledge of all of Woodridge's services	MSHA has not seen the value of marketing the services

See MSHA 1635.

By Woodridge's own admission in this gap analysis, insufficient bed capacity was an issue, which resulted in patients being held in Emergency Departments waiting for beds. This capacity constraint was attributed to physicians not discharging patients early enough and the closure of the LMHI state hospital that led to an increase in WH's census. In recognition of continuing capacity constraints, one of the recommendations in this VSA was to move the adolescent psychiatric unit from Woodridge to the Niswonger Children's Hospital in Johnson City to free up capacity to expand adult psychiatric services at Woodridge, which would result in an increase of inpatient psychiatric beds in Washington County.

The statements in this analysis are at odds with Woodridge's public statements to the HSDA that the LMHI closure did not support the approval of the additional behavioral health beds that SBH proposed in Sullivan County. MSHA's "gap analysis" also identifies a number of operational issues that have limited Woodridge's ability to utilize its beds fully. MSHA acknowledged that despite its many years in the community the medical community is not knowledgeable about all of Woodridge's services. One reason cited regarding why this knowledge was lacking was that MSHA has not seen the value of marketing these behavioral health services. (Woodridge is the only freestanding psychiatric unit operated by MSHA.)

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An issue not explicitly discussed in the VSA but which was raised during testimony at the HSDA Meeting and in the deposition testimony of Marlene Bailey, was that Woodridge's clinical programs were previously under the medical direction of professors from East Tennessee State University's School of Medicine, and their policies restricted the use of its beds. In 2014 Woodridge's medical direction was transferred to members of the Mountain States Medical Group, who are physicians employed by MSHA, which apparently has resulted in eliminating some of the barriers the previously restricted patient flow.

After implementing some of these changes, Woodridge has seen its utilization levels rise significantly, which is an indication that the actual need for inpatient psychiatric services was not reflected in its previous utilization levels. In FY 2014 (July 2013 through June 2014), Woodridge reported an occupancy rate of 76.4% for its 84 beds, which was materially higher than any of its previous three years. See **Exhibit 22**. For the nine-month period from January through September 2014, Woodridge's occupancy rate increased to 81.2%. See MHSA Response to Interrogatories Exhibit F. Of particular note, Woodridge's monthly occupancy in June 20014 reached 84.2% based on an average daily census of 71 patients. See MSHA 1638. This June utilization level is substantially above the utilization levels in any month at Woodridge from FY 2011 through January 2014, which is the last time period prior to June 2014 for which detailed data was available from Woodridge. See **Exhibit 23**. Ms. Bailey testified in her May, 2015 deposition that an average daily census of 75 patients at Woodridge was an "average day" currently, which represents an occupancy rate of 89.3%. See Bailey Deposition, p. 36. She also testified that Woodridge was over 90% in occupancy on the day of her deposition on May 15, 2015. All of these data demonstrate that Woodridge has seen strong growth in utilization by removing operational and clinical constraints and the demand for such services had not been fully satisfied by Woodridge in the past.

Another means to measure of Woodridge's available capacity is a review of daily "Patient Flow Sheets" that reflect the census each morning and the number of beds available during the period August 1, 2014 to October 21, 2014. See MSHA 1441-1517. Each sheet also shows the number of rooms that were blocked on that date and the patients on a waiting list for a bed. Over this period, one to three rooms were blocked on the Willow Unit, which serves children and adolescents on approximately 80% of the days. With only 12 beds in this unit, these blocked beds inhibit the admission of younger patients. If two beds are blocked, for example, then 10 patients represent the maximum capacity that Woodridge can accommodate on that day. These constraints are also reflected in the waiting lists of patients recorded on several days during this period. On a number of days, various units reported zero or one bed available. See **Exhibit 23A** for a sampling of these census reports.

Woodridge on many days has deferred admissions. See MSHA 1440. For the seven-month period from June to December 2013, Woodridge deferred 75 adolescent referrals. Of this total, 23 deferrals were due to a lack of beds and the remainder related to violent behavior or other factors. From January through 2014, Woodridge had an additional 43 adolescent deferrals, or which 26 were related to lack of an available bed. The lack of available beds was the most frequent reason why adolescents were deferred. Over these 12 months, 35 of the adolescent deferrals were Sullivan County residents, the highest of any county.

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The number of adult deferrals was significantly higher than for adolescents. During the period from June through December 2013, 365 adult admissions were deferred. Approximately two-thirds of the total patients were deferred due to a lack of an available bed. Over the shorter period from January through May 2014, Woodridge deferred an additional 107 adult admissions, and again two-thirds were related to the lack of an available bed. Over the twelve-month period, 108 Sullivan County adult admissions were deferred.

The foregoing analysis demonstrates that Woodridge is highly utilized and also contradicts MSHA's claims that there is no unmet need for psychiatric services. There is also strong evidence that as Woodridge eases operational constraints on access to its beds and increases community awareness of its services, utilization will continue to increase within the limits of its already well-utilized bed capacity.

Despite the high utilization of its inpatient services, MSHA has continued to reduce psychiatric services, according to Ms. Bailey. In early 2014, MSHA terminated its freestanding outpatient psychiatric services. See Bailey Deposition, pp. 20-21. While Woodridge continues to offer intensive outpatient services, it has an infrequently utilized partial hospitalization program. As a result, Woodridge's treatment is focused on inpatient care, which has limited available capacity.

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

SBH proposes services to a number of special needs groups. As discussed previously, SBH proposes specialized services for children and adolescents, which are in limited supply throughout Tennessee. SBH informed the HSDA that it is capable of serving cognitively impaired children and adolescents, which Woodridge indicated at the HSDA Meeting that it did not serve. SBH proposes what will be the only dedicated chemical dependency unit in the service area. SBH also proposes a geropsychiatry program to meet the needs of the service area's rapidly growing elderly population.

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.

The application presents proposed staffing by position that appears reasonable and consistent with the projected volume for patients to be served.

Summary of the Conformity with the Service-Specific Guidelines

The SBH project is consistent with the *Guidelines for Growth* for Psychiatric Inpatient Services. As demonstrated by the foregoing analysis, the proposed 72-bed behavioral health facility is consistent with bed need methodology presented in the *Guidelines for Growth* and satisfies the other service-specific criteria. More importantly, the project will enhance access to a comprehensive range of behavioral health services in an area where resources are limited.

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CRITERIA USED FOR REVIEW (Continued)

1. NEED

The health care needed in the area to be served may be evaluated upon the following factors:

a) The population served by the proposal;

Quantitative analysis cannot fully capture the need for behavioral health services given the complex network of providers and community agencies that interact with individuals suffering from mental illness. SBH in its application presented the results of discussions it held with health professionals, law enforcement officials, and community leaders in communities throughout its service area regarding problems they were facing and the need for additional resources.

The following addresses different facets of the need for SBH's project based on excerpts from selected letters of support that are representative of the issues that SBH highlighted.

Redacted

Redacted

Redacted

Redacted

At the HSDA Meeting, Mike Garone of SBH spoke regarding data provided by the Sullivan County Sheriff's Department. Of the total number of mental health transports made by the Sullivan County Sheriff's Department, 27 percent, or 623 transports, are leaving the area with 77 percent of those go to Louisville, Tennessee (Peninsula Hospital), which is 111 miles away. Those 259 admissions that came from just one county would account for a significant portion of the projected utilization in SBH adult unit. See Transcript, Garone, p. 18.

Medical Education

I am an Associate Professor of Psychiatry at ETSU in the Quillen College of Medicine. I am board certified in psychiatry and in psychosomatic medicine. I have served as the Residency Program Director for the ETSU Department of Psychiatry and Behavioral Sciences for the past 3 years...Unfortunately, I was not consulted regarding any letter sent from ETSU opposing this proposed psychiatric facility. On the contrary, our program is in desperate need of training sites and for alternative funding for our residency program. Even with funding from MSHA and from the Veteran's Administration at Mountain Horne, we have not been able to place all of our residents this year in appropriate clinical learning sites. MSHA has indicated the desire and need to decrease the number of residents they fund, and, partially as result of that, we have decreased our overall resident complement numbers.

It is my understanding is that Strategic Behavioral Health has partnered with medical schools in the past and intends to do so, if possible, with our department. Their proposed clinical services will not only benefit the area in terms of services and training offered, they will do so without significant overlap or competition with services offered at Woodridge 30 minutes away in Johnson City. In addition, the additional clinical services and educational opportunities proposed by Strategic Behavioral Health would be of enormous benefit to our training program and would fill a significant gap in the educational services available to us.

I have seen no evidence or data that opening a facility in Kingsport will threaten the existence of Woodridge. Even if that were true, the program and community would still benefit overall from having this resource in the area for child and adolescent treatment and training. Given the huge need for psychiatric services in the tri-cities area, I believe that opposing potential resources based on an unsubstantiated concern that it will financially threaten current facilities is misguided at best and unethical at worst.

Hal Elliott, MD
Associate Professor
Residency Program Director for Psychiatry and Med-Psych
Quillen College of Medicine
East Tennessee State University

The foregoing letters describe in real-life terms the hardships that result from the lack of accessible behavioral health resources in an area. SBH's proposal will address these needs in at least two ways. First, its proposed location in Kingsport will significantly enhance geographic access to care. The SBH presented an analysis indicating how driving times and distances to

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behavioral health facilities would be reduced with the opening of SBH's facility. See SBH Supplemental #1, Bates p. 98. Second, SBH will provide needed additional capacity with its proposed 72 beds to offset at least a portion of the bed capacity that has been lost over the past six years. SBH also brings a greater focus on child and adolescent services than the region's only other provider of these services, Woodridge, does. SBH proposes 28 child and adolescent beds out of it 72 bed total. Only 12 of Woodridge's 84 beds are for children and adolescents. In addition, SBH will also bring outpatient and partial hospitalization programs to the service area that will address the needs of patients with mental illness who do not require inpatient care or need ongoing care following a hospitalization.

Even MSHA representatives recognize the need for additional behavioral health resources in Northeastern. In a public announcement regarding the proposed merger of the MSHA and Wellmont health systems, Alan Levine, president and CEO of MSHA, who would become executive chairman and president of the combined system, stated: "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." See **Exhibit 24**.

Marlene Bailey, Woodridge's Director, stated at the HSDA Meeting: "We agree that there -- we probably need some beds in this state. When the state closed the last ten beds that they had for adolescents, in Middle Tennessee state [verbatim], probably around 2010, we all -- all of the private hospitals, throughout the state -- just like the Youth Villages worker said -- all of those hospitals thought: "What are we gonna do?... All of the private hospitals, throughout the state, have attempted to help with that, but it's really not a good plan for a child to go from Memphis to Johnson City for treatment. You don't have contact with the parents; you don't know the resources in Memphis for after care." See Transcript, p. 51.

Given the many indicators of need for additional inpatient behavioral health resources, the most logical location for such services is in Sullivan County, which has the region's largest county population base and few existing beds. SBH proposes a comprehensive facility that can address many of these needs and augment the resources already in place.

b) The existing or certified services or institutions in the area;

There is a single psychiatric provider in the service area, Wellmont BRMC in Bristol, Sullivan County with 12 adult psychiatric beds

c) The reasonableness of the service area;

SBH defined its primary service area to include Hawkins and Sullivan County in Tennessee and Lee, Scott, and Wise Counties in Virginia. As discussed above, this service area is reasonable based on the current distribution of existing psychiatric providers, the range of services that SBH proposes to offer, and the proximity of its proposed site to the service area population. SBH's proposed service area is very similar to the service areas claimed by other Kingsport providers, including Indian Path Medical Center, a Kingsport hospital owned by MSHA

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

The SBH project will address the special needs of the service area population. The project will offer needed behavioral health beds in an area that is currently underserved. SBH proposes to serve all patients including women, racial and ethnic minorities, and low-income groups. SBH also proposes to offer services unique to the differing needs of individuals in all age categories.

e) Comparison of utilization/occupancy trends and services offered by other area providers;

The occupancy trends at Wellmont BRMC and Woodridge were discussed above. As noted, both facilities have experienced increases in occupancy in recent years. Woodridge's occupancy levels since 2014 have risen to the point where it has limited bed availability.

SBH based its projected utilization on its experience in other new hospitals it has opened and the specific characteristics of the proposed service area with respect to exiting providers and demographics. SBH projected 8,700 patient days in Year 1 and 17,100 days in Year 2. These patient day projections result in projected occupancy rates of 33.1% in Year 1 and 65.1% in Year 2. SBH provided a projection of average daily census by patient care unit in a Supplemental Responses to the HSDA. See Supplemental #1, Bates p. 106.

SBH's application stated that these patient days were based on an assumed average length of stay of 12 days. Mike Garone, who prepared the application on behalf of SBH, acknowledged in his deposition that the 12-day assumption was an error and the expected average length of stay was approximately 10 days. See Garone Deposition, pp. 155-157. Mr. Garone further testified that this correction of the average length of stay does not change the projected number of patient days because the days were based on start-up experience at other SBH facilities. In responses to interrogatories, SBH stated that the average length of stay for its project would be 9.2 days, which result in a projection of 946 inpatients in Year 1 and 1,859 inpatients in Year 2.

These utilization projections are supported by the need for beds under the *Guidelines for Growth* methodology. In considering other data sources that are indicia of need, historical inpatient psychiatric utilization rates in SBH's service area are not reliable indicators of future demand given the lack of access to behavioral health services that currently exists. I was involved in another CON matter that is instructive on this point. Baptist Hospital-Huntingdon, which is located in rural area of West-Central Tennessee, applied for a CON to develop a geropsychiatric unit. An analysis of geropsychiatric utilization rates demonstrated that counties close to the nearest provider of geropsychiatric services had substantially higher use rates than counties farther away from existing providers. See **Exhibit 23B**. Proximity of care greatly influences patient and family awareness of treatment options as well as the patient's willingness or ability to access the services.

In addition, as noted above, a significant percentage of the population in need of treatment across the United States never receives it. Data from research reports, however, can provide estimates

of the scope of the population with serious mental health disorders that would benefit from the comprehensive services that SBH proposes. According to *Behavioral Health, United States, 2012* issued by SAMSHA, in Tennessee an estimated 4 percent of the adult population suffers from a serious mental health disorder. See **Exhibit 24A.** Based on 2013 population estimates, there would have been 9,792 adult residents in SBH's service area with a serious mental health disorder. By 2019, that number would increase to 10,355 service area residents suffering from a serious disorder.

According to the same SAMSHA report, an estimated 5.3 percent of the child and adolescent population ages 4 to 17 were reported to have definite or severe behavioral difficulties. Applying that percentage to the population ages 5 to 17 in the SBH service area results in an estimated 2,368 children and adolescents with definite or severe behavioral problems. By 2019, the number would be 2,044. Placed into the context of this large service area population with serious behavioral health needs, SBH's projected utilization appears reasonable.

SBH will draw the majority of its patients from its defined service area, but typically a portion of patients will come from counties that are not in the primary service area. Given the comprehensive nature of its project, SBH will likely draw at least 20 percent of its total admissions from counties outside of its service area, most likely from other counties in Southwestern Virginia and Northeastern Tennessee. This draw from outside the service area will likely be strongest for child and adolescent patients, other than from Washington County where Woodridge is located, given that Woodridge is the only provider of these services in the Northeastern Tennessee/Southwestern Virginia region and operates only a 12-bed unit. This consideration further supports SBH's ability to achieve its utilization projections.

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

As noted above, SBH proposes to serve all patients including Medicare, TennCare and medically indigent patients. Medicare, which will cover the majority of the patients in SBH's geropsychiatric unit, is estimated to represent 27% of total revenues. TennCare, which will be the primary payor for child and adolescent patients, is projected to be 38% of total revenues, and charity care will represent an additional 4.8%. of total revenues SBH has also expressed a willingness to enter into a contract with TDMHSAS similar to one it has with Woodridge to serve uninsured patients that previously would have been served by LMHI.

2. *ECONOMIC FEASIBILITY*

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;

Michael A. Orians, CFO, confirms that Strategic Behavioral Health, LLC (parent company of SBH-Kingsport, LLC) has the necessary financial resources through cash balances, access to a revolving credit loan, and cash net flows to fund the project. A letter

from Stephen C. Taylor of Fifth Third Bank confirms the availability of a $15.5 million revolving credit loan with a current variable rate of 3.75%.

b) The reasonableness of the proposed project costs;

SBH's parent company has significant experience in constructing behavioral health facilities of the type proposed. The total project cost of $11,717,915 is a reasonable estimate for construction of a 72-bed facility. The cost per square foot of construction is approximately $153. This compares favorably with recent projects approved by the HSDA. See SBH Supplemental #1, Bates p. 121.

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

SBH based its projected charges and revenues on its existing pricing structure at other facilities it operates. There is no projected impact on existing patient charges from this project.

d) Participation in state/federal revenue programs;

SBH is a new provider but committed in its application to participate in the Medicare and TennCare programs and the projections in the application indicate that patients covered under state and federal programs will have access to the services proposed in its application. SBH has also expressed willingness to contract with TDMHSAS to provide care for uninsured patients similar to the arrangement it currently has with Woodridge.

e) Alternatives considered; and

There are two alternatives to the project: maintain the status quo or for SBH to construct a smaller facility. If SBH elected to do nothing and not develop a behavioral health facility in Sullivan County, the same problems that exist today would continue into the foreseeable future. Patients of all ages in SBH's would not have appropriate geographic access to inpatient and outpatient behavioral health services. The difficulties outlined in SBH's application and in the letters of support for the project with respect to patients crowding emergency departments and jails, lack of continuity of treatment, families unable to travel to more distant facilities to be with loved ones during treatment, and patients simply not access treatment.

SBH could have elected to construct a facility with fewer than 72 beds, but such a decision would have constrained the scope of programs it could offer. A primary consideration is that SBH's internal need analyses as well as the calculated need under the *Guidelines for Growth* formula exceed the requested 72 beds.

In addition, the clinical units need to be of sufficient size to permit different clinical tracks for patients with differing disorders and needs. A significant component of the SBH proposal is the request for 28 child and adolescent beds. Developing a smaller unit for children and adolescents, such as the 12-bed unit at Woodridge, would limit the scope of services that could be provided.

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A significantly smaller unit would result in younger and older patients being placed in the same environment with limited ability to separate patients with a history of violence from other patients. Smaller units provide less flexibility when beds must be blocked in a semiprivate room due to health concerns (e.g., infections, lice, etc.) or incompatibility of patients.

Neither of these alternatives would appropriately address the need for behavioral health services in SBH's service area.

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

There are no less costly or more effective alternatives to fully achieve the benefits proposed by SBH in its application. There are no comprehensive behavioral health providers in SBH's service area. As discussed in the preceding response, developing a smaller facility would constrain SBH's ability to provide effective programming for each of the groups it proposes to serve.

Based on the foregoing discussion, the economic feasibility of SBH's project has been demonstrated.

3. *CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF ADEQUATE AND EFFECTIVE HEALTH CARE FACILITIES AND 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, affiliation of the project with health professional schools);*

The SBH project will contribute to the orderly development of adequate and effective health care facilities and services.

b) *The positive or negative effects attributed to duplication or competition;*

Competition

The SBH project will positively affect competition within the health care delivery system in its proposed service area. There is a now only a single provider in Sullivan County, Wellmont BRMC, which offers only a 12-bed adult psychiatric unit in a hospital-based setting in the SBH service area. There are no beds designated for child/adolescent, geropsychiatric, or chemical dependency patients and no freestanding behavioral health hospital in the service area.

Moreover, all of the acute care and psychiatric services in and around SBH's proposed service are dominated by two health systems: Wellmont and MSHA. In an announcement dated April 1, 2015, the two organizations have agreed to explore combining their assets and operations into a single integrated health system. These two systems recently announced plans to consolidate their

organizations and seek a Certificate of Public Advantage ("COPA") under a recently modified statute in Tennessee and a similar statute in Virginia. There may be effectively a single choice for residents of the proposed service area requiring psychiatric and chemical dependency treatment absent the approval of SBH's project.

Impact

The impact of the SBH project on existing providers should not be significant. A primary purpose of SBH's proposal is to allow patients to be treated closer to their homes. As noted above, the TDMHSAS concurs that this is a statewide objective. Undoubtedly, some patients whom SBH will serve from its five-county service area may have otherwise traveled to an existing provider for treatment; however, SBH expects also to serve patients who cannot be placed currently due to the availability of the appropriate type of beds or who are unwilling to leave their local community and travel to Johnson City, Louisville, Tennessee, or other more distant facilities in Tennessee and Virginia.

MHSA has alleged that the approval of SBH's project would have a substantial detrimental impact on its operations, and as a consequence, it would impair its ability to provide access to uninsured patients in the area. As a starting point for its claim, MSHA has contended that Woodridge has been experiencing significant financial losses and could not withstand the impact that would result from SBH's approval.

Woodridge reflected losses in prior years only after corporate overhead allocations were deducted from its Net Operating Income Before Support allocation. Based on direct operating revenues and expenses, Woodridge had a positive margin in the FY 201 through 2013. While Woodridge may have experienced losses after allocations in these prior years, in FY 2014, which encompasses the period from July 1, 2013 to June 30, 2014, Woodridge's financial performance improved dramatically. Woodridge's net operating income before allocation of corporate overhead was $2,152,734. After allocations and all other deductions, Woodridge had a positive bottom line of $99,121. See **Exhibit 25**. Woodridge's FY 2014 bottom line performance represented a $1.3 million improvement over FY 2013.

In the single month of June 2014, the last month of FY 2014, Woodridge had net operating income before allocations of $712,605 and a bottom line of $449,826, indicating that its financial performance is improving significantly. See **Exhibit 26**. June 2014 represented the highest occupancy of any month in recent years for which MSHA has provided data, and all indications are that its utilization has risen significantly since June 2014. See **Exhibit 23** previously discussed.

Based on the deposition testimony of Marlene Bailey, Director of Behavioral Health Programs at Woodridge, this improving financial performance is due, in part, to increases in Woodridge's utilization as well as operational changes and its discontinuation of certain unprofitable outpatient services. See Bailey Deposition, pp. 37-38. Given these facts, Woodridge is not in the dire financial circumstances that MSHA alleged at the HSDA Meeting.

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MSHA is a single corporation that operates its individual hospitals under D/B/A's. Woodridge operates under a single Tennessee hospital license with Johnson City Medical Center ("JCMC") and under the same Chief Executive Officer and Chief Nursing Officer as JCMC. As a consequence, Woodridge's financial performance must also be put in the context of MSHA's overall financial position as well as that of Johnson City Medical Center.

The most recent publicly available audited financial statements that were located were contained in an official statement issued in connection with a 2013 MSHA bond offering. See **Exhibit 26A**. These statements covered MSHA's 2011 and 2012 fiscal years. In FY 2012 MSHA had total cash and investments of $626 million. And total assets of over $1.9 billion. MSHA had an excess of revenues over expenses of approximately $28 million. MSHA is a large and financially sound organization. Exhibit 74 to Mr. Levine's deposition, a statement of revenues and expenses for the first 9 months of MSHA's FY 2015, indicates that as of March 31, 2015 MSHA had an excess of revenues over expenses of $20,801,698. See **Exhibit 26B**.

Johnson City Medical Center reported its financial results for FY 2013 on its 2013 Joint Annual Report of Hospitals. See **Exhibit 26C**. With $339 million in total assets and a fund balance of $261 million, it has a strong financial position. In addition, Johnson City Medical Center had an excess of revenues over expenses more of than $30 million. As an operating unit of MSHA, Johnson City Medical Center is also on strong financial footing.

Whatever impact that Woodridge might experience from the opening of a single 72-bed behavioral health hospital in another county will not materially impair MSHA's or Johnson City Medical Center's overall operations or that of Woodridge itself.

A review of the impact analysis that MSHA representatives presented at the HSDA Meeting reveals a number of inconsistencies and unrealistic assumptions. See **Exhibit 27**.

This impact analysis is based on an assumption that 50% of the patients that SBH projects to serve from its service area will be redirected from SBH. MSHA gave no consideration to SBH's ability to serve patients who are now being transported long distances to facilities other than Woodridge or patients who are now being placed in acute care hospitals or jails, or simply not receiving services, because of the lack of available resources in the service area. In addition, MSHA did not consider the different mix of beds that SBH proposes in comparison to Woodridge's bed composition. SBH, for example, proposes 28 child and adolescent beds, or 39% of its 72 bed complement. Woodridge operates only 12 child and adolescent beds, or 14% of its 84 bed total.

A portion of Woodridge's growth in recent years has resulted from its contract with TDMHSAS to serve uninsured patients after LMHI closed, some of whom reside outside of Woodridge's historical service area or SBH's proposed service area. SBH would not likely serve these patients from more distant counties. MSHA representatives claimed at the HSDA Meeting that the grants received from MSHA do not cover the costs of caring for all of the uninsured patients they treat. To the extent that uninsured patients who reside in SBH's service area were served by SBH rather than Woodridge, the result would be a positive financial impact on Woodridge.

MSHA is also assuming that the volume lost to SBH will not be replaced with other patients requiring behavioral health treatment. As Woodridge's own experience has demonstrated, when it removed operational barriers, its level of utilization increased. Given that capacity constraints remain at Woodridge, particular in its child and adolescent unit, a reduction in patients from SBH's service area should be mitigated by an increase in utilization from other counties it serves.[4] MSHA has failed to accurately project the potential loss of patients it would experience if SBH were approved.

Putting aside the question of the volume impact, it was interesting to learn through discovery that the impact analysis presented to the HSDA is one of several versions that MSHA prepared. An initial version of the impact analysis concluded that the projected impact of the SBH project would result in only a $50,000 loss to Woodridge in SBH's second year of operation. See MSHA 919. After reviewing this analysis, MSHA's Corporate Director of Strategic Planning, Casey McDevitt, stated in an email: "I'm just concerned the net income difference between the current state vs. the SBH presence will not represent a very convincing impact to the agency. I know our attorney is concerned they would claim that MSHA is in a position to absorb the loss we would experience." See MSHA 82.

Based on these concerns about showing too little impact, the MSHA embarked on a different set of assumptions attempting to reach resulting projections that Woodridge would experience a financial loss of approximately $1.5 million annually due to the operation of SBH. This revised analysis is also fraught with problems.

This "revised" impact analysis, presented previously in **Exhibit 27**, resulted in a significant reclassification of expenses from variable to fixed among the support expenses allocated to Woodridge, resulting in the alleged Year 2 impact from SBH's project rising to $1.5 million from the accounting system modifications noted above. MSHA uses various statistics to allocate these support expenses, and many of the allocations are based on units of service or revenue statistics that vary directly with changes in the volume of patients served. The greater degree of variability in expenses, the lower the projected impact because with the loss of revenue or volume comes a proportional reduction in variable expenses. Although the individual who prepared the projections[5] indicated in an email[6] that Woodridge would see a decrease in certain categories of support allocations as a consequence of the reduction in patient volume, most of this overhead was reassigned to a fixed expense category and used to attempt to show that Woodridge would experience significant operating losses if the SBH project were approved.

Shane Hilton, Vice President and Chief Financial Officer for Market Operations at MSHA, ultimately reviewed the various financial impact analyses. In his deposition, Mr. Hilton attempted to explain why the support allocation expenses were reclassified from variable to fixed

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[4] One adjustment that should also be made to MSHA's impact analysis, which it could not have known about previously, is the number of discharges that SBH projects to serve based on SBH's correction of its average length of stay from 12 days to 9.2 days.

[5] The impact analysis was prepared by Ms. Debbie Wyse, who was then employed in the MSHA Corporate Finance Office. Ms. Wyse, according to deposition testimony, no longer is employed by MSHA and was not deposed.

[6] See MSHA 82.

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expenses and were assumed to remain on Woodridge's financial statements after accounting for the impact of SBH's project. He stated: "Just because the volume is going away doesn't necessarily mean that the expense would go away, which is what this case would be. You know, those allocated expenses we can't necessarily eliminate." See Hilton Deposition, p. 32. While theoretically some of these support expenses might remain within MSHA, from the perspective of how MSHA evaluates Woodridge's financial performance, Woodridge would in fact see a reduction in its allocated expenses if its volume were decline as it projects with the opening of SBH's facility.

Putting aside the theoretical issue of support allocations, the proposed reclassification of expenses that MSHA ultimately performed does not appear to be logical. Woodridge's revised analysis asserted that its direct expenses declined $1.9 million between FY 2013 and FY 2014 (prior to any impact from SBH) despite the fact that Woodridge's patient volume increased in FY 2014. Fixed expenses were $1.8 million higher per Ms. Wyse's analysis in FY 2014 compared to FY 2013, which resulted in an increase in contribution margin in FY 2014 of $3.1 million. The contribution margin is the basis on which MSHA projected the financial impact, and the greater the contribution margin, the greater the dollar impact for each patient lost. MSHA appears to have undertaken a series of accounting adjustments in order to artificially boost the potential financial impact of SBH's project, and these adjustments are without foundation. As a result, the MSHA impact analysis as a whole is unsupported and should not be considered.

Regardless of the level of impact, which appears to be substantially below the $1.6 million that MSHA claims based on the many unrealistic assumptions that were employed, 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.

In addition to the financial impact, MSHA alleged at the HSDA Meeting that the SBH project will adversely affect medical education. See Transcript, Elrod, p. 60. This statement is contradicted by the testimony of Marlene Bailey at the very same HSDA Meeting who stated: "Actually, ETSU Psychiatry has been managing -- medically managing -- the adolescent unit for some time, and effective July 1, it's going to be taken over by the Mountain States Medical Group doctors, which are owned and operated by Mountain States. We have a different philosophy. Our philosophy is not going to be focusing on training of the residents and the medical students. See Transcript, p. 50-51.

In summary, the SBH project should not have material detrimental impact on Woodridge. In considering impact in a CON review, one question must be answered: Do the benefits that result from a project outweigh the impact on existing providers? In the case of SBH's project, the benefits clearly outweigh whatever level of impact it may be reasonably projected to have on Woodridge. Access to behavioral health services, which has been contracting for the last several years, will be enhanced for a large population in Northeast Tennessee. SBH proposes a comprehensive range of programs that will address the needs of individuals suffering from mental illness across the age spectrum. Absent this project, residents of the service area will continue to face barriers to care that create a wide range of problems throughout these communities.

CONCLUSION

SBH's proposal to develop a freestanding, 72-bed behavioral health hospital in Kingsport, Sullivan County, is consistent with the Tennessee CON Criteria Used for Review and with the service-specific criteria for the Inpatient Psychiatric Services set forth in the *Guidelines for Growth*. This project will enhance access to inpatient and outpatient behavioral health care and augment, rather than unnecessarily duplicate, the existing resources in the service area. SBH's proposal is needed, economically feasible, and will contribute to the orderly development of adequate and effective health care facilities and services.

The HSDA should approve SBH's CON application CN1312-050.

SBH-KINGSPORT 001959

Exhibit 2

Daniel J. Sullivan
SBH-Kingsport Report
Information Reviewed

1. Tennessee *Guidelines for Growth*
2. Rules of Tennessee Health Services and Development Agency
3. Memorandum on the standard and scope of review in administrative appeals
4. HSDA file for SBH-Kingsport project (CN1312-050)
5. HSDA File for Crestwyn Behavioral Health (CN1310-040)
6. HSDA for Rolling Hills Hospital (CN1312-051)
7. HSDA file for TrustPoint Hospital (CN1502-006)
8. CON application for Indian Path Medical Center (CN9606-042)
9. Population Data from Tennessee Department of Health
10. Joint annual reports of hospitals for hospital provers in Northeastern Tennessee
11. Depositions of:
    a. Jim Shaheen
    b. Mike Garone
    c. Marlene Bailey
    d. Shane Hilton
    e. Kasey McDevitt
    f. Alan Levine
12. MSHA Deposition exhibits 14-66
13. Discovery responses by both parties
14. Mental Health, US, 2010, SAMSHA
15. Behavioral Health US, 2012, SAMSHA
16. County health rankings for Tennessee and Virginia, University of Wisconsin/RWJ Foundation
17. MSHA 2013 Bond Official Statement
18. Tennessee Health Care Financing Administration, FY2016 Budget Presentation
19. Grading the States, 2009, NAMI
20. Shrinking Inpatient Psychiatric Capacity: Cause for Celebration or Concern? National Health Policy Forum
21. The Shortage of Public Hospital Beds for Mentally Ill Persons: A Report of the Treatment Advocacy Center
22. Trends And Issues In Child And Adolescent Mental Health, Health Affairs
23. Survey Assesses Trends in Psychiatric Hospitalization Rates, NIMH
24. State Estimates of Adult Mental Illness from the 2011 and 2012 National Surveys on Drug Use and Health, SAMSHA
25. Behavioral Health Barometer, Tennessee, 2014, SAMSHA
26. MSHA Social Responsibility Plan, 2012
27. Mental Illness: Fact and Numbers, NAMI
28. Parity or Disparity: The State of Mental Health in America 2015, Mental Health America
29. Affordable Care Act Will Expand Mental Health and Substance Use Disorder Benefits and Parity Protections for 62 Million American, ASPE Policy Brief

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WORK EXPERIENCE:

1990 - Present	**President** Sullivan Consulting Group, Inc. Alpharetta, Georgia
1988 - 1990	**Partner** Ernst & Young Atlanta, Georgia
1980 - 1988	**Vice President** Amherst Associates Inc. Atlanta, Georgia and Tampa, Florida
1974 - 1980	**Assistant Administrator** Private Diagnostic Clinic Duke University Medical Center Durham, North Carolina

EDUCATION:

Master in Health Administration
Duke University

A.B. in Economics and Public Policy Studies
Duke University

ORGANIZATIONS: Member, Society for Healthcare Strategy & Market Development

PROFESSIONAL EXPERIENCE:

Development of strategic plans for multihospital systems and individual health care organizations throughout the United States.

Assistance in the preparation of Certificate of Need applications for the construction of new hospitals and nursing homes, ambulatory surgery centers, major renovations of existing facilities, conversion of beds to new services, introduction of specialty services and technology, and development of home care services.

Preparation of financial feasibility studies for projects involving hospitals, long-term care facilities, ambulatory surgery centers, assisted living facilities, and other health care facilities and services.

Facilitation of planning processes for the creation of integrated health delivery systems.

Valuation of health care organizations and physician practices.

Market research for investor-owned health care companies in the areas of need and demand assessment, competition, and reimbursement characteristics of various geographic regions in connection with the development of specialty hospitals and long-term care services.

Expert testimony in connection with Certificate of Need litigation in several states in variety of areas relating to health care planning and financial issues.

Expert testimony in litigation challenging rules promulgated by various state agencies.

Expert testimony in civil litigation on a range of issues relating to health care planning, health care finance, and valuation of health care organizations.

Member of the South Carolina CON Review Panel, 2012, charged with evaluating the effectiveness of the CON program and suggesting changes.

Direction of product costing engagements for hospitals involving the determination of procedural level costs for use in product costing information systems.

Testimony before various state agencies and policy boards on issues related to health planning standards, need determination, financial access, and health financing.

PUBLICATIONS:

"Evaluating and Selecting Among Joint Venture Opportunities," *Topics in Health Care Financing*, Vol. 12, No.2, Winter 1985.

"New Strategies in a Changing Regulatory Environment," *Amherst Quarterly*, Winter 1985.

"Maximizing Hospital Outpatient Revenues," *Journal of Ambulatory Care Management*, Vol. 10, No.1, February 1983.

PRESENTATIONS:

"Economic Impact of Ambulatory Surgery Centers," Tennessee Bar Association, October 2003.

Considerations in Certificate of Need Regulation, Kentucky Health Strategy Forum, August 1999.

"Marketing Outpatient Services," Georgia Society for Health Care Planning and Marketing, October 1992.

"Evaluating and Negotiating Managed Care Contracts," West Virginia Hospital Association, February 1991.

"Certificate of Need Strategies," West Virginia Healthcare Financial Management Association, May 1990.

"Determining the Need for Retirement Housing," Florida Health Care Association, August 1989.
"Marketing Nursing Home Cost Effectiveness," American Health Care Association Annual Meeting, October 1989.

"Joint Ventures," Georgia Hospital Association, September 1986.

"Joint Ventures with Physicians," North Carolina-South Carolina Health Care Financial Management Associations Annual Meeting, August 1986.

"Medicare Reimbursement Trends," South Carolina Health Care Financial Management Association, January 1986.

"Alternative Revenue Sources," North Carolina Hospital Association, November 1985.

"Product Costing," Aspen Systems Seminar Series, 1984-85.

"Procedural Rate-Setting" Dixie Institute of Health Care Financial Management Association, 1983.

SBH-KINGSPORT 001965

State ID 90281

TENNESSEE DEPARTMENT OF HEALTH
JOINT ANNUAL REPORT OF HOSPITALS
2013

SCHEDULE A - IDENTIFICATION*

1. Name of Hospital Johnson City Medical Center — Federal Tax I.D. # 62-0476282
   Did your facility name change during the reporting period? ○ YES ◉ NO
   County Washington
2. Address of Facility — Street 400 North State of Franklin; City Johnson City; State Tennessee; Zip 37604-609
3. Telephone Number (423) 431-6111 (Area Code Number)
4. Name of Chief Executive Officer David (First Name) Nicely (Last Name)
   Signature of Chief Executive Officer _____
5. Name of person(s) coordinating form completion Jason Williams
   Telephone Number if different than above (423) 302-3364 (Area Code Number)
6. 501 Office Use Only
7. Reporting period used for this facility:
   Beginning Date 07/01/2012 Ending Date 06/30/2013
8. 365 Office Use Only
9. Does your hospital own or operate or have other hospitals licensed as satellites of your hospital? ◉ YES ○ NO
   If yes, please complete the following.

	NAME OF HOSPITAL	STATE ID	SATELLITE	OWN	OPERATE	OWN AND OPERATE
1	James H. and Cecile Quillen Rehab Hospital	90751	☑	○	○	◉
2	Woodridge Psychiatric Hospital	90411	☑	○	○	◉
3			☐	○	○	○
4			☐	○	○	○
5			☐	○	○	○

SBH-KINGSPORT 001966

SCHEDULE B - CLASSIFICATION*

State ID 90281

1. CONTROL:

A. Indicate the type of organization that is responsible for establishing policy for overall operation of the hospital

1. Government-Non-Federal	2. Government-Federal	3. Nongovernmental, not-for-profit	4. Investor-owned, for-profit
○ 11 State	○ 17 Armed Forces	○ 20 Church-operated	○ 23 Individual
○ 12 County	○ 18 Veterans Admin.	◉ 21 Other Nonprofit Corporation	○ 24 Partnership
○ 13 City	○ 19 Other, please specify	○ 22 Other not-for-profit, please specify	○ 25 Corporation
○ 14 City-County			
○ 15 Hospital district or authority			

B. Is the hospital part of a health system? ◉ YES ○ NO

If yes, please provide the name and location of the health system.

Name Mountain States Health Alliance City Johnson City State Tennessee

C. Does the controlling organization lease the physical property from the owner(s) of the hospital? ○ YES ◉ NO

D. What is the name of the legal entity that owns and has title to the land and physical plant of the hospital?

Mountain States Health Alliance

E. Is the hospital a division of a holding company? ○ YES ◉ NO

F. Does the hospital itself operate subsidiary corporations? ○ YES ◉ NO

G. Is the hospital managed under contract? ○ YES ◉ NO If YES, length of contract From _____ To _____

If yes, please provide name, city, and state of the organization that manages the hospital.

Name _____ City _____ State _____

Name _____ City _____ State _____

H. Is the hospital part of a health care alliance? ◉ YES ○ NO (see definition of alliance)

If yes, please provide the name, city, and state of the alliance headquarters.

Name Premier Inc City San Diego State California

Name _____ City _____ State _____

I. Is the hospital part of a health network? ◉ YES ○ NO (see definition of network)

If yes, please provide the the name, city, and state of the network.

Name Integrated Solutions Health Network City Johnson City State Tennessee

Name _____ City _____ State _____

2. SERVICE:

A. Indicate the ONE category that BEST describes your hospital.

◉ 01 General medical and surgical	○ 07 Rehabilitation
○ 02 Pediatric	○ 08 Orthopedic
○ 03 Psychiatric	○ 09 Chronic disease
○ 04 Tuberculosis and other respiratory diseases	○ 10 Alcoholism and other chemical dependency
○ 05 Obstetrics and gynecology	○ 11 Long term acute care
○ 06 Eye, ear, nose and throat	○ 12 Other-specify treatment area

SBH-KINGSPORT 001967

B. Does your hospital own or have a contract with any of the following?

	(1) Yes	(2) No	Specify one: 1) Own	2) Contract	Number of Physicians	FTE Physicians
1. Independent Practice Association	○	◉	○	◉	0	0.0
2. Group Practice Without Walls	○	◉	○	◉	0	0.0
3. Open Panel Physician-Hospital Organization (PHO)	◉	○	◉	○	2,600	0.0
4. Closed Panel Physician-Hospital Organization (PHO)	○	◉	○	◉	0	0.0
5. Management Services Organization (MSO)	○	◉	○	◉	0	0.0
6. Integrated Salary Model	◉	○	◉	○	196	0.0
7. Equity Model	○	◉	○	◉	0	0.0
8. Foundation	○	◉	○	◉	0	0.0

3. Have any of the following insurance products been developed for use in Tennessee by your hospital, health system, health network alliance or as a joint venture with an insurer?
Check all that apply.

	(1) Your Hospital	(2) Health System	(3) Health Network	(4) Alliance	(5) Joint Venture With Insurer
A. Health Maintenance Organization	(1) ☐	(2) ☑	(3) ☐	(4) ☐	(5) ☐
B. Preferred Provider Organization	(1) ☐	(2) ☐	(3) ☐	(4) ☐	(5) ☐
C. Indemnity Fee For Service Plan	(1) ☐	(2) ☑	(3) ☐	(4) ☐	(5) ☐

4. Does your hospital have a formal written contract that specifies the obligations of each party with:
   A. Health Maintenance Organization (HMO)? ◉ YES ○ NO
      1. How many do you contract with? 7
      2. Number of different contracts 17
   B. Preferred Provider Organization (PPO)? ◉ YES ○ NO
      1. How many do you contract with? 21
      2. Number of different contracts 44

5. What percentage of the hospital's net patient revenue is paid on a capitated basis?
If the hospital does not participate in any capitated arrangement, please enter "0". 0.0 %

6. How many covered lives are in your capitation agreements? 0

SBH-KINGSPORT 001968

SCHEDULE C - ACCREDITATIONS AND APPROVALS* State ID 90281

1. ACCREDITATIONS:

A. Joint Commission on Accreditation of Healthcare Organizations (JCAHO)		
Date of most recent accrediting letter or survey 04/02/2012	◉YES	○NO
If Yes, Is the hospital accredited under either/both of the following manuals:		
1. Comprehensive Accreditation Manual for Hospitals (CAMH)	◉YES	○NO
2. Comprehensive Accreditation Manual for Behavioral Health Care (CAMBHC)	○YES	◉NO
3. Other manuals, please specify		
B. Commission on Accreditation of Rehabilitation Facilities (CARF)		
Date of most recent accrediting letter or survey	○YES	◉NO
C. American College of Surgeons Commission on Cancer	○YES	◉NO
D. American Osteopathic Association (AOA)	○YES	◉NO
E. TÜV Healthcare Specialists	○YES	◉NO
F. Community Health Accreditation Program (CHAP)	○YES	◉NO

2. CERTIFICATIONS:

Medicare Certification	◉YES	○NO

3. OTHER:

A. THA Membership	◉YES	○NO
B. Hospital Alliance of Tennessee, Inc. Membership	◉YES	○NO
C. American Hospital Association Membership	◉YES	○NO
D. American Medical Association Approval for Residencies (and Internships)	◉YES	○NO
E. State Approved School of Nursing:		
Registered Nurses	○YES	◉NO
Licensed Practical Nurses	○YES	◉NO
F. Medical School Affiliation	◉YES	○NO
G. Tennessee Association of Public and Teaching Hospitals (TNPath)	○YES	◉NO
H. National Association of Children's Hospitals and Related Institutions (NACHRI)	◉YES	○NO
I. National Association of Public Hospitals (NAPH)	◉YES	○NO
J. Other, please specify College of American Pathologists (Lab)		

Field is limited to 255 characters

SBH-KINGSPORT 001969

SCHEDULE D - SERVICES* State ID 90281

1. CERTIFICATE OF NEED:

Do you have an approved **but not completed,**certificate of need (CON) ? (•) YES ( ) NO
If yes, please specify:

Name of Service or Activity Requiring the CON	# of Beds (if applicable)	Date of Approval
Construction, Renovation, Expansion, and Replacement of Health Care Ins	0	07/28/2010
Construction, Renovation, Expansion, and Replacement of Health Care Ins	0	09/28/2011
	0	

2. Does your hospital own or operate Tennessee physician primary care clinics? ( ) YES (•) NO If yes, how many? 0
How many physicians practice in these clinics? 0

3. Does your hospital own or operate other physician/specialty clinics located in Tennessee? ( ) YES (•) NO If yes, how many? 0
How many physicians practice in these clinics? 0

4. Does your hospital own or operate a blood bank? ( ) YES (•) NO
If yes, please indicate:

A. Distributes blood within the hospital ( ) YES (•) NO
B. Collects blood within the hospital ( ) YES ( ) NO
C. Distributes blood outside the hospital ( ) YES ( ) NO
D. Collects blood from outside the hospital ( ) YES ( ) NO

5. Does your hospital own or operate an ambulance service? (•) YES ( ) NO
If yes, please specify the counties where services are located.

Washington Greene Carter

Please specify the type of service and ownership relationship:

A. Land Transport	( ) YES	(•) NO	If yes,	( ) own;	( ) operate;	(•) own and operate;	( ) own in joint venture
B. Helicopter	(•) YES	( ) NO	If yes,	(•) own;	( ) operate;	( ) own and operate;	( ) own in joint venture
C. Special Neonatal Helicopter	( ) YES	(•) NO	If yes,	( ) own;	( ) operate;	( ) own and operate;	( ) own in joint venture
D. Special Neonatal Land Transport	(•) YES	( ) NO	If yes,	( ) own;	( ) operate;	(•) own and operate;	( ) own in joint venture

SBH-KINGSPORT 001970

6. Does your hospital own or operate an off-site outpatient/ambulatory clinic located in Tennessee? ○ YES ◉ NO
If yes, please complete the following.

Name of Clinic	County	City				
			○ own	○ operate	○ own and operate	○ own in joint venture
			○ own	○ operate	○ own and operate	○ own in joint venture

7. Does your hospital own or operate an off-site ambulatory surgical treatment center located in Tennessee? ○ YES ◉ NO
If yes, please complete the following.

Name of Center	County	City				
			○ own	○ operate	○ own and operate	○ own in joint venture
			○ own	○ operate	○ own and operate	○ own in joint venture

8. Does your hospital own or operate an off-site birthing center located in Tennessee? ○ YES ◉ NO
If yes, please complete the following.

Name of Center	County	City				
			○ own	○ operate	○ own and operate	○ own in joint venture
			○ own	○ operate	○ own and operate	○ own in joint venture

9. Does your hospital own or operate an off-site outpatient diagnostic center located in Tennessee? ◉ YES ○ NO
If yes, please complete the following.

Name of Center	County	City				
Mountain States Imaging Center at Med Tech Park	Washington	Johnson City	○ own	○ operate	◉ own and operate	○ own in joint venture
Women's Health and Imaging Center	Washington	Johnson City	○ own	○ operate	◉ own and operate	○ own in joint venture

10. Does your hospital own or operate an off-site outpatient physical therapy rehab center located in Tennessee? ◉ YES ○ NO
If yes, please complete the following.

Name of Center	County	City				
Mountain States Rehab	Washington	Johnson City	○ own	○ operate	◉ own and operate	○ own in joint venture
			○ own	○ operate	○ own and operate	○ own in joint venture

SBH-KINGSPORT 001971

11. Does your hospital own or operate a hospice that has a separate license located in Tennessee? ◯ YES ◉ NO
If yes, please complete the following.

Name of Hospice	County	City				
			◯ own	◯ operate	◯ own and operate	◯ own in joint venture
			◯ own	◯ operate	◯ own and operate	◯ own in joint venture

12. Does your hospital own or operate an off-site assisted-care living facility located in Tennessee? ◯ YES ◉ NO
If yes, please complete the following.

Name of Facility	County	City				
			◯ own	◯ operate	◯ own and operate	◯ own in joint venture
			◯ own	◯ operate	◯ own and operate	◯ own in joint venture

13. Does your hospital own or operate a home for the aged located in Tennessee? ◯ YES ◉ NO
If yes, please complete the following.

Name of Home	County	City				
			◯ own	◯ operate	◯ own and operate	◯ own in joint venture
			◯ own	◯ operate	◯ own and operate	◯ own in joint venture

14. Does your hospital own or operate an urgent care center? ◯ YES ◉ NO
If yes, please complete the following.

Name of Center	County	City				
			◯ own	◯ operate	◯ own and operate	◯ own in joint venture
			◯ own	◯ operate	◯ own and operate	◯ own in joint venture

15. Does your hospital own or operate a home health agency? ◯ YES ◉ NO
If yes, please complete the following.

Name of Agency: _____

Location of Agency: City _____ County _____

Number of Visits _____

◯ own ◯ operate ◯ own and operate ◯ own in joint venture

Name of Agency: _____

Location of Agency: City _____ County _____

Number of Visits _____

◯ own ◯ operate ◯ own and operate ◯ own in joint venture

SBH-KINGSPORT 001972

16. Does your hospital own or operate an off-site nursing home located in Tennessee? ◯ YES ◉ NO
If yes, please complete the following.

_____ _____ _____ ◯own ◯operate ◯own and operate ◯own in joint venture
Name of Home County City

Number of Beds - Total 0 = Medicare only (SNF) _____ + Medicaid only (NF) _____ + Medicare/Medicaid (SNF/NF) _____ + Not Certified _____

_____ _____ _____ ◯own ◯operate ◯own and operate ◯own in joint venture
Name of Home County City

Number of Beds - Total 0 = Medicare only (SNF) _____ + Medicaid only (NF) _____ + Medicare/Medicaid (SNF/NF) _____ + Not Certified _____

17. Does your hospital operate a hospital-based skilled nursing unit (subacute unit) licensed as a nursing home for skilled nursing care (excluding swing beds)? ◉ YES ◯ NO If yes, please complete the following.

Franklin Transitional Care | 13 | 0
Name of SNF | Number of Licensed Beds | Number of Staffed Beds

0 | 0
Number of Admissions | Number of Patient Days

18. Does your hospital own, operate, or contract a mobile unit that operates in Tennessee? ◯ YES ◉ NO
If yes, specify name(s) and whether owned, operated, or contracted.

A. List mobile services:

1	◯contract	◯own	◯operate	◯own and operate	◯own in joint venture	_____	# of visits
2	◯contract	◯own	◯operate	◯own and operate	◯own in joint venture	_____	# of visits
3	◯contract	◯own	◯operate	◯own and operate	◯own in joint venture	_____	# of visits
4	◯contract	◯own	◯operate	◯own and operate	◯own in joint venture	_____	# of visits
5	◯contract	◯own	◯operate	◯own and operate	◯own in joint venture	_____	# of visits
6	◯contract	◯own	◯operate	◯own and operate	◯own in joint venture	_____	# of visits

B. List counties served (where you take the service):
List counties for service 1 in 18A on line 1, for service 2 on line 2, etc.

1						
2						
3						
4						
5						
6						

SBH-KINGSPORT 001973

19. HOSPITAL-BASED SERVICES (See Explanation):

Utilization of Selected Services	Is This Service Provided In Your Hospital? YES	NO	To Inpatients Unit of Measure	Number	To Outpatients Unit of Measure	Number
A. Miscellaneous:						
Lithotripsy						
Percutaneous	◉	○	Procedures	5	Procedures	3
Extracorporeal Shock Wave	◉	○				
# fixed units inside hospital 0			Procedures	0	Procedures	0
# fixed units off site 0					Procedures	0
# of mobile units 1			Procedures	5	Procedures	103
# days per week (mobile units) 3						
Renal Dialysis						
# of dedicated stations 7						
Hemo Dialysis	◉	○	Patients	772	Patients	123
			Treatments	2,871	Treatments	111
Peritoneal Dialysis	◉	○	Patients	86	Patients	9
			Treatments	2,283	Treatments	43
B. Oncology/Therapies:						
Chemotherapy	◉	○	Patients	140	Patients	3,158
					Encounters	14,933
Hyperthermia	○	◉	Treatments	0	Treatments	0
Radiation Therapy-Megavoltage	◉	○				
# fixed units inside hospital 2			Patients	139	Patients	947
			Treatments	555	Treatments	9,886
# fixed units off site 0						

SBH-KINGSPORT 001974

SCHEDULE D - SERVICES (continued)* State ID 90281

Utilization of Selected Services	Is This Service Provided In Your Hospital? YES	NO	To Inpatients Unit of Measure	Number	To Outpatients Unit of Measure	Number
C. Radiology:						
Computerized Tomographic Scanners CT/CAT	◉	○	Patients	2,372	Visits	3,081
# fixed units inside hospital 1			Procedures	4,499	Procedures	4,258
# fixed units off site 0					Procedures	0
# of mobile units 0			Procedures	0	Procedures	0
# days per week (mobile units) 0						
Ultrafast CT	◉	○	Patients	7,116	Visits	9,244
# fixed units inside hospital 3			Procedures	13,534	Procedures	12,772
# fixed units off site 1					Procedures	2,847
# of mobile units 0			Procedures	0	Procedures	0
# days per week (mobile units) 0						
Magnetic Resonance Imaging	◉	○				
# fixed units inside hospital 2			Procedures	3,279	Procedures	3,740
# fixed units off site 1					Procedures	2,552
# of mobile units 0			Procedures	0	Procedures	0
# days per week (mobile units) 0						
Nuclear Medicine	◉	○	Procedures	2,243	Procedures	4,305
Radium Therapy	○	◉	Procedures	0	Procedures	0
Isotope Therapy	◉	○	Procedures	451	Procedures	6,703
Positron Emission Tomography	◉	○				
# fixed units inside hospital 1			Procedures	92	Procedures	1,181
# fixed units off site 0					Procedures	0
# of mobile units 0			Procedures	0	Procedures	0
# days per week (mobile units) 0						
Mammography	◉	○	Procedures	30	Procedures	24,429
# of ACR accredited units 3						
# other fixed units inside hospital 0						
# other fixed units off site 0						
# of mobile units 0						
# days per week (mobile units) 0						
Bone Densitometry	◉	○	Procedures	3	Procedures	2,537
# of units 1						

SBH-KINGSPORT 001975

SCHEDULE D - SERVICES (continued)* State ID 90281

Note: Pediatric patients should be defined as patients 14 years old and younger.

Utilization of Selected Services	Is This Service Provided In Your Hospital? YES	NO	In Cath Lab Setting Unit of Measure	Number	Outside Cath Lab Setting Unit of Measure	Number
D. Cardiac:						
Cardiac Catheterization						
Date Initiated 11/01/1986						
# labs 6						
Intra-Cardiac or Coronary Artery	◉	○	Adult Procedures	3,212	Adult Procedures	0
			Pediatric Procedures	0	Pediatric Procedures	0
Percutaneous Transluminal Coronary Angioplasty	◉	○	Adult Procedures	125	Adult Procedures	0
			Pediatric Procedures	0	Pediatric Procedures	0
Stents	◉	○	Adult Procedures	1,449	Adult Procedures	0
			Pediatric Procedures	0	Pediatric Procedures	0
All Other Heart Procedures	◉	○	Adult Procedures	1,467	Adult Procedures	0
			Pediatric Procedures	1	Pediatric Procedures	0
All Other Non-Cardiac Procedures	◉	○	Adult Procedures	1,548	Adult Procedures	316
			Pediatric Procedures	11	Pediatric Procedures	0
Thrombolytic Therapy	○	◉	Adult Procedures	0	Adult Procedures	0
			Pediatric Procedures	0	Pediatric Procedures	0
			To Inpatients		To Outpatients	
Open Heart Surgery	◉	○	Adult Operations	572		
# dedicated O.R.'s 3			Pediatric Operations	0		
E. Surgery:						
Inpatient	◉	○	Encounters	5,859		
# operating rooms 14			Procedures	6,856		
Outpatient (one day)	◉	○			Encounters	5,389
# dedicated O.R.'s 9					Procedures	6,390
F. Rehabilitation:						
Cardiac	◉	○	Patients	700	Patients	929

SBH-KINGSPORT 001976

SCHEDULE D - SERVICES (continued)*

State ID 90281

Utilization of Selected Services	Is This Service Provided In Your Hospital? YES	NO	To Inpatients Unit of Measure	Number	To Outpatients Unit of Measure	Number
F. Rehabilitation (continued):						
Chemical Dependency	○	◉	Patients	0	Patients	0
					Episodes of Care	0
Nutritional Counseling	◉	○	Patients	13,192	Patients	0
					Episodes of Care	0
Pulmonary	○	◉	Patients	0	Patients	0
					Episodes of Care	0
G. Physical Rehabilitation:						
Occupational Therapy	◉	○	Patients	6,072	Patients	471
					Episodes of Care	505
Orthotic Services	○	◉	Patients	0	Patients	0
					Episodes of Care	0
Physical Therapy	◉	○	Patients	8,064	Patients	2,507
					Episodes of Care	4,390
Prosthetic Services	○	◉	Patients	0	Patients	0
					Episodes of Care	0
Speech/Language Therapy	◉	○	Patients	3,026	Patients	345
					Episodes of Care	365
Therapeutic Recreational Service	○	◉	Patients	0	Patients	0
					Episodes of Care	0

Do you have a dedicated inpatient physical rehabilitation unit? ○ YES ◉ NO

If yes, please complete the following. Number of assigned beds 0 Number of admissions 0 Number of patient days 0

Do you have a dedicated outpatient physical rehabilitation unit? ◉ YES ○ NO

H. Pain Management:	◉	○	Patients	0	Patients	31

SBH-KINGSPORT 001977

SCHEDULE D - SERVICES (continued)* State ID 90281

Utilization of Selected Services	Is This Service Provided In Your Hospital? YES	NO	To Inpatients Unit of Measure	Number	To Outpatients Unit of Measure	Number
I. Obstetrics/Newborn:						
Obstetrics Level of Care						
Level I	○	◉				
Level II	○	◉				
Level III	◉	○				
Cesarean Section Deliveries	◉	○	Deliveries	371		
Non C-Section Deliveries	◉	○	Deliveries	864		
Birthing Rooms # rooms 0 # LDRP beds 21 # LDR beds 0	◉	○	Deliveries	1,235		
Labor Rooms # rooms 0	○	◉				
Postpartum Services # beds 0	○	◉	Patients	0	Visits	0
Newborn Nursery # bassinets 18	◉	○	Infants Discharged Patient Days	1,294 2,061		
Premature Nursery # bassinets 0	○	◉	Infants Discharged Patient Days	0 0		
Isolation Nursery # bassinets 1	◉	○	Patient Days	0		

SBH-KINGSPORT 001978

Utilization of Selected Services	Is This Service Provided In Your Hospital? YES	NO	To Inpatients Unit of Measure	Number	To Outpatients Unit of Measure	Number
J. Transplants:						
Organs						
Total Donors			Donors	17		
Total Harvested	○	◉	Donations	13		
Transplants	○	◉	Transplants	0		
Organ Bank	○	◉	Organs	0		
Type of Organ:						
Heart	○	◉	# Harvested	4		
			# Transplanted	0		
Liver	○	◉	# Harvested	13		
			# Transplanted	0		
Kidneys	○	◉	# Harvested	17		
			# Transplanted	0		
Pancreas	○	◉	# Harvested	4		
			# Transplanted	0		
Intestine	○	◉	# Harvested	1		
			# Transplanted	0		
Any Other _____	○	◉	# Harvested	0		
			# Transplanted	0		
Tissues						
Total Donors			Donors	49		
Total Harvested	○	◉	Donations	49		
Transplants	○	◉	Transplants	0		
Tissue Bank	○	◉	Tissues	0		
Type of Tissue:						
Eye	○	◉	# Harvested	38		
			# Transplanted	0	# Transplanted	0
Bone	○	◉	# Harvested	22		
			# Transplanted	0	# Transplanted	0
Bone Marrow	○	◉	# Harvested	0		
			# Transplanted	0	# Transplanted	0
Connective	○	◉	# Harvested	0		
			# Transplanted	0	# Transplanted	0
Cardiovascular	○	◉	# Harvested	11		
			# Transplanted	0	# Transplanted	0
Stem Cell	○	◉	# Harvested	0		
			# Transplanted	0	# Transplanted	0
Other Skin	○	◉	# Harvested	23		
			# Transplanted	0	# Transplanted	0

SBH-KINGSPORT 001979

Utilization of Selected Services	Is This Service Provided In Your Hospital? YES	NO	To Inpatients Unit of Measure	Number	To Outpatients Unit of Measure	Number
K. Other:						
Hyperbaric Oxygen Therapy	◉	○	Patients	6		
Gamma Knife	○	◉	Patients	0	Patients	0
Cyberknife	○	◉	Patients	0	Patients	0
L. Intensive/Intermediate:						
Burn Care Unit # beds 0	○	◉	Patients	0	Patients	0
			Patient Days	0		
Cardiac Care Unit # beds 15	◉	○	Patients	1,744		
			Patient Days	3,905		
Medical Intensive Care Unit # beds 20	◉	○	Patients	1,651		
			Patient Days	6,236		
Mixed Intensive Care Unit # beds 0	○	◉	Patients	0		
			Patient Days	0		
Neonatal Level of Care (Indicate highest level of care.)						
Level I # beds 0	○	◉	Patients	0		
			Patient Days	0		
Level II A # beds 0	○	◉	Patients	0		
			Patient Days	0		
Level II B # beds 0	○	◉	Patients	0		
			Patient Days	0		
Level III A # beds 0	○	◉	Patients	0		
			Patient Days	0		
Level III B # beds 0	○	◉	Patients	0		
			Patient Days	0		
Level III C # beds 39	◉	○	Patients	517		
			Patient Days	8,288		
Pediatric Care Unit # beds 10	◉	○	Patients	501		
			Patient Days	1,696		
Stepdown ICU # beds 109	◉	○	Patients	7,383		
			Patient Days	34,187		
Stepdown CCU # beds 0	○	◉	Patients	0		
			Patient Days	0		
Surgical Intensive Care Unit # beds 8	◉	○	Patients	610		
			Patient Days	2,490		

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SCHEDULE D - SERVICES (continued)* State ID 90281

Utilization of Selected Services	Is This Service Provided In Your Hospital? YES	NO	To Inpatients Unit of Measure	Number	To Outpatients Unit of Measure	Number
L. Intensive/Intermediate (continued):						
Other, specify Neuro Number of beds 8	◉	○	Patients Patient Days	13 16		
Other, specify Number of beds 0	○	◉	Patients Patient Days	0 0		
M. Psychiatric Partial Hospitalization	○	◉	Patients	0		
N. Psychiatric Intensive Outpatient Care	○	◉			Patients	0
O. Electroconvulsive Treatment	○	◉	Patients Treatments	0 0	Patients Treatments	0 0
P. Other Convulsive Treatment	○	◉	Patients Treatments	0 0	Patients Treatments	0 0
Q. Negative Pressure Ventilated Room If yes, number of beds 55	◉	○				

R. 23 Hour Observation ◉ YES ○ NO Outpatients 9,758

S. Cancer Patients:

1. How many patients were diagnosed with cancer at your facility during this reporting period? 784
2. How many patients were both diagnosed and provided the first course of treatment for cancer at your facility during this reporting period? 783
3. How many patients were diagnosed elsewhere but provided the first course of treatment at your facility during this reporting period? 336

SBH-KINGSPORT 001981

SCHEDULE E - FINANCIAL DATA*

State ID 90281

Dates covered from 07/01/2012 to 06/30/2013 Use zeros where applicable. Do not leave blank lines in this schedule.

A. CHARGES (For reporting period only. Do not include revenue related losses; round to the nearest dollar.)

	Gross Patient Charges	minus	Adjustments To Charges	equals	Net Patient Revenue
1. Government					
a) Medicare Inpatient - Total (include managed care)	$692,798,112	-	$574,321,231	=	$118,476,881
1) Medicare Managed Care - Inpatient	$209,045,253	-	$174,512,262	=	$34,532,991
b) Medicare Outpatient - Total (include managed care)	$295,906,177	-	$263,699,413	=	$32,206,764
1) Medicare Managed Care - Outpatient	$113,356,153	-	$103,663,014	=	$9,693,139
c) Medicaid/TennCare Inpatient* (for EAH use 7.b.2.)	$147,046,561	-	$118,544,211	=	$28,502,350
d) Medicaid/TennCare Outpatient* (for EAH use 7.b.2.)	$97,903,124	-	$85,442,255	=	$12,460,869
e) Other	$15,670,517	-	$13,996,530	=	$1,673,987
f) Total Government Sources	$1,249,324,491	-	$1,056,003,640	=	$193,320,851
* see instructions					
2. Cover Tennessee					
a) Cover TN	$3,460,242	-	$2,991,485	=	$468,757
b) Cover Kids	$4,420,216	-	$2,574,881	=	$1,845,335
c) Access Tennessee	$4,423,953	-	$2,766,675	=	$1,657,278
d) Total Cover Tennessee	$12,304,411	-	$8,333,041	=	$3,971,370
3. Nongovernment					
a) Self-Pay	$152,394,787	-	$151,344,543	=	$1,050,244
b) Blue Cross Blue Shield	$259,422,451	-	$166,243,170	=	$93,179,281
c) Commercial Insurers (excludes Workers Comp)	$166,895,039	-	$86,303,604	=	$80,591,435
d) Workers Compensation	$13,954,692	-	$8,626,753	=	$5,327,939
e) Other	$44,019,208	-	$33,861,929	=	$10,157,279
f) Total Nongovernment Sources	$636,686,177	-	$446,379,999	=	$190,306,178
4. Totals					
a) Total Inpatient (excludes Newborn)	$1,200,621,418				
b) Newborns	$2,943,402				
c) Total Inpatient (includes Newborn) (A4a + A4b)	$1,203,564,820	-	$956,782,643	=	$246,782,177
d) Total Outpatient	$694,750,259	-	$553,934,037	=	$140,816,222
e) Grand Total (A1f + A2d + A3f)	$1,898,315,079	-	$1,510,716,680	=	$387,598,399
5. Bad Debt					
a) Medicare Enrollees			$2,131,443		
b) Other Government			$393,443		
c) Cover Tennessee			$27,399		
d) Blue Cross and Commercially Insured Patients			$5,704,622		
e) All Other			$30,793,685		
f) Total Bad Debt			$39,050,592		
6. Nongovernment and Cover Tennessee Adjustments to Charges					
a) Nongovernment Contractual			$355,603,406		
b) Cover Tennessee Contractual			$8,305,642		
c) Charity Care - Inpatient			$42,536,195		
d) Charity Care - Outpatient			$11,742,090		
e) Other Adjustments, specify types _____			$0		
f) Total Nongovernment Adjustments			$418,187,333		

Amount of discounts provided to uninsured patients $54,858,969

$54,278,285 Total Charity (A6c + A6d)

$93,328,877 Total Charity plus Bad Debt (A5f + A6c + A6d)

SBH-KINGSPORT 001982

A. CHARGES (continued)

7. Other Operating Revenue

a) Tax appropriations	$0
b) State and Local government contributions:	
1) Amount designated to offset indigent care	$0
2) Essential Access Hospital (EAH) payments	$5,160,368
3) Critical Access Hospital (CAH) payments	$0
4) Amount used for other	$0
5) Total	$5,160,368
c) Other contributions:	
1) Amount designated to offset indigent care	$0
2) Amount used for other	$0
3) Total	$0
d) Other (include cafeteria, gift shop, etc.)	$12,159,365
e) Total other operating revenue (A7a + A7b5 + A7c3 + A7d)	$17,319,733

8. Nonoperating Revenue (No negative numbers! Losses or expenses should be reported in B2g.)

a) Contributions	$1,342,544
b) Grants	$564,885
c) Interest Income	$392,656
d) Other	$0
e) Total nonoperating revenue (add A8a through A8d)	$2,300,085
f) TOTAL REVENUE (Net A4e + A7e + A8e)	$407,218,217

B. EXPENSES (for the reporting period only; round to the nearest dollar)

1. Payroll Expenses for all categories of personnel specified below; (see definitions page)

a) Physicians and dentists (include only salaries)	$0
b) Medical and dental residents (include medical and dental interns)	$0
c) Trainees (medical technology, x-ray therapy, administrative, and so forth)	$0
d) Registered and licensed practical nurses	$61,145,859
e) All other personnel	$65,162,234
f) Total payroll expenses (add B1a through B1e)	$126,308,093

2. Nonpayroll Expenses

a) Employee benefits (social security, group insurance, retirement benefits)	$28,543,270
b) Professional fees (medical, dental, legal, auditing, consultant and so forth)	$37,144,164
c) Contracted nursing services (include staff from nursing registries, service contracts, and temporary help agencies)	$2,767,553
d) Depreciation expense	$23,545,019
e) Interest expense	$15,361,082
f) Energy expense	$3,923,502
g) All other expenses (supplies, purchased services, nonoperating expenses, and so forth)	$139,190,005
h) Total nonpayroll expenses (add B2a through B2g)	$250,474,595
i) TOTAL EXPENSES (add B1f + B2h)	$376,782,688

3. Are system overhead/management fees included in your expenses? (●) YES ( ) NO

If yes, specify amount $36,255,432

SBH-KINGSPORT 001983

C. CURRENT ASSETS

1. Current Assets is defined as the value of cash, accounts receivable, inventories, marketable securities and other assets that could be converted to cash in less than 1 year.
   What were your current assets on the last day of your reporting period (specified in Schedule A7 on page 2)? $80,198,531
   Net receivables are defined as the collectibles as of the last day of your reporting period, whether or not they are currently due.
2. What were your net receivables on the last day of your reporting period? $75,428,023

D. FIXED ASSETS recorded on the balance sheet at the end of the reporting period (include actual or estimated value of plant/equipment that is leased).

1. Gross plant and equipment assets (including land, building, and equipment) $540,525,674
2. LESS: Deduction for accumulated depreciation $302,166,678
3. NET FIXED plant and equipment assets (D.1. Less D.2.; if zero please explain on separate sheet) $238,358,996

E. OTHER ASSETS recorded on the balance sheet at the end of the reporting period (include assets not included above as current or fixed assets).
What were your other assets on the last day of your reporting period (specified in Schedule A7 on page 2)? $20,893,167

F. TOTAL ASSETS
Total Assets is the sum of current assets, fixed assets and other assets (C.1.+D.3.+E.).
What were your total assets on the last day of your reporting period (specified in Schedule A7 on page 2)? $339,450,694

G. CURRENT LIABILITIES
Current liabilities is defined as the amount owed for salaries, interest, accounts payable, and other debts due within one (1) year. What were your current liabilities on the last day of your reporting period? $71,719,865

H. LONG TERM LIABILITIES

1. Long Term Liabilities is defined as the amount owed for leases, bond repayment and other items due after one (1) year. What were your long term liabilities on the last day of your reporting period? $6,460,943
2. Long Term Debt is defined as the value of obligations of over 1 year that require interest to be paid. What was your long term debt on the last day of your reporting period? $3,212,122

I. OTHER LIABILITIES
Other liabilities includes those liabilities not reported as current (item G.) or long term (item H.1.).
What were your total liabilities on the last day of your reporting period (specified in Schedule A7 on page 2)? $78,180,808

J. CAPITAL ACCOUNT
Capital Account includes Fund Balance or Stockholder's Equity and all general, specific purpose, restricted or unrestricted funds. The Capital Account is the excess of assets over its liabilities.
What was your capital account on the last day of your reporting period? $261,269,886
Note: Total Assets should equal Liabilities plus Capital Account (i.e. item F.=G.+H.1.+I.+J.).

K. 1. Federal Income Tax: $0

2. Local Property Taxes Paid During the Reporting Period:
   a) Taxes on the Inpatient Facility $115,618
   b) Taxes on all Other Property $109,157

3. Other Local, State, or Federal Taxes: (exclude sales tax) $0

L. Does your hospital bill include charges incurred for the following professional services?

Radiology - ○ YES ◉ NO Pathology - ○ YES ◉ NO Anesthesiology - ○ YES ◉ NO Other - Specify _____

SBH-KINGSPORT 001984

M. TennCare Utilization and Revenue:

1. Inpatient Utilization and Revenue for TennCare Managed Care Organizations:

MCO	NUMBER OF ADMISSIONS	NUMBER OF PATIENT DAYS	GROSS REVENUE	NET REVENUE
United Health Care Community Plan	0	0	$0	$0
Amerigroup	0	0	$0	$0
Blue Care	2,252	9,786	$59,792,668	$9,141,681
TennCare Select	118	543	$3,540,614	$447,282
TennCare, MCO (Not Specified)	1,424	6,597	$46,198,776	$11,854,284
Total MCO	3,794	16,926	$109,532,058	$21,443,247

2. Outpatient Utilization and Revenue for TennCare Managed Care Organizations:

MCO	NUMBER OF PATIENTS	NUMBER OF VISITS	GROSS REVENUE	NET REVENUE
United Health Care Community Plan	0	0	$0	$0
Amerigroup	0	0	$0	$0
Blue Care	7,758	18,297	$45,721,216	$5,337,628
TennCare Select	553	1,520	$3,209,176	$324,282
TennCare, MCO (Not Specified)	6,333	14,363	$39,633,756	$7,190,983
Total MCO	14,644	34,180	$88,564,148	$12,852,893

SBH-KINGSPORT 001985

SCHEDULE F - BEDS AND BASSINETS*

State ID 90281

1. PLEASE GIVE THE NUMBER OF:

   A. TOTAL LICENSED ADULT AND PEDIATRIC BEDS AS OF THE LAST DAY OF THE REPORTING PERIOD (exclude beds in a sub-acute unit that are licensed as nursing home beds) 501

   B. The number of adult and pediatric staffed beds set up, staffed and in use as of the last day of the reporting period. 497

   C. NEWBORN NURSERY BASSINETS AS OF THE LAST DAY OF THE REPORTING PERIO 18

   D. Licensed Beds that were not staffed at any time during the reporting period. 0

2. STAFFED ADULT, PEDIATRIC, AND NEONATAL BEDS (exclude newborn nursery, include neonatal care units):

   Was there a temporary or a permanent change in the total number of beds set up and staffed during the period? ○ YES ◉ NO
   If yes, give beds added or withdrawn (show increase by + and decrease by -) and date of change.

   Bed change (+ or -) 0 Bed change (+ or -) 0 Bed change (+ or -) 0 Bed change (+ or -) 0

   Date: Date: Date: Date:

3 SWING BEDS:

   A. Does your facility utilize swing beds? ○ YES ◉ NO If yes, number of Acute Care beds designated as Swing Beds. 0

   B. PLEASE SPECIFY THE FOLLOWING FOR BEDS WHEN USED FOR LONG TERM SKILLED OR INTERMEDIATE CARE:

(How many admissions and how many days did you provide in the following categories?)

INTERMEDIATE CARE	ADMISSIONS	PATIENT DAYS
Private Pay	0	0
Other	0	0
Total	0	0

SKILLED CARE	ADMISSIONS	PATIENT DAYS
Commercial	0	0
Blue Cross	0	0
Medicare	0	0
Private Pay	0	0
Other	0	0
Total	0	0

SBH-KINGSPORT 001986

4. A. Number of Beds Set Up and Staffed on a typical day

SERVICE	BEDS
Medical	0
Surgical	0
Medical/Surgical	360
Obstetrics	21
Gynecological	0
OB/GYN	0
Pediatric	24
Eye	0
Neonatal Care	39
Intensive Care (excluding Neonatal)	53
Orthopedic	0
Urology	0
Rehabilitation	0
Chronic/Extended Care	0
Pulmonary	0
Psychiatric	0
Psychiatric specifically for Children and Youth under age 18	0
Psychiatric specifically for Geriatric Patients	0
Chemical Dependency	0
Chemical Dependency specifically for Children and Youth under age 18	0
Chemical Dependency specifically for Geriatric Patients	0
Swing Beds (for long term skilled or intermediate care)	0
Other, specify	0
Unassigned	0
TOTAL	497

B. Number of Patients in hospital on a typical day. Exclude normal newborns (See Instructions), long term skilled or intermediate patients. 369

5. OBSERVATION BEDS

A. Do you use inpatient staffed beds for 23-hour observation? (•) YES ( ) NO If yes, number of beds 497

B. Do you have beds assigned to dedicated 23-hour observation unit? ( ) YES (•) NO If yes, number of beds 0

C. Do you have beds in a "same-day-surgery" unit that are used for both same-day surgery and 23-hour observation? ( ) YES (•) NO
If yes, number of beds 0

SBH-KINGSPORT 001987

SCHEDULE G - UTILIZATION*

State ID 90281

1. INPATIENT UTILIZATION (include normal newborns)

Patient Census Records:

Please indicate whether you are reporting Admissions and Inpatient Days ○

or Discharges and Discharge Patient Days ◉

2. UTILIZATION BY MAJOR DIAGNOSTIC CATEGORIES:

MAJOR DIAGNOSTIC CATEGORIES	ADMISSIONS OR DISCHARGES	INPATIENT DAYS OR DISCHARGE PATIENT DAYS
01 Nervous System	2,233	9,869
02 Eye	43	115
03 Ear, Nose, Mouth and Throat	231	651
04 Respiratory System	3,383	18,686
05 Circulatory System	5,113	22,663
06 Digestive System	1,923	10,278
07 Hepatobiliary System & Pancreas	819	4,531
08 Musculoskeletal Sys. & Connective Tissue	2,696	11,629
09 Skin, Subcutaneous Tissue & Breast	809	3,305
10 Endocrine, Nutritional & Metabolic	757	2,818
11 Kidney & Urinary Tract	1,402	7,173
12 Male Reproductive System	63	267
13 Female Reproductive System	201	730
14 Pregnancy, Childbirth & the Puerperium	1,514	4,530
15 Normal Newborns & Other Neonates with Conditions Originating in the Perinatal Period	487	7,501
16 Blood and Blood Forming Organs and Immunological Disorders	342	1,614
17 Myeloproliferative Disorders & Poorly Differentiated Neoplasms	220	1,474
18 Infectious & Parasitic Diseases	1,119	9,106
19 Mental Diseases & Disorders	99	414
20 Alchohol/Drug Use & Alcohol/Drug-Induced Organic Mental Disorders	155	543
21 Injuries, Poisoning, & Toxic Effects of Drugs	448	1,593
22 Burns	14	44
23 Factors Influencing Health Status and Other Contacts with Health Services	133	511
24 Multiple Significant Trauma	125	1,030
25 Human Immunodeficiency Virus Infections	15	54
26 Other DRGs Associated with All MDCs	394	6,624
TOTAL	24,938	127,753

SBH-KINGSPORT 001988

3. UTILIZATION BY REVENUE SOURCE (excluding normal newborns -- see Instructions)

Patients should be categorized according to primary payer and counted only once.

Please indicate whether you are reporting Admissions and Inpatient Days ○ or Discharges and Discharge Patient Days ◉

	ADMISSIONS OR DISCHARGES	INPATIENT DAYS OR DISCHARGE PATIENT DAYS	OUTPATIENT VISITS*
a) Self Pay	1,976	11,108	17,585
b) Blue Cross/Blue Shield	2,784	12,595	52,809
c) Champus/TRICARE	197	859	3,191
d) Commercial Insurance (excludes Workers Comp)	1,648	7,906	31,407
e) Cover TN	16	51	383
f) Cover Kids	118	261	1,153
g) Access TN	12	41	151
h) Medicaid/Tenncare	3,875	20,358	43,663
i) Medicare - Total	12,616	70,622	93,407
Medicare Managed Care	4,411	26,293	36,795
j) Workers Compensation	114	574	959
k) Other	288	1,317	4,783
l) Total	23,644	125,692	249,491

* Should include emergency department visits and hospital outpatient visits

4. NUMBER OF PATIENTS BY AGE GROUP (excluding normal newborns -- see Instructions)

Please indicate whether you are reporting Admissions and Inpatient Days ○ , or Discharges and Discharge Patient Days ◉

Age	ADMISSIONS OR DISCHARGES	INPATIENT DAYS OR DISCHARGE PATIENT DAYS	OUTPATIENT VISITS*
Under 15 years	1,455	11,100	12,034
15-17 years	255	802	3,912
18-64 years	11,810	57,127	160,947
65-74 years	4,635	25,798	38,706
75-84 years	3,659	20,551	23,268
85 years & older	1,830	10,314	10,624
GRAND TOTAL	23,644	125,692	249,491

* Should include emergency department visits and hospital outpatient visits

SBH-KINGSPORT 001989

5. PATIENT ORIGIN (excluding normal newborns -- see Instructions)
Indicate usual residence of patients and number of patient days. Please indicate whether you are reporting

Admissions and Inpatient Days ○ or Discharges and Discharge Patient Days ◉

** List only those counties in other states that represent at least 1 percent of the total admissions or discharges to your hospital. If you have fewer than 500 total discharges or admissions annually, list only those counties that represent at least 2 percent of your total admissions or discharges.

County #	Tennessee County of Residence	Number of Admissions or Discharges	Number of Inpatient Days or Discharge Patient Days
01	Anderson	6	11
02	Bedford	0	0
03	Benton	0	0
04	Bledsoe	0	0
05	Blount	4	6
06	Bradley	3	19
07	Campbell	0	0
08	Cannon	0	0
09	Carroll	0	0
10	Carter	3,133	16,369
11	Cheatham	0	0
12	Chester	0	0
13	Claiborne	7	60
14	Clay	0	0
15	Cocke	93	635
16	Coffee	1	5
17	Crockett	0	0
18	Cumberland	1	6
19	Davidson	6	16
20	Decatur	0	0
21	DeKalb	0	0
22	Dickson	5	92
23	Dyer	0	0
24	Fayette	0	0
25	Fentress	1	3
26	Franklin	0	0
27	Gibson	0	0
28	Giles	0	0

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5. PATIENT ORIGIN (continued)

County #	Tennessee County of Residence	Number of Admissions or Discharges	Number of Inpatient Days or Discharge Patient Days
29	Grainger	15	83
30	Greene	1,575	8,558
31	Grundy	0	0
32	Hamblen	69	490
33	Hamilton	6	15
34	Hancock	10	42
35	Hardeman	0	0
36	Hardin	0	0
37	Hawkins	266	1,625
38	Haywood	0	0
39	Henderson	0	0
40	Henry	0	0
41	Hickman	0	0
42	Houston	0	0
43	Humphreys	0	0
44	Jackson	0	0
45	Jefferson	24	155
46	Johnson	966	5,011
47	Knox	36	196
48	Lake	0	0
49	Lauderdale	0	0
50	Lawrence	1	2
51	Lewis	0	0
52	Lincoln	1	5
53	Loudon	3	8
54	McMinn	0	0
55	McNairy	0	0
56	Macon	1	3
57	Madison	0	0
58	Marion	0	0
59	Marshall	0	0
60	Maury	0	0
61	Meigs	2	12
62	Monroe	4	26

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5. PATIENT ORIGIN (continued)

County #	Tennessee County of Residence	Number of Admissions or Discharges	Number of Inpatient Days or Discharge Patient Days
63	Montgomery	1	3
64	Moore	0	0
65	Morgan	0	0
66	Obion	0	0
67	Overton	0	0
68	Perry	0	0
69	Pickett	0	0
70	Polk	0	0
71	Putnam	1	4
72	Rhea	0	0
73	Roane	4	24
74	Robertson	0	0
75	Rutherford	1	1
76	Scott	0	0
77	Sequatchie	0	0
78	Sevier	10	37
79	Shelby	3	21
80	Smith	0	0
81	Stewart	0	0
82	Sullivan	1,922	10,415
83	Sumner	3	24
84	Tipton	1	7
85	Trousdale	0	0
86	Unicoi	1,517	7,872
87	Union	1	3
88	Van Buren	0	0
89	Warren	0	0
90	Washington	10,583	53,866
91	Wayne	1	9
92	Weakley	0	0
93	White	1	4
94	Williamson	3	5
95	Wilson	1	8
96	TN County Unknown	0	0
	Tennessee Total	20,292	105,756

SBH-KINGSPORT 001992

5. PATIENT ORIGIN (continued)

State & County Residence	Number of Admissions or Discharges	Number of Inpatient Days or Discharge Patient Days
ALABAMA COUNTIES: (Specify)		
1) Lauderdale	2	6
2) Jefferson	1	2
Other Alabama Counties	3	11
Alabama Total	6	19
GEORGIA COUNTIES: (Specify)		
1) Fulton	4	10
2) Cherokee	2	5
Other Georgia Counties	9	49
Georgia Total	15	64
MISSISSIPPI COUNTIES: (Specify)		
1) Lauderdale	1	5
2)	0	0
Other Mississippi Counties	0	0
Mississippi Total	1	5
ARKANSAS COUNTIES: (Specify)		
1) Nome	1	4
2)	0	0
Other Arkansas Counties	0	0
Arkansas Total	1	4
MISSOURI COUNTIES: (Specify)		
1) Christian	1	2
2) Johnson	1	2
Other Missouri Counties	1	2
Missouri Total	3	6

SBH-KINGSPORT 001993

5. PATIENT ORIGIN (continued)

State & County Residence	Number of Admissions or Discharges	Number of Inpatient Days or Discharge Patient Days
KENTUCKY COUNTIES: (Specify)		
1) Harlan	46	443
2) Letcher	21	99
Other Kentucky Counties	15	165
Kentucky Total	82	707
VIRGINIA COUNTIES: (Specify)		
1) Smyth	451	2,756
2) Wise	461	2,834
Other Virginia Counties	1,571	9,342
Virginia Total	2,483	14,932
NORTH CAROLINA COUNTIES: (Specify)		
1) Avery	247	1,308
2) Mitchell	98	876
Other North Carolina Counties	204	1,051
North Carolina Total	549	3,235
OTHER STATES: (Specify)		
1) Florida	56	223
2) West Virginia	35	177
All Other States and Countries	121	564
RESIDENCE UNKNOWN:	0	0
GRAND TOTAL	23,644	125,692

SBH-KINGSPORT 001994

6. Delivery Status:

   A. Number of Infants Born Alive 1,235

   B. Number of Deaths Among Infants Born Alive 13

   C. Number of Fetal Deaths (350 grams or 20 weeks or more gestation) 14

SBH-KINGSPORT 001995

SCHEDULE H - PSYCHIATRIC AND CHEMICAL DEPENDENCY UNITS* State ID 90281

1. TYPE OF UNIT - PSYCHIATRIC:
   A. Do you have a dedicated psychiatric unit? ◯ YES ◉ NO If yes, please complete items on this page and on the next page.
   B. Do you have a designated Gero-Psychiatric Unit? ◯ YES ◉ NO

2. BEDS
   A. Number of assigned beds 0
   B. Date unit opened _____

3. UTILIZATION BY AGE GROUPS:
   Please indicate if you are reporting Admissions and Inpatient Days ◯ or Discharges and Discharge Patient Days. ◯

	Inpatient			Partial Care or Day Hospital	Outpatient
AGE GROUPS	Number of Patients on September 30	Number of Admissions or Discharges	Number of Inpatient or Discharge Patient Days	Number of Sessions	Number of Visits
Children and/or Adolescents Ages 0 - 17	0	0	0	0	0
Adults Ages 18 - 64	0	0	0	0	0
Elderly Ages 65 and older	0	0	0	0	0
Total	0	0	0	0	0

4. Is the psychiatric service managed under a management contract different from the hospital itself? ◯ YES ◉ NO
   If yes, please specify name of organization that manages the unit. _____

5. Do you have contracts with Behavioral Health Organizations? ◯ YES ◉ NO

6. Does your hospital use:

			If Yes, Number of Patients Secluded or Restrained		Number of Times Seclusion or Restraint was Initiated	
			Age 0-17	Age 18+	Age 0-17	Age 18+
A. Seclusion	◯ YES	◉ NO	0	0	0	0
B. Mechanical Restraints	◯ YES	◉ NO	0	0	0	0
C. Physical Holding Restraints	◯ YES	◉ NO	0	0	0	0
D. Chemical Restraints	◯ YES	◉ NO	0	0	0	0

SBH-KINGSPORT 001996

SCHEDULE H - PSYCHIATRIC AND CHEMICAL DEPENDENCY UNITS (continued)*

State ID 90281

7. FINANCIAL DATA - PSYCHIATRIC

	INPATIENT CHARGES		OUTPATIENT CHARGES		TOTAL CHARGES		ADJUSTMENTS TO CHARGES		NET PATIENT REVENUE
		plus		equals		minus		equals	
A. GROSS PATIENT REVENUE & NET PATIENT REVENUE BY PAYER:									
1. Self Pay	$0	+	$0	=	$0	-	$0	=	$0
2. Blue Cross/Blue Shield	$0	+	$0	=	$0	-	$0	=	$0
3. Champus/TRICARE	$0	+	$0	=	$0	-	$0	=	$0
4. Commercial Insurance (excludes Workers Comp)	$0	+	$0	=	$0	-	$0	=	$0
5. Cover TN	$0	+	$0	=	$0	-	$0	=	$0
6. Cover Kids	$0	+	$0	=	$0	-	$0	=	$0
7. Access TN	$0	+	$0	=	$0	-	$0	=	$0
8. Medicaid/Tenncare	$0	+	$0	=	$0	-	$0	=	$0
9. Medicare - Total	$0	+	$0	=	$0	-	$0	=	$0
Medicare Managed Care	$0	+	$0	=	$0	-	$0	=	$0
10. Workers Compensation	$0	+	$0	=	$0	-	$0	=	$0
11. Other	$0	+	$0	=	$0	-	$0	=	$0

B. NON-GOVERNMENT ADJUSTMENTS TO REVENUE	
1. Bad Debt	$0
2. Charity Care	$0
3. Contractual Adjustments	$0
4. Total	$0
5. Amount of discounts provided to uninsured patients	$0

8. A. SERVICE CHARGES

	INPATIENT CHARGES	OUTPATIENT CHARGES
1. Routine Treatment	$0	$0
2. Ancillary Services	$0	$0
3. Other	$0	$0
4. Total	$0	$0

B. Do these charges include physicians' fees? ◯ YES ◯ NO

SBH-KINGSPORT 001997

SCHEDULE H - PSYCHIATRIC AND CHEMICAL DEPENDENCY UNITS (continued)* State ID 90281

1. TYPE OF UNIT - CHEMICAL DEPENDENCY:
   Do you have a dedicated chemical dependency unit? ○ YES ◉ NO If yes, please complete items on this page and on the next page.

2. BEDS
   A. Number of assigned beds 0
   B. Date unit opened _____

3. UTILIZATION BY AGE GROUPS:
   Please indicate if you are reporting Admissions and Inpatient Days ○ or Discharges and Discharge Patient Days. ○

	Inpatient			Partial Care or Day Hospital	Outpatient	Residential Care
AGE GROUPS	Number of Patients on September 30	Number of Admissions or Discharges	Number of Inpatient or Discharge Patient Days	Number of Sessions	Number of Visits	Number of Visits
Children and/or Adolescents Ages 0 - 17	0	0	0	0	0	0
Adults Ages 18 - 64	0	0	0	0	0	0
Elderly Ages 65 and older	0	0	0	0	0	0
Total	0	0	0	0	0	0

4. Is the chemical dependency service managed under a management contract different from the hospital itself? ○ YES ◉ NO
   If yes, please specify name of organization that manages the unit. _____

5. Do you have contracts with Behavioral Health Organizations? ○ YES ◉ NO

SBH-KINGSPORT 001998

6 FINANCIAL DATA - CHEMICAL DEPENDENCY

	INPATIENT CHARGES	plus	OUTPATIENT CHARGES	equals	TOTAL CHARGES	minus	ADJUSTMENTS TO CHARGES	equals	NET PATIENT REVENUE
A. GROSS PATIENT REVENUE & NET PATIENT REVENUE BY PAYER:									
1. Self Pay	$0	+	$0	=	$0	-	$0	=	$0
2. Blue Cross/Blue Shield	$0	+	$0	=	$0	-	$0	=	$0
3. Champus/TRICARE	$0	+	$0	=	$0	-	$0	=	$0
4. Commercial Insurance (excludes Workers Comp)	$0	+	$0	=	$0	-	$0	=	$0
5. Cover TN	$0	+	$0	=	$0	-	$0	=	$0
6. Cover Kids	$0	+	$0	=	$0	-	$0	=	$0
7. Access TN	$0	+	$0	=	$0	-	$0	=	$0
8. Medicaid/Tenncare	$0	+	$0	=	$0	-	$0	=	$0
9. Medicare - Total	$0	+	$0	=	$0	-	$0	=	$0
Medicare Managed Care	$0	+	$0	=	$0	-	$0	=	$0
10. Workers Compensation	$0	+	$0	=	$0	-	$0	=	$0
11. Other	$0	+	$0	=	$0	-	$0	=	$0

B. NON-GOVERNMENT ADJUSTMENTS TO REVENUE	
1. Bad Debt	$0
2. Charity Care	$0
3. Contractual Adjustments	$0
4. Total	$0
5. Amount of discounts provided to uninsured patients	$0

7. A. SERVICE CHARGES	INPATIENT CHARGES	OUTPATIENT CHARGES
1. Routine Treatment	$0	$0
2. Ancillary Services	$0	$0
3. Other	$0	$0
4. Total	$0	$0

B. Do these charges include physicians' fees? ◯ YES ◯ NO

SBH-KINGSPORT 001999

SCHEDULE I - EMERGENCY DEPARTMENT*

State ID 90281

1. What is the direct telephone number into your Emergency Department? (423) 431-6561

2. Is the Emergency Department managed under a management contract different from the hospital itself? ○ YES ◉ NO
   If yes, with whom is the contract held? _____

3. Emergency Department:

   Number of visits by payer:

A. Self Pay	8,265	H. Medicaid/Tenncare		L. Grand Total 52,954
B. Blue Cross/Blue Shield	6,305	United Health Care Community Plan	6,776	
C. Champus/TRICARE	643	Amerigroup	0	
D. Commercial Insurance (excludes Workers Comp)	4,928	Blue Care	8,945	
		TennCare Select	452	
		TennCare, MCO (Not Specified)	747	
		TennCare Total	16,920	
E. Cover TN	41	I. Medicare - Total	14,266	
F. Cover Kids	22	Medicare Managed Care	4,899	
G. Access TN	5	J. Workers Compensation	327	
		K. Other	1,232	

4. Is your Emergency Department staffed 24 hours per day? ◉ YES ○ NO If no, please give hours covered. 0

SBH-KINGSPORT 002000

SCHEDULE I - EMERGENCY DEPARTMENT (continued)* State ID 90281.

5. Indicate the number of the following personnel available in the hospital on a normal day and how many are available to the Emergency Department.

	ON HOSPITAL CAMPUS	IN EMERGENCY DEPARTMENT
A. PHYSICIANS:		
Board certified in Emergency Medicine	3	3
Board eligible in Emergency Medicine	2	2
Declared Speciality of Emergency Medicine	1	1
Board Certified Psychiatrists	1	0
Other Physicians Available to Emergency Department	3	0
B. NURSES:		
Nurse Practitioners	2	1
R.N.'s with formal emergency training and experience	22	52
Other R.N.'s	0	0
L.P.N.'s and other nursing support personnel	0	0
Clerical Staff	2	11
C. OTHER:		
E.M.T.	0	0
E.M.T. advanced	0	0

SBH-KINGSPORT 002001

6. SUPPORTIVE SERVICES:

	YES	NO
A. COMMUNICATIONS:		
Two-Way radio in ER with Access to:		
Central Emergency Dispatch Center	◉	○
Ambulances	◉	○
Other hospitals	◉	○
B. HELIPORT:	◉	○
C. PHARMACY IN ER:	○	◉
D. BLOOD BANK (check ONLY one):		
Fully stocked	○	
Common blood types only	◉	

7. Do you have dedicated centers for the provision of specialized emergency care for the following:

A. Designated Trauma Center ◉ YES ○ NO

B. Burns ○ YES ◉ NO

If yes, do you have a designation by a government agency as a Burn Center? ○ YES ○ NO

C. Pediatrics ◉ YES ○ NO

D. Other, specify

_____

8. Triage: A. Total number of patients who presented in your ER. 53,265.

B. Total number treated in your ER. 52,954

C. Total number not treated in your ER but referred to physician or clinic for treatment. 0

SBH-KINGSPORT 002002

SCHEDULE J - PERSONNEL ON PAYROLL AS OF LAST DAY OF REPORTING PERIOD AND USE OF CONTRACT EMPLOYEES*

State ID 90281

	Full-Time Equivalent**	Full-Time Equivalent Budgeted Vacancies	Use Contract Staff in this Employee Category***
1. Administration:			
A. Administrators & Assistants	5.7	0.0	☐
B. Director, Health Services Research & Assistants	0.0	0.0	☐
C. Marketing & Planning Officer(s) & Assistants	0.0	0.0	☐
D. Financial and Accounting Officer(s) & Assistants	2.0	0.0	☐
2. Physician and Dental Services:			
A. Physicians	0.0	0.0	☐
B. Medical residents	0.0	0.0	☐
C. Dentists	0.0	0.0	☐
D. Dental residents	0.0	0.0	☐
3. Nursing Services:			
A. RNs - Administrative	3.2	0.0	☐
B. RNs - Patient care/clinical	904.6	30.6	☑
C. LPNs	47.9	0.0	☑
D. Ancillary nursing personnel	277.4	0.0	☐
4. Certified Nurse Midwives	0.0	0.0	☐
5. Nurse Anesthetists	0.0	0.0	☐
6. Physicians assistants	0.0	0.0	☐
7. Nurse practitioners	0.0	1.0	☐
8. Medical record service:			
A. Medical record administrators	1.8	0.2	☐
B. Medical record technicians (certified or accredited)	2.1	0.0	☐
C. Other Medical record technicians	0.0	0.0	☐
9. Pharmacy:			
A. Pharmacists, licensed	19.0	0.0	☐
B. Pharmacy technicians	31.5	0.0	☐
C. Clinical Phar-D	19.4	0.5	☐
10. Clinical laboratory services:			
A. Medical Technologists	22.1	0.0	☐
B. Other laboratory personnel	94.2	7.1	☐
11. Dietary services:			
A. Dietitians	2.7	0.0	☐
B. Dietetic technicians	0.0	0.0	☐
12. Radiological services:			
A. Radiographers (radiologic technologists)	36.6	0.0	☐
B. Radiation therapy technologists	11.2	0.0	☐
C. Nuclear medicine technologists	11.9	1.8	☐
D. Other radiologic personnel	57.6	6.9	☐
13. Therapeutic services:			
A. Occupational therapists	7.2	0.8	☑
B. Occupational therapy assistants & aides	0.0	0.0	☐
C. Physical therapists	17.8	0.9	☐
D. Physical therapy assistants & aides	8.1	1.6	☐
E. Recreational therapists	0.0	0.0	☐
14. Speech and hearing services:			
A. Speech Pathologist	6.3	0.7	☐
B. Audiologist	0.0	0.0	☐
15. Respiratory therapy services:			
A. Respiratory therapists	55.5	2.0	☐
B. Respiratory therapy technicians	16.0	0.0	☐
16. Psychiatric services:			
A. Clinical psychologists	0.0	0.0	☐
B. Psychiatric social workers	0.0	0.0	☐
C. Psychiatric registered nurses	0.0	0.0	☐
D. Other mental health professionals	0.0	0.0	☐
17. Chemical dependency services:			
A. Clinical psychologists	0.0	0.0	☐
B. Social workers	0.0	0.0	☐
C. Registered nurses	0.0	0.0	☐
D. Other specialists in addiction and/or in chemical dependency	0.0	0.0	☐
18. Medical Social workers	41.2	0.0	☐
19. Surgical technicians	52.2	0.2	☐
20. All other certified professional & technical	32.5	0.0	☐
21. All other non-certified professional & technical	18.0	1.9	☐
22. All other personnel	818.7	0.0	☑
TOTAL	2,624.4	56.2	

** Full-time + Part-time specified in Full Time Equivalent

*** Please check if contract staff is used.

SBH-KINGSPORT 002003

SCHEDULE K - MEDICAL STAFF*

State ID 90281

	(1) Number of Active and Associate Medical Staff (Include Board Certified)	(2) Number of Active and Associate Medical Staff Who Are Board Certified	(3) Number of House Staff Who Are Interns, Externs or Residents
1. MEDICAL SPECIALTIES:			
A. General and family practice	37	31	21
B. Pediatric	38	34	16
C. General internal medicine	97	75	80
D. Psychiatric	0	0	0
E. Neonatologist	4	4	0
F. Cardiologists	22	21	34
G. Neurologists	9	6	0
H. Other medical specialties	85	74	65
2. SURGICAL SPECIALTIES:			
A. General surgery	17	16	33
B. Obstetrics and gynecology	27	20	13
C. Perinatologists	0	0	0
D. Gynecology	3	3	0
E. Orthopedic	21	19	0
F. Neurosurgeons	12	10	0
G. Cardiovascular	0	0	0
H. Gastroenterology	9	9	27
I. Other surgical specialties	23	15	0
3. OTHER SPECIALTIES:			
A. Pathology	11	11	8
B. Radiology	21	21	0
C. Anesthesiology	16	16	0
D. Other specialties	60	54	0
4. DENTAL SPECIALTIES:	2	1	0
TOTAL	514	440	297

SBH-KINGSPORT 002004

SCHEDULE L - PERINATAL*

State ID 90281

1A. Name of person completing Perinatal survey Allison Cohran

1B. Telephone Number (423) 431-6640

1C. Fax Number (423) 431-5494

Please complete the following questions.

2. Births
   - A. Total number of live births 1,235
   - B. Birth weight below 2500 grams (5lb 8oz) 236
   - C. Birth weight below 1500 grams (3 lb 5oz) 54

3. Number of babies on ventilator longer than 24 hours 85

4. Number of babies received from referring hospitals for neonatal management 165

	YES	NO
5. Is Medical Director of Obstetrics board certified/eligible in maternal-fetal medicine?	◉	○
6. Is Medical Director of the Nursery board certified/eligible in neonatal-perinatal?	◉	○

7. Do the following subspecialty consultants spend more than 2/3 full-time effort at your hospital?

	YES	NO
A. OBSTETRICS:		
Perinatal Sonologist	○	◉
Hematologist	○	◉
Cardiologist	○	◉
B. NEONATAL:		
Pediatric Radiologist	○	◉
Pediatric Cardiologist	◉	○
Pediatric Neurologist	○	◉
Pathologist	○	◉
Pediatric Surgeon	◉	○

SBH-KINGSPORT 002005

SCHEDULE M - SURVEY ON NURSING PERSONNEL*

State ID 90281

(As of the last day of the reporting period)

1. Registered Nurses

HIGHEST EDUCATION LEVEL	FTE NUMBER CURRENTLY EMPLOYED	NUMBER OF BUDGETED VACANCIES	NUMBER OF POSITIONS YOU PLAN TO ADD IN THE NEXT 12 MONTHS	NUMBER OF POSITIONS YOU PLAN TO ELIMINATE IN THE NEXT 12 MONTHS	PRIMARY ROLE (NUMBER OF POSITIONS)	
					CLINICAL	ADMINISTRATIVE
Total	875.3	0.0	0.0	0.0	1,004.0	57.0
Bachelors Degree	485.3	0.0	0.0	0.0	564.0	30.0
Associate Degree	381.6	0.0	0.0	0.0	429.0	27.0
Diploma	8.4	0.0	0.0	0.0	11.0	0.0
Masters Degree	0.0	0.0	0.0	0.0	0.0	0.0
Doctorate Degree	0.0	0.0	0.0	0.0	0.0	0.0

2. Advanced Practice Nurses

NURSING PERSONNEL CATEGORY	FTE NUMBER CURRENTLY EMPLOYED	NUMBER OF BUDGETED VACANCIES	NUMBER OF POSITIONS YOU PLAN TO ADD IN THE NEXT 12 MONTHS	NUMBER OF POSITIONS YOU PLAN TO ELIMINATE IN THE NEXT 12 MONTHS	PRIMARY ROLE (NUMBER OF POSITIONS)	
					CLINICAL	ADMINISTRATIVE
Total	2.0	0.0	0.0	0.0	2.0	0.0
Nurse Practitioner	2.0	0.0	0.0	0.0	2.0	0.0
Clinical Nurse Specialist	0.0	0.0	0.0	0.0	0.0	0.0
CRNA	0.0	0.0	0.0	0.0	0.0	0.0
Certified Nurse Midwife	0.0	0.0	0.0	0.0	0.0	0.0

3. Licensed Practical Nurses

LPNs	NUMBER OF POSITIONS YOU PLAN TO ADD IN THE NEXT 12 MONTHS	NUMBER OF POSITIONS YOU PLAN TO ELIMINATE IN THE NEXT 12 MONTHS
Total	0.0	0.0

4. Recruitment of Nursing Personnel

The following are selected specialties for which hospitals commonly report recruiting difficulties.
Please specify other categories as necessary.

NURSING PERSONNEL CATEGORY	FTE NUMBER CURRENTLY EMPLOYED	NUMBER OF BUDGETED VACANCIES	NUMBER OF POSITIONS YOU PLAN TO ADD IN THE NEXT 12 MONTHS	NUMBER OF POSITIONS YOU PLAN TO ELIMINATE IN THE NEXT 12 MONTHS
CCU/ICU	159.6	0.0	0.0	0.0
ER	60.0	0.0	0.0	0.0
Other (Specify):				
	0.0	0.0	0.0	0.0
	0.0	0.0	0.0	0.0

SBH-KINGSPORT 002006

SCHEDULE N - HEALTH CARE PLANS ACCEPTED*

State ID 90281

The Health Consumer Right-to-Know Act of 1998 which was signed by Governor Sundquist in May, 1998 requires hospitals to report to the Department of Health "health care plans accepted by the hospital" as well as a variety of information that is included in earlier schedules of the Joint Annual Report. In order to allow the Joint Annual Report to meet the entire reporting requirement described in this act, please list all health insurance plans with which you currently - as of the last day of this reporting period - have a valid contract. List each plan separately not just the name of the company. For example, if you have contracts to provide services to individuals enrolled in Blue Choice and Blue Preferred, list both plans and do not only list Blue Cross & Blue Shield of Tennessee.

Plans:

Aetna - EPO Elect Choice
Aetna - HMO QPOS
Aetna - HMO - Select Choice
Aetna - HMO - US Access
Aetna - POS - Managed Choice
Aetna - PPO - Open Choice
Beechstreet - PPO
Bluecross TN - PPO
Bluecross TN - PPO - Blue Select
Bluecross TN - PPO - Blue Select - SNF
Bluecross TN - PPO - Blue Preferred
Bluecross TN - PPO - Blue Preferred SNF
Bluecross TN - HMO - TennCare BlueCare - SNF
Bluecross TN - HMO - TennCare Select - SNF
Bluecross TN - HMO - TennCare BlueCare
Bluecross TN - HMO - TennCare Select
CareCenters Mgmt Consulting - Work Comp - HMO
CareCenters Mgmt Consulting - Work Comp - POS
CareCenters Mgmt Consulting - Work Comp - Med CFFS
CareCenters Mgmt Consulting - Work Comp - Med PPO
CareCenters Mgmt Consulting - Work Comp - Med POS
CareCenters Mgmt Consulting - Work Comp - Med HMO
CareCenters Mgmt Consulting - Work Comp - PPO
Evolutions - PPO Network
First Health/CCN - PPO
Formost - PPO
Health Payors Org - Facility Agreement
Humana - Champus TriCare
Initial Group - PPO - Initial Health Alliance
Initial Group - PPO - Workers' Comp
Integrated Solutions Health Network - Crestpoint - Med Adv
Integrated Solutions Health Network - Laughlin Employee Plan
Integrated Solutions Health Network - MSHA Pref - Ford Air
Integrated Solutions Health Network - MSHA Pref - APWU
Integrated Solutions Health Network - MSHA Pref - Woodgrain
ISHN - MSHA Pref - Columbus
ISHN - MSHA Pref - Serco
ISHN - MSHA Pref - NSA
ISHN - Unicoi Co Memorial Emp
ISHN - Universal Fibers
United Healthcare - AARP Med Adv - SNF
United Healthcare - HMO - JDH Choice/Pref
United Healthcare - Gatekeeper - JDH Select
United Healthcare - HMO Comm Plan TnCare
National Provider Network
NovaNet - Workers' Comp Network
PHCS - PPO
Response Oncology - Facility Agreement
Ryan White Medical Services - Outpatient Services
UMWA - Direct afreement
United Healthcare of TN - NPO
United Healthcare of TN - POS
United Healthcare of TN - PPO
USA MCO - PPO Network
Virginia Medicaids via ISHN - Amerigroup/Inova
Virginia Medicaids via ISHN - Coventry
Virginia Medicaids via ISHN - Majestacare
Virginia Medicaids via ISHN - Optima/Sentara
Virginia Medicaids via ISHN - Virginia Premier

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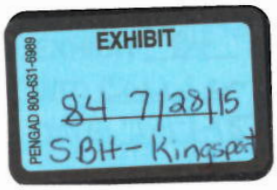

Woodridge Psychiatric Hospital
Key Operating Indicators
For the Period Ended June 30, 2014

MONTH OF JUNE						TWELVE MONTHS YEAR TO DATE				
Actual	Budget	Bud Var	Prior Yr	PY Var		Actual	Budget	Bud Var	Prior Yr	PY Var
					Operating Statistics (excl Long-Term Care)					
71	60	17.4%	62	15.1%	Average Daily Census	64	62	3.1%	61	5.6%
84.2%	71.8%	17.4%	66.8%	26.0%	Occupancy Percent	76.4%	74.1%	3.1%	66.1%	15.7%
2,123	1,809	17.4%	1,845	15.1%	Patient Days	23,426	22,726	3.1%	22,182	5.6%
357	301	18.6%	307	16.3%	Admissions	4,061	3,788	7.7%	3,825	6.7%
2,141	1,847	15.9%	1,891	13.2%	Adjusted Patient Days	23,671	23,177	2.1%	22,738	4.1%
360	307	17.1%	315	14.4%	Adjusted Admissions	4,124	3,863	6.7%	3,921	5.2%
375	457	-18.0%	449	-16.5%	Outpatient Visits	4,482	5,434	-17.5%	5,378	-16.7%
62	51	21.6%	82	-24.4%	ED Visits	740	663	11.6%	685	8.0%
					Revenue By Source					
18.3%	21.2%	-2.9%	21.2%	-2.9%	Medicare	18.8%	22.4%	-3.6%	22.4%	-3.6%
12.9%	11.8%	1.1%	11.8%	1.2%	Managed Medicare	12.2%	10.1%	2.1%	10.1%	2.1%
2.0%	0.9%	1.0%	0.9%	1.0%	Medicaid	1.6%	1.7%	-0.1%	1.7%	-0.1%
28.6%	42.0%	-13.4%	42.8%	-14.2%	TennCare	26.3%	46.5%	-20.2%	46.7%	-20.4%
6.3%	11.3%	-4.9%	10.9%	-4.6%	Blue Cross	9.4%	9.7%	-0.3%	9.7%	-0.3%
1.5%	4.2%	-2.7%	4.2%	-2.7%	United - River Valley	1.5%	2.3%	-0.8%	2.3%	-0.7%
3.9%	5.2%	-1.3%	5.2%	-1.3%	Managed Care / Commercial	4.1%	4.9%	-0.8%	4.9%	-0.8%
24.0%	1.2%	22.8%	0.9%	23.2%	Charity / Self Pay	23.9%	0.7%	23.2%	0.7%	23.2%
2.6%	2.2%	0.4%	2.1%	0.4%	Other Patient Revenue	2.1%	1.6%	0.5%	1.6%	0.5%
100.0%	100.0%		100.0%		Total Gross Patient Revenue	100.0%	100.0%		100.0%	
$2,463	$2,492	-1.1%	$2,334	5.5%	IP Revenue per Patient Day	$2,480	$2,493	-0.5%	$2,355	5.3%
$117	$206	-43.4%	$240	-51.4%	OP Revenue per Outpatient Visit	$135	$207	-34.5%	$244	-44.4%
$981	$677	44.9%	$678	44.6%	Operating Revenue per Adjusted Patient Day	$745	$676	10.2%	$707	5.3%
$648	$648	0.1%	$691	6.2%	Operating Expense per Adjusted Patient Day	$654	$626	4.4%	$668	2.2%
$5,833	$4,068	43.4%	$4,076	43.1%	Operating Revenue per Adjusted Admission	$4,275	$4,054	5.5%	$4,102	4.2%
$3,854	$3,896	1.1%	$4,152	7.2%	Operating Expense per Adjusted Admission	$3,753	$3,757	0.1%	$3,875	3.2%
35.7%	22.5%	58.9%	23.7%	50.8%	Net Revenue % of Gross Revenue	25.5%	22.6%	12.6%	25.2%	1.0%
$5,234	$3,367	55.4%	$3,323	57.5%	Net Revenue per Adjusted Admission	$3,628	$3,385	7.2%	$3,448	5.2%
					Labor Management					
214	218	1.9%	213	-0.3%	Employed Full Time Equivalents	207	219	5.4%	224	7.4%
1	1	-63.6%	0	-125.1%	Contract Full Time Equivalents	1	1	-42.5%	1	28.5%
215	219	1.7%	214	-0.5%	Total Full Time Equivalents	208	220	5.3%	225	7.5%
3.01	3.55	15.2%	3.39	11.2%	FTEs per Adjusted Occupied Bed (incl Cont Lbr)	3.21	3.46	7.2%	3.62	11.2%
102.1	121.7	16.1%	116.2	12.1%	Man Hours per Adjusted Admission (incl Cont Lbr)	105.0	118.1	11.3%	119.5	12.1%
$16.05	$16.16	0.7%	$16.57	3.1%	Average Hourly Rate (excl Cont Lbr)	$16.91	$16.14	-4.8%	$16.88	-0.1%
$33,389	$33,609	0.7%	$34,474	3.1%	Salary Expense per FTE (excl Cont Lbr)	$35,165	$33,564	-4.8%	$35,116	-0.1%
$2,511	$2,120	-18.5%	$2,428	-3.5%	Salary Wages/Benefits per Adjusted Admission	$2,114	$2,049	-3.2%	$2,184	3.2%
52.7%	71.2%	26.0%	81.6%	35.5%	Salary Wages/Benefits % of Net Revenue	65.6%	68.4%	4.2%	72.0%	8.9%
					Patient Resource Management					
5.97	0.00	100.0%	0.00	100.0%	Overall Medicare Average Length of Stay	4.61	0.00	100.0%	0.00	100.0%
5.95	6.01	1.1%	6.01	1.0%	Overall Average Length of Stay	5.74	6.00	4.3%	5.80	1.0%
0.97	0.86	12.2%	0.91	6.2%	Overall Medicare Case Mix Index	0.97	0.86	12.5%	0.91	6.8%
0.88	0.90	-2.8%	0.85	3.1%	Overall Case Mix Index	0.88	0.90	-2.5%	0.86	2.4%
0.00	0.00	0.0%	0.00	0.0%	Acute Medicare Case Mix Index	0.00	0.00	0.0%	0.00	0.0%
0.00	0.00	0.0%	0.00	0.0%	Acute Overall Case Mix Index	0.00	0.00	0.0%	0.00	0.0%
1.2%	7.4%	83.6%	9.2%	86.8%	Supply Expense % of Net Revenue	5.9%	7.3%	20.0%	7.0%	15.7%
$64	$250	74.6%	$305	79.1%	Supply Expense per Adjusted Admission	$213	$248	14.3%	$240	11.3%

SBH-KINGSPORT 002009

Woodridge Psychiatric Hospital
Statement of Revenue and Expense
For the Period Ended June 30, 2014

MONTH OF JUNE Actual	Budget	Bud Var	Prior Yr	PY Var		TWELVE MONTHS YEAR TO DATE Actual	Budget	Bud Var	Prior Yr	PY Var
					Patient Revenue					
5,229,646	4,507,630	16.0%	4,306,151	21.4%	Inpatient Revenue	58,085,025	56,653,705	2.5%	52,246,602	11.2%
43,757	94,253	-53.6%	107,866	-59.4%	Outpatient Revenue	606,945	1,123,753	-46.0%	1,310,612	-53.7%
5,273,403	4,601,883	14.6%	4,414,017	19.5%	Total Gross Patient Revenue	58,691,970	57,777,458	1.6%	53,557,214	9.6%
					Deductions from Revenue					
2,038,497	2,433,160	16.2%	2,359,906	13.6%	Contractual Adjustments	28,055,703	30,464,673	7.9%	26,794,689	-4.7%
1,099,935	1,065,336	-3.2%	968,795	-13.4%	Charity	14,494,304	13,375,482	-8.4%	12,497,985	-16.0%
28,670	64,800	55.8%	36,534	21.5%	Contra Revenue - Charity	723,153	813,042	11.1%	706,036	-2.4%
182,069	3,879	-4594.2%	2,143	-8397.7%	Provision for Bad Debt	207,275	48,570	-326.8%	38,346	-440.5%
39,157	0	100.0%	0	100.0%	Uninsured Discount	250,219	0	100.0%	0	100.0%
9,389,328	3,567,175	5.0%	3,368,378	-0.6%	Total Deductions	43,730,655	44,701,767	2.2%	40,037,057	-9.2%
1,884,075	1,034,709	82.1%	1,045,639	80.2%	***Net Patient Service Revenue***	14,961,315	13,075,692	14.4%	13,520,157	10.7%
0	0	0.0%	0	0.0%	Premium Revenue	0	0	0.0%	0	0.0%
215,758	215,446	0.1%	237,015	-9.0%	Other Operating Revenue	2,667,125	2,585,060	3.2%	2,563,747	4.0%
215,758	215,446	0.1%	237,015	-9.0%	***Total Other Operating Revenue***	2,667,125	2,585,060	3.2%	2,563,747	4.0%
2,099,833	1,250,154	68.0%	1,282,654	63.7%	***Total Operating Revenue***	17,628,440	15,660,752	12.6%	16,083,905	9.6%
					Operating Expense					
587,134	602,533	2.6%	604,657	2.9%	Salaries	7,288,692	7,355,126	0.9%	7,861,827	7.3%
0	0	0.0%	0	0.0%	Provider Salaries	25,855	0	100.0%	0	100.0%
8,532	4,847	-76.0%	2,714	-214.4%	Contract Labor	94,370	58,969	-60.0%	121,404	22.3%
397,129	129,127	-207.5%	246,240	-61.3%	Employee Benefits	2,402,435	1,533,484	-56.7%	1,753,402	-37.0%
205,294	223,070	8.0%	131,823	-55.7%	Fees	2,879,468	2,673,476	-7.7%	2,570,116	-12.0%
22,873	76,728	70.2%	95,890	76.1%	Supplies	877,176	958,670	8.5%	940,293	6.7%
10,850	16,419	33.9%	12,036	9.9%	Utilities	152,504	158,214	3.6%	152,010	-0.3%
42,575	26,976	-57.8%	17,267	-146.6%	Other Expense	338,512	344,948	1.9%	235,108	-44.0%
0	0	0.0%	0	0.0%	Medical Costs	0	0	0.0%	0	0.0%
55,338	60,156	8.0%	138,266	60.0%	Depreciation	717,072	732,926	2.2%	857,915	16.4%
0	0	0.0%	0	0.0%	Amortization	0	0	0.0%	0	0.0%
57,503	57,503	0.0%	57,696	0.3%	Interest & Taxes	699,622	699,624	0.0%	701,966	0.3%
1,387,228	1,197,360	-15.9%	1,306,590	-6.2%	***Total Operating Expense***	15,475,705	14,515,438	-6.6%	15,194,039	-1.9%
712,605	52,794	1249.8%	(23,936)	3077.2%	***Net Operating Income before Support Allocation***	2,152,734	1,145,314	88.0%	889,866	141.9%
81,616	81,616	0.0%	88,503	7.8%	Support Allocation - Salaries, Contract Labor & Benefits	991,536	991,536	0.0%	1,071,722	7.5%
73,079	73,079	0.0%	77,083	5.2%	Support Allocation - Other	906,001	906,001	0.0%	948,949	4.5%
557,911	(101,900)	647.5%	(189,521)	394.4%	***Net Operating Income after Support Allocation***	255,198	(752,222)	133.9%	(1,130,805)	122.6%
0	0	0.0%	0	0.0%	Net Investment Income	0	0	0.0%	0	0.0%
0	0	0.0%	0	0.0%	Realized Gain on Investments	0	0	0.0%	0	0.0%
0	0	0.0%	0	0.0%	Gain / (Loss) from Affiliates	0	0	0.0%	0	0.0%
0	0	0.0%	0	0.0%	Gain / (Loss) on Disposal	0	0	0.0%	0	0.0%
0	0	0.0%	0	0.0%	Loss on Extinguishment of LTD / Derivatives	0	0	0.0%	0	0.0%
0	0	0.0%	0	0.0%	Minority Interest	0	0	0.0%	0	0.0%
0	0	0.0%	0	0.0%	Taxes - Non Operating	0	0	0.0%	0	0.0%
(104,508)	0	100.0%	(93,816)	-11.4%	Incentive Pay	(109,284)	0	100.0%	(94,558)	-15.6%
(3,577)	0	100.0%	0	100.0%	Other Non Operating Income / (Expense)	(46,793)	0	100.0%	0	100.0%
(108,085)	0	100.0%	(93,816)	-15.2%	***Total Non Operating Income / (Expense)***	(156,077)	0	100.0%	(94,558)	-65.1%
449,826	(101,900)	541.4%	(283,337)	258.8%	***Total Revenue Over Expense Before CFV of Derivatives***	99,121	(752,222)	113.2%	(1,225,363)	108.1%
0	0	0.0%	0	0.0%	Change in Fair Value of Interest Rate Swaps	0	0	0.0%	0	0.0%
0	0	0.0%	0	0.0%	Gain / (Loss) in Swaption / Call Option	0	0	0.0%	0	0.0%
449,826	(101,900)	541.4%	(283,337)	258.8%	***Total Excess Revenue Over Expense***	99,121	(752,222)	113.2%	(1,225,363)	108.1%
0	0	0.0%	0	0.0%	Net Unrealized Gain / (Loss) on Investments	0	0	0.0%	0	0.0%
449,826	(101,900)	541.4%	(283,337)	258.8%	***Increase in Unrestricted Net Assets Before Change in Accounting Principle***	99,121	(752,222)	113.2%	(1,225,363)	108.1%
0	0	0.0%	0	0.0%	Cumulative Effect of Change in Accounting Principle	0	0	0.0%	0	0.0%
449,826	(101,900)	541.4%	(283,337)	258.8%	***Total Increase in Unrestricted Net Assets***	99,121	(752,222)	113.2%	(1,225,363)	108.1%
717,361	170,454	320.9%	78,210	817.2%	***EBITDA before Support Allocation***	3,413,351	2,577,864	32.4%	2,355,188	44.9%
154,694	154,694	0.0%	165,586	-6.6%	***Support Allocation***	1,897,536	1,897,536	0.0%	2,020,671	-6.1%
562,667	15,759	3470.4%	(87,375)	744.0%	***EBITDA after Support Allocation***	1,515,815	680,328	122.8%	334,517	353.1%

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Woodridge Psychiatric Hospital
Key Operating Indicators
For the Period Ended May 31, 2015

MONTH OF MAY						ELEVEN MONTHS YEAR TO DATE				
Actual	Budget	Bud Var	Prior Yr	PY Var		Actual	Budget	Bud Var	Prior Yr	PY Var
					Operating Statistics (excl Long-Term Care)					
75	60	25.9%	68	11.3%	Average Daily Census	71	59	20.2%	64	12.3%
89.5%	71.0%	25.9%	80.4%	11.3%	Occupancy Percent	85.0%	70.7%	20.2%	75.7%	12.3%
2,330	1,850	25.9%	2,094	11.3%	Patient Days	23,933	19,908	20.2%	21,303	12.3%
426	308	38.3%	389	9.5%	Admissions	4,320	3,318	30.2%	3,724	16.0%
2,347	1,876	25.2%	2,113	11.1%	Adjusted Patient Days	24,129	20,142	19.8%	21,530	12.1%
429	312	37.4%	393	9.3%	Adjusted Admissions	4,355	3,357	29.7%	3,764	15.7%
361	436	-17.2%	398	-9.3%	Outpatient Visits	4,361	3,978	9.6%	4,107	6.2%
8	57	-86.0%	76	-89.5%	ED Visits	634	611	3.8%	678	-6.5%
					Revenue By Source					
15.1%	18.0%	-2.9%	20.3%	-5.2%	Medicare	16.2%	18.0%	-1.9%	18.8%	-2.7%
15.6%	12.6%	3.0%	8.8%	6.8%	Managed Medicare	14.4%	12.6%	1.8%	12.2%	2.3%
1.8%	1.5%	0.3%	2.0%	-0.1%	Medicaid	1.7%	1.5%	0.2%	1.6%	0.1%
25.0%	50.2%	-25.3%	28.9%	-3.9%	TennCare	27.3%	50.2%	-23.0%	26.1%	1.2%
11.1%	9.2%	1.8%	9.5%	1.5%	Blue Cross	9.4%	9.2%	0.1%	9.7%	-0.3%
1.3%	1.6%	-0.2%	1.4%	-0.1%	United - River Valley	1.8%	1.6%	0.2%	1.5%	0.3%
4.4%	4.3%	0.2%	2.3%	2.2%	Managed Care / Commercial	3.4%	4.3%	-0.9%	4.1%	-0.7%
24.5%	0.6%	23.9%	24.1%	0.4%	Charity / Self Pay	24.6%	0.6%	24.0%	23.9%	0.6%
1.2%	1.9%	-0.7%	2.6%	-1.5%	Other Patient Revenue	1.3%	1.9%	-0.6%	2.0%	-0.7%
100.0%	100.0%		100.0%		Total Gross Patient Revenue	100.0%	100.0%		100.0%	
$2,462	$2,631	-6.4%	$2,475	-0.5%	IP Revenue per Patient Day	$2,579	$2,631	-2.0%	$2,481	3.9%
$119	$155	-23.3%	$121	-1.7%	OP Revenue per Outpatient Visit	$116	$155	-25.2%	$137	-15.6%
$705	$703	0.3%	$577	22.2%	Operating Revenue per Adjusted Patient Day	$666	$710	-6.1%	$721	-7.6%
$705	$751	6.2%	$700	-0.7%	Operating Expense per Adjusted Patient Day	$692	$738	6.2%	$735	5.9%
$3,857	$4,224	-8.7%	$3,106	24.2%	Operating Revenue per Adjusted Admission	$3,691	$4,256	-13.3%	$4,126	-10.5%
$3,854	$4,513	14.6%	$3,767	-2.3%	Operating Expense per Adjusted Admission	$3,834	$4,426	13.4%	$4,266	8.8%
24.5%	22.4%	9.6%	21.3%	15.3%	Net Revenue % of Gross Revenue	21.8%	22.5%	-3.0%	24.5%	-10.8%
$3,305	$3,539	-6.6%	$2,636	16.5%	Net Revenue per Adjusted Admission	$3,121	$3,557	-12.2%	$3,475	-10.2%
					Labor Management (excl Long-Term Care)					
222	208	-7.0%	210	-5.9%	Employed Full Time Equivalents	222	207	-7.3%	207	-7.6%
1	2	66.0%	0	-58.2%	Contract Full Time Equivalents	1	2	61.8%	1	37.0%
223	209	-6.5%	210	-5.9%	Total Full Time Equivalents	223	209	-6.7%	208	-7.4%
2.94	3.46	14.9%	3.09	4.6%	FTEs per Adjusted Occupied Bed (incl Cont Lbr)	3.08	3.47	10.9%	3.23	4.2%
91.8	118.4	22.5%	94.7	3.1%	Man Hours per Adjusted Admission (incl Cont Lbr)	97.7	118.8	17.7%	105.3	7.2%
$19.10	$20.02	4.8%	$19.29	1.0%	Average Hourly Rate (excl Cont Lbr)	$18.96	$19.64	3.5%	$19.25	1.5%
$39,724	$41,645	4.6%	$40,122	1.0%	Salary Expense per FTE (excl Cont Lbr)	$39,434	$40,859	3.5%	$40,038	1.5%
$2,489	$3,033	17.6%	$2,443	-2.3%	Labor Exp (excl Phys) per Adjusted Admission	$2,544	$2,932	13.2%	$2,578	1.3%
75.6%	85.7%	11.8%	86.1%	12.2%	Labor Exp % of Net Revenue	81.5%	82.4%	1.1%	74.4%	-9.6%
					Patient Resource Management					
4.31	4.81	10.4%	5.68	26.7%	Overall Medicare Average Length of Stay	5.49	4.84	-13.5%	4.46	-23.0%
5.47	6.01	8.9%	5.38	-1.6%	Overall Average Length of Stay	5.54	6.00	7.7%	5.72	3.2%
0.99	0.97	1.9%	0.98	0.7%	Overall Medicare Case Mix Index	0.99	0.97	2.0%	0.97	2.2%
0.90	0.88	1.8%	0.90	-0.1%	Overall Case Mix Index	0.90	0.88	2.4%	0.88	2.8%
0.00	0.00	0.0%	0.00	0.0%	Acute Medicare Case Mix Index	0.00	0.00	0.0%	0.00	0.0%
0.00	0.00	0.0%	0.00	0.0%	Acute Overall Case Mix Index	0.00	0.00	0.0%	0.00	0.0%
6.1%	7.2%	14.7%	7.5%	17.9%	Supply Expense % of Net Revenue	7.0%	7.3%	3.8%	6.5%	-7.2%
$203	$255	20.4%	$212	4.3%	Supply Expense per Adjusted Admission	$219	$259	15.6%	$227	3.7%

SBH-KINGSPORT 002012

Woodridge Psychiatric Hospital

Statement of Revenue and Expense

For the Period Ended May 31, 2015

MONTH OF MAY						ELEVEN MONTHS YEAR TO DATE				
Actual	Budget	Bud Var	Prior Yr	PY Var		Actual	Budget	Bud Var	Prior Yr	PY Var
					Patient Revenue					
5,736,202	4,887,985	17.8%	5,183,076	10.7%	Inpatient Revenue	61,720,545	52,377,028	17.8%	52,855,379	16.8%
42,828	67,410	-36.5%	48,034	-10.8%	Outpatient Revenue	504,556	615,428	-18.0%	563,188	-10.4%
5,779,030	4,935,395	17.1%	5,231,110	10.5%	Total Gross Patient Revenue	62,225,101	52,992,456	17.4%	53,418,567	16.5%
					Deductions from Revenue					
3,054,128	2,599,375	-17.5%	2,869,689	-6.4%	Contractual Adjustments	32,950,746	27,780,349	-18.6%	26,016,206	-26.7%
1,206,439	1,142,544	-5.6%	1,183,792	-1.9%	Charity	14,905,313	12,267,754	-21.5%	13,394,370	-11.3%
82,512	68,602	-20.3%	44,882	-83.8%	Contra Revenue - Charity	602,665	736,595	18.2%	694,483	13.2%
15,072	3,948	-281.7%	2,210	-582.0%	Provision for Bad Debt	71,930	42,394	-69.7%	25,206	-185.4%
2,435	15,797	84.6%	16,982	85.7%	Uninsured Discount	100,623	225,075	55.3%	211,062	52.3%
4,360,585	3,830,266	-13.8%	4,117,555	-5.9%	Total Deductions	48,631,277	41,052,167	-18.5%	40,341,327	-20.5%
1,418,445	1,105,129	28.4%	1,113,555	27.4%	***Net Patient Service Revenue***	13,593,824	11,940,289	13.8%	13,077,240	4.0%
0	0	0.0%	0	0.0%	Premium Revenue	0	0	0.0%	0	0.0%
236,860	214,022	10.7%	105,860	123.8%	Other Operating Revenue	2,480,216	2,352,652	5.4%	2,451,366	1.2%
236,860	214,022	10.7%	105,860	123.8%	***Total Other Operating Revenue***	2,480,216	2,352,652	5.4%	2,451,366	1.2%
1,655,325	1,319,151	25.5%	1,219,415	35.7%	***Total Operating Revenue***	16,074,040	14,292,940	12.5%	15,528,606	3.5%
					Operating Expense					
700,717	687,704	-1.9%	633,136	-10.7%	Salaries	7,525,861	7,269,418	-3.5%	6,701,558	-12.3%
0	0	0.0%	0	0.0%	Provider Salaries	0	0	0.0%	25,855	100.0%
4,731	14,475	67.3%	1,999	-136.7%	Contract Labor	79,751	158,250	49.6%	85,838	7.1%
296,639	180,456	-64.4%	239,757	-23.7%	Employee Benefits	2,762,662	1,727,249	-59.9%	2,005,306	-37.8%
249,872	180,565	-38.4%	203,530	-22.8%	Fees	2,348,443	1,901,842	-23.5%	2,674,174	12.2%
87,131	79,594	-9.5%	83,302	-4.6%	Supplies	951,873	869,254	-9.5%	854,303	-11.4%
10,405	13,231	21.4%	10,156	-2.4%	Utilities	147,851	161,750	8.6%	141,654	-4.4%
66,710	60,365	-10.5%	26,868	-148.1%	Other Expense	637,810	621,214	-2.7%	295,937	-115.5%
0	0	0.0%	0	0.0%	Medical Costs	0	0	0.0%	0	0.0%
72,915	44,521	-63.8%	58,624	-24.4%	Depreciation	582,973	557,612	-4.5%	661,734	11.9%
0	0	0.0%	0	0.0%	Amortization	0	0	0.0%	0	0.0%
59,189	59,189	0.0%	59,420	0.4%	Interest & Taxes	639,621	639,621	0.0%	642,119	0.4%
1,548,309	1,320,100	-17.3%	1,316,814	-17.6%	***Total Operating Expense***	15,676,845	13,906,209	-12.7%	14,088,478	-11.3%
107,016	(950)	-	(97,399)	209.9%	***Net Operating Income before Support Allocation***	397,195	386,731	2.7%	1,440,129	-72.4%
70,224	64,581	-8.7%	84,287	16.7%	Support Allocation - Salaries, Contract Labor & Benefits	711,382	687,833	-3.4%	909,920	21.8%
35,367	24,552	-44.1%	77,983	54.6%	Support Allocation - Other	310,750	262,478	-18.4%	632,922	62.7%
1,425	(90,082)	101.6%	(259,668)	100.5%	***Net Operating Income after Support Allocation***	(624,938)	(563,580)	-10.9%	(302,713)	-106.4%
0	0	0.0%	0	0.0%	Net Investment Income	0	0	0.0%	0	0.0%
0	0	0.0%	0	0.0%	Realized Gain on Investments	0	0	0.0%	0	0.0%
0	0	0.0%	0	0.0%	Gain / (Loss) from Affiliates	0	0	0.0%	0	0.0%
0	0	0.0%	0	0.0%	Gain / (Loss) on Disposal	0	0	0.0%	0	0.0%
0	0	0.0%	0	0.0%	Loss on Extinguishment of LTD / Derivatives	0	0	0.0%	0	0.0%
0	0	0.0%	0	0.0%	Minority Interest	0	0	0.0%	0	0.0%
0	0	0.0%	0	0.0%	Taxes - Non Operating	0	0	0.0%	0	0.0%
0	0	0.0%	0	0.0%	Incentive Pay	0	0	0.0%	(4,776)	100.0%
(4,679)	0	100.0%	(10,838)	56.8%	Other Non Operating Income / (Expense)	(20,332)	0	100.0%	(43,216)	53.0%
(4,679)	0	100.0%	(10,838)	56.8%	***Total Non Operating Income / (Expense)***	(20,332)	0	100.0%	(47,992)	57.6%
(3,254)	(90,082)	96.4%	(270,506)	98.8%	***Total Revenue Over Expense Before CFV of Derivatives***	(645,270)	(563,580)	-14.5%	(350,705)	-84.0%
0	0	0.0%	0	0.0%	Change in Fair Value of Interest Rate Swaps	0	0	0.0%	0	0.0%
0	0	0.0%	0	0.0%	Gain / (Loss) in Swaption / Call Option	0	0	0.0%	0	0.0%
(3,254)	(90,082)	96.4%	(270,506)	98.8%	***Total Excess Revenue Over Expense***	(645,270)	(563,580)	-14.5%	(350,705)	-84.0%
0	0	0.0%	0	0.0%	Net Unrealized Gain / (Loss) on Investments	0	0	0.0%	0	0.0%
(3,254)	(90,082)	96.4%	(270,506)	98.8%	***Increase in Unrestricted Net Assets Before Change in Accounting Principle***	(645,270)	(563,580)	-14.5%	(350,705)	-84.0%
0	0	0.0%	0	0.0%	Cumulative Effect of Change in Accounting Principle	0	0	0.0%	0	0.0%
(3,254)	(90,082)	96.4%	(270,506)	98.8%	***Total Increase in Unrestricted Net Assets***	(645,270)	(563,580)	-14.5%	(350,705)	-84.0%
234,441	102,761	128.1%	9,807	2290.5%	***EBITDA before Support Allocation***	1,599,457	1,583,964	1.0%	2,695,990	-40.7%
105,591	89,132	18.5%	162,269	-34.9%	***Support Allocation***	1,022,132	950,311	7.6%	1,742,842	-41.4%
128,850	13,628	845.5%	(152,462)	184.5%	***EBITDA after Support Allocation***	577,324	633,653	-8.9%	953,148	-39.4%

SBH-KINGSPORT 002013

SUPPLEMENTAL EXHIBIT H

Woodridge Inpatient Days by Unit

	September	October	November	December	January	February	March	April	May	June
7796 - Adult Psych - Poplar	701	703	700	632	725	586	715	650	729	671
7801 - Adolescent Psych - Willow	293	276	315	233	324	219	327	321	306	298
7802 - Geropsych - Spruce	363	407	400	416	401	354	398	390	411	386
7803 - Psych - ITU - Cedar	833	841	850	850	859	742	837	794	884	830

HIGHLY CONFIDENTIAL

SBH-KINGSPORT, LLC
CON Application
CN1312-050

Harsh K. Trivedi, MD, MBA

I. Background, Training and Experience

I am a physician licensed to practice medicine in the State of Tennessee. I am trained in psychiatry, with a specialization in child and adolescent psychiatry. I practice at Vanderbilt Psychiatric Hospital in Nashville, where I regularly evaluate and treat hospitalized psychiatric patients.

I received my medical degree from Mount Sinai School of Medicine in New York, NY, completed a residency at Hillside Hospital, Albert Einstein College of Medicine in Glen Oaks, NY and completed a fellowship at Children's Hospital Boston, Harvard Medical School, Boston, MA. I am board-certified in psychiatry by the American Board of Psychiatry and Neurology, with a subspecialty certification in child and adolescent psychiatry.

I have previously taught at Harvard Medical School and Brown Medical School and since 2010, I have been an Associate Professor at Vanderbilt Medical School. I am Editor-in-Chief of *Child and Adolescent Psychiatric Clinics of North America.* This is a peer-reviewed journal that publishes original articles relating to all aspects of child and adolescent psychiatry.

I have a Masters in Business Administration from the Haslam School of Business at the University of Tennessee. I have also completed a Congressional Fellowship related to health policy in the United States Senate.

From 2007 to 2010, I served as the Director of Adolescent Services at Brown Medical School affiliated Bradley Hospital in East Providence, Rhode Island. In this role, I was responsible for the administrative, clinical, and financial oversight of the department. This included a variety of clinical inpatient, partial hospital, and intensive outpatient services. I managed over 100 employees (85 FTEs) at a 60-bed psychiatric hospital for youth. During this time, I was on the leadership team that oversaw the planning, fundraising, and construction of a new $30 million inpatient psychiatric hospital. This included hiring and on-boarding new staff and providers, developing clinical programming, and budget oversight. Relevant to this CON application, Bradley Hospital is home to the Center for Autism and Developmental Disabilities (CADD) program. This is a specialized inpatient program specifically dedicated to the evaluation and treatment of youth with developmental disorders, intellectual disabilities, and autism spectrum disorders.

I am currently Executive Director and Chief Medical Officer for Vanderbilt Behavioral Health. In this role, I am responsible for the administrative, clinical, and financial oversight of the Vanderbilt Psychiatric Hospital in Nashville, TN. This is an 88-bed facility, with approximately 3500 annual discharges. We also offer partial hospitalization and operate a community mental health center. We conduct nearly 70,000 outpatient visits each year,

including 15% being co-located within medical/surgical sites, and 30,000 of which occur in local Davidson county schools. We also provide emergency psychiatric assessments of patients in crisis in both the Vanderbilt University Hospital Emergency Room and the Vanderbilt Children's Hospital Emergency Room.

I am a member of several local, regional and national committees that are relevant to the matters at issue here. A list of all my professional work, along with more detailed information about my education, training, background, and publications, are contained in my curriculum vitae, which is attached and incorporated by reference.

While I work at Vanderbilt University Medical Center and information is provided regarding Vanderbilt Behavioral Health services to establish expertise, all opinions presented here or in my testimony are expressly mine alone. They do not necessarily reflect the views of Vanderbilt University Medical Center.

II. Materials Reviewed

I have been asked to review the proposal by Strategic Behavioral Health (SBH) to build a new, freestanding 72-bed psychiatric hospital in Kingsport, Tennessee. I have reviewed the following materials in preparing my report in this case:

SBH-Kingsport CON Application
SBH-Kingsport Supplemental 1
SBH-Kingsport Supplemental 2
SBH-Kingsport Transcript of CON application June 25, 2014
Report of Daniel J. Sullivan
Deposition of Mr. Doyle
Deposition of Mr. Shaheen
MSHA Responses to SBH-Kingsport First Set of Interrogatories
SBH-Kingsport Responses to MSHA First Set of Interrogatories

I have also personally visited Woodridge Psychiatric Hospital in Johnson City, Tennessee and met with members of the hospital's staff. I expect to review additional materials as they are made available to me, including the deposition of Mr. Sullivan and the report of Deborah Kolb Collier, and I reserve the right to supplement and modify my opinions based on the additional information I review.

III. Opinions

A. Levels of Care

To understand the need for psychiatric services in a community and how to best plan for the provision of such services, it is important to understand the various levels of psychiatric care. These levels of care are analogous to the levels of care in other specialties of medicine. For example, a patient presenting to the hospital with a massive stroke will need to receive care in a neuro-intensive care unit (ICU), with step down to an inpatient medical unit, followed by step down to an acute rehabilitation facility, and then be discharged home with outpatient physical therapy services. Similarly, patients in psychiatric crisis progress through treatment with different levels of care, as summarized in Table 1.

Table 1: Levels of Psychiatric Care

Level of Care	**Inpatient**	**Partial Hospital**	**Intensive Outpatient**	**Outpatient**	**Crisis Stabilization**	**Residential/ Therapeutic Community**
Hours of contact/day	24 hours/day	6 hours/day	3 hours/day	1 hour/day	24 hours/day	24 hours/day
Duration of treatment	7 days	2 weeks	2-4 weeks	Months	3 days	Months
Severity of Illness	++++	+++	++	+	++++	Chronic +++
Least Restrictive	No	Yes	Yes	Yes	No	No
Cost of Care/Day	$$$$	$$$	$$	$	$$$	$$$$

There is a fundamental principle in behavioral health to provide care in the least restrictive treatment setting. This principle acknowledges that a patient's civil liberty and freedom should not be limited unless there is imminent risk for harm and/or lesser levels of care are insufficient to adequately meet the patient's need for care. When patients in psychiatric crisis are evaluated, whether in an emergency room or by mobile crisis teams, this "least restrictive alternative" is the guiding principle when making treatment recommendations.

The most restrictive level of care in psychiatry is inpatient hospitalization. This requires treatment in a unit that is generally locked. This type of care is reserved for those with the most imminent risk for self-harm or harm to others. These patients have the greatest severity of mental illness with acuity of presentation. Inpatient hospitalization is best viewed as a last resort, or as a way to stabilize a patient who is experiencing an acute psychiatric crisis.

Partial hospitalization programs are less restrictive in that patients are able to live at home and come in for treatment daily. These programs generally provide six hours of therapeutic interaction daily. They are utilized either as a stepdown from inpatient or to prevent inpatient

hospitalization for patients who are decompensating, but do not need to be in an inpatient unit. Average length of treatment is two weeks and daily cost of the program is approximately half that of an inpatient unit. This is a particularly attractive option for those who are employed or attending college, as patients can attend without missing important life obligations.

Intensive outpatient (IOP) is a step below partial hospitalization. IOPs generally provide three hours of therapeutic interaction daily. They are deemed less restrictive because patients are able to live at home and come in for treatment daily. IOPs are utilized either as a stepdown from inpatient or partial hospitalization; or to prevent inpatient hospitalization for patients who are decompensating, but do not need to be on an inpatient unit. Average length of treatment is 2-4 weeks and daily cost of the program is approximately one-fourth that of an inpatient unit. Being able to better catch patients who are beginning to decompensate with IOP services is better for the patient and limits unnecessary utilization of inpatient or even partial hospital services.

Outpatient care is a broad category generally encompassing psychiatric services that occur in one ambulatory appointment per day. Patients live at home, lead their routine lives, and come for an appointment in the same way that they would see their primary care provider or other medical subspecialist.

Crisis stabilization units (CSU) are an important level of care as they provide approximately 72 hours of acute therapeutic intervention in a 24 hours/day format to help patients quickly recover. 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 for past two days). The best analogy to general medicine is the idea of observation status versus inpatient status for medical admissions. The medical patients on observation status are akin to psychiatric patients who are cared for in a CSU. By the end of 72 hours, a decision must be made whether the patient can be discharged or whether they need inpatient hospitalization. Tennessee currently has some adult CSU beds with some pediatric CSU beds in the planning stages. 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.

The final level of care to consider is residential (also termed therapeutic community for substance abuse patients). There are patients for whom even a 7-day inpatient hospitalization will not be sufficient. These patients benefit from care in a residential setting, akin to being admitted to a short-term or long-term rehabilitation facility after a medical stay for a hip replacement or after a massive stroke. This is not considered least restrictive as patients are out of home; however, it is less restrictive than an inpatient unit, as residential treatment centers are more voluntary and offer greater freedoms. Residential treatment is reserved for those with more chronic presentations or those who have failed multiple inpatient hospitalizations.

B. Simply Building Additional Inpatient Beds Is Not the Solution

From time to time, inpatient beds may not be immediately available for all those who need them. In fact, the report of Mr. Sullivan identifies several days when one or more of the units at Woodridge Psychiatric Hospital had limited bed availability. However, this does not mean that the solution to any such temporary shortages is the construction of more inpatient beds. Many factors other than licensed bed supply can impact bed availability. For example, bed availability can be affected by patients staying longer than expected. The average length of stay on inpatient units in Tennessee is 7 days, with shorter duration for those admitted for detoxification due to substance abuse. Patients can and often do continue to occupy inpatient beds past the time strictly necessary to stabilize and treat their psychiatric conditions. This occurs, for example, when a child is kept in an inpatient setting while awaiting a residential bed, or an elderly patient requires discharge to a skilled nursing unit, but no such beds are immediately available. There are also patients who are admitted to inpatient units, or are kept longer in inpatient units than necessary, because of the lack of treatment options for lower levels of care (e.g., strong outpatient programs).

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. As our State Commissioner of Mental Health Douglas Varney stated previously in regard to the closure of beds at Lakeshore: "It's a matter of deciding how to use limited resources in an effective way. We believe people can be better served in the community [whether it's for] psychiatric inpatient care or other kinds of services we operate. Reinvestment into the community is unprecedented." (http://www.mentalhealthweeklynews.com/m-article-detail/tenn-hospital-closure-paves-way-for-mh-community-reinvestment-.aspx).

It is important to note that margins in behavioral health are quite thin. The largest margins in behavioral health occur for more acute services, particularly inpatient and partial hospitalization services. By contrast, outpatient services, while vital to the system of care as discussed above, tend to be less profitable or even unprofitable. An organization which wants to be a good steward of limited healthcare resources must utilize revenues from inpatient services to help keep afloat less profitable service lines, which ultimately reach many more patients.

The SBH-Kingsport application provides virtually no information about outpatient services and mainly emphasizes the 72 new inpatient beds that would be added if the project is approved. Adding these beds will not address the needs for less restrictive treatment options. These beds are duplicative of existing community resources. Moreover, to the extent SBH is claiming to address a need because of high occupancy rates at existing providers, as noted above, a much more efficient and ultimately productive way to address any such capacity issues is through development of better outpatient and stepdown levels of care. 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 report of Mr. Sullivan also suggests that a new hospital should be constructed on the basis that there is not adequate geographic access for inpatient care. For example, at page 20 of his report he quotes a Regional Administrator for the Tennessee Department of Children's

Services stating that "a large portion of our population has to travel outside of their home county to receive the needed mental health care." But inpatient psychiatric care is a centralized service, meaning that it is not practical, feasible, or desirable to have inpatient psychiatric beds in every community or county. The geographic distribution of inpatient beds in the Tri-Cities provides access to residents of the area within a reasonable drive-time and is consistent with the geographic distribution of inpatient resources in other parts of Tennessee and elsewhere. Moreover, outpatient providers such as Frontier Health have established community access points which are geographically well-dispersed and form the foundation of a strong mental health system.

C. Current Economic Climate for Hospitals and Affordable Care Act

Tennessee hospitals face ongoing economic challenges. The State's decision (thus far) not to expand Medicaid coverage through the Affordable Care Act is placing additional and substantial burdens on Tennessee hospitals. As the rate of uninsured patients rises, many Tennessee hospitals are struggling to keep their doors open.

Nonprofit healthcare providers, like Woodridge Psychiatric Hospital, must perform a delicate balancing act to stay financially healthy. Insured inpatients generally provide the highest reimbursement. But as noted above, outpatient and other services, which are not necessarily lucrative, are important. Moreover, it is essential to provide care for all patients, not just those who are well-insured.

This context is important to consider as the state-operated psychiatric hospitals in Tennessee have closed beds. The closure of Lakeshore in East Tennessee and the closure of pediatric beds at Middle Tennessee Mental Health Institute have placed greater importance on Tennessee psychiatric hospitals, including Woodridge, that are willing to serve as safety net providers for their communities. The population of patients formerly treated at these hospitals is largely uninsured. Reimbursement for such patients is often inadequate and is not assured. Woodridge is performing an essential public service in caring for substantial numbers of uninsured patients that would formerly have been seen at Lakeshore.

Consistent with the company's historic performance at its existing facilities, SBH does not propose to treat significant numbers charity/indigent patients (5% according to their response to Interrogatory 11(d)). The 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, such as Woodridge. This is a recipe for financial stress and instability at Woodridge.

D. MSHA's Efforts to Improve Access to Mental Health Services via Outpatient/CSU

It is my understanding that there is a collaborative effort underway between Frontier Health and MSHA to create a Crisis Stabilization Unit (CSU) for adolescents. A number of providers across the state, including myself, participated in a children and youth crisis services planning committee convened by the Department of Mental Health and the Bureau of TennCare. There was support through that effort for the creation of CSU beds for youth. Tennessee has

such beds for adults, but none for children. The creation of the first pediatric CSU in the Tri-Cities area is an exciting and worthwhile endeavor.

MSHA is in the final planning stages of renovating a medical office building in Gray, Tennessee, that will serve as a 12-bed adolescent CSU. The CSU facility will be owned by MSHA and staffed and operated by Frontier Health physicians. The CSU will primarily treat adolescents, ages 11 to 17, and offer 72- to 96-hour admissions. The facility is expected to open in late 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. CSU facilities have successfully been run in a number of states as a method to reduce the number of patients requiring inpatient hospitalization.

The patient centered benefits of CSUs are 1) they are typically smaller facilities which allows them to be more geographically dispersed, drawing patients from their home catchment area, 2) they are voluntary in nature and thus less restrictive than an inpatient unit, 3) they are an effective solution to prevent inpatient hospitalization (see SAMHSA study https://store.samhsa.gov/shin/content/SMA14-4848/SMA14-4848.pdf), and 4) provide intensive services from highly trained staff to get patients back on track and out of crisis. The CSU model also provides assistance in linking patients with appropriate outpatient follow-up to improve health and functioning following the crisis. Moreover, multiple studies have found that there is a significant cost savings that can result from crisis services, due to reduced inpatient utilization, emergency department visits, and more appropriate use of community-based behavioral health services.

CSU units can significantly alleviate demand for inpatient beds as they provide greater access and can cycle many more patients through due to their shorter lengths of stay than traditional inpatient units. 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.

E. Cognitive vs. Non-Cognitive Programs

It is apparent from reviewing the SBH application that the proposed new hospital will not offer any new services that are not already available in the Tri-Cities. At the hearing and in Mr. Sullivan's report (see page 18), it has been suggested that SBH is "willing to accept" cognitively-impaired children, and that this provides a justification for approval. But if one is familiar with the nature of non-cognitive psychiatric treatment programs, and the nature of the proposed SBH facility, it is apparent that this is not a persuasive justification.

1) SBH's Suggested Non-Cognitive Based Program Is Insufficient to Meet the Highly Specific Needs of this Patient Population

In analyzing SBH's claim that it can accept and treat patients needing non-cognitive based programs, consider an appropriate analogy – a tertiary care center is either a Level I Trauma Center or it is not. No one would fathom Level II trauma center being willing to take Level I trauma patients (http://www.amtrauma.org/?page=traumalevels). Having taken part in the construction of the new Bradley Hospital in East Providence, Rhode Island, which has a true inpatient unit for the management of patients with developmental delays, let me first explain how a program for developmental delays is designed.

The Center for Autism and Developmental Disabilities at Bradley Hospital offers "unique and highly specialized clinical services for children and adolescents between the ages of 4 and 18, who present with serious behavioral disorders in addition to a developmental disability, such as, autism or intellectual disability. Successful treatment requires the involvement of many different types of professionals, including psychiatrists, pediatricians, nurses, psychologists, social workers, specialists in communication disorders, special education teachers, occupational therapists, physical therapists and milieu staff. Families also have the opportunity to participate in the center's genetics and neuroimaging" assessments (http://www.bradleyhospital.org/uploadedFiles/BRAD/Content/Programs_and_Services/CADD/CADD%20Handbook_2014.pdf). Treatment is offered within highly specialized services such as the Communication, Occupational and Sensory Treatment (COAST) Clinic which diagnoses physical, neurological, cognitive, behavioral, communication or sensory processing challenges. Treatment focuses on helping youth with:

- completion of self-care activities such as bathing, dressing or tooth brushing;
- participation in daily home activities, including morning and bedtime routines;
- ability to feed self and participate in mealtime routines;
- safe chewing and swallowing;
- meeting delays in developmental milestones;
- alterations in fine and gross motor development impacting coordination, strength, endurance and body awareness;
- and ability to communicate purposefully and intentionally

Keeping this in mind, I must confess that even with all of the wonderful expertise present on the Vanderbilt campus, I cannot and do not claim to be able to meaningfully evaluate and treat youth with developmental delays. Even with having the Kennedy Center on campus, having every medical specialist available, and even having ABA-certified therapists evaluating children in our inpatient unit with coverage by pediatric hospitalists, we are not fully equipped to

offer a true non-cognitive based program. We understand that to truly help these kids improve, you need to have the real thing; good intentions do not help kids get better.

The proposed SBH facility in Kingsport simply does not offer facilities and staffing that would be absolutely essential to providing a true non-cognitive based program. At best, SBH will offer treatment for patients with mild to moderate developmental delay or intellectual disabilities. But existing inpatient units, including Woodridge, can already manage such patients.

Thus, the SBH-Kingsport project does not broaden availability of services. The patients who are most in need of help are those with severe to profound impairments, for whom the SBH-Kingsport project will not be an option.

Crisis Stabilization Units (CSU)

Crisis Stabilization Units (CSU) offer 24/7/365 intensive, short-term stabilization for someone experiencing a mental health emergency and is willing to receive services. The average length of stay in a CSU is 3 days. The service is free of charge.

Services may include:

- Individual and/or family counseling and support;
- Medication management and administration;
- Stress management counseling;
- Individualized treatment plan development that empowers the consumer;
- Mental illness/substance abuse awareness/education; and
- Identification and development of natural support systems.

Note: Crisis Stabilization Services can only be accessed by referral from Mobile Crisis Services or Crisis Walk-In Services.

CSU LOCATIONS:

Frontier Health
Johnson City, TN
877-928-9062

Helen Ross McNabb
Knoxville, TN
865-541-6958

Volunteer Behavioral Health
Cookeville, TN
800-704-2651

Volunteer Behavioral Health
Chattanooga, TN
800-704-2651

Mental Health Cooperative
Nashville, TN
615-726-0125

Pathways of Tennessee
Jackson, TN
731-541-8330

Alliance Healthcare Services
Memphis, TN
901-577-9400

Cherokee Health Systems
Morristown, TN
423-586-5074 or 1-855-602-1082 (tollfree)

SBH-KINGSPORT 002026

East Tennessee State University
James H. Quillen College of Medicine
Department of Psychiatry and Behavioral Sciences • Box 70567 • Johnson City, Tennessee 37614-1707 • (423) 439-8010 • Fax: (423) 439-2210

Melanie M. Hill

June 24, 2014

Executive Director

Tennessee Health Services and Development Agency

Andrew Jackson Building, 9th Floor

502 Deaderick Street, Nashville TN 37243

Dear Ms. Hill,

I spoke with Mr. Mike Garone from Strategic Behavioral Services on the evening of 6/24/14 regarding the CON hearing for a psychiatric facility in Kingsport. My understanding is that the hearing is scheduled for 6/25/14 at 8:30 am. I am writing this letter at 11:30 pm on 6/24/14 because I want to make sure that the interests of the residents in the ETSU psychiatry training program are represented.

I am an Associate Professor of Psychiatry at ETSU in the Quillen College of Medicine. I am board certified in psychiatry and in psychosomatic medicine. I have served as the Residency Program Director for the ETSU Department of Psychiatry and Behavioral Sciences for the past 3 years. I was the Residency Program Director at Wake Forest University Behavioral Health in Winston-Salem, NC for 4 years between 2006 and 2010. I have spent 15 years in academic psychiatry and in resident education.

Unfortunately, I was not consulted regarding any letter sent from ETSU opposing this proposed psychiatric facility. On the contrary, our program is in desperate need of training sites and for alternative funding for our residency program. Even with funding from MSHA and from the Veteran's Administration at Mountain Home, we have not been able to place all of our residents this year in appropriate clinical learning sites. MSHA has indicated the desire and need to decrease the number of residents they fund, and, partially as result of that, we have decreased our overall resident complement numbers.

Recently, Dr. Jill McCarley resigned from the ETSU faculty to join the VA. Because of that, we have been forced to withdraw from staffing the only child and adolescent psychiatric unit in the area at Woodridge

Hospital. We simply do not have the child and adolescent resources to support this unit. This withdrawal has put the Woodridge child and adolescent unit in danger of closing due to a lack of child and adolescent psychiatrists and has placed our residency program in danger of not having appropriate child and adolescent rotations for our residents. If we do not have child and adolescent experiences, we will not qualify for accreditation and will be forced to close our residency program. Having child services through Strategic Behavioral Health would solve that problem.

My understanding is that Strategic Behavioral Health has partnered with medical schools in the past and intends to do so, if possible, with our department. Their proposed clinical services will not only benefit the area in terms of services and training offered, they will do so without significant overlap or competition with services offered at Woodridge 30 minutes away in Johnson City. In addition, the additional clinical services and educational opportunities proposed by Strategic Behavioral Health would be of enormous benefit to our training program and would fill a significant gap in the educational services available to us.

I have seen no evidence or data that opening a facility in Kingsport will threaten the existence of Woodridge. Even if that were true, the program and community would still benefit overall from having this resource in the area for child and adolescent treatment and training. Given the huge need for psychiatric services in the tri-cities area, I believe that opposing potential resources based on an unsubstantiated concern that it will financially threaten current facilities is misguided at best and unethical at worst.

I regret that I cannot attend the CON hearing. However, I am very confident that Dr. Jill McCarley is in a unique position to assess and represent the best interests of the community and our residency program. I support her perspective without reservation.

Best Regards,

Hal Elliott, MD
Associate Professor
Residency Program Director for Psychiatry and Med-Psych
Quillen College of Medicine
East Tennessee State University
423-439-2225
Fax: 423-439-2250

MOUNTAIN STATES HEALTH ALLIANCE

2015 COMMUNITY HEALTH NEEDS ASSESSMENT

INDIAN PATH MEDICAL CENTER

Published June 29, 2015

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Introduction

Mountain States Health Alliance (MSHA) is an integrated health care delivery system providing a comprehensive continuum of care to people in 29 counties in Tennessee, Virginia, Kentucky, and North Carolina. MSHA was formed after Johnson City Medical Center Hospital, Inc. acquired six Columbia/HCA hospitals in Northeast Tennessee on September 1, 1998; and was later renamed Mountain States Health Alliance in January 1999.

Today, MSHA is the largest regional health care system with 13 hospitals operating at approximately $1.0 billion in net revenues. The hospitals are:

- Johnson City Medical Center
- Niswonger Children's Hospital
- Woodridge Psychiatric Hospital
- Franklin Woods Community Hospital
- Unicoi County Community Hospital
- Indian Path Medical Center
- Johnson County Community Hospital
- Sycamore Shoals Hospital
- Dickenson Community Hospital
- Johnston Memorial Hospital
- Norton Community Hospital
- Russell County Medical Center
- Smyth County Community Hospital

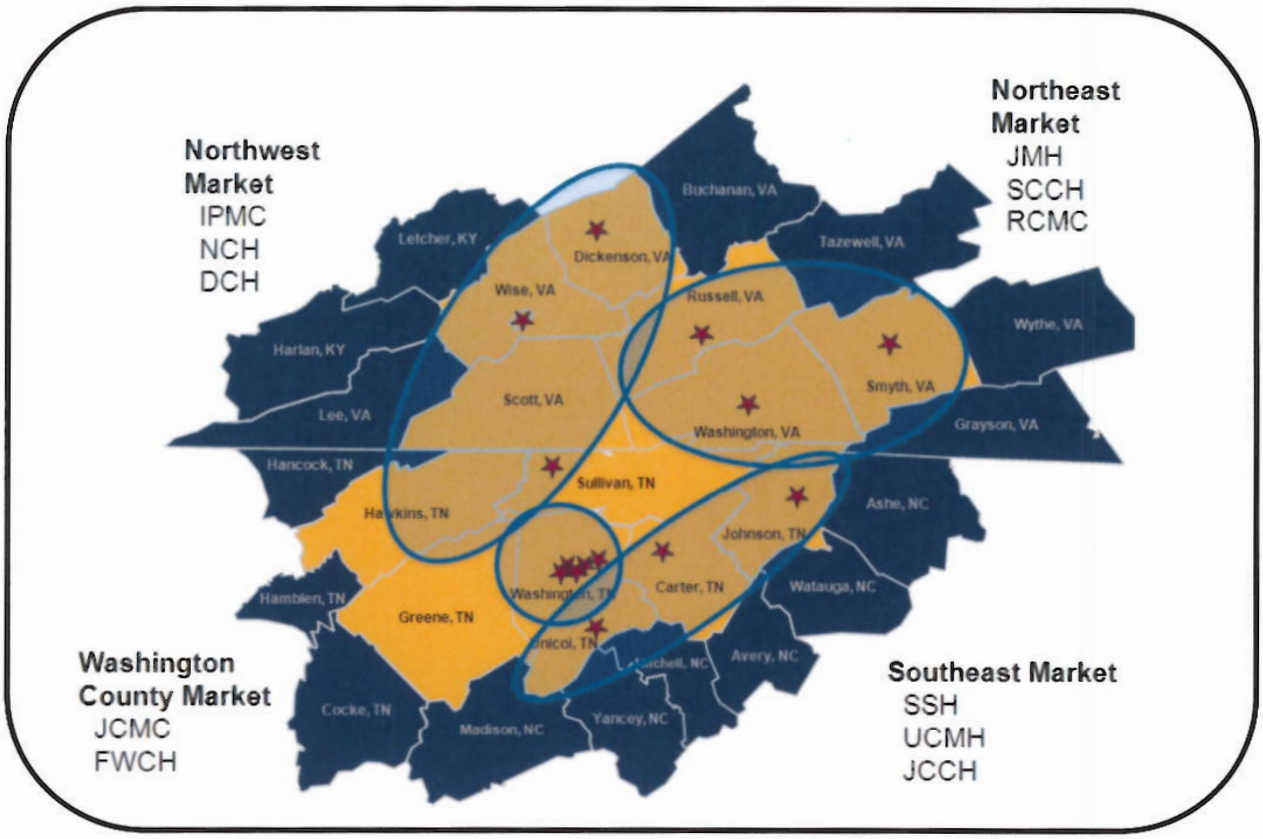
In addition to 13 hospitals, MSHA's integrated health care delivery system includes primary/preventive care centers and numerous outpatient care sites, including First Assist Urgent Care, MedWorks, Same Day Surgery, and Mountain States Rehabilitation.

Executive Summary

Regional and national rankings for health factors continue to be disappointing as cancer, heart disease, and diabetes rates continue to increase each year. Obesity and smoking continue to be major problems in the United States, leading to additional diseases. From a global perspective, the United States falls behind other developing nations in health outcomes. Clearly, there are many needs that exist and need attention. The interrelatedness between the health of a community, its economic status, and its educational attainment levels is becoming increasingly recognized. Mountain States Health Alliance (MSHA) exists to *"identify and respond to the health care needs of individuals and communities in our region and to assist them in attaining their highest possible level of health."* In doing so, MSHA recognizes this is a very complex challenge that involves the engagement of many prongs of the community.

In order for MSHA to serve its region most effectively, it is essential to understand each community's individual needs. MSHA has conducted a Community Health Needs Assessment to profile the health of the residents within the local region (a map of the MSHA service area is provided on the following page). Activities associated with the development of this assessment have taken place from spring of 2014 through spring of 2015, including state, regional and county-specific secondary data collection and primary data obtained through individual surveys and focus groups with individuals from the local communities.

SBH-KINGSPORT 002031



★ Represents county in which MSHA owns a facility. MSHA has part-ownership in other hospitals but they are not included in this assessment.

*Service Area is defined by approximately 80% of inpatient population.

Throughout the assessment, high priority was given to determining the health status and available resources within each community. Community members from each county met with MSHA to discuss current health priorities and identify potential solutions. The information gathered from a local perspective, paired with regional, state and national data, helps to communicate the region's health situation in order to begin formulating solutions for improvement.

In 2014, Tennessee ranked 45th and Virginia ranked 21st out of 50 states for overall health outcomes. Both states had high rates of adult obesity, cancer deaths, infant mortality, and diabetes. Though Virginia's overall ranking is moderately low, the health outcomes in Southwest Virginia counties, where MSHA's facilities are located, resembles those of Tennessee. After compiling the various sources of information, the top health priorities were identified for the communities that each of the MSHA hospitals serve. This effort has determined the top health priorities identified in Sullivan County to include **obesity, diabetes, cancer, heart disease, and substance abuse/NAS**. There are certainly a number of other health challenges in this community, but these rise to the top based on this assessment.

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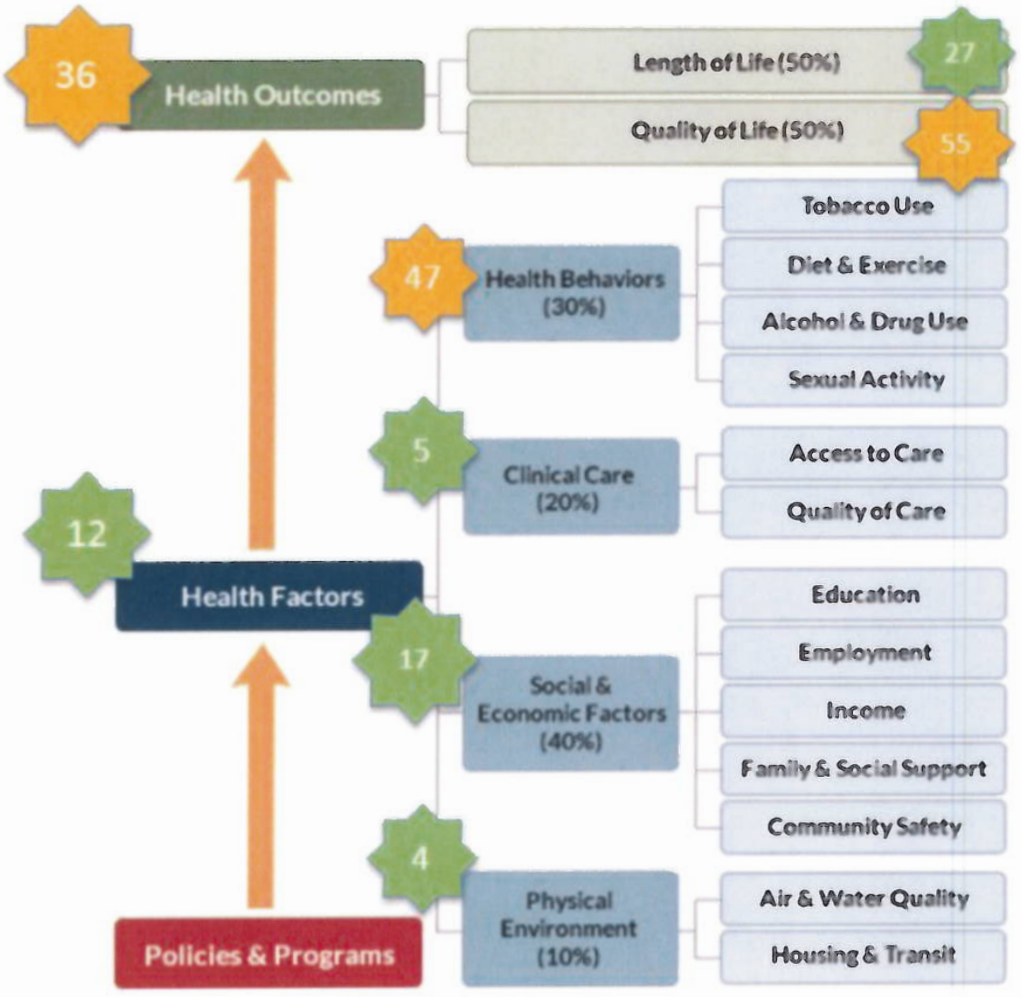
According to the 2015 County Health Rankings, Sullivan County is ranked 36th in Tennessee for health outcomes and 12th for health factors out of 95 counties. The leading causes of death for ages 65 and over are heart disease, cancer, and stroke. Sullivan County also ranked 47th in health behaviors. When compared to other Tennessee counties, Sullivan County has high physical inactivity, low consumption of vegetables, and high overweight/obesity rates. As for social and economic factors, Sullivan County ranks 17th due to high rates of high school education and lower unemployment rates; however the county does have high rates of children in poverty and low rates of college education.

Sullivan County Health Ranking
2015 County Health Rankings
www.countyhealthrankings.org



*Ranking is in comparison to all 95 counties in the state of Tennessee.

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Community Interview Summary

MSHA Strategic Planning Department completed a focus group in order to connect with community members of Sullivan County and determine the needs of the community that Indian Path Medical Center serves. MSHA hospital administration teams were contacted in order to obtain names of individuals in the community who were considered public health officials or community leaders. The 10 participants included representatives from the local health department, the Chamber, school nursing program, school system administration and economic development. These individuals were invited to discuss and assist in determining the health priorities and resources available in their community of Sullivan County.

Collecting Community Input

In order to complete the community health needs assessment for Indian Path Medical Center, MSHA met with various individuals from Sullivan County, TN. The organizations that were represented are listed in Table 1.1.

Table 1.1 – Summary Organizations Participating in IPMC's CHNA

Reported Organizations Providing Input for Assessment
Healthy Kingsport
Kingsport City Schools
United Way of Greater Kingsport
Sullivan County Health Department
IPMC Health Resource Center
Sullivan County Department of Education
Kingsport Chamber of Commerce
Kingsport Board of Mayor and Alderman

To begin the community health needs assessment, MSHA's strategic planning staff presented data that had been collected to illustrate past and current health trends for Tennessee and Sullivan County. The presentation depicted the current national health rankings, in addition to providing a snapshot of the county.

Following the presentation, each participant was given a survey to determine the individual's personal assessment of their county's health priorities. Secondly, the individuals were asked to submit ideas and suggestions as to how MSHA could use the available resources in order to improve the health priorities determined. After the surveys had been completed, each group discussed the questions and continued brainstorming ways to address obstacles and utilize resources. All of the information collected from the surveys and open discussion was evaluated and prioritized based on health needs.

In surveys obtained from the Sullivan County representatives, several community health needs and resources were identified. Table 1.2 lists the survey questions given to each participant in the assessment.

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Table 1.2 – Community Survey Questions

	Survey Questions
1	How would you rate the general health status of the patient population in this community on a scale of 1 to 10 (with 1 being the poorest and 10 being the best)?
2	Keeping in mind resources are not unlimited, can you identify the top 1-2 health priorities in your local community that you feel should be addressed in the following areas: a)Health Outcomes/Diseases b)Health Behaviors c)Social Environment
3	What existing resources, such as organized groups or public health initiatives have been developed and are in place to address these health priorities?
4	What ideas do you have that may serve to improve these health priorities?

Health Status Rating

Overall, the general health status of Sullivan County was rated as 3.6 on a scale of 1 – 10, with 1 being the poorest and 10 being the best. Individual responses ranged from 1.5 to 8. The health ranking for Sullivan County can be found below in Table 1.3.

Table 1.3 – Average Health Status Ranking

MSHA Facility/County	Number of Individuals	Average of Health Status Rating
INDIAN PATH MEDICAL CENTER, Sullivan County, TN	10	3.6

Top Health Priorities

From the results of the surveys, the most prevalent health priorities in Sullivan County were diabetes, heart disease, cancer, obesity (physical inactivity/poor diet), and substance abuse/NAS. Table 1.4 lists the health priorities input provided by community participants.

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Table 1.4 – Top Identified Health Priorities

Top Health Priorities	Responses	% of Total Responses
Health Outcomes/Diseases		
Obesity	10	100%
Cancer	9	90%
Diabetes	9	90%
Cardiovascular Disease	9	90%
Oral Health	3	30%
Behavioral Health	1	10%
Health Behaviors		
Smoking and Tobacco Use	6	60%
Prescription Drug Abuse/NAS	4	40%
Physical Inactivity	2	20%
Social Environment		
Education	1	10%
Food Insecurity	1	10%
Lack of Free Medical Care	1	10%

*Individuals submitted multiple answers regarding health priorities.

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These priorities are consistent with the secondary data findings.

- Obesity
  - Self-reported physical inactivity rates among Sullivan County residents exceed the state average (35% vs. 30%)
- Cancer
  - Both age-adjusted lung cancer and prostate cancer mortality rates of men well exceed the state average
  - The three year average rate of cancer deaths per 100,000 in Sullivan County well exceeds the state rate (292 vs. 214)
  - Cancer is the number one cause of death in those ages 22 to 64
- Diabetes
  - The prevalence rate of diabetes in Sullivan County well exceeds the state average (14% vs. 11%)
- Cardiovascular Disease
  - The rate of cardiovascular deaths per 100,000 in Sullivan County is nearly twice the state rate (403 vs. 226)
  - Heart disease is the number one cause of death in those ages 1 to 14 and 65+ in Sullivan County
- Substance Abuse/NAS
  - The rate of Neonatal Abstinence Syndrome in Sullivan County is nearly triple the state rate per 1,000 live births (17.8 vs. 6.7)

All of these issues lead to a higher percentage of self-reported age-adjusted fair or poor health rates in Sullivan County compared to the state (22% vs. 19%) as well as a higher number of years of potential life lost before 75 per 100,000 (a measure of premature death) at just short of 9,000 in the county vs. 8,700 in TN.

SBH-KINGSPORT 002037

County Health
Rankings & Roadmaps
Building a Culture of Health, County by County

Sullivan (SL)

	Sullivan County	Error Margin	Top U.S. Performers*	Tennessee	Rank (of 95)
Health Outcomes					36
Length of Life					27
Premature death	8,978	8,421-9,534	5,200	8,696	
Quality of Life					55
Poor or fair health	22%	20-25%	10%	19%	
Poor physical health days	5.4	4.8-6.0	2.5	4.3	
Poor mental health days	4.5	3.8-5.1	2.3	3.4	
Low birthweight	8.6%	8.0-9.1%	5.9%	9.2%	
Health Factors					12
Health Behaviors					47
Adult smoking	26%	23-28%	14%	23%	
Adult obesity	33%	30-36%	25%	32%	
Food environment index	6.7		8.4	6.9	
Physical inactivity	35%	32-38%	20%	30%	
Access to exercise opportunities	77%		92%	70%	
Excessive drinking	9%	7-11%	10%	9%	
Alcohol-impaired driving deaths	23%		14%	28%	
Sexually transmitted infections	259		138	504	
Teen births	49	47-51	20	47	
Clinical Care					5
Uninsured	15%	14-17%	11%	16%	
Primary care physicians	754:1		1,045:1	1,388:1	
Dentists	1,424:1		1,377:1	1,996:1	
Mental health providers	865:1		386:1	786:1	
Preventable hospital stays	86	81-92	41	73	
Diabetic monitoring	90%	85-94%	90%	86%	
Mammography screening	66.5%	61.5-71.5%	70.7%	61.8%	
Social & Economic Factors					17
High school graduation	92%			87%	
Some college	55.2%	52.4-58.0%	71.0%	57.7%	
Unemployment	7.5%		4.0%	8.2%	
Children in poverty	28%	23-33%	13%	27%	
Income inequality	4.9	4.7-5.2	3.7	4.8	
Children in single-parent households	35%	32-39%	20%	36%	
Social associations	14.7		22.0	11.5	
Violent crime	530		59	621	
Injury deaths	73	67-79	50	78	
Physical Environment					7
Air pollution - particulate matter	13.0		9.5	13.8	
Drinking water violations	4%		0%	4%	
Severe housing problems	11%	10-12%	9%	15%	
Driving alone to work	87%	86-88%	71%	84%	
Long commute - driving alone	24%	22-25%	15%	32%	

* 90th percentile, i.e., only 10% are better.
Note: Blank values reflect unreliable or missing data

2015

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Identifying Available Resources

MSHA realizes that there are numerous resources in all of the counties it serves that can provide care for individuals. Our goal, in order to reduce costs and provide the best care possible for patients, is to identify these resources to prevent duplication of services and efforts. The interviewees were asked to list all of the services and resources within their community. The interviewees acknowledged that many resources currently exist to help meet health needs. Table 1.5 lists the current resources within each county that offer health services to the community.

Table 1.5 – Identified Available Resources

Resources Available
Sullivan County, Tennessee
Coordinated School Health
East Tennessee State University, School of Public Health
Friends in Need
Health Resources Center
Healthy Kingsport
Parish Nurse Program
PEAK (young professional organization)
Providence Medical Clinic
School System
Sullivan County Health Council
Sullivan County Health Department
United Way of Greater Kingsport, Health Safety & Stability Vision Council
YMCA

*MSHA understands that there are other resources available in each county that are not listed in this table. This table represents only the resources listed by participants in community health needs assessment. MSHA will continue to identify resources.

Improving Health Priorities

The community members who were surveyed provided helpful ideas as to how to begin formulating a plan to improve the health priorities throughout the region. To enhance existing resources, the participants stressed the significance of increasing public awareness of both addressing one's health needs and the availability of health care options within each community. Additional suggestions as to how MSHA can improve the previously identified health priorities are listed in Table 1.6.

Table 1.6 – Ideas to Improve Health Priorities

	Responses
1	Mobile dental clinic linked to dental providers
2	Collaboration across various health systems/programs to provide united approach/solutions
3	Engage business leaders
4	Consolidate efforts among stakeholders to maximize scarce resources
5	More city and corporate support
6	Community forum/Health Summit similar to 1999 Economic Summit
7	Education through public media campaign
8	Target kids
9	Invest more resources and leadership time and commitment to Healthy Kingsport
10	Collaborative Impact Model

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However, it is also helpful to understand from a more global perspective the health status of our nation as a whole, since many issues we face in our service area are not limited to just our region. Compiled on an annual basis, the *America's Health Rankings* publication developed by the United Health Foundation, the American Public Health Association and Partnership for Prevention provides one of the most comprehensive assessments regarding the status of the nation's health. The following information in the national and regional overview is from the 2015 edition

SBH-KINGSPORT 002040

Health is a result of our behaviors, our individual genetic predisposition to disease, the environment and the community in which we live, the clinical care we receive and the policies and practices of our health care and prevention systems. Each of us, individually, as a community, and as a society, strives to optimize these health determinants, so that all of us can have a long, disease-free, and robust life regardless of race, gender or socio-economic status.

This report looks at the four groups of health determinants that can be affected:

1. **Behaviors** include the everyday activities we do that affect our personal health. It includes habits and practices we develop as individuals and families that have an effect on our personal health and on our utilization of health resources. These behaviors are modifiable with effort by the individual supported by community, policy and clinical interventions.

2. **Community and environment** reflects the reality that the daily conditions in which we live our lives have a great effect on achieving optimal individual health.

3. **Public and health policies** are indicative of the availability of resources to encourage and maintain health and the extent that public and health programs reach into the general population.

4. **Clinical care reflects** the quality, appropriateness and cost of the care we receive at doctors' offices, clinics and hospitals.

All health determinants are intertwined and must work together to be optimally effective. For example, an initiative that addresses tobacco cessation requires not only efforts on the part of the individual but also support from the community in the form of public and health policies that promote non-smoking and the availability of effective counseling and care at clinics. Similarly sound prenatal care requires individual effort, access to and availability of prenatal care coupled with high quality health care services. Addressing obesity, which is a health epidemic now facing this country, requires coordination among almost all sectors of the economy including food producers, distributors, restaurants, grocery and convenience stores, exercise facilities, parks, urban and transportation design, building design, educational institutions, community organizations, social groups, health care delivery and insurance to complement and augment individual actions.

America's Health Rankings® combines individual measures of each of these determinants with the resultant health outcomes into one, comprehensive view of the health of a state. Additionally, it discusses health determinants separately from health outcomes and provides related health, economic and social information to present a comprehensive profile of the overall health of each state.

America's Health Rankings® employs a unique methodology, developed and periodically reviewed by a panel of leading public health scholars, which balances the contributions of various factors, such as smoking, obesity, binge drinking, high school graduation rates, children in poverty, access to care and incidence of preventable disease, to a state's health. The report is based on data from the

SBH-KINGSPORT 002041

U.S. Departments of Health and Human Services, Commerce, Education and Labor; U.S. Environmental Protection Agency; U.S. Census Bureau, the American Medical Association; the American Dental Association; the Dartmouth Atlas Project; and the Trust for America's Health.

Purpose

The ultimate purpose of *America's Health Rankings®* is to stimulate action by individuals, elected officials, health care professionals, employers, and communities to improve the health of the population of the United States. We do this by promoting public conversation concerning health in our states, as well as providing information to facilitate citizen, community and group participation. We encourage participation in all elements: behaviors, community and environment, clinical care, and public and health policies. Each person individually, and in their capacity as an employee, employer, voter, community volunteer, health official or elected official, can contribute to the advancement of the healthiness of their state. Proven, effective and innovative actions can improve the health of people in every state whether the state is first or 50th.

Findings

Comparison to Other Nations

When health in the United States is compared to health in other countries, the picture is disappointing. The World Health Organization, in its annual World Health Statistics 2013, compares the United States to the nations of the world on a large variety of measures. While the U.S. does exceed many countries, it is far from the best in many of the common measures used to gauge healthiness and lags behind its peers in other developed countries.

The United States ranks at or near the bottom among high-income countries on nearly all indicators of mortality, survival, and life expectancy. Life expectancy is a measure that indicates the number of years that a newborn is expected to live. Japan, San Marino, and Switzerland are the persistent leaders for developed countries in this measure, with an overall life expectancy of 83 years. At 81 years for women and 76 years of men, the United States ranks 33rd among the 193 reporting nations of the WHO. The United States male life expectancy rates are on par with Chile, Cuba, Brunei Darussalam, and Maldives, while the female life expectancy rates are on par with Columbia, Costa Rica, Czech Republic, Estonia, Poland, and Qatar. There are 32 other countries that exceed the United States in healthy life expectancy, including Australia, Italy, Spain, France, Germany, Greece and the United Kingdom.

One of the underlying causes for these differences is the gap in infant mortality rates between the United States and many other countries. The infant mortality rate for the U.S. in 2011 was 6 deaths per 1,000 live births, ranking 40th among WHO nations. The infant mortality rates in Finland, Japan, and Sweden were one third that of the U.S. rate. Of the 193 countries rated, 39 countries had lower infant mortality rates than the United States.

These countries also have considerably lower infant mortality rates than that of non-Hispanic whites in the United States, which is the ethnic/racial group with the lowest infant mortality rate. The racial/ethnic disparities related to infant mortality could be related to differences in risk factors among different racial/ethnic groups, including risk for low birth weight delivery, access to medical care, and socioeconomic status. However, many of the racial/ethnic differences in infant mortality remain unexplained. It should also be noted that the reporting and classification of infant mortality varies among countries, which could be reflected in the ranks.

In addition to infant mortality, youth and young adults' mortality impacts life expectancy. Unintentional injuries claim approximately 30 percent of the years lost before age 50, along with violence and suicides, among U.S. young adults and adolescents. Non-communicable (chronic)

SBH-KINGSPORT 002042

diseases, such as cancer, heart disease, and other conditions that are not caused by infections, begin to be more of a contributing factor after the age of 30.

Differences in healthy life expectancy are also affected by the effectiveness of treating disease, especially those that are amenable to care, including bacterial infections, treatable cancers, diabetes, cardiovascular and cerebrovascular disease, some ischemic heart disease, and complications from common surgical procedures. The age-adjusted amenable mortality rate before age 75 for the United States was 95.5 deaths per 100,000 population in 2006 to 2007, which is still a slower rate of improvement than in other Organization for Economic Cooperation and Development (OECD) nations studied. The rate in the U.S. is 50 percent higher than the rate in France, Japan, Italy, and Australia.

Additionally, the study indicated that despite spending more than any other country on health care, the United States continues to slip further behind and has one of the highest inequalities in health compared to other developed countries. The U.S. ranks among the worst OECD countries for child health well-being, having an inequality higher than average. Furthermore, although the United States has the highest income per person, it continues to rank as the worst country for income inequality, which is thought to explain why it has the highest index of health and social problems compared to other developed nations.

Physical inactivity and obesity play major contributions to disease worldwide and in the United States. Physical inactivity is the fourth leading risk factor for global mortality, and is responsible for an estimated 6 to 10 percent of non-communicable diseases, such as type 2 diabetes, heart disease, colon cancer, and breast cancer. North America has 34 percent of the world's biomass due to obesity; however, it only makes up for 6 percent of the world's population. Asia, on the other hand, has 61 percent of the world's population, yet only has 13 percent of its biomass due to obesity. While the U.S. is only one of several countries that form North America, it is the only North American nation to rank among the heaviest nations globally. It is estimated that eliminating physical activity in the United States would add approximately 1 year to life expectancy and dramatically reduce the burden of chronic diseases.

The results of these studies should be a wake-up call to everyone in the United States to strive to improve all aspects of our health system, including education, safety, prevention, and clinical care. Other countries have improved their overall health, indicating that we, too, can do the same.

National Changes since 1990

In the past year, 20 health measures improved, 8 measures declined, and 1 measure remained unchanged. Table 1 shows the national changes in the last year. These improvements were offset by deterioration in several measures, including increases in the prevalence of obesity, the percentage of children in poverty and lack of health insurance.

Since 2012, the prevalence of smoking declined from 21.2 percent to 19 percent among adults. The binge drinking prevalence rate dropped from 18.3 percent to 16.8 percent of adults who binged in the last 30 days, and physical inactivity decreased from 26.2 percent to 25.3 percent. The incidence of pertussis increased sharply from 9.0 to 15.5 cases per 100,000 populations. The percentages of children in poverty, lack of health insurance, child immunization coverage, and low birth weight have also suppressed faster improvement in our nation's health.

SBH-KINGSPORT 002043

Table 1 – National Successes and Challenges

SUCCESSES

Smoking	Since 1990, smoking decreased 36% from 29.5% to 19.0% of adults who smoke regularly.
High School Graduation	At 81% of ninth graders graduating within 4 years, high school graduation is still a challenge. However, it is slowly trending upward from 71.7% in 2004.
Violent Crime	At 387 offenses per 100,000 population, violent crime is 37% lower than in 1990 and 49% lower than its peak in 1993.
Air Pollution	The average amount of fine particulates in the air continues to decline from 13.2 micrograms per cubic meter in 2003 to 9.9 micrograms per cubic meter in 2014.
Preventable Hospitalizations	Preventable hospitalizations continue to decline. In 2001, there were 82.5 discharges per 1,000 Medicare beneficiaries; in 2014, there were 62.9 discharges per 1,000 Medicare beneficiaries.
Occupational Fatalities	Occupational fatalities have declined in the last 8 years from 5.3 deaths per 100,000 workers in 2007 to 3.8 deaths per 100,000 workers. This is the second consecutive year the rate is below 4 deaths per 100,000 workers.
Infant Mortality	Since 1990, infant mortality decreased 41% from 10.2 to 6.0 deaths per 1,000 live births, although most of that decline occurred between 1990 and 1999. Even though the infant mortality rate is the lowest in US history, it is double the rate of many developed countries. In addition, large racial and geographic disparities exist within the country.
Premature Death	Since 1990, premature death declined 20% from 8,716 to 6,976 years of potential life lost before age 75. Premature death, like several other metrics, has leveled off in the last decade compared with improvements made in the 1990s.
Cancer Deaths	Cancer deaths declined 4% from 197.5 deaths in 1990 to 189.9 deaths per 100,000 population.
Cardiovascular Deaths	Since 1990, cardiovascular deaths declined 38% from 405.1 to 251.4 deaths per 100,000 population. This continues a relatively constant improvement of 2% to 3% yearly.

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CHALLENGES

Obesity	Since 1990, obesity has increased 153% from 11.6% to 29.4% of adults.
Physical Inactivity	Physical inactivity remains high at 23.5% of adults and has not changed appreciably for the last decade.
Children in Poverty	At 19.9% of children, the children in poverty measure is far above the 23-year low of 15.8% in the 2002 Edition and near the 1990 level of 20.6%.
Public Health Funding	State public health funding continues its slow decline over the past 4 years. Since 2011, it decreased from $95.01 to $90.00 in expenditures per person at the state level.
Immunization Coverage — Children	Nationwide, comprehensive immunization coverage among children aged 19 to 35 months is only 70.4%. It increased marginally in the past year.
Immunization Coverage — Adolescents	Nationwide, comprehensive immunization coverage among teens aged 13 to 17 years is only 67.1%. It increased marginally in the past year.
Low Birthweight	In the last 20 years, the prevalence of low birthweight infants has increased from 7.1% to 8.0% nationwide. The good news is that it appears to have peaked in 2009 and is trending downward.
Diabetes	In the nation, 9.6% of adults report they have been told they have diabetes. There has been a steady, upward climb in the prevalence of diabetes, although data from the last 3 years shows a leveling of the prevalence.

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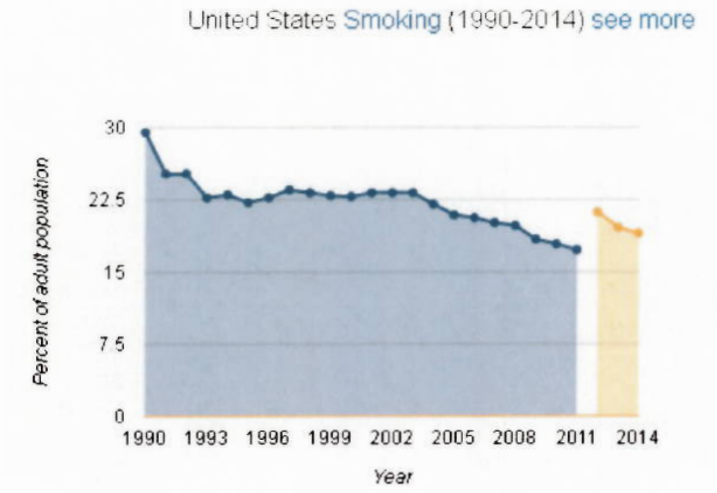
The United States has the potential to return to the rates of improvement typical in the 1990s. However, to do so, it must address the drivers of health directly by focusing on reducing important risk factors. For example, the prevalence of smoking had been stagnant for many years and recently started to show improvement in the last two decades. However, there was an increase in rates from 2010 to 2012. In the last year, the prevalence of smoking declined in the United States from 21.2 percent to 19 percent of adults who smoke regularly; however Tennessee ranks 46th as one of the bottom five states with 24.3 percent of adults smoking and Virginia ranks 24th at 19.1 percent.

Graph 1 - Prevalence of Smoking Since 1990

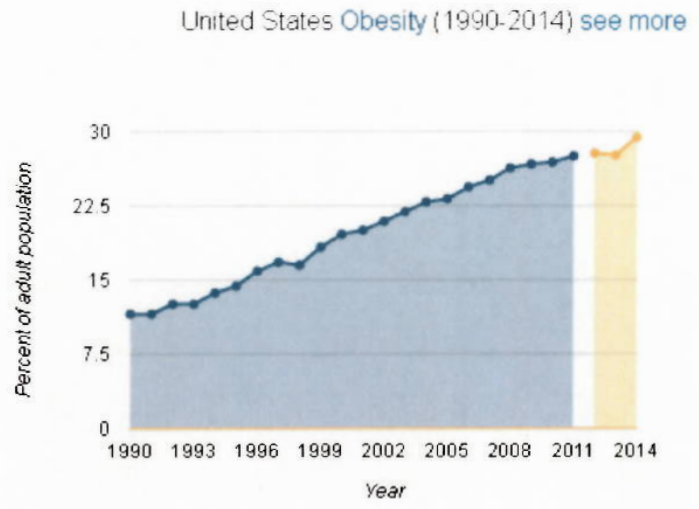


Unprecedented and unchecked growth in the prevalence of obesity over the last 20 years has also dramatically affected the overall health of the United States. The prevalence of obesity, a risk factor for numerous illnesses including heart disease and diabetes, appears to be leveling off after increasing for decades. However, more than one in four people in the U.S. is considered obese - a category that the Centers for Disease Control and Prevention reserves for those who are significantly over the suggested body weight given their height. In the United States, the prevalence of obesity is 29.4 percent of adults, which has increased from 27.8 percent in 2012. Virginia's obesity score ranks 18th at 27.2 percent, while Tennessee ranks 47th at 33.7 percent of obese adults.

These very high obesity rates are gathered from the Behavioral Risk Factor Surveillance System, the nation's largest phone survey about health, and rely on self-reported height and weight. Actual obesity rates, as measured by health professionals, may be almost 10 percent higher, meaning that over one-third of the population is now obese.

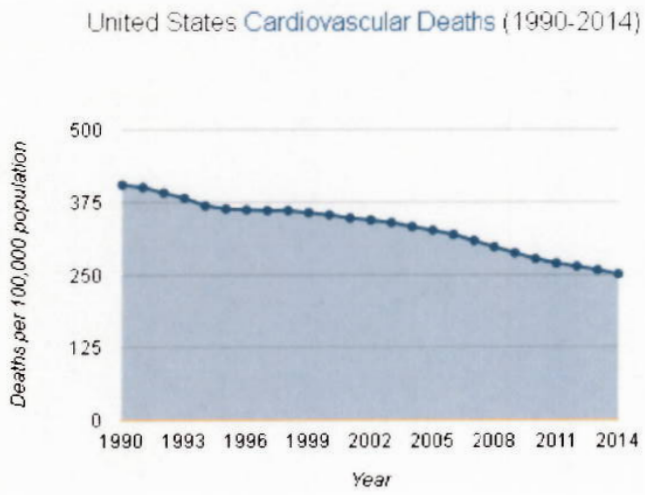
SBH-KINGSPORT 002046

Graph 2 - Prevalence of Obesity Since 1990



Despite increasing risk factors such as obesity, high cholesterol, and high blood pressure, deaths contributed to cardiovascular disease have consistently declined by 2 to 3 percent per year for the last decade. Cardiovascular disease accounts for 30 percent of Medicare spending, 17 percent of medical spending, and totals nearly $150 billion each year. For cardiovascular deaths, Virginia ranked 25th with a rate of 241.1 per 100,000 and Tennessee ranked 44th with the rate of 300.6.

Graph 3 – Prevalence of Cardiovascular Deaths Since 1990



Like cardiovascular disease, potentially preventable hospitalizations have steadily decreased over the past 12 years. Preventable hospitalizations (hospitalizations that may be preventable with high quality primary and preventive care) have decreased from 82.5 to 62.9 discharges per 1,000 Medicare enrollees since 2001. Preventable hospitalizations reflect how efficiently a population uses various health care options for care and often occur as a result of a failure to detect or treat conditions early. Preventable hospitalizations could be avoided with earlier, less costly interventions. Virginia ranked 22nd in this measure with a 55.2 rate and Tennessee ranked 47th with a rate of 78.5.

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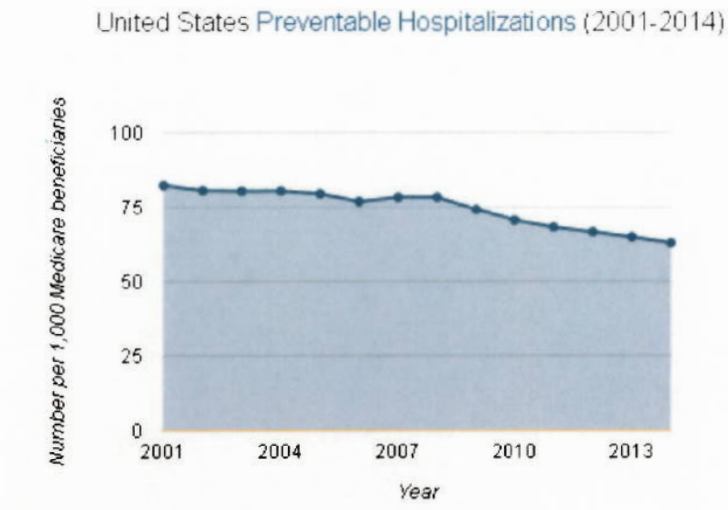
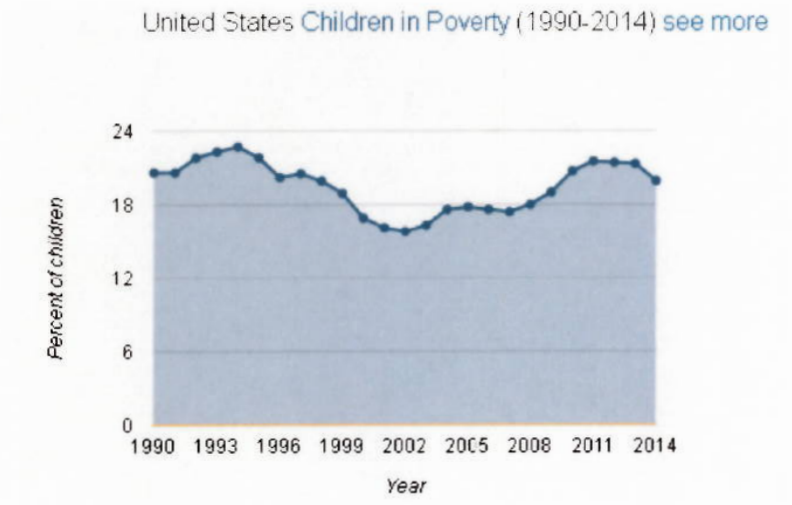
Graph 4 – Preventable Hospitalizations Since 2001



The current economic climate also increases the challenge of maintaining a healthy population. Poverty is an indication of the lack of access to health care, including preventive care, for this vulnerable population. Graph 5 shows the recent increase in the percentage of children in poverty in the last few years, increasing from 16.1 percent of children in the 2011 Edition to 19.9 percent of children in the 2014 Edition. On this measure Virginia ranks 12th with a 14.5 percent of children living in poverty and Tennessee ranks 45th with 26.7 percent. In the 2002 Edition, the child poverty rate was at a historic low of 15.8 percent of persons under age 18.

Graph 5 – Children in Poverty since 1990



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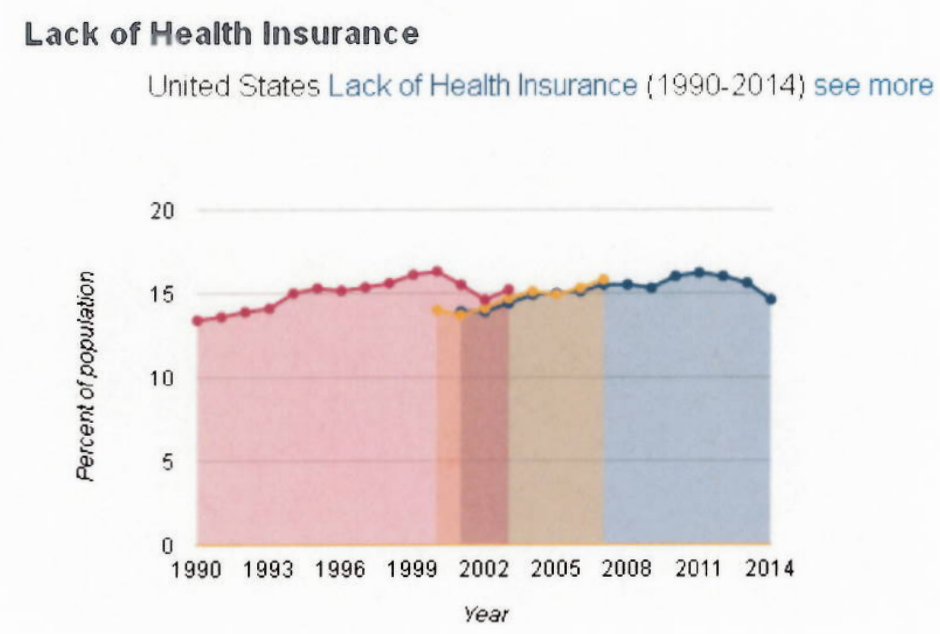
Lack of health insurance coverage increased from 13.9 percent in the 2001 Edition to 14.6 percent of the population in the 2014 Edition. Lack of health insurance not only inhibits people from getting the proper care when needed but also reduces access to necessary preventive care to curtail or minimize future illnesses.

Massachusetts, with the lack of health insurance at 3.8 percent of the population, is substantially better than all other states and less than one-fourth of the national average. Texas has a rate six times that of Massachusetts. Changes in national health care laws have the potential to dramatically affect this metric over the next few years.

Graph 6 – Lack of Health Insurance Since 2001



SBH-KINGSPORT 002049

2014 State Results

America's Health Rankings®-2014 Edition shows Hawaii at the top of the list of healthiest states again this year. The state has steadily remained within the top 5 healthiest states since 1990. Hawaii has consistently sustained its place within the top 5 healthiest states for the last 22 years, excluding 2002 when it was ranked 6th. Hawaii's strengths include its number one position for overall health rank and ranking in the top 5 states for a low rate of preventable hospitalizations, high immunization coverage among children, low prevalence of smoking and obesity, high per capita public health funding, a low rate of uninsured population, and low cancer and cardiovascular mortality rates. Hawaii's three challenges are a high prevalence of binge drinking, low high school graduate rate, and a high incidence of Salmonella infections.

Mississippi is 50th this year, the same as the last ten years, excluding in 2011 when it ranked 49th. It has been in the bottom three states since the 1990 Edition. The state ranks well for a low prevalence of binge drinking, higher immunization coverage among children, and small disparity in health status by educational attainment. In the past year, despite ranking last in the nation for immunization coverage among adolescents, coverage increased from 30.2 percent to 35.4 percent of persons aged 13 to 17 years. Mississippi also ranks last in many health outcomes, including infant mortality, low birth weight, premature death, cardiovascular death, infectious diseases, and overall health status. Mississippi's prevalence of obesity, physical inactivity, and diabetes remain among the highest in the nation with approximately 690,000 physically inactive adults, 770,000 obese adults, and 280,000 adults with diabetes. It ranks 48th in health determinants and 49th in health outcomes; therefore, its overall ranking is unlikely to change significantly in the near future

2014 Edition Ranking

2014 RANK (1–50)	STATE	SCORE
1	Hawaii	.91
2	Vermont	.85
3	Massachusetts	.74
4	Connecticut	.74
5	Utah	.73
6	Minnesota	.73
7	New Hampshire	.68
8	Colorado	.57
9	North Dakota	.55
10	Nebraska	.50
11	New Jersey	.47
12	Oregon	.41
13	Washington	.40
14	New York	.39
15	Rhode Island	.37
16	Maryland	.35
17	California	.35
18	Idaho	.34
18	South Dakota	.34
20	Maine	.30
21	Virginia	.30
22	Montana	.28
23	Wisconsin	.23
24	Iowa	.22
25	Wyoming	.21

2014 Edition Ranking

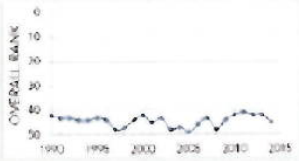
2014 RANK (1–50)	STATE	SCORE
26	Alaska	.13
27	Kansas	.08
28	Pennsylvania	.01
29	Arizona	-.04
30	Illinois	-.08
31	Texas	-.11
32	Florida	-.15
33	New Mexico	-.18
34	Michigan	-.21
35	Delaware	-.23
36	Missouri	-.28
37	North Carolina	-.29
38	Georgia	-.32
39	Nevada	-.33
40	Ohio	-.36
41	Indiana	-.38
42	South Carolina	-.64
43	Alabama	-.66
44	West Virginia	-.71
45	Tennessee	-.71
46	Oklahoma	-.74
47	Kentucky	-.75
48	Louisiana	-.80
49	Arkansas	-.93
50	Mississippi	-1.00

SBH-KINGSPORT 002051

Tennessee

Overall Rank: 45

Change: ▼ 3
Determinants Rank: 44
Outcomes Rank: 46



Strengths:
- Low prevalence of binge drinking
- Low incidence of pertussis
- Ready availability of primary care physicians

Challenges:
- High prevalence of obesity
- High prevalence of physical inactivity
- High violent crime rate

Ranking:
Tennessee is 45th this year; it was 42nd in 2013. The ranking for senior health in Tennessee was 43rd in 2014.

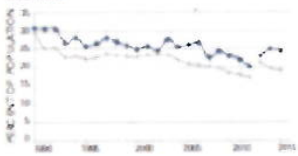
Highlights:
- In the past year, physical inactivity increased by 17 percent from 28.6 percent to 33.6 percent of adults.
- In the past year, binge drinking decreased by 15 percent from 11.3 percent to 9.6 percent of adults, the lowest rate in the nation.
- In the past year, preventable hospitalizations decreased by 10 percent from 80.8 to 73.1 per 1,000 Medicare beneficiaries.
- In the last 2 years, immunization coverage among adolescents increased by 16 percent from 52.7 percent to 61.2 percent of adolescents aged 13 to 17 years.
- Since 1990, children in poverty decreased by 10 percent from 29.6 percent to 26.7 percent of children.

State Health Department Website:
http://health.state.tn.us

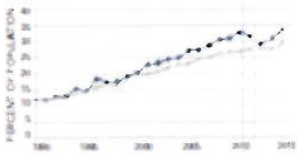
	2014 VALUE	2014 RANK	NO 1 STATE
Behaviors			
Smoking (Percent of adult population)	24.3	46	10.3
Binge Drinking (Percent of adult population)	9.6	1	9.6
Drug Deaths (Deaths per 100,000 population)	17.2	40	3.0
Obesity (Percent of adult population)	33.7	47	21.3
Physical Inactivity (Percent of adult population)	33.6	49	16.2
High School Graduation (Percent of incoming ninth graders)	83.0	20	93.0
Community & Environment			
Violent Crime (Offenses per 100,000 population)	644	50	123
Occupational Fatalities (Deaths per 100,000 workers)	5.0	32	2.2
Infectious Disease (Combined score Chlamydia, Pertussis, *Salmonella**)	0.01	29	-0.9
Chlamydia (Cases per 100,000 population)	507.9	39	233.0
Pertussis (Cases per 100,000 population)	4.8	10	1.6
Salmonella (Cases per 100,000 population)	17.2	35	6.8
Children in Poverty (Percent of children)	26.7	45	9.2
Air Pollution (Micrograms of fine particles per cubic meter)	9.5	30	4.9
Policy			
Lack of Health Insurance (Percent of population)	13.9	26	3.8
Public Health Funding (Dollars per person)	$83	20	$219
Immunization--Children (Percent aged 19 to 35 months)	68.5	33	82.1
Immunization--Adolescents (Percent aged 13 to 17 years)	61.2	36	81.3
Clinical Care			
Low Birthweight (Percent of live births)	9.2	44	5.7
Primary Care Physicians (Number per 100,000 population)	124.4	19	324.6
Dentists (Number per 100,000 population)	50.9	36	107.6
Preventable Hospitalizations (Number per 1,000 Medicare beneficiaries)	73.1	46	28.2
ALL DETERMINANTS	-0.43	44	0.71
OUTCOMES			
Diabetes (Percent of adult population)	12.2	46	6.5
Poor Mental Health Days (Days in previous 30 days)	3.7	24	2.5
Poor Physical Health Days (Days in previous 30 days)	5.0	49	2.8
Disparity in Health Status (Percent difference by education level**)	32.1	38	15.5
Infant Mortality (Deaths per 1,000 live births)	7.3	41	4.2
Cardiovascular Deaths (Deaths per 100,000 population)	300.6	44	184.7
Cancer Deaths (Deaths per 100,000 population)	213.5	44	145.7
Premature Deaths (Years lost per 100,000 population)	9,168	43	5,345
ALL OUTCOMES	-0.29	46	0.34
OVERALL	-0.71	45	0.91

*Negative score denotes less disease than US average, positive score indicates more than US average
**Difference in the percentage of adults aged 25 and older with vs without a high school education who report their health is very good or excellent

SMOKING



OBESITY



STATE ◆——◆ NATION

The 2012-2014 data in the above graphs are not directly comparable to prior years. See Methodology for additional information.

ECONOMIC ENVIRONMENT	TN	US
Annual Unemployment Rate (2013)	8.2	7.4
Annual Underemployment Rate (2013)	14.7	13.8
Median Household Income (2013)	$42,499	$51,939

MEASURE	ADULT POPULATION AFFECTED
Smoking	1,163,000
Obesity	1,595,000
Physical Inactivity	1,691,000
Diabetes	615,000

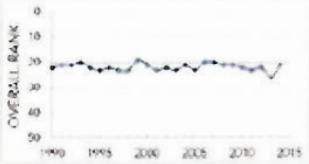
SBH-KINGSPORT 002052

Virginia

VIRGINIA

Overall Rank: 21

Change: ▲ 5
Determinants Rank: 19
Outcomes Rank: 23



Strengths:

- Low rate of drug deaths
- Low violent crime rate
- Low percentage of children in poverty

Challenges:

- Low immunization coverage among children
- Low immunization coverage among teens
- High infant mortality rate

Ranking:

Virginia is 21st this year; it was 26th in 2013. The ranking for senior health in Virginia was 21st in 2014.

Highlights:

- In the past year, air pollution decreased by 6 percent from 9.3 to 8.7 micrograms of fine particles per cubic meter.
- In the last 2 years, drug deaths decreased by 10 percent from 9.3 to 8.4 deaths per 100,000 population.
- In the last 10 years, preventable hospitalizations decreased by 25 percent from 73.8 to 55.2 per 1,000 Medicare beneficiaries.
- Since 1990, cardiovascular deaths decreased by 42 percent from 413.2 to 241.1 deaths per 100,000 population.
- Since 1990, infant mortality decreased by 38 percent from 10.6 to 6.6 deaths per 1,000 live births.

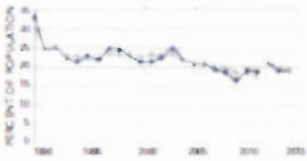
State Health Department Website:

www.vdh.state.va.us

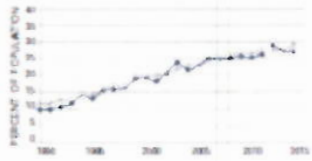
	2014 VALUE	2014 RANK	NO 1 STATE
Behaviors			
Smoking (Percent of adult population)	19.0	24	10.3
Binge Drinking (Percent of adult population)	15.9	20	9.6
Drug Deaths (Deaths per 100,000 population)	8.4	4	3.0
Obesity (Percent of adult population)	27.2	18	21.3
Physical Inactivity (Percent of adult population)	23.0	20	16.2
High School Graduation (Percent of incoming ninth graders)	84.0	16	93.0
Community & Environment			
Violent Crime (Offenses per 100,000 population)	190	4	123
Occupational Fatalities (Deaths per 100,000 workers)	4.4	25	2.2
Infectious Disease (Combined score Chlamydia, Pertussis, *Salmonella**)	-0.29	16	-0.9
Chlamydia (Cases per 100,000 population)	431.8	26	233.0
Pertussis (Cases per 100,000 population)	7.7	18	1.6
Salmonella (Cases per 100,000 population)	14.1	25	6.8
Children in Poverty (Percent of children)	14.5	12	9.2
Air Pollution (Micrograms of fine particles per cubic meter)	8.7	19	4.9
Policy			
Lack of Health Insurance (Percent of population)	12.4	20	3.8
Public Health Funding (Dollars per person)	$68	28	$219
Immunization--Children (Percent aged 19 to 35 months)	69.2	29	82.1
Immunization--Adolescents (Percent aged 13 to 17 years)	58.5	42	81.3
Clinical Care			
Low Birthweight (Percent of live births)	8.1	27	5.7
Primary Care Physicians (Number per 100,000 population)	125.8	16	324.6
Dentists (Number per 100,000 population)	61.6	19	107.6
Preventable Hospitalizations (Number per 1,000 Medicare beneficiaries)	55.2	22	28.2
ALL DETERMINANTS	0.24	19	0.71
OUTCOMES			
Diabetes (Percent of adult population)	9.8	26	6.5
Poor Mental Health Days (Days in previous 30 days)	3.3	11	2.5
Poor Physical Health Days (Days in previous 30 days)	3.6	15	2.8
Disparity in Health Status (Percent difference by education level**)	29.1	27	15.5
Infant Mortality (Deaths per 1,000 live births)	6.6	31	4.2
Cardiovascular Deaths (Deaths per 100,000 population)	241.1	25	184.7
Cancer Deaths (Deaths per 100,000 population)	189.5	23	145.7
Premature Deaths (Years lost per 100,000 population)	6,502	19	5,345
ALL OUTCOMES	0.06	23	0.34
OVERALL	0.30	21	0.91

*Negative score denotes less disease than US average, positive score indicates more than US average
**Difference in the percentage of adults aged 25 and older with vs without a high school education who report their health is very good or excellent

SMOKING



OBESITY



STATE ◆——◆ NATION ◆——◆

The 2012-2014 data in the above graphs are not directly comparable to prior years. See Methodology for additional information.

ECONOMIC ENVIRONMENT	VA	US
Annual Unemployment Rate (2013)	5.5	7.4
Annual Underemployment Rate (2013)	11.5	13.8
Median Household Income (2013)	$67,820	$51,939

MEASURE	ADULT POPULATION AFFECTED
Smoking	1,159,000
Obesity	1,632,000
Physical Inactivity	1,481,000
Diabetes	631,000

SBH-KINGSPORT 002053

As Mountain States Health Alliance works to develop an implementation plan based on the findings from this assessment, key focus areas for consideration to impact the health of our community would be the 27 measures that comprise the *America's Health Rankings*. These determinants have been carefully selected by leaders in health and public policy as factors which have the greatest impact on future health of a population. For a state (or area for that matter) to improve the health of its population, efforts must focus on changing the determinants of health. A description of these determinants is outlined below.

Selection of Components

Four primary considerations drove the design of *America's Health Rankings*® and the selection of the individual measures:

1. The overall rankings had to represent a broad range of issues that affect a population's health,
2. Individual measures needed to use common health measurement criteria,
3. Data had to be available at a state level, and
4. Data had to be current and updated periodically.

While not perfect, the measures selected are believed to be the best available indicators of the various aspects of healthiness at this time and are consistent with past reports.

The measures are divided into two categories - Determinants and Outcomes. For further clarity, determinants are divided into four groups: Behaviors, Community and Environment, Public and Health Policies, and Clinical Care. These four groups of measures influence the health outcomes of the population in a state, and improving these inputs will improve outcomes over time. Most measures are actually a combination of activities in all four groups. For example, the prevalence of smoking is a behavior that is strongly influenced by the community and environment in which we live, by public policy including taxation and restrictions on smoking in public places, and by the care received to treat the chemical and behavioral addictions associated with tobacco. However, for simplicity, we placed each measure in a single category.

For *America's Health Rankings*® to continue to meet its objectives it must evolve and incorporate new information as it becomes available. The Scientific Advisory Committee provides guidance for the evolution of the rankings, balancing the need to change with the desire for longitudinal comparability. Over the last few years, change is being driven by: 1) the acknowledgment that health is more than years lived but also includes the quality of those years; 2) data about the quality and cost of health care delivery are becoming available on a comparative basis; and 3) measurement of the additional determinants of health are being initiated and/or improved. The committee also emphasizes that the real impact on health will be made by addressing the determinants, and making improvements on these items will affect the long-term health of the population. The determinants are the predictors of our future health.

Outcomes are traditionally measured using mortality measures which include premature death, infant mortality, cancer and cardiovascular mortality. While these measures overlap significantly, they do present different views of mortality outcomes of a population. Two measures of the quality of life- poor mental health days and poor physical health days - are also included and defined as the number of days in the previous 30 days when a person indicates their activities are limited due to mental or physical health difficulties.

As with all indices, the positive and negative aspects of each measure must be weighed when choosing and developing them. These aspects for consideration include: 1) the interdependence of

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the different measures; 2) the possibility that the overall ranking may disguise the effects of individual measures; 3) an inability to adjust all data by age and race; 4) an over-reliance on mortality data; and 5) the use of indirect measures to estimate some effects on health. These concerns cannot be addressed directly by adjusting the methodology; however, assigning weights to the individual measures can mitigate their impact.

Each measure is assigned a weight that determines its percentage of the overall score. Determinants account for 75 percent of the overall ranking and outcomes account for 25 percent, a shift from the 50/50 balance in the original 1990 index. This reflects the importance and growing availability of determinant data.

A short description of each measure immediately follows. The data for each year is the most current data available at the time the report was compiled.

The table includes the core measures included in the current model, plus supplemental measures that can be used to further understand each state's unique situation. The supplemental measures are more fully described at http://www.americashealthrankings.org/About/Model.

Data for each state and the United States is available at Get Informed or by clicking the link above.

Core Measures

Determinants

Behaviors	Description
Smoking	Percentage of adults who are current smokers (smoked at least 100 cigarettes in their lifetime and currently smoke)
Binge Drinking	Percentage of adults who self-report having 4 or more (women) or 5 or more (men) alcoholic beverages on at least 1 occasion in the past 30 days.
Drug Deaths	Number of deaths due to drug injury of any intent (unintentional, suicide, homicide, or undetermined) per 100,000 population
Obesity	Percentage of adults who are obese, with a body mass index (BMI) of 30.0 or higher.
Physical Inactivity	Percentage of adults who report doing no physical activity or exercise (such as running, calisthenics, golf, gardening, or walking) other than their regular job in the last 30 days.
High School Graduation	Percentage of incoming ninth graders who graduate in 4 years from a high school with a regular degree.

Community and Environment

Violent Crime	Number of murders, rapes, robberies, and aggravated assaults per 100,000 population.
Occupational Fatalities	Number of fatalities from occupational injuries per 100,000 workers
Children in Poverty	Percentage of persons younger than 18 years who live in households at or below the poverty threshold
Infectious Disease	Combined average z-score using the values of incident cases of chlamydia, pertussis, and *Salmonella* per 100,000 population

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Air Pollution	Average exposure of the general public to particulate matter of 2 5 microns or less in size (PM2 5)

Policy

Lack of Health Insurance	Percentage of the population that does not have health insurance privately, through their employer or the government
Public Health Funding	State funding dedicated to public health as well as federal funding directed to states by the Centers for Disease Control and Prevention and the Health Resources and Services Administration
Immunization-Children	Percentage of children receiving the recommended doses of DTaP, polio, MMR, Hib hepatitis B, varicella, and PCV vaccines by age 19-35 months.
Immunization-Adolescents	Percentage of adolescents aged 13 to 17 years who have received 1 dose of Tdap since the age of 10 years, 1 dose of meningococcal conjugate vaccine, and 3 doses of HPV vaccine (females only)

Clinical Care

Low Birth weight	Percentage of infants weighing less than 2,500 grams (5 pounds, 8 ounces) at birth
Primary Care Physicians	Number of primary care physicians (including general practice, family practice, OB-GYN, pediatrics, and internal medicine) per 100,000 population
Dentists	Number of dentists per 100,000 population
Preventable Hospitalizations	Discharge rate among the Medicare population for diagnoses that are amenable to non-hospital based care.

Outcomes

Diabetes	Percentage of adults who have been told by a health professional that they have diabetes (does not include pre-diabetes or diabetes during pregnancy)
Poor Mental Health Days	Number of days in the previous 30 days when a person indicates their activities were limited due to mental health difficulties
Poor Physical Health Days	Number of days in the previous 30 days when a person indicates their activities were limited due to physical health difficulties
Disparity in Health Status	Percent difference in adults aged 25 and older who did not graduate high school and adults with at least a high school education who self-report being in excellent or very good health.
Infant Mortality	Number of infant deaths (before age 1) per 1,000 live births
Cardiovascular Deaths	Number of deaths due to all cardiovascular diseases, including heart disease and strokes, per 100,000 population
Cancer Deaths	Number of deaths due to all causes of cancer per 100,000 population
Premature Death	Number of years of potential life lost prior to age 75 per 100,000 population

Supplemental Measures

Behaviors

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Cholesterol Check	Percentage of adults who have had their blood cholesterol checked within the last 5 years
Dental Visit, Annual	Percentage of adults who have visited the dentist or dental clinic within the past year for any reason
Diet, Fruit	Number of fruits consumed on an average day.
Diet, Vegetables	Number of vegetables consumed on an average day.
Teen Birth Rate	Number of births per 1,000 mothers aged 15 to 19 years.
Youth Smoking	Percentage of high school youth who smoked cigarettes on at least 1 day during the last 30 days
Youth Obesity	Percentage of high school students who were greater or equal to the 95th percentile for body mass index, based on sex and age-specific reference data from the 2000 CDC growth charts

Chronic Disease

Heart Disease	Percentage of adults who have been told by a health professional that they have angina or coronary heart disease.
High Cholesterol	Percentage of adults who have had their cholesterol checked and been told that it was high
Heart Attack	Percentage of adults who have been told by a health professional that they had a heart attack (myocardial infarction)
Stroke	Percentage of adults who have been told by a health professional that they had a stroke.
Hypertension	Percentage of adults who have been told by a health professional that they have high blood pressure

Clinical Care

Preterm Birth	Percentage of babies born before 37 weeks gestation

Economic Environment

Personal Income	Per capita personal income in current dollars
Median Household Income	The amount of income that divides the income distribution into 2 equal groups
Unemployment Rate	Total unemployed as a percentage of the civilian labor force (U-3 definition)
Underemployment Rate	Total unemployed, plus all marginally attached workers, plus total employed part-time for economic reasons, as a percent of the civilian labor force (U-6 Definition)
Income Disparity (Gini coefficient)	A common measure of income inequality, where 0 represents complete equality and 1 indicates complete inequality

Outcomes

Low Health Status	Percentage of adults who describe their general health as fair or poor
Suicide	Number of deaths due to intentional self-harm per 100,000 population

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Overview

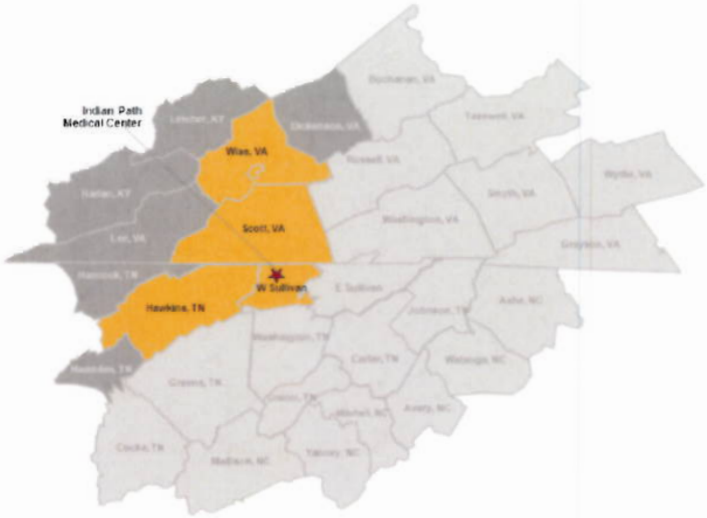
The County Snapshots consists of demographics, key indicators of health status, interview highlights, and local resources. The model for the key indicators of health status analysis was based on the 2015 *County Health Rankings*, a key component of the Mobilizing Action Toward Community Health (MATCH). MATCH is collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute. Indicators are organized into two broad categories: Health Outcomes and Health Factors. The Health Factors have multiple components, including Clinical Care, Health Behaviors, Social and Economic Factors, and Physical Environment. A number of additional key indicators of health status were included in this analysis from other sources (they are noted in blue font in the snapshot section). For each indicator, the state and county score is provided as well as a comparison of the county's performance to that of the state.

INDIAN PATH MEDICAL CENTER

Service Area Counties:

- West Sullivan, TN
- Hawkins, TN
- Scott, VA
- Wise, VA

Primary Service Area Map:



Facility Profiles:

Indian Path Medical Center (IPMC), Kingsport, Tenn., is a 261-bed, not-for-profit hospital. IPMC provides convenient parking, easy access and private rooms, as well as a variety of menu options and convenient room service 24 hours a day. All ancillary and outpatient services are on the ground floor to provide more expedient care. IPMC joined Mountain States Health Alliance in 1998. This hospital serves as a regional referral center providing advanced care in the areas of orthopedics, oncology, cardiology, and women's.

A 6-page profile of each county is provided. The profile includes demographic highlights, key indicators of health status, utilization projections, and survey results specific to the county. A detailed demographic analysis by county is provided in the appendix which follows the collection of county snapshots.

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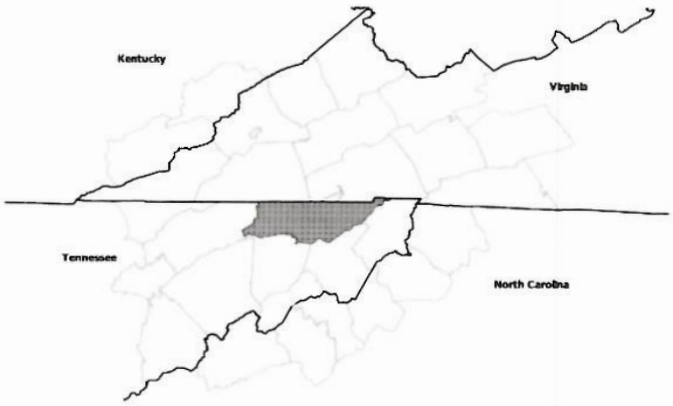
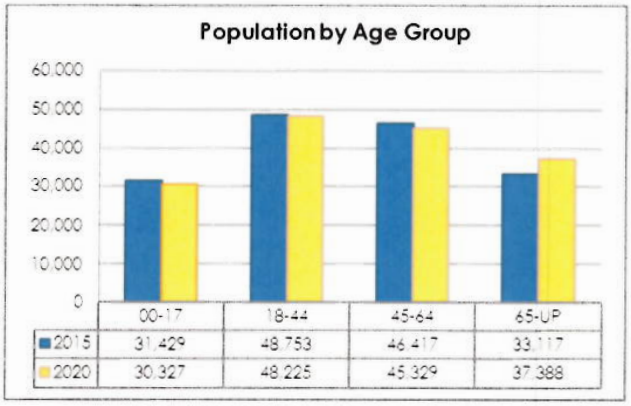
Demographic Highlights:

- Large elderly population compared to TN and US
- Declining rate of females of child-bearing age expected
- Low average household income level (15.6% of households make less than $15,000)
- Low level of educational attainment compared to state and country (6.6% with no high school education compared to 5.9% nationally)
- Low level of diversity compared to state and national

Service Area Map:



Age Distribution and Population Projections:



Key Statistics:

	Sullivan County	Tennessee	U.S.
2015 Total Population	159,716	6,735,022	321,369,000
% Change 2015-2020	1.0%	5.5%	4.1%
% of Population 65+ (2015)	20.7%	15.6%	14.9%
% Minority (2015)	6.6%	26.1%	38.3%

	2015	2020	% Change
Total Male Population	77,249	78,076	1.1%
Total Female Population	82,467	83,193	0.9%
Females, Child Bearing Age (15-44)	27,268	26,913	-1.3%

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Local Health Highlights:

STRENGTHS:

- Unemployment Rate
- Medical Doctors
- Decreased percentage of individuals with no health insurance
- Percentage of Children Un/Improperly Restrained in a Crash
- STDs

WEAKNESSES:

- Prevalence of asthma and diabetes
- Vaccinations
- Smoking during pregnancy
- Pre-1950 Housing
- Deaths due to cardiovascular, diabetes, cerebrovascular, cancer, suicide, and injuries

Leading Causes of Death:

Ages 1 - 14 years

Cause of Death	Rate	Rank
Heart Disease	4.12	1
Cancer	4.12	2
Anemia	4.12	3
All Other Causes	4.12	*

Ages 15 - 21 years

Cause of Death	Rate	Rank
Accidents	53.6	1
Suicide	23	2
All Other Causes	53.5	*

Ages 22 - 64

Cause of Death	Rate	Rank
Cancer	144.7	1
Heart Disease	141.2	2
Accidents	45.2	3
Suicide	22	4
Respiratory	22	5
Cerebrovascular	15.1	6
Liver/Cirrhosis	13.9	7
Diabetes Mellitus	12.7	8
Septicemia	8.1	9
Viral Hepatits	7	10
All Other Causes	119.1	*

Ages 65+

Cause of Death	Rate	Rank
Heart disease	1238.4	1
Cancer	1127.7	2
Respiratory	449.7	3
Alzheimers Disease	280.2	4
Cerebrovascular	256	5
Flu/Pneumonia	176.4	6
Diabetes Mellitus	148.7	7
Hypertension	131.5	8
Septicemia	100.3	9
Accidents	76.1	10
All Other Causes	1307.5	*

Key Indicators of Health Status:

County: Sullivan, TN

	TN	Sullivan	2010	Desired
Health Outcomes				
Mortality (years of potential life lost/100,000)	8,790	9,005	9,860	
Low Birth Weight (3-yr avg %)	9.0%	8.1%	8.7%	
General Health Status (% fair/poor health)*	19.0%	21.0%	19.0%	
Very Low Birth Weight (%)	1.6%	1.0%	1.4%	
Infant Mortality (3-yr avg rate per 1,000)	8.1	9.2	9.1	
Mortality Rate (3-yr avg rate per 100,000)	953.0	1,281.3	945.5	
Cardiovascular Deaths (per 100,000)	226.5	402.6	280.9	
Cancer Deaths (3-yr avg rate per 100,000)	214.4	291.7	206.3	
Diabetes Mellitus Deaths (per 100,000)	28.7	35.0	31.2	
Cerebrovascular Deaths (per 100,000)	47.0	56.4	54.6	
Suicide Deaths (per 100,000)	15.0	19.5	15.6	
Mortality rate for ages 1 - 14 yrs	66.8	16.5	24.5	
Mortality rate for ages 15 - 21 yrs	70.4	130.1	98.8	
Mortality rates for ages 65+	4,870.1	5,292.5	5,202.00	
Lung Cancer Deaths (3-yr avg rate per 100,000)	68.8	93.6	71.9	
Female Breast Cancer Deaths (3-yr avg rate per 100,000)	14.1	17.1	19.6	
Prevalence of Asthma (%)	9.3%	13.2%	12.4%	
Prevalence of Diabetes (%)	11.0%	14.0%	13.0%	
Health Determinants				
Health Care Resources				
No Health Insurance (%)*	21.0%	15.0%	17.9%	
Medicaid/Tenncare Enrollees (%)	18.7%	17.4%	18.1%	
Medical Doctors Per Capita (per 100,000)	246.1	289.5	312.3	↑
Dentists Per Capita (per 100,000)	52.2	61.2	93.8	↑
Percent without Pneumococcal Vaccinations (%)*	74.2%	66.7%	67.3%	
Percent without Influenza Vaccinations (%)*	59.4%	50.7%	53.4%	
No Diabetic Eye Exams (%)	74.3%	72.2%	53.6%	
No Diabetic HbA1c Testing (%)	15.0%	10.0%	10.0%	
No Biennial Mammography (%)*	23.3%	29.3%	23.3%	
Inadequate or No Prenatal Care (%)	10.7%	38.1%	8.1%	
Month Prenatal Care Began	3.2	3.2	2.9	
First Trimester Prenatal Care (%)	59.3%	61.9%	67.6%	↑
Children (0-18yrs) with Medicaid/Tenncare Coverage (%)	46.8%	46.0%	44.9%	
Hospital Staffed Beds (per 1,000)	3.6	6.7	4.7	↑
Licensed Nursing Beds (per 1,000 65+)	44.8	34.7	37.7	↑
# of Primary Care MDs	7,703	102	100	
# of Psychiatric Specialists	684	9	9	
Inpatient Discharge Rate (per 1,000) - Total	126.3	132.8	131.2	
Health Behaviors (continued)				
Cigarette Smoking (%)*	23.0%	25.0%	30.4%	
Smoking During Pregnancy (%)	16.3%	27.9%	29.8%	
Physical Inactivity (%)*	30.0%	31.0%	34.4%	
Overweight/Obesity (% BMI > 25)	67.8%	67.8%	67.9%	
Obesity (% BMI > 30)*	32.0%	35.0%	30.0%	
Low Fruit and Vegetable Consumption (% <5 a day)*	79.7%	73.0%	76.6%	
Binge Drinking (%)*	10.0%	9.0%	8.5%	
% of Children (0-4) Un/Improperly Restrained in a Crash	14.5%	5.3%	13.5%	
Teen Birth Rate (per 1,000)	37.3	42	60	
Sexually Transmitted Diseases	446	188	194	
Violent Crime (per 100,000)	667.0	512.0	538	
Motor Vehicle Crash Deaths (per 100,000)	19	16	22	
Unmarried Mother Birth Rate (%)	44.1%	42.7%	39.8%	
Injury-related Mortality (3-yr avg rate per 100,000)	53.7	88.2	81.9	
Young Driver Crash Rate 15 - 24	11.9	08.6	10.83	
Elderly Drive Crash Rate (60+)	31.3	28.5	25.14	
Homicides (per 100,000)	8	3.2	13	
All accidental deaths per 100,000 population	52	45.4	46.2	
Average Fatality Rate in Alcohol-Related Crashes (per 100,000 population)	6.9	3.5	5.11	

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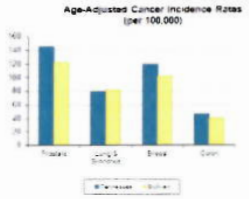
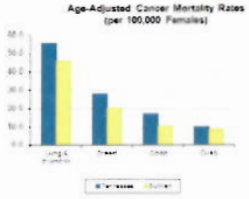
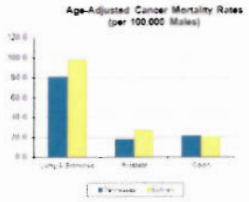
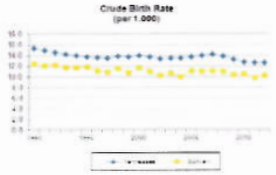
Cancer Incidence:

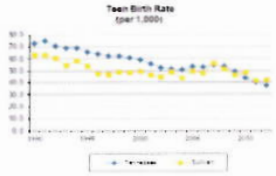






Birth Rate Trend:





Key Indicators of Health Status:

Socioecomonic Factors				
High School Graduation Rate (%)	86.0%	90.0%	81.7%	↑
Level of Education (%)	83.2%	82.7%	80.4%	↑
Unemployment (%)	8.8%	8.4%	5.8%	↓
Children (age 0 to 17) in poverty ratio (%)	26.5%	26.9%	22.4%	↓
Divorce Rate (per 1,000)	4.3	5.1	4.8	↓
Food Stamp Recipients (% of individuals)	21.1%	18.8%	16.2%	↓
Poverty Rate (% of all ages)	18.4%	18.2%	14.1%	↓
Temporary Assistance for Needy Families	2.6%	1.7%	1.9%	↓
High School Dropout Rate	6.9%	3.6%	7.1%	↓
Average Annual Wage	$ 36,576	$ 35,000	$ 32,141	↑
Physical Environment				↓
Air Quality Cancer Risk (per 1,000,000)	4.6	4.7	40.4	↓
Air Quality Hazard Index (per 1,000,000)	1.4	4.7	3.7	↓
Air Quality - Fine Particulate Matter in Air (3 yr avg Mg/m3)*	13.2	13.0	14.5	↓
Ozone Level (ppb)*	0.062	0.063	0.082	↓
Nitrate Levels in drinking water (mg/L Average)	0.7	0.4	0.6	↓
Pre-1950 Housing (%)	11.8%	15.8%	19.4%	↓
Lead Poisoned Children (%)	0.1%	n/a	0.7%	↓
Child Abuse and Neglect (rate per 1,000)	5.5	7.8	11.6	↓
Communicable Diseases				↓
Hepatitis A (per 100,000)	0.3	0.0	n/a	↓
Campylobacter Infection (per 100,000)	7.2	12.7	n/a	↓
Salmonella, Non Typhoid (per 100,000)	17.6	5.7	n/a	↓
Shigellosis (per 100,000)	3.3	0.0	n/a	↓
AIDS/HIV (per 100,000)	29.3	9.1	n/a	↓
Primary and Secondary Syphilis (per 100,000)	4.3	0.6	n/a	↓
Penicillin-Sensitive *Streptococcus pneumoniae* (per 100,000)	0.0	0.0	n/a	↓
Group B *Streptococcus* (per 100,000)	6.2	6.4	n/a	↓
Chlamydia (per 100,000)	517.3	259.8	n/a	↓
Gonorrhea (per 100,000)	144.8	36.8	n/a	↓

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Inpatient Projections

	2014	2019		2024	
DRG Service Line	**Discharges**	**Discharges**	**% Change**	**Discharges**	**% Change**
Cardiac Surgery	237	240	1.30%	250	5.50%
Cardiology	1,851	1,601	-13.50%	1,382	-25.40%
Cardiology Intervention	594	552	-7.10%	519	-12.70%
Endocrinology	508	402	-21.00%	362	-28.80%
ENT Surgery	34	33	-1.80%	33	-2.10%
Gastroenterology	1,693	1,606	-5.10%	1,592	-5.90%
General Medicine	1,716	1,738	1.30%	1,645	-4.10%
General Surgery	1,204	1,161	-3.60%	1,141	-5.20%
Gynecology	156	145	-7.00%	139	-10.60%
Hematology	220	217	-1.50%	223	1.20%
Neonatology	676	629	-7.00%	592	-12.50%
Nephrology	920	855	-7.00%	762	-17.20%
Neurology	986	979	-0.70%	1,010	2.50%
Neurosurgery	428	416	-2.90%	414	-3.20%
Normal Newborns	969	1,005	3.70%	1,000	3.20%
OB Deliveries Sections	567	490	-13.50%	456	-19.60%
OB Deliveries Vaginal	991	1,053	6.30%	1,055	6.50%
OB Other	130	125	-4.00%	122	-6.10%
Oncology Medicine	251	241	-4.00%	218	-13.20%
Oncology Surgery	109	111	1.50%	108	-1.00%
Ophthalmic Medicine	12	11	-12.20%	10	-18.30%
Ophthalmic Surgery	1	1	-9.40%	1	-6.70%
Oral Surgery	18	17	-7.60%	17	-6.90%
Orthopedic Medicine	227	227	0.00%	231	1.80%
Orthopedic Surgery	1,487	1,576	6.00%	1,610	8.20%
Otolaryngology	88	77	-12.90%	74	-15.80%
Plastic Surgery	37	34	-8.20%	31	-16.10%
Psychiatry	1,440	1,580	9.70%	1,502	4.30%
Pulmonary	2,500	2,159	-13.60%	2,046	-18.20%
Rehabilitation	433	338	-22.00%	351	-18.90%
Rheumatology	73	71	-3.30%	70	-3.50%
Substance Abuse	172	178	3.30%	173	0.50%
Thoracic Surgery	153	145	-5.50%	141	-7.50%
Trauma Medical	71	68	-4.30%	69	-2.70%
Unspecified	4	4	2.30%	4	4.50%
Urology Medicine	66	58	-12.70%	53	-19.70%
Urology Surgery	148	140	-5.10%	130	-12.00%
Vascular Surgery	246	245	-0.60%	246	0.00%
Womens Other	13	12	-4.90%	11	-12.20%
Grand Total	**21,429**	**20,537**	**-4.20%**	**19,794**	**-7.60%**

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Outpatient Projections

	2014	2019		2024	
Site of Care	**Volumes**	**Volumes**	**% Change**	**Volumes**	**% Change**
ED	93,692	94,233	0.60%	90,513	-3.40%
Home	211,861	245,806	16.00%	267,901	26.50%
Hosp OP/ASC	255,993	275,109	7.50%	281,172	9.80%
Office/Clinic	1,497,314	1,605,147	7.20%	1,556,518	4.00%
Other	72,130	78,500	8.80%	78,786	9.20%
SNF	4,604	4,958	7.70%	5,181	12.50%
Urgent/Retail	4,389	4,798	9.30%	4,586	4.50%
Virtual		31,971		128,757	
Grand Total	**2,139,982**	**2,340,523**	**9.40%**	**2,413,414**	**12.80%**

Interview Highlights:

INTERVIEWEES:

- 10 individuals

KEY FINDINGS:

- Average rating of health status is 3.6 with a range in responses of 1.5 to 8.
- Top health issues are:
  - Obesity
  - Cancer
  - Diabetes
  - Cardiovascular Disease
  - Substance Abuse/NAS
- Additional health issues are:
  - Smoking and Tobacco Use
  - Oral Health
  - Physical Inactivity
  - Behavioral Health
  - Education
  - Food Insecurity
  - Lack of Free Medical Center
- Ideas to improve these conditions include:
  - Mobile dental clinic linked to dental providers
  - Collaboration across various health systems/programs to provide united approach/solutions
  - Engage business leaders
  - Consolidate efforts among stakeholders to maximize scarce resources
  - More city and corporate support
  - Community forum/Health Summit similar to 1999 Economic Summit
  - Education through public media campaign
  - Target kids
  - Invest more resources and leadership time and commitment to Healthy Kingsport
  - Collaborative Impact Model

Sources:

- Medstat
- County Health Rankings
- TN Advisory Commission on Intergovernmental Relations
- TN Dept of Health
- BRFSS
- TennCare
- Kidscount
- TN Dept of Safety and Homeland Security
- EPA
- CDC Wonder
- TN Dept of Environment & Conservation
- Childhood Lead Poisoning Prevention Program

Local Resources:

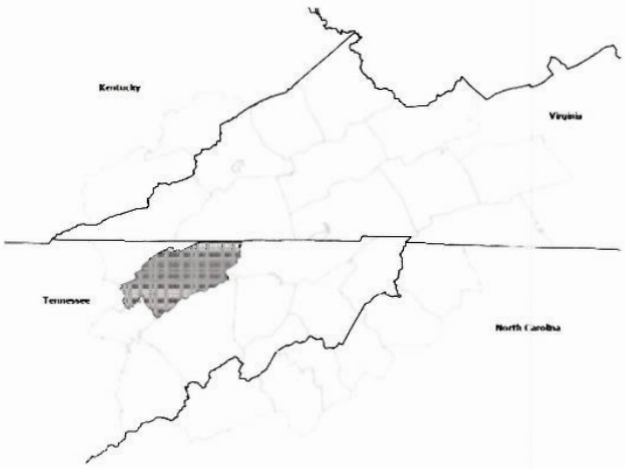
- Coordinated School Health
- East Tennessee State University, School of Public Health
- Friends in Need
- Health Resources Center
- Healthy Kingsport
- Parish Nurse Program
- PEAK (young professional organization)
- Providence Medical Clinic
- School System
- Sullivan County Health Council
- Sullivan County Health Department
- United Way of Greater Kingsport, Health Safety & Stability Vision Council
- YMCA

SBH-KINGSPORT 002065

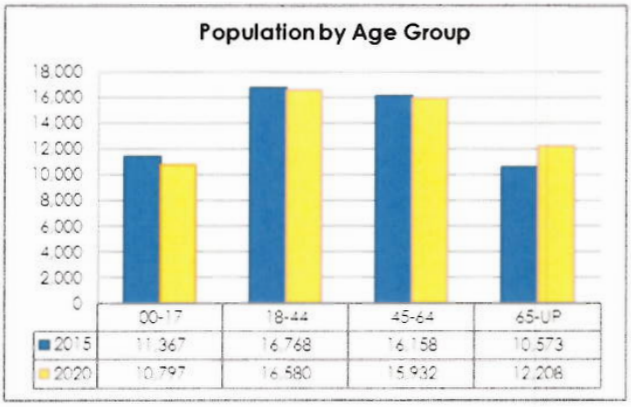
Demographic Highlights:

- Large elderly population compared to TN and US
- Declining rate of females of child-bearing age expected
- Low average household income level (14.5% of households make less than $15,000)
- Lower level of educational attainment compared to state and country (10.2% with no high school education compared to 5.9% nationally)
- Low level of diversity compared to state and national

Service Area Map:



Age Distribution and Population Projections:



SBH-KINGSPORT 002066

Key Statistics:

	Hawkins County	Tennessee	U.S.
2015 Total Population	54,866	6,735,022	321,369,000
% Change 2015-2020	1.2%	5.5%	4.1%
% of Population 65+ (2015)	19.3%	15.6%	14.9%
% Minority (2015)	4.7%	26.1%	38.3%

	2015	2020	% Change
Total Male Population	27,010	27,310	1.1%
Total Female Population	27,856	28,207	1.3%
Females, Child Bearing Age (15-44)	9,433	9,335	-1.0%

HAWKINS COUNTY, TN

2015 COUNTY SNAPSHOT

Local Health Highlights:

STRENGTHS:

- Binge Drinking
- Unemployment Rate
- Health Insurance
- Vaccinations
- STDs
- Violent Crime

WEAKNESSES:

- High School Graduation Rates
- Smoking During Pregnancy
- Deaths due to cardiovascular, cancer, diabetes, injuries, and suicide
- No Biennial Mammogram

Key Indicators of Health Status:

SBH-KINGSPORT 002067

Leading Causes of Death:

Ages 1 - 14 years

Cause of Death	Rate	Rank
Cancer	3.4	1
Flu/Pneumonia	3.4	1
Homicide	3.4	1
All Other Causes	6.57	*

Ages 15 - 21 years

Cause of Death	Rate	Rank
Accidents	75.7	1
Suicide	12.6	2
All Other Causes	19	*

Ages 22 - 64

Cause of Death	Rate	Rank
Cancer	140.4	1
Heart Disease	101.8	2
Accidents	69.2	3
Suicide	25.7	4
Diabetes Mellitus	16.8	5
Respiratory	15.8	6
Liver/Cirrhosis	14.8	7
Cerebrovascular	13.8	8
Viral Hepatitis	8.9	9
Septicemia	6.9	10
All Other Causes	115.7	*

Ages 65+

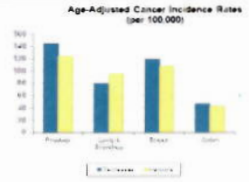
Cause of Death	Rate	Rank
Heart diseases	1244.3	1
Cancer	1150.7	2
Respiratory	346.6	3
Cerebrovascular	246.1	4
Alzheimer's	242.6	5
Diabetes Mellitus	142.1	6
Nephritis	104	7
Flu/Pneumonia	93.6	8
Accidents	79.7	9
Pneumonitis	62.4	10
All Other Causes	1026	*

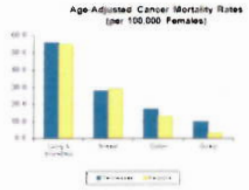
County: Hawkins, TN

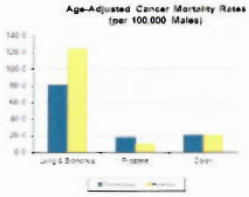
	TN	Hawkins	2010	Desired
Health Outcomes				
Mortality (years of potential life lost/ 100,000)	8,790	9,725	9,417	
Low Birth Weight (3-yr avg %)	9.0%	10.3%	8.40%	
General Health Status (% fair/poor health)*	19.0%	26.0%	23%	
Very Low Birth Weight (%)	1.6%	1.0%	1.20%	
Infant Mortality (3-yr avg rate per 1000)	8.1	8.1	7.3	
Mortality Rate (3-yr avg rate per 100,000)	953.0	1,092.9	936.9	
Cardiovascular Deaths (per 100,000)	226.5	264.8	267.7	
Cancer Deaths (3-yr avg rate per 100,000)	214.4	267.9	194.4	
Diabetes Mellitus Deaths (per 100,000)	28.7	43.6	36	
Cerebrovascular Deaths (per 100,000)	47.0	40.2	32.6	
Suicide Deaths (per 100,000)	15.0	18.4	17.2	
Mortality rate for ages 1- 14 yrs	66.8	30.0	17.2	
Mortality rate for ages 15 - 21yrs	70.4	94.0	137.5	
Mortality rates for ages 65+	4,870.1	4,602.8	5,08190	
Lung Cancer Deaths (3-yr avg rate per 100,000)	68.8	92.3	62	
Female Breast Cancer Deaths (3-yr avg rate per 100,000)	14.1	14.6	35.2	
Prevalence of Asthma (%)	9.3%	13.2%	12.8%	
Prevalence of Diabetes (%)	11.0%	13.0%	14.0%	
Health Determinants				
Health Care Resources				
No Health Insurance (%)*	21.0%	15.0%	16.40%	
Medicaid/Tenncare Enrollees (%)	18.7%	20.7%	22.10%	
Medical Doctors Per Capita (per 100,000)	246.1	29.9	314	*
Dentists Per Capita (per 100,000)	52.2	12.3	22.5	*
Percent without Pneumococcal Vaccinations (%)*	74.2%	66.7%	72.30%	
Percent without Influenza Vaccinations (%)*	59.4%	49.3%	59.30%	
No Diabetic Eye Exams (%)	74.3%	72.2%	52.40%	
No Diabetic HbA1c Testing (%)	16.0%	14.0%	10.40%	
No Biennial Mammography (%)*	29.3%	29.3%	23.30%	
Inadequate or No Prenatal Care (%)	40.7%	42.4%	5.50%	
Month Prenatal Care Began	3.2	3.2	2.9	
First Trimester Prenatal Care (%)	59.3%	57.6%	63.10%	*
Children (0-18 yrs) with Medicaid/Tenncare Coverage (%)	46.8%	50.0%	49.80%	
Hospital Staffed Beds (per 1,000)	3.6	0.9	0.8	*
Licensed Nursing Beds (per 1,000E5+)	44.8	36.9	39.7	*
# of Primary Care MDs	7,703	14	24	
# of Psychiatric Specialists	684	1	1	
Inpatient Discharge Rate (per 1,000) - Total	126.3	115.5	120	
Health Behaviors (continued)				
Cigarette Smoking (%)*	23.0%	26.0%	28.90%	
Smoking During Pregnancy (%)	16.3%	30.5%	30.10%	
Physical Inactivity (%)*	30.0%	33.0%	38.40%	
Overweight/Obesity (% BMI > 25)	67.8%	67.8%	67.90%	
Obesity (% BMI > 30)*	32.0%	34.0%	32.00%	
Low Fruit and Vegetable Consumption (% <5 a day)*	76.7%	73.0%	76.60%	
Binge Drinking (%)*	10.0%	5.0%	7.90%	
% of Children (0-4) Un/Improperly Restrained in a Crash	14.5%	5.8%	10.90%	
Teen Birth Rate (per 1,000)	37.3	34.6	54	
Sexually Transmitted Diseases (3-yr avg per 10,000)	446	141	144	
Violent Crime (per 100,000)	667.0	280.0	701	
Motor Vehicle Crash Deaths (per 100,000)	19	29	29	
Unmarried Mother Birth Rate (%)	44.1%	40.7%	39.90%	
Injury-related Mortality (3-yr avg rate per 100,000)	53.7	97.2	90.1	
Young Driver Crash Rate 15 - 24	116.9	79.4	78.6	
Elderly Drive Crash Rate (80+	31.0	21.5	18	
Homicides (per 100,000)	8	3.4	17	
All accidental deaths per 100,000 population	52	55.3	80.7	
Average Fatality Rate in Alcohol-Related Crashes (per 100,000 population)	6.9	6.8	10.98	

SBH-KINGSPORT 002068

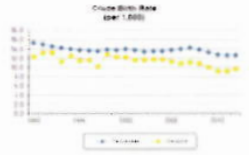
Cancer Incidence:

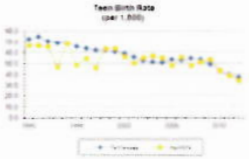






Birth Rate Trend:





Key Indicators of Health Status:

Socioecomonic Factors				
High School Graduation Rate (%)	86.0%	91.0%	81.20%	↑
Level of Education (%)	83.2%	79.0%	76.50%	↑
Unemployment (%)	8.8%	9.4%	7.60%	↓
Children (age 0 to 17) in poverty ratio (%)	26.5%	26.5%	23.90%	↓
Divorce Rate (per 100,000)	4.3	4.9	4.9	↓
Food Stamp Recipients (% of individuals)	21.1%	22.4%	20.50%	↓
Poverty Rate (% of all ages)	18.4%	17.9%	20.30%	↓
Temporary Assistance for Needy Families	2.6%	1.5%	1.90%	↓
High School Dropout Rate	6.9%	2.4%	6.30%	↓
Average Annual Wage	$ 36,576	$ 28,610	$ 25,023	↑
Physical Environment				
Air Quality Cancer Risk (per 1000,000)	4.6	3.5	21.9	↓
Air Quality Hazard Index (per 1000,000)	1.4	8.9	2	↓
Air Quality - Fine Particulate Matter in Air (3 yr avg Mg/m 3)*	13.2	12.8	14.5	↓
Ozone Level (ppb)*	0.062	0.063	0.082	↓
Nitrate Levels in drinking water (mg/L)	0.7	0.85	2	↓
Pre-1950 Housing (%)	11.8%	13.7%	14.40%	↓
Lead Poisoned Children (%)	0.1%	n/a	0.30%	↓
Child Abuse and Neglect (rate per 1,000)	5.5	6.5	3.7	↓
Communicable Diseases				
Hepatitis A (per 100,000)	0.3	0.0	n/a	↓
Campylobacter Infection (per 100,000)	7.2	6.9	n/a	↓
Salmonella, Non Typhoid (per 100,000)	17.6	12.5	n/a	↓
Shigellosis (per 100,000)	3.3	1.8	n/a	↓
AIDS (per 100,000)	29.3	4.4	n/a	↓
Primary and Secondary Syphilis (per 100,000)	4.3	0.0	n/a	↓
Penicillin-Sensitive *Streptococcus pneumoniae* (per 100,000)	0.0	0.0	n/a	↓
Group B *Streptococcus* (per 100,000)	6.2	7.2	n/a	↓
Chlamydia (per 100,000)	517.3	297.7	n/a	↓
Gonorrhea (per 100,000)	144.8	3.5	n/a	↓

SBH-KINGSPORT 002069

Inpatient Projections

	2014	2019		2024	
DRG Service Line	**Discharges**	**Discharges**	**% Change**	**Discharges**	**% Change**
Cardiac Surgery	63	65	2.80%	68	7.70%
Cardiology	561	494	-12.00%	436	-22.30%
Cardiology Intervention	213	199	-6.80%	185	-13.20%
Endocrinology	182	144	-21.00%	129	-29.30%
ENT Surgery	15	15	-2.50%	14	-4.70%
Gastroenterology	526	500	-5.00%	495	-5.90%
General Medicine	705	718	1.90%	675	-4.20%
General Surgery	394	389	-1.40%	383	-2.90%
Gynecology	64	58	-8.90%	55	-14.40%
Hematology	91	91	0.50%	96	5.50%
Neonatology	213	195	-8.40%	181	-14.90%
Nephrology	272	257	-5.60%	235	-13.60%
Neurology	342	344	0.60%	358	4.80%
Neurosurgery	149	144	-3.30%	142	-4.90%
Normal Newborns	310	319	3.00%	315	1.80%
OB Deliveries Sections	166	142	-14.40%	131	-21.20%
OB Deliveries Vaginal	321	338	5.30%	336	4.70%
OB Other	28	27	-4.60%	26	-7.40%
Oncology Medicine	107	104	-3.00%	95	-11.20%
Oncology Surgery	48	49	2.20%	49	1.80%
Ophthalmic Medicine	3	3	-14.80%	2	-23.60%
Ophthalmic Surgery	3	3	-6.80%	3	-4.60%
Oral Surgery	7	6	-9.00%	6	-8.30%
Orthopedic Medicine	84	85	1.00%	86	2.70%
Orthopedic Surgery	416	444	6.80%	458	10.20%
Otolaryngology	28	25	-12.20%	23	-16.70%
Plastic Surgery	17	16	-5.70%	14	-14.90%
Psychiatry	410	447	9.10%	422	2.90%
Pulmonary	921	802	-12.90%	764	-17.10%
Rehabilitation	162	127	-21.40%	133	-17.70%
Rheumatology	24	23	-4.70%	23	-6.00%
Substance Abuse	37	37	1.20%	36	-3.10%
Thoracic Surgery	56	54	-3.60%	53	-5.70%
Trauma Medical	22	21	-5.30%	21	-6.50%
Unspecified	4	4	1.60%	4	3.20%
Urology Medicine	16	14	-14.40%	13	-21.80%
Urology Surgery	33	30	-9.30%	27	-18.50%
Vascular Surgery	84	82	-2.90%	81	-4.10%
Womens Other	3	3	-7.80%	2	-19.50%
Grand Total	**7,100**	**6,817**	**-4.00%**	**6,574**	**-7.40%**

SBH-KINGSPORT 002070

Outpatient Projections

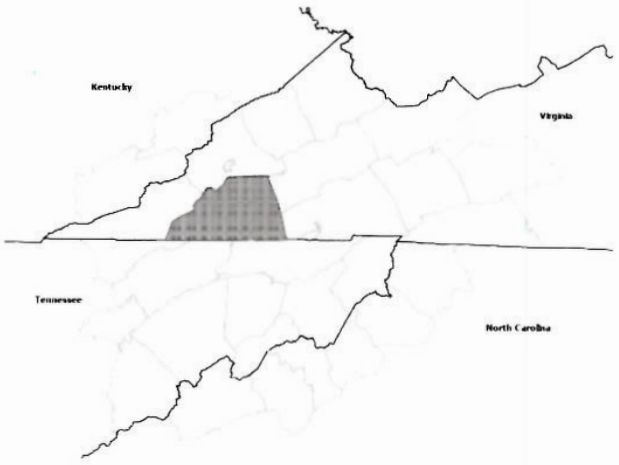
	2014	2019		2024	
Site of Care	**Volumes**	**Volumes**	**% Change**	**Volumes**	**% Change**
ED	30,771	30,709	-0.20%	29,250	-4.90%
Home	104,888	124,740	18.90%	138,276	31.80%
Hosp OP/ASC	81,291	87,807	8.00%	90,003	10.70%
Office/Clinic	479,332	511,407	6.70%	491,681	2.60%
Other	34,003	37,352	9.80%	37,055	9.00%
SNF	1,022	1,123	9.80%	1,189	16.30%
Urgent/Retail	490	522	6.60%	510	4.10%
Virtual		10,859		44,215	
Grand Total	**731,798**	**804,518**	**9.90%**	**832,179**	**13.70%**

SBH-KINGSPORT 002071

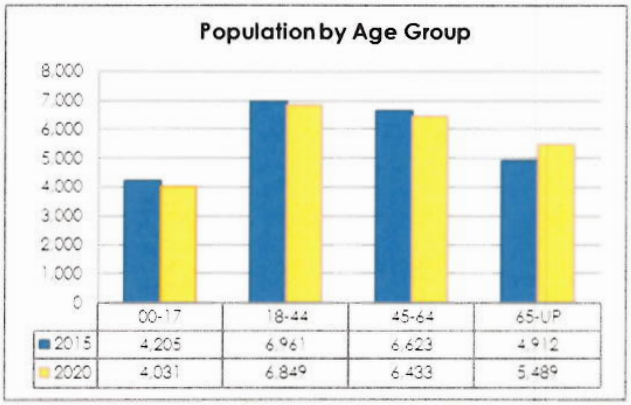
Demographic Highlights:

- Large elderly population compared to VA and US
- Declining rate of females of child-bearing age expected
- Low average household income level (18.2% of households make less than $15,000)
- Lower level of educational attainment compared to state and country (13.8% with no high school education compared to 5.9% nationally)
- Low level of diversity compared to state and national

Service Area Map:



Age Distribution and Population Projections:



Key Statistics:

	Scott County	Virginia	U.S.
2015 Total Population	22,701	8,417,864	321,369,000
% Change 2015-2020	0.4%	4.7%	4.1%
% of Population 65+ (2015)	21.6%	14.0%	14.9%
% Minority (2015)	3.4%	30.8%	38.3%

	2015	2020	% Change
Total Male Population	11,389	11,457	0.6%
Total Female Population	11,312	11,345	0.3%
Females, Child Bearing Age (15-44)	3,686	3,612	-2.0%

SBH-KINGSPORT 002072

Local Health Highlights:

STRENGTHS:

- Lowest rate of AIDS/HIV cases
- Low Binge Drinking percentage
- Low STD rate
- High Rate of High School Graduation

WEAKNESSES:

- High rates of Medicaid enrollees
- High Teen Birth Rate
- High rates of death due to cardiovascular, cancer, cerebrovascular, diabetes, suicide, and injuries
- Low percentages of prenatal care
- High percentage of smoking
- High rates of poverty and children in poverty

Leading Causes of Death (all ages):

Cause of Death	Rate	Rank
Malignant Neoplasms	341.5	1
Heart Disease	259.4	2
Chronic Lower Respiratory	82.1	3
Unintentional Injury	69.2	4
Cerebrovascular Disease	64.8	5
Alzheimer's Disease	51.9	6
Diabetes Mellitus	47.6	7
Influenza & Pneumonia	30.3	8
Suicide	25.9	9
Nephritis & Nephrosis	21.6	10

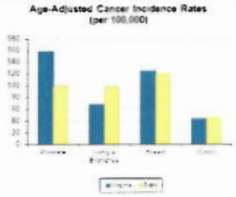
Key Indicators of Health Status:

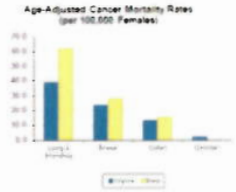
County: Scott, VA

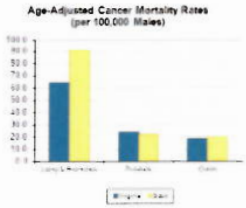
	VA	Scott	2010	Desired	
Health Outcomes					
Low Birth Weight (%)	8.3%	8.3%	10%		↓
General Health Status (% fair/poor health)	14.0%	24.0%	22%		↓
Very Low Birth Weight (%)	1.6%	0.5%	3.10%		↓
Infant Mortality (per 100,000)	8.3	12.0	2		↓
Mortality Rate (per 100,000)	735.8	899.9	957.8		↓
Cardiovascular Deaths (per 100,000)	181.3	172.6	239.1		↓
Cancer Deaths (5-yr avg rate per 100,000)	174.8	195.0	178.5		↓
Diabetes Mellitus Deaths (Age Adjusted Rate per 100,000)	20.0	47.6	38.5		↓
Cerebrovascular Deaths (Age Adjusted Rate per 100,000)	40.8	64.8	41.1		↓
Suicide Deaths (Age Adjusted Rate per 100,000)	12.9	25.9	22.8		↓
Mortality rate for ages 0 - 4 yrs (per 100,000)	152.9	265.0	266		↓
Mortality rate for ages 5 - 14 yrs (per 100,000)	13.5	0.0	0		↓
Mortality rate for ages 15 - 19 yrs (per 100,000)	44.5	82.3	79.9		↓
Mortality rates for ages 65+ (per 1,000)	43.6	48.0	49.1		↓
Lung Cancer Deaths (5-yr avg rate per 100,000)*	49.5	76.8	74.6		↓
Female Breast Cancer Deaths (5-yr avg rate per 100,000)*	23.5	27.9	25.4		↓
Percent of Adults with Asthma*	8.0%	6.0%	12.40%		↓
Prevalence of Diabetes (% of adults)*	9.0%	8.0%	12.90%		↓
Psychosis Discharges (per 100,000)	332.7	47.6	44		↓
Health Determinants					
Health Care Resources					
No Health Insurance (%)	18.0%	19.0%	23.60%		↓
Medicaid/Tennicare Enrollees (%)	14.7%	24.1%	26.90%		↓
Medical Doctors Per Capita (per 100,000)	255.5	12.7	75.6		↑
No Biennial Mammography (%)*	28.0%	26.0%	29.20%		↓
PSA Testing Past 2 Years (%)*	56.0%	56.0%	45.20%		↑
Pap Test Past 3 Years (%)*	84.0%	79.0%	12%		↑
Sigmoidoscopy/Colonoscopy (%)*	72.0%	64.0%	51%		↑
Inadequate or No Prenatal Care (%)	13.0%	12.0%	19%		↓
First Trimester Prenatal Care (%)	81.9%	26.1%	14.70%		↑
Hospital Staffed Beds (per 1,000)	2.2	0.0	0		↑
Licensed Nursing Beds (per 1,000 65+)	3.9	13.0	14		↑
# of Primary Care MDs Per Capita (per 100,000)	122.3	25.9	71.2		↑
# of Psychiatric Specialists	6,827	0	0		↓
State Mental Health Facility Beds (per 100,000)*	18.7	28.7	23.7		↑
Inpatient Discharge Rate (per 1,000) - Total	157.2	136.1	148.8		↓
Could Not See Doctor Due to Cost (%)	10.0%	14.0%	11%		↓
Health Behaviors (continued)					
Cigarette Smoking (%)	18.0%	30.0%	3150%		↓
Physical Inactivity (%)	24.0%	32.0%	22%		↓
Overweight/Obesity (% BMI > 25)	62.0%	66.0%	57%		↓
Obesity (% BMI > 30)	28.0%	28.0%	30%		↓
Low Fruit and Vegetable Consumption (% <5 a day)	80.0%	85.0%	76%		↓
Binge Drinking (%)	18.0%	12.0%	15%		↓
Teen Birth Rate (per 1,000)	18.6	27.4	24.4		↓
Sexually Transmitted Diseases (per 100,000)	385.0	1210	1619		↓
Violent Crime (per 100,000)	233.0	163.0	166		↓
Motor Vehicle Crash Deaths (per 100,000)	11.0	27.0	26		↓
Unmarried Mother Birth Rate (%)	35.0%	45.0%	31%		↓
Injury-related Mortality (Age Adjusted Rate per 100,000)	33.4	69.2	61.8		↓
Homicides (per 100,000)	5.0	0.0	3.3		↓

SBH-KINGSPORT 002073

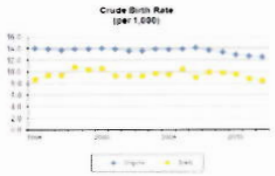
Cancer Incidence:

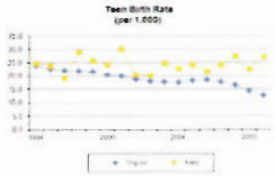






Birth Rate Trend:





Key Indicators of Health Status:

Socioecomonic Factors				
High School Graduation Rate (%)	88.0%	94.0%	92.30%	*
Level of Education (%)	88.0%	73.0%	75%	*
Unemployment (%)	6.2%	8.1%	9.50%	↓
Children (age 0 to 17) in poverty ratio (%)	15.5%	28.2%	24.10%	↓
Food Stamp Eligible Recipients (% of individuals)	11.6%	18.1%	16.80%	↓
Poverty Rate (% of all ages)	12.0%	21.0%	19.20%	↓
Temporary Assistance for Needy Families	0.8%	1.7%	1.70%	↓
High School Dropout Rate	1.4%	0.6%	0.70%	↓
Physical Environment				
Pre-1950 Housing (%)	13.2%	21.0%	26.60%	↓
Lead Poisoned Children (%)	0.2%	0.5%	0.60%	↓
Child Abuse and Neglect (rate per 1,000)	3.3	5.8	12.3	↓
Daily Fine Particulate Matter	12.5	13	12.3	↓
Communicable Diseases				
Hepatitis A (per 100,000)	0.6	4.3	0	↓
Campylobacter infection (per 100,000)	9.4	30.3	17.6	↓
Salmonellosis (per 100,000)	14.1	13.0	17.6	↓
Shigellosis (per 100,000)	1.1	0.0	0	↓
AIDS/HIV cases (per 100,000)	305.3	43.2	0	↓
Early Stage Syphilis (per 100,000)	7.3	0.0	0	↓
Tuberculosis (per 100,000)	2.9	4.3	0	↓
Chlamydia (per 100,000)	432.5	121.1	149.2	↓
Gonorrhea (per 100,000)	85.1	4.3	8.8	↓

SBH-KINGSPORT 002074

Inpatient Projections

	2014	2019		2024	
DRG Service Line	**Discharges**	**Discharges**	**% Change**	**Discharges**	**% Change**
Cardiac Surgery	35	36	2.00%	37	6.70%
Cardiology	313	269	-14.10%	230	-26.50%
Cardiology Intervention	106	98	-8.00%	91	-14.20%
Endocrinology	86	69	-19.60%	64	-26.00%
ENT Surgery	3	3	0.60%	3	5.30%
Gastroenterology	271	258	-4.70%	257	-5.30%
General Medicine	314	323	2.80%	304	-3.10%
General Surgery	177	173	-2.50%	168	-5.10%
Gynecology	31	28	-8.80%	27	-13.50%
Hematology	44	44	0.10%	46	4.70%
Neonatology	73	67	-7.90%	63	-14.30%
Nephrology	129	119	-7.60%	106	-17.50%
Neurology	151	153	1.50%	162	7.30%
Neurosurgery	55	53	-3.50%	53	-4.50%
Normal Newborns	122	125	2.60%	123	0.90%
OB Deliveries Sections	74	63	-14.40%	58	-21.10%
OB Deliveries Vaginal	126	133	5.40%	132	4.50%
OB Other	22	21	-4.90%	20	-8.40%
Oncology Medicine	51	49	-4.00%	44	-12.80%
Oncology Surgery	20	20	-1.80%	19	-5.80%
Ophthalmic Medicine	4	4	-8.60%	4	-11.40%
Ophthalmic Surgery	1	1	-11.70%	1	-11.40%
Oral Surgery	3	3	-9.60%	3	-8.50%
Orthopedic Medicine	42	43	1.60%	44	4.40%
Orthopedic Surgery	174	183	5.10%	187	7.40%
Otolaryngology	9	8	-14.30%	7	-19.10%
Plastic Surgery	8	7	-9.30%	6	-22.10%
Psychiatry	177	194	9.50%	184	3.70%
Pulmonary	451	393	-12.90%	371	-17.70%
Rehabilitation	82	64	-22.20%	66	-19.10%
Rheumatology	16	16	-3.00%	16	-2.40%
Substance Abuse	18	18	1.60%	18	0.20%
Thoracic Surgery	29	27	-7.90%	26	-11.60%
Trauma Medical	7	7	0.00%	7	3.20%
Unspecified	2	2	14.10%	3	28.20%
Urology Medicine	8	7	-11.20%	6	-19.80%
Urology Surgery	13	12	-5.90%	11	-13.10%
Vascular Surgery	29	28	-5.20%	27	-8.20%
Womens Other	3	3	-7.90%	2	-17.60%
Grand Total	**3,279**	**3,121**	**-4.80%**	**2,996**	**-8.60%**

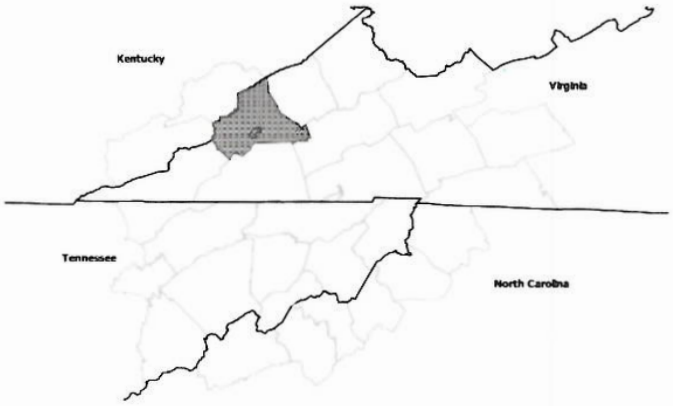
Outpatient Projections

	2014	2019		2024	
Site of Care	**Volumes**	**Volumes**	**% Change**	**Volumes**	**% Change**
ED	13,446	13,581	1.00%	13,103	-2.50%
Home	26,269	30,400	15.70%	33,094	26.00%
Hosp OP/ASC	31,502	33,773	7.20%	34,494	9.50%
Office/Clinic	190,828	203,487	6.60%	197,184	3.30%
Other	17,896	19,750	10.40%	19,841	10.90%
SNF	617	657	6.40%	681	10.40%
Urgent/Retail	160	167	5.00%	164	2.60%
Virtual		4,872		17,840	
Grand Total	**280,717**	**306,688**	**9.30%**	**316,400**	**12.70%**

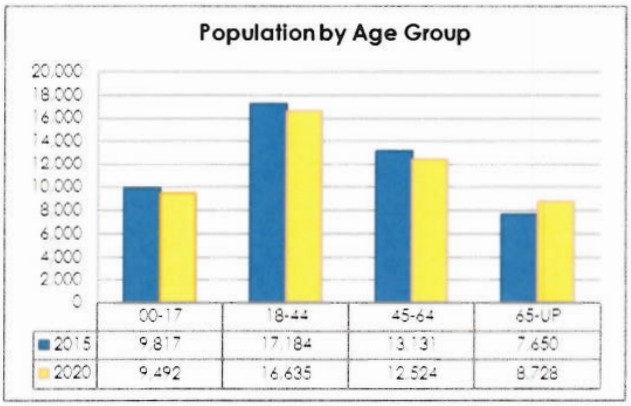
Demographic Highlights:

- Large elderly population compared to VA and US
- Declining rate of females of child-bearing age expected
- Low average household income level (21.4% of households make less than $15,000)
- Lower level of educational attainment compared to state and country (12.9% with no high school education compared to 5.9% nationally)
- Low level of diversity compared to state and national

Service Area Map:



Age Distribution and Population Projections:



Key Statistics:

	Norton & Wise	Virginia	U.S.
2015 Total Population	47,782	8,417,864	321,369,000
% Change 2015-2020	-0.8%	4.7%	4.1%
% of Population 65+ (2015)	16.0%	14.0%	14.9%
% Minority (2015)	8.1%	30.8%	38.3%

	2015	2020	% Change
Total Male Population	24,421	24,184	-1.0%
Total Female Population	23,361	23,195	-0.7%
Females, Child Bearing Age (15-44)	8,618	8,317	-3.5%

SBH-KINGSPORT 002077

Local Health Highlights (Wise County):

STRENGTHS:

- Binge Drinking
- STDs
- Injury-related mortality
- High school graduation rate
- Violent crime

WEAKNESSES:

- High percent of Medicaid eligible and Temporary Assistance for Needy Families
- Smoking
- Pre-1950s Housing
- Prenatal Care
- Low fruit and vegetable consumption
- High rates of death due to cardiovascular, cancer, diabetes, cerebrovascular, and suicide
- Teen birth rate
- Poverty and children in poverty rates

Leading Causes of Death (Wise County):

Source:

Cause of Death	Rate	Rank
Heart Disease	172.9	1
Malignant Neoplasms	203.4	2
Chronic Lower Respiratory Disease	99.8	3
Suicide	49.7	4
Hypertension & Renal Disease	49.7	4
Diabetes Mellitus	24.9	5
Unintentional Injury	24.9	5
Cerebrovascular Disease	24.9	5

Key Indicators of Health Status (Wise County):

County: Wise, VA

	VA	Wise	2010	Desired
Health Outcomes				
Low Birth Weight (%)	8.3%	9.6%	8%	
General Health Status (% fair/poor health)	14.0%	26.0%	28%	
Very Low Birth Weight (%)	1.6%	0.7%	2.35%	
Infant Mortality (per 100,000)	6.3	6.3	4	
Mortality Rate (per 100,000)	736.8	1,033.2	1095	
Cardiovascular Deaths (per 100,000)	161.3	223.1	252.1	
Cancer Deaths (5-yr avg rate per 100,000)	174.8	226.8	219.4	
Diabetes Mellitus Deaths (Age Adjusted Rate per 100,000)	20.0	24.1	33.4	
Cerebrovascular Deaths (Age Adjusted Rate per 100,000)	40.8	52.9	43.7	
Suicide Deaths (Age Adjusted Rate per 100,000)	12.9	24.1	25.2	
Mortality rate for ages 0-4 yrs (per 100,000)	152.9	129.8	167.1	
Mortality rate for ages 5-14 yrs (per 100,000)	13.5	0.0	0	
Mortality rate for ages 15-19 yrs (per 100,000)	44.5	36.9	0	
Mortality rates for ages 65+ (per 1000)	43.6	57.1	63.4	
Lung Cancer Deaths (5-yr avg rate per 100,000)*	49.5	74.6	74.6	
Female Breast Cancer Deaths (5-yr avg rate per 100,000)*	23.4	27.9	25.4	
Percent of Adults with Asthma*	9.0%	6.0%	12.40%	
Prevalence of Diabetes (% of adults)*	9.0%	10.0%	12.90%	
Psychosis Discharges (per 100,000)	332.7	185.8	184	
Health Determinants				
Health Care Resources				
No Health Insurance (%)	16.0%	20.0%	23.50%	
Medicaid/Tennicare Enrollees (%	14.7%	27.0%	23.30%	
Medical Doctors	255.5	59.9	59.9	
No Biennial Mammography (%)*	28.0%	26.0%	29.20%	
PSA Testing Past 2 Years (%)*	56.0%	53.0%	45.20%	
Pap Test Past 3 Years (%)*	84.0%	82.0%	12%	
Sigmoidoscopy/Colonoscopy (%)*	72.0%	66.0%	51%	
Inadequate or No Prenatal Care (%)	12.0%	14.0%	16%	
First Trimester Prenatal Care (%)	81.9%	68.3%	66.20%	
Hospital Staffed Beds (per 1000)	2.2	2.3	0	
Licensed Nursing Beds (per 1,000 65+)	3.9	6.7	49.3	
# of Primary Care MDs Per Capita (per 100,000)	73.7	50.5	51.1	
# of Psychiatric Specialists	6,827	1	1	
State Mental Health Facility Beds (per 100,000)*	19.7	28.7	23.7	
Inpatient Discharge Rate (per 1000) Total		108.0	219.8	
Could Not See Doctor Due to Cost (%)	16.0%	16.0%	12%	
Health Behaviors				
Cigarette Smoking (%)	18.0%	34.0%	31.50%	
Physical Inactivity (%)	24.0%	38.0%	21%	
Overweight/Obesity (% BMI > 25)	62.0%	66.0%	56%	
Obesity (% BMI > 30)	28.0%	35.0%	31%	
Low Fruit and Vegetable Consumption (% <5 a day)	60.0%	66.0%	77%	
Binge Drinking (%)	12.0%	14.0%	13%	
Teen Birth Rate (per 1000)	18.6	28.5	32.7	
Sexually Transmitted Diseases (per 100,000)	385.0	215.0	259.9	
Violent Crime (per 100,000)	203.0	160.0	184	
Motor Vehicle Crash Deaths (per 100,000)	11.0	14.0	19	
Unmarried Mother Birth Rate (%)	36.0%	40.0%	37%	
Injury-related Mortality (Age Adjusted Rate per 100,000)	33.4	77.9	52.4	
Homicides (per 100,000)	5.0	0.0	3.3	

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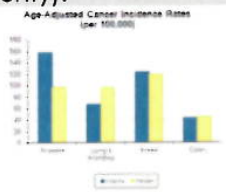
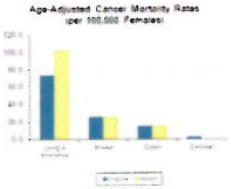
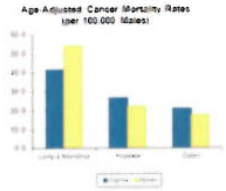
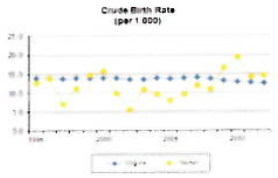
Cancer Incidence (Wise County):

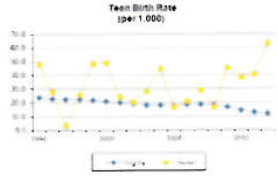






Birth Rate Trend (Wise County):





Key Indicators of Health Status (Wise County):

Socioecomonic Factors				
High School Graduation Rate (%)	88.0%	86.0%	84.90%	↑
Level of Education (%)	88.0%	74.0%	71%	↑
Unemployment (%)	6.2%	6.7%	7%	↓
Children (age 0 to 17) in poverty ratio (%)	15.5%	29.3%	27.10%	↓
Food Stamp Eligible Recipients (% of individuals)	11.6%	22.3%	21%	↓
Poverty Rate (% of all ages)	12.0%	26.0%	19.30%	↓
Temporary Assistance for Needy Families	0.8%	1.6%	2.10%	↓
High School Dropout Rate	1.4%	1.8%	1.90%	↓
Physical Environment				
Pre-1950 Housing (%)	13.2%	19.4%	21.60%	↓
Lead Poisoned Children (%)	0.2%	0.0%	0.50%	↓
Child Abuse and Neglect (rate per 1,000)	3.3	15.5	18.6	↓
Daily Fine Particulate Matter	12.5	12.7	12.3	↓
Communicable Diseases				
Hepatitis A (per 100,000)	0.6	4.4	0	↓
Campylobacter Infection (per 100,000)	9.4	13.2	11	↓
Salmonellosis (per 100,000)	14.1	17.5	17.6	↓
Shigellosis (per 100,000)	1.1	0.0	0	↓
AIDS/HIV cases (per 100,000)	305.3	98.6	107.9	↓
Early Stage Syphilis (per 100,000)	7.3	0.0	0	↓
Tuberculosis (per 100,000)	2.9	2.2	0	↓
Chlamydia (per 100,000)	432.5	335.4	242.3	↓
Gonorrhea (per 100,000)	85.1	19.7	11	↓

SBH-KINGSPORT 002079

Local Health Highlights (Norton City):

STRENGTHS:

- Very low birth weight rate
- Binge drinking
- STDs
- Violent crime
- Lead poisoned children

WEAKNESSES:

- Reported general health status
- Very high rate of Medicaid enrollees
- High rates of death due to cardiovascular, cancer, diabetes, cerebrovascular, suicide, and injuries
- Prenatal care
- Smoking
- Increased rates of physical inactivity, overweight, and obesity
- Poverty and children in poverty
  Child abuse and neglect

Leading Causes of Death (Norton City):

Wise

Cause of Death	Rate	Rank
Malignant Neoplasms	222	1
Heart Disease	248.8	2
Unintentional Injury	79.4	3
Chronic Lower Respiratory Disease	65	4
Cerebrovascular Disease	63	5
Nephritis & Nephrosis	33.7	6
Alzheimer's Disease	23.9	7
Suicide	24.1	8
Diabetes Mellitus	24	9
Influenza & Pneumonia	12.9	10

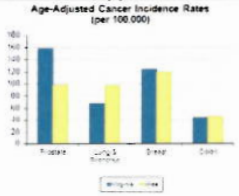
Key Indicators of Health Status (Norton City):

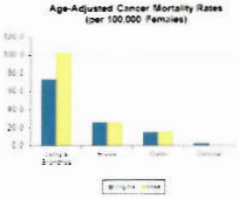
County: Norton, VA

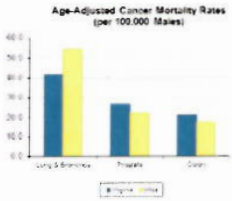
	VA	Norton	2010	Desired
Health Outcomes				
Low Birth Weight (%)	8.3%	9.3%	10%	
General Health Status (% fair/poor health)	14.0%	11.0%	0%	
Very Low Birth Weight (%)	1.6%	2.6%	6.50%	
Infant Mortality (per 1,000)	6.3	7.1	1	
Mortality Rate (per 100,000)	735.8	884.4	854.2	
Cardiovascular Deaths (per 100,000)	161.3	370.0	169.4	
Cancer Deaths (5-yr avg rate per 100,000)	174.8	183.7	215.8	
Diabetes Mellitus Deaths (Age Adjusted Rate per 100,000)	20.0	24.7	22.5	
Cerebrovascular Deaths (Age Adjusted Rate per 100,000)	40.8	24.7	62.7	
Suicide Deaths (Age Adjusted Rate per 100,000)	12.9	49.3	18	
Mortality rate for ages 0 - 4 yrs (per 100,000)	152.9	411.8	526.3	
Mortality rate for ages 5 - 14 yrs (per 100,000)	18.5	0.0	0	
Mortality rate for ages 15 - 19 yrs (per 100,000)	44.5	0.0	0	
Mortality rates for ages 65+(per 1000)	49.6	47.0	44.4	
Lung Cancer Deaths (5-yr avg rate per 100,000)*	49.5	74.6	74.6	
Female Breast Cancer Deaths (5-yr avg rate per 100,000)*	23.4	27.9	25.4	
Percent of Adults with Asthma*	8.0%	6.0%	12.40%	
Prevalence of Diabetes (% of adults)*	9.0%	7.0%	12.93%	
Psychosis Discharges (per 100,000)	392.7	394.7	1,262	
Health Determinants				
Health Care Resources				
No Health Insurance (%)	16.0%	16.0%	24.76%	
Medicaid/Tenncare Enrollees (%)	14.7%	35.5%	30%	
Medical Doctors	255.5	53.9	59.9	
No Biennial Mammography (%)*	28.0%	33.0%	29.20%	
PSA Testing Past 2 Years (%)*	56.0%	57.0%	45.20%	
Pap Test Past 3 Years (%)*	84.0%	77.0%	12%	
Sigmoidoscopy/Colonoscopy (%)*	72.0%	63.0%	51%	
Inadequate or No Prenatal Care (%)	13.0%	9.0%	32%	
First Trimester Prenatal Care (%)	81.9%	62.3%	82.90%	
Hospital Staffed Beds (per 1,000)	2.2	3.1	22.1	
Licensed Nursing Beds (per 1,000 65+)	3.9	10.9	73.7	
# of Primary Care MDs Per Capita (per 100,000)	73.7	42.7	510.1	
# of Psychiatric Specialists	6,827	1	1	
State Mental Health Facility Beds (per 100,000)*	19.7	28.7	29.7	
Inpatient Discharge Rate (per 1000) - Total	157.2	139.0	74.6	
Could Not See Doctor Due to Cost (%)	10.0%	13.0%	12%	
Health Behaviors				
Cigarette Smoking (%)	18.0%	26.0%	31.50%	
Physical Inactivity (%)	24.0%	25.0%	22%	
Overweight/Obesity (% BMI > 25)	62.0%	61.0%	56%	
Obesity (% BMI > 30)	28.0%	28.0%	27%	
Low Fruit and Vegetable Consumption (% <5 a day)	90.0%	95.0%	76%	
Binge Drinking (%)	18.0%	10.0%	15%	
Teen Birth Rate (per 1000)	19.6	52	19.5	
Sexually Transmitted Diseases (per 100,000)	365.0	278.0	259.9	
Violent Crime (per 100,000)	233.0	212.0	325	
Motor Vehicle Crash Deaths (per 100,000)	11.0	14.0	15	
Unmarried Mother Birth Rate (%)	35.0%	50.0%	46%	
Injury-related Mortality (Age Adjusted Rate per 100,000)	39.4	24.7	36.6	
Homicides (per 100,000)	5.0	0.0	3.3	

SBH-KINGSPORT 002080

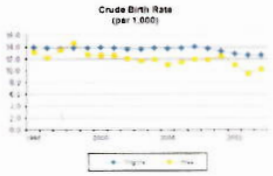
Cancer Incidence (Norton City):

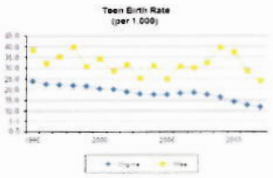






Birth Rate Trend (Norton City):





Key Indicators of Health Status (Norton City):

Socioecomonic Factors				
High School Graduation Rate (%)	88.0%	98.0%	83.10%	↑
Level of Education (%)	88.0%	81.0%	68%	↑
Unemployment (%)	6.2%	6.3%	6.60%	↓
Children (age 0 to 17) in poverty ratio (%)	15.5%	31.2%	31.40%	↓
Food Stamp Eligible Recipients (% of individuals)	11.6%	27.4%	28.60%	↓
Poverty Rate (% of all ages)	12.0%	18.0%	20.90%	↓
Temporary Assistance for Needy Families	0.8%	2.6%	3.80%	↓
High School Dropout Rate	1.4%	1.8%	2.40%	↓
Physical Environment				
Pre-1950 Housing (%)	13.2%	20.4%	26.60%	↓
Lead Poisoned Children (%)	0.2%	0.0%	0.00%	↓
Child Abuse and Neglect (rate per 1,000)	3.3	3.7	6.7	↓
Daily Fine Particulate Matter	12.5	12.8	11.8	↓
Communicable Diseases				
Hepatitis A (per 100,000)	0.6	4.4	0	↓
Campylobacter Infection (per 100,000)	9.4	13.2	11	↓
Salmonellosis (per 100,000)	14.1	17.5	17.6	↓
Shigellosis (per 100,000)	1.1	0.0	0	↓
AIDS/HIV cases (per 100,000)	305.3	98.7	0	↓
Early Stage Syphilis (per 100,000)	7.3	0.0	0	↓
Tuberculosis (per 100,000)	2.9	2.2	0	↓
Chlamydia (per 100,000)	432.5	335.4	242.3	↓
Gonorrhea (per 100,000)	85.1	19.7	11	↓

SBH-KINGSPORT 002081

Inpatient Projections

	2014	2019		2024	
DRG Service Line	**Discharges**	**Discharges**	**% Change**	**Discharges**	**% Change**
Cardiac Surgery	53	53	0.20%	55	3.30%
Cardiology	927	799	-13.80%	701	-24.30%
Cardiology Intervention	224	207	-7.50%	195	-12.80%
Endocrinology	241	193	-19.70%	177	-26.70%
ENT Surgery	17	15	-9.80%	14	-15.30%
Gastroenterology	736	688	-6.60%	673	-8.50%
General Medicine	869	876	0.80%	820	-5.60%
General Surgery	465	441	-5.10%	426	-8.30%
Gynecology	81	73	-10.00%	67	-16.80%
Hematology	91	90	-1.60%	92	1.10%
Neonatology	148	135	-8.50%	125	-15.40%
Nephrology	383	354	-7.50%	314	-18.10%
Neurology	332	328	-1.30%	335	0.80%
Neurosurgery	99	94	-5.40%	91	-8.40%
Normal Newborns	336	344	2.50%	338	0.60%
OB Deliveries Sections	186	158	-15.00%	145	-22.20%
OB Deliveries Vaginal	311	326	4.80%	323	3.70%
OB Other	101	96	-4.70%	93	-7.60%
Oncology Medicine	99	94	-4.80%	85	-14.60%
Oncology Surgery	26	26	0.80%	25	-2.20%
Ophthalmic Medicine	10	9	-12.60%	8	-18.00%
Oral Surgery	7	6	-9.00%	6	-13.90%
Orthopedic Medicine	82	83	0.80%	84	2.30%
Orthopedic Surgery	366	381	4.10%	384	5.00%
Otolaryngology	35	29	-16.20%	27	-22.50%
Plastic Surgery	27	25	-6.20%	23	-14.80%
Psychiatry	325	353	8.50%	329	1.10%
Pulmonary	1,197	1,035	-13.50%	964	-19.50%
Rehabilitation	181	145	-20.00%	154	-14.90%
Rheumatology	35	34	-3.50%	35	-1.20%
Substance Abuse	37	38	3.00%	38	2.10%
Thoracic Surgery	49	45	-7.80%	44	-11.10%
Trauma Medical	32	31	-3.10%	32	-1.60%
Unspecified	5	5	0.00%	5	0.00%
Urology Medicine	27	22	-16.70%	20	-26.70%
Urology Surgery	50	45	-9.60%	41	-17.20%
Vascular Surgery	86	83	-3.50%	82	-5.10%
Womens Other	1	1	-1.00%	1	-10.10%
Grand Total	**8,277**	**7,763**	**-6.20%**	**7,370**	**-11.00%**

SBH-KINGSPORT 002082

Outpatient Projections

	2014	2019		2024	
Site of Care	**Volumes**	**Volumes**	**% Change**	**Volumes**	**% Change**
ED	29,773	29,910	0.50%	28,603	-3.90%
Home	54,945	63,828	16.20%	69,750	26.90%
Hosp OP/ASC	83,295	89,646	7.60%	91,776	10.20%
Office/Clinic	408,336	431,832	5.80%	409,652	0.30%
Other	22,723	24,930	9.70%	25,051	10.20%
SNF	1,353	1,477	9.20%	1,554	14.90%
Urgent/Retail	337	350	3.80%	338	0.20%
Virtual		9,463		38,779	
Grand Total	**600,763**	**651,436**	**8.40%**	**665,503**	**10.80%**

SBH-KINGSPORT 002083

Interview Highlights:

INTERVIEWEES:

- Three individuals

KEY FINDINGS:

- Average rating of health status is 3, with a range in responses of 1 to 4
- Top health issues are:
  - Diabetes
  - Obesity
  - Drug Abuse
  - Smoking
  - Lack of Specialty Care
  - Mental Health
- Ideas to improve these conditions include:
  - Additional specialty providers
  - Press releases/fliers to inform public about health programs
  - Give physicians and patients diabetes fact sheets
  - In home monitoring of chronic conditions
  - Dental assistants/hygienists to visit schools
  - Train ER physicians on minor dental procedures
  - Social/community support programs
  - Increased hospital and home health referrals to PACE and MEOC programs

Sources:

- Medstat
- County Health Rankings
- Kidscount
- VA Atlas of Community Health
- VA Dept of Health
- Kaiser Family Foundation
- VA Dept of Behavioral Health and Developmental Services
- VA Dept of Social Services
- U.S. Census
- CDC Wonder

Local Resources:

- Lenowisco Health District
- Mountain Empire Older Citizens
- Free Clinics
- Quit Line referral
- Local health departments
- Diabetes support groups
- Farmer's Market
- PACE program (Program of All Inclusive Care for the Elderly)
- Mountain Laurel Cancer Research Center
- Pharmacy connect program
- Children's Advocacy Center
- Healthy Families program

SBH-KINGSPORT 002084

APPENDIX

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SBH-KINGSPORT 002085

Mountain State Health Alliance
Sullivan County, TN

Population and Gender	Market 2015 Population	Market 2015 % of Total	Market 2020 Population	Market 2020 % of Total	Market Population % Change	National 2015 % of Total
Female Population	82,467	51.6%	83,193	51.6%	0.9%	50.8%
Male Population	77,249	48.4%	78,076	48.4%	1.1%	49.2%
Total	159,716	100.0%	161,269	100.0%	1.0%	100.0%

Age Groups	Market 2015 Population	Market 2015 % of Total	Market 2020 Population	Market 2020 % of Total	Market Population % Change	National 2015 % of Total
00-17	31,429	19.7%	30,327	18.8%	(3.5)%	23.1%
18-44	48,753	30.5%	48,225	29.9%	(1.1)%	35.9%
45-64	46,417	29.1%	45,329	28.1%	(2.3)%	26.3%
65-UP	33,117	20.7%	37,388	23.2%	12.9%	14.7%
Total	159,716	100.0%	161,269	100.0%	1.0%	100.0%

Ethnicity/Race	Market 2015 Population	Market 2015 % of Total	Market 2020 Population	Market 2020 % of Total	Market Population % Change	National 2015 % of Total
Asian & Pacific Is. Non-Hispanic	1,181	0.7%	1,426	0.9%	20.8%	5.3%
Black Non-Hispanic	3,819	2.4%	4,313	2.7%	12.9%	12.3%
Hispanic	3,015	1.9%	3,712	2.3%	23.1%	17.6%
White Non-Hispanic	149,096	93.4%	148,907	92.3%	(0.1)%	61.8%
All Others	2,605	1.6%	2,911	1.8%	11.8%	3.1%
Total	159,716	100.0%	161,269	100.0%	1.0%	100.0%

Language*	Market 2015 Population	Market 2015 % of Total	Market 2020 Population	Market 2020 % of Total	Market Population % Change	National 2015 % of Total
Germanic Lang at Home	285	0.2%	283	0.2%	(0.7)%	0.5%
Only English at Home	147,691	97.3%	149,340	97.4%	1.1%	79.0%
Other Indo-European Lang at Home	602	0.4%	601	0.4%	(0.2)%	1.8%
Other Lang at Home	202	0.1%	203	0.1%	0.5%	0.9%
Spanish at Home	2,177	1.4%	2,186	1.4%	0.4%	13.0%
All Others	764	0.5%	758	0.5%	(0.8)%	4.7%
Total	151,721	100.0%	153,371	100.0%	1.1%	100.0%

SBH-KINGSPORT 002086

Mountain State Health Alliance
Sullivan County, TN

Household Income	Market 2015 Households	Market 2015 % of Total	Market 2020 Households	Market 2020 % of Total	Market Households % Change	National 2015 % of Total
<$15K	10,586	15.6%	9,374	13.6%	(11.5)%	12.7%
$15-25K	10,321	15.2%	9,508	13.8%	(7.9)%	10.8%
$25-50K	18,992	28.0%	19,038	27.7%	0.2%	23.9%
$50-75K	11,811	17.4%	11,702	17.0%	(0.9)%	17.8%
$75-100K	6,376	9.4%	6,984	10.2%	9.5%	12.0%
$100K-200K	7,914	11.7%	9,619	14.0%	21.5%	17.9%
>$200K	1,858	2.7%	2,505	3.6%	34.8%	5.0%
Total	67,858	100.0%	68,730	100.0%	1.3%	100.0%

Education Level**	Market 2015 Population	Market 2015 % of Total	Market 2020 Population	Market 2020 % of Total	Market Population % Change	National 2015 % of Total
Less than High School	7,645	6.6%	7,867	6.7%	2.9%	5.9%
Some High School	9,906	8.6%	10,189	8.7%	2.9%	8.0%
High School Degree	40,421	35.1%	41,336	35.2%	2.3%	28.1%
Some College/Assoc. Degree	34,264	29.7%	34,808	29.6%	1.6%	31.1%
Bachelor's Degree or Greater	23,046	20.0%	23,244	19.8%	0.9%	26.9%
Total	115,282	100.0%	117,444	100.0%	1.9%	100.0%

*Excludes population age <5, **Excludes population age <25

SBH-KINGSPORT 002087

Mountain State Health Alliance

Hawkins County, TN

Population and Gender	Market 2015 Population	Market 2015 % of Total	Market 2020 Population	Market 2020 % of Total	Market Population % Change	National 2015 % of Total
Female Population	27,856	50.8%	28,207	50.8%	1.3%	50.8%
Male Population	27,010	49.2%	27,310	49.2%	1.1%	49.2%
Total	54,866	100.0%	55,517	100.0%	1.2%	100.0%

Age Groups	Market 2015 Population	Market 2015 % of Total	Market 2020 Population	Market 2020 % of Total	Market Population % Change	National 2015 % of Total
00-17	11,367	20.7%	10,797	19.5%	(5.0)%	23.1%
18-44	16,768	30.6%	16,580	29.9%	(1.1)%	35.9%
45-64	16,158	29.5%	15,932	28.7%	(1.4)%	26.3%
65-UP	10,573	19.3%	12,208	22.0%	15.5%	14.7%
Total	54,866	100.0%	55,517	100.0%	1.2%	100.0%

Ethnicity/Race	Market 2015 Population	Market 2015 % of Total	Market 2020 Population	Market 2020 % of Total	Market Population % Change	National 2015 % of Total
Asian & Pacific Is. Non-Hispanic	219	0.4%	212	0.4%	(3.2)%	5.3%
Black Non-Hispanic	723	1.3%	818	1.5%	13.1%	12.3%
Hispanic	853	1.6%	1,087	2.0%	27.4%	17.6%
White Non-Hispanic	52,310	95.3%	52,496	94.6%	0.4%	61.8%
All Others	761	1.4%	904	1.6%	18.8%	3.1%
Total	54,866	100.0%	55,517	100.0%	1.2%	100.0%

Language*	Market 2015 Population	Market 2015 % of Total	Market 2020 Population	Market 2020 % of Total	Market Population % Change	National 2015 % of Total
Chinese at Home	69	0.1%	68	0.1%	(1.5)%	1.0%
French at Home	34	0.1%	31	0.1%	(8.8)%	0.7%
Only English at Home	51,017	98.0%	51,681	98.0%	1.3%	79.0%
Other Lang at Home	94	0.2%	93	0.2%	(1.1)%	0.9%
Spanish at Home	759	1.5%	762	1.4%	0.4%	13.0%
All Others	112	0.2%	120	0.2%	7.1%	5.3%
Total	52,085	100.0%	52,755	100.0%	1.3%	100.0%

SBH-KINGSPORT 002088

Mountain State Health Alliance
Hawkins County, TN

Household Income	Market 2015 Households	Market 2015 % of Total	Market 2020 Households	Market 2020 % of Total	Market Households % Change	National 2015 % of Total
<$15K	3,255	14.5%	2,901	12.7%	(10.9)%	12.7%
$15-25K	3,216	14.3%	2,764	12.1%	(14.1)%	10.8%
$25-50K	7,036	31.2%	6,868	30.1%	(2.4)%	23.9%
$50-75K	3,923	17.4%	3,943	17.3%	0.5%	17.8%
$75-100K	2,332	10.4%	2,550	11.2%	9.4%	12.0%
$100K-200K	2,445	10.9%	3,323	14.6%	35.9%	17.9%
>$200K	313	1.4%	480	2.1%	53.4%	5.0%
Total	22,520	100.0%	22,829	100.0%	1.4%	100.0%

Education Level**	Market 2015 Population	Market 2015 % of Total	Market 2020 Population	Market 2020 % of Total	Market Population % Change	National 2015 % of Total
Less than High School	3,991	10.2%	4,095	10.3%	2.6%	5.9%
Some High School	3,728	9.5%	3,828	9.6%	2.7%	8.0%
High School Degree	16,946	43.3%	17,338	43.4%	2.3%	28.1%
Some College/Assoc. Degree	10,064	25.7%	10,237	25.6%	1.7%	31.1%
Bachelor's Degree or Greater	4,411	11.3%	4,463	11.2%	1.2%	26.9%
Total	39,140	100.0%	39,961	100.0%	2.1%	100.0%

*Excludes population age <5, **Excludes population age <25

SBH-KINGSPORT 002089

Mountain State Health Alliance
Scott County, VA

Population and Gender	Market 2015 Population	Market 2015 % of Total	Market 2020 Population	Market 2020 % of Total	Market Population % Change	National 2015 % of Total
Female Population	11,312	49.8%	11,345	49.8%	0.3%	50.8%
Male Population	11,389	50.2%	11,457	50.3%	0.6%	49.2%
Total	22,701	100.0%	22,802	100.0%	0.4%	100.0%

Age Groups	Market 2015 Population	Market 2015 % of Total	Market 2020 Population	Market 2020 % of Total	Market Population % Change	National 2015 % of Total
00-17	4,205	18.5%	4,031	17.7%	(4.1)%	23.1%
18-44	6,961	30.7%	6,849	30.0%	(1.6)%	35.9%
45-64	6,623	29.2%	6,433	28.2%	(2.9)%	26.3%
65-UP	4,912	21.6%	5,489	24.1%	11.8%	14.7%
Total	22,701	100.0%	22,802	100.0%	0.4%	100.0%

Ethnicity/Race	Market 2015 Population	Market 2015 % of Total	Market 2020 Population	Market 2020 % of Total	Market Population % Change	National 2015 % of Total
Asian & Pacific Is. Non-Hispanic	55	0.2%	78	0.3%	41.8%	5.3%
Black Non-Hispanic	187	0.8%	243	1.1%	30.0%	12.3%
Hispanic	324	1.4%	432	1.9%	33.3%	17.6%
White Non-Hispanic	21,938	96.6%	21,848	95.8%	(0.4)%	61.8%
All Others	197	0.9%	201	0.9%	2.0%	3.1%
Total	22,701	100.0%	22,802	100.0%	0.4%	100.0%

Language*	Market 2015 Population	Market 2015 % of Total	Market 2020 Population	Market 2020 % of Total	Market Population % Change	National 2015 % of Total
Only English at Home	21,319	98.6%	21,450	98.6%	0.6%	79.0%
Other Asian-Pacific Lang at Home	40	0.2%	43	0.2%	7.5%	0.9%
Other Indo-European Lang at Home	15	0.1%	14	0.1%	(6.7)%	1.8%
Spanish at Home	225	1.0%	216	1.0%	(4.0)%	13.0%
Vietnamese at Home	8	0.0%	10	0.1%	25.0%	0.5%
All Others	14	0.1%	14	0.1%	0.0%	4.8%
Total	21,621	100.0%	21,747	100.0%	0.6%	100.0%

SBH-KINGSPORT 002090

Mountain State Health Alliance

Scott County, VA

Household Income	Market 2015 Households	Market 2015 % of Total	Market 2020 Households	Market 2020 % of Total	Market Households % Change	National 2015 % of Total
<$15K	1,753	18.2%	1,473	15.2%	(16.0)%	12.7%
$15-25K	1,408	14.6%	1,318	13.6%	(6.4)%	10.8%
$25-50K	2,722	28.3%	2,578	26.6%	(5.3)%	23.9%
$50-75K	1,404	14.6%	1,538	15.9%	9.5%	17.8%
$75-100K	1,125	11.7%	1,039	10.7%	(7.6)%	12.0%
$100K-200K	1,078	11.2%	1,538	15.9%	42.7%	17.9%
>$200K	136	1.4%	203	2.1%	49.3%	5.0%
Total	9,626	100.0%	9,687	100.0%	0.6%	100.0%

Education Level**	Market 2015 Population	Market 2015 % of Total	Market 2020 Population	Market 2020 % of Total	Market Population % Change	National 2015 % of Total
Less than High School	2,323	13.8%	2,354	13.9%	1.3%	5.9%
Some High School	1,835	10.9%	1,864	11.0%	1.6%	8.0%
High School Degree	6,538	39.0%	6,632	39.1%	1.4%	28.1%
Some College/Assoc. Degree	4,321	25.8%	4,362	25.7%	1.0%	31.1%
Bachelor's Degree or Greater	1,766	10.5%	1,764	10.4%	(0.1)%	26.9%
Total	16,783	100.0%	16,976	100.0%	1.2%	100.0%

*Excludes population age <5, **Excludes population age <25

SBH-KINGSPORT 002091

Mountain State Health Alliance
Wise County, VA

Population and Gender	Market 2015 Population	Market 2015 % of Total	Market 2020 Population	Market 2020 % of Total	Market Population % Change	National 2015 % of Total
Female Population	23,361	48.9%	23,195	49.0%	(0.7)%	50.8%
Male Population	24,421	51.1%	24,184	51.0%	(1.0)%	49.2%
Total	47,782	100.0%	47,379	100.0%	(0.8)%	100.0%

Age Groups	Market 2015 Population	Market 2015 % of Total	Market 2020 Population	Market 2020 % of Total	Market Population % Change	National 2015 % of Total
00-17	9,817	20.6%	9,492	20.0%	(3.3)%	23.1%
18-44	17,184	36.0%	16,635	35.1%	(3.2)%	35.9%
45-64	13,131	27.5%	12,524	26.4%	(4.6)%	26.3%
65-UP	7,650	16.0%	8,728	18.4%	14.1%	14.7%
Total	47,782	100.0%	47,379	100.0%	(0.8)%	100.0%

Ethnicity/Race	Market 2015 Population	Market 2015 % of Total	Market 2020 Population	Market 2020 % of Total	Market Population % Change	National 2015 % of Total
Asian & Pacific Is. Non-Hispanic	241	0.5%	285	0.6%	18.3%	5.3%
Black Non-Hispanic	2,222	4.7%	2,095	4.4%	(5.7)%	12.3%
Hispanic	752	1.6%	944	2.0%	25.5%	17.6%
White Non-Hispanic	43,894	91.9%	43,247	91.3%	(1.5)%	61.8%
All Others	673	1.4%	808	1.7%	20.1%	3.1%
Total	47,782	100.0%	47,379	100.0%	(0.8)%	100.0%

Language*	Market 2015 Population	Market 2015 % of Total	Market 2020 Population	Market 2020 % of Total	Market Population % Change	National 2015 % of Total
French at Home	151	0.3%	152	0.3%	0.7%	0.7%
Only English at Home	44,033	97.5%	43,755	97.6%	(0.6)%	79.0%
Other Indo-European Lang at Home	38	0.1%	36	0.1%	(5.3)%	1.8%
Other Lang at Home	162	0.4%	155	0.4%	(4.3)%	0.9%
Spanish at Home	628	1.4%	614	1.4%	(2.2)%	13.0%
All Others	135	0.3%	127	0.3%	(5.9)%	4.5%
Total	45,147	100.0%	44,839	100.0%	(0.7)%	100.0%

SBH-KINGSPORT 002092

Mountain State Health Alliance
Wise County, VA

Household Income	Market 2015 Households	Market 2015 % of Total	Market 2020 Households	Market 2020 % of Total	Market Households % Change	National 2015 % of Total
<$15K	4,027	21.4%	3,637	19.3%	(9.7)%	12.7%
$15-25K	2,810	14.9%	2,753	14.6%	(2.0)%	10.8%
$25-50K	4,749	25.2%	4,623	24.6%	(2.7)%	23.9%
$50-75K	3,236	17.2%	3,126	16.6%	(3.4)%	17.8%
$75-100K	1,868	9.9%	1,967	10.5%	5.3%	12.0%
$100K-200K	1,913	10.2%	2,367	12.6%	23.7%	17.9%
>$200K	247	1.3%	334	1.8%	35.2%	5.0%
Total	18,850	100.0%	18,807	100.0%	(0.2)%	100.0%

Education Level**	Market 2015 Population	Market 2015 % of Total	Market 2020 Population	Market 2020 % of Total	Market Population % Change	National 2015 % of Total
Less than High School	4,274	12.9%	4,318	13.0%	1.0%	5.9%
Some High School	4,631	14.0%	4,675	14.1%	1.0%	8.0%
High School Degree	10,469	31.7%	10,514	31.7%	0.4%	28.1%
Some College/Assoc. Degree	9,575	29.0%	9,606	29.0%	0.3%	31.1%
Bachelor's Degree or Greater	4,103	12.4%	4,070	12.3%	(0.8)%	26.9%
Total	33,052	100.0%	33,183	100.0%	0.4%	100.0%

*Excludes population age <5, **Excludes population age <25

SBH-KINGSPORT 002093

MOUNTAIN STATES HEALTH ALLIANCE

2015 COMMUNITY HEALTH NEEDS ASSESSMENT

JOHNSON CITY MEDICAL CENTER

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Introduction

Mountain States Health Alliance (MSHA) is an integrated health care delivery system providing a comprehensive continuum of care to people in 29 counties in Tennessee, Virginia, Kentucky, and North Carolina. MSHA was formed after Johnson City Medical Center Hospital, Inc. acquired six Columbia/HCA hospitals in Northeast Tennessee on September 1, 1998; and was later renamed Mountain States Health Alliance in January 1999.

Today, MSHA is the largest regional health care system with 13 hospitals operating at approximately $1.0 billion in net revenues. The hospitals are:

- Johnson City Medical Center
- Niswonger Children's Hospital
- Woodridge Psychiatric Hospital
- Franklin Woods Community Hospital
- Unicoi County Community Hospital
- Indian Path Medical Center
- Johnson County Community Hospital
- Sycamore Shoals Hospital
- Dickenson Community Hospital
- Johnston Memorial Hospital
- Norton Community Hospital
- Russell County Medical Center
- Smyth County Community Hospital

In addition to 13 hospitals, MSHA's integrated health care delivery system includes primary/preventive care centers and numerous outpatient care sites, including First Assist Urgent Care, MedWorks, Same Day Surgery, and Mountain States Rehabilitation.

Executive Summary

Regional and national rankings for health factors continue to be disappointing as cancer, heart disease, and diabetes rates continue to increase each year. Obesity and smoking continue to be major problems in the United States, leading to additional diseases. From a global perspective, the United States falls behind other developing nations in health outcomes. Clearly, there are many needs that exist and need attention. The interrelatedness between the health of a community, its economic status, and its educational attainment levels is becoming increasingly recognized. Mountain States Health Alliance (MSHA) exists to *"identify and respond to the health care needs of individuals and communities in our region and to assist them in attaining their highest possible level of health."* In doing so, MSHA recognizes this is a very complex challenge that involves the engagement of many prongs of the community.

In order for MSHA to serve its region most effectively, it is essential to understand each community's individual needs. MSHA has conducted a Community Health Needs Assessment to profile the health of the residents within the local region (a map of the MSHA service area is provided on the following page). Activities associated with the development of this assessment have taken place from spring of 2014 through spring of 2015, including state, regional and county-specific secondary data collection and primary data obtained through individual surveys and focus groups with individuals from the local communities.

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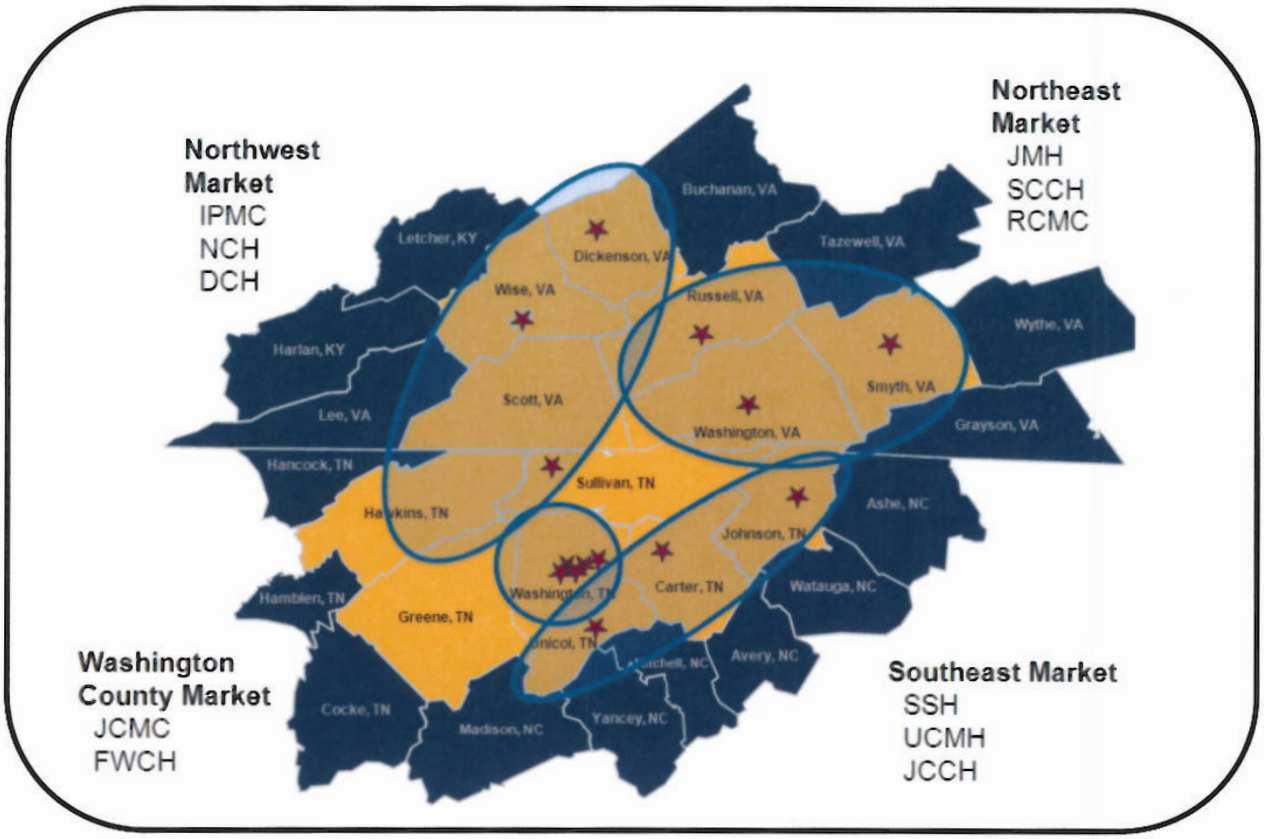

★ Represents county in which MSHA owns a facility. MSHA has part-ownership in other hospitals but they are not included in this assessment.

*Service Area is defined by approximately 80% of inpatient population.

Throughout the assessment, high priority was given to determining the health status and available resources within each community. Community members from each county met with MSHA to discuss current health priorities and identify potential solutions. The information gathered from a local perspective, paired with regional, state and national data, helps to communicate the region's health situation in order to begin formulating solutions for improvement.

In 2014, Tennessee ranked 45th and Virginia ranked 21st out of 50 states for overall health outcomes. Both states had high rates of adult obesity, cancer deaths, infant mortality, and diabetes. Though Virginia's overall ranking is moderately low, the health outcomes in Southwest Virginia counties, where MSHA's facilities are located, resembles those of Tennessee. After compiling the various sources of information, the top health priorities were identified for the communities that each of the MSHA hospitals serve. This effort has determined the top health priorities identified in Washington County, TN to include **substance and prescription drug abuse, smoking, obesity/diabetes/physical activity and cardiovascular disease**. There are certainly a number of other health challenges in this community, but these rise to the top based on this assessment.

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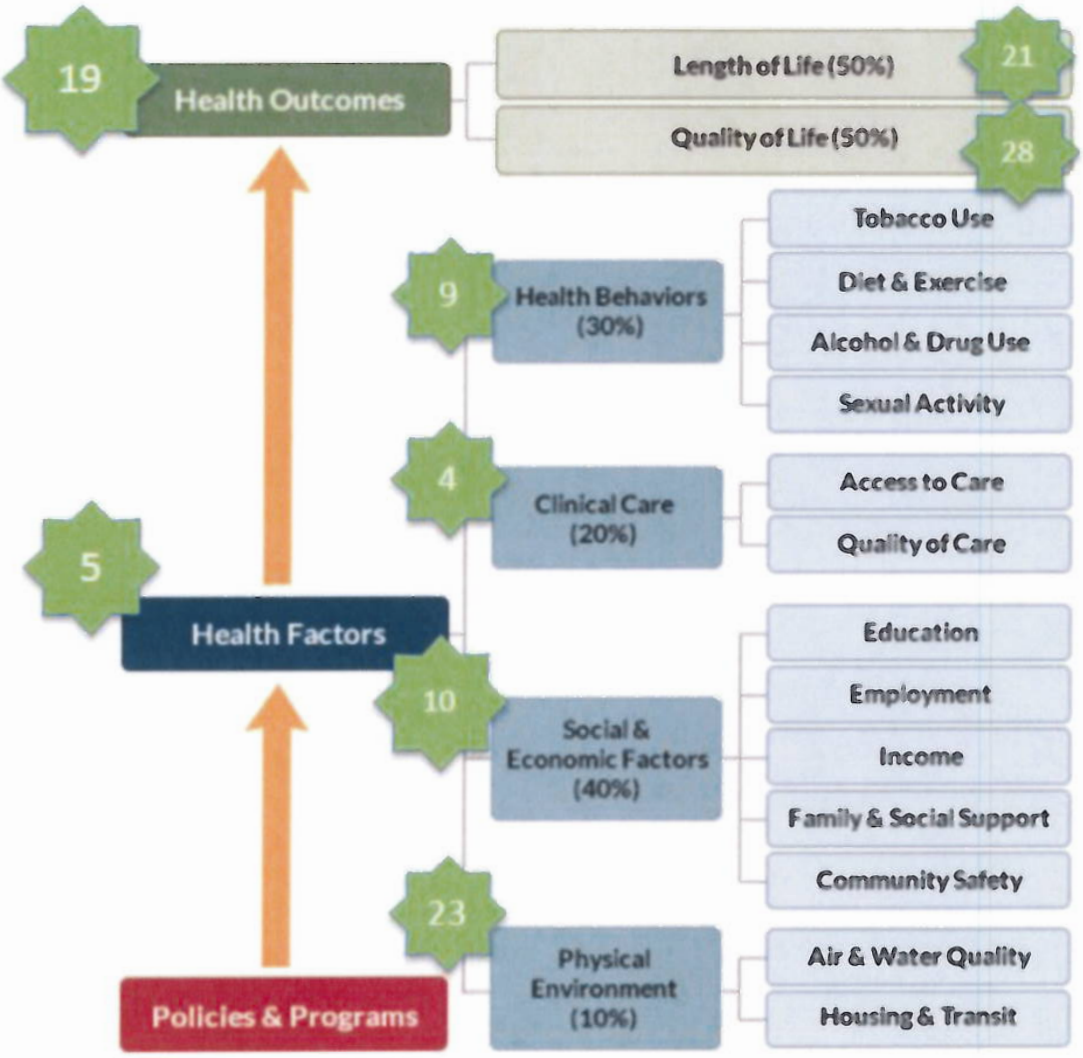
According to the 2015 County Health Rankings, Washington County is ranked 19th in Tennessee for health outcomes and 5th for health factors out of 95 counties. The leading causes of death for ages 65 and over are heart disease, cancer, and stroke. Washington County, TN also ranked 9th in health behaviors and 10th in social and economic factors. While Tennessee compares favorably within the state of Tennessee, it does not compare favorably to the top performing counties in the nation. Washington County, TN has high rates of smoking, obesity, and physical inactivity. Many of these health issues are the result of lack-luster social and economic factors such as high rates of poverty, income inequality and unemployment.

Washington County, TN Health Ranking
2015 County Health Rankings
www.countyhealthrankings.org



*Ranking is in comparison to all 95 counties in the state of Tennessee.

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Community Interview Summary

Between spring 2014 and spring 2015 the MSHA Strategic Planning Department completed individual interviews and a focus group in order to connect with community members of Washington County, TN and determine the needs of the community that Johnson City Medical Center serves. MSHA hospital administration teams were contacted in order to obtain names of individuals in the community who were considered public health officials or community leaders. The 18 interviewees included representatives from the county and regional health departments, community health center, East Tennessee State University, Chamber of Commerce, local government, United Way, local emergency medical service and several local non-profit community organizations. These individuals were invited to discuss and assist in determining the health priorities and resources available in their community of Washington County.

Collecting Community Input

In order to complete the community health needs assessment for Johnson City Medical Center, MSHA met with various individuals from Washington County, TN. The organizations that were represented are listed in Table 1.1.

Table 1.1 – Summary Organizations Participating in JCMC's CHNA

Reported Organizations Providing Input for Assessment
Washington County Health Department
Frontier Health
ETSU College of Nursing
ETSU Johnson City Community Health Center
ETSU College of Public Health
Washington County Commission
Northeast Tennessee Regional Health Department
Washington County/Johnson City Emergency Medical Services
United Way
Project Access
Chamber of Commerce
Families Free
City of Johnson City
Center on Aging and Health

To begin the community health needs assessment, MSHA's strategic planning staff presented data that had been collected to illustrate past and current health trends for Tennessee and Washington County. The presentation depicted the current national health rankings, in addition to providing a snapshot of the county.

Following the presentation, each participant was given a survey to determine the individual's personal assessment of their county's health priorities. Secondly, the individuals were asked to submit ideas and suggestions as to how MSHA could use the available resources in order to improve the health priorities determined. After the surveys had been completed, each group discussed the questions and continued brainstorming ways to address obstacles and utilize resources. All of the information collected from the surveys and open discussion was evaluated and prioritized based on health needs.

In surveys obtained from the Washington County representatives, several community health needs and resources were identified. Table 1.2 lists the survey questions given to each participant in the assessment.

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Table 1.2 – Community Survey Questions

	Survey Questions
1	How would you rate the general health status of the patient population in this community on a scale of 1 to 10 (with 1 being the poorest and 10 being the best)?
2	Keeping in mind resources are not unlimited, can you identify the top 1-2 health priorities in your local community that you feel should be addressed in the following areas: a)Health Outcomes/Diseases b)Health Behaviors c)Social Environment
3	What existing resources, such as organized groups or public health initiatives have been developed and are in place to address these health priorities?
4	What ideas do you have that may serve to improve these health priorities?

Health Status Rating

Overall, the general health status of Washington County, TN was rated as 5.3 on a scale of 1 – 10, with 1 being the poorest and 10 being the best. Individual responses ranged from 2 to 7. The health ranking for Washington County can be found below in Table 1.3.

Table 1.3 – Average Health Status Ranking

MSHA Facility/County	Number of Individuals	Average of Health Status Rating
JOHNSON CITY MEDICAL CENTER, Washington County, TN	18	5.3

Top Health Priorities

From the results of the surveys, the most prevalent health priorities in Washington County were substance and prescription drug abuse, smoking, obesity/diabetes/physical activity and cardiovascular disease. Table 1.4 lists the health priorities input provided by community participants.

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Table 1.4 – Top Identified Health Priorities

Washington County, TN		
Top Health Priorities	**Responses**	**% of Total Responses**
Health Outcomes/Diseases		
Obesity	10	62.50%
Cardiovascular Disease	8	50.00%
Diabetes	7	43.75%
Cancer	4	25.00%
Mental Health	3	18.75%
Liver Disease (Hepatitis C)	2	12.50%
Neonatal Abstinence Syndrome	2	12.50%
Health Behaviors		
Substance and Prescription Drug Abuse	12	75.00%
Smoking/Tobacco Use	11	68.75%
Physical Inactivity	10	62.50%
Poor Nutrition	6	37.50%
Risk Taking	1	6.25%
Social Environment		
Education	5	31.25%
Income inequality	3	18.75%
Literacy	3	18.75%
Poverty	2	12.50%
Aging population	2	12.50%
Transportation Barriers	2	12.50%
Stigma of substance use and mental health disorders	1	6.25%
Access to care	1	6.25%
Living wage	1	6.25%
Lack of Job Training	1	6.25%
Built Environment for Physical Activity	1	6.25%
Poor Parenting Skills	1	6.25%
Convenient Access to Fast Food	1	6.25%
Economy	1	6.25%
Adverse Childhood Experiences	1	6.25%
Domestic Violence	1	6.25%

*Individuals submitted multiple answers regarding health priorities.

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These priorities are consistent with the secondary data findings.

- Substance and prescription drug abuse
  - The rate of drug poisoning deaths per 100,000 in Washington County, TN exceeds the state average (17 vs. 16).
  - While the state average for Neonatal Abstinence Syndrome is 6.7 per 1,000, it is three times that rate in Washington County, TN at 18.7 per 1,000.
  -
- Smoking
  - Maternal smoking rates in Washington County, TN exceed those of the state (26% vs. 23%)
  - Approximately 24% of Washington County adults smoke compared to 23% of TN and 18% when compared nationally.
- Obesity/Diabetes/Physical Activity
  - Close to 33% of Washington County, TN residents are obese, compared to 27% nationally.
  - Additionally, another 38% of Washington County, TN residents are considered overweight compared to state and national percentages of 36%
  - Self-reported physical inactivity rates among Washington County, TN residents exceed the national average (32% vs. 23%)
- Cardiovascular disease
  - The age-adjusted death rate for heart disease in Washington County, TN exceeds both the state (232.45 vs. 218.67 per 100,000 population) and the nation (184.55 per 100,000)

All of these issues lead to a higher percentage of self-reported age-adjusted fair or poor health rates in Washington County, TN compared nationally(19% vs. 16%) as well as a higher number of years of potential life lost before 75 per 100,000 (a measure of premature death) at 8,155 in the county vs. 6,851 nationally.

County Health
Rankings & Roadmaps
Building a Culture of Health, County by County

Washington (WS)

	Washington County	Error Margin	Top U.S. Performers*	Tennessee	Rank (of 95)
Health Outcomes					19
Length of Life					21
Premature death	8,403	7,831-8,974	5,200	8,696	
Quality of Life					28
Poor or fair health	19%	15-22%	10%	19%	
Poor physical health days	4.5	3.8-5.2	2.5	4.3	
Poor mental health days	3.8	3.0-4.6	2.3	3.4	
Low birthweight	8.4%	7.9-9.0%	5.9%	9.2%	
Health Factors					5
Health Behaviors					9
Adult smoking	24%	21-28%	14%	23%	
Adult obesity	31%	27-35%	25%	32%	
Food environment index	7.3		8.4	6.9	
Physical inactivity	30%	26-34%	20%	30%	
Access to exercise opportunities	72%		92%	70%	
Excessive drinking	7%	5-10%	10%	9%	
Alcohol-impaired driving deaths	31%		14%	28%	
Sexually transmitted infections	201		138	504	
Teen births	33	31-35	20	47	
Clinical Care					4
Uninsured	17%	15-18%	11%	16%	
Primary care physicians	596:1		1,045:1	1,388:1	
Dentists	1,846:1		1,377:1	1,996:1	
Mental health providers	345:1		386:1	786:1	
Preventable hospital stays	82	77-87	41	73	
Diabetic monitoring	89%	84-93%	90%	86%	
Mammography screening	63.6%	58.7-68.5%	70.7%	61.8%	
Social & Economic Factors					10
High school graduation	93%			87%	
Some college	66.0%	62.3-69.6%	71.0%	57.7%	
Unemployment	7.3%		4.0%	8.2%	
Children in poverty	24%	18-29%	13%	27%	
Income inequality	5.1	4.8-5.5	3.7	4.8	
Children in single-parent households	31%	27-36%	20%	36%	
Social associations	13.9		22.0	11.5	
Violent crime	415		59	621	
Injury deaths	71	64-77	50	78	
Physical Environment					23
Air pollution - particulate matter	13.1		9.5	13.8	
Drinking water violations	0%		0%	4%	
Severe housing problems	15%	14-17%	9%	15%	
Driving alone to work	87%	86-88%	71%	84%	
Long commute - driving alone	22%	20-23%	15%	32%	

* 90th percentile, i.e., only 10% are better.
Note: Blank values reflect unreliable or missing data

2015

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Identifying Available Resources

MSHA realizes that there are numerous resources in all of the counties it serves that can provide care for individuals. Our goal, in order to reduce costs and provide the best care possible for patients, is to identify these resources to prevent duplication of services and efforts. The interviewees were asked to list all of the services and resources within their community. The interviewees acknowledged that many resources currently exist to help meet health needs. Table 1.5 lists the current resources within each county that offer health services to the community.

Table 1.5 – Identified Available Resources

Resources Available
Washington County, Tennessee
Families Free
Health Department
Washington County Anti-Drug Coalition
Tennessee Suicide Prevention Network
Tennessee Prevention Alliance
TAADAS
Tweetsie Trail
Senior Center
Food Pantries
One Acre Café
Backpack/Student food supplement program
Project Access
JCCH
Johnson City Housing Authority
United Way
Coordinated School Health
Head Start
Johnson City Parks and Recreation
Morning Mile
JCMC/FWCH
ETSU College of Medicine
ETSU College of Public Health
ETSU College of Pharmacy
ETSU College of Nursing
ETSU College of Clinical and Rehabilitative Health Sciences
Day Center
MEAL
Girls on the Run
Washington County Health Council
Washington County Wellness Committee
The Women's Fund of the East Tennessee Foundation
Appalachian Funders Network
Washington County PDAM
Local school systems
Local churches
UT-Washington County Extension Service

*MSHA understands that there are other resources available in each county that are not listed in this table. This table represents only the resources listed by participants in community health needs assessment. MSHA will continue to identify resources.

Improving Health Priorities

The community members who were surveyed provided helpful ideas as to how to begin formulating a plan to improve the health priorities throughout the region. To enhance existing resources, the

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participants stressed the significance of increasing public awareness of both addressing one's health needs and the availability of health care options within each community. Additional suggestions as to how MSHA can improve the previously identified health priorities are listed in Table 1.6.

Table 1.6 – Ideas to Improve Health Priorities

	Responses
1	Organizational collaboration
2	Comprehensive community emphasis on exercise
3	Increase physical activity in schools
4	Health education on the health effects of behaviors: smoking, food choices, inactivity
5	Expansion of Project Access
6	Increase health care access with financial resources and partnerships
7	Focus on high school graduation
8	Increase number of walking trails
9	CEASE program
10	Provide/promote smoking cessation programs
11	Offer wellness initiatives
12	Work with schools on food options for students
13	Promote early screenings
14	Educate children early on the importance of exercise and healthy eating
15	Healthcare navigators/care coordinators to help community members with health education and free/reduced cost health care services
16	Offer additional activities/opportunities for families to engage in physical activity
17	Develop network of clinics, hospitals, long-term health facilities and health departments to discuss and develop health improvement initiatives.
18	Better marketing of health resources to the community
19	Promote literacy programs for educational attainment

However, it is also helpful to understand from a more global perspective the health status of our nation as a whole, since many issues we face in our service area are not limited to just our region. Compiled on an annual basis, the *America's Health Rankings* publication developed by the United Health Foundation, the American Public Health Association and Partnership for Prevention provides one of the most comprehensive assessments regarding the status of the nation's health. The following information in the national and regional overview is from the 2015 edition

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Health is a result of our behaviors, our individual genetic predisposition to disease, the environment and the community in which we live, the clinical care we receive and the policies and practices of our health care and prevention systems. Each of us, individually, as a community, and as a society, strives to optimize these health determinants, so that all of us can have a long, disease-free, and robust life regardless of race, gender or socio-economic status.

This report looks at the four groups of health determinants that can be affected:

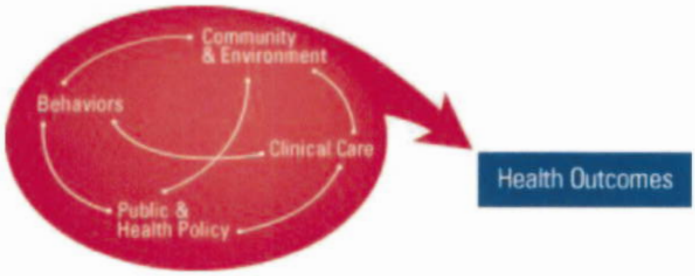
1. **Behaviors** include the everyday activities we do that affect our personal health. It includes habits and practices we develop as individuals and families that have an effect on our personal health and on our utilization of health resources. These behaviors are modifiable with effort by the individual supported by community, policy and clinical interventions.

2. **Community and environment** reflects the reality that the daily conditions in which we live our lives have a great effect on achieving optimal individual health.

3. **Public and health policies** are indicative of the availability of resources to encourage and maintain health and the extent that public and health programs reach into the general population.

4. **Clinical care reflect**s the quality, appropriateness and cost of the care we receive at doctors' offices, clinics and hospitals.

All health determinants are intertwined and must work together to be optimally effective. For example, an initiative that addresses tobacco cessation requires not only efforts on the part of the individual but also support from the community in the form of public and health policies that promote non-smoking and the availability of effective counseling and care at clinics. Similarly sound prenatal care requires individual effort, access to and availability of prenatal care coupled with high quality health care services. Addressing obesity, which is a health epidemic now facing this country, requires coordination among almost all sectors of the economy including food producers, distributors, restaurants, grocery and convenience stores, exercise facilities, parks, urban and transportation design, building design, educational institutions, community organizations, social groups, health care delivery and insurance to complement and augment individual actions.



America's Health Rankings® combines individual measures of each of these determinants with the resultant health outcomes into one, comprehensive view of the health of a state. Additionally, it discusses health determinants separately from health outcomes and provides related health, economic and social information to present a comprehensive profile of the overall health of each state.

America's Health Rankings® employs a unique methodology, developed and periodically reviewed by a panel of leading public health scholars, which balances the contributions of various factors, such as smoking, obesity, binge drinking, high school graduation rates, children in poverty, access to care and incidence of preventable disease, to a state's health. The report is based on data from the

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U.S. Departments of Health and Human Services, Commerce, Education and Labor; U.S. Environmental Protection Agency; U.S. Census Bureau, the American Medical Association; the American Dental Association; the Dartmouth Atlas Project; and the Trust for America's Health.

Purpose

The ultimate purpose of *America's Health Rankings®* is to stimulate action by individuals, elected officials, health care professionals, employers, and communities to improve the health of the population of the United States. We do this by promoting public conversation concerning health in our states, as well as providing information to facilitate citizen, community and group participation. We encourage participation in all elements: behaviors, community and environment, clinical care, and public and health policies. Each person individually, and in their capacity as an employee, employer, voter, community volunteer, health official or elected official, can contribute to the advancement of the healthiness of their state. Proven, effective and innovative actions can improve the health of people in every state whether the state is first or 50th.

Findings

Comparison to Other Nations

When health in the United States is compared to health in other countries, the picture is disappointing. The World Health Organization, in its annual World Health Statistics 2013, compares the United States to the nations of the world on a large variety of measures. While the U.S. does exceed many countries, it is far from the best in many of the common measures used to gauge healthiness and lags behind its peers in other developed countries.

The United States ranks at or near the bottom among high-income countries on nearly all indicators of mortality, survival, and life expectancy. Life expectancy is a measure that indicates the number of years that a newborn is expected to live. Japan, San Marino, and Switzerland are the persistent leaders for developed countries in this measure, with an overall life expectancy of 83 years. At 81 years for women and 76 years of men, the United States ranks 33rd among the 193 reporting nations of the WHO. The United States male life expectancy rates are on par with Chile, Cuba, Brunei Darussalam, and Maldives, while the female life expectancy rates are on par with Columbia, Costa Rica, Czech Republic, Estonia, Poland, and Qatar. There are 32 other countries that exceed the United States in healthy life expectancy, including Australia, Italy, Spain, France, Germany, Greece and the United Kingdom.

One of the underlying causes for these differences is the gap in infant mortality rates between the United States and many other countries. The infant mortality rate for the U.S. in 2011 was 6 deaths per 1,000 live births, ranking 40th among WHO nations. The infant mortality rates in Finland, Japan, and Sweden were one third that of the U.S. rate. Of the 193 countries rated, 39 countries had lower infant mortality rates than the United States.

These countries also have considerably lower infant mortality rates than that of non-Hispanic whites in the United States, which is the ethnic/racial group with the lowest infant mortality rate. The racial/ethnic disparities related to infant mortality could be related to differences in risk factors among different racial/ethnic groups, including risk for low birth weight delivery, access to medical care, and socioeconomic status. However, many of the racial/ethnic differences in infant mortality remain unexplained. It should also be noted that the reporting and classification of infant mortality varies among countries, which could be reflected in the ranks.

In addition to infant mortality, youth and young adults' mortality impacts life expectancy. Unintentional injuries claim approximately 30 percent of the years lost before age 50, along with violence and suicides, among U.S. young adults and adolescents. Non-communicable (chronic)

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diseases, such as cancer, heart disease, and other conditions that are not caused by infections, begin to be more of a contributing factor after the age of 30.

Differences in healthy life expectancy are also affected by the effectiveness of treating disease, especially those that are amenable to care, including bacterial infections, treatable cancers, diabetes, cardiovascular and cerebrovascular disease, some ischemic heart disease, and complications from common surgical procedures. The age-adjusted amenable mortality rate before age 75 for the United States was 95.5 deaths per 100,000 population in 2006 to 2007, which is still a slower rate of improvement than in other Organization for Economic Cooperation and Development (OECD) nations studied. The rate in the U.S. is 50 percent higher than the rate in France, Japan, Italy, and Australia.

Additionally, the study indicated that despite spending more than any other country on health care, the United States continues to slip further behind and has one of the highest inequalities in health compared to other developed countries. The U.S. ranks among the worst OECD countries for child health well-being, having an inequality higher than average. Furthermore, although the United States has the highest income per person, it continues to rank as the worst country for income inequality, which is thought to explain why it has the highest index of health and social problems compared to other developed nations.

Physical inactivity and obesity play major contributions to disease worldwide and in the United States. Physical inactivity is the fourth leading risk factor for global mortality, and is responsible for an estimated 6 to 10 percent of non-communicable diseases, such as type 2 diabetes, heart disease, colon cancer, and breast cancer. North America has 34 percent of the world's biomass due to obesity; however, it only makes up for 6 percent of the world's population. Asia, on the other hand, has 61 percent of the world's population, yet only has 13 percent of its biomass due to obesity. While the U.S. is only one of several countries that form North America, it is the only North American nation to rank among the heaviest nations globally. It is estimated that eliminating physical activity in the United States would add approximately 1 year to life expectancy and dramatically reduce the burden of chronic diseases.

The results of these studies should be a wake-up call to everyone in the United States to strive to improve all aspects of our health system, including education, safety, prevention, and clinical care. Other countries have improved their overall health, indicating that we, too, can do the same.

National Changes since 1990

In the past year, 20 health measures improved, 8 measures declined, and 1 measure remained unchanged. Table 1 shows the national changes in the last year. These improvements were offset by deterioration in several measures, including increases in the prevalence of obesity, the percentage of children in poverty and lack of health insurance.

Since 2012, the prevalence of smoking declined from 21.2 percent to 19 percent among adults. The binge drinking prevalence rate dropped from 18.3 percent to 16.8 percent of adults who binged in the last 30 days, and physical inactivity decreased from 26.2 percent to 25.3 percent. The incidence of pertussis increased sharply from 9.0 to 15.5 cases per 100,000 populations. The percentages of children in poverty, lack of health insurance, child immunization coverage, and low birth weight have also suppressed faster improvement in our nation's health.

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Table 1 – National Successes and Challenges

SUCCESSES

Smoking	Since 1990, smoking decreased 36% from 29.5% to 19.0% of adults who smoke regularly.
High School Graduation	At 81% of ninth graders graduating within 4 years, high school graduation is still a challenge. However, it is slowly trending upward from 71.7% in 2004.
Violent Crime	At 387 offenses per 100,000 population, violent crime is 37% lower than in 1990 and 49% lower than its peak in 1993.
Air Pollution	The average amount of fine particulates in the air continues to decline from 13.2 micrograms per cubic meter in 2003 to 9.9 micrograms per cubic meter in 2014.
Preventable Hospitalizations	Preventable hospitalizations continue to decline. In 2001, there were 82.5 discharges per 1,000 Medicare beneficiaries; in 2014, there were 62.9 discharges per 1,000 Medicare beneficiaries.
Occupational Fatalities	Occupational fatalities have declined in the last 8 years from 5.3 deaths per 100,000 workers in 2007 to 3.8 deaths per 100,000 workers. This is the second consecutive year the rate is below 4 deaths per 100,000 workers.
Infant Mortality	Since 1990, infant mortality decreased 41% from 10.2 to 6.0 deaths per 1,000 live births, although most of that decline occurred between 1990 and 1999. Even though the infant mortality rate is the lowest in US history, it is double the rate of many developed countries. In addition, large racial and geographic disparities exist within the country.
Premature Death	Since 1990, premature death declined 20% from 8,716 to 6,976 years of potential life lost before age 75. Premature death, like several other metrics, has leveled off in the last decade compared with improvements made in the 1990s.
Cancer Deaths	Cancer deaths declined 4% from 197.5 deaths in 1990 to 189.9 deaths per 100,000 population.
Cardiovascular Deaths	Since 1990, cardiovascular deaths declined 38% from 405.1 to 251.4 deaths per 100,000 population. This continues a relatively constant improvement of 2% to 3% yearly.

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CHALLENGES

Obesity	Since 1990, obesity has increased 153% from 11.6% to 29.4% of adults.
Physical Inactivity	Physical inactivity remains high at 23.5% of adults and has not changed appreciably for the last decade.
Children in Poverty	At 19.9% of children, the children in poverty measure is far above the 23-year low of 15.8% in the 2002 Edition and near the 1990 level of 20.6%.
Public Health Funding	State public health funding continues its slow decline over the past 4 years. Since 2011, it decreased from $95.01 to $90.00 in expenditures per person at the state level.
Immunization Coverage — Children	Nationwide, comprehensive immunization coverage among children aged 19 to 35 months is only 70.4%. It increased marginally in the past year.
Immunization Coverage — Adolescents	Nationwide, comprehensive immunization coverage among teens aged 13 to 17 years is only 67.1%. It increased marginally in the past year.
Low Birthweight	In the last 20 years, the prevalence of low birthweight infants has increased from 7.1% to 8.0% nationwide. The good news is that it appears to have peaked in 2009 and is trending downward.
Diabetes	In the nation, 9.6% of adults report they have been told they have diabetes. There has been a steady, upward climb in the prevalence of diabetes, although data from the last 3 years shows a leveling of the prevalence.

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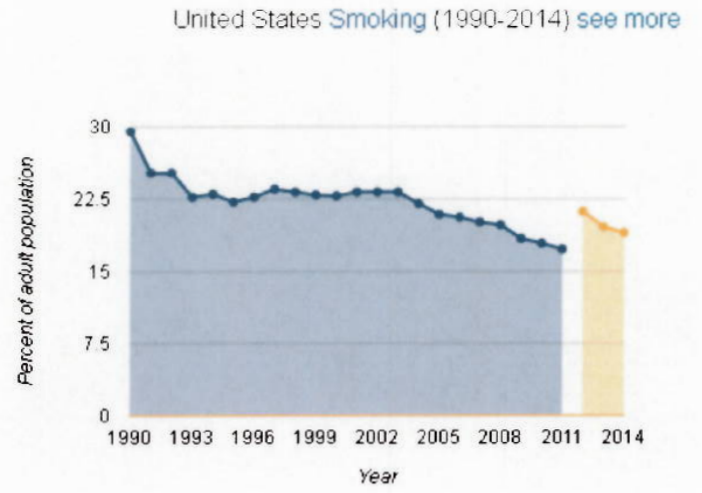
The United States has the potential to return to the rates of improvement typical in the 1990s. However, to do so, it must address the drivers of health directly by focusing on reducing important risk factors. For example, the prevalence of smoking had been stagnant for many years and recently started to show improvement in the last two decades. However, there was an increase in rates from 2010 to 2012. In the last year, the prevalence of smoking declined in the United States from 21.2 percent to 19 percent of adults who smoke regularly; however Tennessee ranks 46th as one of the bottom five states with 24.3 percent of adults smoking and Virginia ranks 24th at 19.1 percent.

Graph 1 - Prevalence of Smoking Since 1990



Unprecedented and unchecked growth in the prevalence of obesity over the last 20 years has also dramatically affected the overall health of the United States. The prevalence of obesity, a risk factor for numerous illnesses including heart disease and diabetes, appears to be leveling off after increasing for decades. However, more than one in four people in the U.S. is considered obese - a category that the Centers for Disease Control and Prevention reserves for those who are significantly over the suggested body weight given their height. In the United States, the prevalence of obesity is 29.4 percent of adults, which has increased from 27.8 percent in 2012. Virginia's obesity score ranks 18th at 27.2 percent, while Tennessee ranks 47th at 33.7 percent of obese adults.

These very high obesity rates are gathered from the Behavioral Risk Factor Surveillance System, the nation's largest phone survey about health, and rely on self-reported height and weight. Actual obesity rates, as measured by health professionals, may be almost 10 percent higher, meaning that over one-third of the population is now obese.

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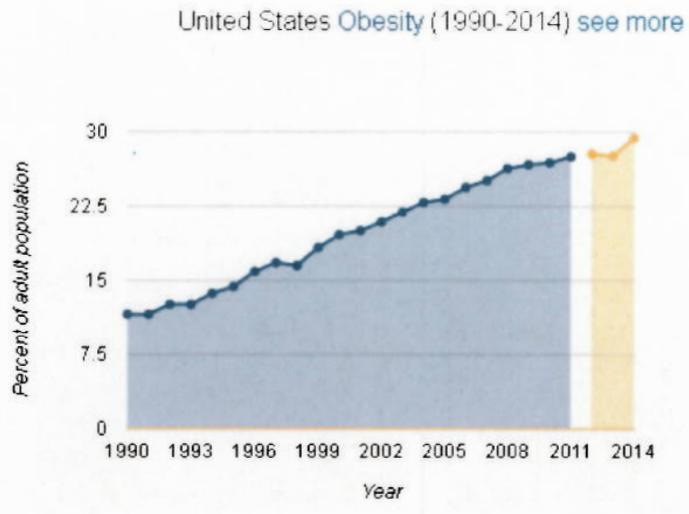
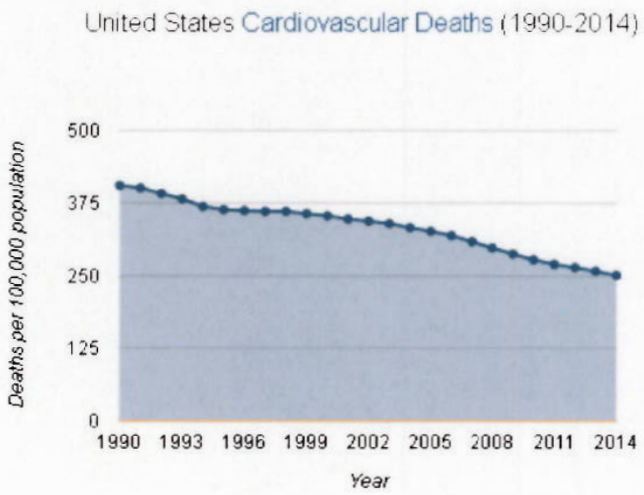
Graph 2 - Prevalence of Obesity Since 1990



Despite increasing risk factors such as obesity, high cholesterol, and high blood pressure, deaths contributed to cardiovascular disease have consistently declined by 2 to 3 percent per year for the last decade. Cardiovascular disease accounts for 30 percent of Medicare spending, 17 percent of medical spending, and totals nearly $150 billion each year. For cardiovascular deaths, Virginia ranked 25th with a rate of 241.1 per 100,000 and Tennessee ranked 44th with the rate of 300.6.

Graph 3 – Prevalence of Cardiovascular Deaths Since 1990



Like cardiovascular disease, potentially preventable hospitalizations have steadily decreased over the past 12 years. Preventable hospitalizations (hospitalizations that may be preventable with high quality primary and preventive care) have decreased from 82.5 to 62.9 discharges per 1,000 Medicare enrollees since 2001. Preventable hospitalizations reflect how efficiently a population uses various health care options for care and often occur as a result of a failure to detect or treat conditions early. Preventable hospitalizations could be avoided with earlier, less costly interventions. Virginia ranked 22nd in this measure with a 55.2 rate and Tennessee ranked 47th with a rate of 78.5.

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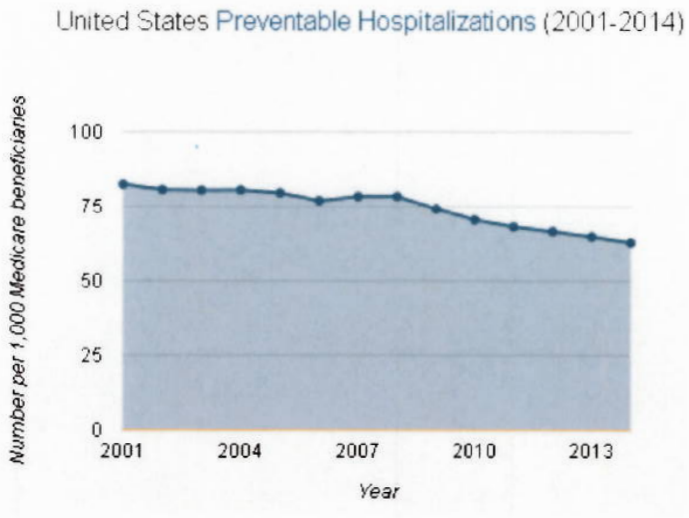
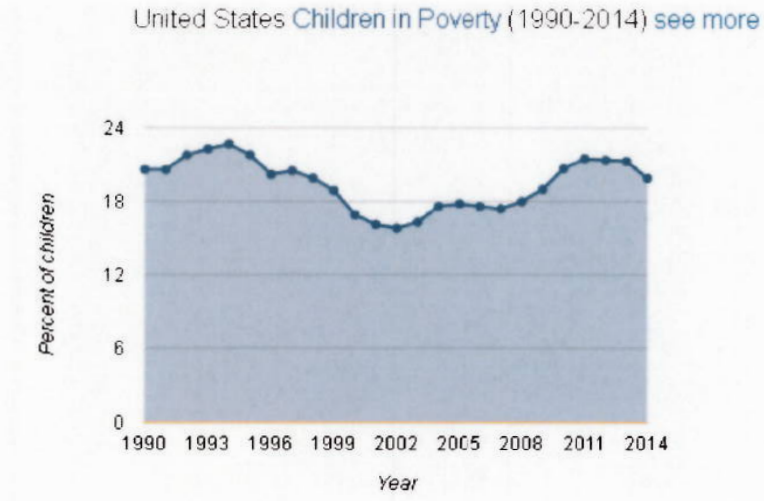
Graph 4 – Preventable Hospitalizations Since 2001



The current economic climate also increases the challenge of maintaining a healthy population. Poverty is an indication of the lack of access to health care, including preventive care, for this vulnerable population. Graph 5 shows the recent increase in the percentage of children in poverty in the last few years, increasing from 16.1 percent of children in the 2011 Edition to 19.9 percent of children in the 2014 Edition. On this measure Virginia ranks 12th with a 14.5 percent of children living in poverty and Tennessee ranks 45th with 26.7 percent. In the 2002 Edition, the child poverty rate was at a historic low of 15.8 percent of persons under age 18.

Graph 5 – Children in Poverty since 1990



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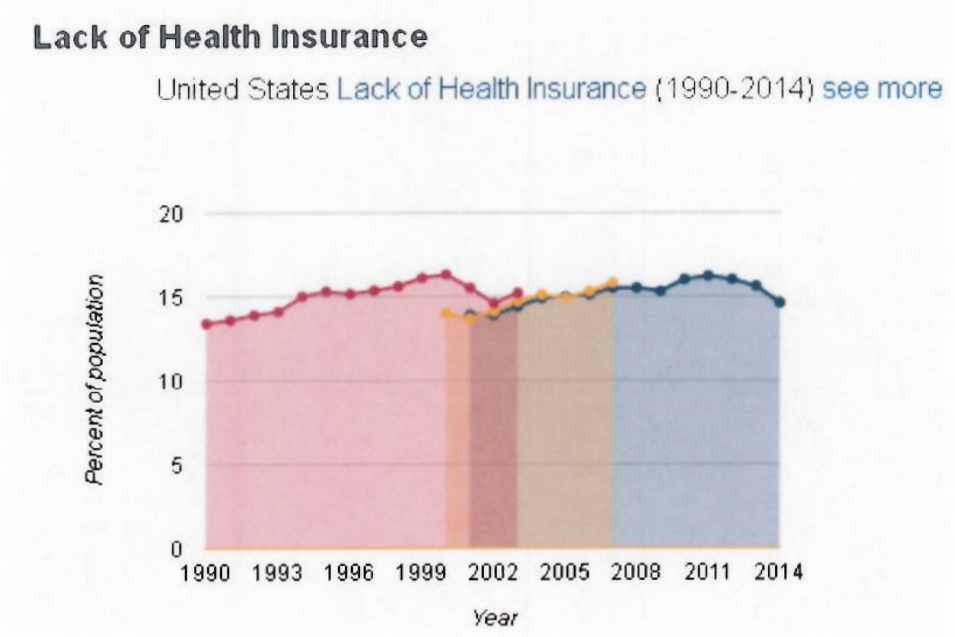
Lack of health insurance coverage increased from 13.9 percent in the 2001 Edition to 14.6 percent of the population in the 2014 Edition. Lack of health insurance not only inhibits people from getting the proper care when needed but also reduces access to necessary preventive care to curtail or minimize future illnesses.

Massachusetts, with the lack of health insurance at 3.8 percent of the population, is substantially better than all other states and less than one-fourth of the national average. Texas has a rate six times that of Massachusetts. Changes in national health care laws have the potential to dramatically affect this metric over the next few years.

Graph 6 – Lack of Health Insurance Since 2001



SBH-KINGSPORT 002114

2014 State Results

America's Health Rankings®-2014 Edition shows Hawaii at the top of the list of healthiest states again this year. The state has steadily remained within the top 5 healthiest states since 1990. Hawaii has consistently sustained its place within the top 5 healthiest states for the last 22 years, excluding 2002 when it was ranked 6th. Hawaii's strengths include its number one position for overall health rank and ranking in the top 5 states for a low rate of preventable hospitalizations, high immunization coverage among children, low prevalence of smoking and obesity, high per capita public health funding, a low rate of uninsured population, and low cancer and cardiovascular mortality rates. Hawaii's three challenges are a high prevalence of binge drinking, low high school graduate rate, and a high incidence of Salmonella infections.

Mississippi is 50th this year, the same as the last ten years, excluding in 2011 when it ranked 49th. It has been in the bottom three states since the 1990 Edition. The state ranks well for a low prevalence of binge drinking, higher immunization coverage among children, and small disparity in health status by educational attainment. In the past year, despite ranking last in the nation for immunization coverage among adolescents, coverage increased from 30.2 percent to 35.4 percent of persons aged 13 to 17 years. Mississippi also ranks last in many health outcomes, including infant mortality, low birth weight, premature death, cardiovascular death, infectious diseases, and overall health status. Mississippi's prevalence of obesity, physical inactivity, and diabetes remain among the highest in the nation with approximately 690,000 physically inactive adults, 770,000 obese adults, and 280,000 adults with diabetes. It ranks 48th in health determinants and 49th in health outcomes; therefore, its overall ranking is unlikely to change significantly in the near future

2014 Edition Ranking

2014 RANK (1–50)	STATE	SCORE
1	Hawaii	.91
2	Vermont	.85
3	Massachusetts	.74
4	Connecticut	.74
5	Utah	.73
6	Minnesota	.73
7	New Hampshire	.68
8	Colorado	.57
9	North Dakota	.55
10	Nebraska	.50
11	New Jersey	.47
12	Oregon	.41
13	Washington	.40
14	New York	.39
15	Rhode Island	.37
16	Maryland	.35
17	California	.35
18	Idaho	.34
18	South Dakota	.34
20	Maine	.30
21	Virginia	.30
22	Montana	.28
23	Wisconsin	.23
24	Iowa	.22
25	Wyoming	.21

2014 Edition Ranking

2014 RANK (1–50)	STATE	SCORE
26	Alaska	.13
27	Kansas	.08
28	Pennsylvania	.01
29	Arizona	-.04
30	Illinois	-.08
31	Texas	-.11
32	Florida	-.15
33	New Mexico	-.18
34	Michigan	-.21
35	Delaware	-.23
36	Missouri	-.28
37	North Carolina	-.29
38	Georgia	-.32
39	Nevada	-.33
40	Ohio	-.36
41	Indiana	-.38
42	South Carolina	-.64
43	Alabama	-.66
44	West Virginia	-.71
45	Tennessee	-.71
46	Oklahoma	-.74
47	Kentucky	-.75
48	Louisiana	-.80
49	Arkansas	-.93
50	Mississippi	-1.00

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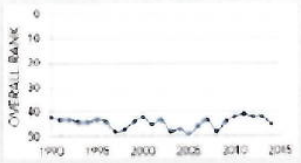
Tennessee

TENNESSEE

Overall Rank: 45

Change: ▼ 3
Determinants Rank: 44
Outcomes Rank: 46



Strengths:
- Low prevalence of binge drinking
- Low incidence of pertussis
- Ready availability of primary care physicians

Challenges:
- High prevalence of obesity
- High prevalence of physical inactivity
- High violent crime rate

Ranking:
Tennessee is 45th this year; it was 42nd in 2013. The ranking for senior health in Tennessee was 43rd in 2014.

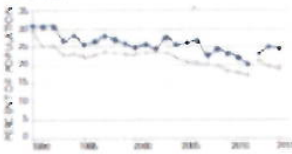
Highlights:
- In the past year, physical inactivity increased by 17 percent from 28.6 percent to 33.6 percent of adults.
- In the past year, binge drinking decreased by 15 percent from 11.3 percent to 9.6 percent of adults, the lowest rate in the nation.
- In the past year, preventable hospitalizations decreased by 10 percent from 80.8 to 73.1 per 1,000 Medicare beneficiaries.
- In the last 2 years, immunization coverage among adolescents increased by 16 percent from 52.7 percent to 61.2 percent of adolescents aged 13 to 17 years.
- Since 1990, children in poverty decreased by 10 percent from 29.6 percent to 26.7 percent of children.

State Health Department Website:
http://health.state.tn.us

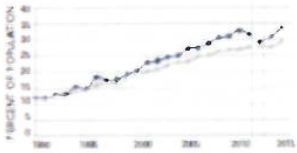
	2014 VALUE	2014 RANK	NO.1 STATE
Behaviors			
Smoking (Percent of adult population)	24.3	46	10.3
Binge Drinking (Percent of adult population)	9.6	1	9.6
Drug Deaths (Deaths per 100,000 population)	17.2	40	3.0
Obesity (Percent of adult population)	33.7	47	21.3
Physical Inactivity (Percent of adult population)	33.6	49	16.2
High School Graduation (Percent of incoming ninth graders)	83.0	20	93.0
Community & Environment			
Violent Crime (Offenses per 100,000 population)	644	50	123
Occupational Fatalities (Deaths per 100,000 workers)	5.0	32	2.2
Infectious Disease (Combined score Chlamydia, Pertussis, *Salmonella**)	0.01	29	-0.9
Chlamydia (Cases per 100,000 population)	507.9	39	233.0
Pertussis (Cases per 100,000 population)	4.8	10	1.6
Salmonella (Cases per 100,000 population)	17.2	35	6.8
Children in Poverty (Percent of children)	26.7	45	9.2
Air Pollution (Micrograms of fine particles per cubic meter)	9.5	30	4.9
Policy			
Lack of Health Insurance (Percent of population)	13.9	26	3.8
Public Health Funding (Dollars per person)	$83	20	$219
Immunization–Children (Percent aged 19 to 35 months)	68.5	33	82.1
Immunization–Adolescents (Percent aged 13 to 17 years)	61.2	36	81.3
Clinical Care			
Low Birthweight (Percent of live births)	9.2	44	5.7
Primary Care Physicians (Number per 100,000 population)	124.4	19	224.6
Dentists (Number per 100,000 population)	50.9	36	107.6
Preventable Hospitalizations (Number per 1,000 Medicare beneficiaries)	73.1	46	28.2
ALL DETERMINANTS	-0.43	44	0.71
OUTCOMES			
Diabetes (Percent of adult population)	12.2	46	6.5
Poor Mental Health Days (Days in previous 30 days)	3.7	24	2.5
Poor Physical Health Days (Days in previous 30 days)	5.0	49	2.8
Disparity in Health Status (Percent difference by education level**)	32.1	38	15.5
Infant Mortality (Deaths per 1,000 live births)	7.3	41	4.2
Cardiovascular Deaths (Deaths per 100,000 population)	300.6	44	194.7
Cancer Deaths (Deaths per 100,000 population)	213.5	44	145.7
Premature Deaths (Years lost per 100,000 population)	9,168	43	5,345
ALL OUTCOMES	-0.29	46	0.34
OVERALL	-0.71	45	0.91

*Negative score denotes less disease than US average, positive score indicates more than US average
**Difference in the percentage of adults aged 25 and older with vs without a high school education who report their health is very good or excellent

SMOKING



OBESITY



STATE ◆——◆ NATION

The 2012–2014 data in the above graphs are not directly comparable to prior years. See Methodology for additional information.

ECONOMIC ENVIRONMENT	TN	US
Annual Unemployment Rate (2013)	8.2	7.4
Annual Underemployment Rate (2013)	14.7	13.8
Median Household Income (2013)	$42,499	$51,939

MEASURE	ADULT POPULATION AFFECTED
Smoking	1,163,000
Obesity	1,595,000
Physical Inactivity	1,691,000
Diabetes	615,000

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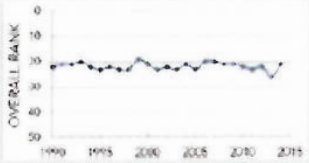
Virginia

VIRGINIA

Overall Rank: 21

Change: ▲ 5
Determinants Rank: 19
Outcomes Rank: 23



Strengths:
- Low rate of drug deaths
- Low violent crime rate
- Low percentage of children in poverty

Challenges:
- Low immunization coverage among children
- Low immunization coverage among teens
- High infant mortality rate

Ranking:
Virginia is 21st this year; it was 26th in 2013. The ranking for senior health in Virginia was 21st in 2014.

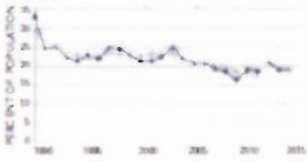
Highlights:
- In the past year, air pollution decreased by 6 percent from 9.3 to 8.7 micrograms of fine particles per cubic meter.
- In the last 2 years, drug deaths decreased by 10 percent from 9.3 to 8.4 deaths per 100,000 population.
- In the last 10 years, preventable hospitalizations decreased by 25 percent from 73.8 to 55.2 per 1,000 Medicare beneficiaries.
- Since 1990, cardiovascular deaths decreased by 42 percent from 413.2 to 241.1 deaths per 100,000 population.
- Since 1990, infant mortality decreased by 38 percent from 10.6 to 6.6 deaths per 1,000 live births.

State Health Department Website:
www.vdh.state.va.us

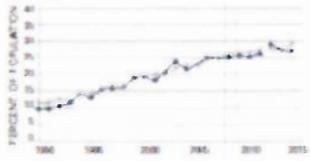
	2014 VALUE	2014 RANK	NO 1 STATE
Behaviors			
Smoking (Percent of adult population)	19.0	24	10.3
Binge Drinking (Percent of adult population)	15.9	20	9.6
Drug Deaths (Deaths per 100,000 population)	8.4	4	3.0
Obesity (Percent of adult population)	27.2	18	21.3
Physical Inactivity (Percent of adult population)	23.0	20	16.2
High School Graduation (Percent of incoming ninth graders)	84.0	16	93.0
Community & Environment			
Violent Crime (Offenses per 100,000 population)	190	4	123
Occupational Fatalities (Deaths per 100,000 workers)	4.4	25	2.2
Infectious Disease (Combined score Chlamydia, Pertussis, *Salmonella**)	-0.29	16	-0.9
Chlamydia (Cases per 100,000 population)	431.8	26	233.0
Pertussis (Cases per 100,000 population)	7.7	18	1.6
Salmonella (Cases per 100,000 population)	14.1	25	6.8
Children in Poverty (Percent of children)	14.5	12	9.2
Air Pollution (Micrograms of fine particles per cubic meter)	8.7	19	4.9
Policy			
Lack of Health Insurance (Percent of population)	12.4	20	3.8
Public Health Funding (Dollars per person)	$68	28	$219
Immunization–Children (Percent aged 19 to 35 months)	69.2	29	82.1
Immunization–Adolescents (Percent aged 13 to 17 years)	58.5	42	81.3
Clinical Care			
Low Birthweight (Percent of live births)	8.1	27	5.7
Primary Care Physicians (Number per 100,000 population)	125.8	16	324.6
Dentists (Number per 100,000 population)	61.6	19	107.6
Preventable Hospitalizations (Number per 1,000 Medicare beneficiaries)	55.2	22	28.2
ALL DETERMINANTS	0.24	19	0.71
OUTCOMES			
Diabetes (Percent of adult population)	9.8	26	6.5
Poor Mental Health Days (Days in previous 30 days)	3.3	11	2.5
Poor Physical Health Days (Days in previous 30 days)	3.6	15	2.8
Disparity in Health Status (Percent difference by education level**)	29.1	27	15.5
Infant Mortality (Deaths per 1,000 live births)	6.6	31	4.2
Cardiovascular Deaths (Deaths per 100,000 population)	241.1	25	184.7
Cancer Deaths (Deaths per 100,000 population)	189.5	23	145.7
Premature Deaths (Years lost per 100,000 population)	6,502	19	5,345
ALL OUTCOMES	0.06	23	0.34
OVERALL	0.30	21	0.91

*Negative score denotes less disease than US average, positive score indicates more than US average.
**Difference in the percentage of adults aged 25 and older with vs without a high school education who report their health is very good or excellent.

SMOKING



OBESITY



STATE ◆ NATION +

The 2013-2014 data in the above graphs are not directly comparable to prior years. See Methodology for additional information.

ECONOMIC ENVIRONMENT	VA	US
Annual Unemployment Rate (2013)	5.5	7.4
Annual Underemployment Rate (2013)	11.5	13.8
Median Household Income (2013)	$67,620	$51,939

MEASURE	ADULT POPULATION AFFECTED
Smoking	1,159,000
Obesity	1,632,000
Physical Inactivity	1,481,000
Diabetes	631,000

SBH-KINGSPORT 002118

As Mountain States Health Alliance works to develop an implementation plan based on the findings from this assessment, key focus areas for consideration to impact the health of our community would be the 27 measures that comprise the *America's Health Rankings*. These determinants have been carefully selected by leaders in health and public policy as factors which have the greatest impact on future health of a population. For a state (or area for that matter) to improve the health of its population, efforts must focus on changing the determinants of health. A description of these determinants is outlined below.

Selection of Components

Four primary considerations drove the design of *America's Health Rankings*® and the selection of the individual measures:

1. The overall rankings had to represent a broad range of issues that affect a population's health,
2. Individual measures needed to use common health measurement criteria,
3. Data had to be available at a state level, and
4. Data had to be current and updated periodically.

While not perfect, the measures selected are believed to be the best available indicators of the various aspects of healthiness at this time and are consistent with past reports.

The measures are divided into two categories - Determinants and Outcomes. For further clarity, determinants are divided into four groups: Behaviors, Community and Environment, Public and Health Policies, and Clinical Care. These four groups of measures influence the health outcomes of the population in a state, and improving these inputs will improve outcomes over time. Most measures are actually a combination of activities in all four groups. For example, the prevalence of smoking is a behavior that is strongly influenced by the community and environment in which we live, by public policy including taxation and restrictions on smoking in public places, and by the care received to treat the chemical and behavioral addictions associated with tobacco. However, for simplicity, we placed each measure in a single category.

For *America's Health Rankings*® to continue to meet its objectives it must evolve and incorporate new information as it becomes available. The Scientific Advisory Committee provides guidance for the evolution of the rankings, balancing the need to change with the desire for longitudinal comparability. Over the last few years, change is being driven by: 1) the acknowledgment that health is more than years lived but also includes the quality of those years; 2) data about the quality and cost of health care delivery are becoming available on a comparative basis; and 3) measurement of the additional determinants of health are being initiated and/or improved. The committee also emphasizes that the real impact on health will be made by addressing the determinants, and making improvements on these items will affect the long-term health of the population. The determinants are the predictors of our future health.

Outcomes are traditionally measured using mortality measures which include premature death, infant mortality, cancer and cardiovascular mortality. While these measures overlap significantly, they do present different views of mortality outcomes of a population. Two measures of the quality of life- poor mental health days and poor physical health days - are also included and defined as the number of days in the previous 30 days when a person indicates their activities are limited due to mental or physical health difficulties.

As with all indices, the positive and negative aspects of each measure must be weighed when choosing and developing them. These aspects for consideration include: 1) the interdependence of

SBH-KINGSPORT 002119

the different measures; 2) the possibility that the overall ranking may disguise the effects of individual measures; 3) an inability to adjust all data by age and race; 4) an over-reliance on mortality data; and 5) the use of indirect measures to estimate some effects on health. These concerns cannot be addressed directly by adjusting the methodology; however, assigning weights to the individual measures can mitigate their impact.

Each measure is assigned a weight that determines its percentage of the overall score. Determinants account for 75 percent of the overall ranking and outcomes account for 25 percent, a shift from the 50/50 balance in the original 1990 index. This reflects the importance and growing availability of determinant data.

A short description of each measure immediately follows. The data for each year is the most current data available at the time the report was compiled.

The table includes the core measures included in the current model, plus supplemental measures that can be used to further understand each state's unique situation. The supplemental measures are more fully described at http://www.americashealthrankings.org/About/Model.

Data for each state and the United States is available at Get Informed or by clicking the link above.

Core Measures

Determinants

Behaviors	Description
Smoking	Percentage of adults who are current smokers (smoked at least 100 cigarettes in their lifetime and currently smoke)
Binge Drinking	Percentage of adults who self-report having 4 or more (women) or 5 or more (men) alcoholic beverages on at least 1 occasion in the past 30 days.
Drug Deaths	Number of deaths due to drug injury of any intent (unintentional, suicide, homicide, or undetermined) per 100,000 population
Obesity	Percentage of adults who are obese, with a body mass index (BMI) of 30.0 or higher.
Physical Inactivity	Percentage of adults who report doing no physical activity or exercise (such as running, calisthenics, golf, gardening, or walking) other than their regular job in the last 30 days
High School Graduation	Percentage of incoming ninth graders who graduate in 4 years from a high school with a regular degree.

Community and Environment

Violent Crime	Number of murders, rapes, robberies, and aggravated assaults per 100,000 population.
Occupational Fatalities	Number of fatalities from occupational injuries per 100,000 workers
Children in Poverty	Percentage of persons younger than 18 years who live in households at or below the poverty threshold
Infectious Disease	Combined average z-score using the values of incident cases of chlamydia, pertussis, and *Salmonella* per 100,000 population

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Air Pollution	Average exposure of the general public to particulate matter of 2.5 microns or less in size (PM2.5)

Policy

Lack of Health Insurance	Percentage of the population that does not have health insurance privately, through their employer, or the government
Public Health Funding	State funding dedicated to public health as well as federal funding directed to states by the Centers for Disease Control and Prevention and the Health Resources and Services Administration
Immunization-Children	Percentage of children receiving the recommended doses of DTaP, polio, MMR, Hib, hepatitis B, varicella, and PCV vaccines by age 19-35 months.
Immunization-Adolescents	Percentage of adolescents aged 13 to 17 years who have received 1 dose of Tdap since the age of 10 years, 1 dose of meningococcal conjugate vaccine, and 3 doses of HPV vaccine (females only)

Clinical Care

Low Birth weight	Percentage of infants weighing less than 2,500 grams (5 pounds, 8 ounces) at birth
Primary Care Physicians	Number of primary care physicians (including general practice, family practice, OB-GYN, pediatrics, and internal medicine) per 100,000 population
Dentists	Number of dentists per 100,000 population
Preventable Hospitalizations	Discharge rate among the Medicare population for diagnoses that are amenable to non-hospital based care

Outcomes

Diabetes	Percentage of adults who have been told by a health professional that they have diabetes (does not include pre-diabetes or diabetes during pregnancy)
Poor Mental Health Days	Number of days in the previous 30 days when a person indicates their activities were limited due to mental health difficulties
Poor Physical Health Days	Number of days in the previous 30 days when a person indicates their activities were limited due to physical health difficulties
Disparity in Health Status	Percent difference in adults aged 25 and older who did not graduate high school and adults with at least a high school education who self-report being in excellent or very good health
Infant Mortality	Number of infant deaths (before age 1) per 1,000 live births
Cardiovascular Deaths	Number of deaths due to all cardiovascular diseases, including heart disease and strokes, per 100,000 population
Cancer Deaths	Number of deaths due to all causes of cancer per 100,000 population
Premature Death	Number of years of potential life lost prior to age 75 per 100,000 population

Supplemental Measures

Behaviors

SBH-KINGSPORT 002121

Cholesterol Check	Percentage of adults who have had their blood cholesterol checked within the last 5 years.
Dental Visit, Annual	Percentage of adults who have visited the dentist or dental clinic within the past year for any reason
Diet, Fruit	Number of fruits consumed on an average day
Diet, Vegetables	Number of vegetables consumed on an average day
Teen Birth Rate	Number of births per 1,000 mothers aged 15 to 19 years.
Youth Smoking	Percentage of high school youth who smoked cigarettes on at least 1 day during the last 30 days
Youth Obesity	Percentage of high school students who were greater or equal to the 95th percentile for body mass index, based on sex and age-specific reference data from the 2000 CDC growth charts.

Chronic Disease

Heart Disease	Percentage of adults who have been told by a health professional that they have angina or coronary heart disease
High Cholesterol	Percentage of adults who have had their cholesterol checked and been told that it was high
Heart Attack	Percentage of adults who have been told by a health professional that they had a heart attack (myocardial infarction).
Stroke	Percentage of adults who have been told by a health professional that they had a stroke.
Hypertension	Percentage of adults who have been told by a health professional that they have high blood pressure

Clinical Care

Preterm Birth	Percentage of babies born before 37 weeks gestation

Economic Environment

Personal Income	Per capita personal income in current dollars
Median Household Income	The amount of income that divides the income distribution into 2 equal groups
Unemployment Rate	Total unemployed as a percentage of the civilian labor force (U-3 definition)
Underemployment Rate	Total unemployed, plus all marginally attached workers, plus total employed part-time for economic reasons, as a percent of the civilian labor force (U-6 Definition)
Income Disparity (Gini coefficient)	A common measure of income inequality, where 0 represents complete equality and 1 indicates complete inequality

Outcomes

Low Health Status	Percentage of adults who describe their general health as fair or poor
Suicide	Number of deaths due to intentional self-harm per 100,000 population

SBH-KINGSPORT 002122

Overview

The County Snapshots consists of demographics, key indicators of health status, interview highlights, and local resources. The model for the key indicators of health status analysis was based on the 2015 *County Health Rankings*, a key component of the Mobilizing Action Toward Community Health (MATCH). MATCH is collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute. Indicators are organized into two broad categories: Health Outcomes and Health Factors. The Health Factors have multiple components, including Clinical Care, Health Behaviors, Social and Economic Factors, and Physical Environment. A number of additional key indicators of health status were included in this analysis from other sources (they are noted in blue font in the snapshot section). For each indicator, the state and county score is provided as well as a comparison of the county's performance to that of the state.

JOHNSON CITY MEDICAL CENTER

Service Area Counties:

- Washington, TN
- Sullivan, TN
- Unicoi, TN
- Carter, TN
- Greene, TN
- Johnson, TN

Primary Service Area Map:

Facility Profiles:

Johnson City Medical Center (JCMC), MSHA's flagship facility, is a 445-bed regional tertiary referral center for the entire service area. JCMC is one of six Level 1 Trauma Centers in the state of Tennessee. As East Tennessee's leading Heart Hospital, JCMC has been named as a Top 100 Heart Hospitals by Solucient. JCMC is also the leading Cancer Center in the region, enjoying relationships with Harvard, Duke, and Vanderbilt. JCMC is the first and one of two Nurse Magnet hospitals in the State. JCMC also includes Niswonger Children's Hospital and Woodridge Psychiatric Hospital.

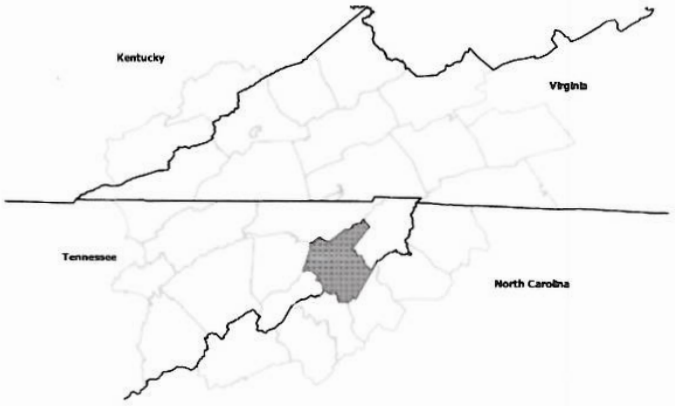
A 6-page profile of each county is provided. The profile includes demographic highlights, key indicators of health status, utilization projections, and survey results specific to the county. A detailed demographic analysis by county is provided in the appendix, which follows the collection of county snapshots.

SBH-KINGSPORT 002124

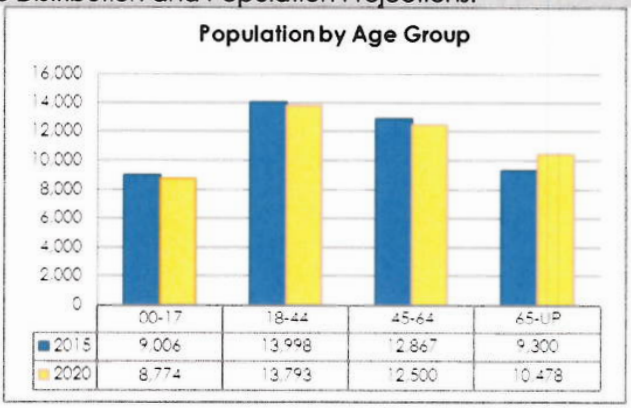
Demographic Highlights:

- Large elderly population compared to TN and US
- Declining rate of females of child-bearing age expected
- Low average household income level (20.6% of households make less than $15,000)
- Lower level of educational attainment compared to state and country (9.1% with no high school education compared to 5.9% nationally)
- Low level of diversity compared to state and national

Service Area Map:



Age Distribution and Population Projections:



Key Statistics:

	Carter County	Tennessee	U.S.
2015 Total Population	45,171	6,735,022	321,369,000
% Change 2015-2020	0.8%	5.5%	4.1%
% of Population 65+ (2015)	20.6%	15.6%	14.9%
% Minority (2015)	4.5%	26.1%	38.3%

	2015	2020	% Change
Total Male Population	22,105	22,298	0.9%
Total Female Population	23,066	23,247	0.8%
Females, Child Bearing Age (15-44)	7,730	7,608	-1.6%

SBH-KINGSPORT 002125

Local Health Highlights:

STRENGTHS:

- Divorce Rate
- STD
- Teen Pregnancy
- Binge Drinking
- Deaths due to diabetes
- Children Un/Improperly Restrained in a Crash

WEAKNESSES:

- Pre-1950 housing
- Diabetic HbA1c testing
- Smoking During Pregnancy
- Deaths due to cardiovascular and cancer
- No Biennial Mammogram
- Air Quality Hazard Index

Leading Causes of Death:

Leading Causes of Death

Ages 1 - 14 years

Cause of Death	Rate	Rank
Accidents	22.5	1
Motor Vehicle Accident	11.1	2
Malformation/Abnormalities	7.3	3
All Other Causes	0.0	*

Ages 15 - 21 years

Cause of Death	Rate	Rank
Accidents	17.9	1
Meningitis	6	2
Suicide	5.9	3
All Other Causes	0	*

Ages 22 - 64

Cause of Death	Rate	Rank
Cancer	116.8	1
Heart Disease	85.9	2
Accidents	46.9	3
Chronic Lower Respiratory	30.6	4
Liver & Cirrhosis	21.1	5
Diabetes Mellitus	14.3	6
Influenza/Pneumonia	15.3	7
Suicide	14.4	8
Cerebrovascular Disease	11.5	9
Viral Hepatitis	8.6	10
All Other Causes	91.1	*

Ages 65+

Cause of Death	Rate	Rank
Heart Disease	1153.9	1
Cancer	1041.2	2
Chronic Lower Respiratory	348.2	3
Influenza & Pneumonia	307.2	4
Alzheimer's Disease	273.1	5
Cerebrovascular Disease	218.5	6
Accidents	105.8	7
Diabetes Mellitus	102.4	8
Septicemia	75.1	9
Pneumonitis	58	10
All Other Causes	1031	*

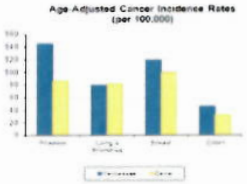
Key Indicators of Health Status:

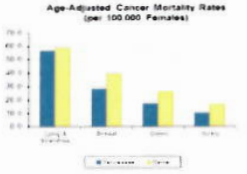
County: Carter, TN

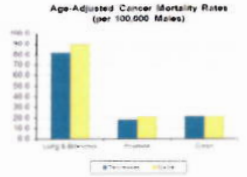
	TN	Carter	2010	Desired
Health Outcomes				↓
Mortality (years of potential life lost/ 100,000)	8,790	9,292	9447	↓
Low Birth Weight (3-yr avg %)	9.0%	9.2%	9.30%	↓
General Health Status (% fair/poor health)*	19.0%	25.0%	26.00%	↓
Very Low Birth Weight (%)	1.6%	1.0%	3.30%	↓
Infant Mortality (3-yr avg rate per 1,000)	8.1	10.8	11.7	↓
Mortality Rate (3-yr avg rate per 100,000)	953.0	1,053.0	972.6	↓
Cardiovascular Deaths (per 100,000)	226.5	237.9	295.6	↓
Cancer Deaths (3-yr avg rate per 100,000)	214.4	237.9	220.5	↓
Diabetes Mellitus Deaths (per 100,000)	28.7	18.3	35.3	↓
Cerebrovascular Deaths (per 100,000)	47.0	45.0	48.7	↓
Suicide Deaths (per 100,000)	15.0	15.0	23.5	↓
Mortality rate for ages 1- 14 yrs	66.8	86.4	95.2	↓
Mortality rate for ages 15 - 21yrs	70.4	30.0	107.2	↓
Mortality rates for ages 65+	4,870.1	4,714.4	5472	↓
Lung Cancer Deaths (3-yr avg rate per 100,000)	68.8	77.4	71.6	↓
Female Breast Cancer Deaths (3-yr avg rate per 100,000)	14.1	17.3	20.5	↓
Prevalence of Asthma (%)	9.3	13.2	90.5	↓
Prevalence of Diabetes (%)	11.3	12.8	57.7	↓
Health Determinants				↓
Health Care Resources				↓
No Health Insurance (%)*	21.0%	22.0%	16.40%	↓
Medicaid/Tenncare Enrollees (%)	18.7%	19.6%	20.20%	↓
Medical Doctors Per Capita (per 100,000)	246.1	71.4	55.7	↑
Dentists Per Capita (per 100,000)	52.2	27.9	32	↑
Percent without Pneumococcal Vaccinations (%)*	74.2%	66.7%	72.30%	↓
Percent without Influenza Vaccinations (%)*	59.4%	50.7%	59.30%	↓
No Diabetic Eye Exams (%)	74.3%	72.2%	58.30%	↓
No Diabetic HbA1c Testing (%)	16.0%	24.0%	18.30%	↓
No Biennial Mammography (%)*	23.3%	29.3%	23.30%	↓
Inadequate or No Prenatal Care (%)	40.7%	33.6%	5.50%	↓
Month Prenatal Care Began	3.2	2.9	2.9	↓
First Trimester Prenatal Care (%)	59.3%	66.4%	72.40%	↑
Children (0-18 yrs) with Medicaid/Tenncare Coverage (%)	46.8%	52.3%	54.60%	↓
Hospital Staffed Beds (per 1,000)	3.6	2.1	2	↑
Licensed Nursing Beds (per 1,000 65+)	44.8	56.7	61	↑
# of Primary Care MDs	7,703	18	18	↓
# of Psychiatric Specialists	684	1	0	↓
Inpatient Discharge Rate (per 1,000) - Total	126.3	112.1	118.9	↓
Health Behaviors (continued)				↓
Cigarette Smoking (%)*	23.0%	28.0%	28.90%	↓
Smoking During Pregnancy (%)	16.3%	29.8%	37.30%	↓
Physical Inactivity (%)*	30.0%	33.0%	38.40%	↓
Overweight/Obesity (% BMI > 25)*	67.8%	67.8%	67.90%	↓
Obesity (% BMI > 30)*	32.0%	35.0%	34.00%	↓
Low Fruit and Vegetable Consumption (% <5 a day)*	76.7%	73.0%	76.60%	↓
Binge Drinking (%)*	10.0%	5.0%	7.90%	↓
% of Children (0-4) Un/Improperly Restrained in a Crash	14.5%	5.2%	7.40%	↓
Teen Birth Rate (per 1,000)	37.3	34.4	49	↓
Sexually Transmitted Diseases (per 100,000)	446	150	108	↓
Violent Crime (per 100,000)	667.0	219.0	240	↓
Motor Vehicle Crash Deaths (per 100,000)	19	18	19	↓
Unmarried Mother Birth Rate (%)	44.1%	42.7%	43.60%	↓
Injury-related Mortality (3-yr avg rate per 100,000)	53.7	50.1	75.6	↓
Young Driver Crash Rate 15 - 24	116.9	94.6	103.5	↓
Elderly Drive Crash Rate (65+)	31.3	24	28.8	↓
Homicides (per 100,000)	8	4.0	0	↓
All accidental deaths per 100,000 population	52	46.7	53.7	↓
Average Fatality Rate in Alchohol-Related Crashes (per 100,000 population)	6.9	3.5	11.1	↓

SBH-KINGSPORT 002126

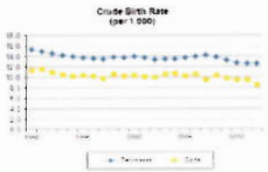
Cancer Incidence:

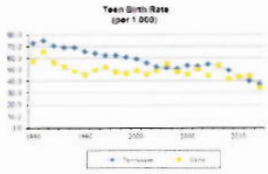






Birth Rate Trend:





Key Indicators of Health Status:

Socioecomonic Factors				↓
High School Graduation Rate (%)	86.0%	92.0%	88.60%	↑
Level of Education (%)	83.2%	78.6%	75.90%	↑
Unemployment (%)	8.8%	11.1%	8.10%	↓
Children (age 0 to 17) in poverty ratio (%)	26.5%	31.4%	30.30%	↓
Divorce Rate (per 100,000)	4.3	4.1	18	↓
Food Stamp Recipients (% of individuals)	21.1%	22.3%	17.70%	↓
Poverty Rate (% of all ages)	18.4%	20.6%	21.50%	↓
Temporary Assistance for Needy Families (% of individuals)	2.6%	1.1%	1.10%	↓
High School Dropout Rate	6.9%	6.7%	7.10%	↓
Average Annual Wage	$ 36,576	$ 27,962	$23,987	↑
Physical Environment				↓
Air Quality Cancer Risk (per 1,000,000)	4.6	3.1	24.1	↓
Air Quality Hazard Index (per 1,000,000)	1.4	9.1	2.8	↓
Air Quality - Fine Particulate Matter in Air (3 yr avg Mg/m3)*	13.2	12.7	14.5	↓
Ozone Level (ppb)*	0.062	0.063	0.082	↓
Nitrate Levels in drinking water (mg/L)	0.70	0.50	1.60	↓
Pre-1950 Housing (%)	11.8%	19.4%	23.60%	↓
Lead Poisoned Children (%)	0.1%	n/a	0.90%	↓
Child Abuse and Neglect (rate per 1,000)	5.5	4.9	5.2	↓
Communicable Diseases				↓
Hepatitis A (per 100,000)	0.3	0.0	n/a	↓
Campylobacter Infection (per 100,000)	7.2	6.8	n/a	↓
Salmonella, Non Typhoid (per 100,000)	17.6	3.4	n/a	↓
Shigellosis (per 100,000)	3.3	0.0	n/a	↓
AIDS/HIV (per 100,000)	29.3	8.2	n/a	↓
Primary and Secondary Syphilis (per 100,000)	4.3	0.0	n/a	↓
Penicillin-Sensitive *Streptococcus pneumoniae* (per 100,000)	0.0	0.0	n/a	↓
Group B *Streptococcus* (per 100,000)	6.2	0.0	n/a	↓
Chlamydia (per 100,000)	517.3	164.3	n/a	↓
Gonorrhea (per 100,000)	144.8	27.1	n/a	↓

SBH-KINGSPORT 002127

Inpatient Projections

	2014	2019		2024	
DRG Service Line	Discharges	Discharges	% Change	Discharges	% Change
Cardiac Surgery	71	68	-3.50%	69	-3.20%
Cardiology	622	539	-13.30%	477	-23.20%
Cardiology Intervention	248	226	-8.90%	209	-15.70%
Endocrinology	159	126	-20.90%	113	-29.00%
ENT Surgery	11	10	-6.80%	10	-11.90%
Gastroenterology	646	611	-5.40%	599	-7.30%
General Medicine	633	635	0.30%	594	-6.20%
General Surgery	364	352	-3.20%	342	-6.20%
Gynecology	55	50	-8.40%	47	-13.90%
Hematology	96	93	-2.80%	95	-0.80%
Neonatology	199	184	-7.50%	172	-13.50%
Nephrology	330	305	-7.50%	276	-16.30%
Neurology	318	316	-0.70%	321	1.00%
Neurosurgery	125	122	-2.10%	122	-2.10%
Normal Newborns	242	249	2.90%	246	1.50%
OB Deliveries Sections	141	121	-14.50%	111	-21.20%
OB Deliveries Vaginal	275	288	4.80%	286	3.90%
OB Other	45	43	-4.50%	42	-7.30%
Oncology Medicine	121	117	-3.10%	107	-11.20%
Oncology Surgery	35	35	-0.70%	33	-5.70%
Ophthalmic Medicine	7	6	-11.50%	6	-16.80%
Ophthalmic Surgery	2	2	-11.70%	2	-11.50%
Oral Surgery	7	7	-6.60%	7	-6.10%
Orthopedic Medicine	84	84	-0.40%	84	0.40%
Orthopedic Surgery	355	373	5.10%	379	6.80%
Otolaryngology	32	28	-12.80%	27	-16.60%
Plastic Surgery	14	13	-6.70%	12	-16.70%
Psychiatry	462	513	11.00%	486	5.30%
Pulmonary	905	781	-13.60%	741	-18.10%
Rehabilitation	89	75	-16.30%	80	-9.70%
Rheumatology	29	27	-6.20%	27	-7.50%
Substance Abuse	62	64	3.30%	62	0.00%
Thoracic Surgery	52	49	-6.30%	47	-9.90%
Trauma Medical	26	24	-8.40%	24	-7.40%
Urology Medicine	25	22	-10.50%	22	-13.80%
Urology Surgery	60	56	-6.10%	53	-12.40%
Vascular Surgery	102	99	-2.60%	96	-5.70%
Womens Other	4	4	-8.90%	3	-20.80%
Grand Total	**7,053**	**6,719**	**-4.70%**	**6,428**	**-8.90%**

SBH-KINGSPORT 002128

Outpatient Projections

	2014	2019		2024	
Site of Care	**Volumes**	**Volumes**	**% Change**	**Volumes**	**% Change**
ED	28,480	28,487	0.00%	27,274	-4.20%
Home	62,251	72,114	15.80%	78,595	26.30%
Hosp OP/ASC	70,077	74,750	6.70%	75,887	8.30%
Office/Clinic	378,290	403,160	6.60%	388,891	2.80%
Other	27,103	29,580	9.10%	30,021	10.80%
SNF	1,708	1,850	8.30%	1,945	13.90%
Urgent/Retail	666	699	5.10%	668	0.40%
Virtual		7,613		31,509	
Grand Total	**568,574**	**618,252**	**8.70%**	**634,791**	**11.60%**

Interview Highlights:

INTERVIEWEES:

- Seventeen (17) individuals

KEY FINDINGS:

- Average rating of health status is 4.7, with a range in responses of 2.5 to 7
- Top health issues are:
  - Obesity
  - Smoking/Tobacco Use
  - Diabetes
  - Substance and Prescription Drug Abuse
- Additional health issues are:
  - Physical Inactivity
  - Poor Nutrition
  - Education
  - Poverty
  - Cardiovascular Disease
  - Cancer
  - COPD
  - Asthma
  - Shift in family culture/norms
  - Transportation barriers
  - Access to dental care
  - Built environment for physical activity
  - Cultural barriers (pride, trust)
  - Fast food culture
  - High cost healthy food
  - Hypertension
  - Stroke
  - Immunizations
  - Literacy
  - Prenatal care/education
  - Teen pregnancy
  - Utilization of health screenings
- Ideas to improve these conditions include:
  - Smoking Cessation Programs
  - MSHA Mobile Health bus travel to Roan Mountain
  - Increase community health events
  - Community Paramedic Program
  - Cooking education classes
  - More public healthcare initiatives for free healthcare and screenings
  - Low cost or free exercise programs/opportunities
  - Low cost or free nutrition coaches
  - Local farmers markets
  - Support groups for grandparents raising grandchildren
  - Organizational collaboration
  - Healthcare navigators/care coordinators
  - COPD clinics
  - Urgent care clinics
  - Care transition coordination
  - Tighter legislation on tobacco products
  - Better promotion/marketing of health programs and services

SBH-KINGSPORT 002130

- Legislation on artificial sugar substances
- Additional mental health services
- Parenting skills classes
- Community gardens
- Repeal TN pregnancy criminalization legislation
- Project Access
- Promote health education to younger populations
- Inpatient and outpatient substance abuse treatment programs

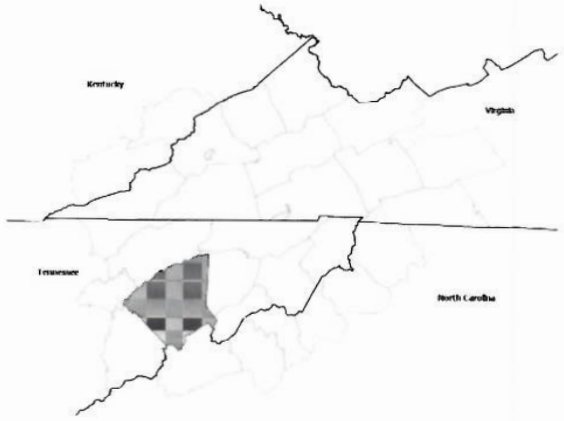
Sources:	Local Resources:
▪ Medstat ▪ County Health Rankings ▪ TN Advisory Commission on Intergovernmental Relations ▪ TN Dept of Health ▪ BRFSS ▪ TennCare ▪ Kidscount ▪ TN Dept of Safety and Homeland Security ▪ EPA ▪ CDC Wonder ▪ TN Dept of Environment & Conservation ▪ Childhood Lead Poisoning Prevention Program	▪ Local Health Clinics ▪ Free blood sugar testing at local community events ▪ MSHA Mobile Health bus ▪ Company wellness programs ▪ Coordinated School Health ▪ Carter County Health Council ▪ Carter County Health Department ▪ Walking trails/Tweetsie Trail ▪ Healthy Tennessee / Small Starts ▪ Tennessee Education Initiative ▪ Carter County Anti-Drug Coalition ▪ TNCEP ▪ Tobacco Settlement Fund ▪ TIPS-Maternal Smoking Cessation Program ▪ ReadNPlay ▪ Mommy and Me Support Group ▪ Red Legacy ▪ Project Access ▪ MSHA Health Resources Center

SBH-KINGSPORT 002131

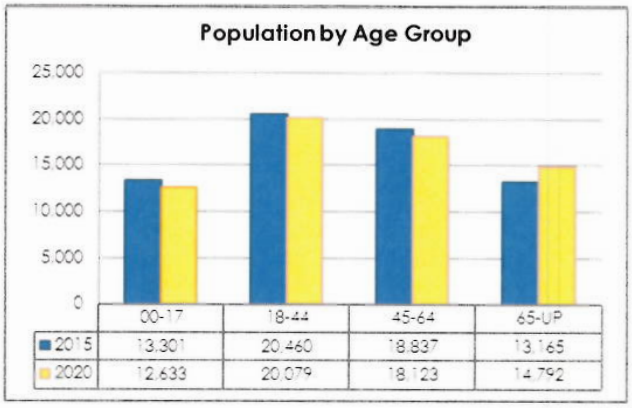
Demographic Highlights:

- Large elderly population compared to TN and US
- Declining rate of females of child-bearing age expected
- Low average household income level (19.0% of households make less than $15,000)
- Lower level of educational attainment compared to state and country (7.6% with no high school education compared to 5.9% nationally)
- Low level of diversity compared to state and national

Service Area Map:



Age Distribution and Population Projections:



Key Statistics:

	Greene County	Tennessee	U.S.
2015 Total Population	65,763	6,735,022	321,369,000
% Change 2015-2020	-0.2%	5.5%	4.1%
% of Population 65+ (2015)	20.0%	15.6%	14.9%
% Minority (2015)	7.2%	26.1%	38.3%

	2015	2020	% Change
Total Male Population	32,312	32,269	-0.1%
Total Female Population	33,451	33,358	-0.3%
Females, Child Bearing Age (15-44)	11,327	11,036	-2.6%

SBH-KINGSPORT 002132

Local Health Highlights:

STRENGTHS:

- High School Graduation Rate
- Infant Mortality
- Binge Drinking
- STDs
- Violent Crime Rate
- Young Drive Crash Rate

WEAKNESSES:

- Poverty Rate
- Pre-1950 Housing
- Deaths due to cardiovascular, cancer, cerebrovascular, injuries, and diabetes
- No Biennial Mammogram
- Smoking During Pregnancy

Leading Causes of Death:

Ages 1 - 14 years

Cause of Death	Rate	Rank
Accidents	6.1	1
Cancer	3.1	2
Congenital Malformations	3	3
All Other Causes	3	*

Ages 15 - 21 years

Cause of Death	Rate	Rank
Accidents	26.3	1
Homicide	10.5	2
Septicemia	5.3	3
Cancer	5.3	3
Suicide	5.2	4
All Other Causes	15.7	*

Ages 22 - 64

Cause of Death	Rate	Rank
Cancer	163.8	1
Heart diseases	119.1	2
Accidents	81.4	3
Respiratory	37.7	4
Suicide	25.4	5
Liver &Cirrhosis	20.1	6
Diabetes	20	7
Cebrovascular	13.1	8
Septicemia	13	9
Flu/Pneumonia	12.3	10
All Other Causes	139.4	*

Ages 65+

Cause of Death	Rate	Rank
Heart diseases	1375	1
Cancer	1107.5	2
Respiratory	431.5	3
Respiratory	354.25	4
Cerebrovascular	319.3	5
Flu/Pneumonia	189.9	6
Alzheimer's	158.2	7
Diabetes Mellitus	143.8	8
Accidents	141	9
Nephritis	115.1	10
All Other Causes	701.3	*

Key Indicators of Health Status:

County: Greene, TN

2013 Population: 69,339

	TN	Greene	2010	Desired
Health Outcomes				
Mortality (years of potential life lost/100,000)	8,790	10,052	9,870	
Low Birth Weight (3-yr avg %)	9.0%	10.7%	8.50%	
General Health Status (%fair/poor health)*	19.0%	23.0%	22%	
Very Low Birth Weight (%)	1.6%	1.0%	1.00%	
Infant Mortality (3-yr avg rate per 1,000)	8.1	4.6	7.8	
Mortality Rate (3-yr avg rate per 100,000)	953.0	1,238.9	981.1	
Cardiovascular Deaths (per 100,000)	226.5	302.1	326.7	
Cancer Deaths (3-yr avg rate per 100,000)	214.4	282.4	237.8	
Diabetes Mellitus Deaths (per 100,000)	28.7	38.2	29.8	
Cerebrovascular Deaths (per 100,000)	47.0	54.4	58.2	
Suicide Deaths (per 100,000)	15.0	22.0	22.5	
Mortality rate for ages 1 - 14 yrs	66.8	9.0	31.1	
Mortality rate for ages 15 - 21yrs	70.4	31.4	135.2	
Mortality rates for ages 65+	4,870.1	5,041.3	5300.8	
Lung Cancer Deaths (3-yr avg rate per 100,000)	68.8	102.3	85.1	
Female Breast Cancer Deaths (3-yr avg rate per 100,000)	14.1	13.8	34.8	
Prevalence of Asthma (%)	9.3	13.2	12.8	
Prevalence of Diabetes (%)	11.00%	12.00%	11.00%	
Health Determinants				
Health Care Resources				
No Health Insurance (%)*	21.0%	17.0%	16.40%	
Medicaid/Tenncare Enrollees (%)	18.7%	18.3%	20.20%	
Medical Doctors Per Capita (per 100,000)	246.1	119.1	137.3	*
Dentists Per Capita (per 100,000)	52.2	29.1	46.5	*
Percent without Pneumococcal Vaccinations (%)*	74.2%	66.7%	72.30%	
Percent without Influenza Vaccinations (%)*	59.4%	49.3%	59.30%	
No Diabetic Eye Exams (%)	74.3%	72.2%	49.90%	
No Diabetic HbA1c Testing (%)	16.0%	18.0%	11.60%	
No Biennial Mammography (%)*	23.3%	29.3%	23.30%	
Inadequate or No Prenatal Care (%)	40.7%	37.0%	9.50%	
Month Prenatal Care Began	3.0	2.9	2.9	
First Trimester Prenatal Care (%)	59.3%	63.0%	67.70%	*
Children (0-18 yrs) with Medicaid/Tenncare Coverage (%)	46.8%	44.8%	48.20%	
Hospital Staffed Beds (per 1,000)	3.6	3.8	2.6	*
Licensed Nursing Beds (per 1,000 65+)	44.8	40.9	44.8	*
# of Primary Care MDs	7,703	36	59	
# of Psychiatric Specialists	684	8	5	
Inpatient Discharge Rate (per 1,000) - Total	126.3	121.5	141.7	
Health Behaviors (continued)				
Cigarette Smoking (%)*	23.0%	29.0%	28.90%	
Smoking During Pregnancy (%)	16.3%	29.8%	32.90%	
Physical Inactivity (%)*	30.0%	34.0%	38.40%	
Overweight/Obesity (%BMI > 25)	67.8%	67.8%	67.90%	
Obesity (%BMI > 30)*	32.0%	32.0%	33.00%	
Low Fruit and Vegetable Consumption (%<5 a day)*	76.7%	73.0%	76.60%	
Binge Drinking (%)*	10.0%	4.0%	7.90%	
%of Children (0-4) Un/Improperly Restrained in a Crash	14.5%	10.2%	7.90%	
Teen Birth Rate (per 1,000)	37.3	43.2	60	
Sexually Transmitted Diseases (3 yr avg per 10,000)	446	190	141	
Violent Crime (per 100,000)	667.0	373.0	743	
Motor Vehicle Crash Deaths (per 100,000)	19	24	24	
Unmarried Mother Birth Rate (%)	44.1%	49.1%	44.20%	
Injury-related Mortality (3-yr avg rate per 100,000)	53.7	73.8	87.7	
Young Driver Crash Rate 15 - 24	116.9	108.3	132.4	
Elderly Drive Crash Rate (65+)	31.3	31.7	31.2	
Homicides (per 100,000)	8	4.0	3	
All accidental deaths per 100,000 population	52	72	64.1	
Average Fatality Rate in Alchohol-Related Crashes (per 100,000 population)	6.9	5.1	7.05	

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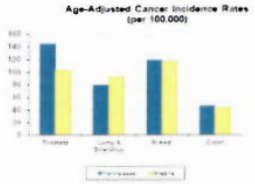
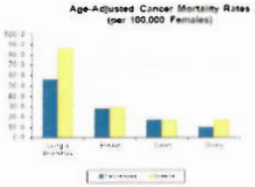
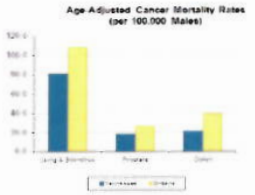
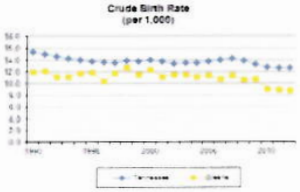
Cancer Incidence:

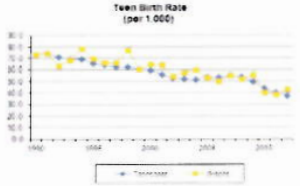






Birth Rate Trend:





Key Indicators of Health Status:

Socioecomonic Factors				
High School Graduation Rate (%)	86.0%	94.0%	93.40%	↑
Level of Education (%)	83.2%	79.2%	75.90%	↑
Unemployment (%)	8.6%	10.3%	10.90%	↓
Children (age 0 to 17) in poverty ratio (%)	26.5%	37.8%	29.50%	↓
Divorce Rate (per 100,000)	4.3	5.1	5.7	↓
Food Stamp Recipients (% of individuals)	21.1%	19.4%	19%	↓
Poverty Rate (% of all ages)	18.4%	24.4%	17.80%	↓
Temporary Assistance for Needy Families	2.6%	1.6%	1.70%	↓
High School Dropout Rate	6.9%	1.9%	1.90%	↓
Average Annual Wage	$ 36,576	$ 32,331	$ 31,490	↑
Physical Environment				↓
Air Quality Cancer Risk (per 1,000,000)	4.6	3.4	22.6	↓
Air Quality Hazard Index (per 1,000,000)	1.4	8.4	2.2	↓
Air Quality - Fine Particulate Matter in Air (3 yr avg Mg/m3)*	13.2	12.8	14.5	↓
Ozone Level (ppb)*	0.062	0.063	0.082	↓
Nitrate Levels in drinking water (mg/L)	0.70	1.30	2.80	↓
Pre-1950 Housing (%)	11.8%	16.0%	18.70%	↓
Lead Poisoned Children (%)	0.1%	n/a	0.20%	↓
Child Abuse and Neglect (rate per 1,000)	5.5	4.4	4.8	↓
Communicable Diseases				↓
Hepatitis A (per 100,000)	0.3	0.0	n/a	↓
Campylobacter infection (per 100,000)	7.2	4.5	n/a	↓
Salmonella, Non Typhoid (per 100,000)	17.6	21.1	n/a	↓
Shigellosis (per 100,000)	3.3	0.0	n/a	↓
AIDS/HIV (per 100,000)	29.3	7.7	n/a	↓
Primary and Secondary Syphilis (per 100,000)	4.3	4.5	n/a	↓
Penicillin-Sensitive *Streptococcus pneumoniae* (per 100,000)	0.0	0.0	n/a	↓
Group B *Streptococcus* (per 100,000)	6.2	10.6	n/a	↓
Chlamydia (per 100,000)	517.3	215.7	n/a	↓
Gonorrhea (per 100,000)	144.8	21.1	n/a	↓

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Inpatient Projections

	2014	2019		2024	
DRG Service Line	**Discharges**	**Discharges**	**% Change**	**Discharges**	**% Change**
Cardiac Surgery	91	94	3.10%	100	9.30%
Cardiology	760	654	-14.00%	553	-27.20%
Cardiology Intervention	259	239	-7.80%	223	-13.80%
Endocrinology	229	181	-20.80%	163	-28.70%
ENT Surgery	22	21	-2.40%	21	-2.50%
Gastroenterology	733	694	-5.30%	691	-5.70%
General Medicine	788	797	1.20%	750	-4.90%
General Surgery	550	546	-0.70%	538	-2.20%
Gynecology	52	49	-5.90%	47	-9.00%
Hematology	72	71	-1.40%	73	1.90%
Neonatology	249	231	-7.40%	216	-13.30%
Nephrology	387	362	-6.30%	324	-16.30%
Neurology	444	441	-0.60%	451	1.70%
Neurosurgery	154	148	-3.90%	147	-4.40%
Normal Newborns	389	402	3.20%	398	2.20%
OB Deliveries Sections	185	159	-13.80%	148	-20.20%
OB Deliveries Vaginal	429	453	5.60%	452	5.30%
OB Other	38	36	-4.40%	35	-7.00%
Oncology Medicine	131	125	-4.90%	112	-14.20%
Oncology Surgery	44	44	0.80%	44	-0.90%
Ophthalmic Medicine	3	3	-4.60%	3	-3.90%
Ophthalmic Surgery	2	2	-15.90%	2	-22.20%
Oral Surgery	11	10	-11.80%	9	-17.10%
Orthopedic Medicine	90	88	-2.30%	87	-2.90%
Orthopedic Surgery	565	596	5.40%	605	7.10%
Otolaryngology	45	39	-13.40%	36	-19.10%
Plastic Surgery	15	15	-1.40%	14	-6.90%
Psychiatry	468	519	10.80%	496	5.90%
Pulmonary	1,359	1,152	-15.20%	1,071	-21.20%
Rehabilitation	167	138	-17.10%	149	-11.00%
Rheumatology	38	37	-2.60%	37	-3.20%
Substance Abuse	40	42	4.60%	41	3.20%
Thoracic Surgery	34	33	-1.80%	32	-4.60%
Trauma Medical	34	33	-2.80%	34	0.20%
Urology Medicine	26	23	-12.70%	21	-19.30%
Urology Surgery	65	61	-6.00%	57	-12.40%
Vascular Surgery	137	136	-0.80%	137	0.20%
Womens Other	4	4	-6.50%	3	-17.80%
Grand Total	**9,109**	**8,678**	**-4.70%**	**8,321**	**-8.60%**

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Outpatient Projections

	2014	2019		2024	
Site of Care	**Volumes**	**Volumes**	**% Change**	**Volumes**	**% Change**
ED	38,850	39,090	0.60%	37,609	-3.20%
Home	103,040	120,440	16.90%	131,920	28.00%
Hosp OP/ASC	135,865	147,630	8.70%	149,508	10.00%
Office/Clinic	561,214	598,528	6.60%	577,772	3.00%
Other	28,381	30,833	8.60%	31,028	9.30%
SNF	1,660	1,795	8.20%	1,892	14.00%
Urgent/Retail	560	589	5.10%	575	2.60%
Virtual		13,032		52,023	
Grand Total	**869,570**	**951,936**	**9.50%**	**982,326**	**13.00%**

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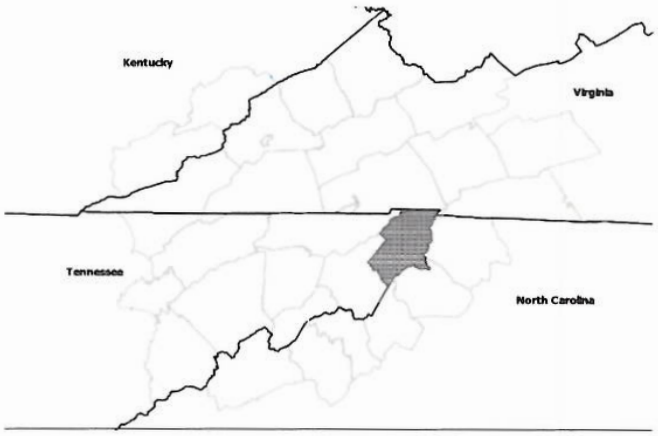
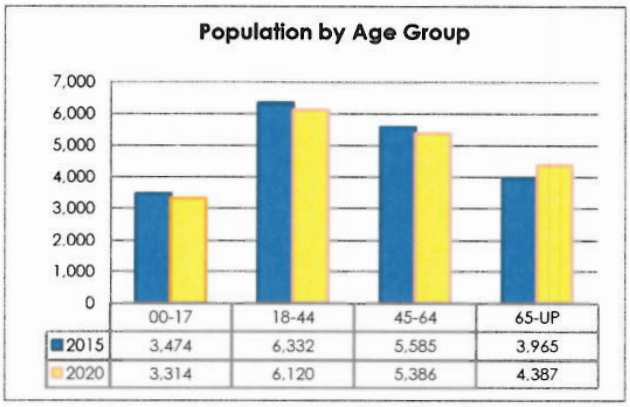
Demographic Highlights:

- Large elderly population compared to TN and US
- Large declining rate of females of child-bearing age expected
- Large disparity between genders (males account for 54% of total vs. females at 46% of total)
- Unemployment rate above national rate
- Low average household income level (21.6% of households make less than $15,000)
- Lower level of educational attainment compared to state and country (11.3% with no high school education compared to 5.9% nationally)
- Low level of diversity compared to state and national

Service Area Map:



Age Distribution and Population Projections:



Key Statistics:

	Johnson County	Tennessee	U.S.
2015 Total Population	19,356	6,735,022	321,369,000
% Change 2015-2020	-0.8%	5.5%	4.1%
% of Population 65+ (2015)	20.5%	15.6%	14.9%
% Minority (2015)	5.8%	26.1%	38.3%

	2015	2020	% Change
Total Male Population	10,358	10,273	-0.8%
Total Female Population	8,998	8,934	-0.7%
Females, Child Bearing Age (15-44)	2,836	2,745	-3.2%

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Local Health Highlights:

STRENGTHS:

- STD
- Crime Rate
- Low Birth Weight
- Cerebrovascular Deaths
- Binge Drinking
- High School Drop Out

WEAKNESSES:

- No Health Insurance
- Prevalence of Asthma
- Vaccinations
- Smoking during Pregnancy
- Deaths due to cardiovascular, cancer, and injuries
- No Biennial Mammogram
- Prenatal Care
- Teen Birth Rate
- Poverty
- Level of Education

Leading Causes of Death:

Ages 1 - 14 years

Cause of Death	Rate	Rank
All Causes	0	1

Ages 15 - 21 years

Cause of Death	Rate	Rank
Accidents	67.1	1
All Other Causes	0.5	*

Ages 22 - 64

Cause of Death	Rate	Rank
Cancer	144.3	1
Accidents	54.1	2
Heart Disease	45.1	3
Respiratory	27.1	4
Suicide	18	5
Homicide	18	5
All Other Causes	90.3	*

Ages 65+

Cause of Death	Rate	Rank
Cancer	1090.1	1
Heart Disease	946.6	2
Respiratory	315.6	3
Flu/Pneumonia	229.5	4
Alzheimer's Disease	172.1	5
Diabetes Mellitus	143.4	6
Cerebrovascular	114.7	7
Parkinson's	86.1	8
Pneumonitis	86.1	8
Accidents	86.1	8
Aortic Aneurysm/ Dissection	57.4	9
Suicide	28.7	10
All Other Causes	1319.5	*

Key Indicators of Health Status:

County: Johnson, TN

	TN	Johnson	2010	Desired
Health Outcomes				
Mortality (years of potential life lost/ 100,000)	8,790	9,480	11423.0	
Low Birth Weight (3-yr avg %)	9.0%	5.4%	10.9%	
General Health Status (% "fair/poor health)"	19.0%	27.0%	26.5%	
Very Low Birth Weight (%)	1.6%	0.7%	3.0%	
Infant Mortality (3-yr avg rate per 1,000)	8.1	3.8	15.4	
Mortality Rate (3-yr avg rate per 100,000)	953.0	1,043.4	979.1	
Cardiovascular Deaths (per 100,000)	226.5	245.3	217.1	
Cancer Deaths (3-yr avg rate per 100,000)	214.4	248.3	202.9	
Diabetes Mellitus Deaths (per 100,000)	28.7	26.7	32.6	
Cerebrovascular Deaths (per 100,000)	47.0	21.3	65.1	
Suicide Deaths (per 100,000)	15.0	16.0	5.4	
Mortality rate for ages 1- 14 yrs	66.8	0.0	13.6	
Mortality rate for ages 15 - 21 yrs	70.4	67.6	112.4	
Mortality rates for ages 65+	4,870.1	4,675.9	5116.4	
Lung Cancer Deaths (3-yr avg rate per 100,000)	68.8	87.5	79.2	
Female Breast Cancer Deaths (3-yr avg rate per 100,000)	14.1	14.3	18.1	
Prevalence of Asthma (%)	9.3%	13.2%	10.2%	
Prevalence of Diabetes (%)	11.0%	12.8%	12.0%	
Health Determinants				
Health Care Resources				
No Health Insurance (%)*	21.0%	17.0%	16.4%	
Medicaid/Tenncare Enrollees (%)	18.7%	21.4%	23.1%	
Medical Doctors Per Capita (per 100,000)	246.1	32.9	27.5	
Dentists Per Capita (per 100,000)	52.2	11.0	27.3	
Percent without Pneumococcal Vaccinations (%)*	74.2%	66.7%	72.3%	
Percent without Influenza Vaccinations (%)*	59.4%	50.7%	59.3%	
No Diabetic Eye Exams (%)	74.3%	72.2%	66.8%	
No Diabetic HbA1c Testing (%)	16.0%	17.0%	14.8%	
No Biennial Mammography (%)*	29.3%	29.3%	29.3%	
Inadequate or No Prenatal Care (%)	40.7%	56.0%	26.9%	
Month Prenatal Care Began	3.2	3.1	2.9	
First Trimester Prenatal Care (%)	59.3%	44.0%	71.5%	
Children (0-18 yrs) with Medicaid/Tenncare Coverage (%)	46.6%	57.9%	58.3%	
Hospital Staffed Beds (per 1,000)	3.6	0.1	0.1	
Licensed Nursing Beds (per 1,000 65+)	44.8	37.2	39.4	
# of Primary Care MDs	7,703	5	5.0	
# of Psychiatric Specialists	684	0	0.0	
Inpatient Discharge Rate (per 1,000) - Total	126.3	129.4	134.3	
Health Behaviors (continued)				
Cigarette Smoking (%)*	23.0%	24.0%	26.9%	
Smoking During Pregnancy (%)	16.3%	38.9%	31.9%	
Physical Inactivity (%)*	30.0%	32.0%	38.4%	
Overweight/Obesity (% BMI > 25)	67.8%	67.8%	67.9%	
Obesity (% BMI > 30)*	32.0%	32.0%	31.0%	
Low Fruit and Vegetable Consumption (% <5 a day)*	76.7%	73.0%	41.5%	
Binge Drinking (%)*	10.0%	3.0%	7.9%	
% of Children (0-4) Un/Improperly Restrained in a Crash	14.5%	7.1%	12.5%	
Teen Birth Rate (per 1,000)	37.3	49.5	37.5	
Sexually Transmitted Diseases (per 100,000)	446	104	83.0	
Violent Crime (per 100,000)	667.0	454.0	430.0	
Motor Vehicle Crash Deaths (per 100,000)	19	24	29.0	
Unmarried Mother Birth Rate (%)	44.1%	40.8%	44.8%	
Injury-related Mortality (3-yr avg rate per 100,000)	53.7	71.5	91.4	
Young Driver Crash Rate 15 - 24	116.9	92.1	76.2	
Elderly Drive Crash Rate (65+)	31.3	24.8	24.1	
Homicides (per 100,000)	8	10.7	5.5	
All accidental deaths per 100,000 population	52	53.3	65.1	
Average Fatality Rate in Alcohol-Related Crashes (per 100,000 population)	6.9	2.8	6.7	

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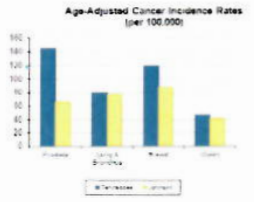
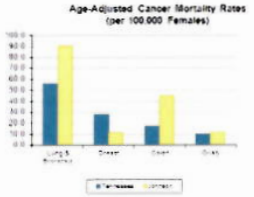
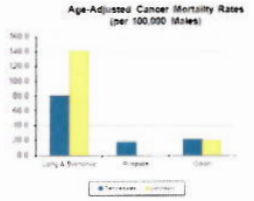
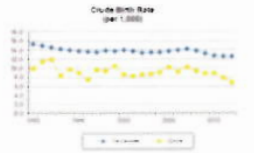
Cancer Incidence:

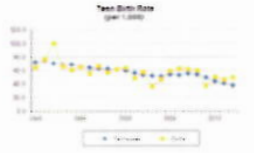






Birth Rate Trend:





Key Indicators of Health Status:

Socioecomonic Factors			
High School Graduation Rate (%)	86.0%	89.0%	90.3%
Level of Education (%)	83.2%	70.1%	63.3%
Unemployment (%)	8.8%	8.0%	9.7%
Children (age 0 to 17) in poverty ratio (%)	26.5%	37.0%	32.5%
Divorce Rate (per 100,000)	4.3	4.3	3.2
Food Stamp Recipients (% of individuals)	21.1%	25.5%	28.2%
Poverty Rate (% of all ages)	18.4%	26.1%	25.8%
Temporary Assistance for Needy Families	2.6%	2.1%	2.3%
High School Dropout Rate	6.9%	2.3%	6.8%
Average Annual Wage	$ 36,576	$ 24,806	$ 20,785
Physical Environment			
Air Quality Cancer Risk (per 1,000,000)	4.6	2.3	15.6
Air Quality Hazard Index (per 1,000,000)	1.4	4.9	1.0
Air Quality - Fine Particulate Matter in Air (3 yr avg Mg/m3)*	13.2	13.0	14.5
Ozone Level (ppb)*	0.062	0.063	0.1
Nitrate Levels in drinking water (mg/L Avg.)	0.70	0.51	0.78
Pre-1950 Housing (%)	11.8%	15.1%	19.0%
Lead Poisoned Children (%)	0.1%	n/a	0.5%
Child Abuse and Neglect (rate per 1,000)	5.5	11.6	6.0
Communicable Diseases			
Hepatitis A (per 100,000)	0.3	0.0	n/a
Campylobacter Infection (per 100,000)	7.2	0.0	n/a
Salmonella, Non Typhoid (per 100,000)	17.6	0.0	n/a
Shigellosis (per 100,000)	3.3	0.0	n/a
AIDS/HIV (per 100,000)	29.3	9.7	n/a
Primary and Secondary Syphilis (per 100,000)	4.3	0.0	n/a
Penicillin-Sensitive *Streptococcus pneumoniae* (per 100,000)	0.0	0.0	n/a
Group B *Streptococcus* (per 100,000)	6.2	5.5	n/a
Chlamydia (per 100,000)	517.3	88.9	n/a
Gonorrhea (per 100,000)	144.8	0.0	n/a

SBH-KINGSPORT 002139

Inpatient Projections

	2014	2019		2024	
DRG Service Line	Discharges	Discharges	% Change	Discharges	% Change
Cardiac Surgery	27	27	-1.20%	27	0.90%
Cardiology	242	209	-13.40%	186	-22.90%
Cardiology Intervention	99	91	-8.40%	85	-14.00%
Endocrinology	49	39	-21.30%	35	-29.50%
ENT Surgery	6	5	-11.30%	5	-15.00%
Gastroenterology	234	219	-6.50%	213	-8.80%
General Medicine	224	224	0.00%	208	-7.00%
General Surgery	166	154	-7.40%	149	-10.30%
Gynecology	13	12	-9.10%	11	-15.10%
Hematology	28	28	-1.70%	28	1.20%
Neonatology	61	55	-9.10%	51	-16.70%
Nephrology	96	90	-6.70%	79	-17.70%
Neurology	138	135	-1.90%	138	-0.40%
Neurosurgery	46	44	-4.30%	43	-5.80%
Normal Newborns	91	92	0.60%	88	-3.10%
OB Deliveries Sections	55	46	-15.50%	42	-23.20%
OB Deliveries Vaginal	98	101	2.90%	98	-0.10%
OB Other	8	8	-5.30%	7	-9.00%
Oncology Medicine	54	51	-5.70%	46	-15.40%
Oncology Surgery	15	15	-1.80%	14	-7.60%
Ophthalmic Medicine	4	3	-15.80%	3	-24.50%
Ophthalmic Surgery	1	1	-10.50%	1	-8.80%
Oral Surgery	5	4	-10.40%	4	-11.60%
Orthopedic Medicine	22	22	-0.90%	21	-3.00%
Orthopedic Surgery	162	168	3.80%	169	4.40%
Otolaryngology	11	9	-18.70%	8	-26.70%
Plastic Surgery	7	7	2.00%	7	2.90%
Psychiatry	159	173	8.80%	162	2.10%
Pulmonary	319	273	-14.50%	257	-19.40%
Rehabilitation	29	24	-18.40%	25	-13.60%
Rheumatology	6	5	-8.60%	5	-12.90%
Substance Abuse	15	15	0.10%	14	-5.10%
Thoracic Surgery	21	20	-4.70%	20	-6.40%
Trauma Medical	7	7	-6.40%	6	-7.20%
Urology Medicine	6	5	-14.70%	5	-21.80%
Urology Surgery	16	15	-9.10%	13	-18.20%
Vascular Surgery	48	47	-2.00%	47	-3.10%
Womens Other	4	4	-10.60%	3	-21.70%
Grand Total	**2,592**	**2,445**	**-5.70%**	**2,326**	**-10.30%**

Outpatient Projections

	2014	2019		2024	
Site of Care	**Volumes**	**Volumes**	**% Change**	**Volumes**	**% Change**
ED	8,849	8,688	-1.80%	8,148	-7.90%
Home	20,858	24,071	15.40%	26,235	25.80%
Hosp OP/ASC	19,681	20,789	5.60%	20,846	5.90%
Office/Clinic	135,034	141,401	4.70%	133,637	-1.00%
Other	23,929	25,945	8.40%	25,892	8.20%
SNF	490	531	8.40%	554	13.20%
Urgent/Retail	121	125	3.50%	120	-0.20%
Virtual		3,116		12,540	
Grand Total	**208,961**	**224,666**	**7.50%**	**227,974**	**9.10%**

Interview Highlights:

INTERVIEWEES:

- Eleven individuals

KEY FINDINGS:

- Average rating of health status is 5.14, with a range of 3 to 7
- Top health issues are:
  - Diabetes
  - Cancer
  - Obesity
  - Cardiovascular Disease
  - Behavioral/Mental Health
  - Asthma
  - Smoking/Tobacco Use
  - Inactivity
  - Poor Nutrition
  - Substance Misuse/Abuse
  - Education
  - Fatalism (feeling of no control of outcomes)
  - Geographic Isolation / Transportation Barrier
  - Built Environment
  - Poverty
  - Familial Dynamics (disrupted families, multi-generational living)
  - Lack of Activities/Resources
- Ideas to improve these conditions include:
  - Better marketing of available health-related programs and resources
  - Comprehensive smoking cessation services
  - Enhance access to physical activity through built environment and physical fitness activities
  - Behavioral health services
  - Inpatient and outpatient substance abuse treatment
  - Recruiting specialists to area
  - Enhance telehealth services
  - Community engagement
  - Use churches to disseminate information
  - After school health programs for children

SBH-KINGSPORT 002142

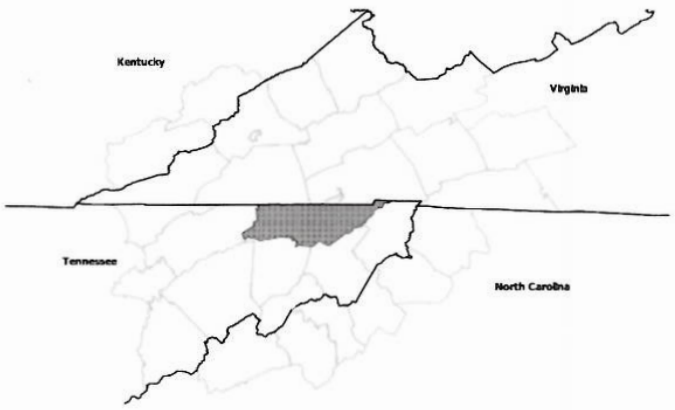
Sources:	Local Resources:
• Medstat • County Health Rankings • TN Advisory Commission on Intergovernmental Relations • TN Dept of Health • BRFSS • TennCare • Kidscount • TN Dept of Safety and Homeland Security • EPA • CDC Wonder • TN Dept of Environment & Conservation • Childhood Lead Poisoning Prevention Program	• After School Programs • Anti-Drug/Action Coalition • Cancer Support Group • Coordinated School Health • Extended Hours Clinic • Frontier Health • Intensive Outpatient Program • Johnson County Health Council • Medical Mission • Pregnancy Support Center • Telemedicine • Tennessee Department of Health – Primary Prevention Initiative • Johnson County Health Department • UT-TSU Extension Service

SBH-KINGSPORT 002143

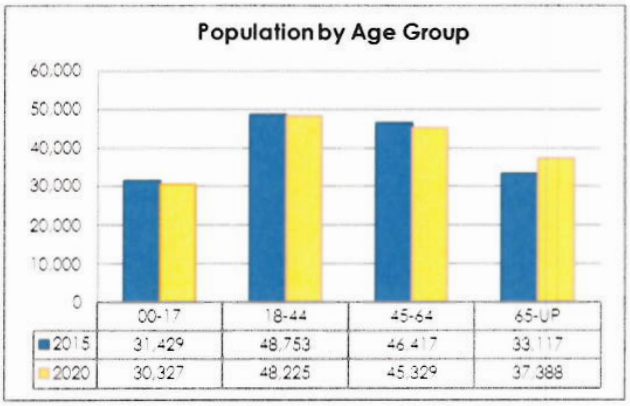
Demographic Highlights:

- Large elderly population compared to TN and US
- Declining rate of females of child-bearing age expected
- Low average household income level (15.6% of households make less than $15,000)
- Low level of educational attainment compared to state and country (6.6% with no high school education compared to 5.9% nationally)
- Low level of diversity compared to state and national

Service Area Map:



Age Distribution and Population Projections:



Key Statistics:

	Sullivan County	Tennessee	U.S.
2015 Total Population	159,716	6,735,022	321,369,000
% Change 2015-2020	1.0%	5.5%	4.1%
% of Population 65+ (2015)	20.7%	15.6%	14.9%
% Minority (2015)	6.6%	26.1%	38.3%

	2015	2020	% Change
Total Male Population	77,249	78,076	1.1%
Total Female Population	82,467	83,193	0.9%
Females, Child Bearing Age (15-44)	27,268	26,913	-1.3%

SBH-KINGSPORT 002144

Local Health Highlights:

STRENGTHS:

- Unemployment Rate
- Medical Doctors
- Decreased percentage of individuals with no health insurance
- Percentage of Children Un/Improperly Restrained in a Crash
- STDs

WEAKNESSES:

- Prevalence of asthma and diabetes
- Vaccinations
- Smoking during pregnancy
- Pre-1950 Housing
- Deaths due to cardiovascular, diabetes, cerebrovascular, cancer, suicide, and injuries

Leading Causes of Death:

Ages 1 - 14 years

Cause of Death	Rate	Rank
Heart Disease	4.12	1
Cancer	4.12	2
Anemia	4.12	3
All Other Causes	4.12	*

Ages 15 - 21 years

Cause of Death	Rate	Rank
Accidents	53.6	1
Suicide	23	2
All Other Causes	53.5	*

Ages 22 - 64

Cause of Death	Rate	Rank
Cancer	144.7	1
Heart Disease	141.2	2
Accidents	45.2	3
Suicide	22	4
Respiratory	22	5
Cerebrovascular	15.1	6
Liver/Cirrhosis	13.9	7
Diabetes Mellitus	12.7	8
Septicemia	8.1	9
Viral Hepatitis	7	10
All Other Causes	119.1	*

Ages 65+

Cause of Death	Rate	Rank
Heart disease	1238.4	1
Cancer	1127.7	2
Respiratory	449.7	3
Alzheimer's Disease	280.2	4
Cerebrovascular	256	5
Flu/Pneumonia	176.4	6
Diabetes Mellitus	148.7	7
Hypertension	131.5	8
Septicemia	100.3	9
Accidents	76.1	10
All Other Causes	1307.5	*

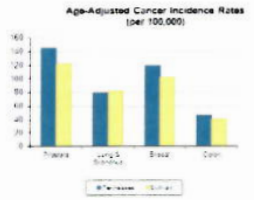
Key Indicators of Health Status:

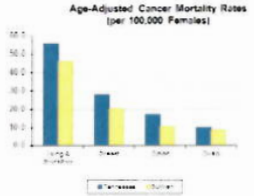
County: Sullivan, TN

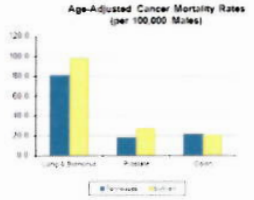
	TN	Sullivan	2010	Desired
Health Outcomes				
Mortality (years of potential life lost/100,000)	8,790	9,006	9,860	
Low Birth Weight (3-yr avg %)	9.0%	8.1%	8.7%	
General Health Status (% fair/poor health)*	19.0%	21.0%	19.0%	
Very Low Birth Weight (%)	1.6%	1.0%	1.4%	
Infant Mortality (3-yr avg rate per 1000)	8.1	9.2	9.1	
Mortality Rate (3-yr avg rate per 100,000)	953.0	1,281.3	945.5	
Cardiovascular Deaths (per 100,000)	226.5	402.6	280.9	
Cancer Deaths (3-yr avg rate per 100,000)	214.4	291.7	206.3	
Diabetes Mellitus Deaths (per 100,000)	28.7	35.0	31.2	
Cerebrovascular Deaths (per 100,000)	47.0	56.4	54.6	
Suicide Deaths (per 100,000)	15.0	19.5	15.6	
Mortality rate for ages 1 - 14 yrs	66.8	16.5	24.5	
Mortality rate for ages 15 - 21 yrs	70.4	130.1	98.8	
Mortality rates for ages 65+	4,870.1	5,292.5	5,202.00	
Lung Cancer Deaths (3-yr avg rate per 100,000)	68.8	93.6	71.9	
Female Breast Cancer Deaths (3-yr avg rate per 100,000)	14.1	17.1	19.6	
Prevalence of Asthma (%)	9.3%	13.2%	12.4%	
Prevalence of Diabetes (%)	11.0%	14.0%	13.0%	
Health Determinants				
Health Care Resources				
No Health Insurance (%)*	21.0%	15.0%	17.9%	
Medicaid/Tenncare Enrollees (%)	18.7%	17.4%	18.1%	
Medical Doctors Per Capita (per 100,000)	246.1	289.5	312.3	*
Dentists Per Capita (per 100,000)	52.2	61.2	93.8	*
Percent without Pneumococcal Vaccinations (%)*	74.2%	66.7%	67.3%	
Percent without Influenza Vaccinations (%)*	59.4%	50.7%	53.4%	
No Diabetic Eye Exams (%)	74.3%	72.2%	53.6%	
No Diabetic HbA1c Testing (%)	15.0%	10.0%	10.0%	
No Biennial Mammography (%)*	23.3%	29.3%	23.3%	
Inadequate or No Prenatal Care (%)	10.7%	38.1%	8.1%	
Month Prenatal Care Began	3.2	3.2	2.9	
First Trimester Prenatal Care (%)	59.3%	61.9%	67.6%	*
Children (0-18yrs) with Medicaid/Tenncare Coverage (%)	46.8%	46.0%	44.9%	
Hospital Staffed Beds (per 1,000)	3.6	6.7	4.7	*
Licensed Nursing Beds (per 1,000 65+)	44.8	34.7	37.7	*
# of Primary Care MDs	7,703	102	100	
# of Psychiatric Specialists	684	9	9	
Inpatient Discharge Rate (per 1,000) - Total	126.3	132.8	131.2	
Health Behaviors (continued)				
Cigarette Smoking (%)*	23.0%	25.0%	30.4%	
Smoking During Pregnancy (%)	16.3%	27.9%	29.8%	
Physical Inactivity (%)*	30.0%	31.0%	34.4%	
Overweight/Obesity (% BMI >25)	67.8%	67.8%	67.9%	
Obesity (% BMI >30)*	32.0%	35.0%	30.0%	
Low Fruit and Vegetable Consumption (% <5 a day)*	73.7%	73.0%	76.6%	
Binge Drinking (%)*	10.0%	9.0%	8.5%	
% of Children (0-4) Un/Improperly Restrained in a Crash	14.5%	5.3%	13.5%	
Teen Birth Rate (per 1,000)	37.3	42	60	
Sexually Transmitted Diseases	446	168	194	
Violent Crime (per 100,000)	667.0	512.0	538	
Motor Vehicle Crash Deaths (per 100,000)	19	16	22	
Unmarried Mother Birth Rate (%)	44.1%	42.7%	39.8%	
Injury related Mortality (3-yr avg rate per 100,000)	53.7	88.2	81.9	
Young Driver Crash Rate 15 - 24	76.9	86.6	90.83	
Elderly Drive Crash Rate (60+)	31.3	28.5	25.14	
Homicides (per 100,000)	8	3.2	13	
All accidental deaths per 100,000 population	52	45.4	46.2	
Average Fatality Rate in Alcohol-Related Crashes (per 100,000 population)	6.9	3.5	5.11	

SBH-KINGSPORT 002145

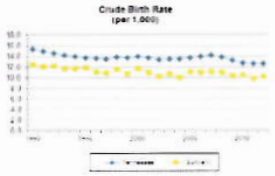
Cancer Incidence:







Birth Rate Trend:



Key Indicators of Health Status:

Socioeconomic Factors				
High School Graduation Rate (%)	86.0%	90.0%	81.7%	↑
Level of Education (%)	83.2%	82.7%	80.4%	↑
Unemployment (%)	8.8%	8.4%	5.8%	↓
Children (age 0 to 17) in poverty ratio (%)	26.5%	26.9%	22.4%	↓
Divorce Rate (per 1,000)	4.3	5.1	4.8	↓
Food Stamp Recipients (% of individuals)	21.1%	18.8%	16.2%	↓
Poverty Rate (% of all ages)	18.4%	18.2%	14.1%	↓
Temporary Assistance for Needy Families	2.6%	1.7%	1.9%	↓
High School Dropout Rate	6.9%	3.6%	7.1%	↓
Average Annual Wage	$ 36,576	$ 35,000	$ 32,141	↑
Physical Environment				↓
Air Quality Cancer Risk (per 1,000,000)	4.6	4.7	40.4	↓
Air Quality Hazard Index (per 1000,000)	1.4	4.7	3.7	↓
Air Quality - Fine Particulate Matter in Air (3 yr avg M g/m 3)*	13.2	13.0	14.5	↓
Ozone Level (ppb)*	0.062	0.063	0.062	↓
Nitrate Levels in drinking water (mg/L Average)	0.7	0.4	0.6	↓
Pre-1950 Housing (%)	11.8%	15.8%	19.4%	↓
Lead Poisoned Children (%)	0.1%	n/a	0.7%	↓
Child Abuse and Neglect (rate per 1,000)	5.5	7.8	11.6	↓
Communicable Diseases				↓
Hepatitis A (per 100,000)	0.3	0.0	n/a	↓
Campylobacter Infection (per 100,000)	7.2	12.7	n/a	↓
Salmonella, Non Typhoid (per 100,000)	17.6	5.7	n/a	↓
Shigellosis (per 100,000)	3.3	0.0	n/a	↓
AIDS/HIV (per 100,000)	29.3	9.1	n/a	↓
Primary and Secondary Syphilis (per 100,000)	4.3	0.6	n/a	↓
Penicillin-Sensitive *Streptococcus pneumoniae* (per 100,000)	0.0	0.0	n/a	↓
Group B *Streptococcus* (per 100,000)	6.2	6.4	n/a	↓
Chlamydia (per 100,000)	517.3	259.8	n/a	↓
Gonorrhea (per 100,000)	144.8	36.8	n/a	↓

SBH-KINGSPORT 002146

Inpatient Projections

	2014	2019		2024	
DRG Service Line	**Discharges**	**Discharges**	**% Change**	**Discharges**	**% Change**
Cardiac Surgery	237	240	1.30%	250	5.50%
Cardiology	1,851	1,601	-13.50%	1,382	-25.40%
Cardiology Intervention	594	552	-7.10%	519	-12.70%
Endocrinology	508	402	-21.00%	362	-28.80%
ENT Surgery	34	33	-1.80%	33	-2.10%
Gastroenterology	1,693	1,606	-5.10%	1,592	-5.90%
General Medicine	1,716	1,738	1.30%	1,645	-4.10%
General Surgery	1,204	1,161	-3.60%	1,141	-5.20%
Gynecology	156	145	-7.00%	139	-10.60%
Hematology	220	217	-1.50%	223	1.20%
Neonatology	676	629	-7.00%	592	-12.50%
Nephrology	920	855	-7.00%	762	-17.20%
Neurology	986	979	-0.70%	1,010	2.50%
Neurosurgery	428	416	-2.90%	414	-3.20%
Normal Newborns	969	1,005	3.70%	1,000	3.20%
OB Deliveries Sections	567	490	-13.50%	456	-19.60%
OB Deliveries Vaginal	991	1,053	6.30%	1,055	6.50%
OB Other	130	125	-4.00%	122	-6.10%
Oncology Medicine	251	241	-4.00%	218	-13.20%
Oncology Surgery	109	111	1.50%	108	-1.00%
Ophthalmic Medicine	12	11	-12.20%	10	-18.30%
Ophthalmic Surgery	1	1	-9.40%	1	-6.70%
Oral Surgery	18	17	-7.60%	17	-6.90%
Orthopedic Medicine	227	227	0.00%	231	1.80%
Orthopedic Surgery	1,487	1,576	6.00%	1,610	8.20%
Otolaryngology	88	77	-12.90%	74	-15.80%
Plastic Surgery	37	34	-8.20%	31	-16.10%
Psychiatry	1,440	1,580	9.70%	1,502	4.30%
Pulmonary	2,500	2,159	-13.60%	2,046	-18.20%
Rehabilitation	433	338	-22.00%	351	-18.90%
Rheumatology	73	71	-3.30%	70	-3.50%
Substance Abuse	172	178	3.30%	173	0.50%
Thoracic Surgery	153	145	-5.50%	141	-7.50%
Trauma Medical	71	68	-4.30%	69	-2.70%
Unspecified	4	4	2.30%	4	4.50%
Urology Medicine	66	58	-12.70%	53	-19.70%
Urology Surgery	148	140	-5.10%	130	-12.00%
Vascular Surgery	246	245	-0.60%	246	0.00%
Womens Other	13	12	-4.90%	11	-12.20%
Grand Total	**21,429**	**20,537**	**-4.20%**	**19,794**	**-7.60%**

SBH-KINGSPORT 002147

Outpatient Projections

	2014	2019		2024	
Site of Care	**Volumes**	**Volumes**	**% Change**	**Volumes**	**% Change**
ED	93,692	94,233	0.60%	90,513	-3.40%
Home	211,861	245,806	16.00%	267,901	26.50%
Hosp OP/ASC	255,993	275,109	7.50%	281,172	9.80%
Office/Clinic	1,497,314	1,605,147	7.20%	1,556,518	4.00%
Other	72,130	78,500	8.80%	78,786	9.20%
SNF	4,604	4,958	7.70%	5,181	12.50%
Urgent/Retail	4,389	4,798	9.30%	4,586	4.50%
Virtual		31,971		128,757	
Grand Total	**2,139,982**	**2,340,523**	**9.40%**	**2,413,414**	**12.80%**

Interview Highlights:

INTERVIEWEES:

- 10 individuals

KEY FINDINGS:

- Average rating of health status is 3.6 with a range in responses of 1.5 to 8.
- Top health issues are:
  - Obesity
  - Cancer
  - Diabetes
  - Cardiovascular Disease
  - Substance Abuse/NAS
- Additional health issues include:
  - Smoking and Tobacco Use
  - Oral Health
  - Physical Inactivity
  - Behavioral Health
  - Education
  - Food Insecurity
  - Lack of Free Medical Center
- Ideas to improve these conditions include:
  - Mobile dental clinic linked to dental providers
  - Collaboration across various health systems/programs to provide united approach/solutions
  - Engage business leaders
  - Consolidate efforts among stakeholders to maximize scarce resources
  - More city and corporate support
  - Community forum/Health Summit similar to 1999 Economic Summit
  - Education through public media campaign
  - Target kids
  - Invest more resources and leadership time and commitment to Healthy Kingsport
  - Collaborative Impact Model

Sources:

- Medstat
- County Health Rankings
- TN Advisory Commission on Intergovernmental Relations
- TN Dept of Health
- BRFSS
- TennCare
- Kidscount
- TN Dept of Safety and Homeland Security
- EPA
- CDC Wonder
- TN Dept of Environment & Conservation
- Childhood Lead Poisoning Prevention Program

Local Resources:

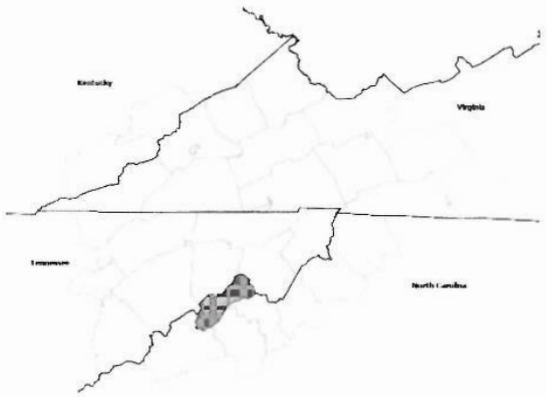
- Coordinated School Health
- East Tennessee State University, School of Public Health
- Friends in Need
- Health Resources Center
- Healthy Kingsport
- Parish Nurse Program
- PEAK (young professional organization)
- Providence Medical Clinic
- School System
- Sullivan County Health Council
- Sullivan County Health Department
- United Way of Greater Kingsport, Health Safety & Stability Vision Council
- YMCA

SBH-KINGSPORT 002149

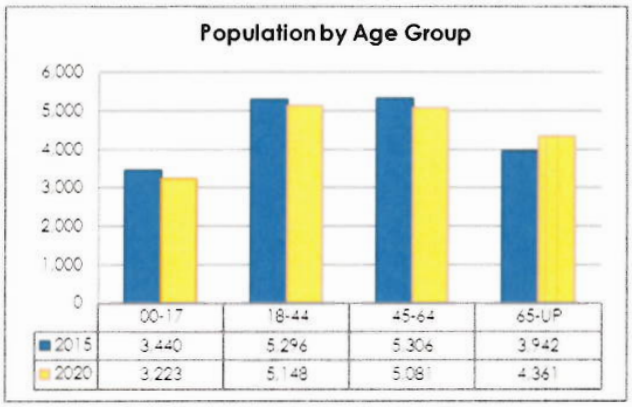
Demographic Highlights:

- Large elderly population compared to TN and US
- Declining rate of females of child-bearing age expected
- Low average household income level (19.1% of households make less than $15,000)
- Lower level of educational attainment compared to state and country (10.6% with no high school education compared to 5.9% nationally)
- Low level of diversity compared to state and national

Service Area Map:



Age Distribution and Population Projections:



	00-17	18-44	45-64	65-UP
2015	3,440	5,296	5,306	3,942
2020	3,223	5,148	5,081	4,361

SBH-KINGSPORT 002150

Key Statistics:

	Unicoi County	Tennessee	U.S.
2015 Total Population	17,984	6,735,022	321,369,000
% Change 2015-2020	-1.0%	5.5%	4.1%
% of Population 65+ (2015)	21.9%	15.6%	14.9%
% Minority (2015)	6.8%	26.1%	38.3%

	2015	2020	% Change
Total Male Population	8,824	8,741	-0.9%
Total Female Population	9,160	9,072	-1.0%
Females, Child Bearing Age (15-44)	2,962	2,855	-3.6%

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Local Health Highlights:

STRENGTHS:

- STD
- High school graduation rate
- Health Insurance
- Percent of Children Un/Improperly Restrained in a Crash

WEAKNESSES:

- Low birth weight
- Pre-1950 Housing
- Teen birth rate
- Smoking During Pregnancy
- Deaths due to cardiovascular, cancer, diabetes, cerebrovascular, injuries and suicide

Leading Causes of Death:

Ages 1 - 14 years

Cause of Death	Rate	Rank
All Causes	0	1

Ages 15 - 21 years

Cause of Death	Rate	Rank
All Causes	0	1

Ages 22 - 64

Cause of Death	Rate	Rank
Cancer	160.1	1
Heart Disease	110.1	2
Accidents	50.1	3
Diabetes Mellitus	30	4
Suicide	30	4
Liver/Cirrhosis	20	5
Flu/pneumonia	10	6
Respiratory	10	6
Malformations/ Deformations	10	6
All Other Causes	70.2	*

Ages 65+

Cause of Death	Rate	Rank
Heart diseases	1299.4	1
Cancer	1045.2	2
Cerebrovascular	452	3
Respiratory	395.5	4
Alzheimer's	254.2	5
Diabetes Mellitus	169.5	6
Flu/Pneumonia	113	7
Parkinson's	56.5	8
Aortic Aneurysm and Dissection	56.5	9
Hypertension	56.5	10
All Other Causes	1242.9	*

Key Indicators of Health Status:

County: Unicoi, TN

	TN	Uni Co	2010	Desired
Health Outcomes				
Mortality (years of potential life lost/100,000)	8,790	9,655	10,961	↓
Low Birth Weight (3-yr avg %)	9.0%	12.3%	7.7%	↓
General Health Status (% fair/poor health)*	19.0%	22.0%	22.0%	↑
Very Low Birth Weight (%)	1.6%	1.3%	3.0%	↓
Infant Mortality (3-yr avg rate per 1,000)	8.1	7.6	7	↓
Mortality Rate (3-yr avg rate per 100,000)	953.0	1373.3	1046.80	↓
Cardiovascular Deaths (3-yr avg rate per 100,000)	226.5	446.0	368.2	↓
Cancer Deaths (3-yr avg rate per 100,000)	214.4	300.4	218.9	↓
Diabetes Mellitus Deaths (3-yr avg rate per 100,000)	28.7	35.6	36.8	↓
Cerebrovascular Deaths (3-yr avg rate per 100,000)	47.0	67.2	43.7	↓
Suicide Deaths (per 100,000)	15.0	22.4	11.3	↓
Mortality rate for ages 1- 14 yrs	66.8	0.0	24.9	↓
Mortality rate for ages 15 - 21yrs	70.4	0.0	151.6	↓
Mortality rates for ages 65+	4,870.1	5,141.2	5,897.40	↓
Lung Cancer Deaths (3-yr avg rate per 100,000)	68.8	119.4	63.7	↓
Female Breast Cancer Deaths (3-yr avg rate per 100,000)	14.1	13.1	27.9	↓
Prevalence of Asthma (%)	9.3%	13.2%	12.4%	↓
Prevalence of Diabetes (%)	11.0%	12.0%	14.0%	↓
Health Determinants				
Health Care Resources				
No Health Insurance (%)*	21.0%	15.0%	14.0%	↓
Medicaid/Tenncare Enrollees (%)	18.7%	19.1%	20.2%	↓
Medical Doctors Per Capita (per 100,000)	246.1	49.1	537.9	↑
Dentists Per Capita (per 100,000)	52.2	27.3	60.7	↑
Percent without Pneumococcal Vaccinations (%)*	74.2%	66.7%	67.7%	↑
Percent without Influenza Vaccinations (%)*	59.4%	50.7%	55.3%	↑
No Diabetic Eye Exams (%)	74.3%	72.2%	64.0%	↓
No Diabetic HbA1c Testing (%)	15.0%	17.0%	12.5%	↑
No Biennial Mammography (%)*	23.3%	29.3%	25.1%	↑
Inadequate or No Prenatal Care (%)	40.7%	32.5%	6.4%	↓
Month Prenatal Care Began	3.2	3.0	2.9	↓
First Trimester Prenatal Care (%)	59.3%	67.5%	85-94%	↓
Children (0-18 yrs) with Medicaid/Tenncare Coverage (%)	46.8%	50.7%	46.1%	↑
Hospital Staffed Beds (per 1,000)	3.6	2.6	1.5	↓
Licensed Nursing Beds (per 1,000 65+)	44.8	83.0	87.5	↓
# of Primary Care MDs	7,703	5	5	↑
# of Psychiatric Specialists	684	1	0	↓
Inpatient Discharge Rate (per 1,000) - Total	126.3	158.9	174.5	↓
Health Behaviors (continued)				
Cigarette Smoking (%)*	23.0%	21.0%	25.4%	↓
Smoking During Pregnancy (%)	15.3%	29.4%	37.3%	↓
Physical Inactivity (%)*	30.0%	32.0%	31.2%	↓
Overweight/Obesity (% BMI > 25)	67.8%	67.8%	63.8%	↓
Obesity (% BMI > 30)*	32.0%	33.0%	30.0%	↓
Low Fruit and Vegetable Consumption (% <5 a day)*	76.7%	73.0%	37.1%	↓
Binge Drinking (%)*	10.0%	6.0%	7.5%	↓
% of Children (0-4) Un/Improperly Restrained in a Crash	14.5%	5.3%	19.0%	↓
Teen Birth Rate (per 1,000)	37.3	45.4	59	↓
Sexually Transmitted Diseases (100,000)	446	98	73	↓
Violent Crime (per 100,000)	667.0	139.0	207	↓
Motor Vehicle Crash Deaths (per 100,000)	19	21	32	↓
Unmarried Mother Birth Rate (%)	44.1%	38.0%	33.8%	↓
Injury-related Mortality (3-yr avg rate per 100,000)	53.7	87.7	124.8	↓
Young Driver Crash Rate 15 - 24	116.9	62.3	79.3	↓
Elderly Drive Crash Rate (65+)	31.3	19.4	14.2	↓
Homicides (per 100,000)	8	0.0	11.3	↓
All accidental deaths per 100,000 population	52	33.6	39.5	↓
Average Fatality Rate in Alchohol-Related Crashes (per 100,000 population)	6.9	4.6	5.3	↓

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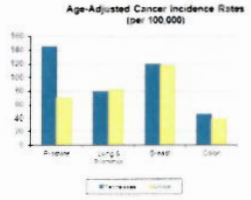
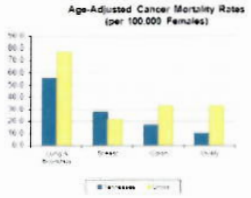
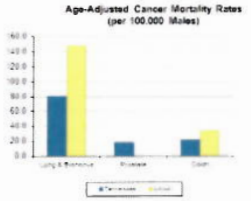
Cancer Incidence:







Birth Rate Trend:

Key Indicators of Health Status:

Socioecomonic Factors				
High School Graduation Rate (%)	86.0%	94.0%	77.0%	↓
Level of Education (%)	83.2%	75.3%	63.3%	↓
Unemployment (%)	8.8%	8.1%	7.9%	↓
Children (age 0 to 17) in poverty ratio (%)	26.5%	29.0%	30.3%	↓
Divorce Rate (per 100,000)	4.3	3.4	4	↓
Food Stamp Recipients (% of individuals)	21.1%	22.1%	10.6%	↓
Poverty Rate (% of all ages)	18.4%	20.4%	14.9%	↓
Temporary Assistance for Needy Families	2.6%	1.4%	2.1%	↓
High School Dropout Rate	6.9%	19%	6.0%	↓
Average Annual Wage	$ 36,576	$ 30,910	$30,235	↓
Physical Environment				
Air Quality Cancer Risk (per 1,000,000)	4.6	2.8	216	↓
Air Quality Hazard Index (per 1,000,000)	1.4	7	2.2	↓
Air Quality - Fine Particulate Matter in Air (3 yr avg M g/m3)*	13.2	13.1	14.7	↓
Ozone Level (ppb)*	0.062	0.063	0.082	↓
Nitrate Levels in drinking water (mg/L Avg.)	0.70	1.34	1.08	↓
Pre-1950 Housing (%)	11.8%	21.6%	9.4%	↓
Lead Poisoned Children (%)	0.1%	n/a	0.0%	↓
Child Abuse and Neglect (rate per 1000)	5.5	6.0	5	↓
Communicable Diseases				
Hepatitis A (per 100,000)	0.3	0.0	n/a	↓
Campylobacter Infection (per 100,000)	7.2	11.3	n/a	↓
Salmonella, Non Typhoid (per 100,000)	17.7	5.6	n/a	↓
Shigellosis (per 100,000)	3.3	0.0	n/a	↓
AIDS/HIV (per 100,000)	293	58	n/a	↓
Primary and Secondary Syphilis (per 100,000)	4.3	0.0	n/a	↓
Penicillin-Sensitive *Streptococcus pneumoniae* (per 100,000)	0.0	0.0	n/a	↓
Group B *Streptococcus* (per 100,000)	6.2	0.0	n/a	↓
Chlamydia (per 100,000)	517.3	146.6	n/a	↓
Gonorrhea (per 100,000)	144.8	22.5	n/a	↓

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Inpatient Projections

	2014	2019		2024	
DRG Service Line	**Discharges**	**Discharges**	**% Change**	**Discharges**	**% Change**
Cardiac Surgery	27	27	1.80%	29	5.90%
Cardiology	284	247	-13.00%	220	-22.60%
Cardiology Intervention	126	116	-7.70%	110	-12.80%
Endocrinology	72	56	-21.60%	52	-28.10%
ENT Surgery	6	6	-1.90%	6	-2.70%
Gastroenterology	294	277	-5.70%	274	-6.70%
General Medicine	219	221	1.00%	206	-5.80%
General Surgery	184	175	-4.70%	169	-7.90%
Gynecology	24	22	-8.60%	21	-13.50%
Hematology	53	52	-2.30%	53	-0.10%
Neonatology	64	60	-7.00%	56	-12.40%
Nephrology	172	160	-6.90%	140	-18.80%
Neurology	141	141	-0.30%	142	1.00%
Neurosurgery	41	38	-7.90%	37	-10.40%
Normal Newborns	91	94	3.50%	94	2.80%
OB Deliveries Sections	52	45	-13.50%	42	-19.50%
OB Deliveries Vaginal	105	111	5.70%	111	5.40%
OB Other	15	14	-4.00%	14	-6.10%
Oncology Medicine	69	66	-4.20%	60	-13.30%
Oncology Surgery	20	20	-2.20%	19	-5.10%
Ophthalmic Medicine	2	2	-15.70%	1	-26.30%
Oral Surgery	8	7	-12.30%	7	-16.60%
Orthopedic Medicine	58	56	-3.10%	56	-3.80%
Orthopedic Surgery	150	153	1.90%	152	1.20%
Otolaryngology	13	12	-6.50%	12	-4.50%
Plastic Surgery	4	4	-3.80%	4	-12.10%
Psychiatry	148	163	10.20%	156	5.50%
Pulmonary	406	339	-16.50%	309	-23.90%
Rehabilitation	35	28	-19.70%	29	-16.90%
Rheumatology	9	8	-9.60%	8	-13.90%
Substance Abuse	9	9	3.90%	9	1.40%
Thoracic Surgery	14	14	-2.10%	13	-3.80%
Trauma Medical	12	11	-8.00%	11	-7.40%
Unspecified	1	1	8.70%	1	17.40%
Urology Medicine	12	10	-13.80%	9	-21.30%
Urology Surgery	27	26	-5.50%	25	-9.10%
Vascular Surgery	43	41	-3.50%	40	-6.00%
Womens Other	1	1	-15.10%	1	-33.10%
Grand Total	**3,011**	**2,834**	**-5.90%**	**2,697**	**-10.40%**

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Outpatient Projections

Site of Care	2014 Volumes	2019 Volumes	% Change	2024 Volumes	% Change
ED	9,919	9,938	0.20%	9,518	-4.00%
Home	18,118	20,713	14.30%	22,390	23.60%
Hosp OP/ASC	29,338	31,605	7.70%	32,399	10.40%
Office/Clinic	148,825	157,392	5.80%	151,068	1.50%
Other	8,047	8,593	6.80%	8,372	4.00%
SNF	562	596	5.90%	624	11.00%
Urgent/Retail	304	329	8.20%	324	6.60%
Virtual		3,315		12,682	
Grand Total	**215,112**	**232,480**	**8.10%**	**237,377**	**10.40%**

Interview Highlights:

INTERVIEWEES:

- Eight individuals

KEY FINDINGS:

- Average rating of health status is 4.9, with a range in responses of 3 to 6
- Top health issues are:
  - Obesity
  - Diabetes
  - Cancer
  - Substance/Prescription Drug Abuse
- Additional identified health priorities:
  - Addiction
  - Neonatal Abstinence Syndrome
  - Mental Health
  - COPD/ Respiratory Needs
  - Cardiovascular disease
  - Physical inactivity
  - Utilization of wellness screenings
  - Parenting education
  - Smoking/Tobacco and vapor cigarette use
  - Second-Hand Smoke
  - Medical non-compliance
  - Access to urgent care clinics
  - Access to primary care clinics
  - Access to physical activity
  - Access to long-term care
  - Unemployment
  - Access to health education
  - Fast food prevalence
  - Transportation barriers
  - Cultural barriers
- Ideas to improve these conditions include:
  - Better marketing of available health-related programs and resources
  - Community gardens
  - Fitness center programs
  - Increase health education programs and opportunities
  - Community health events
  - School-based fitness programs
  - Nutrition education
  - Wellness screenings
  - More urgent care clinics
  - More primary care clinics
  - Legislative regulations on prescription drugs/prescribing practices
  - Legislation on smoking/vapor cigarettes
  - Diabetes education
  - Family support services
  - Elderly support services
  - Offering SNAO benefits at farmers market
  - Substance abuse/mental health facilities and programs

Sources:	Local Resources:

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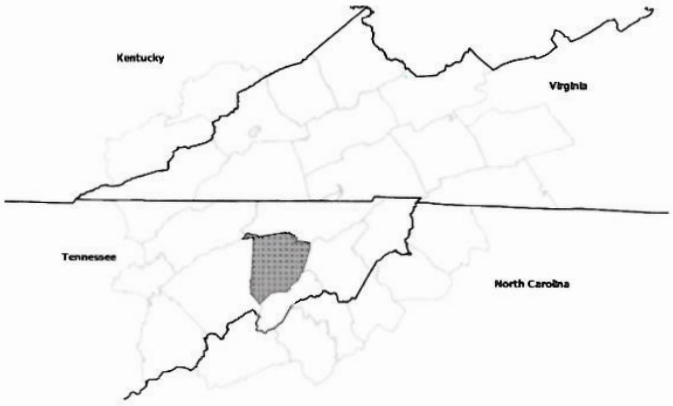
▪ Medstat ▪ County Health Rankings ▪ TN Advisory Commission on Intergovernmental Relations ▪ TN Dept of Health ▪ BRFSS ▪ TennCare ▪ Kidscount ▪ TN Dept of Safety and Homeland Security ▪ EPA ▪ CDC Wonder ▪ TN Dept of Environment & Conservation ▪ Childhood Lead Poisoning Prevention Program	▪ Telamon Migrant Head Start ▪ Unicoi County Health Department ▪ Unicoi County Chamber of Commerce ▪ Unicoi County Memorial Hospital ▪ Unicoi County Family YMCA ▪ Senior Center ▪ Walking trails ▪ Alzheimers Support Group ▪ Farmers Market ▪ Tobacco Settlement Funds ▪ SNAP ▪ Community health events

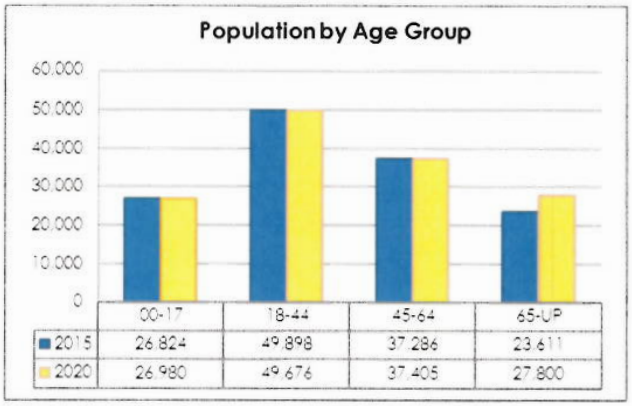
Demographic Highlights:

- Slightly larger elderly population compared to TN and US
- Slight inclining rate of females of child-bearing age expected
- Low average household income level (16.2% of households make less than $15,000)
- Level of educational attainment close to national average (5.2% with no high school education compared to 5.9% nationally)
- Low level of diversity compared to state and national

Service Area Map:



Age Distribution and Population Projections:



	00-17	18-44	45-64	65-UP
2015	26,824	49,898	37,286	23,611
2020	26,980	49,676	37,405	27,800

Key Statistics:

	Washington County	Tennessee	U.S.
2015 Total Population	137,619	6,735,022	321,369,000
% Change 2015-2020	3.1%	5.5%	4.1%
% of Population 65+ (2015)	17.2%	15.6%	14.9%
% Minority (2015)	10.4%	26.1%	38.3%

	2015	2020	% Change
Total Male Population	67,293	69,376	3.1%
Total Female Population	70,326	72,485	3.1%
Females, Child Bearing Age (15-44)	27,500	27,551	0.2%

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Local Health Highlights:

STRENGTHS:

- No health insurance
- Violent crime
- High school graduation STDs

WEAKNESSES:

- Unemployment rate
- Smoking during pregnancy
- Deaths due to cardiovascular, cancer, cerebrovascular, suicide, and injuries

Leading Causes of Death:

Ages 1 - 14 years

Cause of Death	Rate	Rank
Congenital Malformations, Deformations and Chromosomal Abnormalities	5.24	1
All Other Causes	0	*

Ages 15 - 21 years

Cause of Death	Rate	Rank
Accidents	17.6	1
Suicide	8.8	2
Homicide	8.8	3
Nephritis/ Nephrosis	8.8	4
All Other Causes	8.64	*

Ages 22 - 64

Cause of Death	Rate	Rank
Heart Disease	142.6	1
Cancer	133.9	2
Accidents	42.2	3
Liver & Cirrhosis	30.6	4
Suicide	29.1	5
Respiratory	24.7	6
Septicemia	10.2	7
Diabetes Mellitus	8.7	8
Cerebrovascular	8.7	9
Nephritis	8.7	10
All Other Causes	87.5	*

Ages 65+

Cause of Death	Rate	Rank
Heart Disease	1350.9	1
Cancer	1026.5	2
Respiratory	308.5	3
Alzheimer's Disease	297.8	4
Cerebrovascular	292.5	5
Flu/ Pneumonia	202.1	6
Accidents	148.9	7
Nephritis/ Nephrosis	95.7	8
Hypertension	95.7	9
Parkinson's	74.5	10
All Other Causes	1207.4	*

Key Indicators of Health Status:

County: Washington, TN

	TN	Wash Co	2010	Desired
Health Outcomes				↓
Mortality (years of potential life lost/ 100,000)	8,790	8,155	9672	↓
Low Birth Weight (3-yr avg %)	9.0%	7.5%	8.9%	↓
General Health Status (% fair/poor health)*	19.0%	19.0%	210%	↓
Very Low Birth Weight (%)	16%	17%	2.5%	↓
Infant Mortality (3-yr avg rate per 1,000)	8.1	9.9	9.4	↓
Mortality Rate (3-yr avg rate per 100,000)	953.0	1085.5	928.2	↓
Cardiovascular Deaths (per 100,000)	226.5	368.6	264.2	↓
Cancer Deaths (3-yr avg rate per 100,000)	214.4	237.7	200.5	↓
Diabetes Mellitus Deaths (per 100,000)	28.7	14.2	16.2	↓
Cerebrovascular Deaths (per 100,000)	47.0	511	53.9	↓
Suicide Deaths (per 100,000)	15.0	218	9.4	↓
Mortality rate for ages 1- 14 yrs	66.8	5.2	23.5	↓
Mortality rate for ages 15 - 21yrs	70.4	52.6	110.3	↓
Mortality rates for ages 65+	4,870.1	5,100.5	52319	↓
Lung Cancer Deaths (3-yr avg rate per 100,000)	68.8	72.2	63.6	↓
Female Breast Cancer Deaths (3-yr avg rate per 100,000)	14.1	13.8	24	↓
Prevalence of Asthma (%)	9.3%	13.2%	12.4%	↓
Prevalence of Diabetes (%)	110%	110%	12.8%	↓
Health Determinants				↓
Health Care Resources				↓
No Health Insurance (%)*	210%	15.0%	17.9%	↓
Medicaid/Tenncare Enrollees (%)	18.7%	15.4%	16.3%	↓
Medical Doctors Per Capita (per 100,000)	246.1	348.8	329.6	↑
Dentists Per Capita (per 100,000)	52.2	50.4	72.4	↑
Percent without Pneumococcal Vaccinations (%)*	74.2%	66.7%	72.3%	↓
Percent without Influenza Vaccinations (%)*	59.4%	50.7%	59.3%	↓
No Diabetic Eye Exams (%)	74.3%	72.2%	53.1%	↓
No Diabetic HbA1c Testing (%)	16.0%	15.0%	15.1%	↓
No Biennial Mammography (%)*	23.3%	29.3%	23.3%	↓
Inadequate or No Prenatal Care (%)	40.7%	34.6%	5.6%	↓
Month Prenatal Care Began	3.2	3.0	2.9	↓
First Trimester Prenatal Care (%)	59.3%	65.4%	74.6%	↑
Children (0-18 yrs) with Medicaid/Tenncare Coverage (%)	46.8%	40.3%	39.10%	↓
Hospital Staffed Beds (per 1,000)	3.6	4.8	4.9	↑
Licensed Nursing Beds (per 1,000 65+)	44.8	47.1	511	↑
# of Primary Care MDs	7,703	68	68	↓
# of Psychiatric Specialists	684	22	22	↓
Inpatient Discharge Rate (per 1000) - Total	126.3	134.1	149.5	↓
Health Behaviors (continued)				↓
Cigarette Smoking (%)*	23.0%	26.0%	28.9%	↓
Smoking During Pregnancy (%)	16.3%	19.5%	25.4%	↓
Physical Inactivity (%)*	30.0%	29.0%	38.4%	↓
Overweight/Obesity (% BMI > 25)	67.8%	67.8%	67.9%	↓
Obesity (% BMI > 30)*	32.0%	29.0%	29.0%	↓
Low Fruit and Vegetable Consumption (% <5 a day)*	76.7%	73.0%	415%	↓
Binge Drinking (%)*	10.0%	7.0%	7.9%	↓
% of Children (0-4) Un/Improperly Restrained in a Crash	14.5%	5.2%	9.4%	↓
Teen Birth Rate (per 1,000)	37.3	32	46	↓
Sexually Transmitted Diseases (100,000)	446	186	214	↓
Violent Crime (per 100,000)	667.0	451.0	493	↓
Motor Vehicle Crash Deaths (per 100,000)	19	18	18	↓
Unmarried Mother Birth Rate (%)	44.1%	35.8%	36.6%	↓
Injury-related Mortality (3-yr avg rate per 100,000)	53.7	76.2	79.3	↓
Young Driver Crash Rate 15 - 24	116.9	135.2	117.1	↓
Elderly Drive Crash Rate (60+)	31.3	37	43.8	↓
Homicides (per 100,000)	8	17	3.5	↓
All accidental deaths per 100,000 population	52	50.3	45.3	↓
Average Fatality Rate in Alchohol-Related Crashes (per 100,000 population)	6.9	3.4	6.28	↓

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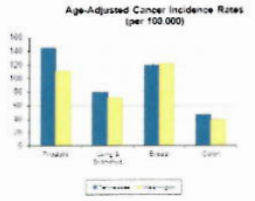
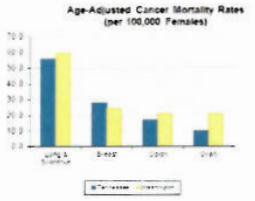
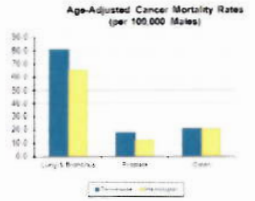
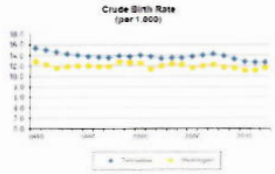
Cancer Incidence:

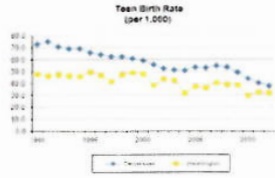






Birth Rate Trend:





Key Indicators of Health Status:

Socioecomonic Factors				↓
High School Graduation Rate (%)	86.0%	90.0%	84.9%	↑
Level of Education (%)	83.2%	85.1%	82.8%	↑
Unemployment (%)	8.8%	9.6%	6.1%	↓
Children (age 0 to 17) in poverty ratio (%)	26.5%	23.5%	20.8%	↓
Divorce Rate (per 1,000)	4.3	5.3	4.6	↓
Food Stamp Recipients (% of individuals)	21.1%	16.6%	15.3%	↓
Poverty Rate (% of all ages)	18.4%	18.3%	14.0%	↓
Temporary Assistance for Needy Families	2.6%	1.2%	1.4%	↓
High School Dropout Rate	6.9%	2.3%	3.2%	↓
Average Annual Wage	$ 36,576	$ 35,215	$30,516	↑
Physical Environment				↓
Air Quality Cancer Risk (per 1,000,000)	4.6	4.0	33.6	↓
Air Quality Hazard Index (per 1,000,000)	1.4	1.2	4.1	↓
Air Quality - Fine Particulate Matter in Air (3 yr avg Mg/m3)*	13.2	12.8	14.5	↓
Ozone Level (ppb)*	0.062	0.063	0.082	↓
Nitrate Levels in drinking water (mg/L Avg.)	0.70	0.27	0.38	↓
Pre-1950 Housing (%)	11.8%	13.4%	16.6%	↓
Lead Poisoned Children (%)	0.1%	n/a	0.8%	↓
Child Abuse and Neglect (rate per 1,000)	5.5	5.5	3.1	↓
Communicable Diseases				↓
Hepatitis A (per 100,000)	0.3	0.0	n/a	↓
Campylobacter Infection (per 100,000)	7.2	9.6	n/a	↓
Salmonella, Non Typhoid (per 100,000)	17.6	5.6	n/a	↓
Shigellosis (per 100,000)	3.3	1.6	n/a	↓
AIDS/HIV (per 100,000)	29.3	16.5	n/a	↓
Primary and Secondary Syphilis (per 100,000)	4.3	0.8	n/a	↓
Penicillin-Sensitive *Streptococcus pneumoniae* (per 100,000)	0.0	0.0	n/a	↓
Group B *Streptococcus* (per 100,000)	6.2	8.0	n/a	↓
Chlamydia (per 100,000)	517.3	202.6	n/a	↓
Gonorrhea (per 100,000)	144.8	41.0	n/a	↓

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Inpatient Projections

	2014	2019		2024	
DRG Service Line	**Discharges**	**Discharges**	**% Change**	**Discharges**	**% Change**
Cardiac Surgery	164	170	3.80%	182	10.90%
Cardiology	1,524	1,381	-9.40%	1,272	-16.50%
Cardiology Intervention	670	636	-5.10%	615	-8.20%
Endocrinology	456	377	-17.30%	354	-22.40%
ENT Surgery	19	19	-2.00%	18	-3.00%
Gastroenterology	1,454	1,414	-2.80%	1,436	-1.20%
General Medicine	1,476	1,518	2.80%	1,462	-0.90%
General Surgery	1,026	1,026	0.00%	1,031	0.50%
Gynecology	105	99	-5.30%	97	-7.20%
Hematology	220	226	2.50%	239	8.50%
Neonatology	660	628	-4.80%	604	-8.50%
Nephrology	747	719	-3.70%	662	-11.30%
Neurology	788	803	1.90%	851	8.10%
Neurosurgery	320	323	1.00%	338	5.50%
Normal Newborns	760	804	5.80%	816	7.30%
OB Deliveries Sections	465	409	-12.10%	388	-16.60%
OB Deliveries Vaginal	895	971	8.40%	993	10.90%
OB Other	110	108	-1.80%	108	-2.00%
Oncology Medicine	262	262	0.10%	246	-6.00%
Oncology Surgery	97	103	6.40%	105	8.40%
Ophthalmic Medicine	11	10	-7.90%	10	-10.20%
Ophthalmic Surgery	8	8	-0.80%	8	6.00%
Oral Surgery	31	29	-7.40%	29	-6.30%
Orthopedic Medicine	218	225	3.10%	233	6.80%
Orthopedic Surgery	954	1,043	9.30%	1,097	15.00%
Otolaryngology	83	75	-10.20%	74	-10.30%
Plastic Surgery	24	24	-1.70%	22	-7.20%
Psychiatry	1,335	1,502	12.50%	1,451	8.70%
Pulmonary	1,988	1,752	-11.90%	1,686	-15.20%
Rehabilitation	325	282	-13.10%	315	-3.20%
Rheumatology	76	75	-1.70%	76	-0.40%
Substance Abuse	181	190	5.00%	189	4.50%
Thoracic Surgery	89	85	-4.50%	84	-5.60%
Trauma Medical	71	70	-2.00%	73	3.20%
Unspecified	2	2	0.90%	2	1.70%
Urology Medicine	73	66	-9.80%	61	-16.30%
Urology Surgery	130	128	-1.40%	125	-4.20%
Vascular Surgery	254	257	1.10%	261	2.80%
Womens Other	12	11	-8.70%	10	-19.30%
Grand Total	**18,083**	**17,828**	**-1.40%**	**17,624**	**-2.50%**

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Outpatient Projections

	2014	2019		2024	
Site of Care	**Volumes**	**Volumes**	**% Change**	**Volumes**	**% Change**
ED	69,931	72,043	3.00%	70,998	1.50%
Home	153,277	185,700	21.20%	209,747	36.80%
Hosp OP/ASC	190,142	210,092	10.50%	220,008	15.70%
Office/Clinic	1,208,462	1,334,727	10.40%	1,333,601	10.40%
Other	53,254	59,778	12.20%	62,306	17.00%
SNF	3,178	3,587	12.90%	3,887	22.30%
Urgent/Retail	1,932	2,148	11.10%	2,158	11.70%
Virtual		25,381		104,289	
Grand Total	**1,680,177**	**1,893,457**	**12.70%**	**2,006,995**	**19.50%**

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Interview Highlights:

INTERVIEWEES:

- 18 individuals

KEY FINDINGS:

- Average rating of health status is 5.3, with a range in responses of two (2) through seven (7)
- Top health issues are:
  - Substance and prescription drug abuse
  - Smoking/tobacco use
  - Obesity
  - Cardiovascular disease
- Additional health issues are:
  - Physical inactivity
  - Diabetes
  - Poor nutrition
  - Education
  - Cancer
  - Mental health
  - Income inequality
  - Literacy
  - Liver disease (Hepatitis C)
  - Neonatal Abstinence Syndrome (NAS)
  - Poverty
  - Aging population
  - Transportation barriers
  - Risk taking
  - Stigma of mental health disorders and substance abuse
  - Access to care
  - Living wage
  - Lack of job training
  - Built environment to promote physical activity
  - Parenting skills
  - Access to fast food
  - Economy
  - Adverse Childhood Experiences (ACEs)
  - Domestic violence
- Ideas to improve these conditions include:
  - Organizational collaboration
  - Emphasis on exercise
  - Increase physical activity in schools
  - Health education on health effects of behaviors: smoking, eating, inactivity
  - Expansion of Project Access
  - Increase health care access with financial resources and partnerships
  - Focus on high school graduation
  - Increase number of walking trails
  - Promote CEASE program
  - Provide/promote smoking cessation programs
  - Offer wellness initiatives
  - Work with schools on food options
  - Promote early screenings
  - Educate children early on the importance of exercise and healthy eating

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- Healthcare navigators to help community members with health education and free/reduced cost health care services
- Offering additional activities for families to promote physical activity
- Develop network of clinics, hospitals, long-term care facilities, and health departments to discuss and develop health improvement initiatives.
- Better marketing of health resources to the community
- Promote literacy programs for educational attainment

Sources:	Local Resources:
▪ Medstat ▪ County Health Rankings ▪ TN Advisory Commission on Intergovernmental Relations ▪ TN Dept of Health ▪ BRFSS ▪ TennCare ▪ Kidscount ▪ TN Dept of Safety and Homeland Security ▪ EPA ▪ CDC Wonder ▪ TN Dept of Environment & Conservation ▪ Childhood Lead Poisoning Prevention Program	• Families Free • Health Department • Washington County Anti-Drug Coalition • Tennessee Suicide Prevention Network • Tennessee Prevention Alliance • TAADAS • Tweetsie Trail • Senior Center • Food Pantries • One Acre Café • Backpack/Student food supplement program • Project Access • JCCH • Johnson City Housing Authority • United Way • Coordinated School Health • Head Start • Johnson City Parks and Recreation • Morning Mile • JCMC/FWCH • ETSU College of Medicine • ETSU College of Public Health • ETSU College of Pharmacy • ETSU College of Nursing • ETSU College of Clinical and Rehabilitative Health Sciences • Day Center • MEAL • Girls on the Run • Washington County Health Council • Washington County Wellness Committee • The Women's Fund of the East Tennessee Foundation • Appalachian Funders Network • Washington County PDAM • Local school systems • Local churches • UT-Washington County Extension

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APPENDIX

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6. Washington, TN Detailed Demographics

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Mountain State Health Alliance

Carter County, TN

Population and Gender	Market 2015 Population	Market 2015 % of Total	Market 2020 Population	Market 2020 % of Total	Market Population % Change	National 2015 % of Total
Female Population	23,066	51.1%	23,247	51.0%	0.8%	50.8%
Male Population	22,105	48.9%	22,298	49.0%	0.9%	49.2%
Total	45,171	100.0%	45,545	100.0%	0.8%	100.0%

Age Groups	Market 2015 Population	Market 2015 % of Total	Market 2020 Population	Market 2020 % of Total	Market Population % Change	National 2015 % of Total
00-17	9,006	19.9%	8,774	19.3%	(2.6)%	23.1%
18-44	13,998	31.0%	13,793	30.3%	(1.5)%	35.9%
45-64	12,867	28.5%	12,500	27.5%	(2.9)%	26.3%
65-UP	9,300	20.6%	10,478	23.0%	12.7%	14.7%
Total	45,171	100.0%	45,545	100.0%	0.8%	100.0%

Ethnicity/Race	Market 2015 Population	Market 2015 % of Total	Market 2020 Population	Market 2020 % of Total	Market Population % Change	National 2015 % of Total
Asian & Pacific Is. Non-Hispanic	129	0.3%	123	0.3%	(4.7)%	5.3%
Black Non-Hispanic	570	1.3%	611	1.3%	7.2%	12.3%
Hispanic	777	1.7%	940	2.1%	21.0%	17.6%
White Non-Hispanic	43,145	95.5%	43,286	95.0%	0.3%	61.8%
All Others	550	1.2%	585	1.3%	6.4%	3.1%
Total	45,171	100.0%	45,545	100.0%	0.8%	100.0%

Language*	Market 2015 Population	Market 2015 % of Total	Market 2020 Population	Market 2020 % of Total	Market Population % Change	National 2015 % of Total
French at Home	63	0.2%	64	0.2%	1.6%	0.7%
Only English at Home	41,998	98.1%	42,400	98.1%	1.0%	79.0%
Other Indo-European Lang at Home	79	0.2%	77	0.2%	(2.5)%	1.8%
Spanish at Home	412	1.0%	413	1.0%	0.2%	13.0%
Tagalog at Home	125	0.3%	125	0.3%	0.0%	0.6%
All Others	158	0.4%	158	0.4%	0.0%	4.9%
Total	42,835	100.0%	43,237	100.0%	0.9%	100.0%

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Mountain State Health Alliance
Carter County, TN

Household Income	Market 2015 Households	Market 2015 % of Total	Market 2020 Households	Market 2020 % of Total	Market Households % Change	National 2015 % of Total
<$15K	3,924	20.6%	3,550	18.4%	(9.5)%	12.7%
$15-25K	2,963	15.6%	2,734	14.2%	(7.7)%	10.8%
$25-50K	5,691	29.9%	5,757	29.9%	1.2%	23.9%
$50-75K	3,341	17.6%	3,257	16.9%	(2.5)%	17.8%
$75-100K	1,667	8.8%	1,930	10.0%	15.8%	12.0%
$100K-200K	1,268	6.7%	1,808	9.4%	42.6%	17.9%
>$200K	172	0.9%	245	1.3%	42.4%	5.0%
Total	19,026	100.0%	19,281	100.0%	1.3%	100.0%

Education Level**	Market 2015 Population	Market 2015 % of Total	Market 2020 Population	Market 2020 % of Total	Market Population % Change	National 2015 % of Total
Less than High School	2,964	9.1%	3,038	9.2%	2.5%	5.9%
Some High School	3,909	12.0%	4,002	12.1%	2.4%	8.0%
High School Degree	12,544	38.6%	12,793	38.7%	2.0%	28.1%
Some College/Assoc. Degree	8,678	26.7%	8,784	26.6%	1.2%	31.1%
Bachelor's Degree or Greater	4,428	13.6%	4,447	13.5%	0.4%	26.9%
Total	32,523	100.0%	33,064	100.0%	1.7%	100.0%

*Excludes population age <5, **Excludes population age <25

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Mountain State Health Alliance
Greene County, TN

Population and Gender	Market 2015 Population	Market 2015 % of Total	Market 2020 Population	Market 2020 % of Total	Market Population % Change	National 2015 % of Total
Female Population	33,451	50.9%	33,358	50.8%	(0.3)%	50.8%
Male Population	32,312	49.1%	32,269	49.2%	(0.1)%	49.2%
Total	65,763	100.0%	65,627	100.0%	(0.2)%	100.0%

Age Groups	Market 2015 Population	Market 2015 % of Total	Market 2020 Population	Market 2020 % of Total	Market Population % Change	National 2015 % of Total
00-17	13,301	20.2%	12,633	19.3%	(5.0)%	23.1%
18-44	20,460	31.1%	20,079	30.6%	(1.9)%	35.9%
45-64	18,837	28.6%	18,123	27.6%	(3.8)%	26.3%
65-UP	13,165	20.0%	14,792	22.5%	12.4%	14.7%
Total	65,763	100.0%	65,627	100.0%	(0.2)%	100.0%

Ethnicity/Race	Market 2015 Population	Market 2015 % of Total	Market 2020 Population	Market 2020 % of Total	Market Population % Change	National 2015 % of Total
Asian & Pacific Is. Non-Hispanic	357	0.5%	464	0.7%	30.0%	5.3%
Black Non-Hispanic	1,466	2.2%	1,624	2.5%	10.8%	12.3%
Hispanic	1,972	3.0%	2,346	3.6%	19.0%	17.6%
White Non-Hispanic	61,056	92.8%	60,233	91.8%	(1.4)%	61.8%
All Others	912	1.4%	960	1.5%	5.3%	3.1%
Total	65,763	100.0%	65,627	100.0%	(0.2)%	100.0%

Language*	Market 2015 Population	Market 2015 % of Total	Market 2020 Population	Market 2020 % of Total	Market Population % Change	National 2015 % of Total
French at Home	148	0.2%	142	0.2%	(4.1)%	0.7%
Germanic Lang at Home	129	0.2%	128	0.2%	(0.8)%	0.5%
Only English at Home	60,044	96.2%	60,016	96.2%	(0.1)%	79.0%
Other Asian-Pacific Lang at Home	74	0.1%	70	0.1%	(5.4)%	0.9%
Spanish at Home	1,719	2.8%	1,702	2.7%	(1.0)%	13.0%
All Others	311	0.5%	311	0.5%	0.0%	5.9%
Total	62,425	100.0%	62,369	100.0%	(0.1)%	100.0%

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Mountain State Health Alliance
Greene County, TN

Household Income	Market 2015 Households	Market 2015 % of Total	Market 2020 Households	Market 2020 % of Total	Market Households % Change	National 2015 % of Total
<$15K	5,081	19.0%	4,637	17.4%	(8.7)%	12.7%
$15-25K	4,255	15.9%	3,968	14.9%	(6.8)%	10.8%
$25-50K	8,445	31.6%	8,384	31.4%	(0.7)%	23.9%
$50-75K	4,258	15.9%	4,295	16.1%	0.9%	17.8%
$75-100K	2,499	9.3%	2,545	9.5%	1.8%	12.0%
$100K-200K	1,823	6.8%	2,343	8.8%	28.5%	17.9%
>$200K	398	1.5%	493	1.9%	23.9%	5.0%
Total	26,759	100.0%	26,665	100.0%	(0.4)%	100.0%

Education Level**	Market 2015 Population	Market 2015 % of Total	Market 2020 Population	Market 2020 % of Total	Market Population % Change	National 2015 % of Total
Less than High School	3,557	7.6%	3,590	7.6%	0.9%	5.9%
Some High School	5,984	12.8%	6,070	12.9%	1.4%	8.0%
High School Degree	18,659	39.9%	18,843	40.0%	1.0%	28.1%
Some College/Assoc. Degree	11,382	24.4%	11,443	24.3%	0.5%	31.1%
Bachelor's Degree or Greater	7,152	15.3%	7,137	15.2%	(0.2)%	26.9%
Total	46,734	100.0%	47,083	100.0%	0.8%	100.0%

*Excludes population age <5, **Excludes population age <25

Mountain State Health Alliance

Johnson County, TN

Population and Gender	Market 2015 Population	Market 2015 % of Total	Market 2020 Population	Market 2020 % of Total	Market Population % Change	National 2015 % of Total
Female Population	8,998	46.5%	8,934	46.5%	(0.7)%	50.8%
Male Population	10,358	53.5%	10,273	53.5%	(0.8)%	49.2%
Total	19,356	100.0%	19,207	100.0%	(0.8)%	100.0%

Age Groups	Market 2015 Population	Market 2015 % of Total	Market 2020 Population	Market 2020 % of Total	Market Population % Change	National 2015 % of Total
00-17	3,474	18.0%	3,314	17.3%	(4.6)%	23.1%
18-44	6,332	32.7%	6,120	31.9%	(3.4)%	35.9%
45-64	5,585	28.9%	5,386	28.0%	(3.6)%	26.3%
65-UP	3,965	20.5%	4,387	22.8%	10.6%	14.7%
Total	19,356	100.0%	19,207	100.0%	(0.8)%	100.0%

Ethnicity/Race	Market 2015 Population	Market 2015 % of Total	Market 2020 Population	Market 2020 % of Total	Market Population % Change	National 2015 % of Total
Asian & Pacific Is. Non-Hispanic	58	0.3%	65	0.3%	12.1%	5.3%
Black Non-Hispanic	469	2.4%	531	2.8%	13.2%	12.3%
Hispanic	340	1.8%	401	2.1%	17.9%	17.6%
White Non-Hispanic	18,237	94.2%	17,914	93.3%	(1.8)%	61.8%
All Others	252	1.3%	296	1.5%	17.5%	3.1%
Total	19,356	100.0%	19,207	100.0%	(0.8)%	100.0%

Language*	Market 2015 Population	Market 2015 % of Total	Market 2020 Population	Market 2020 % of Total	Market Population % Change	National 2015 % of Total
French at Home	29	0.2%	30	0.2%	3.5%	0.7%
Germanic Lang at Home	11	0.1%	11	0.1%	0.0%	0.5%
Only English at Home	18,104	97.9%	17,990	97.9%	(0.6)%	79.0%
Other Indo-European Lang at Home	42	0.2%	40	0.2%	(4.8)%	1.8%
Spanish at Home	276	1.5%	272	1.5%	(1.5)%	13.0%
All Others	26	0.1%	25	0.1%	(3.9)%	4.9%
Total	18,488	100.0%	18,368	100.0%	(0.7)%	100.0%

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Mountain State Health Alliance

Johnson County, TN

Household Income	Market 2015 Households	Market 2015 % of Total	Market 2020 Households	Market 2020 % of Total	Market Households % Change	National 2015 % of Total
<$15K	1,673	21.6%	1,411	18.2%	(15.7)%	12.7%
$15-25K	1,293	16.7%	1,221	15.8%	(5.6)%	10.8%
$25-50K	2,176	28.0%	2,170	28.0%	(0.3)%	23.9%
$50-75K	1,242	16.0%	1,151	14.9%	(7.3)%	17.8%
$75-100K	704	9.1%	806	10.4%	14.5%	12.0%
$100K-200K	574	7.4%	861	11.1%	50.0%	17.9%
>$200K	97	1.3%	123	1.6%	26.8%	5.0%
Total	7,759	100.0%	7,743	100.0%	(0.2)%	100.0%

Education Level**	Market 2015 Population	Market 2015 % of Total	Market 2020 Population	Market 2020 % of Total	Market Population % Change	National 2015 % of Total
Less than High School	1,614	11.3%	1,614	11.3%	0.0%	5.9%
Some High School	2,449	17.1%	2,449	17.1%	0.0%	8.0%
High School Degree	5,794	40.4%	5,770	40.4%	(0.4)%	28.1%
Some College/Assoc. Degree	3,025	21.1%	2,997	21.0%	(0.9)%	31.1%
Bachelor's Degree or Greater	1,468	10.2%	1,455	10.2%	(0.9)%	26.9%
Total	14,350	100.0%	14,285	100.0%	(0.5)%	100.0%

*Excludes population age <5, **Excludes population age <25

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Mountain State Health Alliance
Sullivan County, TN

Population and Gender	Market 2015 Population	Market 2015 % of Total	Market 2020 Population	Market 2020 % of Total	Market Population % Change	National 2015 % of Total
Female Population	82,467	51.6%	83,193	51.6%	0.9%	50.8%
Male Population	77,249	48.4%	78,076	48.4%	1.1%	49.2%
Total	159,716	100.0%	161,269	100.0%	1.0%	100.0%

Age Groups	Market 2015 Population	Market 2015 % of Total	Market 2020 Population	Market 2020 % of Total	Market Population % Change	National 2015 % of Total
00-17	31,429	19.7%	30,327	18.8%	(3.5)%	23.1%
18-44	48,753	30.5%	48,225	29.9%	(1.1)%	35.9%
45-64	46,417	29.1%	45,329	28.1%	(2.3)%	26.3%
65-UP	33,117	20.7%	37,388	23.2%	12.9%	14.7%
Total	159,716	100.0%	161,269	100.0%	1.0%	100.0%

Ethnicity/Race	Market 2015 Population	Market 2015 % of Total	Market 2020 Population	Market 2020 % of Total	Market Population % Change	National 2015 % of Total
Asian & Pacific Is. Non-Hispanic	1,181	0.7%	1,426	0.9%	20.8%	5.3%
Black Non-Hispanic	3,819	2.4%	4,313	2.7%	12.9%	12.3%
Hispanic	3,015	1.9%	3,712	2.3%	23.1%	17.6%
White Non-Hispanic	149,096	93.4%	148,907	92.3%	(0.1)%	61.8%
All Others	2,605	1.6%	2,911	1.8%	11.8%	3.1%
Total	159,716	100.0%	161,269	100.0%	1.0%	100.0%

Language*	Market 2015 Population	Market 2015 % of Total	Market 2020 Population	Market 2020 % of Total	Market Population % Change	National 2015 % of Total
Germanic Lang at Home	285	0.2%	283	0.2%	(0.7)%	0.5%
Only English at Home	147,691	97.3%	149,340	97.4%	1.1%	79.0%
Other Indo-European Lang at Home	602	0.4%	601	0.4%	(0.2)%	1.8%
Other Lang at Home	202	0.1%	203	0.1%	0.5%	0.9%
Spanish at Home	2,177	1.4%	2,186	1.4%	0.4%	13.0%
All Others	764	0.5%	758	0.5%	(0.8)%	4.7%
Total	151,721	100.0%	153,371	100.0%	1.1%	100.0%

SBH-KINGSPORT 002172

Mountain State Health Alliance
Sullivan County, TN

Household Income	Market 2015 Households	Market 2015 % of Total	Market 2020 Households	Market 2020 % of Total	Market Households % Change	National 2015 % of Total
<$15K	10,586	15.6%	9,374	13.6%	(11.5)%	12.7%
$15-25K	10,321	15.2%	9,508	13.8%	(7.9)%	10.8%
$25-50K	18,992	28.0%	19,038	27.7%	0.2%	23.9%
$50-75K	11,811	17.4%	11,702	17.0%	(0.9)%	17.8%
$75-100K	6,376	9.4%	6,984	10.2%	9.5%	12.0%
$100K-200K	7,914	11.7%	9,619	14.0%	21.5%	17.9%
>$200K	1,858	2.7%	2,505	3.6%	34.8%	5.0%
Total	67,858	100.0%	68,730	100.0%	1.3%	100.0%

Education Level**	Market 2015 Population	Market 2015 % of Total	Market 2020 Population	Market 2020 % of Total	Market Population % Change	National 2015 % of Total
Less than High School	7,645	6.6%	7,867	6.7%	2.9%	5.9%
Some High School	9,906	8.6%	10,189	8.7%	2.9%	8.0%
High School Degree	40,421	35.1%	41,336	35.2%	2.3%	28.1%
Some College/Assoc. Degree	34,264	29.7%	34,808	29.6%	1.6%	31.1%
Bachelor's Degree or Greater	23,046	20.0%	23,244	19.8%	0.9%	26.9%
Total	115,282	100.0%	117,444	100.0%	1.9%	100.0%

*Excludes population age <5, **Excludes population age <25

SBH-KINGSPORT 002173

Sg2 MARKET SNAPSHOT

Mountain State Health Alliance
Unicoi County, TN

Population and Gender	Market 2015 Population	Market 2015 % of Total	Market 2020 Population	Market 2020 % of Total	Market Population % Change	National 2015 % of Total
Female Population	9,160	50.9%	9,072	50.9%	(1.0)%	50.8%
Male Population	8,824	49.1%	8,741	49.1%	(0.9)%	49.2%
Total	17,984	100.0%	17,813	100.0%	(1.0)%	100.0%

Age Groups	Market 2015 Population	Market 2015 % of Total	Market 2020 Population	Market 2020 % of Total	Market Population % Change	National 2015 % of Total
00-17	3,440	19.1%	3,223	18.1%	(6.3)%	23.1%
18-44	5,296	29.5%	5,148	28.9%	(2.8)%	35.9%
45-64	5,306	29.5%	5,081	28.5%	(4.2)%	26.3%
65-UP	3,942	21.9%	4,361	24.5%	10.6%	14.7%
Total	17,984	100.0%	17,813	100.0%	(1.0)%	100.0%

Ethnicity/Race	Market 2015 Population	Market 2015 % of Total	Market 2020 Population	Market 2020 % of Total	Market Population % Change	National 2015 % of Total
Asian & Pacific Is. Non-Hispanic	51	0.3%	72	0.4%	41.2%	5.3%
Black Non-Hispanic	88	0.5%	143	0.8%	62.5%	12.3%
Hispanic	842	4.7%	1,012	5.7%	20.2%	17.6%
White Non-Hispanic	16,759	93.2%	16,299	91.5%	(2.7)%	61.8%
All Others	244	1.4%	287	1.6%	17.6%	3.1%
Total	17,984	100.0%	17,813	100.0%	(1.0)%	100.0%

Language*	Market 2015 Population	Market 2015 % of Total	Market 2020 Population	Market 2020 % of Total	Market Population % Change	National 2015 % of Total
French at Home	40	0.2%	42	0.3%	5.0%	0.7%
Germanic Lang at Home	57	0.3%	57	0.3%	0.0%	0.5%
Only English at Home	16,318	95.2%	16,188	95.2%	(0.8)%	79.0%
Other Asian-Pacific Lang at Home	13	0.1%	9	0.1%	(30.8)%	0.9%
Spanish at Home	716	4.2%	704	4.1%	(1.7)%	13.0%
All Others	5	0.0%	5	0.0%	0.0%	5.9%
Total	17,149	100.0%	17,005	100.0%	(0.8)%	100.0%

SBH-KINGSPORT 002174

Mountain State Health Alliance

Unicoi County, TN

Household Income	Market 2015 Households	Market 2015 % of Total	Market 2020 Households	Market 2020 % of Total	Market Households % Change	National 2015 % of Total
<$15K	1,447	19.1%	1,329	17.7%	(8.2)%	12.7%
$15-25K	1,296	17.1%	1,189	15.9%	(8.3)%	10.8%
$25-50K	2,058	27.2%	2,023	27.0%	(1.7)%	23.9%
$50-75K	1,154	15.2%	1,171	15.6%	1.5%	17.8%
$75-100K	699	9.2%	700	9.3%	0.1%	12.0%
$100K-200K	810	10.7%	940	12.5%	16.1%	17.9%
>$200K	113	1.5%	149	2.0%	31.9%	5.0%
Total	7,577	100.0%	7,501	100.0%	(1.0)%	100.0%

Education Level**	Market 2015 Population	Market 2015 % of Total	Market 2020 Population	Market 2020 % of Total	Market Population % Change	National 2015 % of Total
Less than High School	1,402	10.6%	1,411	10.7%	0.6%	5.9%
Some High School	1,762	13.3%	1,767	13.4%	0.3%	8.0%
High School Degree	5,358	40.6%	5,353	40.6%	(0.1)%	28.1%
Some College/Assoc. Degree	3,271	24.8%	3,248	24.7%	(0.7)%	31.1%
Bachelor's Degree or Greater	1,421	10.8%	1,396	10.6%	(1.8)%	26.9%
Total	13,214	100.0%	13,175	100.0%	(0.3)%	100.0%

*Excludes population age <5, **Excludes population age <25

SBH-KINGSPORT 002175

Sg2 MARKET SNAPSHOT

Mountain State Health Alliance
Washington County, TN

Population and Gender	Market 2015 Population	Market 2015 % of Total	Market 2020 Population	Market 2020 % of Total	Market Population % Change	National 2015 % of Total
Female Population	70,326	51.1%	72,485	51.1%	3.1%	50.8%
Male Population	67,293	48.9%	69,376	48.9%	3.1%	49.2%
Total	137,619	100.0%	141,861	100.0%	3.1%	100.0%

Age Groups	Market 2015 Population	Market 2015 % of Total	Market 2020 Population	Market 2020 % of Total	Market Population % Change	National 2015 % of Total
00-17	26,824	19.5%	26,980	19.0%	0.6%	23.1%
18-44	49,898	36.3%	49,676	35.0%	(0.4)%	35.9%
45-64	37,286	27.1%	37,405	26.4%	0.3%	26.3%
65-UP	23,611	17.2%	27,800	19.6%	17.7%	14.7%
Total	137,619	100.0%	141,861	100.0%	3.1%	100.0%

Ethnicity/Race	Market 2015 Population	Market 2015 % of Total	Market 2020 Population	Market 2020 % of Total	Market Population % Change	National 2015 % of Total
Asian & Pacific Is. Non-Hispanic	1,723	1.3%	1,938	1.4%	12.5%	5.3%
Black Non-Hispanic	5,448	4.0%	5,992	4.2%	10.0%	12.3%
Hispanic	4,490	3.3%	5,150	3.6%	14.7%	17.6%
White Non-Hispanic	123,331	89.6%	125,943	88.8%	2.1%	61.8%
All Others	2,627	1.9%	2,838	2.0%	8.0%	3.1%
Total	137,619	100.0%	141,861	100.0%	3.1%	100.0%

Language*	Market 2015 Population	Market 2015 % of Total	Market 2020 Population	Market 2020 % of Total	Market Population % Change	National 2015 % of Total
Chinese at Home	400	0.3%	403	0.3%	0.8%	1.0%
Germanic Lang at Home	497	0.4%	514	0.4%	3.4%	0.5%
Only English at Home	124,597	95.5%	128,679	95.5%	3.3%	79.0%
Other Indo-European Lang at Home	572	0.4%	586	0.4%	2.5%	1.8%
Spanish at Home	3,399	2.6%	3,479	2.6%	2.4%	13.0%
All Others	1,064	0.8%	1,082	0.8%	1.7%	4.7%
Total	130,529	100.0%	134,743	100.0%	3.2%	100.0%

SBH-KINGSPORT 002176

Mountain State Health Alliance
Washington County, TN

Household Income	Market 2015 Households	Market 2015 % of Total	Market 2020 Households	Market 2020 % of Total	Market Households % Change	National 2015 % of Total
<$15K	9,365	16.2%	8,993	15.0%	(4.0)%	12.7%
$15-25K	7,745	13.4%	7,785	13.0%	0.5%	10.8%
$25-50K	16,023	27.7%	15,901	26.5%	(0.8)%	23.9%
$50-75K	10,659	18.4%	11,228	18.7%	5.3%	17.8%
$75-100K	5,615	9.7%	6,034	10.1%	7.5%	12.0%
$100K-200K	6,531	11.3%	7,728	12.9%	18.3%	17.9%
>$200K	2,015	3.5%	2,359	3.9%	17.1%	5.0%
Total	57,953	100.0%	60,028	100.0%	3.6%	100.0%

Education Level**	Market 2015 Population	Market 2015 % of Total	Market 2020 Population	Market 2020 % of Total	Market Population % Change	National 2015 % of Total
Less than High School	4,979	5.2%	5,295	5.2%	6.4%	5.9%
Some High School	8,727	9.0%	9,208	9.1%	5.5%	8.0%
High School Degree	29,518	30.6%	31,134	30.7%	5.5%	28.1%
Some College/Assoc. Degree	28,123	29.1%	29,508	29.1%	4.9%	31.1%
Bachelor's Degree or Greater	25,224	26.1%	26,306	25.9%	4.3%	26.9%
Total	96,571	100.0%	101,451	100.0%	5.1%	100.0%

*Excludes population age <5, **Excludes population age <25

SBH-KINGSPORT 002177

MOUNTAIN STATES HEALTH ALLIANCE

Fiscal Year 2015
Third Quarter ending March 31, 2015

Quarterly Financial Information
&
Historical Maximum Annual Debt Service Coverage Ratio

Consolidated & Unaudited

Mountain States Health Alliance
Consolidated Balance Sheet (Unaudited)
At March 31, 2015

	Consolidated
ASSETS	
CURRENT ASSETS	
Cash and Cash Equivalents	66,697,783
Current Portion AWUIL	8,766,960
Accounts Receivable (Net)	177,184,581
Other Receivables	29,556,831
Due From Affiliates	3,607
Due From Third Party Payors	0
Inventories	26,595,071
Prepaid Expense	9,056,403
	317,861,237
ASSETS WHOSE USE IS LIMITED	53,472,246
OTHER INVESTMENTS	613,990,075
PROPERTY, PLANT AND EQUIPMENT	
Land, Buildings and Equipment	1,646,398,411
Less Allowances for Depreciation	799,540,545
	846,857,866
OTHER ASSETS	
Pledges Receivable	3,293,981
Long Term Compensation Investment	24,779,130
Investments in Unconsolidated Subsidiaries	5,150,938
Land / Equipment Held for Resale	7,508,959
Assets Held for Expansion	14,310,717
Investments in Subsidiaries	0
Goodwill	156,596,125
Deferred Charges and Other	24,677,269
	236,317,118
TOTAL ASSETS	2,068,498,542
LIABILITIES AND NET ASSETS	
CURRENT LIABILITIES	
Accounts Payable and Accrued Expense	86,782,632
Accrued Salaries, Benefits, and PTO	50,937,845
Claims Payable	7,076,164
Accrued Interest	9,380,091
Due to Affiliates	(0)
Due to Third Party Payors	13,390,443
Current Portion of Long Term Debt	24,332,448
	191,899,622
OTHER NON CURRENT LIABILITIES	
Long Term Compensation Payable	12,186,841
Long Term Debt	1,052,651,287
Estimated Fair Value of Interest Rate Swaps	3,594,920
Deferred Income	24,775,531
Professional Liability Self-Insurance and Other	22,078,311
	1,115,286,890
TOTAL LIABILITIES	1,307,186,512
NET ASSETS	574,094,938
NONCONTROLLING INTERESTS IN SUBSIDIARIES	187,217,092
TOTAL LIABILITIES AND NET ASSETS	2,068,498,542

Mountain States Health Alliance

Statement of Revenue and Expense (Unaudited)

For the Period Ended March 31, 2015

	NINE MONTHS YEAR TO DATE
	Actual
Revenue, Gains and Support	
Patient Service Revenue, Net of Contractual Allowances and Discounts	840,390,491
Provision for Bad Debt	-100,375,420
Net Patient Service Revenue	740,015,071
Premium Revenue	21,492,711
Net Investment Gain	1,617,630
Net Derivative Gain	11,382,997
Other Revenue, Gains and Support	16,375,449
Total Revenue, Gains and Support	790,883,858
Expense	
Salaries and Wages	252,527,296
Provider Salaries	56,840,825
Contract Labor	4,316,492
Employee Benefits	54,797,727
Fees	88,105,565
Supplies	131,862,997
Utilities	12,634,273
Medical Costs	20,005,846
Other Expense	64,250,281
Loss on Extinguishment of LTD / Derivatives	0
Depreciation	50,634,568
Amortization	1,174,794
Interest & Taxes	32,931,495
Consolidation Allocation	1
Total Expenses	770,082,160
Excess of Revenue, Gains and Support over Expenses and Losses	20,801,698

MOUNTAIN STATES HEALTH ALLIANCE (Consolidated)
UNAUDITED QUARTERLY DISCLOSURE - FY 2015 - Third Quarter ending March 31, 2015
Historical Maximum Annual Debt Service Coverage

Calculation:	Third Quarter ending March 31, 2015	Twelve Months ending March 31, 2015
Income available for debt service		
Excess of revenue over expenses (before extraord. items)	$ 4,894,660	$ 53,130,067
Plus depreciation expense	16,796,866	62,466,816
Plus amortization expense	362,218	1,564,302
Plus interest expense	10,776,560	43,889,294
Subtotal	32,830,304	161,050,479
Annualized quarterly total income available for debt service	x 4	n/a
Total income available for debt service	131,321,216	161,050,479
Maximum annual debt service	67,246,000	67,246,000
Maximum annual debt service coverage	2.0	2.4

MOUNTAIN STATES HEALTH ALLIANCE

Management Discussion For the Quarter Ended March 31, 2015 and Nine Months Fiscal Year to Date 2015

Volumes

Quarter ended March 31, 2015 versus quarter ended March 31, 2014

For the third quarter, strong volume growth continued even with higher than normal inclement winter weather:
Inpatient admissions were up 1,215 or 8.4%
Observation patients were down 241 or 4.1%.
Total "patients in a bed" were up 974 or 4.8%
Emergency room visits were up 3,960 or 6.8%
Urgent care visits were up 1,827 or 7.9%
Surgeries were up 236 or 2.7%

Fiscal Year to Date (Three Quarters)

Compared to the prior year fiscal year to date:
Inpatient admissions were up 3,989 or 9.5%
Observation patients were down 965 or 5.2%
Total "patients in a bed" were up 3,024 or 5.0%
Emergency room visits were up 12,675 or 7.1%
Urgent care visits were up 7,425 or 11.4%
Surgeries were up 1,597 or 6.2%

Statement of Revenue and Expenses

Quarter ended March 31, 2015 versus quarter ended March 31, 2014

Revenue

Net patient service revenue increased $17.6 million or 7.6% from the same quarter last year due to the volume increases listed above. **Other** revenue declined $7.7 million or 79.7% mainly due to an increase in minority interest related to the non-wholly owned hospitals. **Premium** revenue increased $5.5 million or 120.9% due to an increase in covered lives in the system owned health plan.

Expenses

Salaries and benefits increased $3.8 million or 3.2% as a result of the volume noted above. FTEs per AOB for the quarter declined from 4.33 to 4.27 due to a continued focus on daily labor management.
Supply cost as a % of net for the quarter increased slightly to 17.8% from 17.7% and is mainly due to the higher costs of specialty drugs.
Fees increased $1.0 million or 3.4% primarily due to an increase in physician fees.
Medical costs increased $5.1 million or 119% due to an increase in covered lives in the system owned health plan.

All other expenses increased $.4 million or 1.8% primarily due to an increase in maintenance contracts.
Interest expense declined by $.4 million or 3.5%.
Depreciation/Amortization expense declined by $2.5 million of 12.8%.

Operating EBITDA of $36.4 million was above the same quarter last year by $9.1 million or 33.1%.

Fiscal Year to Date (Three Quarters)

Net patient service revenue increased $52.1 million or 7.6% from the same quarter last year due to the volume increases listed above. **Other** revenue declined $17.8 million or 52.1% due mainly due an increase in minority interest related to the non-wholly owned hospitals and meaningful use dollars received in the prior year. **Premium** revenue increased $15.7 million or 273.1% due to an increase in covered lives in the system owned health plan.

Salaries and benefits (including contract labor) increased $6.4 million or 1.8% as a result of the volume noted above. FTEs per AOB of 4.36 declined from 4.54 for the prior fiscal year to date due to a continued focus on daily labor management.
Supply cost as a % of net for the fiscal year to date increase slightly to 17.8% from 17.7% in the prior fiscal year to date. The increase is mainly due to the higher costs of specialty drugs.
Fees increased $.6 million or 0.7% primarily due to an increase in physician fees.
Medical costs increased $14.6 million or 270.1% due to an increase in covered lives in the system owned health plan.
All other expenses increased $1.9 million or 2.5% primarily due to an increase in maintenance contracts.
Interest expense declined by $.5 million or 1.5%.
Depreciation/Amortization expense declined by $7.1 million or 12.1%.

Operating EBITDA of $103.1 million was above the same three quarters last year by $30.2 million or 41.5%.

Balance Sheet

The only significant changes were a result of the normal annual debt service payments. Other noteworthy items are: (1) increase in net accounts receivable of $15.9 million due to the increase in volume and increase in utilization of high deductible health plans resulting in an increase in patient liability and a longer collection cycle (2) decrease in the fair value of the interest rate swaps of $7.0 million and (3) increase in deferred income of $11.7 million. The deferred income is mainly related to investment earnings and will be included in earnings at the end of the fiscal year.

SBH-KINGSPORT 002183

Statistics:

The following table contains historical utilization statistics and payor mix for the quarters and fiscal years to date ended March 31, 2015 and March 31, 2014.

	Q3 FY15	Q3 FY14	YTD FY15	YTD FY14
Admissions	15,753	14,538	46,182	42,193
Observation Patients	5,630	5,871	17,469	18,434
Patients in Bed	**21,383**	**20,409**	**63,651**	**60,627**
Patient Days	74,833	71,613	213,313	204,452
Average Length of Stay	4.75	4.93	4.62	4.85
Average Daily Census (incl. observation patients)	894	861	842	813
Emergency Room Visits	62,282	58,322	190,768	178,093
Urgent Care Visits	24,890	23,063	72,384	64,959
Inpatient Surgeries	2,842	2,660	8,453	8,162
Outpatient Surgeries	5,977	5,923	18,817	17,511
Total Surgical Cases	**8,819**	**8,583**	**27,270**	**25,673**
FTEs	7,077	6,949	7,012	7,015
FTEs per AOB	4.27	4.33	4.36	4.54

Payor Mix	YTD FY15	YTD FY14
Medicare	29.6%	32.0%
Managed Medicare	21.3%	19.7%
TennCare/Medicaid	14.1%	14.5%
Mangaged Care/Other	27.8%	26.1%
Self-Pay	7.2%	7.7%
	100.0%	100.0%

SBH-KINGSPORT 002184

Daniel J. Sullivan
SBH-Kingsport Report
Information Reviewed

1. Tennessee *Guidelines for Growth*
2. Rules of Tennessee Health Services and Development Agency
3. Memorandum on the standard and scope of review in administrative appeals
4. HSDA file for SBH-Kingsport project (CN1312-050)
5. HSDA File for Crestwyn Behavioral Health (CN1310-040)
6. HSDA for Rolling Hills Hospital (CN1312-051)
7. HSDA file for TrustPoint Hospital (CN1502-006)
8. CON application for Indian Path Medical Center (CN9606-042)
9. Population Data from Tennessee Department of Health
10. Joint annual reports of hospitals for hospital provers in Northeastern Tennessee
11. Depositions of:
    a. Jim Shaheen
    b. Mike Garone
    c. Marlene Bailey
    d. Shane Hilton
    e. Kasey McDevitt
    f. Alan Levine
12. MSHA Deposition exhibits 14-66
13. Discovery responses by both parties
14. Mental Health, US, 2010, SAMSHA
15. Behavioral Health US, 2012, SAMSHA
16. County health rankings for Tennessee and Virginia, University of Wisconsin/RWJ Foundation
17. MSHA 2013 Bond Official Statement
18. Tennessee Health Care Financing Administration, FY2016 Budget Presentation
19. Grading the States, 2009, NAMI
20. Shrinking Inpatient Psychiatric Capacity: Cause for Celebration or Concern? National Health Policy Forum
21. The Shortage of Public Hospital Beds for Mentally Ill Persons: A Report of the Treatment Advocacy Center
22. Trends And Issues In Child And Adolescent Mental Health, Health Affairs
23. Survey Assesses Trends in Psychiatric Hospitalization Rates, NIMH
24. State Estimates of Adult Mental Illness from the 2011 and 2012 National Surveys on Drug Use and Health, SAMSHA
25. Behavioral Health Barometer, Tennessee, 2014, SAMSHA
26. MSHA Social Responsibility Plan, 2012
27. Mental Illness: Fact and Numbers, NAMI
28. Parity or Disparity: The State of Mental Health in America 2015, Mental Health America
29. Affordable Care Act Will Expand Mental Health and Substance Use Disorder Benefits and Parity Protections for 62 Million American, ASPE Policy Brief

HealthSouth Rehabilitation Hospital-Sullivan
2013 Inpatient Origin

County	Number of Admissions or Discharges	Number of Inpatient Days or Discharge	% of Total Discharges	Cumulative % of Discharges
Sullivan	406	5,979	47.8%	47.8%
Other Virginia	227	3,413	26.7%	74.6%
Hawkins	125	1,757	14.7%	89.3%
Washington	32	483	3.8%	93.1%
Harlan, KY	17	229	2.0%	95.1%
Greene	14	206	1.6%	96.7%
Dickenson, VA	12	167	1.4%	98.1%
Carter	3	50	0.4%	98.5%
Washington, VA	3	39	0.4%	98.8%
Hamblen	2	39	0.2%	99.1%
All Other States and Countries	2	19	0.2%	99.3%
Grainger	1	19	0.1%	99.4%
Johnson	1	20	0.1%	99.5%
Union	1	26	0.1%	99.6%
Dawson, GA	1	17	0.1%	99.8%
South Carolina	1	23	0.1%	99.9%
West Virginia	1	16	0.1%	100.0%
TOTAL	**849**	**12,502**	**100.0%**	

Source: Joint Annual Report of Hospitals

Wellmont Holston Valley Medical Center
2013 Inpatient Origin

County	Number of Admissions or Discharges	Number of Inpatient Days or Discharge Patient Days	% of Total Discharges	Cumulative % of Discharges
Sullivan	7,010	31,230	39.3%	39.3%
Hawkins	3,045	13,958	17.1%	56.4%
Other Virginia Counties	2,480	11,495	13.9%	70.3%
Scott, VA	1,803	8,005	10.1%	80.4%
Wise, VA	1,087	5,392	6.1%	86.5%
Washington	1,012	4,061	5.7%	92.2%
Greene	658	3,218	3.7%	95.9%
Other Kentucky Counties	33	1,338	0.2%	96.1%
Hancock	205	995	1.2%	97.2%
Carter	116	453	0.7%	97.9%
Hamblen	51	286	0.3%	98.2%
Unicoi	63	282	0.4%	98.5%
Pike, KY	36	261	0.2%	98.7%
Johnson	45	191	0.3%	99.0%
Perry, KY	17	174	0.1%	99.1%
Cocke	24	144	0.1%	99.2%
Grainger	20	140	0.1%	99.3%
Claiborne	14	68	0.1%	99.4%
Bradley	1	51	0.0%	99.4%
Other North Carolina Counties	17	50	0.1%	99.5%
Campbell	3	47	0.0%	99.5%
Knox	12	38	0.1%	99.6%
Sevier	12	35	0.1%	99.7%
Jefferson	8	29	0.0%	99.7%
Texas	5	23	0.0%	99.7%
Blount	4	21	0.0%	99.8%
Other Georgia Counties	6	16	0.0%	99.8%
Ashe, NC	3	15	0.0%	99.8%
Shelby	4	12	0.0%	99.8%
Wilson	3	12	0.0%	99.8%
Avery, NC	4	11	0.0%	99.9%
Williamson	2	10	0.0%	99.9%
Jackson, GA	1	10	0.0%	99.9%
Sequatchie	1	7	0.0%	99.9%
Cobb, GA	2	7	0.0%	99.9%
Tishomingo, MS	1	6	0.0%	99.9%
Hamilton	2	5	0.0%	99.9%
Monroe	2	5	0.0%	99.9%
Loudon	3	4	0.0%	99.9%
Obion	1	4	0.0%	99.9%
Roane	2	4	0.0%	100.0%
McMinn	1	3	0.0%	100.0%
Tuscaloosa, AL	1	3	0.0%	100.0%
St. Francis, AR	1	3	0.0%	100.0%
Stewart	1	2	0.0%	100.0%
Carroll	1	1	0.0%	100.0%
Union	1	1	0.0%	100.0%
Lee, AL	1	1	0.0%	
TOTAL	17,825	82,127	100.0%	

Source: Joint Annual Report of Hospitals

Wellmont Bristol Regional Medical Center
Psychiatric and Substance Abuse Discharges by County

County State	2011	2012	2013	2011	2012	2013
Washington, VA	309	351	409	25.5%	27.8%	31.1%
Sullivan, TN	207	239	289	17.1%	18.9%	21.9%
Wise, VA	178	183	137	14.7%	14.5%	10.4%
Smyth, VA	128	111	137	10.6%	8.8%	10.4%
Lee, VA	81	91	73	6.7%	7.2%	5.5%
Russell, VA	42	56	46	3.5%	4.4%	3.5%
Scott, VA	56	57	42	4.6%	4.5%	3.2%
Wythe, VA	53	47	39	4.4%	3.7%	3.0%
Dickenson, VA	31	23	37	2.6%	1.8%	2.8%
Buchanan, VA	31	33	28	2.6%	2.6%	2.1%
Tazewell, VA	56	42	25	4.6%	3.3%	1.9%
Hawkins, TN	7	11	14	0.6%	0.9%	1.1%
Washington, TN	9	8	11	0.7%	0.6%	0.8%
Carter, TN	7	6	11	0.6%	0.5%	0.8%
Grayson, VA	4	1	4	0.3%	0.1%	0.3%
Greene, TN	2		3	0.2%	0.0%	0.2%
Unicoi, TN	1	1	3	0.1%	0.1%	0.2%
Johnson, TN	5	1	2	0.4%	0.1%	0.2%
Hamblen, TN	1		2	0.1%	0.0%	0.2%
Cocke, TN			1	0.0%	0.0%	0.1%
Harlan, KY			1	0.0%	0.0%	0.1%
Madison, NC			1	0.0%	0.0%	0.1%
Hancock, TN	1	1	1	0.1%	0.1%	0.1%
Ashe, NC			1	0.0%	0.0%	0.1%
Letcher, KY	2	1		0.2%	0.1%	0.0%
Grand Total	**1,211**	**1,263**	**1,317**	**100.0%**	**100.0%**	**100.0%**

Source: MSHA, 000792

Strategic Behavioral Health-Kingsport
Historical and Projected Service Area Population

	2013					
	Tennessee		Virginia			
Cohort	Hawkins	Sullivan	Lee	Scott	Wise	Total
Under 18	11,651	30,323	4,822	4,237	8,290	59,322
18 to 64	34,807	95,805	15,777	13,673	26,114	186,177
65+	10,815	32,323	4,586	4,730	6,185	58,639
Total	57,273	158,451	25,185	22,640	40,589	304,138

	2015					
	Tennessee		Virginia			
Cohort	Hawkins	Sullivan	Lee	Scott	Wise	Total
Under 18	10,943	28,473	4,818	4,227	8,318	56,779
18 to 64	35,059	96,734	15,693	13,608	25,859	186,953
65+	11,739	34,287	4,647	4,891	6,459	62,023
Total	57,741	159,494	25,159	22,725	40,636	305,755

	2019					
	Tennessee		Virginia			
Cohort	Hawkins	Sullivan	Lee	Scott	Wise	Total
Under 18	8,989	23,553	4,809	4,204	8,389	49,943
18 to 64	35,827	99,677	15,485	13,444	25,233	189,667
65+	13,425	38,477	4,804	5,317	7,197	69,220
Total	58,241	161,707	25,098	22,965	40,819	308,830

	Annual % Change, 2013-2019					
	Tennessee		Virginia			
Cohort	Hawkins	Sullivan	Lee	Scott	Wise	Total
Under 18	-3.6%	-3.5%	0.0%	-0.1%	0.2%	-2.4%
18 to 64	0.4%	0.6%	-0.3%	-0.2%	-0.5%	0.3%
65+	3.1%	2.5%	0.7%	1.7%	2.2%	2.4%
Total	0.2%	0.3%	0.0%	0.2%	0.1%	0.2%

Source: Tennessee data: Tennessee Department of Health, Division of Policy, Planning and Assessment, Office of Health Statistics.

Source: Virginia data: US Census Bureau, Population and Housing Units Estimates; Weldon Cooper Center for Public Service, Demographics & Workforce Group, www.coopercenter.org/demographics/

Strategic Behavioral Health-Kingsport
Total Psychiatric Bed Need Under Guidelines for Growth Formula

	2015	2019
Total Service Area Population	305,755	308,830
Psychiatric Beds Needed per 100,000	30	30
Total Psychiatric Beds Needed	**92**	**93**
Existing Psychiatric Beds	12	12
Net Psychiatric Bed Need	**80**	**81**
SBH Proposed Beds	72	72

Strategic Behavioral Health-Kingsport
Adult Psychiatric Bed Need Under Guidelines for Growth Formula

	2015	2019
Service Area Population 18-64	186,953	189,667
Psychiatric Beds Needed per 100,000	30	30
Total Psychiatric Beds Needed	**56**	**57**
Existing Psychiatric Beds	12	12
Net Psychiatric Bed Need	**44**	**45**
SBH Proposed Beds (Including Chemical Dependency)	28	28

Strategic Behavioral Health-Kingsport
Child/Adolescent Psychiatric Bed Need Under Guidelines for Growth Formula

	2015	2019
Service Area Population Under 17	56,779	49,943
Psychiatric Beds Needed per 100,000	30	30
Total Psychiatric Beds Needed	**17**	**15**
Existing Psychiatric Beds	-	-
Net Psychiatric Bed Need	**17**	**15**
SBH Proposed Beds	28	28

Wellmont Bristol Regional Medical Center
Psychiatric Bed Utilization

	2011	2012	2013
Beds	12	12	12
Discharges	335	431	427
Patient Days	2,448	2,745	2,884
Average Length of Stay	7.3	6.4	6.8
Average Daily Census	6.7	7.5	7.9
Occupancy %	55.9%	62.5%	65.8%

Source: Joint Annual Reports of Hospitals

whw

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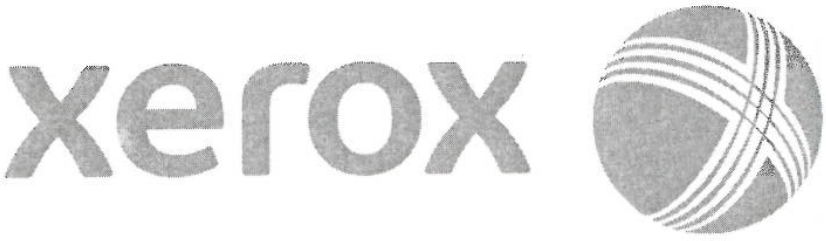

PATIENT FLOW SHEET

CENSUS: 68

DATE: 4/15

TIME: 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	19	14	5
Blocked Beds	0	0	0	0	0
Beds Available	0	0	7	0	7

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments (Admitted/Unit)
[redacted]	HVMC	M	41	2 hrs	Poplar/Cedar	

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PATIENT FLOW SHEET

CENSUS: 71

DATE: 1/2/15

TIME: 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	22	12	7
Blocked Rooms	ϕ	ϕ	ϕ	ϕ	ϕ
Beds Available	4	6	4	2	5

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	HVMC ED	F	30	12 HRS	Laurel/Cedar	
[redacted]	Takano	M	23	16 HRS	Cedar	

MSHA 001907

SBH-KINGSPORT 002196

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PATIENT FLOW SHEET

CENSUS: 69

DATE: 1-3-15

TIME: 0745

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	13	14	22	14	6
Blocked Rooms	0	0	0	0	0
Beds Available	1	2	4	0	6

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
0						

MSHA 001908

SBH-KINGSPORT 002197

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PATIENT FLOW SHEET

CENSUS:_____

DATE: 1/4/15
TIME: 7:40

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	13	16	24	13	7
Blocked Rooms	1	~~0~~	~~0~~	~~0~~	~~0~~
Beds Available	~~0~~	~~0~~	2	1	5

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	HVMC	F		12+	Laurel	
[redacted]	JCMC ED	M	43	4-5 hrs	laurel or cedar	

MSHA 001909

SBH-KINGSPORT 002198

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PATIENT FLOW SHEET

CENSUS 79

DATE: 1/5/15

TIME: 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	26	13	10
Blocked Rooms	619B	Ø	Ø	Ø	318B
Beds Available	Ø	Ø	Ø	1M	1M

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit:	Comments: (Admitted/Unit)
[redacted]	JUMC	F	52	1/3/15 1828	Laurel	
	JUMC 409	F	85	13hrs	Hawthorn	
	JUMC	M	51	2 hrs	Poplar	

MSHA 001910

SBH-KINGSPORT 002199

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PATIENT FLOW SHEET

CENSUS: 74

DATE: 1/6/15

TIME: 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	13	16	22	13	11
Blocked Beds	619B	0	0	0	318B
Beds Available	0	0	4	1M	0

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments (Admitted/Unit)
[redacted]	JTMC 409	F	65	17hrs	New Leaf	
	JTMC	M	30	6hrs	Cedar	

MSHA 001911

SBH-KINGSPORT 002200

PATIENT FLOW SHEET

CENSUS: 71

DATE: 01/07/15

TIME: 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	11	16 Full	22	13 Full	9
Blocked Rooms	Ø	Ø	Ø	412 B	Ø
Beds Available	3	Ø	4	Ø	3

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments (Admitted/Unit)
[redacted]	RMC	F	85	3 days	New Leaf	Will need re-eval

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PATIENT FLOW SHEET

CENSUS 75

DATE 4/8/15

TIME 2230

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Patients	12	16	25	13	9
Booked Beds	12	8	0	4+2	8
Beds Available	2	2	1F	8	3

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments (Admitted/Dnd)
0						

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PATIENT FLOW SHEET

CENSUS: 80

DATE: 1-9-15

TIME: 745

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	15	26	13	12
Blocked Rooms	0	0	0	412-15	0
Beds Available	0	1	0	0	0

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	Tazewell	F R M	32	11 hrs	Laurel/Poplar	
[redacted]	JCMC Peds	M	11	7 hrs	Willow	

MSHA 001914

SBH-KINGSPORT 002203

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PATIENT FLOW SHEET

CENSUS: 74

DATE: 1-10-15

TIME: 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	12	15	22	13	12
Blocked Rooms	618B	Ø	Ø	412B	Ø
Beds Available	1F	1F	4	Ø	Ø

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
Ø						

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PATIENT FLOW SHEET

CENSUS: 80

DATE: 1-11-15

TIME: 0800

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	13	14	24	13	12
Blocked Rooms	618B	∅	∅	412B	∅
Beds Available	∅	∅	∅	∅	∅

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments. (Admitted/Unit)
[redacted]	Unicoi	M	54	3 hrs	Laurel	
[redacted]	IPMU	M	38	1 hr	Laurel	

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PATIENT FLOW SHEET

CENSUS: 80

DATE: 1/12/15

TIME: 2230

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	13	16	26	13	12
Blocked Rooms	0	0	0	412B	0
Beds Available	1F	0	0	0	0

Name on Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	HUMC	M	55	Thurs	Poplar	
	HUMC	M	34	Thurs	Poplar	

MSHA 001917

SBH-KINGSPORT 002206

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PATIENT FLOW SHEET

CENSUS: 79

DATE: 1/13/15

TIME: 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	13	17	27	12	11
Blocked Rooms	0	0	0	412B	0
Beds Available	1F	0	0	1F	1M

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	VAMC	M	46	1hr	Poplar	

MSHA 001918

SBH-KINGSPORT 002207

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PATIENT FLOW SHEET

CENSUS: 81

DATE: 1/14/15

TIME: 0732

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	26	13	12
Blocked Rooms	0	0	0	0	0
Beds Available	0	0	0	1m	0

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult-	Potential Unit	Comments: (Admitted/Unit)
[redacted]	JRMC PICU	F	17	9hrs	Willow	
	JCCH ED	F	59	8hrs	Spruce/Poplar	
	HVMC	F	14	7hrs	Willow	
	BRMC	F	64	2hrs	Laurel/Cedar	

MSHA 001919

SBH-KINGSPORT 002208

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PATIENT FLOW SHEET

CENSUS: 72

DATE: 1/13/15

TIME: 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	13	15	21	11	12
Blocked Rooms	0	0	0	0	0
Beds Available	1m	1m	5	3	0

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
0						

MSHA 001920

SBH-KINGSPORT 002209

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PATIENT FLOW SHEET

CENSUS: 79

DATE: 1-17-15

TIME: 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	25	12	12
Blocked Rooms	Ø	Ø	Ø	Ø	Ø
Beds Available	Ø	Ø	1M	1M, 1F	Ø

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	Takoma	F	48	8 hrs	Poplar	
[redacted]	HVMC	F	34	6 hrs	Laurel	
[redacted]	HVMC	F	46	4 hrs	Poplar	

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PATIENT FLOW SHEET

CENSUS: 79

DATE: 1-16-14

TIME: 0800

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	15	25	13	12
Blocked Rooms	Ø	Ø	Ø	Ø	Ø
Beds Available	Ø	~~1F~~ 1M	1F	1F	Ø

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	HumCED	M	15	19 hrs	Willow	deferred 1/15/14. referred to other facilities due to Ø beds

MSHA 001922

SBH-KINGSPORT 002211

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PATIENT FLOW SHEET

CENSUS: 81

DATE: 1-18-15

TIME: 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	26	13	12
Blocked Rooms	Ø	Ø	Ø	412B	Ø
Beds Available	Ø	Ø	Ø	Ø	Ø

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult-	Potential Unit	Comments: (Admitted/Unit)
[redacted]	JCMCER	M	34	7 hrs	Cedar	
	JCMCER	F	28	1 hr	Poplar	
	SSHCP	F	16	8 hrs	Willow	

MSHA 001923

SBH-KINGSPORT 002212

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PATIENT FLOW SHEET

CENSUS: 84

DATE: 1/19/15

TIME: 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	17	26	13	12
Blocked Rooms	0	0	0	412B	0
Beds Available	0	0	0	0	0

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments (Admitted/Unit)
[redacted]	SSH	F	16	29 hrs	Willow	
	Laughlin	F	B	9 hrs	Willow	

MSHA 001924

SBH-KINGSPORT 002213

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 80

DATE: 1/21/15

TIME: 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	25	14	11
Blocked Rooms	618A	0	0	0	0
Beds Available	0	0	1m	0	1m

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
	SSH ICU	F			Poplar/Laurel	
	HVMC	M			Laurel/Cedar	
	BRMC	M			Cedar	
	BRMC	M			Cedar	
	BRMC	M			Poplar/Laurel	
	BRMC	F			Laurel/Cedar	
	Calm Center	M			Cedar/Laurel	
	HVMC	M			Poplar	
	Hawkins	F			Spruce	
	C	M			Poplar	
		M			Willow	

MSHA 001925

SBH-KINGSPORT 002214

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 81

DATE: 1-25-15

TIME: 0800

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	26	14	11
Blocked Rooms	0	0	0	0	0
Beds Available	0	0	0	0	1F

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	IPMC ED	M	11	31 hrs	Willow	
	JCMC 230	F	62	20 hrs	Spruce/	New Leaf
	BRMC ED	F	31	9 hrs	Poplar	
	NWGH PICU	M	12	11 hrs	Willow	

MSHA 001926

SBH-KINGSPORT 002215

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PATIENT FLOW SHEET

CENSUS: 80

DATE: 1-24-15

TIME: 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	25	13	12
Blocked Rooms	0	0	0	0	0
Beds Available	0	0	1M	1M	0

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	BPMC	F	64	11 hrs	New Leaf	
[redacted]	JPMC ED	M	16	16 hrs	Willow	
[redacted]	JPMC ED	M	20	5hrs	Cedar	
[redacted]	JCMC	M	53	13 hrs	Lar/Cede	
[redacted]	Laughlin	F	13	13 hrs	Willow	-accepted to Peninsula @ 8:00
[redacted]	HVMC	F	26	15 hrs	Poplar	

MSHA 001927

SBH-KINGSPORT 002216

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PATIENT FLOW SHEET

CENSUS: 78

DATE: 1-23-15

TIME: 0740

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census -	14	16	27	14	7
Blocked Rooms	Ø	Ø	Ø	Ø	Ø
Beds Available	Ø	Ø	Ø	Ø	5

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	Bristol Floor	M	50	4 days	Cedar	
	Bristol ER	F	47	3 days	Laurel / Cedar	
	JCMC ER	F	48	8 hrs	Spruce	
	BRMC ER	M	52	22 hrs	Spruce / Laurel	
	HVMC ER	M	44	11 hrs	Laurel / Cedar	
	SSH ED	F	34	7 hrs	Poplar	

MSHA 001928

SBH-KINGSPORT 002217

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 81

DATE: 1/22/15

TIME: 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	27	14	10
Blocked Rooms	0	0	0	0	0
Beds Available	0	0	0	0	2

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments (Admitted/Unit)
[redacted]	BRMC	M			Cedar	
	BRMC	M			Cedar	
	BRMC	F			Laurel/Cedar	
	HAWMC	M			Poplar	
	Hawkins	F			Spruce	
	CSU	F			Laurel	
	BRMC	F			Cedar	

MSHA 001929

SBH-KINGSPORT 002218

whw

MSHA 001930.pdf
07/26/15 10:24 AM

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 78

DATE: 2-1-15

TIME: 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	12	16	25	13	12
Blocked Rooms	Ø	0	0	410B	0
Beds Available	2F	0	1M	0	0

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	JCMC Peds	M	16	36 hrs	Willow	
[redacted]	BRMC ED	M	15	36 hrs	Willow	
[redacted]	BRMC	F	15	8 hrs	Willow	
[redacted]	UMCOL	F	16	5 hrs	Willow	
[redacted]	BRMC	F	59	12 hrs	Poplar/Spruce	
[redacted]	JCMC	M	77	8 hrs	Spruce/Laurel/Cedar	

MSHA 001930

SBH-KINGSPORT 002220

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 78

DATE: 2/2/15

TIME: 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	12	16	25	13	12
Blocked Rooms	0	0	0	4 (OB)	0
Beds Available	2	0	1F	0	0

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	BMC PICU	F	16	24 hrs	Willow	
	FWCH	M	16	2 hrs	Willow	
	Franklin	F	56	1/30/15	Dow 200	
	BMC	M	15	13 hrs	Willow	
	BMC	F	15	26 hrs	Willow	

MSHA 001931

SBH-KINGSPORT 002221

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 69

DATE: 2/3/15

TIME: 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	13	15	18	11	12
Blocked Rooms	0	0	0	410B	0
Beds Available	1M	1F	0	2	0

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	Home floor	F	76	15 hrs	New Leaf	
	Home floor	F	56	16 hrs	New Leaf	
	BRMC ED	M	15	2/1/15	Willow	
	Takoma	F	15	2 hrs	Willow	

MSHA 001932

SBH-KINGSPORT 002222

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 66

DATE: 2/4/15

TIME: 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	15	9	12
Blocked Rooms	0	0	0	4/DB	0
Beds Available	0	0	11	4	0

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	ICU floor	F	84	12 hrs	New Leaf	
	ICU floor	F	76	2/2/15	New Leaf	
	ICU floor	F	55	1/30/15	New Leaf	

MSHA 001933

SBH-KINGSPORT 002223

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 67

DATE: 2/5/15

TIME: 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	18	10	9
Blocked Rooms	0	0	0	0	0
Beds Available	0	0	8	4	3

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	3MC floor	F	84	2/3/15	Newleaf	
	BMC ED	F	48	3hrs	Laurel	
	3MC ED	M	47	2hrs	Laurel	
	BMC	M	38	5hrs	Cedar	

MSHA 001934

SBH-KINGSPORT 002224

Highly Confidential

PATIENT FLOW SHEET

CENSUS:_71_____ DATE: _2/6/15_____

TIME_0730_____

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	23	11	7
Blocked Rooms	0	0	0	0	0
Beds Available	0	0	3	3	5

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	JCCH	M	36	11 hours	Cedar/Laurel	
[redacted]	SSH ED	F	25	5 hours	Cedar/ Laurel	
[redacted]	Group Home	M	38	11 hours	Cedar/Laurel	
[redacted]	BRMC	M	38	18 hours	Cedar	

MSHA 001935

SBH-KINGSPORT 002225

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 74 DATE: 2/7/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	13	16	21	13	11
Blocked Rooms	0	0	0	0	0
Beds Available	1F	0	5	1M	1F

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)

MSHA 001936

SBH-KINGSPORT 002226

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 80 DATE: 2/8/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	26	14	10
Blocked Rooms	0	0	0	0	0
Beds Available	0	0	0	0	2

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	JCCH ED	M	39	5 hours	Poplar/Laurel	
[redacted]	JCMC ED	M	24	8 hours	Cedar/Laurel	
[redacted]	IPMC ED	M	59	4 hours	Any	
[redacted]	HVMC ED	M	32	13 hours	Laurel/Poplar	
[redacted]	CCS	M	41	7 hours	Poplar	

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 80

DATE: 2/9/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	15	17	24	13	12
Blocked Rooms	0	0	0	0	0
Beds Available	0	0	2	1	0

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	JCMC 6319	M	80	3/8/15	New Leaf	
[redacted]	VAMC	M	88	2 hrs	New Leaf	

MSHA 001938

SBH-KINGSPORT 002228

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 79 DATE: 2/10/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	26	14	9
Blocked Rooms	0	0	0	0	317b
Beds Available	0	0	0	0	2

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	JCMC	F	22		Spruce/Laurel	
[redacted]	IPMC	M	22		Poplar	PVT Room
[redacted]	HVMC	F	20		Poplar	
[redacted]	HVMC	M	37		Cedar	
[redacted]	HVMC	F	70		New Leaf	VRE MRSA
[redacted]	HVMC	M	44		Poplar	
[redacted]	HVMC	F	50		Laurel	
[redacted]	BRMC	F	43		Laurel	
[redacted]	Hawkins	M	21		Cedar	
[redacted]	Hancock	F	56		Laurel	

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PATIENT FLOW SHEET

CENSUS: 79

DATE: 2/11/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	13	17	24	14	11
Blocked Rooms	0	0	225b	0	317b
Beds Available	1 m	0	1 f	0	0

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	HVMC	M	37	2/9/15	Cedar	
[redacted]	HVMC	M	44	2/10/15	Laurel/Poplar	
[redacted]	Hawkins Co	M	21	3 hrs	Cedar	
[redacted]	Laughlin	M	15	2 hrs	Willow	

MSHA 001940

SBH-KINGSPORT 002230

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 73 DATE: 2/12/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	13	15	20	14	11
Blocked Rooms	0	0	225b	0	0
Beds Available	1 f	1 f	5	0	1 m

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	JCMC 7505	M	61	14 hrs	Spruce	
[redacted]	SSH ED	F	83	12 hrs	N.Leaf/Spruce	
[redacted]	CSU	M	35	7 hrs	Laurel	
[redacted]	Takoma	M	33	2/10/15	Cedar	
[redacted]	Takoma	F	14	12 hrs	Willow	
[redacted]	BRMC	M	43	7 hrs	Laurel	
[redacted]	HVMC	F	16	6 hrs	Willow	

MSHA 001941

SBH-KINGSPORT 002231

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 73

DATE: 2/13/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	12	14	22	14	11
Blocked Rooms	0	0	0	0	0
Beds Available	0	0	0	0	1M

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	Home	F	81	70 hours	New Leaf	
[redacted]	SSH ED	F	17	36 hours	Willow	
[redacted]	HVMC	F	76	18 hours	Spruce	

MSHA 001942

SBH-KINGSPORT 002232

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 80 DATE: 2/13/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	25	14	11
Blocked Rooms	0	0	225B	0	0
Beds Available	0	0	0	0	1M

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	HVMC ED	F	16	11 hours	Willow	
[redacted]	JCMC 7505	M	61	36 hours	New Leaf	
[redacted]	SSH 303	F	83	36 hours	Spruce/New Leaf	
[redacted]	Home	F	81	21 hours	New Leaf	
[redacted]	HVMC ED	F	31	12 hours	Laurel/Cedar	

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PATIENT FLOW SHEET

CENSUS: 73 DATE: 2/14/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	12	12	24	14	11
Blocked Rooms	0	0	225B	0	0
Beds Available	2M	0	1M	0	1M

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	Home	F	81	48 hours	New Leaf	
[redacted]	SSH ED	F	17	11 hours	Willow	

MSHA 001944

SBH-KINGSPORT 002234

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PATIENT FLOW SHEET

CENSUS: 69

DATE: 2/17/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	13	9	22	14	11
Blocked Rooms	0	0	0	0	0
Beds Available	1	7	4	0	1

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	BRMC	M	44		Cedar	
[redacted]	BRMC	F	55		Spruce	
[redacted]	BRMC	M	48		Cedar	
[redacted]	HVMC	M	78		New Leaf	

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 72

DATE: 2/18/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	12	14	23	14	9
Blocked Rooms	0	0	0	0	0
Beds Available	2	2	3	0	3

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	HVMC	M	78	2/17/15	New Leaf	

MSHA 001946

SBH-KINGSPORT 002236

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PATIENT FLOW SHEET

CENSUS: 68

DATE: 2/19/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	11	15	24	14	4
Blocked Rooms	0	0	0	0	0
Beds Available	3	1	2	0	8

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	HVMC	M	78	2/17/15	New Leaf	

MSHA 001947

SBH-KINGSPORT 002237

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 68 DATE: 2/20/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	15	23	13	3
Blocked Rooms	0	0	0	0	0
Beds Available	0	1 M	3	1 F	9

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	IPMC ED	F	20	2 hours	Cedar	

MSHA 001948

SBH-KINGSPORT 002238

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PATIENT FLOW SHEET

CENSUS: 69 DATE: 2/21/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	23	13	3
Blocked Rooms	0	0	0	0	0
Beds Available	0	0	3	1 F	9

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	HVMC ED	M	78	48 hours (since reconsult	New Leaf	
[redacted]	HVMC Floor	F	43	44 hours	Laurel	
[redacted]	HVMC Floor	F	70	36 hours	Cedar	Needs blocked room until culture comes back
[redacted]	Home	F	67	7 hours	New Leaf	
[redacted]	JCMC ED	F		9 hours	Laurel	

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PATIENT FLOW SHEET

CENSUS: 71 DATE: 2/22/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	24	14	3
Blocked Rooms	0	0	0	0	0
Beds Available	0	0	2	0	9

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	HVMC ED	M	78	2/17/15; reconsulted on 2/19/15	New Leaf	To be reconsulted today
[redacted]	HVMC Floor	F	43	2/19/15	Laurel	To be reconsulted today
[redacted]	HVMC Floor	F	70	2/19/15	Cedar	To be reconsulted today
[redacted]	Home	F	67	31 hours	New Leaf	
[redacted]	SSH ICU	F	18	21 hours	Laurel/Cedar	
[redacted]	IPMC ED	M	28	6 hours	Laurel/Cedar	

MSHA 001950

SBH-KINGSPORT 002240

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 73 DATE: 2/23/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	15	17	25	13	3
Blocked Rooms	0	0	0	0	0
Beds Available	0	0	1	1	9

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	JCMC ED	M	68	1 hr	N Leaf/Cedar	
[redacted]	SSH ICU	F	18	2/21./15	Laurel/Cedar	
[redacted]	SSH Floor	M	43	2/22/15	Laurel/Poplar	
[redacted]	HVMC	F	43	2/22/15	Laurel	
[redacted]	HVMC	F	70	2/22/15	Cedar/Spruce	
[redacted]	Home	F	67	2/20/15	Spruce	
[redacted]	Laughlin	M	19	2/22/15	Poplar	
[redacted]	Hawkins	M	36	2/23/15	Laurel	

MSHA 001951

SBH-KINGSPORT 002241

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 69 DATE: 2/24/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	14	23	13	5
Blocked Rooms	0	0	0	0	0
Beds Available	0	2	3	1	7

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	HVMC	M	78	2/22/15	New Leaf	
[redacted]	HVMC	F	70	2/22/15	New Leaf	MRSA/VRE

MSHA 001952

SBH-KINGSPORT 002242

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 63

DATE: 2/25/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	13	12	19	14	5
Blocked Rooms	0	0	0	0	0
Beds Available	1	4	7	0	7

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	HVMC	F	70	2/22/15	New Leaf	MRSA/VRE

Highly Confidential

PATIENT FLOW SHEET

CENSUS: _59_____ DATE: _2/26/15_____

TIME_0730_____

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	12	13	16	13	5
Blocked Rooms	0	0	0	411a	0
Beds Available	2	3	10	0	7

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	HVMC	F	68	1 hr	New Leaf	

MSHA 001954

SBH-KINGSPORT 002244

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 62

DATE: 2/27/15

TIME 0800

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	12	13	19	13	5
Blocked Rooms	0	514A	0	411A	0
Beds Available	2	2	7	0	7

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)

MSHA 001955

SBH-KINGSPORT 002245

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 66

DATE: 2/28/15

TIME 0800

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	12	20	12	7
Blocked Rooms	0	0	229B	411A	312A, 312B, 313A, 313B
Beds Available	0	4	5	1F	1M

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	JCMC floor	M	33	14 hours	Poplar	Pending medical stability
[redacted]	Jefferson Co	F	21	12 hours	Poplar	Pending medical stability

MSHA 001956

SBH-KINGSPORT 002246

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MSHA 001957.pdf
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PATIENT FLOW SHEET

CENSUS: 71 DATE: 3/1/15

TIME 0800

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	20	13	8
Blocked Rooms	0	0	229B	411A	312A, 312B, 313A, 313B
Beds Available	0	0	5	0	0

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)

MSHA 001957

SBH-KINGSPORT 002248

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 74

DATE: 3/2/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	12	15	24	13	10
Blocked Rooms	0	0	229b	411a	0
Beds Available	2	1	1	0	2

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
None						

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PATIENT FLOW SHEET

CENSUS: 78

DATE: 3/3/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	12	15	26	13	12
Blocked Rooms	0	0	0	411a	0
Beds Available	2	1	0	0	0

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	JCMC PEDS	F	17	9 hrs	Willow	
[redacted]	Hawkins Co	F	17	7 hrs	Willow	
[redacted]	HVMC	M	18	4 hrs	Cedar	
[redacted]	HVMC	M	39	3 hrs	Cedar	

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PATIENT FLOW SHEET

CENSUS: 77

DATE: 3/4/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	13	15	25	12	12
Blocked Rooms	0	0	0	411a	0
Beds Available	2	1	1	1	0

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
None						

MSHA 001960

SBH-KINGSPORT 002251

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 71 DATE: 3/5/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	13	14	22	10	12
Blocked Rooms	619b	0	0	408b 411a	0
Beds Available	0	2	4	2	0

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	JCMC	F	16	8 hrs	Willow	
[redacted]	BRMC	M	16	6 hrs	Willow	
[redacted]	BRMC	F	50	6 hrs	Cedar	
[redacted]	BRMC	F	12	5 hrs	Willow	

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 75 DATE: 3/6/15

TIME 0830

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	13	16	21	13	12
Blocked Rooms	0	0	0	0	0
Beds Available	1M	0	5	1F	0

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	Takoma ER	F	49	3 hours	Laurel	
[redacted]	BRMC ED	F	12	7 hours	Willow	

MSHA 001962

SBH-KINGSPORT 002253

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 70 DATE: 3/7/15

TIME 0800

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	15	16	14	11
Blocked Rooms	0	0	0	0	0
Beds Available	0	1M	10	0	1F

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	BRMC ED	F	48	11 hours	Cedar	

MSHA 001963

SBH-KINGSPORT 002254

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 81 DATE: 3/9/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	15	17	26	13	10
Blocked Rooms	0	0	0	0	0
Beds Available	0	0	0	1 f	2

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	HVMC	M	32	2/8/15	Laurel	
[redacted]	Hancock	F	56	2/8/15	Laurel	
[redacted]	HVMC	F	70	2/8/15	New Leaf	
[redacted]	HVMC	F	20	2/8 15	Poplar	
[redacted]	HVMC	M	37	7 hrs	Cedar	

MSHA 001964

SBH-KINGSPORT 002255

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 77 ___ DATE: 3/10/15

TIME_0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	17	22	13	11
Blocked Rooms	0	0	0	411a	0
Beds Available	0	0	4	0	1 m

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	SSH ED	F	13	6 hrs	Willow	
[redacted]	Laughlin	F	15	5 hrs	Willow	

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 78

DATE: 3/11/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	13	16	24	13	12
Blocked Rooms	0	0	0	411a	0
Beds Available	1	0	2	0	0

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	Laughlin	F	15	3/10/15	Willow	

MSHA 001966

SBH-KINGSPORT 002257

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 82 DATE: 3/12/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	15	17	26	13	11
Blocked Rooms	0	0	0	0	0
Beds Available	0	0	0	1	1

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	IPMC ICU	F	40	12 hrs	Poplar	
[redacted]	IPMC ED	M	60	6 hrs	Cedar/Laurel	
[redacted]	JCMC	M	39	1 hr	Poplar	
[redacted]	CSU	F	45	6 hrs	Laurel	
[redacted]	Takoma	M	43	11 hrs	Poplar	
[redacted]	BRMC	F	21	5 hrs	Poplar	
[redacted]	Hawkins	F	55	1 hr	Laurel	

MSHA 001967

SBH-KINGSPORT 002258

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 82

DATE 3/13/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	15	27	14	12
Blocked Rooms	0	0	0	0	0
Beds Available	0	1F	0	0	0

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments (Admitted/Unit)
[redacted]	JCMC ED	M	38	10 hrs	Laurel/Cedar	
[redacted]	JCMC PICU	M	17	16 hrs	Willow	
[redacted]	JCMC PICU	F	16	20 hrs	→	Peninsula Pending
[redacted]	Hawkins	M	52	24 hrs	Cedar	
[redacted]	Laughlin	F	22	14 hrs	Cedar	
[redacted]	Hawkins	F	55	27 hrs	any	

MSHA 001968

SBH-KINGSPORT 002259

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 81

DATE: 3-14-15

TIME: 0715

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)	
Census	14	16	26	14	11	
Blocked Rooms	0	0	0	0	0	
Beds Available	0	0	0	0	1	

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)	
[redacted]	JCMC	F		>12hr	Spruce/New	Lea C	
[redacted]	SSH ED	F	20	5hr	Poplar		
[redacted]	Tallman ICU	F	21	8hr	Poplar/Laurel		
[redacted]	BRMC ED	M	52	12hr	Poplar		
[redacted]	BRMC ED	F	14	10hr	Willow		
[redacted]	HVMC ED	M	57	>12hr	Poplar		

MSHA 001969

SBH-KINGSPORT 002260

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 80

DATE: 3-15-13

TIME: 0645

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	15	26	13	12
Blocked Rooms	0	0	0	0	0
Beds Available	0	1	0	1	0

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	JCMC	F	66	>24hr	NewLeaf/Cedar	
[redacted]	BRMC ED	F	14	>24hr	Willow	
[redacted]	IPMC	F	68	>12hr	Spruce/NewLeaf	
[redacted]	Takoma ED	M	29	2hr	Poplar	
[redacted]	BRMC ED	M	25	2hr	Poplar	
[redacted]	Home	M	90	4hr	NewLeaf	

MSHA 001970

SBH-KINGSPORT 002261

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 81 DATE: 3/16/15

TIME

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	26	14	11
Blocked Rooms	0	0	0	0	0
Beds Available	0	0	0	0	1 m

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	JCMC ED	M	47	6 hrs	Cedar	
[redacted]	JCMC ED	M	51	5 hrs	Poplar	
[redacted]	JCMC ED	F	48	5 hrs	Poplar	
[redacted]	JCMC ED	F	20	4 hrs	Cedar	
[redacted]	JCMC ED	M	42	2 hrs	Spruce/Laurel	
[redacted]	BRMC ED	F	14	3/13/15	Willow	
[redacted]	BRMC ED	M	44	3/15/15	Poplar	
[redacted]	Home	M	90	3/14/15	Spruce/NL	
[redacted]	HVMC	M	36	7 hrs	Laurel	
[redacted]	BRMC ICU	M	54	3/15/15	Poplar	

MSHA 001971

SBH-KINGSPORT 002262

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 74 DATE: 3/17/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	15	23	13	9
Blocked Rooms	0	0	0	0	0
Beds Available	0	1 m	3	1 f	4

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	BRMC	F	36	6 hrs	Laurel	

MSHA 001972

SBH-KINGSPORT 002263

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 75

DATE: 3/18/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	15	17	22	13	8
Blocked Rooms	0	0	0	408a	0
Beds Available	0	0	4	0	4

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	Hancock Co	M	29	7hrs	Cedar	
[redacted]	BRMC ED	M	50	7 hrs	Cedar	
[redacted]	HVMC Ed	M	48	5 hrs	Cedar	

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 70

DATE: 3-19-15

TIME: 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)	
Census	13	16	25	9	7	
Blocked Rooms	0	0	0	1	0	
Beds Available	1	0	1	4	5	

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)	
[redacted]	HVHED	M	48	>24	Cedar		
[redacted]	JCMC 2401	M	70	12	Cedar		
[redacted]	HVHMCED	M	51	8	Cedar		
[redacted]	HVHMC	M	57	4	Willow		
[redacted]	TRHMCED	M	18		Cedar		

MSHA 001974

SBH-KINGSPORT 002265

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 79

DATE: 3-20-15

TIME: 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)	
Census	13	17	27	13	9	
Blocked Rooms	0	0	0	1	0	
Beds Available	1	0	0	0	3	

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)	
[redacted]	HVMC	M	33	Cedar			
[redacted]	HVMC	M	22	Cedar			
[redacted]	HVMC	M	24	Cedar			
[redacted]	HVMC	F	43	Poplar			
[redacted]	Takoma	M	21	Laurel			
[redacted]	Hancock Co	M	63	Laurel/Cedar			

MSHA 001975

SBH-KINGSPORT 002266

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 79

DATE: 3/21/15

TIME 0800

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	15	26	13	11
Blocked Rooms	0	0	0	408A	0
Beds Available	0	1F	0	0	1M

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	JCMC ED	M	70	10 hours	Laurel/Cedar	
[redacted]	JCMC ED	M	44	7 hours	Laurel	
[redacted]	JCMC ED	M	44	14 hours	Poplar	
[redacted]	IPMC ICU	F	38	6 hours	Laurel	
[redacted]	JCMC ED	M	37	3 hours	Laurel/Poplar	
[redacted]	JCMC ED	M	21	1.5 hours	Poplar/Laurel	

MSHA 001976

SBH-KINGSPORT 002267

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 80

DATE: 3/22/15

TIME 0800

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	26	13	11
Blocked Rooms	0	0	0	408A	0
Beds Available	0	0	0	0	1M

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	BRMC Floor	F	69	Since 3/20	Cedar/Laurel	
[redacted]	HVMC	M	57	Since 3/20	Cedar/Laurel	
[redacted]	Laughlin	F	30	Since 3/20	Cedar	
[redacted]	HVMC ED	M	70	Since 3/20	Poplar/Spruce	
[redacted]	BRMC ICU	F	52	20 hours	Poplar	
[redacted]	IPMC ICU	F	57	18 hours	Laurel	
[redacted]	JCMC ED	M	28	13 hours	Poplar	
[redacted]	JCMC ED	M	30	13 hours	Laurel	
[redacted]	FWCH Floor	F	78	14 hours	Spruce/NL	
[redacted]	JCMC ED	M	48	11 hours	Poplar	
[redacted]	JCMC ED	M	45	2 hours	Laurel	

MSHA 001977

SBH-KINGSPORT 002268

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 81

DATE: 3/23/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	26	13	12
Blocked Rooms	0	0	0	408a	0
Beds Available	0	0	0	0	0

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	IPMC Floor	M	68	7 hrs	Spruce	
[redacted]	JCMC Floor	F	76	3/22/15	New Leaf	
[redacted]	IPMC Foor	F	36	3/22/15	Laurel	
[redacted]	FWCH	F	78	3/21/15	New Leaf	
[redacted]	BRMC	F	69	3/21/15	Spruce	
[redacted]	HVMC	M	57	3/21/15	Cedar/Laurel	
[redacted]	Lauglin	F	30	3/21/15	Cedar	
[redacted]	HVMC	M	70	3/21/15	Poplar/Spruce	Justin Gilliam HVMC Poplar
[redacted]	BRMC	F	52	3/21/15	Poplar	Jeremy Robertson Hawkins Cedar
[redacted]	HVMC	M	33	3/22/15	Poplar	Kimberly Allen Hawkins Poplar

MSHA 001978

SBH-KINGSPORT 002269

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 78

DATE: 3/24/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	11	16	26	13	12
Blocked Rooms	0	0	0	0	0
Beds Available	3	0	0	1 f	0

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	FWCH	F	78	3/21/15	New Leaf	
[redacted]	BRMC	F	69	3/21/15	Spruce/NL	
[redacted]	Home	M	70	3/21/15	Spruce/Poplar	
[redacted]	Home	F	82	3/23/15	New Leaf	
[redacted]	IPMC	M	68	3/23/15	NL /Spruce	

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 73

DATE: 3/25/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	12	13	22	14	12
Blocked Rooms	0	0	221b	0	0
Beds Available	2	3	4	0	0

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	BRMC	F	69	3/21/15	New Leaf	
[redacted]	Home	F	82	3/24/15	New Leaf	

MSHA 001980

SBH-KINGSPORT 002271

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 78

DATE: 3/26/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	24	14	10
Blocked Rooms	0	0	0	0	0
Beds Available	0	0	2	0	2

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	BRMC	F	69	3/21/15	New Leaf	
[redacted]	HVMC	M	31	6 hrs	Poplar	
[redacted]	Takoma	F	53	5 hrs	Poplar	

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 80 DATE: 3/27/15

TIME 0800

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	13	16	26	13	12
Blocked Rooms	619B	0	0	0	0
Beds Available	0	0	0	408A	0

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	BRMC Floor	M	33	Since 3/26	Cedar	
[redacted]	HCMH	F	21	Since 3/26	Poplar	
[redacted]	Takoma ED	M	58	Since 3/26	Spruce/ NL	
[redacted]	BRMC	F	27	Since 3/26	Laurel	
[redacted]	Laughlin	M	43	Since 3/26	Poplar	
[redacted]	IPMC Floor	M	68	Since 3/26	New Leaf	
[redacted]	HVMC ED	F	29	5 hours	Laurel	
[redacted]	HVMC ED	F	46	8 hours	Cedar	
[redacted]	JCMC ED	M	36	8 hours	Any	
[redacted]	IPMC ED	F	25	4 hours	Poplar	
[redacted]	JCMC ED	F	20	6 hours	Cedar	

MSHA 001982

SBH-KINGSPORT 002273

Highly Confidential

[redacted]	JCMC ED	M	42	10 hours	Poplar	

PATIENT FLOW SHEET (2)

CENSUS:_____ DATE: _____

TIME:_____

	Cedar (14)	Laurel (16)	Poplar (24)	Spruce (14)	Willow (12)
Census					
Blocked Rooms					
Beds Available					

MD RECOMMENDED TRANSFERS AT BED HUDDLE: (Room #'s)

CEDAR	LAUREL	POPLAR	SPRUCE	WILLOW	Comments:

REASON THE TRANSFERS ARE REMAINING: (Room #'s)

(Discussed @ 3:30pm)

CEDAR	Comments:	POPLAR	Comments:	WILLOW	Comments:
LAUREL		SPRUCE			

MSHA 001983

SBH-KINGSPORT 002274

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 79

DATE: 3/28/15

TIME 0800

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	13	16	26	14	10
Blocked Rooms	619B	0	0	0	0
Beds Available	0	0	0	0	2

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	BRMC Floor	M	33	Since 3/26	Cedar	
[redacted]	JCMC Floor	M	57	13 hours	Poplar	
[redacted]	Takoma ED	M	58	Since 3/26	Spruce/ NL	
[redacted]	BRMC ED	M	22	17 hours	Poplar	
[redacted]	Laughlin	M	43	Since 3/26	Poplar	
[redacted]	IPMC Floor	M	68	Since 3/26	New Leaf	
[redacted]	HVMC ED	M	34	12 hours	Cedar	
[redacted]	Hawkins Co ED	M	18	2 hours	Poplar	
[redacted]	Hawkins Co ED	M	57	22 hours	Poplar	
[redacted]	Laughlin ICU	M	24	22 hours	Poplar/Larl	
[redacted]	HVMC ED	M	47	22 hours	Poplar	

MSHA 001984

SBH-KINGSPORT 002275

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[redacted]	Takoma ED	F	40	15 hours	Cedar/Larl	
[redacted]	JCMC ED	F	20	5 hours	Poplar	

PATIENT FLOW SHEET (2)

CENSUS:_____ **DATE:** _____

TIME:_____

	Cedar (14)	Laurel (16)	Poplar (24)	Spruce (14)	Willow (12)
Census					
Blocked Rooms					
Beds Available					

MD RECOMMENDED TRANSFERS AT BED HUDDLE: (Room #'s)

CEDAR	LAUREL	POPLAR	SPRUCE	WILLOW	Comments:

REASON THE TRANSFERS ARE REMAINING: (Room #'s)

(Discussed @ 3:30pm)

CEDAR	Comments:	POPLAR	Comments:	WILLOW	Comments:

MSHA 001985

SBH-KINGSPORT 002276

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 80 DATE: 3/29/15

TIME 0800

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	13	16	26	14	11
Blocked Rooms	619B	0	0	0	0
Beds Available	0	0	0	0	1

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	BRMC ED	M	32	Since 3/27	Poplar	
[redacted]	Laughlin	M	43	Since 3/26	Poplar	
[redacted]	IPMC Floor	M	68	Since 3/26	New Leaf	
[redacted]	HVMC ED	M	34	Since 3/27	Cedar	
[redacted]	Hawkins Co ED	M	18	Since 3/27	Poplar	
[redacted]	Laughlin ICU	M	24	Since 3/27	Poplar/Larl	
[redacted]	HVMC ED	M	47	Since 3/27	Poplar	
[redacted]	Takoma ED	M	40	Since 3/27	Cedar/Larl	
[redacted]	JCMC Floor	F	22	22 hours	Poplar	
[redacted]	JCMC Floor	F	28	21 hours	Poplar	
[redacted]	IPMC Floor	M	50	18 hours	Laurel	

MSHA 001986

SBH-KINGSPORT 002277

Highly Confidential

[redacted]	JCMC Floor	F	47	18 hours	Poplar	
[redacted]	JCMC Floor	F	34	17 hours	Poplar	
[redacted]	SSH ED	M	24	15 hours	Cedar	
[redacted]	SSH ICU	M	30	13 hours	Cedar/Larl	
[redacted]	IPMC ED	M	53	13 hours	Poplar	
[redacted]	JCMC Floor	M	31	13 hours	Poplar	
[redacted]	IPMC ED	F	68	4 hours	Spruce/Larl	
[redacted]	Hawkins Co ED	M	33	12 hours	Poplar/Larl	

PATIENT FLOW SHEET (2)

CENSUS:_____ DATE: _____

TIME:_____

	Cedar (14)	Laurel (16)	Poplar (24)	Spruce (14)	Willow (12)
Census					
Blocked Rooms					
Beds Available					

MD RECOMMENDED TRANSFERS AT BED HUDDLE: (Room #'s)

CEDAR	LAUREL	POPLAR	SPRUCE	WILLOW	Comments:

MSHA 001987

SBH-KINGSPORT 002278

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 82 DATE: 3/30/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	13	17	27	14	11
Blocked Rooms	619b	0	0	0	0
Beds Available	0	0	0	0	1m

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	FWCH ED	F			Poplar	Devon Profitt BRMC Poplar
[redacted]	JCMC	F			Poplar	Daniel Cradic HVMC Cedar
[redacted]	IPMC	M			Laurel	Matthew Forbis HVMC Poplar
[redacted]	JCMC	F			Poplar	Douglas McMurray Hawkins Popl
[redacted]	JCMC	F			Poplar	Tara Godsey HVMC Cedar
[redacted]	SSH ICU	M			Laurel/Cedar	Susan Dalton Home Poplar
[redacted]	IPMC	M			New Leaf	Keith Hughes BRMC ED Laurel
[redacted]	Laughlin	M			Poplar	Johnny Davis HVMC ED Cedar
[redacted]	Laughlin	M			Poplar	Jonathan Fields HVMC Poplar
[redacted]	Takoma	F			Cedar	Linda Tipton HVMC ED Laurel

MSHA 001988

SBH-KINGSPORT 002279

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 79

DATE: 3/31/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	17	24	14	10
Blocked Rooms	0	0	1	0	0
Beds Available	0	0	1	0	2

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	Laughlin	M	24	72 hrs +	Laurel	May require re-eval
[redacted]	Hawkins Co ED	F	37	60 hrs +	Poplar	
[redacted]	HVMC ER	M	21	2 hrs	Cedar	
[redacted]	Laughlin ED	M	22	8 hrs	Cedar	

MSHA 001989

SBH-KINGSPORT 002280

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MSHA 001990.pdf
07/26/15 10:25 AM

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PATIENT FLOW SHEET

CENSUS: _76_____ DATE: _4/1/15_____

TIME__0730_____

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	13	15	24	13	11
Blocked Rooms	0	0	0	0	0
Beds Available	1	1	2	1	1

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
None						

MSHA 001990

SBH-KINGSPORT 002282

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 64

DATE: 4/2/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	7	13	20	13	11
Blocked Rooms	0	0	0	0	0
Beds Available	7	3	6	1	1

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	IPMC ED	F	13	8 hrs	Willow	

MSHA 001991

SBH-KINGSPORT 002283

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 63

DATE: 04/03/2015

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	Unit Closed	16	23	13	11
Blocked Rooms		0	0	0	0
Beds Available		0	3	1 male	1 male

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	Laughlin ED	M	35	6	Cedar	
[redacted]	Laughlin ED	F	15	13	Willow	

MSHA 001992

SBH-KINGSPORT 002284

Highly Confidential

PATIENT FLOW SHEET

CENSUS: _70___ ___

DATE: _4/4/15_____

TIME_0800_____

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	11	11	25	13	10
Blocked Rooms	0	0	0	0	0
Beds Available	3	5	1M	1M	1M, 1F

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)

MSHA 001993

SBH-KINGSPORT 002285

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 76

DATE: 4/5/15

TIME 0800

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	12	14	25	14	11
Blocked Rooms	0	0	0	0	0
Beds Available	2	2	1F	0	1M

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	HVMC ED	F	9	8 hours	Willow	

MSHA 001994

SBH-KINGSPORT 002286

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 69

DATE: 4/6/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	15	16	14	10
Blocked Rooms	0	0	0	0	0
Beds Available	0	2	10	0	2

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 74 DATE: 4/7/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	22	13	9
Blocked Rooms	0	0	0	410b	0
Beds Available	0	0	4	0	3

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
None						

MSHA 001996

SBH-KINGSPORT 002288

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 65 DATE: 4/8/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	13	13	17	12	10
Blocked Rooms	0	0	10 Water damage	0	0
Beds Available	1f	3	0	2	2

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
None						

Highly Confidential

PATIENT FLOW SHEET

DATE: 4/10/15

TIME_0800

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	15	22	13	11
Blocked Rooms	0	0	229A, 229B 230A, 230B	0	0
Beds Available	0	0	0	1F	1M

Name	Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]		BRMC	M	53	12 hours	Poplar	
[redacted]		Takoma	M	29	13 hours	Laurel	
[redacted]		HVMC ED	F	33	5 hours	Poplar	

MSHA 001998

SBH-KINGSPORT 002290

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 77

DATE: 4/11/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	12	25	14	12
Blocked Rooms	0	0	0	0	0
Beds Available	0	4	1F	0	0

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
none						

MSHA 001999

SBH-KINGSPORT 002291

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 81

DATE: 4/13/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	15	26	14	12
Blocked Rooms	0	0	0	0	0
Rooms Available	0	1 f	0	0	0

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	HVMC	M	31	7 hrs	Cedar/Laurel	
[redacted]	Russel Co Va	F	14	15hrs	Willow	

MSHA 002000

SBH-KINGSPORT 002292

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 78

DATE: 4/14/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	15	16	23	13	11
Blocked Rooms	0	0	0	0	0
Beds Available	0	0	3	1m	1f

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	HVMC	F	48	5 hrs	Cedar	
[redacted]	HVMC	M	20	2 hrs	Laurel	

MSHA 002001

SBH-KINGSPORT 002293

Highly Confidential

PATIENT FLOW SHEET

CENSUS:_81_____ DATE: _4/15/15_____

TIME_0730_____

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	15	16	26	14	10
Blocked Rooms	0	0	0	0	0
Beds Available	0	0	0	0	2

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	BRMC	M	41	5 hrs	Poplar	

MSHA 002002

SBH-KINGSPORT 002294

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 80

DATE: 4/16/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	25	14	11
Blocked Rooms	0	0	0	0	0
Beds Available	0	0	1 m	0	1 m

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	JCMC 2223	F	25	10 hrs	Poplar	
[redacted]	BRMC ICU	F	36	12 hrs	Laurel/Cedar	

MSHA 002003

SBH-KINGSPORT 002295

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 79 DATE: 4/17/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	15	24	14	12
Blocked Rooms	0	0	0	0	0
Beds Available	0	1M	2	0	0

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	Peds ED	F	17	6 hours	Willow	

MSHA 002004

SBH-KINGSPORT 002296

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 76 DATE: 4/18/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	12	16	25	11	12
Blocked Rooms	0	0	0	0	0
Beds Available	2	0	1	3	0

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	Peds Floor	F	17	31 hours	Willow	
[redacted]	Peds ED	F	16	8 hours	Willow	
[redacted]	Peds ED	M	12	7 hours	Willow	

MSHA 002005

SBH-KINGSPORT 002297

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 79

DATE: 4/19/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	25	12	12
Blocked Rooms	0	0	0	0	0
Beds Available	0	0	1 F	2	0

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	Peds 207	F	16	Since 4/18/15	Willow	
[redacted]	Peds 204	M	12	Since 4/18/15	Willow	

MSHA 002006

SBH-KINGSPORT 002298

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 79

DATE: 4/20/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	23	14	12
Blocked Rooms	0	0	0	0	0
Beds Available	0	0	3	0	0

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	JCMC 7403	F	77	11 hrs	Spruce	
[redacted]	PEDS 207	F	16	16 hrs	Willow	
[redacted]	PEDS 204	M	12	4/18/15	Willow	
[redacted]	BRMC ED	F	36	6 hrs	Cedar	
[redacted]	BRMC ED	M	16	7 hrs	Willow	
[redacted]	Home	F	77	22 hrs	New Leaf	

MSHA 002007

SBH-KINGSPORT 002299

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 74 DATE: 4/21/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	21	13	12
Blocked Rooms	0	0	0	0	0
Beds Available	0	0	5	1 f	0

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	JCMC PEDS	F	16	9 hrs	Willow	
[redacted]	Home	F	77	4/19/15	New Leaf	
[redacted]	BRMC	M	51	4 hrs	Cedar	
[redacted]	Hancock	M	16	11 hrs	Willow	
[redacted]	HVMC	M	83`	10 hrs	New Leaf	
[redacted]	Laughlin	M	27	6 hrs	Cedar	
[redacted]	HVMC	M	44	2 hrs	Cedar	
[redacted]	Laughlin	F	61	2 hrs	Cedar	
[redacted]	HVMC	M	83	4/20/15	New Leaf	

MSHA 002008

SBH-KINGSPORT 002300

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 82 DATE: 4/22/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	13	17	27	13	12
Blocked Rooms	617b	0	0	0	0
Beds Available	0	0	0	1 f	0

14

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	JCMC	F	33	12 hrs	Poplar	[redacted] Laughlin Poplar
[redacted]	HVMC	M	83	4/20/15	New Leaf	
[redacted]	HVMC	F	27	4/21/15	Cedar	
[redacted]	BRMC ICU	F	22	4/21/15	Poplar	
[redacted]	Holston Home	F	14	7 hrs	Willow	
[redacted]	JCMC	M	14	4/21/15	Willow	
[redacted]	Hancock	M	15	4/21/15	Willow	
[redacted]	VAMC	M	37	8 hrs	Poplar	
[redacted]	BRMC	M	52	4 hrs	Laurel	
[redacted]	Takoma	M	31	3 hrs	Cedar	

MSHA 002009

SBH-KINGSPORT 002301

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 80 DATE: 4/23/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	13	17	26	13	11
Blocked Rooms	617b	0	0	0	0
Beds Available	0	0	0	1f	1f

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	JCMC	M	14	4/21/15	Willow	Plus 10 pts waiting
[redacted]	IPMC ED	M	29	1 hr	Poplar	
[redacted]	JCCH	F	34	16hrs	Cedar	
[redacted]	UCMH	M	22	7 hrs	Laurel/Cedar	
[redacted]	JCMC ED	M	29	8 hrs	Cedar	
[redacted]	IPMC	M	27	4/22/15	Poplar	
[redacted]	BRMC	F	22	4/21/15	Poplar	
[redacted]	HVMC	F	27	4/21/15	Cedar	
[redacted]	Hancock	M	15	4/21/15	Willow	
[redacted]	HVMC	M	44	4/22/15	Cedar	

MSHA 002010

SBH-KINGSPORT 002302

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 80 DATE: 4/24/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	13	16	26	13	12
Blocked Rooms	617B	0	0	0	0
Beds Available	0	0	1 F	1M	0

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]ley	JCCH	F	34	Since 4/22	Cedar	
[redacted]oll	IPMC ED	F	35	16 hours	Larl/Cedr	
[redacted]	JCCH	M	45	10 hours	Poplar	
[redacted]	BRMC ICU	F	22	Since 4/21	Poplar	
[redacted]	Peds ED	M	12	15 hours	Willow	
[redacted]	IPMC ED	M	10	19 hours	Willow	
[redacted]	Home	F	41	Since 4/22	Poplar	
[redacted]	HVMC ED	M	9	11 hours	Willow	
[redacted]	HVMC ED	F	14	Since 4/20	Willow	
[redacted]	Holston Couns.	F	30	Since 4/22	Poplar	
[redacted]	Takoma ED	F	29	Since 4/21	Laurel	

MSHA 002011

SBH-KINGSPORT 002303

Highly Confidential

[redacted]	HVMC ED	F	28	12 hours	Poplar	
[redacted]	HVMC ED	F	14	7 hours	Willow	
[redacted]	BRMC ED	M	30	Since 4/22	Cedar/Larl	
[redacted]	Takoma ED	M	16	16 hours	Willow	
[redacted]	BRMC ED	M	31	Since 4/22	Larl/Cedar	
[redacted]	Takoma ED	M	14	Since 4/22	Willow	
[redacted]	JCMC	M	19	12 hours	Poplar/Larl	
[redacted]	SSH ED	F	81	10 hours	New Leaf	
[redacted]	HVMC ED	F	20	11 hours	Cedar	
[redacted]	JCMC ED	M	30	13 hours	Cedar/Larl	
[redacted]	SSH ED	M	24	5 hours	Larl/Cedar	

PATIENT FLOW SHEET (2)

CENSUS:_____ DATE: _____

TIME:_____

	Cedar (14)	Laurel (16)	Poplar (24)	Spruce (14)	Willow (12)
Census					
Blocked Rooms					
Beds Available					

MD RECOMMENDED TRANSFERS AT BED HUDDLE: (Room #'s)

CEDAR	LAUREL	POPLAR	SPRUCE	WILLOW	Comments:

MSHA 002012

SBH-KINGSPORT 002304

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 81

DATE: 4/25/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	26	13	12
Blocked Rooms	0	0	0	0	0
Beds Available	0	0	0	1M	0

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	HVMC ED	M	9	Since 4/23	Willow	
[redacted]	HVMC ED	F	14	Since 4/23	Willow	
[redacted]	HVMC ED	F	14	Since 4/24	Willow	
[redacted]	BRMC ED	M	30	Since 4/22	Cedar/Larl	
[redacted]	Takoma ED	M	16	Since 4/23	Willow	
[redacted]	BRMC ED	M	31	Since 4/22	Larl/Cedar	
[redacted]	Takoma ED	M	14	Since 4/22	Willow	
[redacted]	BRMC Floor	F	17	Since 4/24	Willow	
[redacted]	HVMC	M	52	Since 4/24	Larl/Spruce	
[redacted]	HVMC Floor	F	25	Since 4/24	Poplar	
[redacted]	JCMC ED	M	39	7 hours	Poplar	

MSHA 002013

SBH-KINGSPORT 002305

Highly Confidential

[redacted]	IPMC ED	M	42	6 hours	Poplar	
[redacted]	BRMC ED	M	32	6 hours	Poplar	
[redacted]	CSU	M	35	5 hours	Poplar	
[redacted]	BRMC ED	M	22	4 hours	Poplar/Larl	
[redacted]	JCMC ED	M	26	10 hours	Larl/Cedar	
[redacted]	SSH ED	M	32	6 hours	Larl/Cedar	
[redacted]	HVMC Floor	M	83	8 hours	New Leaf	
[redacted]	HVMC ED	M	61	10 hours	Spruce	
[redacted]	BRMC ED	M	66	Since 4/24	Cedar/Spruce	
[redacted]	Laughlin	F	51	Since 4/24	Cedar	

PATIENT FLOW SHEET (2)

CENSUS:_____ DATE: _____

TIME:_____

	Cedar (14)	Laurel (16)	Poplar (24)	Spruce (14)	Willow (12)
Census					
Blocked Rooms					
Beds Available					

MD RECOMMENDED TRANSFERS AT BED HUDDLE: (Room #'s)

CEDAR	LAUREL	POPLAR	SPRUCE	WILLOW	Comments:

MSHA 002014

SBH-KINGSPORT 002306

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 82

DATE: 4/26/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	26	14	12
Blocked Rooms	0	0	0	0	0
Beds Available	0	0	0	0	0

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	HVMC ED	M	9	Since 4/23	Willow	
[redacted]	HVMC ED	F	14	Since 4/23	Willow	
[redacted]	HVMC ED	F	14	Since 4/24	Willow	
[redacted]	Takoma ED	M	16	Since 4/23	Willow	
[redacted]	BRMC Floor	F	17	Since 4/24	Willow	
[redacted]	HVMC	M	52	Since 4/24	Larl/Spruce	
[redacted]	CSU	M	35	Since 4/25	Poplar	
[redacted]g	HVMC Floor	M	83	Since 4/25	New Leaf	
[redacted]	HVMC ED	M	61	10 hours	Spruce	
[redacted]	BRMC ED	M	66	Since 4/24	Cedar/Spruce	
[redacted]	BRMC ED	M	43	Since 4/25	Cedar	

MSHA 002015

SBH-KINGSPORT 002307

Highly Confidential

[redacted]	JCMC Floor	F	29	19 hours	Poplar	
[redacted]	JCMC ED	F	33	15 hours	Cedar	
[redacted]	BRMC ED	M	32	8 hours	Poplar	
[redacted]	Unicoi ED	F	22	10 hours	Cedar	
[redacted]	HVMC ED	M	8	10 hours	Willow	
[redacted]	Hawkins Co ED	M	34	9 hours	Poplar	
[redacted]	BRMC ED	M	39	5 hours	Laurel	
[redacted]	IPMC ED	F	48	6 hours	Cedar	
[redacted]	JCMC ED	M	28	4 hours	Poplar	

PATIENT FLOW SHEET (2)

CENSUS:_____ DATE: _____

TIME:_____

	Cedar (14)	Laurel (16)	Poplar (24)	Spruce (14)	Willow (12)
Census					
Blocked Rooms					
Beds Available					

MD RECOMMENDED TRANSFERS AT BED HUDDLE: (Room #'s)

CEDAR	LAUREL	POPLAR	SPRUCE	WILLOW	Comments:

MSHA 002016

SBH-KINGSPORT 002308

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 82 DATE: 4/27/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	26	14	12
Blocked Rooms	0	0	0	0	0
Beds Available	0	0	0	0	0

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	JCMC ED	M	46	12 hrs	Laurel	Plus 7 waiting
[redacted]	JCMC ED	F	20	14 hrs	Laurel	
[redacted]	UCMH	F	22	4/25/15	Cedar	
[redacted]	Home	F	14	4/24/15	Willow	
[redacted]	HVMC ED	F	14	2/24/15	Willow	
[redacted]	BRMC	F	17	4/24/15	Willow	
[redacted]	Laughlin	M	42	4/26/15	Poplar	
[redacted]	HVMC	M	52	4/25/15	Spruce	
[redacted]	HVMC	M	61	4/25/15	Spruce	
[redacted]	BRMC	M	43	4/25/15	Cedar	

MSHA 002017

SBH-KINGSPORT 002309

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 77

DATE: 4/28/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	13	16	24	13	11
Blocked Rooms	0	0	0	0	0
Beds Available	1 f	0	2	1m	1m

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	JCMC ED	F	83	1 hr	Spruce	
[redacted]	UCMH	M	80	4/27/15	New Leaf	
[redacted]	IPMC	M	88	6 hrs	New Leaf	
[redacted]	BRMC	F	17	4/24/15	Willow	
[redacted]	BRMC	M	43	4/25/15	Cedar	
[redacted]	Takoma	M	28	4/27/15	Cedar	
[redacted]	Laughlin	M	28	5 hrs	Cedar	

MSHA 002018

SBH-KINGSPORT 002310

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 77 DATE: 4/29/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	23	14	10
Blocked Rooms	0	0	0	0	0
Beds Available	0	0	3	0	2

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	UCMH	M	80	4/27/15	New Leaf	
[redacted]	IPMC	M	88	4/28/15	New Leaf	
[redacted]	SSH	F	77	7 hrs	New Leaf	
[redacted]	IPMC	M	34	1 hr	Cedar/Laurel	
[redacted]	Laughlin	M	28	4/28/15	Cedar	

MSHA 002019

SBH-KINGSPORT 002311

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 75 DATE: 4/30/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	23	13	9
Blocked Rooms	0	0	0	0	0
Beds Available	0	0	3	1	3

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	IPMC ED	M	88	58 hr	New Leaf	S Patel accepted pt 4/29/15
[redacted]	BRMC ED	M	27	10 hr +	Laurel	
[redacted]	HVMC ED	M	71	12 hr	New Leaf	

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 80

DATE: 5/1/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	18	24	13	11
Blocked Rooms	0	0	0	0	0
Beds Available	0	0	2	1M	1M

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	HVMC ED	F	20	Since 4/28	Cedar	
[redacted]	IPMC ED	F	13	5 hours	Willow	

MSHA 002021

SBH-KINGSPORT 002313

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MSHA 002022.pdf
07/26/15 10:26 AM

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PATIENT FLOW SHEET

CENSUS: 75 DATE: 5/2/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	13	15	25	11	11
Blocked Rooms	0	516A	0	409B	0
Beds Available	1F	0	1F	1M, 1F	1M

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	Peds Floor	F	13	Since 5/1/15	Willow	
[redacted]	HVMC Floor	M	72	Since 4/29/15	New Leaf	
[redacted]	Unicoi ED	F	14	Since 5/1/15	Willow	
[redacted]	Peds Floor	F	17	Since 5/1/15	Willow	
[redacted]	IPMC ED	M	81	10 hours	New Leaf	
[redacted]	SSH ED	F	14	10 hours	Willow	
[redacted]	HVMC ED	F	15	6 hours	Willow	
[redacted]	Hawkins Co	M	49	8 hours	Poplar	

PATIENT FLOW SHEET (2)

MSHA 002022

SBH-KINGSPORT 002315

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PATIENT FLOW SHEET

CENSUS: 79 DATE: 5/3/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	13	16	26	13	11
Blocked Rooms	0	0	0	0	0
Beds Available	1M	0	0	1M	1M

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	Peds Floor	F	13	Since 5/1/15	Willow	
[redacted]	HVMC Floor	M	72	Since 4/29/15	New Leaf	
[redacted]	Peds Floor	F	17	Since 5/1/15	Willow	
[redacted]	IPMC ED	M	81	10 hours	New Leaf	
[redacted]	SSH ED	F	14	10 hours	Willow	
[redacted]	HVMC ED	F	15	6 hours	Willow	
[redacted]	JCMC ED	F	50	8 hours	Larl/Cedar	
[redacted]	SSH ED	F	71	4 hours	New Leaf	
[redacted]	JCMC ED	F	47	5 hours	Poplar	
[redacted]	BRMC ED	M	24	7 hours	Cedar/Larl	

MSHA 002023

SBH-KINGSPORT 002316

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PATIENT FLOW SHEET

CENSUS: 82

DATE: 5/4/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	26	14	12
Blocked Rooms	0	0	0	0	0
Beds Available	0	0	0	0	0

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	JCMC PEDS	F	13	5/1/15	Willow	
[redacted]	JCMC PEDS	F	17	5/1/15	Willow	
[redacted]	SSH ED	F	71	5/3/15	New Leaf	
[redacted]	HVMC	M	72	5/1/15	New Leaf	
[redacted]	HVMC	F	15	5/2/15	Willow	
[redacted]	BRMC	F	14	5/3/15	Willow	
[redacted]	Hawkins Co	F	57	5/3/15	Cedar	
[redacted]	JCMC ED	M	31	6 hrs	Poplar	
[redacted]	JCMC Floor	F	34	5/3/15	Laurel	
[redacted]	Hawkins Co	M	69	2 hrs	New Leaf	

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SBH-KINGSPORT 002317

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PATIENT FLOW SHEET

CENSUS: 83 DATE: 5/5/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	27	14	12
Blocked Rooms	0	0	0	0	0
Beds Available	0	0	0	0	0

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	JCMC ED	M	19	5/4/15	Poplar	[redacted]
[redacted]	FWCH ED	M	52	5/4/15	Laurel	[redacted]
[redacted]	IPMC ED	F	12	5/4/15	Willow	[redacted]
[redacted]	JCMC ED	M	35	7 hrs	Poplar	[redacted]
[redacted]	HVMC ED	F	15	5/2/15	Willow	
[redacted]	BRMC	F	14	5/3/15	Willow	
[redacted]	Hawkins Co	F	57	5/3/15	Willow	
[redacted]	Hawkins Co	F	63	5/4/15	Spruce	
[redacted]	BRMC	F	14	5/4/15	Willow	
[redacted]	BRMC	F	40	5/4/15	Cedar	

MSHA 002025

SBH-KINGSPORT 002318

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PATIENT FLOW SHEET

CENSUS: 82

DATE: 5/6/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	26	14	11
Blocked Rooms	0	0	0	0	0
Beds Available	0	0	0	0	1m

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	IPMC	M	82	8 hrs	New Leaf	[redacted]
[redacted]	JCCH ED	F	44	10 hrs	Laurel	[redacted]
[redacted]	JCMC CPC	M	66	9 hrs	Laurel	
[redacted]	Hawkins Co	F	57	5/3/15	Cedar	
[redacted]	Hawkins Co	F	63	5/4/15	Spruce	
[redacted]	BRMC ED	F	14	5/4/15	Willow	
[redacted]	BRMC	F	40	5/4/15	Cedar	
[redacted]	HVMC	M	24	5/4/15	Cedar	
[redacted]	Hawkins	F	39	5/4/15	Poplar	
[redacted]	HVMC	M	4	5/5/15	Cedar	

MSHA 002026

SBH-KINGSPORT 002319

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PATIENT FLOW SHEET

CENSUS: 81 DATE: 5/7/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	17	25	14	11
Blocked Rooms	0	0	0	0	0
Beds Available	0	0	1F	0	1 M

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	JCMC ED	M	26	5/6/15	Cedar	[redacted]
[redacted]	JCMC ED	M	52	5 hrs	Laurel	[redacted]
[redacted]	IPMC ED	F	62	5/6/15	Spruce/Cedar	
[redacted]	JCMC ED	M	29	5 hrs	Cedar	
[redacted]	BRMC	F	11	6 hrs	Willow	
[redacted]	Laughlin	M	43	8 hrs	Poplar	
[redacted]	Takoma	M	51	8 hrs	Cedar	
[redacted]	SSH ED	F	86	8 hrs	New Leaf	
[redacted]	HVMC	F	34	8 hrs	Poplar	
[redacted]	HVMC	M	60	6 hrs	Laurel	

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PATIENT FLOW SHEET

CENSUS: 81

DATE: 5/8/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	26	13	12
Blocked Rooms	0	0	0	0	0
Beds Available	0	0	0	1F	0

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	HVMC Floor	M	72	Since 5/5/15	New Leaf	
[redacted]	HVMC ED	M	60	Since 5/6/15	Cedar/Lari	
[redacted]	Unicoi ED	M	73	Since 5/7/15	New Leaf	
[redacted]	HVMC ED	M	61	Since 5/7/15	Spruce	
[redacted]	HVMC ED	M	21	Since 5/7/15	Cedar	
[redacted]	HVMC ED	M	36	7 hours	Poplar	
[redacted]	Takoma ED	F	40	10 hours	Poplar	
[redacted]	HVMC ED	M	48	3 hours	Poplar	

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PATIENT FLOW SHEET

CENSUS: 80

DATE: 5/9/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	26	14	10
Blocked Rooms	0	0	0	0	0
Beds Available	0	0	0	0	2

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	HVMC ED	M	36	Since 5/8/15	Poplar	
[redacted]	HVMC ED	M	48	Since 5/8/15	Poplar	
[redacted]	Takoma ED	M	43	Since 5/8/15	Poplar	
[redacted]	HVMC ED	M	43	Since 5/8/15	Laurel	
[redacted]	BRMC ED	M	61	Since 5/8/15	Larl/Cedar	
[redacted]	HVMC ED	M	79	Since 5/8/15	New Leaf	
[redacted]	JCMC ED	M	49	10 hours	Larl/Cedar	
[redacted]	JCMC ED	M	51	12 hours	Poplar	
[redacted]	JCMC ED	M	47	19 hours	Poplar	
[redacted]	IPMC ED	F	39	3 hours	Poplar	
[redacted]	IPMC ED	M	34	5 hours	Larl/Cedar	

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[redacted]	Takoma	F	49	10 hours	Laurel	
[redacted]	Hawkins Co	F	12	6 hours	Willow	
[redacted]	HVMC ED	F	57	7 hours	Spruce/Poplar	
[redacted]	Hawkins Co	M	24	10 hours	Cedar	

PATIENT FLOW SHEET (2)

CENSUS:_____ **DATE:** _____

TIME:_____

	Cedar (14)	Laurel (16)	Poplar (24)	Spruce (14)	Willow (12)
Census					
Blocked Rooms					
Beds Available					

MD RECOMMENDED TRANSFERS AT BED HUDDLE: (Room #'s)

CEDAR	LAUREL	POPLAR	SPRUCE	WILLOW	Comments:

REASON THE TRANSFERS ARE REMAINING: (Room #'s)

(Discussed @ 3:30pm)

MSHA 002030

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PATIENT FLOW SHEET

CENSUS: 81

DATE: 5/10/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	26	14	11
Blocked Rooms	0	0	0	0	0
Beds Available	0	0	0	0	1M

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	Takoma ED	M	43	Since 5/8/15	Poplar	
[redacted]	HVMC ED	M	43	Since 5/8/15	Laurel	
[redacted]	BRMC ED	M	61	Since 5/8/15	Larl/Cedar	
[redacted]	Takoma ED	F	49	Since 5/9/15	Laruel/Spruce	
[redacted]	SSH ED	M	23	2 hours	Poplar	
[redacted]	JCMC ED	F	50	Since 5/9/15	Poplar	
[redacted]	JCMC ED	F	32	Since 5/9/15	Laurel	
[redacted]	JCMC ED	M	47	Since 5/9/15	Laurel	
[redacted]	IPMC ED	M	60	Since 5/9/15	Poplar	
[redacted]	JCMC ED	M	32	Since 5/9/15	Poplar	
[redacted]	JCMC ED	M	54	6 hours	Poplar	

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[redacted]	JCMC ED	F	41	2 hours	Cedar	
[redacted]	JCMC ED	M	19	Since 5/9/15	Poplar	
[redacted]	HVMC ED	M	31	7 hours	Poplar	
[redacted]	HVMC ED	M	60	5 hours	Spruce	
[redacted]	Hawkins Co	M	27	Since 5/9/15	Poplar	

PATIENT FLOW SHEET (2)

CENSUS:_____ DATE: _____

TIME:_____

	Cedar (14)	Laurel (16)	Poplar (24)	Spruce (14)	Willow (12)
Census					
Blocked Rooms					
Beds Available					

MD RECOMMENDED TRANSFERS AT BED HUDDLE: (Room #'s)

CEDAR	LAUREL	POPLAR	SPRUCE	WILLOW	Comments:

REASON THE TRANSFERS ARE REMAINING: (Room #'s)

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PATIENT FLOW SHEET

CENSUS: 82 DATE: 5/11/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	27	14	11
Blocked Rooms	0	0	0	0	0
Beds Available	0	0	0	0	1 m

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	IPMC ED	M	37	11 hrs	Laurel	David Quesenberry Hawkins Popl
[redacted]	IPMC ED	M	53	10 hrs	Laurel/Cedar	Kmica Miller Hawkins Cedar
[redacted]	IPMC ED	F	52	9 hrs	Cedar	Crystal Wanner HVMC Poplar
[redacted]	JCMC Floor	F	44	8 hrs	Poplar	
[redacted]	Takoma	M	43	5/8/15	Poplar	
[redacted]	HVMC	M	43	5/9/15	Laurel	
[redacted]	BRMC	M	61	5/8/15	Cedar	
[redacted]	Takoma	F	49	5/9/15	Spruce/Laurel	
[redacted]	HVMC	M	60	5/10/15	Spruce	
[redacted]	HVMC	M	31	5/10/15	Laurel/Poplar	

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PATIENT FLOW SHEET

CENSUS: 80

DATE: 5/12/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	24	14	12
Blocked Rooms	0	0	0	0	0
Beds Available	0	0	2	0	0

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	HVMC	M	43	5/9/15	Laurel	
[redacted]	BRMC	M	61	5/8/15	Cedar	
[redacted]	Hawkins Co	M	27	5/9/15	Poplar	
[redacted]	HVMC	M	31	5/10/15	Laurel	
[redacted]	HVMC	M	60	5/10/15	Cedar	
[redacted]	HVMC	F	36	5/11/15	Laurel	
[redacted]	Hawkins Co	F	41	5/11/15	Laurel	
[redacted]	Hancock Co	M	63	6 hrs	Cedar/Laurel	
[redacted]	HVMC	M	17	3 hrs	Willow	

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SBH-KINGSPORT 002327

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PATIENT FLOW SHEET

CENSUS: 79

DATE: 5/13/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	13	16	26	13	11
Blocked Rooms	0	0	0	0	0
Beds Available	1 f	0	0	1 m	1 m

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
None						

MSHA 002035

SBH-KINGSPORT 002328

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PATIENT FLOW SHEET

CENSUS: 79 ____ DATE: 5/14/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	25	13	10
Blocked Rooms	0	0	0	0	0
Beds Available	0	0	1 m	1 f	2

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	HVMC	M	60	1 hr	Laurel/Cedar	

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PATIENT FLOW SHEET

CENSUS:_77_____ DATE: _5/15/15_____

TIME_0730_____

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	23	14	10
Blocked Rooms	0	0	0	0	0
Beds Available	0	0	3	0	2

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	SSH ED	F	71	9 hours	New Leaf	
[redacted]	JCMC ED	M	25	12 hours	Cedar/Larl	
[redacted]	JCMC ED	F	39	12 hours	Larl/Cedar	

PATIENT FLOW SHEET (2)

MSHA 002037

SBH-KINGSPORT 002330

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PATIENT FLOW SHEET

CENSUS: 77 DATE: 5/16/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	15	25	12	11
Blocked Rooms	0	0	0	0	0
Beds Available	0	1F	1M	2	0

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)

PATIENT FLOW SHEET (2)

MSHA 002038

SBH-KINGSPORT 002331

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PATIENT FLOW SHEET

CENSUS: 80 DATE: 5/17/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	25	14	11
Blocked Rooms	0	0	0	0	0
Beds Available	0	0	1F	0	1F

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	IPMC Floor	F	66	Since 5/15/15	New Leaf	
[redacted]	SSH ICU	M	35	Since 5/16/15	Laurel	
[redacted]	HVMC ED	M	40	Since 5/16/15	Cedar	
[redacted]	BRMC	F	41	14 hours	Cedar/Larl	
[redacted]	HVMC	M	61	8 hours	Spruce	

PATIENT FLOW SHEET (2)

MSHA 002039

SBH-KINGSPORT 002332

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PATIENT FLOW SHEET

CENSUS: 81

DATE: 05/18/2015

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	26	14	11
Blocked Rooms	0	0	0	0	0
Beds Available	0	0	0	0	1

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	JCCH ER	M	76	8	New Leaf	
[redacted]	Unicoi ER	F	22	12+	Laurel/Cedar	
[redacted]	SSH ER	F	55	18+	Laurel/Cedar	
[redacted]	SSH ICU	M	35	24+	Laurel	
[redacted]	IPMC 5th Floor	F	66	50 +	Spruce/NL	Will need re-eval
[redacted]	HVMC Floor	M	35	48 +	Cedar	Will need re-eval
[redacted]	Takoma ED	M	40	8	Poplar	
[redacted]	Hawkins Co ED	M	51	12+	Cedar	
[redacted]	HVMC ER	M	61	30+	Spruce	
[redacted]	BRMC ED	F	41	48+	Cedar	

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PATIENT FLOW SHEET

CENSUS: 78

DATE: 05/19/2015

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	15	16	25	12	10
Blocked Rooms	0	0	0	0	0
Beds Available	0	0	1	2	2

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	IPMC 5th Floor	F	66	72+	New Leaf	Re-eval 05/18/2015
[redacted]	IPMC ER	F	87	10 +	New Leaf	
[redacted]	JCMC 6200	M	21	15	Laurel/Cedar	
[redacted]	SSH ER	M	52	3	Laurel/Cedar	
[redacted]	JCMC ER	F	35	4	Cedar	
[redacted]	HVMC ER	F	19	7	Poplar	
[redacted]	BRMC Floor	F	62	12	Laurel/Cedar	
[redacted]	Hawkins Co ER	M	51	30+	Cedar	
[redacted]	BRMC ICU	M	56	7	Poplar/Laurel	
[redacted]	HVMC ER	M	35	72 +	Cedar	

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PATIENT FLOW SHEET

CENSUS: 78

DATE: 05/20/2015

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	15	16	25	13	9
Blocked Rooms	0	0	0	0	0
Beds Available	0	0	1	1	3

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	IPMC 5th Floor	F	66	05/15/15	New Leaf	Re-eval 05/19/2015
[redacted]	IPMC ER	M	30	7 hrs	Laurel/Cedar	
[redacted]	HVMC ER	M	43	5	Laurel/Cedar	
[redacted]	HVMC ER	M	31	10	Poplar/Laurel	
[redacted]	HVMC ER	M	55	8	Spruce/Poplar	
[redacted]	BRMC ICU	M	56	05/18/15	Laurel	
[redacted]	BRMC Floor	F	62	05/18/15	Laurel/Cedar	
[redacted]	BRMC ER	M	66	12	New Leaf	Questionable delirium
[redacted]	BRMC ER	F	68	7	Laurel/NL	
[redacted]	BRMC ICU	F	17	12+	Willow	OD 5/17/15. Awaiting labs/sbar

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PATIENT FLOW SHEET

CENSUS: 78

DATE: 05/21/2015

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	25	14	9
Blocked Rooms	0	0	0	0	0
Beds Available	0	0	1	0	3

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	IPMC 5th Floor	M	66	05/15/2015	New Leaf	Re-eval 05/19/2015
[redacted]	JCMC ER	F	61	7 hrs	Laurel	
[redacted]	BRMC ER	F	68	15 +	Laurel/NL	
[redacted]	BRMC ER	M	66	24	New Leaf	Questionable delirium
[redacted]	HVMC ER	M	43	15 +	Laurel/Cedar	
[redacted]	BRMC Floor	F	62	05/18/2015	Laurel/Cedar	May need re-eval
[redacted]	HVMC ER	M	31	05/19/2015	Poplar/Laurel	
[redacted]	BRMC ER	F	67	15 +	Cedar/NL	
[redacted]	BRMC ER	M	34	10 +	Laurel/Cedar	
[redacted]	HVMC ER	M	61	10+	Spruce	

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PATIENT FLOW SHEET

CENSUS: _77_____ DATE: _5/22/15_____

TIME_0800_____

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	25	13	9
Blocked Rooms	0	0	0	0	0
Beds Available	0	0	1F	1M	3

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	HVMC	M	71	9 hours	Spruce	
[redacted]	BRMC	F	68	7 hours	New Leaf	
[redacted]	HVMC ED	M	61	11 hours	Larl/Spruce	
[redacted]	Takoma ED	F	42	12 hours	Larl/Cedar	
[redacted]	HVMC Floor	M	55	9 hours	Larl	
[redacted]	HVMC ED	F	31	11 hours	Larl/Cedar	
[redacted]	SSH ED	M	30	7 hours	Poplar	
[redacted]	HVMC ED	M	55	2 hours	Cedar/Larl	
[redacted]	JCMC Floor	M	46	19 hours	Poplar	

MSHA 002044

SBH-KINGSPORT 002337

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PATIENT FLOW SHEET

CENSUS: 79 _ DATE: 5/23/15

TIME 0745

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	25	14	10
Blocked Rooms	0	0	0	0	0
Beds Available	0	0	1M	0	2

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	BRMC ED	F	68	Since 5/19/15	New Leaf	
[redacted]	JCMC ED	F	31	Since 5/22/15	Cedar	
[redacted]	JCMC ED	F	25	4 hours	Cedar	
[redacted]	HVMC ED	F	23	4 hours	Poplar	
[redacted]	HVMC ED	M	26	2 hours	Poplar/Larl	
[redacted]	Laughlin ED	F	19	8 hours	Cedar	
[redacted]	HVMC ED	F	20	1 hour	Cedar	

PATIENT FLOW SHEET (2)

MSHA 002045

SBH-KINGSPORT 002338

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 80 DATE: 5/24/15

TIME 0745

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	26	13	11
Blocked Rooms	0	0	0	0	0
Beds Available	0	0	0	1F	1M

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	BRMC ED	F	68	Since 5/19/15	New Leaf	Re-evaluated on 5/23
[redacted]	HVMC ED	F	20	Since 5/23	Cedar	
[redacted]	HVMC ED	F	50	Since 5/23	Larl	
[redacted]	Takoma ED	F	39	Since 5/23	Larl	
[redacted]	HVMC	F	20	Since 5/23	Poplar	
[redacted]	Hancock Co	F	32	11 hours	Larl	
[redacted]	Laughlin	M	24	8 hours	Cedar	
[redacted]	BRMC ED	F	68	6 hours	New Leaf	

PATIENT FLOW SHEET (2)

MSHA 002046

SBH-KINGSPORT 002339

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 72 DATE: 5/28/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	15	22	13	8
Blocked Rooms	0	0	221a	0	0
Beds Available	0	1 m	3	1 m	4

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	IPMC	F	89	12 hrs	New Leaf	
[redacted]	FWCH ED	M	84	2 hrs	New Leaf	
[redacted]	BRMC	F	66	5/27/15	New Leaf	
[redacted]	Reflections	F	79	5/27/15	New Leaf	

MSHA 002047

SBH-KINGSPORT 002340

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 77 DATE: 5/29/15

TIME 0745

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	17	23	14	9
Blocked Rooms	0	0	0	0	0
Beds Available	0	0	3	0	0

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	Refelctions	F	79	Since 5/25	New Leaf	
[redacted]	BRMC ED	F	66	Since 5/26	New Leaf	
[redacted]	IMPC ED	F	89	Since 5/27	New Leaf	
[redacted]	JCMC ED	M	56	4 hours	Cedar/Larl	
[redacted]	BRMC ED	M	28	Since 5/28	Larl/Cedar	
[redacted]	BRMC ED	M	22	1 hour	Poplar	
[redacted]	Laughlin	M	35	4 hours	Poplar	

MSHA 002048

SBH-KINGSPORT 002341

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 73 ____ DATE: 5/30/15

TIME 0815

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	13	15	24	13	8
Blocked Rooms	0	0	0	0	0
Beds Available	1F	1F	2	1M	4

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	BRMC ED	F	66	Since 5/26	New Leaf	
[redacted]	Unicoi ED	M	59	1 hour	Larl/Cedar	

MSHA 002049

SBH-KINGSPORT 002342

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PATIENT FLOW SHEET

CENSUS:_77_____ DATE: _5/31/15_____

TIME_0745_____

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	13	16	25	14	9
Blocked Rooms	0	0	0	0	0
Beds Available	1M	0	1F	0	3

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	BRMC ED	F	66	Since 5/26	New Leaf	
[redacted]	Hawkins Co	F	40	6 hours	Laurel	
[redacted]	HVMC ED	F	52	5 hours	Laurel	

MSHA 002050

SBH-KINGSPORT 002343

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MSHA 002051.pdf
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PATIENT FLOW SHEET

CENSUS: _80_____ DATE: _6/2/15_____

TIME_0730_____

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	13	17	26	14	10
Blocked Rooms	0	0	0	0	0
Beds Available	1 f	0	0	0	2

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	JCMC ED	M	39	5 hrs	Poplar	
[redacted]	JCMC ED	F	61	3 hrs	Poplar	E Coli in urine
[redacted]	IPMC ED	M	67	13 hrs	Spruce	
[redacted]	SSH Floor	F	86	6/1/15	New Leaf	
[redacted]	SSH ED	M	77	6/1/15	New Leaf	
[redacted]	BRMC	F	66	5/29/15	New Leaf	
[redacted]	Takoma	M	61	5/31/15	Spruce	
[redacted]	HVMC ICU	F	32	9 hrs	Cedar	
[redacted]	HVMC	F	27	7 hrs	Cedar	
[redacted]	Hawkins Co	F	48	8 hrs	Spruce/Laurel	

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PATIENT FLOW SHEET

CENSUS: 72 DATE: 6/3/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	15	20	13	10
Blocked Rooms	0	0	0	0	0
Beds Available	0	1	6	1 f	2

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	SSH Floor	F	86	6/1/15	New Leaf	
[redacted]	SSH ED	M	77	6/1/15	New Leaf	
[redacted]	BRMC	F	66	5/29/15	New Leaf	

MSHA 002052

SBH-KINGSPORT 002346

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PATIENT FLOW SHEET

CENSUS: 72 DATE: 6/4/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	13	15	22	12	10
Blocked Rooms	0	0	0	0	0
Beds Available	1 f	1 m	4	2	2

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	SSH Floor	F		6/1/15	New Leaf	
[redacted]	Takoma ED	M	15	3 hrs	Willow	
[redacted]	Takoma ED	M	24	2 hrs	Cedar	

MSHA 002053

SBH-KINGSPORT 002347

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 70 DATE: 6/5/15

TIME 0745

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	11	14	25	13	8
Blocked Rooms	0	510A/510B	0	411B	0
Beds Available	3	0	1F	0	4

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)

MSHA 002054

SBH-KINGSPORT 002348

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PATIENT FLOW SHEET

CENSUS: 75

DATE: 6/7/15

TIME 0745

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	23	13	9
Blocked Rooms	0	0	0	411B	0
Beds Available	0	0	0	0	3

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	Fransis Marion LTC	F	81	6/3/15	New Leaf	
[redacted]	BRMC ED	F	75	6 hours	New Leaf	
[redacted]	Lakeway Regional ED	M	32	6 hours	Cedar	

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PATIENT FLOW SHEET

CENSUS: 78 DATE: 6/8/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	15	17	22	13	11
Blocked Rooms	0	0	0	411b	0
Beds Available	0	0	4	0	1 f

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	JCMC Floor	M	53	6/7/15	Laurel/Cedar	
[redacted]	IPMC ED	M	86	4 hrs	New Leaf	
[redacted]	BRMC ED	F	75	6/7/15	New Leaf	
[redacted]	\BRMC	F	50	6/7/15	Cedar	
[redacted]	BRMC	F	28	6/7/15	Cedar	
[redacted]	Hawkins	F	17	6/8/15	Willow	
[redacted]	BRMC	M	43	6/8/15	Laurel	
[redacted]	HVMC	M	64	6/8/15	Spruce	
[redacted]	HVMC	M	12	6/8/15	Willow	

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PATIENT FLOW SHEET

CENSUS: 78 DATE: 6/9/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	13	16	24	13	12
Blocked Rooms	0	0	0	411b	0
Beds Available	1 f	0	2	0	0

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	JCMC 7510	M	53	6/7/15	Laurel/Cedar	
[redacted]	IPMC ED	M	86	6/8/15	New Leaf	
[redacted]	Home	M	82	6/8/15	New Leaf	
[redacted]	JCMC Floor	M	25	6/8/15	Laurel	
[redacted]	IPMC ED	M	82	6/8/15	New Leaf	
[redacted]	SSH ED	M	59	6/8/15	Laurel	
[redacted]	BRMC ED	M	43	6/8/15	Laurel	
[redacted]	BRMC Floor	F	68	6 hrs	New Leaf	
[redacted]	Takoma	M	60	2 hrs	Spruce/Laurel	

MSHA 002057

SBH-KINGSPORT 002351

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PATIENT FLOW SHEET

CENSUS: 74 DATE: 6/10/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	21	13	10
Blocked Rooms	0	0	0	411b	0
Beds Available	0	0	5	0	2

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	IPMC ED	M	86	6/8/15	New Leaf	Stephen Champ Laurel
[redacted]	Home	M	82	6/8/15	N Leaf/Spruce	
[redacted]	IPMC ED	M	82	6/8/15	New Leaf	
[redacted]	JCMC Floor	M	25	6/8/15	Laurel/Cedar	
[redacted]	SSH ED	M	91	6/9/15	New Leaf	
[redacted]	JCMC ED	M	44	6/9/15	Laurel	
[redacted]	JCMC ED	M	42	7 hrs	Cedar	
[redacted]	JCMC ED	M	41	5 hrs	Cedar	
[redacted]	BRMC Ed	M	35	6/9/15	Cedar	
[redacted]	Hawkins Co	M	33	6/9/15	Cedar	

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PATIENT FLOW SHEET

CENSUS: 81 DATE: 6/11/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	26	13	12
Blocked Rooms	0	0	0	411b	0
Beds Available	0	0	0	0	0

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	JCMC ED	M			Cedar	Everett Rutledge New Leaf
[redacted]	IPMC ED	M			Poplar/Spruce	PC White New Leaf
[redacted]	JCMC ED	M			Laurel/Cedar	Joyce Parks New Leaf
[redacted]	IPMC ED	M			Laurel/Cedar	
[redacted]	HVMC	M			Poplar	
[redacted]	CALM	M			Poplar	
[redacted]	Laughlin	M			Spruce	
[redacted]	HVMC ED	F			Poplar	
[redacted]	Takoma	F			Laurel	
[redacted]	HVMC	F			Poplar	

MSHA 002059

SBH-KINGSPORT 002353

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PATIENT FLOW SHEET

CENSUS: 76

DATE: 06/12/2015

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	12	16	24	12	12
Blocked Rooms	1	0	0	1	0
Beds Available	1	0	2	1	0

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	BRMC Floor	F	68	06/08/2015	New Leaf	Needs re-eval
[redacted]	Takoma ER	F	42	06/11/2015	Laurel	
[redacted]	Laughlin ICU	F	52	06/11/2015	Laurel	
[redacted]	Takoma ER	F	27	06/11/2015	Poplar	
[redacted]	Takoma ER	M	33	06/11/2015	Cedar	
[redacted]	HVMC ER	F	51	3 hrs	Laurel	

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PATIENT FLOW SHEET

CENSUS: 80 DATE: 6/14/15

TIME 0745

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	25	13	12
Blocked Rooms	0	0	218A	411B	0
Beds Available	0	0	0	0	0

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	JCCH ED	M	37	10 hours	Laurel/Cedar	
[redacted]	JCMC ED	F	37	9 hours	Poplar	
[redacted]	JCMC ED	M	27	7 hours	Poplar	
[redacted]	HVMC Floor	F	58	Since 6/12	Spruce/N.L	
[redacted]	JCMC ED	F	35	3 hours	Poplar	
[redacted]	Takoma ED	M	24	3 hours	Cedar	
[redacted]	BRMC ED	F	16	2 hours	Willow	

MSHA 002061

SBH-KINGSPORT 002355

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PATIENT FLOW SHEET

CENSUS: 81 DATE: 6/15/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	17	25	13	12
Blocked Rooms	0	0	218a	411b	0
Beds Available	0	0	0	0	0

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	JCMC Floor	F			Laurel	[redacted] Leaf
[redacted]	JCMC Floor	F			Willow	[redacted] Cedar
[redacted]	IPMC ED	M			New Leaf	
[redacted]	IPMC ED	F			Laurel	
[redacted]	JCMC Floor	F			Poplar	
[redacted]	IPMC ED	F			Poplar	
[redacted]	JCMC ED	M			Poplar	[redacted]
[redacted]	JCMC ED	F			Laurel	[redacted]
[redacted]	JCMC ED	M			Poplar	
[redacted]	HVMC	M			Cedar	

MSHA 002062

SBH-KINGSPORT 002356

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PATIENT FLOW SHEET

CENSUS: 80 DATE: 6/16/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	25	13	12
Blocked Rooms	0	0	218a	411b	0
Beds Available	0	0	0	0	0

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	JCMC Floor	M	45	6/15/16	Poplar	William Rice BRMC New Leaf
[redacted]	IPMC ED	F	53	2 hrs	Cedar	Mark Harris Laughlin Laurel
[redacted]	IPMC ED	M	91	6/14/15	New Leaf	Lanise Temoir Gibson Place L/C
[redacted]	HVMC	F	58	6/12/15	Spruce	Sarah Calextio HVMC Cedar
[redacted]	HVMC	M	60	6/15/15	Cedar	Ada Stapleton HVMC New Leaf
[redacted]	BRMC	F	30	6/13/15	Cedar	
[redacted]	BRMC	M	24	6/15/15	Poplar	
[redacted]	Takoma	F	42	6/15/15	Laurel	
[redacted]	Takoma	M	48	6/15/15	Poplar	
[redacted]	Laughlin	M	60	6/15/15	Poplar	

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PATIENT FLOW SHEET

CENSUS: 77 DATE: 6/17/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	17	23	13	10
Blocked Rooms	0	0	218a	411b	318a
Beds Available	0	0	2	0	1

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	BRMC	M	69	6/13/15	New Leaf	
[redacted]	HVMC	M	60	6/14/15	Cedar	
[redacted]	Laughlin	M	60	6/15/15	Laurel/Cedar	
[redacted]	HVMC	F	65	6/16/16	Spruce	
[redacted]	HVMC	M	14	6 hrs	Willow	
[redacted]	HVMC	F	29	6/16/15	Laurel/Cedar	
[redacted]	JCMC ED	M	39	2 hrs	Poplar/Laurel	

MSHA 002064

SBH-KINGSPORT 002358

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PATIENT FLOW SHEET

CENSUS: 74 DATE: 6/18/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	21	13	10
Blocked Rooms	0	0	0	411b	317b
Beds Available	0	0	5	0	1f

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	HVMC	M	60	6/17/15	New Leaf	
[redacted]	HVMC	F	65	6/16/15	Spruce	
[redacted]	HVMC	M	74	6/17/15	New Leaf	

MSHA 002065

SBH-KINGSPORT 002359

Highly Confidential

PATIENT FLOW SHEET

CENSUS: 79

DATE: 6/19/15

TIME 0745

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	26	14	9
Blocked Rooms	0	0	0	0	317B
Beds Available	0	0	0	0	2

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	HVMC ED	M	74	Since 6/17	Spruce/N.L	
[redacted]	SSH ED	M	55	Since 6/18	Poplar	
[redacted]	SSH ED	M	32	Since 6/18	Poplar	
[redacted]	Takoma ED	M	49	6 hours	Poplar	
[redacted]	Hancock Co	M	63	14 hours	Laurel	
[redacted]	Knoxville	M	70	11 hours	Spruce/NL	

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PATIENT FLOW SHEET

CENSUS: 78 DATE: 6/20/15

TIME 0745

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	13	16	25	14	10
Blocked Rooms	0	0	0	0	317B
Beds Available	1F	0	1M	0	1M

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	Knoxville	M	70	Since 6/18	Spruce/NL	
[redacted]	HVMC ED	F	63	14 hours	Spruce/NL/Cedar?	

MSHA 002067

SBH-KINGSPORT 002361

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PATIENT FLOW SHEET

CENSUS: _78_____ DATE: _6/21/15_____

TIME_0745_____

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	15	25	14	10
Blocked Rooms	0	0	0	0	317B
Beds Available	0	1F	1F	0	1M <13

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	HVMC	F	51	10 hours	Larl/Cedar	
[redacted]	Takoma ED	M	26	9 hours	Larl/Cedar	
[redacted]	HVMC	M	40	1 hour	Larl/Cedar	
[redacted]	BRMC	M	48	13 hours	Cedar	Awaiting labs, abnormal K

MSHA 002068

SBH-KINGSPORT 002362

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PATIENT FLOW SHEET

CENSUS: 80

DATE: 06/22/2015

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	17	25	14	10
Blocked Rooms	0	0	6	0	1
Beds Available	0	0	0	0	1

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	IPMC ED	F	80	20 hr +	New Leaf	Possible Delirium
[redacted]	IPMC ED	M	30	8 hr	Laurel/Cedar	
[redacted]	IPMC ED	M	21	6 hr +	Poplar	
[redacted]	JCMC ED	M	34	7 hr	Laurel	
[redacted]	SSH ED	F	46	7 hr	Cedar	
[redacted]	Takoma ED	F	28	7 hr +	Laurel/Cedar	

MSHA 002069

SBH-KINGSPORT 002363

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PATIENT FLOW SHEET

CENSUS: 77

DATE: 6/23/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	14	24	14	11
Blocked Rooms	0	513a 515b		0	317b
Beds Available	0	0	0	0	0

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	SSH ED	M	34	6 hrs	Laurel	
[redacted]	JCMC ED	M	55	5 hrs	Poplar	
[redacted]	IPMC ED	F	16	3 hrs	Willow	
[redacted]	SSH ED	M	18	2 hrs	Laurel	
[redacted]	Frances Marion	F	81	2 hrs	New Leaf	
[redacted]	HVMC	F	21	2 hrs	Poplar	

MSHA 002070

SBH-KINGSPORT 002364

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PATIENT FLOW SHEET

CENSUS: 79

DATE: 6/24/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	25	14	25
Blocked Rooms	0	0	0	0	317b
Beds Available	0	0	1	0	1 f

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	JCMC Floor	M	26	6 hrs	Cedar	
[redacted]	JCMC ED	M	49	5 hrs	Poplar	
[redacted]	Frances Marion	F	81	6/23/15	New Leaf	
[redacted]	HVMC ED	F	63	9 hrs	Spruce	
[redacted]	HVMC	F	21	6/23/15	Cedar	
[redacted]	HVMC	F	31	7 hrs	Laurel	
[redacted]	Calm	F	10	12 hrs	Willow	
[redacted]	Hawkins	M	24	7 hrs	Poplar	
[redacted]	WCDC	F	42	5 hrs	Cedar	
[redacted]	Takoma	F	49	1 hr	Laurel	

MSHA 002071

SBH-KINGSPORT 002365

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PATIENT FLOW SHEET

CENSUS: 78 DATE: 6/25/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	24	14	10
Blocked Rooms	0	0	223a 223b	0	317b
Beds Available	0	0	0	0	1

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	JCMC ED	M	51	6/24/15	Poplar/Laurel	[redacted] HVMC Poplar
[redacted]	JCMC ED	F	39	9 hrs	Poplar	[redacted] New Leaf
[redacted]	JCMC ED	M	33	8 hrs	Laurel	
[redacted]	SSH ED	M	23	7 hrs	Poplar	
[redacted]	SSH ED	F	26	12 hrs	Cedar/Laurel	
[redacted]	HVMC	F	63	6/23/15	Spruce	
[redacted]	BRMC	F	44	7 hrs	Poplar	
[redacted]	Hawkins	M	24	6 hrs	Poplar	
[redacted]	BRMC	M	70	7 hrs	Cedar	
[redacted]	HVMC	M	22	5 hrs	Poplar	

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PATIENT FLOW SHEET

CENSUS: 79

DATE: 6/26/15

TIME 0745

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	25	13	11
Blocked Rooms	0	0	0	0	317B
Beds Available	0	0	1F	1F	0

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	Francis Marion	F	81	Since 6/22	New Leaf	
[redacted]	SSH Floor	F	42	Since 6/25	Laurel	
[redacted]	Freewill Baptist	M	14	Since 6/25	Willow	
[redacted]	BRMC ED	M	55	Since 6/25	Laurel	
[redacted]	JCMC ED	F	38	Since 6/25	Laurel/Poplar	
[redacted]	HVMC ED	M	40	Since 6/25	Laurel	
[redacted]	HVMC ED	M	22	Since 6/24	Larl/Cedar	

MSHA 002073

SBH-KINGSPORT 002367

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[redacted]	Tenova North ED	F	50	Since 6/26	Cedar	
[redacted]	North Knox	F	26	Since 6/26	Larl/Poplar	
[redacted]	UT Medical	M	51	Since 6/25	Poplar	
[redacted]	Jefferson Mem.	F	60	Since 6/26	Spruce/N.L	
[redacted]	Physicians Reg.	M	42	Since6/26	Poplar	

PATIENT FLOW SHEET (2)

CENSUS:_____ DATE: _____

TIME:_____

	Cedar (14)	Laurel (16)	Poplar (24)	Spruce (14)	Willow (12)
Census					
Blocked Rooms					
Beds Available					

MD RECOMMENDED TRANSFERS AT BED HUDDLE: (Room #'s)

CEDAR	LAUREL	POPLAR	SPRUCE	WILLOW	Comments:

MSHA 002074

SBH-KINGSPORT 002368

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PATIENT FLOW SHEET

CENSUS: 76

DATE: 6/27/15

TIME 0745

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	13	16	24	12	10
Blocked Rooms	617B	0	0	0	317B
Beds Available	0	0	2	2	1M <13

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	Francis Marion	F	81	Since 6/22	New Leaf	Awaiting labs
[redacted]	JCCH	F	15	Since 6/26	Willow	
[redacted]	Free Will GH	M	14	Since 6/25	Willow	
[redacted]	HVMC ED	M	58	Since 6/26	Larl/Cedar	
[redacted]	BRMC ICU	M	58	Since 6/26	Cedar	
[redacted]	HVMC ED	F	64	Since 6/26	Spruce	
[redacted]	Hawkins Co	F	20	Since 6/26	Cedar	
[redacted]	BRMC Floor	F	67	Since 6/26	New Leaf	
[redacted]	Takoma ED	M	35	3 hours	Poplar	
[redacted]	HVMC ED	M	32	7 hours	Poplar	
[redacted]	Knox CSU	M	26	Since 6/25	Cedar/Larl	

MSHA 002075

SBH-KINGSPORT 002369

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PATIENT FLOW SHEET

CENSUS: 79

DATE: 6/28/15

TIME 0800

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	25	13	11
Blocked Rooms	0	0	222B	0	317B
Beds Available	0	0	0	1M	0

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	Peds Floor	F	15	Since 6/26	Willow	
[redacted]	Hawkins Co	F	20	Since 6/26	Cedar	
[redacted]	Jefferson Mem.	F	60	Since 6/26	Spruce/N.L	
[redacted]	JCMC Floor	M	49	Since 6/27	Laurel/Poplar	*MRSA, needs blocked room*
[redacted]	Takoma ED	F	42	Since 6/27	Cedar/Larl	
[redacted]	HVMC ED	F	58	Since 6/27	Cedar	
[redacted]	HVMC ED	M	32	Since 6/27	Any	
[redacted]	Takoma ED	M	21	4 hours	Cedar/Larl	

MSHA 002076

SBH-KINGSPORT 002370

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PATIENT FLOW SHEET

CENSUS: 78

DATE: 6/29/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	23	14	11
Blocked Rooms	0	0	222b	0	317b
Beds Available	0	0	2	0	0

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	JCMC Floor	M	49	6/27/15	Laurel/Poplar	MRSA
[redacted]	JCMC ED	F	63	7 hrs	Laurel	
[redacted]	Takoma	F	42	6/27/15	Cedar/Laurel	
[redacted]	HVMC ED	F	58	6/27/15	Cedar/Laurel	
[redacted]	Takoma	M	21	6/28/15	Cedar/Laurel	
[redacted]	HVMC ED	M	30	6/29/15	Poplar/Laurel	
[redacted]	CSU	M	47	6/29/15	Poplar/Laurel	
[redacted]	Jefferson Co	F	60	6/27/15	Spruce	[redacted] Blount Co Cedar
[redacted]	Parkwest	M			Cedar	[redacted] Ft Sanders Poplar
[redacted]	Ft Sanders	M			Laurel	

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PATIENT FLOW SHEET

CENSUS: 76

DATE: 6/30/15

TIME 0730

	Cedar (14)	Laurel (16)	Poplar (26)	Spruce (14)	Willow (12)
Census	14	16	25	13	8
Blocked Rooms	0	0	22b	41 2b	31 7b
Beds Available	0	0	0	0	3

Name of Patient Waiting	Location	M/F	Age	LOS Since Consult	Potential Unit	Comments: (Admitted/Unit)
[redacted]	JCMC ED	F	47	3 hrs	Spruce	
[redacted]	HVMC	F	81	3 hrs	New Leaf	
[redacted]	Laughlin	F	18	4 hrs	Poplar	
[redacted]	HVMC	M	33	4 hrs	Poplar	
[redacted]	Hancock	M	20	5 hrs	Poplar	
[redacted]	Knoxville	F	79	14 hrs	New Leaf	

Ranking of Tennessee Counties by Total Population
2015

County	Total Population	Rank
Shelby	946,559	1
Davidson	663,151	2
Knox	459,124	3
Hamilton	349,273	4
Rutherford	302,237	5
Williamson	207,872	6
Montgomery	191,068	7
Sumner	175,054	8
Sullivan	**159,494**	**9**
Washington	132,599	10
Blount	129,973	11
Wilson	126,472	12
Bradley	104,364	13
Madison	99,971	14
Sevier	96,116	15
Maury	82,526	16
Putnam	78,416	17
Anderson	76,949	18
Robertson	71,437	19
Greene	70,520	20
Tipton	64,759	21
Hamblen	64,438	22
Cumberland	58,340	23
Hawkins	57,741	24
Carter	57,359	25
Coffee	54,817	26
Jefferson	54,482	27
Roane	54,079	28
McMinn	53,476	29
Loudon	51,495	30
Gibson	51,412	31
Dickson	51,127	32
Bedford	48,099	33
Monroe	46,563	34
Lawrence	42,373	35
Fayette	41,835	36
Campbell	41,783	37
Franklin	41,391	38
Warren	40,662	39
Cheatham	40,088	40

Ranking of Tennessee Counties by Total Population
2015

County	Total Population	Rank
Weakley	38,790	41
Dyer	38,246	42
Cocke	37,207	43
Lincoln	34,624	44
Rhea	33,767	45
Henry	32,766	46
Claiborne	32,765	47
Marshall	31,413	48
Obion	31,365	49
Giles	29,293	50
Marion	28,652	51
Henderson	28,279	52
Carroll	28,012	53
Lauderdale	27,264	54
White	27,132	55
McNairy	26,755	56
Hardeman	26,231	57
Hardin	26,075	58
Hickman	24,465	59
Macon	23,419	60
Grainger	23,236	61
Overton	22,593	62
Scott	21,915	63
Morgan	21,870	64
Smith	19,771	65
Union	19,347	66
DeKalb	18,996	67
Fentress	18,553	68
Humphreys	18,519	69
Unicoi	18,419	70
Johnson	18,090	71
Haywood	18,044	72
Chester	17,593	73
Wayne	16,815	74
Polk	16,570	75
Benton	16,208	76
Sequatchie	15,246	77
Crockett	14,611	78
Cannon	14,218	79
Stewart	13,659	80

Ranking of Tennessee Counties by Total Population
2015

County	Total Population	Rank
Grundy	13,322	81
Bledsoe	12,610	82
Meigs	12,331	83
Lewis	12,112	84
Decatur	11,883	85
Jackson	11,383	86
Lake	9,676	87
Houston	8,413	88
Trousdale	8,275	89
Perry	8,025	90
Clay	7,681	91
Hancock	6,645	92
Moore	6,364	93
Van Buren	5,433	94
Pickett	4,998	95

Source: Tennesse Department of Health

SBH-KINGSPORT 002375

SBH-KINGSPORT 002376

Woodridge Hospital
Inpatient Utilization

	2010	2011	2012	2013	2014
Beds	84	84	84	84	84
Discharges	3,310	3,412	3,573	3,824	4,081
Patient Days	19,572	19,827	21,329	22,182	23,426
ALOS	5.9	5.8	6.0	5.8	5.7
ADC	53.6	54.3	58.3	60.8	64.2
Occupancy %	63.8%	64.7%	69.4%	72.3%	76.4%

Sources: Joint Annual Reports of Hospitals; MSHA 874

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

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.

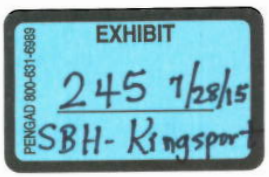
"Northeast Tennessee and Southwest Virginia disproportionately suffer from serious health issues - cardiovascular disease, diabetes, addiction and access to mental health services, to name a few - and they must be addressed," said Alan Levine, president and CEO of Mountain States, who would become executive 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 Hoyd, 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.bestogetherbettertogether.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.

For Businesses For Investors For Media Giving Highlands Wellmont Health Network Notice of Privacy Practices Patient Login

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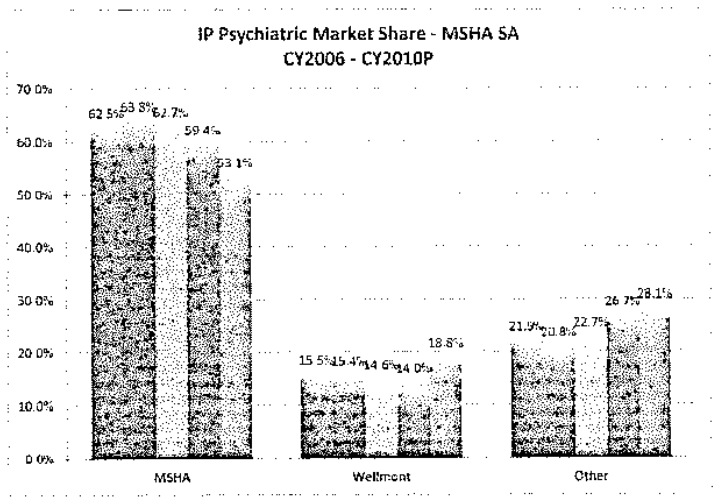
MSHA-001597

SBH-KINGSPORT 002379

MSHA Proc Psychiatry

Sum of Cases		CY					
System	Hospital Name	2005	2006	2007	2008	2009	2010P
MSHA	Woodridge Psychiatric Hospital	1,295	2,883	2,885	2,934	2,548	2,723
	Indian Path Medical Center	2,346	2,043	1,635	1,485	479	21
	Russell County Medical Center	535	540	528	436	408	501
	Sycamore Shoals Hospital	191	205	186	141	253	267
	Johnson City Medical Center	363	46	61	76	72	72
	Johnston Memorial Hospital	14	11	12	17	13	12
	Norton Community Hospital	16	8	11	7	7	1
	North Side Hospital	3	4	5	6	4	7
	Smyth County Community Hospital	5	8	3	5	5	0
	Dickenson Community Hospital	4	1	3	2		0
MSHA Total		*4,772*	*5,749*	*5,329*	*5,109*	*3,789*	*3,604*
Wellmont	Wellmont Bristol Regional Medical Center	872	1,053	897	993	1,161	1,176
	Takoma Regional Hospital	187	152	144	135	114	119
	Wellmont Hawkins County Memorial Hospital	65	116	126	3	4	11
	Wellmont Holston Valley Medical Center	17	26	33	20	30	28
	Wellmont Lonesome Pine Hospital	20	16	17	15	23	4
	Lee Regional Medical Center	11	13	18	25	6	5
	Mountain View Regional Medical Center	13	11	8	9	2	0
	Wellmont Hancock County Hospital	1			2		0
Wellmont Total		*1,186*	*1,387*	*1,243*	*1,202*	*1,340*	*1,343*
All Other		*1,672*	*1,876*	*1,926*	*2,296*	*2,002*	*2,183*
Grand Total		**7,630**	**9,012**	**8,498**	**8,607**	**7,131**	**7,129**

	2005	2006	2007	2008	2009	2010P
MSHA	62.5%	63.8%	62.7%	59.4%	53.1%	
Wellmont	15.5%	15.4%	14.6%	14.0%	18.8%	
Other	21.9%	20.8%	22.7%	26.7%	28.1%	



Top 15 Hospitals for Service Area IP - Psychiatry							
Hospital Name	System	2006	2007	2008	2009	2010P	% Change 06 - 10
Woodridge Psychiatric Hospital	MSHA	2,883	2,885	2,934	2,548	2,723	-6%
Indian Path Medical Center	MSHA	2,043	1,635	1,485	479	21	-99%
Wellmont Bristol Regional Medical Center	Wellmont	1,053	897	993	1,161	1,176	12%
Peninsula Hospital	All Other	784	899	1,004	705	936	19%
Russell County Medical Center	MSHA	540	528	436	408	501	-7%
Sycamore Shoals Hospital	MSHA	205	186	141	253	267	30%
Carilion New River Valley Medical Center	All Other	199	170	173	205	199	0%
Takoma Regional Hospital	Wellmont	152	144	135	114	119	-22%
Morristown-Hamblen Healthcare System	All Other	129	73	121	123	112	-13%
Johnson City Medical Center	MSHA	46	61	76	72	72	57%
Twin County Regional Healthcare, Inc.	All Other	110	87	111	102	93	-15%
Frye Regional Med Center	All Other	112	108	113	80	63	-44%
Cannon Memorial Hospital	All Other	12	5	24	91	119	889%
Mission Hospital	All Other	4	39	160	132	129	3133%
Mercy Medical Center St. Mary's	All Other	60	53	76	62	83	38%
Total Market Cases		9,012	8,498	8,607	7,131	7,129	-21%

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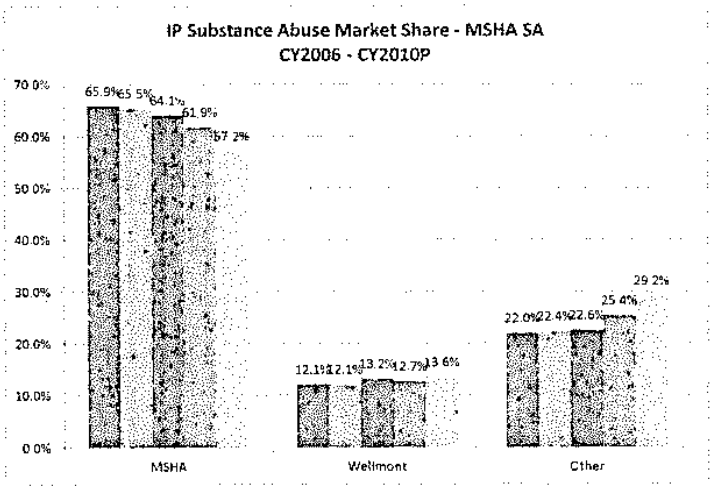
MSHA Proc Substance Abuse

Sum of Cases

System	Hospital Name	2006	2007	2008	2009	2010	2010P
MSHA	Woodridge Psychiatric Hospital	402	553	256	324	352	469
	Indian Path Medical Center	493	367	334	164	14	19
	Johnson City Medical Center	85	83	121	118	101	135
	Russell County Medical Center	30	37	57	44	15	20
	Sycamore Shoals Hospital	25	27	24	13	10	13
	Johnston Memorial Hospital	9	14	20	20	23	31
	Norton Community Hospital	20	17	15	11	12	16
	Smyth County Community Hospital	4	10	10	8	6	8
	North Side Hospital	10	8	8	2	7	9
	Dickenson Community Hospital	5	6	7			0
MSHA Total		*1,083*	*1,122*	*852*	*704*	*540*	*720*
Wellmont	Wellmont Bristol Regional Medical Center	123	100	84	74	56	75
	Wellmont Holston Valley Medical Center	28	31	32	32	35	47
	Wellmont Lonesome Pine Hospital	14	28	24	14	6	8
	Lee Regional Medical Center	15	23	7	10	10	13
	Takoma Regional Hospital	8	6	11	6	6	8
	Mountain View Regional Medical Center	6	16	9	2	2	3
	Wellmont Hawkins County Memorial Hospital	5	4	7	6	13	17
	Wellmont Hancock County Hospital			2	1		0
Wellmont Total		*199*	*208*	*176*	*145*	*128*	*171*
All Other		*362*	*384*	*301*	*289*	*276*	*368*
Grand Total		1,644	1,714	1,329	1,138	944	1,259

	2006	2007	2008	2009	2010	2010P
MSHA	65.9%	65.5%	64.1%	61.9%	57.2%	
Wellmont	12.1%	12.1%	13.2%	12.7%	13.6%	
Other	22.0%	22.4%	22.6%	25.4%	29.2%	



Top 15 Hospitals for Service Area IP - Substance Abuse							
Hospital Name	2006	2007	2008	2009	2010	2010P	% Change 06 - 10
Woodridge Psychiatric Hospital	402	553	256	324	352	469	17%
Indian Path Medical Center	493	367	334	164	14	19	-96%
Johnson City Medical Center	85	83	121	118	101	135	58%
Wellmont Bristol Regional Medical Center	123	100	84	74	56	75	-39%
Russell County Medical Center	30	37	57	44	15	20	-33%
Wellmont Holston Valley Medical Center	28	31	32	32	35	47	67%
Watauga Medical Center	24	42	22	28	22	29	22%
Carilion New River Valley Medical Center	19	27	23	29	28	37	96%
Peninsula Hospital	34	22	19	21	20	27	-22%
Frye Regional Med Center	42	35	15	16	5	7	-84%
Sycamore Shoals Hospital	25	27	24	13	10	13	-47%
Margaret R Pardee Mem	14	24	22	13	17	23	62%
Baptist Hospital of East Tennessee	27	43	17			0	-100%
Wellmont Lonesome Pine Hospital	14	28	24	14	6	8	-43%
Johnston Memorial Hospital	9	14	20	20	23	31	244%
Total Market Cases	1,644	1,714	1,329	1,138	944	1,259	-23%

Exhibit 8

NATIONAL HEALTH POLICY FORUM

Issue Brief – No. 823
August 1, 2007

Shrinking Inpatient Psychiatric Capacity: Cause for Celebration or Concern?

Eileen Salinsky, *Principal Research Associate*

Christopher Loftis, PhD, *Research Associate*

OVERVIEW — *This issue brief examines reported capacity constraints in inpatient psychiatric services and describes how these services fit within the continuum of care for mental health treatment. The paper summarizes the type and range of acute care services used to intervene in mental health crises, including both traditional hospital-based services and alternative crisis interventions, such as mobile response teams. It reviews historical trends in the supply of inpatient psychiatric beds and explores the anticipated influence of prospective payment for inpatient psychiatric services under Medicare. The paper also considers other forces that may affect the need for and supply of acute mental health services, including key factors that could improve the quality and efficiency of inpatient psychiatric care.*

THE GEORGE WASHINGTON UNIVERSITY
WASHINGTON DC

SBH-KINGSPORT 002384

Issue Brief – No 823
August 1, 2007

Shrinking Inpatient Psychiatric Capacity: Cause for Celebration or Concern?

The April 2007 tragedy at Virginia Tech, while unprecedented in terms of the number of lives lost in a mass shooting, is also sadly evocative of disturbing headlines from the past. Although it is very rare for people with mental disorders to be violent towards others, mental health crises do occur every day and too often result in harm to self or suicide. In 2004, over 32,000 people committed suicide in the United States, making it the 11th leading cause of death.[1] Tragedies that result from a failure to intervene effectively in an individual's mental health crisis are particularly appalling, as they are often preventable.

Multiple cultural, legal, and medical obstacles hinder crisis intervention, but gaps in mental health treatment capabilities are significant. The mental health system that exists today is widely perceived to be ineffective in both preventing mental health crises from developing and intervening in crises when they occur. As discussed in the report issued by the President's New Freedom Commission on Mental Health,[2] disjointed policies and reforms of the past have converged to create the "patchwork relic" that is the current mental health system. Understandably, the commission focused the bulk of its work "upstream" – identifying the changes that are needed to ensure that as few people as possible ever experience a mental health crisis. The commission concluded that the "nation must replace unnecessary institutional care with effective, efficient community services that people can count on" and articulated a vision for what a consumer- and family-centered system of care would look like.

Institution-based treatment resources are, in fact, contracting, but this reduction in inpatient psychiatric services is not being balanced by the development of strong, comprehensive community-based systems of care. The number of dedicated psychiatric hospital beds has dropped precipitously over the last decade, and many communities report serious constraints in inpatient psychiatric capacity. New outpatient models are being developed, but they have not been implemented at the scale necessary to compensate for the decrease in inpatient beds.

The commission recognized that acute care services are an essential part of the mental health care continuum and noted the inadequacy of these services in terms of both scope and availability. The commission's Subcommittee on Acute Care documented the shortage of acute care capacity as a growing problem nationally.[3] Given the historical reliance on inpatient

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services, some consumer advocates have been rather reluctant to emphasize acknowledged deficiencies in hospital-based psychiatric capacity. Many advocates fear that policy attention to inpatient psychiatric services will only detract from the challenging task of developing a system of care that is directed at prevention, early intervention, and community-based services. However, even if such a system were in place today, people with mental disorders would continue to experience crises that warrant intervention.

This paper presents information on the decreasing supply of acute mental health services, describes the forces that have led to this trend, and identifies proposals that have been made to address perceived inadequacies. This narrow emphasis is not intended to imply that expansion of acute mental health services merits priority over the development of a more robust system of community-based care. In addition, the paper does not address how training and models of professional practice influence provision of acute care services. A comprehensive analysis of existing mental health system service capacity, while worthwhile, is beyond the scope of this issue brief. The following focuses on important changes in acute mental health capacity and discusses the influence of federal policy, particularly Medicaid and Medicare reimbursement, on these services.

WHAT IS ACUTE MENTAL HEALTH CARE?

Acute mental health care can be broadly defined as a short term response to the urgent needs of an individual experiencing a mental health crisis. The specific behaviors and conditions constituting a mental health crisis are open to interpretation, by individuals and mental health professionals alike. Generally speaking, a danger of suicide, harm to self due to intentional acts or impaired self-care, or harm to others is commonly used to identify a person's need for acute care services. These services ideally include assessment and short-term interventions to defuse the immediate crisis, along with treatment planning to provide referrals for follow-on monitoring and, possibly, additional treatment. It is important to note that many people with mental disorders never experience a mental health crisis necessitating acute services.

Acute mental health services have traditionally been provided in inpatient hospital settings, hospital emergency departments (EDs), and other urgent care facilities. Recently, alternative forms of effective crisis intervention (such as mobile crisis units and crisis intervention in residential programs) have been developed that do not require 24-hour medical supervision in an institutional setting. Some consumer-driven services do not rely primarily on mental health care providers but rather support consumers and their families in managing their own psychiatric symptoms.

However, these nontraditional forms of acute care are not widely available, and most communities continue to rely heavily on hospital-based psychiatric services to intervene in mental health crises. For the purposes of

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this paper, "acute care" refers broadly to crisis intervention services that can be provided in either an inpatient or an outpatient setting. Nonetheless, given that hospitals continue to be the dominant and most widely studied setting for acute mental health care, much of the discussion focuses on inpatient psychiatric services.

Acute mental health treatment differs from acute care for general medical/surgical cases in a number of ways. Over 85 percent of the costs of inpatient psychiatric care are captured by the routine costs of staffing the unit in which psychiatric patients are placed. In general, inpatient psychiatric patients do not use a large amount of ancillary services, such as laboratory, imaging services, telemetry, and operating room suites.[4]

The critical danger facing patients in mental health crisis is typically the risk that their behavior will result in harm (rather than organ or metabolic failure). Therefore, providing the appropriate level of supervision and behavioral management to minimize this risk is an important component of acute psychiatric care. Diagnostic workups of psychiatric cases generally do not rely on capital-intensive technologies; rather, they involve expert interpretation of symptoms, patient interviews, and medical records. Care may also include treatment for medical comorbidities, such as wound care, orthopedic services, or cardiac care. These comorbidities may be linked to injuries sustained during the crisis episode or may reflect preexisting conditions.

Acute care services are often the first and, in some cases, the only type of care people with mental disorders access. However, individuals with persistent serious mental illness (SMI)—about 5 percent of the population[5]—often experience mental health crises recurrently and are particularly likely to use inpatient psychiatric services. Persons with SMI are particularly vulnerable to experiencing a mental health crisis when their chronic mental disorders are exacerbated by co-occurring health issues or other personal problems, such as insufficient financial resources, interpersonal conflict, social isolation, or housing instability.

Sometimes referred to as "frequent flyers," these more vulnerable patients are heavy users of inpatient psychiatric and ED services, but the clinical and social circumstances of persons experiencing a mental health crisis can

While many patients may accept acute psychiatric services voluntarily, some refuse care and may be compelled to remain in the custody of health care providers against their will. Legal standards for involuntary commitment to inpatient facilities for acute mental health care typically rest on demonstrating an immediate danger of serious harm to self or others. Once committed to an inpatient facility, patients may still refuse treatment, such as medication. Legal standards for compulsory treatment, which vary across states, usually hinge on determining a patient's competency to make treatment decisions in his or her own self-interest. States have applied varying standards for compulsory treatment and have allowed "outpatient commitment" when a patient is assessed to be gravely disabled by mental illness or there is potential for a patient's condition to deteriorate absent treatment. The legal framework for outpatient commitment, in terms of relevant state statutes and case law, is not as well developed as the law used to guide judicial decisions regarding inpatient commitment. These differences may contribute, in part, to the continued reliance on inpatient psychiatric services to deliver acute mental health care.

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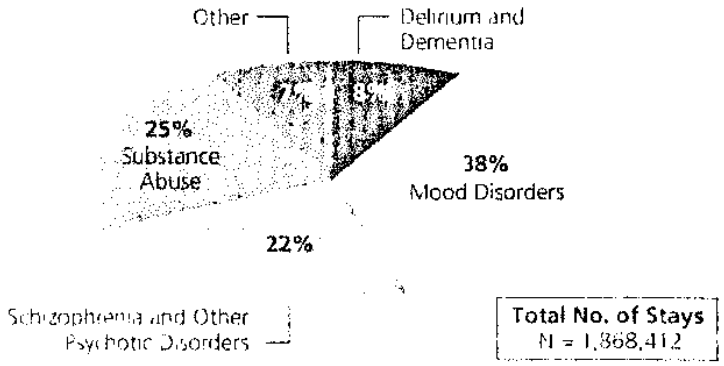
vary widely; these differences can influence whether, how, where, and what type of acute mental health services are used. Examples of cases requiring acute mental health care include a mother who is suicidal after the recent death of a child, a depressed senior citizen who has stopped all self-care activities after the loss of a spouse, a returning veteran failing to recognize heart palpitations as a symptom of post-traumatic stress disorder, a teen who has overdosed on illegal drugs, and a homeless man who is psychotic, hearing voices, and threatening to kill himself. Such cases can present quite differently, with the need for acute treatment varying significantly.

FIGURE 1
Distribution of Mental Health and Substance Abuse Admissions in General Hospitals



Source: Agency for Healthcare Research and Quality, "Care of Adults with Mental Health and Substance Abuse Disorders in U.S. Community Hospitals, 2004," HCUP Fact Book #10, 2007. Available at www.ahrq.gov/data/hcup/factbk10/factbk10.pdf.

Most psychiatric hospital stays are for depression or some other form of mood disorder, schizophrenia or other psychoses, and/or substance abuse. Although approximately one-quarter of psychiatric hospitalizations identify substance abuse as the principal diagnosis, many people hospitalized for other types of mental disorders also have co-occurring substance abuse problems. Over one-half of patients hospitalized for psychiatric care in general hospitals have a substance abuse problem (Figure 1).

The acute service needs of psychiatric patients depend on a wide variety of factors that, while influenced by diagnosis, may be affected to a greater extent by the severity and duration of the disorder, the patient's receptivity to treatment, existing comorbidities, and the extent to which patients have necessary social supports to promote treatment compliance. In reality, the actual acute care services individuals receive may be dictated less by their needs and more by the availability of those services within the community in which they live and their ability to pay for those services, either directly or through public or private health insurance.

TRENDS IN INPATIENT PSYCHIATRIC CAPACITY

Capacity for inpatient psychiatric services, the most widely available form of acute mental health care, has declined dramatically over the last four decades and bed supply has shifted across service providers. Inpatient psychiatric services can be delivered in a variety of settings, including public mental hospitals, private freestanding psychiatric hospitals, and psychiatric units within general hospitals. Increasingly, inpatient psychiatric

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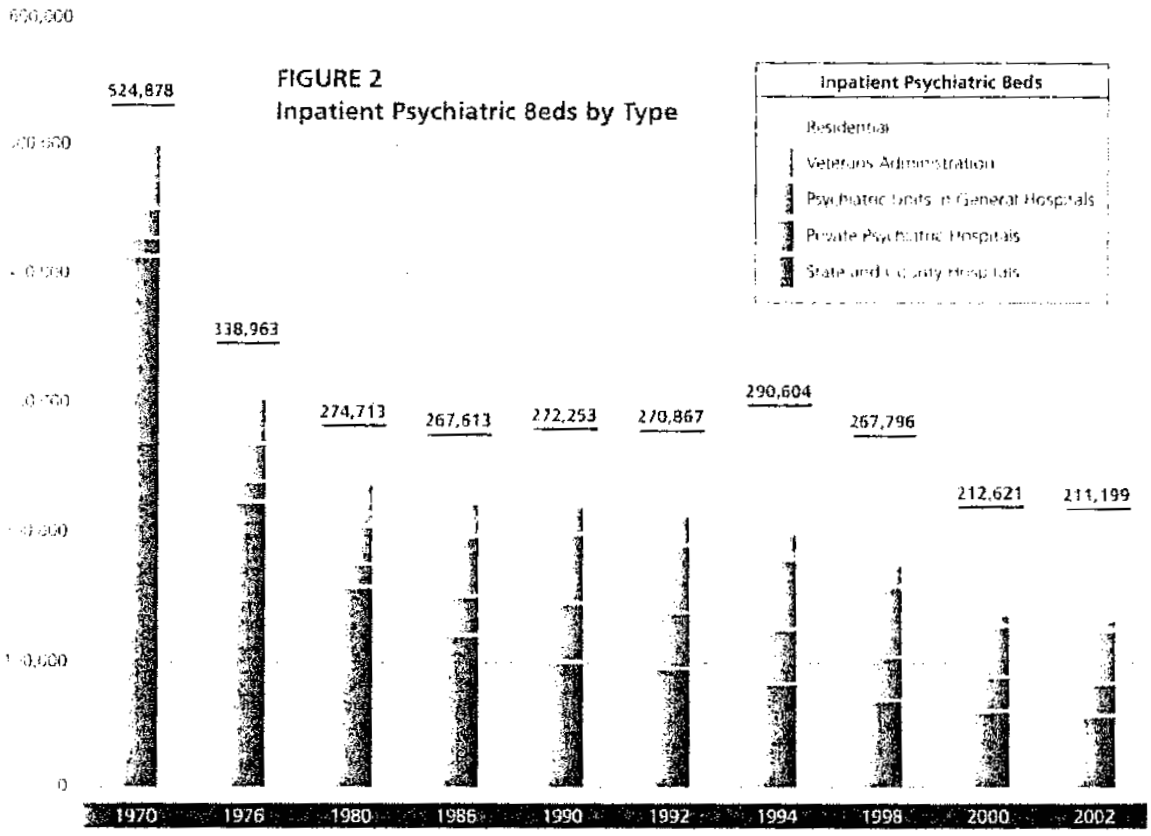
services are also being delivered in nonspecialized medical/surgical beds located in general hospitals, commonly referred to as "scatter beds."[6] Over time, the availability and interchangeability of different types of inpatient psychiatric beds have varied considerably (Figure 2).

Downsizing by state- and county-run mental hospitals is the primary reason for the large decrease observed in the total number of dedicated inpatient psychiatric beds. In 1970, there were approximately 524,878 psychiatric beds in the United States, with about 80 percent of these beds provided by state or county mental hospitals. By 2002, the total number of psychiatric beds had declined to 211,199, with over 68 percent of inpatient capacity provided by the private sector. Private-sector capacity grew

FIGURE 2
Inpatient Psychiatric Beds by Type



Source: Daniel J. Tefft et al., "Highlights of Organized Mental Health Services in 2002 and Major National and State Trends," in Center for Mental Health Services, Mental Health, United States 2004, Ronald W. Manderscheid and Joyce T. Berry, Eds., DHHS pub. no. (SMA) 06-4195 (Rockville, MD: Substance Abuse and Mental Health Services Administration, 2006), Table 19.2, chap. 19, p. 203, available at http://download.ncadi.samhsa.gov/ken.pdfs/SMA06-4195/CMHS_MHUS_2004.pdf.

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considerably between 1970 and the 1990s, partially offsetting contractions in the public sector. However, since the mid-1990s, private-sector closures have added to the continuing decline in public inpatient psychiatric beds. These trends have led to capacity levels for inpatient psychiatric services that are now significantly lower than they had been throughout the 1980s and much of the 1990s.[7]

Public Mental Hospitals

Much of the decrease in state- and county-run psychiatric beds was precipitated by a shift away from institutional, long-term, custodial care for persons with severe and persistent mental illness. A variety of forces drove the "deinstitutionalization" movement that began in the 1960s, accelerated during the 1970s, and continues today. Scandals over the inhumane conditions within many facilities, patient advocacy efforts, evolving treatment techniques (including new psychotropic pharmaceutical agents), and budgetary pressures converged to prompt the discharge of psychiatric patients residing in institutions into community settings. When Medicaid was enacted in 1965, the program excluded "institutions for mental diseases" (IMDs) from reimbursement, which intensified states' financial incentives to move patients out of public psychiatric hospitals. Between 1965 and 1990, the resident population of public mental hospitals dropped from approximately 500,000 to less than 100,000.[8] On any given day, this resident population included a mix of long-stay and short-stay acute patients.

It is difficult to characterize precisely how the significant decline in public psychiatric beds affected acute psychiatric capacity. States were initially slow to close public mental hospitals entirely, preferring instead to reduce beds and census levels. Arguably, acute-care capacity initially increased in these facilities as more long-term patients were discharged to live in the community, nursing homes, and other types of facilities—freeing beds for short-term stays. At the same time, the demand for acute services increased, since the discharged high-risk patients, particularly vulnerable to mental health crises, often found themselves in settings where they lacked adequate access to the outpatient services they needed.

More recent developments have likely served to reduce the acute care capacity available from public mental hospitals. Following the rapid deinstitutionalization of resident patients in the 1960s and 1970s, some

The IMD Exclusion

When Medicaid was enacted in 1965, Congress barred federal contributions for any care delivered in certain institutions that fall within the definition of an "institution for mental diseases" (IMD). The ban was intended to prevent states from supplanting resources that had historically been dedicated to supporting persons with mental illness in state and local mental hospitals. An institution for mental disease is defined as "a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in the provision of diagnostic services, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services." The exclusion applies only to persons between the ages of 22 and 64. IMD residents 65 and older have been exempted from the exclusion since Medicaid was enacted, and state Medicaid plans have had the option of exempting those under the age of 22 since 1972.

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long-term care services continued to be provided by public psychiatric hospitals (particularly for forensic purposes). However, by the early 1980s, these facilities became primarily acute care sites in many states. In other states, public hospitals were closed to all but long-stay patients. Closures of public psychiatric facilities became more common in the 1990s, and bed closures within facilities continued at a steady but slower rate as a result of tightening state budgets and increasing reliance on Medicaid to fund mental health services. These more recent closures likely represent a decrease in acute, not long-term, capacity. However, state and local mental hospitals rarely designate beds for short-term or long-term use, making it difficult to accurately determine acute capacity levels in public institutions.

Private Psychiatric Hospitals and General Hospitals

The dramatic decline of psychiatric (primarily long-term care) beds in public mental hospitals over the last 40 years tends to obscure more subtle changes in private inpatient psychiatric capacity during this period. Given the historic focus of private psychiatric hospitals and general hospitals on short-term, acute treatment rather than custodial care, capacity in these institutions was less directly affected by the movement to deinstitutionalize psychiatric residents from long-term care mental hospitals. In fact, the demand for acute services stimulated by the needs of these former residents of government psychiatric hospitals, combined with increasingly generous inpatient psychiatric coverage through Medicare, Medicaid, and private insurers, likely precipitated an initial increase in the supply of private psychiatric beds.

Over time, policy changes have significantly influenced private-sector decisions to both expand and (more recently) contract inpatient psychiatric capacity. While acute care capacity levels in private, freestanding psychiatric hospitals and psychiatric units of general hospitals rose steadily between 1970 and 1980, expansion accelerated significantly between 1980 and 1990. This spike in private-sector capacity can be attributed to a confluence of factors, including the following:

- **Relaxation of certificate of need (CON) requirements** — As states began to loosen or eliminate CON laws that had required hospitals to obtain regulatory approval prior to adding or expanding services, hospitals were able to increase psychiatric bed capacity without facing significant administrative and legal hurdles.
- **Changes to Medicaid's IMD rule** — After rule changes in the early 1970s allowed Medicaid funds to be used for the care of children in psychiatric hospitals, many states decided to include this option in their state plans. This change created a new revenue stream for psychiatric hospitals that had generally been barred from receiving Medicaid dollars. Combined with expanding coverage for inpatient psychiatric services through commercial insurers, this change in Medicaid policy helped to

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fuel a significant expansion in the number of freestanding psychiatric hospitals. Between 1976 and 1992, approximately 300 new private (mostly for-profit) psychiatric hospitals were opened.[7] As the for-profit psychiatric hospital industry grew, marketing to parents struggling to control "troublesome" children became more prevalent.[8] During this period, the increase in the use of inpatient psychiatric hospitalization for children was particularly striking. Among children hospitalized in short stay institutions for psychiatric disorders, nearly one-quarter were hospitalized in for-profit psychiatric hospitals.

■ **Implementation of prospective payment under Medicare in 1983** — When Medicare replaced cost-based reimbursement for hospital services with a prospective payment system (PPS), psychiatric services (in both freestanding psychiatric hospitals and dedicated units of general hospitals) were exempted. As hospital-wide length-of-stay averages and occupancy levels dropped, many general hospitals opened psychiatric units to boost census and revenue. The cost-based reimbursement mechanism established for PPS-exempt services tended to favor new units and facilities and likely contributed to the expansion in the number of private psychiatric hospitals and dedicated units. Lengths of stay for psychiatric admissions declined, but numbers of admissions increased.[9]

Private inpatient psychiatric capacity held relatively stable during the early 1980s but began to decline sharply as financial incentives shifted. Increased managed care penetration in Medicaid and among commercial insurers; reductions in third-party payment rates, followed by increases in utilization management; and declining growth in Medicare reimbursement rates led many inpatient psychiatric service providers to close or reduce capacity levels.

Evolution of Cost-Based Payment for Inpatient Psychiatric Services under Medicare

TEFRA — When Medicare established inpatient prospective payment for most types of hospital care in 1983, inpatient psychiatric services were exempted and continued to be reimbursed under rules established by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). Psychiatric facilities were exempted from PPS because diagnosis (the basis for PPS payment methodology) did not provide an accurate prediction of resource use by psychiatric patients and failed to capture variations observed in costs and lengths of stay.

TEFRA established both facility-specific baseline payment rates (based on an individual facility's actual average cost per discharge) and target rates for cost increases based on update factors set in legislation. Exempt providers were paid their actual costs per discharge, provided these costs did not exceed their target rate, and were given bonus payments if costs fell below target and some relief payments if costs exceeded target.

BBA — The Balanced Budget Act of 1997 (BBA) modified TEFRA rules in a number of important ways. A national payment cap was established (set at the 75th percentile of the distribution of target amounts for all psychiatric facilities in fiscal year 1996) and inflated to the current year using an annual update factor. Each facility's payment was limited to the lesser of its target or the national cap amount. New providers' baseline costs were limited to 110 percent of the median target amount of all established providers, with geographic wage and annual inflation adjustments. A variable, provider-specific formula to update target amounts was also established, giving smaller update increases to providers whose costs were less than their targets.

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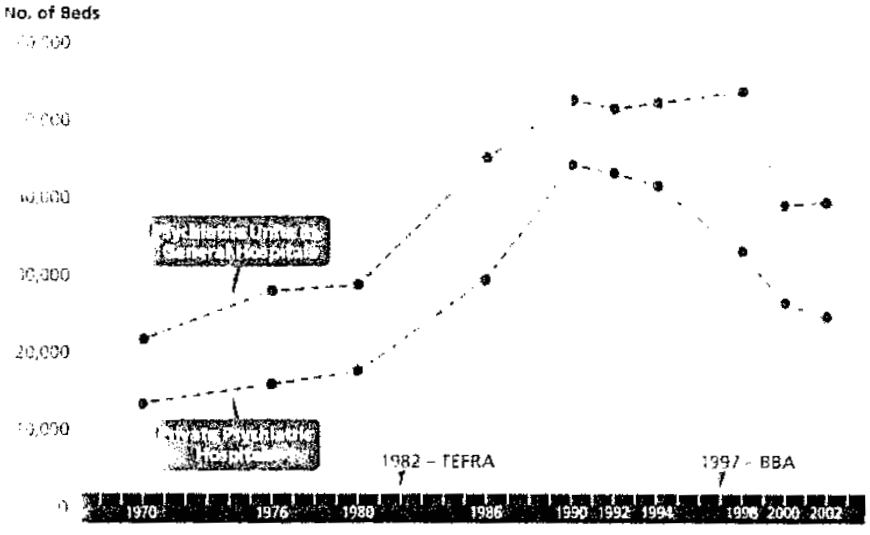
This downsizing trend was initially evident among private psychiatric hospitals in the mid-1990s. General hospitals also began to close or reduce the size of psychiatric units in the late 1990s, partly as a result of these changing financial incentives. (Figure 3)

Complex factors beyond the direct profitability of psychiatric services have reportedly played important roles in general hospitals' decisions to eliminate dedicated psychiatric units. Although some would argue that psychiatric services are still profitable for hospitals, they may be less profitable than other inpatient services and represent an opportunity cost for hospital administrators. A variety of other issues, such as the purported unwillingness of psychiatrists to serve inpatients or provide on-call services in EDs and the impact of psychiatric cases on ED overcrowding, may also play a role in general hospitals' decisions to eliminate dedicated psychiatric units. The rationale behind hospital decisions to close psychiatric units is not well documented nor is the impact of such closures on hospital finances and utilization.

The burden of treating people with mental disorders in EDs is well established. Psychiatric patients remain in hospital EDs more than twice as long as other patients, with 42 percent spending nine or more hours in the emergency room, and staff have to spend twice as much time looking for beds for psychiatric patients as they do to find beds for nonpsychiatric patients.[12] Figure 4 (next page) presents results from a cross-sectional study of EDs indicating that mental health–related visits increased 75 percent between 1992 and 2003.[13] Survey data reveal that 60 percent of emergency

FIGURE 3
Private Inpatient Psychiatric Beds



Note: Values are imputed for years in which data were not collected

Source: SAMHSA, Mental Health, United States, 2004

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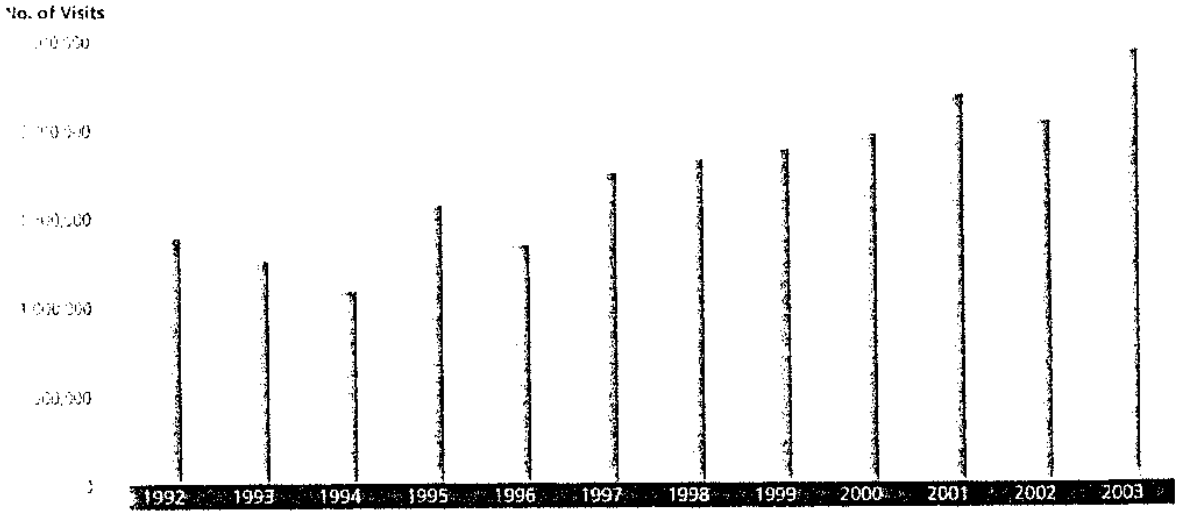
physicians believe the upsurge in ED visits from individuals with mental illness is negatively affecting access to emergency medical care for all patients, causing longer wait times, fueling patient frustration, limiting the availability of hospital staff and decreasing the number of available ED beds.[14]

Available data suggest that psychiatric bed closures by private hospitals have continued, but the relationship between these closures and increasing ED use is uncertain. The American Hospital Association reports that the combined number of psychiatric beds in freestanding psychiatric hospitals and dedicated units of general hospitals has declined by an additional 3 percent since 2002 (the most recent year for which comparable, national data are available across all types of inpatient psychiatric beds). Most of this decline was due to a reduction of beds in general hospitals. Bed capacity in freestanding psychiatric hospitals, though down from the level reported in 2002, rebounded slightly in 2005.[5]

"Other" Kinds of Psychiatric Beds

While general hospitals have reduced psychiatric beds, they have reportedly increased the use of nonspecialized scatter beds to treat psychiatric patients. Although this trend is not well documented, some observers

FIGURE 4
Emergency Department Visits for Mental Health Disorders



Source: Centers for Disease Control and Prevention, Advance Data from Vital and Health Statistics, nos. 245, 271, 275, 285, 293, 304, 313, 320, 326, 335, 340, 358, published 1993 through 2004, available at www.cdc.gov/nchs/products/pubs/pubd/ad/ad.htm

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have raised concerns about the growing use of scatter beds. Because these beds are not located in contained, locked units with high levels of security to regulate the access and egress of patients and visitors, these beds cannot be used for patients who are committed to an inpatient facility on an involuntary basis. Therefore, hospitals may be able to avoid serving difficult (and costly) patients by relying solely on scatter beds for the provision of psychiatric services. Because the nursing staff in general medical/surgical units do not have specialized expertise in the unique treatment needs of psychiatric patients, some question whether the care delivered in scatter beds is comparable in quality to the care delivered in dedicated psychiatric units.

Other alternative forms of around-the-clock psychiatric services include residential treatment centers (RTCs) for children and partial hospitalization programs or day treatment for adults that incorporate a residential option. These facilities are sometimes viewed as hybrids between institutional and community settings and are not reimbursed in the same way as hospitals. It is unclear whether all of these programs provide the level of patient supervision required to truly meet acute care needs. However, these bed types are often included in efforts to monitor psychiatric bed capacity.

Capacity in these newer forms of 24-hour psychiatric care beds has more than tripled, rising from only 24,435 beds in 1970 to 78,967 beds in 2002.[16] Although the number of RTC beds has risen steadily over this period, bed supply associated with partial hospitalization programs has fluctuated, in large part due to Medicare payment policy. After reimbursement for partial hospitalization programs under Medicare was explicitly authorized in 1987, capacity in these programs rose sharply, with bed supply more than doubling between 1992 and 1994. Fraud and abuse investigations revealed financial irregularities and quality of care concerns in a number of partial hospitalization programs.[17] Subsequent improvements in regulatory oversight were followed by a decrease in the number of residential beds available through these programs.[18]

Newer forms of acute treatment "beds" have helped to offset the declines in inpatient hospital beds, but this increase has not been large enough to counterbalance the magnitude of reductions in inpatient psychiatric capacity. Between 1990 and 2002, the number of beds reportedly available through "other" facilities rose by 23,565, while bed supply from traditional inpatient psychiatric providers fell by 86,619.[19]

A CRISIS IN CRISIS INTERVENTION SERVICES?

Anecdotal reports suggest that inpatient psychiatric capacity is becoming severely constrained in many communities and that more locales are beginning to experience this problem, although the magnitude of the shortage is not well documented. A 2006 survey of state mental health authorities revealed that over 80 percent of the states are reporting a shortage in psychiatric beds; 34 states report a shortage of acute care beds, 16 states

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report a shortage of long-term care beds, and 24 states report a shortage of forensic beds.[20] As a result, 27 states report longer waiting lists for inpatient psychiatric services and 14 states are struggling with overcrowding in public psychiatric facilities. The American Psychiatric Association has called the inpatient psychiatric delivery system "fragile and beset by problems."[21]

Reports of long wait times to find inpatient placements for psychiatric patients and of increased reliance on jails to address persons in mental health crisis are becoming increasingly common. Police are often dispatched to respond to 911 calls regarding persons in mental health crisis and traditionally have taken people into custody if harm to self or others appears imminent. Depending on the circumstances, officers may place these individuals under criminal arrest or escort them to the hospital emergency room until admission to a secure bed can be made. Across the country, police officers are reporting longer times spent in hospital emergency rooms while waiting for a bed to be found for persons in custody, as well as increased incarceration rates as officers seek to avoid the time delays associated with hospital-based services.

Reports of long wait times to find inpatient placements for psychiatric patients and of increased reliance on jails to address persons in mental health crisis are becoming increasingly common.

Although there appears to be widespread consensus that current capacity levels for acute psychiatric services are inadequate, the need for additional inpatient psychiatric beds is unclear. The President's New Freedom Commission on Mental Health Subcommittee on Acute Care[22] notes that "in some communities, the shortage of acute care beds has risen to crisis proportions. Too often, budget shortfalls have reduced funding for other essential community mental health services, consequently increasing the demand for already limited inpatient care as an alternative." This statement reflects the tensions inherent in responding to the prevailing shortage of inpatient psychiatric beds. Advocates for persons with mental illness argue that perceptions of inpatient psychiatric bed shortages are distorted by inadequate funding for high-quality outpatient treatment and community-based forms of crisis intervention, resulting in unnecessarily high, or inflated, demand for inpatient psychiatric care. Evidence supports the belief that comprehensive and appropriately intensive outpatient services provide better health outcomes than inpatient treatment and reduce the demand for psychiatric hospitalization.[23] Many advocates believe that if ambulatory services were adequately funded and more easily accessible, demand for inpatient psychiatric hospitalization would decrease and obviate the need for additional inpatient bed capacity.

Community-based forms of crisis intervention, such as assertive community treatment and mobile crisis response teams, have been found to be highly effective and cost-efficient relative to inpatient-based acute treatment. Mobile crisis response services are often provided through collaborative arrangements between local mental health authorities and

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police departments. Mobile crisis teams include trained mental health professionals who can relieve first responders at the call site, evaluate and frequently stabilize the person in crisis, and triage to community-based services for follow-up treatment. Where implemented, mobile crisis response has been found to produce lower hospitalization rates than those resulting from ED-based interventions[24] and to minimize the amount of time police officers must spend intervening in mental crises.[25] Small-scale studies have also found acute care services delivered through residential programs to be both less costly than and as effective as psychiatric hospitalization.[26] However, since it is likely that such programs vary considerably in terms of quality and intensity of services, it is difficult to generalize from available research.

Alternative forms of crisis intervention and intensive outpatient treatment do not appear to be widely accessible, largely as a result of funding limitations. Reimbursement constraints appear to have hampered the growth of community-based mental health services capacity. Often, public mental health agencies are the only providers of such services, and capacity levels are subject to budgetary limitations at the state and local level.

Despite these perceptions, capacity levels for alternative forms of crisis intervention have not been well documented. Unlike hospital beds, the capacities of community-based crisis intervention modalities are somewhat hard to gauge, very little information on the magnitude or quality of these service offerings is collected nationally, and regulatory oversight is very limited. The scope, staffing, and protocols of these programs vary substantially, further complicating efforts to develop national data.

ACUTE MENTAL HEALTH SERVICES IN THE 21ST CENTURY: CRYSTAL BALL

Financing and regulatory policies are likely to play a pivotal role in influencing the capacity of both outpatient and inpatient psychiatric services. Growth (or downsizing) in one sector will likely influence the utilization, financial viability, and capacity of the other. But the nature of this dynamic is hard to predict. Ideally, policies regarding inpatient and outpatient services would be considered in tandem to recognize this interplay and achieve a strategic balance of resource investment.

Impact of Inpatient Psychiatric Facility PPS

It is unclear whether recent changes to Medicare payment policy for inpatient psychiatric services will compound or mitigate psychiatric bed shortages. In January 2005, Medicare began paying for inpatient psychiatric services on a prospective basis, ending the 22-year PPS exemption that had applied to psychiatric facilities. Efforts to develop a diagnosis-based PPS for psychiatric facilities have been fraught with difficulty, leading to a three-year delay to the October 2002 implementation deadline set in the

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Balanced Budget Refinement Act of 1999. For many of the same reasons that psychiatric services were exempted from inpatient PPS in 1983, a psychiatric patient classification system based solely on diagnosis poorly predicts the influence of case mix differences on variation in costs.

The PPS methodology ultimately developed for inpatient psychiatric facilities (IPF-PPS) set a prospective per diem base payment rate with payment amounts for each case adjusted for (i) patient characteristics—age, principal diagnosis (coded by diagnosis-related group, or DRG), select comorbidities, length of stay (recognizing the higher costs incurred in the early days of a psychiatric stay and the higher first-day costs associated with the operation of a full-service emergency room), and use of electroconvulsive therapy—and (ii) facility characteristics—rural location, teaching status, geographic wage index, and cost of living adjustments for Alaska and Hawaii. Outlier payments were made available for high-cost cases. A three-year blended transition period was established, with a stop-loss provision during the transition guaranteeing an average payment per case no less than 70 percent of the payment amount under TEFRA (the Tax Equity and Fiscal Responsibility Act of 1982). Full transition to the IPF-PPS payment methodology and elimination of stop-loss protections is slated for 2008.

Psychiatric providers are cautiously monitoring the effect of IPF-PPS on an industry that has experienced significant fluctuation in inpatient psychiatric capacity over the past two decades.

Some researchers believe that the IPF-PPS methodology does not adequately reflect patient differences that account for substantial variations in the resources needed to provide effective treatment. The cost of treating psychiatric patients is largely a function of the staff time spent assessing, directing, guiding, and monitoring them. Some of the patient characteristics found to affect staff time, such as severity of diagnosis and degree of suicidal or assaultive tendencies, are not reflected in DRG-based classifications.[2] For example, patients at extreme risk for harming themselves or others may be subject to seclusion or restraint procedures that require one-on-one observation from medical staff. Providers that draw more resource-intensive patients may be disadvantaged by this deficiency in the payment methodology.

Psychiatric providers are cautiously monitoring the effect of IPF-PPS on an industry that has experienced significant fluctuation in inpatient psychiatric capacity over the past two decades. Payment analysts predict that the IPF-PPS methodology implemented will likely serve to increase the reimbursement levels available to public mental hospitals, but the impact on other provider types is less certain. Some worry that the IPF-PPS may encourage general hospitals (which tend to have higher average cost structures than freestanding facilities) to further reduce inpatient psychiatric capacity in favor of more reliably profitable medical

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services or to shift beds from specialized units to scatter beds, which will not be reimbursed under IPF-PPS.

Others believe that IPF-PPS will not reduce bed supply and could create incentives for capacity expansions. While less efficient providers might eliminate psychiatric services, organizations that have developed the expertise and economies of scale to deliver psychiatric services in the most efficient manner could expand their operations, further enhancing their financial viability. Concerns have been raised that such expansions might be concentrated within for-profit, freestanding hospitals because they have lower cost structures and greater ability to target desirable patients. Such a shift has the potential to increase the overall supply of psychiatric beds but reduce access for the neediest patients. Both Medicaid's IMD exclusion and alleged attempts by freestanding facilities to limit utilization by the uninsured (for example, by avoiding the requirements of the Emergency Medical Treatment and Active Labor Act, or EMTALA, by not offering ED services) restrict the degree to which low-income patients can use the services of private, freestanding psychiatric hospitals.

The generosity of Medicare payments relative to those of other insurers could influence access for non-Medicare patients in unpredictable ways.

The generosity of Medicare payments relative to those of other insurers could influence access for non-Medicare patients in unpredictable ways. The extent to which IPF-PPS effects will be augmented or counterbalanced by the coverage and reimbursement policies of other insurers is unclear. Shifts in providers' relative competitive positions and available capacity will affect their ability to negotiate with private payers and influence Medicaid payment rates.

The impact of IPF-PPS merits on-going attention from policymakers. Medicare represents a fairly modest share of revenue for both psychiatric units of general hospitals and freestanding psychiatric hospitals (about 30 percent).[5] However, historically changes in Medicare payment have had a significant influence on psychiatric capacity levels. It is too early to know if the move to prospective payment will have a positive or negative effect on psychiatric bed supply, but some impact is likely.

Changes in Medicare psychiatric payment policy may ultimately lead to changes to Medicaid policy as well. Some have called for private psychiatric hospitals to be exempted from the IMD exclusion to ensure that this type of inpatient psychiatric facility is available to meet the needs of Medicaid beneficiaries in the event that alternative placements are unavailable. Proposals to exempt some providers from (or entirely eliminate) the IMD exclusion are controversial, given the desire to move away from institution-based services. Ideally, policy efforts to assess and respond to IPF-PPS would also consider changes in the availability of outpatient mental health services and the extent to which access to these services is shaping demand for inpatient psychiatric care.

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FORECAST FOR OUTPATIENT SERVICES

Many consumer advocates believe that the best way to address shortages of psychiatric beds is to increase the availability of comprehensive, community-based services that include crisis intervention capabilities. However, such expansions are unlikely if funding streams for these activities remain unchanged. Some advocates believe that public and private health insurers should be more generous in their coverage and reimbursement for mental health services. Policy efforts to achieve parity in health insurance coverage for mental health services would likely increase the funding available for some types of outpatient mental health services. However, even broadly constructed parity requirements will have limited impact on the financing available for the many types of mental health services that fall outside the traditional medical model.

Health insurers do not typically cover the broad range of evidence-based services found to support mental health recovery. Many of the therapies demonstrated to be effective in treating mental illness, such as assertive community treatment and multisystemic therapy, include a range of interventions that are more closely associated with social support services than with medical services. Examples of these services include monitoring health status and treatment compliance through home visits and assisting patients to secure housing and employment. Hopes that managed care plans might create innovative, patient-focused interventions to better address mental disorders (and other types of chronic diseases) generally have not been met, and insurers find that prevailing financial incentives are not aligned to encourage such innovation. The feasibility of managing utilization of such services in a fee-for-service context is challenging; administrators of health plans may be wary of the adverse risk selection potential inherent in providing mental health benefits that are far more generous than standard offerings.

Federal officials have begun to question the inclusion of some of these comprehensive services within state Medicaid programs and are calling for increased delineation of such bundled services to clarify the appropriateness of Medicaid coverage. Reducing the federal matching funds available to finance outpatient mental health would likely lead to a decrease in the availability of these services. In light of prevailing outpatient financing policies, inpatient psychiatric shortages are not likely to be alleviated by expanded outpatient mental health capacity in the near future.

WILD CARD: BETTER INFORMATION

Research suggests that psychiatric services are particularly responsive to financial incentives.[29] Multiple theories have been posited to explain these observations, including (i) that psychiatric services are highly inefficient and have more opportunities to improve when faced with constrained resources; (ii) that appropriate treatment approaches are not well defined,

Consumer advocates believe that the best way to address shortages of psychiatric beds is to increase the availability of comprehensive, community-based services that include crisis intervention capabilities.

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giving providers latitude to change practices to maximize prevailing incentives; and (iii) that undertreatment of psychiatric cases is less visible because quality of care is difficult to measure." All of these explanations suggest that better information is needed to guide mental health practice and policy.

The success of future attempts to monitor acute mental health capacity levels holistically will require more accurate data on both inpatient- and outpatient-based acute mental health services. Information on outpatient acute services is particularly difficult to track, as the nature of these services can vary widely and conventional capacity metrics have yet to be developed. Mental health treatment experts believe that untapped opportunities to provide more acute care in outpatient settings abound, but the circumstances under which outpatient treatment could be substituted for inpatient care are not well defined.

Experts have called for additional research to develop better methods for classifying levels of acute care and defining the clinical standards and protocols appropriate to each level. Such standards would help to guide the monitoring and assessment of acute capacity levels, regardless of the setting in which these services are offered. Improved standards for defining acute mental health care needs and services would be useful for a much wider variety of purposes, however. Well-defined acute care standards could be used to develop regulatory requirements at the state and local level, to construct analytic models to forecast the impact of proposed closures or expansions of psychiatric facilities, to guide utilization review techniques, and to evaluate whether IPF-PPS payment incentives are appropriately aligned.

A number of strategies have also been proposed to improve the efficiency and quality of both hospital- and community-based acute care services. Some of these needed improvements in clinical practice (such as expanded use of electronic medical records to facilitate continuity of care and better coordination among inpatient and outpatient providers to allow for seamless transitions across care sites) are certainly not unique to mental health services. But realizing these improvements within the mental health context does pose special challenges. The profound degree of fragmentation found in these services, as well as heightened sensitivity regarding patient confidentiality and autonomy of decision making, add a level of complexity that may be difficult to overcome in the absence of more formal integration across provider organizations.

The extent to which the delivery of acute services is complicated by the cognitive and behavioral effects of mental disorders can not be underestimated. Some have called for the expanded use of advance psychiatric directives to facilitate the delivery of acute services. Advance directives allow patients to both establish treatment preferences and authorize designated persons to make treatment decisions on their behalf in advance of crises during which their mental competency may be compromised.

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These treatment planning efforts could address some of the legal and logistical hurdles that undermine the efficiency and effectiveness of acute mental health services.

Better information on both preferred and prevailing acute mental health practices, combined with well-calibrated financial incentives, has the potential to shape provider practices and encourage strategic decisions regarding service offerings and capacity levels that are advantageous for both treatment facilities and the communities they serve. But the interplay of these various incentives and best-practice recommendations—and the relative power of each—continue to evolve, making predictions regarding future capacity levels very speculative.

CONCLUSION

Ideally, mental health crises would be averted entirely. But they do occur and require effective interventions to mitigate their consequences. The word "crisis" is almost synonymous with terrible outcomes characterized by a devastating loss of control and an unanticipated disruption to the natural order of things. Yet, "crisis" is actually derived from the Greek word meaning "decision." Mental health crises have the potential to be turning points that lead to recovery if appropriate decisions are made and response plans are in place.

The probability of positive outcomes is greatly enhanced by supportive acute mental health services. Policymakers face a number of difficult decisions in attempting to redirect the mental health system away from crisis-oriented care toward a system that optimizes consumer health and functionality. Efforts to build a more robust community-based system will be challenging. Some believe that the "old" system serves as a crutch, delaying investments in new approaches. Others believe that stabilizing inpatient psychiatric bed capacity in the short-term is crucial, given that a community-based infrastructure may take time to develop. The degree of fragmentation in mental health services exacerbates these tensions and suggests that the transition to a community-based model will not be seamless.

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Endnotes / continued ➤

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Endnotes / continued

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12. American Psychiatric Association, "Emergency Departments See Dramatic Increase in People with Mental Illness Seeking Care," press release, June 2, 2004; available at www.psych.org/news_room/press_releases/emergencystudy06032004.pdf.

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Endnotes / continued ➤

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The National Health Policy Forum is a nonpartisan research and public policy organization at The George Washington University. All of its publications since 1998 are available online at www.nhpf.org.

SBH-KINGSPORT 002404

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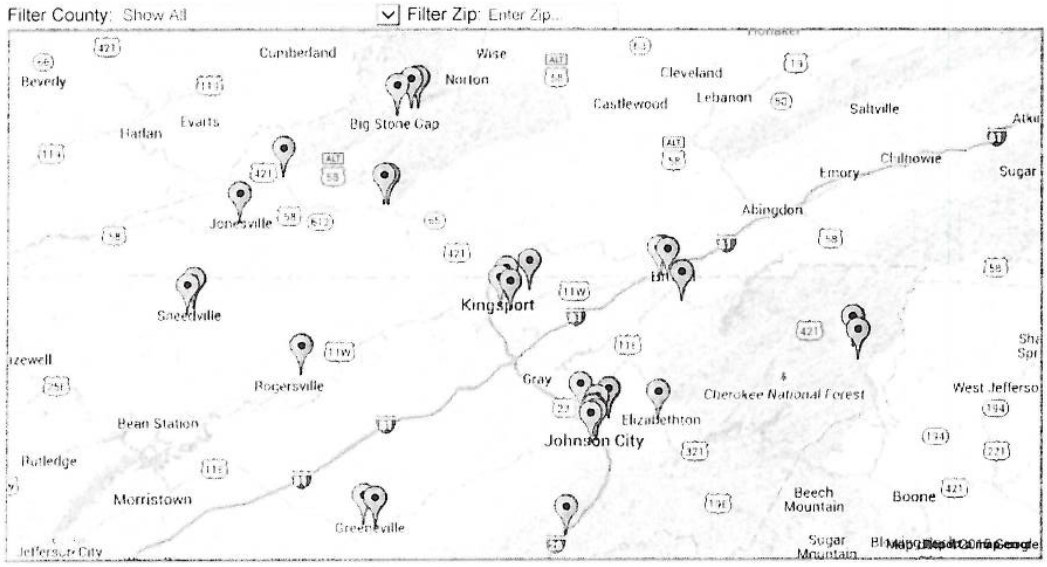

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Therapists assist people with mental health, substance abuse, and co-occurring substance abuse problems, including depression, anxiety, mood and thought disorders through individual, group and family sessions. You begin treatment with a clinical assessment to determine the level of services needed. Services include 24/7 crisis hot line, psychiatric, medication evaluation and case management.

Click on program name for more information

Outpatient Services, Adults

- Church Street Pavilion
- Holston Counseling
- Tennessee Community Support

Outpatient Services, Children and Youth

- Adventure Program
- Holston Children & Youth

Outpatient Services, All Ages

- Bristol Regional Counseling Center
- Charlotte Taylor Center
- Erwin Mental Health Center
- Hancock County Mental Health
- Hawkins County Mental Health
- Johnson County Counseling Center
- Nolachuckey-Holston Area Mental Health
- Watauga Behavioral Health

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Therapists assist people with mental health, substance abuse, and co-occurring substance abuse problems, including depression, anxiety, mood and thought disorders through individual, group and family sessions. You begin treatment with a clinical assessment to determine the level of services needed. Services include 24/7 crisis hot line, psychiatric, medication evaluation and case management.

Click on program name for more information

Outpatient Services, Children and Youth

- Wise County Children & Youth Services

Outpatient Services, All Ages

- Lee County Behavioral Health
- Scott County Behavioral Health
- Wise County Behavioral Health

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JOINT ANNUAL REPORT OF HOSPITALS

2014

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State ID 90411

TENNESSEE DEPARTMENT OF HEALTH
JOINT ANNUAL REPORT OF HOSPITALS
2014

SCHEDULE A - IDENTIFICATION*

1. Name of Hospital Woodridge Psychiatric Hospital — Federal Tax I.D. # 62-0582605
   Did your facility name change during the reporting period? ◎ YES ◎ NO
   County Washington
2. Address of Facility — Street 403 State of Franklin Road; City Johnson City; State Tennessee; Zip 37604
3. Telephone Number (423) 928-7111
   Area Code Number
4. Name of Chief Executive Officer Lindy (First Name) White (Last Name)
   Signature of Chief Executive Officer Lindy White, CEO
5. Name of person(s) coordinating form completion Laken Fritz
   Telephone Number if different than above (423) 302-3354
   Area Code Number
6. 0 Office Use Only
7. Reporting period used for this facility:
   Beginning Date 07/01/2013 Ending Date 06/30/2014
8. 365 Office Use Only
9. Does your hospital own or operate or have other hospitals licensed as satellites of your hospital? ◎ YES ◎ NO
   If yes, please complete the following.

	NAME OF HOSPITAL	STATE ID	SATELLITE	OWN	OPERATE	OWN AND OPERATE
1			☐	◎	◎	◎
2			☒	◎	◎	◎
3			☐	◎	◎	◎
4			☐	◎	◎	◎
5			☐	◎	◎	◎

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SCHEDULE B - CLASSIFICATION*

State ID 90411

1. CONTROL:

A. Indicate the type of organization that is responsible for establishing policy for overall operation of the hospital.

1. Government-Non-Federal	2. Government-Federal	3. Nongovernmental, not-for-profit	4. Investor-owned, for-profit
○ 11 State	○ 17 Armed Forces	○ 20 Church-operated	○ 23 Individual
○ 12 County	○ 18 Veterans Admin.	◉ 21 Other Nonprofit Corporation	○ 24 Partnership
○ 13 City	○ 19 Other, please specify	○ 22 Other not-for-profit, please specify	○ 25 Corporation
○ 14 City-County			
○ 15 Hospital district or authority			

B. Is the hospital part of a health system? ◉ YES ○ NO

If yes, please provide the name and location of the health system.

Name Mountain States Health Alliance City Johnson City State Tennessee

C. Does the controlling organization lease the physical property from the owner(s) of the hospital? ○ YES ◉ NO

D. What is the name of the legal entity that owns and has title to the land and physical plant of the hospital?

Mountain States Health Alliance

E. Is the hospital a division of a holding company? ○ YES ◉ NO

F. Does the hospital itself operate subsidiary corporations? ○ YES ◉ NO

G. Is the hospital managed under contract? ○ YES ◉ NO If YES, length of contract From _____ To _____

If yes, please provide name, city, and state of the organization that manages the hospital.

Name _____ City _____ State _____

Name _____ City _____ State _____

H. Is the hospital part of a health care alliance? ◉ YES ○ NO (see definition of alliance)

If yes, please provide the name, city, and state of the alliance headquarters.

Name Premier, Inc City San Diego State California

Name _____ City _____ State _____

I. Is the hospital part of a health network? ◉ YES ○ NO (see definition of network)

If yes, please provide the the name, city, and state of the network.

Name Mountain States Health Alliance City Johnson City State Tennessee

Name _____ City _____ State _____

2. SERVICE:

A. Indicate the ONE category that BEST describes your hospital.

○ 01 General medical and surgical	○ 07 Rehabilitation
○ 02 Pediatric	○ 08 Orthopedic
◉ 03 Psychiatric	○ 09 Chronic disease
○ 04 Tuberculosis and other respiratory diseases	○ 10 Alcoholism and other chemical dependency
○ 05 Obstetrics and gynecology	○ 11 Long term acute care
○ 06 Eye, ear, nose and throat	○ 12 Other-specify treatment area

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B. Does your hospital own or have a contract with any of the following?

	(1) Yes	(2) No	Specify one: 1) Own	2) Contract	Number of Physicians	FTE Physicians
1. Independent Practice Association	○	◉	○	◉	0	0.0
2. Group Practice Without Walls	○	◉	○	◉	0	0.0
3. Open Panel Physician-Hospital Organization (PHO)	◉	○	◉	○	2,558	0.0
4. Closed Panel Physician-Hospital Organization (PHO)	○	◉	○	◉	0	0.0
5. Management Services Organization (MSO)	○	◉	○	◉	0	0.0
6. Integrated Salary Model	◉	○	◉	○	204	0.0
7. Equity Model	○	◉	○	◉	0	0.0
8. Foundation	○	◉	○	◉	0	0.0

3. Have any of the following insurance products been developed for use in Tennessee by your hospital, health system, health network alliance or as a joint venture with an insurer?
Check all that apply.

	(1) Your Hospital	(2) Health System	(3) Health Network	(4) Alliance	(5) Joint Venture With Insurer
A. Health Maintenance Organization	☐	☑	☐	☐	☐
B. Preferred Provider Organization	☐	☐	☐	☐	☐
C. Indemnity Fee For Service Plan	☐	☑	☐	☐	☐

4. Does your hospital have a formal written contract that specifies the obligations of each party with:
   A. Health Maintenance Organization (HMO)? ◉ YES ○ NO
      1. How many do you contract with? 8
      2. Number of different contracts 11
   B. Preferred Provider Organization (PPO)? ◉ YES ○ NO
      1. How many do you contract with? 16
      2. Number of different contracts 23

5. What percentage of the hospital's net patient revenue is paid on a capitated basis?
If the hospital does not participate in any capitated arrangement, please enter "0". 0.0 %

6. How many covered lives are in your capitation agreements? 0

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SBH-KINGSPORT 002411

SCHEDULE C - ACCREDITATIONS AND APPROVALS* State ID 90411

1. ACCREDITATIONS:

A. Joint Commission on Accreditation of Healthcare Organizations (JCAHO)		
Date of most recent accrediting letter or survey 04/02/2012	◉YES	○NO
If Yes, is the hospital accredited under either/both of the following manuals:		
1. Comprehensive Accreditation Manual for Hospitals (CAMH)	◉YES	○NO
2. Comprehensive Accreditation Manual for Behavioral Health Care (CAMBHC)	○YES	◉NO
3. Other manuals, please specify		
B. Commission on Accreditation of Rehabilitation Facilities (CARF)		
Date of most recent accrediting letter or survey	○YES	◉NO
C. American College of Surgeons Commission on Cancer	○YES	◉NO
D. American Osteopathic Association (AOA)	○YES	◉NO
E. TÜV Healthcare Specialists	○YES	◉NO
F. Community Health Accreditation Program (CHAP)	○YES	◉NO

2. CERTIFICATIONS:

Medicare Certification	◉YES	○NO

3. OTHER:

A. THA Membership	◉YES	○NO
B. Hospital Alliance of Tennessee, Inc. Membership	◉YES	○NO
C. American Hospital Association Membership	◉YES	○NO
D. American Medical Association Approval for Residencies (and Internships)	◉YES	○NO
E. State Approved School of Nursing:		
Registered Nurses	○YES	◉NO
Licensed Practical Nurses	○YES	◉NO
F. Medical School Affiliation	○YES	◉NO
G. Tennessee Association of Public and Teaching Hospitals (TNPath)	○YES	◉NO
H. National Association of Children's Hospitals and Related Institutions (NACHRI)	○YES	◉NO
I. National Association of Public Hospitals (NAPH)	○YES	◉NO
J. Other, please specify		

Field is limited to 255 characters

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SBH-KINGSPORT 002412

SCHEDULE D - SERVICES*

State ID 90411

1. CERTIFICATE OF NEED:

Do you have an approved, **but not completed**,certificate of need (CON) ? ○ YES ◉ NO

If yes, please specify:

Name of Service or Activity Requiring the CON	# of Beds (if applicable)	Date of Approval
	0	
	0	
	0	

2. Does your hospital own or operate Tennessee physician primary care clinics? ○ YES ◉ NO If yes, how many? 0
   How many physicians practice in these clinics? 0

3. Does your hospital own or operate other physician/specialty clinics located in Tennessee? ○ YES ◉ NO If yes, how many? 0
   How many physicians practice in these clinics? 0

4. Does your hospital own or operate a blood bank? ○ YES ◉ NO
   If yes, please indicate:

A. Distributes blood within the hospital	◉ YES	◉ NO
B. Collects blood within the hospital	◉ YES	◉ NO
C. Distributes blood outside the hospital	◉ YES	◉ NO
D. Collects blood from outside the hospital	◉ YES	◉ NO

5. Does your hospital own or operate an ambulance service? ○ YES ◉ NO
   If yes, please specify the counties where services are located.

Please specify the type of service and ownership relationship:

A. Land Transport	◉ YES	◉ NO	If yes,	◉ own;	◉ operate;	◉ own and operate;	◉ own in joint venture
B. Helicopter	◉ YES	◉ NO	If yes,	◉ own;	◉ operate;	◉ own and operate;	◉ own in joint venture
C. Special Neonatal Helicopter	◉ YES	◉ NO	If yes,	◉ own;	◉ operate;	◉ own and operate;	◉ own in joint venture
D. Special Neonatal Land Transport	◉ YES	◉ NO	If yes,	◉ own;	◉ operate;	◉ own and operate;	◉ own in joint venture

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6. Does your hospital own or operate an off-site outpatient/ambulatory clinic located in Tennessee? ○ YES ◉ NO
If yes, please complete the following.

Name of Clinic	County	City				
			○own	○operate	○own and operate	○own in joint venture
			○own	○operate	○own and operate	○own in joint venture

7. Does your hospital own or operate an off-site ambulatory surgical treatment center located in Tennessee? ○ YES ◉ NO
If yes, please complete the following.

Name of Center	County	City				
			○own	○operate	○own and operate	○own in joint venture
			○own	○operate	○own and operate	○own in joint venture

8. Does your hospital own or operate an off-site birthing center located in Tennessee? ○ YES ◉ NO
If yes, please complete the following.

Name of Center	County	City				
			○own	○operate	○own and operate	○own in joint venture
			○own	○operate	○own and operate	○own in joint venture

9. Does your hospital own or operate an off-site outpatient diagnostic center located in Tennessee? ○ YES ◉ NO
If yes, please complete the following.

Name of Center	County	City				
			○own	○operate	○own and operate	○own in joint venture
			○own	○operate	○own and operate	○own in joint venture

10. Does your hospital own or operate an off-site outpatient physical therapy rehab center located in Tennessee? ○ YES ◉ NO
If yes, please complete the following.

Name of Center	County	City				
			○own	○operate	○own and operate	○own in joint venture
			○own	○operate	○own and operate	○own in joint venture

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11. Does your hospital own or operate a hospice that has a separate license located in Tennessee? ◯ YES ◉ NO
If yes, please complete the following.

Name of Hospice	County	City				
			◎own	◎operate	◎own and operate	◎own in joint venture
			◎own	◎operate	◎own and operate	◎own in joint venture

12. Does your hospital own or operate an off-site assisted-care living facility located in Tennessee? ◯ YES ◉ NO
If yes, please complete the following.

Name of Facility	County	City				
			◎own	◎operate	◎own and operate	◎own in joint venture
			◎own	◎operate	◎own and operate	◎own in joint venture

13. Does your hospital own or operate a home for the aged located in Tennessee? ◯ YES ◉ NO
If yes, please complete the following.

Name of Home	County	City				
			◎own	◎operate	◎own and operate	◎own in joint venture
			◎own	◎operate	◎own and operate	◎own in joint venture

14. Does your hospital own or operate an urgent care center? ◯ YES ◉ NO
If yes, please complete the following.

Name of Center	County	City				
			◎own	◎operate	◎own and operate	◎own in joint venture
			◎own	◎operate	◎own and operate	◎own in joint venture

15. Does your hospital own or operate a home health agency? ◯ YES ◉ NO
If yes, please complete the following.

Name of Agency: _____
Location of Agency: City _____ County _____
Number of Visits _____
◎own ◎operate ◎own and operate ◎own in joint venture

Name of Agency: _____
Location of Agency: City _____ County _____
Number of Visits _____
◎own ◎operate ◎own and operate ◎own in joint venture

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16. Does your hospital own or operate an off-site nursing home located in Tennessee? ○ YES ◉ NO
If yes, please complete the following.

_____ _____ _____ ○own ○operate ○own and operate ○own in joint venture
Name of Home County City

Number of Beds - Total 0 = Medicare only (SNF) _____ + Medicaid only (NF) _____ + Medicare/Medicaid (SNF/NF) _____ + Not Certified _____

_____ _____ _____ ○own ○operate ○own and operate ○own in joint venture
Name of Home County City

Number of Beds - Total 0 = Medicare only (SNF) _____ + Medicaid only (NF) _____ + Medicare/Medicaid (SNF/NF) _____ + Not Certified _____

17. Does your hospital operate a hospital-based skilled nursing unit (subacute unit) licensed as a nursing home for skilled nursing care (excluding swing beds)? ○ YES ◉ NO If yes, please complete the following.

_____ _____ _____
Name of SNF Number of Licensed Beds Number of Staffed Beds

_____ _____
Number of Admissions Number of Patient Days

18. Does your hospital own, operate, or contract a mobile unit that operates in Tennessee? ○ YES ◉ NO
If yes, specify name(s) and whether owned, operated, or contracted.

A. List mobile services:

1	_____	○contract	○own	○operate	○own and operate	○own in joint venture	_____ # of visits
2	_____	○contract	○own	○operate	○own and operate	○own in joint venture	_____ # of visits
3	_____	○contract	○own	○operate	○own and operate	○own in joint venture	_____ # of visits
4	_____	○contract	○own	○operate	○own and operate	○own in joint venture	_____ # of visits
5	_____	○contract	○own	○operate	○own and operate	○own in joint venture	_____ # of visits
6	_____	○contract	○own	○operate	○own and operate	○own in joint venture	_____ # of visits

B. List counties served (where you take the service):
List counties for service 1 in 18A on line 1, for service 2 on line 2, etc.

1	_____	_____	_____	_____	_____	_____
2	_____	_____	_____	_____	_____	_____
3	_____	_____	_____	_____	_____	_____
4	_____	_____	_____	_____	_____	_____
5	_____	_____	_____	_____	_____	_____
6	_____	_____	_____	_____	_____	_____

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19. HOSPITAL-BASED SERVICES (See Explanation):

Utilization of Selected Services	Is This Service Provided In Your Hospital? YES	NO	To Inpatients Unit of Measure	Number	To Outpatients Unit of Measure	Number
A. Miscellaneous:						
Lithotripsy						
Percutaneous	○	◉	Procedures	0	Procedures	0
Extracorporeal Shock Wave	○	◉				
# fixed units inside hospital 0			Procedures	0	Procedures	0
# fixed units off site 0					Procedures	0
# of mobile units 0			Procedures	0	Procedures	0
# days per week (mobile units) 0						
Renal Dialysis						
# of dedicated stations 0						
Hemo Dialysis	○	◉	Patients	0	Patients	0
			Treatments	0	Treatments	0
Peritoneal Dialysis	○	◉	Patients	0	Patients	0
			Treatments	0	Treatments	0
B. Oncology/Therapies:						
Chemotherapy	○	◉	Patients	0	Patients	0
					Encounters	0
Hyperthermia	○	◉	Treatments	0	Treatments	0
Radiation Therapy-Megavoltage	○	◉				
# fixed units inside hospital 0			Patients	0	Patients	0
			Treatments	0	Treatments	0
# fixed units off site 0						

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SCHEDULE D - SERVICES (continued)* State ID 90411

Utilization of Selected Services	Is This Service Provided In Your Hospital? YES	NO	To Inpatients Unit of Measure	Number	To Outpatients Unit of Measure	Number
C. Radiology:						
Computerized Tomographic Scanners CT/CAT	○	◉	Patients	0	Visits	0
# fixed units inside hospital 0			Procedures	0	Procedures	0
# fixed units off site 0					Procedures	0
# of mobile units 0			Procedures	0	Procedures	0
# days per week (mobile units) 0						
Ultrafast CT	○	◉	Patients	0	Visits	0
# fixed units inside hospital 0			Procedures	0	Procedures	0
# fixed units off site 0					Procedures	0
# of mobile units 0			Procedures	0	Procedures	0
# days per week (mobile units) 0						
Magnetic Resonance Imaging	○	◉				
# fixed units inside hospital 0			Procedures	0	Procedures	0
# fixed units off site 0					Procedures	0
# of mobile units 0			Procedures	0	Procedures	0
# days per week (mobile units) 0						
Nuclear Medicine	○	◉	Procedures	0	Procedures	0
Radium Therapy	○	◉	Procedures	0	Procedures	0
Isotope Therapy	○	◉	Procedures	0	Procedures	0
Positron Emission Tomography	○	◉				
# fixed units inside hospital 0			Procedures	0	Procedures	0
# fixed units off site 0					Procedures	0
# of mobile units 0			Procedures	0	Procedures	0
# days per week (mobile units) 0						
Mammography	○	◉	Procedures	0	Procedures	0
# of ACR accredited units 0						
# other fixed units inside hospital 0						
# other fixed units off site 0						
# of mobile units 0						
# days per week (mobile units) 0						
Bone Densitometry	○	◉	Procedures	0	Procedures	0
# of units 0						

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Note: Pediatric patients should be defined as patients 14 years old and younger.

Utilization of Selected Services	Is This Service Provided In Your Hospital? YES	NO	In Cath Lab Setting Unit of Measure	Number	Outside Cath Lab Setting Unit of Measure	Number
D. Cardiac:						
Cardiac Catheterization						
Date Initiated _____						
# labs 0						
Intra-Cardiac or Coronary Artery	○	◉	Adult Procedures	0	Adult Procedures	0
			Pediatric Procedures	0	Pediatric Procedures	0
Percutaneous Transluminal Coronary Angioplasty	○	◉	Adult Procedures	0	Adult Procedures	0
			Pediatric Procedures	0	Pediatric Procedures	0
Stents	○	◉	Adult Procedures	0	Adult Procedures	0
			Pediatric Procedures	0	Pediatric Procedures	0
All Other Heart Procedures	○	◉	Adult Procedures	0	Adult Procedures	0
			Pediatric Procedures	0	Pediatric Procedures	0
All Other Non-Cardiac Procedures	○	◉	Adult Procedures	0	Adult Procedures	0
			Pediatric Procedures	0	Pediatric Procedures	0
Thrombolytic Therapy	○	◉	Adult Procedures	0	Adult Procedures	0
			Pediatric Procedures	0	Pediatric Procedures	0
			To Inpatients		To Outpatients	
Open Heart Surgery	○	◉	Adult Operations	0		
# dedicated O.R.'s 0			Pediatric Operations	0		
E. Surgery:						
Inpatient	○	◉	Encounters	0		
# operating rooms 0			Procedures	0		
Outpatient (one day)	○	◉			Encounters	0
# dedicated O.R.'s 0					Procedures	0
F. Rehabilitation:						
Cardiac	○	◉	Patients	0	Patients	0

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SCHEDULE D - SERVICES (continued)*

State ID 90411

Utilization of Selected Services	Is This Service Provided In Your Hospital? YES	NO	To Inpatients Unit of Measure	Number	To Outpatients Unit of Measure	Number
F. Rehabilitation (continued):						
Chemical Dependency	○	◉	Patients	0	Patients Episodes of Care	0 0
Nutritional Counseling	○	◉	Patients	0	Patients Episodes of Care	0 0
Pulmonary	○	◉	Patients	0	Patients Episodes of Care	0 0
G. Physical Rehabilitation:						
Occupational Therapy	○	◉	Patients	0	Patients Episodes of Care	0 0
Orthotic Services	○	◉	Patients	0	Patients Episodes of Care	0 0
Physical Therapy	○	◉	Patients	0	Patients Episodes of Care	0 0
Prosthetic Services	○	◉	Patients	0	Patients Episodes of Care	0 0
Speech/Language Therapy	○	◉	Patients	0	Patients Episodes of Care	0 0
Therapeutic Recreational Service	○	◉	Patients	0	Patients Episodes of Care	0 0

Do you have a dedicated inpatient physical rehabilitation unit? ○ YES ◉ NO

If yes, please complete the following. Number of assigned beds 0 Number of admissions 0 Number of patient days 0

Do you have a dedicated outpatient physical rehabilitation unit? ○ YES ◉ NO

H. Pain Management:	○	◉	Patients	0	Patients	0

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SCHEDULE D - SERVICES (continued)* State ID 90411

Utilization of Selected Services	Is This Service Provided In Your Hospital? YES	NO	To Inpatients Unit of Measure	Number	To Outpatients Unit of Measure	Number
I. Obstetrics/Newborn:						
Obstetrics Level of Care						
Level I	○	◉				
Level II	○	◉				
Level III	○	◉				
Cesarean Section Deliveries	○	◉	Deliveries	0		
Non C-Section Deliveries	○	◉	Deliveries	0		
Birthing Rooms # rooms 0 # LDRP beds 0 # LDR beds 0	○	◉	Deliveries	0		
Labor Rooms # rooms 0	○	◉				
Postpartum Services # beds 0	○	◉	Patients	0	Visits	0
Newborn Nursery # bassinets 0	○	◉	Infants Discharged Patient Days	0 0		
Premature Nursery # bassinets 0	○	◉	Infants Discharged Patient Days	0 0		
Isolation Nursery # bassinets 0	○	◉	Patient Days	0		

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SCHEDULE D - SERVICES (continued)* State ID 90411

Utilization of Selected Services	Is This Service Provided in Your Hospital? YES	NO	To Inpatients Unit of Measure	Number	To Outpatients Unit of Measure	Number
J. Transplants:						
Organs						
Total Donors			Donors	0		
Total Harvested	○	◉	Donations	0		
Transplants	○	◉	Transplants	0		
Organ Bank	○	◉	Organs	0		
Type of Organ:						
Heart	○	◉	# Harvested	0		
			# Transplanted	0		
Liver	○	◉	# Harvested	0		
			# Transplanted	0		
Kidneys	○	◉	# Harvested	0		
			# Transplanted	0		
Pancreas	○	◉	# Harvested	0		
			# Transplanted	0		
Intestine	○	◉	# Harvested	0		
			# Transplanted	0		
Any Other _____	○	◉	# Harvested	0		
			# Transplanted	0		
Tissues						
Total Donors			Donors	0		
Total Harvested	○	◉	Donations	0		
Transplants	○	◉	Transplants	0		
Tissue Bank	○	◉	Tissues	0		
Type of Tissue:						
Eye	○	◉	# Harvested	0		
			# Transplanted	0	# Transplanted	0
Bone	○	◉	# Harvested	0		
			# Transplanted	0	# Transplanted	0
Bone Marrow	○	◉	# Harvested	0		
			# Transplanted	0	# Transplanted	0
Connective	○	◉	# Harvested	0		
			# Transplanted	0	# Transplanted	0
Cardiovascular	○	◉	# Harvested	0		
			# Transplanted	0	# Transplanted	0
Stem Cell	○	◉	# Harvested	0		
			# Transplanted	0	# Transplanted	0
Other _____	○	◉	# Harvested	0		
			# Transplanted	0	# Transplanted	0

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SCHEDULE D - SERVICES (continued)* State ID 90411

Utilization of Selected Services	Is This Service Provided In Your Hospital? YES	NO	To Inpatients Unit of Measure	Number	To Outpatients Unit of Measure	Number
K. Other:						
Hyperbaric Oxygen Therapy	○	◉	Patients	0		
Gamma Knife	○	◉	Patients	0	Patients	0
Cyberknife	○	◉	Patients	0	Patients	0
L. Intensive/Intermediate:						
Burn Care Unit # beds 0	○	◉	Patients Patient Days	0 0	Patients	0
Cardiac Care Unit # beds 0	○	◉	Patients Patient Days	0 0		
Medical Intensive Care Unit # beds 0	○	◉	Patients Patient Days	0 0		
Mixed Intensive Care Unit # beds 0	○	◉	Patients Patient Days	0 0		
Neonatal Level of Care (Indicate highest level of care.)						
Level I # beds 0	○	◉	Patients Patient Days	0 0		
Level II A # beds 0	○	◉	Patients Patient Days	0 0		
Level II B # beds 0	○	◉	Patients Patient Days	0 0		
Level III A # beds 0	○	◉	Patients Patient Days	0 0		
Level III B # beds 0	○	◉	Patients Patient Days	0 0		
Level III C # beds 0	○	◉	Patients Patient Days	0 0		
Pediatric Care Unit # beds 0	○	◉	Patients Patient Days	0 0		
Stepdown ICU # beds 0	○	◉	Patients Patient Days	0 0		
Stepdown CCU # beds 0	○	◉	Patients Patient Days	0 0		
Surgical Intensive Care Unit # beds 0	○	◉	Patients Patient Days	0 0		

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SCHEDULE D - SERVICES (continued)*

State ID 90411

Utilization of Selected Services	Is This Service Provided In Your Hospital? YES	NO	To Inpatients Unit of Measure	Number	To Outpatients Unit of Measure	Number
L. Intensive/Intermediate (continued):						
Other, specify _____ Number of beds 0	○	◉	Patients Patient Days	0 0		
Other, specify _____ Number of beds 0	○	◉	Patients Patient Days	0 0		
M. Psychiatric Partial Hospitalization	○	◉	Patients	0		
N. Psychiatric Intensive Outpatient Care	◉	○			Patients	116
O. Electroconvulsive Treatment	○	◉	Patients Treatments	0 0	Patients Treatments	0 0
P. Other Convulsive Treatment	○	◉	Patients Treatments	0 0	Patients Treatments	0 0
Q. Negative Pressure Ventilated Room If yes, number of beds 0	○	◉				

R. 23 Hour Observation ○ YES ◉ NO Outpatients 0

S. Cancer Patients:

1. How many patients were diagnosed with cancer at your facility during this reporting period? 0
2. How many patients were both diagnosed and provided the first course of treatment for cancer at your facility during this reporting period? 0
3. How many patients were diagnosed elsewhere but provided the first course of treatment at your facility during this reporting period? 0

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SCHEDULE E - FINANCIAL DATA*

State ID 90411

Dates covered from 07/01/2013 to 06/30/2014 Use zeros where applicable. Do not leave blank lines in this schedule.

A. CHARGES (For reporting period only. Do not include revenue related losses; round to the nearest dollar.)

	Gross Patient Charges	minus	Adjustments To Charges	equals	Net Patient Revenue
1. Government					
a) Medicare Inpatient - Total (include managed care)	$18,249,646	-	$13,854,198	=	$4,395,448
1) Medicare Managed Care - Inpatient	$6,462,769	-	$5,082,935	=	$1,379,834
b) Medicare Outpatient - Total (include managed care)	$97,283	-	$79,789	=	$17,494
1) Medicare Managed Care - Outpatient	$18,011	-	$9,678	=	$8,333
c) Medicaid/TennCare Inpatient* (for EAH use 7.b.2.)	$1,755,819	-	$1,195,694	=	$560,125
d) Medicaid/TennCare Outpatient* (for EAH use 7.b.2.)	$983	-	$0	=	$983
e) Other	$4,037,743	-	$2,538,063	=	$1,499,680
f) Total Government Sources	$24,141,474	-	$17,667,744	=	$6,473,730
2. Cover Tennessee * see instructions					
a) Cover TN	$24,817	-	$105	=	$24,712
b) Cover Kids	$351,836	-	$255,790	=	$96,046
c) Access Tennessee	$0	-	$0	=	$0
d) Total Cover Tennessee	$376,653	-	$255,895	=	$120,758
3. Nongovernment					
a) Self-Pay	$349,724	-	$342,723	=	$7,001
b) Blue Cross Blue Shield	$1,940,688	-	$1,151,473	=	$789,215
c) Commercial Insurers (excludes Workers Comp)	$9,462,211	-	$7,070,116	=	$2,392,095
d) Workers Compensation	$31,785	-	$25,105	=	$6,680
e) Other	$22,389,434	-	$20,993,936	=	$1,395,498
f) Total Nongovernment Sources	$34,173,842	-	$29,584,353	=	$4,589,489
4. Totals					
a) Total Inpatient (excludes Newborn)	$58,085,025				
b) Newborns	$0				
c) Total Inpatient (includes Newborn) (A4a + A4b)	$58,085,025	-	$47,203,704	=	$10,881,321
d) Total Outpatient	$606,944	-	$304,288	=	$302,656
e) Grand Total (A1f + A2d + A3f)	$58,691,969	-	$47,507,992	=	$11,183,977
5. Bad Debt					
a) Medicare Enrollees			$278,537		
b) Other Government			$65,493		
c) Cover Tennessee			$0		
d) Blue Cross and Commercially Insured Patients			$450,323		
e) All Other			$136,075		
f) Total Bad Debt			$930,428		
6. Nongovernment and Cover Tennessee Adjustments to Charges					
a) Nongovernment Contractual			$14,503,651		
b) Cover Tennessee Contractual			$255,896		
c) Charity Care - Inpatient			$14,393,212		
d) Charity Care - Outpatient			$101,092		
e) Other Adjustments, specify types _____			$0		
f) Total Nongovernment Adjustments			$29,253,651		

Amount of discounts provided to uninsured patients $266,278

$14,494,304 Total Charity (A6c + A6d)

$15,424,732 Total Charity plus Bad Debt (A5f + A6c + A6d)

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SCHEDULE E - FINANCIAL DATA (continued)* State ID 90411

A. CHARGES (continued)

7. Other Operating Revenue

a) Tax appropriations	$0
b) State and Local government contributions:	
1) Amount designated to offset indigent care	$0
2) Essential Access Hospital (EAH) payments	$3,777,337
3) Critical Access Hospital (CAH) payments	$0
4) Amount used for other	$0
5) Total	$3,777,337
c) Other contributions:	
1) Amount designated to offset indigent care	$0
2) Amount used for other	$0
3) Total	$0
d) Other (include cafeteria, gift shop, etc.)	$2,667,125
e) Total other operating revenue (A7a + A7b5 + A7c3 + A7d)	$6,444,462

8. Nonoperating Revenue (No negative numbers! Losses or expenses should be reported in B2g.)

a) Contributions	$100
b) Grants	$0
c) Interest income	$0
d) Other	$0
e) Total nonoperating revenue (add A8a through A8d)	$100
f) TOTAL REVENUE (Net A4e + A7e + A8e)	$17,628,539

B. EXPENSES (for the reporting period only; round to the nearest dollar)

1. Payroll Expenses for all categories of personnel specified below; (see definitions page)

a) Physicians and dentists (include only salaries)	$0
b) Medical and dental residents (include medical and dental interns)	$0
c) Trainees (medical technology, x-ray therapy, administrative, and so forth)	$0
d) Registered and licensed practical nurses	$3,204,379
e) All other personnel	$5,192,943
f) Total payroll expenses (add B1a through B1e)	$8,397,322

2. Nonpayroll Expenses

a) Employee benefits (social security, group insurance, retirement benefits)	$2,402,435
b) Professional fees (medical, dental, legal, auditing, consultant and so forth)	$2,478,578
c) Contracted nursing services (include staff from nursing registries, service contracts, and temporary help agencies)	$94,370
d) Depreciation expense	$717,072
e) Interest expense	$699,622
f) Energy expense	$114,469
g) All other expenses (supplies, purchased services, nonoperating expenses, and so forth)	$2,625,561
h) Total nonpayroll expenses (add B2a through B2g)	$9,132,097
i) TOTAL EXPENSES (add B1f + B2h)	$17,529,419

3. Are system overhead/management fees included in your expenses? (●) YES ( ) NO
If yes, specify amount $1,897,536

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C. CURRENT ASSETS

1. Current Assets is defined as the value of cash, accounts receivable, inventories, marketable securities and other assets that could be converted to cash in less than 1 year.
   What were your current assets on the last day of your reporting period (specified in Schedule A7 on page 2)? $6,174,949
   Net receivables are defined as the collectibles as of the last day of your reporting period, whether or not they are currently due.
2. What were your net receivables on the last day of your reporting period? $3,880,920

D. FIXED ASSETS recorded on the balance sheet at the end of the reporting period (include actual or estimated value of plant/equipment that is leased).

1. Gross plant and equipment assets (including land, building, and equipment) $11,164,613
2. LESS: Deduction for accumulated depreciation $5,146,457
3. NET FIXED plant and equipment assets (D.1. Less D.2.; if zero please explain on separate sheet) $6,018,156

E. OTHER ASSETS recorded on the balance sheet at the end of the reporting period (include assets not included above as current or fixed assets)
What were your other assets on the last day of your reporting period (specified in Schedule A7 on page 2)? $0

F. TOTAL ASSETS
Total Assets is the sum of current assets, fixed assets and other assets (C.1.+D.3.+E.).
What were your total assets on the last day of your reporting period (specified in Schedule A7 on page 2)? $12,193,106

G. CURRENT LIABILITIES
Current liabilities is defined as the amount owed for salaries, interest, accounts payable, and other debts due within one (1) year. What were your current liabilities on the last day of your reporting period? $2,266,161

H. LONG TERM LIABILITIES

1. Long Term Liabilities is defined as the amount owed for leases, bond repayment and other items due after one (1) year. What were your long term liabilities on the last day of your reporting period? $65,093
2. Long Term Debt is defined as the value of obligations of over 1 year that require interest to be paid. What was your long term debt on the last day of your reporting period? $0

I. OTHER LIABILITIES
Other liabilities includes those liabilities not reported as current (item G.) or long term (item H.1.).
What were your total liabilities on the last day of your reporting period (specified in Schedule A7 on page 2)? $2,331,254

J. CAPITAL ACCOUNT
Capital Account includes Fund Balance or Stockholder's Equity and all general, specific purpose, restricted or unrestricted funds. The Capital Account is the excess of assets over its liabilities.
What was your capital account on the last day of your reporting period? $9,861,851
Note: Total Assets should equal Liabilities plus Capital Account (i.e. item F.=G.+H.1.+I.+J.).

K. 1. Federal Income Tax: $0

2. Local Property Taxes Paid During the Reporting Period:
   a) Taxes on the Inpatient Facility $0
   b) Taxes on all Other Property $0

3. Other Local, State, or Federal Taxes: (exclude sales tax) $0

L. Does your hospital bill include charges incurred for the following professional services?
Radiology - ○ YES ◉ NO Pathology - ○ YES ◉ NO Anesthesiology - ○ YES ◉ NO Other - Specify _____

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MSHA-001662

M. TennCare Utilization and Revenue:

1. Inpatient Utilization and Revenue for TennCare Managed Care Organizations:

MCO	NUMBER OF ADMISSIONS	NUMBER OF PATIENT DAYS	GROSS REVENUE	NET REVENUE
United Health Care Community Plan	0	0	$0	$0
Amerigroup	0	0	$0	$0
Blue Care	23	136	$348,782	$52,800
TennCare Select	5	30	$73,900	$31,186
TennCare, MCO (Not Specified)	536	3,239	$7,959,906	$3,367,484
Total MCO	564	3,405	$8,382,588	$3,471,470

2. Outpatient Utilization and Revenue for TennCare Managed Care Organizations:

MCO	NUMBER OF PATIENTS	NUMBER OF VISITS	GROSS REVENUE	NET REVENUE
United Health Care Community Plan	0	0	$0	$0
Amerigroup	0	0	$0	$0
Blue Care	0	0	$0	$0
TennCare Select	0	0	$0	$0
TennCare, MCO (Not Specified)	0	0	$0	$0
Total MCO	0	0	$0	$0

MSHA-001663
SBH-KINGSPORT 002428

SCHEDULE F - BEDS AND BASSINETS* State ID 90411.

1. PLEASE GIVE THE NUMBER OF:

A. TOTAL LICENSED ADULT AND PEDIATRIC BEDS AS OF THE LAST DAY OF THE REPORTING PERIOD (exclude beds in a sub-acute unit that are licensed as nursing home beds) 84

B. The number of adult and pediatric staffed beds set up, staffed and in use as of the last day of the reporting period. 84

C. NEWBORN NURSERY BASSINETS AS OF THE LAST DAY OF THE REPORTING PERIOD 0

D. Licensed Beds that were not staffed at any time during the reporting period. 0

2. STAFFED ADULT, PEDIATRIC, AND NEONATAL BEDS (exclude newborn nursery, include neonatal care units):

Was there a temporary or a permanent change in the total number of beds set up and staffed during the period? ○ YES ◉ NO
If yes, give beds added or withdrawn (show increase by + and decrease by -) and date of change.

Bed change (+ or -) 0 Bed change (+ or -) 0 Bed change (+ or -) 0 Bed change (+ or -) 0
Date: _____ Date: _____ Date: _____ Date: _____

3 SWING BEDS:

A. Does your facility utilize swing beds? ○ YES ◉ NO If yes, number of Acute Care beds designated as Swing Beds. 0

B. PLEASE SPECIFY THE FOLLOWING FOR BEDS WHEN USED FOR LONG TERM SKILLED OR INTERMEDIATE CARE:

(How many admissions and how many days did you provide in the following categories?)

INTERMEDIATE CARE	ADMISSIONS	PATIENT DAYS
Private Pay	0	0
Other	0	0
Total	0	0

SKILLED CARE	ADMISSIONS	PATIENT DAYS
Commercial	0	0
Blue Cross	0	0
Medicare	0	0
Private Pay	0	0
Other	0	0
Total	0	0

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4. A. Number of Beds Set Up and Staffed on a typical day

SERVICE	BEDS
Medical	0
Surgical	0
Medical/Surgical	0
Obstetrics	0
Gynecological	0
OB/GYN	0
Pediatric	0
Eye	0
Neonatal Care	0
Intensive Care (excluding Neonatal)	0
Orthopedic	0
Urology	0
Rehabilitation	0
Chronic/Extended Care	0
Pulmonary	0
Psychiatric	84
Psychiatric specifically for Children and Youth under age 18	12
Psychiatric specifically for Geriatric Patients	0
Chemical Dependency	0
Chemical Dependency specifically for Children and Youth under age 18	0
Chemical Dependency specifically for Geriatric Patients	0
Swing Beds (for long term skilled or intermediate care)	0
Other, specify	0
Unassigned	0
TOTAL	84

B. Number of Patients in hospital on a typical day. Exclude normal newborns (See Instructions), long term skilled or intermediate patients. 64

5. OBSERVATION BEDS

A. Do you use inpatient staffed beds for 23-hour observation? ○ YES ◉ NO If yes, number of beds 0

B. Do you have beds assigned to dedicated 23-hour observation unit? ○ YES ◉ NO If yes, number of beds 0

C. Do you have beds in a "same-day-surgery" unit that are used for both same-day surgery and 23-hour observation? ○ YES ◉ NO
If yes, number of beds 0

MSHA-001665
SBH-KINGSPORT 002431

SCHEDULE G - UTILIZATION* State ID 90411

1. INPATIENT UTILIZATION (include normal newborns)
   Patient Census Records:
   Please indicate whether you are reporting Admissions and Inpatient Days ○
   or Discharges and Discharge Patient Days ◉

2. UTILIZATION BY MAJOR DIAGNOSTIC CATEGORIES:

MAJOR DIAGNOSTIC CATEGORIES	ADMISSIONS OR DISCHARGES	INPATIENT DAYS OR DISCHARGE PATIENT DAYS
01 Nervous System	16	203
02 Eye	0	0
03 Ear, Nose, Mouth and Throat	0	0
04 Respiratory System	0	0
05 Circulatory System	0	0
06 Digestive System	0	0
07 Hepatobiliary System & Pancreas	0	0
08 Musculoskeletal Sys. & Connective Tissue	1	5
09 Skin, Subcutaneous Tissue & Breast	0	0
10 Endocrine, Nutritional & Metabolic	0	0
11 Kidney & Urinary Tract	0	0
12 Male Reproductive System	0	0
13 Female Reproductive System	0	0
14 Pregnancy, Childbirth & the Puerperium	1	3
15 Normal Newborns & Other Neonates with Conditions Originating in the Perinatal Period	0	0
16 Blood and Blood Forming Organs and Immunological Disorders	0	0
17 Myeloproliferative Disorders & Poorly Differentiated Neoplasms	0	0
18 Infectious & Parasitic Diseases	0	0
19 Mental Diseases & Disorders	3,847	22,101
20 Alchohol/Drug Use & Alcohol/Drug-Induced Organic Mental Disorders	176	845
21 Injuries, Poisoning, & Toxic Effects of Drugs	2	3
22 Burns	0	0
23 Factors Influencing Health Status and Other Contacts with Health Services	1	1
24 Multiple Significant Trauma	0	0
25 Human Immunodeficiency Virus Infections	0	0
26 Other DRGs Associated with All MDCs	37	265
TOTAL	4,081	23,426

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SCHEDULE G - UTILIZATION (continued)* State ID 90411

3. UTILIZATION BY REVENUE SOURCE (excluding normal newborns -- see Instructions)

Patients should be categorized according to primary payer and counted only once.

Please indicate whether you are reporting Admissions and Inpatient Days ○ or Discharges and Discharge Patient Days ◉

	ADMISSIONS OR DISCHARGES	INPATIENT DAYS OR DISCHARGE PATIENT DAYS	OUTPATIENT VISITS*
a) Self Pay	28	134	44
b) Blue Cross/Blue Shield	136	785	1,177
c) Champus/TRICARE	34	238	0
d) Commercial Insurance (excludes Workers Comp)	499	2,654	2,442
e) Cover TN	1	2	0
f) Cover Kids	5	54	0
g) Access TN	0	0	3
h) Medicaid/Tenncare	568	3,176	8
i) Medicare - Total	1,060	7,243	806
Medicare Managed Care	641	4,634	232
j) Workers Compensation	0	0	0
k) Other	1,750	9,140	0
l) Total	4,081	23,426	4,482

* Should include emergency department visits and hospital outpatient visits

4. NUMBER OF PATIENTS BY AGE GROUP (excluding normal newborns -- see Instructions)

Please indicate whether you are reporting Admissions and Inpatient Days ○ or Discharges and Discharge Patient Days ◉

Age	ADMISSIONS OR DISCHARGES	INPATIENT DAYS OR DISCHARGE PATIENT DAYS	OUTPATIENT VISITS*
Under 15 years	168	1,301	13
15-17 years	208	1,530	25
18-64 years	3,497	18,764	4,228
65-74 years	152	1,304	190
75-84 years	42	408	26
85 years & older	14	119	0
GRAND TOTAL	4,081	23,426	4,482

* Should include emergency department visits and hospital outpatient visits

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5. PATIENT ORIGIN (excluding normal newborns -- see Instructions)
Indicate usual residence of patients and number of patient days. Please indicate whether you are reporting

Admissions and Inpatient Days ○ or Discharges and Discharge Patient Days ◉

** List only those counties in other states that represent at least 1 percent of the total admissions or discharges to your hospital. If you have fewer than 500 total discharges or admissions annually, list only those counties that represent at least 2 percent of your total admissions or discharges.

County #	Tennessee County of Residence	Number of Admissions or Discharges	Number of Inpatient Days or Discharge Patient Days
01	Anderson	5	30
02	Bedford	0	0
03	Benton	0	0
04	Bledsoe	0	0
05	Blount	7	36
06	Bradley	0	0
07	Campbell	4	19
08	Cannon	0	0
09	Carroll	1	4
10	Carter	413	2,239
11	Cheatham	0	0
12	Chester	0	0
13	Claiborne	8	72
14	Clay	0	0
15	Cocke	8	50
16	Coffee	0	0
17	Crockett	0	0
18	Cumberland	0	0
19	Davidson	1	8
20	Decatur	0	0
21	DeKalb	0	0
22	Dickson	0	0
23	Dyer	0	0
24	Fayette	0	0
25	Fentress	0	0
26	Franklin	0	0
27	Gibson	0	0
28	Giles	0	0

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5. PATIENT ORIGIN (continued)

County #	Tennessee County of Residence	Number of Admissions or Discharges	Number of Inpatient Days or Discharge Patient Days
29	Grainger	4	23
30	Greene	293	1,725
31	Grundy	0	0
32	Hamblen	19	142
33	Hamilton	2	10
34	Hancock	23	115
35	Hardeman	0	0
36	Hardin	0	0
37	Hawkins	229	1,340
38	Haywood	0	0
39	Henderson	0	0
40	Henry	0	0
41	Hickman	0	0
42	Houston	0	0
43	Humphreys	0	0
44	Jackson	0	0
45	Jefferson	5	55
46	Johnson	141	731
47	Knox	29	242
48	Lake	0	0
49	Lauderdale	0	0
50	Lawrence	0	0
51	Lewis	0	0
52	Lincoln	0	0
53	Loudon	3	15
54	McMinn	2	2
55	McNairy	0	0
56	Macon	0	0
57	Madison	0	0
58	Marion	0	0
59	Marshall	0	0
60	Maury	1	1
61	Meigs	1	7
62	Monroe	0	0

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5. PATIENT ORIGIN (continued)

County #	Tennessee County of Residence	Number of Admissions or Discharges	Number of Inpatient Days or Discharge Patient Days
63	Montgomery	0	0
64	Moore	0	0
65	Morgan	1	11
66	Obion	0	0
67	Overton	0	0
68	Perry	0	0
69	Pickett	0	0
70	Polk	0	0
71	Putnam	1	2
72	Rhea	0	0
73	Roane	1	3
74	Robertson	0	0
75	Rutherford	1	2
76	Scott	0	0
77	Sequatchie	0	0
78	Sevier	12	80
79	Shelby	0	0
80	Smith	0	0
81	Stewart	0	0
82	Sullivan	1,016	5,832
83	Sumner	0	0
84	Tipton	0	0
85	Trousdale	0	0
86	Unicoi	150	1,001
87	Union	1	4
88	Van Buren	0	0
89	Warren	0	0
90	Washington	1,321	7,556
91	Wayne	0	0
92	Weakley	0	0
93	White	0	0
94	Williamson	1	3
95	Wilson	0	0
96	TN County Unknown	0	0
	Tennessee Total	3,704	21,360

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5. PATIENT ORIGIN (continued)

State & County Residence	Number of Admissions or Discharges	Number of Inpatient Days or Discharge Patient Days
ALABAMA COUNTIES: (Specify)		
1) Coffee	1	6
2) Marshall	1	5
Other Alabama Counties	2	9
Alabama Total	4	20
GEORGIA COUNTIES: (Specify)		
1) Cherokee	1	4
2) Richmond	1	6
Other Georgia Counties	1	1
Georgia Total	3	11
MISSISSIPPI COUNTIES: (Specify)		
1)	0	0
2)	0	0
Other Mississippi Counties	0	0
Mississippi Total	0	0
ARKANSAS COUNTIES: (Specify)		
1)	0	0
2)	0	0
Other Arkansas Counties	0	0
Arkansas Total	0	0
MISSOURI COUNTIES: (Specify)		
1) Clay	1	6
2)	0	0
Other Missouri Counties	0	0
Missouri Total	1	6

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5. PATIENT ORIGIN (continued)

State & County Residence	Number of Admissions or Discharges	Number of Inpatient Days or Discharge Patient Days
KENTUCKY COUNTIES: (Specify)		
1) Harlan	4	18
2) Pike	3	13
Other Kentucky Counties	2	11
Kentucky Total	9	42
VIRGINIA COUNTIES: (Specify)		
1) Washington	53	305
2) Wise	41	216
Other Virginia Counties	226	1,215
Virginia Total	320	1,736
NORTH CAROLINA COUNTIES: (Specify)		
1) Avery	6	33
2) Buncombe	5	39
Other North Carolina Counties	10	51
North Carolina Total	21	123
OTHER STATES: (Specify)		
1) Ohio	2	12
2) Florida	7	29
All Other States and Countries	10	87
RESIDENCE UNKNOWN:	0	0
GRAND TOTAL	4,081	23,426

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6. Delivery Status:

A. Number of Infants Born Alive 0

B. Number of Deaths Among Infants Born Alive 0

C. Number of Fetal Deaths (350 grams or 20 weeks or more gestation) 0

MSHA-001673

SBH-KINGSPORT 002439

SCHEDULE H - PSYCHIATRIC AND CHEMICAL DEPENDENCY UNITS* State ID 90411

1. TYPE OF UNIT - PSYCHIATRIC:
   A. Do you have a dedicated psychiatric unit? (•) YES ( ) NO If yes, please complete items on this page and on the next page.
   B. Do you have a designated Gero-Psychiatric Unit? (•) YES ( ) NO

2. BEDS
   A. Number of assigned beds 84
   B. Date unit opened 06/01/1985

3. UTILIZATION BY AGE GROUPS:
   Please indicate if you are reporting Admissions and Inpatient Days (•) or Discharges and Discharge Patient Days. ( )

	Inpatient			Partial Care or Day Hospital	Outpatient
AGE GROUPS	Number of Patients on September 30	Number of Admissions or Discharges	Number of Inpatient or Discharge Patient Days	Number of Sessions	Number of Visits
Children and/or Adolescents Ages 0 - 17	0	375	2,844	0	0
Adults Ages 18 - 64	0	3,496	18,835	1,685	70
Elderly Ages 65 and older	0	210	1,747	81	5
Total	0	4,081	23,426	1,766	75

4. Is the psychiatric service managed under a management contract different from the hospital itself? ( ) YES (•) NO
   If yes, please specify name of organization that manages the unit. _____

5. Do you have contracts with Behavioral Health Organizations? (•) YES ( ) NO

6. Does your hospital use:

			If Yes, Number of Patients Secluded or Restrained		Number of Times Seclusion or Restraint was Initiated	
			Age 0-17	Age 18+	Age 0-17	Age 18+
A. Seclusion	(•) YES	( ) NO	0	0	0	0
B. Mechanical Restraints	(•) YES	( ) NO	10	23	15	37
C. Physical Holding Restraints	(•) YES	( ) NO	0	0	0	0
D. Chemical Restraints	( ) YES	(•) NO	0	0	0	0

MSHA-001674
SBH-KINGSPORT 002440

7. FINANCIAL DATA - PSYCHIATRIC

	INPATIENT CHARGES	plus	OUTPATIENT CHARGES	equals	TOTAL CHARGES	minus	ADJUSTMENTS TO CHARGES	equals	NET PATIENT REVENUE
A. GROSS PATIENT REVENUE & NET PATIENT REVENUE BY PAYER:									
1. Self Pay	$322,950	+	$4,936	=	$327,886	-	$293,223	=	$34,663
2. Blue Cross/Blue Shield	$1,868,495	+	$141,052	=	$2,009,547	-	$1,285,534	=	$724,013
3. Champus/TRICARE	$0	+	$0	=	$0	-	$0	=	$0
4. Commercial Insurance (excludes Workers Comp)	$7,140,437	+	$362,107	=	$7,502,544	-	$4,828,986	=	$2,673,558
5. Cover TN	$0	+	$0	=	$0	-	$0	=	$0
6. Cover Kids	$0	+	$0	=	$0	-	$0	=	$0
7. Access TN	$0	+	$0	=	$0	-	$0	=	$0
8. Medicaid/Tenncare	$15,247,728	+	$989	=	$15,248,717	-	$11,005,885	=	$4,242,832
9. Medicare - Total	$18,576,781	+	$97,862	=	$18,676,643	-	$12,680,942	=	$5,995,701
Medicare Managed Care	$7,407,202	+	$28,008	=	$7,435,210	-	$5,150,909	=	$2,284,301
10. Workers Compensation	$0	+	$0	=	$0	-	$0	=	$0
11. Other	$14,926,633	+	$0	=	$14,926,633	-	$13,636,086	=	$1,290,547

B. NON-GOVERNMENT ADJUSTMENTS TO REVENUE	
1. Bad Debt	$207,275
2. Charity Care	$15,217,457
3. Contractual Adjustments	$28,305,922
4. Total	$43,730,654
5. Amount of discounts provided to uninsured patients	$250,219

8. A. SERVICE CHARGES

	INPATIENT CHARGES	OUTPATIENT CHARGES
1. Routine Treatment	$0	$0
2. Ancillary Services	$12,018,892	536
3. Other	$0	$0
4. Total	$12,018,892	$36

B. Do these charges include physicians' fees? ○ YES ◉ NO

MSHA-001675

SBH-KINGSPORT 002441

SCHEDULE H - PSYCHIATRIC AND CHEMICAL DEPENDENCY UNITS (continued)* State ID 90411

1. TYPE OF UNIT - CHEMICAL DEPENDENCY:
   Do you have a dedicated chemical dependency unit? ○ YES ◉ NO If yes, please complete items on this page and on the next page.

2. BEDS
   A. Number of assigned beds 0
   B. Date unit opened

3. UTILIZATION BY AGE GROUPS:
   Please indicate if you are reporting Admissions and Inpatient Days ◉ or Discharges and Discharge Patient Days. ◉

	Inpatient			Partial Care or Day Hospital	Outpatient	Residential Care
AGE GROUPS	Number of Patients on September 30	Number of Admissions or Discharges	Number of Inpatient or Discharge Patient Days	Number of Sessions	Number of Visits	Number of Visits
Children and/or Adolescents Ages 0 - 17	0	0	0	0	0	0
Adults Ages 18 - 64	0	0	0	0	0	0
Elderly Ages 65 and older	0	0	0	0	0	0
Total	0	0	0	0	0	0

4. Is the chemical dependency service managed under a management contract different from the hospital itself? ○ YES ◉ NO
   If yes, please specify name of organization that manages the unit.

5. Do you have contracts with Behavioral Health Organizations? ○ YES ◉ NO

MSHA-001676
SBH-KINGSPORT 002442

SCHEDULE H - PSYCHIATRIC AND CHEMICAL DEPENDENCY UNITS (continued)* State ID 90411

6. FINANCIAL DATA - CHEMICAL DEPENDENCY

	INPATIENT CHARGES	plus	OUTPATIENT CHARGES	equals	TOTAL CHARGES	minus	ADJUSTMENTS TO CHARGES	equals	NET PATIENT REVENUE
A. GROSS PATIENT REVENUE & NET PATIENT REVENUE BY PAYER:									
1. Self Pay	$0	+	$0	=	$0	-	$0	=	$0
2. Blue Cross/Blue Shield	$0	+	$0	=	$0	-	$0	=	$0
3. Champus/TRICARE	$0	+	$0	=	$0	-	$0	=	$0
4. Commercial Insurance (excludes Workers Comp)	$0	+	$0	=	$0	-	$0	=	$0
5. Cover TN	$0	+	$0	=	$0	-	$0	=	$0
6. Cover Kids	$0	+	$0	=	$0	-	$0	=	$0
7. Access TN	$0	+	$0	=	$0	-	$0	=	$0
8. Medicaid/Tenncare	$0	+	$0	=	$0	-	$0	=	$0
9. Medicare - Total	$0	+	$0	=	$0	-	$0	=	$0
Medicare Managed Care	$0	+	$0	=	$0	-	$0	=	$0
10. Workers Compensation	$0	+	$0	=	$0	-	$0	=	$0
11. Other	$0	+	$0	=	$0	-	$0	=	$0

B. NON-GOVERNMENT ADJUSTMENTS TO REVENUE	
1. Bad Debt	$0
2. Charity Care	$0
3. Contractual Adjustments	$0
4. Total	$0
5. Amount of discounts provided to uninsured patients	$0

7. A. SERVICE CHARGES	INPATIENT CHARGES	OUTPATIENT CHARGES
1. Routine Treatment	$0	$0
2. Ancillary Services	$0	$0
3. Other	$0	$0
4. Total	$0	$0

B. Do these charges include physicians' fees? ◉ YES ○ NO

MSHA-001677 SBH-KINGSPORT 002443

SCHEDULE I - EMERGENCY DEPARTMENT*

State ID 90411

1. What is the direct telephone number into your Emergency Department? _____

2. Is the Emergency Department managed under a management contract different from the hospital itself? ◎ YES ◎ NO
   If yes, with whom is the contract held? _____

3. Emergency Department:

   Number of visits by payer:

A. Self Pay	0	H. Medicaid/Tenncare		L. Grand Total	0
B. Blue Cross/Blue Shield	0	United Health Care Community Plan	0		
C. Champus/TRICARE	0	Amerigroup	0		
D. Commercial Insurance (excludes Workers Comp)	0	Blue Care	0		
		TennCare Select	0		
		TennCare, MCO (Not Specified)	0		
		TennCare Total	0		
E. Cover TN	0	I. Medicare - Total	0		
F. Cover Kids	0	Medicare Managed Care	0		
G. Access TN	0	J. Workers Compensation	0		
		K. Other	0		

4. Is your Emergency Department staffed 24 hours per day? ◎ YES ◎ NO If no, please give hours covered. 0

MSHA-001678
SBH-KINGSPORT 002444

5. Indicate the number of the following personnel available in the hospital on a normal day and how many are available to the Emergency Department.

	ON HOSPITAL CAMPUS	IN EMERGENCY DEPARTMENT
A. PHYSICIANS:		
Board certified in Emergency Medicine	0	0
Board eligible in Emergency Medicine	0	0
Declared Speciality of Emergency Medicine	0	0
Board Certified Psychiatrists	0	0
Other Physicians Available to Emergency Department	0	0
B. NURSES:		
Nurse Practitioners	0	0
R.N.'s with formal emergency training and experience	0	0
Other R.N.'s	0	0
L.P.N.'s and other nursing support personnel	0	0
Clerical Staff	0	0
C. OTHER:		
E.M.T.	0	0
E.M.T. advanced	0	0

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6. SUPPORTIVE SERVICES:

	YES	NO
A. COMMUNICATIONS:		
Two-Way radio in ER with Access to:		
Central Emergency Dispatch Center	○	◉
Ambulances	○	◉
Other hospitals	○	◉
B. HELIPORT:	○	◉
C. PHARMACY IN ER:	○	◉
D. BLOOD BANK (check ONLY one):		
Fully stocked	◉	
Common blood types only	◉	

7. Do you have dedicated centers for the provision of specialized emergency care for the following:

A. Designated Trauma Center ○ YES ◉ NO

B. Burns ○ YES ◉ NO

If yes, do you have a designation by a government agency as a Burn Center? ○ YES ◉ NO

C. Pediatrics ○ YES ◉ NO

D. Other, specify

_____

8. Triage: A. Total number of patients who presented in your ER. 0

B. Total number treated in your ER. 0

C. Total number not treated in your ER but referred to physician or clinic for treatment. 0

MSHA-001680

SBH-KINGSPORT 002446

SCHEDULE J - PERSONNEL ON PAYROLL AS OF LAST DAY OF REPORTING PERIOD AND USE OF CONTRACT EMPLOYEES*

State ID 90411

	Full-Time Equivalent**	Full-Time Equivalent Budgeted Vacancies	Use Contract Staff in this Employee Category***
1. Administration:			
A. Administrators & Assistants	0.0	0.0	
B. Director, Health Services Research & Assistants	0.0	0.0	
C. Marketing & Planning Officer(s) & Assistants	0.0	0.0	
D. Financial and Accounting Officer(s) & Assistants	0.0	0.0	
2. Physician and Dental Services:			
A. Physicians	0.0	0.0	
B. Medical residents	0.0	0.0	
C. Dentists	0.0	0.0	
D. Dental residents	0.0	0.0	
3. Nursing Services:			
A. RNs - Administrative	0.0	0.0	
B. RNs - Patient care/clinical	53.0	0.0	
C. LPNs	6.9	3.0	
D. Ancillary nursing personnel	2.1	0.0	
4. Certified Nurse Midwives	0.0	0.0	
5. Nurse Anesthetists	0.0	0.0	
6. Physicians assistants	0.0	0.0	
7. Nurse practitioners	1.0	0.0	
8. Medical record service:			
A. Medical record administrators	0.0	0.0	
B. Medical record technicians (certified or accredited)	0.0	0.0	
C. Other Medical record technicians	0.0	0.0	
9. Pharmacy:			
A. Pharmacists, licensed	1.5	0.0	
B. Pharmacy technicians	2.0	0.0	
C. Clinical Phar-D	1.0	0.0	
10. Clinical laboratory services:			
A. Medical Technologists	0.0	0.0	
B. Other laboratory personnel	0.1	0.4	
11. Dietary services:			
A. Dietitians	0.5	0.0	
B. Dietetic technicians	0.0	0.0	
12. Radiological services:			
A. Radiographers (radiologic technologists)	0.0	0.0	
B. Radiation therapy technologists	0.0	0.0	
C. Nuclear medicine technologists	0.0	0.0	
D. Other radiologic personnel	0.0	0.0	
13. Therapeutic services:			
A. Occupational therapists	0.0	0.0	
B. Occupational therapy assistants & aides	0.0	0.0	
C. Physical therapists	0.0	0.0	
D. Physical therapy assistants & aides	0.0	0.0	
E. Recreational therapists	0.0	0.0	
14. Speech and hearing services:			
A. Speech Pathologist	0.0	0.0	
B. Audiologist	0.0	0.0	
15. Respiratory therapy services:			
A. Respiratory therapists	0.0	0.0	
B. Respiratory therapy technicians	0.0	0.0	
16. Psychiatric services:			
A. Clinical psychologists	0.0	0.0	
B. Psychiatric social workers	1.0	0.0	
C. Psychiatric registered nurses	48.5	0.0	
D. Other mental health professionals	0.0	8.6	
17. Chemical dependency services:			
A. Clinical psychologists	0.0	0.0	
B. Social workers	0.0	0.0	
C. Registered nurses	0.0	0.0	
D. Other specialists in addiction and/or in chemical dependency	0.0	0.0	
18. Medical Social workers	0.0	0.0	
19. Surgical technicians	0.0	0.0	
20. All other certified professional & technical	1.0	0.0	
21. All other non-certified professional & technical	0.0	0.0	
22. All other personnel	90.7	2.6	
TOTAL	209.3	14.6	

** Full-time + Part-time specified in Full Time Equivalent

*** Please check if contract staff is used.

MSHA-001681

SBH-KINGSPORT 002447

SCHEDULE K - MEDICAL STAFF*

State ID 90411

	(1) Number of Active and Associate Medical Staff (Include Board Certified)	(2) Number of Active and Associate Medical Staff Who Are Board Certified	(3) Number of House Staff Who Are Interns, Externs or Residents
1. MEDICAL SPECIALTIES:			
A. General and family practice	0	0	0
B. Pediatric	0	0	0
C. General internal medicine	0	0	0
D. Psychiatric	7	5	0
E. Neonatologist	0	0	0
F. Cardiologists	0	0	0
G. Neurologists	0	0	0
H. Other medical specialties	0	0	0
2. SURGICAL SPECIALTIES:			
A. General surgery	0	0	0
B. Obstetrics and gynecology	0	0	0
C. Perinatologists	0	0	0
D. Gynecology	0	0	0
E. Orthopedic	0	0	0
F. Neurosurgeons	0	0	0
G. Cardiovascular	0	0	0
H. Gastroenterology	0	0	0
I. Other surgical specialties	0	0	0
3. OTHER SPECIALTIES:			
A. Pathology	0	0	0
B. Radiology	0	0	0
C. Anesthesiology	0	0	0
D. Other specialties	0	0	0
4. DENTAL SPECIALTIES:	0	0	0
TOTAL	7	5	0

MSHA-001682

SBH-KINGSPORT 002448

SCHEDULE L - PERINATAL*

State ID 90411

1A. Name of person completing Perinatal survey _____

1B. Telephone Number

1C. Fax Number

Please complete the following questions.

2. Births
   - A. Total number of live births 0
   - B. Birth weight below 2500 grams (5lb 8oz) 0
   - C. Birth weight below 1500 grams (3 lb 5oz) 0

3. Number of babies on ventilator longer than 24 hours 0

4. Number of babies received from referring hospitals for neonatal management 0

	YES	NO
5. Is Medical Director of Obstetrics board certified/eligible in maternal-fetal medicine?	○	◉
6. Is Medical Director of the Nursery board certified/eligible in neonatal-perinatal?	○	◉
7. Do the following subspecialty consultants spend more than 2/3 full-time effort at your hospital?		
A. OBSTETRICS:		
Perinatal Sonologist	○	◉
Hematologist	○	◉
Cardiologist	○	◉
B. NEONATAL:		
Pediatric Radiologist	○	◉
Pediatric Cardiologist	○	◉
Pediatric Neurologist	○	◉
Pathologist	○	◉
Pediatric Surgeon	○	◉

Redacted

MSHA-001683

SBH-KINGSPORT 002449

SCHEDULE M - SURVEY ON NURSING PERSONNEL*

State ID 90411

(As of the last day of the reporting period)

1. Registered Nurses

HIGHEST EDUCATION LEVEL	FTE NUMBER CURRENTLY EMPLOYED	NUMBER OF BUDGETED VACANCIES	NUMBER OF POSITIONS YOU PLAN TO ADD IN THE NEXT 12 MONTHS	NUMBER OF POSITIONS YOU PLAN TO ELIMINATE IN THE NEXT 12 MONTHS	PRIMARY ROLE (NUMBER OF POSITIONS)	
					CLINICAL	ADMINISTRATIVE
Total	51.7	0.0	0.0	0.0	59.0	7.0
Bachelors Degree	24.8	0.0	0.0	0.0	28.0	3.0
Associate Degree	25.0	0.0	0.0	0.0	29.0	4.0
Diploma	0.0	0.0	0.0	0.0	0.0	0.0
Masters Degree	1.9	0.0	0.0	0.0	2.0	0.0
Doctorate Degree	0.0	0.0	0.0	0.0	0.0	0.0

2. Advanced Practice Nurses

NURSING PERSONNEL CATEGORY	FTE NUMBER CURRENTLY EMPLOYED	NUMBER OF BUDGETED VACANCIES	NUMBER OF POSITIONS YOU PLAN TO ADD IN THE NEXT 12 MONTHS	NUMBER OF POSITIONS YOU PLAN TO ELIMINATE IN THE NEXT 12 MONTHS	PRIMARY ROLE (NUMBER OF POSITIONS)	
					CLINICAL	ADMINISTRATIVE
Total	1.0	0.0	0.0	0.0	1.0	0.0
Nurse Practitioner	1.0	0.0	0.0	0.0	1.0	0.0
Clinical Nurse Specialist	0.0	0.0	0.0	0.0	0.0	0.0
CRNA	0.0	0.0	0.0	0.0	0.0	0.0
Certified Nurse Midwife	0.0	0.0	0.0	0.0	0.0	0.0

3. Licensed Practical Nurses

LPNs	NUMBER OF POSITIONS YOU PLAN TO ADD IN THE NEXT 12 MONTHS	NUMBER OF POSITIONS YOU PLAN TO ELIMINATE IN THE NEXT 12 MONTHS
Total	0.0	0.0

4. Recruitment of Nursing Personnel

The following are selected specialties for which hospitals commonly report recruiting difficulties.
Please specify other categories as necessary.

NURSING PERSONNEL CATEGORY	FTE NUMBER CURRENTLY EMPLOYED	NUMBER OF BUDGETED VACANCIES	NUMBER OF POSITIONS YOU PLAN TO ADD IN THE NEXT 12 MONTHS	NUMBER OF POSITIONS YOU PLAN TO ELIMINATE IN THE NEXT 12 MONTHS
CCU/ICU	0.0	0.0	0.0	0.0
ER	0.0	0.0	0.0	0.0
Other (Specify):				
	0.0	0.0	0.0	0.0
	0.0	0.0	0.0	0.0

MSHA-001684

SBH-KINGSPORT 002450

SCHEDULE N-HEALTH CARE PLANS ACCEPTED*

State ID 90411

The health Consumer Right-to Know Act of 1998 which was signed but Governor Sunquist in May, 1998 requires hospitals to report to the Department of health "health care plans accepted by the hospital" as well as a variety of information that is included in earlier schedules of the Joint Annual Report. In order to allow the Joint Annual Report to meet the entire reporting requirement described in this act, please list all health insurance plans with which you currently-as of the last day of this reporting period-have a valid contract. List each plan separately not just the name of the company. For example, if you have contracts to provide services to individuals enrolled in Blue Choice and Blue Preferred, list both plans and do not only list Blue Cross & Blue Shield fo Tennessee.

Plans:

Aetna	EPO - "Elect Choice"
Aetna	HMO - "QPOS"
Aetna	HMO - "Select Choice"
Aetna	HMO - "US Access"
Aetna	POS - "Managed Choice"
Aetna	PPO - "Open Choice"
Align	PPO - "Open Choice"
Amerigroup	HMO
BeechStreet/Viant	PPO
Americhoice UBH	BHO
CIGNA BHO	BHO
Coventry	HMO
Crestpoint	PPO - MA Plan
Crestpoint	CrestPoint MSHA Employee Plan
First Health/CCN	PPO
Horizon Health	PPO
Initial Group	PPO - Initial Health Alliance
Initial Group	PPO - Workers' Comp
ISHN	Laughlin Employee Plan
ISHN	MSP for Woodgrain Millworks
ISHN	MSP for Serco
ISHN	Unicoi County Memorial Employees
ISHN	Universal Fibers
Majesticare	HMO
LifeSynch	PPO - Psych
Magellan	Facility Agreement - Psych
Optima Medicaid	HMO
Optima Commercial/Exchange	HMO
PHCS	PPO
UMWA	Direct employer
United Behavioral Health BHO	PPO
USA MCO	PPO Network
Value Options Commercial	BHO
Virginia Premier	HMO Medicaid
Tricare Value Options	BHO

MSHA-001685

SBH-KINGSPORT 002451

TENNESSEE DEPARTMENT OF HEALTH

Division of Health Statistics
4th Floor, Cordell Hull Building
425 5th Avenue North
Nashville, TN 37243
Telephone: (615) 741-1954 - Fax: (615) 253-1688

JOINT ANNUAL REPORT OF HOSPITALS

2010

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State ID 90411

TENNESSEE DEPARTMENT OF HEALTH
JOINT ANNUAL REPORT OF HOSPITALS
2010

SCHEDULE A - IDENTIFICATION

1. Name of Hospital Woodridge Psychiatric Hospital — Federal Tax I.D. # 62-0582605
   Did your facility name change during the reporting period? ○ YES ◉ NO
   County Washington
2. Address of Facility — Street 403 State of Franklin Road; City Johnson City; State Tennessee; Zip 37604-
3. Telephone Number (423) 928-7111 (Area Code Number)
4. Name of Chief Executive Officer Ann (First Name) Fleming (Last Name)
   Signature of Chief Executive Officer _____
5. Name of person(s) coordinating form completion Jessica Shelton
   Telephone Number if different than above (423) 431-1997 (Area Code Number)
6. 84 Office Use Only
7. Reporting period used for this facility:
   Beginning Date 07/01/2009 Ending Date 06/30/2010
8. 365 Office Use Only
9. Does your hospital own or operate or have other hospitals licensed as satellites of your hospital? ○ YES ◉ NO
   If yes, please complete the following.

	NAME OF HOSPITAL	STATE ID	SATELLITE	OWN	OPERATE	OWN AND OPERATE
1			☐	○	○	○
2			☐	○	○	○
3			☐	○	○	○
4			☐	○	○	○
5			☐	○	○	○

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SCHEDULE B - CLASSIFICATION State ID 90411

1. CONTROL:

A. Indicate the type of organization that is responsible for establishing policy for overall operation of the hospital.

1. Government-Non-Federal	2. Government-Federal	3. Nongovernmental, not-for-profit	4. Investor-owned, for-profit
○ 11 State	○ 17 Armed Forces	○ 20 Church-operated	○ 23 Individual
○ 12 County	○ 18 Veterans Admin.	◉ 21 Other Nonprofit Corporation	○ 24 Partnership
○ 13 City	○ 19 Other, please specify	○ 22 Other not-for-profit, please specify	○ 25 Corporation
○ 14 City-County			
○ 15 Hospital district or authority			

B. Is the hospital part of a health system? ◉ YES ○ NO

If yes, please provide the name and location of the health system.

Name Mountain States Health Alliance City Johnson City State Tennessee

C. Does the controlling organization lease the physical property from the owner(s) of the hospital? ○ YES ◉ NO

D. What is the name of the legal entity that owns and has title to the land and physical plant of the hospital?

Mountain States Health Alliance

E. Is the hospital a division of a holding company? ○ YES ◉ NO

F. Does the hospital itself operate subsidiary corporations? ○ YES ◉ NO

G. Is the hospital managed under contract? ○ YES ◉ NO If YES, length of contract From _____ To _____

If yes, please provide name, city, and state of the organization that manages the hospital.

Name _____ City _____ State _____

Name _____ City _____ State _____

H. Is the hospital part of a health care alliance? ◉ YES ○ NO (see definition of alliance)

If yes, please provide the name, city, and state of the alliance headquarters.

Name Premier, Inc. City San Diego State California

Name _____ City _____ State _____

I. Is the hospital part of a health network? ◉ YES ○ NO (see definition of network)

If yes, please provide the the name, city, and state of the network.

Name Mountain States Healthcare Network City Johnson City State Tennessee

Name _____ City _____ State _____

2. SERVICE:

A. Indicate the ONE category that BEST describes your hospital.

○ 01 General medical and surgical	○ 07 Rehabilitation
○ 02 Pediatric	○ 08 Orthopedic
◉ 03 Psychiatric	○ 09 Chronic disease
○ 04 Tuberculosis and other respiratory diseases	○ 10 Alcoholism and other chemical dependency
○ 05 Obstetrics and gynecology	○ 11 Long term acute care
○ 06 Eye, ear, nose and throat	○ 12 Other-specify treatment area

_____

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B. Does your hospital own or have a contract with any of the following?

	(1) Yes	(2) No	Specify one: 1) Own	2) Contract	Number of Physicians	FTE Physicians
1. Independent Practice Association	○	◉	○	○	0	0.0
2. Group Practice Without Walls	○	◉	○	○	0	0.0
3. Open Panel Physician-Hospital Organization (PHO)	○	◉	○	○	0	0.0
4. Closed Panel Physician-Hospital Organization (PHO)	○	◉	○	○	0	0.0
5. Management Services Organization (MSO)	○	◉	○	○	0	0.0
6. Integrated Salary Model	◉	○	◉	○	155	0.0
7. Equity Model	○	◉	○	○	0	0.0
8. Foundation	○	◉	○	○	0	0.0

3. Have any of the following insurance products been developed for use in Tennessee by your hospital, health system, health network alliance or as a joint venture with an insurer?
Check all that apply.

	(1) Your Hospital	(2) Health System	(3) Health Network	(4) Alliance	(5) Joint Venture With Insurer
A. Health Maintenance Organization	(1) ☐	(2) ☐	(3) ☐	(4) ☐	(5) ☑
B. Preferred Provider Organization	(1) ☐	(2) ☐	(3) ☐	(4) ☐	(5) ☐
C. Indemnity Fee For Service Plan	(1) ☐	(2) ☐	(3) ☐	(4) ☐	(5) ☐

4. Does your hospital have a formal written contract that specifies the obligations of each party with:
   A. Health Maintenance Organization (HMO)? ◉ YES ○ NO
      1. How many do you contract with? 4
      2. Number of different contracts 5
   B. Preferred Provider Organization (PPO)? ◉ YES ○ NO
      1. How many do you contract with? 16
      2. Number of different contracts 20

5. What percentage of the hospital's net patient revenue is paid on a capitated basis?
If the hospital does not participate in any capitated arrangement, please enter "0". 0.0 %

6. How many covered lives are in your capitation agreements? 0

SBH-KINGSPORT 002455

SCHEDULE C - ACCREDITATIONS AND APPROVALS State ID 90411

1. ACCREDITATIONS:

A. Joint Commission on Accreditation of Healthcare Organizations (JCAHO)		
Date of most recent accrediting letter or survey 04/25/2009	◉YES	○NO
If Yes, is the hospital accredited under either/both of the following manuals:		
1. Comprehensive Accreditation Manual for Hospitals (CAMH)	◉YES	○NO
2. Comprehensive Accreditation Manual for Behavioral Health Care (CAMBHC)	○YES	◉NO
3. Other manuals, please specify		
B. Commission on Accreditation of Rehabilitation Facilities (CARF)		
Date of most recent accrediting letter or survey	○YES	◉NO
C. American College of Surgeons Commission on Cancer	○YES	◉NO
D. American Osteopathic Association (AOA)	○YES	◉NO
E. TÜV Healthcare Specialists	○YES	◉NO
F. Community Health Accreditation Program (CHAP)	○YES	◉NO

2. CERTIFICATIONS:

Medicare Certification	◉YES	○NO

3. OTHER:

A. THA Membership	◉YES	○NO
B. Hospital Alliance of Tennessee, Inc. Membership	◉YES	○NO
C. American Hospital Association Membership	◉YES	○NO
D. American Medical Association Approval for Residencies (and Internships)	○YES	◉NO
E. State Approved School of Nursing:		
Registered Nurses	○YES	◉NO
Licensed Practical Nurses	○YES	◉NO
F. Medical School Affiliation	○YES	◉NO
G. Tennessee Association of Public and Teaching Hospitals (TNPath)	○YES	◉NO
H. National Association of Children's Hospitals and Related Institutions (NACHRI)	○YES	◉NO
I. National Association of Public Hospitals (NAPH)	○YES	◉NO
J. Other, please specify		

Field is limited to 255 characters

SBH-KINGSPORT 002456

SCHEDULE D - SERVICES State ID 90411

1. CERTIFICATE OF NEED:

Do you have an approved, **but not completed,** certificate of need (CON)? ○ YES ◉ NO

If yes, please specify:

Name of Service or Activity Requiring the CON	# of Beds (if applicable)	Date of Approval
	0	
	0	
	0	

2. Does your hospital own or operate Tennessee physician primary care clinics? ○ YES ◉ NO If yes, how many? 0
How many physicians practice in these clinics? 0

3. Does your hospital own or operate other physician/specialty clinics located in Tennessee? ◉ YES ○ NO If yes, how many? 1
How many physicians practice in these clinics? 4

4. Does your hospital own or operate a blood bank? ○ YES ◉ NO
If yes, please indicate:

A. Distributes blood within the hospital ○ YES ○ NO
B. Collects blood within the hospital ○ YES ○ NO
C. Distributes blood outside the hospital ○ YES ○ NO
D. Collects blood from outside the hospital ○ YES ○ NO

5. Does your hospital own or operate an ambulance service? ○ YES ◉ NO
If yes, please specify the counties where services are located.

Please specify the type of service and ownership relationship:

A. Land Transport ○ YES ○ NO If yes, ○ own; ○ operate; ○ own and operate; ○ own in joint venture
B. Helicopter ○ YES ○ NO If yes, ○ own; ○ operate; ○ own and operate; ○ own in joint venture
C. Special Neonatal Helicopter ○ YES ○ NO If yes, ○ own; ○ operate; ○ own and operate; ○ own in joint venture
D. Special Neonatal Land Transport ○ YES ○ NO If yes, ○ own; ○ operate; ○ own and operate; ○ own in joint venture

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6. Does your hospital own or operate an off-site outpatient/ambulatory clinic located in Tennessee? ○ YES ◉ NO
If yes, please complete the following.

Name of Clinic	County	City				
			○ own	○ operate	○ own and operate	○ own in joint venture
			○ own	○ operate	○ own and operate	○ own in joint venture

7. Does your hospital own or operate an off-site ambulatory surgical treatment center located in Tennessee? ○ YES ◉ NO
If yes, please complete the following.

Name of Center	County	City				
			○ own	○ operate	○ own and operate	○ own in joint venture
			○ own	○ operate	○ own and operate	○ own in joint venture

8. Does your hospital own or operate an off-site birthing center located in Tennessee? ○ YES ◉ NO
If yes, please complete the following.

Name of Center	County	City				
			○ own	○ operate	○ own and operate	○ own in joint venture
			○ own	○ operate	○ own and operate	○ own in joint venture

9. Does your hospital own or operate an off-site outpatient diagnostic center located in Tennessee? ○ YES ◉ NO
If yes, please complete the following.

Name of Center	County	City				
			○ own	○ operate	○ own and operate	○ own in joint venture
			○ own	○ operate	○ own and operate	○ own in joint venture

10. Does your hospital own or operate an off-site outpatient physical therapy rehab center located in Tennessee? ○ YES ◉ NO
If yes, please complete the following.

Name of Center	County	City				
			○ own	○ operate	○ own and operate	○ own in joint venture
			○ own	○ operate	○ own and operate	○ own in joint venture

SBH-KINGSPORT 002458

11. Does your hospital own or operate a hospice that has a separate license located in Tennessee? ◯ YES ◉ NO
If yes, please complete the following.

Name of Hospice	County	City				
			◯ own	◯ operate	◯ own and operate	◯ own in joint venture
			◯ own	◯ operate	◯ own and operate	◯ own in joint venture

12. Does your hospital own or operate an off-site assisted-care living facility located in Tennessee? ◯ YES ◉ NO
If yes, please complete the following.

Name of Facility	County	City				
			◯ own	◯ operate	◯ own and operate	◯ own in joint venture
			◯ own	◯ operate	◯ own and operate	◯ own in joint venture

13. Does your hospital own or operate a home for the aged located in Tennessee? ◯ YES ◉ NO
If yes, please complete the following.

Name of Home	County	City				
			◯ own	◯ operate	◯ own and operate	◯ own in joint venture
			◯ own	◯ operate	◯ own and operate	◯ own in joint venture

14. Does your hospital own or operate an urgent care center? ◯ YES ◉ NO
If yes, please complete the following.

Name of Center	County	City				
			◯ own	◯ operate	◯ own and operate	◯ own in joint venture
			◯ own	◯ operate	◯ own and operate	◯ own in joint venture

15. Does your hospital own or operate a home health agency? ◯ YES ◉ NO
If yes, please complete the following.

Name of Agency: _____
Location of Agency: City _____ County _____
Number of Visits _____
◯ own ◯ operate ◯ own and operate ◯ own in joint venture

Name of Agency: _____
Location of Agency: City _____ County _____
Number of Visits _____
◯ own ◯ operate ◯ own and operate ◯ own in joint venture

SBH-KINGSPORT 002459

16. Does your hospital own or operate an off-site nursing home located in Tennessee? ◯ YES ◉ NO
If yes, please complete the following.

_____ _____ _____ ◯ own ◯ operate ◯ own and operate ◯ own in joint venture
Name of Home County City

Number of Beds - Total 0 = Medicare only (SNF) _____ + Medicaid only (NF) _____ + Medicare/Medicaid (SNF/NF) _____ + Not Certified _____

_____ _____ _____ ◯ own ◯ operate ◯ own and operate ◯ own in joint venture
Name of Home County City

Number of Beds - Total 0 = Medicare only (SNF) _____ + Medicaid only (NF) _____ + Medicare/Medicaid (SNF/NF) _____ + Not Certified _____

17. Does your hospital operate a hospital-based skilled nursing unit (subacute unit) licensed as a nursing home for skilled nursing care (excluding swing beds)? ◯ YES ◉ NO If yes, please complete the following.

_____ _____ _____
Name of SNF Number of Licensed Beds Number of Staffed Beds

_____ _____
Number of Admissions Number of Patient Days

18. Does your hospital own, operate, or contract a mobile unit that operates in Tennessee? ◯ YES ◉ NO
If yes, specify name(s) and whether owned, operated, or contracted.

A. List mobile services:

1 _____ ◯ contract ◯ own ◯ operate ◯ own and operate ◯ own in joint venture _____ # of visits
2 _____ ◯ contract ◯ own ◯ operate ◯ own and operate ◯ own in joint venture _____ # of visits
3 _____ ◯ contract ◯ own ◯ operate ◯ own and operate ◯ own in joint venture _____ # of visits
4 _____ ◯ contract ◯ own ◯ operate ◯ own and operate ◯ own in joint venture _____ # of visits
5 _____ ◯ contract ◯ own ◯ operate ◯ own and operate ◯ own in joint venture _____ # of visits
6 _____ ◯ contract ◯ own ◯ operate ◯ own and operate ◯ own in joint venture _____ # of visits

B. List counties served (where you take the service):
List counties for service 1 in 18A on line 1, for service 2 on line 2, etc.

1 _____ _____ _____ _____ _____ _____
2 _____ _____ _____ _____ _____ _____
3 _____ _____ _____ _____ _____ _____
4 _____ _____ _____ _____ _____ _____
5 _____ _____ _____ _____ _____ _____
6 _____ _____ _____ _____ _____ _____

SBH-KINGSPORT 002460

19. HOSPITAL-BASED SERVICES (See Explanation):

Utilization of Selected Services	Is This Service Provided In Your Hospital? YES	NO	To Inpatients Unit of Measure	Number	To Outpatients Unit of Measure	Number
A. Miscellaneous:						
Lithotripsy						
Percutaneous	○	◉	Procedures	0	Procedures	0
Extracorporeal Shock Wave	○	◉				
# fixed units inside hospital 0			Procedures	0	Procedures	0
# fixed units off site 0					Procedures	0
# of mobile units 0			Procedures	0	Procedures	0
# days per week (mobile units) 0						
Renal Dialysis						
# of dedicated stations 0						
Hemo Dialysis	○	◉	Patients	0	Patients	0
			Treatments	0	Treatments	0
Peritoneal Dialysis	○	◉	Patients	0	Patients	0
			Treatments	0	Treatments	0
B. Oncology/Therapies:						
Chemotherapy	○	◉	Patients	0	Patients	0
					Encounters	0
Hyperthermia	○	◉	Treatments	0	Treatments	0
Radiation Therapy-Megavoltage	○	◉				
# fixed units inside hospital 0			Patients	0	Patients	0
			Treatments	0	Treatments	0
# fixed units off site 0						

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SCHEDULE D - SERVICES (continued) State ID 90411

Utilization of Selected Services	Is This Service Provided In Your Hospital? YES	NO	To Inpatients Unit of Measure	Number	To Outpatients Unit of Measure	Number
C. Radiology:						
Computerized Tomographic Scanners CT/CAT	○	◉	Patients	0	Visits	0
# fixed units inside hospital 0			Procedures	0	Procedures	0
# fixed units off site 0					Procedures	0
# of mobile units 0			Procedures	0	Procedures	0
# days per week (mobile units) 0						
Ultrafast CT	○	◉	Patients	0	Visits	0
# fixed units inside hospital 0			Procedures	0	Procedures	0
# fixed units off site 0					Procedures	0
# of mobile units 0			Procedures	0	Procedures	0
# days per week (mobile units) 0						
Magnetic Resonance Imaging	○	◉				
# fixed units inside hospital 0			Procedures	0	Procedures	0
# fixed units off site 0					Procedures	0
# of mobile units 0			Procedures	0	Procedures	0
# days per week (mobile units) 0						
Nuclear Medicine	○	◉	Procedures	0	Procedures	0
Radium Therapy	○	◉	Procedures	0	Procedures	0
Isotope Therapy	○	◉	Procedures	0	Procedures	0
Positron Emission Tomography	○	◉				
# fixed units inside hospital 0			Procedures	0	Procedures	0
# fixed units off site 0					Procedures	0
# of mobile units 0			Procedures	0	Procedures	0
# days per week (mobile units) 0						
Mammography	○	◉	Procedures	0	Procedures	0
# of ACR accredited units 0						
# other fixed units inside hospital 0						
# other fixed units off site 0						
# of mobile units 0						
# days per week (mobile units) 0						
Bone Densitometry	○	◉	Procedures	0	Procedures	0
# of units 0						

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Note: Pediatric patients should be defined as patients 14 years old and younger.

Utilization of Selected Services	Is This Service Provided In Your Hospital? YES	NO	In Cath Lab Setting Unit of Measure	Number	Outside Cath Lab Setting Unit of Measure	Number
D. Cardiac:						
Cardiac Catheterization Date Initiated _____ # labs 0						
Intra-Cardiac or Coronary Artery	○	◉	Adult Procedures Pediatric Procedures	0 0	Adult Procedures Pediatric Procedures	0 0
Percutaneous Transluminal Coronary Angioplasty	○	◉	Adult Procedures Pediatric Procedures	0 0	Adult Procedures Pediatric Procedures	0 0
Stents	○	◉	Adult Procedures Pediatric Procedures	0 0	Adult Procedures Pediatric Procedures	0 0
All Other Heart Procedures	○	◉	Adult Procedures Pediatric Procedures	0 0	Adult Procedures Pediatric Procedures	0 0
All Other Non-Cardiac Procedures	○	◉	Adult Procedures Pediatric Procedures	0 0	Adult Procedures Pediatric Procedures	0 0
Thrombolytic Therapy	○	◉	Adult Procedures Pediatric Procedures	0 0	Adult Procedures Pediatric Procedures	0 0
			To Inpatients		To Outpatients	
Open Heart Surgery # dedicated O.R.'s 0	○	◉	Adult Operations Pediatric Operations	0 0		
E. Surgery:						
Inpatient # operating rooms 0	○	◉	Encounters Procedures	0 0		
Outpatient (one day) # dedicated O.R.'s 0	○	◉			Encounters Procedures	0 0
F. Rehabilitation:						
Cardiac	○	◉	Patients	0	Patients	0

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SCHEDULE D - SERVICES (continued) State ID 90411

Utilization of Selected Services	Is This Service Provided In Your Hospital? YES	NO	To Inpatients Unit of Measure	Number	To Outpatients Unit of Measure	Number
F. Rehabilitation (continued):						
Chemical Dependency	○	◉	Patients	0	Patients Episodes of Care	0 0
Nutritional Counseling	◉	○	Patients	168	Patients Episodes of Care	0 0
Pulmonary	○	◉	Patients	0	Patients Episodes of Care	0 0
G. Physical Rehabilitation:						
Occupational Therapy	○	◉	Patients	0	Patients Episodes of Care	0 0
Orthotic Services	○	◉	Patients	0	Patients Episodes of Care	0 0
Physical Therapy	○	◉	Patients	0	Patients Episodes of Care	0 0
Prosthetic Services	○	◉	Patients	0	Patients Episodes of Care	0 0
Speech/Language Therapy	○	◉	Patients	0	Patients Episodes of Care	0 0
Therapeutic Recreational Service	○	◉	Patients	0	Patients Episodes of Care	0 0

Do you have a dedicated inpatient physical rehabilitation unit? ○ YES ◉ NO

If yes, please complete the following. Number of assigned beds 0 Number of admissions 0 Number of patient days 0

Do you have a dedicated outpatient physical rehabilitation unit? ○ YES ◉ NO

H. Pain Management:	○	◉	Patients	0	Patients	0

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SCHEDULE D - SERVICES (continued) State ID 90411

Utilization of Selected Services	Is This Service Provided In Your Hospital? YES	NO	To Inpatients Unit of Measure	Number	To Outpatients Unit of Measure	Number
I. Obstetrics/Newborn:						
Perinatal Level of Care						
Level I	○	◉				
Level II - A	○	◉				
Level II - B	○	◉				
Level III	○	◉				
Cesarean Section Deliveries	○	◉	Deliveries	0		
Non C-Section Deliveries	○	◉	Deliveries	0		
Birthing Rooms	○	◉	Deliveries	0		
# rooms 0						
# LDRP beds 0						
# LDR beds 0						
Labor Rooms	○	◉				
# rooms 0						
Postpartum Services	○	◉	Patients	0	Visits	0
# beds 0						
Newborn Nursery	○	◉	Infants Discharged	0		
# bassinets 0			Patient Days	0		
Premature Nursery	○	◉	Infants Discharged	0		
# bassinets 0			Patient Days	0		
Isolation Nursery	○	◉	Patient Days	0		
# bassinets 0						

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SCHEDULE D - SERVICES (continued) State ID 90411

Utilization of Selected Services	Is This Service Provided In Your Hospital? YES	NO	To Inpatients Unit of Measure	Number	To Outpatients Unit of Measure	Number
J. Transplants:						
Organs						
Total Donors			Donors	0		
Total Harvested	○	◉	Donations	0		
Transplants	○	◉	Transplants	0		
Organ Bank	○	◉	Organs	0		
Type of Organ:						
Heart	○	◉	# Harvested	0		
			# Transplanted	0		
Liver	○	◉	# Harvested	0		
			# Transplanted	0		
Kidneys	○	◉	# Harvested	0		
			# Transplanted	0		
Pancreas	○	◉	# Harvested	0		
			# Transplanted	0		
Intestine	○	◉	# Harvested	0		
			# Transplanted	0		
Any Other _____	○	◉	# Harvested	0		
			# Transplanted	0		
Tissues						
Total Donors			Donors	0		
Total Harvested	○	◉	Donations	0		
Transplants	○	◉	Transplants	0		
Tissue Bank	○	◉	Tissues	0		
Type of Tissue:						
Eye	○	◉	# Harvested	0		
			# Transplanted	0	# Transplanted	0
Bone	○	◉	# Harvested	0		
			# Transplanted	0	# Transplanted	0
Bone Marrow	○	◉	# Harvested	0		
			# Transplanted	0	# Transplanted	0
Connective	○	◉	# Harvested	0		
			# Transplanted	0	# Transplanted	0
Cardiovascular	○	◉	# Harvested	0		
			# Transplanted	0	# Transplanted	0
Stem Cell	○	◉	# Harvested	0		
			# Transplanted	0	# Transplanted	0
Other _____	○	◉	# Harvested	0		
			# Transplanted	0	# Transplanted	0

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SCHEDULE D - SERVICES (continued) State ID 90411

Utilization of Selected Services	Is This Service Provided In Your Hospital? YES	NO	To Inpatients Unit of Measure	Number	To Outpatients Unit of Measure	Number
K. Other:						
Hyperbaric Oxygen Therapy	○	◉	Patients	0		
Gamma Knife	○	◉	Patients	0	Patients	0
Cyberknife	○	◉	Patients	0	Patients	0
L. Intensive/Intermediate:						
Burn Care Unit	○	◉	Patients	0	Patients	0
# beds 0			Patient Days	0		
Cardiac Care Unit	○	◉	Patients	0		
# beds 0			Patient Days	0		
Medical Intensive Care Unit	○	◉	Patients	0		
# beds 0			Patient Days	0		
Mixed Intensive Care Unit	○	◉	Patients	0		
# beds 0			Patient Days	0		
Neonatal Intensive Care Unit	○	◉	Patients	0		
# beds 0			Patient Days	0		
Neonatal Intermediate Care Unit	○	◉	Patients	0		
# beds 0			Patient Days	0		
Pediatric Care Unit	○	◉	Patients	0		
# beds 0			Patient Days	0		
Stepdown ICU	○	◉	Patients	0		
# beds 0			Patient Days	0		
Stepdown CCU	○	◉	Patients	0		
# beds 0			Patient Days	0		
Surgical Intensive Care Unit	○	◉	Patients	0		
# beds 0			Patient Days	0		

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SCHEDULE D - SERVICES (continued)

State ID 90411

Utilization of Selected Services	Is This Service Provided In Your Hospital? YES	NO	To Inpatients Unit of Measure	To Inpatients Number	To Outpatients Unit of Measure	To Outpatients Number
L. Intensive/Intermediate (continued):						
Other, specify _____ Number of beds 0	○	◉	Patients Patient Days	0 0		
Other, specify _____ Number of beds 0	○	◉	Patients Patient Days	0 0		
M. Psychiatric Partial Hospitalization	◉	○	Patients	2,529		
N. Psychiatric Intensive Outpatient Care	◉	○			Patients	0
O. Electroconvulsive Treatment	○	◉	Patients Treatments	0 0	Patients Treatments	0 0
P. Other Convulsive Treatment	○	◉	Patients Treatments	0 0	Patients Treatments	0 0
Q. Negative Pressure Ventilated Room If yes, number of beds 0	○	◉				

R. 23 Hour Observation ○ YES ◉ NO Outpatients 0

S. Cancer Patients:

1. How many patients were diagnosed with cancer at your facility during this reporting period? 0
2. How many patients were both diagnosed and provided the first course of treatment for cancer at your facility during this reporting period? 0
3. How many patients were diagnosed elsewhere but provided the first course of treatment at your facility during this reporting period? 0

SBH-KINGSPORT 002468

SCHEDULE E - FINANCIAL DATA

State ID 90411

Dates covered from 07/01/2009 to 06/30/2010 Use zeros where applicable. Do not leave blank lines in this schedule.

A. CHARGES (For reporting period only. Do not include revenue related losses; round to the nearest dollar.)

	Gross Patient Charges		Adjustments To Charges		Net Patient Revenue
1. Government					
a) Medicare Inpatient - Total (include managed care)	$13,739,715	-	$9,359,480	=	$4,380,235
1) Medicare Managed Care - Inpatient	$1,337,018	-	$880,215	=	$456,803
b) Medicare Outpatient - Total (include managed care)	$141,580	-	$103,630	=	$37,950
1) Medicare Managed Care - Outpatient	$31,373	-	$18,924	=	$12,449
c) Medicaid/TennCare Inpatient* (for EAH use 7.b.2.)	$1,301,990	-	$1,235,575	=	$66,415
d) Medicaid/TennCare Outpatient* (for EAH use 7.b.2.)	$0	-	$0	=	$0
e) Other	$2,074,943	-	$1,259,421	=	$815,522
f) Total Government Sources	$17,258,228	-	$11,958,106	=	$5,300,122
2. Cover Tennessee * see instructions					
a) Cover TN	$29,309	-	$17,779	=	$11,530
b) Cover Kids	$166,668	-	$96,673	=	$69,995
c) Access Tennessee	$26,586	-	$16,884	=	$9,702
d) Total Cover Tennessee	$222,563	-	$131,336	=	$91,227
3. Nongovernment					
a) Self-Pay	$6,559,530	-	$5,286,561	=	$1,272,969
b) Blue Cross Blue Shield	$1,865,308	-	$1,138,769	=	$726,539
c) Commercial Insurers (excludes Workers Comp)	$7,863,972	-	$5,148,759	=	$2,715,213
d) Workers Compensation	$0	-	$0	=	$0
e) Other	$6,776,733	-	$5,515,297	=	$1,261,436
f) Total Nongovernment Sources	$23,065,543	-	$17,089,386	=	$5,976,157
4. Totals					
a) Total Inpatient (excludes Newborn)	$39,923,985				
b) Newborns	$0				
c) Total Inpatient (includes Newborn) (A4a + A4b)	$39,923,985	-	$28,882,239	=	$11,041,746
d) Total Outpatient	$622,349	-	$296,589	=	$325,760
e) Grand Total (A1f + A2d + A3f)	$40,546,334	-	$29,178,828	=	$11,367,506
5. Bad Debt					
a) Medicare Enrollees			$157,129		
b) Other Government			$53,954		
c) Cover Tennessee			$0		
d) Blue Cross and Commercially Insured Patients			$391,177		
e) All Other			$50,388		
f) Total Bad Debt			$652,648		
6. Nongovernment and Cover Tennessee Adjustments to Charges					
a) Nongovernment Contractual			$16,562,600		
b) Cover Tennessee Contractual			$131,336		
c) Charity Care - Inpatient			$84,355		
d) Charity Care - Outpatient			$866		
e) Other Adjustments, specify types _____			$0		
f) Total Nongovernment Adjustments			$16,779,157		

Amount of discounts provided to uninsured patients $245,349

$85,221 Total Charity (A6c + A6d)

$737,869 Total Charity plus Bad Debt (A5f + A6c + A6d)

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A. CHARGES (continued)

7. Other Operating Revenue

a) Tax appropriations	$0
b) State and Local government contributions:	
1) Amount designated to offset indigent care	$0
2) Essential Access Hospital (EAH) payments	$486,903
3) Critical Access Hospital (CAH) payments	$0
4) Amount used for other	$0
5) Total	$486,903
c) Other contributions:	
1) Amount designated to offset indigent care	$0
2) Amount used for other	$0
3) Total	$0
d) Other (include cafeteria, gift shop, etc.)	$147,091
e) Total other operating revenue (A7a + A7b5 + A7c3 + A7d)	$633,994

8. Nonoperating Revenue (No negative numbers! Losses or expenses should be reported in B2g.)

a) Contributions	$0
b) Grants	$0
c) Interest Income	$0
d) Other	$13,140
e) Total nonoperating revenue (add A8a through A8d)	$13,140
f) TOTAL REVENUE (Net A4e + A7e + A8e)	$12,014,640

B. EXPENSES (for the reporting period only; round to the nearest dollar)

1. Payroll Expenses for all categories of personnel specified below; (see definitions page)

a) Physicians and dentists (include only salaries)	$0
b) Medical and dental residents (include medical and dental interns)	$0
c) Trainees (medical technology, x-ray therapy, administrative, and so forth)	$0
d) Registered and licensed practical nurses	$2,865,881
e) All other personnel	$4,504,499
f) Total payroll expenses (add B1a through B1e)	$7,370,380

2. Nonpayroll Expenses

a) Employee benefits (social security, group insurance, retirement benefits)	$1,973,559
b) Professional fees (medical, dental, legal, auditing, consultant and so forth)	$2,344,523
c) Contracted nursing services (include staff from nursing registries, service contracts, and temporary help agencies)	$56,452
d) Depreciation expense	$532,014
e) Interest expense	$709,469
f) Energy expense	$96,715
g) All other expenses (supplies, purchased services, nonoperating expenses, and so forth)	$1,930,886
h) Total nonpayroll expenses (add B2a through B2g)	$7,643,618
i) TOTAL EXPENSES (add B1f + B2h)	$15,013,998

3. Are system overhead/management fees included in your expenses? (●) YES ( ) NO
If yes, specify amount $1,047,453

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C. CURRENT ASSETS

1. Current Assets is defined as the value of cash, accounts receivable, inventories, marketable securities and other assets that could be converted to cash in less than 1 year.
   What were your current assets on the last day of your reporting period (specified in Schedule A7 on page 2)? $4,416,867
   Net receivables are defined as the collectibles as of the last day of your reporting period, whether or not they are currently due.
2. What were your net receivables on the last day of your reporting period? $1,464,058

D. FIXED ASSETS recorded on the balance sheet at the end of the reporting period (include actual or estimated value of plant/equipment that is leased).

1. Gross plant and equipment assets (including land, building, and equipment)	$8,569,739
2. LESS: Deduction for accumulated depreciation	$2,334,111
3. NET FIXED plant and equipment assets (D.1. Less D.2.; if zero please explain on separate sheet)	$6,235,628

E. OTHER ASSETS recorded on the balance sheet at the end of the reporting period (include assets not included above as current or fixed assets).
What were your other assets on the last day of your reporting period (specified in Schedule A7 on page 2)? $0

F. TOTAL ASSETS
Total Assets is the sum of current assets, fixed assets and other assets (C.1.+D.3.+E.).
What were your total assets on the last day of your reporting period (specified in Schedule A7 on page 2)? $10,652,495

G. CURRENT LIABILITIES
Current liabilities is defined as the amount owed for salaries, interest, accounts payable, and other debts due within one (1) year. What were your current liabilities on the last day of your reporting period? $1,735,672

H. LONG TERM LIABILITIES

1. Long Term Liabilities is defined as the amount owed for leases, bond repayment and other items due after one (1) year. What were your long term liabilities on the last day of your reporting period? $224,683
2. Long Term Debt is defined as the value of obligations of over 1 year that require interest to be paid. What was your long term debt on the last day of your reporting period? $0

I. OTHER LIABILITIES
Other liabilities includes those liabilities not reported as current (item G.) or long term (item H.1.).
What were your total liabilities on the last day of your reporting period (specified in Schedule A7 on page 2)? $1,960,355

J. CAPITAL ACCOUNT
Capital Account includes Fund Balance or Stockholder's Equity and all general, specific purpose, restricted or unrestricted funds. The Capital Account is the excess of assets over its liabilities.
What was your capital account on the last day of your reporting period? $8,692,140
Note: Total Assets should equal Liabilities plus Capital Account (i.e. item F.=G.+H.1.+I.+J.).

K. 1. Federal Income Tax: $0

2. Local Property Taxes Paid During the Reporting Period:
   a) Taxes on the Inpatient Facility $0
   b) Taxes on all Other Property $0

3. Other Local, State, or Federal Taxes: (exclude sales tax) $68

L. Does your hospital bill include charges incurred for the following professional services?
Radiology - ○ YES ◉ NO Pathology - ○ YES ◉ NO Anesthesiology - ○ YES ◉ NO Other - Specify _____

SBH-KINGSPORT 002471

M. TennCare Utilization and Revenue:

1. Inpatient Utilization and Revenue for TennCare Managed Care Organizations:

MCO	NUMBER OF ADMISSIONS	NUMBER OF PATIENT DAYS	GROSS REVENUE	NET REVENUE
AmeriChoice East (John Deere)	0	0	$0	$0
AmeriChoice (Middle)	0	0	$0	$0
AmeriGroup	0	0	$0	$0
Blue Care	2	10	$18,365	$4,000
PHP	0	0	$0	$0
TennCare Select	1	6	$10,773	$2,400
TLC Family Care	0	0	$0	$0
UAHC (Omnicare)	0	0	$0	$0
Unison Health Plan	0	0	$0	$0
TennCare, MCO	0	0	$0	$0
Total MCO	3	16	$29,138	$6,400
BHO				
TBH	40	280	$542,379	$83,824
Premier	296	1,797	$3,624,067	$1,108,386
Total BHO	336	2,077	$4,166,446	$1,192,210

2. Outpatient Utilization and Revenue for TennCare Managed Care Organizations:

MCO	NUMBER OF PATIENTS	NUMBER OF VISITS	GROSS REVENUE	NET REVENUE
AmeriChoice East (John Deere)	0	0	$0	$0
AmeriChoice (Middle)	0	0	$0	$0
AmeriGroup	0	0	$0	$0
Blue Care	0	0	$0	$0
PHP	0	0	$0	$0
TennCare Select	0	0	$0	$0
TLC Family Care	0	0	$0	$0
UAHC (Omnicare)	0	0	$0	$0
Unison Health Plan	0	0	$0	$0
TennCare, MCO	0	0	$0	$0
Total MCO	0	0	$0	$0
BHO				
TBH	0	0	$0	$0
Premier	0	0	$0	$0
Total BHO	0	0	$0	$0

SBH-KINGSPORT 002472

SCHEDULE F - BEDS AND BASSINETS State ID 90411

1. PLEASE GIVE THE NUMBER OF:

   A. TOTAL LICENSED ADULT AND PEDIATRIC BEDS AS OF THE LAST DAY OF THE REPORTING PERIOD (exclude beds in a sub-acute unit that are licensed as nursing home beds) 84

   B. The number of adult and pediatric staffed beds set up, staffed and in use as of the last day of the reporting period. 84

   C. NEWBORN NURSERY BASSINETS AS OF THE LAST DAY OF THE REPORTING PERIO 0

   D. Licensed Beds that were not staffed at any time during the reporting period. 0

2. STAFFED ADULT, PEDIATRIC, AND NEONATAL BEDS (exclude newborn nursery, include neonatal care units):

   Was there a temporary or a permanent change in the total number of beds set up and staffed during the period? ◉ YES ○ NO
   If yes, give beds added or withdrawn (show increase by + and decrease by -) and date of change.

   Bed change (+ or -) 9 Bed change (+ or -) 0 Bed change (+ or -) 0 Bed change (+ or -) 0
   Date: 11/18/2009 Date: Date: Date:

3 SWING BEDS:

   A. Does your facility utilize swing beds? ○ YES ◉ NO If yes, number of Acute Care beds designated as Swing Beds. 0

   B. PLEASE SPECIFY THE FOLLOWING FOR BEDS WHEN USED FOR LONG TERM SKILLED OR INTERMEDIATE CARE:

(How many admissions and how many days did you provide in the following categories?)

INTERMEDIATE CARE	ADMISSIONS	PATIENT DAYS
Private Pay	0	0
Other	0	0
Total	0	0

SKILLED CARE	ADMISSIONS	PATIENT DAYS
Commercial	0	0
Blue Cross	0	0
Medicare	0	0
Private Pay	0	0
Other	0	0
Total	0	0

SBH-KINGSPORT 002473

4. A. Number of Beds Set Up and Staffed on a typical day

SERVICE	BEDS
Medical	0
Surgical	0
Medical/Surgical	0
Obstetrics	0
Gynecological	0
OB/GYN	0
Pediatric	0
Eye	0
Neonatal Intensive Care	0
Neonatal Intermediate Care	0
Intensive Care (excluding Neonatal)	0
Orthopedic	0
Urology	0
Rehabilitation	0
Chronic/Extended Care	0
Pulmonary	0
Psychiatric	84
Psychiatric specifically for Children and Youth under age 18	0
Psychiatric specifically for Geriatric Patients	0
Chemical Dependency	0
Chemical Dependency specifically for Children and Youth under age 18	0
Chemical Dependency specifically for Geriatric Patients	0
Swing Beds (for long term skilled or intermediate care)	0
Other, specify	0
Unassigned	0
TOTAL	84

B. Number of Patients in hospital on a typical day. Exclude normal newborns (See Instructions), long term skilled or intermediate patients. 54

5. OBSERVATION BEDS

A. Do you use inpatient staffed beds for 23-hour observation? ○ YES ◉ NO If yes, number of beds 0

B. Do you have beds assigned to dedicated 23-hour observation unit? ○ YES ◉ NO If yes, number of beds 0

C. Do you have beds in a "same-day-surgery" unit that are used for both same-day surgery and 23-hour observation? ○ YES ○ NO
If yes, number of beds 0

SBH-KINGSPORT 002474

SCHEDULE G - UTILIZATION State ID 90411

1. INPATIENT UTILIZATION (include normal newborns)
   Patient Census Records:
   Please indicate whether you are reporting Admissions and Inpatient Days ○
   or Discharges and Discharge Patient Days ◉

2. UTILIZATION BY MAJOR DIAGNOSTIC CATEGORIES:

MAJOR DIAGNOSTIC CATEGORIES	ADMISSIONS OR DISCHARGES	INPATIENT DAYS OR DISCHARGE PATIENT DAYS
01 Nervous System	9	87
02 Eye	0	0
03 Ear, Nose, Mouth and Throat	0	0
04 Respiratory System	3	9
05 Circulatory System	0	0
06 Digestive System	2	23
07 Hepatobiliary System & Pancreas	0	0
08 Musculoskeletal Sys. & Connective Tissue	0	0
09 Skin, Subcutaneous Tissue & Breast	0	0
10 Endocrine, Nutritional & Metabolic	1	20
11 Kidney & Urinary Tract	0	0
12 Male Reproductive System	0	0
13 Female Reproductive System	0	0
14 Pregnancy, Childbirth & the Puerperium	2	13
15 Normal Newborns & Other Neonates with Conditions Originating in the Perinatal Period	0	0
16 Blood and Blood Forming Organs and Immunological Disorders	0	0
17 Myeloproliferative Disorders & Poorly Differentiated Neoplasms	0	0
18 Infectious & Parasitic Diseases	1	22
19 Mental Diseases & Disorders	2,844	17,417
20 Alchohol/Drug Use & Alcohol/Drug-Induced Organic Mental Disorders	448	1,981
21 Injuries, Poisoning, & Toxic Effects of Drugs	0	0
22 Burns	0	0
23 Factors Influencing Health Status and Other Contacts with Health Services	0	0
24 Multiple Significant Trauma	0	0
25 Human Immunodeficiency Virus Infections	0	0
26 Other DRGs Associated with All MDCs	0	0
TOTAL	3,310	19,572

SBH-KINGSPORT 002475

3. UTILIZATION BY REVENUE SOURCE (excluding normal newborns -- see Instructions)

Patients should be categorized according to primary payer and counted only once.

Please indicate whether you are reporting Admissions and Inpatient Days ○ or Discharges and Discharge Patient Days ◉

	ADMISSIONS OR DISCHARGES	INPATIENT DAYS OR DISCHARGE PATIENT DAYS	OUTPATIENT VISITS*
a) Self Pay	591	3,214	178
b) Blue Cross/Blue Shield	167	889	391
c) Champus/TRICARE	35	205	0
d) Commercial Insurance (excludes Workers Comp)	486	2,592	1,152
e) Cover TN	0	0	0
f) Cover Kids	3	39	0
g) Access TN	0	0	0
h) Medicaid/Tenncare	450	2,744	131
i) Medicare - Total	966	6,566	668
Medicare Managed Care	759	5,359	264
j) Workers Compensation	0	0	0
k) Other	612	3,323	9
l) Total	3,310	19,572	2,529

* Should include emergency department visits and hospital outpatient visits

4. NUMBER OF PATIENTS BY AGE GROUP (excluding normal newborns -- see Instructions)

Please indicate whether you are reporting Admissions and Inpatient Days ○ or Discharges and Discharge Patient Days ◉

Age	ADMISSIONS OR DISCHARGES	INPATIENT DAYS OR DISCHARGE PATIENT DAYS	OUTPATIENT VISITS*
Under 15 years	122	912	30
15-17 years	194	1,302	48
18-64 years	2,875	16,386	2,230
65-74 years	91	714	149
75-84 years	20	165	60
85 years & older	8	93	12
GRAND TOTAL	3,310	19,572	2,529

* Should include emergency department visits and hospital outpatient visits

SBH-KINGSPORT 002476

5. PATIENT ORIGIN (excluding normal newborns -- see Instructions)
Indicate usual residence of patients and number of patient days. Please indicate whether you are reporting

Admissions and Inpatient Days ○ or Discharges and Discharge Patient Days ◉

** List only those counties in other states that represent at least 1 percent of the total admissions or discharges to your hospital. If you have fewer than 500 total discharges or admissions annually, list only those counties that represent at least 2 percent of your total admissions or discharges.

County #	Tennessee County of Residence	Number of Admissions or Discharges	Number of Inpatient Days or Discharge Patient Days
01	Anderson	5	28
02	Bedford	0	0
03	Benton	1	9
04	Bledsoe	0	0
05	Blount	3	23
06	Bradley	1	5
07	Campbell	0	0
08	Cannon	0	0
09	Carroll	0	0
10	Carter	260	1,649
11	Cheatham	0	0
12	Chester	0	0
13	Claiborne	3	14
14	Clay	0	0
15	Cocke	12	74
16	Coffee	0	0
17	Crockett	0	0
18	Cumberland	0	0
19	Davidson	2	5
20	Decatur	0	0
21	DeKalb	0	0
22	Dickson	0	0
23	Dyer	0	0
24	Fayette	0	0
25	Fentress	0	0
26	Franklin	0	0
27	Gibson	0	0
28	Giles	1	6

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5. PATIENT ORIGIN (continued)

County #	Tennessee County of Residence	Number of Admissions or Discharges	Number of Inpatient Days or Discharge Patient Days
29	Grainger	7	27
30	Greene	296	1,757
31	Grundy	0	0
32	Hamblen	19	107
33	Hamilton	1	7
34	Hancock	24	132
35	Hardeman	0	0
36	Hardin	0	0
37	Hawkins	254	1,452
38	Haywood	0	0
39	Henderson	0	0
40	Henry	0	0
41	Hickman	0	0
42	Houston	0	0
43	Humphreys	0	0
44	Jackson	0	0
45	Jefferson	8	25
46	Johnson	115	699
47	Knox	17	107
48	Lake	0	0
49	Lauderdale	0	0
50	Lawrence	0	0
51	Lewis	0	0
52	Lincoln	0	0
53	Loudon	1	6
54	McMinn	0	0
55	McNairy	0	0
56	Macon	0	0
57	Madison	0	0
58	Marion	0	0
59	Marshall	0	0
60	Maury	0	0
61	Meigs	0	0
62	Monroe	0	0

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5. PATIENT ORIGIN (continued)

County #	Tennessee County of Residence	Number of Admissions or Discharges	Number of Inpatient Days or Discharge Patient Days
63	Montgomery	0	0
64	Moore	0	0
65	Morgan	0	0
66	Obion	0	0
67	Overton	0	0
68	Perry	0	0
69	Pickett	0	0
70	Polk	1	5
71	Putnam	0	0
72	Rhea	0	0
73	Roane	2	12
74	Robertson	0	0
75	Rutherford	1	10
76	Scott	0	0
77	Sequatchie	0	0
78	Sevier	3	47
79	Shelby	0	0
80	Smith	0	0
81	Stewart	0	0
82	Sullivan	952	5,587
83	Sumner	0	0
84	Tipton	0	0
85	Trousdale	0	0
86	Unicoi	108	603
87	Union	0	0
88	Van Buren	0	0
89	Warren	0	0
90	Washington	902	5,322
91	Wayne	0	0
92	Weakley	0	0
93	White	0	0
94	Williamson	0	0
95	Wilson	0	0
96	TN County Unknown	0	0
	Tennessee Total	2,999	17,718

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5. PATIENT ORIGIN (continued)

State & County Residence	Number of Admissions or Discharges	Number of Inpatient Days or Discharge Patient Days
ALABAMA COUNTIES: (Specify)		
1)	0	0
2)	0	0
Other Alabama Counties	0	0
Alabama Total	0	0
GEORGIA COUNTIES: (Specify)		
1)	0	0
2)	0	0
Other Georgia Counties	0	0
Georgia Total	0	0
MISSISSIPPI COUNTIES: (Specify)		
1)	0	0
2)	0	0
Other Mississippi Counties	0	0
Mississippi Total	0	0
ARKANSAS COUNTIES: (Specify)		
1) Pulaski	1	3
2)	0	0
Other Arkansas Counties	0	0
Arkansas Total	1	3
MISSOURI COUNTIES: (Specify)		
1)	0	0
2)	0	0
Other Missouri Counties	0	0
Missouri Total	0	0

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5. PATIENT ORIGIN (continued)

State & County Residence	Number of Admissions or Discharges	Number of Inpatient Days or Discharge Patient Days
KENTUCKY COUNTIES: (Specify)		
1) Harlan	3	19
2) Bell	2	16
Other Kentucky Counties	2	10
Kentucky Total	7	45
VIRGINIA COUNTIES: (Specify)		
1) Scott	63	367
2) Washington	39	267
Other Virginia Counties	172	997
Virginia Total	274	1,631
NORTH CAROLINA COUNTIES: (Specify)		
1) Avery	3	39
2) Buncombe	2	15
Other North Carolina Counties	5	16
North Carolina Total	10	70
OTHER STATES: (Specify)		
1) Texas	3	15
2) West Virginia	2	15
All Other States and Countries	14	75
RESIDENCE UNKNOWN:	0	0
GRAND TOTAL	3,310	19,572

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6. Delivery Status:

A. Number of Infants Born Alive 0

B. Number of Deaths of Infants Born Alive 0

C. Number of Fetal Deaths (500 grams or more or in the absence of weight, 22 weeks or more gestation) 0

SBH-KINGSPORT 002482

SCHEDULE H - PSYCHIATRIC AND CHEMICAL DEPENDENCY UNITS State ID 90411

1. TYPE OF UNIT - PSYCHIATRIC:
   A. Do you have a dedicated psychiatric unit? (●) YES ( ) NO If yes, please complete items on this page and on the next page.
   B. Do you have a designated Gero-Psychiatric Unit? ( ) YES (●) NO

2. BEDS
   A. Number of assigned beds 84
   B. Date unit opened 06/01/1985

3. UTILIZATION BY AGE GROUPS:
   Please indicate if you are reporting Admissions and Inpatient Days (●) or Discharges and Discharge Patient Days. ( )

	Inpatient			Partial Care or Day Hospital	Outpatient
AGE GROUPS	Number of Patients on September 30	Number of Admissions or Discharges	Number of Inpatient or Discharge Patient Days	Number of Sessions	Number of Visits
Children and/or Adolescents Ages 0 - 17	2	329	1,988	253	0
Adults Ages 18 - 64	4	2,833	17,094	2,175	0
Elderly Ages 65 and older	0	132	795	101	0
Total	6	3,294	19,877	2,529	0

4. Is the psychiatric service managed under a management contract different from the hospital itself? ( ) YES (●) NO
   If yes, please specify name of organization that manages the unit. _____

5. Do you have contracts with Behavioral Health Organizations? (●) YES ( ) NO

6. Does your hospital use:

			If Yes, Number of Patients Secluded or Restrained		Number of Times Seclusion or Restraint was Initiated	
			Age 0-17	Age 18+	Age 0-17	Age 18+
A. Seclusion	(●) YES	( ) NO	0	0	0	0
B. Mechanical Restraints	(●) YES	( ) NO	8	21	27	46
C. Physical Holding Restraints	( ) YES	(●) NO	0	0	0	0
D. Chemical Restraints	( ) YES	(●) NO	0	0	0	0

SBH-KINGSPORT 002483

7. FINANCIAL DATA - PSYCHIATRIC

	INPATIENT CHARGES	plus	OUTPATIENT CHARGES	equals	TOTAL CHARGES	minus	ADJUSTMENTS TO CHARGES	equals	NET PATIENT REVENUE
A. GROSS PATIENT REVENUE & NET PATIENT REVENUE BY PAYER:									
1. Self Pay	$6,566,308	+	$8,114	=	$6,574,422	-	$5,283,868	=	$1,290,554
2. Blue Cross/Blue Shield	$1,772,644	+	$91,477	=	$1,864,121	-	$1,200,771	=	$663,350
3. Champus/TRICARE	$0	+	$0	=	$0	-	$0	=	$0
4. Commercial Insurance (excludes Workers Comp)	$5,622,322	+	$295,850	=	$5,918,172	-	$3,745,839	=	$2,172,333
5. Cover TN	$0	+	$0	=	$0	-	$0	=	$0
6. Cover Kids	$0	+	$0	=	$0	-	$0	=	$0
7. Access TN	$0	+	$0	=	$0	-	$0	=	$0
8. Medicaid/Tenncare	$11,062,825	+	$65,881	=	$11,128,706	-	$8,288,620	=	$2,840,086
9. Medicare - Total	$13,704,298	+	$158,137	=	$13,862,435	-	$9,493,875	=	$4,368,560
Medicare Managed Care	$1,358,496	+	$35,042	=	$1,393,538	-	$934,534	=	$459,004
10. Workers Compensation	$0	+	$0	=	$0	-	$0	=	$0
11. Other	$1,195,587	+	$2,890	=	$1,198,477	-	$678,952	=	$519,525

B. NON-GOVERNMENT ADJUSTMENTS TO REVENUE	
1. Bad Debt	$60,271
2. Charity Care	$85,221
3. Contractual Adjustments	$28,014,327
4. Total	$28,159,819
5. Amount of discounts provided to uninsured patients	$491,987

8. A. SERVICE CHARGES

	INPATIENT CHARGES	OUTPATIENT CHARGES
1. Routine Treatment	$0	$0
2. Ancillary Services	$8,599,463	$12,964
3. Other	$0	$0
4. Total	$8,599,463	$12,964

B. Do these charges include physicians' fees? ○ YES ◉ NO

SBH-KINGSPORT 002484

SCHEDULE H - PSYCHIATRIC AND CHEMICAL DEPENDENCY UNITS (continued) State ID 90411

1. TYPE OF UNIT - CHEMICAL DEPENDENCY:
   Do you have a dedicated chemical dependency unit? ○ YES ◉ NO If yes, please complete items on this page and on the next page.

2. BEDS
   A. Number of assigned beds 0
   B. Date unit opened _____

3. UTILIZATION BY AGE GROUPS:
   Please indicate if you are reporting Admissions and Inpatient Days ○ or Discharges and Discharge Patient Days. ○

	Inpatient			Partial Care or Day Hospital	Outpatient	Residential Care
AGE GROUPS	Number of Patients on September 30	Number of Admissions or Discharges	Number of Inpatient or Discharge Patient Days	Number of Sessions	Number of Visits	Number of Visits
Children and/or Adolescents Ages 0 - 17	0	0	0	0	0	0
Adults Ages 18 - 64	0	0	0	0	0	0
Elderly Ages 65 and older	0	0	0	0	0	0
Total	0	0	0	0	0	0

4. Is the chemical dependency service managed under a management contract different from the hospital itself? ○ YES ○ NO
   If yes, please specify name of organization that manages the unit. _____

5. Do you have contracts with Behavioral Health Organizations? ○ YES ○ NO

SBH-KINGSPORT 002485

6. FINANCIAL DATA - CHEMICAL DEPENDENCY

	INPATIENT CHARGES	plus	OUTPATIENT CHARGES	equals	TOTAL CHARGES	minus	ADJUSTMENTS TO CHARGES	equals	NET PATIENT REVENUE
A. GROSS PATIENT REVENUE & NET PATIENT REVENUE BY PAYER:									
1. Self Pay	$0	+	$0	=	$0	-	$0	=	$0
2. Blue Cross/Blue Shield	$0	+	$0	=	$0	-	$0	=	$0
3. Champus/TRICARE	$0	+	$0	=	$0	-	$0	=	$0
4. Commercial Insurance (excludes Workers Comp)	$0	+	$0	=	$0	-	$0	=	$0
5. Cover TN	$0	+	$0	=	$0	-	$0	=	$0
6. Cover Kids	$0	+	$0	=	$0	-	$0	=	$0
7. Access TN	$0	+	$0	=	$0	-	$0	=	$0
8. Medicaid/Tenncare	$0	+	$0	=	$0	-	$0	=	$0
9. Medicare - Total	$0	+	$0	=	$0	-	$0	=	$0
Medicare Managed Care	$0	+	$0	=	$0	-	$0	=	$0
10. Workers Compensation	$0	+	$0	=	$0	-	$0	=	$0
11. Other	$0	+	$0	=	$0	-	$0	=	$0

B. NON-GOVERNMENT ADJUSTMENTS TO REVENUE	
1. Bad Debt	$0
2. Charity Care	$0
3. Contractual Adjustments	$0
4. Total	$0
5. Amount of discounts provided to uninsured patients	$0

7. A. SERVICE CHARGES

	INPATIENT CHARGES	OUTPATIENT CHARGES
1. Routine Treatment	$0	$0
2. Ancillary Services	$0	$0
3. Other	$0	$0
4. Total	$0	$0

B. Do these charges include physicians' fees? (●) YES ( ) NO

SBH-KINGSPORT 002486

SCHEDULE I - EMERGENCY DEPARTMENT State ID 90411

1. What is the direct telephone number into your Emergency Department? _____

2. Is the Emergency Department managed under a management contract different from the hospital itself? ○ YES ◉ NO
   If yes, with whom is the contract held? _____

3. Emergency Department:

   Number of visits by payer:

A. Self Pay	0	H. Medicaid/Tenncare		L. Grand Total	0
B. Blue Cross/Blue Shield	0	AmeriChoice East (John Deere)	0		
C. Champus/TRICARE	0	AmeriChoice (Middle)	0		
D. Commercial Insurance (excludes Workers Comp)	0	AmeriGroup	0		
		Blue Care	0		
		PHP	0		
		TennCare Select	0		
E. Cover TN	0	TLC Family Care	0		
F. Cover Kids	0	UAHC (Omnicare)	0		
G. Access TN	0	Unison Health Plan	0		
		TennCare, MCO Unspecified	0		
		TBH	0		
		Premier	0		
		TennCare Total	0		
		I. Medicare - Total	0		
		Medicare Managed Care	0		
		J. Workers Compensation	0		
		K. Other	0		

4. Is your Emergency Department staffed 24 hours per day? ○ YES ○ NO If no, please give hours covered. 0

SBH-KINGSPORT 002487

5. Indicate the number of the following personnel available in the hospital on a normal day and how many are available to the Emergency Department.

	ON HOSPITAL CAMPUS	IN EMERGENCY DEPARTMENT
A. PHYSICIANS:		
Board certified in Emergency Medicine	0	0
Board eligible in Emergency Medicine	0	0
Declared Speciality of Emergency Medicine	0	0
Board Certified Psychiatrists	0	0
Other Physicians Available to Emergency Department	0	0
B. NURSES:		
Nurse Practitioners	0	0
R.N.'s with formal emergency training and experience	0	0
Other R.N.'s	0	0
L.P.N.'s and other nursing support personnel	0	0
Clerical Staff	0	0
C. OTHER:		
E.M.T.	0	0
E.M.T. advanced	0	0

SBH-KINGSPORT 002488

6. SUPPORTIVE SERVICES:

	YES	NO
A. COMMUNICATIONS:		
Two-Way radio in ER with Access to:		
Central Emergency Dispatch Center	○	◉
Ambulances	○	◉
Other hospitals	○	◉
B. HELIPORT:	○	◉
C. PHARMACY IN ER:	○	◉
D. BLOOD BANK:		
Fully stocked	○	◉
Common blood types only	○	◉
Blood expanders	○	◉

7. Do you have dedicated centers for the provision of specialized emergency care for the following:

A. Designated Trauma Center ○ YES ◉ NO

B. Burns ○ YES ◉ NO

If yes, do you have a designation by a government agency as a Burn Center? ○ YES ◉ NO

C. Pediatrics ○ YES ◉ NO

D. Other, specify

_____

8. Triage: A. Total number of patients who presented in your ER. 0

B. Total number treated in your ER. 0

C. Total number not treated in your ER but referred to physician or clinic for treatment. 0

SBH-KINGSPORT 002489

SCHEDULE J - PERSONNEL ON PAYROLL AS OF LAST DAY OF REPORTING PERIOD AND USE OF CONTRACT EMPLOYEES

State ID 90411

	Full-Time Equivalent**	Full-Time Equivalent Budgeted Vacancies	Use Contract Staff in this Employee Category***
1. Administration:			
A. Administrators & Assistants	0.7	0.0	☐
B. Director, Health Services Research & Assistants	0.0	0.0	☐
C. Marketing & Planning Officer(s) &Assistants	0.0	0.0	☐
D. Financial and Accounting Officer(s) & Assistants	0.0	0.0	☐
2. Physician and Dental Services:			
A. Physicians	0.0	0.0	☐
B. Medical residents	0.0	0.0	☐
C. Dentists	0.0	0.0	☐
D. Dental residents	0.0	0.0	☐
3. Nursing Services:			
A. RNs - Administrative	0.0	0.0	☐
B. RNs - Patient care/clinical	42.7	0.0	☐
C. LPNs	9.6	0.7	☐
D. Ancillary nursing personnel	26.5	0.0	☐
4. Certified Nurse Midwives	0.0	0.0	☐
5. Nurse Anesthetists	0.0	0.0	☐
6. Physicians assistants	0.0	0.0	☐
7. Nurse practitioners	0.6	0.0	☐
8. Medical record service:			
A. Medical record administrators	0.0	0.0	☐
B. Medical record technicians (certified or accredited)	0.0	0.0	☐
C. Other Medical record technicians	0.0	0.0	☐
9. Pharmacy:			
A. Pharmacists, licensed	1.5	0.0	☐
B. Pharmacy technicians	1.1	0.1	☐
C. Clinical Phar-D	0.0	0.0	☐
10. Clinical laboratory services:			
A. Medical Technologists	0.0	0.0	☐
B. Other laboratory personnel	0.3	0.0	☐
11. Dietary services:			
A. Dietitians	0.1	0.2	☐
B. Dietetic technicians	0.0	0.0	☐

** Full-time + Part-time specified in Full Time Equivalent

*** Please check if contract staff is used.

	Full-Time Equivalent**	Full-Time Equivalent Budgeted Vacancies	Use Contract Staff in this Employee Category***
12. Radiological services:			
A. Radiographers (radiologic technologists)	0.0	0.0	☐
B. Radiation therapy technologists	0.0	0.0	☐
C. Nuclear medicine technologists	0.0	0.0	☐
D. Other radiologic personnel	0.0	0.0	☐
13. Therapeutic services:			
A. Occupational therapists	0.0	0.0	☐
B. Occupational therapy assistants & aides	0.0	0.0	☐
C. Physical therapists	0.0	0.0	☐
D. Physical therapy assistants & aides	0.0	0.0	☐
E. Recreational therapists	0.0	0.0	☐
14. Speech and hearing services:			
A. Speech Pathologist	0.0	0.0	☐
B. Audiologist	0.0	0.0	☐
15. Respiratory therapy services:			
A. Respiratory therapists	0.0	0.0	☐
B. Respiratory therapy technicians	0.0	0.0	☐
16. Psychiatric services:			
A. Clinical psychologists	0.0	0.0	☐
B. Psychiatric social workers	0.0	0.0	☐
C. Psychiatric registered nurses	0.0	0.0	☐
D. Other mental health professionals	20.3	10.7	☐
17. Chemical dependency services:			
A. Clinical psychologists	0.0	0.0	☐
B. Social workers	0.0	0.0	☐
C. Registered nurses	0.0	0.0	☐
D. Other specialists in addiction and/or in chemical dependency	0.0	0.0	☐
18. Medical Social workers	0.0	0.0	☐
19. Surgical technicians	0.0	0.0	☐
20. All other certified professional & technical	0.7	0.0	☐
21. All other non-certified professional & technical	0.0	0.0	☐
22. All other personnel	81.0	0.0	☑
TOTAL	185.1	11.7	

SBH-KINGSPORT 002490

SCHEDULE K - MEDICAL STAFF

State ID 90411

	(1) Number of Active and Associate Medical Staff (Include Board Certified)	(2) Number of Active and Associate Medical Staff Who Are Board Certified	(3) Number of House Staff Who Are Interns, Externs or Residents
1. MEDICAL SPECIALTIES:			
A. General and family practice	26	25	0
B. Pediatric	43	40	0
C. General internal medicine	82	78	0
D. Psychiatric	10	10	2
E. Neonatologist	4	4	0
F. Cardiologists	24	20	0
G. Neurologists	6	5	0
H. Other medical specialties	39	37	0
2. SURGICAL SPECIALTIES:			
A. General surgery	17	17	8
B. Obstetrics and gynecology	22	18	0
C. Perinatologists	0	0	0
D. Gynecology	2	2	0
E. Orthopedic	16	15	0
F. Neurosurgeons	8	7	0
G. Cardiovascular	3	2	0
H. Gastroenterology	11	11	0
I. Other surgical specialties	14	13	0
3. OTHER SPECIALTIES:			
A. Pathology	8	8	0
B. Radiology	17	17	0
C. Anesthesiology	11	11	0
D. Other specialties	59	57	0
4. DENTAL SPECIALTIES:	3	0	0
TOTAL	425	397	10

SBH-KINGSPORT 002491

SCHEDULE L - PERINATAL State ID 90411

1A. Name of person completing Perinatal survey Engie Trivett
1B. Telephone Number (423) 431-6679
1C. Fax Number (423) 431-5494

Please complete the following questions.

2. Births
   A. Total number of births 0
   B. Birth weight below 2500 grams (5lb 8oz) 0
   C. Birth weight below 1500 grams (3 lb 5oz) 0

3. Number of babies on ventilator longer than 24 hours 0

4. Number of babies received from referring hospitals for neonatal management 0

	YES	NO
5. Is Medical Director of Obstetrics board certified/eligible in maternal-fetal medicine?	○	◉
6. Is Medical Director of the Nursery board certified/eligible in neonatal-perinatal?	○	◉

7. Do the following subspecialty consultants spend more than 2/3 full-time effort at your hospital?

	YES	NO
A. OBSTETRICS:		
Perinatal Sonologist	○	◉
Hematologist	○	◉
Cardiologist	○	◉
B. NEONATAL:		
Pediatric Radiologist	○	◉
Pediatric Cardiologist	○	◉
Pediatric Neurologist	○	◉
Pathologist	○	◉
Pediatric Surgeon	○	◉

SBH-KINGSPORT 002492

SCHEDULE M - SURVEY ON NURSING PERSONNEL

State ID 90411

(As of the last day of the reporting period)

1. Registered Nurses

HIGHEST EDUCATION LEVEL	FTE NUMBER CURRENTLY EMPLOYED	NUMBER OF BUDGETED VACANCIES	NUMBER OF POSITIONS YOU PLAN TO ADD IN THE NEXT 12 MONTHS	NUMBER OF POSITIONS YOU PLAN TO ELIMINATE IN THE NEXT 12 MONTHS	PRIMARY ROLE (NUMBER OF POSITIONS)	
					CLINICAL	ADMINISTRATIVE
Total	40.0	0.0	0.0	0.0	34.0	6.0
Bachelors Degree	18.0	0.0	0.0	0.0	14.0	4.0
Associate Degree	20.7	0.0	0.0	0.0	18.7	2.0
Diploma	1.1	0.0	0.0	0.0	1.1	0.0
Masters Degree	0.2	0.0	0.0	0.0	0.2	0.0
Doctorate Degree	0.0	0.0	0.0	0.0	0.0	0.0

2. Advanced Practice Nurses

NURSING PERSONNEL CATEGORY	FTE NUMBER CURRENTLY EMPLOYED	NUMBER OF BUDGETED VACANCIES	NUMBER OF POSITIONS YOU PLAN TO ADD IN THE NEXT 12 MONTHS	NUMBER OF POSITIONS YOU PLAN TO ELIMINATE IN THE NEXT 12 MONTHS	PRIMARY ROLE (NUMBER OF POSITIONS)	
					CLINICAL	ADMINISTRATIVE
Total	0.0	0.0	0.0	0.0	0.0	0.0
Nurse Practitioner	0.0	0.0	0.0	0.0	0.0	0.0
Clinical Nurse Specialist	0.0	0.0	0.0	0.0	0.0	0.0
CRNA	0.0	0.0	0.0	0.0	0.0	0.0
Certified Nurse Midwife	0.0	0.0	0.0	0.0	0.0	0.0

3. Licensed Practical Nurses

LPNs	NUMBER OF POSITIONS YOU PLAN TO ADD IN THE NEXT 12 MONTHS	NUMBER OF POSITIONS YOU PLAN TO ELIMINATE IN THE NEXT 12 MONTHS
Total	0.0	0.0

4. Recruitment of Nursing Personnel

The following are selected specialties for which hospitals commonly report recruiting difficulties.
Please specify other categories as necessary.

NURSING PERSONNEL CATEGORY	FTE NUMBER CURRENTLY EMPLOYED	NUMBER OF BUDGETED VACANCIES	NUMBER OF POSITIONS YOU PLAN TO ADD IN THE NEXT 12 MONTHS	NUMBER OF POSITIONS YOU PLAN TO ELIMINATE IN THE NEXT 12 MONTHS
CCU/ICU	0.0	0.0	0.0	0.0
ER	0.0	0.0	0.0	0.0
Other (Specify):				
Psych	40.0	0.0	0.0	0.0
	0.0	0.0	0.0	0.0

SBH-KINGSPORT 002493

SCHEDULE N - HEALTH CARE PLANS ACCEPTED

State ID 90411

The Health Consumer Right-to-Know Act of 1998 which was signed by Governor Sundquist in May, 1998 requires hospitals to report to the Department of Health "health care plans accepted by the hospital" as well as a variety of information that is included in earlier schedules of the Joint Annual Report. In order to allow the Joint Annual Report to meet the entire reporting requirement described in this act, please list all health insurance plans with which you currently - as of the last day of this reporting period - have a valid contract. List each plan separately not just the name of the company. For example, if you have contracts to provide services to individuals enrolled in Blue Choice and Blue Preferred, list both plans and do not only list Blue Cross & Blue Shield of Tennessee.

Plans:

Woodridge - Beechstreet - PPO
Americhoice UBH - TennCare BHO
Cariten/Humana - HMO
Cariten/Humana - POS
Cariten/Humana - PPO
Cariten/Humana - WorXs
Cariten/Humana - Senior Health (Med Adv)
CIGNA BHO - BHO
Dept of Labor - Facity Agreement
Encompass - Baxter Ee's - Direct
Evolutions - PPO Network
First Health - PPO
Formost - PPO
GEHA PPO USA - PPO
Initial Group - PPO - Initial Health Alliance
Initial Group - PPO - Workers' Comp
LifeSynch - PPO - Psych
Magellan - Commercial Facility Agreement
PHCS - PPO
UMWA - Direct
UBH - PPO
USA MCO - PPO Network
ValueOptions - Commercial BHO
ValueOptions - TennCare BHO
Virginia Medicaid - Medicaid

SBH-KINGSPORT 002494

TENNESSEE DEPARTMENT OF HEALTH

Health Statistics
6th Floor, Cordell Hull Building
425 5th Avenue North
Nashville, TN 37243
Telephone: (615) 741-1954 - Fax: (615) 253-1688

JOINT ANNUAL REPORT OF HOSPITALS

2011

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State ID 90411

TENNESSEE DEPARTMENT OF HEALTH
JOINT ANNUAL REPORT OF HOSPITALS
2011

SCHEDULE A - IDENTIFICATION

1. Name of Hospital Woodridge Psychiatric Hospital — Federal Tax I.D. # 62-0582605
   Did your facility name change during the reporting period? ○ YES ◉ NO
   County Washington
2. Address of Facility — Street 403 State of Franklin Road; City Johnson City; State Tennessee; Zip 37604-
3. Telephone Number (423) 928-7111 (Area Code Number)
4. Name of Chief Executive Officer Ann (First Name) Fleming (Last Name)
   Signature of Chief Executive Officer _____
5. Name of person(s) coordinating form completion Joshua McFall
   Telephone Number if different than above (423) 302-3355 (Area Code Number)
6. 84 Office Use Only
7. Reporting period used for this facility:
   Beginning Date 07/01/2010 Ending Date 06/30/2011
8. 365 Office Use Only
9. Does your hospital own or operate or have other hospitals licensed as satellites of your hospital? ○ YES ◉ NO
   If yes, please complete the following.

	NAME OF HOSPITAL	STATE ID	SATELLITE	OWN	OPERATE	OWN AND OPERATE
1			☐	○	○	○
2			☐	○	○	○
3			☐	○	○	○
4			☐	○	○	○
5			☐	○	○	○

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SCHEDULE B - CLASSIFICATION

State ID 90411

1. CONTROL:

A. Indicate the type of organization that is responsible for establishing policy for overall operation of the hospital.

1. Government-Non-Federal	2. Government-Federal	3. Nongovernmental, not-for-profit	4. Investor-owned, for-profit
○ 11 State	○ 17 Armed Forces	○ 20 Church-operated	○ 23 Individual
○ 12 County	○ 18 Veterans Admin.	◉ 21 Other Nonprofit Corporation	○ 24 Partnership
○ 13 City	○ 19 Other, please specify	○ 22 Other not-for-profit, please specify	○ 25 Corporation
○ 14 City-County			
○ 15 Hospital district or authority			

B. Is the hospital part of a health system? ◉ YES ○ NO

If yes, please provide the name and location of the health system.

Name Mountain States Health Alliance City Johnson City State Tennessee

C. Does the controlling organization lease the physical property from the owner(s) of the hospital? ○ YES ◉ NO

D. What is the name of the legal entity that owns and has title to the land and physical plant of the hospital?

E. Is the hospital a division of a holding company? ○ YES ◉ NO

F. Does the hospital itself operate subsidiary corporations? ○ YES ◉ NO

G. Is the hospital managed under contract? ○ YES ◉ NO If YES, length of contract From To

If yes, please provide name, city, and state of the organization that manages the hospital.

Name City State

Name City State

H. Is the hospital part of a health care alliance? ◉ YES ○ NO (see definition of alliance)

If yes, please provide the name, city, and state of the alliance headquarters.

Name Premier, Inc. City San Diego State California

Name City State

I. Is the hospital part of a health network? ◉ YES ○ NO (see definition of network)

If yes, please provide the the name, city, and state of the network.

Name Mountain States Healthcare Network City Johnson City State Tennessee

Name City State

2. SERVICE:

A. Indicate the ONE category that BEST describes your hospital.

○ 01 General medical and surgical	○ 07 Rehabilitation
○ 02 Pediatric	○ 08 Orthopedic
◉ 03 Psychiatric	○ 09 Chronic disease
○ 04 Tuberculosis and other respiratory diseases	○ 10 Alcoholism and other chemical dependency
○ 05 Obstetrics and gynecology	○ 11 Long term acute care
○ 06 Eye, ear, nose and throat	○ 12 Other-specify treatment area

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B. Does your hospital own or have a contract with any of the following?

	(1) Yes	(2) No	Specify one: 1) Own	2) Contract	Number of Physicians	FTE Physicians
1. Independent Practice Association	○	◉	○	○	0	0.0
2. Group Practice Without Walls	○	◉	○	○	0	0.0
3. Open Panel Physician-Hospital Organization (PHO)	○	◉	○	○	0	0.0
4. Closed Panel Physician-Hospital Organization (PHO)	○	◉	○	○	0	0.0
5. Management Services Organization (MSO)	○	◉	○	○	0	0.0
6. Integrated Salary Model	◉	○	◉	○	155	0.0
7. Equity Model	○	◉	○	○	0	0.0
8. Foundation	○	◉	○	○	0	0.0

3. Have any of the following insurance products been developed for use in Tennessee by your hospital, health system, health network alliance or as a joint venture with an insurer?
Check all that apply.

	(1) Your Hospital	(2) Health System	(3) Health Network	(4) Alliance	(5) Joint Venture With Insurer
A. Health Maintenance Organization	(1) ☒	(2) ☒	(3) ☒	(4) ☒	(5) ☒
B. Preferred Provider Organization	(1) ☒	(2) ☒	(3) ☒	(4) ☒	(5) ☒
C. Indemnity Fee For Service Plan	(1) ☒	(2) ☒	(3) ☒	(4) ☒	(5) ☒

4. Does your hospital have a formal written contract that specifies the obligations of each party with:
   A. Health Maintenance Organization (HMO)? ◉ YES ○ NO
      1. How many do you contract with? 4
      2. Number of different contracts 5
   B. Preferred Provider Organization (PPO)? ◉ YES ○ NO
      1. How many do you contract with? 16
      2. Number of different contracts 20

5. What percentage of the hospital's net patient revenue is paid on a capitated basis?
If the hospital does not participate in any capitated arrangement, please enter "0". 0.0 %

6. How many covered lives are in your capitation agreements? 0

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SCHEDULE C - ACCREDITATIONS AND APPROVALS State ID 90411

1. ACCREDITATIONS:

A. Joint Commission on Accreditation of Healthcare Organizations (JCAHO)		
Date of most recent accrediting letter or survey 04/25/2009	◉YES	○NO
If Yes, Is the hospital accredited under either/both of the following manuals:		
1. Comprehensive Accreditation Manual for Hospitals (CAMH)	◉YES	○NO
2. Comprehensive Accreditation Manual for Behavioral Health Care (CAMBHC)	○YES	◉NO
3. Other manuals, please specify		
B. Commission on Accreditation of Rehabilitation Facilities (CARF)		
Date of most recent accrediting letter or survey	○YES	◉NO
C. American College of Surgeons Commission on Cancer	○YES	◉NO
D. American Osteopathic Association (AOA)	○YES	◉NO
E. TÜV Healthcare Specialists	○YES	◉NO
F. Community Health Accreditation Program (CHAP)	○YES	◉NO

2. CERTIFICATIONS:

Medicare Certification	◉YES	○NO

3. OTHER:

A. THA Membership	◉YES	○NO
B. Hospital Alliance of Tennessee, Inc. Membership	○YES	◉NO
C. American Hospital Association Membership	○YES	◉NO
D. American Medical Association Approval for Residencies (and Internships)	◉YES	○NO
E. State Approved School of Nursing:		
Registered Nurses	○YES	◉NO
Licensed Practical Nurses	○YES	◉NO
F. Medical School Affiliation	○YES	◉NO
G. Tennessee Association of Public and Teaching Hospitals (TNPath)	○YES	◉NO
H. National Association of Children's Hospitals and Related Institutions (NACHRI)	○YES	◉NO
I. National Association of Public Hospitals (NAPH)	○YES	◉NO
J. Other, please specify		

Field is limited to 255 characters

SBH-KINGSPORT 002499

SCHEDULE D - SERVICES

State ID 90411

1. CERTIFICATE OF NEED:

Do you have an approved, **but not completed,** certificate of need (CON) ? ○ YES ◉ NO

If yes, please specify:

Name of Service or Activity Requiring the CON	# of Beds (if applicable)	Date of Approval
	0	
	0	
	0	

2. Does your hospital own or operate Tennessee physician primary care clinics? ○ YES ◉ NO If yes, how many? 0
How many physicians practice in these clinics? 0

3. Does your hospital own or operate other physician/specialty clinics located in Tennessee? ◉ YES ○ NO If yes, how many? 1
How many physicians practice in these clinics? 4

4. Does your hospital own or operate a blood bank? ○ YES ◉ NO
If yes, please indicate:

A. Distributes blood within the hospital ○ YES ◉ NO
B. Collects blood within the hospital ○ YES ◉ NO
C. Distributes blood outside the hospital ○ YES ◉ NO
D. Collects blood from outside the hospital ○ YES ◉ NO

5. Does your hospital own or operate an ambulance service? ○ YES ◉ NO
If yes, please specify the counties where services are located.

Please specify the type of service and ownership relationship:

A. Land Transport ○ YES ○ NO If yes, ○ own; ○ operate; ○ own and operate; ○ own in joint venture
B. Helicopter ○ YES ○ NO If yes, ○ own; ○ operate; ○ own and operate; ○ own in joint venture
C. Special Neonatal Helicopter ○ YES ○ NO If yes, ○ own; ○ operate; ○ own and operate; ○ own in joint venture
D. Special Neonatal Land Transport ○ YES ○ NO If yes, ○ own; ○ operate; ○ own and operate; ○ own in joint venture

SBH-KINGSPORT 002500

6. Does your hospital own or operate an off-site outpatient/ambulatory clinic located in Tennessee? ○ YES ◉ NO
If yes, please complete the following.

Name of Clinic	County	City				
			○ own	○ operate	○ own and operate	○ own in joint venture
			○ own	○ operate	○ own and operate	○ own in joint venture

7. Does your hospital own or operate an off-site ambulatory surgical treatment center located in Tennessee? ○ YES ◉ NO
If yes, please complete the following.

Name of Center	County	City				
			○ own	○ operate	○ own and operate	○ own in joint venture
			○ own	○ operate	○ own and operate	○ own in joint venture

8. Does your hospital own or operate an off-site birthing center located in Tennessee? ○ YES ◉ NO
If yes, please complete the following.

Name of Center	County	City				
			○ own	○ operate	○ own and operate	○ own in joint venture
			○ own	○ operate	○ own and operate	○ own in joint venture

9. Does your hospital own or operate an off-site outpatient diagnostic center located in Tennessee? ○ YES ◉ NO
If yes, please complete the following.

Name of Center	County	City				
			○ own	○ operate	○ own and operate	○ own in joint venture
			○ own	○ operate	○ own and operate	○ own in joint venture

10. Does your hospital own or operate an off-site outpatient physical therapy rehab center located in Tennessee? ○ YES ◉ NO
If yes, please complete the following.

Name of Center	County	City				
			○ own	○ operate	○ own and operate	○ own in joint venture
			○ own	○ operate	○ own and operate	○ own in joint venture

SBH-KINGSPORT 002501

11. Does your hospital own or operate a hospice that has a separate license located in Tennessee? ◯ YES ◉ NO
If yes, please complete the following.

Name of Hospice	County	City				
			◯ own	◯ operate	◯ own and operate	◯ own in joint venture
			◯ own	◯ operate	◯ own and operate	◯ own in joint venture

12. Does your hospital own or operate an off-site assisted-care living facility located in Tennessee? ◯ YES ◉ NO
If yes, please complete the following.

Name of Facility	County	City				
			◯ own	◯ operate	◯ own and operate	◯ own in joint venture
			◯ own	◯ operate	◯ own and operate	◯ own in joint venture

13. Does your hospital own or operate a home for the aged located in Tennessee? ◯ YES ◉ NO
If yes, please complete the following.

Name of Home	County	City				
			◯ own	◯ operate	◯ own and operate	◯ own in joint venture
			◯ own	◯ operate	◯ own and operate	◯ own in joint venture

14. Does your hospital own or operate an urgent care center? ◯ YES ◉ NO
If yes, please complete the following.

Name of Center	County	City				
			◯ own	◯ operate	◯ own and operate	◯ own in joint venture
			◯ own	◯ operate	◯ own and operate	◯ own in joint venture

15. Does your hospital own or operate a home health agency? ◯ YES ◉ NO
If yes, please complete the following.

Name of Agency: _____
Location of Agency: City _____ County _____
Number of Visits _____
◯ own ◯ operate ◯ own and operate ◯ own in joint venture

Name of Agency: _____
Location of Agency: City _____ County _____
Number of Visits _____
◯ own ◯ operate ◯ own and operate ◯ own in joint venture

SBH-KINGSPORT 002502

16. Does your hospital own or operate an off-site nursing home located in Tennessee? ◯ YES ◉ NO
If yes, please complete the following.

_____ _____ _____ ◯ own ◯ operate ◯ own and operate ◯ own in joint venture
Name of Home County City

Number of Beds - Total 0 = Medicare only (SNF) _____ + Medicaid only (NF) _____ + Medicare/Medicaid (SNF/NF) _____ + Not Certified _____

_____ _____ _____ ◯ own ◯ operate ◯ own and operate ◯ own in joint venture
Name of Home County City

Number of Beds - Total 0 = Medicare only (SNF) _____ + Medicaid only (NF) _____ + Medicare/Medicaid (SNF/NF) _____ + Not Certified _____

17. Does your hospital operate a hospital-based skilled nursing unit (subacute unit) licensed as a nursing home for skilled nursing care (excluding swing beds)? ◯ YES ◉ NO If yes, please complete the following.

_____ _____ _____
Name of SNF Number of Licensed Beds Number of Staffed Beds

_____ _____
Number of Admissions Number of Patient Days

18. Does your hospital own, operate, or contract a mobile unit that operates in Tennessee? ◯ YES ◉ NO
If yes, specify name(s) and whether owned, operated, or contracted.

A. List mobile services:

1 _____ ◯ contract ◯ own ◯ operate ◯ own and operate ◯ own in joint venture _____ # of visits
2 _____ ◯ contract ◯ own ◯ operate ◯ own and operate ◯ own in joint venture _____ # of visits
3 _____ ◯ contract ◯ own ◯ operate ◯ own and operate ◯ own in joint venture _____ # of visits
4 _____ ◯ contract ◯ own ◯ operate ◯ own and operate ◯ own in joint venture _____ # of visits
5 _____ ◯ contract ◯ own ◯ operate ◯ own and operate ◯ own in joint venture _____ # of visits
6 _____ ◯ contract ◯ own ◯ operate ◯ own and operate ◯ own in joint venture _____ # of visits

B. List counties served (where you take the service):
List counties for service 1 in 18A on line 1, for service 2 on line 2, etc.

1 _____ _____ _____ _____ _____ _____
2 _____ _____ _____ _____ _____ _____
3 _____ _____ _____ _____ _____ _____
4 _____ _____ _____ _____ _____ _____
5 _____ _____ _____ _____ _____ _____
6 _____ _____ _____ _____ _____ _____

SBH-KINGSPORT 002503

19. HOSPITAL-BASED SERVICES (See Explanation):

Utilization of Selected Services	Is This Service Provided In Your Hospital? YES	NO	To Inpatients Unit of Measure	Number	To Outpatients Unit of Measure	Number
A. Miscellaneous:						
Lithotripsy						
Percutaneous	○	◉	Procedures	0	Procedures	0
Extracorporeal Shock Wave	○	◉				
# fixed units inside hospital 0			Procedures	0	Procedures	0
# fixed units off site 0					Procedures	0
# of mobile units 0			Procedures	0	Procedures	0
# days per week (mobile units) 0						
Renal Dialysis						
# of dedicated stations 0						
Hemo Dialysis	○	◉	Patients	0	Patients	0
			Treatments	0	Treatments	0
Peritoneal Dialysis	○	◉	Patients	0	Patients	0
			Treatments	0	Treatments	0
B. Oncology/Therapies:						
Chemotherapy	○	◉	Patients	0	Patients	0
					Encounters	0
Hyperthermia	○	◉	Treatments	0	Treatments	0
Radiation Therapy-Megavoltage	○	◉				
# fixed units inside hospital 0			Patients	0	Patients	0
			Treatments	0	Treatments	0
# fixed units off site 0						

SBH-KINGSPORT 002504

SCHEDULE D - SERVICES (continued) State ID 90411

Utilization of Selected Services	Is This Service Provided In Your Hospital? YES	NO	To Inpatients Unit of Measure	Number	To Outpatients Unit of Measure	Number
C. Radiology:						
Computerized Tomographic Scanners CT/CAT	○	◉	Patients	0	Visits	0
# fixed units inside hospital 0			Procedures	0	Procedures	0
# fixed units off site 0					Procedures	0
# of mobile units 0			Procedures	0	Procedures	0
# days per week (mobile units) 0						
Ultrafast CT	○	◉	Patients	0	Visits	0
# fixed units inside hospital 0			Procedures	0	Procedures	0
# fixed units off site 0					Procedures	0
# of mobile units 0			Procedures	0	Procedures	0
# days per week (mobile units) 0						
Magnetic Resonance Imaging	○	◉				
# fixed units inside hospital 0			Procedures	0	Procedures	0
# fixed units off site 0					Procedures	0
# of mobile units 0			Procedures	0	Procedures	0
# days per week (mobile units) 0						
Nuclear Medicine	○	◉	Procedures	0	Procedures	0
Radium Therapy	○	◉	Procedures	0	Procedures	0
Isotope Therapy	○	◉	Procedures	0	Procedures	0
Positron Emission Tomography	○	◉				
# fixed units inside hospital 0			Procedures	0	Procedures	0
# fixed units off site 0					Procedures	0
# of mobile units 0			Procedures	0	Procedures	0
# days per week (mobile units) 0						
Mammography	○	◉	Procedures	0	Procedures	0
# of ACR accredited units 0						
# other fixed units inside hospital 0						
# other fixed units off site 0						
# of mobile units 0						
# days per week (mobile units) 0						
Bone Densitometry	○	◉	Procedures	0	Procedures	0
# of units 0						

SBH-KINGSPORT 002505

Note: Pediatric patients should be defined as patients 14 years old and younger.

Utilization of Selected Services	Is This Service Provided In Your Hospital? YES	NO	In Cath Lab Setting Unit of Measure	Number	Outside Cath Lab Setting Unit of Measure	Number
D. Cardiac:						
Cardiac Catheterization						
Date Initiated						
# labs 0						
Intra-Cardiac or Coronary Artery	○	◉	Adult Procedures	0	Adult Procedures	0
			Pediatric Procedures	0	Pediatric Procedures	0
Percutaneous Transluminal Coronary Angioplasty	○	◉	Adult Procedures	0	Adult Procedures	0
			Pediatric Procedures	0	Pediatric Procedures	0
Stents	○	◉	Adult Procedures	0	Adult Procedures	0
			Pediatric Procedures	0	Pediatric Procedures	0
All Other Heart Procedures	○	◉	Adult Procedures	0	Adult Procedures	0
			Pediatric Procedures	0	Pediatric Procedures	0
All Other Non-Cardiac Procedures	○	◉	Adult Procedures	0	Adult Procedures	0
			Pediatric Procedures	0	Pediatric Procedures	0
Thrombolytic Therapy	○	◉	Adult Procedures	0	Adult Procedures	0
			Pediatric Procedures	0	Pediatric Procedures	0
			To Inpatients		To Outpatients	
Open Heart Surgery	○	◉	Adult Operations	0		
# dedicated O.R.'s 0			Pediatric Operations	0		
E. Surgery:						
Inpatient	○	◉	Encounters	0		
# operating rooms 0			Procedures	0		
Outpatient (one day)	○	◉			Encounters	0
# dedicated O.R.'s 0					Procedures	0
F. Rehabilitation:						
Cardiac	○	◉	Patients	0	Patients	0

SBH-KINGSPORT 002506

SCHEDULE D - SERVICES (continued) State ID 90411

Utilization of Selected Services	Is This Service Provided In Your Hospital? YES	NO	To Inpatients Unit of Measure	Number	To Outpatients Unit of Measure	Number
F. Rehabilitation (continued):						
Chemical Dependency	○	◉	Patients	0	Patients	0
					Episodes of Care	0
Nutritional Counseling	○	◉	Patients	0	Patients	0
					Episodes of Care	0
Pulmonary	○	◉	Patients	0	Patients	0
					Episodes of Care	0
G. Physical Rehabilitation:						
Occupational Therapy	○	◉	Patients	0	Patients	0
					Episodes of Care	0
Orthotic Services	○	◉	Patients	0	Patients	0
					Episodes of Care	0
Physical Therapy	○	◉	Patients	0	Patients	0
					Episodes of Care	0
Prosthetic Services	○	◉	Patients	0	Patients	0
					Episodes of Care	0
Speech/Language Therapy	○	◉	Patients	0	Patients	0
					Episodes of Care	0
Therapeutic Recreational Service	○	◉	Patients	0	Patients	0
					Episodes of Care	0

Do you have a dedicated inpatient physical rehabilitation unit? ○ YES ◉ NO

If yes, please complete the following. Number of assigned beds 0 Number of admissions 0 Number of patient days 0

Do you have a dedicated outpatient physical rehabilitation unit? ○ YES ◉ NO

H. Pain Management:	○	◉	Patients	0	Patients	0

SBH-KINGSPORT 002507

SCHEDULE D - SERVICES (continued) State ID 90411

Utilization of Selected Services	Is This Service Provided In Your Hospital? YES	NO	To Inpatients Unit of Measure	Number	To Outpatients Unit of Measure	Number
I. Obstetrics/Newborn:						
Perinatal Level of Care						
Level I	○	◉				
Level II - A	○	◉				
Level II - B	○	◉				
Level III	○	◉				
Cesarean Section Deliveries	○	◉	Deliveries	0		
Non C-Section Deliveries	○	◉	Deliveries	0		
Birthing Rooms # rooms 0 # LDRP beds 0 # LDR beds 0	○	◉	Deliveries	0		
Labor Rooms # rooms 0	○	◉				
Postpartum Services # beds 0	○	◉	Patients	0	Visits	0
Newborn Nursery # bassinets 0	○	◉	Infants Discharged Patient Days	0 0		
Premature Nursery # bassinets 0	○	◉	Infants Discharged Patient Days	0 0		
Isolation Nursery # bassinets 0	○	◉	Patient Days	0		

SBH-KINGSPORT 002508

SCHEDULE D - SERVICES (continued) State ID 90411

Utilization of Selected Services	Is This Service Provided In Your Hospital? YES	NO	To Inpatients Unit of Measure	Number	To Outpatients Unit of Measure	Number
J. Transplants:						
Organs						
Total Donors			Donors	0		
Total Harvested	○	◉	Donations	0		
Transplants	○	◉	Transplants	0		
Organ Bank	○	◉	Organs	0		
Type of Organ:						
Heart	○	◉	# Harvested	0		
			# Transplanted	0		
Liver	○	◉	# Harvested	0		
			# Transplanted	0		
Kidneys	○	◉	# Harvested	0		
			# Transplanted	0		
Pancreas	○	◉	# Harvested	0		
			# Transplanted	0		
Intestine	○	◉	# Harvested	0		
			# Transplanted	0		
Any Other _____	○	◉	# Harvested	0		
			# Transplanted	0		
Tissues						
Total Donors			Donors	0		
Total Harvested	○	◉	Donations	0		
Transplants	○	◉	Transplants	0		
Tissue Bank	○	◉	Tissues	0		
Type of Tissue:						
Eye	○	◉	# Harvested	0		
			# Transplanted	0	# Transplanted	0
Bone	○	◉	# Harvested	0		
			# Transplanted	0	# Transplanted	0
Bone Marrow	○	◉	# Harvested	0		
			# Transplanted	0	# Transplanted	0
Connective	○	◉	# Harvested	0		
			# Transplanted	0	# Transplanted	0
Cardiovascular	○	◉	# Harvested	0		
			# Transplanted	0	# Transplanted	0
Stem Cell	○	◉	# Harvested	0		
			# Transplanted	0	# Transplanted	0
Other _____	○	◉	# Harvested	0		
			# Transplanted	0	# Transplanted	0

SBH-KINGSPORT 002509

SCHEDULE D - SERVICES (continued) State ID 90411

Utilization of Selected Services	Is This Service Provided In Your Hospital? YES	NO	To Inpatients Unit of Measure	Number	To Outpatients Unit of Measure	Number
K. Other:						
Hyperbaric Oxygen Therapy	○	◉	Patients	0		
Gamma Knife	○	◉	Patients	0	Patients	0
Cyberknife	○	◉	Patients	0	Patients	0
L. Intensive/Intermediate:						
Burn Care Unit	○	◉	Patients	0	Patients	0
# beds 0			Patient Days	0		
Cardiac Care Unit	○	◉	Patients	0		
# beds 0			Patient Days	0		
Medical Intensive Care Unit	○	◉	Patients	0		
# beds 0			Patient Days	0		
Mixed Intensive Care Unit	○	◉	Patients	0		
# beds 0			Patient Days	0		
Neonatal Intensive Care Unit	○	◉	Patients	0		
# beds 0			Patient Days	0		
Neonatal Intermediate Care Unit	○	◉	Patients	0		
# beds 0			Patient Days	0		
Pediatric Care Unit	○	◉	Patients	0		
# beds 0			Patient Days	0		
Stepdown ICU	○	◉	Patients	0		
# beds 0			Patient Days	0		
Stepdown CCU	○	◉	Patients	0		
# beds 0			Patient Days	0		
Surgical Intensive Care Unit	○	◉	Patients	0		
# beds 0			Patient Days	0		

SBH-KINGSPORT 002510

SCHEDULE D - SERVICES (continued)

State ID 90411

Utilization of Selected Services	Is This Service Provided In Your Hospital? YES	NO	To Inpatients Unit of Measure	Number	To Outpatients Unit of Measure	Number
L. Intensive/Intermediate (continued):						
Other, specify _____ Number of beds 0	○	◉	Patients Patient Days	0 0		
Other, specify _____ Number of beds 0	○	◉	Patients Patient Days	0 0		
M. Psychiatric Partial Hospitalization	○	◉	Patients	0		
N. Psychiatric Intensive Outpatient Care	◉	○			Patients	294
O. Electroconvulsive Treatment	○	◉	Patients Treatments	0 0	Patients Treatments	0 0
P. Other Convulsive Treatment	○	◉	Patients Treatments	0 0	Patients Treatments	0 0
Q. Negative Pressure Ventilated Room If yes, number of beds 0	○	◉				

R. 23 Hour Observation ○ YES ◉ NO Outpatients 0

S. Cancer Patients:

1. How many patients were diagnosed with cancer at your facility during this reporting period? 0
2. How many patients were both diagnosed and provided the first course of treatment for cancer at your facility during this reporting period? 0
3. How many patients were diagnosed elsewhere but provided the first course of treatment at your facility during this reporting period? 0

SBH-KINGSPORT 002511

SCHEDULE E - FINANCIAL DATA

State ID 90411

Dates covered from 07/01/2010 to 06/30/2011 Use zeros where applicable. Do not leave blank lines in this schedule.

A. CHARGES (For reporting period only. Do not include revenue related losses; round to the nearest dollar.)

	Gross Patient Charges	minus	Adjustments To Charges	equals	Net Patient Revenue
1. Government					
a) Medicare Inpatient - Total (include managed care)	$14,272,493	-	$10,149,186	=	$4,123,307
1) Medicare Managed Care - Inpatient	$2,875,280	-	$1,823,481	=	$1,051,799
b) Medicare Outpatient - Total (include managed care)	$45,371	-	$20,254	=	$25,117
1) Medicare Managed Care - Outpatient	$21,441	-	$5,356	=	$16,085
c) Medicaid/TennCare Inpatient* (for EAH use 7.b.2.)	$1,339,954	-	$969,064	=	$370,890
d) Medicaid/TennCare Outpatient* (for EAH use 7.b.2.)	$1,434	-	$632	=	$802
e) Other	$3,647,318	-	$2,252,630	=	$1,394,688
f) Total Government Sources	$19,306,570	-	$13,391,766	=	$5,914,804
2. Cover Tennessee * see instructions					
a) Cover TN	$23,457	-	$14,217	=	$9,240
b) Cover Kids	$195,468	-	$119,263	=	$76,205
c) Access Tennessee	$56,757	-	$37,556	=	$19,201
d) Total Cover Tennessee	$275,682	-	$171,036	=	$104,646
3. Nongovernment					
a) Self-Pay	$595,565	-	$592,657	=	$2,908
b) Blue Cross Blue Shield	$572,213	-	$357,813	=	$214,400
c) Commercial Insurers (excludes Workers Comp)	$7,927,525	-	$5,149,286	=	$2,778,239
d) Workers Compensation	$17,615	-	$14,435	=	$3,180
e) Other	$13,081,839	-	$10,718,935	=	$2,362,904
f) Total Nongovernment Sources	$22,194,757	-	$16,833,126	=	$5,361,631
4. Totals					
a) Total Inpatient (excludes Newborn)	$41,536,924				
b) Newborns	$0				
c) Total Inpatient (includes Newborn) (A4a + A4b)	$41,536,924	-	$30,305,211	=	$11,231,713
d) Total Outpatient	$240,085	-	$90,717	=	$149,368
e) Grand Total (A1f + A2d + A3f)	$41,777,009	-	$30,395,928	=	$11,381,081
5. Bad Debt					
a) Medicare Enrollees			$156,541		
b) Other Government			$17,207		
c) Cover Tennessee			$0		
d) Blue Cross and Commercially Insured Patients			$285,743		
e) All Other			$188,285		
f) Total Bad Debt			$647,776		
6. Nongovernment and Cover Tennessee Adjustments to Charges					
a) Nongovernment Contractual			$16,066,145		
b) Cover Tennessee Contractual			$171,036		
c) Charity Care - Inpatient			$85,001		
d) Charity Care - Outpatient			$617		
e) Other Adjustments, specify types _____			$0		
f) Total Nongovernment Adjustments			$16,322,799		

Amount of discounts provided to uninsured patients $285,311

$85,618 Total Charity (A6c + A6d)

$733,394 Total Charity plus Bad Debt (A5f + A6c + A6d)

SBH-KINGSPORT 002512

A. CHARGES (continued)

7. Other Operating Revenue

a) Tax appropriations	$0
b) State and Local government contributions:	
1) Amount designated to offset indigent care	$0
2) Essential Access Hospital (EAH) payments	$2,992,319
3) Critical Access Hospital (CAH) payments	$0
4) Amount used for other	$0
5) Total	$2,992,319
c) Other contributions:	
1) Amount designated to offset indigent care	$0
2) Amount used for other	$0
3) Total	$0
d) Other (include cafeteria, gift shop, etc.)	$58,232
e) Total other operating revenue (A7a + A7b5 + A7c3 + A7d)	$3,050,551

8. Nonoperating Revenue (No negative numbers! Losses or expenses should be reported in B2g.)

a) Contributions	$100
b) Grants	$0
c) Interest income	$0
d) Other	$0
e) Total nonoperating revenue (add A8a through A8d)	$100
f) TOTAL REVENUE (Net A4e + A7e + A8e)	$14,431,732

B. EXPENSES (for the reporting period only; round to the nearest dollar)

1. Payroll Expenses for all categories of personnel specified below; (see definitions page)

a) Physicians and dentists (include only salaries)	$0
b) Medical and dental residents (include medical and dental interns)	$0
c) Trainees (medical technology, x-ray therapy, administrative, and so forth)	$0
d) Registered and licensed practical nurses	$2,793,260
e) All other personnel	$4,913,083
f) Total payroll expenses (add B1a through B1e)	$7,706,343

2. Nonpayroll Expenses

a) Employee benefits (social security, group insurance, retirement benefits)	$1,405,132
b) Professional fees (medical, dental, legal, auditing, consultant and so forth)	$2,052,171
c) Contracted nursing services (include staff from nursing registries, service contracts, and temporary help agencies)	$0
d) Depreciation expense	$653,646
e) Interest expense	$706,862
f) Energy expense	$118,866
g) All other expenses (supplies, purchased services, nonoperating expenses, and so forth)	$1,817,392
h) Total nonpayroll expenses (add B2a through B2g)	$6,754,069
i) TOTAL EXPENSES (add B1f + B2h)	$14,460,412

3. Are system overhead/management fees included in your expenses? (●) YES ( ) NO

If yes, specify amount $1,494,793

SBH-KINGSPORT 002513

C. CURRENT ASSETS

1. Current Assets is defined as the value of cash, accounts receivable, inventories, marketable securities and other assets that could be converted to cash in less than 1 year.
   What were your current assets on the last day of your reporting period (specified in Schedule A7 on page 2)? $4,332,014
   Net receivables are defined as the collectibles as of the last day of your reporting period, whether or not they are currently due.
2. What were your net receivables on the last day of your reporting period? $2,040,572

D. FIXED ASSETS recorded on the balance sheet at the end of the reporting period (include actual or estimated value of plant/equipment that is leased).

1. Gross plant and equipment assets (including land, building, and equipment)	$8,838,346
2. LESS: Deduction for accumulated depreciation	$2,975,344
3. NET FIXED plant and equipment assets (D.1. Less D.2.; if zero please explain on separate sheet)	$5,863,002

E. OTHER ASSETS recorded on the balance sheet at the end of the reporting period (include assets not included above as current or fixed assets).
What were your other assets on the last day of your reporting period (specified in Schedule A7 on page 2)? $0

F. TOTAL ASSETS
Total Assets is the sum of current assets, fixed assets and other assets (C.1.+D.3.+E.).
What were your total assets on the last day of your reporting period (specified in Schedule A7 on page 2)? $10,195,016

G. CURRENT LIABILITIES
Current liabilities is defined as the amount owed for salaries, interest, accounts payable, and other debts due within one (1) year. What were your current liabilities on the last day of your reporting period? $1,838,753

H. LONG TERM LIABILITIES

1. Long Term Liabilities is defined as the amount owed for leases, bond repayment and other items due after one (1) year. What were your long term liabilities on the last day of your reporting period? $221,115
2. Long Term Debt is defined as the value of obligations of over 1 year that require interest to be paid. What was your long term debt on the last day of your reporting period? $0

I. OTHER LIABILITIES
Other liabilities includes those liabilities not reported as current (item G.) or long term (item H.1.).
What were your total liabilities on the last day of your reporting period (specified in Schedule A7 on page 2)? $2,059,868

J. CAPITAL ACCOUNT
Capital Account includes Fund Balance or Stockholder's Equity and all general, specific purpose, restricted or unrestricted funds. The Capital Account is the excess of assets over its liabilities.
What was your capital account on the last day of your reporting period? $8,135,148
Note: Total Assets should equal Liabilities plus Capital Account (i.e. item F.=G.+H.1.+I.+J.).

K. 1. Federal Income Tax: $0

2. Local Property Taxes Paid During the Reporting Period:
   a) Taxes on the Inpatient Facility $8
   b) Taxes on all Other Property $48

3. Other Local, State, or Federal Taxes: (exclude sales tax) $0

L. Does your hospital bill include charges incurred for the following professional services?
Radiology - ○ YES ◉ NO Pathology - ○ YES ◉ NO Anesthesiology - ○ YES ◉ NO Other - Specify _____

SBH-KINGSPORT 002514

M. TennCare Utilization and Revenue:

1. Inpatient Utilization and Revenue for TennCare Managed Care Organizations:

MCO	NUMBER OF ADMISSIONS	NUMBER OF PATIENT DAYS	GROSS REVENUE	NET REVENUE
AmeriChoice	0	0	$0	$0
AmeriGroup	0	0	$0	$0
Blue Care	13	74	$166,100	$30,031
PHP	0	0	$0	$0
TennCare Select	4	17	$34,866	$3,200
TLC Family Care	0	0	$0	$0
UAHC (Omnicare)	0	0	$0	$0
Unison Health Plan	0	0	$0	$0
TennCare, MCO	0	0	$0	$0
Total MCO	23	115	$258,270	$44,920
BHO				
TBH	21	136	$266,001	$54,800
Premier	344	2,003	$4,092,670	$1,275,652
Total BHO	365	2,139	$4,378,671	$1,330,452

2. Outpatient Utilization and Revenue for TennCare Managed Care Organizations:

MCO	NUMBER OF PATIENTS	NUMBER OF VISITS	GROSS REVENUE	NET REVENUE
AmeriChoice	0	0	$0	$0
AmeriGroup	0	0	$0	$0
Blue Care	0	0	$0	$0
PHP	0	0	$0	$0
TennCare Select	0	0	$0	$0
TLC Family Care	0	0	$0	$0
UAHC (Omnicare)	0	0	$0	$0
Unison Health Plan	0	0	$0	$0
TennCare, MCO	0	0	$0	$0
Total MCO	0	0	$0	$0
BHO				
TBH	0	0	$0	$0
Premier	0	0	$0	$0
Total BHO	0	0	$0	$0

SBH-KINGSPORT 002515

SCHEDULE F - BEDS AND BASSINETS State ID 90411

1. PLEASE GIVE THE NUMBER OF:

A. TOTAL LICENSED ADULT AND PEDIATRIC BEDS AS OF THE LAST DAY OF THE REPORTING PERIOD (exclude beds in a sub-acute unit that are licensed as nursing home beds) 84

B. The number of adult and pediatric staffed beds set up, staffed and in use as of the last day of the reporting period. 84

C. NEWBORN NURSERY BASSINETS AS OF THE LAST DAY OF THE REPORTING PERIO 0

D. Licensed Beds that were not staffed at any time during the reporting period. 0

2. STAFFED ADULT, PEDIATRIC, AND NEONATAL BEDS (exclude newborn nursery, include neonatal care units):

Was there a temporary or a permanent change in the total number of beds set up and staffed during the period? ○ YES ◉ NO

If yes, give beds added or withdrawn (show increase by + and decrease by -) and date of change.

Bed change (+ or -) 0 Bed change (+ or -) 0 Bed change (+ or -) 0 Bed change (+ or -) 0

Date: _____ Date: _____ Date: _____ Date: _____

3 SWING BEDS:

A. Does your facility utilize swing beds? ○ YES ◉ NO If yes, number of Acute Care beds designated as Swing Beds. 0

B. PLEASE SPECIFY THE FOLLOWING FOR BEDS WHEN USED FOR LONG TERM SKILLED OR INTERMEDIATE CARE:

(How many admissions and how many days did you provide in the following categories?)

INTERMEDIATE CARE	ADMISSIONS	PATIENT DAYS
Private Pay	0	0
Other	0	0
Total	0	0

SKILLED CARE	ADMISSIONS	PATIENT DAYS
Commercial	0	0
Blue Cross	0	0
Medicare	0	0
Private Pay	0	0
Other	0	0
Total	0	0

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4. A. Number of Beds Set Up and Staffed on a typical day

SERVICE	BEDS
Medical	0
Surgical	0
Medical/Surgical	0
Obstetrics	0
Gynecological	0
OB/GYN	0
Pediatric	0
Eye	0
Neonatal Intensive Care	0
Neonatal Intermediate Care	0
Intensive Care (excluding Neonatal)	0
Orthopedic	0
Urology	0
Rehabilitation	0
Chronic/Extended Care	0
Pulmonary	0
Psychiatric	84
Psychiatric specifically for Children and Youth under age 18	0
Psychiatric specifically for Geriatric Patients	0
Chemical Dependency	0
Chemical Dependency specifically for Children and Youth under age 18	0
Chemical Dependency specifically for Geriatric Patients	0
Swing Beds (for long term skilled or intermediate care)	0
Other, specify	0
Unassigned	0
TOTAL	84

B. Number of Patients in hospital on a typical day. Exclude normal newborns (See Instructions), long term skilled or intermediate patients. 54

5. OBSERVATION BEDS

A. Do you use inpatient staffed beds for 23-hour observation? ○ YES ◉ NO If yes, number of beds 0

B. Do you have beds assigned to dedicated 23-hour observation unit? ○ YES ◉ NO If yes, number of beds 0

C. Do you have beds in a "same-day-surgery" unit that are used for both same-day surgery and 23-hour observation? ○ YES ◉ NO
If yes, number of beds 0

SBH-KINGSPORT 002517

SCHEDULE G - UTILIZATION

State ID 90411

1. INPATIENT UTILIZATION (include normal newborns)

Patient Census Records:

Please indicate whether you are reporting Admissions and Inpatient Days ○

or Discharges and Discharge Patient Days ◉

2. UTILIZATION BY MAJOR DIAGNOSTIC CATEGORIES:

MAJOR DIAGNOSTIC CATEGORIES	ADMISSIONS OR DISCHARGES	INPATIENT DAYS OR DISCHARGE PATIENT DAYS
01 Nervous System	11	59
02 Eye	0	0
03 Ear, Nose, Mouth and Throat	0	0
04 Respiratory System	0	0
05 Circulatory System	3	20
06 Digestive System	2	6
07 Hepatobiliary System & Pancreas	0	0
08 Musculoskeletal Sys. & Connective Tissue	0	0
09 Skin, Subcutaneous Tissue & Breast	0	0
10 Endocrine, Nutritional & Metabolic	2	11
11 Kidney & Urinary Tract	0	0
12 Male Reproductive System	0	0
13 Female Reproductive System	0	0
14 Pregnancy, Childbirth & the Puerperium	1	4
15 Normal Newborns & Other Neonates with Conditions Originating in the Perinatal Period	0	0
16 Blood and Blood Forming Organs and Immunological Disorders	0	0
17 Myeloproliferative Disorders & Poorly Differentiated Neoplasms	0	0
18 Infectious & Parasitic Diseases	0	0
19 Mental Diseases & Disorders	2,833	17,219
20 Alchohol/Drug Use & Alcohol/Drug-Induced Organic Mental Disorders	557	2,503
21 Injuries, Poisoning, & Toxic Effects of Drugs	0	0
22 Burns	0	0
23 Factors Influencing Health Status and Other Contacts with Health Services	3	5
24 Multiple Significant Trauma	0	0
25 Human Immunodeficiency Virus Infections	0	0
26 Other DRGs Associated with All MDCs	0	0
TOTAL	3,412	19,827

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3. UTILIZATION BY REVENUE SOURCE (excluding normal newborns -- see Instructions)

Patients should be categorized according to primary payer and counted only once.

Please indicate whether you are reporting Admissions and Inpatient Days ○ or Discharges and Discharge Patient Days ◉

	ADMISSIONS OR DISCHARGES	INPATIENT DAYS OR DISCHARGE PATIENT DAYS	OUTPATIENT VISITS*
a) Self Pay	54	286	77
b) Blue Cross/Blue Shield	54	315	220
c) Champus/TRICARE	23	113	0
d) Commercial Insurance (excludes Workers Comp)	616	3,407	1,279
e) Cover TN	2	8	0
f) Cover Kids	10	74	0
g) Access TN	3	12	0
h) Medicaid/Tenncare	482	2,768	30
i) Medicare - Total	978	6,498	431
Medicare Managed Care	933	6,190	217
j) Workers Compensation	1	6	0
k) Other	1,189	6,340	179
l) Total	3,412	19,827	2,216

* Should include emergency department visits and hospital outpatient visits

4. NUMBER OF PATIENTS BY AGE GROUP (excluding normal newborns -- see Instructions)

Please indicate whether you are reporting Admissions and Inpatient Days ○ or Discharges and Discharge Patient Days ◉

Age	ADMISSIONS OR DISCHARGES	INPATIENT DAYS OR DISCHARGE PATIENT DAYS	OUTPATIENT VISITS*
Under 15 years	122	924	26
15-17 years	179	1,255	7
18-64 years	2,914	16,045	2,053
65-74 years	132	1,038	117
75-84 years	55	481	13
85 years & older	10	84	0
GRAND TOTAL	3,412	19,827	2,216

* Should include emergency department visits and hospital outpatient visits

SBH-KINGSPORT 002519

5. PATIENT ORIGIN (excluding normal newborns -- see Instructions)
indicate usual residence of patients and number of patient days. Please indicate whether you are reporting

Admissions and Inpatient Days ○ or Discharges and Discharge Patient Days ◉

** List only those counties in other states that represent at least 1 percent of the total admissions or discharges to your hospital. If you have fewer than 500 total discharges or admissions annually, list only those counties that represent at least 2 percent of your total admissions or discharges.

County #	Tennessee County of Residence	Number of Admissions or Discharges	Number of Inpatient Days or Discharge Patient Days
01	Anderson	5	26
02	Bedford	0	0
03	Benton	0	0
04	Bledsoe	0	0
05	Blount	12	83
06	Bradley	0	0
07	Campbell	1	4
08	Cannon	0	0
09	Carroll	0	0
10	Carter	291	1,790
11	Cheatham	0	0
12	Chester	0	0
13	Claiborne	9	72
14	Clay	0	0
15	Cocke	9	41
16	Coffee	0	0
17	Crockett	0	0
18	Cumberland	0	0
19	Davidson	2	9
20	Decatur	0	0
21	DeKalb	0	0
22	Dickson	0	0
23	Dyer	0	0
24	Fayette	0	0
25	Fentress	0	0
26	Franklin	1	6
27	Gibson	0	0
28	Giles	0	0

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5. PATIENT ORIGIN (continued)

County #	Tennessee County of Residence	Number of Admissions or Discharges	Number of Inpatient Days or Discharge Patient Days
29	Grainger	12	62
30	Greene	285	1,765
31	Grundy	0	0
32	Hamblen	25	160
33	Hamilton	2	12
34	Hancock	18	79
35	Hardeman	0	0
36	Hardin	0	0
37	Hawkins	270	1,546
38	Haywood	0	0
39	Henderson	0	0
40	Henry	0	0
41	Hickman	0	0
42	Houston	0	0
43	Humphreys	0	0
44	Jackson	0	0
45	Jefferson	9	52
46	Johnson	96	541
47	Knox	16	89
48	Lake	0	0
49	Lauderdale	0	0
50	Lawrence	0	0
51	Lewis	0	0
52	Lincoln	0	0
53	Loudon	1	2
54	McMinn	1	3
55	McNairy	0	0
56	Macon	2	24
57	Madison	0	0
58	Marion	0	0
59	Marshall	0	0
60	Maury	0	0
61	Meigs	0	0
62	Monroe	2	10

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5. PATIENT ORIGIN (continued)

County #	Tennessee County of Residence	Number of Admissions or Discharges	Number of Inpatient Days or Discharge Patient Days
63	Montgomery	0	0
64	Moore	0	0
65	Morgan	0	0
66	Obion	0	0
67	Overton	0	0
68	Perry	0	0
69	Pickett	0	0
70	Polk	0	0
71	Putnam	0	0
72	Rhea	0	0
73	Roane	2	19
74	Robertson	0	0
75	Rutherford	0	0
76	Scott	0	0
77	Sequatchie	0	0
78	Sevier	6	26
79	Shelby	1	1
80	Smith	0	0
81	Stewart	0	0
82	Sullivan	901	5,119
83	Sumner	1	7
84	Tipton	0	0
85	Trousdale	0	0
86	Unicoi	99	627
87	Union	0	0
88	Van Buren	0	0
89	Warren	0	0
90	Washington	1,027	5,910
91	Wayne	0	0
92	Weakley	0	0
93	White	0	0
94	Williamson	0	0
95	Wilson	0	0
96	TN County Unknown	0	0
	Tennessee Total	3,106	18,085

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5. PATIENT ORIGIN (continued)

State & County Residence	Number of Admissions or Discharges	Number of Inpatient Days or Discharge Patient Days
ALABAMA COUNTIES: (Specify)		
1) Mobile	1	6
2) Walker	1	4
Other Alabama Counties	0	0
Alabama Total	2	10
GEORGIA COUNTIES: (Specify)		
1) Crawford	1	5
2) Fulton	1	4
Other Georgia Counties	0	0
Georgia Total	2	9
MISSISSIPPI COUNTIES: (Specify)		
1)	0	0
2)	0	0
Other Mississippi Counties	0	0
Mississippi Total	0	0
ARKANSAS COUNTIES: (Specify)		
1)	0	0
2)	0	0
Other Arkansas Counties	0	0
Arkansas Total	0	0
MISSOURI COUNTIES: (Specify)		
1)	0	0
2)	0	0
Other Missouri Counties	0	0
Missouri Total	0	0

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5. PATIENT ORIGIN (continued)

State & County Residence	Number of Admissions or Discharges	Number of Inpatient Days or Discharge Patient Days
KENTUCKY COUNTIES: (Specify)		
1) Bell	2	8
2) Knox	2	9
Other Kentucky Counties	6	30
Kentucky Total	10	47
VIRGINIA COUNTIES: (Specify)		
1) Bristol	40	205
2) Scott	57	277
Other Virginia Counties	155	948
Virginia Total	252	1,430
NORTH CAROLINA COUNTIES: (Specify)		
1) Ashe	3	37
2) Watauga	3	22
Other North Carolina Counties	15	75
North Carolina Total	21	134
OTHER STATES: (Specify)		
1) Florida	5	36
2) Texas	3	23
All Other States and Countries	11	53
RESIDENCE UNKNOWN:	0	0
GRAND TOTAL	3,412	19,827

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6. Delivery Status:

A. Number of Infants Born Alive 0

B. Number of Deaths of Infants Born Alive 0

C. Number of Fetal Deaths (500 grams or more or in the absence of weight, 22 weeks or more gestation) 0

SBH-KINGSPORT 002525

SCHEDULE H - PSYCHIATRIC AND CHEMICAL DEPENDENCY UNITS

State ID 90411

1. TYPE OF UNIT - PSYCHIATRIC:
   A. Do you have a dedicated psychiatric unit? (●) YES ( ) NO If yes, please complete items on this page and on the next page.
   B. Do you have a designated Gero-Psychiatric Unit? (●) YES ( ) NO

2. BEDS
   A. Number of assigned beds 84
   B. Date unit opened 06/01/1985

3. UTILIZATION BY AGE GROUPS:
   Please indicate if you are reporting Admissions and Inpatient Days (●) or Discharges and Discharge Patient Days. ( )

	Inpatient			Partial Care or Day Hospital	Outpatient
AGE GROUPS	Number of Patients on September 30	Number of Admissions or Discharges	Number of Inpatient or Discharge Patient Days	Number of Sessions	Number of Visits
Children and/or Adolescents Ages 0 - 17	0	319	1,844	0	0
Adults Ages 18 - 64	0	2,929	16,931	2,078	0
Elderly Ages 65 and older	0	182	1,052	138	0
Total	0	3,430	19,827	2,216	0

4. Is the psychiatric service managed under a management contract different from the hospital itself? ( ) YES (●) NO
   If yes, please specify name of organization that manages the unit. _____

5. Do you have contracts with Behavioral Health Organizations? (●) YES ( ) NO

6. Does your hospital use:

			If Yes, Number of Patients Secluded or Restrained		Number of Times Seclusion or Restraint was Initiated	
			Age 0-17	Age 18+	Age 0-17	Age 18+
A. Seclusion	(●) YES	( ) NO	0	0	0	0
B. Mechanical Restraints	(●) YES	( ) NO	3	19	3	32
C. Physical Holding Restraints	( ) YES	(●) NO	0	0	0	0
D. Chemical Restraints	( ) YES	(●) NO	0	0	0	0

SBH-KINGSPORT 002526

7. FINANCIAL DATA - PSYCHIATRIC

	INPATIENT CHARGES	plus	OUTPATIENT CHARGES	equals	TOTAL CHARGES	minus	ADJUSTMENTS TO CHARGES	equals	NET PATIENT REVENUE
A. GROSS PATIENT REVENUE & NET PATIENT REVENUE BY PAYER:									
1. Self Pay	$617,843	+	$8,100	=	$625,943	-	$468,081	=	$157,862
2. Blue Cross/Blue Shield	$642,577	+	$23,611	=	$666,188	-	$415,175	=	$251,013
3. Champus/TRICARE	$0	+	$0	=	$0	-	$0	=	$0
4. Commercial Insurance (excludes Workers Comp)	$7,190,746	+	$140,260	=	$7,331,006	-	$4,366,398	=	$2,964,608
5. Cover TN	$0	+	$0	=	$0	-	$0	=	$0
6. Cover Kids	$0	+	$0	=	$0	-	$0	=	$0
7. Access TN	$0	+	$0	=	$0	-	$0	=	$0
8. Medicaid/Tenncare	$10,939,408	+	$17,986	=	$10,957,394	-	$7,441,000	=	$3,516,394
9. Medicare - Total	$14,350,343	+	$45,731	=	$14,396,074	-	$9,250,679	=	$5,145,395
Medicare Managed Care	$2,873,135	+	$21,611	=	$2,894,746	-	$1,815,097	=	$1,079,649
10. Workers Compensation	$0	+	$0	=	$0	-	$0	=	$0
11. Other	$7,796,008	+	$4,398	=	$7,800,406	-	$5,462,275	=	$2,338,131

B. NON-GOVERNMENT ADJUSTMENTS TO REVENUE	
1. Bad Debt	$29,151
2. Charity Care	$704,243
3. Contractual Adjustments	$26,699,366
4. Total	$27,432,760
5. Amount of discounts provided to uninsured patients	$285,311

8. A. SERVICE CHARGES	INPATIENT CHARGES	OUTPATIENT CHARGES
1. Routine Treatment	$0	$0
2. Ancillary Services	$8,354,354	$5,427
3. Other	$0	$0
4. Total	$8,354,354	$5,427

B. Do these charges include physicians' fees? ○ YES ◉ NO

SBH-KINGSPORT 002527

SCHEDULE H - PSYCHIATRIC AND CHEMICAL DEPENDENCY UNITS (continued) State ID 90411

1. TYPE OF UNIT - CHEMICAL DEPENDENCY:
   Do you have a dedicated chemical dependency unit? ◯ YES ◉ NO If yes, please complete items on this page and on the next page.

2. BEDS
   A. Number of assigned beds 0
   B. Date unit opened

3. UTILIZATION BY AGE GROUPS:
   Please indicate if you are reporting Admissions and Inpatient Days ◯ or Discharges and Discharge Patient Days. ◯

	Inpatient			Partial Care or Day Hospital	Outpatient	Residential Care
AGE GROUPS	Number of Patients on September 30	Number of Admissions or Discharges	Number of Inpatient or Discharge Patient Days	Number of Sessions	Number of Visits	Number of Visits
Children and/or Adolescents Ages 0 - 17	0	0	0	0	0	0
Adults Ages 18 - 64	0	0	0	0	0	0
Elderly Ages 65 and older	0	0	0	0	0	0
Total	0	0	0	0	0	0

4. Is the chemical dependency service managed under a management contract different from the hospital itself? ◯ YES ◉ NO
   If yes, please specify name of organization that manages the unit.

5. Do you have contracts with Behavioral Health Organizations? ◯ YES ◉ NO

SBH-KINGSPORT 002528

6. FINANCIAL DATA - CHEMICAL DEPENDENCY

	INPATIENT CHARGES	plus	OUTPATIENT CHARGES	equals	TOTAL CHARGES	minus	ADJUSTMENTS TO CHARGES	equals	NET PATIENT REVENUE
A. GROSS PATIENT REVENUE & NET PATIENT REVENUE BY PAYER:									
1. Self Pay	$0	+	$0	=	$0	-	$0	=	$0
2. Blue Cross/Blue Shield	$0	+	$0	=	$0	-	$0	=	$0
3. Champus/TRICARE	$0	+	$0	=	$0	-	$0	=	$0
4. Commercial Insurance (excludes Workers Comp)	$0	+	$0	=	$0	-	$0	=	$0
5. Cover TN	$0	+	$0	=	$0	-	$0	=	$0
6. Cover Kids	$0	+	$0	=	$0	-	$0	=	$0
7. Access TN	$0	+	$0	=	$0	-	$0	=	$0
8. Medicaid/Tenncare	$0	+	$0	=	$0	-	$0	=	$0
9. Medicare - Total	$0	+	$0	=	$0	-	$0	=	$0
Medicare Managed Care	$0	+	$0	=	$0	-	$0	=	$0
10. Workers Compensation	$0	+	$0	=	$0	-	$0	=	$0
11. Other	$0	+	$0	=	$0	-	$0	=	$0

B. NON-GOVERNMENT ADJUSTMENTS TO REVENUE	
1. Bad Debt	$0
2. Charity Care	$0
3. Contractual Adjustments	$0
4. Total	$0
5. Amount of discounts provided to uninsured patients	$0

7. A. SERVICE CHARGES	INPATIENT CHARGES	OUTPATIENT CHARGES
1. Routine Treatment	$0	$0
2. Ancillary Services	$0	$0
3. Other	$0	$0
4. Total	$0	$0

B. Do these charges include physicians' fees? ◯ YES ◯ NO

SBH-KINGSPORT 002529

SCHEDULE I - EMERGENCY DEPARTMENT

State ID 90411

1. What is the direct telephone number into your Emergency Department? _____

2. Is the Emergency Department managed under a management contract different from the hospital itself? ○ YES ◉ NO
   If yes, with whom is the contract held? _____

3. Emergency Department:

   Number of visits by payer:

A. Self Pay	0	H. Medicaid/Tenncare		L. Grand Total	0
B. Blue Cross/Blue Shield	0	AmeriChoice	0		
C. Champus/TRICARE	0	AmeriGroup	0		
D. Commercial Insurance (excludes Workers Comp)	0	Blue Care	0		
		PHP	0		
		TennCare Select	0		
		TLC Family Care	0		
E. Cover TN	0	UAHC (Omnicare)	0		
F. Cover Kids	0	Unison Health Plan	0		
G. Access TN	0	TennCare, MCO Unspecified	0		
		TBH	0		
		Premier	0		
		TennCare Total	0		
		I. Medicare - Total	0		
		Medicare Managed Care	0		
		J. Workers Compensation	0		
		K. Other	0		

4. Is your Emergency Department staffed 24 hours per day? ○ YES ◉ NO If no, please give hours covered. 0

SBH-KINGSPORT 002530

5. Indicate the number of the following personnel available in the hospital on a normal day and how many are available to the Emergency Department.

	ON HOSPITAL CAMPUS	IN EMERGENCY DEPARTMENT
A. PHYSICIANS:		
Board certified in Emergency Medicine	0	0
Board eligible in Emergency Medicine	0	0
Declared Speciality of Emergency Medicine	0	0
Board Certified Psychiatrists	0	0
Other Physicians Available to Emergency Department	0	0
B. NURSES:		
Nurse Practitioners	0	0
R.N.'s with formal emergency training and experience	0	0
Other R.N.'s	0	0
L.P.N.'s and other nursing support personnel	0	0
Clerical Staff	0	0
C. OTHER:		
E.M.T.	0	0
E.M.T. advanced	0	0

SBH-KINGSPORT 002531

6. SUPPORTIVE SERVICES:

	YES	NO
A. COMMUNICATIONS:		
Two-Way radio in ER with Access to:		
Central Emergency Dispatch Center	○	◉
Ambulances	○	◉
Other hospitals	○	◉
B. HELIPORT:	○	◉
C. PHARMACY IN ER:	○	◉
D. BLOOD BANK:		
Fully stocked	○	◉
Common blood types only	○	◉
Blood expanders	○	◉

7. Do you have dedicated centers for the provision of specialized emergency care for the following:

A. Designated Trauma Center ○ YES ◉ NO

B. Burns ○ YES ◉ NO

If yes, do you have a designation by a government agency as a Burn Center? ○ YES ◉ NO

C. Pediatrics ○ YES ◉ NO

D. Other, specify

_____

8. Triage: A. Total number of patients who presented in your ER. 0

B. Total number treated in your ER. 0

C. Total number not treated in your ER but referred to physician or clinic for treatment. 0

SBH-KINGSPORT 002532

SCHEDULE J - PERSONNEL ON PAYROLL AS OF LAST DAY OF REPORTING PERIOD AND USE OF CONTRACT EMPLOYEES

State ID 90411

	Full-Time Equivalent**	Full-Time Equivalent Budgeted Vacancies	Use Contract Staff in this Employee Category***
1. Administration:			
A. Administrators & Assistants	0.5	0.0	☐
B. Director, Health Services Research & Assistants	0.0	0.0	☐
C. Marketing & Planning Officer(s) &Assistants	0.0	0.0	☐
D. Financial and Accounting Officer(s) & Assistants	0.0	0.0	☐
2. Physician and Dental Services:			
A. Physicians	0.0	0.0	☐
B. Medical residents	0.0	0.0	☐
C. Dentists	0.0	0.0	☐
D. Dental residents	0.0	0.0	☐
3. Nursing Services:			
A. RNs - Administrative	0.0	0.0	☐
B. RNs - Patient care/clinical	46.2	0.0	☐
C. LPNs	9.2	0.0	☐
D. Ancillary nursing personnel	20.1	14.3	☐
4. Certified Nurse Midwives	0.0	0.0	☐
5. Nurse Anesthetists	0.0	0.0	☐
6. Physicians assistants	0.0	0.0	☐
7. Nurse practitioners	0.0	0.0	☐
8. Medical record service:			
A. Medical record administrators	0.0	0.0	☐
B. Medical record technicians (certified or accredited)	0.0	0.0	☐
C. Other Medical record technicians	0.0	0.0	☐
9. Pharmacy:			
A. Pharmacists, licensed	0.4	1.8	☐
B. Pharmacy technicians	0.9	0.1	☐
C. Clinical Phar-D	1.0	0.0	☐
10. Clinical laboratory services:			
A. Medical Technologists	0.0	0.0	☐
B. Other laboratory personnel	0.2	0.0	☐
11. Dietary services:			
A. Dietitians	0.0	0.5	☐
B. Dietetic technicians	0.0	0.0	☐

	Full-Time Equivalent**	Full-Time Equivalent Budgeted Vacancies	Use Contract Staff in this Employee Category***
12. Radiological services:			
A. Radiographers (radiologic technologists)	0.0	0.0	☐
B. Radiation therapy technologists	0.0	0.0	☐
C. Nuclear medicine technologists	0.0	0.0	☐
D. Other radiologic personnel	0.0	0.0	☐
13. Therapeutic services:			
A. Occupational therapists	0.0	0.0	☐
B. Occupational therapy assistants & aides	0.0	0.0	☐
C. Physical therapists	0.0	0.0	☐
D. Physical therapy assistants & aides	0.0	0.0	☐
E. Recreational therapists	0.0	0.0	☐
14. Speech and hearing services:			
A. Speech Pathologist	0.0	0.0	☐
B. Audiologist	0.0	0.0	☐
15. Respiratory therapy services:			
A. Respiratory therapists	0.0	0.0	☐
B. Respiratory therapy technicians	0.0	0.0	☐
16. Psychiatric services:			
A. Clinical psychologists	0.0	0.0	☐
B. Psychiatric social workers	0.0	0.0	☐
C. Psychiatric registered nurses	0.0	0.0	☐
D. Other mental health professionals	25.9	0.0	☐
17. Chemical dependency services:			
A. Clinical psychologists	0.0	0.0	☐
B. Social workers	0.0	0.0	☐
C. Registered nurses	0.0	0.0	☐
D. Other specialists in addiction and/or in chemical dependency	0.0	0.0	☐
18. Medical Social workers	0.0	0.0	☐
19. Surgical technicians	0.0	0.0	☐
20. All other certified professional & technical	1.0	0.0	☐
21. All other non-certified professional & technical	0.0	0.0	☐
22. All other personnel	63.5	4.3	☑
TOTAL	168.9	21.0	

** Full-time + Part-time specified in Full Time Equivalent

*** Please check if contract staff is used.

SBH-KINGSPORT 002533

SCHEDULE K - MEDICAL STAFF

State ID 90411

	(1) Number of Active and Associate Medical Staff (Include Board Certified)	(2) Number of Active and Associate Medical Staff Who Are Board Certified	(3) Number of House Staff Who Are Interns, Externs or Residents
1. MEDICAL SPECIALTIES:			
A. General and family practice	31	28	0
B. Pediatric	29	25	0
C. General internal medicine	88	77	0
D. Psychiatric	9	7	2
E. Neonatologist	4	4	0
F. Cardiologists	48	44	0
G. Neurologists	14	8	0
H. Other medical specialties	28	27	0
2. SURGICAL SPECIALTIES:			
A. General surgery	10	10	8
B. Obstetrics and gynecology	21	14	0
C. Perinatologists	0	0	0
D. Gynecology	1	1	0
E. Orthopedic	21	15	0
F. Neurosurgeons	5	3	0
G. Cardiovascular	0	0	0
H. Gastroenterology	20	19	0
I. Other surgical specialties	51	38	0
3. OTHER SPECIALTIES:			
A. Pathology	7	7	0
B. Radiology	21	20	0
C. Anesthesiology	13	13	0
D. Other specialties	189	165	0
4. DENTAL SPECIALTIES:	2	0	0
TOTAL	612	525	10

SBH-KINGSPORT 002534

SCHEDULE L - PERINATAL State ID 90411

1A. Name of person completing Perinatal survey Engie Trivett
1B. Telephone Number (423) 854-5947
1C. Fax Number (423) 854-5958

Please complete the following questions.

2. Births
   A. Total number of births 0
   B. Birth weight below 2500 grams (5lb 8oz) 0
   C. Birth weight below 1500 grams (3 lb 5oz) 0

3. Number of babies on ventilator longer than 24 hours 0

4. Number of babies received from referring hospitals for neonatal management 0

	YES	NO
5. Is Medical Director of Obstetrics board certified/eligible in maternal-fetal medicine?	○	◉
6. Is Medical Director of the Nursery board certified/eligible in neonatal-perinatal?	○	◉

7. Do the following subspecialty consultants spend more than 2/3 full-time effort at your hospital?

	YES	NO
A. OBSTETRICS:		
Perinatal Sonologist	○	◉
Hematologist	○	◉
Cardiologist	○	◉
B. NEONATAL:		
Pediatric Radiologist	○	◉
Pediatric Cardiologist	○	◉
Pediatric Neurologist	○	◉
Pathologist	○	◉
Pediatric Surgeon	○	◉

SBH-KINGSPORT 002535

SCHEDULE M - SURVEY ON NURSING PERSONNEL

State ID 90411

(As of the last day of the reporting period)

1. Registered Nurses

HIGHEST EDUCATION LEVEL	FTE NUMBER CURRENTLY EMPLOYED	NUMBER OF BUDGETED VACANCIES	NUMBER OF POSITIONS YOU PLAN TO ADD IN THE NEXT 12 MONTHS	NUMBER OF POSITIONS YOU PLAN TO ELIMINATE IN THE NEXT 12 MONTHS	PRIMARY ROLE (NUMBER OF POSITIONS)	
					CLINICAL	ADMINISTRATIVE
Total	45.0	0.0	0.0	0.0	49.0	10.0
Bachelors Degree	16.6	0.0	0.0	0.0	21.0	2.0
Associate Degree	27.5	0.0	0.0	0.0	27.0	8.0
Diploma	0.9	0.0	0.0	0.0	1.0	0.0
Masters Degree	0.0	0.0	0.0	0.0	0.0	0.0
Doctorate Degree	0.0	0.0	0.0	0.0	0.0	0.0

2. Advanced Practice Nurses

NURSING PERSONNEL CATEGORY	FTE NUMBER CURRENTLY EMPLOYED	NUMBER OF BUDGETED VACANCIES	NUMBER OF POSITIONS YOU PLAN TO ADD IN THE NEXT 12 MONTHS	NUMBER OF POSITIONS YOU PLAN TO ELIMINATE IN THE NEXT 12 MONTHS	PRIMARY ROLE (NUMBER OF POSITIONS)	
					CLINICAL	ADMINISTRATIVE
Total	0.0	0.0	0.0	0.0	0.0	0.0
Nurse Practitioner	0.0	0.0	0.0	0.0	0.0	0.0
Clinical Nurse Specialist	0.0	0.0	0.0	0.0	0.0	0.0
CRNA	0.0	0.0	0.0	0.0	0.0	0.0
Certified Nurse Midwife	0.0	0.0	0.0	0.0	0.0	0.0

3. Licensed Practical Nurses

LPNs	NUMBER OF POSITIONS YOU PLAN TO ADD IN THE NEXT 12 MONTHS	NUMBER OF POSITIONS YOU PLAN TO ELIMINATE IN THE NEXT 12 MONTHS
Total	0.0	0.0

4. Recruitment of Nursing Personnel

The following are selected specialties for which hospitals commonly report recruiting difficulties.
Please specify other categories as necessary.

NURSING PERSONNEL CATEGORY	FTE NUMBER CURRENTLY EMPLOYED	NUMBER OF BUDGETED VACANCIES	NUMBER OF POSITIONS YOU PLAN TO ADD IN THE NEXT 12 MONTHS	NUMBER OF POSITIONS YOU PLAN TO ELIMINATE IN THE NEXT 12 MONTHS
CCU/ICU	0.0	0.0	0.0	0.0
ER	0.0	0.0	0.0	0.0
Other (Specify):				
	0.0	0.0	0.0	0.0
	0.0	0.0	0.0	0.0

SBH-KINGSPORT 002536

SCHEDULE N - HEALTH CARE PLANS ACCEPTED

State ID 90411

The Health Consumer Right-to-Know Act of 1998 which was signed by Governor Sundquist in May, 1998 requires hospitals to report to the Department of Health "health care plans accepted by the hospital" as well as a variety of information that is included in earlier schedules of the Joint Annual Report. In order to allow the Joint Annual Report to meet the entire reporting requirement described in this act, please list all health insurance plans with which you currently - as of the last day of this reporting period - have a valid contract. List each plan separately not just the name of the company. For example, if you have contracts to provide services to individuals enrolled in Blue Choice and Blue Preferred, list both plans and do not only list Blue Cross & Blue Shield of Tennessee.

Plans:

Woodridge - Beechstreet - PPO
Americhoice UBH - TennCare BHO
Cariten/Humana - HMO
Cariten/Humana - POS
Cariten/Humana - WorXs
Cariten/Humana - Senior Health (Med Adv)
CIGNA BHO - BHO
Dept of Labor - Facility Agreement
Encompass - Baxter Ee's - Direct
Evolutions - PPO Network
First Health - PPO
Formost - PPO
GEHA PPO USA - PPO
Initial Group - PPO - Initial Health Alliance
Initial Group - PPO - Workers' Comp
LifeSynch - PPO - Psych
Magellan - Commercial Facility Agreement
PHCS - PPO
UMWA - Direct
UBH - PPO
USA MCO - PPO Network
ValueOptions - Commercial BHO
ValueOptions - TennCare BHO
Virginia Medicaid - Medicaid

SBH-KINGSPORT 002537

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Woodridge Psychiatric Hospital

Fiscal Years 11-14 Actual and FY12-14 Budget

Key Operating Indicators

	FY11 Actual	FY12 Actual	FY13 Actual	FY14 Actual	FY12 Budget	FY13 Budget	FY14 Budget
Operating Statistics (excl Long-Term Care)							
Average Daily Census	54	58	61	64	54	62	62
Occupancy Percent	64.7%	69.4%	72.3%	76.4%	64.7%	73.7%	74.1%
Patient Days	19,827	21,329	22,182	23,426	19,882	22,592	22,726
Admissions	3,430	3,577	3,825	4,061	3,290	3,814	3,788
Adjusted Patient Days	19,942	21,806	22,738	23,671	20,460	23,109	23,177
Adjusted Admissions	3,450	3,657	3,921	4,124	3,386	3,901	3,863
Outpatient Visits	2,216	4,643	5,378	4,482	2,295	4,715	5,434
ED Visits	550	530	685	740	621	560	663
Revenue By Source							
Medicare	32.2%	22.7%	22.4%	18.8%	32.1%	29.0%	22.4%
Managed Medicare	0.0%	8.9%	10.1%	12.2%	0.0%	0.0%	10.1%
Medicaid	2.5%	2.4%	1.7%	1.6%	2.5%	2.5%	1.7%
TennCare	24.1%	42.3%	46.7%	26.3%	24.1%	24.2%	46.5%
Blue Cross	9.6%	10.2%	9.7%	9.4%	9.6%	10.4%	9.7%
United - River Valley	5.2%	2.3%	2.3%	1.5%	5.2%	5.0%	2.3%
Managed Care / Commercial	5.9%	5.6%	4.9%	4.1%	5.9%	5.1%	4.9%
Charity / Self Pay	1.3%	4.0%	0.7%	23.9%	1.3%	2.8%	0.7%
Other Patient Revenue	19.3%	1.6%	1.6%	2.1%	19.3%	21.0%	1.6%
Total Gross Patient Revenue	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
IP Revenue per Patient Day	$2,095	$2,214	$2,355	$2,480	$2,223	$2,317	$2,493
OP Revenue per Outpatient Visit	$108	$227	$244	$135	$560	$254	$207
Operating Revenue per Adjusted Patient Day	$722	$711	$707	$745	$575	$667	$676
Operating Expense per Adjusted Patient Day	$645	$681	$668	$652	$684	$647	$626
Operating Revenue per Adjusted Admission	$4,175	$4,237	$4,102	$4,275	$3,477	$3,954	$4,054
Operating Expense per Adjusted Admission	$3,726	$4,059	$3,875	$3,743	$4,132	$3,832	$3,757
Net Revenue % of Gross Revenue	34.3%	28.5%	25.2%	25.5%	22.7%	24.0%	22.6%
Net Revenue per Adjusted Admission	$4,158	$3,763	$3,448	$3,628	$3,044	$3,292	$3,385
Labor Management							
Employed Full Time Equivalents	189	212	224	207	198	223	219
Contract Full Time Equivalents	0	1	1	1	0	0	1
Total Full Time Equivalents	189	212	225	208	198	224	220
FTEs per Adjusted Occupied Bed (incl Cont Lbr)	3.44	3.54	3.63	3.20	3.54	3.55	3.49
Man Hours per Adjusted Admission (incl Cont Lbr)	114.0	120.7	119.5	105.0	121.7	119.2	118.3
Average Hourly Rate (excl Cont Lbr)	$17.02	$17.70	$16.88	$16.91	$17.91	$17.26	$16.14
Salary Expense per FTE (excl Cont Lbr)	$35,410	$36,822	$35,116	$35,165	$37,254	$35,900	$33,564
Salary Wages/Benefits per Adjusted Admission	$2,078	$2,388	$2,184	$2,114	$2,341	$2,249	$2,049
Salary Wages/Benefits % of Net Revenue	56.5%	71.0%	72.0%	65.6%	86.6%	76.5%	68.4%
Patient Resource Management							
Overall Average Length of Stay	5.78	5.96	5.80	5.74	6.04	5.92	6.00
Overall Medicare Case Mix Index	0.83	0.87	0.91	0.97	0.83	0.88	0.86
Overall Case Mix Index	0.77	0.80	0.86	0.88	0.77	0.82	0.90
Acute Medicare Case Mix Index	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Acute Overall Case Mix Index	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Supply Expense % of Net Revenue	5.0%	5.8%	7.0%	5.9%	7.3%	6.3%	7.3%
Supply Expense per Adjusted Admission	$209	$218	$240	$213	$221	$209	$248

Woodridge Psychiatric Hospital

Fiscal Years 11-14 Actual and FY12-14 Budget

Statement of Revenue and Expense

	FY11 Actual	FY12 Actual	FY13 Actual	FY14 Actual	FY12 Budget	FY13 Budget	FY14 Budget
Patient Revenue							
Inpatient Revenue	41,536,924	47,218,095	52,246,602	58,085,025	44,199,438	52,351,443	56,653,705
Outpatient Revenue	240,086	1,055,878	1,310,612	606,945	1,285,404	1,198,433	1,123,753
Total Gross Patient Revenue	41,777,010	48,273,972	53,557,214	58,691,970	45,484,841	53,549,876	57,777,458
Deductions from Revenue							
Contractual Adjustments	26,699,366	24,112,512	26,794,689	28,055,703	31,670,165	29,187,655	30,464,673
Charity	85,618	9,250,634	12,497,985	14,494,304	2,327,445	10,139,355	13,375,482
Contra Revenue - Charity	618,625	1,086,498	706,036	723,153	1,137,121	1,338,747	813,042
Provision for Bad Debt	29,151	61,301	38,346	207,275	45,485	41,690	48,570
Uninsured Discount	0	0	0	250,219	0	0	0
Total Deductions	27,432,760	34,510,945	40,037,057	43,730,655	35,180,215	40,707,448	44,701,767
Net Patient Service Revenue	14,344,249	13,763,027	13,520,157	14,961,315	10,304,626	12,842,428	13,076,692
Premium Revenue	0	0	0	0	0	0	0
Other Operating Revenue	58,232	1,731,177	2,563,747	2,667,125	1,469,023	2,582,837	2,585,060
Total Other Operating Revenue	58,232	1,731,177	2,563,747	2,667,125	1,469,023	2,582,837	2,585,060
Total Operating Revenue	14,402,481	15,494,204	16,083,905	17,628,440	11,773,649	15,425,265	15,660,752
Operating Expense							
Salaries	6,694,379	7,789,559	7,861,827	7,288,692	7,370,486	8,015,519	7,355,126
Provider Salaries	0	0	0	25,855	0	0	0
Contract Labor	0	40,609	121,404	94,370	0	0	58,969
Employee Benefits	1,405,132	1,936,800	1,753,402	2,404,059	1,548,973	1,811,202	1,533,484
Fees	2,158,998	2,435,943	2,570,116	2,838,702	2,335,744	2,437,543	2,673,476
Supplies	720,200	797,479	940,293	877,176	748,035	813,523	958,670
Utilities	155,767	150,421	152,010	152,504	166,025	163,063	158,214
Other Expense	358,919	378,144	235,108	338,512	481,984	286,733	344,948
Medical Costs	0	0	0	0	0	0	0
Depreciation	653,646	609,568	857,915	717,072	634,371	719,755	732,926
Amortization	0	0	0	0	0	0	0
Interest & Taxes	706,862	704,423	701,966	699,622	704,423	701,966	699,624
Total Operating Expense	12,853,902	14,842,945	15,194,039	15,436,564	13,990,039	14,949,305	14,515,438
Net Operating Income before Support Allocation	1,548,578	651,260	889,866	2,191,876	(2,216,390)	475,960	1,145,314
Support Allocation - Salaries, Contract Labor & Benefits	938,583	1,015,189	1,071,722	991,536	1,015,185	1,071,722	991,536
Support Allocation - Other	556,210	610,301	948,949	906,001	610,304	948,949	906,001
Net Operating Income after Support Allocation	53,785	(974,231)	(1,130,805)	294,340	(3,841,879)	(1,544,711)	(752,222)
Net Investment Income	0	0	0	0	0	0	0
Realized Gain on Investments	0	0	0	0	0	0	0
Gain / (Loss) from Affiliates	0	0	0	0	0	0	0
Gain / (Loss) on Disposal	0	0	0	0	0	0	0
Loss on Extinguishment of LTD / Derivatives	0	0	0	0	0	0	0
Minority Interest	0	0	0	0	0	0	0
Taxes - Non Operating	0	0	0	0	0	0	0
Incentive Pay	(82,565)	(26,743)	(94,558)	(109,284)	0	0	0
Other Non Operating Income / (Expense)	100	(4,403)	0	(46,793)	0	0	0
Total Non Operating Income / (Expense)	(82,465)	(31,146)	(94,558)	(156,077)	0	0	0
Total Revenue Over Expense Before CFV of Derivatives	(28,680)	(1,005,377)	(1,225,363)	138,262	(3,841,879)	(1,544,711)	(752,222)
Change in Fair Value of Interest Rate Swaps	0	0	0	0	0	0	0
Gain / (Loss) in Swaption / Call Option	0	0	0	0	0	0	0
Total Excess Revenue Over Expense	(28,680)	(1,005,377)	(1,225,363)	138,262	(3,841,879)	(1,544,711)	(752,222)
Net Unrealized Gain / (Loss) on Investments	0	0	0	0	0	0	0
Increase in Unrestricted Net Assets Before Change In Accounting Principle	(28,680)	(1,005,377)	(1,225,363)	138,262	(3,841,879)	(1,544,711)	(752,222)
Cumulative Effect of Change in Accounting Principle	0	0	0	0	0	0	0
Total Increase in Unrestricted Net Assets	(28,680)	(1,005,377)	(1,225,363)	138,262	(3,841,879)	(1,544,711)	(752,222)
EBITDA	1,331,828	308,614	334,517	1,554,957	(2,503,085)	(122,990)	680,328

Document produced in native format

Woodridge Psychiatric Hospital Report

Cert by MCRT	Hospital Encounter Number	Social Security Number	Last Name	First Name	Date of Birth	County of Residence	State of Residence	Date of Admission	Time of Admission	Date of Discharge	Number of Uninsured Adult Patient Days	Gender	Race	Ethnicity	Marital Status	Military Status	Primary Language	Job/ Employment Status	Amount of Income	Living Arrangement at Admission	Number of People in Household	Referral Source	Legal Status at Admission	Primary Admission Diagnosis (Axis I or II)	Secondary Admission Diagnosis (All Other Axis I or II Diagnoses)	Primary Discharge Diagnosis (Axis I or II)	Secondary Discharge Diagnosis (All Other Axis I or II Diagnoses)	Living Arrangement at Discharge	Aftercare Arrangements	Discharge Reason	Per Diem Rate	Total Amount for Stay
MCRT	ENC_REDACTED	SSN	LN	FN	DOB	CO	ST	DA	TA	DD	NU	GE	RA	ETH	MS	MIL	PL	EMP	AI	LAA	NPH	RS	LS	PAD	SAD	PRD	SDD	LAD	AFT	DR	Per Diem	Total
x					1/7/1957	85	1	5/22/14	2:43 AM			2	5	2								1	3									464.00	$464.00
x					3/18/1964	90	1	5/27/15	5:11 PM	6/5/15		2	5	2		1						1	3									464.00	$1,856.00
x					10/25/1989	86	1	5/27/14	8:35 PM	6/2/14	4	1	5	2		1						1	3									464.00	$464.00
x					4/9/1991	10	1	5/27/14	7:48 PM	6/11/14	10	1	5	2		1						1	3									464.00	$4,640.00
x					1/19/1970	96	1	5/28/14	8:22 AM	6/2/14	1	1	5	2		1						1	3									464.00	$464.00
x					9/20/1988	10	1	5/28/14	11:45 PM	6/3/14	2	1	5	2		1						1	3									464.00	$928.00
x					6/11/1983	37	1	5/28/14	12:02 PM	6/3/14	2	2	5	3		1						1	3									464.00	$928.00
x					2/17/1971	96	4	5/28/14	5:30 PM	6/4/14	2	2	5	2		1						1	3									464.00	$928.00
x					9/30/1962	90	1	5/29/14	8:12 PM	6/9/14	8	1	5	2		1						1	3									464.00	$3,712.00
x					8/4/1965	90	1	5/30/14	10:06 AM	6/5/14	4	2	5	2		1						1	3									464.00	$1,856.00
x					3/21/1988	96	1	5/31/14	4:50 PM	6/8/14	2	2	5	2		1						1	3									464.00	$928.00
x					1/11/1975	96	1	5/31/14	7:00 PM	6/6/14	3	1	5	2		1						1	3									464.00	$1,392.00
x					8/30/1990	82	1	5/31/14	6:30 PM	6/4/14	3	1	5	2		1						1	3									464.00	$1,392.00
x					9/21/1980	90	1	5/31/14	11:15 PM	6/3/14	2	1	5	2		1						1	3									464.00	$928.00
x					2/28/1978	90	1	6/1/14	1:55 AM	6/3/14	2	1	5	2		1						1	3									464.00	$928.00
x					10/31/1957	90	1	6/1/14	12:19 AM	6/18/14	17	2	5	2		1						1	3									450.00	$7,650.00
x					5/6/1971	96	4	6/2/14	4:35 AM	6/6/14	4	2	5	2		1						1	3									464.00	$1,856.00
x					7/10/1965	90	1	6/2/14	5:18 AM	6/6/14	3	2	5	2		1						1	3									464.00	$1,392.00
x					3/21/1960	86	1	6/2/14	8:45 PM	6/6/14	4	1	5	2		1						1	3									464.00	$1,856.00
x					7/16/1992	96	4	6/8/14	5:40 AM	6/7/14	4	1	5	2		1						1	3									464.00	$928.00
x					5/31/1980	29	1	6/8/14	2:30 AM	6/7/14	4	1	5	2		1						1	3									464.00	$1,856.00
x					1/30/1980	90	1	6/13/14	8:00 PM	6/17/14	8	1	5	3		1						1	3									464.00	$3,712.00
x					5/15/1995	36	1	6/13/14	4:01 PM	6/7/14	4	1	5	2		1						1	3									464.00	$1,856.00
x					5/17/1995	96	1	6/14/14	3:45 AM	6/9/14	5	2	5	2		1						1	3									464.00	$2,320.00
x					6/19/1979	96	1	6/14/14	8:25 PM	6/16/14	2	2	5	2		1						1	3									464.00	$928.00
x					6/24/1977	96	1	6/14/14	5:56 PM	6/16/14	2	1	5	2		1						1	3									464.00	$928.00
x					7/6/1958	37	1	6/14/14	2:00 AM	6/13/14	7	1	5	2		1						1	3									464.00	$3,248.00
x					11/11/1977	90	1	6/15/14	12:50 AM	6/16/14	1	2	5	2		1						1	3									464.00	$464.00
x					11/27/1982	30	1	6/15/14	12:40 AM	6/18/14	3	1	5	2		1						1	3									464.00	$1,392.00
x					8/8/1957	30	1	6/15/14	12:05 AM	6/19/14	4	2	5	2		1						1	3									464.00	$1,856.00
x					7/18/1960	90	1	6/15/14	7:25 PM	6/21/14	6	1	5	2		1						1	3									464.00	$2,784.00
x					10/24/1984	90	1	6/15/14	6:19 PM	6/18/14	3	1	5	2		1						1	3									464.00	$1,392.00
x					9/3/1985	96	3	6/15/14	11:26 AM	6/18/14	3	1	5	2		1						1	3									464.00	$1,392.00
x					9/15/1980	82	1	6/16/14	3:55 AM	6/17/14	6	1	5	2		1						1	3									464.00	$2,784.00
x					9/7/1961	30	1	6/16/14	3:19 PM	6/17/14	6	2	5	2		1						1	3									464.00	$2,784.00
x					5/18/1962	90	1	6/16/14	3:20PM	6/18/14	2	2	5	2		1						1	3									464.00	$928.00
x					7/10/1965	96	1	6/17/14	12:06AM	6/19/14	2	2	5	2		1						1	3									464.00	$928.00
x					10/12/1980	96	3	6/17/14	4:00AM	6/18/14	1	1	5	2		1						1	3									464.00	$464.00
x					2/22/1960	90	1	6/17/14	6:35PM	6/18/14	6	1	5	2		1						1	3									464.00	$2,784.00
x					5/19/1972	37	1	6/17/14	9:35PM	6/20/14	3	2	5	2		1						1	3									464.00	$1,392.00
x					1/19/1970	10	1	6/18/14	11:54AM	6/21/14	4	1	5	2		1						1	3									464.00	$1,856.00
x					12/19/1982	86	3	6/18/14	10:30PM	6/21/14	8	1	5	2		1						1	3									464.00	$3,712.00
x					11/25/1957	96	1	6/19/14	8:53AM	6/25/14	7	2	5	2		1						1	3									464.00	$3,248.00
x					12/30/1955	82	1	6/19/14	9:00PM	6/25/14	6	2	5	2		1						1	3									464.00	$2,784.00
x					5/19/1988	10	1	6/20/14	12:46Am	6/26/14	6	2	5	2		1						1	3									464.00	$2,784.00
x					9/7/1975	96	1	6/20/14	11:05PM	6/26/14	6	1	5	2		1						1	3									464.00	$2,784.00
x					9/19/1980	96	1	6/21/14	4:04PM	6/25/14	4	1	5	2		1						1	3									464.00	$1,856.00
x					6/17/1971	30	1	6/21/14	4:03PM	6/24/14	3	1	5	2		1						1	3									464.00	$1,392.00
x					7/12/1979	96	1	6/12/14	12:46PM	6/27/14	5	1	5	2		1						1	3									464.00	$2,320.00
x					1/6/1958	82	1	6/22/14	8:35PM	6/28/14	8	1	5	2		1						1	3									464.00	$3,712.00

SBH-KINGSPORT 002542

x	10/2/1987	86	1	6/12/14	9:20PM	6/17/14	5	1	5	2	1	1	1	464.00	$2,320.00
x	1/9/1967	46	1	6/12/14	11:00PM	6/17/14	5	2	5	2	1	1	1	464.00	$2,320.00
x	4/17/1977	90	1	6/13/14	6:50AM	6/18/14	5	1	5	2	1	1	1	464.00	$2,320.00
x	5/5/1985	10	1	6/13/14	4:49 PM	6/20/14	7	1	5	2	1	1	3	464.00	$3,248.00
x	5/13/1975	30	1	6/13/14	5:01 PM	6/17/14	4	2	5	2	1	1	3	464.00	$1,856.00
x	12/2/1959	30	1	6/14/14	6:42 PM	6/18/14	4	2	5	2	1	1	3	464.00	$1,856.00
x	1/2/1976	37	1	6/15/14	3:00 AM	6/21/14	6	1	5	2	1	1	3	464.00	$2,784.00
x	11/18/1989	86	1	6/15/14	1:20 AM	6/17/14	2	1	5	2	1	1	1	464.00	$928.00
x	10/27/1971	90	1	6/16/14	2:52 PM	6/23/14	7	1	5	2	1	1	1	464.00	$3,248.00
x	1/18/1983	30	1	6/17/14	12:12 AM	6/20/14	3	1	5	2	1	1	1	464.00	$1,392.00
x	1/5/2001	82	1	6/17/14	5:55 AM	6/20/14	3	1	5	2	1	1	3	450.00	$1,350.00
x	1/25/1983	90	1	6/17/14	4:50 AM	6/21/14	4	2	5	2	1	1	1	464.00	$1,856.00
x	5/19/1957	30	1	6/17/14	7:44 PM	6/18/14	1	1	5	2	1	1	3	464.00	$464.00
x	9/30/1990	90	1	6/17/14	11:30 PM	6/21/14	4	2	5	2	1	1	3	464.00	$1,856.00
x	5/16/1980	10	1	6/17/14	11:55 PM	6/24/14	7	2	5	2	1	1	3	464.00	$3,248.00
x	5/3/1980	10	1	6/18/14	8:00 AM	6/22/14	4	1	5	2	1	1	1	464.00	$1,856.00
x	8/23/1967	82	1	6/19/14	8:35 PM	6/24/14	5	2	5	2	1	1	3	464.00	$2,320.00
x	10/9/1983	90	1	6/20/14	12:00 AM	6/24/14	4	2	5	2	1	1	3	464.00	$1,856.00
x	4/26/1987	37	1	6/20/14	5:33 PM	6/23/14	3	1	5	2	1	1	3	464.00	$1,392.00
x	11/9/1962	90	1	6/20/14	3:55 AM	6/25/14	5	1	6	2	1	1	3	464.00	$2,320.00
x	9/20/1962	90	1	6/20/14	1:43 PM	6/25/14	5	1	5	2	1	1	1	464.00	$2,320.00
x	7/31/1957	82	1	6/21/14	3:03 PM			1	5	2	1	1	3	464.00	$464.00
x	1/15/1971	82	1	6/21/14	10:40 AM			2	5	2	1	1	3	464.00	$464.00
x	1/2/1971	86	1	6/21/14	6:50 PM			1	5	2	1	1	3	464.00	$464.00
x	1/25/1991	96	4	6/21/14	5:11 PM	6/25/14	4	1	5	2	1	1	3	464.00	$1,856.00
x	6/17/1994	47	1	6/21/14	6:48 PM	6/26/14	5	2	5	2	1	1	3	464.00	$2,320.00
x	3/8/1975	90	1	6/21/14	2:33 PM	6/26/14	5	1	5	2	1	1	3	464.00	$2,320.00
x	1/1/1975	90	1	6/22/14	2:36 PM	6/26/14	4	1	5	2	1	1	3	464.00	$1,856.00
x	8/23/1983	90	1	6/22/14	6:47 PM	6/23/14	1	1	5	2	1	1	1	464.00	$464.00
x	1/25/1983	46	1	6/22/14	2:55 AM	6/26/14	4	2	5	2	1	1	1	464.00	$1,856.00
x	12/19/1982	10	1	6/23/14	3:24 PM			1	5	2	1	1	3	464.00	$464.00
x	10/20/1976	86	1	6/23/14	4:42 PM	6/26/14	3	1	5	2	1	1	1	464.00	$1,392.00
x	12/12/1957	90	1	6/24/14	12:20 AM			2	5	2	1	1	3	464.00	$464.00
x	4/4/1995	82	1	6/24/14	2:36 PM			2	5	2	1	1	3	464.00	$464.00
x	1/19/1987	37	1	6/24/14	1:47 PM			1	5	2	1	1	3	464.00	$464.00
x	4/7/1983	86	1	6/24/14	4:12 PM			2	5	2	1	1	3	464.00	$464.00
x	9/5/1971	90	1	6/24/14	12:18 PM			2	5	2	1	1	1	464.00	$464.00
x	2/27/2002	86	1	6/24/14	11:40 PM			2	5	2	1	1	3	450.00	$450.00
x	8/1/1970	90	1	6/25/14	1:00 AM			1	5	2	1	1	3	464.00	$464.00
x	9/7/1975	90	1	6/25/14	1:40 AM			1	5	2	1	1	3	464.00	$464.00
x	11/23/1992	90	1	6/25/14	3:32 PM			1	5	2	1	1	3	464.00	$464.00
x	3/5/1968	90	1	6/25/14	10:41 PM			1	5	2	1	1	3	464.00	$464.00
x	11/30/1993	96	4	6/26/14	3:50 AM			2	5	2	1	1	3	464.00	$464.00
x	12/29/1969	90	1	6/26/14	10:42 AM			1	5	2	1	1	3	464.00	$464.00
x	4/20/1966	96	4	6/26/14	11:25 PM			2	5	2	1	1	3	464.00	$464.00
x	2/14/1972	90	1	6/27/14	5:15 AM			1	5	2	1	1	1	464.00	$464.00
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Total $ Remaining First of Month:	$210,686.67	Adult Per Diem:	$464.00
Total $ Used This Month:	$163,498.00	Child Per Diem	$450.00
Total $ Remaining End of Month:	$47,188.67	Total Patient Days:	334
		Average LOS:	4.28

North Carolina Department of Health and Human Services
Division of Health Service Regulation
Acute and Home Care Licensure and Certification Section
1205 Umstead Drive, Raleigh, NC 27603 or 2712 Mail Service Center
Raleigh, N.C. 27699-2712
Telephone: (919) 855-4620 Fax: (919) 715-3073

For Official Use Only
License # MHH- 0976
Computer:
PC ____ Date _____

License Fee: $2085.00

2015
MENTAL HEALTH / SUBSTANCE ABUSE HOSPITAL LICENSE RENEWAL APPLICATION

Name of Facility: **SBH-Wilmington, LLC**
(Full legal name of corporation, partnership, individual, or other legal entity owning the enterprise or service.)

Doing Business As:
(d/b/a) name(s) under which the facility or services are advertised or presented to the public:

PRIMARY: **Strategic Behavioral Center-Leland**
Other: _____
Other: _____

PAID
CK NO. 51609 4
DATE 12-5-14
42,085

Facility Mailing Address: 2050 Mercantile Drive
Leland, NC 28451

Facility Site Address: 2050 Mercantile Drive
Leland, NC 28451
County: Brunswick
Telephone: (910) 371-2500 Fax: (910) 371-2508

Administrator/Director: Daniel Kern
Title: CEO
(Designated agent (individual) responsible to the governing body (owner) for the management of the licensed facility)

Chief Executive Officer: Daniel Kern **Title :** CEO
(Designated agent (individual) responsible to the governing body (owner) for the management of the licensed facility)

Signature of Licensee or Person with Signatory Authority: The undersigned submits application for the above named facility in accordance with the provisions of 10 NCAC 27G adopted by the Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services and certifies the accuracy of this information.

Signature: Daniel Kern **Date:** 12/2/14

Name of the person to contact for any questions regarding this form:

Name: Daniel Kern **Telephone:** 910-371-2500

E-Mail: daniel.kern@strategicbh.com

"The N.C. Department of Health and Human Services does not discriminate on the basis of race, color, national origin, religion, age, or disability in employment or the provision of services."

EXHIBIT 318 7/30/15 SBH-Kingsport
PENGAD 800-631-6989

Ownership Disclosure: (Please fill in the blanks and make changes where necessary.)

1. What is the name of the legal entity with ownership responsibility and liability?

Owner: (SBH) Strategic Behavioral Health

Street/Box 8295 TOURNAMENT DR, SUITE 201

City: MEMPHIS State: TN Zip code: 38125

Telephone: (901) 969-3100 Fax: (901) 969-3120

~~CEO~~: President; James T. Shaheen

a. Legal entity is: X For Profit ____Not For Profit

b. Legal entity is X Corporation, LLC ____Partnership
____Proprietorship ____Government Unit

NPI Number: 1639357429

c. Does the above entity (partnership, corporation, etc.) own the building from which services are offered?
X Yes ____No

If 'No', name of building owner:

_____ Phone Number_____

2. Is the business operated under a management contract? ___Yes X No

If 'Yes', name and address of the management company.
Name: _____

_____

Street/Box: _____

City: _____ State: _____ Zip: _____

Telephone: (___) _____

Accreditation: If surveyed within the last twelve (12) months, attach a copy of accreditation report and grid. If applicable, attach copy of plan of correction
Is this facility accredited by The Joint Commission? ✓ Yes ____ No Expiration Date: 11/12/16

Ownership Information

How would you describe the ownership? *

☒ Single-Owner LLC ☐ Sole Proprietor

☐ Federal ☐ State ☐ City/Municipality ☐ Indian Health Services

☐ Corporation ☐ Partnership ☐ Non-Profit

Corporations, Partnerships, Non-Profits, and Sole Proprietors:
Does anyone have direct or indirect ownership or control interest of 5% or more in the organization/entity? * ☒ Yes ☐ No

If you answered yes to the above question you must list ownership information for each owner who owns 5% or more.
You MUST provide the full middle name of each individual listed or attest that the individual does not have a middle name.

Ownership 1

Name (must provide Last, First, and full Middle Name) / Business Name* ☐ I attest that I have given the individual's full legal name. He/she does not have a middle name.
John Hull Dobbs Jr. 1985 Trust

Social Security Number / Employer Identification Number *	Date of Birth (MM/DD/CCYY) *	Ownership % *
62-6189416	01 / 01 / 2006	17.74

Business Relationship to Enrolling Provider (Title)	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc)*
Owner	

Address Line 1 *
1000 Ridgeway Loop Road

Address Line 2
#203

City *	State *	ZIP Code+4 *
Memphis	TN	38120

Ownership 2

Name (must provide Last, First, and full Middle Name) / Business Name* ☐ I attest that I have given the individual's full legal name. He/she does not have a middle name.
John Hull Dobbs Jr. 2012 Trust

Social Security Number / Employer Identification Number *	Date of Birth (MM/DD/CCYY) *	Ownership % *
46-6535255	12 / 31 / 2012	5.9

Business Relationship to Enrolling Provider (Title)	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc)*
Owner	

Address Line 1 *
1000 Ridgeway Loop Road

Address Line 2
#203

City *	State *	ZIP Code+4 *
Memphis	TN	38120

Ownership 3

Name (must provide Last, First, and full Middle Name) / Business Name* ☐ I attest that I have given the individual's full legal name. He/she does not have a middle name.
Edward J. Dobbs Grantor Trust

Social Security Number / Employer Identification Number *	Date of Birth (MM/DD/CCYY) *	Ownership % *
62-6225694	01 / 01 / 2006	18.26

Business Relationship to Enrolling Provider (Title)	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc)*
Owner	

Address Line 1 *
1000 Ridgeway Loop Road

Address Line 2
#203

City *	State *	ZIP Code+4 *
Memphis	TN	38120

Ownership Information Continued . . .

Ownership 4

Name (must provide Last, First, and full Middle Name) / Business Name* ☐ I attest that I have given the individual's full legal name. He/she does not have a middle name.

Edward J. Dobbs 2009 Trust

Social Security Number / Employer Identification Number*	Date of Birth (MM/DD/CCYY)*	Ownership %*
27-6107360	05/ 31 / 2009	5.37

Business Relationship to Enrolling Provider (Title)	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc)*
Owner	

Address Line 1*
1000 Ridgeway Loop Road

Address Line 2
#203

City*	State*	ZIP Code+4*
Memphis	TN	38120

Ownership 5

Name (must provide Last, First, and full Middle Name) / Business Name* ☐ I attest that I have given the individual's full legal name. He/she does not have a middle name.

Caroline Kirby Dobbs 1985 Trust

Social Security Number / Employer Identification Number*	Date of Birth (MM/DD/CCYY)*	Ownership %*
62-6189384	01/ 01 / 2006	18.64

Business Relationship to Enrolling Provider (Title)	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc)*
Owner	

Address Line 1*
1000 Ridgeway Loop

Address Line 2
#203

City*	State*	ZIP Code+4*
Memphis	TN	38120

Ownership 6

Name (must provide Last, First, and full Middle Name) / Business Name* ☐ I attest that I have given the individual's full legal name. He/she does not have a middle name.

Caroline Kirby Dobbs Floyd 2012 Trust

Social Security Number / Employer Identification Number*	Date of Birth (MM/DD/CCYY)*	Ownership %*
46-6535398	12 / 31 / 2012	5.00

Business Relationship to Enrolling Provider (Title)	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc)*
Owner	

Address Line 1*
1000 Ridgeway Loop

Address Line 2
#203

City*	State*	ZIP Code+4*
Memphis	TN	38120

Ownership Information Continued. . .

Ownership 7

Name (must provide Last, First, and full Middle Name) / Business Name* ☐ I attest that I have given the individual's full legal name. He/she does not have a middle name.

Juliette C. Dobbs 1985 Trust

Social Security Number / Employer Identification Number*	Date of Birth (MM/DD/CCYY)*	Ownership %*
62-6194021	01/ 01 / 2006	17.64

Business Relationship to Enrolling Provider (Title)	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc)*
Owner	

Address Line 1*
1000 Ridgeway Loop

Address Line 2
#203

City*	State*	ZIP Code+4*
Memphis	TN	38120

Ownership 8

Name (must provide Last, First, and full Middle Name) / Business Name* ☐ I attest that I have given the individual's full legal name. He/she does not have a middle name.

Jackson Dobbs Allen 2012 Trust

Social Security Number / Employer Identification Number*	Date of Birth (MM/DD/CCYY)*	Ownership %*
408-98-9100	12 / 31 / 2012	6.00

Business Relationship to Enrolling Provider (Title)	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc)*
Owner	

Address Line 1*
1000 Ridgeway Loop

Address Line 2
#203

City*	State*	ZIP Code+4*
Memphis	TN	38120

Ownership 9

Name (must provide Last, First, and full Middle Name) / Business Name* ☐ I attest that I have given the individual's full legal name. He/she does not have a middle name.

Social Security Number / Employer Identification Number*	Date of Birth (MM/DD/CCYY)*	Ownership %*
	/ /	

Business Relationship to Enrolling Provider (Title)	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc)*

Address Line 1*

Address Line 2

City*	State*	ZIP Code+4*

Facility Name: Strategic Behavioral Center-Leland
Facility County: Brunswick

License No.: MHH-0976
Facility ID:

For-Profit Individuals or Companies

Complete the information below on **all** individuals who are owners, partners, or shareholders holding an interest of 5% or more of the licensee listed on page 2. Attach additional pages if necessary.
If you are the only owner, complete the information below, listing the percentage interest as 100%.

Owner or Shareholder Name: See Attached
Address: _____
City: _____ State: _____ Zip Code: _____
Phone # of Shareholder: (_____) _____ Fax (_____) _____
Percentage interest in this facility: _____ Title: _____

EXTENSIONS IN OWNERSHIP

North Carolina General Statute also requires information about "affiliates" of the applicant entity. "Affiliate" means any individual, partnership, or corporation which controls a mental health facility and is also directly or indirectly controlled by the applicant entity; or any individual, partnership, or corporation which controls a mental health facility and also directly or indirectly controls the applicant entity.

(a) Is the applicant entity controlled by any other organization that operates licensed mental health facility? Yes _____ No X

(b) Does the applicant entity control any other organizations that control any other licensed mental health facilities? Yes _____ No X

(c) If the answer to (a) or (b) above is "Yes" list the name of the other organization(s) and provide the requested information on the individuals who control 5% or more of that organization. Attach additional pages if necessary.

Organization Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Organization Phone #: (_____) _____ Fax (_____) _____

Organization Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Organization Phone #: (_____) _____ Fax (_____) _____

All responses should pertain to **October 1, 2013 to September 30, 2014.** If otherwise, indicate the actual reporting period used.

_____ to _____

Service Categories:

Services subject to licensure under G.S. 122C are shown in the table below. All applicants must complete the following table for all services which are to be provided by the facility. If the service is not offered, leave the spaces blank.

Rule 10 NCAC 27G Licensure Rules For Mental Health Facilities	Check Box if Facility Provides Service	Beds Assigned by Age (enter # of beds in box for each age range)						
		< 6	6-12	13-17	Total 0-17	18-64	65 +	Total 18 +
.6000 Inpatient hospital treatment for individuals who have mental illness	✓				20			
.1100 Partial hospitalization for individuals who are acutely mentally ill.								
.1200 Psychosocial rehabilitation facilities for individuals with severe and persistent mental illness								
.1300 Residential treatment facilities for children and adolescents who are emotionally disturbed or have a mental illness								
.1400 Day treatment for children and adolescents with emotional or behavioral disturbances								
.1700 Residential treatment Staff Secure for Children or Adolescents—Level III								
.1900 PRTF – Psychiatric Residential Treatment Facility for minors who are emotionally disturbed or who have a mental illness.	✓	N/A			72			

Rule 10 NCAC 27G Licensure Rules for Substance Abuse Facilities	Check Box if Facility Provides Service	Beds Assigned by Age (enter # of beds in box for each age range)						
		< 6	6-12	13-17	Total 0-17	18-64	65 +	Total 18 +
.6000 Inpatient hospital treatment for individuals who have substance abuse disorders # of Treatment beds _____ # of Medical SA beds _____								
.1100 Partial hospitalization for individuals who are acutely mentally ill.								
.3100 Non-hospital medical detoxification for individuals who are substance abusers								
.3200 Social setting detoxification for substance abusers								
.3300 Outpatient detoxification for substance abusers								
.3400 Residential treatment / rehabilitation for individuals with substance abuse disorders								
.3600 Outpatient narcotic addiction treatment								
.3700 Day treatment facilities for individuals with substance abuse disorders								
.4400 Substance Abuse Intensive Outpatient Program								
4500 Substance Abuse Comprehensive Outpatient Treatment Program								

If you have outpatient services, list the location of each N/A

List the names of the outpatient programs _____

SBH-KINGSPORT 002551

Reimbursement Source: Include only services provided in .6000 beds. **Do NOT** include detoxification days of care in the patient days of care column.

The Total for Patient Days of Care must match the grand Total reported for Patient Origin on pages 7.

Reimbursement Source (Primary Only)	Psychiatric Inpatient (.6000 Beds)		Substance Abuse Inpatient (.6000 Beds)	
	Number of Discharges	Patient Days of Care	Number of Discharges	Patient Days of Care
Self Pay/Indigent/Charity	0	0		
Medicare & Medicare Managed Care	N/A	N/A		
Medicaid Healthchoice	15	183		
Commercial Insurance	65	581		
Managed Care Medicaid MCO's	471	5780		
Other (Specify)				
Total Utilization	551	6544		

Psychiatric and Substance Abuse Hospitals:

Other Services Provided	Number of Facility Paid Staff	By Contract Or Outside Consultant On Site	By Contract Or Outside Consultant Off Site
Clinical Psychological Services			1 Consultant
Dental Services			As Needed
Genetic Counseling			As Needed
Occupational Therapy Services			As Needed
Recreational Therapy Services	1		
Speech Therapy Services			As Needed
Social Work Services	3		
Physical Therapy Services			As Needed
Pharmacist - Full Time		Contract (2)	
Pharmacist - Part Time			
Podiatric Services			As Needed
Psychiatric Emergency Services		1	
Substance Abuse Emergency Services			As Needed
Clinical Laboratory			
Other, specify			LabCorp + Millenium

Health Care Transparency Reporting

20 Most Common Outpatient Surgical Cases Table - Enter the number of surgical cases performed only in licensed operating rooms by the top 20 most common outpatient surgical cases in the table below by CPT code. Count each patient undergoing surgery as one case regardless of the number of surgical procedures performed while the patient was having surgery.

CPT Code	Description	Cases
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair	
29880	Arthroscopy, knee, surgical; with meniscectomy (medial and lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed	
29881	Arthroscopy, knee, surgical; with meniscectomy (medial or lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed	
42820	Tonsillectomy and adenoidectomy; younger than age 12	
42830	Adenoidectomy, primary; younger than age 12	
43235	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	
43239	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with biopsy, single or multiple	
43248	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with insertion of guide wire followed by dilation of esophagus over guide wire	
43249	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with balloon dilation of esophagus (less than 30 mm diameter)	
45378	Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)	
45380	Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple	
45384	Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery	
45385	Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	

Continued on next page

20 Most Common Outpatient Surgical Cases Table – Continued

CPT Code	Description	Cases
62311	Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; lumbar or sacral (caudal)	
64483	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or computed tomography); lumbar or sacral, single level	
64721	Neuroplasty and/or transposition; median nerve at carpal tunnel	
66821	Discission of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid); laser surgery (e.g., YAG laser) (one or more stages)	
66982	Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (e.g., iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage	
66984	Extracapsular cataract removal with insertion of intraocular lens prosthesis (stage one procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification)	
69436	Tympanostomy (requiring insertion of ventilating tube), general anesthesia	

Imaging Procedures

20 Most Common Outpatient Imaging Procedures Table - Enter the number of the top 20 common imaging procedures performed in the ambulatory surgical center in the table below by CPT code.

CPT Code	Description	Procedures
70450	Computed tomography, head or brain; without contrast material	
70553	Magnetic resonance (e.g., proton) imaging, brain (including brain stem); without contrast material followed by contrast material(s) and further sequences	
71010	Radiologic examination, chest; single view, frontal	
71020	Radiologic examination, chest; two views, frontal and lateral	
71260	Computed tomography, thorax; with contrast material(s)	
71275	Computed tomographic angiography, chest (noncoronary), with contrast material(s), including noncontrast images, if performed, and image postprocessing	
72100	Radiologic examination, spine, lumbosacral; two or three views	
72110	Radiologic examination, spine, lumbosacral; minimum of four views	
72125	Computed tomography, cervical spine; without contrast material	
73030	Radiologic examination, shoulder; complete, minimum of two views	
73110	Radiologic examination, wrist; complete, minimum of three views	
73130	Radiologic examination, hand; minimum of three views	
73510	Radiologic examination, hip, unilateral; complete, minimum of two views	
73564	Radiologic examination, knee; complete, four or more views	
73610	Radiologic examination, ankle; complete, minimum of three views	
73630	Radiologic examination, foot; complete, minimum of three views	
74000	Radiologic examination, abdomen; single anteroposterior view	
74022	Radiologic examination, abdomen; complete acute abdomen series, including supine, erect, and/or decubitus views, single view chest	
74176	Computed tomography, abdomen and pelvis; without contrast material	
74177	Computed tomography, abdomen and pelvis; with contrast material(s)	

PSYCHIATRIC INPATIENT SERVICES

Patient Origin – Days of Care .6000 Section Only Facility County: Brunswick

Complete the following table for inpatient Days of Care (DoC) reported under .6000. *Total DoC reported here must match* ***Total Patient Days of Care*** *reported under* **Reimbursement Source** *on page 5.*

County	# of Admissions	Days of Care by Age					Total
		< 6	6-12	13-17	18-64	65+	
1. Alamance	4		17	27			44
2. Alexander	1		12				12
3. Alleghany							
4. Anson							
5. Ashe	1		12				12
6. Avery							
7. Beaufort	21		50	199			249
8. Bertie	3		4	22			26
9. Bladen	7		30	41			71
10. Brunswick	56		329	369			698
11. Buncombe							
12. Burke							
13. Cabarrus	3		14	36			50
14. Caldwell							
15. Camden	1			9			9
16. Carteret	26		164	170			310
17. Caswell							
18. Catawba							
19. Chatham							
20. Cherokee	2		12	8			20
21. Chowan	3			26			26
22. Clay							
23. Cleveland	2			14			14
24. Columbus	12		24	99			123
25. Craven	21		106	236			343
26. Cumberland	5		13	32			45
27. Currituck	2		15	11			26
28. Dare	2			20			20
29. Davidson							
30. Davie	1		6				6
31. Duplin	5			38			38
32. Durham	4		28	16			44
33. Edgecombe	8		23	77			100
34. Forsyth	5			71			71
35. Franklin	2		16	8			24
36. Gaston							
37. Gates							
38. Graham							
39. Granville	1			6			6
40. Greene	1		13				13
41. Guilford	2		10	11			21
42. Halifax	2			14			14
43. Harnett	1		6				6
44. Haywood	2			19			19
45. Henderson	5			54			54
46. Hertford							
47. Hoke	1			7			7
48. Hyde							
49. Iredell							
50. Jackson							
51. Johnston	5		7	39			46

Continued on next page

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PSYCHIATRIC INPATIENT SERVICES (.6000) DAYS OF CARE continued

County	# of Admissions	Days of Care by Age					Total
		<6	6-12	13-17	18-64	65+	
52. Jones	2			24			24
53. Lee	5		6	26			32
54. Lenoir	5		26	31			57
55. Lincoln	1		24				24
56. Macon	7		13	55			68
57. Madison							
58. Martin	2		40				40
59. McDowell	1			18			18
60. Mecklenburg	1			8			8
61. Mitchell							
62. Montgomery							
63. Moore							
64. Nash	11		20	76			90
65. New Hanover	104	16	636	717			1369
66. Northampton	3		7	12			19
67. Onslow	23		96	164			260
68. Orange	2		51	7			58
69. Pamlico	3		6	20			26
70. Pasquotank	4			56			56
71. Pender	23		91	199			290
72. Perquimans							
73. Person	3			45			45
74. Pitt	15		72	142			214
75. Polk							
76. Randolph	6		11	52			63
77. Richmond	1			6			6
78. Robeson	49		111	382			493
79. Rockingham							
80. Rowan							
81. Rutherford							
82. Sampson	9		14	72			86
83. Scotland	5		12	35			47
84. Stanly							
85. Stokes							
86. Surry							
87. Swain	1			12			12
88. Transylvania							
89. Tyrrell							
90. Union	3		6	16			22
91. Vance	3		14	9			23
92. Wake	8		18	88			106
93. Warren							
94. Washington	1			23			23
95. Watauga							
96. Wayne	7		42	73			115
97. Wilkes	1			10			10
98. Wilson	25		62	188			250
99. Yadkin							
100. Yancey							
101. Out of State							
TOTAL	551	16	2289	4239	0	0	6,544

GRAND TOTAL

SBH-KINGSPORT 002557

SUBSTANCE ABUSE INPATIENT SERVICES

Patient Origin – Days of Care .6000 Section Only Facility County: _____

Complete the following table for inpatient Days of Care (DoC) reported under Section .6000. *Total DoC reported here must match* ***Total Patient Days of Care*** *reported under* **Reimbursement Source** *on page 5. Do NOT include Detoxification DoC.*

County	# of Admissions	Days of Care by Age					Total
		< 6	6-12	13-17	18-64	65+	
1. Alamance							
2. Alexander							
3. Alleghany							
4. Anson							
5. Ashe							
6. Avery							
7. Beaufort							
8. Bertie							
9. Bladen							
10. Brunswick							
11. Buncombe							
12. Burke							
13. Cabarrus							
14. Caldwell							
15. Camden							
16. Carteret							
17. Caswell							
18. Catawba							
19. Chatham							
20. Cherokee							
21. Chowan							
22. Clay							
23. Cleveland							
24. Columbus							
25. Craven							
26. Cumberland							
27. Currituck							
28. Dare							
29. Davidson							
30. Davie							
31. Duplin							
32. Durham							
33. Edgecombe							
34. Forsyth							
35. Franklin							
36. Gaston							
37. Gates							
38. Graham							
39. Granville							
40. Greene							
41. Guilford							
42. Halifax							
43. Harnett							
44. Haywood							
45. Henderson							
46. Hertford							
47. Hoke							
48. Hyde							
49. Iredell							
50. Jackson							
51. Johnston							

Continued on next page

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SUBSTANCE ABUSE SERVICES (.6000) DAYS OF CARE **continued**

County	# of Admissions	Days of Care by Age					Total
		< 6	6-12	13-17	18-64	65+	
52. Jones							
53. Lee							
54. Lenoir							
55. Lincoln							
56. Macon							
57. Madison							
58. Martin							
59. McDowell							
60. Mecklenburg							
61. Mitchell							
62. Montgomery							
63. Moore							
64. Nash							
65. New Hanover							
66. Northampton							
67. Onslow							
68. Orange							
69. Pamlico							
70. Pasquotank							
71. Pender							
72. Perquimans							
73. Person							
74. Pitt							
75. Polk							
76. Randolph							
77. Richmond							
78. Robeson							
79. Rockingham							
80. Rowan							
81. Rutherford							
82. Sampson							
83. Scotland							
84. Stanly							
85. Stokes							
86. Surry							
87. Swain							
88. Transylvania							
89. Tyrrell							
90. Union							
91. Vance							
92. Wake							
93. Warren							
94. Washington							
95. Watauga							
96. Wayne							
97. Wilkes							
98. Wilson							
99. Yadkin							
100. Yancey							
101. Out of State							
TOTAL							

GRAND TOTAL

SBH-KINGSPORT 002559

TennCare II
Operational Protocol

Bureau of TennCare
Nashville, Tennessee

Revised February 2015

Behavioral Health Services

The CONTRACTOR shall adhere to the following behavioral health network requirements to ensure access and availability to behavioral health services for all members (adults and children). For the purpose of assessing behavioral health provider network adequacy, TENNCARE will evaluate the CONTRACTOR's provider network relative to the requirements described below. Providers serving adults will be evaluated separately from those serving children.

Access to Behavioral Health Services

The CONTRACTOR shall ensure access to behavioral health providers for the provision of covered services. At a minimum, this means that:

The CONTRACTOR shall have provider agreements with providers of the services listed in the table below and meet the geographic **and** time for admission/appointment requirements.

Service Type	Geographic Access Requirements	Maximum Time for Admission/Appointment
Psychiatric Inpatient Hospital Service	Travel distance does not exceed 90 miles for at least 90% of members	4 hours (emergency involuntary)/24 hours (involuntary)/24 hours (voluntary)
24-Hour Psychiatric Residential Treatment	The CONTRACTOR shall contract with at least one (1) provider of service in each Grand Region for **ADULT** members. Travel distance does not exceed 60 miles for at least 75% of **CHILD** members and does not exceed 90 miles for at least 90% of **CHILD** members	Within 30 calendar days
Outpatient Non-MD Services	Travel distance does not exceed 30 miles for ALL members	Within 10 business days; if urgent, within 48 hours
Intensive Outpatient (may include Day Treatment [adult], Intensive Day Treatment [Children & Adolescent] or Partial Hospitalization	Travel distance does not exceed 90 miles for at least 90% of members	Within 10 business days; if urgent, within 48 hours
Inpatient Facility Services (Substance Abuse)	Travel Distance does not exceed 90 miles for at least 90% of members	Within 2 calendar days; for detoxification – within 4 hours in an emergency and 24 hours for non-emergency

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Service Type	Geographic Access Requirements	Maximum Time for Admission/Appointment
24-Hour Residential Treatment Services (Substance Abuse)	The CONTRACTOR shall contract with at least one (1) provider of service in each Grand Region for ADULT members The CONTRACTOR shall contract with at least one (1) provider of service in each Grand Region for CHILD members	Within 10 business days
Outpatient Treatment Services (Substance Abuse)	Travel distance does not exceed 30 miles for ALL members	Within 10 business days; for detoxification – within 24 hours
Mental Health Case Management	Not subject to geographic access standards	Within 7 calendar days
Psychosocial Rehabilitation (may include Supported Employment, Illness Management & Recovery, or Peer Support)	Not subject to geographic access standards	Within 10 business days
Supported Housing	Not subject to geographic access standards	Within 30 calendar days
Crisis Services (Mobile)	Not subject to geographic access standards	Face-to-face contact within 1 hour for emergency situations & 4 hours for urgent situations
Crisis Stabilization	Not subject to geographic access standards	Within 4 hours of referral

TENNCARE will evaluate the need for further action when the above standards are not met. At its sole discretion TENNCARE may elect one of three options: (1) TENNCARE may request a Corrective Action Plan (CAP), (2) a Request for Information (RFI), (3) or an On Request Report (ORR) depending on the severity of the deficiency.

The requested CAP, RFI or ORR response shall detail the CONTRACTOR's network adequacy considering any alternate measures, documentation of unique market conditions and/or its plan for correction. If TENNCARE determines the CONTRACTOR's response demonstrates the existence of alternate measures or unique conditions, TENNCARE may elect to request periodic updates from the CONTRACTOR regarding efforts to address such conditions.

Reference: MCO Contractor Risk Agreement Attachment V Access & Availability for Behavioral Health Services

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EXHIBIT
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PSYCHIATRIC HOSPITAL CAPACITY, HOMELESSNESS, AND CRIME AND ARREST RATES*

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KEYWORDS: mental illness, homelessness, crime, psychiatric hospitals, deinstitutionalization

As a result of developments in pharmacology, stricter standards for involuntary commitment, and changes in public expenditures, there has been a dramatic decline in the capacity of public psychiatric hospitals to maintain America's most severely mentally ill. Psychiatric deinstitutionalization has led to an increased presence of persons with mental illness in urban areas, many "falling through the cracks" of community-based services. This is hypothesized to have contributed to homelessness, crime, and arrests. Individual-level research has documented disproportionate and increasing numbers of mentally ill persons in jails and prisons. It has also found higher rates of violence and arrest among persons with mental illness compared to the general population. This study takes a macro-level social control approach and examines the relationships between psychiatric hospital capacity, homelessness, and crime and arrest rates using a sample of eighty-one U.S. cities. I find that public psychiatric hospital capacity has a statistically significant negative effect on crime and arrest rates, and that hospital capacity affects crime and arrest rates in part, through its impact on homelessness. In addition, I find no crime-reducing effect of private and general psychiatric hospital capacity.

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Sociologists and criminologists have sought to explain the rise and expansion of formal institutions of social control, including the criminal justice, mental health, and welfare systems. Studies have focused largely on the role of socioeconomic conditions such as the contraction of labor markets and the size of minority populations as threats to the social order (Grob, 1994; Inverarity and Grattet, 1989; Jackson, 1989; Liska, 1992; Liska and Chamlin, 1984; Liska et al., 1999; Piven and Cloward, 1971; Scull, 1977; Sutton, 1991). However, comparatively less attention has been given to the consequences, or outcomes associated with the capacity of social control institutions. Classic work by Penrose (1939) demonstrated an inverse relationship between the prison and psychiatric hospital populations in European countries. Palermo and colleagues (1991) showed a similar relationship for the United States as a whole. The impact of psychiatric hospital capacity on crime and arrest rates across U.S. cities, however, has not been directly examined.

In recent decades, the inpatient capacity of public psychiatric hospitals has dropped dramatically. This has stimulated much individual-level research documenting the increasing numbers of persons with mental illness in jails and prisons, many of whom are homeless. Moreover, there has been increased attention to the risk of homelessness, violence, criminal behavior, and arrest among persons with severe mental illness. Building on this research, in an effort to understand the impact of psychiatric hospital capacity in terms of macro-level social control processes, I first discuss changes in the U.S. mental health care system over the last several decades and their impact on the criminal justice system. I then examine the relationships between psychiatric hospital capacity, homelessness, and crime and arrest rates for a sample of cities in the United States.

PSYCHIATRIC DEINSTITUTIONALIZATION

Until the 1960s, substantial numbers of persons with mental illness could be treated in large, publicly funded hospitals. Based on National Institute of Mental Health (NIMH) estimates, in 1960, about 563,000 beds were available in U.S. state and county psychiatric hospitals (314 beds per 100,000 persons), with about 535,400 resident patients. By 1990, the number of beds declined to about 98,800 (40 per 100,000) and the number of residents to 92,059 (NIMH, 1990). Several factors contributed to this drop. First, medications were developed that controlled the symptoms of the most debilitating mental disorders (for example, schizophrenia). Second, an ideological shift, advocating a more liberal position on confinement led to states adopting stricter legal standards for involuntary

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commitment (dangerousness to self or others). Third, fiscal policy changed, including the shifting of costs for mental health care from states to the federal government (for example, Medicare, Medicaid, Social Security Disability Income), followed by budget cuts and substantial underfunding of public mental health services (Gronfein, 1985; Issac and Armat, 1990; Kiesler and Sibulkin, 1987; Mechanic and Rochefort, 1990; Redick et al., 1992; Weinstein, 1990). These trends and associated policies are generally referred to as the deinstitutionalization of the mentally ill.[1]

The sharp decline in public psychiatric hospital capacity has been offset to some extent by inpatient units in private psychiatric and general hospitals. An important component to the changing nature of psychiatric hospitalization is the increasing role of general hospitals. Emergency rooms and psychiatric units in general hospitals provide acute treatment for those with mental illness and can bill Medicaid for doing so (Mechanic, McAlpine, and Olfson, 1998). Although these hospitals may contribute to cities' social control capacity, they still do not provide the long-term treatment found in public psychiatric hospitals. Therefore, as many have argued, the capacity for maintaining and treating America's mentally ill, especially the most severely impaired and economically disadvantaged patients, has substantially diminished (Ehrenkranz, 2001; Lamb and Bachrach, 2001; Torrey, 1995).

Many patients were discharged from state hospitals into the community. Others, as a result of stricter standards for involuntary commitment, were not even admitted—an "opening of the back doors" and "closing of the front doors." Moreover, in the early 1960s the average length of stay was about 6 months, but by the early 1990s it had declined to about 15 days. Overall, the rate of admissions increased slightly (NIMH, 1990). Thus, patients are often stabilized (given medication) and released back into the community, many times without adequate follow-up treatment and support (Wegner, 1990). Not surprisingly, substantial numbers of these patients end up being readmitted. This has been referred to as the "revolving door" phenomenon (Kiesler and Sibulkin, 1987).

Historically, psychiatric hospitals have functioned as a source of control of persons who are unable to care for themselves and whose behavior may be threatening to the social order (Grob, 1994; Horwitz, 1982). An important consequence of reduced hospital capacity is that a large portion of persons with severe mental illness now live in urban areas with less supervision and support. Although many do well, others lack "insight" into their disorders, go untreated, or have difficulty complying with

1. Because many patients ended up in nursing homes, halfway houses, and the criminal justice system, some have referred to this process as *transinstitutionalization* (Torrey, 1997).

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medication regimens, and are unable to support themselves (Mechanic, 1999). This presents considerable difficulties for families and others who are often unable or unwilling to deal with persons whose behavior may at times be unmanageable or threatening (Avision, 1999).

Deinstitutionalization is hypothesized by many to have resulted in an increased number of persons at risk of homelessness and publicly troublesome behavior, increasing the burden on the criminal justice system (Finn and Sulllivan, 1988; Goldsmith, 1983; Grob, 1994; Dowdall, 1999; Issac and Armat, 1990; Johnson, 1990; Lewis et al., 1991; Mechanic and Rochefort, 1990; Morrisey, 1982; Task Force on Homelessness and Severe Mental Illness, 1992; Warner, 1989). Consequently, much individual-level research has focused on the increased proportion of mentally ill persons incarcerated, the likelihood of violent and criminal behavior among the mentally ill, the "criminalization" of mental illness, and the prevalence of mental illness among homeless persons. Despite the relevance of this research for macro-level social control processes, there has been no research directly examining the relationships of hospital capacity, homelessness, and crime at the city-level.

LIMITED HOSPITAL CAPACITY AND THE JUSTICE SYSTEM

In the aftermath of deinstitutionalization, several studies have investigated the extent to which prisons and jails have supplanted public psychiatric hospitals as institutions of social control of the mentally ill. These studies examined the frequency of arrest, jail, and imprisonment among people admitted into psychiatric hospitals before and during deinstitutionalization (Adler, 1986; Arvanites, 1988; Belcher, 1988; Cocozza, Melick, and Steadman, 1978; Goldsmith, 1983). A study in New York found that the percentage of patients with prior arrests increased from 15 percent in the 1946 to 1948 period to 32 percent in 1969 and to 40 percent by 1975 (Melick, Steadman, and Coccozza, 1979). A study of five states reported a 17-percent increase in the percentage of patients with prior arrests between 1968 and 1978 (Arvanites, 1988). Studies of imprisonment were less conclusive, however. For example, in a study of six states, Steadman and colleagues (1984) reported an overall increase (from 8 percent to 11 percent) in the percentage of prison inmates with prior mental hospitalization between 1968 and 1978. Although the increase occurred in only three states, it was enough to outweigh the decrease for the other three, yielding a net increase. Some researchers thus concluded that the mentally ill are being overarrested, but not overimprisoned, and instead are being warehoused in city and county jails (Adler, 1986; Lamb and Grant, 1982; Palermo et al., 1991, Pogrebin and Regoli, 1985; Teplin,

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1990). However, a recent nationally representative survey of state and federal prisoners, jail inmates, and probationers indicates that persons who reported currently or ever having a "mental or emotional condition" are overrepresented in all those groups for both violent and property offenses, but not for drug offenses (Ditton, 1999). That study estimates that up to 16 percent of persons in prisons and jails may have a mental illness, many of whom have committed serious offenses. There are now more persons with mental illness in jails and prisons than in psychiatric hospitals (Torrey, 1995).

Because of a lack of appropriately trained staff and screening procedures, many persons are retained in jails and prisons without adequate treatment. These inmates are less likely than others to be released on bail, more likely to experience abuse from guards and other inmates, and are at an increased risk of suicide (Torrey, 1995). Thus, corrections facilities serve, in part, as alternatives to psychiatric hospitals. Although many jails and prisons provide mental health services, and several communities have programs to divert mentally ill offenders from jail to community treatment, the availability of these services and programs are limited relative to the need for them (Goldstrom et al., 1998; Morris, Steadman, and Veysey, 1997; Steadman, Morris, and Dennis, 1995).

THE "CRIMINALIZATION" OF MENTAL ILLNESS

How disproportionate numbers of the mentally ill end up in criminal justice settings can be understood in several interrelated ways. One is that it results from the "behavior" of the criminal justice system. That is, in the face of limited treatment options, disturbing behavior that might have been dealt with medically is now more likely to be treated as criminal behavior. For example, even though police may recognize some disruptive behavior as resulting from mental illness, they often have little choice but to use "mercy bookings" as a way to get persons into mental health treatment. Police are now one of the main sources of referral of persons into mental health treatment (Engel and Silver, 2001; Lamb et al., 2002). Also, police, who see troublesome situations through the lens of their role as "law enforcers" are motivated to maintain their authority in conflict situations, often invoking the power of arrest to do so. These processes have led some to argue that mental illness has been "criminalized," with mentally ill suspects more likely to be arrested than suspects who are not mentally ill (Lamb and Weinberger, 1998; Lamb et al., 2002; Steury, 1991; Teplin, 1990).

The evidence in support of the criminalization hypothesis comes primarily from systematic observation of police-citizen encounters in

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major cities. One study showed that mentally ill suspects are about 20 percent more likely to be arrested than their counterparts (Teplin, 1984). However, a more recent study of police-citizen encounters in twenty-four police departments in three metropolitan areas contradicts those findings (Engel and Silver, 2001). The study also showed that other factors, not considered in previous research, such as whether suspects are under the influence of drugs, are noncompliant, fight with officers or others, as well as the seriousness of their offense predict the likelihood of arrest. An important implication of their research is that if mentally ill persons are overrepresented in criminal justice settings, it is not solely attributable to discriminatory treatment on the part of police, but in part, due to a greater likelihood of arrest-generating behavior.

Much research has examined a second way that mentally ill persons are more likely than others to end up in criminal justice settings—that is, the direct relationship between mental disorder and the likelihood of violent and criminal behavior (Hiday, 1995; Hodgins, 1993; Link, Andrews, and Cullen, 1992; Link et al., 1999; Monahan, 1992; Steadman and Felson, 1984). Several strategies have been used. One approach samples jails or prisons and administers diagnostic inventories to determine the prevalence of mental illness among inmates. Estimates from these studies vary, but have shown that up to 20 percent of those incarcerated meet diagnostic criteria for a serious mental disorder, with about 5 percent having psychotic disorders (Roth, 1980; Steadman et al., 1987; Teplin, 1990, 1994), a rate higher than that of the general population. Another approach, using samples of those with a mental illness, finds a higher incidence of self-reported violence and arrest compared to the general population (Link et al., 1992; Steadman and Felson, 1984). One of the more rigorous approaches uses representative samples from the general population to estimate the prevalence of mental disorder and asks respondents about their involvement in violence and crime. These studies show that those who suffer from severe mental disorders are at an increased risk of violence and arrest (Link et al., 1992, 1999; Swanson et al., 1990).[2] In many cases, those experiencing certain psychotic symptoms may misperceive the actions of others (including police officers) as threatening and respond aggressively (Link et al., 1999). These studies show, significantly, that the association between mental disorder and violence or arrest holds after

2. Other studies show the risk of violence among the mentally ill is increased when persons have a history of prior violence and co-occurring substance abuse disorders (Monahan et al., 2001). Estimates from the Epidemiological Catchment Area and National Comorbidity studies indicate that about one-half to three-fourths of persons who had an alcohol, or other substance-related disorder throughout their lifetimes had at least one other mental disorder (Kessler et al., 1994; Robins and Reiger, 1991).

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controlling for comparable risk factors, such as sex, age, race, and socioeconomic status.

THE ROLE OF HOMELESSNESS

The effect of hospital capacity on crime and arrest rates at the city-level manifests itself in another set of ways. Psychiatric hospitals provide a place to stay (at least temporarily) for mentally ill persons. Given limited affordable housing options for the mentally ill, cities with less psychiatric inpatient capacity may have higher rates of homelessness (Bachrach, 1992; Jencks 1994; Mechanic and Rochefort, 1990). Studies estimate that approximately one-third of homeless persons meet diagnostic criteria for a major mental illness (Jencks, 1994; Lamb, 1992a; Shlay and Rossi, 1992). Including substance-related disorders, the figure is closer to 75 percent.

Homelessness is considered to be an important pathway to incarceration among the mentally ill (Lamb and Weinberger, 2001). Surveys of jail and prison inmates find that mentally ill offenders are more likely than other inmates to have been homeless at the time of arrest and in the year before arrest (DeLisi, 2000; Ditton, 1999; McCarthy and Hagan, 1991). Because of a lack of community treatment programs and limited staffing (critical for monitoring medication compliance), personal resources, and social supports, many mentally ill homeless persons are at increased risk of police encounters and arrest for not only "public order" types of offenses, such as vagrancy, intoxication, or disorderly conduct, but also for more serious types of crimes, such as assault (Dennis and Steadman, 1991; Hiday et al., 2001; Estroff et al., 1994; Hiday, 1995; McGuire and Rosenbeck, 2004; Mechanic and Rochefort, 1990; Steadman, McCarty, and Morrisey, 1989; Teplin, 1994; Teplin and Pruett, 1992).

Although the presence of homeless persons and public order offenses may be primarily a nuisance, they are a significant source of neighborhood disorder, generating fear and reducing social cohesion among neighborhood residents, thus facilitating more serious crime, such as robbery (see Markowitz et al., 2001; Skogan, 1990). In addition, high levels of urban disorder, including the visibility of homeless mentally ill persons, has led many cities (for example, New York) to take aggressive policing approaches that may contribute to the overrepresentation of mentally ill persons in jails and prisons.

The vulnerability of the homeless mentally ill also increases their risk of being the victims of crime (Dennis and Steadman, 1991). They are easier targets for offenders. Insights from routine activities theory suggest that homeless persons have reduced levels of "capable guardianship" necessary

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to protect themselves from crimes (Felson, 2002; Hagan and McCarthy, 1998). Moreover, the likelihood of victimization among homeless mentally ill persons is increased because of the risks of victimization associated with alcohol use more generally (Felson and Burchfield, 2004). For all of these reasons, cities with higher inpatient psychiatric capacity—with fewer homeless mentally ill persons on the streets—can be predicted to have lower crime and arrest rates.

The consequences of limited long-term care facilities are compounded by the fact that many mentally ill and homeless persons reside, temporarily, in group homes, shelters, or single-room occupancy hotels in more "socially disorganized" urban areas, where there are more economically disadvantaged persons, greater racial diversity, and more fragmented families. Social disorganization theory predicts that such structural characteristics lead to weakened social cohesion, thereby lessening the ability of communities to exert informal control over the behavior of their residents, resulting in increased crime (Bursik and Grasmick, 1993; Sampson and Groves, 1989; Sampson, Raudenbusch, and Earls, 1997). For persons with mental illness, living in such neighborhoods increases the risk of criminal offending beyond individual characteristics (Silver, 2000a, 2000b; Silver, Mulvey, and Monahan, 1999).

RESEARCH QUESTIONS

A key yet underexamined implication of the above research is that the capacity of mental health care systems to manage the behavior of persons with severe mental and addictive disorders—who are at increased risk of criminal offending—may be related to crime and arrest rates across macro-social units. I depart from the focus on individual variation in criminal or violent behavior as a result of mental illness. Instead, this analysis is concerned with the question of social control, conceptualizing hospital capacity and crime rates as social facts, asking whether cities with greater hospital capacity have lower crime and arrest rates. I examine both crime and arrest rates because arrest rates reflect political pressures and police activity in addition to levels of crime (O'Brien, 1996). Arrest rates may be sensitive to policing policies designed to reduce urban disorder, including the visibly homeless and mentally ill. I also examine the mediating role of homelessness in the relationship between psychiatric hospital capacity and crime and arrest rates. I predict that cities with greater hospital capacity will have lower levels of homelessness. Homelessness, in turn, is expected to be related to increased levels of crime and arrest.

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METHODS

SAMPLE

Questions regarding the macro-level relationships between psychiatric hospital capacity, homelessness, and crime/arrest rates raise important issues regarding the appropriate level of analysis. Most public psychiatric hospitals are state-controlled, thus the policy decisions determining the funding, staffing, and capacity of these institutions takes place at the state level. However, crime and control of crime are generally considered local phenomenon. I therefore employ a strategy that apportions psychiatric hospital capacity to the city level using geographic information regarding catchment-area coverage.

The study is based on a sample of eighty-one U.S. cities with populations more than 50,000 where city-level estimates of homelessness from a variety of sources are available that yield a sufficient number of cities for analysis. These cities represent a sample of mid-size to large urban areas where the processes of interest largely take place, and for which complete demographic, psychiatric hospital, and homelessness data are available. Because of some missing data, the sample size drops slightly in the estimated equations. The sample contains about 60 percent of U.S. cities with populations greater than 100,000 and about 80 percent of the fifty largest cities. The sample is well-distributed geographically, with about 23 percent of cities located in the East, 25 percent in the Midwest, 21 percent in the West, and 31 percent in the South. The data examined are from 1989 to 1990. Thus, the period represented is one where the decline in hospital capacity was leveling off from the sharp declines from the 1960s to the 1980s, when crime rates were still comparatively high, before the crime drop of the mid-1990s. Further, in the early 1990s, the public mental health care system was just crossing a threshold where the majority of expenditures previously directed towards state hospital inpatient care were now directed towards community-based services (Lutterman and Hogan, 2000).

MEASURES

Psychiatric Hospital Capacity. The city-level measure of psychiatric hospital capacity comes from the annual *Guide to the Healthcare Field* (American Hospital Association, 1990). These data include the number of beds, admissions, patient census, personnel, average length of stay, source of funding, and expenditures for all hospitals in the United States and include community mental health centers with inpatient units. The level of error is likely low because the data are obtained from reports using a

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standardized instrument, with clearly identifiable variables that are closely monitored by hospital administrations. Capacity data were recorded for both private and public (state and county) psychiatric hospitals, aggregated to the city level, and expressed in terms of population proportions (number of beds per 100,000 residents). Most public psychiatric hospitals serve catchment areas—sets of counties including the ones in which they are located. The data for such hospitals are apportioned using the ratio of city to catchment-area population. For example, if a city makes up 75 percent of the catchment area population, 75 percent of the beds in a hospital serving that catchment area are assigned to the city. Catchment area information was obtained from either the hospitals or the states' mental health departments. A similar procedure was used for cities served by hospitals outside the city.

Because local general hospitals are currently an important component of emergency and inpatient treatment, especially in light of Medicaid reimbursement, I also consider the effects of city population-proportionate number of psychiatric beds in general hospitals (per 100,000) that are reported at the state level and compiled by the Center for Mental Health Services and NIMH.

Given the period under study, during which the number of psychiatric beds in hospitals had reached comparatively lower levels from previous eras and the length of stay had became shorter (from several months to several days), the meaning of additional beds has gone from the ability to incapacitate a larger number of patients for longer periods of time to the ability to incapacitate fewer patients at any given time, and for shorter periods when they are. Census rates generally indicate that the available beds are filled (to 90 percent capacity or above). Whether patients are admitted for short- or long-term stays, capacity measures indicate the degree to which psychiatric hospital systems in a given city are able to manage a volume of persons whose behavior may be disruptive or perceived as threatening.

Crime and Arrest Rates. Crime and arrest rates come from the FBI Uniform Crime Reports (UCR). I focus on the Part I index offenses that include violent (homicide, assault, rape, and robbery) and property (burglary, theft, and motor vehicle theft) crimes.[3] There are, of course,

3. I considered including Part II data that report only arrests for more public order types of crimes, such as public drunkenness, disorderly conduct, and vagrancy. However, Part II data are not often used in research since they contain a high degree of unreliability due to non-reporting and inconsistent enforcement. Estimates in many cities fluctuate greatly from year to year. Also, while many of the offenses the mentally ill are charged with are minor, this does not preclude a focus on serious crimes. According to nationwide studies, about 16 percent of state prisoners and jail inmates have a mental illness. Among those mentally ill inmates,

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well-known limitations associated with UCR data, especially the underestimation of the "true" amount of crime (O'Brien, 1985). However, because the focus of the study is on the covariance of crime with psychiatric hospital capacity, underestimating crime should not seriously bias parameter estimates. Despite the limitations of the UCR data, given the unavailability of city-level victimization statistics, UCR provide the best available data for the present purposes.

Homelessness. Because there are well-known difficulties associated with measures of homelessness (Shlay and Rossi, 1992), I use three city-level measures from two sources. I use the U.S. Census Bureau's 1990 enumeration of persons visible in street locations and residing in shelters (per 100,000 persons). I also use Burt's 1989 homeless rate (number of shelter beds per 10,000), based on survey data from city administrators of the U.S. Department of Housing and Urban Development Comprehensive Homeless Assistance Plan (Burt, 1992). In the analysis, I combine the three correlated measures into a weighted factor score derived from principal components analysis.[4]

Structural Variables. Throughout the analysis, I control for the following demographic structural variables associated with crime, the prevalence of mental illness, and homelessness: percent nonwhite, economic disadvantage (a factor score derived from principal components analysis of percent unemployed and percent of families in poverty), divorce rate, percentage age 15 to 34, and city population (Brenner, 1973;

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53 percent of state prisoners, compared to 46 percent of other state prisoners, were incarcerated for a violent crime (approximately 13 percent of the mentally ill in state prison had committed murder; 12 percent committed sexual assault; 13 percent robbery; and 11 percent assault). Among inmates in federal prison, 33 percent of the mentally ill were incarcerated for a violent offense, compared to 13 percent of other federal inmates. More than 20 percent of mentally ill federal prisoners had committed robbery. Among inmates in local jails, 30 percent of the mentally ill had committed a violent offense, compared to 26 percent of other jail inmates. An estimated 28 percent of mentally ill probationers and 18 percent of other probationers reported their current offense was a violent crime. While it is unfortunate that data on minor offenses lacks the validity and reliability necessary to perform the same statistical analysis as that involving the index offenses, cities having high levels of Part II crimes are also likely to have high levels of more serious crime (Skogan, 1990).

4. The availability of shelter beds is likely to reflect the demand for such beds and is an indicator of the relative degree of homelessness across different cities. These estimates are conservative, or underestimate the true extent of homelessness (Stevens, 1991). Because the primary interest is on the covariance of homelessness with psychiatric hospital capacity and crime and arrest, underestimation should not seriously bias parameter estimates. Despite limitations, these indicators of homelessness are the best available for enough cities, permitting the analysis. The factor loadings for visible street persons, persons in shelters, and the homeless rate are .90, .80, and .56 respectively (eigenvalue = 68.36).

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Catalano and Dooley, 1977, 1983; Elliot and Krivo, 1991; Fenwick and Tausig, 1994; Land, McCall, and Cohen, 1990; Sampson, 1987; Shlay and Rossi, 1992; Steffensmeier and Harer, 1999).[5] All of these measures come from published U.S. Census Bureau figures.

ANALYSIS STRATEGY

First, I compare the hospital capacity of the city sample to estimates for the nation. I then examine the correlations between hospital capacity and crime and arrest rates. The correlations are examined separately for public hospitals, private hospitals, and psychiatric beds in general hospitals, because public hospitals treat a disproportionate amount of disadvantaged patients with more severe disorders. For example, according to recent data, 56 percent of blacks and Hispanics in inpatient psychiatric treatment are in state and county facilities, compared to 47 percent of whites (Milazzo et al., 2001). Of those treated in private psychiatric hospitals, over 85 percent are white, are admitted voluntarily (86 percent), and have private insurance (68 percent) (Koslowe et al., 1991). Moreover, 64 percent of inpatients in public hospitals have a principal diagnosis of schizophrenia, compared to only 19 percent of patients in private hospitals (Koslowe et al., 1991). The correlations are also examined separately for violent and property offenses in order to see whether the relationships between hospital capacity and crime and arrest rates differ depending on type of crimes considered. I then estimate a series of models for the relationships between psychiatric hospital capacity, homelessness, and crime and arrest rates, controlling for economic disadvantage, percentage age 15 to 35, percent nonwhite, divorce rate, and population size.

RESULTS

NATIONAL AND URBAN LEVELS OF PSYCHIATRIC HOSPITAL CAPACITY AND CRIME RATES

First, I compare the national level of psychiatric hospital capacity and crime rates to the urban sample. This is important because first, in terms of generalizability, I want to know how closely data from the urban sample reflects national estimates, and, second, I am concerned that the procedure for apportioning state and county hospital capacity to cities does not bias the data and model estimates. Table 1 shows the hospital

5. Substitution of percentage black for percentage nonwhite yielded similar results. The loadings for the indicators of economic disadvantage (poverty, unemployment) are both .89 (eigenvalue = 78.66).

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capacity and crime rates (per 100,000) for both the nation and the urban sample. The level of city hospital capacity is very close to the national rate. As might be expected, crime rates are higher for the urban sample.

Table 1. Public Psychiatric Hospital Capacity and Crime Rates, 1990

Hospital Capacity		Index Crimes	
National Estimates	City Sample	National Estimates	City Sample
40	38	5820	9700

Note: Hospital capacity is the number of beds per 100,000. Index crimes include murder, robbery, assault, rape, burglary, larceny/theft, and auto theft (total per 100,000).

BIVARIATE CORRELATIONS BETWEEN HOSPITAL CAPACITY AND CRIME AND ARREST RATES

Next, I examine the bivariate correlations between psychiatric hospital capacity and crime and arrest rates for both public and private hospitals, for violent, property, and both types of crime combined. In Table 2, correlations are shown for public hospitals. Consistent with the hypothesized relationships, the correlations of public hospital capacity with both crime and arrest rates are negative. For violent crimes, the correlation between hospital capacity and crime rate is very similar to the correlations involving arrest rates. For property crime however, the correlation between hospital capacity and crime rates are lower than the correlations involving arrest rates. As a result, the correlation between hospital capacity and total crime rate is slightly lower than correlation involving total arrest rates. In the regression analysis, I present results for violent and property crimes combined, but do so for crime and arrest rates separately.

Table 2. Correlations Between Psychiatric Hospital Capacity and Crime and Arrest Rates

	Violent		Property		Total	
	Crime	Arrest	Crime	Arrest	Crime	Arrest
Public Psychiatric	-.143*	-.145*	-.115	-.092	-.145*	-.142*
Private Psychiatric	-.049	.057	.249**	.338*	.184*	.267**
General Hospitals	-.073	-.042	-.139#	.005	-.082	.063

* $p < .05$ ** $p < .01$ # $p < .10$

Note: Violent crimes include murder, robbery, assault, and rape (rates per 100,000). Property crimes include burglary, larceny/theft, and auto theft. Hospital capacity is measured as number of beds per 100,000.

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Turning to the bivariate correlations between private psychiatric hospital capacity and crime and arrest rates (shown in Table 2), a pattern of relationships emerges that is generally opposite from that of public psychiatric hospitals. The correlations are mostly positive, indicating that private hospitals, more likely to serve those with private insurance, less severe disorders, and for shorter inpatient stays (Mechanic, 1999), may not provide the same crime-reducing function as public hospitals. Although seemingly anomalous, the positive correlation between private hospital capacity and crime and arrest rates is consistent with research indicating that where cities have more private hospitals and beds, police may be more likely to arrest mentally ill offenders. This is due to the well-documented organizational reluctance among private hospitals to admit patients who are uninsured, are covered by Medicaid, or have more severe mental illnesses (Schlesinger and Gray, 1999). The correlations between psychiatric beds in general hospitals and crime (see Table 2), show that, with the exception of a small negative correlation with property crimes, there is very little bivariate relationship of crime and arrest rates with general hospital psychiatric beds. The mostly private general hospitals with psychiatric bed allocation may operate in a manner similar to private psychiatric hospitals, in terms of providing only short-term care, thus having a limited crime-reducing effect. Therefore, in the regression analysis, I focus mainly on public psychiatric hospitals, but comment on the sensitivity of the effects of public psychiatric beds when private and general hospital beds are included in the equations.

HOSPITAL CAPACITY, HOMELESSNESS, AND CRIME AND ARREST REGRESSION MODELS

Table 3 presents the results of a series of OLS regression models for the relationships between public hospital capacity, homelessness, and crime and arrest rates. Equation 1 shows the effects of hospital capacity and structural variables on homelessness, followed by equations 2 through 5 estimating the effects of hospital capacity and homelessness on crime and arrest rates. First, the results from equation 1 show that hospital capacity has a statistically significant negative effect on homelessness (beta = -.15). The effects of several structural variables are in the expected direction. Percentage nonwhite and economic disadvantage are associated with increased homelessness. As might be anticipated, homelessness is also more prevalent in larger cities. Hospital capacity and the structural variables account for about 12 percent of the variation in homelessness.

The hospital capacity effect on the crime rate (equation 2) is generally similar to the bivariate correlation. The effect is negative and statistically significant, with a standardized coefficient (beta) of -.13. The effects of the structural variables are in the expected direction. Percentage nonwhite,

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economic disadvantage, percentage age 15 to 34, and divorce are associated with increased crime rates.

Table 3. Regression Models Relationships 1990

	Homelessness		Crime Rate				Arrest Rate			
	(1)		(2)		(3)		(4)		(5)	
Variables	b	Beta	b	Beta	b	Beta	b	Beta	b	Beta
Hospital capacity	-.01*	-.15	-6.90*	-.13	-4.17	-.08	-2.37*	-.17	-2.01#	-.14
Nonwhite	.02**	.31	47.84**	.27	28.40*	.16	5.30*	.13	8.47*	.24
Economic disadvantage	.17**	.17	730.89***	.23	674.23*	.29	36.97	.05	34.74	.05
Divorce	.04	.05	240.72*	.16	266.38#	.17	15.18	.15	18.22	.15
Age 15 to 34	.01	.02	83.77*	.12	89.54#	.13	37.58*	.15	36.34*	.12
Population (1,000s)	.01#	.15	.01	.04	.01	.01	.04	.05	.01	.04
Homelessness	—	—	—	—	134.95**	.34	—	—	62.50*	.12
R^2(n)	.12(80)		.20(79)		.31(79)		.10(75)		.12(75)	

#$p < .10$ *$p < .05$ **$p < .01$ ***$p < .001$
Note: b = unstandardized regression coefficients; Beta = standardized regression coefficients

When homelessness is introduced into the model (equation 3) the results indicate that it has a statistically significant effect on crime rates (beta = .34). Consequently, the hospital capacity effect is reduced by about 40 percent and is no longer significant. Together, hospital capacity and structural variables account for about 31 percent of the variation in crime rate. When the models are estimated separately for violent and property crime rates, the results (not shown) indicate a slightly stronger effect of homelessness on violent crime compared to property crime. However, using a covariance structure model with maximum likelihood estimation with violent and property crime rates specified as endogenous, controlling for the other variables, I constrained the unstandardized effects of homelessness to be equal across the two equations and tested for model fit using the nested chi-sure test (Bollen, 1989). The results indicate no significant difference in the effect of homelessness across the two equations (chi-square, 1 d.f. = 2.72, $p = .10$).

Equations 4 and 5 in Table 3 present the results of regression models for the effects of hospital capacity and the control variables on arrest rates. In equation 4, excluding homelessness, the hospital capacity effect is similar to the bivariate correlation (beta = -.17). The coefficients for the other structural variables are in the expected direction. Comparing the effect of hospital capacity on crime and arrest rates (equations 2 and 4),

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the effect on crime rates is slightly greater (chi -square, 1 d.f. = 9.70, p = .003).

When homelessness is added to the arrest rate model (equation 5), the effect of hospital capacity is reduced (by about 15 percent), yet is still close to conventional levels of statistical significance. Together, hospital capacity and structural variables account for about 12 percent of the variation in arrest rate. When arrest rates are examined separately by types of crimes (not shown), homelessness is found to have a statistically significant and substantial effect on arrests for violent crime (beta = .19), but only a small and nonsignificant effect on arrests for property crime (beta = .08). Again using a covariance structure model with equality constraints on the unstandardized homelessness effect across equations, the difference this time is found to be statistically significant (chi-square, 1 d.f. = 9.82, p = .002). This might be expected given that property crimes are far less likely to be reported, let alone result in arrest.

To determine whether these results are affected by controlling for private and general psychiatric hospital capacity, I reestimated the series of equations including these variables. When the private psychiatric hospital capacity is added, it is found to have no statistically significant effects on any of the dependent variables. The effects of public hospital capacity do increase slightly, but remain substantively unchanged. Moreover, to test for the possibility that the effects of public hospital capacity may be conditioned by private and general hospital capacity, product terms were formed between public capacity and each of these variables and added to the equations. Using nested F-tests, none of these effects were found to be significant.

DISCUSSION

In this study, I first tested the hypothesis that public psychiatric hospital capacity is inversely related to crime and arrest rates at the city level. The results are consistent with that hypothesis and with surveys of jail and prison inmates that find mentally ill offenders are overrepresented among those incarcerated, especially for violent crimes, which have a greater likelihood of resulting in arrest compared to property or drug offenses (Ditton, 1999). The findings are also consistent with arguments that when social control agents must deal with individuals whose behavior may be disturbing or troublesome, in the absence of hospitalization in public psychiatric institutions as an option, arrests may be more frequent, accounting for much of the "transinstitutionalization" that occurs (Adler, 1986; Belcher, 1988; Finn and Sullivan, 1988).

The public hospital capacity effect may be sensitive to outpatient services, which can affect patients' ability to successfully integrate into

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communities. If it is, I cannot be confident that the effect has been isolated. Unfortunately, standard measures of other mental health-related social service provision are not available in the same way that hospital data is. This is due in large part to variation from city to city in terms of public versus private operation, funding streams, profit versus nonprofit status, scope of services (for example, clinics, day treatment, psychiatric rehabilitation, case management), period in operation, and effectiveness. Perhaps because of this fragmentation, these services do not provide the degree of social control that public psychiatric hospitals do. Nevertheless, I addressed the issue by examining the effects of total and community-based per capita state mental health expenditures. Total expenditures reflect the amount spent on all of the cited services and personnel, including both inpatient and outpatient services. Community expenditures include programs and activities provided in community settings, including mental health centers, outpatient clinics, partial care organizations, assertive community treatment and support programs, consumer-run programs (such as club houses and drop-in centers), and services provided by state hospitals off hospital grounds. Available data permitted analyses to be conducted for total community expenditures, and residential and nonresidential service expenditures separately.

I found that though city-apportioned total mental health expenditures are significantly correlated with hospital capacity (because, on average, hospitals account for about half of state mental health budgets), total expenditures are not correlated with crime or arrest rates. As a result, they do not alter the estimated effects of hospital capacity on crime and arrest rates. Further, although total, residential, and nonresidential community-based expenditures are positively associated with homelessness (perhaps reflecting demand for services), they are unrelated to crime or arrest rates. When they are included in the models, the effects of public hospital capacity on homelessness, crime, and arrest rates are not substantively altered. This is consistent with limited research showing that communities with greater mental health services do not show any lower prevalence of mentally ill persons in jail than communities with low levels of mental health services (Fisher, 2003). Together, these findings suggest that community-based services for mental illness may not have that great of an impact on the number of persons arrested or in jail. It should be acknowledged that expenditures for community-based services alone might not provide the best indicator of their social control impact. How wisely money is spent and the effectiveness of services provided are difficult to assess. For example, some programs may be low-cost and highly effective and others expensive, wasteful, and ineffective. Other factors such as the staff to client ratio, staff turnover, and compliance may be useful but are simply unavailable at the city level. It is likely that

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community services simply do not provide the level of social control that public hospitals do.

Examining the relationships between psychiatric hospital capacity, homelessness, and crime and arrests, the results indicate a moderate link between public hospital capacity and homelessness at the city level that is not conditioned by private psychiatric beds, general hospital psychiatric beds or community-based expenditures. Although data on the proportion of mental illness among persons who are arrested and are homeless is not available for a city (or state) level analysis, the findings indicate that increased hospital capacity is associated with overall lower levels of homelessness, and increased homelessness is in turn associated with higher levels of crime and arrests for violent crime. The results indicated that part of the public hospital capacity effect on crime and arrest rates operates through its effect on homelessness.

Because data on homelessness in a large number of cities is only available for 1989 to 1990, I was unable to examine these relationships for other years. It would be useful to be able to examine the relationships between hospital capacity, homelessness and crime over periods in which hospital capacity was high and stable while crime rates were low (early 1960s), as well as periods in which hospital capacity declined as crime rates increased (1970s and 1980s). The results however, are consistent with individual-level research showing that an important pathway by which those who might otherwise receive longer-term inpatient psychiatric care end up committing crime is lack of housing (McGuire and Rosenbeck, 2004). This is due to the "criminogenic" situation that homelessness and mental illness fosters (McCarthy and Hagan, 1991). In the absence of inpatient capacity, more disturbing behavior becomes public, pressure increases on the police to "clean up" such behavior, and opportunities for criminal victimization increase.

I also estimated the equations including a variable capturing the ratio of private to public and general psychiatric hospital beds. The results indicated that, net of other factors in the equations, the predomination of private beds in cities is associated with statistically significant increases in crime (beta = .173) and arrest rates (beta = .359). This is consistent with the possibility that in cities where private hospital beds constitute a larger share of inpatient capacity, police have less access to facilities to readily take problematic persons and may be more likely to resort to arrest. However, police in such locales might be more inclined toward arrest generally.

The study complements our knowledge of the mental disorder and violence-crime association from individual-level research with a macro-level assessment of the relationship between the capacity for control of persons with psychiatric illness and crime and arrest rates. This

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relationship has several important implications for public policy related to community safety and the treatment of the mentally ill. Although some have raised the issue of a moratorium on deinstitutionalization (Lamb, 1992b), the results inform policy decisions regarding the impact of further reductions of psychiatric hospital capacity. The study suggests that modest increases in crime may be expected for given reductions in inpatient hospital capacity. This is especially important now that many states have implemented managed mental health care plans involving strict limitations on inpatient service expenditures (Mechanic, 1999). The exact effect of reduced hospital capacity on crime rates in any given city is difficult to predict, however, because this effect may depend on the availability and quality of a variety of fragmented community-based treatment and housing services that expenditure data alone may not fully capture.

Local jails often serve as conduits through which many mentally ill offenders pass before being transferred to psychiatric hospitals (Liska et al., 1999). Further reductions in psychiatric hospital capacity therefore increase the burden on law enforcement and corrections agencies. In fact, most jails in major metropolitan areas now provide some sort of mental health services. It is estimated that, nationally, corrections departments assume about one-third of the costs of mental health services provided in jails (Goldstrom et al., 1998). There have been increased efforts to provide services within correctional settings as well as support for community treatment alternatives, such as intensive case management, jail diversion programs, and mental health courts for mentally ill persons at risk of offending (Steadman, 1999; Dvoskin, 1994; Morris et al., 1997; Steadman et al., 1995; Watson et al. 2001). In general, the evidence regarding the effectiveness of these often uncoordinated programs is somewhat limited (for a comprehensive review, see Fisher, 2003). In light of the findings of the present study, these types of programs may be insufficient to take the place of public institutions focusing specifically on the inpatient care needs of persons with serious mental illness and substance abuse disorders.

In sum, public psychiatric hospital capacity is an important source of control of those whose behavior or public presence may at times threaten the social order. Although controversial issues in mental health care such as easing standards for involuntary treatment, court-ordered medication compliance, and expanding custodial care continue to be debated (Lamb, 1992b; Mechanic, 1999; Miller, 1993; Torrey, 1997), the study suggests that reductions in public hospital capacity must be weighed against public safety concerns, tolerance, and the willingness to provide high-quality alternative community mental health and housing services.

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SBH-KINGSPORT 002589

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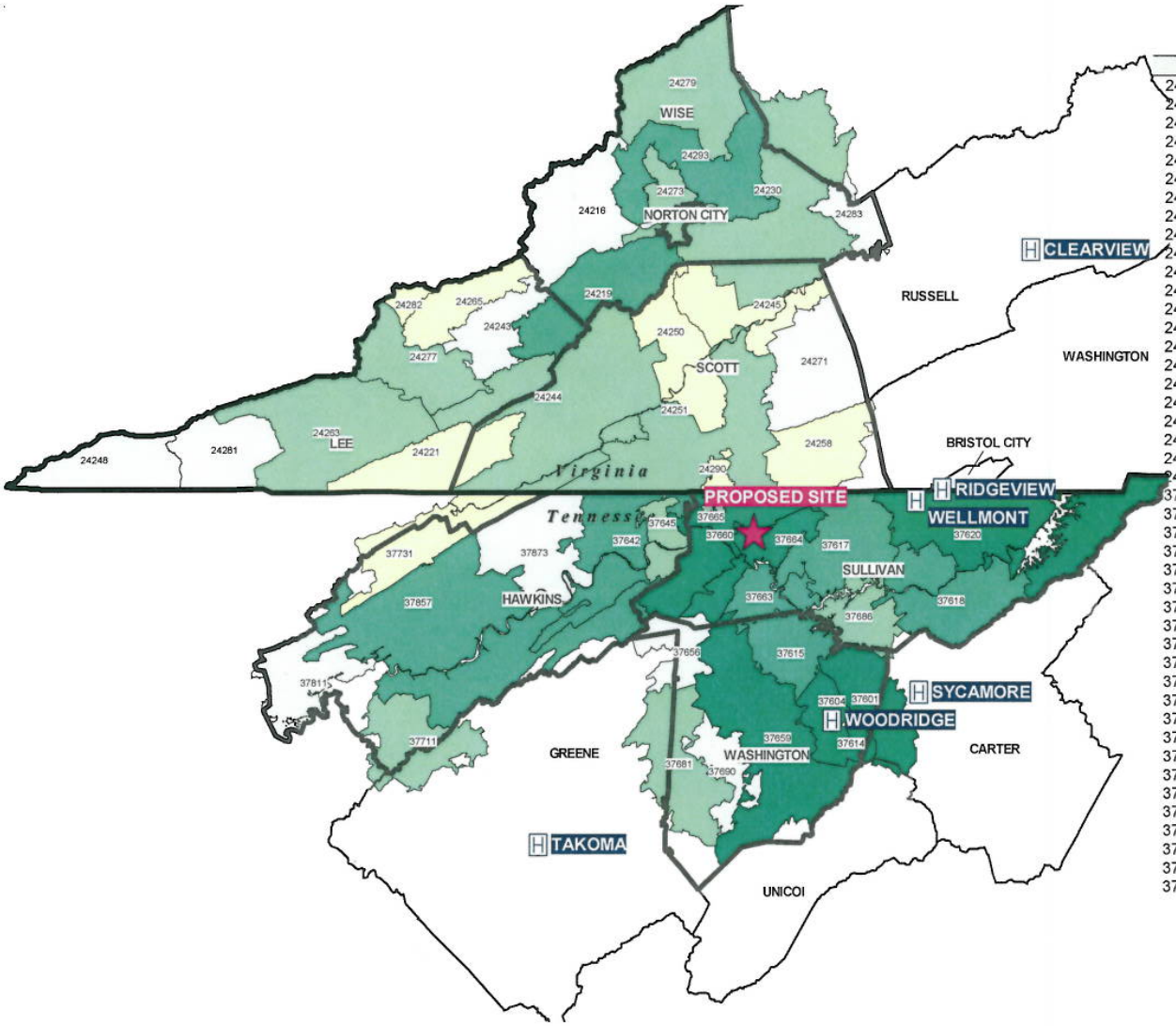
Fred E. Markowitz is associate professor in the Department of Sociology at Northern Illinois University and a member of the NIMH Chicago Consortium for Stigma Research. His research interests include stigma and mental illness, social control, and college campus crime. His recent publications have appeared in *Schizophrenia Bulletin*, *Mental Health Services Research*, and *Journal of Health and Social Behavior*.

SBH-KINGSPORT 002590

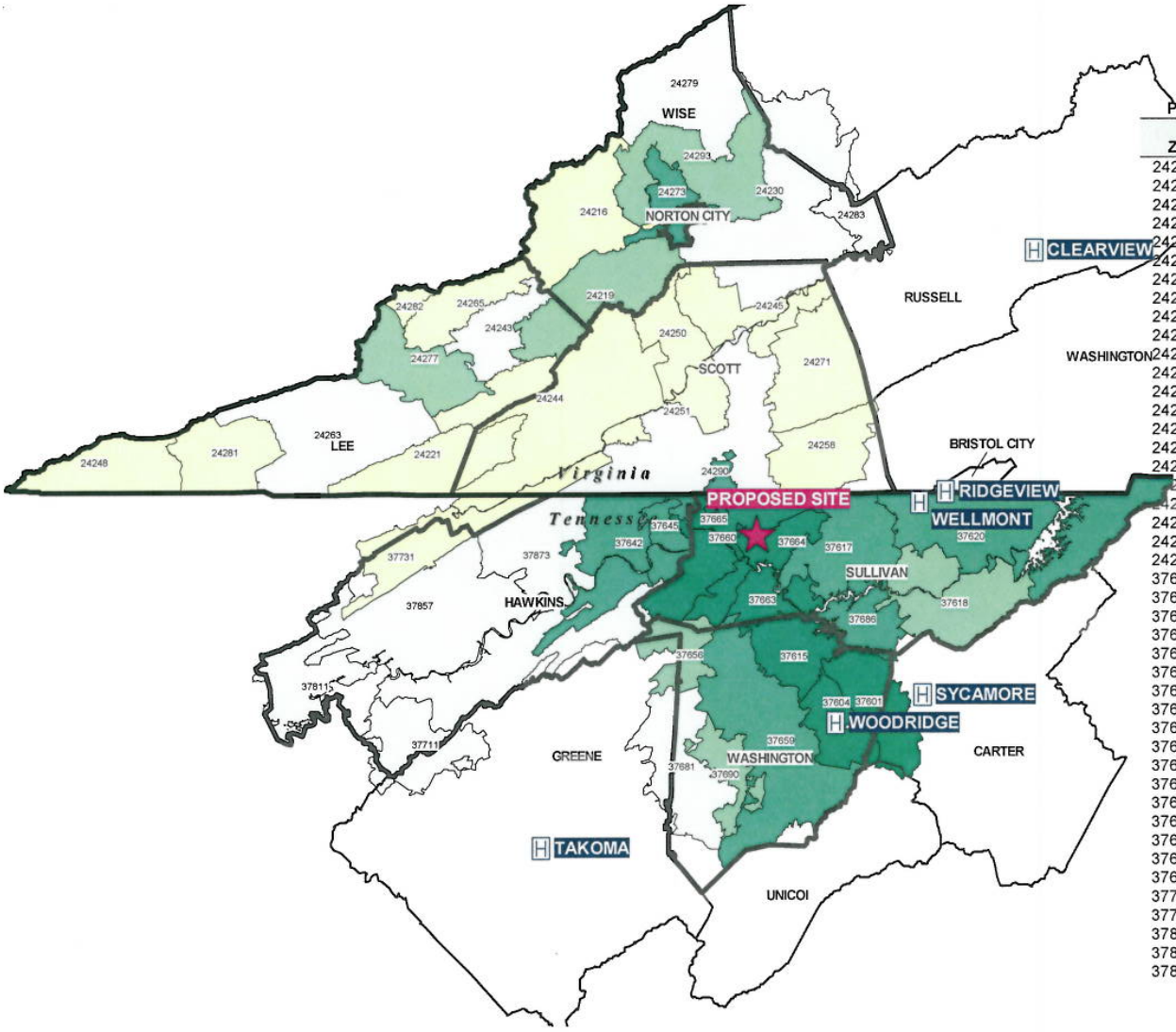
2014 Total Population by ZIP Code
SBH Proposed Service Area and Washington County



2014 POPULATION	
ZIP	VOL
24216	2,845
24219	11,423
24221	1,132
24230	9,662
24243	2,294
24244	5,730
24245	1,084
24248	2,567
24250	1,298
24251	8,671
24258	1,530
24263	6,506
24265	1,269
24271	2,737
24273	6,162
24277	7,320
24279	5,299
24281	2,273
24282	307
24283	2,224
24290	1,895
24293	10,791
37601	37,101
37604	35,554
37614	1,329
37615	20,199
37617	13,729
37618	12,985
37620	38,968
37642	14,604
37645	5,867
37656	3,720
37659	28,995
37660	40,428
37663	14,766
37664	26,550
37665	5,227
37681	6,274
37686	7,243
37690	4,426
37711	5,032
37731	758
37811	3,275
37857	20,594

Source: Claritas, 2014.

2014 Population Density
SBH Proposed Service Area and Washington County



ZIP	2014 POP DENSITY PER SQ. MI.
24216	38
24219	158
24221	19
24230	67
24243	65
24244	34
24245	22
24248	49
24250	24
24251	74
24258	31
24263	58
24265	34
24271	40
24273	222
24277	139
24279	64
24281	47
24282	41
24283	97
24290	315
24293	139
37601	782
37604	1,085
37615	558
37617	234
37618	183
37620	310
37642	227
37645	312
37656	130
37659	224
37660	648
37663	569
37664	786
37665	1,880
37681	96
37686	227
37690	170
37711	92
37731	14
37811	71
37857	99
37873	64

Note: ZIP Code 37614 is a P. O. Box; and, therefore is not included on the map.
Source: Claritas, 2014.

Smoot, Melissa

From: Mike Garone <mgarone@strategicbh.com>
Sent: Wednesday, December 11, 2013 2:46 PM
To: West, Bill
Subject: Financing Letter

Do we need the original signed letter on letterhead, or will a scanned pdf be acceptable?

Mike Garone
Director of Development
Strategic Behavioral Health
Office (901) 969-3100
Cell (901) 277-6522
www.strategicbh.com

P-0036

Strategic Behavioral Health
Office (901) 969-3100
Cell (901) 277-6522
www.strategicbh.com

From: Laura Miller [mailto:lauramiller@is3p.com]
Sent: Wednesday, November 06, 2013 4:58 PM
To: Mike Garone
Cc: 'Jill Sullivan'; 'Chris Reid'; 'Jim Shaheen'
Subject: RE: Kingsport TN CON Application

Mike-
Attached is the project description for Section B - Question II-A. Please let me know if any additional information needs to be included.
I'm working on the square footage calculations and will coordinate with Chris Reid to complete the chart and get it to you early next week.

From: Mike Garone [mailto:mgarone@strategicbh.com]
Sent: Monday, November 04, 2013 12:50 PM
To: Laura Miller
Cc: 'Jill Sullivan'; 'Chris Reid'; 'Jim Shaheen'
Subject: RE: Kingsport TN CON Application

Thank you Laura. I have received your email with the renderings and will include them with the CON Application; however there is more information that will be needed in addition to the renderings. I want to make sure everyone has had the chance to review the information that was sent on 10/31 prior to the call, so I am including it again below and attached. Our CON Attorney will be on the call as well, so he can clarify specifics and answer questions.

Hello Chris and Jill,

I am writing in order to ask for your assistance in the Tennessee CON Application (attached) for our Kingsport, TN Project. 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. We are also working under a very tight timeline. Our attorney is recommending that we get our application filed on Friday, November 8th, so as you can imagine we are scrambling to get everything put together in time. As far as what I am asking of you, there are items within the application that pertain to construction that I need help with. Please reference the attached application for the following:

****THIS PROJECT WILL BE THE 72 BED FACILITY****

1. *Page 9 – Section B – Question II – A*
2. *Page 10 – Square Footage & Cost Per Square Footage Chart*
3. *Page 12 – Section B – Question III – A*
    a. *This is something that I will need to have put together once a site is identified. In the meantime can you please send me the renderings and maybe include the physical layout of the structure at one of our other facilities.*
4. *Page 14 – Bullet 3*
5. *I have filled out most of page 15 based on the College Station Budget, but please verify.*

I have attached a completed application for you to look at and reference. Pages 27, 31, and 89.

Our timeline has been pushed back, but we still need to get this section of the CON Application completed ASAP. Talk with you soon.

Mike Garone
Director of Development
Strategic Behavioral Health
Office (901) 969-3100
Cell (901) 277-6522
www.strategicbh.com

From: Laura Miller [mailto:lauramiller@ls3p.com]
Sent: Monday, November 04, 2013 11:22 AM
To: 'Mike Garone'
Cc: Jill Sullivan; Chris Reid
Subject: RE: Kingsport TN CON Application

Mike-

In preparation for our conference call later this afternoon, I'm going to send you the renderings that we did for the College Station project. Let me know if that's what you need for the CON application for Kingsport. The files are large so they will be sent via our dropbox. You will receive a separate email in a few minutes with a link and instructions for downloading.

Laura L. Miller AIA, LEED AP
Principal | Studio Leader

LS3P ENGAGE DESIGN TRANSFORM

2528 Independence Boulevard, Suite 200, Wilmington, NC 28412 910.397.3636 (DIR) 910.409.1105 (CELL)
CHARLESTON | COLUMBIA | GREENVILLE | CHARLOTTE | RALEIGH | WILMINGTON

Connect with us: LS3P Knowledge Center Facebook Twitter LinkedIn
If you are sending file(s) please use our Info Exchange Site or our Dropbox.

CELEBRATING 50 YEARS ■ 1963-2013

From: Chris Reid [mailto:creid@thomasconstructiongroup.com]
Sent: Friday, November 01, 2013 1:53 PM
To: Laura Miller
Cc: Chris Boney; 'Mike Garone'; Jill Sullivan
Subject: FW: Kingsport TN CON Application
Importance: High

Laura –
See below and attached. There are portion of this CON that we may be able to be adapted from previous information created on other projects..but, we need some help pulling it together next week.

Can you review this and we would like to have a conference call on Monday mid morning, if possible.

Please let us know –

Chris

From: Mike Garone [mailto:mgarone@strategicbh.com]
Sent: Thursday, October 31, 2013 4:45 PM
To: Chris Reid; Jill Sullivan
Cc: 'Jim Shaheen'
Subject: Kingsport TN CON Application
Importance: High

Hello Chris and Jill,

I am writing in order to ask for your assistance in the Tennessee CON Application (attached) for our Kingsport, TN Project. 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. We are also working under a very tight timeline. Our attorney is recommending that we get our application filed on Friday, November 8th, so as you can imagine we are scrambling to get everything put together in time. As far as what I am asking of you, there are items within the application that pertain to construction that I need help with. Please reference the attached application for the following:

THIS PROJECT WILL BE THE 72 BED FACILITY

1. Page 9 – Section B – Question II – A
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4. Page 14 – Bullet 3
5. I have filled out most of page 15 based on the College Station Budget, but please verify.

I have attached a completed application for you to look at and reference. Pages 27 , 31, and 89.

I know this is a lot to ask in a short period of time. Once you have had a chance to review this information please call me to discuss.

Thank you,

Mike Garone
Director of Development
Strategic Behavioral Health
Office (901) 969-3100
Cell (901) 277-6522
www.strategicbh.com

SBH Proposed Site in Comparison to Indian Path Pavilion

Source: MapQuest.

EXHIBIT
376 7/28/15
SBH - Kingsport
PENGAD 800-631-6989

Mike Garone

From:	Mike Garone
Sent:	Thursday, January 23, 2014 9:27 AM
To:	lucretia.sanders@tn.gov
Subject:	Strategic Behavioral Health
Attachments:	SBH Kingsport - Letter of Support Template.docx; CBS Kristy Beach Callebs - Letter of Support.pdf; CBS Harold Leonard - Letter of Support.pdf; CBS Cheri Baird - Letter of Support (color).pdf
Importance:	High

Good morning Mrs. Sanders,

***I have been having emails bounced back to me recently, so I am including a "read receipt" to make sure you have received this email.

I am sorry that both times I called you were unavailable, but I hope that this email will provide you with all of the information that you will need to get the Letter of Support written and sent out to me as soon as possible. As you recall in our meeting we are in the process of applying for a Certificate of Need to build a 72 bed psychiatric hospital in Kingsport, TN. We have chosen to not be in Johnson City as to avoid a political war with Mountain States. We have confirmed there is a significant need within your community and have taken your recommendation to make the majority of our beds allocated towards child and adolescent services. Out of the 72 beds, the breakdown is as follows, 28 child & adolescent, 18 adult, 16 geriatric, 10 substance abuse detox. We are extremely excited to be able to bring the kids of your community home to receive services. I have attached a sample letter of support and some examples written by outpatient therapists that goes over some of the items you might want to include. Specifically what I would focus in on are points pertaining to facilities being at capacity, kids having to leave their communities to access services, the emergency departments not being an appropriate place to treat mental illness, the ability to place emphasis on continuity of care when not having to send kids to Chattanooga, Knoxville and sometimes as far as Memphis.

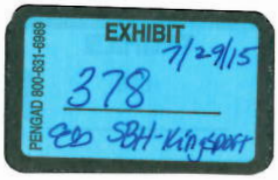
Once the letter is on letterhead and signed please scan (mgarone@strategicbh.com) or fax (901-969-3120) it to me as well as send the hard copy in the mail to:

Mike Garone
Strategic Behavioral Health
8295 Tournament Drive, Suite 201
Memphis, TN 38125

I very much appreciate your support and commitment to bringing much needed mental health resources to the youth of your community. If you have any questions about the letter please contact me on my cell phone.

All the best,

Mike Garone
Director of Development
Strategic Behavioral Health
Office (901) 969-3100
Cell (901) 277-6522
www.strategicbh.com



P-0205

Report on

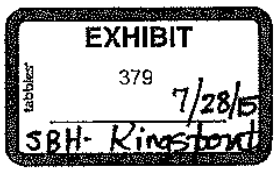
Livingston Regional Hospital
CON Project No. CN0606-042

Certificate of Need Application
To Develop a 10-Bed Geropsychiatric Unit
in
Livingston, Overton County, Tennessee

Prepared by

Daniel J. Sullivan
Sullivan Consulting Group, Inc.

February 2007



Introduction

This report will examine the Certificate of Need (CON) proposal submitted by Livingston Regional Hospital ("LRH") (CN-#0606-042) to convert 10 medical/surgical beds to 10 adult psychiatric beds targeting individuals age 65 and older. LRH is located in Livingston, Overton County, and currently does not offer inpatient psychiatric services.

The project was approved by Tennessee Health Services and Development Agency in September 2006. This decision was appealed by White County Community Hospital ("WCCH"), an existing provider of geropsychiatric services, and is pending an administrative hearing.

This report will evaluate the historical utilization of inpatient geropsychiatric services on the Cumberland Plateau, which encompasses the area proposed to be served by LRH, and the need for additional geropsychiatric beds in light of population and utilization trends, the ability of LRH to achieve the utilization levels set forth in the application, consistency with the CON criteria for psychiatric inpatient services, and the potential impact of the project on existing providers.

Based on these analyses and information, the report will conclude with an evaluation of the project's consistency with required findings in the Tennessee Certificate of Need (CON) criteria.

- Need
- Contribution to the orderly development of health care, and
- Economic feasibility.

SBH-KINGSPORT 002600

Livingston Regional Hospital's Proposed Service Area

The CON application defined the service area for LRH as Overton, Cumberland, Putnam, and Fentress. There was no specific data presented in the CON application to support this service area definition. Exhibit 1 presents a map of the proposed service area for the geropsychiatric program.

Exhibit 1: Livingston Regional Hospital Proposed Service Area

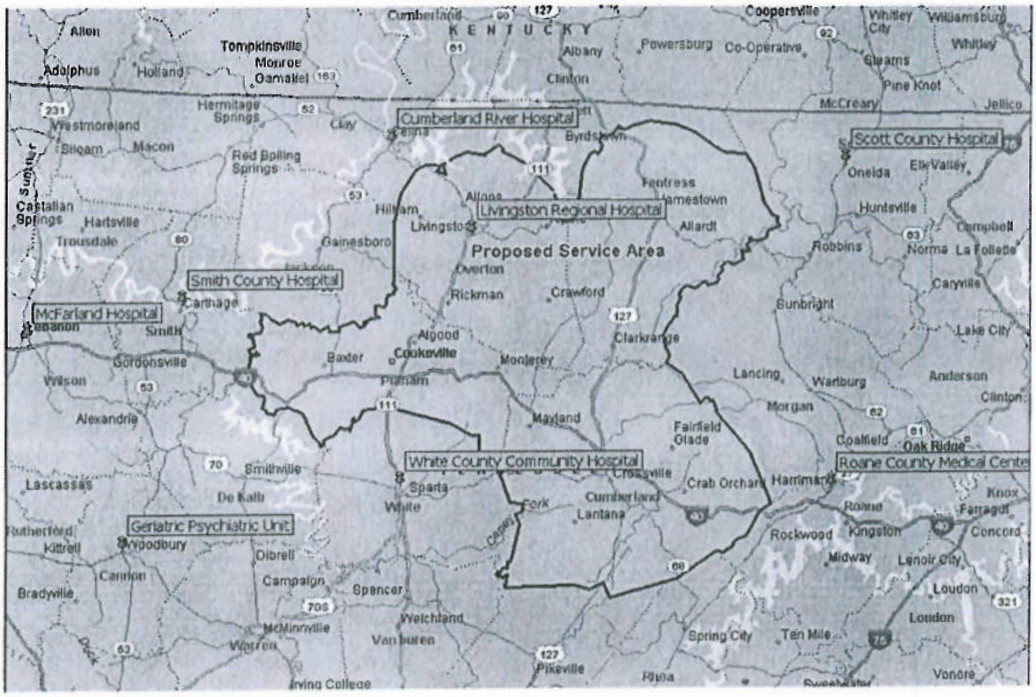


Exhibit 2 displays patient origin data for acute care patients served by LRH from its 2005 Joint Annual Report. These data portray a different service area from which LRH has drawn patients historically than the proposed service area in the LRH application. First, Cumberland County provided only one patient to inpatient discharge to LRH in 2005 and there is no reason to expect geropsychiatric patients to travel to Livingston rather than to other, more accessible facilities. Second, patients from Clay, Pickett, and Jackson Counties represent a meaningful percentage of the historical discharges of the hospital and these counties should be included. In fact, each of these three counties provided a greater percentage of LRH's inpatient discharges than Fentress or Cumberland County, which were included in the proposed geropsychiatric service area by LRH. Exhibit 3 is a map that reflects the historical service area for LRH, and this area would be more appropriate to employ than LRH's geropsychiatric service area in evaluating the need for this project.

SBH-KINGSPORT 002601

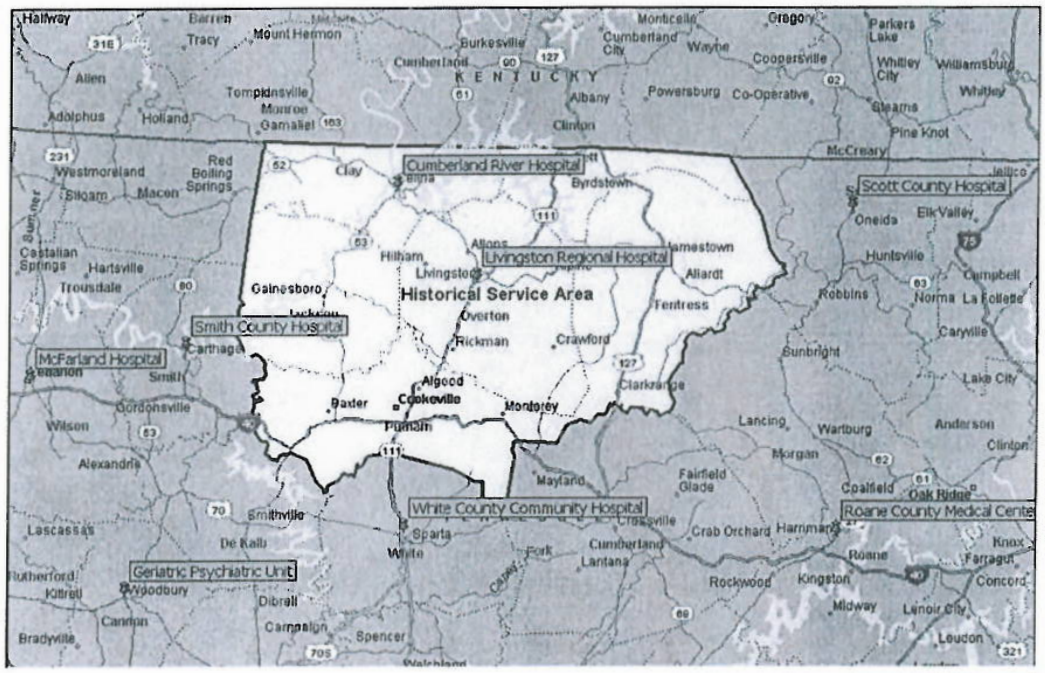
Exhibit 2
Livingston Regional Hospital
2005 Discharges by County

County	Cases	% of Total	Cumulative %
Overton	1,892	57.0%	57.0%
Putnam	466	14.0%	71.0%
Pickett	443	13.3%	84.3%
Clay	234	7.0%	91.4%
Jackson	140	4.2%	95.6%
Fentress	118	3.6%	99.1%
White	11	0.3%	99.5%
Macon	6	0.2%	99.6%
Smith	4	0.1%	99.8%
Cannon	1	0.0%	99.8%
Cumberland	1	0.0%	99.8%
Dekalb	1	0.0%	99.8%
Hamilton	1	0.0%	99.9%
Morgan	1	0.0%	99.9%
Scott	1	0.0%	99.9%
Sevier	1	0.0%	100.0%
Trousdale	1	0.0%	100.0%
Total	3,322	100.0%	

Source: Tennessee Department of Health, JAR-H

SBH-KINGSPORT 002602

Exhibit 3 – Livingston Regional Hospital Historical Service Area



The *Guidelines for Growth* set forth the following standards for determining the service area for psychiatric services:

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.**

The service area definition proposed by LRH fails to meet the standard that the service area be reasonable and based on an optimal balance between population density and service proximity. It is unreasonable to include Cumberland County, which LRH has no history of serving, in its proposed service area. As will be discussed, in the following section, there is ready access to existing geropsychiatric units in each of the counties in LRH's proposed service area. Residents of Cumberland County, in particular, would have easier access to units in White and Roane Counties than to a unit located in Livingston.

SBH-KINGSPORT 002603

The second standard relates to the socio-demographics of the service area, and as will discussed below, there is minimal growth in the proposed service area to support another geropsychiatric unit. Overton County has the fewest elderly residents in the proposed service area and smallest projected growth in this population.

Finally, there is no documented need for a new unit to accommodate patients needing services involuntarily, and LRH's commitment to serve such patients is unclear from the materials submitted to the HSDA. As Becki Poling, Department of Mental Health and Developmental Disabilities wrote in her memorandum dated August 28, 2006, commenting on the LRH project:

> *To ascertain whether there may be a need for geropsychiatric beds in the proposed service area that could serve elderly persons in need of emergency involuntarily hospitalization, I looked at the number of admissions age 65 and older from both the proposed service area and the other four counties in the Cumberland Plateau to the Moccasin Bend Mental Health Institute (MBMHI), the state operated mental health hospital that serves this area. During FY 06, there were 4 admissions age 65 and older to MBMHI from the proposed service area and none from the other 4 counties. This suggests that the needs of the elderly population in this area are being adequately met by the existing geropsychiatric beds in or near the region.*

The LRH proposed service area is inconsistent with these standards. The historical service area of LRH would be a better representation of the area from which LRH would likely draw patients for its proposed geropsychiatric unit. This analysis will focus primarily on the LRH historical service area but will also consider the proposed four-county area that LRH presents in this application.

Overview of Geropsychiatric Services on the Cumberland Plateau

LRH is located in an area between Nashville and Knoxville that is often referred to as the Cumberland Plateau. This area has a number of hospitals offering geropsychiatric services similar to those proposed by LRH. The following Exhibit 4 summarizes the hospitals with geropsychiatric units serving this region and their utilization in 2004 and 2005 based on data reported in the Joint Annual Report of Hospitals. Only the units at White County Community Hospital and Smith County Hospital were utilized at 75% or greater in 2004 and 2005. Of the reporting programs, Cumberland River Hospital, Roane County Hospital, and Stones River Hospital were operating at lower rates. Overall, there is available capacity to serve additional geropsychiatric patients in the region.

Exhibit 5 presents a map of these existing geropsychiatric units.

SBH-KINGSPORT 002604

Exhibit 4
Historical Utilization of Geropsychiatric Services in the Cumberland Plateau Area

2005		Geropsychiatric Services				
Hospital	County	Licensed Beds	Patients	Patient Days	ALOS	Occupancy
Cumberland River Hospital	Clay	8	123	1,141	9.3	39.1%
McFarland Hospital	Wilson	15	-	-	-	-
Roane County Hospital	Roane	8	193	1,750	9.1	59.9%
Scott County Hospital	Scott	-	-	-	-	-
Smith County Hospital	Smith	10	236	2,779	11.8	76.1%
Stones River Hospital	Cannon	22	393	4,910	12.5	61.1%
White County Comm. Hospital	White	10	267	2,813	10.5	77.1%

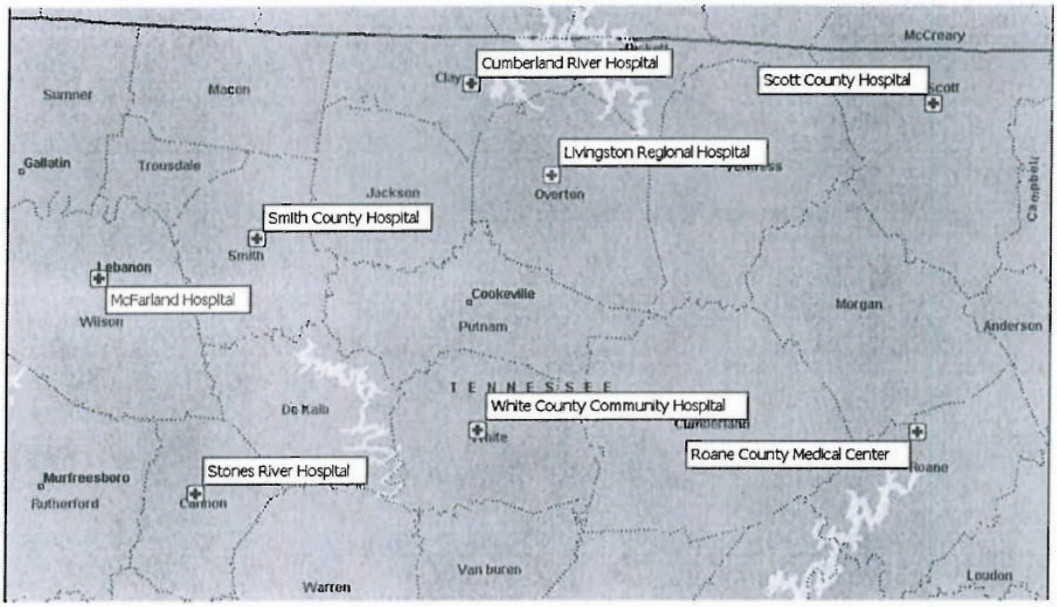
2004		Geropsychiatric Services				
Hospital	County	Licensed Beds	Patients	Patient Days	ALOS	Occupancy
Cumberland River Hospital	Clay	8	113	1,071	9.5	36.7%
McFarland Hospital	Wilson	15	-	-	-	-
Roane County Hospital	Roane	8	157	1,302	8.3	44.6%
Scott County Hospital	Scott	10	37	297	8.0	8.1%
Smith County Hospital	Smith	10	253	2,751	10.9	75.4%
Stones River Hospital	Cannon	22	390	4,388	11.3	54.6%
White County Hospital	White	10	259	2,783	10.7	76.2%

Note: McFarland Hospital did not report utilization data

Source: JAR-H data

SBH-KINGSPORT 002605

Exhibit 5: Geropsychiatric Units in the Cumberland Plateau Area



As the map indicates, there a numerous geropsychiatric units already serving this area and are located in close proximity to LRH's service area.

- Cumberland River Hospital in Celina, Clay County, operates an 8-bed geropsychiatric unit and is located within LRH's service area. Clay County adjoins Overton County where LRH is located.

- Smith County Memorial Hospital is located in Carthage, Smith County, and operates a 10-bed geropsychiatric unit. Smith County is adjacent to Jackson and Putnam Counties.

- White County Community Hospital is located in Sparta, White County, and operates a 10-bed geropsychiatric unit adjacent to Putnam and Cumberland Counties.

- Roane County Medical Center is located in Harriman, Roane County, and operates an 8-bed geropsychiatric unit. Roane County is adjacent to Cumberland County.

- Scott County Hospital is located in Oneida, Scott County, and operates a 10-bed geropsychiatric unit. Scott County is contiguous to Fentress County.

- There are two larger geropsychiatric programs at Stones River Hospital (22 beds) in Cannon County and McFarland Hospital (15 beds) in Wilson County located west of the LRH service area that provide additional access to geropsychiatric services for residents of this area.

SBH-KINGSPORT 002606

There are no apparent geographic accessibility problems for residents of LRH's service area who require inpatient geropsychiatric services.

LRH Service Area Population

The proposed geropsychiatric program at LRH would serve primarily patients age 65 and older. Exhibit 6 presents the estimated and projected population age 65 and older in the historical service area in 2005 through 2010. The service area had an estimated elderly population of 18,791 in 2005, which is expected to grow to 20,997 by 2010. While the elderly population is growing, the absolute growth is relatively small with an overall increase of only 2,206 elderly residents over the five-year period.

Exhibit 6
LRH Service Area Population Age 65 and Over

	2005 Population 65+	2010 Population 65+	Incremental Change 2005-10	CAGR 2005 - 2010
Clay	1,357	1,517	160	2.3%
Fentress	2,556	3,004	448	3.3%
Jackson	1,708	1,860	152	1.7%
Overton	3,310	3,569	259	1.5%
Pickett	973	1,064	91	1.8%
Putnam	8,887	9,983	1,096	2.4%
Grand Total	**18,791**	**20,997**	**2,206**	**2.2%**

Source: Tennessee Department of Health

SBH-KINGSPORT 002607

Need for an Geropsychiatric Beds at LVH

Applicant's Statement of Need

LRH asserts that this project is needed to address the following concerns:

1. There are no geropsychiatric units in the service area proposed by LRH.

2. The elderly population of this 4-county service area is the largest concentration of elderly residents on the Cumberland Plateau and its two largest counties have large medical centers and are becoming popular retirement areas.

3. Geropsychiatric unit utilization in White County, with a service area of similar demographics that will overlap the project, indicates that the LRH unit will meet a strong area need for inpatient care.

4. Available planning formulas also indicate need.

Each of these concerns will be addressed in the following sections.

1. No Geropsychiatric Units in LRH Proposed Service Area

While it is correct that there are no geropsychiatric units in the four-county area proposed by LRH, this service area does not present a reasonable basis for assessing the need for this project. LRH's historical service area, which includes Overton, Clay, Fentress, Jackson, Putnam, and Pickett counties, does include an 8-bed geropsychiatric hospital at Cumberland River Hospital in Celina. Of equal importance, there are other existing geropsychiatric units located in counties that border the LRH service area that are also addressing the needs of this population.

As discussed previously, during the review of the application the Health Services and Development Agency sought input from the Tennessee Department of Mental Health and Developmental Disabilities (TDMHDD) regarding the need for the LRH project. Becki Poling, the Director of Hospital Services at TDMHDD, submitted a memorandum dated August 28, 2006, that set forth her opinions regarding the proposed LRH project after reviewing the application. The following statements are excerpted from her memorandum:

> *Based on Department of Health 2010 population estimates for individuals age 65 and older, there is need for 8.7 geropsychiatric beds in the four county service area identified by the applicant (Cumberland, Fentress, Overton, and Putnam Counties). Currently there are no geropsychiatric or general psychiatric beds in these counties. However, there are two hospitals in Clay and White Counties, adjacent to the proposed service area, that do operate small geropsychiatric units, with a total of 18 beds. When the population age 65 and older for the four counties is combined with the population age 65 and older in the other four counties on the Cumberland Plateau (Pickett, Clay, White, and Jackson*

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Counties), the HSDA formula indicates a need for 11.2 geropsychiatric beds. It would appear that this need could be met by the existing 18 beds.

The applicant states that it is not aware of any geropsychiatric beds between Livingston and Knoxville. However, there is an 8-bed geropsychiatric unit at Roane Medical Center in Harriman, which is between Crossville and Knoxville, and a 10-bed geropsychiatric unit at Scott County Hospital in Oneida, which is just east of Fentress County. The applicant acknowledges that there are also 10 geropsychiatric beds in Smith County, just to the west of the proposed service area. In addition, but further from the proposed service area, there are 20 geropsychiatric beds in Cannon County and 15 geropsychiatric beds at McFarland Hospital in Wilson County. It is likely that some of the geropsychiatric units currently serve individuals from the proposed service area...

In conclusion, based on the number of geropsychiatric beds currently available in the counties adjacent to the proposed service area and based on 30 beds per 100,000 population for determining need, it appears that there are sufficient existing resources to meet the need for inpatient geropsychiatric services on the Cumberland Plateau.

These comments underscore the availability of geropsychiatric services to the population LRH proposes to serve. These other providers were given no consideration in the application submitted by LRH.

2. Concentration of Elderly Population in the Proposed Service Area

LRH argues in its application that its proposed service area has the highest concentration of elderly population on the Cumberland Plateau. The problems with LRH's definition of its service area were discussed previously. Within the four-county area proposed by LRH, the significantly majority of elderly residents (78.7%) are in two counties: Cumberland and Putnam. Overton County, the proposed site of the project, will represent only 11.8% of the 65 and older population in 2010. These percentages are displayed in Exhibit 7. Cumberland County is immediately adjacent to two counties with geropsychiatric programs: White and Roane. Similarly, Putnam County is contiguous to White and Smith Counties, each of which has a geropsychiatric unit. Each county in the four-county service area has at least one county with a geropsychiatric program adjoining it. There is no "concentration" of elderly residents that does not have already have access to geropsychiatric care.

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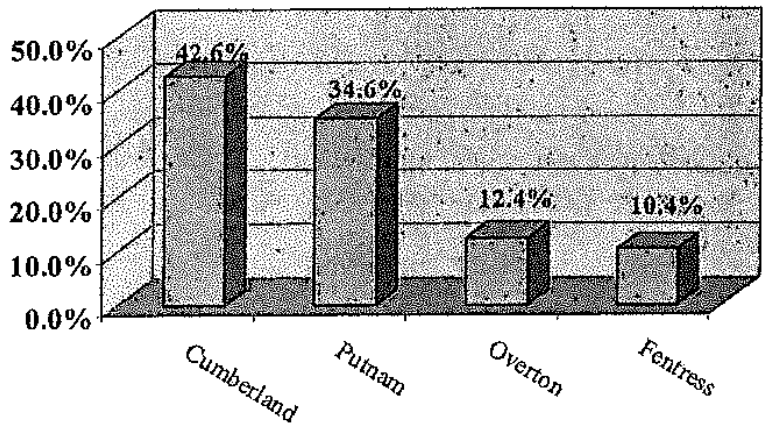
Exhibit 7
2010 LRH Proposed Service Area Population
County % of Total 65+ Population



Source: Tennessee Department of Health

The related argument raised by LRH that this four-county area is becoming a popular retirement area does not support the approval of the project. As seen in Exhibit 8, the overall incremental growth in the 65 and older population is small in the proposed service area. Overton County is projected to have the lowest incremental increase in elderly residents with only 259 additional elderly residents projected during the five-year period from 2005 to 2010. This small increase in elderly residents will not significantly impact on the need for geropsychiatric beds in the future.

Exhibit 8
LRH Proposed Service Area
Incremental Population Growth

County	2005 Population 65+	2010 Population 65+	Incremental Change 2005-10
Cumberland	10,863	12,311	1,448
Putnam	8,887	9,983	1,096
Overton	3,310	3,569	259
Fentress	2,556	3,004	448
Grand Total	25,616	28,867	3,251

Source: Tennessee Department of Health

The population in the historical service area of LRH is even smaller than the four-county area since Cumberland County, the largest county, is excluded. Exhibit 6 previously presented population projections for the LRH historical service area and indicated that the service area population will only increase by 2,206 elderly residents over the five-year period.

3. Experience of White County Community Hospital's Unit as an Indicator of Need

LRH argues that geropsychiatric unit utilization in White County, with a service area of similar demographics that will overlap the project, indicates that the LRH unit will meet a strong area need for inpatient care. To the contrary, the presence of existing programs at White County Community Hospital and other adjacent counties will limit the ability of LRH to capture geropsychiatric unless it does so by adversely affecting these existing providers.

Exhibit 9 presents the patient origin data for White County Community Hospital's geropsychiatric unit for the two most recent years. The counties in LRH's historical service area are shaded in yellow. In 2006, counties in the historical service area of LRH contributed 53.5% of White County Community Hospital discharges. Since population growth is projected to be modest in the LRH service area, if LRH were to begin to serve the majority of the geropsychiatric patients from its historical service area, White County Community Hospital would experience a significant and long-lasting reduction in its volume of geropsychiatric patients.

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Exhibit 9
White County Community Hospital
Geropsychiatric Discharges by County

	2005		2006	
County	Discharges	% of Total	Discharges	% of Total
Putnam	69	25.7%	81	33.5%
White	63	23.4%	54	22.3%
Cumberland	45	16.7%	41	16.9%
Other Counties	45	16.7%	21	8.7%
VanBuren	13	4.8%	17	7.0%
Fentress	10	3.7%	8	3.3%
Warren	7	2.6%	8	3.3%
Overton	10	3.7%	7	2.9%
DeKalb	1	0.4%	3	1.2%
Bledsoe	3	1.1%	2	0.8%
Clay	1	0.4%	-	0.0%
Jackson	2	0.7%	-	0.0%
Grand Total	269	100.0%	242	100.0%

The overlap of the White County Community Hospital geropsychiatric service area and the historical service area of LRH is displayed graphically in Exhibit 10. The area of overlap is in Putnam County, which provided the greatest number of geropsychiatric patients to White County Community Hospital in both 2005 and 2006. LRH claimed Cumberland County as part of its service area in its application, and for reasons cited previously, there is basis to support this claim. Cumberland County was third largest source of geropsychiatric patients to White County Community Hospital, and the extent to which LRH would be successful in attracting patients from this county, the utilization of White County Community Hospital would likely be diminished.

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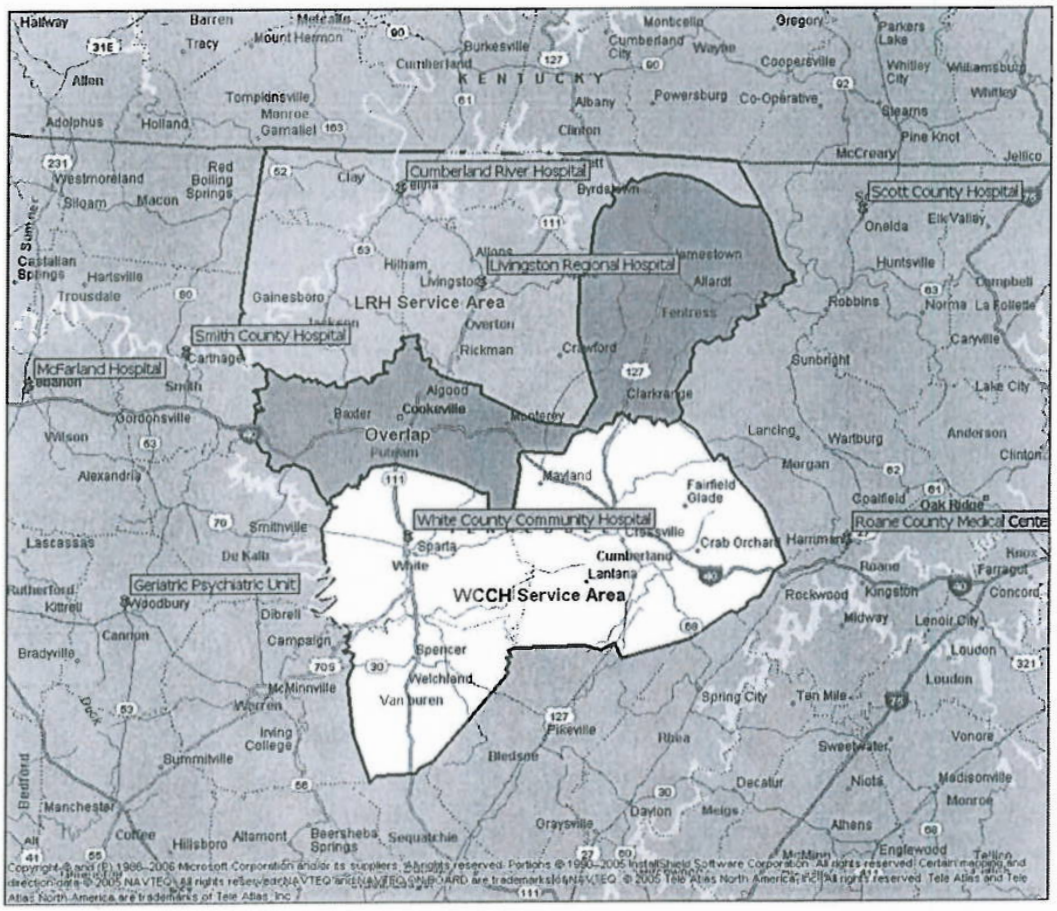
Exhibit 10
Overlap of White County Community Hospital Geropsychiatric Service Area
With Historical Service Area of Livingston Regional Hospital



While patient origin data are not available for other geropsychiatric providers, it is reasonable to expect that in the case of providers located in counties that are in or adjoin the historical service area of LRH (Smith County Hospital, Scott County Hospital, and Cumberland River Hospital) that there would be reduction in volume as well. Since the majority of elderly residents in LRH's historical service area are not in Overton County, this adverse impact would be imposed on existing providers without a material improvement in access to care for the residents of the service area.

4. Need Under Available Planning Formula

LRH employed different projection methodologies in an effort to document the numerical need for its proposed addition of 10 geropsychiatric beds. The calculations included:

- Application of the formula in the *Guidelines for Growth* of 30 psychiatric beds per 100,000 population to the projected population of the proposed four-county service area, which resulted in projected need of 8.7 beds. The application states that "a 10-bed geropsychiatric unit in this 4-county area is generally supported by the State Guideline, applied in a pragmatic way."

- Use of a methodology that LRH contends was in a recently approved application by Woods Memorial Hospital based on national admission data of 14 admissions per 1,000 geriatric population. Based on the four-county service area population, this methodology resulted in a need for 17.7 geropsychiatric beds.

- Geropsychiatric admission rates by county based on data from the Tennessee Hospital Association for residents of the four-county area that when applied to the 2010 elderly population of the four-county service area resulted in a projection of 307 admissions, which is less than the 404 admissions projected using the national admission rate of 14 per 1,000 elderly population. A review of these data yielded other observations by LRH:

    - Admission rates per 1,000 elderly population ranged from 8.1 in Pickett County to 35.6 in Clay County. Overton County had an admission rate of 17.0, which was higher than most of the other counties.

    - Admission rates in many Cumberland Plateau counties are low because of lack of knowledge about, and access to, geropsychiatric programs.

    - Livingston is well placed to serve the geropsychiatric needs in Overton and the three adjacent counties.

- A fourth approach involved interviews with Sunstone Behavioral Health, which manages the geropsychiatric unit in White County. The White County Community Hospital's 10-bed unit served 89 patients from the four-county service area during the first five months of 2006, which annualizes to 214 admissions annually. Based on this number and expected growth using the above methodologies, there will be from 72 to 169 additional admissions in the four-county area by 2010.

There are a number of problems with each of these need calculations by LRH. The fundamental flaw in each analysis is the reliance on the proposed four-county service area. The inclusion of Cumberland County, which LRH has no history of serving, skews each of the projections in the application. Each of the projection methodologies identified by LRH has been re-evaluated in light of LRH's historical service area of Overton, Clay, Fentress, Jackson, Pickett, and Putnam, and, in certain cases, more appropriate utilization data.

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Formula in Guidelines for Growth

As the applicant noted, the *Guidelines for Growth* set forth the following methodology for determining the need for 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.**

The following Exhibit 11 summarizes the projected need for geropsychiatric beds in the LRH historical service area in 2005 and 2010 under the methodology in the *Guidelines for Growth.*

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Exhibit 11
Projected Need for Geropsychiatric Beds in LRH Historical Service Area
Guidelines for Growth Methodology

	2005 Population 65+	2010 Population 65+	Incremental Change 2005-10
Clay	1,357	1,517	160
Fentress	2,556	3,004	448
Jackson	1,708	1,860	152
Overton	3,310	3,569	259
Pickett	973	1,064	91
Putnam	8,887	9,983	1,096
Total Service Area	**18,791**	**20,997**	**2,206**
Target Beds per 100,000	30	30	30
Projected Gross Bed Need	**5.6**	**6.3**	**0.7**
Existing Beds:			
Cumberland River Hospital	8	8	
Net Bed Need	**(2.4)**	**(1.7)**	

These need projections indicate that there are sufficient beds at the Cumberland River Hospital in Clay County to meet the needs for geropsychiatric patients through 2010. In addition, the incremental growth in the population would support less than one additional bed, indicating that the elderly growth in the area has minimal impact on the need for geropsychiatric beds.

Need Based on National Admission Rate

The most optimistic methodology presented by LRH was based on a "national" admission rate of 14 per 1,000 population age 65 and over. No source was provided for this admission rate. Exhibit 12 presents the bed need projections using the same assumptions in the application, but substituting the population in LRH's historical service area. This methodology, which likely

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overstates the projected demand, reflects a net need for only 4.9 beds by 2010, less than half the number requested by LRH.

Exhibit 12
Projected Need for Geropsychiatric Beds in LRH Historical Service Area
National Use Rate Methodology

	2005 Population 65+	2010 Population 65+	Incremental Change 2005-10
Service Area Population	18,791	20,997	2,206
Admissions per 1,000	14	14	14
Projected Admissions	**263**	**294**	**31**
Projected ALOS	12	12	12
Projected Patient Days	3,157	3,527	371
Projected ADC	8.6	9.7	1.0
Target Occupancy Rate	75%	75%	75%
Projected Gross Bed Need	**11.5**	**12.9**	**1.4**
Existing Beds: Cumberland River Hospital	8	8	
Net Bed Need	**3.5**	**4.9**	

One source of national data is the National Center for Health Statistics' National Hospital Discharge Survey (NHDS), which collects data from all hospitals in the United States with lengths of stay of less than 30 days, general hospitals, and children's hospitals. These hospitals would include hospitals similar to LRH. The discharge rate per 1,000 elderly population is 7.39, which almost half of the rate employed by LRH in its application. Exhibit 13 presents the projected need using the NHDS discharge rate for mental health patients.

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Exhibit 13
Projected Need for Geropsychiatric Beds in LRH Historical Service Area
National Hospital Discharge Survey Discharge Rates

	2005	2010	Incremental Change 2005-10
Service Area Population 65+	18,791	20,997	2,206
Admissions per 1,000	7.39	7.39	7.39
Projected Admissions	**139**	**155**	**16**
Projected ALOS	12	12	12
Projected Patient Days	1,666	1,862	196
Projected ADC	4.6	5.1	0.5
Target Occupancy Rate	75%	75%	75%
Projected Gross Bed Need	**6.1**	**6.8**	**0.7**
Existing Beds: Cumberland River Hospital	8	8	
Net Bed Need	**(1.9)**	**(1.2)**	

Source: National Center for Health Statistics, National Hospital Discharge Survey, 2004 annual Summary with Detailed Diagnosis and Procedure Data

The result of this methodology is an excess of 1.2 geropsychiatric beds in the LRH historical service area in 2010, which approximates the results of the methodology using the *Guidelines for Growth* ratio of 30 beds per 1,000.

Need Based on THA Utilization Data

LRH identified admission rates for the four-county area from the Tennessee Hospital Association data system. The discovery materials provided by LRH contained sometimes conflicting discharge numbers for counties and not all counties in the LRH historical service area were included. Exhibit 14 presents the data obtained in discovery that appears closest to the information contained in the application and results in a projection of 310 geropsychiatric discharges in the proposed LRH service area in 2010 (compared to 307 admissions in the application). Since there were 276 discharges in 2005, there is projected increase of only 34

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geropsychiatric discharges in the proposed service area. This relatively small growth in demand is not indicative of the need for more geropsychiatric beds.

Exhibit 14
Projected Geropsychiatric Discharges in the Proposed LRH Service Area
Tennessee Hospital Association Discharge Data

County	2005 Discharges	2005 Population 65+	Utilization Rate	2010 Population 65+	2010 Projected Discharges	Incremental Growth
Cumberland	64	10,863	5.89	12,311	73	9
Fentress	39	2,556	15.26	3,004	46	7
Overton	49	3,310	14.80	3,569	53	4
Putnam	124	8,887	13.95	9,983	139	15
Grand Total	**276**	**25,616**	**10.77**	28,867	310	34

Source: LRH Discovery Documents, 01172

The same analysis was performed for LRH's historical service area, and the results are presented in Exhibit 15. These projections are very similar to those using the proposed four-county service area, with incremental growth of only 33 admissions between 2005 and 2010. While it is difficult to assess the reliability of these discharge data, overall this analysis does not document the need for any number of additional geropsychiatric beds in either the service area proposed in the application or the historical service area of LRH.

LRH went on to compare the results of this projection with the projection using the "national" rate of 14 admissions per 1,000 population age 65 and over. As discussed previously, there is no documentation of the validity of this national rate. Moreover, the most important consideration is the incremental growth in geropsychiatric patients since there is no apparent need for additional geropsychiatric beds today. There is insufficient incremental growth to support any additional beds.

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Exhibit 15
Projected Geropsychiatric Discharges in the Historical LRH Service Area
Tennessee Hospital Association Discharge Data

County	2005 Discharges	2005 Population 65+	Utilization Rate	2010 Population 65+	2010 Projected Discharges	Incremental Growth
Clay	34	1,357	25.06	1,517	38	4
Fentress	39	2,556	15.26	3,004	46	7
Jackson*	23	1,708	13.52	1,860	25	2
Overton	49	3,310	14.80	3,569	53	4
Pickett	8	973	8.22	1,064	9	1
Putnam	124	8,887	13.95	9,983	139	15
Grand Total	**277**	**18,791**	**14.75**	**20,997**	**310**	**33**

*Since data were not available for Jackson County, the average use rate for all other counties was assumed.

Source: LRH Discovery Documents, 01172

The application mixes the results of different projection methodologies based on unsupported data to estimate a broader range of incremental demand. These estimates in the application are not a basis for approving a new geropsychiatric program.

Conclusion on Need for Additional Geropsychiatric Beds

The foregoing analyses demonstrate that if a reasonable service area and reliable data sources are utilized, there is no demonstrated need for additional geropsychiatric beds at LRH. The area has available bed capacity and reasonable geographic access to existing programs.

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Contribution to the Orderly Development of Health Care

The approval of a new geropsychiatric program will necessarily result in a detrimental impact on the utilization of existing providers of geropsychiatric programs serving the counties LRH proposes to serve. White County Community Hospital received 53.5% of its geropsychiatric patients from counties in LRH's historical service area. If LRH is to achieve the projected utilization of the proposed unit in its application, it will need to redirect a significant percentage of these patients from White County Community Hospital.

While patient origin data are not available for other geropsychiatric programs that are proximate to the LRH service area, these programs would similarly be impacted. While every new program has an impact on existing providers, the question remains whether the proposed project will represent necessary or unnecessary duplication of existing resources. In this case, the application by LRH will unnecessarily duplicate such resources because:

- There is available, unused capacity in existing geropsychiatric beds serving this area
- There is insufficient growth in the area to support a new program without diminishing the utilization of existing programs
- Overton County has a small elderly population with minimal projected growth
- LRH has not documented any problems with patients accessing existing programs, including patients requiring involuntary admission
- LRH is not proposing any services that are not provided by other programs in the area.

Based on these factors, the only conclusion that can be reached is that the approval of a geropsychiatric program for LRH will not contribute to the orderly development of health care on the Cumberland Plateau.

Economic Feasibility.

The most important determinant of financial feasibility is the ability of the applicant to achieve the utilization projections in its application. The utilization projections in this application cannot be supported because:

- An inappropriate service area was used in developing the projections
- Certain projection methodologies were based on undocumented assumptions and other documented methodologies indicated no need for additional beds.
- There was no documentation of how LRH would redirect referrals from existing geropsychiatric programs serving the same counties LRH proposes to serve, many of which are closer to the population than LRH.

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Since the projected utilization presented in the application cannot be supported, there is no basis to conclude that the project will achieve economic feasibility. At the same time, the approval of this project will negatively affect the economic feasibility of the programs at White County Community Hospital and other programs serving the area.

SBH-KINGSPORT 002622

DANIEL J. SULLIVAN

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Atlanta, Georgia
(770) 551-9550

WORK EXPERIENCE:

1990 - Present	**President** Sullivan Consulting Group, Inc. Atlanta, Georgia
1988 - 1990	**Partner** Ernst & Young Atlanta, Georgia
1980 - 1988	**Vice President** Amherst Associates Inc. Atlanta, Georgia and Tampa, Florida
1974 - 1980	**Assistant Administrator** Private Diagnostic Clinic Duke University Medical Center Durham, North Carolina

EDUCATION:

Master in Health Administration
Duke University

A.B. in Economics and Public Policy Studies
Duke University

ORGANIZATIONS: Member, Various State Hospital Associations

PROFESSIONAL EXPERIENCE:

Development of strategic plans for multihospital systems and individual health care organizations throughout the United States.

Assistance in the preparation of Certificate of Need applications for the construction of new hospitals and nursing homes, ambulatory surgery centers, major renovations of existing facilities, conversion of beds to new services, introduction of specialty services and technology, and development of home care services.

Preparation of financial feasibility studies for projects involving hospitals, long-term care facilities, ambulatory surgery centers, assisted living facilities, and other health care facilities and services.

Facilitation of planning processes for the creation of integrated health delivery systems.

Valuation of health care organizations and physician practices.

Market research for investor-owned health care companies in the areas of need and demand assessment, competition, and reimbursement characteristics of various geographic regions in connection with the development of specialty hospitals and long-term care services.

Expert testimony in connection with Certificate of Need litigation in several states in variety of areas relating to health care planning and financial issues.

Expert testimony in litigation challenging rules promulgated by various state agencies.

Expert testimony in civil litigation on a range of issues relating to health care planning, health care finance, and valuation of health care organizations.

Assistance in rate review hearings before the state rate setting agency for hospitals in West Virginia.

Direction of product costing engagements for hospitals involving the determination of procedural level costs for use in product costing information systems.

Testimony before various state agencies and policy boards on issues related to health planning standards, need determination, financial access, and health financing.

SBH-KINGSPORT 002624

PUBLICATIONS:

"Evaluating and Selecting Among Joint Venture Opportunities," *Topics in Health Care Financing*, Vol. 12, No.2, Winter 1985.

"New Strategies in a Changing Regulatory Environment," *Amherst Quarterly*, Winter 1985.

"Maximizing Hospital Outpatient Revenues," *Journal of Ambulatory Care Management*, Vol. 10, No.1, February 1983.

PRESENTATIONS:

"Economic Impact of Ambulatory Surgery Centers," Tennessee Bar Association, October 2003.

Considerations in Certificate of Need Regulation, Kentucky Health Strategy Forum, August 1999.

"Marketing Outpatient Services," Georgia Society for Health Care Planning and Marketing, October 1992.

"Evaluating and Negotiating Managed Care Contracts," West Virginia Hospital Association, February 1991.

"Certificate of Need Strategies," West Virginia Healthcare Financial Management Association, May 1990.

"Determining the Need for Retirement Housing," Florida Health Care Association, August 1989.
"Marketing Nursing Home Cost Effectiveness," American Health Care Association Annual Meeting, October 1989.

"Joint Ventures," Georgia Hospital Association, September 1986.

"Joint Ventures with Physicians," North Carolina-South Carolina Health Care Financial Management Associations Annual Meeting, August 1986.

"Medicare Reimbursement Trends," South Carolina Health Care Financial Management Association, January 1986.

"Alternative Revenue Sources," North Carolina Hospital Association, November 1985.

"Product Costing," Aspen Systems Seminar Series, 1984-85.

"Procedural Rate-Setting" Dixie Institute of Health Care Financial Management Association, 1983.

SBH-KINGSPORT 002625

Smoot, Melissa

From: Mike Garone <mgarone@strategicbh.com>
Sent: Tuesday, October 01, 2013 10:45 AM
To: Shannon Castillo
Cc: Mitch Miller
Subject: RE: Meeting Oct 10 9:30
Attachments: Incentive Application - Johnson City - SBH 10-1-13.pdf

Hello Shannon & Mitch,

Attached please find your Application. Under the investment section I have listed out costs by slightly different categories.

Expected Construction Costs:

Land: $1,526,123	Labor: $678,283 (engineering & architecture only)
Materials: $10,449,770 (materials & construction labor)	Soft Costs: $42,762

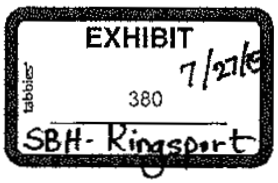
In addition I have included some information below:

What are your estimated expenditures on furniture for use at the facility?

Year 1: $700,000	Year 2: $100,000
Year 3: $50,000	Year 4: N/A
Year 5: N/A	

What are your estimated expenditures on computer equipment for use at the facility?

Year 1: $100,000	Year 2: $25,000
Year 3: N/A	Year 4: N/A
Year 5: N/A	



How many new employees do you expect to hire annually over the first five years?

Year 1: 175	Year 2: 50
Year 3: 25	Year 4: N/A
Year 5: N/A	

How much do you expect to spend annually on **taxable** materials for operations over the first five years? (Taxable goods are purchases on items that will not be used to produce other goods - e.g. office supplies).

Year 1: $1,900,000	Year 2: $2,200,000
Year 3: $2,300,000	Year 4: $2,400,000
Year 5: $2,450,000	

Business Traveler* Information (optional)

*Business travelers do not include locals (those who live in the area) or patients.

Estimated annual number of business travelers to facility: _____50_____

Average length of stay (days / nights): ___12_____ / ____12_____

Percentage of overnight business travelers staying in city: _____100_____

Percentage of overnight business travelers staying in county: ____100_____

Hopefully this provides you with a better understanding of our project. I look forward to meeting with you.

Mike Garone
Director of Development
Strategic Behavioral Health
Office (901) 969-3100
Cell (901) 277-6522
www.strategicbh.com

From: Shannon Castillo [mailto:castillo@thewcedc.com]
Sent: Tuesday, October 01, 2013 10:08 AM
To: mgarone@strategicbh.com

Cc: Mitch Miller
Subject: Meeting Oct 10 9:30

Hello Mike

Thanks for your phone call today. We're glad you are considering Johnson City for your next hospital. Both Mitch and I are happy to meet with you on Thursday, October 10th at 9:30. Our offices are located at 300 East Main Street Suite 406 in Downtown Johnson City.

Please see attached incentive application. This will be helpful for both of us when we meet.

Let me know if you have any questions between now and then.

Shannon K. Castillo

Director of Redevelopment
Washington County Economic Development Council
Castillo@TheWCEDC.com
423-943-0530 (cell)
423-202-3510 X107 (office)
www.TheWCEDC.com

Subscribe to the Comet newsletter HERE.

Johnson City, TN
Industrial Development Bond Board Incentive Application
For New and Expanding Businesses

Company Name: STRATEGIC BEHAVIORAL HEALTH, LLC

Contact Person: MIKE GARONE

Address: 8295 TOURNAMENT DRIVE, SUITE 201
MEMPHIS, TN 38125

Phone: (901) 277-6522 Facsimile: (901) 969-3120

Description of Business: HEALTHCARE – PSYCHIATRIC HOSPITAL

Description of Project: 55,000 SQ/FT NEW CONSTRUCTION / HOSPITAL SET ON 10 AC / 12 MONTH BUILD

Initial Investment: LAND - 1.5 M
MATERIALS / CONST. LABOR - 10.5 M
Building/Land: ENG. / ARCH. - 650K SOFT COST - 50K
Machinery/Equipment: SEE EMAIL
Business/Personal Property: SEE EMAIL

Initial Jobs: 175

Future Investment: $750K YR 3 Future Jobs: 75

Average Weekly Wage Rate: $22/HR

Start Date (Projected): SUMMER 2014

Completion Date (Projected): SUMMER 2015

Signature of Company Contact Person:

P-1763

dkc consulting

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

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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.**

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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:

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[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.

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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.

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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.

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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.

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[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.*

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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

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[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:

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- 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."[15] 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.*

[15] 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

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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.
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- 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.

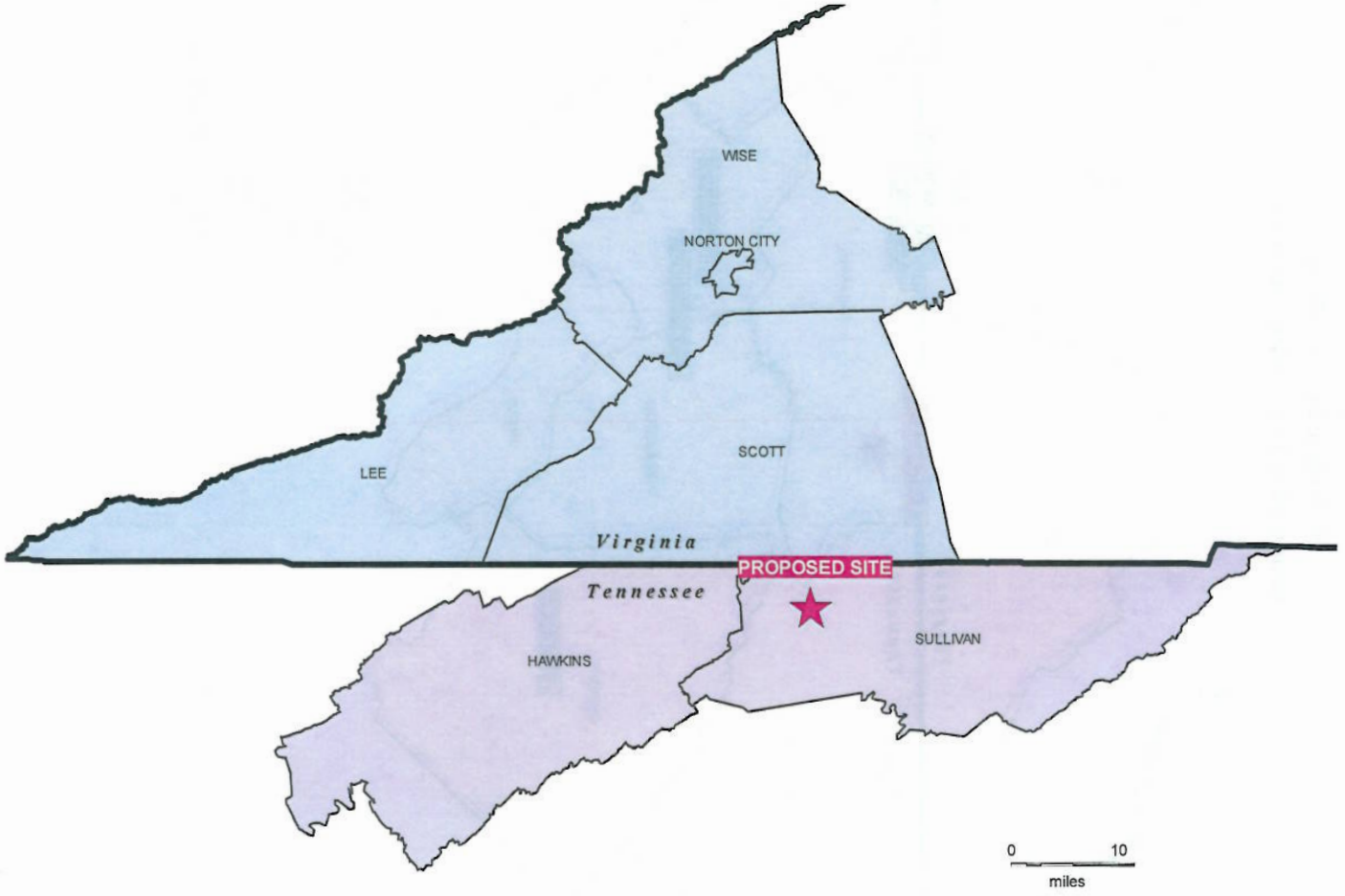
SBH-KINGSPORT 002662

Appendix B:

Exhibits and Maps

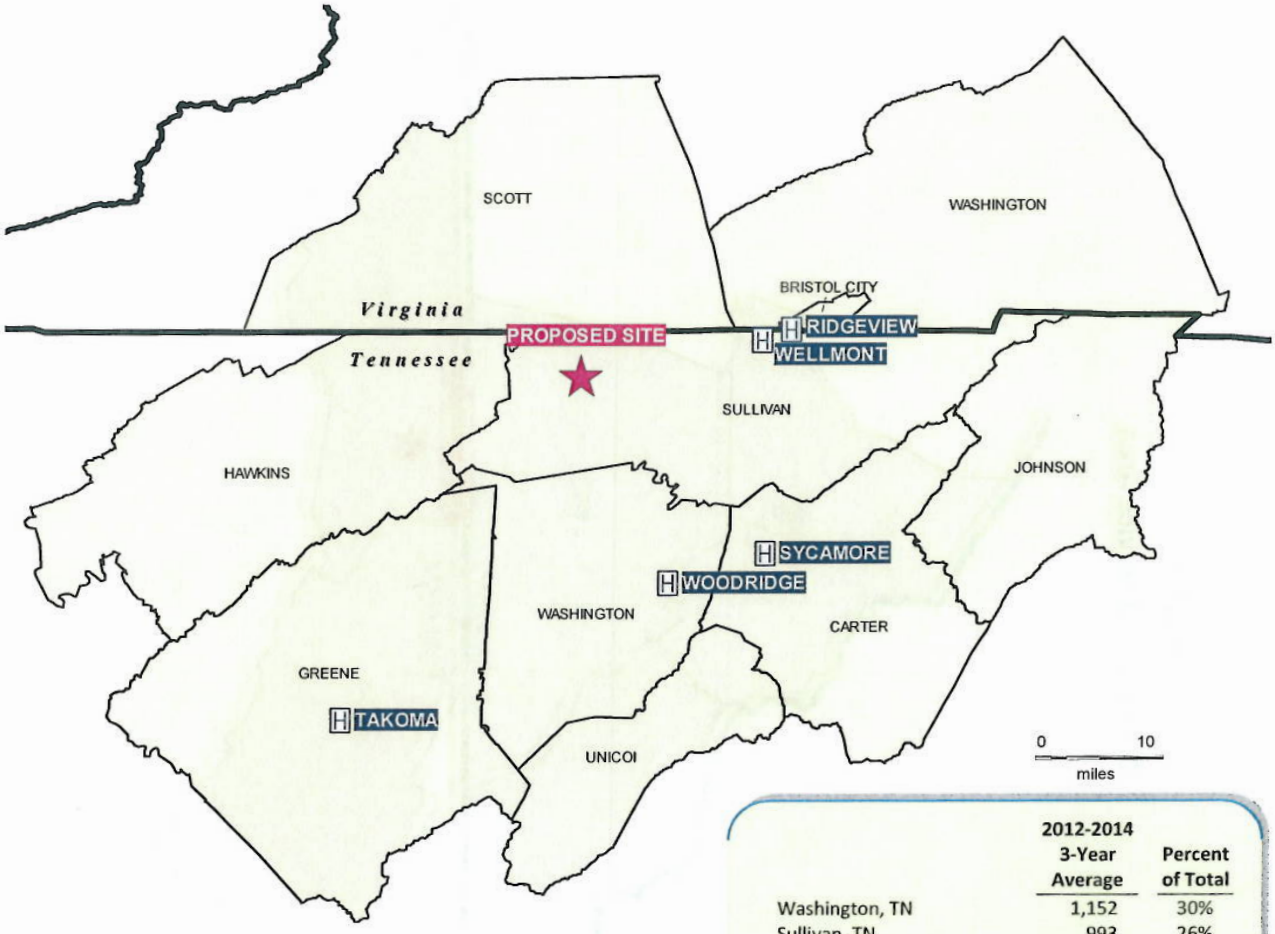
MAP 1

SBH Proposed Service Area



SBH-KINGSPORT 002664

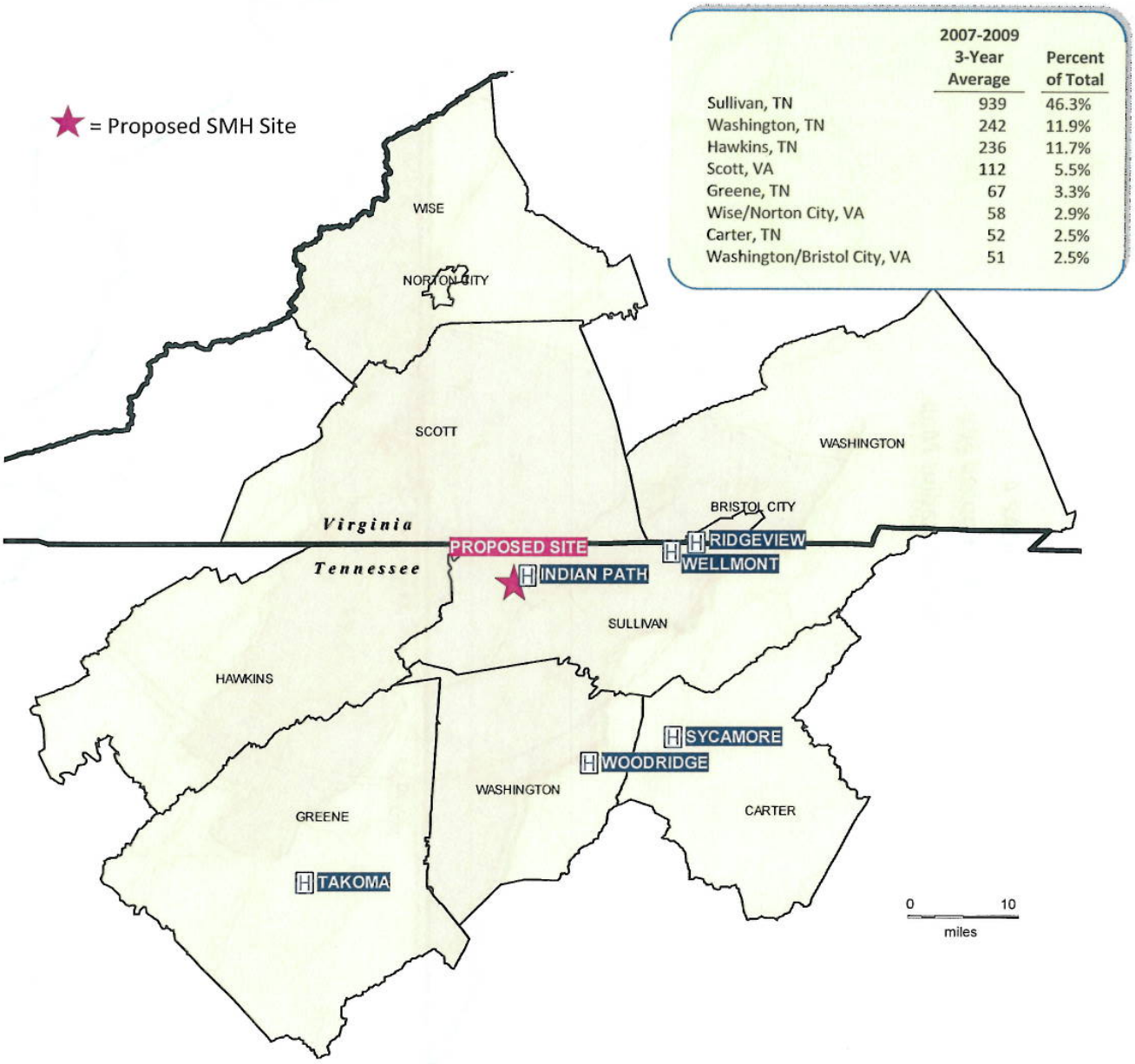
MAP 2
Historical Service Area
Woodridge Psychiatric Hospital



	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.

Map 3
Historical Service Area
Indian Path Psychiatric Pavilion



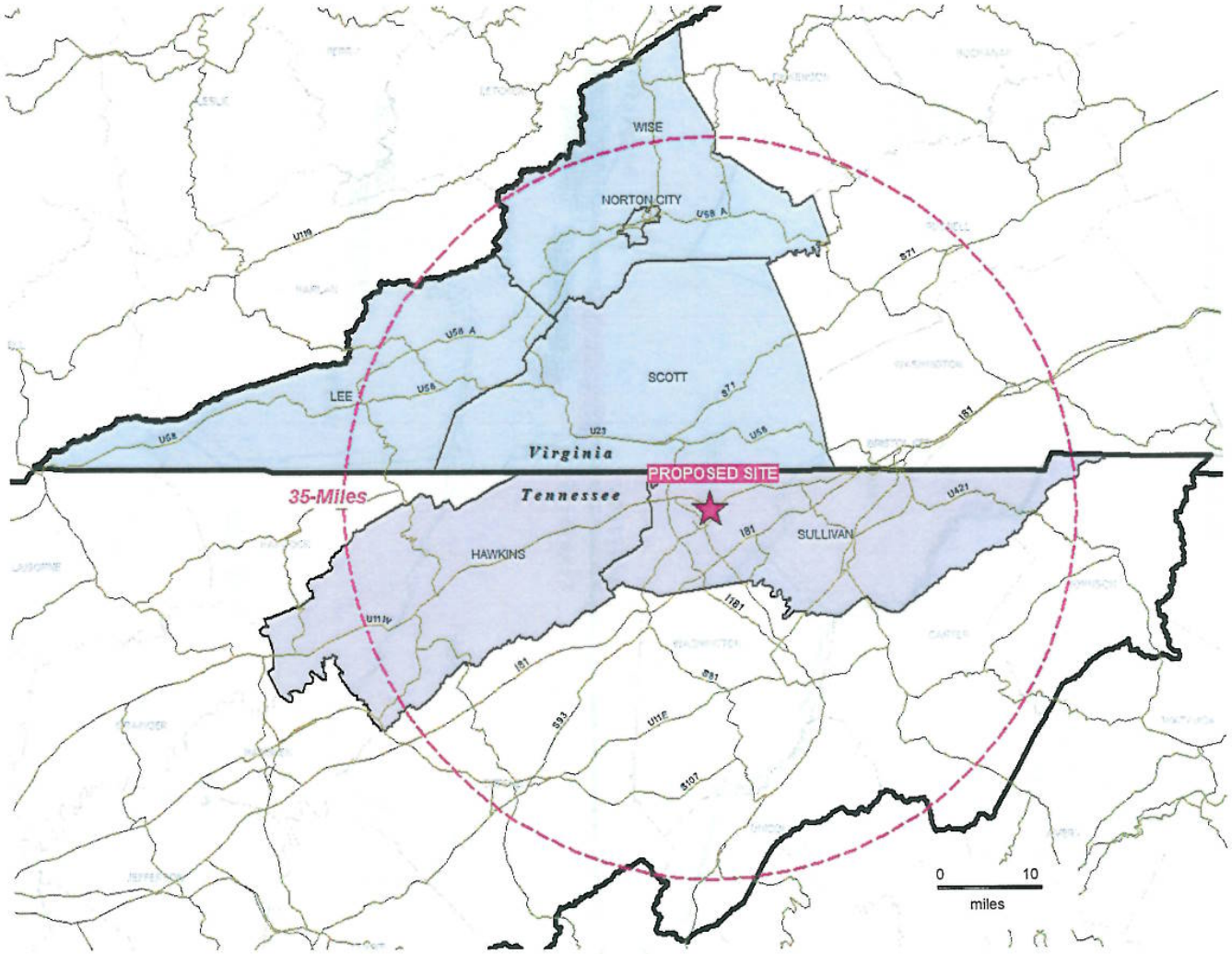
	2007-2009 3-Year Average	Percent of Total
Sullivan, TN	939	46.3%
Washington, TN	242	11.9%
Hawkins, TN	236	11.7%
Scott, VA	112	5.5%
Greene, TN	67	3.3%
Wise/Norton City, VA	58	2.9%
Carter, TN	52	2.5%
Washington/Bristol City, VA	51	2.5%

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

MAP 4

SBH Proposed Site

35-Mile Radius Map



SBH-KINGSPORT 002667

EXHIBIT 1
Drive Times and Distance to SBH Proposed Site

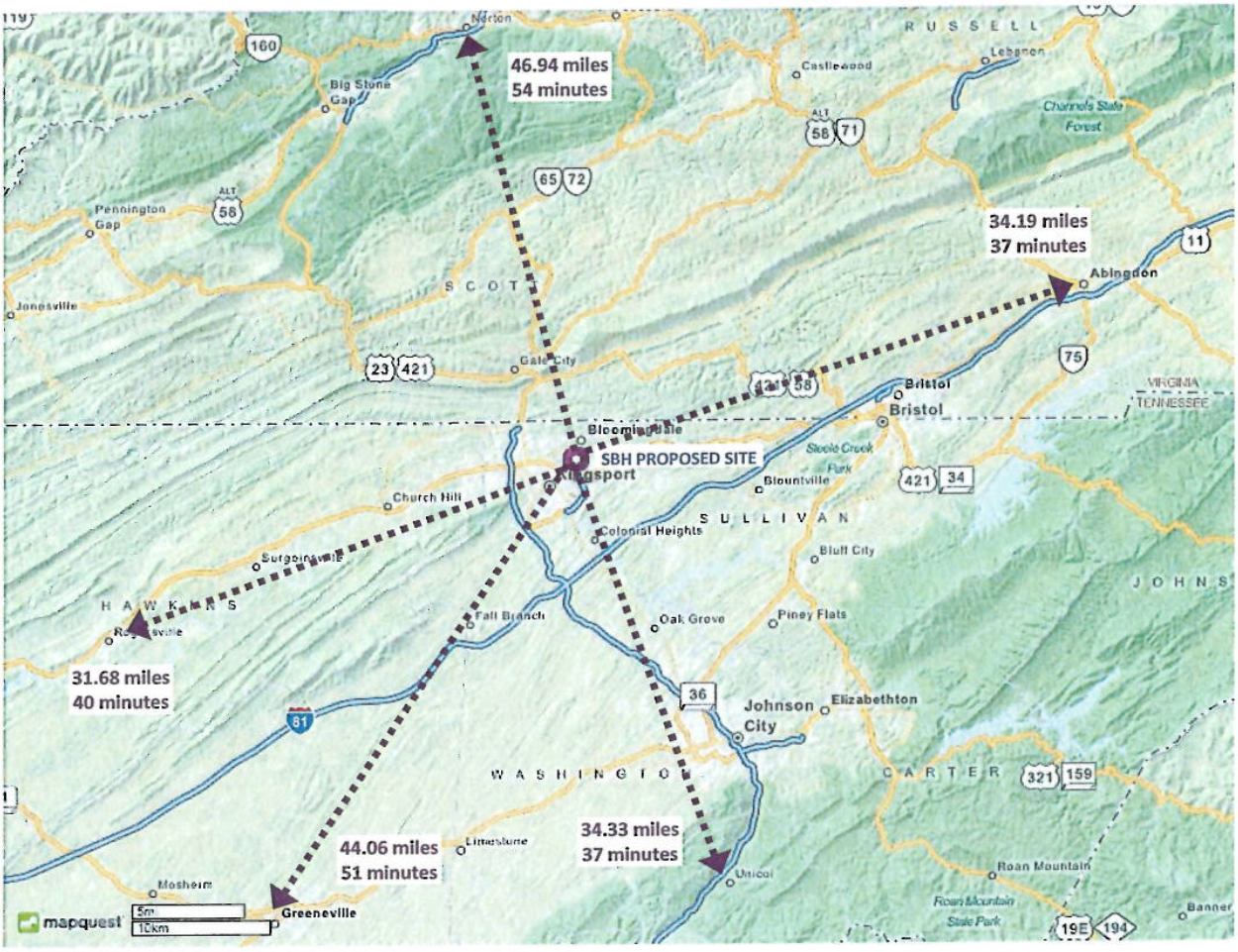
Site		Straight-line Distance	Driving Distance	Drive Time
From:	***Existing Psychiatric Providers in Alternate Service Area:***			
	Clearview Psychiatric Center at RCMC	34.40	52.49	1 hour
	Ridgeview Pavilion	16.86	17.98	22 minutes
	Sycamore Shoals Hospital	20.03	31.01	34 minutes
	Takoma Regional Hospital	32.70	44.62	53 minutes
	Wellmont Bristol Regional Medical Center	14.49	16.30	21 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

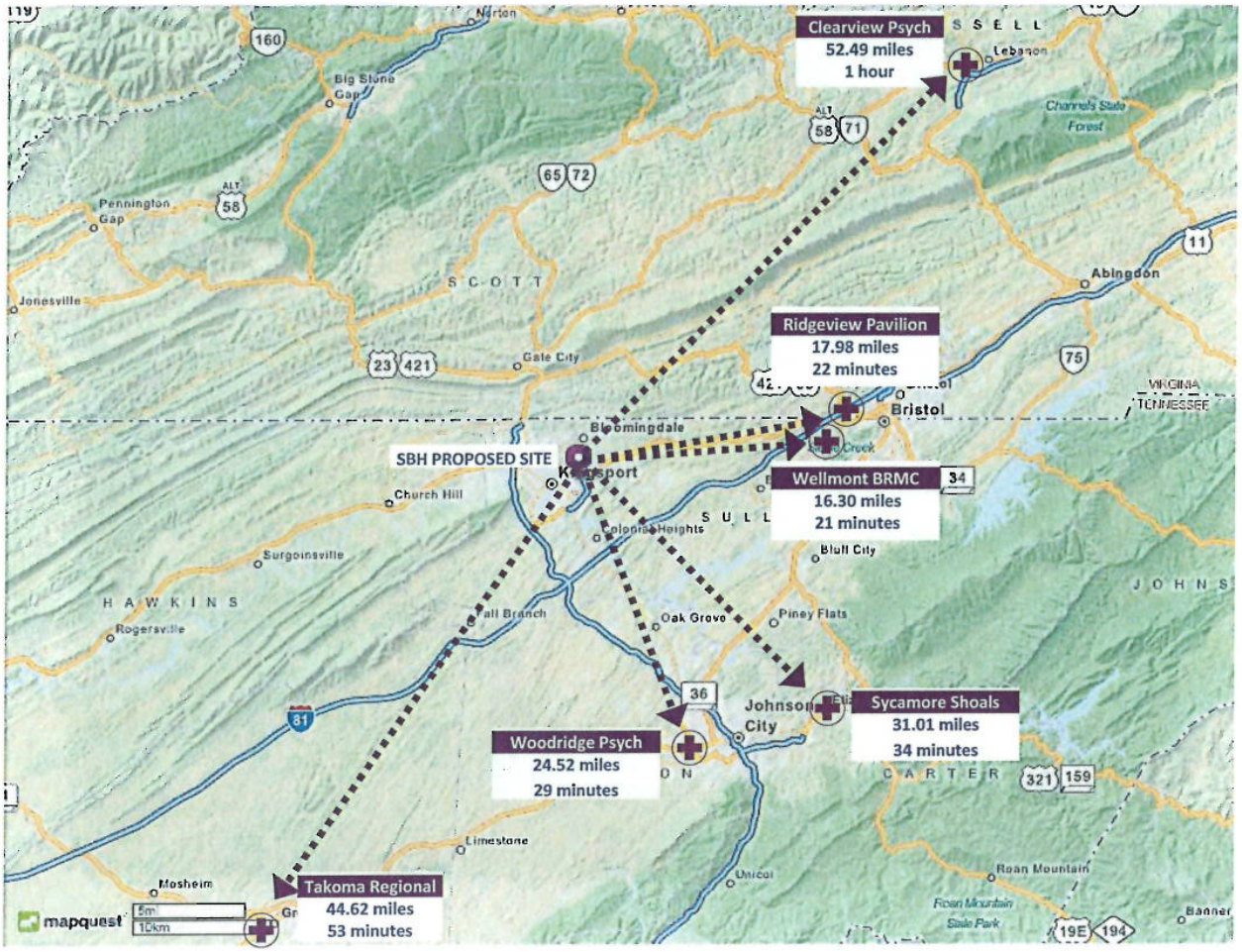
from Outlying Cities within the Radius to SBH Proposed Site



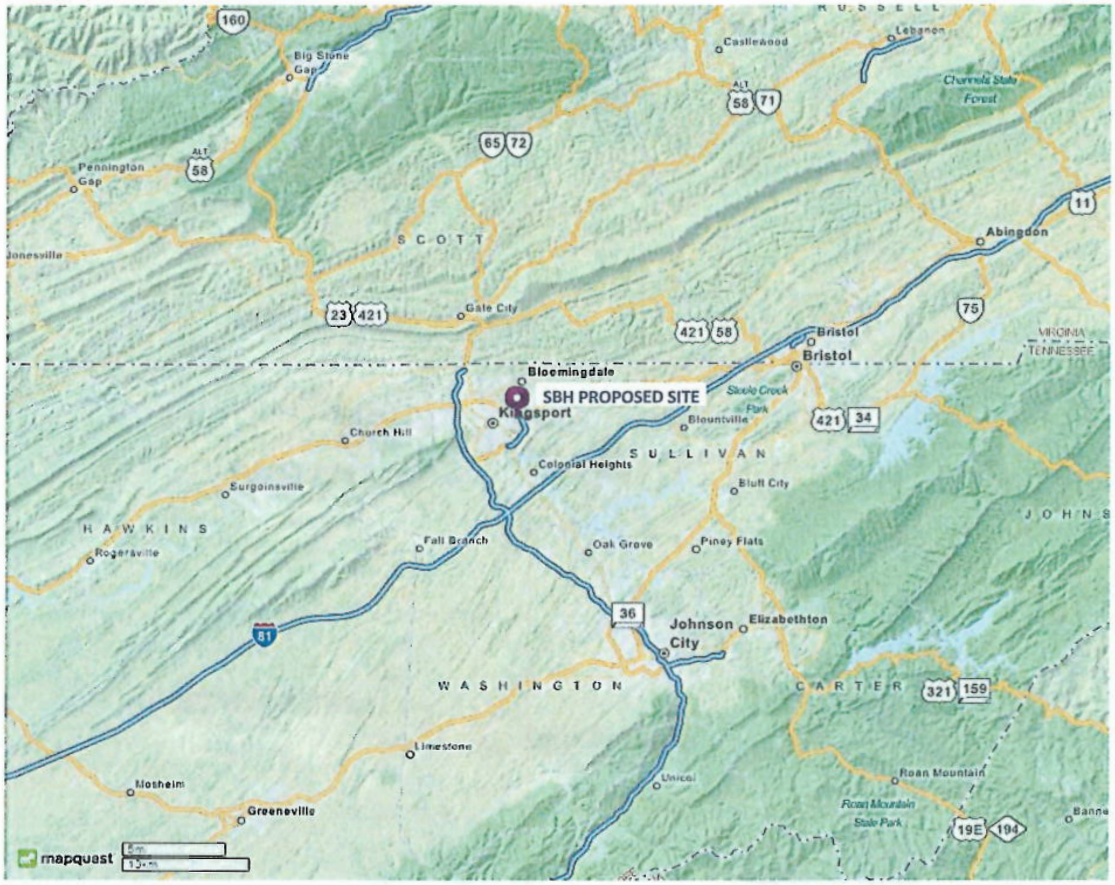
MAP 6

Drive Times

from Existing Psychiatric Providers to SBH Proposed Site



MAP 7
SBH Proposed Site
and Surrounding Topography

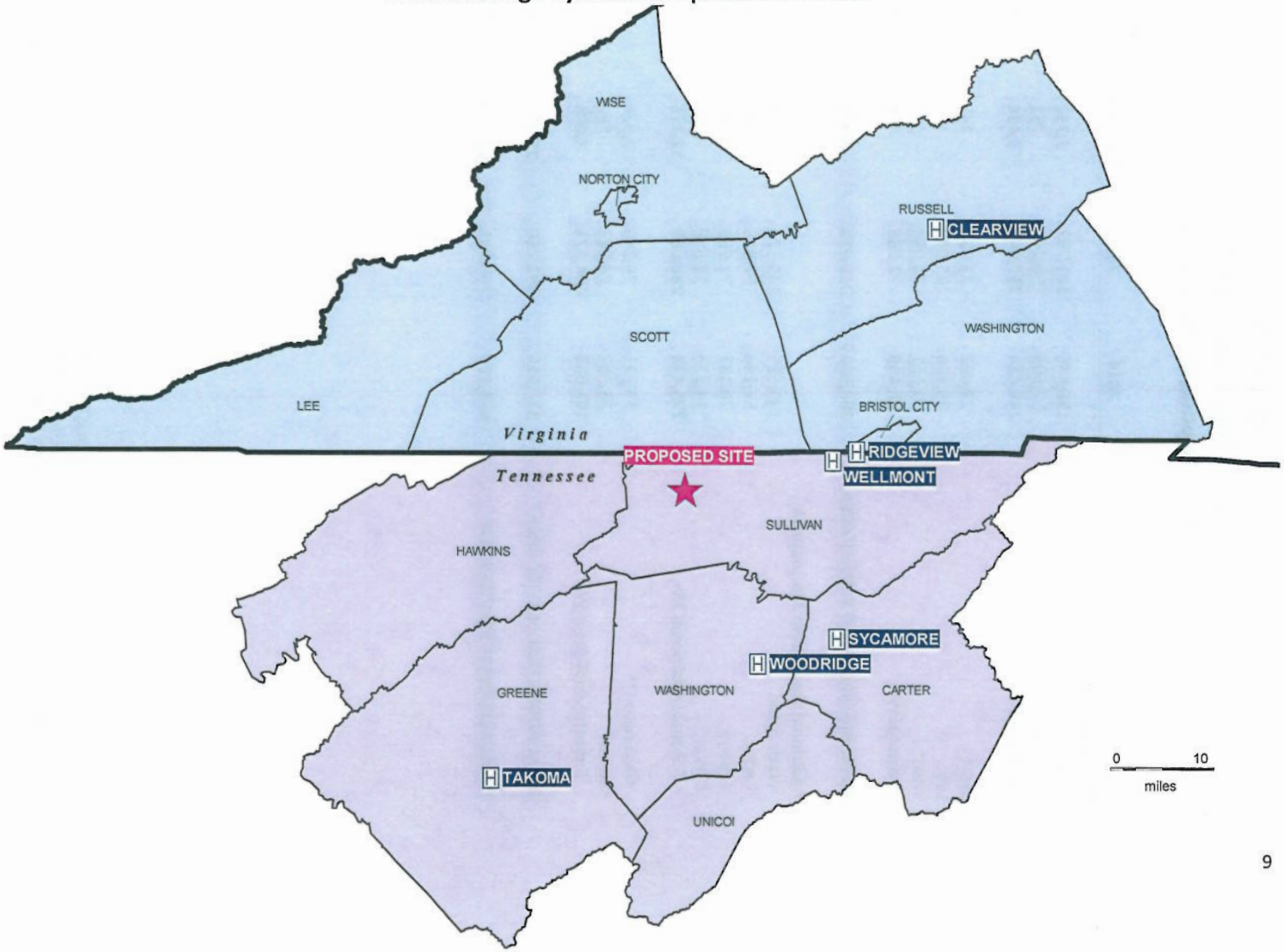


Source: MapQuest, 2015.

MAP 8

Alternate Service Area Map

with Existing Psychiatric Inpatient Services



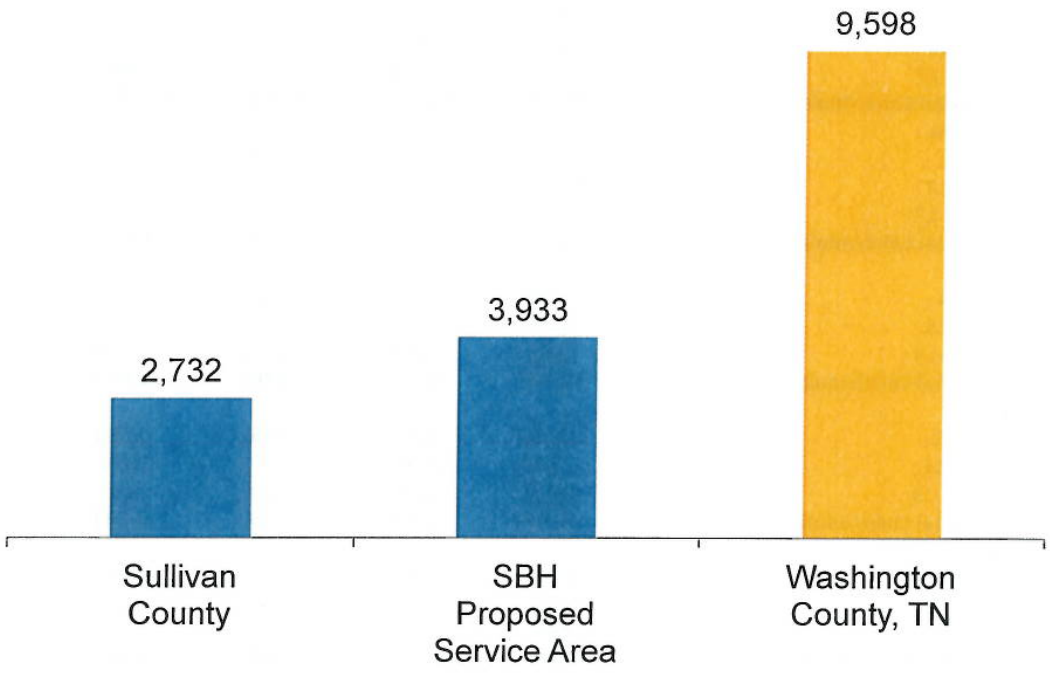
SBH-KINGSPORT 002672

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.

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%)**

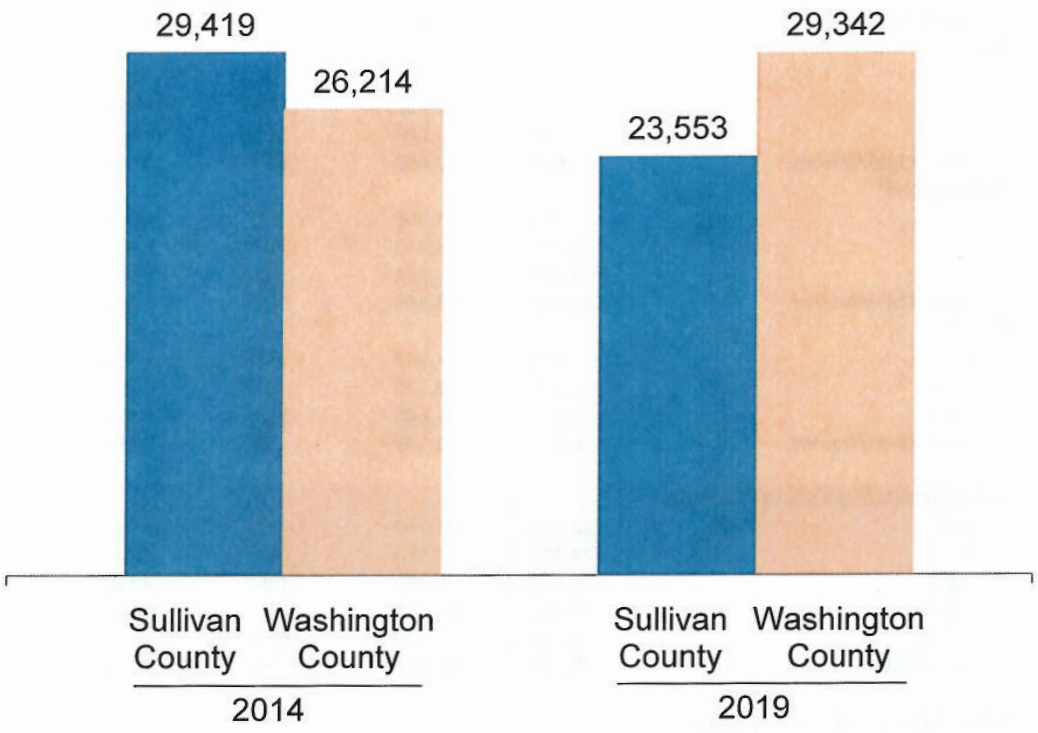
EXHIBIT 4 (Continued)

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.

SBH-KINGSPORT 002676

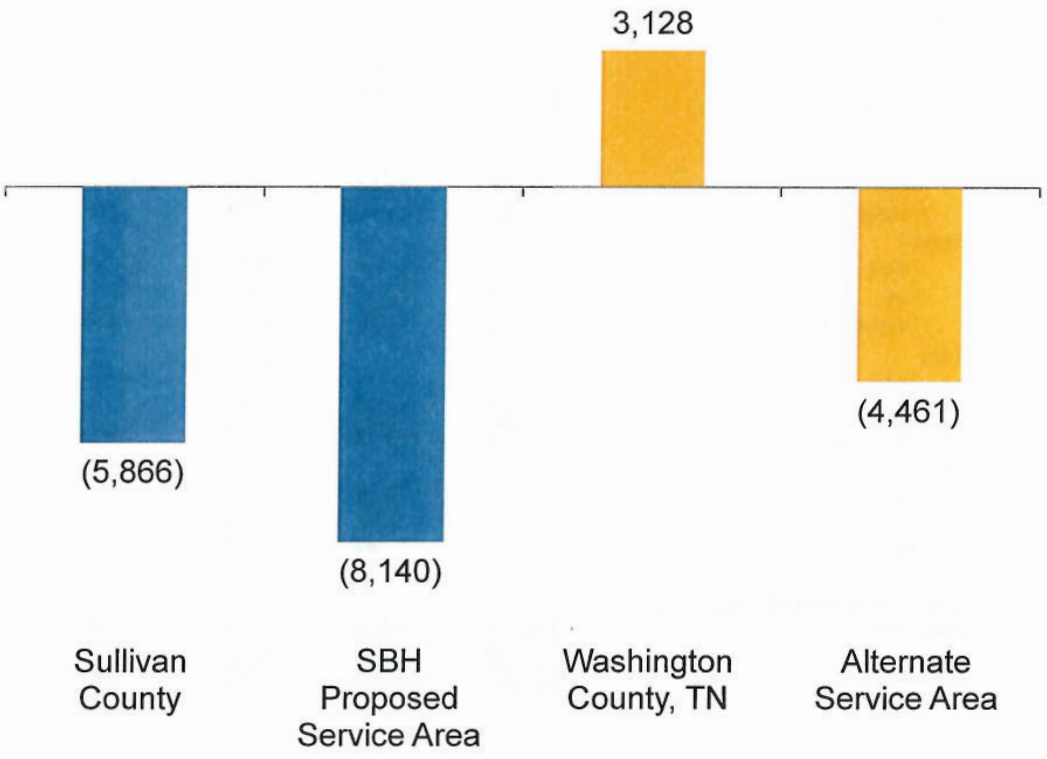
EXHIBIT 5
Comparison of Child and Adolescent Population
2014 and 2019



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.

SBH-KINGSPORT 002677

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.

SBH-KINGSPORT 002678

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%**

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.

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.

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: Non-Age Specific	Adult Beds: 65+	Total Beds
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.

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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.

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.

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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	352	352	79.3	989	989	86.7%
Self Pay	178	5	2.8%	389	17	4.4%
All others	148	37	66.1%	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.

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	41.6%	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.

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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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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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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CURRICULUM VITAE
(Revised 1/13/15)

Name:	**HARSH K. TRIVEDI, MD, MBA**
Office Address:	Harsh K. Trivedi, MD, MBA Vice Chair for Clinical Affairs, Department of Psychiatry Executive Director and Chief Medical Officer, Vanderbilt Behavioral Health Vanderbilt Psychiatric Hospital 1601 23rd Avenue South Nashville, TN 37212
Office Phone Number:	615-327-7024
Business Fax Number:	615-327-7114
Electronic Mail Address:	harsh.k.trivedi@vanderbilt.edu

Education:

Undergraduate	Sophie Davis School of Biomedical Education/ CUNY Medical School, New York, NY Accelerated Seven-Year B.S./M.D. Program B.S. Biomedical Sciences, 1998 Dates Attended 08/93-06/98 Dean's List for all academic semesters *In this accelerated program, the first 5 years comprise the undergraduate coursework plus the first two years of medical school. Upon completing the 5 years at Sophie Davis, all students complete the third and fourth years of medical school at the clinical site. I completed the 7-year program at Mount Sinai School of Medicine (see below).
Medical School	Mount Sinai School of Medicine, New York, NY M.D., 2000 Dates Attended 07/98-05/00
Residency	Zucker Hillside Hospital, LIJ Medical Center, Glen Oaks, NY General Psychiatry Residency Albert Einstein College of Medicine Dates Attended 07/00-06/04 Chief Resident in the Third Year (Historical First in Program)
Congressional Fellowship	Healthcare Legislative Fellow Office of U.S. Senator Jack Reed (D-RI), Washington, DC

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Congressional appointment for the Jeanne Spurlock, MD Congessional Fellowship (01/04-06/04). Drafted the Campus Care and Counseling Act (S.2215/ H.R.3593). Passed Congress and signed into law by President Bush as part of the Garrett Lee Smith Memorial Act. Has provided $160 million to help develop suicide prevention programs for children and adolescents and to help expand mental health services on college campuses.

Fellowship	Children's Hospital Boston, Boston, MA Child and Adolescent Psychiatry Fellowship Harvard Medical School Dates Attended 07/04-06/06
Business School	University of Tennessee Haslam School of Business, Knoxville, TN Physician Executive MBA, 2012 Class President
Additional Training	New York University Psychoanalytic Institute, New York, NY Fellowship in Psychoanalysis Dates Attended 07/02-06/03 Completed Concurrently During Psychiatry Residency (Not an ACGME accredited fellowship)

Licensure and Certification:

Tennessee, License #MD45674, 2010 - Present (Active)

Rhode Island, License #MD12216, 2006 - Present (Inactive)

Massachusetts, License #221535, 2004 - 2010
(Chose not to renew – Inactive Status not available)

New York, License #227261, 2003 – 2006 (Inactive)

Diplomate, American Board of Psychiatry and Neurology
Psychiatry, Certificate #56337, 2006, Recertification in 2016

Diplomate, American Board of Psychiatry and Neurology
Subspecialty Certification in Child and Adolescent Psychiatry
Certificate #6360, 2007, Recertification in 2017

National Board of Medical Examiners
USMLE 1,2,3 Completed 2002

Academic Appointments:

Associate Professor, 2010 - Present
Department of Psychiatry
Vanderbilt Medical School

Assistant Professor, 2007 - 2010
Department of Psychiatry & Human Behavior
Brown Medical School

Instructor, 2004 - 2006
Department of Psychiatry
Harvard Medical School

Hospital Appointments:

Vanderbilt University Medical Center, Nashville, TN
03/10 - Present

Positions held at VUMC:

Regional Medical Director, Vanderbilt Health Affiliated Network
7/14 - Present

Executive Director and Chief Medical Officer, Vanderbilt Behavioral Health, 04/13 - Present

Vice Chair for Clinical Affairs,
Department of Psychiatry, 04/13 - Present

Executive Medical Director, 03/10 – 03/13

Chief-of-Staff, Vanderbilt Psychiatric Hospital, 03/10 - Present

Bradley Hospital, East Providence, RI
09/06 – 02/10

Positions held at Bradley Hospital:

Attending Psychiatrist, 09/06-06/07

Associate Director, Adolescent Services, 06/07-08/07

Director, Adolescent Services, 08/07 - 02/10

Academic positions held at Bradley Hospital:

Site Training Director, 06/07 – 02/10
Responsible for oversight of all academic activities at Bradley Hospital (function as Brown Medical School psychiatry clerkship site director and as associate training director for child psychiatry fellowship and triple board program)

Rhode Island Hospital, Providence, RI
Medical Staff
09/06 – 02/10
As part of position at Bradley Hospital; provide on-call coverage at Hasbro Children's Hospital and Rhode Island Hospital.

Professional Organizations:

American Psychiatric Association
1999 - Present

Committee Member
APA Spurlock Congressional Fellowship
Selection Committee
2004-2008

Board Member
APA Political Action Committee
2004 – 2010

Committee Member
Council on Advocacy and Public Policy
2007 – 2009

Area I Representative
Council on Public Affairs
American Psychiatric Association
2008 – 2009

APA Committee on Reimbursement for Psychiatric Care
2011 - Present

Chair
APA Council on Healthcare Systems and Financing
2013 – Present

APA Joint Reference Committee
2013 - Present

Board of Trustees Work Group on Healthcare Reform
2014 - Present

Indo-American Psychiatric Association
2002 - Present

American Medical Association
2003 - Present

House of Delegates Member
2011 - Present

American Academy of Child and Adolescent Psychiatry
2003 – Present

Tennessee Delegate to Assembly of Regional Organizations.
2010-Present

Committee Chair
Committee on Healthcare, Access, and Economics
2004-2013

Committee Member
AACAP Committee on Advocacy
2005 - 2007

State-Based Mental Health Advocacy Coalition
AACAP Representative
2006 - 2010

Advocacy Liaison
AACAP Department of Government Affairs
2007 – 2010

AACAP Assembly Representative to Council
2012 - 2014

American Association of Physicians of Indian Origin
2004 - Present

American Association of Directors of Psychiatric Residency Training
2007 – 2010

Curriculum Committee
Child and Adolescent Psychiatry Fellowship/Triple Board
Brown Medical School
2006 - 2010

Clinical Clerkship Directors Committee
Brown Medical School
2007 - 2010

Pharmacy and Therapeutics Committee
Committee Chair
Bradley Hospital
2007 – 2010

Clinical Services Governance Council Committee
Department of Psychiatry, Vanderbilt Medical School
2010 – Present
Chair, 2013 - Present

Health Record Executive Committee
Vanderbilt University Medical Center
2010 – 2012

Medical Directors Forum
Vanderbilt University Medical Center
2010 – Present

Executive Medical Directors Committee
Vanderbilt University Medical Center
2010 – Present

Medical Center Medical Board Executive Committee
Vanderbilt University Medical Center
2010 – Present

VUMC Quality Steering Committee
Vanderbilt University Medical Center
2010 – Present

Quality and Safety Council Committee
Vanderbilt Psychiatric Hospital
2010 – Present

Administrative Leadership Committee
Vanderbilt Psychiatric Hospital
2010 – 2012

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Residency Selection Committee
Vanderbilt Psychiatric Hospital
2010 – 2013

Appointment and Promotions Committee
Task Force on Developing Track Definitions
Vanderbilt Department of Psychiatry
2010 – 2011

Patient Experience and Service Improvement Council Committee
Vanderbilt University Medical Center
2011 - 2013

Luton Society Committee
Vanderbilt Department of Psychiatry
2011 – Present

Chair, Faculty Retreat Committee
Vanderbilt Department of Psychiatry
2011 – Present

Vanderbilt Psychiatry Outpatient Strategic Planning Committee
Vanderbilt Department of Psychiatry
2011 – 2012

Leadership Council
Vanderbilt University Department of Psychiatry
2011 - Present

Liaison Committee on Medical Education (LCME)
Medical Students – Student Services Subcommittee
Vanderbilt University School of Medicine
2012 - Present

Vanderbilt Clinical Neurosciences Institute Board (VCNI)
Vanderbilt University Medical Center
2012 – 2013

External Data Reporting Committee
Vanderbilt University Medical Center
2012 – Present

Patient Experience Strategic Roadmap Planning
Vanderbilt University Medical Center
2013

SBH-KINGSPORT 002704

Vanderbilt Medical Group Executive Committee
Vanderbilt University Medical Center
2013 – Present

Rapid Cycle Work Redesign Committee
Vanderbilt University Medical Center
2013 – Present

Vanderbilt ICD-10 Transition Steering Committee
Vanderbilt University Medical Center
2014 – Present

Care Model Steering Committee 2.0
Vanderbilt University Medical Center
2014 - Present

Meaningful Use II Rollout Committee
Vanderbilt University Medical Center
2014 - Present

Clinical Health Information Management Operations Steering Group
Vanderbilt University Medical Center
2014 – Present

Adult Enterprise Cabinet
Vanderbilt University Medical Center
2014 - Present

Clinical Executive Enterprise Committee
Vanderbilt University Medical Center
2014 – Present

Physician Leadership Council
Vanderbilt Health Affiliated Network
2014 – Present

Behavioral Health PCC Executive Team
2014 - Present

Extramural:

Legislative Consultant
Office of Advocacy, Children's Hospital, Boston
2005

Selected to draft a legislative critique of Scientology Bill S.126 "An Act to Ensure Parents of Children Prescribed Psychotropic Drugs Receive Adequate Information," and develop a mental health coalition in opposition of bill.

National Committee for Quality Assurance
Centers for Medicare & Medicaid Services (CMS)
2011

Selected as one of 18 national experts to join Technical Expert Panel (TEP) to guide development of inpatient psychiatric quality measures.

C & Y Crisis System Workgroup
Tennessee Department of Mental Health and Substance Abuse Services
2012 – 2014

Mental Health American of Middle Tennessee
MHAMT President's Cabinet
2015

Editorial Appointments and Ad Hoc Reviewing:

Invited Reviewer for Book Review Section
New England Journal of Medicine
5/05-6/06

Invited Peer Reviewer
Journal of Clinical Psychiatry
12/06 - Present

Consulting Editor
Child and Adolescent Psychiatric Clinics of North America
2/07 – Present

Dell ML, Trivedi HK (eds) (2008), Ethics. *Child and Adolescent Psychiatric Clinics of North America* 17(1):1-244

Rohde LA, Faraone SV, Trivedi HK (eds) (2008), Attention Deficit Hyperactivity Disorder. *Child and Adolescent Psychiatric Clinics of North America* 17(2):245-496

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Henderson SW, Trivedi HK (eds) (2008), Refugee Mental Health. *Child and Adolescent Psychiatric Clinics of North America* 17(3):497-712

Posey DJ, McDougle CJ, Trivedi HK (eds) (2008), Treating Autism Spectrum Disorders. *Child and Adolescent Psychiatric Clinics of North America* 17(4):713-932

Herpertz-Dahlmann B, Hebebrand J, Trivedi HK (eds) (2009), Eating Disorders and Obesity. *Child and Adolescent Psychiatric Clinics of North America* 18(1):1-256

Hunt JI, Dickstein DP, Trivedi HK (eds) (2009), Bipolar Disorder. *Child and Adolescent Psychiatric Clinics of North America* 18(2):257-532

Gleason MM, Schechter DS, Trivedi HK (eds) (2009), Infant and Early Childhood Mental Health. *Child and Adolescent Psychiatric Clinics of North America* 18(3):533-797

Shatkin J, Ivanenko A, Trivedi HK (eds) (2009), Sleep Disorders. *Child and Adolescent Psychiatric Clinics of North America* 18(4):798-1041

Houston M, Sarvet BD, Trivedi HK (eds) (2010), Leadership and Management Core Competencies. *Child and Adolescent Psychiatric Clinics of North America* 19(1):1-182

Fritsch SL, Trivedi HK (eds) (2010), Interface Between Pediatrics and Children's Mental Health. *Child and Adolescent Psychiatric Clinics of North America* 19(2):183-450

Kaminer Y, Trivedi HK (eds) (2010), Adolescent Substance Use Disorder. *Child and Adolescent Psychiatric Clinics of North America* 19(3):451-660

Joshi SV, Pumariega AJ, Trivedi HK (eds) (2010), Cultural Issues in Pediatric Mental Health. *Child and Adolescent Psychiatric Clinics of North America* 19(4):661-896

Grady BJ, Nelson E, Trivedi HK (eds) (2011), Telepsychiatry and Telemental Health. *Child and Adolescent Psychiatric Clinics of North America* 20(1):1-178

Peters TE, Freeman JB, Trivedi HK (eds) (2011), Cognitive-Behavioral Therapy in Youth. *Child and Adolescent Psychiatric Clinics of North America* 20(2):179-412

Bernet W, Freeman, BW, Trivedi HK (eds) (2011), Forensic Psychiatry. *Child and Adolescent Psychiatric Clinics of North America* 20(3):413-600

Pleak RR, Trivedi HK (eds) (2011), Cender Variant Children and Transgender Adolescents. *Child and Adolescent Psychiatric Clinics of North America* 20(4):601-804

Bostic JQ, Bagnell AL, Trivedi HK (eds) (2012), Evidence-Based School Psychiatry. *Child and Adolescent Psychiatric Clinics of North America* 21(1):1-216

Goldman SJ, Wren FJ, Trivedi HK (eds) (2012), Child and Adolescent Depression. *Child and Adolescent Psychiatric Clinics of North America* 21(2):217-456

Rynn MA, Vidair HB, Blackford JU, Trivedi, HK (eds) (2012) Anxiety Disorders. *Child and Adolescent Psychiatric Clinics of North America* 21(3):457-702

Trivedi HK, Chang KD (eds) (October 2012), Better and Safer Pharmacotherapy for Youth with Psychiatric Illness. *Child and Adolescent Psychiatric Clinics of North America* 21(4):703-992

Ritvo RZ, Henderson SW, Trivedi HK (January 2013), Psychodynamic Approaches to Psychopathology, Vol. 1. *Child and Adolescent Psychiatric Clinics of North America* 22(1):1-148

Palmer R, Nascimento LN, Fonagy P, Trivedi HK (eds) (April 2013), Psychodynamic Approaches to Psychotherapy, Vol. 2. *Child and Adolescent Psychiatric Clinics of North America* 22(2):149-374

Simkin DR, Popper CW, Trivedi HK (July 2013), Alternative and Complementary Therapies for Children with Psychiatric Disorders, Part 1. *Child and Adolescent Psychiatric Clinics of North America* 22(3):375-538

Dvir Y, Frazier JA, Trivedi, HK (eds) (October 2013), Psychosis in Youth. *Child and Adolescent Psychiatric Clinics of North America* 22(4):539-768

Siegel M, King BH, Trivedi HK (January 2014), Acute Management of Autism Spectrum Disorders. *Child and Adolescent Psychiatric Clinics of North America* 23(1):1-166

Cozza SJ, Cohen J, Dougherty JG, Trivedi HK (eds) (April 2014), Disaster and Trauma. *Child and Adolescent Psychiatric Clinics of North America* 23(2):167-425

Simkin DR, Popper CW, Trivedi HK (July 2014), Alternative and Complementary Therapies for Children with Psychiatric Disorders. *Child and Adolescent Psychiatric Clinics of North America* 23(3):426-686

Faraone SV, Antshel KM, Trivedi HK (October 2014), ADHD: Non-Pharmacologic Interventions. *Child and Adolescent Psychiatric Clinics of North America* 23(4):687-982

Trivedi HK (January 2015), Top Topics in Child and Adolescent Psychiatry. *Child and Adolescent Psychiatric Clinics of North America* 24(1):1-210

Peer Reviewer
Journal of the American Academy of Child and Adolescent Psychiatry
07/07 – Present

Trivedi HK, Jackson AH (eds) (2010), Policy Paper for AACAP Work Group on Healthcare Access and Economics, *Principles of Care for Treatment of Children and Adolescents with Mental Illnesses in Residential Treatment Center (www.aacap.org)*

Trivedi HK, Wick P (eds) (2014), Policy Paper, *APA Position Statement on Prior Authorizations*

Publications and Presentations:

Articles in Refereed Journals:

Roesnner K, Trivedi H, Gaur L, Howard D, Aversa J, Cooper SM, Sigal LH, Budd RC (1998), Biased T-Cell Antigen Receptor Repertoire in Lyme Arthritis. *Infection and Immunity* 66(3):1092-1099

Trivedi HK, Mendelowitz AJ, Fink M (2003), A Gilles de la Tourette's Form of Catatonia: Treatment with ECT. *Journal of ECT* 19(2):115-117

Hunt JI, Barrett R, Grapentine WL, Ligouri G, Trivedi HK (2008), Exposure to Child and Adolescent Psychiatry for Medical Students: Are There Optimal "Teaching Perspectives"? *Acad Psychiatry* 32(5):357-61

Trivedi HK (collaborator/committee chair) (2009), American Academy of Child and Adolescent Psychiatry Committee on Health Care Access and Economics Task Force on Mental Health. Improving mental health services in primary care: reducing administrative and financial barriers to access and collaboration. *Pediatrics* 123(4):1248-51

Callahan SE, Frederickson AM, Trivedi H, Lee A, Eugene MC, Shekher M, Weiskopf M, Allen-Dicker K, Dicker R, Fornari V, Correll CU (2009), Frequency and Correlates of Inappropriate Pediatric Psychiatric Emergency Room Visits. *J Clin Psychiatry* 70(8):1164-77

Munshi KM, Oken T, Guild DJ, Trivedi HK, Wang BC, Ducharme P, Gonzales-Heydrich J (2010), The Use of Antiepileptic Drugs (AEDs) for the Treatment of Pediatric Aggression and Mood Disorders. *Pharmaceuticals* 3(9):2986-3004

Books, Book Chapters, and Invited Articles:

Trivedi HK, Wang BC, Gonzalez-Heydrich J (2005), Antiepileptic Drugs (AEDs) in the Treatment of Aggression in Children and Adolescents. *Child and Adolescent Psychopharmacology News* 10(1):6-9

Trivedi HK, Beasley PJ (2006), Birth, Childhood, and Adolescence. In: *Behavior and Medicine,* Wedding D, Stuber M, eds. Seattle: Hogrefe and Huber, 31-46

Beasley PJ, Trivedi HK (2008), Depression and Physical Illness: A Guide to the Diagnosis and Treatment of Depressive Disorders in Medically Ill Children and Adolescents. In: *Comprehensive Pediatric Hospital Medicine,* Zaoutis LB, Chang VW, eds. New York: Saunders

Trivedi HK, Kershner J (2009). Practical Child Psychiatry for Pediatrics and Primary Care. Boston: Hogrefe and Huber Publishers.

Trivedi HK (2009), The Role of Pediatricians and Primary Care in Children's Mental Health. Brown Child and Adolescent Behavior Newsletter.

Trivedi HK, Peters T (2010), Birth, Childhood, and Adolescence. In: *Behavior and Medicine,* Wedding D, Stuber M, eds. Seattle: Hogrefe and Huber, 31-45

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Trivedi HK, Pattison NA, Baptista-Neto L (April 2010), Pediatric Medical Home: Foundations, Challenges, and Future Directions. *Child and Adolescent Psychiatric Clinics of North America* 19(2):183-197

Trivedi HK, Pattison NA, Baptista-Neto L (August 2011), Pediatric Medical Home: Foundations, Challenges, and Future Directions. *Pediatric Clinics of North America* 58(4):787-801
Trivedi HK (2011), To Look Great on the Outside: You Need to Start Taking Care of Yourself from the Inside. Ingram Content Group.

Trivedi HK, Stroeh O (2012), Appropriate and Judicious Use of Psychotropic Medication in Youth. *Child and Adolescent Psychiatric Clinics of North America* 21(4): 703-711

Peters TE, Herman T, Patel N, Trivedi HK (2014), Technology and Adolescent Behavioral Healthcare. In: Dewan NA, Luo JS, Lorenzi NM (eds), *Mental Health Practice in a Digital World: A Clinicians Guide (In press)*

Clark N, Herman T, Regier D, Trivedi HK (2104), Technology Tools supportive of DSM-V: An Overview. In: Dewan NA, Luo JS, Lorenzi NM (eds), *Mental Health Practice in a Digital World: A Clinicians Guide (in press)*

Book Reviews:

Trivedi HK (2006), Treating and Preventing Adolescent Mental Health Disorders: What we know and what we don't - A Research Agenda (Book Review). *New England Journal of Medicine* 352(21):2303

Presentations at Scientific Meetings:

Trivedi HK, Eisenberg T, Le A, Correll CU. Characteristics and appropriateness of pediatric psychiatry emergency room visits. AACAP 2003 Annual Meeting, Miami Beach, Florida, October 14-19, 2003

Callahan E, Frederickson A, Trivedi HK, Eugene MC, Le A, Eisenberg T, Shekher M, Weiskopf M, Dicker R, Correll CU. Characteristics and Appropriateness of Pediatric Psychiatric Emergency Visits. AACAP 2007 Annual Meeting, Boston, MA, October 23-28, 2007.

Callahan E, Frederickson A, Trivedi HK, Eisenberg T, Dicker R, Correll CU. Suicidality and Hospitalization as Cause and Outcome of Pediatric

Psychiatric Emergency Room Visits. Annual New Clinical Drug Evaluation Unit (NCDEU) Meeting, Phoenix, AZ, May 27-30, 2008.

Liu Y, Lorberg B, Benoit M, Axelson A, Jellinek M, Beresin E, Varley C, Schlozman S, Prager L, Kishore A, Russell K, Mailutha K, Weder N, Alleyne S, Tandon M, Berland D, P Ly, Heyneman E, Kolevzon A, Santos C, Stubbe D, Trivedi HK, Patel D. Successful Transition to Practice. AACAP 2010 Annual Meeting, New York, NY, October 25-30, 2010 *(Have participated in 2011, 2012, and 2013 as well)*

Baptista-Neto L, Garcia A, Henderson S, Trivedi HK. Emergency Child Psychiatry: *An Update on Policies, Services and Practice.* AACAP 2011 Annual Meeting, Toronto, ON, Canada, October 18-23, 2011

Trivedi HK, Jackson AH, Kroeger K, Muszincki S. Healthcare Systems Reform: *Where Do Child and Adolescent Psychiatrists Fit In the Future of Healthcare Delivery?* AACAP 2011 Annual Meeting Town Hall Presentation, Toronto, ON, Canada, October 18-23, 2011

Cheng K, DelBello M, Galanter C, Trivedi HK. Pediatric Bipolar Disorder: Advances and Challenges in Diagnosis, Biomarkers, and Treatment Modalities. American Psychiatric Association 2011 Annual Meeting, Honolulu, HI, May 14-18, 2011.

Trivedi HK, Peters T, Franklin NY, Stroeh OM. Making it Work: Building a Collaborative, Multidisciplinary Team on a Child and Adolescent Inpatient Psychiatric Unit within a Medical Home Model, AACAP 2013 Annual Meeting, Orlando, FL, October 22-25, 2013.

Trivedi HK, Peters T, Franklin NY, Stroeh OM. Making it Work: Building a Collaborative, Multidisciplinary Team on a Child and Adolescent Inpatient Psychiatric Unit within a Medical Home Model, AACAP 2014 Annual Meeting, San Diego, CA, October 22-25, 2014.

Trivedi HK, Houston M. Healthcare Systems Reform: *What is the role of Child and Adolescent Psychiatrists in Population Health?* AACAP 2014 Annual Meeting Town Hall Presentation, San Diego, CA, October 18-23, 2014

Awards or Recognition for Professional Activities:

National Institutes of Health: Research Apprenticeship Program Award, 1993

One of 12 recipients selected annually to engage in an intensive 12-week research training program with advanced coursework in research design and biostatistics.

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Mack Lipkin Broader Horizons International Research Fellowship, CUNY Medical School, 1997

One of 6 recipients selected annually; Designed and implemented a knowledge and attitudes survey for pregnant women in Ahmedabad, India regarding the World Health Organization (WHO) Expanded Program of Immunization.

Stanley Scholars Research Fellowship in Psychiatry, 2000

One of 25 recipients selected annually to expose promising trainees to research careers in psychiatry.

American Academy of Child and Adolescent Psychiatry Outstanding Resident Award, 2002 and 2003

Selected as one of 20 national recipients of the Young Leaders Award.

Indo-American Psychiatric Association
Dr. Jyotsna Pandya Outstanding Resident Award, 2003

One recipient selected nationally for excellence in the field of psychiatry.

Jeanne Spurlock, MD Congressional Fellowship,
American Psychiatric Foundation, 2003

One recipient selected nationally to work on Capitol Hill developing federal health policy, particularly policy related to children and minorities during PGY IV year.

Von L. Meyer Award, Children's Hospital Boston, 2005

One of 5 recipients selected annually for the advancement of academic non-clinical skills.

Farley Fund Fellowship, Children's Hospital Boston, 2005

One of 15 recipients selected annually for excellence in clinical care, leadership, and patient advocacy.

American Medical Association Foundation Leadership Award, 2005

One of 21 nationally selected recipients for leadership skills in advocacy, community service and education.

American Association of Directors of Psychiatric Residency Training
George Ginsberg Fellowship Award, 2006

One of 7 recipients selected nationally for excellence in education and teaching.

SBH-KINGSPORT 002713

Best Doctors Inc.
Named a "Best Doctor" for 2010, 2011, 2012

University of Tennessee Haslam School of Business
Outstanding Physician Leader of the Year, 2012

Nashville Healthcare Council Fellows Program
Finding innovative solutions for healthcare reform
1 of 30 senior healthcare leaders chosen for prestigious program, 2015

Teaching Activities:

Medical School Courses:

Course Title	*Required (R) or Elective (E)*	*Student Contact Hours*
1. **Evidence Based Medicine for Medical Students** (2004, Albert Einstein College of Medicine)	**Required** weekly lecture for Psychiatry Core Clerkship at Long Island Jewish Medical Center. * Created a new course to correspond to medical school pre-clinical EBM coursework * Innovative format combining didactic lectures and an EBM project with hands-on practicum (including formulating a question, conducting an EBM search, critically appraising the literature, and applying EBM knowledge to patient case).	**Lecture:** 1 hour weekly for duration of Psychiatry core clerkship **Conference**: **Laboratory**: Completion of EBM project – 1 on 1 supervision of all medical students in clerkship (variable time commitment dependent on student needs)

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Course Title	*Required (R) or Elective (E)*	*Student Contact Hours*
2. **Question Based Review of General Psychiatry** (2004, Albert Einstein College of Medicine)	**Required** weekly class for all general psychiatry residents and clinical fellows at Long Island Jewish Medical Center. * Developed a seminar based upon trainees being pre-assigned a subset of questions to look-up and reviewing answers the following week in conference format. Provided as preparation for house officer in service exams and professional board exam.	**Lecture:** **Conference:** 1 hour weekly throughout the academic year **Laboratory:**
3. **Crash Course in Child and Adolescent Psychiatry** (2005-2006, Harvard Medical School)	**Required** orientation course for incoming Child and Adolescent Psychiatry fellows at Children's Hospital Boston. * Created a new course to provide a "crash course" to the essential knowledge necessary to safely and successfully begin treating children and adolescents with mental health problems.	**Lecture:** 3 hours weekly for initial 4 weeks of fellowship **Conference:** **Laboratory:**
4. **Psychopharmacology Lecture Series: Anti-Epileptic Drugs in the Treatment of Aggression in Children and Adolescents** (2005-2006, Harvard Medical School)	**Required** psychopharmacology course for Child and Adolescent Psychiatry fellows at Children's Hospital Boston.	**Lecture:** 1 hour **Conference:** **Laboratory:**

Course Title	*Required (R) or Elective (E)*	*Student Contact Hours*
5. **Normal Child and Adolescent Development: Developmentally Informed Management of Common Medical Problems** (2006 – 2010, Alpert Medical School of Brown University)	**Required** lecture for Psychiatry Core Clerkship. * Innovative format of teaching development in an integrated chronological method utilizing clinical cases, video clips, and handouts.	**Lecture:** 1 hour every sixth week **Conference:** **Laboratory:**
6. **Boot Camp in Child and Adolescent Psychiatry** (2006 – 2010, Alpert Medical School of Brown University)	**Required** orientation course for incoming Child and Adolescent Psychiatry fellows and Triple Board residents at Bradley Hospital. * Revamped an existing course (based on prior work at Children's Hospital Boston) to provide a "bootcamp" to the essential knowledge necessary to safely and successfully begin treating children and adolescents with mental health problems.	**Lecture:** 3 hours weekly for 10 weeks **Conference:** **Laboratory:**
7. **Clinical Interviewing Course** (2006 - 2010, Alpert Medical School of Brown University)	**Required** weekly interviewing course for all Child and Adolescent Psychiatry fellows, Triple Board residents, general psychiatry residents, and medical students at Bradley Hospital. * Innovative format of alternating child, adolescent and family assessment interviews observed in vivo through closed circuit TV with built-in didactic and practicum sessions.	**Lecture:** **Conference:** 1.5 hours weekly throughout academic year **Laboratory:**

SBH-KINGSPORT 002716

Course Title	*Required (R) or Elective (E)*	*Student Contact Hours*
8. **Journal Club** (2006 - 2010, Alpert Medical School of Brown University)	**Required** monthly journal club for all Child and Adolescent Psychiatry fellows and Triple Board residents.	**Lecture:** **Conference:** 1.5 hours monthly throughout academic year **Laboratory:**
9. **Evidence Based Medicine** (2007-2009, Alpert Medical School of Brown University)	**Required** weekly lecture for PGY-I and PGY-II residents in General Psychiatry Residency Training Program. * Innovative format combining didactic lectures and an EBM project with hands-on practicum (including formulating a question, conducting an EBM search, critically appraising the literature, and applying EBM knowledge to patient case). * Required as a core introductory course before residents progress to Journal Club in PGY-III and PGY-IV years.	**Lecture:** 2 hours weekly for 8 months of academic year (shared with co-instructor) **Conference:** **Laboratory:** Each trainee completes an EBM project on a rotating basis – providing 1 on 1 supervision of offline EBM process (variable time commitment dependent on student needs)
10. **Child and Adolescent Development: Adolescent Development** (2007 - 2010, Alpert Medical School of Brown University)	**Required** lecture for general psychiatry residents.	**Lecture:** 1 hour annually **Conference:** **Laboratory:**
11. **Mood Disorders Module: Evidence-Based Treatments for Pediatric Depressive Disorders** (2007 - 2010, Alpert Medical School of Brown University)	**Required** lecture for Child Psychiatry residents and Triple Board residents.	**Lecture:** 1 hour annually **Conference:** **Laboratory:**

SBH-KINGSPORT 002717

Course Title	*Required (R) or Elective (E)*	*Student Contact Hours*
12. Child and Adolescent Psychopharmacology (2007 - 2010, Alpert Medical School of Brown University)	**Required** lecture for child track psychology interns.	**Lecture:** 2 hours annually **Conference:** **Laboratory:**
13. Anxiety Disorders Module (2007 - 2010, Alpert Medical School of Brown University)	**Required** lecture series for Child Psychiatry residents and Triple Board residents. *Module leader responsible for organizing lecture topics and assigning faculty lecturers.	**Lecture:** 6 hours annually **Conference:** **Laboratory:**
14. Psychotic Disorders Module (2007 - 2010, Alpert Medical School of Brown University)	**Required** lecture series for Child Psychiatry residents and Triple Board residents. *Module leader responsible for organizing lecture topics and assigning faculty lecturers.	**Lecture:** 3 hours annually **Conference:** **Laboratory:**
15. Child and Adolescent Psychiatry Orientation (July 2010 - Vanderbilt Medical School)	**Required** orientation course for incoming Child and Adolescent Psychiatry fellows. * Revamped an existing course (based on prior work at Children's Hospital Boston and Bradley Hospital) to provide an orientation to the essential knowledge necessary to safely and successfully begin treating children and adolescents with mental health problems.	**Lecture:** 15 hours during a 3 week course **Conference:** **Laboratory:**

SBH-KINGSPORT 002718

Course Title	*Required (R) or Elective (E)*	*Student Contact Hours*
16. Advocacy and Public Policy Seminar (2010 - Present, Vanderbilt Medical School)	**Required** lecture series for Child Psychiatry residents. *Course organizer and lecturer. Innovative format combining didactics, guest speakers (who run major child-serving systems in Middle Tennessee).	**Lecture:** 8 hours **Conference:** **Laboratory:**
17. Mental Health Intersession (2010 – Present, Vanderbilt Medical School)	**Required** lecture for all first year Vanderbilt medical students. From Cell to Child: Intersection of Cell Biology, Pharmacogenomics, and Human Development.	**Lecture:** 3 hours **Conference:** **Laboratory:**
18. Case Conference (2010 – Present, Vanderbilt Medical School)	**Required** Clinical Case Conference for all faculty, trainees, and medical students in the Department of Psychiatry.	**Lecture:** **Conference:** 8 hours **Primary Discussant:** Six times annually
19. Overview of C/A Psychopharmacology for General Psychiatry Residents (2010 – Present, Vanderbilt Medical School)	**Required** lecture for general psychiatry residents.	**Lecture:** **Conference:** 1 hour **Laboratory:**
20. VMS II Brain and Behavior Small Group Sessions (2011 – Present, Vanderbilt Medical School)	**Required** group session for Vanderbilt Medical Students to practice patient interviewing.	**Lecture:** 6 hours **Conference:** **Laboratory:**
21. Clinical Skills Assessment (2011 – Present, Vanderbilt Medical School)	**Required** board examination for child psychiatry fellows.	**Lecture:** 20 hours **Conference:** **Laboratory:**

SBH-KINGSPORT 002719

Course Title	*Required (R) or Elective (E)*	*Student Contact Hours*
22. Objective Structured Teaching Examination (OSTE) for Generalist Resident Physicians (2011 – Present, Vanderbilt Medical School)	**Required** OSTE for general psychiatry residents.	**Lecture:** 6 hours **Conference:** **Laboratory:**
23. Child and Adolescent Psychiatry Orientation (July 2011 - Present, Vanderbilt Medical School)	**Required** orientation course for incoming Child and Adolescent Psychiatry fellows.	**Lecture:** 15 hours during a 3 week course **Conference:** **Laboratory:**
24. General Psychiatry Lecture Series (2011 - Present, Vanderbilt Medical School)	**Required** lecture for all first year Vanderbilt Psychiatry Residents. Lecture topics included: • Standards of Professional Conduct • Introduction to Acute and Urgent Care-Commitments • Seclusion-Restraints and Assessment of Capacity.	**Lecture:** 1 hour **Conference:** **Laboratory:**
25. Child & Adolescent Seminars (2011 – Present, Vanderbilt Medical School)	**Required** lecture for general psychiatry residents. • Policy – QA/QI Exercise • Mood Stabilizers and Aggression • Outpatient– Management of psychotic patient discharged from inpatient	**Lecture:** 4 hours **Conference:** **Laboratory:**
26. Psychopharmacology Lecture Series (2011 - Present, Vanderbilt Medical School)	**Required** lecture for second year psychiatry residents. • Psychopharmacology – Special Considerations in CA Psychiatry • Psychopharmacology – Mood Stabilizers – Side • Effects / Contraindication / Monitoring	**Lecture:** 2 hours **Conference:** **Laboratory:**

SBH-KINGSPORT 002720

Course Title	*Required (R) or Elective (E)*	*Student Contact Hours*
27. Introduction to Managed Care (2012 - Vanderbilt Medical School)	**Required** lecture for fourth year psychiatry residents.	**Lecture:** 1 hour **Conference:** **Laboratory:**
28. Managed Care-Hospital Issues (2011 - Present, Vanderbilt Medical School)	**Required** lecture for fourth year psychiatry residents.	**Lecture:** 1 hour **Conference:** **Laboratory:**
29. Networking and Attending Meetings (2012 - Vanderbilt Medical School)	**Required** lecture for fourth year psychiatry residents.	**Lecture:** 1 hour **Conference:** **Laboratory:**

Undergraduate Courses:

1. Vanderbilt Faculty VUcepter (2011 – 2014, Vanderbilt University)	**Required** for all incoming freshmen.	**Lecture:** **Conference:** **Laboratory:** 40 hours

Continuing Education:

Program	*Role: Organizer (O) or Lecturer (L)*	*Number of Hours*
1. Capitol Hill Visits Made Easy (Workshop at American Academy of Child and Adolescent Psychiatry 2004 Annual Meeting)	Organizer and Lecturer	3 hours
2. Grassroots Advocacy for Psychiatrists (Workshop at American Psychiatric Association 2006 Annual Meeting)	Organizer and Lecturer	3 hours

SBH-KINGSPORT 002721

Program	*Role: Organizer (O) or Lecturer (L)*	*Number of Hours*
3. **How Child and Adolescent Psychiatrists Can Affect Policy Change** (Workshop at American Academy of Child and Adolescent Psychiatry 2006 Annual Meeting)	Organizer and Lecturer	3 hours
4. **Advocacy in Child and Adolescent Psychiatry: Experiences from the Bedside to Capitol Hill** (2006 - Grand Rounds Presentation at Division of Child and Adolescent Psychiatry, Long Island Jewish Medical Center, Glen Oaks, NY)	Lecturer	1 hour
5. **Advocacy in Child and Adolescent Psychiatry: Experiences from the Bedside to Capitol Hill** (2007 - Multi-Disciplinary Teaching Rounds, New York University Child Study Center, New York, NY)	Lecturer	2 hours
6. **Practical Child and Adolescent Psychiatry: Diagnosing and Treating Adolescent Depression in Primary Care** (2008 - Pediatrics Grand Rounds, Winthrop University Hospital, Mineola, NY)	Lecturer	1 hour
7. **Teaching Tools for the Clinical Setting: Evidence-Based Medicine** (2008 - Brown Faculty Development Workshop)	Lecturer	3 hours

SBH-KINGSPORT 002722

Program	*Role: Organizer (O) or Lecturer (L)*	*Number of Hours*
8. **Understanding Medications for Behavioral and Emotional Problems in Adolescents** (2008 - Rhode Island Coalition Against Domestic Violence, Providence, RI)	Lecturer	2 hours
9. **Typical Anti-Psychotics in Child and Adolescent Psychiatry** (2009 – Bradley Hospital/URI Nursing School Psychopharmacology Course)	Lecturer	1.5 hours
10. **Mental Health Advocacy Training** (Workshop at American Academy of Child and Adolescent Psychiatry 2010 Annual Meeting)	Organizer and Lecturer	2 hours
11. **Health Care Systems Reform and Mental Health Parity** (Workshop at American Academy of Child and Adolescent Psychiatry 2010 Annual Meeting)	Town hall meeting with all members of professional organization. Organizer and Lecturer	2 hours
12. **Successful Transition to Practice** (Workshop at American Academy of Child and Adolescent Psychiatry 2010 Annual Meeting)	Lecturer Rated 9.68/10 by workshop participants; Dr. Trivedi selected as "most effective presenter"	3 hours
13. **Antidepressant Update** (2010 – Meharry Medical School, Nashville, Tennessee)	Lecturer	1 hour

SBH-KINGSPORT 002723

Program	*Role: Organizer (O) or Lecturer (L)*	*Number of Hours*
14. Managing Medically Ill Patients at Vanderbilt Psychiatric Hospital (2010 – Mortality, Morbidity, and Improvement Conference for Department of Psychiatry, Vanderbilt Medical School)	Organizer and Lecturer	1 hour
15. Suicide and Violence Risk Assessment at VPH: An Interactive Introduction to a More Standardized Approach (2011 – Mortality, Morbidity, and Improvement Conference for Department of Psychiatry, Vanderbilt Medical School)	Lecturer	1 hour
16. Reflections of VPH Chief Resident: Managing System Change at Vanderbilt Psychiatric Hospital (2011 - Vanderbilt Medical School)	**Required** lecture for general psychiatry residents.	1 hour
17. Successful Transition to Practice (Workshop at American Academy of Child and Adolescent Psychiatry 2011 Annual Meeting)	Lecturer	3 hours
18. Child/Adolescent Psychiatry Inpatient Care (2011 – Vanderbilt Psychiatric Hospital Child and Adolescent Nursing Course)	Lecturer • Common Diagnoses in C/A Psychiatry • Common Medications, Classes, and Concerns	2 hours
19. Administrative Psychiatry Mentorship (2011-2012 – Vanderbilt Department of Psychiatry)	Organizer and Lecturer	20 hours

SBH-KINGSPORT 002724

Program	*Role: Organizer (O) or Lecturer (L)*	*Number of Hours*
20. April Fest (2012 – Vanderbilt Nurse Residency Program)	Lecturer "Meeting the needs of the whole child.	2 hours

Clinical Teaching:

Outpatient CORE Supervisor (2006 – 2010, Outpatient Department at Bradley Hospital)	Weekly supervision of first year Child and Adolescent Psychiatry residents of their outpatient caseload.
Inpatient Rotation Clinical Supervisor (2006 - 2010, Adolescent Inpatient Unit at Bradley Hospital)	Daily supervision of first year Child and Adolescent Psychiatry residents and Triple Board residents of their inpatient caseload.
Inpatient Rotation Clinical Supervisor (2006 - 2010, Adolescent Inpatient Unit at Bradley Hospital)	Daily supervision of medical students during their core psychiatry clerkship.
Inpatient Clinical Supervisor (2010 – Present Vanderbilt Psychiatric Hospital)	Daily supervision of fellows, residents, and medical students during their inpatient psychiatry rotations.

Research Supervision:

Name	*Status*	*Dates*	*Did work result in publication(s)?*
1. Emily Katz, MD, FAAP	Resident	7/07- 6/08	Yes
2. Elizabeth Kowal, MD	Resident	7/07- 6/08	Yes
3. Gina Liguori, BS	Psychology Assistant	7/07- 6/08	Yes
4. Elizabeth Lowenhaupt, MD	Resident	7/07- 6/08	Yes
5. Gary Maslow, MD	Resident	7/07- 6/08	Yes
6. Tracy Mullare, MD	Resident	7/07- 6/08	Yes

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Name	*Status*	*Dates*	*Did work result in publication(s)?*
7. Todd Peters, MD	Resident	7/09 – 7/10	Yes
8. Sherri Sharp, MD	Resident	7/07- 6/08	Yes
9. Heather Shibley, MD	Resident	7/08 – 6/09	No
10. Matthew Siegel, MD	Resident	7/07- 6/08	Yes
11. Bradley Freeman, MD	Faculty	3/10 – 6/12	Yes
12. Mike Fuller, MD	Chief Resident	7/10 – 6/11	No
13. Jonathan Becker, DO	Chief Resident	1/11 – 6/12	No
14. Todd Peters, MD	Faculty	10/11 - Present	Yes
15. Oliver Stroeh, MD	Faculty	12/11 – 3/13	Yes
16. Jo Ellen Wilson, MD	Chief Resident	7/12 – 6/13	No
17. Nathaniel Clark, MD	Faculty	6/13 – Present	Yes
18. Theresa Herman, MD	Staff	6/13 – Present	Yes

Other Significant Activities:

AACAP Annual Meeting Mentoring Program
2007-Present

Selected nationally for role as mentor during AACAP Annual Meeting Mentoring Program. Mentored 10 medical students and general psychiatry trainees annually about considering future careers in Child and Adolescent Psychiatry.

Mock Board Examiner
2006- 2010

Faculty mock board examiner for Brown Child and Adolescent Psychiatry and Triple Board residents. Facilitate mock board exams for recent graduates taking ABPN board exams for board certification.

Brown Klingenstien Third Generation Grant Mentor
2007- 2010

Volunteer role as mentor to a first or second year Brown medical student considering a future career in Child and Adolescent Psychiatry.

Mock Board Examiner
2010 -Present

SBH-KINGSPORT 002726

Faculty mock board examiner for Vanderbilt Child and Adolescent Psychiatry residents and fellows. Facilitate mock board exams for recent graduates taking ABPN board exams for board certification.

Keynote Speaker for Mental Health Association of Middle Tennessee
2010 Annual Meeting
"Disaster Recovery for Flood Victims: Meeting the Mental Health Needs of Our Community"

National Alliance on Mental Illness: *Research Advances and Hope for the Future – Including Children's Issues*
2011 State Convention – Nashville, TN
Plenary session speaker

Tennessee Suicide Prevention Network
2011 Suicide Prevention Awareness Day Keynote Speaker
2012 Suicide Prevention Awareness Day Keynote Speaker

WoodRidge Behavioral Care
2011 Regional Conference – Nashville, TN
Guest speaker

Vanderbilt Volunteer Services
2014 Presenter: "What's New in Psychiatry"

Wisconsin Psychiatric Association
2014 Presenter – Regional Conference – Kohler, WI
- "Psychiatry and Healthcare Reform / Vanderbilt's Model"
- "Future Models of Psychiatric Care"

Television, Print, Internet and Radio Interviews:

New England Psychologist – "Study: Suicides increase after 'black box' warn issued"
2007 Interviewed and published in the November 2007 Issue as a "Leading Story"

The Tennessean – "Al, Tipper split reflects growing trend among baby boomers"
2010 Interview Topic: More long-term marriages end - Hurt and healing
June 3, 2010

AACAP's Early Career Psychiatrist (ECP) for Advocacy – Website
2011 Selected to participate in the development of the ECP website. Submitted a bio on how to be more involved in patient advocacy.

Vanderbilt School of Medicine "Ask a Psychiatrist Forum"

2011 Selected as one of seven psychiatrists to partner with the Student Wellness Program and answer questions through an anonymous online forum through the Vanderbilt School of Medicine website.

Nashville Public Television *Reports* – "Children's Health Crisis Mental Health"

2011 Interviewed and televised on NPT June 29, 2011.

***The Tennessean* – "Recovery from Nashville flood comes slowly for Bordeaux community"**

2011 Interview Topic: 2010 May Flood in Nashville, Tennessee

***The Pitt News* – "Investigation into Western Psych shooting to result in security changes"**

2012 Interview Topic: Shooting at UPMC Western Psychiatric Institute and Clinic that left two dead and seven injured – Pittsburgh, Pennsylvania

ABC – "Girl with Flesh-Eating Disease Faces 'Horror,' Depression"

2012 Interviewed and televised on ABC Good Morning America, May 15, 2012

ABC – "Domestic Violence / Why would a victim of domestic violence cover it up?" Interviewed on July 3, 2012

Tennessee Voices for Children – "Lasting Change: Children's Mental Health"

2012 Interviewed for a documentary film on July 10, 2012. Scheduled to be completed in 2013.

NBC – "Bipolar Missing Millionaire's GPS Data Released"

2012 Interviewed and televised on National NBC on July 12, 2012

***The Tennessean* – "Spinal Tap Patients Worry About Fungal Meningitis"**

2012 Interviewed on October 8, 2012

NewsChannel 5 – "Runners Begin Processing What Happened At The Boston Marathon" 2013 Interviewed and televised on April 17, 2013

Entertainment Tonight – "How Verbal Violence (Bullying) Impacts Other Emotionally" 2014 Interviewed on August 4, 2014

NPR *Here & Now* – "After Robin William's Death, a Look at Depression" Interviewed and aired on August 12, 2014

Reuters – "Psychiatric Appointments Scare in Major U.S. Cities" Interviewed and published on October 17, 2014

From Sullivan Report Ex. 24A

Table 105. Inpatient private, not-for-profit, and for-profit psychiatric beds, by facility ownership status and state: number and number per 100,000 adults, United States, FY 2007

[Data are based on a survey of hospitals]

State	FY 2007 adult population (1,000s)	Beds in private, not-for-profit hospitals		Beds in private, for-profit hospitals		Beds in all private hospitals	
		Number	Number per 100,000 adults	Number	Number per 100,000 adults	Number	Number per 100,000 adults
United States	227,240	34,133	15.0	17,920	7.9	52,053	22.9
Alabama	3,510	107	3.0	584	16.6	691	19.7
Alaska	500	49	9.8	74	14.8	123	24.6
Arizona	4,674	370	7.9	85	1.8	455	9.7
Arkansas	2,139	481	22.5	348	16.3	829	38.8
California	26,799	2,070	7.7	1,815	6.8	3,885	14.5
Colorado	3,647	300	8.2	140	3.8	440	12.1
Connecticut	2,666	810	30.4	0	0.0	810	30.4
Delaware	659	45	6.8	92	14.0	137	20.8
District of Columbia	472	131	27.7	104	22.0	235	49.8
Florida	14,196	1,235	8.7	1,261	8.9	2,496	17.6
Georgia	6,997	610	8.7	462	6.6	1,072	15.3
Hawaii	986	151	15.3	0	0.0	151	15.3
Idaho	1,090	70	6.4	237	21.7	307	28.2
Illinois	9,585	1,892	19.7	649	6.8	2,541	26.5
Indiana	4,754	886	18.6	386	8.1	1,272	26.8
Iowa	2,267	542	23.9	0	0.0	542	23.9
Kansas	2,076	337	16.2	0	0.0	337	16.2
Kentucky	3,245	695	21.4	463	14.3	1,158	35.7
Louisiana	3,273	188	5.7	675	20.6	863	26.4
Maine	1,037	359	34.6	0	0.0	359	34.6
Maryland	4,267	1,157	27.1	25	0.6	1,182	27.7
Massachusetts	5,051	1,300	25.7	598	11.8	1,898	37.6
Michigan	7,605	1,625	21.4	307	4.0	1,932	25.4
Minnesota	3,926	581	14.8	0	0.0	581	14.8
Mississippi	2,155	148	6.9	568	26.4	716	33.2
Missouri	4,475	983	22.0	702	15.7	1,685	37.7
Montana	737	92	12.5	0	0.0	92	12.5
Nebraska	1,323	259	19.6	0	0.0	259	19.6
Nevada	1,900	18	0.9	257	13.5	275	14.5
New Hampshire	1,018	182	17.9	84	8.2	266	26.1
New Jersey	6,566	1,747	26.6	210	3.2	1,957	29.8
New Mexico	1,464	10	0.7	302	20.6	312	21.3

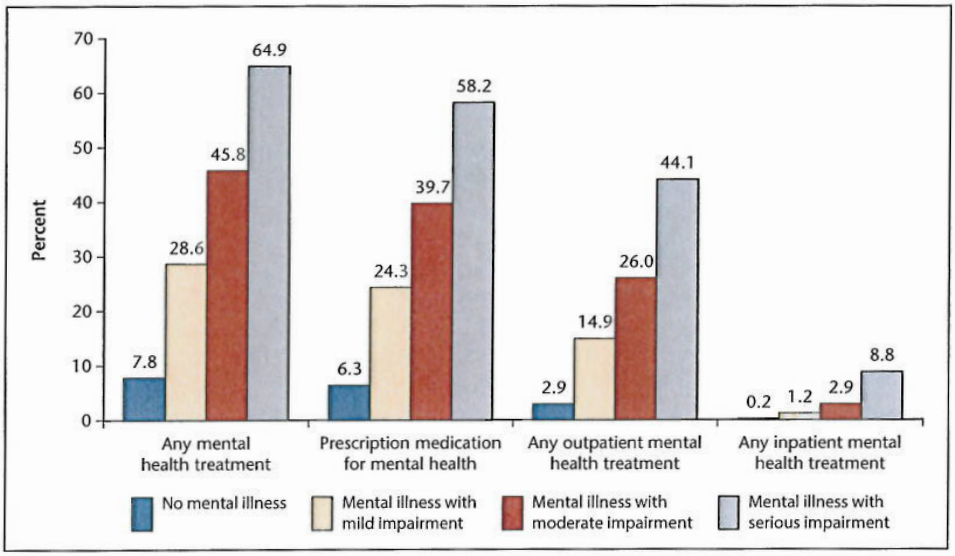
(continued)

X - 1038

SBH-KINGSPORT 002729

From Sullivan Report Ex. 24A

Figure 4-1. Past year mental health treatment types among adults, by past year mental health status and level of impairment: 2011



SOURCE: National Survey on Drug Use and Health, 2011 (revised May 2013), Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. See Appendix Table A-10 for detailed source information.

people reported that they do not know where to get treatment, think they can handle the substance use problem on their own, find treatment inconvenient/lack transportation, or do not think they have time to seek care.

4.1.3 Amount and Adequacy of Treatment

According to the NCS-R, adults with mental health disorders who receive treatment average about four visits to treatment per year. Those who receive treatment in specialized mental health care settings (e.g., from a psychologist) generally have more visits than those treated in general medical settings (e.g., from a primary care doctor) (Wang et al., 2005b). People treated for substance use disorders average six visits per year, with those receiving care in a specialty setting (e.g., substance abuse treatment center) averaging more visits per year than those receiving care in a general medical setting (e.g., primary care practice).

The available data suggest that most mental health or substance abuse treatment does not meet guidelines to be minimally adequate.[1] Adequate treatment in the NCS-R is defined as receiving certain amounts of medication or treatment according to

[1] The NCS-R defined minimally adequate treatment as receiving either pharmacotherapy (≥2 months of an appropriate medication for the mental health disorder plus >4 visits to any type of physician) or psychotherapy (≥8 visits with any health care or human services professional lasting an average of ≥30 minutes), based on available evidence-based guidelines from organizations such as the American Psychiatric Association (1998, 2000, 2002, 2004), the Agency for Healthcare Research and Quality (formerly known as the Agency for Health Care Policy and Research) (1993), and the National Committee for Quality Assurance (1997).

EXHIBIT 388 7/30/15 SBH-Kingsport
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X - 0841

SBH-KINGSPORT 002730

Randall E. Jessee, Ph.D.
Senior Vice President of Specialty Services, Frontier Health

Randall E. Jessee, Ph.D., spent more than 34 years at the forefront of developing, providing and ensuring people have crisis, substance addiction, prevention, and mental health services in Northeast Tennessee, Southwest Virginia and through advocacy and leadership in Tennessee and Virginia, and also through leadership of a multi-state organization, Coalition of Appalachian Substance Abuse Policy, into Kentucky, Ohio and West Virginia, working to develop a concerted, focused, and substantial effort of agencies and institutions already affected to address the threat substance abuse presents to public safety, economic well-being, and quality of life. He is also chair of the Tennessee Co-Occurring Disorders Collaborative and chair of the Tennessee Department of Mental Health Licensure Review Panel.

As a pioneer and champion of co-occurring and crisis services, Dr. Jessee is Senior Vice President of Frontier Health's Specialty Services including Magnolia Ridge Detoxification and Residential A&D Treatment Center and Willow Ridge Women's Residential A&D Treatment Center; 24/7 Mobile Crisis Response; the Crisis Stabilization Unit; Community Justice and Recovery Court Programs; the CALM Walk-In Center Respite Services; SAFE House Domestic Violence Shelter; and HOPE for Tennessee's HIV/AID prevention program.

Under Dr. Jessee' leadership of the TAMHO Addictions and Co-Occurring Disorders Group (COD), developing partnerships with other organizations, providers, and associations within Tennessee has taken place. One significant outcome of this effort has been the creation of a COD Collaborative which consists of founding members of TAMHO, National Alliance on Mental Illness Tennessee, Tennessee Association of Alcohol, Drug and Other Addictions Services, Tennessee Coalition for Mental Health and Substance Abuse Services, Tennessee Voices for Children, and the Tennessee Department of Mental Health. The collaborative has produced a united effort to advocate for, and educate citizens in Tennessee about COD, development of policy recommendations to the Collaborative Membership and to government agencies at the State (Tennessee) and Federal level.

Dr. Jessee was instrumental in developing the State of Tennessee's first Student Assistance Program. The program is still in existence in Kingsport, Tenn., schools. He is credited with the first merger of a freestanding alcohol and drug treatment center and a community mental health center, creating Holston Alcohol and Drug in 1989. He was an early proponent and advocate for the treatment of co-occurring substance use and mental illness diagnoses and opened Frontier Health's Magnolia Ridge, a pioneer alcohol and drug treatment facility that addresses co-occurring mental illness diagnoses. Magnolia Ridge now has 7 detoxification beds for men and women, and 12 beds for men's specialized treatment. The recently opened Willow Ridge is a specialized women's treatment facility with 12 beds. Dr. Jessee also served as administrator of Woodridge Psychiatric Hospital.

Dr. Jessee received his Ph.D., in Human Development and Family Studies with a Developmental and Clinical Psychology emphasis at Pennsylvania State University. He is a Licensed Professional Counselor Mental Health Service Provider and a Licensed Alcohol and Drug Counselor (*license retired*). He also has Master's and Bachelor's degrees in Educational Psychology from the University of Tennessee.

From: McDevitt, Kasey N
Sent: Tuesday, June 17, 2014 4:35 PM
To: Wyse, Debbie L
Subject: RE: Woodridge Data to Oppose CON

Hi Debbie,

In talking with Shane, he does want to include the Grant $$ revenue (as indicated in the most recent JAR) in the financial analysis for the scenario without SBH and for the 50/50 scenario. I am thinking we can just take that $2.3 million number from the 2013 JAR and add it in as other revenue and show what the net income would be in both scenarios. Similar to the below? Not sure if this is exactly how you would do it but I think we can keep it fairly simple.

Our final call with the internal group before the hearing is actually on Thursday at noon so it would be helpful if we could be able to nail this down prior to that call.

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L21

MOUNTAIN STATES HEALTH ALLIANCE
CORPORATE FINANCE

Woodridge Psychiatric Hospital

Woodridge before SBH	FY13	FY14 Proj	FY15 Proj	FY16 Proj
Cases	3,822	3,936	3892	3912
Net Revenue	10,232,671	11,603,480	11,374,884	11,433,337
Other Revenue (Grant Funding)	2,303,290	2,303,290	2,303,290	2,303,290
Direct Costs	9,093,673	7,216,424	7,136,752	7,172,421
Contribution Margin	1,138,998	4,287,057	4,239,132	4,260,916
Fixed Costs	4,909,259	6,691,569	6,691,569	6,691,569
Net Income	(1,467,071)	(101,212)	(149,137)	(127,353)

Woodridge 50/50 Scenario	FY13	FY14 Proj	FY15 Proj	FY16 Proj
Cases	3,822	3,936	3,530	3,200
Net Revenue	10,232,571	11,503,480	9,873,169	8,481,690
Other Revenue (Grant Funding)	2,303,290	2,303,290	2,303,290	2,303,290
Direct Costs	9,093,673	7,216,424	6,407,694	5,741,409
Contribution Margin	995,752	4,094,406	3,305,638	2,609,067
Fixed Costs	4,909,259	6,691,569	6,691,569	6,691,569
Net Income	(1,467,071)	(101,212)	(922,793)	(1,647,988)

EXHIBIT 27 7/23/15 SBH - Kingsport
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Highly Confidential

MSHA-000069

SBH-KINGSPORT 002732

Thanks,
Kasey

Kasey N. McDevitt

Kasey N. McDevitt
Corporate Director, Strategic Planning
Mountain States Health Alliance
303 Med Tech Parkway, Suite 330
Johnson City, TN 37604
423.302.3472

From: McDevitt, Kasey N
Sent: Tuesday, June 17, 2014 1:14 PM
To: Wyse, Debbie L
Subject: RE: Woodridge Data to Oppose CON

I know! I apologize but he just requested this addition this morning. Shane is the one who will have to speak to the financials at the hearing so I would follow-up with him on what exactly he wants. I talk to him this afternoon about some of this stuff...but I would think Friday should be fine! I will let you know after I talk with him.

Thanks,
Kasey

From: Wyse, Debbie L
Sent: Tuesday, June 17, 2014 12:02 PM
To: McDevitt, Kasey N
Subject: RE: Woodridge Data to Oppose CON

KASEY!!!! What is the absolute latest that I can get this to you? I have several things going on right now that I am trying to get done by tomorrow or Thursday. I feel like I can easily get this done by Friday. Please let me know if you need it sooner. I will have to rearrange and prioritize.

Redacted

Highly Confidential

From: Wyse, Debbie L
Sent: Thursday, May 22, 2014 7:30 PM
To: McDevitt, Kasey N
Cc: Hilton, Shane; Malcolm, Dru; Bailey, Marlene
Subject: RE: Woodridge Data to Oppose CON

Kasey
Attached are the files for the financial impact analysis and the Charity $$. Please let me know if you have any questions. Thanks!!

From: McDevitt, Kasey N
Sent: Thursday, April 17, 2014 4:06 PM
To: Wyse, Debbie L
Subject: RE: Woodridge Data to Oppose CON

Thanks so much, Debbie!

Redacted

Highly Confidential

Just passing along the message....we just found out that the CON hearing for next week has now been delayed to June. Looking forward to seeing the analysis you have been working on so we can incorporate into the opposition but didn't want you to stay late to complete it tonight!

Thanks,
Kasey

Kasey N. McDevitt

Kasey N. McDevitt
Corporate Director, Strategic Planning
Mountain States Health Alliance
303 Med Tech Parkway, Suite 330
Johnson City, TN 37604
423.302.3472

From: Wyse, Debbie L
Sent: Thursday, April 17, 2014 8:26 AM
To: Hilton, Shane; McDevitt, Kasey N
Subject: RE: Woodridge Data to Oppose CON

I will revise the report and send back out to you both.

Thank you!
Debbie

From: Hilton, Shane
Sent: Thursday, April 17, 2014 7:51 AM
To: McDevitt, Kasey N; Wyse, Debbie L
Subject: RE: Woodridge Data to Oppose CON

From my perspective,e I would assume we would still have the indirect expenses and would show the financial impact with that assumption.

Shane E Hilton, MBA, FHFMA
CFO, Tennessee Operations
Mountain States Health Alliance
Phone: 423-302-3467

From: McDevitt, Kasey N
Sent: Wednesday, April 16, 2014 6:56 PM
To: Wyse, Debbie L
Cc: Hilton, Shane
Subject: Re: Woodridge Data to Oppose CON

Hi Debbie,

Yes, that definitely makes sense. Just wondering if there is a portion that we would want to assume would not vary with volume. I'm just concerned the net income difference between the current state vs. the SBH presence will not represent

a very convincing impact to the agency. I know our attorney is concerned they would claim that MSHA is in a position to absorb the loss we would experience.

I will connect with you after our call in the morning.

Thanks,
Kasey

Sent from my iPhone

On Apr 16, 2014, at 5:43 PM, "Wyse, Debbie L" <WyseDL@msha.com> wrote:

> Kasey,
> This may help to answer the question related to the Indirect Expense. More than half of the indirect expenses are allocated to the facilities based on a variable statistic. If our volume decreases, so would a good portion of our indirect expenses. The other facilities/departments would pick up a bigger share of the indirect expense.

WOODRIDGE HOSPITAL
FY14 JUL - FEB

OVERHEAD COST CENTERS	ALLOCATION STATISTIC
7795 PSYCH CLINICAL SERVICES	% of services provided
992 EMPLOYEE BENEFITS (MHs)	man-hours
40940 ORGANIZATIONAL DEVELOPMENT	man-hours
40941 AHA TRAINING CENTER	man-hours
40945 PATIENT CENTERED CARE	man-hours
7900 ADMINISTRATION (*)	man-hours
7916 HUMAN RESOURCES (*)	man-hours
7600 NURSING ADMINISTRATION	man-hours
40604 CENTRAL STAFFING SERVICES	man-hours
40598 INFORMATICS	man-hours
7790 PSYCH ADMINISTRATION	man-hours
7816 RESPOND	man-hours
7861 DIETARY	patient days
7848 PATIENT RESOURCE MANAGEMENT (*)	patient days
940 MALPRACTICE	patient revenue
40905 REIMBURSEMENT	patient revenue
40943 BUSINESS DEVELOPMENT	patient revenue
40944 MANAGED CARE	patient revenue
40931 VALUE OPTIMIZATION	patient revenue
40925 ADMINISTRATION-SSU & SSU 1	patient revenue
40926 ADMINISTRATION-SSU & SSU 2	patient revenue
7948 MARKETING AND PUBLIC RELATIONS (*)	patient revenue
40906 BUSINESS OFFICE	patient revenue
7912 MEDICAL RECORDS (*)	patient revenue
7915 CODING (*)	patient revenue
7913 TRANSCRIPTION (*)	patient revenue
7908 ADMITTING & REGISTRATION (*)	patient revenue
40907 PRE-VISIT COORDINATION	patient revenue
40857 MEDICAL STAFF SERVICES	patient revenue
40854 CALL CENTER - MDLINK	patient revenue
7918 EMPLOYEE BENEFITS	salary expense
7991 CONTINGENCY (*)	total expense
40953 BUSINESS HEALTH	total expense
40938 LEGAL	total expense
40904 CORPORATE FINANCE	total expense

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40936 CORP AUDIT & COMPLIANCE	total expense
40950 STRATEGIC PLANNING	total expense
40955 FUND DEVELOPMENT	total expense
40942 GOVERNMENT RELATIONS	total expense
7902 ACCOUNTING (*)	total expense
40903 TAX & SPECIAL PROJECTS	total expense
40952 QUALITY INFORMATION MANAGEMENT	total expense
40845 COMMUNITY HEALTH & WELLNESS	total expense
7550 OTHER REVENUE & EXPENSE (*)	total expense
7990 MANAGEMENT ALLOCATION (*)	% of budgeted expenses
7883 IT-ADVANCES APPLICATIONS	100% to pharmacy
40844 HEART COACH	CVS patient revenue
7710 CENTRAL SUPPLY	exp acct 640300000
7934 INFORMATION TECHNOLOGY (*)	I.S. devices
935 INTEREST EXPENSE - MME	MME depreciation expense
40914 MATERIAL & RESOURCE MANAGEMENT	P.O. line count
7932 PBX & SWITCHBOARD OPERATORS (*)	phone lines
40890 PRINT & MAIL	printing expense account
936 BLDG & AMO DEPRECIATION	square footage
934 INTEREST EXPENSE - BLDG	square footage
7873 FACILITIES & CONSTRUCTION MGMT (*)	square footage
7876 ENVIRONMENTAL SERVICES	square footage
7875 SECURITY	square footage

TOTAL INDIRECTS

Thank you!
Debbie

From: McDevitt, Kasey N
Sent: Wednesday, April 16, 2014 1:45 PM
To: Hilton, Shane
Cc: Wyse, Debbie L
Subject: RE: Woodridge Data to Oppose CON
Importance: High

Hi Shane,

Just wanted to point out my concerns for when you and Debbie discuss the WPH impact analysis. Debbie has shown Woodridge net income projected for FY15 and 16 both with and without SBH taking our patients. The financial impact of removing those patients is not as dramatic as I would've expected (only a difference in net income of $50,000 in year 2/2016).

At initial glance this afternoon, I was noticing a significant difference in Total Cost between the two scenarios of with and without SBH ($3 million difference in FY16). I would expect the direct costs to vary with volume but not all of the indirects. In my past, I have used a ratio of fixed vs. variable for indirects when developing proformas. Just wondering if we should assume all of the indirects would vary per case or if there is a ratio of fixed to variable you would suggest.

I am more than happy to jump on a call with you guys when you talk if I am available! Just let me know.

Thanks!
Kasey

Kasey N. McDevitt

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Kasey N. McDevitt
Corporate Director, Strategic Planning
Mountain States Health Alliance
303 Med Tech Parkway, Suite 330
Johnson City, TN 37604
423.302.3472

From: Wyse, Debbie L
Sent: Wednesday, April 16, 2014 12:56 PM
To: Hilton, Shane
Cc: McDevitt, Kasey N
Subject: Woodridge Data to Oppose CON
Importance: High

Shane,
Do you have any time at all today to discuss this (prior to call tomorrow AM)? Kasey and I discussed briefly but wanted you to look at this to see if you saw any issues.... The one concern Kasey has relates to the total cost.

Thank you!
Debbie Wyse, *MBA, CHFP*
Mountain States Health Alliance
Corporate Finance | Senior Financial Analyst
Telephone: (423) 302-3354 | Facsimile:(423) 302-3450 | wysedl@msha.com

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Woodridge Hospital Daily Census by Patient Unit: March through June 2015

				Beds Available				
				16	16	26	14	12
Date	Census	Occupancy	# of People on Waitlist	Cedar	Laurel	Poplar	Spruce	Willow
3/1/2015	71	84.5%	0	0	0	5	0	0
3/2/2015	74	88.1%	0	2	1	1	0	2
3/3/2015	78	92.9%	4	2	1	0	0	0
3/4/2015	77	91.7%	0	2	1	1	1	0
3/5/2015	71	84.5%	4	0	2	4	2	0
3/6/2015	75	89.3%	2	1	0	5	1	0
3/7/2015	70	83.3%	1	0	1	10	0	1
3/9/2015	81	96.4%	5	0	0	0	1	2
3/10/2015	77	91.7%	2	0	0	4	0	1
3/11/2015	78	92.9%	1	1	0	2	0	0
3/12/2015	82	97.6%	7	0	0	0	1	1
3/13/2015	82	97.6%	6	0	1	0	0	0
3/14/2015	81	96.4%	6	0	0	0	0	1
3/15/2015	80	95.2%	6	0	1	0	1	0
3/16/2015	81	96.4%	10	0	0	0	0	1
3/17/2015	74	88.1%	1	0	1	3	1	4
3/18/2015	75	89.3%	3	0	0	4	0	4
3/19/2015	70	83.3%	5	1	0	1	4	5
3/20/2015	79	94.0%	6	1	0	0	0	3
3/21/2015	79	94.0%	6	0	1	0	0	1
3/22/2015	80	95.2%	11	0	0	0	0	1
3/23/2015	81	96.4%	10	0	0	0	0	0
3/24/2015	78	92.9%	5	3	0	0	1	0
3/25/2015	73	86.9%	2	2	3	4	0	0
3/26/2015	78	92.9%	3	0	0	2	0	2
3/27/2015	80	95.2%	12	0	0	0	0	0
3/28/2015	79	94.0%	13	0	0	0	0	2
3/29/2015	80	95.2%	19	0	0	0	0	1
3/30/2015	82	97.6%	10	0	0	0	0	1

3/31/2015	79	94.0%	4	0	0	1	0	2

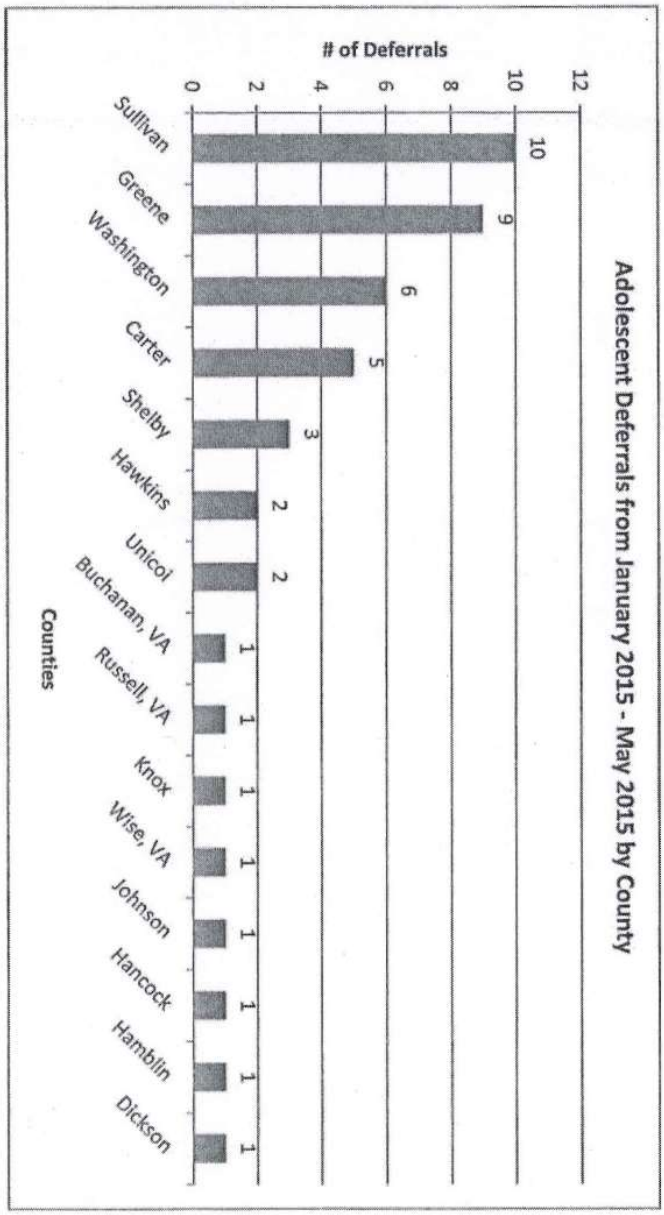
				Beds Available				
				16	16	26	14	12
Date	Census	Occupancy	# of People on Waitlist	Cedar	Laurel	Poplar	Spruce	Willow
4/1/2015	76	90.5%	0	1	1	2	1	1
4/2/2015	64	76.2%	1	7	3	6	1	1
4/3/2015	63	75.0%	2	0	0	3	1	1
4/4/2015	70	83.3%	0	3	5	1	1	2
4/5/2015	76	90.5%	1	2	2	1	0	1
4/6/2015	69	82.1%	0	0	2	10	0	2
4/7/2015	74	88.1%	0	0	0	4	0	3
4/8/2015	65	77.4%	0	1	3	0	2	2
4/10/2015	78	92.9%	3	0	0	0	1	1
4/11/2015	77	91.7%	0	0	4	1	0	0
4/13/2015	81	96.4%	2	0	1	0	0	0
4/14/2015	78	92.9%	2	0	0	3	1	1
4/15/2015	81	96.4%	1	0	0	0	0	2
4/16/2015	80	95.2%	2	0	0	1	0	1
4/17/2015	79	94.0%	1	0	1	2	0	0
4/18/2015	76	90.5%	3	2	0	1	3	0
4/19/2015	79	94.0%	2	0	0	1	2	0
4/20/2015	79	94.0%	6	0	0	3	0	0
4/21/2015	74	88.1%	9	0	0	5	1	0
4/22/2015	82	97.6%	10	0	0	0	1	0
4/23/2015	80	95.2%	10	0	0	0	1	1
4/24/2015	80	95.2%	22	0	0	1	1	0
4/25/2015	81	96.4%	21	0	0	0	1	0
4/26/2015	82	97.6%	20	0	0	0	0	0
4/27/2015	82	97.6%	10	0	0	0	0	0
4/28/2015	77	91.7%	7	1	0	2	1	1
4/29/2015	77	91.7%	5	0	0	3	0	2
4/30/2015	75	89.3%	3	0	0	3	1	3

				Beds Available				
				16	16	26	14	12
Date	Census	Occupancy	# of People on Waitlist	Cedar	Laurel	Poplar	Spruce	Willow
5/1/2015	80	95.2%	2	0	0	2	1	1
5/2/2015	75	89.3%	8	1	0	1	2	1
5/3/2015	79	94.0%	10	1	0	0	1	1
5/4/2015	82	97.6%	10	0	0	0	0	0
5/5/2015	83	98.8%	10	0	0	0	0	0
5/6/2015	82	97.6%	10	0	0	0	0	1
5/7/2015	81	96.4%	10	0	0	1	0	1
5/8/2015	81	96.4%	8	0	0	0	1	0
5/9/2015	80	95.2%	15	0	0	0	0	2
5/10/2015	81	96.4%	16	0	0	0	0	1
5/11/2015	82	97.6%	10	0	0	0	0	1
5/12/2015	80	95.2%	9	0	0	2	0	0
5/13/2015	79	94.0%	0	1	0	0	1	1
5/14/2015	79	94.0%	1	0	0	1	1	2
5/15/2015	77	91.7%	3	0	0	3	0	2
5/16/2015	77	91.7%	0	0	1	1	2	0
5/17/2015	80	95.2%	5	0	0	1	0	1
5/18/2015	81	96.4%	10	0	0	0	0	1
5/19/2015	78	92.9%	10	0	0	1	2	2
5/20/2015	78	92.9%	10	0	0	1	1	3
5/21/2015	78	92.9%	10	0	0	1	0	3
5/22/2015	77	91.7%	9	0	0	1	1	3
5/23/2015	79	94.0%	7	0	0	1	0	2
5/24/2015	80	95.2%	8	0	0	0	1	1
5/28/2015	72	85.7%	4	0	1	3	1	4
5/29/2015	77	91.7%	7	0	0	3	0	0
5/30/2015	73	86.9%	2	1	1	2	1	4
5/31/2015	77	91.7%	3	1	0	1	0	3

				Beds Available				
				16	16	26	14	12
Date	Census	Occupancy	# of People on Waitlist	Cedar	Laurel	Poplar	Spruce	Willow
6/2/2015	80	95.2%	10	1	0	0	0	2
6/3/2015	72	85.7%	3	0	1	6	1	2
6/4/2015	72	85.7%	3	1	1	4	2	2
6/5/2015	70	83.3%	0	3	0	1	0	4
6/7/2015	75	89.3%	3	0	0	0	0	3
6/8/2015	78	92.9%	9	0	0	4	0	1
6/9/2015	78	92.9%	9	1	0	2	0	0
6/10/2015	74	88.1%	10	0	0	5	0	2
6/11/2015	81	96.4%	10	0	0	0	0	0
6/12/2015	76	90.5%	6	1	0	2	1	0
6/14/2015	80	95.2%	7	0	0	0	0	0
6/15/2015	81	96.4%	10	0	0	0	0	0
6/16/2015	80	95.2%	10	0	0	0	0	0
6/17/2015	77	91.7%	7	0	0	2	0	1
6/18/2015	74	88.1%	3	0	0	5	0	1
6/19/2015	79	94.0%	6	0	0	0	0	2
6/20/2015	78	92.9%	2	1	0	1	0	1
6/21/2015	78	92.9%	4	0	0	1	0	1
6/22/2015	80	95.2%	6	0	0	0	0	1
6/23/2015	77	91.7%	6	0	0	0	0	0
6/24/2015	79	94.0%	10	0	0	1	0	1
6/25/2015	78	92.9%	10	0	0	0	0	1
6/26/2015	79	94.0%	12	0	0	1	1	0
6/27/2015	76	90.5%	11	0	0	2	2	1
6/28/2015	79	94.0%	8	0	0	0	1	0
6/29/2015	78	92.9%	10	0	0	2	0	0
6/30/2015	76	90.5%	6	0	0	0	0	3

Source: MSHA001957-001989, MSHA 001990-002021, MSHA 002022-002050, MSHA 002051-002078

Adolescent Deferrals from January 2015 - May 2015 by County

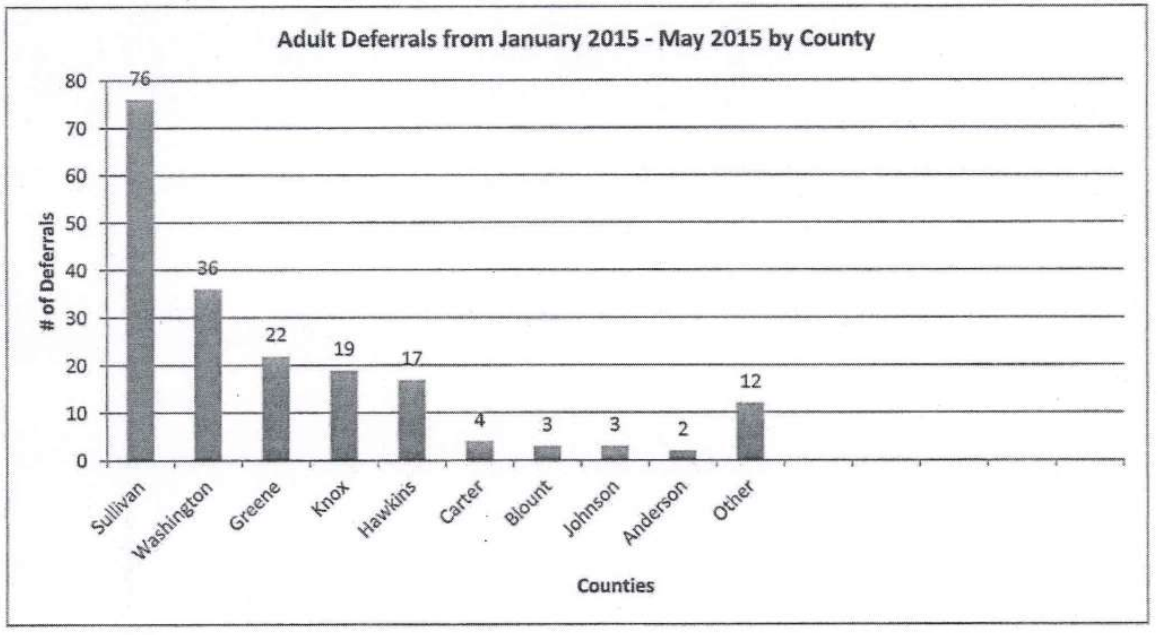


10	Sullivan
9	Greene
6	Washington
5	Carter
3	Shelby
2	Hawkins
2	Unicoi
1	Buchanan, VA
1	Russell, VA
1	Knox
1	Wise, VA
1	Johnson
1	Hancock
1	Hamblin
1	Dickson
45	**TOTAL**

PENGAD 800-631-6989
EXHIBIT
239 7/28/15
SBH-Kingsport

Adult Deferrals from January 2015 - May 2015 by County

Sullivan	Washington	Greene	Knox	Hawkins	Carter	Blount	Johnson	Anderson	Other	TOTAL
76	36	22	19	17	4	3	3	2	12	194



The Others include the following counties which had one deferral each during the time frame January 2015 thru May 31, 2015. The counties are: Jefferson, Anderson, Wythe, VA, Hamblen, Claiborne, Unicoi, Washington, VA Roane, Madison, Maury, Monroe, and Marshall

EXHIBIT 240 7/28/15 SBH-Kingsport PENGAD 800-631-6989

Reasons for Deferrals from January 2015 - May 2015

	Appropriate bed not Available	Violent Behavior	Medical Complexity	Forensic	Other	TOTAL
ADULTS	126	22	14	15	17	194

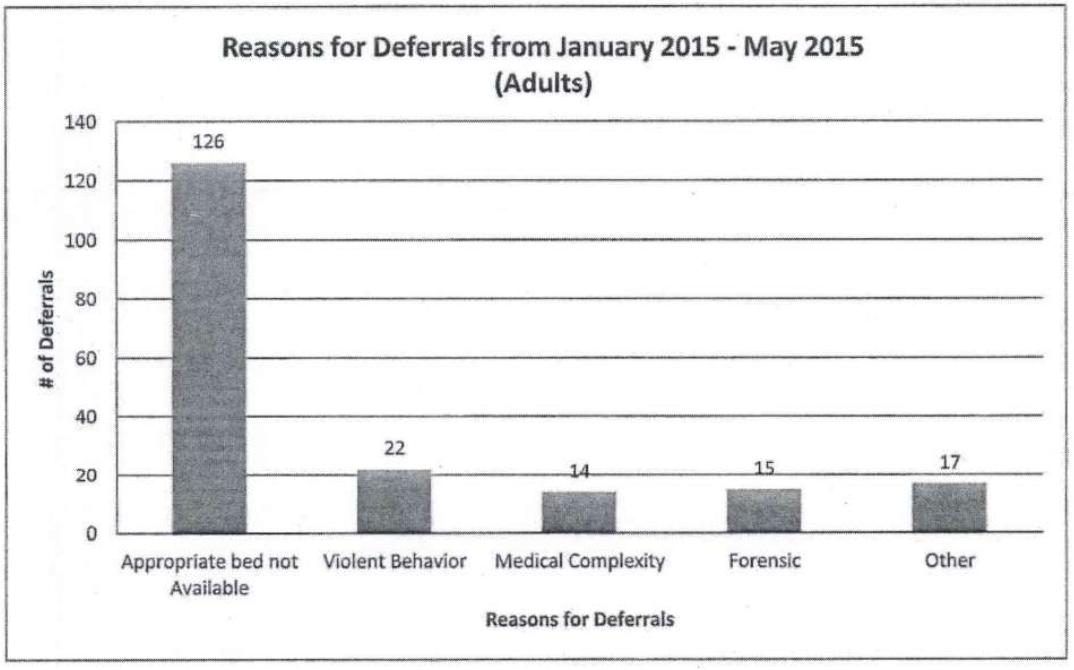
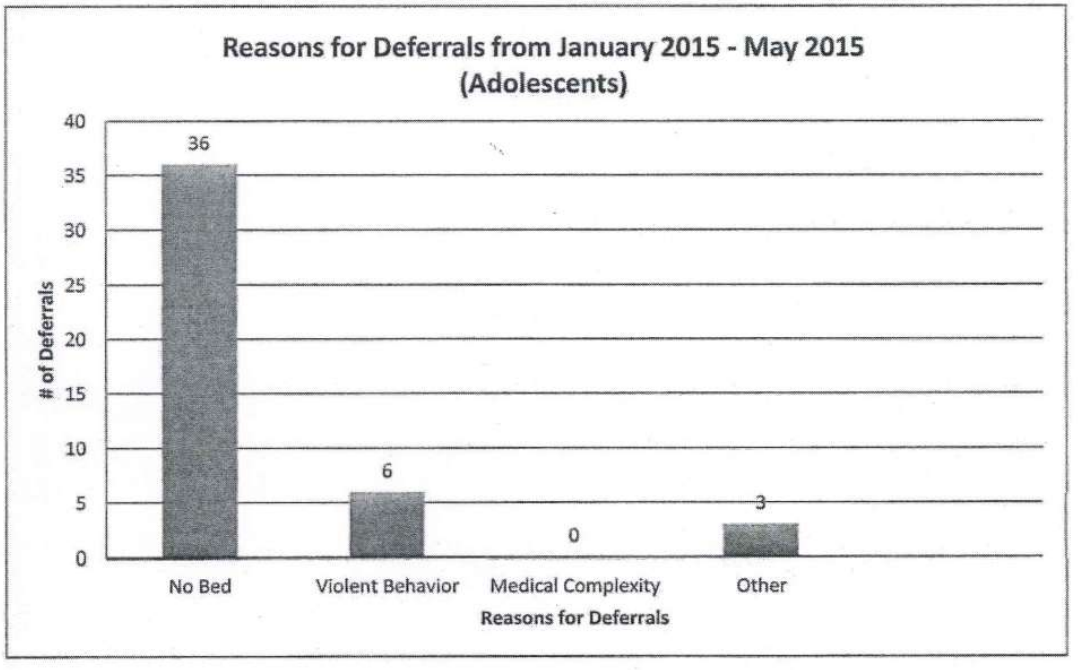


EXHIBIT 242 7/28/15 SBH-Kingsport PENGAD 800-631-6989

Reasons for Deferrals from January 2015 - May 2015

	No Bed	Violent Behavior	Medical Complexity	Other	TOTAL
ADOL	36	6	0	3	45