

JUL 17 10 48 AM '06

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

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

**MOUNTAIN STATE HEALTH ALLIANCE’S REPLY BRIEF IN SUPPORT OF  
PETITION FOR REVIEW OF INITIAL ORDER**

SBH has failed to carry its burden of proof in establishing the need for a new 72-bed psychiatric hospital in Kingsport. There is already an ample supply of inpatient psychiatric beds in the Tri-Cities area. In fact, within 35 miles of the proposed location of SBH-Kingsport, six geographically-dispersed providers currently staff 172 psychiatric beds, as follows:

<u>Facility</u>	<u>Distance</u>	<u>No. of Beds</u>
Wellmont	16 Miles	12 Beds
Ridgeview Pavilion	17 Miles	28 Beds
Woodridge Psych Hospital	18 Miles	84 Beds
Sycamore Shoals	20 Miles	12 Beds
Takoma Regional	33 Miles	16 Beds
Clearview Psychiatric Center	34 Miles	20 Beds

Based on the most recent data available, these 172 beds are 63% full. In other words, at any given moment, 64 beds sit empty, available to accept patients needing psychiatric hospitalization. Most of SBH's Response is focused on perceived deficiencies at Woodridge, and SBH simply ignores the other five providers in the region, which have ample capacity.

In addition to existing providers with plenty of capacity, new resources that are already in the pipeline will reduce the future need for inpatient services. Mountain States Health Alliance has entered into a collaborative relationship with Frontier Health, the leading outpatient psychiatric service provider in Upper East Tennessee and Southwest Virginia, to construct a 12-bed Crisis Stabilization Unit (CSU) for adolescents. The CSU will treat at-risk youth who would otherwise be hospitalized. Frontier Health is also expanding the reach of its clinical outpatient programs to serve the psychiatric needs of Tri-Cities residents closer to home and further reducing the demand for inpatient services.

The Agency made the correct decision when it denied the SBH application. The Agency was right to determine that there was not a need for a new 72-bed psychiatric hospital in the Tri-Cities, that the existing providers were adequately meeting the needs of the community, and that building a new hospital would cause significant damage to Woodridge, the safety-net psychiatric hospital for the region. The Agency, therefore, should set aside the Initial Order in favor of a Final Order that reinstates the Agency's initial decision denying the CON. A proposed Final Order has been attached hereto as **Exhibit A**.

### **Argument**

#### **I. The Testimony From Clinical Providers Overwhelmingly Demonstrates That The Psychiatric Healthcare System In the Tri-Cities Is Working.**

SBH has not demonstrated a lack of access to inpatient psychiatric services sufficient to justify construction of a new 72-bed psychiatric hospital. The evidence at trial demonstrated that

Woodridge, Frontier Health and other community providers are taking steps to provide additional community resources, including the CSU for adolescents, which will create functional inpatient bed capacity, and reduce future demand for inpatient hospitalization. The existing providers are working together to ensure that the psychiatric needs of the community are met now, and in the future. MHSA offered the testimony of three witnesses – Marlene Bailey, Dr. Travis Jesse, and Dr. Harsh Trivedi. The testimony of these witnesses established that the existing healthcare resources in the Tri-Cities community are supplying the necessary psychiatric care and there is not a need for a new 72-bed psychiatric hospital.

In its Response, SBH disregards this testimony by noting that Ms. Bailey is an “unlicensed social worker,” Dr. Jesse is no longer is a “non-practicing, nonclinical psychologist,” and Dr. Trivedi is not a “health planning expert.” (Response, pp. 19, 28). These attacks are not only misplaced, but they unfairly trivialize and minimize the vast experience that these witnesses brought to this case.

Marlene Bailey has worked at Woodridge for nearly 30 years, beginning as an admission coordinator, then serving in a number of different managerial roles before being promoted to Director of Behavioral Health Programs in 2009. (Tr. Vol 3; pp. 001087-001089). She is responsible for the day to day operations of the largest psychiatric hospital in Northeast Tennessee, including directing patient flow, coordinating with outpatient service providers and ensuring the smooth operation of the facility. (*Id.*) During her time as Director, Woodridge has treated approximately 25,000 patients. Not only is Ms. Bailey intimately familiar with the operations of Woodridge, but she was also able to testify about Woodridge’s referral relationships with other providers in the region, past gaps in psychiatric care in the region, and how Woodridge has acted to fill any voids that might have existed. She testified that Woodridge

is meeting the current needs of patients in the region, that Woodridge has partnered with other existing providers to provide an effective system of care, and that Woodridge has implemented numerous process improvements to increase its efficiencies. (*See e.g.* Tr. Vol. 3, 001088-001116). Ms. Bailey testified that in the infrequent instances when Woodridge is at or near capacity, patients are being appropriately referred to other existing providers in the region for care. (*Id.*) Ms. Bailey – who has been working in the mental health field for far longer than anyone called as a witness by SBH – offered important and substantive testimony.

Dr. Randall Jesse is the Senior Vice President of Specialty Services at Frontier Health, which is the leading outpatient psychiatric service provider in Upper East Tennessee and Southwest Virginia. (Tr. Vol. 4 pp. 001181-001183; Ex. 390, p. 002731). Dr. Jesse has a Masters and Ph.D. in Psychology and has been a licensed clinical provider in East Tennessee since 1978. (*Id.*) He is Chair of the multi-State Coalition of Appalachian Substance Abuse, Chair of the Tennessee Co-Occurring Disorders Collaborative, and Chair of the Tennessee Department of Mental Health Licensure Review Panel. (*Id.*) Dr. Jesse directs Frontier's specialty services, including the Magnolia Ridge and Willow Ridge residential detoxification and drug abuse centers, the 24/7 Mobile Crisis Response teams, the Adult Crisis Stabilization Unit, and a number of other leading outpatient programs in the region. (*Id.*) In 2014 alone, Frontier treated 40,000 patients under Dr. Jesse's leadership. (Tr. Vol. 4, p. 001188). Dr. Jesse spoke at length about the various outpatient psychiatric, outreach, and chemical dependency services that Frontier has developed. (*See e.g.* Tr. Vol. 4, pp. 001185-001195). Dr. Jesse testified about the critical role of Woodridge in assisting Frontier and providing safety-net resources for the community. (*Id.*) Dr. Jesse also testified regarding Frontier's construction of the 12-bed Crisis Stabilization Unit for adolescents in collaboration with MHSA, and he explained how the new

CSU will significantly reduce the demand for inpatient psychiatric resources in the future. (*Id.*) Despite Dr. Jesse's decades of experience and what he obviously brings to the table in this case, SBH argues that his testimony should be disregarded because he has transitioned into healthcare management while slowly withdrawing from clinical practice. This argument lacks any merit.

Finally, Dr. Trivedi is a psychiatrist and the Executive Director and Chief Medical Officer for Vanderbilt Behavioral Health, which operates one of the largest psychiatric hospitals in the State. (Tr. Vol 4, pp. 001358-1363). In addition to his clinical responsibilities, Dr. Trivedi has served on the boards of the Tennessee Department of Mental Health's crisis services task force, the Tennessee Association of Mental Health Organizations, the Tennessee Psychiatric Association, and was one of 18 experts chosen from across the country by CMS to guide development of inpatient psychiatric quality measures. Dr. Trivedi's 31-page curriculum vitae sets out his vast experience in public policy psychiatric planning. (*See* Ex. 383, pp. 002698-002728). Dr. Trivedi visited Woodridge to evaluate the operation of the facility and how Woodridge was actively working with local providers to find suitable beds for each patient that was referred to them. (*Id.* at 001373). Dr. Trivedi concluded that Woodridge was appropriately ensuring that no patient was going without appropriate care and that occasional capacity constraints did not justify the construction of a new 72-bed psychiatric hospital. (*Id.* at 001380).

SBH knew that MHSA would call to testify qualified, experienced witnesses who have decades of first-hand knowledge of the psychiatric care in the Tri-Cities community to explain why there is no need for a new 72-bed psychiatric hospital. Yet SBH could not muster a single witness to testify, live or by affidavit, that patients in the proposed service area were having difficulty accessing timely psychiatric care. Instead, the best SBH could offer was Dr. Hal Elliot. Dr. Elliot was the former director of residency at East Tennessee State University. (Tr.

Vol. 1, pp. 000671-672). ETSU is the largest producer of clinical staffing in the region and opposes SBH's project. (*Id.*) At the time of trial, Dr. Elliot was leaving the Tri-Cities and ETSU, driving on his way to Michigan to relocate his practice. (*Id.*) Dr. Elliot's brief testimony, consisting of only 22 pages of the record, is attached as **Exhibit B** to this brief. Dr. Elliot spent most of his time taking parting shots at ETSU, his former employer, and its psychiatric residency program. (Tr. Vol. 1, pp. 000665-000668). Whatever axe Dr. Elliot may have to grind with ETSU, his comments had no bearing on the merits of this application. Dr. Elliot's only testimony about psychiatric care in the Tri-Cities was to note that the geropsych unit at Woodridge, the 12-bed Spruce Unit, was "for the most part...staying full." (Tr. Vol. 1, pp. 000661-662). Dr. Elliot never testified that geropsych patients were having difficulty accessing Woodridge. Dr. Elliot said nothing about other geropsych providers in the region, such as the 12-bed New Leave Senior Care Center at Sycamore Shoals, which has capacity. Dr. Elliott never discussed the health of the overall psychiatric system in the Tri-Cities, the increasing emphasis on outpatient services, or the impact of the pending adolescent CSU. Most important, Dr. Elliott never even testified that a new 72-bed psychiatric hospital in Kingsport was needed to support patient care.

SBH bears the burden of proof in establishing a need for its Project through reliable evidence, not through gerrymandered manipulation of bed need formulas or citation to nationwide statistics. SBH completely failed to identify a single patient or clinician in the community who could not access inpatient psychiatric care in a timely manner.

## **II. There Are No Existing Capacity Concerns in the Tri-Cities**

SBH was unable to find a single law enforcement official willing to testify in support of the Project, live or by affidavit. There is no proof in the contested case record that law

enforcement are experiencing difficulties in the Tri-Cities placing involuntary psychiatric committals. Because it lacks any such evidence, SBH resorts to citing its own unverified statements in the supplemental portion of SBH's original application. (Response Brief, p. 16).

In response to a supplemental question from the Agency's staff, SBH stated as follows:

“In a meeting with Sullivan County Sheriff's Office Chief Deputy Lisa Christian a representative from Strategic Behavioural Health was shown data reflecting mental health transports conducted by the department. In 2012 there were 1,107 transports that had to leave Sullivan County to receive services.”

Ex. 9, p. 001702. But this self-serving and unverified claim cannot appropriately be relied upon even if it did support the need for the Project, which it does not. First, these statements by SBH itself in the context of the original application are unsworn third-hand hearsay and not evidence received in the contested case. MHSA was never given access to the so-called “data” nor did it have an opportunity to cross-examine any witness about these statistics. Even taken at face value, the statement does not justify the need for SBH's Project. The fact that patients being involuntarily committed are leaving Sullivan County is not surprising in light of the fact of the fact that the majority of psychiatric patients from Sullivan County are seen at Woodridge in Washington County, approximately 20 minutes away from Kingsport.

SBH criticizes Woodridge for being at 85% capacity and for occasionally having to defer some patients to other facilities for care, complaints that are illogical considering that, according to SBH, Woodridge is not even part of its service area. In any event, the claims are just not accurate. The total number of deferrals for Woodridge declined by half from 2013 to 2015. (Tr. Vol. 3, p. 001107-1110; 001115). While SBH comments extensively on Woodridge's “patient flow sheets,” Ms. Bailey explained that these sheets do not reflect Woodridge's actual census, nor are they an accurate representation of the availability of psychiatric beds at Woodridge or in the Tri-Cities. (Tr. Vol. 3, pp. 001111-1114). Patient flow sheets are “snapshots” of occupancy

levels at Woodridge, most commonly filled out before discharges have been made on a particular day. (*Id.*) If a patient is listed as “deferred” on a patient flow sheet, it means that Woodridge cannot take that patient at that particular moment in time for a variety of reasons. (Tr. Vol. 3, pp. 001105-1106). Deferred patients often are admitted to Woodridge later on in the day after morning discharges occur. (Tr. Vol. 3, pp. 001106-1107). This process was confirmed by Dr. Elliott, who described how a unit may be temporarily full, patients are appropriately discharged, allowing new patients to be admitted into those beds. If a bed does not open at Woodridge, the deferred patient will be transferred to another available bed in the Tri-Cities region for care. (*Id.*) While a patient is deferred, they continue to receive psychiatric treatment in a hospital setting until an appropriate psychiatric bed becomes available. (Tr. Vol. 3, pp. 001115-1117; Tr. Vol. 4, pp. 1381-1382).

SBH argues that “patients go as far as Blount County or farther away to receive psychiatric hospital care.” (SBH Brief, p. 7). It is true that, that a small percentage of patients from SBH’s proposed service area received psychiatric care outside the Tri-Cities. (Ex. 9, p. 001607). But this fact has little bearing on this case. First, SBH provided no evidence that any of these patients were seen outside of the Tri-Cities because of the lack of available bed capacity. Second, the proposed SBH facility would not have treated any these patients. Of the patients leaving the service area, the vast majority were seen at Peninsula Hospital outside of Knoxville. Peninsula is one of the few hospitals, along with Woodridge, that has agreed to care for State grant patients who would have been seen at the Lakeshore Mental Health Institute prior to its closure. SBH admits that it has not had any discussions with the State about admitting grant patients, that such patients are better left to Woodridge (and Peninsula) and it will not seek to treat them. (Tr. Vol. 3, p. 001082). The remaining patients were seen at Moccasin Bend Mental

Health Institute and the Middle Tennessee Mental Health Institute, state institutions designed to treat chronically and seriously mentally ill patients. That some patients from the proposed service area are being seen at state institutions speaks to the acuity and severity of their illness, not any shortage of private inpatient beds. SBH will not treat these patients either. In other words, the only patients leaving the region for treatment are patients that SBH cannot treat (chronic long-term patients) or will not treat (indigent patients without the ability to pay).

**III. SBH’s Claim that Johnson City Is Not In The Service Area of a Kingsport Psychiatric Hospital Is Unreasonable On Its Face.**

SBH crafted a service area in its application to create the perception of need for its proposed 72-bed psychiatric hospital when no actual need exists. SBH excluded Washington County – the adjacent county of 125,000 people home to the 84-bed Woodridge Psychiatric Hospital, the primary provider of psychiatric services in the Tri-Cities. SBH did not perform any health planning analysis to justify this exclusion.

SBH’s Response justifies this exclusion primarily by focusing on the Agency’s guideline defining a project’s “Service Area” as the county or counties “representing a reasonable area in which a health care institution intends to provide services and in which the majority of its service recipients reside.” Tenn. Comp. R. & Regs. R. 0720-6-.01. While in its Response, SBH attempts to define “majority” as greater than 50%, SBH’s own health planning expert conceded at trial that a reasonable total service area of a health care facility is the geographic area from which the facility can expect to receive 90 to 95 percent of its patients. (Sullivan, Vol. 2, p. 444:10-13). Defining a service area is not, and should never be, an exercise designed to manipulate the application of the State Health Plan’s bed need formula. The selection of the service area is critical—both in order to ascertain the appropriate population for the need calculation and to identify the number of existing beds.

Here, Woodridge, located in Washington County next door to the proposed facility, is the primary psychiatric provider for every county in SBH's proposed service area. To determine what resources are available to the residents of SBH's proposed service area, Woodridge, and its 84-beds must be included in the analysis.

Any evaluation of the need for new psychiatric resources in the Tri-Cities must include Woodridge and other area providers who are currently treating the population SBH claims to serve. The Administrative Judge erred in disregarding these existing community assets, especially in light of the uncontroverted evidence that those resources were excluded by SBH solely to increase the chances of CON approval.

**IV. The Economic Impact On Woodridge Is Contrary to the Orderly Development of Health Care**

SBH seeks to disrupt the working healthcare model in the Tri-Cities by constructing a 72-bed psychiatric hospital when no actual need exists. Surprisingly, SBH's Response is silent as it relates to SBH's plans to target the best-insured patients which the greatest means to pay for their services. SBH essentially concedes that it will not treat indigent patients or otherwise share in the financial burden of caring for the impoverished and most needy members of the community. It admits that the State grant patients that Woodridge has chosen to care for, as the safety-net provider for the region, will stay at Woodridge. SBH further concedes that its facility will result in a multi-million dollar impact on Woodridge and MHSA. SBH's response, principally, is that MHSA can absorb the damage to its bottom line and should be ignored. Such a result would be contrary to the orderly development of health care, particularly in light of the fact that a new 72-bed inpatient psychiatric hospital is simply not needed in the service area.

### **Conclusion**

MHSA is a cornerstone of the TennCare program in Northeast Tennessee, and it provides hundreds of millions of dollars in charity and uncompensated care. Woodridge is the safety-net psychiatric provider for its region, serving thousands of patients without resources who were formerly treated at the State mental health hospital. Along with Frontier Health and other existing providers, Woodridge is working to meet the needs of the Tri-Cities psychiatric community. The introduction of a new unneeded 72-bed provider that will cause serious economic damage to Woodridge and MHSA is the antithesis of proper health planning and contrary to Agency's policy and practice of considering the consequences of a project in the context of the entire health care system, including safety-net providers. The Initial Order should be reversed and SBH's CON should be denied.

Respectfully Submitted:



---

Dan Elrod (BPR No. 003871)  
G. Brian Jackson (BPR No. 015497)  
Travis B. Swearingen (BPR No. 025717)  
Butler Snow LLP  
150 Third Avenue South  
Suite 1600  
Nashville, TN 37201  
(615) 651-6700

*Counsel for Mountain States Health Alliance*

**CERTIFICATE OF SERVICE**

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

*Via e-mail.*

James B. Christoffersen, Esq.  
Tennessee Health Services &  
Development Agency  
500 Deaderick Street, 9<sup>th</sup> Floor  
Nashville, TN 37243

*Via e-mail*

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

this 17th day of June, 2016.

A handwritten signature in black ink, appearing to be "W. West", is written above a horizontal line.

31555869v1

# **EXHIBIT A**

**BEFORE THE TENNESSEE  
HEALTH SERVICES AND DEVELOPMENT AGENCY**

**IN THE MATTER OF:**

**SBH-KINGSPORT, LLC**

)  
)  
)  
)

**DOCKET NO.: 25.00-126908J**

**INITIAL~~FINAL~~ ORDER**

This matter came to be heard on July 27-31, 2015, before Leonard Pogue, Administrative Judge, sitting for the Tennessee Health Services and Development Agency (Agency) in Nashville, Tennessee. The Petitioner, Strategic Behavioral Health-Kingsport, LLC (SBHK), is represented by William West and Charles Grant. The Intervenor, Mountain States Health Alliance (MSHA), is represented by Brian Jackson and Travis Swearingen. The Agency was represented by James B. Christoffersen, General Counsel. This matter became ready for consideration on November 19, 2015, upon the parties' submission of proposed findings of fact and conclusions of law and rebuttal/reply briefs.

The subject of this hearing is the appeal filed by SBHK of the denial of a certificate of need (CON) to SBHK by the Agency for the establishment of a 72 bed psychiatric hospital in Kingsport, Tennessee. After consideration of the record in this matter, it is determined that the SBHK CON should be **GRANTED**. This decision is based upon the following findings of fact and conclusions of law.

**FINDINGS OF FACT**

**I. PROCEDURAL BACKGROUND/PARTIES**

1. On December 3, 2013, SBHK filed a CON application with the Agency to construct and operate a 72-bed mental health hospital in Kingsport, Tennessee at a cost of

approximately \$12 million, with the initiation of psychiatric services beginning in November, 2015.

2. On June 25, 2014, the Agency considered the SBHK application. A motion to approve the CON failed by a vote of four in favor of approval and four opposed. SBHK timely perfected its petition for a contested case proceeding on the denial of its CON application. MSHA, which had opposed the SBHK CON application before the Agency, was granted permission to intervene in the contested case.

3. SBH Kingsport is an entity formed by its parent company, Strategic Behavioral Health, LLC (SBH), a privately owned Memphis based psychiatric hospital company, to build and operate the proposed psychiatric hospital. SBH has acquired, developed, and operates eight psychiatric hospitals in North Carolina, Texas, New Mexico, Colorado and Nevada. SBHK will be SBH's first psychiatric hospital in Tennessee.

4. SBHK proposes that its hospital will have the following inpatient psychiatric bed components: 18 adult psychiatric beds, 28 child and adolescent psychiatric beds, 16 geropsychiatric beds, and 10 chemical dependency beds. SBH has previously developed two facility prototypes, a 72 bed hospital and a 92 bed hospital, for use in its projects across the country.

5. MSHA is a Tennessee non-profit health care system with its principal offices in Johnson City, Tennessee and provides comprehensive medical care in 29 counties in Tennessee, Virginia, Kentucky, and North Carolina. MSHA owns and operates 13 hospitals, including Johnson City Medical Center (JCMC), a 501 bed regional tertiary referral and Level I trauma center, Indian Path Medical Center (IPMC), a 239 bed hospital in Kingsport, and Niswonger Children's Hospital, a 69 bed children's hospital in Johnson City.

6. MSHA, through JCMS's department known as Woodridge Psychiatric Hospital (WPH), operates an 84 bed psychiatric hospital in Johnson City that has 12 child and adolescent beds, 14 geropsychiatric beds, and 58 adult psychiatric beds. WPH's beds are in five separate buildings. WPH provides chemical dependency services in some of the adult psychiatric beds.

## **II. SERVICE AREA**

### **A. Project Origins**

7. In the summer of 2012, SBH began evaluating 95 potential expansion markets across the United States where the company might want to construct a new psychiatric hospital. One of the 95 potential locations identified by SBH was the "Tri-Cities." The Tri-Cities service market was defined to include both Johnson City and Kingsport. To evaluate these 95 markets for need, SBH identified all psychiatric providers located in a 60-mile radius. WPH was noted as the primary provider in the Tri-Cities area and other providers in the area were identified.

8. To project need, SBH applied a 30 bed per 100,000 population formula to these markets, the same formula dictated by the State Health Plan. SBH concluded that the Tri-Cities region ranked 34th in need for new psychiatric beds and that the area ranked 2nd in the country in terms of SBH's ability to staff the facility. SBH considered other metrics in its evaluation and in the final weighted analysis, the Tri-Cities ranked 15<sup>th</sup> out of 27 potential locations for a new psychiatric hospital.

9. James Shaheen is the President and founder of SBH. In early September 2013, Mr. Shaheen chose to proceed with the project and designated Michael Garone, SBH's Director of Development, to take charge of the project. Mr. Garone's expertise is in marketing, not health care.

10. The first area SBH collected information from was Johnson City and SBH submitted an application for economic development incentives from the Johnson City Industrial

Bond Board. In early October 2013, Mr. Garone visited the Tri-Cities and met with seven people, six of whom worked in Johnson City. Soon thereafter, SBH decided to place their proposed new hospital in Kingsport instead of Johnson City. Mr. Shaheen attributed the selection of Kingsport to Sullivan County being the most populated county in upper east Tennessee, a factor critical to staffing. Mr. Garone also noted in an email at that time that SBH chose not to be in Johnson City to avoid MSHA contesting the CON application. SBH did not create documents analyzing or setting out the need for a new psychiatric hospital in Kingsport versus the case for need in Johnson City.

**B. Proposed Service Area**

11. SBHK describes a service area consisting of five counties: Sullivan and Hawkins Counties in Tennessee, and Wise, Scott and Lee Counties in Virginia. In this five county service area, there are 12 inpatient psychiatric beds, all for adults, at Bristol Regional Medical Center (BRMC) in Bristol, Tennessee. SBHK did not provide in its application any projections of how many patients would come from any particular county or zip code within its claimed service area and did not perform a written analysis of historical patient patterns. Mr. Shaheen and Mr. Garone were involved in the development of the CON application but SBH did not engage a health planning expert to assist in determining the service area.

12. Several weeks after filing its CON application, SBH executives made an internal presentation to representatives of the company's owner setting forth the financial rationale and summary for the proposed project. As part of the proposal, SBH identified a catchment area consisting of 25 mile and 50 mile radii around Kingsport to demonstrate where staff and patients would come from. SBH further identified its immediate market as the area within 25 miles of the facility that included, Ridgeview Pavilion with WPH and Magnolia Ridge at or just barely

beyond the 25 mile distance. SBH's proposed catchment area used for its internal business analysis is similar to the service area MSHA has argued is appropriate for CON purposes.

13. IPMC has defined its service area (based on MSHA's 2012 Social Responsibility Plan) as Sullivan County and Hawkins County in Tennessee, plus Scott, Lee, Dickenson and Wise Counties in Virginia and in MSHA'S June, 2015 Community Health Needs Assessment IPMC's primary service area was listed as western Sullivan County, Hawkins County, Wise and Scott Counties. JCMC defines its service area as being six counties: Washington, Sullivan, Unicoi, Carter, Greene and Johnson (all Tennessee)). On the other hand, the historical service area for WHP is larger, reflecting the regional nature of psychiatric hospitals. The WHP service area includes 7 counties in Tennessee and 2 counties in Virginia.

14. In 2013 HealthSouth Rehabilitation Hospital in Kingsport received 91% of its admissions from Sullivan and Hawkins Counties in Tennessee and certain Virginia counties. Wellmont Holston Valley Medical Center (Wellmont Holston) in Kingsport, in 2013, received 86.5% of its admissions from Sullivan and Hawkins County in Tennessee and Scott, Wise and other counties in Virginia.

15. Daniel J. Sullivan was offered by SBHK as an expert witness in the areas of Tennessee CON issues and health care planning issues. After analyzing the CON application and reviewing various comparable facilities, Mr. Sullivan concluded that SBHK's service area is a reasonable basis on which to determine the need for a new behavioral health facility located in Kingsport.

16. Mr. Sullivan noted that Wellmont Holston received only 5.7% of its patients from Washington County, Tennessee in 2013 despite the fact that it is located in Kingsport. BRMC, the only psychiatric provider in Sullivan County (12 beds), received less than one

percent of its psychiatric patients from Washington County and 42.1% of its psychiatric patients were from any of the five counties (including Sullivan County) in SBHK's service area. According to Mr. Sullivan, Indian Path Pavilion, a 61 bed psychiatric hospital formerly located in Kingsport, filed a CON in a project in 1996 when it was owned by HCA that involved combining IPMC and Indian Path Pavilion hospital licenses and described its primary service area as Hawkins and Sullivan Counties in Tennessee, and Wise, Scott and Lee Counties in Virginia. Mr. Sullivan acknowledged that adult and child/adolescent psychiatric services are more regional in nature.

17. Mr. Sullivan found that, in reviewing and acting upon CON applications, the Agency generally has accepted CON applicants' service area definitions, even when the proposed service area excludes contiguous counties from which an applicant might draw patients. Specifically, the Agency recently approved an application by Trustpoint Hospital in Rutherford County, Tennessee to expand its inpatient psychiatric bed capacity. In its application ~~TrustPoint~~Trustpoint defined its service area as including only two counties, Rutherford and Bedford, and excluded the contiguous counties of Davidson and Williamson. Both Davidson and Williamson counties have other large and significant hospital providers of inpatient psychiatric services and Trustpoint's application indicated that Davidson County itself was the second largest source of its admissions, yet its defined service area of Bedford and Rutherford Counties was utilized by the Agency in analyzing the need for ~~Trustpoint's~~TrustPoint's additional psychiatric beds. Also, Rolling Hills Hospital, a psychiatric hospital in Williamson County, Tennessee had its CON application approved with Rutherford and Bedford Counties included as part of Rolling Hills service area. Williamson County is contiguous to both Rutherford County and Davidson County.

18. In contrast, the Tri-Cities is a single region as indicated by SBH's own site selection process and business projections. Patients have historically crossed county lines between Washington and Sullivan counties, including psychiatric patients leaving Sullivan County to receive treatment at WHP in Johnson City.

~~18.~~19. It was the opinion of Mr. Sullivan that it is there is no reason to believe that a psychiatric hospital in Kingsport would be able to draw a significant number of people from Washington County when Washington County residents already have access to inpatient psychiatric care at WPH. He further testified that in health planning the primary service area is the source of approximately 75% of the patients and that he does not believe that Washington County's patients going to SBHK would be within the 75% of patients in the service area definition for a new hospital in Kingsport. Mr. Sullivan projected that approximately 20% of the patient volume at SBHK would likely come from outside the five county service area.

~~19.~~20. Mr. Sullivan did not analyze discharges from Indian Path Pavilion to see where its patients came. He opined that Indian Path Pavilion and WPH during the 2000s involved a different competitive marketplace than 2015. Specifically, Mr. Sullivan argued that after MSHA took over WPH (2005) a decision was made to expand psych services at WPH and de-emphasize those services at Indian Path Pavilion.

~~20.~~21. MSHA offered the testimony of Dr. Deborah Kolb Collier as an expert witness in the areas of Tennessee CON issues and health care planning/finance. Dr. Collier opined that SBHK gerrymandered its proposed service area to exclude consideration of existing psychiatric beds in the surrounding area. She noted that the SBHK CON application did not explain the quantitative basis for the service area and she was surprised that the service area stretches more

than 35 miles northwest into an area of Virginia, while it extends only a few miles to the south, excluding Washington County, Tennessee and its population base.

21-22. Dr. Collier and Mr. Sullivan believe that in formulating a reasonable service area (if a provider does not already offer services in the area) one looks to identify a surrogate or proxy facility which can be used as a reasonable approximation of the proposed project. Dr. Collier opined that Indian Path Pavilion (open until 2009 and less than a mile from the proposed SBHK facility) was the most reasonable proxy. Dr. Collier analyzed Indian Path's historic patient origin mix to identify its service area. According to Dr. Collier, Washington County was the second highest county of origin for patients at Indian Path, accounting for almost 12% of admissions over its last three years of operation, with Hawkins County also almost at 12%. Scott County was fourth with 5.5 %. More patients originated from Washington County than Scott, Wise and Lee Counties combined. Sullivan and Hawkins Counties, Tennessee, and Wise and Scott Counties, Virginia accounted for 66.4% of Indian Path Pavilion's admissions in the 2007-2009 averaged data.

22-23. Dr. Collier examined existing patient origin data in determining what she considered a reasonable service area for SBHK's project. She concluded that there is flow of patients between Washington and Sullivan Counties for health services, including psychiatric services. From 2012-2014, 26% of patients admitted to WPH were from Sullivan County, which represented the second highest volume from any one county. Patients residing in other counties in the SBHK proposed service area also utilize WPH. Over a three year period, residents of the SBHK claimed service area constituted 36% of WPH's inpatients. Dr. Collier testified that Washington County is experiencing more growth than Sullivan County, particularly as it relates

to the child and adolescent population, and that there is a population on the edge of Washington County that could as quickly access Kingsport as WPH

23-24. Dr. Collier believes that SBHK's financial and volume projections will require it to capture patients from Johnson City and that SBHK will market its new facility to a broader service area. She determined that SBHK would need a 75% market share in its proposed service area to meet its projected volume and thinks that is unlikely. Dr. Collier concluded that a service area (11 counties, 6 in Tennessee and 5 in Virginia) that includes Washington County, Tennessee and other counties contiguous to Kingsport is a much more reasonable approximation of where SBHK's patients will likely originate. Two of these Virginia counties in Dr. Collier's alternate service area are not designated by MSHA as being part of IPMC's or JCMC's service areas.

24-25. Mr. Sullivan disagrees with Dr. Collier's proposed alternate service area definition. Mr. Sullivan opined that the area WPH serves is not relevant to what the service area should be for a hospital located in Kingsport, which is in a different location and situation, not part of a major medical center, and would be facing existing competition. He believes WPH currently has no real competition in terms of another comprehensive psychiatric hospital provider and that a hospital in Kingsport would thus have a significant competitive situation than does WPH. Mr. Sullivan thinks it would be very difficult for any psychiatric hospital in Kingsport to draw a material number of patients out of Washington County. Mr. Sullivan opined that the alternate service area proposed by Dr. Collier shows a need for 30 to 38 beds in that area.

Mr. Sullivan's opinions regarding service area are not consistent with how SBHK selected the site for the project and SBHK's internal documents. SBHK's internal definition of the market is very similar to the service area proposed by Dr. Collier. The proposed location of the SBH

facility is geographically closer to the northern populations of Washington County than Woodridge.

~~25-26.~~ Dr. Collier included Russell County and Washington County, Virginia in her alternate service area. Mr. Sullivan has not seen any data that would indicate a provider in Sullivan County would serve a material number of patients from Russell County; Russell County patients traveling to Kingsport would have to pass three psychiatric hospitals. Mr. Sullivan testified that he doubts a significant number of people from Washington County, Virginia would leave to go to a provider located in western Sullivan County, noting that neither Washington County nor Russell County has been a significant source of patients for the HealthSouth hospital in Kingsport. Concerning Carter County, Tennessee, Mr. Sullivan stated that there is not a significant patient flow from Carter County to Kingsport's hospitals. With regard to patient flow to Kingsport from Unicoi County, patients from Unicoi would have to drive past WPH and go a considerable distance farther to get to SBHK. Mr. Sullivan noted that IPMC's recent Community Health Needs Assessment did not include Russell County or Washington County, Virginia or Carter County, Unicoi County or Greene County in Tennessee as part of its primary service area. Mr. Sullivan concluded that the orientation for the Kingsport area healthcare facilities is to the west and north in terms of where their patients come. This conclusion is contradicted by Dr. Collier's opinion and by SBHK's internal description of the market and the area from which it plans to draw patients.

~~26-27.~~ Mr. Sullivan did not perform the type of impact analysis that Dr. Collier performed because he did not have access to the proprietary information that had been available to Dr. Collier. With regard to Dr. Collier's use rate analysis, Mr. Sullivan, unlike Dr. Collier, was not able to utilize the Tennessee Hospital Association's (THA) detailed discharge data because

only members of THA can have access to them. SBH is not a member of THA because it does not currently operate any hospitals in Tennessee.

### **III. NEED**

27-28. Under the *Guidelines for Growth* bed need formula, Mr. Sullivan determined a total need of 92 beds in 2015, rising to 93 beds by 2020 for the proposed service area. Since the only inpatient psychiatric provider in the SBHK proposed service area is BRMC with its 12 beds, the net inpatient psychiatric bed need is 81 in 2015 and 82 beds by 2020. After applying the *Guidelines for Growth* inpatient psychiatric bed need formula, Mr. Sullivan opined the 72 beds proposed by SBHK is consistent with the overall net need.

28-29. Mr. Sullivan also analyzed the bed need for the individual categories of beds at the proposed facility, which include geropsychiatric, children and adolescents, and adult. He determined a need for 44 additional beds for adult inpatient psychiatric patients, which is in excess of SBHK's proposal for an 18 bed adult psychiatric unit and a 10 bed adult chemical dependency unit. No methodology exists for calculating chemical dependency bed need under the *Guidelines for Growth* formula, so Mr. Sullivan included the ten adult chemical dependency beds with the adult psychiatric beds. Mr. Sullivan also analyzed the need for the 65 and older population to determine the geropsychiatric bed need. In his expert opinion there is a need for that too.

29-30. With regard to the 18 and under age group population's bed need calculation, Mr. Sullivan determined that there was a need for 17 child and adolescent beds in 2015 and 15 such beds in 2019. SBHK is proposing 28 of these beds. The fact that the bed need number for child and adolescent beds goes down from 2015 to 2019 reflects the shrinking population in this age category. Mr. Sullivan noted that while SBIK's proposal for 28 beds is in excess of the bed needs guidelines for this age group, very few inpatient psychiatric beds for this population exist

in East Tennessee. Mr. Sullivan expects in-migration from outside the service area for child and adolescent patients to Kingsport, because of the paucity of inpatient psychiatric bed resources available for these patients in the area and, therefore, he felt it was prudent to have additional inpatient psychiatric bed capacity for child and adolescent services. Mr. Sullivan's opinion regarding in-migration of child and adolescent patients conflict with his support for a much smaller service area.

~~30.31.~~ Dr. Collier determined, using her alternative service area, that there will be a net bed need of 30 total beds in 2019. Using Indian Path Pavilion's historic service area (which removes the populations of Lee, Unicoi, and Russell Counties while also removing the 20 psychiatric beds at Clearview Center), Dr. Collier found a net need of 29 total beds in 2019. She acknowledged that if Russell County, Virginia were excluded from her alternate service area, that the bed need there would increase since Russell County's 20 psychiatric hospital beds would be excluded from the bed need calculations, along with Russell County's population. ~~If Russell County is eliminated, her proposed alternate service area, under the Guidelines for Growth formula, would need 51 new psychiatric beds~~ Russell County, however, was also included in the project's market in the SBHK internal documents.

~~31.32.~~ Dr. Collier found that 400 patients from SBHK's proposed service area went to facilities in Blount County and as far away as Vanderbilt in FY 2013. Of these 400, Peninsula Hospital in Blount County received 296 (74%). Mr. Sullivan stated that no testimony was provided as to why individuals residing in the service area might seek admission in a facility out of the area. Before the state mental health hospital in Knoxville (Lakeshore) closed, it served patients from counties in East Tennessee including the TriCities region. Peninsula Hospital, like

Woodridge, accepts uninsured patients covered by the state grant. SBHK does not have any plans to treat these patients.

~~32.~~33. Mr. Sullivan testified that Tennessee has seen a dramatic rise over the last 10-15 years in the number of inpatient psychiatric beds which have been closed, particularly as to state beds. The state regional mental health institute, Lakeshore Mental Health Institute, which had previously served eastern Tennessee, closed in 2012, thereby taking 250 licensed inpatient psychiatric hospital beds out of service in eastern Tennessee. The result is that the regional public mental health institute that now serves eastern Tennessee is Moccasin Bend in Chattanooga, which is over 200 miles from the Tri-Cities area. From 2005 to 2010, hospitals in Tennessee closed 462 psychiatric beds. State facilities typically focus on the chronic, longer stay patients who are typically uninsured.

~~33.~~34. Sullivan County is the ninth largest county in Tennessee by population, but it contains only 12 inpatient adult psychiatric hospital beds. Mr. Sullivan opined there is a high need for additional inpatient and outpatient services in SBHK's proposed five-county service area because the population has limited access to inpatient psychiatric services. Dr. Collier's analysis, however, shows that WPH is accessible to residents of the 5-county area based on the fact that 56.4% of the inpatient psychiatric patients from the 5-county area currently use WPH.

According to Dr. Collier, the adolescent population of Sullivan and Hawkins Counties will decline from 2014 to 2019, but combined the adolescent population of Wise, Scott and Lee Counties in Virginia will slightly increase from 2014 to 2019. There are no inpatient psychiatric facilities in Lee County, Virginia, or between Lee County and Kingsport. Population growth in the area is modest and will not create the need for additional inpatient beds.

34.35. Dr. Collier concluded that compared to the Tennessee average there is higher use of inpatient psychiatric services by Sullivan County residents. In 2013, the state wide use rate was 938.6 per 100,000 population, compared to 1,026.8 for Sullivan County residents and 983.0 in Dr. Collier's alternative service area. Based on her statistical analysis, Dr. Collier believes there is no obvious access problem to psychiatric services in the SBHK proposed service area.

35.36. Mr. Sullivan opined that SBHK's application is consistent with the *Guidelines for Growth* both in terms of establishing a numerical need for beds, as well as satisfying the more qualitative aspects of its proposal.

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

37.38. Marlene Bailey is the current director of behavioral health programs at WPH, where she has worked for the last 26 years. Ms. Bailey explained that when Lakeshore closed in mid-2012 WPH volunteered to take more patients who typically went to Lakeshore. According to Ms. Bailey, WPH required time to adjust not only to an increase in patient census but also an increase in the acuity of the patients who were previously being treated at Lakeshore. This transition caused occasional operational issues which resulted in lag between patients presenting for psychiatric treatment and admission to WPH and a higher bed census. Ms. Bailey testified

about the steps Woodridge has taken to increase the availability of its beds through operational improvements.

~~38.~~39. As of May 31, 2015, admissions at WPH were running more than 1,000 admissions higher than the number of admissions MSHA had budgeted for WPH for the first 11 months of FY 2015. Dr. Collier forecasts WPH's future results from a period of WPH utilization (2010-2013) which was lower than the last half of FY 2014 and all of FY 2015. WPH is currently running in calendar 2015 between 85.2% and 89.5% occupancy generally. If WPH's utilization increases (as measured by patient days) were to continue at the FY 2015 numeric volume of increase, WPH theoretically will be close to 100% full in less than two years from FY 2015, although a one year increase does not establish a reasonable basis to project future volumes.

~~39.~~40. WPH's "patient flow sheets," contain patient data described by Ms. Bailey as a worksheet to show the number of beds available and needed at approximately 7:00 a.m. on the day reported. She noted that patient flow sheets are commonly filled out before discharges have been made on a particular day. Ms. Bailey explained that if a patient is listed as "deferred" on a patient flow sheet, it means that WPH cannot take that patient at that particular moment in time; however, deferred patients are sometimes admitted to WPH later on in the day after morning discharges occur. If a bed does not open at WPH, the deferred patient will be transferred to another available bed in the Tri-Cities region for care and while a patient is deferred, the patient continues to receive psychiatric treatment in a hospital setting. Mr. Sullivan testified that not many people are discharged from a psychiatric hospital between midnight and 7:30 in the morning. He believes the patient flow sheets provide a reasonably close count of the number of patients in the hospital on any given day. The census for 22 of 27 days in May 2015 showed that

90% or more of the WPH beds were occupied. Mr. Sullivan found that the highest levels in the four months of patient flow sheets he examined were as follows: on March 30, 2015, there were 82 patients, and 97.6% occupancy, which was repeated on April 26 and April 27 and on May 5, 2015, there was an occupancy rate of 98.8%. According to Mr. Sullivan, any occupancy at WPH of 76 beds or higher would constitute a WPH occupancy level in excess of 90%. The goal of SBHK's parent company is for its facilities to achieve and maintain at least 85% occupancy and its facility in Wilmington, NC, recently had a 98% occupancy. There was no testimony indicating that any patients in the region had been unable to obtain services locally.

40.41. Mr. Sullivan reviewed WPH "deferral" data. (Sullivan defined a "deferral" to mean that if a patient was referred for admission to an inpatient psychiatric bed and could not be admitted, but was deferred for any reason; such action would be considered a "deferral." Deferral could mean that the patient was placed on a waiting list for \*later admission, or it could mean that the patient was referred to a different facility). He concluded that adult deferrals for the period of June 2013 through December 2013 show 365 deferrals and that 242 of those deferrals were for the following reason: "appropriate bed not available."

41.42. For the period of January through May 2014, there were 107 adult deferrals (70, appropriate bed not available); for the period of January through May, 2015 there were 194 adult deferrals (126, appropriate bed not available). For the period of January through May, 2014 there were 43 adolescent deferrals (26, no bed); for the period of January through May, 2015 there were 45 adolescent deferrals (36, no bed). In the January 2015 through May 2015 time period, 76 of the total of 194 adult deferrals were from Sullivan County, while 17 deferrals were from Hawkins County. January through May, 2015 resulted in an occupancy rate of 86.5% at WPH.

~~The 172 psychiatric beds in the Tri-Cities region operated at 64% occupancy in 2013~~As

explained by Ms. Bailey and Mr. Sullivan, a deferral does not mean that a patient was unable to be admitted. A deferred patient may be admitted later the same day or the next day or admitted to another facility in the area. The 172 psychiatric beds in the Tri-Cities region operated at 63% occupancy in 2013. The occupancy level of the other facilities in Tri-Cities region indicates the availability of beds for patients in the event admission to Woodridge is not possible. There was no testimony presented by SBHK to quantify the number of deferred patients if any would be admitted to its facility.

43. Despite its focus on deferrals, SBH did not present a single Tri-Cities resident, live or by affidavit, to testify in support of its Project. No local government officials claimed there was a need for a new 72-bed psychiatric hospital. No doctors testified that they had trouble getting patients admitted to existing inpatient facilities. No law enforcement officers testified that they were struggling to place involuntary commitments using existing resources.

42.44. While WPH operates at or around 85% capacity on a routine basis, Ms. Bailey feels that WPH is meeting the current needs of patients and providers. Ms. Bailey testified that since WPH implemented its process improvements, WPH's deferrals have been reduced by half from 2013. Further, despite running at 85% capacity, WPH continues to receive outstanding patient satisfaction surveys and has very low restraint rates.

43.45. Mr. Sullivan testified that Allen Levine, the CEO of MSHA, issued a press release in April 2015, in which Mr. Levine stated: "Northeast Tennessee and southwest Virginia disproportionately suffer from serious health issues," including "addiction and access to mental health services" which need to be addressed. Mr. Levine explained that he has never advocated for more inpatient beds to be built and wants to drive down use rates by ensuring that alternative services are available in the community. MSHA performs annual community health assessments

of Sullivan and Washington Counties. According to Mr. Levine, in the course of those community health assessments, no stakeholder has communicated a need for a new 72-bed inpatient hospital.

44.46. MSHA recently announced a task force to explore expanding treatment options for mental health and addiction. The task force will help identify areas where MHSA can invest in additional psychiatric services.

45.47. MSHA has entered into a collaborative relationship with Frontier Health to construct a 12 bed Crisis Stabilization Unit (CSU) for adolescents. The CSU has to receive licensing approval and, if approved, was on pace to be operational before the end of 2015. A CSU provides a level of care prior to psychiatric hospitalization and offers treatment geared towards assessment, evaluation, early intervention, and stabilization within a 24-96 hour time period. Some patients in a CSU can have the same or similar level of severity of psychiatric illness as an inpatient unit. This level of care is advantageous for those with specific psychosocial stressors (loss of job or relationship issues) or readily mitigated treatment issues (a patient who is decompensating due to not taking psychotropic medications). Tennessee currently has some adult CSU beds but no pediatric CSU beds have previously been implemented. Ms. Bailey believes that a CSU meets a different need than an inpatient psychiatric hospital and also opined that without CSUs more individuals would be needing services at WPH or other area hospitals. ~~The~~The occupancy levels at Woodridge remain high even though an adult CSU located in Johnson City (opened in 2009) ~~has not slowed WPH's utilization rates.~~

46.48. Dr. Harsh Trivedi serves as the Executive Director and Chief Medical Officer for Vanderbilt Behavioral Health, the Vice Chair for Clinical Affairs at the Vanderbilt Department of Psychiatry and Vanderbilt, and Regional Chief Medical Officer for the Vanderbilt Affiliated

Health Network. Dr. Trivedi expressed that he was not a health planning expert or a financial expert. In Dr. Trivedi's opinion modern psychiatric care should focus on providing patient centered treatment at the level of care most appropriate for that patient. He opined that patients do not want to be locked in an institution or deprived of their civil liberties. Dr. Trivedi stated that patients should be treated in the least restrictive environment appropriate for their needs. Mr. Sullivan agreed with this principle. Dr. Trivedi feels the SBHK would be duplicative and he would prefer to see a greater availability of lower levels of care.

47-49. Dr. Trivedi opined that the availability of CSU beds can impact the need for inpatient beds for patients of all ages. He believes that if more patients are treated as outpatients or in other treatment settings, then that should alleviate demand for existing licensed beds. Dr. Trivedi thinks that adding a 12 bed CSU for adolescents has the same impact as adding 28 inpatient adolescent beds to the service area. From a health planning perspective, Dr. Collier opined that the appropriate goal is not to build more inpatient psychiatric care but to try to substitute better community distributed services.

50. Dr. Randall Jessee is the Senior Vice President of Specialty Services at Frontier Health, a community-based mental health organization that provides services to 8 counties in northeast Tennessee and 3 counties in southwest Virginia. Frontier provides an extensive array of outpatient mental health services throughout the region. Frontier Health serves approximately 40,000 individuals per year. Dr. Jessee testified regarding Frontier Health's work with MSHA to develop the 12 bed CSU for adolescents. Dr. Jessee stated that proposed CSU is an alternative to inpatient hospitalization, consistent with the goal of avoiding inpatient hospitalization as much as possible. Moreover, Dr. Jessee testified about the strong working relationship between Frontier Health and WPH and the critical role that WPH played as the safety net provider for the region.

48-51. Mr. Shaheen testified that coverage changes under the federal Affordable Care Act, which became effective in insurance policy renewals after July 2014, have increased insurance coverage for inpatient psychiatric and substance abuse care and that since January 2015, SBH has seen significant increases in patients who have access to mental health and substance abuse care because of the Affordable Care Act insurance requirements.

#### **IV. ECONOMIC FEASIBILITY**

49-52. Mr. Sullivan opined that the SBHK project is economically feasible and that SBH had demonstrated that it had adequate funds to complete the project. He found SBHK's proposed project cost of \$12 million was reasonable. He further opined that revenue projections were reasonably developed and that SBHK plans to participate in state and federal programs in terms of reimbursement. Mr. Sullivan believes that SBHK has demonstrated conformity with the state health plan criteria regarding economic feasibility.

50-53. With regard to any alternatives considered to the project, Mr. Sullivan testified that not building a facility in Kingsport would not be the best alternative, because such inaction would do nothing to address the shortage of inpatient psychiatric services and the lack of access to care that he feels currently exists in the area. He testified that it would be possible to build a facility smaller than 72 beds, but given that the *Guidelines for Growth* formula has identified a need for more than 72 beds and that the SBHK project would be serving a service area population of over 300,000 people, Mr. Sullivan opined that building a smaller facility would not be advantageous. He explained that an advantage of a larger psychiatric hospital facility is that it would enable the hospital to treat different patient segments within the populations it serves - a larger facility would create sufficient space within the hospital to separate children from adolescents. Mr. Sullivan was also of the opinion that having a larger facility gives the hospital a clinical advantage in terms of being able to separate patients into different treatment tracks

depending on different diagnoses and patient needs. Lastly, he did not believe there would be an alternative to the SBHK CON project that was less costly or more effective than this project for many of the same reasons listed above.

~~51.54.~~ Mr. Shaheen testified that, after revenues of approximately \$105 million in its FY 2014, SBH projected its revenues would be approximately \$127 million in its FY 2015. As of July 2015, SBH was on track to achieve that revenue figure of \$127 million for 2015 and had \$70 million in its line of credit from commercial banks available to fund the project, as well as \$25-30 million available in annual cash flow from the company. SBH's CFO, James Cagle, is licensed as a certified public accountant in Tennessee. Mr. Cagle testified that SBH's operating cash flows and credit availability establish that there is a very good likelihood that SBH can economically establish and maintain the SBHK CON project.

~~52.55.~~ In Dr. Collier's opinion, SBH has not set forth sufficient evidence that the project is economically feasible as proposed, although she acknowledges that SBH has a sufficient line of credit to complete the project. She feels one cannot assess the economic feasibility of the project because SBHK failed to apply an accurate service area, and therefore, did not consider the appropriate socio-economic demographics and population density for the project, which effects utilization and financial projection. Dr. Collier testified that SBH did not use a distinct utilization projection for this project but based utilization projection on SBH's prior projects. Dr. Collier did not find any indication that SBH investigated other alternatives to its proposed hospital.

#### **V. ORDERLY DEVELOPMENT**

~~53.56.~~ As to the statutory CON criterion of orderly development of healthcare, Mr. Sullivan opined that the SBHK project would contribute to the orderly development of healthcare. He noted that the CON application indicates the intent of SBHK to become an

integral part of the healthcare delivery system within its service area by reaching out to community based organizations involved in mental health treatment such as schools, law enforcement agencies and other types of outpatient mental health providers, to try to integrate their services. Mr. Sullivan opined that the SBHK project will be an enhancement to the overall delivery of mental health in the service area.

54-57. Mr. Sullivan testified that the positive effects attributable to competition were a material consideration supporting the grant of a CON for the proposed project and opined that SBHK would provide a competitive alternative to WPH and to MSHA. He feels that the project will attract additional healthcare professionals, specialized psychiatrists and other staff to the area. Mr. Sullivan believes that SBHK would provide services in ways different from MSHA, giving patients increased choices in terms of where they want to go and could potentially stimulate price competition as it relates to contracting with third-party payors in the market. From these standpoints, Mr. Sullivan opined that any duplication that might occur would be necessary duplication. He explained that in health planning, duplication can be either “necessary” duplication or “unnecessary” duplication. “Unnecessary” duplication would occur where there is no need for what is being proposed and the applicant is merely duplicating what another facility already provides; in the case of SBHK, any duplication that might occur would be “necessary” because more inpatient psychiatric beds are needed in the community. Mr. Sullivan’s views regarding the positive effects of competition, however, are difficult to reconcile with his opinion that WPH is in a different service area.

55-58. With regard to the project’s impact on existing area providers, Mr. Sullivan opined that BRMC primarily serves a Virginia focused population so WPH would be the primary facility that would be impacted. Mr. Sullivan’s opinion is that the SBHK project will not

materially impair MSHA's operation of WPH. According to Mr. Sullivan, MSHA personnel in April 2014 projected that the impact of SBHK's operation on WPH in the first year to be \$30,000 and the second year would be only about \$50,000.

56-59. Mr. Sullivan believes that a factor limiting the impact of the SBHK project on WPH is that WPH is not a distinct hospital; rather, it is a department/service of or satellite hospital of JCMC. On the 2013 Joint Annual Report (JAR) of JCMC to the Tennessee Department of Health, JCMC reports that JCMC owns and operates WPH. The medical staffs of JCMC and WPH are integrated (Dr. Hal Elliott, a former director of the ETSU psychiatry residency program, testified that he was on the medical staff of JCMC while he practiced at WPH). Mr. Sullivan thinks that the more appropriate impact analysis would be to examine the impact of the SBHK project on JCMC or on MSHA. He testified that the 2013 JAR for JCMC indicated that JCMC had a bottom line profit of over \$30 million in fiscal year 2013, and that even if the impact of SBHK were as large as was projected by Dr. Collier's projections, JCMC would not experience a significantly detrimental impact from it. Mr. Sullivan opined a new psychiatric hospital would not require JCMC to discontinue any services and that any impact of SBHK on JCMC would be that which results necessarily when a new facility is approved. He further opined that the weight of health planning analysis favors the benefits that accrue to the community from SBHK's project over and above any monetary impact on WPH or JCMC.

57-60. An analysis performed by Dr. Collier suggests that the presence of SBHK will result in 1,084 lost cases to WPH or a \$1.5 million loss net income per year (\$1.7 million if there is no indigent care at SBHK) based on the proposed service area. When Dr. Collier assumes patients come from her alternative service area, she shows a loss of \$1.6 million (\$1.9 million if there is no indigent care at SBHK). Dr. Collier's estimate was based on SBHK's application

which projected a Year 2 occupancy rate of 72%. SBHK hopes to operate at 85% by Year 3 or 4. As to fewer patients recently, WPH had more positive financial results with 3,724 patients in the first 11 months of FY 2014 than it had with 4,320 patients in the first 11 months of FY 2015.

58.61. Dr. Collier made no analysis of the effects of SBHK's hospital on JCMC. SBHK has not prepared an analysis examining the potential impact of SBHK on any existing provider.

59.62. Mr. Levine testified that MSHA has a yearly cash flow of \$150 million a year with about \$70 million representing debt service and \$70 million a year in depreciation. In the last six years, MSHA has annually spent \$30 million more than its cash flow on capital expenditures and reserving its debt. According to Mr. Levine, MSHA has a BBB-plus bond rating, but MSHA's financial performance metrics are below its bond class median in several respects and MSHA maintains its BBB-plus rating through successful management of its cash flow. If MSHA's bond rating was downgraded, MSHA would be faced with several million dollars per year in additional interest payments.

60.63. Mr. Levine believes that a loss of a couple of million dollars per year would require an examination of other services to offset the loss of revenue. He feels that a loss of insured patients at WPH may drive up the variable costs of its programs (in part, to help subsidize loss revenue for physicians).

61.64. Ms. Bailey described WPH as a safety net hospital for psychiatric patients in the region. WPH receives a grant from the State for patients it takes that previously would have been served at Lakeshore. The grant with the State is reviewed annually for renewal and is subject to change and reduction without notice. When WPH sees more indigent patients than are covered by the grant amount (which has occurred every year), WPH must petition the State to cover the remaining costs. SBHK has not had any conversations directly with representatives from the

State about caring for the indigent patients formerly seen at Lakeshore. SBHK believes it makes sense for those patients to continue to be seen at WPH since there is a reimbursement mechanism in place even after SBHK opens. SBHK's position that uninsured patients would continue to be directed to WPH conflicts with SBHK's position on its service area. SBH, in effect, is asserting that Washington County and WPH are resources for uninsured patients in Sullivan County but not in the service area for other patients.

62-65. In its application, SBHK projects that 5% of its patient volume will be charity care. In written discovery, SBHK listed 4.5 % of its patients are uncompensated. SBHK's definition of uncompensated care includes bad debt, denials, and administrative adjustments. When an auditor reviewed SBH's 2014 financials, it noted that SBH "maintains records to identify and monitor the level of charity care it provides" and that "[t]hese records include the amount of charges foregone for services and supplies furnished under its charity care policy." Dr. Collier testified that she did not see in documents produced by SBHK any precise breakdown of charity patients. According to the auditor's report, \$491,000 of SBH's total expenses of \$92 million in 2014 was attributed to charity care. Extrapolating this expense ratio, Dr. Collier estimates that SBH saw 150 indigent patients in all 8 of its hospitals in the country in 2014, which equates to ½ of one percent.

63-66. The treatment staff at SBHK will include licensed physicians who will be board certified or board eligible in adult or child and adolescent psychiatry. Medical surgical nurses will be on staff to serve on the geriatric units. Behavioral health therapy will be delivered by masters level therapists, and some who are license eligible, as well as case managers. While SBH does not employ physicians, its facilities utilize the open medical staff model, as will SBHK. Mr. Shaheen testified that SBH is able to recruit new physicians into the community as well as to

permit established physicians in the community to be on its medical staff. Mr. Shaheen stated that while there is a shortage of child and adolescent psychiatrists in the Tri-Cities the revenues SBH generates enables it to recruit board certified child and adolescent psychiatrists to the communities in which its facilities are located.

64.67. At all SBH facilities, except those in North Carolina, SBH offers outpatient services as well as inpatient services. It also offers partial hospitalization programs. In outpatient programs at SBH facilities, it is not necessary for a participant to have been an inpatient in any SBH hospital prior to utilizing the programs. SBH asks its physicians to participate in outpatient therapy and shares its therapists with the community. SBH takes both voluntary and involuntary patients.

#### **CONCLUSIONS OF LAW**

1. The Administrative Law Judge sits without the Agency in this de novo hearing pursuant to Tenn. Code Ann. § 68-11-1610.

2. The party petitioning for the hearing bears the burden of proof to establish, by a preponderance of the evidence, that the CON should be granted or denied. Tenn. Comp. R. & Regs. Rule No. 0720-13-.01(3). SBH has the burden of proof to establish that the SBH CON should be granted.

3. Pursuant to T.C.A. § 68-11-1609(a), the Agency shall approve part or all of the CON application or disapprove part or all of the CON application.

4. Tenn. Code Ann. § 68-11-1609(b) provides:

No certificate of need shall be granted unless the action proposed in the application is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, and will contribute to the orderly development of adequate and effective health care facilities or services. In making such determinations, the agency shall use as guidelines the goals, objectives, criteria and standards in the state health plan. Until the

state health plan is approved and adopted, the agency shall use as guidelines the current criteria and standards adopted by the state health planning and advisory board, and any changes implemented by the planning division pursuant to § 68-11-1625. Additional criteria for review of applications shall also be prescribed by rules of the agency....

Therefore, the CON can be approved only if it satisfies the three criteria set forth above.

5. Pursuant to T.C.A. § 68-11-1609(b) the Agency should use "*Tennessee's Health: Guidelines for Growth*," 2000 edition (*Guidelines*) as guidelines until such time as a comprehensive state health plan is prepared. The *Guidelines* sets forth a specific methodology for determining need for many types of health care services, including inpatient psychiatric hospital services. The applicable *Guidelines for Growth* section provides as follows (2000 edition) as to "Psychiatric Inpatient Services:"

A. Need

1. The population-based estimate of the total need for psychiatric inpatient services is 30 beds per 100,000 general population (using population estimates prepared by the Department of Health and applying the data in Joint Annual Reports).
2. For adult programs, the age group of 18 years and older should be used in calculating the estimated total number of beds needed.
3. For child inpatient under age 13 and if adolescent program the age group of 13-17 should be used.
4. These estimates for total need should be adjusted by the existing staffed beds operating in the area as counted by the Department of Health in the Joint Annual Report.

B. Service Area

1. The geographic service area should be reasonable and based on an optimal balance between population density and service proximity or the Community Service Agency.
2. The relationship of the socio-demographics of the service area, and the projected population to receive services, should be considered. The proposal's sensitivity to and responsiveness to the special needs of the service area should be considered including

accessibility to consumers, particularly women, racial and ethnic minorities, low income groups, and those needing services involuntarily.

C. Relationship to Existing Applicable Plans

1. The proposal's relationship to policy as formulated in state, city, county, and/or regional plans and other documents should be a significant consideration.
2. The proposal's relationship to underserved geographic areas and underserved population groups as identified in state, city, county and/or regional plans and other documents should be a significant consideration
3. The impact of the proposal on similar services supported by state appropriations should be assessed and considered.
4. The proposal's relationship to whether or not the facility takes voluntary and/or involuntary admissions, and whether the facility serves acute and/or long-term patients, should be assessed and considered.
5. The degree of projected financial participation in the Medicare and TennCare programs should be considered.

D. Relationship to Existing Similar Services in the Area

1. The area's trends in occupancy and utilization of similar services should be considered.
2. Accessibility to specific special needs groups should be an important factor.

E. Feasibility

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

6. Rule 0720-11-.01 of the Rules of the Tennessee Health Services and Development

Agency sets forth additional criteria for review of CON applications as adopted by the Agency:

**GENERAL CRITERIA FOR CERTIFICATE OF NEED.** The Agency will consider the following general criteria in determining whether an application for a certificate of need should be granted:

(1) Need. The health care needed in the area to be served may be evaluated upon the following factors:

- (a) The relationship of the proposal to any existing applicable plans;
- (b) The population served by the proposal;
- (c) The existing or certified services or institutions in the area;
- (d) The reasonableness of the service area;
- (e) The special needs of the service area population, including the accessibility to consumers, particularly women, racial and ethnic minorities, TennCare participants, and low-income groups;
- (f) Comparison of utilization/occupancy trends and services offered by other area providers;
- (g) The extent to which Medicare, Medicaid, TennCare, medically indigent, charity care patients and low income patients will be served by the project. In determining whether this criteria is met, the Agency shall consider how the applicant has assessed that providers of services which will operate in conjunction with the project will also meet these needs.

(2) Economic Factors. The probability that the proposal can be economically accomplished and maintained may be evaluated upon the following factors:

- (a) Whether adequate funds are available to the applicant to complete the project;
- (b) The reasonableness of the proposed project costs;
- (c) Anticipated revenue from the proposed project and the impact on existing patient charges;
- (d) Participation in state/federal revenue programs;
- (e) Alternatives considered; and
- (f) The availability of less costly or more effective alternative methods of providing the benefits intended by the proposal.

(3) Contribution to the Orderly Development of Adequate and Effective Healthcare Facilities and/or Services. The contribution which the

proposed project will make to the orderly development of an adequate and effective health care system may be evaluated upon the following factors:

- (a) The relationship of the proposal to the existing health care system (for example: transfer agreements, contractual agreements for health services, the applicant's proposed TennCare participation, affiliation of the project with health professional schools);
- (b) The positive or negative effects attributed to duplication or competition;
- (c) The availability and accessibility of human resources required by the proposal, including consumers and related providers;
- (d) The quality of the proposed project in relation to applicable governmental or professional standards.

7. Rule 0720-11-.01(23) of the Rules of the Tennessee Health Services and Development Agency provides that "Service area' means the county or counties, or portions thereof, representing a reasonable area in which a health care institution intends to provide services and in which the majority of its service recipients reside."

#### **NEED**

8. SBH was initially drawn to the Kingsport area by ~~doing~~performing a national evaluation of psychiatric bed need. MSHA questions the process SBH used in formulating its SBHK CON request. ~~However,~~While the need criterion of the Agency in weighing a CON does not prescribe a certain protocol to be followed in developing an application.~~The,~~the service area should make sense in the context of the region and the service area proposed for CON purposes should be consistent with the applicant's actual intentions regarding the area from which it will draw patients. Moreover, the applicant must demonstrate a need for the project and satisfy the other statutory criteria for the grant of the CON by the Agency.

9. The designated service area should be reasonable. ~~Including~~Excluding Washington County, Tennessee and other nearby counties in the proposed SBHK service area ~~may arguably create~~creates a ~~more reasonable~~ service area ~~than that proposed. Yet, this is not~~ reasonable and conflicts with SBHK's actual plans and internal pro forma financials, both of which anticipate that a significant percentage of SBHK's patients will originate from Washington County. The rules of the Agency ~~specifically~~ provide that "service area" means the counties representing a reasonable area in which the services are provided and in which the majority of its service recipients reside, but it is not reasonable for the SBHK service area to exclude 3 contiguous counties, including Washington County (Johnson City), which is the site of the largest provider of inpatient psychiatric services in the region.

10. ~~The two health care planning experts in this matter, both deemed credible, differ as to whether the SBHK proposed service area is reasonable. They examined the region's past and current health care providers' service areas in support of their respective positions. Similar to SBHKs designated services area,~~While several medical facilities in Kingsport and Sullivan County (including MSHA's IPMC) have service areas that consist of Sullivan and Hawkins Counties and a few counties in Virginia, while excluding Washington County, Tennessee. ~~The,~~ these other facilities are not psychiatric hospitals, which are regional providers by their nature. Although there may be instances when the Agency has accepted CON applicants' service area definitions, even when the proposed service area excludes contiguous counties from which an applicant might draw patients, the exclusion of Washington and other counties in the SBHK CON application is contrary to SBHK's internal analysis and conflicts with historic patient flow patterns in the Tri-Cities region.

11. The prior psychiatric hospital in Kingsport, Indian Path Pavilion, drew ~~just~~ 12% of its admissions over its last three-years of operation (2007-09) from Washington County, which represented the second highest source of patients for Indian Path Pavilion. From 2012-2014, 26% of patients admitted to WPH were from Sullivan County. ~~In 2013, both Wellmont Holston in Kingsport and BRMC had very few patients from Washington County and, which demonstrates the flow of patients between the counties. While~~ four of the five counties in the proposed area accounted for approximately 66% of Indian Path Pavilion's admissions from 2007-2009. ~~Mr.~~ but the complete service are for Indian Path Pavilion was very similar to the service area proposed by Dr. Collier Mr. Sullivan projected that approximately 20% of the patient volume at SBHK would likely come from outside the five-county service area, including from Washington County.

~~12. Not including a contiguous county (Washington, Tennessee) where some patients may originate does not make the service area unreasonable. SBHK has established that its designated service area is reasonable.~~

12. The opinions of Dr. Collier regarding the service area are found to be persuasive based on the following:

- Dr. Collier's proposed service area is composed of the counties surrounding the site, very similar to the market area identified by SBHK in its internal documents.
- SBHK's parent company had originally planned to build the facility in Johnson City but moved the location to Kingsport in an attempt to avoid opposition from MSHA. Nothing in the record indicates that the shift to Kingsport was made with the intentions to serve a different market than would have been served from Johnson City.

- SBHK's internal reports and projections confirm that it views the true market area for its facility to be different than what it proposed in the CON application and very similar to Dr. Collier's proposed service area.
- Dr. Collier's opinions are consistent with the fact that the Tri-Cities area is considered a single region for other purposes.

Using Dr. Collier's alternative service area, bed need formula in the Guidelines for Growth, indicates a need for 30 beds, less than one-half of the number proposed by SBHK.

13. In light of the historical patient utilization patterns in Upper East Tennessee, the close economic and other ties among the Tri-Cities, SBHK's own internal planning documents, and the history of this Project, the Agency concludes that a new psychiatric hospital in Kingsport would admit a substantial number of patients that otherwise would have been seen at WPH, including patients from Washington County and from other counties in WPH's service area. SBH's claimed service area excluding Washington County is arbitrary and illogical, not only in terms of the well-established economic and community ties between Johnson City and Kingsport, but also in terms of the historical flow of patients from Sullivan County to WPH and other providers that were artificially excluded from the asserted service area.

14. SBHK has not established that its designated service area is reasonable.

~~13.15. A 72 bed facility for the proposed service area **meets** does not meet the Guidelines for Growth bed need formula. Applying Indian Path Pavilion's service area the need is 29 beds in 2019; using Dr. Collier's alternative service area the need is 30, though eliminating one county in Virginia (Russell) increases the need to 51 formula.~~

14.16. Admissions and patient days at WPH have been growing steadily since 2011 with a considerably higher number of admissions than budgeted for fiscal year 2015 (as of May 31,

2015). Occupancy at WPH in 2015 (January-May) has been between 82-89%. There were days in 2014 and 2015 (January-May) when WPH had in excess of 90% occupancy and deferrals because a bed was not available for both adults and adolescents. The occupancy rates at WPH are consistent with the goals that SBHK's parent has for its own facilities. All of the clinical professionals who testified in the proceeding appeared on behalf of MSHA, except for Dr. Elliott who advocated for another site for residency training. None of these clinicians, nor any other witnesses, indicated that patients are unable to obtain treatment. The occupancy rates for all of the facilities in the service in 2013 was 63%.

~~15.17.~~ Population growth is not spurring the need for more beds; ~~nonetheless,~~ in Sullivan County is. The combined occupancy rates for all of the ninth largest county in Tennessee by population, but it contains only 12 inpatient adult psychiatric hospital beds. Hundreds facilities in the region is 63%. In 2013, a small percentage of patients from SBHK's proposed service area ~~have been traveling~~ traveled over 100 miles outside SBHK's proposed service area to obtain psychiatric inpatient psychiatric hospital services, mostly at Peninsula Hospital (Blount County) ~~and elsewhere. The presenece of~~. Peninsula Hospital, like WPH, accepts uninsured State grant patients, whom SBHK could eliminate some has no plans to accept. Mr. Sullivan acknowledged that patients for a variety of this out of reasons may choose to access inpatient psychiatric care at facilities located outside area where they live. There is no evidence to establish that patients from the service area proposed by SBHK sought admission at Peninsula and other facilities because of inability to obtain service within the reasonable service area. Moreover, the inpatient psychiatric patient flow use rate in Sullivan County is above the state average, indicating that the residents are not experiencing barriers to access.

~~16-18.~~ MSHA is actively working to provide mental health services to the region. It is assisting with treating patients who previously went to Lakeshore and is collaborating on a CSU project. A CSU should decrease the need for inpatient psychiatric beds. ~~However, as evidenced by the Johnson City adult CSU not curtailing WPH's utilization rate, a CSU in of itself does not alleviate the total need for inpatient beds for some CSU patients and non-CSU patients~~The fact that WPH has had high occupancy after the adult CSU opened is not necessarily indicative of the effect of the adolescent CSU. In any event, even using SBHK's service area, which significantly overstates the need, the 28 adolescent beds proposed by SBHK is more than double the number derived from the bed need formula in the Guidelines for Growth.

~~17-19.~~ When all of need criterion are considered, SBHK has ~~established~~failed to establish, by a preponderance of the evidence, that SBHK is necessary to provide needed health care to the proposed service area. SBH failed to demonstrate that there is a lack of access to psychiatric services in the region justifying a new 72-bed psychiatric hospital. At most, SBH proved that there are transient operational bed shortages during peak times of demand. There are far more economical and efficient ways of addressing any such suggested shortages than simply creating significantly more inpatient beds. The evidence demonstrated that Woodridge and Frontier Health have taken steps to provide additional community resources, including the Crisis Stabilization Unit for adolescents, which will create functional bed capacity. Moreover, the development of outpatient services will reduce the necessity of inpatient hospitalization for many patients.

### **ECONOMIC FACTORS**

~~18-20.~~ SBH has adequate funds through its cash flow and line of credit to complete the project and the projected project costs are reasonable. Mr. Sullivan found the revenue projections also to be reasonable and SBHK will participate in Medicare and Medicaid. Dr. Collier's

criticisms of the economic feasibility of the project are primarily based on her opinion that the proposed service area is inappropriate.

~~19.21.~~ As to alternatives to the project, Mr. Sullivan did acknowledge that it would be possible to build a facility smaller than 72 beds. However, he felt the need for a 72 bed facility exists under the *Guidelines* formula and that there are advantages to a larger facility in terms of spacing and separating age groups.

~~20.22.~~ The *Guidelines* address feasibility in terms of the ability of the applicant to meet Tennessee Department of Mental Health licensure requirements related to personnel and staffing for psychiatric inpatient facilities. SBH has retained and recruited the requisite personnel at its other facilities and should be able to draw upon its resources to do the same at SBHK.

~~21.23.~~ When all of these factors are considered, SBHK has established by a preponderance of the evidence, that SBHK can be economically accomplished and maintained, but only with significant adverse impact to WPH, the safety net provider in the region for inpatient psychiatric care.

### ORDERLY DEVELOPMENT

1. SBHK proposes to provide 5% indigent or charity care, take Medicaid/Medicare patients, accept involuntary patient commitments and participate in the TennCare program. ~~SBH has been able to attract medical professionals to staff its other facilities and there was no indication it could not do so for SBHK. The area should benefit from the addition of healthcare professionals~~The proposed Project, however, would serve very few, if any, uninsured patients, leaving those patients to continue being cared for mostly at WPH. Although SBHK has claimed it will provide 5% charity/indigent care at its new hospital, even that low estimate is simply not credible based SBHK's discovery responses and the historical performance of other SBHK facilities, which treat few charity patients. SBHK's executives admitted their intention is for

uninsured patients to continue to be seen at WPH and SBHK has taken no steps to offer services for those patients.

~~22. — The only provider of inpatient beds in the proposed service area, BRMC, has only 12 beds which generally service an adult population; SBHK would provide additional beds for this population as well as for children and adolescents. The presence of SBHK should enhance the overall delivery of mental care in the area.~~

23-24. WPH would be the facility most impacted by SBHK. WPH is safety-net hospital for psychiatric patients in the region and plays a vital role in the area serving TennCare, Medicaid and patients formerly seen at Lakeshore. Dr. Collier estimates a possible loss of \$1.5 ~~million~~ to \$1.9million per year to WPH if SBHK is built, ~~though WPH did have more positive financial results with 3,724 patients in the first 11 months of FY 2014 than it had with 4,320 patients in the first 11 months of FY 2015. The impact of SBHK on WPH is limited by the fact,~~ Although WPH is a satellite or department of JCMC, WPH has its own campus, files its own Joint Annual Reports and ~~consideration should be given to SBHK's impact on JCMC and MSHA. No expert analysis was done regarding the~~ has its own financial statements. A negative impact in the range projected by Dr. Collier could have negative effect ~~of SBHK on JCMC or MSHA. JCMC had profits of over \$30 million in fiscal year 2013 and MSHA is financially operationally healthy. Any adverse impacts on WPH/JCMC/MSHA by the approval of SBHK are outweighed by the benefits that accrue~~ on MSHA's bond ratings and would adversely affect MSHA's ability to ~~the~~ continue to reinvest in community ~~from SBHK and~~ based services, including the provision of ~~the additional inpatient~~ psychiatric beds that SBHK brings services to the most vulnerable segments of the region's population. Any potential positive benefits of the project are outweighed by the adverse impacts on WPH.

~~24.25.~~ When all of these factors are considered, SBHK has ~~established~~failed to establish, by a preponderance of the evidence, that SBHK will contribute to the orderly development of adequate and effective health care facilities and care.

### CONCLUSION

SBH-Kingsport having ~~established~~failed to establish by a preponderance of the evidence that the application for a Certificate of Need for a 72 bed psychiatric hospital in Kingsport, Tennessee meets the statutory and regulatory criteria, it is hereby **ORDERED** that the Certificate of Need filed for SBH-Kingsport be ~~GRANTED~~DENIED.

It is further **ORDERED**, pursuant to Tennessee Code Annotated § 68-11-1610(i), that all of the costs of this contested case proceeding are assessed to and shall be paid by MSHA.

This ~~Initial~~Final Order entered this \_\_\_\_\_ day of ~~February~~June, 2016.

---

Tennessee Health Services and Development  
Agency

~~Leonard Pogue  
Administrative Judge~~

~~Filed in the Administrative Procedures Division, Office of the Secretary of State, this  
\_\_\_\_\_ day of February, 2016.~~

---

---

~~J. Richard Collier, Director  
Administrative Procedures Division~~

**APPENDIX A TO INITIAL ORDER**  
**NOTICE OF APPEAL PROCEDURES**

**Review of Initial Order**

This Initial Order shall become a Final Order (reviewable as set forth below) fifteen (15) days after the entry date of this Initial Order, unless either or both of the following actions are taken:

(1) — A party files a petition for appeal to the agency, stating the basis of the appeal, or the agency on its own motion gives written notice of its intention to review the Initial Order, within fifteen (15) days after the entry date of the Initial Order. If either of these actions occurs, there is no Final Order until review by the agency and entry of a new Final Order or adoption and entry of the Initial Order, in whole or in part, as the Final Order. A petition for appeal to the agency must be filed within the proper time period with the Administrative Procedures Division of the Office of the Secretary of State, 8<sup>th</sup> Floor, William R. Snodgrass Tower, 312 Rosa L. Parks Avenue, Nashville, Tennessee, 37243. (Telephone No. (615) 741-7008). See Tennessee Code Annotated, Section (T.C.A. §) 4-5-315, on review of initial orders by the agency.

(2) — A party files a petition for reconsideration of this Initial Order, stating the specific reasons why the Initial Order was in error within fifteen (15) days after the entry date of the Initial Order. This petition must be filed with the Administrative Procedures Division at the above address. A petition for reconsideration is deemed denied if no action is taken within twenty (20) days of filing. A new fifteen (15) day period for the filing of an appeal to the agency (as set forth in paragraph (1) above) starts to run from the entry date of an order disposing of a petition for reconsideration, or from the twentieth day after filing of the petition, if no order is issued. See T.C.A. §4-5-317 on petitions for reconsideration.

A party may petition the agency for a stay of the Initial Order within seven (7) days after the entry date of the order. See T.C.A. §4-5-316.

**Review of Final Order**

Within fifteen (15) days after the Initial Order becomes a Final Order, a party may file a petition for reconsideration of the Final Order, in which petitioner shall state the specific reasons why the Initial Order was in error. If no action is taken within twenty (20) days of filing of the petition, it is deemed denied. See T.C.A. §4-5-317 on petitions for reconsideration.

A party may petition the agency for a stay of the Final Order within seven (7) days after the entry date of the order. See T.C.A. §4-5-316.

**YOU WILL NOT RECEIVE FURTHER NOTICE OF THE INITIAL ORDER BECOMING A FINAL ORDER**

A person who is aggrieved by a final decision in a contested case may seek judicial review of the Final Order by filing a petition for review in a Chancery Court having jurisdiction (generally, Davidson County Chancery Court) within sixty (60) days after the entry date of a Final Order or, if a petition for reconsideration is granted, within sixty (60) days of the entry date of the Final Order disposing of the petition. (However, the filing of a petition for reconsideration does not itself act to extend the sixty day period, if the petition is not granted.) A reviewing court also may order a stay of the Final Order upon appropriate terms. See T.C.A. §4-5-322 and §4-5-317.

# **EXHIBIT B**

DIRECT EXAMINATION

1  
2 BY MR. WEST:

3 Q. Dr. Elliott, would you state your name and  
4 address for the record, please, sir?

5 A. Okay. My name is Harold Elliott. My address  
6 is 122 Morris Lane, Gray, Tennessee 37615.

7 Q. And are you in the process of relocating?

8 A. Yes.

9 Q. And where are you relocating?

10 A. To Ann Arbor, Michigan.

11 Q. And what is the purpose of your relocation?

12 A. I was formerly the program director at East  
13 Tennessee State for the residency program, psychiatry  
14 residency program, and I'm going to start a new  
15 residency program in affiliation with Michigan State.

16 Q. For their medical school?

17 A. Yeah, for the -- yes.

18 Q. And when did you stop working for ETSU?

19 A. I was there until June 19th of 2015.

20 Q. So just a few weeks ago?

21 A. Yeah. Right.

22 Q. And would you describe for the record what  
23 your job duties were there? Well, let me back up a  
24 step.

25 Can you state your educational background and

1 prior job history?

2 A. Okay. I'm originally from South Carolina. I  
3 went to Davidson College where I got a bachelor's  
4 degree, and I got my MD from Medical University of  
5 South Carolina in Charleston.

6 I did my residency at University of North  
7 Carolina, Chapel Hill. I'm board certified in adult  
8 psychiatry and subspecialty boarded in psychosomatic  
9 medicine or consult liaison psychiatry.

10 I previously was on the faculty at Wake Forest  
11 University where I was the program director for the  
12 residency program there, and recently was the program  
13 director for the psychiatry residency at East  
14 Tennessee State.

15 Q. When did you come to East Tennessee State in  
16 that regard?

17 A. It was 2011.

18 Q. And in the context of your job duties -- could  
19 you describe your job duties at ETSU, what all you  
20 did?

21 A. Sure. I had a 50 percent time administrative  
22 and 50 percent time clinical appointment. And for the  
23 administrative appointment I was the director of the  
24 psychiatry residency program, and I also did clinical  
25 work where I was the inpatient attending doctor on the

1 Spruce Unit at Woodridge and I was seeing outpatients  
2 in the Department of Psychiatry.

3 Q. And so when you say the Spruce Unit at  
4 Woodridge, that's the geropsychiatric unit?

5 A. The gero -- right.

6 Q. At Woodridge Hospital?

7 A. Right. Correct.

8 Q. And did you have staff membership there at  
9 JCMC, Johnson City Medical Center?

10 A. Yes. Yes.

11 Q. Describe, if you would, your patient load at  
12 both places, the hospital and the clinical program,  
13 school.

14 A. At Woodridge Hospital, just like all the other  
15 faculty members, I covered weekend call, but also for  
16 the last two years, I was spending -- I was covering  
17 about 25 to 30 percent of the inpatient time at -- on  
18 the Spruce Unit and that continued until I left.

19 Q. And when was the last day you treated a  
20 patient at Woodridge?

21 A. I don't remember exactly, but I think it was  
22 the first week in June at some point.

23 Q. Of 2015?

24 A. Of 2015.

25 Q. So you were actually somebody who's been

1 working at Woodridge?

2 A. Right. Correct. For three and a half, four  
3 years, yeah.

4 Q. And 30 percent of time, what does that mean in  
5 terms of time of day or amount of hours per month?

6 A. Well, we would take weeks. And so in 2014, I  
7 was the primary backup for the regular doctor who was  
8 on the Spruce. So he would spend three weeks on the  
9 unit covering, then I would spend a week at a time.  
10 So I did a little more than one out of every four  
11 weeks. And then in the last year, when we lost our  
12 primary inpatient doctor, all the faculty members  
13 covered, and it ended up being about once every four  
14 to five weeks. And we spent a week at a time full  
15 time.

16 Q. Full time at the hospital?

17 A. Yes. Stay there until all the patients were  
18 seen.

19 Q. All right. So you're familiar with the  
20 operations of --

21 A. Yes.

22 Q. -- Woodridge at the Spruce Unit?

23 A. Right.

24 Q. In May and June, prior to your leaving that  
25 practice, what has been the -- what have you observed

1 about utilization at Spruce?

2 A. For the most part, we were staying full. I  
3 mean, there were 14 beds, and my recollection is that  
4 most days we had 14 patients in 14 beds. Usually,  
5 when we discharged maybe two or three patients, by the  
6 next day they were filled -- the beds were filled back  
7 up again.

8 Q. All right. And could you describe for the  
9 record your -- the clinical practice that you had at  
10 the medical school?

11 A. I saw outpatients there, regular private  
12 patients, and I would see them about two days a week.

13 Q. And so do you still practice there?

14 A. Oh, no. No. I stopped. I saw my last  
15 patient, I think, on June 18th.

16 Q. And what became of your patients, as far as  
17 you know, after you left?

18 A. Well, it was -- one thing, because of  
19 the shortage of psychiatrists that we had in our  
20 department -- we had maybe five or six psychiatrists  
21 leave in the last 18 months or so -- we couldn't  
22 see -- they could not absorb the patients that I  
23 had, so I had to refer those patients out to other  
24 providers.

25 Q. And where did they go?

1 A. We gave them the name for Frontier Health, but  
2 most of them couldn't get into Frontier, at least they  
3 couldn't get in to see a doctor for months. Several  
4 went to outpatient psychiatrists in the area who might  
5 have been taking patients, and there was a limited  
6 number of those. And I had some who had to go a long  
7 way away to get somebody to see them.

8 MR. JACKSON: Your Honor, please, I just  
9 want to object to this line of questioning and move to  
10 strike on the basis that the testimony that's just  
11 been elicited is about a shortage of psychiatrists at  
12 East Tennessee State University causing a problem in  
13 patients being seen by psychiatrists. It is not  
14 pertinent to the issue we're here about.

15 MR. WEST: Your Honor, if I may, we've  
16 already heard argument from Mr. Jackson about the  
17 systemic issues in East Tennessee. And one of the  
18 things that has surprised me -- one of the things that  
19 Dr. Elliott is capable of testifying factually about  
20 is that ETSU itself is a provider, through its  
21 psychiatric department, the ETSU medical school is a  
22 provider of outpatient services. And if there are  
23 problems or shortages in that department, then that's  
24 one more thing that affects the overall system's  
25 capability of handling the demand and the load for

1 psychiatric services. So I think it's highly relevant  
2 to this case. And this is a gentleman who has factual  
3 experience with it.

4 MR. JACKSON: If I may, Your Honor -- and  
5 I don't mean to take up too much time objecting, but  
6 another objection that I would like to lodge, though,  
7 is that this witness was identified as -- along with  
8 anyone else who wrote a letter of support -- as being  
9 someone who has knowledge as evidenced in their  
10 letters of support.

11 What he's testifying about now was not  
12 contained in his letter of support, so we've had no  
13 notice of this line of inquiry. It's also, basically,  
14 expert testimony. I would submit he's being asked to  
15 give opinions, I suspect, about these issues which  
16 require expertise. So for all of those reasons, but  
17 principally relevance, we would object.

18 THE COURT: He's on your witness list?

19 MR. WEST: Yes. And we've notified them  
20 about him since way back in 2014.

21 THE COURT: All right. I'm going to  
22 overrule your objection, and I'll give the testimony  
23 whatever weight I deem...

24 MR. JACKSON: Thank you, Your Honor.

25 MR. WEST: Thank you, Your Honor.

1 Frankly, I forgot what my last question  
2 was to him. Can you re-read it, please, ma'am?

3 (The requested testimony was read back by  
4 the court reporter as follows:

5 "Question: And where did they go?"

6 BY MR. WEST:

7 Q. Dr. Elliott, you've heard of the CON  
8 application for SBH-Kingsport, LLC, haven't you?

9 A. Yes.

10 Q. And last June, did you write a letter in  
11 support?

12 A. I did.

13 Q. Let me show you what's been marked as  
14 Exhibit 207 and ask you if you can identify that,  
15 please, sir.

16 A. Yes. This was the letter I wrote, I guess it  
17 was in June of 2014.

18 Q. Okay. And would you take a moment and look at  
19 that letter, and I want to ask you some questions  
20 about it.

21 A. (Reviewing document.) Okay.

22 Q. Is there anything in that letter that you  
23 would change?

24 A. There's nothing there that I would change.  
25 There might be some things that I might amend based

1 on things that have happened in the last year in terms  
2 of child and adolescent services.

3 Q. What are those?

4 A. Well, over the last year, I was the program  
5 director for the residency, and we had just -- we  
6 had just come off probation. And we didn't get that  
7 notification until, I think, March that we were going  
8 to come off probation.

9 Q. March of what year?

10 A. Of 2015.

11 Q. This year?

12 A. Yeah, just this year. We'd had a site visit  
13 the year before, but it took them a year to get back  
14 to us. One of the big issues that has come up in the  
15 last year is with the closing -- well, the Willow Unit  
16 has not closed at Woodridge, but they don't have a  
17 child and adolescent psychiatrist to staff that unit,  
18 and so therefore it's not a viable training site for  
19 the psychiatry residents.

20 So for the last year, we have really struggled  
21 to find a viable child and adolescent experience for  
22 our residents. They have to have at least two months  
23 of full-time -- called full-time equivalent of child  
24 and adolescent experience for us to maintain our  
25 accreditation.

1           And over the last year, I've had a constant  
2 dialogue with the administration and with my own chair  
3 that if we didn't obtain that in a way that I thought  
4 met the requirements, that I would have to notify the  
5 accrediting body, the ACGME.

6           And just before I left, I learned that we were  
7 not going to have adequate resources, and I did notify  
8 the ACGME that we were not in compliance with the  
9 requirements for a child and adolescent experience.

10 Q.       What is the ACGME? What does that stand for?

11 A.       Boy, I should know this. The ACG -- it's  
12 basically for accreditation of residency programs.  
13 I'm so used to saying the letters. But basically it's  
14 for accreditation residency programs. And much like  
15 the JCAHO would come into the hospital, they come in  
16 and do site visits and make sure you're maintaining  
17 the appropriate resources for your residents.

18 Q.       And what is the function in the residency  
19 training program of, say, a child -- a board-certified  
20 child and adolescent psychiatrist? What role would  
21 they play in the residency program?

22 A.       In order to get appropriate -- it's the  
23 Accreditation Council for Graduate Medical Education.

24 Sorry.

25           In order to get accreditation and credit if

1 you're doing a residency program for having child and  
2 adolescent, you have to have a supervising  
3 board-certified child and adolescent psychiatrist.

4 So if we don't -- if there's an experience,  
5 even though a resident might be seeing adolescents and  
6 children, if you don't have supervision by somebody  
7 who is board certified, then it doesn't qualify.

8 Q. All right. And, Dr. Elliott, when you sent  
9 this letter of June 24th to Ms. Hill, was it your  
10 intention to communicate this information to the HSDA?

11 A. Yes.

12 MR. WEST: Your Honor, I'd like to make  
13 this the next exhibit -- or Exhibit Number 207.

14 THE COURT: Can I see a copy so I can  
15 identify it for the record? It's not in this book,  
16 right?

17 MR. WEST: I don't believe so, no. This  
18 was one we exchanged on Friday.

19 THE COURT: The book ends at 90.

20 MR. WEST: Yeah.

21 THE COURT: The next exhibit is  
22 Exhibit 207, which is a June 24th, 2014, letter from  
23 Dr. Elliott to Melanie Hill, executive director of the  
24 Tennessee Health Services and Development Agency.

25 (Marked Exhibit No. 207.)

1 BY MR. WEST:

2 Q. Dr. Elliott, what, if anything, have you heard  
3 about the establishment of an adolescent CSU in --  
4 crisis stabilization unit in Washington County or  
5 elsewhere in East Tennessee?

6 A. I haven't heard any -- you mean through the  
7 department?

8 Q. Yes.

9 A. Nothing. I've never heard that was even a  
10 possibility.

11 Q. And do you know what a CSU is?

12 A. Crisis stabilization unit.

13 Q. Right. So are you familiar with the function?

14 A. The concept, yeah.

15 Q. How would you compare that to inpatient  
16 psychiatric hospital care?

17 A. Well, a crisis stabilization unit, my  
18 understanding is that it's a place where there is very  
19 short-term treatment for patients in crisis and they  
20 stay in a facility for maybe two to three days, but  
21 it's not a full-service inpatient facility with things  
22 like group therapy and teachers and things like that  
23 for children and adolescents. It's more of a place --  
24 intermediate place to go if a kid is in a crisis or  
25 patient is in a crisis.

1 Q. Dr. Elliott, why are you testifying in this  
2 case?

3 A. I feel a responsibility to the people of  
4 that area and a responsibility to my residents who I  
5 recruited and taught over the last four years. And my  
6 concern was that we're already in a situation where we  
7 don't have adequate resources to serve the population  
8 we have, and this is a chance to expand the service to  
9 the people of the area.

10 But my biggest concern was that I wanted to  
11 have these kinds of resources available for education  
12 for the residents. These are -- you know, a full  
13 spectrum of child and adolescent services is something  
14 this area doesn't have and, to my knowledge, has never  
15 had.

16 Q. And how many child and adolescent beds does  
17 Woodridge Psychiatric Hospital have?

18 A. They have -- they have, I think, 10. I'm  
19 not -- I'm not -- I think 10 to 12. But like I  
20 said, they're not seeing a child and adolescent  
21 psychiatrist. It's a non-board-certified person.  
22 It's a med/psych doctor, actually.

23 Q. Do you know what building at Woodridge those  
24 beds are in?

25 A. It's in -- there's a main building, and it's

1 on Willow Unit. It's a branch.

2 MR. WEST: That's all the questions I  
3 have at this time, Your Honor.

4 THE COURT: Cross-examination?

5 CROSS-EXAMINATION

6 BY MR. JACKSON:

7 Q. Good afternoon, Dr. Elliott.

8 A. Good afternoon.

9 Q. I represent Mountain States Health Alliance in  
10 this case. Now, as I understand it, you have ended  
11 your medical practice in the Tri-Cities; is that  
12 right?

13 A. Right. Correct.

14 Q. And are you actually, literally, in the middle  
15 of your move?

16 A. I'm in the middle of the move now.

17 Q. So from here you're going to keep on driving  
18 to Michigan?

19 A. Exactly. I'm going to be -- yeah.

20 Q. And you know that -- you know Dr. Goodkin,  
21 right?

22 A. Yes.

23 Q. And what is his role?

24 A. He's the chairman of the department.

25 Q. The chairman of your department?

- 1 A. Uh-huh.
- 2 Q. He's the person you reported to --
- 3 A. Correct.
- 4 Q. -- until you left the university?
- 5 A. Correct.
- 6 Q. And were you aware that he's submitted an
- 7 affidavit in this case?
- 8 A. Yes.
- 9 Q. And you know that when this matter came
- 10 before the Agency, ETSU took a position against the
- 11 application, right?
- 12 A. Correct.
- 13 Q. And so you, here today, are speaking for
- 14 yourself, right?
- 15 A. Correct.
- 16 Q. You're not speaking on behalf of ETSU,
- 17 correct?
- 18 A. Correct.
- 19 Q. You're not speaking on behalf of the
- 20 Department of Psychiatry, correct?
- 21 A. Correct.
- 22 Q. And, in fact, you're not speaking as someone
- 23 who's going to be practicing in Tennessee in the
- 24 future?
- 25 A. That's correct.

1 Q. You'll be practicing in Michigan, right?

2 A. Correct.

3 Q. Okay. And you know that over the past few  
4 months, Woodridge -- you mentioned this lack of a  
5 child and adolescent psychiatrist.

6 A. Correct.

7 Q. You know that there's been an effort to  
8 recruit somebody, right?

9 A. Yes.

10 Q. And you know that these efforts to recruit  
11 specialty physicians takes some time, don't they?

12 A. Yes.

13 Q. And particularly somebody with that  
14 particular skill-set. There's not a huge number of  
15 board-certified child and adolescent psychiatrists out  
16 there, true?

17 A. It's a big, big shortage.

18 Q. And attracting them -- I love the Tri-Cities,  
19 so don't take this the wrong way, but attracting them  
20 to some areas of the country are harder than others,  
21 right?

22 A. Much more difficult to recruit to rural areas.

23 Q. Okay. And you don't deny or dispute that that  
24 effort has been ongoing, right, to recruit somebody?

25 A. From the department, that's the only one I

1 have firsthand knowledge of, not being successful.

2 Q. You know that over the years, Woodridge and  
3 ETSU have had a cooperative relationship?

4 A. You have to define "cooperative."

5 Q. Yeah. Sure. I understand. Any relationship,  
6 you have bumps and what have you.

7 A. Yeah.

8 Q. But Woodridge and the Department of Psychiatry  
9 at ETSU work together on a lot of things?

10 A. They do attempt to work together on a lot of  
11 things.

12 Q. And you know, for example, Woodridge is  
13 subsidizing 10 residency spots at ETSU, right?

14 A. That's not exactly right. They have the  
15 funding available for 10. There are 20 residents.  
16 The Veterans Administration pays for approximately 13.  
17 There is funding -- and this is what I deal with.  
18 This was my job. So we get another funding for maybe  
19 one or two of those, and then Mountain States pays for  
20 the remaining six. But they have enough that if we  
21 billed them for more, they have that available.

22 Q. I see. Okay. Thank you for the correction.  
23 But you would agree that Mountain States, each year,  
24 is contributing towards the cost of residents at ETSU,  
25 right?

1 A. Yes.

2 Q. In the Department of Psychiatry, right?

3 A. Correct.

4 Q. And specifically you said it was six resident  
5 spots, but they're budgeted up to ten; is that  
6 correct?

7 A. Up to ten, correct.

8 Q. And the ten would be \$450,000? Is that what  
9 subsidizing ten would cost?

10 A. I don't -- it's confusing to know how much  
11 that is, because it goes to the administration, and  
12 there's also how much they receive from the  
13 government. So I don't really know exactly.

14 Q. If we have evidence in this case from somebody  
15 else that says it's 450,000, would you have any reason  
16 to dispute that?

17 A. I wouldn't be able to dispute that.

18 Q. Okay. And you know there are also,  
19 annually -- Woodridge is also annually providing some  
20 funding to help support some faculty positions, true?

21 A. Correct.

22 Q. And is that \$45,000?

23 A. That sounds about right.

24 Q. You haven't actually reviewed the entire CON  
25 application that we're here about, have you?

1 A. No.

2 Q. You haven't looked at any of the plans that  
3 SBH has prepared, if they have prepared any, about  
4 what they're going to do exactly, true?

5 A. As far as seeing the actual documents?

6 Q. Yes, sir.

7 A. No.

8 MR. JACKSON: That's all I have. Thank  
9 you.

10 MR. WEST: If I may, Your Honor, I have  
11 some redirect.

12 REDIRECT EXAMINATION

13 BY MR. WEST:

14 Q. Dr. Elliott, you were asked by Mr. Jackson  
15 about residency spots.

16 A. Correct.

17 Q. Have you personally communicated with Mountain  
18 States -- while you were in your job at ETSU, did you  
19 personally communicate with any Mountain States  
20 personnel about residency issues?

21 A. Yes.

22 Q. What was the nature of your communications  
23 with them?

24 A. There were frequent meetings. And I'm not  
25 sure how much detail you want me to go into, but when

1 I first arrived at ETSU, the program was in  
2 significant difficulty. And part of my job was to  
3 bring the program up to accreditation. And I had to  
4 meet with the people in Mountain States on multiple  
5 occasions about citations we received from the  
6 accrediting body, the ACGME. And a lot of the  
7 citations we had were related to the service load  
8 that residents were required to carry at Woodridge.

9 And so when I was saying that sometimes things  
10 were cooperative and sometimes they weren't, those  
11 meetings were very adversarial in that I was in a  
12 situation where I needed to decrease the amount of  
13 service the residents -- and maximize the education,  
14 and there were lots of -- there was lots of  
15 disagreement about how I would do that.

16 Q. And do you know anything about the source of  
17 the funds that Mountain States receives for the  
18 graduate medical education?

19 A. Well, I do know that Medicare funds the  
20 majority of the spots, and then they supposedly pass  
21 that money on to ETSU to pay for residency spots.

22 Q. Why do you use the term "supposedly"?

23 A. A point of contention has been that Mountain  
24 States doesn't send all the money they receive from  
25 the government to ETSU, and they, I think, withhold

1 approximately 25 to 30 percent of that, as opposed to  
2 VA which sends all of the money for teaching.

3 Q. You were asked by Mr. Jackson about the child  
4 psychiatry recruitment effort. How long has it been  
5 since there was a board-certified child and adolescent  
6 psychiatrist at Woodridge?

7 A. May of 2014.

8 Q. And who was it?

9 A. That was Dr. Jill McCarley.

10 Q. And where is she now?

11 A. She's working at the VA.

12 Q. So she is board certified as a child and  
13 adolescent psychiatrist?

14 A. Yes.

15 Q. And so she would be available to be recruited,  
16 wouldn't she?

17 A. Theoretically, yes. She left to go to the VA.

18 Q. Do you know anything about the position of  
19 Strategic Behavioral Health as to similar residency  
20 funding? Have you heard anything about that or have  
21 you seen anything about that?

22 A. I haven't seen anything about that. I did  
23 have discussion, and I'm not sure who it was, about  
24 that they would be open to that and that they had  
25 partnered with other institutions in the past. I

1 think Scott and White in Texas is what I was told.

2 MR. WEST: That's all the redirect I  
3 have, Your Honor.

4 MR. JACKSON: Nothing, Your Honor. Thank  
5 you.

6 THE COURT: Thank you, Dr. Elliott. You  
7 can leave. Please don't discuss your testimony or the  
8 exhibits with anyone else that may testify in this  
9 matter.

10 THE WITNESS: Sure.

11 (Witness was excused.)

12 MR. CHRISTOFFERSEN: For what it's worth,  
13 Your Honor, if I do have a question for a witness,  
14 it's probably easier for me to just interrupt when  
15 that time comes.

16 THE COURT: I apologize I didn't --  
17 you're out of my line of vision is part of the  
18 problem, Mr. Christoffersen, sitting off to the side,  
19 but certainly don't be shy about jumping up and saying  
20 you want to question a witness.

21 And someone has come into the room,  
22 counsel.

23 MR. JACKSON: This is Dr. Collier,  
24 Dr. Deborah Kolb Collier, our expert witness, Your  
25 Honor.

04/27/15 4:28:55