DukeMedicine

Duncan Yaggy, Ph.D.
Chief Planning Officer

March 29, 2011

Craig R. Smith, Chief
Certificate of Need Section
North Carolina Division of Health Service Regulation
701 Barbour Dr.
Raleigh, NC 27603

Re: Comments on applications for Inpatient Rehabilitation Beds in HAS IV

Dear Mr. Smith:

This letter forwards the comments of Duke University Health System on the applications for inpatient rehabilitation beds submitted February 15, 2011 by Johnston Health, UNC Hospitals at Chapel Hill, and WakeMed Rehabilitation Hospital.

Sincerely,

Duncan Yaggy

Duncan Yaggy, Ph.D.
Chief Planning Officer
Duke University Health System

BOX DUMC 3229, Durham NC 27710
LOC 3100 Tower Blvd., Suite 1300
Durham, NC 27707
TEL 919.419.5011
FAX 919.419.5001
EMAIL yaggy001@mc.duke.edu

COMMENTS ON APPLICATIONS FILED FOR DEVELOPMENT OF REHABILATION BEDS

Duke University Health System, Inc. d/b/a Duke Raleigh Hospital submits these comments regarding the applications filed on February 15, 2011 by Johnston Health, UNC Hospitals at Chapel Hill, and WakeMed Rehabilitation Hospital for the development of inpatient rehabilitation beds within Health Service Area (HSA) IV.

In evaluating the applications to determine which project best fills the need identified by the State Medical Facilities Plan, the Certificate of Need Section must answer the following questions:

Would development of the proposed project:

- Increase the supply of beds in the county where they will be most needed?
- Bring the additional beds on line promptly?
- Promote the quality and continuity of care for patients transferring from acute to rehab beds?
- Assure patients of the availability of physicians in the most needed specialties (physiatry, neurology, neurosurgery, orthopedics, etc.)?
- Be financially feasible?
- Be the most cost effective way to add to the supply of rehab beds in HSA IV ?

Reviewing the applications makes clear that Duke Raleigh's proposed project best meets these goals.

Johnston Medical Center – Smithfield (J-8633-11)

Johnston Health proposes an 8-bed rehab facility to be located at Johnston Medical Center – Smithfield (JMC). This proposal does not meet the needs of the service area in the following ways:

- It does not provide access to rehab services in the county where they are most needed.
- It does not reflect reasonable utilization projections.
- The project is not financially feasible.
- It will not promote continuity and coordination of care for rehab patients.
- It does not offer patients access to physicians within certain essential specialties.
- The project is scheduled to open significantly later than other applicants, delaying access to needed services in the service area.
- It is not the most cost effective way to increase the supply of rehab beds in HSA IV.

GEOGRAPHIC NEED

Johnston Health claims a need for 8 rehab beds to be developed in Smithfield based on projected growth in the county. However, this application both 1) ignores that a high growth rate in small population does not lead to the same growth as a nearly comparable rate in a much larger population; and 2) ignores where in the county the growth is actually anticipated.

While it may be true that Johnston County has a slightly higher rate of growth than Wake County (31% compared to 30%), its projected growth over the next decade would create a population increase of 53,336.[1] In contrast, the projected growth in Wake County would create a population increase of 275,193; these incremental additional residents in Wake County equate to more individuals than the entire projected population of Johnston County in 2020 (226,936). Thus, the highest growth rate does not correspond to the area with the largest growth in population, and, correspondingly, where the services are most needed.

Moreover, most of the population growth in Johnston County is occurring in the northern portion surrounding Clayton, not in and around Smithfield. Clayton is on the border of Wake County and residents of that area commonly work and receive health care services in Raleigh rather than Smithfield. As stated in the recent News and Observer article on March 12, 2011, the 2010 census shows that over the past 10 years, Smithfield grew by **99 people,** "making it one of the slowest-growth municipalities in the Triangle and an anomaly in burgeoning Johnston County." In comparison, Clayton nearly doubled during that decade and over 5,000 more people live in Clayton than in Smithfield.[2]

---

[1] Johnston Health Application p.48

[2] http://www.newsobserver.com/2011/03/12/1047383/town-of-smithfield-stuck-on-small.html

Reflecting this geographic reality, as stated on page 66 of JMC's application, approximately 45% of patients from Johnston County currently receive inpatient acute care services in Johnston County, a percentage that has actually declined over the past 3 years. In addition, according to Thomson Reuters inpatient market data, in FY 2009, fewer than 27% of inpatient discharges for patients from Clayton zip codes were from Johnston Medical Center – Smithfield while 57.5% of Clayton residents received inpatient care at a Wake County hospital. Clearly, Johnston County residents are going elsewhere for their healthcare, so they would likely choose to go elsewhere for rehab too. While JMC argues that "having an inpatient rehabilitation facility in the hospital where residents receive much of their health care is a better option than driving to other counties to unfamiliar hospitals and health care facilities," for most Johnston County residents, Wake County hospitals and health care facilities are not unfamiliar, and may in fact be more familiar to patients than JMC – Smithfield.

Notably, while JMC claims that "many" of the Johnston County residents who have received rehab services in the past at other hospitals were "first treated" at JMC (p. 58), it does not provide information about what percentage were admitted as inpatients at JMC before their admission to rehab. Moreover, JMC does not provide any basis for assuming that those patients would have had diagnoses appropriate for the small unit it proposes.

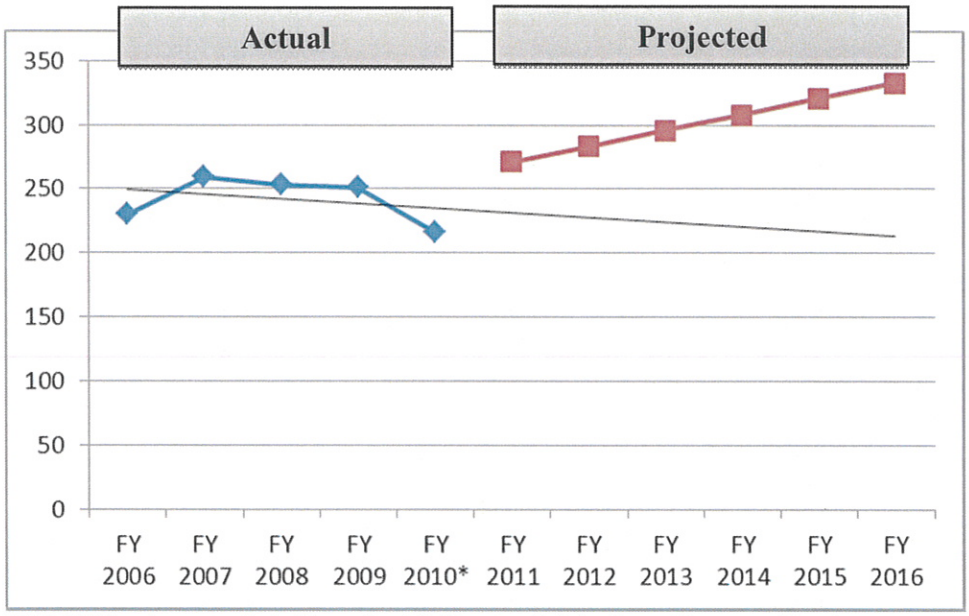
UTILIZATION PROJECTIONS

JMC's utilization projections are unreasonable. Beginning on page 62, rehabilitation discharge volume from Johnston County was simply averaged for the years 2006 – 2010, despite trends that show a decline during this time period:

- FY 2006: 230
- FY 2007: 259
- FY 2008: 253
- FY 2009: 251
- FY 2010: 199 (annualized from 9 months of preliminary data)

Then, despite these flat or declining historical volumes, projections start in FY 2011 at 271 discharges from Johnston County, a 25% increase over 2010 (based on actual FY 2010 inpatient rehab discharges recently released by Thomson Reuters). An additional 22.9% increase is projected from 2011 – 2016, with no explanation why the historic trend will change so dramatically. This projected utilization is illustrated in the graph on the following page.

Inpatient Rehabilitation Discharges, Johnston County Patients



***FY 2010 volume updated to reflect full year of data from Thomson Reuters.**
Other numbers replicated from Johnston Health's application on page 62 and 65.

Moreover, on page 69, JMC predicts volume by diagnosis, but this is not based on any information about the diagnoses of patients with Johnston County origin, nor the type of patients it currently refers out for inpatient rehab services.

FINANCIAL FEASIBILITY

Because the utilization projections are not reasonable, JMC's application does not adequately demonstrate the financial feasibility of the proposed project. In addition, while JMC's projected payor mix is based on historic inpatient rehabilitation discharges for Johnston County patients, the age and diagnosis mix appropriate for the proposed JMC rehabilitation unit is not taken into consideration[3].

JMC's projections also raise questions whether it would meet the 60% rule to qualify for reimbursement as an inpatient rehabilitation facility (IRF). The rule, made pursuant to the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA), requires that at least 60% of admissions of patients to an IRF have one or more specified conditions. JMC categorized all of its projected "Replacement of Lower Extremity Joint" patients in Rehab Impairment Category (RIC) 08 such that they would all be counted toward the 60% threshold. However, as stated on page 80 of the application, only knee or hip replacement patients who undergo a bilateral replacement, have a BMI at or above 50, or are at least 85 years of age qualify to be counted in the 60% for compliance

[3] JMC's payor mix is also based on FY 2010 quarterly data, which the applicant states on page 62 is not as accurate as full-year data due to lack of sufficient audits occurring at year-end.

purposes. Based on its projections, in order for JMC to remain at or above the 60% compliance threshold (and therefore ensure inpatient rehabilitation reimbursement rates), at least 37.5% of the projected knee/hip replacement patients would have to have a bilateral replacement, have a BMI >50, and/or be 85+ years of age. JMC does not provide information to support this assumption, calling into question its ability to maintain status as an IRF and receive the reimbursement rates necessary to support financial feasibility.

Duke Raleigh would also note that JMC's overall financial stability has been in question during the past few years, raising further concerns about the financial feasibility of this project. As noted in The Herald article dated March 9, 2011, despite an increase in Johnston Health's operating revenues in FY 2010, it had losses of $3.9M and carried almost $158M in debt.[4]

COORDINATION AND CONTINUITY OF CARE

JMC's application fails to demonstrate that the project will provide the kind of coordination and continuity of care essential to top-quality rehab services.

Lack of Specialist Integration

JMC does not have convenient access to medical specialists who would normally be involved in the care continuum for a rehab patient. There are no neurosurgeons practicing in Smithfield or Clayton, which means that patients needing rehabilitation after neurosurgery would generally have received their inpatient acute care services at another hospital. In addition, if patients have a setback during their rehabilitation requiring neurosurgical care, it would be necessary to transport the patient out of the county for care at another hospital without immediate access to the patient's entire medical record or history. The two neurosurgeons listed on Johnston Health's website (Tim Garner and Ken Rich – Capital Neurosurgery) are located in Raleigh on the campus of Duke Raleigh Hospital. The only neurologist listed on Johnston Health's website (Ajmal Gilani – Johnston Neurology) is located in Clayton. Similarly, Johnston Health's website includes only one physician in the field of Physical Medicine & Rehabilitation, and he is located in Clayton, not Smithfield (Rachid Idrissi – Advanced Spine and Pain Center). Additionally, according to the website, Dr. Idrissi's primary focus is "Interventional Pain Management," as opposed to rehabilitation services. These three specialty areas are extremely important for the success of inpatient rehabilitation services, and JMC does not appear to have the resources necessary in those areas, instead relying on UNC, located an hour away, to support their rehabilitation program.

The lack of neuroscience services at JMC also raises questions regarding the expected patient mix within the inpatient rehabilitation unit. JMC projects 28.5% of the rehab patients to fall within the Stroke RIC and nearly 5% within the Neurological RIC. With little to no neuroscience services provided at JMC, such patients would likely seek

[4] http://www.theherald-nc.com/2011/03/09/17846/hospital-moving-in-right-direction.html

acute care at a hospital outside Johnston County and therefore would not benefit from any continuity of care at JMC's proposed rehab unit.

Insufficiency of Support Services

JMC projects only 0.5 FTEs for occupational therapy, 1 FTE for physical therapy, and 1 FTE for a physical therapy assistant for the 8-bed rehab unit. There are no FTEs included to account for increased need for support services (such as lab, radiology, dietary, etc.). Additionally, JMC's identified orthotic/prosthetic vendor is located in Fayetteville, which is not as convenient as the other existing rehab units or as Duke Raleigh's proposed unit.

Perhaps to make up for the lack of resources in the county or at the hospital, JMC appears to plan to rely significantly on UNC, located two counties away. It will share a medical director with UNC, which, at a travel distance of at least one hour, would limit the medical director's ability to manage the rehab program, respond to urgent needs, or develop patient's individualized treatment plans. UNC also already provides oversight and management of Chatham's acute and outpatient rehab programs, further diluting the attention that UNC could pay to a remote program in Smithfield. The relationship with UNC will also impose additional costs for consultative services: $75/hour/consultant plus expenses could add up to $78,000 plus expenses annually.

SCHEDULE

JMC's project is not scheduled to open until October 2013, one year later than WakeMed and 16 months later than Duke Raleigh's projected opening date. Accordingly, it is not the best option to meet the immediate needs of the service area.

UNC Hospitals at Chapel Hill (J-8630-11)

UNC Hospitals at Chapel Hill also fails to propose the best alternative for rehab beds in the service area. This proposal does not meet the needs of the service area in the following ways:

- It does not provide access to services in the county where they are most needed.
- It does not reflect reasonable utilization projections.
- The project is not financially feasible.
- The project is scheduled to open significantly later than other applicants, delaying access to needed services in the service area.
- It is not the most cost effective way to increase the supply of rehab beds to HSA IV.

GEOGRAPHIC NEED

UNC claims that some of the beds allocated in the State Medical Facilities Plan should be awarded to the western part of the service area. However, as JMC illustrates on page 54 of its application, Orange County currently has 22.5 beds per 100,000 population, compared with Wake County at 9.1 beds per 100,000 in 2010, dropping to 8.4 beds per 100,000 in 2013. Even if all 14 beds are awarded in Wake County, the capacity would increase only to 10.2 beds per 100,000, less than half of Orange County's current supply per population.

UNC's own experience refutes any claim that there is an unmet need for rehab services in that part of the service area. Only 56.8% of its patients originate within HSA IV, and 32.4% of its patients originate within the 5 county "western" half of the HSA that UNC identifies on page 45. Nearly 12% of patients come from Wake County alone (making it the second largest county of origin for UNC rehab patients). This reflects the undersupply of beds within Wake County requiring patients to travel to Orange for service, further illustrating the need for additional beds to be located within Wake County

UNC claims that *"If all 14 beds were allocated to the eastern region of the HSA, the result would be an imbalance of beds, creating a hardship for patients in the western HSA counties." (Page 45).* In fact, this is completely inaccurate. The Eastern region of the HSA is where the bulk of the population lives. 63% of the population currently lives in Franklin, Wake, and Johnston County but only 54% of the inpatient rehabilitation beds are located here. Even if all 14 beds are allocated to the eastern region of the HSA, the result would still be an imbalance of beds because 58% of the beds would be available for 64% of the population in 2015. Therefore, the beds are needed in Wake County to correct the existing imbalance; adding beds in Orange County would simply exacerbate the problem.

UNC also claims that Orange County merits additional rehab beds because it has a higher than average percentage of population over age 65 and higher than average increase in that population. *(Page 45).* As stated in the comments on Johnston Health's application, focusing on percentages of a total rather than absolute number can be misleading. Wake County may have the smallest percentage of its population under the age of 65 in the HSA, but that population accounts for 41.7% of the entire HSA population over 65. Wake County's 65+ population is also growing the fastest (27.2% as compared to 24.6% in Orange County), so that Wake County is projected to be the home of 43.7% of the entire 65+ population in the HSA in 2015. As a result, the absolute Wake County growth in the 65+ population between 2011 – 2015 (20,795 additional people) is much larger than the total 65+ population in Orange County projected in 2015 (17,053).

Moreover, the 65+ population in the identified "western" counties accounts for only 24.7% of the population of 65+ residents in the HSA. Including Durham into this geography (since it is part of the Western portion), this is 39.5% of the HSA senior population and already holds 38.7% of the inpatient rehabilitation beds.

While UNC focuses its need projections based on the growing 65+ population, in FFY 2009, only 41.6% of UNC's inpatient rehab patients were 65+; an additional 35% were 45-64 years of age. That demographic is projected to grow much more slowly in Orange County than in the HSA as a whole and in Wake County in particular. Utilizing the same data source that UNC uses to emphasize the growth of the 65+ population provides a significantly different result when looking at the 45-64 age group. Replicating the table on page 45 for this age range is as follows:

	2011 Percent of Total County Pop. 45-64	Percent Increase in 45-64 Pop. 2011-2015
Orange County	24.9%	3.3%
Total HSA IV	25.2%	11.0%
Wake County	25.0%	14.6%

These data illustrate that, if percentage growth rates are considered, the second largest demographic utilizing inpatient rehabilitation services is projected to grow more than four times as fast in Wake County than in Orange County.

UTILIZATION PROJECTIONS

UNC's utilization projections are not based on reasonable assumptions.

According to the table on page 56 of historical annual utilization data (replicated below), inpatient rehabilitation days of care has fluctuated over the past 4 years, and the total volume declined between 2007 – 2008 and 2009 – 2010. UNC's rehab volumes in 2010 were below 2007 levels. UNC provides no explanation for this decline, simply

stating "During the most recent year, inpatient days of care and admissions declined slightly due to two months of unusually low utilization."

Inpatient Rehabilitation Days	2004	2005	2006	2007	2008	2009	2010
UNC Hospital Days of Care	6,744	8,007	8,429	9,084	9,046	9,303	8,937
% Growth		18.7%	5.3%	7.8%	-0.4%	2.8%	-3.9%

In fact, UNC's methodology is based on the 4.43% growth rate used in the SMFP, and claims that *"UNC Hospitals verifies that the 4.43% annual growth rate is a reasonable and conservative assumption because this rate is less than the 4.8% compound annual growth rate for UNC Inpatient Rehabilitation for the period from 2004 to 2010." (p. 57).* This assumption is not reasonable, however, given that the overall growth rate (or decline rate) from over the past 4 years is -1.62%. The methodology is accordingly fundamentally flawed.

Other issues raise questions regarding the methodology used:

- Projected ALOS remains relative even (15.20 – 15.23) annually with the exception of in FY 11, in which year it is projected to be significantly lower with no explanation. However, total volume is projected to increase that year by 5.5%.
- Total projected discharges in FY 11 and FY 12 are equal (618) but total days increases 2.3%. Page 59 states *"No growth due to capacity constraints of current unit."* This is an inconsistency that appears in several places in the application.

Data taken from table on page 38:

FY	Quarter	Days	Discharges	FY Days	FY Discharges	Δ Days	Δ Discharges	ALOS	PY Days	PY Discharges	Δ Days	Δ Discharges	ALOS
FY 09	Q1	2,236	142										
FY 09	Q2	2,374	158	9,277	609	---	---	15.23					
FY 09	Q3	2,242	162						9,303	619	---	---	15.03
FY 09	Q4	2,425	147										
FY 10	Q1	2,262	152										
FY 10	Q2	2,278	141	8,930	586	-3.7%	-3.8%	15.24					
FY 10	Q3	2,330	153						8,937	587	-3.9%	-5.2%	15.22
FY 10	Q4	2,060	140										
FY 11	Q1	2,269	153										
FY 11	Q2	2,348	164	9,192	618	2.9%	5.5%	14.87					
FY 11	Q3	2,295	151						9,297	621	4.0%	5.8%	14.97
FY 11	Q4	2,280	150										
FY 12	Q1	2,374	156										
FY 12	Q2	2,305	152	9,402	618	2.3%	0.0%	15.21					
FY 12	Q3	2,375	156						9,374	616	0.8%	-0.8%	15.22
FY 12	Q4	2,348	154										
FY 13	Q1	2,346	154										
FY 13	Q2	2,374	156	9,444	621	0.4%	0.5%	15.21					
FY 13	Q3	2,349	155						9,472	623	1.0%	1.1%	15.20
FY 13	Q4	2,375	156										
FY 14	Q1	2,374	156										
FY 14	Q2	2,650	174	10,334	680	9.4%	9.5%	15.20					
FY 14	Q3	2,624	173						10,676	703	12.7%	12.8%	15.19
FY 14	Q4	2,686	177										
FY 15	Q1	2,716	179										
FY 15	Q2	2,782	183	10,906	718	5.5%	5.6%	15.19					
FY 15	Q3	2,689	177						11,071	729	3.7%	3.7%	15.19
FY 15	Q4	2,719	179										
FY 16	Q1	2,881	190										
FY 16	Q2	2,815	185	11,330	745	3.9%	3.8%	15.21					
FY 16	Q3	2,817	185						11,364	747	2.6%	2.5%	15.21
FY 16	Q4	2,817	185										
FY 17	Q1	2,915	192										
FY 17	Q2	2,848	187	11,399	750	0.6%	0.7%	15.20					
FY 17	Q3	2,786	183						---	---	---	---	---
FY 17	Q4	2,850	188										

- UNC does not provide any assumptions or methodology for the volume projections by RICs.
- Much is emphasized in the application about the growth of the Neuroscience service line and ICU. Page 58-59 states *"As the mix of ICU beds increases, UNC Hospitals will be positioned to accept more transfers of high acuity patients (stroke, trauma, brain and spinal cord injury, and burns) from other hospitals, which, in turn, will increase the percentage of patients eligible for inpatient rehabilitation following their acute care hospitalization."* However, there is no corresponding adjustment to projected mix of patients within these categories in the future volume assumptions.
- UNC makes the point on pages 57 and 59 that its Triangle Physician Network will strengthen transfers and referrals to UNC's inpatient rehabilitation facility. However, patients do not go to inpatient rehabilitation without having been seen in an acute care setting immediately prior. The majority of TPN providers are primary care providers who would refer patients for inpatient acute care or outpatient rehab, but not inpatient rehabilitation.
- Additionally, very few letters of support from physicians who would refer patients for inpatient rehabilitation services. Only UNC and Raleigh Orthopaedics providers are listed.

FINANCIAL FEASIBILITY/COST EFFECTIVENESS

The UNC project is not the most cost-effective proposal. The cost of the project exceeds $8M for only 6 additional beds, making this by far the most expensive project proposed, especially on a per-bed comparison. Moreover, per Form C on page 120 – 121, the Rehabilitation Unit at UNC results in substantial net loss of $3.8M - $4.6M. Rather than allowing UNC to subsidize an expensive, money-losing operation, possibly at taxpayer expense, the Section should approve a project with better financial footing.

Duke Raleigh acknowledges that UNC's costs are high in part due to its plans to renovate its existing inpatient rehab wing, including the reconfiguration from semi-private to private rooms. However, such a conversion might expand the practical capacity of the unit without the need to add additional beds that are needed in other parts of the service area. UNC did not give appropriate consideration to this kind of renovation as a potential alternative to the proposed project.

SCHEDULE

UNC's project is not scheduled to open until October 2013, one year later than WakeMed and 16 months later than Duke Raleigh's projected opening date. Accordingly, it is not the best option to meet the immediate needs of the service area.

GENERAL

UNC fails to answer question 2a at Page 79. In response to the question, "Describe how the local physicians, particularly physiatrists or physicians with training and experience in providing rehabilitation care, were involved in the planning phase of the project," UNC's answer is "The proposed project involves adding six beds to the existing 30-bed UNC Inpatient Rehabilitation Center." As a result, physician involvement in the planning of this project is uncertain.

WakeMed Rehabilitation Hospital (J-8631-11)

Duke Raleigh agrees with WakeMed Rehabilitation Hospital that Wake County is the optimal location for the development of additional rehab beds. However, WakeMed's proposal to develop beds in Wake County does not meet the needs of the service area in the following ways:

- It does not benefit competition and provide alternatives for patients in Wake County and surrounding areas.
- WakeMed is not reliable in developing projects in a timely manner for needed services in the service area.
- The project is not financially feasible.

EFFECT ON COMPETITION

WakeMed currently operates 100% of the beds in Wake County, and 54.2% of the beds in the service area.

WakeMed ironically tries to claim that having the additional beds added to the only existing Wake County facility *"would ensure that consumers' choices are not impeded by the lack of available bed capacity at WakeMed."* Additional beds at WakeMed do not improve the competition on the service area. In fact, giving the beds to WakeMed is the one choice that is least supportive of competition. To the extent that patients currently cannot get into WakeMed, adding capacity at Duke Raleigh provides another option and relieves capacity problems at WakeMed, thus providing two viable options within Wake County for rehab patients.

WakeMed tries to counter this issue by claiming that *"Small rehabilitation units simply do not have sufficient numbers of patients to support the clinical staff and facilities to address the diverse and specialized needs of patients with conditions in all the programmatic areas that WakeMed Rehab Hospital provides."* It states that there is a need for a "critical mass of patients." (p. 29) This is incorrect. The Duke Raleigh application illustrates that it is feasible for a smaller program to have enough patients to support the rehab program and be able to provide a wide range of services. In fact, Duke Raleigh Hospital already refers out of the hospital enough patients to fill a rehab unit at 80% or more capacity. On the same page, the second paragraph talks about following the initial studies' recommendation for regional facilities, as described on pages 6-7. A plan from 1969 does not reflect the current healthcare and consumer environment. On page 112, WakeMed claims that smaller programs could serve only 1 - 2 patient specialties and that this would not alleviate demand for services at WakeMed. Smaller programs can serve more than 1 - 2 specialties as mentioned above. WakeMed states that "historical data indicates that when two inpatient rehab facilities are located in the same city or county, neither program can achieve optimal utilization. Therefore a 'watering-down' effect occurs that results in excess capacity." WakeMed fails to provide any information about which counties have experienced this effect, nor the patient

demographics or growth in those counties as compared to the rapidly growing and significantly highly populated region such as Wake County.

Additionally, regardless of the specialties smaller programs serve, their additional capacity in the service area will indeed allow WakeMed greater ability to meet the demand for some of the more highly specialized, but generally smaller volume, services it offers. That is, even if patients with some diagnoses (traumatic spinal cord injury, low-level traumatic brain injury) may benefit from a critical mass of similar patients to meet all their needs, smaller units can easily meet the needs of patients with conditions such as stroke and hip fractures, freeing up space at WakeMed's unit for other specialty needs.

As comparison, it should be noted that in HSA II, the most highly utilized rehab program is High Point Regional's 16-bed unit, where utilization is much higher than at the larger programs elsewhere in the service area. Clearly a 16-bed unit can be efficiently operated and utilized.

In an additional attempt to argue against a new provider within the region, WakeMed states on page 113 that, as an existing provider of inpatient rehabilitation services, their project is cost-effective in that it can spread its administrative and indirect costs over a larger number of beds. Of their incremental 34.89 FTEs, very few are indirect, support positions, and it states "duplication of administrative staff, capital equipment, and staff expertise adds little value to the community." It should be noted that the number of incremental staff Duke Raleigh Hospital proposes is almost identical, and as Duke Raleigh currently provides care within the entire continuum, with the exception of inpatient rehabilitation, a second program within Wake County will not result in unnecessary duplication of services or costs.

Finally, it should be noted that on page 229 of its application (exhibits), WakeMed shows the Percentile Ranking Report of MedTel Outcomes. In the far right column, all of its patients' data is listed in one column. Its percentile rank is no better than 50th. Therefore, its functional and satisfactional outcomes are **average at best,** with not a single percentile being greater than 50th**.** Providing patients with another choice in Wake County is essential.

NEED

WakeMed emphasizes the importance of the continuum of care to allow patients to receive acute, inpatient rehab, and outpatient care in the same system, and Duke Raleigh agrees that this is essential to providing high quality care to patients. WakeMed ignores, however, that because WakeMed has the only inpatient rehab unit in Wake County, patients are routinely referred from other acute care settings, including Duke Raleigh and Duke University Hospital, to receive their rehab care. Duke Raleigh's proposal enhances the continuum of care by allowing patients to remain within the Duke University Health System, which includes acute, inpatient rehab, outpatient rehab, and home health services. The continuum of care is essential to ensure the best outcomes for patients. Remaining within the Duke system allows physicians to continue to monitor the

care of their patients, be accessible for consults, and improve quality through the continuous utilization of a single medical record. In fact, Duke Raleigh Hospital already refers out of the hospital enough patients to fill a rehab unit at 80% or more capacity.

On page 102, WakeMed projects serving only an additional 145 patients by year three of its project (1,765 in 2011 versus 1,910 in 2015). In contrast, Duke Raleigh projects serving 333 by the third year, and UNC and Johnston Memorial collectively propose serving 350 additional patients. Therefore, the WakeMed proposal is not the best alternative as far as increasing the actual number of patients to be served.

To the extent that WakeMed claims need based on its current high occupancy, the Duke Raleigh proposal would alleviate that situation by providing an option for patients who wish to receive their care in Wake County. Duke Raleigh Hospital recognizes the high utilization rates observed at WakeMed Rehab. The addition of 14 inpatient rehabilitation rehab beds at Duke Raleigh will reduce transfers from Duke Raleigh, Duke University Hospital, and other acute care facilities to WakeMed. This will allow WakeMed to care for an increasing number of its own acute care patients needing rehab services and to reduce the "avoidable days" within its system when patients must remain in acute care due to lack of inpatient rehabilitation beds to which to transfer them.

DELAYS IN IMPLEMENTATION OF PROJECTS

WakeMed's application raises significant questions regarding its ability to implement the proposed project, further hindering WakeMed's ability to meet the need for additional services in the service area.

As set forth on pages 146-47 of its applications, only 2 of WakeMed's CON-approved 13 projects are "on schedule." The remaining 11 are delayed, on average, by over 28 months. (This does not even count the fact that the 4 operating rooms in the surgery center project were originally awarded in 2006 for Apex, which WakeMed then applied to move to Brier Creek, and then applied to relocate again to the current project, which is itself 17 months delayed). Even taking into account litigation delays on some of those projects, WakeMed's track record in bringing projects to completion is terrible. These delayed projects include regulated assets subject to competitive reviews, including 61 acute care beds, 12 neonatal beds, and 4 operating rooms. The service area is still awaiting development of these assets, which other providers were precluded from developing.

At page 74, WakeMed claims that the addition of 14 beds to its hospital would "sooner alleviate capacity issues." However, Duke Raleigh plans to open its facility 4 months sooner than WakeMed, even assuming WakeMed keeps to its proposed timeline.

FINANCIAL FEASIBILITY

In addition to a history of long delays or perpetual postponements of its projects, WakeMed also has a history of filing cost overrun applications to reflect the true cost of

projects that were originally understated. While WakeMed currently proposes a low capital cost for its project, that cost is not reasonable or reliable.