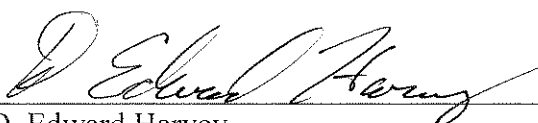


**BEFORE THE TENNESSEE HEALTH SERVICES AND
DEVELOPMENT AGENCY**

IN THE MATTER OF:) **Docket No. 25.00-092967J**
)
SPRING HILL HOSPITAL, INC.) **CON No. CN0604-028A**

NOTICE OF FILING

The Respondent, Spring Hill Hospital, Inc., gives notice that its proposed Findings of Fact and Conclusions of Law are filed herewith.


D. Edward Harvey
FARRIS, MATHEWS, BRANAN,
BOBANGO, HELLEN & DUNLAP, PLC
618 Church Street, Suite 300
Nashville, TN 37219
(615) 726-1200

- Certificate of Service on following page -

CERTIFICATE OF SERVICE

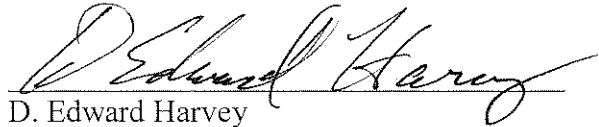
I certify that a copy of the foregoing was served on the following by first class mail on this the 16th day of August, 2007:

Warren L. Gooch
Charles E. Young
Kramer Rayson LLP
800 South Gay Street, Suite 2500
Knoxville, TN 37929

James B. Christoffersen
Reid Brogden
Tennessee Health Services and Development Agency
500 Deaderick Street, Suite 850
Andrew Jackson Building
Nashville, Tennessee 27243

Dan H. Elrod
G. Brian Jackson
Miller & Martin, PLLC
150 Fourth Ave. North, Suite 1200
Nashville, TN 37219

Kathryn A. Stephenson
Trauger & Tuke
222 Fourth Avenue North, 3rd Floor
Nashville, TN 37219


D. Edward Harvey

For Petitioner Williamson Medical Center	Warren L. Gooch Charles E. Young Kramer Rayson LLP 800 S. Gay Street, 37929 P.O. Box 629 Knoxville, TN 37901-0629
For Respondent Spring Hill Hospital, Inc.	D. Edward Harvey Jerry W. Taylor Farris, Mathews, Branam, Bobango, Hellen & Dunlap, PLC 618 Church Street, Suite 300 Nashville, TN 37219 Kathryn A. Stephenson Trauger & Tuke The Southern Turf Building 222 Fourth Ave., North Nashville, TN 37219
For Respondent, State of Tennessee	James B. Christoffersen, Deputy General Counsel Health Services and Development Agency 500 Deaderick Street, Suite 850 Nashville, TN 37243

At the conclusion of the hearing, Judge Pogue directed that the parties file proposed findings of fact and conclusions of law on or before July 30, 2007. That direction was subsequently amended to require filing on or before August 16, 2007. These proposed findings and conclusions are submitted in accordance with that directive. References to the Transcript will be denoted by the name of the witness, followed by the page on the transcript on which the testimony is to be found (e.g., “Kloess, Tr. ___”). References to Exhibits will be denoted by the number of the exhibit, followed by a description of the Exhibit and information intended to assist in finding the cited information within the exhibit (e.g., “Ex. 136, RPC Report, p. ___”).

FINDINGS OF FACT

The Project and Its Genesis

1. This project will establish a community hospital in the rapidly growing city of Spring Hill, which straddles the border between Williamson and Maury Counties, south of Nashville, Tennessee. Spring Hill Hospital will be owned by Spring Hill Hospital, Inc., a subsidiary of HCA, Inc. (Ex. 27, CON Application, p. 0024). It will be part of the TriStar division of HCA, which currently consists of nineteen hospitals. (Kloess, Tr. 920).

2. In late 2005, officials of the City of Spring Hill approached HCA TriStar, explaining that a recently completed Special Census showed their community was growing quickly, and that they wanted to improve access to medical services within the community, perhaps including a hospital. (Ex. 113, Scarvey Deposition, pp. 24, 31-32). After obtaining additional information from several sources, HCA TriStar determined that Spring Hill could support a small community hospital. (Ex. 113, Scarvey Deposition, Tr. 33-34, 41-42; Scarvey, Tr. 1044-46).

3. In the early stages of HCA's consideration of the request from the City of Spring Hill for a hospital, Mr. Scarvey contacted Ed Stall of Healthcare Concepts and asked for an update of a report Mr. Stall had prepared in 2004.¹ Mr. Stall's report made the most conservative assumptions, including a conservative population projection for Maury and Williamson Counties. (Ex. 114, Stall Deposition, p. 134-135; Ex. 113,

¹ In 2004, HCA and Vanderbilt had discussions about the possibility of a joint venture in Spring Hill, which might have included an inpatient facility. (Ex. 112, Rutledge Deposition, pp. 55-56). Those discussions were high-level due to the wide range of issues that arise in connection with a possible joint venture, and the discussions never reached a conclusion. (Ex. 112, Rutledge Deposition, pp. 49, 55-56). During the time that the joint venture was under consideration, HCA hired Mr. Stall to take a generalized look at the area south of Nashville. This was not intended to be a detailed analysis, and of course Mr. Stall did not have available the 2005 Spring Hill Special Census. (Ex. 114, Stall Deposition, pp. 46, 52-53, 78-80). Whatever conclusions Mr. Stall might have reached in that report are irrelevant to the current case.

Scarvey Deposition, 194; Scarvey, Tr. 1040-41; *compare* Ex. 19, Strategic Market Assessment – Spring Hill, Tennessee, p. SHH 13931; *with* Ex. 9, Kolb Report, Exhibit 29A (showing Stall’s population projections to be less than Swanson’s)). In spite of these conservative assumptions, even Mr. Stall’s quick update of the 2004 report showed that Spring Hill could support a community hospital of between 42 and 55 beds in 2010. (Ex. 116, Stall Deposition, p. 142; Ex. 19, Strategic Market Assessment – Spring Hill, Tennessee, p. SHH 13950; Scarvey, Tr. 1042).

4. The update was never intended to be a full analysis. (Ex. 114, Stall Deposition, pp. 114-15, 134). Mr. Stall’s ability to completely analyze the Spring Hill area was limited. Mr. Stall does not do CON work in Tennessee and his work could not have been used as part of a CON application. (Ex. 114, Stall Deposition, p. 154; Scarvey, Tr. 1041).

5. HCA representatives also visited Spring Hill extensively in late 2005 and early 2006. (Scarvey, Tr. 1044). They talked to physicians and concluded that they had strong physician support for a new hospital. (Scarvey, Tr. 1045-46; Simmons, Tr. 1343).

6. The proposed hospital will have 56 beds, and will provide a basic range of adult and pediatric acute care services, including an emergency department, 8 obstetric beds, 8 critical care beds, and 40 medical-surgical beds. The hospital will also provide diagnostic imaging services. The hospital will not provide tertiary care. (Ex. 27, CON Application, p. 0024).

7. The proposed hospital’s primary service area will consist of six ZIP codes encompassing and surrounding Spring Hill, Tennessee. The City of Spring Hill is

contained within two of these ZIP codes. The service area is partly in Maury County and partly in Williamson County. (*Id.*, pp. 0037-38; Luke, Tr. 1647-48).

8. The hospital will be located in Maury County, close to the Williamson County line. The site is about 18 miles south of WMC in Franklin, Williamson County, and 15 miles northeast of MRH in Columbia, Maury County. WMC lies just outside the primary service area; the nearby Franklin ZIP code is in the primary service area, but a market share of only 15% is projected for SHH in that ZIP code. The ZIP code encompassing MRH is included in the primary service area, but a market share of only 5% is projected for SHH in that ZIP code. (*Ex. 27*, pp. 0024, 0037-0039).

9. Before this appeal was filed, SHH was projected to open early in 2010. (*Id.*, p. 0029).

Existing Facilities

10. MRH is the only acute care hospital in Maury County. MRH has 255 medical-surgical beds. (*Otwell*, Tr. 612).

11. MRH is in the process of tripling the size of its emergency department at a cost of \$15.5 million. (*Otwell*, Tr. 611). MRH has planned capital projects over the next five years of \$40 to \$50 million. (*Otwell*, Tr. 631).

12. James Otwell has been CEO at MRH since January 2005. (*Otwell*, Tr. 597). During his tenure, MRH's fortunes have improved. MRH's gross patient revenues have increased, while at the same time its costs have decreased. (*Ex. 102*, Moore Deposition, p. 129). Its debt-to-capitalization ratio and debt service coverage are stronger than its peers. (*Otwell*, Tr. 665). Its consultants believe it has the capacity to access \$41 million in additional debt. (*Otwell*, Tr. 666).

13. MRH has been strong financially since at least 2003. (Ex. 102, Moore Deposition, pp. 10, 52, 94-95).

14. WMC is the only acute care hospital in Williamson County, Tennessee. (Ex. 80, WMC Expansion Application, p. 111).

15. WMC is financially healthy. (Ex. 103, Webb Deposition, p. 12). WMC is currently undertaking a number of capital expenditures either renovating existing facilities, or opening new services; many of these will bring state-of-the-art services to WMC. (Klein, Tr. 775-776, 785-86, 788).

16. In 2003, WMC obtained a CON for a 40-bed expansion, with a cost of \$10.5 million. At the time of trial, those additional beds were scheduled to open fully in June 2007. The new beds will bring WMC to 180 medical/surgical beds. (Klein, Tr. 783, 793; Ex. 80, WMC Expansion CON Application).

17. WMC has never had difficulty servicing its debt, and anticipates that even with SHH it will be able to continue servicing its debt. (Klein, Tr. 816-17; Ex. 103, Webb Deposition, p. 33).

18. Both MRH and WMC have had solid net incomes, and good growth in their net assets over time. (Knapp, Tr. 1422, 1438).

19. MRH and WMC are competitors, and for several years each has explored the possibility of providing additional medical services in Spring Hill. (Otwell, Tr. 611, 668; Klein, Tr. 764; Exs. 29-32, PYA Reports; Exs. 75-78, LBMC Reports).

20. Spring Hill straddles the county line, and WMC and MRH have been wary of extending too far into Spring Hill. For example, for several years the ambulances from WMC and MRH refused to cross the county line. (Klein, Tr. 789).

21. WMC has no plans at any time to put inpatient beds in Spring Hill. (Klein, Tr. 767). Management at WMC believes that inpatient services in Williamson County should be provided at WMC's campus in Franklin. (Klein, Tr. 837).

22. Although reports prepared for MRH in August and September 2005 by Pershing Yoakley & Associates indicate the possible need for a hospital in Spring Hill, it is unlikely that MRH will be able or willing to put inpatient beds in Spring Hill before 2015. (Ex. 29, PYA August 2005 Report, pp. 13, 14; Ex. 31, PYA September 2005 Report, p. MRH 00023; Brown, Tr. 446).

Population Projections

23. Much of the evidence at trial related to and/or was dependent upon population projections for the proposed SHH service area and for Williamson and Maury Counties. The essential question was whether there will be sufficient population in 2010, when the new hospital is projected to open, and in subsequent years to support SHH as well as MRH and WMC.

24. It is undisputed that Spring Hill is a rapidly growing city. (Fox, Tr. 206; Brown, Tr. 438; Otwell, Tr. 639; Elliott, Tr. 1103; York, Tr. 1264; Cole, Tr. 1371-72). In 2000, the U.S. Census found a Spring Hill population of 7,715. (York, Tr. 1261; Ex. 144, U.S. Census Bureau Annual Estimates, p. 8). In 2005, the City conducted its own Special Census, which concluded that the population of Spring Hill was 17,325. (York, Tr. 1262). This represents a 17.6% compound annual growth rate between 2000 and 2005. (Ex. 136, RPC Report, p. 17).

25. The Special Census is the best number for the 2005 population of Spring Hill. (Fox, Tr. 236). The Special Census was properly conducted. (Swanson, Tr. 110,

116; *see also* Fox, Tr. 213). The U.S. Census Bureau has essentially accepted the 2005 Special Census as its estimate for the population of Spring Hill, and the State of Tennessee certified the Special Census after a detailed verification process. (Swanson, Tr. 147; York, Tr. 1262-63; Luke, Tr. 1671-72).

26. Although Petitioners' expert, Dr. David Swanson, attempted to cast some doubt on the accuracy of the Special Census, he did not undertake an investigation of any supposed over-count and was unable to demonstrate any specific over-count. (Swanson, Tr. 111-112, 159, 160; Luke, Tr. 1670-71). The impact of any potential over-count was more than offset by the fact that 450 households did not respond to the Special Census, and those households were not included in the Special Census count. (Dilling, Tr. 1219, 1225).

27. Although Petitioners' experts suggested that the rapid growth in Spring Hill must slow soon (Swanson, Tr. 121 - 123, 127-28; Kolb, Tr. 273), it does not appear that the growth will slow within an identifiable time frame. At the time of trial, Spring Hill was conducting another special census that was not yet complete. (Dilling, Tr. 1221, 1223). The preliminary results of that census were ruled inadmissible. (Tr. 573 - 87, 734 - 42, 984-85). With those results excluded, the only evidence in the record indicates that in 2007 the City has between 23,000 and 27,000 residents. The City Manager, Ken York, testified that in April 2007, there were 9,251 active residential water accounts, an increase of 2,350 water accounts since 2005. (York, Tr. 1263-64). At an average number of persons per household between 2.51 and 3 (York, Tr. 1263; Dilling, Tr. 1219; Brown, Tr. 438-39; Klein, Tr. 823; Ex. 31, PYA Report, p. 10; Ex. 78, WMC 1st Critical Success

Factor for Spring Hill Initial Report, p. WMC PRO 000135), Spring Hill's population would be between 23,220 and 27,753 residents.

28. The growth between 2005 and 2007 exceeds even Dr. Luke's projections. Dr. Swanson and Dr. Luke projected population by ZIP code, not for the City itself. There are two ZIP codes that encompass the City. In 2005, there were 19,265 people in the two ZIP codes who did not live in the City.² No significant population centers have been annexed to the City between 2005 and 2007. (York, Tr. 1272). If there are now 27,000 people in the City, there would be approximately 46,000 in the two ZIP codes (27,000 plus 19,000 living outside the City). If there are now 23,000 people in the City, there would be approximately 42,000 in the two ZIP codes (23,000 plus 19,000). Yet Dr. Luke projected that in 2007 there would be 36,890 residents of the two-ZIP codes. (Ex. 136, RPC Report, p. 44).

29. As both Petitioners' expert, Dr. Swanson, and SHH's expert, Dr. Luke, testified, the rate of growth in a rapidly-growing area tends to follow an S-curve, with growth accelerating ever more rapidly until the available land begins to fill up, when growth will slow significantly. (Swanson, Tr. 101; Luke, Tr. 1680-81; *see also* Ex. 114, Stall Deposition, pp. 130-33 (white hot growth areas are sustainable as long as there is land; growth may accelerate until land is gone)). Dr. Swanson gave examples of areas near Las Vegas that grew at very rapid rates of up to 183% and then slowed only after the areas filled up. (Swanson, Tr. 122-23, 152-53).

30. The City of Spring Hill is not close to filling up. There are more than 10,000 residential lots currently approved for development within the City limits, enough

² With the City population identified by the Special Census, the two ZIP codes encompassing Spring Hill had a population of 36,590 in 2005. (Ex. 136, RPC Report, p. 44). The Special Census identified 17,325 of these as City residents. (*Id.* p. 39).

to hold more than 28,000 additional residents. (Leverette, Tr. 910-11; York, Tr. 1289). These lots have waterlines and roads in place. (York, Tr. 1289). Since 2006, Spring Hill has annexed several hundred acres of vacant farmland that can now be developed. (York, Tr. 1271). There are 16,835 acres now within the City limits, enough to accommodate 111,111 total residents. (York, Tr. 1272, 1280).

31. Spring Hill therefore has currently occupied houses, houses under construction, or approved lots ready for construction that can accommodate 55,000 people.³

32. There is currently enough land within the present City limits to accommodate all but 5,000 of the 116,761 people that Dr. Luke projected would be in the two ZIP codes encompassing Spring Hill in 2014, seven years from now. (Ex. 136, RPC Report, p. 44). These 5,000 can easily be accommodated on land within the urban growth boundary. The City's urban growth boundary contains an additional 39,600 acres. (York, Tr. 1276).

33. The rapid growth of Spring Hill is fueled by a confluence of factors, including the aggressive growth strategy adopted by local officials, the availability of relatively low-cost housing compared to elsewhere in Williamson County and the greater Nashville Metropolitan area, the availability of buildable land, the quality of schools, and the proximity to commercial and employment centers made possible by major roadways such as I-65 and State Highway 840. (Elliott, Tr. 1106, 1109, 1113, 1115, 1117, 1119, 1120-21, 1122; Luke, Tr. 1675-76, 1678; Otwell, Tr. 656; Brown, Tr. 437-38). Limits on the potential for growth (such as topography, housing prices, and official anti-growth

³ 9,251 current active residential water accounts, plus 10,000 lots under construction or approved for construction, times 2.89 residents per household (Dilling, Tr. 1219) yields 55,635 people.

policies) in other areas surrounding Nashville also increase the potential for growth in the Spring Hill area. (Elliott, Tr. 1113, 1120-22, 1125).

34. The Spring Hill area has been a rural area with characteristics as a bedroom community to Nashville, where couples have moved out to Williamson and Maury Counties in search of housing within their price range. (Swanson, Tr. 147-48). The Spring Hill area is now emerging as its own community, with its own retail and employment opportunities. (Elliott, Tr. 1103, 1105).

35. Although at one time many of these new residents were young families, in recent years older people have been moving to Spring Hill. (Leverette, Tr. 901).

36. Spring Hill has a Lowe's and a Home Depot, and will soon have a 400,000 square foot shopping center anchored by the largest Super Target store in Middle Tennessee. (York, Tr. 1265-66; Cole, Tr. 1369-70). These retailers do not build unless they see sufficient rooftops and the potential for continued growth to support their outlets. (Swanson, Tr. 157; York, Tr. 1266-67). Moreover, the presence of these retail outlets will increase the attractiveness of Spring Hill as a residential community. (York, Tr. 1267).

37. Testifying for Petitioners, Dr. Swanson attempted to blunt this evidence of continued rapid growth with his own population projections for the six ZIP code Spring Hill Hospital primary service area.

38. Dr. Swanson's Report contains three scenarios, which he called his "low," "middle," and "high" scenarios. Although his report chooses the "medium" as his projection for the service area (Ex. 2, Swanson Report, p. 13), his testimony on direct

examination addressed only his “high” scenario, an indication that he himself has little confidence in either the “low” or “medium” scenarios.

39. Dr. Swanson’s “low” scenario has absolutely no credibility. That scenario is based on the Claritas estimate of the 2005 population of the service area. (Swanson, Tr. 145). Claritas estimated that the City of Spring Hill would have only 12,633 residents in 2005. (Ex. 136, RPC Report, p. 39). The U.S. Census Bureau now estimates the 2005 population of the City at 17,148. (Swanson, Tr. 147). As Petitioners’ own expert testified, the Claritas estimate “missed the mark by a relatively large amount.” (Fox, Tr. 236). Dr. Swanson himself admitted that the Claritas 2005 estimate therefore does not reflect the population of Spring Hill. (Swanson, Tr. 145).

40. Nevertheless, Dr. Swanson insisted that his “low” scenario is within the range of reason. (Swanson, Tr. 145). Such a contention, in the face of overwhelming facts to the contrary, draws into question his overall credibility.

41. Dr. Swanson’s “medium” scenario is nothing more than the average of his high and low scenarios. (Swanson, Tr. 170). It therefore also lacks credibility, since its reasonableness depends on the reasonableness of the “low” scenario. (Swanson, Tr. 171).

42. Dr. Swanson’s “high” scenario began with the population reported by the 2005 Spring Hill Special Census, and then grew that population forward to 2010 and 2015. (Swanson, Tr. 119). The growth was based on assumptions about birth rates, mortality rates, and migration rates, with migration rates being of primary importance. Dr. Swanson’s projections equated to a 3.1% compound annual growth rate for the six-ZIP code service area (Ex. 9, Kolb Report, p. 11) and 7.6% for the two ZIP codes

encompassing Spring Hill (*Id.*, p. 12). As set forth elsewhere, these projections are already behind the growth curve. (*See* ¶¶ 28, 53, 54).

43. Dr. Swanson's migration assumptions are questionable. First, his testimony at trial was inconsistent with his expert report and apparently also with his deposition testimony. (Swanson, Tr. 134, 172-73; Ex. 2, Swanson Report, p. 20). Second, his employment ratios, particularly for the Maury County side of Spring Hill, did not take into account the changing nature of northern Maury County from a rural area to a suburban area. (Swanson, Tr. 150-51; Luke, Tr. 1692-94). Third, Dr. Swanson's analysis considered only the supply side of employment, not the demand side. (Luke, Tr. 1691). Fourth, as noted in the previous paragraph, Dr. Swanson's migration assumptions have led to projections that are already below the actual rate of growth.

44. SHH called Dr. Ron Luke, of Research and Planning Consultants ("RPC"), as an expert in health planning. Dr. Luke has experience in developing demographic models. (Luke, Tr. 1598-1605; 1623-24). It is also clear from both Dr. Luke's testimony and Dr. Deborah Kolb's testimony that population projections are an integral part of health planning. (Luke, Tr. 1597-98, 1611-12, 1744; Kolb, Tr. 314).

45. Petitioners attempted to characterize Dr. Luke as a professional witness by citing his testimony regarding the applicability of the *Guidelines for Growth* in other CON cases in Tennessee. (Luke, Tr. 1775-90). Petitioners failed, however, to establish that the factual circumstances of these other cases justified a comparison to the factual circumstances of the present case. (*See* Luke, Tr. 1806-20 (discussing some of the specific circumstances of the other cases); *see also* Luke, Tr. 1824 (specific issues that parties focus on in a case can affect opinions)). In addition, as was clear from the

testimony of both Dr. Luke and Melanie Hill (Luke, Tr. 1783-84; Hill, Tr. 1232-35), the HSDA's approach to the *Guidelines for Growth* has shifted in recent years, and Petitioners failed to demonstrate that the approach at the time of the other cases justified a comparison to the present case.

46. Dr. Luke is a credible expert. In the recent past, both WMC and counsel for MRH have had sufficient confidence in Dr. Luke that they have hired him as a health planning and demographic expert. (Luke, Tr. 1625, 1779-80; Klein, Tr. 798, 826).

47. Petitioners also pointed out that Dr. Luke did not specifically visit Spring Hill before submitting his report that supported the CON application. (Luke, Tr. 1657, 1752). Dr. Luke was, however, generally familiar with the area. (Luke, Tr. 1657). Furthermore, before submitting his expert report in this case, he did become specifically familiar with Spring Hill, but he found no facts that caused him to change his population projections. (Luke, Tr. 1650-51, 1658).

48. Dr. Luke's population projections assumed that the historical 17.9% compound annual growth rate for the City of Spring Hill will continue for another seven years through 2014. (Luke, Tr. 1662, 1673). Dr. Luke projected that the two ZIP codes encompassing Spring Hill will be home to 116,763 persons in 2014. (Ex. 136, RPC Report, p. 44). As set forth above, there is more than enough land within the current Spring Hill city and urban growth boundaries to accommodate this projected population.

49. Although Dr. Swanson's report attempts to criticize Dr. Luke for using a compound annual growth rate method – rather than Dr. Swanson's own cohort component method – at trial Dr. Swanson admitted that he does not object to the compound annual growth rate method, and that his own method is generally no more

accurate. (Exhibit 2, Swanson Report, p. 10; Swanson, Tr. 167, 169; *see also* Luke, Tr. 1654-55). Dr. Swanson has no experience in CON cases and does not know what projection methods are typically used in such cases. (Swanson, Tr. 144). Typically CON cases use trend extrapolation, such as a compound annual growth rate, to project population. (Luke, Tr. 1653, 1655-56).

50. Although Dr. Swanson visited the area, he made no specific investigation of the area; in particular, Dr. Swanson did not consider the availability of buildable land or the carrying capacity of the City. (Swanson, Tr. 156). He did not talk to Spring Hill City officials. (Swanson, Tr. 157).

51. Population projections that take into account all the factors fueling growth in the Spring Hill area could have been developed in a full-blown structural model. (Swanson, Tr. 153-56). Neither Dr. Swanson nor Dr. Luke created such a model. (Swanson, Tr. 155). Without a full-blown structural model, the factors fueling growth can be considered in developing population projections. (Swanson, Tr. 155). Dr. Swanson did not consider many of these factors. (Swanson, Tr. 156-57). At Dr. Luke's suggestion, SHH tested Dr. Luke's population projections by consulting people who had specific factual knowledge of conditions in the Spring Hill area, such as Mr. Elliott, Mr. Charles, Mr. York, Mr. Cole, and Mayor Leverette. (Luke, Tr. 1659-61; *see* Luke, Tr. 1660 ("there was no way somebody coming in from another state like me [or Dr. Swanson] could possibly be as familiar with detailed subdivision patterns, with the relative attractiveness of different areas around Nashville [as the public officials and local residents would be]"). The testimony of these witnesses supported Dr. Luke's population

projections, and demonstrated that Dr. Swanson's "high" scenario is below the actual rate of population growth.

52. Since 2005, the growth rate in the Spring Hill area, especially in Maury County, has accelerated rather than leveled off. (Charles, Tr. 1554-55, 1562, 1574-75; York, Tr. 1264, 1285-86). There were 773 building permits issued in Maury County in 2005; there were 1,111 in 2006. (Charles, Tr. 1554; Ex. 133, Permits for Maury, Marshall, Bedford). Edsel Charles, who provides growth forecasts relied upon by builders and lenders across the country (Charles, Tr. 1550), conservatively predicts that the growth will continue "in a major way" for years. (Charles, Tr. 1564, 1570, 1589).

53. Petitioners' expert, Dr. William Fox, tried to dispute Dr. Luke's projections by noting that Dr. Luke's projected rate of population growth would require that 2508 people be added to Spring Hill in 2006 and in 2007. (Fox, Tr. 214). As noted above, however, the actual experience of Spring Hill indicates an even more rapid growth than Dr. Luke projected. Current active residential water accounts indicate an April 2007 Spring Hill population of between 23,000 and 27,000, which mean the population has increased by between 2,950 and 4,500 people annually since the April 2005 Special Census. (See Fox, Tr. 237-38).

54. Therefore, Dr. Luke's projections are actually below the rate of growth in Spring Hill between 2005 and 2007. Dr. Swanson's of course would be even lower than that.⁴

⁴ As noted above, Dr. Swanson's projections were by ZIP code, not for the city itself. Dr. Swanson's "high" scenario projected a 2010 total population for the two ZIP codes of 39,697. (Ex. 2, Swanson Report, pp. 39, 43). If 19,000 of these residents live outside the city limits (see footnote 2 above), then Dr. Swanson's "high" scenario projects approximately 20,000 people in the City limits in 2010.

55. The Court finds that Dr. Luke's population projections for the two ZIP codes encompassing the City of Spring Hill are well within the range of reason. Dr. Swanson's "high" projections are, at best, at the low end of the range of reason. (*See* Swanson, Tr. 146 (Q: "'I think that if the Census Bureau accepted the Special Census I would be more inclined to look at that as being more reasonable for a low scenario or some other choice.' Is that what you said?" A: "I said that."); Luke, Tr. 1698).

56. Dr. Luke and Dr. Swanson also projected population for the remaining four ZIP codes in the SHH primary service area. There was no significant disagreement between the two sets of projections, and the Court therefore finds both to be reasonable.

57. Dr. Luke also prepared population projections for Williamson and Maury Counties. (Ex. 136, RPC Report, p. 44; Luke, Tr. 1664-65). Dr. Swanson did not. The Court notes that, except for the two Spring Hill ZIP codes, Dr. Luke used the Claritas estimates and projections for the two counties, a source that the experts agreed was generally reliable outside of the Spring Hill City limits. (Swanson, Tr. 138, 145; Kolb, Tr. 314; Luke, Tr. 1656, 1664-65).

58. Dr. Swanson noted that, according to U.S. Census data between 1995 and 2000, 56% of people who moved into a house in Williamson County moved from elsewhere in Williamson County, and Dr. Swanson suggested that Dr. Luke was somehow "double counting" population growth in the counties. (Swanson, Tr. 183). Looking at the same data, Mr. Elliott concluded that "a very high percentage" of families moving to Williamson County are moving from out of state. (Elliott, Tr. 1127; *see also* York, Tr., 1286, 1287 (people are moving in from out of state)). Dr. Swanson's suggestion assumes that, when families move to Spring Hill from other parts of the

county, they leave behind houses that thereafter stand empty. There is no evidence to support this assumption, which is also counterintuitive.

59. The Court finds that Dr. Luke is qualified to project population for health planning purposes and to render opinions on such population projections. The Court further finds that Dr. Luke's population projections for the Williamson and Maury Counties are within the range of reason.

Impact – Number of Discharges

60. If SHH is built, WMC and MRH will have less business (discussed by the witnesses largely as a function of number of inpatient discharges) than they will if they remain the only hospitals in Williamson and Maury Counties. The impact of SHH cannot, however, be addressed without taking into consideration the growth in population that is occurring and will continue to occur in the hospitals' service areas, and particularly in Spring Hill. (*See* Otwell, Tr. 653-54 (recent and expected population growth will result in surge in demand for services)).

61. Dr. Deborah Kolb, Petitioners' health planning expert, prepared an impact analysis for MRH and WMC as part of her expert report. (Ex. 9, Kolb Report, at Exhibits 32 and 34). This analysis assumed a total number of discharges in the two counties based on (a) Dr. Swanson's "high" scenario population projections, (b) a constant use rate, and (c) a constant rate of out-migration from the counties to other hospital facilities. Dr. Kolb further assumed that, in allocating these discharges to WMC, MRH, and SHH, SHH would obtain the level of discharges projected by Dr. Luke. (Kolb, Tr. 322). As set forth in more detail below, these assumptions represent a worst case scenario for MRH and WMC because Dr. Swanson's population projections result in the lowest overall

discharges for the two Counties, and Dr. Luke's SHH projections result in a higher number of these discharges from SHH rather than from MRH and WMC.

62. At trial, Dr. Kolb presented an additional analysis for MRH and WMC based on the updated data contained in Dr. Luke's expert report. This analysis made the same assumptions as in her expert report, although the use rate in the new analysis was lower because Dr. Luke's expert report incorporated a lower use rate. (Ex. 11, Impact Analysis Update, pp. 23, 29; Kolb, Tr. 323-24).

63. The Court has already found that Dr. Swanson's "high" scenario population projections are, at best, at the low end of reasonable. Discharge projections based on his "high" scenario would therefore also be at the low end of the reasonable range.

64. Dr. Kolb's constant use rate assumption is reasonable. Dr. Luke made the same assumption in his utilization projections. (Luke, Tr. 1707). Dr. Kolb attempted to argue that it was also reasonable to assume that use rates would decline throughout the seven-year forecast horizon. (Kolb, Tr. 297). Yet, she believed that use rates in Tennessee have been fairly stable overall. (Kolb, Tr. 317-318). For other projects she has held the use rate constant, or projected a decline for only a few years. (Kolb, Tr. 319). In addition, she has no opinion about whether any historical decline in use rate was statistically significant, or when a decline in use rate would level off. (Kolb, Tr. 319). Dr. Luke, on the other hand, demonstrated that the recent slight decline in use rate is not likely to continue. (Luke, Tr. 1708-10; Ex. 145, Total Discharge Rates per 1,000 Population).

65. Dr. Kolb's constant out-migration assumption is conservative and tends to decrease the number of discharges from the facilities in the two Counties. According to WMC, its 40-bed expansion will likely cause out-migration from Williamson County to decline. In its CON application for that expansion, WMC predicted that its Williamson County market share would increase from 25% to 50% by 2011. (Ex. 80, WMC Expansion CON Application, p. 0097; Kolb, Tr. 320-21). WMC has already increased its market share to 38%. (Klein, Tr. 866-67; Luke, Tr. 1727-28). Since WMC is the only hospital in Williamson County, this increase in Williamson County market share represents, of necessity, a decrease in out-migration. (Kolb, Tr. 321). With the new beds that WMC is opening in 2007, out-migration is likely to further decline.

66. Dr. Kolb's assumptions in Exhibits 32 and 34 to her report (Trial Exhibit 9) and in Trial Exhibit 11 therefore represent a worst case scenario for the number of discharges at WMC and MRH.

67. Even with these assumptions, Dr. Kolb projected in her expert report that WMC will have more discharges (more patients) in every year after SHH opens than it had in 2005. (Ex. 9, Kolb Report, Exhibit 34; Kolb, Tr. 322-23). Even in her updated analysis at trial, Dr. Kolb still projected that WMC will have more discharges in every year after SHH opens than it had in 2005-2006. (Kolb, Tr. 271-72, 324; Ex. 11, Impact Analysis Update).

68. Dr. Luke agreed that, even with the Swanson population projections, which are at the low end of the range of reason, discharges at WMC will increase over 2005 levels. In 2010 WMC will have 6% more discharges than in 2005, and in 2014 will have 14% more. (Luke, Tr. 1717-18; Ex. 147, Volume Projection Comparison, p. 1).

69. WMC was strong financially in 2005 with the number of discharges it had in that year (Ex. 103, Webb Deposition, pp. 12, 33) and it will remain strong.

70. The picture is similar for MRH. Dr. Kolb projected in her report that, except for a slight dip in 2012; MRH will have more discharges in every year after SHH opens than it had in 2005. (Ex. 9, Kolb Report, Exhibit 32; Kolb, Tr. 322). In her updated analysis at trial, Dr. Kolb projected that MRH will have more discharges in every year after SHH opens than it had in 2005-2006. (Kolb, Tr. 271-72, 324; Ex. 11, Impact Analysis Update).

71. Dr. Luke agreed that, even with the Swanson population projections, which are at the low end of the range of reason, discharges at MRH will increase over 2005 levels. Even with these population projections that are at the low end of the range of reason, in 2010 MRH will have 3% more discharges than in 2005, and in 2014 it will have 6% more. (Luke, Tr. 1717-18; Ex. 147, Volume Projection Comparison, p. 1).

72. MRH was strong financially in 2005 with the number of discharges it had in that year (Ex. 102, Moore Deposition, pp. 52, 94-95, 129), and it will remain strong.

73. The impact that SHH will have on MRH is limited by MRH's location. Fifty percent of MRH's discharges come from counties south of MRH. (Otwell, Tr. 641-42). These counties are not in SHH's primary service area, and there is no factual evidence indicating that any of these patients would drive 15 miles past MRH to reach SHH. People living north of MRH already tend to travel north for their medical care (Otwell, Tr. 610; Ex. 102, Moore Deposition, pp. 118; Scarvey, Tr. 1046-47; Simmons, Tr. 1333), and so there are not a significant number of these patients that MRH would lose. Not surprisingly, MRH has a small market share in Spring Hill, which is on the

northern border of the MRH service area. (Otwell, Tr. 641; Pope, Tr. 1203; Brown, Tr. 429).

74. Deriving the number of discharges from the reasonable population projections by Dr. Luke, and assuming that SHH will receive the share of those discharges projected by Dr. Luke, MRH will have 10% more discharges in 2010 than it had in 2005. This percentage will steadily grow through 2014 to a 30% increase. (Ex. 136, RPC Report, p. 32).

75. Deriving the number of discharges from the reasonable population projections by Dr. Luke, and assuming that SHH will receive the share of those discharges projected by Dr. Luke, WMC will have 11% more discharges in 2010 than it had in 2005. This percentage will steadily grow through 2014 to a 30% increase. (Ex. 136, RPC Report, p. 32).

76. The Court therefore finds that it is reasonable to project that, even in the worst case scenario, MRH and WMC will see an increase over current discharges after SHH opens.

Impact -- Financial

77. Petitioners each presented an expert who opined that Petitioners will “lose” millions of dollars in net revenues to Spring Hill Hospital. Martin Brown testified that MRH will “lose” in excess of \$43 million to SHH over five years. (Brown, Tr. 407). Jeffrey Potter opined that WMC will “lose” almost \$19 million to SHH over five years. (Ex. 35, Potter Report, p. 20). As set forth below, however, these are not “losses” when compared to current revenues. Rather, they are simply reductions in potential future revenue increases that the hospitals would enjoy in the absence of SHH.

78. Mr. Brown testified for Petitioners that a hospital will be in dire straights if, eight years from now, it has the same number of discharges as it has now. (Brown, Tr. 409-410). As set forth above, however, SHH will not prevent either MRH or WMC from increasing their discharges even under the worst case scenario. Mr. Brown went on to suggest that hospitals must double their rates of growth in order to survive financially. (Brown, Tr. 459). This is a speculative and generalized statement that Mr. Brown made no effort to apply or analyze in the specific circumstances of MRH and WMC.

79. Clearly, Petitioners will have fewer discharges if SHH is built than if it is not. Any time a competitor hospital opens, existing hospitals will lose business and revenues to the new hospital. (Brown, Tr. 422; Potter, Tr. 502; Ex. 102, Moore Deposition, pp. 131-32; Ex. 103, Webb Deposition, p. 52).

80. If SHH is not built, discharges and revenues at the existing hospitals will increase due to the population increase. Mr. Klein, WMC's COO, acknowledged that it would make sense to net the expected financial impact of SHH against this expected increase. (Klein, Tr. 831-32).

81. The Petitioners did not offer any testimony about the effect on the Petitioners of SHH netted against the increase in population (and therefore in overall discharges in the two Counties) that is clearly going to occur. (Potter, Tr. 502; Otwell, Tr. 652; Knapp, Tr. 1425, 1428). Mr. Brown and Mr. Potter did no more than take the discharges that Dr. Kolb and Dr. Luke projected for SHH and translate those discharges into dollar amounts. (See Potter, Tr. 506 ("My calculations were a financial impact of the volume that would be lost to Spring Hill Hospital. It was not a calculation of what does Williamson Medical Center look like in the future. ... [I]ncreasing volume and

increasing admissions does not change the fact that the financial impact is \$18.8 million.”)).

82. Neither Mr. Brown nor Mr. Potter made any effort to project the financial condition of MRH and WMC, with or without SHH. (Brown, Tr. 423-24; Potter, Tr. 493, 501). They could have done so, but the Petitioners did not ask them to. (Brown, Tr. 425; Potter, Tr. 501, 506). Yet, whether the financial impact of SHH would be “material” depends in part on the overall financial condition of MRH and WMC. (Potter, Tr. 504).

83. The testimony of Rick Knapp was the only evidence offered by any party about the financial impact on MRH and WMC of the net of (1) the increase in overall discharges in the two Counties resulting from population growth and (2) the number of patients who could chose SHH rather than WMC or MRH.

84. In *voir dire* of Mr. Knapp, Petitioners established that, although Mr. Knapp’s CV states that he is a CPA in Ohio and Georgia, he is not currently licensed in either state. (Knapp, Tr. 1400-02). The Court acknowledges the error, but finds that Mr. Knapp was not attempting to deceive the Court or the parties.

85. A CPA license is not required to testify about the financial aspects of health planning. (Knapp, Tr. 1405-06). Mr. Knapp has a great deal of experience in his field, and under cross examination ably demonstrated his ability to handle whatever complex calculations might be involved in the case. (Knapp, Tr. 1395-97, 1493-94, 1496-97, 1510-11). Even if the Court were to discount Mr. Knapp’s testimony somewhat, the substance of his testimony remains uncontroverted. Moreover, Mr. Knapp’s opinions were well-supported and presented in detail. His opinions stand on their own merit.

86. Assuming Dr. Luke's projections and allocations of discharges in Williamson and Maury Counties, and assuming that Mr. Potter's per discharge revenue calculations for WMC are correct, WMC will nevertheless enjoy \$3.3 million more in operating income in 2010 than it did in 2006. By 2014, that increase is projected to grow to \$8.7 million. (Ex. 124, Impact of Market Growth and SHH; Ex. 125, Impact of Market Growth and SHH; Knapp, Tr. 1429-35).

87. Assuming Dr. Luke's projections and allocation of discharges in Williamson and Maury Counties, and assuming that Mr. Brown's per discharge revenue calculations for MRH are correct, MRH will enjoy \$15.7 million more in net income in 2010 than it did in 2006. By 2014, that increase is projected to grow to \$21.3 million. (Ex. 124, Impact of Market Growth and SHH; Ex. 125, Impact of Market Growth and SHH; Knapp, Tr. 1445-47).

88. The population growth in Maury and Williamson Counties, and the resulting increase in overall discharges within those Counties, will more than offset the financial impact caused by those patients who choose to go to SHH rather than to MRH and WMC. (Knapp, Tr. 1463).

89. The Court notes that a hospital can thrive in the face of a new competing hospital. (*See Klein*, 815-16 (you have to adjust the way you operate); Kloess, Tr. 933 (competition can be healthy, causing a hospital to improve services)).

90. In 2001, Middle Tennessee Medical Center ("MTMC"), located in Murfreesboro in Rutherford County, Tennessee, opposed a CON application filed by HCA for a new hospital (now StoneCrest Hospital) to be built in Smyrna, Rutherford County. (Ex. 99, Ferguson Affidavit ¶ 3). In opposing that application, MTMC

predicted to the HSDA that, if the new hospital was built, MTMC would suffer a 17-23% decline in admissions, resulting in a loss of some \$16 million over two years. (Ex. 99, Ferguson Affidavit, Ex. A, p. 30).

91. The CON application was granted, and StoneCrest Hospital opened in the fourth quarter of 2003. (Scarvey, Tr. 1050).

92. In 2006, MTMC filed a CON application for a replacement facility. (Ex. 99, Ferguson Affidavit, ¶ 4 and Ex. B). The application stated that “MTMC’s current facility is already bed capacity constrained, despite the opening of StoneCrest Medical Center in 2003.” (*Id.* at p. 024). The application showed that occupancy at MTMC was 73.8% in 2003, 78.2% in 2004, 76.3% in 2005, and 84.1% in 2006. (*Id.* at p. 053). The application’s historical data chart and projected data chart also showed that MTMC was projected to significantly increase its bottom line financially in spite of the opening of StoneCrest. (*Id.* at pp. 063, 065). Obviously, the opening of the new hospital did not adversely affect the existing hospital, despite dire predictions that it would.

Bed Need

93. The State of Tennessee last updated *Tennessee’s Health Guidelines for Growth* in 2000. (Hill, Tr. 1232-33; Ex. 7, Guidelines for Growth). The lack of a more recent update has been a continuing source of frustration for the HSDA and its members. (Hill, Tr. 1233-34, 1235). The Comptroller’s 2004 audit found that the State Health Planning and Advisory Board has failed to develop a comprehensive state health plan. (Hill, Tr. 1235).

94. The *Guidelines* contain a complicated bed need formula, which purports to calculate the number of beds “needed” in a county. The Tennessee Department of Health

concluded that, under the bed need formula in the *Guidelines*, both Maury and Williamson Counties are currently overbedded, and that the additional 56 beds of the SHH were therefore not “needed.” (Ex. 8, Department of Health Review, p. 8).

95. The *Guidelines* are only guidelines. Agency members consider the *Guidelines* along with other information brought to them by an applicant. (Hill, Tr. 1237).

96. WMC’s 40-bed CON application also did not satisfy the bed need formula in the *Guidelines*, but the application was granted. (Klein, Tr. 828-29, 847). WMC argued in its CON application that the bed need formula in the *Guidelines* “flies in the face of common sense.” (Ex. 80, WMC Expansion CON Application, p. 000217). Instead, WMC contended, the old bed need formula of 4 beds per 1,000 residents showed that “Williamson County is woefully under-bedded.” (*Id.*, p. 000218; Klein, Tr. 860).

97. The addition of 40 beds at WMC will not cure any “woefully” under-bedded situation. (Klein, Tr. 860).

98. WMC’s CEO and COO believe that the additional 40 beds will be sufficient to serve Williamson County for only three or four years after the beds open in 2007. (Ex. 151, Miller Comments 2-13-06; Klein, Tr. 860).

99. A hospital can be full and turning away patients at occupancy rates of 50%. (Klein, Tr. 847-48).

100. WMC’s 40-bed CON application projected that the 40 new beds would be 80% to 84% occupied in fiscal years 2007 and 2008. (Ex. 80, WMC Expansion CON Application, p. 000143). WMC projected that all 180 beds would be 81.6% occupied in 2008. (*Id.*, p. 000224; Klein, Tr. 847). WMC projected that in 2008, at 70% occupancy,

Williamson County would need 210 beds. (Ex. 80, WMC Expansion CON Application, p. 000229; Klein, Tr. 861). These predictions were made before the 2005 Special Census demonstrated the rapid growth in Spring Hill at the southern border of Williamson County. (Klein, Tr. 857).

101. The StoneCrest CON application also did not satisfy the bed need formula in the *Guidelines*, but the application was granted. (Ex. 12, Department of Health Memorandum, p. 8). After StoneCrest Hospital opened, utilization at StoneCrest was sufficient to support a bed expansion, and utilization at MTMC has been sufficient to support a replacement hospital. (Kloess, Tr. 929; Scarvey, Tr. 1051; Ex. 99, Ferguson Affidavit, ¶ 4 and Ex. B).

102. A bed-to-population ratio is used frequently in the health planning field to determine bed need. (Kolb, Tr. 326). Dr. Kolb has previously stated that 1.8 beds per 1,000 population is a “low” ratio, and has indicated that 2.1 beds per 1,000 is also low. (Kolb, Tr. 328; *see* Ex. 14, CON Application for Martin Memorial, p. DSK01345 (“Even if the proposed Satellite Hospital were in existence today, the ratio of beds to population for the county would only be 2.1 per 1,000.”)).

103. With SHH’s beds and Dr. Swanson’s “high” scenario population projections, there would be 1.9 beds per 1,000 population in 2010 in the two Counties. With SHH’s beds and Dr. Luke’s population projections, there would be 1.75 beds per 1,000 population in 2010 in the two Counties. (Kolb, Tr. 329).

104. Before HCA filed the SHH CON application, Mr. Brown and Pershing Yoakley and Associates (“PYA”) prepared a series of reports for MRH regarding the needs of the Spring Hill area. (Exs. 29-32, PYA Reports; Otwell, Tr. 663).

105. PYA concluded, among other things, that the residents of Spring Hill will need up to 60 additional beds (at 85% occupancy) by 2015. (Ex. 31, PYA 9-20-05 Report, p. MRH 00037).

106. On November 15, 2005, only five months before HCA filed the SHH CON application, Mr. Potter's employer, LBMC, performed a strategic analysis for WMC regarding, among other issues, services to Spring Hill. (Ex. 77, WMC Strategic Plan). LBMC projected that Williamson County would need additional hospital beds by 2010, and that, in addition to the 40 beds to be opened in 2007, WMC should open 60 more beds in 2010 and more beds in phases thereafter, bringing WMC to 300 beds in 2020. (Ex. 77, WMC Strategic Plan, p. WMC PRO 0123; Klein, Tr. 770, 836). There is no evidence in the record of any changed circumstances that would alter the conclusions of that report.

107. WMC's CEO believes WMC will need 300 beds by 2020. (Klein, Tr. 837).

108. Other health care companies have been eyeing Spring Hill for several years. Vanderbilt Hospital has been interested in developing services, including an inpatient facility, in Spring Hill. (Otwell, Tr. 655; Ex. 112, Rutledge Deposition, pp. 33-34).

109. WMC has no intention of placing inpatient beds in Spring Hill. (Klein, Tr. 767, 810).

110. The Court finds that, except for the bed need formula in the *Guidelines for Growth*, all evidence points to the need for additional acute care beds in Williamson and

Maury Counties, and that it is reasonable for those beds to be located at the center of the area of rapid population growth.

Access

111. Dr. Kolb believes that the function of the CON process is to balance accessibility to needed healthcare services for the public against cost effectiveness and cost efficiency. She acknowledges that cost is not the only issue to be considered. (Kolb, Tr. 313; *see also* Pope, Tr. 1201 (there can be reasons other than population, such as convenience, to establish medical services)).

112. In June 2006, Spring Hill resident Melissa Nesbitt twice spent an hour during morning rush hour trying to get to WMC while in severe pain with a kidney stone. (Nesbitt, Tr. 1162-64).

113. Spring Hill resident Angela Thompson's young son occasionally wakes up early in the morning with severely low blood sugar, when rush hour traffic can significantly slow the drive to health care in Franklin or Nashville. (A. Thompson, Tr. 1168-71).

114. Spring Hill resident Layla Thompson and her husband spent a frightening and confusing night searching for an emergency room for their severely ill baby. If there had been a hospital in Spring Hill, they would have been at an emergency room nine minutes after they left home. (L. Thompson, Tr. 1191-96).

115. Although MRH operates an urgent care center in Spring Hill, the center is open only from 8:00 a.m. to 8:00 p.m. (Pope, Tr. 1198-99). Each of the emergencies summarized above happened outside of those hours.

116. MRH opened a primary care clinic in Spring Hill in 1998, a specialty clinic in 2005, and an urgent care center in 2006. Based on the utilization of the primary care clinic, MRH concluded that a diagnostic center was needed in Spring Hill, and that opened in 2006. (Otwell, Tr. 615-19). The next logical step in Spring Hill is an emergency department, surgery services, and beds to place those patients in, all of which SHH will provide. (Scarvey, Tr. 1053-54).

117. Recruiting physicians and maintaining a good medical community is aided by having a good hospital. It would be easier to recruit physicians to Spring Hill if the community had a hospital. (Otwell, Tr. 684-85; Klein, Tr. 832; Simmons, Tr. 1334). Spring Hill currently has fewer physicians per person than Franklin, and yet even Franklin needs additional physicians. (Klein, Tr. 833).

118. The Court finds that a hospital in Spring Hill will significantly improve access to medical care, including not only emergency and acute care services but also the presence of physicians, for the citizens of Spring Hill.

Financial Projections for SHH

119. A new hospital is expected to lose money in its initial years. (Taylor, Tr. 998). A new hospital is a long term investment. (Taylor, Tr. 999).

120. SHH is projected to generate positive net income in its fourth year of operations. (Ex. 95, SHH Projected Income Statement). Its net income will improve in every year after its first year. (*Id.*).

121. Nevertheless, net income is not the appropriate line for evaluating an investment. Instead, HCA looks to cash flow, or EBITDA. (Taylor, Tr. 997). Anyone evaluating an investment from a return standpoint looks at cash flow. (Taylor, Tr. 1003).

SHH is projected to generate positive cash flow in its second year of operations, and will continue to improve thereafter. (Taylor, Tr. 997).

122. HCA is fully prepared to support SHH financially. (Kloess, Tr. 933).

123. After the appeal in this case was filed, Mr. Taylor, HCA TriStar's CFO, discovered and corrected an error in the SHH pro forma that had been filed with the CON application. This error was not material, because both before and after the correction, SHH showed a projected positive net income in the fourth year of operations. (Ex. 27, CON Application, p. 0076; Ex. 23, Updated Pro Forma).

124. To assist Mr. Knapp in preparing his expert report, Mr. Taylor prepared an updated spreadsheet, using both Dr. Luke's updated utilization projections and more recent revenues from the proxy hospitals that had supplied the underlying data for the original CON pro forma. (Taylor, Tr. 1001). This spreadsheet, which is Trial Exhibit 95 and is the most up-to-date financial projection, shows that SHH will generate positive net income in its fourth year of operations; its net income improves in every year after its first year; it will generate positive cash flow in its second year of operations; and EBITDA will improve in every year thereafter. (Taylor, Tr. 997, 1001, 1002).

125. Mr. Taylor's financial projection is somewhat conservative. It assumes 100% debt financing, but the project will not be fully debt financed. (Taylor, Tr. 1004). It contemplates less revenue per adjusted discharge than StoneCrest receives. (Knapp, Tr. 1413-14, 1505-06).

126. The Court is not disturbed that Mr. Taylor's financial projections have been modified over time. Any *pro forma* with many numbers is likely to have an error of some sort, such as the error that was corrected by Mr. Taylor in Exhibit 23. (Knapp, Tr.

1519-20). Since the projections are based on historical numbers, it makes sense to update the projections as more recent numbers become available, such as in the *pro forma* that is Exhibit 95. (Taylor, Tr. 998-99). The correction in Exhibit 23 and the update in Exhibit 95 do not materially change the CON Application. The project itself has not changed in scope. The project continues to show positive EBITDA in its second year of operation. In contrast, the need and access justifications for the project have intensified because the population has grown even more rapidly than expected.

127. Petitioners speculated that HCA will have to increase its charges in order to pay for the project. (Klein, Tr. 811). There is no factual evidence to support this speculation. Indeed, even if HCA were to increase its charges, its actual reimbursement will be dictated by government fixed rates and negotiated rates with private payors, or by HCA's generous charity care and uninsured policies. (Taylor, Tr. 1006-07; *compare* Ex. 102, Moore Deposition, pp. 66-67 and Ex. 103, Webb Deposition, pp. 57-58).

128. Petitioners suggested that the SHH projected occupancy rates of 82% by 2014 cannot be obtained. (Ex. 110, Kloess Deposition, pp. 67-68; Ex. 9, Kolb Report, p. 23). However, the evidence they cite in support of this assertion is from hospitals that are not directly comparable to SHH, a small community hospital. (Taylor, Tr. 1009). The Court also notes that the projected occupancy rate for SHH is similar to the rate LBMC projected for WMC, and similar to the occupancy rate WMC projected for itself in its expansion application. (Klein, Tr. 847, 853; Ex. 80, pp. 00133, 143, 224; *see also* Brown, Tr. 439 (70% to 85% occupancy rate is a common assumption)).

129. Even if SHH does not obtain the occupancy rates projected by Dr. Luke within the projected time frame, HCA considers the SHH a long term investment and will

continue to stand behind the hospital. (Kloess, Tr. 932; Taylor, Tr. 1000). Further, fewer patients at SHH will mean more patients at MRH and WMC, which will lessen any adverse impact on these hospitals.

130. Even if SHH does not reach the occupancy rates projected by Dr. Luke, and instead reaches a point mid-way between Dr. Luke's projections and Dr. Kolb's projections (which are based on Dr. Swanson's "high" scenario of population), SHH will still have positive EBITDA in year two of operations and thereafter. (Knapp, Tr. 1517-18; Ex. 128, Mid-Point between Kolb and RPC).

131. Dr. Kolb attempted to demonstrate that SHH will not have a positive number on its net income line even in its fifth year of operation. (Ex. 13, Spring Hill Hospital Pro Forma based on RPC Volumes). Although her demonstration used updated utilization projections from Dr. Luke's expert report, it did not also use updated revenue projections that were available from Mr. Knapp's expert report. (Kolb, Tr. 309; Ex. 13, Spring Hill Hospital Pro Forma based on RPC Volumes; Knapp, Tr.1451-54; Ex. 127, Kolb's Restated SHH Pro Forma). Her demonstration therefore does little to establish a financial picture for SHH. If she had used the updated financial information as well as the updated utilization projections, her results would have been almost identical to Mr. Taylor's. (Knapp, Tr. 1454; Ex. 127).

132. HCA would not propose to build a hospital that would lose over \$11 million in its first five years, and HCA has the financial wherewithal to fund the hospital. (Kolb, Tr. 324; Brown, Tr. 429; Taylor, Tr. 1000).

CONCLUSIONS OF LAW

1. This contested case was initiated and held before an Administrative Law Judge sitting without the Agency pursuant to Tennessee Code Annotated 68-11-1610. As a proceeding convened by the Agency, this contested case is a *de novo* hearing. *Big Fork Mining Company v. Tennessee Water Quality Control Board*, 620 S.W.2d 515, 521 (Tenn. Ct. App. 1981).

2. Petitioners have the burden of proving, by a preponderance of the evidence, that the proposed project does not satisfy one or more of the three controlling statutory criteria set forth in the first sentence of Tennessee Code Annotated 68-11-1609(b) as follows:

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 and/or services.

This section of the statute goes on to state that, in the absence of a state health plan, the agency shall use as guidelines criteria prescribed by the rules of the agency. *Id.*

Necessary to Provide Needed Healthcare in the Area to be Served

3. There is ample evidence that the proposed SHH is needed to meet health care needs in the area to be served, and Petitioners have failed to show by a preponderance of the evidence that it is not.

4. Pursuant to Rule 07-20-11-.01(1) of the Rules of the Tennessee Health Services and Development Agency, the need for the SHH may be evaluated based on 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 accessibility to consumers, particularly women, racial and ethnic minorities, and low-income groups;
- (f) Comparison of utilization/occupancy trends and services offered by other area providers; and
- (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.

Petitioners attempted to attack the SHH CON application only as to subsections (b) and (c) of this Rule. In particular, the Petitioners asserted that there would not be sufficient population in the proposed service area to support SHH as well as Petitioners.

5. The population to be served by the proposed SHH is primarily within the six ZIP codes encompassing and surrounding the City of Spring Hill, and especially the two ZIP codes encompassing Spring Hill. The only credible evidence submitted by Petitioners regarding this population was Dr. Swanson's testimony about his population projections. The Court has found that these projections are at the low end of reasonable, and that Dr. Luke's projections for the ZIP codes are also within the range of reason.

6. There are currently no acute care hospital facilities within the two ZIP codes encompassing Spring Hill, a rapidly growing area within Williamson and Maury Counties. MRH and WMC have no plans to establish any such facilities within Spring Hill. WMC is particularly adamant that no such facilities are needed, in spite of the long drive times from Spring Hill to WMC. It is unusual for patients to travel south to MRH.

This effectively leaves Spring Hill, which comprises much of the population to be served by SHH, without ready access to a hospital. The absence of a hospital in Spring Hill also reduces the likelihood that physicians will locate offices in the community, which further reduces the access for this population to health care services.

7. The State Health Plan states that “preference should be given to patient accessibility, availability, and affordability needs when making a certificate of need determination” (Ex. 7, State Health Plan, p. 5). Accessibility is clearly a current problem for the citizens of Spring Hill. This problem will be addressed by the proposed hospital.

8. Dr. Luke projected that the two ZIP codes will have a population of 60,372 by 2010 and 116,761 by 2014. Dr. Luke projected that the six ZIP codes, which include the already populous cities of Franklin and Columbia, will have a population of 170, 522 by 2010 and 235,382 by 2014. He further projected that Williamson and Maury Counties will have a combined population of 283, 222 by 2010 and 359,493 by 2014. Petitioners have failed to demonstrate by a preponderance of the evidence that these population projections are not within the range of reason.

9. Given the reasonableness of Dr. Luke’s population projections, the Court concludes that there will be a need for a 56-bed community hospital in Spring Hill by 2010. This conclusion is bolstered by the work of Mr. Stall, which reached essentially the same conclusion, by the work performed by PYA for MRH, and by WMC’s bed need projections in its 40-bed expansion CON application.

10. Although WMC’s witnesses clearly would like any additional beds in Williamson County to be located on WMC’s campus in Franklin, a further expansion at

WMC would do little to help the citizens of Spring Hill, who already face long drive times to WMC.

11. It is not significant in this case that 56 beds in Spring Hill would not satisfy the bed-need formula set forth in the *Guidelines for Growth*. The formula is a guideline only, and has not been updated since 2000. By a beds-per-thousand method of calculating bed need, Williamson and Maury Counties remain under-bedded.

Economically Accomplished and Maintained

12. Petitioners have failed to demonstrate by a preponderance of the evidence that SHH is not financially feasible. In fact, the overwhelming weight of the evidence, as set forth in the findings of fact above, shows that SHH will be economically feasible when it is evaluated under the criteria of Rule 0720-4-.01(2).

13. Pursuant to Rule 0720-11-.01(2), the economic feasibility of SHH may be evaluated based on 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;
- (f) The availability of less costly or more effective alternative methods of providing the benefits intended by the proposal.

Petitioners attacked SHH primarily with respect to subsections (c) and (f), contending that the funds spent on the hospital could be recouped only by higher charges, and that,

without spending the funds to build a new hospital, MRH and WMC could provide the needed healthcare for the citizens of Spring Hill.

14. There is no evidence to support the contention that funds spent on the hospital can be recouped only through higher charges. Charges cannot be unilaterally set by a hospital. Instead, charges are largely a matter of government dictate and contractual negotiation. All evidence is that HCA has the wherewithal to build the hospital even within these constraints.

15. Nor can MRH and WMC provide comparable services to the citizens of Spring Hill. The evidence is clear that even now, few citizens of Spring Hill choose to go to MRH; instead, patients tend to travel north for their healthcare needs. Yet, during peak traffic times, it can take an hour to drive from Spring Hill to WMC.

16. Petitioners also attempted to demonstrate that SHH will not have a positive net income within the five-year planning horizon. This is not a criteria listed in the statute or the Rule. Furthermore, all evidence demonstrates that SHH will have increasing EBITDA and net income in every year; that SHH will have positive EBITDA in year two; and that SHH will have positive net income in year five. A new hospital is expected to lose money initially, and there is no doubt that HCA can support SHH until it is able to support itself.

**Contribution to the Orderly Development
of Adequate and Effective Health Care Facilities and/or Services**

17. The Petitioners have failed to demonstrate by a preponderance of the evidence that SHH will not contribute to the orderly development of adequate and effective health care facilities and/or services. Moreover, the overwhelming weight of

the evidence in this proceeding, as set forth in the findings of fact above, shows that SHH will improve access to healthcare without at the same time having any adverse impact on Petitioners.

18. The criteria set forth in Rule 0720-11-.01(3) for determining whether or not SHH will contribute to the orderly development of adequate and effective health care services are as follows:

- (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; and
- (d) The quality of the proposed project in relation to applicable governmental or professional standards.

Petitioners attacked the SHH application only with respect to (b), contending that MRH and WMC would be unable to continue to provide services if they lost discharges to SHH.

19. It is undisputed that if Spring Hill has no hospital, the existing hospitals, MRH and WMC, will have more patients than they would if Spring Hill has a hospital. Patients from Spring Hill have to be treated somewhere. It is also undisputed that, as the population in Maury and Williamson Counties increases, there will be a need for additional hospital services. The issue before the Court, therefore, is not whether additional hospital services will be needed in these two counties, and not whether, in the absence of a new hospital, the existing hospitals would grow more rapidly. Rather, the issue here is whether the impact that the new hospital in Spring Hill will have on WMC

and MRH would be inconsistent with the statutory and regulatory criteria when weighed against the benefits that a new hospital would bring.

20. There is no evidence in this case that SHH would have a material negative impact on MRH and WMC, even under the worst case scenario where (a) the population grows at the rate projected by Dr. Swanson and (b) SHH pulls the number of discharges from WMC and MRH projected by Dr. Luke. Petitioners' own expert, Dr. Kolb, demonstrated that under these facts, both WMC and MRH would have more discharges in every year after SHH opens than they had in 2005, a year in which both hospitals were financially healthy. Mr. Knapp testified, without contradiction, that the net of the population growth against the impact of SHH results in millions of dollars of increased revenues for MRH and WMC.

21. Although Petitioners contended that a competitor hospital would prevent them from growing their discharges, and that growth was necessary to their survival, they failed to demonstrate how Dr. Kolb's worst-case projections fell short of their purported need for growth, and failed to demonstrate any negative net financial impact resulting from SHH. The only evidence of the financial impact on Petitioners was the testimony of Mr. Knapp, who demonstrated that Petitioners' net income will improve by millions of dollars over 2005 levels in every year after SHH is built.

Public Policy Reasons for the Decision

22. Tennessee Code Annotated § 68-11-1625 declares that it is the policy of the State of Tennessee that

(1) Every citizen should have reasonable access to emergency and primary care; [and] (2) The state's health care resources should be developed to address the needs of Tennesseans while encouraging competitive markets,

economic efficiencies and the continued development of the state's health care industry

Also, the philosophy of the former Health Planning Commission, which is included in the *Guidelines for Growth*, states that

[t]he HPC feels that preference should be given to patient accessibility, availability, and affordability needs when making a certificate of need determination of establishment, relocation, replacement, or discontinuation of health care institutions or services.

The residents of the rapidly-growing City of Spring Hill are entitled to the same access to health care, including acute hospital care and emergency care, as the citizens of Franklin and Columbia, where WMC and MRH are located. Further, it is clear that the growth in population in the area can reasonably be expected by 2010 to create occupancy levels that require WMC and MRH to turn away patients at peak times, as WMC was forced to do on several occasions before its 40-bed expansion. This will create access problems for all citizens of Williamson and Maury Counties.

23. Tennessee Code Annotated § 68-11-1603 states:

It is declared to be the public policy of this state that the establishment and modification of health care institutions, facilities, and services shall be accomplished in a manner that is orderly, economical and consistent with the effective development of necessary and adequate means of providing for the health care of the people of Tennessee. To this end, the provisions of this section shall be equitably applied to all health care entities, regardless of ownership or type, except those owned and operated by the United States government.

(emphasis added). WMC and MRH are publicly-owned hospitals, but this does not entitle them to special consideration.⁵ Nothing in the statutes, the regulations, the rules, or the *Guidelines* purports to protect WMC and MRH from competition, to assist them in

⁵ HCA is no less a valued corporate citizen in Tennessee, paying \$40 million annually in state and local taxes, donating millions annually to charities, providing millions of dollars for public interest projects, and serving a large portion of TennCare patients. (Kloess, Tr. 921-23, 927).

maximizing their net income, or to assist them in continuing to serve as the sole source of hospital services in their respective counties.

Costs of the Proceeding

24. Pursuant to Tennessee Code Annotated § 68-11-1610(i), “all costs of the contested case proceeding, including the administrative law judge’s costs and deposition costs such as expert witness fees, shall be assessed against the losing party in the contested case.” The Petitioners, MRH and WMC, are the losing parties in this contested case.

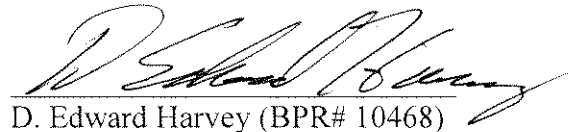
Accordingly, **IT IS HEREBY ORDERED THAT** Certificate of Need Application # CN0694-028 filed by Spring Hill Hospital, Inc. for the establishment of a 56-bed acute care hospital in Spring Hill, Maury County, Tennessee is hereby **GRANTED**, on the grounds that the Petitioners have failed to prove by a preponderance of the evidence that the facility is not needed, that it is not economically feasible, or that it will not contribute to the orderly development of adequate and effective health care services in the area.

IT IS FURTHER ORDERED that all of the costs of this contested case proceeding, including the administrative law judge’s costs, deposition costs, and expert witness fees, are assessed equally to, and shall be paid by, the Petitioners MRH and WMC.

So **ORDERED** this _____ day of _____, 2007.

Leonard F. Pogue, III
Administrative Law Judge

Respectfully Submitted,



D. Edward Harvey (BPR# 10468)
Jerry W. Taylor (BPR# 9662)
FARRIS, MATHEWS, BRANAN,
BOBANGO, HELLEN & DUNLAP, PLC
618 Church Street, Suite 300
Nashville, TN 37219
(615) 726-1200

Kathryn A. Stephenson (BPR #13430)
TRAUGER & TUKE
The Southern Turf Building
222 Fourth Avenue North
Nashville, TN 37219-2117
(615) 256-8585

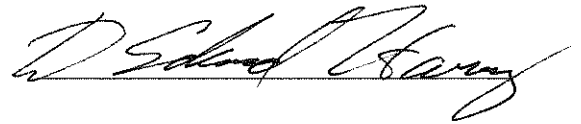
CERTIFICATE OF SERVICE

I certify that a copy of the foregoing has been served on the following by email on this the 16 day of August 2007:

G. Brian Jackson
Miller & Martin, PLLC
150 Fourth Ave., North, Suite 1200
Nashville, TN 37219

Charles E. Young
Kramer Rayson LLP
800 S. Gay Street
Knoxville, TN 37929

James B. Christoffersen, Esq.
Deputy General Counsel
Tennessee Health Services and Development Agency
Suite 850
500 Deaderick Street
Andrew Jackson Building
Nashville, Tennessee 27243

A handwritten signature in black ink, appearing to read "D. Samuel Harvey", is written over a horizontal line.