WRITTEN COMMENTS ON 2025 WAKE COUNTY ACUTE CARE BEDS COMPETITIVE REVIEW

SUBMITTED BY NOVANT HEALTH

October 1, 2025

Eight CON applications were submitted in response to the need identified in the 2025 SMFP for 267 additional acute care beds in Wake County. The applications include:

- CON Project ID # J-012671-25, WakeMed (WakeMed Raleigh): Add 164 acute care beds at WakeMed Raleigh
- CON Project ID # J-012672-25, WakeMed North Hospital (WakeMed North): Add 35 acute care beds at WakeMed North
- CON Project ID # J-012673-25, WakeMed Garner Hospital (WakeMed Garner): Add 78 acute care beds at WakeMed Garner
- CON Project ID # J-012677-25, UNC Health Rex (Rex Hospital): Add 106 acute care beds at Rex Hospital
- CON Project ID # J-012680-25, UNC Health Rex Wake Forest Hospital (Rex Wake Forest): Develop a new 50-bed acute care hospital
- CON Project ID # J-012686-25, Novant Health Knightdale Medical Center (NH Knightdale): Develop a new 26-bed acute care hospital
- CON Project ID # J-012689-25, Duke Cary Hospital (Duke Cary): Add 120 beds at Duke Cary
- CON Project ID # J-012690-25, Duke Raleigh Hospital (Duke Raleigh): Add 101 beds at Duke Raleigh

Novant Health submits these comments in accordance with N.C. Gen. Stat. § 131E-185(a1)(1) to address the representations in the competing applications, including their ability to conform with applicable statutory and regulatory review criteria. These comments also discuss the comparative analysis of the applicable and most significant issues concerning this competitive batch review. Other non-conformities may exist in the competing applications and Novant Health may develop additional opinions, as appropriate upon further review and analysis. Nothing in these comments is intended to amend any statement in the Novant Health application; to the extent the Agency deems any comment an amendment to the NH Knightdale application, Novant Health respectfully asks the Agency to disregard the comment.

With the exception of NH Knightdale, all applications submitted for beds are for facilities owned or proposed by existing health systems in Wake County. Unlike the other applicants, NH Knightdale will give area residents an additional choice of providers, thereby improving competition for acute care services in Wake County.

The Agency should consider which health systems require SMFP assets to achieve their goals. Existing health systems have several options to achieve their goals without using SMFP-regulated assets. Existing health systems can transfer assets between facilities and increase acute care bed flexibility by adding observation beds and receiving temporary increases in licensed acute care bed capacity. Since Novant Health has no acute care beds in Wake County, it can only enter the service area if the Agency approves its application.

Approving NH Knightdale makes the best use of the acute care beds in the 2025 SMFP because:

- It provides a new competitor
- It improves geographic access in a part of Wake County with no beds
- Existing hospitals and health systems have alternatives to increase their acute care bed capacity without award of SMFP resources (transferring beds, increasing the number of unlicensed observation beds, receiving temporary increases in licensed acute care bed capacity).
- NH Knightdale is the only applicant that does not have the option to expand existing facilities or create a new facility by transferring assets from other health system facilities in Wake County.

COMPARATIVE ANALYSIS OF THE COMPETING ACUTE CARE BED APPLICATIONS

Pursuant to G.S. § 131E-183(a)(1) and the 2025 State Medical Facilities Plan, no more than 267 acute care beds may be approved for Wake County in this review. Because the applications in this review collectively propose to develop 680 additional acute care beds in Wake County, all applications cannot be approved for the total number of beds proposed. Therefore, a comparative review is required as part of the Agency findings after each application is reviewed independently against the applicable statutory review criteria. The following summarizes the competing applications relative to the potential comparative factors for this 2025 Wake County acute care bed review.

Conformity with CON Review Criteria and Rules

Only applicants demonstrating conformity with all applicable review Criteria and rules can be approved, and only the application submitted by Novant Health demonstrates conformity to all Criteria:

Conformity of Applicants

Applicant	Project I.D.	Conforming/ Non-Conforming
Novant Knightdale	J-012686-25	Conforming
WakeMed Raleigh	J-012671-25	Non-Conforming
WakeMed North	J-012672-25	Non-Conforming
WakeMed Garner	J-012673-25	Non-Conforming
Rex Hospital	J-012677-25	Non-Conforming
Rex Hospital Wake Forest	J-012680-25	Non-Conforming
Duke Cary	J-012689-25	Conforming
Duke Raleigh	J-012690-25	Conforming

The Novant Health application is based on reasonable and supported volume projections and adequate projections of cost and revenues. As discussed separately in this document, the WakeMed and Rex applications contain errors and flaws which result in one or more non-conformities with statutory and

regulatory review Criteria. Therefore, the Novant Health and Duke applications are the **most effective** alternative regarding conformity with applicable review Criteria and rules.

Scope of Services

While the Agency found in the 2024 Wake County acute care bed review that the tertiary care hospital applicant was more effective on the scope of services factor, Novant Health does not believe tertiary providers should automatically receive preference on this factor. By definition, these facilities offer a broader range of services, but most acute care patients in Wake County do not require tertiary-level care. The majority could be appropriately served at either a tertiary or a community hospital. What Wake County truly lacks is a new community hospital in the eastern part of the county, one that will expand access to essential acute care services for residents while also enhancing competition.

Geographic Accessibility

There are eight applications proposing to develop new acute care beds in existing, approved but undeveloped or new locations. The following table illustrates where the existing and proposed acute care beds are or are proposed to be located within Wake County.

Hospitals	Total Beds*	Beds proposed	Address	Location within Wake County	Existing	New
	A	B	C	D	E	F
Duke Cary**	40	120	Cary	Western	Approved	
UNC Rex Holly Springs	50	0	Holly Springs	Western	Existing	
WakeMed Cary	200	0	Cary	Central/West	Existing	
Duke Raleigh**	164	101	Raleigh	Central	Existing	
UNC Rex Raleigh	436	106	Raleigh	Central	Existing	
WakeMed Raleigh	517	164	Raleigh	Central	Existing	
WakeMed North	71	35	North Raleigh	Central/North	Existing	
UNC Rex Wake Forest	0	50	Wake Forest	Central/ North		New
WakeMed Garner***	31	78	Garner	South/Southeast	Approved	
Novant Knightdale	0	26	Knightdale	Central/East		New
Total	1,509	680				

**Duke Raleigh currently has 204 licensed acute care beds however 40 AC beds are approved to be transferred to Duke Cary.

***WakeMed Garner is approved for a 31 acute care Bed hospital with 22 AC beds being transferred from WakeMed Raleigh and 9 new AC beds

Note: The Agency decisions regarding the 44 acute care beds from the 2023 SMFP need determination and 70 acute care beds from the 2024 SMFP need determination are all currently under appeal. The respective acute care beds are not existing, approved or proposed as defined by the Acute Care Bed Rules. Therefore, the 144 acute care beds (44 + 70) from the 2023 SMFP and the 2024 SMFP are not included in any of the acute care bed totals in Column A.

With regard to this comparative factor between the two applications proposing to develop acute care beds in new locations:

- Novant Knightdale, which is proposed to be located in the Central/East area of Wake County that currently has no acute care beds and, in a town, Knightdale, with no existing acute care beds, is the **most effective** alternative.

- UNC Rex Wake Forest, which is proposed to be located in the Central/North area of Wake County that currently only has 71 acute care beds and, in a town, Wake Forest, with no existing acute care beds, is a less effective alternative than Novant Knightdale.

The applications of WakeMed North, WakeMed Cary, WakeMed Raleigh, UNC Rex Raleigh, Duke Raleigh and Duke Cary applications all propose to locate acute care beds in a facility at a location which either currently offers acute care beds or is approved to offer acute care beds, therefore they are all least effective alternatives.

Competition (Access to a New or Alternate Provider)

Even though Wake County already hosts three established health care systems, the benefits of competition can still be realized through the entry of a new provider, i.e., Novant Health. Generally, the introduction of a new provider into a service area is the more effective alternative, as increased patient choice encourages all providers to improve quality and reduce costs in order to compete for patients. At the same time, the expansion of an existing provider that currently controls fewer acute care beds than a dominant competitor can also promote competition by stimulating each provider in the market to raise quality or operate more efficiently.

In the 2024 Wake County acute care bed review, this comparative factor was evaluated at the health system level. As shown in the table below, four health systems submitted a combined total of eight applications as part of this review.

Health Systems	Applications in this Review	Existing Wake Co. Provider
Novant	**Novant Knightdale**	**No**
WakeMed	WakeMed North, WakeMed Cary & WakeMed Raleigh	Yes
UNC	UNC Rex Raleigh & UNC Rex Wake Forest	Yes
Duke	Duke Raleigh. Duke Cary & Duke Garner	Yes

Novant Health, through its Novant Knightdale application, would qualify as a new provider in the Wake County service area. Accordingly, with respect to Criterion 18 and this comparative factor, the Novant Knightdale proposal represents the more effective alternative to enhance competition and improve patient choice in Wake County. The Agency should not diminish the importance of this factor simply because three health care systems already operate in the county; the introduction of a new provider will bring distinct competitive benefits. This is especially true in eastern Wake County, where residents currently face fewer hospital options and would most directly benefit from expanded choice and improved access.

Access by Service Area Residents

On page 33, the 2025 SMFP defines the service area for acute care beds as “the acute care bed service area in which the bed is located. The acute care bed service areas are the single and multicounty groupings

shown in Figure 5.1." Figure 5.1, on page 38, shows Cabarrus County as a single-county acute care bed service area. Thus, the service area for this review is Cabarrus County. Facilities may also serve residents of counties not included in their service area.

The following table illustrates access by service area residents during the third full fiscal year following project completion.

Projected Service to Cabarrus County Residents, Project Year 3

Comparative	Novant Knightdale	WakeMed Raleigh	WakeMed North	WakeMed Garner	Rex Hospital	Rex Hospital Wake Forest	Duke Cary	Duke Raleigh
# of Wake County Patients	1,782	24,963	10,369	5,764	25,866	*	7,429	9,707
% of Wake County Patients	100.0%	80.7%	82.6%	71.7%	64.1%	*	70.6%	62.9%

* Rex Hospital Wake Forest did not provide patient origin projections in a manner that isolates projected utilization for Wake County residents.
Source: CON applications, Section C.3

As shown in the previous table, Novant Health plans to serve the highest percentage of patients from Wake County during the third project year.

It would be inappropriate to directly compare the absolute number of Wake County patients served between the competing applications because the size of the various facilities is vastly different. NH Knightdale, with 26 proposed acute care beds, will naturally serve fewer patients simply because of its smaller capacity. In contrast, other facilities with significantly larger bed capacity are able to serve a larger volume of patients simply by virtue of their scale. This disparity in bed size makes any direct comparison based on the absolute number of patients served misleading and unfair.

Instead, the Agency should focus on the *percentage* of Wake County patients served by each facility. This approach will provide a more accurate and equitable comparison of how each hospital is meeting the needs of the community. For example, a smaller hospital like NH Knightdale could serve a higher percentage of the service area population relative to its size, demonstrating its efficiency and effectiveness in addressing the needs of the community. Meanwhile, a larger facility like Rex Hospital could treat a larger number of patients simply due to its bed count, but this doesn't necessarily indicate that it is equally effective or adequately addressing the needs of *service area residents*.

By comparing the percentage of patients served, the Agency will be able to more accurately assess each hospital's role in meeting the healthcare needs of Wake County, regardless of the differences in size of the facilities. This ensures a fairer and more meaningful comparison of how each applicant contributes to the overall healthcare landscape in the region. Therefore, regarding access by service area residents, the application submitted by **Novant Health** is the **most effective** alternative.

Access by Underserved Groups

Underserved groups are defined in G.S. § 131E-183(a)(13) as follows:

"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 access by underserved groups, applications are typically compared with respect to Medicare patients and Medicaid patients. [1] Access by each group is treated as a separate factor.

The Agency may use one or more of the following metrics to compare the applications:

- Total Medicare or Medicaid patients
- Medicare or Medicaid admissions as a percentage of total patients
- Total Medicare or Medicaid dollars
- Medicare or Medicaid dollars as a percentage of total gross or net revenues
- Medicare or Medicaid cases per patient

The above metrics the Agency uses are determined by whether or not the applications included in the review provide data that can be compared as presented above and whether or not such a comparison would be of value in evaluating the alternative factors.

Projected Medicare

The following table compares projected access by Medicare patients in the third full fiscal year following project completion for all the applicants in the review.

Projected Medicare Revenue – 3rd Full FY

Applicant	Form F.2b Total Medicare Revenue	Form C.1b Discharges	Avg Medicare Rev. per Discharge	Form F.2b Gross Revenue	% of Gross Revenue
Novant Knightdale	$30,148,629	1,782	$16,918	$74,066,466	**40.7%**
WakeMed Raleigh	$2,884,177,584	30,924	$93,267	$7,019,531,920	41.1%
WakeMed North	$455,999,224	12,557	$36,314	$699,805,969	65.2%
WakeMed Garner	$296,292,393	8,036	$36,871	$1,096,386,934	27.0%
Rex Hospital	$358,378,659	40,344	$8,883	$577,386,793	62.1%
Rex Hospital Wake Forest	$125,448,136	3,067	$40,903	$208,882,217	60.1%
Duke Cary	$164,532,512	10,517	$15,644	$291,564,457	56.4%
Duke Raleigh	$540,701,206	15,443	$35,013	$886,921,722	61.0%

Novant Knightdale projects that 40.7% of its gross revenue will be derived from Medicare patients in the third full fiscal year, which is highly competitive among the applicants in this review. Although some existing facilities report higher percentages, these reflect established tertiary hospitals with larger patient volumes and more complex case mixes. For a new community hospital, Novant Knightdale's Medicare payer mix demonstrates a strong commitment to serving older adults, who represent one of the most significant drivers of inpatient utilization in Wake County.

[1] Due to differences in definitions of charity care among applicants, comparisons of charity care are inconclusive.

On a per-discharge basis, Novant Knightdale projects an average Medicare revenue of $16,918 per discharge, which is consistent with expectations for a community hospital serving a broad range of general acute care patients. This level is notably higher than Rex Hospital ($8,883) and Duke Cary ($15,644), both of which are established providers.

Taken together, these projections confirm that Novant Knightdale will provide meaningful access to Medicare beneficiaries while expanding geographic access in eastern Wake County, an area with a large and growing base of older residents.

Projected Medicaid

The following table compares projected access by Medicaid patients in the third full fiscal year following project completion for all the applicants in the review.

Projected Medicaid Revenue – 3rd Full FY

Applicant	Form F.2b Total Medicaid Revenue	Form C.1b Discharges	Avg Medicaid Rev. per Discharge	Form F.2b Gross Revenue	% of Gross Revenue
Novant Knightdale	$15,862,622	1,782	$8,902	$74,066,466	**21.4%**
WakeMed Raleigh	$1,331,580,846	30,924	$43,060	$7,019,531,920	19.0%
WakeMed North	$57,347,203	12,557	$4,567	$699,805,969	8.2%
WakeMed Garner	$339,233,850	8,036	$42,214	$1,096,386,934	30.9%
Rex Hospital	$54,988,749	40,344	$1,363	$577,386,793	9.5%
Rex Hospital Wake Forest	$11,416,137	3,067	$3,722	$208,882,217	5.5%
Duke Cary	$42,548,228	10,517	$4,046	$291,564,457	14.6%
Duke Raleigh	$98,107,395	15,443	$6,353	$886,921,722	11.1%

Based on the table above, Novant Knightdale projects the second highest Medicaid revenue as a percentage of gross revenue (21.4%) and is therefore a more effective alternative compared to all other competing applications. This projection reflects not only Novant Health's commitment to serving a substantial base of Medicaid patients, but also the geographic location of the proposed facility. By locating in eastern Wake County, Novant Knightdale will expand access to hospital care in an area that includes a large base of medically underserved residents.

Locating a full-service community hospital in Knightdale ensures that these populations can obtain needed acute care services closer to home, improving both convenience and health outcomes. Accordingly, Novant Knightdale represents not only a financially effective alternative under this comparative factor, but also the alternative that most meaningfully advances equitable access to care for medically underserved residents of Wake County.

Projected Average Net Revenue

The following table compares projected average net revenue per patient day in the third full fiscal year following project completion for each facility. Generally, regarding this factor, the application proposing the lowest average net revenue per patient day is the more effective alternative since a lower average may indicate a lower cost to the patient or third-party payor.

Projected Net Revenue – 3rd Full FY

Applicant	Form C.1b Discharges	Form F.2b Net Revenue	Average Net Revenue Per Discharge
Novant Knightdale	1,782	$20,853,127	**$11,702**
WakeMed Raleigh	30,924	$2,066,664,344	$66,830
WakeMed North	12,557	$189,175,371	$15,065
WakeMed Garner	8,036	$276,209,174	$34,371
Rex Hospital	40,344	$216,320,161	$5,362
Rex Hospital Wake Forest	3,067	$81,872,026	$26,694
Duke Cary	10,517	$116,852,450	$11,111
Duke Raleigh	15,443	$349,603,866	$22,638

Novant Knightdale projects the third lowest average net revenue per discharge among all applicants, and is therefore an effective alternative under this comparative factor. Importantly, Novant Knightdale's projected revenue per discharge is both competitive and consistent with the cost profile of a community hospital, reinforcing its role as a lower-cost, high-access alternative to the larger tertiary providers in the county.

When combined with Novant Knightdale's geographic location in eastern Wake County and its commitment to serving a substantial share of Medicaid patients, this financial profile underscores the project's effectiveness in expanding access to cost-effective care for a medically underserved population base. Thus, Novant Knightdale is not only an effective alternative under this factor, but also one that will enhance both affordability and accessibility of acute care services in Wake County.

Projected Average Operating Expense

The following table compares projected average operating expense per patient day in the third full fiscal year following project completion for each facility. Generally, regarding this factor, the application proposing the lowest average operating expense per discharge is the more effective alternative since a lower average may indicate a lower cost to the patient or third-party payor or a more cost-effective service.

Projected Operating Expenses – 3rd Full FY

Applicant	Form C.1b Discharges	Form F.2b Operating Expense	Average OpEx Per Discharge
Novant Knightdale	1,782	$23,649,498	**$13,271**
WakeMed Raleigh	30,924	$913,345,877	$29,535
WakeMed North	12,557	$112,582,964	$8,966
WakeMed Garner	8,036	$253,941,348	$31,600
Rex Hospital	40,344	$331,706,195	$8,222
Rex Hospital Wake Forest	3,067	$68,954,315	$22,483
Duke Cary	10,517	$108,940,302	$10,358
Duke Raleigh	15,443	$367,287,608	$23,783

Novant Knightdale projects an average operating expense per discharge of $13,271 in the third full fiscal year. While this figure is not the lowest among applicants, it is important to recognize that Novant's calculation is based on the smallest denominator of discharges of all applicants (1,782). Given the relatively low patient volume of a new community hospital compared to established tertiary facilities, fixed and start-up costs are spread across fewer discharges, which naturally inflates the per-discharge figure.

Even under these circumstances, Novant Knightdale's operating expense per discharge remains highly competitive. It is significantly lower than WakeMed Garner ($31,600) and WakeMed Raleigh ($29,535), both of which are existing facilities with larger patient bases. This demonstrates that Novant Knightdale can deliver care at a cost level comparable to or better than many existing providers, despite being a new entrant with lower initial patient volume.

Accordingly, when viewed in the context of its scale and mission as a community hospital in an underserved geography, Novant Knightdale represents a financially responsible and effective alternative that balances cost-efficiency with the need to expand geographic access in eastern Wake County.

Conclusion

The following table lists the comparative factors and indicates whether each application was most effective, more effective, less effective or least effective for each factor.

Comparative Factor	Novant Knightdale	WakeMed Raleigh	WakeMed North	WakeMed Garner	Rex Hospital	Rex Hospital Wake Forest	Duke Cary	Duke Raleigh
Conformity with Review Criteria	**Most Effective**	Less Effective	Less Effective	Less Effective	Less Effective	Less Effective	**Most Effective**	**Most Effective**
Geographic Accessibility	**Most Effective**	Less Effective	Less Effective	Less Effective	Less Effective	Less Effective	Less Effective	Less Effective
Enhance Competition	**Most Effective**	Less Effective	Less Effective	Less Effective	Less Effective	Less Effective	Less Effective	Less Effective
Access by Service Area Residents	**Most Effective**	Less Effective	Less Effective	Less Effective	Less Effective	Less Effective	Less Effective	Less Effective
Access by Medicare Recipients	Less Effective	Less Effective	**Most Effective**	Less Effective	**Most Effective**	Less Effective	Less Effective	Less Effective
Access by Medicaid Recipients	**More Effective**	Less Effective	Less Effective	**Most Effective**	Less Effective	Less Effective	Less Effective	Less Effective
Average Net Revenue per Patient	**More Effective**	Less Effective	Less Effective	Less Effective	**Most Effective**	Less Effective	**More Effective**	Less Effective
Avg. Operating Expense per Patient	Less Effective	Less Effective	**More Effective**	Less Effective	**Most Effective**	Less Effective	Less Effective	Less Effective

Novant Knightdale is the ***most effective*** alternative for the following comparatives:

- Conformity with Review Criteria
- Geographic Accessibility
- Competition (Access to a New or Alternative Provider)
- Access by Service Area Residents

Novant Knightdale is a ***more effective*** alternative for the following comparatives:

- Access by Medicaid Recipients
- Average Net Revenue per Patient

No other applicant compares more favorably than Novant Knightdale under the comparative analysis. Accordingly, Novant Health's application should be approved as submitted. Approval of Novant Knightdale would not preclude the approval of other applications, provided they demonstrate conformity with the applicable statutory review criteria and administrative rules. However, Novant Knightdale clearly represents the most effective alternative to expand access, promote competition, and meet the acute care needs of Wake County residents.

Most importantly, approval of Novant Knightdale would directly address the existing gap in eastern Wake County, bringing a full-service community hospital to an area that has long lacked convenient access to acute care services and where a large base of medically underserved residents stands to benefit.

COMMENTS SPECIFIC TO ALL WAKEMED APPLICATIONS: WAKEMED RALEIGH APPLICATION PROJECT ID # J-012671-25, WAKEMED NORTH APPLICATION PROJECT ID # J-012672-25, AND WAKEMED GARNER APPLICATION PROJECT ID # J-012673-25

WakeMed has submitted three concurrent and complementary applications that share many aspects including identical acute care bed utilization assumptions and methodology. As such, Novant Health has grouped the below comments which apply to each of the WakeMed applications.

Unreasonable Shift Assumptions for WakeMed North

In its projected acute care bed utilization methodology, WakeMed North assumes that it will serve an increasing number of acute care discharges that are shifted from WakeMed Raleigh. In fact, WakeMed North's projected bed need is based entirely on this shift of patients. As shown on page 165 of the WakeMed North application, in FY 2032, Project Year 3, WakeMed Raleigh is projected to shift 2,781 patients to WakeMed North, as excerpted below.

Table 13: Total Patients Shifted from WakeMed Raleigh Campus to WakeMed North by ZIP Code, FY 2030 - FY 2035, per WakeMed Raleigh Campus CON Application

ZIP	a. WakeMed Raleigh Campus Patients before Shift						b. % Shift	c. Patients shifted from WakeMed Raleigh Campus to WakeMed North					
	PY1	PY2	PY3	Extra				PY1	PY2	PY3	Extra		
	FY30	FY31	FY32	FY33	FY34	FY35		FY30	FY31	FY32	FY33	FY34	FY35
27587	1,668	1,717	1,768	1,820	1,874	1,929	33%	550	567	583	601	618	637
27616	1,556	1,592	1,629	1,667	1,706	1,746	27%	420	430	440	450	461	471
27614	569	580	591	602	614	626	33%	188	191	195	199	203	207
27596	618	640	663	687	712	738	33%	204	211	219	227	235	244
27615	603	607	611	616	621	626	33%	199	200	202	203	205	207
27525	447	460	473	487	501	515	33%	148	152	156	161	165	170
27549	715	732	750	768	786	805	27%	193	198	203	207	212	217
27703	369	378	387	396	405	414	33%	122	125	128	131	134	137
27613	395	399	403	407	411	415	27%	107	108	109	110	111	112
27597	1,691	1,741	1,792	1,845	1,899	1,955	6%	101	104	108	111	114	117
27604	1,595	1,618	1,641	1,664	1,688	1,712	6%	96	97	98	100	101	103
27609	648	653	658	663	669	675	12%	78	78	79	80	80	81
27610	4,294	4,377	4,462	4,549	4,637	4,727	0%	0	0	0	0	0	0
27591	1,281	1,314	1,348	1,383	1,419	1,456	6%	77	79	81	83	85	87
27617	308	314	320	327	334	341	33%	102	104	106	108	110	113
27571	180	185	190	195	201	207	27%	49	50	51	53	54	56
27545	1,286	1,318	1,351	1,384	1,418	1,453	0%	0	0	0	0	0	0
27522	67	68	69	70	71	72	33%	22	22	23	23	23	24
Total Cases Shifted from WakeMed Raleigh Campus to WakeMed North								**2,656**	**2,716**	**2,781**	**2,847**	**2,911**	**2,983**

Notes:

a. See Exhibit C.5, p21 for WakeMed Raleigh Campus patient projections.
b. WakeMed assumption. See Exhibit C.5, p12, Table 6 for shift analysis.
*c. a * b*

Based on WakeMed North's assumed ALOS of 3.33 days (as stated on page 174 of the WakeMed North application), these shifted patients will account for 9,261 days or an average daily census of 25 patients – which would fill WakeMed North's proposed 25 additional beds at over 100% of capacity (note, this estimate of the impact of the shift from WakeMed Raleigh to WakeMed North is understated as it does not account for WakeMed North's assumed inmigration). However, WakeMed North fails to demonstrate that these proposed shifts are reasonable and supported.

WakeMed discusses and proposes this shift as if WakeMed North will be a new hospital that offers a new geographic access point for patients that are currently receiving care at WakeMed Raleigh. However, WakeMed North has offered inpatient acute care services since 2015. It may be reasonable to assume that significant patient shifts to a new hospital based on the offering of a new geographic point of access with increased proximity for patients. However, it is not reasonable to assume the significant shift of care from two existing hospitals using patient proximity/drive times as the sole basis without any other supporting factors. WakeMed North provides no discussion or evidence to indicate that WakeMed Raleigh patients will suddenly shift their chosen location of care in FY 2030 more than 15 years after WakeMed North opened its inpatient services. WakeMed North attempts to provide the reasoning for its projected shift by stating on page 164, "*When the proposed project opens, WakeMed North will have more acute inpatient bed capacity, but WakeMed Raleigh capacity will not increase until later. When these 60 North beds open WakeMed North can absorb patients from WakeMed Raleigh. See the project schedule in Table 1 above. As a result, WakeMed expects that some WakeMed Raleigh Campus catchment area inpatients will shift to WakeMed North."*

WakeMed North assumes that patients who are already driving past its facility to a busier, larger, tertiary medical center will suddenly choose differently when the only change is that WakeMed North has added beds. WakeMed North does not address why this patient behavior would change while both WakeMed Raleigh and WakeMed North are adding beds.

WakeMed North states on page 164 that "*WakeMed conservatively limited the maximum shift to 33 percent away from WakeMed Raleigh Campus to WakeMed North.*" However, WakeMed North provides no analysis, discussion, or evidence that supports the reasonableness of a maximum shift of 33% from WakeMed Raleigh to WakeMed North in the future. As WakeMed North states on page 60, "*Over the years, growth in the service area population and demand for services necessitated that WakeMed North be transitioned to a Community Hospital. While still offering obstetric and neonatal services,* ***the hospital developed additional medical-surgical services, initiated physician coverage for Cardiology, General Surgery, and Orthopaedic patients****, added other specialist physician offices, and attracted more scheduled inpatients. Concurrently, local EMS providers began conserving miles and* ***taking more patients from northern Wake County and southern Franklin County to WakeMed North rather than to WakeMed Raleigh Campus*** *and other area hospitals*" (**emphasis added**). As such, WakeMed North's historical growth has been through the development of community hospital services and a shift of patients from WakeMed Raleigh that has been occurring for some time. As such, many WakeMed Raleigh patients that can be appropriately served by WakeMed North have shifted there already. There is no evidence that up to 33 percent of the remaining WakeMed Raleigh patients could be appropriately served at WakeMed North.

In the instance of its proposed new WakeMed Garner facility, WakeMed states that only 76% of WakeMed Raleigh patients could be appropriately served at WakeMed Garner (see page 6 of Exhibit C.5 of the WakeMed Garner application). Thus, 24% of WakeMed Raleigh patients cannot be served at WakeMed Garner. Notably, WakeMed fails to provide a similar analysis for the percentage of WakeMed Raleigh patients that could be served at WakeMed North. WakeMed North does not and will not have the same breadth of services as WakeMed Raleigh and will not be able to serve many complex or sub-specialty patients (e.g. open-heart surgery, trauma, pediatric, etc.). As evidence of the significant difference of these hospitals' patient acuity, in FY 24, WakeMed North's ALOS was 3.33 days compared to WakeMed Raleigh's 5.87 day ALOS, according to Exhibit C.5, page 14.

WakeMed North and WakeMed Garner are assumed to have similar capabilities. WakeMed states that 95% of WakeMed North patients can be served at WakeMed Garner and assumes WakeMed Garner and

WakeMed North will have an equivalent ALOS. Given these similarities, it can be inferred that WakeMed North can only serve approximately 76 percent of WakeMed Raleigh patients, similar to WakeMed Garner.

Given the historical growth of WakeMed North due to the development of community hospital services there and the shift of patients from WakeMed Raleigh, it is clear that some or all of those WakeMed Raleigh acuity-appropriate patients have already shifted to WakeMed North. In its current application, WakeMed North assumes an additional 33% of patient in seven zip codes will shift from WakeMed Raleigh to WakeMed North. Notably, WakeMed's projection methodologies do not include any acuity-adjustment or patient selection, thus its assumed shifts are applied to all acute care patients, regardless of DRG, specialty, acuity, etc. Given that these zip codes where a 33% shift is assumed are the most proximate to WakeMed North, the current patients that are choosing to go to WakeMed Raleigh are more likely to composed of higher acuity patients that cannot be appropriately served at WakeMed North. Yet, WakeMed North provides no DRG or other analysis to demonstrate that this proposed shift is reasonable.

As such, WakeMed fails to provide reasonable utilization projections for WakeMed North in its three applications. As such, each of the three WakeMed applications is **non-conforming with Criteria (1), (3), (4), (5), (6), (8), and (18(a) and 10A NCAC 14C .3803.**

Unreasonable Shift Assumptions for WakeMed Garner

In its projected acute care bed utilization methodology, WakeMed Garner assumes that it will serve acute care discharges that are shifted from other WakeMed facilities based on a series of unfounded assumptions related to patient proximity to facilities and the ability of WakeMed Garner to serve patients of differing acuity levels. WakeMed Garner states on page 6 of Exhibit C.5 that "*These assumptions are not arbitrary."* However, WakeMed Garner provides no evidence from its own experience or the experience of other providers that supports its assumptions.

As noted above, the WakeMed system has developed WakeMed North and that facility's historical growth has been through the development of community hospital services and a shift of patients from WakeMed Raleigh that has been occurring for some time. However, the WakeMed Garner assumed shifts provide no evidence from the experience of WakeMed North. As stated on page 7 of Exhibit C.5, "*ZIP Codes where patients were historically treated at WakeMed Raleigh are assumed to shift to WakeMed Garner at the following rates:*

- *If Garner is 10 or more minutes closer than the source hospital: 55% shift*
- *If Garner is 4 – 9 minutes closer than the source hospital: 45% shift*
- *If Garner is 0 – 3 minutes closer than the source hospital: 20% shift*
- *If Garner is farther than the source hospital: 10% shift*

Given there is no support evidence or experience cited, it is clear that WakeMed Garner's shift assumptions are, in fact, arbitrary. For example, WakeMed Garner does not provide any evidence to support its distinction that patients in zip codes that are four minutes closer to WakeMed Garner than WakeMed Raleigh will shift at a 45% rate whereas patients in zip codes that are three minutes closer to WakeMed Garner than WakeMed Raleigh will shift at a 20% rate. Further, WakeMed states that only 76% of WakeMed Raleigh patients could be appropriately served at WakeMed Garner (see page 6 of Exhibit C.5 of the WakeMed Garner application). While the proposed shifts of 10 to 55% are being applied to the entire WakeMed Raleigh patient cohort in a given zip code, only 76% can reasonably be served at

WakeMed Garner according to WakeMed's own analysis. This reveals that each of these shifts to WakeMed Garner is actually greater than stated as only 76% percent of WakeMed Raleigh patients can be served.

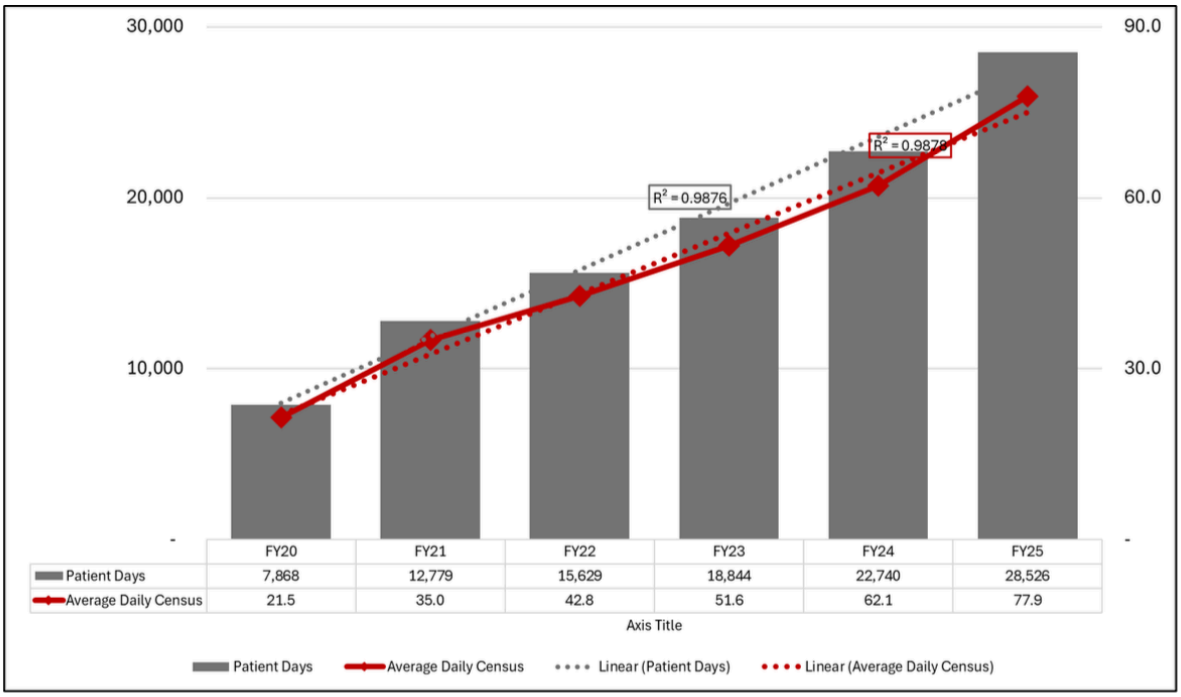
As such, WakeMed fails to provide reasonable utilization projections for WakeMed Garner in its three applications. As such, each of the three WakeMed applications is **non-conforming with Criteria (1), (3), (4), (5), (6), (8), and (18(a) and 10A NCAC 14C .3803.**

Failure to Assume Reasonable Ramp Up Period

On pages 166-174 of its application, WakeMed Garner discusses the proposed shift of discharges to its facility from WakeMed Raleigh, WakeMed North, and WakeMed Cary. Of note, WakeMed Garner assumes these shifts will occur fully and immediately once its facility opens in FY 2029. As such, WakeMed Garner fails to assume there will be any ramp-up of its facility, despite evidence from its own historical experience at WakeMed North that the utilization of new facilities grows over time.

As shown below, excerpted from page 46 of the WakeMed North application, WakeMed North's patient days and average daily census have increased since FY 2020. WakeMed North opened with 61 acute care beds in 2015 and did not add capacity until 2023. As shown, in the data below, WakeMed North operated well below 50 percent of occupancy in FY 2020 and began increasing utilization in FY 2021 and 2022, prior to the development of additional beds. As such, this data indicates that WakeMed North experienced a ramp-up period greater than five years.

Figure 4: WakeMed North Annual Days of Care and Average Daily Census, FY 2019-2024



Source: WakeMed internal data. The Figure shows days in columns and ADC in connected red dots.

WakeMed Garner provide no discussion or evidence to support the reasonableness of an immediate and full shift of patients from other WakeMed facilities and no ramp-up period at its facility. This is unreasonable given the WakeMed North experience cited above.

As such, WakeMed fails to provide reasonable utilization projections for WakeMed Garner in its three applications. As such, each of the three WakeMed applications is **non-conforming with Criteria (1), (3), (4), (5), (6), (8), and (18(a) and 10A NCAC 14C .3803.**

Unreasonable Occupancy Rates

WakeMed North projects unreasonable occupancy rates in excess of 110% for multiple years before the start of its proposed project. These projected occupancy rates are impossible given that WakeMed North notes that it does not have "surge" capacity currently and that temporary bed waivers only permit a hospital to increase its bed capacity by up to 10 percent. As WakeMed North's project year bed utilization projections rely on these unreasonable prior year projections, its project year projections are unreasonable.

As shown below in an excerpt from its Exhibit C.5, WakeMed North is projected to operate above 110% of capacity in FYs 2025, 2027, 2028, and 2029.

		FY24	FY25(Ann)	FY26	FY27	FY28	FY29	FY30	FY31	FY32	FY33	FY34	FY35
	WakeMed North Campus				**Interim**			**1st Full**	**2nd Full**	**3rd Full**	**Extra**	**Extra**	**Extra**
m	Discharges after shifts	6,674	8,133	8,430	8,627	8,830	8,581	11,982	12,264	12,557	12,859	13,164	13,487
n	ALOS	3.33	3.59	3.33	3.33	3.33	3.33	3.33	3.33	3.33	3.33	3.33	3.33
o	Patient Days	22,194	29,224	28,072	28,728	29,404	28,575	39,900	40,839	41,815	42,820	43,836	44,912
p	ADC	61	80	77	79	81	78	109	112	115	117	120	123
q	Acute Care Beds, Licensed	71	71	71	71	71	71	131	131	131	131	131	131
r	Percent Occupancy, Calculated	85.6%	112.8%	108.3%	110.9%	113.5%	110.3%	83.5%	85.4%	87.5%	89.6%	91.7%	93.9%

Hospitals may temporarily receive permission from DHSR to increase bed capacity by up to 10% over licensed bed capacity, by using observation beds for inpatients, under 10A NCAC 13B .13111. However, WakeMed North states specifically in its application that it cannot do so as it does not have the physical space:

> Floor plans in Exhibit K.2 show that the new five-story tower addition will enable WakeMed to place the proposed new acute care beds in one nursing unit. This will enhance quality, providing efficient nurse staffing. The total build-out of 60 beds (25+35) would use three floors of the tower. Although 15 beds on the third unit will be designated "Observation," and used as such most of the time, in the case of emergency, such as a pandemic or catastrophic event, the configuration will permit immediate use of the observation beds as temporary acute care beds during demand surges, with prior Agency approval per 10A NCAC 13B.3111. WakeMed North has no such surge capacity today.

See WakeMed North, page 87. Emphasis added.

As such, according to its application, WakeMed North does not have capacity today to accommodate a temporary increase in its bed capacity under 10A NCAC 13B .13111 that could allow occupancy rates in excess of 100 percent. Moreover, even if WakeMed North did have "surge capacity", it would only allow an increase of up to 10% of bed capacity, or 110% in total. However, as shown above, WakeMed North projects occupancy rates greater than 110% in four separate years.

In its WakeMed Raleigh application, WakeMed states on page 182 that "*It is not reasonable for a hospital to plan for 100 percent bed occupancy. The Performance Standard is designed to allow time to clean*

*bedrooms between patients and to buffer peak times of the day when new admissions and discharges overlap, as well as to accommodate seasonal peaks in patient demand.***"** WakeMed includes an almost identical statement on page 176 of the WakeMed Garner application, stating "*It is not reasonable for a hospital to plan for 100 percent bed occupancy. The Performance Standard is designed to allow time to clean bedrooms between patients and to buffer peak times of the day when new admissions and discharges overlap, as well as to accommodate seasonal peaks in patient demand*." WakeMed makes clear in these statements that projected occupancy in excess of 100% does not account for patient turnover, peak times during the day, or seasonal patient demand. Yet, inexplicably, WakeMed North's projected utilization assumes that it will achieve well over 100% of capacity in multiple years and, as such, does not account for patient turnover, peak times during the day, or seasonal patient demand.

Given these factors, WakeMed North's projected utilization is unreasonable. As such, each of the three WakeMed applications is **non-conforming with Criteria (1), (3), (4), (5), (6), (8), and (18(a) and 10A NCAC 14C .3803.**

COMMENTS SPECIFIC TO WAKEMED RALEIGH APPLICATION
PROJECT ID # J-012671-25

Failure to Demonstrate Most Effective Alternative

WakeMed Raleigh's application fails to demonstrate that its proposed project is the most effective alternative to meeting the needs of its patients. While WakeMed argues that "a significant number of patients will still need WakeMed Raleigh's complex services, due to the complexity of their medical needs" (page 59) after the proposed expansions at WakeMed Garner and WakeMed North, it also states that 76 percent of WakeMed Raleigh patients, per page 59, could be appropriately served at WakeMed Garner or WakeMed North, community hospitals offering general acute care services.

While WakeMed Raleigh proposes to shift some of these community hospital-appropriate patients to WakeMed North and WakeMed Garner, WakeMed's planned shifts in NH Knightdale's proposed service area are limited. As such, Knightdale and surrounding area patients who can be effectively served at a community hospital will not have a convenient, nearby option and instead will need to continue to be served at large, complex, tertiary medical centers.

WakeMed Raleigh's application highlights the need for services in Knightdale as proposed in NH Knightdale, stating on page 68:

> *The western portion of ZIP code 27545, the Knightdale area of Eastern Wake County—adjacent to the newly extended I-540 corridor—is experiencing a rapid residential boom as well. According to Aterio, that overall ZIP code population would jump by 31.4 percent, from 27,215 in 2020 to 35,765 by 2025, and then reach 38,420 by 2030—significantly higher than the national growth average.22 This surge is being driven in large part by new subdivisions and increased transit access along the I-540 western strip, which is enhancing the area's appeal for suburban development. Housing supply is struggling to keep up: by 2030, the area is projected to face a 4,282-home deficit, and the county is racing to catch up with new permits. These trends underscore the pressing need for increased hospital capacity to serve the rapidly expanding population on Knightdale's western (WakeMed Raleigh Campus) side*.

Data and maps presented through WakeMed Raleigh's application indicate the need for greater access to healthcare services in the Knightdale and surrounding areas, including the Overall Social Vulnerability Score map on page 72 and the Social Vulnerability Theme Scores maps on page 73.

Despite this apparent need, WakeMed Raleigh's application proposes to offer more of the same: an expansion of capacity at a busy medical center. Notably, WakeMed Raleigh's planned shifts are limited in NH Knightdale's proposed service area. In the NH Knightdale Primary Service Area, only six to ten percent of WakeMed Raleigh patients are proposed to shift to either WakeMed Garner or WakeMed North, which suggests that 90 to 94% of WakeMed Raleigh patients from these zip codes are expected to remain in place at a tertiary, congested trauma center. As stated above, WakeMed Raleigh notes that 76% of its patients could be served at a community hospital like WakeMed Garner or WakeMed North. Therefore, 68 to 71% (76% x 90-94%) of WakeMed Raleigh patients originating from NH Knightdale's primary service area are community hospital appropriate patients who WakeMed proposes to serve in a congested tertiary medical center. As NH Knightdale demonstrates, a portion of these patients can be better served at a smaller, convenient local community hospital.

Based on the factors discussed above, WakeMed Raleigh has failed to demonstrate that it has proposed the most effective alternative for the patients it proposes to serve. Thus, the WakeMed Raleigh application is **non-conforming with Criterion (4).**

Unreasonable Observation Bed Projections at WakeMed Raleigh

As discussed throughout its application, WakeMed Raleigh proposes to shift a significant number of acute care patients to WakeMed North and WakeMed Garner over the course of its projection period. These shifts are expected to drive significant changes in WakeMed Raleigh's acute care utilization. As shown below in an excerpt from its Exhibit C.5, WakeMed Raleigh's acute care days are projected to peak at 203,572 days in FY 2028 and decline for two years before slowly rebounding.

		FY24	FY25(Ann)	FY26	FY27	FY28	FY29	FY30	FY31	FY32	FY33	FY34	FY35
	WakeMed Raleigh Campus		Interim	Interim	Interim	Interim	Interim	Interim	Interim	Interim	1st Full	2nd Full	3rd Full
g	Discharges after shifts	31,231	32,610	33,196	33,929	34,680	30,158	27,753	28,356	28,975	29,608	30,262	30,924
h	ALOS	5.87	5.76	5.87	5.87	5.87	6.23	6.51	6.51	6.51	6.51	6.51	6.52
i	Patient Days	183,296	187,740	194,861	199,163	203,572	187,884	180,672	184,598	188,627	192,748	197,006	201,624
j	ADC	502	514	534	546	558	515	495	506	517	528	540	552
k	Acute Care Beds, Licensed	539	539	539	560	560	538	538	538	538	702	702	702
l	Percent Occupancy, Calculated	93.2%	95.4%	99.0%	97.4%	99.6%	95.7%	92.0%	94.0%	96.1%	75.2%	76.9%	78.7%

In addition to its proposed additional acute care beds, WakeMed Raleigh's project includes additional components stating, "*To complement the acute care beds, the project will include acquisition of one additional CT scanner and development of 16 unlicensed observation beds*" (page 30).

Yet, despite the complementary nature of observation beds, WakeMed Raleigh's observation bed utilization projections entirely fail to account for its projected dramatic changes in its acute care utilization. On page 187 of its application, WakeMed Raleigh provides its observation bed utilization projections assumptions stating "*The Applicant takes the annualized FY 2025 observation days for observation patients admitted from the ED (Table 23) and grows them at the total WakeMed Raleigh catchment area weighted CAGR of 2.17 percent found in Step 6, Table 7 of the acute care beds methodology. The projections for boarding census and observation days are in Table 24. Although most observation patients are admitted from the ED, a small number originate from other hospital sources, such as same-day surgery. For these projections, WakeMed conservatively uses only observation patients admitted from the ED as the baseline."* As such, WakeMed Raleigh's observation bed projections begin with a FY 2025 baseline number and are grown consistently through the projection period, without any adjustment for its projected changes in acute care utilization.

WakeMed Raleigh fails to demonstrate why its future observation utilization will not be impacted by its projected inpatient shifts. As such, WakeMed Raleigh's projected observation utilization is not reasonable and supported. Thus, the WakeMed Raleigh application is **non-conforming with Criteria (1), (3), (4), (5), (6), (8), and (18(a) and 10A NCAC 14C .3803.**

Understated Expenses and Inconsistent Financial Statements

WakeMed Raleigh's Acute Care Bed financial statements, specifically Form F.3b, fail to account for capital expense of its previously approved bed projects. On page 207, in its Form F.3b Assumptions, under Depreciation, WakeMed Raleigh states "*Depreciation Calculated only per projected capital spend for **the project** on a straight-line method; no depreciation historically assigned at the department level, therefore*

no depreciation is shown on Last Full Year and Interim years" (**emphasis added**). Similarly, assumptions for projected Interest and Financing Expense only discuss the currently proposed project.

However, WakeMed Raleigh assumes in its application that a previously approved project for 21 additional acute care beds will proceed, stating on page 23, "*Project No. J-12538-24, WakeMed Raleigh Campus, approved the addition of 21 new acute care beds from the 2024 SMFP need determination. While these beds are under appeal at the time this application is submitted, the Applicant has prepared this current CON application with the assumption that the Agency decision will be upheld, and the beds awarded to WakeMed Raleigh Campus*."

As such, WakeMed Raleigh's acute care utilization projections, and accordingly its staffing, revenue projections, and direct expenses all account for the addition of these 21 beds. However, WakeMed Raleigh's Acute Care Bed Depreciation, Interest, and Financing Expense are understated as they do not account for the 21 bed project.

Additionally, the financial statements provided for the WakeMed System in the WakeMed Raleigh application differ from the same statements included in the WakeMed North and WakeMed Garner applications. WakeMed does provide any discussion of why the financial projections for its System would differ between projects as each application includes consistent utilization projections. As such, the WakeMed System financials are unreasonable.

Given the factors cited above, the WakeMed Raleigh application is **non-conforming with Criterion (5).**

COMMENTS SPECIFIC TO WAKEMED NORTH APPLICATION
PROJECT ID # J-012672-25

Failure to Account for Previous Project

WakeMed North proposes to develop 25 additional acute care beds in a new bed tower on its campus. This scope is identical to WakeMed North's 2024 proposal to develop 25 additional beds (Project ID# J-012536-24) which was denied and appealed by WakeMed.
See https://info.ncdhhs.gov/dhsr/coneed/pdf/appealsFiled/2025/AppealsFeb2025.pdf

As WakeMed has appealed its 2024 WakeMed North project, it still intends to develop those 25 beds. However, WakeMed North fails to discuss how it can develop both its 2024 bed project and its current bed project when the projects have an identical scope to develop 25 acute care beds in the same location on the second floor of its proposed tower. As shown in the line drawings included in Exhibit K.2, the proposed second floor of the tower only has 25 bed spaces. As such, it is impossible for both projects to be developed in that space. Further, WakeMed North has not provided utilization projections or discussion of the impact of the development of both its 2024 and current bed projects such that it would add a total 50 additional beds.

Given the above discussion, WakeMed North fails to demonstrate the need for the project and that it has chosen the most effective alternative. As such, the WakeMed North application is **non-conforming with Criteria (1), (3), (4), (5), (6), (8), and (18(a) and 10A NCAC 14C .3803.**

Understated Expenses and Inconsistent Financial Statements

WakeMed North's Acute Care Bed financial statements, specifically Form F.3b, fail to account for capital expense of its previously approved bed projects. On page 207, in its Form F.3b Assumptions, under Depreciation, WakeMed Raleigh states "*Depreciation Calculated only per projected capital spend for **the project** on a straight-line method; no depreciation historically assigned at the department level, so no depreciation is shown on Last Full Year and Interim years*" (**emphasis added**). Similarly, assumptions for projected Interest and Financing Expense only discuss the currently proposed project.

However, WakeMed North assumes in its application that a previously approved project for 35 additional acute care beds will proceed, stating on page 23, "*Project No. J-12419-23, WakeMed North, approved the addition of 35 new acute care beds from the 2023 SMFP need determination. While those beds are under appeal, the Applicant has prepared this proposal with the assumption that the Agency decision will be maintained, and the beds awarded to WakeMed North*."

As such, WakeMed North's acute care bed utilization projections, and accordingly its staffing, revenue projections, and direct expenses all account for the addition of these 35 beds. However, WakeMed North's Acute Care Bed Depreciation, Interest, and Financing Expense are understated as they do not account for the 35-bed project. Additionally, the financial statements provided for the WakeMed System in the WakeMed North application differ from the same statements included in the WakeMed Raleigh and WakeMed Garner applications. WakeMed does provide any discussion of why the financial projections for its System would differ between projects as each application includes consistent utilization projections. As such, the WakeMed System financials are unreasonable.

Given the factors cited above, the WakeMed North application is **non-conforming with Criterion (5).**

COMMENTS SPECIFIC TO WAKEMED GARNER APPLICATION
PROJECT ID # J-012673-25

Miscalculated Delivery Discharges and Related Utilization

In its application, WakeMed Garner projects its annual delivery discharges, stating that "*This forecast of total annual delivery discharges is a foundational figure. It will be used directly to project the number of birthing mothers in Section B and to forecast the distribution of birth types (vaginal and C-section) in Section C.*" (page 193). However, WakeMed Garner applies incorrect population growth rates to its historical discharges resulting in an erroneous number of annual delivery discharges and consequently erroneous projections for obstetric bed utilization, C-Section cases, Level II Neonatal bed utilization, and OB procedure room utilization.

On page 185 of its application, WakeMed Garner provides 2025 to 2030 population growth rates for females aged 15 to 44 in the WakeMed Garner catchment area, as shown in the excerpted table below.

Table 28: WakeMed Garner Catchment Area Population Growth Rate by ZIP Code, Females Aged 15 to 44, 2025 - 2030

ZIP	City	County	CY25	CY30	CAGR
27501	Angier	Harnett	4,511	4,758	1.07%
27504	Benson	Johnston	4,005	4,383	1.82%
27520	Clayton	Johnston	10,798	11,581	1.41%
27524	Four Oaks	Johnston	2,785	3,004	1.53%
27526	Fuquay-Varina	Wake	12,543	13,379	1.30%
27527	Clayton	Johnston	8,476	9,394	2.08%
27529	Garner	Wake	11,639	12,039	0.68%
27539	Apex	Wake	5,391	5,512	0.44%
27545	Knightdale	Wake	7,350	7,518	0.45%
27577	Smithfield	Johnston	5,198	5,607	1.53%
27592	Willow Spring	Wake	3,567	3,756	1.04%
27603	Raleigh	Wake	13,171	13,355	0.28%
27606	Raleigh	Wake	14,709	14,338	-0.51%
27610	Raleigh	Wake	18,339	18,601	0.28%
Total Catchment Area			***122,482***	***127,225***	***0.76%***

Source: National demographer Claritas, see Exhibit C.4, p5

In the next step in its methodology, WakeMed Garner states that "*Using the population CAGR of females aged 15 to 44 in the WakeMed Garner catchment area, the Applicant forecast delivery discharges by patient ZIP Code at WakeMed System hospitals annually through FY 2031.*" However, the resulting tables (Tables 29 a, b, and c) do not use the population growth rates from Table 28 resulting in miscalculated WakeMed System delivery discharges by facility, as shown below.

Table 29.a: WakeMed Cary Delivery Discharges

ZIP	FY25	FY26	FY27	FY28	FY29	FY30	FY31	Actual CAGR	Pop. CAGR from Table 28
27501	76	77	78	79	80	81	82	**1.28%**	**1.07%**
27504	22	22	22	22	22	22	22	**0.00%**	**1.82%**
27520	48	49	50	51	52	53	54	**2.00%**	**1.41%**
27524	10	10	10	10	10	10	10	**0.00%**	**1.53%**
27526	489	495	501	508	515	522	529	**1.31%**	**1.30%**
27527	22	22	22	22	22	22	22	**0.00%**	**2.08%**
27529	88	89	90	91	92	93	94	**1.11%**	**0.68%**
27539	129	130	131	132	133	134	135	**0.76%**	**0.44%**
27545	20	20	20	20	20	20	20	**0.00%**	**0.45%**
27577	13	13	13	13	13	13	13	**0.00%**	**1.53%**
27592	57	58	59	60	61	62	63	**1.70%**	**1.04%**
27603	131	131	131	131	131	131	131	**0.00%**	**0.28%**
27606	151	150	149	148	147	146	145	**-0.67%**	**-0.51%**
27610	69	69	69	69	69	69	69	**0.00%**	**0.28%**

Table 29.b: WakeMed North Delivery Discharges

ZIP	FY25	FY26	FY27	FY28	FY29	FY30	FY31	Actual CAGR	Pop. CAGR from Table 28
27501	2	2	2	2	2	2	2	**0.00%**	**1.07%**
27504	4	4	4	4	4	4	4	**0.00%**	**1.82%**
27520	11	11	11	11	11	11	11	**0.00%**	**1.41%**
27524	2	2	2	2	2	2	2	**0.00%**	**1.53%**
27526	12	12	12	12	12	12	12	**0.00%**	**1.30%**
27527	15	15	15	15	15	15	15	**0.00%**	**2.08%**
27529	27	27	27	27	27	27	27	**0.00%**	**0.68%**
27539	2	2	2	2	2	2	2	**0.00%**	**0.44%**
27545	55	55	55	55	55	55	55	**0.00%**	**0.45%**
27577	1	1	1	1	1	1	1	**0.00%**	**1.53%**
27592	4	4	4	4	4	4	4	**0.00%**	**1.04%**
27603	13	13	13	13	13	13	13	**0.00%**	**0.28%**
27606	12	12	12	12	12	12	12	**0.00%**	**-0.51%**
27610	82	82	82	82	82	82	82	**0.00%**	**0.28%**

Table 29.c: WakeMed Raleigh Delivery Discharges

ZIP	FY25	FY26	FY27	FY28	FY29	FY30	FY31	Actual CAGR	Pop. CAGR from Table 28
27501	61	62	63	64	65	66	67	**1.59%**	**1.07%**
27504	52	53	54	55	56	57	58	**1.85%**	**1.82%**
27520	133	135	137	139	141	143	145	**1.46%**	**1.41%**
27524	31	31	31	31	31	31	31	**0.00%**	**1.53%**
27526	78	79	80	81	82	83	84	**1.25%**	**1.30%**
27527	126	129	132	135	138	141	144	**2.28%**	**2.08%**
27529	312	314	316	318	320	322	324	**0.63%**	**0.68%**
27539	31	31	31	31	31	31	31	**0.00%**	**0.44%**
27545	208	209	210	211	212	213	214	**0.48%**	**0.45%**
27577	57	58	59	60	61	62	63	**1.70%**	**1.53%**
27592	54	55	56	57	58	59	60	**1.79%**	**1.04%**
27603	260	261	262	263	264	265	266	**0.38%**	**0.28%**
27606	153	152	151	150	149	148	147	**-0.66%**	**-0.51%**
27610	684	686	688	690	692	694	696	**0.29%**	**0.28%**

As shown above, there is not a single instance where WakeMed Garner applied the correct population growth for females aged 15 to 44 across the 14 zip code WakeMed Garner catchment area for each of its three hospitals. Given this comprehensive miscalculation, WakeMed Garner's resulting delivery discharges are also miscalculated. And, as noted above, the utilization projections that rely directly on the deliver discharges, as "a foundational figure", are also miscalculated.

As such, WakeMed Garner fails to provide reasonable utilization projections in its application. As such, the WakeMed Garner application is **non-conforming with Criteria (1), (3), (4), (5), (6), (8), and (18(a) and 10A NCAC 14C .3803.**

Insufficient Surgical Services at WakeMed Garner

As WakeMed Garner notes in its application, its currently proposed project is a change of scope to its previously approved project to develop a 31-bed hospital with two operating rooms, one GI/endoscopy room and four procedure rooms. WakeMed Garner's current application proposes to add 78 additional acute care beds and projects that acute care bed utilization at the facility will increase substantially. Per the previous project, Project ID # J-012264-22, WakeMed Garner projected to serve 8,637 patient days in its third project year. By comparison, WakeMed Garner's current application projects that it will serve 26,760 patient days in its third project year, more than three times its previous projections.

This substantial increase in patient utilization will require additional resources. In addition to the proposed 78 additional beds in its current application, WakeMed Garner proposes to add 42 observation beds, six Labor/Delivery/Recovery beds, one dedicated C-Section room, one OB procedure room, four Neonatal Level II beds, 15 newborn bassinets, 1 CT scanner, 1 ultrasound, and related expansions in clinical support space. However, WakeMed Garner proposes no change to its surgical services, aside from the addition of

a dedicated C-Section room and OB procedure room, which will only provide specialized services related to obstetrics. As shown through the analysis below, WakeMed Garner's proposed surgical services will not have sufficient capacity for its projected utilization.

The table below provides a comparison of WakeMed Garner's previously and currently proposed surgical utilization.

WakeMed Garner Surgical Utilization Comparison for Project Year 3

	2022 CON	2025 CON	Ratio
Shared ORs	2	2	**1.0**
IP Cases	519	1,114	**2.1**
OP Cases	1,980	5,786	**2.9**
Total Surgical Hours	4,346	16,220	**3.7**
Standard Hours per OR per Year	1,950	1,950	**1.0**
Total Surgical Hours/Standard Hours per OR per Year	2.2	8.3	**3.7**
Procedure Rooms	4	4	**1.0**
Procedure Room Procedures	1,035	NA	NA

Source: Forms C.3b for each application. Pg 212 for 2022 WakeMed Garner procedures.

As shown above, WakeMed Garner's 2025 proposes the same number of ORs and procedure rooms, with the same capacity, but proposes 3.7 times more surgical hours resulting in an operating room need (Total Surgical Hours/Standard Hours per OR per Year) of 8.3 ORs with only two ORs and four procedure rooms.

WakeMed Garner fails to explain how the same scope of surgical services can reasonably accommodate 3.7 times more surgical utilization. Further, if WakeMed Garner proposes to effectively utilize two ORs and four procedure rooms in its 2022 CON, then it is unreasonable to assume that the same resources could accommodate 3.7 times more utilization.

Given its limited surgical resources, it is unreasonable to assume that WakeMed Garner will be able to serve the acuity and volume of inpatients it projects to shift from WakeMed Raleigh.

As such, WakeMed Garner fails to provide reasonable utilization projections in its application. As such, the WakeMed Garner application is **non-conforming with Criteria (1), (3), (4), (5), (6), (8), and (18(a) and 10A NCAC 14C .3803.**

<u>Unsupported Observation Bed Utilization for WakeMed Garner</u>

WakeMed Garner proposes to develop 78 additional acute care beds as well as 42 additional observation beds. As shown in the table on page 33 of its application, excerpted below, WakeMed Garner, in total, will have 56 observation beds and 109 acute care beds, or more than one observation bed for every two acute care beds.

Table 2: WakeMed System Existing, Approved, Appealed, and Proposed Acute Care and Clinical Observation Bed Inventory - Excluding Neonatal Beds

		Bed Status					
Notes	Bed Type	Existing	CON Approved	CON Appeal	Existing + Approved + Appealed	Proposed in 2025	Existing + Approved + Appealed + Proposed
WakeMed Raleigh Campus							
(a)	Acute Care Bed Total	539	(22)	21	538	164	702
	Clinical Observation	*73*		*(21)*	*52*	*16*	*68*
WakeMed North							
(b)	Acute Care Bed Total	71		35	106	25	131
	Clinical Observation			*15*	*15*		*15*
WakeMed Garner							
(c)	Acute Care Bed Total		31		31	78	109
	Clinical Observation		*14*		*14*	*42*	*56*
WakeMed Raleigh License Total (H0199)							
(d)	Acute Care Bed Total	610	9	56	675	267	942
	Clinical Observation	*73*	*14*	*(6)*	*81*	*58*	*139*
WakeMed Cary (H0276)							
(e)	Acute Care Bed Total	200		33	233		233
	Clinical Observation	*24*		*7*	*31*		*31*
WAKEMED SYSTEM							
(f)	**Acute Care Bed Total**	**810**	**9**	**89**	**908**	**267**	**1,175**
	Clinical Observation	***97***	***14***	***1***	***112***	***58***	***170***

Notes:

a. 22 acute care beds approved to move from WakeMed Raleigh Campus to WakeMed Garner when opened 2028; Project No. J-12264-22
21 new acute care beds recommended approval from Project No. J-12538-24; developed after appeal settled
b. 35 new acute care beds recommended approval from Project No. J-12419-23; developed after appeal settled
c. 31 acute care beds approved – 22 relocated from WakeMed Raleigh Campus to WakeMed Garner, 9 new, Project No. J-12264-22; under development
d. a + b + c
e. 9 new acute care beds recommended approval from Project No. J-12418-23 and 24 new acute care beds recommended approval from Project No. J-12437-24; developed after appeals settled.
f. d + e

This ratio of observation beds to acute care beds is significantly higher than other WakeMed facilities. As calculated in the table below, WakeMed Garner's ratio of observation beds to acute care beds (0.51) is the highest in the WakeMed system and more than 3.5 times higher than the overall system ratio (0.14).

Observation Bed to Acute Care Bed Ratio

	Observation Beds	Acute Care Beds	Ratio
WakeMed Garner	56	109	0.51
WakeMed Raleigh	68	702	0.10
WakeMed North	15	131	0.11
WakeMed Cary	31	233	0.13
WakeMed System	**170**	**1,175**	**0.14**

Source: Forms C.3b for each application. Pg 212 for 2022 WakeMed Garner procedures.

In order to justify its unreasonably large number of additional observation beds, WakeMed Garner provides an unsupported utilization methodology. On page 225 of its application, WakeMed Garner provides its observation bed utilization assumptions, stating "*The following tables build upon this analysis to project the full utilization of the proposed observation beds at WakeMed Garner. Table 68 details the need for the 56 observation beds. It begins by applying the 14.3% observation-to-ED visit ratio to Garner's projected ED visits to forecast the annual number of observation patients. The table then uses an Average Length of Stay (ALOS) of 1.5 days and a 76% peak load factor to calculate total patient days and determine the peak daily census. The 76% peak load factor is WakeMed Raleigh's peak load factor for observation beds, sourced from WakeMed internal data.*"

WakeMed Garner's assumed 14.3% observation-to-ED visit ratio is derived from WakeMed Cary's experience as shown on the previous page (224). The use of WakeMed Cary's experience appears to be cherry-picked and inconsistent. As demonstrated in its application, the majority of WakeMed Garner's projected patients are assumed to be shifted from WakeMed Raleigh and other ratios within WakeMed Garner's observation bed methodology (peak load factor) are derived from WakeMed Raleigh's experience. Notably, data provided in WakeMed Raleigh's application shows that in FY 2024, WakeMed Raleigh's emergency room admitted a daily average of 23.9 observation patients from the ED and served 136,102 total emergency visits equal to a 6.4% observation-to-ED visit ratio, or less than half projected for WakeMed Garner (see page 186 for observation patients admitted from the ED and page 188 for ED visits).

Additionally, WakeMed Garner projects a 1.5 day ALOS for its observation patients stating in the "d" note below Table 68 that this "*ALOS assumption is based on WakeMed experience*" (page 225). WakeMed Garner does not identify if this ALOS assumption is based on any particular facility or any particular year. While WakeMed Garner provides very little support for this ALOS assumption, the experience of WakeMed Raleigh indicates that it is unreasonable. As shown in Table 23 of page 186 of WakeMed Raleigh's application, excepted below, WakeMed Raleigh assumes an ALOS of 1.0 days for its observation patients as its annual observation days are calculated by multiplying Daily Average Observation Patients by 365 days.

Table 23: WakeMed Raleigh Historical Observation Days: FY 2024 – FY 2025 (8 months annualized)

	FY24	FY25 (Ann)	2 Year Total
a. Daily Average Observation Patients admitted from ED	23.9	23.8	47.7
b. Annual Observation Days	8,724	8,687	17,441
c. Peak Observation Patients admitted from ED	44	40	84
d. Peak Load Factor	0.84	0.68	**0.76**

Notes:

a. From WakeMed internal data, displayed rounded to the nearest tenth
*b. a * 365; FY 2024 was a leap year but is calculated at 365 days.*
c. From WakeMed Internal data
d. *(c – a) / a*

Further, WakeMed Raleigh, an existing acute care hospital with 539 acute care beds and ED visits exceeding 130,000 annually reports a total of ~8,700 observation days. By contrast, WakeMed Garner projects that its 109 acute care bed facility with 45,000 to 47,000 ED visits annually will provide 9,700 to 10,100 observation days, as shown below.

Table 68: WakeMed Garner Projected Observation Patients and Beds, FY 2029 – FY 2031

Note	Metric	FY29	FY30	FY31
a.	ED Visits	45,522	46,433	47,363
b.	Ratio of Observation to ED Visits	14.3%	14.3%	14.3%
c.	Projected Obs Patients	6,510	6,640	6,773
d.	Observation ALOS	1.5	1.5	1.5
e.	Projected Obs Days	9,765	9,960	10,160
f.	Observation ADC	27	27	28
g.	Observation Peak Census	48	48	49
h.	Observation Beds	56	56	56
i.	Occupancy per day	48.2%	48.2%	50.0%
j.	Peak Occupancy	85.7%	85.7%	87.5%

Notes:

a: Step 51, Table 66
b: Step 52, Table 67, row c
*c: a*b*
d: ALOS assumption based on WakeMed experience
*e: c*d*
f: e / 365
*g: f * 1.76 (1 + 76% peak load factor)*
h: Total number of observation beds at WakeMed Garner
i: f / h
j: g / h

Given the unsupported assumptions used to project WakeMed Garner's observation bed utilization, as well as its significant inconsistency with other available WakeMed data, it is clear that the resulting observation bed projections are unreasonable. Thus, the WakeMed Garner application is **non-conforming with Criteria (1), (3), (4), (5), (6), (8), and (18(a) and 10A NCAC 14C .3803.**

Incomplete and Understated Expenses for WakeMed Garner Financial Statements

WakeMed Garner's financial statements are incomplete and fail to account for multiple expense items. As shown on pages 222-241 of its application, WakeMed Garner only provided financial statements (Forms F.2a, F.2b, F.3a, and F.3b) for its entire facility and for the WakeMed System, but does not include service line financial statements for the services it proposes to develop in its project such as acute care beds, Level III NICU beds, Imaging services (for proposed CT and US), or observation beds. As such, it is impossible to determine the financial feasibility of those service components and determine the reasonableness of their financial projections. Further, the lack of these financial statements precludes any comparison to other acute care beds projects in this competitive review.

Additionally, WakeMed Garner's entire facility Form F.3b, Projected Operating Costs upon Project Completion, does not include projections for multiple expense items that are needed to provide its proposed services. WakeMed Garner's expenses do not include Pharmacy, Rental Expense, Management Fees, or Medicaid Assessment Fee. These line items are included on the WakeMed System Form F.3b in the WakeMed Garner application as well as the Forms F.3b for WakeMed North and WakeMed Raleigh included in those respective applications. WakeMed Garner does not provide any discussion or reasoning to explain why its facility will not incur these costs.

These missing expenses are significant. In FY 2031, which is WakeMed Garner's third project year, WakeMed North, the WakeMed facility closet in bed size to WakeMed Garner, is projected to incur more $17 million in expenses for Pharmacy, Rental Expense, Management Fees, and Medicaid Assessment Fee. If WakeMed Garner's financial projections fail to include these expenses, then it has not demonstrated the financial feasibility of its project.

Additionally, the financial statements provided for the WakeMed System in the WakeMed Garner application differ from the same statements included in the WakeMed North and WakeMed Raleigh applications. WakeMed does provide any discussion of why the financial projections for its System would differ between projects as each application includes consistent utilization projections. As such, the WakeMed System financials are unreasonable.

Given the factors cited above, the WakeMed Garner application is **non-conforming with Criterion (5).**

**COMMENTS SPECIFIC TO BOTH UNC HEALTH REX APPLICATIONS,
REX WAKE FOREST APPLICATION PROJECT ID # J-012680-25
AND
REX HOSPITAL APPLICATION PROJECT ID # J-012677-25**

Rex has submitted two concurrent and complementary applications that share many aspects including identical acute care bed utilization assumptions and methodology. As such, Novant Health has grouped the below comments which apply to both Rex applications.

Unreasonable Growth Assumptions

Rex projects overall acute care patient day growth for its facilities of 5.0 percent annually based on its historical experience. See pages 163 and 134 of the Rex Wake Forest and Rex Hospital applications, respectively. However, Rex's applications do not provide historical discharge data that would allow further evaluation of the drivers of this growth. In fact, according to North Carolina Hospital Industry Data Institute (HIDI) data, this growth is mostly the result of an increasing average length of stay (ALOS), and demonstrate that Rex's number of patients of served is growing at a slower rate. Rex fails to demonstrate what it is reasonable for its total utilization to grow at 5.0 percent annually through 2034 given these factors.

As shown in the table below, based on HIDI data, from SFY 2019-2025 annualized, Rex's discharges have only grown 2.0 percent annually. Rex adopted a growth rate more than double its historical experience, without an adequate explanation.

Rex Hospital and Rex Holly Springs Acute Care Utilization, Excluding Neonates

	SFY19	SFY20	SFY21	SFY22	SFY23	SFY24	SFY25*	CAGR
Days	111,930	110,086	125,053	134,039	143,671	147,696	152,205	**5.3%**
Discharges	28,289	26,825	27,035	27,681	29,435	30,817	31,931	**2.0%**
ALOS	3.96	4.10	4.63	4.84	4.88	4.79	4.77	**3.2%**

Rex's applications entirely fail to address that its increasing ALOS has been the primary driver of its acute care utilization growth.

In projecting future utilization, Rex assumes that its ALOS will remain constant stating on pages 175 and 146 of the Rex Wake Forest and Rex Hospital applications, respectively, "*To project total discharges across the UNC Health Rex license, UNC Health Rex utilized the historical average length of stay (ALOS) for its entire license, which, for FY 2025 annualized, was 4.8 days. UNC Health Rex has used this ALOS value to project discharges through FY 2034; these are shown in Table 18 below."* Rex's assumption that its ALOS will remain consistent during the projection period is notable. As detailed above, Rex's historical growth in ALOS has been the driver of its historical growth overall. If Rex's ALOS were to remain consistent through the projection period, as assumed, then the basis for its historical growth (increasing ALOS) will stop. Rex does not explain why it is reasonable to assume utilization for its facilities will grow 5.0 annually give that it assumes the basis for this historical growth will stop.

As such, Rex fails to provide reasonable utilization projections in its two applications. As such, the Rex Hospital and the Rex Wake Forest applications are **non-conforming with Criteria (1), (3), (4), (5), (6), (8), and (18(a) and 10A NCAC 14C .3803.**

Unsupported Rex Holly Springs and Rex Wake Forest Shifts and Ramp-Up

Throughout the Rex Hospital and Rex Wake Forest applications, Rex discusses the "more gradual ramp up in services" that has occurred at UNC Health Rex Holly Springs Hospital (Rex Holly Springs). In the Form C Assumptions and Methodology for each of those applications, Rex acknowledges the delay and more gradual ramp up of Holly Springs even from projections made in 2023 CON applications. Rex's inability to shift volume from Rex Hospital to Rex Holly Springs and the slower than projected ramp-up of Rex Holly Springs is evidence that Rex Holly Spring's projected utilization is unreasonable. Further, the failures at Rex Holly Springs indicate that the projected shift of volume from Rex Hospital to Rex Wake Forest and the projected ramp-up of Rex Wake Forest are unsupported.

On pages 135 of the Rex Hospital application and page 164 of the Rex Wake Forest application, Rex states:

> "*As shown in Table 1-1, the actual acute care days at UNC Health Rex Holly Springs Hospital for FY 2024 were lower than what was projected in the previous application* [Project ID # J-012371-2]. *Moreover, the annualized acute care days for FY 2025 are less than the acute care days projected in UNC Health Rex's 2023 application. While UNC Health Rex continues to expect that additional patients needing community hospital services will shift to the Holly Springs campus, the impact of opening that facility during the pandemic (Fall 2021) and the more gradual ramp up in services that has followed has delayed those shifts. As such, this application projects the shifts will occur one year later (i.e., the acute care days that, in the previous CON application, were projected for FY 2025 are now projected for the remainder of FY 2026, etc.). This is in part to account for the annualized total acute care days at UNC Health Rex Holly Springs Hospital in FY 2025, which are only slightly less than the projected acute care days for UNC Health Rex Holly Springs Hospital in FY 2024 from the 2023 CON application cited above. Starting in FY 2030 – one year later than FY 2029, the first year for which historical projections for UNC Health Rex Holly Springs Hospital were not made in UNC Health Rex's 2023 CON application – UNC Health Rex has grown acute care days at UNC Health Rex Holly Springs Hospital by 5.0 percent, the same growth rate utilized for all acute care days on the UNC Health Rex license shown in Table 1-2.*

As such, the projected utilization at Rex Holly Springs (for both the Rex Hospital and Rex Wake Forest applications) relies on a one-year delay of the projections included in a 2023 CON application. Rex clearly acknowledges that this shift has not occurred as projected. Rex states that Rex Holly Springs FY 2025 acute care days are "only slightly less than the FY 2024 projected acute care days for that hospital from the 2023 CON application." In fact, in FY 2025 (annualized based on 10 months of data per page 133 of the Rex Hospital application), Rex Holly Springs provided 10,256 acute care days or just 89 percent of the 11,577 acute care days projected for that hospital in the 2023 application. Despite the actual experience of Rex Hospital failing to shift volume to Rex Holly Springs and Rex Holly Springs failing to achieve its projected utilization, even with a one year delay, Rex's applications assume it will achieve the 2023 projections with a one-year delay. Rex provides no evidence or discussion of any changes at Rex Hospital or Rex Holly Springs to support its assumption that it will reverse its trends of failing to meet its utilization projections. As such, the projected utilization for Rex Holly Springs is unreasonable and unsupported.

Of note, the Rex Holly Springs utilization projections in the 2023 CON application relied on a shift acuity-appropriate patients from specified service area from Rex Hospital to Rex Holly Springs, just as the 2025 Rex Wake Forest application relies on a shift acuity-appropriate patients from specified service area from Rex Hospital to Rex Wake Forest. Given Rex's continued historical failure to shift volume from Rex Hospital to Rex Holly Springs, it is unreasonable to assume that Rex Hospital will shift volume to Rex Wake Forest as projected.

The unreasonableness of the Rex Wake Forest projections is highlighted by a comparison of the initial years of operation for Rex Wake Forest and Rex Holly Springs as shown below.

Comparison of Acute Care Days for Initial Operating Years

	Partial FY	1st Full FY of Operation	2nd Full FY of Operation	3rd Full FY of Operation
Rex Wake Forest	NA	6,286	9,641	13,145
Rex Holly Springs	2,984	6,870	7,831	10,256
Rex Wake Forest as Percent of Rex Holly Springs		**91%**	**123%**	**128%**

As shown above, while Rex Wake Forest is projected to only achieve 91% of Rex Holly Springs' acute care utilization in a comparison of each facility's first full year of operation, Rex Wake Forest is projected to achieve 123% and 128% of Rex Holly Spring's acute care utilization in a comparison of the second and third years of operation, respectively. This analysis demonstrates that Rex Wake Forest's projected ramp-up is much more aggressive than is supported by Rex's actual experience from Rex Holly Springs. Further, Rex Wake Forest is expected to care for 13,145 patient days in its third year of operation, which is a level that Rex Holly Springs is not expected achieve until FY 2028, its sixth full year of operation. As such, the projected utilization of Rex Wake Forest is projected to increase much more rapidly than Rex Holly Springs and to achieve higher target occupancy levels twice as fast (in three years compared to six years). Rex provides no discussion or factors to support the assumptions that the experience at Rex Wake Forest will be so substantially different from Rex Holly Springs. As such, Rex Wake Forest's projected utilization is unsupported.

As such, Rex fails to provide reasonable utilization projections in its two applications. As such, the Rex Hospital and the Rex Wake Forest applications are **non-conforming with Criteria (1), (3), (4), (5), (6), (8), and (18(a)) and 10A NCAC 14C .3803.**

Proposed Shift is Unreasonable and Unsupported

As noted above, Rex's inability to shift volume from Rex Hospital to Rex Holly Springs and the slower than projected ramp-up of Rex Holly Springs is evidence that Rex Holly Spring's projected utilization is unreasonable. Rex's central assumption for projecting utilization historically at Rex Holly Springs and presently at Rex Wake Forest is that 80% of select patients in a defined geographic area will shift from Rex Hospital to a new site of care, stating in the Rex Wake Forest and Rex Hospital applications that "*UNC Health Rex has assumed that 80 percent of the selected ZIP code acute care days for selected services that UNC Health Rex Hospital is projected to treat, as shown above in Table 1-9, will instead be treated at UNC*

Health Rex Wake Forest Hospital, starting in FY 2032 and extending through FY 2034" (pages 171 and 141 of the Rex Wake Forest and Rex Hospital applications, respectively). Rex provides no support for this significant percentage and as noted above, its historical experience at Rex Holly Springs fails to provide evidence that it is reasonable. This 80% shift is higher than can be reasonably supported by the experience of Rex or other providers and higher than percentages used in similar CON applications. Additionally, Rex applies this high shift percentage uniformly across its selected geography. Higher assumed shifts might be reasonable to assume in areas closest to the proposed site of care, but Rex fails to justify such a high shift from the areas furthest from the proposed Rex Wake Forest. Further, multiple areas within the Rex Wake Forest selected zip codes are closer to Rex Hospital itself than Rex Wake Forest, including portions of zip codes 27613 and 27616. Despite these dynamics, Rex proposes a uniform 80% shift of selected patients across its selected zip codes.

As Rex fails to demonstrate the reasonableness of its proposed shift and its historical experience at Rex Holly Springs fails to justify it, the utilization projections in its two applications are not reasonable. As such, the Rex Hospital and the Rex Wake Forest applications are **non-conforming with Criteria (1), (3), (4), (5), (6), (8), and (18(a)) and 10A NCAC 14C .3803.**

COMMENTS SPECIFIC TO REX WAKE FOREST APPLICATION
PROJECT ID # J-012680-25

Failure to Identify Patients Proposed to Serve

Rex provides entirely inconsistent and contradictory definitions of the patients it proposes to serve at Rex Wake Forest.

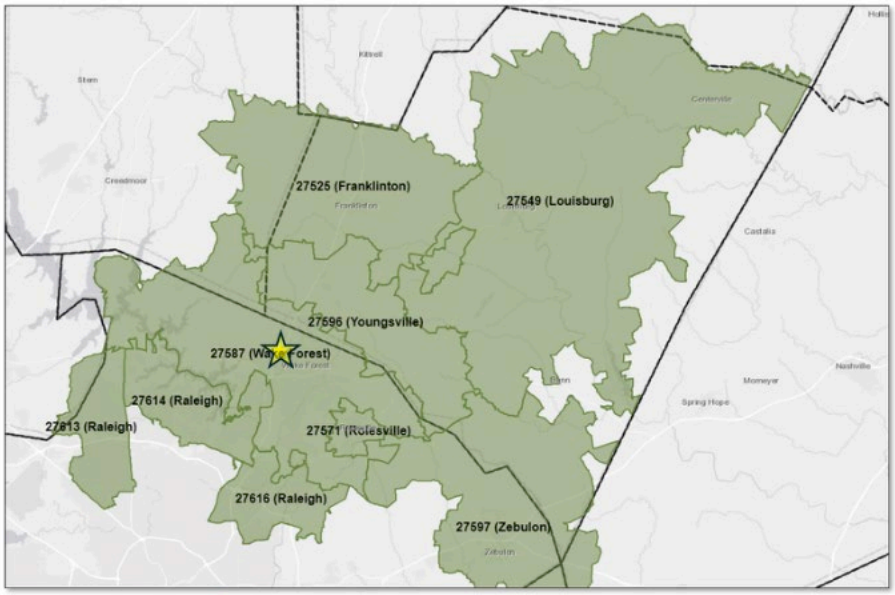
In its response to Section C.3.b, Projected Patient Origin, as excerpted below for inpatient services, Rex clearly states that "*Wake and Franklin counties (Selected ZIP Codes)^*" will comprise 71.7 percent of patients for each of the service components (Inpatient Services, Outpatient Surgery & Procedure Room Procedures, Emergency Department Visits, and Imaging Procedures) as well as the Entire Facility or Campus. Per the ^ note following the table, these Wake and Franklin counties are defined by ten zip codes, with Rex stating that "*Selected ZIP Codes include ZIP Codes 27616, 27614, 27613, 27597, 27587, and 27571 in Wake County; and ZIP codes 27596, 27549, and 27525, and 27508 in Franklin County.*"

Inpatient Services	UNC Health Rex Wake Forest Hospital*					
	1st Full FY		2nd Full FY		3rd Full FY	
	07/01/2031 to 06/30/2032		07/01/2032 to 06/30/2033		07/01/2033 to 06/30/2034	
County or other geographic area such as ZIP code	**Number of Patients ****	**% of Total**	**Number of Patients ****	**% of Total**	**Number of Patients ****	**% of Total**
Wake and Franklin counties (Selected ZIP Codes)^	1,051	71.7%	1,612	71.7%	2,198	71.7%
Franklin (All Other ZIP Codes)	196	13.3%	300	13.3%	409	13.3%
Wake (All Other ZIP Codes)	147	10.0%	225	10.0%	307	10.0%
Other^^	74	5.0%	113	5.0%	155	5.0%
Total	**1,467**	**100.0%**	**2,250**	**100.0%**	**3,067**	**100.0%**

* This should match the name provided in Section A, Question 4.
** Home health agencies should report the number of unduplicated clients.
^ Selected ZIP Codes include ZIP Codes 27616, 27614, 27613, 27597, 27587, and 27571 in Wake County; and ZIP codes 27596, 27549, and 27525, and 27508 in Franklin County.
^^ Other Includes Durham, Granville, Nash, and other counties in NC as well as other states.

It is clear and unambiguous from these responses that 71.7% of Rex Wake Forest's patients across all service lines will originate from these ten zip codes.

However, Rex Wake Forest contradicts this patient origin projection in remainder of its application, specifically in Section C.4 and Form C Assumptions and Methodology. As shown in the excerpts below, in the tables and maps on pages 66 and 167-168, Rex provides a definition of its "Selected ZIP codes" that includes only nine zip codes and notably does not include zip code 27508.



ZIP Codes Contiguous with ZIP Code 27587 (Wake Forest)[36]

ZIP Code (City/Town)	*County*
27616 (Raleigh)	Wake
27614 (Raleigh)	Wake
27613 (Raleigh)	Wake
27597 (Zebulon)	Wake
27587 (Wake Forest)	Wake
27571 (Rolesville)	Wake
27596 (Youngsville)	Franklin
27549 (Louisburg)	Franklin
27525 (Franklinton)	Franklin

Source: Pages 66 and 167-168 of Rex Wake Forest Application.

The patient utilization that originates from this nine zip code area is the foundation of Rex Wake Forest's patient utilization projections. Given the discrepancy between its projected patient origin and projected patient utilization, Rex Wake Forest failed to identify the population that it proposes to serve.

Rex Wake Forest's methodology for projecting acute care utilization states that "*UNC Health Rex has assumed that 15 percent of the total acute care days at UNC Health Rex Wake Forest Hospital will be "inmigrating" acute care days from areas outside of the nine ZIP codes listed in Table 1-5*" (page 172). As such, acute care days from the nine zip codes shown in the excerpt above are projected to comprise 85 percent of total utilization, according to the Form C Assumptions and Methodology. However, as noted above, Rex Wake Forest's responses to Section C.3.b show contradictory information: Specifically, that 71.7 percent of utilization is projected to originate from ten ZIP codes. Simply put, it is impossible contradiction for Rex Wake Forest to state 85 percent of patients will originate from nine ZIP codes and that 71.7 percent of patients will originate from ten ZIP codes comprised of the same nine ZIP codes plus one additional ZIP code.

Rex Wake Forest's response to Section C.3.b, Projected Patient Origin, shown above, states that 13.3% of its patient utilization will originate "Franklin (All Other ZIP Codes)" or Franklin County zip codes not

including zip codes 27596, 27549, 27525, and 27508, which are part of the defined 10 zip codes that comprise 71.7% of projected patients. Rex does not define the zip codes or areas that are included in this "Franklin (All Other ZIP Codes)" that comprise 13.3% of its projected utilization. However, as stated on page 67 of Rex's application, "the ZIP codes of 27596, 27549, and 27525 comprise nearly 90 percent of the total Franklin County population."

Franklin County ZIP Codes Contiguous with Wake Forest
Total Population

ZIP Code (Town)	*2024 Population*	*% of Population of Franklin County*
27549 (Louisburg)	25,045	32.7%
27596 (Youngsville)	22,268	29.1%
27525 (Franklinton)	19,617	25.6%
Select Franklin County ZIP Codes	**66,930**	**87.4%**
Franklin County*	76,603	100.0%

Source: Esri, see Exhibit C.4-3.
* As some ZIP codes in the defined areas exist outside of Franklin County, the Esri populations noted above and the Franklin County population as noted by the NC OSBM are discrepant; the percentages above are based on the same data source, Esri, to maintain consistency, given the NC OSBM does not provide population by ZIP code.

As such, zip code 27508 and all other Franklin County zip codes comprise less than 13 percent of the county population. Rex fails to demonstrate why it would be reasonable for 13% of its patient population to originate from Franklin (All Other ZIP Codes) when those zip codes and zip code 27508 together represent less than 13% of the Franklin County total population. Further, Franklin (All Other ZIP codes) are areas that are further from the proposed Rex Wake Forest and are not in zip codes that are contiguous with the Wake Forest zip code of 27587.

As such, Rex Wake Forest has failed to identify the population it proposes to serve. As such, the Rex Wake Forest application is **non-conforming with Criteria (1), (3), (4), (5), (6), (8), and (18(a)) and 10A NCAC 14C .3803.**

Contradictory Assumptions About Patients Proposed to Be Served

In its Form C Assumptions and Methodology, Rex Wake Forest assumes that all of its inpatient acute care inmigration patients, 15% of its total acute care utilization, will be patients not served by Rex Hospital today, stating "*UNC Health Rex believes it is reasonable that an additional volume of patients – patients who are not served by UNC Health Rex today – will originate from outside of these nine ZIP codes, whether from Wake County or other North Carolina counties. Given this, UNC Health Rex has assumed that 15 percent of the total acute care days at UNC Health Rex Wake Forest Hospital will be "inmigrating" acute care days from areas outside of the nine ZIP codes listed in Table 1-5, and as such are not accounted for in the total projected acute care days for the UNC Health Rex license as shown in both Table 1-2 and Table 1-4 above"* (page 172). Said another way, Rex Wake Forest assumes that 15% of its acute care utilization will be shifted from other providers.

However, Rex Wake Forest provides contradictory assumptions for specific inpatient services including inpatient OR cases, C-Section cases, and Level II Neonatal days of care.

On pages 177-182, Rex Wake Forest provides its assumptions and methodology for projected OR utilization at Rex Hospital, Rex Wake Forest, and Rex Holly Springs. Rex Wake Forest's inpatient OR cases by applying an assumed ratio of inpatient OR cases to acute care days to total Rex Wake Forest acute care days, as shown in the excerpted Table 2-4 below.

Table 2-4: Projected Operating Room Utilization – UNC Health Rex Wake Forest Hospital Prior to Shift of Cases to Procedure Room

	FY32 (PY1)	*FY33 (PY2)*	*FY34 (PY3)*
Acute Care Days	6,286	9,641	13,145
Inpatient OR Cases*	310	475	648
Outpatient OR Cases**	543	834	1,137
Total OR Cases Prior to Procedure Room Shift	**853**	**1,309**	**1,785**

* Inpatient OR Cases = Acute Care Days x 0.05
** Outpatient OR Cases = Inpatient OR Cases x 1.75

Given that Rex Wake Forest's total acute care days include days shifted from other providers, which comprise 15% of total days, Rex Wake Forest's inpatient OR cases should also include cases shifted from other providers that would comprise 15% of total inpatient OR cases. However, in the remaining steps of its OR methodology, Rex Wake Forest assumes that none of its inpatient OR cases will shift from other providers and that 100% of its inpatient OR cases will shift from the UNC Health Rex license, stating on page 182, "UNC Health Rex then subtracted the projected inpatient and outpatient OR cases at UNC Health Rex Holly Springs Hospital, as well as the projected inpatient and outpatient OR cases at UNC Health Rex Wake Forest Hospital from FY 2032 through FY 2034, from the inpatient and outpatient OR cases for the entirety of the UNC Health Rex license to provide OR volume projections for UNC Health Rex Hospital, which are shown in Table 2-9 below." As the excerpted table below shows, Rex Wake Forest determined Rex Hospital OR volume by subtracting all of Rex Wake Forest's OR volume (as well as Rex Holly Springs volume) from the UNC Health Rex license projected volumes without any adjustment for the 15% of inpatient utilization that it had previously assumed would be shifted from other providers.

Table 2-9: Projected Operating Room Surplus/Deficit – UNC Health Rex Hospital

	*FY25**	*FY26*	*FY27*	*FY28*	*FY29*	*FY30*	*FY31*	*FY32 (PY1)*	*FY33 (PY2)*	*FY34 (PY3)*
Inpatient Cases: Total License	7,597	7,438	7,283	7,131	6,982	6,836	6,693	6,553	6,416	6,282
Inpatient Cases: Holly Springs	343	326	310	304	297	291	285	279	273	267
Inpatient Cases: Wake Forest								310	475	648
Inpatient Cases: Main Campus	7,254	7,112	6,973	6,827	6,684	6,545	6,408	5,964	5,667	5,366
Outpatient Cases: Total License	15,253	15,941	16,661	17,412	18,198	19,019	19,877	20,774	21,711	22,691
Outpatient Cases: Holly Springs	2,394	2,502	2,615	2,733	2,856	2,985	3,120	3,260	3,408	3,561
Outpatient Cases: Wake Forest								543	834	1,137
Outpatient Cases: Main Campus	12,859	13,439	14,046	14,679	15,342	16,034	16,757	16,970	17,470	17,993
Inpatient Hours @ 218.3 minutes	26,392	25,877	25,370	24,839	24,320	23,811	23,314	21,699	20,619	19,524
Outpatient Hours @ 128.3 minutes	27,497	28,738	30,034	31,389	32,806	34,286	35,833	36,287	37,356	38,475
Total Hours	53,890	54,615	55,404	56,229	57,126	58,097	59,146	57,986	57,976	57,998
OR Need @ 1,950 hours	27.6	28.0	28.4	28.8	29.3	29.8	30.3	29.7	29.7	29.7
OR Capacity	25.0	25.0	25.0	27.0**	27.0	27.0	27.0	26.0^	26.0	26.0
OR Deficit/(Surplus) With Proposed ORs	**2.64**	**3.01**	**3.41**	**1.84**	**2.30**	**2.79**	**3.33**	**3.74**	**3.73**	**3.74**

Source: UNC Health Rex internal data.
* FY 2025 data annualized based on ten months of historical data.
** Includes two ORs proposed through Project ID # J-012538-24.
^ As discussed above and in Section D, one shared OR from the existing inventory of UNC Health Rex Hospital will be relocated to UNC Health Rex Wake Forest Hospital as part of the proposed project.

As inpatient OR cases are a component of total inpatient utilization, it is unreasonable for Rex Wake Forest to assume that 15% of total inpatient utilization will be shifted from other providers but no inpatient OR cases will be shifted from other providers.

Rex Wake Forest makes similarly contradictory assumptions for C-Section cases and Level II Neonatal days of care. On pages 184-187, Rex Wake Forest provides its C-Section utilization methodology which projects C-Section cases by applying an assumed ratio of C-Sections to acute care days to total Rex Wake Forest acute care days, as shown in the excerpted Table 2-18 below.

Table 2-18: Projected C-Sections – UNC Health Rex Wake Forest Hospital

	FY32 (PY1)	*FY33 (PY2)*	*FY34 (PY3)*
Acute Care Days	6,286	9,641	13,145
Ratio of C-Sections to Acute Care Days, All Facilities	0.023	0.023	0.023
C-Sections	**142**	**218**	**297**
Total C-Section Rooms	2	2	2

Source: UNC Health Rex internal data (ratio).
* C-Sections = Acute Care Days x Ratio.

Rex Wake Forest then determined Rex Hospital C-Section volume by subtracting all of Rex Wake Forest's C-Sections (as well as Rex Holly Springs volume) from the UNC Health Rex license projected volumes without any adjustment for the 15% of inpatient utilization that it had previously assumed would be shifted from other providers, as shown in Rex Wake Forest Table 2-19 below.

Table 2-19: Projected C-Sections – UNC Health Rex License by Campus

	FY25	*FY26*	*FY27*	*FY28*	*FY29*	*FY30*	*FY31*	*FY32*	*FY33*	*FY34*
UNC Health Rex License Total	1,610	1,641	1,672	1,704	1,737	1,770	1,803	1,838	1,873	1,909
UNC Health Rex Holly Springs Hospital	236	279	292	306	321	337	354	371	390	409
UNC Health Rex Wake Forest Hospital								142	218	297
UNC Health Rex Hospital*	1,375	1,362	1,380	1,398	1,416	1,433	1,450	1,324	1,265	1,202

* UNC Health Rex Hospital = UNC Health Rex License Total – UNC Health Rex Wake Forest Hospital – UNC Health Rex Holly Springs Hospital.

On pages 189-191, Rex Wake Forest provides its Level II neonatal beds utilization methodology which projects Level II neonatal days by applying an assumed ratio of Level II neonatal days to acute care days to total Rex Wake Forest acute care days, as shown in the excerpted Table 3-4 below.

Table 3-4: Projected Level II Neonatal Care Days – UNC Health Rex Wake Forest Hospital

	FY32 (PY1)	*FY33 (PY2)*	*FY34 (PY3)*
Acute Care Days	6,286	9,641	13,145
Ratio of Neonatal Care Days to Acute Care Days	0.03	0.03	0.03
Level II Neonatal Care Days*	**191**	**293**	**399**

Source: UNC Health Rex internal data (ratio).
* Level II Neonatal Care Days = Acute Care Days x Ratio.

Rex Wake Forest then determined Rex Hospital Level II neonatal days volume by subtracting all of Rex Wake Forest's Level II neonatal days from the UNC Health Rex license projected volumes without any adjustment for the 15% of inpatient utilization that it had previously assumed would be shifted from other providers, as shown in Rex Wake Forest Table 3-7 below. Rex states that it "*conservatively projects that all neonatal care days at UNC Health Rex Wake Forest Hospital will be shifted from UNC Health Rex Hospital in Raleigh"* (page 191).

Table 3-7: Projected Neonatal Care Days – UNC Health Rex License by Campus

	FY25	FY26	FY27	FY28	FY29	FY30	FY31	FY32	FY33	FY34
UNC Health Rex License	4,523	4,472	4,422	4,373	4,324	4,276	4,228	4,181	4,134	4,088
UNC Health Rex Wake Forest Hospital								191	293	399
UNC Health Rex Hospital*	4,523	4,472	4,422	4,373	4,324	4,276	4,228	3,990	3,841	3,689

Note: UNC Health Rex Holly Springs Hospital does not have neonatal beds.
* UNC Health Rex Hospital = UNC Health Rex License – UNC Health Rex Wake Forest Hospital

Again, as C-Section cases and Level II neonatal days are a component of total inpatient utilization, it is unreasonable for Rex Wake Forest to assume that 15% of total inpatient utilization will be shifted from other providers but no C-Section cases and no Level II neonatal days will be shifted from other providers.

Given that it has provided contradictory and unreasonable assumptions about the patients it proposes to serve, Rex Wake Forest has failed to identify the population it proposes to serve. As such, the Rex Wake Forest application is **non-conforming with Criteria (1), (3), (4), (5), (6), (8), and (18(a)) and 10A NCAC 14C .3803.**

Inconsistent and Unreasonable Utilization Assumptions

Through the course of its projection methodology, Rex Wake Forest relies on historical ratios between different utilization metrics to project utilization. A close review of these assumed ratios reveals that Rex Wake Forest inconsistently and unreasonably cherry picked data points and assumptions in its Form C Assumptions and Methodology. The inconsistent ratios are particularly notable given the differences between the proposed Rex Wake Forest and Rex Hospital, a much larger tertiary acute care facility, as well as all Wake County facilities as well as the differences between the selected zip code area and Wake County total.

For example, in its projections for inpatient OR cases, Rex Wake Forest examines and uses the historical experience of acuity appropriate Rex only patients from its select nine zip codes stating:

> *UNC Health Rex analyzed the ratio of "acuity-appropriate" acute care days from patients originating from the nine ZIP codes in Table 1-5 to the "acuity-appropriate" inpatient OR cases from patients originating from the nine ZIP codes in Table 1-5 at UNC Health Rex Hospital only, as shown in Table 2-2 below. As both these ZIP codes and the select DRGs provide an accurate representation of the geographic origin and acuity of patients that UNC Health Rex Wake Forest Hospital will serve, and because UNC Health Rex anticipates that the majority of its acute care days will shift from existing acute care days from UNC Health Rex Hospital – as shown in Table 1-10 above – UNC Health Rex has determined that this ratio is a reasonable way to assess the volume of inpatient surgical cases at UNC Health Rex Wake Forest Hospital.*
>
> *See* Rex Wake Forest page 177.

However, in its assumptions for projected Rex Wake Forest outpatient OR cases, Rex uses the experience of all acute care facilities, not Rex alone, stating on page 77 that "*UNC Health Rex also analyzed the ratio of "acuity-appropriate" inpatient OR cases from patients originating from the nine ZIP codes in Table 1-5 to the "acuity-appropriate" outpatient OR cases from patients originating from the nine ZIP codes in Table*

*1-5 at **all** acute care facilities that provided outpatient surgical services to that population"* (**emphasis added**). Please note that Rex Wake Forest provides no information as to how it determined "acuity-appropriate" outpatient OR cases or even that these cases were actually performed in operating rooms as opposed to procedure rooms or other settings, as HIDI data can make such distinctions difficult. As such, it is impossible to determine the reasonableness of this data.

As Rex Wake Forest states above in the excerpt from page 177 in defending its use of Rex Hospital's experience in its inpatient OR case projections, "the majority of acute care days will shift from existing acute care days from UNC Health Rex Hospital." Further, Rex Wake Forest assumes that all of its outpatient OR cases will shift from Rex Hospital (see page 182 and the previous "Contradictory Assumptions About Patients Proposed to Be Served" comment). Rex Wake Forest does not provide any discussion as to why data from all hospitals and not Rex Hospital alone is appropriate for projecting outpatient OR cases when it states that Rex Hospital alone experience is appropriate for inpatient OR cases. As such, it is illogical and inconsistent for Rex Wake Forest to rely on the experience of all acute care facilities in its projections of outpatient OR cases when it previously states that the experience of Rex Hospital only in the selected nine zip codes is the most reasonable experience to examine for inpatient OR cases.

Following its use of inconsistent ratios for inpatient (Rex Hospital alone) and outpatient OR cases (all facilities), Rex Wake Forest uses the experience of Rex Holly Springs alone to project its procedure room utilization, stating "*For reasons described above, UNC Health Rex believes that UNC Health Rex Holly Springs Hospital is the most reasonable analog to calculate ratios to project services at UNC Health Rex Wake Forest Hospital" (page 183).* As such, it is clear that Rex Wake Forest, according to its own statements, has used less reasonable analogs to calculate ratios in project inpatient OR and outpatient OR cases. Again, Rex Wake Forest does not explain why "the most reasonable analog" to its proposed facility, Rex Holly Springs, is not used for its projection of inpatient or outpatient OR cases.

Throughout the remaining services in its Form C Assumptions and Methodology, Rex Wake Forest uses inconsistent data sources as listed below:

- Inpatient OR Cases: **Rex Hospital** experience in selected zip codes (discussed above)
- Outpatient OR Cases: **All facilities** experience in selected zip codes (discussed above)
- Procedure Room Cases: **Rex Holly Springs total experience** (discussed above)
- C-Section Cases: **Rex Holly Springs total experience**
- Observation Days: **Average of Rex Hospital and Rex Holly Springs**
- Neonatal Level II Days: **Rex Hospital** experience in selected zip codes
- ED Admits: **All facilities** in selected zip codes
- ED Outpatients: **All Wake County facilities** total
- Imaging and Ancillary Services: **Rex Holly Springs total experience**
- Interventional Radiology (IR): **Rex Hospital and Rex Holly Springs combined total**

Again, Rex Wake Forest does not provide any reasons or discussion to support its use of the experience of Rex Hospital or all facilities in Wake County when it clearly states that Rex Holly Springs is the most reasonable analog.

Moreover, even when Rex Wake Forest used the experience of Rex Holly Springs, it mischaracterizes the data as in the case of its projected Procedure Room and C-Section utilization. As shown in the tables excerpted below from page 183, Rex Wake Forest calculates a ratio of 0.68 outpatient OR cases to procedure room cases for Rex Holly Springs (as there are fewer outpatient OR cases than procedure room

cases) and then multiplies that ratio and its previously projected outpatient OR cases, instead of appropriately dividing the outpatient OR cases by the calculated ratio. As a result, Rex Wake Forest projects fewer procedure room cases than outpatient OR cases, which is the opposite of Rex Holly Springs experience.

UNC Health Rex Holly Springs Hospital had a ratio of outpatient OR cases to procedure room cases of 0.68 for FY 2024, as shown in Table 2-10 below.

Table 2-10: Ratio of Outpatient OR Cases to Procedure Room Cases
UNC Health Rex Holly Springs Hospital
FY 2024

Outpatient OR Cases	2,019
Procedure Room Cases	2,990
Ratio*	**0.68**

Source: UNC Health Rex internal data.
* Ratio = Outpatient OR Cases ÷ Procedure Room Cases.

This ratio of 0.68 was applied to the projected total outpatient OR cases at UNC Health Rex Wake Forest Hospital to project procedure room cases at that facility prior to any OR cases shifted to procedure rooms. This is shown in Table 2-11 below.

Table 2-11: Projected Procedure Room Cases Without OR Shift
UNC Health Rex Wake Forest Hospital

	FY32 (PY1)	*FY33 (PY2)*	*FY34 (PY3)*
Total Outpatient OR Cases	543	834	1,137
Ratio of Outpatient OR Cases to Procedure Room Cases – UNC Health Rex Holly Springs Hospital	0.68	0.68	0.68
Procedure Room Cases Without OR Shift*	**367**	**563**	**767**

Source: UNC Health Rex internal data (ratio).
* Procedure Room Cases Without OR Shift = Total Outpatient OR Cases x Ratio

In its C-Section utilization projections, Rex Wake Forest again mischaracterizes the experience of Rex Holly Springs. Rex Wake Forest states that it uses the average of FY 2024 and FY 2025 Rex Holly Springs ratio of C-Sections to Acute Care Days.

The ratio described above for FY 2024 and FY 2025, along with the average of those two ratios, is shown in Table 2-16 below. This ratio is 0.023.

Table 2-16: Historical Ratio of Acute Care Days to C-Section Cases
UNC Health Rex Holly Springs Hospital

	FY24	*FY25*	*Average*
Acute Care Days	6,870	7,841	
C-Sections	137	174	
Ratio of C-Sections to Acute Care Days	**0.022**	**0.024**	**0.023**

Source: UNC Health Rex internal data.

However, this is false in several ways. First, it appears that the data presented in the table excerpted above is FY 2023 and 2024 data (not 2024 and 2025) but somewhat inconsistent when compared to C-Section data presented in Table 2-14 on page 185 (which shows 137 C-Sections and 176 (not 174 as shown in the table) in FY 2023 and 2024, respectively) and acute care days presented in Table 1-1 (which shows 6,870 and 7,831 (not 7,841 as shown in the table) acute care days in FY 2023 and 2024, respectively and on pages 83, 165, 166, 174, and 186). Further, the stated ratios and average are incorrect using the presented data. Novant Health has provided correctly calculated ratios in the table below.

Correctly Calculated Rex Holly Springs Ratios

	FY23	FY24	Average
Acute Care Days	6,870	7,831	
C-Sections	137	174	
Ratio of C-Sections to Acute Care Days	0.020	0.022	**0.021**

In total, Rex Wake Forest's projected C-Section utilization is based on older and misstated data, as well as inaccurately calculated ratios, from Rex Holly Springs. As such, the projected C-Section utilization at Rex Wake Forest is not based on Rex Holly Springs' historical experience.

Notably, Rex Wake Forest uses the experience of Rex Hospital in the selected zip codes to project Neonatal Level II days rather than the experience of Rex Holly Springs. As detailed below, the Rex Wake Forest application provides contradictory information regarding the presence or absence of Level II neonatal services at Rex Holly Springs.

In its projections for IR, Rex Wake Forest states "*Interventional Radiology largely incorporates imaging technology to effectively and properly perform interventional procedures using minimally invasive techniques. As such, UNC Health Rex believes that it is appropriate to utilize the historical ratio of IR procedures to acute care days at* ***a comparable facility*** *– i.e., mirroring the same methodology utilized to project imaging and ancillary services, as above – to appropriately project the number of IR procedures in the third full fiscal year following development of the proposed project. UNC Health Rex believes that the* ***existing UNC Health Rex hospital license – i.e., UNC Health Rex Hospital and UNC Health Rex Holly Springs Hospital – is an appropriate benchmarking*** *comparison for the appropriate ratio for IR procedures"* (page 165) (**emphasis added**). As noted above, Rex Wake Forest states that Rex Holly Springs provides the most reasonable analog to Rex Wake Forest. It is entirely unreasonable for Rex Wake Forest to assume that the UNC Health Rex Hospital license, which combines Rex Hospital and Rex Holly Springs, is the most appropriate benchmark for IR services.

Finally, Rex Wake Forest provides inconsistent assumptions in its ED projections. Rex Wake Forest first projects its ED admissions based on Rex Hospital experience in the selected zip codes consistent with its inpatient acute care utilization assumptions. Yet, entirely inconsistently, Rex Wake Forest assumes that its percentage of total ED visits that will result in admission will be consistent with <u>all</u> Wake County facilities, regardless of patient origin. Rex Wake Forest does not provide any discussion to support the assumption that its experience as a 50-bed community hospital that is expected to primarily serve patients from nine or ten selected zip codes in northern Wake County will be consistent with the average experience of all Wake County facilities, which include the breadth of emergency services from freestanding EDs to Level I trauma centers, <u>regardless of patient origin</u>.

Furthermore, Rex Wake Forest makes no attempt in its projections to account for its own planned development of a freestanding ED in North Raleigh. As Rex Wake Forest states on page 70, "there will be a portion of the drive time radii for the [Rex Wake Forest and Rex's proposed North Raleigh freestanding ED] that will overlap." Despite this overlapping service area, Rex Wake Forest fails to discuss this facility in its methodology for projected ED utilization.

Based on the factors discussed above, Rex Wake Forest has failed to provide reasonable and supported assumptions for its projected utilization. As such, the Rex Wake Forest application is **non-conforming with Criteria (1), (3), (4), (5), (6), (8), and (18(a) and 10A NCAC 14C .3803.**

Contradictory Information Regarding Presence or Absence of Level II Neonatal Beds at Rex Holly Springs

In addition to its contradictory information regarding the Level II neonatal patients it proposes to serve, as noted above, Rex Wake Forest provides contradictory information regarding Rex Holly Springs' use of Level II neonatal beds.

On page 24 of its application, in the * note below the completed table provided in response to Section A.5.e, Rex Wake Forest states "*Per its 2025 HLRA, a total of 489 acute care beds are currently licensed to UNC Health Rex, including 439 licensed beds at UNC Health Rex Hospital and 50 licensed beds at UNC Health Rex Holly Springs Hospital. Please note that this total includes six Level IV NICU beds and 15 Level III neonatal beds at UNC Health Rex Hospital* ***and two Level II neonatal beds at UNC Health Rex Holly Springs Hospital*** *for a total of 23 neonatal beds on the UNC Health Rex Hospital license."* (**emphasis added**).

Further, Rex Wake Forest states on page 42 "*Of note, the UNC Health Rex Hospital license also includes 23 existing and approved neonatal care beds, comprised of six Level IV NICU beds and 15 Level III neonatal care beds at UNC Health Rex Hospital, and two Level II neonatal care beds at UNC Health Rex Holly Springs Hospital, all of which are noted in Section A.5.e.*"

However, Rex Wake Forest plainly contradicts the presence of Level II neonatal beds at Rex Holly Springs in its methodology for projecting Level II neonatal bed utilization by campus on pages 189-191. Rex Wake Forest provides no historical or projected utilization for Rex Holly Springs Level II neonatal beds. Further, Rex Wake Forest assumes that Level II neonatal bed utilization at Rex Hospital is equivalent to projected UNC Health Rex License utilization minus Rex Wake Forest, as shown in the excerpted Table 3-7 below, without any adjustment for utilization at Rex Holly Springs.

Table 3-7: Projected Neonatal Care Days – UNC Health Rex License by Campus

	FY25	*FY26*	*FY27*	*FY28*	*FY29*	*FY30*	*FY31*	*FY32*	*FY33*	*FY34*
UNC Health Rex License	4,523	4,472	4,422	4,373	4,324	4,276	4,228	4,181	4,134	4,088
UNC Health Rex Wake Forest Hospital								191	293	399
UNC Health Rex Hospital*	4,523	4,472	4,422	4,373	4,324	4,276	4,228	3,990	3,841	3,689

Note: UNC Health Rex Holly Springs Hospital does not have neonatal beds.
* UNC Health Rex Hospital = UNC Health Rex License – UNC Health Rex Wake Forest Hospital

In fact, the Note under Table 3-7 states "UNC Health Rex Holly Springs Hospital does not have neonatal beds." This cannot be reconciled with Rex Wake Forest's above statements in its application stating that Rex Holly Springs has two Level II neonatal beds.

The presence or absence of Level II neonatal beds at Rex Holly Springs and their utilization would be relevant information to evaluate the proposed development of Level II neonatal beds at Rex Wake Forest and their projected utilization. In fact, Rex Wake Forest states that Rex Holly Springs is its "*most reasonable analog*" (Page 183).

As noted above, Rex Wake Forest's application inconsistently and unreasonably cherry picks data points and assumptions in its Form C Assumptions and Methodology.

Based on the discussion above, Rex Wake Forest has failed to provide reasonable and supported assumptions for its projection utilization. As such, the Rex Wake Forest application is **non-conforming with Criteria (1), (3), (4), (5), (6), (8), and (18(a)) and 10A NCAC 14C .3803.**

COMMENTS SPECIFIC TO REX HOSPITAL APPLICATION
PROJECT ID # J-012677-25

Failure to Identify Patients Proposed to Serve

Rex Hospital's projected patient origin fails to account for the projected impact of the development of Rex Wake Forest and projected increase in utilization at Rex Holly Springs, as assumed in the Rex Hospital application.

In its response to Section C.3.a, Rex Hospital states "*UNC Health Rex's projected patient origin for its acute care beds is based on its existing patient origin for that service. The proposed project will not impact patient origin for UNC Health Rex Hospital. Please see Form C Assumptions and Methodology for projected acute care bed discharges, which are used to complete the table below.*" Rex Hospital's Form C Assumptions and Methodology specify a planned shift of acute care discharges from Rex Hospital to Rex Wake Forest. As shown in the concurrent Rex Wake Forest application, these shifted acute care discharges are projected to originate from Wake and Franklin counties, predominantly per the excerpt below.

b. **Service Component(s)** – Complete the following table for each service component included in this proposal for the facility or campus identified in Section A, Question 4.

Inpatient Services	UNC Health Rex Wake Forest Hospital*					
	1st Full FY		2nd Full FY		3rd Full FY	
	07/01/2031 to 06/30/2032		07/01/2032 to 06/30/2033		07/01/2033 to 06/30/2034	
County or other geographic area such as ZIP code	Number of Patients **	% of Total	Number of Patients **	% of Total	Number of Patients **	% of Total
Wake and Franklin counties (Selected ZIP Codes)^	1,051	71.7%	1,612	71.7%	2,198	71.7%
Franklin (All Other ZIP Codes)	196	13.3%	300	13.3%	409	13.3%
Wake (All Other ZIP Codes)	147	10.0%	225	10.0%	307	10.0%
Other^^	74	5.0%	113	5.0%	155	5.0%
Total	**1,467**	**100.0%**	**2,250**	**100.0%**	**3,067**	**100.0%**

* This should match the name provided in Section A, Question 4.
** Home health agencies should report the number of unduplicated clients.
^ Selected ZIP Codes include ZIP Codes 27616, 27614, 27613, 27597, 27587, and 27571 in Wake County; and ZIP codes 27596, 27549, and 27525, and 27508 in Franklin County.
^^ Other Includes Durham, Granville, Nash, and other counties in NC as well as other states.

Source: Page 50 of Rex Wake Forest Application.

Given the planned shift of acute care patients originating from Wake and Franklin counties from Rex Hospital to Rex Wake Forest, it is unreasonable for Rex Hospital to assume that its projected patient origin for acute care beds will be equivalent to its existing patient origin for that service as stated in its response to Section C.3.a.

Further, Rex Hospital's Form C Assumptions and Methodology assume increasing shifts from Rex Hospital to Rex Holly Springs. Given its location and Rex's assumptions in prior CON application, the increased shifts of acute care discharges are projected to originate from Wake, Harnett, Lee, and Chatham counties, predominantly. Given the assumed increasing shift of acute care patients originating from Wake and Harnett, Lee, and Chatham counties from Rex Hospital to Rex Wake Forest, it is unreasonable for Rex Hospital to assume that its projected patient origin for acute care beds will be equivalent to its existing patient origin for that service as stated in its response to Section C.3.a.

As such, Rex Hospital has failed to identify the population it proposes to serve. As such, the Rex Hospital application is **non-conforming with Criteria (1), (3), (4), (5), (6), (8), and (18(a)) and 10A NCAC 14C .3803.**