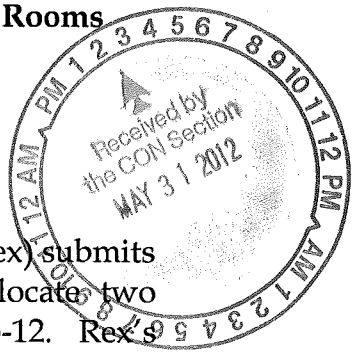
Comments on WakeMed Application to Relocate Two Operating Rooms



submitted by

Rex Hospital

In accordance with N.C. GEN. STAT. § 131E-185(a1)(1), Rex Hospital (Rex) submits the following comments related to WakeMed's application to relocate two operating rooms to its main campus in Raleigh, Project ID # J-8815-12. Rex'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). In order to facilitate the Agency's ease in reviewing the comments, Rex has organized its discussion by issue, specifically noting the general CON statutory review criteria and specific regulatory criteria and standards creating the non-conformity relative to each issue.

While Rex understands the need to redeploy resources such as operating rooms to maximize utilization, it does not believe WakeMed's application should be approved. While the project itself may make sense to WakeMed, it still must be conforming with all applicable review criteria in order to be approved. Rex does not believe that WakeMed's application is conforming with all the review criteria, and as such, it should be disapproved.

Rex identified the following specific issues, each of which contributes to WakeMed's non-conformity:

(1) Contrived (and therefore unreasonable) need arguments;
(2) Inconsistency with the goals of its 2009 ASC application;
(3) Unreasonable and unsupported utilization assumptions; and,
(4) Failure to adequately respond to the criteria and standards for operating rooms.

Each of the issues listed above are discussed in turn below. Please note that relative to each issue, Rex has identified the statutory review criteria and specific regulatory criteria and standards creating the non-conformity.

<u>Contrived Need Arguments</u>

A key theme in WakeMed's application is the need for operating rooms at the hospital and the lack of newly-approved hospital-based operating rooms in Wake County in recent years. Missing completely from its discussion is the fact that WakeMed has had four operating rooms, initially approved for

development in Apex and ultimately for Capital City Surgery Center (CCSC) which could have, at any time, been proposed for reallocation to the hospital. Instead, WakeMed has remained determined in its efforts to develop those operating rooms in an ASC—not in a hospital. Even more notably missing is the fact that WakeMed's ongoing development of CCSC will *reduce* its number of hospital-based operating rooms by another four rooms. Thus, WakeMed has taken specific steps to decrease its hospital-based capacity and the "need" for additional capacity at WakeMed Raleigh has been created by—and not addressed by—its own previously-approved projects. In addition, as discussed in detail below, WakeMed now assumes less surgery volume will shift from the hospital to CCSC, further reducing the need for a project it continues to develop.

One of the key arguments WakeMed makes on the first page of Section III involves the need for additional "shared" (i.e. hospital-based ORs used for inpatient and outpatient cases) surgical capacity. It discusses the higher utilization at hospitals compared to ambulatory surgery centers and how the higher volume impacts the hospital's flexibility and patients' choice in scheduling. In addition to the lack of discussion of WakeMed's own contribution to the growth in ASC capacity, WakeMed also omits the fact that WakeMed Raleigh has the least utilized operating rooms among the hospitals in Wake County, as shown in the table on page 67. Therefore, of all the hospitals in Raleigh, WakeMed already has the most flexibility, and if its downward trend in utilization continues, driven in part by its shifting of cases to the ASC, it will have even more capacity in the future.

Moreover, WakeMed's statements contradict its own plans to convert shared operating rooms at WakeMed Raleigh into dedicated ambulatory surgical operating rooms at Capital City Surgery Center. On pages 82 and 83 of its application to develop Capital City Surgery Center (Project ID # J-8364-09), WakeMed discussed the need to separate its inpatient and outpatient surgical segments. In particular, it stated that its "greatest opportunity for improvement is found in the circumstance of comingling of thousands of inpatient surgical cases with thousands of outpatient surgeries in one large, but overburdened surgical suite." WakeMed's solution to this problem was to propose (and be approved) to relocate four of its shared operating rooms from the Raleigh hospital to be dedicated outpatient ORs in the ASC. Thus, WakeMed itself proposed to reduce the number of shared operating rooms at the hospital in favor of dedicated ambulatory surgical ORs. Any "need" that WakeMed claims to have for additional shared operating rooms is obviated by the fact that WakeMed chose and continues to develop a project which will decrease the number of shared operating rooms at WakeMed Raleigh by four. WakeMed's argument that it needs additional hospital-based OR capacity is clearly artificial,

as it stems from its own decision to redeploy four of its hospital-based ORs to the ASC.

Based on this factor, the Agency should find WakeMed's application non-conforming with Criterion 3.

Inconsistency with the Goals of the 2009 Application

As part of this relocation and redesignation proposed in the 2009 application for CCSC, WakeMed projected that 65 percent of its outpatient surgery volume would shift to the ASC, accomplishing its goal of diminishing the comingling of outpatient and inpatient surgical cases. As shown in the table below, the ASC project was supposed to dramatically lower the number of outpatient cases done at the hospital, while also moderating the utilization per operating room.

Volume from 2009 application, page 104

	2007	2008	2009	2010	PY 1	PY 2	PY 3
Raleigh IP*	7,281	6,486	5,931	6,212	6,618	7,020	7,438
Raleigh OP	9,463	9,165	7,734	8,102	3,410	3,457	3,500
Raleigh Total	16,744	15,651	13,665	14,314	10,028	10,477	10,938
ORs*	18	18	18	18	14	14	14
Cases/OR	930	870	759	795	716	748	781

**Less C-Section and Open Heart*

With this proposed project, and before the development of CCSC is complete, WakeMed now assumes that only 30 percent of its outpatient surgery volume will shift to the ASC. As a result, the proposed project will re-create the high utilization and comingling scenario that drove the need for its ASC. As shown below, following development of the proposed project, WakeMed projects the ORs in the hospital to have nearly the same number of outpatient cases and the same high level of utilization per OR that it claimed supported its need for the ASC.

Volume projected after shift to CCSC, page 91

	2013	2014	2015
Raleigh IP*	7,524	7,710	7,900
Raleigh OP	6,458	6,605	6,756
Raleigh Total	13,982	14,315	14,656
ORs (main)*	16	16	16
Cases/OR (main)	874	895	916

*Less C-Section and Open Heart

The change in the percentage of cases projected to shift to the ASC is unreasonable for several reasons. First, the application provides no methodology by which the percentage was calculated. In fact, WakeMed states that surgeons who currently practice at the hospital "indicated that they intend to shift relatively few of their outpatient surgery cases to CCSC." (See application, page 45.) The application contains no other basis for calculating the change from 65 to 30 percent, and therefore the Agency has no basis for deeming this projection to be reasonable. Next, WakeMed has recently indicated that it does not use shifts in physician practice patterns to project utilization. Specifically, in deposition testimony given by Stan Taylor, WakeMed's Vice President for Corporate Planning, Mr. Taylor stated that projecting volume based on physicians and shifting volume from physicians is "absurd." As shown in the following excerpt from his deposition from March 1, 2012, Mr. Taylor makes it clear that he disagrees with the use of anything other than historical trends and market share to project utilization:

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Q. And I believe you said that you're not familiar with--specifically with what WakeMed's application assumed, in terms of whether any of the Wake Heart and Vascular physicians would shift from WakeMed to Rex, correct?

A. I'm--what I'm saying is that the way we project volume is we look at historical utilization; we look at population aging; we look at utilization rates in the market. We don't make assumptions about where physicians will or will not practice. That's, to me, immaterial. If you have the

24 facilities and services in the market, you will be

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1 able to attract the physicians to practice there,
2 especially if you have the referral network still.
3 Q. Was it--was it implicit in the WakeMed projections
4 that the same historical referral pattern would
5 remain in place in the future?
6 A. We--with our historical projections, utilization
7 rates, we looked at population aging; we put that
8 into a model, and we project forward. We do not
9 make any assumptions about which physicians will
10 or will not be practicing. We don't look at who's
11 retiring. We don't look at who's new coming into
12 the market. We look at what the population base
13 needs today and what our current share of that
14 population base is, project it forward.
15 Q. Okay. But, I mean, is it fair to say that there
16 were no--that by projecting historical trends
17 forward, you weren't--WakeMed--WakeMed's
18 applications were not projecting--were not
19 factoring in any physician shifts, correct?
20 A. I--what I've said is it's immaterial. But
21 physicians shift every day, and to base a
22 projection on physicians is absurd. You need to
23 base it on the population need, show that the
24 population needs the services, show what the

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1 historical utilization is of your facility, and
2 then project forward.
3 Ten years ago, we had all the orthopedics in
4 town at our facility. Today, we have--I think,
5 today, I don't think we have any private
6 orthopedics left. So we employ 11 orthopedics.
7 We have the same kind of volume, same kind of
8 trends that we had 10 years ago. So I think to
9 base it on some physician-based model is an absurd
10 way to project it.

Please note that emphasis has been added. See Exhibit 1 for the printed excerpt of this testimony. Judy Orser, another Planner for WakeMed, provided similar

testimony about the unreasonableness of projecting volume based on physician shifts:

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Q. And do you, as a health planner, think it was reasonable for Rex to count on a 100 percent shift of the business of Wake Heart and Vascular by 2015?
A. No.
Q. Okay. Why not?
A. Because I don't--number one, I think--I don't think you can predict what physicians are going to

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do. I--that's a--that's a large group.

(emphasis added)

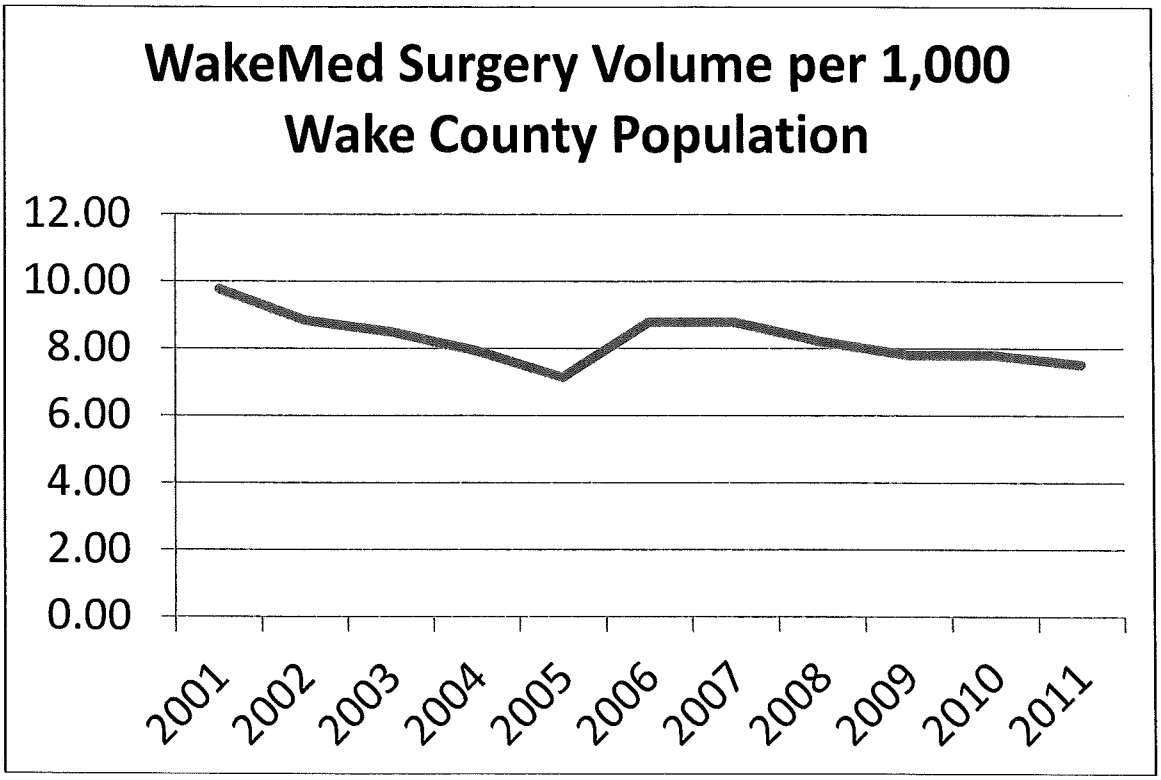
Please see Exhibit 2 for the printed excerpt of Ms. Orser's testimony. Based on this testimony, given under oath only a few weeks prior to the filing of WakeMed's application, WakeMed does not believe that projecting volume based on physician shifts is reasonable—even when those physicians are employed as was the case with the physicians about whom these witnesses were testifying. As such, WakeMed's change in projected shifts of volume from unnamed and non-employed physicians as the basis of its projected utilization at WakeMed Raleigh should be discredited, and the Agency should determine its projections to be unreliable. In addition, the change in the percentage of cases to be shifted creates an unsupported assumption regarding the source of WakeMed Raleigh's surgical volume, which is discussed in further detail below.

As a result of these issues, the WakeMed application should be found non-conforming with Criterion 3.

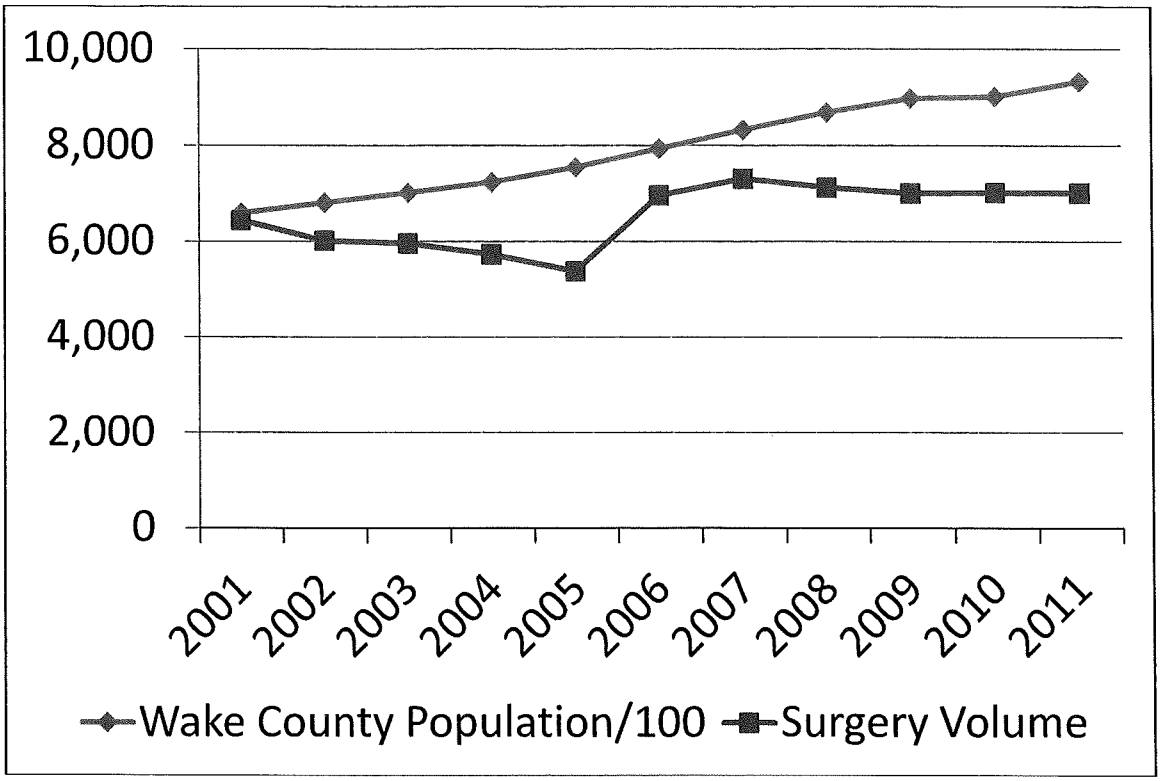
Unreasonable and Unsupported Utilization Assumptions

In addition to the issues discussed above, WakeMed's application is also non-conforming because of its unreasonable utilization projections. The application projects surgical utilization at WakeMed to increase, based on several factors including population growth and the aging of the population. Neither of these factors is new, however, and in fact, population growth is projected to slow in comparison to historical growth, as shown on page 69 of the application. However, even with the tremendous growth in population and its aging, surgical volume at WakeMed has not kept up with that growth, but has experienced an inverse relationship to population growth. As shown in the following chart,

with the exception of one year in the past decade, the trend in the ratio of WakeMed's surgery volume per 1,000 Wake County population has been generally negative, decreasing as the population increased.



The chart below also shows the inverse relationship between population growth and surgery volume at WakeMed, with both similarly scaled (population per 100 compared to non-open heart surgery volume) to allow a side-by-side comparison.



Please see Exhibit 6 for the data used to create these charts; data are from the *SMFP* for 2001 through 2010, from licensure report data for 2011 and from OSBM for population.

Thus, WakeMed fails to provide a reasonable basis for reversing its historical downward trend in surgical utilization, given that it has historically had an inverse relationship with population growth and provides no compelling rationale for that to change in the future. In recent litigation, WakeMed's expert witnesses have criticized Rex for projecting reversals in historical trends, even for services previously-approved by the CON Section (similar to WakeMed's exempt acquisition of the two-room ASC from which the ORs in this review are to be transferred). In a contested case hearing conducted in June 2011, Karin Sandlin of Keystone Planning Group testified as an expert in health care planning on behalf of WakeMed, stating that it was unreasonable to project future growth when the historical trend, even in just the past three years, had been negative. Ms. Sandlin also testified that it was reasonable instead to project the negative trend to continue in the future, as shown below.

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Q And why did you feel this information was relevant to your analysis?

A Again, their utilization has been declining consistently for the past several years. And to the extent

that Rex projects that their utilization will begin to increase in 2010, there's a burden upon the applicant to provide adequate justification for why that decreasing trend will all of a sudden begin to increase. And there was no information provided regarding their historical utilization.

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Q And what does that show with regard to what was happening with Rex's volume?

A This shows that there has been a consistent decrease in procedures, both diagnostic and interventional, and the resulting diagnostic equivalent cases since 2001 with the exception of year 2006.

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Q And what does that document show?

A This document shows Rex's historical cardiac cath utilization for diagnostic equivalent caths, their actual utilization from fiscal 2007 to 2009. And the red line indicates their projected utilization based on the historical two year compound annual growth rate in comparison to the projections based on Rex's methodology in their application.

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Q And was there a reason you focused on those two years?

A I also included the 2009 utilization, 3,489, and provided those three years because that is what's consistent with the historical data provided in the Rex application.

Q So that information came directly from what Rex had provided to the Agency; is that correct?

A Yes, ma'am.

Q And so what did your calculations show with regard to what the utilization of the cardiac cath labs would be at Rex Hospital?

A I'm sorry. Can you repeat the question?

Q What did your calculations demonstrate with regard to the utilization of the cardiac cath labs at Rex Hospital?

A There's a negative two year compound annual growth

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rate for diagnostic equivalent caths at Rex Hospital.

Q And projecting that out, how did that impact the

utilization of the cardiac cath labs at Rex Hospital?
A When you apply that negative growth rate to their fiscal 2009 actual, it results in a decreasing trend of projected utilization.
Q And what did this analysis show you with regard to the need for four cardiac cath labs at Rex Hospital?
A This shows that they currently do not demonstrate the need for four cardiac cath labs and that they do not project to need four cardiac cath labs.

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Q Okay. And it looks like here at the bottom what you were doing was projecting you said--I guess the projections of Rex were in the blue line?
A Yes, sir.
Q Okay. And you said what we should do is basically continue Rex's negative historical trend of cardiac cath downward at the compound annual growth rate. Is that what you did there, basically?
A Yes. In light of there being no discussion of the reasons why for the past several years beyond 2007 that Rex's cardiac catheterization lines have been declining, in the absence of any justification of why they've been declining, I projected forward based on Rex's historical compound annual growth rate.

(emphasis added)

Please see Exhibit 3 for the printed excerpt of this hearing testimony.

Using the rationale of WakeMed's expert, projecting WakeMed's historical decline in surgical volume to continue at the historical compound annual growth rate of -1.6 percent would result in the following utilization through the third project year:

Year	*WakeMed Surgery Volume Projected at Its Historical CAGR*
2008	17,560
2009	17,173
2010	16,940
2011	16,810

2012	16,456
PY 1	16,191
PY 2	15,930
PY 3	15,674
CAGR	**-1.6%**

As shown, projecting WakeMed's volume based on its historical growth rate results in a continuing decline in surgical cases and obviates the need for the proposed project. Please note that this analysis (as well as others in these comments) is not merely an intellectual exercise; rather, it is based on the testimony of experts relied upon by WakeMed to criticize Agency findings in other reviews. As such, the Agency should hold WakeMed to the opinions regarding health planning that it has previously expressed in its opposition to the Agency's position.

The application also refers to surgeon recruitment as a basis for WakeMed's optimism regarding its surgical volume. On page 68 of the application, WakeMed shows that the number of surgeons has increased by 24 percent over the past two years, primarily from April 2011 to April 2012. While the number of surgeons may have increased by 24 percent, what is clear from WakeMed's application is that this increase has not positively impacted WakeMed's surgical volume; instead, as shown on page 43 of the application, WakeMed Raleigh's total surgical cases (less C-Section and open heart) in FY 2011 were 16,810 and are projected to be only 16,456 for FY 2012, based on annualizing five months of data during which the number of surgeons at WakeMed were presumably increasing. Thus, WakeMed believes its 24 percent increase in surgeons will generate 354 *fewer* cases in FY 2012 compared to FY 2011. Clearly these surgeons will not drive the reversal in surgical volume trends projected by WakeMed.

On page 73, WakeMed asserts that the increase in inpatient beds at the Raleigh hospital will drive an increase in inpatient surgical volume. As noted on that same page, however, WakeMed increased its bed capacity by more than 10 percent in 2010. The impact of this bed increase on surgical utilization was negative, as total surgical volume decreased from 16,940 in FY 2010 to 16,810 in FY 2011, with further declines for annualized FY 2012, as noted above. Inpatient surgical volume also declined in FY 2011 to 7,788 cases compared to 7,898 in FY 2010. Thus, the increase in bed capacity at WakeMed Raleigh correlated negatively with its surgical volume and is not a reasonable basis for projecting future growth. Moreover, WakeMed does not believe it needs additional acute care beds at its Raleigh hospital. In recent deposition testimony given during discovery in the contested case in the 2011 Wake County acute care bed review, several WakeMed witnesses testified to this fact.

Testimony from March 1, 2012 by Stan Taylor:

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Q. Now, I believe you testified earlier that you are now of the opinion that the need determination in the 2011 State Medical Facilities Plan for 101 additional acute care beds in Wake County is incorrect?
A. I don't believe the need calculation in the 2011 Plan is incorrect. I believe the 2012 newer, better data came out that showed that they weren't needed.
Q. Fair enough. Given that opinion, would WakeMed

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develop the two certificates of need that it was conditionally approved for in this review, or would it relinquish one or both of them?
A. I believe our board, especially our finance committee, would look very carefully at utilization trends. And if our utilization and the utilization in the community continues downward, I would expect that we might relinquish one of those CONs.

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Q. Is it possible that WakeMed would not develop all

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of those 101 beds even if they were ultimately awarded to WakeMed?
A. It's possible, yes.
Q. And do you know how many WakeMed would be likely to develop of that 101, based on what you know now?
A. I think it's going to depend on trends in utilization, what we see in the market over the next year.
Q. All right, sir. Is it possible that WakeMed would develop none of the 101 beds if they were ultimately awarded to WakeMed?
A. Anything is possible.

(emphasis added)

Please see Exhibit 1 for the printed excerpt of this testimony.

Therefore, WakeMed may not develop all of the those beds, and even if WakeMed eventually is able to develop the additional beds it was awarded in 2011, if they are not needed as WakeMed believes, they will be underutilized and will certainly not drive an increase in surgical utilization.

In addition, as noted above, although WakeMed was approved to develop CCSC based on a projected shift of 65 percent of its outpatient surgery cases, it now estimates only 30 percent will shift. It should also be noted, as stated on page 55 of the 2009 CCSC application, that WakeMed projected that 90 percent of the ASC's surgical volume would be shifted from WakeMed Raleigh. With the proposed decrease in the shift from WakeMed, and with the historical decrease in WakeMed's surgical volume, the applicant is now clearly proposing to shift volume from other providers to the ASC. Although the Agency is not reviewing the CCSC projections as a direct part of this review, this factor should not be overlooked, as it is essentially an assumption that shifts volume back to WakeMed from what was used to approve the CCSC application. In the CCSC application, the Agency believed that WakeMed had reasonably demonstrated a need to shift the majority of its outpatient volume to an ASC, and that this shift would be the primary driver of volume at the ASC—not gains in market share, significant shifts of physician practice patterns, or other factors. In this application, WakeMed changes this approach, and in so doing asserts that it no longer needs the shift in volume to CCSC to achieve reasonable utilization, and that the majority of WakeMed's outpatient surgery volume will remain at the hospital. In essence, WakeMed is projecting to achieve a system-wide market share gain and to shift volume from existing providers, without ever demonstrating the reasonableness of those assumptions. The application, in fact, does not even try to do so, but merely states on page 45 that the "percentage reduction...has been reduced." As a result, WakeMed projects to re-capture 35 percentage points of its outpatient surgery volume without ever demonstrating it is reasonable to do so. This assumption is unsubstantiated and is not accompanied by any documentation for the Agency to verify its reasonableness. Moreover, WakeMed has recently criticized Rex for using similar (although more thoroughly documented) assumptions. In testimony from Judy Orser, she found fault with Rex's projected shifts, even though the physicians in question (unlike WakeMed's) were employed, and even though Rex had documented the shifts with letters of support:

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12 Rex has postulated that Rex Heart and
13 Vascular Associates is going to shift 100 percent
14 of their business, <u>but they have no evidence that</u>

that's going to occur yet, other than letters of support from physicians. But at the time that this was filed, you know, they didn't know if the physicians were going to do it or not. The CON Section believed it, but, you know, if you wait another year, then you can actually see if there's a shift in their business the way it's projected.

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Q. With regard to the first bullet point, please explain your opinion relating to need methodology should be based on verifiable data, not conjuncture.
A. Rex has no evidence, other than support letters, that Wake Heart & Vascular is going to shift a hundred percent of its business. An application was submitted too soon after the affiliation agreement for there to be any evidence of the shift in business.

(emphasis added)

Ms. Orser also testified that she believes the use of shifting physician volume should only be used when it can be documented historically, and when those shifts are creating capacity issues—neither of which has occurred at CCSC, which has yet to open:

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Q. With regard to your own personal opinion, do you believe that shifts in physician relationships can ever be used as an underlying factor in calculating need in a CON application?
Q. I wouldn't say never, but I think it needs to be reasonable.
Q. Can you think of any circumstance where it would be reasonable, in your opinion, to use a shift in physician relationships as an underlying factor in projecting need?
A. I think if you have evidence that the physicians have--have brought new volume to you, and, because of that physician shift, your utilization has increased, and you're now having capacity issues as a result, that that is a better example of when

you can use a shift in physician volume. I think you need to have some evidence of it rather than speculation.

Q. So, in your opinion, do you need to provide historical proof that the shifts have already begun to occur in order to project future shifts?

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A. I think you--I think there has to have been enough of a shift, and you have to have--there has to have been enough an increase in business such that you're having capacity issues that warrant additional resources.

(emphasis added)

Please see Exhibit 2 for the printed excerpt of this testimony.

Another WakeMed Planner, Robbie Roberts, also testified that it is unreasonable to project volume based on shifts in physician volume, even with letters from physicians indicating such as shift, as demonstrated in the following deposition testimony (see Exhibit 4 for the full text of these excerpts):

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Q. Do you agree that some of the Wake Heart and Vascular physicians are going to shift their inpatient volume to Rex?

A. They stated their intent, but I don't know (a) which doctors will do so, (b) to what extent they'll be able to do so, then, (c) whether they'll actually do it.

Q. Would you agree that the physicians are the ones most knowledgeable of whether that will occur?

A. I think that's predicting something that may or may not happen in the future.

Q. And who, in your opinion, would be the best person to make that prediction?

A. I don't know that there's any one person that can make that prediction. Or, you know, what we're

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talking about is something that may or may not happen in the future, and intent and reality are two different things.

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Q. I'm--I'm trying to understand why you--you don't believe the assumption itself. Let me ask you this. Why do you not believe the assumption itself that there would be a--a inpatient volume shift; why do you not believe that assumption?
A. There's no historical proof that a shift has begun to occur.
Q. In what form, in your opinion, would that historical proof be in?
A. Some sort of data, either through an independent source or through Rex, that indicated that the shift had begun to occur.

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Q. So--so you're looking at--at--for historical volume data?
A. Yes.
Q. Is that correct?
A. Yes.

(emphasis added)

Please see Exhibit 4 for a printed excerpt of this testimony.

With no support whatsoever, WakeMed has based a significant portion of its future utilization on a shift that was previously approved, which it now says will not occur due in part to shifts in volume from other physicians. Based on the testimony cited above, WakeMed clearly believes a historical record of volume shifts is needed in order to demonstrate the reasonableness of these assumptions, at a minimum. Thus, the Agency should find these assumptions and the utilization projections to be unreasonable.

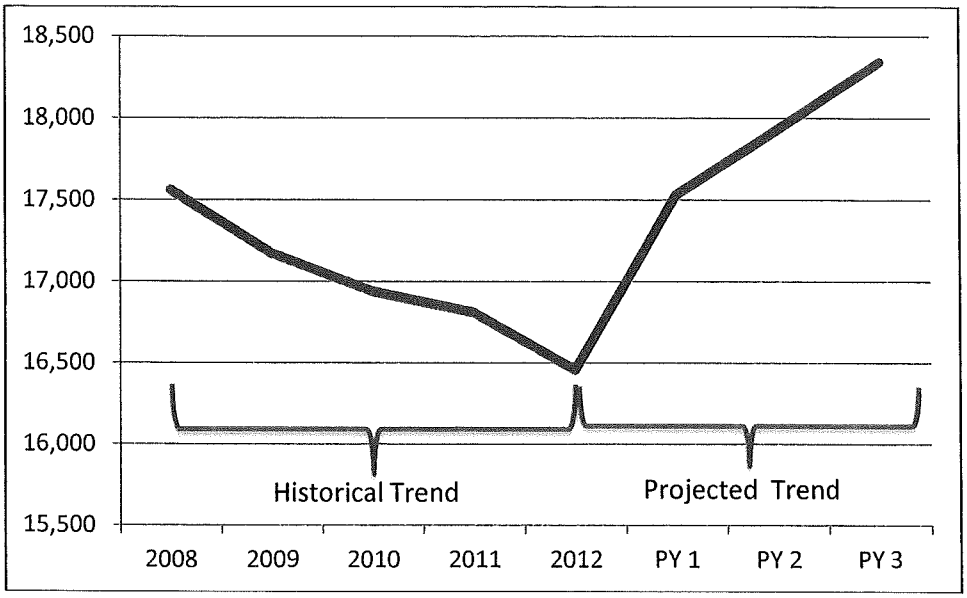
In summary, although WakeMed has attempted to undergird its utilization projections through several rationales, the bottom line is that WakeMed projects a reversal in surgical volume which is unsupported by any assumption. Although trends can be reversed, WakeMed's application does not provide enough evidence for the Agency to determine that its utilization projections are reasonable. As shown in the following table, WakeMed Raleigh's surgical utilization, as provided in its application, has declined since 2008.

	2008	2009	2010	2011	2012	CAGR	Change
WM Raleigh IP	8,395	7,839	7,898	7,788	7,797	-1.8%	-598
WM Raleigh OP	9,165	9,334	9,042	9,022	8,659	-1.4%	-506
WM Raleigh Total	17,560	17,173	16,940	16,810	16,456	-1.6%	-1,104
						Total	**-2,208**

Without any credible support, WakeMed projects this historical trend to reverse, as shown below.

Projected, prior to shift to CCSC					
	2013	2014	2015	CAGR	Change
WM Raleigh IP	8,307	8,497	8,691	2.3%	384
WM Raleigh OP	9,225	9,435	9,651	2.3%	426
WM Raleigh Total	17,532	17,932	18,342	2.3%	810
				Total	**1,620**

As noted in the table above, WakeMed projects volume growth *prior* to the shift of cases to the ASC; thus, the development of the ASC is not a rationale for the increase in volume. Although population growth can drive increased utilization of health care services, WakeMed has not demonstrated that population growth is a reasonable basis for its utilization projections, given that population growth has not historically resulted in increased surgical utilization at WakeMed. As shown in the following chart, WakeMed would have the Agency believe that the trend will not only reverse itself, but that the growth rate would be higher than the rate of decline has been, and that WakeMed will exceed the number of cases performed in 2012 by more than 1,800 cases by 2015—just three years later. As seen in graphical form below, this projection is not supported by the historical trend, and with no other credible support, the Agency should determine these projections not to be reasonable.



Finally, notwithstanding its projections to the contrary in this application, WakeMed's management believes that utilization of health care services has been declining and will continue to do so in the future. Specifically, the response below from Stan Taylor in his deposition on March 1, 2012 indicates his belief that hospital-based utilization will decline:

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Q. Let me rephrase the question. Have you done any analysis of how the Affordable Care Act and the individual mandate contained in that Act will affect the financial viability of any acute care facility or service line?

A. We've done some research on that. I believe the long-term effect is a significant reduction in utilization of acute care facilities.

(emphasis added)

Please see Exhibit 1 for the printed excerpt of this testimony.

In addition to Mr. Taylor, another member of WakeMed's management team, Allen Gambill, testified similarly about the declining trends in hospital utilization:

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Q. Okay. What--let me pick up on your last comment. What changes across healthcare in general would

have changed the need for acute care beds in Wake County?

A. Utilization patterns changed significantly. People are using hospital services--people are using, in general, healthcare services considerably less.

Q. Okay.

A. In particular--I guess you can link that to the economic condition of the country. Numerous articles have been indicated to where people are postponing healthcare services. It's a question of whether or not it's going to return.

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Q. And what did you see in the 2012 Plan?

A. Decrease in utilization overall. And I--I haven't done a side-by-side comparison, which would probably be interesting to do. But, in general, as I understand it, is that there's been a decline in utilization of hospital services. It's not Wake County--exclusive to Wake County. It's not exclusive to North Carolina. Birthrates are even down across the country. It's more of a matter of a reflection of the economic situation.

(emphasis added)

Please see Exhibit 5 for the printed excerpt of this testimony.

While both of these witnesses were referring specifically to acute care bed utilization, since a significant portion of acute care utilization is driven by surgical volume, the decrease in acute care utilization expected by WakeMed must also be accompanied by a decrease in surgical utilization. Moreover, a change in such general demographic trends, such as a decline in birthrates, as well as the overall economic situation should not affect only bed utilization, but surgery as well. Indeed, in its application, WakeMed refers to the historical decline in its surgical utilization; however, unlike the testimony of its witnesses regarding acute care inpatient utilization, WakeMed asserts that this trend will reverse itself—without any compelling support for that assertion.

On the basis of these issues, WakeMed's application should be found non-conforming with Criterion 3 and the performance standards in the rules for operating rooms.

Failure to Adequately Respond to the Criteria and Standards

10A NCAC 14C .2102(c) applies to the proposed project. Although WakeMed responded to this rule for WakeMed Raleigh, the site to which the operating rooms are proposed to be relocated, it failed to respond to this rule for the existing facility. Included in the information required by the rule are data that are not otherwise publicly available, such as surgical volume for the most recent 12-month period and projected volume for the first three project years. WakeMed's failure to include this information for the ASC from which the operating rooms are proposed to be relocated results in non-conformity with this rule.

WakeMed is also non-conforming with 10A NCAC 14C .2102(c)(8). As shown on page 30 of the application, 57.5 percent of WakeMed Raleigh's current surgical cases are outpatient; following development of the proposed project and the volume shift to CCSC, only 47.2 percent of its cases will be outpatient, as shown on page 54. In addition, WakeMed projects its surgery volume to grow substantially, particularly in comparison to its historical decline in volume as discussed above. However, the applicant projects no change in the top 20 procedures performed at WakeMed Raleigh, which is clearly unreasonable in light of these other significant changes. As such, the applicant is non-conforming with this rule.

Exhibit 1

Transcript of the Testimony of **W. Stanley Taylor**

Date: March 1, 2012
Volume: I

Case: Wake County Bed Review

Printed On: May 31, 2012

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STATE OF NORTH CAROLINA — IN THE OFFICE OF ADMINISTRATIVE HEARINGS

COUNTY OF WAKE

HOLLY SPRINGS HOSPITAL II, LLC,

Petitioner,

v. — 11 DHR 12727

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

Respondent,

and

REX HOSPITAL, INC., HARNETT HEALTH SYSTEM, INC. and WAKEMED,

Intervenors.

(CAPTION CONTINUED ON NEXT Page)

DEPOSITION OF
W. STANLEY TAYLOR

THURSDAY, MARCH 1, 2012
9:33 A.M.

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RALEIGH, NORTH CAROLINA

VOLUME I

REX HOSPITAL, INC.,
Petitioner,
v.
11 DHR 12794
N.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF HEALTH SERVICE REGULATION, CERTIFICATE OF NEED SECTION,
Respondent,
and
WAKEMED, HOLLY SPRINGS HOSPITAL II, LLC, and HARNETT HEALTH SYSTEM, INC.,
Intervenors.

HARNETT HEALTH SYSTEM, INC.,
Petitioner,
v.
11 DHR 12795
N.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF HEALTH SERVICE REGULATION, CERTIFICATE OF NEED SECTION,
Respondent,
and
REX HOSPITAL, INC., HOLLY SPRINGS HOSPITAL II, LLC, and WAKEMED,
Intervenors.

WAKEMED,
Petitioner,
v.
11 DHR 12796
N.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF HEALTH SERVICE REGULATION, CERTIFICATE OF NEED SECTION,
Respondent,
and
HOLLY SPRINGS HOSPITAL II, LLC, REX HOSPITAL, INC. and HARNETT HEALTH SYSTEM, INC.,
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ALSO PRESENT: NATHAN MARVELLE
DAWN CARTER (VIA TELEPHONE)

I recall.

Q. And when did WakeMed open WakeMed-Cary?

A. December 17th, 1991.

Q. Has that hospital been successful, in terms of growing its utilization over the years?

A. Yes.

Q. And in growing revenue?

A. Yes. It had a rough start, largely due to the State's condition that OB services not be offered, but it has grown over the past 10 years.

Q. And would it be fair to say that WakeMed-Cary has been successful, in terms of growing its market share?

A. Yes.

Q. Now, I believe you testified earlier that you are now of the opinion that the need determination in the 2011 State Medical Facilities Plan for 101 additional acute care beds in Wake County is incorrect?

A. I don't believe the need calculation in the 2011 Plan is incorrect. I believe the 2012 newer, better data came out that showed that they weren't needed.

Q. Fair enough. Given that opinion, would WakeMed

develop the two certificates of need that it was conditionally approved for in this review, or would it relinquish one or both of them?

A. I believe our board, especially our finance committee, would look very carefully at utilization trends. And if our utilization and the utilization in the community continues downward, I would expect that we might relinquish one of those CONs.

Q. Has there been any discussion of that possibility at WakeMed to which you're privy?

A. Not that I'm aware of.

Q. You mentioned the finance committee of the board at WakeMed. Please describe for us what that committee's functions are?

A. To approve capital expenditures and the budget for the health system.

Q. Do you provide any staff services to that committee?

A. No, I don't.

Q. Who does staff that?

A. Mike DeVaughn, our Chief Financial Officer.

Q. All right. And do you know who is the chair of the finance committee?

community have a surplus of beds and do not use all of the beds that they have. I believe that, although I would like to have the 79 beds, that the 2012 data shows that there weren't 101 beds needed, and that would probably indicate that if the State had done the--had looked at that data and paid attention to that data, they probably would not have approved those beds.

Q. And was that new data that--or newer data that you reference available to the Agency at the time that it made its decision in these applications?

A. Yes, I believe it was.

Q. And on what do you base that belief?

A. The draft Plan--I don't have the exact date--but it's--it's published, I believe, in early summer every year during the review.

Q. Now, for purposes of the next question, please assume the following hypothetical facts. Assume that WakeMed is successful in this contested case, and that, ultimately, all 101 beds identified as needed in the 2011 Plan are awarded to WakeMed. Do you understand that hypothetical, sir?

A. Yes.

Q. Is it possible that WakeMed would not develop all

of those 101 beds even if they were ultimately awarded to WakeMed?

A. It's possible, yes.

Q. And do you know how many WakeMed would be likely to develop of that 101, based on what you know now?

A. I think it's going to depend on trends in utilization, what we see in the market over the next year.

Q. All right, sir. Is it possible that WakeMed would develop none of the 101 beds if they were ultimately awarded to WakeMed?

A. Anything is possible.

Q. And that would ultimately be a decision for the finance committee for the board of WakeMed; is that right?

A. Yes, that's correct.

Q. Now, you mentioned a moment ago in your testimony that other providers in the county were not using all of their beds currently. Could you expand on what you meant by that, sir?

A. I believe Rex has a surplus of 36 beds in the most recent data. I'm not sure what Duke Raleigh's surplus is, but I think their utilization is

A. I believe that's correct.
Q. And based on any analysis you've done so far, how will that affect the financial viability of hospitals with lower utilization rates?
MS. MURRAY: Object to the form.
Q. Let me rephrase the question. Have you done any analysis of how the Affordable Care Act and the individual mandate contained in that Act will affect the financial viability of any acute care facility or service line?
A. We've done some research on that. I believe the long-term effect is a significant reduction in utilization of acute care facilities.
Q. And is there any short-term effect that you have identified?
A. The short-term effect, we expect to see a higher--higher patient volumes in our emergency departments as people have coverage for the first time. We also expect to see people utilize some services sooner than maybe today, at lower cost, because they're--they have coverage prior to reaching Medicare age.
Q. And have you done any analysis of a positive financial impact that the Affordable Care Act may

Q. Okay. Did--would you--did you have any conversations with anyone about whether or not to obtain any--and I don't think I've asked this question. Did you have any conversations with either one about whether to seek to obtain any letters from any of the Wake Heart and Vascular physicians?

A. In what context?

Q. In--to support WakeMed.

A. I'd need to go back to the application. Some of them may have supported our bid application. I'm not sure.

Q. And I believe you said that you're not familiar with--specifically with what WakeMed's application assumed, in terms of whether any of the Wake Heart and Vascular physicians would shift from WakeMed to Rex, correct?

A. I'm--what I'm saying is that the way we project volume is we look at historical utilization; we look at population aging; we look at utilization rates in the market. We don't make assumptions about where physicians will or will not practice. That's, to me, immaterial. If you have the facilities and services in the market, you will be

able to attract the physicians to practice there, especially if you have the referral network still.

Q. Was it--was it implicit in the WakeMed projections that the same historical referral pattern would remain in place in the future?

A. We--with our historical projections, utilization rates, we looked at population aging; we put that into a model, and we project forward. We do not make any assumptions about which physicians will or will not be practicing. We don't look at who's retiring. We don't look at who's new coming into the market. We look at what the population base needs today and what our current share of that population base is, project it forward.

Q. Okay. But, I mean, is it fair to say that there were no--that by projecting historical trends forward, you weren't--WakeMed--WakeMed's applications were not projecting--were not factoring in any physician shifts, correct?

A. I--what I've said is it's immaterial. But physicians shift every day, and to base a projection on physicians is absurd. You need to base it on the population need, show that the population needs the services, show what the

historical utilization is of your facility, and then project forward.

Ten years ago, we had all the orthopedics in town at our facility. Today, we have--I think, today, I don't think we have any private orthopedics left. So we employ 11 orthopedics. We have the same kind of volume, same kind of trends that we had 10 years ago. So I think to base it on some physician-based model is an absurd way to project it.

Q. Do you think that--you've indicated you think it's unreasonable that 100 percent of the Wake Heart and Vascular physician volumes would shift from WakeMed to Rex.

A. I think it's unreasonable on many levels. I think it's unreasonable to assume a hundred percent will shift. I think it's more unreasonable to assume that the physicians that are there today will be there tomorrow. I know for a fact that some of them are retiring. I know that physicians move and leave and relocate and jump between groups. I think it's an absurd way to try to project volume.

Q. And the ones retiring are the ones that you've already mentioned, right?

Exhibit
2

Transcript of the Testimony of **Judy Orser**

Date: February 24, 2012
Volume: I

Case: Wake County Bed Review

Printed On: May 31, 2012

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STATE OF NORTH CAROLINA	IN THE OFFICE OF ADMINISTRATIVE HEARINGS
COUNTY OF WAKE	
HOLLY SPRINGS HOSPITAL II, LLC,)	
)	
Petitioner,)	
v.)	11 DHR 12727
)	
N.C. DEPARTMENT OF HEALTH AND)	
HUMAN SERVICES, DIVISION OF HEALTH)	
SERVICE REGULATION, CERTIFICATE OF)	
NEED SECTION,)	
)	
Respondent,)	
and)	
)	
REX HOSPITAL, INC., HARNETT HEALTH)	
SYSTEM, INC. and WAKEMED,)	
)	
Intervenors.)	
)	

(CAPTION CONTINUED ON NEXT PAGE)

DEPOSITION OF
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FRIDAY, FEBRUARY 24, 2012
9:16 A.M.

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VOLUME I

REX HOSPITAL, INC., Petitioner, v. N.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF HEALTH SERVICE REGULATION, CERTIFICATE OF NEED SECTION, Respondent, and WAKEMED, HOLLY SPRINGS HOSPITAL II, LLC, and HARNETT HEALTH SYSTEM, INC., Intervenors.	11 DHR 12794
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WAKEMED, Petitioner, v. N.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF HEALTH SERVICE REGULATION, CERTIFICATE OF NEED SECTION, Respondent, and HOLLY SPRINGS HOSPITAL II, LLC, REX HOSPITAL, INC. and HARNETT HEALTH SYSTEM, INC., Intervenors.	11 DHR 12796

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ALSO PRESENT: DAWN CARTER

able to speak to whether that is a reasonable projection?

A. You could ask Stan Taylor.

Q. Would you anticipate, for example, that many women in the north Raleigh area would travel to Rex-Holly Springs to deliver their babies?

A. No.

Q. Why not?

A. Because they'd have to bypass Rex and WakeMed-Cary, and it's--it's--I just don't know that many of them would do that.

Q. Are you aware that Rex projected that 100 percent of the 2010 patient day volume associated with Wake Heart and Vascular Associates would shift from WakeMed to Rex by 2015?

A. Yes.

Q. And do you, as a health planner, think it was reasonable for Rex to count on a 100 percent shift of the business of Wake Heart and Vascular by 2015?

A. No.

Q. Okay. Why not?

A. Because I don't--number one, I think--I don't think you can predict what physicians are going to

do. I--that's a--that's a large group. I just don't believe in any way, shape, or form that they are going to shift a hundred percent of their patient days away from WakeMed. They've been practicing at WakeMed for a number of years. Rex is--and they do a tremendous number of cardiac cath procedures. I don't know the number specifically off the top of my head, but as Rex put it in their application, in excess of 6,000 procedures. Rex will only have four cath labs.

I just don't think it's reasonable to expect that they're going to move all--well, actually, Rex didn't project that they were going to move all their cath cases. They just said that they were going to move all of their inpatient days. They--they only projected an increase of roughly 500 cath cases, which is less than 20 percent of their inpatients who had cath procedures done based on my estimates. I just--I just don't think it's reasonable in any way, shape or form.

Q. Any other reasons than the ones you just mentioned why you do not think it's reasonable?

A. Not all the physicians said that they were going to shift all of their patients. And based on--and

forth in this paragraph?

A. I guess I struggle with what you're asking me when you say "what is the basis for your opinions." I mean, I've been around healthcare for a long time, so I guess that's the basis for my opinions. I think that, you know, you went from a high need of a 101 beds, the next year down to 29 beds. So that's a pretty significant difference. Allowing more time to see if, you know, the next year's Plan generates additional bed needs, you know, that could have occurred.

Rex has postulated that Rex Heart and Vascular Associates is going to shift 100 percent of their business, but they have no evidence that that's going to occur yet, other than letters of support from physicians. But at the time that this was filed, you know, they didn't know if the physicians were going to do it or not. The CON Section believed it, but, you know, if you wait another year, then you can actually see if there's a shift in their business the way it's projected.

And then the Rex outpatient facility opened in December. I'm not sure when the Novant am/surg facility will open. It will probably be another

A. Yes.

Q. Are those bullet points the reasons that, in your opinion, Rex's need methodology was unreasonable, and all three applications should have been found nonconforming?

A. Yes.

Q. With regard to the first bullet point, please explain your opinion relating to need methodology should be based on verifiable data, not conjuncture.

A. Rex has no evidence, other than support letters, that Wake Heart & Vascular is going to shift a hundred percent of its business. An application was submitted too soon after the affiliation agreement for there to be any evidence of the shift in business. So their projections that the physicians are going to shift a hundred percent business are based solely on physician letters of support, some of which clearly, at least, to me, do not intend to shift a hundred percent of their business, and, therefore, I thought that, in this instance, it was extremely aggressive to make that assumption, and--but, unfortunately, because of the way the numbers fall out, Rex can't meet the

based on actual evidence, but my gut tells me they can do whatever they want when it comes to making a decision.

Q. With regard to your own personal opinion, do you believe that shifts in physician relationships can ever be used as an underlying factor in calculating need in a CON application?

Q. I wouldn't say never, but I think it needs to be reasonable.

Q. Can you think of any circumstance where it would be reasonable, in your opinion, to use a shift in physician relationships as an underlying factor in projecting need?

A. I think if you have evidence that the physicians have--have brought new volume to you, and, because of that physician shift, your utilization has increased, and you're now having capacity issues as a result, that that is a better example of when you can use a shift in physician volume. I think you need to have some evidence of it rather than speculation.

Q. So, in your opinion, do you need to provide historical proof that the shifts have already begun to occur in order to project future shifts?

A. I think you--I think there has to have been enough of a shift, and you have to have--there has to have been enough an increase in business such that you're having capacity issues that warrant additional resources.

Q. In your view, can an application be approved based on that underlying factor if the applicant does not have capacity issues?

A. It probably depends on what they're applying for. I mean, it may mean--it may be that they need a new piece of equipment or--you know, I think it depends on the type of CON application; but, when it comes to beds, for example, if you're asking for more beds, I think you need to have some evidence that you're having capacity issues.

Q. What if you're--what if an applicant is seeking to replace beds, do they need to demonstrate they're having capacity issues, in your opinion?

A. Well, they have to, in my opinion, meet the performance thresholds in AC-5 in order to replace the beds. I mean, if they're not--if they're not operating at the performance threshold required by AC-5, in order to replace beds, then I think they need to have some serious evidence of need to

Exhibit
3

STATE OF NORTH CAROLINA COUNTY OF WAKE	IN THE OFFICE OF ADMINISTRATIVE HEARINGS

WAKEMED, Petitioner, v. NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF HEALTH SERVICE REGULATION, CERTIFICATE OF NEED SECTION, Respondent, and REX HOSPITAL, INC. d/b/a REX HEALTHCARE, Respondent-Intervenor.	)	No. 10-DHR-8008 TRANSCRIPT OF HEARING

Before Honorable Beecher R. Gray

Administrative Law Judge

WEDNESDAY, JUNE 29, 2011

Courtroom A

Office of Administrative Hearings

1711 New Hope Church Road

Raleigh, North Carolina

9:00 a.m.

Volume 3
Pages 366 through 583

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EXHIBITS

NUMBER	DESCRIPTION	REF.	REC.
Joint			
1	CON application: Rex Hospital, Inc. d/b/a Rex Healthcare/Construct an addition to the hospital to expand and consolidate surgical and vascular services, Project ID No. J-8532-10	399 490 513	
2	agency file: Rex Hospital, Inc. d/b/a Rex Healthcare's application to construct an addition to the hospital to expand and consolidate surgical and vascular services, Project ID No. J-8532-10	375 397 488	
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several years.

Q And if you would turn to WakeMed Trial Exhibit 126, Ms. Sandlin?

(Witness complies.)

Q What is this document?

A This document illustrates what I was just describing. The blue line at the top provides the projections from Rex's 2006 application for cardiac cath procedures. And the red line below provides Rex's actual cardiac cath procedures, and these are diagnostic equivalent procedures. And this shows how much lower the actual was compared to what Rex projected that they would perform.

Q And why did you feel this information was relevant to your analysis?

A Again, their utilization has been declining consistently for the past several years. And to the extent that Rex projects that their utilization will begin to increase in 2010, there's a burden upon the applicant to provide adequate justification for why that decreasing trend will all of a sudden begin to increase. And there was no information provided regarding their historical utilization.

Q And Ms. Sandlin, if you would turn to WakeMed Trial Exhibit 131?

Mr. Qualls: Sorry; 131?

Ms. Fradenburg: 131.

(Witness complies.)

Q Are you there?

A Yes, ma'am.

Q Have you reviewed this document?

A Yes.

Q And what does this show?

A This provides Rex Hospital's cardiac catheterization volumes from 2001 to 2009.

Q And what does that show with regard to what was happening with Rex's volume?

A This shows that there has been a consistent decrease in procedures, both diagnostic and interventional, and the resulting diagnostic equivalent cases since 2001 with the exception of year 2006.

Q And what was the overall decrease from 2001 to 2009?

A According to this exhibit, 34.4 percent for diagnostic equivalent cases.

Q And have you calculated those numbers and come up with the 34.4 percent?

A I can do that real quick for you.

(Witness operates calculator.)

And are you asking for the compound annual growth rate or the total percent difference?

Q The compound annual growth rate.

A Okay. The compound annual growth rate is negative 5.13 percent, and I don't think that's how it's characterized here on the exhibit.

Q And what about the percent change as that's calculated there on the exhibit?

(Witness operates calculator.)

A I calculate 34.4.

Q And is that positive or negative?

A Negative.

Q And Ms. Sandlin, did you do any analysis regarding, based on the historical utilization, what Rex's utilization of cardiac cath would be in the future?

A Yes.

Q And if you would turn to WakeMed Trial Exhibit 128, Ms. Sandlin?

(Witness complies.)

Q Do you recognize that document?

A Yes.

Q And what does that document show?

A This document shows Rex's historical cardiac cath utilization for diagnostic equivalent caths, their actual utilization from fiscal 2007 to 2009. And the red line indicates their projected utilization based on the historical two year compound annual growth rate in comparison to the projections based on Rex's methodology in their application.

Q And where did--and did you prepare this document?
A Yes, ma'am.
Q Where did you get the number 3,646?
A I took that from Rex's application.
Q And the same with the number 3,616?
A Yes, ma'am.
Q And what years did those correlate with?
A 3,646 was their diagnostic equivalent caths for 2007, and 3,616 was their diagnostic equivalent of utilization for fiscal 2008.
Q And was there a reason you focused on those two years?
A I also included the 2009 utilization, 3,489, and provided those three years because that is what's consistent with the historical data provided in the Rex application.
Q So that information came directly from what Rex had provided to the Agency; is that correct?
A Yes, ma'am.
Q And so what did your calculations show with regard to what the utilization of the cardiac cath labs would be at Rex Hospital?
A I'm sorry. Can you repeat the question?
Q What did your calculations demonstrate with regard to the utilization of the cardiac cath labs at Rex Hospital?
A There's a negative two year compound annual growth

rate for diagnostic equivalent caths at Rex Hospital.

Q And projecting that out, how did that impact the utilization of the cardiac cath labs at Rex Hospital?

A When you apply that negative growth rate to their fiscal 2009 actual, it results in a decreasing trend of projected utilization.

Q And what did this analysis show you with regard to the need for four cardiac cath labs at Rex Hospital?

A This shows that they currently do not demonstrate the need for four cardiac cath labs and that they do not project to need four cardiac cath labs.

Q And what do you base that opinion on that they currently don't meet the need for four cardiac cath labs?

A Based on the analysis that we described of applying 80 percent to their most recent fiscal 2009 utilization.

Q And there's a line on the exhibit that references 60 percent capacity---

A (interposing) Yes.

Q ---for four cath labs. Why is that on the---

A That's consistent with the performance standard for cardiac cath labs on the--projecting forward, it's evaluated based on 60 percent capacity compared to based on historically the performance standards look at 80 percent capacity.

STATE OF NORTH CAROLINA
COUNTY OF WAKE

IN THE OFFICE OF
ADMINISTRATIVE HEARINGS

WAKEMED, Petitioner, v. NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF HEALTH SERVICE REGULATION, CERTIFICATE OF NEED SECTION, Respondent, and REX HOSPITAL, INC. d/b/a REX HEALTHCARE, Respondent-Intervenor.	)	No. 10-DHR-8008 TRANSCRIPT OF HEARING

Before Honorable Beecher R. Gray

Administrative Law Judge

THURSDAY, JUNE 30, 2011

Courtroom A

Office of Administrative Hearings

1711 New Hope Church Road

Raleigh, North Carolina

9:00 a.m.

Volume 4
Pages 584 through 805

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By Ms. Murray	766-804			

OFFER OF PROOF

By Mr. Qualls 711-713

EXHIBITS

NUMBER	DESCRIPTION	REF.	REC.
Joint			
1	CON application: Rex Hospital, Inc. d/b/a Rex Healthcare/Construct an addition to the hospital to expand and consolidate surgical and vascular services, Project ID No. J-8532-10	674	
2	agency file: Rex Hospital, Inc. d/b/a Rex Healthcare's application to construct an addition to the hospital to expand and consolidate surgical and vascular services, Project ID No. J-8532-10	721	

And so we don't have to pull out so many notebooks, I'm going to put that one up on the screen. Do you recall that exhibit?

A Yes, sir.

Q Okay. And it looks like here at the bottom what you were doing was projecting you said--I guess the projections of Rex were in the blue line?

A Yes, sir.

Q Okay. And you said what we should do is basically continue Rex's negative historical trend of cardiac cath downward at the compound annual growth rate. Is that what you did there, basically?

A Yes. In light of there being no discussion of the reasons why for the past several years beyond 2007 that Rex's cardiac catheterization lines have been declining, in the absence of any justification of why they've been declining, I projected forward based on Rex's historical compound annual growth rate.

Q And the compound annual growth rate was 2 percent, I think you calculated; is---

A (interposing) Well---

Q ---that correct? And let me show you this footnote here. The reason I ask is that for diagnostic caths it looks like it was 2.65 percent and for therapeutic caths it was 1.63 percent?

Exhibit
4

Transcript of the Testimony of **Robbie Roberts**

Date: February 15, 2012
Volume: II

Case: Wake County Bed Review

Printed On: May 31, 2012

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STATE OF NORTH CAROLINA — IN THE OFFICE OF ADMINISTRATIVE HEARINGS

COUNTY OF WAKE

HOLLY SPRINGS HOSPITAL II, LLC,

Petitioner,

v. — 11 DHR 12727

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

Respondent,

and

REX HOSPITAL, INC., HARNETT HEALTH SYSTEM, INC. and WAKEMED,

Intervenors.

(CAPTION CONTINUED ON NEXT Page)

DEPOSITION OF ROBBIE ROBERTS

WEDNESDAY, FEBRUARY 15, 2012
9:02 A.M.

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VOLUME II

REX HOSPITAL, INC.,
Petitioner,
v.

11 DHR 12794

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

WAKEMED, HOLLY SPRINGS HOSPITAL II, LLC, and HARNETT HEALTH SYSTEM, INC.,
Intervenors.

HARNETT HEALTH SYSTEM, INC.,
Petitioner,
v.

11 DHR 12795

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

REX HOSPITAL, INC., HOLLY SPRINGS HOSPITAL II, LLC, and WAKEMED,
Intervenors.

WAKEMED,
Petitioner,
v.

11 DHR 12796

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

HOLLY SPRINGS HOSPITAL II, LLC, REX HOSPITAL, INC. and HARNETT HEALTH SYSTEM, INC.,
Intervenors.

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ALSO PRESENT: DAWN CARTER
NATHAN MARVELLE

correct?

A. I have no opinion.

Q. Do--do you question the physicians' intent?

A. I have no opinion.

Q. Is it fair to say that all of your opinions regarding the physician support letters, if any, would be contained in WakeMed's comments filed during this review?

A. I would say that's probably accurate.

Q. Do you agree that some of the Wake Heart and Vascular physicians are going to shift their inpatient volume to Rex?

A. They stated their intent, but I don't know (a) which doctors will do so, (b) to what extent they'll be able to do so, then, (c) whether they'll actually do it.

Q. Would you agree that the physicians are the ones most knowledgeable of whether that will occur?

A. I think that's predicting something that may or may not happen in the future.

Q. And who, in your opinion, would be the best person to make that prediction?

A. I don't know that there's any one person that can make that prediction. Or, you know, what we're

talking about is something that may or may not happen in the future, and intent and reality are two different things.

Q. Is that always the case with projections in CON applications?

A. I think--I don't--can you--I'm not sure I understand what you're asking.

Q. Do--do you believe that projections in--in CON applications are, to some extent, a prediction of the future?

A. I think they are a--an educated guess based on what you know to be true in the present day.

Q. And do we know to be true that, as of the time Rex filed the Rex-Main application, the 21 Wake Heart and Vascular physicians were already employed with Rex?

A. I believe that to be true.

Q. Is there a range that you believe would be a--a reasonable percentage of what inpatient volume days of Wake Heart and Vascular would--would shift to Rex from non-Rex Wake County facilities?

A. I don't know that one can put a percentage on that.

Q. Do you think there--there would be some percentage

of a shift?

A. There could be, but I don't know what percent that would be.

Q. Do you know when, you know, a physician--strike that.

Do you know--do you have any opinion as to when an inpatient shift would occur as a result of the hiring of the Wake Heart and Vascular physicians? Like when--when would be a start date, in--in your opinion, that some type of inpatient volume shift would occur?

A. Some of that might depend on what their employment contract stated.

Q. Why would the employment contract matter?

A. If there was some stipulation about whether shift would occur, if it--if there was to be a shift occurring. I don't have any knowledge or access to that information, so that's purely an opinion.

Q. Are--are you aware that, in Rex's Main application, they projected a gradual shift?

A. They did.

Q. Do--do you have any reason to--to question that--that a gradual shift would occur?

A. I don't know that the gradual shift will occur to

the--to the extent that Rex asserted in its application.

Q. And--and why--why do you question that?

A. Well, it made an assumption, and all projections are based on assumptions. But we have no--like any assumption, you have no proof that that will occur, if you haven't already begun to see that occur.

Q. Do you believe that Rex was required to provide some type of backup data for its utilization projections in the Rex-Main application?

A. In what form?

Q. I'm--I'm trying to understand why you--you don't believe the assumption itself. Let me ask you this. Why do you not believe the assumption itself that there would be a--a inpatient volume shift; why do you not believe that assumption?

A. There's no historical proof that a shift has begun to occur.

Q. In what form, in your opinion, would that historical proof be in?

A. Some sort of data, either through an independent source or through Rex, that indicated that the shift had begun to occur.

Q. So--so you're looking at--at--for historical volume data?
A. Yes.
Q. Is that correct?
A. Yes.
Q. Other than historical volume data, is there anything in your opinion that Rex needed to provide to demonstrate that that assumption was reasonable?
A. I think the--also proof that Rex could accommodate Wake Heart and Vascular's cardiac cath procedure volume.
Q. Do you--do you believe that some of Wake Heart and Vascular's cardiac cath procedure volume will shift from non-Rex facilities in Wake County to Rex?
A. I don't know.
Q. And what--why do you not know?
A. I don't know that they will or--and I don't know that they won't. I don't know that the practice pattern of Wake Heart and Vascular will--I can't definitively say that it will change.
Q. Are you familiar with the practice pattern of Wake Heart and Vascular?

Exhibit 5

Transcript of the Testimony of **Allen Gambill**

Date: February 29, 2012
Volume: I

Case: Wake County Bed Review

Printed On: May 31, 2012

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STATE OF NORTH CAROLINA — IN THE OFFICE OF ADMINISTRATIVE HEARINGS

COUNTY OF WAKE

HOLLY SPRINGS HOSPITAL II, LLC,

Petitioner,

v. — 11 DHR 12727

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

Respondent,

and

REX HOSPITAL, INC., HARNETT HEALTH SYSTEM, INC. and WAKEMED,

Intervenors.

(CAPTION CONTINUED ON NEXT Page)

DEPOSITION OF
ALLEN LEE GAMBILL

TUESDAY, FEBRUARY 28, 2012
9:05 A.M.

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VOLUME I

REX HOSPITAL, INC.,
Petitioner,
v.
11 DHR 12794
N.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF HEALTH SERVICE REGULATION, CERTIFICATE OF NEED SECTION,
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and
WAKEMED, HOLLY SPRINGS HOSPITAL II, LLC, and HARNETT HEALTH SYSTEM, INC.,
Intervenors.

HARNETT HEALTH SYSTEM, INC.,
Petitioner,
v.
11 DHR 12795
N.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF HEALTH SERVICE REGULATION, CERTIFICATE OF NEED SECTION,
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REX HOSPITAL, INC., HOLLY SPRINGS HOSPITAL II, LLC, and WAKEMED,
Intervenors.

WAKEMED,
Petitioner,
v.
11 DHR 12796
N.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF HEALTH SERVICE REGULATION, CERTIFICATE OF NEED SECTION,
Respondent,
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ALSO PRESENT: NATHAN MARVELLE
CAROL JONES

A. --with the development of the 2012 Plan, it identified significant changes, I think, that have occurred, and that have occurred across healthcare in general.

Q. Okay. What--let me pick up on your last comment. What changes across healthcare in general would have changed the need for acute care beds in Wake County?

A. Utilization patterns changed significantly. People are using hospital services--people are using, in general, healthcare services considerably less.

Q. Okay.

A. In particular--I guess you can link that to the economic condition of the country. Numerous articles have been indicated to where people are postponing healthcare services. It's a question of whether or not it's going to return.

Q. Has WakeMed postponed any healthcare services as a result of that phenomenon you just described?

A. WakeMed has seen, at times--I know other hospitals have seen at times--reductions in the number of--of patients or people presenting themselves for services. I believe the 2012 Plan reflects that

notice that the need, based on the arithmetic, was at the WakeMed facilities. As I mentioned earlier, Rex did not seem to have an occupancy issue in--in their calculation. And so, if you take the position that patients do--25 percent that do choose to go somewhere in particular, the ones that vote with their feet, if you will, they tended to go to the WakeMed facilities, as reflected in the 2011 Plan.

Q. And what did you see in the 2012 Plan?

A. Decrease in utilization overall. And I--I haven't done a side-by-side comparison, which would probably be interesting to do. But, in general, as I understand it, is that there's been a decline in utilization of hospital services. It's not Wake County--exclusive to Wake County. It's not exclusive to North Carolina. Birthrates are even down across the country. It's more of a matter of a reflection of the economic situation.

Q. In the--you said that essentially--and tell me if I'm mis-paraphrasing here--you said that, basically, you felt that, in looking at the 2011 SMFP, that the WakeMed facilities drove the need; is that fair?

Exhibit
6

WakeMed Surgical Volume and WakeMed population

Data Year	SMFP Year	Non-Open Heart Cases	Wake County Population	Ratio of Cases/1000 Pop	Wake County Population/100
2001	2003	6,439	659,127	9.77	6,591
2002	2004	6,015	680,443	8.84	6,804
2003	2005	5,958	701,347	8.50	7,013
2004	2006	5,732	723,095	7.93	7,231
2005	2007	5,378	753,828	7.13	7,538
2006	2008	6,960	792,940	8.78	7,929
2007	2009	7,304	831,746	8.78	8,317
2008	2010	7,122	868,068	8.20	8,681
2009	2011	7,005	897,214	7.81	8,972
2010	2012	7,021	900,993	7.79	9,010
2011		7,013	932,665	7.52	9,327