December 30, 2016

Ms. Martha Frisone, Assistant Chief
Health Planning and Certificate of Need Section
2704 Mail Service Center
Raleigh, NC 27699-2704

Re: Comments Regarding Cape Fear Surgical Center CON Project No. O-011275-16

Dear Ms. Frisone:

I am writing on behalf of Wilmington Surgery Center d/b/a Wilmington SurgCare to submit comments regarding Cape Fear Surgical Center CON Project No. O-011275-16. These comments are submitted in accordance with N.C. GEN. STAT. § 131E-185(a1)(1).

Thank you for your consideration of this information.

Sincerely,

David J. French
Consultant to Wilmington SurgCare

Comments by Wilmington SurgCare Regarding Cape Fear Surgical Center, LLC CON Project ID # O-011275-16

Cape Fear Surgical Center, LLC (CFSC) proposed a multi-specialty ambulatory surgical facility with six operating rooms and three multi-specialty GI endoscopy procedure rooms in a new facility with 48,356 S.F. and a CON capital cost amount of $28,946,325.

This application contains major deficiencies that cause it to be nonconforming to numerous CON review criteria and regulatory standards as follows:

- **The CFSC proposal involves the largest and one of the most expensive freestanding ambulatory surgical facilities that has ever been proposed in North Carolina.**
- **The facility design includes unjustified and excess square footage which causes this project to lack the required energy efficiency capabilities.**
- **The methodology and assumptions predict a shift of thousands of surgery cases to begin in 2016, three years prior to the facility's opening.**
- **Utilization projections are based on unreliable and overstated volume estimates with too few participating physicians.**
- **CFSC fails to provide reasonable assumptions to support the expected volume of total joint cases.**
- **The application fails to explain the unmet need to relocate existing multi-specialty GI endoscopy procedure rooms and operating rooms from licensed facilities that already provide more surgical specialties as compared to the proposed facility.**
- **CFSC's proposal is not financially feasible because it relies upon overstated volumes and unreliable expense projections.**
- **Staffing projections erroneously omit nursing staff to provide for extended hours of recovery for total joint patients.**
- **No documentation is provided for pathologist and radiologist services.**
- **This proposal lacks documentation of new clinical training agreements specific to the CSFC facility location and services.**

- **The CFSC proposal fails to enhance competition but instead adds to the market dominance of New Hanover Regional Medical Center.**

Wilmington SurgCare provides comments and documentation regarding how the CFSC application does not conform to specific CON criteria and regulatory standards as follows:

Criterion 1 "*The proposed project shall be consistent with applicable policies and need determinations in the State Medical Facilities Plan, the need determination of which constitutes a determinative limitation on the provision of any health service, health service facility, health service facility beds, dialysis stations, operating rooms, or home health offices that may be approved.*"

Policy GEN-3 states:

"A certificate of need applicant applying to develop or offer a new institutional health service for which there is a need determination in the North Carolina State Medical Facilities Plan shall demonstrate how the project will promote safety and quality in the delivery of health care services while promoting equitable access and maximizing healthcare value for resources expended. A certificate of need applicant shall document its plans for providing access to services for patients with limited financial resources and demonstrate the availability of capacity to provide these services. A certificate of need applicant shall also document how its projected volumes incorporate these concepts in meeting the need identified in the State Medical Facilities Plan as well as addressing the needs of all residents in the proposed service area."

The CFSC application is nonconforming to Criterion 1 because the proposal fails to demonstrate it will maximize healthcare value, causing it to be inconsistent with Policy GEN 3 Basic Principles. Financial projections are flawed due to overstated utilization projections. Please see the comments regarding Criterion 3 and 5 that are incorporated herein.

Policy GEN-4 states:

"Any person proposing a capital expenditure greater than $2 million to develop, replace, renovate or add to a health service facility pursuant to G.S. 131E-178 shall include in its certificate of need application a written statement describing the project's plan to assure improved energy efficiency and water conservation. In approving a certificate of need proposing an expenditure greater than $5 million to develop, replace, renovate or add to a health service facility pursuant to G.S. 131E-178, the Certificate of Need Section shall impose a condition requiring the applicant to develop and implement an Energy Efficiency and Sustainability Plan for the project that conforms to or exceeds energy efficiency and water conservation standards incorporated in the latest editions of the North Carolina State Building Codes. The plan must be consistent with the applicant's representation in the written statement as described in paragraph one of Policy GEN-4. Any person awarded a certificate of need for a project or an exemption from review pursuant to G.S. 131E-184 are required to submit a plan of energy efficiency and water conservation that conforms to the rules, codes and standards implemented by the Construction Section of the Division of Health Service Regulation. The plan must be consistent with the applicant's representation in the written statement as described in paragraph one of Policy GEN-4. The plan shall not adversely affect patient or resident health, safety or infection control."

The CFSC application is nonconforming to Criterion 1 because the proposal is inconsistent with Policy Gen-4 due to its excessively large building design with unnecessary square footage that significantly detracts from the building's energy efficiency. Examples of unnecessary space in the proposed CFSC include the massively oversized "sterile core" that is approximately 4,000 S.F. as well as the nearby "vendor storage" room. These unjustified spaces will greatly increase the facility's heating and cooling demand. Given the fact that the proposed project will result in vacant spaces at NHRMC and Wilmington Health, the proposed CFSC project also contributes to excess utility costs at these existing facilities. Please see the comments regarding Criterion 12 and Attachment 1 for additional information regarding the building design.

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 CFSC application is nonconforming to Criterion 3 because CFSC fails to provide adequate assumptions regarding its projected patient origin that is included on page 120. Patient origin projections for the proposed project are contrived and unreasonable because the application does not provide the historical numbers of cases and the patient origin percentages for the physicians who are expected to utilize CFSC. There are no worksheets in the application that document ***"the 2016 operating room and procedure room patient origin for each of the participating physicians who are projected to perform procedures at the proposed ASC."*** The annual numbers and percentages for 2016 operating rooms and procedure rooms for each participating physicians is omitted from the application. Furthermore, the data for 2016 is incomplete because the application was submitted on November 15, 2016, which is prior to the completion of the year.

The application provides inconsistent information regarding the surgical specialties and the composition of the medical staff for the proposed facility.

As stated on page 38 of the CFSC application, the proposed facility will provide orthopedic surgery (including spine surgery), otolaryngology surgery, gynecologic surgery, urologic surgery and GI/endoscopy procedures. However, this list of surgical specialties is inconsistent with the medical staff table on page 151 that shows no listings for Ob/Gyns and urologists. No surgery projections are provided by the individual physicians who expect to shift utilization to the proposed facility. Furthermore, the letters of support included in Exhibit 28 lack information regarding the surgical specialties for most of the persons who signed the letters. The medical staff list by specialty on page 151 of the application does not correspond to the physician letters in Exhibit 28 because

none of the letters appear to be from otolaryngologists (or EENT), gynecologists, and urologists.

The CFSC application is based on unreliable data regarding surgery utilization at New Hanover Regional Medical Center (NHRMC). As seen in the Attachment 7 comments from Laura Rackley to the Operating Room Work Group, NHRMC reports its procedure room volumes as part of its surgery volumes because "Licensure Application guidelines are not clear on this issue." Because NHRMC does not have a clear understanding of how to report its procedure room cases and its operating room cases, the volumes that are contained in the CFSC application are questionable. It is unclear if the cases that are projected to shift from NHRMC are performed in licensed operating rooms or procedure rooms.

The application fails to conform to Criterion 3 because CFSC's projected utilization is not based on reasonable, credible and supported assumptions.

The CFSC application fails to provide adequate information to support the projected shift of ambulatory patients. As discussed in the CFSC application (as well as the other proposals) the strong growth in the population in New Hanover County, new residents and prospective future ambulatory patients will contribute to the growth in overall demand for ambulatory surgery. Also, the growth of the senior population in the county supports increased need for ambulatory surgery for individuals who have never previously required ambulatory surgery. Contrary to these demographic facts, page 101 of the CFSC application falsely claims that the expected shifts of ambulatory surgery cases are reasonable because the projected patients ***"are already patients of Wilmington Health and EmergeOrtho and thus are likely to follow their doctor, if that is where the doctor prefers to do the procedure."*** This assertion is questionable because the huge population growth in New Hanover County is due to the fact that many new persons are moving to the area. As new residents, these persons do not have previous physician relationships with Wilmington Health or EmergeOrtho. Furthermore, existing residents of New Hanover County are free to choose to obtain

healthcare services from numerous physicians other than Wilmington Health and EmergeOrtho.

Only a subset of physicians with EmergeOrtho (previously OrthoWilmington, PA) is expected to perform ambulatory surgery at CFSC. While the EmergeOrtho Wilmington website (www.orthowilmington.com) lists 24 physicians, there are only 12 EmergeOrtho physician support letters included in Exhibit 28. Therefore, it appears that a sizable number of physicians with EmergeOrtho are unwilling or unable to participate in the proposed project. The application fails to disclose how the expected shift of cases for the subset of EmergeOrtho physicians in the table on page 98 of the application was derived since there are no figures for the individual participating physicians.

Only a subset of physicians with Wilmington Health is projected to perform ambulatory surgery at the proposed facility. The application fails to disclose how the expected shift of cases for the participating physicians with Wilmington Health on page 98 was calculated since there is no data provided for the individual participating physicians.

The CFSC methodology is flawed because the assumptions show the "expected shift" of cases begins in 2016 which is several years prior to the opening of the facility. The proposed CFSC new facility will initially lack accreditation and payor agreements with insurance companies that require accreditation as a pre-condition of submitting an application as a new provider. The following chart appears at the top of page 98 of the application showing that the shift begins in CY2016, which is prior to the submission of this application.

Cases to Shift from NHRMC to CFSC

	CY 2016
EmergeOrtho	2,105
Wilmington Health	304
Other Surgeons at NHRMC	1,883
Total	4,292

Page 101 of the CFSC application also shows the following potential shift of cases.

Projected Shift from NHRMC to CFSC

	CY 2016	*CY 2017*	*CY 2018*	*CY 2019*	*CY 2020*	*CY 2021*	*CY 2022*	*CAGR*
EmergeOrtho	2,105	2,164	2,225	2,287	2,351	2,417	2,484	2.8%
Wilmington Health	304	313	321	330	340	349	359	2.8%
Other Surgeons at NHRMC	1,883	1,936	1,990	2,046	2,103	2,162	2,222	2.8%
Total Joints	250	257	264	272	279	287	295	2.8%
New Wilmington Health Surgeon	NA	374	384	395	406	418	429	2.8%
Total	4,542	5,043	5,184	5,330	5,479	5,632	5,790	2.8%

Page 102 of the application shows the following projections.

Projected Shift to CFSC from Wilmington SurgCare

	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022	CAGR
Wilmington Health	850	867	884	902	920	938	957	2.0%
EmergeOrtho	495	509	523	538	553	568	584	2.8%
Total	1,345	1,376	1,407	1,440	1,473	1,507	1,541	

It is unreasonable to estimate the expected shifts in surgery cases (and procedure room cases) to a new proposed facility that will not exist in 2016, 2017, 2018 and 2019. But pages 96 to 102 of the application repeatedly contend that the physicians will begin to shift surgery and endoscopy cases from existing facilities to the proposed new surgery center years before the facility opens. This fictitious projection makes it appear that CFSC has ownership rights of some specific number of cases that will be performed at other facilities for the years prior to the completion of CFSC. In this way the application falsely projects that the volumes of OR cases and procedure room cases will continue

to ramp up in 2017, 2018 and through June 30, 2019. The application also incorrectly portrays the potential shift in OR volumes as "Wilmington Health" and "EmergeOrtho" when in fact the proposed participating individual physicians are a subset of these groups.

A new ambulatory surgical center such as CFSC will not initially have agreements with all insurers and it could take considerable time to obtain authorization to be reimbursed for Medicare and Medicaid patients in the first year of operation. (For example, Mallard Creek Surgery Center's 2015 evaluation report that was submitted to the Health Planning and Certificate of Need Section explained that while it opened in May 2014, the facility experienced a delay in receiving authorization from CMS; it was only able to begin accepting Medicare patients on December 8, 2014 and Medicaid patients on February 23, 2015.) Since CFSC has no planned date for when it will obtain accreditation, insurance contracting will probably be delayed until the later months of Year 1 or possibly Year 2. Therefore the expected shift in cases that could potentially occur in Year 1 once CFSC opens would still be far less than the historical volumes of cases performed by the participating surgeons at other facilities. Given these circumstances, and based on the fact that surgery patients have a right to choose their physician and their surgical facility, CFSC's methodology and assumptions regarding the projected shift of surgery cases are fatally flawed.

Physician letters of support contained in Exhibit 28 do not provide sufficient information to support the utilization projections. EmergeOrtho physician support letters from page 476 to 487 in CFSC Exhibit 28 lack credibility because the letters contain no surgery volume projections. Instead of providing individual projections for the participating physicians, EmergeOrtho provides an aggregate projection of the surgery cases for an unspecified number of physicians as seen on page 466 of Exhibit 28. But, how can the aggregate number be reliable when its component numbers are concealed?

Multiple EmergeOrtho physicians provide letters of support for the CFSC project and for the Brunswick Surgery Center without reconciling the overlap and double counting of surgery cases they expect to shift. In contrast to EmergeOrtho physicians' letters in the CFSC proposal, the Brunswick Surgery Center's application (CON Project ID # O-11282-16) includes letters from individual EmergeOrtho physicians each with specific volume projections that are credible. However, many of the same EmergeOrtho physicians wrote letters of support for both CON applications. Based on the numerical specificity of the Brunswick support letters, this must be the priority project for the EmergeOrtho physicians. EmergeOrtho support letters for the CFSC proposal represent an unconvincing attempt to double count physician volumes that are already committed in support of the Brunswick application. Please see copies of the letters from EmergeOrtho physicians for the Brunswick Surgery Center in Attachment 6.

Walter W. Freuh, MD
Eric Lescault, MD
Albert W. Marr, MD
Craig A. Rineer, MD
R. Mark. Rodgers, MD
Richard Bahner, MD
Jon K. Miller, MD
D. Todd Rose, MD
Scott Q. Hannum, MD

CFSC letters of support from physicians are based on unsupported projection of surgery cases regarding the expected shift of cases. An excerpt of the letter from Scott Hannum, MD (Exhibit page 466) is provided below:

"Based on a review of New Hanover Regional Medical Center's utilization and discussions with our partners, we have identified the following surgical cases and procedures historically performed at New Hanover Regional Medical Center that we intend to shift to the proposed ASC."

	OR Cases
Performed by EmergeOrtho physicians	2,105
Performed by Wilmington Health physicians	304
Performed by other surgeons	1,883
Total Joint Cases	250

This letter is from Dr. Hannum is unclear because the text refers to surgical cases and procedures but the table only shows OR cases. This letter is unreliable because it fails to identify the physician names and specialties and the timeframe for when the expected shift will occur. The application fails to provide a copy of the NHRMC utilization data that was reportedly reviewed.

An excerpt of the letter from Jonathan Hines, MD (Exhibit page 470) is provided below:

"Based on a review of Wilmington Health's utilization and discussions with our partners, we have identified the following surgical cases and procedures performed by Wilmington Health physicians that we intend to shift to the proposed ASC:"

	To Shift
OR Cases performed at New Hanover Regional Medical Center	304
OR Cases performed at Wilmington SurgCare	850
GI /Endoscopy Procedures performed at Wilmington Health Endoscopy Center	4,672

This letter from Dr. Hines is not credible because it fails to provide the physician names and specialties and the timeframe for when the shift will occur. The application fails to provide a copy of the Wilmington Health utilization data that was supposedly reviewed and is the basis for the expected shift.

An excerpt of the letter from Mark Foster, MD (Exhibit page 476) is provided below:

"Based on a review of EmergeOrtho's utilization and discussion with our partners, we have identified the following surgical cases historically performed by EmergeOrtho physicians that we intend to shit to the proposed ASC."

	OR Cases
Performed at New Hanover Regional Medical Center	*2,105*
Performed at Wilmington SurgCare	*495*

This letter from Dr. Foster fails to identify the physicians and the timeframe for when the shift of OR cases will occur. The application fails to provide a copy of the EmergeOrtho utilization data that was reportedly reviewed. The 2,105 OR cases that appear in the table of this letter could be a reiteration or duplicative of the same number in the letter from Scott Hannum, MD. However, the Hannum letter states that the volumes are surgical cases and procedures, whereas Dr. Foster's letter states that the numbers are surgical cases.

Other letters contained in Exhibit 28 (pages 488 to 536) fail to identify the specialties of the persons who signed the letters. Some of the letters appear to be signed by physicians while others are physicians' assistants or other healthcare providers.

The proposed project is based on unreasonable utilization projections because the project lacks a sufficient number of participating surgeons on its medical staff. The table on page 151 in Section VII of the application documents that a total of 55 physicians are projected to be active members of the medical staff at the proposed facility. Of these physicians, 29 are expected to be anesthesiologists and the remaining

26 are the surgical specialists including EENTs.(2), general surgeons (4), orthopedic surgeons (16) and other physicians (4). This information cannot be verified by the physician letters in Exhibit 28 because many of the letters do not identify the surgical specialty of the individual physicians. The following table shows the utilization projections and the projected numbers of surgeons:

	YR 1	YR 2	YR 3
OR Cases	6,860	7,045	7,235
Multi-Specialty GI Procedure Room Cases	4,884	4,946	5,009
Combined Cases	11,744	11,991	12,244
Total Physicians on CFSC Medical Staff	55	55	55
Anesthesiologist	29	29	29
Surgeons (excluding Anesthesiologists)	26	26	26
Combined Cases	11,744	11,991	12,244
Surgeons (excluding Anesthesiologists)	26	26	26
Combined Cases per Surgeon	452	461	471

The application provides no documentation to support the reasonableness of the projections of 452 to 471 annual combined cases per surgical specialist. The CFSC application also provides no documentation to designate what numbers of surgeons and surgical specialties would be available to serve pediatric, adolescent and adult patients. For purposes of comparison the following table shows the utilization and numbers of physicians on the medical staffs of some of the largest ambulatory surgical centers in eastern North Carolina:

2016 LRA Data for Ambulatory Surgical Facilities	ORs	GI Endo Procedure Rooms	Procedure Rooms	OR Cases	GI Cases in GI Rooms	Other Procedures	**Total Combined Cases**	Total # Medical Staff	# Anesthesiologists	**# Surgeons (excluding Anesth.)**	**Combined Cases / Surgeons**
Vidant SurgiCenter	10	0	0	11,332	0	0	**11,332**	134	26	**108**	**85**
Capital City Surgery Center	8	0	3	6,647	0	0	**6,647**	60	9	**51**	**111**
Blue Ridge Day Surgery Center	6	0	3	6,034	0	973	**7,007**	85	15	**70**	**82**
Wilmington SurgCare	7	3	0	8,464	240	212	**8,916**	90	5	**85**	**99**

As seen in the table above, these ASCs with six to ten operating rooms have much larger numbers of surgical specialists (excluding anesthesiologists) as compared to the

proposed CFSC. Total combined annual cases per surgeon (excluding anesthesiologists) for these existing facilities range between 82 and 111 cases per surgeon as compared to the unrealistic CFSC projections of 452 to 471 cases per surgeon.

Utilization projections for CFSC are based on the unsupported shift of cases away from existing facilities that are already accredited and have existing payor agreements. The proposed new surgical center has no specified date for obtaining accreditation and no existing payor agreements. Therefore it is unreasonable for huge numbers of surgical cases to be shifted to the proposed surgery center before it is in operation and during Year 1 prior to the facility having obtained accreditation and established and fully implemented all of its payor agreements. The application provides no timeline for when the proposed facility will obtain agreements with insurance and managed care companies. Many companies, including BCBSNC, will not accept applications from new providers until after the facilities obtain accreditation. According to the project schedule in Section XII of the application, Cape Fear Surgical Center has not determined when it will obtain accreditation prior to July 1, 2021. Even if the proposed facility someday obtains accreditation and payor agreements, the application provides no documentation of any financial or quality of care benefits to the surgery patients that are unreasonably projected to be shifted from existing facilities. No documentation is provided to demonstrate that CFSC will obtain an agreement with the Accountable Care Organization that has been established between Wilmington Health and BCBSNC. No documentation is provided to demonstrate that CFSC will obtain a provider agreement with North Carolina DHHS Vocational Rehabilitation. None of the physician letters of support in CFSC's Exhibit 28 specifically state the numbers of cases the individual physicians expect to shift from Wilmington SurgCare

The CFSC application does not adequately demonstrate that its estimates of the total number of total joint patients to be treated at the proposed surgery center were based on reasonable, credible and supported assumptions. No physicians are named who are committed to perform a specific number of these cases. While page

98 of the application states that these cases will require specific protocols, these capabilities are not documented. No patient selection criteria are included in the application for total joint patients even though these patients would be at potentially greater risk for complications. The application fails to document that the proposed facility will have policies and procedures to successfully perform total joint arthroplasty as an outpatient procedure; these are necessary to address and prevent the complications that have historically made it an inpatient procedure. Serious complications include bleeding, venous thromboembolism, uncontrolled pain, nausea and urinary retention. Existing ASCs that have demonstrated the capability to perform total joint cases offer extended hours of recovery at the facilities for up to 23 hours. However, the proposed CFSC states that its hours of operation will be limited to 7:30AM to 5:00PM on Monday through Friday. Consequently, the application fails to demonstrate the availability of staff to care for the recovery of the total joint patients.. No other facilities or home health agencies have been identified to provide recovery care for the total joint patients. Cape Fear Surgical Center has not documented when it will have policies and payor agreements established to support the shift of total joint orthopedic cases. Furthermore, the Centers for Medicare and Medicaid Services have not approved reimbursement for ambulatory total joint cases in ASCs. Consequently the expected shift of these total joint cases is not adequately supported.

Utilization projections for CFSC are based on the unsupported assumption that the proposed hospital-physician collaboration creates competency in successfully developing and operating a freestanding ambulatory surgery center. The CFSC application discusses the supposed benefits of hospital-physician collaboration ad nauseam. However, one should not blindly accept this premise because the previous NHRMC joint venture with physicians to develop Atlantic Surgicenter (CON Project # O-6984-04) as a new ASC was abandoned and these operating rooms later became licensed as part of the hospital. This change in the status of the operating rooms at Atlantic Surgicenter from ASC licensure to hospital licensure means that the volume growth reported in the NHRMC License Renewal Applications reflects the utilization of operating rooms that transitioned back to the hospital in recent

years. It is also unclear if the licensure changes from ASC to hospital outpatient department (HOPD) for this facility were properly coordinated with the transition of physician ownership because it appears that the HOPD status was obtained prior to the timeframe when the hospital acquired the physicians' ownership interest in the <u>operations</u> of the ASC.

As seen in Attachment 2, the 2012 License Renewal Application shows that Atlantic Surgicenter had 24 anesthesiologists and 72 other surgical specialists on its medical staff (including 13 orthopedic surgeons) as a freestanding ASC. This NHRMC hospital-physician "collaborative" ASC performed 4,066 annual OR cases for that year or approximately 46.5 annual cases per surgeon. This utilization level at Atlantic SurgiCenter also demonstrates the unrealistic CFSC projections of 452 cases per surgeon in Year 1 based on 26 surgical specialists on its medical staff. This is calculated based on 55 total physicians minus 29 anesthesiologists equals 26 remaining surgical specialists.

The CFSC proposal fails to adequately demonstrate that there is an unmet need to relocate the three GI procedure rooms to the proposed facility. These existing multi-specialty GI procedure rooms at Wilmington Health are already reimbursed at the ASC rates and provide patients with access to numerous specialties. The applicants fail to describe any facility limitations or operational problems that impair the existing procedure rooms. Since these existing rooms are already licensed and accredited, procedures performed in these rooms have existing payor agreements. The proposed new CFSC facility will initially lack accreditation which will then cause delays in obtaining new payor agreements.

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 CFSC proposal is nonconforming to Criterion 3a because the application provides inconsistent and incomplete information regarding the surgical specialties to be provided at the proposed facility. CFSC states it will provide orthopedic surgery (including spine surgery), otolaryngology surgery, gynecologic surgery, urologic surgery and GI/endoscopy procedures. However, this list of surgical specialties is inconsistent with the medical staff table on page 151 that shows no listings for Ob/Gyns and urologists.

The following table compares the scope of ambulatory surgical services that are potentially available at the WH multi-specialty procedure rooms and the NHRMC operating rooms as compared to the projected surgical specialties at CFSC. More ambulatory surgical specialties are currently available at the existing facilities as compared to the scope of services at the proposed CFSC.

Ambulatory Surgical Specialties	*Existing WH Multi-Specialty GI Procedure Rooms (CON App pg. 38.)*	*Existing NHRMC ORs (All Sites Combined) 2016 LRA*	**Proposed CFSC ORs and Procedure Rooms (CON App. Pg. 38.)**
Cardiothoracic		*Yes*	
General Surgery	*Yes*	*Yes*	
Neurosurgery		*Yes*	
OB/GYN	*Yes*	*Yes*	**Yes**
Ophthalmology		*Yes*	
Oral Surgery		*Yes*	
Orthopaedics		*Yes*	**Yes**
Otolaryngology	*Yes*	*Yes*	**Yes**
Plastic	*Yes*	*Yes*	
Urology	*Yes*	*Yes*	**Yes**
Other		*Yes*	
GI Endoscopy	*Yes*	*Yes in Procedure Rooms*	**Yes**
No. of Specialties	*6*	*12*	**5**

The above table shows that the proposed project that involves the relocation of existing multi-specialty procedure rooms and licensed operating rooms will decrease overall access to ambulatory surgery for patients in New Hanover County. If the multi-specialty procedure rooms are shifted from Wilmington Health, it appears that access for general surgery and plastic surgery procedures will be diminished. (General surgery is not a proposed specialty at CFSC in the CON narrative which appears to be inconsistent with the physician support letters in the Exhibit 28.) Relocating operating rooms from NHRMC to the proposed project will decrease the number of shared (inpatient and outpatient) operating rooms available in New Hanover County to serve numerous surgical specialties.

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."*

The CFSC application is nonconforming to Criterion 4 because it is not an effective alternative and fails to conform to Criterion 3 and 3a. Pages 121 and 122 of the application provide cursory analysis of the alternatives considered. These omit the obvious option of converting and/or expanding the existing Atlantic SurgiCenter as a freestanding ambulatory surgical facility. This option would avoid the cost of purchasing the land and would involve minimal site costs. The facility was previously licensed as an ASC and could be easily converted back from an HOPD. Attachment 2, includes the 2012 License Renewal Application for Atlantic SurgiCenter that had 24 anesthesiologists and 72 other surgical specialists on its medical staff (including 13 orthopedic surgeons) when it was a freestanding ASC. Atlantic SurgiCenter, as an ASC with only four operating rooms, had a much larger medical staff than what is projected for CFSC.

This application neglects to explain the necessity of relocating multi-specialty GI procedure rooms from Wilmington Health because the phrase "hospital-physician collaboration" is simply a buzz phrase and not a legitimate explanation. The CFSC

application fails to disclose the planned future uses and capital costs related to the proposed vacated spaces at both Wilmington Health and NHRMC that will result from the relocation of existing procedure rooms and operating rooms. The energy costs for these vacated spaces should be also considered in the Agency analysis regarding Policy GEN-4. Please see the comments regarding GEN 4 and Criterion 12.

The proposed project is not an effective alternative because the proposal offers fewer surgical specialties as compared to the existing scope of services at both Wilmington Health and NHRMC. The option of maintaining the status quo for the Wilmington Health procedure rooms and NHRMC operating rooms would provide superior patient access to a greater number of surgical specialties as compared to the proposed project.
As seen in the CFSC application, very few physicians with other groups other than Wilmington Health and EmergeOrtho have expressed support for the proposed project. The CFSC application does not commit to encourage a broad range of other surgical specialists to join its medical staff.

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 application fails to conform to Criterion 5 because CFSC's projected utilization is not based on reasonable, credible and supported assumptions. See Criterion (3) for discussion. Consequently, operating costs and revenues that are based on this projected utilization are unreliable. Therefore, the applicants did not adequately demonstrate that the financial feasibility of the proposal is based on reasonable assumptions regarding revenues and operating costs. Revenue projections are overstated and unreasonable because CFSC lacks adequate physician support to achieve the exceedingly high utilization projections. No surgery projections are provided by the individual physicians who expect to shift utilization. No documentation is provided to verify when any payors will reimburse the facility for the total joint procedures.

Operational projections are inaccurate and unreliable because:

- Salaries are understated because staff are omitted to serve total joint patients who require extended recovery times
- The medical supplies expenses fail to include the cost of implants for total joint cases
- Medical supply cost amounts for the cases and procedures for the base year assumption are not provided
- Other direct cost amounts for cases and procedures for the base year assumption are not stated
- No expenses are budgeted for staff education
- No expenses are budgeted for repairs and maintenance cost
- Utilities cost are inaccurate and understated because the assumed rate per square foot for the base year is not provided.

The application fails to conform to criterion 5 for additional reasons unrelated to criterion 3. The projected start-up and working capital costs shown on page 159 of the application are unreliable because CFSC wrongly assumes that revenues will exceed expenses after only two months from the time of treating the first patient. This is totally unrealistic because the application fails to demonstrate that it can obtain accreditation and negotiate payor agreements in two months. It takes a new ASC considerable time to obtain authorization and reimbursement for Medicare and Medicaid in the first year of operation. For example, Mallard Creek Surgery Center's 2016 evaluation report to the Certificate of Need and Health Planning Section explained that while it opened in May 2014, the facility experienced a delay in receiving authorization from CMS; it was only able to begin accepting Medicare patients in December 2015 and Medicaid patients in February 2015. This information was submitted to the Health Planning and Certificate of Need Section and is publicly available.

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 CFSC application is nonconforming to Criterion 3 because the need for the proposed project is not adequately demonstrated; therefore the project represents unnecessary duplication of services. Wilmington SurgCare and NHRMC are the two facilities that provide surgical services in licensed operating room in the service area of New Hanover County. The 2016 License Renewal Application for Wilmington SurgCare shows it is licensed for seven ambulatory operating rooms plus three GI endoscopy procedure rooms. The 2016 LRA for NHRMC reports a total of 38 operating rooms including 4 ambulatory rooms, 29 shared rooms, 5 inpatient rooms (including its 3 C-section rooms) plus 5 GI endoscopy procedure rooms. Atlantic Surgicenter with 4 operating rooms is licensed as part of NHRMC.

The proposed CFSC project involves the relocation of three operating rooms from NHRMC. A more limited scope of services is proposed at CFSC as compared to the ambulatory surgery scope of services at NHRMC. Furthermore, the project application includes no discussion of the future use of the vacated operating rooms at the existing NHRMC facilities. Given the fact that operating rooms and support space is incredibly expensive to construct, it is contrary to the intent of the CON law to allow for the relocation of existing resources without sufficient justification.

Wilmington Health holds the license to three GI endoscopy procedure rooms that have been approved to provide multiple specialties. CFSC proposed the relocation of these three multi-specialty GI procedure rooms to the new ASC. However, the application fails to explain what the financial benefit to patients or payors will be to relocate these procedure rooms from one location to another within Wilmington. The application includes no discussion of facility limitations in the current location or the proposed use of the vacated space. A more limited scope of services is proposed at the CFSC for these procedure rooms as compared to the current scope of services at Wilmington Health. it

is contrary to the intent of the CON law to allow for the relocation of existing resources without sufficient justification.

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 application is nonconforming to Criterion 7 because CFSC fails to provide adequate staffing levels for its proposed scope of services that includes performing total joint cases. According to articles in Becker's ASC and Modern Healthcare (Attachments 3 and 4), ambulatory surgery centers that have demonstrated the capability to perform total joint cases offer extended hours of recovery at the facilities for up to 23 hours. However, the proposed CFSC states that its hours of operation will be limited to 7:30AM to 5:00PM on Monday through Friday. Consequently the application fails to demonstrate the availability of staff for the total joint patients to have time to safely recover following surgery. No other facilities or home health agencies have been identified in the application to provide recovery care for the total joint patients.

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 is nonconforming to Criterion 8 because CFSC fails to document the availability of pathology and radiology professional services; no letters of support are included to demonstrate the availability of these necessary services. Radiology professional services are essential to the proposed CFSC project due to the scope of services that requires imaging services for orthopedic spine surgery, total joint cases and other procedures. Pathology professional services are crucial because the applicant projects to perform GI endoscopy cases that involve biopsies to detect colon

cancer. Without the professional interpretation of pathology services, the GI endoscopy is not feasible. In the CON findings for O-7672-06 / HealthSouth Wilmington Surgery Center, LP and Ashton Holdings, LLC, the Agency correctly determined that the applicants did not identify the provider of pathology services and therefore was nonconforming to Criterion 8.

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 is nonconforming to Criterion 12 due to omitted construction costs, unjustified excess square footage for the building design and the lack of square footage information regarding the department spaces that comprise the ASC building. As seen in Attachment 1, the facility design and capital cost estimate are not reasonable. CFSC capital costs are unreliable because the construction cost estimate provides no information regarding the costs to provide site clearing and grading, water and sewer, underground utilities and storm water drainage and/or retention. These essential project components have been omitted from the construction cost estimate that is included in Exhibit 27. The construction cost estimate only states "Site development for parking, roadways, sidewalks and landscape will be included with the project." However, the preliminary site plan included in Exhibit 27, page 454, shows minimal parking layout for the project.

Site development costs for the CFSC proposal are also understated due to the omission of planning and construction costs for storm water system and the requirement for underground electrical and telephone service. New Hanover County has ordinances that mandate storm water management systems for large developments such as Barclay Commons which includes the proposed site.

Furthermore, there are requirements for underground electrical and telephone applicable to the proposed site which are already evident for the adjacent existing EmergeOrtho office building. . Therefore, the applicant did not adequately demonstrate that the proposed cost, design, and means of construction represent the most reasonable alternative and the application is nonconforming to this criterion.

The fundamental purpose of the CON law is to limit the construction of health care facilities in North Carolina to those that are needed by the public and that can be operated efficiently and economically for the public's benefit.[1] The total CFSC capital cost is not based on reasonable assumptions because the proposed building square footage of 48,356 S.F. is excessive for an ambulatory surgical facility with six operating rooms and three procedure rooms. Such a large facility increases the overall capital cost for the project which in turn increases the depreciation expense and drives up energy cost for the building. Given the fact that CFSC provides only the gross total square feet of its proposed ASC, the following table provides comparative square footage information for existing ASCs:

2016 LRA Data for Ambulatory Surgical Facilities	Licensed ORs	Licensed GI Endo Procedure Rooms	Procedure Rooms	Existing Total Facility S.F.
Vidant SurgiCenter	10	0	0	42,787
Capital City Surgery Center	8	0	3	31,000
Blue Ridge Day Surgery Center	6	0	3	20,962
Wilmington SurgCare	7	3	0	22,548

The proposed facility CFSC is excessively large as compared to the existing facilities listed above. The overly large facility design is inconsistent with the fundamental purpose of the CON law.

The project application lacks adequate justification for the excessively large "sterile core" which appears to be more than 4,000+ S.F. and greatly expands the overall

[1] In re: Humana Hosp. Corp. v. N.C. Dep't of Human Res., 81 N.C. App. 628, 632, 345 S.E.2d 235, 237 (1986). See N.C. Gen. Stat. § 131E-175.

footprint of the building. While the 4,000+ S.F. "sterile core" is the largest building component of the entire project, the application neglects to adequately demonstrate the need for this huge space. For purposes of illustration, please see Attachment 5 which shows that the 4,000+ S.F. "sterile core" space is so large that **16 EMS vehicles** could be parked within the space.

Page 168 of the CFSC application fails to provide a table with the proposed square footages of each department/section of the project. The omission of this square footage data makes it impossible for the Agency to evaluate the reasonableness of the facility square footage by department/area or make comparisons to competing projects, or previous CON applications. The omission of this information is critical to the analysis of the CFSC application due to the huge size of the facility and the unjustified "sterile core" area that is central to the excessively large facility layout. The CFSC application does not explain the intended use for this huge space. Exhibit 23, pages 426 lists only a few items of equipment and shelving that is assigned to the huge "clean core" room. However, the plan shows other storage rooms located in proximity to the operating rooms as seen in CFSC Exhibit 5.

Criterion 13c *"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:*

(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."

The application is nonconforming to Criterion 13c because the projected payor mix for the operating room surgery cases shown on page 140 includes no specific assumptions to explain why it differs from the historical payor mix data shown on page 141. The following table provides a comparison of the historical OR cases' payor mix information on page 140 as compared to the proposed CFSC with the unexplained variances for each payor category:

PAYOR	CY 2015 NHRMC Current Number of OR Cases As a Percent of Total Cases (CFSC Page 140)	CFSC PY 2 7/1/19 – 6/30/20 Projected Number of Cases As a Percent of Total Cases (CSSC Page 141)	Variance Between Variance for Projected and Historical OR Cases
Self Pay/Indigent/Charity	3.4%	3.3%	-0.10%
Medicare/Medicare Managed Care	31.4%	30.1%	-1.30%
Medicaid	8,2%	10.7%	2.50%
Commercial/Managed Care	44.5%	43.9%	-0.60%
Other	12.5%	12.1%	-0.40%
TOTAL	100.0	100.1%	0.10%

In addition to the fact that the variances are not explained, the payor percentages for Operating Room Surgical Cases on page 141 are unreliable because the percentages total to more than 100 percent. CFSC fails to explain why the percentage of Medicare patients for PY2 is expected to be lower than the historical NHRMC percentage given the growth of the aging population, which is the largest segment of the population that utilizes healthcare. Payor percentages for CFSC PY2 are unreliable because the application provides no explanation for why the Medicaid percentage for CFSC is projected to be 10.7 percent as compared to historical data of 8.2% for a difference of 2.5 percent.

CFSC fails to explain if the proposed project will include any surgeons that will serve pediatric and adolescent patients, which could potentially increase the Medicaid percentage at the proposed facility. The application fails to include any other historical payor mix data for the subset of physicians who are expected to perform at CFSC in

order to explain the basis for the projected payor percentages for the project. Payor percentages are also unreliable due to the lack of assumptions regarding when the facility will obtain accreditation, when the facility will obtain Medicare and Medicaid certification and when payor agreements will be completed for managed care and insurance companies.

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 is nonconforming to Criterion 14 because CFSC fails to adequately document that the proposed CFSC facility will establish new clinical affiliation and training agreements with training programs at the proposed new facility. CFSC LLC is a separate legal entity and the existing clinical training agreements of related entities do not grant CFSC a waiver for this CON criterion. Neither New Hanover Regional Medical Center nor Wilmington Health is described as a parent company. The fact that New Hanover Regional Medical Center has ownership interest in the proposed project does not extend the hospital's existing clinical affiliation agreements to the proposed new ambulatory surgical facility. The CFSC application does not state that it will be directly managed by New Hanover Regional Medical Center. Similarly, Wilmington Health may have existing clinical training agreements but these agreements do not pertain to the proposed project. When these agreements involving NHMC and Wilmington Health were implemented, the proposed CSFS did not exist.

Page 129 of the CFSC application states **"Relationships established with area clinical training programs via NHRMC and Wilmington Health will not change as a result of the proposed project."** This information does not convey the extent to which students with clinical training programs will have access to the proposed CFSC facility. At minimum the applicants should have sent letters to the clinical training

programs to document CFSC's commitment to enter into new clinical training agreements that would provide access for students to utilize the proposed new CFSC.

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 is nonconforming to Criterion 18a because the project fails to enhance competition in any way. The proposed project is extraordinarily expensive and offers a more limited scope of ambulatory surgical services as compared to maintaining the status quo at Wilmington Health and NHRMC.

The CFSC application is nonconforming to CON Criterion 18a for the same reason that the application does not conform to Criteria 3, 4 and 5. The need for the project has not been adequately demonstrated and the proposal is not an effective alternative. Financial projections are not based on reasonable projections. For these reasons the CFSC proposal fails to enhance competition.

The proposed project also fails to enhance competition because NHRMC has ownership interest in the proposed project and there is no long term guarantee that the physician ownership will remain beyond the initial three years of operation. NHRMC has market dominance in New Hanover County. Previously-approved projects to establish new ambulatory surgery centers in New Hanover County have been acquired by NHRMC and resulted in the operating rooms becoming licensed as hospital-based operating rooms. Atlantic Surgicenter (CON Project # O-6984-04) with four operating rooms was originally licensed as a freestanding licensed ambulatory surgical facility in New Hanover County. This facility is no longer licensed as a freestanding ambulatory surgical facility because it was acquired and became licensed as part of New Hanover

Regional Medical Center. Also, a Declaratory Ruling was issued in 2013 for CON Project # O-7671-06 for Same Day Surgery Center New Hanover, LLC allowing this project to be developed with the two operating rooms at New Hanover Regional Medical Center instead of a freestanding ambulatory surgical facility. Consequently, these operating rooms are now included in the inventory of New Hanover Regional Medical Center. In total, New Hanover Regional Medical Center now owns 84.44 percent of the operating rooms in the service area.

In addition to the CON review criteria, the CFSC application is nonconforming to 10A NCAC 14C .2103 Performance Standards because the methodology and assumptions are flawed and the utilization projections are not credible. It is entirely unreasonable for CFSC to assume that in 2016, 2017 and 2018 a huge shift of ambulatory surgery cases could occur and divert patients away from existing facilities to the proposed facility; the CFSC will not become operational until 2019. Also, the proposal lacks sufficient number of physicians on the medical staff to achieve the CFSC volume projections. As discussed previously in the Criterion 3 comments the physician support letters are not credible for multiple reasons.

Comparative Analysis

Facility Design and Energy Efficiency

Policy GEN-4 is applicable to all of the applications in this review and relates to the energy efficiency and water conservation standards of the project. It is reasonable and appropriate to compare the energy efficiency and water conservation of the three projects. The Agency has previously utilized facility design as a comparative factors in competitive reviews.[2]

Both CFSC and SCW propose to develop new multispecialty ambulatory surgical facilities, while Wilmington SurgCare proposes the less costly renovation and expansion of its existing facility. The following table provides a comparison of the proposed projects at completion:

	Total Number of ORs and Procedure Rooms	Total Facility S.F.	Total Facility S.F. per Operating Room and Procedure Room
CFSC	9 (6 ORs + 3 Proc. Rms.)	48,356	5,373
SCW	4 (3 ORs + 1 Proc. Rm.)	12,500	3,125
Wilmington SurgCare	11 (10 ORs + 1 Proc. Rm.)	26,867	2,442

In general, the overall size of a facility is a major factor that relates to the energy use of the building and the amount of water utilized in the building systems. The CFSC application involves the relocation of operating rooms and procedure rooms from existing facilities; there are no specific plans for utilizing the vacated spaces. The large size of the proposed CFSC facility would result in 5,373 S.F. per OR/Procedure Room without adequate demonstration of the need for such large space allocations. This excess building size detracts from the energy efficiency and water conservation of the facility. The need for a facility to include 6 ORs and 3 Procedure Rooms is not adequately demonstrated due to the overstated utilization projections. Consequently,

[2] In the 2007 New Hanover Nursing Home Review, the Agency included Policy NH-8 and Nursing Facility Design as a comparative factor. In the 2010 Mecklenburg County Adult Care Review, the Agency compared facility design alternatives for projects that involve new construction and upfit/renovations.

the CFSC application is the least effective proposal regarding facility design and energy efficiency. The SCW facility design totals 12,500 S.F which would result in 3,126 S.F. per OR/Procedure Room. While this facility design is more compact as compared to the CFSC proposal, the need for a facility to include 3 ORs and 1 Procedure Room is not adequately demonstrated due to the overstated utilization projections. Consequently, the SCW building design is not justified. Wilmington SurgCare's proposed project combines renovations and new construction to improve existing services, improve building systems, improve energy efficiency and water conservation and add surgical capacity. The building design is the most energy efficient based on the 2,422 S.F. per OR/Procedure Room analysis. The operational projections for the Wilmington SurgCare facility are based on reasonable and supported assumptions. Consequently the Wilmington SurgCare application is the most effective building design.

Scope of Surgical Services

The following table provides a summary of the proposed scope of surgical specialties for the three applications.

	Cape Fear Surgical Center	Surgery Center of Wilmington	Wilmington SurgCare
Scope of Surgical Specialties for Projected Cases and Procedures	Orthopedic (including spine) Otolaryngology, Gynecology, Urology, GI Endoscopy	Neurosurgery, Ophthalmology, Dental and Oral Surgery	General Surgery, Vascular Surgery, Neurology, Gynecology, Ophthalmology, Orthopedic Surgery, Otolaryngology, Plastic Surgery, Podiatry, Urology, GI Endoscopy

SCW proposes to provide the fewest surgical specialties in its application and thus is the least effective proposal. CFSC proposes to provide at least five surgical specialties. However the scope of surgical services for the proposed project involves fewer surgical specialties as compared to the existing ambulatory surgery services at NHRMC. Wilmington SurgCare proposes to provide the broadest scope of surgical specialties and is the most effective application.

Adequacy of Physician Support

In Section VII the SCW application projects the smallest medical staff with only 13 physicians and includes the fewest physician support letters; consequently, the SCW application is the least effective proposal. CFSC projects a total of 55 members on its medical staff and includes numerous physician support letters. The Wilmington SurgCare application reasonably projects a medical staff with a total of 85 physicians and the application includes numerous physician support letters. Based on the comparison of Table VII information and the letters of support, the Wilmington SurgCare proposal is comparatively superior.

Adequacy of Clinical Training

The CFSC and SCW application lack adequate documentation that their proposed new ambulatory surgical centers will establish new agreements with clinical training programs in the area. While these applications refer to agreements that have been established for other facilities, the other agreements are not specific to the CFSC and SCW proposed projects. The Wilmington SurgCare proposal includes documentation of existing clinical training agreements for its facility. Consequently, the Wilmington SurgCare proposal is comparatively superior.

Demonstration of Need

The CFSC project application projects utilization for its proposed project based on the expected shift of cases from existing facilities. As discussed in the Criterion 3 comments, the CFSC methodology and assumptions are not credible. The projected shift of cases is predicted to begin before CFSC is even developed. Physician support letters are unreliable. The SCW application includes surgery case projections that far exceed the volumes that are projected by the neurosurgeons. Thousands of ophthalmology cases are projected with no physicians committed to perform the surgery. As discussed in the Criterion 3 comments, the SCW methodology and assumptions are overstated and unreliable. The Wilmington SurgCare application provides utilization projections that are based on reasonable and supported

methodology and assumptions. Consequently, the proposals by CFSC and SCW are the least effective proposals regarding the demonstration of need and the application by Wilmington SurgCare is comparatively superior.

Access by Medically Underserved Groups

The following table provides a summary of the projected Medicare and Medicaid percentages for the total combined cases for the three applications

	Cape Fear Surgical Center	Surgery Center of Wilmington	Wilmington SurgCare
Year 2 Medicare % Total Combined Cases	32.5%	48%	51.26%
Year 2 Medicaid % Total Combined Cases	6.84%	10%	7.78%
Year 2 Medicare and Medicaid Combined Total%	39.34%	55%	59.04%

CFSC projects the lowest access for medically underserved groups with 32.5 percent Medicare and 6.84 percent Medicaid. CFSC projects the lowest combined Medicare and Medicaid percentage. SCW projects 48 percent Medicare and 10 percent Medicaid. However the SCW percentages for the payor categories are not based on reasonable volume projections or reliable assumptions as discussed in the comments regarding Criterion 13(c). Wilmington SurgCare projects the highest Medicare percentage and the second highest Medicaid percentage and the highest combined Medicare and Medicaid percentage. In addition, the CFSC application includes letters of support from NC DHHS Vocational Rehabiltation and DHHS Services for the Blind to document that these agencies refer patients to the facility.

Accordingly, the proposals by CFSC and SCW are the least effective proposals regarding access by medically underserved groups and the application by Wilmington SurgCare is comparatively superior.

Overall Comparison of Proposals			
	Cape Fear Surgical Center	**Surgery Center of Wilmington**	**Wilmington SurgCare**
Project Completion Services Provided	July 1, 2019	January 1, 2019	January 1, 2020
Accreditation Date	No later than July 1, 2021	April 1, 2019	Existing Accreditation
Facility Location	Iron Gate Drive Wilmington NC	4310 Carolina Beach Road Wilmington, NC	1801 S. 17th St. Wilmington NC
Site	3.6 acres	4.51 acres	5.89
Ownership Info	Purchase Option	Letter of Intent	Existing Lease
# Operating Rooms	6 ORs including 3 relocated from NHRMC and 3 from Need Determination	3 ORs from Need Determination	10 ORs including 7 existing at the facility and 3 from Need Determination
# GI Procedure Rooms or Other Procedure Rooms	3 Multi-specialty GI Endo to be relocated from Wilmington Health	1 Procedure Room	1 Procedure Room 3 existing GI Endoscopy Rooms to be eliminated
Total Gross Facility S.F.	48,356 S.F	12,500 S.F.	26,867 S.F.
New Construction S.F.	48,356 S.F.	12,400 S.F.	4,319 S.F.
Renovations S.F.	None	None	4,273 S.F.
Total Capital Cost	$28,946,325	$9,645,317	$5,600,388
Proposed Project Results in Vacant S.F. at Existing Facilities	Yes at Wilmington Health and NHRMC	None	None
Scope of Surgical Specialties for Projected Cases and Procedures	Orthopedic (including spine) Otolaryngology, Gynecology, Urology, GI Endoscopy	Neurosurgery, Ophthalmology, Dental and Oral Surgery	General Surgery, Vascular Surgery, Neurology, Gynecology, Ophthalmology, Orthopedic Surgery, Otolaryngology, Plastic Surgery, Podiatry, Urology, GI Endoscopy
Weekly Hours of Operation	7:30 AM to 5:00 PM Monday to Friday	6:30 AM to 4:00 PM Monday to Friday with option for extended stay	6:00 AM to 5:30 PM Monday through Friday
# Anesthesiologists	29	2	5
# Surgeons and Others (Section VII)	26	11	79
# Total Medical Staff (Table VII)	55	13	84
Anesthesiology Provider Identified	American Anesthesiology of North Carolina	Salem Anesthesia	Coastal Anesthesia Associates
Pathology Provider Identified	None	None	Wilmington Pathology and Coast Carolina Pathology
Radiologist Provider Identified	None	None	G. William Eason, MD, Airlie Radiology Associates, P.A.

	Cape Fear Surgical Center	Surgery Center of Wilmington	Wilmington SurgCare
Clinical Training Agreements	Not adequately documented	Not adequately documented	Existing agreements documented
Need Methodology Description	Projected shift of cases from existing facilities	Market share by surgical specialties	Growth rate based on multiple factors and internal shift of GI endoscopy cases
Physician Support Letters with Names of Physicians to Perform Cases	22 physician support letters from a variety of physicians stating they will obtain privileges at the ASC	5 neurosurgeons 1 ophthalmology practice 1 dentist 1 oral surgeon	45 physician support letters from named specialties commitments to perform cases
Documentation of Physicians Recruitment	Not adequately documented	Not adequately documented	Adequate documentation provided
Proposal Demonstrates Need	Not reasonable due to timeline for projected shift and too few physicians	Not reasonable due to unreliable case projections, unnamed ophthalmologist and too few physicians	Need methodology based on credible utilization projections with reasonable and supported assumptions
Year 1 Volumes OR Cases Procedure Room Cases Total Combined Cases	6,860 4,884 11,744	1,904 190 2,094	10,680 288 10,968
Year 2 Volumes OR Cases Procedure Room Cases Total Combined Cases	7,045 4,946 11,991	2,615 262 2,877	11,267 304 11,571
Year 3 Volumes OR Cases Procedure Room Cases Total Combined Cases	7,235 5,009 12,244	3,321 297 3,618	11,887 321 12,208
Year 2 Medicare % Total Combined Cases	32.5%	48%	51.26%
Year 2 Medicaid % Total Combined Cases	6.84%	10%	7.78%
Year 2 Medicare and Medicaid Combined Total%	39.34%	55%	59.04%
Support Letters from Referral Sources of Medically Underserved	Not adequately documented	Not adequately documented	Yes, letters from NC DHHS Vocational Rehab and NC DHHS Services to the Blind

Financial Comparisons

The three proposed projects have different timeframes for their first three years of operation following the completion of the projects as seen in the following table.

	Cape Fear Surgical Center	Surgery Center of Wilmington	Wilmington SurgCare
Year 1	7/1/2019 to 6/30/2020	1/1/2019 to 12/31/2019	1/1/2020 to 12/31/2020
Year 2	7/1/2020 to 6/30/2021	1/1/2020 to 12/31/2020	1/1/2021 to 12/31/2021
Year 3	7/1/2021 to 6/30/2022	1/1/2021 to 12/31/2021	1/1/2022 to 12/31/2022

For the purposes of comparing the revenues and expenses for the proposed projects, the following financial statistics are utilized:

- CFSC revenues and expenses based on the average values for Year 2 (7/1/2020 to 6/30/2021) and Year 3 (7/1/2021 to 6/30/2022) because the averages are representative of the amounts for the period (1/1/2021 to 12/30/2021) that would be comparable to the other applications.
- Surgery Center of Wilmington revenues and expenses based on Year 3 (1/1/2021 to 12/31/2012)
- Wilmington SurgCare revenues and expenses based on Year 2 (1/1/2021 to 12/31/2012)

	Cape Fear Surgical Center	Surgery Center of Wilmington	Wilmington SurgCare
Average Gross Patient Revenue per Total Case	$4,472	$8,176	$10,275
Average Net Patient Revenue per Total Case	$1,574	$3,215	$1,582
Average Total Expense per Total Case	$1,457	$2,465	$1,387

Neither CFSC nor SCW demonstrate that their gross revenues are based on reasonable and supported assumptions regarding projected utilization. Please see Criteria 3 and 5 for discussion. Consequently, the proposals by CFSC and SCW are the

least effective proposals regarding revenues and the application by Wilmington SurgCare is comparatively superior.

Also, neither CFSC nor SCW demonstrate that their expense projections are based on reasonable and supported assumptions regarding projected utilization. Please see Criteria 3 and 5 for discussion. Consequently, the proposals by CFSC and SCW are the least effective proposals regarding expenses and the application by Wilmington SurgCare is comparatively superior.

ATTACHMENTS

1. Architect Letter Regarding Building Design and Construction Cost
2. 2012 License Renewal Application Atlantic Surgicenter
3. Becker's ASC Review Article
4. Modern Healthcare Article
5. Sterile Core Space Showing 16 EMS Vehicles
6. EmergeOrtho Physician Support Letters for Brunswick Surgery Center
7. Comments from Laura Rackley to Operating Room Methodology Work Group 11/1/2016

ATTACHMENT 1

TIMOTHY S. KNAPP, AIA, LEED AP

5800 PROVIDENCE GROVE LANE CHARLOTTE NC 28270

December 21, 2016

Via Email

Mr. James Shafer
Administrator
Wilmington SurgCare
1801 South Seventeenth Street
Wilmington, NC 28410

RE: **CON APPLICATION REVIEW**
Cape Fear Surgical Center, LLC
Project ID#O-011275-16

Dear Mr. Shafer:

At your request, I have reviewed the architect supplied information included in the above referenced Certificate of Need (CON) Application. Specifically, the Project Description, Capital Cost, Medical Equipment list, Site Information, Design & Construction Schedule, Exhibit 5 Project Line Drawing, Exhibit 16 Energy Efficiency & Sustainability Plan, Exhibit 26 Certified Construction Cost Estimate and Exhibit 27 Site Plan and Zoning.

The review and analysis of this information was made based on my 25 years of experience in the healthcare architecture and engineering field in addition to the following resources:

- North Carolina State Building Code – 2012 edition (NCBC)
- North Carolina Department of Health and Human Services Rules for Licensing Hospitals – 1996 (DHSR Rules)
- National Fire Protection Association (NFPA) – 2012 edition
    - Chapter 13 – Installation of Sprinkler Systems
    - Chapter 99 – Essential Electrical Systems
    - Chapter 101 - Life Safety Code
- FGI Guidelines for Design and Construction of Hospitals and Outpatient Facilities – 2014 edition (FGI)
- American Society of Heating, Refrigerating and Air-Conditioning Engineers Section 90.1 Energy Standard for Buildings except Low-Rise Residential Buildings – 2007 edition (ASHRAE)
- The Advisory Board Facilities Planning Forum (www.advisory.com) a best practices firm that uses a combination of research, technology, and consulting to improve the performance of health care organizations and educational institutions.
- CODE OF ORDINANCES City of WILMINGTON, NORTH CAROLINA Codified through Ordinance No. O-2016-54, adopted July 19, 2016

I would like to offer the following specific comments on the following items:

ARCHITECTS CERTIFICATION OF COST ESTIMATE

1. The architect states that the *"floor will be divided into two smoke compartments"*. However, with the current plan layout, the only location for a continuous smoke barrier to be constructed is along the locker room wall, across the double egress corridor doors and down to the clinical director's office. This creates a smoke compartment that is approximately 25,300 sf which is in excess of the 22,500 sf permitted by NPA 101 Section 20.3.7 Subdivision of Building Spaces and the NCBC.
2. The letter states that *"the exterior walls will be constructed of non-load bearing, 6", 16-gauge metal studs behind 2" of fully taped and sealed Thermax insulation board sheathing"*. The location of this proposed project is in

Wilmington, North Carolina and therefore in Climate Zone 3 as defined by ASHRAE 90.1. Per the Thermax manufacturers website (http://building.dow.com/en-us/products/thermax-sheathing), two (2) inches of Thermax insulation yields an effective insulation r-vale of R-13. The required insulation in above ground metal framed walls in Climate Zone 3 is R-13+7.5 ci. The "ci" stands for "continuous insulation" (i.e. insulation that runs continuous across the face of the wall and is not interrupted by the cavities created between metal stud framing. As described (and presumably cost estimated) the proposed structure will not meet the minimum requirements of the NCBC.

3. The letter states that *"a new type 1 essential electrical system..."* will be installed and that *"emergency power will be provided by an onsite generator"*. Neither the site plan nor the floor plan indicates where this unit will be placed, how it will be visually screened from the road and adjacent properties, and how it will be refueled. In addition, an emergency generator requires a room containing the electrical switchgear and emergency power distribution panels to be separated by 2-hour fire rated construction and having two (2) separate exits. There is only one electrical room (identified as ELECT on the plan) shown and the size of this room may be just barely adequate to accommodate the normal power distribution panels and transformers while providing the required service clearances.
4. Since there is no indication of a bulk oxygen storage tank on the site, the Med Gas room is where full oxygen cylinders are connected together (via a manifold) to supply the OR's and Pre/Post areas. This is also the area where empty cylinders are also stored awaiting pick-up by the medical gas supplier. This room is approximately 10'x14' and is likely inadequate to accommodate the number of cylinders required to support 9 OR's and 24 Pre/Post patient positions with adequate redundancy.
5. The building is described to be fully sprinklered, however, there is no room on the plan labeled "fire sprinkler riser room" (or other similar indication) that is accessible from the exterior of the building. Additionally, the Drive-under canopies at the Main Entry and Patient Discharge require a "pre-action" sprinkler system whereby the sprinkler pipe in the unconditioned canopy ceiling is "dry" with the water being held inside the conditioned building ceiling area using a pre-action valve and alarm assembly that provides water to the dry pipes in the canopies upon detection of a fire. This assembly requires a closet for inspection and maintenance of the systems. None of these spaces are indicated on the plan.
6. The letter states that *"the areas will be served by a* (singular) *new hospital grade AHU"*. A singular AHU will not adequately support the temperature, humidity and air-flow needs of 9 OR's and 24 Pre/Post rooms and the rest of the entire facility. Multiple HVAC units of varying sizes and configurations will be required. It is not clear if this has been considered in the construction cost estimate.

ARCHITECTS LETTER CERTIFYING COMPLIANCE WITH GEN-4: ENERGY EFFICIENCY AND SUSTAINABILITY

1. Under "Architectural", the architect states that wall insulation shall "meet or exceed ASHRAE 90.1 – 2007 requirements". As discussed above in item 2, this facility will not meet the requirements of the Energy Code.

SITE PLAN

1. The Floor Plan indicates a loading dock drive sloping down 40' to the dock. This does not align with the service drive shown on the site plan. The turning radii of the drives shown on the site plan will not accommodate the 60' minimum radius required for trucks large enough to use a loading dock.
2. There is no location shown for the emergency generator and required visual screening.
3. The architect stated that landscaping was included in the cost estimate. However, the trees and general landscaping shown on the site plan (and presumably included in the construction cost estimate) does not meet the requirements of Article 8 – Landscaping and Tree Preservation of the City of Wilmington Ordinance.
4. The approximately 48,300 sf new ASC and 31,000 sf EmergeOrtho building requires a minimum of one (1) parking space per 250 sf of building area per Article 9 - Off Street Parking and Loading of the City Ordinance. This requires approximately 397 parking spaces which shall include the appropriate number of Handicap Accessible and Van accessible spaces. It is unclear how this number of spaces will be achieved with the other site improvements missing from the site plan.
5. Per a conversation with the City of Wilmington Engineer, the storm water management for sites in this area are served by a city-owned storm water facility (a large detention pond across an adjacent road) under a separate permit from the State. However, undeveloped properties such as the site for this project are also served by this facility with the requirement that impervious development cannot exceed 75% of the total site. Any development in excess of tis 75% (which this site plan exceeds) requires an on-site BMP (detention pond or other storm water management). Neither of these are indicated nor considered in the construction costs.

FLOOR PLAN COMMENTS

1. FGI 3.7-3.5.3 require one (1) staff toilet in the recovery area. Section 3.7-3.4.3.2 (7)(b) requires one (1) patient toilet in the recovery area plus one (1) toilet for every eight (8) patient care stations or fraction thereof. This means the recovery area is required to have a total of five (5) toilets and only four are shown.
2. The amount of storage (bulk, clean, sterile and equipment) is excessive for a facility of this size and compared to contemporary facilities around the state. Much of this is created by inefficiencies in the plan configurations of major spaces (i.e. sterile storage is 4,113 sf because the OR's are organized in a "race-track" configuration and the center is determined by the size of this design)
3. Generally, ASC's need to be efficient both in terms of functional adjacencies and space allocations. Larger facilities require more staff, more utilities and more capital expenditures to affect the same operations as smaller more "lean" facilities.

MEDICAL EQUIPMENT LIST

1. It is unusual to have the extraordinary expense for surgical video integration included in an outpatient facility.
2. The 4,113 sf sterile storage core is not listed in the equipment list and does not have <u>any</u> shelving or other medical equipment shown for this entire space.
3. Oxygen flow meters and Air flow meters are not accounted for in the 9 OR's.

If there are any points in this letter that are unclear or I can provide any further clarification, please let me know. Thank you for the opportunity to be of service.

Sincerely,

Timothy S. Knapp, AIA, LEED AP

ATTACHMENT 2

COPY

North Carolina Department of Health and Human Services
Division of Health Service Regulation
Acute and Home Care Licensure and Certification Section
2712 Mail Service Center • Raleigh, North Carolina 27699-2712
http://www.ncdhhs.gov/dhsr/

Beverly Eaves Perdue, Governor
Lanier M. Cansler, Secretary

Drexdal Pratt, Director

Azzie Y. Conley, Chief
Phone: 919-855-4620
Fax: 919-715-8476

MEMORANDUM

TO: Ambulatory Surgical Facilities
Atlantic Surgicenter, LLC -- Wilmington

FROM: Azzie Y. Conley, RN, Section Chief

SUBJECT: **2012 Ambulatory Surgical Facility License Renewal Application**

PLEASE READ CAREFULLY

Enclosed is your 2012 License Renewal Application. Please complete this application and return the **original plus ONE COPY** no later than December 1, 2011 to the address below.

Acute and Home Care Licensure and Certification Section 2712 Mail Service Center Raleigh, N C 27699-2712	*or Overnight mail address*	Acute and Home Care Licensure and Certification Section 1205 Umstead Drive Raleigh, N C 27603

Data on file with the Division indicates that your facility/entity is an **Ambulatory Surgical Facility (ASF)** with **4** Surgical/Endoscopy room(s). Your annual licensure fee, as authorized by Sections 41.2(a) – 41.2(i) of Session Law 2005-622, is **$1,150.00** . This amount is comprised of a base fee of **$850.00** plus an additional per Surgical/Endoscopy room fee of **$75.00** .

Payment should be in the form of check, money order or certified check and must be payable to "**NC - DHSR**." Payment should include the facility's license number and be submitted with your license renewal application. A separate check is required for each licensed entity.

Your completed renewal application **and the license renewal fee** must be received by December 1, 2011 to ensure your license is renewed with an effective date of January 1, 2012. Failure to possess a valid license may compromise your facility's ability to operate and/or adversely impact its funding sources.

A portion of this application (pp. 1-2) contains **preprinted** information from our data systems, based on your last ASF license renewal application or the most recent information that has been reported to this office. If any of this preprinted- information has changed, **mark through the incorrect information with a *RED* pen and write in the correct information. Prior to amending the D/B/A or legal entity, please contact this office for further instructions.** Please review the "***ownership disclosure***" section carefully to verify

--- continued

North Carolina Department of Health and Human Services
Division of Health Service Regulation
Acute and Home Care Licensure and Certification Section
1205 Umstead Drive, 2712 Mail Service Center
Raleigh, N.C. 27699-2712
Telephone: (919) 855-4620 Fax: (919) 715-3073

For Official Use Only
License # AS0103
Medicare Provider #:
Computer: 070498
PC ______ Date ___________
Total License Fee......... $1,150.00

2012
AMBULATORY SURGICAL FACILITY LICENSE RENEWAL APPLICATION

Legal Identity of Applicant: **Atlantic Surgicenter, LLC**
(Full legal name of corporation, partnership, individual, or other legal entity owning the enterprise or service.)

Doing Business As
(d/b/a) name(s) under which the facility or services are advertised or presented to the public:

PRIMARY: **Atlantic Surgicenter, LLC**
Other: ______________________
Other: ______________________

Facility Mailing Address: 9104 market Street
Wilmington, NC 28411

Facility Site Address: 9104 Market Street
Wilmington, NC 28411
County: New Hanover
Telephone: (910)686-2840
Fax: (910)452-8133

Administrator/Director: Jose Yong
Title: Administrator

Chief Executive Officer (PRINT OR TYPE): Jose A. Yong
Title: Administrator
(Designated agent (individual) responsible to the governing body (owner) for the management of the licensed facility)

Name of the person to contact for any questions regarding this form:

Name: Jose A. Yong

Telephone: 910 686-2840

E-Mail: ~~pachurchwell@bellsouth.net~~ tyong@atlanticsurgicenter.com

DHSR-4137 (08/2011)
"The N.C. Department of Health and Human Services does not discriminate on the basis of race, color, national origin, religion, age, or disability in employment or the provision of services."

Ownership Disclosure (Please fill in any blanks and make changes where necessary.)

1. What is the name of the legal entity with ownership responsibility and liability?

Owner:	Wilmington Physicians LLC, New Hanover Regiomal CTR
National Provider Identifier (NPI):	1942334045
Federal Employer ID#:	20-0714432
Street/Box:	9104 market Street
City:	Wilmington State: NC Zip: 28411
Telephone:	(910)686-2840 Fax: (910)763-9971
CEO:	Mr. Jack Barto

Is your facility part of a Health System? [i.e., are there other ambulatory surgical facilities, hospitals, nursing homes, home health agencies, etc. owned by your facility, a parent company or a related entity?]
__✓__ Yes ____ No

a. Legal entity is: _X_ For Profit ___ Not For Profit

b. Legal entity is: ___ Corporation __✓__ Limited Liability Corporation ___ Partnership
___ Proprietorship ___ Limited Liability Partnership ___ Government Unit

c. Does the above entity (individual, partnership, corporation, etc.) **LEASE** the building from which services are offered? _X_ Yes ___ No

If "**YES**", name and address of building owner:

Senca Properties, LLC

2. Is the business operated under a management contract? ~~X~~ No

If 'Yes', name and address of the management company

Name:	~~Surgery Consultants of America, Inc.~~
Street/Box:	~~12670 Creekside LaneSuite 401~~
City:	~~Fort Myers~~ State: FL Zip: 33919
Telephone:	~~(239)482-1771~~

3. Accreditation: (Please fill in any blanks and change where necessary. **If you are deemed, please attach a copy of the deeming letter from the accrediting agency.** If surveyed within the last twelve (12) months, attach or mail a copy of your accreditation report and grid to this office. If applicable, attach copy of plan of correction.)

a. Is this facility TJC accredited? ___ Yes _X_ No Expiration Date: ________

b. Is this facility AAAHC accredited? _✓_ Yes ___ No Expiration Date: 6-3-2014

c. Is this facility AAAASF accredited? ___ Yes _✓_ No Expiration Date: ________

d. Is this facility DNV accredited? ___ Yes _✓_ No Expiration Date: ________

e. Are you a Medicare deemed provider? ___ Yes _✓_ No

Reporting Period: All responses should pertain to **October 1, 2010 to September 30, 2011.**

Meals:

a. Are meals provided for patients? ____ Yes ✓ No

b. If 'Yes', describe arrangements for this service: ____________

c. If 'Yes', what is the date of the last sanitation inspection: ____________

d. Date of last Fire Marshal inspection: 7-19-2010

e. Date inspected by the Health Department: ____________

Hours:

Indicate the number of hours (e.g., 8 hrs) that the facility is routinely open for surgery and recovery each day: (Use a zero "O" if not open)

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Ø						Ø

Anesthesia:

a. Qualifications of persons administering anesthesia (check one or more)
✓ Anesthesiologist ___ Other M.D. ✓ CRNA ___ RN ___ DDS

b. Name of Anesthesia Group:
American Anesthesiology

c. Provide information regarding the use and storage of flammable anesthesia: Ø

Other Information Needed:

a. Name of laboratory and pathology services utilized: Solstas Lab Partners

b. Name of hospital with which transfer agreement has been made: New Hanover Regional Medical Center

c. Describe arrangements for emergency transportation of patients from the facility:
The local EMS company, Vitalink, is contacted + given the information and then they come to the facility to transport the patient to the hospital.

d. Do you provide recovery care services overnight? ____ Yes ✓ No

e. Are abortions performed in this facility? ____ Yes ✓ No

If 'Yes', please give the number of abortions performed during the reporting period: ____________

Composition of Surgical Staff:

Please indicate below the number of physicians credentialed to perform surgery in your ambulatory surgical program during the reporting period.

Surgical Specialist	Number
Anesthesiologist	24
Gastroenterologist	10
General Dentist	–
General Surgeon	10
Gynecologist	6
Neurologist	–
Obstetrician	–
Ophthalmologist	7
Oral Surgeon	1
Orthopedic Surgeon	13
Otolaryngologist	6
Plastic Surgeon	7
Podiatrist	5
Thoracic Surgeon	–
Urologist	7
Urologist/Cystoscopy	–
Vascular Surgeon	–
Other	–
Total:	96

Name of Chief of Staff: Robert Cortina MD / J. Holt Evans, MD

Name of Director of Nursing: Kathy Wines, RN, BSN, MHA, CNOR

Surgical Operating Rooms; Procedure Rooms; and Gastrointestinal Endoscopy Rooms, Cases and Procedures:

A. Total Existing Licensed Surgical Operating Rooms: # 4

Surgical Operating Rooms are defined as being built to meet specifications and standards for operating rooms specified by the *Construction Section* of the *Division of Health Service Regulation* **and** which are fully equipped to perform surgical procedures. Do not include those rooms listed in Part B. or C., which follow.

Additional CON approved surgical operating rooms pending development: # 0

CON Project ID Number(s) ____

- Total recovery room beds: # 12

B. Procedure Rooms (Excluding Operating Rooms and Gastrointestinal Endoscopy Rooms)

Report rooms, which are not equipped for or do not meet all the specifications for an operating room, that are used for performance of procedures other than Gastrointestinal Endoscopy procedures.

Total Procedure Rooms: # 1

C. Gastrointestinal Endoscopy Rooms, Cases and Procedures:

Is facility licensed for **only** endoscopy rooms with **no** surgical ORs? Yes (No) [circle one]

Report the number of *Gastrointestinal Endoscopy* rooms, and the Endoscopy cases and procedures **performed in these rooms** during the reporting period.

Total Existing Gastrointestinal Endoscopy Rooms: # ____

Additional CON approved GI Endoscopy Rooms pending development: # ____

CON Project ID Number(s) ____

Additional GI Endoscopy Rooms pending development pursuant to SB 714: # ____

	Number of Cases		Number of Procedures*	
	Inpatient	Outpatient	Inpatient	Outpatient
GI Endoscopy				
Non-GI Endoscopy				
Totals				

Count each patient as one case regardless of the number of procedures performed while the patient was in the GI endoscopy room.

*As defined in 10A NCAC 14C .3901 "Gastrointestinal (GI) endoscopy procedure" means a single procedure, identified by CPT code or ICD-9-CM procedure code, performed on a patient during a single visit to the facility for diagnostic or therapeutic purposes.

Surgical and Non-Surgical Cases

NOTE: Read the following instructions carefully.

Surgical Cases by Specialty Area Table - Enter the number of **surgical** cases by surgical specialty area in the chart below. Count each patient undergoing surgery as one case regardless of the number of surgical procedures performed while the patient was having surgery. Categorize each case into one specialty area – the total number of surgical cases is an unduplicated count of surgical cases. **Count all surgical cases, including surgical cases operated on in procedure rooms or in any other location.**

Surgical Specialty Area	Cases
Cardiothoracic	—
General Surgery	810
Neurosurgery	—
Obstetrics and GYN	175
Ophthalmology	425
Oral Surgery	26
Orthopedics	1215
Otolaryngology	773
Plastic Surgery	575
Urology	47
Vascular	—
Other Surgeries (specify) (Podiatry)	20
Other Surgeries (specify)	
Total Surgical Cases	4066

Non-Surgical Cases by Category Table - Enter the number of **non-surgical** cases by category in the table below. Count each patient undergoing a procedure or procedures as one case regardless of the number of non-surgical procedures performed. Categorize each case into one non-surgical category – the total number of non-surgical cases is an unduplicated count of non-surgical cases. **Count all non-surgical cases, including cases receiving services in operating rooms or in any other location, *except* do not count cases having endoscopies in GI Endoscopy rooms. Report cases having endoscopies in GI Endoscopy Rooms on page 5.**

Non-Surgical Category	Cases
Pain Management	0
Cystoscopy	0
Non-GI Endoscopies *(not reported on page 5)*	0
GI Endoscopies *(not reported on page 5)*	1127
YAG Laser	0
Other (specify)	0

Other (specify)	0
Other (specify)	0
Total Non-Surgical Cases	1127

Average Operating Room Availability and Average Case Times:
The Operating Room Methodology assumes that the average operating room is staffed 9 hours a day, for 260 days per year, and utilized at least 80% of the available time. This results in 1872 hours per OR per year. The Operating Room Methodology also assumes 1.5 hours for each Outpatient Surgery.

Based on **your facility's** experience, please complete the table below by showing the assumptions for the **average operating room in your facility.**

Average Hours per Day **Routinely** Scheduled for Use *	Average Number of Days per Year **Routinely** Scheduled for Use	Average "Case Time" ** in **Minutes** for Ambulatory Cases
9	261	48.95

* (Use only Hours per Day **routinely** scheduled when determining. Example: 2 rooms @ 8 hours per day <u>plus</u> 2 rooms @ 10 hours per day <u>equals</u> 36 hours per day; <u>divided</u> by 4 rooms <u>equals</u> an average of 9 hours / per room / per day.)

** **"Case Time" = Time from Room Set-up Start to Room Clean-up Finish**. Definition 2.4 from the "Procedural Times Glossary" of the AACD, as approved by ASA, ACS, and AORN. *<u>NOTE</u>: This definition includes all of the time for which a given procedure requires an OR/PR. It allows for the different duration of Room Set-up and Room Clean-up Times that occur because of the varying supply and equipment needs for a particular procedure*

<u>Reimbursement Source</u>

Primary Payer Source	**Number of Cases**
Self Pay/Indigent/Charity	136
Medicare & Medicare Managed Care	1595
Medicaid	339
Commercial Insurance	52
Managed Care	2094
Other (Specify) WIC / Tricare	59 / 918
TOTAL	5193

Patient Origin -Ambulatory Surgical Services

Facility County: New Hanover

In an effort to document patterns of utilization of ambulatory surgical services in North Carolina's licensed freestanding ambulatory surgical facilities, you are asked to provide the county of residence for each patient *(as reported on page 6)* who had **Ambulatory Surgery** in your facility during the reporting period.

Total No. of Patients should match Total Surgical Cases from "Surgical Cases by Specialty Area" Table on page 6.

County	No. of Patients	County	No. of Patients	County	No. of Patients
1. Alamance		37. Gates		73. Person	
2. Alexander		38. Graham		74. Pitt	3
3. Alleghany		39. Granville	1	75. Polk	2
4. Anson		40. Greene	1	76. Randolph	
5. Ashe		41. Guilford	2	77. Richmond	
6. Avery		42. Halifax		78. Robeson	13
7. Beaufort		43. Harnett		79. Rockingham	1
8. Bertie		44. Haywood		80. Rowan	
9. Bladen	38	45. Henderson		81. Rutherford	1
10. Brunswick	402	46. Hertford		82. Sampson	31
11. Buncombe		47. Hoke	1	83. Scotland	1
12. Burke	1	48. Hyde		84. Stanly	
13. Cabarrus		49. Iredell		85. Stokes	1
14. Caldwell		50. Jackson	1	86. Surry	
15. Camden	1	51. Johnston		87. Swain	
16. Carteret	21	52. Jones	20	88. Transylvania	
17. Caswell		53. Lee		89. Tyrrell	
18. Catawba		54. Lenoir	5	90. Union	1
19. Chatham	1	55. Lincoln		91. Vance	3
20. Cherokee		56. Macon		92. Wake	5
21. Chowan		57. Madison		93. Warren	1
22. Clay	1	58. Martin		94. Washington	
23. Cleveland		59. McDowell		95. Watauga	3
24. Columbus	96	60. Mecklenburg	1	96. Wayne	6
25. Craven	26	61. Mitchell		97. Wilkes	
26. Cumberland	9	62. Montgomery		98. Wilson	
27. Currituck		63. Moore	2	99. Yadkin	
28. Dare		64. Nash		100. Yancey	
29. Davidson		65. New Hanover	1488		
30. Davie		66. Northampton		101. Georgia	7
31. Duplin	139	67. Onslow	1094	102. South Carolina	21
32. Durham		68. Orange		103. Tennessee	5
33. Edgecombe		69. Pamlico		104. Virginia	7
34. Forsyth		70. Pasquotank		105. Other States	44
35. Franklin		71. Pender	557	106. Other	3
36. Gaston		72. Perquimans		**Total No. of Patients**	4026

Patient Origin –Gastrointestinal (GI) Endoscopy Services

Facility County: New Hanover

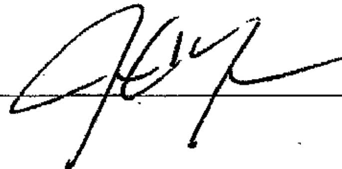
In an effort to document patterns of utilization of gastrointestinal endoscopy services in North Carolina's licensed freestanding ambulatory surgical facilities, you are asked to provide the county of residence for each patient who had a **Gastrointestinal Endoscopy** in your facility during the reporting period.

Total No. of Patients should match Total GI Endoscopy cases from the "Gastrointestinal Endoscopy Rooms, Cases and Procedures" Table on page 5 plus the Total GI Endoscopy cases from the "Non-Surgical Cases by Category" Table on page 6.

County	No. of Patients	County	No. of Patients	County	No. of Patients
1. Alamance		37. Gates		73. Person	
2. Alexander		38. Graham		74. Pitt	
3. Alleghany		39. Granville		75. Polk	
4. Anson		40. Greene		76. Randolph	
5. Ashe		41. Guilford		77. Richmond	
6. Avery		42. Halifax		78. Robeson	7
7. Beaufort		43. Harnett		79. Rockingham	
8. Bertie		44. Haywood		80. Rowan	
9. Bladen	10	45. Henderson		81. Rutherford	
10. Brunswick	120	46. Hertford		82. Sampson	8
11. Buncombe		47. Hoke		83. Scotland	
12. Burke		48. Hyde		84. Stanly	
13. Cabarrus		49. Iredell		85. Stokes	
14. Caldwell		50. Jackson		86. Surry	
15. Camden		51. Johnston		87. Swain	
16. Carteret	4	52. Jones		88. Transylvania	
17. Caswell		53. Lee		89. Tyrrell	
18. Catawba		54. Lenoir		90. Union	
19. Chatham		55. Lincoln		91. Vance	
20. Cherokee		56. Macon		92. Wake	2
21. Chowan		57. Madison		93. Warren	
22. Clay		58. Martin		94. Washington	
23. Cleveland		59. McDowell		95. Watauga	
24. Columbus	33	60. Mecklenburg		96. Wayne	1
25. Craven		61. Mitchell		97. Wilkes	
26. Cumberland		62. Montgomery		98. Wilson	
27. Currituck		63. Moore		99. Yadkin	
28. Dare		64. Nash		100. Yancey	
29. Davidson	1	65. New Hanover	492		
30. Davie		66. Northampton		101. Georgia	
31. Duplin	96	67. Onslow	75	102. South Carolina	
32. Durham		68. Orange	1	103. Tennessee	
33. Edgecombe		69. Pamlico		104. Virginia	
34. Forsyth		70. Pasquotank		105. Other States	
35. Franklin		71. Pender	277	106. Other	
36. Gaston		72. Perquimans		**Total No. of Patients**	1127

This application must be completed and submitted with <u>ONE COPY</u> to the Acute and Home Care Licensure and Certification Section, Division of Health Service Regulation prior to the issuance of a 2012 Ambulatory Surgical Facility license.

<u>AUTHENTICATING SIGNATURE:</u> The undersigned submits application for licensure subject to the provisions of G.S. 131E-147 and Licensure Rules 10A NCAC 13C adopted by the Medical Care Commission, and certifies the accuracy of this information.

Signature:  **Date:** 10/26/2011

PRINT NAME & TITLE OF APPROVING OFFICIAL Jose A. [illegible] Administrator

<u>Please be advised</u>, the licensure fee <u>must</u> accompany the completed application and be submitted to the Acute and Home Care Licensure and Certification Section, Division of Health Service Regulation, <u>prior</u> to the issuance of an ambulatory surgical facility license.

ATTACHMENT 3

Becker's ASC Review

31 ASCs with 23-hour stays

Written by Carrie Pallardy and Anuja Vaidya | May 09, 2014 |

Here are 31 surgery centers that are able to offer 23-hour stays to patients who require extended time for recovery.

Ambulatory Surgical Center of Stevens Point (Wisconsin): The Ambulatory Surgical Center of Stevens Point opened in 2006 and in 2010 began performing total joint procedures and thus offering an overnight stay program for patients when necessary. This is a multispeciality surgery center that performs knee replacement, shoulder replacement, hip replacement and some spine procedures that may necessitate the patient remaining up to 23 hours. "Our 23 hour stay program provides patients with one on one nursing case, catered meals and an enclosed room which was specifically built for this patient population" says administrator Becky Ziegler-Otis RHIA, CPHQ CHC CASC. "The center services the community with the following specialties: urology, podiatry, ophthalmology, pain management, general surgery, spine and orthopedics."

Bailey Square Surgery Center (Austin, Texas). The surgery center includes 23 hour stay capabilities, and it features 12 operating rooms and two endoscopy suites. Founded in 1973, the facility was the state's first freestanding ambulatory surgery center. Its physician team performs more than 11,000 surgeries annually in a number of specialties, including ENT, general surgery, gynecology and ophthalmology.

Beacon Orthopaedics & Sports Medicine Surgery Center (Cincinnati). Beacon Orthopaedics & Sports Medicine's ambulatory surgery center is equipped with 23-hour stay rooms for patients who need extended recovery. The surgery center is accredited by the Accreditation Association for Ambulatory Health Care and includes viewing rooms where families can see the operating room environment and watch the procedure as its being performed. Beacon Orthopaedics offers MRI, DEXA bone density scanners and X-ray as well as physical therapy and athletic trainers. Orthopedic surgeons have a special interest in total joint replacement, arthroscopic procedures and sports medicine. The practice also includes a spine center and partners with Chiropractic Care.

Carlsbad (Calif.) Surgery Center. The surgery center is able to offer patients 23-hour stay options. It was opened in 2009 and is accredited by the Accreditation Association for Ambulatory Health Care. It is a member of the California Ambulatory Surgery Association and the San Diego Regional Chamber of Commerce. The center's medical staff have expertise in ENT, general surgery, spine orthopedics, pain management and vascular surgery.

Cedar Lake Surgery Center (Biloxi, Mis.). Cedar Lakes Surgery Center was established in 1977 as the first freestanding outpatient surgery center in Mississippi. It has since grown into a 16,000-squre-foot facility that can accommodate 23-hour stays. Technology at the surgery center includes the Intstatrac sinus surgery computer system, laser technology and advanced arthroscopy equipment. The ASC also includes procedure areas for endoscopy and pain management. The surgery center is wholly physician-

owned and houses the first surgical suite dedicated to performing and teaching balloon Sinuplasty techniques. Surgeons at the center have a special interest in internal medicine, gastroenterology, ophthalmology, plastic surgery, orthopedics and otolaryngology.

Centrum Surgical Center (Englewood, Colo.). Centrum Surgical Center includes six preoperative stations, one pediatric preoperative station and four operating rooms. The center can accommodate for patients who need 23-hour stays and includes a closed anesthesia staff with radiology capabilities onsite. The surgery center includes orthopedic surgery, plastic surgery, urology, pain management, ENT, ophthalmology and oral surgery. The ASC was founded in 1994 and is accredited by the Accreditation Association for Ambulatory Health Care. It is a HealthOne facility.

Creekside Surgery Center (Anchorage, Alaska). The surgery center offers 23-hour stays and has the capability of discharging the patient to an assisted living facility that is able to accommodate a longer stay. "Creekside started providing overnight stays in 2011," says Sue Sumpter, administrator/executive director at the center. "For patients to stay at the facility, we offered shift differential to our nursing staff to work a 7 p.m. to 7 a.m. shift. We arranged for meals with a local caterer."

The procedures that typically require 23-hour stays or extended stays at the assisted living facility are laminectomies, anterior cervical disc fusions, hip arthroplasty, knee arthroplasty, shoulder arthroplasty, thyroidectomy and parathyroid cases.

The center opened in November 2010, and includes more than 15 physicians.

Cypress Surgery Center (Wichita, Kan.). This Symbion-managed facility can accommodate patients requiring 23-hour stays. The most common procedure that requires a 23-hour stay is a hysterectomy. The center performs 11,000 surgical and non-surgical procedures each year, and is accredited by the Accreditation Association for Ambulatory Health Care. The center's medical director is David Grainger, MD, and the administrator is Misty Sachs. Cypress Surgery Center physicians offer surgical care in numerous specialties, including urology, orthopedics, gastroenterology, ENT, ophthalmology and general surgery.

DISC Sports and Spine Center (Marina del Rey, Calif.). DISC is able to provide patients with 23-hour overnight stays. There are private patient rooms for overnight stays with flat screen TVs and satellite service, full hospital beds and blankets patients are able to take home with them. Skilled nurses are also staffed near the patient rooms overnight, with a maximum ratio of one nurse for every two patients. DISC has partnered with Smith & Nephew to provide advanced operating rooms that have a centralized flow of information to optimize equipment, control media and configure the room for each particular surgeon. The surgery center is accredited by the Accreditation Association for Ambulatory Health Care and serves as the official medical providers for the U.S. Olympic Team, Red Bull America athletes and Los Angeles Kings. Surgeons are able to provide an array of orthopedic and spine procedures in the ASC, including partial knee replacements and minimally invasive spine surgery.

East Memphis Surgery Center (Memphis, Tenn.). The surgery center provides patients the option of 23-hour stays. Typically, plastic surgery patients require this option. The center is managed by Symbion

and accredited by the Joint Commission. Opened in 1993, the surgery center is a limited partnership with Memphis-based Baptist Memorial Health Care and physician partners. Its medical staff includes more than 95 physicians providing care in a wide array of specialties, such as ENT, gynecology, general surgery, podiatry, orthopedics and pain management.

Greater Sacramento (Calif.). Greater Sacramento Surgery Center has a 23-hour stay program, which allows patients to stay overnight when necessary. The surgery center is accredited by the Accreditation Association for Ambulatory Health Care. Physicians at the surgery center perform arthroscopic knee surgery, shoulder surgery, GI procedures, ovary surgery and colonoscopy.

Harmony Surgery Center (Fort Collins, Colo.). Harmony Surgery Center has a convalescence care license which allows patients to have an extended recovery stay. The multispecialty ASC includes four operating rooms, two GI endoscopy rooms, a pain management room and six private overnight extended recovery suites. The nurse-to-patient ratio for overnight stays does not exceed one to three. It is accredited by the Joint Commission and is an active member in the Colorado Ambulatory Surgery Center Association. There are 27 physician investors who have a special interest in bariatric surgery, ENT, orthopedic surgery, urology, ophthalmology and pain management.

Hudson Crossing Surgery Center (Fort Lee, N.J.). Hudson Crossing Surgery Center opened in 2005 and includes a 14-bed post-anesthesia care unit providing for up to 23-hour postoperative stays. The surgery center has five operating rooms and has treated more than 30,000 patients since its inception. The surgery center is managed by Surgery Works and led by President Barry Salzman. Surgeons at the center specialize in ENT, orthopedics, neurosurgery, ophthalmology, spine, pain management and urology. The center is accredited by the Accreditation Association of Ambulatory Health Care and includes the Medtronic Fusion Navigation and Sinus Irrigation ENT equipment, Zeiss microscopes for spine and ENT procedures and Lumenis Holminum Laser Lithotripsy equipment.

Lakewalk Surgery Center (Duluth, Minn.). The surgery center includes 23-hour stay capabilities. Patients undergoing total knee replacement procedures require this option. The independent, outpatient facility has a patient satisfaction rating of 97 percent. It includes private rooms, and the patient infection rate for the period ending March 31, 2013, was 0.114 percent. The center provides surgical services in a number of specialties, including orthopedics and podiatry, gastroenterology, ophthalmology and general surgery. More than 80 physicians perform procedures at the center.

Loveland (Colo.) Surgery Center. Loveland Surgery Center includes a convalescence center for patients who need an extended stay. The rooms include televisions. Loveland hosts about 3,400 orthopedic, spine, pain management and ENT procedures annually. It has seven physician-owners. The center's spine program was an early adopter of the level-three Prestige cervical disc replacement, Paradigm Spine's coflex device, the multi-level NeoDisc replacement and the Dynamic Stabilization System for a posterior lumbar fusion. Loveland Surgery holds a convalescent license, allowing it to cover more complex surgeries. The surgery center is accredited by The Joint Commission.

MALO Center for Ambulatory Surgery (Rutherford, N.J.). The 11,000-square-foot center provides 23-hour stay capabilities for adult and pediatric patients. The center includes four operating rooms and

offers a 3DHD imaging system to assist surgeons performing endoscopic surgeries. It offers care in numerous specialties such as bariatrics, ENT, gynecology, neurosurgery, orthopedics, urology, podiatry, spine and interventional pain management. The center also provides patients with direct transfer to the West Orange, N.J.-based Kessler Institute for Rehabilitation.

Microsurgical Spine Center (Puyallup, Wash.). The surgery center, managed by Symbion, can accommodate patients who need 23-hour stay options. Patients undergoing multi-level spine fusions are most likely to need an extended stay option. The surgery center is accredited by the Accreditation Association for Ambulatory Health Care and is a part of Puyallup-based NeoSpine. Richard Wohns, MD, is the medical director of the surgery center as well as NeoSpine. The center is staffed by a team of five physicians performing artificial disc surgery, fusions, decompressions, minimally invasive surgery and stem cell injections.

Midtown Surgical Center (Denver). Midtown Surgical Center can accommodate 23-hour stay patients at its multispecialty ASC. The surgery center has eight preoperative stations, five operating rooms, one minor procedure room and three GI endoscopy suites. Surgeons at the ASC perform orthopedic surgery, plastic surgery, urological procedures, ophthalmology, ENT and pain management. The facility is accredited by the Accreditation Association for Ambulatory Health Care. It was founded in 1995 and is a HealthOne facility.

Millennium Surgical Center (Cherry Hill, N.J.). Millennium Surgical Center work with the Millennium Physicians Network to provide patients with care in the ASC. The surgery center has 23-hour overnight stay capabilities and an infection rate of less than 0.1 percent. The surgery center was opened in October 2007 and accredited by the Joint Commission. Surgeons at the ASC perform orthopedics, spine, pain management and podiatry services. The procedures performed at the surgery center range from minimally invasive spine surgery and anterior discectomy with fusion to reconstructive shoulder and knee surgery. The surgery center includes 25 physician owners.

Minimally Invasive Spine Institute (Lafayette, Colo.). The Symbion-managed surgery center is able to offer 23-hour stays for its patients, typically needed by those who have undergone multi-level spinal fusions. The center offers minimally invasive spine procedures, neurosurgery, non-surgical procedures and plastic and general surgery. Physicians from Boulder Neurosurgical Associates, Alpine Spine Center and Colorado Center for Spine Medicine, all located in Boulder, Colo., perform procedures at the surgery center.

Northern Wyoming Surgical Center (Cody). The physicians of Big Horn Basin Bone & Joint Clinic perform a majority of their surgeries at Northern Wyoming Surgical Center, which includes 23-hour stays. The ASC has four overnight stay rooms and provides patients with select meals prepared by a local restaurant. In addition to orthopedics, the surgery center offers neurosurgery and spine procedures, general surgery, gynecology, ophthalmology, endoscopy, urology and pain management. The surgery center has been serving its community for more than 10 years and is jointly owned by the physicians and West Park Hospital. It is Medicare-certified and a member of the Ambulatory Surgery Center Association.

Northwest Michigan Surgery Center (Traverse City). The facility is able to provide 23-hour stay options for patients. The 34,000-square-foot surgery center includes six operating rooms, four procedure rooms and more than 44 pre- and postoperative beds. It is a member of the American Surgery Center Association and the Michigan Ambulatory Surgery Association. It provides surgical services in gastroenterology, ENT, podiatry, orthopedics, ophthalmology, urology and gynecology. It includes 80 physicians and 43 anesthesia providers.

Outpatient Surgery Center of La Jolla (Calif.). Outpatient Surgery Center of La Jolla includes 23-hour stay capabilities. Surgeons at the center have a special interest in spine and orthopedic surgery, otolaryngology, general surgery and pain management. The surgery center is accredited by the Accreditation Association for Ambulatory Health Care. The surgery center has adopted global fee pricing and works with cash pay patients. It is affiliated with the California Ambulatory Surgery Association, Surgery One, La Jolla Lap Band and San Diego Joint Replacement Network.

Presidio Surgery Center (San Francisco). Founded in 1989 as a joint venture with Sutter Health, Presidio Surgery Center is currently a joint venture between several physician groups and Sutter. The facility accommodates 23-hour stays for those who have more complex procedures, such as laparoscopic appendectomy, anterior cervical discectomy, complex orthopedic surgery and total joint surgery. The ASC has two ACLS-certified registered nurses and security. It provides meals, internet, TV and DVDs for patients staying over night. The center has undergone accreditation by the Joint Commission.

Rockwall (Texas) Surgery Center. Rockwall Surgery Center includes extended care stays of 23-hours or less. In addition to an overnight recovery area, the facility provides one meal in the evening for patients staying all night as well as wireless internet and satellite television. Rockwall Surgery Center includes four operating rooms. It is accredited by the Joint Commission and is an affiliate of United Surgical Partners International. Physicians at the center specialize in orthopedics, gynecology, general surgery, pain management, colorectal surgery and podiatry.

San Leandro (Calif.) Surgery Center. San Leandro Surgery Center provides same day surgery and overnight stays for 23-hours. All nurses at the center have current advanced cardiac life support certification and the ASC provides meals for patients when necessary. The surgery center includes 50 physicians in the San Leandro area who perform a variety of procedures, such as general surgery, neurosurgery, gynecology, orthopedics, oral surgery, ophthalmology, urology, podiatry, ENT and pain management. The surgery center is led by medical director Ronald Rubenstein, MD, and executive director Sheila L. Cook, RN. The ASC is accredited by the Accreditation Association for Ambulatory Health Care.

St. Louis Spine & Orthopedic Center (Town and Country, Mo.). The surgery center provides patients with the option of 23-hour stays, and spine procedure patients most commonly require the option. The surgery center is managed by Symbion and includes 11 physicians offering spine surgery, orthopedic surgery and pain management services. The surgery center's administrator is Christine Slattery and the director of nursing is Kimberly Watson, BSN, RN.

The Surgery Center (Middleburg Heights, Ohio). The Surgery Center was founded by local surgeons in 1984 and includes 23-hour beds for patients undergoing complex procedures. Extended recovery care at the center includes semi-private rooms with TV, DVD and private phone lines. The physicians specialize in ENT, general surgery, gastroenterology, gynecology, orthopedics, pain management, plastic surgery and urology. The surgery center is accredited by the Joint Commission. The facility currently includes 76 credentialed physicians and performs approximately 6,000 cases per year. There are six operating rooms, two procedure rooms and four extended stay beds in the 20,000-square-foot facility.

Thomas Ambulatory Surgery Center (Leitchfield, Ky.). The surgery center offers 23-hour stay options and is a part of Twin Lakes Regional Medical Center. The medical center is a fully equipped, acute-care hospital offering a wide array of services, including orthopedics, gynecology, ENT and pediatrics. The outpatient surgery center helps the medical center control the cost of healthcare while offering high-quality surgical services. The center was named after the late Ralph G. Thomas, MD, who practiced general surgery in Grayson County and also served as a surgeon with the U.S. Army Medical Corps, during the Korean War.

Vail (Colo.) Valley Surgery Center. The facility can accommodate patients who require 23-hour stays. The center is a joint venture between the Vail Valley Medical Center and around 25 physician-investors. Opened in 2002, the multispecialty ASC handles more than 6,400 cases annually. It is fully licensed by the State of Colorado and Medicare. The center's medical staff provide care in orthopedics, pain management, gastroenterology, general surgery, ophthalmology, ENT, plastic surgery and podiatry.

Wills Eye Surgery Center (Cherry Hill, N.J.). The surgery center includes 23-hour stay capabilities for its patients. The center is accredited by the Accreditation Association for Ambulatory Health Care and certified by Medicare. The surgery center is the flagship of the Wills Eye Surgical Network, and it was opened in July 1995. The surgery center provides surgical services in numerous specialties, including ophthalmology, ENT, general surgery, anesthesia, orthopedics, pediatric surgery and plastic surgery.

ATTACHMENT 4

Modern Healthcare

Replacing joints faster, cheaper and better?

By Harris Meyer | June 4, 2016

Before Stacey Cook received the first of two hip replacements last year at an outpatient surgery center in Davenport, Iowa, his surgeon, Dr. John Hoffman, told him he would be standing and walking within a few hours and would go home the next morning.

Cook, a safety facilitator at Monsanto Co. in his mid-40s, didn't believe it. "I said, 'Yeah, right,'" he recalled. "But I was surprised that was exactly what happened. Six hours later I was walking."After each surgery, he went home the next morning, receiving assistance from family and friends for the first week. A year later, he's walking the golf course and even shooting basketball.

Cook's experience with Hoffman and the Mississippi Valley Surgery Center differed sharply from that of most U.S. patients who receive total hip or knee replacements, known as arthroplasties. They typically are operated on in an inpatient surgical unit, spend several days in a hospital bed, then move to a skilled-nursing or rehabilitation facility or receive home healthcare.

But that's starting to change, and tensions are rising between hospitals and orthopedic surgeons as a result. Building on advances in surgical technique, anesthesia and pain control, a small but growing number of surgeons around the country are moving more of their total joint replacement procedures out of the hospital, performing these lucrative operations in outpatient facilities. Some are sending their patients home within a few hours, while others have their patients recover overnight in the surgery center or hospital during 23-hour stays. These surgeons say very few of their patients require skilled nursing, rehab or home healthcare. The Ambulatory Surgery Center Association says close to 40 centers around the country are performing outpatient joint replacements, and outpatient surgery companies such as Surgical Care Affiliates are aiming to increase them.

Moving these procedures to outpatient settings poses a major threat to hospital finances, since total joint replacements are one of the largest and most profitable service lines at many hospitals. In 2014, more than 400,000 Medicare beneficiaries received a hip or knee replacement, costing the government more than $7 billion for the hospitalizations alone—over $50,000 per case. The financial threat will be even greater if the CMS changes its rules and allows Medicare and Medicaid payment for these outpatient procedures, which observers expect will happen in the next few years. The migration of total joint replacements to outpatient settings also raises questions about the future of Medicare's mandatory bundled-payment initiative for inpatient procedures in 67 markets around the country, called the Comprehensive Care for Joint Replacement program, which began in April. If the CMS decides to pay for ambulatory procedures, that could undercut the hospital bundling initiative.

MH Takeaways The migration of lucrative joint-replacement surgeries to outpatient settings will cause friction between surgeons and hospitals and raises questions about the premise of Medicare's new bundled-payment initiative for hospital-based procedures. Critics ask, so what? "Why would we not encourage the migration to outpatient if the outcome is the same and the cost is lower?" said Jeff Goldsmith, a national adviser to Navigant Healthcare. Goldsmith, a Medicare beneficiary, recently underwent a hip replacement and recovered so quickly he thinks it could have been done on an outpatient basis. "Why preserve the (inpatient bundling) program if the whole point is to save money for Medicare?" he said.

Until recently, outpatient total joint replacements were rare. Most providers and patients thought a several-day hospital stay was needed because of the pain, mobility and infection risks associated with these major surgeries. Now, when patients' health plans allow it, leading surgeons in this field say they are doing many or most of their joint replacements on an outpatient basis—except for patients who are extremely obese or have unstable chronic conditions. They say even healthy patients in their 70s or 80s can be candidates for outpatient surgery, but careful patient selection is essential.

Many more surgeons are eager to learn these improved clinical processes and start doing joint replacements outside the hospital. "Dr. Hoffman has surgeons and administrators from all over the country come tour and watch our processes two or three times a month," said Michael Patterson, CEO of the Mississippi Valley Surgery Center, who recommends slow, careful adoption of outpatient procedures. "We advise surgeons that first they need to be able to get patients in and out of the hospital within 24 hours. They can't go straight from three- to five-day stays to 23 hours."

The emerging outpatient delivery model is driven by both patients' and payers' desire to reduce their costs, increase convenience and satisfaction and diminish the risk of hospital-acquired infections. Orthopedic surgeons say doing joint replacements on an outpatient basis cuts costs nearly in half, although reimbursement is also lower. "People want quality at a reduced cost," said Dr. Patrick Toy, who has done nearly 250 hip and knee replacements at the outpatient Campbell Clinic in Memphis, Tenn., which he partially owns. "This hits the nail on the head."

Despite the looming financial threat, many hospitals have not settled on a strategy to address the outpatient migration, particularly where local surgeons have not yet adopted this new practice pattern. In some markets, hospitals and surgeons are starting to collaborate, while in others there may be conflict over who will capture the big dollars from joint replacements, which are surging as the baby boomers move into their creakier years.

"This is coming whether we like it or not, and we have to figure out how to better partner with physician practices to deliver the best care for patients and hopefully protect patient volume for the hospital," said Kyle Armstrong, CEO of Baptist Memorial Hospital-Collierville, a suburb of Memphis served by Toy's free-standing surgery center. "I can imagine there will be some areas where it is contentious." His system has considered buying or partnering in a Memphis outpatient surgery center.

In 2014, 23% of 354 hospitals analyzed by the Advisory Board Co. performed at least some outpatient knee replacements, while 7% performed at least some outpatient hip replacements. Experts say those numbers likely have increased in the past two years as more surgeons and their teams gain confidence with new and improved clinical protocols, making it possible to release patients more quickly.

"More hospitals are starting to move joint replacement into outpatient settings to compete with (free-standing) ambulatory surgery centers," said Shruti Tiwari, a senior consultant at the Advisory Board. "Patients are warming up to the idea, particularly younger and healthier patients who don't have time for a three-day hospital stay and a protracted recovery process."

"The smart, strategic hospital management teams understand they need to get ahead of this, so that when volume shifts out of their buildings they won't lose patients," said Brian Tanquilut, a senior healthcare analyst at Jefferies & Co. "That's why the investor-owned hospital companies are making a big push on surgery centers."

Even at hospitals that are already collaborating with their surgeons on outpatient joint replacements, executives caution that there are problems making outpatient joint replacements financially viable.

"The current ambulatory reimbursement system isn't really sufficient to cover the overall cost of care,"

said Michael Dandorph, chief operating officer at Rush University Medical Center in Chicago. He projects that up to 25% of joint replacements may be done on an outpatient basis within five years if Medicare starts paying for them. "On a single-case basis, we're taking a revenue hit. But if it produces better outcomes and lowers the cost, that should attract more patients," he said.

Orthopedic surgeons say that while they would like to collaborate with hospitals on outpatient joint replacements, institutional inertia makes it hard to implement innovative practices that better serve patients.

Dr. Richard Berger performs nearly 800 outpatient total joint replacement procedures a year, split between Rush University Medical Center's ambulatory surgery unit and the Munster (Ind.) Specialty Surgery Center, a free-standing facility he partially owns. "Even at Rush, which is a great hospital, it's hard to make changes and try new things," he said. "At the surgery center, I make one phone call and anything I want to do, I can do."

"You can control costs so much better in the ambulatory surgery center setting," said Dr. Alexandra Page, who chairs the American Academy of Orthopaedic Surgeons' Health Care Systems Committee and whose practice partner has started doing joint replacements in a free-standing outpatient center in San Diego. "That works for everyone but the hospital."

Some hospitals, such as Rush and CentraCare Health's St. Cloud (Minn.) Hospital, are responding by working with surgeons to do same-day or 23-hour joint replacement procedures either in hospital-run surgical units or outpatient centers, depending on each patient's needs. Dr. Joseph Nessler and his colleagues at St. Cloud Orthopedics, a 21-physician independent practice group, are doing more than 300 total joint replacements a year on an outpatient basis, divided between the physician-owned St. Cloud Surgical Center and the hospital. The chosen surgical setting is based on each patient's medical condition and whether an overnight stay is needed.

St. Cloud Hospital staff have honed their clinical processes to reduce the percentage of patients who need blood transfusions from 25% to zero, get patients up and moving within hours after surgery, and ensure they see a physical therapist that same day, said Naomi Schneider, the hospital's orthopedics director. They have also launched an intensive pre-surgical education program for patients, using videos and online resources, so they are ready for the rapid return home.

Even though about 25% of the total joint replacements Nessler and his colleagues performed last year were at their free-standing surgery center, the hospital still saw nearly a 10% jump in volume for joint replacements, Schneider said. That's because the combined program is drawing patients from all over the region who want a high-quality, in-and-out experience. Currently, there are no other providers in the area offering a well-established outpatient joint replacement program.

Rush also anticipates benefits from working with a renowned outpatient surgery provider like Berger. "If 15% of cases move to the ambulatory setting but we're able to attract more patients overall, that's good for us and it's good for the industry because we're producing better outcomes and lowering the cost of care," said Dandorph, whose hospital performed 3,200 total joint replacements last year. "We're trying to figure out how to do that in partnership rather than being competitive."

Other hospital systems, such as UnityPoint Health in Iowa and Illinois, are buying an ownership interest in outpatient surgery centers where orthopedists are performing same-day joint replacement procedures. Last year, UnityPoint acquired an interest in the Mississippi Valley Surgery Center; Hoffman and his colleagues performed more than 200 total joint replacements there in 2015.

The other new partner in Hoffman's surgery center is Surgical Care Affiliates, a publicly traded operator of ambulatory surgery clinics across the country. The company, which just announced an investment in a

clinical platform to expand its network of surgeons performing outpatient joint replacements, says it now has 18 centers doing these procedures.

"There will always be a large population that will need the hospital," said Amanda Olderog, director of strategic business development at UnityPoint Health-Trinity Hospital in Rock Island, Ill., whose system does about 1,000 total joint replacements a year. "But for patients who are healthier and often younger that can be done outpatient, our goal is to work with our surgeons to serve patients in the best way we can, in the best location."

A major factor delaying the migration of joint replacements out of the hospital setting, however, is that the CMS has limited Medicare and Medicaid payments to inpatient procedures only. It withdrew its 2012 proposed rule to allow payment for outpatient total knee replacements in the face of negative industry comments.

The American Hospital Association opposed the rule change, arguing that outpatient joint replacements hadn't been proven safe. An AHA spokeswoman says the association has not reconsidered its position. Nevertheless, many experts say the outpatient procedures are now considered safe if done by well-prepared surgical teams on properly selected patients.

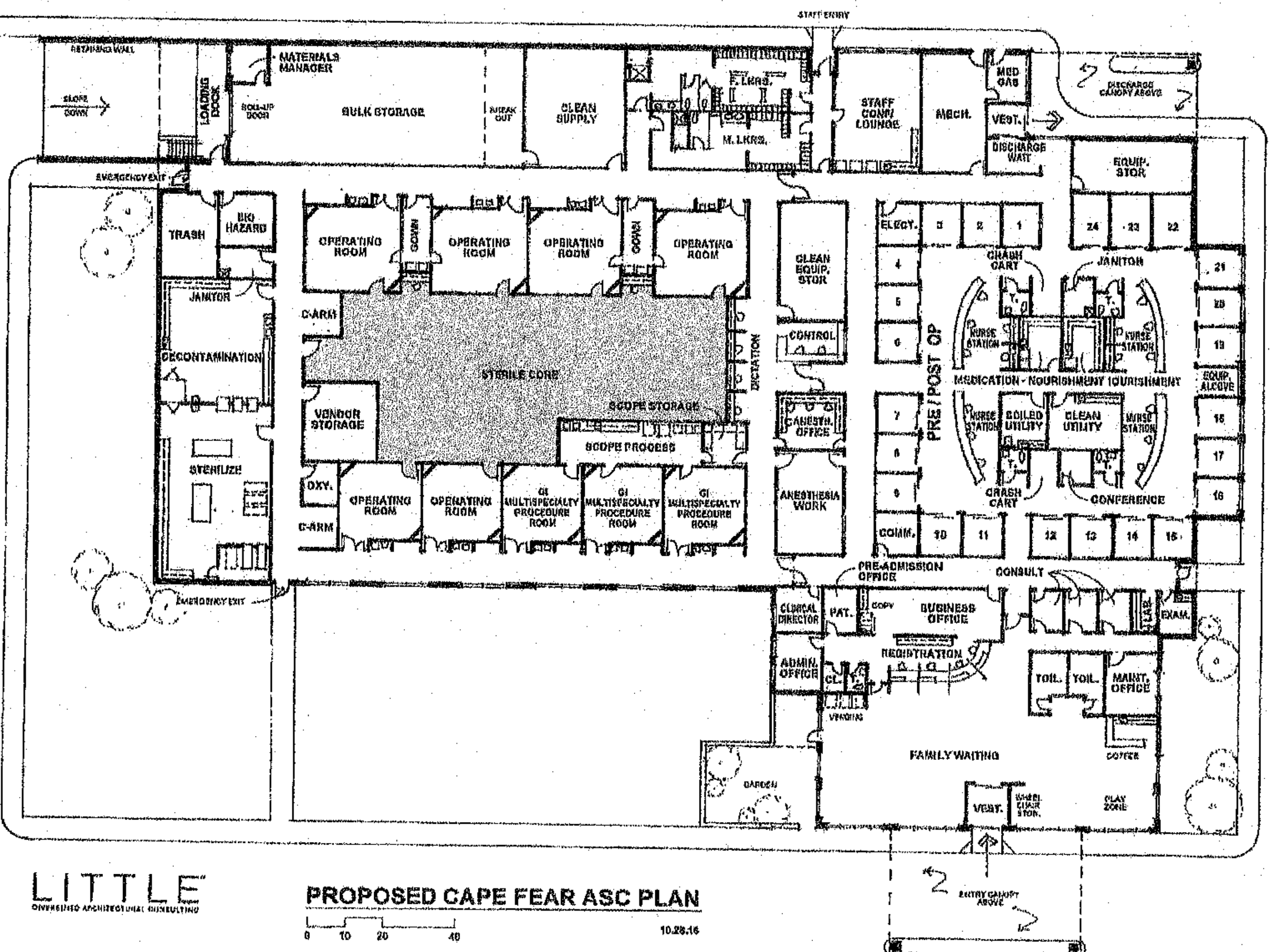
Some orthopedic surgeons and the Ambulatory Surgery Center Association have lobbied the CMS to change its payment rule, which would greatly increase the number of potential patients for outpatient joint replacements since the majority of people who need hip and knee implants are age 65 or older. A CMS spokesman would not say whether the agency is considering lobbyists' request.

Private payers also are sometimes balky about paying for outpatient joint replacements, surgeons and administrators say. Some orthopedic groups, such as the Orthopedic & Sports Institute of the Fox Valley in Appleton, Wis., and Monterey (Calif.) Peninsula Surgery Center, have signed bundled-payment contracts with insurers for outpatient joint replacements, according to the Ambulatory Surgery Center Association. Blue Shield of California is one insurer paying for these outpatient procedures under a bundled-fee arrangement.

But experts expect payers to embrace the trend as more patients opt for having these procedures done in the cheaper outpatient setting, reducing their out-of-pocket costs under high-deductible health plans.

"Think about the value equation," Toy said. "We are doing the same thing we can do in the hospital, but arguably better."

ATTACHMENT 5

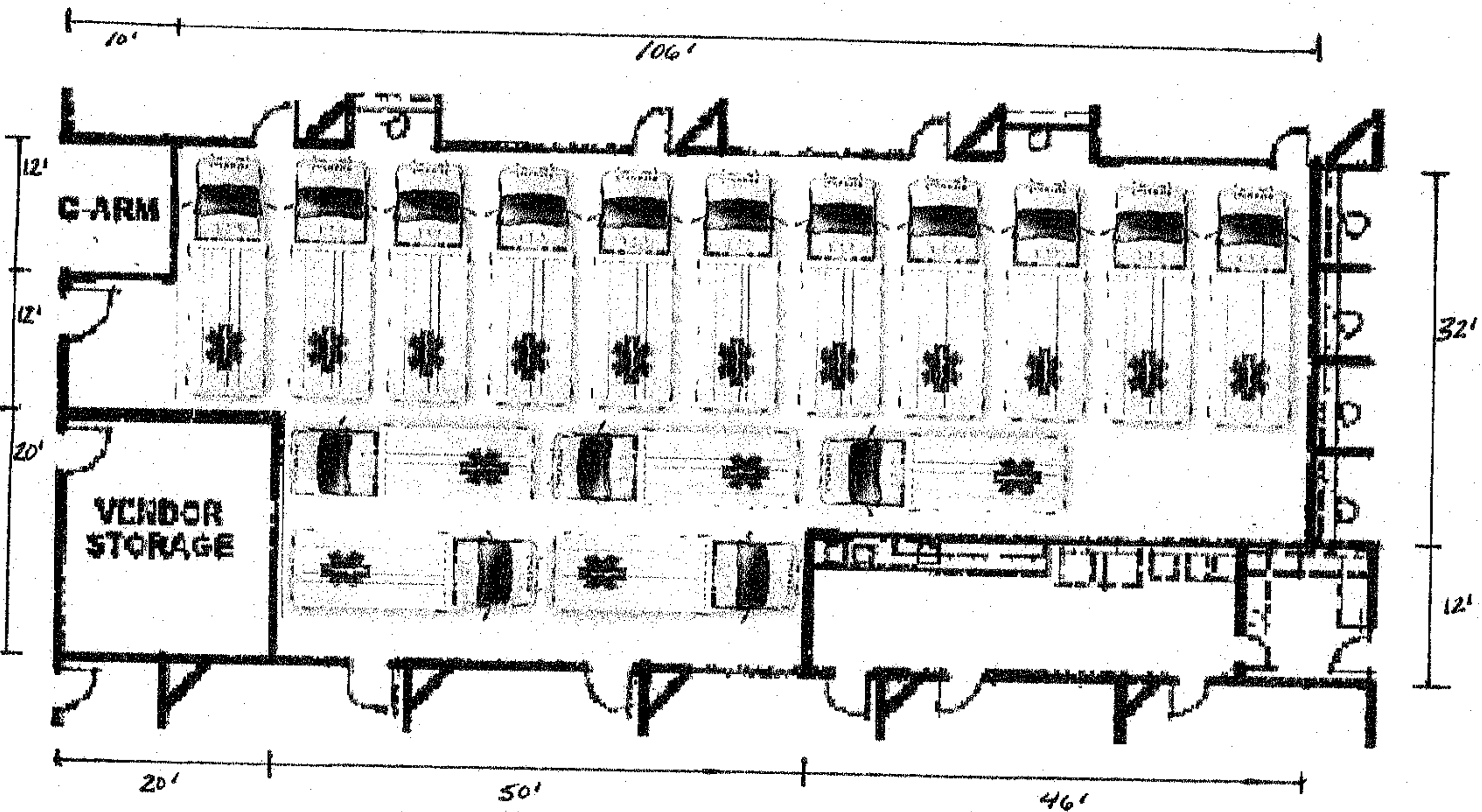


PROPOSED CAPE FEAR ASC PLAN

0 10 20 40

10.28.16

Illustration by Strategic Healthcare Consultants



ATTACHMENT 6

2716 Ashton Drive
Wilmington, NC 28412
TEL: 910.332.3800
TOLL FREE: 800.800.3305
FAX: 910.251.0421

November 7, 2016

Ms. Martha Frisone
Assistant Chief, Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
2704 Mail Center Service
Raleigh, NC 27699-2704

Dear Ms. Frisone:

I am writing to express my support for the CON application filed by Brunswick Surgery Center, LLC (BSC). I am a board-certified Orthopaedic Surgeon who treats many patients from Brunswick County and surrounding communities. I am excited to have the opportunity to participate in the development of the first ambulatory surgery center in Brunswick County. As the vast majority of my surgical patients are outpatients, I am confident that the proposed project will help patients receive cost effective care in a facility dedicated to ambulatory surgery and more conducive to quality outcomes.

As the local population continues to rapidly increase and age, and as technological advances and payor trends drive services to outpatient settings, it is evident that there will continue to be a growing demand for outpatient orthopaedic surgical services in Brunswick County. The proposed facility is necessary to support this increasing demand in an efficient, cost effective manner.

The proposed ASC will be designed for and committed to delivering high-quality surgical services to ensure a superior patient experience and clinical outcome. The proposed location in Leland is geographically accessible, and will provide equitable access to all residents of Brunswick County. Based on my experience and feedback from my patients, the proposed BSC ASC in Brunswick County will be embraced and well utilized by service area residents.

Based on my historical experience performing outpatient surgery on Brunswick County residents, I anticipate performing approximately 370 surgical cases at BSC in year one of the project and that this number will gradually increase thereafter.

Sincerely,

Michael M. Marushack, M.D.
EmergeOrtho

EmergeOrtho.com

2716 Ashton Drive
Wilmington, NC 28412
TEL: 910.332.3800
TOLL FREE: 800.800.3305
FAX: 910.251.0421

November 7, 2016

Ms. Martha Frisone
Assistant Chief, Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
2704 Mail Center Service
Raleigh, NC 27699-2704

Dear Ms. Frisone:

I am writing to express my support for the CON application filed by Brunswick Surgery Center, LLC (BSC). I am a board-certified Orthopaedic Surgeon who treats many patients from Brunswick County and surrounding communities. I am excited to have the opportunity to participate in the development of the first ambulatory surgery center in Brunswick County. As the vast majority of my surgical patients are outpatients, I am confident that the proposed project will help patients receive cost effective care in a facility dedicated to ambulatory surgery and more conducive to quality outcomes.

As the local population continues to rapidly increase and age, and as technological advances and payor trends drive services to outpatient settings, it is evident that there will continue to be a growing demand for outpatient orthopaedic surgical services in Brunswick County. The proposed facility is necessary to support this increasing demand in an efficient, cost effective manner.

The proposed ASC will be designed for and committed to delivering high-quality surgical services to ensure a superior patient experience and clinical outcome. The proposed location in Leland is geographically accessible, and will provide equitable access to all residents of Brunswick County. Based on my experience and feedback from my patients, the proposed BSC ASC in Brunswick County will be embraced and well utilized by service area residents.

Based on my historical experience performing outpatient surgery on Brunswick County residents, I anticipate performing approximately 325 surgical cases at BSC in year one of the project and that this number will gradually increase thereafter.

Sincerely,

Eric J. Lescault, D.O.
EmergeOrtho

EmergeOrtho.com

2716 Ashton Drive
Wilmington, NC 28412
TEL: 910.332.3800
TOLL FREE: 800.800.3305
FAX: 910.251.0421

November 7, 2016

Ms. Martha Frisone
Assistant Chief, Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
2704 Mail Center Service
Raleigh, NC 27699-2704

Dear Ms. Frisone:

I am writing to express my support for the CON application filed by Brunswick Surgery Center, LLC (BSC). I am a board-certified Orthopaedic Surgeon who treats patients from Brunswick County and surrounding communities. I am excited to have the opportunity to participate in the development of the first ambulatory surgery center in Brunswick County. As a portion of my surgical patients are outpatients, I am confident that the proposed project will help patients receive cost effective care in a facility dedicated to ambulatory surgery and more conducive to quality outcomes.

As the local population continues to rapidly increase and age, and as technological advances and payor trends drive services to outpatient settings, it is evident that there will continue to be a growing demand for outpatient orthopaedic surgical services in Brunswick County. The proposed facility is necessary to support this increasing demand in an efficient, cost effective manner.

The proposed ASC will be designed for and committed to delivering high-quality surgical services to ensure a superior patient experience and clinical outcome. The proposed location in Leland is geographically accessible, and will provide equitable access to all residents of Brunswick County. Based on my experience and feedback from my patients, the proposed BSC ASC in Brunswick County will be embraced and well utilized by service area residents.

Based on my historical experience performing outpatient surgery on Brunswick County residents, I anticipate performing approximately 20 surgical cases at BSC in year one of the project and that this number will gradually increase thereafter.

Sincerely,

Jon K. Miller, M.D.
EmergeOrtho

EmergeOrtho.com

2716 Ashton Drive
Wilmington, NC 28412
TEL: 910.332.3800
TOLL FREE: 800.800.3305
FAX: 910.251.0421

November 7, 2016

Ms. Martha Frisone
Assistant Chief, Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
2704 Mail Center Service
Raleigh, NC 27699-2704

Dear Ms. Frisone:

I am writing to express my support for the CON application filed by Brunswick Surgery Center, LLC (BSC). I am a board-certified Orthopaedic Surgeon who treats many patients from Brunswick County and surrounding communities. I am excited to have the opportunity to participate in the development of the first ambulatory surgery center in Brunswick County. As the vast majority of my surgical patients are outpatients, I am confident that the proposed project will help patients receive cost effective care in a facility dedicated to ambulatory surgery and more conducive to quality outcomes.

As the local population continues to rapidly increase and age, and as technological advances and payor trends drive services to outpatient settings, it is evident that there will continue to be a growing demand for outpatient orthopaedic surgical services in Brunswick County. The proposed facility is necessary to support this increasing demand in an efficient, cost effective manner.

The proposed ASC will be designed for and committed to delivering high-quality surgical services to ensure a superior patient experience and clinical outcome. The proposed location in Leland is geographically accessible, and will provide equitable access to all residents of Brunswick County. Based on my experience and feedback from my patients, the proposed BSC ASC in Brunswick County will be embraced and well utilized by service area residents.

Based on my historical experience performing outpatient surgery on Brunswick County residents, I anticipate performing approximately 125 surgical cases at BSC in year one of the project and that this number will gradually increase thereafter.

Sincerely,

Craig A. Rineer, M.D.
EmergeOrtho

EmergeOrtho.com

2716 Ashton Drive
Wilmington, NC 28412
TEL: 910.332.3800
TOLL FREE: 800.900.3305
FAX: 910.251.0421

November 7, 2016

Ms. Martha Frisone
Assistant Chief, Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
2704 Mail Center Service
Raleigh, NC 27699-2704

Dear Ms. Frisone:

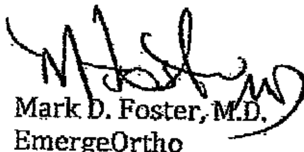
I am writing to express my support for the CON application filed by Brunswick Surgery Center, LLC (BSC). I am a board-certified Orthopaedic Surgeon who treats many patients from Brunswick County and surrounding communities. I am excited to have the opportunity to participate in the development of the first ambulatory surgery center in Brunswick County. As a portion of my surgical patients are outpatients, I am confident that the proposed project will help patients receive cost effective care in a facility dedicated to ambulatory surgery and more conducive to quality outcomes.

As the local population continues to rapidly increase and age, and as technological advances and payor trends drive services to outpatient settings, it is evident that there will continue to be a growing demand for outpatient orthopaedic surgical services in Brunswick County. The proposed facility is necessary to support this increasing demand in an efficient, cost effective manner.

The proposed ASC will be designed for and committed to delivering high-quality surgical services to ensure a superior patient experience and clinical outcome. The proposed location in Leland is geographically accessible, and will provide equitable access to all residents of Brunswick County. Based on my experience and feedback from my patients, the proposed BSC ASC in Brunswick County will be embraced and well utilized by service area residents.

Based on my historical experience performing outpatient surgery on Brunswick County residents, I anticipate performing approximately 190 surgical cases at BSC in year one of the project and that this number will gradually increase thereafter.

Sincerely,



Mark D. Foster, M.D.
EmergeOrtho

2716 Ashton Drive
Wilmington, NC 28412
TEL: 910.332.3800
TOLL FREE: 800.800.3305
FAX: 910.251.0421

November 7, 2016

Ms. Martha Frisone
Assistant Chief, Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
2704 Mail Center Service
Raleigh, NC 27699-2704

Dear Ms. Frisone:

I am writing to express my support for the CON application filed by Brunswick Surgery Center, LLC (BSC). I am a board-certified Orthopaedic Surgeon who treats patients from Brunswick County and surrounding communities. I am excited to have the opportunity to participate in the development of the first ambulatory surgery center in Brunswick County. As a portion of my surgical patients are outpatients, I am confident that the proposed project will help patients receive cost effective care in a facility dedicated to ambulatory surgery and more conducive to quality outcomes.

As the local population continues to rapidly increase and age, and as technological advances and payor trends drive services to outpatient settings, it is evident that there will continue to be a growing demand for outpatient orthopaedic surgical services in Brunswick County. The proposed facility is necessary to support this increasing demand in an efficient, cost effective manner.

The proposed ASC will be designed for and committed to delivering high-quality surgical services to ensure a superior patient experience and clinical outcome. The proposed location in Leland is geographically accessible, and will provide equitable access to all residents of Brunswick County. Based on my experience and feedback from my patients, the proposed BSC ASC in Brunswick County will be embraced and well utilized by service area residents.

Based on my historical experience performing outpatient surgery on Brunswick County residents, I anticipate performing approximately 17 surgical cases at BSC in year one of the project and that this number will gradually increase thereafter.

Sincerely,

Scott Q. Hannum, M.D.
EmergeOrtho

EmergeOrtho.com

2716 Ashton Drive
Wilmington, NC 28412
TEL: 910.332.3800
TOLL FREE: 800.800.3305
FAX: 910.251.0421

November 7, 2016

Ms. Martha Frisone
Assistant Chief, Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
2704 Mail Center Service
Raleigh, NC 27699-2704

Dear Ms. Frisone:

I am writing to express my support for the CON application filed by Brunswick Surgery Center, LLC (BSC). I am a board-certified Orthopaedic Surgeon who treats many patients from Brunswick County and surrounding communities. I am excited to have the opportunity to participate in the development of the first ambulatory surgery center in Brunswick County. As the vast majority of my surgical patients are outpatients, I am confident that the proposed project will help patients receive cost effective care in a facility dedicated to ambulatory surgery and more conducive to quality outcomes.

As the local population continues to rapidly increase and age, and as technological advances and payor trends drive services to outpatient settings, it is evident that there will continue to be a growing demand for outpatient orthopaedic surgical services in Brunswick County. The proposed facility is necessary to support this increasing demand in an efficient, cost effective manner.

The proposed ASC will be designed for and committed to delivering high-quality surgical services to ensure a superior patient experience and clinical outcome. The proposed location in Leland is geographically accessible, and will provide equitable access to all residents of Brunswick County. Based on my experience and feedback from my patients, the proposed BSC ASC in Brunswick County will be embraced and well utilized by service area residents.

Based on my historical experience performing outpatient surgery on Brunswick County residents, I anticipate performing approximately 63 surgical cases at BSC in year one of the project and that this number will gradually increase thereafter.

Sincerely,

Richard S. Bahner, M.D.
EmergeOrtho

EmergeOrtho.com

2716 Ashton Drive
Wilmington, NC 28412
TEL: 910.332.3800
TOLL FREE: 800.800.3305
FAX: 910.251.0421

November 7, 2016

Ms. Martha Frisone
Assistant Chief, Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
2704 Mail Center Service
Raleigh, NC 27699-2704

Dear Ms. Frisone:

I am writing to express my support for the CON application filed by Brunswick Surgery Center, LLC (BSC). I am a board-certified Orthopaedic Surgeon who treats many patients from Brunswick County and surrounding communities. I am excited to have the opportunity to participate in the development of the first ambulatory surgery center in Brunswick County. As a portion of my surgical patients are outpatients, I am confident that the proposed project will help patients receive cost effective care in a facility dedicated to ambulatory surgery and more conducive to quality outcomes.

As the local population continues to rapidly increase and age, and as technological advances and payor trends drive services to outpatient settings, it is evident that there will continue to be a growing demand for outpatient orthopaedic surgical services in Brunswick County. The proposed facility is necessary to support this increasing demand in an efficient, cost effective manner.

The proposed ASC will be designed for and committed to delivering high-quality surgical services to ensure a superior patient experience and clinical outcome. The proposed location in Leland is geographically accessible, and will provide equitable access to all residents of Brunswick County. Based on my experience and feedback from my patients, the proposed BSC ASC in Brunswick County will be embraced and well utilized by service area residents.

Based on my historical experience performing outpatient surgery on Brunswick County residents, I anticipate performing approximately 40 surgical cases at BSC in year one of the project and that this number will gradually increase thereafter.

Sincerely,

D. Todd Rose, M.D.
EmergeOrtho

EmergeOrtho.com

2716 Ashton Drive
Wilmington, NC 28412
TEL: 910.332.3800
TOLL FREE: 800.800.3305
FAX: 910.251.0421

November 7, 2016

Ms. Martha Frisone
Assistant Chief, Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
2704 Mail Center Service
Raleigh, NC 27699-2704

Dear Ms. Frisone:

I am writing to express my support for the CON application filed by Brunswick Surgery Center, LLC (BSC). I am a board-certified Orthopaedic Surgeon who treats patients from Brunswick County and surrounding communities. I am excited to have the opportunity to participate in the development of the first ambulatory surgery center in Brunswick County. As a portion of my surgical patients are outpatients, I am confident that the proposed project will help patients receive cost effective care in a facility dedicated to ambulatory surgery and more conducive to quality outcomes.

As the local population continues to rapidly increase and age, and as technological advances and payor trends drive services to outpatient settings, it is evident that there will continue to be a growing demand for outpatient orthopaedic surgical services in Brunswick County. The proposed facility is necessary to support this increasing demand in an efficient, cost effective manner.

The proposed ASC will be designed for and committed to delivering high-quality surgical services to ensure a superior patient experience and clinical outcome. The proposed location in Leland is geographically accessible, and will provide equitable access to all residents of Brunswick County. Based on my experience and feedback from my patients, the proposed BSC ASC in Brunswick County will be embraced and well utilized by service area residents.

Based on my historical experience performing outpatient surgery on Brunswick County residents, I anticipate performing approximately 12 surgical cases at BSC in year one of the project and that this number will gradually increase thereafter.

Sincerely,

Walter W. Frueh, M.D.
EmergeOrtho

2716 Ashton Drive
Wilmington, NC 28412
TEL: 910.332.3800
TOLL-FREE: 800.800.3305
FAX: 910.251.0421

November 7, 2016

Ms. Martha Frisone
Assistant Chief, Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
2704 Mail Center Service
Raleigh, NC 27699-2704

Dear Ms. Frisone:

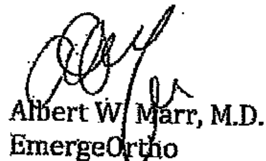
I am writing to express my support for the CON application filed by Brunswick Surgery Center, LLC (BSC). I am a board-certified Orthopaedic Surgeon who treats many patients from Brunswick County and surrounding communities. I am excited to have the opportunity to participate in the development of the first ambulatory surgery center in Brunswick County. As the vast majority of my surgical patients are outpatients, I am confident that the proposed project will help patients receive cost effective care in a facility dedicated to ambulatory surgery and more conducive to quality outcomes.

As the local population continues to rapidly increase and age, and as technological advances and payor trends drive services to outpatient settings, it is evident that there will continue to be a growing demand for outpatient orthopaedic surgical services in Brunswick County. The proposed facility is necessary to support this increasing demand in an efficient, cost effective manner.

The proposed ASC will be designed for and committed to delivering high-quality surgical services to ensure a superior patient experience and clinical outcome. The proposed location in Leland is geographically accessible, and will provide equitable access to all residents of Brunswick County. Based on my experience and feedback from my patients, the proposed BSC ASC in Brunswick County will be embraced and well utilized by service area residents.

Based on my historical experience performing outpatient surgery on Brunswick County residents, I anticipate performing approximately 85 surgical cases at BSC in year one of the project and that this number will gradually increase thereafter.

Sincerely,



Albert W. Marr, M.D.
EmergeOrtho

2716 Ashton Drive
Wilmington, NC 28412
TEL: 910.332.3800
TOLL-FREE: 800.800.3305
FAX: 910.251.0421

November 7, 2016

Ms. Martha Frisone
Assistant Chief, Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
2704 Mail Center Service
Raleigh, NC 27699-2704

Dear Ms. Frisone:

I am writing to express my support for the CON application filed by Brunswick Surgery Center, LLC (BSC). I am a board-certified Orthopaedic Surgeon who treats many patients from Brunswick County and surrounding communities. I am excited to have the opportunity to participate in the development of the first ambulatory surgery center in Brunswick County. As the vast majority of my surgical patients are outpatients, I am confident that the proposed project will help patients receive cost effective care in a facility dedicated to ambulatory surgery and more conducive to quality outcomes.

As the local population continues to rapidly increase and age, and as technological advances and payor trends drive services to outpatient settings, it is evident that there will continue to be a growing demand for outpatient orthopaedic surgical services in Brunswick County. The proposed facility is necessary to support this increasing demand in an efficient, cost effective manner.

The proposed ASC will be designed for and committed to delivering high-quality surgical services to ensure a superior patient experience and clinical outcome. The proposed location in Leland is geographically accessible, and will provide equitable access to all residents of Brunswick County. Based on my experience and feedback from my patients, the proposed BSC ASC in Brunswick County will be embraced and well utilized by service area residents.

Based on my historical experience performing outpatient surgery on Brunswick County residents, I anticipate performing approximately 220 surgical cases at BSC in year one of the project and that this number will gradually increase thereafter.

Sincerely,

Thomas B. Kelso, M.D., PhD
EmergeOrtho

2716 Ashton Drive
Wilmington, NC 28412
TEL: 910.332.3800
TOLL FREE: 800.800.3305
FAX: 910.251.0421

November 7, 2016

Ms. Martha Frisone
Assistant Chief, Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
2704 Mail Center Service
Raleigh, NC 27699-2704

Dear Ms. Frisone:

I am writing to express my support for the CON application filed by Brunswick Ambulatory Surgery Center, LLC (BASC). I am a board-certified Orthopaedic Surgeon who treats patients from Brunswick County and surrounding communities. I am excited to have the opportunity to participate in the development of the first ambulatory surgery center in Brunswick County. As a portion of my surgical patients are outpatient, I am confident that the proposed project will help patients receive cost effective care in a facility dedicated to ambulatory surgery and more conducive to quality outcomes.

As the local population continues to rapidly increase in age, and as technological advances and payor trends drive services to outpatient settings, it is evident that there will continue to be a growing demand for outpatient orthopaedic surgical services in Brunswick County. The proposed facility is necessary to support this increasing demand in an efficient, cost effective manner.

The proposed ASC will be designed for and committed to delivering high-quality surgical services to ensure a superior patient experience and clinical outcome. The proposed location in Leland is geographically accessible, and will provide equitable access to all residents of Brunswick County. Based on my experience and feedback from my patients, the proposed BASC in Brunswick County will be embraced and well utilized by service area residents.

Based on my historical experience performing outpatient surgery on Brunswick County residents, I anticipate performing approximately 12 surgical cases at BASC in year one of the demonstration project and that this number will gradually increase thereafter.

Sincerely,

R. Mark Rodger, M.D.
EmergeOrtho

2716 Ashton Drive
Wilmington, NC 28412
TEL: 910.332.3800
TOLL FREE: 800.800.3305
FAX: 910.251.0421

November 7, 2016

Ms. Martha Frisone
Assistant Chief, Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
2704 Mail Center Service
Raleigh, NC 27699-2704

Dear Ms. Frisone:

I am writing to express my support for the CON application filed by Brunswick Surgery Center, LLC (BSC). I am a board-certified Anesthesiologist who treats many patients from Brunswick County and surrounding communities. I am excited to have the opportunity to participate in the development of the first ambulatory surgery center in Brunswick County. As the vast majority of my patients are outpatients, I am confident that the proposed project will help patients receive cost effective care in a facility dedicated to ambulatory surgery and procedures, and more conducive to quality outcomes.

As the local population continues to rapidly increase and age, and as technological advances and payor trends drive services to outpatient settings, it is evident that there will continue to be a growing demand for outpatient orthopaedic surgical services and procedures in Brunswick County. The proposed facility is necessary to support this increasing demand in an efficient, cost effective manner.

The proposed ASC will be designed for and committed to delivering high-quality surgical and procedural services to ensure a superior patient experience and clinical outcome. The proposed location in Leland is geographically accessible, and will provide equitable access to all residents of Brunswick County. Based on my experience and feedback from my patients, the proposed BSC ASC in Brunswick County will be embraced and well utilized by service area residents.

Based on my historical experience performing outpatient procedures on Brunswick County residents, I anticipate performing approximately 300 procedures at BSC in year one of the project and that this number will gradually increase thereafter.

Sincerely,

David W. Zub, M.D.
EmergeOrtho

EmergeOrtho.com

ATTACHMENT 7

From: Laura Rackley
To: DHSR.SMFP.Petitions-Comments
Cc: Kristy Hubard; Scott Whisnant
Subject: NHRMC Operating Room Methodology Workgroup comments
Date: Tuesday, November 01, 2016 4:34:21 PM

Drs. Ullrich and Greene,

Please see below comments from New Hanover Regional Medical Center regarding the questions posed at the opening meeting on October 11 of the Operating Room Methodology workgroup:

- How should procedure rooms and procedures performed in them be treated? Licensure Application guidelines are not clear on this issue. NHRMC reports procedure room volumes as part of our surgery volumes but given the unclear guidelines expect that not all entities report the same. We fully support the generation of licensure guidelines to allow for data consistency among all reporting entities.
- How are decisions made regarding the use of an operating room or a procedure room? Our organization fully supports the development of guidelines within the licensure application to allow for consistent reporting as this continues to be an ongoing issue.
- Should the methodology's 3/1.5 hour per inpatient/outpatient surgery procedure time or other methodology assumptions be re-considered? With the ever growing shift from Inpatient to Outpatient for more complex cases, we feel this assumption should be reconsidered.
- Interventional radiology procedures are not included in the methodology. Are they in the Truven database? NHRMC reports these procedure on Licensure Renewal Application under section 10d. Other Imaging Equipment – Special Procedures.
- Should the methodology use a tiered system based on the number of ORs or some other factor? What are the case time differences between urban and rural hospitals? In the current licensure application, surgical cases are currently broken down by "Surgical Specialty Area", Inpatient and Outpatient average procedure time by specialty area may be a viable option. We would not suggest utilizing actual OR times for submission as this may result in penalizing facilities that have been successful with OR efficiency (LEAN) efforts.

Laura L Rackley
Manager of Business & Strategic Planning
Business Analysis and Planning
(910) 667-5277