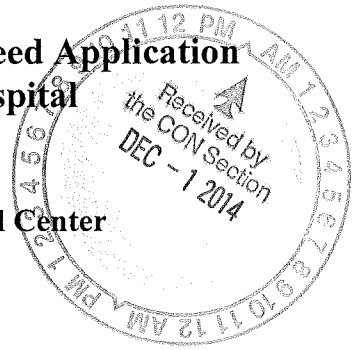
Comments Regarding the Certificate of Need Application Filed by Caldwell Memorial Hospital Project No. E-010358-14



Submitted by: Catawba Valley Medical Center
December 1, 2014

Overview

A Certificate of Need application was filed by Caldwell Memorial Hospital and SCSV, LLC for the November 1, 2014 review cycle to relocate three (3) operating rooms currently located in Lenoir to a proposed site in southern Caldwell County.

The following comments will demonstrate that the application should not be approved as it fails to conform to all applicable review criteria as required by G.S. §131E-183.

CON Review Criterion 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.

The application does not conform to Criterion 3 for the following reasons.

- Volume projections for the proposed CSC are heavily dependent upon Caldwell County residents increasing their utilization of ambulatory surgery services in Caldwell County even though the population of Caldwell County already has more than adequate access to ambulatory surgery services in Caldwell County.

- Utilization projections for the secondary service area overestimate the number of "other counties" likely to utilize CSC, particularly counties for which the new location would actually increase the distance between resources currently available in Lenoir and the proposed new location.

- The assumptions regarding patient "in-migration" are not reasonable.

- The proposed project location will hinder access to ambulatory surgical services for persons aged 65+ and persons living in poverty.

- Current utilization rates indicate that more than sufficient resources exist to meet the need for ambulatory surgical services by Caldwell County residents.

- The proposed 2015 SMFP clearly documents that the supply of operating rooms in Caldwell County exceeds the number needed by 2.45 rooms.

The application proposes the relocation of three (3) operating rooms from Caldwell Memorial Hospital's Hancock Surgery Center in Lenoir , a free-standing ambulatory surgery operating under CMH's license, to a site in Granite Falls located approximately 13.6 miles south of Caldwell Memorial Hospital

(Mapquest). The application asserts that the new location will improve accessibility to ambulatory surgical services for Caldwell County residents, resulting in greater numbers of Caldwell County residents remaining in Caldwell County for these services. The application, however, fails to justify the need for the project or to support the assumptions upon which projected volumes are based.

Primary Service Area

The Caldwell Surgery Center (CSC) CON application defines its primary service area as Caldwell County. However, the application contains no information to document that Caldwell County residents do not currently have sufficient access to ambulatory surgery rooms. The rate at which Caldwell County residents utilize ambulatory surgery services was cited as justification for the development of an additional ambulatory surgery location in Caldwell County. To support this contention, a map is provided on page 36 of the application indicating that Caldwell County ranks in the top 21 counties in North Carolina for the number of ambulatory surgical visits (including endoscopy) per 1,000 population (2009-2010). The applicant also attempts to justify that need exits for the project because the use rate for Caldwell County residents is significantly higher than the statewide rate. In fact, Caldwell County residents underwent 22 more ambulatory surgery visits per 1,000 in 2013 than the North Carolinians as a whole according to data presented on page 53 of the application (87.42 Caldwell County ambulatory surgeries per 1,000 – 65.52 NC surgeries per 1,000 NC residents = 21.9 more ambulatory surgery cases per 1,000 Caldwell County residents). Rather than suggest an unmet need for ambulatory surgery, the higher than normal use rate indicates that resources are more than sufficient to meet residents' needs for ambulatory surgery now and throughout the projection period.

The applicant further assumes that the 2013 use rate for Caldwell County ambulatory surgery cases will increase at a rate of 0.75 percent per year throughout the projection period. This assumption is based on the rate of increase in ambulatory surgery cases for Caldwell County residents between 2012 and 2013, even though the applicant also observes that, "...the overall use rate for North Carolina remained flat." (Page 55) Given that the statewide use rate appears to be stabilizing and that the ambulatory surgery use rate for Caldwell County far exceeds the statewide rate, the applicant provides no justification for the use rate for ambulatory surgery cases continuing to rise for Caldwell County in every year between the present and 2019. In fact the applicant assumes that the use rate for ambulatory surgery will increase by four (4) cases per 1,000 population, between 2013 and 2119, from 87.42 to 91.42 per 1,000. The use rate for ambulatory surgery cases for Caldwell County is already among the highest in North Carolina. This makes it highly unlikely that the use rate for Caldwell County will continue to grow at a rate of 0.75 percent per year throughout the projection period.

The projected, albeit unsupported, increases in the ambulatory surgery use rate for Caldwell County residents disguise the fact that the population of Caldwell County is actually projected to decline over the projection period. See Table 1 on the following page. The fact that population is projected to decline in Caldwell County can be expected to negatively impact the projected volumes for CSC. Caldwell County residents are projected to make up 89.3 percent of CSC's total volume for the first three years of operation. Therefore, declines in the population projected to account for over 89 percent of CSC's volume can also be expected have some stabilizing effect on the growth of ambulatory surgery cases throughout the projection period.

Table 1
Estimated and Projected Populations for CSC Service Area

County	Estimate	Projections							Net Chng
	Jul-12	Jul-13	Jul-14	Jul-15	Jul-16	Jul-17	Jul-18	Jul-19	2012-19
Alexander	37,361	37,183	37,012	36,853	36,714	36,585	36,471	36,367	-994
Ashe	27,326	27,464	27,446	27,524	27,528	27,590	27,608	27,657	331
Avery	17,795	17,856	17,748	17,790	17,712	17,729	17,670	17,673	-122
Burke	90,051	89,551	89,152	88,793	88,468	88,178	87,914	87,675	-2,376
Caldwell	82,590	82,312	82,041	81,794	81,570	81,365	81,181	81,014	-1,576
Catawba	155,353	156,181	156,919	157,659	158,399	159,137	159,877	160,615	5,262
Cleveland	97,800	97,276	96,901	96,568	96,272	96,010	95,775	95,568	-2,232
Lincoln	79,512	79,594	79,942	80,286	80,632	80,978	81,323	81,670	2,158
McDowell	45,264	45,231	45,277	45,317	45,353	45,389	45,417	45,447	183
Watauga	52,472	52,954	53,614	54,272	54,931	55,588	56,250	56,908	4,436
Wilkes	69,625	70,046	70,359	70,671	70,984	71,298	71,608	71,923	2,298

Source: NC Office of State Budget and Management.

As Table 1 illustrates, the projected populations of five of the ten counties included in the primary and secondary service area of CSC are estimated to decline by 2019. This can be expected to negatively impact the need for ambulatory surgery for these populations. In addition, three of the five counties with projected population increases (Ashe, Watauga and Wilkes) would be required to travel longer distances to access the proposed CSC location than is currently required to access ambulatory surgery at either Caldwell Memorial Hospital or Hancock Surgery Center. This is also likely to limit the number of residents from these counties willing to shift from CMH to CSC and challenges the projected volume of patients from these counties. For example, 100 percent of Alexander County residents are expected to shift from CMH to the new location in Granite Falls. CMH reported 25 ambulatory surgery cases originating from Alexander County on its 2014 Hospital License Renewal Application (page 22). On page 61 of the application, a total of 26 Alexander County residents are projected to be treated at CSC in Year 1. This suggests that all Alexander County residents would elect to drive a farther distance to Granite Falls than is now required to access the same services in Lenoir. The application also assumes that virtually all Watauga County residents would do the same (47 patients to CSC in Year 1 as compared to 51 cases at CMH in 2013).

Population growth is projected for Catawba County but according to the application should have virtually no impact on the cases projected for CSC. As the application explains on pages 61-62, no significant gains in patient origin or market share are expected for Catawba County in the CSC application. The proposed location of CSC in the southern portion of Caldwell County would actually place operating rooms closer to residents of Catawba County than the current Lenoir location. The applicant's dependence on many patients driving farther to access the same services already available in Lenoir, coupled with the lack of any anticipated increase in the number of Catawba County residents to be treated at CSC undermines the validity of the volumes projected for CSC and as a result, the long-term financial feasibility of the project.

Even though total Caldwell County population is decreasing, the applicant uses population in the southern portion of the county as justification for relocating the proposed ambulatory surgery center to Granite Falls. According the applicant, 51 percent of Caldwell County's population is located in the southeastern region of the county (page 73 and Exhibit 42). As evidence Exhibit 42 refers to a map attached to Ms. Carter's letter. It is assumed that this is the same map provided on page 73 of the application. However, the map includes no evidence to support the fact that 51 percent of Caldwell County's population resides in the southern portion of Caldwell County. In fact, the application acknowledges that the municipalities located in the southern portion of Caldwell County have a combined population of 16,500 (page 73). This is significantly less than 51 percent of Caldwell County's total population.

Although the total population of Caldwell County is expected to decline throughout the projection period, the oldest segments of the population are expected to increase significantly. As seen in Table 2, the population groups 65-74 and 75+ are expected to increase by 18.4 and 19.3 percent, respectively between 2012 to 2019.

Table 2
Caldwell County Population by Select Age Groups

Age Groups	2012	2017	2019	% Change 2012-19
75+	5,564	6,282	6,640	19.3%
65-74	8,058	9,164	9,537	18.4%
45-64	24,042	24,083	23,724	-1.3%
15-44	30,292	29,404	29,214	-3.6%

Source: NC Office of State Budget and Management.

Even though the oldest segments of the population of Caldwell County are expected to grow significantly by 2019, it does not appear that the applicant has accounted for this anticipated growth in its utilization projections for CSC. Medicare patients are projected to make up the same percentage of patients at CSC in 2019 as the percentage of ambulatory surgery patients treated at CMH in 2013, 47.4%. (Pages 104-105.) Given that the population aged 65+ is expected to grow by 18.8 percent between 2012 and 2019, some increase in the proportion of patients from this age group would be likely. The applicant states repeatedly in the application that an increase in the number of older residents will increase the demand for ambulatory surgery services. The failure to recognize the likelihood that older residents will account for a greater percentage of ambulatory surgery patients at CSC in future suggests that CSC either does not anticipate that this location is likely to attract these patients or that the higher risks associated with surgery on older patients will mean that most of these patients will continue to be treated at the hospital-based location.

In Exhibit 29 the applicant provides selection criteria for CSC patients. The selection criteria for patients at CSC will heavily favor patients in ASA Class I or II. Given the higher risks associated with surgery for older patients, they are less likely to be treated safely at a free-standing ambulatory surgery center remote from a hospital should an emergency arise. The Agency for Healthcare Quality (AHRQ) estimates that 32 percent of Medicare beneficiaries fall into a high risk medical profile, making them inappropriate

candidates for surgery at a non-hospital based ambulatory surgery center.[1] Therefore, it is unlikely that relocating ambulatory surgery rooms to the southern portion of Caldwell County will meet the growing need for ambulatory surgery for a significant proportion of Caldwell County's oldest residents, even though the population aged 65+ is the only segment expected to increase between now and 2019. Expanding the number of hospital-based ambulatory surgery rooms or developing ambulatory surgery rooms at a location closer to the hospital presents a safer alternative for these patients.

The applicant fails to justify that need exists for a new ambulatory surgery center in Caldwell County. In fact the State Medical Facilities Plan documents a surplus of operating rooms in Caldwell County. The 2014 SMFP projects a surplus of 2.09 operating rooms for Caldwell County for 2016 (existing rooms 7 - rooms needed 4.91 = -2.09 rooms). (Table 6B.) The proposed 2015 SMFP projects an even greater surplus in the number of operating rooms in Caldwell County for 2017 of 2.45 rooms. As Table 3 illustrates, every county in CSC's projected service area already has an excess of operating rooms. Clearly, no unmet need exists for operating rooms in Caldwell County to serve the needs of the residents of counties located within CSC's projected service area.

Table 3
Proposed 2015 SMFP Projected Operating Room Need for 2017

Proposed Service Area Counties	Deficit/ Surplus (-)
Alexander County	-2.00
Ashe County	-1.30
Avery County	-1.50
Burke County	-4.53
Caldwell County	-2.45
Catawba County	-13.97
McDowell County	-1.91
Lincoln County	-1.23
Watauga County	-1.84
Wilkes County	-1.59
Total SA	-32.32

Even though the applicant claims that simply relocating ambulatory surgery rooms to the southern portion of Caldwell County will result in an increased number of Caldwell County residents remaining in the county for surgical services, established commuter patterns are likely to continue to result in a large percentage of Caldwell County residents seeking medical services in other counties. As seen below, 34 percent of Caldwell County workers commute to jobs outside Caldwell County. Relocating ambulatory surgery rooms to southern Caldwell County will in no way assure that these outcommuters will choose CSC for their ambulatory surgery services. Given that most employers' health plans favor providers located in close proximity to the majority of its employees, outcommuters will likely be incentivized to

[1] Ambulatory Surgical Services Payment Differential in Medicare, Officer of the Inspector General, April 2014, A-05-12-00020, page 4.

access providers located in the same county as the employer. To avoid out-of-network charges, Caldwell County residents employed outside Caldwell County will likely continue to seek medical services, including ambulatory surgery services, in counties other than Caldwell.

		Noncommuters	Outcommuters
Caldwell County	2010	22,719	11,883

Source: Linc Topic Reports

Secondary Service Area

The applicant explains that the secondary service area defined in the CSC application will be made up of counties other than Caldwell that have historically received ambulatory surgery services at Caldwell Memorial Hospital. As supporting documentation the applicant provides patient origin data on page 62 of the application from CMH's 2014 Hospital License Renewal Application. The application also identifies a number of counties for which patient origin is assumed to be similar at the new CSC as at Caldwell Memorial Hospital.

The application describes how the proposed location of the new CSC will improve geographic access to ambulatory surgery services presently provided at Caldwell Memorial Hospital. However, this is not true for a number of the counties included in the volume projections for CSC. The new location in southern Caldwell County would increase travel times for residents of Avery, Ashe, Wilkes, Watauga, and Alexander Counties. As previously described, the projected patient origin for CSC assumes that virtually all patients from Watauga and Alexander Counties are expected to be seen at CSC in future. Not only is this unlikely given the increased driving time required, a significant percentage of these patients are likely aged 65 and over. Given that approximately one-third of Medicare patients are unlikely candidates for ambulatory surgery in a non-hospital based setting, it can be assumed that a similar percentage of these patients will likewise be unlikely candidates for surgery at CSC.

The same can be argued for the remaining counties that make up CSC's projected service area. It is unlikely that 40 percent of Wilkes County residents now treated at CMH for ambulatory surgery will choose to drive more than an additional sixteen miles to access the same service now provided in Lenoir (77 Wilkes County patients treated at CMH in 2013 as compared to 31 projected to be treated at CSC in Year 1.) (See pages 61-62.) The same can be argued regarding the patients projected from "other counties." These "other counties" represented 50 of CMH's 2013 ambulatory surgery cases. These same counties (Ashe, Avery, McDowell, and Lincoln) are projected to generate 40 cases for CSC in Year 1. Even though Ashe and Avery patients make up less than half (24) of CMH's 50 "other county" cases, the CSC projections assume that 80 percent of CMH's "other county" patients will now migrate to the new CSC location. Given the additional drive times required for patients of Ashe and Avery Counties, it is unlikely that the majority of these patients will choose to drive the additional distance to the new CSC. Even if physician offices are located contiguous to the new CSC, it is likely that patients from Ashe, Avery and Watauga Counties would continue to access physicians based in Lenoir rather than choosing to see the same physicians in office locations located farther from their homes.

The number of cases to be generated by CSC's secondary service area are not reliable for the reasons described. Even though the new CSC location will be closer to Catawba County than the present location in Lenoir, the applicant projects no increase in the number of cases to originate from Catawba County.

However, the applicant assumes that the majority of patients from Ashe, Avery, Alexander and Watauga Counties will drive longer distances to access the same services already available in Lenoir. Given that the physicians will likely be the same as those now seen in Lenoir, no explanation is provided to justify these patients driving longer distances for the same service.

Projected Use Rate

The applicant argues that the rate of ambulatory surgery cases per 1,000 population will rise 0.75 percent annually from 2013 through 2019. This rate of increase in based on the increase in the number ambulatory surgery cases performed on Caldwell County residents per 1,000 from 2012 to 2013. It is further assumed that an increasing number of Caldwell County residents will elect to remain in Caldwell County for ambulatory surgery cases than is presently the case. However, the use rate increase between 2012 and 2013 did not result in an increased number of cases for CMH. As the table below illustrates, the volume of ambulatory surgery cases performed at Caldwell Memorial Hospital has declined in all but one year since 2008-09. Most recently, Caldwell Memorial Hospital experienced a six percent decline in the number of ambulatory surgical cases between 2012 and 2013 while the Caldwell County ambulatory surgery use rate rose by 2 percent. Clearly, an increase in use rate for Caldwell County does not guarantee than increasing number of Caldwell County residents will elect to remain in Caldwell County for their ambulatory surgery services.

Table 4
Caldwell Memorial Hospital Surgical Volume

	Inpatient Surgical Cases	Percent Chng from Previous Year	Outpatient Surgical Cases	Percent Chng from Previous Year	Total Surgical Cases	Percent Chng from Previous Year
2013	1,332	-10.0%	3,046	-6.0%	4,378	-7.2%
2012	1,480	12.9%	3,240	16.2%	4,720	15.1%
2011	1,311	-11.6%	2,789	-2.6%	4,100	-5.7%
2010	1,483	2.7%	2,863	-1.1%	4,346	0.2%
2009	1,444		2,894		4,338	

Source: NC Hospital License Renewal Applications.

A declining population coupled with a likely leveling off of utilization rates for ambulatory surgery will result in fewer ambulatory surgery cases for Caldwell County residents rather than the significant increases projected by the applicant.

The projected number of ambulatory surgery cases for both Caldwell Memorial Hospital and CSC are not based on valid assumptions. In addition to assuming a steady increase in the use rate in ambulatory surgery cases throughout the projection period, the application assumes that significantly more Caldwell County residents will choose to remain in Caldwell County than do presently. The applicant contends that this will occur in large part by relocating operating rooms to the southern portion of Caldwell County. However, many of the residents of southern Caldwell County commute to jobs in counties outside Caldwell, primarily to Catawba County. As a result, their insurance coverage likely favors

providers in the county in which the employer is located. This is likely the reason that such a high percentage of Caldwell County residents currently choose to use providers in neighboring counties, particularly Catawba County. This circumstance will not change as a result of this project.

The volume of ambulatory surgery cases projected for CMH and CSC are also unrealistic in that they are highly dependent upon successfully recruiting additional surgeons, specifically general surgeons. Nationally, the number of general surgeons is expected to fall short of the number needed in 2020 by 21,400 (baseline supply 2020 30,800 and projected requirement of 52,200 general surgeons by 2020 resulting a shortfall of 21,400 general surgeons.)[2] In addition, a 2012 report by the Association of American Medical Colleges states:

> **General Surgery (2007) – "General Surgeon to Population Ratios Declined Steadily"**
> A longitudinal study published in the Archives of Surgery on general surgeons from 1981 to 2005 shows a constant decline. There are 723 fewer general surgeons practicing today than were in 1981. The general surgeon to population ratio decreased steadily across the study period, from 7.68 per 100,000 in 1981 to 5.69 per 100,000 in 2005. The overall number of general surgeons has remained static since 1994, despite an increase in the population of 1% per annum during this period. This coupled with the rise in surgical specialization and the decreased interest among medical student's in general surgical careers has generated concern over a shortage.[3]

These findings illustrate the difficulty hospitals, particularly hospitals located in rural areas such as Caldwell Memorial, are likely to face in recruiting general surgeons to meet future demand. Without additional general surgeons, Caldwell's supply of general surgeons is expected to decline by one due to a planned retirement sometime in 2014-15 (page 52). The loss of one general surgeon will significantly impact the volume of cases at both CMH and CSC. According to the American Board of Surgery, the average number of cases per general surgeon is 500 per year.[4] Assuming that 72 percent of these cases are outpatient cases (the same percentage breakdown of CMH's 2013 general surgery cases), the loss of a single general surgeon can be expected to result in 360 fewer general surgery cases (.72 x 500 = 360).

While the applicant does not quantify the exact number of general surgeons expected to perform cases at the new CSC, only two are identified on page 74 along with projected volumes anticipated in the first year of operation. One general surgeon estimates that he will perform between 800 and 1,000 cases in the first year of CSC's operation. This is far in excess of the average number of annual cases reported by the American Board of Surgery (500). As a result, the number of general cases, while not specifically projected, appears to far exceed the number of cases likely to be generated by two general surgeons. While the applicant contends that recruitment efforts will yield additional general surgeons to practice at CMH and CSC, the fact that the demand for general

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[2] The Physician Workforce: Projections and Research into Current Issues Affecting Supply and Demand, U.S. DHHS, HRSA, Bureau of Health Professions, December 2008.

[3] Recent Studies/Reports on the Inadequacy of the U.S. Physician Supply, Center for Work Force Studies, Association of American Medical Colleges, October 2012.

[4] ABS Survey Finds Increased Caseloads for General Surgeons, From the Annual Meeting of the American Surgical Association by Bruce Jancin, Internal Medicine News Digital Network, April 25 2011.

surgeons far exceeds the current supply makes it difficult to determine the when or if these efforts will be successful.

On page 52 the applicant describes that searches are ongoing for at least two general surgeons, a urologist, and an ENT surgeon. On that same page the applicant states that, "Caldwell Memorial Hospital expects that physician recruitment will result in a positive net gain of surgeons on the medical staff with modest growth in surgery utilization." However, the total number of ambulatory surgery cases at CMH and CSV is projected to increase by 47 percent between 2016 and 2017 alone with additional increases of 9 percent per year projected for years 2018 and 2019. Should recruitment efforts fail to achieve the number of surgeons described in the application, it is unlikely that existing surgeons on the CMH staff will be able to generate this volume of cases.

	2012	2013	2014*	2015	2016	2017	2018	2019
CMH AS Cases	3,240	3,046	2,896	3,116	3,302	1,666	1,737	1,836
CSC Cases	0	0	0	0	0	3,149	3,504	3,864
Total CMH/CSC AS Cases	3,240	3,046	2,896	3,116	3,302	4,815	5,241	5,700
Annual % Change		-6.0%	-4.9%	7.6%	6.0%	45.8%	8.8%	8.8%

Note: 2014 volumes are annualized based on 11 months (page 51).

The applicant also states than one general surgeon is expected to retire "within the next year." (Page 52.) Even so, the number of CMH ambulatory surgery cases is expected to increase by 7.6 percent between 2014 and 2015. As general surgery cases accounted for 38 percent of CMH's total ambulatory surgery cases in 2013, the applicant has failed to justify the projected increase in ambulatory surgery cases between 2014 and 2015.

In addition to assuming a two percent increase in the rate of ambulatory surgical cases per 1,000 population in every year between 2013 and 2019, the applicant asserts on page 64 of the application that the number of inpatient surgery cases at CMH are projected to increase at 2 percent per year beginning in 2016. The reasons given for this increase are the aging of the population and successful physician recruitment. However, the applicant does not explain the increases in inpatient cases projected for the intervening years.

	2012	2013	2014*	2015	2016	2017	2018	2019
CMH Inpatient Cases	1,480	1,332	1,109	1,182	1,245	1,270	1,296	1,322
% Change from Previous Yr		-10.0%	-16.7%	6.6%	5.3%	2.0%	2.0%	2.0%

* Projected based on 11 months data.

One of the reasons given for the projected increase in the number of inpatient surgery cases is successful physician recruitment in the specialties of general surgery, urology, and otolaryngology. Given than a general surgeon is expected to retire in 2015, it is doubtful that such substantial increases can be expected in 2015 and 2016. This is particularly true given double digit declines in the number of inpatient cases in 2013 and 2014. It should also be noted that the vast majority or surgeries performed by otolaryngologists

are performed on an outpatient basis. Therefore, it is unlikely that the recruitment of an otolaryngolgist would substantially impact the number of inpatient cases at CMH.

Utilization projections contained in the application are also overstated because the assumptions related to market share are incorrect. The percentage of Caldwell County residents projected to utilize the new CSC is assumed to be 38 percent as compared to 36.2 percent for CMH in 2013. Therefore, in a single year CSC's market share in Caldwell County is expected to exceed CMH's current market share in Caldwell County. It is highly unlikely that within one year the practice patterns of both physicians and patients can be expected to change to this extent.

The applicant assumes that the market share for ambulatory surgery will increase from 36.22% in 2013 to a combined market share for both CMH and CSC of 57 percent in 2017. The combined market share is further projected to increase to 67 percent by 2019. However, the applicant fails to adequately explain how this volume of patients can be expected. Fewer than 800 patients received ambulatory surgery services at the Hancock Surgery Center in 2013 (774 excluding c-sections). If 55 percent of CMH's 2013 ambulatory surgery cases remain at CMH to achieve the 1,666 cases projected in 2017, this would result in 1,380 CMH ambulatory surgery cases shifting to CSC plus the approximately 800 cases now performed at Hancock Surgery Center. This equals 2,180 cases, well below the 3,150 projected in 2017 at CSC. The application places heavy reliance on successful physician recruitment and the ability to significantly change the practice patterns of seven orthopedic surgeons. Neither of these factors can be guaranteed and without them the utilization projections cannot be substantiated. As a result, the utilization projections are not feasible.

A primary reason given for developing the new surgery location is to allow a greater number of Caldwell County residents to remain in Caldwell County for ambulatory surgery services. However, the supply of ambulatory surgery resources is more than adequate to meet residents' need for ambulatory surgery. The use rate of ambulatory surgical services by Caldwell County residents ranks among the highest in North Carolina. This higher-than-average utilization of ambulatory surgery indicates that resources are easily accessible to Caldwell County residents. The number of operating rooms in Caldwell County already exceeds the need resulting from the SMFP need methodology for operating rooms by greater than two rooms according to the 2014 SMFP. In addition, relocating operating rooms from Lenoir, the most populous municipality in Caldwell County, to the southern portion of Caldwell County is unlikely to increase the number of Caldwell County residents remaining in the county for care.

Orthopedic Utilization

Orthopedic cases are projected to make up the majority of cases to be performed at Caldwell Surgery Center. The projected number of orthopedic cases to be performed at CSC is 1,575 in Year 1, 1,752 in Year 2 and 1,932 in Year 3 (page 65). However, based on license renewal applications for years ending September 2010 through 2013, orthopedic cases performed at Caldwell Memorial Hospital were well below those projected in the application.

	CMH Ortho Amb Cases	Hancock Ortho Amb Cases	Total Ortho Amb Cases
2010	481	521	1002
2011	557	323	880
2012	524	304	828
2013	862	338	1200

As the above table suggests, the number of orthopedic cases would need to increase by more than 31 percent to achieve the volume projected in Year 1 for CSC. In addition, an increase of 61 percent is projected between 2013 and 2019. Given no projected net change in the number of orthopedic surgeons added to the CMH staff through recruitment, achieving this volume would require that a substantial number of patients now treated by the orthopedic surgeons expected to migrate patients to CSC be shifted from other existing providers in other counties to CSC.

Recruitment efforts are cited as one way that the applicant plans to achieve the projected volumes. However, no specific recruitment efforts were described to address the number of orthopedic surgeons. Instead, letters were provided from orthopedic surgeons already practicing in the area stating their intent to perform procedures at CSC. These same surgeons provided estimates of the number of cases they anticipate performing in Year 1 at CSC, ranging from 975 to 1,175 cases (page 47). At present, four of the eleven orthopedic surgeons stating their intent to perform cases at CSC have privileges at Caldwell Memorial Hospital. However, the letters did not address the impact the projected volumes at CSC will have on CMH. Neither did the letters describe how the physicians would achieve these volume increases, particularly those that currently perform cases at CMH as well as at multiple facilities in contiguous counties.

It is also questionable whether the number of orthopedic surgeons identified in the application can generate the number of orthopedic and spine cases projected. The applicant states on page 52 that one orthopedic surgeon retired in 2013 but has since been replaced for no net change in the number of orthopedic surgeons. Four orthopedic surgeons that practice primarily at CMH are listed on page 47: Drs. Hurt, Stanislaw, Keverline, and Hannibal. In 2013, CMH reported a total of 1,200 outpatient orthopedic cases on its 2014 License Renewal Application. Therefore, four orthopedic surgeons generated 1,200 orthopedic cases at CMH or 300 cases per surgeon. Assuming this volume per surgeon continues, these four physicians will continue to generate 1,200 orthopedic cases which now will be split between CMH and CSC. Although the applicant does not identify the ambulatory surgery cases to remain at CMH by specialty, a substantial number of these cases will of necessity be orthopedic cases in order to reach the number of ambulatory surgery cases projected to remain at CMH (1,666, 1737 and 1,836 for Years 1-3, respectively).

Assuming that half the orthopedic cases reported for 2013 move to CSC (600 cases), this would require that 975 cases be generated by the seven orthopedic surgeons identified as willing to migrate cases to CSC. Assuming that these physicians also generate approximately 300 ambulatory surgery cases annually, between 45 percent and 65 percent of total cases would need to be shifted to CSC to achieve the volumes projected for Years 1 – 3. See below. In addition, this does not assume any of these physicians' cases will be performed at CMH. If some of these cases remain at CMH, an even greater percentage of their total cases will be required to shift from current providers in Catawba County to CMH or CSC to

achieve the volumes projected. Given that these surgeons reside in Catawba County and the majority of their patients reside in Catawba County, it is unlikely that most of their patients will in future have their surgeries performed at either Caldwell County facility. Further, the addition of a new operating site for these surgeons is likely to reduce rather than improve their current productivity.

CMH Orthopedic Surgeon Volume: 2013

	Assumed Cases/Yr
Hurt	300
Stanislaw	300
Keverline	300
Hannibal	300
Actual 2013 CMH/CSC Total	1,200

Other Orthopedic Surgeon Volumes Required to Shift to CSC/CMH

		@45%	@50%	@60%	@65%
Geissele	300	135	150	180	195
Johnson	300	135	150	180	195
Krenzel	300	135	150	180	195
Maxy	300	135	150	180	195
McGinnis	300	135	150	180	195
Norcross	300	135	150	180	195
Pekman	300	135	150	180	195
Total	2,100	945	1,050	1,260	1,365
Other Ortho MDs Plus CMH MDs Volume		1,545	1,650	1,860	1,965

In summary, either the majority of patients treated by the above orthopedic surgeons will be shifted to CSC or the orthopedic surgeons now at CMH will be required to perform well in excess of an average 300 cases per year. No evidence is provided to suggest that either of these factors are expected.

Given that the number of orthopedic surgeons is not expected to change significantly (in fact, one orthopedic surgeon retired during 2013, page 52) achieving the aggressive orthopedic projections is unlikely. In addition, as the table above illustrates, substantially more orthopedic cases are performed at CMH than at the Hancock Surgery Center. Achieving the number of orthopedic cases projected for CSC will be impossible given the number of surgeons currently on staff. If, as the applicant states, approximately one-half of CMH cases will be shifted to the new CSC in Year 1 (431) along with 100 percent of Hancock's orthopedic cases (338), a total of 769 orthopedic cases can be expected in Year 1 at CSC. This is significantly below the 1,575 orthopedic cases projected for Year 1 of project, further undermining the feasibility of the projected CSC volumes (page 65).

Need for Minor Procedure Room

The projected number of cases to be performed in ORs at CSC is further undermined by the applicant's statement on page 69 that, "...some podiatry and vascular cases that are projected by the physicians may be performed in the minor procedure room." Without some understanding of the number of projected ambulatory surgery cases to be performed in the minor procedure room as opposed to the three operating rooms, it is impossible to determine whether the projected utilization of the operating rooms is feasible.

Neither are the number of procedures to be performed in the minor procedure room justified. On page 68 the applicant explains that the number of pain management procedures is assumed to be 20 percent of the number of orthopedic and spine cases even though no explanation was given for the use of 20 percent in arriving at the number of projected pain management procedures. Pain management procedures reported for CMH in 2013 on its Hospital License Renewal Application were almost triple the number of ambulatory surgery orthopedic cases (1,200 orthopedic cases and 3,303 pain management cases). In addition, the applicant incorrectly assumed that pain management cases would represent 25 percent of orthopedic and spine cases rather than the 20 percent described on page 68.

Projected Pain Management Procedures at CSC

	Year 1	Year 2	Year 3
CSC Ortho + Spine Cases	1,575	1,752	1,932
Pain Mgt Procs @ 20%	315	350	386
Pain Mgt Procs @ 25%	390	434	479

The line drawing of the proposed CSC suggests that the minor procedure room will be laid out exactly as the three licensed operating rooms. It also appears to be the same size as the proposed operating rooms. The applicant clearly states that the availability of the procedure room will allow provide flexibility for surgeons wishing to perform minimally invasive surgery in the procedure room. This would indicate that the proposed CSC will have not three but four operating rooms.

A significant portion of cases to be performed in the CSC procedure room are expected to involve pain management procedures. Although the applicant states on page 69 of the application that both anesthesiologists and orthopedic surgeons will perform pain management procedures, the letter from Unifour Anesthesia Associates includes no mention of the performance of pain management procedures. In addition, the letters provided in Exhibit 10 only mentions some 340 pain management and minor procedures to be performed by these physicians. This is significantly less than the 831 projected pain management and minor procedures estimated to be performed in the minor procedure room (page 68).

Unifour Anesthesia Associates, PA already provide anesthesia services to multiple locations. According to its website, UAA provides anesthesia services for Caldwell Memorial Hospital, Hancock Surgery Center, Davis Regional Medical Center, Frye Regional Medical Center, Viewmont Surgery Center, and Unifour Surgery Center. UAA also provides pain management services at four office locations in addition to hospital and ASC locations in the region. The applicant did not provide documentation of how Unifour Anesthesia Associates will be able to supply the manpower necessary to support the projected volume at CSC as well as maintain comparable privileges are CMH and other area providers. Without sufficient anesthesia resources, the volume projections for both CSC and CMH are unreasonable.

CON Review Criterion 3a

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

The application does not conform to Criterion 3a for the following reasons.

The application states that one of the primary motivations for relocating three (3) operating rooms from Lenoir to Granite Falls is to increase the number of Caldwell County residents remaining in Caldwell County for ambulatory surgical services. However, the new location actually decreases access for a substantial number of Caldwell County residents. The applicants reference a letter from the Caldwell County Planning Department which states, "The proposed location of the facility in Granite Falls would be a highly effective option to provide access to multiple municipalities in the southeastern region of Caldwell County." The letter goes on to state, "The majority (51 percent) of the total Caldwell County population lives in the southeastern region of the county as illustrated in the attached map." Although the map is not attached to Exhibit 42 of the application, it is assumed that the map referenced is the same as presented on page 73 of the application. However, no population data is provided on the map to document that 51 percent of Caldwell County's population resides in the "multiple municipalities in the southeastern region of Caldwell County" for which the project is purported to improve access.

The population of the municipalities located in the southern portion of Caldwell County is actually less than that for the municipality of Lenoir. As Table 5 illustrates, the combined populations of the municipalities located in the southernmost region of Caldwell County is less than the population of the municipality of Lenoir. Although not all the resident population of Caldwell County is located within municipal areas, Table 5 illustrates that while the proposed location would improve access for the southern municipalities of Caldwell County, it would decrease accessibility for the majority of other municipalities in Caldwell County.

Table 5
Caldwell County Municipal Populations

County/Municipality	Jul-13 Population	% Pop by Municipality
Caldwell County	82,504	100.0%
Blowing Rock(Part)	107	0.1%
Cajah's Mountain	2,776	3.4%
Cedar Rock	295	0.4%
Gamewell	4,013	4.9%
Granite Falls	4,677	5.7%
Hickory(Part)	19	0.0%
Hudson	3,881	4.7%
Lenoir	17,912	21.7%
Rhodhiss(Part)	362	0.4%
Sawmills	5,167	6.3%
Southern Municipalities	16,520	20.0%

Source: Office of State Budget and Management

The relocation of CMH's three operating rooms to the southernmost portion of Caldwell County will also hinder geographic access for the majority of persons aged 65+. Although the growth of the aging population is cited as one justification for the need for a new ambulatory surgery center in Caldwell County, the proposed location of the new ASC is actually more remote from the majority of persons aged 65+ living within municipalities within Caldwell County. See Table 6. As seen, Lenoir not only has the greatest total population of any municipality within Caldwell County, it also has the greatest number of persons aged 65+, exceeding even the combined populations aged 65+ of the southern municipalities.

Table 6
Population Age 65+ and Median Age by Municipality

Municipality/ County	Year	Total Population	Population 65+	Median Age
Lenoir	2010	18,228	3,373	41.5
Cedar Rock	2010	300	93	57.8
Gamewell	2010	4,051	625	41.5
Granite Falls	2010	4,722	667	38.9
Hudson	2010	3,776	655	40.1
Cajah's Mountain	2010	2,823	519	42.7
Sawmills	2010	5,240	697	39.5
Southern Municipalities	2010	16,561	2,538	
Caldwell County	2010	83,029	12,816	41.3

Source: Linc Topic Reports for Selected Geographic Areas.

The relocation of operating rooms from the present location in Lenoir will also hamper access to persons living in poverty. As Table 7 indicates, a greater number of persons living in poverty are located in Lenoir than the total of the municipalities located in the southern portion of Caldwell County. This is true as well for persons 65 and over living in poverty.

Table 7

Caldwell County Municipalities	Year	Median Family Income	Per Capita Income	Families in Poverty	Persons in Poverty	Persons 65+ in Poverty
Cajah's Mountain	2010	$48,571	$22,228	64	328	37
Gamewell	2010	$29,257	$17,493	114	553	55
Granite Falls	2010	$46,544	$25,742	69	495	66
Hudson	2010	$45,296	$19,662	117	532	72
Lenoir	2010	$29,860	$17,948	780	3830	432
Sawmills	2010	$43,878	$17,147	169	954	127
Cedar Rock	2010	$103,229	$66,341	0	2	0
Southern Municipalities				419	2309	302

Source: Linc Topic Reports for Selected Geographic Areas.

Relocating operating rooms from Lenoir to the southern portion of Caldwell County is likely to jeopardize access for these persons in future. The four (4) operating rooms at CMH are already operating at dangerously high capacity. According to the 2014 Hospital License Renewal Application, the four operating rooms located at CMH are operating at virtually 100 percent of capacity. As a result it is likely that a greater number of these Caldwell County residents will be forced to travel greater distances to access ambulatory surgery services than is presently the case. It could also force a greater number of higher risk cases to be performed at CSC than is optimal for patient safety.

CON Review Criterion 4

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

A number of alternatives were discussed and found inferior to the development of a new ambulatory surgery center in Caldwell County. One reason given was the age of the Hancock Surgery Center, approaching one-half of its useful life (page 87). However, the applicant states that its two GI endoscopy rooms will remain at Hancock Surgery Center as will its pain management services and other outpatient services. The Hancock Surgery Center is conveniently located on Morganton Boulevard, separate from Caldwell Memorial Hospital. The location is just one mile off U.S. 321, the major transportation artery through Caldwell County making it easily accessible for the majority Caldwell County residents.

While maintaining the three operating rooms at the Hancock Surgery Center may not represent a cost effective alternative for the applicant, there is clearly a need for additional operating rooms at CMH. As

previously discussed, the four ambulatory surgery rooms at CMH are already operating at 100 percent of capacity. The applicant did not discuss increasing the number of operating rooms at CMH as a more effective alternative for meeting the needs of Caldwell County residents. The applicant also failed to discuss the feasibility of relocating only two operating rooms to the proposed location in the southern portion of Caldwell County. The number of ambulatory surgery centers currently operating in North Carolina with only two operating rooms makes it clear that centers of this size can operate effectively. It would appear that Caldwell County residents would be better served by expanding the number of operating rooms available in Lenoir and reducing the number of operating rooms to be located to the southern portion of the county. The applicant did not discuss this alternative which appears to represent a better alternative for meeting the needs of Caldwell County residents.

Expanding the ambulatory surgery services available in Lenoir would also provide a safer alternative than the proposed location in Granite Falls in the case of a patient emergency. The current location of Hancock Surgery Center is less than one mile from Caldwell Memorial Hospital. Google Maps gives the distance from the Granite Falls location to CMH as 13.5 miles via US 321, the most heavily travelled highway in Caldwell County. The increased distance, coupled with heavy traffic, will create new barriers to emergency care that do not exist at the Hancock Surgery Center. In fact, the proposed location of CSC is only 5.2 miles to Frye Regional Medical Center in Hickory (Catawba County).

The application has not supported the contention that the development of the project represents the least costly or the most effective alternative. For this reason, application does not conform to Criterion 4.

The application also fails to support the need for the relocation of three (3) operating rooms from Hancock Surgery Center to the new CSC. The 2014 State Medical Facilities indicates that Caldwell County already has an excess of two operating rooms which is expected to increase to 2.45 excess rooms by 2017. Therefore, the most effective alternative would involve reducing the number of surplus operating rooms to better accommodate the needs of Caldwell County residents.

CON Review Criterion 5

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

The new CSC, as proposed, will be a separately licensed provider. As such, it will be required to credential and privilege its own medical staff, separate from credentialing by CMH. The application does not clarify whether or not expenses for this function have been considered in estimating start-up costs or initial operating expenses. On page 119 the applicant lists the major expense categories included in start-up costs. While a line item does identify "Misc Consultant Fees," no explanation is provided for the nature of these consulting services. Certainly the physicians performing anesthesia and surgical or other procedures at CSC must be credentialed prior to rendering patient services. It is unclear whether the costs associated with credentialing and privileging these physicians have been adequately accounted for in the start-up costs.

Credentialing and privileging members of the medical staff at CSC will also require on-going resources, however, the applicant does not adequately explain how this function will be carried out. On page 9 the

chart provided identifies that a consultant or contractor will be responsible for Quality Assurance/Outcomes Reporting, both an important part of the ongoing credentialing and privileging process. However, the same chart identifies that the Medical Director and facility staff will be responsible for this function. Table VII.2 does not identify staff responsible for managing the on-going credentialing process at CSC. At a minimum, administrative staff would be required to assure verification of credentials as well as file maintenance. Further, no expenses have been allocated for the medical director position for CSC. Because it is unclear whether administrative and professional expenses related to credentialing and on-going management of the peer review process have been appropriately considered, start-up and operating expenses may be underestimated. As a result is impossible to determine whether the financial projections contained in the application are feasible.

The projected average reimbursement per case may be overestimated. According to VMG Health's *Multi-Specialty ASC Intellimarker* 2010, the average net revenue for ambulatory surgery centers in the US was $1,758. However, the applicant assumes that the average reimbursement for all cases to be performed at CSC will be $2,466. Further assuming an annual increase of 2 percent as anticipated by the applicant in Years 1-3 of the application, the average net revenue in 2017 would be $2,019. This is significantly below the anticipated reimbursement per cases projected by the applicant. These factors undermine the financial projections contained in the application.

As described elsewhere in these comments, the application fails to conform to Criteria 3, 3a, 4, or 5, 13, and 18a. Because the projected utilization is overstated and it is uncertain whether all expenses have been included, the projected revenues are not supportable.

CON Review Criterion 6

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

The application does not conform to Criterion 6 for the following reasons.

As described in response to Criteria 3 and 4, the State Medical Facilities indicates that the number of operating rooms in Caldwell County already exceeds the need for operating rooms by 2.09 rooms (2014 SMFP). The proposed 2015 SMFP identifies an even greater surplus, rising to 2.45 excess operating rooms in Caldwell County by 2017. Relocating three (3) operating rooms to the new CSC will further duplicate existing ambulatory surgical resources in Caldwell County.

The ambulatory surgery use rate for Caldwell County residents indicates that sufficient resources already exist to meet the county's need for ambulatory surgery services. In addition, relocating three operating rooms to the southern portion of Caldwell County will further duplicate existing resources in Catawba County. The number of operating rooms available in Catawba County also exceeds the number needed for the foreseeable future. Therefore, the relocation of operating rooms from Lenoir to Granite Falls only serves to further duplicate resources in neighboring Catawba County.

CON Review Criterion 7

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

The feasibility of the project is heavily dependent upon the success of multiple recruitment efforts. In fact, the utilization projects depend upon having additional surgeons in place by 2017. However, no evidence is provided that the recruitment efforts described will be successful. Although a letter is provided in Exhibit 23 describing the success of multiple physician recruitment efforts, none of these searches include surgeons. The supply of general surgeons already exceeds the demand for their services, making the ability to recruit to a rural area even more difficult.

In addition, the volumes projected for CSC rely on seven orthopedic surgeons significantly changing their practice patterns. Doing so would require that these surgeons add an additional operating site to the multiple facilities where they already have privileges. This can be expected to reduce these surgeons' productivity as well as reduce the cases at existing ambulatory surgery providers in Catawba County. Because the application fails to justify that sufficient physician manpower is available to generate the volumes projected for both CMH and CSC, the application fails to conform to Criterion 7.

CON Review Criterion 8

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

The application does not conform to Criterion 8 for the following reasons.

On page 9 of the application the applicant identifies a number of functions to be carried out by facility staff. Those include Biomedical Equipment Maintenance, Sterile Processing and Housekeeping functions. However, Table VII.2 indentifies no staff positions responsible for these functions (page 108). These discrepancies, in addition to those previously identified, make it impossible to determine whether sufficient arrangements are in place to provide the necessary ancillary and support services or that the costs for providing these functions have been adequately accounted for.

CON Review Criterion 9

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

The application does not conform to Criterion 9 for the reasons provided in response to Criterion 3.

CON Review Criterion 12

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

The application does not justify the need for the proposed project. As a result it does not conform to Criterion 12. In addition, costs for preparation of the Certificate of Need application were not included in the total project costs.

CON Review Criterion 13

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

> *a. The extent to which medically underserved populations currently use the applicant's existing services in comparison to the percentage of the population in the applicant's service area which is medically underserved;*
> *b. Its past performance in meeting its obligation, if any, under any applicable regulations requiring provision of uncompensated care, community service, or access by minorities and handicapped persons to programs receiving federal assistance, including the existence of any civil rights access complaints against the applicant;*
> *c. That the elderly and the medically underserved groups identified in this subdivision will be served by the applicant's proposed services and the extent to which each of these groups is expected to utilize the proposed services; and*
> *d. That the applicant offers a range of means by which a person will have access to its services. Examples of a range of means are outpatient services, admission by house staff, and admission by personal physicians.*

The application does not conform to Criterion 13 for the following reasons. The relocation of three operating rooms from Hancock Surgery Center to Granite Falls can be expected to actually reduce the access to ambulatory surgery services for medically underserved groups. Persons residing in the southern portion of Caldwell County have incomes significantly above those of persons residing in Lenoir. In fact, the number of persons living in poverty in the municipality of Lenoir exceeds the total of all municipalities located in the southern portion of Caldwell County.

Table 8
Income and Poverty Statistics for Caldwell County Municipalities

Municipality Name	Year	Median Family Income	Persons in Poverty	Percent Persons in Poverty	Persons 65+ in Poverty	Percent Persons 65+ in Poverty
Lenoir	2010	$29,860	3,830	21.6	432	14.6
Granite Falls	2010	$46,544	495	10.9	66	11.5
Hudson	2010	$45,296	532	14.5	72	11.7
Cajahs Mountain	2010	$48,571	328	11.8	37	7.8
Sawmills	2010	$43,878	954	18.4	127	19.3

Source: Linc Report, OSBM.

As the above table illustrates, the number of persons living in poverty is much greater for Lenoir than for municipalities located in southern Caldwell County. The total number of persons living in poverty for these municipalities was 2,309 in 2010 as compared to 3,830 in Lenoir. The number of persons aged 65 and over living in poverty was also lower for southern Caldwell County municipalities than Lenoir, 302 as compared to 432. As the chart also illustrates, the median family incomes for residents of southern Caldwell County are well above those for Lenoir area residents. Relocating ambulatory surgery rooms to southern Caldwell County will reduce access for residents traditionally identified as medically underserved in favor of the more affluent population of southern Caldwell County.

The proposed relocation to the southern portion of Caldwell County will also hamper access for persons over the age of 65. The current location of the Hancock Surgery Center is Lenoir. The application proposes relocating the three (3) operating rooms from the Hancock Surgery to the proposed location in Granite Falls. The application indicates that this will improve access for the rapidly growing senior population. However, as the table below illustrates, significantly more persons over the age of 65 reside in Lenoir than in municipalities located in the southern portion of Caldwell County.

Table 9
Caldwell County and Municipality Populations
Total and 65+ Age Group

Municipality/ County	Year	Total Population	Population 65+
Lenoir	2010	18,228	3,373
Granite Falls	2010	4,722	667
Hudson	2010	3,776	655
Cajahs Mountain	2010	2,823	519
Sawmills	2010	5,240	697
Caldwell County	2010	83,029	12,816

Source: LINC Topic Reports, NC OSBM.

The new location of CSC will also hamper access to the county's racial and ethnic minorities. Data compiled by the U.S. Census Bureau shows that the majority of racial and ethnic minorities live in Lenoir, not the southern portion of Caldwell County. Data represent zip code areas that extend beyond municipality boundaries. For example, Sawmills and Cajah's Mountain do not have individual zip codes. The only zip codes located south of Lenoir are Granite Falls and Hudson.

Table 10
Population by Race for Caldwell County and Select Zip Codes

Race	Caldwell County	Lenoir	Hudson	Granite Falls
White	74,276	40,199	11,639	19,233
Black or African American	3,928	3,609	42	211
American Indian/Alaska Native	289	171	0	82
Asian	477	407	0	70
Native Hawaiin/Other Pacific	74	38	0	36
Some Other Race	2,295	1,825	224	246
Two or More Races	1,154	788	69	354
Hispanic	3,796	2,576	621	490

Source: U.S. Census Bureau, American FactFinder, 5-year study 2008 - 2012.

The new location of the proposed Caldwell Surgery Center cannot be expected to improve access for most Caldwell County residents. The majority of Caldwell County residents live in the Lenoir area, not the southern portion of the county. The majority of Caldwell County's residents living in poverty live in the Lenoir area. In addition, the majority of persons of racial and ethnic minorities reside in Lenoir, not the southern portion of Caldwell County. In fact the proposed site of CSC is located in the most affluent portion of Caldwell County and will not improve access for persons historically identified as medically underserved.

CON Review Criterion 14

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

The application fails to justify the need for the project. As a result it does not conform to Criterion 14.

CON Review Criterion 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.

The application does not conform to Criterion 18a for the following reasons.

The application will not improve competition for ambulatory surgery services in Caldwell County. The only existing provider of ambulatory surgery services currently located in the applicant's primary service area is Caldwell Memorial Hospital. According to the application, Caldwell Memorial Hospital will be the sole member of the limited liability partnership SCSV which will own the new ambulatory surgical facility. Therefore, Caldwell Memorial Hospital will continue to operate and own the only ambulatory surgical facilities in Caldwell County. As a result, competition will not improve as a result of this project.

The application does not otherwise demonstrate the expected effects of the proposal on competition in the proposed service area for the applicable reasons elsewhere stated in these comments.

Summary

Based on the information provided in these comments, the Caldwell Memorial Hospital/SCSV application does not conform to all applicable review criteria and should not be approved. The deficiencies in the application that are noted in these comments are intended to apply to all relevant review criteria whether or not those deficiencies are expressly reiterated in the context of a specific criterion.