

**BEFORE THE TENNESSEE
HEALTH SERVICES AND DEVELOPMENT AGENCY
Nashville, Tennessee**

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

APPLICANT SBH-KINGSPORT, LLC'S RESPONSE BRIEF

I. INTRODUCTION

The hearing before Administrative Law Judge Pogue occurred over five days, consisted of the testimony of 10 witnesses, and the submission of 67 exhibits. The parties provided post-hearing briefs. After considering the relevant HSDA statutes, rules, historical practices, and the State Health Plan ("*Guidelines for Growth*" or "*Guidelines*"), Judge Pogue concluded that "[a] 72 bed facility for the proposed service area meets the Guidelines for Growth need formula."¹ The Health Services and Development Agency ("HSDA") should adopt Administrative Law Judge Pogue's Initial Order as its final Order in the matter, thereby granting SBH-Kingsport, LLC ("SBHK") Certification of Need No. CN1312-050 to establish and construct its 72-bed psychiatric hospital in Kingsport, Sullivan County, Tennessee. Judge Pogue's Initial Order is consistent with the HSDA's statutes, rules, historical practices, and the State Health Plan. It should be adopted in full by the HSDA, for the reasons set forth below.

¹ As shown below, no question exists regarding whether there is a need for more psychiatric hospital beds. The question is how many. Also at issue is whether SBHK's service area is reasonable.

II. DISCUSSION

A. SBHK's CON project is needed.

Under the *Guidelines for Growth* formula, the bed need formula is 30 beds per 100,000 population. After considering this formula and other evidence, Judge Pogue concluded that the SBHK project is needed. Judge Pogue's ruling stresses the very high utilization levels of WPH in FY2015, noting the numerous times that WPH's occupancy has been over 90%, thus causing numerous and continuing deferrals. (See, Initial Order, Conclusion no. 14, p. 000487). He also noted that Crisis Stabilization Units ("CSUs") in and of themselves do not alleviate the total need for inpatient beds, as shown by the dramatic increases in inpatient utilization at WPH since 2009, when the adult CSU in Johnson City opened. (See, Initial Order, Conclusion no. 16, p. 000487).

Judge Pogue found that WPH experienced very high occupancy levels of 90% or more in 2015, causing numerous and continuing high deferrals of patients. In fact, Judge Pogue found that if WPH's occupancy rates continue to rise at its 2015 numeric volume of increase, WPH will be 100% full in less than 2 years from FY 2015. (See, Initial Order, Findings 38-43, pp. 000471-000473).

As noted in MSHA's appeal brief, it is uncontested that WPH "is full on a handful of occasions annually." (See, MSHA brief, p. 5). MSHA's admissions on page 5 of its appeal that it is full on several occasions annually, and that it now operates "at or near 85%" occupancy normally, are surely signs that its beds are frequently not available to residents of SBHK's proposed 5-county SBHK service area (occupancy levels of 88% or 89%, which it reached in FY 2015 as shown by this records, can be said to be "near" 85%). The rising frequency of deferrals of SBHK service area residents seeking care at WPH also indicate the need for a new psychiatric hospital in Sullivan County. See Ex. 240, p. 2080, and Ex. 65, p. 1886 (a full-size copy of these exhibit excerpts and Ex. 241 is attached to this brief as **Exh. A**):

Contrary to the argument of Mountain States on page 9 of its brief, the Administrative Law Judge looked beyond the bed need formula to determine whether there was a need. Judge Pogue found that there was high utilization at WPH, that the high WPH utilization caused difficulties for patients, and that the high WPH utilization demonstrated the need for more inpatient psychiatric beds in SBHK's proposed five county service area. For example, Judge Pogue's Conclusion of Law no. 14 states as follows:

14. Admissions and patient days at WPH have been growing steadily since 2011 with a considerably higher number of admissions than budgeted for the fiscal year 2015 (as of May 31, 2015). Occupancy at WPH in 2015 (January - May) has been between 82-89%. There were days in 2014 and 2015 (January - May) when WPH had in excess of 90% occupancy and deferrals because a bed was not available for both adults and adolescents. (Tr. p. 000487).

Similarly, in his Conclusion of Law 16, Judge Pogue concluded:

16. MSHA is actively working to provide mental health services to the region. It is assisting with treating patients who previously went to Lakeshore and is collaborating on a CSU project. A CSU should decrease the need for inpatient psychiatric beds. However, as evidenced by the Johnson City adult CSU not curtailing WPH's utilization rate, a CSU in and of itself does not alleviate the total need for inpatient beds for some CSU patients and non-CSU patients. (Tr. p. 000487).

Similarly, Judge Pogue made findings further establishing the existence of need, particularly as shown by the high utilization rates at WPH. For example, at Finding no. 36, Judge Pogue found as follows:

36. Admissions at WPH have been growing at an increasing rate since 2011, and patient days are up by almost 32% since 2011. Since 2013, admissions are higher at WPH in FY 2015 by more than 23%, and patient days are higher by 3,936 patient days, or 17.7%. WPH had an 89.5% occupancy for the month of May 2015, 89.9% occupancy in November 2014, and an occupancy rate of 88% for July 2015. MSHA's CEO Alan Levine testified that his goal is for MSHA to have fewer inpatient psychiatric admissions, yet WPH grew by 15.5% in inpatient admissions from FY 2014 to FY 2015.

Furthermore, Judge Pogue found as follows:

38. As of May 31, 2015, admissions at WPH were running more than 1,000 admissions higher than the number of admissions MSHA had budgeted for WPH for the first 11 months of FY 2015. Dr. Collier [MSHA's expert] forecasts WPH's future results from a period of WPH utilization (2010-2013) which was lower than the last half of FY 2014 and all of FY 2015. WPH is currently running in calendar 2015 between 85.2% and 89.5% occupancy generally. If WPH's utilization increases (as measured by patient days) were to continue at the FY 2015 numeric volume of increase, WPH would be close to 100% full in less than two years from FY 2015.

1. **MSHA's expert, Dr. Collier, Finds a Net Need for 78 Additional Beds if SBHK's 5-County Service Area Was Used.**

Viewed in terms of the "overall net need" or "total need," as determined by application of the *Guidelines for Growth's* bed need formula of 30 beds per 100,000 population, MSHA's health planning expert, Dr. Deborah Kolb Collier, testified that there was a need, using SBHK's designated service area, for 66 additional adult psychiatric inpatient beds and 12 child and adolescent psychiatric inpatient beds. Dr. Collier agrees that the Guidelines' global 30 bed per 100,000 population formula does not call for the exclusion of any particular age group of the population. (See, Vol. 4, p. 001322). SBH's health planning expert is Daniel J. Sullivan. Mr. Sullivan (Ex. 80, p. 001938), agrees with the overall net need conclusion reached by Judge Pogue in Conclusion of Law no. 13. Given this admission by Dr. Collier, she also agrees with this conclusion regarding the total psychiatric bed need. Thus, Judge Pogue's Conclusion of Law no. 13 at p. 000456 that there is a need for a 72 bed facility for the proposed service area is based on the "population-based estimate of the total need for psychiatric inpatient services" and is not disputed by any health planning experts in this record.²

Relevant portions of Dr. Collier's testimony about the "total need formula" are set forth below:

² The Guidelines for Growth specifically direct the use of the formula "30 beds per 100,000 population" to determine the "population-based estimate of the total need for psychiatric inpatient services." Initial Order, Conclusion no. 5, p. 000482.

Q. So just using the Strategic Behavioral Health, SBH-Kingsport, service area as denominated by the applicant. There is a total need, and excluding the four and under population, there would be a total need of 90.4 patients, 78 plus 12.4 in 2019?

A. Yes. With 12 for the adolescent, 78 for the adults.

Q. So that would be 90.4, but you would need to deduct the 12 beds at the Bristol Regional Medical Center to get the total need; is that correct:

A. If you limited it to that, yes.

Q. So there would be a total need then of a little over 78 beds in 2019 for that age group we were discussing, and the applicant proposed to provide 72 beds, is that correct?

A. That's correct. And the complement of beds would not fit because of the 28-bed proposal for child and adolescent.

Q. But the gross bed need formula -- there would be a need for the gross number of beds; is that correct?

A. There would be a need for 12 child and adolescent and 66 adult.

(Vol. 4, p. 001321)

Q. . . .So from that standpoint, in a gross sense there would be a need for the adult beds proposed by SBH-Kingsport?

A. For the adult beds, yes, if you accepted that service area.

Q. I understand. And the global 30-bed per 100,000 formula does not just by itself deduct out child and adolescent populations per se? You individually analyze adolescents and children; is that correct? as the next step after of the gross bed need analysis?

A. Yes, I segregated the under five, because it's not part of this application.

Q. Right. But does the formula itself tell you to?

A. No, it doesn't tell you to do the 65 and over either, which I also calculated.

(Vol. 4, p. 001322)

B. **MSHA did not provide any proof in this record to contradict Judge Pogue's finding that WPH's patient deferral volume rose significantly in calendar 2015 over the comparable calendar 2014 volume, and remains a problem for many prospective patients needing inpatient psychiatric hospital care.**

MSHA's assertion on page 4 of its brief that "Woodridge's deferral rates have been reduced by half in the last two years" fails to acknowledge the data their own documents disclose that, while process improvements in early 2014 did temporarily reduce the total number of deferrals, over the first five months of 2015 deferrals increased by over 81% for adults at WPH over the levels of adult deferrals the first five months of 2014. (See, Exhibits 65, 240, 241, see Exhibits below).

In the last seven months of 2013, Exhibit 65 indicates there were 365 total adult deferrals at WPH. In the first five months of 2014, there were 107 total adult deferrals at WPH. However, Exhibits 240 and 241 indicate that over the first five months of 2015, there were 194 total adult deferrals at WPH. Thus, when WPH continued to run occupancy levels at or near 85%, as they did in the first six months of 2015, the number of total deferrals increased dramatically, by 81% over the prior levels in 2014 for the same period of time. Accordingly, the process improvements at WPH are insufficient to reduce deferral rates to the level they fell to in early 2014.

On page 5 of its appeal brief, MSHA criticizes SBHK's health planning expert, Dan Sullivan, for his opinions that there are patient access issues at Woodridge now because it operates at or near 85% of its capacity, and is effectively full on many occasions. MSHA makes this attack on Mr. Sullivan even though it admits at page 5 of its appeal brief that WPH is "full" on occasion. Contrary to MSHA's arguments, Mr. Sullivan did in fact examine and testify about the efforts Woodridge has made to resolve capacity issues. However, MSHA makes the misleading claim on page 5 of its brief that "there are other providers in the region with plenty of capacity when Woodridge is full." If by "other providers in the region" MSHA means Peninsula

Hospital in Blount County, Tennessee, over 100 miles away from Kingsport, perhaps this statement could arguably be accurate.

However, the data provided by Dr. Collier and Mr. Sullivan indicate that there is a large volume of patients from the five-county service area for SBHK, as well as from the larger "alternative service area" proposed by Dr. Collier, who are leaving both service areas to go to facilities far beyond either service area. Many of these patients go to Peninsula Hospital in Blount County, Tennessee in particular. These out-of-area admissions went to facilities outside either service area, such as Peninsula Hospital in Blount County, Vanderbilt University Hospital in Davidson County, and Parkridge Valley Child and Adolescent campus in Chattanooga. There were 400 patients from the five-county service area proposed by SBHK who went to these other facilities in 2013. Of these, 296 went to Peninsula Hospital in Blount County. (See, Ex. 381, p. 002686).

Similarly, from the larger "alternate service area" described by Dr. Collier's report, Ex. 381, which includes the five-county service area designated by SBHK, there were 826 patients who left that service area in 2013 to go to facilities such as Peninsula Hospital, Parkridge in Chattanooga, and Vanderbilt in Davidson County. Of these, 495 went to Peninsula Hospital in Blount County. Ex. 381, p. 002687.

These data from exhibits filed by MSHA in the record show that there are no providers in either the five-county SBHK service area or the "alternate service area" designated by Dr. Collier that have much capacity. Otherwise, why would these patients go as far as Blount County or farther away to receive psychiatric hospital care? Also, why are there so many deferrals at WPH, extending throughout the first six months of 2015, as shown by Ex. 221 and Ex. 238, the Patient Flow Sheets for 2015. See Ex. 221, pp. 002739-42 and Ex. 238, pp. 002195-2372.

While, on page 5 of its appeal brief, MSHA asserts that the MSHA's grant patients it now serves by contract with MHSAS resulted in "an increase in the acuity of the patients" at Woodridge, MSHA's own records demonstrate that this is not accurate. For example, the average length of stay data for all WPH patients in 2014 was 5.74 days. (See, Ex. 253). However, in Exhibits 254 and 67, the average length of stay WPH patients covered by the MHSAS grant was only 4.28 days in June of 2014, and 4.26 days in July of 2014. WPH patients covered by the MHSAS grant appear to have a lower average length of stay than the ALOS for all WPH patients, at least as far as these two months of experience indicate. Ms. Bailey testified at Tr. p. 001129 that the average length of stay at WPH MHSAS patients there in August 2014 was 4.27 days.

C. The record shows that SBHK's CON project can be economically accomplished and maintained.

MSHA's appeal brief does not challenge Judge Pogue's findings and conclusions that the SBHK CON project can be "economically accomplished and maintained." Initial Order, pp. 000488 and 000475-000476. Judge Pogue found that Mr. Shaheen and James Cagle, SBH's CFO, had approximately \$70 million available from its bank line of credit and \$25-30 million in annual cash flow from the company to support the development of the SBHK CON project. These findings and conclusions are not seriously challenged anywhere in this record, and especially not challenged in MSHA's appeal brief. Therefore, this record establishes that SBHK's CON application CN1312-050 satisfies the statutory CON criterion that it "can be economically accomplished and maintained" as required by T.C.A. § 68-11-1609(b).

D. SBHK's CON project satisfies the statutory criterion of "contribution to the orderly development of healthcare."

As to the statutory CON criterion of "contribution to the orderly development of healthcare," Judge Pogue found and concluded in his Initial Order that this criterion was satisfied by the SBHK CON project as shown by this record. He noted that Mr. Sullivan pointed out the advantages to the healthcare system in the SBHK service area from the SBHK project's providing additional resources to patients from the service area. Mr. Sullivan testified that SBHK would give the patients increased choices of psychiatric hospital providers as well as new sources of more psychiatrists and other mental health staff for their care. Initial Order, Finding No. 54, p. 000477 and Finding Nos. 53 and 55-56, pp. 000476-78.

In this record and in its appeal brief, MSHA and its employees, experts, and executives never dispute that WPH is a part of Johnson City Medical Center ("JCMC"), the much larger flagship hospital of MSHA. Similarly, MSHA never disputes that federal regulations require that satellite hospitals such as WPH must share their costs and revenues with their parent hospitals. 42 CFR Sec. 413.65. JCMC reported having 501 licensed hospital beds and had high net revenues in its 2013 Joint Annual Report, despite high overhead allocations to MSHA in 2013. See Ex. 83, pp. 001966, 001983, and 001986.

Despite Dr. Collier's acknowledgement (Vol. 4, pp. 001309-001311) that federal regulations require that satellite facilities share revenues and expenses with their parent facilities, MSHA never analyzed or testified about any negative impact of SBHK's new psychiatric hospital on JCMC. Judge Pogue correctly found this failure of proof to be significant. In his Conclusion of Law no. 24, on p. 000489, he concluded as follows:

"The impact of SBHK on WPH is limited by the fact that WPH is a satellite or department of JCMC and consideration should be given to SBHK's impact on JCMC and MSHA. No expert analysis was done regarding the effect of SBHK on JCMC or MSHA. JCMC had profits of over \$30 million in fiscal year 2013 and MSHA is financially operationally healthy. Any adverse impacts on WPH/JCMC/MSHA by the approval of SBHK are outweighed by the benefits

that accrue to the community from SBHK and the provision of the additional inpatient psychiatric hospital beds that SBHK brings."

MSHA does not claim that it showed any negative impact on JCMC from the SBHK CON project in this record. MSHA does not dispute that WPH is a department of JCMC, that JCMC is highly profitable, or that MSHA is also profitable. MSHA never did any detailed financial analysis of the impact of SBHK on MSHA itself; nor did their expert, Dr. Collier. Thus, Judge Pogue is correct in his findings and conclusions that the SBHK CON project does satisfy the statutory CON criterion that it "contributes to the orderly development of healthcare."

E. MSHA has not shown that Judge Pogue's Initial Order misinterpreted any HSDA rules, or that SBHK's proposed 5-county service area is not reasonable.

MSHA asserts that the Administrative Judge somehow "misinterpreted the Agency's rules as it relates to the construction of a reasonable service area," (p. 22, MSHA brief). MSHA never quotes any actual rule of the HSDA that it claims to be misinterpreted by Judge Pogue. MSHA never demonstrates how Judge Pogue's decision does not comply with any HSDA rules. In its appeal brief, MSHA never specifically addresses the rules of the HSDA itself or the history of the HSDA's prior CON decisions regarding psychiatric hospital services areas shown by this record.

Judge Pogue found that a prior HSDA ruling was consistent with how SBHK defined its proposed service area. For example, in TrustPoint Hospital's CON application for new psychiatric hospital beds in Rutherford County (CN1502-006), the applicant defined its service area as merely two counties, Rutherford and Bedford, despite the fact there were patient flows to TrustPoint from, and psychiatric hospitals in, the contiguous counties of Williamson and Davidson. This evidence is found in the record in Ex. 80, p. 001937, and is found in Judge Pogue's Initial Order (pp. 000463-000464).

Judge Pogue addresses the prior CON decisions of the HSDA by concluding in his Conclusion of Law No. 10, p. 000486, as follows: "The Agency has accepted CON applicants' service area definitions, even when the proposed service area excludes contiguous counties from which an applicant might draw patients."

Judge Pogue also made detailed findings of fact, based on the uncontroverted testimony of Mr. Sullivan on this point in the Initial Order's Finding of Fact no. 17, pp. 000463-64, in which he found the following facts to be true:

Specifically, the Agency recently approved an application by TrustPoint Hospital in Rutherford County, Tennessee to expand its inpatient psychiatric bed capacity. In its application, TrustPoint defined its service area as including only two counties, Rutherford and Bedford, and excluded the contiguous counties of Davidson and Williamson. Both Davidson and Williamson counties have other large and significant hospital providers of inpatient psychiatric services and TrustPoint's application indicated that Davidson County itself was the second largest source of its admissions, yet its defined service of Bedford and Rutherford Counties was utilized by the Agency in analyzing the need for TrustPoint's additional psychiatric beds. Also, Rolling Hills Hospital, a psychiatric hospital in Williamson County, Tennessee had its CON application approved with Rutherford and Bedford Counties included as part of Rolling Hills' service area. Williamson County is contiguous to both Rutherford County and Davidson County.

Rolling Hills' CON application, CN1312-0051, was granted in 2014, well before Trustpoint filed its CON application, CN1502-006, in 2015.

MSHA does not challenge these facts as found by Judge Pogue. It is undisputed in this record that the HSDA approved TrustPoint Hospital's two-county service area, and that Rolling Hills Hospital's 2013 CON application's service area included both Rutherford and Bedford Counties. On the contrary, MSHA has presented no CON application in this record which was ever denied because a county contiguous to the claimed service area might be a source of patients to the project in the past or future.

SBHK's exclusion of Washington County, Tennessee from its service area does not indicate that the SBHK CON application's five-county service area is unreasonable, or that Judge

Pogue was inconsistent with prior CON decisions when he found that the five-county SBHK service area was reasonable. Therefore, contrary to MSHA's argument that the HSDA's acceptance of Judge Pogue's Initial Order would "establish unacceptable precedent for future applications," the "precedent for future applications" has already been set by the HSDA in its grant of certificates of need to TrustPoint Hospital and Rolling Hills Hospital as set forth in Finding no. 39 of the Initial Order. Nowhere in this record has MSHA disputed Judge Pogue's findings in Finding of Fact no. 39. MSHA does not assert anywhere that TrustPoint Hospital did not claim a two-county service area. In fact, Dr. Collier, MSHA's expert, admitted that TrustPoint's CON application did so. (See, Collier testimony, Tr. Vol. 4, p. 001302).

F. **MSHA bases its objections to Judge Pogue's Initial Order on evidence from 2013, overlooking evidence in the record from 2014 and 2015 often provided by MSHA and cited by Judge Pogue.**

Judge Pogue makes it clear that his order is based on a *de novo* review of the evidence entered into this hearing record. Accordingly, Judge Pogue considers more current evidence derived from comprehensive information from WPH's 2015 fiscal year that was not available in 2014 in analyzing the need, economic feasibility and contribution to the orderly development of healthcare of the SBHK CON application.

The CON application was filed by SBHK in December 2013. Since then, another 18 months of utilization data for WPH became available by the time of the hearing, in July 2015. Judge Pogue, through this updated record, had the benefit of at least 18 months of additional data which SBHK could not yet utilize when Mr. Garone drafted and filed the CON application in December 2013.

MSHA wants the record evidence limited to 2013. Judge Pogue appropriately determined otherwise. For example, on pages 1 and 4 of its brief, MSHA asserts that the psychiatric providers in the Tri-City region are "only 63% full." However, this utilization

percentage is limited to data from 2013; it does not address data and information that has come into this record since 2013. Judge Pogue correctly states, in Finding no. 38 (p. 000471), that:

Dr. Collier forecasts WPH's future results from a period of WPH's utilization (2010-2013) which was lower than the last half of FY 2014 and all of FY 2015. WPH is currently running in calendar 2015 between 85.2% and 89.5% occupancy generally."

The record contains the Proposed Findings of Fact filed by both parties. SBHK's

Proposed Findings of Fact contained the following chart at Tr. p. 000362.

	2011	2012	2013	2014	2015	Increases from 2011 to 2015
Occupancy	64.7%	69.4%	72.3%	76.4%	85.7%	21% higher
No. of Admits	3,430	3,577	3,825	4,081	4,714	1,284 more
% admissions increase from prior year	3.6%	4.3%	6.5%	6.7%	15.4%	37.4% higher
No. of patient days	19,827	21,329	22,182	23,426	26,118	6,291 more
% increase in patient days from prior year	1.3%	7.8%	4%	5.6%	11.5%	31.7% higher

Data Sources: Exs. 85, 87 and 253. 2010 base data from Ex. 251, WPH 2010 JAR, p. 24. 2011-2014 utilization data from Ex. 253, MSHA document 000874.

Mountain States does not contest the high 2015 occupancy levels found to be occurring at WPH by Judge Pogue in 2015. In fact, the data supporting Judge Pogue's findings came from WPH. Mountain States does not assert that Judge Pogue's findings of high FY 2015 WPH utilization are in error. Instead, Mountain States basically ignores them in its brief, but harkens back repeatedly (as at MSHA appeal brief, pp. 1 and 4) to a report from Dr. Collier at Ex. 381, p. 002688, in which she reported that the occupancy of various psychiatric hospital facilities in her "Alternate Service Area" in 2013 was approximately 63%. MSHA's only effort to deal with WPH's 85% occupancy level in 2015 in its brief, at p. 5, is to admit that its hospital is "full on a handful of occasions annually," and to admit that it operates generally at or near 85% capacity.

MSHA's appeal brief (at p. 5) claims that WPH "has made efforts to solve any temporary capacity issues." However, the record shows that whatever temporary relief from WPH's high utilization levels there might have been in early 2014 in the improvement in processes in WPH's admissions procedures that Ms. Bailey testified about, the number of deferrals in the first five months of 2015 at WPH increased 81% over the number of deferrals over the same period of time in FY 2014. See Ex. 240, p. 002744, and Ex. 65, p. 001883.

The patient flow sheets that are in Ex. 238, pp. 002194-002372, also demonstrate, as does Ex. 221, that throughout the first six months of 2015, WPH was deferring patients almost every day because it was so full. Its capacity to admit patients is hampered by the unusual modular unit structure of the hospital, a point that Ms. Bailey testified about at length at Vol. 3, pp. 001112-001113, in which she stated:

Now it's not simply I discharge one, I admit one. If you discharge one on Cedar, you can't admit a person who needs Poplar to Cedar, because their units are very different and have very distinct identities. So we have to make sure that the person that's coming in is getting to the right bed on the right unit.³

G. MSHA fails to address any HSDA rules specifically.

MSHA never addresses the "majority of patients" component of the HSDA rule definition of "service area." While MSHA correctly cites one sentence of the Court of Appeals ruling in the *Covenant v. Tenn HSDA* case, 2016 WL 1559508, it fails to quote the full context of the appeals court's ruling. The Court in the *Covenant* case explicitly relied upon the opinion of Judge Koch for the Court in *McEwen v. Tenn. Dept. of Safety*, 173 S.W.3d 815 (Tenn. App. 2005). In *McEwen*, Judge Koch wrote for the Court that: "An agency should not ignore the findings of fact and credibility determinations contained in an initial order." 173 S.W.3d at 823.

³ WPH's units, according to Ms. Bailey, are as follows: Cedar – the most acute unit, with 16 licensed beds (although only 14 beds in Cedar are typically available in Cedar); Laurel – a 16-bed step-down unit; Poplar – 26-bed adult unit, including a detox unit; Spruce – a 14-bed geropsychiatric unit; and Willow – a 12-bed child and adolescent unit. Bailey, Tr. Vol. 3, pp. 001156-62.

One of the "decisions" made by HSDA in regard to service area determinations is the adoption by HSDA of its own rule which defines what a "service area" is. That rule is HSDA Rule 0720-9-.01(23), which states as follows:

Tenn. Comp. R. & Regs R. 0720-9-.01: DEFINITION. The following term shall have the following meanings.

(23) "Service Area" means the county or counties or portions thereof, representing a reasonable area in which a healthcare institution intends to provide services and in which the majority of its service recipients reside.

Thus, the HSDA has already defined the term "service area" as set forth above. This rule is a mandatory rule -- it specifies that the term "service area" "shall" have the meaning set forth above. For the HSDA to disregard its own mandatory definition of service area would violate the requirement established by the Tennessee Supreme Court in *Jackson Express v. Tenn. Public Service Commission*, 679 S.W.2d 942, 945 (Tenn. 1984) that administrative agencies must act consistently with their own rules. MSHA's brief never mentions the number of this rule or its actual content.

Dr. Elliott's testimony and letter to the HSDA (Ex. 207) contradict MSHA's claims on page 3 of its brief that SBHK did not present a single Tri-Cities resident or doctor supporting SBHK's statements of need for a new psychiatric hospital in Kingsport. Dr. Elliott testified that he had resided in Gray, Tennessee (in Washington County) until the day of his testimony at the trial in July 2015, that he, as a psychiatrist, saw the Spruce (geropsychiatric) unit at WPH full on many occasions, that he had difficulty placing his patients with other local psychiatrists upon his departure from East Tennessee, and that WPH did not have a board-certified child and adolescent psychiatrist to staff the Willow unit, where WPH's child and adolescent beds are located. (Tr. Vol, 1, p. 000670).

As Mr. Garone testified, SBH's CON application also contains information from the Sullivan County Sheriff's Office regarding the outmigration of patients from Sullivan County to Peninsula Hospital in Blount County (more than 100 miles from the SBHK site in Kingsport) and to Moccasin Bend in Chattanooga, the only remaining state mental health institute in East Tennessee. (Tr. Vol. 3, p. 001081). The CON application states that the Sullivan County Sheriff's office indicated that its personnel took 1,168 mental health transports of people outside Sullivan County for services, including transporting such people to Peninsula Hospital in Blount County and Moccasin Bend in Hamilton County in 2013. (Ex. 9, p. 001702).

With regard to MSHA's statement on p. 4 of its brief that SBHK filed no evidentiary affidavits as proof in the record in this case, it is also undisputed that MSHA also entered no evidentiary affidavits as proof into the record in this case.

MSHA also falsely states in its appeal brief that three medical care providers testified on its behalf in this matter. This is simply not true. Dr. Trivedi was the only medical care provider who testified on behalf of MSHA in this matter, and he does not practice anywhere in the Tri-Cities area. (Tr. Vol. 4, pp. 001362-001363). To the contrary, SBHK also provided a medical care provider, Dr. Elliott (a psychiatrist), who resided and practiced in the Tri-Cities area until June 2015, the month before the hearing herein. Dr. Elliott testified that, contrary to MSHA's assertion that "the existing psychiatric health model in the Tri-Cities is working well," in fact the existing psychiatric healthcare model in the Tri-Cities is not working well and needs additional inpatient psychiatric facility resources as well as other resources. (Ex. 207 and Tr. Vol. 1, pp. 000662-000663 and 000665-000669). Dr. Jessee, a non-practicing nonclinical psychologist, never testified that he, or Frontier, believed that the SBHK psychiatric hospital should not be constructed or was not needed.

H. **Dr. Jessee did not testify that he or Frontier believed that the SBHK CON project was not needed.**

MSHA's comments regarding the testimony of Dr. Randall Jessee, a nonpracticing psychologist who is the senior vice president of specialty services at Frontier Health, also contain a false statement. On page 6 of the MSHA brief, MSHA asserts that Dr. Jessee "testified in opposition to the SBH application." This statement is false. In his testimony, nowhere did Dr. Jessee testify that he was opposed to the SBHK CON application, nor did he assert that Frontier Health was opposed to the SBHK CON application. See Jessee testimony, Tr. Vol. 4, pp. 001181-001221. Therefore, MSHA's assertions in its brief that Dr. Jessee testified in opposition to the SBHK application is simply not true. Dr. Jessee testified that he no longer treats patients and was licensed as a "licensed professional counselor" with mental health provider status. He stated further that: "I presently do not see anyone. I just don't have time any more to do that." (Tr. Vol. 4, pp. 001197-001198).

Dr. Jessee never expressly testified, as claimed by MSHA on page 7 of its brief, that "the CSU will help alleviate any periodic capacity constraints in the Tri-Cities once it opens." Also, the proposed new CSU is designated to serve children and youth, not adults. The adult CSU in Johnson City was opened in 2009, and has not kept WPH from being nearly full on many occasions. He did testify that: "A crisis stabilization unit provides a level of care prior to psychiatric hospitalization." (Tr. Vol. 4, p. 001190). He also testified that Frontier Health operates that Mountain States would not share in the revenues from the CSU (Tr. Vol. 4, page 001201) and that the projected daily rates for CSU services would be between \$475 and \$500. He testified further that Frontier operates the current adult CSU in Johnson City, which has 15 beds as opposed to the projected 12 beds for the child and adolescent CSU. (Tr. Vol. 4, pp. 001202 and 001204). He testified further that the adult CSU has been open in Johnson City

since 2009, and that it operates at an occupancy rate of between 75 and 80%, while Frontier's goal for its operations is 80%. (Tr. Vol. 4, pp. 001204 and 001231). When asked about his understanding of the current occupancy rate of Woodridge Psychiatric Hospital, Dr. Jessee stated: "It's approaching being full on many occasions." (Tr. Vol. 4, p. 001216).

Neither Dr. Collier nor Mr. Sullivan counted the adult CSU's 15 beds in Washington County as inpatient psychiatric hospital beds in counting the inpatient psychiatric beds in either SBHK's designated service area or Dr. Collier's alternate service area. Ms. Bailey testified at Tr. Vol. 3, p. 001146 that the current Tennessee CSU regulations do not permit patients under 18 to be served in a CSU. Ms. Bailey also further testified at Tr. Vol. 3, p. 001142 that CSUs and inpatient hospital facilities serve different needs. When, for example, Dr. Collier analyzed utilization for inpatient psychiatric services in the alternate service area, in Ex. 381, Tr. 002688, nowhere in the facilities she analyzed did she count any beds for any crisis stabilization unit in Johnson City or elsewhere. Similarly, Mr. Sullivan did not count existing CSU beds for adults in Johnson City in any of his analyses for the need for inpatient psychiatric hospital beds. Also, the State Health Plan does not require such a consideration of CSU beds in analyzing inpatient psychiatric bed need issues in CON applications. No CON is required for the establishment of a CSU.

MSHA asserts on page 7 of its appeal brief that the "Quillen Psychiatric Department at East Tennessee State University" will perform certain activities regarding "mental health assessment." However, the pages in the transcript herein to which the brief cites contain no statement whatsoever about "the Quillen psychiatric department at ETSU," or any health assessment programs that the Quillen psychiatric department will carry out.

MSHA's clinical expert, Dr. Trivedi, admitted that the development of a new adolescent CSU unit in Washington County could go forward regardless of whether the SBHK project is

constructed. (Tr. Vol. 4, p. 001385). Dr. Trivedi also stated repeatedly in his testimony that he is "not a health planning expert." (Vol. 4, pp. 001388 and 001395). He also testified that he is not a financial expert. (Vol. 4, p. 001394). Dr. Trivedi was not offered as a health planning expert, but as a clinical expert. He stated further that he has never drafted a CON application in Tennessee, has never presented to or appeared before the HSDA in Tennessee, and has been in Tennessee for only five years. (Vol. 4, pp. 1387-88). Dr. Trivedi also repeatedly mistakenly referred to the SBHK CON application as seeking 77 beds instead of its actual correct total of 72 beds. (Vol. 4, pp. 001386 and 001396). He also erroneously stated that WPH had 80 beds. (Tr. Vol. 4, p. 001366).

I. WPH's own record proof establishes that the "existing psychiatric care model in the Tri-Cities" is not working well.

As it repeatedly did throughout its brief, MSHA asserted on page 8 of its brief that "the existing psychiatric care model in the Tri-Cities is working." However, the facts of this case and the findings of the ALJ in the Initial Order, as well as data from Mr. Sullivan and Dr. Collier, contradict this statement. If the psychiatric care model were working so well, there would not be hundreds of patients from the Tri-Cities area, including at least 400 from the five-county service area designated by SBHK, who would leave the area in 2013 to go hundreds of miles away to obtain psychiatric hospitalization in Blount County or Hamilton County, and there would not be a newly rising rate of deferrals as shown by the exhibits referenced above. Ex. 381, p. 002687. In fact, the daily "patient flow sheets" for the first six months of 2015 would not show the long daily lists of people waiting for beds at WPH if this allegation that "the existing psychiatric care model in the Tri-Cities is working " were true. See patient flow sheets in Ex. 238.

When the high and increasing deferral rates, high volumes of people leaving the area to go outside the area and at considerable distance to obtain psychiatric hospitalization care, and the

problems caused by the unique modular building operations of Woodridge, as testified to by Ms. Bailey (Tr.Vol. 3, pp. 001156-62), existing psychiatric care model in the Tri-Cities is not working well. In fact, two of the three Tri-Cities are actually in Sullivan County: Kingsport and Bristol are in Sullivan County, well within the five-county service area designated by SBHK. As the ALJ noted, in those five counties, available inpatient psychiatric hospital beds are extremely limited. Even if one were to examine the availability of beds at WPH, occupancy rates rising well into the 90%-plus range on numerous days indicate that its beds are often not available either. As noted above, WPH's own data in this record show that the county which has the highest deferral rates in 2015 at WPH is Sullivan County. Ex. 240, p. 002744.

With regard to the proposed adolescent CSU in northeast Tennessee, as noted earlier, Dr. Elliott had heard nothing about it as of the date of the hearing. (Vol. 1, p. 000669). Dr. Trivedi also testified that he is not involved in the actual establishment of the adolescent CSU. (Vol. 4, p. 001390). MSHA's CEO, Mr. Levine, testified that he was not involved in any CSU activities. (Vol. 5, p. 001426). Mr. Bailey testified that, as of July 29, 2015, there was no letter of intent or completed lease for the adolescent CSU. (Vol. 3, pp. 001144-45). Dr. Jessee could not specify at the hearing what any adolescent CSU revenue reimbursement would actually be. (Vol. 4, p. 001202). The rules of the Tennessee MHSAS Department still indicate, as of the date of the filing of this brief, that patients must be 18 or older to receive services at a CSU. MHSAS Rule 0940-5-18-.01(1).

MSHA is wrong when it asserts that the Initial Order is "silent" as to the change in clinical landscape in Tri-Cities. The "changing clinical landscape in the Tri-Cities" includes the radical increase in WPH utilization over the last year or two, to where it is consistently running at 85% or greater in occupancy, and on many days has an occupancy in excess of 90 to 95%. See Ex. 221. Those levels of occupancy at WPH are "changes" to the "clinical landscape" in the

Tri-Cities since 2013. Therefore, MSHA is totally incorrect in its claim that the Initial Order is "silent" on changes in the clinical landscape in the Tri-Cities: the Administrative Judge's Initial Order profoundly dealt with the "changing clinical landscape in the Tri-Cities." Judge Pogue held that, in Dr. Collier's report, she relied too heavily on 2013 data instead of utilizing the data from 2015. Initial Order Finding 38, p. 000471. As Judge Pogue's ruling indicates, SBHK's CON project will improve the "clinical landscape" in SBHK's five-county service area, which includes two of the three Tri-Cities (Kingsport and Bristol).

MSHA's brief criticizes the Initial Order for "barely mentioning Dr. Jessee," who it characterizes as "having the most clinical experience of any witness in the contested case hearing." This is simply not true. Dr. Jessee testified, at Tr. Vol. 4, p. 1198, that he had limited clinical experience and does not clinically practice now:

Q.: And you, yourself, can treat or have treated patients in Frontier or somebody that it's been billed for to the payors?

A.: Yes, I have over the years. I didn't see huge numbers of people, but I did, yes, keep up some practice, yes. I presently do not see any one. I just don't have time anymore to do that.

However, in his Initial Order the Administrative Judge did cite an SBHK clinical witness who has far more recent clinical experience in the Tri-Cities than Dr. Jessee. The Administrative Judge approvingly quoted from the testimony of Dr. Elliott, who, through June 19, 2015, was the psychiatrist practicing in Johnson City who supervised the psychiatric residency program at the ETSU medical school. In addition to those supervisory duties, Dr. Elliott testified that he practiced psychiatry extensively in the area, was on the medical staff at Johnson City Medical Center, and practiced every week at Woodridge Psychiatric Hospital which is the department of Johnson City Medical Center. (Tr. Vol. 1, pp. 000660-83). Thus, the Administrative Judge did "mention," and cite appropriately, the clinical practitioner with the most clinical experience in

the area who testified in this case -- Dr. Elliott. Dr. Elliott supports the approval of the SBHK CON application. (Ex. 207, pp. 002027-28).

J. **SBHK does dispute WPH's assertions regarding why it excluded Washington County from its proposed 5-county service area.**

MSHA erroneously asserts on page 10 of its brief that Woodridge was excluded from the service area projected by SBH "solely to increase the chances of CON approval." It asserts that there is "uncontroverted evidence" that these resources were excluded by SBH solely to increase the chances of CON approval. This assertion is also not true.

For example, at Tr. Vol. 3, pp. 001048-49, Mr. Garone, the contact person for the CON application, states as follows:

Q.: And how did this project come to be located in Kingsport?

A.: So the eastern Tennessee market that was looked at the -- I'll refer to it as the intern project, if that's okay with the Court the intern project that I referenced earlier. So what I did was I went into the community, met with some individuals. And the first place we went in was in Johnson City. Spent some time with them, understood relatively quickly that there was a provider in Johnson City that could accommodate the needs of that county. And so the next move was to talk to people up north in Kingsport, which did not have a facility of any great size, and it made better sense for us to be up there.

Q.: And the facility you mentioned in that answer, you're speaking of psychiatric inpatient hospital facilities?

A.: Yes, I am.

Thus, Mr. Garone's and SBH's decision to locate the site of its facility in Kingsport occurred after SBH executives assessed the extent to which WPH was serving the needs of Washington County. As Mr. Garone stated, it made "better sense" for Strategic to locate its facility in Kingsport. Furthermore, he clearly testified that he believed, based on his conversations with people in Washington County, that there was a psychiatric hospital in Johnson City, Woodridge Psychiatric Hospital, that could accommodate the psychiatric hospital

needs of Washington County. These statements by Mr. Garone in this record controvert MSHA's claim that SBHK excluded Washington County from its service area solely to increase the chances of CON approval. Thus, as Mr. Sullivan later confirmed, the decision to locate in Kingsport was good health planning and avoided duplication of facilities in Washington County itself. In all of Sullivan County, the ninth largest county in Tennessee, there are only 12 beds, at the eastern end of the county in Bristol. (See Ex. 237, p. 002193 and Ex. 243, p. 002373).

Contrary to the implications by MSHA on page 11 of its brief that it was inappropriate for SBH's representatives to meet with people in Johnson City if they were not planning to build a facility in Johnson City, those meetings in Johnson City actually assisted in SBH's decision to locate in Kingsport instead. See Garone testimony cited above.

MSHA's claim in its attack on the service area choice of SBHK on page 12 of its brief that SBH's proposed service area in Virginia is larger than in Tennessee and includes Virginia but excludes counties to the south contiguous to Sullivan County ignores MSHA's own service area designation process. For example, in Ex. 211, at Tr. 002059, Indian Path Medical Center ("IPMC") itself designated, on June 29, 2015, its service area as including only western Sullivan County, Tennessee, and Hawkins County, Tennessee, plus Scott and Wise Counties in Virginia. Thus, it is clear from the map at page 002059 of the record that Indian Path Medical Center, described to the IPS and the public in the CHNA as a "regional referral center hospital" owned by MSHA in Kingsport, Tennessee, also claims a service area in Virginia that is larger than its Tennessee service area. IPMC's claimed service area also excludes Washington County, Tennessee from its service area, even though Washington County is contiguous to western Sullivan County. Thus, the complaints in MSHA's brief about the result of SBHK's service area choices are contradicted by MSHA's own practices in designating its facilities own service areas to the public and the IRS.

K. **Contrary to MSHA's argument, the HSDA's statutes, rules, and guidelines do not require an applicant to follow a "typical" approach.**

On page 13 of its brief, MSHA criticizes SBHK for not following the "typical" approach of a CON application. There is no requirement in the CON statute, HSDA rules or the State Health Plan for any particular procedure to be filed in developing an application for a certificate of need. Furthermore, at this point in this proceeding, there is a great deal more information in this record than SBHK could ever have generated or provided in its CON application. Therefore, the accusations leveled by MSHA on page 13 of its brief against SBHK's CON application are at this point irrelevant, because of all the new evidence that has come into this record in the *de novo* hearing that has taken place on the appeal filed by MSHA. Even if Mr. Sullivan utilized a separate analysis from that engaged in by SBHK in the CON application to justify the SBHK CON, that is merely additional proof that has come in through the *de novo* hearing in this matter that supports the ALJ's Initial Order in this matter and the grant of a certificate of need to SBH. MSHA's criticisms of SBHK's CON application are in reality complaints against the *de novo* hearing process, which is provided by law in contested case hearings on CON applications.

L. **The Initial Order justifies the exclusion of WPH and Washington County from the SBHK service area.**

MSHA erroneously asserts that any evaluation for new inpatient psychiatric resources in the "Tri-Cities" must include Woodridge. The relevant analysis for new psychiatric resources as to this particular CON application is not the Tri-Cities, but is the five-county service area proposed by SBHK. As noted earlier, two of the three Tri-Cities are actually in SBHK's proposed service area; both Kingsport and Bristol are in Sullivan County, and so are in SBHK's proposed service area. Once again the claim that there is "uncontroverted evidence" that SBHK excluded Woodridge from its service area "solely to increase the chances of CON approval" are

false. As noted above, Mr. Garone testified at Vol. 3, pp. 001048-49, that, based on visits he made to Johnson City and the individuals he spoke with there, SBH determined that there was a provider in Johnson City that could accommodate the needs of Washington County. Thus, despite whatever email comments he might have made, in his own testimony and that of Mr. Shaheen support the move of the location of this site to Kingsport, and the choice of five county service area set forth in the CON application.

MSHA argues against Mr. Sullivan's findings that SBH's service area's exclusion of Washington County was reasonable in part because IPMC also excluded Washington County from its service area in the June 2015 IPMC CHNA published on MSHA's website. However, in its attack on Mr. Sullivan, MSHA ignores the actual content of IPMC's CHNA, a Community Health Needs Assessment, that Mountain States drew up and filed with its Form 990 with the IRS. (The CHNA's Ex. 211). See Collier testimony, Vol. 4, pp. 001341-42. The MSHA brief confuses the IPMC CHNA's "market" analysis, set forth on page 4 of the CHNA at 002032, with the explicit "service area" analysis of the CHNA, set forth at page 31 thereof at 002059. See also Levine testimony at Vol. 5, pp. 001451-52.

As Mr. Levine testified at Vol. 5, pp. 001455-58, the four distinctive "administrative markets" that are described in the CHNAs are not meant to be service areas. However, the IPMC CHNAs inform the IRS and the public that IPMC's service area is set forth in the CHNA at page 31 thereof for IPMC (Ex. 211, p. 002059). The same is true for JCMC's service area described in JCMC's CHNA, Ex. 212 at p. 31 thereof. Mr. Levine's testimony makes it clear that the four "market" administrative analysis described in his testimony was addressing page 4 of the CHNA. See Levine testimony at Vol. 5, p. 001458. The argument set forth by MSHA on page 15 of its brief that the CHNA "markets" designation is a service area designation is incorrect since their

argument never mentions that the "service areas" are actually defined on page 31 of the CHNAs for IPMC (Ex. 211) and JCMC (Ex. 212).

With regard to MSHA's assertion regarding a service area for Indian Path Pavilion (a psychiatric hospital in Kingsport which was closed in 2009 by MSHA), the service area identified as Indian Path Pavilion's service area on page 17 of the MSHA brief does not indicate that Russell County, Virginia was a part of Indian Path Pavilion's service area. See p. 17 of MSHA brief. Furthermore, page 16 of the MSHA brief asserts that "Indian Path Pavilion primarily targeted commercially insured and other profitable payor mix similar to SBH's proposed business plan." What this provision fails to note is that, as Ms. Bailey herself testified, during the 2007 to 2009 time period covered by the service area analysis on page 17 of MSHA's brief, Indian Path Pavilion was owned by MSHA. See Bailey testimony at Vol. 3, p. 001149.

Utilizing the table on page 17 of the MSHA brief, the claimed utilization of Indian Path Pavilion from four of the five counties in the SBHK proposed service area (Sullivan, Hawkins, Scott, and Wise) proves that 66.4% of the utilization of Indian Path Pavilion for that time period came from those four counties. Therefore, under the service area definition rule of the HSDA, Rule 0720-9-.01(23), those four counties are sufficient to make out a service area for Indian Path Pavilion. Furthermore, with the addition of Lee County, Virginia to the west of Scott County, these five counties comprise the five counties not only of the proposed SBHK service area, but the five counties that Indian Path Pavilion and Indian Path Medical Center described as their primary service area in CON application CN9602-042 filed with the HSDA when Indian Path Pavilion was owned by HCA in 1996. See Ex.7, p. 001581.

On page 18 of the MSHA brief, MSHA makes the assertion that there are "thousands of people living in Washington County [who] live in closer proximity to the new SBH facility than Woodridge." Whatever the truth of this statement may be, it is also clear that those same

"thousands of people living in Washington County" also live in closer proximity to IPMC in Kingsport than to Johnson City Medical Center in Johnson City. However, IPMC has excluded Washington County from its service area described to the public and the IRS in Ex. 211 despite the fact that many people in northwestern Washington County live closer to IPMC than to JCMC. Ex. 211, p. 31.

The last paragraph on page 18 of the MSHA brief asserts that SBHK's claimed service area is arbitrary. However, even Dr. Collier asserted in Ex. 381, p. 002697, that more than 50% of the SBHK patients would come from the five-county SBHK proposed service area. Dr. Collier asserted that she believed that either 1,084 or 1,056 cases would flow to SBHK from its claimed 5-county service area. SBHK has projected that its year 1 utilization will be 946 cases in year 1 and 1,859 cases in year 2. (Ex. 7, p. 001565). Dr. Collier's projections exceed 50% of SBHK's case projections. Therefore, even Dr. Collier agrees that the SBHK service area patient flow satisfies the requirement of the HSDA rule that a majority of the facility's patients must come from the proposed service area. MSHA never proved or sought to prove in this record that the majority of the patients for SBHK's CON project will not come from the 5-county service area claimed by SBHK in its CON application herein.

M. MSHA makes a number of false statements in its appeal brief.

MSHA begins its brief making false statements regarding psychiatric hospital utilization in northeast Tennessee that are not only inaccurate, but have no citations to the record in this case. For example, on page 1 of its brief, MSHA states: "Existing inpatient psychiatric facilities are only 63% full." This statement is not only false, there is no citation for it to any source in the record.

In the report of Dr. Collier, MSHA's expert, she found that in 2013, three years ago, psychiatric hospitals in her proposed "alternate service area" were 63.1% occupied. WPH's

occupancy that year was 72.5%. (Ex. 381, p. 002688). This same page showed that when WPH's occupancy rose from 69.6% in 2012 to 72.5% in 2013, the occupancy rate for this entire group of hospitals rose from 54% in 2012 to 63.1% in 2013. Thus, since MSHA admits that WPH's 2015 occupancy rate is 85% or higher (MSHA appeal brief, p. 5), Judge Pogue's Finding no. 38 in his Initial Order, p. 00471, is undisputed that "WPH is currently running in calendar 2015 between 85.2% and 89.5% occupancy generally." Thus, overall northeast Tennessee psychiatric hospital utilization generally was much higher in 2015 and beyond than it was in 2013, especially when the utilization rate of the 84-bed WPH (by far the largest inpatient psychiatric hospital in northeast Tennessee) is running between 85.2% and 89.5% occupancy generally in FY 2015.

MSHA makes another false statement on page 1 of its brief when it claims "the only witnesses who actually provide healthcare in the area do not believe this project is needed." No witnesses fitting this description testified this way. Dr. Jessee, a non-practicing, nonclinical psychologist, never testified that the SBHK was not necessary -- he never testified that there was no need for the SBHK project. (See Testimony of Dr. Jessee, Vol. 4 pp. 001181-1220). Dr. Trivedi, a clinical expert for MSHA, does not provide healthcare in Northeast Tennessee or Southwest Virginia. Instead, he practices at Vanderbilt University Medical Center in Nashville. (Vol. 4, pp. 001358-59, 001362-63). Ms. Bailey is an unlicensed social worker. She does not provide healthcare herself, as she testified at Tr. Vol. 3, p. 001174: "No, I'm not clinical, I'm not licensed as a clinical social worker." Alan Levine, MSHA's CEO, also is not a person "who actually provides healthcare"; instead, he is a healthcare executive with an MBA, not a clinical degree. (Levine at Vol. 5, pp. 001408-001409). Dr. Collier's doctorate is in English literature, and she does not provide healthcare in the Tri-Cities area or southwest Virginia. These five witnesses are the only witnesses who testified in this record for MSHA.

In fact, the only psychiatrist or psychologist who testified in this matter on the basis of personal experience providing healthcare in the Tri-Cities area was Dr. Hal Elliott, a witness for SBHK. Dr. Elliott practiced psychiatry in Johnson City from 2011 to June 2015, the month before the hearing. (Tr. Vol. 1, p. 000660). In fact, Dr. Elliott practiced at WPH during that time and was, during that time, on the medical staff of Johnson City Medical Center, of which WPH is a part. He treated patients at Woodridge as late as the first week of June 2015. (Tr. Vol 1, p. 000660). He testified at the hearing that there was a shortage of psychiatrists in the northeast Tennessee area. (Tr. Vol. 1, p. 000622-000623).

Dr. Elliott sent a letter of support to the HSDA in support of the SBHK CON application. (Ex. 207, pp. 002027-002028). He testified at the hearing that he would not now change anything in Ex. 207 except to add subsequent facts to it about Woodridge failing to staff its child and adolescent unit (the "Willow" unit) (Tr. Vol. 1, pp. 000666-000667) with a board-certified child and adolescent psychiatrist. Dr. Elliott also testified that he had heard nothing about the establishment of an adolescent CSU in Washington County or elsewhere in East Tennessee. (Tr. Vol. 1, p. 000669).

In Ex. 207, Dr. Elliott stated that "We simply do not have the child and adolescent resources to support this unit." (Ex. 207, p. 002028). He stated that:

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." (Emphasis added.)

MSHA makes another false statement on page 3 of its brief when it stated: "Moreover, the Administrative Judge approved the Project even though he acknowledged that it would result in a potential annual loss of \$1.5 million by Woodridge, . . .". This statement is false -- Judge Pogue never made such an acknowledgement. Judge Pogue did state in Finding no. 57 (Tr. p.

000478) and Conclusion no. 24 (Tr. p. 000489) that Dr. Collins makes such assertions of loss, but Judge Pogue never "acknowledged" that such a loss would in fact result from the approval of the SBHK CON.

III. CONCLUSION

Judge Pogue's Initial Order is consistent with the record herein, and the HSDA's statutes, its rules , its historical practices, and the Guidelines for Growth/State Health Plan. The HSDA should adopt Judge Pogue's Initial Order as its own Final Order in this matter.

Respectfully submitted,



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CERTIFICATE OF SERVICE

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

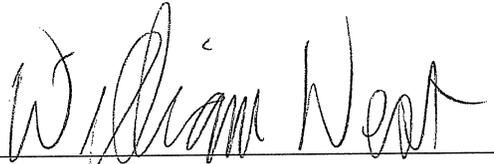
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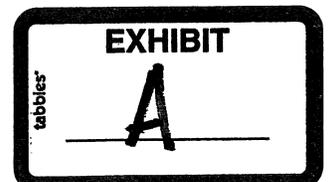
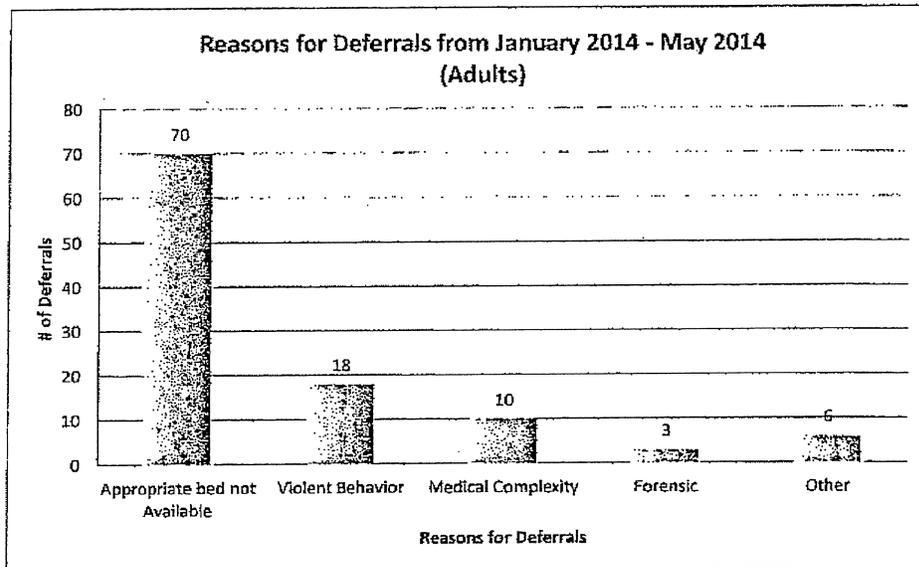
this 10th day of June, 2016.



William West

Reasons for Deferrals from January 2014 - May 2014

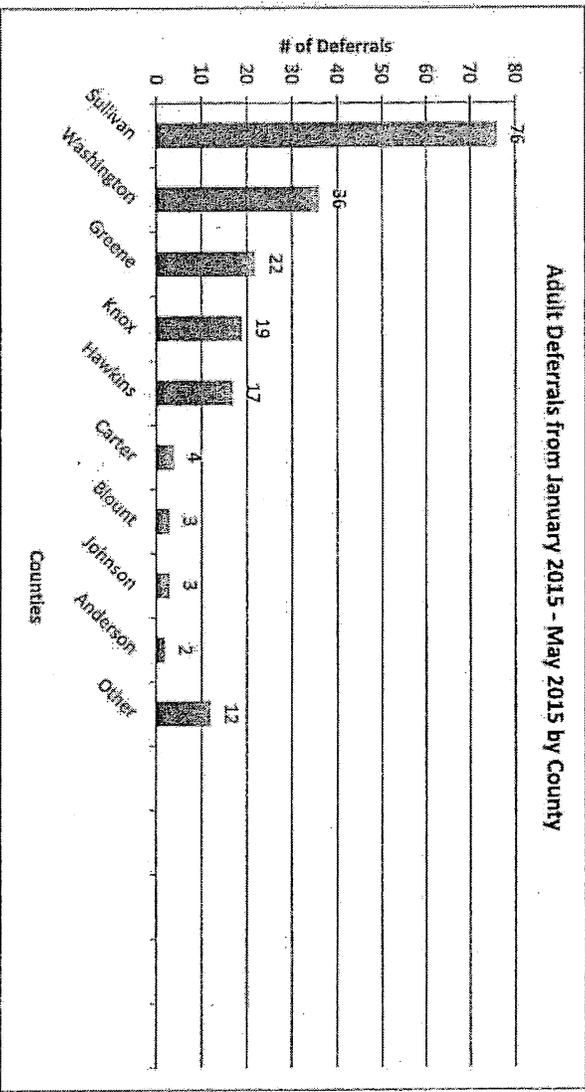
ADULTS	Appropriate bed not Available	Violent Behavior	Medical Complexity	Forensic	Other	TOTAL
	70	18	10	3	6	107



Adult Deferrals from January 2015 - May 2015 by County

76	Sullivan
36	Washington
22	Greene
19	Knox
17	Hawkins
4	Carter
3	Blount
3	Johnson
2	Anderson
12	Other

TOTAL 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, Galiborne, Unicoi, Washington, VA, Roane, Madison, Maury, Monroe, and Marshall



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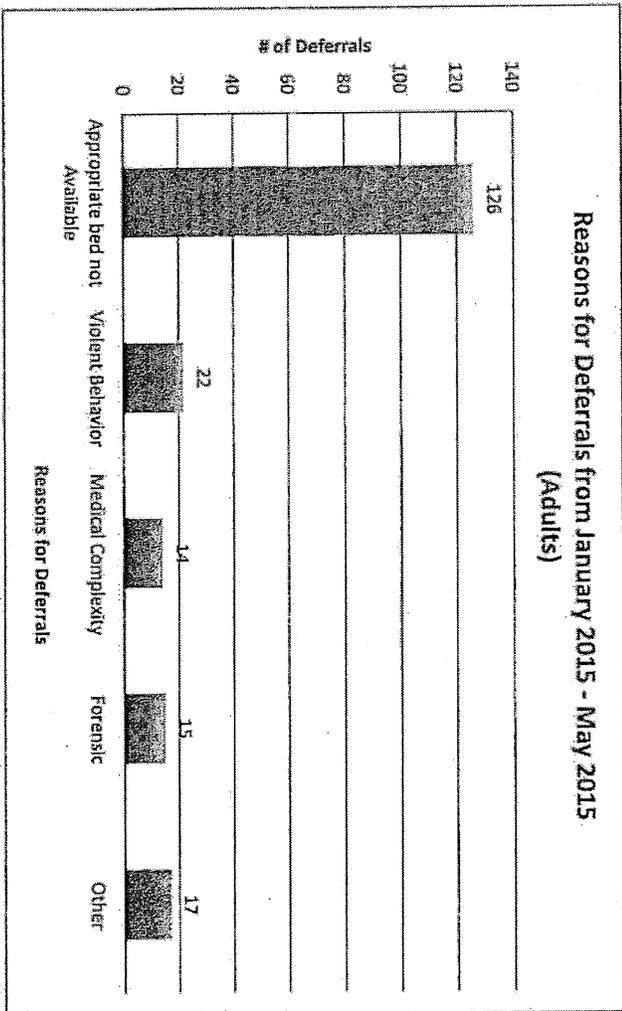
MSHA 002080

SBH-KINGSPORT 002744

Reasons for Deferrals from January 2015 - May 2015

ADULTS

126	Appropriate bed not Available
22	Violent Behavior
14	Medical Complexity
15	Forensic
17	Other



TOTAL 194

