Comments on Competing Applications for Additional Acute Care Beds in Wake County

October 1, 2025

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submitted by

UNC Health Rex Hospital, Inc.

In accordance with N.C. GEN. STAT. § 131E-185(a1)(1), Rex Hospital, Inc. d/b/a UNC Health Rex Hospital (UNC Health Rex) hereby submits the following comments related to competing applications to develop additional acute care beds to meet the need identified in the *2025 State Medical Facilities Plan* (*2025 SMFP*) for 267 additional acute care beds in Wake County. UNC Health Rex's comments on these competing applications include "discussion and argument regarding whether, in light of the material contained in the application and other relevant factual material, the application complies with the relevant review criteria, plans and standards."[1] *See* N.C. GEN. STAT. § 131E-185(a1)(1)(c). To facilitate the Agency's review of these comments, Rex has organized its discussion by issue, noting some of the general Certificate of Need (CON) statutory review criteria and specific regulatory criteria creating the non-conformity on the application. Rex's comments relate to the following applications:

- **WakeMed Raleigh Hospital (WakeMed Raleigh), Develop a new hospital wing and add 164 acute care beds, Project ID # J-012671-25**
- **WakeMed North Hospital (WakeMed North), Change of Scope application to develop 25 acute beds in addition to the 35 acute beds and 15 observation beds previously approved by the Agency in the *2023 SMFP* need determination (Project ID # J-012419-23). The current project would upfit a vacant floor in the previously approved bed tower, Project ID # J-012672-25**
- **WakeMed Garner Hospital (WakeMed Garner), Change of Scope Application to develop 78 additional acute beds at a new 31-bed hospital in Garner (Project ID # J-012264-22) that was previously approved by the Agency, Project ID # J-012673-25**
- **Novant Health Knightdale Medical Center (NH Knightdale), Develop a new 26-bed acute care hospital in Knightdale, Project ID # J-012686-25**
- **Duke Health Raleigh Hospital (Duke Raleigh), Add 101 licensed acute care beds, Project ID # J-012690-25**
- **Duke Health Cary Hospital (Duke Cary), Change of Scope application to develop 120 acute care beds in addition to 40 acute beds from the initial hospital project (Project ID # 012029-21) that was previously approved by the Agency, Project ID # J-012689-25**

Given the number of applications and proposed acute care beds, all the applications cannot be approved. UNC Health Rex's detailed comments include application-specific comments related to each competing application and a comparative analysis relative to its application.

UNC Health Rex has a longstanding demonstrated commitment to developing projects that increase geographic and financial accessibility to healthcare services, foster physician collaboration, and provide cost-effective and efficient patient care services. As detailed in its applications, UNC Health Rex believes

[1] UNC Health Rex is providing comments consistent with this statute; as such, none of the comments should be interpreted as an amendment to the two acute bed applications filed on August 15, 2025 by UNC Health Rex (Project ID #'s J-012677-25 and J-012680-25).

that the most effective way to meet the need for 156 of the 267 total acute care beds in Wake County identified in the *2025 SMFP* is to develop 50 acute care beds at a new hospital in northern Wake County and an additional 106 beds at UNC Health Rex Hospital. The UNC Health Rex applications are the result of prudent healthcare planning to provide greater access to acute care beds in Wake County that balances the need for specialized medical and surgical care at tertiary facilities with the growing demand for community-based care to serve the expanding population of Wake County.

ISSUE-SPECIFIC COMMENTS ON WAKEMED NORTH HOSPITAL

WakeMed North's Change of Scope application to develop 25 additional acute beds to its approved bed tower expansion project from 2023 that would add 35 new acute care beds and 15 observation beds should not be approved. WakeMed's application contains numerous miscalculations, overstatements, and inconsistencies. UNC Health Rex has grouped these by issue, each of which contributes to WakeMed's non-conformity.

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

1. Utilization projections at WakeMed North are dependent on overstated growth in discharges at WakeMed Raleigh.

As noted in the issue-specific comments for WakeMed Raleigh, WakeMed uses an unsupported assumption to calculate growth in discharges at WakeMed Raleigh. This results in overstated discharges in future years, which are then shifted to WakeMed's other hospital campuses. The base volume of patients and the volume to be shifted are therefore unreliable. WakeMed uses the CAGR for the population in the WakeMed Raleigh catchment area ZIP codes to project the number of WakeMed Raleigh discharges from FY 2026 through FY 2035, the third project year. However, this growth rate is not reflective of the historical growth in discharges from the catchment area. Based on historical data, inpatient discharges at WakeMed Raleigh increased 9.2 percent from FY 2019 to FY 2025, representing a CAGR of 1.5 percent. WakeMed thus applies a growth rate that is more aggressive than is supported by its own utilization data.

WakeMed Raleigh Inpatient Discharges, FY2019 – FY 2025(A)

Fiscal Year	*Discharges*
2019	25,760
2020	24,108
2021	25,096
2022	24,466
2023	24,486
2024	27,048
2025	28,128
% Change, 2019-2025	*9.2%*
CAGR	*1.5%*

Source: WakeMed Raleigh application, p. 157.

While the application clearly shows that the historical experience at WakeMed Raleigh has been 1.5 percent growth, the application assumes the growth rate will be 46 percent higher, or 2.2 percent each year going forward, without any reasonable support for such an increase. The following table shows the recalculated discharge totals for WakeMed Raleigh in the first three project years if the

historical growth rate of 1.5 percent is applied, versus the higher figures that WakeMed uses. The higher rate results in 1,850 additional discharges in the first project year and increases to a difference of nearly 2,400 discharges by the third project year. This unsupported variation in discharge volume results in overstated patient days for the first three project years as well, and WakeMed does not adequately explain the use of the higher growth rate in its methodology narrative nor in its assumptions. The projections for discharges and patient days are therefore questionable and not properly supported.

WakeMed Raleigh Difference in Discharges, Project Years 1-3

WakeMed Raleigh Discharges	*1.5% CAGR*	*2.2% CAGR*	*Difference*
FY 2025 (annualized)	28,128	28,128	--
FY 2033 (PY1)	31,627	33,477	1,850
FY 2034 (PY2)	32,094	34,213	2,119
FY 2035 (PY3)	32,568	34,966	2,398

The overstated growth for WakeMed Raleigh directly impacts the projected utilization at WakeMed North. The North campus utilization projections are dependent on growth in inpatient utilization at WakeMed Raleigh that is then shifted to other WakeMed campuses, based on discharge acuity and patient origin. If WakeMed Raleigh's future utilization is adjusted to reflect a more appropriate growth rate supported by its historical trend, there is a reduction in the base volume that can be shifted. Using the incremental number of discharges from the table shown above, there are 13,789 fewer acute patient days of care at WakeMed Raleigh in FY 2035 (2,398 discharges x 5.75 days[2] = 13,789). This equals an average daily census of nearly 38 patients that WakeMed is assuming will be available to shift to its North Raleigh and Garner campuses but which will not materialize under more reasonable and supported assumptions.

The WakeMed North application provides unsupported utilization projections for the first three project years, and is non-conforming with Criteria 1, 3, 4, 5, and 6, as well as the Criteria and Standards for Acute Care Beds, and should not be approved.

2. <u>The WakeMed North application overstates the number of patient days in its utilization projections.</u>

The methodology for calculating future patient days at WakeMed North relies upon the base of historical patient days of care at the facility. However, WakeMed shows two different sets of figures for patient days at WakeMed North from FY 2020 to FY 2025 (annualized). The following table is included in Section C.4 of the WakeMed North application, showing a total of 28,526 annualized patient days for FY 2025:

[2] WakeMed Raleigh's ALOS in FY 2024; see WakeMed Raleigh application, p. 179.

Table 4: WakeMed North Annual Acute Care Patient Days of Care, Average Daily Census, and Occupancy Rate, FY 2019 – FY 2025 (annualized), Excluding Neonatal Beds

Metric	FY20*	FY21	FY22	FY23	FY24*	FY25 (Ann)	CAGR FY20-FY25
a. Patient Days	7,868	12,779	15,629	18,844	22,740	28,526	29.40%
b. Total Beds	55	55	55	59 (f)	71	71	
c. Maximum Patient Days	20,130	20,075	20,075	21,535 (f)	25,986	25,915	
d. Occupancy Rate	39.10%	63.70%	77.90%	87.51%	87.51%	110.10%	
e. Average Daily Census	21.5	35.01	42.82	51.63	62.13	78.15	

** Leap Years*

Source: WakeMed North application, p. 45.

However, in its Form C Methodology, the total acute days are lower for each year from FY 2020 through FY 2024 yet are inexplicably higher for FY 2025. The Section Q table has acute days shown as 29,224 in FY 2025, or nearly 2.5 percent higher than the total from Section C.4. The following table is from Section Q of the WakeMed North application:

Table 18: WakeMed North Historical Patient Days and Average Length of Stay

	FY19	FY20	FY21	FY22	FY23	FY24	FY25 (AN)	CAGR FY19-FY25
Total Discharges	2,169	2,828	4,242	4,820	5,447	6,674	8,133	24.64%
Patient Days	5,312	7,205	11,534	14,052	17,103	22,194	29,224	32.87%
ALOS	2.45	2.55	2.72	2.92	3.14	3.33	3.59	6.60%

Source: FY19-24: Total discharges from WakeMed internal data; FY25 based on 6 months
ALOS=Days / Discharges, rounded to 2 decimal places

Source: WakeMed North application, p. 175.

The utilization projections for WakeMed North are based on the 29,224 patient days that are listed in Table 18 on page 175, not Table 4 that has lower figures despite having the same data source. This results in an additional 698 patient days in FY 2025 that are then carried forward in the projections for future years. Thus, all projected volumes are overstated for the project years. This overstated volume is confirmed by referencing the historical volume shown in the instant application compared with similar data from WakeMed North's 2024 acute care beds application in Wake County. In that application, WakeMed included the following table in Section Q:

Table 15: WakeMed North Historical Patient Days and Average Length of Stay

	FY19	FY20	FY21	FY22	FY23	FY24 (Ann)
Total Discharges	2,168	2,829	4,244	4,822	5,446	6,380
Patient Days	5,759	7,868	12,779	15,629	18,884	22,176
ALOS	2.66	2.78	3.01	3.24	3.47	3.48

Source: FY19-23: Total discharges from WakeMed internal data; FY24 based on 6 months annualized
ALOS=Days – Discharges, rounded to 2 decimal places

Source: WakeMed North 2024 acute beds application (Project ID # J-012536-24), p. 161.

This utilization corresponds very closely with the data shown in WakeMed's table on page 45 of its 2025 application, increasing the likelihood that WakeMed made an error with the historical data that it used to calculate utilization in the proposed project years.

This unexplained variation in patient day volume results in overstated patient days for the first three project years and an unreasonable inpatient average daily census. Moreover, as noted below, WakeMed's annualized utilization for FY 2025 is already erroneous, and this inconsistency creates additional issues with its projected utilization.

Based on these issues, the WakeMed North application is non-conforming with Criteria 3, 4, 5, and 6, and the Criteria and Standards for Acute Care Beds and should not be approved.

3. <u>WakeMed uses unreasonable assumptions for bed occupancy in its future acute bed projections.</u>

On page 45 of its application, WakeMed discusses its perceived acute care capacity challenges, showing data that indicates its acute care beds will effectively be above capacity in FY 2025. WakeMed annualizes six months of patient day utilization to calculate an occupancy rate of 110.1 percent for FY 2025. Because it is not physically possible to be at above 100.0 percent capacity, WakeMed acknowledges that "some acute care patients will spend all or part of their acute stay in other than an acute care bed."[3] This statement indicates that WakeMed North has additional capacity to supplement the 71 licensed beds at the facility. The WakeMed application does not include information on how these patients are roomed or where they receive care upon being admitted to the facility. WakeMed states that there are currently no observation beds at the North campus to place admitted patients, and therefore cannot use a temporary bed expansion request in accordance with 10A NCAC 13B .3111 to provide additional acute bed capacity.[4] Without observation beds or any other identified method of operating more than the number of permanent licensed beds, WakeMed North fails to demonstrate that it can operate at an annual occupancy rate exceeding 100 percent for multiple years, as projected.

Even if WakeMed had stated that it planned to apply for and develop temporary licensed beds, it projects to exceed 110 percent capacity through FY 2029, which would not be possible even with an additional 10 percent bed capacity. While WakeMed North proposed to include 15 observation beds at the North campus in its 2023 acute beds CON application,[5] those beds are proposed to be developed as part of the bed tower that will not be operational until FY 2030, the first year of the project proposed in the instant application. As such, they will not be available to use as temporary licensed beds during the interim period.

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3 WakeMed application, p. 45.

4 Ibid, p. 87.

5 See Project ID # J-012419-23.

		FY24	FY25(Ann)	FY26	FY27	FY28	FY29
	WakeMed North Campus				**Interim**		
m	Discharges after shifts	6,674	8,133	8,430	8,627	8,830	8,581
n	ALOS	3.33	3.59	3.33	3.33	3.33	3.33
o	Patient Days	22,194	29,224	28,072	28,728	29,404	28,575
p	ADC	61	80	77	79	81	78
q	Acute Care Beds, Licensed	71	71	71	71	71	71
r	Percent Occupancy, Calculated	85.6%	112.8%	108.3%	110.9%	113.5%	110.3%

WakeMed North application, Exhibit C.5, page 14.

Of note, WakeMed North's projections assume it will exceed 100 percent of its licensed bed capacity beginning with annualized FY 2025. On page 45, WakeMed states that FY 2025 data is annualized based on six months of actual data. As such, it should be stated that WakeMed North had not in fact exceeded 100 percent of its annual occupancy rate at the time of the application but was merely projecting to do so if its current utilization was sustained for the remaining six months. In other words, the data for annualized FY 2025 does not actually demonstrate that WakeMed North has historically exceeded 100 percent of its licensed bed capacity and therefore does not demonstrate that this occupancy rate will continue in the future.

In previous WakeMed applications, specifically its applications in the 2024 Wake County acute care bed review, WakeMed indicated that it was "boarding" patients in its Emergency Department, and in the methodology for those applications assumed that those patients were not able to be admitted without acute care beds to house those patients. In WakeMed North's instant application, WakeMed inconsistently appears to have no issue admitting patients when no acute care beds are available and counting them in its utilization calculations.

WakeMed's application also discusses "nursing-equivalent patient days," starting on page 48. While this approach may allow WakeMed North to include a discussion of how its acute care beds can be used for the placement for observation patients, it does not demonstrate how the facility is able to admit and treat inpatients beyond its licensed acute care bed capacity.

While hospitals may periodically have a number of patients needing admission that exceed their licensed bed capacity, WakeMed North is projecting far more frequent instances where the number of patients needing admission exceeds its licensed bed capacity. Indeed, WakeMed is projecting this to be, on average, a daily occurrence as indicated by the annual occupancy rates. In Exhibit C.5, page 14, WakeMed projects an average daily census of admitted inpatients that exceeds the number of licensed acute care beds for FY 2025 (annualized) and all four interim years (FY 2026 – FY 2029). During this period, WakeMed North is projected to serve an average of between six (6) and 11 inpatients every day above its licensed bed capacity. With no observation beds to house these patients, and with no other solution proposed for how to serve these patients without available bed capacity, WakeMed's projected utilization is unreasonable.

While the WakeMed North application relies in part on patient shifts from WakeMed Raleigh, the largest portion of its projected utilization relies on growing its historical base of patients, including those that would exceed the licensed bed capacity as described above. Since WakeMed's ability to serve those patients is undocumented and unreasonable, the base of patients it projects to grow in the future is unreasonable and its projected utilization is not adequately supported.

Based on these issues, the WakeMed North application is non-conforming with Criteria 1, 3, 4, 5, and 6 and should not be approved.

4. The WakeMed North application overstates gross and net revenue for the acute beds service component.

According to the Form F.2a and F.2b assumptions on page 181 of its application, WakeMed states that revenues for WakeMed North are based on the actual revenue per case in FY 2025. WakeMed shows Total Gross Revenue of $368,537,722 for FY 2025 in Form F.2a, with 8,581 projected discharges in that year. This equates to $42,948 per discharge. This figure increases to $52,536 in Gross Revenue per Discharge for FY 2030 ($629,481,336 ÷ 11,982 = $52,536). This represents a 22 percent increase or a compound annual growth rate of 4.1 percent over these five years. In its Form F.2b Assumptions on page 181, WakeMed states that Gross Revenue is calculated using the FY 2025 actual amount as a base, with a 3.0 percent annual inflation rate. WakeMed appears to have used a higher growth rate in its financial projections, resulting in overstated gross revenue. In FY 2030, the first project year, the excessive growth rate results in an additional $2,747 in gross revenue per discharge, resulting in an additional $32.9 million in gross revenue ($2,747 x 11,982 = $32,914,554). With this rise in gross revenue, net revenue also increases; in FY 2025 net revenue for WakeMed North is $12,393 per discharge. WakeMed states that net revenue is increased by 1.5 to 2.5 percent annually, depending on payor category. However, the actual increase in the financial projections from FY 2025 to FY 2030 is a 3.1 percent CAGR, with a corresponding overstated net revenue per discharge. Even if one assumes the 2.5 percent CAGR applies to all payor types, this still would result in a decrease of $446 per discharge, representing a reduction of $5.3 million in net revenue for FY 2030 ($446 x 11,982 = $5,343,972). WakeMed offers no explanation for these deviations in its calculations from the stated assumptions. The result is that WakeMed North projects an additional $5 to 8 million in total net revenue per year for each of the first three project years.

WakeMed North Financial Projections, FY 2025-FY 2030

	FY 2025	*FY 2030*	*% Change*	*CAGR*
Gross Revenue	$368,537,722	$629,481,336	71%	11.3%
Net Revenue	$106,346,679	$173,354,446	63%	10.3%
Discharges	8,581	11,982	40%	6.9%
Gross Rev per Discharge	$42,948	$52,536	22%	4.1%
Net Rev per Discharge	$12,393	$14,468	17%	3.1%

Source: WakeMed North application, Forms F.2a-F2.b; Forms C1.a-b.

Based on these issues, the WakeMed North application is non-conforming with Criterion 5 and should not be approved.

5. WakeMed's payor mix data contain errors that affect the analysis of underserved groups.

The WakeMed North application contains errors in payor mix data that create inaccuracies in evaluating the facility's service to underserved populations under Criterion (13c). The application incorrectly characterizes revenue-based payor mix percentages as discharge-based percentages, which affects the accuracy of Medicare and Medicaid access projections.

WakeMed North Payor Mix Errors

The WakeMed North application projects that 65.2 percent of acute care discharges will be Medicare patients (page 126), but this figure appears to represent Medicare's percentage of gross revenue rather than percentage of discharges.

<Acute Care Beds>	
Payor Source	**Percentage of Total Patients Served**
Self-Pay	3.3%
Charity Care	See (a)
Medicare *	65.2%
Medicaid *	8.2%
Insurance *	21.3%
Workers Compensation	%
TRICARE	%
Other (TRICARE, Other Govt)	2.0%
Total	100.0%

* Including any managed care plans.

(a) Charity care is 4.9% of gross patient revenue

(b) Patients in all payor classes estimated from gross patient revenue

Source: WakeMed North application, p. 126.

WakeMed North's projected payor mix for Project Year 3 explicitly states that "patients in all payor classes [are] estimated from gross patient revenue" (p. 126), indicating the calculations in the financial statements are revenue-based, not discharge-based. This methodology is flawed because revenue percentages do not accurately reflect discharge percentages. Different payor types generate varying revenue per discharge due to differences in length of stay, acuity levels, and reimbursement rates. Medicare patients typically have longer stays and higher acuity conditions, generating higher charges per discharge. Commercial plans often reimburse at higher rates, further inflating their revenue percentage. Using revenue percentages as discharge percentages systematically distorts payor mix projections. This is confirmed by the financial projections in the WakeMed North application, which shows Medicare gross revenue comprising exactly 65.2 percent of total gross revenue (Form F.2b, p. 180) – the identical percentage claimed for discharges on page 126.

This error is evident when compared to the application's own demographic data. According to page 70 of the same application, patients age 65 and older accounted for just 24.9 percent of acute care discharges at WakeMed North in FY 2024. It is unreasonable to project that 65 percent of discharges in FY 2032 will be Medicare patients when less than 25 percent of patients in FY 2024 were in the primary Medicare-eligible age group.

This error is also confirmed by WakeMed North's 2024 acute beds application, which projected that 40.2 percent of acute care discharges would be Medicare patients, providing an additional point of reference that demonstrates the 49.2 percent figure does not represent discharge percentages.

<Acute Care Beds>	
Payor Source	**Percentage of Total Patients Served**
Self-Pay	4.6%
Charity Care	see (a)
Medicare *	40.2%
Medicaid *	11.9%
Insurance *	41.0%
Workers Compensation	%
TRICARE	%
Other (Workers Comp/Other Govt/3PL)	2.3%
Total	100.0%

Including any managed care plans.

Note: a. Charity care is 6.0 percent of gross patient revenue.

Source: WakeMed North 2024 acute beds application (Project ID # J-012536-24), p.120.

An additional data point that illustrates WakeMed's payor mix error overstating the percentage of Medicare patients can be found in the annual hospital license report (HLRA) from 2025. Based upon FY 2024 data, WakeMed North had 11,461 inpatient days of care for Medicare beneficiaries, representing 46.8 percent of all inpatient days.

Primary Payer Source	Inpatient Days of Care (total should be the same as The Total General Acute Care Days in Beds by Service)
Self Pay	573
Charity Care	0
Medicare *	11461
Medicaid *	3160
Insurance *	8898
Other (WC/Other Govt/3PL)	419
TOTAL	24511

Source: WakeMed Raleigh 2025 HLRA, Services by Campus, p. 15.

These systematic errors create confusion in evaluating WakeMed's projected service to Medicare patients under Criterion 13(c). When revenue-based percentages are incorrectly presented as discharge-based percentages, it overstates the projected service to this underserved population. The payor mix errors affect Medicaid and other payor projections as well, since the percentage calculations are interdependent.

Therefore, the WakeMed North application contains payor mix errors that affect the accuracy of Criterion 13(c) analysis regarding service to underserved populations.

In summary, based on these issues, the WakeMed North application is non-conforming with Criteria 1, 3, 4, 5, 6, 13(c), and 18a, as well as the Criteria and Standards for Acute Care Beds, and should not be approved.

ISSUE-SPECIFIC COMMENTS ON WAKEMED RALEIGH HOSPITAL

WakeMed Raleigh's application to develop 164 acute beds should not be approved. The WakeMed application overstates the need for the proposed project and contains inconsistencies and omissions in its supporting information. UNC Health Rex has summarized these issues, each of which contributes to WakeMed's non-conformity. Please note that relative to each issue, UNC Health Rex has identified the statutory review criteria and specific regulatory criteria and standards creating the non-conformity.

1. <u>The WakeMed Raleigh application overstates the growth in discharges in its utilization projections.</u>

   The methodology for calculating growth in discharges at WakeMed Raleigh relies upon the projected growth in population age cohorts for the 48 ZIP codes in the hospital's catchment area. In Table 7 of its Form C Methodology on page 166, WakeMed calculates that the population growth in the catchment area, weighted to reflect the historical percentages of discharges by age cohort at WakeMed Raleigh, will have a compound annual growth rate (CAGR) of 2.17 percent from 2025 through 2030. WakeMed uses this CAGR to increase the number of WakeMed Raleigh discharges from FY 2026 through FY 2035, the third project year. However, this growth rate is not reflective of the historical growth in discharges from the catchment area. Table 2 on page 157 shows the yearly discharges at WakeMed Raleigh for the ZIP codes in the catchment area. Discharges for this patient population increased from 25,760 in FY 2019 to 28,128 in FY 2025 (annualized).

	FY19	FY20	FY21	FY22	FY23	FY24	FY25 (Ann)
Total catchment area Non-Neonatal Discharges, WakeMed Raleigh Campus	*25,760*	*24,108*	*25,096*	*24,466*	*24,486*	*27,048*	*28,128*
Annual Percent Change		*-6.41%*	*4.10%*	*-2.51%*	*0.08%*	*10.46%*	*3.99%*

Source: WakeMed Raleigh application, p. 157.

Based on historical data, inpatient discharges increased by 9.2 percent from FY 2019 to FY 2025, representing a CAGR of 1.5 percent. WakeMed thus applies a growth rate that is more aggressive than is supported by its own utilization data.

WakeMed Raleigh Inpatient Discharges, FY2019 – FY 2025(A)

Fiscal Year	*Discharges*
2019	25,760
2020	24,108
2021	25,096
2022	24,466
2023	24,486
2024	27,048
2025	28,128
% Change, 2019-2025	*9.2%*
CAGR	*1.5%*

Source: WakeMed Raleigh application, p. 157.

Although WakeMed states that it is reasonable to use the higher growth CAGR of 2.2 percent because "when 20 beds opened [at WakeMed Raleigh], beds filled immediately, and patient days increased by

8.08 percent,"[6] such an event does not support the projected growth rate through 2035, and it is neither supported by the historical data WakeMed provides nor is the previous growth in patient days indicative of the growth in discharges that WakeMed Raleigh might expect for the proposed project.

The following table shows the recalculated discharge totals for WakeMed Raleigh in the first three project years if the historical growth rate of 1.5 percent is applied, versus the higher figures that WakeMed uses. The higher rate results in 1,850 additional discharges in the first project year and increases to a difference of nearly 2,400 discharges by the third project year. This unsupported variation in discharge volume results in overstated patient days for the first three project years as well, and WakeMed does not adequately explain the use of the higher growth rate in its methodology narrative nor in its assumptions. The projections for discharges and patient days are therefore questionable and not properly supported.

WakeMed Raleigh Difference in Discharges, Project Years 1-3

WakeMed Raleigh Discharges	*1.5% CAGR*	*2.2% CAGR*	*Difference*
FY 2025 (annualized)	28,128	28,128	--
FY 2033 (PY1)	31,627	33,477	1,850
FY 2034 (PY2)	32,094	34,213	2,119
FY 2035 (PY3)	32,568	34,966	2,398

The implications of this overstated growth extend to WakeMed's concurrent applications for acute beds at its WakeMed North and WakeMed Garner campuses. The utilization projections for those facilities that are used to justify additional acute bed capacity are dependent on growth in inpatient utilization at WakeMed Raleigh that is then shifted to other WakeMed campuses, based on discharge acuity and patient origin. If WakeMed Raleigh's future utilization is adjusted to reflect a more appropriate growth rate, there will be a reduction in the base volume that can be shifted. Using the incremental number of discharges from the table shown above, there will be 13,789 fewer acute patient days of care at WakeMed Raleigh in FY 2035 (2,398 discharges x 5.75 days[7] = 13,789). This equals an average census of nearly 38 patients per day that WakeMed is assuming will be available to shift to its North Raleigh and Garner campuses, but which will not materialize with more reasonable and supported assumptions.

Based on these issues, the WakeMed Raleigh application is non-conforming with Criteria 3, 4, 5, and 6, and the Criteria and Standards for Acute Care Beds and should not be approved.

2. <u>WakeMed fails to provide assumptions and supporting documentation for its capital costs.</u>

Although WakeMed provides a breakdown of capital costs for the proposed project by cost category, it neglects to also provide the assumptions and estimates that would verify the reasonableness of these costs. The CON application form states in Section F that an applicant must also describe the assumptions regarding capital costs, as excerpted below. WakeMed provides only minimal assumptions on the same page as the figures for Form F.1a and no additional page with assumptions

[6] WakeMed Raleigh application, p. 167.

[7] WakeMed Raleigh's ALOS in FY 2024; see application p. 179.

used for Form F.1a in Section Q, only the assumptions for Forms F.2 and F.3. Without a description of the methods used to calculate these costs and the sources for these calculations, the total capital cost cannot be validated and shown to be reasonable.

> **CAPITAL COST AND AVAILABILITY OF FUNDS FOR THE CAPITAL COST**
>
> 1. a. Complete Form F.1a Capital Cost, which is found in Section Q.
>
> b. Describe the **assumptions** used to project the capital cost.
>
> - The description should be done in Word or similar software.
> - Include it in Section Q immediately following the completed form to which it relates.
> - Provide any supporting documentation in an Exhibit.
>
> WakeMed Raleigh application, p. 97.

Because of these missing assumptions, the application fails to provide the information necessary for the Agency to evaluate the reasonableness of its projected costs, as required by Criterion 5.

For this reason, the WakeMed Raleigh application is non-conforming with Criteria 5 and 12 and should not be approved.

3. <u>WakeMed omits financial projections for all proposed service components.</u>

WakeMed's proposed project includes not only acute beds but also a new CT scanner and 16 observation beds. On page 24 of its application in Section A.4.f, WakeMed lists a new CT scanner in the list of medical equipment:

f. **Medical Equipment**: Complete the table **only** for the **types of medical equipment included in this proposal.** Facilities with more than one campus on the same license should provide the information for the entire facility (i.e., all campuses on that license).

Type of Medical Equipment	Number of Units WakeMed Raleigh License H0199			
	Existing	Previously Approved to be Added or (Deleted)	Proposed as Part of this Project	Total upon Completion of All Projects
Cardiac catheterization equipment				
CT scanner	10	1	1	13
Gamma knife				
Heart-lung bypass machine				
Linear accelerator				
Lithotriptor				
Major medical equipment *				
MRI scanner				
PET scanner				
Simulator				
Other (describe) **				

* Excluding the medical equipment listed separately in the table.

** This is relevant to a diagnostic center proposal where the medical equipment costs more than $10,000 but less than $2,000,000. It is also relevant to a proposal to develop a new hospital or a new hospital campus which includes acquisition of X-ray, ultrasound, mammography, C-arms, etc. that cost more than $10,000 but less than $2,000,000.

Response: As part of the proposed project, WakeMed will add one fixed computed tomography (CT) scanner at WakeMed Raleigh Campus. Existing, approved, and proposed CT scanners at locations under the WakeMed license (H0199) are provided below. No other Medical Equipment is proposed.

Section C.1 of the application also states that 16 new unlicensed observation beds will be developed.[8] By including this radiology equipment and additional unlicensed beds in the project, WakeMed must provide corresponding utilization and financial projections for these two service components in addition to the corresponding forms for acute beds. While WakeMed has provided utilization projections that are separate for observation days and CT scans in Form C.2a, affirming that these are service components for the project, the same is not true for Forms F.2 and F.3; the application is lacking revenue and operating expense projections for the CT and observation beds service components. While a portion of the revenue and expenses may be included with the acute care beds for inpatients (although not stated as such in the application), the outpatient portion of these services, which comprise the entirety of the observation beds and likely the majority of the CT service, are completely missing. Without the details provided in these forms, the information that that Agency has requested as needed to evaluate conformity under the statutory criteria is unavailable.[9] Accordingly, WakeMed does not demonstrate that its financial projections are reasonable.

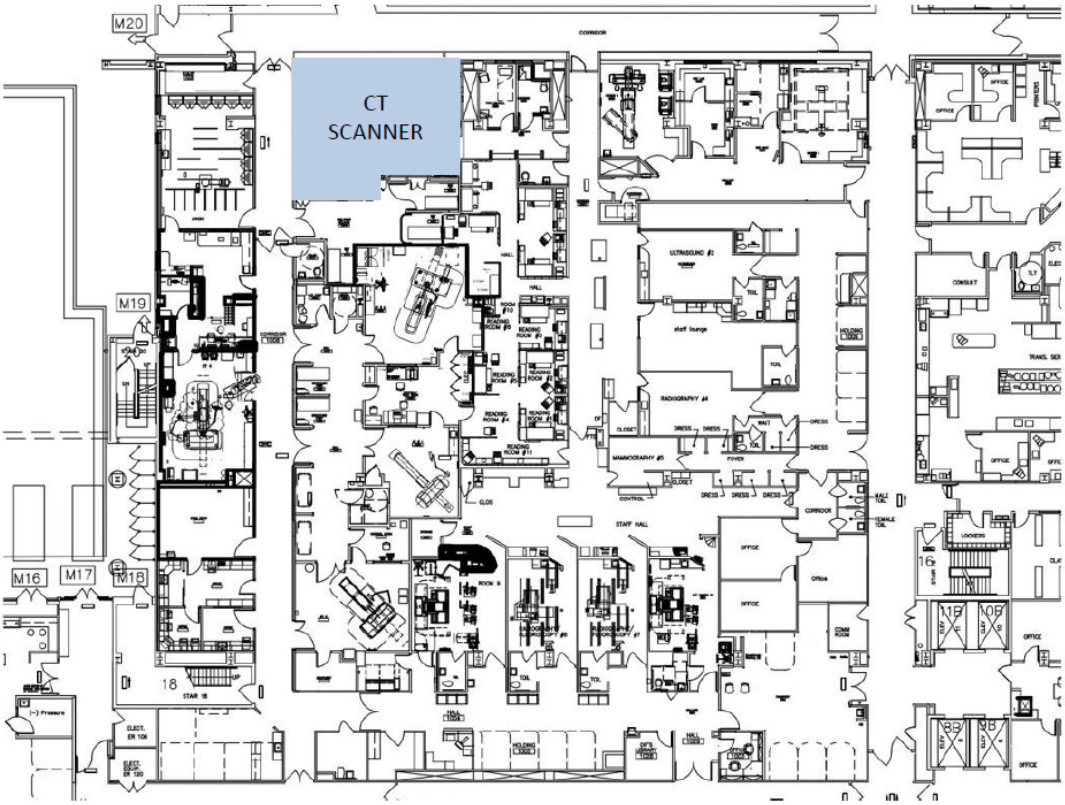
[8] WakeMed application, p. 30.

[9] See N.C.G.S. 131E-182(b).

For this reason, the WakeMed Raleigh application is non-conforming with Criteria 4 and 5 and should not be approved.

4. <u>WakeMed does not include all the capital costs for its proposed project.</u>

WakeMed's certified construction cost estimate in Exhibit F.1 states that the total project budget of $429,692,000 is for the acute care bed expansion of Building E on the WakeMed Raleigh campus. A review of the line drawings shows that Building E will house the additional acute beds and observation beds that are part of the project scope but does not have space for CT imaging. Exhibit K.2 shows line drawings for the renovation of space in the Radiology department to accommodate the additional CT scanner. The Level 1 floorplan indicates that the Radiology department is in Building A, not Building E. There are no additional capital costs in Form F.1a that are associated with the renovation of Building A, and the architect letter in Exhibit F.1 refers only to the acute care bed expansion in Building E. It appears that WakeMed has omitted these costs and included only the project costs for the E Tower expansion. WakeMed therefore has not included all necessary costs for the proposed project and does not have all project costs certified by a licensed architect. WakeMed cannot demonstrate that the project represents the most reasonable alternative for cost, design, and means of construction.



RADIOLOGY DEPARTMENT,
FIRST FLOOR

WMRC A BUILDING - ADDITIONAL CT SCANNER

CERTIFICATE OF NEED APPLICATION

For this reason, the WakeMed Raleigh application is non-conforming with Criteria 4, 5, and 12 and should not be approved.

In summary, based on these issues the WakeMed Raleigh application is non-conforming with Criteria 1, 3, 4, 5, 6, and 12, as well as the Criteria and Standards for Acute Care Beds, and should not be approved.

ISSUE-SPECIFIC COMMENTS ON WAKEMED GARNER HOSPITAL

WakeMed Garner's change of scope application to develop 78 additional acute beds should not be approved. WakeMed's application contains unreasonable assumptions and unsupported utilization projections that do not demonstrate a need for the proposed project. UNC Health Rex has summarized these issues below, each of which contributes to WakeMed's non-conformity.

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

1. Utilization projections at WakeMed Garner are dependent on overstated growth in discharges at WakeMed Raleigh.

   As noted in the issue-specific comments for WakeMed Raleigh, WakeMed uses an unreasonable assumption to calculate growth in discharges at WakeMed Raleigh. This results in overstated discharges in future years, which are then shifted to WakeMed's other hospital campuses. The volume of patients shifted is therefore unreliable. WakeMed uses the CAGR for the population in the WakeMed Raleigh catchment area ZIP codes to project the number of WakeMed Raleigh discharges from FY 2026 through FY 2035, the third project year. However, this growth rate is not reflective of the historical growth in discharges from the catchment area. Based on historical data, inpatient discharges at WakeMed Raleigh increased 9.2 percent from FY 2019 to FY 2025, representing a CAGR of 1.5 percent. WakeMed thus applies a growth rate that is more aggressive than is supported by its own utilization data.

WakeMed Raleigh Inpatient Discharges, FY2019 – FY 2025(A)

Fiscal Year	*Discharges*
2019	25,760
2020	24,108
2021	25,096
2022	24,466
2023	24,486
2024	27,048
2025	28,128
% Change, 2019-2025	*9.2%*
CAGR	*1.5%*

Source: WakeMed Raleigh application, p. 157.

The following table shows the recalculated discharge totals for WakeMed Raleigh in the first three project years if the historical growth rate of 1.5 percent is applied, versus the higher figures that WakeMed uses. The higher rate results in 1,850 additional discharges in the first project year and increases to a difference of nearly 2,400 discharges by the third project year. This unsupported variation in discharge volume results in overstated patient days for the first three project years as well, and WakeMed does not adequately explain the use of the higher growth rate in its methodology narrative

nor in its assumptions. The projections for discharges and patient days are therefore questionable and not properly supported.

WakeMed Raleigh Difference in Discharges, Project Years 1-3

WakeMed Raleigh Discharges	*1.5% CAGR*	*2.2% CAGR*	*Difference*
FY 2025 (annualized)	28,128	28,128	--
FY 2033 (PY1)	31,627	33,477	1,850
FY 2034 (PY2)	32,094	34,213	2,119
FY 2035 (PY3)	32,568	34,966	2,398

The overstated growth for WakeMed Raleigh affects the projected utilization at WakeMed Garner. The Garner utilization projections are dependent on growth in inpatient utilization at WakeMed Raleigh that is then shifted to other WakeMed campuses, based on discharge acuity and patient origin. If WakeMed Raleigh's future utilization is adjusted to reflect a more appropriate growth rate, there is a reduction in the base volume that can be shifted. Using the incremental number of discharges from the table shown above, there are 13,789 fewer acute patient days of care at WakeMed Raleigh in FY 2035 (2,398 discharges x 5.75 days[10] = 13,789). This equals an average census of nearly 38 patients per day that WakeMed is assuming will be available to shift to its North Raleigh and Garner campuses, but which will not materialize using reasonable assumptions.

The Garner application therefore provides unsupported utilization projections for the first three project years, and is non-conforming with Criteria 1, 3, 4, 5, and 6, as well as the Criteria and Standards for Acute Care Beds, and should not be approved.

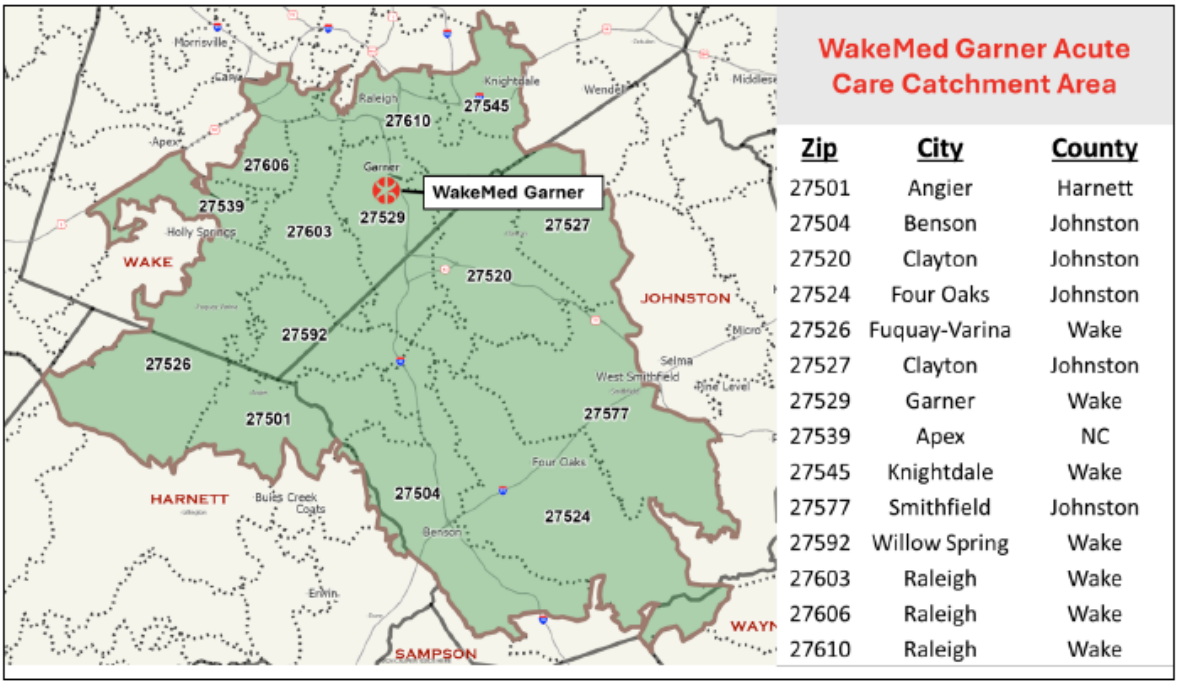
2. <u>The WakeMed Garner "catchment area" definition is overly broad and unsupported.</u>

For its change of scope application, WakeMed has expanded its primary service area ("catchment area") to include eight additional ZIP codes in Wake, Harnett, and Johnston counties to supplement the six ZIP codes that were originally included in its 2022 CON application. There is no reasonable basis provided by WakeMed to project a change in the catchment area for an approved hospital that is not open and does not yet have any operational experience.

The following map shows the expanded catchment area as defined in the instant application:

[10] WakeMed Raleigh's ALOS in FY 2024; see WakeMed Raleigh application, p. 179.

Figure 1: WakeMed Garner Proposed Catchment Area, ZIP Codes



WakeMed Garner Acute Care Catchment Area

Zip	City	County
27501	Angier	Harnett
27504	Benson	Johnston
27520	Clayton	Johnston
27524	Four Oaks	Johnston
27526	Fuquay-Varina	Wake
27527	Clayton	Johnston
27529	Garner	Wake
27539	Apex	NC
27545	Knightdale	Wake
27577	Smithfield	Johnston
27592	Willow Spring	Wake
27603	Raleigh	Wake
27606	Raleigh	Wake
27610	Raleigh	Wake

Source: WakeMed Garner application, p. 150.

WakeMed's inclusion of Johnston County ZIP codes 27504 (Benson), 27524 (Four Oaks), and 27577 (Smithfield) in the Garner catchment area is fundamentally flawed given that the proposed hospital remains undeveloped and the application fails to demonstrate that anything else has changed that would be relevant to the new hospital's catchment area. To the contrary, UNC Health Johnston operates community hospitals in Smithfield and Clayton, both of which have been approved to expand since the original approval of WakeMed Garner,[11] and as such, will be able to serve a greater number of residents from Johnston County. Moreover, the majority of WakeMed patients from these three ZIP codes go to WakeMed Raleigh, and not either or WakeMed's two community hospital campuses. As shown in the following table, at least 82 percent of patients from these three ZIP codes receive care at WakeMed Raleigh.

WakeMed Johnston County ZIP Code Discharges by Campus, FY 2024

WakeMed Campus	***27504***	***27524***	***27577***
WakeMed Raleigh	327	186	338
WakeMed North	5	2	7
WakeMed Cary	63	29	43
Total WakeMed Discharges	**395**	**217**	**388**
WakeMed Raleigh % of Total	*82.8%*	*85.7%*	*87.1%*

Source: WakeMed Garner application, pp. 151-153.

[11] See Project ID #s J-012480-24 and J-012483-24.

The allocation of patients from southern Johnston County indicates that the vast majority are going to WakeMed Raleigh. This is most likely due to the higher level of care and expanded specialty services that the Raleigh campus offers – services that are not available at hospitals in Johnston County and will not be available at WakeMed Garner. While WakeMed applies an analysis of drive time to adjust the potential shift of patients from these ZIP codes to its proposed community hospital in Garner, there are geographic and market conditions that WakeMed ignores when including these three ZIP codes in the catchment area. Wake Med expects that patients from these communities will:

- Bypass their local hospital in Smithfield (UNC Health Johnston – Smithfield Campus), currently expanding
- Bypass the nearby Clayton campus of UNC Health Johnston, currently expanding
- Travel beyond the county to a new, yet undeveloped community hospital in Garner

The two existing UNC Health Johnston facilities are both community hospitals; however, both offer more comprehensive services compared to the proposed Garner hospital. Both are certified as Primary Stroke Centers, and the Smithfield Campus provides interventional cardiac catheterization services, including for emergency or STEMI patients, as well as higher acuity spine fusion surgery. The instant WakeMed Garner application proposes a larger hospital with obstetrics services but fails to propose any higher acuity services that would warrant a larger catchment area, particularly given the existence and ongoing expansion of the two UNC Health Johnston campuses. WakeMed therefore assumes that patients from these communities will choose to travel a longer distance to a new facility offering fewer services than are available locally. This assumption contradicts WakeMed's own methodology stating that "proximity and convenience to WakeMed hospitals will be a significant factor in patient decision to shift between hospitals within the WakeMed System"[12] and that patients "prefer care closer to home when quality and service levels are comparable."[13] Particularly for the Smithfield ZIP code (ZIP 27577), it is unreasonable for WakeMed to include these ZIP codes in the catchment area despite these patients having a local hospital in their own community. This assumption ignores basic healthcare utilization patterns where patients typically seek care locally first, and travel outside their community for advanced high-acuity or highly specialized services.

In addition, WakeMed uses questionable logic in its methodology for incorporating ZIP codes in the catchment area based on proximity to the Garner hospital. WakeMed's drive time analysis shows distance assumptions for each ZIP code to all three WakeMed hospitals in Table 1, shown below.

12 WakeMed Garner application, Exhibit C.5, page 3.

13 Ibid, page 6.

Table 1: WakeMed Garner Catchment Area ZIP Codes Drive-Time from ZIP Code Population Weighted Centroids to WakeMed Hospitals

		Drive-Time (in minutes) to			
Zip Code	City	WakeMed Raleigh	WakeMed Cary	WakeMed North	WakeMed Garner
27501	Angier	37	35	50	27
27504	Benson	30	39	43	23
27520	Clayton	24	32	37	17
27524	Four Oaks	37	46	49	30
27526	Fuquay-Varina	37	31	51	30
27527	Clayton	31	40	39	24
27529	Garner	21	29	35	6
27539	Apex	27	12	38	23
27545	Knightdale	13	28	22	17
27577	Smithfield	33	42	46	26
27592	Willow Spring	34	31	46	22
27603	Raleigh	19	22	33	12
27606	Raleigh	18	12	30	18
27610	Raleigh	10	24	24	14
Average Drive Time Across ZIPs		**26.5**	**30.2**	**38.8**	**20.6**

Notes: Drive-time reflects the estimated travel time from the ZIP Code Population Weighted Centroids to facility, measured in minutes. Average is a simple (unweighted) mean of ZIP code drive-times.
Source: ZIP Population Weighted Centroids from U.S. Department of Housing and Urban Development
https://hudgis-hud.opendata.arcgis.com/datasets/zip-code-population-weighted-centroids-1/about
Source: WakeMed Garner application, Exhibit C.5, p. 4.

The 27539 ZIP code (Apex) is included in the Garner catchment area despite a significant disparity in the driving distance to WakeMed's Cary hospital. WakeMed Garner is 23 minutes away while WakeMed Cary is only a 12 minute drive —Garner is actually 11 minutes farther, yet WakeMed includes this in Garner's catchment area. While WakeMed only shifts 15 percent of discharges from Cary to the Garner facility, it is still unreasonable given the significantly higher drive time. Similarly, for ZIP code 27606 (Raleigh), the Garner hospital is 18 minutes away while WakeMed Cary is 12 minutes away, representing a 6-minute disadvantage for Garner. WakeMed still assumes that 15 percent of the Cary campus patients will shift to the Garner facility. And for the 27526 ZIP code (Fuquay-Varina), the driving distance to the Garner campus is 30 minutes versus 31 minutes to WakeMed Cary—only 1 minute closer, providing no meaningful proximity advantage. WakeMed assumes that 30 percent of the Cary patients will shift to the Garner campus in the first project year, with no reasonable explanation for this notable change. These examples demonstrate that WakeMed's catchment area definition extends beyond areas where Garner provides meaningful geographic advantages.

As noted previously, WakeMed's assumptions for shifting patients in the catchment area also ignore the competitive market dynamics in Wake County and the adjacent Johnston County. In the case of Johnston County, UNC Health Johnston has an established local market presence in key Johnston County ZIP codes. UNC Health Johnston was approved for 24 additional licensed beds in 2024, including the relocation of its obstetrics and neonatal services from the Smithfield Campus to the

Clayton Campus.[14] UNC Health Johnston – Clayton Campus has also submitted a change of scope proposal to expand its emergency department by an additional 15 treatment rooms, which will generate additional resources for the immediate care needs of patients in northwestern Johnston County.[15] The development of these projects will serve to limit the outmigration of patients to facilities in Wake County, including the WakeMed Garner facility. The competitive environment does not appear to have been considered in the WakeMed methodology. As noted earlier, geographic loyalty is a strong influence on utilization patterns: patients often prefer to receive care within their home county, especially when quality alternatives exist. With the existing UNC Health Johnston community hospitals in Johnston County in particular, there are multiple competitors with greater market penetration that will impact WakeMed's ability to grow volume significantly at the Garner facility.

Lastly, WakeMed has no basis for expanding its catchment area. On page 149, WakeMed states that the catchment area was enlarged "to account for the increase in capacity, and service scope associated with increasing the hospital from 31 to the proposed 109 acute care beds." However, the only additional service that is clearly noted in comparison with the original project scope is obstetrics. Obstetrics is generally an elective service that is driven highly by patient choice, and there are multiple existing providers in the area that provide OB services. There is no reason to believe that offering OB services would expand the expected catchment area at all, particularly for medical/surgical services that are unrelated to obstetrics. Obstetrics is generally an elective service that is driven highly by patient choice, and there are multiple existing providers in the area that provide OB services.

WakeMed's expanded catchment area for the Garner hospital lacks geographic logic, particularly for Johnston County ZIP codes where patients would bypass local UNC Health Johnston facilities to travel to Garner. The inclusion of areas where Garner provides minimal or no proximity advantage, combined with the minimal impact of the obstetrics service and WakeMed's failure to consider the existing competitive healthcare infrastructure, renders the catchment area definition unreasonably broad and inconsistent with WakeMed's own stated proximity-based assumptions.

Based on these issues, the WakeMed Garner application is non-conforming with Criteria 3, 4, 5, and 6, and the Criteria and Standards for Acute Care Beds and should not be approved.

3. <u>WakeMed's assumptions for average length of stay are not reasonable.</u>

WakeMed calculates total acute patient days of care at the Garner facility by multiplying its projected discharges by the historical FY 2024 average length of stay (ALOS) at WakeMed North – 3.33 days.[16] WakeMed does not provide a reasonable justification for choosing this figure; the original 2022 WakeMed Garner application used an ALOS of 3.0 days for projecting patient days.

[14] See Project ID # J-012483-24 and J-012480-24 for additional project scope detail.

[15] See Project ID # J-012634-25. UNC Health Johnston received notice from DHSR that the project was approved on September 26, 2025.

[16] WakeMed Garner application, p. 175.

Table Q-1.f
WakeMed Garner Hospital Projected Inpatient Utilization

	FY2027	FY2028	FY2029
Total Service Area	**1,778**	**2,110**	**2,447**
Inmigration 15%	314	372	432
Total Admissions	**2,092**	**2,483**	**2,879**
ALOS	3.00	3.00	3.00
Patient Days	6,275	7,448	8,637
ADC	17.2	20.4	23.7
Beds	31	31	31
Percent Occupancy	**55.5%**	**65.8%**	**76.3%**

Source: Project ID # J-012264-22, p. 189.

The Garner application projects total patient days based on duplicating the WakeMed North ALOS in its calculations. However, only a portion of existing WakeMed North patients are projected to shift to the Garner facility. WakeMed's methodology calculates a maximum of 425 patients shifting from WakeMed North to Garner in FY 2031, the third project year.[17] This is just 5.3 percent of the total discharges projected at WakeMed Garner in FY 2025 (425 ÷ 8,036 = 5.29%). It is not reasonable to use such a small percentage of total discharges as the basis for the ALOS calculation. There is no basis for WakeMed to assume that the Garner hospital will have a longer length of stay than what was originally projected in the approved project.

Furthermore, the introduction of the obstetrics service at WakeMed Garner will result in a *decrease*, not increase, to the hospital's overall ALOS. WakeMed clearly has neglected to calculate the reduction in ALOS that results from the addition of obstetrics cases. Tables 49 and 50 in WakeMed's Form C Assumptions and Methodology show the total number of projected mothers delivering babies and associated patient days in the first three project years (including vaginal and C-section births).[18] The total ALOS for those patients is 2.07 days, as shown in the following summary table:

WakeMed Garner Obstetrics Discharges and ALOS, PY 1-3

WakeMed Garner	***FY 2029***	***FY 2030***	***FY 2031***
Mothers	1,528	1,539	1,552
Patient Days	3,160	3,183	3,211
ALOS	2.07	2.07	2.07

Source: WakeMed Garner application, pp. 208-209.

In contrast to the relatively low percentage of inpatient cases that will shift from WakeMed North to Garner, obstetrics cases account for more than 1,500 annual discharges at the Garner hospital, representing nearly 20 percent of total discharges. This substantial percentage of discharges with a significantly lower length of stay will drive a lower overall ALOS for the Garner hospital, not a higher one. This is a critical error in the Garner methodology, because the ALOS assumption is a key input for WakeMed's utilization projections. If the original 3.0 ALOS were used to calculate patient days,

17 Ibid, p. 169.

18 WakeMed Garner application, pp. 208-209.

WakeMed Garner would not show a need for the number of proposed beds. The following table re-creates WakeMed Garner's methodology Tables 21 and 22 (combined), calculating ALOS with the original 3.0 days.

WakeMed Garner Revised Patient Days and Occupancy Rates, PY 1-3

WakeMed Garner	*FY 2029*	*FY 2030*	*FY 2031*
Discharges	7,661	7,846	8,036
ALOS	3.0	3.0	3.0
Patient Days	22,983	23,538	24,108
ADC	63.0	64.5	66.0
Licensed Beds	109	109	109
Occupancy Rate	57.8%	59.2%	60.6%

This does not account for the expected lower overall ALOS when obstetrics cases are blended with the medical/surgical cases. With this adjustment the total patient days, ALOS, and occupancy rate would be even lower. WakeMed Garner does not project its utilization based on reasonable assumptions and fails to demonstrate need for the proposed additional acute beds.

For this reason, the WakeMed Garner application is non-conforming with Criterion 3 and should not be approved.

4. By WakeMed's own logic, the WakeMed Garner project is not the most effective alternative.

In the WakeMed Raleigh application, WakeMed asserts that there is no need for a new acute care hospital in Wake County at this time. WakeMed contends that a new hospital would "involve significant expense in capital, administrative attention, physician recruitment, and labor."[19] WakeMed also contends that building a new hospital versus developing additional beds at an existing facility results in labor shortages, system-level operational complexities, and the related development of new ancillary and support services.[20] These statements are highly hypocritical. WakeMed's Garner hospital will not open until 2028; it hardly qualifies as an "existing hospital." Moreover, the change of scope that WakeMed proposes is more than just incremental; it represents a tripling of acute care beds and observation beds, and the addition of service components that were not included in the original 2022 application, such as obstetrical and neonatal care services. In many ways, the scope of the instant application represents a new hospital because of the disparity in scale and assets from the original WakeMed Garner hospital concept.

WakeMed is therefore disproving the need for its own project in the Raleigh application. If WakeMed believes that capital costs can be allocated more effectively and there is less risk of disruption to the labor supply by expanding existing hospitals, then it has no need for the Garner hospital as previously approved, let alone a vastly larger facility that will incur significant changes in operations for the WakeMed system as well as the Garner location.

19 WakeMed Raleigh application, p. 92.

20 Ibid, pp. 92-93.

Based on these issues, the WakeMed Garner application is non-conforming with Criteria 4 and 6 and should not be approved.

In summary, based on these issues, the WakeMed Garner application is non-conforming with Criteria 3, 4, 5, and 6, and the Criteria and Standards for Acute Care Beds and should not be approved.

ISSUE-SPECIFIC COMMENTS ON NOVANT HEALTH KNIGHTDALE MEDICAL CENTER

Novant's application to develop acute care beds at a new 26-bed acute care facility in central/eastern Wake County should not be approved. The Novant application contains multiple unreasonable and/or unsupported assumptions that repeat the same information as its 2024 Wake County acute beds application that was found non-conforming by the Agency in its review/findings.[21] UNC Health Rex believes that the Agency should continue to find these assumptions, detailed below, to be unreasonable. Please note that relative to each issue, UNC Health Rex has identified the statutory review criteria and specific regulatory criteria and standards creating the non-conformity. The following issues result in areas of non-conformity for the Novant Health Knightdale Medical Center application:

1. Novant's proposed inpatient market share for Novant Health Knightdale is unsupported and overstated.

   In its Form C.1b Assumptions and Methodology, Novant states that "[t]he projected share of CAC MSDRG labor and delivery discharges to be served at NH Knightdale reflects a conservative approach that accounts for anticipated service adoption patterns, geographic access improvements, Novant Health experience developing community hospitals, and support for the proposed project."[22] Novant's assumptions for market share of medical/surgical discharges are largely based on the expectation that it will develop referral relationships with primary care and specialty providers: "For the PSA, comprising zip codes in closest proximity to the proposed site, Novant Health projects shares of 6.0 percent in CY 2030, 8.0 percent in CY2031, and 10.0 percent in CY2032. These shares reflect the hospital's geographic advantage for eastern Wake County residents, combined with the expected development of referral pathways from Novant Health's expanding network of primary care and specialty providers, including Carolina Family Practice & Sports Medicine, Primary Care Partners, and Village Family Care."[23] Novant also asserts that its market share assumptions are supported by "[t]he strategic collaboration between DUHS and Novant Health, which will strengthen brand awareness and promote coordinated services development that supports sustainable medical/surgical share growth."[24] Based on this information, Novant projects the following market shares of facility-appropriate discharges at the Knightdale facility in the first three project years:

Table Q.9 Projected Share of CAC MSDRG Medical/Surgical Discharges to be Served at NH Knightdale

	CY2030	CY2031	CY2032
Primary Service Area	6.0%	8.0%	10.0%
Secondary Service Area	4.0%	6.0%	8.0%

Source: Novant application, p. 142.

21 See 2024 Wake Acute Bed and OR Review, https://info.ncdhhs.gov/dhsr/coneed/decisions/2025/jan/findings/2024%20Wake%20Acute%20Care%20Bed%20and%20OR%20Review%20Findings.pdf.

22 Novant application, p. 140.

23 Ibid, pp. 141-42.

24 Ibid, p. 142.

Additionally, Novant projects the following market shares for Labor and Delivery discharges at the Knightdale facility, based on alleged support from obstetrical practices and its network of employed primary care practices:

Table Q.7 Projected Share of CAC MSDRG Labor & Delivery Discharges to be Served at NH Knightdale

	CY2030	CY2031	CY2032
Primary Service Area	8.0%	10.0%	12.0%
Secondary Service Area	6.0%	8.0%	10.0%

Source: Novant application, p. 142.

Although Novant states that it will have "an immediate, stable referral base and a strong foundation for capturing… admissions from the first day of hospital operations,"[25] it cannot claim an existing, extensive medical staff to serve as a basis for referrals to the Knightdale hospital. Novant has no existing medical staff in Knightdale and few supporting physicians to justify its market share assumptions.

Novant makes comparisons to the market share attained at its Ballantyne Medical Center in Mecklenburg County that opened in 2024 to demonstrate the validity of its Knightdale market share assumptions. Novant Ballantyne hospital had market shares of 17.4 percent and 6.4 percent, respectively, in the Primary and Secondary Service Areas for that facility.[26]

However, it is unreasonable for Novant to use the Ballantyne hospital in Mecklenburg County as the basis for its assumptions in Wake County. The Novant Ballantyne hospital represented a new location for a large existing network of Novant hospitals and facilities in Mecklenburg and surrounding counties. Novant has been an existing provider in Mecklenburg County since 1903,[27] and as such has a substantial level of familiarity with area residents, not to mention a higher degree of preference for its existing physician clinics and ambulatory facilities. Novant is therefore well-known to Mecklenburg residents, many of whom were born at one of those hospitals. It is therefore without any reasonable basis to assume that a new hospital operated by a provider that has never operated an acute care hospital in that county would be able to achieve a market share that approaches its share in a market where it is a well-established competitor and there is only one other competing system.

Furthermore, the utilization and market share assumptions for the Novant Ballantyne hospital were based largely on shifting volume from Novant's existing related hospitals in the county – which Novant cannot do in Wake County. Novant's methodology for the market share calculations at the Ballantyne hospital was dependent on existing market share at other Novant hospitals, as stated in that application (emphasis added):[28]

25 Ibid.

26 Ibid, p. 144.

27 https://www.novanthealth.org/locations/medical-centers/presbyterian-medical-center/about/

28 NH Ballantyne application (Project ID # F-011625-18), p. 133.

Step 5: Determine Acute Care Market Shares for Service Area Zip Codes

The projected zip code market shares for NHBMC are based on six factors: (1) Novant Health's 2017 market share for each zip code, (2) the relative location on Novant Health and competitor hospitals, (3) road networks, (4) the percentage of Novant Health's existing market share expected to shift to NHBMC, (5) the market share the Applicant expect NHBMC to take from competing facilities, and (6) the ramp-up period to accomplish the shift. The Applicant projected market shares separately for obstetric services because geographic access is likely more important for obstetric services than for medical/surgical services. Table NHBMC.4 shows CY2017 discharges and market shares by hospital for service area zip codes.

Unlike Mecklenburg County, Novant has no other acute care hospitals nearby that can potentially shift patients to the new location based on proximity. The following table shows Novant facilities in Mecklenburg County that could potentially shift patients to the Ballantyne hospital and therefore boost market share:

Distance to Proximate Acute Care Facilities: Novant Health Ballantyne Medical Center

	Distance	*Drive Time*
Novant Health Presbyterian Medical Center	13.5 miles	28 minutes
Novant Health Matthews Medical Center	13.3 miles	19 minutes
Atrium Health Pineville	5.2 miles	10 minutes
Atrium Health Union West	13.8 miles	17 minutes
Carolinas Medical Center (CMC)	12.7 miles	26 minutes

Source: Google Maps.

In contrast, the proposed Knightdale hospital will have no other Novant facilities closer than Kernersville, more than 100 miles to the west. In fact, the Knightdale facility will be approximately 15 minutes or less from three competing facilities:

Distance to Proximate Acute Care Facilities: Novant Health Knightdale Medical Center

	Licensed Acute Beds	*Distance*	*Drive Time*
WakeMed (Raleigh Campus)	610	5.6 miles	8 minutes
Duke Raleigh Hospital	204	7.8 miles	9 minutes
UNC Health Rex Hospital	468	13.2 miles	16 minutes

Source: Google Maps.

The proposed Novant Knightdale facility is proximate to more than 800 acute care beds that are operated by competitors within a 10-minute driving distance. This differs significantly from the market in Mecklenburg County that Novant has chosen to use as a comparative for its market share assumptions. Additionally, there is only one competing acute care hospital that is proximate to the Novant Ballantyne campus (i.e., within a 10-minute drive). For these reasons, Novant Health's experience at the Novant Ballantyne facility is not a reasonable justification for its market share assumptions for the Knightdale hospital.

Novant also asserts that in the instant application there is stronger evidence of physician support for the Knightdale hospital compared to its submission last year. One such example cited is the

collaboration between Novant and DUHS. On page 144 of its application, Novant summarizes the letter of support that DUHS provided, noting DUHS' "clear statements that the facility will enhance patient access in an underserved area, complementing existing acute care services and decompressing capacity constraints at existing facilities."[29] However, supporting Novant's plan to expand acute care capacity is different from referring patients to the facility or otherwise partnering to develop utilization at Novant's facility. Despite its "support" for the project, there is no documentation anywhere in the Novant application that any patients would "shift" from a DUHS hospital to the Novant facility, nor attestations by DUHS physicians that they will refer patients to the Knightdale hospital.

Indeed, the NH Knightdale application does not have anywhere close to the same degree of physician support demonstrated in the Ballantyne application, either in number or location of the physician offices. Specifically, the Novant Health Ballantyne application demonstrated a considerable number of physician practices located within the service area it proposed, including the "home" ZIP code in which the facility is located—which is completely absent in the Knightdale application. The Ballantyne application noted that "Novant Health has identified 205 physicians now on the Novant Health active medical staffs who live in the Ballantyne area."[30] The table below, from page 24 of that application, shows multiple physician practices—within the service area—including 13 in the same ZIP code as the facility (28277).[31]

Novant Ballantyne Medical Center Physician Support – Practice Locations

Zip Code	Practice Name
28173	Novant Health Waxhaw Family & Sports Medicine
28226	Novant Health Primary Care Foxcroft
28277	Novant Health Ballantyne Pediatrics
	Novant Health Bradford Clinic Obstetrics & Gynecology
	Novant Health Carmel OB/GYN - Blakeney
	Novant Health Cotswold Medical Clinic - Arboretum
	Novant Health Express Care - Ballantyne
	Novant Health Mintview OB/GYN - Ballantyne
	Novant Health OB/GYN Urgent Care - Waverly
	Novant Health Psychiatric Associates
	Novant Health Psychiatric Associates - Charlotte
	Novant Health Sleep
	Novant Health Total Spine Specialists
	Novant Health Urgent Care & Occupational Medicine - Waverly
	Novant Health Urgent Care and Occupational Medicine
29707	Novant Health Indian Land Primary Care

This strong local support for the Ballantyne hospital contrasts with the more limited physician support Novant has collected for the proposed Wake County hospital. Exhibit I.2 of the Knightdale application contains letters of support by Novant-employed and community physicians. This physician support is limited to several specialties, and in most cases the ZIP codes where these physicians are located (or the clinic locations closest to Knightdale), are not located in either the primary or secondary service area and these clinics are in other parts of Wake County more removed from the proposed Novant hospital. As such, the absence of any documentation in the letters that the supporting physicians treat

29 See Exhibit I.2, letter from Dr. Thomas Owens, M.D.

30 See Project ID # F-011625-18, p. 23.

31 Ibid, p. 24.

patients from the service area that they intend to refer to the hospital further undermines the credibility of the application's assumptions. In addition, many of the specialties represented by the Novant letters are not typically associated with significant numbers of hospital admissions or surgical referrals. Of the physician support letters received, only two appear to be from physicians that practice within the defined service area – and both are from the Secondary Service Area (ZIP code 27587 – Wake Forest). A high percentage of physician support letters (at least 11 out of 12 identifiable) come from physicians practicing *outside* the hospital's proposed service area. This lack of a geographic presence in the Knightdale service area by the physicians supporting the project raises questions about why most of the physician support for the Knightdale project comes from providers outside the service area, rather than from physicians that are integrated into the communities that Novant proposes to serve, particularly given the lack of any documentation that the physicians treat patients from the service area. The letters that Novant includes in its exhibit do not show abundant evidence of local physician demand and support.

The limited local physician support for the NH Knightdale hospital is significant because without it, Novant cannot demonstrate that it will get the necessary volume of referrals to meet its projected market share figures. Of note, the Ballantyne application upon which NH Knightdale is relying for relevant experience to inform the development of its proposed Wake County hospital projected a 60 percent shift of patients for the primary ZIP code and varying shifts for the remaining service area ZIP codes. Even if the Agency were to believe that Novant could leverage its physician relationships to achieve some market share of hospital patients from Wake County, there is nothing in the application that either 1) supports its projected market share from the particular ZIP codes that comprise the NH Knightdale service area, or that 2) supports its projected market share for multiple clinical specialties identified by its projected DRGs that it states will comprise that market share, but for which there is no physician support.

Exhibit I.2 of the Novant application includes letters of support from physicians in primary care, urology, and orthopedic specialties. However, this exhibit is missing any support from key specialties such as general surgery, neurology, ENT, cardiology, or gastroenterology, all of which typically contribute a high percentage of inpatient surgery cases at hospitals. Urological surgery cases are normally performed in an outpatient setting and as such cannot be expected to account for a high number of inpatient cases. In Exhibit C.1-1, Novant provides a list of the Major Diagnostic Categories (MDCs) and DRG codes that it expects to offer at the Knightdale facility. This list includes MDCs with large numbers of DRGs, such as MDC 4 (Diseases of the Respiratory System) with 27 DRG codes, MDC 5 (Diseases of the Circulatory System) with 12 DRG codes, and MDC 6 (Diseases of the Digestive System), with 41 DRG codes. Novant does not provide support letters from pulmonary or respiratory specialists, from cardiologists, or from gastrointestinal specialists that would validate the inclusion of these DRG codes. Moreover, it is not credible to believe a hospital in a large county like Wake County would be able to achieve any measure of success in attracting patients without the support of a single cardiologist or general surgeon. Even the support of other surgical specialists, such as an orthopedic physician and urologists, is largely meaningless without the support of physicians in other specialties needed to ensure patient safety prior to surgery. Specifically, many patients are recommended for evaluation by a cardiologist prior to undergoing surgery, or other specialists, depending on the patients' pre-existing conditions. Without a broad group of specialists on staff at the proposed hospital, Novant's ability to admit and treat patients is constrained.

Given the lack of existing facilities in Wake County from which to shift patients, the absence of physician support from the primary service area, and only minimal support in the secondary service

area, and the lack of any discussion in the few letters regarding the physicians' experience with service area patients, Novant Knightdale's projected market share capture and resulting utilization projections, despite being lower than what was projected in the 2024 application, is nonetheless inadequately supported and completely unreasonable.

For these reasons, the Novant application is non-conforming with Criteria 1, 3, 4, 5, 6, 8, and 18a, as well as the Criteria and Standards for Acute Care Beds, and should not be approved.

2. Novant does not demonstrate it will have the appropriate resources to provide obstetrical care.

A major difference in Novant's 2025 application for a new hospital in Wake County is the inclusion of obstetrical services. The Knightdale hospital will include six LDRP beds for obstetrical and maternity care. The facility will also include the development of a dedicated C-Section operating room to ensure availability for patients requiring cesarean births.[32]

In addition to the essential physical infrastructure needed for an obstetrics service, including LDRP rooms, operating rooms equipped for cesarean sections, and nursery/neonatal care facilities, there are staffing and support requirements to ensure the safety and quality of care. Hospitals that offer obstetrics care require that physicians or certified nurse midwives will be available 24/7, either on-site or within 30 minutes for emergency response.[33] Nursing staff in labor and delivery units must have specialized obstetric training and neonatal resuscitation certification. Anesthesiologists or certified registered nurse anesthetists (CRNAs) must be available around the clock to support epidurals and emergency cesarean sections, representing one of the most critical staffing components. Obstetrics programs also must offer pediatric coverage, with access to neonatologists or pediatricians capable of performing resuscitation and the immediate care needs for newborns. The combination of specialized staffing, dedicated facilities, and 24/7 coverage requirements makes obstetrics one of the more resource-intensive service lines for hospitals to develop and maintain safely.

Based on its project scope description, the Novant application appears to propose the physical facilities required to offer a comprehensive obstetrics program. However, there is no demonstrated availability of the specialized physician resources necessary to perform obstetrical care around the clock. In Exhibit I.2, Novant includes a support letter from Dr. Barrett Gunter from Unified Women's Health of The Carolinas, a large OB/Gyn provider network with offices mostly in western and central Wake County. While Dr. Barrett's letter "expresses our strong support" for the Novant project, the letter does not include some key provisions. The UWH letter has no mention of the group's commitment to take OB call at the proposed hospital or a commitment to staffing obstetric services at the Knightdale facility. It does not state that UWH physicians will deliver babies at the Knightdale facility or discuss agreements for patient referrals for obstetrical care. And there is no explicit agreement that UWH physicians will utilize the C-Section operating room or LDRP beds at the Knightdale hospital. In order to meet operational requirements, a hospital offering obstetrics services must have OB physicians that are committed to taking call, and a guarantee of coverage for deliveries and emergency C-sections. The UWH letter offers generic support for Novant's proposed facility, but no specifics that demonstrate the necessary operational commitment. Simply stating that UWH is

[32] Novant application, p. 39.

[33] See 10A NCAC 13B .4302. "Medical staff with obstetrical privileges shall be available within 30 minutes to provide services and attend deliveries. An on-call schedule must be available to the Division for review."

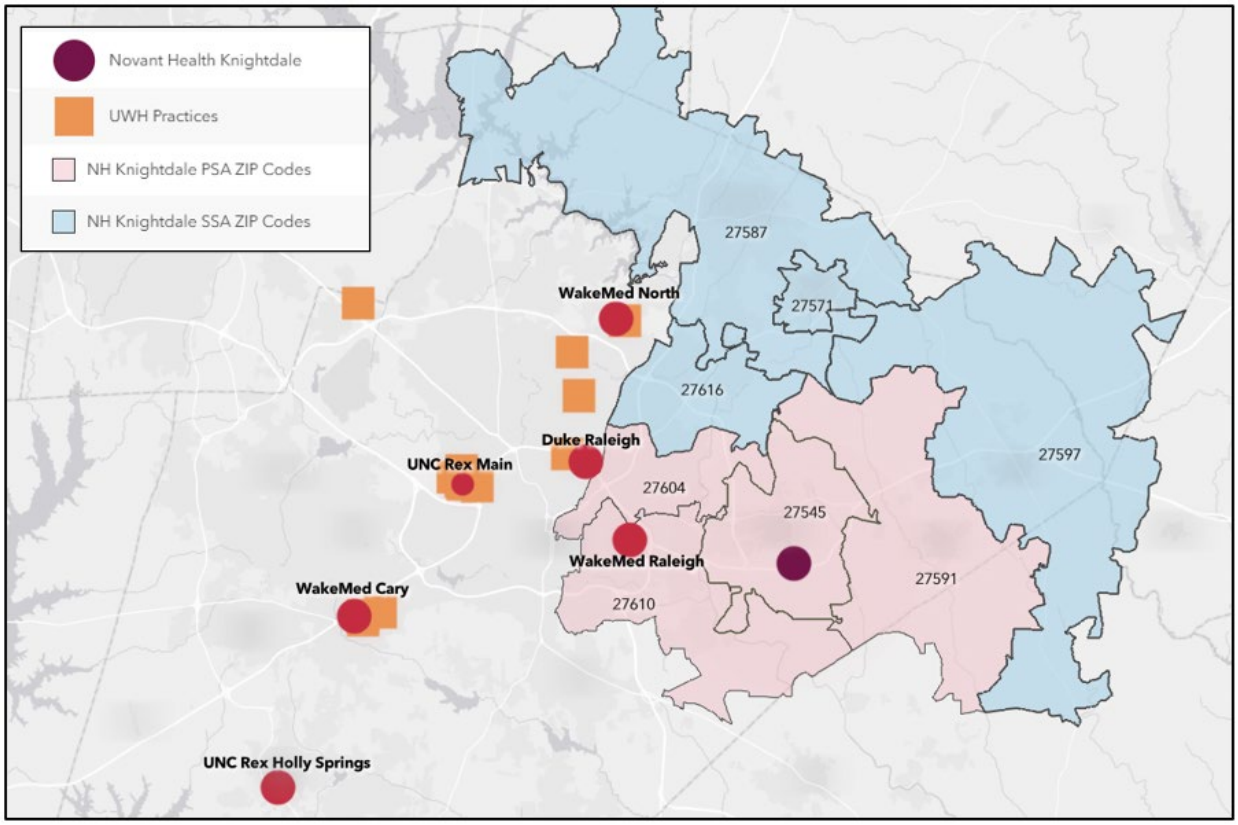
"strongly supportive of new opportunities to expand access to community-based maternity care" does not demonstrate that Novant can offer 24/7 OB coverage and round-the-clock specialized obstetric and neonatal care capabilities at the Knightdale facility.

This is not the first time that Novant has failed to adequately document the necessary support for obstetrics inpatient care in a Wake County hospital proposal. In its proposed 2011 Holly Springs Hospital application, Novant also chose to propose obstetrics services without any letters of support from obstetricians practicing in its service area. The Agency Findings, written by then-Project Analyst Mike McKillip, determined the following concerning this issue:

> *However, the applicant did not provide sufficient documentation from obstetricians practicing in Wake County and surrounding areas to support the reasonableness of its utilization projections for obstetrical services. The applicant states it "will achieve a market share of 40% of total births in the Primary Service Area" by the second and third years of operation (2016 and 2017). However, Exhibit 14 does not contain any letters of support from obstetricians practicing in applicant's proposed service area, or from any other Wake County obstetricians. Exhibit 14 contains only one letter an obstetrician in the local area expressing support for the proposed hospital, and that obstetrician practices in Durham. Exhibit 14 also contains a letter of support from the obstetrician who the applicant identifies as the medical director for obstetrical services, however that physician practices in Winston-Salem. In Section V.3(b), page 228, the applicant provides a list of physicians by medical and surgical specialty that support the proposed hospital, but the list does not include obstetricians. Similarly, in Section V.4, page 229, the applicant provides a list of the Novant Medical Group "Triangle physician network" physicians by medical and surgical specialty that support the proposed hospital, but the list does not include obstetricians.*
>
> …
>
> *Based on the lack of documentation of physician support from obstetricians within its proposed service area, the applicant's market share assumptions for obstetrical services are not supported. Therefore, the applicant's utilization projections for the proposed acute care beds are not supported or reliable. Therefore, the applicant did not adequately demonstrate the need for the acute care beds.*
>
> (emphasis added)

To illustrate the significance of the lack of commitment to practice at, admit patients to, or otherwise support the utilization projections for Novant's proposed hospital, the map below shows the location of the proposed hospital along with the closest UWH offices to the ZIP codes in the Novant Knightdale service area.

Unified Women's Health of The Carolinas – Wake County Practice Locations



Source: Esri.

As shown, none of UWH's locations is within the primary or secondary ZIP codes that define Novant's proposed service area.[34] Notably, UWH's office locations are commonly co-located or in proximity to the hospitals at which they practice, which supports their ability to provide 24/7 and emergency obstetrics coverage. As noted above, UWH's letter did not indicate any intention or desire to develop another office in the service area, much less located adjacent to the proposed Novant hospital.

Just like the previous attempt in its denied 2011 application, the Novant application in the instant review lacks any "documentation of physician support from obstetricians within its proposed service area," and as such, "the applicant's market share assumptions for obstetrical services are not supported. Therefore, the applicant's utilization projections for the proposed acute care beds are not supported or reliable." This is particularly problematic given that Novant's projected market share for obstetrics is higher than its med/surg market share. As the Agency is aware, while some med/surg patients may present through the emergency department, obstetrics patients are inexorably connected to their chosen obstetrician, delivering at a hospital where the obstetrician practices following months of regular visits to the physician clinic. The lack of supporting obstetrician offices in Novant's proposed service area, along with the absence of any commitment to develop a local

[34] Novant chose to identify its PSA ZIP codes as 27545, 27610, 27604, 27591 and its SSA as 27616, 27597, 27587, and 27571. See application pages 42 and 43.

presence to support the proposed hospital, completely undermines the projected obstetrics utilization for the proposed hospital.

Of note, as the Agency is aware, Novant is not required to propose to develop obstetrics beds as part of a new hospital; however, it chose to do so, and as such, is now required to demonstrate the reasonableness of its assumptions and projections, which it has failed to do.

For these reasons, the Novant application is non-conforming with Criteria 3, 4, 5, 6, 7, and 8, and should not be approved.

3. Novant fails to provide evidence of staffing resource availability and related quantifiable support by physicians.

As discussed previously, Novant does not effectively demonstrate that it will have the physician support necessary to provide obstetrics services at NH Knightdale. Without the support of obstetricians and maternal care specialists to care for expectant mothers, the market share assumptions that Novant provides are not supported. Novant projects its market share of Labor and Delivery MS-DRGs for the first three project years as shown in the following table:

Table Q.7 Projected Share of CAC MSDRG Labor & Delivery Discharges to be Served at NH Knightdale

	CY2030	CY2031	CY2032
Primary Service Area	8.0%	10.0%	12.0%
Secondary Service Area	6.0%	8.0%	10.0%

Source: Novant application, p. 141.

These market share rates result in 366 obstetrics-related discharges from the service area in CY 2030, increasing to 603 discharges in CY 2032. Novant has similar assumptions about market share capture for non-obstetrical medical/surgical discharges that will be treated at the Knightdale hospital, with market shares for the PSA and SSA increasing to 10.0% and 8.0%, respectively, in the third project year:

Table Q.9 Projected Share of CAC MSDRG Medical/Surgical Discharges to be Served at NH Knightdale

	CY2030	CY2031	CY2032
Primary Service Area	6.0%	8.0%	10.0%
Secondary Service Area	4.0%	6.0%	8.0%

Source: Novant application, p. 142.

With these market share assumptions for obstetrical and medical/surgical discharges from the service area, Novant projects it will have over 1,000 discharges in CY 2030, the first project year for the proposed hospital, increasing to nearly 1,800 discharges in project year three.

Projected Discharges by Service Area, 2023-2032

Service Area	*CY30*	*CY31*	*CY32*	*CAGR*
Primary Service Area	692	927	1,172	30.1%
Secondary Service Area	310	456	611	40.4%
Total	**1,002**	**1,382**	**1,782**	**33.4%**

Source: Novant application, p. 143.

For the same reason that Novant's projections of obstetric discharges are unsupported, the medical/surgical market share and utilization projections are unsupported. Given the lack of existing facilities in Wake County from which to shift patients, the absence of physician support from the primary service area, and only limited support in the secondary service area, Novant Knightdale's projected market share capture and resulting utilization projections, while lower than those projected in Novant's 2024 application, are nonetheless inadequately supported and therefore unreasonable.

Novant claims that it has addressed the flaws in its patient referral methodology from 2024 through its "strategic collaboration with DUHS," therefore resulting in "coordinated, complementary service delivery."[35] However, while this attempts to demonstrate that Novant's proposed Wake County hospital will not "operate in isolation from established health systems," this was not the Agency's concern nor reason it found the Novant application to be non-conforming in the 2024 review. In the 2024 review and findings, the agency concluded that the Novant application was non-conforming with Criterion 3 for three separate reasons. The first reason was that the Novant project did not reasonably establish how as a new facility in a competitive market it would establish a presence and achieve its market share assumptions:

> Proposing that a brand-new small community hospital, unsupported by an existing hospital system within the Wake County acute care bed service area and competing with three long established hospitals systems within the service area would reasonably command a 20%/10% market shift within a designated group of patients within its first three years of operation is not reasonable or supported by the application, exhibits to the application, comments, response to comments, remarks at the public hearing, or information publicly available during the review and used by the Agency.

Source: 2024 Wake County Acute Care Bed Review & Findings, p. 38.

Novant fails to remedy this in the instant application. The letter of support from DUHS in Exhibit I.2 has no operational commitments or referral projections but rather represents a bland statement that the proposed Novant hospital will "create capacity in Knightdale." The DUHS letter cannot reasonably be assumed to guarantee the proposed Novant hospital will gain access to Duke specialists or that Duke physicians will admit patients to the Knightdale hospital. There are no quantitative commitments that would indicate that this partnership will have a measurable impact on Novant's market share assumptions and its increasing share of discharges in the primary and secondary service areas. As such, the DUHS letter does not demonstrate that the utilization projections in the Novant application are reasonable.

Novant's other support letters from physicians similarly lack evidence that the hospital can attain its market share targets. Included in Exhibit I.2 are support letters from family practitioners in Wake and

[35] Novant application, p. 144.

Durham County. Many of these letters are from Novant-owned primary care practices with locations in Cary and Raleigh (Carolina Family Practice & Sports Medicine, CFPSM) and Wake Forest (Novant Health Primary Care Partners – Ligon Mill; Novant Health Village Family Care). None of these practices, nor the Triangle Community Physicians family practice located in Durham County, have a clinic located in the primary service area that would reasonably be expected to account for significant volume of patient referrals. The nearest CFPSM office location to the proposed NH Knightdale hospital is in north Raleigh, 15 miles from the proposed Knightdale hospital. It is not reasonable to expect that patients from central and western Wake County will prefer to travel to the eastern part of the county to be admitted for surgery or have their ambulatory procedure performed when there are multiple hospital-based and ambulatory surgery facilities within closer proximity, to which these physicians are certainly already referring patients. The distance from the practices to the Knightdale location in eastern Wake County means that any patients referred to NH Knightdale would bypass multiple hospitals and be a significant distance from their physician office.

Of the specialty physician letters that are included, only Associated Urologists of North Carolina includes a statement that it will "utilize the proposed facility for appropriate inpatient admissions, surgical procedures, and emergency consultations…"[36] While this support will benefit the outpatient surgery utilization at NH Knightdale, it is unlikely to result in a significant number of inpatient cases. A 2022 study determined that only 23 percent of urological surgeries met inpatient criteria.[37] Moreover, most of the growth in urological surgeries is in the outpatient setting; the same study found that outpatient Medicare claims increased yearly by an average of 24 percent, with inpatient claims only increasing by one percent. It is unlikely that even with population growth and aging there will be any noticeable increases in admitted urological patients. Novant's application is conspicuous for its lack of letters from hospital-based specialists that would be expected to admit a majority of patients and care for these patients at the hospital. There is nothing in the exhibit to indicate support from surgeons in several specialties Novant proposes to provide or specialists in services such as cardiology that would likely generate significant hospital-based patient care. Novant expresses confidence that "it can recruit the [specialty] physicians and APPs needed to offer high-quality medical and surgical services in Knightdale,"[38] but offers no evidence that it has employment contracts or referral estimates for any of these specialties. Without these specialties accounted for, the Novant assumptions about medical/surgical market share are speculative and unsupported.

Based on this lack of documentation, the Novant application is non-conforming with Criteria 3, 6, 7, and 8, as well as the Criteria and Standards for Acute Care Beds, and should not be approved.

In summary, based on the issues described above, the Novant application is non-conforming with Criteria 1, 3, 4, 5, 6, 7, 8, and 18a, as well as the Criteria and Standards for Acute Care Beds, and should not be approved.

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36 See Exhibit I.2, letter from Dr. Kevin Khoudary, MD.

37 Madhusoodanan, Vinayaka; Carto, Chasea; Parmar, Madhumitab; Ritch, Chada; Parekh, Dipen J.A; Ramasamy, Ranjitha. Trends in outpatient versus inpatient urologic surgery at a university academic medical center. Current Opinion in Urology 32(4): p 433-437, July 2022.

38 See Exhibit I.1, letter from Dr. John W. F. Mann, MD.

ISSUE-SPECIFIC COMMENTS ON DUKE RALEIGH HOSPITAL

Duke's application to expand acute care capacity at Duke Raleigh Hospital (DRAH) by adding 101 acute care beds should not be approved. The DRAH application contains multiple errors, omissions, and inconsistencies as well as unsupported assumptions in its Certificate of Need application form. Please note that relative to each issue, UNC Health Rex has identified the statutory review criteria and specific regulatory criteria and standards creating the non-conformity. The following issues result in areas of non-conformity for the Duke Raleigh application:

1. Duke fails to demonstrate need for additional acute care beds due to calculation errors and unsupported assumptions.

   The DRAH application fails to demonstrate adequate need for 101 additional acute care beds due to fundamental methodological problems including mathematical errors, unsupported assumptions, inadequate geographic and market analysis, and failure to consider reasonable alternatives that collectively overstate utilization and capacity requirements.

   Significantly, the DRAH application contains a mathematical error in its occupancy calculations. On page 68 of its application, Duke presents a table titled "DRAH Projected Utilization with No Growth" that contains an incorrect occupancy calculation.

DRAH Projected Utilization with No Growth
Shift of Patient Days and Beds to DCH

	Patient Days	ADC	Beds	% Occupancy
DRAH FY 2025	65,521	179.5	204	88.0%
Shift to DCH*	4,858	13.3	(40)	
Remaining at DRAH	**60,663**	**192.8**	**164**	**117.6%**

** Year 1 - 1,056 discharges will shift x 4.6 ALOS = 4,858 patient days*
See Section Q assumptions for Form C.1b for DCH

Source: Project ID # J-012690-25, Page 68

   However, the correct calculation reveals:

- Correct ADC: 60,663 ÷ 365 = 166.2 (not 192.8)
- Correct Occupancy: 166.2 ÷ 164 = 101.3% (not 117.6%)

   Duke's error overstates the ADC by 26.6 and the occupancy rate by 16.3 percentage points. While 101.3 percent occupancy still represents a high utilization rate, Duke's mathematical error inflates this to 117.6 percent occupancy. This calculation error significantly exaggerates DRAH's capacity constraints and creates an artificially urgent need for additional beds.

   This contradiction is particularly questionable because Duke simultaneously proposes significant expansion at Duke Cary Hospital (40 beds approved, with 120 additional requested) while claiming urgent capacity constraints at DRAH. Duke projects that substantial patient volumes will shift from DRAH to Cary, which would lower ADC and occupancy at the Raleigh facility, yet fails to explain why both facilities require dramatic capacity increases if volumes are shifting between them (see Issue-

Specific Comments on the Duke Cary Hospital Change of Scope Application for additional analysis). While Duke has already been approved to relocate the 40 beds from DRAH to DCH, the table excerpted above certainly brings into question the plan to relocate 40 beds but only shift the equivalent of a 13.3 ADC, which is only 33 percent occupancy of those beds, while expecting the remaining beds to operate at over 100 percent occupancy. Clearly this plan or the assumptions, or both, are unreasonable.

Additionally, Duke claims that "complexity of cases is increasing at DRAH" to support its need for additional capacity but provides no Case Mix Index (CMI) data, average length of stay (ALOS) trends by service line, or other acuity measures to substantiate this assertion. If case complexity were genuinely driving capacity constraints, this claim would require concrete quantitative support. Without supporting data, this complexity claim amounts to speculation and cannot be relied upon to justify additional bed capacity. The absence of CMI data is particularly problematic because Duke claims increasing complexity drives capacity constraints while simultaneously projecting that 5,001 patients with case weights less than 3.0 will shift from Durham facilities to Wake County.[39] This contradiction suggests Duke's complexity claims are used selectively to inflate need rather than reflecting genuine operational constraints.

Moreover, patient hospital selection involves multiple factors including physician relationships, insurance coverage, established care patterns, and individual preferences – simply residing in Wake County does not automatically guarantee that patients will choose a particular Wake County hospital when additional beds become available. Duke's methodology fails to account for these real-world dynamics that influence patient choice and healthcare utilization patterns.

Duke's overstated occupancy calculation combined with unsupported complexity claims creates a compounding effect that dramatically inflates Duke's apparent need for additional beds. The mathematical error alone overstates occupancy by more than 16 percentage points. When combined with unsubstantiated claims about increasing case complexity, Duke creates an exaggerated picture of capacity constraints. This pattern of presenting information to maximize the appearance of need is demonstrated by several specific examples in Duke's application: (1) the mathematical error in occupancy calculations on page 68 that inflates utilization by 16.3 percentage points;[40] (2) claims of increasing complexity without providing any Case Mix Index data or other quantitative support; and (3) projecting that 5,001 patients (representing 64.4 average daily census per Duke) will shift from Durham facilities without adequate methodology to support such large-scale migration;[41] This approach undermines the reliability of Duke's entire need demonstration and raises fundamental questions about whether the proposed 101 beds are actually necessary to meet genuine capacity requirements.

This pattern is particularly problematic given Wake County's competitive dynamics. Based on 2024 Agency findings, WakeMed controls 54.27 percent of existing acute care beds in Wake County, UNC Health Rex controls 32.21 percent, and Duke controls only 13.52 percent.[42] Duke's projection that it can capture the majority of migrating Durham patients while facing competition from these larger,

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39 Duke Raleigh Hospital 2025 Application, p. 53.

40 Duke Raleigh Hospital 2025 Application, p. 68.

41 Duke Raleigh Hospital 2025 Application, p. 53. Duke states: “"Combined DUH and DRH have an ADC of 64.4 lower acuity Wake County patients."

42 2024 Wake County Acute Care Bed and OR Review, Required State Agency Findings, p. 392.

more established systems lacks adequate support. Furthermore, Duke claims its provider network of "more than 800 providers serving Wake County" and 181 primary care providers supports increased market capture.[43] However, Duke provides no analysis of how this provider network compares to competitors' networks, nor does it account for the reality that UNC Health Rex and WakeMed have operated in Wake County for decades with their own extensive provider networks and established patient relationships.

Furthermore, Duke's geographic analysis fails to account for realistic patient flow patterns and competitive positioning. Duke's patient origin data reveal that DRAH draws patients from a wide geographic area, with 31.4 percent of acute care bed patients originating from outside Wake County.[44] Duke assumes these geographic patterns will remain "constant" with two percent annual growth, but this assumption ignores several critical factors.[45] Duke draws significant volumes from Franklin County (5.1 percent), Johnston County (3.7 percent), and Durham County (2.8 percent), but fails to analyze whether patients from these counties would logically choose DRAH over closer alternatives.[46]

The combination of mathematical errors, unsupported assumptions, inadequate geographic analysis, unreasonable market share projections, and failure to consider alternatives demonstrates that Duke has failed to provide reliable evidence of need for 101 additional acute care beds at DRAH. Duke's methodology demonstrates a pattern of presenting information in ways that maximize the appearance of need while failing to provide adequate supporting documentation or realistic market analysis. This pattern undermines Duke's entire need demonstration, raising fundamental questions about whether the proposed 101 beds are necessary.

Accordingly, the Duke application is non-conforming with Criteria 1, 3, 4, 6, and 18a.

2. Duke's patient migration projections lack supporting methodology and create internal contradictions.

Duke's methodology for projecting patient shifts from Durham facilities to Wake County lacks adequate support and creates internal contradictions within Duke's own system projections. Duke identifies 4,330 Wake County patients (case weight <3.0) currently served at Duke University Hospital who "could appropriately be accommodated closer to home," representing an average daily census (ADC) of 57.1 patients. An additional 671 Wake County patients served at Duke Regional Hospital (ADC of 7.3) could also be served locally.[47]

However, Duke provides no methodology for determining which patients would actually migrate to Wake County facilities versus continuing to receive care in Durham. Duke's assumption that these 5,001 patients (64.4 ADC) would shift to Wake County is unsupported by any analysis of patient preference, physician referral patterns, insurance network considerations, or clinical appropriateness beyond the broad case weight threshold. Duke fails to account for the reality that many patients may prefer to continue receiving care at established Durham facilities even when Wake County options become more available.

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43 Duke Raleigh Hospital 2025 Application, p. 57.
44 Duke Raleigh Hospital 2025 Application, p. 38.
45 Duke Raleigh Hospital 2025 Application, p. 40.
46 Duke Raleigh Hospital 2025 Application, p. 38.
47 Duke Raleigh Hospital 2025 Application, p. 52.

Furthermore, in April 2025, Duke submitted a CON application for 82 additional beds at Duke University Hospital (Project ID # J-012643-25), which directly contradicts the premise that significant patient volumes will migrate to Wake County. If Duke's Wake County projections are realized, the utilization pressure at Duke University Hospital should be substantially reduced, questioning the need for the Durham expansion that Duke claims is urgent and necessary.

Accordingly, Duke's Wake County applications are non-conforming with Criteria 1, 3, 4, 5, and 6 and should not be approved.

For the reasons noted above, the Duke Raleigh Hospital application contains multiple areas of non-conformity and should not be approved.

ISSUE-SPECIFIC COMMENTS ON DUKE CARY HOSPITAL

Duke's application to expand acute care capacity at Duke Cary Hospital by adding 120 acute care beds to the previously approved 40-bed facility should not be approved. The Duke Cary application contains inadequate change of scope justification, unsupported volume projections, and unreasonable assumptions that fail to demonstrate conformity with statutory review criteria. Please note that relative to each issue, UNC Health Rex has identified the statutory review criteria and specific regulatory criteria and standards creating the non-conformity. The following issues result in areas of non-conformity for the Duke Cary application:

1. Duke's change of scope justification lacks adequate documentation of changed circumstances.

   Duke's change of scope application seeks to increase Duke Cary Hospital from 40 beds to 160 beds, representing a 300 percent capacity increase that lacks adequate supporting justification for such a dramatic expansion. The magnitude of this requested increase requires significant documentation of changed circumstances, robust methodology to support projected demand, and detailed analysis of market capture assumptions – none of which Duke has adequately provided.

   First, Duke's application fails to provide the level of detailed analysis and supporting documentation necessary for such a substantial expansion. The application lacks adequate benchmarking data to support the projected market capture required for a 160-bed facility and fails to provide sufficient methodology to justify the scale of expansion. The application does not provide sufficient quantitative support for why a 300 percent increase is now justified.

   Second, the magnitude of the requested expansion requires Duke to achieve substantial market share gains that lack adequate supporting analysis. According to the Duke application on page 138, Duke's entire system served only 9,842 acuity-appropriate discharges from the Duke Cary catchment area in FY 2024.[48] Duke projects this will grow to 16,352 by FY 2034 – a 66 percent increase that must support not only the proposed 160-bed Duke Cary Hospital but also continued high utilization at DRAH.[49]

   HIDI market discharge data indicate that Duke Raleigh Hospital currently captures a relatively small portion of total discharges (not acuity-limited) across Duke Cary's proposed catchment area: 3.8 percent in Zone 1, 4.4 percent in Zone 2, 4.9 percent in Zone 3-South, and 12.1 percent in Zone 3-North.[50] To operate a 160-bed hospital at reasonable occupancy levels, Duke must significantly expand its market presence from this baseline. Duke's own data show that by FY 2034, Duke projects capturing 4,875 total system discharges from the Duke Cary catchment area – representing a substantial increase from current utilization patterns.[51] However, Duke provides insufficient analysis of how it will achieve this market capture given the competitive landscape and established patient referral patterns in Wake County, where UNC Health Rex and WakeMed operate multiple facilities with longstanding community relationships.

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48 Duke Cary Hospital 2025 Application, p. 138.

49 Duke Cary Hospital 2025 Application, p. 144.

50 UNC Health Rex analysis of Duke system discharge data for Duke Cary Hospital catchment area, FFY 2024. HIDI market data.

51 Duke Cary Hospital 2025 Application, p. 144.

Accordingly, the Duke application is non-conforming with Criteria 1, 3, 4, 5, 6, and 18a, as well as the Performance Standards for Acute Care Beds.

2. Duke's growth methodology assumptions are flawed and create overstated and unreliable projections.

Duke's methodology for projecting demand growth is fundamentally flawed because it artificially averages volatile short-term utilization trends with stable long-term population projections to create inflated "projected growth rates" that lack any methodological basis. Duke explicitly states it calculated "the average of the actual historical discharge growth rates with the population growth rate by zone and hospital (Average of Utilization CAGR FY2023-Annualized FY2025 with the Population CAGR from 2025-2030)."[52]

Duke Cary Hospital Catchment Area Average Projected Growth Rate by Zone

Zone	FY2023	FY2024	FY2025 Annualized	*Utilization CAGR*	*Population CAGR*	*Projected Growth Rate*
DRAH						
Zone 1	224	212	229	*1.1%*	*1.6%*	*1.3%*
Zone 2	255	256	340	*15.5%*	*1.3%*	*8.4%*
Zone 3 - North	725	748	914	*12.3%*	*0.8%*	*6.6%*
Zone 3 - South	415	459	500	*9.8%*	*1.4%*	*5.6%*
DRAH Total	**1,619**	**1,675**	**1,983**	***10.7%***	***1.2%***	
DUH						
Zone						
Zone 1	724	815	896	*11.2%*	*1.6%*	*6.4%*
Zone 2	1,371	1,497	1,577	*7.2%*	*1.3%*	*4.3%*
Zone 3 - North	2,790	3,182	3,015	*4.0%*	*0.8%*	*2.4%*
Zone 3 - South	445	550	599	*16.0%*	*1.4%*	*8.7%*
DUH Total	**5,330**	**6,044**	**6,087**	***6.9%***	***1.2%***	
DRH						
Zone						
Zone 1	77	81	102	*15.1%*	*1.6%*	*8.3%*
Zone 2	396	531	495	*11.8%*	*1.3%*	*6.5%*
Zone 3 - North	1,259	1,444	1,602	*12.8%*	*0.8%*	*6.8%*
Zone 3 - South	66	67	77	*8.0%*	*1.4%*	*4.7%*
DRH Total	**1,798**	**2,123**	**2,276**	***12.5%***	***1.2%***	
DUHS Total	**8,747**	**9,842**	**10,346**	***8.8%***		

Source: Duke Cary Hospital 2025 Application, p. 141.

[52] Duke Cary Hospital 2025 Application, p. 141.

Zone 2 demonstrates a particularly egregious example of this flawed approach. Duke shows Zone 2 discharges from DRAH growing at a 15.5 percent utilization CAGR based on two years of volatile data, while the actual population CAGR for the same zone is only 1.3 percent. Rather than using either metric independently, Duke averages these incompatible figures to create an artificial "projected growth rate" of 8.4 percent that has no logical foundation.[53]

This averaging methodology is methodologically unsound for several reasons. First, Duke combines mismatched time periods – a two-year utilization trend with a five-year demographic projection. Second, population growth and healthcare utilization growth are entirely different metrics that should not be arithmetically averaged. Third, Duke's utilization CAGR is based on cherry-picked volatile data rather than stable long-term trends. Duke acknowledges its current projections vastly exceed previous expectations, noting that "these growth rates are much higher than projected in the original 2021 DCH application" where it projected only 1.5 percent CAGR compared to the actual 8.8 percent experienced.[54]

Duke's flawed averaging methodology creates artificially elevated and unreliable projections.

Accordingly, the Duke application is non-conforming with Criteria 3, 4, and 18a.

3. Duke's volume shift assumptions are unsupported and unreasonable.

Duke's volume shift projections are fundamentally flawed and unsupported. Duke projects that substantial volumes will shift from DRAH to Duke Cary, but these assumptions lack adequate documentation and contain unreasonable patient migration rates. Duke's assumptions effectively require patients to "magically" shift to Duke Cary without adequate justification for why such large-scale migration would occur.

Duke projects that the following percentages of "shift-appropriate" discharges will move from DRAH to Duke Cary Hospital by FY 2032: 75 percent of discharges from Zone 1, 75 percent from Zone 2, 35 percent from Zone 3-North, and 60 percent from Zone 3-South.[55] These percentages, particularly the 75 percent shift rates, are unreasonably high and inadequately supported.

Duke's Projected Volume Shift Percentages by Zone (FY 2032)

Zone	*DRAH Shift Percent*
Zone 1	75.0%
Zone 2	75.0%
Zone 3-North	35.0%
Zone 3-South	60.0%

Source: Duke Cary Hospital 2025 Application, p. 143.

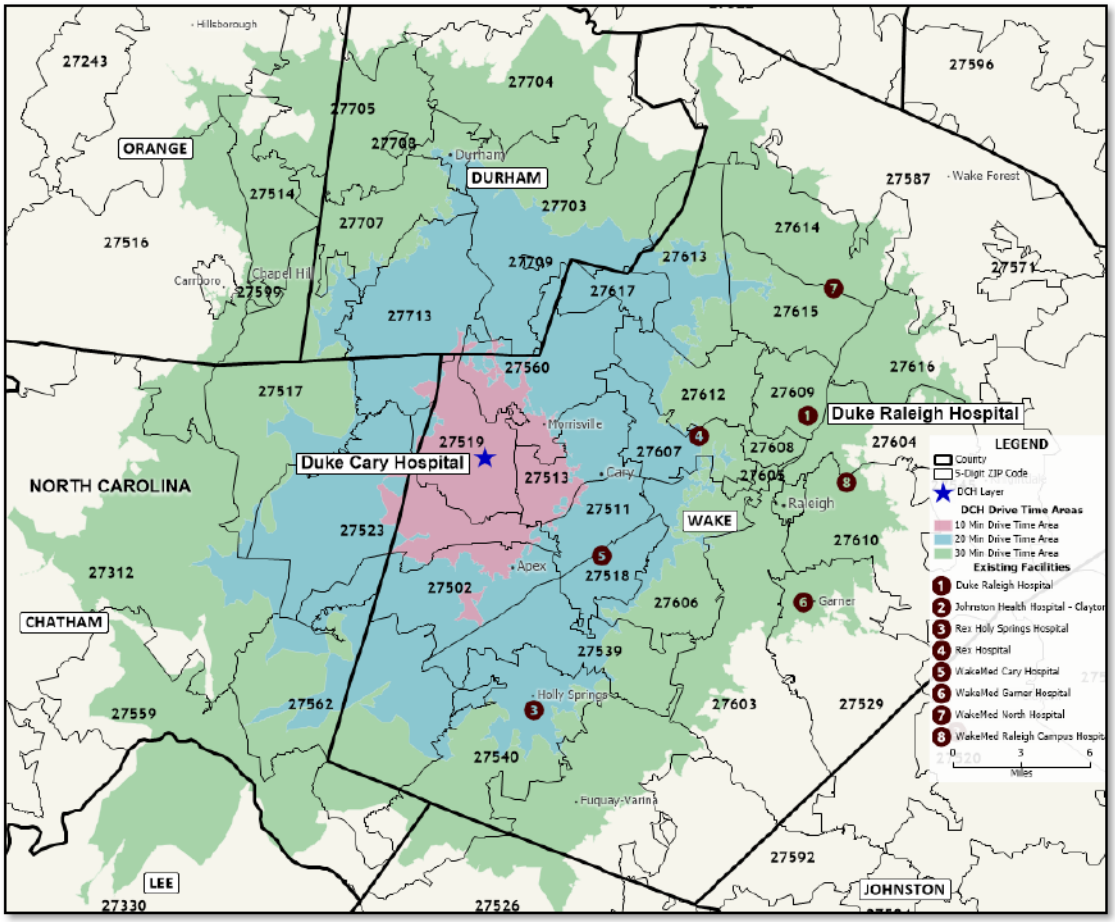
First, Duke's Zone 2 projections are particularly problematic. Duke shows Zone 2 discharges from DRAH growing at a 15.5 percent utilization CAGR, which vastly exceeds the 1.3 percent population

53 Duke Cary Hospital 2025 Application, p. 141.
54 Duke Cary Hospital 2025 Application, p. 139.
55 Duke Cary Hospital 2025 Application, p. 143.

CAGR for the same zone.[56] This disconnect suggests that the baseline Zone 2 utilization projections are overstated, which in turn inflates the volume available to shift to Duke Cary.

Second, Duke's assumption that 75 percent of patients across Zone 1 and Zone 2, which extend across multiple counties, will shift to Duke Cary lacks adequate support. While Duke lists several qualitative factors supporting patient migration, the application lacks benchmarking data, market research, or historical precedent to support such high migration rates across such a broad geographic area, including into multiple counties. More fundamentally, Duke's methodology contains geographic contradictions that undermine its credibility. Duke projects identical 75 percent shift rates for both Zone 1 (0-10 minute drive time) and Zone 2 (10-20 minute drive time), which suggests Duke did not actually consider proximity in its analysis despite creating drive-time zones. Most problematically, Duke's own catchment area includes ZIP codes like 27607 that are geographically closer to DRAH than to the proposed Duke Cary site, yet Duke projects that 75 percent of shift-appropriate patients from these areas will bypass closer options to travel to the more distant facility.

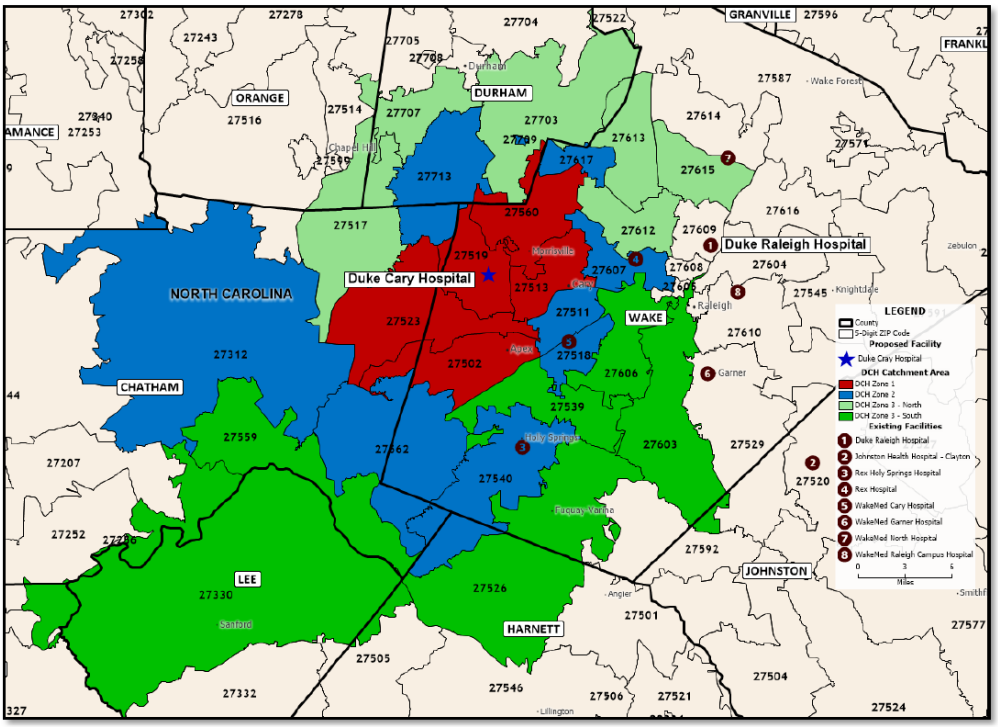
DCH Drive Time Area Map



Source: Duke Cary application, p. 57.

56 Duke Cary Hospital 2025 Application, p. 141.

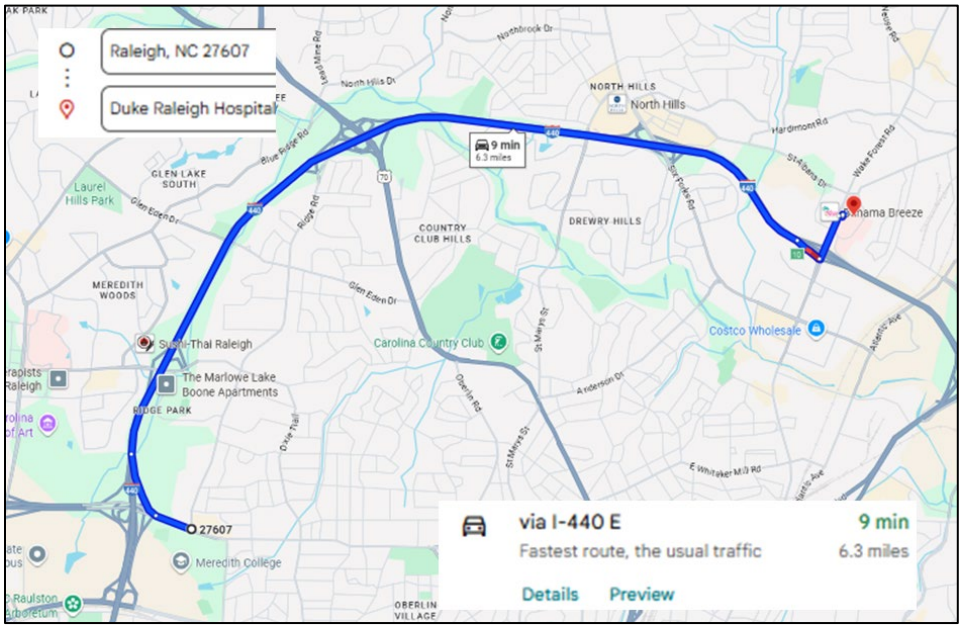
DCH Catchment Area



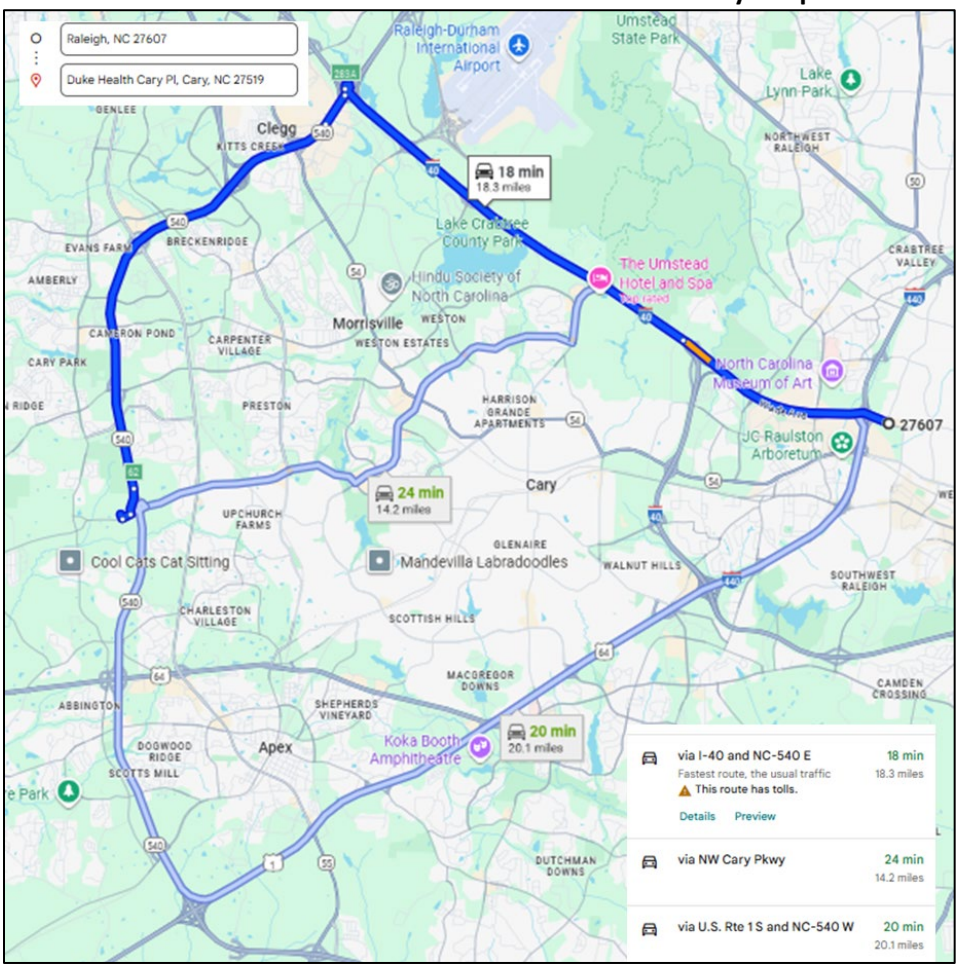
Source: Project ID # J-012689-25, p. 58.

For example, geographic analysis using Google Maps confirms that ZIP code 27607 is approximately 6.3 miles and nine minutes from Duke Raleigh Hospital but over 14 miles and 18 minutes from the proposed Duke Cary Hospital site (see maps below). This contradicts basic healthcare utilization patterns and raises significant questions about the reliability of Duke's entire volume shift methodology.

Drive Time from Zone 1 ZIP Code 27607 to DRAH



Drive Time from Zone 1 ZIP Code 27607 to Duke Cary Hospital



Source: Google Maps, September 19, 2025

Duke's projected Year 3 occupancy for Duke Cary Hospital is only 77.1 percent, just 5.7 percentage points above the required 71.4 percent performance standard. Because Duke's flawed geographic assumptions regarding its volume shifts – such as patients from ZIP codes like 27607 choosing the farther Duke Cary facility instead of the closer Duke Raleigh – are unreasonable and inadequately supported, the facility will fail to meet performance standards, and the need for the project has not been demonstrated.

Accordingly, the Duke application is non-conforming with Criteria 3, 4, 5, 6, and 18a, as well as the Criteria and Standards for Acute Care Beds and should not be approved.

4. DUHS's speculative change of scope application for Duke Cary seeks to reserve need determination for indefinite future development.

Duke's application effectively asks the Agency to reserve 45 percent of the identified *2025 SMFP* need determination (120 of the total 267 beds) for a project with an unreliable development timeline that has been repeatedly extended and modified. Since the original 2021 approval, development of Duke Cary Hospital has experienced multiple delays and modifications, including zoning-related issues that Duke cites and subsequent requests for material compliance changes in March 2024 to alter the opening sequence and now a significant proposed capacity increase through this change of scope application.

While UNC Health Rex understands that projects can be delayed by appeals, the 2021 approval of Duke's original application for the Cary hospital was not appealed, and Duke's shifting development approach raises questions about project execution reliability. The current timeline projects the full hospital opening in July 2030 – nearly a decade from the original 2021 approval – while Duke simultaneously claims urgent current need. This extended development timeline creates uncertainty about when the promised capacity will actually become available to serve Wake County residents, making it inappropriate to reserve nearly half the county's identified bed need for such a protracted development schedule and the uncertainty surrounding the project's completion timeline.

UNC Health Rex acknowledges that new hospitals take many years to develop; however, Duke's delays to develop its originally approved project that were not due to appeals appear to extend beyond typical development timeframes. As such, this speculative reservation of acute care bed capacity prevents other applicants with more definitive and timelier implementation plans from meeting immediate Wake County needs. Duke's pattern of timeline extensions and scope modifications demonstrates insufficient execution certainty to justify allocating 45 percent of the total identified need. Furthermore, this approach is particularly concerning given that Duke's combined applications (221 beds) plus Duke's supported Novant application (26 beds) would capture 93 percent of the total need determination, effectively monopolizing Wake County's acute care bed allocation.

Accordingly, the Duke application is non-conforming with Criteria 3, 4, and 18a.

For the reasons noted above, the Duke Cary Hospital application contains multiple areas of non-conformity and should not be approved.

ISSUE-SPECIFIC COMMENTS ON DUKE APPLICATIONS

Beyond the issue-specific comments discussed above related to the individual DRAH and Duke Cary applications, UNC Health Rex has also identified the following additional issue-specific comments below that apply to both Duke applications. UNC Health Rex has identified the statutory review criteria and specific regulatory criteria and standards creating the non-conformity.

1. Duke's support for the Novant Knightdale Medical Center application creates contradictory market assumptions.

   Duke's support for Novant Health's competing 26-bed Knightdale application fundamentally contradicts its own need claims and reveals flawed market assumptions. In Duke's August 12, 2025 support letter, Duke states that Wake County's growth "continues to place significant pressure on existing inpatient and outpatient resources" and endorses Novant's proposal to "address this need for additional access."[57]

   However, Duke and Novant together propose 247 beds out of the 267-bed need determination (93 percent of total identified need), effectively monopolizing Wake County's acute care allocation despite Duke contributing only 18 percent of the underlying need calculation.[58] This concentration lacks justification given that Duke's projected system deficit represents just 48 beds compared to the 267-bed countywide need.

   The proximity contradiction is equally problematic. The proposed Novant Knightdale facility sits only 11 miles from DRAH, for which Duke seeks 101 additional beds.[59] Duke's support for a competing 26-bed facility in close proximity either indicates significant unmet demand that contradicts Duke's "conservative" growth assumptions or acknowledges that Duke's own volume projections are overstated.

   Duke's support letter references "collaborative partnership aimed at expanding access to both primary care and advanced specialty services,"[60] but provides no analysis of how this partnership affects Duke's volume projections or potential referral relationships that could impact utilization forecasts. While UNC Health Rex does not believe that Duke specifically projected any number of referrals or admissions to support Novant's application, its support nonetheless raises questions about its own resolve to provide the support needed for the success of its own projects.

Accordingly, the Duke applications are non-conforming with Criteria 3 and 18a.

2. Duke's system-wide applications demonstrate a pattern of double-counting volume that undermines its Wake County applications.

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57 Novant Health Knightdale Medical Center 2025 Application, Exhibit Book, p. 158 of PDF, Duke's Letter of Support for Novant Knightdale Medical Center.

58 Even discounting Duke's support for the Novant Health Knightdale proposal, Duke's simultaneous applications request 83 percent of the available acute care bed capacity.

59 Google Maps.

60 Novant Health Knightdale Medical Center 2025 Application, Exhibit Book, p. 158 of PDF, Duke's Letter of Support for Novant Knightdale Medical Center.

Duke's Wake County applications are part of a broader pattern of volume distortions across Duke's 2025 CON portfolio that systematically double-counts the same patient populations to justify expansions in multiple counties. Duke's 2025 applications span four counties with a total request for 375 beds: 82 beds at Duke University Hospital in Durham (Project ID # J-012643-25), 221 beds across two Wake County facilities (101 at Duke Raleigh + 120 at Duke Cary), 46 beds for the Duke Novant Mebane Hospital in Alamance County (Project ID # G-012641-25), plus Duke's support for 26 beds at Novant Knightdale in Wake County. This coordinated strategy undermines the reliability of Duke's claimed need for 221 additional beds in Wake County.

Duke's mathematical contradictions become clear when viewed systematically. According to the *Proposed 2026 SMFP*, Duke's Wake County system currently operates at 199 ADC across 204 licensed beds, representing 12.2 percent of Wake County's projected 2026 total hospital ADC of 1,631.[61] Duke projects its Wake County system will grow to 367.8 ADC by FY 2034 across 425 proposed beds,[62] which would represent approximately 22.5 percent of total Wake County hospital capacity – nearly doubling Duke's market share while simultaneously proposing 128 additional beds in Durham and Alamance counties.

The pattern is most apparent in its Durham-Wake County applications. In April 2025, Duke filed for 82 additional beds at Duke University Hospital, claiming urgent capacity constraints due to utilization growing to 1,013 average daily census by FY 2029.[63] Four months later, Duke's Wake County applications claim that 5,001 patients currently served at Durham facilities (64.4 ADC according to Duke) will shift to Wake County facilities – including 57.1 ADC from the same Duke University Hospital that allegedly needs 82 additional beds.[64]

This represents systematic double-counting: the same 64.4 ADC patients cannot remain at Duke's Durham facilities to justify Durham expansion AND simultaneously migrate to Wake County to justify 221 additional beds there. Combined with additional claimed shifts to Alamance County (12.1 ADC), Duke claims 76.5 ADC (27,910+ patient days annually) will shift away from Durham facilities while simultaneously using Durham capacity constraints to justify 82 additional beds there.[65] If these claimed shifts actually occur, Duke University Hospital's occupancy would drop from Duke's projected 85.3 percent to 79.4 percent – barely above performance standards – while Duke Regional Hospital would fall to 63.1 percent occupancy, nearly 15 percentage points below target occupancy.[66] Duke provides no reconciliation of these contradictory projections or analysis of how Durham utilization would be affected if the claimed shifts actually occur.

Duke's volume misrepresentations become clear when examining the cumulative patient day implications across all their applications. Combined, Duke's projected volume shifts represent approximately 27,910 patient days annually (76.5 ADC)[67] that would move away from existing Durham

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61 *Proposed 2026 SMFP*, Table 5A: Acute Care Bed Need Projections. Total Wake County projected 2026 ADC: 1,631 (199 + 918 + 514).

62 Duke Cary Hospital 2025 Application, p. 77. Duke projects combined system ADC of 367.82 by FY2034 across 425 total beds (265 DRAH + 160 Duke Cary).

63 Duke University Hospital 2025 Application.

64 Duke Raliegh Hospital 2025 Application, p. 53. Duke states: "Combined DUH and DRH have an ADC of 64.4 lower acuity Wake County patients."

65 Combined shifts: 64.4 ADC to Wake County + 12.1 ADC to Alamance County = 76.5 ADC total.

66 Calculations based on Duke's projected Durham utilization minus claimed volume shifts to other counties.

67 64.4 ADC to Wake County + 12.1 ADC to Alamance County.

Duke facilities to new facilities across multiple counties. Duke projects that 5,001 patients will shift from Durham to Wake County (approximately 23,510 patient days), an additional 2,295 discharges will shift from Duke Regional Hospital to Duke Cary by FY 2034, while up to 880 discharges will shift to the proposed Duke Novant Mebane Hospital by 2032.[68]

This coordinated approach to inflating need across multiple applications demonstrates a pattern of regulatory gaming designed to maximize bed approvals without transparent volume accounting. The Wake County applications cannot be properly evaluated because they are built on manipulated baseline assumptions that prevent assessment of genuine need versus creative inflation of demand through systematic double-counting of the same patient populations across Duke's application portfolio.

Accordingly, the Duke Wake County applications are non-conforming with Criteria 3, 4, and 18a because Duke has engaged in systematic volume misrepresentations that prevent proper evaluation of actual patient demand.

[68] Duke Novant Mebane Hospital 2025 Application Shift, Table Q.5, "Shift of Alamance County Discharge Share to Duke Novant Mebane Hospital," the 880 figure appears in the 2032 column for Alamance County under "Projected Discharges Based on % of Share Shift." Duke Raliegh Hospital 2025 Application Shift, p. 53. Duke Cary Hospital 2025 Application Shift, p. 144. DRAH to Duke Cary discharges shift.

COMPARATIVE ANALYSIS

The UNC Health Rex Hospital (Project ID # J-012677-25), the UNC Health Rex Wake Forest Hospital (Project ID # J-012680-25), the Duke Raleigh Hospital (Project ID # J-012690-25), the Duke Cary Hospital (Project ID # J-012689-25), the WakeMed Garner Hospital (Project ID # J-012673-25), the WakeMed Raleigh Hospital (Project ID # J-012671-25), the WakeMed North Hospital (Project ID # J-012672-25), and the Novant Health Knightdale Medical Center (Project ID # J-012686-25) applications each propose to develop acute care beds in response to the *2025 SMFP* need determination for Wake County.

Given that multiple applicants propose to meet all or part of the need for the 267 additional acute care beds in Wake County, not all can be approved. To determine the comparative factors that are applicable in this review, UNC Health Rex examined recent Agency findings for competitive acute care bed reviews. Based on that examination and the facts and circumstances of the competing applications in this review, UNC Health Rex considered the following comparative factors:

- Conformity with Review Criteria
- Scope of Services
- Geographic Accessibility
- Historical Utilization
- Competition (Patient Access to a New Provider)
- Access by Underserved Groups
    - Projected Medicare
    - Projected Medicaid
- Projected Average Net Revenue per Case
- Projected Average Operating Expense per Case

UNC Health Rex believes that the factors presented above and discussed in turn below should be used by the Project Analyst in reviewing the competing applications.

Conformity with Applicable Statutory and Regulatory Review Criteria

As discussed in the application-specific comments above, multiple competing applications contain significant conformity issues that render them non-approvable. In contrast, the two UNC Health Rex applications conform with all applicable statutory and regulatory review criteria. Therefore, regarding conformity with statutory and regulatory review criteria, the UNC Health Rex Hospital and UNC Health Rex Wake Forest Hospital applications are the most effective alternatives.

Scope of Services

Given the wide range of proposed projects, it is challenging to compare all eight acute care bed applications in the review against each other. The applicants include tertiary care facilities such as UNC Health Rex Hospital and WakeMed Raleigh Hospital, as well as community hospitals that offer more limited inpatient services. Additionally, two of the proposed projects are new facilities, while six projects represent expansion or changes of scope to existing facilities. As such, it is reasonable to evaluate this factor separately based on the type of applicant against only projects or facilities that are of the same type, and not comprehensively. The two types of projects in the review, and the facilities in these categories, are summarized in the following table:

2025 Wake Acute Beds Applications

Applicant	*Existing/ Approved*	*New Facility*	*Hospital Type*
UNC Health Rex Hospital	X		Tertiary
UNC Health Rex Wake Forest Hospital		X	Community
Duke Raleigh Hospital	X		Community
Duke Cary Hospital*	X		Community
WakeMed Raleigh Hospital	X		Tertiary
WakeMed North Hospital	X		Community
WakeMed Garner Hospital**	X		Community
Novant Health Knightdale Medical Center		X	Community

*Duke Cary Hospital was approved in 2021, and the current application represents a change in scope to the original application (Project ID # J-012029-21).
**WakeMed Garner Hospital was approved in 2023, and the current application represents a change in scope to the original application (Project ID # J-012264-22).

For the new hospital applications, the UNC Health Rex Wake Forest Hospital offers the most comprehensive scope of specialized services and clinical capabilities. UNC Health Rex Wake Forest Hospital proposes significantly more advanced community hospital services than Novant Health Knightdale Medical Center with nearly double the bed capacity (50 beds), specialized services including Level II neonatal care, and enhanced surgical capabilities for service lines, all of which, unlike the Novant Health application, are supported by letters from physicians who intend to refer or provide the service at UNC Health Rex Wake Forest Hospital. UNC Health Rex Wake Forest Hospital will be supported by one operating room and three procedure rooms (for a total of four operating and procedural spaces), compared to Novant Health Knightdale Medical Center's three procedure rooms. UNC Health Rex Wake Forest Hospital will feature two dedicated C-section rooms versus Novant's single C-section room, and 22 emergency department (ED) bays with dedicated cardiac, trauma, isolation, and behavioral health capabilities, including eight behavioral health support rooms that address critical gaps in emergency psychiatric care for patients experiencing mental health crises. This compares to Novant Health Knightdale Medical Center's more limited 10 ED general treatment rooms without specialized behavioral health infrastructure. Furthermore, UNC Health Rex Wake Forest Hospital will feature a superior scope of imaging services with an interventional radiology room, which will provide minimally invasive procedures guided by imaging to diagnose and treat a wide range of vascular and non-vascular conditions, eliminating the need for patient transfers to facilities with such capabilities. The specialized neonatal services at UNC Health Rex Wake Forest Hospital will serve the growing population of expectant mothers in northern Wake County with Level II capabilities that Novant Health Knightdale Medical Center cannot provide. For these reasons, UNC Health Rex Wake Forest Hospital offers the most effective and comprehensive solution when evaluating the new hospital applications on this comparative factor.

For the existing facilities, only UNC Health Rex Hospital and WakeMed Raleigh Hospital serve as tertiary care facilities with a full range of subspecialty care and access to advanced care specialists in multiple clinical service areas. These two hospitals serve as referral locations for patients needing a higher level of care or more specialized services than a community hospital can provide. However, UNC Health Rex Hospital offers a more effective alternative for scope of services given its unique positioning as the only tertiary hospital in Wake County that is part of a health system led by a quaternary, academic medical center.

UNC Health Rex Hospital provides a site of care for UNC faculty physicians from multiple specialties and offers some of the highest acuity care available in the county. UNC Health Rex Hospital's comprehensive scope

includes higher acuity and tertiary services such as open heart, neurosurgery, and advanced cardiac care including interventional services, as well as specialized maternal and neonatal care. UNC Health Rex Hospital's connection to a health system led by a quaternary, academic medical center provides access to subspecialty expertise and advanced treatment options that distinguish it from other tertiary facilities in Wake County. UNC Health Rex Hospital's 106 proposed acute care beds will support this full continuum of tertiary care and access to quaternary-level expertise for the most complex patients requiring the highest level of specialized services.

In comparison, Duke Raleigh, Duke Cary, WakeMed North, and the WakeMed Garner applications propose more limited scopes of service that restrict their ability to serve higher-acuity patients, and several competing applications propose limited sets of services and DRG codes that significantly restrict their patient care capabilities.

In the 2024 Wake County acute care bed review, the Agency found that UNC Health Rex Hospital and WakeMed Cary were both "more effective," and therefore similar compared to the other competing applications. While UNC Health Rex does not agree with this assessment, WakeMed Cary is not an applicant in this review, and UNC Health Rex Hospital and WakeMed Raleigh are similar in their scope of acute care bed services and should both be found to be most effective. While in the previous review the Agency found that WakeMed Raleigh's status as the only Level I Trauma Center in the service area ranked it higher than UNC Health Rex Hospital, UNC Health Rex does not believe that WakeMed Raleigh's status as a trauma center equates to it providing a materially broader scope of acute care bed services than UNC Health Rex. As such, they should both be considered "most effective."

Regarding the remaining applicants, Novant Health Knightdale is clearly the less effective alternative, due to its smaller size and limited scope of services. As detailed thoroughly in the application-specific comments, while the Novant proposal states that it will provide a number of acute care services, it fails to provide support from physicians that will provide those services, such as general surgery, ENT, and others. Because the applicant has limited existing physician practices within its system to rely on, and no existing acute care hospitals in the service area or anywhere in the Triangle region to provide as demonstration of its ability to develop a similar hospital in the area, the application's statements regarding its scope of services should be particularly scrutinized. For these reasons, as well as its multiple non-conformities with the review criteria, it should be the less effective alternative.

The remaining applicants, while having some differences in the specific scope of services offered, are all nonetheless similar in scope. All are community (non-tertiary) hospitals; all except Duke Raleigh provide or propose obstetrics services, and most provide or propose a similar array of appropriate community hospital medical and surgical services to inpatients. As such, the remaining applications (Duke Raleigh, Duke Cary, UNC Health Rex Wake Forest Hospital, WakeMed North, and WakeMed Garner) should be considered more effective.

Geographic Accessibility

Geographic accessibility should be evaluated based on the location of proposed services relative to underserved geographic areas and the facility's ability to serve residents throughout Wake County. Because two applications propose to develop new hospitals at new sites within the service area, UNC Health Rex believes it is appropriate to consider the new hospital applications together for geographic effectiveness, and to consider existing hospital expansions separately.

New Hospital Applications

For new hospitals, geographic accessibility focuses on expanding access to underserved areas. The two new hospital applications in this review present different approaches to addressing geographic gaps:

A comparison of the proposed new hospitals yields the following differences in distance from existing acute care facilities:

2025 Wake Acute Beds Applications – Proposed New Hospitals

Applicant	*Nearest Acute Care Facility*	*Distance*	*Licensed/ Approved Beds*	*Proposed New Beds*
UNC Health Rex Wake Forest Hospital	WakeMed North	7.7 mi.	106	50
Novant Health Knightdale Medical Center	WakeMed Raleigh	5.6 mi.	538	26

Sources: Google Maps; 2025 CON applications.

UNC Health Rex Wake Forest Hospital offers the most effective alternative for geographic accessibility among new hospital projects. Located in Wake Forest in northern Wake County, this proposed facility will serve residents in an area with limited acute care access, particularly for residents of northern Wake County and southern Franklin County. While WakeMed North Hospital is located in central/north Raleigh within the Raleigh city limits, UNC Health Rex Wake Forest Hospital will be the northernmost acute care facility in Wake County, extending hospital services north beyond the Raleigh city limits for the first time, and will serve a geographically underserved population, addressing documented geographic access gaps and reducing travel times for residents in underserved areas. Northern Wake County is a rapidly growing area that currently does not have an acute care facility located outside of the Raleigh city limits, and Franklin County does not currently have a hospital with any inpatient acute care capacity. As discussed in the UNC Health Rex Wake Forest Hospital application, the need for improved access in Franklin County is particularly acute. Franklin County has been the largest county in North Carolina without an operating acute care hospital for over 10 years, following the closure of Franklin Regional Medical Center in 2015. Currently, Maria Parham-Franklin provides only emergency services and psychiatric care, with no general acute inpatient services available anywhere in Franklin County. As a result, 66.0 percent of Franklin County residents currently seek acute care services in Wake County, requiring significant travel distances. UNC Health Rex Wake Forest Hospital projects that 15.1 percent of its patients (9,105 patients in the third project year) will come from Franklin County, demonstrating the substantial unmet need for geographically accessible acute care services in this underserved population. Franklin County is designated as its own service area in the *2025 SMFP*, yet lacks any functioning acute care capacity, making the UNC Health Rex Wake Forest project critical for addressing this geographic access gap.

The UNC Health Rex project represents the greatest proportional increase of new acute care beds in the surrounding market. WakeMed North Hospital, located in central/north Raleigh within the Raleigh city limits, currently serves as the closest facility to northern Wake County with 106 existing/approved beds. UNC Health Rex Wake Forest's 50 new beds would represent a substantial addition to acute care capacity available to residents of northern Wake County and southern Franklin County, who currently must travel significant distances to reach existing facilities. This geographic positioning demonstrates the significant impact on access for this underserved population.

In comparison, the proposed Novant hospital in Knightdale will be located much closer to existing acute care facilities. The proposed Novant hospital will be 5.6 miles from WakeMed Raleigh Hospital, which has 538

licensed general acute care beds. Additionally, Duke Raleigh Hospital is 7.8 miles in driving distance from the proposed Novant hospital and is currently licensed for 204 acute care beds (with 40 beds set to relocate to Duke Cary). There are a combined 742 acute care beds within eight miles of the proposed Novant hospital. The Novant Knightdale project would increase the total acute care capacity in east central Wake County by only 3.5 percent (26 ÷ 742 = 3.5%), providing minimal proportional increase due to the proximity of existing high-capacity facilities.

The proposed UNC Health Rex Wake Forest Hospital therefore has the greatest effect on increasing geographic access among the new hospitals.

Existing Hospital Applications

The applications proposing expansion of existing facilities will add beds in communities with multiple existing facilities that operate acute care beds. These proposals would increase capacity in existing markets rather than expand geographic access to new areas. Additionally, the Duke Cary Hospital application represents a change of scope to its 2021 approved application to develop 120 beds in addition to the 40 previously approved beds, and the WakeMed Garner application represents a change of scope to its 2022 approved application to develop 78 beds in addition to the 31 previously approved beds.

For existing facilities, it is appropriate to consider the impact on access for residents of the service area by examining the projected number of Wake County residents to be served. Because of the varying types of facilities among the competing applications, examining patient origin and the percentage of Wake County patients alone is not conclusive. The two tertiary hospitals, UNC Health Rex and WakeMed Raleigh, serve many patients from outside of Wake County who migrate for advanced level care and specialized services. Additionally, hospitals located closer to county borders can be expected to have higher percentages of patients from adjacent counties. Therefore, the most appropriate comparison is the total number of Wake County patient discharges for these existing facilities.

2025 Wake Acute Beds Applications – Existing Acute Care Hospitals

Applicant	*Wake County Discharges – PY3*	*Total Discharges – PY3*	*Wake County % of Total*
UNC Health Rex Hospital	25,866	40,344	64.1%
WakeMed North	9,242*	12,557	73.6%
WakeMed Raleigh	23,307*	30,924	75.4%
WakeMed Garner	5,489*	8,036	68.3%
Duke Cary Hospital	8,578	10,517	81.8%
Duke Raleigh Hospital	9,707	15,443	62.9%

Source: 2025 CON applications, Section C.3.

* Sum of identified Wake County ZIP codes plus other Wake County discharges.

UNC Health Rex Hospital projects the highest number of Wake County patient discharges, with 25,866 in the third project year - significantly more than any other facility. WakeMed Raleigh projects the second-highest total with 23,307 discharges. This demonstrates UNC Health Rex Hospital's strong commitment to serving Wake County residents and its effectiveness in providing geographic accessibility through high-volume service to county residents.

Therefore, in summary, the UNC Health Rex applications represent the most effective alternatives for improving geographic access to acute care services in Wake County. UNC Health Rex Wake Forest Hospital addresses a critical geographic gap by locating acute care services in northern Wake County, an area currently underserved by existing acute care facilities, while UNC Health Rex Hospital demonstrates the strongest commitment to serving Wake County residents among existing hospitals through the highest projected volume of county resident discharges.

Historical Utilization

UNC Health Rex believes it is more appropriate to examine patient census and occupancy rate information for the specific facility that has applied to develop new beds, and not the entire health system in aggregate. Assessing the occupancy data by individual facility is a more accurate indication of the immediate need for beds and which facilities represent the highest priority for additional resources.

Viewed this way, the historical utilization for the four applications representing existing facilities is as follows:

Historical Utilization, Existing Acute Care Hospitals

Applicant	*Acute Patient Days of Care*	*Average Daily Census*	*Licensed Beds*	*Occupancy Rate*
UNC Health Rex Hospital	139,173	381.3	418	91.2%
Duke Raleigh Hospital	54,733	150.0	204	73.5%
WakeMed North Hospital	22,740	62.3	71	87.7%
WakeMed Raleigh Hospital	175,743	481.5	539	89.3%

Source: 2025 License Renewal Applications. Excludes neonatal beds (Level II-IV) and days.

Based on the occupancy data for each existing hospital, UNC Health Rex is the most effective applicant. While Duke Raleigh Hospital increased its licensed bed capacity from 186 to 204 beds between 2024 and 2025, its acute patient days actually declined slightly from 54,969 to 54,733, resulting in a lower occupancy rate of 73.5 percent despite having additional licensed capacity. While WakeMed Raleigh and WakeMed North have higher occupancy rates than Duke Raleigh, all three applications are non-conforming with multiple review criteria.

Additionally, while WakeMed Raleigh Hospital shows historical utilization above 80 percent, although lower than UNC Health Rex Hospital's occupancy rate, according to its 2025 LRA, WakeMed Raleigh currently operates only 516 beds despite having 539 licensed beds (excluding neonatal beds). Historical utilization should reflect not just patient demand, but also operational competency in managing bed capacity. A facility that cannot fully operationalize its existing licensed beds may not represent the most effective use of additional acute care resources.

In contrast, UNC Health Rex Hospital efficiently operates all 418 of its licensed acute care beds at 91.2 percent occupancy, demonstrating both strong patient demand and superior operational management of existing resources.

Competition (Patient Access to a New Provider)

UNC Health Rex, WakeMed, and DUHS are three existing, mature, and well-established health systems that provide acute care services in Wake County. Novant Health does not operate any acute care facilities in Wake County. In reviews in which there is a new provider that does not currently operate in the service area, the Agency has typically found that applicant to be a more effective alternative and the other applicants less effective. However, as noted previously, the Novant application is non-conforming with multiple review criteria. Beyond the conformity issues, Novant Health's application demonstrates insufficient local physician support and questionable referral patterns that undermine its competitive viability. While Novant references support from OB/Gyn, Urology, Family Medicine, and Sports Medicine practices, critical gaps remain in core specialties that are integral to a new community acute care hospital, including surgical specialties. Notably, despite Novant's acquisition of Performance Orthopaedic Surgery & Sports Medicine, no letter of support was provided from an orthopedic surgeon, raising questions about actual physician commitment and referral volume potential. Additionally, available information indicates that key supporting practices, including the Sports Medicine clinic, are located in Cary (western Wake County), creating a substantial geographic disconnect from the proposed Knightdale facility. This geographic separation makes consistent patient referrals unlikely, as patients would logically choose acute care facilities closer to their physicians' offices rather than travel significant distances for admissions while bypassing more proximate facilities. The distance between supporting practices and the proposed facility contradicts Novant's projections for capturing market share from eastern Wake County residents.

Furthermore, while Novant emphasizes its strategic collaboration with Duke University Health System, the Duke support letter included in the Novant Knightdale application provides only general endorsement without tangible commitments. The August 12, 2025 letter from Duke's Executive Vice President notably states that Novant's proposed hospital “complements DUHS's plans to expand access in Wake County at its Duke Raleigh and Duke Cary campuses,” but conspicuously fails to indicate that Duke providers will refer patients to the Knightdale facility or commit Duke resources to support the proposed facility.

This omission is particularly significant given the competitive contradiction inherent in Duke's position. Duke is simultaneously operating competing acute care facilities in Wake County and has submitted applications in this very review seeking additional acute care beds at Duke Raleigh Hospital and Duke Cary Hospital. Duke's support appears to be strategic rather than a collaborative operational partnership, as Duke providers would have strong economic incentives to refer patients to Duke's own facilities rather than to a competing hospital serving overlapping patient populations.

The lack of tangible physician commitments, geographic misalignment of supporting practices, and the absence of meaningful operational partnerships suggest that Novant has not established the necessary clinical foundation to support its projected utilization. Without adequate local physician support and sustainable referral patterns, the approval of Novant's application would not meaningfully improve competition in the service area, as the facility would likely struggle to achieve viable operations. Therefore, while Novant represents a new provider in Wake County, its application demonstrates insufficient foundation for successful competition, and the existing provider applications represent more viable alternatives for improving healthcare access and competition in the service area.

Moreover, the Agency’s use of this factor often refers to a presumption that increased patient choice would encourage providers to improve quality or lower costs in order to compete for patients. UNC Health Rex does not believe that either the introduction of a new provider or awarding the beds to an existing provider with fewer beds would necessarily result in higher quality or lower costs in the Wake County

acute care bed service area. As explained in the UNC Health Rex applications, with three competing health systems, Wake County is already the most competitive service area in the state, and all three are well-developed, large health systems with significant resources. In previous reviews, all three have been found conforming with review criteria related to quality and costs. UNC Health Rex hospitals, in particular, continue to be recognized for their quality, and as part of the UNC Health system, strive to lower the cost of providing healthcare services, as described in the applications. In addition, given the need for additional acute care beds at UNC Health Rex shown in the *2025 SMFP* and the need for the specific projects demonstrated in the two applications filed in this review, UNC Health Rex is already competing strongly for patients, and needs additional acute care beds in order to continue serving the growing number of patients that are seeking care at its hospitals. Approving UNC Health Rex's projects will increase patient choice that would otherwise be denied without sufficient acute care bed capacity.

Given the particular issues with its application described above, approval of the Novant Health Knightdale application would not materially enhance competition, and the remaining applications by existing provider systems are equally effective under this factor.

Access by Underserved Groups

The following table shows projected Medicare and Medicaid percentages of gross revenue for the acute care bed service component in the third project year following completion of the project, based on the information provided in Form F.2 of each application.

Medicare and Medicaid Payor Mix – Project Year 3

Applicant	*Medicare % of Gross Revenue*	*Medicaid % of Gross Revenue*	*Total*
WakeMed North Hospital	65.2%	8.2%	73.4%
UNC Health Rex Hospital	**62.1%**	9.5%	71.6%
Duke Raleigh Hospital*	61.0%	11.1%	72.1%
WakeMed Raleigh Hospital	49.5%	16.7%	66.2%
Duke Cary Hospital*	47.8%	13.4%	61.2%
UNC Health Rex Wake Forest Hospital	47.6%	9.8%	57.4%
Novant Health Knightdale Medical Center	40.7%	21.4%	62.1%
WakeMed Garner Hospital	27.0%	30.9%	57.9%

Source: Form F.2 of the respective applications.
*Duke's projected payor mix includes a one-time adjustment of approximately 2% shift from commercial insurance to Medicare to reflect population aging, and a 32-33% shift from self-pay to Medicaid managed care due to North Carolina's Medicaid expansion effective December 1, 2023.

DUHS describes in its applications a shift of managed care patients to Medicare.[69] However, if such a change impacts the percentage of Medicare patients, it is likely to impact all applicants, not just DUHS.

[69] Duke Raleigh Hospital 2025 application states: "A projected one-time shift of a percentage of managed care patients to Medicare, based on an analysis of current patients ages 63 and 64 with adjustment for the prior year 65-year old patients who shifted to Medicare, calculated at 2.96% of managed care inpatients and 1.9% of managed care outpatients," p. 109. Project ID # J-013072-25 (Duke Cary Hospital)

This speculative demographic adjustment provides Duke with a material competitive advantage, increasing its projected Medicare service level (and total Medicare and Medicaid service levels) by approximately three percentage points and improving its ranking among applicants for serving underserved populations.

As discussed in the issue-specific comments above, the WakeMed North Hospital application contains errors in payor mix data that create inaccuracies in evaluating the facility's service to underserved populations under Criterion (13c). The payor mix errors also affect Medicaid and other payor projections, as the percentage calculations are interdependent. Given these fundamental data errors and other non-conformities identified in the issue-specific comments above, the WakeMed North Hospital application fails to demonstrate reliable projections for service to underserved populations, and, at a minimum, it should not be compared with the other applicants who present data in a different way.

Removing WakeMed North Hospital due to these errors, UNC Health Rex Hospital is the most effective for serving Medicare patients, ranking first in the percentage of Medicare gross revenue (62.1 percent). In terms of total Medicare and Medicaid, without the aforementioned aging adjustment, Duke Raleigh Hospital's total Medicare and Medicaid payor mix would decrease from 72.1 percent to approximately 69.1 percent, moving it below UNC Health Rex Hospital, making UNC Health Rex Hospital also the most effective for total service to these underserved groups.

UNC Health Rex also notes that the services proposed by the various applicants are significantly different, with facility types that include community hospitals as well as tertiary care providers such as UNC Health Rex Hospital. However, if the Agency believes a comparison between all applicants is conclusive, then the UNC Health Rex Hospital application is most effective.

Projected Average Net Revenue per Discharge

The following table shows the projected net revenue per inpatient discharge in the third year of operation based on the information provided in each applicant's pro forma financial statements (Form F.2).

Average Net Revenue per Discharge – Project Year 3

Applicant	*Discharges*	*Net Revenue*	*Average Net Revenue Per Discharge*
UNC Health Rex Hospital	34,931	$121,694,658	$3,484
UNC Health Rex Wake Forest Hospital	3,085	$91,264,841	$29,583
Duke Raleigh Hospital	11,959	$228,511,717	$19,108
Duke Cary Hospital	3,655	$40,836,574	$11,173
WakeMed Raleigh Hospital	31,829	$625,803,437	$19,661
WakeMed Garner Hospital	8,036	$276,209,174	$34,371
WakeMed North Hospital	10,033	$153,838,001	$15,333
Novant Health Knightdale Medical Center	2,100	$32,133,546	$15,302

Source: Forms C and F.2 of the respective applications.

states: "There is a one-time aging shift from Managed Care (IP 2.96%; OP 1.90%) into Medicare in FY2026," p. 190.

There is high variation in the average net revenue per discharge for the competing applicants. Some of this is attributable to the different facility types. Tertiary hospitals such as UNC Health Rex Hospital typically treat a greater number of high-acuity and complex patients than community hospitals, which tend to have higher proportions of patients with relatively low acuity chronic medical conditions. Additionally, the applicants use different methodologies in the calculation of revenues and expenses that prevent an accurate comparison. UNC Health Rex Hospital states in its Form F.2 Assumptions that "UNC Health Rex Hospital Main Campus's inpatient services only includes charges relating to room and board. All other charges relating to the patient's inpatient visit are allocated to the applicable department (ex: surgical services, lab, etc.)"[70] This methodology results in a much lower revenue per discharge than facilities that include all services provided to admitted patients. The application for UNC Health Rex Wake Forest Hospital includes revenues and expenses for all services provided to a patient including room, surgery, procedures, pharmacy, therapy, laboratory, and other ancillary services revenues and expenses. The other competing applicants in this review apply differing methods to calculate inpatient operating revenue. This factor is therefore inconclusive, due to the diverse types of facilities and unique methods used for projecting revenue.

Projected Average Operating Expense per Discharge

The following table shows the projected average operating expense per inpatient discharge in the third year of operation for each of the applicants, based on information provided in the applicants' pro forma financial statements (Form F.3).

Average Operating Expense per Discharge – Project Year 3

Applicant	*Discharges*	*Operating Expenses*	*Average Oper Expense Per Disch*
UNC Health Rex Hospital	34,931	$224,451,123	$6,426
UNC Health Rex Wake Forest Hospital	3,085	$59,636,599	$19,331
Duke Raleigh Hospital	11,959	$293,499,934	$24,542
Duke Cary Hospital	3,655	$97,028,674	$26,547
WakeMed Raleigh Hospital	31,829	$644,187,660	$20,239
WakeMed Garner Hospital	8,036	$253,941,348	$31,600
WakeMed North Hospital	10,033	$156,524,225	$15,601
Novant Health Knightdale Medical Center	2,100	$37,377,593	$17,799
UNC Health Rex Hospital	34,931	$224,451,123	$6,426

Source: Forms C and F.3 of the respective applications.

As discussed above, the UNC Health Rex Hospital projections of revenue and expenses only include the room and board portion of a patient's stay. All other expenses relating to the patient's inpatient visit are allocated to the applicable department. UNC Health Rex Wake Forest Hospital and other competing applicants in this review include all service categories in the calculation of inpatient operating expenses. This factor is therefore inconclusive due to the different methods of projecting expenses.

[70] UNC Health Rex 2025 Application, Form F.2 Assumptions, page 154.

Summary of Comparative Analysis

The following tables summarize the comparative factors and state which applications are the most, more, less, or least effective alternative with respect to that comparative factor within their grouping of existing or new facilities, as well as a summary table across all facilities, existing and new. Where applicable, designations of more effective or less effective were determined by comparing applications against a threshold calculated by evenly dividing the difference between the highest and lowest values. Rows shaded in green indicate application of the comparative factor without distinguishing between new or existing facilities.

2025 Comparative Factors Across Existing Facilities

Comparative Factor	UNC Health Rex Hospital	Duke Raleigh Hospital	Duke Cary Hospital	WakeMed Raleigh Hospital	WakeMed North Hospital	WakeMed Garner Hospital
Conformity with Review Criteria	**Yes**	Non-Conforming	Non-Conforming	Non-Conforming	Non-Conforming	Non-Conforming
Scope of Services	**More Effective**	Less Effective	Less Effective	More Effective, but Non-Conforming	Less Effective	Less Effective
Geographic Accessibility	**More Effective**	Less Effective	Least Effective	More Effective, but Non-Conforming	Less Effective	Less Effective
Historical Utilization	**Most Effective**	Less Effective	N/A*	More Effective, but Non-Conforming	More Effective, but Non-Conforming	N/A*
Competition (Patient Access to a new provider)	Less Effective	Less Effective	Less Effective	Less Effective	Less Effective	Less Effective
Access by Underserved Groups - Medicare	**Most Effective**	Less Effective	Less Effective	Less Effective	Most Effective, but Non-Conforming	Less Effective
Access by Underserved Groups - Medicaid	**Less Effective**	Less Effective	Less Effective	Less Effective	Less Effective	More Effective, but Non-Conforming
Average Net Revenue per Case	Inconclusive	Inconclusive	Inconclusive	Inconclusive	Inconclusive	Inconclusive
Average Expense per Case	Inconclusive	Inconclusive	Inconclusive	Inconclusive	Inconclusive	Inconclusive

*Duke Cary Hospital and WakeMed Garner Hospitals are not yet operational and therefore have no available historical utilization data.

2025 Comparative Factors Across New Facilities

Comparative Factor	UNC Health Rex Wake Forest Hospital	NH Knightdale Medical Center
Conformity with Review Criteria	**Yes**	Non-Conforming
Scope of Services	**Most Effective**	Less Effective
Geographic Accessibility	**Most Effective**	More Effective
Historical Utilization	Inconclusive	Inconclusive
Competition (Patient Access to a new provider)	**Most Effective**	Most Effective, but Non-Conforming
Access by Underserved Groups - Medicare	**Most Effective**	Less Effective
Access by Underserved Groups - Medicaid	Less Effective	Most Effective, but Non-Conforming
Average Net Revenue per Case	Inconclusive	Inconclusive
Average Expense per Case	Inconclusive	Inconclusive

2025 Comparative Factors Across All Facilities

Comparative Factor	UNC Health Rex Hospital	UNC Health Rex Wake Forest Hospital	Duke Raleigh Hospital	Duke Cary Hospital	WakeMed Raleigh Hospital	WakeMed North Hospital	WakeMed Garner Hospital	NH Knightdale Medical Center
Conformity with Review Criteria	**Yes**	**Yes**	Non-Conforming	Non-Conforming	Non-Conforming	Non-Conforming	Non-Conforming	Non-Conforming
Scope of Services	**More Effective**	**More Effective among new hospitals,** Less Effective Combined with Existing Facilities	Less Effective	Less Effective	More Effective, but Non-Conforming	Less Effective	Less Effective	Less Effective
Geographic Accessibility	**More Effective**	**Most Effective**	Less Effective	Least Effective	More Effective, but Non-Conforming	Less Effective	Less Effective	**More Effective**
Historical Utilization	**Most Effective**	Inconclusive^	Less Effective	N/A*	More Effective, but Non-Conforming	More Effective, but Non-Conforming	N/A*	Inconclusive^
Competition (Patient Access to a new provider)	Less Effective	**Most Effective**	Less Effective	Less Effective	Less Effective	Less Effective	Less Effective	Most Effective, but Non-Conforming
Access by Underserved Groups - Medicare	**Most Effective**	Less Effective	Less Effective	Less Effective	Less Effective	Most Effective, but Non-Conforming	Less Effective	Less Effective
Access by Underserved Groups - Medicaid	Less Effective	Less Effective	Less Effective	Less Effective	Less Effective	Less Effective	More Effective, but Non-Conforming	Most Effective, but Non-Conforming
Average Net Revenue per Case	Inconclusive	Inconclusive	Inconclusive	Inconclusive	Inconclusive	Inconclusive	Inconclusive	Inconclusive
Average Expense per Case	Inconclusive	Inconclusive	Inconclusive	Inconclusive	Inconclusive	Inconclusive	Inconclusive	Inconclusive

^UNC Health Rex Wake Forest and NH Knightdale Medical Center are proposed facilities and therefore have no historical utilization data.
*Duke Cary Hospital and WakeMed Garner Hospitals are not yet operational and therefore have no available historical utilization data.

Please note that the tables above do not imply that all of the applications are approvable; as noted above, the Novant, DUHS, and WakeMed applications are non-conforming. However, even assuming that all the applications were conforming, the UNC Health Rex applications are the most effective alternatives for the following reasons:

UNC Health Rex Hospital:

- Provides essential access to broad range of acute care services;
- Provides the greatest depth and scope of services (tertiary facility);

- Demonstrates the strongest historical utilization of any facility proposing additional acute care beds with a 90.1% occupancy rate; and
- The 106 proposed acute care beds effectively complement the other approvable applications, providing increased access to subspecialty and high-acuity surgical care in Wake County.

UNC Health Rex Wake Forest Hospital:

- Addresses the most significant geographic access gap by establishing the first acute care facility in northern Wake County, an area currently requiring residents to travel significant distances for hospital services;
- Offers the broadest scope of community hospital services among new facility proposals, including Level II neonatal services, interventional radiology capabilities, specialized emergency department configuration with behavioral health support, and comprehensive surgical capabilities;
- Has significant provider support for its proposed project; and
- With 50 proposed acute care beds, effectively complements other approvable applications by offering community-based surgical services in underserved geographies.

SUMMARY

In summary, UNC Health Rex believes that its two concurrent and complementary applications represent the most effective proposals for awarding 156 of the total 267 additional acute care beds needed in Wake County. UNC Health Rex is also fully conforming with all applicable statutory and regulatory review criteria and is comparatively superior in terms of the relevant factors in this review. As such, the UNC Health Rex applications should be approved.

Please note that in no way does UNC Health Rex intend for these comments to change or amend its two applications filed on August 15, 2025. If the Agency considers any of these comments to be amending the UNC Health Rex applications, those responses should not be considered.