HEALTH SERVICES AND DEVELOPMENT AGENCY MEETING
MARCH 26, 2014
APPLICATION SUMMARY

NAME OF PROJECT:	Rolling Hills Hospital, LLC d/b/a Rolling Hills Hospital
PROJECT NUMBER:	CN1312-051
ADDRESS:	2014 Quail Hollow Road Franklin (Williamson County), TN 37067
LEGAL OWNER:	Rolling Hills Hospital, LLC 6640 Carothers Parkway, Suite 500 Franklin (Williamson County), TN 37067
OPERATING ENTITY:	NA
CONTACT PERSON:	Michael D. Brent (615) 252-2361
DATE FILED:	December 13, 2013
PROJECT COST:	$9,796,909.56
FINANCING:	Cash Reserves
REASON FOR FILING:	Addition of forty (40) adult psychiatric beds to an existing eighty (80)-bed mental health hospital

DESCRIPTION:

Rolling Hills Hospital (RHH) is an eighty (80)-bed mental health hospital in Franklin (Williamson County) licensed by the Department of Mental Health and Substance Abuse Services. The current mix of beds at this hospital is thirty-five (35) adult psychiatric, fifteen (15) geriatric psychiatric, eighteen (18) child/adolescent psychiatric, and twelve (12) chemical dependency detoxification. This is the bed distribution approved when the hospital was first established (CN0612-096) and listed on the Certificate of Need.

Note to Agency members: This application listed its bed distribution as thirty-nine (39) adult psychiatric, fourteen (14) geriatric psychiatric, eighteen (18) geriatric psychiatric, and nine (9) chemical dependency detoxification. The applicant confirmed by email on 3/13/2014 that the bed distribution on the Certificate of Need is the correct distribution.

The applicant is proposing the addition of forty (40) adult psychiatric beds, which would increase the complement of adult psychiatric beds to seventy-five (75) and increase the total licensed bed complement to one hundred twenty (120) beds. This will be accomplished by the construction of a two level addition that will include two twenty (20) bed nursing units.

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).

   See below

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

   Since the proposed project is for the addition of 40 adult (Age 18-64) beds, the Department of Mental Health and Substance Abuse Services (DMHSAS) Report calculates Year 2017 bed need for the Age 18-64 population in the primary service area

   2017 Population: Primary Service Area
   Age 18-64 508,381 X 30 beds/100,000 = 153

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

   This criterion does not apply to this application.

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.

According to the DMHSAS Report, there are 70 adult psychiatric beds in the primary service area and no approved but unimplemented beds operating in the service area. Subtracting the 70 beds from the 153 adult psychiatric bed need results in a net bed need of 83 as displayed below:

2017 Population: Primary Service Area

	Gross Bed Need	minus	Existing and CON Approved Beds	=	Net Bed Need
Age 18-64	153 beds		70 beds		83 beds

When considering only the primary service area, it appears that this criterion has been met.

Applying this formula to the primary and secondary service area combined, the result is as follows:

2017 Population: Primary and Secondary Service Area Combined

	Gross Bed Need	minus	Existing and CON Approved Beds	=	Net Bed Need
Age 18-64	505 beds		684 beds		-179 beds

When considering the primary and secondary service area combined, it appears that this criterion may not be met.

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 service area is based upon the applicant's current patient origin

It appears that this criterion has been met.

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 serves all adults and adolescents and does not discriminate based on gender, race, ethnicity, or income level.

It appears that this criterion has been met.

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.

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.

There is one mental health hospital in the service area supported by state appropriation: Middle Tennessee Mental Health Institute. The applicant anticipates that this facility will support the proposed project.

It appears that this criterion has been met.

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 appears that this criterion has been met.

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

   The applicant projects a payor mix of 39.1% TennCare and 19.1% Medicare.

   It appears that this criterion has been met.

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 applicant provided occupancy trends for inpatient psychiatric services in the primary and secondary service area and indicated that individual facility occupancy rates have remained either consistent or increased.

   It appears that this criterion has been met.

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

   The applicant serves a significant number of elderly and low-income individuals.

   It appears that this criterion has been met.

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 has stated that it currently meets licensure requirements and will continue to do so.

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.

Rolling Hills Hospital (RHH) received approval at the March 28, 2007 Agency meeting (CN0616-096A) to establish an eighty (80) bed mental health hospital with thirty five (35) adult psychiatric beds, fifteen (15) geriatric psychiatric beds, eighteen (18) child and adolescent beds, and twelve (12) chemical dependency detoxification beds. The proposed project is for the addition of forty (40) adult psychiatric beds, which would increase the adult psychiatric bed complement to seventy-five (75), and increase the hospital's licensed bed complement to one hundred twenty (120). The proposed addition to the hospital will include the forty (40) beds and will house a large meeting area where the hospital can host support groups, educational seminars, community in-services, and recovery-based groups. The applicant will also reconfigure some of its existing space to increase efficiency and to better serve the population.

The current 35 adult psychiatric beds are divided between two units:

- Intensive Treatment Program-Mental health issues treated include schizophrenia, psychosis, bipolar disorder with or without mania, substance induced psychosis, suicidality, violent ideation and behavior, homicidal ideation and behavior
- General Psychiatry Program-Mental health issues treated include depression, depression with psychosis, bipolar disorder with or without mania, suicidality, violent ideation, and homicidal ideation

If approved, the applicant projects that the building addition will open July 1, 2015.

<u>Need</u>

The applicant provides the following justification in the application:

- The demand for mental health services is evidenced by the steady increase in the applicant facility's occupancy since its opening in January 2009.
- The Mental Health Parity and Addiction Equity Act requires insurance groups that offer coverage for mental health or substance abuse disorders

to provide the same level of benefits that they do for general medical treatment

- The Affordable Care Act will require all small group and individual market plans created before March 23, 2010 to comply with federal parity requirements
- The applicant also expects that the stigma of mental health will be reduced and there will be continuing improvement in access and coverage.
- The increased number of beds will allow the applicant to reduce the number of diversions and deflections. A deflection happens when there is not a physical bed available for a prospective patient. A diversion occurs when the applicant cannot accommodate a patient due to age, disposition, diagnosis, etc. In the first supplemental response, the applicant identified 116 deflections of Age 18+ adults for the most recent year available.

Bed Need

Psychiatric bed need is based on the psychiatric inpatient services criteria and standards in the Tennessee's Health Guidelines for Growth, 2000. Specifically the bed need formula is a population-based estimate of the total need for psychiatric inpatient services of 30 beds per 100,000 general population.

Primary Service Area (Bedford, Giles, Lawrence, Lincoln, Marshall, Maury, Rutherford, and Williamson Counties)

- When considering only adult psychiatric beds (Age 18-64) the formula calculates an inpatient psychiatric bed need of 153 beds for 2017
- There are 70 beds in the service area that are utilized by the adult population-Rolling Hills (applicant-Williamson County)-35 beds, Trustpoint (Rutherford County)-25 beds, and Lincoln Medical Center (Lincoln County)-10 beds
- Subtracting the existing 70 adult beds from the 153 beds needed results in a net adult psychiatric bed need of 83 beds for 2017

Primary and Secondary Service Area combined (Primary service area counties plus Coffee, Davidson, Dickson, Montgomery, and Sumner Counties)

- When considering only adult psychiatric beds (Age 18-64) the formula calculates an inpatient psychiatric bed need of 505 beds for 2017
- It appears that there are 684 beds in the service area that are either primarily utilized by the adult population for inpatient psychiatric services or shared with the geriatric population

- Subtracting the existing 684 adult beds from the 505 beds needed results in a net adult psychiatric bed surplus of 179 beds for 2017. It should be noted that a significant portion of the existing beds include 300 licensed beds at Middle Tennessee Mental Health Institute where only 195 beds are set up and staffed.

Ownership

The ownership structure for the applicant is as follows:

- The applicant, Rolling Hills Hospital, LLC is a direct wholly owned subsidiary of Psychiatric Solutions Hospital, LLC
- Psychiatric Solutions Hospital, LLC is a wholly owned subsidiary of Psychiatric Solutions, Inc.
- Psychiatric Solutions, Inc. is a wholly owned subsidiary of Universal Health Services, Inc.

Universal Health Services, Inc. (UHS) is a publicly traded corporation on the New York Stock Exchange and is headquartered in King of Prussia, Pennsylvania. As of March 31, 2013, UHS owned and/or operated 23 acute care hospitals and 197 behavioral health care centers in 37 states, Washington D.C., Puerto Rico, and the U.S. Virgin Islands. UHS owns and operates two other mental health hospitals in Tennessee. Community Behavioral Health, a 50 bed facility; and Lakeside Behavioral Health System, a 290 bed facility both in Memphis, Shelby County.

Facility Information

- The addition to Rolling Hills Hospital will be a two-story addition consisting of 29,045 square feet of new construction and 1,220 square feet of renovated construction.
- The lower level will include a new community room, outpatient group rooms, and ancillary administrative functions.
- The upper level will include two 20 bed nursing units, activity spaces, and clinical support spaces.
- The addition and the existing facility will share kitchen, dining room, medical records storage, admission area, plant operations, business office, and administrative offices.
- The overall expansion of the facility will increase space for day rooms, nurses' stations, medication rooms, and activity areas enabling the applicant to reconfigure certain areas in the existing building as it develops subunits within all categories, including the adolescent and geriatric portions. The benefit of subunits allows the separation of higher acuity patients from the general population.

Service Area Demographics

Primary Service Area
Rolling Hills Hospital's declared primary service area is Bedford, Giles, Lawrence, Lincoln, Marshall, Maury, Rutherford, and Williamson Counties.

- The total population of the primary service area is estimated at 763,364 residents in calendar year (CY) 2014 increasing by approximately 7.6% to 825,985 residents in CY 2018
- The total 18-64 age population is estimated at 478,754 residents in CY 2014 increasing approximately 7.7% to 518,571 residents in 2018
- The total population of the state of Tennessee is expected to grow 3.6% during the same timeframe
- The 18-64 age population in the state of Tennessee overall is expected to increase 2.5% during the same timeframe
- The latest 2013 percentage of the primary service area population enrolled in the TennCare program is approximately 13.1%, as compared to the statewide enrollment proportion of 18.5%

Secondary Service Area
The secondary service area consists of Coffee, Davidson, Dickson, Montgomery, and Sumner Counties.

- The total population of the secondary service area is estimated at 1,121,429 residents in calendar year (CY) 2014 increasing by approximately 4.6% to 1,175,102 residents in CY 2018.
- The total 18-64 age population is estimated at 719,896 residents in CY 2014 increasing approximately 2.4% to 737,322 residents in 2018
- The latest 2013 percentage of the secondary service area population enrolled in the TennCare program is approximately 17.8%.

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.

Service Area Historical Utilization

Inpatient Psychiatric (1) Bed Occupancy

Hospital	2012 Beds*	Total Days	% Occupancy
Hillside	14	3,633	70.9%
Lincoln	10	2,369	64.7%
Rolling Hills	68	19,563	78.6%
PSA Subtotal	**92**	**25,565**	**75.9%**
Centennial	132	29,943	62.0%
MTMH	195	60,614	84.9%
St. Thomas	23	5,761	68.4%
Skyline	91	22,361	67.1%
Summit	20	4,449	60.8%
Vanderbilt	88	28,201	87.6%
BHC-Clarksville	26	4,766	50.1%
Sumner	12	1,167	26.6%
SSA Subtotal	**587**	**157,262**	**73.2%**
TOTAL	***679***	**182,827**	**73.6%**

(1) Excludes Chemical Dependency Beds

***Beds that were not accounted for in 2012:**

- **Trustpoint Hospital (Rutherford County), 50 beds-Not open full year 2012**
- **Behavioral Healthcare at Columbia (Maury County), 16 beds-Not open full year in 2012**
- **Summit Medical Center (Davidson County) Convert 20 psychiatric beds to medical/surgical and rehab-Outstanding CON (CN1304-011)**
- **Skyline Medical Center-Madison, (Davidson County), Add eleven adolescent beds-Outstanding CON (CN1110-040)**

- The overall occupancy of inpatient psychiatric facilities in the primary service area in 2012 was 75.9%
- The overall occupancy of inpatient psychiatric facilities in the secondary service area in 2012 was 73.2%
- The overall occupancy of inpatient psychiatric facilities in the primary and secondary service area combined in 2012 was 73.6%

Adult Psychiatric Utilization Trends, 2010-2012

Hospital	2010 Adult Patient Days	2011 Adult Patient Days	2012 Adult Patient Days	10-12 % Change
Hillside	0	237	0	0.0%
Lincoln	292	456	257	-12.0%
Rolling Hills	175	12,056	11,042	8,005.1%
PSA Subtotal	**467**	**12,749**	**14,441**	**2,992.3%**
Centennial	31,251	22,132	17,732	-43.3%
MTMH	53,777	50,951	50,849	-5.4%
St. Thomas	673	680	1,062	57.8%
Skyline	13,159	16,269	8,670	-34.1%
Summit	3,623	4,722	4,231	16.8%
Vanderbilt	18,126	19,578	18,316	1.0%
BHC-Clarksville	102	567	496	386.3%
Sumner	0	0	0	0.0%
SSA Subtotal	**120,711**	**114,899**	**101,356**	**-16.0%**
TOTAL	***121,178***	***127,648***	***115,797***	**-4.4%**

The table above reflects the following:

- There was little adult inpatient psychiatric utilization in the primary service area prior to Rolling Hill Hospital's utilization in 2011.
- Adult psychiatric inpatient utilization in secondary service area locations declined 16% between 2010 and 2012
- When combining the results in the primary and secondary service area, there was a 4.4% decline in adult inpatient psychiatric utilization between 2010 and 2012.

Applicant Historical and Projected Utilization

The applicant's historical and projected utilization for the first two years after project completion is presented in the tables below:

Total Inpatient Psychiatric Utilization Trends
(Includes Chemical Dependency Detoxification)

Beds	2010 Patient Days	2011 Patient Days	2012 Patient Days	Year 1 Patient Days	Year 2 Patient Days	2010 % Occ.	2011 % Occ.	2012 % Occ.	Year 1 % Occ.	Year 2 % Occ.
80 (2012) 120 (Year 1)	362	21,739	22,705	29,565	32,376	1.2%	74.4%	77.8%	68%	74%

Adult Inpatient Psychiatric Utilization Trends
(Includes Chemical Dependency Detoxification)

Beds	2010 Patient Days	2011 Patient Days	2012 Patient Days	Year 1 Patient Days	Year 2 Patient Days	2010 % Occ.	2011 % Occ.	2012 % Occ.	Year 1 % Occ.	Year 2 % Occ.
47 (2012) 87 (Year 1)	178	14,440	14,184	20,711	23,300	1.0%	84.2%	82.7%	65.2%	73.4%

Project Cost

Major costs are:

- Construction Cost- $7,179,765, or 73.3% of cost.
- Fixed Equipment- $813,651, or 8.3% of the total cost.
- For other details on Project Cost, see the Project Cost in the original application.
- The renovated construction cost is $150.00 per square foot (/SF). As reflected in the table below, the renovated construction cost is between the first quartile and the median of statewide hospital renovated construction projects from 2010 to 2012. The new construction cost of $261.95/SF is between the median and 3rd quartile. The combined construction cost of $257.05 is between the median and 3rd quartile.

Statewide Hospital Construction Cost per Square Foot
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: HSDA Applicant's Toolbox

Financing

A December 12, 2013 letter from Steve Filton, Chief Financial Officer of Universal Health Systems, Inc., confirms financial resources to fund the proposed project will be provided from the cash reserves and operating revenue of Universal Health Systems, Inc.

Universal Health Systems, Inc. audited financial statements for the period ending December 31, 2012 indicates $23,471,000 in cash and cash equivalents, total current assets of $1,407,496,000, total current liabilities of $894,058,000, and a current ratio of 1.57:1.

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.

Historical Data Chart

- According to the Historical Data Chart, Rolling Hills Hospital reported positive net operating income less capital expenditures in only one of the three previous years: $331,597 for 2010; $(2,381,702) for 2011; and $(2,495,104) for 2012.
- The retirement of principal in the amount of $3,918,000 in 2011, and $3,839,433 in 2012 lowered net operating income for those years.

Projected Data Chart

Proposed 40 bed Addition

The applicant projects $8,392,561.00 in total gross revenue on 5,110 days during the first year of operation and $12,010,469 on 7,300 days in Year Two (approximately $1,645 per day). The Projected Data Chart reflects the following:

- Net operating income less capital expenditures for the applicant will equal ($162,215) in Year One increasing to $444,994 in Year Two.
- Net operating revenue after contractual adjustments is expected to reach $5,352,021 or approximately 44.6% of total gross revenue in Year Two.
- Charity care totals $25,231 in Year Two, equaling 15.3 patient days.

Rolling Hills Hospital (120 beds, including 40 bed addition)
The applicant projects $48,826,029.00 in total gross revenue on 29,565 days during the first year of operation and $53,454,774 on 32,376 days in Year Two (approximately $1,651 per day). The Projected Data Chart reflects the following:

- Net operating income less capital expenditures for the applicant will equal $3,289,871 in Year One increasing to $3,957,433 in Year Two.
- Net operating revenue after contractual adjustments is expected to reach $23,374,719 or approximately 45.6% of total gross revenue in Year Two.
- Charity care totals $111,901 in Year Two, equaling 67.7 patient days.

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

- The proposed average gross charge is $1,651/day in 2015.
- The average deduction is $896/day, producing an average charge of $755/day.

Medicare/TennCare Payor Mix
- Medicare- Charges will equal $1,490,760 in Year One representing 19% of total gross revenue.
- TennCare-Charges will equal $3,059,980 in Year One representing 39% of total gross revenue.

Staffing
The applicant's proposed direct patient care staffing in Year Two includes the following:
- 19.0 FTE Registered Nurses and
- 0.5 FTE Activity Therapist and
- FTE Social Services Position

Licensure/Accreditation
Rolling Hills Hospital is licensed by the Tennessee Department of Mental Health and Substance Abuse Services, certified by Medicare, and accredited by The Joint Commission. The Joint Commission completed a hospital accreditation survey on September 19, 2012. As a result of the survey, Rolling Hills Hospital became accredited effective July 13, 2012 valid for up to thirty-six (36) months.

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 FACILITIES IN THE SERVICE AREA:

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

Denied Applications:

Summit Medical Center, CN1206-029D, was denied at the September 26, 2012 Agency meeting. The application was for the for the establishment of a 20 bed acute inpatient rehab unit and service in its hospital facility by converting 20 adult psychiatric beds and reclassifying the adult psychiatric unit to an inpatient rehabilitation unit. The estimated cost was projected to be **$2,500,000.00** *Reason for Denial: The application did not meet the statutory criteria.*

Outstanding Certificates of Need

Summit Medical Center, CN1304-11A, has an outstanding Certificate of Need which will expire on September 1, 2016. It was approved at the July 24, 2013 Agency meeting for the conversion of eight (8) inpatient psychiatric beds to medical surgical beds, and the conversion of twelve (12) inpatient psychiatric beds into a new twelve (12) bed acute inpatient rehabilitation unit at the campus of TriStar Summit Medical Center. The estimated project cost is **$4,933,576.00.** *Project Status: A March 5, 2014 report indicates both phases of the project have been completed and all beds have been licensed by the DOH. The orthopedic beds were scheduled to be open and operational on 3/10/14.*

Senior Care of Rutherford, LLC (Trustpoint), CN1207-031A, has an outstanding Certificate of Need which will expire on December 1, 2015. It was approved at the October 24, 2012 Agency meeting for the addition of sixteen (16) psychiatric

beds (8-adult plus 8-geriatric) to its sixty (60) bed hospital. The estimated project cost is **$165,000**. *Project Status: A March 12, 2014 report indicates the project is complete. A final project report is pending. The facility went up to seventy-six beds as a result of the CON, plus another ten (10) beds (total of 86) were added under the statutory exemption available to hospitals with less than 100 beds found at TCA §68-11-107 (g).*

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.

MAF/PME
03/13/14

LETTER OF INTENT

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

DEC 10 '13 AM10:27

LETTER OF INTENT

The Publication of Intent is to be published in The Tennessean, which is a newspaper of general circulation in Williamson County, Tennessee, on or before December 10, 2013, 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 Rolling Hills Hospital, an existing mental health hospital, owned and managed by Rolling Hills Hospital, LLC, a limited liability company, intends to file an application for a Certificate of Need for the addition of forty (40) beds to its existing eighty (80) bed facility. The location of Rolling Hills Hospital is 2014 Quail Hollow Circle, Franklin, Tennessee 37067 (Williamson County), and the estimated project cost is $9,796,909.56.

The anticipated filing date of the application is on or before December 13, 2013. The contact person for this project is Michael D. Brent, Esq., who may be reached at Bradley Arant Boult Cummings LLP, 1600 Division Street, Suite 700, Nashville, Tennessee 37203. Mr. Brent's telephone number is (615) 252-2361 and his e-mail address is mbrent@babc.com.

(Signature)	11/10/13 (Date)	mbrent@babc.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.

ORIGINAL APPLICATION

DEC 13 '13 PM3:26

1. Name of Facility, Agency, or Institution

Rolling Hills Hospital, LLC d/b/a Rolling Hills Hospital
Name

2014 Quail Hollow Circle — Williamson
Street or Route — County

Franklin — TN — 37067
City — State — Zip Code

2. Contact Person Available for Responses to Questions

Michael D. Brent — Attorney
Name — Title

Bradley Arant Boult Cummings LLP — mbrent@babc.com
Company Name — Email Address

1600 Division Street, Suite 700 — Nashville — TN — 37203
Street or Route — City — State — Zip Code

Attorney — 615-252-2361 — 615-252-6361
Association with Owner — Phone Number — Fax Number

3. Owner of the Facility, Agency or Institution

Rolling Hills Hospital, LLC — 615-312-5700
Name — Phone Number

6640 Carothers Parkway, Suite 500 — Williamson
Street or Route — County

Franklin — TN — 37067
City — State — Zip Code

4. Type of Ownership of Control (Check One)

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

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

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

Not Applicable
Name

Street or Route

County

City

State

Zip Code

PUT ALL ATTACHMENT 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 X
B. Option to Purchase ____
C. Lease of ____ Years ____
D. Option to Lease ____
E. Other (Specify) ____ ____

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

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

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

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	39		39	40	79
I. Geriatric Psychiatric	14		14		14
J. Child/Adolescent Psychiatric	18		18		18
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					
P. ICF/MR					
Q. Adult Chemical Dependency (Detox)	9		9		9
R. Child and Adolescent Chemical Dependency					
S. Swing Beds					
T. Mental Health Residential Treatment					
U. Residential Hospice					
TOTAL	80	0	80	40	120

*CON-Beds approved but not yet in service

10. Medicare Provider Number 44-4004

Certification Type Mental Health Hospital

11. Medicaid Provider Number 0444004

Certification Type Mental Health Hospital

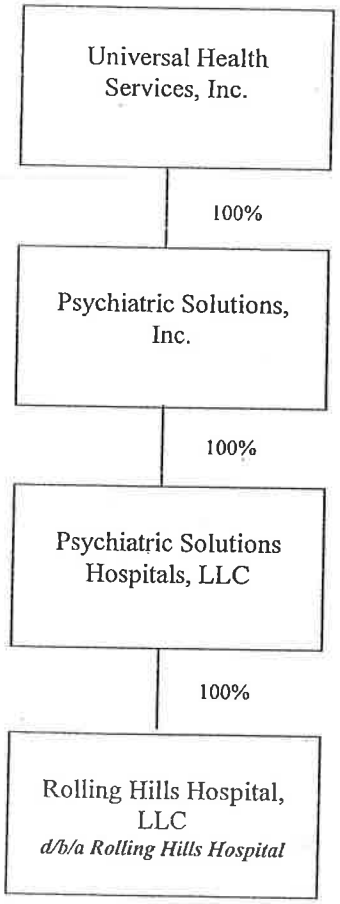
12. If this is a new facility, will certification be sought for Medicare and/or Medicaid? N/A

13. *Identify all TennCare Managed Care Organizations/Behavioral Health Organization (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.

Response to Section A, Item 3: Please See Attachment A.3.

Response to Section A, Item 4: The Applicant, Rolling Hills Hospital, LLC d/b/a Rolling Hills Hospital (the "Applicant") is a direct, wholly-owned subsidiary of Psychiatric Solutions Hospital, LLC. Psychiatric Solutions Hospital, LLC is a wholly-owned subsidiary of Psychiatric Solutions, Inc. Psychiatric Solutions, Inc. is a wholly-owned subsidiary of Universal Health Services, Inc. The Applicant is a Medicare-certified psychiatric hospital located at 2014 Quail Hollow Circle, Franklin, Tennessee 37067. The ownership structure of the Applicant is as follows:



Response to Section A, Item 5: The Applicant does not operate pursuant to a management agreement. All Universal Health Services, Inc.-affiliated hospitals operate autonomously in accordance with the parent company's philosophy on decentralized managerial control. The entities in the Applicant's chain of ownership and control will provide direction, information technology services, and legal services support to the

Applicant. However, the Applicant will continue to own and manage its facility with its own administration team with oversight by its own governing body.

Response to Section A, Item 6: Please see Attachment A.6.

Response to Section A, Item 13: The Applicant currently has contracts with the following Managed Care and Behavioral Health Organizations:

- Aetna Behavioral Health
- Amerigroup Community Care
- Amerivantage Medicare HMO
- Behavioral Medicine Network
- Cigna Behavioral health
- HealthSpring
- BCBS/Magellan Health Services
- Blue Advantage Medicare HMO
- Managed Health Network
- Mental Health Network
- TriCare South—Value Options
- United Behavioral Health
- United HealthCare Community Plan
- Secure Horizons Medicare
- ValueOptions
- VSHP/TennCare Select
- Humana/LifeSynch
- Medicare

The Applicant is currently in negotiation with Windsor Healthplan and ComPsych Corporation. With respect to any other out-of-network plans, the Applicant negotiates such plans under a Single Case Agreement, thus allowing the member to receive in-network benefit coverage. The Applicant also participates as a Certified Application Counselor ("CAC") under the Healthcare Insurance Marketplace, assisting uninsured persons with enrollment processes.

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: The Applicant is Rolling Hills Hospital, LLC d/b/a Rolling Hills Hospital, a Tennessee limited liability company, which is a direct, wholly-owned subsidiary of Psychiatric Solutions Hospital, LLC. Psychiatric Solutions Hospital, LLC is a wholly-owned subsidiary of Psychiatric Solutions, Inc. Psychiatric Solutions, Inc. is a wholly-owned subsidiary of Universal Health Services, Inc. This is an application for a Certificate of Need for the expansion of the current 80-bed mental health hospital by adding 40 beds for a total 120-bed mental health hospital (hereinafter, the Applicant will refer to the hospital as a "mental health hospital," as that term more accurately reflects the scope of care provided by the Applicant). The hospital currently provides inpatient and outpatient adult psychiatric services (39 beds), geriatric psychiatric services (14 beds), child and adolescent psychiatric services (18 beds), and chemical dependency detoxification services (9 beds). The Applicant plans to construct an addition to its current location at 2014 Quail Hollow Circle in Franklin, Tennessee. The additional space will be utilized for 40 new adult psychiatric beds and will also house a large meeting area where the hospital can host support groups, educational seminars, community in-services, and recovery-based groups. As part of the project, the Applicant will also reconfigure some of its existing space to increase efficiency and to better serve the patient population.

The three statutory criteria (need, economic feasibility, and contribution to orderly development) are explained in later detail in the application. To summarize, a need exists in the Applicant's service area due to rapid population growth and

demand for mental health services, as evidenced by the steady increase in the Applicant's occupancy rate since the opening of the Applicant's facility in January 2009. In 2010, the Applicant had an occupancy rate of just twenty-two percent (22%), but over the last 12 months, the Applicant has had a sustained occupancy rate of at least eighty-four percent (84%). More specifically, over the last 12 months, the Applicant has been at maximum occupancy for a total of 24 days, and the Applicant has been at 95% or greater occupancy for 46 days, thus resulting in problematic deflection and diversion activity.

A recent change in the federal regulatory landscape governing mental health services has also contributed to an increase in demand for the Applicant's services. The Mental Health Parity and Addiction Equity Act (the "Act") requires insurance groups that offer coverage for mental health or substance use disorders to provide the same level of benefits that they do for general medical treatment. On November 8, 2013, The Departments of Health and Human Services, Labor and the Treasury issued the long-awaited final rule to implement the Act. The final rule includes additional consumer protections, including the following:

- Ensuring that parity applies to intermediate levels of care received in residential treatment and intensive outpatient settings;
- Clarifying the scope of the transparency required by health plans, including the disclosure rights of plan participants, to ensure compliance with the law;
- Clarifying that parity applies to all plan standards, including geographic limits, facility-type limits and network adequacy; and
- Eliminating an exception to the existing parity rule that was determined to be confusing, unnecessary and open to abuse.

Moreover, the Patient Protection and Affordable Care Act (the "ACA") significantly extends the reach of the Act's requirements. Starting in Calendar Year 2014, the ACA will require all small group and individual market plans created before March 23, 2010 to comply with federal parity requirements. Qualified Health Plans offered through the health insurance exchanges in every state must include coverage for mental health and substance use disorders as one of the ten categories of "Essential Health Benefits," and that coverage must comply with the federal parity requirements set forth in the ACA. Strikingly, in January 2014, mental health coverage will be extended to 32 Million Americans through either health insurance exchanges or Medicaid expansion programs. Also under the ACA, those who cannot afford insurance will qualify for subsidies that will help them to pay their monthly plan premiums and out-of-pocket expenses. Insurers will have to meet certain requirements, including covering individuals regardless of pre-existing conditions. Additionally, the ACA increases the age of children who can remain on their parents' insurance plans to 26 years of age. This has important consequences for mental health treatment, as research suggests that many individual have their first onset of major mental illness (i.e., schizophrenia) in their late teenage years and early 20's. Now that

individuals may remain on their parents' insurance plans up to age 26, they will have access to care during the most critical time for receiving treatment for mental illness. Finally, as a result of the ACA and the local and national advocacy efforts, the Applicant sees the following encouraging trends in mental and mental healthcare:

- A continuing reduction in the stigma of mental illness resulting in more people seeking and receiving treatment;
- A continuing improvement in access and coverage to mental health and addiction services for all Americans; and
- A growing recognition that mental health is integral to overall health and well-being.

Collectively, this legal and cultural scheme is expected to create an increase in consumption and utilization of and demand for mental and mental health services such as those provided by the Applicant. Kathleen Sebelius, Secretary of the Department of Health and Human Services, stated upon the issuance of the final rule that the mental health coverage mandates taking effect under the ACA will result in "the largest expansion of behavioral health care in a generation."

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 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: The proposed 40-bed addition will be a complement composed of two units of 20 beds each, based on the applicant's parent company's vast experience in operating similar facilities. Each 20 bed unit will have one nursing station, with the addition constructed to match the existing construction system and architectural aesthetics. The addition will be two levels, with the top level extended to the east, sharing connection points at three (3) locations on the upper level. Connecting the existing units to the expansion on the upper level allows for enhanced flexibility and usage of the units, as programs need change from time to time. A new center-access corridor will be created to allow for the transport of patients to the new units without having the problem of cross-unit traffic. The lower level will have a new community room, outpatient group rooms and ancillary administration functions. A new bank of elevators will be added that will serve the new addition as well as the existing facility structure for access to the lower level dining room. The new addition will be constructed out of a structural steel frame and concrete floors. The mechanical system will share the facility's existing electrical, fire protection and sprinkler systems. New HVAC units will be provided to serve the addition. The exterior of the addition will be primarily brick to match the existing exterior, with a matching, standing seam metal roof. The main entryway drive will be relocated to the east, with new parking added to accommodate the additional patients, visitors and family members the addition will generate.

The existing site slopes uphill from west to east, and there is an embankment which creates a boundary for the hospital on the north and east property lines. The relatively shallow lot requires a building of any significant size to conform to the site topography in order to maximize its use, and this proposed design accomplishes that objective by the use of two 20 bed units, plus the other areas noted above (creating a two story structure on the west side of the site and a one story structure on the east side). This grade is integrated into the design in a way that creates on grade outdoor courts, an important component for behavioral healthcare facilities.

The new addition is fed from the same common corridor, thereby making for easy and efficient circulation and navigation. Additionally, travel distance to the new unit will not be significantly greater that travel time to the existing units, due to the positioning of the new addition and the addition of new elevators to serve the south end of the building.

Notwithstanding the new areas that will be added as a result of the addition, the addition and the existing facility will share a number of common amenities, such as the kitchen and dining room, medical records storage, admissions area, plant operations (i.e., supply department), business office and administrative offices.

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: With the filing of this application, the Applicant seeks to increase its current 80-bed mental health hospital by 40 beds, resulting in a 120-bed mental health hospital. The additional 40 beds will be adult psychiatric beds.

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
FIRST FLOOR										
Community Room					0	1395	1395			
Outpatient Services					0	1831	1831			
Administration					0	1071	1071			
SECOND FLOOR										
Patient Rooms					0	7486	7486			
Activity Spaces					500	3731	4231			
Clinical Support					0	4984	4984			
B. Unit/Depart. GSF Sub-Total					500	20498	20998			
C. Mechanical/ Electrical GSF					70	474	544			
D. Circulation /Structure GSF					760	8073	8833			
E. Total GSF					1330	29045	30375	150.00	261.95	25[illegible]

SUPPLEMENTAL - # 1
December 26, 2013
12:16pm
31

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: Given the increased demand for mental health treatment in the Applicant's service area, the Applicant has managed to operate five inpatient units in a facility that was originally designed to accommodate only four inpatient units. The Applicant has effectively worked around bed configuration issues, serving the needs of multiple patient populations. However, to best serve those patient populations, additional space, including additional patient rooms, is needed.

Additionally, the Applicant currently experiences difficulty in accommodating the increasing needs of the chronically mentally ill. The existing size and resulting configuration of the facility makes it challenging to effectively separate patient populations, create specialized treatment modalities, and introduce new programs and services to the community. The inability to remediate the aforementioned issues also impacts emergency departments and crisis teams trying to place individuals in need of psychiatric treatment, resulting in deflections, diversions, and a pronounced access to care issue. The Applicant has experienced an unfortunate number of deflections in the past 12 months, which occur when the Applicant could accept the patient but for the lack of a physical bed for the patient to occupy. The Applicant has also experienced some diversion, which occur where a patient has a need that the Applicant is unable to accommodate, such as age, disposition, diagnosis, lack of appropriate programming, etc.

With the addition of 40 acute inpatient beds, the Applicant will have the ability to provide psychiatric treatment to more mental health consumers, significantly reducing placement issues and deflection and diversion activity in its service area. With the requested addition, the Applicant will be able to create distinct and specialized programming, effectively treating all patient populations, remaining a resource for the medical community, law enforcement system and crisis intervention providers.

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.

   b. Provide current and proposed schedules of operations.

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.

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. The project does not involve the acquisition of any majority medical equipment as defined by HSDA rules.

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

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

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

RESPONSE: Please see Attachment B.III.(A).

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: The Applicant facility is located at Quail Hollow Circle, which sits at the intersection of North Carothers Road, Franklin, Tennessee. This site is less than one-half mile from Williamson Medical Center in Franklin, TN and is less than one mile from Interstate 65. Moreover, the completion of State Route 840 in 2012 greatly increased the accessibility of the Applicant facility to the counties of Dickson, Hickman, Rutherford, Williamson and Wilson. State Route 840 connects to Interstate 65 approximately seven miles south of the Applicant facility, and State Route 840 connects to Interstate 40 approximately 36 miles to the west, and to interstate 24 approximately 28 miles to the east. The ease of access from all four major limited access roads (and their respective connections to smaller federal, state and county highways) provides easy access to the Applicant's facility from all points of its service area.

The location of the Applicant facility makes it easily accessible to patients and their families, as well as staff and caregivers. According to the Williamson County Chamber of Commerce, the Franklin Trolley Services will take any passenger to Williamson Medical Center upon request. Otherwise, there is no other public transportation in the area.

Williamson Medical Center and Maury Regional Hospital are the two largest acute care medical centers south of Nashville along the I-65 corridor. With respect to Williamson Medical Center, it is currently licensed for 185 beds. However, it is expanding to accommodate growth in the area. In November, 2013, Williamson Medical Center broke ground on a

$65 million expansion project that will include a dedicated children's emergency department and hospital, expanded surgery and women's services, and surgical suites. The new facility (which is projected to open in January 2015), has been reported as "reflect[ing] a significant partnership with Vanderbilt to provide pediatric inpatient care, bearing the name Monroe Carell Jr. Children's Hospital Vanderbilt at Williamson Medical Center." The Applicant currently receives a substantial number of patients from Monroe Carell Jr. Children's Hospital at Vanderbilt in Nashville, especially when Vanderbilt's behavioral health unit is full, and the Applicant anticipates receiving more behavioral health patients from the new children's hospital at Williamson Medical Center when it opens.

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

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

RESPONSE: Please see Attachment B.IV. Please note that the proposed addition involves 4 private rooms and 18 semi-private rooms. In the majority of mental health care facilities, semi-private rooms are still the "norm," despite the contrary trend in acute and long term care facilities. Accordingly, the Applicant has designed the addition to conform to industry norms and better serve its patient population.

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

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

RESPONSE: Not applicable.

SECTION C: GENERAL CRITERIA FOR CERTIFICATE OF NEED

In accordance with Tennessee Code Annotated § 68-11-1609(b), "no Certificate of Need shall be granted unless the action proposed in the application for such Certificate is necessary to provide needed health care in the area to be served, can

be economically accomplished and maintained, and will contribute to the orderly development of health care." The three (3) criteria are further defined in Agency Rule 0720-4-.01. Further standards for guidance are provided in the state health plan (Guidelines for Growth), developed pursuant to Tennessee Code Annotated §68-11-1625.

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

QUESTIONS

NEED

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

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

RESPONSE:

Acute Care Bed Need Services

1. The following methodology should be used and the need for hospital beds should be projected four years into the future from the current year...(guidelines detail the steps of the bed need projection methodology; see pp. 15-16 of Guidelines for Growth.)

RESPONSE: A chart of the projected acute care bed need for 2013 through 2017 for each county in the Applicant's primary service area follows. Please note that the calculations were made by using the formula in the Guidelines for Growth.

Acute Care Bed Need Projections for 2013 and 2017 in Applicant's Primary Service Area

County	Projected ADC 2017	Projected Need 2017	Licensed Beds 2011	Staffed Beds 2011	Shortage/Surplus Licensed Beds	Shortage/Surplus Staffed Beds
Bedford	26	38	60	60	-22	-22
Giles	20	31	95	81	-64	-50
Lawrence	30	43	99	80	-56	-37
Lincoln	22	33	59	59	-26	-26
Marshall	3	6	25	12	-19	-6
Maury	134	167	255	206	-88	-39
Rutherford	249	312	387	387	-75	-75
Williamson	101	126	185	185	-59	-59
TOTALS:	**585**	**756**	**1,165**	**1,070**	**-409**	**-314**

Source: Tennessee Department of Health, Office of Health Statistics website (Last accessed 12/3/13)

As noted above, the Tennessee Department of Health projects a net surplus of 409 acute care hospital beds in the Applicant's service area.

Because of the Applicant's location and ease of access, its reputation and the increased need for mental health services, the Applicant maintains that it has a secondary service area in addition to its primary service area. The Applicant's secondary service area includes the following counties: Coffee, Davidson, Dickson, Montgomery, and Sumner counties. A chart of the projected acute care bed need for 2013 through 2017 for each county in the Applicant's secondary service area follows. Please note that the calculations were made by using the formula in the Guidelines for Growth.

Acute Care Bed Need Projections for 2013 and 2017 in Applicant's Secondary Service Area

County	Projected ADC 2017	Projected Need 2017	Licensed Beds 2011	Staffed Beds 2011	Shortage/Surplus Licensed Beds	Shortage/Surplus Staffed Beds
Coffee	95	119	214	154	-95	-35
Davidson	2,312	2,890	3,685	2,998	-795	-108
Dickson	58	76	157	122	-81	-46
Montgomery	137	172	270	220	-98	-48
Sumner	133	167	341	236	-174	-69
TOTALS:	**2,735**	**3,424**	**4,667**	**3,730**	**-1,243**	**-306**

Source: Tennessee Department of Health, Office of Health Statistics website (Last accessed 12/5/13)

2. New hospital beds can be approved in excess of the "need standard for a county" if the following criteria are met:

(a) All existing hospitals in the projected service area have an occupancy level greater than or equal to 80 percent for the most recent Joint Annual Report. Occupancy should be based on the number of licensed beds that are staffed for two consecutive years.

(b) All outstanding CON projects for new acute care beds in the proposed service area are licensed.

(c) The Health Facilities Commission may give special consideration to acute care bed proposals for specialty health service units in tertiary care regional referral hospitals.

RESPONSE: The Applicant understands that this project will be viewed under general acute medical/surgical bed guidelines. However, if approved, the Applicant will not provide general acute medical/surgical services. These services are readily available at Williamson Medical Center, a general acute care hospital located within one-half mile of the Applicant. Only the following

services will be provided at the Applicant's hospital: outpatient and inpatient medical detoxification, adult psychiatric, geriatric psychiatric, and adolescent psychiatric services. For these reasons, the Applicant believes that this project should not be considered as an acute medical/surgical application, and the above criteria are not applicable.

Construction, Renovation, Expansion, and Replacement of Health Care Institutions

1. Any project that includes the addition of beds, services, or medical equipment will be reviewed under the standards for those specific activities.

RESPONSE: The Applicant understands that this project will be viewed under general acute medical/surgical bed guidelines. However, if approved, the Applicant will not provide general acute medical/surgical services. These services are readily available at Williamson Medical Center, a general acute care hospital located within one-half mile of the Applicant. Only the following services will be provided at the Applicant's hospital: outpatient and inpatient medical detoxification, adult psychiatric, geriatric psychiatric, and adolescent psychiatric services.

2. For relocation or replacement of an existing licensed health care institution:

> **(a) The applicant should provide plans which include costs for both renovation and relocation, demonstrating the strengths and weaknesses of each alternative.**
>
> **(b) The applicant should demonstrate that there is an acceptable existing or projected future demand for the proposed project.**

RESPONSE: Not applicable

3. For renovation or expansions of an existing licensed health care institution:

> **(a) The applicant should demonstrate that there is an acceptable existing demand for the proposed project.**
>
> **(b) The applicant should demonstrate that the existing physical plant's condition warrants major renovation or expansion.**

RESPONSE: Given the increased demand in the Applicant's service area, the Applicant has a strong need to provide mental health treatment

for the service area population. The most important need considerations in connection with the Applicant's proposed expansion project are as follows:

- To improve availability of beds to mental health patients

The Applicant is requesting 40 additional beds to its current 80 bed configuration due to a lack of mental health beds in the Applicant's service area. The Applicant has relationships with a number of healthcare providers and works diligently to triage and find placement for individuals in need of mental health treatment. Despite those efforts, the Applicant still experiences deflection activity due to its limited number of beds, and the overall size and configuration of the current facility. The Applicant has experienced a steady increase in its occupancy rate since the opening of the Applicant's facility in January 2009. In 2010, the Applicant had an occupancy rate of just twenty-two percent (22%), but over the last 12 months, the Applicant has had a sustained occupancy rate of at least eighty-four percent (84%). More specifically, over the last 12 months, the Applicant has been at maximum occupancy for a total of 24 days, and the Applicant has been at 95% or greater occupancy for 46 days, thus resulting in problematic deflection and diversion activity. With the addition of 40 beds to the Applicant's facility, patients in need of mental health treatment in the Applicant's service area will have easier access and an increased chance of placement in a timely manner, thus decreasing the stress, to both the patient and family members, that obviously arises at the time of a mental health crisis.

- To offer specialized programming to a diverse population of patients needing mental health treatment

The Applicant has effectively worked around bed configuration issues to service the needs of multiple, diverse patient populations. However, to best serve those patient populations, additional space, including additional patient rooms, is needed. The Applicant has managed to operate five inpatient units in a facility that was originally designed to accommodate only four inpatient units. The addition of 40 beds to the Applicant's facility would allow for improved design and a reconfiguration of the existing layout of the Applicant's units, thus allowing the Applicant to handle specialty patients instead of diverting them elsewhere. This increased flexibility will benefit patients in the Applicant's service area in need of specialized, unique mental health treatment, due to age, severity of illness, gender, patient specific mix, and other factors.

- To increase accessibility for emergency departments and crisis teams who depend on the Applicant to place their patients in need of mental health treatment and to increase collaboration with the provider community to ensure appropriate placement of patients in need of mental health treatment

The Applicant has a number of relationships with healthcare providers in the community, including emergency departments and crisis teams, who depend on

the Applicant to place patients in need of mental health treatment. The limitations that exist due to the current size and configuration of the Applicant's facility are hindering the Applicant's ability to serve as a constant option for these other healthcare providers to place patients. The addition of 40 beds would increase the Applicant's ability to take on new patients in need of mental health treatment, which would benefit other healthcare providers in the service area. Moreover, this addition would increase the expediency with which triage and placement of patients would occur, thus decreasing stress on the patients, family members, caregivers and healthcare providers trying to place patients in need of mental health treatment. Because the current demand for mental health treatment in the Applicant's service area exceeds the bed and provider supply, the addition of 40 beds at the Applicant's facility would help decrease the gap in supply and demand, benefiting both the consumers of mental health care and the other healthcare providers, such as emergency departments and crisis teams trying to find suitable placement for patients in need of mental health treatment.

In summary, the addition of 40 beds at the Applicant's facility would allow the Applicant to provide psychiatric treatment to more mental health consumers, significantly reducing placement issues and deflection and diversion activity in its service area. With the requested addition, the Applicant will be able to create distinct and specialized programming, effectively treating all patient populations, remaining a resource for the medical community, law enforcement system and crisis intervention providers. The Applicant has selected a proposed bed complement of 40 beds, with two units of 20 beds each, based on its parent company's vast experience in operating similar mental health hospitals. Each 20 bed unit will have one nursing station, which will allow for efficient and effective access and services to patients. Moreover, this bed complement will make for an efficient layout with efficient, effective staffing.

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 the Joint Annual Reports).

RESPONSE: Charts containing the calculations for psychiatric inpatient services in the Applicant's primary and secondary service areas appears on the following pages.

Projected Psychiatric Bed Need in Applicant's Primary Service Area for 2017

County	2017 Population			2017 Psychiatric Bed Need Projections		
	Adolescent (13-17)[1]	Adult (18-64)[2]	Adult (65+)	Adolescent (13-17)	Adult (18-64)	Adult (65+)
Bedford	3,880	32,282	6,412	1	10	2
Giles	1,963	18,884	5,447	1	6	2
Lawrence	2,908	26,360	7,682	1	8	2
Lincoln	2,301	20,791	6,404	1	6	2
Marshall	2,172	20,707	4,579	1	6	1
Maury	6,066	56,145	12,646	2	17	4
Rutherford	18,580	182,005	30,603	6	55	9
Williamson	14,670	134,498	22,719	4	40	7
Totals:	**52,540**	**491,672**	**96,492**	**17**	**148**	**29**

Total Bed Need: 194

Sources: Tennessee Department of Health Population Projections; Guidelines for Growth (2000 ed.)

As noted in the chart above, the total bed need for 2017 for psychiatric inpatient beds at a rate of 30 beds per 100,000 population in the Applicant's primary service area is 194 beds.

[1] The Tennessee Department of Health Population Projections 2010-2020 do not break down age categories in the 13 to 17 range. Accordingly, we calculated population using 50% of the population of the age range 10 to 14 and 50% of the population of the age range 15 to 19. Although it is not exact, we believe the method is statistically defensible.

[2] The Tennessee Department of Health Population Projections 2010-2020 do not break down age categories in the 18 to 64 range. Accordingly, we included 50% of the population of the age range 15 to 19 in our calculations. Again, although it is not exact, we believe the method is statistically defensible.

DEC 13 '13 PM 3:26

Projected Psychiatric Bed Need in Applicant's Secondary Service Area for 2017

County	2017 Population			2017 Psychiatric Bed Need Projections		
	Adolescent (13-17)[3]	Adult (18-64)[4]	Adult (65+)	Adolescent (13-17)	Adult (18-64)	Adult (65+)
Coffee	3,674	34,592	9,931	1	10	3
Davidson	37,192	396,869	81,389	11	119	24
Dickson	3,632	32,278	7,574	1	10	2
Montgomery	11,921	110,416	17,247	4	33	5
Sumner	12,058	107,467	24,948	4	32	7
Totals:	**68,477**	**681,622**	**141,089**	**21**	**204**	**41**

Total Bed Need: 266

Sources: Tennessee Department of Health Population Projections; Guidelines for Growth (2000 ed.)

As noted in the chart above, the total bed need for 2017 for psychiatric inpatient beds at a rate of 30 beds per 100,000 population in the Applicant's secondary service area is 266 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.

RESPONSE: As show in the charts above, the bed need in the Applicant's primary service area for adults 18 years and older is 177 beds (148 for ages 18-64 plus 29 for ages 65 and up). The bed need in the Applicant's secondary services area for adults 18 years and older is 245 beds (204 for ages 18-64 plus 41 for ages 65 and up).

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

RESPONSE: As show in the charts above, the bed need in the Applicant's primary service area for adolescents between 13 and 17 is 17 beds. The bed need in the Applicant's secondary service area for adolescents between 13 and 17 is 21 beds.

---

[3] As mentioned in footnote 1, the Tennessee Department of Health Population Projections 2010-2020 do not break down age categories in the 13 to 17 range. Accordingly, we calculated population using 50% of the population of the age range 10 to 14 and 50% of the population of the age range 15 to 19. Although it is not exact, we believe the method is statistically defensible.

[4] As mentioned in footnote 2, the Tennessee Department of Health Population Projections 2010-2020 do not break down age categories in the 18 to 64 range. Accordingly, we included 50% of the population of the age range 15 to 19 in our calculations. Again, although it is not exact, we believe the method is statistically defensible.

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: A chart containing the number of existing staffed and licensed beds in the Applicant's primary service area follows:

Staffed and Licensed Psychiatric Beds in Applicant's Primary Service Area

Hospital	County	2012 Staffed Psych Beds	2012 Licensed Psych Beds	2012 Facility Average Daily Census	2013 Staffed Psych Beds	2013 Licensed Psych Beds	2013 Facility Average Daily Census
Hillside Hospital	Giles	14	14	10	*	14	*
Lincoln Medical Center	Lincoln	10	10	7	*	10	*
Trustpoint Hospital*	Rutherford	*	76	*	*	76	*
Rolling Hills Hospital**	Williamson	80	80	62	80	80	67
Totals:		**86**	**180**	**71**		**180**	

*Information is not available at this time.
** Note that Rolling Hills Hospital internal data is at variance with what was reported in its 2012 Joint Annual Report. The data reported in this chart is consistent with the Applicant's internal records. The 2013 ADC is "year to date" as of the filing date of this Application, with 67 patients equaling an average census of 83.75%. As note elsewhere in this Application, during 2013 the Applicant has been at maximum occupancy for a total of 24 days, and the Applicant has been at 95% or greater occupancy for 46 days.

Sources: 2012 Joint Annual Reports and Applicant's Internal Records

A chart containing the number of existing staffed and licensed beds in the Applicant's secondary service area appears on the following page.

Staffed and Licensed Psychiatric Beds in Applicant's Secondary Service Area

Hospital	County	2012 Staffed Psych Beds	2012 Licensed Psych Beds	2012 Facility Average Daily Census	2013 Staffed Psych Beds	2013 Licensed Psych Beds	2013 Facility Average Daily Census
Centennial Medical Center	Davidson	132	132	82	*	132	*
Middle Tennessee Mental Health Institute	Davidson	195	245	166	*	245	*
Saint Thomas West Hospital	Davidson	23	23	16	*	23	*
Skyline Medical Center, Madison Campus	Davidson	91	91	61	*	91	*
Summit Medical Center	Davidson	20	20	12	*	20	*
Vanderbilt University Hospitals	Davidson	88	88	77	*	88	*
Behavioral Healthcare Center at Clarksville	Montgomery	26	26	13	*	26	*

Sumner Regional Medical Center	Sumner	8	12	3	*	12	*
Totals:		**583**	**637**	**430**		**637**	

*Information is not available at this time.

Sources: 2012 Joint Annual Reports and Applicant's Internal Records

Adjusted for the number of existing staffed (rather than licensed) psychiatric beds, the total bed need in the Applicant's primary service area is 108 beds (total bed need of 194 minus 86 existing staffed beds). However, according to the current 2000 Guidelines for Growth, when calculated using the number of existing licensed psychiatric beds, the total bed need in the Applicant's primary service area is 14 beds (total bed need of 194 minus 180 licensed beds). While even with that calculation the bed need in the Applicant's primary service area is at least 14 beds, the Applicant believes that the actual number of beds needed to support not only current demand, but also anticipated growth in the area, is considerably higher. Therefore, **

According to the current 2000 Guidelines for Growth, when considering the number of existing beds in the Applicant's secondary service area, there is a bed surplus in the Applicant's secondary service area of 317 beds (total bed need of 266 minus 583 existing staffed beds). However, the Applicant continues to receive patients from the secondary service area, notwithstanding the bed surplus per the Guidelines for Growth.

Among American cities with metropolitian statistical area (MSA) populations of one million or more, the Nashville MSA (which includes Williamson County, where this facility is located, and several other counties in the Applicant's service area) is estimated to have experienced the 10th most growth (1.7 percent) from 2011 to 2012, according to the U.S. Bureau of the Census data released in 2013. At this rate, Nashville, which had an MSA population of 1.72 million in2012, will be home to approximately two million residents by 2020. Other recent data indicates that the Nashville MSA will continue significant growth for the next two decades, with estimates from the Nashville Area Metropolitan Planning Organization that in 2035 the area will equal or exceed the current size of greater Denver today.

While many of the counties in the applicant's service area have experienced, and continue to experience high growth, Williamson County in particular has been quite remarkable. It is home to numerous corporations, such as Nissan North America and 13 of the largest 25 publicly traded companies in the Nashville region. More than 6,000 businesses are located Williamson County,

which has a proven track record of attracting and growing businesses, and the employees and families which coincide with such business growth.

In addition to the 2017 population projections shown elsewhere in this Application, the following chart indicates such "20 year growth" (to 2035) for the three most populous counties in the Applicant's primary service area.

Population by County (2009, 2012 and 2035)

County	2009 Population	2012 Population*	2035 Population**
Maury	80,685	81,990	114,005
Rutherford	259,078	274,454	409,986
Williamson	180,332	192,911	387,970
Totals:	**520,095**	**549,355**	**911,961**

*As of July 1, 2012

** 2035 estimates are from the "Regional Profile" published by the Nashville Area Metropolitan Planning Organization

Sources: United States Census Bureau, Intercensal Estimates of the Resident Population for Counties of Tennessee: April 1, 2000 to July 1, 2010; United States Census Bureau State & County QuickFacts

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: Williamson County is one of the fastest growing counties in Tennessee. The population increase means that more health-related facilities are and will be needed in the area in the future. Though there are several Davidson County providers of services similar to those provided by the Applicant, the service area currently served by the Applicant is underserved and the addition of beds will provide needed services and better contribute to the orderly development of health care.

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 serves, and will continue to serve, adolescents and adults of all ages, without discrimination with regard to gender, race, and ethnicity. It currently serves a large low-income TennCare and Medicare population and plans to continue such services. In addition, the Applicant will admit self-pay and charity patients. The Applicant will also continue to accept involuntary admissions from the judicial system and local law enforcement.

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: This project will fulfill many of the goals set forth in the Tennessee Guidelines for Growth. This project will support the delivery of services in the most medically appropriate settings. In addition, those institutions that provide services to the elderly, categorically needy, and/or indigent patients are strongly favored. The Applicant currently provides, and will continue to provide, mental health care to elderly and indigent patients. In addition, the Guidelines direct that preference should be given to patient accessibility and availability, both of which will be improved in the Applicant's service area if this project is approved.

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 previously discussed, the Applicant's primary service area consists of Bedford, Giles, Lawrence, Lincoln, Marshall, Maury, Rutherford, and Williamson Counties. As reported by the Health Resources and Services Administration of the U.S. Department of Health and Human Services, the entire area of Bedford, Giles, Lawrence, Lincoln, and Marshall Counties are designed as Medically Underserved Areas ("MUAs"). In addition, portions of Maury, Rutherford and Williamson Counties are designated as MUAs. This project will seek to meet the mental health needs of these underserved areas.

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

RESPONSE: The Applicant anticipates that the State mental health hospital in its service area will support this project.

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: The Applicant will accept involuntary commitments.

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

RESPONSE: The Applicant will contract with all area TennCare MCO's that cover psychiatric and chemical dependency services. Its projected payor mix for TennCare is 39.1% and for Medicare is 19.1%. These are conservative projections based on the Applicant's current payor mix.

D. Relationship to Existing Similar Services in the Area

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

RESPONSE: As noted in the charts below, occupancy rates in the Applicant's primary and secondary service areas have remained consistent or increased over the last five years.

Occupancy Rates in Applicant's Primary Service Area

Facility	2008	2009	2010	2011	2012
Hillside Hospital	64%	71%	64%	57%	71%
Lincoln Medical Center	*	60%	80%	70%	65%
Trustpoint Hospital	**	**	**	**	**
Rolling Hills Hospital	***	43%	69%	74%	78%

*Lincoln Medical Center's psychiatric unit opened on 7/1/2008.
**Information is not yet available.
***Rolling Hills Hospital (the Applicant) opened on 1/1/2009.

Occupancy Rates in Applicant's Secondary Service Area

Facility	2008	2009	2010	2011	2012
Centennial Medical Center	71%	92%	59%	72%	63%

Middle Tennessee Mental Health Institute	95%	83%	73%	84%	85%
Saint Thomas Hospital	71%	75%	89%	91%	69%
Skyline Medical Center Campus	49%	53%	48%	57%	55%
Summit Medical Center	60%	64%	53%	69%	61%
Vanderbilt University Hospitals	85%	74%	76%	83%	88%
Behavioral Healthcare Center at Clarksville	*	*	12%	42%	50%
Sumner Regional Medical Center	**	**	**	**	66%

*The Behavioral Healthcare Center at Clarksville opened on 3/4/2010.
**Sumner Regional Medical Center's psychiatric unit opened on 4/16/2012.

Sources: Tennessee Joint Annual Reports 2008 through 2012

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

RESPONSE: As mentioned previously, the Applicant serves a significant number of elderly and low-income individuals in its service area. This project will increase accessibility for these individuals and promote more efficient and effective care for all patients.

E. Feasibility

1. 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 hereby confirms that it currently meets such licensure requirements and will continue to do so upon the approval of the project.

In addition to the above, the Applicant has reviewed the 2010 Tennessee State Health Plan and the 2012 update, published by the Division of Health Planning, and believes that the approval of its CON application would assist the development of the goals and strategies set forth in the "Five Principles for Achieving Better Health," as found in the State Health Plan, as follows:

(1) ***The purpose of the State Health Plan is to improve the health of Tennesseans***. This project seeks to add beds to the Applicant's existing facility to improve access to mental health care, to enhance the number and quality of the mental health programs offered by the Applicant, and to increase the

Applicant's ability to collaborate with local medical providers and law enforcement officials. These goals are consistent with and vital to the improvement of the medical and mental health of Tennesseans.

(2) ***Every citizen should have reasonable access to healthcare.*** Although the Applicant is a private facility, it is committed to serving elderly and low-income patients in the Medicare and TennCare programs. The Applicant currently accommodates a substantial number of managed care consumers.

(3) ***The state's healthcare resources should be developed to address the needs of Tennesseans while encouraging competitive markets, economic efficiencies, and the continued development of the state's healthcare system.*** This project supports these goals by increasing the competitiveness of the market for private hospital psychiatric services in the Applicant's service area, providing for an economically efficient increase in the number of psychiatric beds in the Applicant's service area, and continuing the development of the system for mental health services in the Applicant's service area.

(4) ***Every citizen should have confidence that the quality of healthcare is continually monitored and standards are adhered to by healthcare providers.*** The Applicant continually monitors applicable standards of care with the goal of always meeting or exceeding such standards, thus assuring that patients and their family members receive quality, appropriate care and support.

(5) ***The state should support the development, recruiting and retention of a sufficient and quality healthcare workforce.*** The Applicant supports the development, recruitment and retention of a sufficient and quality healthcare workforce through their various training programs, community outreach initiatives, and other programs and support.

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: The Applicant is currently an 80-bed Medicare certified mental health hospital located in Franklin, Tennessee. The Applicant provides psychiatric care to adolescents, adults and geriatric mental health consumers. As previously stated in this application, due to the facility's size and resultant configuration, there are significant issues impacting the Applicant's ability to provide specialized psychiatric care to members of its community. At present, the Applicant has maximized its resources, and sometimes has to deflect

patients in need of care. This not only impacts emergency departments and treatment providers, it creates a crisis continuum for the individual and his or her family.

The Applicant has experienced a steady increase in the Applicant's occupancy rate since the opening of the Applicant's facility in January 2009. In 2010, the Applicant had an occupancy rate of just twenty-two percent (22%), but over the last 12 months, the Applicant has had a sustained occupancy rate of at least eighty-four percent (84%). More specifically, over the last 12 months, the Applicant has been at maximum occupancy for a total of 24 days, and the Applicant has been at 95%or greater occupancy for 46 days, thus resulting in problematic deflection and diversion activity. Please note that in a mental health hospital such as the Applicant's facility, "capacity" does not mean 100% occupancy. "Capacity" is a term based on the patient population mix, gender, age, severity of issue, etc. This proposed project will allow the Applicant to better serve the community's mental health needs, remediate access to care issues within its service area and work alongside mental health providers to ensure the placement and safety of individuals experiencing a mental health crisis.

Moreover, as previously mentioned, the Mental Health Parity and Addiction Equity Act (the "Act") requires insurance groups that offer coverage for mental health or substance use disorders to provide the same level of benefits that they do for general medical treatment. The ACA significantly extends the reach of the Act's requirements, and in 2014, the ACA will require all small group and individual market plans created before March 23, 2010 to comply with federal parity requirements. Accordingly, in addition to the increased demand for mental and mental health services generated by local factors, the Applicant anticipates that this need will only increase as a result of this federal parity requirement.

3. Identify the proposed service area <u>and</u> 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.).**

<u>Response</u>: Please see Attachment Need.3. The Applicant's primary service area consists of the following eight counties: Bedford, Giles, Lawrence, Lincoln, Marshall, Maury, Rutherford, and Williamson. In addition to its primary service area, the Applicant maintains that it has a secondary service area consisting of the following five counties: Coffee, Davidson, Dickson, Montgomery and Sumner. While the Applicant still attracts most of its patients from the counties in its primary service area, due to its accessible location and an increased demand and insufficient supply of mental health services, patients seek treatment at the Applicant's facility from counties in the secondary service area.

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

Response: The Applicant facility is approximately one-half mile from Williamson Medical Center and approximately one mile from the intersection of Interstate 65 and Highway 96 in Franklin, Tennessee. Williamson County enjoys a very high per capital income. As such, there is a high concentration of business workers in the county. However, much of the primary service area contains industrial sites and many agricultural areas. 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 : The Applicant's service area has very limited access to rehabilitation, psychiatric and medical detoxification services, thus constituting "special need." The approval of this project will further enable patients who need the specialized care available at the Applicant's facility to obtain those services in a modern, accessible setting close to patients' homes, families and communities.

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 : Within the Applicant's service area, there are only three other hospitals that have licensed psychiatric beds, Hillside Hospital in Giles County Lincoln Medical Center in Lincoln County, and Trustpoint Hospital in Rutherford County. A chart of the utilization data for each of these hospitals and the Applicant follows, with the exception of Trustpoint Hospital for which such information is not yet available:

Facility	Number of Psychiatric Beds	Admissions (CY 2010)	Admissions (CY 2011)	Admissions (CY 2012)
Hillside Hospital	14	38	23	148
Lincoln Medical Center	10	50	72	159
Rolling	80	2,637	2,866	3,067

Hills Hospital (Applicant)				

Sources: Applicant's internal records and 2010, 2011, and 2012 Joint Annual Reports

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: The requested utilization statistics are as follows:

2013 Inpatient Days Through October 2013		
Patient Type	Inpatient Days	Utilization Percentage
BCBS	3,349	16.6%
Tricare	381	1.9%
Commercial	369	1.8%
TennCare	7,894	39.2%
Medicare	3,839	19.0%
Managed Medicare	1,417	7.0%
Other-HMO/PPO	2,910	14.4%
	20,159	100.0%
Occupancy-80 beds	83%	

2012 Inpatient Days		
Patient Type	Inpatient Days	Utilization Percentage
BCBS	4,451	19.6%
Tricare	302	1.3%
Commercial	659	2.9%
TennCare	7,862	34.6%
Medicare	4,392	19.3%
Managed Medicare	1,790	7.9%
Other-HMO/PPO	3,249	14.3%
	22,705	100.0%
Occupancy-80 beds	78%	

2011 Inpatient Days		
Patient Type	Inpatient Days	Utilization Percentage
BCBS	3,805	17.5%
Tricare	369	1.7%
Commercial	3,058	14.1%
TennCare	7,724	35.5%

Medicare	4,720	21.7%
Managed Medicare	2,063	9.5%
Other-HMO/PPO		0.0%
	21,739	100.0%
Occupancy-80 beds	74%	

2015 Projected Utilization (120 Beds)		
Patient Type	Inpatient Days	Utilization Percentage
BCBS	4,967	16.8%
Tricare	591	2.0%
Commercial	532	1.8%
TennCare	11,560	39.1%
Medicare	5,647	19.1%
Managed Medicare	2,070	7.0%
Other-HMO/PPO	4,198	14.2%
	29,565	100.0%
Occupancy-120 beds	68%	

2016 Projected Utilization (120 Beds)		
Patient Type	Inpatient Days	Utilization Percentage
BCBS	5,439	16.8%
Tricare	648	2.0%
Commercial	583	1.8%
TennCare	12,659	39.1%
Medicare	6,184	19.1%
Managed Medicare	2,266	7.0%
Other-HMO/PPO	4,597	14.2%
	32,376	100.0%
Occupancy-120 beds	74%	

Note: Utilization for 2011-2013 is based on actual experience. Projected utilization for 2015-2016 is a combination of the proposed project and existing hospital; with 81.0 ADC in 2015 and 88.7 ADC is 2016. Forecasted ADC is an estimation based on a number of factors such as community need, expanded programming, project ROI and hospital management experience.

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: Please see Attachment Economic Feasibility.1 for a letter supporting the estimated construction costs.

DEC 13 '13 PM3:26

PROJECT COSTS CHART

A. Construction and equipment acquired by purchase

1.	Architectural and Engineering Fees	$765,100
2.	Legal, Administrative (Excluding CON Filing Fee), Consultant Fees	$60,000
3.	Acquisition of Site	N/A
4.	Preparation of Site	$628,120
5.	Construction Costs	$7,179,765
6.	Contingency Fund	$231,000
7.	Fixed Equipment (Not included in Construction Contract)	$813,651
8.	Moveable Equipment (List all equipment over $56,000)	N/A
9.	Other (Specify) _____	$97,280

B. Acquisition by gift, donation, or lease: Not Applicable.

1.	Facility (inclusive of building and land)	
2.	Building only	
3.	Land only	
4.	Equipment (Specify) _____	
5.	Other (Specify) _____	

C. Financing Costs and Fees: Not Applicable.

1.	Interim Financing	
2.	Underwriting Costs	
3.	Reserve of One Year's Debt Service	
4.	Other (specify) _____	

D.	Estimated Project Cost (A+B+C+)	$9,774,916
E.	CON Filing Fee	$21,993.56
F.	Total Estimated Project Cost (D+E)	$9,796,909.56
	TOTAL	**$9,796,909.56**

2. Identify the funding sources for this project.

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

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

F Other—Identify and document funding from all other sources.

Response: The cost of the project will be paid through cash reserves of the Applicant and its affiliates. Please see Attachment C. Economic Feasiblity-2 for documentation of this fact.

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 will be cost effective and consistent with the average costs for similar projects. The project's estimated cost is approximately $337.00 per square foot, which is consistent with the HSDA's published median cost per square foot. A chart of the hospital construction projects approved by the HSDA in 2010-2012 follows:

Hospital Construction Costs Per Square Foot (2010-2012)

	Renovated Construction	New Construction	Total Construction
1st Quartile	$99.12/SF	$234.64/SF	$167.99/SF
Median	$177.60/SF	$259.66/SF	$235.00/SF
3rd Quartile	$249.00/SF	$307.80/SF	$274.63/SF

Source: CON approved applications for years 2010 through 2012

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, include anticipated revenue from the proposed beds only, not from all beds in the facility).

   Response: Please see Attachment C. Economic Feasibility-4. Historical and Projected Data Charts.

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

   Response: The project's average gross charge, average deduction from operating revenue, and average net charge are as follows:

	2 Years Projected	Patient Days	Average Rate
Gross Revenue	$19,074,544	12,435	$1,534
Deduction from Revenue	$10,530,089	12,435	$847
Net Revenue	$8,544,455	12,435	$687

SUPPLEMENTAL- # 1
December 26, 2013
12:16pm

Supplemental Attachment – Section C. Economic Feasibility, Item 4.

Revised Historical Data Chart and Revised Projected Data Chart

SUPPLEMENTAL
December 30, 2013
10:24 am

Supplemental Attachment – Section C, Economic Feasibility, Item 4

Revised Historical Data Chart

SUPPLEMENTAL
December 30, 2013
10:24 am

HISTORICAL DATA CHART

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

	CY 2010	CY 2011	CY 2012
A. Utilization Data (Occupancy)	69%	74%	78%
B. Revenue from Services to Patients			
1. Inpatient Services	$30,294,115	$32,362,383	$33,899,670
2. Outpatient Services	$ 554,155	$ 771,740	$ 1,316,429
3. Emergency Services			
4. Other Operating Revenue (Specify) Dietary Revenue, Medical Records Management Revenue, Miscellaneous	$ 294,348	$ 200,668	$ 288,878
Gross Operating Revenue	**$31,142,618**	**$ 33,334,791**	**$35,504,977**
C. Deductions from Gross Operating Revenue			
1. Contractual Adjustments	$15,298,513	$16,461,824	$17,732,862
2. Provision for Charity Care		$ 77,771	$ 39,193
3. Provisions for Bad Debt	$ 505,728	$ 591,437	$ 822,853
Total Deductions	**$15,804,241**	**$ 17,131,032**	**$18,594,908**
NET OPERATING REVENUE	**$15,338,377**	**$ 16,203,759**	**$16,910,069**
D. Operating Expenses			
1. Salaries and Wages	$ 7,238,083	$ 7,501,807	$ 7,850,732
2. Physician's Salaries and Wages	$ 1,600,877	$ 1,333,177	$ 1,298,550
3. Supplies	$ 960,757	$ 903,911	$ 950,000
4. Taxes		$ 281,349	$ 278,826
5. Depreciation	$ 937,312	$ 1,274,961	$ 1,282,569
6. Rent	$ 90,872	$ 81,774	$ 109,282
7. Interest, other than Capital			
8. Management Fees:			
a. Fees to Affiliates	$ 470,009	$ 360,240	$ 448,800
b. Fees to Non-Affiliates			
9. Other Expenses (Specify) Employee Benefits, Purchased Services, Maintenance, Insurance, Travel/Education/Dues, Other Expenses, Non-Allocated	$ 3,708,870	$ 2,930,225	$ 3,346,981
Total Operating Expenses	**$ 15,006,780**	**$ 14,667,444**	**$ 15,565,740**
E. Other Revenue (Expenses) – Net (Specify)			
NET OPERATING INCOME (LOSS)	**$ 331,597**	**$ 1,536,315**	**$ 1,344,329**
F. Capital Expenditures			
1. Retirement of Principal			
2. Interest			
Total Capital Expenditures			
NET OPERATING INCOME (LOSS)			
LESS CAPITAL EXPENDITURES	$ 331,597	$ 1,536,315	$1,344,329

SUPPLEMENTAL
December 30, 2013
10:24 am

PROJECTED DATA CHART

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

	CY 2015	CY 2016
A. Utilization Data (Occupancy—120 beds)	68%	74%
B. Revenue from Services to Patients		
1. Inpatient Services	$ 45,471,710	$ 49,794,688
2. Outpatient Services	$ 3,271,652	$ 3,575,352
3. Emergency Services		
4. Other Operating Revenue (Specify) Dietary Revenue, Medical Records, Miscellaneous and Management Revenue	$ 82,667	$ 84,734
Gross Operating Revenue	**$ 48,826,029**	**$ 53,454,774**
C. Deductions from Gross Operating Revenue		
1. Contractual Adjustments	$ 25,193,743	$ 27,656,801
2. Provision for Charity Care	$ 102,186	$ 111,901
3. Provisions for Bad Debt	$ 1,196,275	$ 1,311,353
Total Deductions	**$ 26,492,204**	**$ 29,080,055**
NET OPERATING REVENUE	**$ 22,333,825**	**$ 24,374,719**
D. Operating Expenses		
1. Salaries and Wages	$ 9,626,068	$ 10,365,077
2. Physician's Salaries and Wages	$ 1,845,131	$ 2,012,360
3. Supplies	$ 1,175,744	$ 1,280,393
4. Taxes	$ 401,225	$ 405,478
5. Depreciation	$ 1,303,845	$ 1,287,000
6. Rent	$ 101,797	$ 103,641
7. Interest, other than Capital		
8. Management Fees:		
a. Fees to Affiliates	$ 612,320	$ 617,193
b. Fees to Non-Affiliates		
9. Other Expenses (Specify) Employee Benefits, Purchased Services, Maintenance, Insurance, Travel /Education/Dues, Other Expenses, Non-Allocated	$ 3,977,824	$ 4,346,144
Total Operating Expenses	**$ 19,043,954**	**$ 20,417,286**
E. Other Revenue (Expenses) -- Net (Specify)		
NET OPERATING INCOME (LOSS)	**$ 3,289,871**	**$ 3,957,433**
F. Capital Expenditures		
1. Retirement of Principal	$	$
2. Interest		
Total Capital Expenditures	$	$
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES	$ 3,289,871	$ 3,957,433

SUPPLEMENTAL
December 30, 2013
10:24 am

	OTHER EXPENSES CATEGORIES	2015	2016
1	Employee Benefits	$ 1,544,689	$ 1,775,732
2	Purchased Services	$ 1,057,857	$ 1,143,574
3	Maintenance	$ 331,638	$ 331,638
4	Insurance	$ 181,352	$ 197,233
5	Travel/Education/Dues	$ 62,304	$ 63,550
6	Other Expenses	$ 680,699	$ 712,746
7	Non-Allocated	$ 119,285	$ 121,671
	Total Other Expenses	**$3,977,824**	**$4,346,144**

Note: Projected "Other Expenses" provided in the above chart are based on 120 beds.

SUPPLEMENTAL- # 1
December 26, 2013
12:16pm

Supplemental Attachment – Projected Data Chart for 40 Bed Addition

SUPPLEMENTAL
December 30, 2013
10:24 am

PROJECTED DATA CHART

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

	CY 2015	CY 2016
A. Utilization Data (Occupancy—40 bed addition)	35%	50%
B. Revenue from Services to Patients		
1. Inpatient Services	$7,846,103	$11,228,441
2. Outpatient Services	$546,458	$782,028
3. Emergency Services		
4. Other Operating Revenue (Specify)		
Gross Operating Revenue	**$8,392,561**	**$12,010,469**
C. Deductions from Gross Operating Revenue		
1. Contractual Adjustments	$4,390,097	$6,333,064
2. Provision for Charity Care	$17,630	$25,231
3. Provisions for Bad Debt	$209,738	$300,153
Total Deductions	**$4,617,465**	**$6,658,448**
NET OPERATING REVENUE	**$3,775,096**	**$5,352,021**
D. Operating Expenses		
1. Salaries and Wages	$1,200,642	$1,771,142
2. Physician's Salaries and Wages	$354,781	$492,203
3. Supplies	$197,365	$282,446
4. Taxes	$117,684	$117,684
5. Depreciation	$47,000	$47,000
6. Rent	$9,600	$9,600
7. Interest, other than Capital		
8. Management Fees:		
a. Fees to Affiliates	$125,000	$125,000
b. Fees to Non-Affiliates		
9. Other Expenses (Specify) Employee Benefits, Purchased Services, Maintenance, Insurance, Travel/Education/Dues, Other Expenses, Non-Allocated	$625,300	$824,272
Total Operating Expenses	**$2,677,372**	**$3,669,347**
E. Other Revenue (Expenses) -- Net (Specify)		
NET OPERATING INCOME (LOSS)	**$1,097,724**	**$1,682,674**
F. Capital Expenditures		
1. Retirement of Principal		
2. Interest		
Total Capital Expenditures	$	$
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES	$ 1,097,724	$1,682,674

	OTHER EXPENSES CATEGORIES	2015	2016
1	Employee Benefits	$ 204,109	$ 301,094
2	Purchased Services	$169,899	$ 237,857
3	Maintenance	$ 84,172	$ 84,172
4	Insurance	$ 29,808	$ 42,658
6	Other Expenses	$ 137,312	$ 158,491
	Total Other Expenses	**$625,300**	**$824,272**

Note: Projected "Other Expenses" provided in the above chart are based on 40 beds.

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: The current average adult inpatient billable rate (i.e., the Gross Charge) at the Applicant's facility is $1,534 per patient day. The Applicant does not anticipate any adjustments to the current charge schedules as a result of the proposed project. The expansion project is projected to produce $19,074,544 in revenue within the first two years of operation. The Applicant further anticipates a utilization mix similar to its current 2013 mix for the expansion project, with no change or impact to existing patient charges.

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: The following information was obtained from recently-filed CON applications for hospital expansions in Tennessee:

Item	Davidson Co.	Hamilton Co.	Rutherford Co.	Applicant
Average Gross Charge per Patient	$3,397	$1,713	$1,106	$1,534
Average Deduction per Patient	$1,739	Not Provided	$608	$847
Average Net Charge per Patient	$1,658	Not Provided	$498	$687
GSF of Hospital Expansion	9,872	N/A	N/A	29,045
Cost of Hospital Expansion	$3,485,811	$143,000	$165,000	$9,796,910
Total Cost per GSF	$228	N/A	N/A	$337
Total Cost per Bed	$151,217	$8,938	$10,313	$244,923

Source: Recent CON Applications filed by Select Specialty Hospital-Nashville (CN1210-053), Parkridge Valley Hospital (CN1202-006), and Senior Health of Rutherford (CN1207-031).

The Applicant is reimbursed according to a prospective payment system that is calculated using a based rate per diem adjusted for DRG (diagnosis), wage rate, co-morbidity add-ons, and a variable cost component. Most of the Applicant's patients fall into DRG categories 424-433, 521-523, and 12 and 23. These are the predominant diagnoses for mental health and chemical dependency as published in the Federal Register.

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

Response: The Applicant currently projects that the enlarged project will end year two of its operation with an occupancy rate of approximately 74%, which will produce an operating income sufficient to cover the operations of the enlarged facility. Therefore, the project is expected to be profitable within one year of operation. The Applicant's projections show that occupancy will continue to increase beyond year two, due to population growth and other factors noted in this application.

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: The project is anticipated to produce positive net operating income within the first two years of operation. The expected net operating income will be driven by a combination of occupancy rates, expansion of outpatient programs, and efficiencies in operating overhead through the end of year two of the project. Shortfalls in cash flow will be supplanted by the Applicant's ultimate parent company, Universal Health Services, Inc., until the project become self-sustaining, which it is eventually expected to do.

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 participates in Medicare, Medicaid (TennCare) and Tricare insurance programs. Government sponsored or affiliated health insurance programs accounted for approximately 60% of the Applicant's business through October 2013. The Applicant's 2013 mix of payors to date is as follows: 19% Medicare, 39% Managed Medicaid, and 2% Tricare.

The Applicant has assumed the current mix of revenue sources to remain constant for purposes of forecasting revenue and occupancy for the project.

Total Year 1 Inpatient Revenue	$7,846,103	
Medicare	$1,490,760	19%
Managed Medicaid	$3,059,980	39%
Tricare	$156,922	2%

The Applicant currently serves indigent patients. Charge-offs for charity care represent less than 1% of total revenue deductions for 2013 to date. The

Applicant assumes that current indigent care experience will approximate the level of indigent care provided with the proposed project.

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: Please see Attachment Economic Feasibility - 10 for copies of the balance sheet and income statement from the Applicant's most recent reporting period, as well as a copy of the most recent audited financials.

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

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

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 carefully considered its request to add 40 beds to its current facility pursuant to this Certificate of Need application, and an alternative does not exist. If the Applicant foregoes the expansion and the need for psychiatric and substance abuse treatment continues to escalate, the community, treatment providers and mental health consumers will suffer undue hardship. If treatment providers continue to have difficulty finding "placement" for individuals experiencing a mental health crisis, many will go untreated and may never receive the help they so desperately deserve. The Applicant will be forced to continue deflecting individuals in need of psychiatric treatment due to a lack of bed space and/or therapeutic programming, and community providers will continue to struggle with accessing care and triaging individuals who present with psychiatric issues. All of this culminating in an insurmountable crisis for the Applicants community and the thousands of people it serves.

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: In addition to the MCO's noted at Section A, Item 13, above, The Applicant currently has affiliations with the following health care providers, suppliers, institutions and educators:

- Mental Health America
- Tennessee Suicide Prevention Network
- NAMI
- TAADAS
- Tennessee Voices for Children
- Youth Villages
- Centerstone
- Volunteer Behavioral Health
- Vanderbilt Behavioral Health
- HCA/TriStar
- Brentwood Police Department
- Franklin Police Department
- Williamson Medical Center
- Williamson County Sheriff Department
- Maury Regional Medical Center

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 believes that the expansion of its mental health hospital will allow greater access to and create higher quality of psychiatric care, having a very positive effect on the health care system.

The Applicant does not anticipate any material shifting of patients or patient days from other providers in our service area. The basis for this application is to serve the population that currently does not seek treatment due to the lack of available mental health services providers in the service area.

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

Response: The anticipated staffing pattern for all employees providing patient care for Years 1 through 5 of the proposed project is as follows:

Anticipated Staffing Patterns
(Years 1 through 5 of Proposed Project)

	Schedule of New FTEs	2015 Total	2016 Total	2017 Total	2018 Total	2019 Total
	New Adult Psych Pt Days	5115	7320	8760	10220	11680
	ITP ADC	8.4	12.0	14.4	16.8	19.2
	CD ADC	5.6	8.0	9.6	11.2	12.8
	ITP Nursing EPOB	1.17	1.22	1.11	1.13	1.10
	CD Nursing EPOB	1.65	1.16	1.11	1.10	1.11
	Nursing/Clinical EPOB	1.45	1.43	1.31	1.32	1.31
40901	ITP	9.80	14.66	15.91	19.04	21.06
41101	CD	9.24	9.24	10.67	12.32	14.19
40100	Nursing Admin		0.50	0.50	0.50	1.00
40050	Orientation	0.30	0.37	0.41	0.49	0.55
78100	Activity therapist		0.40	0.40	0.50	0.60
79350	Social Services	1.01	2.20	2.20	2.75	3.30
83900	Pharmacy		1.32	1.32	1.32	1.32
83400	Dietary		0.50	0.50	1.00	1.00
84500	Plant Operations	0.50	0.50	0.50	0.50	0.50
84440	Housekeeping	0.55	1.10	1.30	1.30	1.30
85800	Admissions		0.50	1.00	1.00	1.00
87510	Utilization Review	0.41	1.10	1.10	1.10	1.65
87000	Medical Records	0.50	0.75	0.75	1.00	1.00
85300	Patient Accounts			0.50	0.50	1.00
86300	Marketing		1.10	1.10	1.65	1.65
	Outpatient					
76100	ECT	0.20	0.30	0.30	0.30	0.40
44401	Partial Day Hosp	0.55	1.10	1.10	1.10	1.10
47000	IOP	0.55	0.55	0.83	1.10	1.10
	Total New Paid FTEs	**23.60**	**36.19**	**40.40**	**47.47**	**53.71**

Because the demand for provider services is so high, the Applicant is available to pay its staff at the high end of the market range, as evidenced by the following chart, and the Applicant intends to continue paying competitive rates even with the granting of the expansion project:

Position	Applicant's Average Rate of Pay	Market Range of Pay	
MHS (Technician)	$13.02	$9.50	$14.26
Registered Nurse	$29.34	$21.26	$31.89
LP Nurse	$19.80	$14.36	$21.56
Social Worker	$21.65	$18.51	$27.76
Intake Counselor	$22.80	$18.29	$27.44

**Sources of Market Range Pay:* Bureau of Labor Statistics; Applicant's Compensation Data; Economic Research institute; I.H.S. Survey; Mercer Healthcare Survey; Sullivan & Cotter Survey.

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: In addition to its existing staff, the Applicant will recruit additional professional and support staff for the expanded hospital, including specialty staff for geriatric psychiatric services, adult and adolescent psychiatrists, addictive disease specialists, and a complement of psychiatric nurses, psychiatric social workers, family therapists, chemical dependence counselors and support technicians. The Applicant's parent organization, Universal Health Services, Inc. has the ability to survey areas for available staff and will assist in locating the human resources required by DMHSAS.

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 has reviewed and understands the aforementioned requirements.

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 has relationships with the following educational institutions for the training of students in the areas of medicine, nursing, social work, etc.:

- Belmont University School of Nursing – 20 students per clinical rotation, twice per year;
- Cumberland University School of Nursing – 16 students per clinical rotation, twice per year;

- Columbia State University School of Nursing – 10 students per clinical rotation, twice per year;
- ITT Breckinridge School of Nursing – six students per clinical rotation, twice per year;
- MTSU School of Social Work – two students per year;
- UT College of Social Work – six students per year;
- Lipscomb University College of Pharmacy – one advanced practice student monthly, under the supervision of the pharmacist-in-charge, clinical pharmacist and pharmacist resident (PGY2); one PGY2 pharmacist resident, who serves as the clinical pharmacist and staffs the pharmacy two weekends per month; and one introductory level student in his or her third year of education monthly, shadowing the pharmacist in charge, clinical pharmacist or pharmacists resident;
- Belmont University College of Pharmacy – two advanced practice students monthly, under the supervision of the pharmacist-in-charge, clinical pharmacist and pharmacist resident (PGY2); one clinical pharmacist (0.5 FTE) on university faculty and paid entirely by the university; and one introductory level student in his or her third year of education monthly, shadowing the pharmacist in charge, clinical pharmacist or pharmacists resident.

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 is familiar with all licensure requirements of the Tennessee regulatory agencies and relevant Medicare requirements.

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

RESPONSE: The Applicant is licensed by the DMHSAS, certified by Medicare and TennCare, and accredited 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: Please see Attachment Contribution to the Orderly Development of Healthcare – 7(c), which contains a copy of the Applicant's current mental health hospital license issued by DMHSAS and a copy of the Applicant's current accreditation certificate issued by The Joint Commission.

(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: The Applicant has not been cited for any deficiencies.

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: Not applicable.

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: Not applicable.

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 the proposal is approved, the Applicant will be happy to 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.

PROOF OF PUBLICATION

DEC 19 '13 PM 3:2

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 02/01/06
Previous Forms are obsolete

PROJECT COMPLETION FORECAST CHART

Enter the Agency projected Initial Decision date, as published in T.C.A. § 68-11-1609(c): 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	5	4/10/14
2. Construction documents approved by the Tennessee Department of Health	180	10/7/14
3. Construction contract signed	5	10/12/14
4. Building permit secured	10	10/22/14
5. Site preparation completed	60	12/21/14
6. Building construction commenced	1	12/22/14
7. Construction 40% complete	72	3/4/15
8. Construction 80% complete	72	5/15/15
9. Construction 100% complete (approved for occupancy	36	6/20/15
10. *Issuance of license	10	6/30/15
11. *Initiation of service	1	7/1/15
12. Final Architectural Certification of Payment	30	7/31/15
13. Final Project Report Form (HF0055)	15	8/15/15

*** 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.

Affidavit

DEC 18 '13 PM 3:22

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF WILLIAMSON

RICHARD CLARK, 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 – CEO

Sworn to and subscribed before me this 13th day of DECEMBER (Month), 2013 (Year) a Notary Public in and for the County/State of WILLIAMSON / TN.

JUSTIN ADAMS
STATE OF TENNESSEE NOTARY PUBLIC
WILLIAMSON COUNTY

NOTARY PUBLIC

My commission expires DECEMBER (Month), 2015 (Year).

SUPPLEMENTAL- # 1
December 26, 2013
12:16pm

Supplemental Attachment – Section B, Project Description, Item III.A.

Revised Plot Plan

SUPPLEMENTAL- # 1
December 26 2013
12:16pm
81

SITE DATA

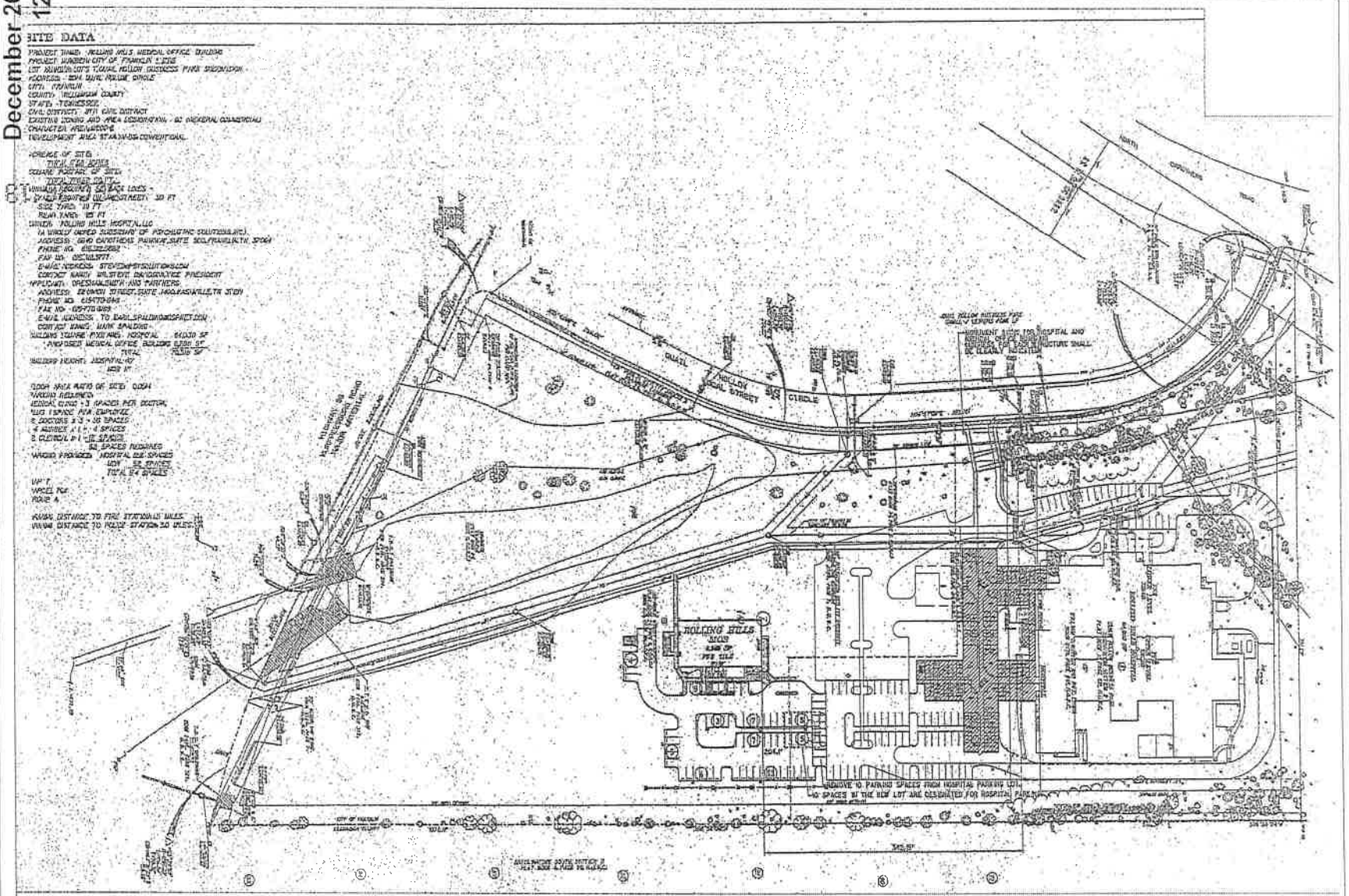
PROJECT NAME: ROLLING HILLS MEDICAL OFFICE BUILDING
PROJECT NUMBER: CITY OF FRANKLIN 4 SITE
LOT NUMBER: LOT 5 TOWNE HOLLOW BUSINESS PARK SUBDIVISION
ADDRESS: 2010 QUAIL HOLLOW CIRCLE
CITY: FRANKLIN
COUNTY: WILLIAMSON COUNTY
STATE: TENNESSEE
CIVIL DISTRICT: 9TH CIVIL DISTRICT
EXISTING ZONING AND AREA DESIGNATION: B2 (GENERAL COMMERCIAL)
CHARACTER AREA/GROUP:
DEVELOPMENT AREA STANDARD: CONVENTIONAL

ACREAGE OF SITE:
TOTAL: 7.84 ACRES
SQUARE FOOTAGE OF SITE:
TOTAL: 341,630 SQ FT
MINIMUM REQUIRED SETBACK LINES -
FRONT YARD: 40 FT
SIDE YARD: 10 FT
REAR YARD: 10 FT
OWNER: ROLLING HILLS HOSPITAL, LLC
(A WHOLLY OWNED SUBSIDIARY OF PSYCHIATRIC SOLUTIONS, INC.)
ADDRESS: 6640 CAROTHERS PARKWAY, SUITE 300, FRANKLIN, TN 37067
PHONE NO.: 615.932.3002
FAX NO.: 615.932.3017
E-MAIL ADDRESS: STEVE.SMITH@PSYCHSOLUTIONS.COM
CONTACT NAME: WILSTEVE DAVIDSON, VICE PRESIDENT
APPLICANT: GRESHAM SMITH AND PARTNERS
ADDRESS: 166 NINTH AVENUE SOUTH, NASHVILLE, TN 37203
PHONE NO.: 615.770.8100
FAX NO.: 615.770.8200
E-MAIL ADDRESS: TO EARL.SPALDING@GSP.COM
CONTACT NAME: MARK SPALDING
BUILDING SQUARE FOOTAGE: HOSPITAL: 84,000 SF
PROPOSED MEDICAL OFFICE BUILDING: 51,000 SF
TOTAL: 135,000 SF
BUILDING HEIGHT: HOSPITAL: 40'
MOB: 37'

FLOOR AREA RATIO OF SITE: 0.394
PARKING REQUIRED:
MEDICAL CLINIC - 3 SPACES PER DOCTOR,
PLUS 1 SPACE PER EMPLOYEE
8 DOCTORS X 3 = 24 SPACES
4 EMPLOYEE X 1 = 4 SPACES
2 CLERICAL X 1 = 2 SPACES
30 SPACES REQUIRED
PARKING PROVIDED: HOSPITAL 236 SPACES
MOB 52 SPACES
TOTAL 288 SPACES

UPT
WITHIN THE
ZONE A

NEAR DISTANCE TO FIRE STATION: 1.5 MILES
NEAR DISTANCE TO POLICE STATION: 2.0 MILES



PLOT PLAN

JJCA
Johnson Johnson Cralmore Architects
450 Franklin Pike
Franklin, TN 37064
tel 615.591.0555
fax 615.127.9557

An Addition To
Rolling Hills Hospital
2010 Quail Hollow Circle, Franklin, Tennessee

UHS

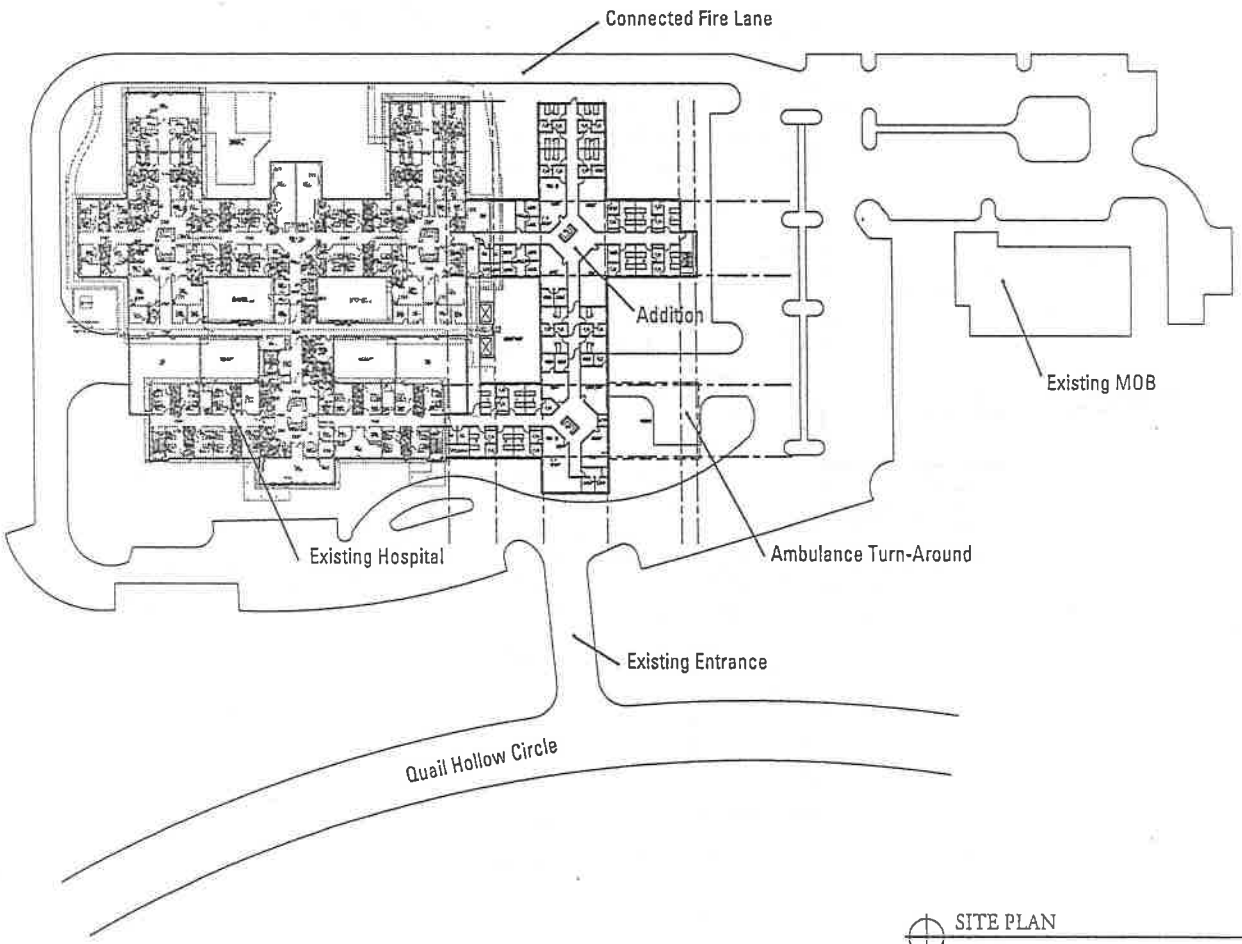
PROJECT NUMBER
09515.28
DATE
November 2013

CON Submittal

Attachment B.IV.

Floor Plans

Rolling Hills Hospital's campus property is 16.38 acres. The property is bordered to the south by Hwy. 96, and to the west by Quail Hollow Circle.



SITE PLAN

32' 0 32'

JJCA

An Addition To
Rolling Hills Hospital
2010 Quail Hollow Circle, Franklin, Tennessee

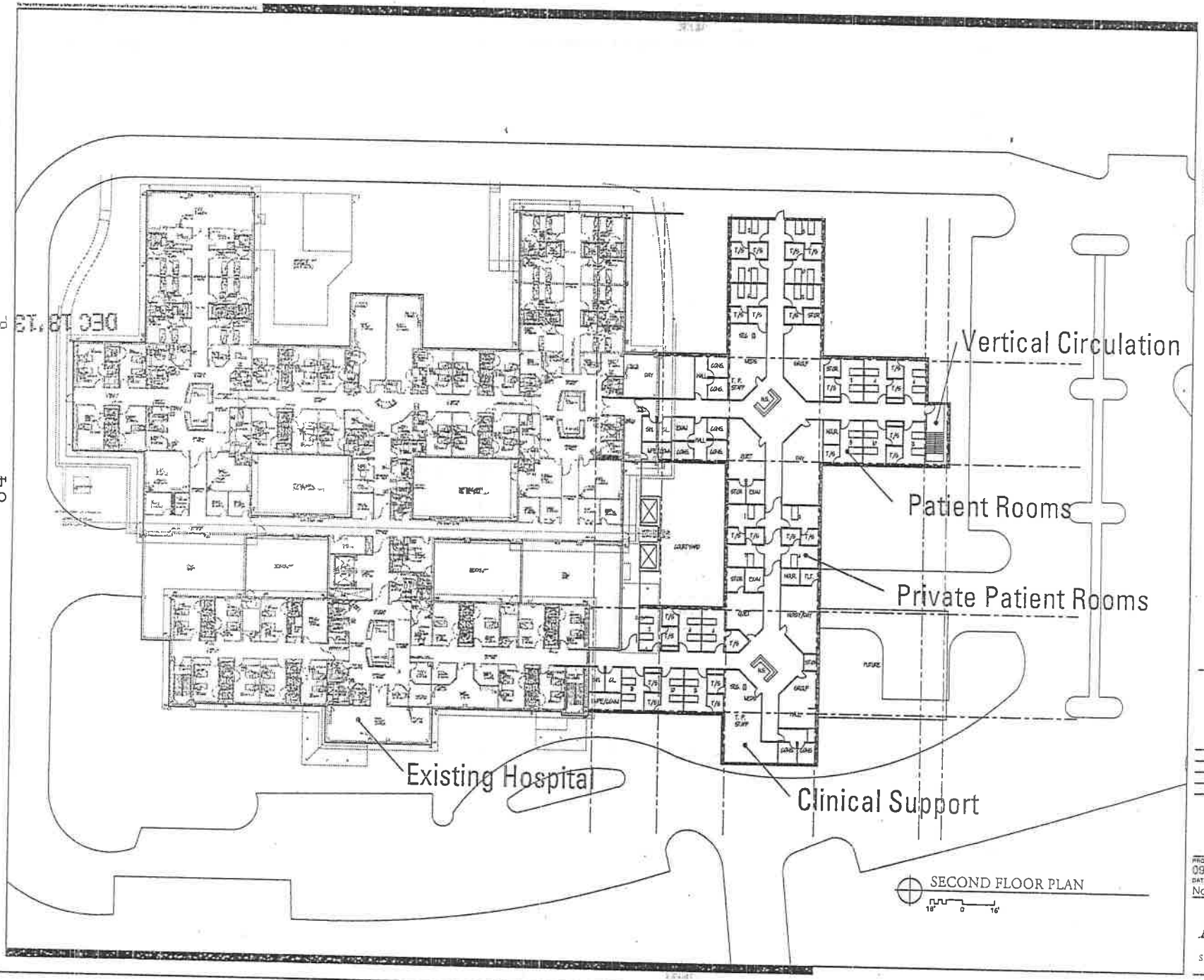
Johnston Johnson Crabtree Architects P.C.

UHS

PROJECT NUMBER
09515.28
DATE
November 2013

A0.0

Site Plan



JJCA

An Addition To
Rolling Hills Hospital
2010 Quail Hollow Circle, Franklin, Tennessee

Johnson Johnson Crabtree Architects PC

UHS

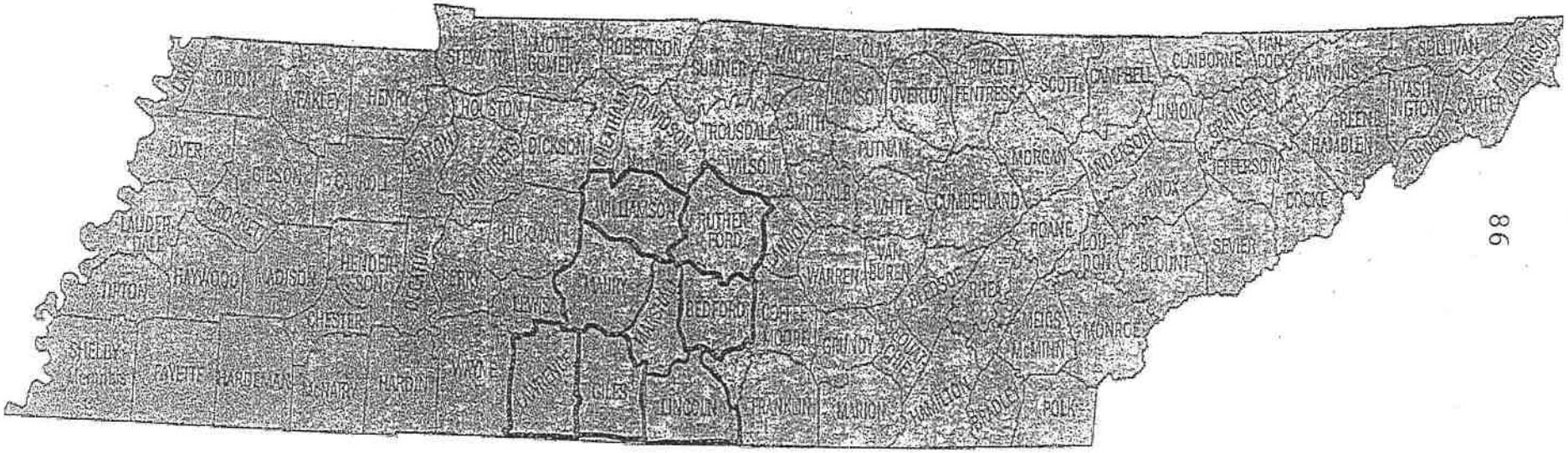
PROJECT NUMBER
09515.28
DATE
November 2013

A2.0
SECOND FLOOR

Section C: General Criteria for Certificate of Need – Need.3

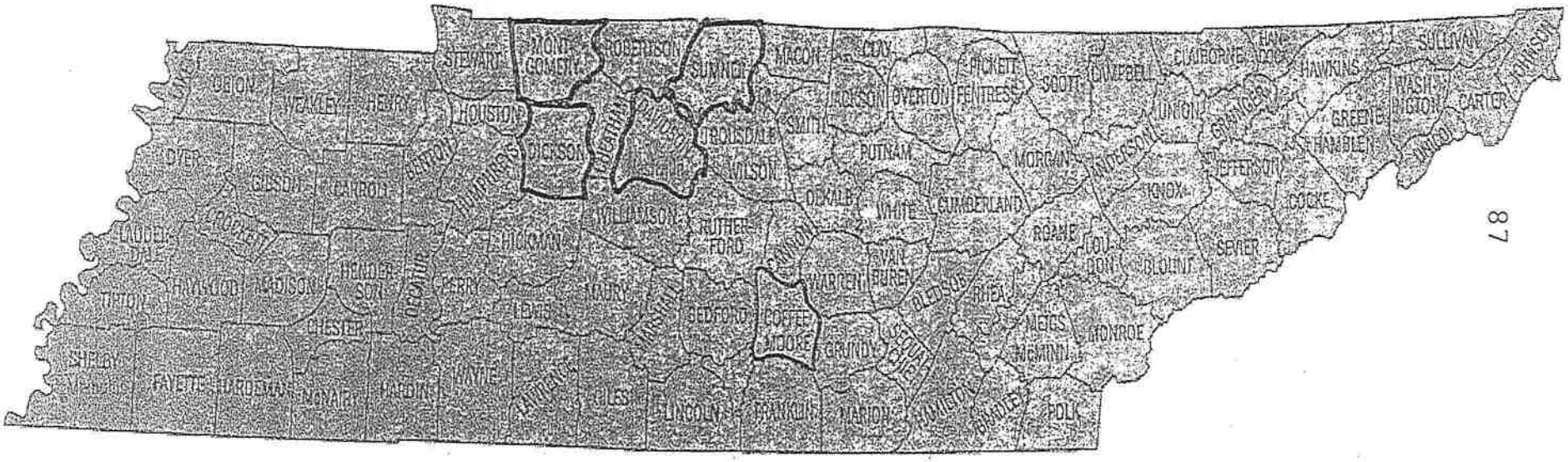
Service Area Map

Applicant's Primary Service Area



DEC 13 '13 PM3:2

Applicant's Secondary Service Area



DEC 19 '13 PM 3:27

HISTORICAL DATA CHART

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

	CY 2010	CY 2011	CY 2012
A. Utilization Data (Occupancy)	66%	74%	78%
B. Revenue from Services to Patients			
1. Inpatient Services	$30,294,115	$32,362,383	$33,899670
2. Outpatient Services	$554,155	$771,740	$1,316,429
3. Emergency Services			
4. Other Operating Revenue (Specify) Dietary Revenue, Medical Records Management Revenue, Miscellaneous	$294,348	$200,668	$288,878
Gross Operating Revenue	**$31,142,618**	**$33,334,791**	**$35,504,977**
C. Deductions from Gross Operating Revenue			
1. Contractual Adjustments	$15,298,513	$16,461,824	$17,732,862
2. Provision for Charity Care		$77,771	$39,193
3. Provisions for Bad Debt	$505,728	$591,437	$822,853
Total Deductions	**$15,804,241**	**$17,131,049**	**$18,597,908**
NET OPERATING REVENUE	**$15,338,377**	**$16,203,759**	**$16,910,069**
D. Operating Expenses			
1. Salaries and Wages	$7,238,083	$7,501,807	$7,850,732
2. Physician's Salaries and Wages	$1,600,877	$1,333,177	$1,298,550
3. Supplies	$960,757	$903,911	$950,000
4. Taxes		$281,349	$278,826
5. Depreciation	$937,312	$1,274,961	$1,282,569
6. Rent	$90,872	$81,774	$109,282
7. Interest, other than Capital			
8. Management Fees:			
a. Fees to Affiliates	$470,009	$360,240	$448,800
b. Fees to Non-Affiliates			
9. Other Expenses (Specify) Employee Benefits, Purchased Services, Maintenance, Insurance, Travel/Education/Dues, Other Expenses, Non-Allocated	$3,708,870	$2,930,225	$3,346,981
Total Operating Expenses	**$15,006,780**	**$14,667,444**	**$15,565,740**
E. Other Revenue (Expenses) – Net (Specify)			
NET OPERATING INCOME (LOSS)	**$331,597**	**$1,536,298**	**$1,344,329**
F. Capital Expenditures			
1. Retirement of Principal		$3,918,000	$3,839,433
2. Interest			
Total Capital Expenditures		**$3,918,000**	**$3,839,433**
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES	$331,597	($2,381,702)	($2,495,104)

PROJECTED DATA CHART

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

	CY 2015	CY 2016
A. Utilization Data (Occupancy—120 beds)	68%	74%
B. Revenue from Services to Patients		
1. Inpatient Services	$45,471,710	$49,794,688
2. Outpatient Services	$3,271,652	$3,575,352
3. Emergency Services		
4. Other Operating Revenue (Specify)_____		
Gross Operating Revenue	**$48,826,029**	**$53,454,744**
C. Deductions from Gross Operating Revenue		
1. Contractual Adjustments	$25,193,743	$27,656,801
2. Provision for Charity Care	$102,186	$111,901
3. Provisions for Bad Debt	$1,196,275	$1,311,353
Total Deductions	**$26,492,204**	**$29,080,055**
NET OPERATING REVENUE	**$22,333,825**	**$24,374,718**
D. Operating Expenses		
1. Salaries and Wages	$9,626,068	$10,365,077
2. Physician's Salaries and Wages	$1,845,131	$2,012,360
3. Supplies	$1,175,744	$1,280,393
4. Taxes	$401,225	$405,478
5. Depreciation	$1,303,845	$1,287,000
6. Rent	$101,797	$103,641
7. Interest, other than Capital		
8. Management Fees:		
a. Fees to Affiliates	$541,920	$570,193
b. Fees to Non-Affiliates		
9. Other Expenses (Specify) Employee Benefits, Purchased Services, Maintenance, Insurance, Travel/Education/Dues, Other Expenses, Non-Allocated	$3,977,824	$4,346,144
Total Operating Expenses	**$18,973,554**	**$20,370,285**
E. Other Revenue (Expenses) -- Net (Specify)		
NET OPERATING INCOME (LOSS)	**$3,360,271**	**$4,004,433**
F. Capital Expenditures		
1. Retirement of Principal	$3,826,784	$3,826,784
2. Interest		
Total Capital Expenditures	**$3,826,784**	**$3,826,784**
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES	**($466,513)**	**$177,649**

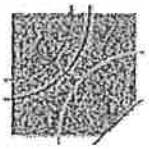
Section C: Economic Feasibility - 1

Letter Supporting Estimated Construction Costs

JJCA

December 11, 2013

James Gore
UHS of Delaware, Inc.
a subsidiary of Universal Health Services
110 Westwood Place
Suite 100
Brentwood, TN 37027



Re: Universal Health Services - Rolling Hills Hospital - Franklin TN (09515.28) - CON Planning (00)
Subject: CON Cost Certification

Dear Jim,

As requested, the design and pre-construction team has prepared a preliminary construction cost estimate for the Addition at Rolling Hills Hospital in Franklin, TN. The estimate is based on the accompanying CON drawings dated November 2013.

We have developed the construction cost estimate in conjunction with UHS and their historical cost data derived from previous projects of like size and scope. The estimated construction cost for the Project would be $7,807,885. (Please note that 4% per year should be added to the overall cost after the March 2014 CON hearing date.)

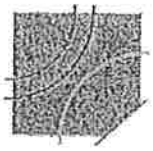
We look forward to working with you on this project. If you have any questions or comments, please do not hesitate to contact us.

Sincerely,

Sincerely,

David J. Brown Architect AIA

Johnson Johnson Crabtree Architects P.C.
4551 Trousdale Dr.
Nashville, TN 37204
tel 615-837-0656
fax 615-837-0657



cc:

Rachael Spangler - JJCA
Richard Clark - Rolling Hills Hospital
John Bennett - UHSI

Section C: Economic Feasibility - 2

Documentation from Chief Financial Officer

UHS

UHS of Delaware, Inc.
A Subsidiary of Universal Health Services

367 South Gulph Road
P.O. Box 61558
King of Prussia, PA 19406

P: 610-768-3300

December 12, 2013

Melanie Hill, Director
Tennessee Health Services & Development Agency
502 Deaderick Street, 9th Floor
Nashville TN 37243

Dear Ms. Hill:

I serve in the capacity of Senior Vice President and Chief Financial Officer of Universal Health Systems, Inc. Universal Health Systems, Inc. is the parent entity of Rolling Hills Hospital, LLC. In support of the application of Rolling Hills Hospital for a certificate of need to add additional beds to its existing facility in Franklin, Tennessee, I confirm that the funding for such expansion will be provided to Rolling Hills Hospital, LLC by Universal Health Systems, Inc., from its cash reserves and operating revenue. As a publicly traded company, Universal Health Systems, Inc., files various financial reports with the SEC, and I understand some of those most recent filings are being provided with the application; however, if you need any additional financial data about the parent entity please let me know.

Thank you for the assistance of you and your staff in this matter.

Sincerely,

Steve Filton
Chief Financial Officer

Section C: Economic Feasibility – 10

Applicant's Balance Sheet and Income Statement

BH 1200

Rolling Hills Hospital
BALANCE SHEET
For the Ten Months Ending October 31, 2013

DATE: 12/03/13
TIME: 09:21 PM
PAGE: 1

	ASSETS	DEC 2012 BALANCE	OCT 2013 BALANCE
(100000 TO 10...	CASH	198,349	(38,105)
(100100 TO 100199)	PATIENT A/R	3,698,287	3,921,442
(100200 TO 100269)	ALLOWANCE FOR PT BAD DEBT	(155,474)	(457,534)
(100270 TO 100299)	ALLOWANCE FOR OTHER BAD DEBT	(386,040)	(352,696)
	TOTAL ALLOWANCE FOR BAD DEBT	(541,514)	(810,230)
(100300 TO 100399)	MEDICARE CONTRACTUAL ALLOWANCE	(89,334)	(116,666)
(100400 TO 100499)	MEDICARE NET DRG REIMBURSEMENT	(14,762)	8,178
(100700 TO 100799)	MEDICARE OP CONTRACTUAL ALLOWANCE	(31,418)	(33,591)
(100800 TO 100899)	OTHER CONTRACTUALS CURRENT	(890,073)	(812,743)
(101000 TO 10...	COST REPORT RECEIVABLES	22,019	22,030
(101100 TO 101299)	OTHER A/R CURRENT	(2,407)	41,603
(101400 TO 101499)	INVENTORY	128,443	128,443
(101500 TO 101599)	PREPAIDS	55,297	118,556
	TOTAL CURRENT ASSETS	2,532,887	2,428,917
(103000 TO 103099)	LAND	6,369,507	6,369,507
(103100 TO 10...	BUILDINGS & IMPROVEMENTS	20,840,313	20,840,315
(103600 TO 103699)	EQUIPMENT	1,680,221	1,703,759
(103900 TO 10...	CONSTRUCTION-IN-PROGRESS	13,869	10,304
	TOTAL FIXED ASSETS	28,903,910	28,923,885
(104200 TO 10...	ACC DEPR-BUILDING & IMPROVEMENTS	(2,204,476)	(3,075,631)
(104400 TO 104499)	ACC DEPR-EQUIPMENT	(514,800)	(711,310)
	TOTAL ACCR DEPRECIATION	(2,719,276)	(3,786,941)
(104500 TO 104599)	GOODWILL	292,946	292,946
(104900 TO 104999)	OTHER ASSETS	1,124,865	1,131,586
	TOTAL ASSETS	30,135,332	28,990,393

Rolling Hills Hospital
BALANCE SHEET
For the Ten Months Ending October 31, 2013

		DEC 2012 BALANCE	OCT 2013 BALANCE
	LIABILITIES & EQUITY		
(200100 TO 200199)	ACCOUNTS PAYABLE	216,182	230,689
(200200 TO 200299)	ACCRUED PAYROLL	318,911	288,625
(200300 TO 200399)	ACCRUED VACATION	236,524	286,705
(200400 TO 200499)	ACCRUED BENEFITS	10	0
(200500 TO 200599)	ACCRUED EMPLOYEE BONUS	40,042	55,583
	TOTAL ACCRUED COMPENSATION	595,487	630,913
(200600 TO 200699)	ACCRUED TAXES OTHER THAN INCOME	146,081	35,627
(200800 TO 20...	OTHER ACCRUED EXPENSES	(561)	79,999
	TOTAL CURRENT LIABILITIES	957,189	977,228
(220100 TO 220199)	INTERCOMPANY REC/PAYABLE	30,167,580	26,542,743
	TOTAL LIABILITIES	31,124,769	27,519,971
(300500 TO 300599)	RETAINED EARNINGS	1,505,667	2,865,253
(410000 TO 69...	CURRENT INCOME	(2,495,104)	(1,394,831)
	TOTAL EQUITY	(989,437)	1,470,422
	TOTAL LIABILITIES & EQUITY	30,135,332	28,990,393

BH 1004

Rolling Hills Hospital
DETAIL INCOME STATEMENT
For the Ten Months Ending October 31, 2013

DATE: 12/03/13
TIME: 09:20 PM
PAGE: 1

CURRENT MONTH ACTUAL	CURRENT MONTH BUDGET	CURRENT MONTH VARIANCE	CURRENT MONTH PRIOR YR		YEAR-TO-DATE ACTUAL	YEAR-TO-DATE BUDGET	YEAR-TO-DATE VARIANCE	YEAR-TO-DATE PRIOR YR
				REVENUE				
3,131,650	2,932,950	198,700	3,218,825	I/P Room and Board	30,275,640	28,684,225	1,591,415	24,841,175
82,370	123,491	(41,121)	148,585	I/P Ancillary	664,243	1,210,326	(546,083)	3,392,845
3,214,020	3,056,441	(157,579)	3,367,410	**Total I/P Gross Revenue**	30,939,883	29,894,551	(1,045,332)	28,234,020
167,426	125,257	42,169	98,075	O/P Revenue	983,608	1,237,629	(254,021)	1,023,654
129,300	150,000	(20,700)	0	PHP Revenue	872,660	825,000	47,660	0
296,726	275,257	(21,469)	98,075	**Total O/P Revenue**	1,856,268	2,062,629	206,361	1,023,654
3,510,746	3,331,698	179,048	3,465,485	**Total Patient Revenue**	32,796,151	31,957,180	838,971	29,257,674
1,674,122	1,564,398	(109,724)	1,783,452	Current I/P Contractual	16,364,873	15,316,708	(1,048,165)	13,997,322
188,177	159,391	(28,786)	45,177	Current O/P Contractual	758,219	1,194,279	436,060	510,022
1,862,299	1,723,789	(138,510)	1,828,629	**Total Current Year Contractual**	17,123,092	16,510,987	(612,105)	14,507,344
1,539,898	1,492,043	47,855	1,583,958	**Total I/P Net Revenue**	14,575,010	14,577,843	(2,833)	14,236,698
108,549	115,866	(7,317)	52,898	**Total O/P Net Revnue**	1,098,049	868,350	229,699	513,632
1,648,447	1,607,909	40,538	1,636,856	**Total Net Patient Revenue**	15,673,059	15,446,193	226,866	14,750,330
10,241	2,516	7,725	(17,417)	Other Revenue	34,585	25,161	9,424	89,480
0	24,097	24,097	24,838	Other Management Fees Revenue	95,170	240,968	145,798	137,634
10,241	26,613	(16,372)	7,421	**Total Other Revenue**	129,755	266,129	(136,374)	227,114
1,658,688	1,634,522	24,166	1,644,277	**NET REVENUE BEFORE BAD DEBT**	15,802,814	15,712,322	90,492	14,977,444
128,069	67,136	(60,933)	46,129	I/P Bad Debt	826,610	653,404	(173,206)	630,572
0	284	284	0	O/P Bad Debt	16	2,127	2,111	857
128,069	67,420	(60,649)	46,129	**Total Bad Debt**	826,626	655,531	(171,095)	631,429
1,530,619	1,567,102	(36,483)	1,598,148	**NET REVENUE**	14,976,188	15,056,791	(80,603)	14,346,015
				OPERATING EXPENSES				
677,952	690,740	12,788	643,453	Salary	6,405,033	6,802,268	397,235	6,268,714
3,333	0	(3,333)	3,185	Facility Bonus	(6,708)	0	6,708	33,663
30,821	0	(30,821)	31,811	Salary - Overtime	390,669	0	(390,669)	282,263
712,106	690,740	(21,366)	678,449	**Total Salaries**	6,788,994	6,802,268	13,274	6,584,640
0	3,784	3,784	0	Pension Expense	0	37,835	37,835	0
6,785	0	(6,785)	5,830	Employer 401k Match	48,142	0	(48,142)	39,051
87	11	(76)	86	Employee Stock Purchase Discount	435	111	(324)	186
1,780	1,719	(61)	1,333	Life & AD&D Insurance	18,279	17,190	(1,089)	16,426
780	668	(112)	629	Dependent Life	9,297	6,678	(2,619)	6,639
170	157	(13)	138	PAI	1,653	1,569	(84)	1,512
3,967	3,054	(913)	3,393	LT Disability Insurance	38,734	30,536	(8,198)	30,205
57,496	57,408	(88)	51,312	Health Insurance	575,025	574,080	(945)	513,492

Rolling Hills Hospital
DETAIL INCOME STATEMENT
For the Ten Months Ending October 31, 2013

CURRENT MONTH ACTUAL	CURRENT MONTH BUDGET	CURRENT MONTH VARIANCE	CURRENT MONTH PRIOR YR		YEAR-TO-DATE ACTUAL	YEAR-TO-DATE BUDGET	YEAR-TO-DATE VARIANCE	YEAR-TO-DATE PRIOR YR
1,639	3,314	1,675	3,074	Dental Insurance	15,879	33,139	17,260	33,337
636	579	(57)	1,259	Vision Care Insurance	6,457	5,790	(667)	6,469
(543)	(1,128)	(585)	(4,427)	COBRA Payment	(6,821)	(11,282)	(4,461)	(13,678)
(27,370)	(28,332)	(962)	(23,095)	Flex P/R Deduction-Pre Tax	(292,514)	(283,318)	9,196	(254,900)
(5,028)	(5,384)	(356)	(4,399)	Flex P/R Deduction-Post Tax	(56,767)	(53,843)	2,924	(49,245)
0	0	0	0	Other Insurance	0	0	0	(2,432)
56,243	13,408	(42,835)	(30,057)	Workmen's Comp	103,865	134,083	30,218	105,958
48,831	50,851	2,020	47,893	Employer FICA	508,592	498,167	(10,425)	484,576
372	49	(323)	269	FUI	8,562	7,034	(1,528)	7,654
24,082	1,571	(22,511)	1,787	SUI	42,737	44,550	1,813	46,722
921	605	(316)	465	Employee Appreciation	5,235	5,165	(70)	8,531
0	0	0	0	Other Benefits	(3,330)	0	3,330	2,889
170,848	102,334	(68,514)	55,490	**Total Benefits**	1,023,460	1,047,484	24,024	983,392
123,247	137,032	13,785	76,884	Prof Fees	1,202,436	1,370,323	167,887	1,058,279
123,247	137,032	13,785	76,884	**Total Professional Fees**	1,202,436	1,370,323	167,887	1,058,279
67,181	80,800	13,619	116,457	Purchased Service	718,989	798,145	79,156	760,569
67,181	80,800	13,619	116,457	**Total Purchased Service**	718,989	798,145	79,156	760,569
22,089	20,622	(1,467)	44,049	General Repairs & Maint	204,770	206,222	1,452	225,832
0	0	0	0	Auto Repairs & Maint	1,347	0	(1,347)	0
0	0	0	0	Other Repairs & Maint	1,570	0	(1,570)	2,802
22,089	20,622	(1,467)	44,049	**Total Repairs & Maint**	207,687	206,222	(1,465)	228,634
18,396	24,369	5,973	23,892	Food	236,058	238,838	2,780	225,774
45,945	38,558	(7,387)	38,361	Drugs	355,703	377,898	22,195	358,565
(3,005)	(2,187)	818	(2,715)	Rebate	(25,006)	(21,867)	3,139	(21,822)
61,336	60,740	(596)	59,538	**Total Revenue Supplies**	566,755	594,869	28,114	562,517
8	3,460	3,452	104	Office Supplies	2,093	34,596	32,503	29,914
11,996	17,844	5,848	6,798	Department Supplies	145,981	178,438	32,457	156,872
17,663	7,024	(10,639)	7,303	Non-Changeable Medical Supp	70,891	69,073	(1,818)	66,937
69	0	(69)	0	Minor Equipment	1,900	0	(1,900)	0
29,736	28,328	(1,408)	14,205	**Total Non-Revenue Supplies**	220,865	282,107	61,242	253,723
91,072	89,068	(2,004)	73,743	**Total Supplies**	787,620	876,976	89,356	816,240
8,828	8,441	(387)	8,621	Prof Insurance	87,698	84,410	(3,288)	86,210
419	405	(14)	263	Auto Insurance	4,185	4,050	(135)	3,748
2,978	2,978	0	2,836	Property Insurance	29,781	29,780	(1)	28,363
340	340	0	338	Other Insurance	3,399	3,400	1	3,378
12,565	12,164	(401)	12,058	**Total Insurance**	125,063	121,640	(3,423)	121,699
805	1,984	1,179	795	Lease/Rent-Building	7,626	19,836	12,210	15,506
7,937	7,866	(71)	9,174	Lease/Rent-Equipment	67,841	78,656	10,815	77,362
8,742	9,850	1,108	9,969	**Total Lease/Rent**	75,467	98,492	23,025	92,868

99

DEC 13 '13 PM3:2

BH 1004

Rolling Hills Hospital
DETAIL INCOME STATEMENT
For the Ten Months Ending October 31, 2013

DATE: 12/03/13
TIME: 09:20 PM
PAGE: 3

CURRENT MONTH ACTUAL	CURRENT MONTH BUDGET	CURRENT MONTH VARIANCE	CURRENT MONTH PRIOR YR		YEAR-TO-DATE ACTUAL	YEAR-TO-DATE BUDGET	YEAR-TO-DATE VARIANCE	YEAR-TO-DATE PRIOR YR
5,548	3,035	(2,513)	11,738	Travel	31,767	30,345	(1,422)	35,482
940	209	(731)	607	Meal & Enter	2,012	2,092	80	2,507
593	993	400	1,313	Dues & Subscriptions	7,836	9,925	2,089	9,987
876	852	(24)	79	Education	10,478	8,521	(1,957)	7,523
0	0	0	0	Other Travel	0	0	0	50
7,957	5,089	(2,868)	13,737	Total Travel	52,093	50,883	(1,210)	55,549
15,001	0	(15,001)	0	Electricity	156,168	0	(156,168)	0
5,542	2,508	(3,034)	5,596	Gas	61,412	56,969	(4,443)	56,842
2,664	5,075	2,411	6,095	Water	32,899	41,184	8,285	41,338
0	11,429	11,429	15,040	Other Utilities	0	159,621	159,621	157,631
4,927	8,516	3,589	8,783	Telephone	68,604	85,156	16,552	85,424
28,134	27,528	(606)	35,514	Total Utilities	319,083	342,930	23,847	341,235
16,106	11,308	(4,798)	12,440	Marketing Expenses	66,505	113,083	46,578	93,637
0	679	679	0	Employee Recruiting	6,464	6,788	324	5,931
0	463	463	0	Employee Relocation	0	4,625	4,625	4,041
0	0	0	368	Physician Recruiting	430	0	(430)	368
214	924	710	221	Bank Charges	2,297	9,242	6,945	3,884
340	383	43	1,549	Postage	5,751	3,827	(1,924)	4,892
2,277	2,400	123	5,199	Other Direct Expenses	30,922	24,004	(6,918)	30,586
18,937	16,157	(2,780)	19,777	Total Other Op Expenese	112,369	161,569	49,200	143,339
47,071	43,685	(3,386)	55,291	Total Other Direct Exp	431,452	504,499	73,047	484,574
4,545	9,739	5,194	0	Legal Fees	87,658	97,385	9,727	245,094
1,937	596	(1,341)	2	Consulting Fees	8,046	5,963	(2,083)	5,212
6,214	1,431	(4,783)	1,277	License Fees	27,480	14,314	(13,166)	13,784
41,308	24,237	(17,071)	8,238	Taxes	258,071	242,371	(15,700)	219,647
0	0	0	(50)	Other Non Allocated Other	(538)	0	538	322
54,004	36,003	(18,001)	9,467	Total Non Allocated Other	380,717	360,033	(20,684)	484,059
1,316,882	1,227,387	(89,495)	1,145,594	Total Operation Cost	11,793,978	12,236,965	442,987	11,670,503
213,737	339,715	(125,978)	452,554	INCOME FROM OPERATION	3,182,210	2,819,826	362,384	2,675,512
14%	22%	8%	28%		21%	19%	(3%)	19%
87,115	88,868	1,753	87,093	Depr-Building Services	871,153	888,677	17,524	863,606
19,706	20,831	1,125	20,899	Depr-Equipment	198,050	208,309	10,259	202,917
2,358	0	(2,358)	0	Depr-Other	18,918	0	(18,918)	0
109,179	109,699	520	107,992	Total Depreciation	1,088,121	1,096,986	8,865	1,066,523
1,426,061	1,337,086	(88,975)	1,253,586	Total Operation Expenses	12,882,099	13,333,951	451,852	12,737,026
104,558	230,016	(125,458)	344,562	INCOME BEFORE INTERCOMPANY	2,094,089	1,722,840	371,249	1,608,989
40,610	40,610	0	37,400	Management Fee	406,100	406,100	0	374,000
304,308	324,816	20,508	320,071	Capital Charge	3,082,820	3,248,158	165,338	3,193,279
344,918	365,426	20,508	357,471	Total Intercompany	3,488,920	3,654,258	165,338	3,567,279

Rolling Hills Hospital
DETAIL INCOME STATEMENT
For the Ten Months Ending October 31, 2013

CURRENT MONTH					YEAR-TO-DATE			
ACTUAL	BUDGET	VARIANCE	PRIOR YR		ACTUAL	BUDGET	VARIANCE	PRIOR YR
(240,360)	(135,410)	(104,950)	(12,909)	INCOME BEFORE TAXES	(1,394,831)	(1,931,418)	536,587	(1,958,290)

Section C: Contribution to the Orderly Development of Healthcare – 7(c)

Applicant's Facility License and The Joint Commission Accreditation Certificate

STATE OF TENNESSEE
DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

LICENSE

THE DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES GRANTS THIS FULL LICENSE IN ACCORDANCE WITH TENNESSEE CODE ANNOTATED TITLE 33, CHAPTER 2, PART 4 TO:

ROLLING HILLS HOSPITAL, LLC

(Name of Licensee)

TO OPERATE A FACILITY OR SERVICE IDENTIFIED AND LOCATED AS FOLLOWS FOR THE PROVISION OF MENTAL HEALTH, PERSONAL SUPPORT, OR ALCOHOL AND DRUG ABUSE SERVICES:

Rolling Hills Outpatient Services Center

(Name of Facility or Service as Known to the Public)

2010 Quail Hollow Circle, Franklin, TN 37067

(Street Address or Location, City or Town)

THE LICENSEE HAS DEMONSTRATED COMPLIANCE WITH T.C.A. TITLE 33, CHAPTER 2, PART 4 AND WITH RULES OF THE DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

THIS LICENSE AUTHORIZES LIFE SAFETY OCCUPANCY CLASSIFICATIONS AND THE FOLLOWING DISTINCT CATEGORY OF FACILITY OR SERVICES TO BE PROVIDED.

Occupancy Classification(s): Day Care; Business

Distinct Category	Accessible to mobile, non-ambulatory Individuals	Approved for persons with hearing loss	vision impairment	Capacity
Alcohol & Drug Non-Residential Rehabilitation Treatment	Y	Y	Y	n/a
Mental Health Outpatient Facility	Y	Y	Y	n/a
Mental Health Partial Hospitalization Facility	Y	Y	Y	n/a

October 01, 2013	September 30, 2014	L000000013550
Effective Date	Date License Expires	License Number

Commissioner of Mental Health and Substance Abuse Services

THIS LICENSE IS NON-TRANSFERABLE AND NON-ASSIGNABLE.
POST THIS LICENSE IN A CONSPICUOUS PLACE.

13550

Site ID: 3958

The Joint Commission

September 19, 2012

Rick Bangert
CEO
Rolling Hills Hospital, LLC
2014 Quail Hollow Circle
Franklin, TN 37067

Joint Commission ID #: 477853
Program: Hospital Accreditation
Accreditation Activity: 60-day Evidence of Standards Compliance
Accreditation Activity Completed: 09/19/2012

Dear Mr. Bangert:

The Joint Commission would like to thank your organization for participating in the accreditation process. This process is designed to help your organization continuously provide safe, high-quality care, treatment, and services by identifying opportunities for improvement in your processes and helping you follow through on and implement these improvements. We encourage you to use the accreditation process as a continuous standards compliance and operational improvement tool.

The Joint Commission is granting your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

- Comprehensive Accreditation Manual for Hospitals

This accreditation cycle is effective beginning July 13, 2012. The Joint Commission reserves the right to shorten or lengthen the duration of the cycle; however, the certificate and cycle are customarily valid for up to 36 months.

Please visit Quality Check® on The Joint Commission web site for updated information related to your accreditation decision.

We encourage you to share this accreditation decision with your organization's appropriate staff, leadership, and governing body. You may also want to inform the Centers for Medicare and Medicaid Services (CMS), state or regional regulatory services, and the public you serve of your organization's accreditation decision.

Please be assured that The Joint Commission will keep the report confidential, except as required by law. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Sincerely,

Mark Pelletier

Mark G. Pelletier, RN, MS
Chief Operating Officer
Division of Accreditation and Certification Operations

Rolling Hills Hospital, LLC

Franklin, TN

has been Accredited by

The Joint Commission

Which has surveyed this organization and found it to meet the requirements for the

Hospital Accreditation Program

July 13, 2012

Accreditation is customarily valid for up to 36 months.

Isabel V. Hoverman, MD, MACP
Chair, Board of Commissioners

Organization ID #: 477853
Print/Reprint Date: 10/01/12

Mark R. Chassin, MD, FACP, MPP, MPH
President

The Joint Commission is an independent, not-for-profit, national body that oversees the safety and quality of health care and other services provided in accredited organizations. Information about accredited organizations may be provided directly to The Joint Commission at 1-800-994-6610. Information regarding accreditation and the accreditation performance of individual organizations can be obtained through The Joint Commission's web site at www.jointcommission.org.

This reproduction of the original accreditation certificate has been issued for use in regulatory/payer agency verification of accreditation by The Joint Commission. Please consult Quality Check on The Joint Commission's website to confirm the organization's current accreditation status and for a listing of the organization's locations of care.

Proof of Publication

CLASSIFIEDS

ALL CLASSIFIED ADS are subject to the applicable rate card, copies of which are available from our Advertising Dept. All ads are subject to approval before publication. The Tennessean reserves the right to edit, refuse, reject, classify or cancel any ad at any time. Errors must be reported in the first day of publication. The Tennessean shall not be liable for any loss or expense that results from an error in or omission of an advertisement. No refunds for early cancellation of order.

Public Notices

0101698834

In the United States District Court for the Middle District of Tennessee Nashville Division

In the Matter of: The Complaint of Daystar Counseling Ministries, Inc. for Exoneration from or Limitation of Liability. Case No. 3:13-cv-01132

Notice of Action Brought for Exoneration from or Limitation of Liability

Notice is given that Daystar Counseling Ministries, Inc. ("Daystar") has filed a complaint claiming the right to exoneration from or limitation of liability for all claims arising out of the voyage of a vessel precisely described as a 1998 Sea Ray 23.5' Sundeck, bearing Hull Identification Number SERV4527B898 (the "Vessel"), from the Cypress Springs Resort marina, with a mailing address of 2240 Cypress Trail, New Concord, Kentucky 42076, on June 27, 2012, with the intended destination of a dock at 258 Waterway Trail, New Concord, Calloway County, Kentucky 42076, on June 27, 2012.

All persons having such claims must file them, as provided in Fed. R. Civ. P. Supplemental Rules for Admiralty and Maritime Claims, Rule F, with the Clerk of the United States District Court for the Middle District of Tennessee, at 801 Broadway, Nashville, Davidson County, Tennessee, and serve on or mail to the attorney for Daystar, Fred C. Statum III, 2200 One Nashville Place, 150 Fourth Avenue North, Nashville, Tennessee 37219, copies thereof on or before January 7, 2014, or be defaulted.

Any claimant desiring to contest the right of Daystar to exoneration from or the right of Daystar to limitation of liability must file an answer to said Complaint, as required by the aforesaid Supplemental Rule F, and serve on or mail to Daystar's attorney a copy, unless his claim has included an answer.

CHIEF DISTRICT JUDGE WILLIAM J. HAYNES, JR.
MIDDLE DISTRICT OF TENNESSEE

0101701506

SUBSTITUTE TRUSTEE'S SALE

Sale at public auction will be on January 7, 2014 at 10:00AM local time, at the east door, Sumner County Courthouse, 100 Public Square, Gallatin, Tennessee, conducted by Shapiro & Kirsch, LLP Substitute Trustee, pursuant to Deed of Trust executed by Julie A. Bumpus and husband, Roger L. Bumpus, to Larry A. Weissman, Trustee, on October 16, 2006 at Record Book 2620, Page 66, Instrument No. 815153; all of record in the Sumner County Register's Office.

Party entitled to enforce security interest: Federal National Mortgage Association, its successors and assigns

The following real estate located in Sumner County, Tennessee, will be sold to the highest call bidder subject to all unpaid taxes, prior liens and encumbrances of record:

Land in Sumner County, Tennessee,

Continued to next column

Continued from last column

being Lot No. 45, on the Plan of Harbor Hills, Section 2, of record in Plat Book 2, Page 13, Register's Office for said County, to which plan reference is hereby made for a more complete description.

Street Address: 239 Sterling Road, Hendersonville, Tennessee 37075

Parcel Number: 172A-A-30.00

Current Owner(s) of Property: Julie A. Bumpus

The street address of the above described property is believed to be 239 Sterling Road, Hendersonville, Tennessee 37075, but such address is not part of the legal description of the property sold herein and in the event of any discrepancy, the legal description referenced herein shall control.

SALE IS SUBJECT TO TENANT(S) RIGHTS IN POSSESSION.

All right of equity of redemption, statutory and otherwise, and homestead are expressly waived in said Deed of Trust, and the title is believed to be good, but the undersigned will sell and convey only as Substitute Trustee.

If you purchase a property at the foreclosure sale, the entire purchase price is due and payable at the conclusion of the auction in the form of a certified/bank check made payable to Shapiro & Kirsch, LLP. No personal checks will be accepted. To this end, you must bring sufficient funds to outbid the lender and any other bidders. Insufficient funds will not be accepted. Amounts received in excess of the winning bid will be refunded to the successful purchaser at the time the foreclosure deed is delivered.

This property is being sold with the express reservation that the sale is subject to confirmation by the lender or trustee. This sale may be rescinded at any time.

Shapiro & Kirsch, LLP Substitute Trustee
www.kirschattorneys.com
Law Office of Shapiro & Kirsch, LLP
555 Perkins Road Extended, Second Floor
Memphis, TN 38117
Phone (901)767-5566
Fax (901)761-5690
File No. 13-052633

0101702627

SUBSTITUTE TRUSTEE'S SALE

Sale at public auction will be on January 7, 2014 at 10:00AM local time, at the east door, Sumner County Courthouse, 100 Public Square, Gallatin, Tennessee, conducted by Shapiro & Kirsch, LLP Substitute Trustee, pursuant to Deed of Trust executed by Jeremy H. Pruitt and Nannette L. Pruitt, husband and wife, to FMLS, Inc., Trustee, on August 26, 2005 at Record Book 2327, Page 718; all of record in the Sumner County Register's Office.

Party entitled to enforce security interest: JPMorgan Chase Bank, National Association, its successors and assigns

The following real estate located in Sumner County, Tennessee, will be sold to the highest call bidder subject to all unpaid taxes, prior liens and encumbrances of record:

Being Lot No. 194 on the Final Plat of Autumn Creek, Section 2 as of record in Plat Book 22, Page 57-59, Register's Office for Sumner County, Tennessee, to which said plan reference is hereby made for a more complete and accurate legal description thereof.

Being the same property conveyed to Jeremy H Pruitt and wife, Nanette L. Pruitt by deed from

Continued to next column

Continued from last column

Towe Building Group, L.L.C. as of record in Record Book 2327, Page 716, Register's Office for said County.

Street Address: 1006 Orange Blossom Court, Hendersonville, Tennessee 37075

Parcel Number: 138K B 004.00

Current Owner(s) of Property: Jeremy H. Pruitt and wife, Nanette L. Pruitt a/k/a Nannette L. Pruitt

Other interested parties: Bank of America, NA

The street address of the above described property is believed to be 1006 Orange Blossom Court, Hendersonville, Tennessee 37075, but such address is not part of the legal description of the property sold herein and in the event of any discrepancy, the legal description referenced herein shall control.

SALE IS SUBJECT TO TENANT(S) RIGHTS IN POSSESSION.

All right of equity of redemption, statutory and otherwise, and homestead are expressly waived in said Deed of Trust, and the title is believed to be good, but the undersigned will sell and convey only as Substitute Trustee.

If you purchase a property at the foreclosure sale, the entire purchase price is due and payable at the conclusion of the auction in the form of a certified/bank check made payable to Shapiro & Kirsch, LLP. No personal checks will be accepted. To this end, you must bring sufficient funds to outbid the lender and any other bidders. Insufficient funds will not be accepted. Amounts received in excess of the winning bid will be refunded to the successful purchaser at the time the foreclosure deed is delivered.

This property is being sold with the express reservation that the sale is subject to confirmation by the lender or trustee. This sale may be rescinded at any time.

Shapiro & Kirsch, LLP Substitute Trustee
www.kirschattorneys.com
Law Office of Shapiro & Kirsch, LLP
555 Perkins Road Extended, Second Floor
Memphis, TN 38117
Phone (901)767-5566
Fax (901)761-5690
File No. 13-052455

0101704505

SUBSTITUTE TRUSTEE'S SALE

Sale at public auction will be on February 11, 2014 at 10:00 AM local time, at the Auction.com Room of the Schermerhorn Symphony Center, One Symphony Place, Nashville, TN 37201 pursuant to Deed of Trust executed by Scott L. Dawkins and Natascha R. Dawkins, husband and wife, to Daniel W. Small, Trustee, as trustee for Guaranty Trust Company on January 20, 2005 at Instrument No. 20050126-0009734; conducted by Shapiro & Kirsch, LLP having been appointed Substitute or Successor Trustee, all of record in the Davidson County Register's Office. Default has occurred in the performance of the covenants, terms, and conditions of said Deed of Trust and the entire indebtedness has been declared due and payable.

Party Entitled to Enforce the Debt: Wells Fargo Bank, N.A., its successors and assigns

The following real estate located in Davidson County, Tennessee, will be sold to the highest call bidder:

The land referred to in this Deed of Trust is as follows:

Land in Davidson County, Tennessee, being Lot No. 227 on the Plan of Village

Continued to next column

Continued from last column

Two, Summerfield, as shown by plat appearing of record in Instrument No. 20000929-0096421, Register's Office of Davidson County, Tennessee, to which plan reference is hereby made for a more complete description.

Being the same property conveyed to Scott L. Dawkins and wife Natascha R. Dawkins, by deed from J. O. Clark Construction, LLC dated January 20, 2005 and being simultaneously recorded herewith in Instrument No: 20050126-0009733, Register's Office for Davidson County, Tennessee.

Street Address: 2405 Leafhollow Path, Antioch, Tennessee 37013

Parcel Number: 164 10 0A 079.00

Current Owner(s) of Property: Scott L. Dawkins and wife, Natascha R. Dawkins

Other interested parties: The Secretary of Housing and Urban Development, Household Financial Center Inc. c/o Finkelstein, Kern, Steinberg & Cunningham, Attys, FFPM/Carmel Holding I LLC c/o David Mendelson, Attorney, Factor Capital, LLC c/o Phillip Kirk, Attorney, Portfolio Recovery Associates, LLC c/o Finkelstein, Kern, Steinberg & Cunningham, Attys, U.S. Department of HUD c/o C&L Service Corporation/Morris Griffin Corporation, U.S. Department of HUD c/o First Madison Services, Inc., Capital One Bank (USA), N.A. c/o Mark A. Sexton, Attorney and Cavalry Portfolio Services LLC assignee of Citifinancial c/o Christopher W. Conner, Attorney

The street address of the above described property is believed to be 2405 Leafhollow Path, Antioch, Tennessee 37013, but such address is not part of the legal description of the property sold herein and in the event of any discrepancy, the legal description herein shall control.

SALE IS SUBJECT TO TENANT(S) RIGHTS IN POSSESSION.

This sale is subject to all matters shown on any applicable recorded plat; any unpaid taxes; any restrictive covenants, easements, or setback lines that may be applicable; any statutory right of redemption of any governmental agency, state or federal; any prior liens or encumbrances as well as any priority cre-

Continued to next column

Continued from last column

ated by a fixture filing; and to any matter that an accurate survey of the premises might disclose. In addition, the following parties may claim an interest in the above-referenced property: The Secretary of Housing and Urban Development, Household Financial Center Inc. c/o Finkelstein, Kern, Steinberg & Cunningham, Attys, FFPM/Carmel Holding I LLC c/o David Mendelson, Attorney, Factor Capital, LLC c/o Phillip Kirk, Attorney, Portfolio Recovery Associates, LLC c/o Finkelstein, Kern, Steinberg & Cunningham, Attys, U.S. Department of HUD c/o C&L Service Corporation/Morris Griffin Corporation, U.S. Department of HUD c/o First Madison Services, Inc., Capital One Bank (USA), N.A. c/o Mark A. Sexton, Attorney and Cavalry Portfolio Services LLC assignee of Citifinancial c/o Christopher W. Conner, Attorney

SALE IS SUBJECT TO ONE YEAR RIGHT OF REDEMPTION HELD BY THE SECRETARY OF HOUSING AND URBAN DEVELOPMENT BY REASON OF THE DEED OF TRUST OF RECORD AT INSTRUMENT NO. 20061030-0134061, IN THE REGISTER'S OFFICE OF DAVIDSON COUNTY, TENNESSEE.

SALE IS SUBJECT TO ONE YEAR RIGHT OF REDEMPTION HELD BY THE SECRETARY OF HOUSING AND URBAN DEVELOPMENT BY REASON OF THE DEED OF TRUST OF RECORD AT INSTRUMENT NO. 20090527-0048514, IN THE REGISTER'S OFFICE OF DAVIDSON COUNTY, TENNESSEE.

All right of equity of redemption, statutory and otherwise, and homestead are expressly waived in said Deed of Trust, and the title is believed to be good, but the undersigned will sell and convey only as Substitute Trustee.

The right is reserved to adjourn the day of the sale to another day, time, and place certain without further publication, upon announcement at the time and place for the sale set forth above. **If you purchase a property at the foreclosure sale, the entire purchase price is due and payable at the conclusion of the auction in the form of a certified/bank check made payable to Shapiro & Kirsch,**

Continued to next column

Continued from last column

LLP. No personal checks will be accepted. To this end, you must bring sufficient funds to outbid the lender and any other bidders. Insufficient funds will not be accepted. Amounts received in excess of the winning bid will be refunded to the successful purchaser at the time the foreclosure deed is delivered.

This property is being sold with the express reservation that the sale is subject to confirmation by the lender or trustee. This sale may be rescinded by the Substitute Trust-

Continued to next column

Continued from last column

ee at any time.

This office may be a debt collector. This may be an attempt to collect a debt and any information obtained may be used for that purpose.

Shapiro & Kirsch, LLP Substitute Trustee
www.Auction.com
Law Office of Shapiro & Kirsch, LLP
555 Perkins Road Extended, Second Floor
Memphis, TN 38117
Phone (901)767-5566
Fax (901)761-5690
File No. 13-054758

0101703991

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 Rolling Hills Hospital, an existing mental health hospital owned and managed by Rolling Hills Hospital, LLC, a limited liability company, intends to file an application for a Certificate of Need for the addition of forty (40) beds to its existing eighty (80) bed facility located at 2014 Quail Hollow Circle, Franklin, Tennessee 37067 (Williamson County). The estimated project cost is $9,796,909.56.

The anticipated filing date of the application is on or before December 13, 2013. The contact person for this project is Michael D. Brent, Esq., who may be reached at Bradley Arant Boult Cummings LLP, 1600 Division Street, Suite 700, Nashville, Tennessee 37203. Mr. Brent's telephone number is (615) 252-2361 and his e-mail address is mbrent@babc.com.

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

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.

Wanted: A Car that lets you decide where to park. Find what you want in The Tennessean Classifieds

Online local news just got better!
tennessean.com
THE TENNESSEAN

Wanted: To clean up in the stock market, not on a daily basis. Find what you want in The Tennessean Classifieds.
careerbuilder

When you're looking for a great deal on used computers and accessories, plug into The Tennessean Classifieds. What you want everyday.

More Readers means faster results. Sell your unwanted items in The Tennessean Classifieds. Call 242-SALE today!

Public Notices

PUBLIC NOTICE
2014-2015 ANNUAL UPDATE TO THE 2013-2018 CONSOLIDATED PLAN FOR HOUSING AND COMMUNITY DEVELOPMENT

Public Hearings: The Metropolitan Development and Housing Agency (MDHA) will host two public meetings on the draft 2014-2015 Annual Update to the 2013-2018 Consolidated Plan (2014 Action Plan) on:

Thursday, December 19, 2013, 5:30 p.m.
Randee Rogers Training Center
1419 Rosa Parks Boulevard
Nashville, TN 37208

Monday, January 6, 2013, 5:30 p.m.
Levy Place Community Room
303 Foster Avenue
Nashville, TN 37207

Public Comment Period: Beginning Monday, December 9, 2013, the draft 2014 Action Plan will be available for public examination and comment. Members of the public may download copies from MDHA's website at www.nashville-mdha.org/consolidated_planning.php or may request copies by contacting the MDHA Community Development Department at 615-252-8505 or TDD at 615-252-8599. Also, copies will be available at MDHA's Community Development Department, located at 712 South Sixth Street, Nashville, TN, between the hours of 7:30 a.m. and 4:00 p.m., Monday-Friday. MDHA will receive written comments through 4 p.m., central time, on Wednesday, January 8, 2014. Comments may be submitted electronically at consolidatedplan@nashville-mdha.org, faxed to 615-252-8533 (Attention: Consolidated Plan), or mailed to MDHA Community Development Department, Attention: Consolidated Plan, P.O. Box 846, Nashville, TN 37202.

Purpose and Summary: MDHA has prepared for submittal to the U.S. Department of Housing and Urban Development (HUD) the 2014-2015 Annual Update to the 2013-2018 Consolidated Plan for Housing and Community Development (2014 Action Plan). The 2014 Action Plan describes community needs and funding priorities for the 2014-2015 program year (April 1, 2014 through March 31, 2015) and serves as Metropolitan Nashville-Davidson County's application for receiving funds for the following programs: Community Development Block Grant (CDBG), HOME Investment Partnerships Act (HOME), the Emergency Solutions Grant (ESG), and Housing Opportunities for Persons with AIDS (HOPWA). Proposed funding allocations are intended to address the priority needs identified in the 2013-2018 Consolidated Plan and to benefit low- and moderate-income households and areas. Details regarding specific activities to be funded are provided in the 2014 Action Plan.

Funding Priorities:
- Increase the supply of affordable housing
- Strengthen collaboration among network of service providers
- Increase access to healthy food choices
- Decrease homelessness
- Develop and implement place-based strategies for community development
- Provide summer programs for low- and moderate-income children and youth
- Provide housing assistance for persons with HIV/AIDS
- Affirmatively further fair housing

Estimated 2014-2015 Funds & Proposed Allocations:

CDBG			
Program	Estimated Allocation	Estimated Program Income	TOTAL Est. Allocation & PI
Acquisition, Demo, Clearance & Relocation	$ 100,000.00		$ 100,000.00
Administration & Planning	$ 845,042.20	$ 40,000.00	$ 885,043.00
Economic Development	$ 660,168.00		$ 993,168.00
Housing	$ 1,115,000.00	$ 160,000.00	$ 1,275,000.00
Public Facilities & Infrastructure	$ 650,000.00		$ 650,000.00
Public Services Other, Non-profit	$ 600,000.00		$ 600,000.00
Capacity Building	$ 25,000.00		$ 22,000.00
TOTAL	$ 4,226,210.00	$ 200,000.00	$ 4,426,210.00

HOME			
Program	Estimated Allocation	Estimated Program Income	TOTAL Est. Allocation & PI
Administration	$ 167,033.00	$ 26,000.00	$ 193,033.00
Downpayment Assistance	$ 100,000.00		$ 102,000.00
Homeowner Rehab	$ 100,000.00		$ 100,000.00
New Construction - Homeownership	$ 200,000.00		$ 200,000.00
New Construction - Rental	$ 603,350.00	$ 234,000.00	$ 837,350.00
Public Rehab	$ 500,000.00		$ 503,000.00
TOTAL	$ 1,670,395.00	$ 260,000.00	$ 1,930,395.00

ESG	
Program	Estimated Allocation
Administration	$ 20,598.30
Emergency Shelter	$ 133,872.50
Street Outreach	$ 22,495.10
HMIS	$ 6,000.00
Rapid Re-housing	$ 93,491.20
Total	$ 274,457.70

HOPWA	
Program	Estimated Allocation
Administration	$ 20,985.90
Supportive Services	$ 135,870.50
Short-term Rent, Utilities & Mortgage	$ 22,495.10
Rent Subsidies	$ 5,002.00
Rapid Re-housing	$ 93,494.20
Total	$ 275,857.70

Request for Accommodations: MDHA makes every effort to provide reasonable accommodations to assist persons with disabilities. Any person needing assistance in accessing this information or who have other needs that require special accommodations may contact 615-252-8555 or TDD at 615-252-8599.

Statement of Non-Discrimination: MDHA does not discriminate on the basis of age, race, sex, sexual orientation, gender identity, genetic information, color, national origin, religion, disability or any other legally protected status in admission to, access to, or operations of its programs, services, or activities.

SAVE BIG on your next grocery bill with coupons from tennessean.com!
Great deals on your favorite national brands
THE TENNESSEAN
GET STARTED! Go to www.tennessean.com

Shop with confidence.
cars.com
Confidence Comes Standard.

©2011 Classified Ventures, LLC™ All rights reserved.

Letters of Support

JACK JOHNSON
SENATOR

11 LEGISLATIVE PLAZA
NASHVILLE, TENNESSEE 37243

(615) 741-2495
(615) 253-0321 (FAX)

109

Senate Chamber

State of Tennessee

NASHVILLE

DEC 13 '13 PM3:2

CHAIRMAN
COMMERCE AND LABOR

VICE CHAIRMAN
STATE AND LOCAL GOVERNMENT

December 4, 2013

Mr. Richard W. Clark
Chief Executive Officer
Rolling Hills Hospital
2014 Quail Hollow Circle
Franklin, TN. 37067

RE: Rolling Hills Hospital, LLC

Dear Mr. Clark:

This letter is written in support of Rolling Hills Hospitals' certificate of need application to add additional acute mental health beds to their existing facility.

Rolling Hills, located in Williamson County, provides inpatient and outpatient mental health care to adolescents, adults and geriatric consumers in Middle Tennessee.

Middle Tennessee has exceptional healthcare providers, but the resources for mental health consumers are inadequate in meeting a growing need. Without additional primary care resources and psychiatric inpatient beds, we will not be able to triage mental health consumers to the appropriate level of care. A growing number of community resources are bearing a burden in access to care issues and needless mental health referrals to local emergency departments. The increasing unmet need for treatment, the 'treatment gap' not only causes a financial strain on our existing resources, as providers of care, it is our responsibility to support innovative initiatives that best meet the needs of our mental health consumers.

With the addition of forty acute inpatient beds to our service area, Rolling Hills Hospital will have the ability to provide an environment of safety and care, improve admission services expediency, and fulfill a need for high-quality inpatient mental health options in Middle Tennessee.

I am pleased to provide strong support to Rolling Hills Hospital certificate of need application. Please feel free to contact me if you have further questions or comments.

Sincerely,

Jack Johnson

23rd DISTRICT
WILLIAMSON COUNTY
sen.jack.johnson@capitol.tn.gov

GLEN CASADA
STATE REPRESENTATIVE
63RD LEGISLATIVE DISTRICT

HOME ADDRESS:
3144 NATOMA CIRCLE
THOMPSON STATION,
TENNESSEE 37046
(615) 043 7396

House of Representatives
State of Tennessee

25 LEGISLATIVE PLAZA
NASHVILLE, TN 37243-0163
(615) 741-4389 OFFICE
(615) 253-0229 FAX
Rep.Glen.Casada@capitol.tn.gov

CHAIRMAN,
House Republican Caucus

MEMBER OF COMMITTEES

CALENDAR & RULES
INSURANCE AND BANKING
GOVERNMENT OPERATIONS
CONSUR AND HUMAN RESOURCES

December 3, 2013

Richard W. Clark
Chief Executive Officer
Rolling Hills Hospital
2014 Quail Hollow Circle
Franklin, TN. 37067

RE: Rolling Hills Hospital, LLC

Mr. Clark:

As a member of the Tennessee General Assembly delegation of Williamson County, I am writing in support of Rolling Hills Hospitals' certificate of need application to add additional acute mental health beds to their existing facility.

Rolling Hills, located in Williamson County, provides inpatient and outpatient mental health care to adolescents, adults and geriatric consumers in Middle Tennessee and is much appreciated by Williamson County residents who need this facility.

I have visited Rolling Hills, and it is an exceptional healthcare provider, but the resources for mental health consumers are inadequate in meeting a growing need. Without additional primary care resources and psychiatric inpatient beds, Rolling Hills will not be able to triage mental health consumers to the appropriate level of care. A growing number of community resources are bearing a burden in access to care issues and needless mental health referrals to local emergency departments. The increasing unmet need for treatment, the 'treatment gap', causes a financial strain on the existing resources. As providers of care, Rolling Hills' intends to shoulder a good portion of the responsibility to support innovative initiatives that best meet the needs of our mental health consumers.

With the addition of forty acute inpatient beds to its' service area, Rolling Hills Hospital will have the ability to provide an environment of safety and care, improve admission services expediency, and fulfill a need for high-quality inpatient mental health options in Middle Tennessee.

Therefore I am most pleased to provide strong support to Rolling Hills Hospital certificate of need application. Please feel free to contact me if you have further questions or comments.

Sincerely,

Glen Casada

Jeremy Durham
State Representative
65th District
Franklin, Spring Hill, Thompson's Station, and Fairview

House Chamber
State of Tennessee

Legislative Plaza 22
Nashville, TN 37243-0231
1-800-449-8366 ext. 44173
(615) 741- 1864
fax (615) 253-0228
rep.jeremy.durham@capitol.tn.gov

December 4, 2013

Richard W. Clark
Chief Executive Officer
Rolling Hills Hospital
2014 Quail Hollow Circle
Franklin, TN. 37067

RE: Rolling Hills Hospital, LLC

I am pleased to write this letter in support of Rolling Hills Hospitals' certificate of need application to add additional acute mental health beds to their existing facility.

Rolling Hills, located in Williamson County, provides inpatient and outpatient mental health care to adolescents, adults and geriatric consumers in Middle Tennessee.

Middle Tennessee has exceptional healthcare providers, but the resources for mental health consumers are inadequate in meeting a growing need. Without additional primary care resources and psychiatric inpatient beds, we will not be able to triage mental health consumers to the appropriate level of care. A growing number of community resources are bearing a burden in access to care issues and needless mental health referrals to local emergency departments. The increasing unmet need for treatment, the 'treatment gap' not only causes a financial strain on our existing resources, as providers of care, it is our responsibility to support innovative initiatives that best meet the needs of our mental health consumers.

With the addition of forty acute inpatient beds to our service area, Rolling Hills Hospital will have the ability to provide an environment of safety and care, improve admission services expediency, and fulfill a need for high-quality inpatient mental health options in Middle Tennessee.

Again, I am glad to add my support to Rolling Hills Hospital certificate of need application. Please feel free to contact me if you have further questions or comments.

Sincerely,

Jeremy Durham

WILLIAMSON COUNTY SHERIFF'S OFFICE
JEFF LONG, SHERIFF
408 CENTURY COURT
FRANKLIN, TENNESSEE 37064
(615) 790-5566

December 9, 2013

Richard W. Clark
Chief Executive Officer
Rolling Hills Hospital
2014 Quail Hollow Circle
Franklin, TN 37067

RE: Rolling Hills Hospital, LLC

On behalf of Williamson County Sheriff's Office this letter is written in support of Rolling Hills Hospital certificate of need application to add additional acute mental health beds to their existing facility.

Rolling Hills, located in Williamson County, provides inpatient and outpatient mental health care to adolescents, adults and geriatric consumers in Middle Tennessee.

Middle Tennessee has exceptional healthcare providers, but the resources for mental health consumers are inadequate in meeting a growing need. Without additional primary care resources and psychiatric inpatient beds, we will not be able to triage mental health consumers to the appropriate level of care. A growing number of community resources are bearing a burden in access to care issues and needless mental health referrals to local emergency departments. The increasing unmet need for treatment, the treatment gap, not only places a financial strain on our existing resources as providers of care, it is our responsibility to support innovative initiatives that best meet the needs of our mental health consumers.

With the addition of forty acute inpatient beds to our service area Rolling Hills Hospital will have the ability to provide an environment of safety and care, improve admission services expediency, and fulfill a need for high quality inpatient mental health options in Middle Tennessee.

Williamson County Sheriff's Office is therefore pleased to provide strong support to Rolling Hills Hospital certificate of need application. Please feel free to contact me if you have further questions or comments.

Sincerely,

Jeff Long
Sheriff, Williamson County

NAMI Tennessee

Richard W. Clark
Chief Executive Officer
Rolling Hills Hospital
2014 Quail Hollow circle
Franklin, TN 37067

RE: Support for Rolling Hills Application
Certificate of Need

I am writing in support of Rolling Hills Hospitals' certificate of need application for additional acute mental health beds to their current facility.

Williamson County and nearby communities are fortunate to have the Rolling Hills Hospital in our area providing inpatient and outpatient mental health care to adolescents, adults and geriatric people living with a mental illness.

Our NAMI organization is a grass roots, non-profit organization of people living with a mental illness, their families and community members. We are dedicated to improving the quality of life for people with a mental illness and their families and we feel that the Rolling Hills Hospital has played an important role in the care of our family members who have a mental illness. Currently, we feel that the current resources are inadequate to take care of the current mental health needs in our greater community in Williamson County. Additional primary care resources and psychiatric inpatient beds are needed to offset the lack of available resources for our family members and NAMI's own members with a mental illness. It creates a financial burden for our families to have to travel to distant hospitals when caring for our family when hospitalized, plus the care currently give at Rolling Hills is at an excellent level and we need more of those services available.

Forty acute inpatient beds are needed in our community and with the expansion, Rolling Hills will have the ability to provide an environment of safety and care and help to filll the developing need for high quality mental health services in Williamson County and our surrounding area in Middle Tennessee.

Please give approval to the Rolling Hills Hospital certificate of need application for forty additional inpatient beds. NAMI Tennessee and the Williamson County affiliate of NAMI Tennessee support this certificate of need. You may contact me if there are additional questions or further support needed.

Yours truly,

(original copy signed by Richard P. Baxter)

Richard P. Baxter
President, NAMI Tennessee
Member, NAMI Williamson County
rpbaxter@comcast.net
615-665-2914

November 14, 2013

Richard W. Clark, CEO
Rolling Hills Hospital
2014 Quail Hollow Circle
Franklin, TN. 37067

Dear Richard,

As the CEO of Mental Health America of Middle Tennessee, I am writing this in support of Rolling Hills Hospitals' certificate of need application to add additional acute mental health beds to their existing facility. I am intimately familiar with Rolling Hills Hospital, which I consider one of the safest, state-of-the-art facilities where people can receive quality care: inpatient and outpatient mental health services for adolescents, adults, and geriatric populations. More importantly, I have been a Williamson County resident and am familiar with the surrounding community and their unmet needs.

No one disputes that Middle Tennessee has exceptional healthcare providers. However, the available resources for mental health consumers are not being met, and the need growing need. Without additional primary care resources and psychiatric inpatient beds, we will not be able to triage and refer mental health consumers to the appropriate level of care. A growing number of community resources are bearing a burden in access to care issues and needless mental health referrals to local emergency departments. The increasing unmet need for treatment, the 'treatment gap' not only causes a financial strain on our existing resources, as providers of care, it is our responsibility to support innovative initiatives that best meet the needs of our mental health consumers.

With the addition of forty (40) acute inpatient beds to our service area, Rolling Hills Hospital will have the ability to provide an environment of safety and care, improve admission services expediency, and fulfill a need for high-quality inpatient mental health options in Middle Tennessee. This will certainly help us make better referrals by knowing such needed resources are in place.

Mental Health America of Middle Tennessee is pleased to provide strong support to Rolling Hills Hospital certificate of need application. Please feel free to contact me if you have further questions or comments.

Sincerely,

Tom Starling

Tom Starling, EdD
President/CEO

295 Plus Park Blvd, Suite 201 ~ Nashville, TN 37217 ~ (615) 269-5355 ~ Fax: (615) 269-5413

155 Covey Drive, Suite 100
Franklin, TN 37067
615.472.1550
www.physiciansurgentcare.com

November 20, 2013

Richard W. Clark
Chief Executive Officer
Rolling Hills Hospital
2014 Quail Hollow Circle
Franklin, TN. 37067

RE: Rolling Hills Hospital, LLC

On behalf of Physicians Urgent Care this letter is written in support of Rolling Hills Hospitals' certificate of need application to add additional acute mental health beds to their existing facility.

Rolling Hills, located in Williamson County, provides inpatient and outpatient mental health care to adolescents, adults and geriatric consumers in Middle Tennessee.

Middle Tennessee has exceptional healthcare providers, but the resources for mental health consumers are inadequate in meeting a growing need. Without additional primary care resources and psychiatric inpatient beds, we will not be able to triage mental health consumers to the appropriate level of care. A growing number of community resources are bearing a burden in access to care issues and needless mental health referrals to local emergency departments. The increasing unmet need for treatment, the 'treatment gap' not only causes a financial strain on our existing resources, as providers of care, it is our responsibility to support innovative initiatives that best meet the needs of our mental health consumers.

With the addition of forty acute inpatient beds to our service area, Rolling Hills Hospital will have the ability to provide an environment of safety and care, improve admission services expediency, and fulfill a need for high-quality inpatient mental health options in Middle Tennessee.

Physicians Urgent Care is therefore pleased to provide strong support to Rolling Hills Hospital certificate of need application. Please feel free to contact me if you have further questions or comments.

Sincerely,

Pamela Whitney
Physicians Urgent Care

275 Cumberland Bend Drive | Nashville | Tennessee | 37228 | Phone: 615-743-1555 | www.mhc-tn.org

November 22, 2013

To

Richard W. Clark
Chief Executive Officer
Rolling Hills Hospital
2014 Quail Hollow Circle
Franklin, TN. 37067

RE: Rolling Hills Hospital, LLC

On behalf of the Mental Health Cooperative, Inc this letter is written in support of Rolling Hills Hospitals' certificate of need application to add additional acute mental health beds to their existing facility.

Rolling Hills, located in Williamson County, provides inpatient and outpatient mental health care to adolescents, adults and geriatric consumers in Middle Tennessee. The Mental Health Cooperative works closely with Rolling Hills hospital as we serve serious and persistently mentally ill adults and children in the Middle Tennessee region. When our Consumers are in need of acute inpatient treatment, Rolling Hills is one of the local hospitals that we will refer to as they provide a full array of services that meet our Consumers needs.

Over the past couple of years, the need for acute inpatient psychiatric beds in the Middle Tennessee area has been growing. With the addition of forty acute inpatient beds to our service area, Rolling Hills Hospital will have the ability to provide an environment of safety and care, improve admission services expediency, and fulfill a need for high-quality inpatient mental health options in Middle Tennessee.

The Mental Health Cooperative, Inc. is therefore pleased to provide support to Rolling Hills Hospital certificate of need application. Please feel free to contact me if you have further questions or comments.

Sincerely,

Amanda Myatt Bracht

Amanda Myatt Bracht, LCSW
Clinical Services, Director
Mental Health Cooperative, Inc.

November 22, 2013

Richard W. Clark
Chief Executive Officer
Rolling Hills Hospital
2014 Quail Hollow Circle
Franklin, TN. 37067

RE: Rolling Hills Hospital, LLC

Amerigroup Corporation is providing this letter in support of Rolling Hills Hospitals' certificate of need application to add forty additional acute mental health beds to their existing facility.

Rolling Hills, located in Williamson County, is a member of Amerigroup's provider network for inpatient and outpatient mental health care services to adolescents, adults and geriatric consumers. Amerigroup is providing this letter of support in response to a growing deficit of available psychiatric inpatient beds for our members in middle Tennessee. The current community resources are not able to provide adequate and appropriate care for our members thereby creating access to care issues and needless mental health referrals to local emergency departments.

For these reasons Amerigroup wishes to provide its support to Rolling Hills Hospital certificate of need application. Please feel free to contact me if you have further questions or comments.

Sincerely,

William G Wood, MD
Chief Medical Officer Behavioral Health
Amerigroup Tennessee

22 Century Boulevard
Suite 220
Nashville, Tennessee 37214
615.316.2400

www.amerigroup.com

Tennessee Suicide
Prevention Network
Advisory Council

Jennifer Harris, MS
Chair, Centerville

Karyl Chassin Best, M. Ed. CT
Co-Chair, Columbia

Tim Tatum, MA
Secretary, Chattanooga

Pam Arnell, MA
Co-Secretary, Pulaski

Harold Leonard, MA, LPC-MHSP
Past Chair, Kingsport

Sabrina Anderson
Jackson

Nancy L. Badger, Ph.D.
Chattanooga

Jodi Burdett, Ed S., LPC-MHSP
Cookeville

Stephanie Bavigar, M. Div.
Nashville

Kathy Bonadetto, LPC, SPE, LMFT
Johnson City

Vickie Bilbrey
Livingston

Bonce Brown, LCSW, BCD, CFAE
Memphis

Lisa Daniel
Memphis

Brenda F. Harper
Lafayette

Linda Phipps Harold
Jonesborough

Anne Hennigs-Rowan, MS
Dunwoody

Emily Hill
Columbia

Cindy Johnson
Clarksville

Mike LaBeaute
Memphis

Rita McNabb
Newport

Tina Mitchell, GCDF
Nashville

Warley Porter
Memphis

Stephanie Robb
Jackson

Micky Roberts
Knoxville

Kim Rudd, M.Ed., LPC-MHSP
Murfreesboro

Sandy Smith
Chattanooga

Kandi Shearer
Johnson City

Anna Shugart, LCSW
Maryville

Anne Stamps
Livingston

Angie Thompson
Nashville

Sheila R. Ward
Jackson

Anne Young, MS, CAS
Knoxville

Granger Brown, MSW, LMSW
Substance Abuse Outreach Coordinator, Nashville

Vladimir Eidown, MTS
Executive Assistant, Nashville

Scott Ridgway, MS
Executive Director, Nashville

Sam Bernard, PhD, FAAETS, DABCEM
Chair Emeritus, Chattanooga

Carol Burroughs, MSCPS
Member Emeritus, Lexington

Barbara Dooley, Ph.D.
Member Emeritus, Memphis

Clark Flatt
Member Emeritus, Hendersonville

Judith Johnson, AAS, CC
Member Emeritus, Smyrna

Claudia H. Mayo, LCSW, BCD
Member Emeritus, Nashville

Ken Tufts, MD
Member Emeritus, Memphis

Midge Tufts
Chair Emeritus, Memphis

Mary Yarbrough, BBA, BSW
Member Emeritus, Nashville

Anita Bernard, MS
Previous Chair, Nashville

Benjamin T. Harrington, MA
Previous Chair, Knoxville

tspn@tspn.org

Tennessee Suicide Prevention Network

"Saving Lives in Tennessee"

November 21, 2013

Richard W. Clark
Chief Executive Officer
Rolling Hills Hospital
2014 Quail Hollow Circle
Franklin, TN 37067

RE: Rolling Hills Hospital, LLC

The Tennessee Suicide Prevention Network (TSPN) wishes to offer its unqualified support for Rolling Hills Hospital's certificate of need application.

TSPN is the statewide public-private organization responsible for implementing the Tennessee Strategy for Suicide Prevention as defined by the National Strategy for Suicide Prevention. Our grass-roots association works across the state to eliminate the stigma of suicide and educate communities about the warning signs of suicide, with the ultimate intention of reducing suicide rates in the state of Tennessee. Mostly this involves organizing and promoting regular regional activities, providing suicide prevention and crisis intervention training to community organizations, and conducting postvention sessions for schools and organizations after suicides occur.

Our agency counts Rolling Hills as one of our strongest allies in Middle Tennessee. For the last several years, they have sponsored our annual Mid-Cumberland Suicide Prevention Awareness Month event at Centennial Park, and they have sponsored some of our statewide conferences as well. Staff members frequently attend our Mid-Cumberland regional meetings, and we include them as a mental health contact point in our regional resource directory.

We are very much aware of the increasing need for mental health resources in Metro Nashville and outlying communities. We know that easy access to appropriate mental health care can make the difference when it comes to saving lives; communities without such resources tend to see considerably higher suicide rates. Hence we welcome any opportunity to add more beds at providers like Rolling Hills. We believe that the proposed forty acute inpatient beds will greatly enhance Rolling Hills's ability to meet the mental health and crisis intervention needs of Middle Tennessee.

You are welcome to contact me if you have further questions or comments about TSPN or its relationship with Rolling Hills Hospital. We again offer our full support for the current application, and we look forward to hearing about the outcome.

Sincerely,

Scott Ridgway

Scott Ridgway, MS
Executive Director

295 Plus Park Boulevard, Suite 201 ◻ Nashville, TN 37217 ◻ Office (615) 297-1077 ◻ Fax (615) 269-5413
National Suicide Prevention Lifeline: 1-800-273-TALK

DEC 18 PM 3:2

Youth VILLAGES.
The force for families.

December 4, 2014

To:

Richard W. Clark
Chief Executive Officer
Rolling Hills Hospital
2014 Quail Hollow Circle
Franklin, TN 37067

RE: Rolling Hills Hospital, LLC

On behalf of Youth Villages this letter is written in support of Rolling Hills Hospitals' certificate of need application to add additional acute mental health beds to their existing facility.

Rolling Hills, located in Williamson County, provides inpatient and outpatient mental health care to adolescents, adults and geriatric consumers in Middle Tennessee.

Middle Tennessee has exceptional healthcare providers, but the resources for mental health consumers are inadequate in meeting a growing need. Without additional primary care resources and psychiatric inpatient beds, we will not be able to triage mental health consumers to the appropriate level of care. A growing number of community resources are bearing a burden in access to care issues and needless mental health referrals to local emergency departments. The increasing unmet need for treatment, the 'treatment gap' not only causes a financial strain on our existing resources, as providers of care, it is our responsibility to support innovative initiatives that best meet the needs of our mental health consumers.

With the addition of forty acute inpatient beds to our service area, Rolling Hills Hospital will have the ability to provide an environment of safety and care, improve admission services expediency, and fulfill a need for high-quality inpatient mental health options in Middle Tennessee.

Youth Villages is therefore pleased to provide strong support to Rolling Hills Hospital certificate of need application. Please feel free to contact me if you have further questions or comments.

Sincerely,

Pat Lawler
CEO
Youth Villages

3320 Brother Boulevard | Memphis, TN 38133 | O: 901.251.5000 | F: 901.251.5001
www.youthvillages.org

COPY-
SUPPLEMENTAL-1

Rolling Hills Hospital

CN1312-051

SUPPLEMENTAL

1. **Section A, Applicant Profile, Item 4**

Please provide a description of Universal Health Services, Inc. including a discussion of other health care institutions owned by type and their location by state.

Does the applicant's parent company own other health care institutions in Tennessee? If yes, please provide the name, current address, current status of Licensure/certification, and percentage of ownership for each health care institution identified.

Response: Universal Health Services, Inc. ("UHS"), a publicly-traded corporation on the New York Stock Exchange, is one of the largest hospital management companies in the nation. UHS, headquartered in King of Prussia, Pennsylvania, was found in the 1978 by Chairman and Chief Executive Officer Alan B. Miller. UHS has steadily grown from a startup company to a Fortune 500 corporation with annual revenue that exceeds $7.5 billion. UHS' principal business is owning and operating, through its subsidiaries, acute care hospitals, behavioral health centers, surgical hospitals, ambulatory surgery centers and radiation oncology centers. As of March 31, 2013, UHS owned and/or operated 23 acute care hospitals and 197 behavioral health centers in 37 states, Washington, D.C., Puerto Rico and the U.S. Virgin Islands.

UHS does own and operate other health care institutions in Tennessee. The information requested in the above question is as follows:

Name	Address	Current Status of Licensure/Certification	Percentage of Indirect Ownership by UHS
Cedar Grove Residential Treatment Center	1640 Lascassas Pike Murfreesboro, TN 37130	Medicaid certified, licensed by State of Tennessee	100%
Community Behavioral Health	135 N. Pauline Street| 4th & 5th Floors Memphis, TN 38105	Medicare and Medicaid certified, licensed by State of Tennessee (license currently inactive while seeking new location)	50%
Compass Intervention Center	7900 Lowrance Road Memphis, TN 38125	Medicaid certified, licensed by State of Tennessee	100%
Hermitage Hall	1220 8th Avenue South Nashville, TN 37203	Medicaid certified, licensed by State of Tennessee	100%
Lakeside Behavioral Health System	2911 Brunswick Road Memphis, TN 38133	Medicare and Medicaid certified, licensed by State of Tennessee	100%
McDowell Center for Children	711 Highway 51 Bypass South Dyersburg, TN 38024	Medicaid certified, licensed by State of Tennessee	100%
Mountain Youth Academy	332 Hospital Road P.O. Box 58 Mountain City, TN 37683	Medicaid certified, licensed by State of Tennessee	100%
Natchez Trace Youth Academy	415 Seven Hawks Lane Waverly, TN 37185	Medicaid certified, licensed by State of Tennessee	100%

SUPPLEMENTAL

Name	Address	Current Status of Licensure/Certification	Percentage of Indirect Ownership by UHS
Oak Plains Academy	1751 Oak Plains Road Ashland City, TN 37015	Medicaid certified, licensed by State of Tennessee	100%
Upper East TN Juvenile Detention Center	307 Wesley Street Johnson City, TN 37601	N/A	100%

2. Section A, Applicant Profile, Item 13

   Your response to this item is noted. Please identify all TennCare MCO/BHOs in the applicant's service area and the TennCare MCO/BHOs with which the applicant contracts.

   Response: The TennCare MCO/BHOs in the Applicant's service area and with which the Applicant contracts are as follows:

   - United HealthCare Community Plan - contracted
   - Amerigroup Community Plan - contracted
   - Blue Care East and West – currently in rate discussions. Currently only have had patients traveling into Middle Tennessee. With the 2015 Bureau of TennCare determination that all MCO/BHOs shall be statewide, we anticipate receiving BlueCare patients that reside in our service area.
   - TennCare Select - contracted
   - Select Kids - contracted

3. **Section B, Project Description, Item II.A (Square Footage and Cost Per Square Footage Chart)**

   Please complete Line E. Total GSF which should include the total renovated square footage, total new square footage, renovated and new square footage combined, the renovated cost per square foot, the new cost per square foot, and the total cost per square foot.

   It appears that the applicant will have seven patient units after completion of the project. Please explain how the addition of 40 beds and the addition of two units improves the design and reconfiguration of the existing layout of the applicant's units.

   Response: Please see Supplemental Attachment Section B, Project Description, Item II.A. for a revised Cost Per Square Footage Chart. The addition of the 40 beds and the two units improves the existing layout by providing additional beds needed to serve the market area, and provides a logical extension of the unit corridors and the service corridors. This connection allows patients to be transported to the various units along the same corridor and allow staff easy access to additional staff, as the two additional nurse stations are placed on a corridor that is directly in line with existing patient unit corridors.

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

(a) Please identify the number of deflections/diversions for the most recent year available by age group, i.e., child/adolescent, adult, and geriatric.

Response: The following chart details the number of deflections/diversions that the Applicant has experienced in the most recent year available:

Deflections – No Bed	Unit Age	Total
No Intensive Treatment Program	Adult 18+	89
No Adolescent	Adolescent 13-18	70
No Geri Psych	Geriatric 55+	9
No Adult	Adult 18+	27
Total Deflections	Total All Ages	195

(b) Please explain in more detail why the applicant is not currently able to create distinct and specialized programming. Please describe in more detail the current configuration of the hospital. Are the child/adolescent, adult, and geriatric units not physically separate to allow for distinct programming targeted to the appropriate age groups within the confines of their unit? In what ways does the expansion improve the distinct and specialized programming?

Response: The adolescent population is currently served on a single physical unit with bed capacity for eighteen patients. Mental health issues treated in the adolescent population, include depression, suicidality, self-mutilation, bipolar disorder, psychosis, acute eating disorders, substance induced depression, substance induced psychosis, behavioral/conduct disorders with or without violent ideation, and homicidal ideation. The current single physical unit prevents the ability to separate the adolescent population to best meet clinical needs, as the inclusion of higher acuity patients (psychosis, extreme self-mutilation, and/or violent behavior) in the general adolescent program is disruptive to the care of others. It can result in premature requests for discharge by patients of lower acuity due to exposure to frightening behaviors (psychosis or violence). It also provides the opportunity for higher-functioning adolescents to mimic high risk behaviors, such as self-mutilation. The addition of too many higher acuity patients (psychosis, extreme self-mutilation, and/or violent behavior) in Adolescent Program can result in a dangerous combination of patients, placing patients and staff at risk for injury, increased need for seclusion and/or restraint, and curtail the treatment benefit for all patients served. The building addition will allow reconfigurations within the existing building, which will create the ability to clinically distinguish patients into two distinct groups and physical units. This will also allow for the allocation of staffing resources to better meet the needs of higher acuity adolescent patients, as patients with higher acuity related to psychosis, extreme self-mutilation, and/or violent behavior can be segregated to allow for unique treatment programming to best meet their clinical needs. Treatment programming would include options such as behavioral modification, reward system, groups based on self-control and coping.

The geriatric population is currently served on a single physical unit with bed capacity for fourteen patients. Mental health issues treated in the geriatric population, include depression, suicidality, bipolar disorder, psychosis, schizophrenia, dementia, violent ideation and behavior, homicidal ideation and behavior. The single physical unit prevents the ability to separate the geriatric population to best meet clinical needs. The inclusion of higher acuity patients (advanced dementia with propensity for disruptive or violent behavior) in the Older Adult Program is disruptive to the care of others. The behaviors in dementia patients can be frightening to elderly frail depressed patients. In addition, the propensity for violent behavior or poor physical boundaries of dementia patients places the elderly frail patients at higher risk for injury or falls.

Benefits of the addition of Older Adult beds: The building addition will allow reconfigurations within the existing building, which will create the ability to clinically distinguish patients into two distinct groups & physical units. This will allow for the allocation of staffing resources to better meet the needs of higher acuity geriatric patients, as those patients with higher acuity related to dementia can be segregated to allow for unique treatment programming to best meet their clinical needs. Treatment programming will include focus on self-control, re-orientation, and the completion of simple tasks of daily living. Conversely, the ability to exclude the higher acuity patients from the depressed frail elderly patients will allow for their clinical needs to be best met by unique programming and create an environment free of disruptive behaviors that can hinder treatment.

The adult population is currently served with a total of forty-eight beds divided between three separate physical units:

Intensive Treatment Program (16 beds), where mental health issues are treated including schizophrenia, psychosis, bipolar disorder with or without mania, substance induced psychosis, suicidality, violent ideation and behavior, homicidal ideation and behavior.

General Psychiatry Program (23 beds) where mental health issues are treated including depression, depression with psychosis, bipolar disorder with or without mania, suicidality, violent ideation, homicidal ideation.

Co-Occurring Program (9 beds), where mental health issues are treated including chemical dependency, medical detoxification, with or without co-morbid mental health issues, such as depression, bipolar disorder.

The current bed capacity does not meet the growing need of the geographic area served by Rolling Hills, resulting in diversions of patients in need of acute hospitalization. While three separate units exists to meet the adult population needs, there is yet greater need for additional units to structure clinical care to best meet clinical needs. On the Intensive Treatment Program, there is a marked need to distinguish the population into higher level acuity and lower level acuity patients. The therapeutic milieu can become disruptive when too many high acuity patients (pronounced psychosis with or without violent, sexually inappropriate, poor physical boundaries) together. The addition of too many higher acuity patients (pronounced psychosis with or without violent, sexually

inappropriate, poor physical boundaries) in the Intensive Treatment Program can result in a dangerous combination of patients, placing patients and staff at risk for injury, increased need for seclusion and/or restraint, and curtail the treatment benefit for all patients served. The General Psychiatry Program is currently a very large unit serving 23 patients. When at capacity, the unit is difficult to manage and assure that each patient is receiving individualized care. The programming has the likelihood of becoming diluted in the effort to treat so many patients at one time. For instance, it is difficult to have a productive therapeutic group with 23 patients participating. The Co-Occurring Program provides specialized medical detoxification that takes commensurate nursing clinical expertise and monitoring. The limited bed capacity restricts the ability for the Applicant to better meet the community needs for this service. These patients cannot simply be "housed" on other units due to the need for highly-trained nursing staff.

The addition of more adult beds will create the ability to clinically distinguish patients into five distinct groups and physical units, allowing for the safer delivery of care for patients requiring intensive care due to their high level of acuity (pronounced psychosis, with or without violent, sexually inappropriate, poor physical boundaries). It will also create the ability to reduce the diversion of admissions for high acuity adult patients, allowing the Applicant the opportunity to meet the unmet needs in the service area for this difficult to treat population. The addition of beds to serve the General Psychiatry adult population will allow for the creation of two more manageable smaller units, allowing for the ability to meet the individual needs of each patient.

The addition of beds to serve the Co-Occurring adult population will allow for greater capacity to provide safe medical detoxification

(c) How will those individuals who are dually diagnosed (mental health/substance abuse) be treated?

Response: Patients with co-occurring substance dependence and mental health illness, such as depression, bipolar disorder, are admitted to acute inpatient program for stabilization. Patients at risk of medical complications related to detoxification from substances, such as alcohol, benzodiazepines, and opiates, will be placed on withdrawal protocols to prevent medical crisis and treat untoward symptomology. The withdrawal protocols include the frequent monitoring of vital signs, withdrawal symptoms (tremors, diaphoresis, nausea, vomiting, etc.) and the administration of medications to reduce risk of seizure, stroke, heart attack, and other untoward symptoms. These patients are involved in treatment programming, which addresses their addictive disorders, specifically twelve-step programming. Concurrently, the patients are offered treatment programming to aid in development of coping strategies and other skills to help address their overall mental health issues.

(d) Will the proposed units be equipped to handle patients with developmental and intellectual disabilities?

Response: The Applicant currently provides services on a case-by-case basis for patients with developmental and intellectual disabilities with intellectual quotient scores of

approximately 55 and above based upon the anticipated ability for the individual patient to benefit from programming. The capacity to admit patients with these specialty needs can be restricted due to high acuities on the units due to the inability to best segregate the patient populations. With the addition of bed capacity and more distinct treatment programming, the ability to provide more services to treat patients with developmental and intellectual disabilities will be enhanced for both adult and adolescent populations

(e) Please identify the crisis stabilization units (CSU), the number of beds in each unit, and their locations that serve the service area. Please describe what a CSU is and describe the services that a CSU provides.

Response: A list of Tennessee CSUs by location is provided below. Mental Health Cooperative, the CSU for Middle Tennessee, has 15 beds.

A Crisis Stabilization Unit (CSU) is a voluntary service that offers 24 hour, seven days a week intensive, short-term stabilization (up to 96 hours) and behavioral health treatment for those persons 18 years of age and older whose behavior health condition does not meet the criteria for involuntary commitment to a psychiatric hospital or other treatment resource.

CSU Locations

Frontier Behavior Health System (Johnson City, TN)
Helen Ross McNabb (Knoxville, TN)
Volunteer Behavioral Health (Cookeville, TN)
Volunteer Behavioral Health (Chattanooga, TN)
Mental Health Cooperative (Nashville, TN)
Pathways of Tennessee (Jackson, TN)
Southeast Mental Health Center (Memphis, TN)
Cherokee Health Systems (Morristown, TN)

A Walk-In Triage Center is a non-hospital, facility-based service affiliated with each of the Crisis Stabilization Units that offers 24 hour, seven days a week behavioral health treatment to adults 18 years of age and older by providing assessment and evaluation, early intervention, prevention, stabilization, referral, and follow-up services for individuals seeking assistance in obtaining appropriate behavioral health services or linkage of services to achieve and/or improve his/her prior level of functioning following a crisis situation.

Crisis stabilization services are short-term supervised care services accessed to prevent further increase in symptoms of a behavioral health illness or to prevent acute hospitalization. Crisis stabilization services are more intensive than regular crisis respite services in that they require more secure environments, highly trained staff, and have typically longer stays. Crisis stabilization services should include availability and utilization of the following types of services on a short-term basis as appropriate:

- 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.

(f) Please identify the mobile crisis teams (MCT) that serve the service area. Please describe the role of the MCT regarding admissions to the facility.

Response: The mobile crisis teams (MCTs) that serve the Applicant's service area are as follows:

MIDDLE TENNESSEE	
Business Address	**Counties Served**
Centerstone Community Mental Health Center P. O. Box 40406 Nashville, TN 37204	Bedford, Cheatham, Coffee, Dickson, Franklin, Giles, Hickman, Houston, Humphreys, Lawrence, Lewis, Lincoln, Marshall, Maury, Montgomery, Moore, Perry, Robertson, Stewart, Wayne
Mental Health Cooperative 275 Cumberland Bend Nashville, TN 37228	Davidson
Volunteer Behavioral Health Care System 413 Spring Street Chattanooga, TN 37405	Bledsoe, Bradley, Cannon, Clay, Cumberland, DeKalb, Fentress, Grundy, Hamilton, Jackson, Macon, Marion, McMinn, Meigs, Overton, Putnam, Pickett, Polk, Rhea, Rutherford, Sequatchie, Smith, Sumner, Trousdale, Van Buren, Warren, White, Williamson, Wilson

All children/youth crisis services statewide are provided by Youth Villages. MCTs assist TennCare BHOs as well as uninsured patients with psychiatric placement to the appropriate level of care and service for individual crisis needs.

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

Please submit a revised plot plan that clearly identifies the location of the 40 bed addition.

Response: Please see Supplemental Attachment Section B, Project Description, Item III.A. for a revised plot plan that clearly identifies the location of the 40 bed addition.

What is the size of the site in acres? Is the size of the site adequate enough to accommodate the addition or will the applicant need to purchase additional adjacent land?

Response: The size of the existing site is approximately 16.38 acres. The size is adequate to accommodate the addition, and the Applicant will not need to purchase any additional adjacent land for this project.

6. **Section B, Project Description, Item B.IV. (Floor Plan)**

The applicant has provided a site plan and a second floor plan. Please also provide a first floor plan.

Response: Please see Supplemental Attachment Section B, Project Description, Item B.IV. for a first floor plan.

Please also provide some "zoomed in" views of the first floor and second floor plans that clearly labels each room on the floor plan and display the relationship with the five units in the existing building leading to the efficient layout being described in the narrative.

Response: Please see Supplemental Attachment Section B, Project Description, Item B.IV. for "zoomed in" views of the first floor and second floor plans.

7. **Section C, Need, Item 1 a., (Project Specific Criteria-Psychiatric Inpatient Services A. Need, 1)**

Population by custom age range is available from the Department of Health, Division of Health Statistics. Please obtain this information so the bed need calculations by age group can be more accurate.

Please complete the following formulas:

Primary Service Area

Licensed Psychiatric Hospital Beds – Calculated Bed Need (Using 2018 Population Data) = Net Need/Surplus

Secondary Service Area

Licensed Psychiatric Hospital Beds – Calculated Bed Need (Using 2018 Population Data) = Net Need/Surplus

Response: On December 23, 2013 at 9:45am CST, the Applicant's outside legal counsel contacted the Department of Health, Division of Health Statistics and spoke with David Merchant. Mr. Merchant advised that he would work on getting the requested information, but that it would be impossible for him to provide this to the outside legal counsel before Friday, December 27, 2013 at the earliest. Accordingly, the Applicant is unable to respond to this question at the present time. The Applicant will respond to this

question under separate cover as soon as possible in the event the Division of Health Statistics is able to provide the information requested; however, if the Division of Health Statistics confirms that it is unable to provide the information requested, the Applicant respectfully requests that the information previously provided be deemed sufficient.

8. **Section C, Need, Item 1 a., (Project Specific Criteria-Psychiatric Inpatient Services C. Relationship to Existing Applicable Plans, 1)**

Please discuss whether the State Health Plan has goals and objectives related to acute inpatient psychiatric services.

Response: The State Health Plan does not specifically address any goals and objectives related to acute inpatient psychiatric services. However, one significant initiative listed in the State Health Plan relates to the Tennessee Department of Mental Health and Substance Abuse Services' (TDMHSAS') Three Year Plan. The plan establishes six goals to benchmark TDMHSAS' progress in better fulfilling its role as the state's mental health and substance use disorders authority. The six goals are as follows:

1. Tennesseans understand that behavioral health is essential to overall health;
2. Services are service recipient and family driven and youth guided;
3. Disparities in services are eliminated;
4. Early screening, assessment and referral to services are common practice;
5. Excellent services are delivered;
6. Technology is used to access services and information.

Although these goals are meant for TDMHSAS and not individual facilities, the Applicant currently and through its expansion will continue to strive to assist TDMHSAS in its achievement of these goals, including providing information about such goals as the Applicant continues to inform other providers, as well as members of the general public, about mental health.

9. **Section C. Need. Item 3 Service Area**

Please complete the following Table for the applicant facility

Response: Please see the chart below.

2012 Patient Origin by County

County	Admits/Discharges	% Total
Bedford	84	2.7
Giles	75	2.5
Lawrence	114	3.7
Lincoln	33	1.1
Marshall	78	2.6
Maury	291	9.5
Rutherford	273	8.9
Williamson	489	16.0
PSA Subtotal	**1,437**	**47.0%**
Coffee	141	4.6
Davidson	477	15.6
Dickson	84	2.8
Montgomery	105	3.4
Sumner	123	4.0
SSA Subtotal	**930**	**30.4%**
Total (PSA&SSA)	**2,367**	**77.4%**
Satellite counties	688	22.6%
Total ALL	**3,055**	**100%**

10. Section C. Need. Item 4 Service Area Demographics

Using current and projected population data from the Department of Health; and the most recent enrollee data from the Bureau of TennCare and demographic information from the US Census Bureau, complete the following table and include data for each county in your proposed service area:

Response: Please see the chart below.

Demographic Variable/ Geographic Area	Total Population-2014	Total Population-2018	Total Population-% change	Age 18-64 Population 2014	Age 18-64 Population 2018	Age 18-64 Population-% change	Age 18-64 Population- 2018 as % of Total	Median Age	Median Household Income	TennCare Enrollees	TennCare Enrollees as % of Total
Bedford	49,718	52,814	6.23%	30,998	32,735	5.6%	62.0%	36.4	$ 39,635	10,767	21.7%
Giles	30,390	30,865	1.56%	18,904	18,956	0.3%	61.4%	42.1	$ 38,014	5,180	17.0%
Lawrence	43,330	44,485	2.67%	26,089	26,435	1.3%	59.4%	39.7	$ 36,663	8,435	19.5%
Lincoln	34,548	35,282	2.12%	20,839	20,766	-0.4%	58.9%	41.8	$ 40,904	6,296	18.2%
Marshall	31,640	32,937	4.10%	20,314	20,819	2.5%	63.2%	38.9	$ 40,687	5,392	17.0%
Maury	86,179	89,978	4.41%	55,078	56,464	2.5%	62.8%	38.4	$ 45,603	14,601	16.9%
Rutherford	266,111	283,020	6.35%	175,991	183,730	4.4%	64.9%	32.2	$ 55,105	36,781	13.8%
Williamson	192,419	207,706	7.94%	128,132	136,544	6.6%	65.7%	38.5	$ 91,146	8,441	4.4%
PSA Sub-Total	*734,335*	*777,087*	*4.42%*	*476,343*	*496,447*	*4.2%*	*63.9%*	*38.5*	*$ 48,470*	*95,894*	*13.1%*
Coffee	55,790	57,676	3.38%	34,037	34,737	2.1%	60.2%	39.7	$ 38,151	11,040	19.8%
Davidson	609,905	627,067	2.81%	394,208	397,815	0.9%	63.4%	33.9	$ 46,676	119,726	19.6%
Dickson	50,860	52,861	3.93%	31,701	32,458	2.4%	61.4%	38.7	$ 45,109	8,939	17.6%
Montgomery	163,381	171,666	5.07%	106,299	111,745	5.1%	65.1%	30.0	$ 49,459	23,540	14.4%
Sumner	166,801	174,631	4.69%	105,384	108,088	2.6%	61.9%	38.6	$ 55,560	23,207	13.9%
SSA Sub-Total	*1,046,737*	*1,083,901*	*3.83%*	*671,628*	*684,842*	*2.0%*	*63.2%*	*36.3*	*$ 46,991*	*186,452*	*17.8%*
Grand Total	1,781,072	1,860,988	4.25%	1,147,971	1,181,289	2.9%	63.5%	*37.6*	$ 95,461	282,346	15.9%
Tennessee	**6,470,546**	**6,674,061**	**3.15%**	**4,070,487**	**4,119,326**	**1.2%**	**61.7%**	**38.0**	**$ 44,140**	**1,198,663**	**18.5%**

Sources:

Total Population 2014 - Tennessee Population Projections, 2010-2020, Division of Health Statistics, Tennessee Department of Health, 2008 Revision at http://health.state.tn.us/statistics/PdfFiles/PopProj2010_2020Full.pdf

Total Population 2018 - Tennessee Population Projections, 2010-2020, Division of Health Statistics, Tennessee Department of Health, 2008 Revision at http://health.state.tn.us/statistics/PdfFiles/PopProj2010_2020Full.pdf

Age 18-64 Population - As noted in the original application, the Tennessee Department of Health Population Projections do not break down age categories from 18-64 years of age. Accordingly, the application has included 50% of the 15-19 years of age population number for the given year in its calculations

Age 20-64 Population - Tennessee Population Projections, 2010-2020, Division of Health Statistics, Tennessee Department of Health, 2008 Revision at http://health.state.tn.us/statistics/PdfFiles/PopProj2010_2020Full.pdf

Median Age - Census 2010 SF1 Table P13 Median Age by Male/Female at Cubit Planning - http://www.tennessee-demographics.com/<COUNTYNAME>-county-demographics

Median Household Income - United States Census Quick Facts by State/County, Median Household income and persons below poverty level percentage (2008-20012) at Cubit Planning - http://www.tennessee-demographics.com/<COUNTYNAME>-county-

TennCare Enrollees - As of September 2013 -- TennCare 2013 Enrollment Data Report available at http://www.tn.gov/tenncare/EnrollmentData/fte 201309.XLS

132

SUPPLEMENTAL- # 1
December 26, 2013
12:16pm

11. Section C, Need, Item 5.

Please complete the following chart:

Response: Please see the chart below.

Hospital	Beds	2010	2010	2010	2010	2011	2011	2011	2011	2012	2012	2012	2012
		Admits	Pat. Days	ALOS	% Occ.	Admits	Pat. Days	ALOS	% Occ.	Admits	Pat. Days	ALOS	%Occ.
Hillside	14	167	3,404	20	67%	138	2,977	21.57	58%	277	3,633	13.12	71%
Lincoln	10	133	3,060	23	84%	116	2,646	22.81	72%	161	2,369	14.71	65%
Rolling Hills	66	2,637	20,216	7.7	84%	2,866	21,739	7.59	90%	3,067	22,705	7.40	94%
PSA Subtotal	90	2,937	26,680	9.08	81%	3,120	27,362	8.77	83%	3,505	28,707	8.19	87%
Centennial	132	4,629	50,840	10.98	106%	3,192	34,808	10.90	72%	3,122	30,460	9.76	63%
MTMHI	245 (195 in 2011 and 2012)	3,102	64,865	20.91	73%	2,745	59,577	21.70	84%	2,881	60,614	21.04	85%
St. Thomas	15 (23 in 2012)	254	4,855	19.11	89%	254	4,979	19.60	91%	279	5,761	20.65	69%
Skyline	110	2,548	19,418	7.62	48%	2,860	22,909	8	57%	2,834	22,152	7.82	55%
Summit	20	565	3,892	6.89	53%	782	5,003	6.4	66%	695	4,449	6.4	61%
Vanderbilt	88	3,127	24,500	7.83	76%	3,176	26,760	8.43	83%	3,373	28,201	8.36	88%
BHC-Clarksville	26	64	982	15	10%	280	4,123	14.73	43%	250	4,766	19.06	
Sumner	0 (12 in 2012)	20	79	3.95	N/A	21	103	4.9	N/A	89	1,167	13.11	27%
SSA Subtotal	636 (586 in 2011; 606 in 2012)	14,309	169,431	11.84	73%	13,310	158,262	11.89	74%	13,523	157,570	11.65	71%
TOTAL	726 (676 in 2011; 696 in 2012)	17,246	196,111	11.37	74%	16,430	185,624	11.3	75%	17,028	186,277	10.94	73%

133
SUPPLEMENTAL- # 1
December 26, 2013
12:16pm

Psychiatric patient origin data for area hospitals can be obtained from hospital discharge data available from the Department of Health, Division of Health Statistics. Please request patient destination MDC 19 discharge data, Age 18-64, for the most recent year available so the following two charts can be completed:

Adult Psychiatric Patient Hospital Destination for Primary Service Area Residents

*Hospital	# Discharges	%Total
Hospital 1		
Hospital 2		
Etc.		

**List Each Hospital*

Adult Psychiatric Patient Hospital Destination for Secondary Service Area Residents

*Hospital	# Discharges	%Total
Hospital 1		
Hospital 2		
Etc.		

**List Each Hospital*

Response: On December 23, 2013 at 9:45am CST, the Applicant's outside legal counsel contacted the Department of Health, Division of Health Statistics, per the instruction set forth in the question above. The representative with whom outside legal counsel spoke, George Wade, advised that he has only received three such requests and that the information we requested must first be approved by legal counsel for the Division of Health Statistics. Mr. Wade is working with the Director of the Division of Health Statistics to gather the requested information, but he advised that he would not be able to provide a response to the Applicant's outside legal counsel until Friday, December 27, 2013 at the earliest. Accordingly, the Applicant is unable to respond to this question at the present time. The Applicant will respond to this question under separate cover as soon as possible in the event the Division of Health Statistics is able to provide the information requested; however, if the Division of Health Statistics confirms that it is unable to provide the information requested, the Applicant respectfully requests that the information previously provided be deemed sufficient.

12. Section C, Need, Item 6

Please see the chart below, and note that the increases are predominantly in the area of Adult Psychiatric Utilization, as the additional beds being sought by the Applicant are for additional adult beds, but the changes in programming and configuration which the additional beds will allow also results in some increase in the areas of child/adolescent and geriatric.

Projected Utilization Details

Facility	Beds	Year 1	Year 1	Year 1	Year 1	Year 2	Year 2	Year 2	Year 2
		Admits	Pat. Days	ALOS	%Occ.	Admits	Pat. Days	ALOS	%Occ.
Rolling Hills	120	3,769	29,565	7.8	68%	4,137	32,376	7.8	74%

Historical And Projected Child/Adolescent Psychiatric Utilization

Facility	Beds	2010	2011	2012	Year 1	Year 2	2010	2011	2012	Year 1	Year 2
		Patient Days	Patient Days	Patient Days	Patient Days	Patient Days	%Occ.	%Occ.	%Occ.	%Occ	%Occ
Rolling Hills	80/120*	3,750	4,740	4,682	4,942	5,066	57%	72%	71%	52%	53%

*Historical data is calculated based on the Applicant's 80 currently licensed beds. The projected data is calculated based on 120 beds, the number of total licensed beds if the project is approved.

Historical And Projected Adult Psychiatric Utilization

Facility	Beds	2010	2011	2012	Year 1	Year 2	2010	2011	2012	Year 1	Year 2
		Patient Days	Patient Days	Patient Days	Patient Days	Patient Days	%Occ.	%Occ.	%Occ.	%Occ	%Occ
Rolling Hills	80/120*	11,260	14,524	15,404	20,711	23,300	86%	81%	86%	81%	91%

*Historical data is calculated based on the Applicant's 80 currently licensed beds. The projected data is calculated based on 120 beds, the number of total licensed beds if the project is approved.

Historical And Projected Geriatric Psychiatric Utilization

Facility	Beds	2010	2011	2012	Year 1	Year 2	2010	2011	2012	Year 1	Year 2
		Patient Days	Patient Days	Patient Days	Patient Days	Patient Days	%Occ.	%Occ.	%Occ.	%Occ	%Occ
Rolling Hills	80/120*	5,216	2,475	2,619	3,912	4,010	55%	52%	55%	45%	46%

*Historical data is calculated based on the Applicant's 80 currently licensed beds. The projected data is calculated based on 120 beds, the number of total licensed beds if the project is approved.

13. Section C. Economic Feasibility Item 1 (Project Cost Chart)

The letter from the architect is noted. Please provide a revised letter that addresses the following: Please provide documentation from a licensed architect or construction professional:

1) a general description of the project,

2) his/her estimate of the cost to construct the project to provide a physical environment, according to applicable federal, state and local construction codes, standards, specifications, and requirements and

3) attesting that the physical environment will conform to applicable federal standards, manufacturer's specifications and licensing agencies' requirements including the new 2010 AIA Guidelines for Design and Construction of Hospital and Health Care Facilities.

The architect's letter indicates that the construction cost will be $7,807,885 while the Project Costs Chart lists construction costs at $7,179,765. Please address this discrepancy.

Response: Please see Supplemental Attachment Section C. Economic Feasibility, Item 1 (Project Cost Chart) for a revised letter from the architect. With respect to the discrepancy in construction cost, the Project Cost Chart breaks the construction cost into two line items (lines 4 and 5, respectively). If you combine the sum of lines 4 and 5, being construction costs [$7,179,765] and site prep costs [$628,120], the total is $7,807,885.00.

14. Section C. Economic Feasibility Item 3

The applicant's construction cost per square foot of $337.00 per square foot which is above the third quartile of previously approved projects. Hospitals with higher project costs typically provide rationale for the higher costs that include shielding for imaging and air/gas intakes/outtakes for surgery, etc. Since this project does not appear to have any extraordinary building requirements please explain the higher than normal construction costs for the proposed project.

Response: The actual construction cost per square foot is $257.05 ($7,807,885 / 30,375 square feet). The $337.00 per square foot is the ratio of the total project cost to the square footage. Therefore, the construction cost per square foot is not, in fact, above the third quartile of previously approved projects. Additionally, the Applicant would note that the addition must incorporate costly materials and hardware to address the patients' safety needs. These materials and hardware include impact resistant drywall, antiligature door hardware, vandal resistant windows and light fixtures, antiligature HVAC grilles and diffusers, specialized toilet accessories and fixtures that help prevent self harm, and other similarly designed hardware and fixtures Each of these materials have a premium cost associated with them but are consistent with UHS' approach to safety in all of their facilities nationwide, and consistent with the type of hardware, fixtures and finishes used in the existing facility. Furthermore, in tying into an existing new structure there is a need to match the existing structure and therefore building materials such as brick and accent metals must be used to fit the addition in with the look and feel of the existing campus. Finally, as the site is sloped it therefore requires additional two story structure and circulation (stairs and elevators) cost to incorporate the addition into the sloping site.

15. Section C. Economic Feasibility Item 4. (Historical Data Chart)

There appears to be calculation errors in the CY 2011 and CY 2012 columns. Please make the necessary corrections and submit a revised Historical Data Chart

Response: Please see Supplemental Attachment – Section C. Economic Feasibility, Item 4. for a revised Historical Data Chart.

Please explain why the applicant has reported a net operating loss in excess of $2 million in both 2012 and 2012.

Response: Rolling Hills Hospital was acquired by UHS in November of 2010 through a series of acquisitions. UHS provides a variety of management and shared services and capital resources to its facilities, which are operated through wholly-owned subsidiaries. By providing such services and resources on a centralized basis, the ultimate costs are reduced. Fees and expenses are allocated to the facilities based upon the nature and extent of such services provided or capital rendered during the year. Each facility is then charged for these costs based on allocation methods determined by UHS management. The net operating losses incurred by the Applicant in 2011 and 2012 are a result of the corporate allocation for such management support and capital charges. The facility produced in excess of $2.8 million in NOI for the time period in question prior to the allocation of such corporate "home office" costs.

Please complete the following chart for the individual "other expenses" on Line D.9.

HISTORICAL DATA CHART-OTHER EXPENSES

	OTHER EXPENSES CATEGORIES	2010	2011	2012
1	Employee Benefits	$ 1,004,663	$1,112,532	$ 1,081,944
2	Purchased Services	$ 941,187	$548,448	$ 936,915
3	Maintenance	$ 261,624	$203,818	$ 256,439
4	Insurance	$ 218,157	$181,516	$ 146,188
5	Travel/Education/Dues	$ 61,897	$ 92,314	$ 66,833
6	Other Expenses	$ 658,858	$ 573,775	$ 583,240
7	Non-Allocated	$ 562,484	$ 217,822	$ 275,422
	Total Other Expenses	**$3,708,870**	**$2,930,225**	**$3,346,981**

16. Section C. Economic Feasibility Item 4. (Projected Data Chart)

There appears to be calculation errors in both the CY 2015 and CY 2016 columns. Please make the necessary corrections and submit a revised Projected Data Chart

Response: Please see Supplemental Attachment – Section C. Economic Feasibility, Item 4. for a revised Projected Data Chart.

Please explain in detail what factors will be in play to take a facility that has reported a net operating loss of $2,495,104 in 2012 to reporting a net operating income by the second year after project completion.

Response: As noted in the response above, the net operating losses incurred by the Applicant in 2011 and 2012 are a result of the corporate allocation for management support and capital charges, and the facility actually produced a positive NOI for the times period in question prior to the allocation of such corporate "home office" costs.

Please complete the following chart for the individual "other expenses" on Line D.9.

PROJECTED DATA CHART-OTHER EXPENSES

	OTHER EXPENSES CATEGORIES	2015	2016
1	Employee Benefits	$ 1,544,689	$ 1,762,063
2	Purchased Services	$ 1,057,857	$ 1,143,574
3	Maintenance	$ 331,638	$ 331,638
4	Insurance	$ 181,352	$ 197,233
5	Travel/Education/Dues	$ 62,304	$ 63,675
6	Other Expenses	$ 680,699	$ 712,746
7	Non-Allocated	$ 119,285	$ 121,671
	Total Other Expenses	**$3,977,824**	**$4,004,433**

Note: Projected "Other Expenses" provided in the above chart are based on 120 beds.

Please complete a Projected Data Chart for the 40 bed addition.

Response: Please see Supplemental Attachment – Projected Data Chart for 40 Bed Addition.

17. Section C, Economic Feasibility, Item 6.B.

Using data from page 32 and 33 of the 2012 Joint Annual Report, please complete the following chart:

Response: Please see the chart below.

Hospital	Average Gross Charge per Patient Day	Average Deduction per Patient Day	Average Net Charge per Patient Day
Hillside	$2330.40	$1451.20	$879.28
Lincoln	$1816.22	$776.37	$1039.85
Centennial	$4294.12	$2572.02	$1209.52
MTMHI*	0	0	0
St. Thomas	$2054.52	$1252.13	$802.38

SUPPLEMENTAL- # 1
December 26, 2013
12:16pm

Skyline*	0	0	0
Summit*	0	0	0
Vanderbilt	$2233.56	$1389.11	$844.45
BHC-Clarksville	$1040.02	$289.92	$750.10
Sumner	$1636.19	$840.11	$796.09

Note: Pages 32 and 33 of the 2012 JARs for these facilities were not populated.

18. Section C, Economic Feasibility, Item 9.

Your response to this item is noted. Using information from page 33 of the Joint Annual Report, please complete the following chart

Please complete the following chart.

Response: Please see the below chart.

Hospital	Medicare total gross revenue as a % of Total	TennCare/Medicaid Gross Revenue as a % of Total
Hillside	100%	0%
Lincoln	97.7%	0%
Centennial	74.1%	0.08%
MTMHI	0%	0%
St. Thomas	99.1%	0.3%
Skyline	0%	0%
Summit	0%	0%
Vanderbilt	25.6%	30.2%
BHC-Clarksville	100%	0%
Sumner	100%	0%

Note: Data taken from 2012 Joint Annual Reports.

19. Section C, Economic Feasibility, Item 10

Your response to this item is noted. Please provide the most recent audited financial statements with accompanying notes for the parent company that will be funding the proposed project.

Response: Please see Supplemental Attachment C – Economic Feasibility, Item 10, for a copy of Universal Health Services, Inc.'s most recent audited financial statements with accompanying notes.

20. Section C, Contribution to Orderly Development, Item 3

Please explain the following acronyms in the staffing table: ITP, CD, EPOB, ECT, and IOP.

Response: The above-referenced acronyms have the following meanings:

- ITP – Intensive Treatment Program
- CD – Chemical Dependency
- EPOB – Employees per Occupied Bed
- ECT – Electroconvulsive Therapy
- IOP – Intensive Outpatient Program

What is the clinical staffing in FTEs for the additional 40 beds?

Response: The Anticipated Staffing Pattern chart provided on page 53 of the original application is for the additional 40 beds only, not the entire 120 bed facility. Clinical staffing is as follows:

	Schedule of New FTEs	Year 1 2015 Total	Year 2 2016 Total	Year 3 2017 Total	Year 4 2018 Total	Year 5 2019 Total
	ITP Nursing EPOB	1.17	1.22	1.11	1.13	1.10
	CD Nursing EPOB	1.65	1.16	1.11	1.10	1.11
	Nursing/Clinical EPOB	1.45	1.43	1.31	1.32	1.31
40901	ITP Unit	9.8	14.7	15.9	19.0	21.1
41101	CD Unit	9.2	9.2	10.7	12.3	14.2
40100	Nursing Admin		0.5	0.5	0.5	1.0
40050	Orientation	0.3	0.4	0.4	0.5	0.5
78100	Activity therapist		0.4	0.4	0.5	0.6
79350	Social Services	1.0	2.2	2.2	2.8	3.3
83900	Pharmacy		1.3	1.3	1.3	1.3

21. Project Completion Chart

Are the days required based on the assumption that the application will be heard at the Agency's March 26, 2014 meeting?

Response: Yes. The estimation of the days required in the Project Completion Chart are based on the assumption that the application will be heard at the Agency's March 26, 2014 meeting.

22. 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: Please see Supplemental Attachment – Proof of Publication for a copy of a Publication Affidavit from The Tennessean.

SUPPLEMENTAL- # 1
December 26, 2013
12:16pm

Supplemental Attachment – Section B, Project Description, Item II.A.

Square Footage and Cost Per Square Footage Chart (Line E.)

SUPPLEMENTAL- # 1
December 26, 2013
12:16pm

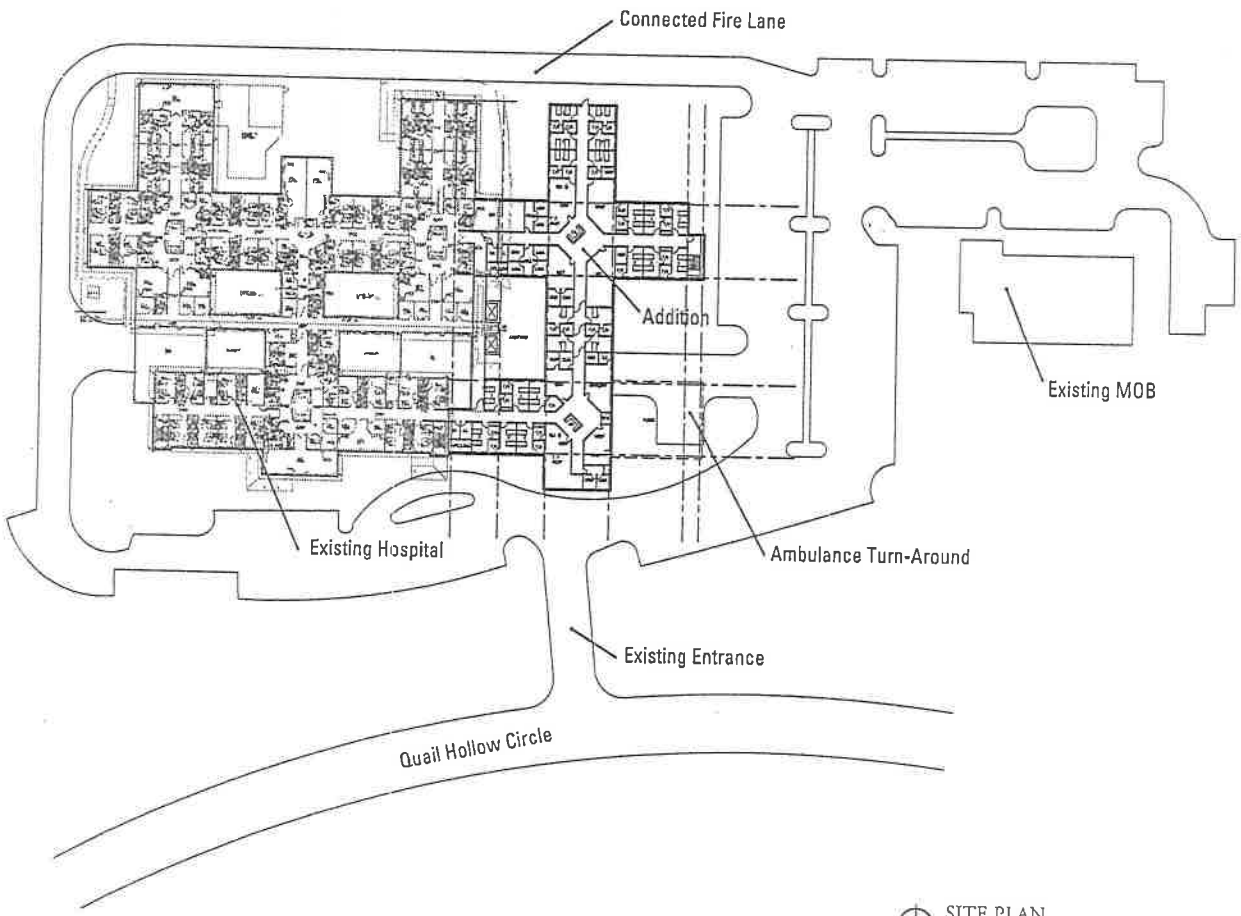
Supplemental Attachment – Section B, Project Description, Item B.IV

First Floor Plan; "Zoomed In" View of First and Second Floor Plans

SUPPLEMENTAL - # 1
December 26, 2013
12:16pm

144

Rolling Hills Hospital's campus property is 16.38 acres. The property is bordered to the south by Hwy. 96, and to the west by Quail Hollow Circle.



JJCA

An Addition To
Rolling Hills Hospital
2010 Quail Hollow Circle, Franklin, Tennessee

Johnson Johnson Cabaret Architects

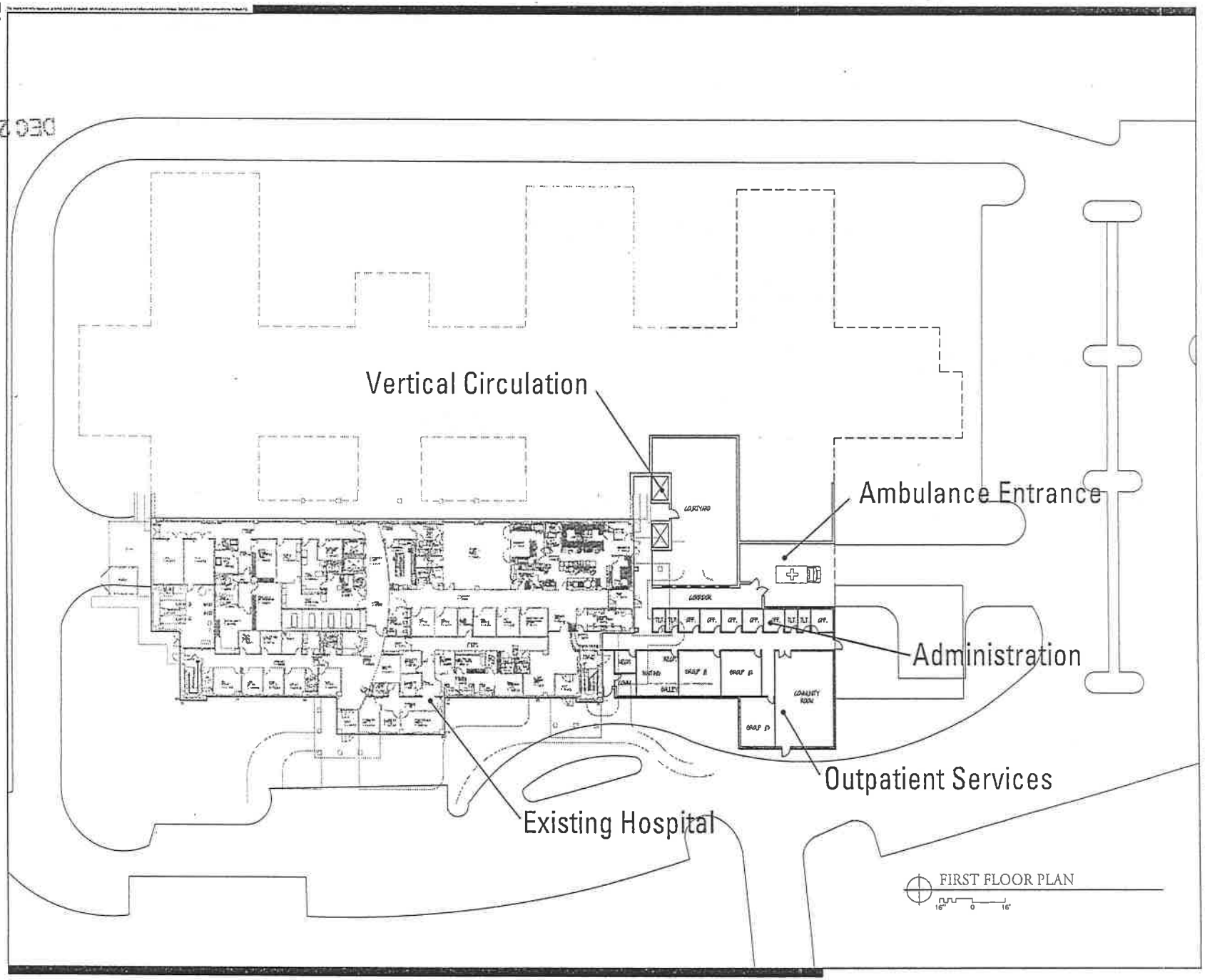
UHS

PROJECT NUMBER
09515.28
DATE
November 2013

A0.0

Site Plan

SUPPLEMENTAL # 1
December 26, 2013
12:16pm
DEC 26 '13 12:16
145



JJCA

An Addition To
Rolling Hills Hospital
2010 Quail Hollow Circle, Franklin, Tennessee

Johnson Johnson Crabtree Architects

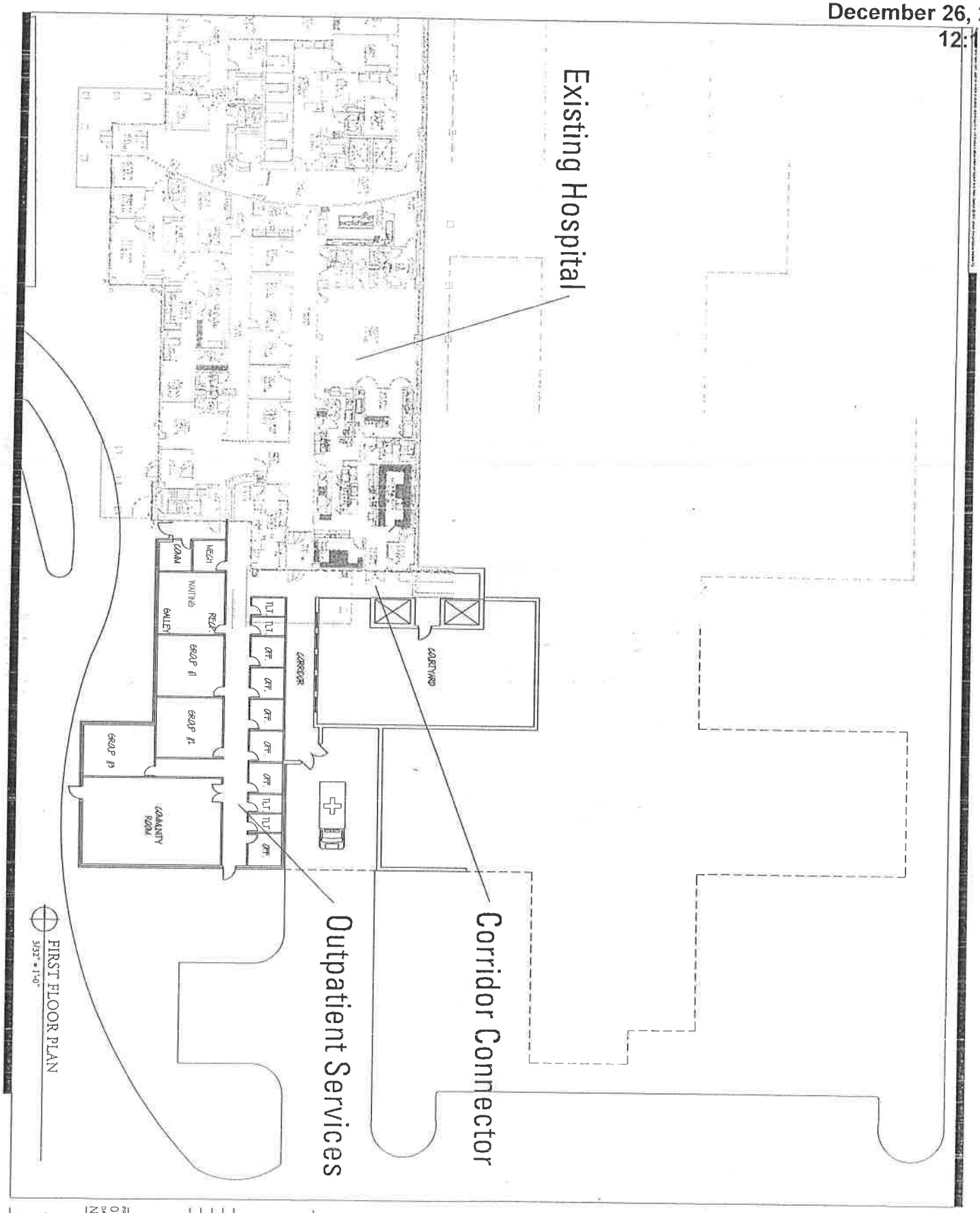
UHS

PROJECT NUMBER
09515.28
DATE
November 2013

A1.0

FIRST FLOOR

SUPPLEMENTAL- # 1
December 26, 2013
12:16pm



JJCA

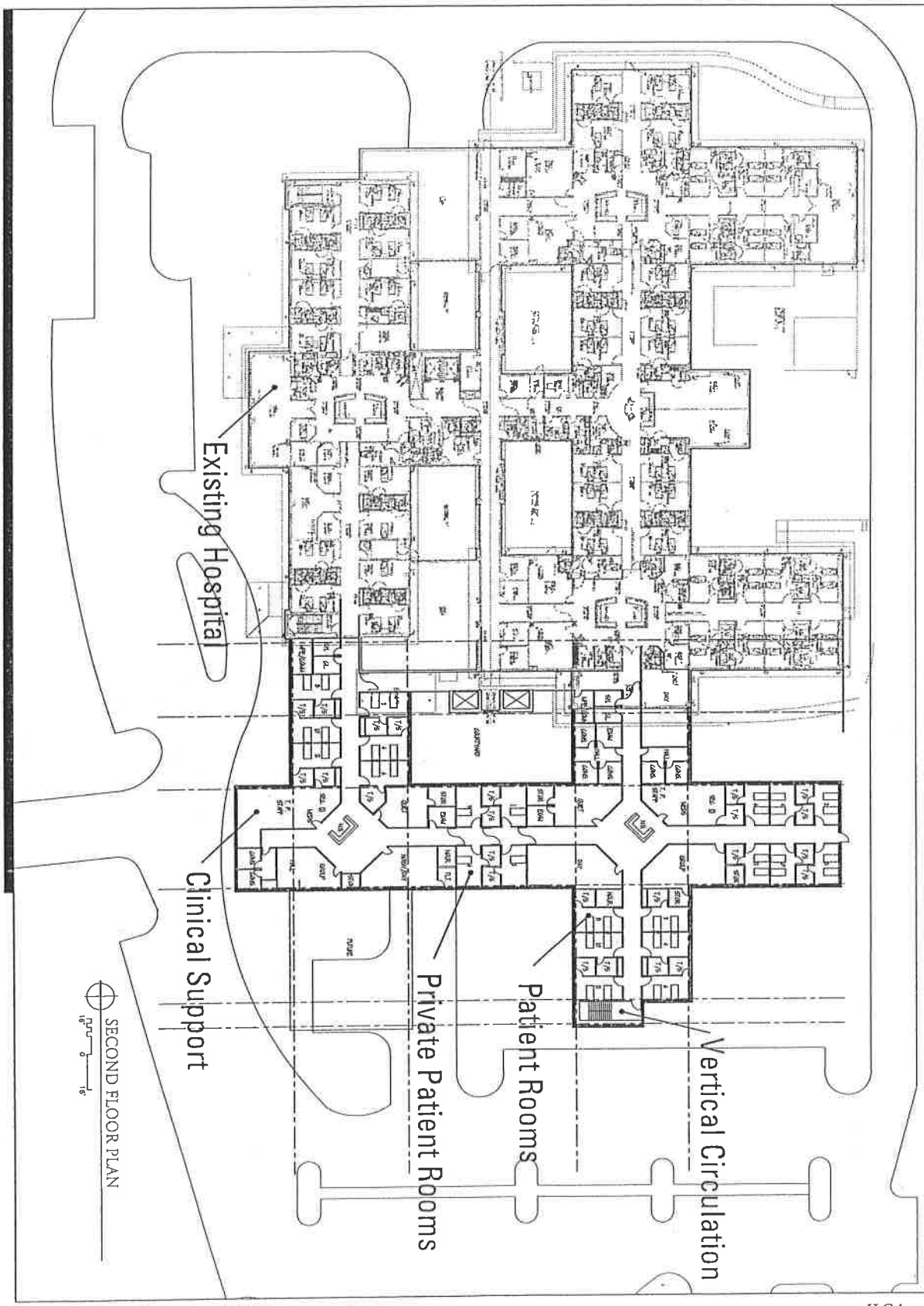
An Addition To
Rolling Hills Hospital
2010 Quail Hollow Circle, Franklin, Tennessee

Johnson Johnson Graduate Architects

PROJECT NUMBER
09515.28
DATE
November 2013

A1.1
ENLARGED FIRST FLOOR

SUPPLEMENTAL- # 1
December 26, 2013
12:16pm



SECOND FLOOR PLAN

JJCA

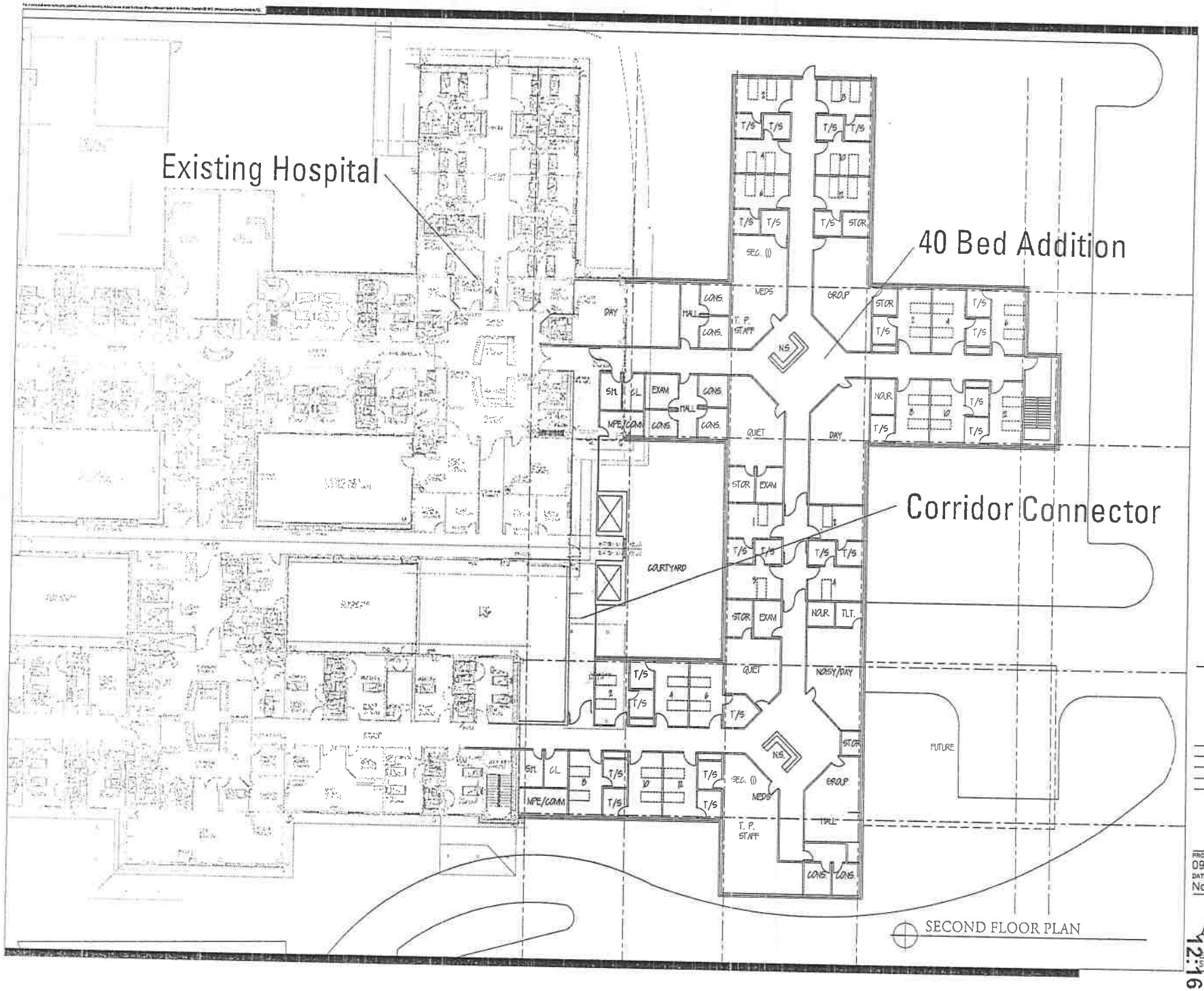
An Addition To
Rolling Hills Hospital
2010 Quail Hollow Circle, Franklin, Tennessee

Johnson Johnson Crabtree Architects

UHS

PROJECT NUMBER
09515.28
DATE
November 2013

A2.0
SECOND FLOOR



JJCA

An Addition To

Rolling Hills Hospital

2010 Quail Hollow Circle, Franklin, Tennessee

Johnson Johnson Crabtree Architects

UHS

SUPPLEMENTAL #1

December 26, 2013

12:16pm

PROJECT NUMBER 0951128

DATE November 2013

ENLARGED SECOND FLOOR

A2

SUPPLEMENTAL- # 1
December 26, 2013
12:16pm

Supplemental Attachment – Section C. Economic Feasibility, Item 1

Revised Letter from Architect

SUPPLEMENTAL- # 1
December 26, 2013
12:16pm

JJCA

Memorandum

Date: 12/23/2013

To:	Richard Clark - Rolling Hills Hospital
Cc:	Rachael Spangler - JJCA;James Gore - UHSI
From:	David Brown - JJCA
Project:	Universal Health Services - Rolling Hills Hospital - Franklin TN (09515.28) - CON Planning (00)
Owner Project #:	
Subject:	Design Factors for 40 Bed Addition-Revised

The design and layout of the new 40 Bed Addition to the Rolling Hills Hospital Campus will be a natural extension of the existing structure and aesthetic. The design will endeavor to incorporate the applicable rules and regulations pertaining to design and construction including the 2010 FGI Guidelines for Design and Construction of Healthcare Facilities, the 2006 NFPA 101 Life Safety Code, the 2009 Body of International Building Codes, and the local rules and regulations of the City of Franklin.

The structure will be non-combustible (IBC, I-2, Type IB), rated and fireproofed steel structure that is fully sprinklered. The interior and exterior walls will be constructed of light gauge steel framing and type X gypsum board. The exterior veneer will be a combination of brick and EIFS along with metal trim and accents. The windows will be constructed of aluminum frames and insulated glazing panels as well as laminated safety glazing (for patient safety). The roof will be internally drained EPDM or TPO adhered roofing material. The HVAC systems will be designed to meet the applicable energy codes.

The addition's configuration is a result of accommodating several factors pertaining to the existing site topography, attaching to the existing structure and addressing existing operational needs. We have listed these factors below with our proposed approach to addressing each of these factors:

- Existing Site Topography – The existing site slopes heavily uphill from west to east. In addition an embankment creates a boundary for the hospital on the north and east property lines. The relatively shallow lot requires a building of any significant size to conform to the site topography in order to maximize its use. The existing design accomplished this by creating a 2-story structure on the west end of the site and a one story structure on the east end of the site. The existing patient units therefore exit to grade which creates an ideal situation for on grade outdoor courts, an important component for behavioral healthcare. As we developed the new addition design it was important to address these existing site features in a similar methodology in order to create a homogenous look and design approach between new and existing and create similar outdoor courts for the new patient population.

- Existing Structure/ Building Configuration – As mentioned in the factor above, the existing structure responds to the sloping site. The existing building has grade level public entrances on the west end with patient units on an upper floor exiting to grade on the east end. Our addition continues this design approach and increases security and efficiency by using the existing entrance as a combined outpatient entrance point and allowing for a discrete ambulance entrance into a secure corridor on the first floor. On the second floor the patient units are continued and feed from the staff/patient access corridor on the second floor. The

Johnson Johnson Crabtree Architects P.C.
4551 Trousdale Dr.
Nashville, TN 37204
tel 615-837-0656
fax 615-837-0657

addition of an elevator to the new design allows the efficient movement of food, supplies, and patients to the south end of the building.

- Operational Needs - In developing a viable addition, the facility requested that we address three primary needs: 1) Outpatient Program Space, 2) 40 Added beds with the ability to adapt unit sizes for various populations and future flexibility, 3) Continuous space to minimize travel distance to the new units. Each of these operational needs is addressed in the design. The Outpatient Program is located on the first floor. Clients will be able to enter the existing admitting entrance, be received and led back to their own discrete therapy space. The Outpatient Program will include a large community room allowing the facility to host community outreach and education programs centered on behavioral health. The added 40 beds are divided into two distinct units connected by a wing that will be designed to flex between the two units so that the units can be continually customized based on census and the patients' needs. The new addition is contiguous to the existing units. This allows staff to go from unit to unit to back each other up when needed. The new addition is fed from the same common corridor and makes circulation on the floor very simple and easy to navigate. Travel distance to the new unit is not much greater that travel time to the existing units through the positioning of the new addition and the addition of an elevator to serve the south end of the building.

Other alternatives for growth were considered on the campus, but determined not workable or feasible. They are as follows:

- Adding on the end of existing wings – At first glance, adding beds to the ends of each existing unit appears to be a viable solution. However, due to the adjacent north and east property line, required setbacks and fire lanes, adding to these wings is not possible. Furthermore, adding beds would require adding existing activity and therapy space which is currently located in the middle of the existing second floor. This type of retrofit can be very disruptive and difficult to construct.

- Standalone structure – the addition of a standalone unit, not attached to the existing structure could be explored and could take advantage of a single story design. However, operationally this would be a costly option since food service, supplies, and staffing would all have to go between two buildings. In addition, with a finite amount of acreage for developing, the setbacks and separation required for a standalone structure would use the site in a much less

SUPPLEMENTAL- # 1
December 26, 2013
12:16pm

efficient manner.

As we continue in our design efforts after CON approval we may find other factors that drive the design and we may chose to address the above factors differently. However, for this point in development our design attempts to appropriately address each of the factors in a economical and efficient manner while still allowing for growth and flexibility for the future.

SUPPLEMENTAL- # 1
December 26, 2013
12:16pm

Supplemental Attachment – Section C, Economic Feasibility, Item 10.

Most Recent Audited Financials of Universal Health Services, Inc.

SUPPLEMENTAL- # 1
December 26, 2013
12:16pm

UNIVERSAL HEALTH SERVICES, INC.

INDEX TO FINANCIAL STATEMENTS
AND FINANCIAL STATEMENT SCHEDULE

Consolidated Financial Statements:

Report of Independent Registered Public Accounting Firm	99
Consolidated Statements of Income for the three years ended December 31, 2012	100
Consolidated Statements of Comprehensive Income for the three years ended December 31, 2012	101
Consolidated Balance Sheets as of December 31, 2012 and 2011	102
Consolidated Statements of Changes in Equity for the three years ended December 31, 2012	103
Consolidated Statements of Cash Flows for the three years ended December 31, 2012	106
Notes to Consolidated Financial Statements	107
Supplemental Financial Statement Schedule II: Valuation and Qualifying Accounts	158

Table of Contents

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the Board of Directors and Stockholders of Universal Health Services, Inc.:

In our opinion, the consolidated financial statements listed in the accompanying index present fairly, in all material respects, the financial position of Universal Health Services, Inc. and its subsidiaries at December 31, 2012 and 2011, and the results of their operations and their cash flows for each of the three years in the period ended December 31, 2012 in conformity with accounting principles generally accepted in the United States of America. In addition, in our opinion, the financial statement schedule listed in the accompanying index presents fairly, in all material respects, the information set forth therein when read in conjunction with the related consolidated financial statements. Also in our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2012, based on criteria established in *Internal Control—Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). The Company's management is responsible for these financial statements, financial statement schedule, and for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in item 9A as *Management's Report on Internal Control over Financial Reporting*. Our responsibility is to express opinions on these financial statements, on the financial statement schedule, and on the Company's internal control over financial reporting based on our integrated audits. We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free of material misstatement and whether effective internal control over financial reporting was maintained in all material respects. Our audits of the financial statements included examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. Our audit of internal control over financial reporting included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, and testing and evaluating the design and operating effectiveness of internal control based on the assessed risk. Our audits also included performing such other procedures as we considered necessary in the circumstances. We believe that our audits provide a reasonable basis for our opinions.

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

As described in *Management's Report on Internal Control over Financial Reporting*, management has excluded Ascend Health Corporation and its subsidiaries from its assessment of internal control over financial reporting as of December 31, 2012 because it was acquired by the Company in a purchase business combination during 2012. We have also excluded Ascend Health Corporation from our audit of internal control over financial reporting. Ascend Health Corporation and its subsidiaries are wholly owned subsidiaries whose total assets and total revenues represent 6% and 1%, respectively, of the related consolidated financial statement amounts as of and for the year ended December 31, 2012.

/s/ PricewaterhouseCoopers LLP

Philadelphia, Pennsylvania
February 28, 2013

155
SUPPLEMENTAL- # 1
December 26, 2013
12:16pm

Table of Contents

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF INCOME

	Year Ended December 31,		
	2012	2011	2010
	(in thousands, except per share data)		
Net revenues before provision for doubtful accounts	$ 7,688,071	$ 7,356,798	$ 5,429,233
Less: Provision for doubtful accounts	726,671	596,576	529,086
Net revenues	6,961,400	6,760,222	4,900,147
Operating charges:			
Salaries, wages and benefits	3,440,917	3,326,378	2,363,3[illegible]
Other operating expenses	1,376,122	1,353,693	968,6[illegible]
Supplies expense	799,621	805,489	716,9[illegible]
Depreciation and amortization	302,426	287,211	216,9[illegible]
Lease and rental expense	94,885	90,323	75,3[illegible]

Transaction costs	5,716	0	53,220
Electronic health records incentive income	(30,038)	0	0
Costs related to extinguishment of debt	29,170	0	0
Income from operations	6,018,819	5,863,094	4,394,433
Interest expense, net	942,581	897,128	505,714
Income before income taxes	178,918	200,792	77,617
Provision for income taxes	763,653	696,336	428,097
Net income	274,616	247,466	152,302
Less: Net income attributable to noncontrolling interests	489,047	448,870	275,795
Net income attributable to UHS	45,601	50,703	45,612
Basic earnings per share attributable to UHS	$ 443,446	$ 398,167	$ 230,183
Diluted earnings per share attributable to UHS	$ 4.57	$ 4.09	$ 2.37
Weighted average number of common shares—basic	$ 4.53	$ 4.04	$ 2.34
Add: Other share equivalents	96,821	97,199	96,786
Weighted average number of common shares and equivalents—diluted	890	1,338	1,187
	97,711	98,537	97,973

The accompanying notes are an integral part of these consolidated financial statements.

Table of Contents

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME

	Year Ended December 31,		
	2012	2011	2010
Net income	$489,047	$448,870	$275,79
Other comprehensive income (loss):			

156
SUPPLEMENTAL- # 1
December 26, 2013
12:16pm

Unrealized derivative gains (losses) on cash flow hedges	6,677	(37,477)	1,396
Amortization of terminated hedge	(336)	(336)	(336)
Minimum Pension Liability	4,986	(12,397)	743
Other comprehensive income (loss) before tax	11,327	(50,210)	1,803
Income tax (benefit) expense related to items of other comprehensive income	4,306	(19,174)	689
Total other comprehensive income (loss), net of tax	7,021	(31,036)	1,114
Comprehensive income	496,068	417,834	276,909
Less: Comprehensive income attributable to noncontrolling interests	45,601	50,703	45,612
Comprehensive income attributable to UHS	$450,467	$367,131	$231,297

The accompanying notes are an integral part of these consolidated financial statements.

Table of Contents

157
SUPPLEMENTAL- # 1
December 26, 2013
12:16pm

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONSOLIDATED BALANCE SHEETS

	December 31, 2012	December 31, 2011
	(Dollar amounts in thousands)	
Assets		
Current assets:		
Cash and cash equivalents	$ 23,471	$ 41,229
Accounts receivable, net	1,067,197	969,802
Supplies	99,000	96,775
Deferred income taxes	104,461	108,324
Other current assets	87,936	99,859
Assets of facilities held for sale	25,431	48,916
Total current assets	1,407,496	1,364,905
Property and Equipment		
Land	387,248	377,984
Buildings and improvements	3,366,146	3,244,117
Equipment	1,344,643	1,256,165
Property under capital lease	27,836	37,037
	5,125,873	4,915,303
Accumulated depreciation	(1,986,110)	(1,818,180)
	3,139,763	3,097,123
Construction-in-progress	242,472	190,857
	3,382,235	3,287,980
Other assets:		
Goodwill	3,036,765	2,627,602
Deferred charges	75,888	111,780
Other	298,459	272,978
	3,411,112	3,012,360
	$ 8,200,843	$ 7,665,245
Liabilities and Stockholders' Equity		
Current liabilities:		
Current maturities of long-term debt	$ 2,589	$ 2,479
Accounts payable	247,033	228,043
Liabilities of facilities held for sale	850	2,329
Accrued liabilities		
Compensation and related benefits	259,646	233,583
Interest	10,774	10,622
Taxes other than income	49,829	45,359
Other	322,275	314,518
Current federal and state income taxes	1,062	0
Total current liabilities	894,058	836,933
Other noncurrent liabilities	395,355	401,908
Long-term debt	3,727,431	3,651,428
Deferred income taxes	183,747	209,592
Commitments and contingencies (Note 8)		
Redeemable noncontrolling interest	234,303	218,266
Equity:		
Class A Common Stock, voting, $.01 par value; authorized 12,000,000 shares: issued and outstanding 6,625,708 shares in 2012 and 6,625,708 shares in 2011	66	66
Class B Common Stock, limited voting, $.01 par value; authorized 150,000,000 shares: issued and outstanding 90,269,397 shares in 2012 and 89,286,305 shares in 2011	903	893
Class C Common Stock, voting, $.01 par value; authorized 1,200,000 shares: issued and outstanding 664,000 shares in 2012 and 664,000 shares in 2011	7	7

SUPPLEMENTAL - # 1
December 26, 2013
12:16pm

Class D Common Stock, limited voting, $.01 par value; authorized 5,000,000 shares: issued and outstanding 31,948 shares in 2012 and 33,164 shares in 2011	0	0
Cumulative dividends	(205,910)	(147,515)
Retained earnings	2,962,433	2,494,076
Accumulated other comprehensive loss	(44,154)	(51,175)
Universal Health Services, Inc. common stockholders' equity	2,713,345	2,296,352
Noncontrolling interest	52,604	50,766
Total Equity	2,765,949	2,347,118
	$ 8,200,843	$ 7,665,245

The accompanying notes are an integral part of these consolidated financial statements.

Table of Contents

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF CHANGES IN EQUITY

For the Years Ended December 31, 2012, 2011 and 2010

(in thousands, except per share data)

	Redeemable Interest	Class A Common	Class B Common	Class C Common	Class D Common	Capital in Excess of Par Value	Cumulative Dividends	Retained Earnings	Accumulated Other Comprehensive Income (Loss)	UHS Common Stockholders' Equity	Noncontrolling Interest	Total
Balance, January 1, 2010	$ 197,152	$ 67	$ 896	$ 7	$ 0	$ 0	($ 108,627)	$1,879,981	($ 21,253)	$ 1,751,071	$ 41,323	$1,792,394
Common Stock												
Issued/(converted) including tax benefits from exercise of stock options	—	—	4	—	—	—	—	10,890	—	10,894	—	10,894
Repurchased	—	—	(3)	—	—	—	—	(11,525)	—	(11,528)	—	(11,528)
Restricted share-based compensation expense	—	—	—	—	—	—	—	3,139	—	3,139	—	3,139
Dividends paid	—	—	—	—	—	—	(19,422)	—	—	(19,422)	—	(19,422)
Stock option expense	—	—	—	—	—	—	—	13,321	—	13,321	—	13,321
Distributions to noncontrolling interests	(23,777)	—	—	—	—	—	—	—	—	—	(8,662)	(8,662)
Capital contributions from noncontrolling interests	—	—	—	—	—	—	—	—	—	—	—	—
Purchase of minority ownership interests in majority owned businesses	—	—	—	—	—	—	—	—	—	—	600	600
Other	4,512	—	—	—	—	—	—	—	—	—	—	—
Comprehensive income:												
Net income	33,874	—	—	—	—	—	—	230,183	—	230,183	11,738	241,9[illegible]
Amortization of terminated hedge (net of income tax effect of $120)	—	—	—	—	—	—	—	—	(216)	(216)	—	(21[illegible]
Unrealized derivative losses on	—	—	—	—	—	—	—	—	868	868	—	8[illegible]

159
SUPPLEMENTAL - # 1
December 26, 2013
12:16pm

cash flow hedges (net of income tax effect of $528)	—	—	—	—	—	—	—	—	462	462	—	462
Minimum pension liability (net of income tax effect of $281)	33,874	—	—	—	—	—	—	230,183	1,114	231,297	11,738	243,035
Subtotal—comprehensive income	211,761	67	897	7	0	0	(128,049)	2,125,989	(20,139)	1,978,772	44,999	2,023,771
Balance, January 1, 2011												

Table of Contents

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF CHANGES IN EQUITY—(Continued)

For the Years Ended December 31, 2012, 2011 and 2010

(in thousands, except per share data)

	Redeemable Interest	Class A Common	Class B Common	Class C Common	Class D Common	Capital in Excess of Par Value	Cumulative Dividends	Retained Earnings	Accumulated Other Comprehensive Income (Loss)	UHS Common Stockholders' Equity	Noncontrolling Interest	Total
Common Stock												
Issued/(converted) including tax benefits from exercise of stock options	—	(1)	12	—	—	—	—	12,622	—	12,633	—	12,633
Repurchased	—	—	(16)	—	—	—	—	(60,466)	—	(60,482)	—	(60,482)
Restricted share-based compensation expense	—	—	—	—	—	—	—	1,957	—	1,957	—	1,957
Dividends paid	—	—	—	—	—	—	(19,466)	—	—	(19,466)	—	(19,466)
Stock option expense	—	—	—	—	—	—	—	15,807	—	15,807	—	15,807
Distributions to noncontrolling interests	(31,016)	—	—	—	—	—	—	—	—	—	(7,416)	(7,416)
Purchase of minority ownership interests in majority owned businesses	—	—	—	—	—	—	—	—	—	—	—	—
Other	—	—	—	—	—	—	—	—	—	—	—	—
Comprehensive income:												
Net income	37,521	—	—	—	—	—	—	398,167	—	398,167	13,183	411,350
Amortization of terminated hedge (net of income tax effect of $120)	—	—	—	—	—	—	—	—	(216)	(216)	—	(216)
Unrealized derivative losses on cash flow hedges (net of income tax effect of $14,363)	—	—	—	—	—	—	—	—	(23,114)	(23,114)	—	(23,114)
Minimum pension liability (net of income tax effect of $4,691)	—	—	—	—	—	—	—	—	(7,706)	(7,706)	—	(7,706)
Subtotal—comprehensive income	37,521	—	—	—	—	—	—	398,167	(31,036)	367,131	13,183	380,31[illegible]

160

SUPPLEMENTAL- # 1

December 26, 2013

12:16pm

Balance, January 1, 2012	218,266	66	893	7	0	0	(147,515)	2,494,076	(51,175)	2,296,352	50,766	2,347,118

Table of Contents

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF CHANGES IN EQUITY—(Continued)

For the Years Ended December 31, 2012, 2011 and 2010

(in thousands, except per share data)

	Redeemable Interest	Class A Common	Class B Common	Class C Common	Class D Common	Capital in Excess of Par Value	Cumulative Dividends	Retained Earnings	Accumulated Other Comprehensive Income (Loss)	UHS Common Stockholders' Equity	Noncontrolling Interest	Total
Common Stock												
Issued/(converted) including tax benefits from exercise of stock options	—	—	14	—	—	—	—	21,670	—	21,684	—	21,684
Repurchased	—	—	(4)	—	—	—	—	(19,150)	—	(19,154)	—	(19,154)
Restricted share-based compensation expense	—	—	—	—	—	—	—	2,308	—	2,308	—	2,308
Dividends paid	—	—	—	—	—	—	(58,395)	—	—	(58,395)	—	(58,395)
Stock option expense	—	—	—	—	—	—	—	20,083	—	20,083	—	20,083
Distributions to noncontrolling interests	(18,961)	—	—	—	—	—	—	—	—	—	(7,933)	(7,933)
Sale of minority ownership interests in majority owned businesses	—	—	—	—	—	—	—	—	—	—	(832)	(832)
Other	—	—	—	—	—	—	—	—	—	—	—	—
Comprehensive income:												
Net income	34,998	—	—	—	—	—	—	443,446	—	443,446	10,603	454,049
Amortization of terminated hedge (net of income tax effect of $120)	—	—	—	—	—	—	—	—	(216)	(216)	—	(216)
Unrealized derivative losses on cash flow hedges (net of income tax effect of $2,528)	—	—	—	—	—	—	—	—	4,149	4,149	—	4,149
Minimum pension liability (net of income tax effect of $1,898)	—	—	—	—	—	—	—	—	3,088	3,088	—	3,088
Subtotal—comprehensive income	34,998	—	—	—	—	—	—	443,446	7,021	450,467	10,603	461,070
Balance, December 31, 2012	$ 234,303	$ 66	$ 903	$ 7	$ 0	$ 0	($ 205,910)	$2,962,433	($ 44,154)	$ 2,713,345	$ 52,604	$2,765,949

The accompanying notes are an integral part of these consolidated financial statements.

161

SUPPLEMENTAL- # 1

December 26, 201

12:16pm

Table of Contents

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF CASH FLOWS

	Year Ended December 31,		
	2012	2011	2010
		(Amounts in thousands)	
Cash Flows from Operating Activities:			
Net income	$ 489,047	$ 448,870	$ 275,795
Adjustments to reconcile net income to net cash provided by operating activities:			
Depreciation & amortization	308,690	295,861	223,997
Gains on sales of assets and businesses, net of losses	(27,085)	(452)	(1,993)
Stock based compensation expense	22,518	18,225	16,799
Costs related to extinguishment of debt	29,170	0	0
Changes in assets & liabilities, net of effects from acquisitions and dispositions:			
Accounts receivable	(71,068)	(134,838)	22,726
Accrued interest	152	(3,577)	8,408
Accrued and deferred income taxes	10,374	85,792	132
Other working capital accounts	28,554	(28,382)	(26,437)
Other assets and deferred charges	30,975	37,160	11,539
Other	6,367	(1,387)	812
Accrued insurance expense, net of commercial premiums paid	62,660	83,612	19,739
Payments made in settlement of self-insurance claims	(75,084)	(82,633)	(50,173)
Net cash provided by operating activities	815,271	718,251	501,344
Cash Flows from Investing Activities:			
Property and equipment additions, net of disposals	(363,192)	(285,682)	(239,274)
Acquisition of property and businesses	(527,847)	(29,466)	(1,958,298)
Proceeds received from sales of assets and businesses	149,311	67,592	21,460
Costs incurred for purchase and implementation of electronic health records application	(54,362)	(38,249)	(17,971)
Return of deposit on terminated purchase agreement	6,500	0	0
Net cash used in investing activities	(789,590)	(285,805)	(2,194,083)
Cash Flows from Financing Activities:			
Reduction of long-term debt	(849,647)	(381,517)	(1,392,08[illegible]
Additional borrowings	913,500	98,100	3,266,14[illegible]
Financing costs	(8,283)	(23,608)	(101,81[illegible]
Repurchase of common shares	(19,154)	(60,482)	(11,52[illegible]
Dividends paid	(58,395)	(19,466)	(19,42[illegible]

162
SUPPLEMENTAL- # 1
December 26, 2013
12:16pm

Issuance of common stock	5,435	4,779	3,594
Profit distributions to noncontrolling interests	(26,895)	(38,497)	(32,456)
Proceeds from sale of noncontrolling interests in majority owned business	0	0	600
Net cash (used in) provided by financing activities	(43,439)	(420,691)	1,713,033
(Decrease) increase in cash and cash equivalents	(17,758)	11,755	20,294
Cash and cash equivalents, beginning of period	41,229	29,474	9,180
Cash and cash equivalents, end of period	$ 23,471	$ 41,229	$ 29,474
Supplemental Disclosures of Cash Flow Information:			
Interest paid	$ 157,415	$ 176,328	$ 76,900
Income taxes paid, net of refunds	$ 264,824	$ 163,029	$ 152,088
Supplemental Disclosures of Noncash Investing and Financing Activities:			
See Notes 2, 4 and 7			

The accompanying notes are an integral part of these consolidated financial statements.

Table of Contents

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

1) BUSINESS AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Services provided by our hospitals, all of which are operated by subsidiaries of ours include general and specialty surgery, internal medicine, obstetrics, emergency room care, radiology, oncology, diagnostic care, coronary care, pediatric services, pharmacy services and/or behavioral health services. We, through our subsidiaries, provide capital resources as well as a variety of management services to our facilities, including central purchasing, information services, finance and control systems, facilities planning, physician recruitment services, administrative personnel management, marketing and public relations.

The more significant accounting policies follow:

A) **Principles of Consolidation:** The consolidated financial statements include the accounts of our majority-owned subsidiaries and partnerships controlled by us or our subsidiaries as the managing general partner. All significant intercompany accounts and transactions have been eliminated.

B) **Revenue Recognition:** We record revenues and related receivables for health care services at the time the services are provided. Medicare and Medicaid revenues represented 39% of our net patient revenues during 2012, 41% during 2011 and 42% during 2010. Revenues from managed care entities, including health maintenance organizations and managed Medicare and Medicaid programs accounted for 49% of our net patient revenues during 2012, 47% during 2011 and 51% during 2010.

We report net patient service revenue at the estimated net realizable amounts from patients and third-party payors and others for services rendered. We have agreements with third-party payors that provide for payments to us at amounts different from our established rates. Payment arrangements include prospectively determined rates per discharge, reimbursed costs, discounted charges and per diem payments. Estimates of contractual allowances under manage

SUPPLEMENT December 26, 2013 12:16pm

care plans are based upon the payment terms specified in the related contractual agreements. We closely monitor our historical collection rates, as well as changes in applicable laws, rules and regulations and contract terms, to assure that provisions are made using the most accurate information available. However, due to the complexities involved in these estimations, actual payments from payors may be different from the amounts we estimate and record.

We estimate our Medicare and Medicaid revenues using the latest available financial information, patient utilization data, government provided data and in accordance with applicable Medicare and Medicaid payment rules and regulations. The laws and regulations governing the Medicare and Medicaid programs are extremely complex and subject to interpretation and as a result, there is at least a reasonable possibility that recorded estimates will change by material amounts in the near term. Certain types of payments by the Medicare program and state Medicaid programs (e.g. Medicare Disproportionate Share Hospital, Medicare Allowable Bad Debts and Inpatient Psychiatric Services) are subject to retroactive adjustment in future periods as a result of administrative review and audit and our estimates may vary from the final settlements. Such amounts are included in accounts receivable, net, on our Consolidated Balance Sheets. The funding of both federal Medicare and state Medicaid programs are subject to legislative and regulatory changes. As such, we cannot provide any assurance that future legislation and regulations, if enacted, will not have a material impact on our future Medicare and Medicaid reimbursements. Adjustments related to the final settlement of these retrospectively determined amounts did not materially impact our results in 2012, 2011 or 2010.

We provide care to patients who meet certain financial or economic criteria without charge or at amounts substantially less than our established rates. Because we do not pursue collection of amounts determined to qualify as charity care, they are not reported in net revenues or in accounts receivable, net. See additional disclosure below in *Charity Care and Uninsured Discounts* for our estimated uncompensated care provided and estimated cost of providing uncompensated care.

C) Provision for Doubtful Accounts: Collection of receivables from third-party payers and patients is our primary source of cash and is critical to our operating performance. Our primary collection risks relate to uninsured patients and the portion of the bill which is the patient's responsibility, primarily co-payments and deductibles. We estimate our provisions for doubtful accounts based on general factors such as payer mix, the agings of the receivables and historical collection experience. We routinely review accounts receivable balances in conjunction with these factors and other economic conditions which might ultimately affect the collectability of the patient accounts and make adjustments to our allowances as warranted. At our acute care hospitals, third party liability accounts are pursued until all payment and adjustments are posted to the patient account. For those accounts with a patient balance after third party liability is finalized or accounts for uninsured patients, the patient receives statements and collection letters. Patients that express an inability to pay are reviewed for potential sources of financial assistance including our charity care policy. If the patient is deemed unwilling to pay, the account is written-off as bad debt and transferred to an outside collection agency for additional collection effort.

Uninsured patients that do not qualify as charity patients are extended an uninsured discount of a minimum of 30% of total charges. Our hospitals establish a partial reserve for self-pay accounts in the allowance for doubtful accounts for both unbilled balances and those that have been billed and are under 90 days old. All self-pay accounts are fully reserved at 90 days from the date of discharge. Third party liability accounts are fully reserved in the allowance for doubtful accounts when the balance ages past 180 days from the date of discharge. Potential charity accounts are fully reserved when it is determined the patient may be unable to pay.

164
SUPPLEMENTAL- # 1
December 26, 2013
12:16pm

As of December 31, 2012, our accounts receivable includes $70 million due from Illinois ($54 million as of December 31, 2011), the collection of which has been delayed due to budgetary and funding pressures experienced by the state. Although as of December 31, 2012 approximately $51 million of the receivables due from Illinois have been outstanding in excess of 60 days ($41 million as of December 31, 2011), and a large portion will likely remain outstanding for the foreseeable future, we expect to eventually collect all amounts due to us and therefore no related reserves have been established in our consolidated financial statements. However, we can provide no assurance that we will eventually collect all amounts due to us from Illinois. Failure to ultimately collect all outstanding amounts due from Illinois would have an adverse impact on our future consolidated results of operations and cash flows.

On a consolidated basis, we monitor our total self-pay receivables to ensure that the total allowance for doubtful accounts provides adequate coverage based on historical collection experience. Our accounts receivable are recorded net of allowance for doubtful accounts of $311 million and $253 million at December 31, 2012 and 2011, respectively.

D) Concentration of Revenues: Our five majority owned acute care hospitals in the Las Vegas, Nevada market contributed, on a combined basis, 14% in 2012, 15% in 2011 and 20% in 2010, of our consolidated net revenues. On a combined basis, our facilities in the McAllen/Edinburg, Texas market (consisting of three acute care facilities, a children's hospital and a behavioral health facility) contributed 4% in 2012, 5% in 2011 and 6% in 2010, of our consolidated net revenues.

E) Charity Care and Uninsured Discounts: A significant portion of the patients treated throughout our portfolio of acute care hospitals are uninsured patients which, in part, has resulted from an increase in the number of patients who are employed but do not have health insurance or who have policies with relatively high deductibles. Patients treated at our hospitals for non-elective services, who have gross income less than 400% of the federal poverty guidelines, are deemed eligible for charity care. The federal poverty guidelines are established by the federal government and are based on income and family size. Because we do not pursue collection of amounts that qualify as charity care, they are not reported in our net revenues or in our accounts receivable, net. We also provide discounts to uninsured patients (included in "uninsured discounts" amounts below) who do not qualify for Medicaid or charity care. Because we do not pursue collection of amounts classified as uninsured discounts, they are not reported in our net revenues or in our accounts receivable, net. In

implementing the discount policy, we first attempt to qualify uninsured patients for governmental programs, charity care or any other discount program. If an uninsured patient does not qualify for these programs, the uninsured discount is applied.

Uncompensated care:

The following table shows the amounts recorded at our acute care hospitals for charity care and uninsured discounts, based on charges at established rates, for the years ended December 31, 2012, 2011 and 2010:

	(dollar amounts in thousands)					
	2012		2011		2010	
	Amount	%	Amount	%	Amount	%
Charity care	$ 778,268	74%	$ 804,301	84%	$ 664,212	82
Uninsured discounts	267,304	26%	151,447	16%	142,467	18
Total uncompensated care	$ 1,045,572	100%	$ 955,748	100%	$ 806,679	100

SUPPLEMENTAL- # 1
December 26, 2013
12:16pm
165

The estimated cost of providing uncompensated care:

The estimated cost of providing uncompensated care, as reflected below, were based on a calculation which multiplied the percentage of operating expenses for our acute care hospitals to gross charges for those hospitals by the above-mentioned total uncompensated care amounts. The percentage of cost to gross charges is calculated based on the total operating expenses for our acute care facilities divided by gross patient service revenue for those facilities. An increase in the level of uninsured patients to our facilities and the resulting adverse trends in the provision for doubtful accounts and uncompensated care provided could have a material unfavorable impact on our future operating results.

	(amounts in thousands)		
	2012	2011	2010
Estimated cost of providing charity care	$ 131,890	$ 145,350	$ 129,820
Estimated cost of providing uninsured discounts related care	45,299	27,363	27,845
Estimated cost of providing uncompensated care	$ 177,189	$ 172,713	$ 157,665

F) Accounting for Medicare and Medicaid Electronic Health Records Incentive Payments: In July 2010, the Department of Health and Human Services published final regulations implementing the health information technology provisions of the American Recovery and Reinvestment Act. The regulation defines the "meaningful use" of Electronic Health Records ("EHR") and established the requirements for the Medicare and Medicaid EHR payment incentive programs. The implementation period for these new Medicare and Medicaid incentive payments started in federal fiscal year 2011 and can end as late as 2016 for Medicare and 2021 for the state Medicaid programs. We recognize income related to Medicare and Medicaid incentive payments using a gain contingency model that is based upon when our eligible hospitals have demonstrated "meaningful use" of certified EHR technology for the applicable period and the cost report information for the full cost report year that will determine the final calculation of the incentive payment is available.

Medicare EHR incentive payments: Federal regulations require that Medicare EHR incentive payments be computed based on the Medicare cost report that begins in the federal fiscal period in which a hospital meets the applicable "meaningful use" requirements. Since the annual Medicare cost report periods for each of our acute care hospitals ends on December 31st, we will recognize Medicare EHR incentive income for each hospital during the fourth quarter of the year in which the facility meets the "meaningful use" criteria and during the fourth quarter of each applicable subsequent year.

Table of Contents

Medicaid EHR incentive payments: Medicaid EHR incentive payments are determined based upon prior period cost report information available at the time our hospitals meet the "meaningful use" criteria. Therefore, the majority of the Medicaid EHR incentive income recognition occurs in the period in which the applicable hospitals are deemed to have met initial "meaningful use" criteria. Upon meeting subsequent fiscal year "meaningful use" criteria, our hospitals may become entitled to additional Medicaid EHR incentive payments which will be recognized as incentive income in future periods. Medicaid EHR incentive payments received prior to our hospitals meeting the "meaningful use" criteria are included in other current liabilities (as deferred EHR incentive income) in our consolidated balance sheet.

G) Cash and Cash Equivalents: We consider all highly liquid investments purchased with maturities of three months or less to be cash equivalents.

H) Property and Equipment: Property and equipment are stated at cost. Expenditures for renewals and improvements are charged to the property accounts. Replacements, maintenance and repairs which do not improve or extend the life of the respective asset are expensed as incurred. We remove the cost

166
SUPPLEMENTAL - # 1
December 26, 2013
12:16pm

and the related accumulated depreciation from the accounts for assets sold or retired and the resulting gains or losses are included in the results of operations. Construction-in-progress includes both construction projects and equipment not yet placed into service.

We capitalize interest expense on major construction projects while in progress. We capitalized interest on major construction projects and the development and implementation of electronic health records applications amounting to $5.7 million during 2012, $400,000 during 2011 and $7.6 million during 2010.

Depreciation is provided on the straight-line method over the estimated useful lives of buildings and improvements (twenty to forty years) and equipment (three to fifteen years). Depreciation expense (excluding discontinued operations) was $270.5 million during 2012, $262.1 million during 2011 and $197.3 million during 2010.

I) Long-Lived Assets: We review our long-lived assets, including amortizable intangible assets, for impairment whenever events or circumstances indicate that the carrying value of these assets may not be recoverable. The assessment of possible impairment is based on our ability to recover the carrying value of our asset based on our estimate of its undiscounted future cash flow. If the analysis indicates that the carrying value is not recoverable from future cash flows, the asset is written down to its estimated fair value and an impairment loss is recognized. Fair values are determined based on estimated future cash flows using appropriate discount rates.

J) Goodwill: Goodwill is reviewed for impairment at the reporting unit level on an annual basis or sooner if the indicators of impairment arise. Our judgments regarding the existence of impairment indicators are based on market conditions and operational performance of each reporting unit. We have designated September 1st as our annual impairment assessment date and performed an impairment assessment as of September 1, 2012 which indicated no impairment of goodwill. There were also no goodwill impairments during 2011 or 2010. Future changes in the estimates used to conduct the impairment review, including profitability and market value projections, could indicate impairment in future periods potentially resulting in a write-off of a portion or all of our goodwill.

Table of Contents

Changes in the carrying amount of goodwill for the two years ended December 31, 2012 were as follows (in thousands):

	Acute Care Services	Behavioral Health Services	Total Consolidated
Balance, January 1, 2011	$389,484	$2,200,430	$2,589,914
Adjustments to goodwill (a)	—	37,688	37,688
Balance, January 1, 2012	389,484	2,238,118	2,627,602
Goodwill acquired during the period	11,110	434,551	445,661
Goodwill divested during the period	(17,450)	(1,902)	(19,352)
Adjustments to goodwill (b)	(448)	(16,698)	(17,14
Balance, December 31, 2012	$382,696	$2,654,069	$3,036,76

(a) Consists of adjustments to prior year purchase price allocations.

(b) The reduction to the Behavioral Health Services' goodwill consists primarily of a reclassification to "assets of facilities held for sale" and represents the

167
SUPPLEMENTAL- # 1
December 26, 2013
12:16pm

goodwill attributable to Peak Behavioral Health Services which we agreed to divest pursuant to our agreement with the Federal Trade Commission in connection with our acquisition of Ascend Health Corporation in October, 2012. Adjustments to prior year purchase price allocations for Acute Care and Behavioral Health Services are also included.

K) Other Assets: Other assets consist primarily of amounts related to: (i) intangible assets acquired in connection with our acquisition of Psychiatric Solutions, Inc. ("PSI") in November, 2010 and Ascend Health Corporation in October, 2012, consisting of Medicare licenses, certificates of need and contracts to manage the operations of behavioral health services owned by third-parties (PSI only); (ii) prepaid fees for various software and other applications used by our hospitals; (iii) costs incurred in connection with the purchase and implementation of an electronic health records application for each of our acute care facilities; (iv) deposits; (v) investments in various businesses, including Universal Health Realty Income Trust; (vi) the invested assets related to a deferred compensation plan that is held by an independent trustee in a rabbi-trust and that has a related payable included in other noncurrent liabilities; (vii) the estimated future payments related to physician-related contractual commitments, as discussed below, and; (viii) other miscellaneous assets. As of December 31, 2012 and 2011, other intangible assets, net of accumulated amortization, were approximately $99 million and $97 million, respectively.

L) Physician Guarantees and Commitments: As of December 31, 2012 and 2011, our accrued liabilities-other, and our other assets included $3 million and $7 million, respectively, of estimated future payments related to physician-related contractual commitments. Pursuant to contractual guarantees outstanding as of December 31, 2012 that are applicable to future years, we have $3 million of potential future financial obligations, substantially all of which are potential obligations during 2013.

M) Self-Insured Risks: We provide for self-insured risks, primarily general and professional liability claims and workers' compensation claims. Our estimated liability for self-insured professional and general liability claims is based on a number of factors including, among other things, the number of asserted claims and reported incidents, estimates of losses for these claims based on recent and historical settlement amounts, estimate of incurred but not reported claims based on historical experience, and estimates of amounts recoverable under our commercial insurance policies. All relevant information, including our own historical experience is used in estimating the expected amount of claims. While we continuously monitor these factors, our ultimate liability for professional and general liability claims could change materially from our current estimates due to inherent uncertainties involved in making this estimate. Our estimated self-insured reserves are reviewed and changed, if necessary, at each reporting date and changes are recognized currently as additional expense or as a reduction of expense. See Note 8 for discussion of adjustments to our prior year reserves for claims related to our self-insured general and professional liability and workers' compensation liability.

Table of Contents

In addition, we also maintain self-insured employee benefits programs for employee healthcare and dental claims. The ultimate costs related to these programs include expenses for claims incurred and paid in addition to an accrual for the estimated expenses incurred in connection with claims incurred but not yet reported.

N) Income Taxes: Deferred tax assets and liabilities are recognized for the amount of taxes payable or deductible in future years as a result of differences between the tax bases of assets and liabilities and their reported amounts in the financial statements. We believe that future income will enable us to realize our deferred tax assets net of recorded valuation allowances relating to state net operating loss carry-forwards.

168
SUPPLEMENTAL- # 1
December 26, 2013
12:16pm

We operate in multiple jurisdictions with varying tax laws. We are subject to audits by any of these taxing authorities. Our tax returns have been examined by the Internal Revenue Service ("IRS") through the year ended December 31, 2006. We believe that adequate accruals have been provided for federal, foreign and state taxes.

See Note 6 for additional disclosure regarding income taxes.

O) Other Noncurrent Liabilities: Other noncurrent liabilities include the long-term portion of our professional and general liability, workers' compensation reserves, pension and deferred compensation liabilities, liability incurred in connection with split-dollar life insurance agreements on the lives of our chief executive officer and his wife and interest rate swap liabilities.

P) Redeemable Noncontrolling Interests and Noncontrolling Interest: Outside owners hold noncontrolling, minority ownership interests of: (i) approximately 28% in our five acute care facilities located in Las Vegas, Nevada; (ii) 20% in an acute care facility located in Washington, D.C.; (iii) approximately 11% in an acute care facility located in Laredo, Texas, and; (iv) 20% in a behavioral health care facility located in Philadelphia, Pennsylvania, the majority ownership interest of which was acquired by us as result of our acquisition of PSI in November, 2010. The redeemable noncontrolling interest balances of $234 million and $218 million as of December 31, 2012 and 2011, respectively, and the noncontrolling interest balances of $53 million and $51 million as of December 31, 2012 and 2011, respectively, consist primarily of the third-party ownership interests in these hospitals.

In connection with the five acute care facilities located in Las Vegas, Nevada, the minority ownership interests of which are reflected as redeemable noncontrolling interests on our Consolidated Balance Sheet, the outside owners have certain "put rights", that are currently exercisable, that if exercised, require us to purchase the minority member's interests at fair market value. The put rights are exercisable upon the occurrence of: (i) certain specified financial conditions falling below established thresholds; (ii) breach of the management contract by the managing member (a subsidiary of ours), or; (iii) if the minority member's ownership percentage is reduced to less than certain thresholds. In connection with the behavioral health care facility located in Philadelphia, Pennsylvania, the minority ownership interest of which is also reflected as redeemable noncontrolling interests on our Consolidated Balance Sheet, the outside owner has a "put option" to put its entire ownership interest to us at any time. If exercised, the put option requires us to purchase the minority member's interest at fair market value. As of December 31, 2012, we believe the fair market value of the minority ownership interests in these facilities, pursuant to the terms of the put options, approximates the book value of the redeemable noncontrolling interests.

Q) Comprehensive Income and Accumulated Other Comprehensive Income: Comprehensive income or loss is comprised of net income, changes in unrealized gains or losses on derivative financial instruments and a pension liability.

The accumulated other comprehensive income ("AOCI") component of stockholders' equity includes: net unrealized gains and losses on effective cash flow hedges; and the net minimum pension liability of a non-contributory defined benefit pension plan which covers employees at one of our subsidiaries. See Note 10, "Pension Plan" for additional disclosure regarding the defined benefit pension plan.

Table of Contents

The amounts recognized in AOCI for the two years ended December 31, 2012 were as follows (in thousands):

	Net Unrealized Gains	Minimum Pension Liability	Total AOCI

169
SUPPLEMENTAL- # 1
December 26, 2013
12:16pm

	(Losses) on Effective Cash Flow Hedges		
Balance, January 1, 2011, net of income tax	$ (5,130)	$(15,009)	$(20,139)
2011 activity:			
Pre-tax amount	(37,813)	(12,397)	(50,210)
Income tax effect	14,483	4,691	19,174
Change, net of income tax	(23,330)	(7,706)	(31,036)
Balance, January 1, 2012, net of income tax	(28,460)	(22,715)	(51,175)
2012 activity:			
Pre-tax amount	6,341	4,986	11,327
Income tax effect	(2,408)	(1,898)	(4,306)
Change, net of income tax	3,933	3,088	7,021
Balance, December 31, 2012, net of income tax	$(24,527)	$(19,627)	$(44,154)

R) **Accounting for Derivative Financial Investments and Hedging Activities:** We manage our ratio of fixed to floating rate debt with the objective of achieving a mix that management believes is appropriate. To manage this risk in a cost-effective manner, we, from time to time, enter into interest rate swap agreements in which we agree to exchange various combinations of fixed and/or variable interest rates based on agreed upon notional amounts.

We account for our derivative and hedging activities using the Financial Accounting Standard Board's ("FASB") guidance which requires all derivative instruments, including certain derivative instruments embedded in other contracts, to be carried at fair value on the balance sheet. For derivative transactions designated as hedges, we formally document all relationships between the hedging instrument and the related hedged item, as well as its risk-management objective and strategy for undertaking each hedge transaction.

Derivative instruments designated in a hedge relationship to mitigate exposure to variability in expected future cash flows, or other types of forecasted transactions, are considered cash flow hedges. Cash flow hedges are accounted for by recording the fair value of the derivative instrument on the balance sheet as either an asset or liability, with a corresponding amount recorded in accumulated other comprehensive income ("AOCI") within stockholders' equity. Amounts are reclassified from AOCI to the income statement in the period or periods the hedged transaction affects earnings. Changes in the fair value of our cash flow hedges are classified as operating on our cash flow statement.

We use interest rate derivatives in our cash flow hedge transactions. Such derivatives are designed to be highly effective in offsetting changes in the cash flows related to the hedged liability. For derivative instruments designated as cash flow hedges, the ineffective portion of the change in expected cash flows of the hedged item are recognized currently in the income statement.

Derivative instruments designated in a hedge relationship to mitigate exposure to changes in the fair value of an asset, liability, or firm commitment attributable to a particular risk, such as interest rate risk, are considered fair value hedges. Fair value hedges are accounted for by recording the changes in the fair value of both the derivative instrument and the hedged item in the income statement.

For hedge transactions that do not qualify for the short-cut method, at the hedge's inception and on a regular basis thereafter, a formal assessment is performed to determine whether changes in the fair values or cash flows of the derivative instruments have been highly effective in offsetting changes in cash flows of the hedged items and whether they are expected to be highly effective in the future.

SUPPLEMENTAL- # 1
December 26, 2013
12:16pm

Table of Contents

S) Stock-Based Compensation: At December 31, 2012, we have a number of stock-based employee compensation plans. Pursuant to the FASB's guidance, we expense the grant-date fair value of stock options and other equity-based compensation pursuant to the straight-line method over the stated vesting period of the award using the Black-Scholes option-pricing model.

The expense associated with share-based compensation arrangements is a non-cash charge. In the Consolidated Statements of Cash Flows, share-based compensation expense is an adjustment to reconcile net income to cash provided by operating activities. The applicable FASB guidance requires that cash flows resulting from tax deductions in excess of compensation cost recognized be classified as financing cash flows. During 2012, 2011 and 2010, there were no net excess tax benefits generated.

T) Earnings per Share: Basic earnings per share are based on the weighted average number of common shares outstanding during the year. Diluted earnings per share are based on the weighted average number of common shares outstanding during the year adjusted to give effect to common stock equivalents.

The following table sets forth the computation of basic and diluted earnings per share, for the periods indicated:

	Twelve Months Ended December 31,		
	2012	2011	2010
Basic and diluted:			
Net Income	$489,047	$448,870	$275,795
Less: Net income attributable to noncontrolling interest	(45,601)	(50,703)	(45,612)
Less: Net income attributable to unvested restricted share grants	(497)	(521)	(918)
Net income attributable to UHS—basic and diluted	$442,949	$397,646	$229,265
Basic earnings per share attributable to UHS:			
Weighted average number of common shares—basic	96,821	97,199	96,786
Total basic earnings per share	$ 4.57	$ 4.09	$ 2.37
Diluted earnings per share attributable to UHS:			
Weighted average number of common shares	96,821	97,199	96,786
Net effect of dilutive stock options and grants based on the treasury stock method	890	1,338	1,187
Weighted average number of common shares and equivalents—diluted	97,711	98,537	97,973
Total diluted earnings per share	$ 4.53	$ 4.04	$ 2.34

The "Net effect of dilutive stock options and grants based on the treasury stock method", for all years presented above, excludes certain outstanding stock options applicable to each year since the effect would have been anti-dilutive. The excluded weighted-average stock options totaled 2.0 million during 2012, 1.4 million during 2011and 1,000 during 2010.

U) Fair Value of Financial Instruments: The fair values of our registered debt and investments are based on quoted market prices. The fair values of other long-term debt, including capital lease obligations, are estimated by discounting cash flows using period-end interest rates and market conditions for instruments with similar maturities and credit quality. The carrying amounts reported in the balance sheet for cash, accounts receivable, accounts payable, and

171
SUPPLEMENTAL- # 1
December 26, 2013
12:16pm

short-term borrowings approximates their fair values due to the short-term nature of these instruments. Accordingly, these items have been excluded from the fair value disclosures included elsewhere in these notes to consolidated financial statements.

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

W) Mergers and Acquisitions: The acquisition method of accounting for business combinations requires that the assets acquired and liabilities assumed be recorded at the date of acquisition at their respective fair values with limited exceptions. Fair value is defined as the exchange price that would be received for an asset or paid to transfer a liability (an exit price) in the principal or most advantageous market for the asset or liability in an orderly transaction between market participants on the measurement date. Any excess of the purchase price (consideration transferred) over the estimated fair values of net assets acquired is recorded as goodwill. Transaction costs and costs to restructure the acquired company are expensed as incurred. The fair value of intangible assets, including Medicare Licenses, Certificates of Need, and certain contracts, is based on significant judgments made by our management, and accordingly, for significant items we typically obtain assistance from third party valuation specialists.

X) Accounting Standards:

Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts for Certain Health Care Entities: During the first quarter of 2012, we adopted the Financial Accounting Standards Board's Accounting Standards Update ("ASU") No. 2011-07, "Health Care Entities (Topic 954): Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts for Certain Health Care Entities," which required certain health care entities to change the presentation in their statement of operations by reclassifying the provision for bad debts associated with patient service revenue from an operating expense to a deduction from patient service revenue (net of contractual allowances and discounts). As a result, the provision for doubtful accounts for our acute care and behavioral health care facilities is reflected as a deduction from net revenues in the accompanying consolidated statements of income for 2012, 2011 and 2010. The adoption of this standard had no impact on our financial position or overall results of operations.

Presentation of Comprehensive Income: In June 2011, the FASB amended its guidance governing the presentation of comprehensive income. The amended guidance eliminates the option to report other comprehensive income and its components in the statement of changes in equity. Under the new guidance, an entity can elect to present items of net income and other comprehensive income in one continuous statement referred to as the statement of comprehensive income or in two separate, but consecutive, statements. While the options for presenting other comprehensive income change under the guidance, other portions of the current guidance will not change. For public entities, these changes are effective for fiscal years, and interim periods within those years, beginning after December 15, 2011. The adoption of this standard did not have an impact on our consolidated financial position or results of operations.

2) ACQUISITIONS AND DIVESTITURES

Year ended December 31, 2012:

2012 Acquisitions of Assets and Businesses:

172
SUPPLEMENTAL- # 1
December 26, 2013
12:16pm

During 2012, we spent $528 million to acquire the following assets and businesses:

- spent $503 million to acquire 9 behavioral health care facilities from Ascend Health Corporation ("Ascend") in October, 2012, and;
- spent $25 million in connection with the acquisition of physician practices and various real property.

Table of Contents

The aggregate net purchase price of the facilities was allocated to assets and liabilities based on their estimated fair values as follows:

	Amount (000s)
Working capital, net	$ 21,000
Property, plant & equipment	60,000
Goodwill	446,000
Other assets	9,000
Income tax assets, net of deferred tax liabilities	(1,000)
Other liabilities	(7,000)
Cash paid in 2012 for acquisitions	$528,000

Goodwill of the facilities acquired is computed, pursuant to the residual method, by deducting the fair value of the acquired assets and liabilities from the total purchase price. The factors that contribute to the recognition of goodwill, which may also influence the purchase price, include the following for each of the acquired facilities: (i) the historical cash flows and income levels; (ii) the reputations in their respective markets; (iii) the nature of the respective operations, and; (iv) the future cash flows and income growth projections.

Assuming the acquisition of Ascend occurred on January 1, 2011, our 2011 pro forma net revenues would have been approximately $6.90 billion and our pro forma net income attributable to UHS and pro forma net income attributable to UHS per diluted share would have been $401 million and $4.06 per diluted share, respectively. The 2011 pro forma net income attributable to UHS and pro forma net income attributable to UHS per diluted share include the after-tax impact of the transaction costs incurred by us in connection with the acquisition of Ascend amounting to $5 million or $.06 per diluted share.

Our 2012 pro forma net revenues would have been approximately $7.11 billion and our pro forma net income attributable to UHS and pro forma net income attributable to UHS per diluted share would have been $464 million and $4.74 per diluted share, respectively.

During the period of October 10, 2012 through December 31, 2012, the facilities acquired from Ascend generated $42 million of net revenues which are included in our consolidated net revenues for the year ended December 31, 2012. The aggregate effect of the earnings generated by these facilities since the date of acquisition, less the cost on the borrowings utilized to finance the acquisition, and less the above-mentioned transaction costs, was not material to our 2012 net income attributable to UHS and net income attributable to UHS per diluted share.

2012 Divestiture of Assets and Businesses:

During 2012, we received $149 million from the divestiture of assets and businesses, including the following:

- received $93 million for the sale of Auburn Regional Medical Center ("Auburn"), a 159-bed acute care hospital located in Auburn, Washington

173
SUPPLEMENTAL- # 1
December 26, 2013
12:16pm

(sold in October);

- received $50 million for the sale of the Hospital San Juan Capestrano, a 108-bed acute care hospital located in Rio Piedras, Puerto Rico (sold in January pursuant to our below-mentioned agreement with the FTC in connection with our acquisition of PSI in November, 2010), and;
- received an aggregate of $6 million for the sale of the real property of two non-operating behavioral health facilities and our majority ownership interest in an outpatient surgery center located in Puerto Rico.

In connection with the receipt of antitrust clearance from the Federal Trade Commission ("FTC") in connection with our acquisition of Ascend Health Corporation in October of 2012, we agreed to certain

conditions, including the divestiture, within approximately six months, of Peak Behavioral Health Services ("Peak"), a 104-bed behavioral health care facility located in Santa Teresa, New Mexico. The revenues of Peak were approximately $18 million and $14 million during 2012 and 2011, respectively.

In connection with the receipt of antitrust clearance from the FTC in connection with our acquisition of PSI in November, 2010, we agreed to divest three former PSI facilities as well as one of our legacy behavioral health facilities in Puerto Rico. Pursuant to the terms of our agreement with the FTC, we divested:

- in July, 2011, the MeadowWood Behavioral Health System, a 58-bed facility located in New Castle, Delaware;
- in December, 2011, the Montevista Hospital (101-bed) and Red Rock Hospital (21-bed), both of which are located in Las Vegas, Nevada, and;
- in January, 2012, the Hospital San Juan Capestrano, a 108-bed facility located in Rio Piedras, Puerto Rico.

The operating results for Auburn, Peak and the three former PSI facilities located in Delaware and Nevada are reflected as discontinued operations during our period of ownership during each of the years presented herein. Since the aggregate income from discontinued operations before income tax expense for these facilities is not material to our consolidated financial statements, it is included as a reduction to other operating expenses. As reflected on the table below, the aggregate pre-tax gain on the divestiture of Auburn, was approximately $26 million. The aggregate pre-tax net gain on the divestiture of San Juan Capestrano in January, 2012 did not have a material impact on our consolidated results of operations during 2012. Assets and liabilities for Peak are reflected as "held for sale" on our Consolidated Balance Sheet as of December 31, 2012, and the assets and liabilities for the Hospital San Juan Capestrano were reflected as "held for sale" on our Consolidated Balance Sheet as of December 31, 2011.

The following table shows the results of operations for Auburn and Peak and the former PSI facilities located in Delaware and Nevada, on a combined basis, which were reflected as discontinued operations during our period of ownership for each of the years presented herein (amounts in thousands):

	Year Ended December 31,		
	2012	2011	2010
Net revenues	$95,226	$159,218	$126,218
Income from discontinued operations	(3,472)	10,422	12,109
Gain on divestiture	26,419	442	[illegible]
Income from discontinued operations, before income tax expense	22,947	10,864	12,1[illegible]
Income tax expense	(8,688)	(4,113)	(4,4[illegible])
Income from discontinued operations, net of income tax expense	$14,259	$ 6,751	$ 7,6[illegible]

174
SUPPLEMENTAL- # 1
December 26, 2013
12:16pm

Year ended December 31, 2011:

2011 Acquisitions of Assets and Businesses:

During 2011, we spent $29 million on the acquisition of businesses and real property, including the following:

- the acquisition of administrative office buildings located in Pennsylvania, Tennessee and a multi-tenant office building located in Washington D.C.;
- a deposit in made connection with execution of a purchase agreement for an acute care hospital in Texas which has since been terminated and the deposit returned to us in 2012, and;
- the acquisition of a cardiology practice in Texas

Table of Contents

The aggregate net cash expenditure related to the properties and/or businesses was allocated to assets and liabilities based on their estimated fair values as follows:

	Amount (000s)
Property, plant & equipment	$ 35,000
Other assets/deposits	11,000
Debt	(17,000)
Cash paid in 2011 for acquisitions and deposits	$ 29,000

2011 Divestitures of Assets and Businesses:

During 2011, we received $68 million from the divestiture of assets and businesses, including the following:

- the above-mentioned sale of three behavioral healthcare facilities (one located in Delaware and two located in Nevada) pursuant to our agreement with the FTC in connection with our acquisition of PSI;
- sale of our majority ownership interest in a radiation oncology center located in Nevada, and;
- the real property of a closed acute care hospital

The aggregate pre-tax net gain on the divestitures of the above-mentioned facilities located in Delaware and Nevada did not have a material impact on our 2011 consolidated results of operations.

Year ended December 31, 2010:

2010 Acquisitions of Assets and Businesses:

During 2010, we spent $1.96 billion and assumed $1.08 billion of debt on the acquisition of businesses and real property, including the following:

- the acquisition of PSI on November 15, 2010 for a total purchase price of $3.04 billion consisting of $1.96 billion in cash plus the assumption of approximately $1.08 billion of PSI's debt, the majority of which has since been refinanced, and;
- the acquisition of substantially all of the assets of an outpatient surgery center located in Florida in which we previously held a 20% minority ownership interest. The purchase price consideration in connection with this transaction, which occurred during the first quarter, consisted of

175
SUPPLEMENTAL- # 1
December 26, 2013
12:16pm

acquisition of the net assets less the assumption of the outstanding liabilities and third-party debt.

The aggregate net purchase price of the facilities was allocated to assets and liabilities based on their estimated fair values as follows:

	Amount (000s)
Working capital, net	$ 60,000
Assets held for sale	67,000
Property, plant & equipment	932,000
Goodwill	1,921,000
Other assets	132,000
Income tax assets, net of deferred tax liabilities	(14,000)
Debt	(1,082,000)
Liabilities held for sale	(1,000)
Redeemable noncontrolling interests	(5,000)
Other liabilities	(52,000)
Cash paid in 2010 for acquisitions	$ 1,958,000

Table of Contents

Goodwill of the facilities acquired is computed, pursuant to the residual method, by deducting the fair value of the acquired assets and liabilities from the total purchase price. The factors that contribute to the recognition of goodwill, which may also influence the purchase price, include the following for each of the acquired facilities: (i) the historical cash flows and income levels; (ii) the reputations in their respective markets; (iii) the nature of the respective operations, and; (iv) the future cash flows and income growth projections.

Assuming the acquisition of PSI occurred on January 1, 2009, our 2010 pro forma net revenues would have been approximately $7.30 billion and our pro forma net income attributable to UHS and pro forma net income attributable to UHS per diluted share would have been $342 million and $3.47 per diluted share, respectively.

During the period of November 16, 2010 through December 31, 2010, the facilities acquired from PSI generated $227 million of net revenues which are included in our consolidated net revenues for the year ended December 31, 2010. The aggregate effect of the earnings generated by these facilities since the date of acquisition, less the cost on the borrowings utilized to finance the acquisition, was not material to our 2010 net income attributable to UHS and net income attributable to UHS per diluted share.

Year ended December 31, 2010:

2010 Divestitures of Assets and Businesses:

During 2010, we received $21 million from the divestiture of assets and businesses, including the following:

- the sale of our minority ownership interest in a healthcare technology company;
- the sale of a portion of our ownership interest in an outpatient surgery center located in Texas, and;

176
SUPPLEMENTAL - # 1
December 26, 2013
12:16pm

- the sale of the real property of Methodist Hospital located in Louisiana that was severely damaged and closed in 2005 as a result of Hurricane Katrina.

The pre-tax gain, net of losses, resulting from the above-mentioned transactions did not have a material impact on our 2010 financial statements.

3) FINANCIAL INSTRUMENTS

Fair Value Hedges:

During 2012, 2011 and 2010, we had no fair value hedges outstanding.

Cash Flow Hedges:

We manage our ratio of fixed and floating rate debt with the objective of achieving a mix that management believes is appropriate. To manage this risk in a cost-effective manner, we, from time to time, enter into interest rate swap agreements in which we agree to exchange various combinations of fixed and/or variable interest rates based on agreed upon notional amounts. We account for our derivative and hedging activities using the Financial Accounting Standard Board's ("FASB") guidance which requires all derivative instruments, including certain derivative instruments embedded in other contracts, to be carried at fair value on the balance sheet. For derivative transactions designated as hedges, we formally document all relationships between the hedging instrument and the related hedged item, as well as its risk-management objective and strategy for undertaking each hedge transaction.

Derivative instruments designated in a hedge relationship to mitigate exposure to variability in expected future cash flows, or other types of forecasted transactions, are considered cash flow hedges. Cash flow hedges are accounted for by recording the fair value of the derivative instrument on the balance sheet as either an asset or liability, with a corresponding amount recorded in accumulated other comprehensive income ("AOCI") within shareholders' equity. Amounts are reclassified from AOCI to the income statement in the period or periods the

177

SUPPLEMENTAL- # 1
December 26, 2013
12:16pm

Table of Contents

hedged transaction affects earnings. We use interest rate derivatives in our cash flow hedge transactions. Such derivatives are designed to be highly effective in offsetting changes in the cash flows related to the hedged liability. For derivative instruments designated as cash flow hedges, the ineffective portion of the change in expected cash flows of the hedged item are recognized currently in the income statement.

For hedge transactions that do not qualify for the short-cut method, at the hedge's inception and on a regular basis thereafter, a formal assessment is performed to determine whether changes in the fair values or cash flows of the derivative instruments have been highly effective in offsetting changes in cash flows of the hedged items and whether they are expected to be highly effective in the future.

The fair value of interest rate swap agreements approximates the amount at which they could be settled, based on estimates obtained from the counterparties. We assess the effectiveness of our hedge instruments on a quarterly basis. We performed periodic assessments of the cash flow hedge instruments during 2012 and 2011 and determined the hedges to be highly effective. We also determined that any portion of the hedges deemed to be ineffective was de minimis and therefore there was no material effect on our consolidated financial position, operations or cash flows. The counterparties to the interest rate swap agreements expose us to credit risk in the event of nonperformance. However, at December 31, 2012, each swap agreement entered into by us was in a net

liability position which would require us to make the net settlement payments to the counterparties. We do not anticipate nonperformance by our counterparties. We do not hold or issue derivative financial instruments for trading purposes.

During the first quarter of 2011, we entered into an interest rate cap on a total notional amount of $275 million whereby we paid a premium of $30,000 in exchange for the counterparty agreeing to pay the difference between 2.25% and three-month LIBOR if the three-month LIBOR rate rises above 2.25% during the term of the cap, which expired in December, 2011. The three-month LIBOR never reached 2.25% during the term of the cap. Therefore, no payment was made to us. We also entered into a forward starting interest rate cap on a total notional amount of $450 million from December, 2011 to December, 2012 reducing to $400 million from December, 2012 to December, 2013 whereby we paid a premium of $740,000 in exchange for the counterparty agreeing to pay the difference between 7.00% and three-month LIBOR if the three-month LIBOR rate rises above 7.00% during the term of the cap. If the three-month LIBOR does not reach 7.00% during the term of the cap, no payment is made to us.

We also entered into six additional forward starting interest rate swaps in the first quarter of 2011 whereby we pay a fixed rate on a total notional amount of $425 million and receive three-month LIBOR. Three of these swaps with a total notional amount of $225 million became effective in March, 2011 and will mature in May, 2015. The average fixed rate payable on these swaps is 1.91%. The three remaining interest rate swaps with total notional amounts of $100 million, $25 million and $75 million became effective in December, 2011 and have fixed rates of 2.50%, 1.96% and 1.32%, and maturity dates in December, 2014, December, 2013 and December, 2012, respectively.

During the fourth quarter of 2010, we entered into three interest rate caps on a total notional amount of $1 billion whereby we paid a premium of $240,000 in exchange for the counterparties agreeing to pay the difference between 2.25% and three-month LIBOR if the three-month LIBOR rate rises above 2.25% during the term of the caps. All of these caps expired in December, 2011. The three-month LIBOR rate never rose above 2.25% during the term of the caps. Therefore, no payments were made to us. We also entered into four forward starting interest rate swaps in the fourth quarter of 2010 whereby we pay a fixed rate on a total notional amount of $600 million and receive three-month LIBOR. Each of the four swaps became effective in December, 2011 and will mature in May, 2015. The average fixed rate payable on these swaps is 2.38%.

During the fourth quarter of 2007, we entered into two interest rate swaps whereby we pay a fixed rate on a total notional principal amount of $150 million and receive three-month LIBOR. Each of the two interest rate

178
SUPPLEMENTAL- # 1
December 26, 2013
12:16pm

swaps had an initial notional principal amount of $75 million. The notional amount of the first interest rate swap reduced to $50 million in October, 2010. The fixed rate payable was 4.76% and it matured in October, 2012. The fixed rate payable on the second interest rate swap was 4.87% and it matured in October, 2011.

We measure our interest rate swaps at fair value on a recurring basis. The fair value of our interest rate swaps is based primarily on quotes from banks. We consider those inputs to be "level 2" in the fair value hierarchy as outlined in the authoritative guidance for disclosures in connection with derivative instruments and hedging activities. The fair value of our interest rate swaps was a liability of $41 million at December 31, 2012, substantially all of which is included in other noncurrent liabilities on the accompanying balance sheet. At December 31, 2011, the fair value of our interest rate swaps was a liability of $48 million, of which $4 million is included in other current liabilities and $44 million is included in other noncurrent liabilities on the accompanying balance sheet.

4) LONG-TERM DEBT

A summary of long-term debt follows:

	December 31, 2012	December 31, 2011
	(amounts in thousands)	
Long-term debt:		
Notes payable and Mortgages payable (including obligations under capitalized leases of $8,267 in 2012 and 9,982 in 2011) and term loans with varying maturities through 2038; weighted average interest at 5.9% in 2012 and 6.1% in 2011 (see Note 7 regarding capitalized leases)	$ 47,216	$ 51,841
Revolving credit and on-demand credit facility	163,500	249,600
Term Loan A, net of unamortized discount of $4,612 in 2012 and $6,103 in 2011	983,438	1,017,647
Term Loan B, net of unamortized discount of $8,724 in 2012 and $19,500 in 2011	737,176	1,439,500
Term Loan A2	894,375	—
Revenue bonds, interest at floating rates of 0.2% at December 31, 2012 and 2011, with varying maturities through 2015	5,300	5,300
Accounts receivable securitization program	249,000	240,000
7.125% Senior Secured Notes due 2016, including unamortized net premium of $15 in 2012 and $19 in 2011	400,015	400,019
7.00% Senior Unsecured Notes due 2018	250,000	250,000
	3,730,020	3,653,907
Less-Amounts due within one year	(2,589)	(2,479)
	$ 3,727,431	$ 3,651,428

On September 21, 2012, we entered into a second amendment ("Second Amendment") to our credit agreement, dated as of November 15, 2010, as amended on March 15, 2011, with several banks and other financial institutions ("Credit Agreement"). The Second Amendment, provides for a new $900 million Term Loan-A ("Term Loan A2") at the same interest rates as our existing Term Loan A and a final maturity date of August 15, 2016. The Second Amendment also provides for the extension of the maturity date on approximately $777 million of our existing $800 million revolving credit facility, and $943 million of our existing Term Loan-A facility, by nine months to mature on August 15, 2016. Approximately $23 million of our revolving credit facility commitment and $45 million of our existing Term Loan-A was not extended and is scheduled to mature on November 15, 2015. The Second Amendment also provides for increased flexibility for refinancing and certain other modifications but substantially all other terms of the Credit Agreement, dated as of November 15, 2010 and as previously amended in March, 2011, including interest rates, remain unchanged.

Table of Contents

On September 21, 2012, we used $700 million of the proceeds from the new Term Loan-A2 facility to extinguish a portion of our higher priced, Term Loan-B facility. Current pricing under the new Term Loan-A2 facility is 1% lower than the Term Loan-B facility and does not include a LIBOR Floor whereas the Term Loan-B facility has a 1% LIBOR Floor. During the third quarter of 2012, in connection with the extinguishment of a portion of our Term Loan-B facility, we recorded a pre-tax charge of $29 million to write-off the related portion of the Term Loan-B deferred financing costs.

179
SUPPLEMENTAL- # 1
December 26, 2013
12:16pm

The Credit Agreement, as amended on September 21, 2012, is a senior secured facility which provides for an initial aggregate commitment amount of $3.43 billion, comprised of an $800 million revolving credit facility, a $988 million Term Loan-A facility, a $746 million Term Loan-B facility and a $900 million Term Loan-A2 facility. The revolving credit facility includes a $125 million sub-limit for letters of credit. The Credit Agreement is secured by substantially all of the assets of the Company and our material subsidiaries and guaranteed by our material subsidiaries.

Borrowings under the Credit Agreement bear interest at either (1) the ABR rate which is defined as the rate per annum equal to, at our election: the greatest of (a) the lender's prime rate, (b) the weighted average of the federal funds rate, plus 0.5% and (c) one month Eurodollar rate plus 1%, in each case, plus an applicable margin based upon our consolidated leverage ratio at the end of each quarter ranging from 0.50% to 1.25% for revolving credit, Term Loan-A and Term Loan- A2 borrowings and 1.75% to 2.00% for Term Loan B borrowings or (2) the one, two, three or six month Eurodollar rate (at our election), plus an applicable margin based upon our consolidated leverage ratio at the end of each quarter ranging from 1.50% to 2.25% for revolving credit, Term Loan-A and Term Loan- A2 borrowings and ranging from 2.75% to 3.00% for Term Loan-B borrowings. The current applicable margins are 0.75% for ABR-based loans, 1.75% for Eurodollar-based loans under the revolving credit, Term Loan-A and Term Loan-A2 facilities and 2.75% under the Term Loan-B facility. The minimum Eurodollar rate for the Term Loan-B facility is 1.00% ("LIBOR Floor").

As of December 31, 2012, we had $574 million of available borrowing capacity pursuant to the terms of our $800 million revolving credit facility, net of $164 million of outstanding borrowings (including borrowings outstanding pursuant to a short-term, on-demand credit facility) and $62 million of outstanding letters of credit. As of December 31, 2012, we had $14 million of outstanding borrowings under a short-term, on-demand credit facility. Outstanding borrowings pursuant to this facility are classified as long-term on our Consolidated Balance Sheet since we have the intent and ability to refinance through available borrowings under the terms of our Credit Agreement.

Quarterly installment payments ("Installment Payments") are due on the Term Loan-A and Term Loan-A2 facilities which are equal to approximately $72 million in 2013, $72 million in 2014, $77 million in 2015 and $46 million in 2016. No Installment Payments are due on the Term Loan-B facility. During 2012, we made scheduled principal payments of $13 million on the Term Loan B facility and $42 million on the Term Loan-A and Term Loan A2 facilities. In 2011, we made scheduled principal payments of $16 million on the Term Loan-B facility and $26 million on the Term Loan-A facility. The Installment Payments due in 2013 on the Term Loan-A and Term Loan-A2 facilities are classified as long-term on our Consolidated Balance Sheet since we expect to have the borrowing capacity and would intend to refinance through available borrowings under the terms of our Credit Agreement.

Our accounts receivable securitization program ("Securitization") with a group of conduit lenders and liquidity banks was amended in October, 2010. We increased the size of the Securitization from $200 million to $240 million (the "Commitments"), and extended the maturity date to October 25, 2013. In May, 2012, we further increased the size of the securitization by $35 million to $275 million. Substantially all of the patient-related accounts receivable of our acute care hospitals ("Receivables") serve as collateral for the outstanding borrowings. The interest rate on the borrowings is based on the commercial paper rate plus a spread of 0.475% and there is a facility fee of 0.375% required on 102% on the Commitments. We have accounted for this Securitization as borrowings. We maintain effective control over the Receivables since, pursuant to the terms of

Table of Contents

the Securitization; the Receivables are sold from certain of our subsidiaries to special purpose entities that are wholly-owned by us. The Receivables, however, are owned by the special purpose entities, can be used only to satisfy the debts of the wholly-owned special purpose entities, and thus are not available to us

180
SUPPLEMENTAL- # 1
December 26, 2013
12:16pm

except through our ownership interest in the special purpose entities. The wholly-owned special purpose entities use the Receivables to collateralize the loans obtained from the group of third-party conduit lenders and liquidity banks. The group of third-party conduit lenders and liquidity banks do not have recourse to us beyond the assets of the wholly-owned special purpose entities that securitize the loans. At December 31, 2012, we had $249 million of outstanding borrowings and $26 million of additional capacity pursuant to the terms of our accounts receivable securitization program. In the event we do not either enter into a new financing agreement, or an agreement to extend the scheduled maturity date of the Securitization, we expect to have the borrowing capacity and would intend to refinance the Securitization upon its scheduled maturity utilizing borrowings under our Credit Agreement. Therefore, outstanding borrowings as of December 31, 2012 under the Securitization are classified as long-term on our Consolidated Balance Sheet.

Our $250 million, 7.00% senior unsecured notes (the "Unsecured Notes") are scheduled to mature on October 1, 2018. The Unsecured Notes were issued on September 29, 2010 and registered in April, 2011. Interest on the Unsecured Note is payable semiannually in arrears on April 1st and October 1st of each year. The Unsecured Notes can be redeemed in whole at anytime subject to a make-whole call at treasury rate plus 50 basis points prior to October 1, 2014. They are also redeemable in whole or in part at a price of: (i) 103.5% on or after October 1, 2014; (ii) 101.75% on or after October 1, 2015, and; (iii) 100% on or after October 1, 2016. These Unsecured Notes are guaranteed by a group of subsidiaries (each of which is a 100% directly owned subsidiary of Universal Health Services, Inc.) which fully and unconditionally guarantee the Unsecured Notes on a joint and several basis, subject to certain customary automatic release provisions.

On June 30, 2006, we issued $250 million of senior notes which have a 7.125% coupon rate and mature on June 30, 2016 (the "7.125% Notes"). Interest on the 7.125% Notes is payable semiannually in arrears on June 30th and December 30th of each year. In June, 2008, we issued an additional $150 million of 7.125% Notes which formed a single series with the original 7.125% Notes issued in June, 2006. Other than their date of issuance and initial price to the public, the terms of the 7.125% Notes issued in June, 2008 are identical to and trade interchangeably with, the 7.125% Notes which were originally issued in June, 2006.

During 2001, we issued $200 million of senior notes which have a 6.75% coupon rate and which matured and were paid in full on November 15, 2011 (the "6.75% Notes").

In connection with the entering into of the Credit Agreement on November 15, 2010, and in accordance with the Indenture dated January 20, 2000 governing the rights of our existing notes, we entered into a supplemental indenture pursuant to which our 7.125% Notes (due in 2016) and our 6.75% Notes (which matured and were paid in full in November, 2011) were equally and ratably secured with the lenders under the Credit Agreement with respect to the collateral for so long as the lenders under the Credit Agreement are so secured.

The average amounts outstanding during 2012, 2011 and 2010 under the current and prior Credit Agreements, demand notes and accounts receivable securitization programs were $2.9 billion, $2.9 billion and $610 million, respectively, with corresponding interest rates of 2.9%, 3.4% and 3.4% including commitment and facility fees. The maximum amounts outstanding at any month-end were $3.06 billion in 2012, $3.03 billion in 2011 and $3.11 billion in 2010. The effective interest rate on our current and prior Credit Agreements, accounts receivable securitization programs, and demand notes, which includes the respective interest expense, commitment and facility fees, designated interest rate swaps expense and amortization of deferred financing costs and original issue discounts, was 4.5% in 2012, 4.6% in 2011 and 5.0% in 2010.

Our Credit Agreement includes a material adverse change clause that must be represented at each draw. The Credit Agreement contains covenants that include a limitation on sales of assets, mergers, change of ownership,

181
SUPPLEMENTAL- # 1
December 26, 2013
12:16pm

liens and indebtedness, transactions with affiliates and dividends; and requires compliance with financial covenants including maximum leverage and minimum interest coverage ratios. We are in compliance with all required covenants as of December 31, 2012.

The carrying values of our debt at December 31, 2012 and 2011 are reflected above. The fair values of our debt at December 31, 2012 and 2011 were $3.8 billion and $3.7 billion, respectively. The fair value of our debt was computed based upon quotes received from financial institutions. We consider these to be "level 2" in the fair value hierarchy as outlined in the authoritative guidance for disclosures in connection with debt instruments.

Aggregate maturities follow:

	(000s)
2013	$ 2,589
2014	2,012
2015	68,588
2016	3,382,793
2017	1,262
Later	272,776
Total	$ 3,730,020

Amounts outstanding under our on-demand credit facility and Securitization program, as well as the scheduled Installment Payments due on our Term Loan-A and Term Loan-A2 facilities, as discussed above, are included in the Credit Agreement maturities which are due in 2016.

5) COMMON STOCK

Dividends

Cash dividends of $.60 per share ($58.3 million in the aggregate), including a $.40 per share special cash dividend ($38.9 million) were declared and paid during 2012. Cash dividends of $.20 per share ($19 million in the aggregate) were declared and paid during each of 2011 and 2010. All classes of our common stock have similar economic rights.

Stock Repurchase Programs

In various prior years, our Board of Directors has approved stock repurchase programs authorizing us to purchase shares of our outstanding Class B Common Stock on the open market at prevailing market prices or in negotiated transactions off the market. There is no expiration date for our stock repurchase programs. The most recent approval occurred during 2007 at which time our Board of Directors authorized the purchase of up to 10 million shares, a portion of which (as reflected below) remains available for purchase as of December 31,

182
SUPPLEMENTAL - # 1
December 26, 2013
12:16pm

2012. The following schedule provides information related to our stock repurchase programs for each of the three years ended December 31, 2012:

	Total number of shares purchased as part of publicly announced programs	Total price paid for shares purchased as part of publicly announced programs (in thousands)	Total number of shares purchased related to stock-based compensation plans (a.)	Total price paid for shares purchased related to stock-based compensation plans (in thousands)	Aggregate number of shares purchased	Aggregate price paid for shares purchased (in thousands)	Maximum number of shares that may yet be purchased under the publicly announced program
Balance as of January 1, 2010							2,152,339
2010.....	—	—	301,933	$ 11,528	301,933	$ 11,528	2,152,339
2011.....	1,384,637	$ 50,576	217,649	$ 9,906	1,602,286	$ 60,482	767,702
2012.....	—	—	433,312	$ 19,154	433,312	$ 19,154	767,702
Total for three year period ended December 31, 2012	1,384,637	$ 50,576	952,894	$ 40,588	2,337,531	$ 91,164	

(a.) During 2012, there were 432,562 shares repurchased at an average price of $44.28 per share related to income tax withholding obligations in connection with stock-based compensation programs, and 750 shares repurchased at an average of $.01 per share related to restricted shares that were forfeited by former employees pursuant to the terms of our restricted stock purchase plan. During 2011, there were 217,649 shares repurchased at an average price of $45.51 per share related to income tax withholding obligations in connection with stock-based compensation programs. During 2010, there were 293,933 shares repurchased at an average price of $39.22 per share related to income tax withholding obligations in connection with stock-based compensation programs and 8,000 shares repurchased at an average price of $.01 per share related to restricted shares that were forfeited by former employees pursuant to the terms of our restricted stock purchase plan.

Stock-based Compensation Plans

At December 31, 2012, we have a number of stock-based employee compensation plans. Pursuant to the FASB's guidance, we expense the grant-date fair value of stock options and other equity-based compensation pursuant to the straight-line method over the stated vesting period of the award using the Black-Scholes option-pricing model.

The expense associated with share-based compensation arrangements is a non-cash charge. In the Consolidated Statements of Cash Flows, share-based compensation expense is an adjustment to reconcile net income to cash provided by operating activities. The applicable FASB guidance requires that cash flows resulting from tax deductions in excess of compensation cost recognized be classified as financing cash flows. During 2012, 2011 and 2010, there were no net excess tax benefits generated.

Compensation costs related to outstanding stock options were recognized as follows: (i) a pre-tax charge of $20.1 million ($12.5 million after-tax) or $.13 per diluted share during 2012; (ii) a pre-tax charge of $15.8 million ($9.8 million after-tax) or $.10 per diluted share during 2011, and; (ii) a pre-tax charge of $13.3 million ($8.3 million after-tax) or $.08 per diluted share during 2010. In addition, during the years ended 2012, 2011 and 2010, compensation costs of $2.3 million ($1.4 million after-tax), $2.0 million ($1.2 million after-tax) and $3.1 million ($2.0 million after-tax) respectively, were recognized related to restricted stock.

We adopted the 2005 Stock Incentive Plan, as amended in 2008 and 2010, (the "Stock Incentive Plan") which replaced our Amended and Restated 1992 Stock Option Plan which expired in July of 2005. An aggregate

183
SUPPLEMENTAL - # 1
December 26, 2013
12:16pm

of twenty-three million shares of Class B Common Stock has been reserved under the Stock Incentive Plan. There were 2,760,050, 2,561,250 and 69,500 stock options, net of cancellations, granted during 2012, 2011 and 2010, respectively. The per option weighted-average grant-date fair value of options granted during 2012, 2011 and 2010, was $10.73, $11.62 and $7.84, respectively. Stock options to purchase Class B Common Stock have been granted to our officers, key employees and directors under our above referenced stock option plans. All stock options were granted with an exercise price equal to the fair market value on the date of the grant. Options are exercisable ratably over a four-year period beginning one year after the date of the grant. All outstanding options expire five years after the date of the grant.

The fair value of each option grant was estimated on the date of grant using the Black-Scholes option-pricing model with the following weighted average assumptions derived from averaging the number of options granted during the most recent five-year period that were granted or have vestings after January 1, 2006. The 2010 weighted-average assumptions were based upon seventeen option grants, the 2011 and 2012 weighted-average assumptions were each based upon eighteen option grants.

Year Ended December 31,	2012	2011	2010
Volatility	33%	29%	27%
Interest rate	1%	2%	3%
Expected life (years)	3.5	3.5	3.6
Forfeiture rate	10%	9%	10%
Dividend yield	0.6%	0.7%	0.7%

The risk-free rate is based on the U.S. Treasury zero coupon four year yield in effect at the time of grant. The expected life of the stock options granted was estimated using the historical behavior of employees. Expected volatility was based on historical volatility for a period equal to the stock option's expected life. Expected dividend yield is based on our actual dividend yield at the time of grant.

The table below summarizes our stock option activity during each of the last three years:

Outstanding Options	Number of Shares	Average Option Price	Range (High-Low)
Balance, January 1, 2010	8,802,450	$ 25.03	$ 31.70 -$16.22
Granted	94,000	$ 30.40	$ 32.28 -$30.32
Exercised	(2,000,250)	$ 24.87	$ 31.70 -$16.22
Cancelled	(301,250)	$ 24.91	$ 31.18 -$16.22
Balance, January 1, 2011	6,594,950	$ 25.16	$ 32.28 -$16.22
Granted	2,894,500	$ 43.66	$ 54.79 -$38.12
Exercised	(1,563,255)	$ 26.38	$ 32.28 -$16.22
Cancelled	(367,250)	$ 32.60	$ 46.97 -$16.22
Balance, January 1, 2012	7,558,945	$ 31.63	$ 54.79 -$16.22
Granted	2,966,850	$ 37.01	$ 44.83 -$36.[illegible]
Exercised	(2,608,007)	$ 23.22	$ 46.97 -$16.[illegible]

SUPPLEMENTAL- # 1
December 26, 2013
12:16pm

Cancelled	(481,550)	$ 38.00	$ 46.97 -$16.22
Balance, December 31, 2012	7,436,238	$ 36.31	$ 54.79 -$16.22
Outstanding options vested and exercisable as of December 31, 2012	2,185,312	$ 30.40	$ 54.79 -$16.22

Table of Contents

The following table provides information about unvested options for the year December 31, 2012:

	Shares	Weighted Average Grant Date Fair Value
Unvested options as of January 1, 2012	4,579,000	$ 9.50
Granted	2,966,850	$ 10.73
Vested	(1,845,249)	$ 7.75
Cancelled	(449,675)	$ 10.32
Unvested options as of December 31, 2012	5,250,926	$ 10.74

The following table provides information about all outstanding options, and exercisable options, at December 31, 2012:

	Options Outstanding	Options Exercisable
Number	7,436,238	2,185,312
Weighted average exercise price	$ 36.31	$ 30.40
Aggregate intrinsic value as of December 31, 2012	$ 89,595,385	$ 39,256,370
Weighted average remaining contractual life	3.0	2.0

The total in-the-money value of all stock options exercised during the years ended December 31, 2012, 2011 and 2010 were $54.4 million, $28.9 million and $26.8 million, respectively.

The weighted average remaining contractual life for options outstanding and weighted average exercise price per share for exercisable options at December 31, 2012 were as follows:

	Options Outstanding			Exercisable Options		Expected to Vest Options(a)	
Exercise Price	Shares	Weighted Average Exercise Price Per Share	Weighted Average Remaining Contractual Life (in Years)	Shares	Weighted Average Exercise Price Per Share	Shares	Weighted Average Exercise Price Per Share
$16.22 – $16.22	586,000	$ 16.22	.9	586,000	$ 16.22	N/A	N/A
$30.32 – $31.18	1,616,000	31.16	2.0	1,032,750	31.17	525,275	31.1
$36.95 – $43.46	2,797,050	37.03	2.9	11,250	39.09	2,508,891	37.0

185
SUPPLEMENTAL- # 1
December 26, 2013
12:16pm

$43.67 – $54.79	2,437,188	43.75	3.1	555,312	43.75	1,694,818	43.75
Total	7,436,238	$ 36.31	3.0	2,185,312	$ 30.40	4,728,984	$ 38.78

(a) Assumes a weighted average forfeiture rate of 9.94%.

In addition to the Stock Incentive Plan, we have the following stock incentive and purchase plans: (i) the 2010 Employees' Restricted Stock Purchase Plan ("2010 Plan"), which replaced the Second Amended and Restated 2001 Employees' Restricted Stock Purchase Plan ("2001 Plan"), which allows eligible participants to purchase shares of Class B Common Stock at par value, subject to certain restrictions, and; (ii) a 2005 Employee Stock Purchase Plan which allows eligible employees to purchase shares of Class B Common Stock at a ten percent discount. There were 117,901, 98,366 and 94,955 shares issued pursuant to the Employee Stock Purchase Plan during 2012, 2011 and 2010, respectively. Compensation expense recorded in connection with this plan was $533,000, $461,000 and $339,000 during 2012, 2011 and 2010, respectively.

We have reserved 6.0 million shares of Class B Common Stock for issuance under these various plans (excluding terminated plans) and have issued approximately 900,000 shares, net of cancellations, pursuant to the terms of these plans (excluding terminated plans) as of December 31, 2012.

During 2012, pursuant to the 2010 Plan, the Compensation Committee ("Committee") approved the issuance of 54,127 restricted shares of our Class B Common Stock at a weighted average price of $36.95 per share ($2.0 million in the aggregate) to our CEO and Chairman of the Board. These shares are scheduled to vest as follows: 50% on the first anniversary date of the grant, and 25% on each of the second and third anniversary dates of the grant, assuming our CEO remains employed by us. In the event that our CEO's employment is terminated for reasons other than death, disability or retirement, any unvested shares will be forfeited, unless otherwise specified in a separation agreement between us and our CEO. We recorded compensation expense of approximately $1 million during 2012 in connection with this grant. The remaining expense associated with these awards (estimated at approximately $1 million as of December 31, 2012) will be recorded over the remaining vesting periods of the awards, assuming the recipient remain employed by us.

During 2011, pursuant to the 2010 Plan, the Committee approved the issuance of 21,500 restricted shares of our Class B Common Stock at a weighted average price of $53.21 per share ($1.1 million in the aggregate) to various employees. 750 of these shares became vested during 2012 and 750 of these shares were cancelled during 2012. The remaining 20,000 shares are scheduled to vest ratably on the second and third anniversaries of the grant date. We recorded compensation expense of $370,000 during 2012 and $198,000 during 2011 in connection with these grants. The remaining expense associated with these awards (estimated at $537,000 as of December 31, 2012) will be recorded over the remaining vesting periods of the awards, assuming the recipients remain employed by us.

The 2001 Plan, as described above, expired in March, 2010. Under this plan, we had 2.4 million shares of Class B Common Stock reserved for issuance and have issued approximately 1.2 million shares, net of cancellations, pursuant to the terms of this plan as of December 31, 2010, of which 62,044 became fully vested during 2012, 78,133 became fully vested during 2011 and 313,770 became fully vested during 2010.

During the first quarter of 2010, pursuant to the 2001 Plan and prior to its expiration, the Committee approved the issuance of 49,472 restricted shares of our Class B Common Stock at $30.32 per share ($1.5 million in the aggregate) to our CEO and Chairman of the Board. These shares, which were issued pursuant to a provision in our CEO's employment agreement, are scheduled to vest ratably on the first, second, third and fourth anniversary dates of the grant, assuming our CEO remains employed by us. In the event that our CEO's employment is terminated by reason of disability, death, without proper cause or due to breach

186
SUPPLEMENTAL - # 1
December 26, 2013
12:16pm

the CEO's employment agreement by us, the vesting of these awards will occur immediately. 12,368 of these shares became fully vested in each of 2012 and 2011. In connection with this grant, we recorded compensation expense of $375,000 in each of 2012 and 2011 and $355,000 during 2010, and the remaining expense associated with this award (estimated at $395,000 as of December 31, 2012) will be recorded over the remaining vesting periods of the award.

During the first quarter of 2009, pursuant to the 2001 Plan, the Committee approved the issuance of 109,850 restricted shares of our Class B Common Stock at $20.26 per share ($2.2 million in the aggregate) to our CEO. These shares are scheduled to vest ratably on the first, second, third and fourth anniversary dates of the grant and are subject to the same conditions and terms as mentioned above in connection with the grant of restricted shares during the first quarter of 2010. 27,462 of these shares became fully vested in each of 2012 and 2011 and 27,463 of these shares became fully vested in 2010. In connection with this grant, we recorded compensation expense of $556,000 during each of 2012, 2011 and 2010 and $482,000 during 2009. The remaining expense associated with this award (estimated at $74,000 as of December 31, 2012) will be recorded over the remaining vesting periods of the award.

During the first quarter of 2008, pursuant to the 2001 Plan, the Committee approved the issuance of 62,190 restricted shares of our Class B Common Stock at $24.12 per share ($1.5 million in the aggregate) to our CEO. These shares are scheduled to vest ratably on the first, second, third and fourth anniversary dates of the grant and are subject to the same conditions and terms as mentioned above in connection with the grant of restricted shares during the first quarter of 2010. 15,548 and 15,546 of these shares became fully vesting during 2012 and 2011, respectively, and 15,548 of these shares became fully vested in each of 2010 and 2009. In connection with this grant, we recorded compensation expense of $15,000 during 2012 and $375,000 during each of 2011 and 2010. This award was fully vested at December 31, 2012.

During the fourth quarter of 2007, pursuant to the 2001 Plan, the Committee approved the issuance of 61,362 restricted shares of our Class B Common Stock at $24.45 per share ($1.5 million in the aggregate) to our CEO. These shares were scheduled to vest ratably on the first, second, third and fourth anniversary dates of the grant and were subject to the same conditions and terms as mentioned above in connection with the grant of restricted shares during the first quarter of 2010. 15,341 of these shares became fully vested in each of 2011 and 2010 and 15,340 of these shares became fully vested in each of 2009 and 2008. In connection with this grant, we recorded compensation expense of $333,000 during 2011 and $375,000 during 2010. This award was fully vested at December 31, 2011.

Additionally, during 2007, pursuant to the 2001 Plan, the Committee approved the issuance of 22,250 restricted shares of our Class B Common stock at a weighted average of $29.62 per share ($659,000 in the aggregate) to various employees. These shares have various vesting schedules. We recorded compensation expense of $42,000 during 2012, $120,000 during 2011 and $135,000 during 2010, in connection with these grants. These awards were fully vested at December 31, 2012.

During the fourth quarter of 2006, pursuant to the 2001 Plan, the Committee approved the issuance of 247,000 restricted shares (net of cancellations) of our Class B Common Stock at $25.71 per share ($6.4 million in the aggregate) to various officers and employees. These shares became fully vested in November, 2010. In connection with this grant, we recorded compensation expense of $1.3 million during 2010. These awards were fully vested at December 31, 2010.

At December 31, 2012, 28,083,325 shares of Class B Common Stock were reserved for issuance upon conversion of shares of Class A, C and D Commo Stock outstanding, for issuance upon exercise of options to purchase Class B Common Stock and for issuance of stock under other incentive plans. Class A, C and D Common Stock are convertible on a share for share basis into Class B Common Stock.

187
SUPPLEMENTAL- #
December 26, 201
12:16pm

In connection with the long-term incentive plans described above, we recorded compensation expense of $2.8 million in 2012, $2.4 million in 2011 and $3.5 million in 2010. Including the compensation expense recognized related to outstanding stock options of $20.1 million in 2012, $15.8 million in 2011 and $13.3 million in 2010, we recorded a total stock compensation expense of $22.9 million in 2012, $18.2 million in 2011 and $16.8 million in 2010.

Table of Contents

6) INCOME TAXES

Components of income tax expense/(benefit) are as follows (amounts in thousands):

	Year Ended December 31,		
	2012	2011	2010
Current			
Federal	$ 254,021	$ 165,409	$ 105,077
Foreign	9,084	300	2,555
State	39,076	22,901	16,547
	302,181	188,610	124,179
Deferred			
Federal and foreign	(21,408)	53,056	26,419
State	(6,157)	5,800	1,704
	(27,565)	58,856	28,123
Total	$ 274,616	$ 247,466	$ 152,302

Deferred taxes are required to be classified based on the financial statement classification of the related assets and liabilities which give rise to temporary differences. Deferred taxes result from temporary differences between the financial statement carrying amounts and the tax bases of assets and liabilities. The components of deferred taxes are as follows (amounts in thousands):

	Year Ended December 31,	
	2012	2011
Deferred income tax assets:		
Self-insurance reserves	$ 112,587	$ 115,201
Compensation accruals	47,571	49,717
State and foreign net operating loss carryforwards and other state and foreign deferred tax assets	54,874	52,506
Other currently non-deductible accrued liabilities	29,934	19,699
Net pension liability—OCI only	12,061	13,959
Doubtful accounts and other reserves	17,562	17,345
Other combined items—OCI only	15,282	17,684
	289,871	286,111
Less: Valuation Allowance	(44,511)	(42,143)
Net deferred income tax assets:	245,360	243,968

188
SUPPLEMENTAL - # 1
December 26, 2013
12:16pm

Deferred income tax liabilities:		
Depreciable and amortizable assets	(322,317)	(342,655)
Other deferred tax liabilities	(2,329)	(2,581)
Net deferred income tax liabilities	$ (79,286)	$(101,268)

There was no material impact of deferred taxes recorded in conjunction with the acquisition of Ascend Health Corporation.

Table of Contents

The effective tax rates, as calculated by dividing the provision for income taxes by income before income taxes, were as follows for each of the years ended December 31, 2012, 2011 and 2010 (dollar amounts in thousands):

	2012	2011	2010
Provision for income taxes	$274,616	$247,466	$152,302
Income before income taxes	763,663	696,336	428,097
Effective tax rate	36.0%	35.5%	35.6%

Impacting the effective tax rates during 2012 was approximately $1 million favorable discrete tax item recorded to adjust the estimated liabilities for uncertain tax positions. Impacting the effective tax rates during 2011 was approximately $1 million favorable discrete tax item recorded to adjust the estimated liabilities for uncertain tax positions. Impacting the effective tax rates during 2010 were the following items: (i) $5 million unfavorable discrete tax item recorded to adjust the non-deductible portion of certain transaction costs incurred during 2010 in connection with our acquisition of PSI; (ii) a $4 million unfavorable discrete tax item recorded to adjust for the non-deductible, $9 million charge incurred from split-dollar life insurance agreements entered into during 2010 on the lives of our chief executive officer and his wife, partially offset by; (iii) a $4 million favorable discrete tax item recorded during 2010 to adjust the estimated non-deductible portion of the previously disclosed South Texas Health System settlement with the government based upon the final agreement.

A reconciliation between the federal statutory rate and the effective tax rate is as follows:

	Year Ended December 31,		
	2012	2011	2010
Federal statutory rate	35.0%	35.0%	35.0%
State taxes, net of federal income tax benefit	3.0	2.9	3.1
Nondeductible transaction costs	0.2	—	1.3
Other items	0.1	0.4	0.4
Impact of income attributable to noncontrolling interests	(2.3)	(2.8)	(4.2)
Effective tax rate	36.0%	35.5%	35.6%

Included in "Other current assets" on our Consolidated Balance Sheet are prepaid federal, foreign, and state income taxes amounting to approximately $7 million and $25 million as of December 31, 2012 and 2011, respectively.

The net deferred tax assets and liabilities are comprised as follows (amounts in thousands):

	Year Ended December 31,	
	2012	2011

189
SUPPLEMENTAL- # 1
December 26, 2013
12:16pm

Current deferred taxes		
Assets	$ 105,639	$ 109,297
Liabilities	(1,178)	(973)
Total deferred taxes-current	104,461	108,324
Noncurrent deferred taxes		
Assets	142,065	135,189
Liabilities	(325,812)	(344,781)
Total deferred taxes-noncurrent	(183,747)	(209,592)
Total deferred tax liabilities	$ (79,286)	$(101,268)

Table of Contents

The assets and liabilities classified as current relate primarily to the allowance for uncollectible patient accounts, compensation-related accruals and the current portion of the temporary differences related to self- insurance reserves. At December 31, 2012, state net operating loss carryforwards (expiring in years 2013 through 2032), and credit carryforwards available to offset future taxable income approximated $959 million, representing approximately $48 million in deferred state tax benefit (net of the federal benefit). At December 31, 2012, related to the acquisition of PSI, there were federal net operating losses of approximately $1 million expiring in 2022 representing approximately $0.4 million in deferred federal tax benefits and foreign net operating loss carryforwards of approximately $9 million expiring through 2021 representing approximately $3 million in deferred foreign tax benefit.

A valuation allowance is required when it is more likely than not that some portion of the deferred tax assets will not be realized. Based on available evidence, it is more likely than not that certain of our state tax benefits will not be realized. Therefore, valuation allowances of approximately $41 million and $39 million have been reflected as of December 31, 2012 and 2011, respectively. During 2012, the valuation allowance on these state tax benefits increased by approximately $2 million due to additional net operating losses incurred. In addition, valuation allowances of approximately $3 million have been reflected as of December 31, 2012 and 2011 related to foreign net operating losses. There were no significant increases in valuation allowances as a result of the acquisition of Ascend Health Corporation.

We adopted the provisions of Accounting for Uncertainty in Income Taxes effective January 1, 2007. During 2012 and 2011, the estimated liabilities for uncertain tax positions (including accrued interest and penalties) were increased in the amount of approximately $1 million due to tax positions taken in the current and prior years. There was no significant increase in 2012 attributable to tax positions taken by Ascend Health Corporation on pre-acquisition tax return years. Also during 2012, the estimated liabilities for uncertain tax positions (including accrued interest and penalties) were reduced due to the lapse of the statute of limitations resulting in a net income tax benefit of approximately $1 million. The balance at each of December 31, 2012 and 2011, if subsequently recognized, that would favorably affect the effective tax rate and the provision for income taxes is approximately $4 million and $5 million respectively.

We recognize accrued interest and penalties associated with uncertain tax positions as part of the tax provision. As of December 31, 2012 and 2011, we have approximately $1 million of accrued interest and penalties. The U.S. federal statute of limitations remains open for the 2009 and subsequent years. Foreign and U.S. state and local jurisdictions have statutes of limitations generally ranging for 3 to 4 years. The statute of limitations on certain jurisdictions could expire within the next twelve months. It is reasonably possible that the amount of unrecognized tax benefits will change during the next 12 months however it is anticipated that any such change, if it were to occur, would not have a material impact on our results of operations.

190
SUPPLEMENTAL- # 1
December 26, 2013
12:16pm

The tabular reconciliation of unrecognized tax benefits for the years ended December 31, 2012, 2011 and 2010 is as follows (amounts in thousands).

	As of December 31,		
	2012	2011	2010
Balance at January 1,	$ 7,403	$ 7,923	$5,754
Additions based on tax positions related to the current year	200	750	1,219
Additions for tax positions of prior years	386	419	2,076
Reductions for tax positions of prior years	(1,165)	(1,628)	(907)
Settlements	—	(61)	(219)
Balance at December 31,	$ 6,824	$ 7,403	$7,923

Table of Contents

7) LEASE COMMITMENTS

Four of our hospital facilities are held under operating leases with Universal Health Realty Income Trust with terms expiring in 2014 and 2016 (see Note 9 for additional disclosure). We also lease the real property of certain facilities acquired by us in connection with the acquisition of PSI in November, 2010 and the acquisition of Ascend in October, 2012 (see Item 2. *Properties* for additional disclosure).

A summary of property under capital lease follows (amounts in thousands):

	As of December 31,	
	2012	2011
Land, buildings and equipment	$ 27,836	$ 37,037
Less: accumulated amortization	(26,540)	(35,264)
	$ 1,296	$ 1,773

Future minimum rental payments under lease commitments with a term of more than one year as of December 31, 2012, are as follows (amounts in thousands):

Year	Capital Leases	Operating Leases
	(000s)	
2013	$ 2,162	$ 58,638
2014	1,369	50,973
2015	1,158	43,496
2016	1,068	36,952
2017	1,077	21,906
Later years	5,117	102,722
Total minimum rental	$11,951	$314,687
Less: Amount representing interest	(3,684)	
Present value of minimum rental commitments	8,267	
Less: Current portion of capital lease obligations	(1,585)	

191
SUPPLEMENTAL- # 1
December 26, 2013
12:16pm

Long-term portion of capital lease obligations	$ 6,682

We incurred no additional capital lease obligations during 2012.

8) COMMITMENTS AND CONTINGENCIES

Professional and General Liability, Workers' Compensation Liability and Property Insurance

Professional and General Liability and Workers Compensation Liability:

Effective January 1, 2008, most of our subsidiaries became self-insured for professional and general liability exposure up to $10 million per occurrence. Prior to our acquisition of Psychiatric Solutions, Inc. ("PSI") in November, 2010, our subsidiaries purchased several excess policies through commercial insurance carriers which provide for coverage in excess of $10 million up to $200 million per occurrence and in the aggregate. However, we are liable for 10% of the claims paid pursuant to the commercially insured coverage in excess of $10 million up to $60 million per occurrence and in the aggregate.

Prior to our acquisition in November, 2010, the PSI subsidiaries were commercially insured for professional and general liability insurance claims in excess of a $3 million self-insured retention to a limit of $75 million. PSI utilized its captive insurance company and that captive insurance company remains in place after our

acquisition of PSI to manage the self-insured retention for all former PSI subsidiaries for claims incurred prior to January 1, 2011. The captive insurance company also continues to insure all professional and general liability claims, regardless of date incurred, for the former PSI subsidiaries located in Florida and Puerto Rico.

Since our acquisition of PSI on November 15, 2010, the former PSI subsidiaries are self-insured for professional and general liability exposure up to $3 million per occurrence and our legacy subsidiaries (which are not former PSI subsidiaries) are self-insured for professional and general liability exposure up to $10 million per occurrence. Effective November, 2010, our subsidiaries (including the former PSI subsidiaries) were provided with several excess policies through commercial insurance carriers which provide for coverage in excess of the applicable per occurrence self-insured retention (either $3 million or $10 million) up to $200 million per occurrence and in the aggregate. We remain liable for 10% of the claims paid pursuant to the commercially insured coverage in excess of $10 million up to $60 million per occurrence and in the aggregate. The 9 behavioral health facilities acquired from Ascend Health Corporation in October, 2012 have general and professional liability policies through commercial insurance carriers which provide for up to $20 million of aggregate coverage, subject to a $10,000 per occurrence deductible. These facilities, like our other facilities, are also provided excess coverage through commercial insurance carriers for coverage in excess of the underlying commercial policy limitations up to $200 million per occurrence and in the aggregate.

Our estimated liability for self-insured professional and general liability claims is based on a number of factors including, among other things, the number of asserted claims and reported incidents, estimates of losses for these claims based on recent and historical settlement amounts, estimates of incurred but not reported claims based on historical experience, and estimates of amounts recoverable under our commercial insurance policies. While we continuously monitor these factors, our ultimate liability for professional and general liability claims could change materially from our current estimates due to inherent uncertainties

192
SUPPLEMENTAL - # 1
December 26, 2013
12:16pm

involved in making this estimate. Given our significant self-insured exposure for professional and general liability claims, there can be no assurance that a sharp increase in the number and/or severity of claims asserted against us will not have a material adverse effect on our future results of operations.

As of December 31, 2012, the total accrual for our professional and general liability claims, including the estimated claims related to the facilities acquired from PSI, was $279 million, of which $48 million is included in current liabilities. As of December 31, 2011, the total accrual for our professional and general liability claims, including the estimated claims related to the facilities acquired from PSI, was $292 million, of which $60 million is included in current liabilities.

We recorded reductions to our professional and general liability self-insurance reserves (relating to prior years) amounting to $27 million during 2012, $11 million during 2011 and $49 million during 2010. The favorable change recorded during 2012 resulted from favorable changes in our estimated future claims payments pursuant to a reserve analysis. The favorable change recorded during 2011 consisted primarily of third-party recoveries and reserve reductions in connection with PHICO–related claims which we became liable for upon PHICO's (a former commercial insurance carrier) liquidation in 2002. The favorable changes in our estimated future claims payments recorded during 2010 were due to: (i) an increased weighting given to company-specific metrics (to 75% from 50%), and decreased general industry metrics (to 25% from 50%), related to projected incidents per exposure, historical claims experience and loss development factors; (ii) historical data which measured the realized favorable impact of medical malpractice tort reform experienced in several states in which we operate, and; (iii) a decrease in claims related to certain higher risk specialties (such as obstetrical) due to a continuation of the company-wide patient safety initiative undertaken during the last several years. As the number of our facilities and our patient volumes have increased, thereby providing for a statistically significant data group, and taking into consideration our long-history of company-specific risk management programs and claims experience, our reserve analyses have included a greater emphasis on our historical professional and general liability experience which has developed favorably as compared to general industry trends.

As of December 31, 2012, the total accrual for our workers' compensation liability claims was $66 million, of which $35 million is included in current liabilities. As of December 31, 2011, the total accrual for our workers' compensation liability claims was $65 million, of which $34 million is included in current liabilities.

There were no material adjustments to our prior year reserves for workers' compensation claims recorded during 2012 or 2011. Based upon the results of workers' compensation reserves analyses, during 2010, we recorded a reduction to our prior year reserves for workers' compensation claims amounting to $4 million.

Property Insurance:

We have commercial property insurance policies covering catastrophic losses, including windstorm damage, up to a $1 billion policy limit per occurrence, subject to a $250,000 deductible for the majority of our properties (the properties acquired from Psychiatric Solutions, Inc. are subject to a $50,000 deductible). Losses resulting from named windstorms are subject to deductibles between 3% and 5% of the declared total insurable value of the property. In addition, we have commercial property insurance policies covering catastrophic losses resulting from earthquake and flood damage, each subject to aggregated loss limits (as opposed to per occurrence losses). Our earthquake limit is $250 million, subject to a deductible of $250,000, except for facilities located within documented fault zones. Earthquake losses that affect facilities located in fault zones within the United States are subject to a $100 million limit and will have applied deductibles ranging from 1% to 5% of the declared total insurable value of the property. The earthquake limit in Puerto Rico is $25 million. Flood losses have either a

193
SUPPLEMENTAL- # 1
December 26, 2013
12:16pm

$250,000 or $500,000 deductible, based upon the location of the facility. The 9 behavioral health facilities acquired from Ascend Health Corporation in October, 2012 have commercial property insurance policies which provide for full replacement cost coverage, subject to a $10,000 deductible.

Legal Proceedings

We are subject to claims and suits in the ordinary course of business, including those arising from care and treatment afforded by our hospitals and are party to litigation, as outlined below.

Two Rivers Psychiatric Hospital:

In April, 2011, the Centers for Medicare and Medicaid Services ("CMS") issued notice of its decision terminating Two Rivers Psychiatric Hospital ("Two Rivers") in Kansas City, Missouri from participation in the Medicare and Medicaid program. The termination notice was issued as a result of surveys conducted which allegedly found Two Rivers to be out of compliance with the conditions of participation required for participation in the Medicare program and for Two Rivers' alleged failure to alleviate an "immediate jeopardy" situation. Two Rivers filed an administrative appeal with the U.S. Department of Health and Human Services, Departmental Appeal Board, Civil Remedies Division, seeking review and reversal of that decision. In addition, Two Rivers filed a complaint in the U.S. District Court for the Western District of Missouri seeking a temporary restraining order and preliminary injunction against CMS rescinding the termination action. Later in April, 2011, the District Court issued a temporary restraining order abating the termination action pending a preliminary injunction hearing or an agreement with CMS. In May, 2011, Two Rivers and CMS entered into a settlement agreement which resulted in the rescission of the termination notice and actions by CMS. Pursuant to the terms of the agreement, Two Rivers was required to submit an acceptable plan of correction relative to the immediate jeopardy citation and engage independent experts in various disciplines to analyze and develop implementation plans for Two Rivers to meet the applicable Medicare conditions of participation. Both of these actions have occurred. Pursuant to the agreement, CMS conducted an initial survey of Two Rivers in April 2012 to determine if the Medicare conditions of participation, which formed the basis of the termination action in April 2011, had been met. In late April, 2012, CMS advised Two Rivers that it has successfully passed this initial survey. Pursuant to the terms of the agreement, a second survey will be conducted in early 2013 to further confirm that Two Rivers is in compliance with all Medicare/Medicaid Conditions of Participation. During the term of this agreement, Two Rivers remains eligible to receive reimbursements for services rendered to Medicare and

Medicaid beneficiaries. Two Rivers remains fully committed to providing high-quality healthcare to their patients and the community it serves. We therefore intend to work expeditiously and collaboratively with CMS in an effort to resolve these matters. We can provide no assurance that Two Rivers will not ultimately lose its Medicare certification. The operating results of Two Rivers did not have a material impact on our consolidated results of operations or financial condition for the years ended December 31, 2012 or 2011.

Office of Inspector General ("OIG") and Other Government Investigations

In September, 2010, we, along with many other companies in the healthcare industry, received a letter from the United States Department of Justice ("DOJ") advising of a False Claim Act investigation being conducted in connection with the implantation of implantable cardioverter defibrillators ("ICDs") from 2003 to the present at several of our acute care facilities. The DOJ alleges that ICDs were implanted and billed by our facilities in contravention of a

194
SUPPLEMENTAL- # 1
December 26, 2013
12:16pm

National Claims Determination regarding these devices. We have established a reserve in connection with this matter which did not have a material impact on our consolidated financial statements.

In July, 2012, one of our subsidiaries, Peachford Behavioral Health System of Atlanta located in Atlanta, Georgia, received a subpoena from the OIG for the Department of Health and Human Services requesting various documents from 2004 to the present. We are in the process of securing and collecting the requested documents for production. At present, we are uncertain as to the focus, scope or extent of the investigation, liability of the facility and/or potential financial exposure, if any, in connection with this matter.

In February, 2013, the OIG served a subpoena requesting various documents from January 2008 to the present directed at Universal Health Services, Inc. ("UHS") concerning it and UHS of Delaware, Inc., and several UHS owned facilities including: Keys of Carolina, Old Vineyard Behavioral Health, The Meadows Psychiatric Center, Streamwood Behavioral Health, Hartgrove Hospital, Rock River Academy and Residential Treatment Center, Roxbury Treatment Center, Harbor Point Behavioral Health Center, f/k/a, The Pines Residential Treatment Center, including the Crawford, Brighton and Kempsville campuses, Wekiva Springs Center and River Point Behavioral Health. Prior to receiving this subpoena: (i) the Keys of Carolina and Old Vineyard received notification during the second half of 2012 from the United States Department of Justice of its intent to proceed with an investigation following requests for documents from January, 2007 to the present from the North Carolina state Attorney General's Office; (ii) Harbor Point Behavioral Health Center received a subpoena in December, 2012 from the Attorney General of the Commonwealth of Virginia requesting various documents from July 2006 to the present, and; (iii) The Meadows Psychiatric Center received a subpoena from the OIG in February, 2013 requesting certain documents from 2008 to the present. At present, we are uncertain as to the focus, scope or extent of the investigations, liability of the facilities and/or potential financial exposure, if any, in connection with these matters. Unrelated to these matters, the Keys of Carolina was closed and the real property was sold in January, 2013.

Matters Relating to PSI:

The following matters pertain to PSI or former PSI facilities (owned by subsidiaries of Psychiatric Solutions, Inc.) which were in existence prior to the acquisition of PSI and for which we have assumed the defense as a result of our acquisition which was completed in November, 2010:

Garden City Employees' Retirement System v. PSI:

This is a purported shareholder class action lawsuit filed in the United States District Court for the Middle District of Tennessee against PSI and the former directors in 2009 alleging violations of federal securities laws. We intend to defend the case vigorously. Should we be deemed liable in this matter, we believe we would be entitled to commercial insurance recoveries for amounts paid by us, subject to certain limitations and deductibles. Included in our consolidated balance sheets as of December 31, 2012 and 2011, is an estimated reserve (current liability) and corresponding commercial insurance recovery (current asset) which did not have a material impact

on our financial statements. Although we believe the commercial insurance recoveries are adequate to satisfy potential liability and related legal fees in connection with this matter, we can provide no assurance that the ultimate liability will not exceed the commercial insurance recoveries which would make us liable for the excess.

195
SUPPLEMENTAL- # 1
December 26, 2013
12:16pm

Department of Justice Investigation of Friends Hospital:

In October, 2010, Friends Hospital in Philadelphia, Pennsylvania, received a subpoena from the DOJ requesting certain documents from the facility. The requested documents have been collected and provided to the DOJ for review and examination. Another subpoena was issued to the facility in July 2011 requesting additional documents, which have been collected and delivered to the DOJ. At present, we are uncertain as to the focus, scope or extent of the investigation, liability of the facility and/or potential financial exposure, if any, in connection with this matter.

Department of Justice Investigation of Riveredge Hospital:

In 2008, Riveredge Hospital in Chicago, Illinois received a subpoena from the DOJ requesting certain information from the facility. Additional requests for documents were also received from the DOJ in 2009 and 2010. The requested documents have been provided to the DOJ. At present, we are uncertain as to the focus, scope or extent of the investigation, liability of the facility and/or potential financial exposure, if any, in connection with this matter.

Virginia Department of Medical Assistance Services Recoupment Claims:

The Virginia Department of Medical Assistance Services ("DMAS") has conducted audits at seven former PSI Residential Treatment Centers operated in the Commonwealth of Virginia to confirm compliance with provider rules under the state's Medicaid Provider Services Manual ("Manual"). As a result of those audits, DMAS claims the facilities failed to comply with the requirements of the Manual and has requested repayment of Medicaid payments to those facilities. PSI had previously filed appeals to repayment demands at each facility which are currently pending. We have recently reached a preliminary settlement of this matter which requires finalization of a definitive agreement and approval of Virginia state officials. The aggregate refund of Medicaid payments made to those facilities, as requested by DMAS, and the settlement amount is not material to our consolidated financial position or results of operations.

General:

The healthcare industry is subject to numerous laws and regulations which include, among other things, matters such as government healthcare participation requirements, various licensure, certifications, and accreditations, reimbursement for patient services, and Medicare and Medicaid fraud and abuse. Government action has increased with respect to investigations and/or allegations concerning possible violations of fraud and abuse and false claims statutes and/or regulations by healthcare providers. Currently, and from time to time, some of our facilities are subjected to inquiries and/or actions and receive notices of potential non-compliance of laws and regulations from various federal and state agencies. Providers that are found to have violated these laws and regulations may be excluded from participating in government healthcare programs, subjected to potential licensure, certification, and/or accreditation revocation, subjected to fines or penalties or required to repay amounts received from the government for previously billed patient services. We monitor all aspects of our business and have developed a comprehensive ethics and compliance program that is designed to meet or exceed applicable federal guidelines and industry standards. Because the law in this area is complex and constantly evolving, governmental investigation or litigation may result in interpretations that are inconsistent with industry practices, including ours. Although we believe our policies, procedures and practices comply with governmental regulations, there is no assurance that we will not be faced with sanctions, fines or penalties in connection with such inquiries or actions, including with respect to the investigations and other matters discussed herein. Even if we were to ultimately prevail, such inquiries and/or actions could have a material adverse effect on us.

Table of Contents

196
SUPPLEMENTAL- # 1
December 26, 2013
12:16pm

The outcome of any current or future litigation or governmental or internal investigations, including the matters described above, cannot be accurately predicted, nor can we predict any resulting penalties, fines or other sanctions that may be imposed at the discretion of federal or state regulatory authorities. We record accruals for such contingencies to the extent that we conclude it is probable that a liability has been incurred and the amount of the loss can be reasonably estimated. No estimate of the possible loss or range of loss in excess of amounts accrued, if any, can be made at this time regarding the matters specifically described above because the inherently unpredictable nature of legal proceedings may be exacerbated by various factors, including, but not limited to: (i) the damages sought in the proceedings are unsubstantiated or indeterminate; (ii) discovery is not complete; (iii) the proceeding is in its early stages; (iv) the matters present legal uncertainties; (v) there are significant facts in dispute; (vi) there are a large number of parties, or; (vii) there is a wide range of potential outcomes. It is possible that the outcome of these matters could have a material adverse impact on our future results of operations, financial position, cash flows and, potentially, our reputation.

In addition, various suits and claims arising against us in the ordinary course of business are pending. In the opinion of management, the outcome of such claims and litigation will not materially affect our consolidated financial position or results of operations.

In addition to our long-term debt obligations as discussed in Note 4-*Long-Term Debt* and our operating lease obligations as discussed in Note 7-*Lease Commitments*, we have various other contractual commitments outstanding as of December 31, 2012 as follows: (i) other combined estimated future purchase obligations of $290 million related to a long-term contract with third-parties consisting primarily of certain revenue cycle data processing services for our acute care facilities ($106 million), expected future costs to be paid to a third-party vendor in connection with the purchase, implementation and on-going operation of an electronic health records application for each of our acute care facilities ($181 million) and estimated minimum liabilities for physician commitments expected to be paid in the future ($3 million), and; (ii) combined estimated future payments of $225 million related to our non-contributory, defined benefit pension plan ($208 million consisting of estimated payments through 2087) and other retirement plan liabilities ($17 million).

As of December 31, 2012 we were party to certain off balance sheet arrangements consisting of standby letters of credit and surety bonds. Our outstanding letters of credit and surety bonds as of December 31, 2012 totaled $80 million consisting of: (i) $66 million related to our self-insurance programs, and; (ii) $14 million of other debt and public utility guarantees.

9) RELATIONSHIP WITH UNIVERSAL HEALTH REALTY INCOME TRUST AND RELATED PARTY TRANSACTIONS

Relationship with Universal Health Realty Income Trust:

At December 31, 2012, we held approximately 6.2% of the outstanding shares of Universal Health Realty Income Trust (the "Trust"). We serve as Advisor to the Trust under an annually renewable advisory agreement pursuant to the terms of which we conduct the Trust's day-to-day affairs, provide administrative services and present investment opportunities. In addition, certain of our officers and directors are also officers and/or directors of the Trust. Management believes that it has the ability to exercise significant influence over the Trust, therefore we account for our investment in the Trust using the equity method of accounting. We earned an advisory fee from the Trust, which is included in net revenues in the accompanying consolidated statements of income, of approximately $2.1 million during 2012, $2.0 million during 2011 and $1.8 million during 2010.

Our pre-tax share of income from the Trust was $1.2 million during 2012, $4.6 million during 2011 and $1.0 million during 2010, and is included in net revenues in the accompanying consolidated statements of income for each year. Included in our share of the Trust's income for 2011 was approximately $3.7 million related to our share of the following: (i) an aggregate gain realized by the Trust during 2011 in connection with the sale of medical office buildings by various limited liability companies ("LLCs") in which the Trust formerly held noncontrolling, majority ownership interests; (ii) an aggregate gain recorded by the Trust during 2011 in

197
SUPPLEMENTAL- # 1
December 26, 2013
12:16pm

connection with its purchases of third-party minority ownership interests in various LLCs in which the Trust formerly held noncontrolling majority ownership interests (the Trust now owns 100% of each of these entities), partially offset by; (iii) a provision for asset impairment recorded by the Trust during 2011 in connection with a medical office building located in Atlanta, Georgia.

The carrying value of our investment in the Trust was $9.3 million and $9.9 million at December 31, 2012 and 2011, respectively, and is included in other assets in the accompanying consolidated balance sheets. The market value of our investment in the Trust was $39.9 million at December 31, 2012 and $30.7 million at December 31, 2011, based on the closing price of the Trust's stock on the respective dates.

Total rent expense under the operating leases on the four hospital facilities with the Trust (as discussed below) was $16.3 million during each of 2012 and 2011 and $16.2 million during 2010. In addition, certain of our subsidiaries are tenants in several medical office buildings owned by limited liability companies in which the Trust holds either 100% of the ownership interest or various noncontrolling, majority ownership interests.

The Trust commenced operations in 1986 by purchasing certain properties from us and immediately leasing the properties back to our respective subsidiaries. Most of the leases were entered into at the time the Trust commenced operations and provided for initial terms of 13 to 15 years with up to six additional 5-year renewal terms. Each lease also provided for additional or bonus rental, as discussed below. The base rents are paid monthly and the bonus rents are computed and paid on a quarterly basis, based upon a computation that compares current quarter revenue to a corresponding quarter in the base year. The leases with our subsidiaries are unconditionally guaranteed by us and are cross-defaulted with one another.

Pursuant to the terms of the leases with the Trust, we have the option to renew the leases at the lease terms described above by providing notice to the Trust at least 90 days prior to the termination of the then current term. In addition, we have rights of first refusal to: (i) purchase the respective leased facilities during and for 180 days after the lease terms at the same price, terms and conditions of any third-party offer, or; (ii) renew the lease on the respective leased facility at the end of, and for 180 days after, the lease term at the same terms and conditions pursuant to any third-party offer. We also have the right to purchase the respective leased facilities at the end of the lease terms or any renewal terms at their appraised fair market value as well as purchase any or all of the four leased hospital properties at their appraised fair market value upon one month's notice should a change of control of the Trust occur.

The table below details the renewal options and terms for each of our four hospital facilities leased from the Trust, giving effect to the above-mentioned renewals:

Hospital Name	Type of Facility	Annual Minimum Rent	End of Lease Term	Renewal Term (years)
McAllen Medical Center	Acute Care	$ 5,485,000	December, 2016	15(a)
Wellington Regional Medical Center	Acute Care	$ 3,030,000	December, 2016	15(b)
Southwest Healthcare System, Inland Valley Campus	Acute Care	$ 2,648,000	December, 2016	15(b)
The Bridgeway	Behavioral Health	$ 930,000	December, 2014	10(c)

(a) We have three 5-year renewal options at existing lease rates (through 2031).

(b) We have one 5-year renewal options at existing lease rates (through 2021) and two 5-year renewal options at fair market value lease rates (2022 through 2031).

SUPPLEMENTAL- # 1
December 26, 2013
12:16pm

(c) We have two 5-year renewal options at fair market value lease rates (2015 through 2024).

Split-dollar Life Insurance Agreements:

In December, 2010, our Board of Directors approved the Company's entering into supplemental life insurance plans and agreements on the lives of our chief executive officer and his wife. As a result of these

agreements, based on actuarial tables and other assumptions, during the life expectancies of the insureds, we would pay approximately $25 million in premiums and certain trusts, owned by our chief executive officer, would pay approximately $8 million in premiums. Based on the projected premiums mentioned above, and assuming the policies remain in effect until the death of the insureds, we will be entitled to receive death benefit proceeds of no less than $33 million representing the $25 million of aggregate premiums paid by us as well as the $8 million of aggregate premiums paid by the trusts. During each of 2012 and 2011, we paid approximately $1.4 million in premium payments and during the fourth quarter of 2010, we paid approximately $6 million in premium payments. These agreements did not have a material effect on our consolidated financial statements or results of operations during 2012 and 2011. Included in our financial statements during 2010, was a pre-tax and after-tax expense of $9 million recorded during the fourth quarter of 2010 representing the present value of our projected premium funding commitment over the terms of the policies.

Other Related Party Transactions:

A member of our Board of Directors and member of the Executive Committee is Of Counsel to the law firm used by us as our principal outside counsel. This Board member is also the trustee of certain trusts for the benefit of our CEO and his family. This law firm also provides personal legal services to our CEO.

10) PENSION PLAN

We maintain contributory and non-contributory retirement plans for eligible employees. Our contributions to the contributory plan amounted to $27.3 million, $21.7 million and $20.8 million in 2012, 2011 and 2010, respectively. The non-contributory plan is a defined benefit pension plan which covers employees of one of our subsidiaries. The benefits are based on years of service and the employee's highest compensation for any five years of employment. Our funding policy is to contribute annually at least the minimum amount that should be funded in accordance with the provisions of ERISA.

The following table shows the reconciliation of the defined benefit pension plan as of December 31, 2012 and 2011:

	2012	2011
	(000s)	
Change in plan assets:		
Fair value of plan assets at beginning of year	$ 87,940	$ 73,402
Actual return (loss) on plan assets	13,824	5,689
Employer contributions	7,786	14,065
Benefits paid	(4,946)	(4,541)
Administrative expenses	(530)	(675)
Fair value of plan assets at end of year	$104,074	$ 87,940

SUPPLEMENTAL- # 1
December 26, 2013
12:16pm
199

Change in benefit obligation:		
Benefit obligation at beginning of year	$108,446	$ 93,513
Service cost	1,144	1,162
Interest cost	4,659	5,047
Benefits paid	(4,946)	(4,541)
Actuarial (gain) loss	5,226	13,265
Benefit obligation at end of year	$114,529	$108,446
Amounts recognized in the Consolidated Balance Sheet:		
Other noncurrent liabilities	10,455	20,506
Total liability at end of year	$ 10,455	$ 20,506
Additional year end information for Pension Plan		
Projected benefit obligation	$114,529	$108,446
Accumulated benefit obligation	112,675	106,609
Fair value of plan assets	104,074	87,940

Table of Contents

	2012	2011 (000s)	2010
Components of net periodic cost (benefit)			
Service cost	$ 1,144	$ 1,162	$ 1,140
Interest cost	4,659	5,047	4,958
Expected return on plan assets	(7,301)	(6,566)	(5,151)
Recognized actuarial loss	4,219	2,427	2,538
Net periodic cost	$ 2,721	$ 2,070	$ 3,485

	2012	2011
Measurement Dates		
Benefit obligations	12/31/2012	12/31/2011
Fair value of plan assets	12/31/2012	12/31/2011

	2012	2011
Weighted average assumptions as of December 31		
Discount rate	4.05%	4.40%
Rate of compensation increase	4.00%	4.00%

	2012	2011	2010
Weighted-average assumptions for net periodic benefit cost calculations			
Discount rate	4.40%	5.54%	5.96%
Expected long-term rate at return on plan assets	8.00%	8.00%	8.00%
Rate of compensation increase	4.00%	4.00%	4.00%

200
SUPPLEMENTAL- # 1
December 26, 2013
12:16pm

The accumulated benefit obligation was $112,675 and $106,609 as of December 31, 2012 and 2011, respectively. The accumulated benefit obligation exceeded the fair value of plan assets as of December 31, 2012 and 2011. In 2012 and 2011, the accrued pension cost is included in non-current liabilities in the accompanying Consolidated Balance Sheet. We estimate that there will be $3,305 of net loss that will be amortized from accumulated other comprehensive income over the next fiscal year.

Our pension plans assets were $104,074 and $87,940 at December 31, 2012 and 2011, respectively. The market values of our pension plan assets at December 31, 2012 and December 31, 2011 by asset category are as follows:

December 31, 2012	Total	Level 1	Level 2	Level 3
Equities:				
U.S. Large Cap	$ 22,800	$ —	$ 22,800	$ —
U.S. Mid Cap	1,566	—	1,566	—
U.S. Small-Mid Cap	7,738	—	7,738	—
U.S. Small Cap	1,583	—	1,583	—
International Developed	10,779	—	10,779	—
Emerging Markets	3,912	—	3,912	—
Fixed income:				
Long Duration Fixed Income	51,355	—	51,355	—
Real Estate:				
REIT Fund	3,904	—	3,904	—
Cash/Currency:				
Cash Equivalents	437	—	437	—
Total market value	$104,074	$ —	$104,074	$ —

Table of Contents

December 31, 2011	Total	Level 1	Level 2	Level 3
Equities:				
U.S. Large Cap	$18,921	$ —	$18,921	$ —
U.S. Mid Cap	1,281	—	1,281	—
U.S. Small-Mid Cap	6,332	—	6,332	—
U.S. Small Cap	1,282	—	1,282	—
International Developed	8,692	—	8,692	—
Emerging Markets	3,123	—	3,123	—
Fixed income:				
Long Duration Fixed Income	44,587	—	44,587	—
Real Estate:				
REIT Fund	3,269	—	3,269	—

201
SUPPLEMENTAL- # 1
December 26, 201
12:16pm

Cash/Currency:				
Cash Equivalents	453	—	453	—
Total market value	$87,940	$ —	$87,940	$ —

To develop the expected long-term rate of return on plan assets assumption, we considered the historical returns and the future expectations for returns for each asset class, as well as the target asset allocation of the pension portfolio.

The following table shows expected benefit payments for the years ended December 31, 2012 through 2022 for our defined pension plan. There will be benefit payments under this plan beyond 2022.

Estimated Future Benefit Payments (000s)	
2013	$ 5,451
2014	5,724
2015	5,692
2016	6,182
2017	6,379
2018-2022	34,251
Total	$63,679

Plan Assets	2012	2011
Asset Category		
Equity securities	47%	45%
Fixed income securities	49%	50%
Other	4%	5%
Total	100%	100%

Investment Policy, Guidelines and Objectives have been established for the defined benefit pension plan. The investment policy is in keeping with the fiduciary requirements under existing federal laws and managed in accordance with the Prudent Investor Rule. Total portfolio risk is regularly evaluated and compared to that of the plan's policy target allocation and judged on a relative basis over a market cycle. The following asset allocation policy and ranges have been established in accordance with the overall risk and return objectives of the portfolio:

	Policy	As of 12/31/12	Permitted Range
Total Equity	46%	47%	43-49%
Total Fixed Income	50%	49%	45-55%
Other	4%	4%	0-10%

Table of Contents

In accordance with the investment policy, the portfolio will invest in high quality, large and small capitalization companies traded on national exchanges, and investment grade securities. The investment managers will not write or buy options for speculative purposes; securities may not be margined or sold short.

202
SUPPLEMENTAL- # 1
December 26, 2013
12:16pm

The manager may employ futures or options for the purpose of hedging exposure, and will not purchase unregistered sectors, private placements, partnerships or commodities.

11) SEGMENT REPORTING

Our reportable operating segments consist of acute care hospital services and behavioral health care services. The "Other" segment column below includes centralized services including information services, purchasing, reimbursement, accounting, taxation, legal, advertising, design and construction and patient accounting as well as the operating results for our other operating entities including outpatient surgery and radiation centers. The chief operating decision making group for our acute care hospital services and behavioral health care services is comprised of our Chief Executive Officer, the President and the Presidents of each operating segment. The Presidents for each operating segment also manage the profitability of each respective segment's various facilities. The operating segments are managed separately because each operating segment represents a business unit that offers different types of healthcare services or operates in different healthcare environments. The accounting policies of the operating segments are the same as those described in the summary of significant accounting policies included in this Annual Report on Form 10-K for the year ended December 31, 2012. The corporate overhead allocations, as reflected below, are utilized for internal reporting purposes and are comprised of each period's projected corporate-level operating expenses (excluding interest expense). The overhead expenses are captured and allocated directly to each segment, to the extent possible, with the non-directly allocated overhead expenses allocated based upon each segment's respective percentage of total facility-based operating expenses.

2012	Acute Care Hospital Services	Behavioral Health Services	Other	Total Consolidated
		(Dollar amounts in thousands)		
Gross inpatient revenues	$ 12,406,567	$ 5,764,370	—	$18,170,937
Gross outpatient revenues	$ 6,134,615	$ 646,177	$ 48,183	$ 6,828,975
Total net revenues	$ 3,461,416	$ 3,460,141	$ 39,843	$ 6,961,400
Income (loss) before allocation of corporate overhead and income taxes	$ 337,385	$ 838,603	($412,325)	$ 763,663
Allocation of corporate overhead	($ 162,056)	($ 84,597)	$ 246,653	$ 0
Income (loss) after allocation of corporate overhead and before income taxes	$ 175,329	$ 754,006	($165,672)	$ 763,663
Total assets	$ 2,984,169	$ 4,979,965	$ 236,709	$ 8,200,843

2011	Acute Care Hospital Services	Behavioral Health Services	Other	Total Consolidated
		(Dollar amounts in thousands)		
Gross inpatient revenues	$ 11,770,248	$ 5,507,728	—	$17,277,976
Gross outpatient revenues	$ 5,431,146	$ 606,876	$ 53,240	$ 6,091,262
Total net revenues	$ 3,423,957	$ 3,308,862	$ 27,403	$ 6,760,222
Income (loss) before allocation of corporate overhead and income taxes	$ 352,931	$ 729,142	($385,737)	$ 696,336
Allocation of corporate overhead	($ 131,225)	($ 62,710)	$ 193,935	$ 0
Income (loss) after allocation of corporate overhead and before income taxes	$ 221,706	$ 666,432	($191,802)	$ 696,336
Total assets	$ 2,782,102	$ 4,373,379	$ 509,764	$ 7,665,245

Table of Contents

203
SUPPLEMENTAL- # 1
December 26, 2013
12:16pm

2010	Acute Care Hospital Services	Behavioral Health Services	Other	Total Consolidated
	(Dollar amounts in thousands)			
Gross inpatient revenues	$ 10,623,407	$ 2,563,867	—	$13,187,274
Gross outpatient revenues	$ 4,596,317	$ 350,192	$ 49,245	$ 4,995,754
Total net revenues	$ 3,272,488	$ 1,597,022	$ 30,637	$ 4,900,147
Income (loss) before allocation of corporate overhead and income taxes	$ 352,334	$ 353,046	($277,283)	$ 428,097
Allocation of corporate overhead	($ 128,588)	($ 43,362)	$ 171,950	$ 0
Income (loss) after allocation of corporate overhead and before income taxes	$ 223,746	$ 309,684	($105,333)	$ 428,097
Total assets	$ 2,681,803	$ 4,360,262	$ 485,871	$ 7,527,936

12) QUARTERLY RESULTS (unaudited)

The following tables summarize the quarterly financial data for the two years ended December 31, 2012 and 2011:

2012	First Quarter	Second Quarter	Third Quarter	Fourth Quarter	Total
	(amounts in thousands, except per share amounts)				
Net revenues	$ 1,793,036	$ 1,723,084	$ 1,680,353	$ 1,764,927	$ 6,961,400
Net income	$ 142,570	$ 117,444	$ 81,373	$ 147,660	$ 489,047
Less: Net income attributable to noncontrolling interests	$ 13,963	$ 9,883	$ 9,556	$ 12,199	$ 45,601
Net income attributable to UHS	$ 128,607	$ 107,561	$ 71,817	$ 135,461	$ 443,446
Earnings per share attributable to UHS-Basic:					
Total basic earnings per share	$ 1.33	$ 1.11	$ 0.74	$ 1.39	$ 4.57
Earnings per share attributable to UHS-Diluted:					
Total diluted earnings per share	$ 1.31	$ 1.10	$ 0.73	$ 1.39	$ 4.53

The 2012 quarterly financial data presented above includes the following:

First Quarter:

- a favorable $30.2 million pre-tax impact ($18.8 million, or $.19 per diluted share, net of taxes) resulting from an agreement entered into with the United States Department of Health and Human Services, the Secretary of Health and Human Services, and the Centers for Medicare and Medicaid Services (referred to collectively as "HHS"). This agreement, which was part of an industry-wide settlement with HHS related to litigation that was pending for several years contending that acute care hospitals in the U.S. were underpaid from the Medicare inpatient prospective payment system during a number of prior years;
- a favorable $7.0 million pre-tax impact ($4.3 million, or $.04 per diluted share, net of taxes) representing the 2011 portion of the net Medicaid supplemental reimbursements we expect to receive pursuant to the Oklahoma Supplemental Hospital Offset Payment Program;
- an aggregate unfavorable $8.3 million pre-tax impact ($5.1 million, or $.05 per diluted share, net of taxes) resulting from: (i) the revised Supplemental Security Income ratios utilized for calculating Medicare disproportionate share hospital reimbursements for federal fiscal years 2006 through 2009

204
SUPPLEMENTAL- # 1
December 26, 2013
12:16pm

($2.4 million unfavorable after-tax impact), and; (ii) the write-off of receivables related to revenues recorded during 2011 at two of our acute care hospitals located in Florida resulting from reductions in certain county reimbursements due to reductions in federal matching Inter-Governmental Transfer funds ($2.7 million unfavorable after-tax impact).

Second Quarter:

- an unfavorable $8.0 million pre-tax impact ($5.0 million, or $.05 per diluted share, net of taxes) recorded in connection with the implementation of EHR applications;
- a favorable $5.5 million pre-tax impact ($3.4 million, or $.03 per diluted share, net of taxes) representing net Medicaid reimbursements related to prior years.

Third Quarter:

- a favorable $2.2 million pre-tax impact ($1.3 million, or $.01 per diluted share, net of taxes) recorded in connection with the implementation of EHR applications;
- an unfavorable $29.2 million pre-tax impact ($18.1 million, or $0.19 per diluted share, net of taxes) resulting from the write-off of deferred financing costs related to the portion of our Term Loan B credit facility that was extinguished during the third quarter of 2012.

Fourth Quarter:

- a favorable $26.4 million pre-tax impact ($16.4 million, or $0.17 per diluted share, net of taxes) gain resulting from the sale of an acute care facility located in Auburn, Washington;
- a favorable $8.9 million pre-tax impact ($5.5 million, or $.06 per diluted share, net of taxes) recorded in connection with the implementation of EHR applications;
- a favorable $27.2 million pre-tax impact reduction ($15.5 million, or $.16 per diluted share, net of taxes) to our professional and general liability self-insurance reserves relating to years prior to 2012, as discussed in *Self-Insured Risks.*

2011	First Quarter	Second Quarter	Third Quarter	Fourth Quarter	Total
	(amounts in thousands, except per share amounts)				
Net revenues	$ 1,723,296	$ 1,711,255	$ 1,662,675	$ 1,662,996	$ 6,760,222
Net income	$ 129,987	$ 116,034	$ 94,842	$ 108,007	$ 448,870
Less: Net income attributable to noncontrolling interests	$ 15,794	$ 12,385	$ 9,788	$ 12,736	$ 50,703
Net income attributable to UHS	$ 114,193	$ 103,649	$ 85,054	$ 95,271	$ 398,167
Earnings per share attributable to UHS-Basic:					
Total basic earnings per share	$ 1.17	$ 1.06	$ 0.87	$ 0.99	$ 4.09
Earnings per share attributable to UHS-Diluted:					
Total diluted earnings per share	$ 1.15	$ 1.04	$ 0.86	$ 0.98	$ 4.04

The 2011 quarterly financial data presented above includes the following:

Fourth Quarter:

SUPPLEMENTAL- # December 26, 201 12:16pm

- a favorable $10.4 million pre-tax reduction ($6.4 million, or $.07 per diluted share, net of taxes) to our professional and general liability self-insurance reserves relating to years prior to 2011, as discussed in *Self-Insured Risks*.

Table of Contents

13) SUPPLEMENTAL CONDENSED CONSOLIDATING FINANCIAL INFORMATION

Certain of our senior notes are guaranteed by a group of subsidiaries (the "Guarantors"). The Guarantors, each of which is a 100% directly owned subsidiary of Universal Health Services, Inc., fully and unconditionally guarantee the senior notes on a joint and several basis, subject to certain customary release provisions.

The following financial statements present condensed consolidating financial data for (i) Universal Health Services, Inc. (on a parent company only basis), (ii) the combined Guarantors, (iii) the combined non guarantor subsidiaries (all other subsidiaries), (iv) an elimination column for adjustments to arrive at the information for the parent company, Guarantors, and non guarantors on a consolidated basis, and (v) the parent company and our subsidiaries on a consolidated basis.

Investments in subsidiaries are accounted for by the parent company and the Guarantors using the equity method for this presentation. Results of operations of subsidiaries are therefore classified in the parent company's and Guarantors' investment in subsidiaries accounts. The elimination entries set forth in the following condensed consolidating financial statements eliminate distributed and undistributed income of subsidiaries, investments in subsidiaries, and intercompany balances and transactions between the parent, Guarantors, and non guarantors.

Certain revisions have been made to correct immaterial errors in the condensed consolidating balance sheet as of December 31, 2011 and the condensed consolidating statements of operations for the twelve months ended December 31, 2011 and 2010, which had the following impact: (i) on the condensed consolidating balance sheet certain noncurrent assets decreased by $53.8 million of the Non-guarantor subsidiaries, with corresponding offsetting adjustments to the same items in the Consolidating Adjustments column; (ii) on the condensed consolidating balance sheet certain noncurrent liabilities decreased by $53.8 million of the Guarantor subsidiaries, with corresponding offsetting adjustments to the same items in the Eliminations column; (iii) on the condensed consolidating statements of operations for the twelve months ended December 31, 2011 interest expense decreased by $87.2 million for the Guarantor Subsidiaries and interest expense increased by $87.2 million for the Non-guarantor Subsidiaries for the twelve months ended December 31, 2011; (iv) net income and net income attributable to UHS for the Guarantor subsidiaries increased by $53.8 million for the twelve months ended December 31, 2011, and net income and Net income attributable to UHS decreased for the Non-guarantor subsidiaries by $53.8 million; (iv) on the condensed consolidating statements of operations for the twelve months ended December 31, 2010, net revenues and other operating expenses increased by $0.3 million for the Parent with corresponding offsetting adjustment to the same items in the Consolidating Adjustments column.

Table of Contents

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES

206
SUPPLEMENTAL- # 1
December 26, 2013
12:16pm

CONDENSED CONSOLIDATING STATEMENTS OF INCOME
FOR THE TWELVE MONTHS ENDED DECEMBER 31, 2012
(amounts in thousands)

	Parent	Guarantors	Non Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Net revenues before provision for doubtful accounts	$ 0	$5,152,816	$2,562,781	$ (27,526)	$7,688,071
Less: Provision for doubtful accounts	0	411,538	315,133	0	726,671
Net Revenues	0	4,741,278	2,247,648	(27,526)	6,961,400
Operating charges:					
Salaries, wages and benefits	0	2,452,187	988,730	0	3,440,917
Other operating expenses	0	899,274	502,592	(25,744)	1,376,122
Supplies expense	0	496,848	302,773	0	799,621
Depreciation and amortization	0	210,867	91,559	0	302,426
Lease and rental expense	0	59,596	37,071	(1,782)	94,885
Transaction costs	0	5,716	0	0	5,716
EHR incentive income	0	(14,284)	(15,754)	0	(30,038)
Costs related to extinguishment of debt	29,170	0	0	0	29,170
	29,170	4,110,204	1,906,971	(27,526)	6,018,819
Income (loss) from operations	(29,170)	631,074	340,677	0	942,581
Interest expense	172,467	3,749	2,702	0	178,918
Interest (income) expense, affiliate	0	93,363	(93,363)	0	0
Equity in net income of consolidated affiliates	(567,906)	(141,983)	0	709,889	0
Income before income taxes	366,269	675,945	431,338	(709,889)	763,663
Provision (benefit) for income taxes	(77,177)	237,072	114,721	0	274,616
Net income	443,446	438,873	316,617	(709,889)	489,047
Less: Income attributable to noncontrolling interests	0	0	45,601	0	45,601
Net income attributable to UHS	$ 443,446	$ 438,873	$ 271,016	$ (709,889)	$ 443,446

Table of Contents

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATING STATEMENTS OF INCOME
FOR THE TWELVE MONTHS ENDED DECEMBER 31, 2011
(amounts in thousands)

	Parent	Guarantors	Non Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Net revenues before provision for doubtful accounts	$ 0	$4,917,358	$2,465,916	$ (26,476)	$7,356,7[illegible]

207
SUPPLEMENTAL- # 1
December 26, 2013
12:16pm

Less: Provision for doubtful accounts	0	340,121	256,455	0	596,576
Net revenues	0	4,577,237	2,209,461	(26,476)	6,760,222
Operating charges:					
Salaries, wages and benefits	0	2,371,961	954,417	0	3,326,378
Other operating expenses	200	923,579	454,601	(24,687)	1,353,693
Supplies expense	0	499,200	306,289	0	805,489
Depreciation and amortization	0	207,981	79,230	0	287,211
Lease and rental expense	0	60,768	31,344	(1,789)	90,323
Income (loss) from operations	200	4,063,489	1,825,881	(26,476)	5,863,094
Interest expense	(200)	513,748	383,580	0	897,128
Interest (income) expense, affiliate	195,404	3,212	2,176	0	200,792
Equity in net income of consolidated affiliates	0	87,205	(87,205)	0	0
Income before income taxes	(518,797)	(157,009)	0	675,806	0
Provision (benefit) for income taxes	323,193	580,340	468,609	(675,806)	696,336
Net income	(74,974)	198,091	124,349	0	247,466
Less: Income attributable to noncontrolling interests	398,167	382,249	344,260	(675,806)	448,870
Net income attributable to UHS	0	0	50,703	0	50,703
	$ 398,167	$ 382,249	$ 293,557	$ (675,806)	$ 398,167

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATING STATEMENTS OF INCOME
FOR THE TWELVE MONTHS ENDED DECEMBER 31, 2010
(amounts in thousands)

	Parent	Guarantors	Non Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Net revenues before provision for doubtful accounts	$ 903	$3,494,351	$1,981,571	$ (47,592)	$5,429,233
Less: Provision for doubtful accounts	0	272,335	256,751	0	529,086
Net revenues	903	3,222,016	1,724,820	(47,592)	4,900,147
Operating charges:					
Salaries, wages and benefits	0	1,611,394	751,989	0	2,363,383
Other operating expenses	0	633,838	381,218	(46,444)	968,612
Supplies expense	0	422,877	294,048	0	716,9[illegible]
Depreciation and amortization	0	147,645	69,285	0	216,9[illegible]
Lease and rental expense	0	48,872	27,539	(1,148)	75,3[illegible]
Transaction costs	0	53,220	0	0	53,2[illegible]

208
SUPPLEMENTAL- # 1
Dec 26, 2013
12:16pm

	0	2,917,846	1,524,179	(47,592)	4,394,433
Income from operations	903	304,170	200,641	0	505,714
Interest expense, net	70,283	6,729	605	0	77,617
Interest (income) expense, affiliate	0	60,876	(60,876)	0	0
Equity in net income of consolidated affiliates	(271,944)	(134,760)	0	406,704	0
Income before income taxes	202,564	371,325	260,912	(406,704)	428,097
Provision (benefit) for income taxes	(27,619)	134,547	45,374	0	152,302
Net income	230,183	236,778	215,538	(406,704)	275,795
Less: Income attributable to noncontrolling interests	0	0	45,612	0	45,612
Net income attributable to UHS	$ 230,183	$ 236,778	$ 169,926	$ (406,704)	$ 230,183

Table of Contents

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATING STATEMENTS OF COMPREHENSIVE INCOME
FOR THE TWELVE MONTHS ENDED DECEMBER 31, 2012
(amounts in thousands)

	Parent	Guarantors	Non Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Net income	$443,446	$438,873	$316,617	$ (709,889)	$ 489,047
Other comprehensive income (loss):					
Unrealized derivative gains on cash flow hedges	6,677	0	0	0	6,677
Amortization of terminated hedge	(336)	0	0	0	(336)
Minimum Pension Liability	0	4,986	0	0	4,986
Other comprehensive income before tax	6,341	4,986	0	0	11,327
Income tax expense related to items of other comprehensive income	2,408	1,898	0	0	4,306
Total other comprehensive income, net of tax	3,933	3,088	0	0	7,021
Comprehensive income	447,379	441,961	316,617	(709,889)	496,068
Less: Comprehensive income attributable to noncontrolling interests	0	0	45,601	0	45,601
Comprehensive income attributable to UHS	$447,379	$441,961	$271,016	$ (709,889)	$ 450,467

Table of Contents

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATING STATEMENTS OF COMPREHENSIVE INCOME

209
SUPPLEMENTAL- # 1
December 26, 2013
12:16pm

FOR THE TWELVE MONTHS ENDED DECEMBER 31, 2011
(amounts in thousands)

	Parent	Guarantors	Non Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Net income	$398,167	$382,249	$344,260	$ (675,806)	$ 448,870
Other comprehensive income (loss):					
Unrealized derivative gains on cash flow hedges	(37,477)	0	0	0	(37,477)
Amortization of terminated hedge	(336)	0	0	0	(336)
Minimum Pension Liability	0	(12,397)	0	0	(12,397)
Other comprehensive income before tax	(37,813)	(12,397)	0	0	(50,210)
Income tax expense related to items of other comprehensive income	(14,483)	(4,691)	0	0	(19,174)
Total other comprehensive income, net of tax	(23,330)	(7,706)	0	0	(31,036)
Comprehensive income	374,837	374,543	344,260	(675,806)	417,834
Less: Comprehensive income attributable to noncontrolling interests	0	0	50,703	0	50,703
Comprehensive income attributable to UHS	$374,837	$374,543	$293,557	$ (675,806)	$ 367,131

Table of Contents

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATING STATEMENTS OF COMPREHENSIVE INCOME
FOR THE TWELVE MONTHS ENDED DECEMBER 31, 2010
(amounts in thousands)

	Parent	Guarantors	Non Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Net income	$230,183	$236,778	$215,538	$ (406,704)	$ 275,795
Other comprehensive income (loss):					
Unrealized derivative gains on cash flow hedges	1,396	0	0	0	1,396
Amortization of terminated hedge	(336)	0	0	0	(336)
Minimum Pension Liability	0	743	0	0	743
Other comprehensive income before tax	1,060	743	0	0	1,803
Income tax expense related to items of other comprehensive income	408	281	0	0	689
Total other comprehensive income, net of tax	652	462	0	0	1,114
Comprehensive income	230,835	237,240	215,538	(406,704)	276,909
Less: Comprehensive income attributable to noncontrolling interests	0	0	45,612	0	45,6[illegible]
Comprehensive income attributable to UHS	$230,835	$237,240	$169,926	$ (406,704)	$ 231,2[illegible]

SUPPLEMENTAL - # 1
December 26, 2013
12:16pm

Table of Contents

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATING BALANCE SHEET
AS OF DECEMBER 31, 2012
(amounts in thousands)

	Parent	Guarantors	Non Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Assets					
Current assets:					
Cash and cash equivalents	$ 0	$ 11,949	$ 11,522	$ 0	$ 23,471
Accounts receivable, net	7,154	741,983	318,060	0	1,067,197
Supplies	0	61,100	37,900	0	99,000
Deferred income taxes	61,364	43,555	322	(780)	104,461
Other current assets	2,188	75,117	10,631	0	87,936
Current assets held for sale	0	0	25,431	0	25,431
Total current assets	70,706	933,704	403,866	(780)	1,407,496
Investments in subsidiaries	5,781,479	1,323,832	0	(7,105,311)	0
Intercompany receivable	644,105	0	360,538	(1,004,643)	0
Intercompany note receivable	0	0	1,007,453	(1,007,453)	0
Property and equipment	0	3,867,471	1,500,874	0	5,368,345
Less: accumulated depreciation	0	(1,288,975)	(697,135)	0	(1,986,110)
	0	2,578,496	803,739	0	3,382,235
Other assets:					
Goodwill	820	2,554,531	481,414	0	3,036,765
Deferred charges	67,831	5,839	2,218	0	75,888
Other	9,645	209,558	79,256	0	298,459
	$ 6,574,586	$ 7,605,960	$ 3,138,484	$ (9,118,187)	$ 8,200,843
Liabilities and Stockholders' Equity					
Current liabilities:					
Current maturities of long-term debt	$ 0	990	1,599	0	$ 2,589
Accounts payable and accrued liabilities	10,985	740,484	138,088	0	889,557
Current liabilities held for sale	0	0	850	0	850
Federal and state taxes	0	900	620	(458)	1,062
Total current liabilities	10,985	742,374	141,157	(458)	894,058
Intercompany payable	0	1,004,643	0	(1,004,643)	
Other noncurrent liabilities	46,048	243,478	105,829	0	395,3[illegible]
Long-term debt	3,676,940	5,372	45,119	0	3,727,4[illegible]
Intercompany note payable	0	1,007,453	0	(1,007,453)	
Deferred income taxes	127,268	56,801	0	(322)	183,7[illegible]

SUPPLEMENTAL- # 1
December 26, 2013
12:16pm

Redeemable noncontrolling interests	0	0	234,303	0	234,303
UHS common stockholders' equity	2,713,345	4,545,839	2,559,472	(7,105,311)	2,713,345
Noncontrolling interest	0	0	52,604	0	52,604
Total equity	2,713,345	4,545,839	2,612,076	(7,105,311)	2,765,949
	$ 6,574,586	$ 7,605,960	$ 3,138,484	$ (9,118,187)	$ 8,200,843

Table of Contents

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATING BALANCE SHEET
AS OF DECEMBER 31, 2011
(amounts in thousands)

	Parent	Guarantors	Non Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Assets					
Current assets:					
Cash and cash equivalents	$ 0	$ 33,221	$ 8,008	$ 0	$ 41,229
Accounts receivable, net	8,891	663,593	297,318	0	969,802
Supplies	0	59,467	37,308	0	96,775
Deferred income taxes	67,189	41,755	322	(942)	108,324
Other current assets	33,057	56,864	9,938	0	99,859
Current assets held for sale	0	48,916	0	0	48,916
Total current assets	109,137	903,816	352,894	(942)	1,364,905
Investments in subsidiaries	5,213,573	1,181,849	0	(6,395,422)	0
Intercompany receivable	669,112	0	20,375	(689,487)	0
Intercompany note receivable	0	0	1,148,839	(1,148,839)	0
Property and equipment	0	3,650,025	1,456,135	0	5,106,160
Less: accumulated depreciation	0	(1,184,283)	(633,897)	0	(1,818,180)
	0	2,465,742	822,238	0	3,287,980
Other assets:					
Goodwill	820	2,132,103	494,679	0	2,627,602
Deferred charges	103,434	5,972	2,374	0	111,780
Other	10,412	241,107	21,459	0	272,978
	$ 6,106,488	$ 6,930,589	$ 2,862,858	$ (8,234,690)	$ 7,565,24
Liabilities and Stockholders' Equity					
Current liabilities:					
Current maturities of long-term debt	$ 0	$ 1,133	$ 1,346	$ 0	$ 2,4

212
SUPPLEMENTAL- # 1
December 26, 2013
12:16pm

Accounts payable and accrued liabilities	14,201	616,026	201,898	0	832,125
Current liabilities held for sale	0	2,329	0	0	2,329
Federal and state taxes	0	0	620	(620)	0
Total current liabilities	14,201	619,488	203,864	(620)	836,933
Intercompany payable	0	689,487	0	(689,487)	0
Other noncurrent liabilities	49,840	249,033	103,035	0	401,908
Long-term debt	3,594,182	3,616	53,630	0	3,651,428
Intercompany note payable	0	1,148,839	0	(1,148,839)	0
Deferred income taxes	151,913	58,001	0	(322)	209,592
Redeemable noncontrolling interests	0	0	218,266	0	218,266
UHS common stockholders' equity	2,296,352	4,162,125	2,233,297	(6,395,422)	2,296,352
Noncontrolling interest	0	0	50,766	0	50,766
Total equity	2,296,352	4,162,125	2,284,063	(6,395,422)	2,347,118
	$ 6,106,488	$ 6,930,589	$ 2,862,858	$ (8,234,690)	$ 7,665,245

Table of Contents

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATING STATEMENTS OF CASH FLOWS
FOR THE TWELVE MONTHS ENDED DECEMBER 31, 2012
(amounts in thousands)

	Parent	Guarantors	Non Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Net cash provided by (used in) operating activities	$ (21,608)	$ 594,606	$ 242,273	$ 0	$ 815,271
Cash Flows from Investing Activities:					
Property and equipment additions, net of disposals	0	(312,190)	(51,002)	0	(363,192)
Acquisition of property and businesses	0	(513,596)	(14,251)	0	(527,847)
Proceeds received from sale of assets and businesses	0	142,667	6,644	0	149,311
Costs incurred for purchase and development of electronic health records application	0	(54,362)	0	0	(54,362)
Return of Deposit on terminated purchase agreement	6,500	0	0	0	6,500
Net cash provided by (used in) investing activities	6,500	(737,481)	(58,609)	0	(789,590)
Cash Flows from Financing Activities:					
Reduction of long-term debt	(843,002)	0	(8,258)	1,613	(849,64
Additional borrowings	913,500	1,613	0	(1,613)	913,50
Financing costs	(8,283)	0	0	0	(8,28
Repurchase of common shares	(19,154)	0	0	0	(19,15

SUPPLEMENTAL- # 1
December 26, 2013
12:16pm
213

Dividends paid	(58,395)	0	0	0	(58,395)
Issuance of common stock	5,435	0	0	0	5,435
Profit distributions to noncontrolling interests	0	0	(26,895)	0	(26,895)
Changes in intercompany balances with affiliates, net	25,007	119,990	(144,997)	0	0
Net cash provided by (used in) financing activities	15,108	121,603	(180,150)	0	(43,439)
Increase (decrease) in cash and cash equivalents	0	(21,272)	3,514	0	(17,758)
Cash and cash equivalents, beginning of period	0	33,221	8,008	0	41,229
Cash and cash equivalents, end of period	$ 0	$ 11,949	$ 11,522	$ 0	$ 23,471

Table of Contents

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATING STATEMENTS OF CASH FLOWS
FOR THE TWELVE MONTHS ENDED DECEMBER 31, 2011

(amounts in thousands)

	Parent	Guarantors	Non Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Net cash provided by (used in) operating activities	$ (4,990)	$ 518,462	$ 204,779	$ 0	$ 718,251
Cash Flows from Investing Activities:					
Property and equipment additions, net of disposals	0	(226,848)	(58,834)	0	(285,682)
Acquisition of property and businesses	0	0	(29,466)	0	(29,466)
Proceeds received from sale of assets and businesses	0	0	67,592	0	67,592
Costs incurred for purchase and development of electronic health records application	0	(38,249)	0	0	(38,249)
Net cash used in investing activities	0	(265,097)	(20,708)	0	(285,805)
Cash Flows from Financing Activities:					
Reduction of long-term debt	(382,060)	(1,442)	0	1,985	(381,517)
Additional borrowings	98,100	0	1,985	(1,985)	98,100
Financing costs	(23,608)	0	0	0	(23,608)
Repurchase of common shares	(60,482)	0	0	0	(60,482)
Dividends paid	(19,466)	0	0	0	(19,466)
Issuance of common stock	4,779	0	0	0	4,779
Profit distributions to noncontrolling interests	0	0	(38,497)	0	(38,497)
Changes in intercompany balances with affiliates, net	387,727	(240,087)	(147,640)	0	0
Net cash provided by (used in) financing activities	4,990	(241,529)	(184,152)	0	(420,691)
Increase (decrease) in cash and cash equivalents	0	11,836	(81)	0	11,75[illegible]

214

SUPPLEMENTAL- # 1
December 26, 2013
12:16pm

Cash and cash equivalents, beginning of period	0	21,385	8,089	0	29,474
Cash and cash equivalents, end of period	$ 0	$ 33,221	$ 8,008	$ 0	$ 41,229

Table of Contents

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATING STATEMENTS OF CASH FLOWS
FOR THE TWELVE MONTHS ENDED DECEMBER 31, 2010
(amounts in thousands)

	Parent	Guarantors	Non Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Net cash provided by (used in) operating activities	$ (139,226)	$ 342,633	$ 297,937	$ 0	$ 501,344
Cash Flows from Investing Activities:					
Property and equipment additions, net of disposals	0	(186,967)	(52,307)	0	(239,274)
Acquisition of property and businesses	0	(1,958,904)	606	0	(1,958,298)
Proceeds received from sale of assets and businesses	0	21,460	0	0	21,460
Costs incurred for purchase and development of electronic health records application	0	(17,971)	0	0	(17,971)
Net cash used in investing activities	0	(2,142,382)	(51,701)	0	(2,194,083)
Cash Flows from Financing Activities:					
Reduction of long-term debt	(1,388,679)	(753)	(2,654)	0	(1,392,086)
Additional borrowings	3,266,146	0	0	0	3,266,146
Financing costs	(101,815)	0	0	0	(101,815)
Repurchase of common shares	(11,528)	0	0	0	(11,528)
Dividends paid	(19,422)	0	0	0	(19,422)
Issuance of common stock	3,594	0	0	0	3,594
Profit distributions to noncontrolling interests	0	0	(32,456)	0	(32,456)
Proceeds from sale of noncontrolling interest in majority owned business	0	0	600	0	600
Changes in intercompany balances with affiliates, net	(1,609,070)	1,816,520	(207,450)	0	0
Net cash provided by (used in) by financing activities	139,226	1,815,767	(241,960)	0	1,713,033
Increase (decrease) in cash and cash equivalents	0	16,018	4,276	0	20,294
Cash and cash equivalents, beginning of period	0	5,367	3,813	0	9,18[illegible]
Cash and cash equivalents, end of period	$ 0	$ 21,385	$ 8,089	$ 0	$ 29,4[illegible]

215
SUPPLEMENTAL- # 1
December 26, 2013
12:16pm

SCHEDULE II—VALUATION AND QUALIFYING ACCOUNTS

(amounts in thousands)

Description	Balance at beginning of period	Charges to costs and expenses	Acquisitions of business	Write-off of uncollectible accounts	Balance at end of period
Allowance for doubtful accounts receivable:					
Year ended December 31, 2012	$ 253,405	$ 726,671	$ 5,632	$ (674,321)	$ 311,387
Year ended December 31, 2011	$ 248,622	$ 613,619	$ —	$ (608,836)	$ 253,405
Year ended December 31, 2010	$ 168,876	$ 546,909	$ 56,596	$ (523,759)	$ 248,622

Included in the charges to costs and expenses are $17,043 in 2011 and $17,823 in 2010, related to facilities that were divested or recorded as held for sale during 2012.

216

SUPPLEMENTAL- # 1
December 26, 2013
12:16pm

SUPPLEMENTAL- # 1
December 26, 2013
12:16pm

Supplemental Attachment – Proof of Publication

Publication Affidavit from The Tennessean

0101703991

218

Affidavit of Publications

SUPPLEMENTAL- # 1
December 26, 2013
12:16pm

DEC 26 '13 12:21

Newspaper: THE TENNESSEAN

State Of Tennessee

TEAR SHEET ATTACHED

Account Number: 534576
Advertiser: BRADLEY ARANT BOULT CUMMINGS A

RE: NOTIFICATION OF INTENT

I, V Perry **Sales Assistant** for the above mentioned newspaper, hereby certify that the attached advertisement appeared in said newspaper on the following dates:

12/10/2013 V Perry

Subscribed and sworn to me this 10 day of Dec, 2013

Lela Bates
NOTARY PUBLIC

LELA BATES
STATE OF TENNESSEE NOTARY PUBLIC
DAVIDSON COUNTY
COMMISSION EXPIRES 5/6/15

to limitation of liability must file an answer to said Complaint, as required by the aforesaid Supplemental Rule F, and serve on or mail to Daystar's attorney a copy, unless his claim has included an answer.
CHIEF DISTRICT JUDGE WILLIAM J. HAYNES, JR.
MIDDLE DISTRICT OF TENNESSEE

0101701506
SUBSTITUTE TRUSTEE'S SALE

Sale at public auction will be on **January 9, 2014 at 10:00AM local time**, at the east door, Sumner County Courthouse, 100 Public Square, Gallatin, Tennessee, conducted by Shapiro & Kirsch, LLP Substitute Trustee, pursuant to Deed of Trust executed by Julie A. Bumpus and husband, Roger L. Bumpus, to Larry A. Weissman, Trustee, on October 16, 2006 at Record Book 2620, Page 66, Instrument No. 815153; all of record in the Sumner County Register's Office.
Party entitled to enforce security interest: Federal National Mortgage Association, its successors and assigns
The following real estate located in Sumner County, Tennessee, will be sold to the highest call bidder subject to all unpaid taxes, prior liens and encumbrances of record:
Land in Sumner County, Tennessee,

Continued to next column

File No. 13-052633

0101702627
SUBSTITUTE TRUSTEE'S SALE

Sale at public auction will be on January 7, 2014 at 10:00AM local time, at the east door, Sumner County Courthouse, 100 Public Square, Gallatin, Tennessee, conducted by Shapiro & Kirsch, LLP Substitute Trustee, pursuant to Deed of Trust executed by Jeremy H. Pruitt and Nannette L. Pruitt, husband and wife, to FMLS, Inc., Trustee, on August 26, 2005 at Record Book 2327, Page 718; all of record in the Sumner County Register's Office.
Party entitled to enforce security interest: JPMorgan Chase Bank, National Association, its successors and assigns
The following real estate located in Sumner County, Tennessee, will be sold to the highest call bidder subject to all unpaid taxes, prior liens and encumbrances of record:
Being Lot No. 194 on the Final Plat of Autumn Creek, Section 2 as of record in Plat Book 22, Page 57-59, Register's Office for Sumner County, Tennessee, to which said plan reference is hereby made for a more complete and accurate legal description thereof.
Being the same property conveyed to Jeremy H Pruitt and wife, Nanette L. Pruitt by deed from

Continued to next column

Phone (901)767-5566
Fax (901)761-5690
File No. 13-052455

0101704505
SUBSTITUTE TRUSTEE'S SALE

Sale at public auction will be on **February 13, 2014 at 10:00 AM local time**, at the Auction.com Room of the Schermerhorn Symphony Center, One Symphony Place, Nashville, TN 37201 pursuant to Deed of Trust executed by Scott L. Dawkins and Natascha R. Dawkins, husband and wife, to Daniel W. Small, Trustee, as trustee for Guaranty Trust Company on January 20, 2005 at Instrument No. 20050126-0009734; conducted by Shapiro & Kirsch, LLP having been appointed Substitute or Successor Trustee, all of record in the Davidson County Register's Office.
Default has occurred in the performance of the covenants, terms, and conditions of said Deed of Trust and the entire indebtedness has been declared due and payable.
Party Entitled to Enforce the Debt: Wells Fargo Bank, N.A., its successors and assigns
The following real estate located in Davidson County, Tennessee, will be sold to the highest call bidder:
The land referred to in this Deed of Trust is as follows:
Land in Davidson County, Tennessee, being Lot No. 227 on the Plan of Village

Continued to next column

any statutory right of redemption of any governmental agency, state or federal; any prior liens or encumbrances as well as any priority cre-

Continued to next column

chase price and payable conclusion auction in t of a certif check made to Shapiro &

Continued to

SUPPLEMENTAL
December 26, 2013
12:16pm

Public Notices

Public No

0101703991
NOTIFICATION OF INTENT TO APPLY CERTIFICATE OF NEED

This is to provide official notice Health Services and Development cy and all interested parties, in a ance with T.C.A. § 68-11-1601 et se the Rules of the Health Services a velopment Agency, that Rolling Hill pital, an existing mental health ho owned and managed by Rolling Hill pital, LLC, a limited liability compa tends to file an application for a C cate of Need for the addition of for beds to its existing eighty (80) bed ty located at 2014 Quail Hollow Franklin, Tennessee 37067 (Willia County). The estimated project c $9,796,909.56.
The anticipated filing date of the ap tion is on or before December 13,
The contact person for this project chael D. Brent, Esq., who may be re at Bradley Arant Boult Cummings 1600 Division Street, Suite 700, Nash Tennessee 37203. Mr. Brent's telep number is (615) 252-2361 and his e address is mbrent@babc.com.
Upon written request by interested ties, a local Fact-Finding public he shall be conducted. Written reques hearing should be sent to:
Health Services and Developmen Agency
Andrew Jackson Building, 9th Floo
502 Deaderick Street
Nashville, Tennessee 37243
Pursuant to T.C.A. § 68-11-1607(c)(1 Any health care institution wishin oppose a Certificate of Need applic must file a written notice with Health Services and Development A cy no later than fifteen (15) days fore the regularly scheduled Health ices and Development Agency me at which the application is origi scheduled; and (B) Any other pe wishing to oppose the application r file written objection with the He Services and Development Agency prior to the consideration of the app tion by the Agency.

SAVE
BIG
THE TENNESSEAN

Shop with confi

©2011 Classified Ventures, LLC™. All rights reserved.

SUPPLEMENTAL- # 1
December 26, 2013
12:16pm

DEC 26 '13 PM 2:11

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF WILLIAMSON

RICHARD CLARK, 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 - CEO

Sworn to and subscribed before me this 26th day of December (Month), 2013 (Year) a Notary Public in and for the County/State of WILLIAMSON / TN.

JUSTIN ADAMS
STATE OF TENNESSEE NOTARY PUBLIC
WILLIAMSON COUNTY

NOTARY PUBLIC

My commission expires DECEMBER (Month), 2015 (Year).

SUPPLEMENTAL - #2
-COPY-

Rolling Hills Hospital

CN1312-051

SUPPLEMENTAL
December 30, 2013
10:24 am

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

(a) With the number of adolescent diversions and the issues concerning high vs. lower acuity of adolescent patients, does the applicant have plans for future adolescent unit expansion?

Response: Yes. As referenced in Section B, Project Description, Item 11.C. of the original application, the proposed project will allow the Applicant further flexibility to develop a subunit within the existing building, thus enabling the separation of low and high acuity adolescent patients. This separation into two distinct groups of patients will allow the Applicant to expand its adolescent programming and subsequently allow the Applicant to accommodate more patients that require varying levels of specialized care, observation and programming.

(b) The applicant notes 89 adult diversions for "No Intensive Treatment Program." Will the proposed project play a role in reducing the number of those diversions?

Response: Please note as clarification that the word "No" in "No Intensive Treatment Program" (as well as the word "No" in the other categories) was intended as an abbreviation of the word "number," and was not meant to imply there was not an Intensive Treatment Program at the Applicant's facility. There is, in fact, an Intensive Treatment Program at the Applicant's facility. The proposed project and addition of beds will have a direct effect on reducing the number of deflections and diversions to the Applicant's Intensive Treatment Program, thus allowing the Applicant to accommodate more chronically ill, high acuity adult patients that require intensive levels of specialized care, observation and programming. Moreover, the expansion of the Applicant's facility will allow for reconfiguration of existing units to meet the needs and demands of the community, as such needs and demands change from time to time.

(c) With the number of geriatric diversions and the issues concerning high vs. lower acuity of geriatric patients, does the applicant have plans for future geriatric unit expansion?

Response: Yes. As referenced in Section B, Project Description, Item 11.C. of the original application, the proposed project will allow the Applicant further flexibility to develop a subunit within the existing building, thus enabling the separation of low and high acuity geriatric patients. This separation into two distinct groups will allow the Applicant to expand its geriatric programming and subsequently allow the Applicant to accommodate more geriatric patients that require varying levels of specialized care, observation and programming.

(d) Will the proposed project have any impact on easing the high vs. low acuity issues with the geriatric and adolescent patient population? If yes, please explain.

Response: Yes. As referenced in Section B, Project Description, Item 11.C. of the original application, the proposed project will have a direct impact on easing the high versus low acuity issues that the Applicant currently faces. Due to the present nursing unit configurations and available bed space at the Applicant's current facility, the Applicant is often unable to effectively separate patients according to acuity. The proposed project will increase the Applicant's facility square foot allocation, bed space, environment of care space (i.e., day rooms, additional nurses stations, medication rooms and activity areas), and will enable the Applicant to develop subunits and single occupancy rooms to allow for the physical separation of patient populations. Newly-admitted patients or those whose clinical condition improves or deteriorates will be

SUPPLEMENTAL
December 30, 2013
10:24 am

directed to the most appropriate unit. Patients with different acuity levels will be cared for in separate units according to clinical disposition and existing levels of acuity and associated behaviors. At the completion of the proposed project, this physical separation of patient populations will allow the Applicant's clinical leadership the ability to implement individualized care planning and diagnostic or age specific specialized programming. The Applicant will also be able to separate patients based on their activities of daily living (ADLs), such as hygiene, self-care requirements, risk of fall and pre-existing physiological or medical dispositions and conditions. Finally, the proposed project and its corollary benefit of allowing the Applicant to separate patients based on acuity will allow the Applicant to accommodate more geriatric and adolescent patients that require varying levels of specialized care, programming and observation.

(e) Please explain how the addition of 40 adult beds will help segregate the higher acuity geriatric patients with dementia from the depressed frail elderly patients.

Response: The addition of 40 beds to the Applicant's existing facility will increase the square foot allocation, bed space, environment of care space (i.e., day rooms, additional nurses stations, medication rooms and activity areas), and will enable the Applicant to develop subunits and single occupancy rooms to allow for the physical separation of higher acuity geriatric patients with dementia from the depressed, frail, elderly patients. The Applicant intends for a subunit within its geriatric service line will incorporate a dementia-specific program, wherein geriatric patients suffering from dementia will receive specific, tailored programming separate and apart from the depressed, frail, elderly patients.

(f) Please complete the following charts

Response: Please see the charts below.

Adult Psychiatric Bed Mix

Program	Current Beds	Beds after Project Completion
Intensive Treatment	16	28
General Psychiatry	23	51
Co-Occurring	9	9
TOTAL	**48**	**88**

Note: The Applicant currently has 18 Adolescent beds and 14 Geriatric beds. The Adolescent and Geriatric bed complements will not change as a result of the proposed project.

Bed Type	Current Private Beds	Current Semi-Private beds	After Project Private Beds	After Project Semi-Private Beds	After Project Total Beds
Adult	0	48	4	84	88
Geriatric	0	14	0	14	14
Child/Adol.	0	18	0	18	18
Total	**0**	**80**	**4**	**116**	**120**

(g) Are the Co-Occurring Beds the same as the Adult Chemical Dependency beds in Chart A.9.?

SUPPLEMENTAL
December 30, 2013
10:24 am

Response: Yes. The Co-Occurring Beds are the same as the Adult Chemical Dependency Beds in Chart A.9.

2. **Section C, Need, Item 1 a., (Project Specific Criteria-Psychiatric Inpatient Services A. Need, 1)**

Your response to this item is noted. When you obtain the custom population data, please complete the formulas below.

Primary Service Area

Licensed Total Psychiatric Hospital Beds – Calculated Total Psychiatric Bed Need (Using 2018 Population Data) = Net Need/Surplus

Licensed Adult Psychiatric Hospital Beds – Calculated Adult Bed Need (Using 2018 Population Data) = Net Need/Surplus

Secondary Service Area

Licensed Total Psychiatric Hospital Beds – Calculated Total Psychiatric Bed Need (Using 2018 Population Data) = Net Need/Surplus

Licensed Adult Psychiatric Hospital Beds – Calculated Adult Bed Need (Using 2018 Population Data) = Net Need/Surplus

Response: Please see the charts below, which calculate bed need based upon population estimates for 2018 as provided by the Department of Health, Division of Health Statistics to the Applicant on December 27, 2013.

Projected Psychiatric Bed Need in Applicant's Primary Service Area for 2018

County	2018 Population Estimates			2018 Psychiatric Bed Need Projections		
	Adolescent (13-17)	Adult (18-64)	Adult (65+)	Adolescent (13-17)	Adult (18-64)	Adult (65+)
Bedford	3,533	30,205	7,595	1	9	2
Giles	1,723	17,207	5,892	1	5	2
Lawrence	3,115	24,496	8,001	1	7	2
Lincoln	1,660	22,930	4,949	0	7	1
Marshall	2,166	19,361	5,495	1	6	2
Maury	5,328	50,118	14,097	2	15	4
Rutherford	22,172	214,732	33,222	7	64	10
Williamson	18,739	139,522	27,729	6	42	8
Totals:	**58,436**	**518,571**	**106,980**	**18**	**156**	**32**

Total Bed Need: 206

Adult Bed
Need: 188

Source: Tennessee Department of Health Population Projections; Guidelines for Growth (2000 ed.)

Projected Psychiatric Bed Need in Applicant's Secondary Service Area for 2018

County	2018 Population Estimates			2018 Psychiatric Bed Need Projections		
	Adolescent (13-17)	Adult (18-64)	Adult (65+)	Adolescent (13-17)	Adult (18-64)	Adult (65+)
Coffee	2,854	36,716	7,380	1	11	2
Davidson	38,281	433,351	85,594	11	130	26
Dickson	5,274	34,827	7,566	2	10	2
Montgomery	16,029	120,878	18,946	5	36	6
Sumner	12,504	111,550	29,697	4	33	9
Totals:	**74,942**	**737,322**	**149,183**	**22**	**221**	**45**

Total Bed
Need: 288

Adult Bed
Need: 266

Source: Tennessee Department of Health Population Projections; Guidelines for Growth (2000 ed.)

As noted in the Applicant's original application, the number of total licensed psychiatric beds in the Applicant's primary service area is 180, of which 131 are licensed adult psychiatric beds. Accordingly, there is a net total psychiatric bed need of 26 beds and a net adult psychiatric bed need of 57 beds in the Applicant's primary service area. Similarly, as noted in the Applicant's original application, the number of licensed psychiatric beds in the Applicant's secondary service area is 637, of which 623 are licensed adult psychiatric beds. Thus, there is a net total psychiatric bed surplus of 349 beds and a net adult psychiatric bed surplus of 357 beds in the Applicant's secondary service area. However, as noted in the Applicant's original application, the Applicant believes that the actual number of beds needed to support not only current demand, but also anticipated growth in the area, is considerably higher.

SUPPLEMENTAL
December 30, 2013 10:24 am

3. **Section C. Need. Item 4 Service Area Demographics**

Your response to this item is noted. Please note that the population projections provided were updated in 2008 and based on the 2000 Census. The Department of Heath now has a 2013 update based on the 2010 Census. Please obtain this data from the Department of Health, Division of Health Statistics and update the demographic table provided in the supplemental response.

Response: Please see the revised chart below.

Demographic Variable/ Geographic Area	Total Population- 2014	Total Population- 2018	Total Population- % change	Age 18-64 Population 2014	Age 18-64 Population 2018	Age 18-64 Population-% change	Age 18-64 Population- 2018 as % of Total	Median Age	Median Household Income	TennCare Enrollees	TennCare Enrollees as % of Total
Bedford	47,368	50,566	6.8%	28,299	30,205	6.7%	59.7%	36.4	$ 39,635	10,767	21.7%
Giles	29,315	29,285	-0.1%	17,541	17,207	-1.9%	58.8%	42.1	$ 38,014	5,180	17.0%
Lawrence	42,329	42,387	0.1%	24,627	24,496	-0.5%	57.8%	39.7	$ 36,663	8,435	19.5%
Lincoln	34,281	35,697	4.1%	21,651	22,930	5.9%	64.2%	41.8	$ 40,904	6,296	18.2%
Marshall	31,286	32,015	2.3%	19,167	19,361	1.0%	60.5%	38.9	$ 40,687	5,392	17.0%
Maury	82,280	83,256	1.2%	50,476	50,118	-0.7%	60.2%	38.4	$ 45,603	14,601	16.9%
Rutherford	293,582	329,446	12.2%	192,147	214,732	11.8%	65.2%	32.2	$ 55,105	36,781	13.8%
Williamson	202,923	223,333	10.1%	124,846	139,522	11.8%	62.5%	38.5	$ 91,146	8,441	4.4%
PSA Sub-Total	*763,364*	*825,985*	*7.6%*	*478,754*	*515,571*	*7.7%*	*62.8%*	*38.5*	*$ 48,470*	*95,894*	*13.1%*
Coffee	54,273	56,841	4.7%	33,843	36,716	8.5%	64.6%	39.7	$ 38,151	11,040	19.8%
Davidson	656,385	682,330	4.0%	431,523	433,351	0.4%	63.5%	33.9	$ 46,676	119,726	19.6%
Dickson	50,860	51,964	2.2%	32,371	34,827	7.6%	67.0%	38.7	$ 45,109	8,939	17.6%
Montgomery	187,649	200,561	6.9%	116,312	120,878	3.9%	60.3%	30.0	$ 49,459	23,540	14.4%
Sumner	172,262	183,406	6.5%	105,847	111,550	5.4%	60.8%	38.6	$ 55,560	23,207	13.9%
SSA Sub-Total	*1,121,429*	*1,175,102*	*4.6%*	*719,896*	*737,322*	*2.4%*	*62.7%*	*36.5*	*$ 46,991*	*186,452*	*15.8%*
Grand Total	1,884,793	2,001,087	5.8%	1,198,650	1,255,893	4.6%	62.8%	37.6	$ 95,461	282,346	15.9%
Tennessee	6,588,698	6,833,509	3.6%	4,101,723	4,204,944	2.5%	61.5%	38.0	$ 44,140	1,198,663	18.5%

Sources: Population - Tennessee Population Estimates from the Tennessee Department of Health, Division of Health Statistics as sent to the Applicant on December 27, 2013; Median Age - Census 2010 SF1 Table P13 Median Age by Male/Female at Cubit Planning - http://www.tennessee-demographics.com/<COUNTYNAME>-county-demographics; Median Household Income - United States Census Quick Facts by State/County, Median Household income and persons below poverty level percentage (2008-20012) at Cubit Planning - http://www.tennessee-demographics.com/<COUNTYNAME>-county-; TennCare Enrollees - As of September 2013 -- TennCare 2013 Enrollment Data Report available at http://www.tn.gov/tenncare/EnrollmentData/fte_201309.XLS

4. **Section C, Need, Item 5.**

The occupancy rate for BHC-Clarksville was not included on the utilization chart. Please re-submit the chart with this information.

Response: The occupancy rate for BHC-Clarksville in 2012 was 50%. Please see the revised chart below:

Hospital	Beds	2010	2010	2010	2010	2011	2011	2011	2011	2012	2012	2012	2012
		Admits	Pat. Days	ALOS	% Occ.	Admits	Pat. Days	ALOS	% Occ.	Admits	Pat. Days	ALOS	%Occ.
Hillside	14	167	3,404	20	67%	138	2,977	21.57	58%	277	3,633	13.12	71%
Lincoln	10	133	3,060	23	84%	116	2,646	22.81	72%	161	2,369	14.71	65%
Rolling Hills	66	2,637	20,216	7.7	84%	2,866	21,739	7.59	90%	3,067	22,705	7.40	94%
PSA Subtotal	90	2,937	26,680	9.08	81%	3,120	27,362	8.77	83%	3,505	28,707	8.19	87%
Centennial	132	4,629	50,840	10.98	106%	3,192	34,808	10.90	72%	3,122	30,460	9.76	63%
MTMHI	245 (195 in 2011 and 2012)	3,102	64,865	20.91	73%	2,745	59,577	21.70	84%	2,881	60,614	21.04	85%
St. Thomas	15 (23 in 2012)	254	4,855	19.11	89%	254	4,979	19.60	91%	279	5,761	20.65	69%
Skyline	110	2,548	19,418	7.62	48%	2,860	22,909	8	57%	2,834	22,152	7.82	55%
Summit	20	565	3,892	6.89	53%	782	5,003	6.4	66%	695	4,449	6.4	61%
Vanderbilt	88	3,127	24,500	7.83	76%	3,176	26,760	8.43	83%	3,373	28,201	8.36	88%
BHC-Clarksville	26	64	982	15	10%	280	4,123	14.73	43%	250	4,766	19.06	50%
Sumner	0 (12 in 2012)	20	79	3.95	N/A	21	103	4.9	N/A	89	1,167	13.11	27%
SSA Subtotal	636 (586 in 2011; 606 in 2012)	14,309	169,431	11.84	73%	13,310	158,262	11.89	74%	13,523	157,570	11.65	71%
TOTAL	726 (676 in 2011; 696 in 2012)	17,246	196,111	11.37	74%	16,430	185,624	11.3	75%	17,028	186,277	10.94	73%

227
SUPPLEMENTAL
December 30, 2013
10:24 am

SUPPLEMENTAL
December 30, 2013
10:24 am

With regards to hospital destination data, your request will be taken under advisement.

Response: The Applicant appreciates consideration of its request. To the extent that it is helpful in your review of the application, we have completed the following charts based upon the Division of Health Statistics' recommendation that we use the publicly-available patient origin information contained in the most recent Joint Annual Report for each hospital. Please note that the information contained in the Joint Annual Reports is broader than the information requested by the agency, because the patient origin information is not separated by patient type (i.e., Major Diagnostic Category (MDC) code 20 patients are included with MDC code 19 patients in the calculations below). In addition, some hospitals report patient origin information by admissions instead of by discharges. We have indicated the hospitals that report patient origin information by discharges including a double asterisk next to each hospital.

Adult Psychiatric Patient Hospital Destination for Primary Service Area Residents

Hospital	Number of Discharges/Admissions	%Total
Behavioral Healthcare Center at Clarksville	3	1%
Centennial Medical Center**	4,161	16%
Hillside Hospital	1,445	88%
Lincoln Medical Center	1,569	92%
Middle Tennessee Mental Health Institute	655	23%
Rolling Hills Hospital	663	22%
Saint Thomas West Hospital**	4,188	19%
Skyline Medical Center, Madison Campus**	399	11%
Summit Medical Center**	450	4%
Sumner Regional Medical Center**	23	<1%
Trustpoint Hospital	*	*
Vanderbilt University Hospitals**	6,890	14%

*Information is not available.

**Indicates that the hospital reports patient origin by discharges. All other hospitals without a double asterisk (**) report patient origin by admissions.
Source: 2012 Tennessee Joint Annual Reports

SUPPLEMENTAL
December 30, 2013
10:24 am

Adult Psychiatric Patient Hospital Destination for Secondary Service Area Residents

Hospital	Number of Discharges/Admissions	%Total
Behavioral Healthcare Center at Clarksville	250	41%
Centennial Medical Center**	13,567	53%
Hillside Hospital	3	<1%
Lincoln Medical Center	9	<1%
Middle Tennessee Mental Health Institute	1,556	54%
Rolling Hills Hospital	930	30%
Saint Thomas West Hospital**	9,348	41%
Skyline Medical Center, Madison Campus**	2,026	56%
Summit Medical Center**	6,344	59%
Sumner Regional Medical Center**	5,424	80%
Trustpoint Hospital	*	*
Vanderbilt University Hospitals**	16,455	33%

*Information is not available.

**Indicates that the hospital reports patient origin by discharges. All other hospitals without a double asterisk (**) report patient origin by admissions.

Source: 2012 Tennessee Joint Annual Reports

5. **Section C, Need, Item 6**

Your response to this item is noted. The bed numbers listed should reflect the bed numbers for the associated program. For example instead of 80/120 for the Child/Adolescent chart, the number of beds should reflect the number of child/adolescent beds.

Response: Please see Supplemental Attachment – Section C, Need, Item 6 for revised utilization charts.

There appears to be an error in the Child/Adolescent Chart. Patient days are increasing in the projected years while occupancy declined to 52% in Year 1 and 53% in Year 2. Please make the necessary corrections.

Response: Please see Supplemental Attachment – Section C, Need, Item 6 for a revised Child/Adolescent utilization chart. This revised chart with corrected calculations shows an increase in patient days and a corresponding increase in occupancy during the first two years.

There appears to be an error in the Geriatric Chart. Patient days are increasing in the projected years while occupancy declined to 45% in Year 1 and 46% in Year 2. Please make the necessary corrections.

SUPPLEMENTAL
December 30, 2013
10:24 am

Response: Please see Supplemental Attachment – Section C, Need, Item 6 for a revised Geriatric utilization chart. This revised chart with corrected calculations shows an increase in patient days and a corresponding increase in occupancy during the first two years.

Please explain why geriatric utilization declined by over 50 percent from 2010 (5,216 patient days) to 2011 (2,475 patient days).

Response: As with other similar facilities, from time-to-time the Applicant experiences attrition in its physicians on staff. The Applicant experienced attrition in its geriatric psychiatric physician specialists over the time period in question, but since then the Applicant has seen an increase in geriatric utilization and anticipates that with the proposed expansion and a renewed focus on the geri-psych patient population, it will be able to attract more geri-psych patients and thus increase its geri-psych population.

Adult patient days and adult occupancy do not correspond for either historical or projected data. In fact based on 39 beds, adult occupancy is in excess of 100% in 2011 and 2012. Please make the necessary corrections and submit revised utilization charts for the applicant facility.

Response: Please see revised utilization charts, but the Applicant would note that the number of beds used for such chart is 48, rather than 39, as the Applicant included the 9 "detox beds" along with the 39 other adult beds, given that such detox beds are typically occupied by adults.

6. **Section C. Economic Feasibility Item 4. (Projected Data Chart)**

There appears to be calculation errors in the 2016 column of the Projected Data Chart-120 beds.

Response: Please see Supplemental Attachment Section C, Economic Feasibility, Item 4 for a revised Projected Data Chart—120 beds.

There appears to be a calculation error in the 2015 column of the Projected Data Chart-40 bed addition.

Response: Please see Supplemental Attachment Section C, Economic Feasibility, Item 4 for a revised Projected Data Chart—40 bed addition.

Please make the necessary corrections and submit revised Projected Data Charts.

Response: Please note that in addition to the two revised Project Data Chart, there is also attached as part of Supplemental Attachment Section C, Economic Feasibility, Item 4 a revised Historical Data Chart. Both the revised Projected Data Charts and the revised Historical Data Chart have deleted any entry for line F1 as to "Retirement of Principal," as the Applicant believes the inclusion of entries on line F1 may have been confusing. Question 15 of the Agency's first Request for Supplemental Information requested information as to why the Applicant has reported a net operating loss in excess of $2 million in both 2011 and 2012, and in the Applicant's First Supplemental Response it

SUPPLEMENTAL
December 30, 2013
10:24 am

was noted that the Applicant's parent entity, UHS, provides a variety of management and shared services and capital resources to its facilities, which are operated through wholly-owned subsidiaries, and that certain accounting allocations are made for such services, based on allocation methods determined by UHS management. Earlier versions the Projected Data Charts and the Historical Data Chart included such accounting allocation on line F1 (in addition to certain "home office" management costs which were included on line D8a). The inclusion of the accounting allocation on line F1 resulted in net operating losses for the Applicant in 2011 and 2012, but in the answers provided by the Applicant in the Applicant's First Supplemental Response the Applicant noted that the facility had actually produced Net Operating Income in excess of $2.8 million for the time period in question prior to the allocation of such corporate "home office" costs. Upon further review and consultation with UHS management, the Applicant believes it to be more accurate to include the "home office" management costs on line D8a (and those costs are still included in the revised Projected Data Charts and the revised Historical Data Chart), but the other portion of such UHS accounting allocations for each subsidiary facility should not be shown on line F1 as "Retirement of Principal," and they have now been deleted from the revised Projected Data Charts and the revised Historical Data Chart. However, as noted above, the full financial statements of all such subsidiary facilities of UHS, including the Applicant, will show an allocation equal to 12.75% of total assets to reflect such allocation.

Please also note that as part of Supplemental Attachment Section C, Economic Feasibility, Item 4, the Applicant has included revised charts specifying the breakdown of "other expenses" categories for the Projected Data Charts.

7. **Section C, Economic Feasibility, Item 6.B.**

It appears that charges per day for area providers were based on inpatient and outpatient revenue. Since inpatient days generate inpatient revenue, these calculations should have been based on inpatient revenue only. Please recalculate these charts with that understanding. Please also recalculate the gross charge, deduction, and net charge per day for the applicant as well, if necessary.

Response: Please see the revised chart below, which is based on inpatient revenue only. No recalculation of the gross charge, deduction or net charge per day for the Applicant is necessary.

Hospital	Average Gross Charge per Patient Day	Average Deduction per Patient Day	Average Net Charge per Patient Day
Hillside	$2330.40	$1451.20	$879.28
Lincoln	$1460.78	$776.37	$1039.85
Centennial	$4243.89	$2572.02	$1209.52
MTMHI*	0	0	0
St. Thomas	$2054.52	$1252.13	$802.38
Skyline*	0	0	0
Summit*	0	0	0

SUPPLEMENTAL
December 30, 2013
10:24 am

Hospital	Average Gross Charge per Patient Day	Average Deduction per Patient Day	Average Net Charge per Patient Day
Vanderbilt	$2097.94	$1389.11	$844.45
BHC-Clarksville	$1040.02	$289.92	$750.10
Sumner	$1636.19	$840.11	$796.09

Note: Pages 32 and 33 of the 2012 JARs for these facilities were not populated.

SUPPLEMENTAL
December 30, 2013
10:24 am

SUPPLEMENTAL
December 30, 2013
10:24 am

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF WILLIAMSON

RICHARD CLARK, 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 - CEO

Sworn to and subscribed before me this 30th day of December (Month), 2013 (Year) a Notary Public in and for the County/State of WILLIAMSON / TN.

JUSTIN ADAMS
STATE OF TENNESSEE NOTARY PUBLIC
WILLIAMSON COUNTY

NOTARY PUBLIC

My commission expires DECEMBER (Month), 2015 (Year).

SUPPLEMENTAL
December 30, 2013
10:24 am

Supplemental Attachment – Section C, Need, Item 6

Revised Utilization Charts

Facility	Beds	Year 1	Year 1	Year 1	Year 1	Year 2	Year 2	Year 2	Year 2
		Admits	Pat. Days	ALOS	Occ. %	Admits	Pat. Days	ALOS	Occ. %
Rolling Hills	120	3769	29565	7.8	68%	4137	32376	7.8	74%

Historical and projected Child/Adolescent Utilization

Facility	Beds	2010	2011	2012	Year 1	Year 2	2010	2011	2012	Year 1	Year 2
		Pat. Days	Pat. Days	Pat. Days	Pat. Days	Pat. Days	Occ. %	Occ. %	Occ. %	Occ. %	Occ. %
Rolling Hills	18 beds	3750	4740	4682	4942	5066	57%	72%	71%	75%	77%

Historical and projected Adult Psychiatric Utilization

Facility	Beds	2010	2011	2012	Year 1	Year 2	2010	2011	2012	Year 1	Year 2
		Pat. Days	Pat. Days	Pat. Days	Pat. Days	Pat. Days	Occ. %	Occ. %	Occ. %	Occ. %	Occ. %
Rolling Hills	2010: 36 beds 2011-2012: 48 beds Year 1-Year 2: 88 beds	11250	14524	15404	20711	23300	86%	83%	88%	64%	73%

Historical and projected Geriatric/OA Psychiatric Utilization

Facility	Beds	2010	2011	2012	Year 1	Year 2	2010	2011	2012	Year 1	Year 2
		Pat. Days	Pat. Days	Pat. Days	Pat. Days	Pat. Days	Occ. %	Occ. %	Occ. %	Occ. %	Occ. %
Rolling Hills	2010: 26 beds 2011-Year 2: 14 beds	5216	2475	2619	3912	4010	55%	48%	51%	77%	78%

SUPPLEMENTAL
December 30, 2013
10:24 am

SUPPLEMENTAL
December 30, 2013
10:24 am

Supplemental Attachment – Section C, Economic Feasibility, Item 4

Revised Projected Data Chart—120 Beds and Revised Projected Data Chart—40 Bed Addition

SUPPLEMENTAL - #3
-COPY-

Rolling Hills Hospital

CN1312-051

SUPPLEMENTAL #3
December 30, 2013
2:42 pm

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

Your response to this item is noted. It is clear how the addition of 40 adult beds should have an impact on reducing diversions and creating flexibility for adult patients through the development of sub-units; however it remains unclear how the proposed project will have any impact on the development of sub-units for adolescent patients or geriatric patients as the applicant points out in the footnote to the "Adult Psychiatric Bed Mix" table that "The Applicant currently has 18 Adolescent beds and 14 Geriatric beds. The Adolescent and Geriatric bed complements will not change as a result of the proposed project."

It appears that your responses are in conflict with one another. Please explain how the proposed project, which is mainly the addition of 40 adult beds, will help create sub-units for geriatric and adolescent patients when those bed complements are not changing

Response: You are correct that the bed complements for adolescent and geriatric will not change, but will remain at 18 adolescent beds and 14 geriatric beds. However, the overall expansion of the facility will increase the Applicant's overall square footage, including environment of care space (i.e., day rooms, additional nurses stations, medication rooms and activity areas), and such additional ancillary space will better enable the Applicant to reconfigure certain areas in the existing building as it develops subunits within all categories, including the adolescent and geriatric portions.

SUPPLEMENTAL #3

December 30, 2013

2:42 pm

SUPPLEMENTAL #3
December 30, 2013
2:42 pm

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF WILLIAMSON

RICHARD CLARK, 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 - CEO

Sworn to and subscribed before me this 30th day of December (Month), 2013 (Year) a Notary Public in and for the County/State of WILLIAMSON / TN.

JUSTIN ADAMS
STATE OF TENNESSEE NOTARY PUBLIC
WILLIAMSON COUNTY

NOTARY PUBLIC

My commission expires DECEMBER (Month), 2015 (Year).

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

DEC 10 '13 AM 10:27

LETTER OF INTENT

The Publication of Intent is to be published in The Tennessean, which is a newspaper of general circulation in Williamson County, Tennessee, on or before December 10, 2013, 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 Rolling Hills Hospital, an existing mental health hospital, owned and managed by Rolling Hills Hospital, LLC, a limited liability company, intends to file an application for a Certificate of Need for the addition of forty (40) beds to its existing eighty (80) bed facility. The location of Rolling Hills Hospital is 2014 Quail Hollow Circle, Franklin, Tennessee 37067 (Williamson County), and the estimated project cost is $9,796,909.56.

The anticipated filing date of the application is on or before December 13, 2013. The contact person for this project is Michael D. Brent, Esq., who may be reached at Bradley Arant Boult Cummings LLP, 1600 Division Street, Suite 700, Nashville, Tennessee 37203. Mr. Brent's telephone number is (615) 252-2361 and his e-mail address is mbrent@babc.com.

(Signature)	11/10/13 (Date)	mbrent@babc.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; Sandra Braber-Grove
Director, Office of Contracts and Privacy/Division of General Counsel

DATE: March 7, 2014; amended March 16, 2014

RE: Review and Analysis of Certificate of Need Application
Rolling Hills Hospital - CN1312-051

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
CN1312-051

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. Michael D. Brent (Attorney, Bradley Arant Boult Cummings, LLP) on behalf of Rolling Hills Hospital, LLC d/b/a Rolling Hills Hospital, a direct, wholly-owned subsidiary of Psychiatric Solutions Hospital, LLC, for the addition of forty (40) adult psychiatric beds to its existing eighty (80)-bed mental health hospital, bringing the total number of beds to one hundred twenty (120). The Applicant reports that the new addition is expected to house these forty (40) beds as well as a large meeting area where it can host support groups, educational seminars, community in-services, and recovery-based groups. Further, it is reported that the project will enable the Applicant to reconfigure some existing space to increase efficiency and to better serve the patient population. The Applicant's primary service area consists of these Tennessee Counties: Bedford, Giles, Lawrence, Lincoln, Marshall, Maury, Rutherford, and Williamson. Due to the Applicant's location, ease of access, and its reputation, the Applicant reports that it has a secondary service area consisting of these Tennessee Counties: Coffee, Davidson, Dickson, Montgomery, and Sumner.

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. Michael D. Brent (Attorney, Bradley Arant Boult Cummings, LLP) has submitted, on behalf of Rolling Hills Hospital, LLC d/b/a Rolling Hills Hospital, a direct, wholly-owned subsidiary of Psychiatric Solutions Hospital, LLC, (who is a wholly-owned subsidiary of Psychiatric Solutions, Inc., who is a wholly-owned subsidiary of Universal Health Services, Inc.) an application for a Certificate of Need seeking to add forty (40) adult psychiatric beds to its existing eighty (80)-bed mental health hospital, located at 2014 Quail Hollow Circle, Franklin (Williamson County), Tennessee. The additional forty (40) beds would bring the total number of psychiatric beds in this facility to one hundred twenty (120). The Applicant Profile indicates that the type of institution is "Mental Health Hospital" (Item 7.F.) and the purpose of review is "Change in Bed Complement/Increase" (Item 8.G.).

Applicant Profile, Ownership, Management, and Licensure - amended 3/16/2014

As previously noted, the Applicant Profile indicates that the type of institution is "Mental Health Hospital" (Item 7.F.) and the purpose of review is "Change in Bed Complement/Increase" (Item 8.G.). The Applicant Profile also shows that the Owner of the Facility, Agency or Institution is Rolling Hills Hospital, LLC (Item 3.). Item 9. of the Applicant Profile shows the bed complement data of current beds [eighty (80)]: adult psychiatric services (39 beds), geriatric psychiatric services (14 beds), child and adolescent psychiatric services (18 beds), and adult chemical dependency detoxification services (9 beds); proposed beds [forty (40)]: adult psychiatric services (40 beds); and total beds upon approval and completion [one hundred twenty (120)]: adult psychiatric services (79 beds), geriatric psychiatric services (14 beds), child and adolescent psychiatric services (18 beds), and adult chemical dependency detoxification services (9 beds). This information was later corrected and confirmed between the Applicant and HSDA staff on March 13, 2014. The correct bed complement data for the eighty (80) beds is: adult psychiatric services (35 beds), geriatric psychiatric services (15 beds), child and adolescent psychiatric services (18 beds), and adult chemical dependency detoxification services (12 beds); and the correct bed complement for the one hundred twenty (120) beds if the project is approved would be: adult psychiatric services (75 beds), geriatric psychiatric services (15 beds), child and adolescent psychiatric services (18 beds), and adult chemical dependency detoxification services (12 beds).

As shown on Page 11 of the application, the Applicant is Rolling Hills Hospital, LLC, d/b/a Rolling Hills Hospital, a direct, wholly-owned subsidiary of Psychiatric Solutions Hospital, LLC, (who is a wholly-owned subsidiary of Psychiatric Solutions, Inc., who is a wholly-owned subsidiary of Universal Health Services, Inc.). The Applicant reports that it does not operate pursuant to a management agreement; all Universal Health Services, Inc.-affiliated hospitals operate autonomously in accordance with the parent company's philosophy on decentralized managerial control. The Applicant further reports that the entities in the Applicant's chain of ownership and control will provide direction, information technology services, and legal services support to the Applicant; however, the Applicant will continue to own and manage its facility with its own administration team with oversight by its own governing body. In

response to a request for additional information about Universal Health Systems, Inc., the Applicant provided a chart showing the other nine (9) Tennessee health care institutions 100% owned and operated by Universal Health Systems, Inc. (Supplemental #1, Pages 1-2). Further, the Applicant described Universal Health Systems, Inc. as a publicly-traded corporation and "one of the largest hospital management companies in the nation" headquartered in King of Prussia, PA and founded in 1978 by Chairman and CEO Alan B. Miller. Also reported on Supplemental #1, Pages 1-2, as of March 31, 2013, Universal Health Systems, Inc. owns and/or operates 23 acute care hospitals and 197 behavioral health centers in 37 states, Washington, DC, Puerto Rico, and the U.S. Virgin Islands.

The Applicant reports that while the entity, located at 2014 Quail Hollow Circle in Franklin, Tennessee, is called "Rolling Hills Hospital", it is more accurate to refer to it as a "mental health hospital" as that term more accurately reflects the scope of care provided by the Applicant (Application, Page 13).

The Applicant is currently licensed by the Department of Mental Health and Substance Abuse Services and accredited by The Joint Commission (appropriate documentation was submitted with the application). The Applicant currently provides inpatient and outpatient services: adult psychiatric services (39 beds), geriatric psychiatric services (14 beds), child and adolescent psychiatric services (18 beds), and adult chemical dependency detoxification services (9 beds). As noted on Page 3, this information was later corrected and confirmed between the Applicant and HSDA staff on March 13, 2014. The correct current distribution of beds is as follows: adult psychiatric services (35 beds), geriatric psychiatric services (15 beds), child and adolescent psychiatric services (18 beds), and adult chemical dependency detoxification services (12 beds).

The Proposed Project

As noted, the Applicant seeks to add forty (40) adult psychiatric beds (to serve individuals 18-64 years of age) to its existing eighty (80)-bed mental health hospital by constructing an addition to its current location at 2014 Quail Hollow Circle in Franklin, (Williamson County) Tennessee. The Applicant reports that the new addition is expected to house these forty (40) beds as well as a large meeting area where it can host support groups, educational seminars, community in-services, and recovery-based groups. The forty (40) beds will be two (2) units of twenty (20) beds each, consisting of four (4) private rooms and eighteen (18) semi-private rooms. Further, it is reported that the project will enable the Applicant to reconfigure some existing space to increase efficiency and to better serve the patient population. The Applicant reports that it has managed to operate five (5) inpatient units in a facility that was originally designed to accommodate only four (4) inpatient units. The Applicant works around bed configuration issues, serving the needs of multiple patient populations. The additional space will enable the Applicant to best serve the patient populations, particularly by enabling them to clinically distinguish patients into five (5) distinct groups and physical units that would allow for the safer delivery of care for patients requiring intensive care due to their high level of acuity as explained on Supplemental #1, Page 5. The Applicant also reports that it currently experiences difficulty in accommodating the increasing needs of the chronically mentally ill. The existing size and resulting configuration of the facility makes it

challenging to effectively separate patient populations, create specialized treatment modalities, and introduce new programs and services to the community. The Applicant reports that it has experienced a higher number of deflections (turn-aways) in the past twelve (12) months because there is no physical bed for the patient to occupy. A chart on Supplemental #1, Page 3 shows a total of 195 deflections/diversions for the most recent year. The Applicant also reports that it is experiencing other diversions due to the Applicant's inability to accommodate someone due to age, disposition, or lack of programming. The Applicant states that with the addition of these forty (40) beds, the Applicant will have the ability to provide psychiatric treatment to more mental health consumers, significantly reducing placement issues and deflection and diversion activity in its service area. Further, the Applicant reports that it will be able to create distinct and specialized programming, effectively treating all patient populations while remaining a resource for the medical community, law enforcement system, and crisis intervention providers. (Application, Pages 19-20; more detailed explanation provided on Supplemental #1, Pages 3-5)

The new addition, explained briefly on Page 16 of the application, will be two (2) levels, with the top level extended to the east, sharing connection points at three (3) locations on the upper level. The Applicant reports that connecting the existing units to the expansion on the upper level allows for enhanced flexibility and usage of the units, as program needs change from time to time. A new center-access corridor will be created to allow for the transport of patients to the new units without having the problem of cross-unit traffic. The lower level will have a new community room, outpatient group rooms, and ancillary administration functions. A new bank of elevators will be added that will serve the new addition as well as the existing facility structure for access to the lower level dining room. Further, the new addition is fed from the same common corridor thereby making for easy and efficient circulation and navigation. Travel distance to the new unit will not be significantly greater than travel time to the existing units, due to the positioning of the new addition and the addition of new elevators to serve the south end of the building. Since the existing site slopes uphill from west to east, there is an embankment which creates a boundary for the facility on the north and east property lines. The shallow lot requires a building of any significant size to conform to the site topography in order to maximize its use. The existing facility will also share a number of other common amenities, including the kitchen and dining room; medical records storage; admissions area; plant operations such as the supply department; a business office; and other administrative offices.

As will be explained later in this report, the Applicant reports that the request for the additional beds comes at a time when there is an increased demand for mental health services; the Applicant is experiencing a steady increase in its own occupancy rates; and changes on the federal front (The Mental Health Parity and Addiction Equity Act and the Patient Protection and Affordable Care Act) have contributed to, and will continue to contribute to, an increase in demand for mental health services (the U.S. Department of Health and Human Services' Secretary has stated that the mental health coverage mandates taking effect will result in the largest expansion of behavioral health care in a generation [Application, Page 15]).

The Applicant reports that there is no major medical equipment involved in the project.

The Applicant reports a total estimated project cost (Application, Page 44) of $9,774,916.00 (excluding the CON application filing fee); with construction costs of $7,179,765.00, preparation of site costs of $628,120.00, architectural and engineering fees of $765,100.00, and fixed equipment costs of $813,651.00. The anticipated date the project will be 100% complete (approved for occupancy) is June 20, 2015. The issuance of a license is expected to occur on June 30, 2015 and the initiation of services is expected to occur on July 1, 2015.

Service Areas

The Applicant's primary service area consists of these Tennessee Counties: Bedford, Giles, Lawrence, Lincoln, Marshall, Maury, Rutherford, and Williamson. The Applicant reports that Bedford, Giles, Lawrence, Lincoln, and Marshall Counties are designated as "Medically Underserved Areas" by the Health Resources and Services Administration of the U.S. Department of Health and Human Services. Due to the Applicant's location, ease of access, and its reputation, the Applicant reports that it has a secondary service area consisting of these Tennessee Counties: Coffee, Davidson, Dickson, Montgomery, and Sumner.

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 offer the following in support of approval of the application:

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 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 is a Need 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 reports a primary service area consisting of these eight (8) Tennessee Counties: Bedford, Giles, Lawrence, Lincoln, Marshall, Maury, Rutherford, and Williamson. The Applicant also reports a secondary service area consisting of these five (5) Tennessee Counties: Coffee, Davidson, Dickson, Montgomery, and Sumner. The Applicant used calculations of total population and total bed need. As encountered during reviews of other CON applications, there are different ways to calculate the need for inpatient psychiatric beds. As shown in Section C.1., for purposes of the application under review, which is seeking to add forty (40) adult psychiatric beds, a review of the population numbers for ages 18-64 years and, therefore, the need for that population was conducted for the Applicant's primary service area (the eight (8)-county service area). The Applicant reports that Bedford, Giles, Lawrence, Lincoln, and Marshall Counties are designated as "Medically Underserved Areas" by the Health Resources and Services Administration of the U.S. Department of Health and Human Services. With the addition of these forty (40) beds, the Applicant reports that it will have the ability to provide psychiatric treatment to more mental health consumers, significantly reducing placement issues and deflection and diversion activity in its service area. The Applicant reported that it has experienced a higher number of deflections (turn-aways) in the past twelve (12) months because there is no physical bed for the patient to occupy. A chart on Supplemental #1, Page 3 shows a total of 195 deflections/diversions for the most recent year. Further, the Applicant reports that it will be able to create distinct and specialized programming, effectively treating all patient populations while remaining a resource for the medical community, law enforcement system, and crisis intervention providers. (Application, Pages 19-20; more detailed explanation provided on Supplemental #1, Pages 3-5)

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. Since the application under review is to increase the number of adult psychiatric beds in an existing facility, the Applicant has its own history of providing psychiatric services. As will be discussed in Section C.2., the Applicant has reported rather high Net Operating Losses for both Calendar Years 2011 and 2012 as well as projecting a Net Operating Loss for the first Calendar Year of operation (2015), but projects a positive Net Operating Income for the second Calendar Year of operation (2016). The Applicant indicates that the project will be financed through Cash Reserves of the Applicant and its affiliates as shown in submitted documentation from the Chief Financial Officer. Overall, adequate funding appears to be available and projected gross operating revenue should be sufficient to ensure the economic feasibility of the project.

4. The project does contribute to the orderly development of healthcare as described in further detail in Section C.3. The Applicant is currently licensed by the Tennessee Department of Mental Health and Substance Abuse

Services, certified by both Medicare and TennCare, and accredited by The Joint Commission. The Applicant has not been cited for any deficiencies. The Applicant is fully aware of the licensing and certification requirements for medical and clinical staff. Further, the Applicant understands program requirements, laws, rules, and regulations for the maintenance and operation of a facility of this type. The reported staffing plan meets the TDMHSAS licensing requirements for this type of facility and reported salaries are in line with the submitted Market Range of Pay. The Applicant reports that it believes the expansion of its mental health hospital will allow greater access to psychiatric care having a positive effect on the health care system, which is echoed in several letters of support that show that the addition of these forty (40) inpatient psychiatric beds will provide an environment of safety and care and fulfill a need for inpatient mental health options in the service area. The Applicant reports that is has affiliations with many health care providers, community organizations, police departments and has many relationships with educational institutions for the training of students in the areas of medicine, nursing, social work, and other similar areas.

C. ANALYSIS

1. Need

The Formula for Determining Need and Other Factors to Consider

As noted above, the formula for determining the need for inpatient psychiatric beds, as stated in the Guidelines for Growth publication, is thirty (30) beds per a population of 100,000. As also stated, in practice, however, application of the formula 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.

Need Shown by Steady Growth and Change in Federal Regulations

As previously noted, the Applicant reports that the request for the additional beds comes at a time when there is an increased demand for mental health services; the Applicant is experiencing a steady increase in its own occupancy rates (22% in 2010 to approximately 84% over the last twelve (12) months); and changes on the federal front (The Mental Health Parity and Addiction Equity Act and the Patient Protection and Affordable Care Act) have contributed to, and will continue to contribute to, an

increase in demand for mental health services (the U.S. Department of Health and Human Services' Secretary has stated that the mental health coverage mandates taking effect will result in the largest expansion of behavioral health care in a generation). The Mental Health Parity and Addiction Equity Act requires insurance groups that offer coverage for mental health and substance use disorders to provide the same level of benefits that they do for general medical treatment. The Applicant also believes that the Patient Protection and Affordable Care Act extends the reach of the Mental Health Parity and Addiction Equity Act's requirements, which when coupled with encouraging trends in mental health care such as a continuing reduction in the stigma of mental illness; a continuing improvement in access to and coverage of mental health and addiction services; and a growing recognition that mental health is integral to overall health and well-being, there will be an increase in consumption and utilization of mental health services such as those provided by the Applicant.

Calculations and Existing Beds - amended 3/16/2014

The Applicant reported a projected psychiatric bed need of 194 for 2017 based on applying the formula (30 beds per 100,000 population) to the total population of the eight (8)-county service area. Department staff found no similar calculations for the current year (2014) and the first two years of expected operation (2015 and 2016).

As encountered during reviews of other CON applications, there are different ways to calculate the need for inpatient psychiatric beds. For purposes of the application under review, which is seeking to add forty (40) adult inpatient psychiatric beds, a review of the population numbers for ages 18-64 years and, therefore, the need for that population was conducted.

Population Numbers for the Adult (18-64 years of age) Population Only

County	**2014**	**2015**	**2016**	**2017**
Bedford	28,371	28,790	29,196	29,669
Giles	17,574	17,500	17,410	17,281
Lawrence	24,676	24,626	24,619	24,584
Lincoln	21,657	22,048	22,381	22,610
Marshall	19,230	19,188	19,223	19,307
Maury	50,602	50,470	50,350	50,238
Rutherford	192,073	197,542	203,013	208,737
Williamson	125,447	128,901	132,420	135,955
TOTALS:	479,630	489,065	498,612	508,381

Source of Population Figures: "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; 2013 Revision (6/13)" [Note: the population numbers for the age category of 15-19 were divided by 5, then multiplied by 2 to obtain population for the 18 and 19 year olds; which was then added to the population numbers for the 20-64 year olds]

Inpatient Psychiatric Bed Need --- Adult --- for the Eight (8)-County Service Area

2014	2015	2016	2017
479,630 ÷ 100,000 x 30 = 143.89	489,065 ÷ 100,000 x 30 = 146.72	498,612 ÷ 100,000 x 30 = 149.58	508,381 ÷ 100,000 x 30 = 152.51

Remember, though, that the application of the formula alone is not sufficient to determine need. One must factor in the number of existing beds in the service area as well as the utilization of those beds to determine true need. Again, there are different ways to conduct these calculations.

A chart on Page 31 of the application shows a total of ~~180~~ 190* licensed psychiatric beds (2012) as follows:

Hillside Hospital in Giles County:	14
Lincoln Medical Center in Lincoln County:	10
Trustpoint Hospital in Rutherford County:	~~76~~ 86*
Rolling Hills Hospital in Williamson County:	80

*Trustpoint's actual number of beds is 86, not 76 which brings the total to 190, not 180; this was confirmed and corrected between legal counsel for Trustpoint and HSDA staff on March 14, 2014

Department staff have identified, as reported in the 2012 Joint Annual Reports (JARs), that there are an additional 16 beds at the Behavioral Healthcare Center at Columbia in Maury County. Thus, the total number of existing beds, using these figures, is 206. Another factor to consider is whether all of these existing beds are available to those expected to be served by the new beds -- adults. If any of these beds are geriatric psychiatric beds, adolescent psychiatric beds, or other 'specialty' beds designated for other uses, they may not be available for inpatient psychiatric use by adults (individuals who are 18-64 years of age).

Adjusting the figures as follows shows a total number of existing inpatient psychiatric beds available for adults of 70, leaving an unmet need of 74 beds in 2014. If the project is approved, which would increase the existing adult inpatient psychiatric bed count to 110 in 2015 (70 + 40), there would still be an unmet need for subsequent years (see table above):

Hillside Hospital in Giles County:	0 (the 14 are designated geriatric)
Lincoln Medical Center in Lincoln County:	10 (used for both geriatric and adult)
Trustpoint Hospital in Rutherford County:	25** (others are non-adult or other)
Rolling Hills Hospital in Williamson County:	35*** (others are non-adult or other)
BHC at Columbia in Maury County:	0 (the 16 are designated geriatric)

**adjusted based on confirmed data received by HSDA staff from Trustpoint's legal counsel on March 14, 2014

***adjusted based on corrected and confirmed data received by HSDA staff from the Applicant on March 13, 2014

As you can see, different calculations show different things. The bottom line is that there appears to be an unmet need for adult inpatient psychiatric beds in the Applicant's primary service area. The occupancy chart submitted on Page 6, Supplemental (December 30, 2013) shows that the existing facilities with these beds are operating at capacities, in 2012, of 71% (Hillside); 65% (Lincoln), and 94% (Rolling Hills) further supporting the need for additional adult inpatient psychiatric beds in the Applicant's primary service area. Please also see the discussion in Section C.3. (Effect on Existing Providers and Letters of Support or Opposition).

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 the project will be financed through Cash Reserves of the Applicant and its affiliates as shown in submitted documentation from the Chief Financial Officer. Since the application under review is to increase the number of adult psychiatric beds in an existing facility, the Applicant has its own history of providing psychiatric services. As noted in Section B.3., the Applicant has reported rather high Net Operating Losses for both Calendar Years 2011 and 2012. On Supplemental #1, Page 16 the Applicant explains that Rolling Hills Hospital was acquired by Universal Health Services, Inc. in November 2010 through a series of acquisitions. Universal Health Services, Inc. provides a variety of management and shared services as well as capital resources to its facilities, which are operated through wholly-owned subsidiaries. The Applicant reports that such a system results in the reduction of ultimate costs, but goes on to explain that fees and expenses are allocated to the facilities based upon the nature and extent of such services provided or capital rendered during the year. The net operating losses reported are a result of the corporate allocation for such management support and capital charges. The Applicant reports, on Supplemental Page 21 (December 30, 2013), that the facility actually produced a Net Operating Income each of these calendar years prior to the allocation of the corporate costs.

Ownership and Management

The Applicant, Rolling Hills Hospital, LLC, d/b/a Rolling Hills Hospital, is a direct, wholly-owned subsidiary of Psychiatric Solutions Hospital, LLC, who is a wholly-owned subsidiary of Psychiatric Solutions, Inc., who is a wholly-owned subsidiary of Universal Health Services, Inc. The Applicant reports that it does not operate pursuant to a management agreement; all Universal Health Services, Inc.-affiliated hospitals operate autonomously in accordance with the parent company's philosophy on decentralized managerial control. The Applicant further reports that the entities in the Applicant's chain of ownership and control will provide direction, information technology services, and legal services support to the Applicant; however, the Applicant will continue to own and manage its facility with its own administration team with oversight by its own governing body. As noted on Supplemental #1, Pages 1-2, Universal Health Systems, Inc. is a publicly-traded corporation and "one of the largest hospital management companies in the nation" headquartered in King of Prussia, PA and founded in 1978 by Chairman and CEO Alan B. Miller; and as of March 31, 2013, Universal Health Systems, Inc. owns and/or operates 23 acute care hospitals and 197 behavioral health centers in 37 states, Washington, DC, Puerto Rico, and the U.S. Virgin Islands.

Expected Cost, Description of Construction for the Proposed Addition, and Alternatives

The Applicant reports a total estimated project cost (Application, Page 44) of $9,774,916.00 (excluding the CON application filing fee); with construction costs of $7,179,765.00, preparation of site costs of $628,120.00, architectural and engineering fees of $765,100.00, and fixed equipment costs of $813,651.00. The Applicant reports, on Page 45 of the Application, that the project will be cost-effective and consistent with the average costs for similar projects and that the approximately $337.00 per square foot cost is consistent with the HSDA's published median cost per square foot. Since $337.00 per square foot is above the third quartile of previously approved projects, the Applicant was asked to explain the higher than normal constructions costs for the proposed project. On Page 15 of Supplemental #1, the Applicant reports that the actual construction cost per square foot is $257.05 and that the $337.00 per square foot is the ratio of the total project cost to the square footage. The Applicant also explains that the addition needs to incorporate costly materials and hardware to address the patients' safety needs, including such things as impact resistant drywall, antiligature door hardware, vandal resistant windows and light fixtures, antiligature HVAC grilles and diffusers, specialized toilet accessories and fixtures that help prevent self harm, and other similarly designed hardware and fixtures. It is noted that each of these materials has a premium cost.

An additional explanation for the higher cost is what is necessary to incorporate the addition into the sloping site. The Applicant reports that the new addition is expected to house forty (40) beds as well as a large meeting area where it can host support groups, educational seminars, community in-services, and recovery-based groups. The forty (40) beds will be two (2) units of twenty (20) beds each, consisting of four (4) private rooms and eighteen (18) semi-private rooms. As previously mentioned, the new addition, explained briefly on Page 16 of the application, will be two (2) levels, with the top level extended to the east, sharing connection points at three (3) locations on the upper level. The Applicant reports that connecting the existing units to the expansion on the upper level allows for enhanced flexibility and usage of the units, as program needs change from time to time. A new center-access corridor will be created to allow for the transport of patients to the new units without having the problem of cross-unit traffic. The lower level will have a new community room, outpatient group rooms, and ancillary administration functions. A new bank of elevators will be added that will serve the new addition as well as the existing facility structure for access to the lower level dining room. The new addition will be constructed out of a structural steel frame and concrete floors. The mechanical system will share the facility's existing electrical, fire protection and sprinkler system, but new HVAC units will be provided to serve the addition. The exterior of the addition will be primarily brick to match the existing exterior, with a matching, standing seam metal roof. The main entryway drive will be relocated to the east, with new parking added to accommodate the additional patients, visitors, and family members the addition will generate. Since the existing site slopes uphill from west to east, there is an embankment which creates a boundary for the facility on the north and east property lines. The shallow lot requires a building of any significant size to conform to the site topography in order to maximize its use. The proposed design creates a two-story structure on the west side of the site and a one-

story structure on the east side of the site. Further, the new addition will be fed from the same common corridor thereby making for easy and efficient circulation and navigation. Travel distance to the new unit will not be significantly greater than travel time to the existing units, due to the positioning of the new addition and the addition of new elevators to serve the south end of the building. The existing facility will also share a number of other common amenities, including the kitchen and dining room; medical records storage; admissions area; plant operations such as the supply department; a business office; and other administrative offices. As noted, the Applicant believes the project will be cost-effective and consistent with the average costs for similar projects. The Applicant reports that an alternative does not exist and that if the Applicant foregoes the expansion and the need for psychiatric and substance abuse treatment continues to escalate, the community will suffer undue hardship. Further, if the addition is not built, the Applicant will be forced to continue deflecting individuals in need of psychiatric treatment due to a lack of bed space and community providers will continue to struggle with accessing care for those with psychiatric issues.

Revenue and Expense Information (including Utilization Numbers)

The Applicant currently operates as a Mental Health Hospital. As noted elsewhere, the historical data submitted with the application shows rather high Net Operating Losses for both Calendar Years 2011 and 2012. On Supplemental #1, Page 16 the Applicant explains that Rolling Hills Hospital was acquired by Universal Health Services, Inc. in November 2010 through a series of acquisitions. Universal Health Services, Inc. provides a variety of management and shared services as well as capital resources to its facilities, which are operated through wholly-owned subsidiaries. The Applicant reports that such a system results in the reduction of ultimate costs, but goes on to explain that fees and expenses are allocated to the facilities based upon the nature and extent of such services provided or capital rendered during the year. The net operating losses reported are a result of the corporate allocation for such management support and capital charges. The Applicant reports, on Supplemental Page 21 (December 30, 2013), that the facility actually produced a Net Operating Income each of these calendar years prior to the allocation of the corporate costs.

Historical data presented on Page 41 of the Application shows utilization statistics as follows: 21,739 inpatient patient days in 2011 (a 74% occupancy of the 80 beds); 22,705 inpatient patient days in 2012 (a 78% occupancy of the 80 beds); and 20,159 inpatient patient days through October 2013 (an 83% occupancy of the 80 beds). Projected utilization for 2015 (Year 1) is 29,565 inpatient patient days (a 68% occupancy of the 120 beds) and for 2016 (Year 2) is 32,376 inpatient patient days (a 74% occupancy of the 120 beds). The Applicant explains that the projected utilization is a combination of the proposed project and existing hospital with an Average Daily Census (ADC) of 81.0 in Year 1 and 88.7 in Year 2, based on community need, expanded programming, and hospital management experience.

The Applicant reports a current average adult inpatient billable rate of $1,534.00 per patient day. The Applicant does not anticipate any adjustments to the current charge as a result of the proposed project. The Applicant reports that the addition is expected to produce $19,074,544.00 in gross revenue within the first two years of

operation. If there are any shortfalls in cash flow, they will be supplanted by the Applicant's ultimate parent company, Universal Health Systems, Inc. until the project is self-sustaining. Using information from other CON applications for expansions in surrounding areas (see Application, Page 49), the Applicant reports that the average gross charge per patient is $3,397.00 (Davidson County), $1,713.00 (Hamilton County), and $1,106.00 (Rutherford County) and believes that their charge of $1,534.00 is reasonable in comparison. The Applicant's current (2013) payor mix is: 19% Medicare, 39% Managed Medicaid, and 2% Tricare. The Applicant anticipates the current mix to remain constant for purposes of forecasting revenue and occupancy for the project.

3. Contribution to the Orderly Development of Health Care

Licensure

The Applicant is currently licensed by the Tennessee Department of Mental Health and Substance Abuse Services, certified by both Medicare and TennCare, and accredited by The Joint Commission. Appropriate documentation was submitted with the application. The Applicant has not been cited for any deficiencies. The Applicant is fully aware of the licensing and certification requirements for medical and clinical staff. Further, the Applicant understands program requirements, laws, rules, and regulations for the maintenance and operation of a facility of this type.

Staffing and Reported Salaries

On Pages 53-54 of the Application, the Applicant submitted a chart of the anticipated staffing patterns for the new 40-bed addition. The chart includes both clinical and non-clinical staff (plant operations, housekeeping, patient accounts, and marketing) as well as outpatient staff. This chart shows a total FTE of 23.60 for Year 1 (2015) while a "clinical staff only" chart submitted in Supplemental #1 (Page 19) shows a Year 1 FTE total of 24.57. Department staff cannot explain the apparent discrepancy. For each subsequent year of operation (2016 through 2019), staffing will increase, as Average Daily Census (ADC) numbers increase, to 36.19, 40.40, 47.47, and 53.71 (total) with "clinical staff only" numbers of 32.51, 34.93, 40.45, and 45.52. The staffing plan does meet the TDMHSAS licensing requirements for this type of facility. The submitted chart for Average Rate of Pay shows salaries that are in line with the submitted Market Range of Pay (as reported by the Applicant from the Bureau of Labor Statistics). The Applicant reports that it pays its staff at "the high end of the market range" and will continue to pay competitive rates if this project is approved. The Applicant also reports that in addition to its existing staff, the Applicant, with the help of Universal Health Services, Inc., will recruit additional professional and support staff for the addition, including specialty staff such as psychiatric social workers, family therapists, chemical dependence counselors, and support technicians.

Effect of the New Addition to the Existing Facility

As noted previously, the project will enable the Applicant to reconfigure some existing space to increase efficiency and to better serve the patient population. The Applicant reports that it has managed to operate five (5) inpatient units in a facility

that was originally designed to accommodate only four (4) inpatient units. The Applicant works around bed configuration issues, serving the needs of multiple patient populations. The additional space will enable the Applicant to best serve the patient populations, particularly by enabling them to clinically distinguish patients into five (5) distinct groups and physical units that would allow for the safer delivery of care for patients requiring intensive care due to their high level of acuity. The Applicant explains, on Supplemental #1 Pages 4-5, that there is a need to distinguish the population into higher level acuity and lower level acuity patients for the overall safety of the patients. As explained, when higher acuity patients are mixed with lower acuity patients there is a potential for a dangerous combination of patients, placing patients and staff at risk for injury, the increased need for seclusion and/or restraint, and the curtailment of the treatment benefit for all patients served. The additional units will allow for better management of staff and patients and a more efficient delivery of services. The Applicant reports that the segregation of patients allows for treatment programming that is better suited to meet the clinical needs of the patients. As noted by the Applicant, patients with different acuity levels will be cared for in separate units according to clinical disposition and existing levels of acuity and associated behaviors. Upon approval and completion of the new addition, the Applicant's clinical leadership will have the ability to implement individualized care planning and diagnostic or age-specific specialized programming and care. The Applicant reports that with the addition of these forty (40) beds, patients in need of mental health treatment in the Applicant's service area will have easier access to needed services and an increased chance of placement in a timely manner, decreasing the stress experienced by both the individual and family members.

Effect on Existing Providers and Letters of Support or Opposition

The Applicant reports that it believes the expansion of its mental health hospital will allow greater access to psychiatric care as well as "create higher quality" psychiatric care, having a positive effect on the health care system. The Applicant reports that it does not anticipate any material shifting of patients or patient days from other providers in the service area because the Applicant is seeking to serve the population that currently does not seek treatment due to the lack of available mental health services in the service area.

As noted earlier, The Applicant reported that it has experienced a higher number of deflections (turn-aways) in the past twelve (12) months because there is no physical bed for the patient to occupy. A chart on Supplemental #1, Page 3 shows a total of 195 deflections/diversions for the most recent year. As discussed in Section C.1., application of the formula to population numbers and the utilization of existing adult psychiatric beds in the Applicant's service area shows an unmet need for this population (individuals 18-64 years of age).

The Applicant reported that the current demand for mental health treatment in the Applicant's service area exceeds the bed and provider supply, and the addition of these forty (40) beds would help decrease the gap in supply and demand. In a previous TDMHSAS report, statistics from the department's Office of Crisis Services and Suicide Prevention showed a growing need for inpatient psychiatric beds due to an upward trend in the total volume of inpatient psychiatric admissions across the

state. The crisis services providers who serve a similar service area as the Applicant report psychiatric admissions of 2,341 in Fiscal Year (FY) 2010; 2,937 in FY2011; 3,058 in FY2012; 3,444 for FY2013. The statewide inpatient admissions for the time period of July 1, 2013 through January 31, 2014 are estimated at 19,466. It is important to note that this data does not include any individuals who are referred for inpatient psychiatric hospitalization by an entity or professional who is not a crisis services provider. Also, the available crisis services data does not break out inpatient psychiatric admissions for the specific counties of the proposed service area for this project.

TDMHSAS staff is not aware of any letters of opposition. The Applicant submitted several letters of support with the application. The letters state that there is a growing need and the current resources are inadequate in meeting the growing need. Further, there are needless mental health referrals to local emergency departments. Several letters speak to a 'treatment gap' that causes a financial strain on existing resources and the letter writers are in support of new initiatives that best meet the needs of mental health consumers. The letters show that the addition of these forty (40) inpatient psychiatric beds will provide an environment of safety and care and fulfill a need for inpatient mental health options in the service area.

Working Relationships with Existing Health Care Providers and Participation in the Training of Students (Internships, Residencies, Etc.)

The Applicant reports that is has affiliations with many health care providers and others, including but not limited to the Managed Care and Behavioral Health Organizations listed on Page 12 of the application (Aetna, Amerigroup, Cigna, Healthspring, Blue Cross Blue Shield/Magellan, United Behavioral Health, ValueOptions, VSHP/TennCare Select, Humana/LifeSynch, Medicare) as well as many community organizations and police departments as listed on Page 52 of the application.

The Applicant reports many relationships with educational institutions for the training of students in the areas of medicine, nursing, social work, and other similar areas. These relationships include Belmont University School of Nursing, Cumberland University School of Nursing, Columbia State University School of Nursing, ITT Breckinridge School of Nursing, MTSU School of Social Work, Lipscomb University College of Pharmacy, and Belmont University College of Pharmacy. Details of the clinical rotations, number of students for each rotation, and times per year the rotations occur can be found on Page 54-55 of the application.

Provision of Information

The Applicant reports that if the CON application is approved, the Applicant will be happy to 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.

.sbg