

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

IN THE MATTER OF:

SPRING HILL HOSPITAL, INC.

DOCKET NO: 25.00-092967J

PETITIONERS' PROPOSED FINDINGS OF FACT AND CONCLUSIONS OF LAW

Petitioners Maury Regional Hospital (“MRH”) and Williamson Medical Center (“WMC”) submit the following proposed Findings of Fact and Conclusions of Law.

The Parties

A. Petitioner Maury Regional Hospital

1. Petitioner MRH is a public non-profit facility formed by Private Act of the Tennessee General Assembly in 1949 to provide health care services. MRH’s central campus in Columbia is anchored by a 255-bed acute care hospital. This hospital serves eight counties in southern Middle Tennessee with a combined population of approximately 250,000. As a public hospital affiliated with Maury County, MRH has a responsibility to treat all patients, regardless of their ability to pay.

2. With a medical staff of approximately 170 physicians, MRH provides vital health care services to medically underserved areas and to patients with limited financial resources. MRH operates a primary care clinic on its main campus that treats more than 40,000 patients annually, of whom more than 50% are TennCare patients or are uninsured. In addition to its main hospital in Columbia, MRH operates Marshall Medical Center in Lewisburg, Wayne Medical Center in Waynesboro and the Lewis Ambulatory Care Center in Hohenwald. All three

of these facilities are located in outlying rural counties with a particularly high percentage of residents who are uninsured or are TennCare patients. Before MRH committed to operating these facilities, residents of Wayne, Lewis and Marshall Counties had difficulty accessing medical care.

3. Spring Hill is a Maury County municipality. MRH operates facilities and programs in Spring Hill to address the health care needs of area residents. MRH has expanded its services over the years as Spring Hill has grown from a very small village to its present size. For example, MRH constructed a primary care facility in 1998, and expanded that facility in 2004; opened a specialty care facility in 2005 providing ENT, Gastroenterology, Orthopedic, Cardiology, Obstetrics/Gynecology and Podiatry services; and constructed an outpatient diagnostic imaging center in 2006, pursuant to a Certificate of Need (“CON”) issued by the Health Services and Development Agency (“HSDA”). To date, MRH has invested more than \$6.2 million in direct construction and expansion costs in bringing these medical services to Spring Hill.

4. In addition to investing \$6.2 million in providing health care to the Spring Hill community, MRH has carefully considered and evaluated whether there is a need for any additional patient services in Spring Hill, including an examination of whether there is any need for an hospital. In fact, in the summer and fall of 2005, MRH engaged Pershing Yoakley & Associates to evaluate the health care needs of the Spring Hill community. (Tr. 389-91.) This evaluation concluded that a full service hospital was not needed in Spring Hill. (Tr. 397-988.)

5. The Mayor of Spring Hill, Danny Leverette, testified that he had no reason to believe that MRH has ever failed to address the health care needs of his community. (Tr. 906.)

This testimony is supported by the evidence showing that MRH has a long history of providing medical services to the Spring Hill community.

B. Petitioner Williamson Medical Center

6. Petitioner WMC is a publicly owned, not for profit hospital located in Franklin, Tennessee. Founded in 1957 as a Hill-Burton facility, WMC has grown into a hospital offering comprehensive in-patient and out-patient services. As a county-owned hospital, WMC has a responsibility to treat the citizens of Williamson County, regardless of their ability to pay.

7. More than 350 physicians practice at WMC, representing 39 medical specialties. WMC participates in all TennCare plans available in the service area and also participates in Cover Tennessee. WMC provides a full-time family physician for Williamson County Health Department patients in Franklin and a part-time physician for patients in Fairview.

8. WMC recently completed \$83 million in additions and renovations to its facilities, including the addition of 40 medical/surgical hospital beds, which increased its licensed beds from 145 to 185. All of these additional beds became fully staffed and operational in July 2007.

9. In seeking and obtaining a CON for each of the projects that comprised its recent growth and \$83 million investment in the health care needs of its service area, WMC addressed the rapidly growing population of Williamson County, including Spring Hill. In addition, WMC has evaluated the need for additional medical services in Spring Hill, including a hospital. In Summer 2005, WMC engaged health care consultants Lattimore, Black, Cain and Morgan (“LBMC”) to evaluate such health care needs. (Tr. 766-67.) LBMC’s evaluation concluded that a hospital was not needed in Spring Hill. (Tr. 767; Tr. Ex. 76, WMC Strategic Plan 2005.)

10. WMC obtained assistance from Williamson County to fund its expansion projects, which had a combined cost of \$83 million. The original amount of revenue bonds

issued by Williamson County on behalf of WMC was \$30 million, but the County also gifted \$20 million to WMC's expansion projects in the form of general obligation bonds, which are backed by the full faith and credit of the municipality issuing them. WMC borrowed an additional \$10 million on its own, and the remaining \$23 million was taken from WMC's operations and cash reserves. (Tr. 535; Tr. Ex. 49, Webb. Aff.)

11. The majority of Spring Hill residents live in Williamson County. However, Spring Hill officials have never approached WMC about providing different or additional medical services in Spring Hill. (Tr. 915.)

C. Respondent Spring Hill Hospital

12. Respondent Spring Hill Hospital, Inc. is a wholly-owned subsidiary of Hospital Corporation of America, Inc. ("HCA"), the nation's largest for-profit hospital company. HCA owns and/or operates 182 hospitals and 94 outpatient surgery centers in 22 states, England and Switzerland. HCA operates several hospitals in the Nashville area through its local division, Tri-Star Health System ("HCA/TriStar").

HCA's CON Application and the HSDA's Decision

13. HCA proposes to construct and operate a new 56-bed hospital in Spring Hill, Tennessee at a total initial cost of approximately \$110 million. It filed a CON application for the project in April 2006. (Tr. Ex. 27, Spring Hill Hospital CON Application.)

14. The proposed Spring Hill Hospital ("SHH") would be located in Maury County, approximately 14 miles from the main campus of MRH in Columbia and approximately 17 miles from WMC's main campus in Franklin. The proposed hospital would offer only basic medical-surgical and obstetrical services; SHH would not offer any tertiary level services. (Tr. Ex. 27, SHH App., p. 5.) For example, SHH would not have a neonatal intensive care unit or perform

open heart surgery. Such complex medical treatments would have to be handled at MRH, WMC or the various tertiary care hospitals located in Nashville.

15. The HSDA considered HCA's CON application on July 26, 2006. MRH and WMC filed timely written objections to HCA's CON application pursuant to Tenn. Code Ann. § 68-11-1607 and then appeared at the HSDA hearing in opposition to the application. After hearing presentations from the applicant and opponents for 30 minutes per side, then hearing public comments, the HSDA voted to approve HCA's application. MRH and WMC subsequently initiated this contested case proceeding. After extensive pretrial discovery, the case was heard beginning on April 11, 2007. In all, the Court heard approximately two weeks of testimony and argument.

16. At the hearing, the Petitioners offered testimony from the following witnesses: David Swanson, Ph.D; William Fox, Ph.D.; Deborah Kolb, Ph.D.; Robin Gage (by deposition); Tim Scarvey (by deposition); Chris Taylor (by deposition); Martin Brown, C.P.A.; Jeffrey Potter, C.P.A.; Larry Kloess (by deposition); Ed Stall (by deposition); Robert Otwell; Paul Rutledge (by deposition); Ron Luke, Ph.D. (by deposition); Phyllis Brown (by affidavit); Dustin Flowers (by affidavit); Byron Quinton (by affidavit); Bob Phillips (by affidavit); Trent Ogilvie (by affidavit); Waymon Hickman (by affidavit); Dennis Miller (by affidavit); Don Webb (by affidavit); Allen Lovell (by affidavit); Jacqueline Stafford, M.D. (by affidavit); Starling Evins , M.D. (by affidavit); and Rodger Klein. The Respondent offered testimony from the following witnesses: Daniel Leverette; Larry Kloess; Chris Taylor; Tim Scarvey; Larry Moore (by deposition); Don Webb (by deposition); Preston Elliott; Melissa Nesbitt; Angela Thompson; Jennifer Scott; Layla Thompson; Charles L. Pope; Bradley Dilling; Melanie Hill; Kenneth C. York; John O. Simmons, M.D.; Craig Cole, Rick Knapp; Edward Hickman; Edsel Charles; Ron

Luke, Ph.D.; Gordon Ferguson (by affidavit); Ed Stall (by affidavit); Rebecca Sharber (by affidavit); and Dennis Miller (by deposition). The Court personally observed the live witnesses and heard their testimony to make determinations about the credibility of each witness and the proper weight to afford his or her testimony. These findings of fact take into account the Court's conclusions about the credibility of each witness. Where contradictory evidence was introduced through different witnesses, the Court has relied in part on its credibility assessment to determine the weight that should be afforded to each version of events.

Contested Case – Purpose and Process

17. The purpose of this contested case is to determine whether SHH satisfies the criteria for a Certificate of Need set forth in Tenn. Code Ann. § 68-11-1609(b) and in Rules 0720-11-.01(1)-(3) of the HSDA. The general criteria of need, economic feasibility, and orderly development of health care are discussed below in more detail.

18. This tribunal is charged with making the determination de novo. In making its determination, this tribunal sits for and on behalf of the HSDA. (Tenn. Comp. R. & Regs. R. 0720-6-.02.) With respect to this proceeding, the sole effect of the HSDA's initial vote to approve HCA's application is to allocate the burden of proof in the contested case. Because the HSDA voted to approve HCA's application, MRH and WMC have the burden of proof here. Otherwise, this tribunal independently evaluates the proposal at issue without taking into account or assigning any weight to the HSDA's initial vote.

19. The purpose of the contested case process is to allow a more detailed examination of a proposed project and to explore fully the issues and matters in controversy. By necessity, the HSDA's review of applications is limited in scope. In light of time constraints and resource limitations, it is not possible for each and every application to be subject to an extensive hearing.

In the present case, at its public meeting, the HSDA heard approximately one hour of unsworn statements from the parties and parties' counsel, as well as public comments. The Petitioners had no opportunity to conduct discovery before the meeting, nor did they have the ability to cross-examine any of the speakers.

20. In contrast with the initial review by the HSDA, this tribunal has had the benefit of extensive sworn testimony received through an adversarial proceeding. The Court has heard sworn testimony from 43 witnesses. One hundred fifty-one exhibits have been received into evidence. This tribunal has the benefit of a vast amount of information that was not available to the HSDA at the time of the initial application and meeting.

21. Further, a CON application should be revoked if it is determined that the HSDA's initial decision to grant the application "was based, in whole or in part, on information or data in the application which was false, incorrect, or misleading, whether intentional or not." Tenn. Code Ann. § 68-11-1619(3).

Tennessee CON Process – Background, Purpose and Policy

22. Beginning in the 1970s, the federal government urged states to control rising health care costs by using health planning to manage the escalating growth of health care services and facilities. To this end, in 1973, the Tennessee General Assembly enacted legislation creating the Tennessee Health Facilities Commission (the "Commission") and Tennessee's CON process. *See East Tenn. Health Improvement Council, Inc. v. Tennessee Health Facilities Comm.*, 626 S.W.2d 272, 274 (Tenn. Ct. App. 1981); *see also* Tennessee Health Services and Development Agency website, "Certificate of Need Program," § I, "CON History," *available at* <http://www.state.tn.us/hsda/>.

23. Approximately 35 states, including Tennessee, use CON processes to regulate capital expenditures on health care facilities. The Tennessee Legislature reaffirmed the State's commitment to the CON program as recently as 2002, when it enacted the "Tennessee Health Services and Planning Act of 2002," Tenn. Code Ann. §§ 68-11-1601 to 1627 ("Health Planning Act of 2002"). This law made few substantive changes in the CON law, although it did replace the Commission with a newly-constituted HSDA.

24. In the Health Planning Act of 2002, the Legislature also stated that it is the "declared... 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." *Id.*

CON General Criteria and Guidelines for Growth

25. The Tennessee Legislature has adopted three primary criteria that must be considered in determining whether a CON should be granted:

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.

Id. § 68-11-1609(b). HCA's application can be approved only if it satisfies all three criteria. Put differently, if the Petitioners have demonstrated that the project fails to satisfy any one of the three general criteria, the CON must be denied.

26. In addition to the three general criteria, the HSDA is directed to consider the State Health Plan:

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.

Id. The “current criteria and standards” referred to in the statute are set forth in a publication entitled *Guidelines for Growth* (2000 ed.) (the “*Guidelines*”) which incorporates the three general statutory criteria of need, economic feasibility and contribution to the orderly development of health care. (Tr. Ex. 7, *Guidelines for Growth*.) *Guidelines* contains additional considerations for the HSDA stemming from the three general criteria. The HSDA is also authorized to create additional criteria for consideration in its Rules, which are set forth in Tenn. Comp. Rules & Regs 0720-4-01. Tenn. Code Ann. § 68-11-1609(b).

27. *Guidelines* sets forth a specific methodology for determining need for many types of health care services, including acute care hospital services. The *Guidelines* need formula for acute care hospital beds is calculated by county and takes into account patient migration patterns. (Tr. Ex. 7, *Guidelines*.)

28. *Guidelines* contains an exception under which new acute care beds can be approved even where the bed need formula shows no need for additional beds. For this exception to apply, however, all existing hospitals within the service area of the proposed new beds must have an occupancy level of 80 percent or higher, and all outstanding CON projects for new beds in the service area must be licensed and operational. These criteria have not been demonstrated here, however, so this exception to the general rule does not apply.

29. There is also special consideration given to acute care bed proposals for specialty units in tertiary referral hospitals; however, SHH will not be such a hospital so this exception to the general rule also does not apply.

30. In this contested case, evidence has been presented showing that there is strong support for SHH among several residents of the Spring Hill area. Construction of a new hospital in Spring Hill is viewed by many as an important amenity for a growing town and a boost to the local economy. Such civic pride and boosterism, while certainly admirable and understandable, cannot substitute for the statutory criteria. The tribunal is charged with deciding this matter according to the criteria adopted by the Legislature. Community support and enthusiasm or economic development may not be considered in determining whether a CON should be granted.

Need for HCA's Proposed Spring Hill Hospital

A. Need Analyses in Spring Hill Before the SHH CON Application

31. In 2004, HCA considered developing health care services in southern Williamson County. Working with Vanderbilt University Medical Center ("VUMC"), HCA commissioned an assessment of the area's health care needs from Ed Stall, a health planning consultant regularly engaged by HCA to analyze the need for new facilities and services. (Tr. 1038.)¹ Stall was an experienced health care consultant who had worked for HCA on many occasions in connection with HCA's strategic planning, including market feasibility studies and market projections for future health care needs. (Tr. Ex. 114, Stall Dep. at 19-20.)² Stall's work for HCA in the past had included evaluation of whether new or replacement hospitals were needed in various markets. (Stall Dep. 27-28.) Stall's 2004 report concluded that the Spring Hill area did not yet need a hospital, and the HCA/VUMC endeavor ended. (Tr. Ex. 18, Stall 2004 Report.)

¹ HCA executive Tim Scarvey insisted that Stall was not typically employed by HCA to project future health care needs, but rather was typically used "for hindsight analysis of trends" that had already taken place. (Tr. Ex. 113, Scarvey Dep. 198)) However, Stall contradicted this assertion in his own testimony and explained that HCA frequently retained him to perform such analyses. (Tr. Ex. 114, Stall Dep. 31-34.) Moreover, Scarvey himself admitted that in this case, Stall was specifically retained to perform projections. (Tr. Ex. 113, Scarvey Dep. 198.)

² The court reporter did not transcribe the video deposition excerpts that were played at the hearing; however, each corresponding portion of the deposition was made a trial exhibit.

32. HCA and Vanderbilt were not the only health care providers evaluating the Spring Hill area during this period to determine whether additional services were needed. In 2005, WMC hired consultants to analyze the need for medical facilities in Spring Hill. (Tr. 533.) Additionally, in May 2005, HCA officials met with WMC officials at Centennial Medical Center and discussed the lack of need for a hospital in Spring Hill. (Tr. 533.)

33. MRH conducted its own evaluation of Spring Hill's health care needs in 2005. MRH retained the firm of Pershing, Yoakley & Associates, P.C. ("PYA") to perform a high-level analysis of the Spring Hill marketplace to determine whether there might be a need for additional MRH facilities or services. (Tr. 389-90; Tr. Ex. 55, PYA Report.) With respect to whether a new hospital was needed in Spring Hill, the 2005 MRH analysis concluded that such a facility would not be needed or feasible in the near or intermediate term. (Tr. 397-98.) This analysis also concluded that, if another health care provider were to construct a hospital in Spring Hill, the impact on MRH would be devastating. (Tr. 401-02.)

34. In the Fall of 2005, a Spring Hill real estate developer named Rick Dickson contacted HCA and invited its executives to a meeting in Spring Hill with local officials. At that meeting, held on November 1, 2005, Dickson promoted the idea of HCA offering health care services in the city, including possibly a hospital. (Tr. 888-89, 902-03.) The Spring Hill City officials present at the meeting had no background or expertise in health care and had not conducted any research or retained or consulted with any health care expert to advise the City on whether a new hospital was actually needed in Spring Hill and/or whether HCA was the best company to solicit for such an endeavor. (Tr. 903-05.) Neither WMC nor MRH was ever invited to a similar meeting with City officials, and, in fact, City officials never considered arranging such a meeting with MRH and WMC. (Tr. 905). At the November 1 meeting, the

City officials presented a slide show highlighting, among other things, that there are many young and insured families in the Spring Hill area. (Tr. Ex. 110, Kloess Dep. 106.)

35. A few weeks after HCA and Spring Hill officials met, HCA requested that its longtime consultant Ed Stall update his 2004 analysis of the need for health care services in Spring Hill. (Tr. 1060.) Stall performed a bed need analysis of the area and summarized his work in a second report. (Tr. Ex. 114, Stall Dep., 80) This 2006 report again concluded that Spring Hill did not yet need a hospital. (Tr. Ex. 19, Stall 2006 Report.) Stall, who was not called by HCA to testify at the hearing, is the only expert not hired for litigation purposes to have analyzed this project for HCA. In both 2004 and 2006, Stall concluded that there was no need for a hospital in Spring Hill. (Tr. 1061.) Stall's conclusion concurred with that of the independent analyses performed by WMC and MRH, all of which concluded that, while the area might one day need a new hospital, it did not need one at the present time.

36. After conceding that there was no need for a hospital in Spring Hill, and submitting his conclusions to HCA, Stall never heard back from anyone at HCA about the Spring Hill project. (Tr. Ex. 114, Stall Dep. 149.) Stall's reports were neither referred to in the HCA CON application nor revealed by HCA until the discovery process in this contested case. (Tr. Ex. 27, SHH App.) Stall testified that he was willing and qualified to do additional analysis of the Spring Hill proposal, and that he has no understanding of why he was not asked to do further work on the project. (Tr. Ex. 114, Stall Dep. 149.)

37. Tim Scarvey, an HCA executive who was the "point person" on this project, testified that he disagreed with Stall's conclusion that no hospital was needed in Spring Hill in 2010. (Tr. Ex. 113, Scarvey Dep., 64-65.) According to Scarvey, "further analysis from an expert" revealed that there was in fact a need for a hospital in 2010. (Tr. Ex. 113, Scarvey Dep.

64.) However, as discussed below, the proof clearly demonstrated that no other expert was retained by HCA to evaluate health care needs in Spring Hill until after HCA had made the decision to seek approval for a new hospital.

38. Larry Kloess, the President of HCA/TriStar, was the person at HCA who directed that Stall be retained to update his 2004 analysis. (Tr. Ex. 110, Kloess Dep. 76.) Kloess had worked with Stall over the years and knew he was someone HCA relied on for consulting advice. (Id.) Unlike Scarvey, Kloess could not identify any deficiencies with Stall's work and further could not recall anyone at HCA ever expressing the opinion that there was something wrong with Stall's analysis. (Tr. Ex. 110, Kloess Dep. 78.)

39. In addition to relying on outside consultants such as Stall to evaluate proposed new facilities, HCA has an internal review process called the Capital Assets Management System ("CAMS") which prepares internal financial analyses for capital investments for use by HCA's senior management. (Tr. Ex. 115, Taylor Dep. 98.) HCA consultant Stall testified that HCA's internal review process meant that a proposal such as the SHH project would typically be "very, very scrutinized." (Tr. Ex. 114, Stall Dep. 155.) However, HCA did not begin the CAMS review process for SHH until after it had filed an application for a CON and after the HSDA's initial vote of approval. (Tr. Ex. 115, Taylor Dep. 97-98.) Moreover, even though a CAMS analysis is "standard operating procedure" at HCA, HCA management instructed the CAMS staff to stop working on the SHH analysis before it was complete and it has never been completed. (Tr. Ex. 115, Taylor Dep. 99-101.) Other than the Stall analysis (concluding there was no need for a hospital in 2010) and the Luke analysis (prepared for litigation purposes after the decision to apply for a CON had been made), HCA has not prepared or caused to be prepared any other analysis or report addressing the supposed need for a hospital in Spring Hill. (Tr. 942.)

40. Despite the fact that its longtime, outside consultant had made a negative assessment of the need for a hospital in Spring Hill, and no internal analysis of the proposed project was performed, HCA, nevertheless, chose to proceed with the instant application for a 56-bed hospital. This decision was made sometime after HCA's meeting with Spring Hill city officials on November 1, 2005 and January 11, 2006, when an HCA internal e-mail indicated that it had now been determined that there was a need for a new hospital in Spring Hill by the year 2010. (Tr. Ex. 110, Kloess Dep. 131.) It is unclear how HCA made this determination as of January 11. At that time, only the Stall analysis had been performed, and Stall had not reached such a conclusion.

41. In early March 2006, after HCA decided to build a 56-bed hospital and at the recommendation of its outside legal counsel, HCA hired Dr. Ron Luke of Research Planning Consultants, Inc. ("RPC") to produce a report projecting volumes at the proposed Spring Hill hospital. (Tr. 1625; Tr. Ex. 109, Gage Dep. 30.) HCA had already decided both to build a hospital and determined the size of the facility before retaining Luke. HCA never asked Luke to give an opinion on whether some other type of health care facility should be constructed or what size the project should be. (Tr. 1751; Tr. Ex. 109, Gage Dep. 30.)

42. Luke was retained at the suggestion of HCA's litigation counsel. HCA management had not relied on him in the past and were unfamiliar with his qualifications and expertise. (Tr. Ex. 113, Scarvey Dep. 65) In fact, HCA's executives knew nothing at all about Luke's background, experience or qualifications either in the field of population projections or health care generally. (*See, e.g.*, Tr. Ex. 113, Scarvey Dep. at 65; Tr. Ex. 115, Taylor Depo at 50-51.) Ed Stall likewise knew nothing about Luke's background or expertise. (Tr. Ex. 114, Stall Dep. 156.) No one at HCA ever verified or reviewed Luke's work to ensure that it was accurate.

(Tr. Ex. 115, Taylor Dep. 75-76.). Although HCA executive Scarvey testified that he believed Luke to be more qualified than Stall in projecting populations, he could not articulate any reasons why he believed this to be true, other than recommendations of outside legal counsel. (Tr. 1063.)³

43. In March 2006, HCA publicly announced its intent to build a 56-bed hospital in Spring Hill. On April 13, 2006, it filed its application for a CON with the HSDA. HCA attached to its application a report created by Dr. Luke on April 12, 2006 (the “First RPC Report”) projecting Spring Hill’s population and setting forth other projections and analyses about the proposed hospital. (Tr. Ex. 15, RPC Report.) Luke’s report, prepared after HCA’s decision to pursue the hospital, was the first analysis for HCA claiming that a new hospital would be needed in Spring Hill in 2010. On April 26, 2006, Luke revised his report (the “Second RPC Report”), which was attached to HCA’s Second Supplemental Responses to the HSDA. (Tr. Ex. 27, SHH App., Second Supp., Second RPC Report.)

44. Luke’s population projections as set forth in the Second RPC Report have remained the same since April 26, 2006. (Tr. 1751-52.)

B. Need for Additional Beds in Maury and Williamson Counties

45. The Health Planning Act of 2002 directs the Tennessee Department of Health to review every CON application and to provide the HSDA with a report that includes an analysis of whether the application complies with the *Guidelines*. Tenn. Code Ann. § 68-11-1608(a)(5). The bed need formula is incorporated into every certificate of need application filed with the HSDA. (Tr. Ex. 27, SHH App., Question C(I), 32.) Melanie Hill, Executive Director of the HSDA, testified that the *Guidelines* are a starting point for every project. (Tr. 1236-37.)

³ HCA/TriStar CEO Larry Kloess testified that HCA generally relies on its attorneys to recommend experts, such as Ron Luke, for litigation purposes, but that HCA relies on its own experts, such as Ed Stall, when making business decisions. (Tr. 941-42.)

46. The Department of Health report, which is prepared for every CON application, concluded that SHH did not satisfy the hospital bed need formula set forth in the *Guidelines* and did not meet the requirements to be excepted from the formula. In fact, the Department of Health determined that in 2010 there will actually be a surplus of 50 licensed beds in Maury County and a surplus of 81 licensed beds in Williamson County. (Tr. Ex. 27, SHH App.)

47. In its original application and through the testimony of its management, HCA has admitted that the proposed hospital does not meet the *Guidelines* bed need criteria, and does not meet the criteria to be excepted from the general guidelines. (Tr. Ex. 110, Kloess Dep. 81-84; Tr. Ex. 27, SHH App., Question C(I), p. 33.)

48. In Revised Figure 21 of the RPC Report attached to the CON application, HCA presented its bed need numbers to the HSDA as the number of beds needed to be physically located in the SHH service area in Maury and Williamson Counties. (Tr. Ex. 27, SHH App.) In the discovery phase of this proceeding, it was determined that Revised Figure 21 actually set forth the number of beds HCA contended would be needed to serve the counties' residents regardless of where they actually obtain hospital services. (Pet'rs' Reply Br. Mar. 28, 2007 at 13; Tr. Ex. 109, Gage Dep. 82-83.) Therefore, Revised Figure 21 includes beds that will actually be located in Davidson County and any other county where residents from the SHH service area may go to seek medical services. (Tr. Ex. 109, Gage Dep. 82.) The RPC Report never sets forth the number of beds actually needed to be physically located in Maury or Williamson Counties. (Tr. Ex. 109, Gage Dep. 84.) Further, the RPC Report never explains that the hospital bed need numbers set out in Revised Figure 21 are without reference to where the beds will be located. (Tr. Ex. 109, Gage Dep. 83.)

49. The so-called “occupancy rates” set forth in Figure 22 of the RPC Report are similarly misleading. Although the Figure is labeled “Maury and Williamson County Combined Occupancy Rates,” the calculation of the occupancy rates includes patients who will be treated in other counties. In other words, the numerator of the occupancy percentage equation includes patients who are being treated for tertiary and other services in Davidson County, while the denominator consists of the beds physically located in Maury and Williamson Counties. (Tr. Ex. 111, Luke Dep. 196-97.) This method of presenting occupancy rate is inherently misleading.

50. HCA’s representation of bed need and occupancy rates set forth in Revised Figure 21 and Figure 22 of the RPC Report, and submitted to the HSDA by HCA, completely ignored well-established patient treatment patterns. Some tertiary services are not currently available in Maury or Williamson Counties and are not expected to be available in the foreseeable future in those areas. (Tr. Ex. 111, Luke Dep. 181-84, 195-96.) Thus, even though out-migration for tertiary services will continue in the future, HCA’s “bed need analysis” included such patients when calculating the “bed need” for the area. (Id.) HCA’s methodology has the effect of significantly overstating bed need.

51. In addition to out-migration for tertiary level services, a certain percentage of patients choose to seek medical treatment outside Maury and Williamson Counties for other reasons that also have nothing to do with quality of care. Patients may elect to seek treatment at facilities in Nashville because of commuting patterns or because patients may prefer to be treated at major medical centers. Indeed, HCA’s own witnesses demonstrated this reality. Spring Hill residents Angela Thompson and Layla Thompson testified that they drove past WMC, which offers more services than the proposed SHH, to take their children to Vanderbilt for treatment.

(Tr. 1170, 1195.) HCA's "bed need" calculations set forth in the RPC Reports did not account for this recognized phenomenon of out-migration.

52. In addition, HCA's CON Application states that if SHH is approved and opens, HCA will de-license 56 beds at other HCA facilities in Middle Tennessee. (Tr. 960; Tr. Ex. 27, SHH App., Question B(2)(II)(A)). Specifically, HCA proposed to de-license 28 beds at Hendersonville Medical Center and 28 beds at Horizon Medical Center. (Id.) By letter dated April 27, 2006, Larry Kloess stated that HCA may change the facility(ies) at which the beds would be de-licensed. (Tr. Ex. 27, SHH App., Second Supplemental Responses) In March 2006, Kloess sent an e-mail to Tim Scarvey, discussing de-licensing beds at Tennessee Christian Hospital, a facility outside the SHH service area. (Tr. 964; Tr. Ex. 92, Kloess e-mail.) HCA never informed the HSDA of this change. (Tr. 964-65.)

53. The Certificate of Need granted to SHH does not reflect HCA's commitment to de-license 56 beds in Middle Tennessee. (Tr. 960; Tr. Ex. 90, SHH Certificate of Need.) Kloess admitted at trial that the Certificate of Need should be corrected to reflect the de-licensure condition. (Tr. 961.)

54. Since the HSDA approved the SHH CON Application in July 2006, HCA has added a number of hospital beds into the Middle Tennessee area at Centennial Medical Center ("Centennial").

55. At the February 2007 HSDA meeting, the HSDA approved CON Application CN 0611095, in which HCA requested permission to convert twenty-five (25) beds at Centennial from rehabilitation beds to medical/surgical beds. (Tr. 961; Tr. Ex. 91, Centennial CON Application.) The CON Application included Williamson County and Maury County in Centennial's secondary service area. (Tr. 963.)

56. In addition, at the May 2007 HSDA meeting, HCA presented CON Application CN 0701009 for the addition of twenty (20) licensed neonatal intensive care unit beds at Centennial. (Tr. 1251.) CN 0701009 was subsequently approved by the HSDA.⁴

57. HCA has therefore already added forty-five (45) beds into an area where its expert projects a need for fifty-six (56) beds.

C. HCA's Population Projections

58. HCA's claim that a new hospital is needed in Spring Hill completely depends upon the population projections prepared by Luke and set forth in the RPC Report submitted with the CON application. Luke's population projections not only form the basis of HCA's claim of need, they also are the means by which HCA claims that existing health care facilities will not be adversely affected by the new hospital. HCA has repeatedly emphasized the concept that a growing pool of patients in the Spring Hill area will negate any adverse impact of the new facility on existing providers.

59. HCA did not offer any testimony from a full-time, professional demographer in support of Luke's population projections. Luke is not a professional demographer. Although Luke claims expertise in the field of demography, his claimed expertise stems primarily from work on litigation matters. Luke is certainly experienced as a professional expert witness in litigation. Approximately 75% of his personal working time and 75% of his firm's time is spent consulting on matters in litigation. (Tr. 1737-38.) In addition to CON cases, Luke has offered testimony as an expert witness in cases involving toxic torts, contracts, vehicle liability, employment discrimination, housing markets, statistical issues, water resources and antitrust. Luke has even personally performed drive time studies on a number of occasions. (Tr. 1739-40.)

⁴ This Court can take judicial notice of the approval of CN 0701009 as an official governmental agency decision on the record. (Tenn. Code Ann. § 4-5-313(6)(A)(ii).)

However, Luke has offered testimony about population projections just three times over his long career as a professional expert witness. (Tr. 1743.)

60. Luke also has essentially no pertinent non-litigation experience or training in the field of population studies. His sole contribution to the published literature on the subject of population projections was an eight-page article authored 17 years ago for a publication called “Water Resources Bulletin.” Luke has never attended a conference or professional meeting relating to population projections except for one conference back in the 1970s. He has never taught a course or authored a textbook in population projections and had never designed, conducted or even encountered a Special Census before his work on this case. (Tr. 1746-48.)

61. To prepare his population projections, Luke simply calculated Spring Hill’s historical annual growth rate from 2000 to 2005. He then took the resulting rate of 17% and projected forward to the year 2014, compounding annually. (Tr. Ex. 15, First RPC Report.) Luke testified that it is reasonable to project that Spring Hill will have a compound annual growth rate of 17% for a period of 14 years, from 2000 through 2014. Although Luke asserted that it was important to consider various factors such as zoning regulations and land use patterns when making population projections, he did not actually have any knowledge about such issues at the time he prepared his Spring Hill projections. (Tr. 1675, 1753.) Any such analysis appears to have been nothing more than a post hoc effort to validate the initial projections Luke made in April 2006.

62. The projections Ron Luke employed in the RPC report were prepared at Luke’s direction by Robin Gage, an RPC employee. (Tr. Ex. 109, Gage Dep. 59.) Gage has no formal training in population projections, has never taken a course about population projections and does not even hold herself out to be an expert in projecting population. (Tr. Ex. 109, Gage Dep.

38.) While Gage is aware of the existence of more complicated methodologies to project population growth, she has never used those methodologies and does not know why she was directed by Luke to use the annual growth rate projection method in this case. (Tr. Ex. 109, Gage Dep. 45-46.) Even though she had no substantive knowledge about the methodology used to project the population it was Gage, not Luke, who was present at the HSDA's public meeting to attempt to answer any questions the HSDA raised about the projections. (HSDA Hr'g Tr., p. 98.)

63. The Court heard extensive testimony about Luke's population projections from Petitioners' experts. As discussed below, the expert testimony demonstrated that Luke's population projections are not reasonable, and in fact are implausible on their face. The proof established that such a period of sustained growth at the HCA-projected rate in a community like Spring Hill would be unprecedented. (Tr. 121-22.)

64. The Petitioners offered testimony from Dr. David Swanson, a nationally-recognized expert in the field of demography and local population projections. Unlike Luke, Swanson is not a professional expert witness and derives an insignificant percentage of his income from litigation-related work. Swanson, who is a Professor at the University of Mississippi and Director of the Center for Population Studies there, has written dozens of articles about population projections in peer-reviewed journals. He has co-authored a textbook on the subject of projecting local populations. State and Local Population Projections Methodology and Analysis (2001 2nd ed.) In fact, Swanson is the co-author of the current edition of a textbook on demography that has been called the "Bible of Demography" and is owned and regularly consulted by HCA's expert, Ron Luke. (Tr. 88-89, 1747.)

65. In addition to his academic work, Swanson has also had wide-ranging experience with population projections in both the public and private sectors. He has served as the State Demographer of Alaska. He has performed population analyses for states, municipalities, private businesses and school districts. (Tr. 92-93.) He is experienced in projecting population growth in high-growth communities like Spring Hill. Swanson's testimony and background established him as an eminently qualified expert in the field of population projections.

66. When Swanson was retained by the Petitioners, he was not asked to reach any particular conclusions about the population of Spring Hill. (Tr. 96-97.) Swanson approached his engagement in the same objective manner with which he approached his consulting and academic work - not favoring any particular conclusion but merely applying the appropriate methodology and reporting his results to the client, whether favorable or not. (Tr. 96-97.)

67. Swanson provided the Court with a credible and reliable projection of Spring Hill's future population, which he summarized in a detailed and thoroughly-documented report. This analysis projects a future population of Spring Hill which is substantially lower than that submitted by Luke. (Tr. Ex. 2, Swanson Report; Tr. Ex. 3, Swanson Spreadsheets.) Unlike Luke, Swanson actually visited Spring Hill before developing his projections. (*Compare* Tr. 98 *with* Tr. 1752.) Swanson looked at the land use patterns, growth potential, and types of industry to set a context for projecting the population. (Tr. 99.) He testified that, while Spring Hill has experienced and is likely to continue to experience substantial growth in the near future, the extreme population growth projected by Luke and relied on by HCA to justify its hospital is implausible and not likely to be achieved.

68. Swanson analyzed the methodology used by Luke and the application of that methodology and found the application flawed. Although Swanson testified that there was

nothing inherently wrong with using a compound annual growth method to generate a simple and inexpensive projection, Luke's projection of a very high annual growth rate far into the future was unreasonable and generated unreliable results. (Tr. 128.) Swanson has never seen any city or county sustain a 17% rate of growth for the time period projected by Luke in the RPC Report. (Tr. 121.) In fact, Luke's projections imply a "doubling time" of only four years. In other words, using Luke's projected annual growth rate leads to the population of Spring Hill doubling every four years. This leads to absurd results in the very near future. Carried forward, Luke's methodology would result in Spring Hill having a population roughly the size of Orlando, Florida in only 13 years. (Tr. 58.) While the Court acknowledges that Spring Hill is a growing community, the Court simply does not find a projection of such extreme growth to be credible.⁵

69. HCA's population projections relied on the 2005 Spring Hill Special Census as a starting point. Swanson testified about several concerns he had about the Special Census that might have affected its accuracy, such as the effect of annexation in Spring Hill between 2000 and 2005. Swanson also testified that the documentation from the Special Census was insufficient to ensure that all residents counted were properly included. (Tr. 111.) However, Swanson also testified that, even if the 2005 Special Census is accepted at face value, his opinions are not materially affected and Luke's projections extrapolating a 17% growth rate remain unreasonable. (Tr. 119-20.)

70. Swanson performed his own population projections for Spring Hill, using the cohort-component method, a widely-accepted projection methodology. He developed a low,

⁵ Although Luke insisted that it was somehow inappropriate to extend his 17% annual growth rate into the future past 2014 (the last year for which he projected a population), Luke could offer no articulate explanation of why, if it is reasonable to project a 17% growth rate from 2005-2014, one cannot project that same rate forward a few more years. Luke admitted that the population growth would stop at some point in time; however, he refused to say when that would likely occur except to claim (without much explanation) that it would certainly be later than 2014. Moreover, other testimony offered by HCA encouraged the Court to believe that 17% growth would occur in Spring Hill until available developable land "fills up" with housing. According to the evidence presented, approximately 250,000 people will be needed to "fill up" Spring Hill. (Tr. 1277.)

medium and high projection, which is standard practice to account for the inherent uncertainty of future growth. (Tr. 115.) For his “high” scenario, Swanson accepted at face value the population estimate from Spring Hill’s Special Census, notwithstanding his concerns about its accuracy. (Tr. 119-20.) Even Dr. Swanson’s “high” scenario projections fall far below Luke’s projections used by HCA in its application.

71. The Petitioners also offered testimony from Dr. Bill Fox, Director of the Center for Business and Economic Research and the William B. Stokely Distinguished Professor of Business at the University of Tennessee. Fox is an expert in public finance and regional and urban economics and is one of the leading authorities on the Tennessee economy. Fox also has a long history of advising Tennessee’s state and local government officials on economic issues.

72. Fox’s background and testimony established that he is an experienced, sophisticated consumer of demographic data and an expert in economic and population forecasting in Tennessee. (Tr. 200.) Fox reviewed Luke’s report and testified that its population projections were unreasonable and outside the range of an acceptable forecast. (Tr. 200-02.) Fox testified that while Luke’s methodology might be appropriate for the quick calculation of an estimate, it was not an acceptable method for projecting growth over long periods of time, particularly in a rapid growth area. (Tr. 200.)

73. Fox also noted that the Luke analysis assumed that Spring Hill will continue to grow with no changes in outside influences. (Tr. 212.) Fox noted that there were changes in Spring Hill housing prices, employment growth, schools and health care that called this assumption into question. (Tr. 202; Tr. Ex. 5, Fox Report.)

74. Fox’s also reviewed Swanson’s projections and was of the opinion that Swanson had used a more appropriate methodology resulting in reasonable projections. (Tr. 225.)

75. Petitioners' expert Dr. Deborah Kolb, a health planner with more than 20 years of experience in strategic planning, assessing the financial feasibility of health care projects and conducting financial impact analyses, including extensive experience with hospitals in general and even working for HCA, also testified that Luke's population projections were grossly overstated. (Tr. 253-54.) Kolb pointed out certain problems with RPC's population projections. (Tr. 272.) For example, Luke took the growth rate from 2000 to 2005 from the Special Census and applied it to the two Spring Hill zip codes. There is, however, no basis for extending the growth projection beyond Spring Hill's city limit. Even HCA's own witness, Edsel Charles, testified that adjacent Thompson's Station is not a high growth area like Spring Hill. (Tr. 1573.) However, Ron Luke applied the 17% growth rate to both cities.

76. In sum, the evidence demonstrated that SHH's population projections were unreasonably high and project a level of population growth for Spring Hill that is unlikely to be sustained. The Court finds that the projections prepared by Dr. David Swanson are more reasonable and reliable projections of the range of likely population growth for this community. If Swanson's "high" population projections are substituted for those of Luke, then SHH is not needed. (Tr. 292, 310.)

D. HCA's Utilization Projections

77. Although overestimation of Spring Hill's future population is the central factor HCA relies upon to support its application, the utilization projections for the proposed hospital also form a critical component of the application.

78. Utilization rate is an important consideration in projecting the need for additional health care services. The utilization rate is essentially the frequency with which the population in

a service area consumes a particular type of health care service. This rate is calculated in terms of a ratio of the number of discharges per one thousand people in a given area. (Tr. 270.)

79. The utilization rate HCA used to demonstrate need in this case is too high, compounding the effect of the overstated population projections. (Tr. 280.) The in-patient utilization rate for SHH's six-zip code "service area" actually declined 4.2% from 2002 to 2005, a decline that SHH's expert Luke acknowledged. (Tr. 179.) HCA's failure to take into account the declining use rates for hospital services further undermines the merits of the application.

80. Further, Kolb explained that population projections are crucial in accurately predicting utilization; therefore, HCA's overstated population projection led to errors in HCA's utilization rate calculations. (Tr. 272.) These errors in HCA's utilization projections had the effect of overstating SHH's projected discharges.

81. This overstatement of utilization is illustrated by the fact that RPC lowered its utilization projections for the proposed SHH subsequent to submitting its original report that was attached to HCA's CON Application. The First RPC Report dated April 12, 2006, projected a utilization rate for SHH of 10,296 per 100,000 people. (Tr. Ex. 15, First RPC Report.) RPC's Third Report dated February 12, 2007, projected a lower utilization for SHH – 9,605. (Tr. Ex. 136, Third RPC Report; Tr. 272.) The Third RPC Report created in 2007 lowered the overall volume projections at the proposed new hospital by changing both the use rate and the baseline population used to project the patient volumes. (Tr. Ex. 142, Third RPC Report, Figure 16A, p. 30.)

82. Kolb testified that if HCA's unreasonably high and unreliable population projections and inaccurate use rate assumptions are disregarded, or adjusted to make them reasonable, there is no need for a new hospital in Spring Hill. Either the hospital will have a

much lower daily census (and correspondingly lower revenues and steeper losses) than projected in the application, or the hospital will achieve its financial goals only by capturing more patients from MRH and WMC than is projected in HCA's application, thereby magnifying the adverse impact on those facilities. (Tr. 292; Tr. Ex. 9, Kolb Report.)

83. HCA's utilization rates also fail to take into account the lower rate at which Spring Hill area residents (a young population) use hospital services. The use rates in HCA's application also ignore the trend, both locally and generally, of declining use rates. (Tr. 280-82.)

E. Accounting for Patient Out-migration

84. Patient out-migration refers to the fact that in any service area—here Maury and Williamson Counties—a certain number of residents will travel outside the area for some health care services. Conversely, when people living outside a service area travel into the area for health care services, this is known as “in-migration.”

85. In the case of Maury and Williamson Counties, for many years there has been a net out-migration of patients, meaning the number of residents of these two counties who seek health care services outside the counties is greater than the number of persons from elsewhere who seek health care service within the counties. (Tr. 286-88; Tr. Ex. 9, Kolb Report, Ex. 21; Tr. Ex. 109, Gage Dep. 49-50, 79-80.) Most of these patients out-migrate to Nashville, mainly for tertiary care (i.e., treatment of complex medical problems such as organ transplant and pediatric neurosurgery at tertiary care centers such as Vanderbilt). (Tr. 288; Tr. Ex. 109, Gage Dep. 50.) This is because many tertiary services are not offered in Williamson or Maury County. In fact, 41% of patients in zip code 37174 and 51% of the patients residing in zip code 37179 received their hospital care from Davidson County facilities in the year 2004. (HCA's Resp. to Pet's Interrog. No. 51.)

86. Construction of the proposed 56-bed Spring Hill Hospital would not alter or reduce such tertiary out-migration since the proposed community hospital would not offer tertiary care. (Tr. 288; Tr. Ex. 109, Gage Dep. 50-51, 79-81.) Moreover, the number of patients out-migrating from Williamson and Maury Counties for non-tertiary level services is small; thus, capturing those patients does not support a need for a new hospital. (Tr. Ex. 9, Kolb Report, Ex. 21.)

87. HCA's own consultant, Robin Gage, testified that it is important for an analyst to consider, investigate and address out-migration when determining the need for a proposed health care project. (Tr. Ex. 109, Gage Dep. 43-44.) However, the bed need projections in Revised Figure 21 of the RPC Report prepared by HCA's consultant and presented to the HSDA in its CON application did not take into account the net out-migration of patients from Maury and Williamson Counties. (Tr. Ex. 109, Gage Dep. 78, 82.) RPC, and then HCA, failed to consider out-migration despite the fact that, when its original report was prepared, RPC was fully aware that many residents of the service area traveled to Davidson County for health care services. (Tr. Ex. 15, First RPC Report p. 2.) Instead, HCA's "bed need analysis" simply used discharge rates for all residents of Maury and Williamson Counties without accounting for the fact that many of those residents seek treatment in Nashville or elsewhere and not in Maury or Williamson Counties. (Tr. Ex. 109, Gage Dep. 83-84.) Therefore, HCA's analysis of bed need does not show the number of hospital beds needed in Maury and Williamson Counties. Rather, it shows the number of beds needed by residents of Maury and Williamson Counties, even if some of those beds would be located in Davidson County and other counties where residents obtain hospital services. HCA's bed need analysis is meaningless.

88. Because HCA has already added forty-five (45) hospital beds at Centennial, whose service area includes Maury and Williamson Counties, and because the SHH CON Application presented a need to the HSDA of 56 beds to serve Maury and Williamson Counties with no regard to the beds' location, the number of beds approved for SHH arguably should be reduced from fifty-six (56) to eleven (11).

Financial Feasibility of HCA's Proposed Spring Hill Hospital Project

89. CON applicants must present financial projections illustrating that a project will be financially feasible and therefore represents a reasonable capital investment of health care resources. Applications must contain such projections for a period of two years.

90. While it is uncontested that HCA has sufficient funds available to sustain a loss at SHH, this fact standing alone does not satisfy the financial feasibility criterion. The question to be decided is whether a proposed project is financially feasible, not whether the owner of the project can afford to sustain a project that is not financially feasible.

A. SHH Financial Projections

91. HCA submitted five years of financial projections in support of its application. (Tr. Ex. 27, SHH App., p. 51a.) These projections assume that the Spring Hill area will grow at the unprecedented rates discussed above, and further assume inflated utilization projections. Even using these most favorable assumptions, HCA acknowledged in its application that SHH will lose money for the first three years of operation. The pro forma in HCA's original application projected SHH would lose money until its fourth year of operation (2013). In the first three years, HCA's application projected losses range from \$14.4 million (2010) to \$3.9 million (2012). (Tr. 27, SHH App.)

92. Further, HCA has admitted that the financial projections for SHH contained in the application were actually incorrect and overstated. To project the revenues and expenses at the proposed new hospital, it was necessary for HCA to project the number of Emergency Department (“ED”) visits at SHH each year. HCA then incorporated this data into the overall financial projections submitted in support of its CON application. (Tr. Ex. 115, Taylor Dep. 19-20, 23.)

93. The numbers generated by RPC were set forth in HCA’s CON application. (Tr. Ex. 27, SHH App., Figure 16, p. 43c.) However, another incorrect set of numbers was actually used by HCA to calculate the financial projections for the proposed facility. (Tr. Ex. 115, Taylor Dep. 20-21.) The incorrect data resulted from an error made by Chris Taylor, the CFO of HCA/TriStar, in his preparation of the financial projections. (Tr. Ex. 115, Taylor Dep. 33-34.)

94. Taylor testified that the error relating to ED visits affected the financial projections in several respects. It caused errors in the gross revenue, deductions, net operating revenues, other expenses, total operating expenses, net operating income and net operating income or loss less capital expenditures and interest expense. He stated that the “correction kind of flows through the income statement.” (Tr. Ex. 115, Taylor Dep. 27.)

95. To obtain an accurate picture of the financial feasibility of this project, correct ED visit data must be used and a revised analysis performed to determine the effect on the projected net operating income or loss. (Tr. Ex. 115, Taylor Dep. 28.) However, HCA did not prepare a revised analysis to correct the ED error before the HSDA considered and approved its CON application at a public hearing on July 26, 2006. Instead, this error was not disclosed, and this revised analysis was not performed until months later. (Id.)

96. When HCA's errors in the CON application are corrected, the financial performance of SHH is even worse. The first three years of the project — already projected to sustain losses — become much more unprofitable under the revised pro forma. According to Mr. Taylor, his revised analysis using what he believed to be the correct ED visit numbers from RPC resulted in a negative change in the five-year projected net income (loss) less capital expenditures figures of between \$2,000,000.00 and \$2,500,000.00. (Tr. Ex. 115, Taylor Dep. 28.) In the year 2013, the first year in which a profit was projected for the Spring Hill project, the net income or profit of \$1,065,584 shown on the pro forma in fact should have been only \$200,000 to \$300,000, according to Mr. Taylor's testimony. (Tr. Ex. 115, Taylor Dep. 30.)

97. The projections of net income (loss) less capital expenditures which Mr. Taylor developed after the HSDA hearing are more reliable and accurate than the projections contained in the pro forma submitted with the CON application and considered by the HSDA. (Tr. Ex. 115, Taylor Dep. 31-32.)

98. In his revised analysis, Mr. Taylor corrected the ED visit numbers which he had used for the financial projections in the pro forma by using the ED visit numbers provided by RPC and found in Figure 16 on page 43c of HCA's CON application. (Those same numbers were contained in Figure 16 of the First RPC Report of April 12, 2006 and the Second RPC Report of April 26, 2006, both of which HCA submitted to the HSDA.) But in its expert disclosures in the contested case proceeding, HCA provided another projection of ED visits (the "Third RPC Report"). In this version, dated February 12, 2007, Figure 16A on page 30 contains ED visit numbers completely different from those provided by RPC and submitted by HCA with its CON application. (Tr. Ex. 136, Third RPC Report.)

99. According to the Third RPC Report, the correct total number of ED visits for the five-year projection period is 8,257 fewer than the total number of ED visits previously projected and submitted in Figure 16 on page 43c of Spring Hill's CON application. (Tr. Ex. 142, Third RPC Report.)

100. Thus, even if HCA's inflated projections of population, utilization and income somehow occur, the proposed hospital is not a sound investment of health care resources. An investment of \$110 million to build a 56-bed facility will result in losses of approximately \$30 million over five years, according to HCA's own projections. In contrast, WMC added 40 beds and renovated its campus dramatically for \$83 million.

101. Moreover, the only way HCA is able to show a profit at all during the projection period is by manipulating the pro forma. If the assumptions contained in the CON application are applied to Luke's latest utilization projections,⁶ the proposed hospital will lose money for all of its first five years. (Tr. 292; Tr. Ex. 9, Kolb Report, Chart 18.) Even Chris Taylor testified that he would not be surprised to learn that SHH would show no profits in the first five (5) years using Luke's utilization figures. (Tr. 1019.)

102. While HCA's original application projected that the new hospital would lose approximately \$25 million over its first five years of operation, HCA now expects to lose more than \$29 million over that period of time. Moreover, projections for the facility's first year of profitability (2013) have declined from the \$1,065,584 amount presented to the HSDA to \$179,000. (Tr. Ex. 123, Knapp Report.)

⁶ It bears noting that Luke's utilization, discharge and average length of stay projections have changed several times throughout this proceeding, resulting in different bed need projections in all three (3) RPC Reports. (*Compare* Tr. Ex. 15, First RPC Report with Tr. Ex. 27, SHH App., Second Supp., Second RPC Report *and* Tr/ Ex/ 136, Third RPC Report.)

103. In written discovery served on HCA in this case, HCA was asked if there were any statements or information in the CON application that were no longer accurate or complete. (Pet'rs' Interrog. No. 38.) In response under oath to this Interrogatory, HCA identified two minor corrections to the CON application, in the nature of typographical errors. However, HCA did not disclose the numerous errors in the application's financial projections. (Resp.'s Interrog. Response No. 38.)

104. Further, during his deposition on November 28, 2006, Kloess, the President of HCA/TriStar, testified under oath that he was not aware of any fact, statement or projection in the application that was incorrect. (Tr. Ex. 110, Kloess Dep. 84.) Contrary to HCA's answer to written discovery and contrary to Mr. Kloess' deposition, CFO Taylor testified in his deposition on November 30, 2006 that he was aware of errors in HCA's financial projections and that he had previously discussed the existence of the errors with Kloess. (Tr. Ex. 115, Taylor Dep. 32-33.) HCA offered no explanation for its conflicting responses.

B. Patient Volume Projections

105. In addition to stating in its application that SHH would lose money during the first three years, and now having to concede that those losses will be larger than the application stated, HCA also failed to demonstrate that SHH is economically feasible for another reason: it assumes that residents in the entire service area, not just Spring Hill and Thompson's Station, will come to SHH for services. Such an assumption is unrealistic in light of the fact that SHH will not have a full range of medical services. Patients requiring advanced services could not be treated at SHH and would most likely need to be transferred to a hospital that could treat them.

106. SHH must have 75% occupancy to break even after four years of significant losses. (Tr. Ex. 27, SHH App., p. 51a.) The application submitted by HCA initially projected

that SHH would have an occupancy rate of 81% by Year Four. (Tr. Ex. 27, SHH App., p. 51a.) Although the occupancy rates presented to the HSDA were revised downward after the initiation of this contested case, HCA still claims that in Year Five its Spring Hill Hospital will have 82% occupancy. (Tr. Ex. 27, SHH App., Luke Report p. 26.) Kloess admitted that no medical/surgical facility in HCA/TriStar's system of 21 hospitals has enjoyed a 75% occupancy rate. (Tr. 959.) HCA/Tristar's CFO Taylor admitted that when he first saw Luke's report, prepared after HCA had decided to go forward with the hospital, Taylor thought that the occupancy levels seemed "a little high." (Tr. Ex. 115, Taylor Dep. 68.)

107. Kolb's report projects a lower occupancy rate for SHH than put forth by HCA and Luke. (Tr. Ex. 9, Kolb Report.) She used the pro forma from HCA's application and the population projections from Swanson's "high" scenario, which were based on the Spring Hill Special Census. (Tr. 292.) Kolb's results illustrated that SHH is not needed nor is it financially feasible. (Tr. 292, 310.)

108. In sum, the shifting financial projections offered by HCA and the testimony offered by the Petitioners demonstrate that the SHH project fails to satisfy the criterion of economic feasibility.

Contribution of HCA's Proposed Spring Hill Hospital to the Orderly Development of Health Care

A. Duplication of Existing Services

109. HCA's proposed 56-bed community hospital will offer basic medical/surgical services to an area that is already adequately bedded. No services will be offered at SHH that are not already offered at the two nearby existing hospitals.

110. The occupancy rates at MRH's main campus have been steadily declining in recent years, averaging only 55% in 2006. This is due to many factors, including the increasing prevalence of patients who are treated in an outpatient setting rather than in an acute care hospital and the overall declining hospital utilization rates in its eight-county service area. (Tr. 613.) WMC's occupancy rates have been higher than those of MRH, but to a significant extent this reflects the fact that WMC has been undergoing a major construction project which has at times reduced bed capacity and artificially inflated occupancy rates. At times during the construction, WMC had as few as 116 staffed beds. WMC's occupancy rates do not adequately reflect utilization of WMC's full licensed bed complement. (Tr. Ex. 48, D. Miller Aff.)

111. HCA admits that the proposed SHH facility will not offer the level of sophistication of care offered at either MRH or WMC, much less other facilities located in Davidson County such as Vanderbilt, St. Thomas or Centennial Medical Center. HCA's proposed new hospital would be a secondary facility with limited services and facilities, and could not treat most of the life-threatening illnesses and complex emergencies that may be sustained by Spring Hill area residents. Persons with such life-threatening, complex conditions would need to be taken to MRH, WMC or to tertiary care facilities in Nashville. Similarly, critically ill babies and high-risk expectant mothers would most likely continue to be taken to facilities with neonatal intensive care units and not to Spring Hill Hospital, which would have no such advanced services.

112. Kolb testified that the minimal, 5% non tertiary out-migration experienced by the SHH service area is not sufficient to fill a 56-bed hospital in Spring Hill; therefore, either SHH will have a significant adverse impact on WMC and MRH or SHH will not be financially viable. (Tr. 289; Tr. Ex. 9, Kolb Report, Exs. 21, 22.)

B. Adverse Impact on Existing Hospitals

113. In addition to duplicating existing services and adding beds to an adequately bedded area, SHH would have a dramatic negative impact on MRH and WMC and on the ability of those facilities to continue to provide access to critical health care services for the citizens of Maury and Williamson counties.

114. The main campus of MRH is located just 14 miles from the site of the proposed new hospital. MRH is a regional referral center for an eight county service area in southern Middle Tennessee. MRH provides vital health care services in communities that would not otherwise have access to such services. Many of these services and facilities operate at a financial loss, and depend upon MRH for financial support and for capital investment for upkeep, renovation and improvement. (Tr. Ex. 42, P. Brown Aff.; Tr. Ex. 43, D. Flowers Aff.; Tr. Ex. 44, B. Quinton Aff.)

115. MRH operates Marshall Medical Center in Lewisburg, Tennessee. Phyllis Brown, the CFO of that facility testified that before 1995, HCA and a variety of other private operators owned the hospital. In 1995, MRH assumed responsibility for operating the facility. Marshall County is a town with a population of 11,000 people and the Marshall Medical Center serves as the only emergency care facility for the entire county. If the Marshall Medical Center ceased to exist, residents of Lewisburg would be required to travel to Columbia to receive emergency care. Marshall Medical Center has a payer mix of 42% Medicare, 22% Blue Cross,

15% TennCare, 10% commercial and 8% self pay/no insurance. Marshall Medical Center regularly incurs operating losses. (Tr. Ex. 42, P. Brown Aff.) Testimony of Bob Phillips, a pharmacist who is the Mayor of Lewisburg and a longtime member of the Marshall County Commission, also emphasized the important role MRH has played in supporting Marshall Medical Center and the difficulty the community experienced when the facility was repeatedly sold by various private owners, including HCA. (Tr. Ex. 46, T. Ogilvie Aff.)

116. MRH also operates the Lewis Ambulatory Care Center in Hohenwald, Tennessee. Dr. Dustin Flowers, Director of the Center testified that in the early 1990s the clinic was operated by a private company, which went bankrupt. MRH then assumed operation of the facility. Hohenwald is the only town in Lewis County, with a population of approximately 3,800. The county as a whole has a population of approximately 12,000 people. The Lewis Ambulatory Care Center is the only urgent care center for Lewis County. If it did not exist, citizens of Hohenwald would have to travel either to Linden or to Columbia (which is 45 minutes away) for urgent care. The Lewis Ambulatory Care Center operates consistently at a loss of between \$100,000 and \$250,000 a year. The payer mix averages 25% Medicare, 25% TennCare, 25% Blue Cross and 25% self-pay/bad debt, managed care and other commercial insurance. Lewis County does not have the tax base to operate Lewis Ambulatory Care Center. Without MRH's support, the facility would necessarily be closed. (Tr. Ex. 43, D. Flowers Aff.)

117. MRH operates Wayne Medical Center in Waynesboro, Tennessee. Byron Quinton, the Chief Executive Officer of Wayne Medical Center testified that MRH assumed the operation of that facility in 1995. Over the preceding 20 years the hospital had been operated by several different private operators, including HCA. But each operator had eventually divested itself of the facility. The payer mix of Wayne Medical Center is typically 70% Medicare and

only 15 to 20% commercial insurance. The remainder of patients are TennCare or uninsured. Wayne County has the highest unemployment rate of any county in Tennessee, at approximately 14%. Waynesboro is the primary town in Wayne County, with a population of approximately 2,500 people, and a county population of approximately 16,000. Wayne Medical Center is the only facility offering emergency services in the county. If it ceased to operate, citizens of the county would have to travel either 30 minutes to Savannah, Tennessee or 45 minutes to Florence, Alabama to receive emergency care. In addition, Wayne Medical Center transfers substantial funds to Wayne County each year. Wayne County does not have a sufficient tax base to operate Wayne Medical Center. Without MRH's financial support or the support of another outside entity, Wayne Medical Center would be forced to close. (Tr. Ex. 44, B. Quinton Aff.)

118. MRH operates an Ambulatory Care Center in Columbia that provides medical care for area residents, including residents of the housing units operated by the Columbia Housing Authority. Many of those residents have no medical insurance or inadequate insurance. (Tr. Ex. 46, T. Ogilvie Aff.)

119. Eleven (11) governmental entities from within the WMC and MRH service areas passed resolutions opposing the SHH project and submitted them to the HSDA. (Tr. Exs. 58-65, 69-71.)

120. Since 2002, WMC has applied for, and received, five Certificates of Need, the purpose of which was to expand WMC and its services. To assist WMC in funding these expansion projects, Williamson County issued \$30 million in revenue bonds and \$20 million in general obligation bonds. General obligation bonds are backed by the full faith and credit of the municipality issuing them. WMC borrowed an additional \$10 million on its own, and the remaining \$23 million was taken from WMC's operations and cash reserves over the first four

years of the project. In addition to WMC's indebtedness related to the expansion projects, in Fiscal Year 2005-2006, WMC also had five outstanding loans for various capital projects such as the purchase of land and equipment. Those additional loans amounted to approximately \$25.5 million. The proposed SHH will make it much more difficult for WMC to retire this debt while maintaining and enhancing the care it provides Williamson County citizens. (Tr. Ex. 49, D. Webb Aff.)

121. The Petitioners offered testimony from Martin D. Brown, a Certified Public Accountant licensed in Tennessee and a member of the PYA firm. Brown testified regarding the financial impact SHH will have on MRH. PYA is one of the leading health care advisory and accounting firms in Tennessee, serving around 60 hospitals in Tennessee since 2003 (about one-third of all hospitals in the state). Brown has personally worked for many leading Tennessee hospitals, including the University of Tennessee Medical Center, Vanderbilt Medical Center, St. Thomas Health Systems, Mountain States Health Alliance and Covenant Health System. (Tr. 384-86.)

122. Brown's analysis established that if SHH is built, MRH will sustain financial losses that will be severely detrimental to its operations. Those losses will be between \$5 million to \$12 million every year, with cumulative losses over five years of approximately \$40 million. (Tr. 408.) Such losses will reduce MRH's ability to provide for future fixed expenses and needs for capital expenses such as renovation and maintenance of MRH's main campus in Columbia, as well as the outlying facilities in the MRH system such as Wayne Medical Center, Marshall Medical Center, and Lewis Ambulatory Care Clinic. MRH faces substantial capital requirements in the near future, including need for conversion of semi-private rooms to private rooms, electronic medical records and other technological improvements and similar capital

requirements. (Tr. 414.) Brown also responded to HCA financial expert Rick Knapp's testimony that WMC and MRH would not be injured financially because they would supposedly maintain the same number of discharges they had in 2005. As Brown testified, having the same number of discharges today as a hospital had 10 years ago would put that hospital in dire financial straits in light of factors such as increased expenses, increased capital spending and possible decreases in reimbursement by payers. (Tr. 409.)

123. Petitioners also offered testimony by Jeff Potter, another Certified Public Accountant licensed in Tennessee and a partner with LBMC, the largest Certified Public Accounting firm in Tennessee. Potter testified with respect to the economic hardship SHH will cause WMC. Potter has worked in the health care industry for over 20 years and approximately 95% of his clients are hospital or health care related. He has worked on several CON projects for health care facilities such as Baptist Hospital of East Tennessee, Williamson Medical Center, Wellmont Health Systems and Mountain States Health Alliance.

124. Potter's report illustrates the impact of patient volume shift from WMC to SHH and then converts that number to financial impact on WMC. (Tr. Ex. 35, Potter Report.) Taking what every expert in the case agrees is a conservative approach, Potter accepted HCA's estimates of inpatient and outpatient volumes for SHH at face value; determined how much profit (or "contribution margin") WMC makes on the services SHH admits it will take from WMC; and then determined that WMC stands to suffer approximately \$18 million in lost profits in the first five (5) years of SHH's operation. (Tr. 490-91.) Put differently, WMC will lose on average approximately \$3.8 million a year from its bottom line. For the past few years, WMC has averaged a profit of roughly \$8.5 million a year; thus, SHH threatens to cut WMC's profits almost in half. This constitutes a material loss that will drastically affect WMC's abilities to

service its debt while maintaining and enhancing the care it provides Williamson County citizens.

125. The only expert offered by HCA to address specifically the detrimental financial impact of SHH was Rick Knapp. Knapp has testified for hire in hundreds of cases. In all or most of these cases, he has represented himself to be a licensed Certified Public Accountant. (Tr. 1398-1400.) In the present case, Knapp testified under oath that he is a Certified Public Accountant in Ohio and Georgia. (Tr. 1399-1400.) In fact, however, Knapp is not licensed in either state. He has not been licensed in Ohio since 1977. He has never been licensed in Georgia. (Tr. Ex. 121, Letter from Accountancy Board of OH; Tr. Ex. 122, Letter from GA State Board of Accountancy.) The Court finds and concludes that Knapp misrepresented his credentials under oath to this Court. The Court further finds and concludes that, as a result of these misrepresentations, Knapp's opinion and analysis lacks credibility and will be afforded no weight in this proceeding.

126. Even if there was no issue with Knapp's credentials and fundamental credibility, Knapp did not actually perform his own analysis of the proposed SHH project's financial feasibility. He appeared to have simply taken pieces of the analyses performed by other experts and cobbled together an opinion. Even so, Mr. Knapp estimated WMC stands to suffer \$13,629,761.00 in lost profits in the first five years of SHH's operation. (Tr. Ex. 123, Knapp Report, Appendix D.) Thus, assuming solely for the sake of argument that Mr. Knapp is correct, WMC will lose on average approximately \$2.7 million a year from its bottom line. Again, this is a material loss that is likely to drastically affect WMC's ability to service its debt while maintaining and enhancing the care it provides Williamson County citizens.

127. Mr. Knapp also estimated MRH's lost profits for the first five years of SHH's operation as \$6,266,119. (Tr. Ex. 123, Knapp Report, Appendix D.) Again, assuming Mr. Knapp is correct, MRH will sustain a substantial loss that will severely impact its ability to provide health care services to its patients. The concept of "orderly development" of health care resources envisions development of resources as they are needed in the marketplace. HCA demonstrated how such development can occur with its experience with StoneCrest Hospital in Rutherford County. In that instance, for fifteen years HCA operated a freestanding emergency room in the community until the population of the area grew to the point where a new hospital could be supported. (Tr. 947-48.) In the present case, HCA seeks to circumvent the incremental, orderly development of health care with a speculative project based on future "need" that may or may not materialize in the time frames in question. To approve such a project, especially in light of its severe impact on existing providers, would not contribute to the orderly development of health care.

Conclusions of Law

128. Based on all of the foregoing findings of fact, including the Court's assessment of the credibility and demeanor of all of the witnesses, the Court reaches the following Conclusions of Law.

129. HCA's Certificate of Need was issued erroneously in that it did not reflect the condition that HCA would, upon SHH's opening, de-license 56 beds at one or more of its facilities in Middle Tennessee.

130. The proposed SHH is not "necessary to provide needed health care" to the proposed service area. Maury and Williamson Counties are both overbedded under the

applicable existing State Health Plan, *Guidelines for Growth*, which is the starting point for any analysis of need. Moreover, multiple analyses by both HCA and the petitioners independent of the CON process have concluded that there is no need for a new hospital in Spring Hill at this time (or in 2010, when SHH is proposed to open). HCA's case for need rests completely on population projections prepared by its litigation expert and which are simply not credible. While there has been very substantial growth in the Spring Hill area, the level of growth to date and reasonably expected in the immediate future does not justify a new hospital. The CON process contemplates the incremental orderly development of health care services in conjunction with population growth, an approach followed by HCA itself in Smyrna. MRH and WMC have committed substantial resources to Spring Hill in accordance with such an incremental approach. The present application by HCA represents a speculative effort by HCA, in anticipation of growth that may or may not occur. Such premature construction of new health care facilities is not consistent with the CON criterion of need.

131. The proposed SHH cannot be “economically accomplished and maintained.” HCA clearly has the resources to build SHH, but it will likely operate at a loss for several years even under HCA's overly-aggressive assumptions. The magnitude and length of the projected losses are indicative of the lack of actual need for the facility. Moreover, the pro formas presented by HCA are based on unrealistic population and utilization projections. It is likely that HCA will bring to bear its significant resources in an effort to make SHH successful. HCA may well succeed in doing so. But any such success can only be achieved with a significant adverse impact on both MRH and WMC. Financial success of one facility by undermining the ability of existing hospitals to serve their communities does not satisfy the “financial feasibility” criterion of the CON process.

132. The proposed SHH will not contribute to the orderly development of adequate and effective health care facilities or services in the community. In recent years, MRH and WMC have made significant capital investments to serve the needs of their service areas, which include Spring Hill. Many of these projects were approved under the CON process. Authorizing construction of a new hospital in Spring Hill before there is a sufficient population to support the need for such a facility would have a severe impact on both MRH and WMC. While the CON process does not guarantee immunity from any competition, it does serve to prevent speculative development of health care resources and requires that new facilities be approved only if there is a genuine need.

133. Further, the Court finds that HCA's CON Application contained admittedly false and incorrect information and data and that the HSDA's decision to grant the SHH CON was based in whole or in part on such false, incorrect or misleading information and data. Therefore, pursuant to Tenn. Code Ann. § 68-11-1619(3), HCA's CON should be revoked. HCA's Application for a CON fails to satisfy the criteria for a Certificate of Need set forth in Tenn. Code Ann. § 68-11-1609(b) and in HSDA Rules 0720-11-.01(1)-(3) and therefore should be **DENIED**.

WHEREFORE, the Court **hereby ORDERS, ADJUDGES, AND DECREES** that Certificate of Need Application No. CN 0604-028A filed by HCA on April 13, 2006 is denied.

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

Leonard F. Pogue, III
Administrative Law Judge