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RE: In the Matter of: Spring Hill Hospital, Inc Docket No. 25.00-092967J

Enclosed is an Initial Order rendered in connection with the above-styled case.

Administrative Procedures Division
Tennessee Department of State

BEFORE THE TENNESSEE HEALTH SERVICES
AND DEVELOPMENT AGENCY

IN THE MATTER OF:

SPRING HILL HOSPITAL, INC

DOCKET NO.: 25.00-092967J

ORDER

THIS ORDER IS AN INITIAL ORDER RENDERED BY AN ADMINISTRATIVE JUDGE WITH THE ADMINISTRATIVE PROCEDURES DIVISION.

THE INITIAL ORDER IS NOT A FINAL ORDER BUT SHALL BECOME A FINAL ORDER UNLESS:

1. THE ENROLLEE FILES A WRITTEN APPEAL, OR EITHER PARTY FILES A PETITION FOR RECONSIDERATION WITH THE ADMINISTRATIVE PROCEDURES DIVISION NO LATER THAN OCTOBER 29, 2007.

YOU MUST FILE THE APPEAL, PETITION FOR RECONSIDERATION WITH THE ADMINISTRATIVE PROCEDURES DIVISION. THE ADDRESS OF THE ADMINISTRATIVE PROCEDURES DIVISION IS:

SECRETARY OF STATE
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IF YOU HAVE ANY FURTHER QUESTIONS, PLEASE CALL THE ADMINISTRATIVE PROCEDURES DIVISION, 615/741-7008 OR 741-5042, FAX 615/741-4472. PLEASE CONSULT APPENDIX A AFFIXED TO THE INITIAL ORDER FOR NOTICE OF APPEAL PROCEDURES.

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

IN THE MATTER OF:

SPRING HILL HOSPITAL, INC.

DOCKET NO: 25.00-092967J

INITIAL ORDER

This matter came to be heard on April 11-24, 2007, before Leonard Pogue, Administrative Judge, sitting for the Tennessee Health Services and Development Agency (Agency) in Nashville, Tennessee. The Petitioner, Maury Regional Hospital (MRH), was represented by Dan H. Elrod, G. Brian Jackson, and Bryant C. Witt of Nashville. The Petitioner, Williamson Medical Center (WMC), was represented by Warren L. Gooch and Charles E. Young of Knoxville. The Respondent, Spring Hill Hospital (SHH), was represented by D. Edward Harvey, Jerry W. Taylor and Kathryn A. Stephenson of Nashville. The Agency was represented by James B. Christoffersen, Deputy General Counsel. This matter became ready for consideration on August 16, 2007, upon the parties' submission of proposed findings of fact and conclusions of law.

The subject of this hearing is the appeal filed by MRH and WMC of the granting of a certificate of need (CON) to SHH by the Agency for the establishment of a 56 bed hospital in Spring Hill, Tennessee. After consideration of the record in this matter, it is determined that the Spring Hill Hospital CON be **DENIED**. This decision is based upon the following findings of fact and conclusions of law.

FINDINGS OF FACT

Procedural Background

1. In April 2006, Hospital Corporation of America, Inc. (HCA) filed an application with the Agency for a CON to construct and operate a new 56 bed hospital in Spring Hill, Tennessee at a cost of approximately \$110 million. SHH was projected to open in 2010. The Agency approved the CON application at its regular monthly meeting on July 26, 2006.

2. The CON application was opposed by both MRH and WMC. MRH and WMC subsequently initiated this contested case proceeding by timely filing Petitions for a Contested Case Hearing.

3. The proposed SHH would be located in Maury County (close to the Williamson County line), approximately 14 miles from MRH in Columbia and approximately 17 miles from WMC in Franklin.

Existing Medical Facilities

4. MRH, a public non-profit facility, operates a 255-bed acute care hospital in Columbia, Tennessee. The hospital serves eight counties in southern Middle Tennessee. 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. MRH is in the process of tripling the size of its emergency department at a cost of \$15.5 million. MRH has planned capital projects over the next five years of \$40 to \$50 million.

5. MRH operates facilities and programs in Spring Hill to address the health care needs of area residents and has expanded its services over the years in Spring Hill.

MRH constructed a primary care facility in 1998 in Spring Hill and expanded that facility in 2004. MRH 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. To date, MRH has invested more than \$6.2 million in construction and expansion costs in bringing these medical services to Spring Hill.

6. A review for the possible need of a hospital in Spring Hill was done for MRH in 2005. This evaluation concluded that a full service hospital was not feasible in Spring Hill in the near or immediate term.

7. 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 the Spring Hill community.

8. WMC is a publicly owned not for profit hospital located in Franklin, Tennessee. WMC recently completed \$83 million in additions and renovations to its facilities, including the addition of 40 medical/surgical hospital beds (July 2007), which increased its beds from 145 to 185. WMC provides a full-time family physician for Williamson County Health Department patients in Franklin and a part-time physician for patients in Fairview.

9. In 2005, WMC evaluated the need for additional medical services in Spring Hill, including a hospital. WMC concluded that its planning for Spring Hill should involve outpatient services rather than inpatient beds.

10. 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.

Proposed SHH

11. In 2004, HCA and Vanderbilt University Medical Center discussed the possibility of a joint venture in the Spring Hill area, including a potential inpatient facility. 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. Mr. Stall's 2004 report, not intended to be a detailed analysis, concluded that the Spring Hill area did not yet need a hospital.

12. In the Fall of 2005, a Spring Hill real estate developer and then Chairman of the Spring Hill Chamber of Commerce, contacted HCA and invited its executives to a meeting in Spring Hill with local officials. At that meeting, held on November 1, 2005, city officials promoted the idea of HCA offering health care services in the city, including possibly a hospital. 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. Neither WMC nor MRH was ever invited to a similar meeting with city officials.

13. In January 2006, HCA contacted Mr. Stall and asked for an update of his 2004 report. Mr. Stall performed a bed need analysis of the area and summarized his work in a second report. The second report made conservative assumptions and was not a

comprehensive analysis. Mr. Stall's update of the 2004 report concluded that a 56 bed hospital was not needed in 2010 and that the bed need in 2010 was 42.

14. HCA representatives also visited Spring Hill extensively in late 2005 and early 2006. They determined that there was community and physician support for a new hospital. Ultimately, HCA decided that Spring Hill could support a 56 bed hospital by the year 2010.

15. HCA has a standard 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. HCA did not begin the CAMS review process for SHH until after it had filed its application for a CON and after the Agency's initial vote of approval. As a result of this appeal, HCA management instructed the CAMS staff to stop working on the SHH analysis before it was complete and it has never been completed. Other than the Stall reports, and the analysis performed by HCA's health care planning expert, Dr. Ron Luke (prepared 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 need for a hospital in Spring Hill.

16. In early March 2006, HCA hired Dr. Ron Luke of Research Planning Consultants, Inc. (RPC) to produce a report projecting volumes at the proposed Spring Hill hospital. HCA never asked Dr. Luke to give an opinion on whether some other type of health care facility should be constructed or what size the project should be. Dr. Luke was retained at the suggestion of HCA's litigation counsel. HCA management had not relied on him in the past and was unfamiliar with his qualifications and expertise.

17. 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 Agency. HCA attached to its application a report created by Dr. Luke on April 12, 2006 (First RPC Report) projecting Spring Hill's population and setting forth other projections and analyses about the proposed hospital. On April 26, 2006, Dr. Luke revised his report (Second RPC Report), which was attached to HCA's Second Supplemental Responses to the Agency.

18. SHH will be owned by Spring Hill Hospital, Inc., a subsidiary of HCA, Inc. It will be part of the local TriStar division of HCA, which currently consists of 19 hospitals.

19. 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 (more complex medical care). Such tertiary care would have to be handled at MRH, WMC or the various tertiary care hospitals located in Nashville.

20. The proposed hospital's primary service area will consist of six ZIP codes encompassing and surrounding Spring Hill. 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. WMC lies just outside the primary service area and the ZIP code encompassing MRH is included in the primary service area.

Bed Need

21. The Health Planning Act of 2002 directs the Tennessee Department of Health to review every CON application and to provide the Agency with a report that includes an analysis of whether the application complies with *Tennessee's Health Guidelines for Growth*. A bed need formula is incorporated into every certificate of need application filed with the Agency. The bed need formula calculates the number of beds needed in a county.

22. The Department of Health report 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. 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. Melanie Hill, Executive Director of the Agency, testified that the *Guidelines* are only guidelines and that Agency members consider the *Guidelines* along with other information brought to them by an applicant.

23. WMC's 40-bed CON application also did not satisfy the bed need formula in the *Guidelines*, but the application was granted. The StoneCrest Hospital (Smyrna) CON application too did not satisfy the bed need formula in the *Guidelines*, but the application was granted. After StoneCrest Hospital opened, utilization at StoneCrest was sufficient to support a bed expansion.

24. WMC's 40-bed CON application projected that the 40 new beds would be 80% to 84% occupied in fiscal years 2007 and 2008 and WMC projected that all of its beds would be 81.6% occupied in 2008. The WMC CON application further projected that in 2008, at 70% occupancy, Williamson County would need 210 beds. WMC's

officials believed that the additional 40 beds would be sufficient to serve its population for several years after the beds open in 2007.

25. Before HCA filed the SHH CON application, MRH consultants prepared a series of reports that concluded, among other things, that the residents of Spring Hill will need up to 60 additional beds (at 85% occupancy) by 2015. In November, 2005, WMC consultants performed an analysis that concluded, among other things, 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.

26. A bed-to-population ratio is used frequently in the health planning field to assist in determining bed need. MRH's and WMC's health care planning expert, Dr. Deborah Kolb, testified that she wouldn't necessarily consider a 1.8 bed-to-population ratio to be low and that bed ratio should not be the sole factor in determining need. Dr. Kolb has previously stated in a Florida CON application that 1.8 beds per 1,000 population is a low ratio. Combining SHH's beds and the high scenario population projections of MRH's and WMC's population and demographic expert Dr. David Swanson, 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.

27. In Revised Figure 21 of the RPC Report attached to the CON application, HCA presented its bed need numbers to the Agency as the number of beds needed to be physically located in the SHH service area in Maury and Williamson Counties. However, 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. The RPC Report never sets forth the number of beds actually needed to be physically located in Maury or Williamson Counties. 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.

28. The occupancy rates set forth in Figure 22 of the RPC Report are similarly prepared. 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.

29. 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 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. HCA’s bed need calculations set forth in the RPC Reports also did not account for this type of out-migration. The number of patients out-migrating from Williamson and Maury Counties for non-tertiary level services is small.

Population Projections

30. Spring Hill is a rapidly growing city. In 2000, the U.S. Census found a Spring Hill population of 7,715. In 2005, the City conducted its own Special Census,

which concluded that the population of Spring Hill was 17,325. This represents a 17.6% compound annual growth rate between 2000 and 2005. The Special Census was properly conducted. The State of Tennessee certified the Special Census after a detailed verification process.

31. MRH's and WMC's demographic expert, Dr. David 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 and that the documentation from the Special Census was insufficient to ensure that all residents counted were properly included. However, he did not undertake an investigation of any possible over-count and was unable to demonstrate any specific over-count. The impact of any potential over-count should be 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.

32. Spring Hill 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. Based on the water accounts and using an average number of persons per household between 2.51 and 3 (based on 2005 census), Spring Hill's 2007 population would be between 23,220 and 27,753 residents.

33. There are approximately 10,000 residential lots currently approved for development within the Spring Hill city limits. These lots have water lines and roads in place. Since 2006, Spring Hill has annexed several hundred acres of vacant farmland that can now be developed. There are 16,835 total acres within the city limits. Spring Hill's urban growth boundary contains an additional 39,600 acres.

34. Spring Hill's growth can be attributed to a number 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. Limits on the potential for growth (such as topography, housing prices, and official anti-growth policies) in other areas surrounding Nashville also increase the potential for growth in the Spring Hill area. Since 2005, the growth rate in the Spring Hill area, especially in Maury County, has accelerated rather than leveled off. Edsel Charles, who provides growth forecasts relied upon by builders and lenders, predicts that the growth will continue for years.

35. The Spring Hill area is emerging as its own community, with its own retail and employment opportunities. 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.

36. SHH called Dr. Ron Luke, as an expert in health care planning. Dr. Luke has limited experience in developing demographic models and is not a professional demographer. Nonetheless, it is also clear from both Dr. Luke's testimony and Dr. Kolb's testimony that population projections are an integral part of health care planning. Approximately 75% of Dr. Luke's personal working time and 75% of his firm's time is spent consulting on matters in litigation. In addition to CON cases, Dr. 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. In the recent past, WMC retained Dr. Luke as a health planning and demographic expert.

37. Dr. Luke has little non-litigation experience or training in the field of population studies. His only contribution to the published literature on the subject of population projections was an eight-page article authored 17 years ago. Dr. Luke has never attended a conference or professional meeting relating to population projections except for one conference in the 1970s. He has never taught a course or authored a textbook in population projections and had never designed, conducted or encountered a Special Census before his work on this case.

38. To prepare his population projections, Dr. Luke 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. As a result, Dr. Luke projects that the two ZIP codes encompassing Spring Hill will be home to 60,373 persons in 2010 and 116,763 persons in 2014. Dr. 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 Dr. 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 population projections.

39. The projections Dr. Luke employed in the RPC report were prepared at Dr. Luke's direction by Robin Gage, an RPC employee. Ms. Gage has no formal training in population projections, has never taken a course about population projections and does not hold herself out to be an expert in projecting population.

40. MRH and WMC offered testimony from Dr. David Swanson, an expert in the field of demography and local population projections. Dr. Swanson derives a very small percentage of his income from litigation-related work. Dr. 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 and is the co-author of the current edition of a textbook on demography that is regularly consulted by Dr. Luke.

41. Dr. Swanson has had numerous experiences 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. When Dr. Swanson was retained by MRH and WMC, he was not asked to reach any particular conclusions about the population of Spring Hill. Dr. Swanson testified that he approached the engagement not favoring any particular conclusion but merely applying the appropriate methodology and reporting his results, whether favorable or not.

42. The future population of Spring Hill, as projected by Dr. Swanson, is substantially lower than that submitted by Dr. Luke. Dr. Swanson looked at the land use patterns, growth potential, and types of industry but did not talk to city officials. He testified that, while Spring Hill has experienced and is likely to continue to experience substantial growth in the near future, the population growth projected by Dr. Luke is implausible and not likely to be achieved.

43. Dr. Swanson analyzed the methodology used by Dr. Luke and the application of that methodology and found the application flawed. Although Dr. Swanson testified that there was nothing inherently wrong with using a compound annual growth method, Dr. Luke's projection of a very high annual growth rate far into the future was unreasonable and generated unreliable results. Dr. Swanson has never seen any city or county sustain a 17% rate of growth for the time period projected by Dr. Luke. Dr. Luke's projected annual growth rate leads to the population of Spring Hill doubling every four years.

44. Dr. Swanson performed his own population projections for Spring Hill using the cohort-component method. He developed a low, medium and high projection, which is standard practice to account for the inherent uncertainty of future growth. His low scenario is based on the Claritas estimate of the 2005 population of the service area. The Claritas estimate was ultimately low and does not reflect the 2005 population of Spring Hill. Dr. Swanson's medium scenario is the average of his high and low scenarios. For his high scenario, Dr. Swanson accepted the population estimate from Spring Hill's 2005 Special Census, notwithstanding his concerns about its accuracy, and then grew that population forward to 2010 and 2015. The growth was based on assumptions about birth rates, mortality rates, and migration rates. Dr. Swanson's high scenario projections fall far below Dr. Luke's projections.

45. MRH and WMC offered testimony from Dr. Bill Fox, Director of the Center for Business and Economic Research and a professor of business at the University of Tennessee. Dr. Fox was tendered and accepted as an expert in economic and population forecasting in Tennessee.

46. Dr. Fox reviewed Dr. Luke's report and testified that its population projections were unreasonable and outside the range of an acceptable forecast. Dr. Fox testified that while Dr. 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.

47. Dr. Fox also noted that the Dr. Luke analysis assumed that Spring Hill will continue to grow with no changes in outside influences. Dr. Fox stated that there were and would be changes in Spring Hill housing prices, employment growth, schools and health care that called this assumption into question. Dr. Fox also reviewed Dr. Swanson's projections and was of the opinion that Dr. Swanson had used a more appropriate methodology resulting in reasonable projections.

48. MRH's and WMC's expert Dr. Deborah Kolb, a health care 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 Dr. Luke's population projections were overstated and not credible. Dr. Kolb noted certain problems with RPC's population projections. For example, Dr. Luke took the growth rate from 2000 to 2005 from the Special Census and extended the growth projection beyond Spring Hill's city limits. Edsel Charles testified that adjacent Thompson's Station is not a high growth area like Spring Hill. However, Dr. Luke applied the 17% growth rate to both cities.

SHH Utilization Projections

49. Hospital utilization is a factor in projecting the need for additional health care services. A hospital utilization rate is calculated in terms of a ratio of the number of hospitalizations per one thousand people in a given area. Further, Dr. Kolb explained that population projections are crucial in accurately predicting utilization.

50. The utilization rate for SHH's six-zip code service area declined 4.2% from 2002 to 2005. Dr. Luke did not take into account in his report this declining use rate for hospital service. Dr. Luke testified that, based on his review of the data, he did not believe that the declining use rate was likely to continue. SHH's utilization rates also do not take into account the lower rate at which Spring Hill area residents (a young population) use hospital services. Dr. Kolb believed that use rates in Tennessee have been fairly stable overall. She had no opinion about when the current use rate would level off.

51. Dr. Luke lowered his utilization projections for the proposed SHH subsequent to submitting his original report that was attached to the CON application. The First RPC Report, dated April 12, 2006, projected a utilization rate for SHH of 10,296 per 100,000 people. RPC's Third Report, dated February 12, 2007, projected a lower utilization for SHH, 9,605. The Third RPC Report 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.

52. Larry Kloess, president of HCA/TriStar testified that no medical/surgical facility in HCA/TriStar's system of hospitals has enjoyed a 75% occupancy rate. SHH projects that it will have an occupancy rate of 82% by its fifth year of operation. Dr.

Kolb's report projects a lower occupancy rate based on the pro forma from HCA's application and the population projections from Dr. Swanson's high scenario.

Access

53. Dr. Kolb believes that the function of the CON process is to balance accessibility and availability to needed healthcare services against cost effectiveness and cost efficiency.

54. 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. However, Ms Nesbitt did not call an ambulance and was unaware that an urgent care center was located in Spring Hill.

55. 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. However, Ms. Thompson's emergency trips have not been by ambulance and on occasion were specifically to Vanderbilt University Medical Center. Ms. Thompson was unfamiliar with the Spring Hill urgent care center and would consider it for treatment if open at the time of need.

56. In December 2006, Spring Hill resident Layla Thompson and her husband spent a confusing night searching for an emergency room for their severely ill baby. If there had been a hospital in Spring Hill, they believe they would have been at an emergency room nine minutes after they left home.

57. MRH opened a primary care clinic in Spring Hill in 1998, a specialty clinic in 2005, an urgent care center in 2006, and a diagnostic center in 2006. Tim

Scarvey, vice president of development for HCA, testified that the next step in Spring Hill is an emergency department, surgery services, and beds to place those patients.

58. Recruiting physicians and maintaining a good medical community is aided by having a good hospital. SHH would help attract physicians to the area. Spring Hill currently has fewer physicians per person than Franklin and the Franklin area needs more primary care physicians.

Financial Projections

59. HCA submitted five years of financial projections in support of its application. 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 ranging from \$14.4 million (2010) to \$3.9 million (2012).

60. After the appeal in this case was filed, Chris Taylor, HCA CFO, discovered and corrected an error in the SHH pro forma that had been filed with the CON application. 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. Mr. Taylor testified that an 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. According to Mr. Taylor, the correction of the error flows through the income statement. Both before and after the correction, SHH showed a projected positive net income in the fourth year of operations.

61. The first three years of the project become 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. In the year 2013, the first year in which a profit was projected for SHH, 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.

62. 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. Projections for the facility's first year of profitability (2013) have declined from the \$1,065,584 amount presented to the Agency to \$179,000.

63. Mr. Taylor testified that a new hospital is expected to lose money in its initial years and that a new hospital is a long term investment. SHH is projected to generate positive net income in its fourth year of operations. Its net income should improve every year after its first year.

64. According to Mr. Taylor, HCA looks to cash flow, or EBITDA, when evaluating an investment. SHH is projected to generate positive cash flow in its second year of operations and will continue to improve thereafter.

65. To assist SHH expert Rick 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. This spreadsheet 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.

66. Dr. Kolb testified that if SHH's market share projections are correct then SHH cannot achieve financial viability. She further stated that either the hospital will have a much lower daily census than projected in the application, or the hospital, to achieve its financial goals, would have to attempt to capture more patients from MRH and WMC than is projected in SHH's application.

67. Dr. Kolb testified that if the assumptions contained in the CON application are applied to Dr. Luke's latest utilization projections, the proposed hospital will lose money for all of its first five years. Although her analysis used updated utilization projections from Dr. Luke's expert report, it did not use updated revenue projections from Mr. Knapp's expert report. If she had used the updated financial information as well as the updated utilization projections, her results would have been similar to Mr. Taylor's.

68. Mr. Knapp testified that 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 SHH will still have positive EBITDA in year two of operations and thereafter.

69. HCA indicated that it is fully prepared to support SHH financially.

Impact

70. If SHH is built, WMC and MRH will have less business than they will if they remain the only hospitals in Williamson and Maury Counties. No services will be offered at SHH that are not already offered at WMC and MRH.

71. The occupancy rates at MRH have been declining in recent years, averaging less than 60% in 2006. Discharges in its eight-county service area have declined every year since 2003. Fifty percent of MRH's discharges come from outside of Maury County. The farther people live north of MRH there is an inclination for those individuals to travel north for their medical care. MRH has a small market share of the city of Spring Hill, which is on the northern border of the MRH service area.

72. WMC's occupancy rates have been higher than those of MRH, but to some extent this reflects the fact that WMC has been undergoing a major construction project which has at times reduced bed capacity and inflated occupancy rates. WMC's occupancy rates do not adequately reflect utilization of WMC's full licensed bed complement.

73. Based on his population and use projections, Dr. Luke projects that MRH will have 10% more discharges in 2010 than it had in 2005. This percentage will steadily grow through 2014 to a 30% increase.

74. Based on his population and use projections, Dr. Luke projects that WMC will have 11% more discharges in 2010 than it had in 2005. This percentage will steadily grow through 2014 to a 30% increase.

75. In her report, Dr. Kolb opines that under the best case of steady use rates that SHH will prevent MRH from growing and limit WMC to marginal growth over a

period of nine years. If use rates continue to decline, MRH and WMC would have significantly fewer discharges in 2014 than 2005.

76. Dr. Kolb believes that were SHH to achieve its projected utilization that there would be a significant adverse impact on MRH and WMC. Dr. 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.

77. As previously noted, MRH has planned capital projects over the next five years of \$40 to \$50 million. James Otwell, CEO of MRH testified that its debt-to-capitalization ratio and debt service coverage are stronger than its peers. In 2006 MRH's gross patient revenues increased, while its costs have decreased. Mr. Otwell testified that MRH has 30 days of cash reserves (\$17-18 million) which he considered low compared to other hospitals. Its consultants believe it has the capacity to access \$41 million in additional debt. The CFO of MRH testified that MRH is currently strong financially.

78. As previously noted, 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. WMC has never had difficulty servicing its debt. WMC is financially healthy. Rodger Klein, COO of WMC, testified that WMC has cash reserves of \$30 million.

79. 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. 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 projects. 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. These additional loans amounted to approximately \$25.5 million.

80. MRH offered testimony from Martin Brown, a Certified Public Accountant licensed in Tennessee and a member of the PYA firm. Mr. Brown testified regarding the financial impact SHH will have on MRH. PYA and Mr. Brown perform health care advisory and accounting services in Tennessee, serving approximately 60 hospitals in Tennessee since 2003.

81. Mr. Brown's analysis established that if SHH is built MRH will sustain cumulative financial losses over five years of approximately \$40 million. Mr. Brown stated that such losses will reduce MRH's ability to provide for future fixed expenses and needs for capital expenses such as renovation and maintenance of all of its facilities. MRH faces 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. Mr. Brown also responded to Mr. 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. Mr. Brown testified that 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.

82. WMC offered testimony by Jeff Potter, a Certified Public Accountant licensed in Tennessee and a partner with LBMC, the largest Certified Public Accounting

firm in Tennessee. Mr. Potter has worked in the health care industry for over 20 years and approximately 95% of his clients are hospital or health care related.

83. Mr. Potter's report illustrates the impact of patient volume shift from WMC to SHH and then converts that number to financial impact on WMC. Mr. Potter accepted SHH'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 years of SHH's operation. 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 and affect WMC's ability to service its debt.

84. If SHH is not built, discharges and revenues at the existing hospitals will increase due to the population increase. Neither Mr. Brown nor Mr. Potter made any effort to project the financial condition of MRH and WMC, with or without SHH.

85. SHH offered the testimony of Rick Knapp regarding the financial impact of SHH. Mr. Knapp testified that he is a Certified Public Accountant in Ohio and Georgia. However, in *voir dire* of Mr. Knapp, MRH and WMC established that he is not currently licensed in either state. It is determined that a CPA license is not required to testify about the financial aspects of health care planning.

86. Mr. Knapp's opinions are essentially contingent upon Mr. Luke's projections being accurate.

87. Mr. Knapp estimated WMC stands to suffer \$13,629,761.00 in lost profits in the first five years of SHH's operation. Mr. Knapp also estimated MRH's lost profits for the first five years of SHH's operation as \$6,266,119.00.

88. Mr. Knapp was of the opinion that 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.

89. As stated by Mr. Knapp, 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 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.

90. As stated by Mr. Knapp, 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.

91. SHH offered proof regarding the opening of a new hospital and its impact on an existing hospital. In 2001, Middle Tennessee Medical Center (MTMC), located in Murfreesboro, Rutherford County, Tennessee, opposed a CON application filed by HCA for a new hospital (now StoneCrest Hospital) to be built in Smyrna, Rutherford County. In opposing that application, MTMC predicted to the Agency 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. The CON application was granted, and StoneCrest Hospital opened in the fourth quarter of 2003.

92. In 2006 MTMC filed a CON application for a replacement facility. The application stated that “MTMC’s current facility is already bed capacity constrained, despite the opening of StoneCrest Medical Center in 2003.” 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. 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. In her report, Dr. Kolb found the SHH comparisons to StoneCrest to be misleading. Dr. Kolb notes that Rutherford County and Smyrna are significantly more populous than Maury County or Spring Hill and the CON applications of SHH and StoneCrest are different in methodology and assumptions.

93. MRH is located 14 miles from the site of the proposed SHH. MRH provides health care services in eight counties, some that have limited 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.

94. 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 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. 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.

95. MRH also operates the Lewis Ambulatory Care Center in Hohenwald, Tennessee. 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.

96. 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. Each prior operator 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. 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.

97. 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.

CONCLUSIONS OF LAW

1. The Administrative Law Judge sits without the Agency in this de novo hearing pursuant to Tenn. Code Ann. § 68-11-1610.
2. The party petitioning for the hearing bears the burden of proof to establish, by a preponderance of the evidence, that the CON should be granted or denied. Tenn. Comp. R. & Regs. Rule No. 0720-13-.01(3). MRH and WMC have the burden of proof to establish that the SHH CON should be denied.

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

No certificate of need shall be granted unless the action proposed in the application is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, and will contribute to the orderly development of adequate and effective health care facilities or services. In making such determinations, the agency shall use as guidelines the goals, objectives, criteria and standards in the state health plan. Until the state health plan is approved and adopted, the agency shall use as guidelines the current criteria and standards adopted by the state health planning and advisory board, and any changes implemented by the planning division pursuant to § 68-11-1625. Additional criteria for review of applications shall also be prescribed by rules of the agency.

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

4. Pursuant to T.C.A. § 68-11-1609(b) the Agency should use “*Tennessee’s Health: Guidelines for Growth*”, 2000 edition (*Guidelines*) as guidelines until such time as a comprehensive state health plan is prepared. The *Guidelines* sets forth a specific methodology for determining need for many types of health care services, including acute care hospital services. The *Guidelines* need formula for acute care hospital beds is calculated by county and takes into account patient migration patterns.

5. Rule 0720-11-.01 of the Rules of the Tennessee Health Services and Development Agency sets forth additional criteria for review of CON applications as adopted by the Agency:

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

- (1) Need. The health care needed in the area to be served may be evaluated upon the following factors:
 - (a) The relationship of the proposal to any existing applicable plans;

- (b) The population served by the proposal;
 - (c) The existing or certified services or institutions in the area;
 - (d) The reasonableness of the service area;
 - (e) The special needs of the service area population, including the accessibility to consumers, particularly women, racial and ethnic minorities, TennCare participants, and low-income groups;
 - (f) Comparison of utilization/occupancy trends and services offered by other area providers;
 - (g) The extent to which Medicare, Medicaid, TennCare, medically indigent, charity care patients and low income patients will be served by the project. In determining whether this criteria is met, the Agency shall consider how the applicant has assessed that providers of services which will operate in conjunction with the project will also meet these needs.
- (2) Economic Factors. The probability that the proposal can be economically accomplished and maintained may be evaluated upon the following factors:
- (a) Whether adequate funds are available to the applicant to complete the project;
 - (b) The reasonableness of the proposed project costs;
 - (c) Anticipated revenue from the proposed project and the impact on existing patient charges;
 - (d) Participation in state/federal revenue programs;
 - (e) Alternatives considered; and
 - (f) The availability of less costly or more effective alternative methods of providing the benefits intended by the proposal.
- (3) Contribution to the Orderly Development of Adequate and Effective Healthcare Facilities and/or Services. The contribution which the proposed project will make to the orderly development of an adequate and effective health care system may be evaluated upon the following factors:
- (a) The relationship of the proposal to the existing health care system (for example: transfer agreements, contractual agreements

for health services, the applicant's proposed TennCare participation, affiliation of the project with health professional schools);

(b) The positive or negative effects attributed to duplication or competition;

(c) The availability and accessibility of human resources required by the proposal, including consumers and related providers;

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

NEED

6. Both MRH and WMC have continuously updated, improved, and expanded their respective hospitals. MRH has directly invested resources in Spring Hill, including a primary care facility, specialty care facility and outpatient diagnostic imaging center. WMC recently completed \$83 million in renovations and additions. Both hospitals have planned projects over the next few years. MRH and WMC each recently evaluated the need for a hospital in Spring Hill and both concluded that such was not practical at this time. Spring Hill officials did not approach MRH or WMC about providing additional services or a hospital in Spring Hill. There has been no proof offered that either MRH or WMC has failed to meet the health care needs of Spring Hill citizens.

7. Prior to submitting the SHH CON application, HCA consulted Ed Stall, a hospital consultant it regularly engages, to update his 2004 report (no hospital needed) regarding the need for a hospital in Spring Hill. Although his report made conservative assumptions and was not a comprehensive analysis, his report is of some assistance in determining need. Mr. Stall's updated 2006 report concluded that a 56 bed hospital in Spring Hill was not needed in 2010. Prior to the SHH CON application, MRH consultants

estimated that with 85% occupancy Spring Hill residents would need up to 60 beds by 2015 and WMC consultants estimated that WMC should open 60 more beds by 2010. It should be noted that 1) the MRH estimate calls for the beds in 2105, not 2010 and, 2) the additional beds called for at WMC are for the entire WMC service area not just Spring Hill.

8. The SHH CON application did not satisfy the *Guidelines* bed need formula. However, WMC's 40-bed CON application and Stonecrest's CON application each failed the formula but both were granted a CON by the Agency. Pursuant to Tenn. Code Ann. § 68-11-1609(b), the *Guidelines* are not mandatory but should be merely used as a guide. Additional evidence was presented and should be considered as to whether or not additional beds are needed in the Spring Hill area.

9. In determining bed need and occupancy rates, Dr. Luke failed to account for out-migration in his Report presented to the Agency. 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. 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. HCA's methodology has the effect of overstating bed need since SHH would not alter or reduce such tertiary out-migration since SHH would not offer tertiary care. Also, some patients seek treatment out of county for non-tertiary care and Dr. Luke also failed to account for this type of out-migration. 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.

10. The factor most driving bed need is population. Much of the evidence at this hearing related to and/or was dependent upon population projections for the proposed SHH service area. The essential question is whether there will be sufficient population in 2010 when SHH is projected to open and in subsequent years to support SHH as well as MRH and WMC. According to Dr. Luke, the two zip codes encompassing Spring Hill will have a population of 60,373 in 2010 and 116,371 in year 2014. Dr. Luke established this number by using a 17% growth rate and compounding annually. Dr. Swanson has never seen a city sustain a 17% rate of growth for the time period projected by Dr. Luke. SHH argues that Dr. Luke's predictions for the growth rate between 2005 and 2007 are already behind the population as established by the April 2007 city of Spring Hill water accounts. However, the population projections to establish the need for the hospital extend all the way to 2014. Dr. Luke's methodology leads to the population of Spring Hill doubling every four years until the growth stops (sometime after 2014). Dr. Swanson's population numbers were far below Dr. Luke's projections. Dr. Fox and Dr. Kolb felt that Dr. Swanson's methodology was more appropriate and resulted in reasonable projections.

11. Residential lots approved for development, schools planned to be built, requested annexation and new businesses all demonstrate real growth in Spring Hill. Further, Spring Hill has available housing, land, residential lots, and infrastructure to accommodate much more additional growth, even that estimated by Dr. Luke. However,

the capacity to grow does not mean that the housing, lots and land will be occupied with Dr. Luke's population numbers by 2010 or 2014.

12. Dr. Luke's population forecast forms the basis of the alleged need for SHH. Dr. Swanson testified that Dr. Luke's annual growth projections were unreasonable and unreliable. Dr. Fox found Dr. Luke's numbers unreasonable and unacceptable. Dr. Kolb stated that Dr. Luke's projections were overstated and not credible. Based on their professional qualifications and testimony, the opinions of Dr. Swanson, Dr. Fox and Dr. Kolb are found to be more credible than Dr. Luke's. Therefore, the population growth forecast of Dr. Luke is determined to be unreasonable.

13. Spring Hill officials and many of its residents support SHH. Several Spring Hill residents testified about lengthy trips for emergency care, though some were not familiar with the urgent care facility located in Spring Hill. However, community support, without the requisite level of need, does not satisfy the criteria to determine whether or not a CON should be granted.

14. When all of these factors are considered, MRH and WMC have established, by a preponderance of the evidence, that SHH is not "necessary to provide needed health care" to the proposed service area.

ECONOMIC FACTORS

15. Although there was an error in the financial projections prepared in support of the SHH CON application, the subsequent corrected financial projections still show a positive net income in SHH's fourth year of operation. The anticipated profit decreased from approximately \$1 million to approximately \$250,000. With the correction, estimated losses increased from \$25 million to \$29 million. Even though the

\$4 million increase is not insignificant, it is not of such magnitude to be of concern since new hospitals are expected to lose money in initial years of operation. SHH's corrected and updated financial projections do not materially alter the CON application.

16. Significant to HCA is the cash flow or EBITDA of an investment. SHH is projected to have positive cash flow in year two of its operation and continue to improve every year thereafter.

17. SHH financial projections rely, in part, on Dr. Luke's population and use rates. For the reasons previously cited (Conclusions of Law Nos. 9, 10, 12) this casts an element of doubt on the financial estimates. Based on her review of Dr. Luke's and HCA projections, Dr. Kolb opined that SHH was not financially viable. However, occupancy rates at a mid-point between Dr. Luke's projections and Dr. Swann's projections mean that SHH will still have positive EBITDA in year two.

18. Even if SHH does not obtain the occupancy rates projected by Dr. Luke within the projected time frame, HCA considers SHH a long term investment and has the financial ability to fund SHH.

19. When all of these factors are considered, MRH and WMC have failed to establish, by a preponderance of the evidence, that SHH cannot "be economically accomplished and maintained."

CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE

20. Despite recent declining occupancy rates at MRH, Dr. Luke projects that MRH and WMC would have more discharges after SHH opens than each hospital had in 2005. Dr. Luke's analysis is based on his questionable population and use projections. Dr. Kolb projected, that with declining use rates, discharges for MRH and WMC would

be less in 2014 than 2005. Dr. Kolb believes that MRH and WMC will suffer significantly, with stable or declining use rates, if SHH were to be built.

21. It is reasonable to expect changes in revenue for MRH and WMC if they were to face additional competition in the form of SHH. It is therefore necessary to examine the effects of this competition. With SHH in the marketplace, MRH stands to lose approximately \$40 million over five years and WMC lose approximately \$18 million over the first five years of SHH's operation. Mr. Knapp opined that with SHH both MRH and WMC will actually see more in operating income in 2010 (MRH, \$15.7 million; WMC, \$3.3 million) and 2014 (MRH, \$21.3 million, WMC, \$8.7 million) than in 2006. However, Mr. Knapp's numbers are derived, in part, on Dr. Luke's questionable projections making Mr. Knapp's forecast of little value.

22. Due to projected losses of \$40 and \$18 million, MRH and WMC would be limited in providing for future expenses, needed renovations, technological improvements, and debt payment, resulting in a reduction of health care services to their patients. Additionally, MRH provides extensive health care in eight counties, including services to some facilities that operate at a deficit (Findings of Fact Nos. 94-97). With losses of \$40 million, MRH likely would be less able to provide for the health care needs of many of the citizens in the eight counties.

23. SHH argues that MRH's and WMC's opposition to SHH is similar to MTMC's opposition to the CON application of StoneCrest Medical Center in 2001. By 2006, MTMC had sustained such growth that it sought a CON for a replacement facility. The StoneCrest analogy, though relevant, offers limited guidance. The geographic areas

involved are different and the populations of the towns and counties are significantly different.

24. The CON process does not guarantee freedom from any competition, but it does require that new facilities be approved only if there is a genuine need. In recent years, MRH and WMC have made significant capital investments to serve the needs of their service areas, which include Spring Hill. 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. MRH and WMC have demonstrated that it will be adversely impacted by SHH and be negatively affected. The proposed SHH will not contribute to the orderly development of adequate and effective health care facilities or services in the community.

25. When all of these factors are considered, MRH and WMC have established, by a preponderance of the evidence, that SHH will not “contribute to the orderly development of adequate and effective health care facilities or services.”

CONCLUSION

Maury Regional Hospital and Williamson Medical Center having established by a preponderance of the evidence that the application for a Certificate of Need for Spring Hill Hospital fails to meet the statutory and regulatory criteria, it is hereby **ORDERED** that the Certificate of Need filed for the Spring Hill Hospital be **DENIED**.

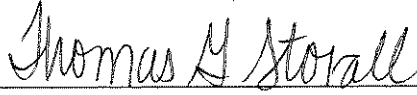
It is further **ORDERED**, pursuant to Tennessee Code Annotated § 68-11-1610(i), that all of the costs of this contested case proceeding, including the administrative law judge’s costs, deposition costs, and expert witness fees, are assessed to and shall be paid by SHH.

This Initial Order entered this 12th day of October, 2007.



Leonard Pogue
Administrative Judge

Filed in the Administrative Procedures Division, Office of the Secretary of State,
this 12th day of October, 2007.



Thomas G. Stovall, Director *abs*
Administrative Procedures Division

APPENDIX A TO INITIAL ORDER NOTICE OF APPEAL PROCEDURES

Review of Initial Order

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

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

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

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

Review of Final Order

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

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

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

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