ATTACHMENT - REQUIRED STATE AGENCY FINDINGS

FINDINGS
C = Conforming
CA = Conditional
NC = Nonconforming
NA = Not Applicable

DECISION DATE: October 26, 2012
PROJECT ANALYST: Bernetta Thorne-Williams
CHIEF: Craig R. Smith

PROJECT I.D. NUMBER: G-8828-12/ Alamance Regional Medical Center, Inc/ Expand and renovate existing emergency and surgery departments, upgrade central energy plant, relocate the existing Cancer Center and rehabilitation services/Alamance County

REVIEW CRITERIA FOR NEW INSTITUTIONAL HEALTH SERVICES

G.S. 131E-183(a) The Department shall review all applications utilizing the criteria outlined in this subsection and shall determine that an application is either consistent with or not in conflict with these criteria before a certificate of need for the proposed project shall be issued.

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

C

The applicant, Alamance Regional Medical Center, Inc (ARMC), whose parent company is ARMC Health Care, is a licensed 238 acute care beds hospital (which consists of 182 general acute care beds, 44 psychiatric beds and 12 substance abuse beds). ARMC has provided services to the residents of North Carolina, on its existing campus, since 1995. In this application, ARMC proposes to expand and renovate its emergency and surgery departments, upgrade its central energy plant, and relocate the existing Cancer Center and rehabilitation services. The applicant proposes to construct 111,916 square feet of new space and to renovate 56,350 square feet.

The applicant does not propose to develop beds or services or acquire equipment for which there is a need determination in the 2012 State Medical Facilities Plan (SMFP). However, Policy GEN-4: Energy Efficiency and Sustainability for Health Service Facilities, on page 40 of the 2012 SMFP, is applicable to the review of this proposal. Policy GEN-4 states:

"Any person proposing a capital expenditure greater than $2 million to develop, replace, renovate or add to a health service facility pursuant to G.S. 131E-178 shall include in its

certificate of need application a written statement describing the project's plan to assure improved energy efficiency and water conservation.

In approving a certificate of need proposing an expenditure greater than $5 million to develop, replace, renovate or add to a health service facility pursuant to G.S. 131E-178, the Certificate of Need Section shall impose a condition requiring the applicant to develop and implement an Energy Efficiency and Sustainability Plan for the project that conforms to or exceeds energy efficiency and water conservation standards incorporated in the latest editions of the North Carolina State Building Codes. The plan must be consistent with the applicant's representation in the written statement as described in paragraph one of Policy GEN-4.

Any person awarded a certificate of need for a project or an exemption from review pursuant to G.S. 131E-184 are required to submit a plan of energy efficiency and water conservation that conforms to the rules, codes and standards implemented by the Construction Section of the Division of Health Service Regulation. The plan must be consistent with the applicant's representation in the written statement as described in paragraph one of Policy GEN-4. The plan shall not adversely affect patient or resident health, safety or infection control."

In Section III.2, page 118, the applicant states how the project will assure improved energy efficiency and water conservation. The applicant states:

"The proposed project will be developed in such a manner as to improve energy efficiency and water conservation. In particular, the proposed project will incorporate energy savings features as well as other appropriate improvements in the expanded central energy plant. The new cancer center will either meet or exceed the North Carolina State Energy Conservation Code. …"

In Section XI.7, pages 201-202 and Exhibit 18, the applicant states:

"[T]*he proposed project will meet or exceed the North Carolina State Energy Conservation Code. Some of the proposed features for water conservation include:*

- *Condensate recovery from all AHUs will be recovered water being used first in the cooling towers and secondly in irrigation.*
- *Low flow fixtures.*
- *Meters for cooling tower, domestic hot water, boiler make up, and irrigation (if any):*

Energy conservation measures will likely include:

- *VAV systems in non-sensitive areas.*
- *Reduction of air flow during unoccupied periods in non-sensitive areas.*
- *Full DDC building automation system with individual room thermostats.*
- *Basic commissioning shall be provided by the design engineer.*

- *Leakage test on all ductwork above 2" static pressure.*
- *Free cooling will be accomplished either through the use of a flat plate heat exchanger or outside economizers.*
- *Extensive use of air flow monitors.*
- *Power Logic breakers and switchgear to provide enhanced electrical metering.*
- *Registration for EPA Energy Star Program.*
- *Maximize use of water cooled equipment such as freezers and imaging systems.*
- *Use of T-8 lamps with electronic ballast for the majority of fixtures."*

The applicant adequately demonstrates the proposal includes improved energy efficiency sustainability and water conservation. Therefore, the application is consistent with Policy GEN-4 and conforming to this criterion.

(2) Repealed effective July 1, 1987.

(3) The applicant shall identify the population to be served by the proposed project, and shall demonstrate the need that this population has for the services proposed, and the extent to which all residents of the area, and, in particular, low income persons, racial and ethnic minorities, women, handicapped persons, the elderly, and other underserved groups are likely to have access to the services proposed.

C

The applicant, Alamance Regional Medical Center, Inc (ARMC), whose parent company is ARMC Health Care, is a licensed 238 acute care beds hospital (which consists of 182 general acute care beds, 44 psychiatric beds and 12 substance abuse beds). ARMC has provided services to the residents of North Carolina, on its existing campus, since 1995. In this application, ARMC proposes to expand and renovate the following three major departments/services; emergency, surgical and oncology. ARMC proposes the development of behavioral health holding rooms and a clinical decision unit to operate within the emergency department, to increase the size of its operating rooms, upgrade its central energy plant, relocate the existing Cancer Center to a newly constructed building adjacent to the Medical Arts Building (MOB), and to relocate its existing rehabilitation services to the vacated space of the Cancer Center. The proposed changes involve the following departments/areas which are discussed below:

First floor

In Section II.1, pages 17-24, the applicant states:

"The only service component involved in this project that is located on the first floor of the medical center is the emergency department, which will remain on the first floor but will relocate some of its components to new or renovated space within the department. The Clinical Decision Unit (CDU) … will be developed.

…

As depicted in the table below, the project proposes to retain all 26 emergency treatment rooms for acute care and add rooms for specialty needs, including fast-track (16 rooms), behavioral holding (eight rooms), and a clinical decision unit (eight bays). The fast-track rooms will continue to be used for acute patients when needed; …

Existing Treatment Rooms	*Proposed Treatment Rooms*	*Incremental Treatment Rooms*
26 treatment rooms/bays	*26 acute treatment rooms*	*0 treatment rooms*
*0 fast track**	*16 fast track*	*16 fast track*
Total ED Treatment Rooms [26]	*42 Treatment Rooms*	*16 Incremental Treatment Rooms*
Other New-Treatment Rooms to be added with the project		
	*8 behavioral holding rooms^*	
	8 CDU rooms	

**While none of the existing treatment rooms are designated as "fast-track," fast-track patients are generally cared for in ten of the 26 rooms located near the entrance of the department.*
^In the proposed ED, psychiatric patients with emergency medical needs will be treated in a general treatment room (or higher level of care, if required) and then will be moved to a behavioral health holding room until they can be admitted to an inpatient psychiatric facility. For that reason these rooms are not considered emergency treatment rooms.

The 26 rooms will form a rectangle around the nurse [sic] *station to allow nursing staff to have visual access to most of the 26 acute rooms. … The department currently has one isolation room but will add a second one with the proposed project. Although none of the rooms will be specifically designated for "trauma" patients, four of the acute treatment rooms adjacent to the trauma support area will be larger and, as such, will more readily accommodate the technology needs as well as the staff required to deal with more critical acute patients …*

The Emergency Medical Services (EMS) workroom and support areas will be located near the emergency entrance to the department. A decontamination area will be located adjacent to the acute area and the emergency entrance …

On the opposite side of the acute area but immediately accessible to the area will be staff offices and a police substation and interview room.

Clinical Decision Unit (CDU)

The eight-bed CDU will be located between the acute and fast-track areas surrounding its own nurse station.

Fast-Track/Non-acute

The project proposes to locate 16 non-acute treatment rooms … from the acute treatment area and adjacent to the waiting area.

Behavioral Holding

At present, behavioral health patients are being treated and held in emergency treatment rooms until they can be transferred to the ARMC psychiatric unit, another facility, or discharged home. The back hallway in the emergency department … is the primary placement area …

[T]*his project proposes to construct eight rooms and a nurse station specifically designed for behavioral health. … Security will also monitor the cameras from the nurse station area.*

Access to the area will be secured and the corridor and common areas will be monitored by cameras to ensure the safety of the behavioral patients.

Discharge

ARMC plans to locate the discharge area between the acute treatment, CDU and non-acute areas. … The proposed discharge carrels will provide more privacy for each transaction than is currently available. …

Miscellaneous Department Areas

The expanded emergency department will include other support areas such as an on-call room with bathroom, a conference/classroom … and various staff offices, including an office for bed coordinators.

Outpatient Registration

Although not a part of the emergency department, the outpatient registration area will be renovated in order to accommodate the creation of the behavioral health unit … .

In Section II.1, pages 24-27, the applicant states:

Second Floor

"Surgical Services (ORs, SDS / Recovery, Procedure Rooms)

Operating Rooms (9 shared)

All of the nine shared operating rooms located at the medical center were constructed with the original hospital building in 1995. … Because of the age of the rooms, none of the nine are properly sized for today's surgical standards. In order to right-size the operating rooms, five will be relocated to new space and four will be renovated in existing space … .

Cystoscopy/Procdure Room

The project proposes to renovate a room that will be used to perform cystoscopies as well as related procedures.

Same Day Surgery (Prep/Recovery Bays)

Same day surgery preps and recovers its patients in 15 bays located adjacent to the operating rooms … . This project proposes to relocate and expand the number of prep/recovery bays by nine for a total of 24 same day surgery prep and recovery bays for the nine shared operating rooms and Cysto/Procedure room.

Bronchoscopy Procedure Room

[T]*his project proposes to relocate the bronchoscope equipment to one of the renovated procedure rooms in the surgery department, creating a dedicated bronchoscopy room. … The creation of this room will increase the number of procedure rooms from two to three.*

Pain Management

This project proposes to relocate pain management procedures from the Medical Arts Building to one of the procedure rooms in the surgery department on the second floor of the medical center. …

Electroconvulsive Therapy Room (ECT)

Currently, ECT is located on the ground floor of the medical center … . With the completion of the proposed project, ECT will relocate from the ground floor to the surgery department and will share space with pain management in a procedure room. Because ECT procedures are scheduled for Monday, Wednesday and Friday mornings only, sharing procedure space with pain management (scheduled Monday through Friday from 1:00 PM to 5:00 PM) will be a workable arrangement for both services.

OR Support space

Support space for the surgery department, including anesthesia workroom, anesthesia office, pharmacy, surgical administrative offices, physician and staff lockers and break rooms, operating room control, on-call area, and inpatient holding space …. This space … will be renovated to accommodate the function known as "supply chain."

Cancer Center

In Section II.1, pages 27-37, the applicant discusses the proposed changes to the Cancer Center. The applicant states:

"Cancer services (including radiation therapy, medical oncology, chemotherapy / infusion / pharmacy / lab / clinical trails and other support services) occupy

approximately 17,700 square feet of space on the first floor of the MAB [Medical Arts Building]. …

…

This project proposes to relocate the existing Cancer Center from its current space on the ground floor of the MAB to a new building located adjacent to and connect to one side of the MAB. One component of the Cancer Center will not relocate – the two existing linear accelerators will remain in their present location and the new Cancer Center will be designed and developed around them.

Rehabilitation Services

In Section II.1, pages 37-38, the applicant states:

"Following the Cancer Center's relocation to the new building, the vacated space will be backfilled by the relocation of the rehabilitation services, including physical therapy, occupational therapy, speech language pathology, cardiac rehab, pulmonary rehab and the fitness center. … The proposed space will also provide for office and cubicles for all staff that provide rehabilitation services for the medical center."

Central Energy Plant

In Section II.1, page 38, the applicant states:

"In order to support the energy needs of the proposed expansion of the emergency department, surgical services and the new Cancer Center, ARMC proposes to expand its cooling capacity at the central energy plant with the installation of a high efficiency chiller and cooling tower. In order to accommodate the additional equipment in the existing CEP footprint, ARMC plans to relocate the carpentry and paint shop to other space not yet identified."

Population to be Served

In Section III.5(a), page 126, the applicant states:

"ARMC's primary service area is Alamance County. … In FY 2011, 87 percent of ARMC's facility-wide patient origin was attributed to Alamance County."

The following table illustrates historical and projected patient origin for the proposed service components for the first two operating years of the project, as reported by the applicant in Section III.4(b), pages 122-125, and Section III.5(c), pages 127-131.

ARMC Current and Projected Patient Origin

	% of Total

Emergency Department			
County	Current FY 2011	Projected Yr 1 FY2016	Projected Yr 2 FY 2017
Alamance	84.9%	84.9%	84.9%
Other*	15.1%	15.1%	15.1%
Total	**100.0%**	**100.0%**	**100.0%**

*Includes Alexander, Alleghany, Ashe, Beaufort, Bertie, Bladen, Brunswick, Buncombe, Burke, Cabarrus, Caldwell, Carteret, Caswell, Catawba, Chatham, Columbia, Craven, Columbus, Dare, Davidson, Davie, Duplin, Durham, Edgecombe, Forsyth, Franklin, Gaston, Granville, Guilford, Halifax, Harnett, Haywood, Henderson, Hertford, Hoke, Iredell, Johnson, Lee, Lenoir, Lincoln, McDowell, Mecklenburg, Mitchell, Montgomery, Moore, Nash, New Hanover, Onslow, Orange, Pasquotank, Pender, Person, Pitt, Randolph, Richmond, Robeson, Rockingham, Rowan, Sampson, Stanly, Stokes, Surry, Union, Vance, Wake, Warren, Watauga, Wayne, Wilkes, Wilson, and Yadkin Counties and other states.

% of Total Operating Rooms			
County	Current FY 2011	Projected Yr 1 FY 2016	Projected Yr 2 FY 2017
Alamance	82.6%	82.6%	82.6%
Other*	17.4%	17.4%	17.4%
Total	**100.0%**	**100.0%**	**100.0%**

*Includes Alleghany, Beaufort, Brunswick, Buncombe, Cabarrus, Caldwell, Carteret, Caswell, Chatham, Cumberland, Davidson, Davie, Durham, Forsyth, Gaston, Granville, Guilford, Harnett, Iredell, Johnson, Mecklenburg, Montgomery, Moore, Nash, New Hanover, Onslow, Orange, Pamlico, Pender, Person, Pitt, Randolph, Rockingham, Rowan, Sampson, Stanly, Stokes, Surry, Wake, and Wilkes Counties and other states.

% of Total Chemo/Infusion			
County	Current FY 2011	Projected Yr 1 FY 2016	Projected Yr 2 FY 2017
Alamance	83.7%	83.7%	83.7%
Other*	16.3%	16.3%	16.3%
Total	**100.0%**	**100.0%**	**100.0%**

*Includes Caswell, Chatham, Davidson, Gaston, Guilford, Iredell, New Hanover, Orange, Pender, Person, Randolph, Rockingham, and Wake Counties and other states.

% of Total Rehabilitation Services			
County	Current	Projected	Projected

	FY 2011	Yr 1 FY 2016	Yr 2 FY 2017
Alamance			
Physical	85.6%	85.6%	85.6%
Occupational	82.9%	82.9%	82.9%
Speech	82.1%	82.1%	82.1%
Other*			
Physical	14.4%	14.4%	14.4%
Occupational	17.1%	17.1%	17.1%
Speech	17.9%	17.9%	17.9%
Total	**100.0%**	**100.0%**	**100.0%**

*Includes Caswell, Chatham, Davidson, Forsyth, Granville, Guilford, Lincoln, Mecklenburg, Orange, Person, Randolph, Rockingham, and Wake Counties.

% of Total Cardiac Rehab			
County	Current FY 2011	Projected Yr 1 FY 2016	Projected Yr 2 FY 2017
Alamance	87.4%	87.4%	87.4%
Other*	12.6%	12.6%	12.6%
Total	**100.0%**	**100.0%**	**100.0%**

*Includes Caswell, Guilford, Orange, and Randolph Counties.

% of Total Pulmonary Rehab			
County	Current FY 2011	Projected Yr 1 FY 2016	Projected Yr 2 FY 2017
Alamance	92.1%	92.1%	92.1%
Other*	7.9%	7.9%	7.9%
Total	**100.0%**	**100.0%**	**100.0%**

*Includes Caswell, Guilford, Orange, and Randolph Counties.

In Section III.5(d), page 131, the applicant states:

"ARMC does not expect any changes in its patient origin as a result of the proposed project."

The applicant adequately identified the population it proposes to serve.

Need for the Proposed Project

The applicant states the need to renovate and expand the existing service components is based on the following factors:

- Address current and future Emergency Department (ED) capacity concerns;
- Develop behavioral health holding rooms;
- Develop a Clinical Decision Unit (CDU);
- Improve Surgical Services Departments and functions;
- Improve Oncology Department (Cancer Center);
- Expand Rehab Services; and
- Provide upgrades to the Central Energy Plant

In Section III.6(a), page 131, the applicant states, *"ARMC is the only provider in the service area of the services involved in the proposed project.*

ED capacity concerns

In Section III.1, page 58, the applicant states:

> *"The growth in emergency department utilization has totally overwhelmed the capacity available at the hospital, causing delays, boarding of patients, and a general disruption in the flow of patients through the system.*
>
> …
>
> [S]*ince 2006, the emergency department has been operating well above the American College of Emergency Physicians recommended visits per room. While ARMC has continued to streamline its patient and staff flows to facilitate faster throughput, the current configuration of the department limits any further meaningful attempts to change how the department operates."*

In Section III.1, pages 62-63 the applicant states:

> *"The extreme crowding in the emergency department has caused the number of patients that leave without being treated to rise. From 2008 to 2011, nearly 12,000 patients left the emergency department at some point during the emergency visit without completing the treatment process, most (more than 7,000) after being triaged but before being seen.* … [F]*rom 2008 to 2011, the number leaving increased from 4.8 percent of total ED visits to 7.0 percent of visits.*
>
> …
>
> *With the capacity problems in the department, the number of patients that are leaving prior to treatment is expected to increase. The Nursing Director for Emergency Services verifies the problem of patients leaving without being seen in her letter of support (Exhibit 30), 'Based on an analysis of emergency services at ARMC, the department is treating approximately 50 percent more patients than it was designed to treat. Additional patient care opportunities are not being met, as evidenced by the rate of patients leaving without medical exam due to overcrowding and wait times.'"*

In Section III.1(b), pages 94-95, the applicant provides historical utilization and CAGR (compound annual growth rate) for ED visit volume, the applicant states:

"With the exception of 2010, emergency visits at ARMC have increased steadily over the past several years, exceeding the rate of population growth in Alamance County. Approximately 85 percent of ARMC's ED visits originate from Alamance County. While the population of the county grew by a compound annual growth rate (CAGR) of only 1.6 percent between 2005 and 2011. ED visits at ARMC increased by a compound annual growth rate of 2.3 percent during that same period. This observation suggests that it is not the modest population growth but rather increasing emergency use rates within Alamance County that have impacted ARMC's volume growth of ED visits.

The following table illustrates ARMC's historical utilization and CAGR … for ED visit volume.

Fiscal Year	*Total ED Visits*	*# of Treatment Rooms*	*Visits per Room*
2005	*47,602*	*26*	*1,831*
2006	*49,983*	*26*	*1,922*
2007	*52,458*	*26*	*2,018*
2008	*53,448*	*26*	*2,056*
2009	*54,978*	*26*	*2,115*
2010	*53,632*	*26*	*2,063*
2011	*54,408*	*26*	*2,093*
2005-2011 CAGR	*2.3%*	--	*2.3%*

…

Industry standards for the number of emergency visits per treatment room vary from 1,200 visits per year to around 2,000 visits, depending on patient acuity, level of care provided, and other factors … . A 2012 report from the American College of Emergency Physicians (ACEP) provides optimal capacity ranges for the number of treatment rooms and the associated number of annual visits per treatment room, depending on the emergency department's annual number of visits. These findings for hospitals within a range of 50,000 to 60,000 annual ED visits are shown in the table below. …

ACEP Recommended Number of ED Visits per Treatment Room

Annual number of ED visits	*Treatment Rooms*		*Annual visits per treatment room*	
	Low	*High*	*Low*	*High*
50,000 ED visits	*30*	*40*	*1,667*	*1,250*

60,000 ED visits	*35*	*47*	*1,714*	*1,277*

Shown above, … the study recommends that an emergency department with 50,000 annual visits should have between 30 (or 1,667 annual visits per room) and 40 (or 1,250 annual visits per room) treatment rooms to adequately provide care. … [T]*he ED at ARMC has been performing well above the recommended range of visits per treatment room for a number of years, indicating a need for increased capacity to meet current volume demand."*

In Section III.1(b), page 96, the applicant states:

"The projected volume is shown in the following table, along with the resulting number of visits per room that ARMC would face with only its existing 26 treatment rooms.

ARMC Projected Total ED Volume 2012-2017

Fiscal Year	***Total ED Visits***	***# of Treatment Rooms***	***Visits per Room***
2012	*55,250*	*26*	*2,125*
2013	*56,105*	*26*	*2,158*
2014	*56,973*	*26*	*2,191*
2015	*57,855*	*26*	*2,225*
2016	*58,750*	*26*	*2,260*
2017	*59,659*	*26*	*2,295*
CAGR	*1.55%*	-	*1.55%*

Without the additional capacity proposed in this project, ARMC would be faced with the need to accommodate nearly 2,300 patients per room by 2017 (56,659 [sic] *visits / 26 existing rooms = 2,295* [59,659 visits / 26 existing rooms = 2,995]*), 34 to 80 percent higher than the industry threshold … . As a result, ARMC would experience per room volumes that well exceed what is recommended for its existing 26 room capacity."*

In Section IV.1, page 135, the applicant provides the historical and the projected utilization for the ED, as illustrated in the tables below.

ED	Historical		Interim		
	FFY 1/1/10-12/21/10	FFY 1//1/11-12/21/11	FFY 1/1/12-12/31/12	FFY 1/1/13-12/31/12	FFY 1/1/14-12/31/14
# of Treatment Rooms	26	26	26	26	26
# of Visits	53,632	54,408	55,250	56,105	56,973
# of Cases per Rooms	2,063	2,093	2,125	2,158	2,191

ED	Projected		
	Project Yr 1	Project Yr 2	Project Yr 3
	FFY 1/1/15-12/31/15	FFY 1/1/16-12/31/16	FFY 1/1/17-12/31/17
# of Treatment Rooms	42	42	42
# of Visits	57,855	58,750	59,659
# Cases per Rooms	1,378	1,399	1,420

As illustrated in the tables above, for FY10 – FY14 the applicant counts the 26 treatment bays in the ED (which the applicant states have been used for behavior health patients and patients in need of further observation). For FY15 – FY17, the applicant adds 16 treatment bays for "fast track" patients for a total of 42 treatment bays [26+16=42]. The applicant projects 1,420.4 visits per treatment bay [59,659/42=1,420.45] in Fiscal Year 2017. Without the addition of the 16 treatment bays the applicant would be projected to serve 2,295 patients per treatment bay by FY 2017 [59,659/26=2,294.57]. This utilization would far exceed the recommended utilization for ED visits per treatment rooms as recommended by the ACEP for hospitals with under 30 treatment rooms. The applicant's projections are based on reasonable and credible historical ED utilization as the only hospital in Alamance County.

The applicant adequately demonstrated the need to renovate and expand its existing ED by 16 treatment bays to *"support the current utilization and growth in the number of emergency visits … improve the way patients move through the department."* [1]

Develop behavioral health holding rooms

In Section III.1, pages 59-63, the applicant states:

> *"The most critical need at present and a major concern of health care providers is the ability to properly care for the large number of behavioral health patients that present in the emergency department for care. Because of the long waits for impatient admissions to a psychiatric facility, ARMC must hold these patients many hours. …* [F]*rom May 2010 to January 2012, the average length of stay for behavioral health patients ranged from slightly less than nine and one-half hours to nearly 19 hours.*
>
> …
> *This fact is further intensified by the fact that during that same time period, an average of three to seven behavioral health patients were in the emergency department at the same time, … . This clearly creates a problem for an emergency department such as ARMC's, which has no dedicated behavioral health rooms and only four treatment rooms that are even conducive to holding behavioral hea1th patients.*
>
> *However, the average does not adequately portray some of the more critical days of operation. For example, between 9:00 AM January 18, 2012 and 4:00 PM January 20,*

[1] ARMC Application, page 59

2012, the department was holding no fewer than 13 behavioral health patients at any one time and, during a four-hour period on the afternoon of January 19, was ***holding 20 behavioral health patients awaiting transfers.*** [Emphasis in original] … *Further, because involuntary patients must be observed by a police officer, the department was further congested with a large number of police officers."*

Exhibit 30 contains a letter dated May 7, 2012 from the Medical Director of Emergency Services, which states in part:

"I am also aware of the need for space dedicated to behavioral health patients. Because of the multiple issues occurring in the state with regard to behavioral health, ARMC has continued to see an increasing number of patients presenting in the ED that need this specialized care. Because of capacity issues in area psychiatric hospitals, we have held some patients for as long as three weeks waiting for a bed. Holding these patients in a treatment room further strains the ability of the hospital to adequately care for urgent and emergent patients. Expanding the department's space to include behavioral health holding will help alleviate this problem."

In Section III.1(b), pages 99-100, the applicant discusses the need to develop eight behavioral health beds. The applicant states:

"[P]*sychiatric patients present and are initially treated within the emergency treatment rooms first … . Following medical clearance, patients will be moved to holding rooms pending disposition. …*

…

Based on its 2011 experience, ARMC conservatively assumes that behavioral health ED visits will account for 5.2 percent of its total projected ED visits (54,408 total visits / 2,808 behavioral ED visits = 5.16% [sic] [2,808 behavioral ED visits / 54,408 = 5.16]*) … Behavioral health visits have grown exponentially faster than visits in general.*

ARMC Projected Behavioral ED Volume FY2012 – FY2017

Fiscal Year	***Total ED Visits***	***5.16 percent =***	***Behavioral ED Visits***
2012	*55,250*	*5.16%*	*2,851*
2013	*56,105*	*5.16%*	*2,896*
2014	*56,973*	*5.16%*	*2,940*
2015	*57,855*	*5.16%*	*2,986*
2016	*58,750*	*5.16%*	*3,032*
2017	*59,659*	*5.16%*	*3,079*

> [T]*he median length of stay for a behavioral health patient held in the ED is 14.5 hours. Therefore, one behavioral holding room could accommodate approximately 1.6 psychiatric patients per day (24 hours per day / 14.5 hours per patient = 1.6 patients per day), which equates to an average of 584 behavioral patients per room. … To accommodate this projected volume, ARMC will need a minimum of six behavioral holding rooms (3,079 projected patients / 584 patients per room = 5.3 rooms) assuming 100 percent utilization of all rooms. … ARMC proposes to develop eight behavioral holding rooms, which translates to utilization of 65 percent of capacity in Project Year 3, calculated on a 24-hour basis. …"*

The applicant states the eight rooms for behavioral health patients will be used to hold patients awaiting transfer to a psychiatric bed, therefore, those rooms are not counted as part of the additional ED treatment bays.

The applicant adequately demonstrated the need to develop eight behavioral health rooms based on, *"an urgent opportunity to build space and create processes where we can safely and privately house and care for this population of patients* [behavioral health] *while awaiting admission and placement at various state and local facilities."*[2]

Develop a Clinical Decision Unit (also known as an observation unit)

In Section III.1, pages 63-65, the applicant states:

> "[T]*here are other issues that exacerbate the flow of patients from the emergency department to inpatient admission or discharge. One of these is the need to observe patients prior to deciding the appropriate clinical disposition. …* [T]*he CDU will provide an alternative to boarding the patient in the emergency department for an extended period of time prior to discharge or hospital inpatient admission. The patient may require diagnostic evaluation and additional monitoring …*
>
> …
>
> *In order to meet this growing need to determine whether a patient qualifies for admission to the hospital and to maintain patient safety and quality of care, ARMC proposes to create a Clinical Decision Unit (CDU) in the emergency department. …* [T]*he CDU will include eight beds and will be located between the acute treatment area and the fast-track rooms."*

In Section III.1(b),pages 98-99, the applicant discusses the need to develop eight clinical decision beds. The applicant states:

> *"Clinical Decision Unit (CDU)*

[2] ARMC Application, page 61

ARMC proposes to create an eight-bed clinical decision unit (CDU) …. Because the patients observed in the CDU will first have been seen in one of the ED treatment rooms, there is not an additional utilization metric for CDU patients or visits.

…

The following table restates ARMC's projected ED visits along with the ACEP recommendations for CDU spaces and ARMC's actual proposed number of CDU spaces.

	2012	***2013***	***2014***	***2015***	***2016***	***2017***
Projected ED Visits	*55,250*	*56,105*	*56,973*	*57,855*	*58,750*	*59,659*
Recommended CDU Space	*8-10*	*8-10*	*8-10*	*8-10*	*8-10*	*8-10*
Proposed CDU Space	*--*	*--*	*--*	*8*	*8*	*8*

The applicant states the eight rooms for CDU will be used for observation and monitoring of patients to determine the best course of care (i.e. admission or discharge), therefore, those rooms are not counted as part of the additional 16 ED treatment bays proposed.

The applicant adequately demonstrated the need to develop eight CDU rooms to ensure, *"while patients may not meet qualifying criteria for an inpatient admission, for patient safety and quality of care reasons, it may be important that they be actively observed in the outpatient setting"*[3]

Surgical Services

In Section III.1, pages 68-70, the applicant states:

"In 1995, Alamance Regional Medical Center facility was opened, combining the two older acute care hospitals in the county, Alamance General Hospital and Alamance County Hospital. The combination of the hospitals included 11 operating rooms for ARMC's surgery department.

In May, 2003, ARMC filed a certificate of need application (Project ID # G-6827-03) to develop an outpatient center in Mebane, North Carolina. At the time, ARMC planned to develop a hospital-based ambulatory surgery center with two operating rooms and one endoscopy room (relocated from the hospital in Burlington), as well as hospital-based diagnostic services and an urgent care center. These outpatient services were to be developed in conjunction with the construction of additional medical office space on the Mebane campus.

In July 2005, Mebane ASC Investors, LLC, a wholly owned subsidiary of ARMC, Inc. … filed a certificate of need application to change the scope of the previously approved project (Project ID # G-7315-05). The change in scope application proposed to relocate a total of three operating rooms from the hospital in Burlington, rather than two

[3] ARMC Application, page 65

operating rooms and one endoscopy room. … Mebane Outpatient Surgery Center opened in May 2008 with three operating rooms.

In October 2005, ARMC submitted a certificate of need application (Project ID # G-7419-05) to convert one endoscopy room to an operating room for a total of nine shared operating rooms at ARMC. The room was converted and became operational on September 2, 2008 following the transfer of three operating rooms to the Mebane Outpatient Surgery Center.

[W]*hile operating rooms have been relocated and one endoscopy room was converted to an operating room, none of the hospital* [sic] *operating rooms have been renovated since they were constructed in the mid 1990s. As such, most of the rooms are severely undersized and have difficulty accommodating imaging equipment and other technology used in surgeries being performed today. Of the nine operating rooms, five are less than 500 square feet, four are between 500 and 600 square feet and one is over 600 square feet. The proposed project will develop all the rooms to typical present-day square footage between 600 and 700 square feet in size … Because of the varying sizes of rooms, flexibility for scheduling is limited, particularly for orthopedic cases which must be done in the larger rooms because of the size of the equipment used and the amount of supplies needed.*

[T]*he need for larger rooms primarily involves the extensive use of image-guided surgery technology, which has revolutionized traditional surgical techniques … Moreover, guided-imagery is used today in a variety of surgical procedures including tumor biopsies, tumor resections, traumatic spinal injury repair, traumatic bone repair, reconstructive orthopaedic surgery as well as sinus surgeries."*

In Section III.1, pages 74-77, the applicant states:

"With the renovation of the surgery department, most of the support spaces will be converted to other uses. … The staff and physicians lockers and lounge will be displaced by the renovation for the right-sized operating rooms. … [T]*he new design places all these functions in one location to the right of the operating rooms … The design and placement of this space will also allow staff and physicians to enter the lower entrance in their street clothes (not contaminating the sterile core), and after changing into scrubs in the locker rooms, the staff and physicians have immediate access through the upper corridor to the sterile core of the operating rooms. The control room (where management of the operating rooms occurs) is immediately adjacent to the operating rooms, giving staff shorter walks to and from the entire operating suite.*

The proposed plan includes a conference room, a feature that is not now part of the surgery department. …

…

ARMC proposes to create space in the department that is designated for storage. … [T]*he renovated space will provide five dedicated spaces of varying sizes that will allow the department to safely store all the equipment and supplies needed in the surgery department.*

In summary, the surgery department is long overdue for a renovation of existing space and the expansion is necessary to right-size the operating rooms and to provide support space for those functions that will be displaced in the expansion. The consolidation of similar services (bronchoscopies, pain management and ECTs) will address fragmentation issues, improve staff's ability to monitor post procedures, minimize risk associated with patient transfers, provide better continuity of care for all surgical patients, improve patient outcomes, and will improve patient satisfaction."

In Section III.1(b), pages 101-106, the applicant provides the projected utilization for its Surgical Services. The applicant states:

"[T]*he proposed project involves the right-sizing of ARMC's nine shared operating rooms as well as the replacement and / or relocation of various procedure rooms and procedure room functions."*

Additionally, in Section III.1(b), pages 101-106, the applicant provides the historical utilization for its operating rooms, cystoscopy, bronchoscopy, ECT, and pain management procedures, as illustrated in the table below.

Historical Procedures 2009-2011

Fiscal Year	OR Cases	Cysto/ Procedure Room	Bronchoscopy Procedures	ECT Procedures	Pain Management Procedures
2009	15,239	727	90	432	2,891
2010	15,130	725	99	366	2,532
2011	15,205	884	184	312	2,634
CAGR	-0.11%	10.27%	42.9%	-15.02	-4.55%

As illustrated in the above table, ARMC experienced a decrease its CAGR of -0.11% in its OR cases, -15.02% in ECT, and -.55% in its pain management procedures. However, the applicant did have an increase in the number of procedures performed in most component areas from 2010 to 2011.

In Section III.1, page 101, the applicant states:

"ARMC experienced a slight decline in surgical cases from 2009 to 2010 followed by an increase in 2011. ARMC does not expect any continued decline in its volume of surgical cases at the medical center. … ARMC has conservatively projected future volume for each service component using the 2010 to 2020 Alamance County population compound annual growth rate of 1.55 percent."

The following table, illustrates the projected number of procedures for each of the components identified in ARMC's surgical services, as stated in Section III.1(b), pages 101-106 of the application.

Projected Procedures 2012-2017

Fiscal Year	OR Cases	Cystoscopy Procedures	Bronchoscopy Procedures	ECT Procedures	Pain Management Procedures
2012	15,440	898	187	317	2,675
2013	15,679	912	190	322	2,716
2014	15,922	926	193	327	2,758
2015	16,168	940	196	332	2,801
2016	16,418	955	199	337	2,844
2017	16,673	969	202	342	2,888

The applicant currently operates nine operating rooms at ARMC. In the proposed application the applicant does not propose to increase the number of its ORs or to develop a specialty OR. Therefore, 1,872 hours per room per year, as promulgated in the Criteria and Standards for Surgical Services and Operating Rooms, 10A NCAC 14C .2100 does not apply. The applicant projects to perform 1,852 hours [16,673 / 9 = 1,852.5] per room per year by FY2017.

In Section IV, pages 135-137, the applicant provides the historical and projected utilization for the first three years of the proposed project components, as illustrated in the tables below.

Cysto/Procedure Rooms					
	Prior Full FY 1/1-12/31/10	Last Full FY 1/1-12/31/11	First Full FY 1/1-12/31/15	Second Full FY 1/1-12/31/16	Third Full FY 1/1-12/31/17
# of Procedure Rooms	1	1	1	1	1
# of Procedures	725	884	940	955	969

See page 136 for the number of procedures projected to be performed in the interim years Jan.1, 201 – Dec. 31, 2014.

ECT					
	Prior Full FY	Last Full FY	First Full FY	Second Full FY	Third Full FY

	1/1-12/31/10	1/1-12/31/11	1/1-12/31/15	1/1-12/31/16	1/1-12/31/17
# of Procedure Rooms	NA	NA	1	1	1
# of Procedures	366	312	332	337	342

See page 136 for the number of procedures projected to be performed in the interim years Jan.1, 201 – Dec. 31, 2014.

Pain Management					
	Prior Full FY 1/1-12/31/10	Last Full FY 1/1-12/31/11	First Full FY 1/1-12/31/15	Second Full FY 1/1-12/31/16	Third Full FY 1/1-12/31/17
# of Procedure Rooms	NA	NA	1	1	1
# of Procedures	2,532	2,634	2,801	2,844	2,888

See page 137 for the number of procedures projected to be performed in the interim years Jan.1, 201 – Dec. 31, 2014.

Bronchoscopy					
	Prior Full FY 1/1-12/31/10	Last Full FY 1/1-12/31/11	First Full FY 1/1-12/31/15	Second Full FY 1/1-12/31/16	Third Full FY 1/1-12/31/17
# of Procedure Rooms	NA	NA	1	1	1
# of Procedures	99	184	196	199	202

See page 137 for the number of procedures projected to be performed in the interim years Jan.1, 201 – Dec. 31, 2014.

The applicant adequately demonstrated the need to expand its surgery departments including the following procedure rooms: Cystoscopy, Bronchoscopy, Pain Management, Electroconvulsive Therapy (ECT), Same Day Surgery (Prep/Recovery Bays), and improve its OR Support Space. *"The consolidation of similar services (bronchoscopies, pain management and ECTs) will address fragmentation issues, improve staff's ability to monitor post procedures, minimize risk associated with patient transfers, provide better continuity of care for all surgical patients, improve patient outcomes, and will improve patient satisfaction."*[4]

Oncology Department

In Section III.1, pages 78-80, the applicant discusses the increase in the number of people diagnosed with cancer in North Carolina. On pages 79-80, the applicant states:

[4] ARMC Application, page 77

"The number of people being diagnosed with cancer in North Carolina steadily increased from 2000 to 2009 …. This growth is likely the result of greater public education and awareness of cancer symptoms which, in turn, has resulted in earlier diagnoses and treatment initiation.

…

Thus, with the growth in the number of cancer diagnoses, the need for diagnostic and treatment services such as those provided in the ARMC Cancer Center will continue to expand."

In Section III.1, page 51, the applicant states that the Cancer Center at ARMC is a Comprehensive Community Cancer Center accredited by the American College of Surgeons.

In Section III.1, page 81, the applicant states:

"Because of the quality of its services resulting in high utilization even from patients in other counties and a long-standing commitment to the Alamance community, the Cancer Center no longer has sufficient space to accommodate the existing volume of patients being diagnosed and treated as well as those patients in clinical trails that most be closely monitored and followed even after treatments end. The need for the proposed project is to allow ARMC the ability to continue providing excellent quality of care for cancer patients in Alamance and surrounding counties and to have space to meet the growing demand associated with the continued increase of cancer cases brought about primarily by the aging population. To do this, ARMC proposes to expand, reorganize, and relocate its oncology-related services, which requires a new building."

In Section III.1, pages 81-91, the applicant discusses the areas/services which will be affected by the proposed Cancer Center relocation which includes the following areas:

- Lobby and Public Space;
- Resource Center;
- Community Room and Conference Room;
- Administrative and Other Support Offices;
- Laboratory;
- Radiation Oncology;
- Chemotherapy/Infusion;
- Pharmacy;
- Medical Oncology and Multi-Disciplinary Clinic; and
- Clinical Trails.

In Section III.1, pages 107-110, the applicant provides the historical and the projected utilization for the Cancer Center. The applicant states:

"While the Cancer Center will house many functions, only one involves patient volume – chemotherapy / infusion. The Cancer Center does include space for pharmacy and lab,

and will continue to following the proposed project. However, the volume associated with the Cancer Center pharmacy correlates directly to the volume of chemotherapy / infusion treatments and is included in that count. …

Chemotherapy / Infusion

One of the main components of the proposed Cancer Center relocation is the expansion of the chemotherapy / infusion area, which will increase ARMC's capacity from 16 existing chemotherapy / infusion chairs to 25 infusion therapy chairs. …

The table below provides ARMC's historical chemotherapy / infusion treatment volume from 2009 through 2011.

Fiscal Year	*Chemotherapy / Infusion Treatments*
2009	*9,723*
2010	*8,914*
2011	*8,960*
CAGR	*-4.00%*

As shown in the table above, ARMC experienced a decline in chemotherapy / infusion treatments from 2009 to 2010, which coincides with ARMC's opening of the Mebane Cancer Center in Mebane, which resulted in a shift in volume to the new outpatient center. … As previously stated, ARMC has conservatively projected future volume for each service component using the 2010 to 2020 Alamance County population compound annual growth rate of 1.55 percent. The resulting chemotherapy / infusion treatment volume is provided in the table below.

Fiscal Year	*Chemotherapy / Infusion Treatments*
2012	*9,099*
2013	*9,239*
2014	*9,382*
2015	*9,528*
2016	*9,675*
2017	*9,825*

Based on these projections, and on the fact that its existing 16 chairs are currently operating well above capacity, ARMC knows that it will need additional chemotherapy / infusion therapy chairs in order to accommodate future volume.

ARMC determined that the average chemotherapy / infusion therapy treatment time is five hours, based on historical experience. ARMC's experience indicates that a typical patient's treatment time ranges from three to seven hours. … Given the inherent variable

nature of infusion therapy treatments and its experience of a three to seven hour range per treatment, ARMC believes that an average of five hours per treatment is the most accurate assumption. This is equivalent to 2.0 visits per chair per day (10 hours of operation / 5 hours per treatment). … Furthermore, on any given day, there will always be some chairs that cannot accommodate even two patients due to a patient reaction and resulting [sic] *longer than average treatment time. …*

As ARMC proposes to have 25 chemotherapy / infusion chairs, the maximum capacity is expected to be 12,500 chemotherapy / infusion therapy procedures per year (2.0 visits per chair per day x 250 days per year x 25 chairs). As shown below, ARMC will reach nearly 80 percent of this capacity by Project Year Three."

ARMC Projected Chemotherapy/Infusion Therapy Volume as a Percentage of Maximum Capacity

Chemotherapy/Infusion Therapy	***PY 1: 1/1/15-12/31/15***	***PY 2: 1/1/16-12/31/16***	***PY 3: 1/1/17 12/31/17***
Projected Volume	*9,528*	*9,675*	*9,825*
Volume at maximum capacity	*12,500*	*12,500*	*12,500*
Projected volume as % of maximum capacity	*76%*	*77%*	*79%*

In Section III.1(b) page 111, the applicant provides the historical and projected volume for the chemotherapy / infusion chairs from 2009 to 2014 as a percentage of capacity without the addition of the 9 purposed chemotherapy / infusion chairs, as illustrated below.

Chemotherapy/Infusion Therapy	***2009***	***2010***	***2011***	***2012***	***2013***	***2014***
Projected Volume	*9,723*	*8,914*	*8,960*	*9,099*	*9,239*	*9,382*
Volume at maximum capacity	*8,000*	*8,000*	*8,000*	*8,000*	*8,000*	*8,000*
Projected volume as % of maximum capacity	*122%*	*111%*	*112%*	*114%*	*115%*	*117%*

As illustrated in the table above, the Cancer Center experienced a drop in volume from 2009 to 2010 which the applicant states is the result of the opening of the Cancer Center in Mebane and the shifting of some of its patients. The applicant projects its growth for cancer center patients will mirror that of the Alamance County population compound annual growth rate of 1.55 percent. This is an increase of 140 patients in 2013, 143 patients in 2014, 146 patients in 2015, 147 patients in 2016, and 150 additional patients in 2017. This is reasonable given the projected growth and aging of the population in Alamance County.

The applicant adequately demonstrates the need to consolidate its radiation and medical oncology, pharmacy and cancer related supported services in one location.

Rehabilitative Services

In Section III.1(b), pages 91-92, the applicant states:

> *"At present, rehabilitation services are located on the ground level of the hospital and are not easily accessible from any entry point in the hospital. The most convenient access is through the door that opens from the Medical Arts Building …. However, even that entry is more than 150 steps away from the rehabilitation department. For patients that have had a hip replacement or some other orthopedic procedure, pulmonary or heart procedure, even 150 steps is a long walk for rehabilitation. …*
>
> *The proposed project will relocate all rehabilitation services – physical, occupational, speech language pathology, cardiac rehab and pulmonary rehab – to space vacated by the relocated Cancer Center. The location is ideal in that cars can drive up to the building entrance, patients can access the building and reach the elevators to the ground level within 30 or less steps. Further, the space … will allow the rehabilitation services to be properly situated and patient flow from one area to another, as required by various therapy programs, will be much improved …"*

In Section III.1(b) pages 111-116, the applicant provides historical and projected number of procedures for its rehabilitative services, including physical, occupational, speech therapy and cardiac and pulmonary rehab, as illustrated in the tables below.

Historical Procedures 2009-2011

Fiscal Year	Physical Therapy Procedures	Occupational Therapy Procedures	Speech Therapy Procedures	Cardiac Rehab Procedures	Pulmonary Rehab Procedures
2009	13,052	4,920	1,187	3,865	1,251
2010	12,184	5,250	983	4,016	1,211
2011	13,428	4,934	1,402	4,550	1,443
CAGR	1.43%	0.14%	8.68%	8.50%	7.40%

Projected Procedures 2012-2017

Fiscal Year	Physical Therapy Procedures	Occupational Therapy Procedures	Speech Therapy Procedures	Cardiac Rehab Procedures	Pulmonary Rehab Procedures
2012	13,636	5,010	1,424	4,620	1,465
2013	13,847	5,088	1,446	4,692	1,488
2014	14,061	5,167	1,468	4,765	1,511
2015	14,279	5,247	1,491	4,838	1,534
2016	14,500	5,328	1,514	4,913	1,558

2017	14,724	5,410	1,537	4,989	1,582
CAGR	1.5%	1.5%	1.4%	1.5%	1.5%

As illustrated in the table above, the applicant reports a historical Compound Annual Growth Rate (CAGR) from 2009 through 2010 of 1.43% for physical therapy procedures, 0.14% for occupational therapy procedures, 8.68% for speech therapy, 8.50% for cardiac rehab procedures and 7.40% for pulmonary rehab procedures. ARMC than projects the number of procedures to be performed in each of the rehabilitation service areas over the next five years (2012-2017). The project analyst calculated the CAGR from 2012 through 2017 for those services which indicates a 1.5% in all the service areas with the exception of speech therapy which is 1.4%. Thus, the applicant used the Alamance County compound annual growth rate in population from 2010 to 2020 to project its increase in utilization for the above mentioned rehabilitation services.

The applicant adequately demonstrates the need to relocate its rehabilitation services to make it more convenient and easily accessible to its patients.

Upgrade Central Energy Plant (CEP)

In Section II.1, page 38, the applicant discusses it plan to expand the cooling capacity at its central energy plant with the installation of a high efficiency chiller and cooling tower in order to support the proposed renovation and expansion project. ARMC states, *"The original footprint of the CEP will not change with this project."*

The applicant adequately demonstrates the need to upgrade its central energy plant to assure the functionality of its proposed expansion and renovations.

In summary, the applicant adequately demonstrated the need to renovate and expand its existing emergency and surgery departments, upgrade its central energy plant, and relocate the existing Cancer Center and rehabilitation services. Furthermore, the applicant adequately demonstrates the need for the proposal for all of the following reasons:

1) The growth and aging of the Alamance County population;
2) The need to address facility constraints and to meet the need of existing patients and future growth; and
3) The expansion and renovations will maximize efficiency for patients requiring emergency department, surgical, oncology or rehabilitative services.

The applicant adequately identified the population to be served and demonstrated the need the population has for each component of the project. Therefore, the application is conforming to this criterion.

(3a) In the case of a reduction or elimination of a service, including the relocation of a facility or a service, the applicant shall demonstrate that the needs of the population presently served will be met adequately by the proposed relocation or by alternative arrangements, and the effect of the reduction, elimination or relocation of the service on the ability of low income

persons, racial and ethnic minorities, women, handicapped persons, and other underserved groups and the elderly to obtain needed health care.

NA

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

C

In Section III.3, pages 119-121, the applicant describes several alternatives considered which include the following:

1) Maintain Status Quo – the applicant decided to do nothing would not address the capacity issue within the ED, surgical department and cancer center.

2) Construct an Urgent Care Center at ARMC – the applicant concluded that this option would not solve the problems associated with behavioral health patients and CDU patients. The applicant also concluded that there are four existing urgent care facilities within two miles of the hospital which could have resulted in duplication of services.

3) Expand Emergency Services at Another Location in the County – The applicant considered expanding the emergency department to another location in the county as a healthplex. The applicant concluded that none of the other towns in Alamance County had sufficient population to support a freestanding emergency department.

4) Renovate and Expand Fewer Shared Operating Rooms – The applicant rejected this option because it would not meet the needs of the surgical services, therefore, this was not considered an effective alternative.

5) Develop the Surgery Project Separately from the Proposed Project – The applicant concluded that in order to renovate the surgery department that the infrastructure on the first floor would have to be constructed in order to allow for the expansion on the second floor.

6) Expand and Renovate the Cancer Center in its Present Location – The applicant rejected this option because it would have meant expanding behind and beyond the linear accelerators and the current occupants of the building could not be relocated to the current Cancer Center space.

The applicant concluded that developing the project as proposed was its most effective and least costly because it involves less new construction and more usable renovated square footage to meet the growing needs of all departments involved.

Furthermore, the application is conforming to all other applicable statutory and regulatory review criteria, and thus, is approvable. A project that cannot be approved cannot be an

effective alternative. The application is conforming to all other applicable statutory and regulatory review criteria. Therefore, the application is conforming to this criterion and approved subject to the following conditions.

1. **Alamance Regional Medical Center, Inc. shall materially comply with all representations made in its certificate of need application.**

2. **Alamance Regional Medical Center, Inc. shall not acquire, as part of this project, any equipment that is not included in the project's proposed capital expenditure in Section VIII of the application and which would otherwise require a certificate of need.**

3. **Upon completion of the project, Alamance Regional Medical Center, Inc. shall be licensed for no more than:**

    - **42 emergency department treatment rooms,**
    - **an 8-room clinical decision unit,**
    - **8 behavioral health holding rooms,**
    - **9 shared operating rooms,**
    - **24 same day surgery prep and recovery bays, and the,**
    - **16 chemotherapy/infusion chairs in the relocated Cancer Center.**

4. **Prior to issuance of the certificate of need, Alamance Regional Medical Center, Inc. shall acknowledge acceptance of and agree to comply with all conditions stated herein in writing to the Certificate of Need Section.**

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

C

In Section VIII.1, pages 186-187, the applicant states the capital cost for the project will be $64,002,632 including $1,621,432 for site costs, $48,618,135 for construction contract, $666,000 for fixed equipment purchase/lease, $1,167,000 for movable equipment purchase/lease, $400,000 for furniture costs, $4,200,000 for architect/engineering fees, $1,061,404 for financing costs (bond, loan, etc), $2,441,228 for interest during construction, and $3,827,433 for Other (Contingency). In Section IX, page 96, the applicant states that there will be no start up or initial operating expenses associated with the proposed project. In Section VIII.3, page 187, the applicant states that the project will be funded by the accumulated reserves of its parent company, ARMC Health Care. Exhibit 24 contains a May 15, 2012 letter from the Chief Financial Officer for Alamance Regional Medical Center, which states:

"As the Chief Financial Officer for ARMC I am responsible for the financial operations of the hospital. As such, I am very familiar with the organization's financial position.

ARMC will fund the capital costs of the project, estimated to be $64,002,632, with hospital reserves. As shown … audited financials included with the application, ARMC has sufficient cash and assets limited as to use in reserves required for the capital costs of the proposed project. While ARMC expects to fund the project with reserves, in the event that funding with bonds becomes a more cost-effective option, ARMC will seek bond financing. To this end, ARMC has included funds in the capital cost to cover financing for a bond issue.

…"

Exhibit 25 of the application contains the consolidated financial statements for ARMC Health Care and Affiliates for the years ending December 31, 2010 and December 31, 2011. As of December 31, 2011, ARMC Health Care and Affiliates had $37,568,565 in cash and cash equivalents, unrestricted net assets of $96,636,434 and $161,184,886 in net assets (total assets less total liabilities). The applicant adequately demonstrated the availability of sufficient funds for the capital needs of the project.

The applicant provided pro forma financial statements for the first three years of the project for the proposed expansion and renovations scanner. In Form C, the applicant projects expenses will exceed revenues for the proposed ED and rehabilitation services department renovations and expansion for the first three operating years of the project. However, the applicant projects that revenue will exceed operating expenses in each of the first three operating years of the project for its surgical services and Cancer Center, as illustrated in the tables below.

	Project Yr 1 1/1/15-12/31/15	Project Yr 2 1/1/16-12/31/16	Project Yr 3 1/1/17-12/31/17
Emergency Department			
Projected # Patient Days/Cases	57,855	58,750	59,659
Projected Average Charge (Gross Patient Revenue/ Projected # of Procedures)	$477	$491	$506
Gross Patient Revenue	27,580,647	28,847,677	30,172,914
Deductions from Gross Patient Revenue	4,477,600	4,683,297	4,898,444
Net Patient Revenue	10,766,502	11,261,105	11,778,430
Total Expenses	16,187,093	16,722,911	17,305,955
Net Income	(5,420,591)	(5,461,806)	(5,527,525)

	Project Yr 1 1/1/15-12/31/15	Project Yr 2 1/1/16-12/31/16	Project Yr 3 1/1/17-12/31/17
Rehabilitation Services			
Projected # Patient Days/Cases	27,389	27,813	28,243

Projected Average Charge (Gross Patient Revenue/ Projected # of Procedures)	$102	$105	$108
Gross Patient Revenue	2,780,952	2,908,706	3,042,329
Deductions from Gross Patient Revenue	1,464,377	1,531,650	1,602,012
Net Patient Revenue	1,316,574	1,377,056	1,440,317
Total Expenses	2,120,731	2,181,112	2,243,441
Net Income	(804,157)	(804,056)	(803,124)

	Project Yr 1 1/1/15-12/31/15	Project Yr 2 1/1/16-12/31/16	Project Yr 3 1/1/17-12/31/17
Surgical Services			
Projected # Patient Days/Cases	16,168	16,418	16,673
Projected Average Charge (Gross Patient Revenue/ Projected # of Procedures)	$1,640	$1,690	$1,740
Gross Patient Revenue	26,520,491	27,738,818	29,013,115
Deductions from Gross Patient Revenue	13,092,686	13,694,153	14,323,250
Net Patient Revenue	13,427,804	14,044,666	14,689,865
Total Expenses	13,026,778	13,397,868	13,781,894
Net Income	401,026	646,797	907,971

	Project Yr 1 1/1/15-12/31/15	Project Yr 2 1/1/16-12/31/16	Project Yr 3 1/1/17-12/31/17
Cancer Center - Chemotherapy			
Projected # Patient Days/Cases	9,528	9,675	9,825
Projected Average Charge (Gross Patient Revenue/ Projected # of Procedures)	$4,721	$4,863	$5,009
Gross Patient Revenue	44,981,314	47,047,716	49,209,046

Deductions from Gross Patient Revenue	23,572,951	24,655,871	25,788,540
Net Patient Revenue	21,408,364	22,391,845	23,420,506
Total Expenses	21,119,994	21,986,363	22,790,368
Net Income	288,369	405,482	630,138

The applicant also projects a positive net income for the entire hospital in each of the first three operating years of the project. The assumptions used by the applicant in preparation of the pro forma financial statements are reasonable, including projected utilization, costs and charges. See the financial section for the assumptions regarding cost and charges. See Criterion (3) for discussion of utilization projections which is hereby incorporated as if fully set forth herein. The applicant adequately demonstrated that the financial feasibility of the proposal is based upon reasonable projections of costs and charges, and therefore, the application is conforming to this criterion.

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

C

Alamance Regional Medical Center, Inc. in Burlington is the only hospital in Alamance County. ARMC provides emergency, surgical, oncology and rehabilitative care services. In this application, Alamance Regional Medical Center, Inc. proposes to expand and renovate its emergency, surgical, oncology and rehabilitative departments, including an upgrade to its central energy plant. The applicant adequately demonstrates the need for its proposed renovation and expansion based on reasonable, credible and supported projected utilization (which is based on historical utilization as the only hospital in Alamance County and as a Community Cancer Center recognized by the American College of Surgeons). See Criterion (3) for additional discussion of the respective services and the recent and projected utilization for each project component which is hereby incorporated as if fully set forth herein. This analysis demonstrates the reasonableness of the proposed project. Thus, the applicant adequately demonstrates the renovation and expansion of the proposed service components at Alamance Regional Medical Center, Inc will not result in the unnecessary duplication of services. Consequently, the application is conforming to this criterion.

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

C

In Section VII.1(a), page 170, the applicant states:

"Please note that detailed staffing information for the Cancer Center is only provided … for chemo / infusion, which includes chemo pharmacy as that is the only specific component of the Cancer Center for which ARMC is projecting patient-driven volume …"

In Section VII.3(b), page 180, the applicant states:

> *"No new positions will result from the proposed project. However, the project will require incremental FTEs in existing positions as outlined …"*

In Section VII.1(a), pages 170-176, the applicant provides the existing staff for each component proposed and the incremental change for its ED, OR and Oncology Departments for the second full fiscal year, as illustrated in the table below.

Department	**Existing FTE Positions**	**Proposed Incremental Change in FTE Positions**
Emergency		
RN	48.12	67.97
LPN	0.73	0.0
Flow Coordinator	2.26	8.40
ED Technician	19.64	25.1
Unit Secretary	8.86	25.20
Armed Security	43.1	8.40
SANE Nurse	0.16	1.50
Registration Specialist	21.51	23.50
Financial Verification Discharge Specialist	4.20	6.00
Total	**122.04**	**178.30**
OR		
Nurse	43.30	50.41
Nursing Assist 1	7.75	9.24
Unit Clerk	4.83	2.94
Unit Coordinator	3.00	5.00
Surgical Tech	17.14	18.37
Anesthesia Tech	0.94	1.00
Total	**80.90**	**90.90**
Oncology/Chemo/Infusion		
Supp RN level II	0.25	2.00
Weekend RN FTEs	0.10	0.20

Total	**9.35**	**11.20**

In Section V.3(c), pages 143-144, the applicant identifies the Chief of Staff/Medical Director as well as those physicians that will serve as the director for the proposed service components as summarized below.

- Dr. Chapman T. McQueen is a board certified otolaryngolgist who will continue to serve as Chief of Staff/Medical Director for ARMC.
- Dr. Jonathan Williams is board certified in emergency medicine and will continue to serve as the Medical Director for the emergency department.
- Dr. Janak K. Choksi is board certified in internal medicine and medical oncology and will serve as the Medical Director for the oncology department.
- Dr. Glenn S. Chrystal is board certified in internal medicine and radiation oncology and will serve as the Medical Director of radiation oncology.
- Dr. Mark Miller is board certified in internal medicine and will continue to serve as the Medical Director for rehabilitation services.

In Exhibit 20, the applicant provides copies of the curriculum vitae for Dr. Williams, Dr. Janak K. Choksi, Dr. Chrystal and Dr. Miller.

The applicant adequately demonstrated the availability of adequate health manpower and management personnel for the provision of the proposed services. Therefore, the application is conforming to this criterion.

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

C

The applicant is an existing hospital and provider of emergency, surgical, oncology and rehabilitative services and the necessary ancillary and support services are currently available. In Section II.2(a), page 39, the applicant states:

"ARMC and its predecessors have been in operation as an acute care facility for more than 90 years. The main hospital campus, the site of the proposed project, currently has all ancillary and support services in place necessary to support hospital operations. These existing ancillary and support services will also support any increase in emergency, surgical and cancer services as a result of the expansion proposed in this application. ARMC's existing ancillary and support services, including pre-admission testing, laboratory, radiology, pharmacy, dietary, housekeeping, maintenance, and administration, among others, are available to support the proposed expansion and renovation …"

See Exhibit V, for a letter dated May 15, 2012, from the President of Alamance Regional Medical Center documenting that ARMC has sufficient ancillary and support services.

The applicant adequately demonstrated the availability of the necessary ancillary and support services and that the proposed services would be coordinated with the existing health care system. Therefore, the application is conforming to this criterion.

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

NA

(10) When applicable, the applicant shall show that the special needs of health maintenance organizations will be fulfilled by the project. Specifically, the applicant shall show that the project accommodates: (a) The needs of enrolled members and reasonably anticipated new members of the HMO for the health service to be provided by the organization; and (b) The availability of new health services from non-HMO providers or other HMOs in a reasonable and cost-effective manner which is consistent with the basic method of operation of the HMO. In assessing the availability of these health services from these providers, the applicant shall consider only whether the services from these providers:

(i) would be available under a contract of at least 5 years duration;
(ii) would be available and conveniently accessible through physicians and other health professionals associated with the HMO;
(iii) would cost no more than if the services were provided by the HMO; and
(iv) would be available in a manner which is administratively feasible to the HMO.

NA

(11) Repealed effective July 1, 1987.

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

C

In Section XI.4, page 199, the applicant provides the existing and proposed square footage for the facility, as illustrated in the tables below:

Existing/Proposed Project	***Square Feet***
Total square feet of existing facility	*373,110*

Total square feet of new construction	*111,916*
Total square feet at the completion of the proposed project	*485,026*
Total square feet in the existing facility to be renovated	*56,350*

Further in Section XI.4, page 199, the applicant provides the existing and proposed square footage for each department to be renovated or expanded, as illustrated in the table below.

Department	**Existing SF**	**New SF**	**Renovated SF**	**Total Department SF**
Emergency	17,458	27,516	20,500*	44,974
Surgery	40,338	16,200	22,450	56,538
Mechanical Penthouse	0	12,000	0	12,000
Rehabilitation	8,900		13,400	13,400
Cancer Center	17,700	56,200	0	60,405
Total	**84,396**	**111,916**	**56,350**	**187,317****

*Renovation square footage is greater than existing square footage because the renovation includes the outpatient registration area, which will be renovated with the emergency department …
**Total square footage does not equal new square footage because the total includes the linear accelerators, which are not part of this project.

In Section XI.4,(f), page 200, the applicant provides the total cost per square foot, as illustrated in the table below.

	Estimated Square Feet	***Construction Cost Per Sq. Ft.***	***Total Cost per Square Foot***
Total Project	*168,266*	*$288.94*	*$380.37*

In Section VIII.1, page 186, the applicant states the subtotal cost for construction contract is $48,618,135, however, based on the estimated square footage and the construction cost per square foot it would be $48,618,778 [166,266x288.94=48,618,778]. However, this is less than $645.00 [48,618,778-48,618,135=643] 1 or .001% difference and could result from rounding. The applicant has included $3,827,433 in the proposed project's capital cost as its contingency to cover any shortfalls that might occur.

Exhibit 27 contains a May 16, 2012 letter from the Vice President of Clark Patters Lee Design Professionals, which states:

"I certify that I am a licensed architect in the State of North Carolina. To the best of my knowledge, information, and belief, and based on historical cost data, our experience with costs on comparative health care projects, and a preliminary cost estimate prepared by the hospitals [sic] *Construction Manager, we believe the probable construction cost for the Facility Expansion Project should be $48,618,135.00. This figure includes inflation escalation and construction contingency."*

See Exhibit 4 for a line drawing and Exhibit 28 for a site plan for the proposed project. In Section XI.7, pages 201-202, the applicant provides a list of several steps that will be taken to ensure the facility is energy efficient.

The applicant adequately demonstrates that the cost, design, and means of construction represent the most reasonable alternative for the proposed hospital expansion and renovation project. See Criterion (5) for discussion of costs and charges which is hereby incorporated by reference as if fully set forth herein. Therefore, the application is conforming to this criterion.

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

(a) The extent to which medically underserved populations currently use the applicant's existing services in comparison to the percentage of the population in the applicant's service area which is medically underserved;

C

The Division of Medical Assistance (DMA) maintains a website which offers information regarding the number of persons eligible for Medicaid assistance and estimates of the percentage of uninsured for each county in North Carolina. The following table illustrates those percentages for Alamance county and statewide.

	Total # of Medicaid Eligibles as % of Total Population	**Total # of Medicaid Eligibles Age 21 and older as % of Total Population**	**% Uninsured CY 2009 (Estimate by Cecil G. Sheps Center)**
Alamance	16%	6.1%	21.0%
Statewide	17%	6.7%	19.7%

*More current data, particularly with regard to the estimated uninsured percentages, was not available.

The majority of Medicaid eligibles are children under the age of 21. This age group would not typically utilize the health services proposed in this application.

Moreover, the number of persons eligible for Medicaid assistance may be greater than the number of Medicaid eligibles who actually utilize health services. The DMA website includes information regarding dental services which illustrates this point. For dental services only, DMA provides a comparison of the number of persons eligible for dental services with the number actually receiving services. The statewide percentage of persons eligible to receive dental services who actually received dental services was 45.9% for those age 20 and younger and 30.6% for those age 21 and older. Similar information is not provided on the website for other types of services covered by Medicaid. However, it is reasonable to assume that the percentage of those actually receiving other types of health services covered by Medicaid is less than the percentage that is eligible for those services.

The Office of State Budget & Management (OSBM) maintains a website which provides historical and projected population data for each county in North Carolina. In addition, data is available by age, race or gender. However, a direct comparison to the applicants' current payor mix would be of little value. The population data by age, race or gender does not include information on the number of elderly, minorities or women utilizing health services. Furthermore, OSBM's website does not include information on the number of handicapped persons.

In Section VI.12 and VI.13, pages 159-163, the applicant provides the payor mix during Calendar Year 2011 for the entire hospital and each proposed service components, as illustrated in the tables below:

Entire Hospital and ED Services

ARMC CY 2011 Payor Mix 1/1/11 to 12/31/11 As a % of Total Procedures		
	Entire Hospital	Emergency Services
Self Pay/Indigent/Charity	9.9%	29.4%
Medicare/Medicare Managed Care	56.9%	26.1%
Medicaid	11.4%	19.5%
Managed Care/Commercial	16.6%	21.4%
Other*	5.2%	3.6%
Total	100.0%	100.0%

*Others includes workers comp and other government payors

OR and Chemotherapy Services

ARMC CY 2011 Payor Mix 1/1/11 to 12/31/11 As a % of Total Procedures		
	OR Services	Chemotherapy
Self Pay/Indigent/Charity	5.6%	1.8%
Medicare/Medicare Managed Care	38.3%	61.2%
Medicaid	13.4%	8.3%

Managed Care/Commercial	39.6%	27.5%
Other*	3.1%	1.1%
Total	100.0%	100.0%

*Others includes workers comp and other government payors

Rehabilitative Services

ARMC CY 2011 Payor Mix 1/1/11 to 12/31/11 As % of Total Procedures					
	Cardiac Rehab	Physical Therapy	Pulmonary Rehab	Occupational Therapy	Speech Therapy
Self Pay/Indigent/Charity	0.7%	4.1%	0.0%	13.5%	8.7%
Medicare/Medicare Managed Care	61.4%	51.5%	80.8%	43.4%	46.1%
Medicaid	0.8%	7.8%	0.0%	5.5%	3.0%
Managed Care/Commercial	35.5%	29.2%	17.0%	31.9%	41.7%
Other*	1.6%	7.4%	2.1%	5.7%	0.5%
Total	100.0%	100.0%	100.0%	100.0%	100.0%

*Other includes workers comp and government payors

In Section VI.2, page 150, the applicant states:

> *"ARMC is not only easily accessible by these underserved groups, but by the remainder of the population as well. Hospital policies and procedures do not discriminate with regard to patient care access on the basis of race, ethnicity, sex, age, religion, income, residence or any other factor which might restrict access to services. … "*

The applicant demonstrated that medically underserved populations currently have adequate access to the services offered at Alamance Regional Medical Center. Therefore, the application is conforming to this criterion.

(b) Its past performance in meeting its obligation, if any, under any applicable regulations requiring provision of uncompensated care, community service, or access by minorities and handicapped persons to programs receiving federal assistance, including the existence of any civil rights access complaints against the applicant;

Recipients of Hill-Burton funds were required to provide uncompensated care, community service and access by minorities and handicapped persons. In Section VI.11, pages 158-159, the applicant states:

"ARMC has no obligations to provide uncompensated care, community service or access to care by the medically underserved, minorities or handicapped persons during the last three years. However, in order to maintain ARMC's § 501 (c)(3) tax exempt status, it is necessary to fulfill a general obligation to provide access to health care services for all patients needing care regardless of their ability to pay.

…

This includes charity care for patients who are unable to pay. In fact, ARMC spends over $100,000 every day providing charity care to patients in need.

…

Finally, ARMC is in full compliance with Title III of the Americans with Disabilities Act, the Civil Rights Act, and all other federally mandated regulations concerning minorities and handicapped persons."

In Section VI.10(a), page 158, the applicant states:

"No civil rights equal access complaints have been filed against ARMC in the past five years."

The application is conforming to this criterion.

(c) That the elderly and the medically underserved groups identified in this subdivision will be served by the applicant's proposed services and the extent to which each of these groups is expected to utilize the proposed services; and

C

In Section VI.14(a) and Section VI.15(a), pages 164-169, the applicant provides the projected payor mix for the second full fiscal year (2016) of operations for the proposal, as illustrated in the table below.

Entire Hospital and ED Services

ARMC CY 2016 Payor Mix 1/1/16 to 12/31/16 As a % of Total Procedures		
	Entire Hospital	Emergency Services
Self Pay/Indigent/Charity	9.9%	29.4%
Medicare/Medicare Managed Care	56.9%	26.1%
Medicaid	11.4%	19.5%

Managed Care/Commercial	16.6%	21.4%
Other*	5.2%	3.6%
Total	100.0%	100.0%

OR and Chemotherapy Services

ARMC CY 2016 Payor Mix 1/1/16 to 12/31/16 As a % of Total Procedures		
	OR Services	Chemotherapy
Self Pay/Indigent/Charity	5.6%	1.8%
Medicare/Medicare Managed Care	38.3%	61.2%
Medicaid	13.4%	8.3%
Managed Care/Commercial	39.6%	27.5%
Other*	3.1%	1.1%
Total	100.0%	100.0%

Rehabilitative Services

ARMC CY 2016 Payor Mix 1/1/16 to 12/31/16 As % of Total Procedures					
	Cardiac Rehab	Physical Therapy	Pulmonary Rehab	Occupational Therapy	Speech Therapy
Self Pay/Indigent/Charity	0.7%	4.1%	0.0%	13.5%	8.7%
Medicare/Medicare Managed Care	61.4%	51.5%	80.8%	43.4%	46.1%
Medicaid	0.8%	7.8%	0.0%	5.5%	3.0%
Managed Care/Commercial	35.5%	29.2%	17.0%	31.9%	41.7%
Other*	1.6%	7.4%	2.1%	5.7%	0.5%
Total	100.0%	100.0%	100.0%	100.0%	100.0%

*Other includes workers comp and government payors in all tables

In Section VI.15(b), page 169, the applicant states:

> *"ARMC does not expect any changes in its current payor mix as a result of the proposed project."*

The applicant demonstrated that medically underserved populations will have adequate access to the proposed service components. Therefore, the application is conforming with this criterion.

(d) That the applicant offers a range of means by which a person will have access to its services. Examples of a range of means are outpatient services, admission by house staff, and admission by personal physicians.

C

In Section VI.9(a), page 157, the applicant states:

"Persons will have access to services at ARMC through referrals from physicians on the medical staff. Typically, patients are also admitted through the emergency department. For specific procedures, patients are admitted by physicians with privileges at the hospital, who will perform the surgical or other procedure."

The applicant demonstrated the means by which patients will have access to the proposed services. Therefore, the application is conforming with this criterion.

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

C

In Section V.1(a) and (c), pages 140-141, the applicant provides documentation that ARMC will continue to accommodate the clinical needs of area health professional training programs. The table below includes some of the clinical training programs that currently utilize ARMC.

School	**Clinical Program**
Alamance Community College	Nursing
Duke University – Graduate Program	Physical Therapy
Elon University – Graduate Program	Physical Therapy
Guilford Tech Comm College – Associate Degree	Allied Health
Rockingham Comm College – Associate Degree	Allied Health
NC A&T University	Nursing
University of NC at Chapel Hill	Physical Therapy Occupational Therapy Radiologic Science Pharmacy Nursing

The information provided is reasonable and credible and supports a finding of conformity with this criterion.

(15) Repealed effective July 1, 1987.
(16) Repealed effective July 1, 1987.
(17) Repealed effective July 1, 1987.
(18) Repealed effective July 1, 1987.

(18a) The applicant shall demonstrate the expected effects of the proposed services on competition in the proposed service area, including how any enhanced competition will have a positive impact upon the cost effectiveness, quality, and access to the services proposed; and in the case of applications for services where competition between providers will not have a favorable impact on cost-effectiveness, quality, and access to the services proposed, the applicant shall demonstrate that its application is for a service on which competition will not have a favorable impact.

C

The applicant is currently a provider of the proposed service components which includes emergency department, OR, rehabilitative and oncology services. In Section V.7, pages 146-149, the applicant discusses how the proposed renovations and expansion of those departments/services will foster competition by promoting cost effectiveness, quality, and access to services in the proposed service area. The applicant states:

> *"The proposed project will foster competition by promoting cost effectiveness, quality, and access to services in Alamance County and surrounding areas and will thus be in compliance with the spirit and legislative intent of the Certificate of Need Law. Although ARMC provides care for a majority of Alamance County residents, some choose to leave the county for care elsewhere. The improvements and expansion resulting from the proposed project will enhance competition between ARMC and other facilities that serve Alamance County patients."*

Further, in Section V.7, pages 146-149, the applicant provides a narrative which explains why ARMC believes the renovations and expansion of its hospital is critical to its mission to provide quality care to patients residing in Alamance County. See also Sections II, III, VI and VII of the application for additional discussion by the applicant about the impact of its proposal on cost effectiveness, quality and access to emergency, surgical, oncology and rehabilitative services.

The applicant adequately demonstrates that its proposal would enhance competition by promoting cost effectiveness, quality and access to the proposed service components based on the following analysis:

1) Projected utilization of the emergency and surgical departments, oncology and rehabilitation services are based on reasonable, credible and supported assumptions which are based on historical utilization. See Criterion (3) for discussion regarding projected utilization which is hereby incorporated as if fully set forth herein. The applicant adequately demonstrates the financial feasibility of the proposal is based upon reasonable projections of costs and charges. See the Pro Formas. See Criterion (5) for discussion regarding financial feasibility which is hereby incorporated as if fully set forth herein. Therefore, the applicant adequately demonstrates the cost effectiveness of its proposal.
2) The applicant projects to provide adequate access to medically underserved groups, including self pay / charity care patients, Medicare beneficiaries and Medicaid recipients. See Section VI of the application. See Criterion (13c) for discussion

regarding projected access by these groups which is hereby incorporated as if fully set forth herein.

3) The applicant adequately documents that it will provide quality care. See Sections II and VII of the application.

Therefore, the applicant adequately demonstrates that its proposal is conforming to this criterion.

(19) Repealed effective July 1, 1987.

(20) An applicant already involved in the provision of health services shall provide evidence that quality care has been provided in the past.

C

ARMC is accredited by the Joint Commission and certified for Medicare and Medicaid participation. According to the files in the Acute and Home Care Licensure and Certification Section, Division of Health Service Regulation, a complaint survey was conducted on February 23-24, 2012, for which sanctions or penalties related to quality of care were imposed by the State resulting in the identification of an Immediate Jeopardy (IJ). The IJ resulted from an incidence that occurred beginning on February 16, 2012 in which the hospital failed to, "*Provide organized nursing services and systems in place to ensure a safe setting and safe care for the protection of psychiatric patients, staff and visitors.*" A plan of correction for the hospital was put in place on February 24, 2012. The proposed expansion of the emergency department and the development of holding rooms for behavioral health patients should facilitate the hospital's compliance with its corrective action plan. Therefore, the application is conforming to this criterion.

(21) Repealed effective July 1, 1987.

(b) The Department is authorized to adopt rules for the review of particular types of applications that will be used in addition to those criteria outlined in subsection (a) of this section and may vary according to the purpose for which a particular review is being conducted or the type of health service reviewed. No such rule adopted by the Department shall require an academic medical center teaching hospital, as defined by the State Medical Facilities Plan, to demonstrate that any facility or service at another hospital is being appropriately utilized in order for that academic medical center teaching hospital to be approved for the issuance of a certificate of need to develop any similar facility or service.

NA