March 30, 2017

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

Re: CON Project ID No. E-11298-17 Blue Ridge HealthCare Surgery Center, Burke County

Dear Ms. Frisone:

I am writing on behalf of Caldwell Memorial Hospital, to provide written comments regarding the above referenced proposal in accordance with N.C. GEN. STAT. § 131E-185(1).

Thank you for your consideration of this information.

Sincerely,

David J. French

Consultant to Caldwell Memorial Hospital

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Caldwell Memorial Hospital Comments Regarding Blue Ridge HealthCare Surgery Center CON Project ID No. E-11298-17

Blue Ridge HealthCare Hospitals and Blue Ridge HealthCare Surgery Center (BRHCSC) have filed a certificate of need application with the North Carolina Department of Health and Human Services to develop a new ambulatory surgery center. The BRHCSC application fails to conform to numerous CON review criteria and regulatory performance standards. Some of the major deficiencies include:

- The application provides patient origin percentages that are inconsistent with historical data and lack reasonable and sufficient assumptions.
- BRHCSC fails to provide credible utilization projections because the ambulatory surgery cases expected to be shifted from the Morganton operating rooms to the proposed project in Valdese far exceed the volumes estimated by the few physician letters; also, no physicians are named who have committed to perform ambulatory surgery for OB/GYN, Ophthalmology, Oral Surgery, Urology and other specialties.
- Blue Ridge HealthCare Hospital's substantial loss of support from surgical specialists undermines its proposal. Too few physicians have committed to utilize the proposed facility. Consequently, the financial projections are based on unsupported volumes.
- The proposed project represents unnecessary duplication of healthcare services, which, if approved, would result in severely underutilized operating rooms.
- Expense projections are not reliable due to unreasonably low salary projections, the omission of pharmacy consulting costs and other uncorroborated expenses.
- Capital costs are unreliable because no additional surgical equipment is budgeted to enable the proposed BRHCSC to serve additional surgical specialties.

- **Start-up and working capital costs are unreasonably projected to be zero even though the proposed project is to be operated as a licensed ambulatory surgical facility that is required to be financially separate from the hospital.**
- **The payor percentages for the proposed facility are not credible because they are based on unsupported volumes of cases, including multiple surgical specialties that have not been historically performed in the Blue Ridge Valdese ORs.**
- **The projected payor percentages for the project are unreliable because they are inconsistent with the 2017 Blue Ridge HealthCare data and resulting payor percentages; the applicants do not disclose their internal data and assumptions.**
- **No facility plans are provided to demonstrate how it is possible to physically separate the proposed project from the hospital.**
- **The project capital costs are unreliable because the application provides no discussion of how the building systems (mechanical, electrical and life safety) can be modified and upgraded to meet the licensure requirements for an ambulatory surgical facility.**
- **The application fails to comply with the regulatory performance standards for operating rooms and GI endoscopy procedure rooms due to the multiple flaws in the methodology and assumptions.**

Caldwell Memorial Hospital provides comments and documentation regarding how the BRHCSC application does not conform to specific CON criteria and regulatory standards as follows:

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 BRHCSC application fails to conform to Criterion 3 because the projected patient origin percentages are inconsistent and the projected utilization for the proposed services are not based on reasonable, credible and supported assumptions.

The BRHCSC application fails to adequately identify the population to be served because the patient origin assumptions are speculative and inconsistent. The application also fails respond to Question III.7 that asks for the current patient origin data for ambulatory surgery and GI endoscopy patients for the existing general acute care hospital. The omission of this data is critical because page 70 of the application states, "BRHCSC expects the patient origin of the Blue Ridge Surgery Center baseline projected utilization for surgical and GI endoscopy cases to closely match the historical patient origin for the outpatient cases performed at Blue Ridge Valdese and Blue Ridge Morganton, respectively. The following table shows the comparison of the Blue Ridge HealthCare 2017 License Renewal Application (LRA) patient origin to the proposed project:

Table 1

Comparison of the Current Ambulatory Surgery Patient Origin at BRHC and the Projected Patient Origin

	BRHC Actual								BRHC Actual to BRHCSC	
	2017 LRA				BRHCSC Projected				% Variances	
	Pts	%		YR 1	%	YR 2	%		YR 1	YR 2
Burke	2158	56.94%		2488	56.40%	2655	57.17%		-0.53%	0.23%
Caldwell	662	17.47%		616	13.97%	637	13.72%		-3.50%	-3.75%
McDowell	438	11.56%		487	11.04%	504	10.85%		-0.52%	-0.70%
Catawba	215	5.67%		414	9.39%	428	9.22%		3.71%	3.54%
Other	317	8.36%		406	9.20%	420	9.04%		0.84%	0.68%
Totals	3790			4411		4644				

Comparison of the Current GI Endoscopy Patient Origin at BRHC and the Projected Patient Origin

	BRHC Actual								BRHC Actual to BRHCSC	
	2017 LRA				BRHCSC Projected				% Variances	
	Pts	%		YR 1	%	YR 2	%		YR 1	YR 2
Burke	1228	58.87%		1216	62.07%	1344	64.31%		3.20%	5.44%
Caldwell	364	17.45%		317	16.18%	318	15.22%		-1.27%	-2.23%
McDowell	288	13.81%		255	13.02%	256	12.25%		-0.79%	-1.56%
Catawba	116	5.56%		86	4.39%	87	4.16%		-1.17%	-1.40%
Other	90	4.31%		85	4.34%	85	4.07%		0.02%	-0.25%
Totals	2086			1959		2090				

It is not possible to conclusively determine if the applicants relied on the Blue Ridge HealthCare Hospitals' 2017 LRA patient origin data (included in Comments Exhibit A) or some other data source due to the lack of information provided in the application. Therefore the patient origin projections are not based on reasonable assumptions.

As seen in the above comparison table, the ambulatory surgery patient origin for the proposed project shows unexplained variances from the current patient origin percentages that are calculated based on the Blue Ridge HealthCare 2017 LRA :

- **The Year 1 percentage of ambulatory surgery patients is projected to be 56.4 percent which is 0.53 percent less than the historical 56.94 percent and shows no significant "ramp-up" for Burke percentages in Year 2.**

These projections for ambulatory surgery patients are inconsistent with the application's narrative assumptions.

- The table shows that the number of Caldwell ambulatory surgery patients decreases by 3.5 percent in Year 1 and 3.75 percent in Year 2 as compared to historical percentages. Given the proximity of the proposed project to the border of Caldwell County, this change in patient origin is not adequately explained.
- Also the increases in the percentages (3.71 in Year 1 and 3.41 in Year 2) of ambulatory surgery patients from Catawba County are not explained.

In contrast, the comparison table on the previous page does show increased percentages (3.20 percent in Year 1 and 5.44 percent in Year 2) for Burke County GI endoscopy patients as compared to the historical percentage for GI endoscopy patients and decreases in the percentages of patients from Caldwell, McDowell, Catawba and Other Counties. Perhaps these assumptions for increases in Burke patients illustrate the expected "ramp-up" that was discussed in the narrative of the BRHCSC application. However, the inconsistencies between the ambulatory surgery patient origin percentages and the GI endoscopy patient origin percentages are not adequately explained.

As discussed on pages 69 and 70 of the application, the percentages of surgery and endoscopy patients from Burke County are projected to "ramp-up" due to the expected recruitment of a gastroenterologist and an orthopedic surgeon as well as the "repatriation" of ENT patients and other surgical patients. However, these "to-be-recruited" physicians are unnamed and no recruitment had occurred at the time the BRHCSC application was submitted.

It is irrational to expect that patients who have historically left Burke County to obtain ambulatory surgery and GI endoscopy at other facilities will be "repatriated" when there is no evidence that these patients have been held hostage or coerced to utilize other physicians or facilities. The application fails to demonstrate that there is a need for the patient population to be "repatriated."

Blue Ridge HealthCare Hospitals and the proposed BRHCSC have no ownership right of a specific market share or certain numbers of patients; patients will continue to have the right to choose to leave Burke County for their healthcare needs. Competition from existing and approved ambulatory surgical facilities and hospitals in adjoining counties is likely to support high levels of continued outmigration from Burke County because these facilities have competitive advantages over the proposed BRHCSC including larger medical staffs, greater depth of surgical specialties and existing payor agreements. The CON-approved Caldwell Surgery Center is strongly supported by area surgeons and will offer patients new state-of-the-art operating rooms and new surgical equipment, unlike the facility offerings proposed for Valdese.

The concept of "repatriated" ambulatory surgery cases is unreasonable because the medical staff at the Blue Ridge Healthcare Hospitals is rapidly dwindling. As seen in the following table, numerous physicians have left the medical staff and very few physicians have been added. The application fails to demonstrate that physician recruitment is keeping pace with the number of physicians who are no longer willing or able to remain on the medical staff at Blue Ridge Healthcare System.

For the period from 2014 to the current year, the number of surgeons on staff at Blue Ridge Healthcare Hospitals has decreased by 27.7 percent -- shrinking from 47 surgeons in 2014 to 34 surgeons on the current staff. The largest decrease has occurred for orthopedic surgeons as seen in Table 2.

Table 2.

CHS BLUE RIDGE HEALTHCARE MEDICAL STAFF - SURGEONS

	2014	2017	Change	ADDITIONS	DEPARTURES		
Gastroenterology	5	3	-2	None	Deborah Levenson, MD	Duane Moise, MD	
General Surgery	5	5	0	None	None		
Obstetrics-Gynecology	9	7	-2	None	David Kirk, MD	Thomas Pope, MD	
Ophthalmology	12	9	-3	None	William Orrison, MD	Joshua Rhinebolt, MD	Larry Willis, MD
Oral Surgery	1	1	0	None	None		
Orthopedics	11	5	-6	William Bell, MD	Matthew Hannibal	Jeffrey Keverline, MD	Timothy Kirkland, MD
					James Marion, MD	Ralph Maxy, MD	Stephen Sladika, MD
						James Stanislaw, MD	
Otolaryngology	3	2	-1	None	Elzie Hart, MD		
Urology	1	2	1	Richard Rose, MD	None		
Totals	47	34	-13				

Sources: CHS Blue Ridge HealthCare http://www.blueridgehealth.org/physicians.html

Internet Archive https://archive.org/web/

The BRHCSC application does not sufficiently document that there is any connection between the statewide growth in outpatient surgery utilization as described on page 31 of the application and the actual ambulatory surgery volume at the Blue Ridge Healthcare Hospitals. While the total population for North Carolina has increased, the Burke County population has experienced little growth. Over the past five years, the actual surgery utilization of Blue Ridge HealthCare operating rooms has also declined. Outpatient surgical cases show a decrease of 10.3 percent from 4,322 cases in FFY 2011 to 3,877 cases in FFY 2015. The five year trend shows a negative compound annual growth rate as seen in the following table.

Table 3.

Operating Room Utilization		Blue Ridge HealthCare	
		Inpatient	Ambulatory
FFY 2011	2013 SMFP	1,411	4,322
FFY 2012	2014 SMFP	1,161	3,989
FFY 2013	2015 SMFP	1,188	3,551
FFY 2014	2016 SMFP	1,212	3,716
FFY 2015	2017 SMFP	1,148	3,877
CAGR 2011-2015		-5.03%	-2.68%

Source: 2013 to 2017 SMFP

For the same five year period, the only facility in Burke County that has experienced growth in outpatient surgery utilization is Surgery Center of Morganton Eye Physicians which increased from 2,276 cases in FFY 2011 to 2,407 cases in FFY 2015.

The proposed project does not document a genuine commitment or timeline to offer physicians the opportunity to invest in the proposed project. Instead, the application specifically states that Blue Ridge HealthCare Surgery Center, LLC has a single member, Blue Ridge HealthCare Systems Inc. Consequently, the proposed project offers questionable value to recruit new physicians or create

"physician collaboration" because no real ownership offers have yet been extended to any physicians.

The BRHCSC application speculates that the comparatively low ambulatory surgery use rate for the Burke County population might be ameliorated by the proposed project. However, the applicants provide no documentation that <u>any</u> Burke County residents who required outpatient surgical services were unable to obtain those services. Furthermore, the Burke population has access to Viewmont Surgery Center in nearby Catawba County and Surgery Center of Morganton Eye Physicians in Burke County. In addition, Caldwell Surgery Center is CON-approved for development in Caldwell County.

The proposed project in Valdese involves no shift of cases from operating rooms at Blue Ridge Morganton that are utilized at over 100 percent capacity. In the previously-approved Project No. F-10218-13 Randolph Surgery Center, LLC and The Carolinas Medical Center, the applicants projected a shift of ambulatory surgery cases to its proposed new facility from an existing ambulatory surgery center that was operating at 20 percent above its capacity. No such circumstance exists with the BRHCSC proposal because the operating rooms at both the Blue Ridge Morganton and Valdese campuses are currently underutilized. Changing the designation of the ORs in Valdese to an ambulatory surgical facility would not result in any future growth of the population or the ambulatory surgery use rate.

An initial step in the methodology on page 43 of the application is based on the assumption that ambulatory surgery utilization for Blue Ridge Valdese and Blue Ridge Morganton are each expected to increase by 3.3 percent annually. This annual growth assumption is unreasonable because the applicants make other statements regarding expected physician recruitment and "repatriated cases" to project further growth over and above the 3.3 percent annual increases. The 3.3 percent annual growth projection is inconsistent with the historical trend for the period from FFY 2011 to FFY 2015 with a five year CAGR of -2.86 percent that is shown in Table 2.

Even the applicants admit that this 3.3% annual growth assumption and resulting projections of "potential outpatient surgery utilization" are unreliable because the application states, *"Please note that the potential cases by facility and the interim years' utilization (CY 2017 and 2018) have only been projected in order to demonstrate the potential volume to be served at Blue Ridge Surgery Center, once it begins operation in CY 2019. These projections are not intended to be used as interim or project year projections for CHS Blue Ridge-Valdese and CHC Blue Ridge-Morganton."*

The BRHSSC methodology and assumptions are unbelievable to project that 80 percent of the potential ambulatory surgery cases will be shifted from the Blue Ridge Morganton ORs to the proposed BRHCSC for multiple reasons:

1. **Blue Ridge Morganton recently completed a 42,000 S.F. renovation and expansion to develop a replacement surgery department with four shared operating rooms and one dedicated inpatient operating room. At the time it secured the exemption for this project, Blue Ridge estimated the project cost would exceed $26 million. It is implausible for the applicants to forecast that <u>80 percent of all ambulatory surgery cases</u> would shift from these "state-of-the-art" operating rooms in Morganton to the older and less spacious operating rooms at Blue Ridge Valdese (that were last renovated approximately 10 years ago).**
2. **Physician support letters are not sufficient to support the utilization projections. Exhibit 25 includes only four letters of support from physicians that include letters from one gastroenterologist, one otolaryngologist, one general surgeon and one orthopedic surgeon.**
3. **Blue Ridge HealthCare officials have previously testified that the hospital has made substantial investments in spine surgery equipment for the operating rooms at CHS Blue Ridge-Morganton. The application makes no representations that this equipment will be transferred to the proposed project in Valdese to enable the surgeons to perform ambulatory spine cases. Also, there is no evidence that ophthalmology equipment is**

available at Blue Ridge Valdese because no eye surgery cases have been reported at this facility location in recent years. Therefore the projected shift of 80 percent of these spine and ophthalmology cases has no merit.

4. Surgical specialties that are largely omitted from the BRHCSC application narrative and physician support letters include OB/GYN, Ophthalmology, Oral Surgery, Urology and Other. As seen in the attached 2017 Blue Ridge HealthCare LRA, the surgical specialties of OB/GYN, Ophthalmology, Oral Surgery, Urology and Other specialties totaled 948 ambulatory surgery cases or 42.95% percent of the total ambulatory cases for the existing ORs at Morganton. No surgeons practicing in these specialties have documented their willingness to shift any ambulatory surgery cases to the proposed project.

The four physician support letters in Exhibit 25 are not sufficient documentation to support the validity of the utilization projections. These few physicians who wrote letters of support do not have the authority or sufficient knowledge to make reliable projections for all other surgeons and other surgical specialties. Therefore the applicants' projections for the expected shift of 80 percent of all ambulatory cases from Blue Ridge-Morganton are entirely speculative. CON findings on previous projects involving operating rooms typically include an analysis of the physicians support letters to determine the reasonableness of the utilization projection as follows:

- Findings for Project ID No. E-11105-15, Caldwell Surgery Center (3 ORs) included the reference to the 18 physicians named in the CON narrative and the corresponding physician letters with volume projections in the Exhibits.
- Findings for Project ID No. F-10218-13, Randolph Surgery Center (2 ORs) included reference to "support letters from 25 ENT surgeons and 13 eye surgeons."
- Findings for Project ID No. J-8815-12, WakeMed (2 ORs) included reference to "letters of support from 21 physicians and surgeons."

Based on the much higher levels of support from physicians as documented in previous CON applications and findings, the BRHCSC proposal falls far short.

The BRHCSC application describes how it expects that future recruitment of an ENT physician will somehow "repatriate" ENT patients who have left Burke County to obtain surgical procedures. Given the fact that patients living in Burke County have every right to choose to utilize a physician or a facility in another county, the use of the term "repatriate" by the applicants is preposterous. Also, the speculative volume projections for other physicians to be recruited cannot offset the unbelievable projection that all surgeons performing cases at Blue Ridge-Morganton are willing to shift 80 percent of their ambulatory cases to the proposed project in Valdese.

While the BRHCSC application states that it will provide additional physician support letters to augment its proposal, a CON applicant may not amend its application after it has been filed and deemed complete. (See Presbyterian–Orthopaedic Hosp. v. N.C. Dept. of Human Res., 122 N.C. App. 529, 537, 470 S.E.2d 831, 836 (1996); 10A N.C.A.C. 14C.0204.) Any CON letters of support for the proposed BRHCSC project submitted after the CON due date by physicians who are not already named in the BRHCSC application should be interpreted as an improper amendment to the application. Letters not included in the application cannot be used to demonstrate the reasonableness of the BRHCSC utilization projections or the BRHCSC assumptions for purposes of showing conformity with any of the statutory or regulatory Review Criteria.

The analysis and projections for the ambulatory surgery use rates for Burke County residents on pages 50 to 52 of the BRHCSC application are illogical; the statewide trend shows a decline in the ambulatory surgery use rate at a time when the population is growing and aging. In addition, more ambulatory surgical centers have been developed so patients have greater access to these new facilities. Cleveland County is one of the counties listed in the table on page 51 of the application; the availability of Cleveland Ambulatory Services (whose

parent company is CHS) has failed to boost the ambulatory surgery use rate for the Cleveland County population. In fact, this facility with four operating rooms is listed in the 2017 SMFP as an underutilized facility. Therefore the statewide trend and the specific utilization of an ambulatory surgical facility in a similar county actually disprove BRHCSC's assertion regarding the projected increase in the ambulatory surgery use rate.

Page 52 of the application also provides the implausible depiction of the "Projected Baseline & EmergeOrtho Outpatient Surgery Use Rate for Burke County Residents." These projections are unreasonable and unsupported because the application does not explain why the baseline ambulatory surgery use rate will increase <u>prior</u> to the development of the proposed project and <u>prior</u> to the arrival of the unnamed physicians that the applicants might recruit. In other words, there is no basis for the ambulatory surgery use rate to increase during the intervening years.

It also does not make sense that the projected EmergeOrtho incremental surgery utilization included in the table on page 52 should be in addition to the baseline use rate projections. Since no physician has been recruited, the projected utilization is unsupported. Furthermore the applicants' "conservative" assumption that 100 percent of the incremental EmergeOrtho patients would be from Burke County has no factual basis. It is entirely unrealistic for a potential newly-recruited surgeon to serve only patients from a single county.

Pages 52 to 55 of the application provide an alternate methodology that is based on a series of improbable assumptions:

- **7.6 percent annual growth for CHS-Blue Ridge Valdese**
- **plus the 80 percent shift of the projected CHS-Blue Ridge Morganton ambulatory surgery cases**
- **plus the incremental cases from the recruited orthopedic surgeon**
- **plus "repatriated" ENT and other ambulatory cases**

These assumptions are improbable because:

- The future years' 7.6 percent annual growth for CHS-Blue Ridge Valdese is unreliable because there is no documentation of newly-recruited surgeons or new surgical specialties for the current and intervening years prior to the start of operation.
- The application fails to provide adequate documentation from the majority of physicians at Blue Ridge Morganton to indicate their willingness to shift cases to the proposed facility.
- Incremental cases attributed to an unnamed "to-be-recruited" orthopedic surgeon are highly speculative because surgeons are free to choose where they perform their surgery cases.
- The concept of "repatriated" surgical cases is nonsense because these are patients who have already had their surgery done outside of Burke County and all future patients from Burke County are free to choose to utilize physicians and facilities outside of Burke County.

The methodology and assumptions regarding the GI endoscopy cases that are provided on pages 55 to 63 are unreasonable for multiple reasons:

- While the GI endoscopy cases at Blue Ridge Morganton show a consistent trend of decreasing utilization, the application assumes (on page 57) that the utilization will remain constant. This is unrealistic because two gastroenterologists recently left the medical staff as discussed on page 59 of the application.
- The projected 80 percent shift of the projected Blue Ridge Morganton endoscopy cases is not adequately supported because patients living near Morganton can choose to utilize the existing Carolina Digestive Care practice.
- The GI endoscopy use rate that is depicted on page 62 is misleading because this data only reflects the cases performed in licensed GI procedure rooms and excludes the cases performed in physician offices.

- The application does not sufficiently document that there is any connection between the statewide growth in GI endoscopy utilization as described on pages 62 and 63 of the application and the use rate for Burke County due to the loss of gastroenterologists as discussed on page 59. Even if one additional gastroenterologist is recruited, this does not make up for the recent loss of the two gastroenterologists.

In addition to the many deficiencies related to Criterion 3, the application does not adequately address the surplus of operating rooms in Burke County. As seen in the 2017 SMFP, Burke County has a surplus of 4.13 operating rooms. The downward trends in ambulatory surgery combined with the surplus of ORs at Blue Ridge Healthcare do not support the applicants' assertion that there is a growing demand or unmet need for an ambulatory surgical facility in Burke County. Given this surplus capacity, it is unreasonable to shift ambulatory surgery cases from Blue Ridge Morganton (where the new surgery suite has just been completed) because it will cause these "state-of-the-art" ORs at the main hospital to be severely underutilized leading to loss of productivity and higher operating costs. If Blue Ridge Morganton actually experienced a reduction of fully 80 percent of its total ambulatory surgery cases, this would result in a severe loss of revenue, staff reductions in surgery, and diminished utilization of the hospital's imaging and laboratory services.

Projecting such a dramatic shift of the vast majority of ambulatory cases out of the Blue Ridge Morganton operating rooms just after the completion of a multi-million dollar surgery suite renovation is unreasonable and unsupportable. These projections assume – with very limited physician support – that a highly unlikely shift of 80 percent of ambulatory cases can be expected to occur from the newly-updated operating rooms at Morganton to the older, smaller operating rooms in a less convenient location in Valdese.

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 BRHCSC proposal is nonconforming to Criterion 3a because the application provides incomplete utilization information. The applicants proposed the elimination of hospital-based surgical services in the hospital-licensed operating rooms at the Blue Ridge Valdese campus; this would result in an overall reduction in the total number of Blue Ridge HealthCare Hospitals' licensed operating rooms and GI endoscopy rooms. However, the project application provides no utilization projections for the remaining hospital-licensed operating rooms and procedure room at Blue Ridge Morganton to demonstrate that the facility would have adequate capacity to meet the need for surgical and GI endoscopy services for the population following the development of the proposed ambulatory surgical facility.

Page 25 of the application states one existing GI endoscopy procedure room at Blue Ridge Morganton will be converted to a procedure room that will be utilized for multiple specialties, including GI endoscopy. This so-called "relabeling" of the procedure room will reduce the inventory of GI endoscopy rooms in the service area which makes Criterion 3a applicable to the proposed project. However, the utilization projections for the multi-specialty procedure room are entirely omitted from the application. The applicant fails to address how the needs of the population presently served will be met adequately by this proposed reduction. The application fails to address how the reduction will affect 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.

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 BRHCSC application is nonconforming to Criterion 4 because it is not an effective alternative and it fails to conform to Criteria 3 and 3a. As discussed in the Criterion 3 comments, the utilization projections for the proposed project are unreasonable because the expected shift of cases from Blue Ridge Morganton are grossly overstated. The vast majority of physicians practicing in Burke County provided no support letters in the application. Therefore the proposed project is not an effective alternative.

The proposed location is not an effective alternative because the Valdese population of less than 5,000 persons is not of sufficient size to support the proposed facility or attract and maintain a sufficient number of physicians.

There are no freestanding ambulatory surgical centers in North Carolina that are located in municipalities of less than 5,000 persons such as proposed by BRHCSC. North Carolina has only two multispecialty ambulatory surgical facilities that are located in counties with less than 90,000 populations.

County	County 2015 Population	Municipality	Municipality 2015 Population	Facility	# Operating Rooms	2016 Surgery Cases
Wilson County	81,689	Wilson	46,357	Eastern Regional Surgical Center	4	1,374
Carteret County	69,826	Morehead City	9,462	The Surgical Center of Morehead City	2	1,985

Sources: North Carolina Office of State Budget and Management 2015 Certified Estimates
https://ncosbm.s3.amazonaws.com/s3fs-public/demog/muniestbycounty_2015.html
https://ncosbm.s3.amazonaws.com/s3fs-public/demog/muniestbymuni_2015.html
2017 License Renewal Applications

Eastern Regional Surgical Center is located in a Wilson with a 2015 municipal population of over 46,000 persons. With a medical staff of 30 physicians, the four operating rooms at the facility are severely underutilized.

The Surgical Center of Morehead City is located in a port city with a population of 9,462. With a total of 24 physicians on staff, the two operating rooms at the facility are utilized at approximately 80 percent of capacity.

The BRHCSC application fails to adequately document that the proposed location is an effective alternative due to the small size of the population combined with the very limited number of physician support letters.

In addition, the proposed project location in Valdese is 12 miles distant from Morganton, the largest municipality in Burke County where the majority of surgeons have established their primary office locations. The following table shows that the populations of both Morganton and Valdese have declined over the period from 2010 to 2015.

Table 4.

July 2015 Municipal Estimates by County and State Populations for Reference

Geographic Area				Growth	
County	Municipality	Apr-10	Jul-15	Amount	Percent
Burke		90,914	89,114	-1,800	-1.02
	Connelly Springs	1,669	1,639	-30	-1.8
	Drexel	1,858	1,842	-16	-0.86
	Glen Alpine	1,517	1,535	18	1.19
	Hickory(Part)	66	66	0	0
	Hildebran	2,023	1,978	-45	-2.22
	Long View(Part)	752	738	-14	-1.86
	Morganton	16,918	16,716	-202	-1.19
	Rhodhiss(Part)	700	723	23	3.29
	Rutherford College	1,341	1,368	27	2.01
	Valdese	4,490	4,442	-48	-1.07

Source: www.osbm.nc.gov/demog/municipal-estimates
Accessed March 7, 2017

The applicants do not sufficiently explain how the proposed location in Valdese would be convenient or accessible to patients and physicians from Morganton and western Burke County.

The proposed project is not an effective alternative because the facility plan provided in Exhibit 6 shows the entire existing outpatient building with no separation of the proposed ambulatory surgical facility from the hospital outpatient services that include imaging /radiology, the lab and the emergency department. While the application narrative states that minor renovations are required to provide firewall separation from the hospital-based services, this is not possible because the facility plans for the surgery suite show that the existing staff locker rooms and other spaces that are required by licensure standards share a common corridor with the hospital-based Imaging Center. The plan shows no separation of the reception and waiting areas that are supposed to be dedicated solely for the proposed ambulatory surgical facility. Lacking a

facility plan that shows the actual scope of work and where firewalls and the dedicated waiting and reception area are proposed to be constructed, the cost estimate in Exhibit 24 is uncorroborated.

BRHCSC fails to demonstrate that the proposed project is a more cost effective alternative as compared to the existing and approved ambulatory surgical facilities in neighboring counties. Furthermore, page 87 of the application makes the false claim that patients will gain access by physician referral. This statement is inaccurate because the application lacks documentation from any physicians expressing their willingness to perform OB/GYN, Ophthalmology, Oral Surgery, Urology and other surgical specialties.

As explained in the application, ambulatory surgery cases are reimbursed at substantially lower rates as compared to the hospital reimbursement. If one were to accept the premise that 80 percent of the ambulatory surgery utilization could be shifted to the BRHCSC, this would result in a huge loss of revenue to CHS Blue Ridge Healthcare System Inc. However, if the project is actually expected to strengthen the financial position of the Health System, that information and any internal financial analyses have been omitted from the project application. Given the financial magnitude of this project and the radical changes in utilization, the Blue Ridge Healthcare Hospitals would have to dramatically increase patient charges and reduce operational costs, including staffing levels.

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 capital cost estimates for the proposed project are unreliable due to the absence of a facility line drawing and a description of the scope of the proposed renovations to provide physical separation and dedicated waiting and reception

areas. The architect cost estimate in Exhibit 24 includes no square footage figures and includes no assumptions or explanations describing the basis of the projected capital costs. While the narrative of the application describes firewall separation, the architect has failed to document what building modifications are actually required to meet licensure requirements.

The application and the architect letter also fail to address the fact that the mechanical requirements in 10A NCAC 13B .6255 for hospitals are not the same as the mechanical requirements in 10A NCAC 13C .1405 for ambulatory surgical facilities. No contingency amounts are budgeted for the modifications and upgrades to the mechanical and electrical systems to make the proposed ambulatory surgical facility operationally separate from the existing hospital outpatient departments. It is unlikely that the capital budget is adequate for the proposed project to meet the life safety and accreditation standards with such a slapdash renovation plan of simply installing firewalls and not addressing the critical building systems.

As seen in the Criterion 3 comments, the BRHCSC utilization projections are not reasonable and adequately supported. Therefore, because the projected revenues and expenses are based on unreasonable utilization, the financial projections are also unreasonable. Additional errors and omissions in the financial statements include:

- Understated salaries, as seen on page 92 of the application, that are mistakenly based on outdated salary rates with no adjustments for inflation in future years.
- The omission of expenses for a contract pharmacist because the income statement shows no expense for contract labor or purchased services.
- The omission of any depreciation expenses for any new surgical equipment or instruments purchased by the lessee during the first three years of operation.

The BRHCSC application fails to adequately explain how the proposed project is financially separate from the hospital services based on the responses in Section IX of the application. The application states that there will be no start-up costs or working capital needs because the revenues from the hospital-based surgery will be utilized to support the project during the start-up period. This intermingling of revenues to subsidize the ambulatory surgery center shows that no actual financial separation will occur with the development of the proposed project. Furthermore, if physician ownership does occur, the hospital's funding of the start-up and working capital (instead of a loan or capital call from all members) could be viewed as a form of private inurement to induce the newly recruited physician members to refer patients.

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 BRHCSC application is nonconforming to Criterion 6 because the need for the proposed project is not adequately demonstrated; therefore the project represents unnecessary duplication of services. As discussed in the Criterion 3 comments, the BRHCSC utilization projections are based on multiple unreasonable assumptions including the unsubstantiated shift of 80 percent of the ambulatory surgery cases from Blue Ridge Morganton. The application lacks any documentation of support from the vast majority of physicians in Burke County.

Patients and surgeons in Morganton have convenient access to a state-of-the-art surgery department with spacious operating rooms and advanced technology. In contrast, the Valdese proposal would recycle an outdate facility with the minimum investment in the building and no new surgical equipment. Blue Ridge Morganton recently completed the construction of a new surgery department with spacious operating rooms equipped with advanced technology.

"These new ORs are the biggest advances Burke County has ever seen in the area of surgical medicine," said Chris Hanger, MD, chief of anesthesia. "I'm excited. It's going to be fun. The patients and surgeons are going to love it."

The newspaper article in Comments Exhibit C underscores the fact that Blue Ridge's goal of modernizing surgical capacity in Morganton will continue with additional renovations for "converting old space into new outpatient prep and recovery rooms." Such a large investment in surgical services at Blue Ridge Morganton is entirely inconsistent with the applicants' assumption that 80 percent of the ambulatory surgery cases will be shifted to the proposed project in Valdese.

It just does not make sense for surgeons with offices in Morganton to shift 80 percent of their ambulatory cases to the proposed facility in Valdese because it is not productive for surgeons to drive to and from Valdese. Even though the proposal would not increase the inventory of operating rooms, the need for a separately licensed ambulatory surgical facility in Valdese is not adequately demonstrated. Since the utilization projections are unreasonable, the BRHCSC proposal represents unnecessary duplication of services.

The BRHCSC application is nonconforming to Criterion 6 because the proposal represents unnecessary duplication of healthcare services. As seen in the 2017 SMFP, Burke County has a surplus of 4.13 operating rooms. Given this surplus capacity, it is unreasonable to shift ambulatory surgery cases from CHS-Blue Ridge Morganton (where the new surgery suite has just been completed) because it will cause these "state-of-the-art" ORs to be underutilized. This underutilization will lead to productivity loss, staff reductions and higher operating costs. The proposed project, if approved, would also not improve access for the medically underserved population of the service area because:

- The project could potentially shift some ambulatory surgery volumes (based on letters from three surgeons and one gastroenterologist) from Morganton to Valdese causing the operating rooms at Blue Ridge Morganton to be less productive and more costly, and thereby contributing to staff reductions and future increases in patient charges.
- Any surgeons who may choose to drive to and from Valdese will be less productive and less available to their patients due to their increased driving times.
- The development of the ambulatory surgical facility in Valdese would not improve access for the majority of low income persons. The U.S. Census 2014 American Community Survey that was released in late 2015 shows that Morganton, which is the Burke County seat and has the largest population, has the most residents living in poverty at 4,437. [1]

The BRHCSC application does not analyze the availability capacity, utilization and surplus of operating rooms in the secondary service area (Catawba, Caldwell and McDowell Counties) even though the assumptions in the methodology involve redirecting ("repatriating") patients that would have otherwise utilized existing and approved facilities in these other counties. The following projections show that the proposed project includes large numbers of ambulatory surgery patients from adjoining counties:

Table 5.

	Year 1	Year 2	% Increase
Caldwell	616	637	3.41%
McDowell	487	504	3.49%
Catawba	414	428	3.38%
Other	406	420	3.45%
Combined Totals	1,923	1,989	3.43%

Source: BRHCSC CON application page 58

[1] "Poverty rates increase in Burke County; children affected at higher rates" The News Herald, February 6, 2016

These projections are unreliable and inconsistent because the application contains no support letters from physicians or other healthcare providers located in these other counties. The few physician letters of support contained in Exhibit 24 make no mention of serving increased numbers of ambulatory surgery patients from Caldwell, McDowell and Catawba Counties. Furthermore, pages 46, 47 and 52 of the BRHCSC application discuss the planned recruitment of physicians and the supposed "repatriation" of Burke County patients that would otherwise go to facilities in other counties.

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 the applicants omit the consulting pharmacist position and fail to provide salary projections that are based on reasonable assumptions.

No consulting rates or contract hours are provided in the staffing table on page 92 for the consulting contract pharmacist position that is described on page 15 and in Exhibit 7. In addition, the absence of budgeted expenses in the financial pro forma for the contract pharmacist services demonstrates a further lack of adequate resources for the proposed project.

Page 92 of the application provides the staffing and salary projections for the second full fiscal year (1/1/2020 to 12/31/2020) following completion of the project with 21 full time registered nurse positions shown to have an annual salary of $58,533. This salary projection is unreasonable because the Bureau of Labor Statistics reports that the yearly mean salary of a registered nurse in North Carolina in 2015 was $60,460 as seen in Comments Exhibit B. Because the estimated RN salary for Year 2020 is less than the 2015 mean RN salary, the

application fails to demonstrate adequate resources to fill these essential positions. The application provides no narrative to explain why it would be reasonable to expect to attract RN personnel in 2020 with projected salaries that are lower than the 2015 yearly mean salary. This lack of explanation suggests that the application erroneously included outdated salary projections for its proposed staff. As a result, the applicant's projections for the financial feasibility of its project are not based upon "reasonable projections of costs" as required to demonstrate conformity with Criterion 5.

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 BRHCSC fails to document the availability of pharmacy consulting services and the physician letters of support do not adequately demonstrate that the proposed project will be coordinated with the health system.

In Section II, page 16, the applicants state that the proposed project will obtain contract pharmacy services from Bruce Cannon as documented in Exhibit 7. This is inconsistent with the staffing table on page 92 of Section VII which has no listing for a contract pharmacist. Furthermore, the financial pro forma omits any expenses for contract pharmacy services. Due to the omissions in the staffing table and financial pro forma related to the pharmacy contract services, the application fails to adequately demonstrate that the proposed project will be coordinated with the health system.

Exhibit 25 of the application provides letters of support with utilization projections from only three surgeons and one gastroenterologist stating their support for the proposed project. These four physician support letters do not

sufficiently demonstrate that the projected utilization for the proposed project is based on reasonable and credible assumptions. There are no letters of support from any ophthalmologists, obstetrician-gynecologists, oral surgeons or urologists. Consequently, the application fails to effectively show that the proposed project will be coordinated with the health system for all of the ambulatory surgical specialties. While physicians may submit letters during the public comment period, the application cannot be amended with information contained in any letters or materials received during the written comment period. Any physician letters submitted during the comment period cannot be used to demonstrate conformity with the statutory or regulatory Review Criteria.

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 the omission of drawings that actually depict the scope of the project and show the physical separation of the proposed ambulatory surgical facility from the hospital services.

Facility plans in Exhibit 6 that are labeled "Carolinas Healthcare System Blue Ridge Valdese Lobby Level" are simply a schematic plan of the existing hospital and do not in any way depict the scope of renovations; therefore it is impossible to evaluate the capital cost. The facility plan shows the entire existing outpatient building with no separation of the proposed ambulatory surgical facility from the hospital outpatient services that include imaging /radiology, lab and emergency department. While the application narrative states that minor renovations are required to provide firewall separation from the hospital-based services, this is not possible because the facility plans for the surgery suite show that the

existing staff locker rooms and other spaces (that are required by licensure standards) share a common corridor with the hospital-based Imaging Center. No separation of the reception and waiting area is illustrated. The facility plans fail to show how the Radiology / Imaging Center, Laboratory and Emergency Department can be isolated from the proposed ambulatory surgical facility due to shared corridors. BRHCSC fails to describe how it would be feasible to install firewalls or renovate the building to isolate the stairwells that are located adjacent to the space that is labeled "Registration and Check In." Furthermore, there is no documentation that the proposed project is feasible without major modifications to the existing stairwells, corridors and entrances that serve the hospital departments.

Lacking a facility plan that shows the actual scope of work, the capital cost estimate in Exhibit 24 is not based on reasonable assumptions. Furthermore, there is no documentation that the proposed project can be physically separate and modified to meet the ambulatory surgical facility licensure requirements for the mechanical systems that are specific to licensed ambulatory surgical facilities. Also, the application lacks adequate documentation from a licensed architect that the proposed ambulatory surgical facility will have life safety and emergency power systems that are required for newly licensed facilities in accordance with 10A NCAC 13C .1400. The architect letter in Exhibit 24 provides no description of how the project can be planned and developed without disrupting the operations of the adjoining hospital departments in conformance with the hospital licensure rules and life safety requirements.

The application includes no capital costs or deprecation expenses for the purchase of any additional surgery equipment to accommodate the projected shift of 80 percent of all types of ambulatory surgery cases from the Morganton ORs. Historically, the types of ambulatory surgery procedures performed at Blue Ridge Morganton are substantially different from the types of cases performed at Blue Ridge Valdese. According to the 2017 Blue Ridge Healthcare LRA , no OB/GYN, Ophthalmology or Oral Surgery cases have been performed in the

Valdese ORs. Also, according to the deposition testimony of Jon Mercer, the spine surgery equipment is solely located at the Blue Ridge Morganton campus. The proposed project is not based on reasonable capital cost projections because the operating rooms at Valdese lack the specialized surgical equipment for multiple specialties. Also, the application unrealistically expects that <u>none</u> of the existing surgical equipment will require replacement by 2019 to 2021 and that no new surgical equipment will be necessary to accommodate future physician recruitment.

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."

Pages 89 to 92 show that the proposed payor mix for BRHCSC is unreasonably assumed to be identical to the historical 2016 utilization of Blue Ridge Valdese. This assumption is incorrect because the applicants' methodology assumes that thousands of ambulatory surgery cases would be shifted from Blue Ridge Morganton, which includes different surgical specialties as compared to that of Blue Ridge Valdese. If one assumes that the proposed project will be utilized by ambulatory surgery patients that would otherwise have utilized both Blue Ridge Morganton and Valdese, then the ambulatory surgery payor mix that is reported in the 2017 Blue Ridge LRA would represent the combination of all ambulatory

surgery patients. The following table provides a side-by-side comparison of the ambulatory surgery payor percentages from the Blue Ridge HealthCare 2017 LRA and the projected percentages for the proposed project:

Table 6.

2017 LRA CHS-Blue Ridge HealthCare (Combined)				BRHCSC - Page 90
Payor	Cases	% Cases of Total		% Cases of Total
Medicare	1,664	41.0%		32.7%
Medicaid	620	15.3%		23.0%
Managed	1,443	35.5%		35.7%
Other	167	4.1%		5.2%
Self Pay / Charity	166	4.1%		3.3%
Totals	4,060	100.0%		99.9%

As seen in the table, the proposed project is projected to serve a lower percentage of Medicare patients and a higher percentage of Medicaid patients as compared to the 2017 Blue Ridge LRA percentages for ambulatory surgery. The reason that the BRHCSC percentages do not add to 100 percent is probably due to computer rounding. There is no explanation provided in the application regarding the inconsistency between the projected payor mix and the historical payor mix because page 90 of the application simply states "Projected payor mix is based on the historical payor mix for the cases and procedures to be served at Blue Ridge Surgery Center based on CHS-Blue Ridge internal data." The application is not based on reasonable assumptions due to the omission of the Blue Ridge internal data that is supposedly the basis for the projected payor percentages. The application neither provides the data it footnotes nor explains why the projections are inconsistent with available LRA data.

The proposed ambulatory surgical facility in Valdese would not improve access for the large segment of low income persons who live in Morganton, the largest municipality in the County. The U.S. Census 2014 American Community Survey

that was released in late 2015 shows that Morganton has the most residents living in poverty at 4,437 persons as seen in the newspaper article in Comments Exhibit D.

For these reasons, the applicants do not adequately demonstrate that medically underserved populations will have adequate access to the proposed services at BRHCSC. Therefore, the application is nonconforming to Criterion 13(c).

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 or have a positive impact on cost effectiveness, quality and access to services.

As discussed in the comments regarding Criteria 3 and 5 the proposed BRHCSC facility is not needed and it is not financially feasible due, in part, to the unreasonable utilization projections. The Criteria 4 and 12 comments explain why the facility plan is deficient and unworkable. As discussed in the comments regarding Criterion 13(c), the proposed project fails to demonstrate that it will improve access for the medically underserved population. In addition, the proposal is not an effective project to improve patient access because only four physicians practicing in Burke County have documented their willingness to perform surgery at the proposed facility. For these reasons, the project application is nonconforming to Criterion 18(a).

In addition to inconsistencies, omissions and other deficiencies that cause nonconformity to the CON review criteria, BRHCSC fails to conform to the regulatory criteria for:

10A NCAC 14C.2103 (b) Performance Standards.

The projected utilization and methodology for the operating rooms outlined in Section III. (b) are inaccurate and overstated due to flaws in the methodology as discussed in the Criterion 3 comments. It is unreasonable to project increased ambulatory surgery utilization and a shift of thousands of ambulatory surgery cases to the proposed project because the Burke County population is decreasing, the number of surgeons on the medical staff are rapidly declining, and too few physicians have documented their support for the project.

10A NCAC 14C.2103 (f) Performance Standards.

The operating room assumptions and methodology are not adequately supported due to:

- Inconsistent patient origin projections
- Unreasonable 3.3 annual percent growth rate projection that is contrary to the historical growth rate
- Unbelievable projection that 80 percent of all ambulatory cases will shift to the proposed project from the "state-of-the-art" ORs at CHS Blue Ridge-Morganton
- Implausible projections that ambulatory surgery patients will be "repatriated" back to Burke County based on anticipated physician recruitment that would not make up for the 27.7 percent decrease in the numbers of gastroenterologists and surgeons who have left the BRHC medical staff since 2014
- Absence of utilization projections for the remaining operating rooms at Blue Ridge Morganton

- **Insufficient documentation of physician support**

10A NCAC 14C.3903 (b) Performance Standards.

The projected utilization and methodology for the operating rooms outlined in Section III.(b) are inaccurate and overstated due to flaws in the methodology as discussed in the Criterion 3 comments.

10A NCAC 14C.3903 (e) Performance Standards.

The GI endoscopy procedure room assumptions and methodology are not adequately supported due to:

- **Unreasonable projections that ignore the trend of decreasing utilization at the Blue Ridge Morganton GI endoscopy rooms resulting from the departure of two gastroenterologists**
- **Improbable projection of an 80 percent shift of GI endoscopy from Blue Ridge Morganton to the proposed project**
- **Insufficient documentation that there is any connection between the statewide growth in GI endoscopy utilization and the expected use rate for Burke County**
- **Insufficient documentation of physician support for the facility.**

In summary, there are numerous deficiencies in the BRHCSC project application that cause the application to be inconsistent with the statutory review criteria and the regulatory performance standards. For all of these reasons, the BRHCSC project application should be denied.

Comments Exhibits

A. Excerpts of 2017 LRA Blue Ridge HealthCare Hospitals, Inc.

B. Bureau of Labor Statistics Registered Nurses May 2015 Annual Mean Wages

C. "Poverty rates increase in Burke County; children affected at higher rates," The News Herald, Feb 6, 2016

D. "Hospital staff welcomes new operating facility," The News Herald, Feb 8, 2017

Comments Exhibit A

REC'D DEC 0 5 2016

North Carolina Department of Health and Human Services
Division of Health Service Regulation
Acute and Home Care Licensure and Certification Section
Regular Mail: 2712 Mail Service Center
Raleigh, North Carolina 27699-2712
Overnight UPS and FedEx only: 1205 Umstead Drive
Raleigh, North Carolina 27603
Telephone: (919) 855-4620 Fax: (919) 715-3073

For Official Use Only
License # H0062 Medicare # **340075**
FID #: 943191
PC 25 Date 12/9/16

License Fee: **$6,062.50**

2017
HOSPITAL LICENSE
RENEWAL APPLICATION

Legal Identity of Applicant: **Blue Ridge HealthCare Hospitals, Inc.**
(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: **Carolinas HealthCare System Blue Ridge**
Other: CMC-Blue Ridge, Valdese Campus
Other:

Facility Mailing Address: 2201 South Sterling St
Morganton, NC 28655

Facility Site Address: 2201 South Sterling St
Morganton, NC 28655
County: Burke
Telephone: (828)580-5000
Fax: (828)580-5509

PAID
0000321530
12-7-16
$6,062.50

Administrator/Director: Kathy C Bailey
Title: President/CEO
(Designated agent (individual) responsible to the governing body (owner) for the management of the licensed facility)

Chief Executive Officer: Kathy C Bailey **Title:** President & CEO
(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: Robert Fritts **Telephone:** 828-580-5545
E-Mail: robert.fritts@blueridgehealth.org

E. Swing Beds

Number of Swing Beds *	0
Number of Skilled Nursing days in Swing Beds	0

* in a hospital designated **as a swing-bed hospital** by CMS (Centers for Medicare & Medicaid Services)

F. Reimbursement Source (For "Inpatient Days," show Acute Inpatient Days only, excluding normal newborns.)

Campus – *If multiple sites:* Combined (Morganton + Valdese)

Primary Payer Source	Inpatient Days of Care (total should be the same as D.1.a – q total on p. 6)	Emergency Visits (total should be the same as G.3.b. on p. 8)	Outpatient Visits (excluding Emergency Visits and Surgical Cases)	Inpatient Surgical Cases (total should be same as 9.d. Total Surgical Cases-Inpatient Cases on p. 12)	Ambulatory Surgical Cases (total should be same as 9.d. Total Surgical Cases-Ambulatory Cases on p. 12)
Self Pay/Indigent/Charity	1,854	14,079	2,440	57	166
Medicare & Medicare Managed Care	12,449	14,508	55,407	978	1,664
Medicaid	6,513	14,879	9,786	152	620
Commercial Insurance	482	511	1,338	6	46
Managed Care	3,077	11,544	27,230	322	1,397
Other (Specify)	16	3,041	1,512	44	167
TOTAL	24,391	58,562	97,713	1,559	4,060

G. Services and Facilities

1. Obstetrics

	Enter Number of Infants
a. Live births (Vaginal Deliveries)	632
b. Live births (Cesarean Section)	249
c. Stillbirths	5

d. Delivery Rooms - Delivery Only (not Cesarean Section)	Ø
e. Delivery Rooms - Labor and Delivery, Recovery	Ø
f. Delivery Rooms – LDRP (include Item **"D.1.m"** on Page 6)	16
g. Normal newborn bassinets (Level I Neonatal Services) Do not include with totals under the section entitled Beds by Service (Inpatient)	16

2. Abortion Services

Number of procedures per Year Ø

(Feel free to footnote the type of abortion procedures reported)

Swing-Beds

[illegible] Swing-Beds	
Number of Skilled Nursing days in Swing-Beds	

[illegible] a Swing-bed hospital by CMS (Centers for Medicare & Medicaid Services)

[illegible] Service [illegible] (Show Acute Inpatient Days only, excluding normal newborns.)

[illegible]

[illegible]	Inpatient Days [illegible]	Emergency Visits [illegible]	Outpatient Visits (excluding Emergency Visits and Surgical Cases)	Inpatient Surgical Cases (total should be same as 9.d. Total Surgical Cases-Inpatient Cases on p.12)	Ambulatory Surgical Cases (total should be same as 9.d. Total Surgical Cases-Ambulatory Cases on p. 12)
[illegible]	[illegible]	1,183	1,129	56	86
[illegible]	[illegible]	9,463	25,630	965	862
[illegible]	[illegible]	9,105	4,527	150	321
[illegible]	[illegible]	235	619	6	24
[illegible]	[illegible]	7,530	12,596	317	724
[illegible]	[illegible]	1,485	1,298	44	87
[illegible]	[illegible]	[illegible]	45,199	1,538	2,104

Services and Facilities

Infants	Enter Number of Infants
[illegible]	
[illegible] Cesarean Section	
[illegible]	

[illegible] Rooms (Delivery Only, not Cesarean Section)	
[illegible] Rooms (Labor and Delivery, Recovery)	
[illegible] (Include Licensed Beds on Page 6)	
[illegible] (Neonatal Services) [illegible] Beds by Service (Inpatient)	

Abortion Services Number of procedures per Year

(*[illegible] the type of abortion procedures reported*)

Swing Beds

[illegible] Swing Beds	0
Number of Skilled Nursing days in Swing Beds	0

[illegible] Hospital is certified as a swing-bed hospital by CMS (Centers for Medicare & Medicaid Services)

Reimbursement Source (for Inpatient Days, show Acute Inpatient Days only, excluding normal newborns.)

Campus – Hospital Site: Valdese

[illegible]	Inpatient Days of Care (total should be the same [illegible])	Emergency Visits (total should be the same [illegible] on p. 8)	Outpatient Visits (excluding Emergency Visits and Surgical Cases)	Inpatient Surgical Cases (total should be same as 9.d. Total Surgical Cases-Inpatient Cases on p. 12)	Ambulatory Surgical Cases (total should be same as 9.d. Total Surgical Cases-Ambulatory Cases on p. 12)
[illegible]	0	4,395	1,312	1	80
Medicare & Medicare [illegible]	0	5,045	29,718	13	801
[illegible]	0	5,144	5,259	2	299
[illegible]	0	498	779	–	22
[illegible]	0	4,014	14,634	4	673
[illegible]	0	1,051	812	1	81
[illegible]	0	20,363	52,514	21	1,956

Services and Facilities

[illegible]	Enter Number of Infants
[illegible] (Vaginal Deliveries)	
[illegible] (Cesarean Section)	
[illegible]	

[illegible] Rooms – Delivery Only (not Cesarean Section)	
[illegible] Labor and Delivery, Recovery	
[illegible] (include [illegible] "Delete" on Page 6)	
[illegible] (Level I Neonatal Services)	
[illegible] beds by Service (Inpatient)	

2\. Abortion Services — Number of procedures per Year ________
(please note the type of abortion procedures reported)

9. Surgical Operating Rooms, Procedure Rooms, Gastrointestinal Endoscopy Rooms, Surgical and Non-Surgical Cases and Procedures

REMINDER: If this License includes more than one campus, please copy pages 11-14 (through Section 9) for each campus. Show the Cumulative Totals and submit a duplicate of pages 11-14 for each campus.

Campus – If multiple sites: Valdese

a) Surgical Operating Rooms

Report the number of *Surgical Operating Rooms* which meet the specifications and standards for operating rooms required by the Construction Section of the Division of Health Services Regulation, and which are fully equipped to perform surgical procedures. These surgical operating rooms include rooms located in Obstetrics and surgical suites.

Type of Room	Number of Rooms
Dedicated Open Heart Surgery	0
Dedicated C-Section	0
Other Dedicated Inpatient Surgery *(Do not include dedicated Open Heart or C-Section rooms)*	0
Dedicated Ambulatory Surgery	4
Shared - Inpatient / Ambulatory Surgery	0
Total Surgical Operating Rooms	4

Of the Total Surgical Operating Rooms above, how many are equipped with advanced medical imaging devices (excluding mobile C-arms) or radiation equipment for the performance of cardiac, vascular, neurosurgical or interventional procedures, and/or intraoperative cancer treatments? (i.e., radiation therapy, etc.) in such rooms as hybrid ORs.	4

b) Procedure Rooms (Excluding Operating Rooms and Gastrointestinal Endoscopy Rooms)

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

Number of Procedure Rooms: 4

c) Gastrointestinal Endoscopy Rooms, Cases and Procedures

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

Total Number of Existing Gastrointestinal Endoscopy Rooms: 2

	Number of Cases Performed in GI Endoscopy Rooms		Number of Procedures* Performed in GI Endoscopy Rooms	
	Inpatient	Outpatient	Inpatient	Outpatient
GI Endoscopy	0	1,344	8	2189
Non-GI Endoscopy	0	0	0	0

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/ICD-10-CM procedure code, performed on a patient during a single visit to the facility for diagnostic or therapeutic purposes.

9. Surgical Operating Rooms, Procedure Rooms, Gastrointestinal Endoscopy Rooms, Surgical and Non-Surgical Cases and Procedures *(continued)*

(Campus – *If multiple sites:* Valdese)

d. Surgical Cases by Specialty Area Table

Report the number of surgical cases performed only in licensed operating rooms by surgical specialty area in the table 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 performed only in licensed operating rooms. The total number of surgical cases should match the total number of patients listed on the Patient Origin Tables on pages 27 and 28.**

Surgical Specialty Area	Inpatient Cases	Ambulatory Cases
Cardiothoracic (Excluding Open Heart Surgery)	0	0
Open Heart Surgery (from 2.d. on page 9)	0	
General Surgery	0	543
Neurosurgery	0	0
Obstetrics and GYN (excluding C-Sections)	0	0
Ophthalmology	0	0
Oral Surgery	0	0
Orthopedics	0	750
Otolaryngology	0	131
Plastic Surgery	0	0
Urology	0	279
Vascular	0	0
Other Surgeries (specify)	0	3
Other Surgeries (specify)	0	147
Dedicated C-Sections Performed in Dedicated C-Section ORs	N/A	
Other C-Sections Performed in Other ORs	N/A	
Total Surgical Cases Performed Only in Licensed ORs	0	1,853

e. Non-Surgical Cases by Category Table

Report the number of non-surgical cases by category in the table below. Count each patient undergoing a non-surgical procedure(s) 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 11.**

Non-Surgical Category	Inpatient Cases	Ambulatory Cases
Pain Management	0	33
Cystoscopy	0	0
Non-GI Endoscopies *(not reported in 9.c. on page 11)*	0	0
GI Endoscopies *(not reported in 9.c. on page 11)*	0	24
YAG Laser	0	0
Other (specify)	0	80
Other (specify)	0	0
Other (specify)	0	0
Total Non-Surgical Cases	0	137

[illegible] responses should [illegible] October 1, 2015 through September 30, 2016

Valdese

[illegible] 20 Most Common Outpatient Surgical Cases Table: Enter the number of surgical cases performed only in [illegible] operating rooms and / or licensed endoscopy room by the top 20 most common outpatient surgical cases in the table below by CPT code. Count each patient undergoing surgery as one case regardless of the number of surgical procedures performed while the patient was having surgery.

[illegible]	Description	Cases
[illegible]	Arthroscopy, shoulder, surgical; with rotator cuff repair	51
[illegible]	Arthroscopy, knee, surgical; with meniscectomy (medial and lateral, including any meniscal [illegible]), including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed	88
[illegible]	Arthroscopy, knee, surgical; with meniscectomy (medial or lateral, including any meniscal [illegible]), including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed	42
[illegible]	Tonsillectomy and adenoidectomy; younger than age 12	13
[illegible]	[illegible] primary; younger than age 12	2
[illegible]	[illegible] gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	58
[illegible]	[illegible] gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with biopsy, single or multiple	795
[illegible]	[illegible] gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with insertion of guide wire followed by dilation of esophagus [illegible]	0
[illegible]	[illegible] gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with balloon dilation of esophagus (less than 30 mm diameter)	120
[illegible]	Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)	192
[illegible]	Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple	589
[illegible]	Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery	57
[illegible]	Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	260
[illegible]	[illegible] diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, [illegible] steroid, other solution), not including neurolytic substances, including needle or catheter [illegible] localization when performed, epidural or subarachnoid; lumbar [illegible]	0
[illegible]	[illegible] anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance [illegible]; lumbar or sacral, single level	0
[illegible]	[illegible] and/or transposition; median nerve at carpal tunnel	59
[illegible]	[illegible] secondary membranous cataract (opacified posterior lens capsule and/or anterior [illegible] laser surgery (e.g., YAG laser) (one or more stages)	0
[illegible]	[illegible] cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or [illegible]), complex, requiring devices or techniques not generally used in routine cataract surgery (e.g., iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage	0
[illegible]	[illegible] cataract removal with insertion of intraocular lens prosthesis (stage one procedure), manual or mechanical technique (e.g., irrigation and aspiration or [illegible])	0
[illegible]	Tympanostomy (requiring insertion of ventilating tube), general anesthesia	18

(Campus – *if multiple sites:* Valdese)

9.b. 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 1,872 hours per operating room per year.

The Operating Room Methodology also assumes an average of 3 hours for each Inpatient Surgery and an average of 1.5 hours for each Outpatient Surgery.

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

Average Hours per Day Routinely Scheduled for Use*	Average Number of Days per Year **Routinely** Scheduled for Use	Average "Case Time" ** in **Minutes** for Inpatient Cases	Average "Case Time" ** in **Minutes** for Ambulatory Cases
[illegible]	252	[illegible]	60

* Consider only Hours per Day **routinely** scheduled when determining the answer. Example:

A facility has 3 ORs; 2 are routinely scheduled for use 8 hours per day, and 1 is routinely scheduled for use 9 hours per day.

2 rooms x	8 hours	=	16 hours	
1 room x	9 hours	=	9 hours	
	Total hours per day		25 hours	÷ 25 hours divided by 3 ORs = **8.3 Average Hours per day Routinely Scheduled for Use**

** Definition: 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. *NOTE: This definition includes all of the time for which a given procedure requires an OR/PR. It allows for the variation in duration of Room Set-up and Room Clean-up Times that occur because of the varying supply and equipment needs for a particular procedure.*

9. Surgical Operating Rooms, Procedure Rooms, Gastrointestinal Endoscopy Rooms, Surgical and Non-Surgical Cases and Procedures

NOTE: If this License includes more than one campus, please copy pages 11-14 (through Section 9) for each site. Submit the Cumulative Totals and submit a duplicate of pages 11-14 for each campus.

(**Campus – *If multiple sites:*** Morganton)

a) Surgical Operating Rooms

Report *Surgical Operating Rooms* built to meet the specifications and standards for operating rooms required by the Construction Section of the Division of Health Services Regulation, and which are fully equipped to perform surgical procedures. These surgical operating rooms include rooms located in Obstetrics and surgical suites.

Type of Room	Number of Rooms
Dedicated Open Heart Surgery	Ø
Dedicated C-Section	1
Other Dedicated Inpatient Surgery ***(Do not include dedicated Open Heart or C-Section rooms)***	Ø
Dedicated Ambulatory Surgery	Ø
Shared - Inpatient / Ambulatory Surgery	5
Total of Surgical Operating Rooms	6

Of the **Total of Surgical Operating Rooms**, above, how many are equipped with advanced medical imaging devices (excluding mobile C-arms) or radiation equipment for the performance of endovascular, cardiovascular, neuro-interventional procedures, and/or intraoperative cancer treatments? Your facility may or may not refer to such rooms as "hybrid ORs."	Ø

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 surgical procedures other than Gastrointestinal Endoscopy procedures.

Total Number of Procedure Rooms: 1

c) Gastrointestinal Endoscopy Rooms, Cases and Procedures:

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

Total Number of existing Gastrointestinal Endoscopy Rooms: 1

	Number of Cases Performed In GI Endoscopy Rooms		Number of Procedures* Performed in GI Endoscopy Rooms	
	Inpatient	Outpatient	Inpatient	Outpatient
GI Endoscopy	259	439	424	608
Non-GI Endoscopy	–	–	–	–

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 [ICD-10-CM] procedure code, performed on a patient during a single visit to the facility for diagnostic or therapeutic purposes."

9. Surgical Operating Rooms, Procedure Rooms, Gastrointestinal Endoscopy Rooms, Surgical and Non-Surgical Cases and Procedures *(continued)*

(Campus – *If multiple sites:* Morganton **)**

d) Surgical Cases by Specialty Area Table

Enter the number of surgical cases performed only in licensed operating rooms by surgical specialty area in the table 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 performed only in licensed operating rooms. The total number of surgical cases should match the total number of patients listed in the Patient Origin Tables on pages 27 and 28.**

Surgical Specialty Area	Inpatient Cases	Ambulatory Cases
Cardiothoracic (excluding Open Heart Surgery)	0	0
Open Heart Surgery (from 8.(a) 4. on page 9)	0	
General Surgery	454	695
Neurosurgery	0	0
Obstetrics and GYN (excluding C-Sections)	102	478
Ophthalmology	3	191
Oral Surgery	2	11
Orthopedics	597	458
Otolaryngology	39	106
Plastic Surgery	0	0
Urology	56	192
Vascular	0	0
Other Surgeries (specify)	0	1
Other Surgeries (specify)	56	75
Number of C-Sections Performed in Dedicated C-Section ORs	249	
Number of C-Sections Performed in Other ORs	0	
Total Surgical Cases Performed Only in Licensed ORs	1559	2207

e) 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 11.**

Non-Surgical Category	Inpatient Cases	Ambulatory Cases
Pain Management	0	0
Cystoscopy	0	0
Non-GI Endoscopies *(not reported in 9. C on page 11)*	0	0
GI Endoscopies *(not reported in 9. C on page 11)*	12	8
YAG Laser	0	0
Other (specify)	0	0
Other (specify)	0	0
Other (specify)	0	0
Total Non-Surgical Cases	12	8

Morganton

20 Most Common Outpatient Surgical Cases Table - Enter the number of surgical cases performed only in licensed operating rooms and / or licensed endoscopy room by the top 20 most common outpatient surgical cases in the table below by CPT code. Count each patient undergoing surgery as one case regardless of the number of surgical procedures performed while the patient was having surgery.

CPT Code	Description	Cases
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair	2
29880	Arthroscopy, knee, surgical; with meniscectomy (medial and lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed	28
29881	Arthroscopy, knee, surgical; with meniscectomy (medial or lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed	45
42820	Tonsillectomy and adenoidectomy; younger than age 12	4
42830	Adenoidectomy, primary; younger than age 12	2
43235	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	27
43239	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with biopsy, single or multiple	190
43248	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with insertion of guide wire followed by dilation of esophagus over guide wire	0
43249	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with balloon dilation of esophagus (less than 30 mm diameter)	8
45378	Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)	92
45380	Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple	142
45384	Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery	9
45385	Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	56
62311	Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; lumbar or sacral (caudal)	1
64483	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or computed tomography); lumbar or sacral, single level	0
64721	Neuroplasty and/or transposition; median nerve at carpal tunnel	33
66821	Discission of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid); laser surgery (e.g., YAG laser) (one or more stages)	0
66982	Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (e.g., iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage	0
66984	Extracapsular cataract removal with insertion of intraocular lens prosthesis (stage one procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification)	0
69436	Tympanostomy (requiring insertion of ventilating tube), general anesthesia	7

(Campus – *If multiple sites:* Morganton)

9f. 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 1,872 hours per operating room per year.

The Operating Room Methodology also assumes an average of 3 hours for each Inpatient Surgery and an average of 1.5 hours for each Outpatient Surgery.

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

Average Hours per Day **Routinely** Scheduled for Use *	Average Number of Days per Year **Routinely** Scheduled for Use	Average "Case Time" ** in **Minutes** for Inpatient Cases	Average "Case Time" ** in **Minutes** for Ambulatory Cases
10	252	180	90

* Use only Hours per Day **routinely** scheduled when determining the answer. Example:

A facility has 3 ORs: 2 are routinely scheduled for use 8 hours per day, and 1 is routinely scheduled for use 9 hours per day.

2 rooms	x	8 hours	=	16 hours	
1 room	x	9 hours	=	9 hours	
		Total hours per day		25 hours	25 hours divided by 3 ORs = **8.3 Average Hours per day Routinely Scheduled for Use**

** **"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.*

Patient Origin – Inpatient Surgical Cases

Facility County: Burke

In an effort to document patterns of Inpatient utilization of Surgical Services in North Carolina hospitals, please provide the county of residence for each inpatient surgical patient served in your facility. Count each inpatient surgical patient once regardless of the number of surgical procedures performed while the patient was having surgery. However, each admission as an inpatient surgical case should be reported separately.

The Total from this chart should match the Total Inpatient Cases reported on the "Surgical Cases by Specialty Area" Table on page 12.

County	No. of Patients	County	No. of Patients	County	No. of Patients
1. Alamance		37. Gates		73. Person	
2. Alexander	5	38. Graham		74. Pitt	
3. Alleghany		39. Granville		75. Polk	
4. Anson		40. Greene		76. Randolph	
5. Ashe		41. Guilford		77. Richmond	
6. Avery	1	42. Halifax		78. Robeson	
7. Beaufort		43. Harnett		79. Rockingham	1
8. Bertie		44. Haywood		80. Rowan	
9. Bladen	1	45. Henderson		81. Rutherford	9
10. Brunswick		46. Hertford		82. Sampson	
11. Buncombe	3	47. Hoke		83. Scotland	
12. Burke	1,035	48. Hyde		84. Stanly	
13. Cabarrus	2	49. Iredell		85. Stokes	
14. Caldwell	192	50. Jackson		86. Surry	
15. Camden		51. Johnston		87. Swain	
16. Carteret		52. Jones		88. Transylvania	
17. Caswell		53. Lee		89. Tyrrell	
18. Catawba	68	54. Lenoir		90. Union	
19. Chatham		55. Lincoln	7	91. Vance	
20. Cherokee		56. Macon		92. Wake	1
21. Chowan		57. Madison	1	93. Warren	
22. Clay		58. Martin		94. Washington	
23. Cleveland	12	59. McDowell	170	95. Watauga	
24. Columbus		60. Mecklenburg	4	96. Wayne	
25. Craven		61. Mitchell	9	97. Wilkes	3
26. Cumberland		62. Montgomery		98. Wilson	
27. Currituck		63. Moore		99. Yadkin	
28. Dare		64. Nash		100. Yancey	
29. Davidson		65. New Hanover			
30. Davie		66. Northampton		101. Georgia	
31. Duplin		67. Onslow		102. South Carolina	1
32. Durham		68. Orange		103. Tennessee	
33. Edgecombe		69. Pamlico		104. Virginia	
34. Forsyth		70. Pasquotank		105. Other States	
35. Franklin		71. Pender		106. Other	9
36. Gaston	1	72. Perquimans		**Total No. of Patients**	1,535

Patient Origin – Ambulatory Surgical Cases

Facility County: Burke

In an effort to document patterns of Ambulatory utilization of Surgical Services in North Carolina hospitals, please provide the county of residence for each ambulatory surgery patient served in your facility. Count each ambulatory patient once regardless of the number of procedures performed while the patient was having surgery. However, each admission as an ambulatory surgery case should be reported separately.

The Total from this chart should match the Total Ambulatory Surgical Cases reported on the "Surgical Cases by Specialty Area" Table on page 12.

County	No. of Patients	County	No. of Patients	County	No. of Patients
1. Alamance		37. Gates		73. Person	
2. Alexander	17	38. Graham		74. Pitt	
3. Alleghany		39. Granville		75. Polk	
4. Anson		40. Greene		76. Randolph	
5. Ashe	1	41. Guilford		77. Richmond	
6. Avery	15	42. Halifax		78. Robeson	
7. Beaufort		43. Harnett		79. Rockingham	
8. Bertie		44. Haywood	1	80. Rowan	1
9. Bladen		45. Henderson	1	81. Rutherford	81
10. Brunswick		46. Hertford		82. Sampson	1
11. Buncombe	21	47. Hoke		83. Scotland	
12. Burke	2,158	48. Hyde		84. Stanly	
13. Cabarrus		49. Iredell	5	85. Stokes	
14. Caldwell	662	50. Jackson		86. Surry	
15. Camden		51. Johnston		87. Swain	
16. Carteret	1	52. Jones		88. Transylvania	
17. Caswell		53. Lee		89. Tyrrell	
18. Catawba	215	54. Lenoir		90. Union	
19. Chatham		55. Lincoln	20	91. Vance	
20. Cherokee	1	56. Macon	2	92. Wake	2
21. Chowan		57. Madison		93. Warren	
22. Clay		58. Martin		94. Washington	
23. Cleveland	66	59. McDowell	438	95. Watauga	8
24. Columbus		60. Mecklenburg	7	96. Wayne	
25. Craven		61. Mitchell	27	97. Wilkes	6
26. Cumberland		62. Montgomery		98. Wilson	
27. Currituck		63. Moore		99. Yadkin	1
28. Dare		64. Nash		100. Yancey	5
29. Davidson		65. New Hanover	1		
30. Davie	2	66. Northampton		101. Georgia	
31. Duplin		67. Onslow		102. South Carolina	1
32. Durham		68. Orange		103. Tennessee	
33. Edgecombe	1	69. Pamlico		104. Virginia	
34. Forsyth	1	70. Pasquotank		105. Other States	2
35. Franklin		71. Pender		106. Other	12
36. Gaston	7	72. Perquimans		**Total No. of Patients**	3,790

Patient Origin – Gastrointestinal Endoscopy (GI) Cases

Facility County: Burke

In an effort to document patterns of utilization of Gastrointestinal Endoscopy Services in North Carolina hospitals, please provide the county of residence for each GI Endoscopy patient served in your facility. Count each patient once regardless of the number of procedures performed while the patient was receiving GI Endoscopy Services. However, each admission for GI Endoscopy services should be reported separately.

The Total from this chart should match the GI Endoscopy cases reported on the "Gastrointestinal Endoscopy Rooms, Cases and Procedures" Table on page 11 plus the Inpatient and Ambulatory GI Endoscopy cases from the "Non-Surgical Cases by Category" Table on page 12. Do not include patients from the "Non-GI Endoscopy Cases" fields on page 12.

County	No. of Patients	County	No. of Patients	County	No. of Patients
1. Alamance		37. Gates		73. Person	
2. Alexander	3	38. Graham		74. Pitt	
3. Alleghany		39. Granville		75. Polk	
4. Anson		40. Greene		76. Randolph	
5. Ashe		41. Guilford		77. Richmond	
6. Avery	4	42. Halifax		78. Robeson	
7. Beaufort		43. Harnett		79. Rockingham	
8. Bertie		44. Haywood		80. Rowan	1
9. Bladen		45. Henderson		81. Rutherford	24
10. Brunswick		46. Hertford		82. Sampson	
11. Buncombe	4	47. Hoke		83. Scotland	
12. Burke	1,228	48. Hyde		84. Stanly	1
13. Cabarrus		49. Iredell	1	85. Stokes	
14. Caldwell	369	50. Jackson	1	86. Surry	
15. Camden		51. Johnston		87. Swain	
16. Carteret	1	52. Jones		88. Transylvania	
17. Caswell		53. Lee		89. Tyrrell	
18. Catawba	116	54. Lenoir		90. Union	
19. Chatham		55. Lincoln	6	91. Vance	
20. Cherokee		56. Macon		92. Wake	1
21. Chowan		57. Madison		93. Warren	
22. Clay		58. Martin		94. Washington	
23. Cleveland	8	59. McDowell	288	95. Watauga	1
24. Columbus		60. Mecklenburg	4	96. Wayne	
25. Craven		61. Mitchell	8	97. Wilkes	4
26. Cumberland		62. Montgomery		98. Wilson	
27. Currituck		63. Moore		99. Yadkin	1
28. Dare		64. Nash		100. Yancey	
29. Davidson		65. New Hanover	1		
30. Davie		66. Northampton		101. Georgia	
31. Duplin		67. Onslow		102. South Carolina	
32. Durham		68. Orange		103. Tennessee	
33. Edgecombe		69. Pamlico		104. Virginia	
34. Forsyth		70. Pasquotank		105. Other States	1
35. Franklin		71. Pender		106. Other	4
36. Gaston	6	72. Perquimans		**Total No. of Patients**	2,086

Comments Exhibit B

One occupation for multiple geographical areas

Occupation:Registered Nurses(SOC Code291141)
Period:May 2015

Area Name	Annual mean wage(2)
North Carolina(3700000)	60460

(2)Annual wages have been calculated by multiplying the hourly mean wage by 2,080 hours.

SOC code: Standard Occupational Classification code -- see http://www.bls.gov/soc/home.htm
Date extracted on :Mar 20, 2017

Comments Exhibit C

THE NEWS HERALD

Poverty rates increase in Burke County; children affected at higher rates

BY SHARON MCBRAYER Staff Writer Feb 6, 2016

The U.S. Census 2014 American Community Survey that was released in late 2015 show s Burke County continues to lose residents to other areas .

Taylor Dellinger, data analyst with Western Piedmont Council of Governments, recently made a presentation to the Burke County Chamber of Commerce on the economic perspective of the county based on the survey. What Dellinger found when he analyzed the data was that Burke County is still feeling effects from the Great Recession.

However, it's not all bad news for the county.

Population

While Burke County's population grew between 2000 and 2010 to 90,912, it has continued to fall since. And 20-year projections show the county will continue to lose population in some of the younger age groups.Estimates from 2014 put the population of Burke County at 89,198, a loss of 1.9 percent since 2010.

The losses have been across the board among the younger population groups except the 20- to 24-year-old group. That age group increased 15.1 percent from 2010 to 2014.The next age group that showed gains of 4.9 percent was the 55- to 59-year-olds. The age groups from 65 years old and up all show population gains.

While the significant child-bearing age groups have continued to see population losses since 2000, 20-year projections — 2015-2035 — from the N.C. Office of Management and Budget show those groups growing. But the younger populations — 5- to 24-year-olds — are expected to continue to decline in the county, the projections show.

The 18- to 20-year-olds will be an interesting group to watch in the coming years, Dellinger said. The question is will they come back to Burke County after college and get jobs or will they move away for employment? That's something that won't be seen for several years, he said.

Education

It appears more residents in Burke County are going for a higher education.But the metro area of Hickory-Lenoir-Morganton comes in last place, at 80.7 percent, among the 15 metro areas in the state for the number of its high school graduates. The Raleigh metro area has the largest number of residents with a high school diploma, at 91.1 percent. It comes in next to last, at 18.1 percent, of the metro areas, behind Rocky Mount, for the number of residents with a bachelor's degree or higher. The Durham-Chapel Hill metro area, at 48.8 percent, has the largest number of residents with a bachelor's degree or graduate degree.

According to the American Community Survey, residents in Burke County who took some college classes but didn't receive a degree in 2000 was 10,347. That number increased to 13,558 in 2014.The number of folks getting an associate degree increased from 2000 to 2014 by 2,637 and those getting a bachelor's degree increased by 2,239. Even the number of people getting graduate degrees increased, going from 2,364 in 2000 to 3,627 in 2014.

However, the number of high school graduates fell over the same period, going from 30.4 percent in 2000 to 28.5 percent in 2014. Burke County lags behind the Hickory-Lenoir-Morganton metropolitan statistical area and the state for the number of high school graduates, according to the survey.

Employment

It's no secret that manufacturing has had major losses in Burke County, both in furniture and textiles, starting around 2000. However, manufacturing jobs still exist in the county and wages have grown since 2010, according to state commerce figures.

In 2000, manufacturing made up 38 percent of jobs in the county. According to figures from the N.C. Department of Commerce's Labor and Economic Analysis Division, manufacturing now makes up 28 percent of all the jobs in Burke County. In the U.S., manufacturing makes up 9 percent of jobs, according to commerce figures.

While manufacturing has suffered losses, the services sector in Burke County grew from 41 percent in 2000 to 51 percent in 2015. Trade remained at 11 percent over the 15-year period but the construction sector shrank by 1 percent. Weekly wages appear to have increased, going from $581 in 2010 to $643 in 2015, according to first quarter numbers from the N.C. Labor and Economic Analysis Division. The unemployment rate in Burke County for December was 5.4 percent, according to information from the N.C. Department of Commerce.

Poverty

While wages have increased, so have poverty rates in Burke County since 2010. And it is children that seem to be affected the most

Poverty in Burke County particularly affects families with children, Dellinger said.For a family with two parents and two children, the poverty level income is $24,000 a year, he said.Burke

County's poverty rate is 20.7 percent but for children under 18 years old, that rate is 32.6 percent, according to the latest American Community Survey.

Morganton, which is the county seat and has the largest population of the towns, has the most residents living in poverty at 4,437.

The town of Hildebran has the highest percentage of residents in the county living in poverty Hildebran's poverty rate is 30.7 percent but the rate for children under 18 jumps to 58.8 percent.

Morganton's percentage of residents in poverty follows at 27.9 percent but its children living in poverty jumps to 49.8 percent. The median income of city residents is $35,144, according to the five-year survey.

The town of Valdese follows Morganton, with a poverty rate of 19.4 percent and a median income of town residents at $38,274. But the poverty rate for children is 38 percent.

Children in Glen Alpine and Connelly Springs actually fare better than the general population when it comes to living in poverty. Glen Alpine has the second-highest median income in the county at $44,181 and a poverty rate at 12.4 percent. And it has fewer children living in poverty there than other towns in the county. The poverty rate for those younger than 18 years old in the town is 11.7 percent.

While the median income for Connelly Springs is one of the lowest in the county at $33,669, the number of children living in poverty is the second-lowest in Burke County at 13.8 percent.

Much of the poverty rate increase has to do with lasting effects of the economic recession, Dellinger said. Those living in poverty are either getting unemployment benefits or have lost their benefits, or have lost their jobs and are now working lower-wage service jobs, he said.

Business sectors

Two sectors that have experienced employment gains in Burke County are food manufacturers and doctors offices. Dellinger said food manufacturers include bakeries such as Bimbo Bakery in Valdese and chicken farming such as those that supply Case Farms. He said the food manufacturer sector is doing really well in Burke County.

The food services sector is also doing well in the county due to more restaurants, including those that have opened in the Morganton Heights Shopping Center, he said.

The other sector doing well in the county is health care, particularly doctor's offices and outpatient clinics. And that sector will continue to do well and even grow as baby boomers age, Dellinger said.

Housing

The housing market took a big hit in Burke County during the Great Recession and it looks like it's going to take some more time for it to fully recover. That's true for the region as well, said Dellinger.Permits for site-built homes in the county were 268 in 2007 before the housing market took a nosedive, along with the economy. The number of permits issued continued to go down, with the lowest point being 50 permits issued in 2012, according to information from Western Piedmont Council of Governments.From the low point in 2012, the number of site-built permits has climbed, with 65 issued in 2013 and 79 issued in 2014.

Homeowners, too, were majorly affected, with home foreclosures skyrocketing at the height of the recession. Foreclosures were at 463 in 2010 but fell to 227 in 2014, according to numbers provided to WPCOG.Owner-occupied housing makes up 57 percent of the total number of housing units in Burke County, which includes site-built homes, mobile homes, condos and apartments. Another 25 percent — 10,300 units — are being rented. But one of five units — 18 percent — in Burke County is vacant, Dellinger said. That means 7,437 units in the county are empty, with about 20 percent of those units up for sale or rent and another 30 percent are seasonal housing, he said. The other 50 percent of vacant units are sitting empty, meaning they are not for sale or rent, Dellinger said. It's not really clear why so many homes are empty, he said.

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THE NEWS HERALD

Hospital staff welcomes new operating facility

- Special to The News Herald
- Feb 8, 2017

Late into Wednesday night, surgical staff at Carolinas HealthCare System Blue Ridge finished moving equipment, supplies and beds from the old operating suite to the brand new 29,000-square-foot state-of-the-art operating wing.

The staff moved an entire operating suite in about 10 hours, finishing up around midnight, according to Deanne Avery, director of capital projects. “We had about 30 staff here – nurses, surgical techs, everybody helped,” she said. “They were excited to move into a space they helped design.”

Indeed, everyone Thursday morning – the first full day of operating in the new area – came in smiling and excited to get started.

“These new ORs are the biggest advances Burke County has ever seen in the area of surgical medicine,” said Chris Hanger, MD, chief of anesthesia. “I’m excited. It’s going to be fun. The patients and surgeons are going to love it.”

The new operating rooms almost doubled in size — going from less than 400 square feet to approximately 700 square feet. Most of the equipment has been attached to booms and arms so they can be raised and lowed from the ceiling, taking up no foot space. One nurse controls movements of lights, cameras and equipment at the touch of a button.

“The technology is just phenomenal,” said Terry Moore, BSN, RN, director of surgical services. “We are probably leading the hospitals systems in this area in technology. We’re ready to take on the future here.”

Surgeons having the first cases in the brand new rooms were Quincy Greene, MD, general surgery; Philene Krogel, MD, OB/GYN; and Ken Bonfield, MD, eye surgery.

Greene had a variety of surgeries scheduled and couldn’t wait to get started in the new space.

“This is exciting and the biggest development since I’ve been here,” Greene said. “The new ORs are modern and expansive.”

Bonfield agreed saying the rooms were very clean, and that everything went smoothly.

“It’s just a beautiful environment,” he said.

DeeDee Lambert, RN, recently retired from the hospital after 37 years but came back part time because she wanted to help with the transition.

“These ORs are much bigger, much nicer and the technology is much improved compared to the old,” she said. “We can provide better and safer patient care.”

The new wing of the hospital features five operating rooms that have cameras embedded into the surgical LED lights. Several mounted monitors allow them to be used as teaching tools and for examining X-rays made instantaneously by lowering a boom.

A new post-surgery recovery area has 11 bays for patients including one that has a built-in lift. Each station is equipped for a nurse and two patients.

“This is a lot more elbow room than they used to have,” Avery said.

Blue Ridge is not finished with the renovation. The next phases call for converting the old space into the new out-patient prep and recovery rooms.

“Additional subsequent phases of follow-up construction will take us through the end of the year,” Avery said. “It’s all going to be very sophisticated when fully realized.