Carolinas HealthCare System

November 1, 2010

Mr. Craig R. Smith, Chief
Certificate of Need Section
Division of Health Service Regulation
2704 Mail Service Center
Raleigh, North Carolina 27699-2704

Dear Mr. Smith:

Carolinas HealthCare System (CHS) is submitting comments related to CaroMont Health, Inc.'s and Gaston Memorial Hospital, Inc.'s (GMH's) application to develop a freestanding emergency department in Mount Holly, Gaston County. The comments provide a detailed explanation as to why we believe **there is no reasonable way that the Agency can approve GMH's application.**

Based on our review of GMH's 2010 application, it is clear that GMH did not take the time to address all of the findings of non-conformity identified by the Administrative Law Judge (ALJ) relative to its 2009 application, Project ID # F-8340-09. Not only do a number of reasons the ALJ found GMH's 2009 application non-conforming also apply to GMH's 2010 application, but also GMH's current proposal presents new issues which render its application non-conforming with a number of the review criteria. CHS has summarized below the most egregious issues relative to GMH's application which document why its proposal should not be approved.

Issues New to the 2010 Application

- GMH fails to demonstrate the need for its proposed project regardless of the outcome of the litigation over the 2009 review, especially given the ALJ's Decision that recommends approval of CHS's proposed emergency department in Mount Holly, which GMH did not address in the 2010 application.

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- ❑ GMH fails to identify the population it proposes to serve, in direct contradiction to Agency testimony given in the contested case hearing for the 2009 review.

- ❑ GMH fails to demonstrate need for the proposed project as it fails to adequately demonstrate need for six Rapid Medical Evaluation (RME) bays and twelve treatment rooms; GMH relies on the American College of Emergency Physicians' data to determine capacity for its treatment rooms, but does not address the impact of RME bays on treatment room capacity.

- ❑ GMH fails to demonstrate need for the proposed project as it provides contradictory population growth data in its application.

- ❑ GMH fails to demonstrate that its proposed facility is the most effective alternative and most effective means of construction. Although the 2010 application projects lower visit volume and fewer ED treatment rooms, GMH proposes the *exact same square footage and footprint* as its 2009 application.

- ❑ GMH fails to demonstrate that its proposed facility is the most effective alternative and most effective means of construction. The proposed facility layout is identical to the 2009 application, despite fewer treatment rooms and lower volumes; GMH simply changes room designations and adds spaces that apparently were not needed for the higher volume ED proposed in the 2009 application.

- ❑ GMH fails to provide any letters of support for the 2010 project.

- ❑ GMH fails to demonstrate that the proposed project is a cost effective alternative, as GMH increases its net revenue per visit by 12 percent in the 2010 application presumably in an attempt to demonstrate financial feasibility with lower volumes than in the 2009 application.

Issues in Both 2009 and 2010 Applications

- ❑ GMH fails to demonstrate need for the proposed project as it relies on unsupported projections of an internal shift of patients to its freestanding ED.

- GMH fails to demonstrate need for the proposed project as it erroneously relies on third party survey results that were not adequately documented in its application.

- GMH fails to demonstrate need for the proposed project as it fails to adequately demonstrate need for six Rapid Medical Evaluation (RME) bays; GMH fails to document consistently how the RME bays will be used, fails to define capacity for the RME bays or demonstrate why the facility needs to have six RME bays in addition to the proposed treatment rooms.

- GMH fails to demonstrate that the acquisition of one ultrasound and two radiography units are not an unnecessary duplication of existing services given that GMH currently operates underutilized ultrasound and radiography units at CaroMont Imaging Services-Belmont.

- GMH fails to demonstrate that the proposed project is a cost-effective alternative. GMH's 2010 MedPlex application represents a more costly alternative than its current emergency department; the MedPlex ED expense per patient is 251 percent higher than GMH's overall ED expense per patient.[1]

- GMH fails to demonstrate financial feasibility of the project based upon reasonable costs and charges.

  - GMH assumes the same average charge per patient in its MedPlex income statement as it does for the total ED income statement. Based on GMH's own assumptions that the MedPlex ED will not treat higher acuity patients (who use more ancillary services than less acute patients), it is not reasonable that the MedPlex charge would be the same as the total (combined hospital and MedPlex) ED charge.

  - In its total ED income statement, GMH fails to include all the staffing expense necessary for both the MedPlex ED and the hospital's existing ED.

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1 In addition, for comparative purposes, please note that GMH's 2010 application represents a more costly alternative than CHS's 2009 application. The average cost per ED visit proposed by CHS was $318.64 while the average cost per ED visit proposed by GMH in its 2010 application is $455.79.

- In its total ED income statement, GMH fails to include all the indirect expenses necessary for both the MedPlex ED and the hospital's existing ED.

- GMH projects drastically different overhead expenses for the MedPlex compared with the total ED income statement. GMH provides no explanation for this disparity.

- The total ED income statement (which purports to include the MedPlex) does not include Capitalized Expense, Depreciation - Buildings, or Depreciation - Equipment, all of which are included in the MedPlex income statement.

- GMH fails to provide a utilities expense in its MedPlex or total ED income statements, nor does it provide an explanation for the exclusion.

- ☐ GMH fails to demonstrate that its proposed facility is the most effective alternative and most effective means of construction. GMH fails to demonstrate a need for the number of RME bays it proposes in addition to the number of proposed treatment rooms. GMH fails to demonstrate that its proposed facility - with 143 percent more space comparatively than any other North Carolina freestanding ED - is needed and an effective alternative.

As demonstrated in detail in the attached comments, given the numerous issues—both old and new—GMH's 2010 application should not be approved.

We appreciate your consideration of these comments.

Sincerely,

F. Del Murphy, Jr.
Vice President-Planning and Market Development
Carolinas HealthCare System

Comments on the CaroMont Health, Inc. and Gaston Memorial Hospital, Inc. Freestanding Emergency Department Application, Project ID # F-8586-10

submitted by

Carolinas HealthCare System

In accordance with N.C. GEN. STAT. § 131E-185(a1)(1), Carolinas HealthCare System (CHS) hereby submits the following comments related to CaroMont Health, Inc.'s and Gaston Memorial Hospital, Inc.'s application to develop a freestanding emergency department in Mount Holly, Gaston County. Pursuant to relevant statutory criteria, CHS's comments include "*discussion and argument regarding whether, in light of the material contained in the application and other relevant factual material, the application complies with the relevant review criteria, plans and standards.*" See N.C. GEN. STAT. § 131E-185(a1)(1)(c). As such, CHS's comments are organized by the general CON statutory review criteria as they relate to the following application: CaroMont Health, Inc. and Gaston Memorial Hospital, Inc. (GMH), Freestanding Emergency Department, Project ID # F-8586-10.

HISTORY

The following table provides a timeline of filings to develop emergency departments in Mount Holly, Gaston County. Also included in the table is the current status of each of the filings.

		Gaston I	Gaston II	CHS	Gaston III
Project ID #		F-8207-08	F-8340-09	F-8339-09	F-8586-10
Filing Date		9/15/2008	5/15/2009	5/15/2009	9/15/2010
Competitive		No	Yes; F-8339-09	Yes; F-8340-09	No
Analyst		Hutchison	Hutchison	Hutchison	Miles
Decision		D	CA	D	Under Review
Appeal	**Administrative Law Judge (ALJ) Recommended Decision**	09 DHR 1938 Withdrawn on 6/22/09	09 DHR 6116 GMH was found non-conforming and CHS was found conforming	09 DHR 6116 GMH was found non-conforming and CHS was found conforming	-
	Final Agency Decision	N/A	Pending With the ALJ's ruling, the DHSR director could approve either project, approve both or deny both.	Pending With the ALJ's ruling, the DHSR director could approve either project, approve both or deny both.	-

As documented in the table above, GMH filed an application on September 15, 2008, Project ID # F-8207-08, to develop a freestanding emergency department (also referred to as a MedPlex) in Mount Holly, Gaston County. That application, hereinafter referred to as Gaston I, was denied on February 27, 2009. On March 19, 2009, GMH appealed the denial of Gaston I. GMH subsequently withdrew its appeal of Gaston I's denial on June 22, 2009.

On May 15, 2009, GMH filed an application, Project ID # F-8340-09, hereinafter referred to as Gaston II, to develop a freestanding emergency department in Mount Holly, Gaston County. Gaston II was deemed competitive with CHS's application to develop an emergency department in Gaston County pursuant to 10A NCAC 14C .0202(f). Gaston II was subsequently approved by CON Section findings dated October 9, 2009 and, as discussed in detail below, is currently under appeal.

CURRENT STATUS

The two competitive applications involved in the 2009 review—Gaston II and CHS's proposed emergency department—are currently under appeal. On July 26, 2010, the Administrative Law Judge (ALJ) issued a Recommended Decision. The ALJ's Recommended Decision found GMH's[1] Gaston II application non-conforming with certain statutory review criteria and CHS's application conforming to all applicable statutory and regulatory criteria. In particular, with regard to GMH's Gaston II application, the ALJ determined that, as noted in conclusion of law # 20:

> *CMHA met its burden of proving by a preponderance of the evidence that the Agency did substantially prejudice petitioner's rights and did: exceed its authority or jurisdiction; act erroneously; fail to use proper procedure; act arbitrarily or capriciously; fail to act as required by rule or law; or otherwise violate the standards in N.C. Gen. Stat. § 150B-23, by finding that the CaroMont Application was conforming or conditionally conforming to the following statutory criteria: Criteria 3, 4, 5, 6, and 18a.*

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1 The Gaston II applicant was CaroMont Health, Inc. and Gaston Memorial Hospital, Inc. Please note that the ALJ's Recommended Decision refers to the applicant as CaroMont.

The ALJ determined that CHS's application was conforming with all applicable review criteria, as noted in conclusion of law # 19:

> *CMHA met its burden of proving by a preponderance of the evidence that the Agency did substantially prejudice petitioner's rights and did: exceed its authority or jurisdiction; act erroneously; fail to use proper procedure; act arbitrarily or capriciously; fail to act as required by rule or law; or otherwise violate the standards in N.C. Gen. Stat. § 150B-23, by finding that the CMHA Application was nonconforming to the following statutory and regulatory criteria: Criteria 3, 4, 5, 6, 18a and rule 10A NCAC 14C .2303(1).*

As of the date of these comments, a Final Agency Decision (FAD) regarding the 2009 review has not been issued. The deadline for the FAD is November 19, 2010. There are multiple possible scenarios for the FAD, some of which will be discussed below in turn. Although CHS is advocating that the Final Agency Decision-Maker adopt the ALJ's conclusions that GMH II was unapprovable and CHS's application was approvable, CHS maintains that **under any of these FAD scenarios, there is no reasonable way that the Agency can approve Gaston III**.

(1) The FAD could uphold the ALJ's Recommended Decision by finding that CHS's application was conforming and Gaston II was non-conforming.

If so, GMH has failed to demonstrate the need for Gaston III in light of CHS's approval. That is, GMH failed to address the impact of CHS's potential approval. This interpretation is consistent with prior Agency findings. In the 2007 Rowan Regional Medical Center-South Findings, the Agency found the applicant[2] nonconforming with Criterion 3 where the applicant failed to demonstrate the need for additional services in the service area relative to existing services currently offered **and those services recently approved or proposed**. As such, the applicant failed to demonstrate that there was not sufficient existing, approved or proposed capacity in the area to meet the needs of the population it proposed to serve. In particular, on February 27, 2008, CMC-NorthEast, Project ID # F-7951-07, was approved for a freestanding emergency department in Kannapolis with 10 treatment rooms to expand the hospital's emergency department capacity. The Analyst noted that the applicants were aware this application had been

[2] Rowan Regional Medical Center's application, Project ID # F-7994-07, was filed in October 2007. At the time the application was filed, the CMC-NorthEast application, Project ID # F-7951-07, (which was filed in September 2007) was under review.

filed but did not address the impact of its potential approval on the projected utilization at Rowan Regional Medical Center-South. See the 2007 Rowan Regional Medical Center Findings pages 46, 47, and 50, Exhibit 1.

In addition, in the 2006 Mint Hill Hospital/Healthplex Findings, the Agency found both applications in the review[3] nonconforming with Criterion 3 where, in a previous review, the Certificate of Need Section approved the development of a new 50-bed hospital in the proposed service area, Presbyterian Hospital Mint Hill.[4] See the 2006 Mint Hill Hospital/Healthplex Findings pages 42 and 61, Exhibit 2.

Relative to Gaston III, GMH failed to take into account the impact of the 2009 review. Although there is no existing emergency department in the proposed service area, in the event the FAD upholds the ALJ's Recommended Decision by finding that CHS's application was conforming and Gaston II was non-conforming, GMH has failed to demonstrate the need for its proposed emergency department in addition to CHS's proposed emergency department in Gaston County. In fact, as noted on page 51 of Gaston III, GMH states that "*the east Gaston area, including western Mecklenburg County has a central population area in Mount Holly and a population large enough to support a freestanding emergency department.*" (emphasis added).

Moreover, Gaston III cannot be approved under this scenario because many of the reasons the ALJ found Gaston II non-conforming also apply to Gaston III. Please see the application specific comments below for additional detail.

(2) The FAD could uphold the ALJ's Recommended Decision finding that CHS's application was conforming and uphold the Agency's approval of Gaston II.

If so, (as with the previous scenario), GMH has failed to demonstrate the need for Gaston III in light of CHS's approval. That is, GMH failed

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3 Project ID #s F-7707-06 and F-7709-06 were filed in September 2006 and subsequently denied on February 5, 2007. At the time these applications were filed Presbyterian Hospital Mint Hill's application was under review. During the course of the review of Project ID #s F-7707-06 and F-7709-06, the Presbyterian Hospital Mint Hill application was approved and appealed.

4 Presbyterian Hospital Mint Hill's application, Project ID # F-7648-06, was filed in July 2006. The application was approved on December 22, 2006 and was subsequently appealed.

to address the impact of CHS's potential approval. As discussed in detail above, this interpretation is consistent with prior Agency findings such as the 2007 Rowan Regional Medical Center-South Findings and the 2006 Mint Hill Hospital/Healthplex Findings. Please see Exhibits 1 and 2 for relevant excerpts from these findings.

Relative to Gaston III, GMH failed to take into account the impact of the 2009 review. Although there is no existing emergency department in the proposed service area, in the event the FAD upholds the ALJ's Recommended Decision by finding that CHS's application was conforming and upholds the Agency's decision approving Gaston II, GMH has failed to demonstrate the need for two (much less three) emergency departments in the service area. In fact, as noted on page 51 of Gaston III, GMH states that "*the east Gaston area, including western Mecklenburg County has a central population area in Mount Holly and a population large enough to support a freestanding emergency department.*" (emphasis added).

(3) The FAD could uphold the ALJ's Recommended Decision finding that the Gaston II application was non-conforming and uphold the Agency's denial of CHS's application.

If so, Gaston III cannot be approved because many of the reasons the ALJ found Gaston II non-conforming also apply to Gaston III. Please see discussion below for additional detail.

(4) The FAD could reverse the ALJ's Recommended Decision and uphold the Agency's denial of CHS's application and the Agency's approval of Gaston II.

Under this scenario, CHS would argue that the North Carolina Court of Appeals should arrive at the proper decision and find that CHS's application was approvable and Gaston II was not approvable. ***Until such litigation is resolved, the Agency cannot approve Gaston III, as GMH has not demonstrated that Gaston III is needed under any/all outcomes that could occur once litigation is concluded.***

Therefore, under any of these potential FAD scenarios, there is no reasonable way that the Agency can approve Gaston III.

APPLICATION-SPECIFIC COMMENTS

(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.*

GMH fails to demonstrate the need of the population for the proposed project based on the numerous mistakes and inconsistencies described below.

Failure to Identify the Population to be Served

On page 42 of its application, GMH identifies the population growth trends for its six zip code service area and suggests that each zip code has demonstrated historical growth and in turn is projected to grow in the future.

6-Zip Code Area Population Growth

		2000	2010	2015 (Projected)	2000 - 2010 Percent Growth	2010 - 2015 Percent Growth
28012	Belmont	18,309	19,833	20,710	8.32%	4.42%
28032	Cramerton	2,054	2,408	2,570	17.23%	6.73%
28098	Lowell	3,010	3,611	3,916	19.97%	8.45%
28120	Mount Holly	16,300	18,745	19,952	15.00%	6.44%
28164	Stanley	11,546	13,562	14,502	17.46%	6.93%
28214	Charlotte	20,764	30,799	35,112	48.33%	14.00%
Total Population		**71,983**	**88,958**	**96,762**	**23.58%**	**8.77%**

Source: Nielsen Claritas, August 2010.

However, on page 74 of its application, GMH provides contradictory population data. According to GMH, the populations for zip codes 28012 and 28032 declined from 2009 to 2010, yet the table above from page 42 projects positive growth from 2010 to 2015. In fact, the data provided by GMH on page 74 show that from 2009 to 2010 zip code 28012 declined by 2.8 percent and zip code 28032 declined by 12.3 percent.

Contradictory Population Data

Zip Code	*2009 Data from page 74*	*2010 Data from page 42*	*2009 to 2010 Change*	*2009 to 2010 Percent Change*
28012	20,406	19,833	-573	-2.8%
28032	2,747	2,408	-339	-12.3%
28098	3,550	3,611	61	1.7%
28120	17,326	18,745	1,419	8.2%
28164	13,042	13,562	520	4.0%
28214	29,940	30,799	859	2.9%
Total	**87,011**	**88,958**	**1,947**	**2.2%**

GMH's utilization methodology relies substantially on projected population growth in all of the zip codes in its service area and relies on the data provided on page 42. However, the data on page 74 provide much different growth rates including directional changes for zip codes 28012 and 28032. GMH's utilization methodology relies on unreasonable assumptions of population growth as it provides contradictory data in its application.

On page 79 of its application, GMH projects that 10 percent of ED visits would originate from outside of its six zip code service area. GMH states plainly that it does not know where these patients will come from: "*GMH cannot know where these in-migration patients will originate from*" (pg. 79). If GMH cannot project the origin of these in-migration patients, then it cannot identify the population it proposes to serve.

In fact, testimony provided by the Agency in the 2009 appeal supports this interpretation. In particular, Martha Frisone stated that "*we consider the in-migration to be part of the service area.*" Please see Exhibit 3 for an excerpt of Martha Frisone's April 15, 2010 testimony (pages 17-19).

Failure to Demonstrate Need of the Population Proposed to be Served

Reliance On and Erroneous Use of Third Party Survey

On page 54 of its application, GMH argues that "*Mount Holly is the logical choice to locate the MedPlex for several reasons*" and then cites the results of a phone survey performed by InTandem. In Step 5 of its need methodology, GMH cites the same phone survey as support for its internal visit shift. This phone survey is the same one used by GMH in Gaston II as shown by a comparison of the survey date and results. In its

Findings for that project (Project ID # F-8340-09), the Agency rejected the use of this survey and found the survey to be unreliable as shown below:

> *The survey results provided in Exhibit 12 do not include sufficient information regarding the scope and validity of the survey, such as the number of persons interviewed, how or why they were selected to be interviewed, if they currently utilize ED services at GMH or other providers, the number of responses received compared to the number of persons sampled, and discussion to validate that the size of the sample was large enough to generalize results to all zip code residents. Further, the applicants provide only two survey questions with their respective responses (Questions #7 and #8), which are contradictory to each other. Specifically in response to Question #7, the majority of respondents were in favor of their area having a local hospital with a full time emergency department, yet in response to Question #8, the same majority of respondents indicated they would use a freestanding 24-hour emergency ED developed in Mount Holly.*

See pages 39 and 40 of Agency Findings in Gaston II.

As the Agency notes, GMH provided the responses to only two of the survey's questions in the 2009 application. In the current application, GMH provides the responses to only one of the survey's questions (Question #8) and no more information about the scope or validity of the survey.

The ALJ notes the Agency's rejection of this survey in her Recommended Decision:

> 100. The Agency determined that it did not have sufficient information about the telephone survey to determine its scope or validity, and found the results of the survey to be unreliable. (Jt. Ex. 1 at 988-89)
>
> 127. The Agency determined that the survey results did not include sufficient information regarding the scope and validity of the survey, and that the survey could not validate CaroMont's assumptions.

Thus, the Agency should again find that GMH "[relies] *on survey results that are not adequately documented in the application*" (page 45 of Findings for Gaston II, Project ID # F-8340-09) as nothing about the survey has changed.

Unsupported Internal Shift Projections

The ALJ's Recommended Decision states: "*105. The Agency was inconsistent when it found the ED projections for the internal shift of patients in the 2008 Application* [Gaston I] *not supportable and found the ED projections for the internal shift of patients based on the same methodology and assumptions in the 2009 Application* [Gaston II] *to be supportable.*" In the proposed project, GMH has again relied on the same methodology and assumptions to project the internal shift of patients. Namely, GMH proposes a 75 percent internal shift in the current application based on "*the subjective judgment of CaroMont Health's administration and consultant*" (page 78). In fact, the ALJ comments specifically on the reliance on this subjective judgment and states that the Agency was inconsistent in its treatment of this assumption:

125. CaroMont's 2008 Application was disapproved by the Agency because it projected utilization based upon an assumption made on the experience of its administrative team and proximity of patients to the proposed facility as was done by Moses Cone in a similar application. (CMHA Ex. 94) In an attempt to validate its assumptions, in 2009 CaroMont hired an independent marketing firm which performed a telephone survey of the six zip code service area to determine the percentage of residents who might use the freestanding ED in Mount Holly. (Jt. Ex. 1 at 987)

126. CaroMont used the telephone survey to support the assumptions on which it based its utilization and market share projections.

127. The Agency determined that the survey results did not include sufficient information regarding the scope and validity of the survey, and that the survey could not validate CaroMont's assumptions.

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134. The Agency was inconsistent with the Agency's denial of the 2008 CaroMont Medplex application because: (1) the Agency denied the 2008 Application because the utilization projections were not supportable; and (2) the difference between the 2008 Application and the 2009 Application is that the latter Application included the unverifiable telephone survey.

The ALJ's decision holds that the Agency has to be consistent with its findings in Gaston I. Thus, the Agency must also deny Gaston III.

Failure to Adequately Demonstrate the Need for All Project Components

Treatment Rooms

In its application, GMH determines the number of treatment rooms required at the MedPlex by dividing projected volume by a projected annual capacity of 1,292 visits per room. However, in its two previous applications for freestanding EDs, GMH assumed that the annual capacity of its treatment rooms was 1,800 visits per room. GMH states that its

current capacity definition of 1,292 visits per room is based on data from the American College of Emergency Physicians. However, this source makes no mention of the effect of RME bays, as proposed in the GMH application, and their impact on room capacity.

If the use of RME bays *"alleviates the need for patients to wait in either the waiting room or treatment room before receiving diagnostic tests and imaging studies"* (pg. 31) then the capacity of GMH's treatment rooms should be greater than in traditional EDs. Similarly, if the RME bays have *"diagnostic equipment available, including a scale, thermometer, sphygmomanometer, spirometer, etc.[,]"* then the capacity of GMH's treatment rooms should be greater than in traditional EDs as diagnostic functions have been relocated to the RME bays.

Despite this evidence that GMH's treatment rooms should have greater capacity than treatment rooms in EDs without RME bays, GMH has assumed that its treatment rooms will have less than capacity than it assumed in two previous CON applications.

If GMH had assumed the same capacity for its treatment rooms in the current application, as it had in its two previous applications for freestanding EDs in the same location, then its visit projections would only demonstrate the need for eight treatment rooms, or four less than it proposes (8.4 treatment rooms needed = 15,203 visits in PY3 ÷ 1,800 visits per room). In the Agency's findings for Gaston II, it erroneously applied an ED treatment room capacity of 1,250 visits per year and the ALJ stated that *"150. If the Agency had recalculated CaroMont's projections using CaroMont's assumption of 1,800 visits per room and CaroMont's projected internal shift projection of 11,151 visits, then no more than 7 treatment rooms should have been approved"* and found the Agency's actions to be *"arbitrary and capricious."* Please see page 25 of the ALJ's Recommended Decision in 09 DHR 6116.

Rapid Medical Evaluation (RME) Bays

In the Agency Findings for Gaston I, Project ID # F-8207-08, the CON Section examined the number of rooms proposed and found that GMH *"did not include as treatment rooms the six proposed Rapid Medical Evaluation (RME) bays . . . Because the applicants intend to use the proposed six RME bays for treating minor complaints, the project analyst determined the applicants propose to develop a total 18 treatment rooms, which include 12 'monitored' rooms and 6 rapid medical evaluation bays."* See Gaston I page 17. In an attempt to refute this previous finding, GMH stated in the previously

approved Gaston II that "*the Rapid Medical Evaluation triage bays are not treatment rooms and do not take the place of treatment rooms.*" See Gaston II page 30. In its current application, Gaston III, GMH provided additional discussion (page 31) to support its position that the RME bays will only be used for diagnostic, not treatment purposes; however, the information included in its application is contradictory. At one point in the Gaston III application, GMH states that "*[t]he RME triage bays are smaller than the proposed treatment rooms and* ***will not be constructed to have a headwall with medical gases including air, oxygen, and suction****. Furthermore, the RME triage bays will only have diagnostic equipment available, including a scale, thermometer, sphygmomanometer, spirometer, etc. No equipment related to the treatment of an injury or illness will be utilized in the RME triage bays. If a patient requires immediate treatment they will be escorted to a treatment room.*" See Gaston III page 31 (emphasis added). However, this statement directly contradicts other information provided, specifically the medical equipment list found on page 621, which includes oxygen, medical air, and suction for each of the six RME bays.

In light of the contradictory information mentioned above, CHS maintains that GMH fails to properly document how RME bays will be used, and as such, does not adequately demonstrate a need for six RME bays. If the RME bay is used purely as triage, GMH has failed to demonstrate the need for six spaces. As outlined under Criterion 12, the standard freestanding emergency department provides two triage bays. GMH does not explain the need for four additional triage spaces. Please see Exhibit 4 for a copy of CMHA's Hearing Exhibit # 46 which provides a facility comparison of North Carolina healthplex applications. As documented in the Exhibit, the healthplex facilities (excluding Gaston) percent of triage/RME to treatment rooms ranges from 10 to 29 percent. Gaston III proposes six RME bays and 12 treatment rooms, which equates to 50 percent. GMH does not explain the need for this high of a ratio. No other existing or proposed freestanding emergency department in North Carolina operates more than two triage bays.

However, if the RME bay is used for all, or even some, pre-diagnostic care as is indicated in the table provided on page 30 of GMH's application, then part of a patient's actual visit time is spent in an RME bay, rather than utilizing a treatment room as they would under a traditional model. As such, the RME bay should either be counted as part of the treatment room capacity or the capacity of the 12 proposed treatment rooms should be higher because the average length of stay in a treatment room would be shorter. GHM states in its application that the capacity of a treatment room is 1,292 visits per room per year. However, under the RME model it

appears as though the treatment rooms serve a lesser function than a traditional emergency department room and should have a higher capacity. As noted previously, despite this evidence that GMH's treatment rooms should have greater capacity than treatment rooms in EDs without RME bays, GMH has assumed that its treatment rooms will have less than capacity than it assumed in two previous CON applications.

Notwithstanding the contradictory information provided in Gaston III's medical equipment list, GMH includes additional language in Gaston III relative to RME bays in an attempt to more clearly indicate that RME bays will take the place of the traditional triage function. Regarding Gaston II, the ALJ made the following findings of fact relative to RME bays:

171. The CaroMont Application did not contain any information about the capacity of RME bays.

172. In the Agency findings for CaroMont's 2008 MedPlex application, the Agency denied CaroMont, in part, because CaroMont proposed to use the RME bays as "fast track" treatment rooms. (Jt. Ex. 1 at 852) The 2009 Application omitted that descriptive phrase. (Jt. Ex. 3 at 29)

173. In testimony, it was the Agency's position that: the Agency did not consider the RME bays as "treatment rooms"; the Agency found that CaroMont demonstrated the need for RME bays; the Agency was not sure of the scope of what would occur in CaroMont's proposed RME bays; the Agency would not know if CaroMont started using its RME bays as treatment rooms; the CaroMont Application did not contain any utilization projections for its proposed RME bays; the CaroMont Application did not contain any definition of capacity for its proposed RME bays; the Agency did not discern CaroMont's RME bay capacity; the Agency did not assess how many RME bays CaroMont needed; and the Agency just accepted the number of RME bays CaroMont proposed. (Tr. Vol. 2 at 99-101; Tr. Vol. 13 at 57-59, 139-54)

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175. The Agency findings contained no analysis of how RME bays would have an impact on the number of treatment rooms CaroMont needed.

176. In the Agency findings regarding the Davie County replacement hospital, the Agency counted all types of rooms that Davie had listed in its application as treatment rooms, including areas defined as "fast track rooms, major resuscitation rooms, urgent/emergent rooms and behavioral health rooms, and determined that Davie's assumptions and methodology only supported the need for 16 treatment rooms and conditioned Davie to only develop a total of 16 treatment rooms rather than 20 treatment rooms. (CMHA Ex. 23 at 40)

177. The Agency was inconsistent in its evaluation of RME bays between the 2008 and 2009 CaroMont Application reviews and with the Davie County findings.

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195. CaroMont's Application proposed six (6) Rapid Medical Evaluation (RME) bays. (Jt. Ex. 3 at 16)

196. In the Agency findings regarding the 2008 Application, the Agency determined:

> "...the six RME bays are proposed to be used as both triage and fast track patient treatment areas. Specifically, on pg. 76 of the application, the applicants state
>
> *"RME bays provide a cost effective, efficient space for initial patient triage and evaluation...Patients arriving by private vehicle will be greeted by an emergency severity index-trained registered nurse...unstable patients will be placed in 12 monitored beds for physician evaluation and intervention...Stable, low acuity patients deemed to require further diagnostic workups will have appropriate imaging and lab testing ordered and initiated immediately in the RME bays...Develop a 'Fast Track' for treating minor-presenting complaints and use discharge lounge for patients awaiting discharge...The RME physician will discuss results and*
>
> *discharge plan with the patient and family in adjacent consultation room..."*
>
> Because the applicants intend to use the proposed six RME bays for treating minor complaints, the project analyst determined the applications propose to develop a total of 18 treatment rooms, which include 12 "monitored" rooms and 6 rapid medical evaluation (RME) bays..."

(Jt. Ex. 1 at 852)

197. The 2009 Application states:

> "RME bays provide a cost effective, efficient space for initial patient triage and evaluation...Patients arriving by private vehicle will be greeted by an emergency severity index-trained registered nurse...unstable patients will be placed in 12 treatment beds for physician evaluation and intervention...Stable, low acuity patients deemed to require further diagnostic workups will have appropriate imaging and lab testing ordered and initiated immediately in the RME bays...Expedite minor-presenting complaints using RME and treatment rooms...The RME physician will discuss results, treatments, and discharge plan with the patient and family in a treatment room..."

(Jt. Ex. 3 at 29)

198. In the 2009 Application, CaroMont removed the reference to "fast-track".

199. In both of the 2008 and 2009 Applications, CaroMont proposed fourteen (14) treatment rooms with six (6) triage/RME bays for a freestanding ED facility.

200. In the 2008 Application, the Agency determined that since the RME bays would be used for minor complaints, the RME bays had to be counted as treatment rooms. (Jt. Ex. 1 at 852)

201. In 2009, the Agency findings are silent as to whether RME bays should be counted as treatment rooms and contain no analysis of the six (6) RME bays utilization or capacity for reasonableness.

...

203. The Agency was inconsistent in its review of CaroMont's 2008 and 2009 Applications concerning their relative compliance with Criteria 3 and 6 related to the issues of unnecessary duplication.

Although GMH redacted certain language from Gaston I in its Gaston II application, the ALJ correctly found that there were not enough differences between the applications to justify the Agency's *"inconsistent"* treatment of compliance with Criteria 3 and 6 regarding RME bays. As noted previously, GMH includes additional language in Gaston III relative to RME bays in an attempt to indicate that RME bays will take the place of the traditional triage function. However, despite the addition of this language, inconsistencies (see discussion above) still remain which call into question how these rooms will be used. In addition, Gaston III does not contain any information regarding the capacity or utilization of the RME bays. In light of the ALJ's Recommended Decision, the Agency should review Gaston III in a manner consistent with Gaston I as no additional information of substance has been provided.

Ultrasound and Radiography Units

GMH does not demonstrate that the proposed one ultrasound and two radiography units are needed given that GMH operates existing ultrasound and radiography units at CaroMont Imaging Services-Belmont. On page 65 of its application, GMH reports that CaroMont Imaging Services-Belmont provided 3,405 general radiography procedures on two general radiography units in FY 2009 at its location in zip code 28012. GMH fails to report that CaroMont Imaging Services-Belmont provided 2,729 ultrasound procedures on one ultrasound unit in FY 2009, according to GMH's 2010 Hospital License Renewal Application. In fact, GMH fails to report any providers of ultrasound services in its proposed service area as requested in Section III.6.(a). With the proposed project, GMH will relocate the CT scanner from CaroMont Imaging Services-Belmont to the proposed MedPlex. GMH states that its decision to acquire two additional radiography units and one ultrasound rather than relocate its existing imaging capacity in the service area is based on cost; specifically, that *"[t]he cost associated with dismantling, relocating, and installing this equipment was found to be less effective as compared to purchasing new equipment"* (page 58). GMH's argument fails to demonstrate that additional capacity is needed, which must be shown regardless of whether the existing equipment is fully depreciated. In fact, if GMH's argument is accepted then any duplication of services could proceed as long as the addition of capacity is cheaper than physically relocating existing

capacity. GMH fails to consider an alternative whereby GMH would relocate and replace the equipment in question from CaroMont Imaging Services-Belmont. No cost would be incurred for dismantling, relocating, and installing the existing equipment, rather it would be decommissioned. Furthermore, additional unneeded capacity would not be added to the service area.

In FY 2009, the radiography units at CaroMont Imaging Services-Belmont operated at 36 percent capacity (36 percent capacity = 3,405 radiography procedures ÷ 9,360 procedure capacity per year[5]). These units currently have an excess capacity of 5,955 procedures. In the third project year, the MedPlex's two radiography units are projected to operate at 46 percent capacity, according to GMH's capacity definitions with an excess capacity of 9,398 procedures (46 percent = 8,074 procedures ÷ 17,472 procedure capacity per year). If GMH is to proceed as proposed and add two new duplicative X-ray units to the service area, then the combined utilization percentage will be 43 percent (43 percent = [3,405 + 8,074 procedures] ÷ [9,360 + 17,472 procedure capacity per year]). If GMH were to relocate and replace the two X-ray units, the combined utilization percentage would be 66 percent (66 percent = [3,405 + 8,074 procedures] ÷ 17,472 procedure capacity per year). GMH does not discuss why it has not chosen to relocate this imaging capacity and thus has not demonstrated the need for the proposed additional units.

	CIS-Belmont FY 2009	*MedPlex FY 2015*	*If Duplicated*	*If Relocated and Combined*
Capacity	9,360	17,472	26,832	17,472
Volume	3,405	8,074	11,479	11,479
Excess Capacity	**5,955**	9,398	**15,353**	**5,993**
Utilization Percentage	**36.4%**	**46.2%**	**42.8%**	**65.7%**

For all of the foregoing reasons, GMH should be found nonconforming with Criterion 3.

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5 Based on the number of procedures per hour (two) from page 89, but number of days per week (five) and hours per day (nine) based on David Legarth's hearing testimony in 09 DHR 6116: "*[t]hat facility is a scheduled outpatient imaging center. It does not operate on Sundays – Saturdays and Sundays. It only operates between 8 and 5 or 9 and 5 for scheduled visits.*" See Exhibit 5 for the relevant excerpt from David Legarth's hearing testimony in 09 DHR 6116. Thus, capacity of radiography units at CaroMont Imaging Services-Belmont is 9,360 procedures per year = five days per week x 52 weeks per year x nine hours per day x two units x 2 hour per procedure.

(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.*

GMH fails to demonstrate that it has proposed the least costly or most effective alternative. As discussed under Criterion 3, the applicant does not demonstrate the need of the population for the proposed project and has therefore also failed to demonstrate that its chosen alternative is the least costly or most effective.

Costs and Charges

GMH's Gaston III application represents a more costly alternative to its projected patients than its previously proposed Gaston II application. Specifically, net revenue per ED visit is 12 percent higher in Gaston III than in Gaston II and so patients will pay 12 percent more every time they visit the proposed ED. Similarly, net revenue per CT scan is three percent higher in Gaston III than in Gaston II. Data are provided only for FFYs 2013 and 2014 in the tables below as they are the only two overlapping years of operation for the proposed MedPlexes in Gaston II and III.

Comparison of Net Revenue per ED Visit at MedPlex

Net Revenue per Visit	*2013*	*2014*
Gaston III	$423	$444
Gaston II	$379	$398
Percent Difference	**11.7%**	**11.7%**

Comparison of Net Revenue per CT Scan at MedPlex

Net Revenue per Visit	*2013*	*2014*
Gaston III	$601	$631
Gaston II	$582	$611
Percent Difference	**3.3%**	**3.3%**

The result of this increase in costs to patients/payors is that the proposed MedPlex shows a positive net income at the lower volume in Gaston III than was projected in Gaston II. However, if the proposed MedPlex had the same gross charge and net revenue per ED visit and CT scan as proposed in Gaston II, net income for the project would be negative in the three project years, as summarized in the table below and shown in detail in Exhibit 6.

Restated Net Income for MedPlex

	2012	2013	2014
Restated Gross Revenue	$27,560,495	$29,450,201	$31,596,430
Restated Deductions	$21,563,984	$23,056,169	$24,753,985
Restated Net Patient Revenue	$5,996,511	$6,394,032	$6,842,445
Stated Total Expenses	$6,433,487	$6,735,204	$6,929,397
Restated Net Income	**-$436,976**	**-$341,172**	**-$86,952**

On page 53 of its application, GMH states that "*the proposed project to develop a freestanding emergency department in Mount Holly will promote cost-effective approaches.*" However, GMH's proposed facility will be more costly per patient than its current emergency department. According to the Form C for the freestanding emergency department, the total expense per patient in the third project year will be $455.79. GMH's total emergency department, which includes the MedPlex and the hospital, will have an expense per patient of only $181.12 according to its Form B. Thus, GMH is proposing a facility that will provide emergency services at 251 percent of the cost that its total emergency department on average will provide those services.

Comparison of Total Expense per Patient

	Project Year 1	*Project Year 2*	*Project Year 3*
MedPlex Total Expense per Patient	$443.08	$454.38	$455.79
Entire Emergency Department Total Expense per Patient	$178.39	$179.73	$181.12
MedPlex as Percent of Entire ED	**248%**	**253%**	**252%**

Moreover, emergency department patients treated at GMH's main hospital emergency department must have an even lower expense per patient than the average expense of $181.12 in order to offset the higher MedPlex per patient expense when calculating the average.

Ancillary Unnecessary Duplication

It can be assumed that any patient in the service area needing more than one type of outpatient imaging procedure (such as CT and X-ray) will now have to visit two different locations. GMH failed to demonstrate in its application that it is more effective to split diagnostic imaging between two sites. Clearly, requiring patients who were previously served at a single site to travel between two sites that are more than four miles apart is not the most effective alternative.

RME Bay Unnecessary Duplication

Further, GMH's proposal represents a particularly inefficient use of space and resources which negatively impacts both staff and patients. As part of the proposed project, GMH proposes to develop six rapid medical evaluation (RME) bays. On pages 30 through 33, GMH describes the throughput of the MedPlex, summarizing the process using the following table:

Traditional ED		Proposed MedPlex	
Step	**Process**	**Step**	**Process**
1.	Arrive in ED	1.	Arrive in ED
2.	Initial ABC Assessment	2.	Initial ABC Assessment
3.	If Triage available to Triage	3.	To Rapid Medical Evaluation Triage Bay
4.	If Triage not available to Waiting Room	4.	Diagnostic Testing or Imaging based on Standards of Care
5.	If in Waiting Room to Triage	5.	To Results Lounge or Treatment Room
6.	If Standards of Care used to Diagnostic Testing or Imaging	6.	If in Results Lounge to Treatment Room for test results and treatment
7.	If Standard of Care not used to Treatment Room if available; if Treatment Room not available to Waiting Room	7.	Receive test results and treatment completed
8.	If in Waiting Room to Treatment Room	8.	Patient discharged or transferred for admission
9.	If in Treatment Room to Diagnostic Testing or Imaging		
10.	Back to Treatment Room for test results		
11.	Receive test results and treatment completed		
12.	Patient discharged or admitted		

GMH intends the above table to demonstrate the efficiencies created by the MedPlex process. At first glance, it appears that the MedPlex process is shorter. However, the table is misleading. For example, in the traditional ED process column, GMH has inserted the steps taken if a triage or treatment room is not available; however, the hospital left those steps out in the MedPlex process. If at any peak time the RME bays or treatment rooms were full, two steps would be added to the process on the right. Further, step five of the traditional emergency department is duplicative of step three. This chart fails to accurately document the alleged efficiencies created over a traditional emergency department.

In fact, the proposed MedPlex process is actually less efficient for a facility this size. GMH states that the six RME bays will replace the typical triage function in an emergency department. Each patient will receive an evaluation in an RME bay immediately upon arrival at the emergency department and then will be sent to the radiology and laboratory departments for any diagnostic testing. Patients will then be transferred to a results lounge or a treatment bay. If the patient is sent to the results lounge they will eventually be transferred to a treatment room for treatment. If a patient arrives with a minor complaint, it appears as though GMH would not treat the patient in the RME bay, but would instead, transfer the patient to a treatment room. CHS believes that this care model is not only highly inefficient at the projected volume as it introduces one more hand-off from the RME bay to the final treatment room, but is overly burdensome for patients who are at the emergency department because they are not feeling well.

As the Chief Medical Officer of the Carolinas HealthCare System Metro Group, Dr. James Hunter, testified in the hearing on the 2009 review, the RME care model is not as efficient for lower volume, one-physician EDs. As Dr. Hunter noted in his testimony "*[w]ith the RME bays, they work particularly well with high-volume emergency departments with multiple physician staffing.*" The limitations of Gaston's model are that they will "*have to be aware of the hand-offs and use of the room, you know, to make sure that they are there. The physician is going to have perhaps two physical areas to monitor, as opposed to one.*" See Exhibit 7 for the relevant excerpt from Dr. Hunter's hearing testimony in 09 DHR 6116. Moreover, asking each patient to move multiple times throughout the approximately 46,000 square foot facility into at least four different rooms[6] in order to receive care is highly unlikely to improve patient satisfaction.

Both WakeMed and CHS have led the development of freestanding emergency departments in the Carolinas. Each of these approved and/or operational facilities proposes two triage bays in the main waiting room. Although they may move to receive diagnostic imaging tests, patients largely remain in one location. No other existing or approved freestanding emergency department in North Carolina has more than two triage bays. As demonstrated by multiple organizations developing this model, it appears to be the more effective and efficient model of freestanding emergency department care for a facility of the size and volume proposed by GMH.

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6 RME bay, diagnostic testing, results lounge and treatment room.

Inefficient Facility Design

Please see Exhibit 4 for a copy of CMHA's Hearing Exhibit # 46 which provides a facility comparison of North Carolina healthplex applications. As documented in the Exhibit, the average (excluding Gaston) ED square feet per treatment space is 969 square feet. Gaston III proposes 2,353 ED square feet per treatment room, which equates to **143 percent more space than the average healthplex facility** as demonstrated in Exhibit 4. GMH has built inefficiencies into the freestanding emergency department process by developing costly additional space and, as such, has failed to demonstrate that the building's design represents the most reasonable or least costly alternative.

As a result, the proposed facility is oversized. As noted previously, GMH submitted a 2009 application, Gaston II (Project ID # F-8340-09), to develop a freestanding emergency department in Mount Holly. In its previously approved application, GMH stated that the proposed new freestanding emergency department would contain a total of 46,108 square feet. As documented in Exhibit 4, Gaston II proposed 2,017 ED square feet per treatment space. In its current proposal, GMH proposes 46,108 total square feet for the freestanding emergency department, *the exact same size and footprint*, despite the fact that GMH has projected lower volumes and proposed to provide fewer treatment rooms. Given the decrease in the number of treatment rooms, Gaston III proposes 2,353 ED square feet per treatment space, a 17 percent increase from Gaston II. Please note that the proposed layout in Gaston III remains exactly the same as that proposed in Gaston II, it is only the room designations that change. In particular, Gaston III moves the pharmacy and medication rooms to spaces that were identified as treatment rooms in Gaston II. As proposed in Gaston III, the spaces vacated by pharmacy and medication become spaces that did not exist in Gaston II—a nurse office and EMS work room. Absent discussion from GMH it is unclear whether this reconfiguration represents the more effective alternative and design. In addition, GMH has failed to identify a need for these additional rooms—a nurse office and EMS work room—that did not exist in Gaston II.

Department/Section	*Gaston II Project ID # F-8340-09*	*Gaston III Project ID # F-8586-10*	*Difference (2009-2010)*
Emergency	28,233	28,233	0
Administrative	5,030	5,030	0
Mechanical	6,567	6,567	0
Loading/Building Support	6,278	6,278	0
Total	**46,108**	**46,108**	**0**

GMH failed to provide an explanation as to why Gaston III, which proposes fewer treatment rooms, is the same size as Gaston II and therefore did not adequately demonstrate in the application currently under review that the cost and design of the proposed new project represent the most reasonable alternatives. Therefore, GMH 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.

Given GMH's failure to demonstrate that its project as proposed is the most effective alternative, its application should be found 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.*

For the reasons discussed below, GMH fails to demonstrate the immediate and long-term financial feasibility of the project.

Erroneous Financial Assumptions

As noted above in the discussion under Criterion 4, GMH's proposed project is a more costly alternative to its projected patients than its previous proposal, Gaston II. If the MedPlex had the same gross charge and net revenue per ED visit and CT scan as proposed in Gaston II, net income for the project would be negative in the three project years, as summarized in the table below and shown in detail in Exhibit 6.

Moreover, GMH fails to include all of the staffing expense necessary to operate its entire emergency department through the third project year. In

the first project year, GMH projects $9,418,038 in total salaries for its entire emergency department which represents an increase of $1,942,302 over the prior year (see Form B, pages 154 - 155). This increase of close to $2 million should represent the additional staff needed for the opening of the proposed MedPlex net of any staff reductions at GMH's existing ED allowed by reduced volume due to the shift of visit to the MedPlex. In the first project year, the MedPlex projects $3,257,975 in total salaries, thus the required reduction in salary expense at the GMH's existing emergency department is $1,315,373 or 18 percent reduction in salary expense from the year prior to the first project year. This reduction in salary expense is unreasonable as ED visits at GMH's existing ED are projected to decrease only by 10 percent.

	FY 2012 (Last Year Prior to Project)	*FY 2013 (Project Year 1)*	*Difference*	*FY 2012 to 2013 Percent Change*
GMH Total ED Salary Costs	$7,475,436	$9,418,038	$1,942,602	26.0%
MedPlex Salary Costs	$0	$3,257,975	$3,257,975	N/A
Main ED Salary Costs (Total - MedPlex)	$7,475,436	$6,160,063	($1,315,373)	-17.6%
Main ED Visits	111,594	100,410	(11,184)	-10.0%

Similarly, GMH fails to include all of the indirect expenses necessary to operate its entire emergency department through the third project year. In the first project year, GMH projects $5,896,695 in total indirect costs for its entire emergency department which represents an increase of $1,136,429 over the prior year (see Form B, pages 154 - 155). This increase of more than $1 million should represent the indirect expenses associated with the opening of the proposed MedPlex net of any reductions allowed at GMH's existing ED. In the first project year, the MedPlex projects $2,025,651 in indirect expenses, thus the required reduction in indirect expense at the GMH's existing emergency department is $889,222 or 19 percent reduction in indirect expense from the year prior to the first project year. Again, this reduction in indirect expense is unreasonable as ED visits at GMH's existing ED are projected to decrease only by 10 percent.

	FY 2012 (Last Year Prior to Project)	*FY 2013 (Project Year 1)*	*Difference*	*FY 2012 to 2013 Percent Change*
GMH Total ED Indirect Expense	$4,760,266	$5,896,695	$1,136,429	23.9%
MedPlex Indirect Expense	$0	$2,025,651	$2,025,651	N/A
Main ED Indirect Expense (Total - MedPlex)	$4,760,266	$3,871,044	($889,222)	-18.7%
Main ED Visits	111,594	100,410	(11,184)	-10.0%

GMH assumes an equal average charge[7] per patient for its MedPlex and total emergency department financial statements. However, as GMH suggests throughout its application in its adjustments for acuity[8], the MedPlex is not projected to treat any patients that require inpatient admission and so will on the whole, treat lower acuity patients than its current ED. As shown in Exhibit 14 of Gaston II (Gaston III does not provide this information by acuity level), the utilization rate of ancillary services varies significantly by acuity level.

Ancillary Utilization Rates		**Level V**	**Level IV**	**Level III**	**Level II**	**Level I**	**Level I-IV**	**Level I-V**
Lab	Tests per 100 ED Visits	897.3	304.7	83.5	24.3	21.9	152.0	321.1
Pharmacy	Units per 100 ED Visits	914.7	290.4	170.2	93.5	26.6	198.3	360.9
Ultrasound	Procedures per 100 ED Visits	23.0	11.8	0.3	0.2	0.5	4.4	8.6
General Radiography	Films per 100 ED Visits	77.4	78.0	34.9	1.4	2.5	44.7	52.1
CT	Scans per 100 ED Visits	62.5	35.8	0.6	0.2	1.5	13.0	24.3

GMH provides no explanation for why charges would be equivalent despite this disparity in ancillary utilization between patients seen at the MedPlex and patients for the total emergency department. As such, GMH has likely overstated the revenue for the MedPlex as the charges for the MedPlex should be lower than its total emergency department based on the lower utilization of ancillary services. Given that GMH fails to provide projected charges for the MedPlex that correspond to the patients it projects to serve at the MedPlex, it is impossible to determine the revenue impact and thus the impact on financial feasibility of these overstated charges.

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7 Including an ED visit charge and ancillary service charges.

8 In Step 2 of its need methodology, GMH states that it used "*actual 2009 Emergency Department visits (from all hospitals, but excluding ED visits which resulted in an inpatient admission*" (page 73). In Step 8 of its need methodology, GMH states "[i]*t is important to note that the GMH Emergency Department data that was used to generate the ancillary service volumes for the MedPlex does not represent any patients who were either admitted to GMH or received surgical services*" (page 81).

In addition to these issues, GMH projects drastically different overhead expenses for the proposed MedPlex compared to its total emergency department. According to the Form C assumptions for the freestanding emergency department, overhead is projected to be ten percent of direct expenses (page 147). By contrast, GMH's total emergency department is projected to have overhead expenses of 38.9 percent of direct expenses based on its historical experience in 2009 (page 162). GMH provides no explanation for this disparity and it seems unreasonable to project significantly lower overhead expenses for the MedPlex, which is operated as part of the GMH's emergency department, than GMH experienced historically and projects for the future for its combined emergency departments, including the MedPlex.

If the MedPlex's overhead expense is projected to be at the same level as the historical and projected overhead expense of GMH's total emergency department, then the MedPlex shows a loss of $1,442,732 in project year three, as demonstrated below (includes restated net revenue from above analysis).

	Project Year 3
Restated Net Revenue (shown in Exhibit 6)	$6,842,445
Stated Direct Expenses	$4,742,534
Stated Indirect Expenses	$2,186,863
Understated Overhead*	$1,355,780
Restated Indirect Expenses	**$3,542,643**
Restated Net Income	**-$1,442,732**

*Understated Overhead is calculated as follows: $1,355,780 = (Overhead Expense as Percentage of Direct Expenses at 38.9% x Stated Direct Expenses of $4,742,534) - Stated Overhead Expenses of $489,066.

As demonstrated, the proposed MedPlex is not financially feasible using financial assumptions that are consistent with GMH's own assumptions for the total emergency department.

It should also be noted that GMH fails to provide a line item expense for utilities in its MedPlex or total emergency department financial statements, nor does it provide an explanation for the exclusion. In addition, GMH lists its projected annual expenses for medical supplies, other supplies, and equipment maintenance, but fails to provide any support for these assumptions. The basis for these projections is unclear and thus their reasonableness cannot be determined.

The total emergency department pro forma Form B does not include Capitalized Expense, Depreciation - Buildings, or Depreciation - Equipment, all of which are included in the MedPlex pro forma. Given that the MedPlex is operated as part of total emergency department, these expenses should be included on Form B. GMH has not included these expenses in the overhead line item on Form B as this expense maintains its relationship of 38 percent of direct expenses throughout and the increase from FY 12 to FY 13, the first project year, is only $1,046,880 whereas the depreciation expense for building and equipment for the MedPlex is $1,212,467. As such GMH's Form B financial statement is understated by the depreciation expense associated with the project. Further, these expenses will be incurred by Gaston Memorial Hospital, Inc. and should be included on the associated statement of revenues and expenses.

Given these inconsistent assumptions, GMH's financial statements are unreliable. As shown in the above analyses, GMH's financial statements contain unsupported and inconsistent assumptions, understate expenses, and overstate revenue. Therefore, the applicant should be found nonconforming with Criterion 5.

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

Given the current appeal of the 2009 review, approval of Gaston III could result in unnecessary duplication of services given that Gaston III does not address the potential approval of CHS's proposed emergency department. As noted previously, in the event that the FAD upholds the ALJ's Recommended Decision by finding that CHS's application was conforming (under scenarios 1 and 2 discussed previously), GMH has failed to demonstrate the need for Gaston III in light of CHS's approval. That is, GMH failed to address the impact of CHS's potential approval. As discussed in detail above, this interpretation is consistent with prior Agency findings such as the 2007 Rowan Regional Medical Center-South Findings and the 2006 Mint Hill Hospital/Healthplex Findings. Please see Exhibits 1 and 2 for relevant excerpts from these findings.

Relative to Gaston III, GMH failed to take into account the impact of the 2009 review. Although there is no existing emergency department in the proposed service area, in the event the FAD upholds the ALJ's Recommended Decision by finding that CHS's application was conforming and Gaston II was non-conforming, GMH has failed to demonstrate the need for its proposed emergency department in addition

to CHS's proposed emergency department in Gaston County. In fact, as noted on page 51 of Gaston III, GMH states that "*the east Gaston area, including western Mecklenburg County has a central population area in Mount Holly and a population large enough to support* ***a*** *freestanding emergency department.*" (emphasis added).

(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.*

The applicants propose to construct a freestanding emergency department in Mount Holly, Gaston County. However, on October 9, 2009, GMH was previously approved by the CON Section to construct a freestanding emergency department on the same site. That decision is currently under appeal. Differences between Gaston III and Gaston II include fewer treatment rooms in Gaston III and volume projections that are based only on internal shifts. Despite the fact that the proposals are not identical, but merely "*similar,*" as characterized by GMH on page 6 of its application, GMH fails to provide any independent physician support for Gaston III. Instead, GMH relies on the support previously submitted with Gaston II. Given that the projects are similar but not identical and that Gaston II was filed more than a year prior to Gaston III, it is not reasonable to expect that the same physicians who supported Gaston II would also support Gaston III particularly in light of the ALJ's Recommended Decision and the FAD which could result in the approval of CHS's application.

(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.*

GMH fails to demonstrate that the cost, design, and means of construction proposed represent the most reasonable alternative. The applicant proposes to develop a two-story, 46,108 square foot facility on approximately 5.9 acres of land for the freestanding hospital-based outpatient department. The proposed facility is oversized as described below.

As noted previously, GMH submitted a 2009 application, Gaston II (Project ID # F-8340-09), to develop a freestanding emergency department

in Mount Holly. Please see Exhibit 4 for a copy of CMHA's Hearing Exhibit # 46 which provides a facility comparison of North Carolina healthplex applications. In Gaston II, GMH stated that the proposed new freestanding emergency department would contain a total of 46,108 square feet. As documented in CMHA's Hearing Exhibit # 46, Exhibit 4, Gaston II proposed 2,017 ED square feet per treatment space. In its current proposal, GMH proposes 46,108 total square feet for the freestanding emergency department, *the exact same size and footprint*, despite the fact that GMH has projected lower volume and proposed to provide fewer treatment rooms. Given the decrease in the number of treatment rooms, Gaston III proposes 2,353 ED square feet per treatment space, a 17 percent increase from Gaston II. Please note that the proposed layout in Gaston III remains exactly the same as that proposed in Gaston II; it is only the room designation that changes. In particular, Gaston III moves the pharmacy and medication rooms to spaces that were identified as treatment rooms in Gaston II. As proposed in Gaston III, the spaces vacated by pharmacy and medication become spaces that did not exist in Gaston II—a nurse office and EMS work room. Absent discussion from GMH, it is unclear whether this reconfiguration represents the more effective alternative and design. In addition, GMH has failed to identify a need for these additional rooms—a nurse office and EMS work room—that did not exist in Gaston II.

Department/Section	*Gaston II Project ID # F-8340-09*	*Gaston III Project ID # F-8586-10*	*Difference (2009-2010)*
Emergency	28,233	28,233	0
Administrative	5,030	5,030	0
Mechanical	6,567	6,567	0
Loading/Building Support	6,278	6,278	0
Total	**46,108**	**46,108**	**0**

GMH failed to provide an explanation as to why Gaston III, which proposes fewer treatment rooms, is the same size as Gaston II and therefore did not adequately demonstrate in the application currently under review that the cost and design of the proposed new project represent the most reasonable alternatives, particularly in light of CMHA's Hearing Exhibit # 46 which provides a facility comparison of the total ED square feet of North Carolina healthplexes.[9] In fact, when

[9] As documented in CMHA's Hearing Exhibit # 46, the healthplexes (excluding Gaston) total ED square feet range from 6,638 to 13,100 square feet.

compared to Gaston II, Gaston III is proposing a 33 percent[10] reduction in volume but the facility is remaining the same size, with the ED square feet per treatment space increasing by 17 percent from Gaston II. Therefore, GMH 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.

SUMMARY

As of the date of these comments, a Final Agency Decision (FAD) regarding the 2009 review has not been issued. The deadline for the FAD is November 19, 2010. As noted previously, there are multiple possible scenarios for the FAD. CHS maintains that under any of the FAD scenarios discussed, ***there is no reasonable way that the Agency can approve Gaston III***. Not only did Gaston III fail to take into account the impact of the 2009 review, but also a number of the reasons the ALJ found Gaston II non-conforming also apply to Gaston III. Notwithstanding the nonconformities with the Gaston III application itself, given that GMH has not demonstrated that Gaston III is needed under any/all outcomes that could occur once litigation is concluded, the Agency cannot approve Gaston III.

---

10 In Gaston II Project Year 3 ED treatments = 22,191 (page 66) while in Gaston III Project Year 3 ED treatments = 15,203 (page 80). 33 percent = (22,191-15,203)/22,191.

Exhibit 1

ATTACHMENT - REQUIRED STATE AGENCY FINDINGS

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

DECISION DATE:	March 28, 2008
FINDINGS DATE:	April 4, 2008
PROJECT ANALYST:	Carol L. Hutchison
CHIEF:	Lee B. Hoffman
PROJECT I.D. NUMBER:	F-7994-07/ Rowan Regional Medical Center (Lessee), Rowan Health Services Corporation, Novant Health Inc. (Lessor), and Rowan Regional Medical Center-South, LLC/ Relocate 50 existing licensed acute care beds from Rowan Regional Medical Center in Salisbury to establish a new separately licensed hospital in Kannapolis / Rowan 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

Rowan Regional Medical Center (RRMC) proposes to relocate 50 existing acute care beds to Kannapolis to establish a new separately licensed hospital. The proposal does not result in an increase in the total number of licensed beds, operating rooms or gastrointestinal endoscopy procedure rooms located in Rowan County. Further, 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 2007 State Medical Facilities Plan (2007 SMFP). Therefore, there are no need determinations in the 2007 SMFP that are applicable to this proposal.

However, because the applicants propose to construct new space to replace 50 existing acute care beds to be relocated from Salisbury to Kannapolis, Policy

Projected Outpatient Visits
Project Years 1-3

Zip Code	*City/Town*	*PY 1 2011*	*PY 2 2012*	*PY 3 2013*
28023	*China Grove*	*2,875*	*3,504*	*4,137*
28025	*Concord*	*3,332*	*4,110*	*4,911*
28027	*Concord*	*1,779*	*2,213*	*2,666*
28081	*Kannapolis*	*6,694*	*8,186*	*9,698*
28083	*Kannapolis*	*6,033*	*7,403*	*8,801*
28088	*Landis*	*601*	*729*	*856*
28138	*Rockwell*	*1,611*	*1,980*	*2,358*
Total Outpatient Visits in Defined Service Area		*22,925*	*28,123*	*33,427*
Other In-migration (10%)		*2,547*	*3,125*	*3,714*
Total Outpatient visits		*25,472*	*31,248*	*37,142*

Source: Exhibit 20, Table 21
Note: Project Year 1 begins 1/1/2011

The previous table reflects total outpatient visits at RRMC-S in the defined service area for the first three years of the proposed project."

However, the applicants did not demonstrate the need for additional outpatient services in the proposed service area relative to existing outpatient services currently offered and those services recently approved or proposed, as indicated in the following table:

Carolinas HealthCare System & CMC-NorthEast	**Novant**	**RRMC**
NorthEast Outpatient Center-Copperfield (existing)	Presbyterian Diagnostic Center at Cabarrus – Concord (proposed)	South Rowan Medical Mall – China Grove (existing)
NorthEast Pavilion –Concord (existing)		
NorthEast Outpatient Rehab Center – Concord (existing)		
Southern Piedmont Imaging – Kannapolis (approved)		
Renaissance Square – Davidson (existing)		
CMC-Kannapolis – Kannapolis (approved)		

The outpatient facilities identified above offer an array of outpatient diagnostic, imaging and physician services to residents of the proposed service area. For example, NorthEast Outpatient Center in Copperfield offers outpatient surgery, endoscopy procedures, pain management, and diagnostic imaging services, including CT, MRI, X-ray, ultrasound, and mammography. NorthEast Pavilion offers outpatient oncology and cardiology diagnostic and treatment services. NorthEast Renaissance Square provides women's health services, diagnostic and imaging services, and internal medicine and pediatric services. CMC-NorthEast operates an outpatient rehabilitation center in

Concord for physical therapy, occupational therapy, speech therapy and other rehab services, and Southern Piedmont Imaging Center was recently approved to provide diagnostic and imaging services to Kannapolis and the surrounding area. Also, RRMC owns South Rowan Medical Mall in China Grove, but the applicants did not provide a description of the outpatient diagnostic imaging services offered at this location. Therefore, given all of the above resources, the applicants failed to demonstrate that there is not sufficient existing or approved capacity in the area to meet the outpatient needs of the population proposed to be served.

Further, the applicants did not provide a statistical basis for how the projected incremental increases in outpatient visits market share were determined for each zip code area. It should be noted that these increases, which range from 2.5% to 20%, are in addition to the market share to be shifted from RRMC. Thus, the applicants did not adequately demonstrate that the projected numbers of outpatient visits to be proposed at the new hospital are based on reasonable and supported assumptions. Therefore, the applicants did not adequately demonstrate the need for all of the outpatient visits proposed to be provided at the new hospital.

Projected Emergency Department Visits and Emergency Treatment Rooms

The applicants propose to develop a new emergency department with 12 treatment bays and two triage rooms. On page 66 of the application, the applicants state

"2005 North Carolina Emergency Department Visit Use Rate

*RRMC-S used the North Carolina Emergency Department Visit Use Rate for community hospitals defined by the American Hospital Association (AHA) to project emergency department visits. Data compiled from the AHA Annual Survey are used to calculate state specific utilization rates. The 2005 North Carolina Emergency Department Visit Use Rate was 436 visits per 1,000 population as reflected in Exhibit 20, Table 22. In addition, the 2005 North Carolina Emergency Department Visit Use Rate was increased 1.3% annually to reflect the increasing use of emergency services in North Carolina and nationally.** [*Note: In footnote 19, on page 67 of the application, the applicants reference the *American College of Emergency Physicians, 'The National Report Card on the State of Emergency Medicine' www.myacep.org; The Advisory Board Company, 'Future of EDs,' June 11, 2005; 'A Growing Hole in the Safety Net: Physician Charity Care Declines Again,' Center for Health System Change, www.hschange.org; American College of Physicians-American Society of Internal Medicine, www.medicalreporter.health.org."] The projected North Carolina Emergency Department Visit Use Rate was used to determine total emergency department visits and RRMC market share by zip code in the defined service area for the first three years of the proposed project."*

Projected Emergency Department Visits
Project Years 1-3

Zip Code	*City/Town*	*PY 1 2011*	*PY 2 2012*	*PY 3 2013*
28023	*China Grove*	*940*	*1,161*	*1,388*
28025	*Concord*	*1,621*	*2,025*	*2,451*
28027	*Concord*	*1,298*	*1,636*	*1,996*
28081	*Kannapolis*	*2,443*	*3,026*	*3,632*
28083	*Kannapolis*	*2,200*	*2,735*	*3,293*
28088	*Landis*	*246*	*302*	*360*
28138	*Rockwell*	*593*	*739*	*891*
Total Emergency Department Visits in Defined Service Area		*9,341*	*11,623*	*14,012*
Other In-migration (10%)		*1,038*	*1,291*	*1,557*
Total Emergency Department visits		*10,379*	*12,914*	*15,569*
Emergency Treatment Rooms Needed @ Planning Capacity		*8*	*10*	*12*

Source: Exhibit 20, Table 22 Note: Project Year 1 begins 1/1/2011
Numbers may not sum due to whole unrounded figures used in calculations

The previous table reflects total emergency department visits, and emergency department treatment rooms needed based upon American College of Emergency Physicians emergency planning capacity of 1,333 Emergency Visits per Treatment Room for Emergency Departments with 20,000 Visits, included in Exhibit 20, Table 23, which results in a need at RRMC-S for 12 emergency treatment rooms in CY 2013."

However, the applicants did not provide documentation to support their assumption that the service area zip code ED use rate would increase 1.3% annually from 2005 to 2013. In addition, the applicants did not provide a statistical basis for how the projected increases in emergency department visits market share were determined for each zip code area. It should be noted that the increases, which range from 7.5% to 30%, are in addition to the market share to be shifted from RRMC. Thus, the applicants did not adequately demonstrate that the projected numbers of emergency department visits at the proposed new hospital are based on reasonable and supported assumptions. Further, on February 27, 2008, CMC-NorthEast (Project I.D. #F-7951-07) was approved for a freestanding emergency department in Kannapolis with 10 treatment rooms to expand the hospital's emergency department capacity. The applicants were aware this application had been filed but did not address the impact of its potential approval on the projected utilization at RRMC-S. In summary, the applicants did not adequately demonstrate the need the persons projected to be served have for the proposed emergency department services.

Projected Ancillary Services Utilization

On page 69 of the application, the applicants state

Exhibit 2

ATTACHMENT - REQUIRED STATE AGENCY FINDINGS

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

DECISION DATE: February 5, 2007
PROJECT ANALYST: Martha J. Frisone
CHIEF: Lee B. Hoffman

PROJECT I.D. NUMBERS:

F-7707-06/ The Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas Medical Center–Mint Hill, Mercy Hospital, Inc. and CS Center, LLC/ Relocate 50 existing acute care beds and one existing gastrointestinal endoscopy procedure room from Carolinas Medical Center–Mercy/Pineville and four existing dedicated outpatient operating rooms from Carolinas Surgery Center–Randolph to establish a new hospital in Mint Hill/ Mecklenburg County

F-7709-06/ The Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas Medical Center–University/ Develop a healthplex (i.e., freestanding emergency room with outpatient imaging and diagnostic services) in Mint Hill which will be licensed as part of Carolinas Medical Center–University/ Mecklenburg 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 – Project I.D. #F-7707-06
NA – Project I.D. #F-7709-06

procedures that are over the defined capacity of the three fixed units."

According to the above statements, the following table illustrates projected utilization for only the three units of fixed x-ray equipment at CMC-Mint Hill Hospital during the first three operating years, as reported by the applicants in Section IV.1, page 249.

	# OF X-RAY PROCEDURES
Year One (9/1/09 – 8/31/10)	13,011
Year Two (9/1/10 – 8/31/11)	18,216
Year Three (9/1/11 – 8/31/12)	23,570

Source: Section IV.1, page 249.

As shown in the above table, using "Methodology 2" described above, the applicants project that the fixed x-ray equipment at CMC-Mint Hill Hospital will perform a total of 23,570 procedures during Year Three. However, this projection exceeds the applicants' stated capacity of 22,464 procedures for the fixed equipment by about 5% [23,570 / 22,464 = 1.049]., and therefore is not reasonable.

Duplication of Previously Approved Hospital

Section III.7 of the application requests that the applicant *"Explain and provide specific documentation of the inadequacy or inability of existing providers to meet the identified need."* In response, on pages 227-228, the applicants state

"[T]*here are no providers of the proposed services in the four zip code service area; thus, no providers can meet the identified need within the service area. Moreover, there are no hospitals in the service area, and, as demonstrated in Section III.1, CHS believes there is a need for a hospital in Mint Hill. No existing providers can meet the need for the proposed services at a location in the four zip code service area. In fact, the proposed project is designed specifically to address and meet the need represented by the lack of providers in the service area."*

Although there is no existing hospital in the proposed service area, in a previous review, the Certificate of Need Section approved the development of a new 50-bed hospital in the proposed service area, Presbyterian Hospital Mint Hill (see Project I.D. #F-7648-06). The new hospital will be located approximately three miles from the proposed CMC-Mint Hill Hospital. Presbyterian Hospital Mint

the need represented by the lack of providers in the service area."

Although there is no existing ER facility which also offers outpatient imaging and diagnostic services in the proposed service area, in a previous review, the Certificate of Need Section approved the development of a new 50-bed hospital in the proposed service area, Presbyterian Hospital Mint Hill (see Project I.D. #F-7648-06). The new hospital will be located approximately three miles from the proposed CMC-Mint Hill Hospital. Presbyterian Hospital Mint Hill will offer the same services proposed by CMC-Mint Hill Healthplex, as illustrated in the following table.

SERVICES TO BE PROVIDED	PRESBYTERIAN HOSPITAL MINT HILL	CMC-MINT HILL HEALTHPLEX
# of General med/surg beds	38	NA
# of ICU beds	4	NA
# of LDRPs	8	NA
Level I Nursery (unlicensed bassinets)	yes	NA
# of Unlicensed Observation Beds	10	3
# of Shared ORs	4	NA
# of Dedicated C-section ORs	1	NA
# of GI endoscopy Rooms	1	NA
ER	yes	yes
Lab	yes	yes
Pharmacy	yes	yes
Cardiopulmonary	yes	no
Respiratory Therapy	yes	no
PT/ST/OT	yes	no
CT scanner	yes	yes
Nuclear Medicine	yes	no
US	yes	yes
X-ray	yes	yes
Mammography	yes	no

Further, the population proposed to be served by Presbyterian Hospital Mint Hill and CMC-Mint Hill Healthplex is similar, as illustrated in the following table.

Exhibit 3

STATE OF NORTH CAROLINA — IN THE OFFICE OF ADMINISTRATIVE HEARINGS

COUNTY OF GASTON — 09-DHR-6116

THE CHARLOTTE MECKLENBURG HOSPITAL AUTHORITY d/b/a CAROLINAS REHABILITATION-MOUNT HOLLY AND d/b/a CAROLINAS HEALTHCARE SYSTEM, PETITIONER, VS. N.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF HEALTH SERVICE REGULATION, CERTIFICATE OF NEED SECTION, RESPONDENT, and CAROMONT HEALTH, INC., and GASTON MEMORIAL HOSPITAL, INC. RESPONDENT-INTERVENORS.	VOLUME 4

HEARING BEFORE THE

HONORABLE SELINA BROOKS
ADMINISTRATIVE LAW JUDGE

At Charlotte, North Carolina

April 15, 2010

REPORTER: KATHLEEN D. BROWNING, STENOGRAPH SHORTHAND REPORTER, NOTARY PUBLIC

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* * * * *

I N D E X

of the written comment period, the department shall insure that a public hearing is conducted."

And then if you move on to the subparagraph (a) and (b), (a) says that:

"One of the reasons, or one of the things that the public hearing is for is an opportunity for the proponents of each application under review to respond to the written comments submitted to the department about its application."

Q. Okay. And let's shift gears back to the CHS application and the Agency review of that. Do you recall, you were here for Ms. Hutchinson's testimony, about the in-migration that CHS proposed for its application, correct?

A. Yes.

Q. Okay. And generally it's your understanding that in-migration is a concept that is used in CON health planning to describe patients that are expected to be served by a facility outside of the defined service area?

A. Well, the CON section has taken the position that the service area is everywhere that -- how do you explain that? We do have applicants who will put some in-migration percentage in their application, usually to

cover that part of the service area. That's where I'm having difficulty, because we consider the in-migration to be part of the service area. It's just that part of the service area where it's, you know, you are going to have five, ten, fifteen percent of your patients are going to come from farther away than typical, and they may vary.

So Charlotte is on an interstate highway. A hospital in Charlotte could easily end up with patients from New York, from New Jersey, from Florida. But it may vary from year to year, as to how many from New York end up somehow in a hospital in Charlotte. But overall, year to year, it's that percentage that are not necessarily residents of a five, or ten, or twenty-mile radius, or certain counties contiguous to the county where the facility is located remains fairly stable. It will be five percent or ten percent. And that is typically what an applicant in a field application is calling their in-migration.

It's that percentage they get every year from farther away than typical. And five percent may only stay about the same, but where those people come from within that five percent may vary from year to year.

Q. You don't recall discussing with Ms. Hutchinson, during the review, CHS's proposed

in-migration projections, do you?

A. I don't recall any specific discussion. We may very well have, but I don't recall any discussions at the time.

Q. And you don't recall, during the review, discussing with Ms. Hutchinson the assertion in the findings that CHS's proposed service area here unduly overlaps with the Northcross and Steele Creek's service areas?

A. Now, let me be sure, for the sake of the record, that we are clear. You are talking about an oral conversation between Ms. Hutchinson and I?

Q. Yes.

A. I don't recall that, but obviously that information is in her findings, and I would have reviewed her findings.

Q. Okay. You didn't specifically -- you never, during the review, measured by patient or projected visits, what the amount of overlap might be between the proposed CMS-Mount Holly service area and the service areas of the Northcross and Steele Creek facilities?

A. No, I did not.

Q. Okay. Do you agree -- you heard Ms. Hutchinson testify about that, didn't you?

A. I was here during her testimony about that,

Exhibit 4

EXHIBIT
tabbies
46

CR-Mount Holly
Healthplex Reviews
Facility Comparison

ATTACHMENT 4

Applicant	*Total # of ED Pt Treatment Spaces*	*Total Building SF*	*Total ED SF*	*Total ED SF Per Treatment Space*	
CHS					
CMC-Waxhaw I	8	21,000	7,600	950	
CMC-Mint Hill	10	20,400	7,900	790	
CMC-Steele Creek	8	22,500	8,150	1,019	
CMC-Kannapolis	10	23,973	8,920	892	
CMC-Waxhaw II	8	21,000	7,600	950	
CMC-Northcross	9	21,000	13,100	1,456	
CMC-Mount Holly	8	26,000	9,705	1,213	
Others					
WakeMed North	7	13,442	5,313	759	
WakeMed Apex	10	72,900	9,759	976	
WakeMed East	10	29,241	9,759	976	
Moses Cone/High Point	10	29,036	7,984	798	
NorthEast Harrisburg	6	23,689	6,638	1,106	
JMH Clayton	10	50,950	9,250	925	
WakeMed Brier Creek	14	24,257	10,536	753	
WakeMed South	10	23,480	9,759	976	
Gaston Memorial Hospital I	13	30,950	21,850	1,681	
Gaston Memorial Hospital II	14	46,108	28,233	2,017	
				969	*Average, excluding Gaston*

	Patient Room Type				
	Treatment Rooms Stated in Application	Triage/RME Bays	Observation Beds	Other	Triage/RME % of Treatment Rooms
CHS					
CMC-Waxhaw I	8	+2	+3		25%
CMC-Mint Hill	10	+2	+2		20%
CMC-Steele Creek	8	+2	+2		25%
CMC-Kannapolis	10	+1	+2		10%
CMC-Waxhaw II	8	+2	+2		25%
CMC-Northcross	9	+2	+2		22%
CMC-Mount Holly	8	+1	+2		13%
Others					
WakeMed North	7	+2	+3		29%
WakeMed Apex	10	+2		+1 Resuscitation	20%
WakeMed East	10	+2		+1 Resuscitation	20%
Moses Cone/High Point	10	+1			10%
NorthEast Harrisburg	6	+1	+1		17%
JMH Clayton	10	+2	+4		20%
WakeMed Brier Creek	14	+2			14%
WakeMed South	10	+2			20%
Gaston Memorial Hospital I	14	+6			43%
Gaston Memorial Hospital II	14	+6			43%

Source: Respective CON Applications, Section II.1, XI.4, and line drawings

Exhibit 5

STATE OF NORTH CAROLINA — IN THE OFFICE OF ADMINISTRATIVE HEARINGS

COUNTY OF GASTON — 09-DHR-6116

THE CHARLOTTE-MECKLENBURG HOSPITAL AUTHORITY d/b/a CAROLINAS REHABILITATION-MOUNT HOLLY AND D/B/A CAROLINAS HEALTHCARE SYSTEM,
Petitioner,

vs.

N.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF HEALTH SERVICE REGULATION, CERTIFICATE OF NEED SECTION,
Respondent,

And

CAROMONT HEALTH, INC., AND GASTON MEMORIAL HOSPITAL, INC. HEALTHCARE SYSTEM,
Intervenor-Respondent.

HEARING BEFORE THE
HONORABLE SELINA BROOKS
ADMINISTRATIVE LAW JUDGE

VOLUME 8

At Charlotte, North Carolina

April 22, 2010

REPORTER: CAROL S. LOEWEN, RPR
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I-N-D-E-X

E-X-H-I-B-I-T-S

NO.	ADMITTED
7	27
37	25
38	44
49	11
138	88
147	27

compare to the cost of a CT scanner?
A. The cost is minimal as compared to a CT scanner.
Q. Okay. In this particular argument by CMHA they've done some calculation of the capacity of the ultrasound and x-ray equipment. Are you familiar with that?
A. Yes.
Q. Okay. Do you have any opinions related to Ms. Carter's calculation of the capacity for that equipment?
A. Yes, I do.
Q. Please explain those.
A. I think that the -- I think that what was presented was a little misleading. If you were to look at the utilization of the machines at the facility, you would have to use the capacity of those machines at that facility. That facility is a scheduled outpatient imaging center. It does not operate on Sundays -- Saturdays and Sundays. It only operates between 8 and 5 or 9 and 5 for scheduled visits. Because of that the capacity of those machines at that facility will be dramatically less than what they would be at a free-standing ED where essentially they're available 24 hours a day. So when you actually

look at the utilization of those pieces of equipment as outpatient imaging systems at an outpatient imaging center, the utilization, although not over some established amount that doesn't exist, is reasonable for an outpatient center.

Q. Okay. Let's talk about the next issue that CMHA raised with regards to the Caromont project, the criterion -- and are you familiar with Ms. Carter's testimony regarding Criterion 3A and Caromont's proposal to relocate its CT scanner from its imaging facility in Belmont to the free-standing ED?

A. Yes, I am.

Q. Okay. Let's start by turning to page 17 of the Caromont application. Do you have opinions related to this testimony by Ms. Carter?

A. Yes, I do.

Q. Okay. And is the information on page 17 of the Caromont application related to your opinions?

A. Yes, it is.

Q. Can you please explain that.

A. Yes. In the -- essentially the last two sentences of the second full paragraph which begins: The end results, in the middle of that -- in the middle of

Exhibit 6

Gaston Memorial Hospital, Inc.
Freestanding Emergency Department

Form C - Statement of Revenue and Expenses, ***REVISED***

		Year 1 Full FY	Year 2 Full FY	Year 3 Full FY
	From	10/1/2012	10/1/2013	10/1/2014
	To	9/30/2013	9/30/2014	9/30/2015
# of ED Visits		14,520	14,823	15,203
# of OP CT Scans		2,623	2,623	2,623
REVENUE				
Gross Patient Revenue				
Self Pay/Indigent/Charity		$6,465,205	$6,928,668	$7,459,700
Medicare/Medicare Managed Care		$4,834,208	$5,150,112	$5,505,306
Medicaid		$8,092,426	$8,664,880	$9,319,104
Commercial Insurance		$4,395,148	$4,686,028	$5,013,976
Managed Care		$2,957,028	$3,147,348	$3,360,635
Other		$816,479	$873,165	$937,708
Total		$27,560,495	$29,450,201	$31,596,430
Deductions from Gross Patient Revenue				
Charity Care		$6,314,643	$6,768,777	$7,289,416
Medicare Contractual Adjustment		$3,545,741	$3,775,799	$4,034,046
Medicaid Contractual Adjustment		$6,638,516	$7,108,911	$7,646,665
Commercial Insurance Contractual Adjustment		$2,249,764	$2,399,668	$2,568,910
Managed Care Contractual Adjustment		$1,226,907	$1,304,691	$1,391,567
Other Contractual Adjustments		$549,381	$588,050	$632,197
Bad Debt		$1,039,031	$1,110,273	$1,191,185
Total Deductions from Patient Revenue		$21,563,984	$23,056,169	$24,753,985
Net Patient Revenue		$5,996,511	$6,394,032	$6,842,445
Other Revenue				
Total Revenue		$5,996,511	$6,394,032	$6,842,445
Total Expenses		$6,433,487	$6,735,204	$6,929,397
Total Expenses / Total Patient Days, Cases or Procedures		$443	$454	$456
Net Income		($436,976)	($341,172)	($86,952)

Gaston Memorial Hospital, Inc.
Freestanding Emergency Department
Emergency Services

Form D - Gross Revenue Work Sheet, *REVISED*

Year Year 1
From 10/1/2012
To 9/30/2013

Payor	% of Total	# of Patient Days, Cases or Procedures	x	Projected Average Charge	=	Gross Revenue
Self Pay/Indigent/Charity	27.4%	3,978		$ 1,608.11		$ 6,397,833
Medicare/Medicare Managed Care	14.5%	2,105		$ 1,608.11		$ 3,385,715
Medicaid	32.8%	4,763		$ 1,608.11		$ 7,658,720
Commercial Insurance	13.9%	2,018		$ 1,608.11		$ 3,245,616
Managed Care	8.3%	1,205		$ 1,608.11		$ 1,938,030
Other	3.1%	450		$ 1,608.11		$ 723,842
Total	100.0%	14,520		$ 1,608.11		$ 23,349,757

Year Year 2
From 10/1/2013
To 9/30/2014

Payor	% of Total	# of Patient Days, Cases or Procedures	x	Projected Average Charge	=	Gross Revenue
Self Pay/Indigent/Charity	27.4%	4,062		$ 1,688.52		$ 6,857,927
Medicare/Medicare Managed Care	14.5%	2,149		$ 1,688.52		$ 3,629,195
Medicaid	32.8%	4,862		$ 1,688.52		$ 8,209,490
Commercial Insurance	13.9%	2,060		$ 1,688.52		$ 3,479,022
Managed Care	8.3%	1,230		$ 1,688.52		$ 2,077,401
Other	3.1%	460		$ 1,688.52		$ 775,897
Total	100.0%	14,823		$ 1,688.52		$ 25,028,932

Year Year 3
From 10/1/2014
To 9/30/2015

Payor	% of Total	# of Patient Days, Cases or Procedures	x	Projected Average Charge	=	Gross Revenue
Self Pay/Indigent/Charity	27.4%	4,166		$ 1,772.95		$ 7,385,423
Medicare/Medicare Managed Care	14.5%	2,204		$ 1,772.95		$ 3,908,344
Medicaid	32.8%	4,987		$ 1,772.95		$ 8,840,944
Commercial Insurance	13.9%	2,113		$ 1,772.95		$ 3,746,620
Managed Care	8.3%	1,262		$ 1,772.95		$ 2,237,190
Other	3.1%	471		$ 1,772.95		$ 835,577
Total	100.0%	15,203		$ 1,772.95		$ 26,954,098

Gaston Memorial Hospital, Inc.
Freestanding Emergency Department
Emergency Services

Form E - Net Revenue Work Sheet, ***REVISED***

Year Year 1
From 10/1/2012
To 9/30/2013

Payor	% of Total	# of Patient Days, Cases or Procedures	x	Projected Average Reimbursement Rate	=	Net Revenue
Self Pay/Indigent/Charity	27.4%	3,978		$ 20.91		$ 83,190
Medicare/Medicare Managed Care	14.5%	2,105		$ 464.75		$ 978,485
Medicaid	32.8%	4,763		$ 281.42		$ 1,340,280
Commercial Insurance	13.9%	2,018		$ 762.25		$ 1,538,434
Managed Care	8.3%	1,205		$ 985.77		$ 1,188,011
Other	3.1%	450		$ 472.79		$ 212,812
Total	100.0%	14,520		$ 378.75		$ 5,341,211

Year Year 2
From 10/1/2013
To 9/30/2014

Payor	% of Total	# of Patient Days, Cases or Procedures	x	Projected Average Reimbursement Rate	=	Net Revenue
Self Pay/Indigent/Charity	27.4%	4,062		$ 21.95		$ 89,150
Medicare/Medicare Managed Care	14.5%	2,149		$ 487.98		$ 1,048,832
Medicaid	32.8%	4,862		$ 295.49		$ 1,436,656
Commercial Insurance	13.9%	2,060		$ 800.36		$ 1,649,059
Managed Care	8.3%	1,230		$ 1,035.06		$ 1,273,444
Other	3.1%	460		$ 496.43		$ 228,116
Total	100.0%	14,823		$ 397.69		$ 5,725,257

Year Year 3
From 10/1/2014
To 9/30/2015

Payor	% of Total	# of Patient Days, Cases or Procedures	x	Projected Average Reimbursement Rate	=	Net Revenue
Self Pay/Indigent/Charity	27.4%	4,166		$ 23.05		$ 96,007
Medicare/Medicare Managed Care	14.5%	2,204		$ 512.38		$ 1,129,506
Medicaid	32.8%	4,987		$ 310.26		$ 1,547,160
Commercial Insurance	13.9%	2,113		$ 840.38		$ 1,775,901
Managed Care	8.3%	1,262		$ 1,086.81		$ 1,371,394
Other	3.1%	471		$ 521.25		$ 245,662
Total	100.0%	15,203		$ 417.57		$ 6,165,631

Exhibit 7

STATE OF NORTH CAROLINA — IN THE OFFICE OF ADMINISTRATIVE HEARINGS

COUNTY OF GASTON — 09-DHR-6116

THE CHARLOTTE-MECKLENBURG HOSPITAL AUTHORITY D/B/A CAROLINAS REHABILITATION-MOUNT HOLLY AND D/B/A CAROLINAS HEALTHCARE SYSTEM,
PETITIONER,

VS.

N.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF HEALTH SERVICE REGULATION, CERTIFICATE OF NEED SECTION,
RESPONDENT,

And

CAROMONT HEALTH, INC., AND GASTON MEMORIAL HOSPITAL, INC.,
RESPONDENT-INTERVENORS.

VOLUME 2

HEARING BEFORE THE

HONORABLE SELINA BROOKS
ADMINISTRATIVE LAW JUDGE

At Charlotte, North Carolina

April 13, 2010

REPORTER: KAREN B. RAY, CVR
NOTARY PUBLIC

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* * * * * *

I N D E X

is and you extract ideas from all those groups. And so I would consider that research.

Q. Based on your experience in emergency medicine and healthcare administration from a clinical perspective, do you have any opinions about the relative floor plans in the Gaston application versus the CHS application?

A. I do. First, they're both accepted models. So they're both widely-accepted models. They both have their strengths and weaknesses as everything does. My particular preference is the CHS model, but I don't think there's anything, what I call a clinically-significant difference in the floor plans. So some of the processes will be different. They'll do things slightly different in each one, but I don't think that either one is superior from a patient care perspective. I think they're clinically equivalent.

Q. And do you understand the concept that was discussed some yesterday about RME bays or rapid medical evaluation bays that Gaston proposed?

A. Yes, I do.

Q. Okay. Just briefly, can you describe for the Judge what you understand those to be?
A. It's a way stop to your treatment area so that you come into the waiting room. It's an initial evaluation place. So it's a quick stop where you have the opportunity, as a physician or a nurse, to see the patient earlier in their visit, perhaps get some studies going that are either known because you're a physician or known because of protocol before -- and get that started before the patient goes back to their final treatment room.
Q. And what is your understanding about whether CHS proposed these RME bays in addition to the treatment rooms?
A. No. The CHS plan does not have the RMEs.
Q. Okay. You said strengths and weaknesses of each. What are the strengths of the CHS plan as compared -- the floor plan or design as compared to the Gaston floor plan and design?
A. For the CHS plan, we will bring you -- as long as there is a room available, we'll bring you directly back to your treatment area. Then all those treatment areas are visible from the

common nursing station where the physician is. With low-volume emergency departments, where you predict that you're only going to have one physician staffing, either all the time or most of the time, that puts all the patients within the visibility of the physician there. With the RME bays, they work particularly well with high-volume emergency departments with multiple physician staffing. That can create, and you can work around it, but can create another physical area where there's patients that's out of the flow or visibility of the physician and it introduces one more hand-off from the triage RME bay back to the final treatment room. So, as I said, there are pluses and minuses of both of them.

Q. Now, when you say the hand-off, just to be clear, is that occurring in the Gaston model or the CHS model?

A. That would be in the Gaston model. If you stop at the RME bay with a triage nurse or a physician there, then nursing has to communicate with nursing into the next area. That's what I call a hand-off. Where in the CHS model, if we pull to full, which means you

don't stop, you go straight back to a room and have registration and your triage is done in a treatment room, you'll eliminate one hand-off.

Q. And so what are the limitations of the Gaston proposal, if any?

A. They will have -- they will just have to be aware of the hand-offs and use of the room, you know, to make sure that they are there. The physician is going to have perhaps two physical areas to monitor, as opposed to one.

Q. And why are you concerned about the hand-off? What concerns do those raise, if any?

MR. HUFFSTETLER: Object to leading. And I think it mischaracterizes the testimony. I don't believe he said he was concerned about the hand-off. I think he said that both were clinically equivalent.

THE COURT: Rephrase your question.

Q. Describe the hand-off for the Judge and whether or not that -- what that entails.

A. A hand-off -- we're talking emergency department here, but any transition of patient requires, you know, transmitting information along. That's what we call a hand-off. It