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May 28, 2010

By Hand Delivery

Certificate of Need Section - DHSR
Attn: Mr. Mike McKillip, Project Analyst
NC Department of Health and Human Services
701 Barbour Drive
Raleigh, NC 27603

Re: Project ID No. N-8499-10
Hoke Healthcare, LLC (Hoke Community Medical Center)
Comments on CON Application

Dear Mr. McKillip:

On behalf of our client FirstHealth of the Carolinas and pursuant to N.C. Gen. Stat. § 131E-185(a1)(1), enclosed please find two copies of written comments concerning the above-referenced Certificate of Need application currently under review.

Sincerely,
Nelson Mullins Riley & Scarborough LLP

Franklin Scott Templeton

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Comments in opposition to
Project ID No. N-8499-10
Hoke Healthcare, LLC (Hoke Community Medical Center)

Comments submitted by FirstHealth of the Carolinas.

Pursuant to NCGS § 131E-185, FirstHealth of the Carolinas (FirstHealth) submits these comments in opposition to Hoke Community Medical Center (HCMC), a CON Application filed by Hoke Healthcare, LLC, a wholly owned subsidiary of Cumberland County Hospital System, Inc. (d/b/a Cape Fear Valley Health System) (collectively CFVHS). As highlighted below and described in the pages that follow, the HCMC Application suffers from multiple fatal flaws, and cannot be approved.

Key Reasons Why the CFVHS Application Cannot Be Approved:

- The Application contains absolutely no evidence regarding necessary interim financing, and fails to demonstrate the immediate or long-term financial feasibility of the project, in violation of Criterion 5.

- Over half of the proposed service area population lives closer to the existing CFVHS main hospital campus than to the proposed project site. It is not reasonable to assume that people who live closer to a large hospital that offers many services will drive further to obtain services from a smaller hospital that offers fewer services.

- The project proposes to radically modify and relocate two undeveloped CONs, at a total cost that is $88 million more than the previously approved capital costs.

- The Application lacks substantiation for its proposed market share shifts, a key component of the volume projections, in violation of Criteria 1, 3, 4, 5, 6 and 18a.

- The Application's pro formas overstate revenues and may understate expenses, rendering the project infeasible by Year 3.

These and other reasons why the Application cannot be approved are discussed in detail on the following pages. In most respects, this Application is simply a recycling of CFVHS's flawed CON Application in Project No. N-8353-09 for Cape Fear Valley West Community Hospital, and contains many of the same (or similar) flaws as existed in that 2009 Application.

I. The Application Does Not Comply With Criterion 5.

Criterion 5 requires the applicant to demonstrate the availability of funds for the project. *See* NCGS § 131E-183(a)(5). CFVHS's Application fails to do so. On page 235 of the Application, CFVHS states *"Cumberland County Hospital System, Inc. intends to finance its community hospital project costs in the amount of $92,269,192 through a tax-exempt revenue bond issue and cash reserves."* CFVHS provides, at Exhibit 3, a letter from BB&T regarding bond financing.[1] The applicant also states on page 235 that *"Also included in Exhibit 3 is a letter from Sandra S. Williams, Chief Financial Officer for CCHS, committing to borrow and disburse the funds for the construction and development project."* On page 236 (Item 9(b)), CFVHS states *"CCHS intends to maintain its financial ratios by obtaining interim financing for the development of the new community hospital."*[2]

The Application contains absolutely no evidence, however, regarding the necessary interim financing, and thereby is nonconforming with Criterion 5 and must be disapproved.

Contrary to CFVHS's statement on page 235, the Exhibit 3 letter from CFO Sandra Williams says absolutely nothing about the hospital obtaining interim financing to develop HCMC. The letter from BB&T at Exhibit 3 likewise says nothing about interim financing, and instead discusses only bond financing. There is no evidence *whatsoever* of any steps taken by the applicant, or of any interest by any lender, regarding interim financing. The Application and exhibits provide no information such as the name of a lender, the amount to be financed, or the terms and restrictions of such interim financing. The Application provides no evidence that any interim financing commitment, or even an expression of interest to provide interim financing, was in place on April 15, 2010, the date the Application was filed. Thus, the interim financing to be obtained cannot be viewed as a source of funding for the project.

There is a line of credit referenced in the Application's supporting documents, but that line of credit is not the interim financing referenced in the Application. Page 4 of the September 30, 2009 audited financial statements of CFVHS included in the Application refers to a line of credit facility for $153,700,000, and directs the reader to Note 5 in the financials for more information. Note 5, however, says nothing about the line of credit, nor does the Application say anything about the line of credit such as the name of the lender, the amount of credit still available, and whether the line of credit could even be used to fund the construction of HCMC. Since the Application states (on page 236) that the interim financing is *to be obtained* for the development of HCMC, it appears that the interim financing to be obtained is not the line of credit already referenced in the financials, and that the line of credit referenced in the financials is *not* the anticipated sources of interim funding to develop HCMC. This is similar to at least one situation previously reviewed by the Agency, where an applicant failed to provide any documentation regarding availability of a line of credit. *See* Agency Findings on the 2003 Good Hope Hospital Application, Project ID No. N-6801-03, at p. 40 (Appendix 1).

It also appears that CFVHS failed to include the interest cost of the intended interim financing. While a construction interest cost is identified on line 19 of the capital cost form at page 234, it is not clear that such

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[1] For ease of reference, exhibits to the applicant's CON Application are referred to herein as "Exhibit __," and documents attached to these comments are referred to as "Appendix __."

[2] The interim financing is not explained in the Application, but is likely some type of interim loan to be used until CFVHS obtains and completes the tax-exempt bond financing.

expense is related to any interim financing. The current interest rate on interim financing would be approximately 2.6%, or $1,950,000 per year on a $75 million loan. *See* Appendix 2.

CFVHS cannot now come back with documentation regarding the interim financing, because that would be an amendment to the Application. *See* 10A NCAC 14C.0204 (an applicant may not amend an application). Nor would it be appropriate for the Agency to conditionally approve CFVHS upon submission of the required documentation. This is a *competitive* review, and there are numerous other problems with the Application as discussed in these comments. *C.f. Dialysis Care of North Carolina, LLC v. NCDHHS*, 137 N.C. App. 638, 650, 529 S.E.2d 257, 264 (2000) (in a *non-competitive* review, the applicant was conditionally approved to provide missing evidence of a portion of financing, when application contained evidence of majority of funding).

In this case, there is no evidence of the interim funding at all, which CFVHS admits is required in order to maintain its financial ratios (required for its existing $310,000,000 in bond debt). As noted on page 19 of the financials, CFVHS bond covenants require it to maintain specified financial ratios, levels of working capital, and equity and other non-financial covenants. As such, CFVHS proposes to obtain interim financing to maintain those required ratios, yet provides absolutely no information indicating any efforts towards or commitment of such funding. The applicant has therefore failed to demonstrate the availability of funds for the project, and the Application is non-conforming with Criterion 5.

CFVHS's Application is similar to the situation the Court of Appeals examined in *Retirement Villages, Inc. v. NCDHR*, 124 N.C. App. 495, 477 S.E.2d 697 (1996), a copy of which is provided as Appendix 3. In *Retirement Villages*, one of the applicants, Beaver Properties, represented that related companies, Brian Center Management Corporation (BCMC) and Brian Center Corporation would fund the project. The Court of Appeals held that:

> *we agree that in the cases where the project is to be funded other than by the applicants, the application must contain evidence of a commitment to provide the funds by the funding entity. We hold that without such a commitment, an applicant cannot demonstrate availability of funds or the requisite financial feasibility.*

124 N.C. App. at 499, 477 S.E.2d at 699. In *Retirement Villages*, BCMC had a letter from a bank indicating that it would loan BCMC the money, but the Court of Appeals held that *"this does not constitute a commitment from BCMC that will provide the financing." Id.* Thus, the Court of Appeals held that the Agency should have found Beaver Properties non-conforming with Criterion 5.

Retirement Villages applies here. The money to develop HCMC is not coming entirely from CFVHS; the majority of it is coming from third party sources - interim financing, to be followed by bond financing. *See* pp. 235-36 of the Application. Therefore, CFVHS was required to provide a commitment of funding from the funding entities. CFVHS has failed to provide any commitment of interim financing, nor is there even a letter from a lender expressing interest in loaning money for such purpose. *C.f. Burke Health Investors v. NCDHR*, 135 N.C. App. 568, 575, 522 S.E.2d 96, 101 (1999) (letter from bank expressing interest in loaning funds deemed sufficient); *Dialysis Care of North Carolina, LLC v. NDHHS*, 137 N.C. App. 638, 642, 529 S.E.2d 257, 259 (2000) (same). The letter from BB&T Capital Markets at Exhibit 3 says nothing regarding interim financing; it only addresses a proposed $75 million in bonds. Since the Application fails

to demonstrate the availability of funds for the project, the Application does not conform to Criterion 5, and therefore must be disapproved.

In addition to failing to document the interim financing, CFVHS also failed to include any bond financing costs of issuance in the capital costs of the project, as required in Application Section VIII (p. 234, line 18). Bond financing costs of issuance for this project would amount to approximately $937,500. *See* Appendix 2. This omission is also grounds for finding the Application nonconforming with Criterion 5.

Criterion 5 also requires the applicant to demonstrate the immediate and long-term financial feasibility of the project. NCGS § 131E-183(a)(5). CFVHS's Application fails to demonstrate that feasibility. In the pro forma financial statements, Form B at Tab 13 of the Application shows the facility first having positive net income in Year 3, of $2,412,115. This positive net income is only achievable, however, by the inclusion of $4,284,676 in Other Revenue. On page 3 of tab 13, CFVHS states *"Other Revenue represents the collected professional fees for provision of services by employed Hospitalists, CRNA's and ED Physicians."* CFVHS does not explain its assumptions and methodology for projecting Other Revenue in either Section X of its Application, however, or in the Form B and financial assumptions included at Tab 13.

Since the applicant has failed to provide the assumptions and methodology used in calculating the Other Revenue, the unsupported projections are unreliable, and the Application therefore fails to reasonably demonstrate the immediate or long-term financial feasibility of the project, in violation of Criterion 5. When the Other Revenues are subtracted from the Form B, the Year 1 Net Income drops to $-9,029,752, the Year 2 Net Income drops to $-6,503,916, and the Year 3 Net Income drops to $-1,872,652. CFVHS therefore does not reasonably project immediate or long-term financial feasibility of the project.

Additionally, in the Form D and Form E for Other Outpatient Services at the end of Tab 13, the applicant shows the other outpatient cases for Years 1 - 3 to be 14,757, 18,120, and 21,618 outpatient cases, respectively. CFVHS fails to explain, however, how these volumes were projected in either Section III, pages 168-169, or Section IV, pages 192-197. Since the applicant has failed to provide the assumptions and methodology used in calculating these projections, the unsupported projections, and the revenues predicted to flow therefrom, are unreliable. Other outpatient services are projected to be $14,268,034 of Net Patient Revenue in Year 3, which represents 24% of the Total Revenue. Because the Application fails to reasonably demonstrate the immediate or long-term financial feasibility of the project, however, the Application does not conform to Criterion 5, and must be disapproved.

In addition to the missing interim financing, missing bond costs, and the unsupported financial projections, the Application also fails to adequately demonstrate CFVHS's ability to meet its stated $25 million reserve obligation to the project ($17,269,192 for construction plus $7,730,908 for start-up and initial operating expenses). The letter from CFVHS's CFO at Exhibit 3 purports to commit $25,000,000 of the applicant's accumulated reserves for the HCMC project. CFVHS's balance sheet (Exhibit 5 at p. 7) shows approximately $74 million in cash and short-term investments as of September 30, 2009. There is no information in the Application demonstrating, however, that CFVHS can afford to deplete fully *one-third* of its cash and short-term investments for this project. CFVHS has ongoing capital needs, including undeveloped CONs and pending CON applications that may require use of accumulated reserves. Further, in May 2008, the CEO of CFVHS wrote the agency that *"CFVHS is experiencing some difficult cash flows with the implementation and other operations."* *See* Appendix 4. Notably, CFVHS was experiencing difficult cash flows even before the worldwide economic crisis fully hit in September 2008, and before many

hospitals were experiencing tighter credit markets. Therefore, CFVHS's reserves are likely needed, and more appropriately used, for things other than a $92 million hospital.

For at least the foregoing reasons, the Application fails to conform to Criterion 5, and must be disapproved.

II. The Application Does Not Comply With Criterion 1.

In order to be found conforming with Criterion 1, the applicant must comply with all applicable SMFP policies. This includes Policy Gen-3. If an applicant fails to demonstrate the need for its project, it will be found non-conforming with Policy Gen-3. *See* the last sentence of Policy Gen-3. As discussed elsewhere in these comments, CFVHS has failed to demonstrate the need for its project and, therefore, it fails to conform to Policy Gen-3 and Criterion 1. There are, however, two other reasons why the project fails to comply with Policy Gen-3 and Criterion 1: (A) it does not promote equitable access, and (B) the project does not maximize health care value for resources expended.

A. The Project Fails to Promote Equitable Access.

At page 101, the Application defines its service area as eight zip codes in three counties: Cumberland, Hoke, and Robeson. The total service area population is represented to be 215,747, but this includes a ninth zip code in Hope Mills, which is included for OB projections only. *See* note below the chart on page 101 of the Application. Thus, the Hope Mills population should be excluded for any service other than OB.

On page 118 of its *2009* Application for essentially this same hospital, CFVHS indicated that approximately 30% of the population in six of the zip codes in the proposed service area (28314, 28306, 28304, 28357, 28377, 28386) are geographically closer to the proposed hospital site than to CFVHS's main campus, Cape Fear Valley Medical Center (CFVMC). This meant, of course, that 70% of the service area population in those six zip codes lived closer to CFVMC. On page 113 of the *current* Application, CFVHS references both census tract and zip code populations, but the result is unchanged: based on CFVHS's data, approximately 70% of the population in six of the eight service area zip codes live closer to CFVMC than to the proposed HCMC. One of those zip codes is, in fact, the street address zip code for CFVMC, at 1638 Owen Drive, Fayetteville, NC 28304. *See* Application, page 5 (Letter of Intent, showing at bottom the street address of CFVMC).

In addition, the town of Parkton (zip code 28371) in northern Robeson County, is closer to CFVMC than to zip code 28376, which is the zip code of the proposed location for HCMC, and the proposed HCMC site. *See* Appendix 5. Thus, Parkton and its population (5,970) should be added to the list of places that are closer to CFVMC than to the proposed HCMC. Hope Mills, whose zip code is included for OB projections only, is also substantially closer to CFVMC than to HCMC. *See id.*

According to the table on page 113 of the Application, the 2009 total population for these seven zip codes is 151,310 people. 70% of 151,310 is 105,917. Remove the population of Hope Mills (29,257), which is included only for OB projections, from the total service area population of 215,747, and the total service area population is 186,490. 105,917 is 57% of 186,490. Therefore 57% of the total service area population lives closer to CFVMC than to HCMC.

It is not reasonable to expect that people who live closer to an existing hospital (particularly one that offers more services than does the proposed facility) will travel to a more distant hospital. The Application offers no information explaining why people would drive a greater distance to go to HCMC when they could more easily get to CFVMC.

If the majority of people that a project proposes to serve are already being served by a facility that is both closer to them and offers more services, the project does not promote access to health care, because there

is already access to health care. While Hoke County does not yet have a hospital, CFVHS's proposal to build a 50-bed hospital in a service area where a majority of the population lives closer to a larger hospital which provides more services simply makes no sense. To the extent that HCMC is intended to benefit anyone, it appears that the majority of the beneficiaries are Fayetteville area residents who already have access to health care.

B. The Project Does Not Maximize Health Care Value.

The foundation for the CFVHS Application rests on two undeveloped CONs. The failure to develop these CONs and the astronomical cost increases associated with CFVHS's current plan to develop these CONs does not comport with Policy Gen-3's mandate that the project maximize health care value for the resources expended.

The source of the beds for HCMC is an undeveloped 2005 CON, Project I.D. No. M-7093-04. This CON was issued more than five years ago. The CON allowed CFVHS to add 44 beds at a total capital cost of $1,851,245. In 2006, the Agency approved a cost overrun (Project I.D. No. M-7436-05) for $980,381, bringing the total capital cost for the 44-bed CON project to $2,831,626.

In the five years since the CON was approved, CFVHS states that it has developed only 3 of the 44 beds.[3] These beds were placed in the Cardiac Services Intensive Care Unit. The other 41 beds have never been developed. In progress reports filed in 2008 and 2009, CFVHS informed the Agency that the bed project had been put *"on hold." See* Appendix 6.

One of the two operating rooms for HCMC comes from Project I.D. No. M-8004-07, in which CFVHS was approved for one additional operating room at CFVMC, at a capital cost of $643,338. On March 31, 2009, CFVHS filed a progress report for the OR project, which showed that no progress had been made toward development of the OR. No explanation for the lack of progress was offered. *See* Appendix 6.

As far as FirstHealth is aware, the Agency did not initiate any action to take these beds or the OR back from CFVHS. *See* NCGS § 131E-189(a) (*"If no progress report is provided, or, after reviewing the progress, the Department determines that the holder of the certificate is not meeting the timetable and the holder cannot demonstrate that it is making good faith efforts to meet the timetable, the Department may withdraw the certificate."*).

The combined capital cost total for the bed CON and the OR CON is $3,474,964.

Now, in mid-2010, CFVHS has announced that it wishes to spend $92,269,192 to develop the bed CON and the OR CON. This is an increase of $88,794,228, or 25.6 times more than what the Agency originally approved.

CFVHS offers only the barest of explanations concerning why it cannot develop the project as originally proposed. *See* page 179, "Maintain the Status Quo," under explanation of alternatives considered. *See also* the discussion of Criterion 4 in these comments.

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[3] See also the discussion in Section XII. The 2009 Hospital License Renewal Application suggests that none of the 44 beds was ever developed.

Of the eight zip codes proposed to be served by HCMC, CFVHS acknowledges that for six of these zip codes, CFVMC in Fayetteville is closer for 70% of the population. *See* page 113 of the Application. In reality, seven of the eight zip codes are closer to CFVMC. The ninth zip code, which is for OB only (Hope Mills), is also closer to CFVMC.

This leaves the Hoke County zip code, 28376, as the one zip code in the service area that does not have easy access to an existing hospital.

For the Hoke County zip code, 28376, which both the CFVHS and FirstHealth Applications are proposing to serve, CFVHS is the more expensive provider:

Hoke County
FY2008 Emergency Department Visits

	Visits	Total Charges	Charge per Visits	Variance
Hoke County ED Patients				
CFVMC	4,602	$6.7 million	$1,464	
FMRH	4,883	$6.0 million	$1,236	15.6% Less
All ED Patients				
CFVMC	83,676	$130.5 million	$1,561	
FMRH	48,467	$60.0 million	$1,238	20.7% Less

Source: Emergency Department Data, Thomson Reuters, March 2009. FMRH is FirstHealth's Moore Regional Hospital.

Hoke County
FY2009 Emergency Department Visits

	Visits	Total Charges	Charge per Visits	Variance
Hoke County ED Patients				
CFVMC	5,018	$8.2 million	$1,636	
FMRH	5,522	$6.5 million	$1,173	28.3% Less
All ED Patients				
CFVMC	87,368	$160.3 million	$1,835	
FMRH	49,016	$59.6 million	$1,216	33.7% Less

Source: Emergency Department Data, Thomson Reuters, March 2010.

In addition to establishing that CFVHS remains the more expensive provider, the data also clearly indicates that in the past year, FirstHealth has *decreased* its average charge per visit for Hoke County residents by 5.1 percent [($1,236 - $1,173) / $1,236], while CFVMC has *increased* its charge to Hoke County residents by 11.8 percent [($1,636 – $1,464) / $1,464].

Hoke County
FY2008 Emergency Department Visits
Primary Diagnosis Comparison

		Average Charge		
Primary Dx	Description	CFVMC	FMRH	FMRH Variance
3829	Otitis media NOS	$427	$168	-61%
4659	Acute URI NOS	$544	$218	-60%
462	Acute pharyngitis	$673	$273	-59%
4660	Acute bronchitis	$1,362	$643	-53%
07999	Viral infection NOS	$746	$368	-51%
5990	Urinary tract INF NOS	$2,032	$1,042	-49%
49392	Asthma NOS w exacer	$1,329	$733	-45%
0340	Strep sore throat	$719	$436	-39%
7840	Headache	$2,387	$1,458	-39%
78703	Vomiting alone	$1,368	$904	-34%
7806	Fever	$1,067	$720	-33%
7242	Lumbago	$1,363	$1,046	-23%
8470	Neck sprain	$1,871	$1,474	-21%
7802	Syncope & collapse	$2,487	$2,787	12%

Source: Emergency Department Data, Thomson Reuters, March 2009.

As the previous table indicates, in FY2008 for the most commonly diagnosed diseases in the Emergency Department, FirstHealth's FMRH has a lower charge in 13 of the 14 common Primary Diagnosis Codes included in the Thomson Reuters report. The average variance from CFVMC average charge to the FMRH average charge is 40.0 percent.

Hoke County
FY2009 Emergency Department Visits
Primary Diagnosis Comparison

		Average Charge		
Primary Dx	Description	CFVMC	FMRH	FMRH Variance
920	Contusion head X eye	$2,177	$797	-63.4%
5990	Urinary tract INF NOS	$2,362	$901	-61.9%
3829	Otitis media NOS	$476	$185	-61.1%
462	Acute pharyngitis	$712	$283	-60.3%
4659	Acute URI NOS	$590	$239	-59.5%
7999	Viral infection 362	$801	$362	-54.8%
4660	Acute bronchitis	$1,542	$712	-53.8%
64893	Oth CCE comp preg-AP	$1,852	$970	-47.6%
7840	Headache	$2,476	$1,458	-41.1%
8472	Lumbar region sprain	$1,299	$797	-38.6%

7242	Lumbago	$1,624	$1,059	-34.8%
8470	Neck sprain	$2,271	$1,510	-33.5%
78703	Vomiting alone	$1,274	$919	-27.9%
78060	Fever NOS	$907	$727	-19.8%

Source: Emergency Department Data, Thomson Reuters, March 2010.

As the previous table indicates, in FY2009 for the most commonly diagnosed diseases in the Emergency Department, FMRH has a lower charge in 14 of the 14 common Primary Diagnosis Codes between CFVMC and FMRH Emergency Departments included in the Thomson Reuters report. The average variance from CFVMC average charge to the FMRH average charge is 47.0 percent.

Overall, FirstHealth is less expensive than CFVHS:

Inpatient Discharges
FY2009 YTD
Average DRG Charge Comparison

	CFVMC			FMRH			
DRG Service Line	**Total Charges**	**Discharges**	**Average Charge**	**Total Charges**	**Discharges**	**Average Charge**	**FMRH Variance**
GENERAL SURGERY	$23,807,753	477	$49,911	$11,738,403	366	$32,072	-36%
GENERAL MEDICINE	$24,085,551	697	$34,556	$8,142,088	347	$23,464	-32%
NEUROLOGY	$9,248,826	388	$23,837	$3,732,290	228	$16,370	-31%
NEPHROLOGY	$4,938,249	224	$22,046	$1,913,948	123	$15,561	-29%
ENDOCRINE	$4,132,802	238	$17,365	$1,408,968	111	$12,693	-27%
PULMONARY	$20,343,298	821	$24,779	$7,927,039	426	$18,608	-25%
GYNECOLOGY	$2,457,186	141	$17,427	$725,290	54	$13,431	-23%
RHEUMATOLOGY	$287,623	19	$15,138	$153,274	13	$11,790	-22%
UROLOGY	$1,340,236	43	$31,168	$1,447,611	59	$24,536	-21%
DERMATOLOGY	$1,668,234	99	$16,851	$682,705	50	$13,654	-19%
OPHTHALMOLOGY	$12,918	1	$12,918	$59,486	5	$11,897	-8%
ORTHOPEDICS	$14,318,065	460	$31,126	$14,618,319	507	$28,833	-7%
VASCULAR SURGERY	$5,834,493	147	$39,690	$2,622,290	67	$39,139	-1%
DENTISTRY	$55,771	5	$11,154	$38,972	3	$12,991	16%
OTOLARYNGOLOGY	$444,458	33	$13,468	$457,048	26	$17,579	31%
Totals	**$112,975,463**	**3,793**	**$29,785**	**$55,667,731**	**2,385**	**$23,341**	**-22%**

Thus, the applicant is asking the Agency to find that the HCMC project maximizes health care value where:

- The applicant is proposing to spend $92 million to develop two CONs that were only supposed to cost $3 million.
- The applicant acknowledges that most of the people it plans to serve live closer to the applicant's existing facility, not to the proposed facility.

- The applicant told the Agency in 2008 that it was having cash flow problems.
- The applicant does not have funding for a $92 million hospital.
- The applicant's charges in most service lines are higher than the competition's.

These facts do not demonstrate value for the health care consumer, nor are they consistent with cost control, which is one of the key principles of the CON program. *See* NCGS § 131E-175(1). To the contrary, the facts presented in the Application demonstrate expensive and unnecessary duplication.

Although the Agency's 2003 decision on the Good Hope Application (Project I.D. No. M-6801-03) was written before Policy Gen-3 was incorporated into the SMFP, the Good Hope decision is nonetheless instructive here. In the 2003 Good Hope Application, the applicants proposed to radically modify a 2001 CON for a replacement hospital for Good Hope in Erwin, by doubling the size and cost of the facility and moving it to a new location. The Agency scrutinized the proposal to ascertain whether the applicant adequately explained why it needed to make these radical changes. Finding no such justification, the Agency disapproved the Application.

The situation here is even more extreme than in Good Hope, because CFVHS proposes to increase the cost of two previously approved CONs by 2,555%. As explained below, CFVHS, like Good Hope, has failed to adequately explain why it needs to radically modify its previously approved CONs, and its Application must be disapproved.

III. The Application Does Not Comply With Criterion 3.

Criterion 3 requires the applicant to demonstrate the need that the identified population has for the proposed services. NCGS § 131E-184(a)(3). CFVHS begins its methodologies used to project future need on page 134 of its Application. The second of the two assumptions presented by CFVHS is an assumption of 10% in-migration.

CFVHS is required to explain and justify all of its assumptions, including its in-migration percentage. CFVHS failed to clearly define the origin of these 10% of annual HCMC visits, procedures, days of care, deliveries, etc, other than to state that they come "from other zip codes in Cumberland County and on occasion from patients historically served by CFVMC." *See* Application page 137.[4] CFVHS failed to list these zips codes to fully define the source of the in-migration patients, or to explain why these patients would use the proposed facility. This could mean that the applicant is expecting patients to drive past an existing facility, e.g., CFVMC, or a hospital in another county, to use its proposed facility. This is an illogical assumption, however, particularly since the applicant is proposing to offer far fewer services than are available at CFVMC. In many past Agency findings, the Agency has required that the applicant clearly identify or define the in-migration by listing zip codes or other detailed, descriptive information. *See* Appendix 7 (Agency findings for FMC-Kernersville (Project I.D. # G-7604-06) at pages 20-21[5]); deposition testimony of the former Chief of the CON Section at pages 64-68 in the FMC-Kernersville project (Office of Administrative Hearings, 06 DHR 2044, Volume I, Deposition of Lee B. Hoffman, February 8, 2007)[6] (also at Appendix 7, at end).

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[4] While CFVHS asserts that in-migration *"is historically between 10% and 20% of total utilization,"* Application at p.136 n.49, CFVHS admits in another currently pending CON Application (to add a da Vinci surgical robot) that its in-migration from outside the CFVMC service area in FY 2009 was only 3.5% - approximately one-third the level asserted here. *See* CON Application for Project I.D. No. M-8498-10, at p.62.

[5] Agency findings Project I.D. G-7604-06 at pages 20-21: "The level of inmigration [for FMC-Kernersville] is assumed to be 20%. This is based on experience at Presbyterian Hospital Huntersville. [The applicant] believe[s] the level of inmigration is conservative, because PHH serves 80% of its discharges from a 10 zip code area, while the FMC-Kernersville service area will only be seven zip codes.... However, the mere fact that Presbyterian Hospital Huntersville (PHH) serves 80% of its discharges from a 10 zip code service area does not demonstrate that the applicants' assumption is *"conservative."* The applicants do not provide sufficient information in the Application to show that the 10 zip codes in PHH's service area are similar to the 7 zip codes in FMC-K's proposed service area. *Further, the applicants did not adequately demonstrate that it is reasonable to assume that inmigration would be 20% at FMC-K based only on the experience at one other hospital.... immigration at the proposed FMC-K is unlikely to be as high as 20%, particularly given there are four tertiary hospitals in Forsyth and Guilford counties...* Moreover, in Section III.5(a), page III-21, the applicants state *"20 percent will come from other zip codes in Forsyth and Guilford Counties, Other North Carolina Counties, and Other States."* (Emphasis added.) Thus, the applicants state that some portion of the 20% inmigration will be residents of other Forsyth and Guilford County zip codes. *However, the applicants did not identify those zip codes."* (Emphasis added.)

[6] Q. Okay. We talked a little while ago about service area. Have you seen in CON applications hospitals defining the service area for particular services to be certain zip code areas as opposed to entire counties? A. Yes. Q. Okay. And were you aware in this case, Ms. Hoffman, that Forsyth and Novant had defined the service area for the proposed hospital in Kernersville to be several zip codes in Forsyth and Guilford counties? A. Well, yes and no. That's what the problem was. Apparently, their primary service area was certain zip codes in that area, but then they also -- 20% of their patients were coming from a service area beyond that area. Q.I believe you indicated, Ms. Hoffman, that a problem that you had with this Kernersville application was the level of in migration. Is that right? A. Not just the level. *Not just that it was 20% immigration, but they weren't specific about where that 20% was coming from.* Q. Okay. So is it possible that if the applicant had explained more specifically where that 20% was coming from, that 20% might have been an appropriate level of in migration?... A. *Not just where they were coming from, but that those patients -- it was reasonable to expect those patients would come to this facility. So it's much more than just identifying where they're coming from, but does that population, that 20%, whoever they are, need the services at this facility and would they come to this facility for those services.* Q. So if I'm understanding correctly, Ms. Hoffman, the problem that you

The primary assumption that CFVHS utilized to determine projected HCMC volumes was a "Percent Market Volume Shift." The following services' projected volumes utilized the "Percent Market Volume Shift":

- Inpatient Days (page 141),
- Obstetric Inpatient Days (page 148),
- Inpatient and Outpatient Surgery (page 156),
- Outpatient Cases (page 161), and
- Emergency Visits (page 165).

Throughout the need methodology, CFVHS uses the following statements to base its market volume shift:

> *geographic proximity of the zip population to the proposed HCMC community hospital, discussion with CFVHS representatives working and living in the proposed service area, congestion at the existing campus of CFVMC on Owen Road, and mileage and driving time analysis.*

It should be noted, however, that CFVHS does not provide anywhere in the Application or its exhibits the following:

- Mileage analysis,
- Drive time analysis,
- Evidence of congestion of CFVMC,
- Meeting minutes or other evidence relating to discussions with CFVHS representatives working and living in the proposed service area, or
- Geographic proximity analysis of the zip codes with the proposed HCMC facility. In fact, as shown above, 57% of the total service area lives closer to CFVMC than to HCMC.

The primary factors leading to a market volume shift are not presented in the Application validating CFVHS's "Percent Market Volume Shift."

CFVHS includes additional factors that also "support" the market volume shift for each of the previously identified services. CFVHS states the following in the need methodologies:

> *The following factors were considered important to the determination of the percent of existing market volume projected to shift from the current CFVMC to the new HCMC hospital.*
>
> - *Physician support for the project is overwhelming.*
> - *Community support for the project is overwhelming.*
> - *There currently are 5 CFVHS employed physician practices with 14 physicians in the defined service area: including Hoke Family Medical Center, Hope Mills Family Care, Cape Fear Valley*

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identified with the Kernersville application was not the 20% level of immigration itself, but rather where the patients would come from and whether it would be reasonable that that 20% would choose the Kernersville hospital. A. *Actually, I believe it was all of that. It was also the 20% looked unreasonably high as well for a facility in this location.... Q. Do you believe in all cases, Ms. Hoffman, that a 20% level of in migration for a hospital is automatically unreasonable? A. No. It's up to the applicant to demonstrate the reasonableness.* (Emphasis added.)

Pediatric Care, Cape Fear Valley OB\GYN Clinic, and Perinatology Clinic.

- *Congestion and traffic on Owen Road, where CFVMC is located, will continue to grow with the expected population growth in the defined service area.*
- *HCMC offers a choice for inpatient and outpatient care closer to home.*
- *The proposed location of HCMC on Hwy 401 will result in ease of access to the existing population in the defined zip code service area.*
- *Some patients will continue to seek care at other CFVHS hospitals, therefore 100% of the demand for inpatient services in the service area will not shift to HCMC.*

However, CFVHS fails to include in its methodology how it converts anecdotal statements like "Physician support for the project is overwhelming" and "Congestion and traffic on Owen Road" into quantitative data that results in a "Percent Market Volume Shift."

Inpatient Days

On page 141 of the Application, CFVHS projects the "Percent Market Volume Shift" for acuity adjusted, non-obstetrical inpatient days. However, instead of including a discussion of the how CFVHS determined non-obstetrical inpatient days, CFVHS on the bottom of page 157 and page 158 discusses how obstetrical inpatient days were determined.

The following table from page 141 presents the "Percent Market Volume Shift" for the service areas zip codes for inpatient days:

Zip Code	County	PY 1 FY 2014	PY 2 FY 2015	PY 3 FY2016
28304	Cumberland	10.5%	12.8%	15.0%
28306	Cumberland	10.5%	12.8%	15.0%
28314	Cumberland	10.5%	12.8%	15.0%
28371	Robeson	7.0%	8.5%	10.0%
28357	Hoke/Robeson	7.0%	8.5%	10.0%
28376	Hoke	56.0%	68.0%	80.0%
28386	Hoke/Robeson	7.0%	8.5%	10.0%
28377	Hoke/Robeson	7.0%	8.5%	10.0%

CFVHS provides no evidence, other than anecdotal evidence, to support any of the projected market volume shifts. For example, lacking any basis of support, it is just as likely for the "Percent Market Volume Shift" of zip code 28304 to be 1.0%, 2.0%, and 3.0% in Year 1 through 3, respectively. The percentages have no basis of support, resulting in unreasonable inpatient volume projections.

On Application page 142, CFVHS assumes a ramp-up progression of 70%, 85%, and 100% of the Year 3 proposed market shift percent during the first three years of operation, respectively. CFVHS provides no

supporting documentation, however, to show that 70%, 85%, and 100% are reasonable assumptions. Again, CFVHS could just have easily assumed a ramp-up progression of 50%, 75%, and 100%, or 33%, 66%, and 100%. The percentages have no basis of support, resulting in unreasonable inpatient volume projections.

Obstetrical Inpatient Days

On page 148 of the Application, CFVHS projects the "Percent Market Volume Shift" for acuity adjusted, non-obstetrical inpatient days. The following table is from page 148 of the Application, and although labeled as "Non-Obstetric Inpatient Days," it appears in fact to relate to obstetrical patient days.

Zip Code	County	City/Town	PY 1 FY 2014	PY 2 FY 2015	PY 3 FY 2016
28304	Cumberland	Fayetteville	26.8%	38.3%	45.0%
28306	Cumberland	Fayetteville	26.8%	38.3%	45.0%
28314	Cumberland	Fayetteville	26.8%	38.3%	45.0%
28348	Cumberland	Hope Mills	17.9%	25.5%	30.0%
28371	Robeson	Parkton	17.9%	25.5%	30.0%
28357	Hoke/Robeson	Lumbar Bridge	23.8%	34.0%	40.0%
28376	Hoke	Raeford	53.6%	76.5%	90.0%
28386	Hoke/Robeson	Shannon	17.9%	25.5%	30.0%
28377	Hoke/Robeson	Red Springs	17.9%	25.5%	30.0%

CFVHS again provides no evidence, other than anecdotal evidence, to support any of the projected market volume shifts. For example, lacking any basis of support, it is just as likely for the "Percent Market Volume Shift" of zip code 28304 to be 5.0%, 10.0%, and 15.0% in Years 1 through 3, respectively. The percentages have no basis of support, resulting in unreasonable obstetrical inpatient volume projections.

Based on Application pages 142 and 149, CFVHS assumes a ramp up progression of 70%, 85%, and 90% of the proposed market shift during the first three years of operation, respectively. CFVHS provides no supporting documentation, however, to show that 70%, 85%, and 90% are reasonable assumptions. Again, CFVHS could just have easily assumed a ramp-up progression of 50%, 75%, and 100%, or 33%, 60%, and 80%. The percentages have no basis of support, resulting in unreasonable obstetrical inpatient volume projections.

Observation Patient Days

On page 153 of the Application, CFVHS uses a ratio of 1 observation day for every 5.6 inpatient days. This ratio is based on the CFVHS FY2008 observation day ratio from the proposed zip code service area. CFVHS fails to explain, however, why the observation day ratio from CFVHS, which includes services to patients with any DRG, is comparable to HCMC, which CFVHS identifies on page 138 as only treating DRGs with a FY2008 relative weight of less than 2.0, and excluding patients with cancer, neurology, and nephrology concerns.

Surgical Cases

On page 156, CFVHS projects the "Percent Market Volume Shift" for inpatient and outpatient surgery. The following table is from page 156 of the Application and presents the "Percent Market Volume Shift" for the zip codes in the service area for inpatient and outpatient surgery:

Inpatient Surgery

Zip Code	County	PY 1 FY 2014	PY 2 FY 2015	PY 3 FY 2016
28304	Cumberland	10.5%	12.8%	15.0%
28306	Cumberland	10.5%	12.8%	15.0%
28314	Cumberland	10.5%	12.8%	15.0%
28371	Robeson	7.0%	8.5%	10.0%
28357	Hoke/Robeson	7.0%	8.5%	10.0%
28376	Hoke	56.0%	68.0%	80.0%
28386	Hoke/Robeson	7.0%	8.5%	10.0%
28377	Hoke/Robeson	7.0%	8.5%	10.0%

Outpatient Surgery

Zip Code	County	PY 1 FY 2014	PY 2 FY 2015	PY 3 FY 2016
28304	Cumberland	17.5%	21.3%	25.0%
28306	Cumberland	17.5%	21.3%	25.0%
28314	Cumberland	17.5%	21.3%	25.0%
28371	Robeson	10.5%	12.8%	15.0%
28357	Hoke/Robeson	10.5%	12.8%	15.0%
28376	Hoke	56.0%	68.0%	80.0%
28386	Hoke/Robeson	10.5%	12.8%	15.0%
28377	Hoke/Robeson	10.5%	12.8%	15.0%

CFVHS again provides no evidence, other than anecdotal evidence, to support any of the projected market volume shifts. For example, lacking any basis of support, it is just as likely for the "Percent Market Volume Shift" of zip code 28304 to be 5.0%, 10.0%, and 15.0% in Years 1 through 3, respectively. The percentages have no basis of support, resulting in unreasonable obstetrical inpatient volume projections.

Again, based on Application pages 142 and 156, CFVHS assumes a ramp-up progression of 70%, 85%, and 100% of the Year 3 proposed market shift during the first three years of operation, respectively. CFVHS provides no supporting documentation, however, to show that 70%, 85%, and 100% are reasonable assumptions. Again, CFVHS could just have easily assumed a ramp-up progression of 50%, 75%, and 100%, or 33%, 60%, and 80%. The percentages have no basis of support, resulting in unreasonable inpatient and outpatient surgical volume projections.

Outpatient Cases

On page 161 of the Application, CFVHS projects the "Percent Market Volume Shift" for outpatient cases. The following table is from page 161, and presents the "Percent Market Volume Shift" for the zip codes in the service area for outpatient cases:

Zip Code	2014	2015	2016
28304	17.5%	21.3%	25.0%
28306	17.5%	21.3%	25.0%
28314	17.5%	21.3%	25.0%
28371	10.5%	12.8%	15.0%
28357	10.5%	12.8%	15.0%
28376	56.0%	68.0%	80.0%
28386	10.5%	12.8%	15.0%
28377	10.5%	12.8%	15.0%

CFVHS provides no evidence, other than anecdotal evidence, however, to support any of the projected market volume shifts for outpatient cases. For example, lacking any basis of support, it is just as likely for the "Percent Market Volume Shift" of zip code 28304 to be 7.0%, 10.0%, and 13.0% in 2014-2016, respectively. The percentages have no basis of support, resulting in unreasonable outpatient volume projections.

Again, CFVHS assumes a ramp-up progression of 70%, 85%, and 100% of the Year 3 proposed market shift during the first three years of operation, respectively. CFVHS provides no supporting documentation, however, to show that 70%, 85%, and 100% are reasonable assumptions. Again, CFVHS could just have easily assumed a ramp-up progression of 50%, 75%, and 100%, or 33%, 60%, and 80%. The percentages have no basis of support, resulting in unreasonable outpatient volume projections.

Emergency Visits

On page 165 of the Application, CFVHS projects the "Percent Market Volume Shift" for emergency visits. The following table is from page 165, and presents the "Percent Market Volume Shift" for the zip codes in the service area for emergency visits:

Zip Code	City	County	2014	2015	2016
28304	Fayetteville	Cumberland	21.0%	25.5%	30.0%
28306	Fayetteville	Cumberland	21.0%	25.5%	30.0%
28314	Fayetteville	Cumberland	21.0%	25.5%	30.0%
28371	Parkton	Hoke [sic]	14.0%	17.0%	20.0%
28357	Lumber Bridge	Hoke/Robeson	14.0%	17.0%	20.0%
28376	Raeford	Hoke	63.0%	76.5%	90.0%
28386	Shannon	Hoke/Robeson	14.0%	17.0%	20.0%
28377	Red Springs	Hoke/Robeson	14.0%	17.0%	20.0%

CFVHS provides no evidence, other than anecdotal evidence, however, to support any of the projected market volume shifts. For example, lacking any basis of support, it is just as likely for the "Percent Market Volume Shift" of zip code 28304 to be 10.0%, 15.0%, and 20.0% in 2014-2016. The percentages have no basis of support, resulting in unreasonable emergency volume projections.

Again, CFVHS assumes a ramp-up progression of 70%, 85%, and 100% of the Year 3 proposed market shift during the first three years of operation, respectively. CFVHS provides no supporting documentation, however, to show that 70%, 85%, and 100% are reasonable assumptions. Again, CFVHS could just have easily assumed a ramp-up progression of 50%, 75%, and 100%, or 33%, 60%, and 80%. The percentages have no basis of support, resulting in unreasonable emergency volume projections.

Year 3 "Percent Market Volume Shift"

The following table presents the Year 3 "Percent Market Volume Shift" for the zip codes in the proposed service area:

Zip Code	County	City/Town	IP Days	OB IP Days	IP Surgery	OP Surgery	OP Cases	ED
28304	Cumberland	Fayetteville	15.0%	45.0%	15.0%	25.0%	25.0%	30.0%
28306	Cumberland	Fayetteville	15.0%	45.0%	15.0%	25.0%	25.0%	30.0%
28314	Cumberland	Fayetteville	15.0%	45.0%	15.0%	25.0%	25.0%	30.0%
28348	Cumberland	Hope Mills		30.0%				
28371	Robeson	Parkton	10.0%	30.0%	10.0%	15.0%	15.0%	20.0%
28357	Hoke/Robeson	Lumber Bridge	10.0%	40.0%	10.0%	15.0%	15.0%	20.0%
28376	Hoke	Raeford	80.0%	90.0%	80.0%	80.0%	80.0%	90.0%
28386	Hoke/Robeson	Shannon	10.0%	30.0%	10.0%	15.0%	15.0%	20.0%
28377	Hoke/Robeson	Red Springs	10.0%	30.0%	10.0%	15.0%	15.0%	20.0%

CFVHS has used essentially the same anecdotal statements to determine the Year 3 "Percent Market Volume Shift" across its services, yet has managed to reach a wide range of percentages for the proposed services. Some of the percentages vary, without explanation, from its 2009 CON Application for essentially the same hospital, while other percentages remain the same, again without explanation. The percentages have no basis of support, resulting in unreasonable volume projections, and the Application must therefore be disapproved.

IV. The Application Does Not Comply With Criterion 3a.

In the HCMC Application, CFVHS proposes to radically change two previously approved CONs that will affect CFVMC (the 44 bed CON and the OR CON), and proposes to relocate one operating room from its Highsmith-Rainey Hospital. CFVHS also states that it will relocate and replace a 16-slice CT scanner. Thus, CFVHS is proposing a relocation of assets and a reduction in service at CFVMC and Highsmith-Rainey. CFVHS should therefore have explained why these reductions would not adversely affect patients at CFVMC and Highsmith-Rainey. *See* NCGS § 131E-183(a)(3a). The applicant failed to do so.

Section III, Questions 7(c), 7(d), 8(a) and 8(b) are designed to elicit information relevant to Criterion 3a.

Question 7(c) asks:

> (c) If not relocating an entire facility that the needs of the patients who will remain at the existing facility will be *adequately* met with the remaining beds, operating rooms, equipment, or services that will not be relocated;

The applicant responded in part:

> *CFVHS does not propose to relocate licensed acute care beds and operating rooms from CFVMC…*

Question 7(d) asks:

> (d) that the relocation will not have a negative impact on the patients served in terms of any changes in services, costs to the patient or *level* of access by medically underserved populations.

The applicant responded in part:

> *CFVHS does not propose to relocate licensed acute care beds and operating rooms from CFVMC…*

Question 8(a) asks:

> If an existing facility proposes a reduction of beds, operating rooms, medical equipment, or services at its facility, the applicant *shall* demonstrate:
>
> (a) that the needs of the *patients* will be adequately met with the remaining beds, operating rooms, equipment or services:

The applicant responded in part:

> *The proposed project does not include a reduction of licensed acute care beds. In addition, one of the two operating rooms is CON approved but*

not yet operational....

Question 8(b) asks:

> (b) that *the* reduction will not have a negative impact on the patients to be served in terms of any changes in services, costs to the patient or level of access by medically underserved populations.

The applicant responded in part:

> *CFVHS does not propose a reduction in licensed beds and operating rooms at CFVMC...*

Application, pages 189-190.

These answers are insufficient. Neither Criterion 3a nor Questions 7 and 8 ask about *licensed* beds or operating rooms. Rather, the criterion and the questions ask about reductions and relocations, without regard to licensure status. CFVHS was approved to add 44 beds and 1 OR. Only 3 of these beds have been implemented. The Agency issued these CONs for a specified location, and must take into account how the failure to implement the 41 beds and the OR will affect CFVMC. Likewise, the Agency must consider how the reduction in OR capacity will affect Highsmith-Rainey.

The 44 bed CON provides that the beds were supposed to be installed in specified locations at CFVMC (3 North Nephrology; 3 North Observation; 2 East Observation; 4 North). Presumably, this was based upon a need that the Application demonstrated at the time. CFVHS assumes that some patients will shift to HCMC, but its assumptions are not reasonable. More than half of the population living in the service area live closer to CFVMC than to HCMC. It is not reasonable to assume that patients who live closer to CFVMC will drive to HCMC instead, especially since HCMC offers fewer services than CFVMC.

Although CFVHS states in response to Question 7(a) that "there is no available space at CFVMC for the additional 41 beds," *see* Application, page 188, CFVHS does not explain why that is the case or what happened to the space that was listed in the CON for Project I.D. No. M-7093-04. According to the chart on page 25 of the Application, the space in 4 North, where 16 beds were proposed to be located, is now office space. The applicant never explains why this space cannot be converted back to patient rooms.

As is the case with the beds, CFVHS has decided not to develop one of its ORs (Project I.D. No. M-8004-07) at CFVMC, and instead develop it at HCMC. There is nothing in the Application to show that the OR is not needed at CFVMC, or that it is not feasible to develop the OR at CFVMC. Indeed, this CON was only issued in March 2008. The applicant provides no information to show a dramatic change in circumstances over the last year. The assumption that some surgical patients will shift to HCMC is flawed, for the reasons previously stated.

Another of the ORs is proposed to come from Highsmith-Rainey. CFVHS states on page 187 that 2.1 ORs were needed at Highsmith-Rainey in FY 08-09, and that 3 shared surgical ORs will remain at Highsmith-Rainey. On page 189 of the Application, the applicant shows a decrease in OP surgical volume at Highsmith-Rainey for the first three years of the project. The only explanation given for why Highsmith-Rainey's surgical volume would decrease during the first three years of the project is given on Table 78 at

Exhibit 30 of the Application, and is based solely upon the projected 10% volume shift to HCMC (which, as explained herein, is unsupported and therefore unreasonable). Since the basis for that projected shift in surgical volume has not been reasonably explained, the assumption is unsupported and unreasonable, and therefore unreliable.

The applicant's assumptions that some of Highsmith-Rainey's surgical volume will shift to HCMC is faulty for two reasons. First, few if any of Highsmith-Rainey's inpatient surgeries are likely to shift to HCMC. Highsmith-Rainey is an LTACH and, presumably, inpatients who are having surgeries at Highsmith-Rainey are LTACH patients. HCMC, by contrast, is not an LTACH, and will only treat patients with a DRG weight of < 2.0. *See* Application, page 138. Therefore, the surgical volume attributable to the LTACH inpatients is not likely to shift from Highsmith-Rainey to HCMC. Second, the volume shifts for *any* patients are questionable since the majority of patients in the proposed service area live closer to CFVMC and Highsmith-Rainey than to the proposed HCMC site (according to MapQuest, Highsmith-Rainey is only five minutes from CFVMC).

Interestingly, in 2008, CFVHS's CEO wrote to Lee Hoffman, Chief of the CON Section, requesting that Highsmith-Rainey be allowed to keep 44 beds that were supposed to be moved to CFVHS's Valley Pavilion. The letter states: *"We are currently running 82 percent occupancy in the 66 operational beds in our LTAC facility at* [Highsmith-Rainey] *and believe that continuing and growing need demonstrates that we keep 44 of the originally requested 46 beds intact...."* *See* Appendix 4 at p.3. On page 180 of the Application, CFVHS states *"In addition, utilization of the LTAC beds at [Highsmith-Rainey] currently exceeds 85% and as soon as the federal moratorium on LTAC beds is lifted, [Highsmith-Rainey] hopes to add additional LTAC beds."*

If Highsmith-Rainey is busy enough that it needs to keep 44 beds, and is projecting to need more beds in the future, then it is reasonable to infer that surgical volume at Highsmith-Rainey may increase, not decrease. Therefore, relinquishing the OR to HCMC may have a negative impact on patients served by Highsmith-Rainey. The Application, however, does not explain how an increase in demand for the beds at Highsmith-Rainey correlates to a drop in demand for surgical services at Highsmith-Rainey.

As discussed earlier in these comments, CFVHS is more expensive than FirstHealth in many service lines. There is no indication that CFVHS will lower its charges if it is allowed to build HCMC. In fact, given the high cost to build the facility (approximately $88 million more than the originally approved CONs for Project I.D. Nos. M-7093-04 and M-8004-07) and CFVHS's stated cash flow concerns, the HCMC project may have the tendency to raise costs for health care consumers.

The applicant also states, on pages 19 and 29, that it will relocate and replace a 16-slice CT scanner from CFVMC to HCMC. The only 16-slice CT scanner in the CFVHS system is located in the CFVMC ED. *See* Application, page 19. This is the only CT scanner in the CFVMC ED. CT scanners in EDs are commonplace in most of the larger hospitals in North Carolina. The applicant provides no information concerning how the needs of CFVMC ED patients who need CT scans will be met, if the CT scanner is moved to HCMC.

This situation is similar to the Agency's decision in Project I.D. No. F-7951-07 (CMC-NorthEast Freestanding ED), attached as Appendix 8, in which CMC-NE was disapproved on Criterion 3a grounds to relocate a CT scanner from its Copperfield location to the new freestanding ED in Kannapolis. As in this

case, CMC-NE did not provide any CT utilization data for the existing location to show how the relocation of the CT scanner would affect patients served at the existing location.

In sum, the applicant has proposed a reduction in service at both CFVMC and Highsmith-Rainey, and has failed to adequately explain how the needs of these patients will be addressed. Thus, the Application is non-conforming with Criterion 3a.

V. The Application Does Not Comply With Criterion 4.

Criterion 4 requires the applicant to demonstrate that it has selected the least costly or most effective alternative. NCGS § 131E-184(a)(4). Here, CFVHS proposes to spend $88,794,228 more than it was originally approved for in the 44 bed CON, the cost overrun for the 44 beds, and the OR CON. There is no possibility that an additional expense of $88,794,228 is a "least costly" alternative compared to a CON-approved cost of $3,474,964.

Nevertheless, the applicant offers this explanation for why it should be allowed to spend an additional $88,794,228:

> *Further analysis has shown that to implement the remaining beds as planned will require substantial additional capital expenditure. All of the original locations referenced in the above table are in one of the original bed towers at CFVMC. As a result, the older rooms must be brought to current licensure standards. The financial impact of these requirements was not realized at the time of the CON application for the 44 beds and subsequently cannot be developed as originally approved.*

Application, pp. 25-26; *see also* p. 179.

This explanation is unsupported for several reasons. First, CFVHS operates a large health care system that has filed many applications for CONs proposing to add beds. *See* Appendix 4 (May 26, 2008 letter from CFVHS CEO Michael Nagowski to Lee Hoffman, in which Mr. Nagowski describes four different CFVHS Applications for beds). CFVHS is undoubtedly familiar with the costs to implement beds, whether in new space or existing space.

Second, the CON Application from which the beds are coming to establish HCMC, Project I.D. No. M-7093-04, itself produced a cost overrun application. Even assuming in 2004 that CFVHS had underestimated its costs, it surely knew by the time it filed its cost overrun application in 2005 what it would cost to implement the beds.

Third, even if you make the highly improbable assumption that costs for the bed project had risen *ten to twenty times* in four years over the cost overrun approved amount, that amount would still be far less than what CFVHS proposes to spend now. Tellingly, the current CON Application provides no dollar figures of what it would cost to implement the beds at CFVMC as originally proposed. This suggests that the "further analysis" mentioned on page 25 was either never done or, if it was done, it did not support the applicant's belief that a $92 million expenditure is "least costly" when compared to a $3 million expense.

The 44 beds in Project I.D. M-7093-04 were supposed to go into existing space. The HCMC Application provides insufficient information about what has happened to that space since 2004. On page 25 of the Application, CFVHS provides a table showing that only 3 of the 44 beds have been implemented in the CSICU.[7] The 4 North Unit, which was to have the largest complement of beds (16), is now being used as offices. There is no indication of what has happened to 2 East, 3 North or 3 Floor Nephrology since 2004. The failure to provide more detail about the status of the space into which the 41 beds would be located

[7] See also the discussion in Section XII, pointing out the discrepancy in what CFVMC says happened with these beds.

makes it even more difficult for the Agency to conclude that the applicant is proposing the least costly or more effective alternative.

The Agency should consider the original 2004 Application and 2005 cost overrun application for the 44 beds, and the statements CFVHS made at that time about how relatively easy and inexpensive it would be to implement the 44 beds. For example:

> *These [44] beds can be accommodated in existing space within the Medical Center, some of which has been previously licensed bed space converted to office, waiting, and support areas. The remaining available space is within areas we utilize for short term/observational patient care yet meets state code requirements for licensed bed space. The forty-four (44) beds will increase Cape Fear Valley Medical Center's acute licensed bed capacity to 438 beds.*
>
> *The up-fitting time and expense for Cape Fear Valley Medical Center will be minimal. Twenty-eight (28) of the additional forty-four (44) acute care beds available can be operational within 90 days of the CON Section's approval. The remaining sixteen (16) can be operational within twelve (12) months of the Section's approval.*

See page 29 of Project I.D. No. M-7093-04, attached as Appendix 9.

In its subsequent cost overrun application, CFVHS explained:

> *Once design was underway by the architect firm engaged to supervise modernization of the Four North medical surgical unit, it became apparent that the support staff and physician on-call alternate space was inappropriate and that these personnel should be closer to the Four North patient care area. Accordingly, 2,455 square feet of space in Four West will be modernized to accommodate support staff and physicians on-call. An additional 559 square feet of space was added to the original 7,516 Four North area for the planned implementation of the 16 acute care beds.*
>
> *Two other factors have influenced the original costs of the planned modernization for 31 of the 44 acute beds: since the original cost estimates were provided in August 2004, costs in the construction industry have changed over 16 percent due to international market (steel and petroleum-related materials) inflation and the weather impact in the United States on petroleum related products.*
>
> *The change in scope (square footage) and material cost increases have been approved by our Board of Trustees.*

The applicant then provided an implementation schedule, showing that the entire project would be completed in September 2006, almost four years before the HCMC project was filed, and seven years before the HCMC project is proposed to be operational:

Initial and Current Applications	Beds	Abridged Application	Implementation Dates
Three North Nephrology	1	1	March 5, 2005
CSICU	3	3	March 5, 2005
Three North Observation –M/S	9	9	March 5, 2005
Two North Observation – M.S	15	15	September 30, 2006
Four North – Offices – M/S	16	16	September 03, 2006
Total	44	44	

Source: page 20 of Application for Project I.D. No. M-7436-05

See pages 19 and 20 of Project I.D. No. M-7436-05, attached as Appendix 10.

Interestingly, in 2004 the applicant expressly rejected the idea of new construction, because it was more costly. *"New construction to gain only 44 beds is unnecessary since those beds can be integrated into space, which is currently available." See* page 36 of Project I.D. No. M-7093-04, attached as Appendix 9.

Considering all of this information, the Agency must ask:

1. What happened over the course of the last six years that now makes it impossible to develop the project as originally proposed?
2. How can spending 25.8 times more than what the Agency previously approved be the "least costly or most effective" alternative?
3. Why is a seven-year delay in implementing these beds in the best interest of patients?
4. Why is new construction to gain only 41 acute care beds 12 miles from the main hospital necessary?

Unfortunately, the Application provides no answers to these questions.

The applicant's explanation regarding the reason why it cannot develop the OR at CFVMC is equally vague. The applicant states on page 179 that *"The CON approved operating room at CFVMC was to be located in the cardiac surgery suite. Cardiac surgery procedures have decreased during the last several years. As a result, the proposed expansion of cardiac surgery is no longer a practical alternative."*

The situation here is even more extreme than the one presented in the 2003 Good Hope Application, Project I.D. No. M-6801-03 (findings attached as Appendix 1), in which the applicant proposed to double the size and cost, and relocate a replacement hospital approved in a 2001 CON Application. Good Hope was required to provide specific information about why it needed to spend double the amount to build a larger hospital in a new location. The applicant did not provide the information the Agency needed, and the Application was disapproved under Criterion 4 and many other grounds.

The testimony that Ms. Hoffman gave six years ago in the Good Hope contested case hearing is applicable to this case:

> *Well, in the preapplication conference, we said because you are going to – or proposing so much larger a facility than you were*

approved for before, you're going to have to justify the reasons for these changes in your application.

And that's what I thought we had stressed in the preapplication conference; that it was such a big change, that they were going to have a big job of justifying the additional square footage because they had already been approved for an alternative that they represented as a very viable alternative.

And so that's what we were looking for, is where is that justification that this is a more effective alternative than the one they'd been approved for.

Testimony of Lee B. Hoffman, June 9, 2004, page 4881, Case No. 08 DHR 1838 (emphasis added) (excerpt attached as Appendix 11).

Instead of simply adding beds and an operating room as it originally proposed at a relatively modest cost, CFVHS is proposing an entirely different and very expensive infrastructure (*e.g.*, lab, pharmacy, ED, administrative space, etc.) that was not part of the original Applications. It is also proposing services that were not part of the original Applications, *e.g.*, OB and ED. CFVHS is going from an increase of zero square feet to an increase of 145,832 square feet. *See* Application, page 245 (Tab 11). To quote Ms. Hoffman's testimony from Good Hope, *"Where is that justification that is a more effective alternative than the one they'd been approved for?"* The answer is: CFVHS has failed to provide the justification. The Agency should apply its findings on the 2003 Good Hope Application here. Like Good Hope, CFVHS has entirely failed to demonstrate that spending $92.3 million, adding new services, and building 145,832 square feet is the least costly of its options, when just a few years ago, the applicant took the position that a $3 million expenditure would meet its needs.

As far as whether this Application presents the most effective alternative, the applicant suggests in various places that it needs to decompress its campus at CFVMC. *See, e.g.,* Application at page 179. As is the case with the missing cost information, the Application provides no detail to back up its assertion about decompression. Decompression was not an issue when these beds were sought in 2004, or when the cost overrun application was submitted in 2005 and approved in 2006; how did it become an issue in 2010? The Application does not answer this question.

Since more than half of the applicant's service area population lives closer to CFVMC, it is unlikely that HCMC will serve to decompress CFVMC, even if it needs decompression. It is more likely that the majority of the population will continue to use CFVMC. This also makes it less likely that HCMC will lead to *"improved access,"* as the applicant claims on page 179 of the Application. The majority of the population CFVHS proposes to serve already has access to an existing facility, and they live closer to that existing facility than to the proposed facility.

The Application also attempts to use BRAC (the military Base Realignment and Closure initiative) to justify why CFVHS needs to spend $89 million more than its originally approved CONs. *See* Application, page 103. To be sure, the area is growing, but BRAC is not a new phenomenon. BRAC's potential impact has been known since at least 2005. *See id.; see also* page 25 of the CFVHS 2005 Cost Overrun Application, Project I.D. No. M-7436-05, which discusses BRAC, attached as Appendix 10. BRAC did not lead CFVHS

to conclude that it needed to build a new hospital when it applied for the cost overrun in 2005, new beds in 2006 and 2007, or the OR in 2007. BRAC does not change the fact that more than half of the service area population lives closer to CFVHS than to HCMC. BRAC does not supply the missing justification for the HCMC project.

CFVHS briefly discusses (on page 180) expanding its Health Pavilion North campus by adding acute care beds to develop a community hospital. CFVHS concludes that based on population growth, the Spring Lake area, though growing, cannot support a freestanding hospital. However, CFVHS fails to identify the capital costs associated with expanding the Health Pavilion North campus. Since, HCMC is expected to cannibalize patients from CFVMC, expanding the Health Pavilion North campus would be expected to do the same. In fact, on pages 181-82, CFVHS identifies the patient origins of the proposed HCMC services, and they show that 74-80% of patients will originate from Cumberland County, and only 4-5% of patients will originate from Hoke County. The Health Pavilion North campus would provide easy access for Cumberland County residents to seek services, and would also help "decompress" CFVMC.

The Agency is required to analyze the alternatives the applicant has identified to determine whether the applicant has chosen the least costly or most effective alternative. The Agency cannot just take the applicant's word that the alternative the applicant chose is in fact the least costly or most effective alternative. The Agency must apply the same rigorous analysis that it used in the Good Hope review. As the facts of the HCMC Application show, CFVHS has not chosen the least costly or most effective alternative. The alternative CFVHS has chosen is extreme and expensive, and it will not improve access for the patients in the service area. The Application should therefore be found non-conforming with Criterion 4.

VI. The Application Does Not Comply With Criterion 6.

Pursuant to Criterion 6, the applicant must demonstrate that its proposal will not result in the unnecessary duplication of services. NCGS § 131E-183(a)(6). Given that more than half of the population CFVHS proposes to serve lives closer to the existing CFVMC than the proposed new hospital, it is not reasonable to expect that this population will go to a more distant facility, especially one that offers fewer services than CFVMC, and this proposal therefore duplicates services at CFVMC. In addition, the Agency has already approved a hospital in Hoke County – FirstHealth's 2009 Application. For these reasons, this project constitutes an unnecessary duplication of services, and should be disapproved under Criterion 6.

VII. The Application Does Not Comply With Criterion 12.

Under Criterion 12, the applicant must demonstrate that *"the cost, design and means of construction proposed represent the most reasonable alternative and the construction project will not unduly increase the cost of providing health services by the person proposing the construction project or the costs and charges to the public . . . ."* NCGS § 131E-183(a)(12). For the reasons stated in the discussion regarding Criterion 4, the HCMC project, which is approximately $89 million more expensive and 145,832 square feet larger than what was originally approved, is not the most reasonable alternative. As discussed in references to Criterion 3a in these comments, there is also danger that this project will lead to increased costs and charges to the public.

Again, the situation here is reminiscent of Good Hope's 2003 Application, Project I.D. No. M-6801-03, where the applicant proposed a radical alteration of a previously approved CON project. *See* Appendix 1 at page 44. The Agency correctly found the Good Hope 2003 Application non-conforming with Criterion 12, and it should also find the CFVHS proposal non-conforming with Criterion 12.

VIII. The Application Should Have Answered the CT Scanner Rules.[8]

A CON application must comply with all applicable criteria and rules before a CON can be issued. NCGS § 131E-183. The applicant, not the Agency, must answer the criteria and rules.

The CT Scanner rules unambiguously require an applicant proposing to acquire a CT scanner to both answer the CT scanner rules and meet certain performance standards. *See* 10A NCAC 14C.2301 *et seq.* On page 29 of the Application, CFVHS states that it will relocate and replace a 16-slice CT scanner from CFVHS to HCMC. Then, on page 168, CFVHS states that HCMC *"will have a comprehensive array of diagnostic equipment including: . . . a new 16-slice CT scanner."* Application Exhibit 29 contains a vendor quote for a new 16-slice CT scanner, at a price of $809,160. The equipment list, also at Exhibit 29, lists a Lightspeed 16-slice CT scanner at a cost of $809,160. Thus, it appears the applicant is planning to buy a new CT scanner.

The applicant failed, however, to answer the CT Scanner rules. The Application projects, on page 194, that the CT scanner will achieve 6,561 HECT units in Year 3, but CFVHS does not explain how it came up with this number, and does not take into account the fact that more than half of the people in its service area live closer to CFVMC than to HCMC. Similarly, there is no charge data for the top 20 CT scans, and no information about the CT scanner's hours of operation. *See* 10A NCAC 14C .2302(f) and (j).[9]

These errors are not just minor oversights than can be corrected through a condition. The applicant's volume projections and therefore its financials depend to a certain extent on CT scans. It is not clear how the applicant derived its projections for CT scans. Thus, the projections are unreliable. Moreover, there is no way to know if the applicant will satisfy the other criteria under the CT Scanner rules, such as the hours of operation. Without the charge information, the Agency cannot determine whether the Application meets the CON law's goal of cost control. Given these failures, the multiple other problems with this Application, and the fact that this is a competitive review, the appropriate course is to deny the Application.

---

[8] The applicant also should have answered the question in Section IV., Question 2 regarding CT scanner capacity.

[9] On page 196, the applicant states "The Hoke Community Medical Center Radiology Department, scanner will be staffed Monday-Sunday from 7 a.m. – 7 p.m." This sentence does not make sense and does not explain the hours of operation for the CT scanner.

IX. The Application Should Have Answered the Acute Care Bed Rules.

CFVHS is proposing to move 41 beds from a CON that has never been implemented. The beds were allocated under the 2004 SMFP. These beds are therefore "new" beds and the acute care bed rules should have been answered. *See* 10A NCAC 14C.3801 *et seq.* The fact that these rules may have been answered in 2004 when the Application was first filed should not matter. More than six years have passed, and the project has been *radically* changed from what was proposed originally. The Agency would be justified in requiring the applicant to answer these rules again to determine whether there have been any material changes.

X. The Application May Have Understated the Capital Costs of the Project.

As expensive as the HCMC proposal is, the capital costs of $92.3 million may actually be understated. For certain, as addressed in Section I above, CFVHS failed to include the costs of bond financing, which would likely exceed $1 million. As an additional example, it is also not clear from looking at the capital cost form on page 234 (Tab 8) whether CFVHS budgeted for information technology (IT) for HCMC. IT costs, which include things such as computer hardware and software, wiring, and telephone systems, can be a very significant expense for a hospital the size of HCMC. For example, in the 2008 Holly Springs Hospital Application, Project I.D. No. J-8190-08, the applicant budgeted $4.5 million for IT. *See* Appendix 12. Holly Springs Hospital and HCMC have several features in common: both propose 41 licensed acute care beds, including 4 ICU beds. Both propose 4 LDR rooms and 2 triage rooms. Both propose 16 ED treatment bays.

Although CFVHS has budgeted approximately $3.2 million for contingency, there is no way to know whether this amount would cover the IT costs. Moreover, the contingency may be needed for other costs (such as bond financing). The 15% cost overrun allowed under the CON Law is irrelevant as far as the approvability of the Application is concerned; the applicant is required to include all of its capital costs in the Application, and demonstrate the availability of funds for the project. As discussed elsewhere in these comments, the applicant has clearly failed to demonstrate the availability of funds for HCMC.

The architectural space plan in Exhibit 9 includes a room for Information Systems and Switchboard, but this is for the construction of the room, not for the hardware, software, and wiring needed to run the IT equipment in the hospital.

XI. OB Services Are Not Needed at HCMC.

Of the 41 licensed beds proposed to be located at HCMC, 16 will be obstetric post partum beds. The applicant also plans 4 LDR rooms, 2 triage observation rooms for pregnant women, and a C-Section room. *See* Application, page 28. With 40% of the beds at HCMC devoted to OB cases, the applicant is planning to establish a large OB program.

There are, however, already 2 large OB programs nearby, at FirstHealth Moore Regional Hospital in Pinehurst, and CFVMC in Fayetteville. Both of these programs are equipped with neonatal intensive care services, which is something the HCMC program does not propose. Womack Army Medical Center also offers birthing services. The Application does not discuss, however, either the FirstHealth or the Womack OB services. The Application contains market share shift assumptions on page 149, but never explains why women would switch from existing, well-known OB programs with NICUs, to a new program that does not have an NICU.[10] CFVHS offers vague explanations such as "overwhelming" community support and "overwhelming" physician support. Community and physician support are important, but they provide neither the quantitative nor the qualitative justifications for 16 OB beds in a $92.3 million hospital located 11 miles (per MapQuest) from the existing facility at CFVMC.

In the Good Hope case, Ms. Hoffman testified about how the Agency considers public support:

> *A: Well, it helps us understand what the issues and concerns are of the public, and it helps us identify potential issues for us to look at in evaluation of the project and to determine whether or not there might be some things we overlooked in our review that we just -- we didn't see some information that was provided by the applicant and maybe we overlooked it. What public comment can't do, though is fill in gaps in information that the applicant was supposed to provide in this application. And also we end up getting alot of public comments about issues that aren't the subject of any of the review criteria that are used in a CON review. So they're really not pertinent, and we have to review the application against the criteria in the law and the rules, and sometimes the public's interests are outside the scope of the review criteria.*

Testimony of Lee B. Hoffman, in Contested Case 03 DHR 1838, June 9, 2004, page 4856-47 (attached as Appendix 11).

The applicant also states that current CFVMC OB services are *"at capacity."* *See* Application, page 149. If so, and if the capacity issue is due to a lack of beds, CFVHS should have considered deploying some of the 41 beds in Project I.D. No. M-7093-04 to OB. This could have been done less expensively than $92.3 million, and may not have even required another CON application.

CFVHS also talks about the physicians it employs in the service area, one of which is an OB practice. *See* Application, page 149. However, the applicant does not indicate the number of women seen by these

[10] Given that some complications may not be detected until the birth actually occurs, some women who are in a "low risk" category may prefer to give birth in a facility with an NICU for added peace of mind.

physicians who are: (1) within the age range likely to give birth; (2) live closer to HCMC than to other facilities with birth programs; and (3) would choose HCMC for birthing services over existing facilities.

The applicant cites traffic conditions on Owen Road as another reason why it should be allowed to develop these 16 beds in a $92.3 million hospital. *See id.* No supporting information is provided about these traffic conditions (photographs, traffic counts, etc.), nor does the applicant provide any correlation between the traffic and the birthing program.

The applicant also states that "HCMC offers a choice for inpatient and outpatient care closer to home." *See id.* As far as OB is concerned, service area residents already have a choice between two well-established programs with NICU services: FirstHealth and CFVMC; military families can also use Womack.

As the Agency will recall, North Carolina Baptist Hospital twice proposed to develop an OB program, without NICU services, at a relocated Davie County Hospital, and both times, it was rejected because the applicant failed to demonstrate the need for the OB program at its hospital. *See* Agency Findings for Project I.D. No. G-8164-08 and Project I.D. No. G-7984-07, attached at Appendices 13 and 14. Like HCMC, the Davie facility is proposed to be located about 10 miles from a large, well-established OB program with an NICU at Forsyth Medical Center. The Agency found no need for the OB program at Davie, and the same reasoning should apply here.[11]

[11] The Davie project proposed 4 OB beds, whereas the HCMC project proposes 16 OB beds. The large scale of the HCMC OB program, coupled with its proximity to CFVMC, makes the HCMC OB program even more difficult to justify than the Davie OB program.

XII. There is a Discrepancy Between This Application and Project I.D. No. M-7436-05.

On page 25 of the current Application, CFVHS states *"As shown in the previous table, only 3 beds have been implemented in the CSICU at this time. Further analysis has shown that to implement the remaining beds as planned will require substantial additional capital expenditure."* The referenced table is reproduced below:

LOCATION	ORIGINAL	REMAINING 41 BEDS
2 East (Observation)	15	15
3 North (Observation)	9	9
3 Floor Nephrology	1	1
CSICU	3	--
4 North (Currently offices)	16	16
[Total]	44	41

Source: HCMC Application, page 25

However, on page 19 of its 2005 Application in Project I.D. No. M-7436-05 (the cost overrun application for the 44 bed application), CFVHS stated: "*Once CON approval was obtained, CFVMC began the process to up-fit designated areas for placement of the beds. By March of this year, one bed had been added to the nephrology unit, three beds became operational in the cardiac surgery intensive care unit and nine beds with the Three North Observation Unit opened for medical-surgical patients." See* Appendix 10. The applicant then provided a table on page 20 of that Application, as follows:

Initial and Current Applications	Beds	Abridged Application	Implementation Dates
Three North Nephrology	1	1	March 5, 2005
CSICU	3	3	March 5, 2005
Three North Observation –M/S	9	9	March 5, 2005
Two North Observation – M.S	15	15	September 30, 2006
Four North – Offices – M/S	16	16	September 03, 2006
Total	44	44	

Source: page 20 of Application for Project I.D. No. M-7436-05

The discrepancy lies with the one bed in Three North Nephrology and the nine beds in Three North Observation. In the 2005 cost overrun application, CFVHS represented that these ten beds had been implemented in March 2005. In June 2009, however, in Project No. M-8353-09 (Cape Fear Valley West Community Hospital) and then again in the current HCMC Application, the applicant represented that these ten beds had never been implemented. CFVHS does not reconcile these two very different statements. If the ten beds were in fact implemented in 2005, then that means: (a) a key representation in the 2009 and 2010 Applications is false; (b) ten beds for the current and the 2009 projects are therefore coming from an unknown source, other than the beds awarded pursuant to the 2004 44-bed Application; and (c) CFVHS's current and 2009 claims that it was too difficult to implement these 44 beds as planned is also false. If, on the other hand, these ten beds were never implemented, then that means that a key representation in the cost overrun application was false. The 2009 Hospital License Renewal Application, at its page 4, does not resolve this issue. In fact, the license renewal application contains yet another anomaly, because it indicates that all 44 beds were licensed, but never staffed, including the three CSICU beds. *See*

Appendix 15, line q. and line 1. The difference between the number of licensed beds and the number of staffed beds shown on the 2009 license renewal application is 44.

Given the discrepancy between the 2005 cost overrun application, and the current (as well as the 2009) Application and the 2009 license renewal application, the magnitude of the costs involved in the current project, and the lack of specificity in the current Application concerning why the 44 beds could not be implemented as originally planned, the Agency must scrutinize this Application very carefully. Upon close scrutiny, the Agency should determine that the current Application must be denied.

For all the reasons stated in these comments, as well as for other reasons that the Agency may discover, CFVHS's Application is fatally flawed and must be disapproved.

Appendixes

1. Agency Findings on the 2003 Good Hope Hospital Application, Project I.D. No. N-6801-03.
2. Memo from David Kasdin, Citigroup Global Markets Inc.
3. *Retirement Villages, Inc. v. NCDHR*, 124 N.C. App. 495, 477 S.E.2d 697 (1996).
4. May 2008 letter from CFVHS to CON Section.
5. Mapquest Maps.
6. CFVMC Progress Reports.
7. Agency findings for FMC-Kernersville (Project I.D. # G-7604-06); deposition testimony in the FMC-Kernersville project (06 DHR 2044, Volume I, Deposition of Lee B. Hoffman, February 8, 2007) (excerpt).
8. Agency decision in Project I.D. No. F-7951-07 (CMC-NorthEast Freestanding ED).
9. Pages from Project I.D. No. M-7093-04.
10. Pages from Project I.D. No. M-7436-05.
11. Testimony of Lee B. Hoffman, June 9, 2004, Case No. 08 DHR 1838 (excerpt).
12. 2008 Holly Springs Hospital Application, Project I.D. No. J-8190-08 (excerpt).
13. Agency decision in Project I.D. No. G-8164-08.
14. Agency decision in Project I.D. No. G-7984-07.
15. CFVMC 2009 Hospital License Renewal Application.

Attachment 1

ATTACHMENT - REQUIRED STATE AGENCY FINDINGS

FINDINGS
C = Conforming
CA = Conditional
NC = Nonconforming
NA = Not Applicable

DATE:	September 26, 2003
PROJECT ANALYST:	Andrea C. Phillips
CHIEF:	Lee B. Hoffman
PROJECT I.D. NUMBER:	M-6801-03/Good Hope Health System, L.L.C./Replacement of Existing Hospital / Harnett County

REVIEW CRITERIA FOR NEW INSTITUTIONAL HEALTH SERVICES

G.S. 131E-183(a) The Department shall review all applications utilizing the criteria outlined in this subsection and shall determine that an application is either consistent with or not in conflict with these criteria before a certificate of need for the proposed project shall be issued.

(1) The proposed project shall be consistent with applicable policies and need determinations in the State Medical Facilities Plan, the need determination of which constitutes a determinative limitation on the provision of any health service, health service facility, health service facility beds, dialysis stations, ambulatory surgical operating rooms, or home health offices that may be approved.

NC

Good Hope Hospital Health System, L.L.C. (GHHS) [Good Hope or GHH], located in Erwin, proposes to replace its existing hospital with a new, two-story 112,945 square foot building on a 35-acre site on Highway 421, approximately 10 miles from its current location. The applicant states in Section I, page 5, *"Good Hope Health System, LLC is a limited liability company formed by Good Hope Hospital Inc. and Triad Hospitals Inc. for the purpose of developing a replacement hospital facility in Harnett County. Good Hope Health System, LLC will have ownership of the proposed replacement hospital facility."* Good Hope Hospital is currently licensed for 29 psychiatric beds and 43 general acute beds, including 36 medical/surgical beds and seven ICU/CCU beds. Although the applicant proposes to relocate the existing hospital, it does not propose to replace all of the existing licensed beds. Rather, Good Hope proposes to replace only 34 general acute beds and twelve psychiatric beds. There is one need determination and one policy in the SMFP applicable to review of the proposed project.

NEED DETERMINATIONS

Good Hope does not propose to increase the number of licensed beds in any category, or to acquire equipment for which there is a need determination in the 2003 State Medical Facilities Plan. However, Good Hope is proposing to have one more shared operating at the new replacement hospital than it has in the existing facility. Therefore, the need determination for operating rooms in the 2003 State Medical Facilities Plan is applicable to this review.

The applicant states in Section III.2, page 74 of the application, *"The proposal includes the replacement of a total of 46 licensed beds and the development of three shared operating rooms allocated to the Good Hope Hospital in the previously approved CON and in accordance with the 2003 SMFP Operating Room inventory."* However, the Agency has determined that the current application submitted by Good Hope Health System, LLC is for a new project, not a change in scope of a previously project, approved on July 27, 2001. Therefore, the applicant must demonstrate that the addition of a third operating room is consistent with the need determinations in the 2003 State Medical Facilities Plan, which was the plan in effect at the beginning of this review. The 2003 Hospital Operating Room Inventory in the 2003 SMFP shows Good Hope Hospital has a total of two existing shared operating rooms. Further, Good Hope Hospital's 2003 License Renewal Application shows a total of two existing shared operating rooms. In this current application, GHHS is proposing to construct a third shared operating room at its new facility in Harnett County. However, according to the 2003 SMFP, promulgated in 10 NCAC 03R .6408, there is no need for any additional operating rooms in Ambulatory Surgery Service Area 23, which includes Franklin, Harnett, Johnston and Wake Counties. Therefore, Good Hope is nonconforming with the operating room need determination in the 2003 State Medical Facilities Plan.

POLICIES

Policy AC-5: Replacement of Acute Care Bed Capacity

Good Hope Hospital proposes to construct new space to replace existing acute care beds. Therefore, Policy AC-5 applies. Policy AC-5, as promulgated in 10 NCAC 3R .6437(c), states,

> *"The evaluation of proposals for either partial or total replacement of acute beds (i.e., construction of new space for existing acute care beds) shall be evaluated against the utilization of the total number of acute care beds in the applicant's hospital in relation to utilization targets which follow. Any hospital proposing replacement of acute care beds must*

demonstrate the need for maintaining the acute care bed capacity proposed within the application.

Total Licensed Acute Care Bed	*Target Occupancy (Percent)*
1 – 49	*65*
50 – 99	*70*
100 – 199	*75*
200 – 699	*80*
700+	*81.5%"*

In addressing Policy AC-5, the applicant states in Section III, page 75,

"In response to this policy, GHHS will reduce the number of acute care beds from 43 to 34. In addition, the applicant proposes a reduction of the licensed inpatient psychiatric beds from 29 to 12."

The applicant proposes to reduce its licensed bed capacity as shown in the following table, in Application Section III, page 75.

	Current Beds	Proposed Beds
Med/Surg	36	29
ICU/CCU	7	5
Psychiatric	29	12
Total	72	46

Pursuant to utilization targets in Policy AC-4 of the 2003 SMFP, the target occupancy for Good Hope's general acute care beds is 65%. According to its 2003 Hospital Renewal Application, during Fiscal Year 2001-2002, GHH provided 7,723 days of care in its 43 existing acute care beds for an average occupancy of 49.2% (43 x 365 = 15,695; 7,723/15,695 = 4921). Based on 34 licensed acute care beds, the current utilization would be an average occupancy rate of about 62%. To achieve a target occupancy of 65% for the proposed 34 beds would require the provision of 8,067 days of acute care [.65 x (34 x 365) = 8066.5] or only 344 more days than currently provided.

The applicant states in Section III, page 59 that according to the North Carolina Office of State Planning, Harnett County grew by 14 percent from 1980 to 1990, ranking the county 26th in size out of 100 counties in the state. Further, the State Planning Office projects that Harnett will experience an 18 percent growth from 2000 to 2010, *"nearly 2 percent per year, which will rank the county 11th in the state."* Therefore, the applicant provided sufficient evidence to demonstrate it is reasonable to project the facility would increase its utilization from 7,723 acute care days in FY2002 to 8,067 acute care days by 2008 to reach occupancy of 65% in its 34 acute care beds. Consequently, the applicant adequately demonstrated the

need to retain 34 acute care beds and is conforming with Policy AC-5. See Criterion 3 regarding discussion of need for all components of the project.

In summary, although the applicant is conforming with the applicable policy in the 2003 SMFP, it is nonconforming with the need determination for operating rooms in the 2003 SMFP. Therefore the application is nonconforming with this criterion.

(2) Repealed effective July 1, 1987.

(3) The applicant shall identify the population to be served by the proposed project, and shall demonstrate the need that this population has for the services proposed, and the extent to which all residents of the area, and, in particular, low income persons, racial and ethnic minorities, women, handicapped persons, the elderly, and other underserved groups are likely to have access to the services proposed.

C

Good Hope Health System, L.L.C. proposes to replace Good Hope Hospital with a new two-story, 112,945 square foot building on a 35-acre site on U.S. Highway 421 in Central Harnett County near Lillington. The proposed location is approximately 10 miles northwest of its current location.

However, Good Hope Hospital already has a certificate of need to build a replacement hospital in Erwin. This certificate of need was issued December 14, 2001 for a new hospital described in Project I.D. #M-6394-01.

"Good Hope Hospital, Inc. proposed in the original application to finance the project through HUD financing. Good Hope accomplished the steps necessary to secure HUD financing, except Medical Care Commission approval. The Medical Care Commission indicated that it was not approving the HUD financing because it thought Good Hope Hospital and Betsy Johnson Hospital should merge. Given the Medical Care Commission's disapproval, Good Hope Hospital was not able to obtain the HUD financing and had to explore other alternatives to finance the project.

Good Hope Hospital determined that the most effective alternative to obtain needed capital for the replacement hospital project was a joint venture with an affiliate of Triad Hospitals, Inc., the parent company of Quorum Health Resources, Inc, who was currently managing the Hospital. Good Hope Health System, LLC was formed to accomplish this joint venture, pursue this application and obtain the needed capital, once the changes in the replacement hospital were approved."

POPULATION TO BE SERVED

In its new facility, Good Hope Hospital proposes to provide inpatient acute care services, outpatient diagnostic and treatment services as well as inpatient psychiatric services primarily to residents of Harnett County. The following table shows the current patient origin for the existing facility, provided in Section III.4(a) of the application.

Good Hope Hospital FY 2001

County	% Patients
Harnett	76.81%
Johnston	6.24%
Lee	4.19%
Cumberland	3.28%
Sampson	1.64%
Wake	2.75%
Moore	0.53%
Other	4.56%
Total	100.0%

Source: 2002 Hospital Licensure Application. This table is based on patient origin for inpatient acute care and inpatient psychiatric patients for 2000-2001. *"(The 2001-2002 patient origin data for Good Hope Hospital is not complete.)"*

The following table in Application Section III.5(c) shows projected patient origin for the first and second years following completion of the proposed project. The applicant states on page 80, *"Good Hope does not expect any significant changes in patient origin as a result of the project. Patient Origin is assumed to remain the same as historical patient origin."*

Patient Origin for Total Admissions: FY 2006 and FY 2007
(Acute & Psychiatric Inpatient Admissions)

County	Year 1 Patients	Year 1 % of Patients	Year 2 Patients	Year 2 % of Patients
Harnett	2,145	76.81%	2,489	76.81%
Johnston	174	6.24%	202	6.24%
Lee	117	4.19%	136	4.19%
Cumberland	92	3.28%	106	3.28%
Sampson	46	1.64%	53	1.64%
Wake	77	2.75%	89	2.75%
Moore	15	0.53%	17	0.53%
Other	127	4.56	148	4.56
Total	2,793	100.0%	3,240	100.0%

The applicant states on page 82,

> *"GHHS does not expect that the proposed replacement hospital (located in central Harnett County) will change the service area for the hospital. The primary service area will remain Harnett County and the projected patient origin percentages are expected to remain the same as the historical percentages... ."*

The applicant adequately identified the population to be served.

NEED FOR REPLACEMENT

The applicant states that the need for the replacement hospital is based on the age and facility constraints of the existing hospital facility. The original Good Hope Hospital was constructed in 1913, at a site located near the present facility. The oldest portion of the existing facility remaining in use was constructed in 1921. Since that time, the applicant states the acute care facility has had eleven additions. In 1930, Good Hope constructed another building *"adjacent to but not connected to the original building."* The applicant states on page 15, *"Due to the problems inherent in trying to renovate buildings that were as old as those on the existing hospital site, Good Hope chose to add on to the existing buildings in an attempt to provide the needed additional space for patients and services."* The acute care facility has had ten additions since that time. In addition, the applicant states on page 15, *"Because the multiple additions were made at various times throughout the 80-year span of the facility's existence, less consideration was given to meeting the needs of the future technological advances that we take for granted in construction today."* There are five additional buildings on the Good Hope campus, including the medical records house, plant operations building, physical therapy gymnasium and a modular building that houses patients accounts. Good Hope also leases four offices to visiting specialty physicians and surgeons.

The applicant states a consulting engineer visited the facility and in some detail examined the condition of the hospital. The engineer's facility report regarding the hospital's systems, includes the following findings described in Application Section III, pages 44 – 46:

Basic Plant/Mechanical Systems

- The floor heights at GHH vary from building to building, up to floor heights of 12'6", which is *"considerably less than the 14'6" in use today and would make remodeling the facility difficult. Remodeling could be done but would require a higher than normal cost and would require running large amounts of ductwork exposed on the roof."* The engineer states that running exposed ductwork is not a desirable feature.
- No central chilled water in the facility. Air conditioning is provided by several small, self-contained cooling systems located throughout the hospital. *"In assessing the many heating and cooling systems in place at Good Hope, the consulting engineer stated that of 20 different areas that were considered, 17 were 'in poor condition and needed to replaced as soon as possible.' "* One of the areas had no air or heating system, and the other two were in fair condition and should give five to eight years of additional service.
- The domestic hot water system, including one gas hot water heater and three hot water storage tanks, is in need of replacement. The applicant states the gas hot water heater was installed in 1986, and is in fair to poor condition and *"will likely need to be replaced as soon as possible."* Further, one of the hot water storage tanks is very old and the other three, according to the report, *"likely could need replacing within five years."* The applicant states that if the gas water heater fails, the entire facility would be without hot water.
- The online cylinder and gaseous standby is located at the southwest corner and provides oxygen for the hospital. The gaseous standby requires the maintenance staff to manually check the system regularly to monitor capacity in the liquid tank. The engineering assessment also indicated *"that the medical gas system does not have pressure alarms and cut-off valves for zone control, which means if any one area must be shut down for any reason, the entire system must be shut down."*
- A major concern of the electrical power system is that water pipes cross the main electrical panel in the basement and *"could pose problems if there were to be a leak in the water pipes."* The applicant further states that lights in the hospital are surface mounted due to the low floor to floor height and are not energy efficient. The applicant also states, *"The emergency and radiology addition constructed in 1978 uses an old Federal Pacific electrical panel. The age of the equipment makes it impossible to get replacement parts, which means that parts must either be constructed by maintenance or otherwise manipulated in order to work. There are three different power sources serving the hospital in order to meet the demands of the facility."* In addition, the applicant states there is limited electrical power in patient rooms, laboratory,

radiology and hospital corridors and exit doors on the outside of the facility. Areas without emergency power would *"have no electrical access to the hospital generator should there be a power failure."* The applicant states on page 46, *"In 1997, the engineering consultants recommended that the electrical systems be replaced within seven years in the 1920 Critical Care Unit, the 1930 Business Office area and the 1964 patient care areas."*

The engineer's facility report regarding the hospital's buildings and departments, also include the following findings, described in Application Section III, page 47 – 58:

Facility Buildings/Departments

- The hospital's main entrance is adjacent to the existing emergency entrance and *"results in congestion for patients and visitors entering the main lobby, particularly when there are ambulances at the emergency entrance. In addition, the primary parking area for visitors and patients is on the west side of the hospital, which means that anyone entering the hospital by the main entrance must cross the emergency access."* The applicant states the entrance to the hospital presents a hazard for pedestrians who are crossing when emergency vehicles are approaching and reduces privacy for patients who are unloaded at the main entrance.
- Various offices occupy space created for patient care in 1930. Additionally, the rooms are small and *"provide little privacy for patient admission interviews and for other uses such as board room, utilization review office, and the radiologist's office and view space. Because there is so little space in the radiology department, mammography and nuclear medicine services are located in this area as well."*
- The Critical Care Unit is housed in the 1921 building with seven beds, and although adequate for critical care patients, provide no bathroom facilities in the five private rooms. The only patient bathroom in the unit is located in the two-bed "step-down" unit at the west end of the unit. In addition, there are no cabinets or lockers for patients to store personal belongings. Further, there is no storage in this area, and equipment necessary for use in the critical care unit must be placed anywhere there is available space. Another concern in this area is the ability to move within the department for emergencies. The applicant indicates that the double door to the outside opens to steps, not ramps, and moving acute patients on a gurney out this door would be impossible. The other door that allows access to the unit is the original front door of the 1921 facility. The applicant indicates that the corridor approaching this door is very narrow and the gurney would not be able to pass through the door to exit the unit. The applicant states, *"Therefore, concerns about emergency transportation from this portion of the facility are indicative of the need for improved facilities."*

- Mammography and nuclear medicine services occupy various offices near the hospital entrance that were originally created for patient care, because there is so little space in the radiology department.
- The medical/surgical patient wing has many of the same problems arising from the age of the building. Most of the rooms were constructed for shared sinks and toilets in the style of a suite, which means as many as three patients may be using one small bathroom. The sharing of bathrooms results in four bathrooms to serve 14 beds. The applicant indicates that this standard is not in keeping with current standards for patient care or privacy requirements. In addition, there is no centralized heating and/or conditioning systems in this area, thus hallways in this part of the facility must be heated and cooled with air coming from individual patient rooms. The applicant states that this is inefficient and insufficient to adequately heat and cool the hallways. Hallways are heated with air coming from individual rooms. The applicant states that the single zone system that provides heat for patient rooms was installed in 1973, and needs replacing. Windows in other patient rooms face the outside brick wall. The stress laboratory located in this area has moisture problems, particularly in the floor, which causes the room to have a constant smell of mildew. The floor has been replaced three times in the past twelve years due to excessive moisture from the ground below, which has caused the floor to rot over time.
- The Adult Mental Health Unit (Psychiatric Unit) was constructed in 1970, and 8,100 square feet of space was added in 1982. When the addition was completed, patients were moved to the new space, and rooms in the 1970 addition became offices. The applicant states the *"disjointed construction and patient/staff flow issues limit the effectiveness of this area of the hospital."* Further, the applicant states the north exist opens to steps, rather than a ramp, which is problematic when moving geriatric psychiatric patients in wheelchairs from the building. Other shortcomings in the facility related to adult mental health services cited by the applicant include: the configuration of mental health services and inpatient psychiatric beds detracts from staff efficiency; space for indoor therapy and outdoor recreation is very limited; and the facility lacks adequate staff work space and storage.
- The two 1973 dietary services additions, approximately 2,266 was designated primarily for dietary services. The area is currently being used as a small cafeteria to prepare food for the hospital staff and patients, and has a deteriorating ceiling due to a previous leaking roof and poor humidity control. The applicant states, *'The age and condition of the building cause the staff to expend additional time maintaining the food preparation area."*
- The 1978 radiology department and emergency addition are housed in the same area, and both departments total 3,600 square feet, consisting of 1,600 square feet for each and 400 square feet of the emergency waiting area. Both these departments need more space, and there is no toilet area in the emergency department. The applicant states on page 52, "*The minimal space creates cramped quarters for control areas for the operation of the equipment,*

dressing rooms, staff space, film storage, dark room and other support space." The applicant further states, *"Both departments need more square footage to accommodate and consolidate existing services; additional square footage that will be provided with the proposed project."* Emergency patients must use the restrooms in the radiology department. The applicant indicates that maintaining patient privacy has been difficult because the areas are so closely situated. Both departments lack space for to store equipment, and the hallways have become the only available space for storage. Other shortcomings of the emergency department cited by the applicant include: the number of treatment beds and space are inadequate to serve the patient volume; the existing department lacks space so that lower acuity patients can be efficiently treated; lack of specialized treatment rooms for trauma, orthopedics and OB/GYN causes delays in treatment; the configuration of imaging and emergency departments causes crowding and compromises patient confidentiality; lack of decontamination room and negative pressure room for patients with infectious diseases or chemical spills; lack of a secure room for psychiatric patients; and lack of adequate space for patient holding and observation, staff workspace and storage space for equipment and supplies.

- Shortcomings of the imaging department cited by the applicant include: the overall department space and individual rooms are *"undersized for modern imaging equipment and systems;"* mammography and nuclear medicine are located outside the department causing inconvenience to staff and patients; the configuration of the department, delays the smooth flow of scheduled inpatient and outpatient procedures; and inadequate space for patient holding, staff workspace and storage space for film storage, files, equipment and supplies.
- The applicant states that the configuration of the materials management department does not allow for efficient use of space. This department does not have adequate storage space. Space is inadequate for respiratory therapy, and pharmacy items, as well as medical and surgical supplies. In addition, the configuration of the department does not allow for efficient use of space.
- The surgery and laboratory departments were constructed below ground level, and the ground slopes down toward an exit door for the surgery department. The same situation exists for the laboratory. With any large amount of rain, the applicant states that water seeps under the outside doors and floods into these departments. This also creates moisture, which is problematic for maintaining expensive, fragile equipment. Temperatures must be kept cooler than normal in the surgery department to prevent problems with humidity that may interfere with surgery equipment. Power cords are strung from the ceiling in the surgery department because of flooding. The surgery department is undersized and crowded, which creates poor patient flow; the surgery department lacks a pre-operative area, and the 3-bed recovery area is inadequate; the HVAC systems are inadequate and outdated; additional time must be scheduled to sanitize operating rooms due to their ages and

configuration; the decontamination and sterile processing rooms are undersized and the space has inadequate work space.

- The emergency wash area in the laboratory is in the middle of the floor, and near the back exit. This arrangement does not provide adequate protection for laboratory equipment, if an emergency wash was required. The laboratory has been flooded due to facility deficiencies and age of the building; and overall department space and rooms are undersized. Further, the department lacks adequate workspace and storage space.
- GHH uses exterior storage for housekeeping equipment. The applicant states that the area is not appropriate for storage, but is the only space available.
- Hope House, on the existing Good Hope campus, is an old converted residence currently being used for financial services, human resources and medical information services offices. The applicant states the space is a short-term solution, does not provide adequate traffic flow and cannot meet additional space needs for these departments. Also, the electrical systems in Hope House were not meant to support large numbers of computers and technological equipment.
- The Medical Records department is located on the Good Hope campus in another old house constructed in the 1900s. Rooms in this house are not configured for offices and medical records storage, and *"do not provide appropriate flow that is conducive to good productivity."* Some staff members work at desks located in hallways, and the physician's dictation and incomplete file area are in the main hospital. Staff must travel between this house and the main hospital, and transport records, which is particularly problematic during inclement weather. Some records are being stored off-site to alleviate lack of space at Good Hope. In addition, the medical records house does not have sprinklers.

On page 58, the applicant states the independent engineer concluded that while the existing facility could be remodeled, the various structures with numerous deficiencies would *"make remodeling this structure into a state-of-the-art hospital difficult."* The engineer noted that the remodeling would require a *"higher than normal cost and would require running large amounts of ductwork exposed on the roof. Running this exposed ductwork is not a desirable feature."* The applicant states that following this assessment, as well as in-depth interviews with physicians, board members and staff, the facility assessment report concludes, *"for the long term good of the hospital and its many constituencies, a replacement facility is the sound choice."*

NEW FACILITY

The applicant provided the following table in application Section XI, page 139, comparing the existing facility with the proposed facility, by department.

Service/Department	Existing Sq. Feet 1/	Proposed Sq. Feet
Surgery	3,145	5,590
Recovery	255	3,055
OP Surgery-Prep/Recovery	1,644	Included in Recovery
Radiology	1,800	6,805
Emergency	1,800	4,965
Lobby/Gift Shop	867	5,200
Registration	356	1,605
Medical Records	3,100	2,205
Education	175	2,130
Dietary	2,266	3,705
Mechanical	696	7,305
Materials Management	1,707	1,370
Housekeeping/Security	1,300	660
Plant Operations	1,500	650
Human Resources/Quality	169/640	1,495
Accounting	1,708	Included in Human Resources/Quality
Administration	973	1,625
Medical/Surgical Pt. Care	5,465	16,455
Observation	Included above in Medical/Surgical Pt. Care	4,655
Critical Care Unit	1,800	4,755
Cardiopulmonary Testing	756	1,460
Inpatient Psychiatric Unit	6,152	7,975
Physical Therapy (IP/OP)	2,800	2,215
Laboratory	1,888	2,705
Pharmacy	420	825
Storage	0	1,605
Sub-waiting	0	810
Central Sterile Processing	0	780
Medical Staff Facilities	0	490
Business Office	Existing in business office	1,595
Information Systems	Existing in business office	710
Electrical/Communications	0	1,065
External Storage	Included below	600
Vertical Circulation	0	3,840
Common Circulation	14,271	9,175
Canopies, Dock, Door Soffits	Included above	2,865
TOTAL	52,188	112,945

1/ Includes only direct department square footage; does not include circulation square footage.

The applicant describes the proposed components of the new facility on pages 18 through 31 of the application, as summarized below:

Lobby/Reception/Registration – The lobby in the existing facility seats approximately 16 people. The current lobby also serves radiology outpatients, and is a back-up waiting area for the laboratory. The reception desk, a check-in space manned by hospital volunteers, and gift shop are both situated in 867 square feet of space. This arrangement does not provide privacy for the four registration stations in this small area. The proposed lobby will seat approximately 25 people, and will be located adjacent to the entrance of the hospital. The chapel and gift shop will also be accessed through the lobby. Patient registration and admitting will be located next to the main lobby. The applicant states registration cubicles will provide privacy for patients being registered.

Administrative and Support Area –Administration, finance, business office and medical records are in various locations throughout various buildings on the existing hospital. Administration, finance, business office and medical records for the existing hospital are *"housed in both cramped quarters within the hospital and scattered locations in other buildings on the campus."* The administrator, chief nursing officer and support occupy approximately 973 square feet of space. Financial services are located in Hope House on the west side of the campus, and the hospital controller and accountant occupy one room in the house approximately 208 square feet. Payroll and accounts payable occupy 195 square feet in the same building, and medical information services occupies approximately 369 square feet of space, that includes a storage room, larger room and smaller room. The smaller room shares space with the break area and back entrance for the house, which the applicant states *"detracts from overall efficiency and work flow."* The applicant proposes to locate the administrative suite on the first floor of the hospital. The space includes offices and support for the administrators and staff, as well as a small conference room, which will result in *"consolidation of related administrative functions."*

Medical Records is located in an old house, approximately 3,100 feet of space. Medical records personnel are located at various locations on the first floor. The applicant proposes to locate the medical records department at the replacement hospital, behind administration and in proximity to patient registration and the physician lounge. Medical records will be located behind administration and include space for three medical records technicians, two utilization review coordinators, one coder, and one transcriptionist, an office for the department manager, secure medical records files for mental health records, and physician space for physicians to update records and dictate. The file update area will also serve as a physician lounge, and will permit physician consultations and *"other activities that require privacy."*

The Human Resources department is currently located in a small space with limited work areas for human resources staff, in an old house on the existing hospital campus. The area is only 169 square feet. The applicant states on page 22,

"Due to the nature of human resources, many employee files must be maintained and this small space severely limits the work area for the human resources staff." In the proposed facility, the applicant states human resources will be located in 1,495 square feet of space near administration and medical records that will be shared with quality management.

Quality Management, which includes risk management, compliance and safety issues for GHH, is currently located in a one room office in 640 square feet of space above the outpatient physical therapy department on the west side of the existing campus. The office is only accessible from the outside of the building up *"very steep stairs."* In the proposed replacement hospital it will share space with human resources as describe above.

Education Classrooms are currently located in two small rooms in the upstairs of the medical records building. The larger computer classroom is approximately 240 square feet of space and the small staff education room is 175 square feet of space. In the proposed facility, staff education and meeting rooms for clinical education programs, community health and wellness programs, staff education and medical staff education will be located within several areas of the hospital.

Emergency Department – Currently in the emergency department, the staff and emergency physicians provide emergency care to patients in 1,600 square feet of space, with 400 square feet of space for the waiting area. This space consists of four treatment rooms, with five monitored beds. One of the rooms is larger than the other three, and is used for traumas. Due to the amount of emergency equipment and emergency staff who attend to a trauma, this larger room is currently the only room that can be used for traumas. GHH sees 75 to 80 patients per year, and the applicant indicates 97 percent must be transferred to a trauma center in another hospital and 3 percent are treated and admitted to Good Hope. The other three emergency rooms are not designated as specialty rooms, but are used as needed. The applicant, also states on page 25, *"Good Hope has attempted to create a fast-track service but with space so limited, this level of service has not been workable. Currently, there is no room or space available specifically for minor problems such as sprained limbs, minor sore throats and other non-emergent ailments."* There is also no designated space for psychiatric patients although many of these patients are admitted through the emergency department. The applicant states on page 25, *"This lack of a well designed and conveniently located psychiatric room is frequently a problem due to the high volumes of ever-growing psychiatric patients. Good Hope Hospital is the exclusive provider of emergency psychiatric services for both Lee and Harnett Counties."* Located in the Emergency Department is a small waiting area, triage room, nursing station and a registration office. This waiting area is also used by families of patients receiving CT scanner services.

In the proposed new facility, the emergency services department will be located immediately left of the main lobby and reception area. The space proposed for emergency services is approximately 4,965 square feet. On page 25, the applicant states emergency services will consist of the following:
1 Fast Track Treatment Room – two treatment bays
1 Trauma Room – two treatment bays
3 Enclosed Exam Treatment Rooms – (1 psychiatric, 2 general)
1 Exam/Treatment Room with adjacent decontamination area (negative pressure)
Triage Area
Nurses Station
Consult Office
Staff Locker Rooms

The trauma room will be equipped to meet the specials needs of patients who have serious injuries and other potentially life-threatening situations, who must be stabilized before they can be transported to a larger trauma facility. The emergency department at GHH last year served more than 11,000 patients and about 80 were classified as trauma patients.

The exam rooms will be multi-purpose, shared rooms: One of the three rooms will be equipped to accommodate gynecological patients and one especially designed for orthopedic patients. The applicant states, *"As an inpatient psychiatric facility, Good Hope often has patients who are admitted to the psychiatric unit through the emergency room. In the new facility these patients will have a room designated for their special needs. The room will be specially designed to prevent violent patients from harming the staff or bringing injury to themselves."* This area will also include a "fast track" room with two bays for patients with minor injuries or illnesses.

In addition, included in emergency services will be a triage room, that opens into the emergency waiting area, which the applicant states will enhance patient flow. The triage nurse will be able to see and assess patients who come in through the emergency door located to the right of the triage room. Support space for emergency services will include: a nurses station with three seated areas and a large area to accommodate several staff members, lounge/workroom with a bathroom, an EMS workroom, a clean and soiled utility space, decontamination area just inside the ambulance door, and wheelchair and equipment storage. The proposed emergency waiting area will open to the main lobby, and family members and friends will have access to the main lobby, chapel, gift shop and vending services in the dining room. The proximity to the main lobby will also provide overflow waiting space for emergency services.

Cardiopulmonary services – These services, including respiratory therapy, are currently provided in several separate areas of the hospital. In the new facility,

cardiopulmonary services will be located adjacent to the emergency department and near the outpatient/emergency entrance. The applicant states on page 27, *"This arrangement will provide ideal access for outpatients and enable the cardiopulmonary staff to quickly respond to emergency patients."*

Radiology – Radiology currently operates in a building that was constructed in 1978. Radiology and emergency share a central hallway and waiting area, but most radiology patients wait in the main lobby. The small area houses a radiography/fluoroscopy room as well as the radiography/tomography room. Ultrasound, a two-chair sub waiting area, staff work area, film processing and storage are all located in this area. The applicant says because the space is so limited, nuclear medicine and radiologist's viewing area are located in the 1930's building off the main hall.

The radiology area will include a radiography and fluorography unit, a radiography and tomography unit, nuclear medicine unit, CT scanner, one ultrasound and one mammography unit. The proposed new radiology department will have rooms for radiology file storage, a dark room and work area, two dressing rooms, holding alcove for inpatients and a physician consulting area, which were also proposed in the previous application. The added space for radiology will include a physician consulting area, which will provide privacy for physicians, and allow them to view films and discuss treatment options.

Laboratory – The applicant states the current laboratory has 1,888 square feet of space, which consists primarily of a large room with laboratory equipment. The laboratory also has a smaller room where phlebotomists draw blood and a two-chair waiting space in the hallway. The proposed laboratory at the new facility, between surgical services and psychiatric unit will have quick access to these departments. In the new facility, the applicant states the new laboratory will include 2,705 square feet of space adjacent to the emergency department. The applicant states on page 28, *"With this location, laboratory staff can quickly respond to the emergency and radiology departments and provide outpatient access near the outpatient/emergency entrance."*

Physical Therapy – The existing physical therapy services are located in a building constructed in 1986 west of the main hospital buildings. Outpatient therapy is provided in this area, including a pool, physical therapy equipment, a whirlpool, large table and staff areas. Some minimal physical therapy is provided in a room beyond the medical/surgical patient rooms in that wing. In the proposed facility, the inpatient physical therapy will be located on the second floor in close proximity to inpatient medical/surgical beds. The applicant proposes to also relocate outpatient physical therapy to the new facility. Outpatient therapy will include whirlpool, treadmills and other equipment and will be located on the ground floor for ease of access.

Pharmacy – The existing pharmacy department is approximately 420 square feet of space, and because of the limited space, non-drug items used in the pharmacy are stored in the materials management department. The applicant proposed 511 square feet of space in Section XI, page 142 for the pharmacy in the previous application. The applicant states on page 28, *"The new facility plans show pharmacy services in 825 square feet of space on the second floor medical/surgical unit to enable immediate access to the inpatient medical/surgical and critical care beds. This arrangement provides ideal coordination of services and supports clinical pharmacy consultation as well as expedites the delivery of medications."*

Surgery Department – The existing surgery department, constructed in 1985, consists of approximately 3,400 square feet of space. The space currently has two operating rooms, three recovery beds in a small post anesthesia care unit (PACU), sterile processing services and a nurses station. Outpatient surgery and endoscopy procedures are performed in these operating rooms as well. The applicant states the existing surgery department lacks adequate storage for large equipment. The applicant also states on page 28, *"Due to the limited space in the existing PACU, scheduling can be problematic and requires a great deal of skill to manage."* The applicant states patients in recovery can create serious backlogs in the post-operative process and schedules. Outpatients are transferred to the outpatient surgery department, where they are further monitored, prior to being discharged. Inpatients are monitored in the PACU before being returned to the inpatient room for additional care by the medical/surgical staff.

The new surgery department will be located on the first floor to the right of the radiology space. The applicant states on page 29,

> *"GHHS is proposing to construct three operating rooms as consistent with the previously approved project (M-6394-01). The 2003 State Medical Facilities Plan (SMFP) inventory of operating rooms reflects the hospitals* [sic] *two existing share* [sic] *operating rooms plus the third operating room that is CON approved for development by Good Hope Hospital. Therefore, Good Hope Hospital already has a total of three shared operating rooms that are allocated in the SMFP. The volume of surgical and endoscopy procedures has increased since the previous CON was issued and therefore the need for three operating rooms is now even greater."*

As background, Good Hope Hospital was authorized in a settlement agreement to develop a third shared operating room as part of a previously project. However, the applicant is now proposing a new project for a replacement hospital and must demonstrate in this application the need for any services it proposes to provide in the new facility. Good Hope Hospital's 2003 Hospital Renewal Application shows

Good Hope Hospital's existing facility has a total of two shared operating rooms, as stated on page 55 of the application. Therefore, the applicant must demonstrate the need in this review for the third operating it proposes to develop.

The applicant also plans to develop surgery support space, including a nurses station, anesthesia office, staff lockers, clean and soiled utilities rooms and physician dictation. A large storage space will be provided for surgical equipment near the operating room. Sterile processing will be located near the surgery department and will include decontamination, sterilization, clean work room sterile storage and equipment storage for surgical equipment.

The pre-operative and post-operative suite will be located adjacent to surgery and includes a nurses station, anesthesia consult room and three pre-operative bays. Five stations for post-operative recliners are adjacent to the pre-operative area for outpatients having minor procedures. The post-anesthesia care unit (PACU), with five bays will be located adjacent to the surgery suites and provide recovery space for patients needing more intensive surgery support.

Mobile Services

Good Hope Hospital currently provides MRI services to its patients through a contract with Alliance Imaging. GHH provides mobile cardiac catheterization services only one day per week or 52 days per year through an agreement with Duke University Hospital. At the existing hospital, the vehicles for these mobile services are parked in the hospital's physician parking lot. The applicant states on page 30, *"This location does not provide convenient access for patients because the mobile units have outside entrances. The current facility does not have a covered walkway to the mobile service location; patients must be transported outdoors."*

The applicant states on page 30,

> *"In the proposed facility, the MRI and Cardiac Catheterization mobile services will be accessed through a covered walkway connector so that patients will protected from the weather. MRI and cardiac catheterization patient will be received and screened at the sub-waiting area near the pre-operative/post-operative area of outpatient surgery."*

Following their procedures, MRI patients will return to the post-operative dressing area. In addition, cardiac catheterization patients will be transported to the observation unit. The applicant adequately demonstrated that a covered canopy for MRI and cardiac catheterization services is needed at the new replacement hospital.

Observation Beds

The applicant states that the existing hospital does not have space to accommodate cardiac catheterization patients and therefore these patients recover in the ICU unit as observation patients. The applicant stated, *"Patients are transported over a circuitous route to and from the mobile cardiac catheterization unit, which is uncomfortable for the patients and is labor intensive."*

The applicant states on page 33,

> *"In addition, the new facility will provide a total of 10 observation beds: five beds on the medical/surgical floor and five beds adjacent to surgery. The five beds on the second floor medical/surgical unit will accommodate overnight observation patients; the five beds on the first floor will service outpatient surgical patients and cardiac catheterization patients that could require several hours of recovery (but would not be expected to stay overnight)."*

On page 29 of the application, the applicant states it proposes *"five observation rooms and a cardiac catheterization recovery room"* on the first floor. However, the floor plan in the application identifies all five rooms the space on the first floor as "cardiac cath recovery." Therefore, the application has provided inconsistent information regarding its proposed observation beds. See additional discussion in Criterion (4) regarding other issues with the proposed configuration of this unit.

Medical /Surgical Unit – The existing medical/surgical unit is located in the 1964 addition to the facility and consists of 36 beds in 5,454 square feet of space. Some of the rooms are semi-private and joined by a bathroom in a suite arrangement. The nurses station is located in the middle of the unit with access to both areas. Outpatients must be transported through the medical/surgical unit to the operating room and back, following recovery in the PACU. The applicant states on page 30, *"This adds to the congestion on the floor."* Further, there are often multiple family members and support persons present for each patient, which the applicant states *"further congestion in the limited space."*

The applicant states that the proposed medical/surgical unit will include 29 private acute care beds, which will be located on the second floor of the proposed replacement hospital. All 29 acute care patient rooms in the medical/surgical unit will be private rooms. The plan also includes a staff conference room. The medical/surgical unit will also have room for equipment storage, and rooms for clean and soiled utilities. Physicians will have a dictation station. The medical/surgical nurses station will also include space for clean utilities and medications in an enclosed room. The unit manager's office will also be in the medical/surgical unit.

Critical Care Unit – The critical care unit, built in 1921, is the oldest building still remaining on the Good Hope campus, and is approximately 1,800 square feet in size. The CCU currently has five private rooms and one step-down room with two beds, for a total of seven beds in the CCU unit. The applicant states that the nurses station is in the center, however the space is limited, as are the patient rooms.

The applicant states the proposed CCU will have five private beds, one of which will be an isolation room. The five critical care beds will have break away glass front walls, and the nurses station will be situated in the center for easy access to any patient. The unit will have clean and soiled utility rooms and storage areas. The unit will also include a bathroom within easy access to each room and a small waiting area for families of patients in the CCU. The area will include offices and a small conference room *"to allow ICU staff to attend meetings and obtain additional training without leaving the unit."*

Isolation Rooms – The applicant proposes the new facility will have three isolation rooms, two of which will be located in the medical/surgical unit and one in the critical care unit. Negative pressure capabilities will be provided in outpatient surgery, in the PACU and in a treatment room adjacent to the decontamination area of the emergency room,

Psychiatric Unit – The existing inpatient psychiatric unit, located in the 1982 building, contains space for 29 patients, in various room configurations. The unit is kept locked, and the nurses station is located to the right of the entrance to the 1970 building. The psychiatric care unit in the proposed facility will have 12 beds, in four private rooms and four semi-private rooms, with two beds per room for eight beds. The nurses station will be in the center of the unit, across the hall from all patient rooms. The unit will be self-contained, with a patient dining room, occupational therapy and quiet therapy room, workroom, seclusion room and courtyard. The unit also has an office for a medical director, admissions office, office for a social worker, exam room, charting area, and space for the personal effects and a laundry area for patients.

ANALYSIS OF PROPOSED SERVICES

Although the applicant demonstrates the need to replace its existing facility, the applicant does not adequately demonstrate that the population projected to be served needs the scope of services proposed by the applicant, as discussed below.

Acute Care Inpatient Utilization – The applicant states that GHH had an average daily census of 21.16 acute care patients in FY2002. The applicant states on page 68 that it projects growth in acute inpatient utilization based on "1.8 percent growth in population plus the growth attributed to physician recruitment." The following table shows the information provided on page 68 of the application.

Population Growth	2003	2004	2005	2006	2007	2008
Annual increase based on 1.8% annual growth	NA	NA	32	32	33	33
Acute Admissions (1.8 growth/yr.)	1,756	1,756	1,788	1,820	1,853	1,886
Physician Recruitment						
Admissions Increases						
1 Physician to be recruited 2005 (last quarter)			21	85	95	98
3 Physicians to be recruited in 2006				257	280	294
4 Physicians to be recruited in 2007					381	392
3 Physicians to be recruited in 2008						288
11 Physicians – Admissions from Physician Recruitment			21	342	756	1,072
Population Growth plus Physician Recruitment						
Admissions increase	2003	2004	2005	2006	2007	2008
TOTALS	1,756	1,756	1,809	2,162	2,609	2,958

In addition, the applicant shows on page 72 the following historical and projected utilization of its licensed acute care beds for the years from FY2000 to 2008.

Year	Acute Care Patient days	% Change
FY1999-2000	8,006	–
FY2000-2001	6,991	-12.7%
FY2001-2002	7,723	10.5%
FY2002-2003	7,200	-6,7%
FY2003-2004	7,200	–
FY2004-2005	7,417	3.0%
FY2005-2006	8,864	19.50%
FY2006-2007	10,697	20.68%
FY2007-2008	12,128	13.40%

The above table shows the applicant is projecting significant increases in utilization of its licensed acute care beds in the first three operating years of the new facility. These increases are dependent on the applicant increasing its market share in the proposed service area through recruitment of additional physicians who are expected to increase the number of admissions above and beyond population growth. However, GHHS does not provide current or projected market share data for existing facilities in the area to demonstrate the basis for its projected increase in admissions due to physician recruitment. In fact, the only market share data provided in the application is based on Good Hope's discharges in FY99 as reported to HCIA (see Exhibit 10). Further, GHHS is projecting patient origin for the new replacement hospital to remain the same as historical patient origin even though the hospital is moving farther away from the population it currently serves in Sampson and Cumberland Counties. Therefore, it is not reasonable to project the same patient origin or market share from these counties. Further, the applicant is projecting to add 11 additional physicians and assumes an

average of 86 to 97 admissions per year per physician. However, the applicant did not state in its application the basis for its assumptions regarding admissions per new physician. In summary, the applicant did not adequately document in the application the reasonableness of its assumptions regarding increases in inpatient admissions.

Psychiatric Utilization

The applicant states on page 90 of the application that GHH had an average daily census of 8.3 psychiatric patients in FY2002. The following table shows the applicant's projections for increases in admissions for its psychiatric beds, as stated on page 68 of the application, and projected days of psychiatric care from page 72 of the application.

	2003	2004	2005	2006	2007	2008
Psychiatric Admissions	513	513	528	631	631	631
Physician Growth Estimates			3%	20%	0%	0%
Psychiatric Days of Care	3,011	3,011	3,100	4,064	4,032	4,008
Increases	--	--	2.96%	31%	--	--

The applicant projects increases in utilization of its psychiatric admissions due to the availability of four private rooms and improved geographic access. The applicant states on page 68 that Dr. Duard Bok, Medical Director for the Inpatient Psychiatric Unit at GHH, projects psychiatric admissions to increase by 20% between FY2005 and FY2006 as a result of the new facility. However, the applicant did not provide any documentation that formed the basis of Dr. Bok's assumption that admissions would increase by 20% in a single year. Further, although the applicant projects admissions to grow 20% from FY2005 to 2006, it projects psychiatric patient days of care to increase 31% in the same time period. Thus, the applicant proposes that the average length of stay for psychiatric patients will increase as well.

The following table shows the applicant's current and projected average length of stay in the psychiatric unit.

Year	Admissions	Patient days	Average Length of Stay
FY1999-2000	438	2,789	6.4
FY2000-2001	548	3,052	5.6
FY2001-2002	526	3,142	5.7
FY2002-2003	513	3,011	5.9
FY2003-2004	513	3,011	5.9
FY2004-2005	528	3,100	5.9
FY2005-2006	631	4,064	6.4
FY2006-2007	631	4,032	6.4
FY2007-2008	631	4,008	6.4

The applicant provides no explanation for the projected increase in average length of stay from 5.7 days per admission in FY2002 to 6.4 days per admission in FY2008. Therefore, the applicant's projections for the number of psychiatric days of care to be provided are unsupported.

In summary, the applicant did not adequately demonstrate the reasonableness of its projections regarding persons needing psychiatric services at the new facility.

Observation Beds – The applicant states on page 69,

> *"The utilization trend for observation patients shows 135 percent growth in the past 4 years with 288 patients in FY 1997/98 and 676 patients in FY2001/02. These current numbers include only patients that were admitted as observations and do not include the cardiac catheterization patients that are sent to ICU beds or the post-surgical patients that use inpatient beds for several hours."*

The applicant also states on page 69,

> *"The total number of outpatients that currently utilize an inpatient acute care room ranges from 2 to 9 patients on any given day. This includes observation patients, extended stay outpatient surgery patients and cardiac catheterization patients.*
>
> *In Year 2008, the average daily census of observation beds will total 7+ patients. This includes an average of 3 medical observation patients per day on the 2nd floor observation unit (5 beds) and an average of 4 outpatient surgical observation patients per day on the first floor unit (5 beds) near surgery. In addition, approximately 2 cardiac catheterization patients per week will utilize the observation patients on the first floor. As*

seen in the staffing tables in Section VII, additional nursing staff will be utilized to staff these observation beds."

Although the applicant states total outpatients (i.e. medical observation, outpatient surgery and cardiac cath patients) using inpatient beds range from a low of 2 to a high of 8 patients on a given day, the applicant does not provide the average daily census for patients needing observation on an annual basis which would be somewhere between the high and low range.

On page 69 of the application, the application indicates that 4 outpatient surgery patients will require an observation bed per day which is equivalent to 58% of outpatient surgical patients (2,531 projected outpatient cases/365 days = 6.9 cases/day; 4/6.9 = .5797). However, based on the data in its 2003 Licensure Renewal Application, in FY2003, about 70% of its current outpatient surgical procedures are endoscopy procedures for which the need for an extended stay in an observation bed is questionable. Therefore, only 30% of the current outpatient surgery procedures are non-endoscopy and all of these patients would not be expected to need an extended stay in an observation bed.

In addition, the applicant states on page 73, *"In addition, the observation rooms will be utilized by cardiac catheterization patients that currently average 2 patients per day per day of service."* However, the applicant currently receives only 1 day of mobile cardiac catheterization service per week and thus projects an average daily census of only 2/10 of a cardiac catheterization patient per day (54/260 = .2). Consequently, the applicant does not need to develop observation beds specifically for cardiac catheterization patients that are only at the hospital one day per week as opposed to seven days per week.

Also, the applicant proposes to develop 5 observation beds on the second floor for patients who may need to stay overnight. The applicant states on page 33, *"The five beds on the second floor medical/surgical unit will accommodate overnight observation patients; the five beds on the first floor will service outpatient surgical patients and cardiac catheterization patients that could require several hours of recovery (but would not be expected to stay overnight)."* However, no documentation was provided regarding the number of patients that currently require an overnight stay or the number projected to require an overnight stay. Therefore, the applicant did not adequately demonstrate the need for 5 observation beds on the second floor medical/surgical unit for this purpose.

In summary, the applicant did not demonstrate the need for 10 observation beds given: the small number of cardiac catheterization patients to be served; the lack of documentation to support the projected number of outpatient surgery patients who would need an observation bed as opposed to a bay or recliner in the recovery

unit; and the failure to demonstrate the number of observation patients who would need to stay overnight.

Surgical Utilization

The applicant did not demonstrate the need for a third shared operating room. The applicant projects to provide the following number of surgical procedures in the new facility.

Operating Room Type	Surgical Cases	Operating Rooms (OR)	Cases Per OR Per Day
Shared	2,289	3	3.716

The applicant states its projections exceed the requirements of 3.5 surgical cases per day for each shared operating room during the fourth quarter of the third year of operation following completion of the project. However, the applicant's projections are not based on reasonable assumptions given the most recent experience of the hospital.

In Application Section III, page 70, the applicant states that *"Outpatient surgery utilization is projected to increase by 6.6% annually which is consistent with the percentage growth for the most recent year."* [Emphasis Added] Based on the table on page 72, the most recent year is FY2002-2003, which shows a growth of only 3.8% in outpatient surgical cases from the previous year (1,839/1,772 = 1.038). Therefore, the applicant did not adequately demonstrate a projected growth of 6.6% in outpatient surgical cases is reasonable given the growth in the most recent year is only 3.8%.

The applicant also states, *"Inpatient surgery is projected to hold steady in 2004 and then increase by 5 percent annually based on population and physician recruitment."* However, based on the applicant's table on page 72, the number of inpatient surgical procedures decreased from 346 procedures in 2000-2001 to 297 procedures in 2001-2002. Further, between FY2002 and FY2003, the applicant shows only modest growth of 1.7% (302/297 = 1.0168). But, the applicant is projecting annual increases in the number of inpatient surgical procedures ranging from 4.86% to 5.11% between FY2004 and FY2008, which is not consistent with growth in the "most recent year." The applicant states projected growth in inpatient surgery growth is also based on physician recruitment, but did not provide any documentation in the application regarding the number of inpatient surgical procedures the two surgeons it projects to recruit would be expected to perform.

Applying the most recent growth rate of 3.8% for outpatient procedures, the project analyst estimates the applicant would perform 2,216 outpatient surgical

procedures, as compared to 2,531 outpatient surgical procedures projected by the applicant for the third year of operation. Applying the most recent growth rate of 1.7% for inpatient surgical procedures, the project analyst estimates the applicant would perform 329 inpatient surgical procedures, as compared to the 367 inpatient surgical procedures the applicant projected for the third year of operation. This would result in a total of 2,545 procedures for the third operating year or only 3.26 procedures per operating room (2,545 procedures/260 days/3 shared operating rooms = 3.26). Therefore, using the "most recent growth," the applicant will not meet the required performance standard of 3.5 procedures per day for each operating room by the third year of operation. Consequently, the applicant failed to demonstrate the need for a third shared operating room. See Criterion (1) for additional discussion.

Expansion of Departments

Further, the applicant did not adequately demonstrate that all space it is proposing to develop in each department of the proposed replacement hospital is needed by the population projected to be served. See Criterion (4) for discussion of the amount of space to be constructed.

In summary, the applicant did not adequately demonstrate the need the population projected to be served has for all components of the proposed project. Therefore, the applicant is not conforming with this criterion.

(3a) In the case of a reduction or elimination of a service, including the relocation of a facility or a service, the applicant shall demonstrate that the needs of the population presently served will be met adequately by the proposed relocation or by alternative arrangements, and the effect of the reduction, elimination or relocation of the service on the ability of low income persons, racial and ethnic minorities, women, handicapped persons, and other underserved groups and the elderly to obtain needed health care.

C

Good Hope Hospital proposes to replace its existing hospital by constructing a new hospital approximately ten miles northwest of the existing facility in central Harnett County near Lillington. The applicant indicates that the location will provide a more accessible location to several of the major towns in Harnett County, such as Lillington, Buies Creek, Coats, Benson, and Linden, while continuing to provide access to residents in the Erwin area.

Good Hope is currently licensed for 43 acute care beds and 29 psychiatric beds, but proposes to eliminate nine licensed general acute care beds for a total of 34 acute care beds. The applicant also proposes to eliminate 17 psychiatric beds for a total

complement of 12 psychiatric beds. Good Hope had an average daily census of 21.2 acute care patients in FY 02 and an average daily census of 8.3 psychiatric patients.

Further, GHHS projects providing a total of 12,128 days of care in its 34 acute care beds, which is an average daily census of 33.2 patients and an average occupancy rate of 97.7 percent for fiscal year 2008. In addition, GHH projects providing a total of 4,008 days in its 12 psychiatric beds for an average daily census of 11 patients and an average occupancy rate of 91.7% for fiscal year 2008. Thus, although GHH will reduce its number of licensed general acute care beds by nine and reduce its psychiatric beds by 17, it will not impact the hospital's ability to meet the needs of the population it serves. However, see Criterion (3) regarding the reasonableness of GHHS's assumptions and projections. See Criterion (13) for discussion of access. Therefore, the application is conforming with this criterion.

(4) Where alternative methods of meeting the needs for the proposed project exist, the applicant shall demonstrate that the least costly or most effective alternative has been proposed.

NC

In Application Section II.5, the applicant states that several alternatives were considered prior to the development of the proposed project as listed below.

1. Maintain the status quo – See discussion on pages 34-35 of the application.

2. Renovate and Upgrade the Existing Structure – See discussion on page 35 of the application.

3. Build a Replacement Facility with 72 Beds – See discussion on page 36 of the application.

4. Build a Replacement Facility with 46 Beds near Erwin – See discussion on pages 36-37 of the application.

5. Merger Discussions with Betsy Johnson Regional Hospital – See discussion on pages 37-38 of the application.

6. Other Partnership and Collaboration Alternatives – See discussion on page 38 of the application.

7. Development of New (Replacement) Acute Care Hospital in Central Harnett County – See discussion on page 38 of the application.

On December 14, 2001, the Certificate of Need Section issued a certificate of need to Good Hope Hospital to replace its existing facility with a new replacement hospital as described in Project I.D. #M-6394-01. In Section III, page 43 of this application, the applicant states the following regarding the previous project.

> *"Good Hope Hospital, Inc. proposed in the original application to finance the project through HUD financing. Good Hope accomplished the steps necessary to secure HUD financing, except Medical Care Commission approval. The Medical Care Commission indicated that it was not approving the HUD financing because it thought Good Hope Hospital and Betsy Johnson Hospital should merge. Given the Medical Care Commission's disapproval, Good Hope Hospital was not able to obtain the HUD financing and had to explore other alternatives to finance the project.*
>
> *Good Hope Hospital determined that the most effective alternative to obtain needed capital for the replacement hospital project was a joint venture with an affiliate of Triad Hospitals, Inc., the parent company of Quorum Health Resources, Inc, who was currently managing the Hospital. Good Hope Health System, LLC was formed to accomplish this joint venture, pursue this application and obtain the needed capital, once the changes in the replacement hospital were approved."*

The applicant states in Section I, page 5,

> *"Good Hope Health System, LLC is a limited liability company formed by Good Hope Hospital Inc. and Triad Hospitals Inc. for the purpose of developing a replacement hospital facility in Harnett County. Good Hope Health System, LLC will have ownership of the proposed replacement hospital facility."*

On November 12, 2002, Good Hope Hospital, Inc. and Good Hope Health System, LLC, filed a request for a declaratory ruling regarding its previously approved application with the Division of Facility Services. In the declaratory ruling request, Good Hope Hospital sought approval to:

1. Transfer the pending certificate of need to Good Hope Health System, LLC.
2. Develop the replacement hospital in Lillington rather than Erwin as proposed in the previously approved application.
3. Increase the square footage of the replacement hospital from 61,788 square feet to 67,874 square feet.
4. Increase the total capital cost of the project from $16,159,950 to $18,523,942.

The applicant stated in its November 12, 2002 declaratory ruling request,

"GHHS's development and operation of the replacement hospital will be consistent with the cost and programmatic projections in GHH's Application, as approved by the Department and, therefore, will continue to provide the least costly and most effective alternative to meet the identified need." [Emphasis added]

The following table provides the additional square feet for the alternative project proposed in the declaratory ruling request:

Original Square Footage from CON Application	**61,788**
Change from Semi-private to all Private Rooms	+2,621 SF
Change from Endo Room to Third Operating Room	+162 SF
Increase size of Lab to accommodate existing equipment	+424 SF
Rearrange Surgery, SDS, PACU to better accommodate future growth	+1,391 SF
Include provisions for future stairs and elevators	+1,305 SF
Rearrange ER canopy for future Imaging growth	-290 SF
Enlarge Patient Rooms to provide for future vertical expansion	+373 SF
New Square Footage Total	**67,874**

The request for a declaratory ruling was denied by the Division of Facility Services on January 13, 2003. The applicant subsequently filed a petition for judicial review of the denial of the declaratory ruling in Wake County Superior Court on February 12, 2003. The petition for judicial review remains unresolved at this time.

On April 15, 2003, less than six months from the date of Good Hope's declaratory ruling request, the applicant submitted the application which is the subject of this review.

In Application Section II, page 39, the applicant states,

"Good Hope Hospital's Board of Trustees determined that the most effective option would be to partner with Triad Hospitals Inc. and create a new company 'Good Hope Health System, LLC.' This newly-formed entity will be owned 90% by Triad and 10% by GHH. The entity proposes to lease the existing hospital facility and develop a replacement hospital with 46 beds. (The replacement hospital would be owned by Good Hope Health System, LLC). The Good Hope Health System's Board of Trustees will be comprised of a representative of Good Hope Hospital Inc. as well as Harnett community members and physicians."

In this application, the applicant proposes to construct a replacement facility that includes 46 licensed acute care beds and 10 observation beds for a total of 112,945 square feet at a capital cost of $33,488,750, which is Alternative 6 above. The applicant states on page 36,

"In a previous CON application Project ID # M-6394-01, Good Hope Hospital Inc. proposed to develop a 46 bed replacement facility on 51 acres of land off U.S. Highway 421 northwest of Erwin, North Carolina. The harsh budget [sic] *building and left some of the ancillary and support departments at the old site; patient accounting, computer training, and some plant operations and maintenance functions were to remain at the Denim Drive location. Having personnel located at two sites would diminish staff efficiency and increase operating costs. The concept of using rooftop HVAC systems would result in higher maintenance and energy costs. Another limitation of this previously approved project was that it provided minimal space for outpatient services and observation patients."*

The applicant provides the following table in Exhibit 11 that briefly summarizes some of the changes between the previously approved project and the project currently under review.

Service/Department	Previous Proposed Plan Sq. Feet	Current Proposed Plan Sq. Feet	Justification
Nursing Unit – Patient Room enhancement			
Med/Surg	15,610	21,210	Change in Acute patient room, increasing private rooms, nursing support
CCU [sic]*	6,470	7,975	Change from 6 semi-private rooms to 4 private and 4 semi-private
Observation Beds & Support	0	4,655	1st Floor Observation Room
Storage (Observation unit)	0	1,020	Equipment storage added for swapping out beds and furniture in observation rooms
Subtotal	22,080	34,860	
Departments/Functions Previously Left at Old Location			
Community Training	0	870	Move service from existing hospital (not included in previous project)
IT Training	0	630	Move service from existing hospital (not included in previous project)
Outpatient PT	0	1,915	Move service from existing hospital (not included in previous project)
Business Office	0	1,595	Move service from existing hospital (not included in previous project)
Subtotal	0	5,010	
Surgery and Support	7,845	10,820	Improve circulation, workspace and patient holding
Emergency	4,630	4,965	Design change to improve patient flow
Radiology	4,725	6,805	Enlarge procedure rooms, additional storage and workspace, improve design for mammography
Food Service/Public Access Areas	3,910	9,775	Dining, Lobby, Meeting Rooms, Conference
Circulation, Mechanical	7,380	21,985	Mechanical rooms to accommodate improved building systems higher efficiency
Other Departments	11,218	18,725	Design reconfiguration
TOTAL	61,788	112,945	

* The line is misnamed "CCU" because the square feet and justification describe the psychiatric unit. The CCU includes the Med/Surg line item.

However, the numbers of square feet in each department, as listed in the above table, cannot be derived from the narrative in the application. The square footage by department in this table is not consistent with the square footage by department provided on page 16 of the application.

The following table shows the various increases in space Good Hope has proposed since the first application it submitted to the Certificate of Need Section on April 15, 2001, which was approved July 27, 2001.

Service/Department	Existing Sq. Feet at Good Hope Hospital 1/	Proposed Sq. Feet April 15, 2001 Good Hope Application (p. 13 & 142)	Proposed Sq. Feet Declaratory Ruling Request	Proposed Sq. Feet April 15, 2003 Good Hope Application (p. 16)
Surgery	3,145	4,628		5,590
Recovery	255	1,058		3,055
OP Surgery-Prep/Recovery	1,644	1,389		Included in 3,055 above
Radiology	1,800	4,343		6,805
Emergency	1,800	3,381		4,965
Lobby/Gift Shop	867	1,837		5,200
Registration	356	1,085		1,605
Medical Records	3,100	2,183		2,205
Education	175	1,048		2,205
Dietary	2,266	2,148		3,705
Mechanical	696	1,598		7,305
Materials Management	1,707	1,541		1,370
Housekeeping/Security	1,300	554		660
Plant Operations	1,500	586		650
Human Resources/Quality	169/640	1,015		1,495
Accounting	1,708	733		Included in 1,495 above
Administration	973	1,961		1,625
Medical/Surgical Pt. Care	5,465	10,772		16,455
Observation	Included above in 5,465			4,655
Critical Care Unit	1,800	1,694		4,755
Cardiopulmonary Testing	756	1,378		1,460
Inpatient Psychiatric Unit	6,152	6,201		7,975
Physical Therapy	2,800 (IP/OP)	630 (IP Only)		2,215 (IP/OP)
Laboratory	1,888	1,760		2,705
Pharmacy	420	511		825
Storage	0			1,605
Sub-waiting	0			810
Central Sterile Processing	0			780
Medical Staff Facilities	0			490
Business Office	Existing in business office	0		1,595
Information Systems	Existing in business office			710
Electrical/Communications	0			1,065
External Storage	Included below	484		600
Vertical Circulation	0			3,840
Other Circulation	14,271	6,184		9,175
Canopies, Dock, Door Soffits	Included above	1,086		2,865
TOTAL	52,188	61,788	67,874	112,945

1/ Includes only direct department square footage; does not include circulation square footage

In the previously approved application, the applicant stated that the proposed new replacement hospital would contain a total of 61,788 square feet. However, the new facility would not include space for the existing outpatient physical therapy department, a computer training classroom, patient accounts and the mechanical shop. In the new proposal, the applicant proposes 112,945 total square feet for the replacement hospital which includes new space for functions previously to be left at the existing campus. However, the new space for those functions only accounts for a small portion of the additional 51,157 square feet proposed in the current application. The applicant provided only a minimal explanation for some of the additional square footage in Exhibit 11, pages 19-20. The applicant did not provide sufficient information in its new application to demonstrate that the new proposal is the least costly or most effective alternative of its options, as discussed below.

Lobby/Reception/Registration – On pages 20-21, the applicant states the proposed lobby will seat approximately 25 people and will have access to the chapel and gift shop. Patient registration and admitting will be located next to the main lobby. The applicant states registration cubicles will provide privacy for patients being registered. With the exception of increasing the seating to accommodate 25 people, as opposed to 23 people in the previous application, the applicant did not describe in the narrative any significant changes to the lobby, gift shop, reception and registration areas from the previous application. However, the previous application states in Section II, page 18, *"This entire area will be housed in approximately 2,800 square feet of space."* In fact, the applicant's table of square feet by department in the previous application in Section XI, page 142 showed 2,922 square feet for the lobby, gift shop and registration areas. In comparison, the table on page 16 of the current application shows 6,805 square feet for the lobby, gift shop and registration areas which is an increase of 3,883 square feet from the previous approval. However, the applicant did not provide any discussion regarding the additional 3,883 square feet to be constructed for these areas or why it is necessary. Thus, the applicant failed to adequately demonstrate that the proposed space for the lobby, gift shop, reception and registration areas is not the least costly or most effective alternative of its options.

Administrative and Support Area – On page 21, the applicant states the administrative suite includes offices and support space for the administrators and staff, as well as a small conference room." The applicant states it will result in *"consolidation of related administrative functions."* According to Section XI, page 142 of the previous application, the applicant proposed a total of 3,709 square feet in its fiscal/quality management, accounting and administration areas. According to Section XI, page 139 of the current application, the applicant is proposing a total of 4,715 square feet in its human resources, quality, administration and business office areas. However, the applicant did not describe all of the differences between the administrative and support areas in the current application from that proposed in the previous application except for inclusion of

patient accounts. Thus, a conclusive comparison of the administrative areas as proposed in the two applications could not be completed.

Dietary Department – On page 23, the applicant describes the proposed dietary department that will occupy approximately 3,705 square feet. In its previous application, the applicant stated the dietary department would be located in 2,148 square feet of space. The only difference in the descriptions of this department between the two applications is a statement that the new dining plan will seat 40 individuals as compared to 26 in the drawing for the previous approval. The applicant does not provide any other explanation for the substantial increase in the size of the department. Consequently, the applicant failed to adequately demonstrate that the proposed size of the dietary department is the least costly or most effective alternative of its options.

Emergency Department – On pages 25-27 of the new application, the applicant describes the emergency services department which will have approximately 4,965 square feet of space. In comparison, the applicant proposed only 3,381 square feet for the same department in the previously approved application. In both applications, the applicant states emergency services will consist of the following:
1 Fast Track Treatment Room – two treatment bays for urgent care
1 Trauma Room – two treatment bays
3 Enclosed Exam Treatment Rooms – (1 psychiatric, 2 general)
1 Exam/Treatment Room with adjacent decontamination area (negative pressure)
Triage Area
Nurses Station
Consult Office
Staff Locker Rooms

In this current application, GHHS does not describe any significant change in the design of the emergency services department. The only explanation provided for the increase in square feet is in Exhibit 11 which states, *"Design change to improve patient flow."* However, in Exhibit 11, the applicant states the previous project was for 4,630 square feet when page 13 of the previous application shows only 3,381 square feet for the emergency department. Therefore, the applicant actually proposes 1,584 more square feet in the emergency department than previously approved (4,965-3,381). The applicant failed to adequately demonstrate that the proposed size of the Emergency Department is the less costly or more effective alternative of its options.

Radiology – The proposed radiology department in the previously approved project was 4,343 square feet, as stated in Section XI, page 142. On page 27 of the new application, the proposed radiology department is projected to be 6,805 square feet. The radiology area will include a radiography and fluorography unit, a radiography and tomography unit, nuclear medicine unit, CT scanner, one

ultrasound and one mammography unit, all of which were proposed in the previous application. The proposed new radiology department will have rooms for radiology file storage, a dark room and work area, two dressing rooms, holding alcove for inpatients and a physician consulting area. The space for radiology will include a physician consulting area, which will provide privacy for physicians, and allow them to view films and discuss treatment options. All of these items were included in the previous project. In the table in Exhibit 11, the applicant states justification for the increase is *"Enlarges procedure rooms, additional storage and workspace, improve design for mammography."* However, the applicant proposes an increase of 2,462 additional square feet in this department which is not adequately justified by the brief explanation provided. Therefore, the applicant did not adequately demonstrate that the size of the proposed Radiology Department is the less costly or more effective alternative of its options.

Laboratory – On page 28 of the new application, the applicant states the laboratory will include 2,705 square feet of space. In the previously approved application, the applicant proposed the laboratory would have 1,760 square feet. The applicant does not provide in the new application any description of the laboratory that would show what changes were made in the design. Therefore, the applicant did not adequately demonstrate that the size of the proposed laboratory is the less costly or more effective alternative of its options.

Pharmacy – The applicant states on page 28, *"The new facility plans show pharmacy services in 825 square feet of space on the second floor medical/surgical unit to enable immediate access to the inpatient medical/surgical and critical care beds. This arrangement provides ideal coordination of services and supports clinical pharmacy consultation as well as expedites the delivery of medications."* The applicant proposed 511 square feet for the pharmacy in the previous application. The plan in the current application shows 825 square feet of space for the pharmacy. The applicant did not provide any description in the new application that would show what changes were made in the design of the pharmacy. Therefore, the applicant did not adequately demonstrate that the size of the proposed pharmacy is the less costly or more effective alternative of its options.

Surgery Department – According to the applicant's table in Exhibit 11, page 19, of the new application, the applicant states it was proposing 7,845 feet for surgery and support space in the previous application. However, in Section XI, page 142 in the previous application, the applicant showed a total of only 7,075 square feet of space for the "Surgery, Recovery" and "Op Surgery – Prep/Surgery." The applicant's table in Section XI, page 139 of the new application shows a total of 8,645 square feet of space for these same areas, which is an increase of 1,570 square feet from the previous application. However, Exhibit 11 states surgery and support will be 10,820 square feet which is 3,745 more square feet than previously

approved. In Exhibit 11, the applicant states the only justification for the change is to *"improve circulation, workspace and patient holding."* However, the description of the surgical departments in the two applications do not differ significantly. Yet, the floor plan in the new application indicates that among other changes, an additional room has been added adjacent to the other three operating rooms which is the same size as the operating rooms, but is labeled "storage." The need for this space in addition to other storage space in the facility was not documented. The applicant failed to adequately demonstrate that the proposed size of the surgery unit and support space is the less costly or more effective alternative of its options.

Canopies, Dock, Door Soffits – The applicant states on page 30 of the new application,

> *"In the proposed facility, the MRI and Cardiac Catheterization mobile services will be assessed through a covered walkway connector so that patients will protected from the weather. MRI and cardiac catheterization patient will be received and screened at the sub-waiting area near the pre-operative/post-operative area of outpatient surgery."*

The previously approved application provided 1,086 square feet of space for canopies. The current application proposes 2,895 square feet of space for "Canopies, Dock, Door Soffits." The applicant did not provide adequate information to identify changes made in design that would necessitate an additional 1,779 square feet for this item. Therefore, the applicant failed to adequately demonstrate the proposed design is the less costly or more effective alternative of its options.

Observation beds – The applicant is proposing to add five observation beds on the first floor and five observation beds on the second floor. None of these beds were proposed in the previously approved project. According to its table in Section XI, page 139, the applicant is proposing 4,655 square feet of space for "Observation," which does not include 1,020 square feet of additional space that it states in Exhibit 11 will be used for storage for the observation area. However, the applicant states this square footage is only for the observation beds on the first floor and not those on the second floor. Based on the line drawing, the entire observation space on the first floor is actually proposed to include 9,825 square feet for the 5 bed cardiac cath recovery unit which includes support space, but not the extra waiting area. Further, the "observation" beds on the first floor are twice as large as those on the second floor and have a toilet and shower between each room. The applicant failed to demonstrate the need for an observation area of this size or the separate waiting area adjacent to it. Additionally, the applicant failed to adequately demonstrate the need to operate 10 observation beds. See Criterion (3) for discussion.

Consequently, the applicant did not adequately demonstrate that the proposed plan for observation services is the less costly or more effective alternative of its options.

Medical /Surgical Unit – The applicant states that the medical/surgical unit will include 29 private acute care beds, which will be located on the second floor of the proposed replacement hospital. The space designated for medical/surgical patient care proposed in the previously approved project was a total of 10,772 square feet (12,466 acute care beds + 1,694 CCU). This area included 13 private medical/surgical rooms, 5 private CCU rooms, and 8 semi-private medical/surgical rooms. Based on the table on page 16, the applicant proposes a total of 21,210 square feet for medical/surgical patient care which includes 4,755 square feet for the 5 bed CCU and 16,455 square feet for the other 29 licensed acute care beds and the five observation beds. The new proposal includes 10,438 more square feet than the previously approved application for medical/surgical patient care. The explanation provided by the applicant in Exhibit 11 for the change states, *"Change in Acute patient room, increasing private rooms, nursing support."* However, the size of the CCU alone increased 3,061 square feet but no explanation was provided to justify the changes in this area; although the floor plan for the CCU shows three rooms have been added to the unit that are identical in size to the other five CCU rooms in the area. Additionally, the rest of the patient care area was increased by 3,989 square feet which included five observation beds for which the need was not demonstrated. See previous discussions above and in Criterion (3) regarding observation beds. In summary, the applicant failed to adequately demonstrate that the proposed size of the medical/surgical patient care area, including the CCU and observation beds is the less costly or more effective alternative of its options.

Psychiatric Unit – The psychiatric care unit in the proposed facility will have 12 beds, with four private rooms and four semi-private rooms for a total of 8 rooms. The unit will be self-contained, with a patient dining room, occupational therapy and quiet therapy room, workroom, seclusion room and courtyard. The unit also has an office for a medical director, admissions office, office for a social worker, exam room, charting area, and space for the personal effects and a laundry area for patients. The applicant proposed an inpatient psychiatric unit in the previous application consisting of 12 beds, all configured in semi-private rooms, for a total of 6,201 square feet. In the proposed new application, the applicant proposes four private rooms and four semi-private rooms for a total of 7,975 square feet. Thus, it appears the 1,774 additional square feet results in part from the increase from six rooms (semi-private) to eight rooms (4 private, 4 semi-private) proposed for the inpatient psychiatric unit. However, the net addition of two new rooms is the only difference in the description of the unit. Therefore, it appears the unit was also increased for other undisclosed reasons because 1,774 square feet divided by two rooms would equal 877 square feet per new room which is not reasonable. The applicant did not adequately justify any other increases in the inpatient psychiatric

unit. Consequently, the applicant failed to adequately demonstrate that the proposed size of the psychiatric unit is the less costly or more effective alternative of its options.

Miscellaneous Areas

Information provided by the applicant in Exhibit 11 is not of sufficient detail to determine if the proposed number of square feet for the areas listed in the following table are consistent with the numbers of projected square feet provided on page 16 of the application.

Service/Department	Previous Proposed Plan Sq. Feet	Current Proposed Plan Sq. Feet	Justification
Circulation, Mechanical	7,380	21,985	Mechanical rooms to accommodate improved building systems higher efficiency
Other Departments	11,218	18,725	Design reconfiguration
TOTAL	18,598	40,710	

Based on the table in Exhibit 11, the applicant proposes 22,112 additional square feet of space in the areas listed above. The justifications that were provided for these areas are extremely broad and vague and do not provide sufficient information to demonstrate that the amount of square feet to be constructed is reasonable. Consequently, the applicant failed to adequately demonstrate that the proposed amount of space in these areas is the less costly or more effective alternative of its options.

Additionally, the applicant is not conforming with all other statutory and regulatory review criteria and therefore did not demonstrate that the proposed project is an effective alternative. See Criteria (1), (3), (5), (6) and (12) and 10 NCAC 3R .2100 for discussion.

In summary, the applicant did not adequately demonstrate that the proposed project is the least costly or most effective alternative for replacement of the existing hospital. Therefore, the applicant is not conforming with this criterion.

(5) Financial and operational projections for the project shall demonstrate the availability of funds for capital and operating needs as well as the immediate and long-term financial feasibility of the proposal, based upon reasonable projections of the costs of and charges for providing health services by the person proposing the service.

NC

Good Hope Health System, LLC projects a total capital cost of $33,488,850 for the proposed project. The capital costs include $1,32,000 in site costs, $21,257,000 in construction costs and $10,899,750 in miscellaneous costs of which $1,205,000 is for fixed equipment, $3,895,000 is for fixed and movable equipment, $650,000 is for furniture, $1,900,500 is for architect and engineering fees, $255,500 is for administrative and legal fees, $1,694,802 is for financing costs and $1,299,488 is for contingency costs. Additionally, in Application Section IX, page 122, the applicant projects $30,000 in start-up expenses for the *"estimated cost for staff orientation and training related to the facility and equipment."* The applicant further states on page 122, *"The costs related to staff orientation and training will be funded by Triad contribution to Good Hope Hospital, LLC. Any other costs associated with transitioning to the new facility have been included as 'contingency' in the capital costs of the project."*

In Application Section VIII.4, the applicant states, *"Triad Hospitals Inc. will fund the proposed replacement hospital project from available cash."* However, this statement is not consistent with the documentation provided. Specifically, Exhibit 22 of the application contains a copy of an April 10, 2003 letter from Steve Love, Senior Vice President of Finance and Controller, Triad Hospitals, Inc. for the commitment of funds for the Good Hope replacement hospital project, states,

> *"I am the Senior Vice President of Finance and Controller of Triad Hospitals, Inc. and have responsibility for managing the funds of Triad Hospitals, Inc. Triad Hospitals Inc. and Good Hope Hospital, Inc. have formed a new liability company, Good Hope Health System, LLC. Good Hope Health System LLC will lease and operate the existing Good Hope Hospital until such time as the replacement hospital is constructed. Good Hope Health System, LLC will also own and operate the replacement Hospital.*
>
> *Triad Hospitals Inc. is committed to make the contributions to Good Hope Health System, LLC needed for the purpose of financing the total capital cost of $33,488,750 for the proposed replacement hospital project. The amount includes all capital costs related to the project including but not limited to the land, site improvements, construction, equipment and furniture, architect fees, consulting costs, financing costs (during construction), and contingency. Triad Hospitals Inc. is also committed to fund all the start up and initial operating costs associated with the project.*
>
> *In addition, Triad Hospitals Inc. is also committed to make contributions to Good Hope Health LLC to fund the purchase of assets and the cost of the lease of the existing hospital located in Erwin, for the period of time while the replacement hospital is under*

construction. Triad will meet these obligations through a combination of available cash; $68.3 million of December 31, 2002 as evident from the enclosed financial statements and draws on an existing line of credit in the amount of $250 million." [Emphasis added]

The applicant provided a copy of the audited consolidated financial statements for the years ended December 31, 2002 and 2001 for Triad Hospitals, Inc. indicating that Triad Hospitals had $68.3 in cash and cash equivalents. However, the letter quoted above states the project will be funded with a combination of cash and "draws on an existing line of credit." The applicant did not provide any documentation in its application regarding the availability of the line of credit to be used for the project.

In Section X.5(a), the applicant states the proposed project will not result in any incremental increase in patient charges for services. The applicant states, *"GHHS intends to implement increases in all hospital charges to cover its increases related to salary raises and inflation. No charge increases will be implemented as a direct result of the proposed project. GHHS has assumed that charges will increase by approximately 4 to 5 percent annually."* In Section X.6(a), the applicant states *"The incremental cost per day is $114.87/day. However, most of this cost relates to increased depreciation."* The applicant's pro formas following Section XII show that revenue will exceed expenses in each of the first three years of operation following completion of the replacement hospital. However, the applicant overstated the number of inpatient days of care to be provided and the number of surgical procedures to be performed at the proposed facility. Consequently, the applicant's projections of costs and revenues that are based on the number of inpatient days of care and surgical procedures are not reliable and unsupported. See Criterion (3) for discussion. In summary, the applicant failed to adequately demonstrate that the immediate and long-term financial feasibility of the proposal is based upon reasonable projections of costs and revenues. Therefore, the application is nonconforming with this criterion.

(6) The applicant shall demonstrate that the proposed project will not result in unnecessary duplication of existing or approved health service capabilities or facilities.

NC

Good Hope Hospital proposes to relocate and build a replacement hospital to address deficiencies in its existing facility. However, the applicant did not adequately demonstrate the need for all of the service components to be developed. In addition, the applicant failed to adequately demonstrate that all of the space it is proposing to construct is needed. See Criteria (1), (3) and (4) for analysis and discussion of the previous approval.

In summary, the applicant failed to demonstrate that the proposed project is not an unnecessary duplication of existing or approved health service capabilities or facilities and is nonconforming with this criterion.

(7) The applicant shall show evidence of the availability of resources, including health manpower and management personnel, for the provision of the services proposed to be provided.

C

The applicant states in Application Section VII.3, page 109,

> *"The FTEs in Table VII for Year 2007 include 59.85 FTEs that will be added over the next 4 years for increased utilization of existing services. These FTE increases will be incremental staff additions (for existing service's job descriptions) in response to the expected growth in utilization. These staff additions will be phased in over time and in proportion to changes in utilization. No new job descriptions will be added because the projected growth relates to existing services."*

Good Hope currently has 178 FTE full-time positions and 94 part-time FTE positions, for a total of 211.45 FTE positions. The CEO, CFO and Controller are full-time contract employees and will become employees of Good Hope Health System. GHH proposes to have a total of 234 FTE full-time positions and 102 part-time FTE positions by Year 2 following completion of the proposed project in 2007. Good Hope demonstrated the availability of an adequate number of health manpower and management personnel to provide the proposed services. Therefore, the application is conforming with this criterion.

(8) The applicant shall demonstrate that the provider of the proposed services will make available, or otherwise make arrangements for, the provision of the necessary ancillary and support services. The applicant shall also demonstrate that the proposed service will be coordinated with the existing health care system.

C

The applicant will make available all the necessary ancillary and support services. The applicant currently has transfer agreements with area health care facilities, the names of which are contained in Section V.2(a). Good Hope Hospital has transfer agreements with UNC Hospitals, Betsy Johnson Regional Hospital, NC Baptist Hospital, and Raleigh Community Hospital/Duke University Health System and Central Carolina Hospital. GHHS states it plans to continue these agreements.

Exhibit 17 contains copies of several of these transfer agreements. In Application V.4(a) the applicant states,

> *"The proposed project will continue the existing relationships with other healthcare providers. Please see Exhibit 17 for copies of existing transfer agreements. Many relationships with agencies such as nursing homes and home health care providers are informal and long-standing and have no formal agreements."*

In addition, Application Exhibit 14 contains letters from representatives of several health care organizations, including Cape Fear Valley Health System, The University of North Carolina Hospitals, Duke University Health System, Lee-Harnett Area Mental Health, Tri County Community Health Center, Liberty Commons Nursing and Rehabilitation of Johnston, Harnett County Department of Public Health, Harnett Manor Nursing Home and Brookfield Retirement Center, Inc. expressing support for the proposed replacement hospital. Also, Exhibit 18 contains letters from 31 local physicians and other health care providers expressing support for the proposed project.

Good Hope Hospital adequately demonstrated that the necessary ancillary and support services will be available for the replacement hospital and that the services will be coordinated with the existing health care system. Therefore, the applicant is conforming with this criterion.

(9) An applicant proposing to provide a substantial portion of the project's services to individuals not residing in the health service area in which the project is located, or in adjacent health service areas, shall document the special needs and circumstances that warrant service to these individuals.

NA

(10) When applicable, the applicant shall show that the special needs of health maintenance organizations will be fulfilled by the project. Specifically, the applicant shall show that the project accommodates:

(a) The needs of enrolled members and reasonably anticipated new members of the HMO for the health service to be provided by the organization; and

NA

(b) The availability of new health services from non-HMO providers or other HMOs in a reasonable and cost-effective manner which is consistent with the basic method of operation of the HMO. In assessing the availability of these

health services from these providers, the applicant shall consider only whether the services from these providers:

(i) would be available under a contract of at least 5 years duration;
(ii) would be available and conveniently accessible through physicians and other health professionals associated with the HMO;
(iii) would cost no more than if the services were provided by the HMO; and
(iv) would be available in a manner which is administratively feasible to the HMO.

NA

(11) Repealed effective July 1, 1987.

(12) Applications involving construction shall demonstrate that the cost, design, and means of construction proposed represent the most reasonable alternative, and that the construction project will not unduly increase the costs of providing health services by the person proposing the construction project or the costs and charges to the public of providing health services by other persons, and that applicable energy saving features have been incorporated into the construction plans.

NC

Good Hope Hospital proposes to replace its existing hospital by constructing a new hospital approximately ten miles from its existing facility for a total capital cost of $33,488,750, of which $1,332,000 is for site costs and $21,257,000 is for construction. The proposed replacement hospital will have a total of 112,945 square feet. Construction costs per square foot are projected to be $188.21. Exhibit 23 contains the cost estimate from the applicant's architect, David E. Johnson, NCARB, AIA of Johnson Johnson Crabtree Architects P.C. The April 4, 2003 letter states,

> *"Good Hope Health System, LLC is proposing to develop a replacement Hospital* [sic] *project for their existing services. According to the current planning documents, the size of the facility will be 112,945 square feet. The current construction cost estimate is $21,257,000 or $188.21 SF.*
>
> *This construction cost estimate includes site preparation (excluding Site inspections, survey, fees and permits). The architect and engineering Fees are estimated at $1,900,500."*

Section XI.7 of the application lists energy saving methods to be used in construction of the new facility. Good Hope adequately demonstrated that applicable energy saving features have been incorporated into the construction plans.

On December 14, 2001, Good Hope was issued a certificate of need for a replacement facility with 61,788 square feet for a total capital cost of $16,159,950 of which $10,482,500 is for construction costs. The new application that is the subject of this review proposes a replacement facility with 112,945 square feet for a capital cost of $33,488,750, of which $21,257,000 is for construction costs. The applicant's construction costs in the current alternative are $10,482,500 more than the construction costs in the previously approved alternative. The applicant also proposes to construct 51,157 more square feet than in the previously approved alternative. However, the applicant did not adequately demonstrate in the application currently under review that the cost and design of the proposed new project are the most reasonable alternatives. See Criteria (3) and (4) for discussion of the applicant's other alternatives. Therefore, the application is nonconforming with this criterion.

(13) The applicant shall demonstrate the contribution of the proposed service in meeting the health-related needs of the elderly and of members of medically underserved groups, such as medically indigent or low income persons, Medicaid and Medicare recipients, racial and ethnic minorities, women, and handicapped persons, which have traditionally experienced difficulties in obtaining equal access to the proposed services, particularly those needs identified in the State Health Plan as deserving of priority. For the purpose of determining the extent to which the proposed service will be accessible, the applicant shall show:

(a) The extent to which medically underserved populations currently use the applicant's existing services in comparison to the percentage of the population in the applicant's service area which is medically underserved;

C

In Section VI.6, the applicant states that 7.4% of its gross revenue or $2,702,679 in charity care was provided by GHH in FY2001. The applicant does not distinguish between bad debt and charity care, and both are included in the above. The following table, based on Application Section VI.10, shows the percentage of acute care patient days by payment type who received care from Good Hope Hospital during FY 2002:

Method of Payment	Current Acute Care Patient Days/Percent of Total
Self Pay/Indigent/Charity	8.0%
Medicare	68.4%
Medicaid	9.7%
Commercial Insurance	4.3%
Blue Cross	5.4%
Other*	4.3%
Total	100%

*(incl. Champus, Managed Care and misc. ins.)

The preceding table indicates 78.1% of the acute care patient days of care provided at Good Hope Hospital have some or all of their services paid by Medicare or Medicaid.

The following table, based on Application Section VI.10, shows the percentage of psychiatric patient days by payment type who received care from Good Hope Hospital during FY 2002:

Method of Payment	Current Psychiatric Patient Days/Percent of Total
Self Pay/Indigent/Charity	5.4%
Medicare	26.0%
Medicaid	25.3%
Commercial Insurance	4.6%
Blue Cross	6.0%
Other*	32.7%
Total	100%

*(incl. Champus, Managed Care and misc. ins.)

The preceding table indicates 51.3% of the psychiatric patient days of care provided at Good Hope Hospital have some or all of their services paid by Medicare or Medicaid.

The applicant demonstrated the facility currently provides adequate access to medically underserved populations. Therefore, the applicant is conforming with this criterion.

(b) Its past performance in meeting its obligation, if any, under any applicable regulations requiring provision of uncompensated care, community service, or access by minorities and handicapped persons to programs receiving federal assistance, including the existence of any civil rights access complaints against the applicant;

C

In Section VI.9, the applicant states *"Good Hope Hospital has had no obligation to provide uncompensated care in the past three years."* According to the Licensure and Certification Section of the Division of Facility Services, there are no existing or pending civil rights access complaints against Good Hope Hospital. The applicant is conforming with this criterion.

(c) That the elderly and the medically underserved groups identified in this subdivision will be served by the applicant's proposed services and the extent to which each of these groups is expected to utilize the proposed services; and

C

In Application Section VI.12, Good Hope Hospital states it proposes no change in the utilization by payor source from that provided by the hospital in FY 2002. See Criterion (13a). In Section VI.2 of the application, the applicant states *"Good Hope Health System LLC, will provide access to care for all patients, including those listed above, as documented in the patient rights policy. The hospital practices an open admission policy and does not discriminate based on age, race, national or ethnic origin, disability, sex, income, or ability to pay. Patients will be admitted and services will be provided in compliance with:*

1. *Title VI of Civil Rights Act of 1963*
2. *Section 504 of Rehabilitation Act of 1973*
3. *The Age Discrimination Act of 1975*
4. *American with Disabilities Act"*

Therefore, the applicant adequately demonstrated that medically underserved persons will have adequate access to its services and is conforming with this criterion.

(d) That the applicant offers a range of means by which a person will have access to its services. Examples of a range of means are outpatient services, admission by house staff, and admission by personal physicians.

C

In Application Section VI.7, the applicant states, *"Patients are referred to Good Hope Hospital by physicians who are on the medical staff at the hospital."* GHHS provided a listing of these physicians in Exhibit 13. The applicant also states, *"Good Hope Health System expects to continue to receive patient admissions from physicians and transfers from other healthcare providers, as has occurred historically with the present hospital services."* Further, the applicant states, *"As an existing community acute care facility for more than 90 years, Good Hope Hospital has established working relationships with these providers, some of which are informal."* The applicant included copies of the formal agreements in Exhibit 20. The applicant is conforming with this criterion.

(14) The applicant shall demonstrate that the proposed health services accommodate the clinical needs of health professional training programs in the area, as applicable.

C

In Application Section V.1, the applicant states, *"Good Hope Health System, LLC is committed to accommodating the clinical needs of health professionals. Currently, the hospital has affiliations with the following programs."*

Facility	*Program*
Sampson Community College	Associate Degree Nursing
Central Carolina Community College	Nursing

The applicant further states on page 96, *"These existing relationships will be continued with the proposed replacement hospital. GHHS has contacted clinical health programs in the area to discuss the positive impact of the proposed project."* The applicant included copies of existing agreements between Good Hope Hospital, Sampson Community College as well as Central Carolina Community College, and Harnett Central High School training programs in

Application Exhibit 16. Therefore, the application is conforming with this criterion.

(15) Repealed effective July 1, 1987.
(16) Repealed effective July 1, 1987.
(17) Repealed effective July 1, 1987.
(18) Repealed effective July 1, 1987.

(18a) The applicant shall demonstrate the expected effects of the proposed services on competition in the proposed service area, including how any enhanced competition will have a positive impact upon the cost effectiveness, quality, and access to the services proposed; and in the case of applications for services where competition between providers will not have a favorable impact on cost-effectiveness, quality, and access to the services proposed, the applicant shall demonstrate that its application is for a service on which competition will not have a favorable impact.

NC

The applicant failed to demonstrate that the proposed project will have a positive effect on the cost effectiveness of the proposed services. See Criteria (1), (3), (4), (5), (6) and (12) for discussion.

(19) Repealed effective July 1, 1987.

(20) An applicant already involved in the provision of health services shall provide evidence that quality care has been provided in the past.

C

Good Hope Hospital is accredited by the Joint Commission on Accreditation of Health Care Organizations and certified for Medicare and Medicaid participation. According to the files in Licensure and Certification Section, DFS, no incidents occurred, within the eighteen months immediately preceding the date of this decision, for which any sanctions or penalties related to quality of care were imposed by the State. However, in September 2003, the hospital was provided "Notice of Intent to Issue a Provisional License" due to violations cited pursuant to the Hospital Licensure Act, North Carolina General Statute 131E-79 and the licensing rules entitled Plan Approval, 10A NCAC 13B .3102(b)(1); and Construction Requirements, 10A NCAC 13B .6100 - .6227. The applicant previously applied for and obtained a certificate of need to replace the existing hospital to correct these deficiencies, and the applicant is currently making necessary renovations to the existing physical plant. Therefore, the application is determined to be in conformance with this criterion at this time.

(21) Repealed effective July 1, 1987.

(b) The Department is authorized to adopt rules for the review of particular types of applications that will be used in addition to those criteria outlined in subsection (a) of this section and may vary according to the purpose for which a particular review is being conducted or the type of health service reviewed. No such rule adopted by the Department shall require an academic medical center teaching hospital, as defined by the State Medical Facilities Plan, to demonstrate that any facility or service at another hospital is being appropriately utilized in order for that academic medical center teaching hospital to be approved for the issuance of a certificate of need to develop any similar facility or service.

NC

Section II.8 of the application requests that the applicant respond to any applicable *"special CON rules and criteria."* In response, on page 42, the applicant states, *"There are no special criteria that apply to this project or to the services being provided by Good Hope Hospital. The proposal is for the relocation of existing and approved services (beds and operating rooms). No changes to services, beds or operating rooms will occur upon completion of the project."* However, the existing hospital has only two existing operating rooms and the applicant proposes to add a third shared operating room in this application. Therefore, the Criteria and Standards for Surgical Services and Operating Rooms, promulgated in 10 NCAC 3R Section .2100, are applicable to this review. The applicant did not address all of the rules in the Criteria and Standards for Surgical Services and Operating Rooms in response to the question in Section II.8 of the application form or anywhere else in the application. Therefore, the applicant failed to demonstrate that the proposal to construct a third shared operating room is conforming with each of the rules for Surgical Services and Operating Rooms, as required by 10 NCAC 3R Section .2100, as discussed below.

10A NCAC 14C .2102 **Information Required of Applicant**

(a) *An applicant proposing to establish a new ambulatory surgical facility, to increase the number of operating rooms, to convert a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or to add a specialty to a specialty ambulatory surgical program shall identify each of the following specialty areas that will be provided in the facility:*

(1) gynecology;

-NC- The applicant failed to state whether or not the specialty area of gynecology will be offered in the replacement hospital. The applicant provided a listing in Exhibit 13 of current medical staff members, but gynecology was not specifically identified on the list or elsewhere in the application as one of the specialty areas. Further, in Application Section

III, page 64, the applicant did not specifically state whether or not the specialty area of gynecology will be offered.

(2) otolaryngology;

-C- The applicant provided adequate documentation in Exhibit 13 that otolaryngology will be offered in the replacement hospital.

(3) plastic surgery;

-C- The applicant provided adequate documentation in Exhibit 13 that plastic surgery will be offered in the replacement hospital.

(4) general surgery;

-C- The applicant provided adequate documentation in Exhibit 13 that general surgery will be offered in the replacement hospital.

(5) ophthalmology;

-C- The applicant provided adequate documentation in Exhibit 13 that opthalmology will be offered in the replacement hospital.

(6) orthopedic;

-C- The applicant provided adequate documentation in Exhibit 13 that orthopedics will be offered in the replacement hospital.

(7) oral surgery; and

-C- The applicant provided adequate documentation in Exhibit 13 that oral surgery will be offered in the replacement hospital.

(8) other specialty area identified by the applicant.

-C- The applicant provided adequate documentation in Exhibit 13 that urology will be offered in the replacement hospital.

(b) *An applicant proposing to establish a new ambulatory surgical facility, to increase the number of operating rooms, to convert a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or to add a specialty to a specialty ambulatory surgical program shall provide the following information regarding the services to be offered in the facility following completion of the project:*

(1) *the number and type of existing and proposed operating rooms;*

-C- In Section II, page 29, the applicant states that it currently operates two shared operating rooms. The applicant states on page 29 that it is proposing to construct one additional shared operating room, for a total of three shared operating rooms.

(2) *the number and type of existing and proposed shared operating rooms;*

-C- In Section II, page 29, the applicant states that it currently operates two shared operating rooms. The applicant states on page 29 that it is proposing to develop one additional shared operating room, for a total of three shared operating rooms.

(3) *the current and projected number of surgical procedures, identified by CPT code or ICD-9-CM procedure code, to be performed in the operating rooms;*

-NC- In application Section III, page 72, the applicant provided a listing of the current number of surgical procedures performed in its two existing shared operating rooms. In application Section III, page 72, the applicant also provided the number of projected surgical cases to be performed at the new facility. However, the applicant did not provide the current and projected number of surgical procedures by ICD-9-CM procedure code. Therefore, the application is nonconforming with this rule.

(4) *the fixed and movable equipment to be located in each operating room*

-NC- In Exhibit 21 of the application, the applicant provides a list of some movable and fixed equipment to be acquired for the replacement hospital. However, the applicant failed to provide the movable and fixed equipment to be located in each operating room. Therefore, the applicant is nonconforming with this rule.

(5) *the hours of operation of the proposed operating rooms;*

-NC- The applicant failed to state the hours of operation of the proposed operating rooms. Therefore, the applicant is nonconforming with this rule.

(6) *if the applicant is an existing facility, the average charge for the 20 surgical procedures most commonly performed in the facility during the preceding twelve months and a list of all services and items included in each charge;*

-NC- In Section X.1(a)(1), page 123 of the application, the applicant provided a listing of 19 inpatient procedures, and 20 outpatient procedures, including current charges for each procedure. However, the applicant did not provide a list of all services and items included in each surgical charge. Consequently, the applicant is nonconforming with this rule.

(7) *the projected average charge for the 20 surgical procedures which the applicant projects will be performed most often in the facility and a list of all services and items in each charge; and*

-NC- In Section X.1(a)(1), page 123 of the application, the applicant provided a listing of current charges for surgical procedures. The applicant did not provide the projected average charge for the surgical procedures to be performed most often in the facility and a list of all services and items in each charge. Consequently, the applicant is nonconforming with this rule.

(8) *identification of providers of pre-operative services and procedures which will not be included in the facility's charge.*

-NC- The applicant did not provide the identification of providers of pre-operative services and procedures which will not be included in the facility's surgical charge. Consequently, the applicant is nonconforming with this rule.

.2103 **Performance Standards**

(a) *In projecting utilization for existing, approved, proposed and expanded surgical programs, a program shall be considered to be open five days per week and 52 weeks a year.*

-NC- The applicant did not state the hours of operation of the expanded surgical program at Good Hope Hospital.

(b) *A proposal to establish a new ambulatory surgical facility, to increase the number of operating rooms, to convert a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or to add a specialty to a specialty ambulatory surgical program shall not be approved unless the applicant documents that the average number of surgical cases per operating room to be performed in the applicant's facility is projected to be at least 2.7 surgical cases per day for each inpatient operating room, 4.3 surgical cases per day for each outpatient or ambulatory surgical operating room, 4.3 cases per day for each endoscopy procedure room, and 3.5 surgical cases per day for each shared operating room during the fourth quarter of the third year of operation following completion of the project.*

-NC- The applicant did not adequately document that it would meet the required performance standard of 3.5 procedures per day for each shared operating room by the third year of operation. Consequently, the applicant is nonconforming with this rule. See Criterion (3) for analysis and discussion.

(c) *An applicant proposing to convert a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or to add a specialty to a specialty ambulatory surgical program shall provide documentation to show that each existing ambulatory surgery program in the ambulatory surgical service area that performs ambulatory surgery in the same specialty area as proposed in the application is currently operating at 4.3 surgical cases per day for each outpatient or ambulatory surgical operating room, 4.3 cases per day for each endoscopy procedure room, and 3.5 surgical cases per day for each shared operating room.*

-NA- The applicant does not propose to convert a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or to add a specialty to a specialty ambulatory surgical program.

(d) *An applicant proposing to convert a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or to add a specialty to a specialty ambulatory surgical program shall provide documentation to show that each existing and approved ambulatory surgery program in the ambulatory surgical service area that performs ambulatory surgery in the same specialty areas as proposed in the application is projected to be operating at 4.3 surgical cases per day for each outpatient or ambulatory surgical operating room, 4.3 cases per day for each endoscopy procedure room, and 3.5 surgical cases per day for each shared surgical operating room prior to the completion of the proposed project. The applicant shall document the assumptions and provide data supporting the methodology used for the projections.*

-NA- The applicant does not propose to convert a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or to add a specialty to a specialty ambulatory surgical program.

.2104 **Support Services**

(a) *An applicant proposing to establish a new ambulatory surgical facility, increase the number of operating rooms, convert a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or add a specialty to a specialty ambulatory surgical program shall provide written policies and procedures demonstrating that the facility will have patient referral, transfer, and followup procedures.*

-C- In Application Section V.2(a), page 97, the applicant states, *"Transfer agreements are in place with UNC Hospitals, Betsy Johnson Regional Hospital, NC Baptist Hospital, and Raleigh Community Hospital/Duke University Health System."* The applicant provided copies of transfer agreements with Raleigh Community Hospital/Duke University Health System and Central Carolina Hospital in Exhibit 17 that included policies and procedures for patient referral, transfer and followup. The applicant provided copies of transfer agreements with UNC Hospitals and NC Baptist Hospital in Exhibit 20.

(b) *The applicant shall provide documentation showing the proximity of the proposed facility to the following services*

(1) *emergency services;*

-C- In Sections II and III, the applicant states that the hospital provides emergency services. The applicant also provided documentation showing the proximity of the proposed replacement hospital to

emergency services in Section II, page 20, Section III, page 61, and Section V, page 97, including Betsy Johnson Regional Hospital.

(2) *support services;*

-C- The applicant adequately documents in Sections II, III, IV and V of the application that adequate support services will be provided in the hospital. The applicant also provided documentation showing the proximity of the proposed replacement hospital to support services in Exhibit 17.

(3) *ancillary services; and*

-C- The applicant adequately documents in Sections II, III, IV and V of the application that adequate ancillary services will be provided in the proposed hospital.

(4) *public transportation.*

-NC- The applicant did not provide any information regarding the proximity of the proposed facility to public transportation.

.2105 **Staffing and Staff Training**

(a) *An applicant proposing to establish a new ambulatory surgical facility, to increase the number of operating rooms, to convert a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or to add a specialty to a specialty ambulatory surgical program shall identify, justify and document the availability of the number of current and proposed staff to be utilized in the following areas:*

(1) *administration;*

-NC- The applicant provides a list of current staff and proposed staff for the entire proposed replacement hospital in Section VII.2, page 109-110, and in its staffing table on pages 113-114. However, the applicant failed to adequately identify, justify and document the availability of the number of current and proposed staff to be utilized specifically in surgical administration.

(2) *pre-operative*;

-NC- The applicant provides a list of current staff and proposed staff for the entire proposed replacement hospital in Section VII.2, page 109-110, and in its staffing table on pages 113-114. However, the applicant failed to adequately identify, justify and document the availability of the number of current and proposed staff to be utilized specifically in the pre-operative area for surgical services.

(3) *post-operative*;

-NC- The applicant provides a list of current staff and proposed staff for the entire proposed replacement hospital in Section VII.2, page 109-110, and in its staffing table on pages 113-114. However, the applicant failed to adequately identify, justify and document the availability of the number

of current and proposed staff to be utilized specifically in the post-operative area.

(4) *operating room; and*

-NC- The applicant provides a list of current staff and proposed staff for the entire proposed replacement hospital in Section VII.2, page 109-110, and in its staffing table on pages 113-114. However, the applicant failed to adequately identify, justify and document the availability of the number of current and proposed staff to be utilized specifically in the operating room.

(5) *other.*

-NC- The applicant provides a list of current staff and proposed staff for the entire proposed replacement hospital in Section VII.2, page 109-110, and in its staffing table on pages 113-114. However, the applicant failed to adequately identify, justify and document the availability of the number of current and proposed staff to be utilized specifically in other areas for surgical services.

(b) *The applicant shall identify the number of physicians who currently utilize the facility and estimate the number of physicians expected to utilize the facility and the criteria to be used by the facility in extending surgical and anesthesia privileges to medical personnel.*

-NC- On page 63 of the application, the applicant provides a table which shows 102 members of the medical staff have privileges at the existing facility. The applicant provides a listing of these physicians in Exhibit 13. The applicant did not specifically state which of these physicians have surgical and anesthesia privileges at the existing hospital. The applicant states in Section VII, page 111, *"The physicians at Good Hope Hospital are independent practicing physicians who are members of the medical staff and have admitting privileges at the facility. Physicians that currently have privileges at the existing hospital will be afforded the opportunity to continue their privileges at the new facility."* However, the applicant did not provide the specific criteria to be used by the facility in extending surgical and anesthesia privileges to medical personnel.

(c) *The applicant shall provide documentation that physicians with privileges to practice in the facility will be active members in good standing at a general acute care hospital within the ambulatory surgical service area in which the facility is, or will be, located or will have written referral procedures with a physician who is an active member in good standing at a general acute care hospital in the ambulatory surgical service area.*

-C- The applicant states in Section VII, page 111, *"The physicians at Good Hope Hospital are independent practicing physicians who are members*

of the medical staff and have admitting privileges at the facility. Physicians that currently have privileges at the existing hospital will be afforded the opportunity to continue their privileges at the new facility."

.2106 Facility

(a) *An applicant proposing to establish a licensed ambulatory surgical facility that will be physically located in a physician's or dentist's office or within a general acute care hospital shall demonstrate that reporting and accounting mechanisms exist and can be used to confirm that the licensed ambulatory surgery facility is a separately identifiable entity physically and administratively, and is financially independent and distinct from other operations of the facility in which it is located.*

-NA- The applicant does not propose to establish a separately licensed ambulatory surgical facility.

(b) *An applicant proposing a licensed ambulatory surgical facility shall receive accreditation from the Joint Commission for the Accreditation of Healthcare Organizations, the Accreditation Association for Ambulatory Health Care or a comparable accreditation authority within two years of completion of the facility.*

-NA- The applicant does not propose to establish a licensed ambulatory surgical facility.

(c) *An applicant proposing to establish a new ambulatory surgical facility, to increase the number of operating rooms, to convert a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or to add a specialty to a specialty ambulatory surgical program shall document that the physical environment of the facility conforms to the requirements of federal, state, and local regulatory bodies.*

-C- In Section II, page 33, the applicant documents that the physical environment of the proposed facility, including the operating rooms will conform to the requirements of federal, state, and local regulatory bodies. In Application Section XI, the applicant documents that *"the proposed site can be zoned and permitted to accommodate the proposed site."*

(d) *In competitive reviews, an applicant proposing to perform ambulatory surgical procedures in at least three specialty areas will be considered more favorably than an applicant proposing to perform ambulatory surgical procedures in fewer than three specialty areas.*

-NA- This is not a competitive review.

(e) *The applicant shall provide a floor plan of the proposed facility clearly identifying the following areas:*

(1) *receiving/registering area;*

-C- The floor plan in Exhibit 7 of the application clearly identifies the reception area for registering.

(2) *waiting area;*

-C- The floor plan in Exhibit 7 of the application clearly identifies the waiting area.

(3) *pre-operative area;*

-C- The floor plan in Exhibit 7 of the application clearly identifies the pre-operative area.

(4) *operating room by type;*

-C- The floor plan in Exhibit 7 of the application clearly identifies the location of each operating room by type. The applicant is proposing to operate three shared operating rooms.

(5) *recovery area; and*

-C- The floor plan in Exhibit 7 of the application clearly identifies the post-operative recovery area.

(6) *observation area.*

-C- The floor plan in Exhibit 7 of the application clearly identifies the recovery areas for post-operative observation.

(f) *An applicant proposing to expand by converting a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or by adding a specialty to a specialty ambulatory surgical program that does not propose to add physical space to the existing ambulatory surgical facility shall demonstrate the capability of the existing ambulatory surgical program to provide the following for each additional specialty area:*

(1) physicians;
(2) ancillary services;
(3) support services;
(4) medical equipment;
(5) surgical equipment;
(6) receiving/registering area;
(7) clinical support areas;
(8) medical records;
(9) waiting area;
(10) pre-operative area;
(11) operating rooms by type;
(12) recovery area; and
(13) observation area.

-NA- The applicant is not proposing to expand by converting a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or by adding a specialty to a specialty ambulatory surgical program.

Attachment 2

citi

Date: May 25th, 2010

To: Lynn DeJaco, *FirstHealth of the Carolinas*

From: David Kasdin, *Citigroup Global Markets Inc.*

Re: Preliminary Indications Borrowing Cost for a "A3/A-" Health Care Credit

Given current market conditions, the tax-exempt net interest cost (average coupon) for an amortizing 30-year, $75 million financing offered by an "A3/A-" rated North Carolina health system structured for level annual debt service payments would be approximately 5.40%. The actual rate on the 30-year maturity would be approximately 5.61% or a spread of +165 to MMD (please note MMD has decreased approximately 20 basis points over the last several weeks). Related costs of issuance would amount to approximately $937,500 or approximately 1.25% of total par amount issued. The maximum costs of issuance allowed to be funded with bonds proceeds is $1.5 million or 2% of total par. Based on the estimated interest rates and costs of issuance above, the All-in True Interest Cost would be approximately 5.45% and results in annual debt service payments of just over $5 million.

Since April 2010, a handful of similarly rated health care systems have come to market with spreads ranging between approximately +1.60% to +2.10% to MMD on the long end. For example, Alexian Brothers Health System (IL), Floyd Memorial Hospital (IN) and St. Luke's Hospital (PA), all priced in the first few weeks of April. With final maturities ranging from 2030 to 2034, each system's bonds priced between +1.60% to +1.64% to MMD, with a final yield in the mid-5.00% range.

Additionally, DeKalb Medical Center's (GA) $183 million transaction in late April achieved a spread of +2.10% to MMD on their 2040 term bond, resulting in a 6.25% yield. DeKalb provided a revenue pledge and a fully funded debt service reserve fund. Later that same week, Immanuel Health Systems' (NE) $66 million transaction was sold at +1.60% to MMD on their 2040 term bond, with a yield of 5.71%. Immanuel's security package also included a revenue pledge and a debt service reserve fund.

In the current market environment with a steep yield curve, interim short-term financing options for an "A3/A-" health care credit would be less costly than long-term, fixed rate debt. The estimated interim borrowing cost would be approximately LIBOR + 2.25% or roughly 2.60%.

Please note that all preliminary pricing indications offered in this memo are based on current market conditions and recent comparable transactions and are subject to change.

Attachment 3

Westlaw.
477 S.E.2d 697
124 N.C.App. 495, 477 S.E.2d 697
(Cite as: 124 N.C.App. 495, 477 S.E.2d 697)

Court of Appeals of North Carolina.
RETIREMENT VILLAGES, INC. and Liberty Healthcare Limited Partnership, d/b/a Countryside Villa Of Duplin, Petitioners,
v.
NORTH CAROLINA DEPARTMENT OF HUMAN RESOURCES, Division of Facility Services, Certificate of Need Section, Respondent,
and
Beaver Properties/Wallace, Inc. and Brian Center Health & Retirement/Wallace, Inc., Respondents-Intervenors.
No. COA95-1209.

Nov. 19, 1996.

Nursing facility sought review of Department of Human Resources' denial of application seeking to expand services and award of certificate of need (CON) to second applicant that sought to add nursing beds to its facility. The Court of Appeals, Lewis, J., held that: (1) CON application may be approved even if applicants themselves do not submit financial information; (2) successful applicant did not adequately demonstrate availability of funds or requisite financial feasibility; (3) successful applicant did not satisfy rule requiring assumptions and methodology for computing patient origin to be clearly stated; and (4) unsuccessful applicant failed to define clearly type of services it intended to provide.

Affirmed in part, reversed in part, and remanded.

West Headnotes

[1] Administrative Law and Procedure 15A 796

15A Administrative Law and Procedure
15AV Judicial Review of Administrative Decisions
15AV(E) Particular Questions, Review of
15Ak796 k. Law Questions in General. Most Cited Cases

Statutes 361 219(4)

361 Statutes
361VI Construction and Operation
361VI(A) General Rules of Construction
361k213 Extrinsic Aids to Construction
361k219 Executive Construction
361k219(4) k. Erroneous Construction; Conflict with Statute. Most Cited Cases
If petitioner contends that agency's decision was based on error of law, including error in statutory interpretation, de novo review is required in which court may substitute its own judgment for that of agency.

[2] Administrative Law and Procedure 15A 791

15A Administrative Law and Procedure
15AV Judicial Review of Administrative Decisions
15AV(E) Particular Questions, Review of
15Ak784 Fact Questions
15Ak791 k. Substantial Evidence. Most Cited Cases
If petitioner alleges that agency's decision was not supported by evidence or that decision was arbitrary or capricious, then reviewing court must apply "whole record test," in which agency's ruling should be reversed if it is not supported by substantial evidence.

[3] Administrative Law and Procedure 15A 760

15A Administrative Law and Procedure
15AV Judicial Review of Administrative Decisions
15AV(D) Scope of Review in General
15Ak754 Discretion of Administrative Agency
15Ak760 k. Wisdom, Judgment or

Opinion. Most Cited Cases
Proper application of whole record test for reviewing agency decision takes into account agency's expertise.

[4] Health 198H ⚖276

198H Health
198HI Regulation in General
198HI(C) Institutions and Facilities
198Hk276 k. Nursing Homes. Most Cited Cases
(Formerly 43k3)
Statutory criterion concerning financial and operational projections for health service facility project does not require submission of financial statements by applicants seeking certificate of need (CON); it merely requires Department of Human Resources to determine availability of funds for project from entity responsible for funding, which may or may not be applicant. G.S. § 131E-183(a)(5).

[5] Health 198H ⚖241

198H Health
198HI Regulation in General
198HI(C) Institutions and Facilities
198Hk236 Licenses, Permits, and Certificates
198Hk241 k. Application. Most Cited Cases
(Formerly 204k3 Hospitals)
Where health services facility project is to be funded other than by applicant seeking certificate of need (CON), application must contain evidence of commitment to provide funds by funding entity. G.S. § 131E-183(a)(5).

[6] Health 198H ⚖276

198H Health
198HI Regulation in General
198HI(C) Institutions and Facilities
198Hk276 k. Nursing Homes. Most Cited Cases
(Formerly 43k3)
Letter from bank indicating interest in loaning funding entity money for health services facility project and confirming that second funding entity had money which could be used to fund project, and letter from one entity's president stating that entity would loan certificate of need (CON) applicant any funds necessary for working capital during first three years of operation, did not adequately demonstrate availability of funds or requisite financial feasibility for CON. G.S. § 131E-183(a)(5).

[7] Health 198H ⚖276

198H Health
198HI Regulation in General
198HI(C) Institutions and Facilities
198Hk276 k. Nursing Homes. Most Cited Cases
(Formerly 43k3)
There is no specific methodology that must be used in determining patient origin, under certificate of need (CON) regulations, but patient origin must be projected and all assumptions, including specific methodology by which origin is projected, must be clearly stated. G.S. § 131E-183(a)(3); N.C.Admin. Code title 10, r. 3R.1118.

[8] Health 198H ⚖276

198H Health
198HI Regulation in General
198HI(C) Institutions and Facilities
198Hk276 k. Nursing Homes. Most Cited Cases
(Formerly 43k3)
Assumptions concerning patient origin for proposed health services facility project, which certificate of need (CON) analyst pieced together from various parts of CON application, did not satisfy rule requiring assumptions and methodology for computing patient origin to be clearly stated. G.S. § 131E-183(a)(3); N.C.Admin. Code title 10, r. 3R.1118.

[9] Health 198H ⚖276

198H Health
198HI Regulation in General
198HI(C) Institutions and Facilities
198Hk276 k. Nursing Homes. Most Cited Cases
(Formerly 43k3)
Substantial evidence supported finding that applicant seeking certificate of need (CON) to expand services at nursing facility failed to clearly define type of services it intended to provide; CON application contained contradictory information regarding whether applicant proposed dedicated Alzheimer's unit or not. G.S. § 131E-183(a)(3).

**698 *496 Appeal by petitioners from final agency decision entered 30 June 1995 by John M. Syria, Director of the North Carolina Department of Human Resources Division of Facility Services. Heard in the Court of Appeals 22 August 1996.
Bode, Call & Green, L.L.P. by Robert V. Bode and S. Todd Hemphill, Raleigh, for petitioners-appellants.

Attorney General Michael F. Easley by Assistant Attorney General Lauren M. Clemmons, for respondent-appellee.

Poyner & Spruill, L.L.P. by Mary Beth Johnston and Benjamin P. Dean, Raleigh, for respondents-intervenors.

*497 LEWIS, Judge.

This appeal arises out of an award by the Department of Human Resources ("the Agency") of a certificate of need ("CON") to respondents Beaver Properties/Wallace, Inc. and Brian Center Health & Retirement/Wallace, Inc. (collectively "Beaver Properties") and the denial of a CON application by Retirement Villages, Inc. and Liberty Healthcare Limited Partnership, d/b/a Countryside Villa of Duplin (collectively "Countryside Villa").

The 1993 State Medical Facilities Plan identified a need for thirty nursing home beds in Duplin County. In response to this need, Countryside Villa submitted a CON application on 15 September 1993, seeking to expand the services at its existing Duplin County facility by adding thirty (30) beds. Simultaneously, Beaver Properties filed an application with the CON Section to convert twenty (20) Home for the Aged beds to nursing beds and to construct space for an additional ten (10) nursing beds. By letters dated 25 February 1994, the CON Section disapproved Countryside Villa's application and conditionally approved that of Beaver Properties.

On 24 March 1994, Countryside Villa filed a petition for a contested case hearing challenging the CON Section's decision. After an evidentiary hearing, the administrative law judge ("ALJ") issued a decision recommending that the Agency reverse the CON Section's decision as to the conditional approval of Beaver Properties' application and affirm its disapproval of Countryside Villa's application. The ALJ recommended that the beds at issue be available for a new review. The final agency decision, however, affirmed the entire decision of the CON Section. Countryside Villa appeals.

Countryside Villa asserts that the Agency made several errors in affirming the conditional approval of Beaver Properties' application because Beaver Properties did not satisfy several of the review criteria set out in N.C.Gen.Stat. section 131E-183. We find merit in at least two of these arguments and therefore reverse the Agency's decision as to Beaver Properties.

[1][2][3] Our standard of review in reviewing an agency decision depends upon the nature of the alleged error. **699*Walker v. N.C. Dept. of Human Resources,* 100 N.C.App. 498, 502, 397 S.E.2d 350, 354 (1990), *disc. review denied,* 328 N.C. 98, 402 S.E.2d 430 (1991). If the petitioner contends that the agency's decision was based on an error of law, including an error in statutory interpretation, "de novo" review is *498 required in which the court may substitute its own judgment for that of the agency. *Friends of Hatteras Island v. Coastal Resources Comm.,* 117 N.C.App. 556, 567, 452

S.E.2d 337, 344 (1995). "If, however, it is alleged that the agency's decision was not supported by the evidence or that the decision was arbitrary or capricious, then the reviewing court must apply the 'whole record' test." *In re Appeal of Ramseur,* 120 N.C.App. 521, 524, 463 S.E.2d 254, 256 (1995). Under this test, an agency's ruling should only be reversed if it is not supported by substantial evidence. *Mendenhall v. N.C. Dept. of Human Resources,* 119 N.C.A pp. 6 44, 6 50, 4 59 S.E. 2d 8 20, 824 (1995). "Proper application of the whole record test takes into account the administrative agency's expertise." *Britthaven, Inc. v. N.C. Dept. of Human Resources,* 118 N.C.App. 379, 386, 455 S.E.2d 455, 461,*disc. review denied,* 341 N.C. 418, 461 S.E.2d 754 (1995).

Countryside Villa contends that the Agency erred in ruling that Beaver Properties' application conformed to G.S. 131E-183(a)(5) (" **criterion 5**"), which provides:

(5) Financial and operational projections for the project shall demonstrate the availability of funds for capital and operating needs as well as the immediate and long-term financial feasibility of the proposal, based upon reasonable projections of the costs of and charges for providing health services by the person proposing the service.

N.C.Gen.Stat. § 131E-183(a)(5)(1994).

Countryside Villa maintains that since Beaver Properties only submitted financial information from Brian Center Management Corporation ("BCMC") and Brian Center Corporation ("BCC"), its application was "absolutely non-approvable." Countryside Villa contends that the application should have contained financial statements from the project's applicants because only the financial statements of the applicants themselves are sufficient to show the financial feasibility of the project.

[4] Essentially, Countryside Villa argues that the Agency's interpretation of **criterion 5's** requirements was error. Therefore, we apply de novo review; we find no error in the Agency's interpretation. Contrary to Countryside Villa's contentions, the above statutory criterion does not require the submission of financial statements by the applicants. It merely requires the Agency to determine the availability of funds for the project from the entity responsible for funding, which may or ***499** may not be an applicant. The phrase "by the person proposing the service" describes the person who is to project the reasonable costs and charges. It does not, as Countryside Villa alleges, require the entity proposing the service to demonstrate its ability to finance the project itself. We find nothing in **criterion 5** which precludes a CON applicant from relying on the financial resources of another entity for its funding.

[5] We reject Countryside Villa's assertion that a CON application may only be approved when the applicants themselves submit financial information. However, we agree that in cases where the project is to be funded other than by the applicants, the application must contain evidence of a commitment to provide the funds by the funding entity. We hold that without such a commitment, an applicant cannot adequately demonstrate availability of funds or the requisite financial feasibility.

[6] In the present case, the Agency made no finding that BCC and BCMC committed themselves to provide the necessary funding for Beaver Properties' proposed project; nor do the appellees assert that such documentation exists. Appellees instead focus on the fact that the applicants, BCC, and BCMC are interrelated corporations. However, this fact has little bearing on the issue of whether, for purposes of demonstrating financial feasibility and availability of funds, BCC and BCMC are committed to finance a project for which they are neither named applicants nor legally financially responsible.

****700** Beaver Properties' application estimates that the capital costs to implement the proposed project would be $227,380. Beaver Properties anticipated that $204,642 would come from conventional loans

and $22,738 from owner's equity. Although the application contains a letter from NationsBank indicating its interest in loaning BCMC $204,642 for the addition/conversion and confirming that BCC had in excess of $22,738 which could be used to fund the project, this does not constitute a commitment from BCMC that it will provide the financing; nor does it bind BCC to use its $22,738 for the project. The application also contains a letter from BCC's president stating that BCC would loan Beaver Properties any funds necessary for working capital during the first three years of operation. Although this letter may arguably show commitment to provide working capital during the first three years of operation, it does not commit BCC to expend any money for the capital expenses necessary to implement the project. Therefore, we hold that the Agency erred in finding that Beaver Properties satisfied **criterion 5.**

***500** Countryside Villa also contends that the Agency erred in finding Beaver Properties in conformity with G.S. 131E-183(a)(3) (criterion 3). This criterion requires:

(3) The applicant shall identify the population to be served by the proposed project, and shall demonstrate the need that this population has for the services proposed, and the extent to which all residents of the area, and, in particular, low income persons, racial and ethnic minorities, women, handicapped persons, the elderly, and other underserved groups are likely to have access to the services proposed.

G.S. § 131E-183(3).

Countryside Villa's argument centers around Beaver Properties' answer to question 12 in Section III of the application, which asks for a projected percentage of patient origin. In response to this inquiry, Beaver Properties indicated that 80% of its new and existing patients would be from Duplin County. Countryside Villa maintains that, since there is no way to determine from the application how Beaver Properties arrived at this figure, its application should have been denied.

The Agency found Beaver Properties in conformity with criterion 3 because the question at issue did not require that any particular mathematical formula be used for this projection. The Agency also found that the project analyst at the CON section was aware that Beaver Properties utilized certain assumptions and that these assumptions and the specific methodology were "sufficiently clear" in the application.

[7] While we agree that there is no specific methodology that must be used in determining patient origin, under CON regulations, patient origin must be projected and "[a]*ll assumptions, including the specific methodology by which patient origin is projected, must be clearly stated.*" N.C. Admin.Code tit. 10, r. 3R.1118 (March 1991) (emphasis added) ("rule .1118").

In its final decision, the Agency made the following relevant finding:

10. Among the assumptions *made and identified by* [Beaver Properties] was that [Beaver Properties] would serve all nursing facility patients, that [Beaver Properties] did not anticipate continuing to serve all of the same counties that it had been serving, ***501** and that a turnover of patients in the existing beds would occur over time, thus causing changes in the percentage of county of origin of the patients.

(emphasis added).

[8] However, there is no evidence in the record which supports a finding that Beaver Properties identified any assumptions. After thoroughly reviewing Beaver Properties' application, we observe no clear statement of the assumptions or methodology used by the applicant in projecting patient origin, even though the application does specify assumptions related to other topics. The CON analyst testified that Beaver Properties made certain "assumptions," which he then described. However,

the assumptions referred to are not clearly set out in the application. Rather, they appear to be assumptions which the analyst has pieced together from various parts of the application. We hold that such "assuming" of an applicant's "assumptions" **701 does not satisfy rule .1118, which requires the assumptions and methodology for computing patient origin to be "clearly stated." The above Agency finding is not based on substantial evidence in the record.

Additionally, it appears that the Agency employed the wrong standard in determining whether the assumptions and methodology were contained in the application. Instead of finding that they were "clearly stated," the Agency found that they were "sufficiently clear" and "discernable." For these reasons, we hold that the Agency erred in finding that Beaver Properties' application conformed with criterion 3 and rule .1118.

Countryside Villa also maintains that the Agency erred in affirming the rejection of its application. We find no merit in this argument and affirm the Agency's decision as to Countryside Villa.

Countryside Villa argues that the Agency erred in rejecting its application under criterion 3 on the ground that it proposed a dedicated Alzheimer's Unit. Countryside Villa contends that the application contained no such proposal, but actually proposed Alzheimer's care within the general nursing home population.

[9] Since Countryside Villa essentially argues that there is insufficient evidence to support the Agency's findings, we employ the whole record test, taking into account the Agency's expertise. *See Britthaven,* 118 N.C.App. at 386, 455 S.E.2d at 461. We hold that substantial evidence exists to support a finding that Countryside Villa failed to define clearly the type of services it intended to provide. The *502 application contains contradictory information regarding whether Countryside Villa proposed a dedicated Alzheimer's unit or not. Although the application states that the care will be provided to "residents at all levels of care, rather than in a distinct unit," it also refers to "the Alzheimer's Unit" and provides information on Alzheimer's special care units. Accordingly, the agency did not err in concluding that Countryside Villa failed to conform to criterion 3.

Since we have determined that Beaver Properties and Countryside Villa are each nonconforming to the statutory criteria on at least one ground, we see no need to reach the remainder of Countryside Villa's arguments.

In summary, we reverse that portion of the final agency decision which affirms the CON section's conditional approval of Beaver Properties' application. We affirm that portion of the final agency decision which affirms the CON section's disapproval of Countryside Villa's application. Accordingly, we remand this matter to the CON section for a new review to allocate the beds at issue.

Reversed in part, affirmed in part and remanded.

JOHNSON and WYNN, JJ., concur.
N.C.App.,1996.
Retirement Villages, Inc. v. North Carolina Dept. of Human Resources
124 N.C.App. 495, 477 S.E.2d 697

END OF DOCUMENT

Attachment 4

M-7093-04 andrea

CAPE FEAR VALLEY
TRANSFORMING HEALTHCARE

BEHAVIORAL HEALTH CARE
CAPE FEAR VALLEY MEDICAL CENTER
CAPE FEAR VALLEY REHABILITATION CENTER
HEALTH PAVILION NORTH
HIGHSMITH-RAINEY SPECIALTY HOSPITAL

BLOOD DONOR CENTER
CANCER CENTER
CARELINK
CAPE FEAR VALLEY HOME HEALTH & HOSPICE
CUMBERLAND COUNTY EMS
FAMILY BIRTH CENTER
HEART & VASCULAR CENTER
HEALTHPLEX
LIFELINK CRITICAL CARE TRANSPORT
PRIMARY CARE PRACTICES
SLEEP CENTER

May 26, 2008

Ms. Lee Hoffman
Chief
Certificate of Need Section
Department of Health Service Regulation
2704 Mail Service Center
Raleigh NC 27699-2704

Received by the CON Section
02 JUN 2008 11 : 27

RE: Acute Care Beds

Dear Ms. Hoffman:

Enclosed is the single page of information which we discussed briefly at the Acute Care Committee meeting on May 8, 2008.

History

First Acute Care Bed Request

On June 15, 2004, Cape Fear Valley Health System ("CFVHS") filed its certificate of need application for a construction and modernization project (the Valley Pavilion), Project M-7069-04, which included the transfer of 46 acute care beds from Highsmith Rainey Memorial Hospital ("HRMH") and the relocation of 50 acute care beds from Cape Fear Valley Medical Center ("CFVMC") to be situated in the new Valley Pavilion adjacent to the current CFVMC facility on Owen Drive. Only two patient floors were facility planned and financially planned in the project at that time.

That application was approved without conditions and pursuant to construction schedule will open on or about October 1 of this year.

The 2004 SMFP allocated 44 beds to Cumberland County with a file date of August 15, 2004. Cape Fear Valley Health System had been planning for three years for the Valley Pavilion and chose to file without waiting to address the 44-bed allocation in the fall of 2004.

Second Acute Care Bed Request

On August 16, 2004, CFVHS filed its application (project M-7093) to gain approval for the 44 beds allocated to Cumberland County in the 2004 SMFP. The application identified five areas for placement of the beds. Three of the beds were immediately put into service in the cardiac services intensive care area. During the implementation planning for the remaining 41 beds, cost

estimates provided by the architectural firm were exceeded due to Katrina weather impact, world oil and steel price increases and other related material prices. CFVHS filed its application (project M-7436-05) for a cost overrun for the 44 beds on August 15, 2005 and was approved to continue the development of the beds without conditions.

During the planning for the remaining 41 beds, the State Health Coordinating Council began to identify the need for another 25 acute care beds for Cumberland County in the 2006 SMFP.

Third Request for Acute Care Beds

On June 15, 2006, CFVHS filed its application (project M-7616-06) for the 25 acute care beds allocated in the 2006 SMFP. Plans for those beds included using vacated space for beds to be relocated to the Valley Pavilion. These beds were approved without conditions.

At this point, CFVHS management realized that enough beds had been allocated (44 -3 +25) without having to transfer the 46 beds from HRMH to the Valley Pavilion. Retaining the beds at HRMH supported the LTAC operations trending up.

Originally, CFVHS had planned to relocate 50 beds internally to the Pavilion. We now had 20 of those covered by the allocations (41+25 – 46 which was replacing the transfer from HRMH). Currently, the SHCC was planning another 22 beds to be allocated during the 2007 SMFP year.

Fourth Request for Acute Care Beds

On August 15, 2007, CFVHS filed its application for the 22 newly allocated acute care beds. These beds were approved without condition to occupy space vacated for the Pavilion. Spaces were ready for routine nursing activity with no facility work to be done.

Thus, at this point CFVHS needed only to transfer 2 acute care beds to comply with the new building requirements.

Our Request

As shown on the attached reconciliation page discussed on May 8, we have 91 new acute care beds allocated and approved. We lost six (6) beds due to construction (linking the Pavilion to the older part of CFVMS) resulting in 97 beds available and leaving two (2) beds to be transferred from HRMH to reconcile the project.

CFVHS has need to keep the 44 beds in tact at HRMH. We ask that you consider each of the following reasons to allow us to avoid transferring the 44 beds approved in the 2004 certificate of need application to transfer them to the new tower.

LTAC Need

We are currently running 82 percent occupancy in the 66 operational beds in our LTAC facility at HRMH and believe that continuing and growing need demonstrates that we keep 44 of the originally requested 46 beds intact (we have to transfer two to reconcile the project's total bed requirements).

Financial Challenges

CFVHS is experiencing some difficult cash flows with the implementation of the Pavilion and other operations. At some point, we intend to build onto the Pavilion with more routine bed space to modernize some of our other 391 acute care beds in the existing CFVMC. If additional allocations from the SMFP are not available as those plans mature, we would consider petitioning the state for the necessary transfer of beds.

Surrendering 44 Beds Will Create Acute Care Bed Need

With the current allocations as shown in the draft documents for the 2009 SMFP, should CFVHS surrender the 44 beds originally requested in 2004, the current working documents' excess of 32 beds would create a need of 12 acute care beds. We are happy with the three allocations previously approved and believe that we have met those allocations without having to change our existing licenses to comply with the 2004 facility plans with the exception of two beds at HRMH.

Existing Facility Constraints at CFVMC

Over the course of getting approval for the 91 new beds, each of our applications considered some implementation in the existing facility on Owen Drive. Due to the following reasons, we cannot implement some of those changes:

- Very inefficient to operate three (3) nursing units of 16, 15 and 10 beds.
- Cost prohibitive to renovate space in the oldest and only available building on campus.
- Doubtful the construction section would approve the space for all of the 41 beds.

Critical Mass of Acute Beds Difficult to Achieve

CFVHS petitioned in 2007 for 20 additional acute care beds due to the impeding BRAC realignment. Working under statewide population rates, we were unable to achieve additional acute care bed approval. We believe that surrendering one or two certificate of need applications to transfer the 44 beds discussed above will not only cripple our LTAC operations, we believe that the additional bed-need allocation will not be sufficient to regain our current operating position. As the SMFP has shown for near 10 years, CFVHS has experienced the highest percent utilization in its acute care beds in the state.

Please advise us of your questions. We respectfully request to make no changes to our licensure as having been approved with the exception of two (2) beds to account for the implementation of the Valley Pavilion.

Sincerely,

Michael Nagowski

Michael Nagowski
President and Chief Executive Officer

Attachment

ATTACHMENT

Cape Fear Valley Health System

	Acute Beds With CONs		
	CFVMC	HRMH	
Licensed Beds	394	112	
Project M7069-04 (46 beds from Highsmith 50 beds from within to go into the Valley Pavilion)	46	-46	
	440	66	
Project M-7093-04 (44 beds with Project M-7436-05 cost overrun)	44 [1]		
Project M-76-16-05 (25 beds)	25 [1]		
Project M-7926-07 (22 beds)	22 [1]		
	531	66	= 597

	Actual Licensed Beds		
	CFVMC	HRMH	
Licensed beds	394	112	
CSICU beds from the 44 CON	3 [2]		
New Tower	96 [2]	-2	
Loss in connection -old tower	-6 [3]		
	487	110	= 597

Reconciliation:

New CON approved allocations from SMFP	91 [1]
Used (96 +3)	-99 [2]
Lost in construction	6 [3]
Net to be transferred from HRMH	-2

Attachment 5

MAPQUEST

Notes

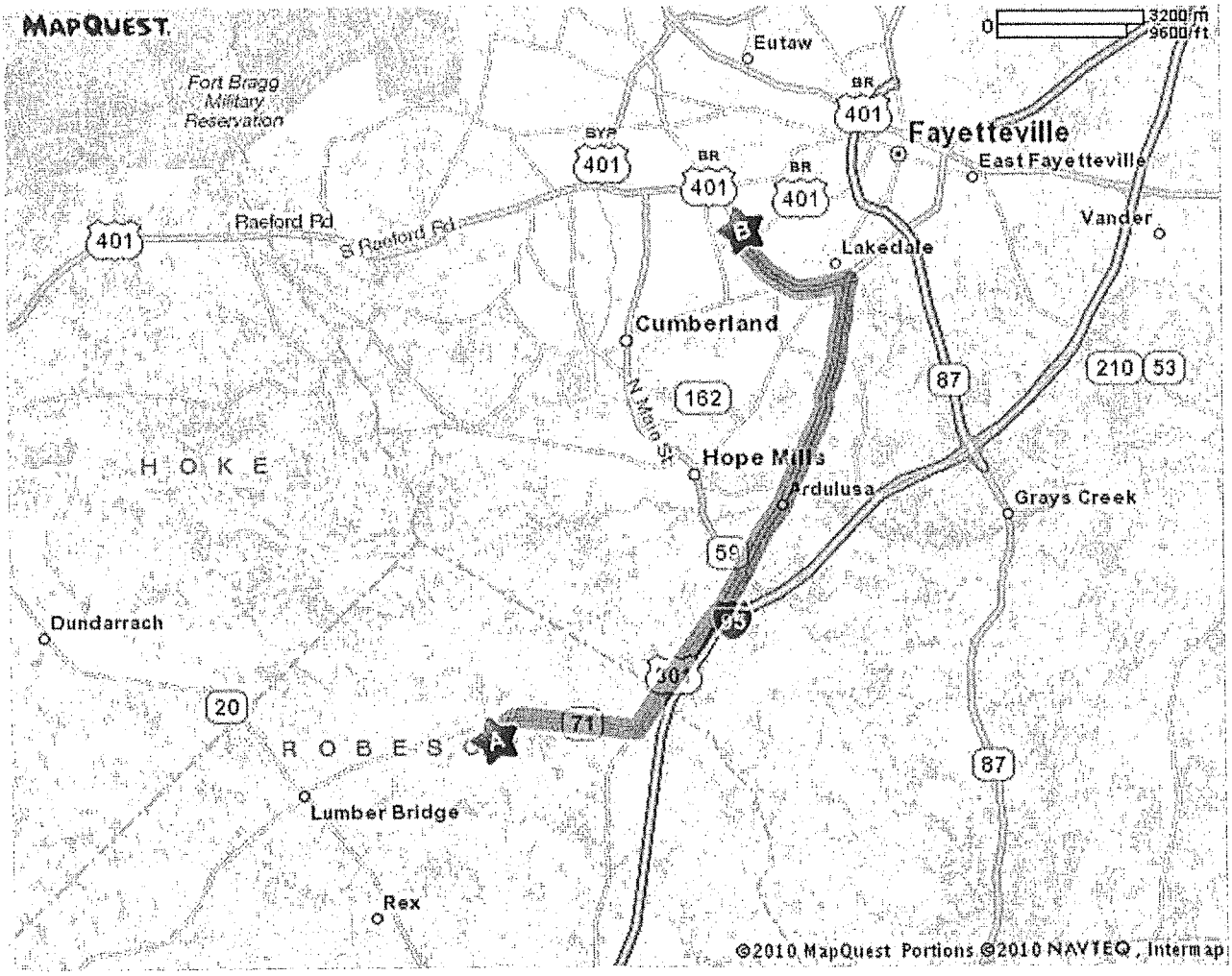
Parkton to CFVMC.

Trip to 1638 Owen Dr

Fayetteville, NC 28304-3424

14.43 miles - about 19 minutes

Route Map Hide



MAPQUEST

Notes

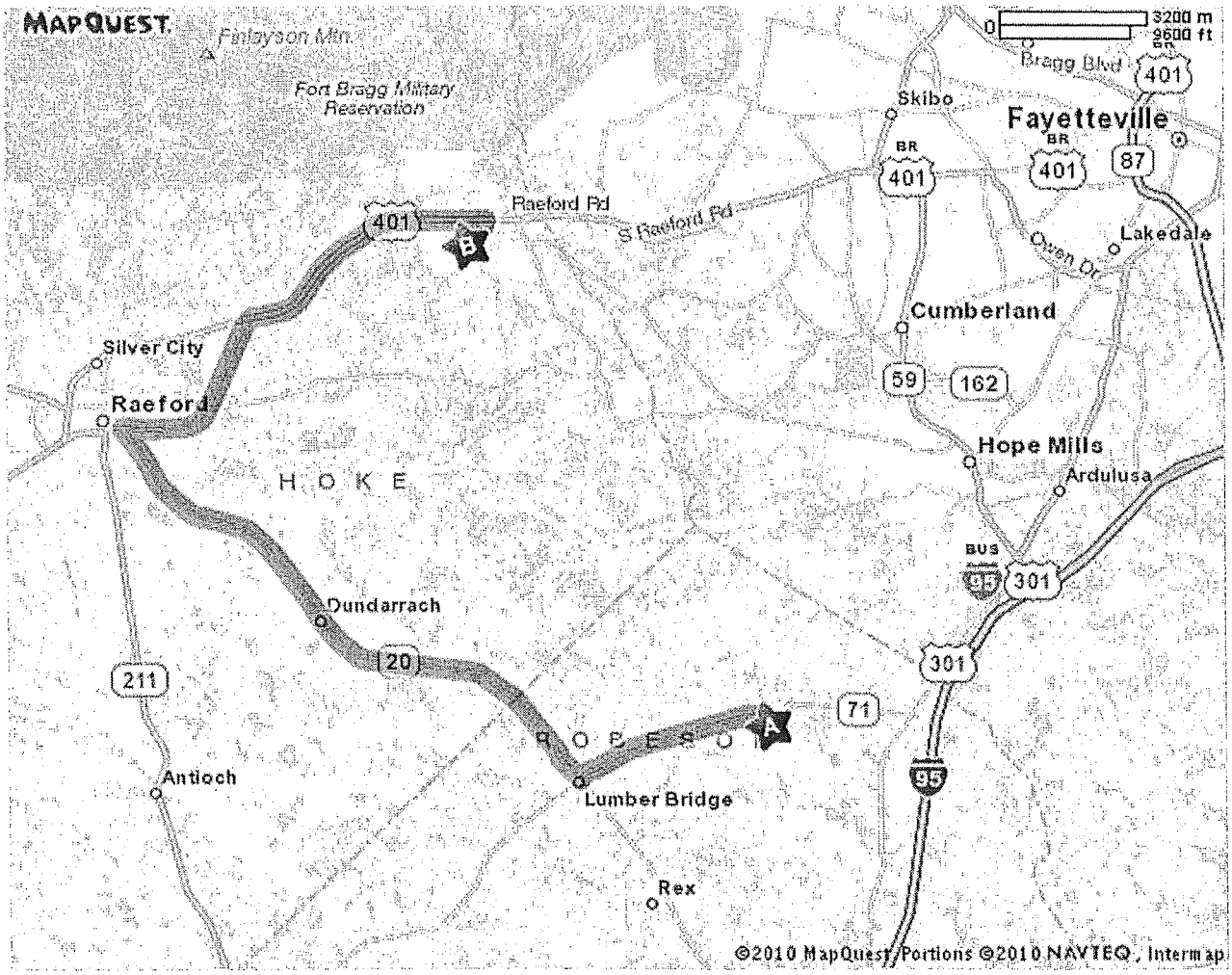
Parkton to Proposed HCMC Site.

Trip to 3195 Johnson Mill Rd

Raeford, NC 28376-6557

23.77 miles - about 32 minutes

Route Map Hide



MAPQUEST

Notes

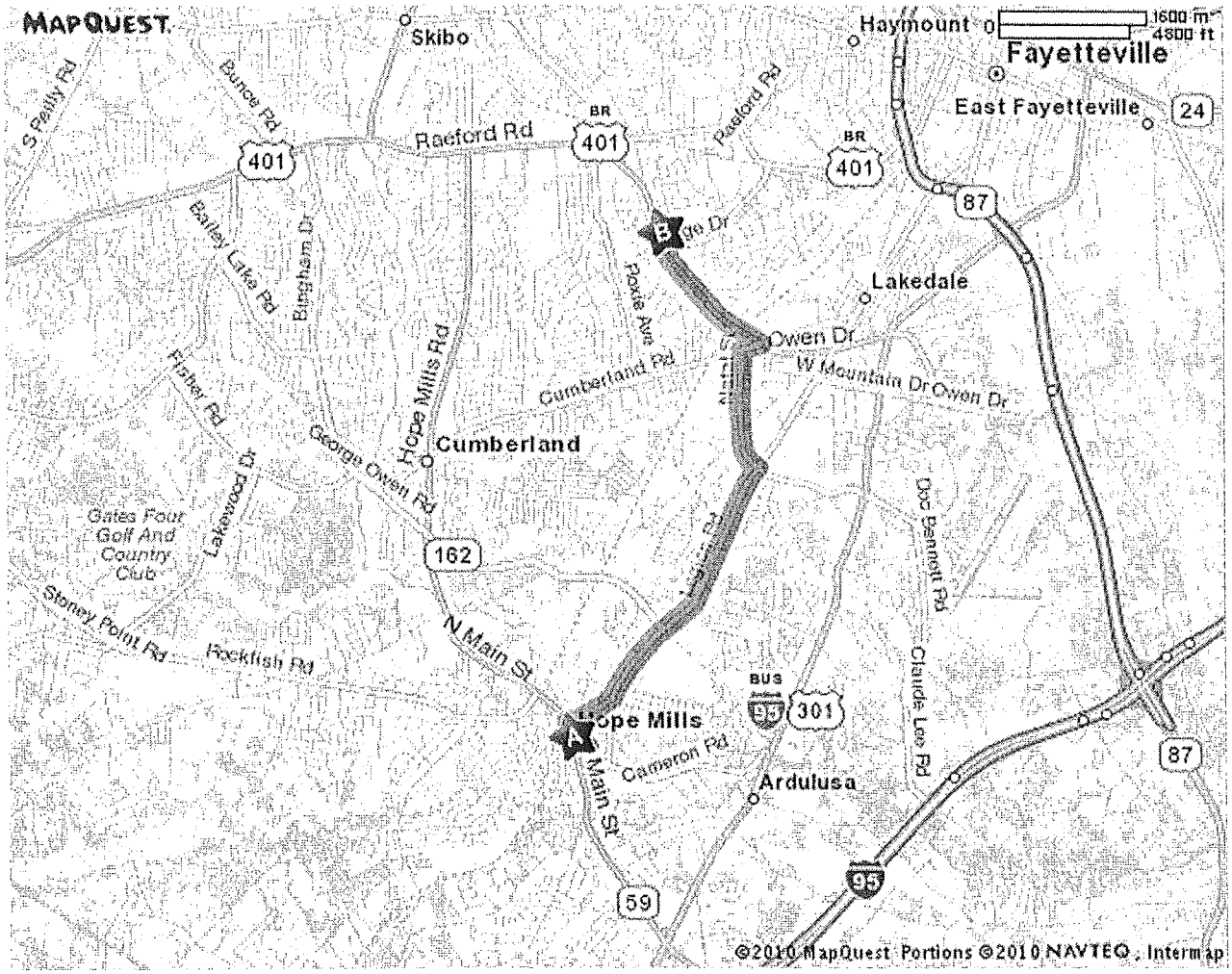
Hope Mills to CFVMC.

Trip to 1638 Owen Dr

Fayetteville, NC 28304-3424

5.59 miles - about 10 minutes

Route Map Hide



MAPQUEST

Notes

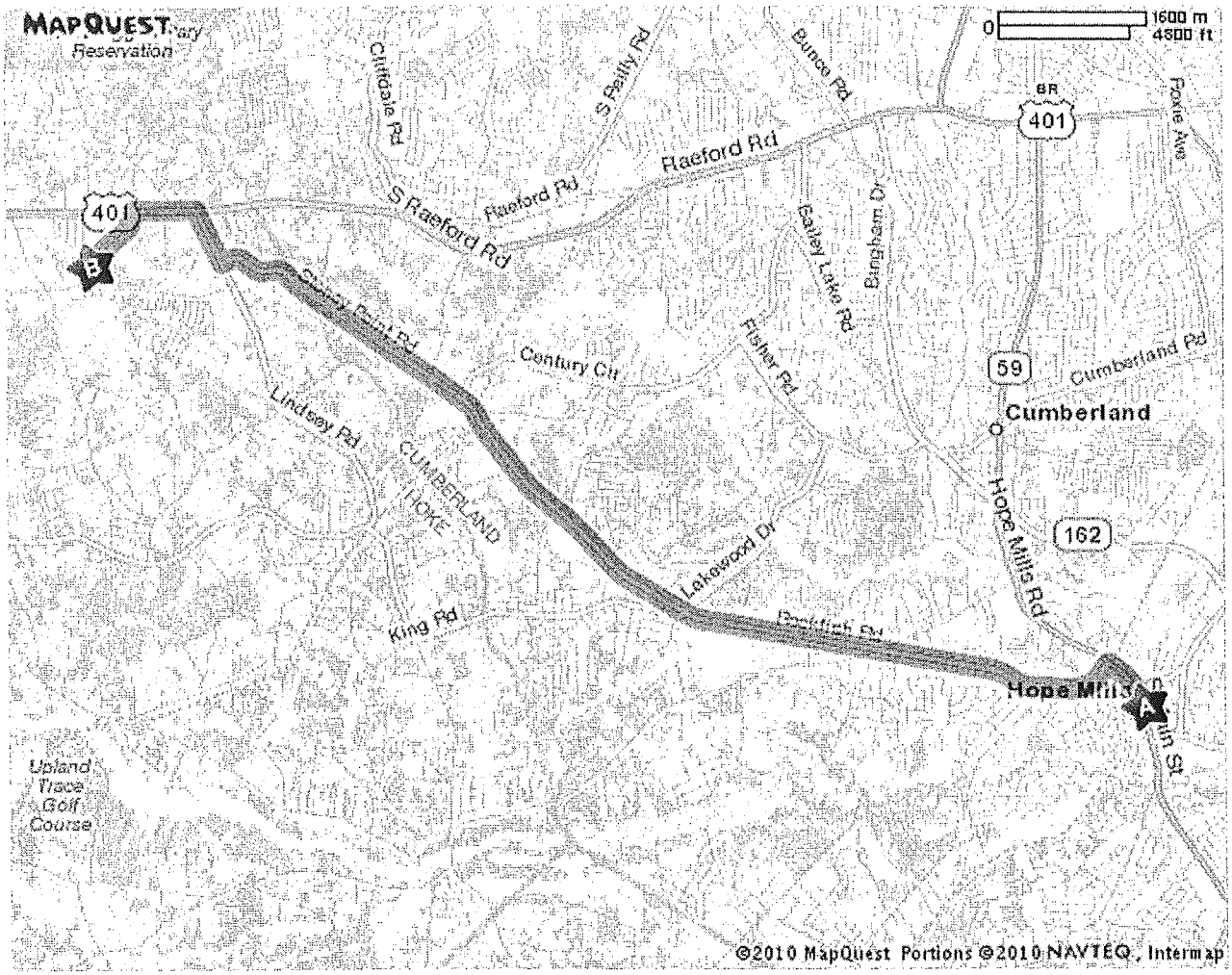
Hope Mills to Proposed HCMC Site.

Trip to 3195 Johnson Mill Rd

Raeford, NC 28376-6557

11.30 miles - about 19 minutes

Route Map Hide



Attachment 6

CERTIFICATE OF NEED
PROGRESS REPORT FORM

County: CUMBERLAND
Facility: CAPE FEAR VALLEY MEDICAL CENTER
Project I.D. #: M-7093-04
Project Description: ADD 44 ACUTE CARE BEDS AT CAPE FEAR VALLEY MEDICAL CENTER

Date of Progress Report: 03/22/2006
Facility I.D. #: 943054
Effective Date of Certificate: 03/02/2005

A. Status of the Project – Describe the current status of the project. If the project is not going to be developed exactly as proposed in the certificate of need application, describe all differences between the project as proposed in the application and the project as currently proposed. Such changes include, but are not limited to, changes in the: 1) design of the facility; 2) number or type of beds to be developed; 3) medical equipment to be acquired; 4) proposed charges; and 5) capital cost of the project. (See the Capital Cost Section of this form for additional questions regarding changes in the total capital cost of the project).

B. Timetable

1. Complete the following. The first column must include the timetable dates found on the certificate of need. If the CON Section has authorized an extension of the timetable in writing, you may substitute the dates from that letter.

	Projected Completion Date (from the Certificate of Need) Month/Day/Year	**Actual Date Completed** Month/Day/Year
Obtained Funds for the Project	AVAILABLE	AVAILABLE
Approval of Final Drawings and Specifications	03/25/05	10/01/05
Acquisition of land/facility		
Construction Contract Executed	06/01/05	
25% completion of construction	09/01/05	
50% completion of construction	11/15/05	
75% completion of construction	02/15/05	
Completion of construction	04/01/06	
Ordering of medical equipment	01/15/06	
Operation of medical equipment	04/15/06	
Occupancy/offering of services	04/15/06	
Licensure		
Certification		

RECEIVED MAR 2006 CERTIFICATE OF NEED SECTION

2. If the project is experiencing significant delays in development: BID PROCESS identified need to submit a cost overrun CON on 11/15/2005. Waiting for decision.
   a. explain the reasons for the delay; and
   b. provide a revised timetable for the CON Section to consider.

C. Medical Equipment Projects – If the project involves the acquisition of any of the following equipment: 1) major medical equipment as defined in NCGS §131E-176(14f); 2) the specific equipment listed in NCGS §131-176(16); 3) equipment that creates an oncology treatment center as defined in NCGS §131-176(18a); or 4) equipment that creates a diagnostic center as defined in NCGS §131E-176(7a), provide the following information for each piece or unit of equipment.

a. Manufacturer
b. Model
c. Serial Number
d. Date acquired

D. Capital Expenditure

1. Complete the following table.
   a. Include all capital costs that have been paid to date as well as those that the applicant(s) are legally obligated to pay.
   b. If you have not already done so, provide copies of the executed construction contracts, including the one for architect and engineering services, and all final purchase orders for medical equipment costing more than $10,000/unit.
   c. If the project involves renovation or construction, provide copies of the Contractors Application for Payment [AIA G702] with Schedule of Values [AIA G703].

	Capital Expense Since Last Report	Total Cumulative Capital Expenditure
Site Costs		
Purchase price of land		
Closing costs		
Legal Fees		
Site preparation costs		
Landscaping		
Other site costs (identify)		
Subtotal Site Costs		
Construction Costs		
Construction Contract		
Miscellaneous Costs		
Moveable Equipment		
Fixed Equipment		
Furniture		
Consultant Fees	68,536.39	110,020.81
Financing Costs		
Interest during Construction		
Other Misc. Costs (identify) – DFS Project Review Fees	1,503.00	1,503.00
Subtotal Misc. Costs	70,039.39	111,523.81
Total Capital Cost of the Project	70,039.39	111,523.81

2. As of the date of this progress report, what is your best estimate of the total actual capital cost of the project?

3. Will the total actual capital cost of the project exceed 115% of the approved capital expenditure on the certificate of need? If yes, explain the reasons for the difference.

E. CERTIFICATION – The undersigned hereby certifies that the responses to the questions in this progress report and the attached documents are correct to the best of his or her knowledge and belief.

Signature of Officer: Lawrence C. Miller

Name and Title of Responsible Officer: Lawrence C. Miller, Director of Reimbursement

Telephone Number of Responsible Officer: 910-609-6460

CERTIFICATE OF NEED
PROGRESS REPORT FORM

County: CUMBERLAND
Facility: CAPE FEAR VALLEY MEDICAL CENTER
Project I.D. #: M-7093-06
Project Description: Add 44 acute care beds @ Cape Fear Valley Medical Center.

Date of Progress Report: 08/20/2005
Facility I.D. #: 943057
Effective Date of Certificate: 03/02/2005

A. **Status of the Project** – Describe the current status of the project. If the project is not going to be developed exactly as proposed in the certificate of need application, describe all differences between the project as proposed in the application and the project as currently proposed. Such changes include, but are not limited to, changes in the: 1) design of the facility; 2) number or type of beds to be developed; 3) medical equipment to be acquired; 4) proposed charges; and 5) capital cost of the project. (See the Capital Cost Section of this form for additional questions regarding changes in the total capital cost of the project).

B. **Timetable**

1. Complete the following. The first column must include the timetable dates found on the certificate of need. If the CON Section has authorized an extension of the timetable in writing, you may substitute the dates from that letter.

	Projected Completion Date (from the Certificate of Need) Month/Day/Year	Actual Date Completed Month/Day/Year
Obtained Funds for the Project	AVAILABLE	
Approval of Final Drawings and Specifications	05/15/05	
Acquisition of land/facility		
Construction Contract Executed	06/01/05	
25% completion of construction	09/11/05	
50% completion of construction	11/15/05	
75% completion of construction	02/15/05	
Completion of construction	04/01/06	
Ordering of medical equipment	01/15/06	
Operation of medical equipment	04/15/06	
Occupancy/offering of services	04/15/06	
Licensure		
Certification		

RECEIVED SEP - 1 '05

2. If the project is experiencing significant delays in development:
   a. explain the reasons for the delay; and Final drawings are not expected to be approved by DFS until 9/15/05. This will push the entire project out at least a couple of months.
   b. provide a revised timetable for the CON Section to consider.

C. **Medical Equipment Projects** – If the project involves the acquisition of any of the following equipment: 1) major medical equipment as defined in NCGS §131E-176(14f); 2) the specific equipment listed in NCGS §131-176(16); 3) equipment that creates an oncology treatment center as defined in NCGS §131-176(18a); or 4) equipment that creates a diagnostic center as defined in NCGS §131E-176(7a), provide the following information for each piece or unit of equipment.

a. Manufacturer
b. Model
c. Serial Number
d. Date acquired

I. Capital Expenditure

1. Complete the following table.
   a. Include all capital costs that have been paid to date as well as those that the applicant(s) are legally obligated to pay.
   b. If you have not already done so, provide copies of the executed construction contracts, including the one for architect and engineering services, and all final purchase orders for medical equipment costing more than $10,000/unit.
   c. If the project involves renovation or construction, provide copies of the Contractors Application for Payment [AIA G702] with Schedule of Values [AIA G703].

	Capital Expense Since Last Report	Total Cumulative Capital Expenditure
Site Costs		
Purchase price of land		
Closing costs		
Legal Fees		
Site preparation costs		
Landscaping		
Other site costs (identify)		
Subtotal Site Costs		
Construction Costs		
Construction Contract		
Miscellaneous Costs		
Moveable Equipment		
Fixed Equipment		
Furniture		
Consultant Fees	44,484.42	44,484.42
Financing Costs		
Interest during Construction		
Other Misc. Costs (identify)		
Subtotal Misc. Costs	44,484.42	44,484.42
Total Capital Cost of the Project	44,484.42	44,484.42

2. What do you project to be the remaining capital expenditure required to complete the project? 2,000,000

3. Will the total actual capital cost of the project exceed 115% of the approved capital expenditure on the certificate of need? If yes, explain the reasons for the difference. No

E. **CERTIFICATION** – The undersigned hereby certifies that the responses to the questions in this progress report and the attached documents are correct to the best of his or her knowledge and belief.

Signature of Officer: Lawrence C. Miller
Name and Title of Responsible Officer: LAWRENCE C. Miller, Director of Reimbursement
Telephone Number of Responsible Officer: 910-609-6440

CON Section

24 JUN 2008 11 : 30

CERTIFICATE OF NEED
PROGRESS REPORT FORM

County: Cumberland
Facility: Cape Fear Valley Medical Center
Project I.D. #: M-7098-04 and M-7436-05
Project Description: Add 44 Acute Care beds to Cape Fear Valley Medical Center

Date of Progress Report: 06/19/2008
Facility I.D. #: 943057
Effective Date of Certificate: 05/01/2006

A. Status of the Project – Describe the current status of the project. If the project is not going to be developed exactly as proposed in the certificate of need application, describe all differences between the project as proposed in the application and the project as currently proposed. Such changes include, but are not limited to, changes in the: 1) design of the facility; 2) number or type of beds to be developed; 3) medical equipment to be acquired; 4) proposed charges; and 5) capital cost of the project. (See the Capital Cost Section of this form for additional questions regarding changes in the total capital cost of the project).

B. Timetable

1. Complete the following. The first column must include the timetable dates found on the certificate of need. If the CON Section has authorized an extension of the timetable in writing, you may substitute the dates from that letter.

	Projected Completion Date (from the Certificate of Need) Month/Day/Year	Actual Date Completed Month/Day/Year
Obtained Funds for the Project		
Approval of Final Drawings and Specifications	05/15/05	
Acquisition of land/facility		
Construction Contract Executed	06/01/05	
25% completion of construction	09/01/05	
50% completion of construction	11/15/05	
75% completion of construction	02/15/06	
Completion of construction	06/06/06	
Ordering of medical equipment	01/15/06	
Operation of medical equipment	06/15/06	
Occupancy/offering of services	06/15/06	
Licensure		
Certification		

2. If the project is experiencing significant delays in development: With the construction of the new Valley Pavilion and its planned opening 10/01/08, this project has been put on
   a. explain the reasons for the delay; and hold.
   b. provide a revised timetable for the CON Section to consider.

C. **Medical Equipment Projects** – If the project involves the acquisition of any of the following equipment: 1) major medical equipment as defined in NCGS §131E-176(14f); 2) the specific equipment listed in NCGS §131-176(16); 3) equipment that creates an oncology treatment center as defined in NCGS §131-176(18a); or 4) equipment that creates a diagnostic center as defined in NCGS §131E-176(7a), provide the following information for each piece or unit of equipment.

a. Manufacturer
b. Model
c. Serial Number
d. Date acquired

D. Capital Expenditure

1. Complete the following table.
   a. Include all capital costs that have been paid to date as well as those that the applicant(s) are legally obligated to pay.
   b. If you have not already done so, provide copies of the executed construction contracts, including the one for architect and engineering services, and all final purchase orders for medical equipment costing more than $10,000/unit.
   c. If the project involves renovation or construction, provide copies of the Contractors Application for Payment [AIA G702] with Schedule of Values [AIA G703].

	Capital Expense Since Last Report	Total Cumulative Capital Expenditure
Site Costs		
Purchase price of land		
Closing costs		
Legal Fees		
Site preparation costs		
Landscaping		
Other site costs (identify)		
Subtotal Site Costs		
Construction Costs		
Construction Contract		
Miscellaneous Costs		
Moveable Equipment		
Fixed Equipment		
Furniture		
Consultant Fees		110,020.81
Financing Costs		
Interest during Construction		
Other Misc. Costs (identify)		1,502.00
Subtotal Misc. Costs		111,523.81
Total Capital Cost of the Project		111,523.81

2. What do you project to be the remaining capital expenditure required to complete the project? 2,720,102.19

3. Will the total actual capital cost of the project exceed 115% of the approved capital expenditure on the certificate of need? If yes, explain the reasons for the difference.

E. CERTIFICATION – The undersigned hereby certifies that the responses to the questions in this progress report and the attached documents are correct to the best of his or her knowledge and belief.

Signature of Officer: Lawrence C. Miller
Name and Title of Responsible Officer: Lawrence C. Miller - Asst Relations Director
Telephone Number of Responsible Officer: 910-609-6440

CERTIFICATE OF NEED
PROGRESS REPORT FORM

Received by the CON Section
15 JAN 2009

County: CUMBERLAND
Facility: CAPE FEAR VALLEY MEDICAL CENTER
Project I.D. #: M-7092-04 AND M-7436-05
Project Description: ADD 44 ACUTE CARE BEDS TO CAPE FEAR VALLEY MEDICAL CENTER

Date of Progress Report: 01/06/2009
Facility I.D. #: 943057
Effective Date of Certificate: 05/01/2006

A. Status of the Project – Describe the current status of the project. If the project is not going to be developed exactly as proposed in the certificate of need application, describe all differences between the project as proposed in the application and the project as currently proposed. Such changes include, but are not limited to, changes in the: 1) design of the facility; 2) number or type of beds to be developed; 3) medical equipment to be acquired; 4) proposed charges; and 5) capital cost of the project. (See the Capital Cost Section of this form for additional questions regarding changes in the total capital cost of the project).

B. Timetable

1. Complete the following. The first column must include the timetable dates found on the certificate of need. If the CON Section has authorized an extension of the timetable in writing, you may substitute the dates from that letter.

	Projected Completion Date (from the Certificate of Need) Month/Day/Year	Actual Date Completed Month/Day/Year
Obtained Funds for the Project		
Approval of Final Drawings and Specifications	05/15/05	
Acquisition of land/facility		
Construction Contract Executed	06/01/05	
25% completion of construction	09/01/05	
50% completion of construction	11/15/05	
75% completion of construction	02/15/06	
Completion of construction	04/01/06	
Ordering of medical equipment	02/15/06	
Operation of medical equipment	06/15/06	
Occupancy/offering of services	06/15/06	
Licensure		
Certification		

2. If the project is experiencing significant delays in development: With the construction of the new Valley Pavilion, this project has been put on hold.
   a. explain the reasons for the delay, and
   b. provide a revised timetable for the CON Section to consider.

C. Medical Equipment Projects – If the project involves the acquisition of any of the following equipment: 1) major medical equipment as defined in NCGS §131E-176(14f); 2) the specific equipment listed in NCGS §131-176(16); 3) equipment that creates an oncology treatment center as defined in NCGS §131-176(18a); or 4) equipment that creates a diagnostic center as defined in NCGS §131E-176(7a), provide the following information for each piece or unit of equipment.

a. Manufacturer
b. Model
c. Serial Number
d. Date acquired

D. Capital Expenditure

1. Complete the following table.
   a. Include all capital costs that have been paid to date as well as those that the applicant(s) are legally obligated to pay.
   b. If you have not already done so, provide copies of the executed construction contracts, including the one for architect and engineering services, and all final purchase orders for medical equipment costing more than $10,000/unit.
   c. If the project involves renovation or construction, provide copies of the Contractors Application for Payment [AIA G702] with Schedule of Values [AIA G703].

	Capital Expense Since Last Report	Total Cumulative Capital Expenditure
Site Costs		
Purchase price of land		
Closing costs		
Legal Fees		
Site preparation costs		
Landscaping		
Other site costs (identify)		
Subtotal Site Costs		
Construction Costs		
Construction Contract		
Miscellaneous Costs		
Moveable Equipment		
Fixed Equipment		
Furniture		
Consultant Fees		110,020.81
Financing Costs		
Interest during Construction		
Other Misc. Costs (identify)		1,503.00
Subtotal Misc. Costs		111,523.81
Total Capital Cost of the Project		111,523.81

2. What do you project to be the remaining capital expenditure required to complete the project? 2,720,102.19

3. Will the total actual capital cost of the project exceed 115% of the approved capital expenditure on the certificate of need? If yes, explain the reasons for the difference.

E. CERTIFICATION – The undersigned hereby certifies that the responses to the questions in this progress report and the attached documents are correct to the best of his or her knowledge and belief.

Signature of Officer: Lawrence C. Miller
Name and Title of Responsible Officer: Lawrence C. Miller - Director
Telephone Number of Responsible Officer: 910-609-6440

CERTIFICATE OF NEED
PROGRESS REPORT FORM

County: CUMBERLAND
Facility: CAPE FEAR VALLEY MEDICAL CENTER
Project I.D. #: M-7098-04 and M-7446-05
Project Description: ADD 44 acute care BEDS TO CAPE FEAR VALLEY MEDICAL CENTER

Date of Progress Report: 01/06/2009
Facility I.D. #: 943057
Effective Date of Certificate: 05/01/2006

A. Status of the Project – Describe the current status of the project. If the project is not going to be developed exactly as proposed in the certificate of need application, describe all differences between the project as proposed in the application and the project as currently proposed. Such changes include, but are not limited to, changes in the: 1) design of the facility; 2) number or type of beds to be developed; 3) medical equipment to be acquired; 4) proposed charges; and 5) capital cost of the project. (See the Capital Cost Section of this form for additional questions regarding changes in the total capital cost of the project).

B. Timetable

1. Complete the following. The first column must include the timetable dates found on the certificate of need. If the CON Section has authorized an extension of the timetable in writing, you may substitute the dates from that letter.

	Projected Completion Date (from the Certificate of Need) Month/Day/Year	Actual Date Completed Month/Day/Year
Obtained Funds for the Project		
Approval of Final Drawings and Specifications	05/05/05	
Acquisition of land/facility		
Construction Contract Executed	06/01/05	
25% completion of construction	09/01/05	
50% completion of construction	11/15/05	
75% completion of construction	02/15/06	
Completion of construction	04/01/06	
Ordering of medical equipment	02/15/06	
Operation of medical equipment	04/15/06	
Occupancy/offering of services	04/15/06	
Licensure		
Certification		

2. If the project is experiencing significant delays in development: With the construction of the new Valley facilities, this project has been put on hold.
   a. explain the reasons for the delay; and
   b. provide a revised timetable for the CON Section to consider.

C. Medical Equipment Projects – If the project involves the acquisition of any of the following equipment: 1) major medical equipment as defined in NCGS §131E-176(14f); 2) the specific equipment listed in NCGS §131-176(16); 3) equipment that creates an oncology treatment center as defined in NCGS §131-176(18a); or 4) equipment that creates a diagnostic center as defined in NCGS §131E-176(7a), provide the following information for each piece or unit of equipment.

a. Manufacturer
b. Model
c. Serial Number
d. Date acquired

D. Capital Expenditure

Complete the following table.

a. Include all capital costs that have been paid to date as well as those that the applicant(s) are legally obligated to pay.
b. If you have not already done so, provide copies of the executed construction contracts, including the one for architect and engineering services, and all final purchase orders for medical equipment costing more than $10,000/unit.
c. If the project involves renovation or construction, provide copies of the Contractors Application for Payment [AIA G702] with Schedule of Values [AIA G703].

	Capital Expense Since Last Report	Total Cumulative Capital Expenditure
Site Costs		
Purchase price of land		
Closing costs		
Legal Fees		
Site preparation costs		
Landscaping		
Other site costs (identify)		
Subtotal Site Costs		
Construction Costs		
Construction Contract		
Miscellaneous Costs		
Moveable Equipment		
Fixed Equipment		
Furniture		
Consultant Fees		110,020.81
Financing Costs		
Interest during Construction		
Other Misc. Costs (identify)		1,503.00
Subtotal Misc. Costs		111,523.81
Total Capital Cost of the Project		111,523.81

2. What do you project to be the remaining capital expenditure required to complete the project? 2,720,102.19

3. Will the total actual capital cost of the project exceed 115% of the approved capital expenditure on the certificate of need? If yes, explain the reasons for the difference.

E. **CERTIFICATION** – The undersigned hereby certifies that the responses to the questions in this progress report and the attached documents are correct to the best of his or her knowledge and belief.

Signature of Officer: Lawrence C. Miller
Name and Title of Responsible Officer: Lawrence C. Miller - Director
Telephone Number of Responsible Officer: 910-609-6440

Effective date: 2/2/05

CERTIFICATE OF NEED
PROGRESS REPORT FORM

County: Cumberland
Facility: Cape Fear Valley Medical Center
Project I.D. #: M-8004-07
Project Description: Renovate space and add one operating room at Cape Fear Valley Medical Center.

Date of Progress Report: 3/31/09
Facility I.D. #: 943057
Effective Date of Certificate: 3/26/2008

A. **Status of the Project** – Describe the current status of the project. If the project is not going to be developed exactly as proposed in the certificate of need application, describe all differences between the project as proposed in the application and the project as currently proposed. Such changes include, but are not limited to, changes in the: 1) design of the facility; 2) number or type of beds to be developed; 3) medical equipment to be acquired; 4) proposed charges; and 5) capital cost of the project. (See the Capital Cost Section of this form for additional questions regarding changes in the total capital cost of the project).

B. **Timetable**

1. Complete the following. The first column must include the timetable dates found on the certificate of need. If the CON Section has authorized an extension of the timetable in writing, you may substitute the dates from that letter.

	Projected Completion Date (from the Certificate of Need) Month/Day/Year	Actual Date Completed Month/Day/Year
Obtained Funds for the Project	Available	
Approval of Final Drawings and Specifications	06/16/2008	
Acquisition of land/facility	Available	
Construction Contract Executed	06/16/2008	
25% completion of construction	07/16/2008	
50% completion of construction	07/21/2008	
75% completion of construction	08/21/2008	
Completion of construction	09/15/2008	
Ordering of medical equipment	04/01/2008	
Operation of medical equipment	08/31/2008	
Occupancy/offering of services	10/01/2008	
Licensure	10/01/2008	
Certification	10/01/2008	

2. If the project is experiencing significant delays in development:

   a. explain the reasons for the delay; and
   b. provide a revised timetable for the CON Section to consider.

C. **Medical Equipment Projects** – If the project involves the acquisition of any of the following equipment: 1) major medical equipment as defined in NCGS §131E-176(14f); 2) the specific equipment listed in NCGS §131-176(16); 3) equipment that creates an oncology treatment center as defined in NCGS §131-176(18a); or 4) equipment that creates a diagnostic center as defined in NCGS §131E-176(7a), provide the following information for each piece or unit of equipment.

   a. Manufacturer
   b. Model
   c. Serial Number
   d. Date acquired

D. Capital Expenditure

1. Complete the following table.
   a. Include all capital costs that have been paid to date as well as those that the applicant(s) are legally obligated to pay.
   b. If you have not already done so, provide copies of the executed construction contracts, including the one for architect and engineering services, and all final purchase orders for medical equipment costing more than $10,000/unit.
   c. If the project involves renovation or construction, provide copies of the Contractors Application for Payment [AIA G702] with Schedule of Values [AIA G703].

	Capital Expense Since Last Report	Total Cumulative Capital Expenditure
Site Costs		
Purchase price of land		
Closing costs		
Legal Fees		
Site preparation costs		
Landscaping		
Other site costs (identify)		
Subtotal Site Costs		
Construction Costs		
Construction Contract		
Miscellaneous Costs		
Moveable Equipment		
Fixed Equipment		
Furniture		
Consultant Fees		
Financing Costs		
Interest during Construction		
Other Misc. Costs (identify)		
Subtotal Misc. Costs		
Total Capital Cost of the Project		

2. What do you project to be the remaining capital expenditure required to complete the project? 720,000

3. Will the total actual capital cost of the project exceed 115% of the approved capital expenditure on the certificate of need? If yes, explain the reasons for the difference. NO

E. CERTIFICATION – The undersigned hereby certifies that the responses to the questions in this progress report and the attached documents are correct to the best of his or her knowledge and belief.

Signature of Officer: Sandy Godwin
Name and Title of Responsible Officer: Sandy Godwin - Director of Planning
Telephone Number of Responsible Officer: 910-615-6852

Attachment 7

ATTACHMENT - REQUIRED STATE AGENCY FINDINGS

FINDINGS
C = Conforming
CA = Conditional
NC = Nonconforming
NA = Not Applicable

DECISION DATE: October 26, 2006

PROJECT ANALYST: Martha J. Frisone
CHIEF: Lee B. Hoffman

PROJECT I.D. NUMBER: G-7604-06/ Novant Health, Inc. (lessor) and Forsyth Memorial Hospital, Inc. d/b/a Forsyth Medical Center (lessee)/ Develop 39 new acute care beds and relocate 11 existing acute care beds from Winston-Salem to establish a new facility in Kernersville for provision of acute inpatient services/ Forsyth County

REVIEW CRITERIA FOR NEW INSTITUTIONAL HEALTH SERVICES

G.S. 131E-183(a) The Department shall review all applications utilizing the criteria outlined in this subsection and shall determine that an application is either consistent with or not in conflict with these criteria before a certificate of need for the proposed project shall be issued.

(1) The proposed project shall be consistent with applicable policies and need determinations in the State Medical Facilities Plan, the need determination of which constitutes a determinative limitation on the provision of any health service, health service facility, health service facility beds, dialysis stations, operating rooms, or home health offices that may be approved.

C

The applicants, Novant Health, Inc. (lessor) (**Novant**) and Forsyth Memorial Hospital, Inc. (lessee), own and operate Forsyth Medical Center (**FMC**), a hospital located in Winston-Salem in Forsyth County, which is currently licensed for 637 acute care, 68 rehabilitation, 80 psychiatric and 20 nursing facility beds. Novant also owns Medical Park Hospital (**MPH**), which is located across the street from FMC. MPH is currently licensed for 136 acute care beds. Pursuant to the certificate of need issued for Project I.D. #G-7011-04, Novant is authorized to relocate 114 existing acute care beds from MPH to FMC. Thus, upon completion of Project I.D. #G-7011-04, FMC would be licensed for 751 acute care beds and

MPH would be licensed for 22 acute care beds [637 + 114 = 751; 136 – 114 = 22].

In this application, Novant and FMC propose to develop 39 new acute care beds and relocate 11 existing acute care beds from FMC to establish a new site for the provision of acute inpatient services in Kernersville in Forsyth County. Upon completion of this project and Project I.D. #G-7011-04, FMC would be licensed for a total of 790 acute care [637 + 114 + 39 = 790], 68 rehabilitation, 80 psychiatric and 20 nursing facility beds. See Criterion (3) for a detailed description of all the services the applicants propose to provide in Kernersville.

Need Determination - The 2006 State Medical Facilities Plan (2006 SMFP) includes a methodology for determining the need for additional acute care beds in North Carolina by service area. Application of the need methodology in the 2006 SMFP identified a need for 90 additional acute care beds in Forsyth County. The 2006 SMFP states:

> *"Any qualified applicant may apply for a certificate of need to acquire the needed acute care beds. A person is a qualified applicant if it proposes to operate the additional acute care beds in a hospital that will provide:*
>
> *(1) a 24-hour emergency services department,*
> *(2) inpatient medical services to both surgical and non-surgical patients, and*
> *(3) if proposing a new licensed hospital, medical and surgical services on a daily basis within at least five of the major diagnostic categories as recognized by the Centers for Medicare and Medicaid Services (CMS), as follows:* ... [as listed in the 2006 SFMP]."

The applicants propose to develop 39 of the 90 new acute care beds available in the 2006 SMFP.[1] The facility in Kernersville will not be a separately licensed hospital, but will be operated under FMC's license, and thus, it will be an additional campus of an existing

[1] North Carolina Baptist Hospital submitted an application proposing to develop the other 51 acute care beds [90 – 39 = 51]. See Project I.D. #G-7600-06. The applications are not competitive.

licensed hospital. The applicants do not propose to develop more acute care beds than are determined to be needed in Forsyth County.

FMC and Novant propose to develop a 24 hour emergency services department at Forsyth Medical Center – Kernersville (FMC-K). In Exhibit 5, page 6, the applicants provide the projected number of inpatient discharges and patient days of care by major diagnostic category (MDC) to be provided at FMC-K during the first three operating years. The applicants project to provide services at FMC-K in 22 of the 25 MDCs listed in the 2006 SMFP. Therefore, the applicants propose to provide medical and surgical services in at least five MDCs recognized by CMS. The applicants adequately demonstrate that FMC-K will provide inpatient medical services to both surgical and non-surgical patients. Thus, Novant and FMC are qualified applicants and the proposal is consistent with the need determination in the 2006 SMFP for additional acute care beds in Forsyth County.

There are no other need determinations in the 2006 SMFP that are applicable to this review.

Policies – Because the applicants propose to construct new space to replace 11 existing acute care beds to be relocated from Winston-Salem to Kernersville[2], Policy AC-5 is applicable to this review. POLICY AC-5: REPLACEMENT OF ACUTE CARE BED CAPACITY states

> *"Proposals for either partial or total replacement of acute care beds (i.e., construction of new space for existing acute care beds) shall be evaluated against the utilization of the total number of acute care beds in the applicant's hospital in relation to the utilization targets found below. In determining utilization of acute care beds, only acute care bed 'days of care' shall be counted. Any hospital proposing replacement of acute care beds must clearly demonstrate the need for maintaining the acute care bed capacity proposed within the application.*

---

[2] Hereinafter, the existing Winston-Salem campus will be referred to as "FMC-WS" and the Kernersville campus as "FMC-K." "FMC" will be used to refer to the entire hospital, including both campuses.

Facility Average Daily Census	*Target Occupancy of Licensed Acute Care Beds (Percent)*
1 – 99	*66.7%*
100 – 200	*71.4%*
Greater than 200	*75.2%*

According to its 2006 Hospital License Renewal Application, during Fiscal Year (FY) 2005, the average daily census (ADC) for the 637 licensed acute care beds at FMC was 564.6 [206,071 / 365 = 564.6]. Thus, based on the above table, the target occupancy for FMC is 75.2% of the capacity of the licensed acute care beds. Based on current utilization, FMC is already operating at 88.2% of licensed acute care capacity. In Exhibit 5, page 4, the applicants provide projected utilization for the total number of acute care beds at FMC during the first three operating years of the proposed project, as illustrated in the following table.

PROJECTED UTILIZATION OF TOTAL # OF ACUTE CARE BEDS

	TOTAL # OF PROJECTED ACUTE CARE PATIENT DAYS		
	YEAR ONE (7/1/09-6/30/10)	YEAR TWO (7/1/10-6/30/11)	YEAR THREE (7/1/11-6/30/12)
FMC-WS (740 acute care beds)	213,810	215,902	218,017
FMC-K (50 acute care beds)	10,613	13,296	16,147
FMC (790 acute care beds)	224,423	229,198	234,164
Average Daily Census (ADC) [1]	614.9	627.9	641.5
% Occupancy [2]	77.8%	79.5%	81.2%

Source: Exhibit 5, page 4.
(1) ADC was calculated by dividing projected acute patient days by 365.
(2) Occupancy was calculated by dividing ADC by 790.

As shown in the above table, in the third operating year, the applicants project an occupancy rate of 81.2% for the entire hospital, which is greater than the target occupancy of 75.2%. The applicants state that they used FMC's actual utilization in FY 2005 as the base year and assumed that utilization would increase at the same rate the population of the service area is projected to increase. See Exhibit 20, Figure 43, for the applicants' assumptions and methodology used to project utilization for the hospital as a whole. The applicants adequately demonstrate the need to maintain FMC's total acute care bed capacity proposed in the application. Therefore, the application is conforming to Policy AC-5. See Criterion (3) for discussion of the applicants' demonstration of need for the acute care beds at FMC-K.

There are no other policies in the 2006 SMFP that are applicable to this review.

In summary, the application is consistent with the need determination in the 2006 SMFP for additional acute care beds in Forsyth County and Policy AC-5. Therefore, the application is conforming to this criterion.

(2) Repealed effective July 1, 1987.

(3) The applicant shall identify the population to be served by the proposed project, and shall demonstrate the need that this population has for the services proposed, and the extent to which all residents of the area, and, in particular, low income persons, racial and ethnic minorities, women, handicapped persons, the elderly, and other underserved groups are likely to have access to the services proposed.

NC

Novant and FMC propose to develop 39 new acute care beds and relocate 11 existing acute care beds from FMC-WS to establish a an additional campus of FMC in Kernersville (**FMC-K**). Based on the applicants' representations in Section II.1, pages II-1 through II-4, the design schematics in Exhibit 16, and the list of equipment to be acquired provided in Exhibit 18, the applicants propose to offer the following services at FMC-K:

- 46 general medical-surgical (med/surg) acute care beds (39 new and 7 existing to be relocated from FMC-WS)
- 4 intensive care unit (ICU) beds (4 existing to be relocated from FMC-WS)
- 10 unlicensed observation beds
- 4 shared operating rooms (ORs) (3 existing shared ORs to be relocated from FMC-WS[3] and 1 existing shared OR to be relocated from MPH)
- a 24 hour Emergency Room (ER), with 14 treatment rooms
- laboratory (lab) services, including phlebotomy, blood bank, pathology, chemistry, hematology coagulation, micro urinalysis and accessioning
- pharmacy

[3] In Project I.D. #G-7311-05, the applicants were authorized to relocate three existing shared ORs to Kernersville where they would be operated under FMC's license as dedicated outpatient ORs.

- 1 cardiac catheterization (cath) unit (to be relocated from FMC-WS[4])
- 1 new CT scanner
- 1 new x-ray unit
- 1 new x-ray/fluoroscopy unit
- 3 mobile C-arms
- 2 mobile x-ray units
- 1 new nuclear medicine camera (without coincidence circuitry)
- 1 new mammography unit
- 1 new *"Cardiac"* ultrasound (US) unit
- 1 new *"Imaging, Handheld"* US unit
- 2 new *"Therapeutic, Genera"* [sic] US units
- 2 stress testing systems with treadmill
- echocardiography equipment (quantity not provided)
- 1 electroencephalograph (EEG) unit
- 3 electrocardiograph (ECG) units
- 1 pulmonary function testing system

The applicants do not propose to offer obstetric or neonatal services at FMC-K, and do not propose to develop any non-surgical procedure rooms on the new campus.

POPULATION TO BE SERVED

The following table illustrates the historical patient origin for FMC, as reported by the applicants in Section III.4(a), page III-19.

COUNTY	PERCENTAGE OF TOTAL DISCHARGES
Forsyth	60.41%
Stokes	7.20%
Surry	6.27%
Davie	5.58%
Yadkin	5.45%
Davidson	4.97%
Wilkes	2.13%
Other NC Counties	5.68%
Other States	2.33%
Total [1]	100.02%

[1] Does not equal 100% due to rounding.

The applicants propose to relocate the cardiac cath unit authorized in Project I.D. #G-7266-05 which was approved to be located at FMC-WS. This unit is not yet operational.

The following table illustrates the projected patient origin for FMC-K campus in the third operating year, as reported by the applicants in Exhibit 20, page 8 and Figure 1.

ZIP CODE	COUNTY	CITY	PROJECTED NUMBER OF DISCHARGES YEAR THREE (7/1/11 – 6/30/12)	PERCENTAGE OF TOTAL DISCHARGES
27284 / 27285 (1)	Forsyth	Kernersville	2,011	59.8%
27051	Forsyth	Walkertown	255	7.6%
27009	Forsyth	Belews Creek	65	1.9%
27265	Guilford	High Point	280	8.3%
27235	Guilford	Colfax	46	1.4%
27310	Guilford	Oak Ridge	35	1.0%
Other			673	20.0%
Total			3,365	100.0%

(1) In a footnote to Figure 1 in Exhibit 20, the applicants state that the 27285 zip code is a *"P.O. Box located within the zip code boundary of 27284."*

In Section III.5(a), page III-20, the applicants state

> *"The service area for FMC-Kernersville consists of zip codes 27284 (including point zip code 27285), 27051, 27009, 27265, 27235, and 27310. The service area for the proposed FMC-Kernersville hospital was developed based on the following analysis:*
>
> *These zip codes represent a contiguous set of zip codes within a 10-mile radius of the proposed hospital location. Major transportation routes I-40 and Business I-40 Business* [sic] *run through the region. These roads run east and west and are direct routes to either Winston-Salem or Greensboro. In addition, to the east in Greensboro I-85 intersects I-40; in North Carolina, I-85 runs from Charlotte, NC to the Virginia border in eastern North Carolina. The applicant has not projected a secondary service area. Approximately 80% of FMC-Kernersville patients will come from residents in the defined service area zip codes. The other 20 percent will come from other zip codes in Forsyth and Guilford Counties, Other North Carolina Counties, and Other States. This service area is consistent with the Kernersville market area definition used by other local development groups."*

The applicants adequately identify the population they propose to serve.

ANALYSIS OF NEED FOR THE PROPOSED SERVICES

In Section III.1, pages III-1 through III-16, the applicants state that 50 acute care beds are needed in Kernersville for the following reasons.

"Kernersville, a growing community of nearly 50,000 people in eastern Forsyth County, does not currently have its own hospital. Residents must therefore travel to Winston-Salem, or to Greensboro or High Point to receive hospital care, including emergency room services. For the reasons stated below, this is no longer a satisfactory answer, and the time has come for Kernersville to have a small community hospital.

The primary objectives of this project are to improve the access to health care services for the residents of Kernersville and the Triad area and to provide an appropriate setting for high-quality patient care and satisfaction. The 2006 State Medical Facilities Plan (SMFP) identifies a need for new acute care beds in Forsyth County. This project proposes to meet that need by adding 39 of the 90 new acute care beds allocated in the 2006 SMFP and shifting 11 existing beds and services that are now located in Winston-Salem to Kernersville. Thus, this project maximizes existing resources while meeting a stated need under the SMFP.

FMC is proposing to construct and operate a satellite hospital called FMC-Kernersville. FMC-Kernersville will be a new acute care hospital with 50 acute care beds (46 general medical/surgical acute inpatient licensed beds plus four Intensive Care licensed acute beds) and 10 observation beds. FMC-Kernersville will be located on Highway 66 South in Kernersville, near the intersection of Interstate 40 in Kernersville, North Carolina (zip code 27284). A map is included in Exhibit 15 to show the exact location of the proposed hospital.

Kernersville, known as the "Heart of the Triad", is projected to be the fastest-growing zip code in Forsyth

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Kernersville, known as the "Heart of the Triad", is projected to be the fastest-growing zip code in Forsyth

County during the next five years. New businesses and industry have chosen Kernersville as a result of its prime location and proximity to both interstate highways and air transportation. In 2006, the North Carolina Manufacturers registrar reported that there are 23 companies with more than 30 employees located in Kernersville. Of those 23 companies, 12 of them have at least 100 employees and six have over 200. Seven of the 23 major employers have been established in the last 20 years.

...

Based upon these and other new job opportunities in the area, the Kernersville Development Plan projects that by the year 2025, the job base will grow from 276,000 to 379,000, a 37% increase. As a result, the area will experience tremendous population growth and greatly increased demand for medical services.

From 2000 to 2005, the population of the Kernersville zip code area increased by 4,748 persons, more than any other area in Forsyth County .... The Kernersville zip code was also third in the top five fastest growing zip codes areas in Forsyth County from 2000 to 2005. From 2005 to 2010, the population of Kernersville is projected to grow more than 10%, faster than any other area in Forsyth County. ...

...

The population growth reported from 2000-2005 was not a one-time occurrence. Since 1970, the Kernersville population has increased 53% each decade. To accommodate the additional population growth, Kernersville has developed several new neighborhoods. ...

... Kernersville is the location of the majority of the population growth in Forsyth County. A new facility in Kernersville will help alleviate crowded conditions on the FMC campus. Thee [sic] *crowded conditions reduce ease of access and frustrates patients and their families. See Exhibit 12 for a letter of explanation from the Novant Health Triad Region President.*

...

As discussed above, Kernersville, due to its proximity to Winston-Salem, High Point and Greensboro (the Triad) and the Piedmont Triad Airport, has been and is projected to remain one of the fastest growing areas in the State. This growth is also evident in the proposed FMC-Kernersville service area.

Exhibit 21 contains an urban planning report prepared by Cheryl Roberts of the Center for Applied Research at Central Piedmont Community College in Charlotte. This report details the current and future growth of the FMC-Kernersville area. ...

As shown in the tables below, the service area for FMC-Kernersville has an estimated 2005 population of 101,379 and is projected to grow more than 25% by 2015. The Town of Kernersville has an estimated population of 22,075, a 29% increase over the 2000 Census population.

...

The two fastest-growing zip codes are High Point, 27265, and Colfax, 27235. The projected 34.3 % growth rate in High Point is due to the huge amounts of residential development. The details of this development are outlined in Exhibit 19. Colfax is the area between Kernersville and Greensboro along Business 40 and Highway 421. Neither High Point nor Colfax is in Forsyth County. ...

...

Thus, the need for this project is demonstrated: (1) by the SMFP need determination for additional beds in Forsyth County; (2) the existing population of Kernersville; (3) the projected growth of the area; (4) the fact that Kernersville does not have its own hospital at the present time; (5) FMC's long-standing presence in the area; and (5) strong and enthusiastic community support for this project.

...

As part of its utilization analysis, the applicant defined hospital service areas for the following six North Carolina Hospitals in the Triad area and for FMC-Kernersville, based on July 1, 2004 to June 30, 2005 discharge volumes.

- *Forsyth Medical Center*
- *High Point Regional Hospital*
- *Medical Park Hospital*
- *Moses H. Cone Memorial Hospital*
- *North Carolina Baptist Hospital*
- *Thomasville Medical Center*

...

Data from the annual hospital licensure renewal applications for these hospitals were used to calculate current and projected service levels and market shares. The potential for FMC-Kernersville to have a material impact of [sic] *the volume of services at each hospital was considered. Where Novant judged there was no possibility of FMC-Kernersville having a material impact on a hospital, Novant dropped the hospital from further analysis (i.e., Thomasville Medical Center and Lexington Memorial Hospital). The service areas of three existing suburban community hospitals, Presbyterian Hospital Huntersville, Presbyterian Hospital Matthews, and Thomasville Medical Center, were used as a basis for projecting service levels and market shares for the proposed FMC-Kernersville. Further details on service area definition can be found in Exhibit 20.*

The reasonableness of locating a new community hospital in the Kernersville area is shown by the projected need for services due to significant population growth experienced over the past years and projected to continue in the foreseeable future (i.e., Kernersville is the fastest-growing area in Forsyth County).

... The table below shows the projected patient days and occupancy rates for FMC-Kernersville in the first three years of operation. Note that FMC-Kernersville's occupancy rate will be well over the required project year 3 target occupancy rate required by the CON Section's

Criteria and Standards for New Acute Beds found at 10A NCAC 14C.3800). As Kernersville continues to grow, its future acute health care needs can be met by the development and expansion of FMC-Kernersville."

Acute Care Beds (including ICU) – The following table illustrates projected utilization of the 50 acute care beds at FMC-K, as reported by the applicants in Section III.1, page III-28, and Exhibit 20, Figure 26.

PROJECTED UTILIZATION OF ACUTE CARE BEDS AT FMC-K

	Year One 7/1/09 - 6/30/10	Year Two 7/1/10 - 6/30/11	Year Three 7/1/11 - 6/30/12
General Med/Surg (46 beds)			
Patient Days	9,768	12,240	14,865
ADC [1]	26.8	33.5	40.7
% Occupancy [2]	58.2%	72.9%	88.5%
ICU (4 beds)			
Patient Days	842	1,056	1,282
ADC	2.3	2.9	3.5
% Occupancy	57.7%	72.3%	87.8%
Total (50 beds)			
Discharges [3]	2,211	2,770	3,364
Average Length of Stay (ALOS) [4]	4.8	4.8	4.8
Patient Days	10,610	13,296	16,147
ADC	29.1	36.4	44.2
% Occupancy	58.1%	72.9%	88.5%

Source: Section III.1, page III-28, and Exhibit 20, Figure 26.

(1) ADC equals total number of patient days of care divided by 365.

(2) Occupancy equals ADC divided by the number of beds.

(3) The applicants did not provide the number of discharges for the 46 med/surg beds or the 4 ICU beds. They only provided the number of discharges for the total number of acute care beds.

(4) ALOS equals patient days divided by discharges.

As shown in the above table, the applicants project that the ADC of the 50 acute care beds at FMC-K in the third operating year will be 44.2 patients, which is an occupancy rate of 88.5%. The applicants provide the assumptions and methodology used to project utilization of the acute care beds at FMC-K in Exhibit 20, where they state

1. *The FMC- Kernersville service area is a collection of seven zip codes in Forsyth and Guilford Counties in North Carolina. One of these zip codes (27285) is a point zip code, a post office box, within the boundary of zip code 27284. In our analysis we combined these two zip codes. ...*

...

2. *For projecting utilization, we have used and relied upon publicly available summary information from the data in the North Carolina Hospital License Renewal Applications ('LRAs'), hospital discharge data compiled by Solucient, and internal data from Novant Health. ...*

...

3. *The applicant assumed the FMC-Kernersville would open on July 1, 2009. We prepared utilization projections for each 12-month period ending June 30, through 2012, the third year of hospital operations. The discharge data used in this study to project inpatient utilization are for discharges during the twelve month period July 1, 2004 through June 30, 2005.*

...

4. *Projecting demand for hospital services requires population data by age and gender for various counties, and zips codes. We used 2000 census data from the U.S. Census, and population estimates and projections from Claritas, Inc. Claritas provided estimates and projections for the years 2005 and 2010 by the following age cohorts:*
   - *Total Population Age 0-14*
   - *Total Population Age 15-44*
   - *Total Population Age 45-64*
   - *Total Population Age 65+*
5. *We interpolated and extrapolated the actual 2000 Census and the 2005 and 2010 Claritas projections based on compound average annual growth rates ("CAGR") to provide estimates and projections for all years from 2000 through 2015 for each age and gender cohort for each geographic area. ...*

...

6. *We used the total population (male and female) for each area to forecast demand for medical and surgical services. FMC-Kernersville will not provide obstetric and newborn services. To project inpatient services at FMC-Kernersville and other North Carolina hospitals, we refined the projection methodology to separately calculate demand for each age cohort. This enabled us to use the most detailed available Forsyth and Guilford County population discharge rates.*

...

8. ***Inpatient Discharge Rates.*** *FMC-Kernersville will be a community-based hospital and will not initially offer the full range of services offered by a tertiary level provider. The projections for FMC-Kernersville include only the range of services that FMC-Kernersville will routinely provide. ... In summary, we did not include projections for Mental Health, Drug and Alcohol Abuse, Rehabilitation, Obstetrics, Normal Newborns, NICU, Inpatients* [sic] *Diagnostic Cardiac Catheterizations, and tertiary level services that FMC-Kernersville does not plan to routinely provide during the projection period. Tertiary level services were defined as discharges in DRGs with a FY 2005 Medicare DRG case weight of 2.0 or greater.*
9. *To project inpatient discharges of the limited DRGs for the service area population, we computed discharge rates limited to FMC-Kernersville medical/surgical services for Forsyth County and for Guilford County. We used the Forsyth County discharge rate for Forsyth zip codes and the Guilford County discharge rate for Guilford zip codes ....*
10. ***Inpatient Market Share.*** *The applicant used the 'Novant System' market share as a starting point for calculating expected market share at FMC-Kernersville. For this analysis, the Novant System includes the applicant hospitals that are currently serving patients from the FMC-Kernersville service area: Forsyth Medical Center, Medical Park Hospital, and Thomasville Medical Center.*
11. *As an indicator of the growth that can be expected from locating a hospital in Kernersville (FMC-Kernersville), we considered our experience with a new 50-bed hospital in Huntersville, North Carolina (Presbyterian Hospital Huntersville). This hospital is part of Novant's Southern Piedmont Region. ...*
12. *For each FMC-Kernersville service area zip code, we calculated the current Novant System market shares for the limited DRGs using inpatient discharge data for the most current twelve months available: July 1, 2004 through June 30, 2005. We assumed 65% of the Novant System market share in the Forsyth County zip codes in the service area would shift to FMC-Kernersville by*

Year 3. We assumed 70% of the Novant market share in the Guilford County zip codes in the service area would shift to FMC-Kernersville since patients would have to drive past FMC-Kernersville to be served at FMC, MPH, or TMC.

13. *The applicant estimates opening of FMC-Kernersville will increase the Novant System market shares in each service area zip code between 5% and 15% due to proximity. We assumed different levels of increase in market share for each zip code, taking into account the next nearest hospital. We capped the Novant System market share in any service area zip code at 70%. ...*
14. *New hospitals take a few years to realize their full market shares. The applicant projects FMC-Kernersville will not reach the market shares shown in figure 12 until the third year of operations. We reduced the FMC-Kernersville market shares for the first two years of operation to allow for this start up period growth in FMC-Kernersville discharges. The third year market shares are reduced by 30% in Year 1 and by 15% in Year 2. Market shares for years after Year 3 are held constant at Year 3 levels. ...*
15. *In making the projections for the new hospital, the applicant relied upon the experience of similar Novant hospitals, Presbyterian Hospital Huntersville and Presbyterian Hospital Matthews. These hospitals are under Novant management and are comparable to FMC-Kernersville in their size and scope of services. All instances where we have relied upon the experience of these hospitals are noted.*
16. ***Medical/Surgical/ICU Services.*** *The applicant projected medical/surgical discharges and patient days for FMC-Kernersville using the following formulas:*
    - *Projected Zip Code Discharges = Limited discharge rate for the county X projected zip code population. Separately calculated for each age cohort.*
    - *FMC-Kernersville Zip Code Discharges = Projected zip code discharges X FMC- Kernersville zip code market share.*
    - *Discharges from FMC-Kernersville Service Area = Σ(FMC-Kernersville Zip Code discharges)*
    - *Total FMC-Kernersville Discharges = FMC-*

Kernersville discharges from services area/Percent FMC-Kernersville discharges from service area.

- *FMC-Kernersville medical/surgical patient days = Total FMC-Kernersville discharges X Average limited medical/surgical length of stay.*

17. *In applying this projection algorithm, we used the following factors and made the following assumptions:*
    - *We used the discharge rates by age cohort for only the medical/surgical services FMC- Kernersville is expected to offer. This limited discharge rate excludes Delivery DRGs (370-375), Mental Health and Drug Abuse DRGs (424-433 and 521-523), Rehab (462), Normal Newborns (391), NICU (385-390), Diagnostic Cardiac Catheterization (124,125) and all DRGs with FY 2005 relative case weight of 2.0 or greater*
    - *The discharge rates were held constant throughout the projection period.*
    - *The level of in-migration is assumed to be 20%. This is based on the experience at Presbyterian Hospital Huntersville. We believe the level of immigration is conservative because PHH serves 80% of its discharges from a 10 zip code service area, while the FMC-Kernersville service area will only be seven zip codes.*
    - *The average length of stay is 4.8 days and is assumed to remain constant during the projection period. The assumption is based on experience of residents from Forsyth and Guilford Counties for the limited DRGs FMC-Kernersville will routinely serve. ...*
    - *Patient days in the intensive care unit ('ICU') will be approximately 8% of total medical/surgical days. This assumption is based on the experience at Presbyterian Hospital Huntersville and Presbyterian Hospital Matthews reported on their 2006 Hospital License Renewal Applications. ...*

...

18. *The following actual numbers demonstrate the procedures for projecting medical/surgical services. The first two calculations use the zip code 27284/27285 of Kernersville in the third year of operation as an example. A spreadsheet model was used to perform*

these calculations with unrounded numbers. Sums generated in our model, using non-rounded figures, may not equal the sums replicated by the following rounded numbers.

19. *Projected Zip Code Discharges = Limited discharge rate X projected zip code population. Separately calculated for each age cohort.*

Projected Discharges for Zip Code 27284 (Year – Twelve months ending June 30, 2012)					
	Ages 0-17	Ages 18-44	Ages 45-64	Ages 65+	Total
Limited discharge rate for Forsyth County	*18.3*	*37.6*	*80.0*	*254.9*	
Projected zip code population	*10,862*	*19,863*	*15,407*	*7,146*	*53,277*
Projected discharges	*199*	*746*	*1,232*	*1,815*	*3,993*

20. *FMC-Kernersville Zip Code Discharges = Projected zip code discharges X FMC- Kernersville zip code market share.*

FMC-Kernersville discharges for Zip Code 27284 (Year – Twelve months ending June 30, 2012)	
Projected zip code discharges	*3,993*
FMC – Kernersville Zip Code market share	*50%*
FMC – Kernersville Zip Code Discharges	*2,011*

21. *Discharges from FMC-Kernersville Service Area = Σ (FMC-Kernersville zip code discharges).*

Discharges from FMC-Kernersville Service Area (Year – Twelve months ending June 30, 2012)	
Zip Codes	*2011-2012*
27284 / 27285	*2,011*
27051	*255*
27009	*65*
27265	*280*
27235	*46*
27310	*35*

Discharges from Service Area	*2,691*

22. *Total FMC-Kernersville Discharges = FMC-Kernersville discharges from services area / Percent FMC-Kernersville discharges from service area.*

Total FMC-Kernersville Discharges Year 3, twelve months ending June 30, 2012	
Discharges from Service Area	2,691
Percent discharges from service area: the applicant Report	80%
Total Discharges	3,364
Discharges from outside Service Area	673

23. *FMC-Kernersville medical/surgical patient days = Total FMC-Kernersville discharges X Average limited medical/surgical length of stay.*

Total FMC-Kernersville Inpatient Days Year 3, twelve months ending June 30, 2012	
Total discharges	3,364
Average medical/surgical length of stay	4.8
Medical/surgical patient days	16,147

...

43. ***Allocation of FMC-Kernersville Discharges.*** *We assume that part of the FMC-Kernersville market share will be a direct shift from other Novant System hospitals. However, FMC-Kernersville is projected to increase the total Novant System market share within its service area zip codes. This additional market share, between 5 and 15 percent in each zip code by Year 3, will come from other hospitals currently serving patients in this area. ...*
44. *Our method of allocating 'Non-Novant System' discharges from FMC-Kernersville is to assume that the actual loss of inpatient volume from each zip code will be proportional to each hospital's current Non-the applicant market share for that zip code. In other words, we assumed that if a Non-Novant hospital currently provides 20 percent of the Non-Novant services to residents of a zip code, that hospital's discharges will be less by 20 percent of the FMC-Kernersville medical/surgical discharges that come from Non-Novant hospitals. The same method is used to allocate impact on the applicant System hospitals. ...*
45. *We also accounted for impact due to in-migration from outside the FMC-Kernersville service area. For the purposes of this analysis we assumed all in-migration would come from Forsyth and Guilford Counties and*

that the impact on each hospital would be proportional to its market share from each county. For example, in the first year of operations, the impact on FMC attributed to the three Forsyth County service area zip codes was 1,046 patients. The in-migration at FMC-Kernersville is assumed to be 20% so we divided this number by 80% to arrive at the total impact to FMC in Forsyth County, 1,308 patients. The impact to FMC from service area zip codes in Guilford County was 69 patients and the total impact from Guilford County was 87 patients (69/80%). Therefore the total impact from the service area was 1,115 patients, the in-migration impact was 279 patients, and the total impact was 1,394 patients in the first year of operations.

...

49. *The applicant calculated a composite ratio of the three years of data, dividing the composite number by the inpatient medical surgical discharges summed for the same three year period from Solucient inpatient discharge data and the applicant* [sic] *internal inpatient discharge data.*
50. *Next, the applicant applied the composite ratio to the projected discharges for each hospital with FMC-Kernersville and without FMC-Kernersville. Finally, we calculated the impact of FMC-Kernersville by subtracting the number of services provided without FMC-Kernersville from the number of service* [sic] *provided with the new hospital. ...*

...

52. *... Based on a review of current and projected service volumes, FMC-Kernersville does not appear to have a material adverse impact on any existing hospitals as compared to the volume of services provided by each hospital in 2005. Medical Park Hospital will be affected more than any other hospital. However, this is simply a shift of services within the Novant Health System and will not have any adverse impact on the availability of services to patients seen at Medical Park Hospital.* (Emphasis in original.)

The applicants state that the "*opening of FMC-Kernersville will increase the Novant System market shares in each service area zip code between 5% and 15% due to proximity. We assumed different*

levels of increase in market share for each zip code, taking into account the next nearest hospital." (Emphasis added.) Further, the applicants state *"We assume that part of the FMC-Kernersville market share will be a direct shift from other Novant System hospitals. However, FMC-Kernersville is projected to increase the total Novant System market share within its service area zip codes. This additional market share, between 5 and 15 percent in each zip code by Year 3, will come from other hospitals currently serving patients in this area."* (Emphasis added.) However, the applicants did not provide documentation to support their assumption that market shares would increase 5 to 15%.

Further, the applicants state *"The level of in-migration is assumed to be 20%. This is based on the experience at Presbyterian Hospital Huntersville. We believe the level of inmigration is conservative because PHH serves 80% of its discharges from a 10 zip code service area, while the FMC-Kernersville service area will only be seven zip codes."* However, the mere fact that Presbyterian Hospital Huntersville (PHH) serves 80% of its discharges from a 10 zip code service area does not demonstrate that the applicants' assumption is *"conservative."* The applicants do not provide sufficient information in the application to show that the 10 zip codes in PHH's service area are similar to the 7 zip codes in FMC-K's proposed service area. Further, the applicants did not adequately demonstrate that it is reasonable to assume that inmigration would be 20% at FMC-K based only on the experience at one other hospital. For example, the FY 2005 patient origin for WakeMed Cary Hospital shows that inmigration for a satellite community hospital located in close proximity to two tertiary hospitals can be significantly less than 20%. The following table illustrates FY 2005 patient origin for WakeMed Cary Hospital, as reported in its 2006 Hospital License Renewal Application.

WakeMed Cary Hospital	
County	% of Total Admissions
Wake	87.14%
Harnett	3.55%
Johnston	3.16%
Chatham	0.76%
Lee	0.68%
Durham	0.65%
Other NC Counties	2.43%
Other States	1.63%
Total	100.00%

As shown in the above table, during FY 2005, only 12.86% of WakeMed Cary Hospital's inpatients were not residents of Wake County. Moreover, WakeMed Cary Hospital is licensed for more than twice as many beds as the proposed FMC-K [114 / 50 = 2.3] and, in July 2005, the population of the Town of Cary had more than five times the population of the Town of Kernersville [115,967 / 21,277 = 5.5]. Thus, based on the experience at WakeMed Cary Hospital, inmigration at the proposed FMC-K is unlikely to be as high as 20%, particularly given there are four tertiary hospitals in Forsyth and Guilford counties.

Moreover, in Section III.5(a), page III-21, the applicants state *"20 percent will come from other zip codes in Forsyth and Guilford Counties, Other North Carolina Counties, and Other States."* (Emphasis added.) Thus, the applicants state that some portion of the 20% inmigration will be residents of other Forsyth and Guilford County zip codes. However, the applicants did not identify those zip codes. Thus they did not demonstrate that residents of those zip codes would not have to drive past other hospitals to utilize the proposed FMC-K. It is unreasonable to assume that residents of Forsyth and Guilford counties would drive past one of the four tertiary acute care hospitals located in Forsyth and Guilford counties to utilize the proposed FMC-K.

In summary, the applicants did not adequately demonstrate that projected utilization of the 50 acute care beds at FMC-K is based on reasonable assumptions. Therefore, the applicants overestimate the number of persons to be served at FMC-K and consequently do not adequately demonstrate the need for 50 acute care beds in Kernersville.

Observation Beds (Unlicensed) – The applicants propose to develop 10 unlicensed observation beds, which will be located on the third floor of the hospital. The following table illustrates projected utilization of the observation beds at FMC-K during the first three operating years, as reported by the applicants in Exhibit 20, Figure 26.

	Observation Days of Care	Percent Occupancy[1]
Year One (7/1/09 – 6/30/10)	1,636	44.8%
Year Two (7/1/10 – 6/30/11)	2,050	56.2%
Year Three (7/1/11 – 6/30/12)	2,489	68.2%

Source: Exhibit 20, Figure 26.
(1) Calculated by dividing days of care by 365 and then dividing the result by 10.

The applicants assume 0.74 observation days for each inpatient discharge *"Based on 10-bed Observation Unit at PHH (2006)."* See Exhibit 20, Figure 25, footnote 1 and Figure 26, footnote 1. However, according to the 2006 Hospital License Renewal Application for PHH, during FY 2005, PHH reported 1,611 observation days (excluding emergency room patients[5]) and 2,448 discharges, which is only 0.66 observation days for every inpatient discharge [1,611 / 2,448 = 0.66], not 0.74. Therefore, the applicants overestimate the number of observation days to be provided at FMC-K during each of the first three operating years. Further, since the projected number of observation days is based on the projected number of inpatient discharges and the applicants overestimated inpatient discharges at FMC-K, the projected number of observation days is also overstated. See discussion above regarding acute care beds. Therefore, the applicants did not adequately demonstrate the need to develop 10 observation beds at FMC-K.

Operating Rooms – The applicants propose to relocate three existing shared ORs from FMC-WS and one existing shared OR from MPH. Pursuant to the certificate of need issued for Project I.D. #G-7311-05, the applicants are authorized to relocate three existing shared ORs from FMC to Kernersville where they are to be converted to dedicated outpatient ORs operated under FMC's license. Thus, in this application, the applicants propose the following changes to Project I.D. #G-7311-05:

- The authorized site for Project I.D. #G-7311-05 is not the same as the site proposed for FMC-K. However, both sites are within the Town of Kernersville.

In Section II.1, page II-2, of this application, the applicants state that *"some of the treatment rooms* [in the emergency room at FMC-K] *will be used to observe emergency department patients."* Thus, the applicants do not propose to use the unlicensed observation beds on the third floor of FMC-K for emergency room patients.

- The three ORs would remain shared ORs rather than be converted to dedicated outpatient ORs.
- An additional fourth OR would be relocated.

Regarding the need for four shared ORs at FMC-K, in Section III.8(b), page III-30, the applicants state *"A hospital must have operating rooms in order to be licensed. The issue is how many rooms are needed when the hospital opens."* The applicants state that FMC-K needs four shared ORs based on the number of inpatient and outpatient surgeries projected to be performed in the third operating year. The following table illustrates projected utilization of the ORs at FMC-K during the first three operating years, as reported by the applicants in Section III.8(b), page III-30, and Exhibit 20, Figures 23 and 24.

	Year One 7/1/09 – 6/30/10	Year Two 7/1/10 – 6/30/11	Year Three 7/1/11 – 6/30/12
Projected # of IP Surgical Procedures	863	1,068	1,282
Projected # of OP Surgical Procedures	1,939	2,400	2,878
Total # of Surgical Procedures	2,802	3,468	4,160
Average # of procedures per room per day (1)	2.7	3.3	4.0

Source: Section III.8(b), page III-30, and Exhibit 20, Figures 23 and 24.
(1) Assumes 260 days of operation per year. Calculated by dividing total # of surgical procedures by 260 and then by 4.

As shown in the above table, during the third operating year, the applicants project that an average of four surgical procedures will be performed per day in each of the four shared ORs at FMC-K. The applicants provide the assumptions and methodology used to project utilization of the four ORs at FMC-K in Exhibit 20, where they state

> *"24. ... The applicant used the total population for each zip code and the usage rate for the zip code's county to forecast demand for inpatient and outpatient surgical services. The following steps were taken to project utilization at FMC- Kernersville.*
>
> *25. First we calculated the usage rate for inpatient and outpatient surgeries separately, using the patient origin data reported by all North Carolina hospitals and ambulatory surgical facilities on their 2006 LRAs. ...*
>
> *26. Next we multiplied the population in each FMC-Kernersville service area zip code times the usage rate for that zip code's county. ...*
>
> *27. The applicant calculated the current the* [sic]

applicant System market share for surgeries at FMC and Medical Park. FMC-Kernersville will be a community hospital and will not initially offer the full range of surgery services offered at FMC and MPH. Therefore, the base market share for the Novant System does not include C-sections or Open Heart Surgeries. ...

28. *Consistent with our inpatient projection, we assumed 65% of the Novant System market share in the Forsyth County zip codes and 70% of the market share in the Guilford County zip codes would shift to FMC-Kernersville by Year 3. The applicant estimates the Novant System market shares in each zip code will increase between 5% and 15% with FMC-Kernersville, as we did with inpatients. ...*

29. *The applicant projects FMC- Kernersville will not reach these market shares until the third year of operations. We discounted the FMC-Kernersville market shares for the first two years of operation to allow for this growth in FMC-Kernersville discharges. We hold market shares constant for years after Year 3. ...*

30. *We multiplied the FMC-Kernersville market shares times the total projected surgeries for each zip code in each year to calculate the surgeries at FMC-Kernersville. In-migration was assumed to be 20%."*

However, the applicants did not adequately demonstrate that it is reasonable to assume that inmigration would be 20% at FMC-K. See discussion above regarding acute care beds. Therefore, the applicants did not adequately demonstrate that the projected number of surgical procedures to be performed at FMC-K is based on reasonable assumptions. Consequently, in this application, the applicants overestimate the number of surgical procedures to be performed at FMC-K and consequently do not adequately demonstrate the need for four shared ORs at FMC-K.

Emergency Room – The applicants propose to develop an ER at FMC-K with 14 treatment rooms. The following table illustrates projected utilization of the ER at FMC-K during the first three

operating years, as reported by the applicants in Exhibit 20, Figure 26.

	# OF ER VISITS
Year One (7/1/09 – 6/30/10)	13,148
Year Two (7/1/10 – 6/30/11)	16,475
Year Three (7/1/11 – 6/30/12)	20,008

Source: Exhibit 20, Figure 26.

The applicants assume 5.95 ER visits for each inpatient discharge, which they state is based on the experience at Presbyterian Hospital Matthews, Presbyterian Hospital Huntersville and Thomasville Medical Center. However, the applicants did not provide documentation to support their assumption that the proposed ER at FMC-K requires 14 treatment rooms in order to provide those visits. Moreover, since the projected number of ER visits is based on the projected number of inpatient discharges and the projected number of inpatient discharges is not reasonable, the projected number of ER visits is also not reasonable. See discussion above regarding acute care beds. Therefore, the applicants did not adequately demonstrate the need to develop 14 treatment rooms in the ER.

Laboratory – The applicants propose to develop a lab at FMC-K. The following table illustrates projected utilization of the lab at FMC-K during the first three operating years, as reported by the applicants in Exhibit 20, Figure 28.

	# OF LAB PROCEDURES		
	INPATIENT	OUTPATIENT AND ER	TOTAL
Year One (7/1/09 – 6/30/10)	37,358	37,571	74,929
Year Two (7/1/10 – 6/30/11)	46,812	47,079	93,891
Year Three (7/1/11 – 6/30/12)	56,850	57,175	114,025

Source: Exhibit 20, Figure 28.

The applicants assume that the lab at FMC-K will perform 16.9 procedures for every inpatient discharge and 1.28 procedures for every outpatient and ER visit based on the experience at Presbyterian Hospital Matthews, Presbyterian Hospital Huntersville and Thomasville Medical Center. However, since the projected number of lab procedures is based on the projected inpatient discharges and the projected inpatient discharges are not reasonable, the projected number of lab procedures is also not reasonable. See discussion above regarding acute care beds. Therefore, the applicants did not

adequately demonstrate the need for the projected number of lab procedures at FMC-K.

Pharmacy – The applicants propose to develop a pharmacy at FMC-K. The following table illustrates projected utilization of the pharmacy at FMC-K during the first three operating years, as reported by the applicants in Exhibit 20, Figure 28.

	# OF PHARMACY UNITS		
	INPATIENT	OUTPATIENT AND ER	TOTAL
Year One (7/1/09 – 6/30/10)	176,536	81,540	258,076
Year Two (7/1/10 – 6/30/11)	221,213	102,176	323,388
Year Three (7/1/11 – 6/30/12)	268,648	124,085	392,733

Source: Exhibit 20, Figure 28.

The applicants assume that the pharmacy at FMC-K will dispense 79.86 pharmacy units for every inpatient discharge and 2.77 pharmacy units for every outpatient and ER visit based on the experience at Presbyterian Hospital Matthews, Presbyterian Hospital Huntersville and Thomasville Medical Center. However, since the projected number of pharmacy units is based on the projected number of inpatient discharges and projected inpatient discharges are not reasonable, the projected number of pharmacy units is also not reasonable. See discussion above regarding acute care beds. Therefore, the applicants did not adequately demonstrate the need for the projected number of pharmacy units at FMC-K.

Cardiac Cath Equipment – The applicants propose to relocate one of FMC's eight existing and approved units of cardiac cath equipment from FMC-WS to FMC-K. In Section II.1, page II-3, the applicants state *"It is anticipated that the cath lab at FMC-Kernersville will be used for diagnostic cardiac catheterization procedures, as well as peripheral vascular procedures."* In Section II.1, page II-3, the applicants state that the unit to be relocated is the one authorized in Project I.D. #G-7266-05 (acquire eighth unit of cardiac cath equipment), which is not yet operational. The proposed new project results in the following changes to the previously approved project.

- The eighth unit of cardiac cath equipment will be located in Kernersville rather than in Winston-Salem with the other units of cardiac cath equipment.

- The eighth unit of cardiac cath equipment would not be used to perform therapeutic cardiac cath procedures at FMC-K. In Project I.D. #G-7266-05, the applicants proposed to perform therapeutic cardiac cath procedures on the eighth unit of cardiac cath equipment.
- The eighth unit of cardiac cath equipment will be used to perform peripheral vascular procedures at FMC-K. In Project I.D. #G-7266-05, the applicants did not propose to perform peripheral vascular procedures on the eighth unit of cardiac cath equipment.

In Section III.8, pages III-27 & 28 and III-30 & 31, the applicants state

> *"Locating this laboratory at the new hospital will improve the accessibility of services for residents of Forsyth County. The laboratory will be used only for diagnostic cardiac catheterizations and peripheral vascular procedures by appropriately credentialed cardiologists, vascular surgeons and interventional radiologists. ... No therapeutic cardiac catheterizations will be performed at FMC-Kernersville per the requirement stated in 10A NCAC 14C.1604(a).*
>
> *There are presently six cardiac catheterization laboratories in operation on the main FMC campus that are used for inpatient, outpatient, scheduled, emergency, diagnostic and therapeutic procedures. Often patients scheduled for diagnostic catheterization procedures can be delayed or bumped by other patients with more emergent needs. Dedicating a catheterization laboratory at Kernersville to diagnostic catheterization procedures and to peripheral vascular procedures will improve geographic accessibility for residents of the eastern portion of Forsyth County and will substantially eliminate delays in scheduled procedures due to bumping. The six laboratories at the main campus have adequate capacity to meet the needs of these other patients. ...*
>
> *Locating this laboratory at the main campus would require more expensive construction, would not improve geographic accessibility as much as locating the catheterization laboratory at FMC-Kernersville, and would*

not promote easier access to peripheral vascular procedures for the residents of Kernersville.

...

This application does not propose to relocate a cath lab that has already been constructed and equipped. The proposal is to relocate a previously CON-approved FMC cath lab from Winston-Salem to Kernersville, within Forsyth County. The lab will continue to be operated under the acute care hospital license of FMC, when it is in Kernersville. Many of the patients to be served by the laboratory should be essentially the same as shown in the prior application. FMC centrally schedules all of its cardiac catheterization laboratories. As part of the relocation of the laboratory, FMC is designating it for diagnostic cardiac catheterizations and peripheral vascular procedures to be performed by appropriately credentialed FMC medical staff members who are specialists in cardiology, interventional radiology, and vascular surgery procedures. It will thus draw patients who can be more conveniently provided these types of procedures at the FMC-Kernersville location."

Projected Cardiac Cath Utilization- Table A below illustrates projected utilization of the eight units of cardiac cath equipment as reported by the applicants in Section II.8, page 18, of Project I.D. #G-7266-05. All of the procedures in the following table were previously projected to be performed at FMC-WS.

TABLE A
PROJECTED CARDIAC CATH UTILIZATION FROM PROJECT I.D. #G-7266-05

	YEAR ONE 7/1/08 – 6/30/09	YEAR TWO 7/1/09 – 6/30/10	YEAR THREE 7/1/10 – 6/30/11
# of Diagnostic Cardiac Cath Procedures	6,031	6,110	6,189
# of Adult Therapeutic Cardiac Cath Procedures	2,334	2,362	2,393
Total # of Cardiac Cath Procedures	8,365	8,472	8,582
Total # of Diagnostic-Equivalent Cardiac Cath Procedures (1)	10,116	10,244	10,377
Average # of Diagnostic-Equivalent Procedures/Unit (8 units) (2)	1,265	1,281	1,297
Percent of capacity (3)	84.3%	85.4%	86.5%

Source: Section II.8, page 18, of Project I.D. #G-7266-05.

(1) Pursuant to 10A NCAC 14C .1601(2), *"One therapeutic cardiac catheterization procedure is valued at 1.75 diagnostic-equivalent procedures. One cardiac catheterization procedure performed on a patient age 14 or under is valued at two diagnostic-equivalent procedures. All other procedures are valued at one diagnostic-equivalent procedure."*

(2) Calculated by dividing the total number of diagnostic-equivalent cardiac cath procedures by eight.

(3) Pursuant to 10A NCAC 14C .1601(2), capacity of one unit of cardiac cath equipment is 1,500 diagnostic-equivalent procedures per year. Calculated by dividing the average number of diagnostic-equivalent procedures per unit by 1,500.

Table B below illustrates the previously projected number of procedures to be performed on the eighth unit of cardiac cath equipment in Winston-Salem, as reported by the applicants in Section II.8, page 26, of Project I.D. #G-7266-05.

TABLE B
PROJECTED UTILIZATION OF THE EIGHTH UNIT OF CARDIAC CATH EQUIPMENT IN WINSTON-SALEM FROM PROJECT I.D. #G-7266-05

	YEAR ONE 7/1/08 – 6/30/09	YEAR TWO 7/1/09 – 6/30/10	YEAR THREE 7/1/10 – 6/30/11
# of Diagnostic Cardiac Cath Procedures	754	764	774
# of Adult Therapeutic Cardiac Cath Procedures	292	296	300
Total # of Cardiac Cath Procedures	1,046	1,059	1,073
Total # of Diagnostic-Equivalent Cardiac Cath Procedures (1)	1,265	1,282	1,299
Percent of capacity (2)	84.3%	85.5%	86.5%

Source: Section II.8, page 26, of Project I.D. #G-7266-05.
(1) Pursuant to 10A NCAC 14C .1601(2), *"One therapeutic cardiac catheterization procedure is valued at 1.75 diagnostic-equivalent procedures. One cardiac catheterization procedure performed on a patient age 14 or under is valued at two diagnostic-equivalent procedures. All other procedures are valued at one diagnostic-equivalent procedure."*
(2) Pursuant to 10A NCAC 14C .1601(2), capacity of one unit of cardiac cath equipment is 1,500 diagnostic-equivalent procedures per year. Calculated by dividing the average number of diagnostic-equivalent procedures per unit by 1,500.

Table C below illustrates the projected number of peripheral vascular procedures to be performed at FMC-K and the projected number of cardiac cath procedures to be performed at FMC-WS and FMC-K during the first three operating years, as reported by the applicants in Exhibit 4, page 13, of this application.

TABLE C
PROJECTED CARDIAC CATH UTILIZATION FROM THIS APPLICATION (PROJECT I.D. #G-7604-06) (1)

	YEAR ONE 7/1/09 – 6/30/10	YEAR TWO 7/1/10 – 6/30/11	YEAR THREE 7/1/11 – 6/30/12
# of Peripheral Vascular Procedures at FMC-K	230	285	343
# of Diagnostic Cardiac Cath Procedures at FMC-K (1 unit)	284	326	370
# of Diagnostic Cardiac Cath Procedures at FMC-WS (7 units)	5,232	5,291	5,351
Total # of Diagnostic Cardiac Cath Procedures (8 units) (2)	5,520	5,622	5,726
# of Adult Therapeutic Cardiac Cath Procedures at FMC-WS	1,952	1,976	1,999
Total # of Cardiac Cath Procedures	7,471	7,596	7,724
Total # of Diagnostic-Equivalent Cardiac Cath Procedures (2) (3)	8,934	9,076	9,222
Average # of Diagnostic-Equivalent Procedures/Unit (8 units) (4)	1,117	1,135	1,153
% Capacity (5)	74.5%	75.7%	76.9%

Source: Exhibit 4, page 13.
(1) The applicants state that *"Some numbers may not add precisely to totals due to rounding in formulas."*
(2) Does not include the peripheral vascular procedures to be performed at FMC-K.
(3) Pursuant to 10A NCAC 14C .1601(2), *"One therapeutic cardiac catheterization procedure is valued at 1.75 diagnostic-equivalent procedures. One cardiac catheterization procedure performed on a patient age 14 or under is valued at two diagnostic-equivalent procedures. All other procedures are valued at one diagnostic-equivalent procedure."*
(4) Calculated by dividing the total number of diagnostic-equivalent cardiac cath procedures by eight.
(5) Pursuant to 10A NCAC 14C .1601(2), capacity of one unit of cardiac cath equipment is 1,500 diagnostic-equivalent procedures per year. Calculated by dividing the average number of diagnostic-equivalent procedures per unit by 1,500.

As shown in Tables A and C above, the applicants project that the eight units of cardiac cath equipment will perform fewer diagnostic-equivalent procedures in each of the first three operating years at FMC-K than at FMC-WS. This projected reduction in the number of procedures to be performed is despite the fact that the unit at FMC-K will begin operation one year later than proposed in Project I.D. #G-7266-05. The applicants do not explain in this application why they now assume they will perform fewer cardiac cath procedures. Further, as shown in Tables B and C above, taken from Project I.D. #G-7266-05, the applicants previously projected that the eighth unit of cardiac cath equipment would perform 1,297 diagnostic-equivalent cardiac cath procedures in the third operating year, which is 86.5% of capacity. However, in this application, the eighth unit of cardiac cath equipment is projected to perform only 370 diagnostic-equivalent cardiac cath procedures in the third operating year or 24.7% of capacity [370 / 1,500 = 0.247], which is less than the required minimum of 60% of capacity. Therefore, the applicants do not adequately demonstrate the need for cardiac cath equipment at FMC-K.

In Exhibit 4, pages 6-7, the applicants provide the assumptions and methodology used to project utilization of the cardiac cath equipment, where they state

> *"1. Estimate July 2005 – June 2006 FMC cardiac catheterization utilization by annualizing nine month* [sic] *of data from July 2005 – March 2006. ...*
> *2. Increase volume using population growth rate for cardiac cath service area weighted by patient origin. ...*
> *3. Increase to reflect positive impact of location in Kernersville. ...*
> *4. Calculate ICD-9 Code for cardiac cath volumes based on historical 2005 utilization at FMC."*

Regarding #3 above, the table following this sentence in the application shows that the applicants assume a 5% increase in FMC's market share for cardiac cath procedures due to providing services in Kernersville. The applicants provide the assumptions and methodology used to project utilization for all eight units of cardiac cath equipment combined. However, they did not provide the assumptions or the methodology used to project the number of

peripheral vascular and cardiac cath procedures to be performed at FMC-K. Therefore, the applicants did not adequately demonstrate that projected utilization of the cardiac cath equipment to be located at FMC-K is based on reasonable assumptions.

CT Scanner – The applicants propose to acquire a CT scanner to be located at FMC-K for a total of five CT scanners on FMC's license (there are four existing CT scanners located at FMC-WS). The following table illustrates the projected number of CT scans to be performed on the proposed CT scanner at FMC-K during the first three operating years, as reported by the applicants in Exhibit 20, Figure 26, and Exhibit 7, pages 3-6.

	# OF CT SCANS (not HECT Units)		
	INPATIENT	OUTPATIENT AND ER	TOTAL
Year One (7/1/09 – 6/30/10)	1,527	6,943	8,469
Year Two (7/1/10 – 6/30/11)	1,913	8,700	10,613
Year Three (7/1/11 – 6/30/12)	2,323	10,565	12,888

Source: Exhibit 20, Figure 26, and Exhibit 7, pages 3-6.

The applicants assume that the CT scanner at FMC-K will perform 0.69 CT scans for every inpatient discharge and 0.43 CT scans for every outpatient and ER visit based on the experience at Presbyterian Hospital Matthews, Presbyterian Hospital Huntersville and Thomasville Medical Center. However, since the projected number of CT scans to be performed at FMC-K is based on the projected number of inpatient discharges and projected inpatient discharges are not reasonable, the projected number of CT scans to be performed at FMC-K is also not reasonable. See discussion above regarding acute care beds. Moreover, the applicants did not adequately demonstrate conformance with all the required rules for acquisition of a CT scanner in 10A NCAC 14C .2303. See 10A NCAC 14C .2303 for discussion. Therefore, the applicants did not adequately demonstrate the need for the CT services proposed to be provided at the proposed FMC-K campus.

Ultrasound (US) – In Section II.1, page II-3, the applicants state that FMC-K will have one US unit. However, according to the list of equipment to be acquired provided in Exhibit 18, the applicants propose to acquire one cardiac US unit, one *"Imaging, Handheld"* US unit and two *"Therapeutic, Genera* [sic]*"* US units for a total of four units of US equipment. The following table illustrates projected US utilization at FMC-K during the first three operating

years, as reported by the applicants in Exhibit 20, Figure 28. However, the applicants did not adequately demonstrate if the following projections represent utilization for all four proposed units.

	# OF US PROCEDURES		
	INPATIENT	OUTPATIENT AND ER	TOTAL
Year One (7/1/09 – 6/30/10)	345	2,088	2,434
Year Two (7/1/10 – 6/30/11)	433	2,617	3,050
Year Three (7/1/11 – 6/30/12)	526	3,178	3,704

Source: Exhibit 20, Figure 28.

The applicants assume the US equipment at FMC-K will perform 0.16 procedures for every inpatient discharge and 0.07 procedures for every outpatient and ER visit based on the experience at Presbyterian Hospital Matthews, Presbyterian Hospital Huntersville and Thomasville Medical Center. However, since the projected number of US procedures is based on the projected number of inpatient discharges and projected inpatient discharges are not reasonable, the projected number of US procedures is also not reasonable. See discussion above regarding acute care beds. Therefore, the applicants did not adequately demonstrate the need to acquire four units of US equipment for the proposed FMC-K campus.

Nuclear Medicine Camera – The applicants propose to acquire one nuclear medicine camera (without coincidence circuitry) to be located at FMC-K. The following table illustrates the projected number of procedures to be performed on the proposed nuclear medicine camera at FMC-K during the first three operating years, as reported by the applicants in Exhibit 20, Figure 26.

	# OF NUCLEAR MEDICINE CAMERA PROCEDURES		
	INPATIENT	OUTPATIENT AND ER	TOTAL
Year One (7/1/09 – 6/30/10)	458	1,485	1,943
Year Two (7/1/10 – 6/30/11)	573	1,861	2,434
Year Three (7/1/11 – 6/30/12)	696	2,260	2,956

Source: Exhibit 20, Figure 26.

The applicants assume that the nuclear medicine camera at FMC-K will perform 0.21 procedures for every inpatient discharge and 0.09 procedures for every outpatient and ER visit based on the experience at Presbyterian Hospital Matthews, Presbyterian Hospital Huntersville and Thomasville Medical Center. However, since the projected number of nuclear medicine camera procedures to be

performed at FMC-K is based on the projected number of inpatient discharges and projected inpatient discharges are not reasonable, the projected number of nuclear medicine camera procedures to be performed at FMC-K is also not reasonable. See discussion above regarding acute care beds. Therefore, the applicants did not adequately demonstrate the need to acquire a nuclear medicine camera (without coincidence circuitry) for the proposed FMC-K campus.

Mammography Unit – The applicants propose to acquire one mammography unit to be located at FMC-K. The following table illustrates the projected number of procedures to be performed on the proposed mammography unit at FMC-K during the first three operating years, as reported by the applicants in Exhibit 20, Figure 26.

	# of Mammography Procedures		
	Inpatient	Outpatient and ER	Total
Year One (7/1/09 – 6/30/10)	2	2,736	2,738
Year Two (7/1/10 – 6/30/11)	2	3,428	3,431
Year Three (7/1/11 – 6/30/12)	3	4,163	4,166

Source: Exhibit 20, Figure 26.

The applicants assume that the mammography unit at FMC-K will perform 0.09 procedures for every inpatient discharge and 0.17 procedures for every outpatient and ER visit based on the experience at Presbyterian Hospital Matthews, Presbyterian Hospital Huntersville and Thomasville Medical Center. However, since the projected number of mammography procedures to be performed at FMC-K is based on the projected number of inpatient discharges and projected inpatient discharges are not reasonable, the projected number of mammography procedures to be performed at FMC-K is also not based reasonable. See discussion above regarding acute care beds. Therefore, the applicants did not adequately demonstrate the need to acquire a mammography unit for the proposed FMC-K campus.

X-ray Equipment – In Section II.1, page II-3, the applicants state that they will acquire one x-ray unit and one x-ray/fluoroscopy unit for FMC-K. However, according to the list of equipment to be acquired provided in Exhibit 18, the applicants also propose to acquire three mobile C-arms and two mobile X-ray units. The following table illustrates projected utilization of *"Other Imaging"*

equipment[6] at FMC-K during the first three operating years, as reported by the applicants in Exhibit 20, Figure 26. However, the applicants did not adequately demonstrate if the following projections represent utilization for all seven proposed units.

	# OF X-RAY PROCEDURES		
	INPATIENT	OUTPATIENT AND ER	TOTAL
Year One (7/1/09 – 6/30/10)	3,574	12,942	16,516
Year Two (7/1/10 – 6/30/11)	4,478	16,218	20,696
Year Three (7/1/11 – 6/30/12)	5,438	19,695	25,133

Source: Exhibit 20, Figure 26.

The applicants assume that the x-ray equipment at FMC-K will perform 1.62 procedures for every inpatient discharge and 0.79 procedures for every outpatient and ER visit based on the experience at Presbyterian Hospital Matthews, Presbyterian Hospital Huntersville and Thomasville Medical Center. However, since the projected number of x-ray procedures is based on the projected number of inpatient discharges and projected inpatient discharges are not reasonable, the projected number of x-ray procedures is also not reasonable. See discussion above regarding acute care beds. Therefore, the applicants did not adequately demonstrate the need to acquire the proposed x-ray equipment for the proposed FMC-K campus.

Other Equipment – Based on the list of equipment to be acquired provided in Exhibit 18 and the design schematic provided in Exhibit 15, the applicants also propose to acquire the following equipment:

- 2 stress testing systems with treadmill
- echocardiography equipment (quantity not provided)
- 1 electroencephalograph (EEG) unit p.3
- 3 electrocardiograph (ECG) units p.3
- 1 pulmonary function testing system

However, the applicants did not provide any discussion of the need for this equipment. Therefore, the applicants did not adequately demonstrate the need to acquire the equipment listed above for the proposed FMC-K campus.

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[6] The Project Analyst assumes that *"Other Imaging"* equipment means the x-ray equipment since projected utilization is provided separately for the nuclear medicine camera, the mammography equipment, US and the CT scanner.

In summary, the applicants adequately identified the population proposed to be served. However, they did not adequately demonstrate the need for all proposed services. Therefore, the application is nonconforming with this criterion.

(3a) In the case of a reduction or elimination of a service, including the relocation of a facility or a service, the applicant shall demonstrate that the needs of the population presently served will be met adequately by the proposed relocation or by alternative arrangements, and the effect of the reduction, elimination or relocation of the service on the ability of low income persons, racial and ethnic minorities, women, handicapped persons, and other underserved groups and the elderly to obtain needed health care.

NC

The applicants propose to relocate the following beds and services from Winston-Salem to Kernersville:

- 11 existing acute care beds
- 1 existing shared OR (3 shared ORs were previously approved to be relocated to Kernersville)
- 1 unit of cardiac cath equipment

Acute Care Beds – In Section III.8, page III-31, the applicants state

"This CON proposes to relocate eleven existing licensed beds (seven acute inpatient beds; four ICU beds) from the FMC campus in Winston-Salem to FMC-Kernersville. In doing so, the needs of the patients remaining at the existing facility (FMC in Winston-Salem) will be adequately met with the remaining beds. ... Due to patient relocation to FMC-Kernersville, FMC will have more resources to devote to its acute and ICU patients. The relocation will also help alleviate overcrowding on the FMC campus. See, e.g., Exhibit 12 for a letter from Gregory J. Beier, FMC's President, documenting this point."

The following table illustrates projected utilization of the acute care beds at FMC-WS (including NICU beds), as reported by the applicants in Exhibit 5, page 4.

	Year One 7/1/09 – 6/30/10	Year Two 7/1/10 – 6/30/11	Year Three 7/1/11 – 6/30/12
Total Acute Care Beds			
Patient Days	213,810	215,902	218,017
ADC [1]	586	592	597
# of Beds (including NICU)	740	740	740
% Occupancy [2]	79.2%	80.0%	80.7%

(1) ADC was calculated by dividing the number of patient days by 365.
(2) % occupancy was calculated by dividing the ADC by the number of acute care beds.

As shown in the above table, the applicants project that the ADC at FMC-WS would be 597 acute care patients (including NICU patients) during the third operating year, which is an occupancy rate of 80.7%. According to its 2006 Hospital License Renewal Application, during FY 2005, FMC provided a total of 206,071 acute patient days of care (including NICU patients), which was an ADC of 565 [206,071 / 365 = 564.6] and an occupancy rate of 88.7% [ADC of 565 divided by 637 licensed acute care beds = 0.887]. The applicants adequately demonstrate that 740 acute care beds would be sufficient to meet the needs of the patients utilizing FMC-WS.

Shared Operating Rooms – In Section III.8, page 27, the applicants state

> *"The new hospital will have four operating rooms. One operating room will be relocated from Medical Park Hospital (MPH). The other three operating rooms were previously CON-approved for relocation to Kernersville as part of an ambulatory surgery center to be operated under the license of and as a department of FMC. ... Neither the relocation from FMC nor MPH is expected to negatively impact those facilities. In fact, as the Agency will recall, in Project I.D. # G-7311-05, FMC was already approved to relocate three of those ORs to Kernersville. FMC proposes to relocate the three exact same ORs from FMC in this project, along with one OR from MPH."*

The certificate of need for Project I.D. #G-7311-05 authorizes the applicants to reduce the number of shared ORs at FMC-WS by three. The proposed project does not affect the previous determination regarding relocation of three existing shared ORs from FMC-WS.

Regarding the impact on MPH of relocating one of the 13 shared ORs to FMC-K, in Section III.8, page III-32, the applicants provide the following projected utilization for the 12 shared ORs remaining at MPH during the first three operating years of FMC-K.

	Projected # of Surgical Procedures to be Performed at MPH	Average # of Procedures per Day per Shared OR (1)
Year One (7/1/09 to 6/30/10)	11,132	3.6
Year Two (7/1/10 to 6/30/11)	11,077	3.6
Year Three (7/1/11 to 6/30/12)	11,012	3.5

Source: Section III.8, page III-32.
(1) Calculated by dividing the total number of surgical procedures by 260 days per year and then dividing by 12.

As shown in the table above, the applicants project that the number of surgical procedures to be performed at MPH will decrease each year through the third operating year at FMC-K. According to its 2006 Hospital License Renewal Application, during FY 2005, a total of 11,674 surgical procedures were performed in the 13 shared ORs at MPH, which is an average of 3.5 procedures per room per day per OR [11,674 / 260 / 13 = 3.5]. Therefore, utilization of the ORs at MPH currently exceeds the minimum threshold of 3.2 procedures per room per day, indicating that all 13 rooms are well utilized at their present location. Regardless, the applicants project surgical utilization at MPH will decrease. However, the applicants do not provide the methodology and assumptions that were used to project decreasing surgical utilization at MPH. Further, the applicants do not state in the application their reasons for projecting that surgical utilization at MPH will decrease. Therefore, the applicants did not demonstrate that 12 shared ORs would be sufficient to meet the needs of the patients that will continue to utilize MPH for surgical services.

Cardiac Cath Equipment – In Section III.8, page III-33, the applicants state

> *"The main campus currently has six cardiac catheterization laboratories in operation. In addition to the CON-approved laboratory (# 8) that will be implemented at Kernersville, FMC has one other (# 7) CON-approved laboratory that has not yet been implemented; this catheterization laboratory (CCL #7 – Project I.D. # G-6990-04) is scheduled to be developed.*

Therefore, there is ample existing and approved cardiac catheterization laboratory capacity remaining for the main campus. ...

Moreover, in Section III.8, page III-35, the applicants state

"The implementation of the cardiac catheterization laboratory at FMC-Kernersville does not represent a reduction in existing capacity at the main campus. There will still be six operating cardiac catheterization laboratories and one approved but not operational laboratories at the main campus. The laboratories are centrally scheduled, including the one at Kernersville."

However, this proposal does reduce the total number of existing and approved units of cardiac cath equipment at FMC-WS. The applicants previously demonstrated the need for a total of eight units of cardiac cath equipment at FMC-WS and were approved to acquire additional units based on that demonstration of need. If this proposal were approved, there would be only seven units of cardiac cath equipment located at FMC-WS. Thus, this proposal represents a reduction in services needed by the population served at FMC-WS.

Further, in Section III.8, page 30, the applicants state *"Many of the patients to be served by the laboratory should be essentially the same as shown in the prior application."* In Section II.8, page 26, of Project I.D. #G-7266-05, the applicants projected that the eighth unit of cardiac cath equipment would perform 774 diagnostic and 300 therapeutic cardiac cath procedures in the third operating year, which is a total of 1,073 cardiac cath procedures. However, in Exhibit 4, pages 13 and 17, of this application, the applicants project that 370 diagnostic and 0 therapeutic cardiac cath procedures will be performed on the eighth unit of cardiac cath equipment at FMC-K. Thus, only 34.5% of the patients projected to be served by the eighth unit of cardiac cath equipment in Project I.D. #G-7266-05 are now projected to have the procedure performed at FMC-K [370 / 1,073 = 0.345].

In summary, the applicants failed to provide sufficient information to demonstrate that seven units of cardiac cath equipment at FMC-WS would be sufficient capacity for the patients who will continue to utilize FMC-WS for cardiac cath services.

In summary, the applicants did not adequately demonstrate that the needs of the population presently served would be adequately met following the proposed relocation of beds and services to Kernersville. Therefore, the application is nonconforming with this criterion.

(4) Where alternative methods of meeting the needs for the proposed project exist, the applicant shall demonstrate that the least costly or most effective alternative has been proposed.

NC

In Section II.5, pages II-8 through II-10, the applicants discussed several alternatives they considered prior to submission of this application. However, the application is not conforming to all applicable statutory and regulatory review criteria. See Criteria (3), (3a), (5), (6), (13c) and the Criteria and Standards for Computed Tomography Equipment promulgated in 10A NCAC 14C .2300. Therefore, the applicants did not adequately demonstrate that their proposal is an effective alternative and the application is nonconforming with this criterion.

(5) Financial and operational projections for the project shall demonstrate the availability of funds for capital and operating needs as well as the immediate and long-term financial feasibility of the proposal, based upon reasonable projections of the costs of and charges for providing health services by the person proposing the service.

NC

In Section VIII.1, page VIII-2, the applicants project that the total capital cost of the project will be $84,893,635, as illustrated below.

Site Costs		
Purchase Price of the Land	$2,925,000	
Site Preparation Costs	$3,060,883	
Subtotal Site Costs		$5,985,883
Construction Costs		
Construction Contract	$52,597,600	
Contingency	$500,000	
Subtotal Construction Costs		$53,097,600
Miscellaneous Costs		
Equipment	$16,214,174	
Furniture	$1,000,000	
Architect & Engineering Fees	$2,807,924	
Other Consultants	$250,000	
Interest during Construction [7]	$2,726,187	
Contingency	$2,811,867	
Subtotal Miscellaneous Costs		$25,810,152
Total Capital Cost		$84,893,635

In Section IX, page IX-1, the applicants also project that start up and initial operating expenses will be $8,775,555. In Section VIII.3, page VIII-3, and Section IX, page IX-1, the applicants state that the capital and working capital needs of the project will be financed with the accumulated reserves of Novant. Exhibit 9 contains a letter signed by the Chief Financial Officer for Novant, which states

> *"As the Chief Financial Officer for Novant Health, Inc., I have authority to obligate funds from accumulated reserves of Novant Health for projects undertaken by Forsyth Medical Center (FMC). Novant Health, Inc. is the not-for-profit parent company of FMC. I am familiar with the CON Application where FMC proposes to construct a new 50-bed acute care hospital in Kernersville, NC. I can and will commit Novant's reserves to cover all of the capital costs associated with this project, including the project capital cost (of approximately $85 Million) working capital, and start-up costs. Please see the line items in the Novant Health CY 2005 audited financial statements entitled 'Cash and Short-Term Equivalents,' 'Net Patient Services Accounts Receivable,' 'Other Current Assets,' and 'Long-Term Investments.' These balance sheet amounts are available to fund the proposed project. Novant Health,*

[7] The applicants project "Interest during Construction" in the event they choose to pursue bond financing.

Inc. also had a Total Assets balance of $2.2 Billion at the end of CY 2005.

In addition, FMC reserves the right to consider in the future funding of all or a portion of this project using bond proceeds. FMC financial staff will make this determination based on market and economic conditions at the time the capital is required. A letter from Citigroup Global Markets, Inc. indicating the appropriateness of this project for tax-exempt bond financing is also included as an Exhibit with our CON application.

Novant Health also has sufficient cash to cover the working capital needs for the proposed new hospital project in the amount specified in section IX of the CON application. Please see the Current Assets section of the Novant Health Balance sheet contained in Novant Health's 2005 audited financial statements, which are included as an exhibit with our CON application.

I confirm to you that Novant has now and will have available the funds from reserves for the project. This will not impact Novant's ability to finance CON projects that are approved and not yet operational or currently under CON review."

Exhibit 9 also contains a letter signed by the Managing Director of Citigroup Global Markets, Inc., which states

"You have advised Citigroup Global Markets Inc. ('Citigroup') that Novant Health ('Novant') may finance the above-referenced Project from cash and accumulated reserves, through tax-exempt bond financing (the 'Bond Issue'), or through some combination thereof depending on market conditions at the time funding is required. The borrower would be Novant, a 501(c)(3) private not-for-profit corporation. The debt would be issued under the Novant Master Trust Indenture through the North Carolina Medical Care Commission. We understand that Forsyth Medical Center and Novant will be applying for a Certificate of Need ('CON') on May 15, 2006. The CON will be for a new 50-bed Hospital with an Emergency Department, Operating Rooms, Imaging, Laboratory,

Pharmacy and Cardiac Catheterization Lab. It is our understanding that the total cost of the project is estimated to be $90-105 million. For purposes of this letter, 'Citigroup' shall include Citigroup Global Markets Inc. and/or any affiliate thereof.

...

Based upon your financial strength, Citigroup would expect to offer a publicly sold tax-exempt bond issue that would either be insured or issued with Novant's stand-alone ratings. We believe that this funding would result in an investment grade rating for the financing."

Exhibit 9 includes the audited financial statements for Novant. As of December 31, 2005, Novant had $207,586,000 in cash and cash equivalents, $25,000,000 in short-term investments, $651,166,000 in long-term investments, $2,252,656,000 in total assets, and $1,268,873,000 in total net assets (total assets less total liabilities). The applicants adequately demonstrate the availability of sufficient funds for the capital and working capital needs of the project.

In the projected revenue and expense statement, the applicants project that revenues will exceed operating costs at FMC-K in each of the first three years of operation. The assumptions used by the applicants in preparation of the pro formas are in the Financials Tab of the application. However, the applicants' utilization projections for FMC-K are unsupported and unreliable. Consequently, costs and revenues that are based on this projected utilization are also not reliable. See Criterion (3) for discussion of projected utilization. Therefore, the applicants did not adequately demonstrate that the financial feasibility of the proposal is based upon reasonable projections of costs and revenues. Consequently, the application is nonconforming with this criterion.

(6) The applicant shall demonstrate that the proposed project will not result in unnecessary duplication of existing or approved health service capabilities or facilities.

NC

Novant and FMC propose to establish an additional campus of FMC in Kernersville for the provision of the following services:

- 46 general med/surg acute care beds (39 new and 7 existing to be relocated from FMC-WS)
- 4 ICU beds (4 existing to be relocated from FMC-WS)
- 10 unlicensed observation beds
- 4 shared ORs (3 existing shared ORs to be relocated from FMC-WS and 1 existing shared OR to be relocated from MPH)
- a 24 hour ER, with 14 treatment rooms
- lab services, including phlebotomy, blood bank, pathology, chemistry, hematology coagulation, micro urinalysis and accessioning
- pharmacy
- 1 cardiac cath unit (to be relocated from FMC-WS)
- 1 new CT scanner
- 1 new x-ray unit
- 1 new x-ray/fluoroscopy unit
- 3 mobile C-arms
- 2 mobile x-ray units
- 1 new nuclear medicine camera (without coincidence circuitry)
- 1 new mammography unit
- 1 new *"Cardiac"* US unit
- 1 new *"Imaging, Handheld"* US unit
- 2 new *"Therapeutic, Genera"* [sic] US units
- 2 stress testing systems with treadmill
- echocardiography equipment (quantity not provided)
- 1 EEG unit
- 3 ECG units
- 1 pulmonary function testing system

However, the applicants did not adequately demonstrate the need for all of the services they propose to provide in Kernersville. See Criterion (3) for discussion. Therefore, the applicants did not adequately demonstrate that the proposal would not result in the unnecessary duplication of existing or approved health service capabilities or facilities. Consequently, the application is nonconforming with this criterion.

(7) The applicant shall show evidence of the availability of resources, including health manpower and management personnel, for the provision of the services proposed to be provided.

C

In Section VII.2, pages VII-1 through VII-4, the applicants provide the projected staffing for FMC-K for the first three operating years. The applicants project to employ a total of 303.9 full-time equivalent (FTE) positions in Year One, 334.9 FTE positions in Year Two and 370.0 FTE positions in Year Three. The applicants propose 8.0 FTE management positions in the first three operating years. In Section VII.3, page VII-6, the applicants state

> *"It is anticipated that FMC-Kernersville staff will be new hires, except for those existing FMC personnel who may choose to apply for the Kernersville positions when the jobs are posted. ... FMC will use its regional human resources personnel to recruit the needed personnel for the proposed new hospital located in Kernersville. ... Based on past experience FMC's COO, CNO, ED Director, Cath Lab Director, Radiology Director, Pharmacy Director, and Surgical Services Vice President do not foresee any major difficulty or significant challenges in recruiting needed personnel for the new hospital, FMC-Kernersville. In fact, during the past two years, FMC has had more new graduate applications than FMC has had positions to offer them."*

In Exhibits 4, 5, 6, 7, 8, 11 and 19, the applicants provide letters from physicians who have agreed to act as medical directors for FMC-K. See also Section II.3, pages II-6 through II-7. In Section VII.6, page VII-11, the applicants state

> *"The support staff ... at FMC-Kernersville will report to management at FMC-Kernersville and will also coordinate with their respective departments at FMC in Winston-Salem to ensure consistency and quality. Other corporate support functions will be provided directly to FMC-Kernersville by FMC in Winston-Salem or by existing NHTR regional corporate resources. Costs for these support services will be charged to FMC-Kernersville as part of administrative overhead expense and are reflected in the pro forma income statements for FMC-Kernersville. These services will include but not be limited to: finance functions such as billing, collections, payroll, accounts payable, general ledger, budget, and financial reporting; education and training; information technology services;*

marketing and public relations; strategic and business planning; legal affairs; materials management and purchasing; risk management; infection control; medical staff affairs and credentialing."

In the pro formas, the applicants project adequate operating expenses for the proposed staffing for the first three operating years. The applicants demonstrate the availability of adequate health manpower and management personnel for the provision of the proposed services. Therefore, the application is conforming to this criterion.

(8) The applicant shall demonstrate that the provider of the proposed services will make available, or otherwise make arrangements for, the provision of the necessary ancillary and support services. The applicant shall also demonstrate that the proposed service will be coordinated with the existing health care system.

C

In Section IV.5, page IV-12; Section II.1, pages II-1 through II-4; and Section II.3, pages II-6 through II-7, the applicants describe the ancillary and support services that will be provided at FMC-K and the services available from FMC-WS or Novant. Exhibit 10 contains a transfer agreement between FMC-WS and FMC-K. Exhibit 10 also contains a list of the facilities with which FMC currently has transfer agreements and a sample agreement. Exhibit 11 contains letters from area physicians supporting the proposal to establish a new site for provision of acute inpatient services in Kernersville. The applicants adequately demonstrated that the necessary ancillary and support services would be available and that the proposed services would be coordinated with the existing health care system. Therefore, the application is conforming to this criterion.

(9) An applicant proposing to provide a substantial portion of the project's services to individuals not residing in the health service area in which the project is located, or in adjacent health service areas, shall document the special needs and circumstances that warrant service to these individuals.

NA

(10) When applicable, the applicant shall show that the special needs of health maintenance organizations will be fulfilled by the project. Specifically, the applicant shall show that the project accommodates:

(a) The needs of enrolled members and reasonably anticipated new members of the HMO for the health service to be provided by the organization; and

NA

(b) The availability of new health services from non-HMO providers or other HMOs in a reasonable and cost-effective manner which is consistent with the basic method of operation of the HMO. In assessing the availability of these health services from these providers, the applicant shall consider only whether the services from these providers:

(i) would be available under a contract of at least 5 years duration;

(ii) would be available and conveniently accessible through physicians and other health professionals associated with the HMO;

(iii) would cost no more than if the services were provided by the HMO; and

(iv) would be available in a manner which is administratively feasible to the HMO.

NA

(11) Repealed effective July 1, 1987.

(12) Applications involving construction shall demonstrate that the cost, design, and means of construction proposed represent the most reasonable alternative, and that the construction project will not unduly increase the costs of providing health services by the person proposing the construction project or the costs and charges to the public of providing health services by other persons, and that applicable energy saving features have been incorporated into the construction plans.

C

The applicants propose to construct 194,994 square feet of new space to establish a new campus of FMC in Kernersville. In Exhibit 16, the architect certifies that the site preparation and construction costs are projected to be $56,158,483. In Section XI.7, page XI-7, the applicants state that applicable energy savings features will be incorporated into the construction plans. The applicants adequately demonstrated that the cost, design and means

of construction represent the most reasonable alternative, and that the construction cost will not unduly increase costs and charges for health services. See Criterion (5) for discussion of costs and charges. The application is conforming to this criterion.

(13) The applicant shall demonstrate the contribution of the proposed service in meeting the health-related needs of the elderly and of members of medically underserved groups, such as medically indigent or low income persons, Medicaid and Medicare recipients, racial and ethnic minorities, women, and handicapped persons, which have traditionally experienced difficulties in obtaining equal access to the proposed services, particularly those needs identified in the State Health Plan as deserving of priority. For the purpose of determining the extent to which the proposed service will be accessible, the applicant shall show:

(a) The extent to which medically underserved populations currently use the applicant's existing services in comparison to the percentage of the population in the applicant's service area which is medically underserved;

C

The following table illustrates the current payor mix for all services provided at FMC during CY 2005, as reported in Section VI.10, page VI-8.

PAYOR CATEGORY	% OF TOTAL PATIENT DAYS / PROCEDURES
Self Pay / Indigent / Charity	12.25%
Medicare	30.19%
Medicaid	16.12%
Commercial Insurance & Managed Care	17.37%
BCBS of NC	18.64%
State Employees Health Plan	2.79%
Other (other Government & Workers Comp.)	2.64%
TOTAL	100.00%

The applicants demonstrated that medically underserved populations currently have adequate access to the services provided at FMC. Therefore, the application is conforming to this criterion.

(b) Its past performance in meeting its obligation, if any, under any applicable regulations requiring provision of uncompensated care, community service, or access by minorities and handicapped persons to programs receiving

federal assistance, including the existence of any civil rights access complaints against the applicant;

C

An examination of the licensure and certification files in the Division of Facility Services for FMC indicates there have been no civil rights access complaints filed against the hospital within the last five years.

(c) That the elderly and the medically underserved groups identified in this subdivision will be served by the applicant's proposed services and the extent to which each of these groups is expected to utilize the proposed services; and

NC

The following table illustrates the projected payor mix for all of the services to be provided at FMC-K during Year Two, as reported in Section VI.12, page VI-11, and the current payor mix for all services provided at FMC during CY 2005, as reported in Section VI.10, page VI-8.

PAYOR CATEGORY	% OF TOTAL PATIENT DAYS / PROCEDURES	
	FMC-K YEAR TWO (PROJECTED)	FMC CY 2005 (ACTUAL)
Self Pay / Indigent / Charity	4.19%	12.25%
Medicare	45.13%	30.19%
Medicaid	4.69%	16.12%
Commercial Insurance & Managed Care	18.75%	17.37%
BCBS of NC	22.87%	18.64%
State Employees Health Plan	2.58%	2.79%
Other (other Government & Workers Comp.)	1.79%	2.64%
TOTAL	100.00%	100.00%

As shown in the above table, the applicants project a significantly different payor mix for FMC-K compared to the actual payor mix for FMC during CY 2005. Specifically, 16.12% of the patients served at FMC during CY 2005 were Medicaid recipients. However, the applicants project that only 4.69% of the patients to be served at FMC-K during Year Two would be Medicaid recipients, which is 71% lower [16.12% – 4.69% = 11.43%; 11.43% / 16.12% = 0.71].

Medicaid recipients are one of the underserved groups identified in the CON law. Further, 12.25% of the patients served at FMC during CY 2005 were classified as self pay/indigent/charity care. However, the applicants project that only 4.19% of the patients to be served at FMC-K would be classified as self pay/indigent/charity care, which is 65.8% lower [12.25% - 4.19% = 8.06%; 8.06% / 12.25% = 0.658]. Patients classified as self pay/indigent/charity care are also underserved groups.

The applicants provide the projected payor mix for the proposed FMC-K, but failed to provide the assumptions on which the FMC-K payor mix is based. Given that the projected FMC-K payor mix significantly differs from the current payor mix for FMC, the applicants did not demonstrate that Medicaid and self pay/indigent/charity care patients would have adequate access to the proposed services offered at FMC-K. Consequently, the application is nonconforming to this criterion.

(d) That the applicant offers a range of means by which a person will have access to its services. Examples of a range of means are outpatient services, admission by house staff, and admission by personal physicians.

C

See Section VI.7 and referenced exhibits, for documentation of the range of means by which patients would have access to the services to be provided at FMC-K. The information provided is reasonable and credible and supports a finding of conformity with this criterion.

(14) The applicant shall demonstrate that the proposed health services accommodate the clinical needs of health professional training programs in the area, as applicable.

C

See Section V.1 and referenced exhibits for documentation that FMC currently accommodates the clinical needs of health professional training programs in the area and that FMC-K will do the same. The information provided is reasonable and credible and supports a finding of conformity with this criterion.

(15) Repealed effective July 1, 1987.

(16) Repealed effective July 1, 1987.

(17) Repealed effective July 1, 1987.

(18) Repealed effective July 1, 1987.

(18a) The applicant shall demonstrate the expected effects of the proposed services on competition in the proposed service area, including how any enhanced competition will have a positive impact upon the cost effectiveness, quality, and access to the services proposed; and in the case of applications for services where competition between providers will not have a favorable impact on cost-effectiveness, quality, and access to the services proposed, the applicant shall demonstrate that its application is for a service on which competition will not have a favorable impact.

NC

The applicants did not adequately demonstrate that the proposal would have a positive impact upon the cost effectiveness and access to the proposed services. See Criteria (3), (3a), (5), and (13c). Therefore, the application is not conforming to this criterion.

(19) Repealed effective July 1, 1987.

(20) An applicant already involved in the provision of health services shall provide evidence that quality care has been provided in the past.

C

FMC and MPH are accredited by the Joint Commission of Accreditation of Health Care Organizations and certified for Medicare and Medicaid participation. According to the files in the Acute and Home Care Licensure and Certification Section, DFS, no incidents occurred, within the eighteen months immediately preceding the date of this decision, for which any sanctions or penalties related to quality of care were imposed by the State on either hospital. Therefore, the application is conforming to this criterion.

(21) Repealed effective July 1, 1987.

(b) The Department is authorized to adopt rules for the review of particular types of applications that will be used in addition to those criteria outlined in subsection (a) of this section and may vary according to the purpose for which a particular review is being conducted or the type of health service reviewed. No such rule adopted by the Department shall require an academic medical center teaching hospital, as defined by the State Medical Facilities Plan, to demonstrate that any facility or service at another hospital is being appropriately utilized in order for that academic medical center teaching hospital to be approved for the issuance of a certificate of need to develop any similar facility or service.

NC

The application is conforming to all applicable Criteria and Standards for Acute Care Beds, as promulgated in 10A NCAC 14C .3800. However, the application is not conforming to all applicable Criteria and Standards for Computed Tomography Equipment, as promulgated in 10A NCAC 14C .2300. The specific criteria are discussed below.

The applicants do not propose to acquire any major medical equipment, as defined in N.C. Gen. Stat. §131E-176(14f), other than the CT scanner. Therefore, the Criteria and Standards for Major Medical Equipment promulgated in 10A NCAC 14C .3100 are not applicable to this review. In addition, the applicants do not propose to increase the total number of ICU beds for which FMC would be licensed. Therefore, the Criteria and Standards for Intensive Care Services promulgated in 10A NCAC 14C .1200 are not applicable to this review. Further, the applicants do not propose to increase the number of operating rooms for which FMC would be licensed. Therefore, the Criteria and Standards for Surgical Services and Operation Rooms promulgated in 10A NCAC 14C .2100 are not applicable to this review. Moreover, the applicants do not propose to increase the total number of cardiac cath units for which FMC would be licensed. Therefore, the Criteria and Standards for Cardiac Catheterization Equipment promulgated in 10A NCAC 14C .1600 are not applicable to this review.

SECTION .3800 CRITERIA AND STANDARDS FOR ACUTE CARE BEDS

.3802	**INFORMATION REQUIRED OF APPLICANT**
.3802(a)	This rule states *"An applicant that proposes to develop new acute care beds shall complete the Acute Care Facility/Medical Equipment application form."*
-C-	The applicants completed the Acute Care Facility/Medical Equipment application form.

.3802(b)(1) This rule states *"An applicant proposing to develop new acute care beds shall submit the following information: (1) the number of acute care beds proposed to be licensed and operated following completion of the proposed project."*

-C- In Exhibit 5, page 2, the applicants state that they propose to add 39 new acute care beds to FMC for a total of 790 licensed and operational acute care beds upon completion of Project I.D. #G-7011-04 and this project. The following table illustrates the current and proposed number of licensed acute care beds for the two licensed hospitals owned by Novant in Forsyth County.

	# OF LICENSED ACUTE CARE BEDS	
	2006 HOSPITAL LICENSE	PROPOSED
FMC-WS	637	740
FMC-K	0	50
Total FMC	637	790
MPH	136	22
Total Novant	773	812

.3802(b)(2) This rule states *"An applicant proposing to develop new acute care beds shall submit the following information: ... (2) documentation that the proposed services shall be provided in conformance with all applicable facility, programmatic, and service specific licensure, certification, and JCAHO accreditation standards."*

-C- In Exhibit 5, page 2, the applicants state *"FMC guarantees the proposed services will follow all applicable facility, programmatic and service-specific licensure, certification, and JCAHO accreditation standards. Please see the letter from Sallye Liner, Executive Vice President and Chief Operating Officer for FMC-Winston-Salem included in Exhibit 5."*

.3802(b)(3) This rule states *"An applicant proposing to develop new acute care beds shall submit the following information: ... (3) documentation that the proposed services shall be offered in a physical environment that conforms to the requirements of federal, state, and local regulatory bodies."*

-C- In Exhibit 5, page 2, the applicants state *"FMC assures the proposed services at FMC-Kernersville shall be offered in a*

physical environment that conforms to the requirements of federal, state, and local regulatory bodies. Please see the letter from David McMillan, Corporate Facilities Planning Director, Novant Health Triad Region found in Exhibit 5."

.3802(b)(4) This rule states *"An applicant proposing to develop new acute care beds shall submit the following information: ... (4) if adding new acute care beds to an existing facility, documentation of the number of inpatient days of care provided in the last operating year in the existing licensed acute care beds by medical diagnostic category, as classified by the Centers for Medicare and Medicaid Services according to the list set forth in the applicable State Medical Facilities Plan."*

-C- In Exhibit 5, page 3, the applicants provide the number of inpatient days of care provided in the existing licensed acute care beds at FMC during the last operating year (CY 2005) by medical diagnostic category (MDC), as classified by the Centers for Medicare and Medicaid Services (CMS) according to the list set forth in the 2006 SMFP.

.3802(b)(5) This rule states *"An applicant proposing to develop new acute care beds shall submit the following information: ... (5) the projected number of inpatient days of care to be provided in the total number of licensed acute care beds in the facility, by county of residence, for each of the first three years following completion of the proposed project, including all assumptions, data and methodologies."*

-C- In Exhibit 5, page 4, the applicants provide the projected number of inpatient days of care to be provided in the total number of licensed acute care beds in the facility, by county of residence, for each of the first three operating years following completion of the project. The applicants provide the assumptions, data and methodology in Exhibit 20. See Criterion (3) for discussion of reasonableness of projections and assumptions.

.3802(b)(6) This rule states *"An applicant proposing to develop new acute care beds shall submit the following information: ... (6) documentation that the applicant shall be able to communicate*

with emergency transportation agencies 24 hours per day, seven days per week."

-C- In Exhibit 5, page 4, the applicants state *"FMC-Kernersville will be able to communicate with emergency transportation 24 hours a day, seven days a week. Please see the confirmation letter from Robin Voss, Director or* [sic] *Emergency and Trauma Services for FMC, found in Exhibit 5."*

.3802(b)(7) This rule states *"An applicant proposing to develop new acute care beds shall submit the following information: ... (7) documentation that services in the emergency care department shall be provided 24 hours per day, seven days per week, including a description of the scope of services to be provided during each shift and the physician and professional staffing that will be responsible for provision of those services."*

-C- In Exhibit 5, page 4, the applicants state *"Please see the letter from Robin Voss, Director or* [sic] *Emergency and Trauma Services for FMC, found in Exhibit 5. In which she describes the scope of services and staffing in the emergency department."*

.3802(b)(8) This rule states *"An applicant proposing to develop new acute care beds shall submit the following information: ... (8) copy of written administrative policies that prohibit the exclusion of services to any patient on the basis of age, race, sex, creed, religion, disability or the patient's ability to pay."*

-C- Exhibit 9 contains a copy of Novant's EMTALA policy, which prohibits the exclusion of services to any patient on the basis of age, race, sex, creed, religion, disability or the patient's ability to pay. The policy states that it applies to all Novant Health care facilities, including FMC-WS and FMC-K.

.3802(b)(9) This rule states *"An applicant proposing to develop new acute care beds shall submit the following information: ... (9) a written commitment to participate in and comply with conditions of participation in the Medicare and Medicaid programs."*

-C- In Exhibit 5, the applicants provide a letter signed by the Executive Vice President and Chief Operating Officer for

FMC, which states *"I confirm to you FMC's commitment to continue to participate in and comply with the conditions of participation for the Medicare and Medicaid programs."*

.3802(b)(10) This rule states *"An applicant proposing to develop new acute care beds shall submit the following information: ... (10) documentation of the health care services provided by the applicant, and any facility in North Carolina owned or operated by the applicant's parent organization, in each of the last two operating years to Medicare patients, Medicaid patients, and patients who are not able to pay for their care."*

-C- In Exhibit 5, the applicants identify the following facilities owned by Novant in North Carolina:

Forsyth Medical Center
Thomasville Medical Center
Medical Park Hospital
Hawthorne Surgical Center
Salem MRI
The Breast Center
Presbyterian Hospital
Presbyterian Hospital Matthews
Presbyterian Hospital Orthopedic
Presbyterian Hospital Huntersville
Presbyterian Same Day Surgery
Presbyterian Imaging Center
Presbyterian Breast Center
Presbyterian South Park Surgical

The applicants provide the number of patient days of care provided to Medicare, Medicaid and self pay patients during the last two operating years at these facilities. In Section VI.6(a), page VI-5, the applicants state that, during CY 2005, FMC provided $18,847,644 in charity care to patients who were unable to pay for their care. Further, the applicants state *"in March 2006 Novant Health, Inc. announced that the system had set a target of providing $300 Million worth of free services during the next three years."*

.3802(b)(11) This rule states *"An applicant proposing to develop new acute care beds shall submit the following information: ... (11) documentation of strategies to be used and activities*

undertaken by the applicant to attract physicians and medical staff who will provide care to patients without regard to their ability to pay."

-C- In Exhibit 5, the applicants provide a letter signed by the Executive Vice President, Forsyth Medical Group, which states *"I am the Executive Vice President for the Forsyth Medical Group (employed physician group in the Novant Health Triad Region). ... As executive vice president overseeing the employed physician practices, I can attest that physicians employed by Forsyth Medical Group (FMG) will provide care to patients at FMC-Kernersville regardless of the patient's ability to pay in accordance with 10A NCAC 14C .3802(b)(11). ... FMG practices are not the same as private physician practices. Just like Forsyth Medical Center and our other affiliated hospitals, we have a charitable mission – to improve community health. As such, our physician practices have a charity care policy which is attached. In 2004, our practices provided more than $3.6 million in indigent and charity care."* Exhibit 5 contains a copy of the charity care policy for Forsyth Medical Group.

.3802(b)(12) This rule states *"An applicant proposing to develop new acute care beds shall submit the following information: ... (13) documentation that the proposed new acute care beds shall be operated in a hospital that provides inpatient medical services to both surgical and non-surgical patients."*

-C- In Exhibit 5, the applicants provide a letter signed by the Executive Vice President and Chief Operating Officer for FMC, which states *"The proposed new 50-bed acute care hospital in Kernersville shall operate as a hospital that provides inpatient medical services to both surgical and non-surgical patients."* Throughout the entire application, the applicants state that FMC-K will be operated under the license of FMC, an existing acute care hospital. In Exhibit 20, the applicants demonstrate that FMC currently provides inpatient medical services to both surgical and non-surgical patients. Inpatient medical services at FMC-K will also be provided to both surgical and non-surgical patients.

.3802(c)(1) This rule states *"An applicant proposing to develop new acute care beds in a new licensed hospital or on a new campus of an*

existing hospital shall also submit the following information: (1) the projected number of inpatient days of care to be provided in the licensed acute care beds in the new hospital or on the new campus, by major diagnostic category as recognized by the Centers for Medicare and Medicaid Services (CMS) according to the list set forth in the applicable State Medical Facilities Plan."

-C- In Exhibit 5, page 6, the applicants provide the projected number of inpatient days of care to be provided at FMC-K by MDC as recognized by the CMS according to the list set forth in the 2006 SMFP.

.3802(c)(2) This rule states *"An applicant proposing to develop new acute care beds in a new licensed hospital or on a new campus of an existing hospital shall also submit the following information: ... (2) documentation that medical and surgical services shall be provided in the proposed acute care beds on a daily basis within at least five of the major diagnostic categories as recognized by the Centers for Medicare and Medicaid Services (CMS) according to the list set forth in the applicable State Medical Facilities Plan."*

-C- In Exhibit 5, page 6, the applicants provide a table showing the projected number of inpatient days of care to be provided at FMC-K by MDC for the first three operating years, which indicates that services will be provided on a daily basis in 10 of the 25 major diagnostic categories recognized by CMS.

.3802(c)(3) This rule states *"An applicant proposing to develop new acute care beds in a new licensed hospital or on a new campus of an existing hospital shall also submit the following information: ... (3) copies of written policies and procedures for the provision of care within the new acute care hospital or on the new campus, including but not limited to the following:*

(A) the admission and discharge of patients, including discharge planning;
(B) transfer of patients to another hospital;
(C) infection control; and
(D) safety procedures."

-C- In Exhibits 2, 5 and 17, the applicants provide copies of written policies and procedures for the admission and discharge of

patients (including discharge planning), transfer of patients to another hospital, infection control and safety.

.3802(c)(4) This rule states *"An applicant proposing to develop new acute care beds in a new licensed hospital or on a new campus of an existing hospital shall also submit the following information: ... (4) documentation that the applicant owns or otherwise has control of the site on which the proposed acute care beds will be located."*

-C- In Exhibit 15, the applicants provide a copy of the May 12, 2006 Agreement of Purchase and Sale between PM Development, LLC (seller) and Novant (buyer) for the proposed site.

.3802(c)(5) This rule states *"An applicant proposing to develop new acute care beds in a new licensed hospital or on a new campus of an existing hospital shall also submit the following information: ... (5) documentation that the proposed site is suitable for development of the facility with regard to water, sewage disposal, site development and zoning requirements; and provide the required procedures for obtaining zoning changes and a special use permit if site is currently not properly zoned."*

-C- In Exhibit 15, the applicants provide an April 27, 2006 letter signed by the Community Development Director for the Town of Kernersville, which indicates that rezoning will be required but he states that he does *"not expect any barriers to future rezoning request* [sic]." Further, he states that the site is suitable for development of a 50-bed hospital with regard to water, sewage disposal and site development. Water, sewer and utilities are already available.

.3803 PERFORMANCE STANDARDS

.3803(a) This rule states *"An applicant proposing to develop new acute care beds shall demonstrate that the projected average daily census (ADC) of the total number of licensed acute care beds proposed to be licensed within the service area, under common ownership with the applicant, divided by the total number of those licensed acute care beds is reasonably projected to be at least 66.7 percent when the projected ADC is less than 100*

patients, 71.4 percent when the projected ADC is 100 to 200 patients, and 75.2 percent when the projected ADC is greater than 200 patients, in the third operating year following completion of the proposed project or in the year for which the need determination is identified in the State Medical Facilities Plan, whichever is later."

-C- 10A NCAC 14C .3801(4) states *"'Service Area' means the single or multi-county area as used in the development of the acute care bed need determination in the applicable State Medical Facilities Plan."* According to the 2006 SMFP, the service area is Forsyth County and Novant owns two acute care hospitals in the service area: FMC and MPH. Upon completion of the project, FMC would be licensed for a total of 790 acute care beds and MPH would be licensed for a total of 22 acute care beds. Thus, the total number of licensed acute cared beds owned by the applicants in the service area will be 812 acute care beds [790 + 22 = 812]. In Exhibit 5, page 9, the applicants project that a total of 232,220 days of care will be provided at FMC and MPH in the third operating year. Based on 812 licensed acute care beds, the ADC is projected to be 636.2 [232,220 / 365 = 636.2], an occupancy rate of 78.4% [636.2 / 812 = .784], which is greater than the 75.2% required by this rule. See Criterion (3) for discussion of projections at the proposed FMC-K campus.

.3803(b) This rule states *"An applicant proposing to develop new acute care beds shall provide all assumptions and data used to develop the projections required in this Rule and demonstrate that they support the projected inpatient utilization and average daily census."*

-C- The applicant's assumptions and data used to develop the projections required in this Rule are provided in Exhibit 20. The applicant's assumptions regarding projected inpatient utilization and ADC for the FMC and MPH system are reasonable and credible and support a finding of conformity with this rule. See Criterion (3) for discussion of projections at the proposed FMC-K campus.

.3804 SUPPORT SERVICES

.3804(a) This rule states *"An applicant proposing to develop new acute care beds shall document that each of the following items shall be available to the facility 24 hours per day, seven days per week:*

(1) laboratory services including microspecimen chemistry techniques and blood gas determinations;
(2) radiology services;
(3) blood bank services;
(4) pharmacy services;
(5) oxygen and air and suction capability;
(6) electronic physiological monitoring capability;
(7) mechanical ventilatory assistance equipment including airways, manual breathing bag and ventilator/respirator;
(8) endotracheal intubation capability;
(9) cardiac arrest management plan;
(10) patient weighing device for a patient confined to their bed; and
(11) isolation capability."

-C- In Exhibit 5, the applicants document that all of the items listed above are currently available 24 hours per day, seven days per week at FMC.

.3804(b) This rule states *"If any item in Paragraph (a) of this Rule will not be available in the facility 24 hours per day, seven days per week, the applicant shall document the basis for determining the item is not needed in the facility."*

-C- All of the items in Paragraph (a) of this Rule will be available 24 hours per day, seven days per week at FMC-K.

.3804(c) This rule states *"If any item in Paragraph (a) of this Rule will be contracted, the applicant shall provide correspondence from the proposed provider of its intent to contract with the applicant."*

-C- In Exhibit 5, page 10, the applicants states that all of the items listed in Paragraph (a) of this Rule will be available at FMC-K on a 24-hour basis.

.3805 STAFFING AND STAFF TRAINING

.3805(a) This rule states *"An applicant proposing to develop new acute care beds shall demonstrate that the proposed staff for the new acute care beds shall comply with licensure requirements set forth in Title 10A NCAC 13B, Licensing of Hospitals."*

-C- In Exhibit 5, page 11, the applicants state *"FMC assures the proposed services shall be provided in conformance with all licensure requirements set forth in Title 10A NCAC 13B, Licensing of Hospitals."* Exhibit 5 also includes a letter signed by the Executive Vice President and Chief Operating Officer for FMC, which states *"All staff for the new acute beds shall comply with licensure requirements set forth in Title 10A NCAC 13B, Licensing of Hospitals."* See Criterion (7) for additional discussion regarding staffing.

.3805(b) This rule states *"An applicant proposing to develop new acute care beds shall provide correspondence from the persons who expressed interest in serving as Chief Executive Officer and Chief Nursing Executive of the facility in which the new acute care beds will be located, documenting their willingness to serve in this capacity."*

-C- Exhibit 5 contains letters from the current Chief Executive Officer and Chief Nursing Executive for FMC that state they will serve in these capacities for both FMC campuses.

.3805(c) This rule states *"An applicant proposing to develop new acute care beds in a new hospital or on a new campus of an existing hospital shall provide a job description and the educational and training requirements for the Chief Executive Officer, Chief Nursing Executive and each department head which is required by licensure rules to be employed in the facility in which the acute care beds will be located."*

-C- Exhibit 3 contains the job descriptions and training requirements for the Chief Executive Officer, Chief Nursing Executive and each department head which is required by licensure rules to be employed in the facility.

(2) head scan with contrast;
(3) head scan without and with contrast;
(4) body scan without contrast;
(5) body scan with contrast;
(6) body scan without contrast and with contrast;
(7) biopsy in addition to body scan with or without contrast; and
(8) abscess drainage in addition to body scan with or without contrast."

-NC- In Exhibit 7, the applicants provide the number of CT scans performed on the four existing CT scanners located at FMC-WS for each type of CT scan listed in this rule during CY 2005. MPH does not have any CT scanners. However, Novant owns Winston-Salem Health Care, a diagnostic center, which has at least one CT scanner based on representations made by Novant in Project I.D. #G-6775-03. The applicants failed to provide the number of CT scans performed on that CT scanner as required by this rule. Therefore, the application is nonconforming with this rule.

.2302(c) This rule states *"The applicant shall project the number of CT scans to be performed on the new CT scanner for each type of CT scan listed in this Paragraph for the first 12 quarters the new CT scanner is proposed to be operated:*

(1) head scan without contrast;
(2) head scan with contrast;
(3) head scan without and with contrast;
(4) body scan without contrast;
(5) body scan with contrast;
(6) body scan without contrast and with contrast;
(7) biopsy in addition to body scan with or without contrast; and
(8) abscess drainage in addition to body scan with or without contrast."

-C- In Exhibit 7, the applicants provide the projected number of scans to be performed on the proposed CT scanner for each type of CT scan listed in this rule for the first 12 quarters of operation of the proposed scanner. See Criterion (3) for discussion regarding the reasonableness of the projections.

.3805(d) This rule states *"An applicant proposing to develop new acute care beds shall document the availability of admitting physicians who shall admit and care for patients in each of the major diagnostic categories to be served by the applicant."*

-C- The applicants propose to serve patients at FMC-K in all of the MDCs listed in the 2006 SFMP, except 15, 19 and 20. See Exhibit 5, page 6. Exhibit 11 contains letters from physicians that document their willingness to admit and care for patients in each of the MDCs proposed to be provided at FMC-K.

.3805(e) This rule states *"An applicant proposing to develop new acute care beds shall provide documentation of the availability of support and clinical staff to provide care for patients in each of the major diagnostic categories to be served by the applicant."*

-C- See Section VII of the application for current and proposed staffing. Exhibit 3 includes a letter signed by the Director of Employment and Recruitment for Novant documenting the availability of sufficient support and clinical staff for FMC-K. Exhibit 5 includes a letter signed by the Vice President, Nursing & Patient Care Services for FMC documenting the availability of support and clinical staff to provide care in each of the MDCs to be served at FMC-K.

SECTION .2300 CRITERIA AND STANDARDS FOR COMPUTED TOMOGRAPHY SCANNERS

.2302 INFORMATION REQUIRED OF APPLICANT

.2302(a) This rule states *"An applicant proposing to acquire a CT scanner shall use the acute care facility/medical equipment application form."*

-C- The applicants used the acute care facility/medical equipment application form.

.2302(b) This rule states *"An applicant proposing to acquire a CT scanner shall provide the number of CT scans that have been performed on its existing CT scanners for each type of CT scan listed in this Paragraph for the previous 12 month period:*
(1) head scan without contrast;

.2302(d) This rule states *"The applicant shall convert the historical and projected number of CT scans to HECT units as follows:*

	Type of CT Scan	No. of Scans		Conversion Factor		HECT Units
1	Head without contrast		X	1.00	=	
2	Head with contrast		X	1.25	=	
3	Head without and with contrast		X	1.75	=	
4	Body without contrast		X	1.50	=	
5	Body with contrast		X	1.75	=	
6	Body without contrast and with contrast		X	2.75	=	
7	Biopsy in addition to body scan with or without contrast		X	2.75 plus body scan HECTs	=	
8	Abscess drainage in addition to body scan with or without contrast		X	4.00 plus body scan HECTs	=	

-NC- In Exhibit 7, the applicants converted the historical and projected number of CT scans to be performed to HECT units as required by this rule. However, in converting the projected number of CT scans to be performed at FMC-K to HECT units they used a conversion factor of 1.5 for the body with contrast procedures when they should have used 1.75. Further, they used a conversion factor of 1.75 for the body without contrast procedures when they should have used 1.5. Therefore, the applicants did not convert the number of CT scans to HECT units in accordance with the factors in this rule. See Criterion (3) for discussion regarding the reasonableness of the projections.

.2302(e) This rule states *"An applicant proposing to acquire a mobile CT scanner shall provide the information requested in Paragraphs (b), (c), and (d) of this Rule for each proposed host facility."*

-NA- The applicants do not propose to acquire a mobile CT scanner.

.2302(f) This rule states *"The applicant shall provide all projected direct and indirect operating costs and all projected revenues for the provision of CT services for the first 12 quarters the new CT scanner is proposed to be operated."*

-C- In Exhibit 7, page 6, the applicants provide the projected direct and indirect operating costs and revenues during the first 12 quarters for the proposed CT scanner to be located at FMC-K.

.2302(g) This rule states *"The applicant shall provide projected costs and projected charges by CPT code for the first 12 quarters the new CT scanner is proposed to be operated."*

-NC- In Exhibit 7, page 7, the applicants state

> *"See the response to Question X.2 in the CON application for the projected CT scan procedure charges for the first three years of operation at FMC-Kernersville. It is not feasible to allocate CT scan procedure costs in such a manner as to reliably predict the average cost per CT scan by CPT code, because the mix of CT scans types (as identified by CPT code) and the inpatient-outpatient CT scan mix varies from year to year depending on patient and referring physician needs, as well as evolution in CT technology. In addition, inpatient CT scans are not generally coded and tracked by CPT code as payors do not permit a hospital to bill separately for an inpatient CPT code. Rather the hospital is paid a lump sum or case rate determined by the DRG assigned to the entire inpatient stay, and that stay includes all the ancillary services, including CT scans. However, using the expense data supplied in the table above in the response to .2302(f), the applicant calculated that the average incremental cost per CT scan at FMC-Kernersville for the first three project years would be:*
>
> - *PY 1 (7/1/09-6/30/10): $88*
> - *PY 2 (7/1/10-6/30/11): $99*
> - *PY 3 (7/1/11-6/30/12): $94*
>
> *Please note that the incremental cost per CT scan does not reflect total average costs per CT scan, as the overhead allocation and other administrative*

expenses outside the CT scan department are not included."

In Section X.2(a)(3), page X-9, the applicants provide projected charges for the CT procedures to be performed at FMC-Kernersville during the first three operating years. However, the applicants provide only the incremental cost per CT scan. The rule requires the total projected CT cost, not the incremental costs. Therefore, the application is nonconforming with this rule.

.2302(h) This rule states *"If an applicant that has been utilizing a mobile CT scanner proposes to acquire a fixed CT scanner for its facility, the applicant shall demonstrate that its projected charge per CPT code shall not increase more than 10% over its current charge per CPT code on the mobile CT scanner."*

-NA- The applicants have not been utilizing a mobile CT scanner.

.2302(i) This rule states *"An applicant proposing to acquire a mobile CT scanner shall provide copies of letters of intent from and proposed contracts with all of the proposed host facilities of the new CT scanner."*

-NA- The applicants do not propose to acquire a mobile CT scanner.

.2302(j) This rule states *"An applicant proposing to acquire a CT scanner shall demonstrate that it has a written commitment from the radiology group of a hospital that it will accept CT readings from the applicant."*

-C- In Exhibits 7 and 11, the applicants provide a letter signed by the President and CEO of Forsyth Radiological Associates, which states *"FRA radiologists can and will staff and provide diagnostic radiology services, diagnostic ultrasound services, computed tomography services, and mobile MRI services at Forsyth Medical Center – Kernersville."* Forsyth Radiological Associates currently provides professional services at all Novant facilities in the Triad.

.2302(k) This rule states *"An applicant proposing to acquire a CT scanner shall demonstrate that the CT scanner shall be available and staffed for performing CT scan procedures at least 66 hours per week."*

-C- In Exhibit 7, the applicants provide a letter signed by the Director of Radiology Services for FMC, which states *"I can attest that the new CT scanner at FMC-Kernersville will be ... available and staffed for performing CT scan procedures for at least 66 hours per week."*

.2303 **REQUIRED PERFORMANCE STANDARDS**

.2303(1) This rule states *"An applicant proposing to acquire a CT Scanner shall demonstrate each of the following: (1) each fixed or mobile CT Scanner to be acquired shall be projected to perform 5,100 HECT units annually in the third year of operation of the proposed equipment."*

-NC- In Exhibit 7, the applicants project that the proposed CT scanner to be located at FMC-K would perform 18,324 HECT units in the third year of operation following completion of the project. However, in converting the projected number of CT scans to be performed at FMC-K to HECT units they used a conversion factor of 1.5 for the body with contrast procedures when they should have used 1.75. Further, they used a conversion factor of 1.75 for the body without contrast procedures when they should have used 1.5. Further, in Exhibit 20, Figure 26, the applicants assume that the CT scanner at FMC-K will perform 0.69 CT scans for every inpatient discharge and 0.43 CT scans for every outpatient and ER visit based on the experience at Presbyterian Hospital Matthews, Presbyterian Hospital Huntersville and Thomasville Medical Center. However, the projected number of CT scans to be performed at FMC-K is based on the projected number of inpatient discharges and projected inpatient discharges are not reasonable. See Criterion (3) for discussion regarding projected acute inpatient discharges. Therefore, the projected number of CT scans to be performed at FMC-K are not reasonable. Consequently, the application is nonconforming with this rule.

.2303(2) This rule states *"An applicant proposing to acquire a CT Scanner shall demonstrate each of the following: ... (2) each existing fixed CT scanner in the applicant's CT service area shall have performed at least 5,100 HECT units in the 12 month period prior to submittal of the application."*

-NC- Pursuant to 10A NCAC 14C .2301(4), *"'Computed tomography (CT) service area' means a geographical area defined by the applicant, which has boundaries that are not farther than 40 road miles from the facility."* In Exhibit 7, the applicants state *"The proposed CT service area includes several zip codes in Forsyth County and two zip codes from Guilford County as defined in Section III."* (Emphasis added.) In Section III.5(a), page III-20, the applicants state

> *"The service area for FMC-Kernersville consists of zip codes 27284 (including point zip code 27285), 27051, 27009, 27265, 27235, and 27310. ... The applicant has not projected a secondary service area. Approximately 80% of FMC-Kernersville patients will come from residents in the defined service area zip codes. The other 20 percent will come from other zip codes in Forsyth and Guilford Counties, Other North Carolina Counties, and Other States."* (Emphasis added.)

In Exhibit 7, the applicants state that the CT service area is defined in Section III. In Section III.5(a), page III-20, the applicants state that the service area consists of six zip codes, three in Forsyth County and three in Guilford County. (Note that the statement in Exhibit 7 regarding the number of zip code areas in Guilford County is not correct.) However, the applicants state that 20% of the patients projected to utilize CT services at FMC-K will be residents of *"other zip codes in Forsyth and Guilford Counties, Other North Carolina Counties, and Other States."* Thus, the applicants' CT service area also includes other zip codes in Forsyth, Guilford and other NC counties that are located within 40 road miles of FMC-K and from which the applicant proposes to serve patients needing CT services.

The applicants do not identify the other North Carolina counties included in the service area for CT services, do not identify the CT scanners operating in those counties and do not provide the historical utilization data for those CT scanners for which data is available. Moreover, the applicants do not demonstrate that those other North Carolina counties are located within 40 road miles of FMC-K. Further, the applicants do not identify all CT scanners operating in Forsyth and Guilford counties and do not provide the historical utilization data for those CT scanners for which data is available, which includes all of the existing hospitals in Forsyth and Guilford counties and diagnostic centers owned by Novant. Therefore, the applicants failed to demonstrate that each existing fixed CT scanner in its CT service area performed at least 5,100 HECT units in the 12 month period prior to submittal of the application as required by this rule. Consequently, the application is nonconforming to this rule.

.2303(3) This rule states *"An applicant proposing to acquire a CT Scanner shall demonstrate each of the following: ... (3) each existing and approved fixed CT scanner in the applicant's CT service area shall be projected to perform 5,100 HECT units annually in the third year of operation of the proposed equipment."*

-NC- In Exhibit 7, page 10, in response to this rule, the applicants provide projected utilization for the proposed CT scanner. However, the proposed CT scanner is not an existing or approved CT scanner as those terms are defined in 10A NCAC 14C .2301. The applicants do not identify the existing and approved fixed CT scanners operating in Forsyth and Guilford counties and did not provide projected utilization data for those CT scanners, which includes all of the existing hospitals in Forsyth and Guilford counties and diagnostic centers owned by Novant.

Further, the applicants did not identify the other North Carolina counties included in the service area for CT services, did not identify the existing and approved CT scanners operating in those counties and did not provide projected utilization data for those CT scanners. Moreover,

the applicants do not demonstrate that those other North Carolina counties are located within 40 miles of FMC-K.

Therefore, the applicants failed to demonstrate that each existing and approved fixed CT scanner in its CT service area is reasonably expected to perform at least 5,100 HECT units in the third operating year of the proposed CT scanner as required by this rule. The application is nonconforming to this rule.

.2303(4) This rule states *"An applicant proposing to acquire a CT Scanner shall demonstrate each of the following: ... (4) each existing mobile CT scanner in the proposed CT service area performed at least an average of 20 HECT units per day per site in the CT scanner service area in the 12 months prior to submittal of the application."*

-NC- In Exhibit 7, page 10, the applicants state *"FMC is not aware of any existing mobile CT scanner in the 7-zip code service area for FMC-Kernersville."* However, the service area includes more than these seven zip codes given the applicants statement that 20% of the CT patients projected to be served are from other zip codes in Forsyth and Guilford counties and other NC counties. The applicants did not discuss existing mobile CT scanners operating in the rest of its CT service area. Therefore, they did not demonstrate that each mobile CT scanner operating in the service area performed an average of 20 HECT units per day per site in the 12 months prior to submittal of the application as required by this rule. Consequently, the application is nonconforming with this rule.

.2303(5) This rule states *"An applicant proposing to acquire a CT Scanner shall demonstrate each of the following: ... (5) each existing and approved mobile CT scanner shall perform at least an average of 20 HECT units per day per site in the CT scanner service area in the third year of operation of the proposed equipment."*

-NC- In Exhibit 7, page 11, the applicants state *"FMC is not aware of any existing mobile CT scanner in the 7-zip code service area for FMC-Kernersville."* However, the service area includes more than these seven zip codes given the

applicants statement that 20% of the CT patients projected to be served are from other zip codes in Forsyth and Guilford counties and other NC counties. The applicants did not discuss the existing and approved mobile CT scanners operating in the rest of its CT service area. Therefore, they did not demonstrate that each existing and approved mobile CT scanner operating in the service area is projected to perform an average of 20 HECT units per day per site in the third operating year as required by this rule. Consequently, the application is nonconforming with this rule.

.2304 **REQUIRED SUPPORT SERVICES**

.2304(a) This rule states *"An applicant proposing to acquire a CT scanner shall document the availability of the following diagnostic services:*

(1) diagnostic radiology services;
(2) therapeutic radiology services;
(3) nuclear medicine services; and
(4) diagnostic ultrasound services."

-C- In Exhibit 7, page 11, the applicants state that all of the services listed above will be available at FMC-K. See also, Section II.1, page II-3. Exhibit 7 also contains a letter signed by the President and CEO of Forsyth Radiological Associates, which states that x-ray, fluoroscopy, ultrasound, computed tomography and mobile MRI services will be available at FMC-K. FMC-WS and FMC-K will be operated as a single licensed hospital.

.2304(b) This rule states *"An applicant proposing to acquire a CT scanner shall document the availability of services through written affiliation or referral agreements to treat patients with the following conditions:*

(1) neurological conditions;
(2) thoracic conditions;
(3) cardiac conditions;
(4) abdominal conditions;
(5) medical oncological conditions;
(6) radiological oncological conditions;
(7) gynecological conditions;
(8) neurosurgical conditions; and
(9) genitourinary and urogenital conditions."

-C- In Section I.12(d), page I-10, the applicants state *"FMC has an active medical staff of over 540 physicians in all of the major specialties."* In Section VII.10, page VII-17, the applicants list the 543 members of the active Medical Staff by specialty. There is one or more specialties represented for all of the conditions listed in this rule. FMC-WS and FMC-K will be operated as a single licensed hospital.

.2304(c) This rule states *"An applicant proposing to acquire a mobile CT scanner shall provide:*
(1) referral agreements between each host site and at least one other provider of CT services in the proposed CT service area to document the availability of CT services if patients require them when the mobile unit is not in service at that host site; and
(2) documentation that each of the services listed in Paragraphs (a) and (b) of this Rule shall be available at each host facility or shall be available through written affiliation or referral agreements."

-NA- The applicants do not propose to acquire a mobile CT scanner.

.2305 **REQUIRED STAFFING AND STAFF TRAINING**

.2305(a)(1) This rule states *"An applicant proposing to acquire a CT scanner shall demonstrate that it can meet the following staffing requirements:*
(1) one board certified radiologist who has had:
(A) training in computed tomography as an integral part of his or her residency training program; or
(B) six months of supervised CT experience under the direction of a qualified diagnostic radiologist; or
(C) at least six months of fellowship training, or its equivalent, in CT; or
(D) an appropriate combination of CT experience and fellowship training equivalent to Parts (a)(1) (A), (B), or (C) of this Rule."

-C- In Exhibit 7, page 12, the applicants state that Dr. Vito Basile has agreed to serve as medical director for CT services at FMC-K. Exhibit 7 also contains Dr. Basile's resume, which indicates that he is a board-certified radiologist and a member of Forsyth Radiological Associates and meets all of the above requirements. In Exhibits 7 and 11, the applicants provide a letter signed by the President and CEO of Forsyth Radiological Associates, which states *"FRA radiologists can and will staff and provide diagnostic radiology services, diagnostic ultrasound services, computed tomography services, and mobile MRI services at Forsyth Medical Center – Kernersville."* Forsyth Radiological Associates currently provides professional services at all Novant facilities in the Triad.

.2305(a)(2) This rule states *"An applicant proposing to acquire a CT scanner shall demonstrate that it can meet the following staffing requirements: ... (2) at least one radiology technologist registered by the American Society of Radiologic Technologists shall be present during the hours of operation of the CT unit."*

-C- In Section VII.2, page VII-3, the applicants project that they will employ 4.8 FTE CT technologist positions in Year One, 6.8 FTE CT technologist positions in Year Two and 7.8 FTE CT technologist positions in Year Three at FMC-K. In Exhibit 7, the applicants provide a letter signed by the Director of Radiology for FMC, which states *"the new CT scanner at FMC-Kernersville will be ... staffed by at least one radiology technologist who will be registered by the American Society of Radiologic Technologists and who will be present during all hours when the CT scanner is in operation at FMC-Kernersville."*

.2305(a)(3) This rule states *"An applicant proposing to acquire a CT scanner shall demonstrate that it can meet the following staffing requirements: ... (3) a radiation physicist with training in medical physics shall be available for consultation for the calibration and maintenance of the equipment. The radiation physicist may be an employee or an independent contractor."*

-C- Exhibit 7 contains a letter signed by the Radiation Safety Officer for FMC, which states that she is a radiation physicist with training in medical physics and *"over 15 years experience."* She is currently employed by FMC to provide such things as annual equipment evaluations, CT dose profiles and consultative medical physics services. She states she will be *"available for consultation for the calibration and maintenance of the proposed CT scanner."*

.2305(b) This rule states *"The applicant shall provide documentation that the diagnostic radiologist has completed CT training in head, spine, body and musculoskeletal imaging."*

-C- Exhibit 7 contains a copy of Dr. Basile's resume, which indicates that he is a board-certified radiologist, a member of Forsyth Radiological Associates, and has experience interpreting CT scans in the required areas. In Exhibit 7, page 13, the applicants state that he currently serves as medical director for CT services at FMC.

.2305(c)(1) This rule states *"An applicant proposing to acquire a CT scanner shall demonstrate that the following staff training is provided: (1) certification in cardiopulmonary resuscitation (CPR) and basic cardiac life support."*

-C- In Exhibit 7, the applicants provide a letter signed by the Director of Radiology Services at FMC, which states *"the new CT scanner at FMC-Kernersville will be ...staffed by personnel who are trained and certified in cardiopulmonary resuscitation (CPR) and basic cardiac life support and who participate in FMC's organized program of staff education and training, which is integral to the CT scanner program and ensures improvements in technique and the proper training of new CT scanner personnel."*

.2305(c)(2) This rule states *"An applicant proposing to acquire a CT scanner shall demonstrate that the following staff training is provided: ... (2) an organized program of staff education and training which is integral to the services program and ensures improvements in technique and the proper training of new personnel."*

-C- In Exhibit 7, the applicants provide a letter signed by the Director of Radiology Services at FMC, which states *"the new CT scanner at FMC-Kernersville will be ...staffed by personnel who are trained and certified in cardiopulmonary resuscitation (CPR) and basic cardiac life support and who participate in FMC's organized program of staff education and training, which is integral to the CT scanner program and ensures improvements in technique and the proper training of new CT scanner personnel."*

.2305(d) This rule states *"An applicant proposing to acquire a mobile CT scanner shall document that the requirements in Paragraphs (a) and (b) of this Rule shall be met at each host facility."*

-NA- The applicants do not propose to acquire a mobile CT scanner.

STATE OF NORTH CAROLINA

COUNTY OF FORSYTH

NOVANT HEALTH, INC. (Lessor) and FORSYTH MEMORIAL HOSPITAL d/b/a FORSYTH MEDICAL CENTER (Lessee),

Petitioners,

and

TOWN OF KERNERSVILLE,

Petitioner-Intervenor,

vs.

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF FACILITY SERVICES, CERTIFICATE OF NEED SECTION,

Respondent.

and

HIGH POINT REGIONAL HEALTH SYSTEM,

Respondent-Intervenor.

IN THE OFFICE OF ADMINISTRATIVE HEARINGS
06 DHR 2044

DEPOSITION

OF

LEE B. HOFFMAN

FEBRUARY 8, 2007
1:01 P.M.

AT NELSON MULLINS RILEY & SCARBOROUGH, LLP
RALEIGH, NORTH CAROLINA

VOLUME I

generally a single county, however, there are some multi-county groupings because there are some counties that don't have any hospitals.

Q. Okay. And the fact that the SMFP defines a service area, for the most part, to be a single county, does that mean that the hospital can only serve patients from that particular single county where it is located?

A. No. It means the beds must be located in that county, but they can serve patients from other counties at that site.

MS. GUNTER: Do you want to take a quick break? We've been going over an hour.

THE WITNESS: That would be great.

(RECESS TAKEN FROM 2:19 P.M. UNTIL 2:33 P.M.)

Q. Ms. Hoffman, have you ever heard of the term "in migration"?

A. Yes, in these applications.

Q. Okay. And what does that term mean, "in migration"?

A. In my mind it means patients coming from counties outside the county in which the facility is located, coming into the county from other counties.

Q. Okay. We talked a little while ago about service area. Have you seen in CON applications hospitals defining the service area for particular services to be certain zip code areas as opposed to entire counties?

A. Yes.

Q. Okay. And were you aware in this case, Ms. Hoffman, that Forsyth and Novant had defined the service area for the proposed hospital in Kernersville to be several zip codes in Forsyth and Guilford counties?

A. Well, yes and no. That's what the problem was. Apparently, their primary service area was certain zip codes in that area, but then they also -- 20% of their patients were coming from a service area beyond that area.

Q. Right. Is there anything wrong, from your perspective, Ms. Hoffman, with a hospital defining -- let me ask it specifically.

Was there anything wrong with Forsyth Medical Center choosing certain zip codes to be its primary service area for this application?

A. No, not if that's reasonable, not if they demonstrate the reasonableness of that.

Attachment 8

ATTACHMENT - REQUIRED STATE AGENCY FINDINGS

FINDINGS
C = Conforming
CA = Conditional
NC = Nonconforming
NA = Not Applicable

DECISION DATE:	February 27, 2008
FINDINGS DATE:	March 5, 2008
PROJECT ANALYST:	Carol L. Hutchison
CHIEF:	Lee B. Hoffman

PROJECT I.D. NUMBERS: **F-7951-07/** Carolinas Medical Center – NorthEast, Inc. d/b/a CMC-NorthEast/ Develop a freestanding emergency department in Kannapolis with CT scanner and other outpatient imaging services, to be licensed as part of Carolinas Medical Center– NorthEast/ Cabarrus County

REVIEW CRITERIA FOR NEW INSTITUTIONAL HEALTH SERVICES

G.S. 131E-183(a) The Department shall review all applications utilizing the criteria outlined in this subsection and shall determine that an application is either consistent with or not in conflict with these criteria before a certificate of need for the proposed project shall be issued.

(1) The proposed project shall be consistent with applicable policies and need determinations in the State Medical Facilities Plan, the need determination of which constitutes a determinative limitation on the provision of any health service, health service facility, health service facility beds, dialysis stations, operating rooms, or home health offices that may be approved.

NA

The applicant does not propose an increase in the number of licensed beds, operating rooms or GI endoscopy rooms located in Cabarrus County. Further, the applicant does not propose to acquire any medical equipment or develop any health service facility beds or services for which there is a need determination in the *2007 State Medical Facilities Plan (2007 SMFP)*. Therefore, there are no need determinations that are applicable to the project. Additionally, there are no policies in the *2007 SMFP* that are applicable to the proposed project. Thus, this criterion is not applicable to the proposed project.

(2) Repealed effective July 1, 1987.

(3) The applicant shall identify the population to be served by the proposed project, and shall demonstrate the need that this population has for the services proposed, and the extent to which all residents of the area, and, in particular, low income persons, racial and ethnic minorities, women, handicapped persons, the elderly, and other underserved groups are likely to have access to the services proposed.

C

Carolinas Medical Center – NorthEast, Inc. d/b/a CMC-NorthEast proposes to develop Carolinas Medical Center-Kannapolis (CMC-Kannapolis), a freestanding emergency department, to be located at Lane Street at the intersection with I-85. The facility would be licensed as part of CMC-NorthEast. Based on the representations in Section II.1, pages 16-18, the design schematic provided in Exhibit 8, and the list of equipment to be acquired provided on page 130 and Exhibit 7 of the application, the applicant proposes to offer the following services at CMC-Kannapolis:

- a new 24 hour freestanding emergency department with 10 treatment rooms,
- 2 new unlicensed observation beds,
- a new laboratory,
- 1 new x-ray unit,
- 1 CT scanner relocated from CMC-NorthEast Outpatient Imaging Center Copperfield, and
- 1 ultrasound unit relocated from CMC-NorthEast Main Campus.

POPULATION TO BE SERVED

The following table illustrates the projected patient origin for CMC-Kannapolis by service type in the second operating year (2011), as reported by the applicant on page 64 of the application.

Projected Patient Origin	
County	**FY2011**
Cabarrus	66.7%
Rowan	33.3%
Total	**100.0%**

The applicant provides the following assumptions regarding its methodology for projecting patient origin on page 64 of the application:

> *"The city of Kannapolis is located in Cabarrus and Rowan counties; however the majority of the Kannapolis population resides in Cabarrus County. Similarly, three of the zip codes in CMC-Kannapolis' service area cross the Cabarrus-Rowan County line: 28081, 28083 and 28138.*

Thus, CMC-NorthEast was unable to determine the county of residence for each emergency patient based on historical patient origin by zip code. Therefore, CMC-NorthEast anticipates that approximately two-thirds of the projected emergency visits will be from Cabarrus County residents and approximately one-third will be from Rowan County residents. This is consistent with CMC-NorthEast's overall patient origin for emergency services."

The applicant adequately identified the population it proposes to serve.

ANALYSIS OF NEED FOR THE PROPOSED SERVICES

In Section III.1(a), on pages 28 of the application, the applicant states

" CMC-NorthEast last expanded its Emergency Department capacity nearly 10 years ago, in 1998. Since then, CMC-NorthEast's Emergency Department utilization has more than doubled (based on annualized FY2007 data).

...

Emergency Services

United States emergency department visits in 2001 rose to 107.5 million, up from 89.8 million in 1992. At the same time, the number of emergency departments decreased by 15 percent. A March 2003 report from the U.S. General Accounting Office (Report: GAO 03-460) found two-thirds of emergency departments diverted ambulances to other hospitals during 2001 (see Exhibit 22). Crowding was most severe in areas with large populations, where nearly 1 in 10 hospitals reported diversion 20 percent of the time (4 hours per day). Ambulances are diverted to other hospitals only when crowding is so severe that patient safety may be jeopardized.

...

Based on a recent study by the American Hospital Association (AHA), emergency department capacity and overcrowding are issues facing many hospitals nationwide.

According to this survey, 69% of urban hospitals report capacity issues in their emergency departments. This is occurring while emergency room visits continue to rise. In 2004, the nationwide emergency visit use rate (per 1,000 population) was over 370.

...

Based on a study performed by the Institutes of Medicine (IOM) regarding emergency departments, demand for emergency care has been growing fast. Emergency department visits grew by 26 percent between 1993 and 2003. But over the same period, the number of emergency departments declined by 425, and the number of hospital beds declined by 198,000. Please refer to Exhibit 22 for key findings from the IOM report. The proposed freestanding emergency department addresses this issue by responding to the increasing local demand for emergency services and expanding access for residents of Cabarrus County and surrounding communities.

Emergency department utilization has increased in North Carolina as well. Based on the 2007 AHA Hospital Statistics report, emergency department visits have increased over 26% since 2000.

	2000	2001	2002	2003	2004	2005
Emergency Department visits	2,983,548	3,230,198	3,322,226	3,433,432	3,483,332	3,784,070

Source: 2007 AHA Hospital Statistics

Need for Expanded Emergency Services in Cabarrus County

CMC-NorthEast's existing Emergency Department in Concord delivers comprehensive emergency treatment, in a facility designed to treat major and minor injuries and illnesses efficiently. CMC-NorthEast's triage system enables the emergency team to identify critically ill patients and the ECC [CMC-NorthEast's Emergency Care Center] *has easy access to radiology, laboratory and operating rooms. The center's treatment rooms feature the latest technology and each patient's progress is tracked by a computerized system. CMC-NorthEast's Emergency Department also features the following:*

- ✓ *All CMC-NorthEast emergency physicians are residency trained and board-certified in emergency medicine.*
- ✓ *CMC-NorthEast emergency nurses hold certifications in advanced cardiac life support, as well as emergency pediatric and trauma care.*
- ✓ *CMC-NorthEast also provides specialized services for victims of domestic violence, including specially trained Sexual Assault Nurse Examiners who work with our community's Sexual Assault Response Team.*
- ✓ *CMC-NorthEast is one of only two trauma centers in the Charlotte area and currently hold* [sic] *a Level 3 center classification.*

CMC-NorthEast's ECC also features a 24-hour Chest Pain Center. The 24-hour Chest Pain Center is a specific area dedicated to evaluating and

treating patients with chest pain as soon as they come to the emergency room with no waiting.

On page 31, the applicant states

"CMC-NorthEast's ECC is served by Cabarrus County EMS. Cabarrus County EMS covers 365 sq. miles of territory and boasted one of the best response times in the State in 2005 at 7.69 minutes. The team responded to 17,604 calls in 2005 at an average of 48 per day.

...

Projections for 2006 are approximately 18,400 calls at an average of a 7.8 minutes response time.

Currently, CMC-NorthEast is operating above Emergency Department capacity, and its department utilization will continue to increase with Cabarrus County population growth. The following provides historical utilization for CMC-NorthEast's Emergency Department.

NorthEast Medical Center
Emergency Department Visits

	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007*
Emergency Department visits	68,411	68,783	71,872	74,106	76,759	81,994

Source: CMC-NorthEast License Renewal Application
**Annualized based on 10 months data*

CMC-NorthEast's Emergency Department currently has 27 exam rooms and 10 additional Fast Track rooms (total 37). ACEP recommends that, for programs like CMC-NorthEast, emergency department exam room capacity is 1,311 to 1,778 patients per year (per treatment room)."

[See table titled "*High and Low Range Estimates for Emergency Department Areas and Bed Quantities*" on page 33 of the application.]

"CMC-NorthEast is currently operating at 2,216 visits per room (81,994/37), which is beyond ACEP's recommended capacity range. Additionally, based on annualized FY2007 data, CMC-NorthEast's inventory of only 37 emergency department exam rooms is below ACEP's recommendation of at least 45 exam rooms to meet <u>current</u> needs (not <u>projected</u> needs.

Based on the most conservative projections, CMC-NorthEast demonstrates the need for at least 55 and up to 75 emergency department

exam rooms. The following table provides overall CMC-NorthEast Emergency Department utilization for the next five years based on the projected population growth rate for Cabarrus County (3.13%).

CMC – NorthEast
**** Projected Emergency Department Utilization***
FY2008-FY2012

	FY2008	FY2009	FY2010	FY2011	FY2012
ED Visits	84,562	87,211	89,943	92,760	95,666

*Data includes ED visits at CMC-NorthEast main campus, NorthEast at Harrisburg and the proposed CMC-Kannapolis.

This is a very conservative growth rate considering the most recent growth of 6.82% from FY2006 to FY2007. Nonetheless, based on ACEP recommendations, CMC-NorthEast demonstrates the need for at least 55 and as many as 75 emergency department exam rooms. As previously stated, CMC-NorthEast is proposing this project to address the key findings of the IOM report on emergency care (e.g., rapidly [sic] *growth demand and decreasing number of emergency departments). Specifically, CMC-NorthEast currently has 37 emergency department treatment rooms at the main campus and previously proposed six (6) additional treatment rooms at NorthEast at Harrisburg (not yet approved). The proposed 10 emergency department treatment rooms in Kannapolis are also needed to address increasing demand for emergency services in the service area.*

Based on historical patient origin, approximately 35.83% of CMC-NorthEast's Emergency Department patients are from Kannapolis and surrounding areas. In FY2006, CMC-NorthEast's Emergency Department treated over 27,000 patients from Kannapolis and adjacent zip codes.

Developing a freestanding emergency department in Kannapolis will effectively decompress capacity constraints at CMC-NorthEast's main hospital campus while improving local access to emergency care services for a considerable population of CMC-NorthEast patients.

Cabarrus County

Cabarrus County has one of the highest population growth rates in the state, according to North Carolina State Demographic population estimates and projections. In the 2000-2010 estimates and projections, Cabarrus County ranks 8th in the state for percent growth and 6th for absolute population growth.

The surge in population in this area is largely attributed to the recent increases in economic and business development. Citing this as the source of growth explains why actual growth in this area has exceeded expected growth projections made by the State in 2000. It also supports the forecasted population growth which is currently projected above 3.13% annually through 2012 (the third year of the proposed project) by North Carolina Office of State Budget and Management. Note the State projections for Cabarrus County in the table below, compared to North Carolina as a whole.

Projected Population Growth
2006-2012

	2006	2007	2008	2009	2010	2011	2012	Average Annual Growth Rate
Cabarrus County	157,176	163,804	169,181	173,695	177,879	182,298	186,717	3.13%
North Carolina	8,860,341	9,040,824	9,201,151	9,348,744	9,485,138	9,623,713	9,762,330	1.70%

Source: NC Office of State Budget and Management, State Demographics
http:// demog.state.nc.us

...

...[T]he North Carolina Research Campus is expected to have a dramatic impact on future population growth in Cabarrus and surrounding counties. Much more than just a research campus, the NCRC will be a mixed use development with a hotel, retail stores, civic center, residential housing, and a specialized secondary school for girls, in addition to world-class laboratory and research facilities. NCRC jobs will result in population and household growth.

To estimate the effects of the NCRC on Cabarrus County and surrounding communities, the city of Kannapolis along with CMC-NorthEast, contracted with Market Street Services to conduct an economic impact analysis of the NCRC being built in Kannapolis. Market Street Services' partner, Economic Impact Group (EIG), conducted the economic impact study.

...

Because the NCRC is under construction and therefore not yet in operation, the economic impact analysis was based on estimates of direct impacts - that is, the jobs and payroll associated with all the job-generating activities at the campus. These include the research labs, private-sector biotechnology companies, retail space, hotel, and other facilities that hire people and pay wages.

...

Cabarrus County currently has about 50,000 jobs and Rowan County about 42,000 jobs. The NCRC is expected to add another 13,616 jobs in Cabarrus and another 4,520 jobs in Rowan, by 2032. The study estimates that over the next 25 years, the NCRC has the potential to bring 89,751 people, 38,060 households and 37,450 jobs to CMC-NorthEast's overall service area. Please refer to Exhibit 4 for copy of the NCRC economic impact study.

The NCRC will have the greatest impact on the Kannapolis area where it is being developed. The following provides a brief history of Kannapolis and a discussion of the need the area has for the proposed freestanding emergency department.

Kannapolis

...On September 12, 2005, Mr. Murdock and Molly Corbett Broad, President of the University of North Carolina system, unveiled plans for the North Carolina Research Campus. This and other events have caused the population in Kannapolis to continue to increase in size and diversity.

City of Kannapolis Population Growth

	1990	2000	2007	2012
Kannapolis (City)	33,961	36,910	39,227	41,318
% Growth	...	8.68%	6.28%	5.33%

Source: Claritas

Claritas population estimates place the 2007 population at nearly 40,000 for the Kannapolis municipality, as seen in the table above. The vast majority of the town population resides in Cabarrus County. Also shown in the table is the projected 5.33% growth in total population in Kannapolis over the five-year period from 2007 to 2012.

While the population of Cabarrus County is expected to grow at a rapid rate, the distribution of this growth amongst age groups is distributed unevenly across the county. Namely, the Town of Kannapolis is expected to increase in its number and percent of elderly more quickly than other parts of the country.

The table below provides projected population data for Kannapolis compared to Cabarrus County and North Carolina. The percent of the population age 65 and older is markedly higher in Kannapolis compared to both Cabarrus County and North Carolina. Furthermore, this population is expected to increase to 15.22% of the total population. This makes Kannapolis an ideal location for increasing access to healthcare in

the region, especially for medically underserved, i.e., Medicare and Medicaid.

Aging Population Comparison

	2007			2012		
	65+	Total	% of Total	65+	Total	% of Total
Kannapolis (zip codes 28081 and 28083)	6,591	45,281	14.56%	7,197	47,282	15.22%
Cabarrus County	17,411	155,656	11.19%	21,503	172,911	12.44%
North Carolina	1,102,807	8,875,404	12.43%	1,295,833	9,466,506	13.69%

Source: Claritas

...

Rapid population growth in suburban communities like Kannapolis quickly creates increased congestion on local roads and thoroughfares. As an example, daily traffic counts are up 14.70% on the section of I-85 that connects Kannapolis to Concord.

Please refer to Exhibit 5 for North Carolina Department of Transportation annual average daily traffic counts for Kannapolis."

[Also see Exhibit 5 for recommendations on Kannapolis thoroughfares according to the 200-2005 Long Range Transportation Plan for the Cabarrus/South Rowan Urban Area.]

On pages 44-52 of the application, the applicant describes its methodology for projecting emergency department visits as follows:

"Methodology for Projecting Emergency Department Visits for Proposed Project

Service Area

The primary service area for the proposed emergency services that will be located in Kannapolis includes zip codes 28081, 28082 and 28083. Additionally, because of the relatively close proximity of the proposed emergency services to Rowan County, and consistent with its historical service line market share, CMC-NorthEast projects that some patients from adjacent Rowan County zip codes will utilize the proposed emergency services. Therefore, CMC-NorthEast includes zip codes 28023, 28088, and 28138 in its secondary service area".

[See map of CMC-Kannapolis's Proposed Service Area for Emergency Services on page 45 of the application.]

On page 46 of the application, the applicant states

"Population

The following table provides projections for CMC-Kannapolis's freestanding emergency department service area.

Note – Population projections do not include zip code 28082 because it is a Kannapolis P.O. Box, which does not report census population.

CMC – Kannapolis
Proposed Service Area-Emergency Services
Projected Population 2007 - 2012

Zip Code	Area	2007	2008	2009	2010	2011	2012
				Cabarrus County			
28081	Kannapolis	23,965	24,136	24,306	24,477	24,647	24,818
28083	Kannapolis	21,316	21,546	21,775	22,005	22,234	22,464
				Rowan County			
28088	Landis	2,894	2,891	2,888	2,884	2,881	2,878
28023	China Grove	13,502	13,552	13,601	13,651	13,700	13,750
28138	Rockwell	10,735	10,870	11,005	11,139	11,274	11,409
Total		**72,412**	**72,993**	**73,575**	**74,156**	**74,738**	**75,319**

Source: Claritas

Emergency Department Visit Use Rate

CMC-NorthEast used Solucient Inpatient Discharge and Emergency Department Visit databases to obtain historical market volume for emergency department visits for the identified service area.

FY2006 Emergency Department Visits by Zip Code

Facility	Emergency Department Visits						Market Share					
	28081	28083	28088	28023	28138	28082	28081	28083	28088	28023	28138	28082
CMC-NorthEast	8,738	7,880	809	2,729	1,339	282	87.5%	90.8%	69.6%	60.8%	35.1%	85.7%
CMC-University	184	191	8	33	22	7	1.8%	2.2%	0.7%	0.7%	0.6%	2.1%
Rowan Regional	581	286	271	1,484	2,185	13	5.8%	3.3%	23.3%	33.1%	57.2%	4.0%
CMC	72	75	13	36	13	2	0.7%	0.9%	1.1%	0.8%	0.3%	0.6%
Presby Hospital	33	40	11	10	9	1	0.3%	0.5%	0.9%	0.2%	0.2%	0.3%
Presby Hosp Matthew	13	12	1	2	0	0	0.1%	0.1%	0.1%	0.0%	0.0%	0.0%
Stanly Mem Hosp	37	7	2	15	122	0	0.4%	0.1%	0.2%	0.3%	3.2%	0.0%
Lake Norman Regional	158	22	10	58	16	15	1.6%	0.3%	0.9%	1.3%	0.4%	4.6%
Others	173	169	38	119	112	9	1.7%	1.9%	3.3%	2.7%	2.9%	2.7%
Grand Total	9,989	8,682	1,163	4,486	3,818	329	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Source: Solucient Inpatient Discharge Database and Emergency Department Database

Based on the 2006 population estimates for these zip codes (see below), CMC-NorthEast calculated an emergency visit use rate for FY2006 for each zip code.

2006 Population by Zip Code

Zip Code	Area	2006
28081	Kannapolis	23,891
28083	Kannapolis	20,906
28088	Landis	2,847
28023	China Grove	13,409
28138	Rockwell	10,534

Source: Claritas

FY 2006 Emergency Department Visit Use Rate (per 100 [sic] *population)*

Zip Code	2006
28081	418.11
28083	415.29
28088	408.50
28023	334.55
28138	362.45

Source: 2006 Solucient total emergency department visits by zip (zip code pop/100) [sic]. However, the above table reflects the number of FY2006 emergency department visits per 1,000 population. For example, on page 47 of the application, 2006 population for zip code 28081 is shown as 23,891 persons, and ED visits by residents of that zip code were 9,989. Therefore, the use rate per 1,000 residents is 418.11 [(9,989 / 23,891) x 1,000 = 418.11]. The rate per 100 residents would be 41.81 visits / 100 population.

On page 48 of the application, the applicant states

"CMC-NorthEast projects the respective emergency department visit use rates will remain constant through the third year of the proposed project. This is a conservative estimate. According to the National Center for Health Statistics (NCHS) latest study on emergency departments, 'From 1994 through 2004, the overall emergency department utilization rate increased by six percent, from 36.0 to 38.2 visits over 100 persons.'

Projected Emergency Department Visits Based on Emergency Department Visit Use Rate

CMC-NorthEast utilized the FY2006 emergency department visit use rates by zip code to determine the demand for emergency department visits in the identified service area.

CMC – Kannapolis
Freestanding Emergency Department Service Area
Projected Emergency Department Visits

Zip Code	Area	2007	2008	2009	2010	2011	2012
28081	Kannapolis	10,020	10,091	10,163	10,234	10,305	10,377
28083	Kannapolis	8,852	8,948	9,043	9,138	9,234	9,329
28088	Landis	1,182	1,181	1,180	1,177	1,177	1,176
28023	China Grove	4,517	4,534	4,550	4,567	4,583	4,600
28138	Rockwell	3,891	3,940	3,989	4,037	4,086	4,135
Total		**28,462**	**28,693**	**28,924**	**29,155**	**29,386**	**29,616**

Totals may not foot due to rounding

Market Share

CMC-NorthEast utilized the market shares calculated by the Solucient Inpatient Discharge and Emergency Department Visit database to project CMC-Kannapolis emergency department market share in the identified service area. To remain conservative, CMC-NorthEast projects no increase in market share by zip code through the third year of the proposed project.

CMC – Kannapolis
Projected Market Share – Emergency Services

Zip Code	Area	2010	2011	2012
28081	Kannapolis	87.5%	87.5%	87.5%
28083	Kannapolis	90.8%	90.8%	90.8%
28088	Landis	69.6%	69.6%	69.6%
28023	China Grove	60.8%	60.8%	60.8%
28138	Rockwell	35.1%	35.1%	35.1%

Source: Solucient Inpatient Discharge Database and Emergency Department Database

Projected CMC-Kannapolis Emergency Department Visits

CMC-NorthEast applied its projected market shares to the number of projected emergency department visits to calculate the number of CMC-Kannapolis emergency visits that it will encounter through the third year of the proposed project (PY2012).

...

"Based on FY2007 CMC-NorthEast emergency department visits by patient acuity level, approximately 82.85% of CMC-NorthEast emergency visits are appropriate for a freestanding emergency department. To remain conservative, CMC-NorthEast projects that 80% of the CMC-Kannapolis service area visits will occur at the proposed new freestanding emergency department.

Additionally, based on FY2006 patient origin by zip code, CMC-NorthEast's emergency department treated 333 patients from zip code 28082, a Kannapolis P.O. Box. Residents of Kannapolis utilize this zip code for their mailing address and are identified by this means at CMC-NorthEast; therefore, CMC-NorthEast also assumed 80% (333 x 80% = 266) of the historical patient origin from zip code 28082 will utilize the proposed freestanding emergency department.

Thus, CMC-NorthEast projects the following emergency visits in Kannapolis.

CMC – Kannapolis
Projected Emergency Department Visits
PY2010 to PY2012

Zip Code	*Area*	*2010*	*2011*	*2012*
28081	*Kannapolis*	*7,162*	*7,212*	*7,262*
28083	*Kannapolis*	*6,635*	*6,705*	*6,774*
28088	*Landis*	*656*	*655*	*654*
28023	*China Grove*	*2,223*	*2,231*	*2,239*
28138	*Rockwell*	*1,133*	*1,146*	*1,160*
28082 (P.O. Box)	*Kannapolis*	*266*	*266*	*266*
Total		***18,075***	***18,215***	***18,355***
% Growth		..	***0.8%***	***0.8%***

Totals may not foot due to rounding"

Emergency Department Visits Analysis

On page 23 of the application, the applicant states

"As described in Section III.1, the need for the proposed project is primarily based on CMC-NorthEast patients in Kannapolis and surrounding areas who currently travel to Concord to receive emergency services. Locating the proposed freestanding emergency department in Kannapolis will provide more convenient and timely local access to emergency services, while also alleviating capacity constraints at CMC-NorthEast's main campus."

CMC-NorthEast is the primary provider of ED visits to residents living in the CMC-Kannapolis service area zip codes (28081, 28082, 28083, 28023, 28088, and 28138). In fact, CMC-NorthEast had a 76.5% market share of all ED visits made by those residents in FY2006 (21,777 resident ED visits / 28,467 total resident ED visits = 0.765). Further, the applicant states CMC-NorthEast's ED is operating above capacity and its utilization is projected to increase at 3.1% CAGR, consistent with Cabarrus County population's CAGR growth rate. The applicant used this growth rate despite the fact that the hospital's annual number of ED visits historically increased by a CAGR of 4.6%, from FY2004 (71,872 ED visits) to FY2007 (82,327 ED visits), and by 7.3% from FY2006 to FY2007 (82,327 / 76,759 = 0.725), as shown in the table below.

CMC-NorthEast Historical ED Utilization

CMC-NorthEast	FY2004	FY2005	FY2006	CAGR 04-06	FY2007*	CAGR 04-07
ED Visits	71,872	74,106	76,759	3.3%	82,327	4.6%

*Data from CMC-NorthEast's 2008 Hospital License Renewal Application.

On page 23 of the application, the applicant states

> *"CMC-NorthEast considered expanding services in the Emergency Department at the hospital's main campus, but determined this is not the most effective alternative. According to CMC-NorthEast's architects, expanding the emergency services in the existing Emergency Department would require significant renovations and new construction. This would interrupt existing emergency services at CMC-NorthEast's main campus and also require a substantial capital expenditure."*

CMC-NorthEast currently has 37 existing ED treatment beds/bays and was recently approved for another 6 ED treatment beds at NorthEast at Harrisburg. Adding the 10 treatment beds proposed in this project, CMC-NorthEast would have a total of 53 ED treatment beds system wide. Thus, based on ACEP recommendations of capacity for an ED treatment room, which range from a low of 1,311 to a high of 1,778 patients per room, CMC-NorthEast would need 55 to 75 ED treatment rooms system wide to provide 95,666 ED visits. Therefore, CMC NorthEast adequately demonstrated the need for a total of 53 treatment rooms.

Further, the table below shows the total number of ED visits projected for CMC-NorthEast's main campus, after the shift of ED visits to NorthEast at Harrisburg and CMC-Kannapolis.

	FY2010	FY2011	FY2012
Total Projected CMC-NorthEast ED Visits	89,943	92,760	95,666
Projected NorthEast at Harrisburg ED Visits*	(4,943)	(5,768)	(6,634)
Projected CMC-Kannapolis ED Visits	(18,075)	(18,215)	(18,355)
Remaining ED visits at CMC-NorthEast	66,925	68,777	70,677
ED Treatment Rooms at CMC-NorthEast	37	37	37
ED Visits/ Treatment Room at CMC-NorthEast	1,809	1,859	1,910

*Supplemental information for NorthEast at Harrisburg Emergency Department and Diagnostic Imaging CON Appeal, September 20, 2007, Page 7

Accordingly, the projected numbers of ED visits remaining at CMC-NorthEast would be 66,925 in FY2010, 68,777 in FY2011, and 70,677 in FY2012. Thus, based on ACEP recommendations, the CMC-NorthEast main campus would need from 40 (low range) to 54 ED treatment beds (high range) by 2012. Therefore, CMC-NorthEast adequately demonstrated the need to maintain 37 treatment beds on the main campus.

Also, on page 24, the applicant states that "*historically, residents from Kannapolis and surrounding areas have accounted for over 35% of CMC-NorthEast's Emergency Department Patient Origin.*" See previous table regarding market share calculations. The applicant projects 80% of the residents of the CMC-Kannapolis service area who receive ED services at CMC-NorthEast would shift to the proposed freestanding ED, and the remaining 20% of residents' visits would continue to be treated at CMC-NorthEast's ED. The applicant based this assumption on patient acuity levels at CMC-NorthEast which showed 82.5% of the hospital's ED visits were appropriate for a freestanding ED. The applicant adequately demonstrated that the projected number of ED visits needed by patients from the proposed service area that are currently served at CMC-NorthEast is based on reasonable assumptions. In summary, the applicant adequately demonstrates the need for an outpatient ED with 10 treatment rooms in Kannapolis.

Observation Bed Analysis

On page 52 of the application, the applicant states

"CMC-NorthEast proposes to include two (2) observation beds to support the proposed ten emergency rooms. An observation bed is necessary to monitor patients who have received treatment, but are not immediately ready to be discharged. Based on CMC-NorthEast's FY2007 emergency department visits, approximately 3.8% of emergency department visits resulted in observation. Therefore, CMC-NorthEast projects the following observation patients at CMC-Kannapolis. This represents 97% utilization of the observation beds (710 / 365 /2).

CMC-Kannapolis
Projected Observation Patients
PY2010 to PY2012

	PY2010	PY2011	PY2012
Observation Patients	700	705	710"

The projected number of observation days is based on the projected number of CMC-Kannapolis ED visits. The applicant assumes CMC-Kannapolis will receive the same percentage of observation patients (3.87%), per total number of freestanding ED visits as occurred at CMC-NorthEast Medical Center in FY2007. The applicant adequately demonstrates the need for two observation beds at CMC-Kannapolis to serve ED patients.

Imaging Services Analysis

On page 52 of the application, the applicant states

"The relocated CT scanner and ultrasound units and proposed new X-ray unit are necessary to support the proposed emergency services in Kannapolis.

Based on historical utilization, the following percent of CMC-NorthEast emergency department visits (excluding emergency patients admitted as inpatients) result [sic] *in an imaging procedure.*

Dept Name	% Emergency Department Visits That result in Test
X-ray	35.85%
Ultrasound	5.68%
CT	19.32%

Totals may not foot due to rounding"

On page 53 of the application, the applicant states

" CMC-Kannapolis
Projected Imaging Procedures
PY2010 to PY2012

	PY2010	PY2011	PY2012
Kannapolis ED Visits	18,075	18,215	18,355
CT Scans	3,492	3,519	3,546
X-Ray Procedures	6,480	6,530	6,580
Ultrasound Procedures	1,026	1,034	1,042

Totals may not foot due to rounding

...

As stated previously, in March 2007 Southern Piedmont Imaging, LLC, a wholly-owned subsidiary of CMC-NorthEast, received CON approval to develop a diagnostic imaging center on the NCRC, CON Project # F-7730-06. The relocated CT scanner and ultrasound machine and proposed X-ray machine for CMC-Kannapolis are not intended for general diagnostic purposes; rather they will support the proposed freestanding emergency department. Thus, the imaging services associated with the proposed project will not duplicate or have a negative affect [sic] *on diagnostic imaging utilization at SPI.*

The relocation of one CT scanner to CMC-Kannapolis will also not result in unnecessary duplication of services in the identified service area. First, CMC-NorthEast already owns and operates the CT scanner, thus the proposed project does not result in a net increase of CT scanners in Cabarrus County. Second, the projected utilization on the relocated CT scanner equates to approximately 5,591 HECTs (in PY2012) based on CMC-NorthEast's conversion factor of approximately 1.58 (3,546 x 1.58).* [*Footnote: *In FY2006, CMC-NorthEast performed 53,395 CT scans that equaled 84,180 HECTS (84,180/53,395 = 1.58]. Thus, the relocated CT scanner satisfies the minimum performance standard for new CT scanners. Third, based on the most recent CT use rate and projected population, the CMC-Kannapolis service area demonstrates the need for five (5) CT scanners.*

CMC-Kannapolis Service Area
CT Scanner Demand

	2007	2012
CMC-Kannapolis Service Area Population	72,412	75,319
2006 CT Use Rate/1000*	210.4	210.4
Projected Demand	15,235	15,847
Projected HECTS (Projected CT scan demand x 1.58 CMC-NorthEast HECT conversion factor)	24,020	24,984
CT Performance Standard (5,100 HECTs)	5,100	5,100
Projected CT Scanner Demand	**5**	**5**

**IMV 2006 CT Benchmark Report"*

On page 54 of the application, the applicant states

> *"CMC-NorthEast has documented that 19.32% of its emergency department visits result in a CT scan. The CT scanner is necessary to support the freestanding emergency department and will be well utilized."*

The projected number of CT scans is based on the projected number of CMC-Kannapolis ED visits. The applicant assumes the same percentage of CT scans (19.32%) performed on CMC-NorthEast ED patients would apply to scans performed on CMC-Kannapolis ED patients. The applicant adequately demonstrates the need for CT services at CMC-Kannapolis to serve ED patients.

On page 55 of the application, the applicant states

> *"The relocation of one ultrasound machine to CMC-Kannapolis will not have a negative affect* [sic] *on existing ultrasound services at CMC-NorthEast. As stated previously, patients from the identified service area account for approximately 35.83% of CMC-NorthEast's patient origin for emergency services. Furthermore, CMC-NorthEast has documented that 5.68% of emergency department visits result in an ultrasound. The ultrasound unit is necessary to support the freestanding emergency department and will be well utilized.*

The projected number of x-ray procedures is based on the projected number of CMC-Kannapolis ED visits. The applicant assumes that the same percentage of ultrasound procedures performed on CMC-NorthEast ED patients (5.68%) would apply to those performed at CMC-Kannapolis. The applicant adequately demonstrates the need for an ultrasound unit at CMC-Kannapolis.

Also, on page 55 of the application, the applicant states

> *"The purchase of one x-ray machine will not result in unnecessary duplication of services in the identified service area. As stated previously, patients from the identified service area account for approximately 35.83% of CMC-NorthEast's patient origin for emergency services. In*

*FY2006, CMC-NorthEast treated over 27,000 patients from the identified service area. Furthermore, CMC-NorthEast has documented that 35.85% of emergency department visits result in an x-ray procedure. The proposed x-ray machine is necessary to support the freestanding emergency department and will be well utilized. Furthermore, the projected total x-ray utilization of 109,487 in FY2012 (see Section IV.2) represents 189.91% of CMC-NorthEast system capacity.** [*Footnote: *CMC-NorthEast owns 14 x-ray machines, thus system x-ray capacity is estimated at 57,652 (14 x 4,118]; therefore, the purchase of one x-ray machine for use at CMC-Kannapolis will not have a negative affect* [sic] *on the existing x-ray services at CMC-NorthEast."*

The applicant assumes the same percentage of x-ray procedures performed on CMC-NorthEast ED patients (35.83%) would apply to those performed at CMC-Kannapolis. Further, the projected number of x-ray procedures is based on the projected number of CMC-Kannapolis ED visits, and because projected ED visits are reasonable, the assumptions regarding projected x-ray procedures also are reasonable for the same reasons. Therefore, the applicant adequately demonstrates the need for an x-ray unit at CMC-Kannapolis.

Laboratory & Pharmacy Analysis

On pages 55-56 of the application, the applicant states

"As described previously in Section II, CMC-Kannapolis will also provide necessary ancillary and support services including a laboratory and pharmacy dispensing machine located directly in the emergency department. The laboratory will include routine chemistry, hematology, and coagulation to support urinalysis and emergency care. In addition, emergency blood banking services will be available. CMC-NorthEast does not have the capability to track emergency visits that result in a lab test or pharmacy dispense, thus CMC-NorthEast is unable to document the historical utilization of these services related to emergency department visits. Therefore, CMC-NorthEast projects the proposed laboratory and pharmacy services will be utilized as the proposed emergency services dictate."

Thus, the applicant uses the projected number of patients needing ED services at CMC-Kannapolis as the basis for the need for laboratory and pharmacy services, as well. Consequently, because the applicant adequately demonstrated the number of projected ED visits is reasonable, the applicant's assumptions regarding the need for the laboratory and pharmacy services are also reasonable.

In summary, the applicant adequately demonstrated the need for the proposed project. Therefore, the application is conforming to this criterion.

(3a) In the case of a reduction or elimination of a service, including the relocation of a facility or a service, the applicant shall demonstrate that the needs of the population presently served will be met adequately by the proposed relocation or by alternative arrangements, and the effect of the reduction, elimination or relocation of the service on the ability of low income persons, racial and ethnic minorities, women, handicapped persons, and other underserved groups and the elderly to obtain needed health care.

CA

In Section III.8, pages 67-68 of the application, the applicant states

> *"CMC-NorthEast will relocate one CT scanner and one ultrasound machine to CMC-Kannapolis as part of the proposed project. However, as described previously, this will not have a negative affect* [sic] *on existing services at CMC-NorthEast."*

Ultrasound

On page 55 of the application, the applicant states

> *"Relocating the ultrasound unit will not negatively affect access to ultrasound services at CMC-NorthEast's main campus. CMC-NorthEast currently owns and operates a total of 10 ultrasound machines. In FY2006, CMC-NorthEast's ultrasound utilization of approximately 22,927 represented 55.68% of the estimated capacity of approximately 41,180 procedures (10 x 4,118). The proposed project will relocate only 10% of CMC-NorthEast's ultrasound capacity (1/10 ultrasound machines). Furthermore, the projected total ultrasound utilization of 28,516 in FY2012 (see Section IV.2) represents 69.25% of CMC-NorthEast system capacity; therefore, relocation of one ultrasound machine to CMC-Kannapolis will not have a negative affect on the existing ultrasound service at CMC-NorthEast's main hospital campus."*

However, the applicant received prior approvals to relocate two of the ten existing ultrasound (US) units from CMC-NorthEast to other sites: one unit to a freestanding ED and diagnostic imaging center in Harrisburg which was previously approved in October 2007, Project I.D. #F-7731-06, and another unit to Southern Piedmont Imaging, LLC in Kannapolis, approved in May 2007, Project I.D. #F-7730-06. The proposed relocation of another US unit to CMC-Kannapolis would leave 7 US units at CMC-NorthEast. On page 88 of the application, the applicant showed 21,075 outpatient US procedures projected at CMC-NorthEast in 2011. Therefore, backing out the numbers of US procedures projected in previously approved projects (2,671 at Southern

Piedmont Imaging and 1,092 at NorthEast at Harrisburg), as well as the 1,034 US procedures projected at CMC-Kannapolis, CMC-NorthEast would have 16,278 outpatient US procedures to be performed at the hospital. Adding in CMC-NorthEast's projected number of inpatient US procedures, would result in a total of 22,853 US procedures to be performed at the hospital's main campus in 2011. Therefore, the 7 US units remaining at the hospital would be operating at an average of 3,265 US procedures per US unit, well below the applicant's estimated US equipment capacity of 4,118 procedures per unit. Thus, the applicant demonstrated that relocating one existing ultrasound unit from the main hospital would not have a negative impact on the ability of patients served at the hospital to receive needed ultrasound services.

Outpatient US Procedures	**FY2011**
NEMC System Wide US Procedures	21,075
So. Piedmont US Procedures	(2,671)
NorthEast at Harrisburg US procedures	(1,092)
CMC-Kannapolis US Procedures	(1,034)
Remaining Outpatient US Procedures at CMC-NorthEast	16,278
Projected Inpatient US Procedures at CMC-NorthEast	6,575
Total US Procedures at CMC-NorthEast	22,853
Total CMC-NorthEast US Procedures per remaining 7 US units	**3,265**

CT Scanner

On page 54, the applicant states

> *"The relocation of one CT scanner to CMC-Kannapolis will not have a negative affect* [sic] *on the existing CT services at CMC-NorthEast. As stated previously, patients from the identified service area account for approximately 35.83% of CMC-NorthEast's patient origin for emergency services. In FY2006, CMC-NorthEast treated over 27,000 patients from the identified service area."*
>
> ...
>
> *...First, CMC-NorthEast already owns and operates the CT scanner, thus the proposed project does not result in a net increase of CT scanners in Cabarrus county. Second, the projected utilization on the relocated CT scanner equates to approximately 5,591 HECTs (in PY2012) ..."*

Currently, CMC-NorthEast has seven existing or approved CT scanners: three existing CT scanners located at the CMC-NorthEast Medical Center's main campus in Concord, two existing CT scanners located at NorthEast Outpatient Imaging Center – Copperfield, one approved new CT scanner to be located at Southern Piedmont Imaging Center (SPI) on the North Carolina Research Campus in Kannapolis, and one approved new CT scanner to be located at NorthEast at Harrisburg.

In the application under review, the applicant proposes to relocate to CMC-Kannapolis, one of the two existing CT scanners at NorthEast Outpatient Imaging Center – Copperfield. The applicant was awarded a certificate of need on March 1, 2006 (Project I.D. #F-7410-05) to acquire the second CT scanner located at Copperfield, based on the needs of the patients served in the outpatient facility. However, if the proposal under review were approved, there would be only one CT scanner remaining at the Copperfield location. Thus, this proposal represents a reduction in CT services for the population served at NorthEast Outpatient Imaging Center – Copperfield. However, in this application the applicant did not provide any CT utilization data for the Copperfield facility to show how the relocation of the CT scanner would affect patients served at that facility. Consequently, the applicant failed to provide sufficient information to demonstrate that one CT scanner would be sufficient capacity for the patients who would continue to utilize NorthEast Outpatient Center - Copperfield for CT scanner imaging services.

In summary, the applicant failed to demonstrate that the needs of the population presently served will be met adequately following the relocation of the CT scanner from Copperfield. Therefore, the applicant is conforming to this criterion subject to the following condition:

Carolinas Medical Center-NorthEast, Inc. d/b/a CMC-NorthEast shall not relocate a CT scanner from NorthEast Outpatient Imaging Center - Copperfield to the new freestanding emergency department.

(4) Where alternative methods of meeting the needs for the proposed project exist, the applicant shall demonstrate that the least costly or most effective alternative has been proposed.

CA

In Section II.5, pages 20-21, the applicant discussed several alternatives it considered prior to submission of this application. The application is conforming, as conditioned, to all applicable statutory review criteria. See Criteria (1), (3), (3a), (5), (6), (7), (8), (12), (13), (14), (18a), and (20). Therefore, the applicant adequately demonstrates that its proposal is an effective alternative and the application is conforming to this criterion subject to the following conditions.

1. **Carolinas Medical Center-NorthEast, Inc. d/b/a CMC-NorthEast shall materially comply with all representations made in the certificate of need application, except as specifically amended by the conditions of approval.**

2. **Carolinas Medical Center-NorthEast, Inc. d/b/a CMC-NorthEast shall not acquire, as part of this project, any equipment that is not included in the project's proposed capital expenditure in Section VIII of the application or that would otherwise require a certificate of need.**

3. **Carolinas Medical Center-NorthEast, Inc. d/b/a CMC-NorthEast shall acknowledge acceptance of and agree to comply with all conditions stated herein to the Certificate of Need Section in writing prior to issuance of the certificate of need.**

(5) Financial and operational projections for the project shall demonstrate the availability of funds for capital and operating needs as well as the immediate and long-term financial feasibility of the proposal, based upon reasonable projections of the costs of and charges for providing health services by the person proposing the service.

C

In Section VIII.1, page 129, the applicant projects the total capital cost of the project will be $17,246,659 as illustrated below.

Site Costs		
Purchase Price of the Land	$1,925,500	
Site Preparation Costs	$963,000	
Subtotal Site Costs		**$2,888,000**
Construction Costs		**$7,427,550**
Miscellaneous Costs		
Fixed Equipment	$2,500,000	
Movable Equipment	$2,300,000	
Furniture	$500,000	
Landscaping	$150,000	
Consultant Fees	$981,109	
Other - Contingency	$500,000	
Subtotal Miscellaneous Costs		**$6,931,109**
Total Capital Cost		**$17,246,659**

In Section IX, page 170, the applicant also states there will be no start up or initial operating expenses. In Section VIII.3, page 131, the applicant states the capital cost of the project will be financed out of accumulated reserves. Exhibit 18 includes a letter from Mark S. Nantz, Executive Vice President, Chief Administrative Officer, Carolinas Medical Center-NorthEast, documenting the availability of funding for the project:

"As shown on our financial statements, NorthEast Medical Center has sufficient accumulated reserves to fund all the capital cost needed for the proposed CMC-Kannapolis facility. The total capital cost of the project

is estimated at $17,246,659. Sufficient accumulated reserves are available to fund this project in addition to other ongoing certificate of need projects that Carolinas Medical Center-NorthEast is undertaking. Carolinas Medical Center-NorthEast has committed all the funds necessary from accumulated reserves to complete this project. Upon issuance of a CON for this project, the available funds will be used for the proposed project."

Exhibit 19 contains the Cabarrus Memorial Hospital (dba NorthEast Medical Center and Subsidiaries) audited consolidated financial statements for the years ended September 30, 2006 and 2005. The line item "*Cash and cash equivalents*," showed $40.2 million as of September 30, 2006. The applicant adequately demonstrated the availability of sufficient funds for the capital needs of the project.

The applicant provided pro forma financial statements for the first three years of the project. In the projected revenue and expense statement, the applicant projects revenues will exceed operating costs at CMC-Kannapolis in each of the first three years of operation, by $809,892, $501,173, and $728,004, respectively. The assumptions used by the applicant in preparation of the pro formas are provided in the Financials Tab of the application. The financial statements are based on reasonable utilization projections. See Criterion (3) for discussion of projected utilization. Therefore, the applicant adequately demonstrates that the financial feasibility of the proposal is based upon reasonable projections of costs and revenues. Consequently, the application is conforming to this criterion.

6) The applicant shall demonstrate that the proposed project will not result in unnecessary duplication of existing or approved health service capabilities or facilities.

C

The applicant adequately demonstrates the need for all of the services it proposes to provide at CMC-Kannapolis. See Criterion (3) for discussion. Therefore, the applicant adequately demonstrates that the proposal would not result in the unnecessary duplication of existing or approved health service capabilities or facilities. Consequently, the application is conforming to this criterion.

(7) The applicant shall show evidence of the availability of resources, including health manpower and management personnel, for the provision of the services proposed to be provided.

CA

In Section VII.1, page 115, the applicant provides the projected staffing for CMC-Kannapolis for the first three operating years. The applicant projects CMC-Kannapolis to employ a total of 48.8 FTE positions in Year One, 58.2 FTE positions in Year Two, and 58.2 FTE positions in Year Three. On pages 120-121 of the application, the applicant states it has in place the administrative staff and physicians necessary to accommodate the requirements of the CMC-Kannapolis freestanding ED project.

"a) The administrative needs for the freestanding Emergency Department will be met by the existing CMC-NorthEast ED Director. The administrative needs for the supporting diagnostic and ancillary services will be managed by the Director of Radiology, Director of laboratory, and Director of Pharmacy respectively. Furthermore, the Lead Technologist from CMC-NorthEast's Radiology Department will oversee all diagnostic imaging equipment to ensure CMC-NorthEast has parity between the hospital-based and freestanding ED diagnostic imaging equipment. The CMC-NorthEast Pharmacy Department will oversee Pyxis management, and the CMC-NorthEast Lab Department will oversee the Lab Techs who will support the freestanding ED in Kannapolis.

b) Support personnel for the proposed expanded services will be provided by new hire staff, as show [sic] *in Table VII.1. These staff include scheduling, registration, billing service, and nursing support positions, as well as environment services workers. In addition, CMC-NorthEast will support the freestanding ED with many support services at the corporate level, including plant operations, security, human resources, materials management, clinical engineering, infection control, information systems, etc.*

c) CMC-NorthEast does not anticipate using contract personnel related to this freestanding ED project.

d) Cabarrus Emergency Medicine Associates and Cabarrus Radiologists, P.A., the physician groups that currently service the CMC-NorthEast, will provide all necessary physician support. CMC-Kannapolis will use board-certified, credentialed emergency physicians to provide professional services and medical direction for the freestanding Emergency Department. A credentialed emergency physician will be present in the facility 24 hours per day / 7 days a week/ 365 days per year."

Exhibit 6 includes letters from physicians who currently serve as medical directors of CMC-NorthEast and who agree to serve as medical directors for

the proposed CMC-Kannapolis. Andrew L. Matthews, MD will be the Medical Director for emergency services. Thomas R. Jones, MD will serve as Director for Imaging Services, and Robert B. Kinney, MD will be the Medical Director for Laboratory Services.

On page 116 of the application, the applicant presents projected staffing for the proposed facility. The table below shows projected FTE positions and related staffing costs for the proposed imaging technologists in Project Year Two (2011).

Position Title	2007 Avg. Salary	FY2001	
		FTEs	Expense
CT Technologist	$76,280	4.2	$374,794
CT Technologist Asst	$59,498	4.2	$292,339
Ultrasound Tech	$71,221	4.2	$349,939
X-ray Tech	$63,585	4.2	$312,422
Total		16.8	$1,329,494

The applicant's projected staffing expenses for CT, ultrasound and x-ray clinical personnel were based on 4.2 FTE technologists per modality working 24 hours a day, 7 days a week and 52 weeks per year. (24 hours X 365 days / 2,080 hours = 4.2 FTE positions). However, assuming the facility will provide 24 hour services, the number of projected FTE positions and related staffing costs do not appear to be sufficient to provide coverage of holidays, staff vacations, sick leave, education/training, and other absences. Therefore, the application is conforming to this criterion, subject to the following condition:

Prior to issuance of the certificate of need, Carolinas Medical Center-NorthEast, Inc. d/b/a CMC-NorthEast shall provide the Certificate of Need Section projections of FTE positions and associated expenses for additional imaging technologists to provide coverage in the event of absences of budgeted staff, or evidence that additional FTE positions are not necessary to assure 24 hour coverage.

(8) The applicant shall demonstrate that the provider of the proposed services will make available, or otherwise make arrangements for, the provision of the necessary ancillary and support services. The applicant shall also demonstrate that the proposed service will be coordinated with the existing health care system.

C

In Section IV.5, page 94; Section II.1, pages 16-18; and Section VII.2, pages 115-116, the applicant describes the ancillary and support services that will be

provided at CMC-Kannapolis and the services available from CMC-NorthEast. Exhibit 22 contains a patient transfer agreement between The Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas Medical Center and Cabarrus Memorial Hospital. Exhibit 13 contains physician letters of support for the project. The applicant adequately demonstrated that the necessary ancillary and support services would be available and that the proposed services would be coordinated with the existing health care system. Therefore, the application is conforming to this criterion.

(9) An applicant proposing to provide a substantial portion of the project's services to individuals not residing in the health service area in which the project is located, or in adjacent health service areas, shall document the special needs and circumstances that warrant service to these individuals.

NA

(10) When applicable, the applicant shall show that the special needs of health maintenance organizations will be fulfilled by the project. Specifically, the applicant shall show that the project accommodates:

(a) The needs of enrolled members and reasonably anticipated new members of the HMO for the health service to be provided by the organization; and

NA

(b) The availability of new health services from non-HMO providers or other HMOs in a reasonable and cost-effective manner which is consistent with the basic method of operation of the HMO. In assessing the availability of these health services from these providers, the applicant shall consider only whether the services from these providers:

(i) would be available under a contract of at least 5 years duration;

(ii) would be available and conveniently accessible through physicians and other health professionals associated with the HMO;

(iii) would cost no more than if the services were provided by the HMO; and

(iv) would be available in a manner which is administratively feasible to the HMO.

NA

(11) Repealed effective July 1, 1987.

(12) Applications involving construction shall demonstrate that the cost, design, and means of construction proposed represent the most reasonable alternative, and that the construction project will not unduly increase the costs of providing health services by the person proposing the construction project or the costs and charges to the public of providing health services by other persons, and that applicable energy saving features have been incorporated into the construction plans.

C

Exhibit 8 contains a line drawing of the proposed 23,973 square foot facility. Exhibit 12 includes a letter from the architect dated September 14, 2007, which states

> *"The estimated cost of construction is based on our healthcare experience and the recent construction experience of Carolinas HealthCare System. Based on this collective information, our knowledge and professional experience, BBH Design, PLLC certifies the estimated cost of construction as $8,390,550.00 and the estimated total capital costs of $17,246,659.00 are complete, accurate, and reasonable for this project."*

The above costs are consistent with costs in Table VIII on page 129 of the application that show the construction contract will be $7,427,550, and the cost of site preparation will be $963,000, for a total of $8,390,550. In Section XI.7, pages 160-161, the applicant states that applicable energy saving features will be incorporated into the new facility. The applicant adequately demonstrated that the cost, design, and means of construction represent the most reasonable alternative, and that the construction costs will not unduly increase costs and charges for health services. See Criterion (5) for discussion of costs and charges. The application is conforming to this criterion.

(13) The applicant shall demonstrate the contribution of the proposed service in meeting the health-related needs of the elderly and of members of medically underserved groups, such as medically indigent or low income persons, Medicaid and Medicare recipients, racial and ethnic minorities, women, and handicapped persons, which have traditionally experienced difficulties in obtaining equal access to the proposed services, particularly those needs identified in the State Health Plan as deserving of priority. For the purpose of determining the extent to which the proposed service will be accessible, the applicant shall show:

(a) The extent to which medically underserved populations currently use the applicant's existing services in comparison to the percentage of the population in the applicant's service area which is medically underserved;

C

In Section VI.10, page 112, the applicant provides the FY 2007 payor mix for all services provided at CMC-NorthEast, as illustrated in the following table.

FY 2007
CMC-NORTHEAST

PAYOR CATEGORY	% OF TOTAL PATIENT DAYS / PROCEDURES
Self Pay/Indigent/Charity	7.7%
Medicare	53.1%
Medicaid	12.2%
Commercial	5.0%
NC State Employees	2.0%
Other (VA, TriCare, Workers Comp)	0.9%
Managed Care	19.0%
TOTAL	100.0%

Note: Totals may not foot due to rounding

The table below shows the payor mix for CMC-NorthEast emergency services provided to patients not admitted to the hospital.

CMC-NORTHEAST
ED SERVICES FOR NON-ADMITTED PATIENTS - FY2007

PAYOR CATEGORY	% OF TOTAL PATIENT DAYS / PROCEDURES
Self Pay	23.7%
Medicare	20.5%
Medicaid	13.8%
Blue Cross	6.4%
Commercial	2.0%
Other (VA, TriCare, Workers Comp)	2.2%
Other (Managed Care)	31.4%
TOTAL	100.0%

Note: Totals may not foot due to rounding

The applicant demonstrated that medically underserved populations currently have adequate access to the services provided at CMC-NorthEast. Therefore, the application is conforming to this criterion.

(b) Its past performance in meeting its obligation, if any, under any applicable regulations requiring provision of uncompensated care, community service, or access by minorities and handicapped persons to programs receiving federal assistance, including the existence of any civil rights access complaints against the applicant;

The Acute and Home Care Licensure and Certification Section, DHSR, indicates there have been no civil rights access complaints filed against CMC-NorthEast within the last five years.

(c) That the elderly and the medically underserved groups identified in this subdivision will be served by the applicant's proposed services and the extent to which each of these groups is expected to utilize the proposed services; and

C

In Section VI.2, page 105, the applicant states *"CMC-NorthEast has a policy to provide all services to all patients regardless of income, racial/ethnic origin, gender, physical or mental conditions, age, ability to pay or any other factor that would classify a patient as underserved. As it will operate under the CMC-NorthEast hospital license, the proposed CMC-Kannapolis freestanding ED will similarly serve all patients having need for the offered healthcare services."* In Section VI.12, pages 113-114, the applicant provides the projected payor mix during the second operating year (October 2010 – September 2011) for the proposed project. The applicant states *"The projected payor mix matches the current payor mix for non-admitted ED patients. CMC-NorthEast does not anticipate any significant change in payor mix for the proposed CMC-Kannapolis freestanding ED service for the second year of operation following completion of the project."* The applicant demonstrated that medically underserved populations would have adequate access to the proposed services. Therefore, the application is conforming to this criterion.

(d) That the applicant offers a range of means by which a person will have access to its services. Examples of a range of means are outpatient services, admission by house staff, and admission by personal physicians.

C

See Section VI.7, on page 109 of the application for the applicant's range of means by which patients would have access to the services to be provided at CMC-Kannapolis. The information provided in the application is reasonable and credible and supports a finding of conformity with this criterion.

(14) The applicant shall demonstrate that the proposed health services accommodate the clinical needs of health professional training programs in the area, as applicable.

C

See Section V.1, including referenced exhibits, pages 97-98, for documentation that CMC-NorthEast will accommodate the clinical needs of area health professional training programs. The information provided in the application is reasonable and credible and supports a finding of conformity with this criterion.

(15) Repealed effective July 1, 1987.

(16) Repealed effective July 1, 1987.

(17) Repealed effective July 1, 1987.

(18) Repealed effective July 1, 1987.

(18a) The applicant shall demonstrate the expected effects of the proposed services on competition in the proposed service area, including how any enhanced competition will have a positive impact upon the cost effectiveness, quality, and access to the services proposed; and in the case of applications for services where competition between providers will not have a favorable impact on cost-effectiveness, quality, and access to the services proposed, the applicant shall demonstrate that its application is for a service on which competition will not have a favorable impact.

CA

The applicant adequately demonstrates that the proposal, as conditioned, would have a positive impact upon the cost effectiveness, quality and access to the proposed services. See Criteria (3), (3a), (5), (7), (8), (12), (13) and (20). Therefore, the application is conforming to this criterion subject to the conditions in the other criteria.

(19) Repealed effective July 1, 1987.

(20) An applicant already involved in the provision of health services shall provide evidence that quality care has been provided in the past.

C

CMC-NorthEast is accredited by the Joint Commission of Accreditation of Health Care Organizations and certified for Medicare and Medicaid participation. According to the Acute and Home Care Licensure and Certification Section, DHSR, no incidents occurred at the facility, within the eighteen months immediately preceding the date of this decision, for which any sanctions or penalties related to quality of care were imposed by the State. Therefore, the application is conforming to this criterion.

(21) Repealed effective July 1, 1987.

(b) The Department is authorized to adopt rules for the review of particular types of applications that will be used in addition to those criteria outlined in subsection (a) of this section and may vary according to the purpose for which a particular review is being conducted or the type of health service reviewed. No such rule adopted by the Department shall require an academic medical center teaching hospital, as defined by the State Medical Facilities Plan, to demonstrate that any facility or service at another hospital is being appropriately utilized in order for that academic medical center teaching hospital to be approved for the issuance of a certificate of need to develop any similar facility or service.

NA

Attachment 9

CAPE FEAR VALLEY MEDICAL CENTER – NEW ACUTE CARE BEDS

CERTIFICATION

The undersigned hereby assures and certifies that:

(a) the work on the proposed project will be initiated in accordance with the timetable set forth on the certificate of need:

(b) completion of the proposed project will be pursued with reasonable diligence;

(c) the proposed project will be constructed, operated and maintained in full compliance with all applicable local, State and Federal laws, rules, regulations and ordinances;

(d) the applicant will materially comply with the representations made in its application in the development of the project and the offering of the services pursuant to N.C.G.S. 131E-181(b); and,

(e) that the information included in this application and all attachments is correct to the best of my knowledge and belief and that it is my intent to carry out the proposed project as described.

LEGAL NAME OF APPLICANT: **Cumberland County Hospital System, Inc.**
d/b/a Cape Fear Valley Health System

NAME OF RESPONSIBLE OFFICER: **Jeannette Council**

TITLE OF OFFICER: **Chair, Board of County Commissioners**

ADDRESS: **117 Dick Street, Suite 512**
Fayetteville NC 28302-1829

SIGNATURE OF OFFICER: Jeannette Council

DATE: 8-10-04

Sworn to and Subscribed before me Deborah S. Hubbard
(Notary Signature)

this the 10th Day of Aug. (Month) 2004

My Commission Expires: 2-28-05

DEBORAH S. HUBBARD NOTARY PUBLIC CUMBERLAND COUNTY, N.C.

RECEIVED AUG 11 2004 CERTIFICATE OF NEED SECTION

CAPE FEAR VALLEY MEDICAL CENTER – NEW ACUTE CARE BEDS

CERTIFICATION

The undersigned hereby assures and certifies that:

(a) the work on the proposed project will be initiated in accordance with the timetable set forth on the certificate of need:

(b) completion of the proposed project will be pursued with reasonable diligence;

(c) the proposed project will be constructed, operated and maintained in full compliance with all applicable local, State and Federal laws, rules, regulations and ordinances;

(d) the applicant will materially comply with the representations made in its application in the development of the project and the offering of the services pursuant to N.C.G.S. 131E-181(b); and,

(e) that the information included in this application and all attachments is correct to the best of my knowledge and belief and that it is my intent to carry out the proposed project as described.

LEGAL NAME OF APPLICANT: **Cumberland County Hospital System, Inc.**
d/b/a Cape Fear Valley Health System

NAME OF RESPONSIBLE OFFICER: **Sid Gautam**

TITLE OF OFFICER: **President, Board of Trustees**

ADDRESS: **1638 Owen Drive**
Fayetteville NC 28304

SIGNATURE OF OFFICER: Sid Gautam

DATE: 7-28-04

RECEIVED
AUG 11 2004
CERTIFICATE OF NEED
SECTION

Sworn to and Subscribed before me Deborah S. Hubbard
(Notary Signature)

this the 28 Day of July (Month) 2004

My Commission Expires: 2-28-05

DEBORAH S. HUBBARD
NOTARY PUBLIC
CUMBERLAND COUNTY, N.C.

CAPE FEAR VALLEY MEDICAL CENTER – NEW ACUTE CARE BEDS

Certificate of Need Application
ACUTE CARE FACILITY/
MEDICAL EQUIPMENT PROJECT
State of North Carolina, Department of Health and Human Services

OFFICE USE ONLY
Project I. D. Number: M-7093-04
Proposal Type: _____

Batch Category:
Beginning of Review:

I. IDENTIFICATION

1. Legal Name of the Applicant: The applicant is the existing legal entity (i. e., person or organization) that will own the facility. If the facility will be leased, complete two copies of Section VIII for the project; one with the lessor as the applicant and the other with the lessee as the applicant.

Cumberland County Hospital System, Inc., d/b/a Cape Fear Valley Health System
(Name of Applicant)

1638 Owen Drive, Post Office Box 2000
(Street & Number)

Fayetteville	**NC**	**28302-2000**	**Cumberland**
(City)	(State)	(Zip)	(County)

2. Name of Parent Company (if applicable):

N/A

(Street & Number)

(City) (State) (Zip)

3. Person to whom all correspondence and questions regarding this application should be directed:

Lawrence C. Miller (Name) **Director of Reimbursement** (Title)

1638 Owen Drive, Post Office Box 2000
(Street & Number)

Fayetteville	**NC**	**28302-2000**	**(910)609-6440**
(City)	(State)	(Zip)	(Area Code & Phone Number)

CAPE FEAR VALLEY MEDICAL CENTER – NEW ACUTE CARE BEDS

II. SCOPE OF SERVICES/QUALITY OF CARE

1. Describe all components of the proposed project. Include a discussion of the proposed beds, equipment to be purchased, and services.

Historical high inpatient utilization at Cape Fear Valley Medical Center over the past 9 quarters has severely challenged our ability to ensure access to services in a timely manner.

Multiple resources are consumed daily by the Health System to improve patient throughput and reduce length of stay in order for us to accommodate patients awaiting admission through our Emergency Department, direct admissions from physicians' offices, and patients waiting at home or at other hospitals for transfer.

Cape Fear Valley Health System requests permission to add the forty-four (44) acute beds determined to be needed in Cumberland County, according to the 2004 State Medical Facilities Plan, to its licensed inventory of beds. Forty-one (41) of the beds are proposed to be used as general acute medical-surgical beds and the remaining three (3) are proposed to be classified as intensive care beds.

These beds can be accommodated in existing space within the Medical Center, some of which has been previously licensed bed space converted to office, waiting, and support areas. The remaining available space is within areas we utilize for short-term/observational patient care yet meets state code requirements for licensed bed space. The forty-four (44) beds will increase Cape Fear Valley Medical Center's acute licensed capacity to 438 beds.

The up-fitting time and expense for Cape Fear Valley Medical Center will be minimal. Twenty-eight (28) of the additional forty-four (44) acute care beds available can be operational within 90 days of the CON Section's approval. The remaining sixteen (16) can be operational within twelve (12) months of the Section's approval.

The following presents the logistics of the bed locations and are identified on floor line drawings in Exhibit 9:

- **One (1) bed will become operational on 3-North and added to the twenty-four (24) bed Nephrology Unit.**
- **Three (3) beds will become operational in the Cardiac Surgery Intensive Care Unit and added to its current eight (8) bed capacity.**
- **Nine (9) beds will become operational within the 3-North Observation Unit and utilized for medical-surgical patients.**
- **Fifteen (15) beds will become operational within the 2-East Observation Unit and utilized for medical-surgical patients.**

II. SCOPE OF SERVICES/QUALITY OF CARE

5. Discuss alternative solutions, including the implications of maintaining the status quo and/or modifying existing resources.

Maintaining Status Quo

Sustained occupancy rates of 90% or greater for medical-surgical beds over a period of 9 quarters has contributed to significant capacity management issues for the Medical Center. Likewise, intensive care beds have operated for 6 quarters with occupancy rates greater then 90%.

In addition to 15-20 patients per day who have admission orders and are housed, out of necessity in observation beds, patients with admission orders for an ICU bed and/or medical-surgical bed frequently have to be held in the Emergency Department due to non-availability of beds.

Efforts by the Health System to improve discharge planning/execution and patient throughput have been substantial but insufficient to meet the incoming volume of patients. The Medical Center, specifically, has struggled with capacity issues to the point that failure to do more than the status quo would be impractical at best. This is especially true in light of our ability to put the proposed beds into operation almost immediately and at minimal cost.

Renovation

Careful attention has been given to evaluation of space within the Medical Center and its suitability for conversion to inpatient bed space. The only such space available and appropriate for said purpose is the space being proposed as part of the scope of this application.

New Construction

An alternative would be to consider the construction of another wing on the campus or an additional unit above the fourth floor of the current Patient Services Tower.

New construction would be more costly than the proposed method estimated at $1,851,245 for minimum renovation and equipment as presented in Section VIII.1. Capital Costs and Financing.

Aside from the obvious difference in the cost of new construction versus renovation, the addition of a new wing would likely affect existing structures on campus such as the heliport or access perimeter roads, which would escalate the overall project cost even further.

New construction to gain only 44 beds is unnecessary since those beds can be integrated into space, which is currently available.

Attachment 10

CAPE FEAR VALLEY MEDICAL CENTER – NEW ACUTE CARE BEDS – COST OVERRUN

CERTIFICATE OF NEED ABRIDGED APPLICATION FORM
State of North Carolina
Department of Health and Human Services

OFFICE USE ONLY

Project I. D. Number: M-7436-05 Batch Category: _____
Proposal Type: _____ Beginning of Review: _____

I. IDENTIFICATION

1. Legal Name of the Owner/Applicant: This applicant is the existing legal entity (i.e., person or organization) that will own the facility. If the facility will be leased, complete two copies of Section VIII for the project; one with the lessor as the applicant and the other with the lessee as the applicant.

Cumberland County Hospital System, Inc., d/b/a Cape Fear Valley Health System
(Name of Applicant)

56-0845796
(Federal Taxpayer I.D. #)

1638 Owen Drive
(Street & Number)

Fayetteville	**NC**	**28304**	**Cumberland**
(City)	(State)	(Zip)	(County)

2. Name of Parent Company (if applicable):

N/A

(Street & Number)

(City) (State) (Zip)

3. Person to whom all correspondence and questions regarding this application should be directed:

Lawrence C. Miller **Director of Reimbursement**
(Name) (Title)

1638 Owen Drive
(Street & Number)

Fayetteville	**NC**	**28304**	**(910)609-6440**
(City)	(State)	(Zip)	(Area Code & Phone Number)

CAPE FEAR VALLEY MEDICAL CENTER – NEW ACUTE CARE BEDS – COST OVERRUN

II. SCOPE OF SERVICES

1. Describe all salient characteristics and the scope of the proposed project. Include a discussion of the beds to be developed, type of equipment to be purchased and services to be provided.

Cape Fear Valley Health System (CFVHS) filed its application on August 16, 2004, to seek approval for the implementation and licensure of 44 acute care beds pursuant to the 2004 State Medical Facilities Plan. On January 28, 2005, the CON Section approved CFVHS's CON application to establish the 44 beds at Cape Fear Valley Medical Center (CFVMC). Space designated for the 44 beds at CFVMC is classified as previously licensed bed space converted to office, storage, waiting, and support areas; and some of the space has been utilized as short-term/observation patient care areas while meeting the state's code requirements for licensed bed space. When completed, CFVMC's acute licensed bed capacity will increase from 394 to 438.

Once CON approval was obtained, CFVMC began the process to up-fit designated areas for placement of the beds. By March of this year, one bed had been added to the nephrology unit, three beds became operational in the cardiac surgery intensive care unit and nine beds within the Three North Observation Unit opened for medical-surgical patients. Once design was underway by the architect firm engaged to supervise modernization of the Four North medical-surgical unit, it became apparent that the support staff and physician on-call alternate space was inappropriate and that these personnel should be closer to the Four North patient care area. Accordingly, 2,455 square feet of space in Four West will be modernized to accommodate support staff and physicians on-call. An additional 559 square feet of space was added to the original 7,516 Four North area for the planned implementation of the 16 acute beds.

Two other factors have influenced the original costs of the planned modernization for 31 of the 44 acute beds: since the original cost estimates were provided in August 2004, costs in the construction industry have changed over 16 percent due to international market (steel and petroleum-related materials) inflation and the weather impact in the United States on petroleum component products.

The change in scope (square footage) and material cost increases have been approved by our Board of Trustees.

Planned implementation of the bed schedule is shown on the following page:

II. SCOPE OF SERVICES

1. (Continued)

Initial and Current Applications	Beds	Abridged Application	Implementation Dates
Three North Nephrology	1	1	March 5, 2005
CSICU	3	3	March 5, 2005
Three North Observation – M/S	9	9	March 5, 2005
Two North Observation – M/S	15	15	September 30, 2006
Four North – Offices – M/S	16	16	September 03,2006
Total	44	44	

Initially, 28 of the beds were to be operational by April 15, 2005. However, due to the reasons stated on the previous page, the schedule was extended 17 months for 15 of the medical/surgical beds and five months for the remaining 16 beds (see Section X., ACTUAL/PROPOSED SCHEDULE) with both units expected to become operational in September 2006.

II. SCOPE OF SERVICES

4. (b) Project the need that the primary service area could be expected to have for the beds, equipment or services proposed in this application for the first year and the anticipated rate of increase for the subsequent year. Provide all assumptions and data supporting the methodology used for the need projections.

Demographic Trends Indicate Patient Services Need:

Presented below are population projections by the Office of State Planning, State Demographic, indicating population for the first year after project completion, 2007, and the overall increase for the second year, 2008. The changes for the six-county service area are projected at 1.26 percent for one year:

County	2007	2008	% Change
Primary Service Area			
Cumberland	317,727	320,151	.76%
Secondary Service Area			
Robeson	129,931	131,245	1.01%
Harnett	106,292	108,657	2.23%
Sampson	65,406	66,536	1.73%
Hoke	42,284	43,559	3.02%
Bladen	33,743	34,016	.81%
	695,383	704,164	1.26%

The Fayetteville Observer reports that Cumberland and surrounding area is projected to increase in significant population changes not reflected in the numbers above resulting from re-location of military personnel to Fort Bragg, the Nation's largest land-based military installation. Nearly three-quarters of a million people will be living in CFVMC's six-county primary and secondary service area within three years. CFVMC is a "high-use" facility currently and will face admission constraints as the population continues to expand.

Physician Growth And Support

Over 450 doctors have privileges with CFVMC. A strong growth in medical staff members creates critical demand for patient bed availability. Since 2001, 53 admitting and 74 total doctors have joined CFVMC's staff while patient beds have increased by only 21 which were transferred from Highsmith-Rainey through September 2004. While the 13 beds placed into service on March 5, 2005, have alleviates some admitting stress, the remaining 31 beds will provide further relief to patient scheduling.

Patient Day Growth

Cape Fear Valley Medical Center's acute inpatient discharge growth has been steady over the past five years. All adult medical/surgical and critical cared beds experienced an increase in utilization among the years.

Attachment 11

STATE OF NORTH CAROLINA — IN THE OFFICE OF ADMINISTRATIVE HEARINGS
COUNTY OF HARNETT — 03 DHR 1838

GOOD HOPE HEALTH SYSTEM, LLC,

Petitioner,

and

THE TOWN OF LILLINGTON,
Petitioner-Intervenor,

vs.

DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF FACILITY SERVICES, CERTIFICATE OF NEED SECTION,

Respondent,

and

BETSY JOHNSON REGIONAL HOSPITAL, INC., and AMISUB OF NORTH CAROLINA, INC., d/b/a CENTRAL CAROLINA HOSPITAL,

Respondent-Intervenors.

Before: The Honorable Fred G. Morrison, Jr.

TRANSCRIPT OF HEARING
Volume 16

At Raleigh, North Carolina
June 9, 2004 - 9:03 a.m.

Reported by:
Cathleen M. Clack

APPEARANCES

For the Petitioner: (Good Hope)	Maureen D. Murray Bill Stewart SMITH MOORE LLP Post Office Box 21927 (27420) 300 North Greene Street, Suite 1400 Greensboro, North Carolina 27401 (336) 378-5482 (336) 378-5400 (fax)
For the Petitioner-Intervenor: (Town of Lillington)	C. Winston Gilchrist MORGAN REEVES & GILCHRIST Post Office Box 1057 Lillington, North Carolina 27546 (910) 893-5131
For the Respondent: (Certificate of Need Section)	Melissa L. Trippe Special Deputy Attorney General NORTH CAROLINA DEPARTMENT OF JUSTICE 9001 Mail Service Center Raleigh, North Carolina 27699-9001 (919) 716-6960
For the Respondent-Intervenor: (Betsy Johnson)	Noah H. Huffstetler, III Denise M. Gunter NELSON MULLINS RILEY & SCARBOROUGH GlenLake One, Suite 200 4140 Parklake Avenue Raleigh, North Carolina 27612 (919) 877-3801 (919) 877-3821 (fax)
(Amisub/Central Carolina)	S. Todd Hemphill BODE, CALL & STROUPE, LLP Post Office Box 6338 (27628-6338) 3105 Glenwood Avenue Suite 300 Raleigh, North Carolina 27612 (919) 881-0338 (919) 881-9548 (fax)

TABLE OF CONTENTS

EXAMINATIONS

I, Cathleen M. Clack, being a Verbatim Reporter and a Notary Public in and for the state of North Carolina, was appointed commissioner by consent to record the hearing of GOOD HOPE HEALTH SYSTEM, LLC, and THE TOWN OF LILLINGTON, vs. NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF FACILITY SERVICES, CERTIFICATE OF NEED SECTION and BETSY JOHNSON REGIONAL HOSPITAL, INC., and AMISUB OF NORTH CAROLINA, INC., d/b/a CENTRAL CAROLINA HOSPITAL, on the 9th day of June 2004, beginning at 9:03 a.m., at the offices of Nelson, Mullins, Riley & Scarborough, located at 4140 Parklake Avenue, Suite 200, Raleigh, North Carolina.

[MR. HUFFSTETLER NOT PRESENT]

THE COURT: We are ready to begin. All counsel are present, on June 9th, I think. We're back on the record in the Good Hope case, and Ms. Murray is completing her cross-examination of Mr. French [sic].

Whereupon,

Page 4881

exact testimony, but after the preapplication conference, based on a conversation that you had, you just couldn't grasp what you were seeing. Can you explain that a little further, please?

A: Well, in the preapplication conference, we said because you are going -- or proposing so much larger a facility than you were approved for before, you're going to have to justify the reasons for these changes in your application.

And that's what I thought we had stressed in the preapplication conference; that it was such a big change, that they were going to have a big job justifying the additional square footage because they had already been approved for an alternative that they represented as a very viable alternative.

And so that's what we were looking for, is where is that justification that this is a more effective alternative than the one they'd been approved for.

Page 4882

Q: Ms. Hoffman, looking at your notes on page 772 and 927, and then going to the findings on page 1185. And mainly I need to ask you about the findings, so if you can -- I don't know that you'll need those pages again, but --

A: Okay.

Q: Ms. Hoffman, beginning at page 1185, that's the beginning of -- well, it's a continuation of the discussion of the Agency's findings in Criterion (4). Is that correct?

A: Yes, ma'am.

Q: It appears that it addresses the proposed facility by areas?

A: Yes, ma'am.

Q: Why does it do that?

A: Because that's the way that the applicant had identified it in the application. They had charts. I think it's -- a copy is on page 772 that you had me go to. That was a copy of the page out of the application. So that was how it was presented in the application. And I was just trying to put on one table various pieces of information from various parts of the application.

Page 4883

Q: And what about with regard to the narrative that follows?

A: The applicant then described the various departments in this format in the application. They described each department separately.

Q: Ms. Hoffman, turn, if you will, to page 1190.

A: I have that.

Q: Do you see there about a third of the way down there's a heading that says, "Canopies, dock, and door soffits?"

A: Yes, ma'am.

Q: Mr. French testified the other day that he had never seen the CON Section provide an analysis of canopies. Do you agree or disagree with -- well, strike that.

Have you ever provided an analysis that included canopies?

A: Well, I don't know that it's been

Page 4884

necessarily written up this way in the application. This was written up this way because it's one of the items on their list, and we evaluated what the applicant provided us.

However, we have, in the past, denied applications for cost overruns because the facility they are proposing is so much larger, and then had to deal -- because we denied them in settlement with negotiations of canopies and docks and doors and soffits and flagpoles and cabinetry in meeting rooms and the type of driveway built, because those are all capital costs, and we were trying to make sure that the applicant gave us the least costly alternative possible. So we were trying to weed out anything that just added to the cost that wasn't a necessary item.

And so, yes, I've negotiated all kinds of things in the evaluation of cost overrun applications.

Q: What determination did you make, if any,

Attachment 12

J-8190-08
Copy

Novant Health, Inc.
Holly Springs Hospital (Wake County)
CON Application
August 15, 2008
Volume 1 of 4

PROJECT CAPITAL COST: Holly Springs Hospital

Site Costs		
	(1) Full purchase price of land 20 Acres X $210,000 per Acre--see contract in Exhibit 18*	$ 4,200,000
	(2) Closing Costs	$ 200,000
	(3) Site Inspection & Survey	$ 172,250
	(4) Legal Fees and subsoil investigation	$ 200,000
	(5) Site Preparation Costs	$ 4,701,598
	(6) Other:	$
	(7) **Sub-Total Site Costs****	**$ 9,473,848**
Construction Contract		
	(8) Cost of Materials ***	$ 22,186,556
	(9) Cost of Labor	$ 33,279,834
	(10) Other: ***Construction Contingency***	$ 1,599,563
	(11) **Sub-Total Construction Contract**	**$ 57,065,953**
Miscellaneous Project Costs		
	(12) Building Purchase	$ N/A
	(13) & (14) Fixed Equipment Purchase/Lease + Movable Equipment Purchase/Lease	$ 15,919,700
	(13) & (14) Information Technology	$ 4,500,000
	(15) Furniture	$ 1,316,000
	(16) Landscaping – included in Row (5)	
	(17) Consultant Fees	
	Architect and Engineering Fees (+ Reimbursables)	$ 4,941,404
	Legal Fees	N/A
	Market Analysis	N/A
	Other (Testing & Special Inspections, CON Consultant)	$ 366,000
	Sub-Total Consultant Fees	***$ 5,307,404***
	(18) Financing Costs /Imputed Interest ****	$
	(19) Interest During Construction	$ 2,848,597
	(20) Other (Specify): ***Project Contingency***	$ 2,880,087
	(21) **Sub-Total Miscellaneous (Rows 12-20)**	**$ 32,771,788**
	(22) Total Capital Cost of Project -***Sum above Subtotals for Rows (7), (11), & (21)***	**$ 99,311,589**

****The land contract has time-sensitive escalation clause, so greatest cost per acre is used for project capital cost to ensure that all essential costs are included.***

*****Site preparation costs include per CON definition: Soil Borings, Clearing and Grading, Roads and Parking, Sidewalks, Water and Sewer, Excavation and Backfill, and Termite Treatment***

******Cost of Materials includes: General Requirements, Concrete/Masonry, Woods/Doors & Windows/Finishes, Thermal & Moisture Protection, Equipment/Specialty Items, and Mechanical/Electrical per CON definitions***

*******Any interest expense associated with future bond financing is included as an expense line item in the Holly Springs Hospital's Pro Forma Income statements included with this CON application.***

Attachment 13

ATTACHMENT - REQUIRED STATE AGENCY FINDINGS

FINDINGS
C = Conforming
CA = Conditional
NC = Nonconforming
NA = Not Applicable

DECISION DATE: December 23, 2008

TEAM LEADER: Martha J. Frisone
CHIEF: Lee B. Hoffman

PROJECT I.D. NUMBER: **Project I.D. #G-8164-08/** Davie County Emergency Health Corporation d/b/a Davie County Hospital and North Carolina Baptist Hospital/ Relocate existing hospital from Mocksville to Bermuda Run/ Davie County

REVIEW CRITERIA FOR NEW INSTITUTIONAL HEALTH SERVICES

G.S. 131E-183(a) The Department shall review all applications utilizing the criteria outlined in this subsection and shall determine that an application is either consistent with or not in conflict with these criteria before a certificate of need for the proposed project shall be issued.

(1) The proposed project shall be consistent with applicable policies and need determinations in the State Medical Facilities Plan, the need determination of which constitutes a determinative limitation on the provision of any health service, health service facility, health service facility beds, dialysis stations, operating rooms, or home health offices that may be approved.

NC

Davie County Emergency Health Corporation d/b/a Davie County Hospital (DCH) and North Carolina Baptist Hospital (Baptist) propose to construct a new facility to replace and expand DCH. The applicants do not propose to acquire any medical equipment or develop any health service facility beds or services for which there is a need determination in the 2008 State Medical Facilities Plan (2008 SMFP). Therefore, there are no need determinations in the 2008 SMFP applicable to this review.

However, there are two policies in the 2008 SMFP that are applicable to this review. Because the applicants propose to construct space to replace 50 acute care beds, Policy AC-5 is

applicable to the review. POLICY AC-5: REPLACEMENT OF ACUTE CARE BED CAPACITY states

> *"Proposals for either partial or total replacement of acute care beds (i.e., construction of new space for existing acute care beds) shall be evaluated against the utilization of the total number of acute care beds in the applicant's hospital in relation to the utilization targets found below. In determining utilization of acute care beds, only acute care bed 'days of care' shall be counted. Any hospital proposing replacement of acute care beds must clearly demonstrate the need for maintaining the acute care bed capacity proposed within the application.*

Facility Average Daily Census	*Target Occupancy of Licensed Acute Care Beds (Percent)*
1 – 99	*66.7%*
100 – 200	*71.4%*
Greater than 200.	*75.2%*

In Exhibit 13, Section III.1(b), pages 71 and 74, and the assumptions for the pro formas, the applicants provide historical and projected utilization of the general acute care beds at DCH, as illustrated in the following table.

YEAR	# OF ACUTE CARE PATIENT DAYS	AVERAGE DAILY CENSUS (ADC)	TOTAL # OF LICENSED ACUTE CARE BEDS	% OCCUPANCY
10/1/04 – 9/30/05 (actual)	1,147	3.1	81	3.8%
10/1/05 – 9/30/06 (actual)	1,527	4.2	81	5.2%
10/1/06 – 9/30/07 (actual)	1,271	3.5	81	4.3%
10/1/07 – 9/30/08 (projected)	1,443	4.0	81	4.9%
10/1/08 – 9/3/09 (projected)	1,481	4.1	81	5.1%
10/1/09 – 9/30/10 (projected)	1,519	4.2	81	5.2%
10/1/10 – 9/30/11 (projected)	1,559	4.3	81	5.3%
10/1/11 – 12/31/11 (projected) (three months)	400	4.4	81	5.4%
1/1/12 – 12/31/12 (projected) (Year One)	11,875	32.5	50	65.1%
1/1/13 – 12/31/13 (projected) (Year Two)	12,273	33.6	50	67.2%
1/1/14 – 12/31/14 (projected) (Year Three)	12,683	34.7	50	69.5%

As shown in the above table, DCH's current average daily census (ADC) is 3.5 patients and its projected ADC during the third operating year of the project is 34.7 patients. Thus, the target occupancy rate for DCH is 66.7%. During the third operating year, the applicants project that the occupancy rate would be 69.5%,

which is greater than the target. See Criterion (3) for analysis of acute care utilization. The applicants adequately demonstrate the need to maintain the acute care bed capacity proposed in the application. Therefore, the applicants adequately demonstrate that the proposal is consistent with Policy AC-5 in the 2008 SMFP.

Further, because the applicants propose to develop new obstetric and neonatal services, including a new dedicated C-section OR, Policy GEN-3 is applicable to the review. Policy GEN-3 states

> *"A CON application to meet the need for new healthcare facilities, services or equipment shall be consistent with the three Basic Principles governing the State Medical Facilities Plan (SMFP); promote cost-effective approaches, expand health care services to the medically underserved, and encourage quality health care services. The Applicant shall document plans for providing access to services for patients with limited financial resources, commensurate with community standards, as well as the availability of capacity to provide those services. The Applicant shall also document how its projected volumes incorporate the three Basic Principles in meeting the need identified in the SMFP as well as addressing the needs of all residents in the proposed service area."*

In Section III.2, pages 93, the applicants state

> *"The proposed project has been developed to meet the three Basic Principles governing the State Medical Facilities Plan (SMFP); promote cost-effective approaches, expand health care services to the medically underserved, and encourage quality health care services. Reference the response to II.1, III.1.a., and V.7 as well as Section VI for evidence of the benefits of the proposed project and its ability to address these three Basic Principles. The projections have been specifically constructed to ensure that all inpatient, emergent, outpatient, surgical and ancillary services are available to all patients in the service area, with particular emphasis on meeting the needs of a community hospital. These projections have also considered the importance of maintaining access for all residents of Davie County as well as southern Yadkin County and the communities of Clemmons and Lewisville*

by ensuring centralized and highway access to the proposed hospital. The projections further allow for increased cost-effectiveness as economies are further achieved by ensuring its patient charges are competitive and its ability to serve more patients who currently have to drive out-of-county to receive a majority of services."

In Section V.7, page 111, the applicants state

"Failure to provide upgrades to the current hospital could impair the hospital's ability to provide optimum patient care and achieve desired patient satisfaction levels, as well as affect its compliance with HIPAA and JCAHO requirements. As such the proposed project offers the most effective alternative to maintaining the status quo and will be better enabled to provide access to quality care for its patients."

In Section VI.2, page 112, the applicants state

"The hospital is committed to improving the health of the residents of the community as demonstrated by the numerous programs and services provided both in and out of the hospital. In FY 2007, DCEHC provided more than $2 million in charity care and bad debt to residents of its service area. DCEHC provides services to all persons in need of medical care, including low income persons, racial and ethnic minorities, women, handicapped persons, elderly and other underserved and medically indigent."

In Exhibit 12, the applicants provide copies of DCH's:

1) Plan for Provision of Health Services;
2) Plan for Care Delivery; and
3) Performance Improvement Plan.

Each of these plans addresses how DCH proposes to provide quality health care services to its patients.

The applicants adequately demonstrate that medically underserved groups would have access to the proposed services. The applicants also adequately demonstrate their ability to encourage quality health care services. Additionally, the applicants demonstrate

projected volumes for the proposed services incorporate the basic principles in meeting the needs of patients to be served. See Criteria (3) and (13) for additional discussion. However, the applicants failed to adequately demonstrate the need for the project proposed in this application given the applicants have already been approved to develop a replacement facility in a prior review. Therefore, the applicants failed to demonstrate the proposed project is a cost-effective approach in addition to the previously approved project. Consequently, the application is not conforming to Policy Gen-3 and is not conforming to this criterion.

(2) Repealed effective July 1, 1987.

(3) The applicant shall identify the population to be served by the proposed project, and shall demonstrate the need that this population has for the services proposed, and the extent to which all residents of the area, and, in particular, low income persons, racial and ethnic minorities, women, handicapped persons, the elderly, and other underserved groups are likely to have access to the services proposed.

NC

The applicants propose to relocate Davie County Hospital from Mocksville to Bermuda Run. The hospital is currently licensed for 81 general acute care beds. However, the hospital is currently designated as a critical access hospital and currently operates a maximum of only 25 of the 81 licensed general acute care beds. The replacement hospital will not be designated as critical access. In addition, DCH is currently designated as a swing bed hospital. According to its 2008 Hospital License Renewal Application, DCH is currently *"approved for up to 49"* swing beds. Chapter 5 of the 2007 SMFP states on page 35, *"Section 1883 of the Social Security Act provides that certain small rural hospitals may use their inpatient facilities to furnish skilled nursing facility ... services to Medicare and Medicaid beneficiaries."* One of the requirements for the swing bed program is that the hospital cannot be located in an area designated as "urbanized" by the most recent U.S. Census. While Mocksville is not an urbanized area according to the 2000 U.S. Census, the proposed site in Bermuda Run is an urbanized area. Thus, the hospital would no longer qualify for swing bed designation, and therefore, would no longer operate swing beds. See Criterion (3a) for additional discussion. Further, the hospital is currently licensed for two shared operating rooms (ORs) and one gastrointestinal (GI) endoscopy room. The applicants propose to

develop 50 general acute care beds, four of which will be designated as obstetric beds. In addition, the applicants propose to develop two shared ORs, one dedicated C-section OR and one GI endoscopy room in the replacement hospital.

The following table compares the beds, medical equipment and services currently provided by DCH with those proposed to be offered in the replacement hospital, as described by the applicants in Section II.1, pages18-22, and Exhibit 20.

BEDS/EQUIPMENT/SERVICES	CURRENT	PROPOSED	INCREASE (DECREASE)
Licensed Acute Care Beds [1]			
general medical/surgical	81	46	(35)
obstetrical (post partum)	0	4	4
Total	81	50	(31)
Unlicensed bassinets	0	3	3
Unlicensed Observation Beds [2]	3	10	7
Gastrointestinal (GI) Endoscopy Rooms	1	1	0
Shared Operating Rooms (ORs)	2	2	0
Dedicated C-section OR	0	1	1
Minor Procedure Rooms	1	1	0
C-arm	1	1	0
CT scanner	1	1	0
Echo	0	2	2
EEG	0	1	1
EKG	2	4	2
EMG / EP System	0	1	1
Mammography units	1	1	0
Pulmonary Function Testing System	1	1	0
Stress Testing	1	1	0
Ultrasound (US) units	2	3	1
Fixed X-ray units [3]	2	3	1
Portable X-ray units	2	2	0
Emergency Services [4]	9 treatment rooms	20 treatment rooms	11 treatment rooms
Laboratory Services	*"yes"*	*"yes"*	
Pharmacy Services	*"yes"*	*"yes"*	
Respiratory Therapy Services	*"yes"*	*"yes"*	
Physical Therapy Services	*"yes"*	*"yes"*	

(1) Although currently licensed for a total of 81 general acute care beds, DCH is designated as a critical access hospital and operates a maximum of only 25 general acute care beds. In addition, DCH is designated as a swing bed hospital. According to its 2008 Hospital License Renewal Application, DCH is currently *"approved for up to 49"* swing beds.

(2) In Section II.1, page 18, the applicants state that DCH has three unlicensed observation beds. However, in its 2008 Hospital License Renewal Application, DCH reports that it does not have any unlicensed observation beds, but does report providing 20 observation days, which therefore must have been provided in the licensed acute care beds.

(3) In Section II.1, page 21, the applicants state the proposed replacement hospital would have three fixed X-ray units. However, according to the equipment list in Exhibit 20, the applicants propose only two fixed X-ray units. The design schematic in Exhibit 6 shows three fixed X-ray units.

(4) The applicants do not provide the current number of treatment rooms in the Emergency Department in the certificate of need application. However, in its 2008 Hospital License Renewal Application, DCH reports that it has nine treatment rooms in the Emergency Room.

As shown in the above table, new and expanded services to be provided at the proposed replacement hospital include:

- 4 new obstetrical (post partum) beds
- 4 new labor/delivery/recovery (LDR) beds
- 3 new unlicensed bassinets
- 7 new unlicensed observation beds per narrative in application. [Note: According to its 2008 Hospital License Renewal Application (LRA), DCH does not report having any unlicensed observation beds. Thus, the new facility would have a total of 10 new unlicensed observation beds, based on information reported in the LRA.]
- 1 new dedicated C-section operating room
- 2 new Echo units
- 1 new EEG unit
- 2 additional EKG units
- 1 new EMG / EP unit
- 1 additional fixed X-ray unit
- 1 additional US unit
- 11 additional Emergency Room treatment rooms

In Exhibit 20, the applicants indicate that all of the existing equipment would be replaced with new equipment at the proposed replacement hospital.

It should be noted that, DCH and Baptist previously filed an application (Project I.D. #G-8078-08) in March of 2008 for review beginning April 1, 2008 to develop a replacement hospital offering the following beds and services: 50 general acute care beds, 10 unlicensed observation beds, Surgery, Radiology, Emergency, Laboratory, Pharmacy, Cardiopulmonary and Physical Therapy. The Agency conditionally approved Project I.D. #G-8078-08 on August 28, 2008 to develop a replacement hospital in Bermuda Run offering the following beds and services: 48 general acute care beds; Surgery, Radiology, Emergency, Laboratory, Pharmacy, Cardiopulmonary and Physical Therapy. That decision is currently under appeal. Thus, the proposed project duplicates the replacement hospital and services approved for the previous project. Additional discussion of the previously approved project appears later in Criterion (3).

Population to be Served

The following table illustrates the current patient origin for acute care services provided by DCH during federal fiscal year (FFY) 2007, as reported by the applicants in Exhibit 24, which consists of a copy of the acute care patient origin table from DCH's 2008 Hospital License Renewal Application.

COUNTY	# OF ADMISSIONS	% OF TOTAL ADMISSIONS
Davie	391	87.9%
Iredell	12	2.7%
Rowan	10	2.2%
Virginia	9	2.0%
Davidson	4	0.9%
Guilford	3	0.7%
Forsyth	3	0.7%
Yadkin	2	0.4%
Haywood	2	0.4%
Wilkes	1	0.2%
Stanly	1	0.2%
Rockingham	1	0.2%
Randolph	1	0.2%
Other States	5	1.1%
Total [1]	445	99.8%

[1] Does not equal 100% due to rounding.

As shown in the above table, during FY 2007, 87.9% of DCH's 445 total acute care admissions were residents of Davie County, 0.7% were residents of Forsyth County, 0.4% were residents of Yadkin County and about 11% were residents of other counties.

In Section III.5(a), page 95, the applicants state *"The geographic boundaries of the proposed project are the same as those historically served by DCH and will include the communities of Clemmons and Lewisville."* Clemmons and Lewisville are located in western Forsyth County. In Section III.5(c), page 96, the applicants state

> *"Current patient origin for DCH is reflective of its critical access designation. The replacement hospital will essentially serve the same region, however due to increased accessibility and the availability of robust services, patient origin is anticipated to reflect these changes. For example, the number of patients originating from zip code 27028*

(Mocksville) will actually increase from historical levels despite the overall percentage of patient origin declining."

The applicants state that the proposed geographic service area is the same as the current geographic service area, but project a substantial increase in the number of inpatients to be served who are residents of Davie, Forsyth and Yadkin counties. In Section III.1, page 68, and Section III.5(a), page 95, the applicants define the proposed primary service area as follows.

COUNTY	ZIP CODE AREAS	MUNICIPALITY
Davie [1]	27006	[2]
	27014	Cooleemee
	27028	Mocksville
Forsyth	27012	Clemmons
	27023	Lewisville
Yadkin	27055	Yadkinville

(1) The primary service area includes all zip code areas in Davie County, i.e., 100% of Davie County.

(2) This is the zip code for Advance, which is not a municipality.

As shown in the above table, the projected primary service area for the proposed replacement hospital consists of six zip code areas. Further, in Section III.1, page 71, the applicants also state *"NCBH/DCEHC-DCH assumed a constant 8.51% in-migration, based on FFY 2006 DCH discharges originating from beyond the 6-zip code service area."* According to DCH's 2008 Hospital License Renewal Application, inmigration from counties not included in the primary service area (all of Davie and parts of Forsyth and Yadkin counties) was 11% during FFY 2007. DCH served patients from the following North Carolina counties not in the primary service area: Iredell, Rowan, Davidson, Guilford, Haywood, Wilkes, Stanly, Rockingham and Randolph. In addition, DCH served residents of Virginia and other states.

The following table illustrates projected patient origin, as provided by the applicants in Section III.5(c), pages 95-96, and Section III.1(b), pages 71 and 74.

Zip Code Area (County) (Municipality)	# of Discharges	% of Total Non-OB Discharges from Primary Service Area (2,317)	% of Total Discharges (2,967)
27006 (Davie) (Advance)	348	15.00%	11.71%
27028 (Davie) (Mocksville) [1]	1,019	44.00%	34.36%
27012 (Forsyth) (Clemmons)	487	21.00%	16.40%
27023 (Forsyth) (Lewisville)	162	7.00%	5.47%
27055 (Yadkin) (Yadkinville)	301	13.00%	10.15%
Subtotal	2,317	100.00%	78.09%
Inmigration	197	8.51%	6.64%
Subtotal	2,514		84.73%
OB Discharges (18% of 2,514)	453		15.27%
Total	2,967		100.00%

[1] Includes Zip Code Area 27014 (Davie) (Cooleemee).

As shown in the above table, OB discharges (453) are projected to be 18% of total non-OB discharges (2,514) during Year Two or 15.27% of all discharges (2,967). However, the applicants do not provide sufficient information in the application to determine where the obstetrical patients projected to utilize DCH reside. Therefore, the applicants did not adequately identify the obstetrical population proposed to be served.

Need for Replacement Facility

In Section III.1(a), pages 57-65, the applicant states

"The need for the project is based on the following issues, each of which will be discussed below:

- *Outmoded facility*
- *Location*
- *Physician recruitment*
- *Community Health Needs*

OVERVIEW

The proposed project is the result of unmet community needs in Davie County. The current facility, which operates as a designated critical access hospital, is no longer conducive to the rendering of cutting-edge health care services. Davie County is thriving economically and experiencing significant population growth. The County is in need of a state-of-the-art health care facility in order to

meet the health care needs of its residents, to aid in physician recruitment to the area, and to ensure that the County is well-positioned for further economic growth. Furthermore, the current facility is disadvantaged by its location. The hospital is located in Mocksville; however, the highest concentration of residents now lives in the Advance/Hillsdale area. Residents of this population center have exhibited an unwillingness to drive to Mocksville for health care services and have therefore been consuming services in Forsyth County. The County is in need of a hospital that is located within the population center, which will create an opportunity for the majority of health care needs to be met within the boundaries of Davie County.

...

OUTMODED FACILITY

The Davie County Hospital was originally constructed in 1956. Similar to most Hill-Burton hospitals constructed during that era, DCEHC-DCH is showing tremendous signs of wear and tear. In addition to an overall lack of aesthetic appeal, the hospital is plagued with an old design that is conducive neither to the modern health care environment nor building code and regulatory compliance. The specific challenges associated with the outmoded facility are described below:

...

The current Hill-Burton design of DCEHC-DCH has a strictly inpatient focus. Other than the emergency department, there is minimal space available for ambulatory care. This puts the hospital at a distinct disadvantage, as the hospital industry has been experiencing a dramatic shift to outpatient care in the past 20 to 25 years. The outpatient services that are currently offered at DCEHC-DCH are scattered inconveniently about the facility and integrated into inpatient services. This design is inconvenient for patients, who find it much easier to access outpatient services that are consolidated into one area. A new facility will allow DCEHC-DCH to centralize all ambulatory services and improve patient

access.

...

The Americans with Disabilities Act of 1990 provides guidelines that public facilities must meet in order to afford an accessible environment for ADA individuals with disabilities. The current facility is noncompliant with these regulations and retrofitting for ADA compliance is not feasible without major renovation, including the consolidation of rooms to create adequate space. Examples of noncompliance include inadequate public toilets (turning radius, grab bars, seat heights, etc.), improper hardware on doors, and improper signage (height requirements, Braille, etc.). North Carolina DFS and JCAHO have not cited the facility for noncompliance due to the 'grandfather clause.' Should DCEHC-DCH have to conduct renovations of existing space, however, current accessibility standards will have to be met at that time. A new facility will allow DCEHC-DCH to design a health care environment that will be convenient and accessible to all individuals, including those with disabilities.

...

American hospitals are serving a patient population that is sicker and demands a higher level of care. This trend is driven by the shift to outpatient care, which results in an inpatient population that requires more intensive and complex care. This level of care often includes the use of multiple pieces of medical equipment. The current patient room at DCH is not designed to accommodate this level of care. A new facility will allow DCEHC to design a health care environment that exceeds the American Institute of Architects' patient room guidelines, creating an optimal space for patients to heal and staff to work.

...

Just as the DCEHC-DCH patient rooms are ill-equipped to accommodate the intense level of health care often required for today's patients, they are also ill-designed to accommodate a patient's family and visitors. In today's

consumer-driven marketplace, patients are demanding that hospitals be designed with their needs in mind, which includes their need to have their families participate in the healing process. Design elements incorporated into the new hospital include a 'family zone' that provides sleep accommodations for family members, while allowing staff to function efficiently in their own distinct work zone. A new facility will allow DCEHC-DCH to design a health care environment that empowers patients and families to partner together to aid in the healing process.

...

The Health Insurance Portability and Accountability Act describes health care providers' responsibility to restrict access to and uses of protected health information. Although patient privacy is a chief concern for DCEHC-DCH today, the current facility impedes the hospital's ability to provide optimal patient privacy. For example, the design of the registration area allows for limited privacy as patients are required to provide personal information and respond to health-related questions.. A new facility will allow DCEHC-DCH to design an environment that will provide superior patient privacy and assure HIPAA compliance.

...

An architectural firm completed a facility assessment of Davie County Hospital in January 2006. The findings indicated significant and costly improvements would be required to update the existing facilities to meet current building code and regulatory guidelines. Issues of concern included life and safety code compliance, ADA accessibility, HVAC, plumbing and electrical systems, and asbestos-containing materials. [See Exhibit 9 for a copy of the 21 page facility assessment dated January 12, 2006.]

LOCATION
When DCEHC-DCH was originally constructed in 1956 as a county-operated facility, the most logical location was the county seat of Mocksville, where the overwhelming majority of the population resided. Over the past 20 years,

however, commercial and residential development in the county has shifted to the northeastern portion of the county. Currently, there are over 12,000 individuals living in the Advance/Hillsdale area. Residents of this population center have exhibited an unwillingness to drive to Mocksville for health care services and have therefore been consuming services out of county. In FFY 2006, only 8.6% of DCEHC-DCH inpatient discharges originated from Advance / Hillsdale. The County is in need of a hospital that is located within the center of the proposed market area, which will make the new hospital accessible for all residents. The proposed location will not only recognize the shift in the population that has occurred over the last several years (to eastern Davie County) but will also address the projected growth areas and will allow for a hospital that will meet the growing needs of a growing population for decades to come.

PHYSICIAN RECRUITMENT

DCEHC has developed the proposed project with the intent of keeping the medical staff open to qualified physicians regardless of employment or 'health system' affiliation. Due to each of the limitations listed above, DCEHC-DCH has struggled in years past to recruit physicians to the area and/or to encourage local physicians to admit patients to DCEHC-DCH. Just as patients demand a state-of-the-art health care facility with leading-edge technology, physicians desire the same environment in order to optimize their practice. A new facility will create leverage for DCEHC-DCH to recruit and hire new physicians to serve the Davie County community and surrounding areas.

COMMUNITY HEALTH NEEDS

The supply of health care manpower has been unable to meet a growing need for health care services in Davie County. The county currently has only 5.5 physicians per 10,000 residents. This ratio is extremely low compared to surrounding counties 7.7 in Davidson, 10.8 in Rowan, and 18.6 in Iredell. There is particularly a deficiency of specialty physicians, at only 1.8 per 10,000 residents. Thomson Healthcare predicts that 27 physicians will be needed to support the demand for health care in Davie County in 2009. Currently, there are approximately 17

physicians working in the county. There is a particular deficiency for cardiology, gastroenterology, obstetrical, gynecology, urology, ophthalmology and otolaryngology services. ...

...

In addition, the Davie County Health Assessment completed in 2007 by The North Carolina Institute for Public Health surveyed over 230 residents and found that one of the community's most significant unmet needs of their community was a hospital, specifically that the County lacked a modem hospital in an accessible location and that more specialty services were needed to meet the growing market demand. Other problems and concerns related specifically to the Davie County Hospital were that the current facility is outdated and unable to provide modern services and that many of the residents had to leave the county for needed services. Please see Exhibit 21 for the 2007 Davie County Health Assessment.

...

TRANSPORTATION ISSUES

If the proposed project is not approved, the hospital in Davie County will not be viable and will have to close. For all of the citizens who live in the Eastern portion of the county, this would result in the need to travel across the Yadkin River to Winston-Salem Hospitals. Yet, the bridges in Forsyth County like the bridges across the State and Nation are aging. If the bridge were to fail due to a natural disaster, the patients in the Eastern portion of the county would be faced with traveling west to Statesville, North to Yadkinville. Both of those travel times would be unacceptable in the case of a life threatening condition. In recent years, the Shallowford road [sic] *bridge over the Yadkin connecting Western Forsyth and Yadkin County was damaged during high waters which washed out the footings on the bridge. The bridge was closed for several months for repairs.*

The DOT estimates that it will take 3 years to upgrade the bridge across the Yadkin on I40 [sic]. *If the current I-40*

bridge were to go out, it could be several years before it could be replaced. In the meantime, patients in the Eastern portion of the county would be without access to lifesaving services. Further, as identified by in [sic] *the November 16 public hearing, there have been car accidents in the recent years that have shut down the bridge for several hours. In the event of a multi car pile up or a hazardous waste accident, the citizens of Davie County would be without access to hospitals in absence of the proposed project."* (Emphasis in original.)

Further, in Section II.5, pages 25-27, the applicants state

"A compelling need for the replacement facility is the age and lack of ability to expand the existing structure. As discussed throughout the application, the existing Davie County Hospital is over 50 years old. While additions have been made to the original facility, much of the electrical, mechanical and plumbing equipment are part of the original construction.

In addition to the structural concerns, the age presents other challenges. The original design is based on older methods of health care delivery, and in particular the role of the hospital as part of the health care system, have changed dramatically since the 1950's. Although DCH strives to provide the highest quality care to residents and surrounding areas, the current design of the hospital, particularly patient care areas, presents challenges in ensuring the requisite patient privacy and comfort, as well as in accommodating the additional equipment necessary for patient care. In addition, hospital construction and design requirements have changed resulting in a facility that no longer meets modern standards of health care delivery. As a result, the existing facility impedes the hospital's ability to provide the highest possible quality of care and therefore, maintaining the status quo does not represent the most effective alternative to meeting the health care needs of the residents of Davie County and the surrounding communities.

One option considered was to renovate the existing facility in Mocksville. Wilkerson and Associates, an architectural firm, was contracted to conduct an assessment of the DCH facility and document the general condition of the property, plant, and equipment. The fifty-year old facility is in need of much repair and substantial upgrades, including equipment. In order to upgrade the existing facility to a fully operational acute care hospital, significant renovation and expansion would have to occur. Additionally, the current purpose of the facility (critical access hospital) would be altered, which would negate any building codes that had previously been grandfathered. Current codes would require larger patient rooms, compliance with fire safety measures, compliance with American Disability Act standards, etc. It is estimated that the cost of upgrading the current facility would approach or potentially exceed the cost of building a replacement facility, thus limiting the viability of this option. For more information on the architectural study, please refer to Exhibit 9."

The applicants adequately demonstrate the existing hospital needs to be replaced. However, the applicants have been approved in a prior review to replace the existing hospital. Therefore, the replacement facility proposed in this application duplicates the previously approved replacement facility, but includes some additional services not proposed in the previous project. See discussion below regarding the need for all proposed project components.

Need for Project Components

Acute Care Beds – DCH is currently licensed for 81 general acute care beds. However, it currently operates no more than 25 general acute beds because of its designation as a critical access hospital. The replacement hospital is proposed to be licensed for only 50 general acute care beds. Thus, the proposal would result in a reduction of 31 general acute care beds in the acute care bed inventory for Davie County [81 – 50 = 31]. Forty-six of the general acute care beds in the replacement facility are proposed to be developed as general medical/surgical beds and four will be designated for obstetrics (post partum). DCH is not currently licensed for any intensive care unit beds and none are proposed for the replacement hospital. Additionally, although DCH currently

operates all its acute care beds as swing beds, none of the acute care beds in the new facility would be swing beds.

In Exhibit 13, and Section III.1(b), pages 71 and 74, the applicants provide historical and projected utilization of the general acute care beds at DCH; as illustrated in the following table.

YEAR	# OF ACUTE CARE PATIENT DAYS	AVERAGE DAILY CENSUS (ADC)	TOTAL # OF LICENSED ACUTE CARE BEDS	% OCCUPANCY
10/1/04 – 9/30/05 (actual)	1,147	3.1	81	3.8%
10/1/05 – 9/30/06 (actual)	1,527	4.2	81	5.2%
10/1/06 – 9/30/07 (actual)	1,271	3.5	81	4.3%
10/1/07 – 9/30/08 (projected)	1,443	4.0	81	4.9%
10/1/08 – 9/3/09 (projected)	1,481	4.1	81	5.1%
10/1/09 – 9/30/10 (projected)	1,519	4.2	81	5.2%
10/1/10 – 9/30/11 (projected)	1,559	4.3	81	5.3%
10/1/11 – 12/31/11 (projected) (three months)	400	4.4	81	5.4%
1/1/12 – 12/31/12 (projected) (Year One)	11,875	32.5	50	65.1%
1/1/13 – 12/31/13 (projected) (Year Two)	12,273	33.6	50	67.2%
1/1/14 – 12/31/14 (projected) (Year Three)	12,683	34.7	50	69.5%

As shown in the above table, DCH's current average daily census (ADC) is 3.5 patients and its projected ADC during the third operating year of the project is 34.7 patients. Thus, the target occupancy rate for DCH is 66.7%. During the third operating year, the applicants calculate that the occupancy rate would be 69.5%.

General Medical/Surgical Beds – The applicants provide the methodology and assumptions used to project utilization of the 46 general medical/surgical beds in Section III.1(b), pages 68-72, where they state:

> *"Step One: Define the patient population. The proposed facility will be a small community hospital and will experience the typical lower-acuity patient population associated with such a facility. Therefore the appropriate population was defined by first eliminating all DRG's of weight >2.0 (using FFY '07 DRG weights; in cases where DRG's are inactive in FFY '07, use the most recent weight available). Additionally, select DRG's with weights < 2.0 associated with the following services were eliminated: Obstetrics, Newborns, Psychiatry, Substance Abuse, Inpatient Rehabilitation, and Cardiac Catherization* [sic].

Step Two: Calculate baseline year (FFY 2006) market discharges for the applicable patient population. Using the North Carolina Hospital Association (NCHA) Patient Data System, NCBH/DCEHC-DCH calculated adjusted [1] market discharges for Federal Fiscal Year (FFY) 2006. The total number of discharges by zip code is listed below:

ZIP CODE	FFY 2006 Discharges [from all hospitals]
27006	883
27012	1,376
27023	532
27028	2,081
27055	1,109
TOTAL	5,981

Step Three: Calculate project year (CY 2012-2014) market discharges for the applicable patient population. Using Solucient Market Planner Plus Inpatient Demand Estimates, NCBH/DCEHC-DCH calculated the average annual growth rate for FFY 2006-2011 for adjusted market discharges.

ZIP CODE	FFY 2006 Adjusted Market Discharges [from all hospitals]	FFY 2006-2011 Projected Average IP Annual Growth	PY 1 Adjusted Market Discharges (CY 2012)	PY 2 Adjusted Market Discharges (CY 2013)	PY 3 Adjusted Market Discharges (CY 2014)
27006	883	3.5%	1,092	1,130	1,169
27012	1,376	2.8%	1,640	1,687	1,735
27023	532	2.7%	628	645	662
27028	2,081	2.9%	2,489	2,561	2,635
27055	1,109	1.0%	1,177	1,188	1,200
TOTAL	5,981	2.6%	7,025	7,210	7,400
Volume from Market Growth (cumulative)			1,044	1,229	1,419

Step Four: Calculate NCBH and DCH FFY 2006 baseline discharges for the applicable patient population. Then, use the Solucient inpatient growth rate shown in Step Three to project DCEHC-DCH project year discharges.

[1] In Step 1, the applicants adjusted the total FFY 2006 discharges reported by all providers for the six zip code areas by eliminating all DRGs with a weight greater than 2.0 and all DRGs for the following services: obstetrics; newborns; psychiatry; substance abuse; inpatient rehabilitation; and cardiac catheterization.

Source of Volume	*FFY 2006 Adjusted Market Discharges* [from NCBH & DCH, which are included in the total adjusted market discharges in Steps 2 and 3 above]	*FFY 2006-2011 Projected Average IP Annual Growth*	*PY 1 Discharges (CY 2012)*	*PY 2 Discharges (CY 2013)*	*PY 3 Discharges (CY 2014)*
NCBH	*1,418*	*2.6%*	*1,668*	*1,711*	*1,756*
DCH	*398*	*2.6%*	*465*	*477*	*490*
[Total]	1,816		2,133	2,188	2,246]
Total NCBH/DCH Incremental Volume (cumulative) [i.e., the incremental growth in adjusted market discharges at NCBH & DCH]	*n/a*	*n/a*	*317* [2,133 - 1,816 = 317]	*373* [2,188 - 1,816 = 373]	*430* [2,246 - 1,816 = 430]

Step Five: Subtract the result from Step Four from the Total Incremental Market Growth shown in Step Three to indicate 'additional market growth.' NCBH/DCEHC-DCH assumed that, as a state-of-the-art new facility, DCEHC-DCH would be well-positioned to capture 15% of the incremental discharges that result from market growth.

Source of Volume	*PY 1 Discharges (CY 2012)*	*PY 2 Discharges (CY 2013)*	*PY 3 Discharges (CY 2014)*
Incremental Market Growth (cumulative) [i.e., total projected market growth in adjusted discharges from all hospitals]	*1,044*	*1,229*	*1,419*
Total NCBH/DCH Incremental Volume (cumulative) [i.e., projected market growth in adjusted discharges from NCBH & DCH only]	*317*	*373*	*430*
Additional Market Growth [i.e., total projected market growth less projected growth at NCBH & DCH only]	*727*	*856*	*989*
@ 15%	*109*	*128*	*148*

Step Six: *Calculate DCEHC-DCH project year (CY 2012-2014) discharges for the applicable patient population by combining sources of volume from Steps Four and Five plus in-migration. NCBH/DCEHC-DCH assumed a constant 8.51% in-migration, based on FFY 2006 DCH discharges originating from beyond the 6-zip code service area.*

Source of Volume	FFY 2006 Adjusted Market Discharges	FFY 2006-2011 Projected Average IP Annual Growth	PY 1 Discharges (CY 2012)	PY 2 Discharges (CY 2013)	PY 3 Discharges (CY 2014)
NCBH	1,418	2.6%	1,668	1,711	1,756
DCH	398	2.6%	465	477	490
Additional Market Growth @ 15%		2.6%	109	128	148
Subtotal			2,242	2,317	2,384
Plus 8.51% In-migration			191	197	204
TOTAL			2,432	2,514	2,598

Step Seven: Calculate Med/Surg Patient Days. *Based on the FFY 2006 NCHA-reported ALOS of all applicable market discharges, an average length of stay of 4.394 days was assumed. Patient days were calculated as follows:*

Metric	PY 1 (CY 2012)	PY 2 (CY 2013)	PY 3 (CY 2014)
Discharges	2,432	2,514	2,598
ALOS	4.394	4.394	4.394
Patient Days	10,688	11,047	11,416
ADC	29	30	31
Proposed Acute Beds	46	46	46
Occupancy Rate	63.7%	65.8%	68.0%

...

It is important to note that the projected discharges result from a combination of incremental market growth and existing NCBH/DCH adjusted patient discharges, projected over time. This validates that projected inpatient discharges will result only from shifting volume from within the health system and from market growth, and will not adversely affect other market providers.

It is also important to note that the projected volume shifting from NCBH (1,756 discharges in PY3) represents only 77% of total projected NCBH discharges originating from the DCEHC/DCH service area (2,287 discharges in

PY3). Thus, NCBH is not relying upon the transfer of all its DCEHC/DCH service area patients to the new hospital in order to ensure its success." (Emphasis in original.)

The applicants' assumptions regarding the projected number of adjusted general medical/surgical discharges are reasonably based on historical utilization by the target population of services provided at North Carolina Baptist Hospital and DCH and increased utilization given a modern state-of-the-art facility.

Obstetrical Beds – DCH does not currently provide obstetrical services. The applicants provide the methodology and assumptions used to project utilization of the 4 obstetrical (post partum) beds in Section III.1(b), pages 73-74, where they state:

"Step One: NCBH/DCEHC-DCH assumed that obstetrical discharges would be 18% of projected general acute care discharges. This assumption is based on the NCHA-reported ratio of obstetrical discharges to general medical/surgical discharges for FFY 2006 for all patients originating from the DCEHC-DCH service area, as shown below:

Zip Code	FFY 2006 Market Obstetrical Discharges	FFY 2006 Market Med/Surg Discharges	OB Discharges as % of Med/Surg Discharges
27006	120	883	14%
27012	275	1,376	20%
27014	21	162	13%
27023	108	532	20%
27028	250	1,919	18%
27055	219	1,109	20%
TOTAL	1,093	5,981	18%

Step Two: Project Year obstetrical discharge, patient day, and occupancy calculations are shown below. NCBH/DCEHC-DCH assumed an average length of stay of 2.71 days based on the FFY 2006 NCHA-reported ALOS of obstetrical patients originating from the DCEHC-DCH service area.

Metric	PY 1 Discharges	PY 2 Discharges	PY 3 Discharges
Med/Surg Discharges	2,432	2,514	2,598
OB Discharges as 18% of Med/Surg	438	453	468
ALOS in days	2.71	2.71	2.71
OB Patient Days	1,187	1,226	1,267
# of OB beds	4	4	4
ADC	3.3	3.4	3.5
Occupancy Rate	81.0%	83.7%	86.5%

NCBH/DCEHC-DCH projects 468 Obstetrical Discharges in Project Year 3, for a total of 1,267 Patient Days. With an average daily census of 3.5, the facility will occupy 87% of the 4 proposed obstetrical beds by Project Year 3."
(Emphasis in original.)

The applicants assume that obstetrical discharges will equal 18% of general medical/surgical discharges, which is an average of the FFY 2006 ratios of OB discharges to total discharges for the six zip code areas in the primary service area. However, the applicants methodology does not take into account the relative size of the female population of child-bearing age in each zip code. Further, the applicants assume that non-OB discharges will increase 1-3.5% per year depending on the specific zip code area. Thus, they also assume OB discharges will increase 1-3.5% per year depending on the specific zip code area. However, the applicants did not provide data to show that the birth rate in each zip code area is reasonably projected to increase at the same rate as non-OB discharges are projected to increase. Indeed, the applicants do not provide any data to show that birth rates are increasing at all. Therefore, the applicants did not adequately demonstrate that projected utilization of the proposed obstetrical beds is based on reasonable and supported assumptions. Consequently, the applicants do not adequately demonstrate the need to develop four obstetrical beds.

Further, the applicants propose to develop four unlicensed labor, delivery, recovery rooms (LDRs) in addition to the four licensed obstetrical beds. However, the applicants did not provide the assumptions or methodology used to determine how many LDRs would be needed for the number of OB patients projected to be served. Therefore, the applicants did not adequately demonstrate the need for four unlicensed LDRs.

Unlicensed Bassinets – The applicants provide the methodology and assumptions used to project utilization of the 3 unlicensed bassinets in the new nursery in Section III.1(b), pages 74-76, where they state:

"Step One: NCBH/DCEHC-DCH assumed that newborn discharges would be 88% of projected obstetrical discharges. This assumption is based on the NCHA-reported ratio of newborn discharges (includes all newborns and neonatology discharges with DRG weight <= 2.0) to obstetrical discharges for FFY 2006 for all patients originating from the DCEHC-DCH service area; as shown below:

Zip Code	FFY 2006 Market Newborn Discharges	FFY 2006 Market Obstetrical Discharges	Newborn Discharges as % of Obstetrical Discharges
27006	102	120	85%
27012	247	275	90%
27014	16	21	76%
27023	96	108	89%
27028	314	250	90%
27055	183	219	84%
TOTAL	958	1,093	88%

Step Two: Project Year newborn discharge, patient day, and occupancy calculations are shown below. NCBH/DCEHC-DCH assumed an average length of stay of 2.1 days based on the FFY 2006 NCHA-reported ALOS of newborn patients (includes all newborns and neonatology discharges with DRG weight < 2.0) originating from the DCEHC-DCH service area.

Metric	PY 1 Discharges	PY 2 Discharges	PY 3 Discharges
Obstetrical Discharges	438	453	468
Newborn Discharges @ 88% of Obstetrical Discharges	385	399	412
ALOS in days	2.1	2.1	2.1
Newborn Days	809	838	865
# of bassinets	3	3	3
ADC	2.2	2.3	2.4
Occupancy Rate	74%	77%	79%

NCBH/DCEHC-DCH projects 412 Newborn Discharges in Project Year 3, for a total of 865 Patient Days. With an average daily census of 2.4, the facility will occupy 74% of the 3 proposed newborn bassinets in Project Year 1 and 79% of the bassinettes [sic] *by Project Year 3.*" (Emphasis in original.)

The applicants assume that births will equal 88% of projected OB discharges. However, the applicants did not adequately demonstrate that projected OB discharges are based on reasonable and supported assumptions. See discussion above. Therefore, the applicants do not adequately demonstrate that projected births are based on reasonable and supported assumptions. Consequently, the applicants do not adequately demonstrate the need to develop three unlicensed bassinets.

Operating Rooms – DCH is currently licensed for two shared ORs and the replacement hospital would be licensed for two shared ORs and one dedicated C-section OR. The following table illustrates historical utilization of the two existing shared ORs, as reported by the applicants in Exhibit 13.

HISTORICAL UTILIZATION OF THE TWO EXISTING SHARED ORS

	FFY 2005	FFY 2006	FFY 2007
# of Inpatient Cases	11	8	10
# of Hours @ 3 hours per Inpatient Case	33	24	30
# of Outpatient Cases	69	62	49
# of Hours @ 1.5 hours per Outpatient Case	103.5	93	73.5
Total Surgical Hours	136.5	117	103.5
Total Surgical Hours / 1,872 Hours per OR	0.07	0.06	0.06

As shown in the above table, the two existing shared ORs are underutilized at their current location. In Section III.1(b), page 79, the applicants provide projected utilization of the two existing shared ORs and the proposed dedicated C-section OR at the replacement hospital, as illustrated in the following table.

PROJECTED UTILIZATION OF THE TWO EXISTING SHARED ORS AND PROPOSED DEDICATED C-SECTION OR

	YEAR ONE (CY 2012)	YEAR TWO (CY 2013)	YEAR THREE (CY 2014)
Projected # of C-sections	118	122	126
Projected # of Inpatient Surgical Cases (excluding C-sections)	348	360	372
Projected # of Hours @ 3 Hours per Inpatient Case	1,044	1,080	1,116
Projected # of Outpatient Surgical Cases	2,581	2,660	2,740
Projected # of Hours @ 1.5 Hours per Outpatient Case	3,872	3,990	4,110
Total Surgical Hours	4,916	5,070	5,226
Total Surgical Hours / 1,872 Hours per OR	3	3	3
Existing and Proposed # of Shared ORs	2	2	2

Inpatient Surgical Cases (Excluding C-sections) – In Section III.1(b), pages 76-77, the applicants provide the methodology and assumptions used to project the number of inpatient surgical cases (excluding C-sections) to be performed at the proposed replacement hospital, where they state:

"Of the 1,816 FFY 2006 applicable patient discharges for NCBH and DCH, 260 or 14.3% were surgical patients, as shown below.

Facility	*FFY 2006 Total Acute Discharges*	*FFY 2006 Non-OB Surgical Discharges*	*FFY 2006 Surgical % of Total Acute Discharges*
NCBH	*1,418*	*251*	*18%*
DCH	*398*	*9*	*2.3%*
Combined Total	*1,816*	*260*	*14.3%*

NCBH/DCEHC-DCH applied the ratio of 14.3% to total med/surg discharge projections, as follows:

Metric	*PY 1 Discharges*	*PY 2 Discharges*	*PY 3 Discharges*
Med/Surg Discharges	*2,432*	*2,514*	*2,598*
Surgical Discharges @ 14.3% of Med/Surg Discharges	*348*	*360*	*372*

The applicants' assumptions regarding the projected number of inpatient surgical cases (excluding C-sections) to be performed are reasonably based on historical utilization by the target population of services provided at North Carolina Baptist Hospital and DCH and increased utilization given a modern state-of-the-art facility.

Outpatient Surgical Cases – In Section III.1(b), pages 77-80, the applicants provide the methodology and assumptions used to project the number of outpatient surgical cases to be performed at the proposed replacement hospital, where they state:

> *"NCHA does not report outpatient surgical activity. Thus, NCBH/DCEHC-DCH elected to use data available in Solucient's Outpatient Procedure Estimate Module to project outpatient surgeries as follows.*
>
> ***Step One: Define the patient population.*** *NCBH/DCEHC-DCH defined the outpatient surgical population using Solucient's Outpatient Procedure Estimate Module's "outpatient major" and "outpatient major invasive" categories. (Excludes all cardiac catherization* [sic] *procedures.)*
>
> ***Step Two: Calculate baseline year market discharges for the applicable patient population.*** *Using Solucient's Outpatient Procedure Estimate Module, NCBH/DCEHC-DCH calculated the number of total procedures that fell within the above-described definition for the five-zip code service area for FFY 2007. The total number of procedures is listed below:*

Zip Code	FFY 2007 Outpatient Major Procedures	FFY 2007 Outpatient Major Invasive Procedures	FFY 2007 Total Outpatient Surgical Procedures
27006	885	186	1,071
27012	1,795	467	2,262
27023	758	196	954
27028	1,710	346	2,056
27055	963	175	1,138
TOTAL	6,111	1,370	7,481

> ***Step Three: Calculate project year (CY 2012-2014) market discharges for the applicable patient population.*** *Using Solucient's Outpatient Procedure Estimate Module, NCBH/DCEHC-DCH calculated the average annual growth rate for FFY 2007-2012 for outpatient surgery from*

. the five-zip code service area and the subsequent project year market procedure totals.

Procedure	*FFY 2007 Market Procedures*	*FFY 2007-2012 Projected Average Annual Growth*	*PY 1 Market Procedures (CY 2011)* [sic][*]	*PY 2 Market Procedures (CY 2012)* [sic][*]	*PY 3 Market Procedures (CY 2013)* [sic][*]
Outpatient Major	*6,111*	*1.9%*	*6,742*	*6,869*	*6,999*
Outpatient Major Invasive	*1,370*	*2.3%*	*1,544*	*1,580*	*1,616*
TOTAL	*7,481*	*2.0%*	*8,286*	*8,449*	*8,615*

[* Year One should be CY 2012, Year Two should be CY 2013 and Year Three should be CY 2014.]

Step Five [sic]*: Calculate DCEHC-DCH project year (CY 2012-2014) discharges for the applicable patient population. NCBH/DCEHC-DCH elected to use inpatient market share to estimate the percentage of total market outpatient surgeries captured by DCEHC-DCH. Inpatient market share calculation is shown below:*

Metric	*PY 1 (CY 2011)* [sic]	*PY 2 (CY 2012)* [sic][*]	*PY 3 (CY 2013)* [sic][*]
Total Discharges	*2,870*	*2,967*	*3,066*
*Total Market Discharges**	*9,214*	*9,422*	*9,638*
INPATIENT MARKET SHARE	*31.2%*	*31.5%*	*31.8%*

**Based on Solucient's FFY 2006-2011 growth rate for ALL inpatient discharges from the DCEHC-DCH Service Area.*

[* Year One should be CY 2012, Year Two should be CY 2013 and Year Three should be CY 2014.]

Procedure	*PY 1 DCEHC-DCH Procedures*	*PY 2 DCEHC-DCH Procedures*	*PY 3 DCEHC-DCH Procedures*
	(CY 2012)	*(CY 2013)*	*(CY 2014)*
Outpatient Major	*2,100*	*3,163*	*2,226*
Outpatient Major Invasive	*481*	*498*	*514*
TOTAL	*2,581*	*2,660*	*2,740*

At 31.8% of total market outpatient surgeries, NCBH/DCEHC-DCH would project 2,740 outpatient procedures in Project Year 3."

The applicants' assumptions regarding the projected number of outpatient surgical cases to be performed are reasonably based on historical utilization by the target population of services provided at North Carolina Baptist Hospital and DCH and increased utilization given a modern state-of-the-art facility.

C-sections – In Section III.1(b), page 77, the applicants provide the methodology and assumptions used to project the number of C-sections to be performed at the proposed replacement hospital, where they state:

"According to the NCHA Patient Data System, 27% of all obstetrical discharges for patients originating from the DCEHC-DCH service area in FY 2006 were surgical. NCBH/DCEHC-DCH held this ratio constant, yielding the following obstetrical surgical discharges:

Metric	*PY1 Discharges (CY 2011) [sic][*]*	*PY1 Discharges (CY 2012) [sic][*]*	*PY1 Discharges (CY 2013) [sic][*]*
DCEHC-DCH OB Discharges	*438*	*453*	*468*
Ratio of Surgical to Non-Surgical	*27%*	*27%*	*27%*
Surgical OB Discharges	*118*	*122*	*126*

[* Year One should be CY 2012; Year Two should be CY 2013 and Year Three should be CY 2014.]

The applicants assume that C-sections will equal 27% of projected OB discharges. However, the applicants did not adequately demonstrate that projected OB discharges are based on reasonable and supported assumptions. See discussion above. Therefore, the applicants do not adequately demonstrate that projected C-sections are based on reasonable and supported assumptions. Consequently, the applicants do not adequately demonstrate the need to develop a dedicated C-section OR.

Gastrointestinal Endoscopy Room – DCH is currently licensed for and the proposed replacement hospital would be licensed for only one GI endoscopy room. The following table illustrates historical utilization of the existing GI endoscopy room, as reported by the applicants in Exhibit 13.

HISTORICAL GI ENDOSCOPY ROOM UTILIZATION

OPERATING YEAR	# OF GI ENDOSCOPY PROCEDURES		
	INPATIENT	OUTPATIENT	TOTAL
FFY 2005	12	504	516
FFY 2006	13	369	382
FFY 2007	12	409	421

In Section III.1(b), page 85, the applicants provide projected utilization of the existing GI endoscopy room at the proposed replacement hospital, as illustrated in the following table.

PROJECTED GI ENDOSCOPY ROOM UTILIZATION

OPERATING YEAR	PROJECTED # OF GI ENDOSCOPY PROCEDURES		
	INPATIENT	OUTPATIENT	TOTAL
Year One (CY 2012)	222	1,361	1,583
Year Two (CY 2013)	230	1,413	1,643
Year Three (CY 2014)	237	1,467	1,704

As shown in the above table, in Year Three, the applicants project that a total of 1,704 GI endoscopy procedures will be performed in the existing GI endoscopy room at the proposed replacement hospital. The applicants use different methodologies to project the number of inpatient and outpatient GI endoscopy procedures to be performed at the proposed replacement hospital.

Inpatient GI Endoscopy Procedures – In Section III.1(b), page 83, the applicants provide the methodology and assumptions used to project the number of inpatient GI endoscopy procedures to be performed at the proposed replacement hospital, where they state:

> *Step One: NCBH/DCEHC-DCH applied NCBH's FFY 2006 percentage of inpatients who received an endoscopy procedure, 6.3%, to project year* [sic] *inpatient discharge projections for DCEHC-DCH as follows:*

Procedure	*PY 1*	*PY 2*	*PY 3*
	(CY 2012)	*(CY 2013)*	*(CY 2014)*
Med/Surg Discharge Projection	*2,432*	*2,514*	*2,598*
% of Discharges with Endoscopies	*6.3%*	*6.3%*	*6.3%*
Endoscopy Patients	*153*	*158*	*164*

Step Two: Multiply endoscopy patients times the projected number of procedures per patient to yield total procedures. NCBH/DCEHC-DCH assumed procedure to patient ratio of 1.45, which is an average of the FFY 2006 experience of DCH (1.16 procedures per patient) and NCBH (1.74 procedures per patient.)

Procedure	*PY 1*	*PY 2*	*PY 3*
	(CY 2012)	*(CY 2013)*	*(CY 2014)*
Endoscopy Patients	*153*	*158*	*164*
Procedures per Patient	*1.45*	*1.45*	*1.45*
Inpatient Procedures	*222*	*230*	*237*

The applicants' assumptions regarding the projected number of inpatient GI endoscopy procedures to be performed are reasonably based on historical utilization by the target population of services provided at North Carolina Baptist Hospital and DCH and increased utilization given a modern state-of-the-art facility.

Outpatient GI Endoscopy Procedures – In Section III.1(b), pages 84-85, the applicants provide the methodology and assumptions used to project the number of outpatient GI endoscopy procedures to be performed at the proposed replacement hospital, where they state:

> *Step One: Define the patient population. NCBH /DCEHC-DCH defined the outpatient endoscopy population using Solucient's Outpatient Procedure Estimate Module's GI Procedure Group, including the following procedures: Colonoscopy, Upper GI*

Endoscopy, Sigmoidoscopy, Endoscopic Retrograde Cholangiopancreatography, Esophagoscopy, Proctosigmoidoscopy, and Anoscopy.

Step Two: Calculate baseline year market discharges for the applicable patient population. *Using Solucient's Outpatient Procedure Estimate Module, NCBH/DCEHC-DCH calculated the number of total procedures that fell within the above-described definition for the five-zip code service area for FFY 2007. The total number of procedures is listed below:*

ZIP CODE	FFY 2007 Outpatient Endoscopy Procedures
27006	696
27012	1,005
27023	426
27028	1,243
27055	425
TOTAL	3,795

Step Three: Calculate project year (CY 2012-2014) market discharges for the applicable patient population. *Using Solucient's Outpatient Procedure Estimate Module, NCBH/DCEHC-DCH calculated the average annual growth rate for FFY 2007-2012 for endoscopy from the five-zip code service area and the subsequent project year market procedure totals.*

Outpatient Procedure	FFY 2007 Market Procedures	FFY 2007-2012 Projected Average Annual Growth	PY 1 Market Procedures (CY 2011) [sic][*]	PY 2 Market Procedures (CY 2012) [sic][*]	PY 3 Market Procedures (CY 2013) [sic][*]
Endoscopy Procedures	3,795	3.7%	4,369	4,488	4,610

[* Year One should be CY 2012, Year Two should be CY 2013 and Year Three should be CY 2014.]

Step Four: Calculate DCEHC-DCH project year (CY 2012-2014) discharges for the applicable patient population. NCBH/DCEHC-DCH elected to use inpatient market share to estimate the percentage of total market endoscopies captured by DCEHC/DCH. Inpatient market share calculation is shown below:

Metric	*PY 1 (CY 2011)* [sic]	*PY 2 (CY 2012)* [sic][^]	*PY 3 (CY 2013)* [sic][^]
Total Discharges	*2,870*	*2,967*	*3,066*
*Total Market Discharges**	*9,214*	*9,422*	*9,638*
INPATIENT MARKET SHARE	*31.2%*	*31.5%*	*31.8%*

**Based on Solucient's FFY 2006-2011 growth rate for ALL inpatient discharges from the DCEHC-DCH Service Area.*

[^ Year One should be CY 2012, Year Two should be CY 2013 and Year Three should be CY 2014.]

Outpatient Procedure	*PY 1 DCEHC-DCH Procedures (CY 2012)*	*PY 2 DCEHC-DCH Procedures (CY 2013)*	*PY 3 DCEHC-DCH Procedures (CY 2014)*
Endoscopy Procedures	*1,361*	*1,413*	*1,467*

(Emphasis in original.) The applicants' assumptions regarding the projected number of outpatient GI endoscopy procedures to be performed are reasonably based on historical utilization by the target population of services provided at North Carolina Baptist Hospital and DCH and increased utilization given a modern state-of-the-art facility.

Minor Procedure Room – DCH currently has one minor procedure room and the replacement hospital would have one minor procedure room. The following table illustrates historical utilization of the minor procedure room, as reported by the applicants in Section III.1(b), page 80.

HISTORICAL MINOR PROCEDURE ROOM UTILIZATION

OPERATING YEAR	# OF PROCEDURES
FFY 2006	129
FFY 2007	153

In Section III.1, page 82, the applicants provide projected utilization of the minor procedure room at the replacement hospital, as illustrated in the following table.

PROJECTED MINOR PROCEDURE ROOM UTILIZATION

OPERATING YEAR	YEAR ONE (CY 2012)	YEAR TWO (CY 2013)	YEAR THREE (CY 2014)
# of Outpatient Minor Procedures	2,258	2,320	2,381
# of Outpatient Minor Invasive Procedures	782	806	832
Total Minor Procedures	3,040	3,126	3,213

As shown in the above table, in Year Three, the applicants project that a total of 3,213 procedures will be performed in the minor procedure room at the proposed replacement hospital. In Section III.1(b), pages 80-82, the applicants provide the methodology and assumptions used to project the number of minor procedures, where they state:

"Step One: Define the patient population. NCBH/DCEHC-DCH defined the 'minor procedure' population using Solucient's Outpatient Procedure Estimate Module's 'outpatient minor' and 'outpatient minor invasive' categories. (Excludes cardiac catherization [sic]*; also excludes endoscopy procedures, whose projections are calculated using a separate methodology.)*

Step Two: Calculate baseline year market discharges for the applicable patient population. Using Solucient's Outpatient Procedure Estimate Module, NCBH/DCEHC-DCH calculated the number of total procedures that fell within the above-described definition for the five-zip code service area for FFY 2007. The total number of procedures is listed below:

Zip Code	*FFY 2007 Outpatient Minor Procedures*	*FFY 2007 Outpatient Minor Invasive Procedures*	*FFY 2007 Total Outpatient Minor Procedures*
27006	*968*	*377*	*1345*
27012	*1,559*	*507*	*2066*
27023	*661*	*211*	*872*
27028	*2,005*	*765*	*2,770*
27055	*1,487*	*401*	*1,888*
TOTAL	*6,680*	*2,261*	*8,941*

Step Three: Calculate project year (CY 2012-2014) market discharges for the applicable patient population. Using Solucient's Outpatient Procedure Estimate Module, NCBH/DCEHC-DCH calculated the average annual growth rate for FFY 2007-2012 for minor procedures from the five-zip code service area and the subsequent project year market procedure totals.

Procedure	*FFY 2007 Market Procedures*	*FFY 2007-2012 Projected Average Annual Growth*	*PY 1 Market Procedures (CY 2011)* [sic][*]	*PY 2 Market Procedures (CY 2012)* [sic][*]	*PY 3 Market Procedures (CY 2013)* [sic][*]
Outpatient Minor	*6,680*	*1.6%*	*7,249*	*7,366*	*7,485*
Outpatient Minor Invasive	*2,261*	*2.1%*	*2,509*	*2,561*	*2,614*
TOTAL	*8,941*	*1.7%*	*9,758*	*9,927*	*10,099*

[* Year One should be CY 2012, Year Two should be CY 2013 and Year Three should be CY 2014.]

Step Four: Calculate DCEHC-DCH project year (CY 2012-2014) discharges for the applicable patient population. NCBH/DCBHC-DCH elected to use inpatient market share to estimate the percentage of total market minor procedures captured by DCEHC-DCH. Inpatient market share calculation is shown below:

Metric	*PY 1 (CY 2011)* [sic]	*PY 2 (CY 2012)* [sic][^]	*PY 3 (CY 2013)* [sic][^]
Total Discharges	*2,870*	*2,967*	*3,066*
*Total Market Discharges**	*9,214*	*9,422*	*9,638*
INPATIENT MARKET SHARE	*31.2%*	*31.5%*	*31.8%*

**Based on Solucient's FFY 2006-2011 growth rate for ALL inpatient discharges from the DCEHC-DCH Service Area.*

[^ Year One should be CY 2012, Year Two should be CY 2013 and Year Three should be CY 2014.]

Procedure	*PY 1 DCEHC-DCH Procedures (CY 2012)*	*PY 2 DCEHC-DCH Procedures (CY 2013)*	*PY 3 DCEHC-DCH Procedures (CY 2014)*
Outpatient Minor	*2,258*	*2,320*	*2,381*
Outpatient Minor Invasive	*782*	*806*	*832*
TOTAL	*3,040*	*3,126*	*3,213*

At 31.8% of total market outpatient surgeries, NCBH/DCEHC-DCH would project 3,213 minor procedures in Project Year 3." (Emphasis in original.)

The applicants' assumptions regarding the projected number of minor procedures to be performed are reasonable based on historical utilization by the target population of services provided at North Carolina Baptist Hospital and DCH and increased utilization given a modern state-of-the-art facility.

Emergency Department (ED) – The following table illustrates historical utilization of the ED at DCH, as reported by the applicants in Exhibit 13.

HISTORICAL EMERGENCY DEPARTMENT UTILIZATION

OPERATING YEAR	# OF ED VISITS
FFY 2005	12,579
FFY 2006	12,389
FFY 2007	11,866

In Section III.1(b), page 89, the applicants provide projected utilization of the Emergency Department at the replacement hospital, as illustrated in the following table.

PROJECTED EMERGENCY DEPARTMENT UTILIZATION

OPERATING YEAR	# EMERGENT ED VISITS	# URGENT ED VISITS	TOTAL ED VISITS
Year One (CY 2012)	5,533	11,382	16,915
Year Two (CY 2013)	5,818	12,225	18,042
Year Three (CY 2014)	6,122	13,133	19,255

As shown in the above table, in Year Three, the applicants project a total of 19,255 ED visits at the proposed replacement hospital. In Section III.1(b), pages 86-89, the applicants provide the methodology and assumptions used to project utilization of the Emergency Department, where they state:

> ***Step One: Define the patient population.*** *NCBH/DCEHC-DCH defined the emergency room patient population by the Thomson Healthcare Emergency Department Estimate categories of 'Emergent' and 'Urgent' Care.*
>
> ***Step Two: Calculate baseline year market visits for the applicable patient population.*** *Using Solucient Emergency Department Estimates, NCBH/DCEHC-DCH calculated the number of total emergent and urgent care visits for the five-zip code service area for FFY 2007. The total number of visits is listed below:*

Visit Type	Zip Code	FFY 2007 Visits	% of Total Visits
Emergent	27006	1,150	
	27028	2,616	
	27012	1,115	
	27023	2,480	
	27055	1,777	
	Total	9,138	23.6%
Urgent	27006	3,965	
	27028	7,553	
	27012	3,236	
	27023	9,024	
	27055	5,866	
	Total	29,644	76.4%
ALL	27006	5,115	
	27028	10,169	
	27012	4,351	
	27023	11,504	
	27055	7,643	
	Total	38,782	100%

> ***Step Three: Calculate project year (CY 2012-2014) market visits for the applicable patient population.*** *Using Solucient Emergency Department Estimates, NCBH/DCEHC-DCH calculated the average annual growth rate for FFY 2007-2012 for the sum of emergent and urgent care visits from the five-zip code service area and the subsequent project year market ED visit totals.*

ZIP CODE	FFY 2007 Market ED Visits	FFY 2007 – 2012 Projected Average Annual Growth	PY 1 Market ED Visits	PY 2 Market ED Visits	PY 3 Market ED Visits
27006	5,115	2.3%	5,757	5,888	6,022
27012	10,169	1.1%	10,751	10,866	10,982
27023	4,351	0.5%	4,474	4,498	4,522
27028	11,504	1.4%	12,379	12,554	12,730
27055	7,643	0.01%	7,648	7,649	7,650
Total	38,782	1.06%	41,010	41,454	41,906
Incremental Volume (cumulative)			2,228	2,672	3,124

Step Four: Calculate NCBH and DCH FFY 2006 baseline ED visits for the applicable patient population. Then, use the average annual ED growth rate for both DCH and NCBH for the applicable patient population to project DCEHC-DCH project year visits.

Source of Volume	FFY 2006 ED Visits	FFY 2002-2006 Average Annual Growth	PY 1 Visits (CY 2012)	PY 2 Visits (CY 2013)	PY 3 Visits (CY 2014)
NCBH	4,798*	9.2%	8,318	9,082	9,916
DCH	10,769	2.4%	12,520	12,826	13,138
Total NCBH/DCH Incremental Volume (cumulative)	n/a	n/a	5,271	6,340	7,488

**Excludes trauma visits (having a physician charge code which indicates extensive treatment time, which can be used as a proxy for severity).*

Since the above result is greater than the Total Incremental Market Growth shown in Step Three, NCBH/DCEHC-DCH assumed no additional market growth beyond that generated by NCBH and DCH.

Step Five: NCBH/DCEHC-DCH assumed a constant 12.7% in-migration, based on FFY 2006 DCH ED visits originating from beyond the 6-zip code service area.

Source of Volume	FFY 2006 Adjusted Market Discharges [sic]	FFY 2006-2011 Projected Average IP Annual Growth [sic]	PY 1 Visits (CY 2012)	PY 2 Visits (CY 2013)	PY 3 Visits (CY 2014)
NCBH	4,798*	9.2%	8,318	9,082	9,916
DCH	10,769	2.4%	12,520	12,826	13,138
Combined Total	15,567	5.1%	20,838	21,908	23,055
Plus 12.7% In-Migration			2,646	2,782	2,928
TOTAL			23,484	24,690	25,983

...

As shown in Step Two above, Solucient would project that 76% of these visits would be of an urgent care nature vs. an emergent care visit. ED visit projections by category are shown below.

Visit Type	PY 1 Visits (CY 2012)	PY 2 Visits (CY 2013)	PY 3 Visits (CY 2014)
Emergent	5,533	5,818	6,122
Urgent	17,951	18,872	19,861
Combined Total	23,484	24,690	25,983

Step Six: Adjust ED visits to account for presence of Mocksville Urgent Care Center. *NCBH/DCEHC-DCH plans to construct an Urgent Care Center (UCC) in Mocksville, NC in FY 2009. (NCBH/DCEHC-DCH plans to submit a letter of no review describing the project at a late date.) Only visits originating from Mocksville/Cooleemee are affected by the presence of the UCC, as NCBH/DCEHC-DCH has assumed that patients from the remaining service area zip codes would choose to utilize the new hospital due to issues of proximity. Adjusted urgent care projections are shown below:*

	PY 1 Visits (CY 2012)	PY 2 Visits (CY 2013)	PY 3 Visits (CY 2014)
Emergent	5,533	5,818	6,122
Urgent	17,951	18,872	19,861
Less UCC visits	6,569	6,648	6,728
Adjusted Urgent Care	11,382	12,225	13,133
TOTAL	16,915	18,042	19,255
ED exam rooms requested	16	16	16
Occupancy	70%	75%	80%

NCBH/DCEHC-DCH projects 6,122 emergent care visits and 13,133 urgent care visits in Project Year 3, for a total of 19,255 ED visits. NCBH/DCEHC-DCH assumed a ratio of 1,500 annual visits per exam room. At 80% occupancy, 16 exam rooms are needed by Project Year 3. (Emphasis in original.)

The applicants' assumptions regarding projected utilization of the ED are reasonably based on historical utilization by the target population of services provided at North Carolina Baptist Hospital and DCH and increased utilization given a modern state-of-the-art facility.

In Section III.1(b), page 89, the applicants state that the proposed ED needs only 16 treatment rooms in Year Three to operate at 80% of capacity, as that term is defined by the applicant. However, in Section II.1, page 21, and the design schematic provided in Exhibit 5, the applicants state that the proposed ED will consist of a total of 20 treatment rooms as follows:

- 8 fast track rooms;
- 2 major resuscitation rooms;
- 8 urgent/emergent rooms; and
- 2 behavioral health rooms.

The applicants did not provide any assumptions or a methodology to demonstrate the need for the four additional ED treatment rooms included in the design of the proposed replacement hospital.

Observation Beds (Unlicensed) – In Section II.1, page 18, the applicants state that DCH has three unlicensed observation beds. However, in its 2008 Hospital License Renewal Application, DCH reports that it has no unlicensed observation beds. In Section

III.1(b), pages 91-92, the applicants describe the assumptions and methodology used to project the number of observation patients at the proposed replacement hospital, as follows:

"Step One: Calculate FFY 2006 NCBH observation patients as a percentage of total ED visits and outpatient surgeries, as shown below.

NCBH Metric	*FFY 2006*
ED Visits	*81,790*
Outpatient Surgeries	*15,842*
Combined Total	*97,632*
Observation Patients	*18,750*
Observation Care as % of (ED + OP Surgery)	*19.2%*

Step Two: Apply the above ratio (19.2%) to projected DCEHC-DCH ED visits and outpatient surgeries to yield projected observation patients.

DCEHC-DCH Projection	*PY 1 (CY 2012)*	*PY 2 (CY 2013)*	*PY 3 (CY 2014)*
ED Visits	*16,915*	*18,042*	*19,255*
Outpatient Surgeries	*2,581*	*2,660*	*2,740*
Combined Total	*19,496*	*20,702*	*21,995*
Observation Care as % of (ED +OP Surgery)	*19.2%*	*19.2%*	*19.2%*
Observation Encounters	*3,743*	*3,975*	*4,223*

Step Three: Project observation bed need. *NCBH/DCEHC-DCH assumed observation beds would be occupied at the rate of 1.5 patients per day per bed, based on the NCBH experience reported by the Executive Nursing Director of the Emergency Department.*

Metric	*PY 1 (CY 2012)*	*PY 2 (CY 2013)*	*PY 3 (CY 2014)*
Observation Patients	*3,743*	*3,975*	*4,223*
Proposed Observation Beds	*10*	*10*	*10*
Patients per Day per Bed	*1.5*	*1.5*	*1.5*
ADC	*6.8*	*7.3*	*7.7*
Occupancy Rate	*68%*	*73%*	*77%*

With 4,223 observation patients, NCBH/DCEHC-DCH projects to occupy the proposed 10 observation beds at 77% by Project Year 3." (Emphasis in original.)

However, projected utilization of the 10 unlicensed observation beds at the proposed replacement hospital is not based on reasonable and supported assumptions. Specifically, in Step One of their methodology, the applicants state that they assume that the ratio of observation patients to ED visits and outpatient surgeries at the proposed replacement hospital would be the same as the current ratio of observation patients to ED visits and outpatient surgeries at North Carolina Baptist Hospital (NCBH). However, NCBH is an academic medical center teaching hospital and a Level I trauma center, offering many more services than will be provided at the proposed replacement hospital. Thus, it is not reasonable to assume that the ratio of observation patients to ED visits and outpatient surgical cases would be similar at both hospitals. Therefore, the applicants did not adequately demonstrate that projected utilization of the 10 unlicensed observation beds at the proposed replacement hospital is based on reasonable and supported assumptions and consequently did not adequately demonstrate the need for ten observation beds.

Medical Equipment – In Exhibit 20, the applicants indicate that all of DCH's existing equipment in Mocksville would be replaced with new equipment at the proposed replacement hospital.

CT scanner – In Section III.1(b), page 92, the applicants provide projected utilization for the existing CT scanner, as illustrated in the following table.

	DCH Average Ratio FFY 2006 – 2007	Projected Utilization (Scans, not HECT units)		
		Year One (CY 2012)	Year Two (CY 2013)	Year Three (CY 2014)
CT Scanner				
Inpatient - % of Discharges	23.57%	676	699	723
Outpatient - % OP + ED	8.6%	3,750	3,946	4,153
Total		4,426	4,645	4,876

As shown in the above table, the applicants assume that the CT scanner will perform 0.2357 CT scans for every inpatient discharge and 0.086 CT scans for every outpatient and ED visit based on the historical experience at DCH.

X-ray Equipment – DCH has two existing fixed X-ray units and the applicants propose to acquire a third fixed X-ray unit as part of this project. In addition, DCH has two existing portable X-ray units

and one existing C-arm. In Section III.1(b), page 92, the applicants provide projected utilization for the existing and additional X-ray units, as illustrated in the following table.

	DCH Average Ratio FFY 2006 – 2007	Projected Utilization		
		Year One (CY 2012)	Year Two (CY 2013)	Year Three (CY 2014)
X-Ray				
Inpatient - % of Discharges	122.53%	3,517	3,635	3,757
Outpatient - % OP + ED	37.9%	16,358	17,317	18,227
Total		19,975	20,952	21,984

As shown in the above table, the applicants assume that the existing and proposed X-ray units will perform 1.2253 procedures for every inpatient discharge and 0.379 procedures for every outpatient and ED visit based on the historical experience at DCH. The applicants project a total of 21,984 X-ray procedures would be performed in Year Three, which is an average of 10 procedures per unit per day [21,984 procedures/ 6 units / 365 = 10.04].

Mammography Unit – In Section III.1(b), page 92, the applicants provide projected utilization for the existing mammography unit, as illustrated in the following table.

	DCH Average Ratio FFY 2006 – 2007	Projected Utilization		
		Year One (CY 2012)	Year Two (CY 2013)	Year Three (CY 2014)
Mammography				
Inpatient - % of Discharges	0.16%	5	5	5
Outpatient - % OP + ED	5.4%	2,327	2,449	2,577
Total		2,332	2,453	2,582

As shown in the above table, the applicants assume that the existing mammography unit will perform 0.0016 procedures for every inpatient discharge and 0.054 procedures for every outpatient and ED visit based on the historical experience at DCH.

Ultrasound Units – DCH has two existing ultrasound units and proposes to acquire a third ultrasound unit as part of this project. However, the applicants did not provide projected utilization for the existing and additional ultrasound units. Therefore, the applicants did not adequately demonstrate the need to acquire a third ultrasound unit as part of this project.

Other Equipment – In Section II.1, pages 18-22, and Exhibit 20, the applicants state that DCH has one existing stress testing unit,

one existing pulmonary function testing unit and two existing EKG units. The applicants also propose to acquire the following equipment as part of this project:

- 2 additional EKG units
- 2 additional echo units
- 1 additional EEG unit
- 1 additional EMG / EP unit

The above equipment will be used to support the other services to be provided at DCH, particularly the services provided by the ED.

Duplication of Previously Approved Replacement Hospital

DCH and Baptist previously filed an application (Project I.D. #G-8078-08) in March of 2008 for review beginning April 1, 2008 to develop a replacement hospital offering the following beds and services: 50 general acute care beds, 10 unlicensed observation beds, Surgery, Radiology, Emergency, Laboratory, Pharmacy, Cardiopulmonary and Physical Therapy. The Agency conditionally approved Project I.D. #G-8078-08 on August 28, 2008, but that decision is currently under appeal.

This application (Project I.D. #G-8164-08) was submitted on July 15, 2008 for the review beginning August 1, 2008. The only differences between this application and Project I.D. #G-8078-08 are that the earlier proposal did not include four obstetrical beds, four unlicensed LDRs, a nursery with three unlicensed bassinets, and a dedicated C-section OR. The applicants did not adequately demonstrate the need for four obstetrical (post partum) beds, four unlicensed LDR beds, three unlicensed bassinets or dedicated C-section OR that are proposed in the project which is the subject of this review.

Further, the applicants have not withdrawn Project I.D. #G-8078-08 and cannot be approved for both projects. Therefore, the project currently under review duplicates the services proposed in the previously approved project. Consequently, the replacement facility in the new project is not needed in addition to the replacement facility already approved.

In summary, the applicants did not adequately identify the obstetric population proposed to be served and did not adequately

demonstrate the need the population to be served has for the proposed replacement hospital or services that are the subject of this application. Therefore, the application is nonconforming with this criterion.

(3a) In the case of a reduction or elimination of a service, including the relocation of a facility or a service, the applicant shall demonstrate that the needs of the population presently served will be met adequately by the proposed relocation or by alternative arrangements, and the effect of the reduction, elimination or relocation of the service on the ability of low income persons, racial and ethnic minorities, women, handicapped persons, and other underserved groups and the elderly to obtain needed health care.

C

The applicants propose to terminate participation in the swing bed program and to relocate the existing hospital 13 miles from its current location in Mocksville, which is located near the geographic center of Davie County, to Bermuda Run, which is in the northeast portion of the county. The relocation of the hospital and the services to be eliminated or reduced are discussed separately below.

Proposed Elimination of 31 General Acute Care Beds

In Exhibit 13, Section III.1(b), pages 71 and 74, and the assumptions for the pro formas, the applicants provide historical and projected utilization of the general acute care beds at DCH, as illustrated in the following table.

Year	# of Acute Care Patient Days	Average Daily Census (ADC)	Total # of Licensed Acute Care Beds	% Occupancy
10/1/04 – 9/30/05 (actual)	1,147	3.1	81	3.8%
10/1/05 – 9/30/06 (actual)	1,527	4.2	81	5.2%
10/1/06 – 9/30/07 (actual)	1,271	3.5	81	4.3%
10/1/07 – 9/30/08 (projected)	1,443	4.0	81	4.9%
10/1/08 – 9/3/09 (projected)	1,481	4.1	81	5.1%
10/1/09 – 9/30/10 (projected)	1,519	4.2	81	5.2%
10/1/10 – 9/30/11 (projected)	1,559	4.3	81	5.3%
10/1/11 – 12/31/11 (projected) (three months)	400	4.4	81	5.4%
1/1/12 – 12/31/12 (projected) (Year One)	11,875	32.5	50	65.1%
1/1/13 – 12/31/13 (projected) (Year Two)	12,273	33.6	50	67.2%
1/1/14 – 12/31/14 (projected) (Year Three)	12,683	34.7	50	69.5%

As shown in the above table, DCH's current average daily census (ADC) was only 3.5 patients, which is an occupancy rate of only 4.3%. Thus, on any given day, 77.5 general acute care beds were unoccupied [81 – 3.5 = 77.5]. Further, as shown in the table above, during the third operating year, the applicants project that the ADC in the general acute care beds at DCH would be 34.7 patients. Thus, assuming the hospital was licensed for 81 general acute care beds, on any given day, 46 general acute care beds would be unoccupied [81 – 34.7 = 46.3]. See Criterion (3) for discussion regarding the reasonableness of the applicants' projected utilization. Thus, the applicants adequately demonstrate that the elimination of 31 existing general acute care beds would not affect the ability of the population to receive needed acute care services.

Elimination of Swing Bed Program

According to its 2008 Hospital License Renewal Application, DCH is currently *"approved for up to 49"* swing beds under the Federal Swing Bed Program (P.L. 96-499). Thus, DCH currently provides skilled nursing care in the existing acute care beds. In fact, during FY 2007, DCH provided 1,730 skilled nursing days of care in its "swing beds," which is an ADC of 4.7 skilled nursing patients [1,730 / 365 = 4.7]. In Section III.1(a), page 64, the applicants state that the swing bed program will be eliminated and the proposed replacement hospital will not provide skilled nursing services because hospitals located in "urbanized areas," as designated in the most recent U.S. Census, are not eligible to participate in the Federal Swing Bed Program. Regarding the needs of the population presently receiving skilled nursing services at DCH, in Section III.1(a), pages 64-65, the applicants state

> *"DCEHC has made every effort to ensure that all of its current and future swing bed patients will be adequately cared for after the closure of DCH. Currently, there are three skilled nursing facilities operating in Davie County with a combined number of 216 licensed beds. Currently, capacity exists at each of the two facilities. Please see the matrix below for a detailed explanation:*

Facility Name	*Licensed Nursing Beds*	*Census*	*% Available Capacity*
Autumn Care of Mocksville	*96*	*92*	*4%*
Bermuda Village Retirement Center	*3*	*3*	*0%*
Bermuda Commons Nursing/Rehab Center[2]	*117*	*21*	*82%*

In addition, Hoots Memorial Hospital located in nearby Yadkin County is a 25 bed Critical Access Hospital with swing beds. Please see Exhibit 22 for a letter from Hoots Memorial Hospital indicating a willingness to accept all current and future DCH swing bed patients."

The applicants adequately demonstrate that the needs of the population presently receiving skilled nursing services at DCH would be adequately met by alternative arrangements following the elimination of skilled nursing services in the swing beds.

Proposed Relocation of Existing Hospital

In Section III.1, pages 61-62, the applicants state

"When DCEHC-DCH was originally constructed in 1956 as a county-operated facility, the most logical location was the county seat of Mocksville, where the overwhelming majority of the population resided. Over the past 20 years, however, commercial and residential development in the county has shifted to the northeastern portion of the county. Currently, there are over 12,000 individuals living in the Advance/Hillsdale area. Residents of this population center have exhibited an unwillingness to drive to Mocksville for health care services and have therefore been consuming services out of county. In FFY 2006, only 8.6% of DCEHC-DCH inpatient discharges originated from Advance/Hillsdale. The County is in need of a hospital that is located within the center of the proposed market area, which will make the new hospital accessible for all residents. The proposed location will not only recognize

2 According to the 2008 license renewal application for Bermuda Commons Nursing and Rehabilitation Center, ownership of the facility changed in April 2007. During FFY 2007, the facility was in operation only during the month of September.

the shift in the population that has occurred over the last several years (to eastern Davie County) but will also address the projected growth areas and will allow for a hospital that will meet the growing needs of a growing population for decades to come."

In Section III.8, pages 97-101, the applicants state

"DCEHC-DCH believes that the proposed project is the most effective, and the only viable alternative to conform with Criterion 3a, as described below.

- *The needs of the population presently served cannot adequately be met in the present facility. As demonstrated in Section III.1 and affirmed by the strong public support demonstrated during the public comment review period for the previous application, the current facility cannot meet the proposed market area's healthcare needs. It is generally understood by the community, county government, patients, and physicians, and by the Agency as evidenced by its findings on page 50 stating that 'the applicant had adequately demonstrated a need to replace Davie County* [sic]*' that the current hospital must be replaced.*

- *DCECH-DCH cannot be replaced on its existing property in Mocksville. The existing site is only 14 acres, most of which is occupied by the surrounding EMS, Senior Services and Adult Home Care facilities. Even if the site were large enough, remaining in the same location would require shutting down the hospital, demolishing it, and rebuilding completely, a process that would leave the county with no hospital for a number of years.*

- *The primary effect of the relocation of the service on all patients, including the underserved, will be to expand access to needed healthcare. DCEHC-DCH expects one of the greatest effects of the proposed relocation on all patients, including the underserved, to be a remarkable and dramatic increase in the number of physicians on active staff at the proposed Davie*

replacement hospital, including primary care physicians as well as sub-specialists. DCEHC-DCH has received considerable public support from physicians expressing their excitement and willingness to be able to provide services in Davie County. A new, state-of-the-art hospital will result in the ability to recruit and retain physicians to the DCEHC-DCH staff, which will have a dramatic effect on the entire proposed market area. Without the proposed replacement hospital and relocation, DCEHC-DCH will likely continue to have challenges retaining physicians to serve its patient population.

- *The proposed application will not represent a hardship to the poor, indigent, or medically underserved. DCHEHC-DCH is not changing its admissions policies because of the relocation. The new hospital will continue to care for all patients in need of treatment and as recognized by the State in its findings from the previous CON application 'as projecting the highest percentage of patient days/procedures to be provided to both Medicare and Medicaid recipients.'*

- *The proposed relocation is necessary to allow for a centralized location within the proposed service area. The new location will actually decrease the driving time and mileage residents of central and western Davie County currently travel to receive their inpatient services. The proposed location for the replacement facility provides enhanced access to inpatient care for those patients who are presently driving to Forsyth County for hospital services. The new hospital will be located on Rt. 801 north of the I-40 interchange in eastern Davie County. This will provide greater accessibility to all of Davie county's population as it is located along a major transportation corridor with an exit directly adjacent to the proposed hospital site. Currently, approximately 80% of all Davie County residents (with a weighted DRG average of <2) are driving into Forsyth County to receive their care. In particular, residents from the central and western portions of Davie County (Mocksville and Cooleemee) currently drive far distances to receive inpatient care.*

Currently, 38% of residents residing in zip code 27014 (Cooleemee) drive to Forsyth County to receive their healthcare, which equates to approximately a 32 mile or 40 minute drive.

In addition, another 38% of Cooleemee residents drive to Rowan County for their care representing almost the same distance. The proposed Davie County Hospital replacement site will shorten the commute time from this area to approximately 19 miles or a 26 minute drive time. Additionally, approximately 64% [sic] *residents in zip code 27028 (Mocksville) currently drive into Forsyth County to obtain inpatient services (with a weighted average DRG of <2). This represents a current drive time of 28 minutes or 24 miles. The proposed location site will reduce the drive to comparable inpatient services to less than half - 12 miles or a 14 minute drive time. Please see Exhibit 5 for a detailed analysis of the entire proposed service area's current patient origin by discharging hospital county.*

DCEHC-DCH is also proposing several measures to ensure that this patient population has access to care by the following initiatives:

1) *Wake Forest University Baptist Medical Center Community Physicians (WFUBMCCP) is building a primary and urgent care center in Mocksville. DCEHC-DCH recognizes that the residents of Mocksville and western Davie County utilize the emergency services department for urgent and primary care related needs. Construction will begin in May on a primary care center located at the intersection of Highway 601 and Country Lane in Mocksville, which is approximately 1.6 miles from the current Davie County Hospital and is expected to open the end of 2008. The Center will increase patient convenience for residents of Davie County for their primary, urgent care, as well as occupational therapy services, which are currently provided at Davie County Hospital. The center will be open 7 days a week and hours of operation will*

be 8:00 a.m. - 10:00 p.m. on weekdays and 9:00 am-9:00 pm on Saturdays and 1:00 pm to 9:00 pm on Sundays. The Center is anticipated to be approximately 7,000 square feet and will include a 6-exam room clinic for primary care, a 3-exam room clinic for urgent care, and a 3-exam room clinic for occupational health. In addition, the plans include an on-site lab and an x-ray room equipped for computed radiography.

According to the emergency data presented in this section, Mocksville residents required 2,616 emergent visits and 7,553 urgent visits during FFY 2007. This is further clarification that the proposed urgent care center in Mocksville will continue to provide access to health services for these residents in a convenient and cost effective setting. The utilization of an urgent care center for non-emergent cases will allow the emergency department at DCEHC-DCH to effectively and quickly respond to the emergent cases.

2) *The proposed replacement hospital will expand physician coverage in Davie County. The proposed facility will be more accessible to specialists who travel from Forsyth County to provide coverage for the facility.*

3) *DCEHC-DCH is also planning on maintaining and continuing the Community Assistance Program and the Social Work offices in Mocksville where they will be centrally located for Davie residents. The Community Alternatives Program is a Medicaid waivered program designed to help the elderly and disabled remain in their own homes rather that being institutionalized.*

DCEHC-DCH also provides Case Management and In-Home Aide services. The case management component includes a plan of care to ensure that all the needed services are provided. In-Home Aide services run the range of personal care (bathing, toileting, grooming, dressing) to home management

tasks (laundry, cooking, sweeping, cleaning, etc) DCECH's [sic] *Social Work program also assists patients and families with discharge plans, placement transition, Advanced Directives* [sic]

4) *Many small hospitals through out the state of North Carolina are struggling financially right now. Due to the high level of fixed costs that hospitals must incur, it is essential that hospitals maintain volumes for cost-effective operations. .With governmental reimbursement pressures increasing, larger facilities are beginning to compete with these smaller facilities, and many towns are at risk of losing access to care in their County* [sic]. *In order to avoid this same situation in Davie County, the Hospital must be located in an area that will see rapid growth in volumes to sustain the operations. The eastern part of the County* [sic] *is the only location that will guarantee that volume growth to make a replacement hospital cost effective.*

In summary, the proposed replacement hospital, including the relocation of DCEHC, is necessary to ensure that patients will have continued access to the proposed services. As demonstrated above, there are several initiatives in progress and planned to further ensure that the residents of the central and western portions of Davie County, particularly the medically underserved, will not be negatively impacted in terms of services, costs, charges, and/or level of access." (Emphasis in original.)

The following table shows the 2000 population for Davie County by census tract obtained from the U.S. Census Bureau web site.[3] The table also indicates the geographic location of the census tract and the municipality included in each census tract, if any.[4]

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3 2000 data is the latest data available for Davie County on the U.S. Census Bureau's web site.

4 According to the NC State Demographer's web site, there are only three municipalities in Davie County – Mocksville, Bermuda Run and Cooleemee.

Census Tract	Area of the County	Municipality	Total Population in 2000
802	Northeast		4,162
803	East	Bermuda Run	6,784
804	Southeast		4,073
805	Central	Mocksville	3,604
806	Central	Mocksville	3,376
807	South	Cooleemee	6,083
801	West		6,773
Total			34,855

In general, the applicants' proposed site in Bermuda Run will negatively impact geographic accessibility for residents of census tracts 805 (Mocksville), 806 (Mocksville), 807 (Cooleemee) and 801 (western Davie County). The following table summarizes the 2000 populations for the Davie County census tracts by area of the county.

Census Tract	Geographic Location Within the County	2000 Population	% of Total
Western & Central Census Tracts (closer to present hospital site)			
801	West	6,773	19.4%
805	Central	3,604	10.3%
806	Central	3,376	9.7%
807	South	6,083	17.5%
Subtotal		19,836	56.9%
Eastern Census Tracts (closer to proposed hospital site)			
802	Northeast	4,162	11.9%
803	East	6,784	19.5%
804	Southeast	4,073	11.7%
Subtotal		15,019	43.1%

Source: 2000 Census data obtained from the U.S. Census Bureau web site.

As shown in the above table, the four census tracts that will be negatively impacted in terms of geographic accessibility by the proposed relocation of the hospital to Bermuda Run included almost 60% of the population of Davie County in 2000. Even if the population of the eastern census tracts increased at a faster rate than the population of the western and central census tracts, a substantial percentage of the population of Davie County would still be negatively impacted by the proposed relocation.

Further, the residents of Davie County who will be negatively impacted by

the relocation include relatively higher populations of medically underserved groups, including lower income persons, the elderly, and racial minorities. The following tables summarize income, poverty status, age and minority population data for Davie County by census tract.

PER CAPITA INCOME

CENSUS TRACT	GEOGRAPHIC LOCATION WITHIN THE COUNTY	2000 POPULATION	PER CAPITA INCOME IN 1999
WESTERN & CENTRAL CENSUS TRACTS (closer to present hospital site)			
801	West	6,773	$19,253
805	Central	3,604	$18,742
806	Central	3,376	$21,392
807	South	6,083	$15,480
Subtotal / Weighted Average		19,836	$18,956
EASTERN CENSUS TRACTS (closer to proposed hospital site)			
802	Northeast	4,162	$21,563
803	East	6,784	$31,237
804	Southeast	4,073	$19,237
Weighted Average		15,019	$25,137

Source: 2000 Census data obtained from the U.S. Census Bureau web site.

As shown in the above table, the per capita income for the western and central census tracts (801, 805, 806 and 807) was $18,956 in 1999. In contrast, the per capita income for the eastern census tracts (802, 803 and 804) was $25,137, a difference of more than $6,000 per year for every person living in the eastern census tracts [$25,137 - $18,956 = $6,181].

POVERTY STATUS

CENSUS TRACT	GEOGRAPHIC LOCATION WITHIN THE COUNTY	# OF INDIVIDUALS BELOW THE POVERTY LEVEL	% OF TOTAL POPULATION (1)
WESTERN & CENTRAL CENSUS TRACTS (closer to present hospital site)			
801	West	430	6.4%
805	Central	501	14.2%
806	Central	274	8.6%
807	South	909	15.0%
Subtotal / Weighted Average		2,114	10.8%
EASTERN CENSUS TRACTS (closer to proposed hospital site)			
802	Northeast	259	6.2%
803	East	275	4.2%
804	Southeast	304	7.5%
Weighted Average		838	5.7%
TOTAL		2,952	8.6%

(1) See the per capita income table for the total population of each census tract.

Source: 2000 Census data obtained from the U.S. Census Bureau web site.

As shown in the above table, in 2000, 10.8% of the population of the western and central census tracts (801, 805, 806 and 807) were living below the poverty level. In contrast only 5.7% of the population of the eastern census tracts (802, 803 and 804) were living below the poverty level.

AGE

CENSUS TRACT	GEOGRAPHIC LOCATION WITHIN THE COUNTY	# OF INDIVIDUALS 65 AND OLDER	% OF TOTAL POPULATION (1)
WESTERN & CENTRAL CENSUS TRACTS (closer to present hospital site)			
801	West	750	11.1%
805	Central	452	12.8%
806	Central	675	21.1%
807	South	771	12.8%
Subtotal / Weighted Average		2,648	13.6%
EASTERN CENSUS TRACTS (closer to proposed hospital site)			
802	Northeast	465	11.2%
803	East	1,210	18.3%
804	Southeast	484	11.9%
Weighted Average		2,159	14.6%
TOTAL		4,807	14.0%

(1) See the per capita income table for the total population of each census tract.
Source: 2000 Census data obtained from the U.S. Census Bureau web site.

As shown in the above table, 13.6% of the population of the western and central census tracts are 65 and older and 14.6% of the population of the eastern census tracts are 65 and older. Thus, the western and central census tracts and the eastern census tracts have approximately the same percentage of population which is age 65 and older. However, Census Tract 806 (Mocksville), which is centrally located in Davie County has the highest percentage of total population aged 65 and older. The hospital is currently located in Census Tract 806.

MINORITY POPULATION

CENSUS TRACT	GEOGRAPHIC LOCATION WITHIN THE COUNTY	# OF PERSONS IDENTIFYING THEMSELVES AS A MINORITY	% OF TOTAL POPULATION (1)
WESTERN & CENTRAL CENSUS TRACTS (closer to present hospital site)			
801	West	573	8.5%
805	Central	805	22.9%
806	Central	416	13.0%
807	South	802	13.3%
Subtotal		2,596	13.3%
EASTERN CENSUS TRACTS (closer to proposed hospital site)			
802	Northeast	211	5.1%
803	East	307	4.6%
804	Southeast	237	5.8%
Subtotal		755	5.1%
TOTAL		3,351	9.8%

(1) See the per capita income table for the total population of each census tract.
Source: 2000 Census data obtained from the U.S. Census Bureau web site.

As shown in the above table, 2,596 people or 13.3% of the population of the western and central census tracts is a member of a racial minority. In contrast, only 755 people or 5.1% of the population of the eastern census tracts is a member of a racial minority. In other words, there are 3.4 times as many members of a racial minority living in the western and central census tracts compared to the eastern census tracts [2,596 / 755 = 3.4].

As shown in the above tables, the residents of central and western Davie County that potentially would be negatively impacted by the proposed relocation include relatively higher proportions of medically underserved groups, including lower income persons, the elderly and racial minorities. However, the applicants provided information to demonstrate the needs of the residents of central and western Davie County are not currently being adequately met by the existing facility in Mocksville, as discussed below.

In Exhibit 5, the applicants provide the number of adjusted acute care discharges[5] for residents of the proposed primary service area (see Criterion 3 for description) discharged from any hospital in

[5] Adjusted acute care discharges do not include DRG's with a weight > 2.0 or any DRG's for obstetrics, newborns, psychiatry, substance abuse, inpatient rehabilitation and cardiac catheterization.

North Carolina during FFY 2006, as illustrated in the following table.

County Location of Hospitals Serving Residents of the Proposed Primary Service Area	# of Adjusted Discharges for Residents of the Proposed Primary Service Area	% of Total Adjusted Discharges of Residents of Proposed Primary Service Area
Forsyth	1,951	65.8%
Davie	392	13.2%
Iredell	329	11.1%
Rowan	201	6.8%
Guilford	18	0.6%
Mecklenburg	13	0.4%
Durham	11	0.4%
Davidson	9	0.3%
Cabarrus	7	0.2%
Orange	6	0.2%
Wake	4	0.1%
Catawba	3	0.1%
Surry	3	0.1%
Rockingham	2	0.1%
Surry	2	0.1%
Ashe	1	0.0%
Buncombe	1	0.0%
Burke	1	0.0%
Burke	1	0.0%
Carteret	1	0.0%
Gaston	1	0.0%
Haywood	1	0.0%
Henderson	1	0.0%
McDowell	1	0.0%
Nash	1	0.0%
New Hanover	1	0.0%
Rutherford	1	0.0%
Yadkin	1	0.0%
Total	**2,964**	**100.0%**

As shown in the above table, during FFY 2006, only 13.2% of the residents of the proposed primary service area (adjusted discharges only) utilized DCH while 65.8% utilized a hospital in Forsyth County, 11.1% utilized a hospital in Iredell County and 6.8% utilized a hospital in Rowan County.

In Exhibit 5, the applicants also provided the number of adjusted

acute care discharges by zip code. The following table illustrates the FFY 2006 adjusted discharges for residents of Zip Code 27028 (Mocksville) who were discharged from any hospital in North Carolina hospital, as illustrated in the following table.

MOCKSVILLE (ZIP CODE 27028)

Hospital County	# of Adjusted Discharges	% of Total
Forsyth	1,107	57.7%
Davie	336	17.5%
Iredell	297	15.5%
Rowan	133	6.9%
Mecklenburg	9	0.5%
Guilford	8	0.4%
Cabarrus	7	0.4%
Davidson	4	0.2%
Durham	4	0.2%
Surry	3	0.2%
Orange	2	0.1%
Catawba	2	0.1%
Wake	2	0.1%
Yadkin	1	0.1%
Gaston	1	0.1%
Burke	1	0.1%
Nash	1	0.1%
Henderson	1	0.1%
TOTAL	1,919	100.0%

As shown in the above table, during FFY 2006, only 17.5% of the residents of the Mocksville zip code (27028) (adjusted discharges only) utilized DCH while 57.7% utilized a hospital in Forsyth County, 15.5% utilized a hospital in Iredell County and 6.9% utilized a hospital in Rowan County. In all, 82.5% of the residents of the Mocksville zip code (27028) (adjusted discharges only) traveled to another county for acute care services [100% – 17.5% = 82.5%]. For the 57.7% of the residents of the Mocksville zip code (27028) (adjusted discharges only) that currently travel to Forsyth County, the proposed replacement hospital would be closer than the hospitals in Forsyth County.

The following table illustrates the FFY 2006 adjusted discharges for residents of Zip Code 27014 (Cooleemee) who were discharged from any hospital in North Carolina hospital, as illustrated in the following table.

COOLEEMEE (ZIP CODE 27014)

Hospital County	# of Adjusted Discharges	% of Total
Rowan	60	37.0%
Forsyth	51	31.5%
Iredell	21	13.0%
Davie	21	13.0%
Guilford	3	1.9%
Durham	2	1.2%
Rockingham	2	1.2%
Mecklenburg	1	0.6%
Catawba	1	0.6%
TOTAL	162	100.0%

As shown in the above table, during FFY 2006, only 13% of the residents of the Cooleemee zip code (27014) (adjusted discharges only) utilized DCH while 37% utilized the hospital in Rowan County, 31.5% utilized a hospital in Forsyth County and 13% utilized a hospital in Iredell County. In all, 87% of the residents of the Cooleemee zip code (27014) (adjusted discharges only) traveled to another county for acute care services [100% – 13% = 87%]. For the 31.5% of the residents of the Cooleemee zip code (27014) (adjusted discharges only) that currently travel to Forsyth County, the location of the proposed replacement hospital would be closer than the hospitals in Forsyth County. For the 50% of the residents of the Cooleemee zip code (27014) (adjusted discharges only) that currently travel to Rowan or Iredell counties [37% + 13% = 50%], the location of the proposed replacement hospital would be approximately the same distance from their homes that these patients currently travel to the hospitals in Rowan and Iredell counties.

Further, in Section III.1, page 71, the applicants state that 1,418 residents of the primary service area admitted to North Carolina Baptist Hospital during FFY 2006 are expected to shift to the proposed replacement hospital, which will be located closer to their homes.

The data provided by the applicants in Exhibit 5 shows that the overwhelming majority of the residents of the Mocksville and Cooleemee zip codes, which roughly correspond to the western and central census tracts, are not currently utilizing DCH for acute care services. Rather, they are utilizing hospitals in Forsyth, Rowan and Iredell counties for acute care services. Thus, the distance and

travel time to the proposed site for the replacement hospital for the overwhelming majority of the residents of the Mocksville and Cooleemee zip codes would be the same or less than the distance and travel time to the hospitals in Forsyth, Rowan and Iredell counties.

The applicants state that the proposed replacement hospital's admission policies will not change and it *"will continue to care for all patients in need of treatment."* The following table compares the current number of acute care patient days by payor category with the projected number of acute care patient days by payor category during the second operating year, as reported by the applicants in Section VI.10, page 117, Exhibit 13 and the Pro Formas.

	# OF ACUTE CARE PATIENT DAYS	
	CURRENT FY 2007	YEAR TWO CY 2013
Self Pay / Indigent / Charity Care	243	440
Medicare	693	3,826
Medicaid	25	1,949
Commercial / Managed Care	310	5,929
Other	0	125
Total	1,271	12,269

As shown in the above table, during FY 2007, DCH provided only 25 acute care patient days to Medicaid beneficiaries. The applicants project that the proposed replacement hospital would provide 1,949 acute care patient days to Medicaid beneficiaries during the second operating year of the proposed replacement hospital. Further, during FY 2007, DCH provided only 243 acute care patient days to self pay / indigent / charity care patients. The applicants project that the proposed replacement hospital would provide 440 acute care patient days to self pay / indigent / charity care patients during the second operating year of the proposed replacement hospital.

The applicants adequately demonstrate that the needs of the population presently receiving acute care services at DCH would be adequately met following the relocation of the hospital.

In summary, the application is conforming to this criterion.

(4) Where alternative methods of meeting the needs for the proposed project exist, the applicant shall demonstrate that the least costly or most effective alternative has been proposed.

NC

In Section II.5, pages 25-27, of the application under review, the applicants discuss the following alternatives considered prior to submission of this application including: 1) maintaining the status quo; 2) renovating the existing facility; 3) constructing a replacement critical access hospital; and 4) constructing a healthplex.[6] However, on March 17, 2008, DCH and Baptist filed an application (Project I.D. #G-8078-08) to develop a replacement hospital offering the following beds and services: 50 general acute care beds, 10 unlicensed observation beds, Surgery, Radiology, Emergency, Laboratory, Pharmacy, Cardiopulmonary and Physical Therapy. In the application currently under review, the applicants failed to discuss why the proposed replacement hospital in this application is a less costly or more effective alternative than the replacement hospital they proposed to develop in the prior review.

Further, the application is not conforming to all applicable statutory and regulatory review criteria. See Criteria (1), (3), (5), (6), (18a), the Criteria and Standards for Neonatal Services promulgated at 10A NCAC 14C .1400, and the Criteria and Standards for Surgical Services and Operating Rooms promulgated at 10A NCAC 14C .2100.

In summary, the applicants do not adequately demonstrate that this proposal is their most effective or least costly alternative. Consequently, the application is not conforming to this criterion.

(5) Financial and operational projections for the project shall demonstrate the availability of funds for capital and operating needs as well as the immediate and long-term financial feasibility of the proposal, based upon reasonable projections of the costs of and charges for providing health services by the person proposing the service.

NC

6 The applicants state that the typical healthplex consists of a freestanding ED, outpatient ORs, diagnostic imaging services and physician offices.

NC

In Section VIII.1, page 131, the applicants project that the total capital cost of the project will be $104,840,762, as illustrated below.

Site Costs		
Purchase Price of the Land	$5,000,000	
Site Preparation Costs	$4,775,378	
Subtotal Site Costs		**$9,775,378**
Construction Costs		**$56,180,917**
Miscellaneous Costs		
Fixed Equipment	$5,110,132	
Movable Equipment	$16,680,874	
Furniture	$1,591,296	
Consultant Fees	$8,957,088	
Contingency	$6,545,077	
Subtotal Miscellaneous Costs		**$38,884,467**
Total Capital Cost		**$104,840,762**

In Section IX, page 138, the applicants project that start up and initial operating expenses will be $5,669,000. In Section VIII.3, page 132, and Section IX, pages 138-139, the applicants state that the capital and working capital needs of the project will be financed with the accumulated reserves of Baptist. The audited financial statements for Baptist are provided in Exhibit 31. As of June 30, 2007, Baptist had $19,382,000 in cash and cash equivalents, $89,499,000 in short-term investments, $596,604,000 in *"Assets whose use is limited: Internally designated for capital improvements,"* $1,408,636,000 in total assets and $884,204,000 in total net assets (total assets less total liabilities). Exhibit 30 contains a letter signed by the Chief Financial Officer for Baptist, which states

> *"Subject: Documentation of funds for the Davie County Emergency Health Corporation Certificate of Need Application to replace Davie County Hospital*
>
> ...
>
> *North Carolina Baptist Hospital agrees to make available from its accumulated reserves a total of $104,840,762 for the capital costs incurred in the development of the aforementioned project and $7,000,000 for working capital*

needs.

As Vice President for Financial Services and Chief Financial Officer for North Carolina Baptist Hospital, I can attest to the availability of funds for this purpose. These funds will be made available from the accumulated reserves of North Carolina Baptist Hospital."

The applicants adequately demonstrate the availability of sufficient funds for the capital and working capital needs of the project.

In the projected revenue and expense statement, the applicants project that revenues will exceed operating costs at DCH in each of the first three operating years. The assumptions used by the applicants in preparation of the pro formas are in the Financials Tab of the application. However, the applicants utilization projections for observation and obstetrical services, including the dedicated C-section OR, are unsupported and unreliable. Consequently, costs and revenues that are based on this projected utilization are also not reliable. See Criterion (3) for discussion of utilization projections. Therefore, the applicants did not adequately demonstrate that the financial feasibility of the proposal is based upon reasonable projections of costs and revenues. Consequently, the application is nonconforming with this criterion.

(6) The applicant shall demonstrate that the proposed project will not result in unnecessary duplication of existing or approved health service capabilities or facilities.

NC

The applicants propose to construct a replacement hospital in the Bermuda Run / Advance area of Davie County, including 46 general medical/surgical acute care beds, 4 obstetrical beds, 10 unlicensed observation beds, 2 shared ORs, 1 dedicated C-section OR, 1 GI endoscopy room, one minor procedure room, an emergency department and various outpatient and ancillary services. However, on August 28, 2008, the applicants were previously approved to construct a replacement hospital on the same site, including 48 acute care beds, 2 shared ORs, 1 GI endoscopy room, one minor procedure room, an emergency department and various outpatient and ancillary services. That decision is currently under appeal. The applicants do not

adequately demonstrate the need the population proposed to be served has for the replacement hospital that is the subject of this review given a replacement hospital already was approved in a prior review. Further, the applicants did not adequately demonstrate the need for 4 licensed obstetrical (post-partum) beds, 4 unlicensed LDRs, 3 unlicensed bassinets in the new nursery, 10 unlicensed observation beds, 1 dedicated C-section OR, 4 of 20 proposed ED treatment rooms or a third US unit. See Criterion (3) for discussion. Therefore, the applicants did not demonstrate that the proposal would not result in the unnecessary duplication of existing or approved health service capabilities or facilities, and the application is nonconforming with this criterion.

(7) The applicant shall show evidence of the availability of resources, including health manpower and management personnel, for the provision of the services proposed to be provided.

C

The following table summarizes staffing of DCH as provided by the applicants in Exhibit 17 (current and projected staffing for the first three operating years) and in the assumptions following the pro formas (projected staffing for the first three operating years).

ENTIRE HOSPITAL	TOTAL # OF FULL-TIME EQUIVALENT (FTE) STAFF POSITIONS
Current Staff (FY 2007)	142.22
Project Year One (CY 2012)	378.10
Project Year Two (CY 2013)	390.10
Project Year Three (CY 2014)	398.20

As shown in the above table, DCH currently employs a total of 142.22 FTE staff positions. The applicants propose to employ a total of 378.1 FTE staff positions in Year One, 390.1 FTE staff positions in Year Two and 398.0 FTE staff positions in Year Three. In Section VII.2, page 124, the applicants provide the projected staffing for obstetrical services during the third operating year, as illustrated in the following table.

OBSTETRICAL SERVICES	TOTAL # OF FTE STAFF POSITIONS
Nursing	14.1
Ancillary	9.4
Administrative (non-clinical)	1.0
Total	24.5

In Section VII.3, page 125, the applicants state that they will recruit the additional staff by publishing job openings in area newspapers, participating in career and health fairs and recruiting at area high schools and colleges. In Section VII.6(c), page 127, the applicants state that DCH will contract with North Carolina Baptist Hospital for management services. In Section V.3(c), page 109, the applicants state *"The Chief of Staff at DCEHC-DCH will continue to be Larry A. Pearce, M.D."* Exhibit 27 contains a letter from Dr. Pearce in which he identifies himself as the President of the DCH Medical Staff. The applicants demonstrate the availability of adequate health manpower and management personnel for the provision of the proposed services. Therefore, the application is conforming to this criterion.

(8) The applicant shall demonstrate that the provider of the proposed services will make available, or otherwise make arrangements for, the provision of the necessary ancillary and support services. The applicant shall also demonstrate that the proposed service will be coordinated with the existing health care system.

C

In Section II.1, pages 18-19, the applicants list the ancillary and support services that will be provided at the proposed replacement hospital. Exhibit 15 contains copies of the existing transfer agreements between DCH and North Carolina Baptist Hospital and DCH and Forsyth Medical Center. Exhibit 27 contains letters from area physicians expressing support for the proposal to construct a replacement hospital. Exhibit 4 contains a letter from the Davie County Health Department expressing support for the proposal to construct a replacement hospital. DCH adequately demonstrated that the necessary ancillary and support services will be available for the replacement hospital and that the services will be coordinated with the existing health care system. Therefore, the application is conforming to this criterion.

(9) An applicant proposing to provide a substantial portion of the project's services to individuals not residing in the health service area in which the project is located, or in adjacent health service areas, shall document the special needs and circumstances that warrant service to these individuals.

NA

(10) When applicable, the applicant shall show that the special needs of health maintenance organizations will be fulfilled by the project. Specifically, the applicant shall show that the project accommodates:

(a) The needs of enrolled members and reasonably anticipated new members of the HMO for the health service to be provided by the organization; and

NA

(b) The availability of new health services from non-HMO providers or other HMOs in a reasonable and cost-effective manner which is consistent with the basic method of operation of the HMO. In assessing the availability of these health services from these providers, the applicant shall consider only whether the services from these providers:

(i) would be available under a contract of at least 5 years duration;

(ii) would be available and conveniently accessible through physicians and other health professionals associated with the HMO;

(iii) would cost no more than if the services were provided by the HMO; and

(iv) would be available in a manner which is administratively feasible to the HMO.

NA

(11) Repealed effective July 1, 1987.

(12) Applications involving construction shall demonstrate that the cost, design, and means of construction proposed represent the most reasonable alternative, and that the construction project will not unduly increase the costs of providing health services by the person proposing the construction project or the costs and charges to the public of providing health services by other persons, and that applicable energy saving features have been incorporated into the construction plans.

NC

The applicants propose to construct a replacement hospital with 167,304 square feet that will have 50 general acute care beds, all of which will be private rooms. In Section XI.5(e), page 156, and Section XI.7, page 157, the applicants state that applicable energy

savings features will be incorporated into the construction plans. In Exhibit 29, the applicants provide a Proposed Capital Cost form signed by an architect registered in North Carolina. The architect's estimate of construction and site prep costs is consistent with the construction and site prep costs projected by the applicant in Section VIII.1, page 131. The applicants adequately demonstrate that applicable energy savings features have been incorporated into the construction plans. Further, the applicants adequately demonstrate that the construction cost will not unduly increase costs and charges for health services. See Criterion (5) for discussion of costs and charges. However, the proposed design for the ED includes 20 treatment rooms, but the applicants only demonstrate the need for 16 treatment rooms in Section III.1(b), pages 86-90. See Criterion (3) for discussion. Therefore, the applicants did not adequately demonstrate the proposed construction design for 20 ED treatment rooms is the most reasonable alternative for development of the 16 ED treatment rooms that were demonstrated to be needed. Therefore, the application is not conforming to this criterion.

(13) The applicant shall demonstrate the contribution of the proposed service in meeting the health-related needs of the elderly and of members of medically underserved groups, such as medically indigent or low income persons, Medicaid and Medicare recipients, racial and ethnic minorities, women, and handicapped persons, which have traditionally experienced difficulties in obtaining equal access to the proposed services, particularly those needs identified in the State Health Plan as deserving of priority. For the purpose of determining the extent to which the proposed service will be accessible, the applicant shall show:

(a) The extent to which medically underserved populations currently use the applicant's existing services in comparison to the percentage of the population in the applicant's service area which is medically underserved;

C

The following table illustrates the current payor mix for acute care services provided at DCH during FY 2007, as reported in Section VI.10, page 117.

PAYOR CATEGORY	% OF TOTAL ACUTE CARE PATIENT DAYS
Self Pay / Indigent / Charity	19.1%
Medicare	54.5%
Medicaid	2.0%
Commercial Insurance / Managed Care	24.4%
Other	0.0%
TOTAL	100.0%

The following table illustrates the current payor mix for outpatient and ER services provided at DCH during FY 2007, as reported in Section VI.11, pages 119-120.

PAYOR CATEGORY	% OF TOTAL REVENUE [1]	
	OP SERVICES	ER SERVICES
Self Pay / Indigent / Charity	16.2%	29.8%
Medicare	29.7%	21.4%
Medicaid	7.7%	11.5%
Commercial Insurance / Managed Care	46.4%	37.3%
Other	0.0%	0.0%
TOTAL	100.0%	100.0%

[1] The applicants state that procedures/visits by payor category data is not available.

The applicants demonstrated that medically underserved populations currently have adequate access to the services provided at DCH. Therefore, the application is conforming to this criterion.

(b) Its past performance in meeting its obligation, if any, under any applicable regulations requiring provision of uncompensated care, community service, or access by minorities and handicapped persons to programs receiving federal assistance, including the existence of any civil rights access complaints against the applicant;

C

In Section VI.8, page 116, the applicants state that there have been no civil rights access complaints filed against DCH during the previous five years.

(c) That the elderly and the medically underserved groups identified in this subdivision will be served by the applicant's proposed services and the

extent to which each of these groups is expected to utilize the proposed services; and

C

The following table compares the actual payor mix for acute care patient days provided at DCH during FY 2007 to the projected payor mix for acute care patient days to be provided at DCH during Year Two (CY 2013), as reported in Section VI.10, page 117, and Section VI.12, page 121, respectively.

PAYOR CATEGORY	FFY 2007		CY 2013 YEAR TWO	
	ACUTE CARE PATIENT DAYS (1)	% OF TOTAL ACUTE CARE PATIENT DAYS	ACUTE CARE PATIENT DAYS (2)	% OF TOTAL ACUTE CARE PATIENT DAYS
Self Pay / Indigent / Charity	105	8.3%	785	6.4%
Medicare	899	70.7%	3,533	28.8%
Medicaid	58	4.6%	1,583	12.9%
Commercial Insurance / Managed Care	209	16.4%	6,196	50.5%
Other ("Agency")	0	0.0%	172	1.4%
TOTAL	1,271	100.0%	12,269	100.0%

(1) Source: Exhibit 13.
(2) Source: Section XIII, Form B-1a.

As shown in the above table, the applicants project significantly different percentages of total acute care patient days by payor category to be provided by DCH in CY 2013 than provided during FFY 2007. In Section VI.12, page 122, the applicants state *"The projected payer mix for all services is based on the zip codes in the proposed service area."* In the assumptions provided with the pro formas, the applicants state

> *"Payor mix for the proposed facility is based on the Solucient database for the defined service area and the major services to be provided at the Replacement Hospital .... The Payor mix differs from that of the present Davie County Hospital due to the expansion of services at the replacement facility. In particular, the current inpatient population includes a higher percentage of Medicare patients in keeping with the facility's Critical Access Hospital status."*

The applicants demonstrated that medically underserved populations are proposed to have adequate access to the proposed services. See discussion in Criterion (3a) for additional discussion of access. Therefore, the application is conforming to this criterion.

(d) That the applicant offers a range of means by which a person will have access to its services. Examples of a range of means are outpatient services, admission by house staff, and admission by personal physicians.

C

See Section VI.7, page 115 and Exhibits 15 and 18, for documentation of the range of means by which patients would have access to the services to be provided at DCH. The information provided is reasonable and credible and supports a finding of conformity with this criterion.

(14) The applicant shall demonstrate that the proposed health services accommodate the clinical needs of health professional training programs in the area, as applicable.

C

See Section V.1, pages 107-108, and Exhibit 26 for documentation that DCH currently accommodates the clinical needs of health professional training programs in the area and will continue to do so. The information provided is reasonable and credible and supports a finding of conformity with this criterion.

(15) Repealed effective July 1, 1987.

(16) Repealed effective July 1, 1987.

(17) Repealed effective July 1, 1987.

(18) Repealed effective July 1, 1987.

(18a) The applicant shall demonstrate the expected effects of the proposed services on competition in the proposed service area, including how any enhanced competition will have a positive impact upon the cost effectiveness, quality, and access to the services proposed; and in the case of applications for services where competition between providers will not have a favorable impact on cost-effectiveness, quality,

and access to the services proposed, the applicant shall demonstrate that its application is for a service on which competition will not have a favorable impact.

NC

The applicants did not adequately demonstrate that the proposal would have a positive impact upon the cost effectiveness of the proposed services. See Criteria (3) and (5). Therefore, the application is not conforming to this criterion.

(19) Repealed effective July 1, 1987.

(20) An applicant already involved in the provision of health services shall provide evidence that quality care has been provided in the past.

C

DCH is accredited by the Joint Commission of Accreditation of Health Care Organizations and certified for Medicare and Medicaid participation. According to the files in the Acute and Home Care Licensure and Certification Section, DHSR, no incidents occurred, within the eighteen months immediately preceding the date of this decision, for which any sanctions or penalties related to quality of care were imposed by the State on the hospital. Therefore, the application is conforming to this criterion.

(21) Repealed effective July 1, 1987.

(b) The Department is authorized to adopt rules for the review of particular types of applications that will be used in addition to those criteria outlined in subsection (a) of this section and may vary according to the purpose for which a particular review is being conducted or the type of health service reviewed. No such rule adopted by the Department shall require an academic medical center teaching hospital, as defined by the State Medical Facilities Plan, to demonstrate that any facility or service at another hospital is being appropriately utilized in order for that academic medical center teaching hospital to be approved for the issuance of a certificate of need to develop any similar facility or service.

NC

DCH proposes to develop new neonatal services, which include a new Level I nursery with 3 unlicensed bassinets. The application is not conforming to all applicable Criteria and Standards for Neonatal Services promulgated in 10A NCAC 14C .1400. The specific criteria are discussed below.

In addition, DCH proposes to develop a dedicated C-section OR, which would increase the number of ORs located in Davie County. The application is not conforming to all applicable Criteria and Standards for Surgical Services and Operating Rooms promulgated in 10A NCAC 14C .2100. The specific criteria are discussed below.

DCH proposes to acquire a replacement CT scanner, which will be installed in the proposed replacement hospital. The proposal will not increase the number of CT scanners owned and operated by DCH. Therefore, the Criteria and Standards for Computed Tomography Equipment promulgated in 10A NCAC 14C .2300 are not applicable to this review.

In addition, DCH does not propose to increase the total number of licensed GI endoscopy rooms in the facility. Rather, the applicants propose to relocate one existing GI endoscopy room to the new facility. Therefore, the Criteria and Standards for Gastrointestinal Endoscopy Procedure Rooms in Licensed Health Service Facilities, promulgated in 10A NCAC 14C .3900 are not applicable to this review.

SECTION .1400 CRITERIA AND STANDARDS FOR NEONATAL SERVICES

10A NCAC 14C .1402 INFORMATION REQUIRED OF APPLICANT

.1402(a) This rule states *"An applicant proposing to develop a new Level I nursery or increase the number of Level II, III or IV neonatal beds shall use the Acute Care Facility/Medical Equipment application form."*

-C- The applicants propose to develop a new Level I nursery, which includes three unlicensed bassinets. They used the Acute Care Facility/Medical Equipment application form.

.1402(b)(1) This rule states *"An applicant proposing to develop a new Level I nursery service or to increase the number of Level II, III or IV neonatal beds shall provide the following additional information: (1) the current number of Level I nursery bassinets, Level II beds, Level III beds and Level IV beds operated by the applicant."*

-NA- In Section II.8, page 45, the applicants state that they do not currently provide neonatal services at DCH.

.1402(b)(2) This rule states *"An applicant proposing to develop a new Level I nursery service or to increase the number of Level II, III or IV neonatal beds shall provide the following additional information: ... (2) the proposed number of Level I nursery bassinets, Level II beds, Level III beds and Level IV beds to be operated following completion of the proposed project."*

-C- In Section II.8, page 46, the applicants provide the proposed number of Level I bassinets, Level II beds, Level III beds and Level IV beds to be operated at DCH, as illustrated in the following table.

LEVEL I BASSINETS	3
Level II Beds	0
Level III Beds	0
Level IV Beds	0
Total	3

.1402(b)(3) This rule states *"An applicant proposing to develop a new Level I nursery service or to increase the number of Level II, III or IV neonatal beds shall provide the following additional information: ... (3) evidence of the applicant's experience in treating the following patients at the facility during the past twelve months, including: (A) the number of obstetrical patients treated at the acute care facility; (B) the number of neonatal patients treated in Level I nursery bassinets, Level II beds, Level III beds and Level IV beds, respectively; (C) the number of inpatient days at the facility provided to obstetrical patients; (D) the number of inpatient days provided in Level II beds, Level III beds and Level IV beds, respectively; (E) the number of high-risk obstetrical patients treated at the applicant's facility and the number of high-risk obstetrical patients referred from the applicant's facility to other facilities or programs; and (F) the number of neonatal patients referred to other facilities for services, identified by required level of neonatal service (i.e. Level II, Level III or Level IV)."*

-NA- In Section II.8, page 46, the applicants state that obstetrical and neonatal services are not currently provided at DCH. Therefore, DCH has no experience treating obstetrical or neonatal patients.

.1402(b)(4) This rule states *"An applicant proposing to develop a new Level I nursery service or to increase the number of Level II, III or IV neonatal beds shall provide the following additional information: ... (4) the projected number of neonatal patients to be served identified by Level I, Level II, Level III and Level IV neonatal services for each of the first three years of operation following the completion of the project, including the methodology and assumptions used for the projections."*

-NC- In Section III.1(b), page 75, the applicants project the number of Level I neonatal patients to be served at DCH during the first three operating years, as illustrated in the following table.

	YEAR 1	YEAR 2	YEAR 3
# of Level I patients	385	399	412

In Section III.1(b), pages 73-76, the applicants provide the methodology and assumptions used for the projections. However, the applicants' assumptions and methodology are not reasonable and supported. See Criterion (3) for discussion.

.1402(b)(5) This rule states *"An applicant proposing to develop a new Level I nursery service or to increase the number of Level II, III or IV neonatal beds shall provide the following additional information: ... (5) the projected number of patient days of care to be provided in Level I bassinets, Level II beds, Level III beds, and Level IV beds, respectively, for each of the first three years of operation following completion of the project, including the methodology and assumptions used for the projections."*

-NC- In Section III.1(b), page 75, the applicants project the number of Level I neonatal days of care to be provided at DCH during the first three operating years, as illustrated in the following table.

	YEAR 1	YEAR 2	YEAR 3
# of Level I patient days	809	838	865

In Section III.1(b), pages 73-76, the applicants provide the methodology and assumptions used for the projections. However, the applicants' assumptions and methodology are not reasonable and supported. See Criterion (3) for discussion.

.1402(b)(6) This rule states *"An applicant proposing to develop a new Level I nursery service or to increase the number of Level II, III or IV neonatal beds shall provide the following additional information: ... (6) if proposing to provide Level I or Level II neonatal services, documentation that at least 90 percent of the anticipated patient population is within 30 minutes driving time one-way from the facility."*

-C- In Section II.8, page 48, the applicants state *"All of the patients will be within 30 minutes driving time one-way from the facility."* In Section III.1(b), page 68, the applicants state that the proposed primary service area for DCH consists of the following zip codes.

Zip Code	City/Township	County
27006	Advance	Davie
27028 (includes 27014)	Mocksville/Cooleemee	Davie
27012	Clemmons	Forsyth
27023	Lewisville	Forsyth
27055	Yadkinville	Yadkin

Residents of the primary service area represent 91.49% of all patients proposed to be served at DCH [100% - 8.51% immigration = 91.49%.] Based on a review of a 2007 North Carolina Department of Transportation map of the state, residents of the primary service area live within 30 minutes driving time one-way from the replacement hospital. Thus, at least 90% of the anticipated patient population lives within 30 minutes driving time one-way from the proposed facility.

.1402(b)(7) This rule states *"An applicant proposing to develop a new Level I nursery service or to increase the number of Level II, III or IV neonatal beds shall provide the following additional information: ... (7) if proposing to provide new Level I or Level II neonatal services, documentation of a written plan to transport infants to Level III or Level IV neonatal services as the infant's care requires."*

-C- Exhibit 15 contains copies of the current transfer agreements between DCH and Baptist and DCH and FMC, which would apply to neonatal patients needing services not provided at DCH.

.1402(b)(8) This rule states *"An applicant proposing to develop a new Level I nursery service or to increase the number of Level II, III or IV neonatal beds shall provide the following additional information: ... (8) evidence that the applicant shall have access to a transport service with at least the following components:*

(A) trained personnel;
(B) transport incubator;
(C) emergency resuscitation equipment;
(D) oxygen supply, monitoring equipment and the means of administration;
(E) portable cardiac and temperature monitors; and
(F) a mechanical ventilator."

-C- In Section II.8, page 48, the applicants state *"DCEHC/DCH will have access to the neonatal transport service offered by WFUBMC's Brenner's Hospital Critical Care Transport Team."* Exhibit 36 contains a letter signed by the Director of WFUBMC's Brenner Children's Hospital Critical Care Transport Team, which states that all of the components listed in this Rule are provided by the Critical Care Transport Team.

.1402(b)(9) This rule states *"An applicant proposing to develop a new Level I nursery service or to increase the number of Level II, III or IV neonatal beds shall provide the following additional information: ... (9) documentation that the proposed service shall be operated in an area organized as a physically and functionally distinct entity with controlled access."*

-C- The design schematic provided in Exhibit 6 shows that the proposed neonatal services will be located in a separate room on the third floor, which is where the applicants propose to locate obstetrical services.

.1402(b)(10) This rule states *"An applicant proposing to develop a new Level I nursery service or to increase the number of Level II, III or IV neonatal beds shall provide the following additional information: ... (10) documentation to show that the new or additional Level I, Level II, Level III or Level IV neonatal services shall be offered in a physical environment that conforms to the requirements of federal, state, and local regulatory bodies."*

-C- In Section II.8, page 48, the applicants state that the proposed facility will be consistent with all licensure, certification and accreditation standards.

.1402(b)(11) This rule states *"An applicant proposing to develop a new Level I nursery service or to increase the number of Level II, III or IV neonatal beds shall provide the following additional information: ... (11) a detailed floor plan of the proposed area drawn to scale."*

-C- Exhibit 6 contains a detailed floor plan of the proposed Level I nursery drawn to scale.

.1402(b)(12) This rule states *"An applicant proposing to develop a new Level I nursery service or to increase the number of Level II, III or IV neonatal beds shall provide the following additional information: ... (12) documentation of direct or indirect visual observation by unit staff of all patients from one or more vantage points."*

-C- The design schematic provided in Exhibit 6 documents direct or indirect visual observation by unit staff of all neonatal patients from one or more vantage points.

.1402(b)(13) This rule states *"An applicant proposing to develop a new Level I nursery service or to increase the number of Level II, III or IV neonatal beds shall provide the following additional information: ... (13) documentation that the floor space allocated to each bed and bassinet shall accommodate equipment and personnel to meet anticipated contingencies."*

-C- The design schematic provided in Exhibit 6 documents that the floor space allocated to each bassinet would accommodate equipment and personnel to meet anticipated contingencies.

.1402(c) This rule states *"If proposing to provide new Level III or Level IV neonatal services the applicant shall also provide the following information:*

(1) documentation that at least 90 percent of the anticipated patient population is within 90 minutes driving time one-way from the facility, with the exception that there shall be a variance from the 90

percent standard for facilities which demonstrate that they provide very specialized levels of neonatal care to a large and geographically diverse population, or facilities which demonstrate the availability of air ambulance services for neonatal patients;

(2) evidence that existing and approved neonatal services in the applicant's defined neonatal service area are unable to accommodate the applicant's projected need for additional Level III and Level IV services;

(3) an analysis of the proposal's impact on existing Level III and Level IV neonatal services which currently serve patients from the applicant's primary service area;

(4) the availability of high risk OB services at the site of the applicant's planned neonatal service;

(5) copies of written policies which provide for parental participation in the care of their infant, as the infant's condition permits, in order to facilitate family adjustment and continuity of care following discharge; and

(6) copies of written policies and procedures regarding the scope and provision of care within the neonatal service, including but not limited to the following:

(A) the admission and discharge of patients;

(B) infection control;

(C) pertinent safety practices;

(D) the triaging of patients requiring consultations, including the transfer of patients to another facility; and

(E) the protocols for obtaining emergency physician care for a sick infant."

-NA- The applicants do not propose to provide new Level III or Level IV neonatal services.

10A NCAC 14C .1403 PERFORMANCE STANDARDS

.1403(a)(1) This rule states *"An applicant shall demonstrate that the proposed project is capable of meeting the following standards: (1) an applicant proposing new Level I or Level II services, or additional Level II beds shall demonstrate that the occupancy of the applicant's total number of neonatal beds is projected to be at least 50% during the first year of operation*

and at least 65% during the third year of operation following completion of the proposed project."

-NC- In Section III.1(b), page 75, the applicants project the following utilization of the three proposed Level I bassinets.

PROJECT YEAR	# OF LEVEL I NEONATAL PATIENT DAYS	AVERAGE ANNUAL % OCCUPANCY RATE [1]
Year One (CY 2012)	809	73.9%
Year Two (CY 2013)	838	76.5%
Year Three (CY 2014)	865	79.0%

[1] Occupancy was calculated as follows: # of Level I neonatal patient days / 365 / 4.

As shown in the above table, in Year One, the applicants project that the average annual occupancy rate for the four Level I bassinets will be 73.9%, which is more than the 50% required by this rule for Year One. Further, in Year Three, the applicants project that the average annual occupancy rate will be 79%, which is more than the 65% required by this rule for Year Three. However, the applicants do not adequately demonstrate that projected utilization of the unlicensed bassinets is based on reasonable and supported assumptions. See Criterion (3) for discussion. Therefore, the applicants do not adequately demonstrate that occupancy of the three unlicensed bassinets will be at least 50% during Year One and at least 65% during Year Three. Consequently, the application is nonconforming with this rule.

.1403(a)(2) This rule states *"An applicant shall demonstrate that the proposed project is capable of meeting the following standards: ... (2) if an applicant proposes an increase in the number of the facility's existing Level III or Level IV beds, the overall average annual occupancy of the total number of existing Level III and Level IV beds in the facility is at least 75%, over the 12 months immediately preceding the submittal of the proposal."*

-NA- The applicants do not propose an increase in the number of existing Level III or Level IV beds.

.1403(a)(3) This rule states *"An applicant shall demonstrate that the proposed project is capable of meeting the following*

standards: ... (3) if an applicant is proposing to develop new or additional Level III or Level IV beds, the projected occupancy of the total number of Level III and Level IV beds proposed to be operated during the third year of operation of the proposed project shall be at least 75%."

-NA- The applicants do not propose to develop new or additional Level III or Level IV beds.

.1403(a)(4) This rule states *"An applicant shall demonstrate that the proposed project is capable of meeting the following standards: ... (4) The applicant shall document the assumptions and provide data supporting the methodology used for each projection in this rule."*

-NC- The applicants do not adequately document the assumptions and provide data supporting the methodology used for each projection in this rule. See Criterion (3) for discussion. Therefore, the application is nonconforming with this rule.

.1403(b) This rule states *"If an applicant proposes to develop a new Level III or Level IV service, the applicant shall document that an unmet need exists in the applicant's defined neonatal service area. The need for Level III and Level IV beds shall be computed for the applicant's neonatal service area by:*

(1) identifying the annual number of live births occurring at all hospitals within the proposed neonatal service area, using the latest available data compiled by the State Center for Health Statistics;

(2) identifying the low birth weight rate (percent of live births below 2,500 grams) for the births identified in (1) of this Paragraph, using the latest available data compiled by the State Center for Health Statistics;

(3) dividing the low birth weight rate identified in (2) of this Paragraph by .08 and subsequently multiplying the resulting quotient by four; and

(4) determining the need for Level III and Level IV beds in the proposed neonatal service area as the product of:

(A) the product derived in (3) of this Paragraph, and

(B) the quotient resulting from the division of the number of live births in the initial year of the

determination identified in (1) of this Paragraph by the number 1000."

-NA- The applicants do not propose to develop a new Level III or Level IV neonatal service.

10A NCAC 14C .1404 SUPPORT SERVICES

.1404(a) This rule states *"An applicant proposing to provide new Level I, Level II, Level III or Level IV services shall document that the following items shall be available, unless an item shall not be available, then documentation shall be provided obviating the need for that item:*

(1) competence to manage uncomplicated labor and delivery of normal term newborn;
(2) capability for continuous fetal monitoring;
(3) a continuing education program on resuscitation to enhance competence among all delivery room personnel in the immediate evaluation and resuscitation of the newborn and of the mother;
(4) obstetric services;
(5) anesthesia services;
(6) capability of cesarean section within 30 minutes at any hour of the day; and
(7) twenty-four hour on-call blood bank, radiology, and clinical laboratory services."

-C- In Section II.8, pages 52-53, the applicants document that DCH will offer all of the services listed in this Rule.

.1404(b) This rule states *"An applicant proposing to provide new Level III* [sic] *Level IV services shall document that the following items shall be available, unless any item shall not be available, then documentation shall be provided obviating the need for that item:*

(1) competence to manage labor and delivery of premature newborns and newborns with complications;
(2) twenty-four hour availability of microchemistry hematology and blood gases;
(3) twenty-four hour coverage by respiratory therapy;
(4) twenty-four hour radiology coverage with portable radiographic capability;
(5) oxygen and air and suction capability;

(6) *electronic cardiovascular and respiration monitoring capability;*
(7) *vital sign monitoring equipment which has an alarm system that is operative at all times;*
(8) *capabilities for endotracheal intubation and mechanical ventilatory assistance;*
(9) *cardio-respiratory arrest management plan;*
(10) *isolation capabilities;*
(11) *social services staff;*
(12) *occupational or physical therapies with neonatal expertise; and*
(13) *a registered dietician or nutritionist with training to meet the special needs of neonates."*

-NA- The applicants do not propose to provide new Level III or Level IV neonatal services.

.1404(c) This rule states *"An applicant proposing to provide new Level IV services shall document that the following items shall be available, unless any item shall not be available, then documentation shall be provided obviating the need for that item:*
(1) *pediatric surgery services;*
(2) *ophthalmology services;*
(3) *pediatric neurology services;*
(4) *pediatric cardiology services;*
(5) *on-site laboratory facilities;*
(6) *computed tomography and pediatric cardiac catheterization services;*
(7) *emergency diagnostic studies available 24 hours per day;*
(8) *designated social services staff; and*
(9) *serve as a resource center for the statewide perinatal network."*

-NA- The applicants do not propose to provide new Level IV neonatal services.

10A NCAC 14C .1405 STAFFING AND STAFF TRAINING

.1405(1)(a) This rule states *"An applicant shall demonstrate that the following staffing requirements for hospital care of newborn infants shall be met: (1) If proposing to provide new Level I or*

II services the applicant shall provide documentation to demonstrate that: (a) the nursing care shall be supervised by a registered nurse in charge of perinatal facilities."

-C- In Section II.8, page 55, the applicants state *"The nursing care will be supervised by a registered nurse who will be in charge of the perinatal unit."*

.1405(1)(b) This rule states *"An applicant shall demonstrate that the following staffing requirements for hospital care of newborn infants shall be met: (1) If proposing to provide new Level I or II services the applicant shall provide documentation to demonstrate that: ... (b) a physician is designated to be responsible for neonatal care."*

-C- In Section II.8, page 55, the applicants state *"A physician will be designated from the medical staff that will be responsible for neonatal care. WFUBMC physicians with neonatal experience will fulfill this role when the proposed project is operational."*

.1405(1)(c) This rule states *"An applicant shall demonstrate that the following staffing requirements for hospital care of newborn infants shall be met: (1) If proposing to provide new Level I or II services the applicant shall provide documentation to demonstrate that: ... (c) the medical staff will provide physician coverage to meet the specific needs of patients on a 24 hour basis."*

-C- In Section II.8, page 55, the applicants state *"Medical staff coverage will be available from the proposed medical staff and with support from the NCBH medical staff to provide the specific needs of nursery patients on a 24 hour basis."*

.1405(2) This rule states *"If proposing to provide new Level III services the applicant shall provide documentation to demonstrate that:*

(a) the nursing care shall be supervised by a registered nurse;

(b) the service shall be staffed by a pediatrician certified by the American Board of Pediatrics; and

(c) the medical staff will provide physician coverage to meet the specific needs of patients on a 24 hour basis."

-NA-	The applicants do not propose to provide new Level III neonatal services.
.1405(3)	This rule states *"If proposing to provide new Level IV services the applicant shall provide documentation to demonstrate that:* *(a) the nursing care shall be supervised by a registered nurse with educational preparation and advanced skills for maternal-fetal and neonatal services;* *(b) the service shall be staffed by a full-time board certified pediatrician with certification in neonatal medicine; and* *(c) the medical staff will provide physician coverage to meet the specific needs of patients on a 24 hour basis."*
-NA-	The applicants do not propose to provide new Level IV neonatal services.
.1405(4)	This rule states *"All applicants shall submit documentation which demonstrates the availability of appropriate inservice training or continuing education programs for neonatal staff."*
-C-	Exhibit 12 contains DCH's Plan for Provision of Health Services, which documents that appropriate inservice training and continuing education programs are provided for all hospital staff, including neonatal staff.
.1405(5)	This rule states *"All applicants shall submit documentation which demonstrates the proficiency and ability of the nursing staff in teaching parents how to care for neonatal patients following discharge to home."*
-C-	In Section II.8, page 56, the applicants state *"The job descriptions for nursing staff in the nursery will include the requirement of competency in patient education."* Exhibit 36 contains a copy of Baptist's Patient/Family Education policy, which the applicants state will be adapted for DCH.
.1405(6)	This rule states *"All applicants shall submit documentation to show that the proposed neonatal services will be provided in conformance with the requirements of federal, state and local regulatory bodies."*

-C- In Section II.8, page 56, the applicants state that the proposed facility will be consistent with all licensure, certification and accreditation standards.

SECTION .2100 CRITERIA AND STANDARDS FOR SURGICAL SERVICES AND OPERATING ROOMS

10A NCAC 14C .2102 INFORMATION REQUIRED OF APPLICANT

.2102(a) This rule states *"An applicant proposing to establish a new ambulatory surgical facility, to increase the number of operating rooms, to convert a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or to add a specialty to a specialty ambulatory surgical program shall identify each of the following specialty areas that will be provided in the facility:*

(1) gynecology;
(2) otolaryngology;
(3) plastic surgery;
(4) general surgery;
(5) ophthalmology;
(6) orthopedic;
(7) oral surgery; and
(8) ther [sic] *specialty area identified by the applicant."*

-C- In Section II.8, page 32, the applicants state *"DCEHC/DCH is an existing hospital with existing operating rooms and is currently capable of providing the above services when a patient needs it with the exception of gynecology. ... The proposed project proposes to add obstetric surgical services to the historical surgical services provided by DCH."*

.2102(b)(1) This rule states *"An applicant proposing to establish a new ambulatory surgical facility, to increase the number of operating rooms except relocations of existing operating rooms between existing licensed facilities within the same service area, to convert a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or to add a specialty to a specialty ambulatory surgical program shall provide the following information:(1) the number and type of operating rooms in each licensed facility which the applicant or a related entity owns a controlling interest in and is located*

in the service area, (separately identifying the number of dedicated open heart and dedicated C-Section rooms)."

-C- Pursuant to 10A NCAC 14C .2101(10), *"'Service area' means the Operating Room Service Area as defined in the applicable State Medical Facilities Plan."* Therefore, the service area, as defined in the 2008 SMFP, is Davie County. In Section II.8, page 33, the applicants state that DCH is currently licensed for two shared ORs.

.2102(b)(2) This rule states *"An applicant proposing to establish a new ambulatory surgical facility, to increase the number of operating rooms except relocations of existing operating rooms between existing licensed facilities within the same service area, to convert a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or to add a specialty to a specialty ambulatory surgical program shall provide the following information: ... (2) the number and type of operating rooms to be located in each licensed facility which the applicant or a related entity owns a controlling interest in and is located in the service area after completion of the proposed project and all previously approved projects related to these facilities (separately identifying the number of dedicated open heart and dedicated C-Section rooms)."*

-C- Pursuant to 10A NCAC 14C .2101(10), *"'Service area' means the Operating Room Service Area as defined in the applicable State Medical Facilities Plan."* Therefore, the service area, as defined in the 2008 SMFP, is Davie County. In Section II.8, page 33, the applicants state that DCH will have two shared ORs and one dedicated C-section OR upon completion of the project.

.2102(b)(3) This rule states *"An applicant proposing to establish a new ambulatory surgical facility, to increase the number of operating rooms except relocations of existing operating rooms between existing licensed facilities within the same service area, to convert a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or to add a specialty to a specialty ambulatory surgical program shall provide the following information: ... (3) the number of inpatient surgical cases, excluding trauma cases reported by Level I, II, or III trauma centers, cases reported by designated*

burn intensive care units, and cases performed in dedicated open heart and dedicated C-section rooms, and the number of outpatient surgical cases performed in the most recent 12 month period for which data is available, in the operating rooms in each licensed facility listed in response to Subparagraphs (b)(1) and (b)(2) of this Rule."

-C- In Exhibit 13, the applicants provide the number of inpatient surgical cases (10) and outpatient surgical cases (49) performed at DCH during FFY 2007.

.2102(b)(4) This rule states *"An applicant proposing to establish a new ambulatory surgical facility, to increase the number of operating rooms except relocations of existing operating rooms between existing licensed facilities within the same service area, to convert a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or to add a specialty to a specialty ambulatory surgical program shall provide the following information: ... (4) the number of inpatient surgical cases, excluding trauma cases reported by level I, II, or III trauma centers, cases reported by designated burn intensive care units and cases performed in dedicated open heart and dedicated C-section rooms, and the number of outpatient surgical cases projected to be performed in each of the first three operating years of the proposed project, in each licensed facility listed in response to Subparagraphs (b)(1) and (b)(2) of this Rule."*

-C- In Section III.1(b), page 79, the applicants provide projected utilization of the ORs at DCH, as illustrated in the following table.

SURGICAL CASES	YEAR	YEAR	YEAR
Inpatient (excluding C-sections)	348	360	372
Outpatient	2,581	2,660	2,740
Total	2,930	3,020	3,112

.2102(b)(5) This rule states *"An applicant proposing to establish a new ambulatory surgical facility, to increase the number of operating rooms except relocations of existing operating rooms between existing licensed facilities within the same service area, to convert a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or to add a*

specialty to a specialty ambulatory surgical program shall provide the following information: ... (5) a detailed description of and documentation to support the assumptions and methodology used in the development of the projections required by this Rule."

-C- The applicants provide a detailed description of and documentation to support the assumptions and methodology used to develop the projections required by this Rule in Section III.1(b), pages 76-80.

.2102(b)(6) This rule states *"An applicant proposing to establish a new ambulatory surgical facility, to increase the number of operating rooms except relocations of existing operating rooms between existing licensed facilities within the same service area, to convert a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or to add a specialty to a specialty ambulatory surgical program shall provide the following information: ... (6) the hours of operation of the proposed new operating rooms."*

-C- In Section II.8, page 34, the applicants state *"The proposed operating rooms will be staffed and scheduled for the hours of 7 a.m.-4 p.m. Monday - Friday with the exception of the C-Section room. The emergency C-Section cases as well as other emergent surgical conditions will be addressed by the emergency room physicians and an on-call team or transferred to an appropriate facility."*

.2102(b)(7) This rule states *"An applicant proposing to establish a new ambulatory surgical facility, to increase the number of operating rooms except relocations of existing operating rooms between existing licensed facilities within the same service area, to convert a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or to add a specialty to a specialty ambulatory surgical program shall provide the following information: ... (7) if the applicant is an existing facility, the average reimbursement received per procedure for the 20 surgical procedures most commonly performed in the facility during the preceding 12 months and a list of all services and items included in the reimbursement."*

-NC- In Section II.8, page 34, the applicants state *"Reference Exhibit 14 for the top 20 surgical procedures most commonly performed in the facility during the preceding 12 months and related charges."* (Emphasis added.) Exhibit 14 contains a list of the 20 outpatient surgical procedures most commonly performed during 2008 and the average charge per procedure. Exhibit 14 also contains a list of the 20 inpatient surgical procedures most commonly performed during 2008 and the average charge per procedure. However, the applicant did not provide the average reimbursement per procedure as required by this rule. The average reimbursement for a procedure is not the same thing as the average charge for a procedure. Therefore, the application is nonconforming with this rule.

.2102(b)(8) This rule states *"An applicant proposing to establish a new ambulatory surgical facility, to increase the number of operating rooms except relocations of existing operating rooms between existing licensed facilities within the same service area, to convert a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or to add a specialty to a specialty ambulatory surgical program shall provide the following information: ... (8) the projected average reimbursement to be received per procedure for the 20 surgical procedures which the applicant projects will be performed most often in the facility and a list of all services and items included in the reimbursement."*

-NC- In Section II.8, page 34, the applicants state *"Reference Exhibit 14 for the top 20 surgical procedures that will be performed most often in the facility."* Exhibit 14 contains a list of the 20 outpatient surgical procedures projected to be performed most often during the first three operating years and the average charge per procedure. Exhibit 14 contains a list of the 20 inpatient surgical procedures projected to be performed most often during the first three operating years and the average charge per procedure. However, the applicant did not provide the projected average reimbursement per procedure as required by this rule. The average reimbursement for a procedure is not the same thing as the average charge for a procedure. Therefore, the application is nonconforming with this rule.

.2102(b)(9) This rule states *"An applicant proposing to establish a new ambulatory surgical facility, to increase the number of*

operating rooms except relocations of existing operating rooms between existing licensed facilities within the same service area, to convert a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or to add a specialty to a specialty ambulatory surgical program shall provide the following information: ... (9) identification of providers of pre-operative services and procedures which will not be included in the facility's charge."

-NC- In Section II.8, page 34, the applicants state *"Aside from the professional fees, all pre-operative services and procedures are included in the facility charge."* However, the applicants fail to identify the providers of the professional services that will not be included in the hospital's charge as required by this rule. Therefore, the application is nonconforming with this rule.

.2102(c) This rule states *"An applicant proposing to relocate existing operating rooms between existing licensed facilities within the same service area shall provide the following information: (1) the number and type of existing and approved operating rooms in each licensed facility in which the number of operating rooms will increase or decrease (separately identifying the number of dedicated open heart and dedicated C-Section rooms); (2) the number and type of operating rooms to be located in each affected licensed facility after completion of the proposed project and all previously approved projects related to these facilities (separately identifying the number of dedicated open heart and dedicated C-Section rooms); (3) the number of inpatient surgical cases, excluding trauma cases reported by Level I, II, or III trauma centers, cases reported by designated burn intensive care units, and cases performed in dedicated open heart and dedicated C-section rooms, and the number of outpatient surgical cases performed in the most recent 12 month period for which data is available, in the operating rooms in each licensed facility listed in response to Subparagraphs (c)(1) and (c)(2) of this Rule; (4) the number of inpatient surgical cases, excluding trauma cases reported by level I, II, or III trauma centers, cases reported by designated burn intensive care units and cases performed in dedicated open heart and dedicated C-section rooms, and the number of outpatient surgical cases projected to be performed in each of the first three operating years of the proposed project, in each*

licensed facility listed in response to Subparagraphs (c)(1) and (c)(2) of this Rule; (5) a detailed description of and documentation to support the assumptions and methodology used in the development of the projections required by this Rule; (6) the hours of operation of the facility to be expanded; (7) the average reimbursement received per procedure for the 20 surgical procedures most commonly performed in each affected licensed facility during the preceding 12 months and a list of all services and items included in the reimbursement; (8) the projected average reimbursement to be received per procedure for the 20 surgical procedures which the applicant projects will be performed most often in the facility to be expanded and a list of all services and items included in the reimbursement; and (9) identification of providers of pre-operative services and procedures which will not be included in the facility's charge."

-NA- DCH does not propose to relocate existing operating rooms between existing licensed facilities within the same service area.

10A NCAC 14C .2103 PERFORMANCE STANDARDS

.2103(a) This rule states *"In projecting utilization, the operating rooms shall be considered to be available for use five days per week and 52 weeks a year."*

-C- In Section II.8, page 36, the applicants state they assume the ORs will be available for use five days per week, 52 weeks per year.

.2103(b)(1) This rule states *"A proposal to establish a new ambulatory surgical facility, to increase the number of operating rooms (excluding dedicated C-section operating rooms), to convert a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or to add a specialty to a specialty ambulatory surgical program shall not be approved unless: (1) the applicant reasonably demonstrates the need for the number of proposed operating rooms in the facility, which is the subject of this review, in the third operating year of the project based on the following formula: {[(Number of facility's projected inpatient cases, excluding trauma cases reported by Level I, II, or III trauma centers, cases reported by designated*

burn intensive care units and cases performed in dedicated open heart and C-section rooms, times 3.0 hours) plus (Number of facility's projected outpatient cases times 1.5 hours)] divided by 1872 hours} minus the facility's total number of existing, approved and proposed operating rooms, excluding one operating room for Level I, II or III trauma centers, one operating room for facilities with designated burn intensive care units, and all dedicated open heart and C-section operating rooms. The number of rooms needed is the positive difference rounded to the next highest number for fractions of 0.50 or greater; or (2) the applicant demonstrates conformance of the proposed project to Policy AC-3 in the State Medical Facilities Plan titled "Exemption From Plan Provisions for Certain Academic Medical Center Teaching Hospital Projects."

-NA- The applicants propose to develop a dedicated C-section OR. Therefore, the rule is not applicable to this review.

.2103(c) This rule states *"A proposal to establish a new ambulatory surgical facility, to increase the number of operating rooms (excluding dedicated C-section operating rooms) except relocations of existing operating rooms between existing licensed facilities within the same service area, to convert a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or to add a specialty to a specialty ambulatory surgical program shall not be approved unless the applicant reasonably demonstrates the need for the number of proposed operating rooms in addition to the rooms in its licensed facilities identified in response to 10A NCAC 14C .2102(b)(2) in the third operating year of the proposed project based on the following formula: {[(Number of projected inpatient cases for all its facilities, excluding trauma cases reported by Level I, II, or III trauma centers, cases reported by designated burn intensive care units and cases performed in dedicated open heart and C-section rooms, times 3.0 hours) plus (Number of projected outpatient cases for all its facilities times 1.5 hours)] divided by 1872 hours} minus the total number of existing, approved and proposed operating rooms, excluding one operating room for Level I, II or III trauma centers, one operating room for facilities with designated burn intensive care units, and all dedicated open heart and C-Section operating rooms in all of its licensed*

	facilities in the service area. A need is demonstrated if the difference is a positive number greater than or equal to 0.50."
-NA-	The applicants propose to develop a dedicated C-section OR. Therefore, the rule is not applicable to this review.
.2103(d)	This rule states *"An applicant that has one or more existing or approved dedicated C-section operating rooms and is proposing to develop an additional dedicated C-section operating room in the same facility shall demonstrate that an average of at least 365 C-sections per room were performed in the facility's existing dedicated C-section operating rooms in the previous 12 months and are projected to be performed in the facility's existing, approved and proposed dedicated C-section rooms during the third year of operation following completion of the project."*
-NA-	DCH does not currently have any existing or approved dedicated C-section ORs. Therefore, the rule is not applicable to this review.
.2103(e)	This rule states *"An applicant proposing to convert a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or to add a specialty to a specialty ambulatory surgical program shall provide documentation to show that each existing ambulatory surgery program in the service area that performs ambulatory surgery in the same specialty area as proposed in the application is currently utilized an average of at least 1,872 hours per operating room per year, excluding dedicated open heart and C-Section operating rooms. The hours utilized per operating room shall be calculated as follows: [(Number of projected inpatient cases, excluding open heart and C-sections performed in dedicated rooms, times 3.0 hours) plus (Number of projected outpatient cases times 1.5 hours)] divided by the number of operating rooms, excluding dedicated open heart and C-Section operating rooms."*
-NA-	The applicants do not propose to convert a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or to add a specialty to a specialty ambulatory surgical program. Therefore, the rule is not applicable to this review.

.2103(f) This rule states *"An applicant proposing to convert a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or to add a specialty to a specialty ambulatory surgical program shall reasonably demonstrate the need for the conversion in the third operating year of the project based on the following formula: [(Total number of projected outpatient cases for all ambulatory surgery programs in the service area times 1.5 hours) divided by 1872 hours] minus the total number of existing, approved and proposed outpatient or ambulatory surgical operating rooms and shared operating rooms in the service area. The need for the conversion is demonstrated if the difference is a positive number greater than or equal to one, after the number is rounded to the next highest number for fractions of 0.50 or greater."*

-NA- The applicants do not propose to convert a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or to add a specialty to a specialty ambulatory surgical program. Therefore, the rule is not applicable to this review.

.2103(g) This rule states *"The applicant shall document the assumptions and provide data supporting the methodology used for each projection in this Rule."*

-NA- The applicants were not required to provide any projections pursuant to this rule. Therefore, the rule is not applicable to this review. However, see Criterion (3) for projected utilization and the applicants' assumptions and methodology used.

10A NCAC 14C .2104 SUPPORT SERVICES

.2104(a) This rule states *"An applicant proposing to establish a new ambulatory surgical facility, increase the number of operating rooms, convert a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or add a specialty to a specialty ambulatory surgical program shall provide written policies and procedures demonstrating that the facility will have patient referral, transfer, and followup procedures."*

-NC- In Section II.8, page 40, the applicants state *"Not applicable. For informational purposes, the applicant is an existing provider of surgical services and currently has referral, transfer and follow-up procedures in place. Reference Exhibit 15 for the transfer policies for the hospital. ... The patient discharge instructions for the surgical patients includes follow up appointment with the referring physician. Reference Exhibit 16 for a copy of the DCH discharge instructions."* Exhibit 15 contains copies of DCH's transfer agreements, not transfer policies. Exhibit 16 contains the discharge instruction sheet given to patients, not patient referral and follow-up procedures. The application is nonconforming with this rule.

.2104(b) This rule states *"The applicant shall provide documentation showing the proximity of the proposed facility to the following services:*

(1) emergency services;
(2) support services;
(3) ancillary services; and
(4) public transportation."

-C- In Section II.8, page 40, the applicants state *"The applicant is an acute care hospital and the proposed project will include emergency, support and ancillary services. The proposed site is on undeveloped land but DCEHC fully anticipates that the Yadkin Valley Public Transportation will add a bus stop at the proposed facility."*

10A NCAC 14C .2105 STAFFING AND STAFF TRAINING

.2105(a) This rule states *"An applicant proposing to establish a new ambulatory surgical facility, to increase the number of operating rooms, to convert a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or to add a specialty to a specialty ambulatory surgical program shall identify, justify and document the availability of the number of current and proposed staff to be utilized in the following areas:*

(1) administration;
(2) pre-operative;
(3) post-operative;
(4) operating room; and
(5) other."

-NC- In Section II.8, page 41, the applicants state *"The following depicts the proposed staff attributed to the surgical services. This staff is a subset of the staffing depicted in the staffing tables in Exhibit 17.*

ROLE	NUMBER STAFF	FTEs
Administration	*1*	*1*
Pre-operative	*6*	*4.9*
Post-operative	*11*	*10.7*
Operating Room	*16*	*15.2*
Other	*5*	*5.0*
Subtotal Operating Room and Obstetric (C-Section) Room staff	*39*	*36.8*

However, the applicants do not identify the current staff for each of the areas listed above. Further, it is not possible to determine the current staff for each of the areas listed above from the current staffing table provided in Exhibit 17. Therefore, the application is nonconforming with this rule.

.2105(b) This rule states *"The applicant shall identify the number of physicians who currently utilize the facility and estimate the number of physicians expected to utilize the facility and the criteria to be used by the facility in extending surgical and anesthesia privileges to medical personnel."*

-NC- In Section II.8, page 41, the applicants state *"The proposed project will be staffed by physicians of DCEHC and physicians of WFUHS. Please refer to the medical staff lists in Exhibit 18 and to the credentialing policies in Exhibits* [sic] *19."* Exhibit 19 contains copies of the credentialing policies for DCH and Baptist. Exhibit 18 contains list of the medical staff at DCH as of 9/17/07 and a list of the medical staff at Baptist as of 5/29/07. The application was submitted on 7/15/08. Thus, the applicants did not provide the number of physicians who currently utilize DCH and did not provide the projected number of physicians expected to utilize DCH. Therefore, the application is nonconforming with this rule.

.2105(c) This rule states *"The applicant shall provide documentation that physicians with privileges to practice in the facility will be active members in good standing at a general acute care hospital within the ambulatory surgical service area in which*

the facility is, or will be, located or will have written referral procedures with a physician who is an active member in good standing at a general acute care hospital in the ambulatory surgical service area."

-C- In Section II.8, page 41, the applicants state that the physicians with privileges to practice at DCH will be members of its Medical Staff or Baptist's Medical Staff.

10A NCAC 14C .2106 FACILITY

.2106(a) This rule states *"An applicant proposing to establish a licensed ambulatory surgical facility that will be physically located in a physician's or dentist's office or within a general acute care hospital shall demonstrate that reporting and accounting mechanisms exist and can be used to confirm that the licensed ambulatory surgery facility is a separately identifiable entity physically and administratively, and is financially independent and distinct from other operations of the facility in which it is located."*

-NA- The applicants do not propose to develop a licensed ambulatory surgical facility.

.2106(b) This rule states *"An applicant proposing a licensed ambulatory surgical facility shall receive accreditation from the Joint Commission for the Accreditation of Healthcare Organizations, the Accreditation Association for Ambulatory Health Care or a comparable accreditation authority within two years of completion of the facility."*

-NA- The applicants do not propose to develop a licensed ambulatory surgical facility.

.2106(c) This rule states *"An applicant proposing to establish a new ambulatory surgical facility, to increase the number of operating rooms, to convert a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or to add a specialty to a specialty ambulatory surgical program shall document that the physical environment of the facility conforms to the requirements of federal, state, and local regulatory bodies."*

-C- In Section II.8, page 42, the applicants state *"The proposed facility is designed to conform to the requirements of federal, state, and local regulatory bodies."*

.2106(d) This rule states *"The applicant shall provide a floor plan of the proposed facility identifying the following areas:*

(1) receiving/registering area;
(2) waiting area;
(3) pre-operative area;
(4) operating room by type;
(5) recovery area; and
(6) observation area."

-C- The design schematic provided in Exhibit 6 identifies all of the areas listed above.

.2106(e) This rule states *"An applicant proposing to expand by converting a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or by adding a specialty to a specialty ambulatory surgical program that does not propose to add physical space to the existing ambulatory surgical facility shall demonstrate the capability of the existing ambulatory surgical program to provide the following for each additional specialty area:*

(1) physicians;
(2) ancillary services;
(3) support services;
(4) medical equipment;
(5) surgical equipment;
(6) receiving/registering area;
(7) clinical support areas;
(8) medical records;
(9) waiting area;
(10) pre-operative area;
(11) operating rooms by type;
(12) recovery area; and
(13) observation area."

-NA- The applicants do not propose to expand by converting a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or add a specialty to a specialty ambulatory surgical program.

DISCUSSION OF COMPARATIVE ANALYSIS

DCH filed its application for review beginning August 1, 2008. Novant Health, Inc. (**Novant**) and Forsyth Memorial Hospital, Inc. d/b/a Forsyth Medical Center (**FMC**) also filed an application for review beginning August 1, 2008 in which they propose to develop a satellite campus in Clemmons (**FMC-Clemmons**) offering the following beds or services: 50 general acute care beds, 6 unlicensed observation beds, Surgery, Radiology, Emergency, Laboratory, Pharmacy, Respiratory Therapy, Physical Therapy and Speech Therapy. DCH proposes in this review to develop a replacement hospital offering the following beds or services: 46 general acute care beds, 4 post partum beds, 10 unlicensed observation beds, Surgery, Radiology, Emergency, Laboratory, Pharmacy, Cardiopulmonary and Physical Therapy. Thus, the applications propose development of some of the same or similar services. Further, the proposed sites are within three to four miles of each other and the applicants propose to serve essentially the same patient population. The following table illustrates the proposed service areas for each proposal.

FMC-CLEMMONS	DCH
Davie County Zip Code Area 27006 Zip Code Area 27028	**Davie County** Zip Code Area 27006 Zip Code Area 27028
Forsyth County Zip Code Area 27012 Zip Code Area 27023 Other "surrounding" zip codes	**Forsyth County** Zip Code Area 27012 Zip Code Area 27023
Yadkin County All Zip Code Areas	**Yadkin County** Zip Code Area 27055
Iredell County All zip code areas	

Pursuant to 10A NCAC 14C .0202(f), *"Applications are competitive if they, in whole or in part, are for the same or similar services and the agency determines that the approval of one or more of the applications may result in the denial of another application reviewed in the same review period."* The analyst determined that the DCH application must be disapproved but not as a result of the approval of the FMC-Clemmons application (Project I.D. #G-8165-08) filed in this review period. Rather, the DCH application was disapproved for other reasons which are discussed elsewhere in the Required State Agency Findings. One of these reasons is DCH and Baptist previously filed an application (Project I.D. #G-8078-08) in March of 2008 for review beginning April 1, 2008 to develop a replacement hospital offering the following beds and services: 50 general acute care beds, 10 unlicensed observation beds, Surgery, Radiology, Emergency, Laboratory, Pharmacy, Cardiopulmonary and Physical Therapy. The Agency conditionally approved Project I.D. #G-8078-08 on August 28, 2008, but that decision is currently under appeal. This application (Project I.D. #G-8164-08) was submitted on July 15, 2008 for the review beginning August 1, 2008. The only differences between this application and Project I.D. #G-8078-08 are that the earlier proposal did not include four obstetrical beds, four unlicensed LDRs, a nursery with three unlicensed bassinets, and a dedicated C-section OR. The applicants did not adequately demonstrate the need for the four obstetrical (post partum) beds, four unlicensed LDR beds,

three unlicensed bassinets or dedicated C-section OR that are proposed in the project which is the subject of this review. Further, the applicants have not withdrawn Project I.D. #G-8078-08 and cannot be approved for both projects. Therefore, the project currently under review duplicates the services proposed in the previously approved project. Consequently, the replacement facility proposed in the new project is not needed in addition to the replacement facility already approved.

Further, for the sake of argument, even if the DCH application filed in this review period was not a duplication of its previously approved project, the analyst determined that the FMC-Clemmons' project, as conditioned, was needed in addition to DCH's facility proposed to be developed in Bermuda Run in this review period. Consequently, the approval of the FMC-Clemmons application would not have resulted in the denial of the proposed DCH application.

In summary, the Agency determined that the two applications submitted for review beginning August 1, 2008 are not competitive, and therefore, a comparative analysis was not prepared.

Attachment 14

ATTACHMENT - REQUIRED STATE AGENCY FINDINGS

FINDINGS
C = Conforming
CA = Conditional
NC = Nonconforming
NA = Not Applicable

DECISION DATE:	February 27, 2008
FINDINGS DATE:	March 5, 2008
TEAM LEADER:	Martha J. Frisone
CHIEF:	Lee B. Hoffman
PROJECT I.D. NUMBERS:	G-7980-07/ Novant Health, Inc. and Medical Park Hospital (MPH)/ Construct new facility for Medical Park Hospital in Clemmons, to include 22 acute care beds and 5 operating rooms relocated from Medical Park Hospital and 28 acute care beds relocated from Forsyth Medical Center/ Forsyth County
	G-7984-07/ North Carolina Baptist Hospital and Davie County Emergency Health Corporation d/b/a Davie County Hospital (DCH)/ Relocate existing hospital from Mocksville to Bermuda Run/ Davie County

REVIEW CRITERIA FOR NEW INSTITUTIONAL HEALTH SERVICES

G.S. 131E-183(a) The Department shall review all applications utilizing the criteria outlined in this subsection and shall determine that an application is either consistent with or not in conflict with these criteria before a certificate of need for the proposed project shall be issued.

(1) The proposed project shall be consistent with applicable policies and need determinations in the State Medical Facilities Plan, the need determination of which constitutes a determinative limitation on the provision of any health service, health service facility, health service facility beds, dialysis stations, operating rooms, or home health offices that may be approved.

C –MPH
NC –DCH

Novant Health, Inc. (Novant) and Medical Park Hospital, Inc. d/b/a Medical Park Hospital (MPH) propose to construct a new facility in Clemmons for MPH (MPH-Clemmons), which is currently located in Winston-Salem. The new facility would

include 22 acute care beds and five operating rooms (ORs) relocated from the existing MPH and 28 acute care beds relocated from Forsyth Medical Center (FMC). Seven of the 13 existing ORs currently licensed at MPH would remain at the existing site in Winston-Salem (MPH-Winston-Salem) and continue to be licensed as part of MPH (i.e., MPH would have two campuses on the same license). Also, it should be noted that, pursuant to the certificate of need issued for Project I.D. #G-7604-06, Novant was previously authorized to relocate one of the 13 ORs at MPH to the Kernersville campus of FMC. Thus, upon completion of Project I.D. #G-7604-06, MPH would be licensed for only 12 shared ORs [13 – 1 = 2]. Novant owns both MPH and FMC and the existing hospitals are located across the street from each other. In summary, upon completion of this project and Project I.D. #G-7604-06, MPH would be licensed for 50 general acute care beds [22 + 28 = 50] and 5 shared ORs on the campus in Clemmons and 7 dedicated outpatient ORs on the campus in Winston-Salem.

The proposal does not result in an increase in the number of general acute care beds, ORs or GI endoscopy rooms located in Forsyth County. Further, the applicants do not propose to acquire any medical equipment for which there is a need determination in the 2007 State Medical Facilities Plan (2007 SMFP). Therefore, there are no need determinations applicable to the review of the proposed project.

However, because the applicants propose to construct space to replace 50 existing acute care beds, Policy AC-5 is applicable to the review. POLICY AC-5: REPLACEMENT OF ACUTE CARE BED CAPACITY states

> *"Proposals for either partial or total replacement of acute care beds (i.e., construction of new space for existing acute care beds) shall be evaluated against the utilization of the total number of acute care beds in the applicant's hospital in relation to the utilization targets found below. In determining utilization of acute care beds, only acute care bed 'days of care' shall be counted. Any hospital proposing replacement of acute care beds must clearly demonstrate the need for maintaining the acute care bed capacity proposed within the application.*

Facility Average Daily Census	*Target Occupancy of Licensed Acute Care Beds (Percent)*
1 – 99	*66.7%*
100 – 200	*71.4%*
Greater than 200	*75.2%*

In Section III.1, page 81, Section IV.1, pages 123-125, and Exhibit 5, Table 59, the applicants provide historical and projected utilization of the general acute care beds at MPH and FMC, as illustrated in the following table.

YEAR	# OF ACUTE CARE PATIENT DAYS (including ICU)	AVERAGE DAILY CENSUS (ADC)	TOTAL # OF LICENSED ACUTE CARE BEDS	% OCCUPANCY
MPH				
7/1/06 – 6/30/07 (actual) [1]	5,759	15.8	136	11.6%
7/1/11 – 6/30/12 (projected) (Year One)	10,506	28.8	50	57.6%
7/1/12 – 6/30/13 (projected) (Year Two)	11,511	31.5	50	63.0%
7/1/13 – 6/30/14 (projected) (Year Three)	12,548	34.4	50	68.8%
FMC (including the Kernersville campus)				
7/1/06 – 6/30/07 (actual)	212,913	583.3	637	91.6%
7/1/11 – 6/30/12 (projected) (Year One)	221,233	606.1	762	79.5%
7/1/12 – 6/30/13 (projected) (Year Two)	222,958	610.8	762	80.2%
7/1/13 – 6/30/14 (projected) (Year Three)	224,660	615.5	762	80.8%

(1) As of 6/30/07, MPH was licensed for 136 general acute care beds and FMC was licensed for 637 general acute care beds. Effective 11/13/2007, 114 general acute care beds were transferred from MPH to FMC pursuant to the certificate of need issued for Project I.D. #G-7011-04. Thus, MPH is currently licensed for 22 general acute care beds and FMC is currently licensed for 751 general acute care beds.

As shown in the above table, MPH's average daily census (ADC) was 15.8 patients in FY 2007 and the projected ADC during the third operating year of the project is 34.4 patients. Thus, the target occupancy rate for MPH is 66.7%. During the third operating year, the applicants project that the acute care occupancy rate at MPH would be 68.8%, which is greater than the target. Further, FMC's ADC was 583.3 patients in FY 2007 and the projected ADC during the third operating year of the project is 615.5 patients. Thus, the target occupancy rate for FMC is 75.2%. During the third operating year, the applicants project that the occupancy rate would be 80.8%, which is greater than the target. In the Impact Analysis in Exhibit 5, the applicants state they used federal fiscal year (FFY) 2006 actual acute care utilization data as the base year. They assumed that acute care utilization would increase at the same rate as the population of the service area is expected to increase. The projections were then adjusted to match the project years, which

are a different fiscal year (7/1 to 6/30 instead of 10/1 to 9/30). See Criterion (3) for analysis of acute care utilization. The applicants adequately demonstrate the need to maintain the acute care bed capacity proposed in the application. Therefore, the applicants adequately demonstrate that the proposal is consistent with Policy AC-5 in the 2007 SMFP. Consequently, the application is conforming to this criterion.

North Carolina Baptist Hospital and Davie County Emergency Health Corporation d/b/a Davie County Hospital (DCH) propose to relocate DCH from Mocksville to Bermuda Run. The hospital is currently licensed for 81 general acute care beds. However, the hospital is designated as a critical access hospital and operates a maximum of only 25 general acute care beds. In addition, DCH is designated as a swing bed hospital. Further, the hospital is currently licensed for two shared operating rooms (ORs) and one gastrointestinal (GI) endoscopy room. The applicants propose to develop 43 general acute care beds, 38 long-term care hospital (LTCH) beds, three shared ORs and one GI endoscopy room in the replacement hospital.

The proposal does not result in an increase in the number of general acute care beds or GI endoscopy rooms located in Davie County. Further, the applicants do not propose to acquire any medical equipment for which there is a need determination in the 2007 State Medical Facilities Plan (2007 SMFP). Although the proposal would result in the development of 38 new LTCH beds, the 2007 SMFP does not include a need methodology or need determination for LTCH beds. Consequently, the 2007 SMFP is not applicable with regard to development of LTCH beds. However, the applicants also propose the development of one new shared OR. The applicants do not state that the proposed third OR would be a dedicated C-section OR. Because, the 2007 SMFP states that there is no need for any additional ORs in Davie County, the proposal is not consistent with the need determination for operating rooms in the 2007 SMFP. See Table 6C on page 65 of the 2007 SMFP.

Further, because the applicants propose to construct space to replace 43 general acute care beds, Policy AC-5 is applicable to the review. POLICY AC-5: REPLACEMENT OF ACUTE CARE BED CAPACITY states

"Proposals for either partial or total replacement of acute care beds (i.e., construction of new space for existing acute care beds) shall be evaluated against the utilization of the total number of acute care beds in the applicant's hospital in relation to the utilization targets found below. In determining utilization of acute care beds, only acute care bed 'days of care' shall be counted. Any hospital proposing replacement of acute care beds must clearly demonstrate the need for maintaining the acute care bed capacity proposed within the application.

Facility Average Daily Census	*Target Occupancy of Licensed Acute Care Beds (Percent)*
1 – 99	*66.7%*
100 – 200	*71.4%*
Greater than 200	*75.2%*

In Exhibit 25, the applicants provide historical and projected utilization of the general acute care beds at DCH, as illustrated in the following table.

YEAR	# OF ACUTE CARE PATIENT DAYS	AVERAGE DAILY CENSUS (ADC)	TOTAL # OF LICENSED ACUTE CARE BEDS	% OCCUPANCY
6/1/04 – 5/31/05 (actual)	2,462	6.7	81	8.3%
6/1/05 – 5/31/06 (actual)	3,234	8.9	81	11.0%
6/1/06 – 5/31/07 (actual)	3,095	8.5	81	10.5%
6/1/07 – 5/31/08 (projected)	3,843	10.5	81	13.0%
6/1/08 – 5/31/09 (projected)	3,843	10.5	81	13.0%
6/1/09 – 5/31/10 (projected)	3,843	10.5	81	13.0%
6/1/10 – 12/31/10 (projected) (six months)	1,922	10.5	81	13.0%
1/1/11 – 12/31/11 (projected) (Year One)	7,464	20.4	43	47.4%
1/1/12 – 12/31/12 (projected) (Year Two)	8,867	24.3	43	56.5%
1/1/13 – 12/31/13 (projected) (Year Three)	10,958	30.0	43	69.8%

As shown in the above table, DCH's current average daily census (ADC) is 8.5 patients and its projected ADC during the third operating year of the project is 30.0 patients. Thus, the target occupancy rate for DCH is 66.7%. During the third operating year, the applicants project that the occupancy rate would be 69.8%, which is greater than the target. However, projected utilization is overstated and is not based on reasonable and supported assumptions. See Criterion (3) for discussion. Therefore, the applicants did not adequately demonstrate that utilization of the 43 licensed general acute care beds at DCH is reasonably projected to

be 66.7% or greater. Consequently, the applicants did not adequately demonstrate the need to construct new space to replace 43 existing general acute care beds. As a result, the application is not consistent with Policy AC-5 in the 2007 SMFP.

In summary, the application is not conforming to the need determination in the 2007 SMFP for new ORs and is not consistent with Policy AC-5 in the 2007 SMFP. Therefore, the application is nonconforming with this criterion.

(2) Repealed effective July 1, 1987.

(3) The applicant shall identify the population to be served by the proposed project, and shall demonstrate the need that this population has for the services proposed, and the extent to which all residents of the area, and, in particular, low income persons, racial and ethnic minorities, women, handicapped persons, the elderly, and other underserved groups are likely to have access to the services proposed.

NC – MPH
NC – DCH

MPH proposes to construct a new facility in Clemmons for MPH, which is currently located in Winston-Salem. The new facility in Clemmons would include 22 acute care beds and five existing ORs relocated from MPH in Winston-Salem and 28 acute care beds relocated from FMC. Seven existing ORs currently licensed at MPH would remain at the existing site in Winston-Salem and continue to be licensed as part of MPH (i.e., MPH would have two campuses on the same license). In Section VI.10, page 152, the applicants describe the proposed changes in the services provided by MPH as follows

"the scope of services currently provided at Medical Park Hospital in Winston-Salem is focused on a facility that functions as a surgical specialty hospital providing inpatient and outpatient surgical care supported by the necessary surgical ancillary services such as a surgical pathology lab, and basic imaging, pharmacy, and lab services. In its current location, MPH does not provide emergency department services, multi-modality imaging, or intensive care services. ... The applicant expects that ... the scope of services will change to that of a full-service community hospital with an emergency department, ICU, medical

inpatients, and full-service radiology, lab, and pharmacy on site."

Further, in Section VI.12, page 155, the applicants state

"MPH-Clemmons will offer services that are not currently offered at MPH due to its configuration as a surgical specialty hospital."

The following table compares the beds, medical equipment and services currently authorized at MPH with those to be offered at the proposed new facility.

BEDS/EQUIPMENT/SERVICES	CURRENT	PROPOSED	DIFFERENCE
General Acute Care Beds			
Medical-Surgical	22	46	24
Intensive Care Unit	0	4	4
Total Acute Care Beds [1]	22	50	28
Unlicensed Observation Beds	0	6	6
Operating Rooms (ORs) [2]			
Shared ORs	12	5	(7)
Dedicated Outpatient ORs	0	7	7
Total ORs	12	12	0
Minor Procedure Room	1	1	0
Emergency Services (number of treatment rooms) [3]	0	12	12
CT scanner	0	1	1
Fixed Radiographic & Fluoroscopic (R/F) X-ray units	1	3	2
Nuclear Medicine Camera (no coincidence circuitry)	0	1	1
Ultrasound (US) units	0	1	1
Mammography units	0	1	1
Laboratory Services [4]	yes	yes	expanded
Pharmacy Services [4]	yes	yes	expanded
Respiratory Therapy Services	no	yes	yes
Physical and Speech Therapy Services	no	yes	yes

(1) The 28 additional acute care beds to be added to MPH's licensed capacity are existing acute care beds to be relocated from FMC.

(2) MPH is currently licensed for 13 shared ORs. However, Novant is authorized to relocate one existing shared OR to the Kernersville campus of FMC, which is expected to take place before development of this project is complete.

(3) MPH does not currently operate an emergency department.

(4) In Section VII.2, page 160, the applicants state that "full service" laboratory and pharmacy services are not currently provided at MPH. The proposed new facility in Clemmons will provide "full service" laboratory and pharmacy services.

As shown in the above table, new services to be provided at the proposed new facility in Clemmons include:

- 4 new intensive care unit beds

- 6 new unlicensed observation beds [Note: In a footnote on page 18, the applicants state that MPH was "approved" to operate 25-30 observation beds as part of Project I.D. #G-7011-04. However, in Project I.D. #G-7011-04, the applicants proposed to relocate 114 existing general acute care beds from MPH to FMC. Although that application mentions the possibility of developing 25-30 unlicensed observation beds at MPH, the CON Section did not review a proposal to develop 25-30 unlicensed observation beds at MPH as part of Project I.D. #G-7011-04, and thus, did not authorize the development of 25-30 unlicensed observation beds at MPH. Further, in its 2008 Hospital License Renewal Application, MPH reports that it has no unlicensed observation beds.]
- emergency services
- 1 new CT scanner
- 2 new X-ray units
- 1 new nuclear medicine camera
- 1 new ultrasound unit
- 1 new mammography unit
- respiratory therapy services
- physical and speech therapy services

Thus, the scope of services to be provided at the new facility in Clemmons will be significantly different from the scope of services currently provided at the existing facility in Winston-Salem. Additionally, the population to be served by the proposed new facility in Clemmons will be significantly different from the population currently served at MPH because MPH does not currently serve a significant number of patients from the proposed service area. Specifically, in a footnote in Section III.8(c), page 119, the applicants state

> *"The majority of inpatient days at MPH currently are from locations other than the proposed five zip code service area. Once* [sic] *MPH acute inpatient unit at South Hawthorne Road* [Winston-Salem] *is closed it is anticipated that this volume will shift to FMC."*

Thus, the majority of inpatient days currently provided at MPH will not be shifted to the new MPH facility in Clemmons, but to FMC instead.

Population to be Served

The following table illustrates the current patient origin for acute care services provided by MPH between July 1, 2006 and June 30, 2007, as reported by the applicants in Section III.4(a), page 111.

COUNTY	% OF TOTAL INPATIENT ADMISSIONS
Forsyth	54.2%
Surry	8.6%
Yadkin	7.9%
Stokes	6.9%
Davidson	6.5%
Davie	5.1%
Wilkes	3.7%
Guilford	1.6%
All Other	5.5%
Total	100.0%

As shown in the above table, during FY 2007, 54.2% of MPH's acute care patients (i.e., inpatients) were residents of Forsyth County and 5.1% were residents of Davie County.

The following table illustrates the current patient origin for surgical services (inpatients and outpatients) provided by MPH between July 1, 2006 and June 30, 2007, as reported by the applicants in Section III.4(a), page 112.

COUNTY	% OF TOTAL SURGICAL CASES	
	INPATIENTS	OUTPATIENTS
Forsyth	55.0%	55.4%
Stokes	7.0%	8.0%
Davie	5.6%	7.2%
Surry	6.7%	6.9%
Yadkin	7.4%	6.4%
Davidson	6.6%	5.5%
Guilford	1.8%	2.4%
Wilkes	3.7%	2.1%
All Other	9.9%	6.1%
Total [1]	103.7%	100.0%

[1] The Project Analyst is unable to determine why the percentages for inpatient surgical cases adds up to more than 100%.

As shown in the above table, during FY 2007, approximately 55% of MPH's surgical patients were residents of Forsyth County, 5.6% of MPH's inpatient surgical patients were residents of Davie

County and 7.2% of MPH's outpatient surgical patients were residents of Davie County.

In Section III.5(a), pages 112-113, the applicants describe the proposed service area for the new facility as follows:

> *"The proposed service area for MPH-Clemmons includes five zip codes. Two zip codes in Forsyth County: 27012 and 27023, and three zip codes in Davie County: 27006, 27018, and 27028. Zip code 27014 is a Post Office Box in Cooleemee in Davie County, which is embedded geographically in the zip code for Mocksville, 27028."*

[Note: there are only three zip codes in Davie County. Therefore, the proposed service area includes all of Davie County.] In Section III.1(b), page 83, the applicants state

> *"While not part of the defined service area, MPH-Clemmons recognizes that patients from other North Carolina counties may choose to travel across service areas to receive services at MPH-Clemmons. As a result, 10% of the total projected utilization in each of the project years has been allocated to the category of 'Other Inmigration.' Other inmigration is expected to come from surrounding zip codes in Forsyth County and the surrounding counties, Iredell and Yadkin. In calendar year 2006 residents of Iredell and Yadkin Counties alone represented over 7% of inpatient volume at MPH as reflected in Exhibit 5, Table 15."*

The applicants states that ten percent of MPH's patients are proposed to be residents of "surrounding" zip codes in Forsyth County and residents of Iredell and Yadkin counties. Thus, the proposed service area for the new facility consists of Davie, Yadkin and Iredell counties, and zip codes in the western portion of Forsyth County. The following tables illustrate projected patient origin by service during the second operating year for the proposed new facility, as reported by the applicants in Section III.5(c), page 114-115.

ACUTE CARE SERVICES

ZIP CODE/COUNTY	# OF PATIENT DAYS	% OF TOTAL PATIENT DAYS
27012 / Forsyth	3,756	32.6%
27023 / Forsyth	1,365	11.9%
27006 / Davie	2,243	19.5%
27014 / Davie	142	1.2%
27028 / Davie	2,853	24.8%
Other Inmigration	1,151	10.0%
Total	11,511	100.0%

INPATIENT SURGICAL SERVICES

ZIP CODE/COUNTY	# OF INPATIENT SURGICAL CASES	% OF TOTAL INPATIENT SURGICAL CASES
27012 / Forsyth	249	29.8%
27023 / Forsyth	114	13.6%
27006 / Davie	155	18.6%
27014 / Davie	13	1.5%
27028 / Davie	220	26.4%
Other Inmigration	83	10.0%
Total	833	100.0%

OUTPATIENT SURGICAL SERVICES

ZIP CODE/COUNTY	# OF OUTPATIENT SURGICAL CASES	% OF TOTAL OUTPATIENT SURGICAL CASES
27012 / Forsyth	1,030	30.1%
27023 / Forsyth	471	13.8%
27006 / Davie	692	20.2%
27014 / Davie	35	1.0%
27028 / Davie	851	24.9%
Other Inmigration	342	10.0%
Total	3,422	100.0%

OUTPATIENT SERVICES (EXCLUDING SURGICAL)

ZIP CODE/COUNTY	# OF PROCEDURES	% OF TOTAL PROCEDURES
27012 / Forsyth	5,745	42.0%
27023 / Forsyth	1,025	7.5%
27006 / Davie	3,396	24.8%
27028 / Davie	2,152	15.7%
Other Inmigration	1,369	10.0%
Total	13,686	100.0%

EMERGENCY SERVICES

ZIP CODE/COUNTY	# OF VISITS	% OF TOTAL VISITS
27012 / Forsyth	6,009	44.6%
27023 / Forsyth	1,183	8.8%
27006 / Davie	3,229	24.0%
27028 / Davie	1,696	12.6%
Other Immigration	1,346	10.0%
Total	13,464	100.0%

The applicants adequately identified the population proposed to be served.

Need for New Building

In Section II.1, page 18, the applicants state

> *"MPH opened 36 years ago. ... MPH's existing facility is outdated in several crucial facility and campus elements as detailed in the response to Question II.5 below. Something must be done to address the MPH facility infrastructure so that MPH, the MPH medical staff, and the MPH employees will be able to continue to enjoy the confidence of and stellar satisfaction ratings from the patients and the families that they care for each day."*

However, in this project, the applicants do not propose any modifications to the existing facility for the patients and medical staff that will continue to use it for surgical services. Rather, in Section II.9, page 60, the applicants state

> *"Novant Health will continue the ongoing process of determining future use of the remaining ORs and the vacated space at MPH. As the planning process continues, the remaining operating rooms will be operated as a hospital based outpatient surgical center. Several other opportunities under consideration include:*
>
> - *Using the vacated space for outpatient or non-acute care services. This could be accomplished at limited expense or additional investment as MPH received a "face lift" in Spring 2007, making it visibly more attractive and patient friendly.*

- *Renovating the existing MPH Hawthorne Rd. OR suite and developing larger surgical support space. This would result in seven larger, more modern and versatile operating rooms at MPH-Hawthorne Rd. campus and address the problem of lack of storage space in the surgical suite.*
- *Seeking CON approval to convert the remaining seven operating rooms to a freestanding ambulatory surgery center.*
- *Development of new outpatient services or relocation of existing FMC outpatient services.*
- *Use space at MPH for NHTR administrative services.*

However, no determination has been made at this point. Discussions between the MPH medical staff and MPH and NHTR management are ongoing. As the proposed MPH-Clemmons project will not be operational until July 2011, Novant plans to use the interim timeframe for determining the future of the remaining facility and services at MPH. If after additional planning, Novant determines that the facility will be used for the development of any new services or expansion of services which require CON approval or exceed CON thresholds, an additional CON application will be filed. At this point, future use of the vacant space has not been determined. As a result, no costs associated with future uses of the existing Hawthorne Rd. MPH facility are included in this application."

In Section II.5, pages 27-29, the applicants state

"MPH was constructed in the late 1960s and became operational in 1971. The MPH campus ... is well cared for, but somewhat dated and is exhibiting many of the issues to be expected for a facility of its age.

MPH on South Hawthorne Rd. is outdated in several respects: (1) aging engineering infrastructure (chiller towers, boilers, HVAC, humidifiers, emergency power distribution from the generator, building-wide steam piping issues due to age, asbestos removal); (2) cramped capacity in patient care areas such as pre-anesthesia visit space, surgical prep and recovery areas that inhibit maximal OR case throughput, and a few under-sized ORs (two or three)

based on modern surgical requirements; (3) a functional shortage of patient, staff, and physician parking with limited opportunities to expand without adding prohibitively expensive parking deck; (4) elevator capacity and age which inhibits the efficient and best use of bed floors; (5) limited storage and support space for nursing stations, PACU soiled holding, dedicated and private patient consultation rooms, and separate female surgeon locker room; and (6) the 13-acre MPH campus is very small compared to modern-day community hospital requirements and is bordered on two sides by Medical Office Buildings housing both physician/surgeon offices and Novant non-clinical support staff. These MOBs are about the same vintage as Medical Park Hospital. Two public roadways bound the other two sides, so that MPH has very little opportunity to expand horizontally.

In spite of these limitations, 'the hospital functions very efficiently.' ... However, at some point in the near future, the facility issues will interfere more and more with the ability to sustain patient, employee, and physician satisfaction.

Novant Health Triad Region has studied the options for MPH over the course of three years, using two well-known and well-respected facilities planning consultants.

...

The status quo would be to do nothing. This is not a satisfactory solution for the patients, medical staff, or employees. The need to undertake at least basic infrastructure renovations has been clearly identified by outside consultants, as well by MPH's maintenance staff and NHTR Facilities Planning and Construction staff. In addition, after the relocation to FMC/North Pavilion of 114 of MPH's 136 licensed acute beds is completed in about February 2008, only 22 acute licensed beds will remain at MPH. During the week, Monday – Friday, MPH routinely experiences an inpatient census of 25- 30. The Proposed 2008 SMFP even suggests that as MPH continues to grow it will need more bed capacity.

...

MPH and the facility planning consultants thoroughly studied the following incremental approaches to address the MPH facility issues identified above: (1) expand internally within the current MPH walls by displacing dietary & pre-anesthesia visits to outside of MPH; (2) reduce the current OR case volumes to match the physical capacity of the prep and recovery areas so that 10 ORs rather than 12 ORs are in operation at MPH; and (3) re-design patient care areas and ORs at MPH and add new square footage at the front end of MPH to maximize the use of all 12 ORs and undertake costly site work due to impact on front drive and parking. All of these configurations would require an investment of $10-15 Million (in today's dollars) to address the immediate infrastructure and some of the flow issues. These options can be characterized as an approach that leaves the main MPH infrastructure 'as is, where is,' with investment in only required upgrades.

With Options (1) and (2) above, the ORs that are too small today remain too small tomorrow or licensed ORs are not operational. The functional parking issues for patients, physicians, and staff continue. In addition, many of the MPH facility storage and support issues described above remain unaddressed. Appearance issues related to aging interior MPH finishes are also not updated. While this approach is less costly in the short term, it would be short-sited. The incremental approach fails to address in a comprehensive manner the longer term issues which include: (a) whether investment should be made in a facility on a site that is too small to accommodate future hospital growth; and (b) how to reconfigure all the MPH ORs and surgical support space in a manner that brings the surgical suites to modern standards so that the surgical suite operates efficiently, patient care processes flow smoothly, and surgeons, staff, and patients remain satisfied with the overall experience.

Option (3) above is the most costly and the most disruptive to current care processes among the renovation/expansion options for MPH on Hawthorne Rd. The site work associated with Option (3) is much more extensive. Also, it

begs the question of whether the expanded MPH should remain on the current campus in Winston-Salem, close to two existing full-service hospitals (FMC and NCBH) or explore an alternative that decompresses the FMC-MPH campus by relocating the hospital to a community hospital location outside Winston-Salem.

...

The option to construct an MPH replacement hospital on South Hawthorne Road was the subject of a 2007 study and analysis by Peterson Associates. This study included not only construction of a total MPH replacement facility on South Hawthorne Rd., but also the replacement and/or demolition of the Medical Office Buildings on the MPH campus, the addition of an outpatient surgery center on the ground floor of the MOB and the addition of a retention pond and a large (1,200 to 1,400 spaces) parking deck on the MPH campus. The estimated total capital expenditure for this combination of facilities on the 13-acre campus is $100 to $120 Million. This would be a multi-stage, multi-year project, with significant and extended impact on the MPH processes of patient care delivery. In addition, even in this option the small size of some of the MPH ORs would not be addressed. Furthermore, because the current 13-acre site is so valuable and the MOB construction cost is greater than on a less compact campus, the MOB rental rates turn out to be higher than the market rate and not of interest to many physicians. If an ED were added to a MPH total replacement hospital on South Hawthorne Rd. [sic] *that would result in three emergency departments within two miles of each other: one at FMC which was recently expanded and relocated on the FMC campus and opened in late 2004, one at NCBH which has recently been CON-approved for a significant expansion and renovation, and one at MPH."*

In Section III.1, pages 62-64, the applicants state

"Novant Health has determined that the development of a 50-bed hospital in Clemmons will provide a community alternative for residents of the defined service area and would help to relieve some of the future pressure for

additional beds at Forsyth Medical Center in Winston Salem. When you review patient origin information provided by FMC and MPH in their annual hospital licensure renewal applications, it is apparent that these Winston-Salem based hospitals and their medical staffs draw patients from multiple counties outside of Forsyth County where both hospitals are located.

...

The unmet need for inpatient acute care services in the greater Clemmons area of Forsyth and Davie Counties is substantiated by the rapidly growing population and the lack of comprehensive inpatient and outpatient services in the defined service area."

Need for Project Components

Acute Care Beds – MPH is currently licensed for 22 general acute care beds. The proposed new facility would be licensed for 50 acute care beds with the addition of 28 existing general acute care beds relocated from FMC [22 + 28 = 50]. Of the 50 licensed acute care beds in the new facility, the applicants propose that 46 will be designated as general medical/surgical beds and 4 will be developed as intensive care unit (ICU) beds. MPH does not currently have any ICU beds.

Medical/Surgical Beds – In Section III.1, page 81, Section IV.1, pages 123-125, and Exhibit 5, Table 59, the applicants provide historical and projected utilization of the general acute care beds at MPH, as illustrated in the following table.

YEAR	# OF ACUTE CARE PATIENT DAYS	AVERAGE DAILY CENSUS (ADC)	# OF GENERAL MEDICAL/ SURGICAL BEDS	% OCCUPANCY
7/1/06 – 6/30/07 (actual) [1]	5,759	15.8	136	11.6%
7/1/11 – 6/30/12 (projected) (Year One)	9,597	26.3	46	57.2%
7/1/12 – 6/30/13 (projected) (Year Two)	10,515	28.8	46	62.6%
7/1/13 – 6/30/14 (projected) (Year Three)	11,462	31.4	46	68.3%

[1] As of 6/30/07, MPH was licensed for 136 general acute care beds. Effective 11/13/2007, 114 general acute care beds were transferred from MPH to FMC pursuant to the certificate of need issued for Project I.D. #G-7011-04. Thus, MPH is currently licensed for 22 general acute care beds. Assuming an ADC of 15.8 patients, the occupancy rate for 22 acute care beds would be 71.8% [15.8 / 22 = 0.718].

As shown in the above table, in Year Three, the applicants project that the proposed new facility will provide 11,462 medical/surgical acute days of care in 46 beds, which is an ADC of 31.4 and an occupancy rate of 68.3%. The following is a description of and discussion regarding the applicants' methodology and assumptions used to project utilization of the 46 general medical/surgical beds at MPH-Clemmons. See Section III.1, pages 82-89.

- Projected medical/surgical acute care days are calculated as follows: (current utilization by zip code x annual zip code specific population growth rates x percent volume shifted from Novant Health Triad Region hospitals) + (other immigration, which is 10% of total medical/surgical acute care days).
- Regarding current utilization, the applicants state *"zip code level acuity adjusted inpatient days were determined using the Solucient database."* The applicants excluded the following diagnostic related groupings (DRGs): mental health and drug abuse, rehabilitation, normal newborns, delivery, neonatal intensive care, diagnostic cardiac catheterization, and all DRGs with a relative weight equal to or greater than 2.0. The following table illustrates the total number of acuity adjusted patient days in all North Carolina hospitals provided to residents of the proposed service area during CY 2004, CY 2005 and CY 2006, as reported by the applicants on page 84.

CALENDAR YEAR	TOTAL # OF ACUITY ADJUSTED PATIENT DAYS AT ALL NC HOSPITALS PROVIDED TO RESIDENTS OF THE PROPOSED SERVICE AREA
2004	19,728
2005	21,302
2006	22,292

The following table illustrates the number of acuity adjusted patient days provided at MPH and FMC to residents of the proposed service area during CY 2004, CY 2005 and CY 2006, as reported by the applicants in Section III.1, pages 85-86, and Exhibit 5, Table 6.

Calendar Year	Total # of Acuity Adjusted Patient Days at MPH and FMC Provided to Residents of the Proposed Service Area					
	MPH		FMC		MPH & FMC Combined	
	Patient Days	Market Share	Patient Days	Market Share	Patient Days	Market Share
2004	525	2.7%	11,413	57.9%	11,938	60.6%
2005	606	2.8%	12,079	56.7%	12,586	59.5%
2006	490	2.2%	12,750	57.2%	13,240	59.4%

As shown in the above table, during CY 2006, 59.4% of the residents of the proposed service area utilized either MPH (2.2%) or FMC (57.2%) for medical/surgical acute care services. Further, the above data shows an average of only 1.3 acuity adjusted patients served per day at MPH from the proposed service area, while an average of 34.9 acuity adjusted patients from the service area were served per day at FMC.

- The applicants assume that the number of acuity adjusted patient days provided at MPH and FMC to residents of the proposed service area during CY 2006 will increase at the same rates the population of each zip code is projected to increase. The applicants obtained zip code specific projected compound average growth rates (CAGR) from Claritas. The following table illustrates the CAGR for each zip code in the proposed service area, as reported by the applicants in Section III.1, page 87, and Exhibit 5, Table 2.

Zip Code / County	Projected CAGR between 2006 and 2014 obtained from Claritas
27006 / Davie	2.8%
27028 / Davie	1.9%
27012 / Forsyth	1.3%
27023 / Forsyth	0.7%
Total	1.7%

- The following table illustrates the applicants' assumptions regarding the number of residents of the proposed service area currently utilizing FMC or MPH that are projected to shift to the proposed new facility, as reported by the applicants in Section III.1, page 87, and Exhibit 5, Table 5.

	% OF CURRENT MPH AND FMC MEDICAL/SURGICAL ACUTE CARE PATIENTS FROM THE PROPOSED SERVICE AREA PROJECTED TO SHIFT TO THE PROPOSED NEW FACILITY IN CLEMMONS
Year One	65.0%
Year Two	70.0%
Year Three	75.0%

Although not reflected in the above table, the majority of the patients projected to shift to Clemmons will come from FMC, not MPH. In fact, based on CY 2006 acuity adjusted patients days reported for MPH and FMC, only 3.7% [490 / 13,240 = 0.037] will be shifted from MPH-Winston-Salem to Clemmons, while 96.3% of the acuity adjusted patient days projected to shift to Clemmons will come from FMC.

On the other hand, 4,984 patient days [5,474 – 490 = 4,984] will be shifted to FMC because the patients' acuity level is 2.0 or greater or the patients do not reside in the proposed service area. [i.e., the total number of patient days provided by MPH during CY 2006 (5,474) as reported by the applicants in Section IV.1, page 123, minus the number of acuity adjusted patient days provided to residents of the proposed service area during CY 2006 (490)]. Thus, 91.1% [4,984 / 5,474 = 0.911] of the total patient days of care currently provided at MPH will shift across the street to FMC, while only 8.9% will shift to the new facility in Clemmons.

Regarding the assumptions in the table above, in Section III.1, page 88, the applicants state

> *"MPH-Clemmons assumed that 75% of the projected acuity adjusted inpatient days would shift to the new community hospital by the third year of operation. Market volume shift for years one and two were projected slightly less as the facility was new and time was allowed for the volume to grow. The following factors were considered important to the determination of the percent of existing market volume projected to shift from the current*

MPH/FMC Campus to the new MPH-Clemmons hospital.

- *All acute care beds at the existing MPH location will be transferred to the new location, therefore 100% of total inpatient days at MPH will have to shift to either MPH-Clemmons or FMC.*
- *MPH-Clemmons is closer to all areas of each of the five zip codes than existing NHTR Winston Salem facilities as reflected in Exhibit 5, Table 1 and Map 5;*
- *There currently are four Forsyth Medical Group employed practices in the defined service area: Medical Associates of Davie/Mocksville-27028 (5 MDs, 3 extenders), Clemmons Family Practice/Clemmons-27012 (3 MDs, 1 extender), Family Medical Associates of Lewisville / Lewisville-27023 (5 MDs), and West Forsyth Family Medicine/Clemmons-27012 (1 MD, 2 extenders); a total of 20 medical providers.*
- *These established physician practices in the market have existing doctor-patient relationships and patient visits to these physician groups grew 14% from 2005 to 2006 and are on target to grow at a similar rate from 2006 to 2007 as reflected in Exhibit 5, Table 17;*
- *Additional physician offices with easier access will be developed in the future on the MPH-Clemmons campus;*
- *Congestion and traffic on I-40 into Winston Salem will increase;*
- *MPH-Clemmons offers a choice for inpatient care closer to home;*
- *The proposed location of MPH-Clemmons adjacent to I-40 and Highway 421 will result in ease of access to the existing population in the defined zip code service area;*
- *Some patients will continue to seek care at other NHTR Winston Salem hospitals, therefore 100% of the demand for inpatient services in the five zip codes will not shift to MPH-Clemmons."*

- The applicants assume that the average length of stay would be 3.7 days, based on the average length of stay (ALOS) at four Novant community hospitals: 1) MPH (ALOS was 3.7 in FFY 2006); 2) Thomasville Medical Center (ALOS was 3.9 in FFY 2006); 3) Presbyterian Hospital Matthews (ALOS was 3.8 in FFY 2006); and 4) Presbyterian Hospital Huntersville (ALOS was 3.4 in FFY 2006). The average ALOS for these four hospitals was 3.7 in FFY 2006. Projected discharges were calculated by dividing projected patient days by the ALOS. See Section III.1, page 89, and Exhibit 5, Table 8.

The applicants adequately demonstrate the need the patients served at Novant Health Triad Region facilities have for 46 general medical/surgical acute care beds in Clemmons.

Intensive Care Unit Beds – In Section III.1, pages 89-90, the applicants provide projected utilization of the four intensive care unit (ICU) beds for the first three operating years of the proposed new facility, as illustrated in the following table.

	YEAR ONE	YEAR TWO	YEAR THREE
Total Acute Care Patient Days	10,506	11,511	12,548
ICU Patient Days (8.7% of Total Acute Care Patient Days)	909	996	1,086
Average Daily Census (ADC)	2.5	2.7	3.0
% Occupancy	62.3%	68.2%	75.0%

As shown in the above table, in Year Three, the applicants project that the proposed new facility will provide 1,086 intensive care unit days of care in 4 beds, which is an ADC of 3.0 and an occupancy rate of 75%. The following is a description of and discussion regarding the applicants' methodology and assumptions used to project utilization of the ICU beds. See Section III.1, pages 89-90.

- In Exhibit 5, Table 8, the applicants calculated the ratio of medical/surgical ICU days to general medical/surgical days for all Novant hospitals in North Carolina. These ratios ranged from 5.6% at Presbyterian Hospital Matthews to 34.3% at Thomasville Medical Center. The ratio at Presbyterian Hospital Huntersville was 8.7%. The applicants state that the ratio for these three hospitals combined (not the average of the three ratios) was 12.4%.

However, based on the data provided by the applicants in Exhibit 5; Table 8, the ratio for these three hospitals combined was only 10.2%.

- In Section III.1, page 90, the applicants state *"It was determined that actual PHH utilization ... was the most reasonable rate to use in the projections as PHH is a 50 bed community hospital, comparable to the proposed project. Intensive care days at PHH represented 8.7% of total inpatient days in FFY 2006."*
- The applicants assume that the ratio of medical/surgical ICU days of care to total general medical/surgical days of care at the proposed new facility in Clemmons will be 8.7%.

However, the applicants do not adequately explain why the experience at Presbyterian Hospital Huntersville in Mecklenburg County is similar to the expected experience at MPH-Clemmons in Forsyth County. In particular, the data provided by the applicants in Exhibit 5, Table 8, shows that the ratio of medical/surgical ICU days to total general medical/surgical days varies significantly from hospital to hospital and is not necessarily related to the number of licensed acute care beds. For example, the applicants report in Exhibit 5, Table 8 that the ratio of medical/surgical ICU days of care to total medical-surgical days of care at Presbyterian Hospital in Charlotte was only 8.4% during FFY 2006. Presbyterian Hospital is licensed for 463 acute care beds and is a tertiary facility which provides significantly more services than what will be provided at the new facility in Clemmons. In addition, the ratio at Presbyterian Hospital Matthews was only 5.6%. The applicants did not adequately demonstrate it is more reasonable to use the ratio calculated for Presbyterian Hospital Huntersville than to use the ratio calculated for Presbyterian Hospital Matthews. Therefore, the applicants did not adequately demonstrate that projected utilization of the four ICU beds at MPH-Clemmons is based on reasonable and supported assumptions. Consequently, the applicants did not adequately demonstrate the need for four ICU beds at MPH-Clemmons.

Observation Beds – In Section III.1, page 90, the applicants provide projected utilization of the six unlicensed observation beds for the first three operating years of the proposed new facility, as illustrated in the following table.

	Year One	Year Two	Year Three
Total Acute Care Patient Days	10,506	11,511	12,548
Observation Days (12.5% of Total Acute Care Patient Days)	1,313	1,439	1,568
Average Daily Census (ADC)	3.6	3.9	4.3
% Occupancy	60.0%	65.7%	71.6%

12.8D
3.5

As shown in the above table, in Year Three, the applicants project that the proposed new facility will provide 1,568 observation days in 6 beds, which is an ADC of 4.3 patients and an occupancy rate of 71.6%. The following is a description of and discussion regarding the applicants' methodology and assumptions used to project utilization of the observation beds. See Section III.1, page 90.

- In Exhibit 5, Table 8, the applicants calculated the ratio of observation days to total acute care days for all Novant hospitals in North Carolina. The ratios range from 3.9% at The Presbyterian Hospital in Charlotte to 50.4% at MPH, which is currently only a surgical specialty hospital. The highest ratio for Novant facilities other than MPH is 12.6% at Presbyterian Hospital Huntersville. The ratio for Presbyterian Hospital Matthews is 8.8% and the ratio for Thomasville Medical Center is 6.4%.
- In Exhibit 5, Table 8, the applicants state that the average ratio of observation days to total acute days of care for MPH, Presbyterian Hospital Matthews, Presbyterian Hospital Huntersville and Thomasville Medical Center was 12.5% during FFY 2006. However, based on the data provided by the applicants in Exhibit 5, Table 8, the combined ratio for these four hospitals was actually 13%.
- The applicants assume that the ratio of observation days to total acute days of care at the proposed facility will be 12.5%.

However, the applicants do not adequately explain why the combined experience at MPH, Presbyterian Hospital Matthews, Presbyterian Hospital Huntersville and Thomasville Medical Center is similar to the expected experience at the proposed new facility in Clemmons. Further, the applicants included the ratio for the existing MPH in calculating the average used to project observation days at the proposed new facility. However, the ratio of observation days to total acute care days at MPH during FFY 2006 was 50.4%, which is significantly higher than any other

Novant hospital because it is a surgical specialty hospital and not a traditional community hospital. The patients currently served at the existing MPH are not the same patients proposed to be served at the new facility in Clemmons. Thus, the applicants should not have included the ratio at MPH in calculating the ratio to be used for a "full-service community hospital." The combined ratio of observation days to total acute care days for Presbyterian Hospital Matthews, Presbyterian Hospital Huntersville and Thomasville Medical Center was only 9.2% during FFY 2006 based on the data provided by the applicants in Exhibit 5, Table 8. The following table illustrates the ratio of observation days to total acute care days for all Novant hospitals, based on the data reported by the applicants in Exhibit 5, Table 8.

HOSPITAL	FFY 2006 OBSERVATION DAYS AS A % OF TOTAL ACUTE CARE DAYS
Forsyth Medical Center	2.1%
The Presbyterian Hospital	3.9%
Presbyterian Orthopaedic Hospital	5.4%
Thomasville Medical Center	6.4%
Presbyterian Hospital Matthews	8.8%
Presbyterian Hospital Huntersville	12.6%
Medical Park Hospital	50.4%

As shown in the above table, the ratio of observation days to total acute care days ranges from a low of only 2.1% at FMC to a high of 50.4% at MPH. Therefore, the applicants did not adequately demonstrate that projected utilization of the six unlicensed observation beds at the proposed MPH-Clemmons is based on reasonable and supported assumptions. Consequently, the applicants did not adequately demonstrate the need for six unlicensed observation beds at the proposed new facility.

Operating Rooms – MPH is currently licensed for 13 shared ORs. Pursuant to a certificate of need issued for Project I.D. #G-7604-06, one shared OR will be relocated to the Kernersville campus of FMC for a total of 12 ORs remaining at MPH. The applicants propose to relocate five of these 12 shared ORs to the proposed facility in Clemmons. Seven ORs will remain at the existing site in Winston-Salem and would continue to be licensed as part of MPH, but as seven dedicated outpatient ORs. The applicants project

utilization separately for the five shared ORs and the seven dedicated outpatient ORs, as discussed below.

Five Shared Operating Rooms – In Section III.1, page 95, Section IV.2, pages 125-126, and Exhibit 5, Table 20, the applicants provide historical and projected utilization of the shared ORs at MPH, as illustrated in the following table.

YEAR	# OF SURGICAL CASES			# OF SHARED ORS	AVERAGE # OF CASES /OR / DAY
	INPATIENT	OUTPATIENT	TOTAL		
7/1/06 – 6/30/07 (actual)	1,188	10,396	11,584	13	3.4
7/1/11 – 6/30/12 (projected) (Year One)	728	3,153	3,881	5	3.0
7/1/12 – 6/30/13 (projected) (Year Two)	833	3,422	4,255	5	3.3
7/1/13 – 6/30/14 (projected) (Year Three)	942	3,699	4,641	5	3.6

As shown in the above table, in Year Three, the applicants project 4,641 surgical cases will be performed in the five shared ORs in Clemmons, which is an average of 3.6 surgical cases per OR per day. The following is a description of and discussion regarding the applicants' methodology and assumptions used to project utilization of the shared ORs. See Section III.1, pages 91-96.

- The applicants state that projected surgical cases are calculated as follows: (current utilization by zip code x annual zip code specific population growth rates x percent volume shifted from Novant's Forsyth County facilities) + (other immigration, which is 10% of total surgical cases).
- Regarding current utilization, on page 91, the applicants report that 4,979 surgical cases were performed on residents of the proposed service area in Novant's Forsyth County facilities during CY 2006. Novant's Forsyth County facilities include: FMC, MPH and Hawthorne Surgical Center (HSC). HSC is a separately licensed freestanding ambulatory surgical facility located on FMC's campus, directly across the street from MPH.
- The applicants assume that the number of surgical cases performed on residents of the proposed service area in Novant's Forsyth County facilities during CY 2006 will increase at the same rates as the population in each zip code is projected to increase. The applicants obtained zip code specific projected compound average growth rates (CAGR) from Claritas. The following table illustrates the CAGR for each zip code in the proposed service area, as reported by

the applicants in Section III.1, page 93, and Exhibit 5, Table 2.

ZIP CODE / COUNTY	PROJECTED CAGR BETWEEN 2006 AND 2014 OBTAINED FROM CLARITAS
27006 / Davie	2.8%
27028 / Davie	1.9%
27012 / Forsyth	1.3%
27023 / Forsyth	0.7%
Total	1.7%

- The following table illustrates the applicants' assumptions regarding the combined total number of residents of the proposed service area currently utilizing Novant's Forsyth County facilities (i.e., FMC, MPH and HSC) projected to shift to the proposed new facility, as reported by the applicants in Section III.1, page 93, and Exhibit 5, Table 23.

	% OF CURRENT NOVANT PATIENTS FROM THE PROPOSED SERVICE AREA PROJECTED TO SHIFT TO THE PROPOSED NEW FACILITY IN CLEMMONS	
	INPATIENTS	OUTPATIENTS
Year One	40.0%	75.0%
Year Two	45.0%	80.0%
Year Three	50.0%	85.0%

The following table illustrates the current number of outpatient surgical cases performed at MPH, FMC and HSC and the number of outpatient surgical cases to be shifted from MPH, FMC and HSC during the third operating year of the proposed new facility in Clemmons

	FY 2007 Outpatient Surgical Cases	
MPH	Total # of outpatient surgical cases performed between 7/1/06 and 6/30/07	10,396
	# of outpatient surgical cases performed on residents of proposed service area	1,566
	% of total # of outpatient surgical cases performed on residents of proposed service area	15.1%
	% of outpatient surgical cases performed on residents of proposed service area to be shifted to Clemmons in Year Three	90%
	# of surgical cases to be shifted to the new facility in Clemmons	1,410
FMC	Total # of outpatient surgical cases performed between 7/1/06 and 6/30/07	6,190
	# of outpatient surgical cases performed on residents of proposed service area	836
	% of total # of outpatient surgical cases performed on residents of proposed service area	13.5%
	% of outpatient surgical cases performed on residents of proposed service area to be shifted to Clemmons in Year Three	80%
	# of surgical cases to be shifted to the new facility in Clemmons	662
HSC	Total # of outpatient surgical cases performed between 7/1/06 and 6/30/07	6,803
	# of outpatient surgical cases performed on residents of proposed service area	1,072
	% of total # of outpatient surgical cases performed on residents of proposed service area	15.8%
	% of outpatient surgical cases performed on residents of proposed service area to be shifted to Clemmons in Year Three	85%
	# of surgical cases to be shifted to the new facility in Clemmons	911

Regarding the assumptions in the tables above, in Section III.1, pages 93-94, the applicants state

> *"Based upon an analysis of the last twelve months of surgical inpatient data, over half of all inpatient surgical procedures from the proposed service area are non-obstetric, low acuity cases, as reflected in Exhibit 5, Table 23. Therefore, MPH assumed that 50% of inpatient surgery will shift from the existing Novant facilities to MPH-Clemmons. Outpatient surgery market volume shift is projected at 85%. This assumes a volume shift of 90% from MPH, 85% from HSC and 80% from FMC as reflected in Exhibit 5, Table 23.*
>
> - *Surgical scheduling for all NTR surgical facilities is centralized and surgical administration works with physicians and patients to maximize utilization of surgical resources.*
> - *MPH-Clemmons is closer to all areas of each of the five zip codes than existing NHTR Winston Salem facilities as reflected in Exhibit 5, Table 1 and Map 5;*
> - *There currently are four NMG-Forsyth employed practices in the defined service area: Medical Associates of Davie/Mocksville-27028 (5 MDs, 3 extenders), Clemmons Family Practice/Clemmons-*

27012 (3 MDs, 1 extender), Family Medical Associates of Lewisville / Lewisville-27023 (5 MDs), and West Forsyth Family Medicine/Clemmons-27012 (1 MD, 2 extenders); a total of 20 medical providers.

- *These established physician practices in the market have existing doctor-patient relationships and patient visits to these physician groups grew 14% from 2005 to 2006 and are on target to grow at a similar rate from 2006 to 2007 as reflected in Exhibit 5, Table 17;*
- *Additional physician offices with easier access will be developed in the future on the MPH-Clemmons campus;*
- *Congestion and traffic on I-40 into Winston Salem will increase;*
- *MPH-Clemmons offers a choice for surgical services closer to home;*
- *The proposed location of MPH-Clemmons adjacent to I-40 and Highway 421 will result in ease of access to the existing population in the defined zip code service area;*
- *Some patients will continue to seek care at other existing surgical facilities; therefore 100% of the demand for services in the five zip codes will not shift to MPH-Clemmons."*

Seven Dedicated Outpatient Operating Rooms – In Section III.1, page 97, and Exhibit 5, Table 25, the applicants provide projected utilization for the seven dedicated outpatient ORs to remain on MPH's Winston-Salem campus, as illustrated in the following table.

YEAR	# OF OUTPATIENT SURGICAL CASES	# OF DEDICATED OUTPATIENT ORS	AVERAGE # OF CASES /OR / DAY
7/1/11 – 6/30/12 (projected) (Year One)	8,638	7	4.75
7/1/12 – 6/30/13 (projected) (Year Two)	8,730	7	4.80
7/1/13 – 6/30/14 (projected) (Year Three)	8,822	7	4.85

As shown in the above table, in Year Three, the applicants project that 8,822 outpatient surgical cases will be performed in the seven dedicated outpatient ORs at MPH's Winston-Salem campus, which is an average of 4.85 surgical cases per OR per day. The following is a description of and discussion regarding the applicants'

methodology and assumptions used to project utilization of the seven dedicated outpatient ORs remaining on the Winston-Salem campus. See Section III.1, pages 96-98.

- The applicants state that the number of projected ambulatory surgical cases was calculated as follows: current adjusted MPH utilization by county of residence x annual county specific population growth rates.
- Regarding "current adjusted MPH utilization," in Section IV.2, page 125, and Exhibit 5, Tables 21 and 23, the applicants report that 10,396 outpatient surgical cases were performed at MPH between July 1, 2006 and June 30, 2007. In Section III.1, page 96, the applicants assume that 2,259 outpatient surgical cases performed at MPH during FY 2007 will shift to either the Kernersville campus of FMC or the proposed new facility in Clemmons because those facilities are closer to their home. Thus, "current adjusted MPH utilization" remaining at the Winston-Salem campus equals 8,137 outpatient surgical cases [10,396 – 2,259 = 8,137] performed in FY 2007. These outpatients do not reside in the proposed service area for the new facility in Clemmons.
- The applicants assume FY 2007 adjusted outpatient surgical cases by county of residence will increase at the same rate the county population is projected to increase. The applicants obtained projected growth rates for each county from the N.C. Office of State Demographics.

The applicants adequately demonstrate that projected utilization of the five shared ORs at the proposed new facility in Clemmons and seven dedicated outpatient ORs on the Winston-Salem campus is based on reasonable and supported assumptions. Therefore, the applicants adequately demonstrate the need the patients served at Novant Health Triad Region facilities have for five shared ORs in Clemmons.

Emergency Department – MPH does not currently have an emergency department. The applicants state that 85% of the residents of the proposed service area that currently utilize the emergency department at FMC are expected to shift to the emergency department at the new facility in Clemmons. In Section III.1, page 105, the applicants provide the projected number of emergency room visits for the proposed new facility in Clemmons

during the first three operating years, as illustrated in the following table.

OPERATING YEAR	DESCRIPTION/	
7/1/11 – 6/30/12 (projected) (Year One)	Population of proposed service area	81,332
	Projected Use Rate per 1,000 population	43.6
	Total # of Projected Emergency Room Visits at any facility	35,461
	Projected Visits to Emergency Department at MPH-Clemmons campus	9,808
	Projected Market Share (MPH projected ED visits / Total estimated ED visits at any facility)	27.7%
	10% immigration	1,090
	Total # of Emergency Room Visits at MPH-Clemmons campus	10,898
7/1/12 – 6/30/13 (projected) (Year Two)	Population of proposed service area	82,747
	Projected Use Rate per 1,000 population	43.6
	Total # of Projected Emergency Room Visits at any facility	36,078
	Projected Visits to Emergency Department at MPH-Clemmons campus	12,117
	Projected Market Share (MPH projected ED visits / Total estimated ED visits at any facility)	33.6%
	10% immigration	1,346
	Total # of Emergency Room Visits at MPH-Clemmons campus	13,464
7/1/13 – 6/30/14 (projected) (Year Three)	Population of proposed service area	84,190
	Projected Use Rate per 1,000 population	43.6
	Total # of Projected Emergency Room Visits at any facility	36,707
	Projected Visits to Emergency Department at MPH-Clemmons campus	14,505
	Projected Market Share (MPH projected ED visits / Total estimated ED visits at any facility)	39.5%
	10% immigration	1,612
	Total # of Emergency Room Visits at MPH-Clemmons campus	16,116

As shown in the above table, in Year Three, the applicants project a total of 16,116 emergency room visits at the proposed new facility in Clemmons. The following is a description of and discussion regarding the applicants' methodology and assumptions used to project emergency room visits. See Section III.1, pages 101-105.

- The applicants state that projected emergency room visits are calculated as follows: (service area population by zip code x the N.C. emergency room use rate per 1,000 population x projected market share for the new facility in Clemmons) + (other immigration, which is 10% of total emergency room visits).
- The applicants obtained the 2005 North Carolina emergency room use rate per 1,000 population (438.0) from the American Hospital Association Annual Survey.
- The applicant's calculated FMC's current market share of total estimated emergency room visits by residents of the proposed service area as follows: the total number of emergency room visits at FMC by residents of the proposed

service area (9,433) was divided by the total estimated number of emergency room visits (32,628). Thus, Novant's current market share is 28.9% [9,433 / 32,628 = 0.289].

- The applicants assume that 85% of the residents of the proposed service area currently using the emergency department at FMC will shift to the proposed new facility in Clemmons [2,106 patients x 85% = 1,790]. The applicants also assume that the market share for zip code areas 27006 (Advance) and 27012 (Clemmons) will increase 30% by the third operating year while the market share for the other zip code areas will remain unchanged. On page 103, the applicants state

    - *"MPH currently does not provide emergency services. The new hospital will bring a new emergency service to a growing population;*
    - *As a community hospital patients will avoid the confusion and wait times associated with large trauma centers.*
    - *MPH-Clemmons is closer to areas of each of the five zip codes than existing NHTR Winston Salem facilities as reflected in Exhibit 5, Table 4 and Map 7 resulting in faster travel time for emergency services ;*
    - *The proposed location of MPH-Clemmons adjacent to I-40 and Highway 421 will result in ease of access to the existing population in the defined zip code service area;*
    - *Some patients will choose to seek emergency care at other NHTR Winston Salem hospitals, and the protocols for emergency care defined by FMC with area ambulance providers will result in bypassing MPH-Clemmons emergency department less than 5% of the time, therefore 100% of the demand for services in the five zip codes will not shift to MPH-Clemmons."*

- The applicants assume the capacity of one emergency treatment room is 1,333 visits per year based on the American College of Emergency Physicians recommendations. Thus, the applicants calculate that,

based on this assumption, 12 treatment rooms are needed in Year Three [16,116 / 1,333 = 12.1].

MPH does not currently operate an emergency department. In Section III.1, pages 77-79, the applicants state

"The existing high utilization at the FMC ED and projected growth in emergency visits in Forsyth County and the surrounding areas is expected to continue. The CDC's National Center for Health Statistics Report reported that in 2005 the ED utilization rate was 39.6 visits per 100 persons nationally, which represented an increase of 31% since 1995. And during the same timeframe, the number of hospital EDs in the U.S. has decreased by 9.1%. Further, emergency room utilization varied by geographic location. In the South, visit rates were even higher, at 41.7 visits per 100 persons. North Carolina emergency room visits per 100 population in 2005 was estimated at 43.6 visits. In addition, the emergency department visit use rate is expected to continue to increase as much as 13 percent growth between 2002 and 2012, related to population increase, uninsured ED utilization, and other variables. The growing ED use rate and the fact that the NC ED use rate is higher than the national norm contribute to growing demand for services in emergency departments in Forsyth and surrounding counties.

...

... Approval and development of FMC-Kernersville and MPH-Clemmons will result in a significant shift in emergency room utilization from the main FMC campus on Hawthorne Road to the two new facilities."

The following table illustrates projected utilization of FMC's emergency treatment rooms through the third operating year of the proposed new facility in Clemmons, as reported by the applicants in Section III.1, page 78.

CALENDAR YEAR	# OF ER VISITS	% INCREASE	TOTAL # OF TREATMENT ROOMS (1)	AVERAGE # OF VISITS PER TREATMENT ROOM
2007 (annualized)	95,874	NA	59	1,625.0
2008 (projected)	98,642	2.9%	59	1,671.9
2009 (projected)	101,249	2.6%	73	1,387.0
2010 (projected)	103,780	2.5%	73	1,421.6
2011 (projected)	106,404	2.5%	73	1,457.6
2012 (projected)	109,079	2.5%	73	1,494.2
2013 (projected)	111,806	2.5%	73	1,531.6
2014 (projected)	114,584	2.5%	73	1,569.6

(1) The existing FMC emergency department in Winston-Salem has 59 treatment rooms. When FMC-Kernersville is completed sometime in 2009, FMC's two emergency departments will have a total of 73 treatment rooms [59 existing in Winston-Salem + 14 new in Kernersville = 73].

Thus, the applicants project that the proposed emergency department at the new facility in Clemmons will serve patients currently served by North Carolina Baptist Hospital and DCH, based on the following findings.

- There are two existing emergency departments located in Forsyth County (FMC and North Carolina Baptist Hospital). MPH does not currently offer emergency department services. FMC currently serves only 2,106 emergency department patients from the proposed service area.
- There is one existing emergency department located in Davie County (DCH).
- The applicants project a 30% market share increase in emergency department visits by Year Three for zip code areas 27006 (Advance in Davie County) and 27012 (Clemmons in Forsyth County).
- In Section III.1, page 102, the applicants report that 2,106 residents of the proposed service area were treated at the FMC emergency room in Winston-Salem between July 1, 2006 and June 30, 2007. The applicants project that 85% of those patients would shift to the proposed new facility in Clemmons, which would be 1,790 patients [2,106 x 0.85 = 1,790.1]. Assuming the same rate of growth used by the applicants to project utilization of the FMC emergency rooms, 2,138 residents of the proposed service area would be expected to shift to the new facility in Clemmons [1,790

x 1.029 x 1.026 x 1.025^5 = 2,138] in 2014. Thus, based on total emergency department visits projected for MPH-Clemmons, only about 13% of the patients to be served in Clemmons are shifting from FMC [2,138 / 16,116 = 0.132]. Therefore, the majority of emergency department patients projected to be served at MPH-Clemmons are served at other existing facilities.

In summary, the applicants failed to demonstrate that the existing emergency departments at North Carolina Baptist Hospital and DCH lack sufficient capacity to meet the needs of the population proposed to be served. Therefore, the applicants did not adequately demonstrate that persons they project to serve need the proposed emergency department services.

Ancillary Services – MPH currently provides limited radiology (one fixed X-ray unit), laboratory and pharmacy services, which are provided to inpatient and outpatient surgical patients. MPH does not currently provide CT scanner, ultrasound, mammography, nuclear medicine, respiratory therapy, physical therapy or speech therapy services to either inpatients or outpatients. In Section III.1, page 107, the applicants provide projected utilization for the following ancillary services for the first three operating years of the proposed new facility in Clemmons, as illustrated in the following table. The table also illustrates the applicants' assumptions regarding projected utilization.

Ancillary Service	Projected # of Scans, Tests, Etc.			Assumptions
	Year One	Year Two	Year Three	
CT Scanner				
Inpatient	1,805	1,978	2,156	# of inpatient CT scans = 63.6% of acute care discharges
Outpatient & ED	5,312	6,565	7,860	# of outpatient CT scans = 24.2% of outpatient & ER visits
Total	7,118	8,543	10,016	
Nuclear Medicine				
Inpatient	463	507	553	# of inpatient NM scans = 16.3% of acute care discharges
Outpatient & ED	843	1,042	1,248	# of outpatient NM scans = 3.8% of outpatient & ER visits
Total	1,306	1,549	1,801	
Mammograms				
Inpatient	0	0	0	
Outpatient & ED	1,596	1,972	2,361	# of outpatient mammograms = 7.3% of outpatient & ER visits
Total	1,596	1,972	2,361	
X-Ray				
Inpatient	3,599	3,944	4,299	# of inpatient x-rays = 126.8% of acute care discharges
Outpatient & ED	7,164	8,853	10,599	# of outpatient x-rays = 32.6% of outpatient & ER visits
Total	10,763	12,796	14,898	
Ultrasound				
Inpatient	539	591	644	# of inpatient ultrasounds = 19% of acute care discharges
Outpatient & ED	1,977	2,443	2,926	#of outpatient ultrasounds = 9% of outpatient & ER visits
Total	2,517	3,035	3,570	
Pharmacy				
Inpatient	225,076	246,606	268,830	# of inpatient pharmacy units = 79.3% of acute care discharges
Outpatient & ED	66,792	82,535	98,817	#of outpatient pharmacy units = 3% of outpatient & ER visits
Total	291,868	329,141	367,648	
Laboratory				
Inpatient	49,348	54,069	58,941	# of inpatient lab tests = 17.4% of acute care discharges
Outpatient & ED	29,881	36,924	44,208	#of outpatient lab tests = 1.4% of outpatient & ER visits
Total	79,229	90,992	103,149	

On page 106, the applicants state that the ratios used to project ancillary service utilization are the average ratios for Thomasville Medical Center, Presbyterian Hospital Matthews and Presbyterian Hospital Huntersville for FFY 2006.

The applicants project a combined total of outpatient visits (i.e., encounters) for CT scanner, nuclear medicine, mammograms, x-ray, ultrasound, pharmacy, laboratory, respiratory therapy, physical therapy and speech therapy services to be provided at MPH-Clemmons during the first three operating years, as illustrated in the following table. [Note: the number of outpatient visits is not the sum of the numbers of procedures, laboratory tests and pharmacy units listed for "Outpatient & ED" because the above numbers combine emergency department visits with the outpatients and a patient could have more than one procedure or test during a single visit or encounter.]

OPERATING YEAR	TOTAL # OF OUTPATIENT VISITS OR ENCOUNTERS
7/1/11 – 6/30/12 (projected) (Year One)	11,073
7/1/12 – 6/30/13 (projected) (Year Two)	13,686
7/1/13 – 6/30/14 (projected) (Year Three)	16,390

Source: Section III.1, page 101.

As shown in the above table, in Year Three, the applicants project a total of 16,390 outpatient visits or encounters at the proposed new facility, excluding emergency department visits. The following is a description of and discussion regarding the applicants' methodology and assumptions used to project the outpatient visits or encounters in the above table. See Section III.1, pages 98-101.

- The applicants state that projected outpatient visits are calculated as follows: (service area population by zip code x the N.C. hospital outpatient use rate per 1,000 population x market share) + (other immigration, which is 10% of total outpatient visits).
- The applicants obtained the 2005 North Carolina hospital outpatient use rate per 1,000 population (150.1) from the American Hospital Association Annual Survey.
- The applicant's calculated Novant's current market share of total hospital outpatient visits by residents of the proposed service area as follows: the total number of outpatient visits at Novant's Forsyth County facilities by residents of the proposed service area (8,805) was divided by the total estimated number of hospital outpatient visits for this same area (112,323). Thus, Novant's current market share of the estimated outpatient visits in the proposed service area is 7.8% [8,805 / 112,323 = 0.78].
- The applicants assume that 85% of the residents of the proposed service area currently using one of Novant's Forsyth County facilities for outpatient visits will shift to the proposed new facility in Clemmons. The applicants also assume that the market share for zip code areas 27006 (Advance) and 27012 (Clemmons) will increase 10% by the third operating year while the market share for the other zip code areas will remain unchanged. On pages 99-100, the applicants state

- *"MPH currently provides only outpatient surgery. The new hospital will be a community hospital and will have a full range of outpatient services including imaging, laboratory, pharmacy, etc., in addition to surgical services. There is currently no hospital in the proposed service area.*
- *Much of FMC's outpatient imaging volume is referred to other NHTR freestanding imaging facilities, such as Salem MRI Center and The Breast Center; therefore, this volume was not included in the calculation of current outpatient visit market share.*
- *MPH-Clemmons is closer to areas of each of the five zip codes than existing NHTR Winston Salem facilities as reflected in Exhibit 5, Table 4 and Map 7;*
- *New physician offices with easier access will be developed in the future on the MPH-Clemmons campus;*
- *Congestion and traffic on I-40 into Winston Salem will increase;*
- *MPH-Clemmons offers a choice for outpatient services closer to home;*
- *The proposed location of MPH-Clemmons adjacent to I-40 and Highway 421 will result in ease of access to the existing population in the defined zip code service area;*
- *Interstate I-40 will result in population growth in the defined zip code service area;*
- *Some patients will continue to seek care at other NHTR Winston Salem hospitals, therefore 100% of the demand for services in the five zip codes will not shift to MPH-Clemmons."*

Thus, the majority of the outpatients proposed to be served at the new facility in Clemmons utilize outpatient services currently provided at FMC. However, the applicants do not adequately demonstrate that FMC lacks sufficient capacity to meet the needs of the hospital outpatients to be shifted from FMC to the proposed new facility in Clemmons. Further, the applicants do not provide the basis for their assumptions regarding the need for the outpatient therapy services to be provided at MPH-Clemmons. Therefore, the

applicants did not adequately demonstrate that all of the proposed outpatient services are needed in Clemmons.

Further, the applicants do not adequately demonstrate the need to acquire the proposed CT scanner. Pursuant to 10A NCAC 14C .2301(4), *"'Computed tomography (CT) service area' means a geographical area defined by the applicant, which has boundaries that are not farther than 40 road miles from the facility."* In Section II.8, page 54, the applicants describe the proposed CT scanner service area as follows:

> *"The proposed Service Area includes five Zip Codes, all of which are within 40 miles of the proposed MPH-Clemmons. Two Zip Codes in Forsyth County: 27012 and 27023, and three Zip Codes in Davie County: 27006, 27014, and 27028."*

In Section II.8, page 55, the applicants state that there is only one existing CT scanner in the proposed service area, which is located at DCH. However, the applicants do not provide the number of HECT units performed by the existing CT scanner at DCH during the 12 months prior to submitting the application. Instead, they state

> *"Davie County Hospital is designated as a critical access hospital pursuant to 42 CFR Part 485, Subpart F, and by the North Carolina Department of Health and Human Services, Office of Research, Demonstrations and Rural Health Development (NC DHHS). ...*
>
> *On the basis of specialized facilities and services, a hospital designed as a Critical Access Hospital is licensed by the State of North Carolina differently than a hospital classified as a "General Acute Care Hospital. Critical Access Hospitals are subject to supplemental licensure rules in North Carolina, which contain less stringent requirements for inpatient and emergency services, which are not applicable for General Acute Care Hospitals. Critical Access Hospitals are permitted by the CAH regulations to staff only up to 25 beds, so their census will be lower than a larger hospital. In addition, all of Davie County Hospital's acute care beds also are designated as 'swing beds.' This program allows DCH to place either*

acute or SNF level patients in a designated swing bed. It is reasonable to assume that SNF level patients will typically require fewer diagnostic CT services than acute inpatients. As a result, it is not appropriate to regard the CT scanner at Davie County Hospital as equivalent to the CT scanners owned and operated by General Acute Care Hospitals or freestanding CT providers and for its utilization to be consistent with those CT scanners. Therefore, utilization of the CT unit at Davie County Hospital should not be at issue in this review.

The applicant believes that because the scope of services at MPH-Clemmons that includes an Emergency Department and ICU, it is imperative that patients and physicians at MPH-Clemmons have on-site access to CT diagnostic services 24 hours per day, 7 days per week. The MPH-Clemmons staffing for the CT scanner as set forth in Section VII of the application is at a level that assumes the availability of the MPH-Clemmons CT scanner 24 hours per day based on a recommendation from NHTR Director of Radiology Services. See the articles in Exhibit 7. In the alternative, the Agency could choose to condition the applicant on CT scanner services and require that an existing Novant Health CT scanner be relocated to MPH-Clemmons. This type of condition was recently utilized by the Agency in the Presbyterian Hospital Mint Hill, Project I.D. # F-7648-06. See the findings at pages 42 and 80."

However, pursuant to 10A NCAC 14C .2303(2), the applicants are required to demonstrate that the existing CT scanner at DCH performed at least 5,100 HECT units during the 12 months prior to submittal of the application. The rule does not exclude CT scanners operated at critical access hospitals. Thus, the applicants did not adequately demonstrate the need for the proposed CT scanner in addition to the existing CT scanner in use at DCH.

Further, in Section III.1, page 83, the applicants state

"While not part of the defined service area, MPH-Clemmons recognizes that patients from other North Carolina counties may choose to travel across service areas to receive services at MPH-Clemmons. As a result, 10% of the total projected utilization in each of the project

years has been allocated to the category of 'Other Inmigration.' Other inmigration is expected to come from surrounding zip codes in Forsyth County and the surrounding counties, Iredell and Yadkin."

As shown in the above table, projected utilization of the proposed CT scanner is based on projected utilization of the acute care beds. Thus, the service area for the proposed CT scanner is actually the same as the service area for the acute care beds. Additionally, the service area for the emergency department is also the same as the service area for the acute care beds. Consequently, the CT scanner service area includes *"surrounding zip codes in Forsyth County and the surrounding counties, Iredell and Yadkin."* The following table identifies the existing CT scanners located in hospitals in Davie, Yadkin, Iredell and Forsyth counties.

FACILITY	COUNTY	# OF CT SCANNERS	# OF CT SCANS PERFORMED DURING FY 2006[1]
Hoots Memorial Hospital	Yadkin	1	747
Davie County Hospital	Davie	1	1,939
Davis Regional Medical Center	Iredell	1	7,522
Iredell Memorial Hospital	Iredell	1	15,965
Lake Norman Regional Medical Center	Iredell	2	17,269
Forsyth Medical Center	Forsyth	4	54,837
N.C. Baptist Hospital	Forsyth	9	77,311
Winston-Salem Health Care	Forsyth	NA	11,749

Source: 2007 Hospital License Renewal Applications, excluding Winston-Salem Health Care, an existing diagnostic center owned by Novant but not licensed by the State.
[1] Utilization for Winston-Salem Health Care is for CY 2006.

As shown in the above table, the existing CT scanner at Hoots Memorial Hospital in Yadkin County performed only 747 CT scans during FY 2006. Further, the existing CT scanner at DCH in Davie County performed only 1,939 CT scans during FY 2006. The applicants did not demonstrate that each of the existing CT scanners located in the proposed CT scanner service area performed at least 5,100 HECT units in the 12 month period prior to submittal of the application, as required by 10A NCAC 14C .2303(2). Further, the applicants did not provide projected utilization for any of the existing CT scanners in the proposed CT scanner service area. Therefore, the applicants did not demonstrate that each existing CT scanner in the service area is projected to perform 5,100 HECT units during the third operating year of the

proposed CT scanner as required by 10A NCAC 14C .2303(3). Consequently, the applicants did not adequately demonstrate the need to acquire the proposed CT scanner.

In summary, the applicants did not adequately demonstrate the need for the following proposed services:

- 4 new intensive care unit beds;
- 6 new unlicensed observation beds;
- new outpatient services, including CT, x-ray, mammography, ultrasound, nuclear medicine, laboratory, pharmacy, respiratory therapy, physical therapy and speech therapy;
- 12 new emergency department treatment rooms; and
- 1 new CT scanner.

Therefore, the application is nonconforming to this criterion.

DCH proposes to relocate Davie County Hospital from Mocksville to Bermuda Run. The following table compares the beds, medical equipment and services currently provided by DCH with those proposed to be offered in the replacement hospital. It should be noted that, according to its 2008 Hospital License Renewal Application, DCH is currently *"approved for up to 49"* swing beds. Chapter 5 of the 2007 SMFP states on page 35, *"Section 1883 of the Social Security Act provides that certain small rural hospitals may use their inpatient facilities to furnish skilled nursing facility ... services to Medicare and Medicaid beneficiaries."* One of the requirements for the swing bed program is that the hospital cannot be located in an area designated as "urbanized" by the most recent U.S. Census. While Mocksville is not an urbanized area according to the 2000 U.S. Census, the proposed site in Bermuda Run is an urbanized area. Thus, the hospital would no longer qualify for swing beds at the proposed site.

BEDS/EQUIPMENT/SERVICES	CURRENT	PROPOSED	INCREASE (DECREASE)
Licensed Acute Care Beds [1]			
Medical-Surgical	81	39	(42)
Obstetrical [2]	0	6	6
Total Acute Care Beds	81	45	(36)
Level I bassinets (unlicensed)	0	4	4
Long-Term Care Hospital (LTCH) Beds	0	38	38
Unlicensed Observation Beds [3]	2	10	8
Gastrointestinal (GI) Endoscopy Rooms	1	1	0
Shared Operating Rooms (ORs)	2	3	1
Minor Procedure Rooms [4]	0	1	1
CT scanner	1	1	0
Fixed Radiographic & Fluoroscopic (R/F) X-ray units [5]	2	3	1
Ultrasound (US) units	NA	2	NA
Mammography units [6]	1	1	0
Emergency Services [7]	9 treatment rooms	16 treatment rooms	7 treatment rooms
Cardiopulmonary Services	yes	yes	
Laboratory Services	yes	yes	
Pharmacy Services	yes	yes	
Physical Therapy Services	yes	yes	

(1) Although currently licensed for a total of 81 general acute care beds, DCH is designated as a critical access hospital and operates a maximum of only 25 general acute care beds.

(2) In Section II.1, page 16, the applicants state that the replacement hospital will have four obstetrical beds. However, in Section II.1, page 20, the applicants state that the replacement hospital will have six obstetrical beds (four postpartum and two antepartum). The design schematic provided in Exhibit 4 shows six obstetrical beds (four postpartum and two antepartum).

(3) In Section II.1, page 16, the applicants state that DCH has two unlicensed observation beds. However, in its 2008 Hospital License Renewal Application, which was filed with the Division of Health Service Regulation shortly after the certificate of need application was submitted, DCH reports that it does not have any unlicensed observation beds.

(4) In Section II.1, page 17, the applicants state that DCH does not have a minor procedure room. However, in its 2008 Hospital License Renewal Application, DCH reports that it has one minor procedure room.

(5) The applicants do not provide the current number of fixed R/F X-ray units in the certificate of need application. However, in its 2008 Hospital License Renewal Application, DCH reports that it has two fixed R/F X-ray units.

(6) The applicants do not provide the current number of mammography units in the certificate of need application. However, in its 2008 Hospital License Renewal Application, DCH reports that it has one mammography unit.

(7) The applicants do not provide the current number of treatment rooms in the Emergency Room in the certificate of need application. However, in its 2008 Hospital License Renewal Application, DCH reports that it nine treatment rooms in the Emergency Room.

As shown in the above table, new and expanded services to be provided at the proposed replacement hospital include:

- 6 new obstetrical beds
- 4 new unlicensed Level I bassinets
- 38 new LTCH beds
- 8 additional unlicensed observation beds per narrative in application. [Note: According to its 2008 Hospital License Renewal Application (LRA), DCH does not report having

any unlicensed observation beds. Thus, the new facility will have a total of 10 new unlicensed observation beds, based on information reported in the LRA.]

- one additional shared OR
- one additional minor procedure room per narrative in application. [Note: According to its 2008 LRA, DCH is already licensed for one minor procedure room. The new facility will have no more than one minor procedure room. Therefore, based on information reported in the LRA, the applicants do not propose an increase in the number of minor procedure rooms.]
- 7 additional Emergency Room treatment rooms
- one additional R/F X-ray unit

Because the applicants did not provide the current number of ultrasound units in the certificate of need application, the analyst is unable to determine if the proposal would result in a change in the number of ultrasound units.

Population to be Served

The following table illustrates the current patient origin for acute care services provided by DCH during FY 2006, as reported by the applicants in Exhibit 23, which consists of a copy of the acute care patient origin table from DCH's 2007 Hospital License Renewal Application.

COUNTY	# OF ADMISSIONS	% OF TOTAL ADMISSIONS
Davie	432	92.7%
Rowan	7	1.5%
Guilford	5	1.1%
Iredell	3	0.6%
Yadkin	3	0.6%
Davidson	2	0.4%
Forsyth	1	0.2%
Wilkes	1	0.2%
Tennessee	1	0.2%
Virginia	7	1.5%
Other States	4	0.9%
Total	466	100.0%

As shown in the above table, during FY 2006, 92.7% of DCH's acute care patients were residents of Davie County, 0.6% were residents of Yadkin County and 0.2% were residents of Forsyth

County. In Section III.5(a), page 71, the applicants state *"The geographic boundaries of the proposed project are the same as those historically served by DCH and will include the communities of Clemmons and Lewisville."* Clemmons and Lewisville are located in western Forsyth County. In Section III.1, page 44, the applicants define the proposed service area as follows.

COUNTY	ZIP CODE AREAS	MUNICIPALITY
Davie	27006	(1)
	27014	Cooleemee
	27028	Mocksville
Forsyth	27012	Clemmons
	27023	Lewisville
Yadkin	27055	Yadkinville

(1) This is the zip code for Advance, which is not a municipality.

As shown in the above table, the projected service area for the proposed replacement hospital consists of six zip code areas. On page 44, the applicants state they *"assumed no immigration beyond the defined service area."* The following table illustrates projected patient origin during the second operating year for the proposed replacement hospital, as reported by the applicants in Section III.5(c), page 72.

COUNTY	# OF DISCHARGES	% OF TOTAL DISCHARGES
Davie	1,429	66.6%
Forsyth	590	27.5%
Yadkin	128	6.0%
Total (1)	2,147	100.1%

(1) Does not equal 100% due to rounding.

As shown in the above table, during the second operating year of the proposed replacement hospital, the applicants project that 66.6% of acute care discharges will be residents of Davie County, 27.7% will be residents of Forsyth County and 6.0% will be residents of Yadkin County. The applicants state that the proposed geographic service area is the same as the current service area, but project a substantial increase in the number of inpatients who are residents of Forsyth and Yadkin counties. The applicants adequately identified the population proposed to be served.

Need for Replacement Facility

In Section III.1, page 36, the applicants state

> *"The current facility, which operates as a designated critical access hospital, is no longer conducive to the rendering of cutting-edge health care services. Davie County is thriving economically and experiencing significant population growth. The County is in need of a state-of-the-art health care facility in order to meet the health care needs of its residents, to aid in physician recruitment to the area, and to ensure that the County is well-positioned for further economic growth. Furthermore, the current facility is disadvantaged by its location. The hospital is located in Mocksville; however, the highest concentration of residents now lives in the Advance/Hillsdale area. Residents of this population center have exhibited an unwillingness to drive to Mocksville for health care services and have therefore been consuming services in Forsyth County. The County is in need of a hospital that is located within the population center, which will create an opportunity for the majority of health care needs to be met within the boundaries of Davie County."*

In Section III.1, pages 38-41, the applicants state

> *"The Davie County Hospital was originally constructed in 1956. Similar to most Hill-Burton hospitals constructed during that era, DCEHC-DCH is showing tremendous signs of wear and tear. In addition to an overall lack of aesthetic appeal, the hospital is plagued with an old design that is conducive neither to the modern health care environment nor building code and regulatory compliance. The specific challenges associated with the outmoded facility are described below:*
>
> ...
>
> *The current Hill-Burton design of DCEHC-DCH has a strictly inpatient focus. Other than the emergency department, there is minimal space available for*

ambulatory care. This puts the hospital at a distinct disadvantage, as the hospital industry has been experiencing a dramatic shift to outpatient care in the past 20 to 25 years. The outpatient services that are currently offered at DCEHC-DCH are scattered inconveniently about the facility and integrated into inpatient services. This design is inconvenient for patients, who find it much easier to access outpatient services that are consolidated into one area. A new facility will allow DCEHC-DCH to centralize all ambulatory services and improve patient access.

...

The Americans with Disabilities Act of 1990 provides guidelines that public facilities must meet in order to afford an accessible environment for ADA [sic] *individuals with disabilities. The current facility is noncompliant with these regulations and retrofitting for ADA compliance is not feasible without major renovation, including the consolidation of rooms to create adequate space. Examples of noncompliance include inadequate public toilets (turning radius, grab bars, seat heights, etc.), improper hardware on doors, and improper signage (height requirements, Braille, etc.). North Carolina DFS and JCAHO have not cited the facility for noncompliance due to the 'grandfather clause.' Should DCEHC-DCH have to conduct renovations of existing space, however, current accessibility standards will have to be met at that time. A new facility will allow DCEHC-DCH to design a health care environment that will be convenient and accessible to all individuals, including those with disabilities.*

...

American hospitals are serving a patient population that is sicker and demands a higher level of care. ... The current patient room [sic] *at DCH is not designed to accommodate this level of care. A new facility will allow DCEHC to design a health care environment that exceeds the American Institute of Architects' patient room guidelines, creating an optimal space for patients to heal and staff to work.*

...

Just as the DCEHC-DCH patient rooms are ill-equipped to accommodate the intense level of health care often required for today's patients, they are also ill-designed to accommodate a patient's family and visitors. In today's consumer-driven marketplace, patients are demanding that hospitals be designed with their needs in mind, which includes their need to have their families participate in the healing process. Design elements incorporated into the new hospital include a 'family zone' that provides sleep accommodations for family members, while allowing staff to function efficiently in their own distinct work zone. A new facility will allow DCEHC-DCH to design a health care environment that empowers patients and families to partner together to aid in the healing process.

...

The Health Insurance Portability and Accountability Act describes health care providers' responsibility to restrict access to and uses of protected health information. Although patient privacy is a chief concern for DCEHC-DCH today, the current facility impedes the hospital's ability to provide optimal patient privacy. For example, the design of the registration area allows for limited privacy as patients are required to provide personal information and respond to health-related questions. A new facility will allow DCEHC-DCH to design an environment that will provide superior patient privacy and assure HIPAA compliance.

...

An architectural firm completed a facility assessment of Davie County Hospital in January 2006. The findings indicated significant and costly improvements would be required to update the existing facilities to meet current building code and regulatory guidelines. Issues of concern included life and safety code compliance, ADA accessibility, HVAC, plumbing and electrical systems, and asbestos-containing materials. The existing structure is

incapable of housing 81 beds, and it would require significant renovation and displacement to various program and services to do so. [See Exhibit 7 for a copy of the 21 page facility assessment dated January 12, 2006.]

...

Due to each of the limitations listed above, DCEHC-DCH has struggled in years past to recruit physicians to the area and/or to encourage local physicians to admit patients to DCEHC-DCH. Just as patients demand a state-of-the-art health care facility with leading-edge technology, physicians desire the same environment in order to optimize their practice. A new facility will create leverage for DCEHC-DCH to recruit and hire new physicians to serve the Davie County community and surrounding areas.

...

The supply of health care manpower has been unable to meet a growing need for health care services in Davie County. The county currently has only 5.5 physicians per 10,000 residents. This ratio is extremely low compared to surrounding counties – 7.7 in Davidson, 10.8 in Rowan, and 18.6 in Iredell. There is particularly a deficiency of specialty physicians, at only 1.8 per 10,000 residents. Solucient predicts that 27 physicians will be needed to support the demand for health care in Davie County in 2009. Currently, there are approximately 17 physicians working in the county. There is a particular deficiency for cardiology, gastroenterology, obstetrical, gynecology, urology, ophthalmology and otolaryngology services. ... The growing prevalence of chronic diseases such as diabetes, heart disease and stroke, particularly among the aging population, are having a profound impact on the demand for inpatient services in our region. ... In addition, the Davie County Health Assessment completed in 2007 by The North Carolina Institute for Public Health surveyed over 230 residents and found that one of the community's most significant unmet needs of their community was a hospital, specifically that the County lacked a modern hospital in an accessible location and that more specialty services such as OB/GYN services were

needed to meet the growing market demand. Other health problems and concerns related specifically to the Davie County Hospital was that the current facility is outdated and unable to provide modern services and that many of the residents had to leave the county for needed services. Please see Exhibit 19 for the Davie County Health Assessment."

The applicants adequately demonstrate the need to replace the existing hospital. However, see discussion below regarding the need for all proposed project components.

Need for Project Components

Acute Care Beds – DCH is currently licensed for 81 general acute care beds. However, it currently operates no more than 25 general acute beds because of its designation as a critical access hospital. The proposed replacement hospital would be licensed for only 45 general acute care beds. [Note: The new facility would also have 38 long-term care hospital (LTCH) beds, which are discussed later in these findings.] Thus, the proposal would result in a reduction of 36 general acute care beds in the acute care bed inventory for Davie County [81 – 45 = 36]. Of the 45 general acute care beds to be located in the replacement facility, the applicants propose that 39 beds will be designated as medical/surgical beds and 6 as obstetrical beds. DCH does not currently provide obstetrical services. Further, DCH is not currently licensed for any intensive care unit beds, and none are proposed for the replacement hospital. Additionally, although DCH currently operates all its acute care beds as swing beds, the applicants do not project any nursing facility days of care to be provided in the new facility. Also, swing beds are not permitted in urbanized areas and the proposed site is located in an urbanized area. Based on these two factors, the Project Analyst assumes that none of the acute care beds in the new facility will be swing beds.

Medical/Surgical Beds – In Exhibit 25, the applicants provide historical utilization of the general acute care beds at DCH for the previous three fiscal years (FYs), as illustrated in the following table.

Attachment 15

North Carolina Department of Health and Human Services
Division of Health Service Regulation
Acute and Home Care Licensure and Certification Section
1205 Umstead Drive, 2712 Mail Service Center
Raleigh, North Carolina 27699-2712
Telephone: (919) 855-4620 Fax: (919) 715-3073

For Official Use Only
License # H0213 Medicare # 340028
Computer: 943057
PC _____ Date _____

License Fee: ~~$7,087.50~~ $8,762.50

2009
HOSPITAL LICENSE
RENEWAL APPLICATION

Legal Identity of Applicant: **Cumberland County Hospital System, Inc.**
(Full legal name of corporation, partnership, individual, or other legal entity owning the enterprise or service.)

Doing Business As
(d/b/a) name(s) under which the facility or services are advertised or presented to the public:

PRIMARY: **Cape Fear Valley Medical Center**
Other: Southeastern Regional Rehabilitation Center;
Other: _____

Facility Mailing Address: P O Box 2000
Fayetteville, NC 28302-2000

Facility Site Address: 1638 Owen Dr
Fayetteville, NC 28304
County: Cumberland
Telephone: (910)609-4000
Fax: (910)609-6160

Administrator/Director: MICHAEL ~~NIGOWSKI~~ Nagowski
Title: CEO
(Designated agent (individual) responsible to the governing body (owner) for the management of the licensed facility).

Chief Executive Officer: Michael Nagowski **Title:** CEO
(Designated agent (individual) responsible to the governing body (owner) for the management of the licensed facility)

Name of the person to contact for any questions regarding this form:

Name: Sandy Godwin **Telephone:** (910) 609-6852

E-Mail: stgodwin@capefearvalley.com

PAID
CK. NO. 456220 - 8,762.50
DATE 1-5-09

All responses should pertain to October 1, 2007 through September 30, 2008.

Type of Health Care Facilities under the Hospital License

List Name(s) of facilities:	Address:	Type of Business / Service:
Cape Fear Valley Medical Center	1638 Owen Drive Fayetteville, NC 28304	General IP + OP Services w/ Psych Detox
Southeastern Regional Rehabilitation Center	1638 Owen Drive Fayetteville, NC 28304	IP Rehab Services

Please attach a separate sheet for additional listings

Ownership Disclosure (Please fill in any blanks and make changes where necessary.)

1. What is the name of the legal entity with ownership responsibility and liability?

Owner: Cumberland County Hospital System, Inc.
Federal Employer ID# 56-0845796
Street/Box: P O Box 2000, 1638 Owen Dr
City: Fayetteville State: NC Zip: 28302-2000
Telephone: (910)609-6700 Fax: (910)609-6160
CEO: ~~Micha4el Nigonski,~~ CEO Michael Nagowski

Is your facility part of a Health System? [i.e., are there other hospitals, ambulatory surgical facilities, nursing homes, home health agencies, etc. owned by your hospital, a parent company or a related entity?]
Yes ✓ No

If 'Yes', name of Health System*: Cape Fear Valley Health System
* *(please attach a list of NC facilities that are part of your Health System)*
If 'Yes', name of CEO: Michael Nagowski

a. Legal entity is: ___ For Profit X Not For Profit

b. Legal entity is: X Corporation ___ LLP ___ Partnership
___ Proprietorship ___ LLC ___ Government Unit

c. Does the above entity (partnership, corporation, etc.) LEASE the building from which services are offered? X Yes ___ No

If "YES", name of building owner:
Per 2007 renewal no longer lease bldg.

2. Is the business operated under a management contract? ___Yes X No

If 'Yes', name and address of the management company.
Name: _____
Street/Box: _____
City: _____ State: _____ Zip: _____
Telephone: (___) _____

Ownership Disclosure *continued. . . .*

3. Vice President of Nursing and Patient Care Services: Linda Dietrich

4. Director of Planning: Sandy Godwin

Facility Data

A. Reporting Period All responses should pertain to the period **October 1, 2007 to September 30, 2008.**

B. General Information (Please fill in any blanks and make changes where necessary.)

a. Admissions to Licensed Acute Care Beds: **include responses to "a – q" on page 4; exclude responses to "2-9" on page 4; and exclude normal newborn bassinets.**	28,846	
b. Discharges from Licensed Acute Care Beds: **include responses to "a – q" on page 4; exclude responses to "2-9" on page 4; and exclude normal newborn bassinets.**	28,765	
c. Average Daily Census: **include responses to "a – q" on page 4; exclude responses to "2-9" on page 4; and exclude normal newborn bassinets.** (leap year)	395.0	
d. Was there a permanent change in the total number of licensed beds during the reporting period?	Yes: X	No:
If 'Yes', what is the current number of licensed beds?	641	
If 'Yes', please state reason(s) (such as additions, alterations, or conversions) which may have affected the change in bed complement:	46 transfer from HRSH 88 CONs 134 see p.4 details	
e. Observations: Number of patients in observation status and not admitted as inpatients, excluding Emergency Department patients. Note: observation patients who did not present via ED. Does not include patients who present via the ED and later placed into Observation.	9,149	

C. Designation and Accreditation

1. Are you a designated trauma center? ____ Yes (____ Designated Level #) ✓ No
2. Are you a critical access hospital (CAH)? ____ Yes ✓ No
3. Are you a long term care hospital (LTCH)? ____ Yes ✓ No
4. If this facility is accredited by the Joint Commission or AOA, specify the accrediting body JCAHO and indicate the date of the last survey 4 / 7 / 06.

D. Beds by Service (Inpatient – Do Not Include Observation Beds or Days of Care)

[Please provide a Beds by Service (p. 4) for each hospital campus (see G.S. 131E-176(2c))]

Please indicate below the number of beds usually assigned (set up and staffed for use) to each of the following services and the number of census inpatient days of care rendered in each unit. NOTE: If your facility has a designated unit(s) for chemical dependency treatment and/or detoxification, please complete the patient origin sheet pertaining to Psychiatric and Substance Abuse Services. If your facility has a Nursing Facility unit and/or Adult Care Bed unit please complete the supplemental packet for Skilled Nursing Facility beds.

Licensed Acute Care (provide details below) *Campus* _____	**Licensed Beds as of September 30, 2008**	**Staffed Beds as of September 30, 2008**	**Annual Census Inpt. Days of Care**
Intensive Care Units			
a. Burn *			*
b. Cardiac	10	10	3,463
c. Cardiovascular Surgery	11	11	3,287
d. Medical/Surgical	44	44	7,738
e. Neonatal Beds Level IV ** (Not Normal Newborn)	21	21	**7,671
f. Pediatric	5	5	1,143
g. Respiratory Pulmonary			
h. Other (List)			
Other Units			
i. Gynecology	36	36	10,041
j. Medical/Surgical ***	201	201	***63,450
k. Neonatal Level III ** (Not Normal Newborn)	23	23	** 6,519
l. Neonatal Level II ** (Not Normal Newborn)			**
m. Obstetric (including LDRP)	34	34	13,105
n. Oncology	39	39	13,810
o. Orthopedics	34	34	10,515
p. Pediatric	29	29	3,812
q. Other (List) Renovations in complete	44	0	
1. Total General Acute Care Beds/Days (a through q)	531 ~~397~~	487	144,554
2. Comprehensive In-Patient Rehabilitation	78	72	19,696
3. Inpatient Hospice	0		
4. Detoxification	0		
5. Substance Abuse / Chemical Dependency Treatment	4	~~0~~	
6. Psychiatry	28	26	4,525
7. Nursing Facility	0		
8. Adult Care Home	0		
9. Other	0		
10. Totals (1 through 9)	641 ~~507~~	585	168,775

* Please report only Census Days of Care of DRG's 504, 505, 506, 507, 508, 509, 510 and 511.
** Per C.O.N. rule definition. Refer to Section .1400 entitled Neonatal Services. (10A NCAC 14C)
*** Exclude Skilled Nursing swing-bed days. (See swing-bed information next page)

Note: 46 Med/Surg beds transferred from HRSH. Construction project completed recognizing 0/S CON approved beds (44+25+22-3

D. Beds by Service (Inpatient) *continued*

Number of Swing Beds *	0
Number of Skilled Nursing days in Swing Beds	0
Number of unlicensed observation beds	0

* means a hospital designated **as a swing-bed hospital** by CMS (Centers for Medicare and Medicaid Services)

E. Reimbursement Source (For "Inpatient Days," show Acute Inpatient Days only, excluding normal newborns.)

Primary Payer Source	Inpatient Days of Care (from p. 4, item D. 1.)	Emergency Visits (from p. 6)	Outpatient Visits (excluding Emergency Visits and Surgical Cases)	Inpatient Surgical Cases (from p.8, Table 8. b)	Ambulatory Surgical Cases (from p. 8, Table 8. b)
Self Pay/Indigent/Charity	7,047	24,190	9,966	335	318
Medicare & Medicare Managed Care	68,226	22,010	37,620	3,073	1,578
Medicaid	37,109	38,003	21,398	1,674	1,089
Commercial Insurance	15,784	12,853	21,498	1,445	1,506
Managed Care	8,882	10,299	16,715	831	1,111
Other (Specify) Tricare	7,506	9,078	12,003	451	608
TOTAL	144,554	116,433	119,200	7,809	6,210

	$ Amount	% of Total Costs	% of Net Revenues
Unreimbursed Medicaid Costs (1)	26,210,000	4.9	
Unreimbursed Charity Care (1) *	54,496,000	10.3	10.7
Bad Debt *	79,470,000		15.6

(1) Unreimbursed Medicaid costs and the unreimbursed charity care should come from the hospital's most recent Medicaid Cost Report.

Charity Care Definition: Health care services that never were expected to result in cash inflows. Charity care results from a provider's policy to provide health care services free of charge to individuals who meet certain financial criteria.

Bad Debt Definition: Health care services that were expected to result in cash inflows but written off after unsuccessful efforts to collect the amount owed.

F. Services and Facilities

1. Obstetrics	Enter Number of Infants
a. Live births (Vaginal Deliveries)	3,008
b. Live births (Cesarean Section)	14,053
c. Stillbirths	51

d. Delivery Rooms - Delivery Only (not Cesarean Section)	
e. Delivery Rooms - Labor and Delivery, Recovery	15
f. Delivery Rooms – LDRP (include Item "**m**" on Page 4)	
g. Normal newborn bassinets (Level I Neonatal Services) Do not include with totals under the section entitled Beds by Service (Inpatient)	48

2. Abortion Services Number of procedures per Year 2

* Per Cape Fear Valley Health System Consolidated Financial Statements. Also referenced in Highsmith Rainey Specialty Hospital

3. **Emergency Department Services** (cases equal visits to ED) before Pavilion Addition

a. Total Number of ED Exam Rooms: 57

a.1. #Trauma Rooms 3 a.2. #Fast Track Rooms 3

b. Total Number of ED visits for reporting period: 116,433

c. Total Number of admits from the ED for reporting period: 18,433

d. Total Number of Urgent Care visits for reporting period: 37,765

e. Does your ED provide services 24 hours a day 7 days per week? ✓ Yes ___ No
If no, specify days/hours of operation:

f. Is a physician on duty in your ED 24 hours a day 7 days per week? ✓ Yes ___ No
If no, specify days/hours physician is on duty:

4. **Medical Air Transport**: Owned or leased air ambulance service:

a. Does the facility operate an air ambulance service? ___ Yes ✓ No
b. If "Yes", complete the following chart.

Type of Aircraft	Number of Aircraft	Number Owned	Number Leased	Number of Transports
Rotary				
Fixed Wing				

5. **Pathology and Medical Lab** (Check whether or not service is provided)

a. Blood Bank/Transfusion Services ✓ Yes ___ No
b. Histopathology Laboratory ✓ Yes ___ No
c. HIV Laboratory Testing ✓ Yes ___ No
Number during reporting period
HIV Serology 1,251
HIV Culture ___
d. Organ Bank ___ Yes ✓ No
e. Pap Smear Screening ___ Yes ✓ No

6. **Transplantation Services** - Number of transplants N/A

Type	Number	Type	Number	Type	Number
a. Bone Marrow-Allogeneic		i. Kidney/Liver		k. Lung	
b. Bone Marrow-Autologous		j. Liver		l. Pancreas	
c. Cornea		f. Heart/Liver		m. Pancreas/Kidney	
d. Heart		g. Heart/Kidney		n. Pancreas/Liver	
e. Heart/Lung		h. Kidney		o. Other	

Do you perform living donor transplants ? ___ Yes ✓ No.

7. Specialized Cardiac Services (for questions, call 855-3865 [Medical Facilities Planning])

(a) Cardiac Catheterization	Diagnostic Cardiac Catheterization ICD-9 37.21, 37.22, 37.23, 37.25	Interventional Cardiac Catheterization- ICD-9 00.66, 99.10, 36.06, 36.07, 36.09; 35.52, 35.71, 35.96	Electro-physiology 37.26, 37.27, 37.34, 37.70, 37.71, 37.72, 37.73, 37.74, 37.75, 37.76, 37.77, 37.79, 37.80, 37.81, 37.82, 37.83, 37.85, 37.86, 37.87, 37.89, 37.94, 37.95, 37.96, 37.97, 37.98, 37.99, 00.50, 00.51, 00.52, 00.53, 00.54
1. Number of Units of Equipment			
2. Number of Patients Age 14 and younger	Ø	2	0
3. Number of Patients Age 15 and older	1,606	1,260	11
Total # of Patients 10/1/07-9/30/08	1,606	1,262	11
4. Number of Procedures* Performed in Fixed Units	All	All	All
5. Number of Procedures* Performed in Mobile Units			
Total # of Procedures 10/1/07-9/30/08			

*A **procedure** is defined to be one visit or trip by a patient to a catheterization laboratory for a single or multiple catheterizations. Count each visit once, regardless of the number of diagnostic, interventional, and/or EP catheterizations performed within that visit.

Name of Mobile Vendor: NA

Number of 8-hour days per week the mobile unit is onsite: NA 8-hour days per week.
(Examples: Monday through Friday for 8 hours per day is 5 8-hour days per week. Monday, Wednesday, & Friday for 4 hours per day is 1.5 8-hour days per week)

(b) Open Heart Surgery	Number of Machines/Procedures
1. Number of Heart-Lung Bypass Machines	3
2. Total Annual Number of Open Heart Surgery Procedures Utilizing Heart-Lung Bypass Machine	299
3. Total Annual Number of Open Heart Surgery Procedures done without utilizing a Heart-Lung Bypass Machine	299
4. Total Open Heart Surgery Procedures (2. + 3.)	
Procedures on Patients Age 14 and younger	
5. **Of total in #2**, Number of Procedures on Patients Age 14 & younger	Ø
6. **Of total in #3**, Number of Procedures on Patients Age 14 & younger	Ø

8. Surgical Operating Rooms and Cases

a) Surgical Operating Rooms

[1] Report *Surgical Operating Rooms* built to meet the specifications and standards for operating rooms required by the Construction Section of the Division of Health Services Regulation, and which are fully equipped to perform surgical procedures. These surgical operating rooms include rooms located in Obstetrics and surgical suites.

NOTE: If this License includes more than one campus, please submit the Cumulative Totals **and** COPY this sheet and Submit a duplicate of this page for each campus.

(**Campus** – *If multiple sites*: _____)

Type of Room	Number of Rooms
Dedicated Open Heart Surgery	2
Dedicated C-Section	3
Other Dedicated Inpatient Surgery	
Dedicated Ambulatory Surgery	
Shared - Inpatient / Ambulatory Surgery	13
Total of Surgical Operating Rooms	18

Does this facility have approval for additional surgical operating rooms (i.e., **not** listed above) **that are being developed** pursuant to a Certificate of Need? ✓ Yes ____ No ____1____ # Rooms

b) Surgical Cases by Specialty Area

NOTE: Read the following instructions carefully.

Enter the number of surgical cases by surgical specialty area in the chart below. Count each patient undergoing surgery as one case regardless of the number of surgical procedures performed while the patient was having surgery. Categorize each case into one specialty area – Total Surgical Cases is an unduplicated count of surgical cases. **Count all surgical cases, including cases performed in procedure rooms or in any other location.**

Surgical Specialty Area	Inpatient Cases	Ambulatory Cases
Cardiothoracic (excluding Open Heart Surgery)	–	182
Open Heart Surgery (from 7.(b) 4.)	299	
General Surgery	1,753	2,580
Neurosurgery	239	166
Obstetrics and GYN (excluding C-Sections)	853	1,497
Ophthalmology	3	3
Oral Surgery	7	2
Orthopedics	1,358	624
Otolaryngology	18	496
Plastic Surgery	0	13
Urology	171	647
Vascular	566	
Other Surgeries (which do not fit into the above categories)	1,231	
Number of C-Section's Performed in Dedicated C-Section ORs	1,311	
Number of C-Section's Performed in Other ORs		
Total Surgical Cases	7,809	6,210

8. Surgical Operating Rooms and Cases *continued*

c) Average Operating Room Availability and Average Case Times:
The Operating Room Methodology assumes that the average operating room is staffed 9 hours a day, for 260 days per year, and utilized at least 80% of the available time. This results in 1872 hours per OR per year.

The Operating Room Methodology also assumes 3 hours for each Inpatient Surgery and 1.5 hours for each Outpatient Surgery.

Based on your hospital's experience, please complete the table below by showing the assumptions for the average operating room in your hospital.

Average Hours per Day **Routinely** Scheduled for Use *	Average Number of Days per Year **Routinely** Scheduled for Use	Average "Case Time" ** in **Minutes** for Inpatient Cases	Average "Case Time" ** in **Minutes** for Ambulatory Cases
9	252	148	103

* Use only Hours per Day **routinely** scheduled when determining. Example: 2 rooms @ 8 hours per day plus 2 rooms @ 10 hours per day equals 36 hours per day; divided by 4 rooms equals an average of 9 hours / per room / per day.

** **"Case Time" = Time from Room Set-up Start to Room Clean-up Finish.** Definition 2.4 from the "Procedural Times Glossary" of the AACD, as approved by ASA, ACS, and AORN. *NOTE: This definition includes all of the time for which a given procedure requires an OR/PR. It allows for the different duration of Room Set-up and Room Clean-up Times that occur because of the varying supply and equipment needs for a particular procedure*

9. Gastrointestinal Endoscopy Rooms, Cases, and Procedures

[1] Report the number of *Gastrointestinal Endoscopy Rooms* and the number of cases and procedures performed in these rooms during the reporting period. (***NOTE*: Other procedure rooms** should be included in **Section 10** below.) Count each patient as one case regardless of the number of procedures performed while the patient was in the GI endoscopy room.

Number of GI Endo Rooms	Total Number GI Endo Cases [a]	Total Number Non-GI Endo Cases [b]	Total Endo Cases [a] + [b]
4	2,694	237	2,931
	Total Number GI Endo Procedures* [c]	Total Number Non-GI Endo Procedures [d]	Total Endo Procedures [c] + [d]
	2,919	239	3,158

*As defined in 10A NCAC 14C .3901 "Gastrointestinal (GI) endoscopy procedure" means a single procedure, identified by CPT code or ICD-9-CM procedure code, performed on a patient during a single visit to the facility for diagnostic or therapeutic purposes.

Does this facility have approval for additional GI Endoscopy rooms (i.e., **not** listed above) **that are being developed** pursuant to a Certificate of Need? _____ Yes ✓ No _____ # Rooms

10. Non-Gastrointestinal Procedure Rooms and Cases

Please report only rooms and cases not reported in 8. or 9.: Report rooms not equipped or meeting all the specifications for an operating room, dedicated to the performance of procedures other than gastrointestinal endoscopy.

a) Total Number of Procedure Rooms: 4

Note: Read the following instructions carefully

b) Enter the number of Non-Surgical cases by specialty area in the chart below. **Count all Non-Surgical cases, including cases performed in Operating Rooms.** Count each patient undergoing a procedure or procedures as one case regardless of the number of procedures performed while the patient was in the room.

Non-Surgical Specialty Area	Inpatient Cases	Ambulatory Cases
Pain Management		
Cystoscopy	131	391
Non GI Endoscopies *(not reported in 9.)*		
GI Endoscopies *(not reported in 9.)*		
YAG Laser		
Other (specify) Bronchs	104	121
Other (specify) Special Proc	1,215	2,285
Other (unspecified)		
Total Non-Surgical Cases	1,450	2,797

10a. Magnetic Resonance Imaging

Indicate the number of machines/instruments and the number of the following types of procedures performed during the 12-month reporting period at your facility. For Hospitals that operate medical equipment at multiple sites, please copy this and provide separate pages for each site.

	Number of Units	TOTAL Number of Procedures*: # 7386 procedures. Number **must** equal the sum of inpatient and outpatient procedures below.					
Fixed MRI Scanners-closed	3	Inpatient Procedures			Outpatient Procedures		
Fixed MRI Scanners-open	–	With Contrast or Sedation	Without Contrast or Sedation	TOTAL Inpatient	With Contrast or Sedation	Without Contrast or Sedation	TOTAL Outpatient
Total Fixed MRI Scanners	3	1,767	1,921	3,688	2,395	1,303	3,698
Mobile MRI Provider 1 Data	0						
Mobile MRI Provider 2 Data							
MRI pursuant to Policy AC-3:							
Other Human Research MRI Scanner							

* An **MRI procedure** is defined as a single discrete MRI study of one patient (single CPT coded procedure). An MRI study means one or more scans relative to a single diagnosis or symptom. **The total number of procedures should be equal to or more than the total number of patients reported on the MRI Patient Origin Table on page 25 of this application.**

Name of Mobile MRI Provider 1: N/A

Name of Mobile MRI Provider 2: N/A

10b. MRI Procedures by CPT Codes

CPT Code	CPT Description	Number of Procedures
70336	MRI Temporomandibular Joint(s)	10
70540	MRI Orbit/Face/Neck w/o	8
70542	MRI Orbit/Face/Neck with contrast	0
70543	MRI Orbit/Face/Neck w/o & with	48
70544	MRA Head w/o	1,065
70545	MRA Head with contrast	0
70546	MRA Head w/o & with	24
70547	MRA Neck w/o	31
70548	MRA Neck with contrast	0
70549	MRA Neck w/o & with	452
70551	MRI Brain w/o	837
70552	MRI Brain with contrast	14
70553	MRI Brain w/o & with	1,377
7055A	IAC Screening	0
	Subtotal for this page	3,866

* October 2007 – February 2008: MRI upgrade resulted in limited hours of operation thus reduced volumes.

10b. MRI Procedures by CPT Codes *continued.....*

CPT Code	CPT Description	Number of Procedures
71550	MRI Chest w/o	14
71551	MRI Chest with contrast	0
71552	MRI Chest w/o & with	8
71555	MRA Chest with OR without contrast	16
72126	Cervical Spine Infusion only	4
72141	MRI Cervical Spine w/o	264
72142	MRI Cervical Spine with contrast	0
72156	MRI Cervical Spine w/o & with	138
72146	MRI Thoracic Spine w/o	110
72147	MRI Thoracic Spine with contrast	0
72157	MRI Thoracic Spine w/o & with	126
72148	MRI Lumbar Spine w/o	381
72149	MRI Lumbar Spine with contrast	2
72158	MRI Lumbar Spine w/o & with	197
72159	MRA Spinal Canal w/o OR with contrast	0
72195	MRI Pelvis w/o	36
72196	MRI Pelvis with contrast	0
72197	MRI Pelvis w/o & with	101
72198	MRA Pelvis w/o OR with Contrast	0
73218	MRI Upper Ext, other than joint w/o	13
73219	MRI Upper Ext, other than joint with contrast	1
73220	MRI Upper Ext, other than joint w/o & with	6
73221	MRI Upper Ext any joint w/o	87
73222	MRI Upper Ext any joint with contrast	14
73223	MRI Upper Ext any joint w/o & with	7
73225	MRA Upper Ext w/o OR with contrast	4
73221	MRI Upper Ext, any joint w/o	87
73222	MRI Upper Ext, any joint with contrast	14
73223	MRI Upper Ext, any joint w/o & with	7
73225	MRA Upper Ext, w/o OR with contrast	4
73718	MRI Lower Ext other than joint w/o	41
73719	MRI Lower Ext other than joint with contrast	0
73720	MRI Lower Ext other than joint w/o & with	76
73721	MRI Lower Ext any joint w/o	130
73722	MRI Lower Ext any joint with contrast	21
73723	MRI Lower Ext any joint w/o & with	34
73725	MRA Lower Ext w/o OR with contrast	496
74181	MRI Abdomen w/o	275
74182	MRI Abdomen with contrast	0
	Subtotal for this page	2,834

10b. MRI Procedures by CPT Codes *continued.....*

CPT Code	CPT Description	Number of Procedures
74183	MRI Abdomen w/o & with	293
74185	MRA Abdomen w/o OR with contrast	394
75552	MRI Cardiac Morphology w/o	Ø
75553	MRI Cardiac Morphology with contrast	Ø
75554	MRI Cardiac Function Complete	Ø
75555	MRI Cardiac Function Limited	Ø
75556	MRI Cardiac Velocity Flow Mapping	Ø
76093	MRI Breast, unilateral w/o and/or with contrast	Ø
76094	MRI Breast, bilateral w/o and/or with contrast	Ø
76125	Cineradiography to complement exam	Ø
76390	MRI Spectroscopy	Ø
76393	MRI Guidance for needle placement	Ø
76394	MRI Guidance for tissue ablation	Ø
76400	MRI Bone Marrow blood supply	Ø
7649A	MR functional imaging	Ø
7649D	MRI infant spine comp w/ & w/o contrast	Ø
7649E	Spine (infants) w/o infusion	Ø
7649H	MR functional imaging	Ø
N/A	Clinical Research Scans	
	Subtotal for this page	686
	Total Number of Procedures for all pages	7,386

10c. Computed Tomography (CT)

How many fixed CT scanners does the hospital have? 4

Does the hospital contract for mobile CT scanner services? ___ Yes ✓ No

If yes, identify the mobile CT vendor _____

Complete the following tables (one for fixed CT scanners; one for mobile CT scanners).

Scans Performed on Fixed CT Scanners *(Multiply # scans by Conversion Factor to get HECT Units)*

	Type of CT Scan	# of Scans		Conversion Factor		HECT Units
1	Head without contrast	3,017	X	1.00	=	3,017
2	Head with contrast	59	X	1.25	=	74
3	Head without and with contrast	39	X	1.75	=	68
4	Body without contrast	1,670	X	1.50	=	2,505
5	Body with contrast	2,504	X	1.75	=	4,382
6	Body without contrast and with contrast	297	X	2.75	=	817
7	Biopsy in addition to body scan with or without contrast	54	X	2.75	=	149
8	Abscess drainage in addition to body scan with or without contrast	37	X	4.00	=	148

Scans Performed on Mobile CT Scanners *(Multiply # scans by Conversion Factor to get HECT Units)*

	Type of CT Scan	# of Scans		Conversion Factor		HECT Units
1	Head without contrast		X	1.00	=	
2	Head with contrast		X	1.25	=	
3	Head without and with contrast		X	1.75	=	
4	Body without contrast		X	1.50	=	
5	Body with contrast		X	1.75	=	
6	Body without contrast and with contrast		X	2.75	=	
7	Biopsy in addition to body scan with or without contrast		X	2.75	=	
8	Abscess drainage in addition to body scan with or without contrast		X	4.00	=	

10d. Other Imaging Equipment

	Number of Units	Number of Procedures		
		Inpatient	Outpatient	Total
Dedicated Fixed PET Scanner	1	16	4,636	4,652
Mobile PET Scanner	0			
PET pursuant to Policy AC-3	0			
Other Human Research PET Scanner	0			
Ultrasound equipment	10	7,408	13,735	21,143
Bone Density Equipment	1		746	746
Fixed X-ray Equipment (excluding fluoroscopic)	7	10,174	60,357	70,531
Fixed Fluoroscopic X-ray Equipment	3	1,029	986	2,015
Special Procedures/ Angiography (neuro & vascular, but not including cardiac cath.)	2	753	2,161	2,914
Coincidence Camera				
Mobile Coincidence Camera Vendor:				
SPECT (same Camera for Spect/Gamma)	5	6,961	6,911	13,872
Mobile SPECT Vendor:				
Gamma Camera	5	1,386	1,999	3,385
Mobile Gamma Camera Vendor:				

* PET **procedure** means a single discrete study of one patient involving one or more PET scans. PET **scan** means an image-scanning sequence derived from a single administration of a PET radiopharmaceutical, equated with a single injection of the tracer. One or more PET scans comprise a PET procedure. **The number of PET procedures in this table should match the number of patients reported on the PET Patient Origin Table on page 27.**

10e. Lithotripsy

	Number of Units	Number of Procedures		
		Inpatient	Outpatient	Total
Fixed				
Mobile				

Lithotripsy Vendor/Owner: _____

11. Radiation Oncology Treatment Data

CPT Code	Description	Number of Procedures	ESTVs/ Procedures Under ACR	Total ACR ESTVs	
	Simple Treatment Delivery:				
77401	Radiation treatment delivery	~~0~~	1.00	~~0~~	
77402	Radiation treatment delivery (<=5 MeV)	~~0~~	1.00	~~0~~	
77403	Radiation treatment delivery (6-10 MeV)	11	1.00	11	
77404	Radiation treatment delivery (11-19 MeV)	129	1.00	129	
77406	Radiation treatment delivery (>=20 MeV)	~~0~~	1.00	~~0~~	
	Intermediate Treatment Delivery:				
77407	Radiation treatment delivery (<=5 MeV)	~~0~~	1.00	~~0~~	
77408	Radiation treatment delivery (6-10 MeV)	~~0~~	1.00	~~0~~	
77409	Radiation treatment delivery (11-19 MeV)	2	1.00	2	
77411	Radiation treatment delivery (>=20 MeV)	~~0~~	1.00	~~0~~	
	Complex Treatment Delivery:				
77412	Radiation treatment delivery (<=5 MeV)	~~0~~	1.00	~~0~~	
77413	Radiation treatment delivery (6-10 MeV)	3,518	1.00	3,518	
77414	Radiation treatment delivery (11-19 MeV)	7,791	1.00	7,791	
77416	Radiation treatment delivery (>= 20 MeV)	5	1.00	5	
	Sub-Total	11,456		11,456	
	For the increased time required for special techniques, ESTV values are indicated below:				
77417	Additional field check radiographs	8,871	.50	4,436	
77418	Intensity modulated radiation treatment (IMRT) delivery	5,448	1.00	5,448	
77432	Stereotactic radiosurg. treatment mgmt Linear Accelerator/CyberKnife or other		3.00		
77432	Stereotactic radiosurg. Treatment mgmt Gamma Knife		3.00		
	Total body irradiation		2.50		
	Hemibody irradiation		2.00		
	Intraoperative radiation therapy (conducted by bringing the anesthetized patient down to the linac)		10.00		
	Neutron and proton radiation therapy		2.00		
	Limb salvage irradiation		1.00		
	Pediatric Patient under anesthesia		1.50		
	Sub-Total	14,319		9,884	
	TOTALS:	25,775		21,340	

Note: For special techniques, list procedures under both the treatment delivery and the special techniques sections.

11. Radiation Oncology Treatment Data *continued*

a.	Number of unduplicated patients who receive a course of radiation oncology treatments. Patients shall be counted more than once if they receive additional courses of treatment. For example, one patient who receives three **courses** of radiation oncology treatment counts as three. **The number of patients reported here should match the number of patients reported in the Radiation Oncology Patient Origin Table on page 26.**	810
b.	Total number of Linear Accelerator(s)	4
c.	Number of Linear Accelerators configured for stereotactic radiosurgery	0
d.	Number of CyberKnife® Systems, Gamma Knife, or other specialized Linear Accelerators. Identify Manufacturer of Equipment _____	0

12. Telemedicine

a. Does your facility utilize telemedicine to have images read at another facility? No

b. Does your facility read telemedicine images? Yes

13. Additional Services:

a) **Check if Service(s) is provided: (for dialysis stations, show number of stations)**

	Check		Check
1. Cardiac Rehab Program (Outpatient)	✓	5. Rehabilitation Outpatient Unit	✓
2. Chemotherapy	✓	6. Podiatric Services	✓
3. Clinical Psychology Services	✓	7. Genetic Counseling Service	✓
4. Dental Services	✓	8. **Number** of Acute Dialysis Stations	9

b) **Hospice Inpatient Unit Data:** N/A

Hospital-based hospice units with licensed hospice beds. List each county served and report **all patients by county of residence.** Use each patient's age on the admission day to the Licensed Hospice Inpatient Facility. **For age categories count each inpatient client only once.**

County of Residence	Age 0-17	Age 18-40	Age 41-59	Age 60-64	Age 65-74	Age 75-84	Age 85+	Total Patients Served	Total Days of Care	Deaths
Out of State										
Total All Ages										

13. Additional Services: *continued* N/A

c) **Mental Health and Substance Abuse**

1. If psychiatric care has a different name than the hospital, please indicate:

2. If address is different than the hospital, please indicate:

3. Director of the above services.

Indicate the program/unit location in the **Service Categories** chart below. If it is in the hospital, include the room number. If it is located at another site, include the building name, program/unit name and address.

Service Categories: All applicants must complete the following table for all mental health services which are to be provided by the facility. If the service is not offered, leave the spaces blank.

Rule 10A NCAC 27G Licensure Rules For Mental Health Facilities	Location of Services	Beds Assigned by Age				
		0-12	13-17	Subtotal 0-17	18 & up	Total Beds
.1100 Partial hospitalization for individuals who are acutely mentally ill.						
.1200 Psychosocial rehabilitation facilities for individuals with severe and persistent mental illness						
.1300 Residential treatment facilities for children and adolescents who are emotionally disturbed or have a mental illness						
.1400 Day treatment for children and adolescents with emotional or behavioral disturbances						
.1500 Intensive residential treatment facilities for children & adolescents who are emotionally disturbed or who have a mental illness						
.5000 Facility Based Crisis Center						

Rule 10A NCAC 13B Licensure Rules For Hospitals	Location of Services	Beds Assigned by Age				
		0-12	13-17	Subtotal 0-17	18 & up	Total Beds
.5200 Dedicated inpatient unit for individuals who have mental disorders	Sep bldg on Campus				28	28

13. Additional Services: *continued*

c) Mental Health and Substance Abuse *continued*

Rule 10A NCAC 27G Licensure Rules for Substance Abuse Facilities	Location of Services	Beds Assigned by Age				
		0-12	13-17	Subtotal 0-17	18 & up	Total Beds
.3100 Nonhospital medical detoxification for individuals who are substance abusers						
.3200 Social setting detoxification for substance abusers						
.3300 Outpatient detoxification for substance abusers						
.3400 Residential treatment/ rehabilitation for individuals with substance abuse disorders						
.3500 Outpatient facilities for individuals with substance abuse disorders	Sep bldg On Campus					
.3600 Outpatient narcotic addiction treatment						
.3700 Day treatment facilities for individuals with substance abuse disorders						

Rule 10A NCAC 13B Licensure Rules For Hospitals	Location of Services	Beds Assigned by Age				
		0-12	13-17	Subtotal 0-17	18 & up	Total Beds
.5200 Dedicated inpatient hospital unit for individuals who have substance abuse disorders (specify type) # of Treatment beds _____ # of Medical Detox beds 4	Sep bldg on Campus				4	4

Patient Origin -General Acute Care Inpatient Services

Facility County: Cumberland

In an effort to document patterns of utilization of General Acute Care Inpatient Services in North Carolina hospitals, please provide the county of residence for each patient admitted to your facility.

County	No. of Admissions	County	No. of Admissions	County	No. of Admissions
1. Alamance	3	37. Gates		73. Person	3
2. Alexander		38. Graham	1	74. Pitt	5
3. Alleghany		39. Granville		75. Polk	
4. Anson	5	40. Greene		76. Randolph	
5. Ashe		41. Guilford	15	77. Richmond	25
6. Avery	1	42. Halifax		78. Robeson	1,983
7. Beaufort		43. Harnett	555	79. Rockingham	3
8. Bertie		44. Haywood		80. Rowan	
9. Bladen	341	45. Henderson		81. Rutherford	
10. Brunswick	13	46. Hertford		82. Sampson	1,020
11. Buncombe	3	47. Hoke	1,368	83. Scotland	66
12. Burke	1	48. Hyde		84. Stanly	2
13. Cabarrus	1	49. Iredell	2	85. Stokes	
14. Caldwell		50. Jackson	1	86. Surry	
15. Camden		51. Johnston	56	87. Swain	
16. Carteret	3	52. Jones		88. Transylvania	
17. Caswell	2	53. Lee	124	89. Tyrrell	
18. Catawba		54. Lenoir	4	90. Union	6
19. Chatham	3	55. Lincoln		91. Vance	1
20. Cherokee		56. Macon		92. Wake	66
21. Chowan		57. Madison		93. Warren	1
22. Clay		58. Martin	1	94. Washington	
23. Cleveland	5	59. McDowell		95. Watauga	
24. Columbus	56	60. Mecklenburg	16	96. Wayne	22
25. Craven		61. Mitchell		97. Wilkes	
26. Cumberland	22,514	62. Montgomery	3	98. Wilson	7
27. Currituck		63. Moore	29	99. Yadkin	1
28. Dare		64. Nash	9	100. Yancey	
29. Davidson	2	65. New Hanover	6		
30. Davie		66. Northampton		101. Georgia	20
31. Duplin	19	67. Onslow	5	102. South Carolina	62
32. Durham	12	68. Orange	4	103. Tennessee	7
33. Edgecombe		69. Pamlico		104. Virginia	43
34. Forsyth	3	70. Pasquotank		105. Other States	305
35. Franklin	3	71. Pender	7	106. Other	
36. Gaston	2	72. Perquimans		**Total No. of Patients**	28,846

Patient Origin – Inpatient Surgical Cases

Facility County: Cumberland

In an effort to document patterns of "Inpatient" utilization of Surgical Services in North Carolina hospitals, please provide the county of residence for each inpatient surgical patient served in your facility. Count each inpatient "once" regardless of the number of surgical procedures performed while the patient was in the operating room. However, each admission as an inpatient operating room patient should be reported separately.

The "Total" from this chart should match the "Total" Inpatient Cases reported on the Surgical Cases by Specialty Area Table on page 8.

County	No. of Patients	County	No. of Patients	County	No. of Patients
1. Alamance	2	37. Gates		73. Person	
2. Alexander		38. Graham		74. Pitt	
3. Alleghany		39. Granville		75. Polk	
4. Anson	2	40. Greene		76. Randolph	
5. Ashe		41. Guilford	6	77. Richmond	7
6. Avery	1	42. Halifax		78. Robeson	621
7. Beaufort		43. Harnett	186	79. Rockingham	3
8. Bertie		44. Haywood		80: Rowan	
9. Bladen	109	45. Henderson		81. Rutherford	
10. Brunswick	7	46. Hertford		82. Sampson	371
11. Buncombe	1	47. Hoke	356	83. Scotland	16
12. Burke		48. Hyde		84. Stanly	
13. Cabarrus	1	49. Iredell	1	85. Stokes	
14. Caldwell		50. Jackson	1	86. Surry	
15. Camden		51. Johnston	21	87. Swain	
16. Carteret	1	52. Jones		88. Transylvania	
17. Caswell	1	53. Lee	36	89. Tyrrell	
18. Catawba		54. Lenoir	1	90. Union	1
19. Chatham		55. Lincoln		91. Vance	
20. Cherokee		56. Macon		92. Wake	24
21. Chowan		57. Madison		93. Warren	1
22. Clay		58. Martin	1	94. Washington	
23. Cleveland		59. McDowell		95. Watauga	
24. Columbus	14	60. Mecklenburg	4	96. Wayne	4
25. Craven		61. Mitchell		97. Wilkes	
26. Cumberland	5,872	62. Montgomery		98. Wilson	
27. Currituck		63. Moore	13	99. Yadkin	1
28. Dare		64. Nash	2	100. Yancey	
29. Davidson	1	65. New Hanover	1		
30. Davie		66. Northampton		101. Georgia	3
31. Duplin	11	67. Onslow	2	102. South Carolina	23
32. Durham	3	68. Orange	2	103. Tennessee	2
33. Edgecombe		69. Pamlico		104. Virginia	9
34. Forsyth		70. Pasquotank		105. Other States	59
35. Franklin	3	71. Pender	2	106. Other	
36. Gaston		72. Perquimans		**Total No. of Patients**	7,809

Patient Origin – Ambulatory Surgical Cases

Facility County: Cumberland

In an effort to document patterns of "Ambulatory" utilization of Surgical Services in North Carolina hospitals, please provide the county of residence for each ambulatory surgery patient served in your facility. Count each ambulatory patient "once" regardless of the number of procedures performed while the patient was in the operating room. However, each admission as an ambulatory operating room patient should be reported separately.

The "Total" from this chart should match the "Total" Ambulatory Cases reported on the Surgical Cases by Specialty Area Table on page 8.

County	No. of Patients	County	No. of Patients	County	No. of Patients
1. Alamance		37. Gates		73. Person	
2. Alexander		38. Graham		74. Pitt	1
3. Alleghany		39. Granville		75. Polk	
4. Anson	2	40. Greene		76. Randolph	2
5. Ashe		41. Guilford	5	77. Richmond	5
6. Avery		42. Halifax		78. Robeson	487
7. Beaufort	1	43. Harnett	126	79. Rockingham	2
8. Bertie		44. Haywood		80. Rowan	2
9. Bladen	102	45. Henderson		81. Rutherford	
10. Brunswick	4	46. Hertford		82. Sampson	230
11. Buncombe		47. Hoke	263	83. Scotland	12
12. Burke		48. Hyde		84. Stanly	
13. Cabarrus		49. Iredell		85. Stokes	
14. Caldwell		50. Jackson		86. Surry	
15. Camden		51. Johnston	12	87. Swain	
16. Carteret		52. Jones		88. Transylvania	
17. Caswell		53. Lee	44	89. Tyrrell	
18. Catawba		54. Lenoir		90. Union	
19. Chatham		55. Lincoln		91. Vance	
20. Cherokee		56. Macon		92. Wake	12
21. Chowan		57. Madison		93. Warren	
22. Clay		58. Martin		94. Washington	
23. Cleveland		59. McDowell		95. Watauga	
24. Columbus	4	60. Mecklenburg	1	96. Wayne	
25. Craven		61. Mitchell		97. Wilkes	1
26. Cumberland	4,803	62. Montgomery	1	98. Wilson	1
27. Currituck		63. Moore	20	99. Yadkin	
28. Dare	1	64. Nash	3	100. Yancey	
29. Davidson		65. New Hanover	4		
30. Davie		66. Northampton		101. Georgia	
31. Duplin	7	67. Onslow	1	102. South Carolina	
32. Durham	2	68. Orange		103. Tennessee	
33. Edgecombe		69. Pamlico		104. Virginia	
34. Forsyth	1	70. Pasquotank		105. Other States	47
35. Franklin		71. Pender	1	106. Other	
36. Gaston		72. Perquimans		**Total No. of Patients**	6,210

Patient Origin – Gastrointestinal Endoscopy (GI) Cases

Facility County: Cumberland

In an effort to document patterns of utilization of Gastrointestinal Endoscopy Services in North Carolina hospitals, please provide the county of residence for each GI Endoscopy patient served in your facility. Count each patient once regardless of the number of procedures performed while the patient was receiving GI Endoscopy Services. However, each admission for GI Endoscopy services should be reported separately.

The "Total" from this chart should equal Item 9. [a] "Total Number GI Endo Cases" from the GI Endo Room Table on page 10, plus the total Inpatient and Ambulatory GI Endoscopies (not reported in 9.) from the Specialty Area Table at the bottom of page 10.

County	No. of Patients	County	No. of Patients	County	No. of Patients
1. Alamance	1	37. Gates		73. Person	
2. Alexander		38. Graham		74. Pitt	
3. Alleghany		39. Granville		75. Polk	
4. Anson		40. Greene		76. Randolph	
5. Ashe		41. Guilford		77. Richmond	51
6. Avery		42. Halifax		78. Robeson	297
7. Beaufort		43. Harnett	92	79. Rockingham	
8. Bertie		44. Haywood		80. Rowan	
9. Bladen	40	45. Henderson		81. Rutherford	
10. Brunswick	1	46. Hertford		82. Sampson	175
11. Buncombe		47. Hoke	85	83. Scotland	39
12. Burke		48. Hyde		84. Stanly	
13. Cabarrus		49. Iredell		85. Stokes	
14. Caldwell	2	50. Jackson		86. Surry	
15. Camden		51. Johnston	45	87. Swain	
16. Carteret		52. Jones		88. Transylvania	
17. Caswell		53. Lee	24	89. Tyrrell	
18. Catawba		54. Lenoir		90. Union	2
19. Chatham		55. Lincoln		91. Vance	
20. Cherokee		56. Macon		92. Wake	5
21. Chowan		57. Madison		93. Warren	
22. Clay		58. Martin		94. Washington	
23. Cleveland		59. McDowell		95. Watauga	
24. Columbus	4	60. Mecklenburg	1	96. Wayne	2
25. Craven		61. Mitchell		97. Wilkes	
26. Cumberland	1966	62. Montgomery	4	98. Wilson	
27. Currituck		63. Moore	78	99. Yadkin	
28. Dare		64. Nash		100. Yancey	
29. Davidson		65. New Hanover	3		
30. Davie		66. Northampton		101. Georgia	1
31. Duplin	4	67. Onslow		102. South Carolina	4
32. Durham	1	68. Orange		103. Tennessee	1
33. Edgecombe		69. Pamlico		104. Virginia	2
34. Forsyth		70. Pasquotank		105. Other States	
35. Franklin		71. Pender	1	106. Other	
36. Gaston		72. Perquimans		**Total No. of Patients**	2,931

Patient Origin - Psychiatric and Substance Abuse Alamance through Johnston

Facility County: Cumberland

Complete the following table below for inpatient Days of Care reported under Section .5200.

County of Patient Origin	Psychiatric Treatment Days of Care			Substance Abuse Treatment Days of Care			Detoxification Days of Care		
	Age 0-17	Age 18+	Totals	Age 0-17	Age 18+	Totals	Age 0-17	Age 18+	Totals
Alamance									
Alexander									
Alleghany									
Anson									
Ashe									
Avery									
Beaufort									
Bertie									
Bladen		38	38						
Brunswick		3	3						
Buncombe									
Burke									
Cabarrus									
Caldwell									
Camden									
Carteret									
Caswell									
Catawba									
Chatham									
Cherokee									
Chowan									
Clay									
Cleveland									
Columbus		2	2						
Craven									
Cumberland		3,879	3,879						
Currituck									
Dare		1	1						
Davidson									
Davie									
Duplin									
Durham									
Edgecombe									
Forsyth									
Franklin									
Gaston		8	8						
Gates									
Graham									
Granville									
Greene									
Guilford		2	2						
Halifax									
Harnett		60	60						
Haywood									
Henderson									
Hertford									
Hoke		139	139						
Hyde									
Iredell									
Jackson									
Johnston		10	10						

** Note: See counties: Jones through Yancey (including Out-of-State) on next page.

Patient Origin - Psychiatric and Substance Abuse **Jones through Yancey** (including Out-of-State)

Facility County: **Cumberland**

(Continued from previous page)

County of Patient Origin	Psychiatric Treatment Days of Care			Substance Abuse Treatment Days of Care			Detoxification Days of Care		
	Age 0-17	Age 18+	Totals	Age 0-17	Age 18+	Totals	Age 0-17	Age 18+	Totals
Jones									
Lee		12	12						
Lenoir									
Lincoln									
Macon									
Madison									
Martin									
McDowell									
Mecklenburg		8	8						
Mitchell									
Montgomery									
Moore									
Nash									
New Hanover									
Northampton									
Onslow									
Orange		6	6						
Pamlico									
Pasquotank									
Pender									
Perquimans									
Person									
Pitt									
Polk									
Randolph									
Richmond		5	5						
Robeson		111	111						
Rockingham									
Rowan									
Rutherford									
Sampson		64	64						
Scotland		1	1						
Stanly									
Stokes									
Surry									
Swain									
Transylvania									
Tyrrell									
Union									
Vance									
Wake		13	13						
Warren									
Washington									
Watauga									
Wayne		19	19						
Wilkes									
Wilson									
Yadkin									
Yancey									
Out of State		144	144						
TOTALS			4,525						

** **Note:** See counties: Alamance through Johnston on previous page.

Patient Origin - MRI Services

Facility County: Cumberland

In an effort to document patterns of utilization of MRI Services in North Carolina, hospitals are asked to provide county of residence for each patient served in your facility. Patients served include patients receiving MRI procedures reported in **Table 10a** of this application (**page 11**). **The total number of patients reported here should be equal to or less than the total number of MRI procedures reported in Table 10a.**

County	No. of Patients	County	No. of Patients	County	No. of Patients
1. Alamance		37. Gates		73. Person	
2. Alexander		38. Graham		74. Pitt	
3. Alleghany		39. Granville		75. Polk	
4. Anson	4	40. Greene		76. Randolph	
5. Ashe		41. Guilford	1	77. Richmond	3
6. Avery		42. Halifax		78. Robeson	295
7. Beaufort		43. Harnett	92	79. Rockingham	
8. Bertie		44. Haywood	1	80. Rowan	
9. Bladen	47	45. Henderson		81. Rutherford	
10. Brunswick	2	46. Hertford		82. Sampson	168
11. Buncombe		47. Hoke	193	83. Scotland	10
12. Burke		48. Hyde		84. Stanly	
13. Cabarrus		49. Iredell		85. Stokes	1
14. Caldwell		50. Jackson		86. Surry	
15. Camden		51. Johnston	3	87. Swain	
16. Carteret		52. Jones		88. Transylvania	
17. Caswell		53. Lee	44	89. Tyrrell	
18. Catawba		54. Lenoir		90. Union	
19. Chatham		55. Lincoln		91. Vance	
20. Cherokee		56. Macon		92. Wake	8
21. Chowan		57. Madison		93. Warren	
22. Clay		58. Martin	1	94. Washington	
23. Cleveland		59. McDowell		95. Watauga	
24. Columbus	7	60. Mecklenburg	6	96. Wayne	1
25. Craven	3,884	61. Mitchell		97. Wilkes	1
26. Cumberland		62. Montgomery	1	98. Wilson	2
27. Currituck		63. Moore	6	99. Yadkin	
28. Dare		64. Nash	3	100. Yancey	
29. Davidson		65. New Hanover	2		
30. Davie		66. Northampton		101. Georgia	4
31. Duplin	3	67. Onslow	1	102. South Carolina	8
32. Durham	1	68. Orange		103. Tennessee	2
33. Edgecombe		69. Pamlico		104. Virginia	10
34. Forsyth		70. Pasquotank		105. Other States	45
35. Franklin		71. Pender		106. Other	
36. Gaston		72. Perquimans		**Total No. of Patients**	4,860

Are mobile MRI services currently provided at your hospital? yes _____ no ✓

Patient Origin - Radiation Oncology Treatment

Facility County: Cumberland

In an effort to document patterns of utilization of Radiation Oncology Treatment in North Carolina, hospitals are asked to provide county of residence for each patient served in your facility. Report the number of unduplicated patients who receive a course of radiation oncology treatments. Patients reported should be receiving radiation oncology [linac] and stereotactic radiosurgery (SRS) procedures using equipment (Linac, CyberKnife, Gamma Knife) listed in Section 11 of this application. Patients should be counted more than once if they receive additional courses of treatment. *(Example: one patient who receives three courses of radiation oncology treatment counts as three.)* **The number of patients reported should match the number of patients receiving radiation oncology procedures reported in Section 11 of this application.**

County	No. of Patients	County	No. of Patients	County	No. of Patients
1. Alamance		37. Gates		73. Person	
2. Alexander		38. Graham		74. Pitt	
3. Alleghany		39. Granville		75. Polk	
4. Anson		40. Greene		76. Randolph	
5. Ashe		41. Guilford		77. Richmond	1
6. Avery		42. Halifax		78. Robeson	42
7. Beaufort		43. Harnett	56	79. Rockingham	
8. Bertie		44. Haywood		80. Rowan	2
9. Bladen	15	45. Henderson		81. Rutherford	
10. Brunswick		46. Hertford		82. Sampson	28
11. Buncombe		47. Hoke	24	83. Scotland	1
12. Burke		48. Hyde		84. Stanly	
13. Cabarrus		49. Iredell		85. Stokes	
14. Caldwell		50. Jackson		86. Surry	
15. Camden		51. Johnston	3	87. Swain	
16. Carteret		52. Jones		88. Transylvania	
17. Caswell		53. Lee	7	89. Tyrrell	
18. Catawba		54. Lenoir		90. Union	
19. Chatham		55. Lincoln		91. Vance	
20. Cherokee		56. Macon		92. Wake	
21. Chowan		57. Madison		93. Warren	
22. Clay		58. Martin		94. Washington	
23. Cleveland		59. McDowell		95. Watauga	
24. Columbus		60. Mecklenburg		96. Wayne	
25. Craven		61. Mitchell		97. Wilkes	
26. Cumberland	625	62. Montgomery		98. Wilson	
27. Currituck		63. Moore	3	99. Yadkin	
28. Dare		64. Nash	1	100. Yancey	
29. Davidson		65. New Hanover			
30. Davie		66. Northampton		101. Georgia	
31. Duplin		67. Onslow		102. South Carolina	1
32. Durham		68. Orange	1	103. Tennessee	
33. Edgecombe		69. Pamlico		104. Virginia	
34. Forsyth		70. Pasquotank		105. Other States	
35. Franklin		71. Pender		106. Other	
36. Gaston		72. Perquimans		**Total No. of Patients**	810

Patient Origin – PET Scanner

Facility County: Cumberland

In an effort to document patterns of utilization of PET Scanner in North Carolina, hospitals are asked to provide county of residence for each patient served in your facility. This data should only reflect the number of patients, not number of scans and should not include other radiopharmaceutical or supply charge codes. **Please count each patient only once. The number of patients in this table should match the number of PET procedures reported in Table 10d on page 14.**

County	No. of Patients	County	No. of Patients	County	No. of Patients
1. Alamance		37. Gates		73. Person	
2. Alexander		38. Graham		74. Pitt	
3. Alleghany		39. Granville		75. Polk	
4. Anson	4	40. Greene		76. Randolph	
5. Ashe		41. Guilford	1	77. Richmond	3
6. Avery		42. Halifax		78. Robeson	279
7. Beaufort		43. Harnett	82	79. Rockingham	
8. Bertie		44. Haywood	1	80. Rowan	
9. Bladen	47	45. Henderson		81. Rutherford	
10. Brunswick	2	46. Hertford		82. Sampson	168
11. Buncombe		47. Hoke	192	83. Scotland	10
12. Burke		48. Hyde		84. Stanly	
13. Cabarrus		49. Iredell		85. Stokes	1
14. Caldwell		50. Jackson		86. Surry	
15. Camden		51. Johnston	3	87. Swain	
16. Carteret		52. Jones		88. Transylvania	
17. Caswell		53. Lee	45	89. Tyrrell	
18. Catawba		54. Lenoir		90. Union	
19. Chatham		55. Lincoln		91. Vance	
20. Cherokee		56. Macon		92. Wake	
21. Chowan		57. Madison		93. Warren	
22. Clay		58. Martin	1	94. Washington	
23. Cleveland		59. McDowell		95. Watauga	
24. Columbus	7	60. Mecklenburg	6	96. Wayne	8
25. Craven		61. Mitchell		97. Wilkes	1
26. Cumberland	3,733	62. Montgomery	1	98. Wilson	2
27. Currituck		63. Moore	6	99. Yadkin	
28. Dare		64. Nash	3	100. Yancey	
29. Davidson		65. New Hanover	2		
30. Davie		66. Northampton		101. Georgia	4
31. Duplin	3	67. Onslow	1	102. South Carolina	8
32. Durham	1	68. Orange		103. Tennessee	2
33. Edgecombe		69. Pamlico		104. Virginia	10
34. Forsyth		70. Pasquotank		105. Other States	15
35. Franklin		71. Pender		106. Other	
36. Gaston		72. Perquimans		**Total No. of Patients**	4,652

This application must be completed and submitted with ONE COPY to the Acute and Home Care Licensure and Certification Section, Division of Health Service Regulation prior to the issuance of a 2009 hospital license.

AUTHENTICATING SIGNATURE: The undersigned submits application for the year 2009 in accordance with Article 5, Chapter 131E of the General Statutes of North Carolina, and subject to the rules and codes adopted thereunder by the North Carolina Medical Care Commission (10A NCAC 13B), and certifies the accuracy of this information.

Signature: Michael Nagowski **Date:** 12/18/08

PRINT NAME OF APPROVING OFFICIAL Michael Nagowski

Please be advised, the license fee must accompany the completed application and be submitted to the Acute and Home Care Licensure and Certification Section, Division of Health Service Regulation, prior to the issuance of a hospital license.