HPS
HEALTH PLANNING SOURCE

March 31, 2011

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:

In accordance with N.C. GEN. STAT. § 131E-185(a1)(1), Johnston Health submits the following comments related to competing applications to develop inpatient rehabilitation beds in HSA IV to meet a need identified in the 2011 State Medical Facilities Plan (SMFP). Johnston Health'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, Johnston Health's comments are organized by the general CON statutory review criteria and specific regulatory criteria and standards, as they relate to the following applications:

- **WakeMed, Project ID# J-8631-11**
- **Duke Raleigh Hospital ("Duke Raleigh"), Project ID # J-8629-11**
- **UNC Hospitals ("UNC"), Project ID # J-8630-11**
- **Johnston Health, Project ID# J-8633-11**

Based on Johnston Health's review of the applications, and as demonstrated in detail in the attached comments, WakeMed's and Duke Raleigh's applications are not conforming with multiple statutory review criteria and should not be approved. Further, Johnston Health represents the most effective alternative for the award of inpatient rehabilitation beds in HSA IV. We appreciate your consideration of these comments.

Sincerely,

Emily Cromer

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Consultant to Johnston Health

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Competitive Comments on HSA IV Inpatient Rehabilitation Bed Applications

submitted by

Johnston Health

In accordance with N.C. GEN. STAT. § 131E-185(a1)(1), Johnston Health submits the following comments related to competing applications to develop inpatient rehabilitation beds in HSA IV to meet a need identified in the *2011 State Medical Facilities Plan* (*SMFP*). Johnston Health'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, Johnston Health's comments are organized by the general CON statutory review criteria and specific regulatory criteria and standards, as they relate to the following applications:

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GENERAL COMPARATIVE COMMENTS

The Johnston Health, WakeMed, Duke Raleigh, and UNC applications each propose to develop inpatient rehabilitation beds in response to the *2011 SMFP* need determination for HSA IV. Johnston Health acknowledges that each review is different and, therefore, the comparative review factors employed by the Project Analyst in any given review may be different depending upon the relevant factors at issue. Given the nature of the review, the Analyst must decide which comparative factors are most appropriate in assessing the applications.

In order to assess the most effective alternative to meet the identified need for the inpatient rehabilitation beds in HSA IV, Johnston Health reviewed and compared the following factors in each application:

- Geographic Access
- Facility Design

- Access by Medicaid Population
- Net Revenue
- Operating Costs
- Uncompensated Care
- Coordination with Existing Health Care Providers

Johnston Health believes that the factors presented above and discussed in turn below should be used by the Analyst in reviewing the competing applications. The factors are appropriate and/or have been used in previous competitive inpatient rehabilitation bed findings.[1] Furthermore, based on a thorough review of the comparative factors, Johnston Health is the most geographically accessible for the HSA population without existing local access; Johnston Health proposes the most effective facility design among applicants proposing to design and develop a new inpatient rehabilitation unit; Johnston Health projects the lowest net revenue per patient day among applicants projecting a positive service component level net income in Year Three; and Johnston Health projects the lowest operating cost per patient day among applicants with reasonable financial projections and assumptions. While Johnston Health is clearly comparatively superior to each of the other applicants on these four comparative factors, it is also superior to some applicants and equally effective as others with regard to Medicaid access, uncompensated care, and coordination with existing health care providers. Therefore, the Johnston Health proposal is the most effective and accessible alternative, given all of these factors, and should be approved as proposed.

Geographic Access

The need determination for which these applications have been submitted is for inpatient rehabilitation services for residents of HSA IV; therefore, the most effective alternative for the distribution of these beds is dependent on the impact the distribution will have on residents in HSA IV. As Johnston Health discusses in Section III.1.(a) of its application, access to inpatient rehabilitation services in HSA IV is not equally available to all residents of the HSA. This is particularly important for the eastern portion of HSA IV (which includes Johnston County) in that Johnston County has the highest current population growth rate in the state and the highest projected population growth rate in the state. While Wake County does have the highest numeric population in the HSA, it also has a proportional number of existing beds, as shown in the analysis on pages 54

[1] Please note that in developing comparative review factors, Johnston Health looked to the 2006 Wake County inpatient rehabilitation bed review (Rex Hospital, Project ID # J-7482-06 and WakeMed, Project ID # J-7485-06) for guidance as it is the only competitive inpatient rehabilitation bed review in recent years. Where appropriate, Johnston Health included relevant comparative factors used in that review.

through 56 of Johnston Health's application. Adding beds in Wake County, for any reason, would not improve geographic access for the growing number of residents in Johnston County.

WakeMed proposes to add 14 additional inpatient rehabilitation beds to its existing facility in Raleigh (Wake County). Since a significant number of WakeMed's inpatient rehabilitation patients originate in counties other than Wake (according to page 75 of its application, 766 patients or 44 percent of total patients originated from counties other than Wake in CY 2010), it seems that a better alternative to easing WakeMed's capacity issues would be to serve those out-of-county patients in their home county, as Johnston Health proposes to do. This is wholly consistent with the position taken by WakeMed's Chief Executive, Dr. Bill Atkinson in an August 5, 2005 article in *The News and Observer*. In this article, Dr. Atkinson expressed his shared belief in the need to treat more patients closer to home, partly because surrounding counties, particularly Wake County, do not have capacity for this growing patient population. According to the article, which refers to WakeMed's intentions to build a hospital in Harnett County, "'WakeMed has an interest in helping Harnett County residents remain in the county for care **because Wake County hospitals are overburdened and cannot easily accommodate patients from neighboring counties**,' said WakeMed chief executive William K. Atkinson...**'We need to take a regional approach**.'"[emphasis added]

As noted in both Johnston Health's application and WakeMed's application, WakeMed's occupancy rate of inpatient rehabilitation beds exceeded 90 percent in FY 2010. Certainly, WakeMed's high occupancy is impacted by the use of its facility by Johnston County residents given a lack of local access to such services. As stated in the Johnston Health application, WakeMed served 201 Johnston County residents in its inpatient rehabilitation beds in 2009 (source: Thomson Reuters). Also according to Thomson Reuters data, WakeMed reported 2,962 patient days associated with these 201 patients. As such, WakeMed filled approximately eight of its 84 beds in 2009 with Johnston County residents (2,962 / 365). Therefore, Johnston Health's proposal to develop eight inpatient rehabilitation beds to serve Johnston County residents in their own home county is not only consistent with Dr. Atkinson's stated position in *The News & Observer*, but also would clearly and directly alleviate some capacity constraints for WakeMed by freeing up eight of its beds for use by other patients. Clearly, locating eight inpatient rehabilitation beds in Johnston County is a better alternative than adding fourteen beds to WakeMed that will be used to serve patients from counties other than Wake County.

Duke Raleigh also proposed to develop the 14 inpatient rehabilitation beds in Raleigh, the same geographic location as WakeMed, the facility with the highest

number of beds in operation in the HSA. According to Google maps, Duke Raleigh Hospital is located 4.3 miles from WakeMed Hospital-Raleigh Campus, which is approximately eight minutes driving time. As previously stated, WakeMed's rehabilitation facility has historically experienced high occupancy rates, in large part due to the volume of patients it serves from other counties, including Johnston County. Duke Raleigh's proposal to locate the additional 14 beds needed in HSA IV in such close proximity to the largest inpatient rehabilitation unit in the HSA (which is already caring for out of county patients) is not the best option for improving access to inpatient rehabilitation services in HSA IV.

The development of an inpatient rehabilitation unit at Duke Raleigh or the addition of beds to WakeMed would not provide local access to the more than 200 residents in Johnston County that traveled to Wake, Durham and Orange counties for inpatient rehabilitation care during the past year. Finally, developing eight inpatient rehabilitation beds in Smithfield would alleviate the pressure now placed on WakeMed's unit and would actually increase its capacity by approximately eight beds if Johnston County residents are able to be cared for in their own county.

Clearly Johnston Health's proposal represents the most effective alternative with regard to improving geographic access to inpatient rehabilitation services in HSA IV.

Facility Design

Duke Raleigh, the only other applicant in addition to Johnston Health that is proposing to develop a new unit, does not propose to include all aspects of the inpatient rehabilitation unit in one location. Duke Raleigh proposes to share space and "other existing rehab resources" with the adjacent orthopedic unit (page 5, Duke Raleigh application). Access to the Activities of Daily Living apartment, or ADL, which is called Homeward Bound Gym in the Duke Raleigh application, requires access through an existing acute care unit. Furthermore, while the specific square footage of the ADL is not provided in the application, a visual assessment of the space compared to the patient rooms and support space suggests that it is not large enough to accommodate patients from the orthopedic unit now utilizing the space, plus the fourteen additional rehabilitation patients that may need to use the space at any given time. While this option may be managed with careful scheduling, it is certainly not optimal compared with locating the entire inpatient rehabilitation unit in one combined space and dedicating the use of the ADL to inpatient rehabilitation patients as is proposed by Johnston Health.

As with the ADL apartment, Duke Raleigh is proposing to share existing space and resources of an orthopedic unit with the service needs of fourteen additional patients that must have intensive rehabilitation treatments on a daily basis. Again, with careful scheduling this shared services arrangement might work but it is clearly not an optimal arrangement in meeting the needs of patients (both orthopedic and inpatient rehabilitation) on a daily basis.

Duke Raleigh also proposes to include semi-private rooms as opposed to all private rooms. Semi-private rooms may limit Duke Raleigh's ability to admit a patient if all the private rooms are taken and the only option would be to place a female with a male in a semi-private room. With the option of planning a new unit such as proposed by Duke Raleigh and Johnston Health, creating all private rooms would be a better option for access for all patients needing care.

Clearly, Johnston Health proposes the most effective alternative with regard to facility design among the applicants proposing to design and develop a new inpatient rehabilitation unit.

Access by Medicaid Population

The following table provides the percentage of Medicaid patient days that each applicant projects in the second full fiscal year.

Facility	*% Medicaid*
UNC Hospitals	21.2%
WakeMed	14.1%
Johnston Health	10.3%
Duke Raleigh	4.6%

While two of the other applicants project higher percentages of Medicaid patient days than Johnston Health, Johnston Health's projection is consistent with the actual payor mix of the market it proposes to serve. Based on data from Thomson Reuters, the FY 2010 historical mix of rehabilitation patient days for Johnston County residents by payor reflected a Medicaid percentage of 10.3 percent. According to Section VI.12.(a) and (b) of each application, both WakeMed and UNC based their projected payor mix on the experience of their existing inpatient rehabilitation beds and Duke Raleigh based its projected payor mix on the payor mix of the patients that it referred to other facilities for inpatient rehabilitation services in the prior year.

Net Revenue

The table below shows each applicant's projected net revenue per patient day in the third full fiscal year.

	UNC Hospitals	*WakeMed*	*Johnston Health*	*Duke Raleigh*
Patient Days	11,364	31,107	2,495	4,228
Inpatient Net Revenue	$9,072,562	$40,479,450	$3,076,773	$5,855,316
Inpatient Net Revenue per patient day	$798	$1,301	$1,233	$1,385

Based on the financials for each applicant, Johnston Health projects the lowest inpatient net revenue per patient day for an inpatient rehabilitation unit that is profitable by the third year of operation[2]. Johnston Health therefore represents the most effective alternative in this regard while Duke Raleigh represents the least effective alternative. Johnston Health recognizes that UNC and WakeMed serve some higher acuity rehabilitation patients that Johnston Health will not, which would affect their net revenue. Nevertheless, Johnston Health does provide both the least costly and most effective alternative (particularly with regard to improved geographic access) for its proposed patients.

Operating Costs

The following table provides the projected operating costs per patient day for each applicant.

	UNC Hospitals	*WakeMed*	*Johnston Health*	*Duke Raleigh*
PY 1	$1,055	$1,137	$1,158	$1,178
PY 2	$1,163	$1,143	$975	$953
PY 3	$1,189	$1,152	$978	$928

As shown in the table, by Year Three, Johnston Health projects the lowest operating costs per patient day with the exception of Duke Raleigh. As discussed later in comments specific to Duke Raleigh's application, Duke Raleigh provided inconsistent financial assumptions and failed to project adequate expenses, including staffing costs. Given that Duke Raleigh is clearly not conforming with Criterion 5, Johnston Health's operating costs per patient day represent the most effective alternative based on reasonable financial

[2] Please note that UNC Hospitals' proposed project is not profitable in the first three years of operation, as provided in the service-component financials of the application.

assumptions and projections that are conforming with Criterion 5. Johnston Health recognizes that UNC and WakeMed serve some higher acuity rehabilitation patients that Johnston Health will not, which would affect their net revenue. Nevertheless, Johnston Health does provide both the least costly and most effective alternative (particularly with regard to improved geographic access) for its proposed patients.

Uncompensated Care

As compared to all of the applications, WakeMed proposed the lowest amount of uncompensated care as a percent of its projected net revenue. The chart below shows the variance in proposed uncompensated care during the first year of operation between all applications.

Proposed Uncompensated Care during the First Year of Operation

	Charity Care	*Bad Debt*	*Total Uncompensated Care*	*Total Net Revenue*	*Uncompensated Care as % of Net Revenue*
Johnston Health	$60,109	$202,704	$262,813	$2,179,063	**12.1%**
UNC Hospitals	$329,226	$614,775	$944,001	$7,442,954	**12.7%**
Duke Raleigh	$328,288	$0	$328,288	$3,650,659	**9.0%**
WakeMed	$774,823	$1,384,102	$2,158,925	$37,141,734	**5.8%**

Johnston Health and UNC Hospitals project the highest percentages of uncompensated care and therefore represent the most effective alternatives in this regard. WakeMed projects the lowest percentage of uncompensated care and therefore represents the least effective alternative in this regard.

Coordination with Existing Health Care Providers

Both UNC and WakeMed, as existing providers of inpatient rehabilitation services as well as acute care services, have established relationships with area health care providers, including those in other counties throughout North Carolina. Duke Raleigh, an existing acute care provider, has established relationships with area health care providers and as part of the Duke University Medical Center hospitals, further increases its scope of established relationships.

Johnston Health, a North Carolina acute care provider for 60 years, has established relationships with existing health care providers inside Johnston County as well as others throughout North Carolina. Furthermore, Johnston Health proposes that its inpatient rehabilitation unit will be managed by UNC Hospitals' physiatrists and a UNC Hospitals rehabilitation nurse manager. Therefore, Johnston Health is fully coordinated with the health care community

and has partnered with an existing high quality provider of inpatient rehabilitation services.

Each of the applicants sufficiently demonstrates coordination with existing health care providers and therefore each represents an equally effective alternative in this regard.

APPLICATION-SPECIFIC COMMENTS

WakeMed

(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.*

WakeMed fails to demonstrate the need of the population for the proposed project, based on the following reasons.

On page 101, WakeMed states "The Primary Rehab Diagnosis categories are more closely tied to patients' secondary ICD-9 diagnosis codes....The secondary diagnoses provide additional information regarding patients' primary condition and co-morbidities. For instance, rather than grouping all Brain Injury patients into a single category, patients can be categorized into Traumatic Brain Injury and Non-Traumatic Brain Injury." Additionally on page 101, WakeMed provides in Table IV.14 a list of the most common rehabilitation conditions historically treated at WakeMed Rehab Hospital and their respective portions of total cases and days. However, WakeMed does not provide the historical ICD-9 volume that would link its methodology of assessing secondary diagnosis codes to the projected patients by medical condition provided in Table IV.14. Given this, it is unclear how the use of secondary diagnosis codes led to the projected inpatient rehabilitation volume by medical condition as presented in Section IV. In the absence of the secondary diagnosis level detail, it is impossible to recreate WakeMed's methodology; as such, it is impossible to determine whether or not WakeMed's projections are reasonable.

On page 100, WakeMed states "WakeMed Rehab Hospital currently treats a relatively low proportion of pediatric cases, but projects that this proportion will increase as a percentage of projected cases, due to increased bed capacity and the growth in pediatric subspecialties at WakeMed Raleigh Hospital." WakeMed subsequently provides the projected volume and

percent of pediatric cases; however it does not provide the methodology used to determine the assumed percentage of pediatric volume and the basis for the annual growth.

Additionally, WakeMed was awarded 16 additional inpatient rehabilitation beds in 2006. Ten of the awarded beds were opened by July 2007 with the remaining beds operational by July 2009. While WakeMed's 2006 application indicated that utilization of those 16 beds would include pediatric patients, it still observed only four pediatric patients and 69 pediatric patient days in its most recent nine months of data from April 2010 to December 2010, as stated on page 80 of its current application. Without the methodology to justify its projections, WakeMed has not reasonably justified how it will increase from its annualized historical pediatric volume, 6 patients and 92 patient days, to 14 patients and 299 patient days in the very next fiscal year, FY 2011 as it projects on page 81 of its application.

WakeMed's projections are not based on clear and justified assumptions, therefore WakeMed is not conforming with Criterion 3.

Duke Raleigh

(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.*

Duke Raleigh fails to demonstrate that its project is consistent with all applicable policies and need determinations in the *State Medical Facilities Plan.*

While the applicant says (page 29), "By locating the beds within Duke Raleigh Hospital, thereby eliminating the need to transfer patients, the project will promote quality and safety," there is no discussion of how specifically the new unit will promote quality and safety. Furthermore, there are no quality policies specific to the rehabilitation unit included in the application to document how Duke Raleigh will assure that quality care is provided in the new unit. The applicant includes some discussion about general hospital quality management; however, there is no indication that it will include these same management tools and goals in the rehabilitation unit. While Duke Raleigh does indicate it will seek accreditation for the new unit from The Joint Commission, the standard accreditation body for inpatient rehabilitation units, Commission on Accreditation of

Rehabilitation Facilities (CARF), was not included in Duke Raleigh's accreditation plans for the new unit.

Further, Duke Raleigh states on page 47 of its application, "The focus within the proposed inpatient rehab unit will also foster positive competition in that the Duke Raleigh rehab unit will have a significant focus and specialization on care for stroke, amputation, and orthopaedic patients. Both WakeMed and UNC are trauma centers and have a children's hospital, allowing them to specialize in providing care for pediatric patients and those with traumatic injuries. ***As these volumes are relatively small within the community, it is important for facilities to have sufficient volume to maintain high quality care.*** Similarly, Duke Raleigh's specialization in the above mentioned services will ensure the provision of high quality care." [emphasis added] Through these statements, Duke Raleigh implies that it will be able to ensure high quality care in its inpatient rehabilitation unit because it will focus on particular medical conditions for which it will have sufficient volume to maintain quality. However, despite indicating otherwise on page six of its application (discussed further under Criterion 3 below), Duke Raleigh does in fact project a very small number of traumatic brain injury and major multiple trauma patients in its utilization tables in Section IV. By its own assessment in the quote referenced above from its application, Duke Raleigh's ability and/or need to provide high quality care to traumatic brain injury and major multiple trauma patients is questionable.

For these reasons, Duke Raleigh has not demonstrated its consistency with the Quality Basic Principle as required by Policy GEN-3 and is not conforming with Criterion 1.

(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.*

Duke Raleigh fails to demonstrate the need of the population for the proposed project, based on the following reasons.

Duke Raleigh failed to identify the population to be served by the proposed project as it did not provide projected patient origin or any related assumptions in Section III.5 or as required by 10A NCAC 14C .2802(e). Additionally, Duke Raleigh did not demonstrate the need in its application given that its utilization projections failed to meet required performance

standards and were based on flawed assumptions in its methodology. Duke Raleigh's failure to demonstrate need is further explained in the following points:

- The performance standards in 10A NCAC 14C .2803 state that an applicant shall not be approved unless occupancy is projected to be 80 percent for the total number of rehabilitation beds to be operated in the facility no later than two years following completion of the proposed project. While Duke Raleigh projects 80 percent occupancy in the fourth quarter of its second year of operation, the annual occupancy of its second project year is only 76 percent. It should be noted that all other applicants exceed 80 percent annual occupancy in the second year of operation. Additionally, the occupancy rates and quarterly distribution of patient days for the first two years of operation are based on assumed lengths of stay and projected patients that cannot be derived or calculated from any information provided in Sections III.1.(a), III.1.(b), or IV. Page 37 of the application states, "Average length of stay remains steady throughout each year (Year 1 at 12.5 and Year 2 at 12.7)," but nowhere does Duke Raleigh state the calculations and methodology used to project the number of patients each quarter (needed to calculate quarterly projected patient days in Table IV-F). Furthermore, since the quarterly occupancy rates are not consistent and no assumptions regarding quarterly distribution were provided, it appears that Duke Raleigh's projected annual utilization was arbitrarily distributed among quarters in order to reach 80 percent occupancy in the fourth quarter of the second year.
- On pages 35 to 37 of the application, Duke Raleigh states various volume-related assumptions and statistics. However, Duke Raleigh again does not describe any methodology, process, or approach to derive the actual projected patients and patient days. The assumptions alone do not provide a need methodology and as they are stated in the application, certainly do not offer the calculations leading to the projected volume figures in Tables IV-C, IV-D, and IV-E. In fact, no direct correlation between the statistics provided on pages 35 through 37 and the projected patients and patient days each year can be determined. As a result, without the need methodology and calculations, there is no way to assess the reasonableness of Duke Raleigh's utilization projections.
- On page 36, Duke Raleigh suggests that the projected inpatient rehabilitation cases are largely based on the 221 patients Duke Raleigh referred to other inpatient rehabilitation facilities during CY 2010. However, Duke Raleigh does not provide any data regarding

the medical conditions, DRG assignment, or patient origin associated with these 221 patients. Additionally Duke Raleigh states that it does not expect to treat all conditions and patient ages and specifically, as stated on page 37, that it will not serve pediatric, major multiple trauma, traumatic brain injury and traumatic spinal cord injury patients. Since there is no information relating to the 221 patients, which was used as the primary basis of Duke Raleigh's utilization projections, there is no way to confirm that this assumption excludes the very conditions that Duke Raleigh does not propose to treat at its facility. This flaw is especially important as the utilization projections during the first two years, which range from 34 to 81 quarterly cases, assume that most, if not all 221 referred patients (55 patients quarterly) will remain and be treated at Duke Raleigh.

- Duke Raleigh does not state anywhere in the application or exhibits the assumed percentage mix of patients by RIC category or the actual data figures leading to the projected volume by medical condition in Tables IV-C, IV-D and IV-E. It should also be noted that on page six of the application, Duke Raleigh states, "As Duke Raleigh Hospital is not a designated trauma center and does not have a burn unit, it is not anticipated that patients will be transferred to the proposed unit with major multiple trauma, traumatic brain injury, or burn diagnosis." However, Table IV-E on page 35 clearly illustrates projected traumatic brain injury and major multiple trauma patients and patient days in Duke Raleigh's utilization projections. Given that there is no methodology to determine projected volume by diagnosis, Duke Raleigh's assumptions are inconsistent and do not adequately demonstrate any sort of projected need for the project. Moreover, Duke Raleigh fails to provide evidence that it proposes to meet the volume requirement of qualifying medical conditions in order to be compliant with the 60 percent rule. (See pages 79 through 81 of the Johnston Health application for an explanation of the 60 percent rule.) As a result, this flawed methodology calls into question the reasonableness of assuming Duke Raleigh could obtain Medicare reimbursement as illustrated in the financials.

Duke Raleigh provides utilization projections without a methodology to derive its volume projection figures and consequently fails to demonstrate a need for its proposed project. Duke Raleigh is therefore not conforming with Criterion 3.

(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.*

Duke Raleigh fails to demonstrate that the financial and operational projections are based on reasonable assumptions and therefore fails to demonstrate the immediate and long-term financial feasibility of the project.

Duke Raleigh fails to provide reasonable projections of costs and revenue based on data inconsistencies between the application and the financials, as well as the failure to adequately capture project related expenses. These specific inconsistencies and omissions are summarized in the following points:

- On page 51 of the application, Duke Raleigh provides the projected charity care in the first and second fiscal years after completion of the project. However these figures do not match the projected charity care amounts in either income statement for the proposed rehabilitation unit or the overall Duke Health System.
- Also on page 51, Duke Raleigh projects no bad debt for the proposed project. This is consistent with the absence of projected bad debt in the financials for the rehabilitation unit. In neither the assumptions nor the responses in Section VI does Duke Raleigh state that charity care also includes bad debt as it is defined in the application's response to Section VI.7.(e) on page 52. It is unreasonable for Duke Raleigh to assume that it will collect 100 percent of the patient's financial portion for the services rendered. Moreover, in each of their applications, Johnston Health, UNC Hospitals and WakeMed project a bad debt amount, separate from charity care, equivalent to 9.3, 8.3, and 4.0 percent of its net revenue, respectively.
- The payor mix provided in Section VI.12.(a) does not match the percentages of total patient days by payor on either Form C or Form D of the financials.
- The proposed organizational chart for rehabilitation services, as provided in Exhibit II.7.A of Duke Raleigh's application, suggests that rehabilitation staffing will include an executive director, an acute rehab manager, a rehab nurse manager, a rehab program manager and a medical director, as well as a liaison. Although the proposed staffing chart in Section VII.2 includes the program manager and liaison, it does not assign or allocate FTEs and associated staffing

costs relating to the other managerial positions provided in the rehabilitation organizational chart. Given this, Duke Raleigh has failed to project reasonable costs relating to the staffing in its proposed project.

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

Duke Raleigh fails to demonstrate that its proposed project will have a favorable impact on quality to the services proposed.

On page 48 of its application, Duke Raleigh states that the ability to care for inpatient rehabilitation patients at the hospital without having to transfer them to another facility along with the presence of critical care services, specifically neurosurgery, will assure a quality inpatient rehabilitation program at Duke Raleigh. However, there is no specific discussion of how these two factors will assure quality in the new unit nor does the applicant include any rehabilitation-specific policies in its application to support its assurances that quality care will be provided. Although Duke Raleigh indicates it will seek accreditation for the new unit from The Joint Commission, it does not indicate that it will seek accreditation from the Commission on Accreditation of Rehabilitation Facilities (CARF), the standard accreditation body for inpatient rehabilitation units.

Further, Duke Raleigh states on page 47 of its application, "The focus within the proposed inpatient rehab unit will also foster positive competition in that the Duke Raleigh rehab unit will have a significant focus and specialization on care for stroke, amputation, and orthopaedic patients. Both WakeMed and UNC are trauma centers and have a children's hospital, allowing them to specialize in providing care for pediatric patients and those with traumatic injuries. ***As these volumes are relatively small within the community, it is important for facilities to have sufficient volume to maintain high quality care.*** Similarly, Duke Raleigh's specialization in the above mentioned services will ensure the provision of high quality care." ***[emphasis added]*** Through these statements, Duke Raleigh implies that it will be able to ensure high quality care in its inpatient rehabilitation unit because it will focus on particular medical conditions for which it will have sufficient volume to maintain quality.

However, despite indicating otherwise on page six of its application (previously discussed under Criterion 3), Duke Raleigh does in fact project a very small number of traumatic brain injury and major multiple trauma patients in its utilization tables in Section IV. By its own assessment in the quote referenced above from its application, Duke Raleigh's ability and/or need to provide high quality care to traumatic brain injury and major multiple trauma patients is questionable at best.

For these reasons, Duke Raleigh is not conforming with this criterion.

SECTION .2800 - CRITERIA AND STANDARDS FOR REHABILITATION SERVICES

10A NCAC 14C .2802 INFORMATION REQUIRED BY APPLICANT

(e) An applicant proposing to establish new rehabilitation beds shall project patient origin by percentage by county of residence. All assumptions, including the specific methodology by which patient origin is projected shall be clearly stated.

Duke Raleigh failed to provide projected patient origin for the proposed new inpatient rehabilitation unit. The response to 10A NCAC 14C .2802 (e) was, "Please see response to III.4.(b)." III.4.(b) requests current patient origin data for existing inpatient rehabilitation facilities. Duke Raleigh is not an existing inpatient rehabilitation facility. The response to III.5.(a) and (b), which requests projected patient origin and would be the appropriate response for a new facility, was entirely omitted from the application. Duke Raleigh did not provide assumptions and a methodology for projecting patient origin for the new inpatient rehabilitation unit anywhere in its application. Therefore, because Duke Raleigh did not provide projected patient origin and a methodology and assumptions for those projections as required by the Criteria and Standards for Rehabilitation Services, the applicant is non-conforming with this rule.

SUMMARY

In summary, based on both its comparative analysis and the comments on the competing applications, as well as the analysis presented in its application, Johnston Health believes that its application represents the most effective alternative for meeting the need identified in the *2011 SMFP* for inpatient rehabilitation beds in HSA IV.