North Carolina Department of Health and Human Services
Division of Health Service Regulation

Pat McCrory
Governor

Aldona Z. Wos, M.D.
Ambassador (Ret.)
Secretary DHHS

Drexdal Pratt
Division Director

January 22, 2015

Susan K. Hackney
PO Box 14210
Research Triangle Park, NC 27709-4210

Exempt from Review

Facility:	Alexander Hospital
Project Description:	Convert 25 acute care beds to 25 inpatient psychiatric beds pursuant to G.S. 131E-184(c)
County:	Alexander
FID #:	932934

Dear Ms. Hackney:

In response to your letter of October 16, 2014, the above referenced proposal is exempt from certificate of need review in accordance with G.S 131E-184(c). Therefore, your client may proceed to offer, develop or establish the above referenced project without a certificate of need.

However, your client needs to contact the Construction and Acute and Home Care Licensure and Certification Sections of the Division of Health Service Regulation to determine if they have any requirements for development of the proposed project.

It should be noted that this determination is binding only for the facts represented by you. Consequently, if changes are made in the project or in the facts provided in your correspondence referenced above, a new determination as to whether a certificate of need is required would need to be made by the Healthcare Planning and Certificate of Need Section. Changes in a project include, but are not limited to: (1) increases in the capital cost; (2) acquisition of medical equipment not included in the original cost estimate; (3) modifications in the design of the project; (4) change in location; and (5) any increase in the number of square feet to be constructed.

If you have any questions concerning this matter, please feel free to contact this office.

Sincerely,

Martha J. Frisone

Martha J. Frisone, Assistant Chief, Certificate of Need

cc: Assistant Chief, Healthcare Planning
Construction Section, DHSR
Acute and Home Care Licensure and Certification Section, DHSR

North Carolina Department of Health and Human Services
Division of Health Service Regulation

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Secretary DHHS

Drexdal Pratt
Division Director

January 22, 2015

S. Todd Hemphill
PO Box 1801
Raleigh, NC 27602-1801

Notice of Agency Decision

Facility:	Alexander Hospital
Project Description:	Convert 25 acute care beds to 25 inpatient psychiatric beds pursuant to G.S. 131E-184(c)
County:	Alexander
FID #:	932934

Dear Mr. Hemphill:

The Healthcare Planning and Certificate of Need Section, Division of Health Service Regulation (Agency) has notified Alexander Hospital that the above-referenced project is exempt from review. A copy of that notice is enclosed.

Any person aggrieved by this decision may file a petition for a contested case hearing in accordance with G.S. 150B, Article 3, as amended, and G.S. 131E-188(a). This petition must be filed with the Office of Administrative Hearings, 6714 Mail Service Center, Raleigh, North Carolina 27699-6714 within thirty (30) days of the date of this decision. [Note: Effective October 1, 2009, OAH requires a filing fee with submittal of petitions for contested cases. Please direct all questions regarding this fee to OAH Clerk's Office (919-431-3000).] G.S. 150B-23 provides that a party filing a petition must also serve a copy of the petition on all parties to the petition. Therefore, if you file a petition for a contested case hearing, you must serve a copy of the petition on the Department of Health and Human Services by mailing a copy of your petition to:

Emery Milliken
Department of Health and Human Services,
Office of Legal Affairs,
Adams Building – Room 154
2001 Mail Service Center
Raleigh, North Carolina, 27699-2001

It is requested that a copy of the petition also be served on the Agency.

Please refer to the Facility ID # (FID) in all correspondence.

Sincerely,

Martha J. Frisone

Martha J. Frisone, Assistant Chief, Certificate of Need

Enclosure

Healthcare Planning and Certificate of Need Section
www.ncdhhs.gov
Telephone: 919-855-3873 • Fax: 919-733-8139
Location: Edgerton Building • 809 Ruggles Drive • Raleigh, NC 27603
Mailing Address: 2704 Mail Service Center •Raleigh, NC 27699-2704
An Equal Opportunity/ Affirmative Action Employer

CERTIFICATE OF SERVICE

I hereby certify that I have served the foregoing notice of the agency decision on the following person by placing a copy in an official depository of the United States Postal Service in a first- class, postage-paid envelope addressed as follows:

S. Todd Hemphill
Poyner Spruill
PO Box 1801
Raleigh, NC 27602-1801

This the 22nd day of January 2015.

Martha J. Frisone
Assistant Chief, Certificate of Need

Poyner Spruill LLP

November 21, 2014

S. Todd Hemphill
Partner
D: 919.783.2958
F: 919.783.1075
themphill@poynerspruill.com

VIA E-MAIL AND U.S. MAIL
Martha Frisone, Interim Chief
Julie Halatek, Project Analyst
Certificate of Need Section
Division of Health Service Regulation
Department of Health and Human Services
2704 Mail Service Center
Raleigh, NC 27699-2704

RE: October 16, 2014 exemption notice and request by Alexander Hospital Investors, LLC and MBHS of North Carolina, LLC to convert 25 acute care beds to psychiatric beds

Dear Ms. Frisone and Ms. Halatek:

This letter is brief follow-up to our October 12, 2014 letter, opposing the above-referenced exemption notice and request ("Exemption Request") submitted by Alexander Hospital Investors, LLC ("AHI") and MBHS of North Carolina, LLC ("MBHS"). As set forth in that letter, because this project is being developed by the same parties in the same building at the same time as their recently approved CON application to develop fifteen (15) child/adolescent chemical dependency (substance abuse) treatment beds pursuant to the need determination in the 2014 State Medical Facilities Plan (hereinafter, the "Application"), they must demonstrate the need for the services proposed to be developed in the Exemption Request.

This issue was specifically addressed in a Request for Declaratory Ruling filed in 2010 by Forsyth Memorial Hospital, Inc., d/b/a Forsyth Medical Center ("FMC"). FMC sought permission to relocate a linear accelerator from FMC to Kernersville Medical Center ("KMC"), without a certificate of need. The request followed the approval in 2006 of FMC's CON application to develop the new hospital at KMC. The Request for Declaratory Ruling projected that the new hospital would be complete in 2011.

The Director rejected that request, finding, *inter alia*, that the relocation of a linear accelerator and the provision of radiation oncology services at KMC was a change in the project to develop the new hospital, and therefore a new institutional health service under G.S. 131E-176(16)e., because the KMC CON application had not proposed those services, and because the relocation was proposed to occur during the development of the hospital or within one year thereafter. A copy of the Declaratory Ruling is attached.

Similarly, AHI's and MBHS' Exemption Request is a change in the project approved in the Application, it is a new institutional health service, and may under no circumstance be developed until at least one year after the fifteen (15) child/adolescent chemical dependency (substance abuse) treatment beds have been developed and operational.

For all of these reasons and those set forth in our prior letter, Frye believes that the Exemption Request must be denied.

Very truly yours,

S. Todd Hemphill
Partner

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH SERVICE REGULATION
RALEIGH, NORTH CAROLINA

IN RE: REQUEST FOR DECLARATORY RULING BY FORSYTH MEMORIAL HOSPITAL, INC. DBA FORSYTH MEDICAL CENTER	)	**DECLARATORY RULING**

I, Jeff Horton, as Director of the Division of Health Service Regulation, North Carolina Department of Health and Human Services ("Department" or "Agency"), do hereby issue this Declaratory Ruling pursuant to North Carolina General Statute § 150B-4 and 10A NCAC 14A .0103 under the authority granted me by the Secretary of the Department of Health and Human Services.

Forsyth Memorial Hospital, Inc. d/b/a Forsyth Medical Center ("FMC") has requested a declaratory ruling to allow it to relocate one of its existing linear accelerators from FMC in Winston-Salem to a new medical office building in Kernersville. S. Todd Hemphill of Bode, Call & Stroupe, LLP provided written comments in response to the request for declaratory ruling and said comments were reviewed prior to the issuance of this ruling.

This ruling will be binding upon the Department and the entity requesting it, as long as the material facts stated herein are accurate. This ruling pertains only to the matters referenced herein. Except as provided by N.C.G.S. § 150B-4, the Department expressly reserves the right to make a prospective change in the interpretation of the statutes and regulations at issue in this Declaratory Ruling. Denise M. Gunter of Nelson Mullins Riley & Scarborough LLP has requested this ruling on behalf of FMC and has provided the material facts upon which this ruling is based.

STATEMENT OF THE FACTS

On September 16, 2009, the CON Section approved FMC's replacement equipment exemption request to replace a linear accelerator ("replacement linear accelerator") in Winston-Salem. The replacement linear accelerator was subsequently installed at the hospital. FMC currently has four linear accelerators located on its Winston-Salem campus. FMC has requested a declaratory ruling to allow it to relocate one of its existing linear accelerators from FMC in Winston-Salem to a new medical office building in Kernersville.

ANALYSIS

N.C. Gen. Stat. §131E-181 (a) states *"A certificate of need shall be valid only for the defined scope, physical location, and person named in the application."* The Agency has previously allowed approved applicants to change the physical location named in their application where convenience dictates or the objectives of the CON law are otherwise advanced. However, as addressed below, FMC's proposal to relocate the replacement linear accelerator would constitute a new institutional health service and a change in scope of a previous project.

In 2006, FMC received a CON, pursuant to a settlement agreement, to develop a new hospital in Kernersville (Project I.D. #G-7604-06). Kernersville Medical Center, which was proposed to be operated as a satellite hospital under FMC's license, is expected to be completed in 2011. The CON application included a list of services to be offered and equipment to be purchased as part of the project. FMC did not represent that it would provide radiation therapy services or that it would acquire a linear accelerator as part of the project.

In this declaratory ruling request, FMC is seeking to relocate the replacement linear accelerator to a medical office building on the campus of Kernersville Medical Center. N.C.G.S. 131E-176(2c) defines a "campus" as:

> the adjacent grounds and buildings, or grounds and buildings not separated by more than a public right-of-way, of a health service and related health care entities.

Additionally, G.S 131E-176(16)e defines a "new institutional health service, " in part, as:

> a change in a project that was subject to certificate of need review and for which a certificate of need was issued, if the change is proposed during the development of the project or within one year after the project was completed.

FMC states the replacement linear accelerator will continue to be operated under FMC's license. Relocating the replacement linear accelerator to a medical office building on the campus of Kernersville Medical Center prior to completion of the project is a change in scope of Project I.D. #G-7604-06 and, therefore, is a new institutional health service.

On September 16, 2009, the CON Section approved FMC's replacement equipment exemption request to replace a linear accelerator. The replacement linear accelerator was subsequently installed at the hospital at a cost of $1,742,951.00. In this declaratory ruling request, FMC projects it will cost $1,935,439.00 to relocate the replacement linear accelerator to the medical office building in Kernersville. G.S 131E-176(16)b defines a "new institutional health service," in part, as:

> ...the obligation by any person of a capital expenditure exceeding two million dollars ($2,000,000) to develop or expand a health service or a health service facility, or which relates to the provision of a health service. The cost of any studies, surveys, designs, plans, working drawings, specifications, and other activities, including staff effort and consulting and other services, essential to the acquisition, improvement, expansion, or replacement of any plan or equipment with respect to which and expenditure is made shall be included in determining if the expenditure exceeds two million dollars ($2,000,000).

The cost of the replacement linear accelerator and the proposed cost to relocate the replacement linear accelerator, together, exceed the $2,000,000 threshold, in less than one year after seeking and obtaining the exemption request. Therefore, relocating the replacement linear accelerator constitutes a new institutional health service.

CONCLUSION

For the foregoing reasons, assuming the statements of fact in the request are true, the request of FMC to relocate the replacement linear accelerator from Winston-Salem to Kernersville is denied.

This the 18th day of May, 2010.

Jeff Horton, Director
Division of Health Service Regulation
N.C. Department of Health and Human Services

CERTIFICATE OF SERVICE

I certify that a copy of the foregoing Declaratory Ruling has been served upon the nonagency party by certified mail, return receipt requested, by depositing the copy in an official depository of the United States Postal Service in a first-class, postage pre-paid envelope addressed as follows:

CERTIFIED MAIL

Denise M. Gunter
Nelson Mullins Riley & Scarborough, LLP
380 Knollwood Street, Suite 350
Winston-Salem, NC 27103

This the 18th day of May, 2010.

Patricia Bryant for
Jesse Goodman
Chief Operating Officer

Poyner Spruill LLP

November 12, 2014

S. Todd Hemphill
Partner
D: 919.783.2958
F: 919.783.1075
themphill@poynerspruill.com

VIA HAND DELIVERY
Martha Frisone, Interim Chief
Julie Halatek, Project Analyst
Certificate of Need Section
Division of Health Service Regulation
Department of Health and Human Services
809 Ruggles Drive
Raleigh, NC 27603

RE: October 16, 2014 exemption notice and request by Alexander Hospital Investors, LLC and MBHS of North Carolina, LLC to convert 25 acute care beds to psychiatric beds

Dear Ms. Frisone and Ms. Halatek:

This letter is submitted on behalf of our client, Frye Regional Medical Center, Inc., in Hickory, North Carolina. Frye opposes the above-referenced exemption notice and request ("Exemption Request") submitted by Alexander Hospital Investors, LLC ("AHI") and MBHS of North Carolina, LLC ("MBHS"), for the following reasons.

AHI's and MBHS' Exemption Request seeks to develop a 25-bed psychiatric hospital by renovating space in the former Alexander Community Hospital. AHI and MBHS purport to be able to do this pursuant to G.S. 131E-184(c), which permits the "conversion of existing acute care beds to psychiatric beds" without a CON, so long as certain requirements are met. However, G.S. 131E-184(c) is completely inapplicable in this instance. There are no "existing acute care beds" at the former Alexander Community Hospital. That hospital has been closed since February 2007 and the license to operate the facility has been revoked since January 2009. See Exhibit A, Notice of Revocation of License. It is a building, and no more.[1]

Rather, to the extent that AHI and MBHS have any right to develop a psychiatric hospital, it is contingent upon compliance with: (1) the terms of a settlement agreement between AHI and the Agency related to the revocation of AHI's license to operate Alexander Community Hospital as an acute care facility, as well as (2) applicable CON law provisions. Copies of the original 2009 Settlement Agreement and a 2013 Amendment to the Settlement Agreement are attached as Exhibits B and C.

The Amendment provides that AHI will not be permitted to be licensed to operate a 25-bed psychiatric hospital unless and until AHI or its designee demonstrates:

> *a. A firm commitment to Alexander Hospital or its designee for financing of funds adequate to upfit and operate the acute care beds or psychiatric beds;*

[1] While there is a reference in the SMFP to Alexander Community Hospital, that does not make it an existing facility. The undisputed facts are that its license was revoked and the hospital has not provided any services in over seven years. In addition, AHI has not filed an annual License Renewal Application in years. Without that application, the facility cannot be licensed.

> *b. In the event that Alexander Hospital or its designee chooses to be licensed as a psychiatric hospital, that it has an agreement with Meridian Behavioral Health Systems or another behavioral health provider to be the manager of, or provider for, inpatient psychiatric services; and*
>
> *c. . Compliance with any and all applicable state licensing and federal regulations.*

See Amendment, Exhibit B, p. 2, ¶1.[2] These requirements are essential, given the fact that as of the date of the Amendment, Alexander Community Hospital had been closed and not operating in any capacity for over six years. In addition, Frye was the facility operator from 2002 to 2007, so AHI has not been involved in the operation of an existing acute care facility for at least 12 years. According to the North Carolina Secretary of State's web site, MBHS was not authorized to do business in North Carolina until May 14, 2014, so it appears that it has never been involved in the provision of health care in this State. The Exemption Request contains no information about MBHS' experience providing behavioral health services.

As our Court of Appeals has previously recognized, where the State Department of Health and Human Services and a petitioner have negotiated an agreement which includes the ability to develop a settlement project, the terms of that settlement agreement, if clear, must be enforced as written. *See Carillon Assisted Living, LLC v. N.C. DHHS*, 175 N.C. App. 265, 270-71, 623 S.E.2d 629, 633 (2006). In the instant case, AHI's and MBHS' ability to develop a newly licensed psychiatric hospital is expressly contingent upon and subject to the requirements that AHI or its designee demonstrate compliance with the conditions quoted above, all of which are clearly set forth in the Amendment. Even assuming, *arguendo*, that these conditions could be construed to relate most directly to the licensure of a new psychiatric hospital, the development of the hospital must necessarily precede its licensure. Given the history of the former Alexander Community Hospital and AHI, it is essential that AHI and MBHS demonstrate their ability to meet these conditions in order for their Exemption Request to be approvable.

Nowhere does the Amendment purport to exempt the development of a new psychiatric hospital from applicable requirements of the current CON law. Neither the Settlement Agreement nor the Amendment contains *any* reference to G.S. 131E-184(c). Therefore, in addition to meeting the express conditions of the Amendment, AHI and MBHS must demonstrate conformity with the CON law and obtain the necessary regulatory approvals from the CON Section. This makes sense, as G.S. 131E-184(c) applies only to an existing, operating acute care facility *currently* providing health care services to patients. Where there is an existing facility, the provider has ongoing, operational experience and resources and by virtue of being an existing provider, presumably is in good standing. The Agency rightfully would assume that an existing acute care facility would have adequate funding and expertise to convert acute care beds to psychiatric beds; otherwise, the provider would not seek permission to do so. Conversely, AHI has nothing but an empty building. Its owners have provided no evidence of having either the financial resources or the expertise to operate an acute care or psychiatric hospital. Consequently, the State required AHI to demonstrate adequate funding and expertise to upfit and operate the psychiatric beds proposed. The Agency should not permit AHI and MBHS to develop and operate a licensed psychiatric hospital unless and until they demonstrate that they can comply with these requirements.[3]

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[2] These requirements were also material terms of the original Settlement Agreement. See Exhibit B, p. 10, ¶4.

[3] The capital costs proposed in AHI's and MBHS' CON application for 15 child/adolescent chemical dependency (substance abuse) treatment beds was $2,496,000. While AHI and MBHS were conditionally approved to develop

Contrary to the footnote on page 2 of the Exemption Request, AHI's and MBHS' proposal also is not exempt from CON review pursuant to G.S. 131E-184(g). The sole purpose of the capital expenditure is not, contrary to AHI's and MBHS' assertion, "to renovate the existing hospital," as there is no existing hospital. Rather, the proposal seeks, at best, to convert a former acute care hospital building into a new psychiatric hospital. In fact, the proposed project to establish a new psychiatric hospital in the former Alexander Community Hospital building likely never would have been considered had AHI not been able to amend the Settlement Agreement with the Agency. Otherwise, AHI would have reopened the building as an acute care hospital years ago under the terms of the original Settlement Agreement. AHI's and MBHS' actions are, at the very least, a change in bed capacity and hence a new institutional health service requiring a certificate of need, under G.S. 131E-176(5), (9a) and (16)c, regardless of cost. Therefore, G.S. 131E-184(g) is inapplicable.

Even if G.S. 131E-184(c) were applicable, which Frye firmly disputes, the Exemption Request must be denied because AHI and MBHS cannot demonstrate that they are capable of performing under the purported contract with Smoky Mountain LME/MCO attached to the Exemption Request, which contract is required under G.S. 131E-184(c)(1). Specifically, Section 2.0 of that contract provides, in pertinent part, as follows:

> *Contractor agrees to make up to thirteen (13) beds of inpatient hospitalization available for referrals of LME/MCO adult enrollees dually diagnosed with I/DD and mental health disorders ("dual diagnosed enrollees"). Contractor agrees to make a minimum of twelve (12) beds of facility-based crisis available for referrals of dual diagnosed adult enrollees separate from the Alexander Hospital facility. The Parties agree that LME/MCO will be intricately involved in the development and implementation of processes and procedures governing the operation of each of the facilities and a best practice clinical model for both identified facilities. (Emphasis added.)*

The problem here is that there is no evidence to indicate that AHI and MBHS own, plan to develop or otherwise have access to another adult psychiatric facility to which these enrollees can be referred. Attached as Exhibit D is the current list of all the licensed private psychiatric hospitals in North Carolina from the Department's web site. None is owned by AHI or MBHS. None is even located in the Smoky Mountain Center 2 service area. Because the contract with Smoky Mountain LME/MCO shows on its face that AHI and MBHS cannot perform their obligations under the contract, that contract may not be used to demonstrate conformity with the requirements of G.S. 131E-184(c).

Finally, the Exemption Request should be denied because it proposes services which require a CON in conjunction with AHI's and MBHS' recently approved CON application. In this regard, the building where the psychiatric hospital is proposed is the same building referenced in their recently approved CON application to develop fifteen (15) child/adolescent chemical dependency (substance abuse) treatment beds in a new licensed inpatient facility in Alexander County, pursuant to the need determination in the 2014 State Medical Facilities Plan (hereinafter, the "Application"). According to the contract with Smoky Mountain LME/MCO attached to the Exemption Request, AHI and MBHS intend for the psychiatric beds

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that project, one of the primary conditions was for the applicants to demonstrate the ability to finance that project. Given the fact that the project proposed in the Exemption Request is to develop 25 psychiatric beds and operate a separate psychiatric hospital, those upfit and operation costs likely are going to cost more than the 15-bed child/adolescent chemical dependency (substance abuse) facility.

to be *adult* psychiatric beds, while the Application proposes to provide chemical dependency services to *children and adolescents*. AHI and MBHS have failed to demonstrate or explain how they expect to operate these disparate services on one site.

Under any circumstance, because the two projects are proposed to be developed in the same building at virtually the same time, the costs associated with the two projects should be considered together. In this regard, G.S. 131E-176(16)b. provides as follows:

> *(16) "New institutional health services" means any of the following:*
>
> ...
>
> *b. Except as otherwise provided in G.S. 131E-184(e),[4] the obligation by any person of a capital expenditure exceeding two million dollars ($2,000,000) to develop or expand a health service or a health service facility, or which relates to the provision of a health service. The cost of any studies, surveys, designs, plans, working drawings, specifications, and other activities, including staff effort and consulting and other services, essential to the acquisition, improvement, expansion, or replacement of any plant or equipment with respect to which an expenditure is made shall be included in determining if the expenditure exceeds two million dollars ($2,000,000).*

The Agency has previously interpreted G.S. 131E-176(16)b, in conjunction with G.S. 131E-176(16)e, to mean that whenever an applicant files a CON application to develop a new institutional health service, it must demonstrate the need for all services proposed to be developed at the same time or within a year of completion of the project, even if some of those services would not require a CON if developed outside this time frame.[5] For this reason, the services proposed in the Exemption Request should have been included as part of the Application, and AHI and MBHS must demonstrate both the need for and capital costs of the project. At the very least, AHI and MBHS must demonstrate that all capital costs related to the Exemption Request are totally *unrelated* to the capital costs identified in the Application, before the Exemption Request can be approved. This is impossible, at this point, because the Exemption Request contains no information regarding the space to be renovated, the services proposed in that space, or the capital costs associated with the project.

For all of these reasons, Frye believes that the Exemption Request must be denied.

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[4] Because AHI's and MBHS' request was filed pursuant to G.S. 131E-184(c), this provision is irrelevant.

[5] See, e.g., Exhibit E, pertinent portions of Required State Agency Findings, Project I.D. #G-7980-07 (MPH) and Project I.D. #G-7984-07 (DCH), pp. 6-83 and 149-153, where the Agency found both applicants had failed to demonstrate the need for multiple services which would not in and of themselves be new institutional health services.

Thank you for your consideration of these comments. If you have any questions, please do not hesitate to contact us.

Very truly yours,

S. Todd Hemphill
Partner

North Carolina Department of Health and Human Services
Division of Health Service Regulation
Acute and Home Care Licensure and Certification Section
2712 Mail Service Center v Raleigh, North Carolina 27699-2712

Beverly Eaves Perdue, Governor
Lanier M. Cansler, Secretary
Jeff Horton, Acting Division Director

http://www.ncdhhs.gov/dhsr

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

VIA CERTIFIED MAIL

January 13, 2009

John W. Kessel, MD
Managing Partner
Alexander Hospital Investors, LLC
1985 Startowd Road
Hickory, NC 28682

Re: **Notice of Revocation of License**
HO274

Dr. Kessel:

Based upon our review we conclude the facility has failed to comply with the provisions of Article 5, Part A of Chapter § 131E of the North Carolina General Statutes. Therefore, the Department hereby initiates revocation of your license.

REVOCATION OF LICENSE

The license to operate Alexander Hospital shall be revoked, within ten (10) days from the date of receipt of the notification. The facts upon which the license revocation is based are set out in the letter from our office on January 12, 2007. The January 12, 2007, letter was in response to correspondence of January 03, 2007, informing our office the above hospital was *"voluntarily closing its facility ... effective February 01, 2007"*. Based a review of the agency file, Alexander Hospital has not reported the provision of any patient care services since September 30, 2006.

APPEAL NOTICE

You have the right to contest the above action by filing a petition for a contested case hearing with the Office of Administrative Hearings within **thirty (30)** days of mailing of this letter. For complete instructions on the filing of petitions, please contact the Office of Administrative Hearings at (919) 733-2698. The mailing address for the Office of Administrative Hearings is as follows:

Office of Administrative Hearings
6714 Mail Service Center
Raleigh, North Carolina, 27699-7447

EXHIBIT A

N.C. Gen. Stat. § 150B-23 provides that you must also serve a copy of the petition on all other parties, which includes the Department of Health and Human Services. The Department's representative for such action is Emery E. Milliken, General Counsel. This person may receive service of process by mail at the following address:

Emery E. Milliken
General Counsel Office of Legal Affairs
Adams Building
Room 111
2005 Mail Service Center
Raleigh, NC 27699-2005

If you do not file a petition within the thirty (30) day period, you lose your right to appeal and the action explained in this letter will become effective as described above.

The previously issue license must be returned to this office. We will notify the appropriate agencies by copy of this letter. Should you have any questions regarding any aspect of this letter, please do not hesitate to contact me at the Department of Health and Human Services, Division of Health Service Regulation, Acute and Home Care Licensure and Certification Section, 2712 Mail Service Center, Raleigh, North Carolina 27699-2708 or contact me at (919) 855-4620.

Sincerely,

Azzie Y. Conley, RN
Section Chief for Acute / Home Care
Licensure and Certification Section

FID: 932934

cc: N.C. Blue Cross-Blue Shield
State Employee's Health Plan
N.C. Board of Nursing
John Booker, SCHS, DHHS
Asst. Dir Fin Operations, Division of Medical Assistance
Asst. Dir. Medical Policy, Division of Medical Assistance
Kathy Turner Director of Nurse Aid Registry
DMA, Program Integrity Division
DMA, Provider Services Division
Lee Hoffman, DHSR Certificate of Need Section
Bill Warren, DHSR Construction Section
Jeff Horton, DHSR, Acting Director
Rufus F. Walker, Jr., Attorney
SA File

STATE OF NORTH CAROLINA

COUNTY OF ALEXANDER

IN THE OFFICE OF
ADMINISTRATIVE HEARING
08 DHR 0575

ALEXANDER HOSPITAL INVESTORS, LLC; CHARLES E. TREFZGER, JR., and DAVID S. JONES,	)
Petitioners,	)
v.	)
N.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF HEALTH SERVICE REGULATION, LICENSURE AND CERTIFICATION SECTION,	)
Respondent.	)

SETTLEMENT AGREEMENT

This Settlement Agreement (the "Agreement") is entered into by Alexander Hospital Investors, LLC ("AHI"), Charles E. Trefzger, Jr. ("Trefzger"), David S. Jones ("Jones"), (collectively, "Petitioners") and the North Carolina Department of Health and Human Services, Division of Health Service Regulation, Licensure and Certification Section (the "Agency" or the "Licensure Section") (collectively referred to hereinafter as "the Parties" and individually as "a Party").

RECITALS

WHEREAS, on or about January 16, 2002, AHI executed a Lease Agreement with Frye Regional Medical Center, Inc. (hereinafter, "Frye"), pursuant to which Frye would lease Alexander Hospital ("the Hospital") from AHI for the purpose of operating a licensed hospital in the facility and on the premises owned by AHI. Accordingly, Frye became the "operator" of the Hospital, while AHI remained the "owner," or "landlord," of the hospital facility and premises.

EXHIBIT B

The Lease Agreement between AHI and Frye references AHI as the "Landlord" and Frye as the "Tenant."

WHEREAS, On or about January 16, 2002, Frye submitted to the Licensure and Certification Section a 2002 Hospital License Application, notifying the Licensure and Certification Section of the licensee's change of ownership and seeking, on behalf of Frye, an initial license for Alexander Hospital. The 2002 Hospital License Application (hereinafter, "Frye's 2002 License Application"), which referred to the Hospital as "Frye Regional Medical Center Alexander Campus," indicated that the facility would be licensed as a Critical Access Hospital containing 25 beds. Without Petitioners' permission, Frye's 2002 License Application erroneously failed to reference the additional 31 beds for which Alexander Hospital previously had been licensed.

WHEREAS, On July 12, 2002, the Licensure and Certification Section notified Frye by letter (hereinafter, "the July 2002 Licensure and Certification Section Letter") that it was issuing a "new certificate" effective June 3, 2002, pursuant to North Carolina General Statutes § 131E-75 *et seq.* This "new certificate," according to the July 2002 Licensure and Certification Section Letter, reflected the licensee's change of ownership to Frye Regional Medical Center, d/b/a Frye Regional Medical Center-Alexander Campus, and also reflected a decrease in the number of licensed general acute care beds, from 56 to 25.

WHEREAS, on February 29, 2008, Petitioners filed a Petition for a Contested Case Hearing seeking administrative review of the Agency's decision to reduce Alexander Hospital's license from 56 to 25 general acute care beds. ("Petitioners' Contested Case" or "the Contested Case");

WHEREAS, there are no known intervenors that have an interest in Petitioners' Contested Case;

WHEREAS, pursuant to N.C. Gen. Stat. § 150B-22, it is the policy of the State to settle disputes between State agencies and other persons whenever possible;

WHEREAS, pursuant to this policy, the Parties have discussed settlement of this contested case;

WHEREAS, the execution of this Settlement Agreement does not constitute an admission of error by any Party and does not constitute a concession by any Party regarding any issue in the Contested Case;

WHEREAS, for and in consideration of the mutual promises and agreements contained herein, which the Parties agree constitute good and satisfactory consideration to resolve all issues among the Parties involving the Contested Case, and to resolve other issues, disputes, and potential disputes described herein;

NOW THEREFORE, pursuant to N.C. Gen. Stat. §§ 150B-22 and 31(b), and subject to the approval of the Director of the Division of Health Service Regulation (the "Director"), the Parties agree to resolve this Contested Case in the manner set forth below.

AGREEMENT

1. Petitioners' Voluntary Dismissal with Prejudice. Within five (5) business days after the Director approves this Settlement Agreement, Petitioners shall file a notice of voluntary dismissal ("the Voluntary Dismissal"), with prejudice, in the Office of Administrative Hearings.

2. Reissuing of License. Upon satisfaction of the conditions outlined in Exhibit A attached and incorporated hereto, the Licensure Section shall issue a license for the Hospital, appropriate to the number of beds and type of facility for which all necessary regulatory and

licensure approvals have been obtained.

3. Release. Each Party hereby releases all other Parties, their officials, employees, and representatives, from any and all liability or claims that have arisen or might arise out of this Contested Case.

4. Expenses. The Parties agree that each shall bear its own expenses, including attorneys' fees, and that no claim for such costs or expenses shall be made by one Party against the other.

5. Effect of Approval. If approved by the Director, this Agreement shall resolve all issues involved in, or arising out of, the Contested Case.

6. Effect of Disapproval. If this Agreement is not approved by the Director, it shall be null and void and the Parties shall be entitled to proceed with the Contested Case. In that event, the Director's review of this Agreement as provided herein shall not prejudice his authority to render the final Agency decision following the hearing in this matter in accordance with Article 3 of Chapter 150B of the North Carolina General Statutes. In addition, if this Agreement is not approved by the Director, the Parties agree that it shall be inadmissible at the contested case hearing for any purpose.

7. Material Compliance Determinations Regarding Petitioners. Any and all determinations concerning whether Petitioners are making good faith efforts to meet all conditions outlined in Exhibit A, are within the discretion of the Agency and shall be clearly communicated to Petitioners with enough notice such that Petitioners will have an opportunity to cure or correct any insufficiencies or non-conformities. In the event the Agency should make any such determinations that are adverse to Petitioners, nothing in this Settlement Agreement shall prejudice any rights that may exist for Petitioners to appeal any such determinations.

8. Waiver of Right to Appeal Agreement. Except as set forth in paragraph 7, above, the Parties irrevocably waive any right to initiate an appeal from this Agreement, assuming that any such right exists; provided that nothing in this Agreement shall be construed to waive any claim for enforcement or breach of this Agreement. The Parties reserve the right to intervene in any appeal of this Agreement that might be filed by any third parties.

9. Merger. The Parties further agree and acknowledge that this written Agreement and the exhibits attached hereto, sets forth all of the terms and conditions among all of them concerning the subject matter of this Agreement, superseding all prior oral and written statements and representations, and that there are no terms and conditions among the Parties, except as specifically set forth in this Agreement and the exhibits attached hereto.

10. Modification or Waiver. No modification or waiver of any provision of this Agreement shall be effective unless it is in writing. Any modification or waiver must be signed by authorized representatives of the Parties and must be adopted and approved by the Director.

11. No Strict Interpretation Against Drafter. Each of the Parties has participated in the drafting of this Agreement and has had the opportunity to consult with counsel concerning its terms. This Agreement shall not be interpreted strictly against any one Party on the ground that it drafted the Agreement.

12. Recitals and Headings. All parts and provisions of this Agreement, including the recitals and paragraph headings, are intended to be material parts of the Agreement.

13. Authority to Settle. The undersigned represent and warrant that they are authorized to enter into this Agreement on behalf of the Parties to this Agreement.

14. *Ex Parte* Presentation. Petitioners authorize counsel for the Agency to present this Agreement to the Director, *ex parte*.

15. Effective Date. This Agreement shall be effective as of the day and year on which it is adopted and approved by the Director of the Division of Health Service Regulation.

16. Binding Effect. This Agreement shall be binding upon and inure to the benefit of the Parties hereto and their respective legal representatives, successors, and assigns.

IN WITNESS WHEREOF, the Parties have executed two originals of this Settlement Agreement, with one original copy being retained by each Party.

ALEXANDER HOSPITAL INVESTORS, INC.

SEE ATTACHED SIGNATURE PAGE

R. Norman McDonald, Manager — Date

Charles E. Trefzger, Jr. — 2/9/09 — Date

David S. Jones — 2/9/09 — Date

K&L GATES, LLP

By: Gina L. Bertolini — 02/12/2009 — Date

Gary S. Qualls
Gina L. Bertolini
430 Davis Drive, Suite 400
Morrisville, NC 27560
Telephone: (919) 466-1182

ATTORNEYS FOR Petitioners

ALEXANDER HOSPITAL INVESTORS, INC.

R. Norman McDonald, Manager — Date 02/04/09

SEE ATTACHED SIGNATURE PAGE

Charles E. Trefzger, Jr. — Date

SEE ATTACHED SIGNATURE PAGE

David S. Jones — Date

K&L GATES, LLP

By: See attached signature page — Date

Gary S. Qualls
Gina L. Bertolini
430 Davis Drive, Suite 400
Morrisville, NC 27560
Telephone: (919) 466-1182

ATTORNEYS FOR Petitioners

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF HEALTH SERVICE REGULATION, LICENSURE AND CERTIFICATION SECTION

By: _____ Date: 2/16/2009
Azzie Conley, Chief

ROY COOPER
Attorney General

By: _____ Date: 2/16/09
Juanita Twyford
Assistant Attorney General
N.C. Department of Justice
P.O. Box 629
Raleigh, NC 27602-0629

COUNSEL FOR THE NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF HEALTH SERVICE REGULATION, LICENSURE AND CERTIFICATION SECTION

APPROVAL AND ADOPTION

The foregoing Settlement Agreement is hereby APPROVED AND ADOPTED this the 17th day of February, 2009.

Jeff Horton, Acting Director
Division of Health Service Regulation

EXHIBIT A

Conditions

1. Petitioners have sought regulatory approval of phase I of renovations and will seek regulatory approval for the additional renovation and reconstruction that will enable the opening of inpatient psychiatric beds at the Hospital.

2. Petitioners have applied for the Hospital's license renewal for 2009.

3. The Licensure Section will issue a Notice of Revocation of License to operate Alexander Hospital, and Petitioners will appeal such action ("the Licensure Appeal").

4. In the context of settling the Licensure Appeal, Petitioners will demonstrate:

   a) a firm commitment for financing of funds adequate to upfit and operate the hospital facility;

   b) an agreement from Horizon Health or another behavioral health provider for the provision of inpatient psychiatric services;

   c) CON approval for additional health service facility beds for the Hospital, not to exceed 50; and

   d) compliance with state licensing and federal regulations consistent with the timelines approved pursuant to Condition 4(c), above.

5. Upon satisfaction of the foregoing conditions, the Licensure Section shall issue a license to the Hospital, including the beds described in Condition 4, above.

STATE OF NORTH CAROLINA

COUNTY OF ALEXANDER

IN THE OFFICE OF
ADMINISTRATIVE HEARINGS
08 DHR 0575

ALEXANDER HOSPITAL INVESTORS, LLC, CHARLES E. TREFZGER, JR., and DAVID S. JONES,	)
Petitioners,	)
v.	)
N.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF HEALTH SERVICE REGULATION, LICENSURE AND CERTIFICATION SECTION,	)
Respondent.	)

AMENDMENT TO SETTLEMENT AGREEMENT

THIS AMENDMENT TO SETTLEMENT AGREEMENT (the "Amendment") is hereby entered into by and between Alexander Hospital Investors, LLC ("Alexander Hospital"); Charles E. Trefzger, Jr.; and David S. Jones ("Petitioners") and the North Carolina Department of Health and Human Services, Division of Health Service Regulation, Licensure and Certification Section (the "Agency" or the "Licensure Section") (collectively referred to as "the Parties").

RECITALS

WHEREAS, Petitioners and the Agency entered into the Settlement Agreement, approved and adopted by the Director of the Division of Health Service Regulation on February 17, 2009 (the "Settlement Agreement"), to resolve all issues between the parties arising out of the above-captioned contested case appeal and to resolve other issues, disputes, and potential disputes described in in the Settlement Agreement;

EXHIBIT C

WHEREAS, Exhibit A to the Settlement Agreement provided that Alexander Hospital will be issued a license upon satisfaction of certain conditions;

WHEREAS, the parties execute this Amendment to clarify the terms under which a license will be issued to Alexander Hospital;

WHEREAS, Alexander Hospital is an existing acute care hospital licensed for 25 acute care beds;

STATEMENT OF AGREEMENT

NOW THEREFORE, pursuant to N.C. Gen. Stat. §§150B-22 and 31(b), and subject to the approval of the Director of the Division of Health Service Regulation (the "Director"), the parties agree to amend the Settlement Agreement in the manner set forth below.

1. License. Upon satisfaction of the conditions outlined below, the Licensure Section shall issue (i) an acute care hospital license for 25 beds, or (ii) a psychiatric hospital license for 25 beds, to Alexander Hospital or its designee. Alexander Hospital or its designee shall determine whether to seek an acute care or psychiatric hospital license. Prior to issuance of the license, Petitioners shall demonstrate:
   a. A firm commitment to Alexander Hospital or its designee for financing of funds adequate to upfit and operate the acute care beds or psychiatric beds;
   b. In the event that Alexander Hospital or its designee chooses to be licensed as a psychiatric hospital, that it has an agreement with Meridian Behavioral Health Systems or another behavioral health provider to be the manager of, or provider for, inpatient psychiatric services; and
   c. Compliance with any and all applicable state licensing and federal regulations.
2. Release. Each Party hereby releases all other Parties, their officials, employees, and

representatives, from any and all liability or claims that have arisen or might arise out of this Contested Case.

3. Expenses. The Parties agree that each shall bear its own expenses, including attorneys' fees, and that no claim for such costs or expenses shall be made by one Party against the other.

4. Merger. The Parties further agree and acknowledge that the Settlement Agreement, and the exhibits attached thereto, and this written Amendment, sets forth all of the terms and conditions among all of them concerning the subject matter of the Settlement Agreement and this Amendment,

5. Amendment Modifies Settlement Agreement. The Parties further agree and acknowledge that this Amendment modifies the Settlement Agreement and all prior oral and written statements and representations only to the extent that the provisions herein differ from those in the Settlement Agreement. Where the terms in the Amendment differ from those in the Settlement Agreement, the parties agree that the terms of the Amendment control. Further, the parties agree that there are no terms and conditions among the Parties regarding the licensure of Alexander Hospital, except as specifically set forth in the Settlement Agreement and in this Amendment.

6. Modification or Waiver. No modification or waiver of any provision of this Amendment shall be effective unless it is in writing. Any modification or waiver must be signed by authorized representatives of the Parties and must be adopted and approved by the Director.

7. No Strict Interpretation Against Drafter. Each of the Parties has participated in the drafting of this Amendment and has had the opportunity to consult with counsel

concerning its terms. This Amendment shall not be interpreted strictly against any one Party on the ground that it drafted the Amendment.

8. Recitals and Headings. All parts and provisions of this Amendment, including the recitals and paragraph headings, are intended to be material parts of the Amendment.

9. Authority to Settle. The undersigned represent and warrant that they are authorized to enter into this Amendment on behalf of the Parties to this Amendment.

10. *Ex Parte* Presentation. Petitioners authorize counsel for the Agency to present this Amendment to the Director, *ex parte.*

11. Effective Date. This Amendment shall be effective as of the day and year on which it is adopted and approved by the Director of the Division of Health Service Regulation.

12. Binding Effect. This Amendment shall be binding upon and inure to the benefit of the Parties hereto and their respective legal representatives, successors, and assigns.

IN WITNESS WHEREOF, the Parties have executed two originals of this Amendment to Settlement Agreement, with one original copy being retained by each Party.

[Remainder of page intentionally left blank]

ALEXANDER HOSPITAL INVESTORS, LLC.

Charles E. Trefzger, Jr., — Date: 11/13/13

CHARLES E. TREFZGER, JR.

Charles E. Trefzger, Jr. — Date: 11/13/13

DAVID S. JONES

David S. Jones — Date: 11/13/13

K&L GATES, LLP

By: _____ — Date: 11/14/13

Gary S. Qualls
Susan K. Hackney
430 Davis Drive, Suite 400
Morrisville, NC 27560
Telephone: (919) 466-1182

ATTORNEYS FOR PETITIONERS

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF HEALTH SERVICE REGULATION, LICENSURE AND CERTIFICATION SECTION

By: _____ Date: 11/15/2013
Azzie Conley, Chief

ROY COOPER
Attorney General

By: _____ Date: 11/14/2013
June Ferrell
Special Deputy Attorney General
N.C. Department of Justice
P.O. Box 629
Raleigh, NC 27602-0629

COUNSEL FOR THE NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF HEALTH SERVICE REGULATION, LICENSURE AND CERTIFICATION SECTION

APPROVAL AND ADOPTION

The foregoing Amendment to Settlement Agreement is hereby APPROVED AND ADOPTED this the 15th day of November, 2013.

Drexdal Pratt, Director
Division of Health Service Regulation

Licensed by the State of North Carolina
Department of Health and Human Services - Division of Health Service Regulation
As of 10/2014

Brynn Marr Hospital
192 Village Dr; Jacksonville, NC 28546
County: ONSLOW Phone: (910)577-1400
Licensee: Brynn Marr Hospital, Inc.
License No: MHH0190

Fellowship Hall
P O Box 13890; Greensboro, NC 27415
County: GUILFORD Phone: (336)621-3381
Licensee: Fellowship Hall, Inc.
License No: MHH0001

Good Hope Hospital, Inc
P. O. Box 639; Erwin, NC 28339-
County: HARNETT Phone: (910)230-4011
Licensee: Good Hope Hospital, Inc
License No: MHH0974

Holly Hill Hospital, L.L.C.
3019 Falstaff Rd; Raleigh, NC 27610-1899
County: WAKE Phone: (919)250-7000
Licensee: Holly Hill Hospital, LLC
License No: MHH0113

Old Vineyard Youth Services
3637 Old Vineyard Road; Winston Salem, NC 27104
County: FORSYTH Phone: (336)794-3550
Licensee: Keystone WSNC, L.L.C.
License No: MHH0188

Strategic Behavioral Center-Garner
3200 Waterfield Road; Garner, NC 27529-
County: WAKE Phone: (919)800-4400
Licensee: SBH-Raleigh, LLC
License No: MHH0973

Strategic Behavioral Center-Leland
2050 Mercantile Drive; Leland, NC 28451-
County: BRUNSWICK Phone: (910)371-2500
Licensee: SBH-Wilmington, LLC
License No: MHH0976

The Wilmington Treatment Center, Inc.
2520 Troy Dr; Wilmington, NC 28401
County: NEW HANOVER Phone: (910)762-2727
Licensee: Wilmington Treatment Center, Inc.
License No: MHH0961

UNC Hospitals at WakeBrook
110 Manning Drive; Chapel Hill, NC 27514-
County: WAKE Phone: ( ) -
Licensee: UNC Hospitals
License No: MHH0975

Veritas Collaborative, LLC
615 Douglas Street; Durham, NC 27705-
County: DURHAM Phone: (919)597-0296
Licensee: Veritas Collaborative, LLC
License No: MHH0972

Total number of facilities: 10

EXHIBIT D

ATTACHMENT - REQUIRED STATE AGENCY FINDINGS

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

DECISION DATE:	February 27, 2008
FINDINGS DATE:	March 5, 2008
TEAM LEADER:	Martha J. Frisone
CHIEF:	Lee B. Hoffman
PROJECT I.D. NUMBERS:	G-7980-07/ Novant Health, Inc. and Medical Park Hospital (MPH)/ Construct new facility for Medical Park Hospital in Clemmons, to include 22 acute care beds and 5 operating rooms relocated from Medical Park Hospital and 28 acute care beds relocated from Forsyth Medical Center/ Forsyth County
	G-7984-07/ North Carolina Baptist Hospital and Davie County Emergency Health Corporation d/b/a Davie County Hospital (DCH)/ Relocate existing hospital from Mocksville to Bermuda Run/ Davie 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 –MPH
NC –DCH

Novant Health, Inc. (Novant) and Medical Park Hospital, Inc. d/b/a Medical Park Hospital (MPH) propose to construct a new facility in Clemmons for MPH (MPH-Clemmons), which is currently located in Winston-Salem. The new facility would include 22 acute care beds and five operating rooms (ORs)

EXHIBIT E

relocated from the existing MPH and 28 acute care beds relocated from Forsyth Medical Center (FMC). Seven of the 13 existing ORs currently licensed at MPH would remain at the existing site in Winston-Salem (MPH-Winston-Salem) and continue to be licensed as part of MPH (i.e., MPH would have two campuses on the same license). Also, it should be noted that, pursuant to the certificate of need issued for Project I.D. #G-7604-06, Novant was previously authorized to relocate one of the 13 ORs at MPH to the Kernersville campus of FMC. Thus, upon completion of Project I.D. #G-7604-06, MPH would be licensed for only 12 shared ORs [13 – 1 = 2]. Novant owns both MPH and FMC and the existing hospitals are located across the street from each other. In summary, upon completion of this project and Project I.D. #G-7604-06, MPH would be licensed for 50 general acute care beds [22 + 28 = 50] and 5 shared ORs on the campus in Clemmons and 7 dedicated outpatient ORs on the campus in Winston-Salem.

The proposal does not result in an increase in the number of general acute care beds, ORs or GI endoscopy rooms located in Forsyth County. Further, the applicants do not propose to acquire any medical equipment for which there is a need determination in the 2007 State Medical Facilities Plan (2007 SMFP). Therefore, there are no need determinations applicable to the review of the proposed project.

However, because the applicants propose to construct space to replace 50 existing acute care beds, Policy AC-5 is applicable to the review. POLICY AC-5: REPLACEMENT OF ACUTE CARE BED CAPACITY states

> *"Proposals for either partial or total replacement of acute care beds (i.e., construction of new space for existing acute care beds) shall be evaluated against the utilization of the total number of acute care beds in the applicant's hospital in relation to the utilization targets found below. In determining utilization of acute care beds, only acute care bed 'days of care' shall be counted. Any hospital proposing replacement of acute care beds must clearly demonstrate the need for maintaining the acute care bed capacity proposed within the application.*

Facility Average Daily Census	*Target Occupancy of Licensed Acute Care Beds (Percent)*
1 – 99	*66.7%*
100 – 200	*71.4%*
Greater than 200	*75.2%*

In Section III.1, page 81, Section IV.1, pages 123-125, and Exhibit 5, Table 59, the applicants provide historical and projected utilization of the general acute care beds at MPH and FMC, as illustrated in the following table.

YEAR	# OF ACUTE CARE PATIENT DAYS (including ICU)	AVERAGE DAILY CENSUS (ADC)	TOTAL # OF LICENSED ACUTE CARE BEDS	% OCCUPANCY
MPH				
7/1/06 – 6/30/07 (actual) [1]	5,759	15.8	136	11.6%
7/1/11 – 6/30/12 (projected) (Year One)	10,506	28.8	50	57.6%
7/1/12 – 6/30/13 (projected) (Year Two)	11,511	31.5	50	63.0%
7/1/13 – 6/30/14 (projected) (Year Three)	12,548	34.4	50	68.8%
FMC (including the Kernersville campus)				
7/1/06 – 6/30/07 (actual)	212,913	583.3	637	91.6%
7/1/11 – 6/30/12 (projected) (Year One)	221,233	606.1	762	79.5%
7/1/12 – 6/30/13 (projected) (Year Two)	222,958	610.8	762	80.2%
7/1/13 – 6/30/14 (projected) (Year Three)	224,660	615.5	762	80.8%

[1] As of 6/30/07, MPH was licensed for 136 general acute care beds and FMC was licensed for 637 general acute care beds. Effective 11/13/2007, 114 general acute care beds were transferred from MPH to FMC pursuant to the certificate of need issued for Project I.D. #G-7011-04. Thus, MPH is currently licensed for 22 general acute care beds and FMC is currently licensed for 751 general acute care beds.

As shown in the above table, MPH's average daily census (ADC) was 15.8 patients in FY 2007 and the projected ADC during the third operating year of the project is 34.4 patients. Thus, the target occupancy rate for MPH is 66.7%. During the third operating year, the applicants project that the acute care occupancy rate at MPH would be 68.8%, which is greater than the target. Further, FMC's ADC was 583.3 patients in FY 2007 and the projected ADC during the third operating year of the project is 615.5 patients. Thus, the target occupancy rate for FMC is 75.2%. During the third operating year, the applicants project that the occupancy rate would be 80.8%, which is greater than the target. In the Impact Analysis in Exhibit 5, the applicants state they used federal fiscal year (FFY) 2006 actual acute care utilization data as the base year. They assumed that acute care utilization would increase at the same rate as the population of the service area is expected to increase. The projections were then adjusted to match

the project years, which are a different fiscal year (7/1 to 6/30 instead of 10/1 to 9/30). See Criterion (3) for analysis of acute care utilization. The applicants adequately demonstrate the need to maintain the acute care bed capacity proposed in the application. Therefore, the applicants adequately demonstrate that the proposal is consistent with Policy AC-5 in the 2007 SMFP. Consequently, the application is conforming to this criterion.

North Carolina Baptist Hospital and Davie County Emergency Health Corporation d/b/a Davie County Hospital (DCH) propose to relocate DCH from Mocksville to Bermuda Run. The hospital is currently licensed for 81 general acute care beds. However, the hospital is designated as a critical access hospital and operates a maximum of only 25 general acute care beds. In addition, DCH is designated as a swing bed hospital. Further, the hospital is currently licensed for two shared operating rooms (ORs) and one gastrointestinal (GI) endoscopy room. The applicants propose to develop 43 general acute care beds, 38 long-term care hospital (LTCH) beds, three shared ORs and one GI endoscopy room in the replacement hospital.

The proposal does not result in an increase in the number of general acute care beds or GI endoscopy rooms located in Davie County. Further, the applicants do not propose to acquire any medical equipment for which there is a need determination in the 2007 State Medical Facilities Plan (2007 SMFP). Although the proposal would result in the development of 38 new LTCH beds, the 2007 SMFP does not include a need methodology or need determination for LTCH beds. Consequently, the 2007 SMFP is not applicable with regard to development of LTCH beds. However, the applicants also propose the development of one new shared OR. The applicants do not state that the proposed third OR would be a dedicated C-section OR. Because, the 2007 SMFP states that there is no need for any additional ORs in Davie County, the proposal is not consistent with the need determination for operating rooms in the 2007 SMFP. See Table 6C on page 65 of the 2007 SMFP.

Further, because the applicants propose to construct space to replace 43 general acute care beds, Policy AC-5 is applicable to the review. POLICY AC-5: REPLACEMENT OF ACUTE CARE BED CAPACITY states

"Proposals for either partial or total replacement of acute care beds (i.e., construction of new space for existing acute care beds) shall be evaluated against the utilization of the total number of acute care beds in the applicant's hospital in relation to the utilization targets found below. In determining utilization of acute care beds, only acute care bed 'days of care' shall be counted. Any hospital proposing replacement of acute care beds must clearly demonstrate the need for maintaining the acute care bed capacity proposed within the application.

Facility Average Daily Census	*Target Occupancy of Licensed Acute Care Beds (Percent)*
1 – 99	*66.7%*
100 – 200	*71.4%*
Greater than 200	*75.2%*

In Exhibit 25, the applicants provide historical and projected utilization of the general acute care beds at DCH, as illustrated in the following table.

YEAR	# OF ACUTE CARE PATIENT DAYS	AVERAGE DAILY CENSUS (ADC)	TOTAL # OF LICENSED ACUTE CARE BEDS	% OCCUPANCY
6/1/04 – 5/31/05 (actual)	2,462	6.7	81	8.3%
6/1/05 – 5/31/06 (actual)	3,234	8.9	81	11.0%
6/1/06 – 5/31/07 (actual)	3,095	8.5	81	10.5%
6/1/07 – 5/31/08 (projected)	3,843	10.5	81	13.0%
6/1/08 – 5/31/09 (projected)	3,843	10.5	81	13.0%
6/1/09 – 5/31/10 (projected)	3,843	10.5	81	13.0%
6/1/10 – 12/31/10 (projected) (six months)	1,922	10.5	81	13.0%
1/1/11 – 12/31/11 (projected) (Year One)	7,464	20.4	43	47.4%
1/1/12 – 12/31/12 (projected) (Year Two)	8,867	24.3	43	56.5%
1/1/13 – 12/31/13 (projected) (Year Three)	10,958	30.0	43	69.8%

As shown in the above table, DCH's current average daily census (ADC) is 8.5 patients and its projected ADC during the third operating year of the project is 30.0 patients. Thus, the target occupancy rate for DCH is 66.7%. During the third operating year, the applicants project that the occupancy rate would be 69.8%, which is greater than the target. However, projected utilization is overstated and is not based on reasonable and supported assumptions. See Criterion (3) for discussion. Therefore, the applicants did not adequately demonstrate that utilization of the 43 licensed general acute care beds at DCH is reasonably projected to be 66.7% or greater. Consequently, the

applicants did not adequately demonstrate the need to construct new space to replace 43 existing general acute care beds. As a result, the application is not consistent with Policy AC-5 in the 2007 SMFP.

In summary, the application is not conforming to the need determination in the 2007 SMFP for new ORs and is not consistent with Policy AC-5 in the 2007 SMFP. Therefore, the application is nonconforming with 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.

NC – MPH
NC – DCH

MPH proposes to construct a new facility in Clemmons for MPH, which is currently located in Winston-Salem. The new facility in Clemmons would include 22 acute care beds and five existing ORs relocated from MPH in Winston-Salem and 28 acute care beds relocated from FMC. Seven existing ORs currently licensed at MPH would remain at the existing site in Winston-Salem and continue to be licensed as part of MPH (i.e., MPH would have two campuses on the same license). In Section VI.10, page 152, the applicants describe the proposed changes in the services provided by MPH as follows

"the scope of services currently provided at Medical Park Hospital in Winston-Salem is focused on a facility that functions as a surgical specialty hospital providing inpatient and outpatient surgical care supported by the necessary surgical ancillary services such as a surgical pathology lab, and basic imaging, pharmacy, and lab services. In its current location, MPH does not provide emergency department services, multi-modality imaging, or intensive care services. ... The applicant expects that ... the scope of services will change to that of a full-service community hospital with an emergency department, ICU, medical

inpatients, and full-service radiology, lab, and pharmacy on site."

Further, in Section VI.12, page 155, the applicants state

"MPH-Clemmons will offer services that are not currently offered at MPH due to its configuration as a surgical specialty hospital."

The following table compares the beds, medical equipment and services currently authorized at MPH with those to be offered at the proposed new facility.

BEDS/EQUIPMENT/SERVICES	CURRENT	PROPOSED	DIFFERENCE
General Acute Care Beds			
Medical-Surgical	22	46	24
Intensive Care Unit	0	4	4
Total Acute Care Beds [1]	22	50	28
Unlicensed Observation Beds	0	6	6
Operating Rooms (ORs) [2]			
Shared ORs	12	5	(7)
Dedicated Outpatient ORs	0	7	7
Total ORs	12	12	0
Minor Procedure Room	1	1	0
Emergency Services (number of treatment rooms) [3]	0	12	12
CT scanner	0	1	1
Fixed Radiographic & Fluoroscopic (R/F) X-ray units	1	3	2
Nuclear Medicine Camera (no coincidence circuitry)	0	1	1
Ultrasound (US) units	0	1	1
Mammography units	0	1	1
Laboratory Services [4]	yes	yes	expanded
Pharmacy Services [4]	yes	yes	expanded
Respiratory Therapy Services	no	yes	yes
Physical and Speech Therapy Services	no	yes	yes

(1) The 28 additional acute care beds to be added to MPH's licensed capacity are existing acute care beds to be relocated from FMC.

(2) MPH is currently licensed for 13 shared ORs. However, Novant is authorized to relocate one existing shared OR to the Kernersville campus of FMC, which is expected to take place before development of this project is complete.

(3) MPH does not currently operate an emergency department.

(4) In Section VII.2, page 160, the applicants state that "full service" laboratory and pharmacy services are not currently provided at MPH. The proposed new facility in Clemmons will provide "full service" laboratory and pharmacy services.

As shown in the above table, new services to be provided at the proposed new facility in Clemmons include:

- 4 new intensive care unit beds
- 6 new unlicensed observation beds [Note: In a footnote on page 18, the applicants state that MPH was "approved" to operate 25-30

observation beds as part of Project I.D. #G-7011-04. However, in Project I.D. #G-7011-04, the applicants proposed to relocate 114 existing general acute care beds from MPH to FMC. Although that application mentions the possibility of developing 25-30 unlicensed observation beds at MPH, the CON Section did not review a proposal to develop 25-30 unlicensed observation beds at MPH as part of Project I.D. #G-7011-04, and thus, did not authorize the development of 25-30 unlicensed observation beds at MPH. Further, in its 2008 Hospital License Renewal Application, MPH reports that it has no unlicensed observation beds.]

- emergency services
- 1 new CT scanner
- 2 new X-ray units
- 1 new nuclear medicine camera
- 1 new ultrasound unit
- 1 new mammography unit
- respiratory therapy services
- physical and speech therapy services

Thus, the scope of services to be provided at the new facility in Clemmons will be significantly different from the scope of services currently provided at the existing facility in Winston-Salem. Additionally, the population to be served by the proposed new facility in Clemmons will be significantly different from the population currently served at MPH because MPH does not currently serve a significant number of patients from the proposed service area. Specifically, in a footnote in Section III.8(c), page 119, the applicants state

> *"The majority of inpatient days at MPH currently are from locations other than the proposed five zip code service area. Once* [sic] *MPH acute inpatient unit at South Hawthorne Road* [Winston-Salem] *is closed it is anticipated that this volume will shift to FMC."*

Thus, the majority of inpatient days currently provided at MPH will not be shifted to the new MPH facility in Clemmons, but to FMC instead.

Population to be Served

The following table illustrates the current patient origin for acute care services provided by MPH between July 1, 2006 and June 30, 2007, as reported by the applicants in Section III.4(a), page 111.

COUNTY	% OF TOTAL INPATIENT ADMISSIONS
Forsyth	54.2%
Surry	8.6%
Yadkin	7.9%
Stokes	6.9%
Davidson	6.5%
Davie	5.1%
Wilkes	3.7%
Guilford	1.6%
All Other	5.5%
Total	100.0%

As shown in the above table, during FY 2007, 54.2% of MPH's acute care patients (i.e., inpatients) were residents of Forsyth County and 5.1% were residents of Davie County.

The following table illustrates the current patient origin for surgical services (inpatients and outpatients) provided by MPH between July 1, 2006 and June 30, 2007, as reported by the applicants in Section III.4(a), page 112.

COUNTY	% OF TOTAL SURGICAL CASES	
	INPATIENTS	OUTPATIENTS
Forsyth	55.0%	55.4%
Stokes	7.0%	8.0%
Davie	5.6%	7.2%
Surry	6.7%	6.9%
Yadkin	7.4%	6.4%
Davidson	6.6%	5.5%
Guilford	1.8%	2.4%
Wilkes	3.7%	2.1%
All Other	9.9%	6.1%
Total [1]	103.7%	100.0%

[1] The Project Analyst is unable to determine why the percentages for inpatient surgical cases adds up to more than 100%.

As shown in the above table, during FY 2007, approximately 55% of MPH's surgical patients were residents of Forsyth County, 5.6% of MPH's inpatient surgical patients were residents of Davie

County and 7.2% of MPH's outpatient surgical patients were residents of Davie County.

In Section III.5(a), pages 112-113, the applicants describe the proposed service area for the new facility as follows:

> *"The proposed service area for MPH-Clemmons includes five zip codes. Two zip codes in Forsyth County: 27012 and 27023, and three zip codes in Davie County: 27006, 27018, and 27028. Zip code 27014 is a Post Office Box in Cooleemee in Davie County, which is embedded geographically in the zip code for Mocksville, 27028."*

[Note: there are only three zip codes in Davie County. Therefore, the proposed service area includes all of Davie County.] In Section III.1(b), page 83, the applicants state

> *"While not part of the defined service area, MPH-Clemmons recognizes that patients from other North Carolina counties may choose to travel across service areas to receive services at MPH-Clemmons. As a result, 10% of the total projected utilization in each of the project years has been allocated to the category of 'Other Inmigration.' Other inmigration is expected to come from surrounding zip codes in Forsyth County and the surrounding counties, Iredell and Yadkin. In calendar year 2006 residents of Iredell and Yadkin Counties alone represented over 7% of inpatient volume at MPH as reflected in Exhibit 5, Table 15."*

The applicants states that ten percent of MPH's patients are proposed to be residents of "surrounding" zip codes in Forsyth County and residents of Iredell and Yadkin counties. Thus, the proposed service area for the new facility consists of Davie, Yadkin and Iredell counties, and zip codes in the western portion of Forsyth County. The following tables illustrate projected patient origin by service during the second operating year for the proposed new facility, as reported by the applicants in Section III.5(c), page 114-115.

ACUTE CARE SERVICES

ZIP CODE/COUNTY	# OF PATIENT DAYS	% OF TOTAL PATIENT DAYS
27012 / Forsyth	3,756	32.6%
27023 / Forsyth	1,365	11.9%
27006 / Davie	2,243	19.5%
27014 / Davie	142	1.2%
27028 / Davie	2,853	24.8%
Other Inmigration	1,151	10.0%
Total	11,511	100.0%

INPATIENT SURGICAL SERVICES

ZIP CODE/COUNTY	# OF INPATIENT SURGICAL CASES	% OF TOTAL INPATIENT SURGICAL CASES
27012 / Forsyth	249	29.8%
27023 / Forsyth	114	13.6%
27006 / Davie	155	18.6%
27014 / Davie	13	1.5%
27028 / Davie	220	26.4%
Other Inmigration	83	10.0%
Total	833	100.0%

OUTPATIENT SURGICAL SERVICES

ZIP CODE/COUNTY	# OF OUTPATIENT SURGICAL CASES	% OF TOTAL OUTPATIENT SURGICAL CASES
27012 / Forsyth	1,030	30.1%
27023 / Forsyth	471	13.8%
27006 / Davie	692	20.2%
27014 / Davie	35	1.0%
27028 / Davie	851	24.9%
Other Inmigration	342	10.0%
Total	3,422	100.0%

OUTPATIENT SERVICES (EXCLUDING SURGICAL)

ZIP CODE/COUNTY	# OF PROCEDURES	% OF TOTAL PROCEDURES
27012 / Forsyth	5,745	42.0%
27023 / Forsyth	1,025	7.5%
27006 / Davie	3,396	24.8%
27028 / Davie	2,152	15.7%
Other Inmigration	1,369	10.0%
Total	13,686	100.0%

EMERGENCY SERVICES

ZIP CODE/COUNTY	# OF VISITS	% OF TOTAL VISITS
27012 / Forsyth	6,009	44.6%
27023 / Forsyth	1,183	8.8%
27006 / Davie	3,229	24.0%
27028 / Davie	1,696	12.6%
Other Inmigration	1,346	10.0%
Total	13,464	100.0%

The applicants adequately identified the population proposed to be served.

Need for New Building

In Section II.1, page 18, the applicants state

> *"MPH opened 36 years ago. ... MPH's existing facility is outdated in several crucial facility and campus elements as detailed in the response to Question II.5 below. Something must be done to address the MPH facility infrastructure so that MPH, the MPH medical staff, and the MPH employees will be able to continue to enjoy the confidence of and stellar satisfaction ratings from the patients and the families that they care for each day."*

However, in this project, the applicants do not propose any modifications to the existing facility for the patients and medical staff that will continue to use it for surgical services. Rather, in Section II.9, page 60, the applicants state

> *"Novant Health will continue the ongoing process of determining future use of the remaining ORs and the vacated space at MPH. As the planning process continues, the remaining operating rooms will be operated as a hospital based outpatient surgical center. Several other opportunities under consideration include:*
>
> - *Using the vacated space for outpatient or non-acute care services. This could be accomplished at limited expense or additional investment as MPH received a "face lift" in Spring 2007, making it visibly more attractive and patient friendly.*

- *Renovating the existing MPH Hawthorne Rd. OR suite and developing larger surgical support space. This would result in seven larger, more modern and versatile operating rooms at MPH-Hawthorne Rd. campus and address the problem of lack of storage space in the surgical suite.*
- *Seeking CON approval to convert the remaining seven operating rooms to a freestanding ambulatory surgery center.*
- *Development of new outpatient services or relocation of existing FMC outpatient services.*
- *Use space at MPH for NHTR administrative services.*

However, no determination has been made at this point. Discussions between the MPH medical staff and MPH and NHTR management are ongoing. As the proposed MPH-Clemmons project will not be operational until July 2011, Novant plans to use the interim timeframe for determining the future of the remaining facility and services at MPH. If after additional planning, Novant determines that the facility will be used for the development of any new services or expansion of services which require CON approval or exceed CON thresholds, an additional CON application will be filed. At this point, future use of the vacant space has not been determined. As a result, no costs associated with future uses of the existing Hawthorne Rd. MPH facility are included in this application."

In Section II.5, pages 27-29, the applicants state

"MPH was constructed in the late 1960s and became operational in 1971. The MPH campus ... is well cared for, but somewhat dated and is exhibiting many of the issues to be expected for a facility of its age.

MPH on South Hawthorne Rd. is outdated in several respects: (1) aging engineering infrastructure (chiller towers, boilers, HVAC, humidifiers, emergency power distribution from the generator, building-wide steam piping issues due to age, asbestos removal); (2) cramped capacity in patient care areas such as pre-anesthesia visit space, surgical prep and recovery areas that inhibit maximal OR case throughput, and a few under-sized ORs (two or three) based on modern surgical requirements; (3) a functional

shortage of patient, staff, and physician parking with limited opportunities to expand without adding prohibitively expensive parking deck; (4) elevator capacity and age which inhibits the efficient and best use of bed floors; (5) limited storage and support space for nursing stations, PACU soiled holding, dedicated and private patient consultation rooms, and separate female surgeon locker room; and (6) the 13-acre MPH campus is very small compared to modern-day community hospital requirements and is bordered on two sides by Medical Office Buildings housing both physician/surgeon offices and Novant non-clinical support staff. These MOBs are about the same vintage as Medical Park Hospital. Two public roadways bound the other two sides, so that MPH has very little opportunity to expand horizontally.

In spite of these limitations, 'the hospital functions very efficiently.' ... However, at some point in the near future, the facility issues will interfere more and more with the ability to sustain patient, employee, and physician satisfaction.

Novant Health Triad Region has studied the options for MPH over the course of three years, using two well-known and well-respected facilities planning consultants.

...

The status quo would be to do nothing. This is not a satisfactory solution for the patients, medical staff, or employees. The need to undertake at least basic infrastructure renovations has been clearly identified by outside consultants, as well by MPH's maintenance staff and NHTR Facilities Planning and Construction staff. In addition, after the relocation to FMC/North Pavilion of 114 of MPH's 136 licensed acute beds is completed in about February 2008, only 22 acute licensed beds will remain at MPH. During the week, Monday – Friday, MPH routinely experiences an inpatient census of 25- 30. The Proposed 2008 SMFP even suggests that as MPH continues to grow it will need more bed capacity.

...

MPH and the facility planning consultants thoroughly studied the following incremental approaches to address the MPH facility issues identified above: (1) expand internally within the current MPH walls by displacing dietary & pre-anesthesia visits to outside of MPH; (2) reduce the current OR case volumes to match the physical capacity of the prep and recovery areas so that 10 ORs rather than 12 ORs are in operation at MPH; and (3) re-design patient care areas and ORs at MPH and add new square footage at the front end of MPH to maximize the use of all 12 ORs and undertake costly site work due to impact on front drive and parking. All of these configurations would require an investment of $10-15 Million (in today's dollars) to address the immediate infrastructure and some of the flow issues. These options can be characterized as an approach that leaves the main MPH infrastructure 'as is, where is,' with investment in only required upgrades.

With Options (1) and (2) above, the ORs that are too small today remain too small tomorrow or licensed ORs are not operational. The functional parking issues for patients, physicians, and staff continue. In addition, many of the MPH facility storage and support issues described above remain unaddressed. Appearance issues related to aging interior MPH finishes are also not updated. While this approach is less costly in the short term, it would be short-sited. The incremental approach fails to address in a comprehensive manner the longer term issues which include: (a) whether investment should be made in a facility on a site that is too small to accommodate future hospital growth; and (b) how to reconfigure all the MPH ORs and surgical support space in a manner that brings the surgical suites to modern standards so that the surgical suite operates efficiently, patient care processes flow smoothly, and surgeons, staff, and patients remain satisfied with the overall experience.

Option (3) above is the most costly and the most disruptive to current care processes among the renovation/expansion options for MPH on Hawthorne Rd. The site work associated with Option (3) is much more extensive. Also, it begs the question of whether the expanded MPH should remain on the current campus in Winston-Salem, close to two existing full-service hospitals (FMC and NCBH) or

explore an alternative that decompresses the FMC-MPH campus by relocating the hospital to a community hospital location outside Winston-Salem.

...

The option to construct an MPH replacement hospital on South Hawthorne Road was the subject of a 2007 study and analysis by Peterson Associates. This study included not only construction of a total MPH replacement facility on South Hawthorne Rd., but also the replacement and/or demolition of the Medical Office Buildings on the MPH campus, the addition of an outpatient surgery center on the ground floor of the MOB and the addition of a retention pond and a large (1,200 to 1,400 spaces) parking deck on the MPH campus. The estimated total capital expenditure for this combination of facilities on the 13-acre campus is $100 to $120 Million. This would be a multi-stage, multi-year project, with significant and extended impact on the MPH processes of patient care delivery. In addition, even in this option the small size of some of the MPH ORs would not be addressed. Furthermore, because the current 13-acre site is so valuable and the MOB construction cost is greater than on a less compact campus, the MOB rental rates turn out to be higher than the market rate and not of interest to many physicians. If an ED were added to a MPH total replacement hospital on South Hawthorne Rd. [sic] *that would result in three emergency departments within two miles of each other: one at FMC which was recently expanded and relocated on the FMC campus and opened in late 2004, one at NCBH which has recently been CON-approved for a significant expansion and renovation, and one at MPH."*

In Section III.1, pages 62-64, the applicants state

"Novant Health has determined that the development of a 50-bed hospital in Clemmons will provide a community alternative for residents of the defined service area and would help to relieve some of the future pressure for additional beds at Forsyth Medical Center in Winston Salem. When you review patient origin information provided by FMC and MPH in their annual hospital licensure renewal applications, it is apparent that these Winston-Salem based

hospitals and their medical staffs draw patients from multiple counties outside of Forsyth County where both hospitals are located.

...

The unmet need for inpatient acute care services in the greater Clemmons area of Forsyth and Davie Counties is substantiated by the rapidly growing population and the lack of comprehensive inpatient and outpatient services in the defined service area."

Need for Project Components

Acute Care Beds – MPH is currently licensed for 22 general acute care beds. The proposed new facility would be licensed for 50 acute care beds with the addition of 28 existing general acute care beds relocated from FMC [22 + 28 = 50]. Of the 50 licensed acute care beds in the new facility, the applicants propose that 46 will be designated as general medical/surgical beds and 4 will be developed as intensive care unit (ICU) beds. MPH does not currently have any ICU beds.

Medical/Surgical Beds – In Section III.1, page 81, Section IV.1, pages 123-125, and Exhibit 5, Table 59, the applicants provide historical and projected utilization of the general acute care beds at MPH, as illustrated in the following table.

YEAR	# OF ACUTE CARE PATIENT DAYS	AVERAGE DAILY CENSUS (ADC)	# OF GENERAL MEDICAL / SURGICAL BEDS	% OCCUPANCY
7/1/06 – 6/30/07 (actual) [1]	5,759	15.8	136	11.6%
7/1/11 – 6/30/12 (projected) (Year One)	9,597	26.3	46	57.2%
7/1/12 – 6/30/13 (projected) (Year Two)	10,515	28.8	46	62.6%
7/1/13 – 6/30/14 (projected) (Year Three)	11,462	31.4	46	68.3%

[1] As of 6/30/07, MPH was licensed for 136 general acute care beds. Effective 11/13/2007, 114 general acute care beds were transferred from MPH to FMC pursuant to the certificate of need issued for Project I.D. #G-7011-04. Thus, MPH is currently licensed for 22 general acute care beds. Assuming an ADC of 15.8 patients, the occupancy rate for 22 acute care beds would be 71.8% [15.8 / 22 = 0.718].

As shown in the above table, in Year Three, the applicants project that the proposed new facility will provide 11,462 medical/surgical acute days of care in 46 beds, which is an ADC of 31.4 and an occupancy rate of 68.3%. The following is a description of and discussion regarding the applicants' methodology and assumptions

used to project utilization of the 46 general medical/surgical beds at MPH-Clemmons. See Section III.1, pages 82-89.

- Projected medical/surgical acute care days are calculated as follows: (current utilization by zip code x annual zip code specific population growth rates x percent volume shifted from Novant Health Triad Region hospitals) + (other immigration, which is 10% of total medical/surgical acute care days).
- Regarding current utilization, the applicants state *"zip code level acuity adjusted inpatient days were determined using the Solucient database."* The applicants excluded the following diagnostic related groupings (DRGs): mental health and drug abuse, rehabilitation, normal newborns, delivery, neonatal intensive care, diagnostic cardiac catheterization, and all DRGs with a relative weight equal to or greater than 2.0. The following table illustrates the total number of acuity adjusted patient days in all North Carolina hospitals provided to residents of the proposed service area during CY 2004, CY 2005 and CY 2006, as reported by the applicants on page 84.

CALENDAR YEAR	TOTAL # OF ACUITY ADJUSTED PATIENT DAYS AT ALL NC HOSPITALS PROVIDED TO RESIDENTS OF THE PROPOSED SERVICE AREA
2004	19,728
2005	21,302
2006	22,292

The following table illustrates the number of acuity adjusted patient days provided at MPH and FMC to residents of the proposed service area during CY 2004, CY 2005 and CY 2006, as reported by the applicants in Section III.1, pages 85-86, and Exhibit 5, Table 6.

Calendar Year	Total # of Acuity Adjusted Patient Days at MPH and FMC Provided to Residents of the Proposed Service Area					
	MPH		FMC		MPH & FMC Combined	
	Patient Days	Market Share	Patient Days	Market Share	Patient Days	Market Share
2004	525	2.7%	11,413	57.9%	11,938	60.6%
2005	606	2.8%	12,079	56.7%	12,586	59.5%
2006	490	2.2%	12,750	57.2%	13,240	59.4%

As shown in the above table, during CY 2006, 59.4% of the residents of the proposed service area utilized either MPH (2.2%) or FMC (57.2%) for medical/surgical acute care services. Further, the above data shows an average of only 1.3 acuity adjusted patients served per day at MPH from the proposed service area, while an average of 34.9 acuity adjusted patients from the service area were served per day at FMC.

- The applicants assume that the number of acuity adjusted patient days provided at MPH and FMC to residents of the proposed service area during CY 2006 will increase at the same rates the population of each zip code is projected to increase. The applicants obtained zip code specific projected compound average growth rates (CAGR) from Claritas. The following table illustrates the CAGR for each zip code in the proposed service area, as reported by the applicants in Section III.1, page 87, and Exhibit 5, Table 2.

Zip Code / County	Projected CAGR between 2006 and 2014 obtained from Claritas
27006 / Davie	2.8%
27028 / Davie	1.9%
27012 / Forsyth	1.3%
27023 / Forsyth	0.7%
Total	1.7%

- The following table illustrates the applicants' assumptions regarding the number of residents of the proposed service area currently utilizing FMC or MPH that are projected to shift to the proposed new facility, as reported by the applicants in Section III.1, page 87, and Exhibit 5, Table 5.

	% OF CURRENT MPH AND FMC MEDICAL/SURGICAL ACUTE CARE PATIENTS FROM THE PROPOSED SERVICE AREA PROJECTED TO SHIFT TO THE PROPOSED NEW FACILITY IN CLEMMONS
Year One	65.0%
Year Two	70.0%
Year Three	75.0%

Although not reflected in the above table, the majority of the patients projected to shift to Clemmons will come from FMC, not MPH. In fact, based on CY 2006 acuity adjusted patients days reported for MPH and FMC, only 3.7% [490 / 13,240 = 0.037] will be shifted from MPH-Winston-Salem to Clemmons, while 96.3% of the acuity adjusted patient days projected to shift to Clemmons will come from FMC.

On the other hand, 4,984 patient days [5,474 – 490 = 4,984] will be shifted to FMC because the patients' acuity level is 2.0 or greater or the patients do not reside in the proposed service area. [i.e., the total number of patient days provided by MPH during CY 2006 (5,474) as reported by the applicants in Section IV.1, page 123, minus the number of acuity adjusted patient days provided to residents of the proposed service area during CY 2006 (490)]. Thus, 91.1% [4,984 / 5,474 = 0.911] of the total patient days of care currently provided at MPH will shift across the street to FMC, while only 8.9% will shift to the new facility in Clemmons.

Regarding the assumptions in the table above, in Section III.1, page 88, the applicants state

> *"MPH-Clemmons assumed that 75% of the projected acuity adjusted inpatient days would shift to the new community hospital by the third year of operation. Market volume shift for years one and two were projected slightly less as the facility was new and time was allowed for the volume to grow. The following factors were considered important to the determination of the percent of existing market volume projected to shift from the current*

MPH/FMC Campus to the new MPH-Clemmons hospital.

- *All acute care beds at the existing MPH location will be transferred to the new location, therefore 100% of total inpatient days at MPH will have to shift to either MPH-Clemmons or FMC.*
- *MPH-Clemmons is closer to all areas of each of the five zip codes than existing NHTR Winston Salem facilities as reflected in Exhibit 5, Table 1 and Map 5;*
- *There currently are four Forsyth Medical Group employed practices in the defined service area: Medical Associates of Davie/Mocksville-27028 (5 MDs, 3 extenders), Clemmons Family Practice/Clemmons-27012 (3 MDs, 1 extender), Family Medical Associates of Lewisville / Lewisville-27023 (5 MDs), and West Forsyth Family Medicine/Clemmons-27012 (1 MD, 2 extenders); a total of 20 medical providers.*
- *These established physician practices in the market have existing doctor-patient relationships and patient visits to these physician groups grew 14% from 2005 to 2006 and are on target to grow at a similar rate from 2006 to 2007 as reflected in Exhibit 5, Table 17;*
- *Additional physician offices with easier access will be developed in the future on the MPH-Clemmons campus;*
- *Congestion and traffic on I-40 into Winston Salem will increase;*
- *MPH-Clemmons offers a choice for inpatient care closer to home;*
- *The proposed location of MPH-Clemmons adjacent to I-40 and Highway 421 will result in ease of access to the existing population in the defined zip code service area;*
- *Some patients will continue to seek care at other NHTR Winston Salem hospitals, therefore 100% of the demand for inpatient services in the five zip codes will not shift to MPH-Clemmons."*

- The applicants assume that the average length of stay would be 3.7 days, based on the average length of stay (ALOS) at four Novant community hospitals: 1) MPH (ALOS was 3.7 in FFY 2006); 2) Thomasville Medical Center (ALOS was 3.9 in FFY 2006); 3) Presbyterian Hospital Matthews (ALOS was 3.8 in FFY 2006); and 4) Presbyterian Hospital Huntersville (ALOS was 3.4 in FFY 2006). The average ALOS for these four hospitals was 3.7 in FFY 2006. Projected discharges were calculated by dividing projected patient days by the ALOS. See Section III.1, page 89, and Exhibit 5, Table 8.

The applicants adequately demonstrate the need the patients served at Novant Health Triad Region facilities have for 46 general medical/surgical acute care beds in Clemmons.

Intensive Care Unit Beds – In Section III.1, pages 89-90, the applicants provide projected utilization of the four intensive care unit (ICU) beds for the first three operating years of the proposed new facility, as illustrated in the following table.

	YEAR ONE	YEAR TWO	YEAR THREE
Total Acute Care Patient Days	10,506	11,511	12,548
ICU Patient Days (8.7% of Total Acute Care Patient Days)	909	996	1,086
Average Daily Census (ADC)	2.5	2.7	3.0
% Occupancy	62.3%	68.2%	75.0%

As shown in the above table, in Year Three, the applicants project that the proposed new facility will provide 1,086 intensive care unit days of care in 4 beds, which is an ADC of 3.0 and an occupancy rate of 75%. The following is a description of and discussion regarding the applicants' methodology and assumptions used to project utilization of the ICU beds. See Section III.1, pages 89-90.

- In Exhibit 5, Table 8, the applicants calculated the ratio of medical/surgical ICU days to general medical/surgical days for all Novant hospitals in North Carolina. These ratios ranged from 5.6% at Presbyterian Hospital Matthews to 34.3% at Thomasville Medical Center. The ratio at Presbyterian Hospital Huntersville was 8.7%. The applicants state that the ratio for these three hospitals combined (not the average of the three ratios) was 12.4%.

However, based on the data provided by the applicants in Exhibit 5, Table 8, the ratio for these three hospitals combined was only 10.2%.

- In Section III.1, page 90, the applicants state *"It was determined that actual PHH utilization ... was the most reasonable rate to use in the projections as PHH is a 50 bed community hospital, comparable to the proposed project. Intensive care days at PHH represented 8.7% of total inpatient days in FFY 2006."*
- The applicants assume that the ratio of medical/surgical ICU days of care to total general medical/surgical days of care at the proposed new facility in Clemmons will be 8.7%.

However, the applicants do not adequately explain why the experience at Presbyterian Hospital Huntersville in Mecklenburg County is similar to the expected experience at MPH-Clemmons in Forsyth County. In particular, the data provided by the applicants in Exhibit 5, Table 8, shows that the ratio of medical/surgical ICU days to total general medical/surgical days varies significantly from hospital to hospital and is not necessarily related to the number of licensed acute care beds. For example, the applicants report in Exhibit 5, Table 8 that the ratio of medical/surgical ICU days of care to total medical-surgical days of care at Presbyterian Hospital in Charlotte was only 8.4% during FFY 2006. Presbyterian Hospital is licensed for 463 acute care beds and is a tertiary facility which provides significantly more services than what will be provided at the new facility in Clemmons. In addition, the ratio at Presbyterian Hospital Matthews was only 5.6%. The applicants did not adequately demonstrate it is more reasonable to use the ratio calculated for Presbyterian Hospital Huntersville than to use the ratio calculated for Presbyterian Hospital Matthews. Therefore, the applicants did not adequately demonstrate that projected utilization of the four ICU beds at MPH-Clemmons is based on reasonable and supported assumptions. Consequently, the applicants did not adequately demonstrate the need for four ICU beds at MPH-Clemmons.

Observation Beds – In Section III.1, page 90, the applicants provide projected utilization of the six unlicensed observation beds for the first three operating years of the proposed new facility, as illustrated in the following table.

	YEAR ONE	YEAR TWO	YEAR THREE
Total Acute Care Patient Days	10,506	11,511	12,548
Observation Days (12.5% of Total Acute Care Patient Days)	1,313	1,439	1,568
Average Daily Census (ADC)	3.6	3.9	4.3
% Occupancy	60.0%	65.7%	71.6%

As shown in the above table, in Year Three, the applicants project that the proposed new facility will provide 1,568 observation days in 6 beds, which is an ADC of 4.3 patients and an occupancy rate of 71.6%. The following is a description of and discussion regarding the applicants' methodology and assumptions used to project utilization of the observation beds. See Section III.1, page 90.

- In Exhibit 5, Table 8, the applicants calculated the ratio of observation days to total acute care days for all Novant hospitals in North Carolina. The ratios range from 3.9% at The Presbyterian Hospital in Charlotte to 50.4% at MPH, which is currently only a surgical specialty hospital. The highest ratio for Novant facilities other than MPH is 12.6% at Presbyterian Hospital Huntersville. The ratio for Presbyterian Hospital Matthews is 8.8% and the ratio for Thomasville Medical Center is 6.4%.
- In Exhibit 5, Table 8, the applicants state that the average ratio of observation days to total acute days of care for MPH, Presbyterian Hospital Matthews, Presbyterian Hospital Huntersville and Thomasville Medical Center was 12.5% during FFY 2006. However, based on the data provided by the applicants in Exhibit 5, Table 8, the combined ratio for these four hospitals was actually 13%.
- The applicants assume that the ratio of observation days to total acute days of care at the proposed facility will be 12.5%.

However, the applicants do not adequately explain why the combined experience at MPH, Presbyterian Hospital Matthews, Presbyterian Hospital Huntersville and Thomasville Medical Center is similar to the expected experience at the proposed new facility in Clemmons. Further, the applicants included the ratio for the existing MPH in calculating the average used to project observation days at the proposed new facility. However, the ratio of observation days to total acute care days at MPH during FFY 2006 was 50.4%, which is significantly higher than any other

Novant hospital because it is a surgical specialty hospital and not a traditional community hospital. The patients currently served at the existing MPH are not the same patients proposed to be served at the new facility in Clemmons. Thus, the applicants should not have included the ratio at MPH in calculating the ratio to be used for a "full-service community hospital." The combined ratio of observation days to total acute care days for Presbyterian Hospital Matthews, Presbyterian Hospital Huntersville and Thomasville Medical Center was only 9.2% during FFY 2006 based on the data provided by the applicants in Exhibit 5, Table 8. The following table illustrates the ratio of observation days to total acute care days for all Novant hospitals, based on the data reported by the applicants in Exhibit 5, Table 8.

HOSPITAL	FFY 2006 OBSERVATION DAYS AS A % OF TOTAL ACUTE CARE DAYS
Forsyth Medical Center	2.1%
The Presbyterian Hospital	3.9%
Presbyterian Orthopaedic Hospital	5.4%
Thomasville Medical Center	6.4%
Presbyterian Hospital Matthews	8.8%
Presbyterian Hospital Huntersville	12.6%
Medical Park Hospital	50.4%

As shown in the above table, the ratio of observation days to total acute care days ranges from a low of only 2.1% at FMC to a high of 50.4% at MPH. Therefore, the applicants did not adequately demonstrate that projected utilization of the six unlicensed observation beds at the proposed MPH-Clemmons is based on reasonable and supported assumptions. Consequently, the applicants did not adequately demonstrate the need for six unlicensed observation beds at the proposed new facility.

Operating Rooms – MPH is currently licensed for 13 shared ORs. Pursuant to a certificate of need issued for Project I.D. #G-7604-06, one shared OR will be relocated to the Kernersville campus of FMC for a total of 12 ORs remaining at MPH. The applicants propose to relocate five of these 12 shared ORs to the proposed facility in Clemmons. Seven ORs will remain at the existing site in Winston-Salem and would continue to be licensed as part of MPH, but as seven dedicated outpatient ORs. The applicants project utilization separately for the five shared ORs and the seven dedicated outpatient ORs, as discussed below.

Five Shared Operating Rooms – In Section III.1, page 95, Section IV.2, pages 125-126, and Exhibit 5, Table 20, the applicants provide historical and projected utilization of the shared ORs at MPH, as illustrated in the following table.

YEAR	# OF SURGICAL CASES			# OF SHARED ORS	AVERAGE # OF CASES /OR / DAY
	INPATIENT	OUTPATIENT	TOTAL		
7/1/06 – 6/30/07 (actual)	1,188	10,396	11,584	13	3.4
7/1/11 – 6/30/12 (projected) (Year One)	728	3,153	3,881	5	3.0
7/1/12 – 6/30/13 (projected) (Year Two)	833	3,422	4,255	5	3.3
7/1/13 – 6/30/14 (projected) (Year Three)	942	3,699	4,641	5	3.6

As shown in the above table, in Year Three, the applicants project 4,641 surgical cases will be performed in the five shared ORs in Clemmons, which is an average of 3.6 surgical cases per OR per day. The following is a description of and discussion regarding the applicants' methodology and assumptions used to project utilization of the shared ORs. See Section III.1, pages 91-96.

- The applicants state that projected surgical cases are calculated as follows: (current utilization by zip code x annual zip code specific population growth rates x percent volume shifted from Novant's Forsyth County facilities) + (other immigration, which is 10% of total surgical cases).
- Regarding current utilization, on page 91, the applicants report that 4,979 surgical cases were performed on residents of the proposed service area in Novant's Forsyth County facilities during CY 2006. Novant's Forsyth County facilities include: FMC, MPH and Hawthorne Surgical Center (HSC). HSC is a separately licensed freestanding ambulatory surgical facility located on FMC's campus, directly across the street from MPH.
- The applicants assume that the number of surgical cases performed on residents of the proposed service area in Novant's Forsyth County facilities during CY 2006 will increase at the same rates as the population in each zip code is projected to increase. The applicants obtained zip code specific projected compound average growth rates (CAGR) from Claritas. The following table illustrates the CAGR for each zip code in the proposed service area, as reported by the applicants in Section III.1, page 93, and Exhibit 5, Table 2.

ZIP CODE / COUNTY	PROJECTED CAGR BETWEEN 2006 AND 2014 OBTAINED FROM CLARITAS
27006 / Davie	2.8%
27028 / Davie	1.9%
27012 / Forsyth	1.3%
27023 / Forsyth	0.7%
Total	1.7%

- The following table illustrates the applicants' assumptions regarding the combined total number of residents of the proposed service area currently utilizing Novant's Forsyth County facilities (i.e., FMC, MPH and HSC) projected to shift to the proposed new facility, as reported by the applicants in Section III.1, page 93, and Exhibit 5, Table 23.

	% OF CURRENT NOVANT PATIENTS FROM THE PROPOSED SERVICE AREA PROJECTED TO SHIFT TO THE PROPOSED NEW FACILITY IN CLEMMONS	
	INPATIENTS	OUTPATIENTS
Year One	40.0%	75.0%
Year Two	45.0%	80.0%
Year Three	50.0%	85.0%

The following table illustrates the current number of outpatient surgical cases performed at MPH, FMC and HSC and the number of outpatient surgical cases to be shifted from MPH, FMC and HSC during the third operating year of the proposed new facility in Clemmons

	FY 2007 OUTPATIENT SURGICAL CASES	
MPH	Total # of outpatient surgical cases performed between 7/1/06 and 6/30/07	10,396
	# of outpatient surgical cases performed on residents of proposed service area	1,566
	% of total # of outpatient surgical cases performed on residents of proposed service area	15.1%
	% of outpatient surgical cases performed on residents of proposed service area to be shifted to Clemmons in Year Three	90%
	# of surgical cases to be shifted to the new facility in Clemmons	1,410
FMC	Total # of outpatient surgical cases performed between 7/1/06 and 6/30/07	6,190
	# of outpatient surgical cases performed on residents of proposed service area	836
	% of total # of outpatient surgical cases performed on residents of proposed service area	13.5%
	% of outpatient surgical cases performed on residents of proposed service area to be shifted to Clemmons in Year Three	80%
	# of surgical cases to be shifted to the new facility in Clemmons	662
HSC	Total # of outpatient surgical cases performed between 7/1/06 and 6/30/07	6,803
	# of outpatient surgical cases performed on residents of proposed service area	1,072
	% of total # of outpatient surgical cases performed on residents of proposed service area	15.8%
	% of outpatient surgical cases performed on residents of proposed service area to be shifted to Clemmons in Year Three	85%
	# of surgical cases to be shifted to the new facility in Clemmons	911

Regarding the assumptions in the tables above, in Section III.1, pages 93-94, the applicants state

> "*Based upon an analysis of the last twelve months of surgical inpatient data, over half of all inpatient surgical procedures from the proposed service area are non-obstetric, low acuity cases, as reflected in Exhibit 5, Table 23. Therefore, MPH assumed that 50% of inpatient surgery will shift from the existing Novant facilities to MPH-Clemmons. Outpatient surgery market volume shift is projected at 85%. This assumes a volume shift of 90% from MPH, 85% from HSC and 80% from FMC as reflected in Exhibit 5, Table 23.*
>
> - *Surgical scheduling for all NTR surgical facilities is centralized and surgical administration works with physicians and patients to maximize utilization of surgical resources.*
> - *MPH-Clemmons is closer to all areas of each of the five zip codes than existing NHTR Winston Salem facilities as reflected in Exhibit 5, Table 1 and Map 5;*
> - *There currently are four NMG-Forsyth employed practices in the defined service area: Medical Associates of Davie/Mocksville-27028 (5 MDs, 3 extenders), Clemmons Family Practice/Clemmons-27012 (3 MDs, 1 extender), Family Medical*

Associates of Lewisville / Lewisville-27023 (5 MDs), and West Forsyth Family Medicine/Clemmons-27012 (1 MD, 2 extenders); a total of 20 medical providers.

- *These established physician practices in the market have existing doctor-patient relationships and patient visits to these physician groups grew 14% from 2005 to 2006 and are on target to grow at a similar rate from 2006 to 2007 as reflected in Exhibit 5, Table 17;*
- *Additional physician offices with easier access will be developed in the future on the MPH-Clemmons campus;*
- *Congestion and traffic on I-40 into Winston Salem will increase;*
- *MPH-Clemmons offers a choice for surgical services closer to home;*
- *The proposed location of MPH-Clemmons adjacent to I-40 and Highway 421 will result in ease of access to the existing population in the defined zip code service area;*
- *Some patients will continue to seek care at other existing surgical facilities; therefore 100% of the demand for services in the five zip codes will not shift to MPH-Clemmons."*

Seven Dedicated Outpatient Operating Rooms – In Section III.1, page 97, and Exhibit 5, Table 25, the applicants provide projected utilization for the seven dedicated outpatient ORs to remain on MPH's Winston-Salem campus, as illustrated in the following table.

YEAR	# OF OUTPATIENT SURGICAL CASES	# OF DEDICATED OUTPATIENT ORS	AVERAGE # OF CASES /OR / DAY
7/1/11 – 6/30/12 (projected) (Year One)	8,638	7	4.75
7/1/12 – 6/30/13 (projected) (Year Two)	8,730	7	4.80
7/1/13 – 6/30/14 (projected) (Year Three)	8,822	7	4.85

As shown in the above table, in Year Three, the applicants project that 8,822 outpatient surgical cases will be performed in the seven dedicated outpatient ORs at MPH's Winston-Salem campus, which is an average of 4.85 surgical cases per OR per day. The following is a description of and discussion regarding the applicants' methodology and assumptions used to project utilization of the

seven dedicated outpatient ORs remaining on the Winston-Salem campus. See Section III.1, pages 96-98.

- The applicants state that the number of projected ambulatory surgical cases was calculated as follows: current adjusted MPH utilization by county of residence x annual county specific population growth rates.
- Regarding "current adjusted MPH utilization," in Section IV.2, page 125, and Exhibit 5, Tables 21 and 23, the applicants report that 10,396 outpatient surgical cases were performed at MPH between July 1, 2006 and June 30, 2007. In Section III.1, page 96, the applicants assume that 2,259 outpatient surgical cases performed at MPH during FY 2007 will shift to either the Kernersville campus of FMC or the proposed new facility in Clemmons because those facilities are closer to their home. Thus, "current adjusted MPH utilization" remaining at the Winston-Salem campus equals 8,137 outpatient surgical cases [10,396 – 2,259 = 8,137] performed in FY 2007. These outpatients do not reside in the proposed service area for the new facility in Clemmons.
- The applicants assume FY 2007 adjusted outpatient surgical cases by county of residence will increase at the same rate the county population is projected to increase. The applicants obtained projected growth rates for each county from the N.C. Office of State Demographics.

The applicants adequately demonstrate that projected utilization of the five shared ORs at the proposed new facility in Clemmons and seven dedicated outpatient ORs on the Winston-Salem campus is based on reasonable and supported assumptions. Therefore, the applicants adequately demonstrate the need the patients served at Novant Health Triad Region facilities have for five shared ORs in Clemmons.

Emergency Department – MPH does not currently have an emergency department. The applicants state that 85% of the residents of the proposed service area that currently utilize the emergency department at FMC are expected to shift to the emergency department at the new facility in Clemmons. In Section III.1, page 105, the applicants provide the projected number of emergency room visits for the proposed new facility in

Clemmons during the first three operating years, as illustrated in the following table.

OPERATING YEAR	DESCRIPTION/	
7/1/11 – 6/30/12 (projected) (Year One)	Population of proposed service area	81,332
	Projected Use Rate per 1,000 population	43.6
	Total # of Projected Emergency Room Visits at any facility	35,461
	Projected Visits to Emergency Department at MPH-Clemmons campus	9,808
	Projected Market Share (MPH projected ED visits / Total estimated ED visits at any facility)	27.7%
	10% immigration	1,090
	Total # of Emergency Room Visits at MPH-Clemmons campus	10,898
7/1/12 – 6/30/13 (projected) (Year Two)	Population of proposed service area	82,747
	Projected Use Rate per 1,000 population	43.6
	Total # of Projected Emergency Room Visits at any facility	36,078
	Projected Visits to Emergency Department at MPH-Clemmons campus	12,117
	Projected Market Share (MPH projected ED visits / Total estimated ED visits at any facility)	33.6%
	10% immigration	1,346
	Total # of Emergency Room Visits at MPH-Clemmons campus	13,464
7/1/13 – 6/30/14 (projected) (Year Three)	Population of proposed service area	84,190
	Projected Use Rate per 1,000 population	43.6
	Total # of Projected Emergency Room Visits at any facility	36,707
	Projected Visits to Emergency Department at MPH-Clemmons campus	14,505
	Projected Market Share (MPH projected ED visits / Total estimated ED visits at any facility)	39.5%
	10% immigration	1,612
	Total # of Emergency Room Visits at MPH-Clemmons campus	16,116

As shown in the above table, in Year Three, the applicants project a total of 16,116 emergency room visits at the proposed new facility in Clemmons. The following is a description of and discussion regarding the applicants' methodology and assumptions used to project emergency room visits. See Section III.1, pages 101-105.

- The applicants state that projected emergency room visits are calculated as follows: (service area population by zip code x the N.C. emergency room use rate per 1,000 population x projected market share for the new facility in Clemmons) + (other immigration, which is 10% of total emergency room visits).
- The applicants obtained the 2005 North Carolina emergency room use rate per 1,000 population (438.0) from the American Hospital Association Annual Survey.
- The applicant's calculated FMC's current market share of total estimated emergency room visits by residents of the proposed service area as follows: the total number of emergency room visits at FMC by residents of the proposed

service area (9,433) was divided by the total estimated number of emergency room visits (32,628). Thus, Novant's current market share is 28.9% [9,433 / 32,628 = 0.289].

- The applicants assume that 85% of the residents of the proposed service area currently using the emergency department at FMC will shift to the proposed new facility in Clemmons [2,106 patients x 85% = 1,790]. The applicants also assume that the market share for zip code areas 27006 (Advance) and 27012 (Clemmons) will increase 30% by the third operating year while the market share for the other zip code areas will remain unchanged. On page 103, the applicants state

    - *"MPH currently does not provide emergency services. The new hospital will bring a new emergency service to a growing population;*
    - *As a community hospital patients will avoid the confusion and wait times associated with large trauma centers.*
    - *MPH-Clemmons is closer to areas of each of the five zip codes than existing NHTR Winston Salem facilities as reflected in Exhibit 5, Table 4 and Map 7 resulting in faster travel time for emergency services ;*
    - *The proposed location of MPH-Clemmons adjacent to I-40 and Highway 421 will result in ease of access to the existing population in the defined zip code service area;*
    - *Some patients will choose to seek emergency care at other NHTR Winston Salem hospitals, and the protocols for emergency care defined by FMC with area ambulance providers will result in bypassing MPH-Clemmons emergency department less than 5% of the time, therefore 100% of the demand for services in the five zip codes will not shift to MPH-Clemmons."*

- The applicants assume the capacity of one emergency treatment room is 1,333 visits per year based on the American College of Emergency Physicians recommendations. Thus, the applicants calculate that, based on this assumption, 12 treatment rooms are needed in Year Three [16,116 / 1,333 = 12.1].

MPH does not currently operate an emergency department. In Section III.1, pages 77-79, the applicants state

> *"The existing high utilization at the FMC ED and projected growth in emergency visits in Forsyth County and the surrounding areas is expected to continue. The CDC's National Center for Health Statistics Report reported that in 2005 the ED utilization rate was 39.6 visits per 100 persons nationally, which represented an increase of 31% since 1995. And during the same timeframe, the number of hospital EDs in the U.S. has decreased by 9.1%. Further, emergency room utilization varied by geographic location. In the South, visit rates were even higher, at 41.7 visits per 100 persons. North Carolina emergency room visits per 100 population in 2005 was estimated at 43.6 visits. In addition, the emergency department visit use rate is expected to continue to increase as much as 13 percent growth between 2002 and 2012, related to population increase, uninsured ED utilization, and other variables. The growing ED use rate and the fact that the NC ED use rate is higher than the national norm contribute to growing demand for services in emergency departments in Forsyth and surrounding counties.*
>
> ...
>
> *... Approval and development of FMC-Kernersville and MPH-Clemmons will result in a significant shift in emergency room utilization from the main FMC campus on Hawthorne Road to the two new facilities."*

The following table illustrates projected utilization of FMC's emergency treatment rooms through the third operating year of the proposed new facility in Clemmons, as reported by the applicants in Section III.1, page 78.

CALENDAR YEAR	# OF ER VISITS	% INCREASE	TOTAL # OF TREATMENT ROOMS (1)	AVERAGE # OF VISITS PER TREATMENT ROOM
2007 (annualized)	95,874	NA	59	1,625.0
2008 (projected)	98,642	2.9%	59	1,671.9
2009 (projected)	101,249	2.6%	73	1,387.0
2010 (projected)	103,780	2.5%	73	1,421.6
2011 (projected)	106,404	2.5%	73	1,457.6
2012 (projected)	109,079	2.5%	73	1,494.2
2013 (projected)	111,806	2.5%	73	1,531.6
2014 (projected)	114,584	2.5%	73	1,569.6

(1) The existing FMC emergency department in Winston-Salem has 59 treatment rooms. When FMC-Kernersville is completed sometime in 2009, FMC's two emergency departments will have a total of 73 treatment rooms [59 existing in Winston-Salem + 14 new in Kernersville = 73].

Thus, the applicants project that the proposed emergency department at the new facility in Clemmons will serve patients currently served by North Carolina Baptist Hospital and DCH, based on the following findings.

- There are two existing emergency departments located in Forsyth County (FMC and North Carolina Baptist Hospital). MPH does not currently offer emergency department services. FMC currently serves only 2,106 emergency department patients from the proposed service area.
- There is one existing emergency department located in Davie County (DCH).
- The applicants project a 30% market share increase in emergency department visits by Year Three for zip code areas 27006 (Advance in Davie County) and 27012 (Clemmons in Forsyth County).
- In Section III.1, page 102, the applicants report that 2,106 residents of the proposed service area were treated at the FMC emergency room in Winston-Salem between July 1, 2006 and June 30, 2007. The applicants project that 85% of those patients would shift to the proposed new facility in Clemmons, which would be 1,790 patients [2,106 x 0.85 = 1,790.1]. Assuming the same rate of growth used by the applicants to project utilization of the FMC emergency rooms, 2,138 residents of the proposed service area would be expected to shift to the new facility in Clemmons [1,790

x 1.029 x 1.026 x 1.025^5 = 2,138] in 2014. Thus, based on total emergency department visits projected for MPH-Clemmons, only about 13% of the patients to be served in Clemmons are shifting from FMC [2,138 / 16,116 = 0.132]. Therefore, the majority of emergency department patients projected to be served at MPH-Clemmons are served at other existing facilities.

In summary, the applicants failed to demonstrate that the existing emergency departments at North Carolina Baptist Hospital and DCH lack sufficient capacity to meet the needs of the population proposed to be served. Therefore, the applicants did not adequately demonstrate that persons they project to serve need the proposed emergency department services.

Ancillary Services – MPH currently provides limited radiology (one fixed X-ray unit), laboratory and pharmacy services, which are provided to inpatient and outpatient surgical patients. MPH does not currently provide CT scanner, ultrasound, mammography, nuclear medicine, respiratory therapy, physical therapy or speech therapy services to either inpatients or outpatients. In Section III.1, page 107, the applicants provide projected utilization for the following ancillary services for the first three operating years of the proposed new facility in Clemmons, as illustrated in the following table. The table also illustrates the applicants' assumptions regarding projected utilization.

ANCILLARY SERVICE	PROJECTED # OF SCANS, TESTS, ETC.			ASSUMPTIONS
	YEAR ONE	YEAR TWO	YEAR THREE	
CT Scanner				
Inpatient	1,805	1,978	2,156	# of inpatient CT scans = 63.6% of acute care discharges
Outpatient & ED	5,312	6,565	7,860	# of outpatient CT scans = 24.2% of outpatient & ER visits
Total	7,118	8,543	10,016	
Nuclear Medicine				
Inpatient	463	507	553	# of inpatient NM scans = 16.3% of acute care discharges
Outpatient & ED	843	1,042	1,248	# of outpatient NM scans = 3.8% of outpatient & ER visits
Total	1,306	1,549	1,801	
Mammograms				
Inpatient	0	0	0	
Outpatient & ED	1,596	1,972	2,361	# of outpatient mammograms = 7.3% of outpatient & ER visits
Total	1,596	1,972	2,361	
X-Ray				
Inpatient	3,599	3,944	4,299	# of inpatient x-rays = 126.8% of acute care discharges
Outpatient & ED	7,164	8,853	10,599	# of outpatient x-rays = 32.6% of outpatient & ER visits
Total	10,763	12,796	14,898	
Ultrasound				
Inpatient	539	591	644	# of inpatient ultrasounds = 19% of acute care discharges
Outpatient & ED	1,977	2,443	2,926	#of outpatient ultrasounds = 9% of outpatient & ER visits
Total	2,517	3,035	3,570	
Pharmacy				
Inpatient	225,076	246,606	268,830	# of inpatient pharmacy units = 79.3% of acute care discharges
Outpatient & ED	66,792	82,535	98,817	#of outpatient pharmacy units = 3% of outpatient & ER visits
Total	291,868	329,141	367,648	
Laboratory				
Inpatient	49,348	54,069	58,941	# of inpatient lab tests = 17.4% of acute care discharges
Outpatient & ED	29,881	36,924	44,208	#of outpatient lab tests = 1.4% of outpatient & ER visits
Total	79,229	90,992	103,149	

On page 106, the applicants state that the ratios used to project ancillary service utilization are the average ratios for Thomasville Medical Center, Presbyterian Hospital Matthews and Presbyterian Hospital Huntersville for FFY 2006.

The applicants project a combined total of outpatient visits (i.e., encounters) for CT scanner, nuclear medicine, mammograms, x-ray, ultrasound, pharmacy, laboratory, respiratory therapy, physical therapy and speech therapy services to be provided at MPH-Clemmons during the first three operating years, as illustrated in the following table. [Note: the number of outpatient visits is not the sum of the numbers of procedures, laboratory tests and pharmacy units listed for "Outpatient & ED" because the above numbers combine emergency department visits with the outpatients and a patient could have more than one procedure or test during a single visit or encounter.]

OPERATING YEAR	TOTAL # OF OUTPATIENT VISITS OR ENCOUNTERS
7/1/11 – 6/30/12 (projected) (Year One)	11,073
7/1/12 – 6/30/13 (projected) (Year Two)	13,686
7/1/13 – 6/30/14 (projected) (Year Three)	16,390

Source: Section III.1, page 101.

As shown in the above table, in Year Three, the applicants project a total of 16,390 outpatient visits or encounters at the proposed new facility, excluding emergency department visits. The following is a description of and discussion regarding the applicants' methodology and assumptions used to project the outpatient visits or encounters in the above table. See Section III.1, pages 98-101.

- The applicants state that projected outpatient visits are calculated as follows: (service area population by zip code x the N.C. hospital outpatient use rate per 1,000 population x market share) + (other immigration, which is 10% of total outpatient visits).
- The applicants obtained the 2005 North Carolina hospital outpatient use rate per 1,000 population (150.1) from the American Hospital Association Annual Survey.
- The applicant's calculated Novant's current market share of total hospital outpatient visits by residents of the proposed service area as follows: the total number of outpatient visits at Novant's Forsyth County facilities by residents of the proposed service area (8,805) was divided by the total estimated number of hospital outpatient visits for this same area (112,323). Thus, Novant's current market share of the estimated outpatient visits in the proposed service area is 7.8% [8,805 / 112,323 = 0.78].
- The applicants assume that 85% of the residents of the proposed service area currently using one of Novant's Forsyth County facilities for outpatient visits will shift to the proposed new facility in Clemmons. The applicants also assume that the market share for zip code areas 27006 (Advance) and 27012 (Clemmons) will increase 10% by the third operating year while the market share for the other zip code areas will remain unchanged. On pages 99-100, the applicants state

- *"MPH currently provides only outpatient surgery. The new hospital will be a community hospital and will have a full range of outpatient services including imaging, laboratory, pharmacy, etc., in addition to surgical services. There is currently no hospital in the proposed service area.*
- *Much of FMC's outpatient imaging volume is referred to other NHTR freestanding imaging facilities, such as Salem MRI Center and The Breast Center; therefore, this volume was not included in the calculation of current outpatient visit market share.*
- *MPH-Clemmons is closer to areas of each of the five zip codes than existing NHTR Winston Salem facilities as reflected in Exhibit 5, Table 4 and Map 7;*
- *New physician offices with easier access will be developed in the future on the MPH-Clemmons campus;*
- *Congestion and traffic on I-40 into Winston Salem will increase;*
- *MPH-Clemmons offers a choice for outpatient services closer to home;*
- *The proposed location of MPH-Clemmons adjacent to I-40 and Highway 421 will result in ease of access to the existing population in the defined zip code service area;*
- *Interstate I-40 will result in population growth in the defined zip code service area;*
- *Some patients will continue to seek care at other NHTR Winston Salem hospitals, therefore 100% of the demand for services in the five zip codes will not shift to MPH-Clemmons."*

Thus, the majority of the outpatients proposed to be served at the new facility in Clemmons utilize outpatient services currently provided at FMC. However, the applicants do not adequately demonstrate that FMC lacks sufficient capacity to meet the needs of the hospital outpatients to be shifted from FMC to the proposed new facility in Clemmons. Further, the applicants do not provide the basis for their assumptions regarding the need for the outpatient therapy services to be provided at MPH-Clemmons. Therefore, the applicants did not adequately demonstrate that all of the proposed outpatient services are needed in Clemmons.

Further, the applicants do not adequately demonstrate the need to acquire the proposed CT scanner. Pursuant to 10A NCAC 14C .2301(4), *"'Computed tomography (CT) service area' means a geographical area defined by the applicant, which has boundaries that are not farther than 40 road miles from the facility."* In Section II.8, page 54, the applicants describe the proposed CT scanner service area as follows:

> *"The proposed Service Area includes five Zip Codes, all of which are within 40 miles of the proposed MPH-Clemmons. Two Zip Codes in Forsyth County: 27012 and 27023, and three Zip Codes in Davie County: 27006, 27014, and 27028."*

In Section II.8, page 55, the applicants state that there is only one existing CT scanner in the proposed service area, which is located at DCH. However, the applicants do not provide the number of HECT units performed by the existing CT scanner at DCH during the 12 months prior to submitting the application. Instead, they state

> *"Davie County Hospital is designated as a critical access hospital pursuant to 42 CFR Part 485, Subpart F, and by the North Carolina Department of Health and Human Services, Office of Research, Demonstrations and Rural Health Development (NC DHHS). ...*
>
> *On the basis of specialized facilities and services, a hospital designed as a Critical Access Hospital is licensed by the State of North Carolina differently than a hospital classified as a "General Acute Care Hospital. Critical Access Hospitals are subject to supplemental licensure rules in North Carolina, which contain less stringent requirements for inpatient and emergency services, which are not applicable for General Acute Care Hospitals. Critical Access Hospitals are permitted by the CAH regulations to staff only up to 25 beds, so their census will be lower than a larger hospital. In addition, all of Davie County Hospital's acute care beds also are designated as 'swing beds.' This program allows DCH to place either acute or SNF level patients in a designated swing bed. It is reasonable to assume that SNF level patients will typically require fewer diagnostic CT services than acute inpatients.*

As a result, it is not appropriate to regard the CT scanner at Davie County Hospital as equivalent to the CT scanners owned and operated by General Acute Care Hospitals or freestanding CT providers and for its utilization to be consistent with those CT scanners. Therefore, utilization of the CT unit at Davie County Hospital should not be at issue in this review.

The applicant believes that because the scope of services at MPH-Clemmons that includes an Emergency Department and ICU, it is imperative that patients and physicians at MPH-Clemmons have on-site access to CT diagnostic services 24 hours per day, 7 days per week. The MPH-Clemmons staffing for the CT scanner as set forth in Section VII of the application is at a level that assumes the availability of the MPH-Clemmons CT scanner 24 hours per day based on a recommendation from NHTR Director of Radiology Services. See the articles in Exhibit 7. In the alternative, the Agency could choose to condition the applicant on CT scanner services and require that an existing Novant Health CT scanner be relocated to MPH-Clemmons. This type of condition was recently utilized by the Agency in the Presbyterian Hospital Mint Hill, Project I.D. # F-7648-06. See the findings at pages 42 and 80."

However, pursuant to 10A NCAC 14C .2303(2), the applicants are required to demonstrate that the existing CT scanner at DCH performed at least 5,100 HECT units during the 12 months prior to submittal of the application. The rule does not exclude CT scanners operated at critical access hospitals. Thus, the applicants did not adequately demonstrate the need for the proposed CT scanner in addition to the existing CT scanner in use at DCH.

Further, in Section III.1, page 83, the applicants state

"While not part of the defined service area, MPH-Clemmons recognizes that patients from other North Carolina counties may choose to travel across service areas to receive services at MPH-Clemmons. As a result, 10% of the total projected utilization in each of the project years has been allocated to the category of 'Other Inmigration.' Other inmigration is expected to come from surrounding zip codes in Forsyth County and the surrounding counties, Iredell and Yadkin."

As shown in the above table, projected utilization of the proposed CT scanner is based on projected utilization of the acute care beds. Thus, the service area for the proposed CT scanner is actually the same as the service area for the acute care beds. Additionally, the service area for the emergency department is also the same as the service area for the acute care beds. Consequently, the CT scanner service area includes *"surrounding zip codes in Forsyth County and the surrounding counties, Iredell and Yadkin."* The following table identifies the existing CT scanners located in hospitals in Davie, Yadkin, Iredell and Forsyth counties.

FACILITY	COUNTY	# OF CT SCANNERS	# OF CT SCANS PERFORMED DURING FY 2006[1]
Hoots Memorial Hospital	Yadkin	1	747
Davie County Hospital	Davie	1	1,939
Davis Regional Medical Center	Iredell	1	7,522
Iredell Memorial Hospital	Iredell	1	15,965
Lake Norman Regional Medical Center	Iredell	2	17,269
Forsyth Medical Center	Forsyth	4	54,837
N.C. Baptist Hospital	Forsyth	9	77,311
Winston-Salem Health Care	Forsyth	NA	11,749

Source: 2007 Hospital License Renewal Applications, excluding Winston-Salem Health Care, an existing diagnostic center owned by Novant but not licensed by the State.
[1] Utilization for Winston-Salem Health Care is for CY 2006.

As shown in the above table, the existing CT scanner at Hoots Memorial Hospital in Yadkin County performed only 747 CT scans during FY 2006. Further, the existing CT scanner at DCH in Davie County performed only 1,939 CT scans during FY 2006. The applicants did not demonstrate that each of the existing CT scanners located in the proposed CT scanner service area performed at least 5,100 HECT units in the 12 month period prior to submittal of the application, as required by 10A NCAC 14C .2303(2). Further, the applicants did not provide projected utilization for any of the existing CT scanners in the proposed CT scanner service area. Therefore, the applicants did not demonstrate that each existing CT scanner in the service area is projected to perform 5,100 HECT units during the third operating year of the proposed CT scanner as required by 10A NCAC 14C .2303(3). Consequently, the applicants did not adequately demonstrate the need to acquire the proposed CT scanner.

In summary, the applicants did not adequately demonstrate the need for the following proposed services:

- 4 new intensive care unit beds;
- 6 new unlicensed observation beds;
- new outpatient services, including CT, x-ray, mammography, ultrasound, nuclear medicine, laboratory, pharmacy, respiratory therapy, physical therapy and speech therapy;
- 12 new emergency department treatment rooms; and
- 1 new CT scanner.

Therefore, the application is nonconforming to this criterion.

DCH proposes to relocate Davie County Hospital from Mocksville to Bermuda Run. The following table compares the beds, medical equipment and services currently provided by DCH with those proposed to be offered in the replacement hospital. It should be noted that, according to its 2008 Hospital License Renewal Application, DCH is currently *"approved for up to 49"* swing beds. Chapter 5 of the 2007 SMFP states on page 35, *"Section 1883 of the Social Security Act provides that certain small rural hospitals may use their inpatient facilities to furnish skilled nursing facility ... services to Medicare and Medicaid beneficiaries."* One of the requirements for the swing bed program is that the hospital cannot be located in an area designated as "urbanized" by the most recent U.S. Census. While Mocksville is not an urbanized area according to the 2000 U.S. Census, the proposed site in Bermuda Run is an urbanized area. Thus, the hospital would no longer qualify for swing beds at the proposed site.

BEDS/EQUIPMENT/SERVICES	CURRENT	PROPOSED	INCREASE (DECREASE)
Licensed Acute Care Beds [1]			
Medical-Surgical	81	39	(42)
Obstetrical [2]	0	6	6
Total Acute Care Beds	81	45	(36)
Level I bassinets (unlicensed)	0	4	4
Long-Term Care Hospital (LTCH) Beds	0	38	38
Unlicensed Observation Beds [3]	2	10	8
Gastrointestinal (GI) Endoscopy Rooms	1	1	0
Shared Operating Rooms (ORs)	2	3	1
Minor Procedure Rooms [4]	0	1	1
CT scanner	1	1	0
Fixed Radiographic & Fluoroscopic (R/F) X-ray units [5]	2	3	1
Ultrasound (US) units	NA	2	NA
Mammography units [6]	1	1	0
Emergency Services [7]	9 treatment rooms	16 treatment rooms	7 treatment rooms
Cardiopulmonary Services	yes	yes	
Laboratory Services	yes	yes	
Pharmacy Services	yes	yes	
Physical Therapy Services	yes	yes	

[1] Although currently licensed for a total of 81 general acute care beds, DCH is designated as a critical access hospital and operates a maximum of only 25 general acute care beds.

[2] In Section II.1, page 16, the applicants state that the replacement hospital will have four obstetrical beds. However, in Section II.1, page 20, the applicants state that the replacement hospital will have six obstetrical beds (four postpartum and two antepartum). The design schematic provided in Exhibit 4 shows six obstetrical beds (four postpartum and two antepartum).

[3] In Section II.1, page 16, the applicants state that DCH has two unlicensed observation beds. However, in its 2008 Hospital License Renewal Application, which was filed with the Division of Health Service Regulation shortly after the certificate of need application was submitted, DCH reports that it does not have any unlicensed observation beds.

[4] In Section II.1, page 17, the applicants state that DCH does not have a minor procedure room. However, in its 2008 Hospital License Renewal Application, DCH reports that it has one minor procedure room.

[5] The applicants do not provide the current number of fixed R/F X-ray units in the certificate of need application. However, in its 2008 Hospital License Renewal Application, DCH reports that it has two fixed R/F X-ray units.

[6] The applicants do not provide the current number of mammography units in the certificate of need application. However, in its 2008 Hospital License Renewal Application, DCH reports that it has one mammography unit.

[7] The applicants do not provide the current number of treatment rooms in the Emergency Room in the certificate of need application. However, in its 2008 Hospital License Renewal Application, DCH reports that it nine treatment rooms in the Emergency Room.

As shown in the above table, new and expanded services to be provided at the proposed replacement hospital include:

- 6 new obstetrical beds
- 4 new unlicensed Level I bassinets
- 38 new LTCH beds
- 8 additional unlicensed observation beds per narrative in application. [Note: According to its 2008 Hospital License Renewal Application (LRA), DCH does not report having

any unlicensed observation beds. Thus, the new facility will have a total of 10 new unlicensed observation beds, based on information reported in the LRA.]

- one additional shared OR
- one additional minor procedure room per narrative in application. [Note: According to its 2008 LRA, DCH is already licensed for one minor procedure room. The new facility will have no more than one minor procedure room. Therefore, based on information reported in the LRA, the applicants do not propose an increase in the number of minor procedure rooms.]
- 7 additional Emergency Room treatment rooms
- one additional R/F X-ray unit

Because the applicants did not provide the current number of ultrasound units in the certificate of need application, the analyst is unable to determine if the proposal would result in a change in the number of ultrasound units.

Population to be Served

The following table illustrates the current patient origin for acute care services provided by DCH during FY 2006, as reported by the applicants in Exhibit 23, which consists of a copy of the acute care patient origin table from DCH's 2007 Hospital License Renewal Application.

COUNTY	# OF ADMISSIONS	% OF TOTAL ADMISSIONS
Davie	432	92.7%
Rowan	7	1.5%
Guilford	5	1.1%
Iredell	3	0.6%
Yadkin	3	0.6%
Davidson	2	0.4%
Forsyth	1	0.2%
Wilkes	1	0.2%
Tennessee	1	0.2%
Virginia	7	1.5%
Other States	4	0.9%
Total	466	100.0%

As shown in the above table, during FY 2006, 92.7% of DCH's acute care patients were residents of Davie County, 0.6% were residents of Yadkin County and 0.2% were residents of Forsyth County. In Section III.5(a), page 71, the applicants state *"The*

geographic boundaries of the proposed project are the same as those historically served by DCH and will include the communities of Clemmons and Lewisville." Clemmons and Lewisville are located in western Forsyth County. In Section III.1, page 44, the applicants define the proposed service area as follows.

COUNTY	ZIP CODE AREAS	MUNICIPALITY
Davie	27006	[1]
	27014	Cooleemee
	27028	Mocksville
Forsyth	27012	Clemmons
	27023	Lewisville
Yadkin	27055	Yadkinville

[1] This is the zip code for Advance, which is not a municipality.

As shown in the above table, the projected service area for the proposed replacement hospital consists of six zip code areas. On page 44, the applicants state they *"assumed no immigration beyond the defined service area."* The following table illustrates projected patient origin during the second operating year for the proposed replacement hospital, as reported by the applicants in Section III.5(c), page 72.

COUNTY	# OF DISCHARGES	% OF TOTAL DISCHARGES
Davie	1,429	66.6%
Forsyth	590	27.5%
Yadkin	128	6.0%
Total [1]	2,147	100.1%

[1] Does not equal 100% due to rounding.

As shown in the above table, during the second operating year of the proposed replacement hospital, the applicants project that 66.6% of acute care discharges will be residents of Davie County, 27.7% will be residents of Forsyth County and 6.0% will be residents of Yadkin County. The applicants state that the proposed geographic service area is the same as the current service area, but project a substantial increase in the number of inpatients who are residents of Forsyth and Yadkin counties. The applicants adequately identified the population proposed to be served.

Need for Replacement Facility

In Section III.1, page 36, the applicants state

> *"The current facility, which operates as a designated critical access hospital, is no longer conducive to the rendering of cutting-edge health care services. Davie County is thriving economically and experiencing significant population growth. The County is in need of a state-of-the-art health care facility in order to meet the health care needs of its residents, to aid in physician recruitment to the area, and to ensure that the County is well-positioned for further economic growth. Furthermore, the current facility is disadvantaged by its location. The hospital is located in Mocksville; however, the highest concentration of residents now lives in the Advance/Hillsdale area. Residents of this population center have exhibited an unwillingness to drive to Mocksville for health care services and have therefore been consuming services in Forsyth County. The County is in need of a hospital that is located within the population center, which will create an opportunity for the majority of health care needs to be met within the boundaries of Davie County."*

In Section III.1, pages 38-41, the applicants state

> *"The Davie County Hospital was originally constructed in 1956. Similar to most Hill-Burton hospitals constructed during that era, DCEHC-DCH is showing tremendous signs of wear and tear. In addition to an overall lack of aesthetic appeal, the hospital is plagued with an old design that is conducive neither to the modern health care environment nor building code and regulatory compliance. The specific challenges associated with the outmoded facility are described below:*
>
> ...
>
> *The current Hill-Burton design of DCEHC-DCH has a strictly inpatient focus. Other than the emergency department, there is minimal space available for ambulatory care. This puts the hospital at a distinct*

disadvantage, as the hospital industry has been experiencing a dramatic shift to outpatient care in the past 20 to 25 years. The outpatient services that are currently offered at DCEHC-DCH are scattered inconveniently about the facility and integrated into inpatient services. This design is inconvenient for patients, who find it much easier to access outpatient services that are consolidated into one area. A new facility will allow DCEHC-DCH to centralize all ambulatory services and improve patient access.

...

The Americans with Disabilities Act of 1990 provides guidelines that public facilities must meet in order to afford an accessible environment for ADA [sic] *individuals with disabilities. The current facility is noncompliant with these regulations and retrofitting for ADA compliance is not feasible without major renovation, including the consolidation of rooms to create adequate space. Examples of noncompliance include inadequate public toilets (turning radius, grab bars, seat heights, etc.), improper hardware on doors, and improper signage (height requirements, Braille, etc.). North Carolina DFS and JCAHO have not cited the facility for noncompliance due to the 'grandfather clause.' Should DCEHC-DCH have to conduct renovations of existing space, however, current accessibility standards will have to be met at that time. A new facility will allow DCEHC-DCH to design a health care environment that will be convenient and accessible to all individuals, including those with disabilities.*

...

American hospitals are serving a patient population that is sicker and demands a higher level of care. ... The current patient room [sic] *at DCH is not designed to accommodate this level of care. A new facility will allow DCEHC to design a health care environment that exceeds the American Institute of Architects' patient room guidelines, creating an optimal space for patients to heal and staff to work.*

...

Just as the DCEHC-DCH patient rooms are ill-equipped to accommodate the intense level of health care often required for today's patients, they are also ill-designed to accommodate a patient's family and visitors. In today's consumer-driven marketplace, patients are demanding that hospitals be designed with their needs in mind, which includes their need to have their families participate in the healing process. Design elements incorporated into the new hospital include a 'family zone' that provides sleep accommodations for family members, while allowing staff to function efficiently in their own distinct work zone. A new facility will allow DCEHC-DCH to design a health care environment that empowers patients and families to partner together to aid in the healing process.

...

The Health Insurance Portability and Accountability Act describes health care providers' responsibility to restrict access to and uses of protected health information. Although patient privacy is a chief concern for DCEHC-DCH today, the current facility impedes the hospital's ability to provide optimal patient privacy. For example, the design of the registration area allows for limited privacy as patients are required to provide personal information and respond to health-related questions. A new facility will allow DCEHC-DCH to design an environment that will provide superior patient privacy and assure HIPAA compliance.

...

An architectural firm completed a facility assessment of Davie County Hospital in January 2006. The findings indicated significant and costly improvements would be required to update the existing facilities to meet current building code and regulatory guidelines. Issues of concern included life and safety code compliance, ADA accessibility, HVAC, plumbing and electrical systems, and asbestos-containing materials. The existing structure is incapable of housing 81 beds, and it would require significant renovation and displacement to various

program and services to do so. [See Exhibit 7 for a copy of the 21 page facility assessment dated January 12, 2006.]

...

Due to each of the limitations listed above, DCEHC-DCH has struggled in years past to recruit physicians to the area and/or to encourage local physicians to admit patients to DCEHC-DCH. Just as patients demand a state-of-the-art health care facility with leading-edge technology, physicians desire the same environment in order to optimize their practice. A new facility will create leverage for DCEHC-DCH to recruit and hire new physicians to serve the Davie County community and surrounding areas.

...

The supply of health care manpower has been unable to meet a growing need for health care services in Davie County. The county currently has only 5.5 physicians per 10,000 residents. This ratio is extremely low compared to surrounding counties – 7.7 in Davidson, 10.8 in Rowan, and 18.6 in Iredell. There is particularly a deficiency of specialty physicians, at only 1.8 per 10,000 residents. Solucient predicts that 27 physicians will be needed to support the demand for health care in Davie County in 2009. Currently, there are approximately 17 physicians working in the county. There is a particular deficiency for cardiology, gastroenterology, obstetrical, gynecology, urology, ophthalmology and otolaryngology services. ... The growing prevalence of chronic diseases such as diabetes, heart disease and stroke, particularly among the aging population, are having a profound impact on the demand for inpatient services in our region. ... In addition, the Davie County Health Assessment completed in 2007 by The North Carolina Institute for Public Health surveyed over 230 residents and found that one of the community's most significant unmet needs of their community was a hospital, specifically that the County lacked a modern hospital in an accessible location and that more specialty services such as OB/GYN services were needed to meet the growing market demand. Other health problems and concerns related specifically to the Davie County Hospital was that the current facility is outdated

and unable to provide modern services and that many of the residents had to leave the county for needed services. Please see Exhibit 19 for the Davie County Health Assessment."

The applicants adequately demonstrate the need to replace the existing hospital. However, see discussion below regarding the need for all proposed project components.

Need for Project Components

Acute Care Beds – DCH is currently licensed for 81 general acute care beds. However, it currently operates no more than 25 general acute beds because of its designation as a critical access hospital. The proposed replacement hospital would be licensed for only 45 general acute care beds. [Note: The new facility would also have 38 long-term care hospital (LTCH) beds, which are discussed later in these findings.] Thus, the proposal would result in a reduction of 36 general acute care beds in the acute care bed inventory for Davie County [81 – 45 = 36]. Of the 45 general acute care beds to be located in the replacement facility, the applicants propose that 39 beds will be designated as medical/surgical beds and 6 as obstetrical beds. DCH does not currently provide obstetrical services. Further, DCH is not currently licensed for any intensive care unit beds, and none are proposed for the replacement hospital. Additionally, although DCH currently operates all its acute care beds as swing beds, the applicants do not project any nursing facility days of care to be provided in the new facility. Also, swing beds are not permitted in urbanized areas and the proposed site is located in an urbanized area. Based on these two factors, the Project Analyst assumes that none of the acute care beds in the new facility will be swing beds.

Medical/Surgical Beds – In Exhibit 25, the applicants provide historical utilization of the general acute care beds at DCH for the previous three fiscal years (FYs), as illustrated in the following table.

HISTORICAL UTILIZATION
AS REPORTED BY THE APPLICANTS IN EXHIBIT 25

FISCAL YEAR	# OF PATIENT DAYS
7/1/04 – 6/30/05	2,462
7/1/05 – 6/30/06	3,234
7/1/06 – 6/30/07	3,095

As shown in the above table, the applicants report that DCH provided a total of 3,095 days of care between 7/1/06 and 6/30/07 in its acute care beds, which are all swing beds. However, based on DCH's 2007 LRA, it appears the above numbers include both the skilled nursing and acute care days of care provided in the swing beds, instead of only acute care days of care. Specifically, in its 2008 Hospital License Renewal Application, DCH reported that it provided only 1,271 acute care days of care between October 1, 2006 and September 30, 2007 in its swing beds, but also provided 1,730 skilled nursing days of care in its swing beds. If the skilled nursing days of care are added to the acute care days of care, the total is 3,001 days of care, which are comparable to the 3,095 patient days reported by the applicants in Exhibit 25 for the period July 1, 2006 to June 30, 2007. Thus, the Project Analyst concludes the applicants erroneously counted skilled nursing days of care as acute days of care in determining historical utilization for its licensed acute care beds. Consequently, the above historical utilization data provided by the applicants in Exhibit 25 does not accurately reflect acute care services provided in the facility, and thus, overstates acute care days of care. The following table illustrates the number of acute care patient days of care as reported by DCH in its last three hospital license renewal applications (LRA).

HISTORICAL UTILIZATION
AS REPORTED BY DCH IN ITS HOSPITAL LICENSE RENEWAL APPLICATIONS

FISCAL YEAR	# OF ACUTE CARE PATIENT DAYS
10/1/04 – 9/30/05 (actual) (2006 LRA)	1,147
10/1/05 – 9/30/06 (actual) (2007 LRA)	1,527
10/1/06 – 9/30/07 (actual) (2008 LRA)	1,271

In Section III.1, page 48, and Exhibit 25, the applicants provide projected utilization for the 39 medical/surgical beds at the proposed replacement hospital during the first three operating years, as illustrated in the following table.

PROJECTED UTILIZATION
AS REPORTED BY THE APPLICANTS IN EXHIBIT 25 AND SECTION III.1, PAGE 48

	YEAR ONE CY 2011	YEAR TWO CY 2012	YEAR THREE CY 2013
# of Discharges	1,489	1,772	2,195
Average length of stay (ALOS)	4.43	4.43	4.43
# of Patient Days	6,595	7,851	9,723
Average Daily Census (ADC)	18.1	21.5	26.6
# of Medical/Surgical Beds	39	39	39
% Occupancy	46.4%	55.1%	68.2%

As shown in the above table, in Year Three, the applicants project that the proposed replacement hospital will provide 9,723 medical/surgical acute days of care in 39 beds, which is an ADC of 26.6 patients and an occupancy rate of 68.2%. The following is a description of and discussion regarding the applicants' methodology and assumptions used to project utilization of the 39 medical/surgical beds (referred to by the applicants as Methodology #1). See Section III.1, pages 44-48, of the application.

- **Step One**: The applicants defined the proposed service area.
- **Step Two**: The applicants identified the diagnostic related groupings (DRGs) appropriate for a community hospital. All DRGs with a weight greater than 2.0 were excluded, as were DRGs with a weight less than 2.0 for obstetrics, newborns, pediatrics, psychiatry, substance abuse, organ transplants, inpatient rehabilitation, burns, trauma, CT scanner, surgery, cardiology, pulmonology, oncology and HIV/AIDs. Obstetrics DRGs are excluded because the applicants developed separate utilization projections for obstetrics and normal newborns. Problem newborn and pediatric discharges are excluded because the applicants expect that these patients will continue to be admitted to Brenner Children's Hospital at North Carolina Baptist Hospital. The applicants state that the other DRGs were excluded because of *"anticipated physician practice patterns."* However, the applicants do not adequately explain what that means. Further, it is not reasonable for a community hospital to exclude all CT scanner, surgery, cardiology, pulmonology, oncology and HIV/AIDs DRGS with a weight less than 2.0.

- **Step Three**: The applicants obtained from the North Carolina Hospital Association Patient Data System the total number of discharges during FY 2006 for the proposed service area for the DRGs identified in Step Two.
- **Step Four**: The applicants state that they adjusted the number of discharges from Step Three by reducing the number of surgical discharges by 50% and adding 25% of pediatric discharges (all pediatric DRGs had been excluded in Step Two). Regarding these adjustments, the applicants state on page 45, *"DCEHC-DCH is intended to have neither robust inpatient surgery nor inpatient pediatric services."* However, the applicants do not explain why they increased the number of discharges by adding back 25% of the pediatric discharges if they do not propose to provide inpatient pediatric services at the replacement hospital. Further, in Step Two, the applicants stated that they eliminated all surgical DRGs. Thus, the statement that they reduced the number of surgical discharges by 50% as part of Step Four is not consistent with their statement regarding Step Two. Consequently, the applicants do not adequately demonstrate that the adjusted discharges are based on reasonable and supported assumptions.
- **Step Five**: The applicants projected the number of adjusted discharges, which resulted from Step Four, forward through the third operating year of the replacement hospital. The applicants obtained projected annual rates of growth for each zip code in the proposed service area from Solucient. These rates of growth range from 1% to 3.5% per year. However, because the adjusted discharges from Step Four are questionable, the projected adjusted discharges in this step are also questionable.

  Step Six: For each zip code in the proposed service area, the applicants estimated the percentage of the adjusted discharges from Step Five to be discharged from the proposed replacement hospital based on a telephone market survey of 502 residents of the proposed service area conducted in late 2006. The applicants identify these percentages as "market capture rates." However, these rates are not the same thing as "market share" because they are not the percentage of the total patients who reside in the service area and were discharged from any facility in the State. Rather, these rates are the percentage of the projected adjusted discharges from Step Five, which

excludes all DRGs with a weight of 2.0 or greater as well as other discharges. Exhibit 21 contains a description of the methodology used and some of the questions asked during the telephone survey. The survey was conducted between November 29, 2006 and December 10, 2006 by Bellomy Research, Inc. The survey respondents were asked how likely they were to use the proposed replacement hospital, what services they were likely to use and how likely they were to change doctors if necessary. The following table illustrates the projected "market capture" rate for each zip code in the proposed service area during the first three operating years of the replacement hospital.

ZIP CODE	PROJECTED "MARKET CAPTURE" RATE		
	YEAR ONE	YEAR TWO	YEAR THREE
27006 (Advance) [1]	55%	63%	76%
27028 (Mocksville/Cooleemee)	32%	37%	45%
27012 (Clemmons)	30%	34%	41%
27023 (Lewisville)	13%	15%	18%
27055 (Yadkinville)	10%	12%	14%
Weighted Average	30%	34%	41%

[1] While Advance is not a municipality, it has a U.S. Post Office zip code. Bermuda Run is included in this zip code.

- **Step Seven**: The applicants applied the "market capture rates" from Step Six to the adjusted discharges from Step Five to project the number of medical/surgical discharges during the first three operating years of the replacement hospital. Further, the applicants assume that the average length of stay would be 4.43 days *"Based on the NCBH experience with the defined patient population."* In response to written comments, the applicants state that this is the ALOS for acute care patients falling within the DRGs identified in Step Two, not all acute care patients at North Carolina Baptist Hospital. Projected medical/surgical discharges were multiplied by the ALOS to calculate projected medical/surgical patient days of care. However, projected medical/surgical discharges are based on the adjusted discharges from Step Five, which are questionable. Therefore, projected medical/surgical discharges are not based on reasonable and supported assumptions. Consequently, projected medical/surgical

patient days of care, which are based on the unreasonable medical/surgical discharges, are also unreasonable.

In Section III.1, pages 48-52, the applicants describe a second methodology (referred to by the applicants as Methodology #2), which they state was used to "substantiate" the results of Methodology #1, which is the methodology actually used by the applicants to project utilization of medical/surgical beds at the proposed replacement hospital. The following is a description of and discussion regarding Methodology #2.

- **Step One**: The applicants defined the proposed service area.
- **Step Two**: The applicants identified the diagnostic related groupings (DRGs) appropriate for a community hospital. All DRGs with a weight greater than 2.0 were excluded, as were DRGs with a weight less than 2.0 for obstetrics, newborns, pediatrics, psychiatry, substance abuse, organ transplants, inpatient rehabilitation, burns, trauma, CT scanner, surgery, cardiology, pulmonology, oncology and HIV/AIDs. Obstetrics DRGs are excluded because the applicants projected utilization separately for obstetrics and normal newborns. Problem newborns and pediatric discharges also are excluded because the applicants expect that these patients will continue to be admitted to North Carolina Baptist Hospital. The applicants state that the "other" DRGs with a weight less than 2.0 are excluded because of *"anticipated physician practice patterns."*
- **Step Three**: The applicants obtained from the North Carolina Hospital Association Patient Data System the total number of discharges during FY 2006 for the proposed service area for the DRGs identified in Step Two.
- **Step Four**: The applicants projected the number of discharges, which resulted from Step Three, forward through the third operating year of the replacement hospital. The applicants obtained projected annual rates of growth for each zip code in the proposed service area from Solucient. These rates of growth range from 1% to 3.5% per year.
- **Step Five**: The applicants assume that 100% of *"all new discharges that result from market growth"* would be served at the proposed replacement hospital. However, the applicants do not provide any documentation to support

this assumption, and therefore, do not adequately demonstrate that their assumption is reasonable. Specifically, the applicants did not provide the basis for their assumption that all new patients in the area would go to DCH as opposed to other existing facilities, such as hospitals in Forsyth County.

- **Step Six**: The applicants determined the number of FY 2005 and FY 2006 discharges of residents of the proposed service area for the DRGs identified in Step Two from DCH and North Carolina Baptist Hospital. The rate of growth between FY 2005 and FY 2006 was calculated for each hospital and used to project FY 2006 discharges forward through the third operating year of the proposed replacement hospital.
- **Step Seven**: The applicants added the results of Steps Five and Six together.
- **Step Eight**: The applicants determined the number of residents of zip codes 27103 (Winston-Salem) and 27127 (Winston-Salem) discharged from North Carolina Baptist Hospital during FYs 2005 and 2006 for the DRGs identified in Step Two. The rate of growth between FY 2005 and FY 2006 was used to project the FY 2006 discharges forward through the third operating year of the proposed replacement hospital. The applicants assume that 29% of these patients would use the proposed replacement hospital *"due to issues of convenience and patient accessibility."* However, the applicants did not adequately demonstrate this assumption is reasonable. For instance, North Carolina Baptist Hospital is located in zip code 27127 and Forsyth Medical Center is located in zip code 27103. Both Winston-Salem hospitals are tertiary facilities, offering significantly more services than will be offered at the replacement hospital in Davie County. The applicants do not adequately demonstrate that it is reasonable for any residents of zip codes 27127 and 27103 to drive to Davie County for acute care services when there is a larger hospital offering more services located in the same zip code where they live.
- **Step Nine**: The applicants added the results of Steps Seven and Eight together.

The applicants state that Methodology #2 substantiates the results of Methodology #1 because it *"validates that projected inpatient*

discharges will result only from shifting volume from within the health system and from market growth, and will not adversely affect other market providers." However, the applicants did not adequately demonstrate that Methodology #2 is based on reasonable and supported assumptions. Therefore, the applicants do not adequately demonstrate that Methodology #2 "substantiates" the results of Methodology #1, which was used to project utilization of the proposed medical/surgical acute care beds in the replacement hospital.

In summary, the applicants did not adequately demonstrate that projected utilization of the 39 medical/surgical acute care beds at the proposed replacement hospital is based on reasonable and supported assumptions. Therefore, the applicants did not adequately demonstrate the need for 39 medical/surgical acute care beds at the proposed replacement hospital.

Obstetrical Beds and Level I bassinets – DCH does not currently provide obstetrical and normal newborn services. Therefore, residents of Davie County must travel to another county if they want to deliver their baby in a hospital. The applicants propose to develop six licensed obstetrical beds (four postpartum and two antepartum) and four Level I unlicensed bassinets as part of the replacement hospital. The following is a description of and discussion regarding the applicants' methodology and assumptions used to project utilization of the obstetrical beds and Level I bassinets. See Section III.1, pages 53-56, of the application.

- **Step One**: The applicants defined the proposed service area.
- **Step Two**: The applicants assume the following DRGs are appropriate for admission to the proposed obstetrical beds and Level I bassinets: 370-385, 388 and 391. The applicants state that *"Problem Newborn DRG's 386, 387, 389, and 390"* were excluded as these babies will be transferred to The Brenner Children's Hospital at North Carolina Baptist Hospital where there is a neonatal intensive care unit.
- **Step Three**: The applicants obtained from the North Carolina Hospital Association Patient Data System the total number of discharges during FY 2006 for the proposed service area for the DRGs identified in Step Two.

- **Step Four**: The applicants projected the discharges identified in Step Three forward through the third operating year of the replacement hospital. The applicants obtained projected annual rates of growth for each zip code in the proposed service area from Solucient. These rates of growth range from (0.69%) to 2.65% per year.
- **Step Five**: For each zip code in the proposed service area, the applicants estimated the percentage of the discharges identified in Step Four who are expected to be discharged from the proposed replacement hospital based on the results of a telephone market survey of 502 residents of the proposed service area conducted in late 2006. The following table illustrates the projected "market capture" rate for each zip code in the proposed service area during the first three operating years of the replacement hospital.

ZIP CODE	PROJECTED "MARKET CAPTURE" RATE		
	YEAR ONE	YEAR TWO	YEAR THREE
27006 (Advance) [1]	55%	63%	76%
27028 (Mocksville/Cooleemee)	32%	37%	45%
27012 (Clemmons)	30%	34%	41%
27023 (Lewisville)	13%	15%	18%
27055 (Yadkinville)	10%	12%	14%
Total	28%	33%	40%

[1] While Advance is not a municipality, it has a U.S. Post Office zip code. Bermuda Run is included in this zip code.

- **Step Six**: The applicants applied the "market capture rates" from Step Six to the adjusted discharges identified in Step Five to project the number of obstetrical discharges during the first three operating years of the replacement hospital. Projected obstetrical discharges were multiplied by an ALOS of 2.71 days to calculate projected obstetrical patient days of care. Projected Level I bassinet discharges were multiplied by an ALOS of 2.24 days to calculate projected Level I bassinet days of care. The applicants state that they obtained FY 2006 average ALOS for obstetrical patients and normal newborns from North Carolina Hospital Association data.

In Section III.1, page 56, the applicants provide projected utilization of the obstetrical beds and Level I bassinets as illustrated in the following table.

	Year One CY 2011	Year Two CY 2012	Year Three CY 2013
# of Obstetrical Discharges	320	375	456
# of Obstetrical Patient Days of Care	868	1,016	1,235
# of OB Beds	6	6	6
ADC	2.4	2.9	3.4
% Occupancy	39.6%	46.4%	56.4%
# of Level I Bassinet Discharges	240	279	338
# of Level I Bassinet Days of Care	537	625	757
# of Level I Bassinets	4	4	4
ADC	1.5	1.7	2.1
% Occupancy	36.8%	42.8%	51.8%

As shown in the above table, during Year Three, the applicants project that 1,235 obstetrical days of care will be provided in the six obstetrical beds, which is an occupancy rate of 56.4%. In Section II.1, page 16, and Section III.1, page 56, the applicants state that there will be only four obstetrical beds. The applicants do propose four postpartum obstetrical beds. However, in Section II.1, page 20, and the design schematic provided in Exhibit 4, the applicants state that there will also be two antepartum rooms in addition to the four postpartum beds. However, the applicants do not state that the antepartum rooms will be used only for observation of pregnant women to determine if they need to be admitted. Thus, the Project Analyst assumes patients in the antepartum rooms will have been admitted to the hospital as inpatients. Therefore, there will be a total of six licensed obstetrical beds. The applicants did not adequately demonstrate the need for six obstetrical beds at the proposed replacement hospital, given that the occupancy rate is projected to be only 56.4% in Year Three.

Further, as shown in the above table, in Year One, the applicants project that the average annual occupancy rate for the four Level I bassinets will be only 36.8%. Further, in Year Three, the applicants project that the average annual occupancy rate for the four Level I bassinets will be only 51.8%. Thus, the applicants did not demonstrate that the occupancy rate for the proposed Level I bassinets would be at least 50% during Year One and 65% during Year Three as required by 10A NCAC 14C .1403(a)(1). Consequently, the applicants did not adequately demonstrate the need for four Level I bassinets, given that the occupancy rate is projected to be only 36.8% in Year One and only 51.8% in Year Three.

Long-Term Care Hospital Beds – DCH proposes to develop 38 LTCH beds in the replacement facility. Effective August 26, 2005, the definitions of "health service facility" and "health service facility bed," promulgated in N.C. Gen. Stat. §131E-176(9b) and (9c) respectively, were amended such that long term care hospital beds are now a separate category of beds from general acute care beds. In fact, LTCH beds are excluded from the inventory of general acute care beds in the 2007 SMFP and listed in a separate inventory on page 47 of the 2007 SMFP. Because DCH is not currently licensed for any LTCH beds, the applicants' project constitutes the development of a new category of health service facility beds not currently offered in the existing facility. Further, the applicants state that their intent is for the 38 proposed LTCH beds to be licensed as part of DCH, not as a separately licensed hospital within a hospital. However, unlike distinct rehabilitation or psychiatric units, LTCH beds cannot be a distinct unit of a hospital. Many LTCH beds are operated as part of a separately licensed "hospital within a hospital" on the same campus as a general acute care hospital. However, the LTCH must independently comply with all Medicare conditions of participation and with the requirements of 42 C.F.R. 412.22(e) for "hospitals within hospitals," which requires, among other things, that the hospital within a hospital demonstrate that it is not under the same control as the general acute care hospital with which it shares a campus.

In Section III.1, page 68, and Exhibit 25, the applicants provide projected utilization for the proposed LTCH beds, as illustrated in the following table.

	Year One CY 2011	Year Two CY 2012	Year Three CY 2013
LTCH Discharges	364	363	362
LTCH Patient Days of Care	9,773	9,851	9,938
# of LTCH Beds	38	38	38
ADC	26.8	27.0	27.2
% Occupancy	70.5%	71.0%	71.7%

As shown in the above table, during Year Three, the applicants project that the proposed replacement hospital would provide 9,938 LTCH days of care, which is an occupancy rate of 71.7%. The following is a description of and discussion regarding the applicants' methodology and assumptions used to project

utilization of the LTCH beds. See Section III.1, pages 66-68, of the application.

- **Step One**: The applicants used the following criteria to identify patients in the proposed service area discharged from any hospital that are appropriate for admission to an LTCH bed. The following patients were included:
  1. Patients with a length of stay greater than 15 days.
  2. Patients aged 18 and older.

  The following patients were excluded:
  1. Patients with DRG 462 (rehabilitation).
  2. Patients with DRGs that fall into major diagnostic categories 19 (mental diseases and disorders) and 20 (substance abuse)
  3. Patients discharged to hospice.
  4. Patients with discharge listed as against medical advice.
- **Step Two**: The applicants applied the screening criteria developed in Step One to inpatient discharges for each of the last five federal fiscal years for all residents of the proposed service area discharged from any North Carolina hospital obtained from the North Carolina Hospital Association Patient Data System.
- **Step Three**: The applicants used a linear regression analysis to project the discharges identified in Step Two forward through the third operating year of the proposed replacement hospital.
- **Step Four**: The applicants assumed a target occupancy rate of 66.7%. Based on this rate, the applicants state that 41 LTCH beds are needed by Year Three [9,928 LTCH days of care / 365 days per year = an ADC of 27.2; 27.2 / 0.667 = 40.8 LTCH beds]. The applicants state they propose only 38 LTCH beds *"due to space constraints with in* [sic] *the replacement hospital."* The applicants assume that 100% of the discharges projected in Step Three would be admitted to the proposed replacement hospital. However, the applicants do not provide documentation to support this assumption and thus failed to demonstrate its projections are reasonable. Moreover, the applicants do not discuss the inability of Select Specialty Hospital – Winston-Salem, which is licensed for 42 LTCH beds, to meet the needs of these patients. In Section II.1, page 15, the applicants state that the proposed replacement hospital would be located

only 11 miles from Select Specialty Hospital – Winston-Salem. They also state that the drive time would be only 13 minutes. Thus, the residents of the proposed service area have reasonable access to the existing LTCH beds at Select Specialty Hospital – Winston-Salem. According to its 2007 Hospital License Renewal Application, during FY 2006, Select Specialty Hospital – Winston-Salem provided 9,218 LTCH days of care, which is an occupancy rate of only 60.1% [9,218 / 365 / 42 = 0.601]. Moreover, according to its 2008 Hospital License Renewal Application, during FY 2007, Select Specialty Hospital – Winston-Salem provided only 6,410 LTCH days of care, which is an occupancy rate of only 41.8%. Therefore, Select Specialty Hospital – Winston-Salem has underutilized capacity. Further, pursuant to a certificate of need issued on June 29, 2004 for Project I.D. #G-6976-04, Select Specialty Hospital – Greensboro is authorized to develop 30 new LTCH beds in Greensboro. However, the applicants do not discuss the inability of Select Specialty Hospital – Greensboro to meet the needs of the patients that DCH proposes to serve. Therefore, the applicants do not adequately demonstrate that 38 new LTCH beds are needed by the population proposed to be served at DCH.

Observation Beds (Unlicensed) – In Section II.1, page 16, the applicants state that DCH has two unlicensed observation beds. However, in its 2008 Hospital License Renewal Application, which was filed with the Division of Health Service Regulation shortly after the certificate of need application was submitted, DCH reports that it has no unlicensed observation beds. Further, the applicants did not provide historical or projected utilization for the observation beds. Therefore, the applicants did not adequately demonstrate the need for observation beds as part of the replacement hospital.

Gastrointestinal Endoscopy Room – DCH is currently licensed for and the proposed replacement hospital would be licensed for only one GI endoscopy room. In Section III.1, page 62, the applicants provide projected utilization of the GI endoscopy room at the replacement hospital, as illustrated in the following table.

OPERATING YEAR	PROJECTED # OF GI ENDOSCOPY PROCEDURES
Year One (CY 2011)	927
Year Two (CY 2012)	1,288
Year Three (CY 2013)	1,548

As shown in the above table, the applicants project that 1,548 GI endoscopy procedures will be performed in the GI endoscopy rooms at the proposed replacement hospital. The following is a description of and discussion regarding the applicants' methodology and assumptions used to project utilization of the GI endoscopy room. See Section III.1, pages 60-62, of the application.

- **Step One**: The applicants defined the proposed service area.
- **Steps Two and Three**: The applicants used *"Solucient's Outpatient Procedure Estimate Module's GI Procedure Group"* to determine the actual number of GI endoscopy procedures performed during FY 2005 on residents of the proposed service area.
- **Step Four**: The applicants projected the FY 2005 GI endoscopy procedures forward through the third operating year of the proposed replacement hospital. They assume that the number of GI endoscopy procedures will increase 2.6% per year, based on Solucient's Outpatient Procedure Estimate Module.

  Step Five: The applicants state that, according to the telephone market survey conducted in late 2006, 42% of the 502 residents of the proposed service area who were surveyed indicated that they were likely to use the proposed replacement hospital for digestive health services. The applicants assume that 42% of the GI endoscopy procedures projected in Step Four would be performed at the proposed replacement hospital based on the results of the telephone survey.

Projected utilization of the GI endoscopy room is based on reasonable and supported assumptions.

Operating Rooms – DCH is currently licensed for two shared ORs. The applicants propose to develop a third shared OR at the replacement hospital, and do not state that it will be a dedicated C-section OR. In Section III.1, page 60, the applicants provide

projected utilization of three shared ORs at the replacement hospital, as illustrated in the following table.

	YEAR ONE (CY 2011)	YEAR TWO (CY 2012)	YEAR THREE (CY 2013)
Inpatient Cases (excluding OB)	135	158	196
C-sections	87	101	123
Outpatient Cases	1,408	1,956	2,351
Total Surgical Cases	1,630	2,215	2,670
# of Shared ORs	3	3	3
Average # of Cases per OR per day [1]	2.1	2.8	3.4

[1] Assumes 260 days per year.

As shown in the above table, the applicants project that three shared ORs will perform an average of 3.4 surgical cases per day during Year Three. The following is a description of and discussion regarding the applicants' methodology and assumptions used to project utilization of the shared ORs. See Section III.1, pages 56-60, of the application.

Inpatient Cases (excluding obstetrical surgical cases) – The applicants state that during FFY 2006, 818 of the 4,758 acuity adjusted discharges identified in Step Three of Methodology #1 (medical/surgical utilization) were surgical patients. The applicants used the 818 actual surgical discharges in FY 2006 as the base year and projected increases through the third operating year of the proposed replacement hospital using Solucient's projected annual growth rate of 2.27%. The applicants then adjusted the numbers downward by 50%. Then, based on the telephone survey conducted in late 2006, the applicants applied the "market capture" rates used for medical/surgical services to calculate the projected number of inpatient surgical cases (excluding C-sections) to be performed at the replacement hospital. The market capture rates are illustrated in the following table.

PROJECT YEAR	PROJECTED MARKET CAPTURE RATE
Year One	30%
Year Two	34%
Year Three	41%

Obstetrical Surgical Cases – The applicants state that, based on data obtained from the North Carolina Hospital Association Patient Data System, during FY 2006, they assume 27% of all obstetrical discharges of residents of the proposed service area will be surgical in nature.

Outpatient Cases

- **Step One**: The applicants defined the proposed service area.
- **Step Two**: The applicants used Solucient's Outpatient Procedure Estimate Module and feedback from physicians to identify the types of outpatient surgical procedures appropriate for the proposed replacement hospital. See Exhibit 20 for a complete list of the "included" surgical procedures, which are appropriate for the replacement hospital.
- **Step Three**: Using Solucient's Outpatient Procedure Estimate Module, the applicants determined the total number of only the "included" surgical cases performed on residents of the proposed service area during FY 2005.
- **Step Four**: Using Solucient's Outpatient Procedure Estimate Module, the applicants projected the FY 2005 outpatient surgical cases forward through the third operating year of the proposed replacement hospital. The applicants state that Solucient projects that the annual rate of growth will be 1.8% for *"outpatient major procedures"* and 2.1% for *"outpatient major invasive"* procedures. However, the applicants do not define or explain the difference between "outpatient major" and "outpatient major invasive" procedures.
- **Step Five**: The applicants state that, according to a telephone market survey conducted in late 2006, 45% of 502 residents of the proposed service area who were surveyed indicated that they were likely to use the proposed replacement hospital for outpatient surgical procedures. However, the applicants state a 45% "market capture" rate was *"particularly aggressive"* and instead assumed a "market capture" rate of only 30% in Year Three. Lower rates were used in Year One (19%) and Year Two (25%).

Projected utilization is based on reasonable assumptions. However, the 2007 SMFP states there is not a need for an additional operating room in Davie County. See Criterion (1) for discussion.

Minor Procedure Room – In Section II.1, page 17, the applicants state that DCH does not have an existing minor procedure room. However, in its 2008 Hospital License Renewal Application, DCH

reports that it has one existing minor procedure room. Further, the applicants did not provide historical or projected utilization for the minor procedure room. Therefore, the applicants did not adequately demonstrate the need for a minor procedure room as part of the replacement hospital.

Emergency Room – In Section III.1, page 66, the applicants provide projected utilization for the Emergency Room at the replacement hospital, as illustrated in the following table.

PROJECT YEAR	# OF ER VISITS	AVERAGE # OF VISITS PER TREATMENT ROOM PER YEAR (1)
Year One (CY 2011)	15,266	954
Year Two (CY 2012)	17,091	1,068
Year Three (CY 2013)	18,978	1,186

(1) The applicants propose a total of 16 treatment rooms in the Emergency Room at the proposed replacement hospital.

As shown in the above table, during Year Three, the applicants project 18,978 visits to the Emergency Room at the proposed replacement hospital. On page 66, the applicants state that they assume that the capacity of one Emergency Room treatment room is 1,500 visits per year and the appropriate target occupancy rate is 79%. Based on these assumptions, the applicants state that the proposed replacement hospital needs 16 treatment rooms [18,978 / 1,500 = 12.7; 12.7 / .79 = 16]. The following is a description of and discussion regarding the applicants' methodology and assumptions used to project Emergency Room visits. See Section III.1, pages 62-66, of the application.

- **Step One**: The applicants defined the proposed service area.
- **Step Two**: The applicants used Solucient's Emergency Department Estimates Category to define the patients to be served. Patients are categorized as "emergent" and "urgent."
- **Step Three**: Using Solucient's Emergency Department Estimates, the applicants determined the total number of emergency room visits made by residents of the proposed service area during FY 2005.
- **Step Four**: Using Solucient's Emergency Department Estimates, the applicants projected the FY 2005 emergency room visits forward through the third operating year of the

proposed replacement hospital. The applicants state that Solucient projects that the annual rate of growth will be 1.1%.

- **Step Five**: For each zip code in the proposed service area, the applicants estimated the percentage of the emergency room visits identified in Step Four expected to use the Emergency Room at the proposed replacement hospital based on a telephone market survey of 502 residents of the proposed service area conducted in late 2006. The following tables illustrate the projected "market capture" rate for each zip code in the proposed service area during the first three operating years of the replacement hospital.

ZIP CODE	PROJECTED "MARKET CAPTURE" RATE		
	YEAR ONE	YEAR TWO	YEAR THREE
27006 (Advance) [1]	74%	78%	81%
27028 (Mocksville/Cooleemee)	74%	78%	81%
27012 (Clemmons)	34%	39%	45%
27023 (Lewisville)	34%	39%	45%
27055 (Yadkinville)	40%	43%	47%
Total	55%	59%	63%

[1] While Advance is not a municipality, it has a U.S. Post Office zip code. Bermuda Run is included in this zip code.

- **Step Six**: The applicants adjusted the projected visits to account for their plans to construct an urgent care center in Mocksville. The applicants assume that 80% of the residents of zip code areas 27028 (Mocksville) and 27014 (Cooleemee) who indicated they would likely use the proposed replacement hospital would choose to use the urgent care facility to be located in Mocksville instead. The applicants assume that residents of the other zip code areas in the proposed service area would choose to use the replacement hospital rather than the urgent care center because the hospital would be closer to their home.

Projected utilization of the Emergency Room is based on reasonable and supported assumptions.

Radiology – The existing hospital has two units of X-ray equipment. The replacement hospital would have three units of X-ray equipment. However, the applicants do not discuss the need for or provide projected utilization for the X-ray equipment. Therefore, the applicants did not adequately demonstrate the need

for the new unit of X-ray equipment as part of the replacement hospital.

The applicants propose to relocate the following existing radiology equipment to the new facility:

- 1 CT scanner;
- 2 fixed X-ray units;
- 2 ultrasound units; and
- 1 mammography unit.

DCH currently provides the following services, which will also be provided at the new facility:

- cardiopulmonary;
- laboratory;
- pharmacy; and
- physical therapy.

In summary, the applicants did not adequately demonstrate the population it proposes to serve needs the following services:

- 39 general medical/surgical beds;
- 6 obstetrical beds;
- 4 Level I bassinets;
- 38 new LTCH beds;
- 10 unlicensed observation beds;
- 1 minor procedure room; and
- 1 additional unit of R/F X-ray equipment.

Therefore, the application is nonconforming with 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.

NC – MPH
NC – DCH

MPH proposes to relocate some services provided at MPH to a site in Clemmons, which is approximately eight miles from the existing site. The existing services to be relocated from MPH include:

- 22 existing general medical/surgical beds; and
- 5 shared operating rooms.

Additionally, the applicants propose to relocate 28 existing acute care beds from FMC to the new facility in Clemmons.

Regarding the scope of services currently provided at MPH in Winston-Salem, on page 152, the applicants state

> *"the scope of services currently provided at Medical Park Hospital in Winston-Salem is focused on a facility that functions as a surgical specialty hospital providing inpatient and outpatient surgical care supported by the necessary surgical ancillary services such as a surgical pathology lab, and basic imaging, pharmacy, and lab services. In its current location, MPH does not provide emergency department services, multi-modality imaging, or intensive care services."*

In Section III.8(d), page 121, the applicants state

> *"The relocation of twenty-two (22) beds and five (5) ORs from MPH and twenty-eight (28) acute beds from FMC to MPH-Clemmons will not have a negative impact on the patients served at MPH in terms of changes in services, the impact on costs and charges, or the level of access for medically underserved orthopedic patients. The MPH-Outpatient Surgery Center will remain as a licensed hospital based outpatient surgery center with a capacity of seven acute care beds* [sic] *and FMC will continue to provide a wide variety of both inpatient and outpatient services.*
>
> ...
>
> *Therefore, the relocation of beds and operating rooms from MPH and FMC to MPH-Clemmons will not impact the ability of the medically underserved to receive health care services as all NHTR Winston Salem facilities will be available to meet their needs. Included in Exhibit 9 is a*

copy of the Novant Health Charity Care policies which will apply to all NHTR facilities."

Proposed Relocation of Operating Rooms

The following table illustrates historical utilization of the existing ORs at MPH during FYs 2004-2007, as reported by MPH in its license renewal applications.

	FFY 2004	FFY 2005	FFY 2006	FFY 2007
# of IP surgical cases	1,280	1,220	1,170	1,165
# of OP surgical cases	9,756	10,454	10,242	10,454
Total # of surgical cases	11,036	11,674	11,412	11,619
Average # of surgical cases per OR per day	3.3	3.5	3.4	3.4

As shown in the above table, during FFY 2006 and FFY 2007, MPH performed an average of 3.4 surgical cases per OR per day. The following table illustrates historical and projected utilization of the seven ORs that will remain on the MPH Winston-Salem campus, as reported by the applicants in Section IV.2, pages 125-126, and Section III.1, page 97.

	FY 2007 (7/1/06 – 6/30/07)	YEAR ONE (7/1/11 – 6/30/12)	YEAR TWO (7/1/12 – 6/30/13)	YEAR THREE (7/1/13 – 6/30/14)
# of Inpatient Surgical Cases	1,188	0	0	0
# of Outpatient Surgical Cases	10,396	8,638	8,730	8,822
Total # of Surgical Cases	11,584	8,638	8,730	8,822
# of ORs	13	7	7	7
Average # of Surgical Cases per OR per Day	3.4	4.7	4.8	4.8

As shown in the above table, during FY 2007, an average of 3.4 surgical cases were performed per day per OR in the 13 shared ORs at MPH. In Year Three, the applicants project that an average of 4.8 outpatient surgical cases will be performed per day per OR in the 7 dedicated outpatient ORs remaining on MPH's Winston-Salem campus. The applicants adequately demonstrate that seven dedicated outpatient ORs on MPH's Winston-Salem campus would be sufficient to meet the needs of the outpatients continuing to need outpatient surgical services at MPH in Winston-Salem.

However, as shown in the above table, the proposal would result in the elimination of inpatient surgical services at MPH's Winston-Salem campus. The applicants project that 100% of the inpatient surgical patients currently served by MPH in Winston-Salem will

go to FMC instead. In the Impact Analysis provided in Exhibit 5, the applicants project the impact on utilization of FMC's ORs following the elimination of inpatient surgical services at MPH's Winston-Salem campus. The following table illustrates historical and projected utilization of ORs on FMC's Winston-Salem campus, as provided by the applicants in Exhibit 5, Tables 69 and 70.

FMC'S WINSTON-SALEM CAMPUS	FFY 2007 (10/1/06 - 9/30/07) (Annualized)	YEAR ONE (7/1/11 - 6/30/12)	YEAR TWO (7/1/12 - 6/30/13)	YEAR THREE (7/1/13 - 6/30/14)
# of dedicated inpatient ORs (includes 3 open heart and 2 C-section)	5	5	5	5
# of dedicated outpatient ORs	2	2	2	2
# of shared ORs	19	18	18	18
Total # of ORs	26	25	25	25
Total # of ORs less dedicated inpatient ORs	21	20	20	20
# of inpatient surgical cases (excluding open heart and C-sections) [1]	9,806	10,394	10,423	10,449
# of outpatient surgical cases	6,190	5,108	5,110	5,109
Total # of surgical cases (excluding open heart and C-section)	15,996	15,502	15,533	15,558
Average # of surgical cases per OR per day [2]	2.9	3.0	3.0	3.0

[1] Projected utilization includes the impact of patients shifting from: 1) FMC's Winston-Salem campus to FMC's Kernersville campus; 2) FMC to MPH's Clemmons campus; and 3) MPH's Winston-Salem campus to FMC's Winston-Salem campus.

[2] The applicants do not provide the number of outpatient surgical cases performed or to be performed in the two dedicated outpatient ORs. Thus, the average number of surgical cases per OR per day includes both the shared and the dedicated outpatient ORs.

As shown in the above table, the applicants project that the 18 shared and 2 dedicated outpatient ORs at FMC will perform an average of 3.0 surgical cases per day per OR during each of the first three operating years of the proposed new facility in Clemmons. Thus, the applicants demonstrated that FMC has sufficient OR capacity to meet the needs of inpatient surgical patients shifting from MPH.

Proposed Relocation of Acute Care Beds

Regarding acute care patients currently utilizing MPH, in a footnote in Section III.8(c), page 119, the applicants state

> *"The majority of inpatient days at MPH currently are from locations other than the proposed five zip code service area. Once* [sic] *MPH acute inpatient unit at South Hawthorne Road* [Winston-Salem] *is closed it is anticipated that this volume will shift to FMC."*

Thus, the applicants assume that MPH's current acute care patients who do not live in the proposed MPH-Clemmons service area will

use FMC's Winston-Salem Campus after MPH's inpatient beds are relocated because FMC is located across the street from the MPH Winston-Salem campus.

The following table illustrates: 1) the total number of acute days of care provided at MPH's Winston-Salem campus during CY 2006; and 2) the number of acuity adjusted patient days provided at MPH to residents of the proposed service area during CY 2006. The information in the table below was provided by the applicants in Section III.1, pages 85-86, Section IV.1, page 123, and Exhibit 5, Table 6.

Total # of Acute Days of Care during CY 2006	5,474
# of Acuity Adjusted Acute Days of Care Provided to Residents of the Proposed Service Area during CY 2006	490
% of Total	8.95%

As shown in the above table, during CY 2006, MPH provided only 490 acute days of care to residents of the proposed service area, which is only 8.95% of the total number of acute days of care [490 / 5,474 = 0.895]. Thus, 91.05% of the acute care days were provided to patients who are expected to shift to FMC. The applicants project that an ADC of 13.7 inpatients will be shifted from MPH to FMC [5,474 / 365 = 15; 490 / 365 = 1.3; 15 – 1.3 = 13.7]. The applicants assume that MPH's other acute care patients who live in the MPH-Clemmons proposed service area will use the new facility in Clemmons because it will be located closer to where they live. The applicants project the number of current patients expected to shift to Clemmons from MPH in Winston-Salem is equivalent to an ADC of 1.3 inpatients.

In the Impact Analysis provided in Exhibit 5, the applicants project the impact on utilization of FMC's acute care beds following the relocation of 22 acute care beds from MPH and relocation of 28 acute care beds from FMC to Clemmons. The following table illustrates historical and projected utilization of the acute care beds on FMC's Winston-Salem Campus, as reported by the applicants in Section III.8(c), page 120.

	FFY 2007 (10/1/06 - 9/30/07) (Annualized)	**YEAR ONE** (7/1/11 - 6/30/12)	**YEAR TWO** (7/1/12 - 6/30/13)	**YEAR THREE** (7/1/13 - 6/30/14)
Total acute care patient days w/o Kernersville or Clemmons projects	207,960	220,226	222,701	225,176
# of Acute care patient days to be shifted to FMC-K		(8,856)	(9,135)	(9,425)

# of Acute care patient days to be shifted to MPH-Clemmons		(10,115)	(11,082)	(12,081)
# of Acute care patient days to be shifted from MPH to FMC		5,626	5,654	5,681
Total acute care patient days at FMC upon completion of both projects	207,960	206,880	208,138	208,352
Average Daily Census (ADC)	570	567	570	574
# of licensed acute care beds on the FMC Winston-Salem Campus [1]	637	712	712	712
% Occupancy	89.4%	79.6%	80.1%	80.6%

[1] During FFY 2007, FMC was licensed for 637 acute care beds. Effective November 17, 2007, FMC is licensed for 751 acute care beds (114 acute care beds were transferred from MPH to FMC pursuant to the certificate of need issued for Project I.D. #G-7011-04). Upon completion of the project under review and Project I.D. #G-7604-06 (develop 39 new acute care beds and relocate 11 existing acute care beds from FMC to establish a satellite campus of FMC in Kernersville), FMC's Winston-Salem campus will be licensed for 712 acute care beds.

As shown in the above table, during FFY 2007, the occupancy rate for the 637 general acute care beds at FMC's Winston-Salem Campus was 89.4%. In Year Three, the applicants project that the occupancy rate for the 712 general acute care beds remaining at FMC's Winston-Salem Campus would be 80.6%. In Section III.1, page 82, the applicants state they assumed that acute care utilization would increase at the same rate the population of the service area is expected to increase. However, the applicants did not adequately demonstrate that 712 acute care beds at FMC's Winston-Salem campus would be sufficient to meet the needs of the patients that currently utilize FMC for acute care services in addition to the patients to be shifted from MPH, which is an increase of about 15.4 patients per day. Specifically, one month after submitting the project which is the subject of this review, FMC and Novant filed a certificate of need application proposing to develop 26 additional acute care beds at FMC to meet the needs of patients projected to be served on FMC's Winston-Salem campus. Thus, the applicants represent in the recent application that 712 acute care beds are not sufficient to meet the needs of the patients that are projected to utilize FMC for acute care services.

In summary, the applicants did not adequately demonstrate that the needs of the population presently served would be adequately met following the proposed relocation of beds and services to Clemmons. Therefore, the application is nonconforming to this criterion.

DCH. The applicants propose to relocate the existing hospital 13 miles from its current location in Mocksville, which is located near the geographic center of Davie County, to Bermuda Run, which is in the northeast portion of the county. DCH is currently approved by the Centers for Medicare and Medicaid Services (CMS) to operate its acute care beds as swing beds to serve patients needing skilled nursing care. Current utilization at DCH shows about 50% of the

total days of care are acute care and 50% are skilled nursing. However, the applicants do not project any skilled nursing days of care in the replacement hospital. Instead, the applicants propose to develop 38 LTCH beds and reduce the number of general acute care beds by 36. Therefore, the Project Analyst concludes that the proposal would result in the elimination of swing beds at DCH.

The relocation of the hospital and the services to be eliminated or reduced are discussed separately below.

Proposed Elimination of 36 General Acute Care Beds

In Exhibit 25, the applicants provide current and projected utilization of the general acute care beds at DCH through the third operating year, as illustrated in the following table.

YEAR	# OF ACUTE CARE PATIENT DAYS	AVERAGE DAILY CENSUS (ADC)	TOTAL # OF LICENSED ACUTE CARE BEDS	% OCCUPANCY
6/1/04 – 5/31/05 (actual)	2,462	6.7	81	8.3%
6/1/05 – 5/31/06 (actual)	3,234	8.9	81	11.0%
6/1/06 – 5/31/07 (actual)	3,095	8.5	81	10.5%
6/1/07 – 5/31/08 (projected)	3,843	10.5	81	13.0%
6/1/08 – 5/31/09 (projected)	3,843	10.5	81	13.0%
6/1/09 – 5/31/10 (projected)	3,843	10.5	81	13.0%
6/1/10 – 12/31/10 (projected) (six months)	1,922	10.5	81	13.0%
1/1/11 – 12/31/11 (projected) (Year One)	7,464	20.4	45	45.4%
1/1/12 – 12/31/12 (projected) (Year Two)	8,867	24.3	45	54.0%
1/1/13 – 12/31/13 (projected) (Year Three)	10,958	30.0	45	66.7%

As shown in the above table, during FY 2007, the ADC in the general acute care beds at DCH was only 8.5 patients, which is an occupancy rate of only 10.5%. Thus, on any given day, 72.5 general acute care beds were unoccupied [81 – 8.5 = 72.5]. However, in its 2008 Hospital License Renewal Application, DCH reported that it provided only 1,271 acute days of care between 10/1/06 and 9/30/07, which is an ADC of only 3.5 patients [1,271 / 365 = 3.5]. Thus, on any given day, 77.5 general acute care beds were unoccupied [81 – 3.5 = 77.5].

Further, as shown in the table above, during the third operating year, the applicants project that the ADC in the general acute care beds at DCH would be 30 patients. Thus, assuming the hospital was licensed for 81 general acute care beds, on any given day, 51 general acute care beds would be unoccupied [81 – 30 = 51]. Further, the applicants overstate projected utilization of the general acute care

beds. Thus, the number of unoccupied general acute care beds would be even greater than 51. See Criterion (3) for discussion regarding the reasonableness of the applicants' projected utilization. Thus, the applicants adequately demonstrate that the needs of the population presently receiving acute care services at DCH would be adequately met following the elimination of 36 existing general acute care beds.

Elimination of Swing Bed Program

The applicants currently provide skilled nursing care in their existing acute care beds under the Federal Swing Bed Program (P.L. 96-499). In fact, during FY 2007, DCH provided 1,730 skilled nursing days of care in its "swing beds," which is an ADC of 4.7 skilled nursing patients [1,730 / 365 = 4.7]. However, the applicants do not project any skilled nursing days of care at the proposed replacement hospital. Further, hospitals located in "urbanized areas," as designated in the most recent U.S. Census, are not eligible to participate in the Federal Swing Bed Program. The proposed replacement hospital would be located in an "urbanized area" as designated in the 2000 Census. Thus, the Project Analyst concluded the applicants are eliminating the swing bed program and provision of skilled nursing services. The applicants failed to provide any discussion of the impact on the patients currently receiving skilled nursing services at DCH of the elimination of the swing bed program. The applicants did not adequately demonstrate that the needs of the population presently receiving skilled nursing services at DCH would be adequately met following the proposed elimination of skilled nursing services in the swing beds.

Proposed Relocation of Existing Hospital

In Section III.1, pages 39-40, the applicants state

> *"When DCEHC-DCH was originally constructed in 1956 as a county-operated facility, the most logical location was the county seat of Mocksville, where the overwhelming majority of the population resided. Over the past 20 years, however, commercial and residential development in the county has shifted to the northeastern portion of the county. Thus the highest concentration of residents now lives in the Advance/Hillsdale area (zip code 27006). In fact, there are only 4,500 and 1,000 people within the city limits of Mocksville and Cooleemee, respectively, while there are over 12,000 individuals living in the Advance/Hillsdale*

area. Residents of this population center have exhibited an unwillingness to drive to Mocksville for health care services and have therefore been consuming services out of county. In FFY 2006, only 8.6% of DCEHC-DCH inpatient discharges originated from Advance/Hillsdale. The County is in need of a hospital that is located within the population center, which will create an opportunity for the majority of health care needs to be met within the boundaries of Davie County."

The applicants state that the replacement hospital should be located in the "Advance/Hillsdale" area of Davie County, which is located in the northeastern portion of the county, because that is where the *"highest concentration of residents now lives."* The applicants state that the populations of the City of Mocksville (4,500) and the City of Cooleemee (1,000) are less than the population of the "Advance/Hillsdale" area (12,000). However, the population figures for Mocksville and Cooleemee include only those persons living within the city limits of each city and not those persons who live near those municipalities but outside the city limits. In comparison, "Advance/Hillsdale" are not municipalities and therefore have no city limit boundaries. In fact, the only city in the northeast portion of the county is Bermuda Run. Consequently, the population of the "Advance/Hillsdale" area includes the population of the City of Bermuda Run and the surrounding area outside the city limits of Bermuda Run. Thus, the applicants population count for the three areas are not based on the same approach and cannot be conclusively compared.

In Section III.8, pages 73-74, the applicants state

"The decision to replace and relocate the facility is based on need demonstrated in Section III.1.(a) and Section III.1.(b). DCEHC-DCHEC's existing facility limits the quality of services and efficiency of care at the hospital. DCEHC-DCH needs additional space, a new design, and an upgraded infrastructure to adequately meet the market's needs. The proposed location will only serve to enhance accessibility for the population center of the market area.

... With the completion of the proposed replacement facility, the number of patients served at DCEHC-DCH is expected to increase, demanding that DCEHC-DCH retain all acute care beds and expanded [sic] *and current service*

offering at DCEHC-DCH. Please see Section III.1(b) for projected utilization, demonstrating the need for the proposed components for the project. The proposed location will only serve to enhance accessibility for local residents.

DCEHC-DCH is proposing to relocate its current facility in an effort to improve care and service to the residents of Davie County and the surrounding communities. DCEHC-DCHEC is only proposing to add obstetrical services to meet patient demand as well as upgrade facilities to enhance the patient experience and efficiency of its staff and physicians. The proposed location, which is located closer to the population center of the market area, will also serve to enhance access for all patients. The proposed site is located at the intersection of I-40 and NC Hwy 801 offering direct transportation access for all patients."

In Section II.2, page 21, the applicants state

"Relocating to Advance, NC within Davie County will provide greater access for the majority of Davie County residents living in the areas of greatest growth and population in the county. The new hospital will provide ease of access with its location along two main transportation corridors – Interstate 40, NC Hwy 801 and NC Hwy 158."

As stated in the language of this criteria, *"...the applicant shall demonstrate that the needs of the population presently served will be met adequately by the proposed relocation or by alternative arrangements."* The applicants state the proposed replacement facility will *"serve to enhance access for all patients"* and *"provide greater access for the majority of Davie County residents living in the areas of greatest growth and population in the county."* However, the applicants did not adequately demonstrate that relocating the hospital from Mocksville, which is located in the geographic center of Davie County, to a site in the northeastern portion of Davie County, will meet the needs of the population it presently serves. Specifically, the applicants propose to relocate the hospital approximately 13 miles and 13 minutes driving time to the north and east from the existing site, and approximately one mile from the border between Davie and Forsyth counties. As such, it is reasonable to assume that the proposed location will

generally improve geographic access for residents of the eastern portion of the county, but will generally increase travel times for residents in the western and central portions of the county. Of course, depending on the specific location of a resident's home within each of the census tracts, as well as their proximity to existing road systems, the impact on travel times of the proposed relocation will vary within each census tract.

The following table shows the 2000 population for Davie County by census tract obtained from the U.S. Census Bureau web site.[1] The table also indicates the geographic location of the census tract and the municipality included in each census tract, if any.[2]

CENSUS TRACT	AREA OF THE COUNTY	MUNICIPALITY	TOTAL POPULATION IN 2000
802	Northeast		4,162
803	East	Bermuda Run	6,784
804	Southeast		4,073
805	Central	Mocksville	3,604
806	Central	Mocksville	3,376
807	South	Cooleemee	6,083
801	West		6,773
Total			34,855

In general, the applicants' proposed site in Bermuda Run will negatively impact geographic accessibility for residents of census tracts 805 (Mocksville), 806 (Mocksville), 807 (Cooleemee) and 801 (western Davie County). The following table summarizes the 2000 populations for the Davie County census tracts by area of the county.

CENSUS TRACT	GEOGRAPHIC LOCATION WITHIN THE COUNTY	2000 POPULATION	% OF TOTAL
WESTERN & CENTRAL CENSUS TRACTS (closer to present hospital site)			
801	West	6,773	19.4%
805	Central	3,604	10.3%
806	Central	3,376	9.7%
807	South	6,083	17.5%
Subtotal		19,836	56.9%
EASTERN CENSUS TRACTS (closer to proposed hospital site)			

1 2000 data is the latest data available for Davie County on the U.S. Census Bureau's web site.

2 According to the NC State Demographer's web site, there are only three municipalities in Davie County – Mocksville, Bermuda Run and Cooleemee.

802	Northeast	4,162	11.9%
803	East	6,784	19.5%
804	Southeast	4,073	11.7%
Subtotal		15,019	43.1%

Source: 2000 Census data obtained from the U.S. Census Bureau web site.

As shown in the above table, the four census tracts that will be negatively impacted in terms of geographic accessibility by the proposed relocation of the hospital to Bermuda Run included almost 60% of the population of Davie County in 2000. Even if the population of the eastern census tracts increased at a faster rate than the population of the western and central census tracts, a substantial percentage of the population of Davie County would still be negatively impacted by the proposed relocation.

Further, the residents of Davie County who will be negatively impacted by the relocation include relatively higher populations of medically underserved groups, including lower income persons, the elderly, and racial minorities. The following tables summarize income, poverty status, age and minority population data for Davie County by census tract.

PER CAPITA INCOME

CENSUS TRACT	GEOGRAPHIC LOCATION WITHIN THE COUNTY	2000 POPULATION	PER CAPITA INCOME IN 1999
WESTERN & CENTRAL CENSUS TRACTS (closer to present hospital site)			
801	West	6,773	$19,253
805	Central	3,604	$18,742
806	Central	3,376	$21,392
807	South	6,083	$15,480
Subtotal / Weighted Average		19,836	$18,956
EASTERN CENSUS TRACTS (closer to proposed hospital site)			
802	Northeast	4,162	$21,563
803	East	6,784	$31,237
804	Southeast	4,073	$19,237
Weighted Average		15,019	$25,137

Source: 2000 Census data obtained from the U.S. Census Bureau web site.

As shown in the above table, the per capita income for the western and central census tracts (801, 805, 806 and 807) was $18,956 in 1999. In contrast, the per capita income for the eastern census tracts (802, 803 and 804) was $25,137, a difference of more than $6,000 per year for every person living in the eastern census tracts [$25,137 - $18,956 = $6,181].

POVERTY STATUS

CENSUS TRACT	GEOGRAPHIC LOCATION WITHIN THE COUNTY	# OF INDIVIDUALS BELOW THE POVERTY LEVEL	% OF TOTAL POPULATION (1)
WESTERN & CENTRAL CENSUS TRACTS (closer to present hospital site)			
801	West	430	6.4%
805	Central	501	14.2%
806	Central	274	8.6%
807	South	909	15.0%
Subtotal / Weighted Average		2,114	10.8%
EASTERN CENSUS TRACTS (closer to proposed hospital site)			
802	Northeast	259	6.2%
803	East	275	4.2%
804	Southeast	304	7.5%
Weighted Average		838	5.7%
TOTAL		2,952	8.6%

(1) See the per capita income table for the total population of each census tract.

Source: 2000 Census data obtained from the U.S. Census Bureau web site.

As shown in the above table, in 2000, 10.8% of the population of the western and central census tracts (801, 805, 806 and 807) were living below the poverty level. In contrast only 5.7% of the population of the eastern census tracts (802, 803 and 804) were living below the poverty level.

AGE

CENSUS TRACT	GEOGRAPHIC LOCATION WITHIN THE COUNTY	# OF INDIVIDUALS 65 AND OLDER	% OF TOTAL POPULATION (1)
WESTERN & CENTRAL CENSUS TRACTS (closer to present hospital site)			
801	West	750	11.1%
805	Central	452	12.8%
806	Central	675	21.1%
807	South	771	12.8%
Subtotal / Weighted Average		2,648	13.6%
EASTERN CENSUS TRACTS (closer to proposed hospital site)			
802	Northeast	465	11.2%
803	East	1,210	18.3%
804	Southeast	484	11.9%
Weighted Average		2,159	14.6%
TOTAL		4,807	14.0%

(1) See the per capita income table for the total population of each census tract.

Source: 2000 Census data obtained from the U.S. Census Bureau web site.

As shown in the above table, 13.6% of the population of the western and central census tracts are 65 and older and 14.6% of the population of the eastern census tracts are 65 and older. Thus, the western and central census tracts and the eastern census tracts have approximately the same percentage of population which is age 65 and older. However, Census Tract 806 (Mocksville), which is centrally located in Davie County has the highest percentage of total population aged 65 and older. The hospital is currently located in Census Tract 806.

MINORITY POPULATION

CENSUS TRACT	GEOGRAPHIC LOCATION WITHIN THE COUNTY	# OF PERSONS IDENTIFYING THEMSELVES AS A MINORITY	% OF TOTAL POPULATION (1)
WESTERN & CENTRAL CENSUS TRACTS (closer to present hospital site)			
801	West	573	8.5%
805	Central	805	22.9%
806	Central	416	13.0%
807	South	802	13.3%
Subtotal		2,596	13.3%
EASTERN CENSUS TRACTS (closer to proposed hospital site)			
802	Northeast	211	5.1%
803	East	307	4.6%
804	Southeast	237	5.8%
Subtotal		755	5.1%
TOTAL		3,351	9.8%

(1) See the per capita income table for the total population of each census tract.

Source: 2000 Census data obtained from the U.S. Census Bureau web site.

As shown in the above table, 2,596 people or 13.3% of the population of the western and central census tracts is a member of a racial minority. In contrast, only 755 people or 5.1% of the population of the eastern census tracts is a member of a racial minority. In other words, there are 3.4 times as many members of a racial minority living in the western and central census tracts compared to the eastern census tracts [2,596 / 755 = 3.4].

As shown in the above tables, the residents of Davie County that would be negatively impacted by the proposed relocation include relatively higher proportions of medically underserved groups, including lower income persons, the elderly and racial minorities. Although the applicants state that the proposed site will improve access for the residents of Davie County, they did not discuss the impact on accessibility for residents with a lower income, the elderly or members of a racial minority.

In summary, the applicants did not adequately demonstrate that the needs of the population presently served will be met adequately by the proposed project. Further, the applicants did not adequately demonstrate the effect of the proposal on the ability of low income persons, racial and ethnic minorities, women, handicapped persons and other underserved groups and the elderly to obtain needed

healthcare. Therefore, the application is nonconforming with this criterion.

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

NC – MPH
NC – DCH

MPH. In Section II.5, pages 27-33, the applicants discuss the alternatives considered prior to submission of this application and the basis for selection of the proposed project. However, the application is not conforming to all applicable statutory and regulatory review criteria. See Criteria (3), (3a), (5), (6), (18a), 10A NCAC 14C .1200 and 10A NCAC 14C .2300. Therefore, the applicants did not adequately demonstrate that the proposed project is an effective alternative, and the application is nonconforming to this criterion.

DCH. In Section II.5, pages 23-25, the applicants discuss the alternatives considered prior to submission of this application and the basis for selection of the proposed project. However, the application is not conforming to all applicable statutory and regulatory review criteria. See Criteria (1), (3), (3a), (5), (6), (18a), 10A NCAC 14C .1400, and 10A NCAC 14C .2100. Therefore, the applicants did not adequately demonstrate that the proposed project is an effective alternative, and the application is not conforming to this criterion.

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

NC – MPH
NC – DCH

MPH. In Section VIII.1, page 177, the applicants project that the total capital cost of the project will be $95,928,160, as illustrated below.

Site Costs

COMPARATIVE ANALYSIS

Pursuant to 10A NCAC 14C .0202(f), *"Applications are competitive if they, in whole or in part, are for the same or similar services and the agency determines that the approval of one or more of the applications may result in the denial of another application reviewed in the same review period."* The applications were submitted in the same review period. MPH proposes to develop a new hospital in Clemmons offering the following beds or services: 50 general acute care beds, 6 unlicensed observation beds, Surgery, Radiology, Emergency, Laboratory, Pharmacy, Respiratory Therapy, Physical Therapy and Speech Therapy. DCH proposes to develop a replacement hospital offering the following beds or services: 45 general acute care beds, 38 LTCH beds, 10 unlicensed observation beds, Surgery, Radiology, Emergency, Laboratory, Pharmacy, Cardiopulmonary and Physical Therapy. Thus, the proposals are for the same or similar services. Further, the proposed sites are within three to four miles of each other and the applicants propose to serve essentially the same patient population. See Criterion (3) for discussion of the population to be served. Therefore, the Agency determined that the applications are competitive.

Consequently, after considering all of the information in each application and reviewing each application against all applicable review criteria, the Certificate of Need Section determined that neither of the applications in this review is conforming to all of the review criteria and standards and that, for the reasons set out in these findings, no application can be approved standing alone. Further, for the reasons set forth below, it is not possible to make a conclusive comparison of the two proposals for the purpose of determining which application is comparatively superior to the other application. Nonetheless, the Project Analyst compared the two applications in the following categories utilizing the information provided by the applicants in their respective applications. For the reasons set forth below and in the rest of the findings both applications are denied.

GEOGRAPHIC ACCESS

The following table compares the proposed service areas for MPH and DCH.

MPH	DCH
Davie County Zip Code Area 27006 Zip Code Area 27028	**Davie County** Zip Code Area 27006 Zip Code Area 27028
Forsyth County Zip Code Area 27012 Zip Code Area 27023 Other "surrounding" zip codes	**Forsyth County** Zip Code Area 27012 Zip Code Area 27023
Yadkin County Zip Code Area 27055 All other zip codes	**Yadkin County** Zip Code Area 27055
Iredell County All zip code areas	

As shown in the above table, MPH and DCH propose very similar service areas. DCH's proposed site is located at the first exit in Davie County on I-40 West, approximately one mile from the Yadkin River, which forms the boundary between Davie and Forsyth counties. MPH proposes to locate the new facility in Clemmons between Exits 182 and 184 on I-40. Exit 182 is the last exit in Forsyth County on I-40 West, approximately two miles from the Yadkin River. Thus, although located in a different county, MPH's site is located approximately three miles from DCH's site. Therefore, the two proposals are equally effective alternatives with regard to geographic access for the population proposed to be served at each new facility.

FACILITY DESIGN

The following table compares the square footage by service or department proposed by MPH and DCH. The source of the data in the table is Section XI.4(e) of the applications.

SERVICE OR DEPARTMENT	MPH	DCH
INPATIENT SERVICES (Acute, LTCH and Observation Beds)	36,469	94,185
ANCILLARY AREAS		
Emergency Department	12,119	
Diagnostic and Treatment	20,143	
Surgery Suite	26,831	
Other ancillary or support services	25,715	
Total Ancillary Areas	84,808	79,807
SUPPORT AREAS		
Pharmacy	2,041	
Administration	9,589	
Central Energy Plant, Mechanical & Circulation	56,732	
Public Areas	12,307	
Total Support Areas	80,669	55,336
TOTAL	201,946	229,328

As shown in the above table, MPH proposes a total of 201,946 square feet, while DCH proposes a total of 229,328 square feet. However, MPH proposes only 50 general acute care beds and 6 unlicensed observation beds. In contrast, DCH proposes 45 general acute care beds, 38 LTCH beds, 4 unlicensed Level I bassinets and 10 unlicensed observation beds. Because DCH provided square footage for the general acute care and LTCH beds combined, it is not possible to compare the applications with regard to the square footage proposed for only the general acute care beds. In addition, DCH did not provide a breakdown of the total square footage for each ancillary area and support area listed above. Thus, due to the differences in the two projects, it is not possible to make conclusive comparisons of the two applications with regard to the proposed designs of the facilities in terms of square footage by service or department.

SCOPE OF SERVICES

The following table compares the scope of health services proposed in each application, as described in Section II.1 of the respective applications and as indicated by the design schematics provided in the exhibits of the respective applications.

SERVICE OR DEPARTMENT	MPH (Clemmons Campus Only)	DCH
ACUTE CARE BEDS		
# of Medical/Surgical Beds	46	39
# of Intensive Care Unit Beds	4	0
# of Obstetrical Beds	0	6
Total Licensed Acute Care Beds	50	45
# OF LEVEL I BASSINETS (unlicensed)	0	4
LONG-TERM CARE HOSPITAL BEDS	0	38
OBSERVATION BEDS (unlicensed)	6	10
SURGERY		
# of Shared Operating Rooms	5	3
# of GI Endoscopy Rooms	0	1
# of Minor Procedure Rooms	0	1
RADIOLOGY		
CT Scanner	1	1
Fixed X-ray Units	2	3
Nuclear Medicine Camera	1	0
Ultrasound Units	1	2
Mammography Units	1	1
EMERGENCY SERVICES		
# of Treatment Rooms	12	16
LABORATORY SERVICES	yes	yes
PHARMACY SERVICES	yes	yes
CARDIOPULMONARY SERVICES (includes Respiratory Therapy)	yes	yes
PHYSICAL THERAPY SERVICES	yes	yes
SPEECH THERAPY SERVICES	yes	no

Sources: Section II.1 of the respective applications and the design schematics provided in the exhibits of the respective applications.

As shown in the above table, there are a few minor differences between the two proposals, which are discussed below.

- MPH proposes 46 medical/surgical acute care beds. DCH proposes 39 medical/surgical acute care beds. However, DCH did not adequately demonstrate the need for 39 medical/surgical acute care beds. See Criterion (3) for discussion.
- MPH proposes to provide intensive care unit services. However, MPH did not adequately demonstrate the need for four ICU beds. See Criterion (3) for discussion. DCH does not propose to provide intensive care unit services.
- DCH proposes to provide obstetrical and normal newborn services. However, DCH did not adequately demonstrate the need for six obstetrical beds and four Level I bassinets (unlicensed). See Criterion (3) for discussion. MPH does not propose to provide obstetrical or normal newborn services.

- MPH proposes 6 unlicensed observation beds. However, MPH did not adequately demonstrate the need for 6 unlicensed observation beds. See Criterion (3) for discussion. DCH proposes 10 unlicensed observation beds. However, DCH did not adequately demonstrate the need for 10 unlicensed observation beds. See Criterion (3) for discussion.
- DCH proposes to develop 38 LTCH beds. However, DCH did not adequately demonstrate the need for 38 new LTCH beds. See Criterion (3) for discussion. MPH does not propose to provide LTCH services.
- MPH proposes to relocate five existing ORs and adequately demonstrates that the population proposed to be served needs five ORs. See Criterion (3) for discussion. DCH proposes to relocate two existing ORs and add one new OR for a total of three ORs. However, the 2007 SMFP states there is not a need for any additional ORs in Davie County. See Criterion (1) for discussion.
- MPH does not propose to develop any GI endoscopy rooms as part of the new facility in Clemmons. DCH proposes to relocate one existing GI endoscopy room and adequately demonstrates the need for one GI endoscopy room as part of the replacement hospital. See Criterion (3) for discussion.
- DCH proposes one minor procedure room. However, DCH does not adequately demonstrate the need for one minor procedure room as part of the replacement hospital. See Criterion (3) for discussion. MPH does not propose to develop a minor procedure room as part of the new facility in Clemmons.
- DCH proposes to acquire a CT scanner to replace its existing CT scanner. The replacement CT scanner will be installed in the proposed replacement hospital. MPH proposes to acquire a new CT scanner for the new facility in Clemmons. However, MPH did not adequately demonstrate the need to acquire a new CT scanner. See Criterion (3) for discussion.
- MPH proposes two new units of fixed X-ray equipment. However, MPH did not adequately demonstrate the need for the proposed new outpatient services at the facility in Clemmons. See Criterion (3) for discussion. DCH proposes three units of X-ray equipment. DCH currently has two units. Thus, DCH's proposal results in the addition of a third unit. However, DCH did not adequately demonstrate the need for the additional unit of X-ray equipment. See Criterion (3) for discussion.
- MPH proposes one nuclear medicine camera. However, MPH did not adequately demonstrate the need for the proposed new outpatient services at the facility in Clemmons. See Criterion (3) for discussion. DCH does not propose a nuclear medicine camera.
- MPH proposes one ultrasound unit. However, MPH did not adequately demonstrate the need for the proposed new outpatient services at the facility in Clemmons. See Criterion (3) for discussion. DCH proposes to relocate its existing ultrasound units.
- MPH proposes one mammography unit. However, MPH did not adequately demonstrate the need for the proposed new outpatient services at the facility in Clemmons. See Criterion (3) for discussion. DCH proposes to relocate its existing mammography unit.
- MPH proposes to provide emergency services. However, MPH does not adequately demonstrate that the residents of the proposed service area need 12 new emergency department treatment rooms at the facility in Clemmons. See Criterion (3) for discussion. DCH proposes to provide

emergency services and adequately demonstrates the need for 16 emergency department treatment rooms in the replacement hospital. See Criterion (3) for discussion.

- MPH proposes to offer laboratory, pharmacy, respiratory therapy, physical therapy and speech therapy services. However, MPH did not adequately demonstrate the need for the proposed new outpatient services at the facility in Clemmons. See Criterion (3) for discussion. DCH proposes to relocate its existing laboratory, pharmacy, cardiopulmonary and physical therapy services to the replacement facility.

In summary, neither DCH nor MPH adequately demonstrated the need for all the beds, equipment or services proposed to be provided at their respective new facilities. See Criterion (3) for discussion. Therefore, it is not possible to make a conclusive comparison of the two proposals with regard to the scope of services that would be provided based on patient needs.

STAFFING

The following table compares: 1) projected full-time equivalent (FTE) positions per occupied acute care bed; and 2) nursing hours per adjusted patient day during the third operating year. The third operating year was selected for comparison because both applicants assume utilization will "ramp up" during the first two operating years. MPH's third operating year is 7/1/13 – 6/30/14. DCH's third operating year is CY 2013.

FTEs PER OCCUPIED ACUTE CARE BED	MPH	DCH
Third Operating Year	7/1/13 – 6/30/14	1/1/13 – 12/31/13
Total Acute Care Patient Days	12,548	10,958
Occupied Beds or Average Daily Census (ADC) (Patient Days / 365)	34.4	30.0
Total FTEs [1]	376.1	384.0
FTEs per Occupied Bed (FTEs / ADC)	10.9	12.8
NURSING HOURS PER ADJUSTED PATIENT DAY		
Total Acute Care Patient Days	12,548	10,958
Inpatient Revenue (DCH - Form B-1; MPH - Form B-1a) [2]	$38,576,610	$42,771,000
Inpatient Revenue per Patient Day	$3,074	$3,903
Outpatient Revenue (DCH - Form B-1; MPH - Form B-1a) [3]	$78,216,265	$63,850,000
Outpatient Days (Outpatient Revenue / Inpatient Revenue per Patient Day)	25,442	16,359
Adjusted Patient Days (Inpatient Days + Outpatient Days)	37,990	27,317
RN FTEs [4]	98.3	63.0
LPN FTEs [4]	0.0	0.0
Aide FTEs [4]	16.4	23.5
Total RN, LPN, Aide FTEs [4]	114.7	86.5
Licensed Nursing Hours (RN/LPN FTEs x 2,080 hours per FTE per year)	204,464	131,040
Licensed Nursing Hours per Adjusted Patient Day (Licensed Nursing Hours / Adjusted Patient Days)	5.4	4.8
Total Nursing Hours (Total RN, LPN, Aide FTEs x 2,080 hours per FTE per year)	238,576	179,920
Total Nursing Hours per Adjusted Patient Day (Total Nursing Hours / Adjusted Patient Days)	6.3	6.6

[1] Total FTEs for MPH is from Section VII and does not include the staff on the Winston-Salem campus. Total FTEs for DCH is from the assumptions following the pro formas and Exhibit 16 and does not include the staff for the LTCH beds.

[2] Inpatient revenue for DCH does not include the revenues associated with the LTCH beds.

[3] Outpatient revenue for MPH does not include the revenues associated with the seven dedicated outpatient ORs on the Winston-Salem campus.

Poyner Spruill LLP

October 30, 2014

S. Todd Hemphill
Partner
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themphill@poynerspruill.com

VIA E-MAIL AND U.S. MAIL
Martha Frisone, Interim Chief
Julie Halatek, Project Analyst
Certificate of Need Section
Division of Health Service Regulation
Department of Health and Human Services
2704 Mail Service Center
Raleigh, NC 27699-2704

RE: Exemption notice and request by Alexander Hospital Investors, LLC and MBHS of North Carolina, LLC to convert 25 acute care beds to psychiatric beds

Dear Ms. Frisone and Ms. Halatek:

This firm represents, Frye Regional Medical Center, Inc., in Hickory, North Carolina. Frye is a general acute care hospital with 355 licensed beds, including 209 general acute care beds and 84 psychiatric bed. Frye is located approximately 17 miles from the site of the former Alexander Community Hospital, the location where Alexander Hospital Investors, LLC and MBHS of North Carolina, LLC (collectively, "AHI") are seeking to convert 25 acute care beds to psychiatric beds.

Frye recently became aware of AHI's October 16, 2014 exemption request. Our firm requested a copy of this request on their behalf on October 20, 2014, which we received yesterday. Frye would like to respond to this request. On behalf of Frye, we ask that you refrain from entering a decision regarding AHI's request until we are allowed to comment. Frye plans to file comments on or before November 7, 2014.

If you have any questions, please do not hesitate to contact me. Thank you for your consideration on this matter.

Very truly yours,

S. Todd Hemphill
Partner

K&L GATES

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October 16, 2014

Susan K. Hackney
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VIA HAND DELIVERY

Ms. Martha Frisone, Chief
Certificate of Need Section
Division of Health Service Regulation
Department of Health and Human Services
809 Ruggles Drive
Raleigh, NC 27603

Re: Exemption Notice for Alexander Hospital Investors, LLC and MBHS of North Carolina, LLC to convert 25 existing acute care beds to psychiatric beds

Dear Martha:

Alexander Hospital Investors, LLC and MBHS of North Carolina, LLC (collectively ("Alexander") are planning to convert Alexander Hospital's 25 acute care beds to psychiatric beds (the "Project"). This letter provides prior notice of this conversion and requests confirmation that Alexander's Project is permitted without CON review.

I. BACKGROUND

Alexander Hospital, located at 326 Third Street South West in Taylorsville, Alexander County, has 25 existing acute care beds. *See* Exhibit 1, Excerpt from Hospitals Licensed by the State of North Carolina, http://www.ncdhhs.gov/dhsr/data/hllist.pdf; Exhibit 2, 2014 State Medical Facilities Plan ("SMFP"), Table 5A. The building consists of 54,000 square feet on 12.5 acres of land. Alexander Hospital Investors, LLC ("AHI") is the licensee for Alexander Hospital.

In conjunction with MBHS of North Carolina ("MBHS"), AHI plans to convert its acute care beds to psychiatric beds in order to offer inpatient acute psychiatric services to residents of Alexander County and other nearby counties.

II. EXEMPTION NOTICE

Under North Carolina law, a CON is required only prior to offering or developing a "new institutional health service." A "new institutional health service" includes a variety of services and activities, including a change in bed capacity or a capital expenditure exceeding $2 million to develop a health service facility. *See* N.C. Gen. Stat. §§ 131E-176(16)(c) and (b).

The North Carolina General Assembly saw fit to exempt certain types of services or proposals from CON review, pursuant to N.C. Gen. Stat. § 131E-184. One such exempt service or proposal includes the "conversion of existing acute care beds to psychiatric beds." N.C. Gen. Stat. § 131E-184(c). To obtain this exemption, (1) the hospital proposing the conversion must execute a contract with, *inter alia,* at least one of the area mental health, developmental disabilities, and substance abuse authorities; and (2) the total number of beds to be converted cannot be more than twice the number of beds for which the contract provides. N.C. Gen. Stat. § 131E-184(c). The exemption in N.C. Gen. Stat. § 131E-184(c) encompasses costs incurred to renovate the facility for the provision of inpatient psychiatric service regardless of the capital expenditure involved.[1]

AHI and MBHS have executed a contract with Smoky Mountain Center, a local management entity,[2] committing to provide inpatient psychiatric services to patients referred by Smoky Mountain Center. *See* Exhibit 3, Contract among Alexander Hospital Investors, LLC, MBHS of North Carolina, and Smoky Mountain Center. Accordingly, Alexander complies with N.C. Gen. Stat. § 131E-184(c)(1). Further, Alexander has obligated to provide thirteen beds for Smoky Mountain Center's referrals to Alexander Hospital. Therefore, the number of beds to be converted, twenty-five (25), is no more than twice the number of beds provided to Smoky Mountain Center, thirteen (13), and complies with N.C. Gen. Stat. § 131E-184(c)(2).

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[1] In addition to being exempt under N.C. Gen. Stat. § 131E184(c), capital costs in excess of $2,000,000 are exempt pursuant to N.C. Gen. Stat. § 131E-184(g). Alexander's sole purpose for the capital expenditure is to renovate the existing hospital, the only building on the main campus, in order to provide inpatient psychiatric services. Financial and administrative control of Alexander Hospital will be exercised at the building to be renovated. No outside entity will exercise financial or administrative control over Alexander Hospital. Because the conversion of acute care beds to psychiatric beds is exempt from CON review, it does not result in a change in bed capacity. Further, there is no addition of a health service facility or any other new institutional health service.

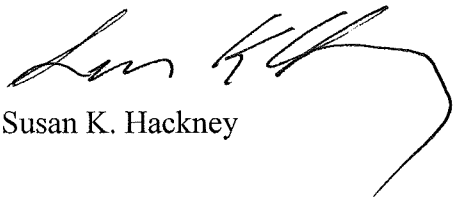
[2] A "local management entity" ("LME") is an area authority that is responsible for managing, coordinating, facilitating and monitoring the provision of mental health, developmental disabilities, and substance abuse services in the area that they serve.

III. CONCLUSION

Based on the foregoing information, we hereby request the Agency's confirmation that the proposal described above is exempt from CON review, pursuant to N.C. Gen. Stat. § 131E-184(c), and thus Alexander may convert its existing twenty-five acute care beds to inpatient acute psychiatric beds without CON review.

If you require additional information to consider this request, please contact us at the above number as soon as possible. We thank you for your consideration of this request.

Sincerely,



Susan K. Hackney

EXHIBITS

Exhibit 1	Excerpt from Hospitals Licensed by the State of North Carolina
Exhibit 2	2014 State Medical Facilities Plan ("SMFP"), Table 5A
Exhibit 3	Contract among Alexander Hospital Investors, LLC, MBHS of North Carolina and Smoky Mountain Center

Hospitals

Licensed by the State of North Carolina
Department of Health and Human Services - Division of Health Service Regulation

As of 10/2014

Alamance Regional Medical Center
PO Box 202; Burlington, NC 27216-0202
County: ALAMANCE Phone: (336)538-7450
Licensee: Alamance Regional Medical Center, Inc.
License No: H0272
HOSPITAL BEDS: General: 182 Psych: 44 Sub Abuse: 12

Operating Room(s):
C-Section: 2
Ambulatory Surgery: 3
Shared Inpatient/Ambulatory Surgery: 9
Endoscopy: 4

Alexander Hospital
1985 Startowd Road; Hickory, NC 28682-
County: ALEXANDER Phone: (828)377-4745
Licensee: Alexander Hospital Investors, LLC
License No: H0274
HOSPITAL BEDS: General: 25

Operating Room(s):
Shared Inpatient/Ambulatory Surgery: 2
Endoscopy: 1

Alleghany Memorial Hospital
P O Box 9; Sparta, NC 28675
County: ALLEGHANY Phone: (336)372-5511
Licensee: Alleghany County Memorial Hospital, Inc.
License No: H0108
HOSPITAL BEDS: General: 41

Operating Room(s):
Shared Inpatient/Ambulatory Surgery: 2

Angel Medical Center, Inc.
P O Box 1209; Franklin, NC 28744-
County: MACON Phone: (828)524-8411
Licensee: Angel Medical Center, Inc.
License No: H0034
HOSPITAL BEDS: General: 59

Operating Room(s):
C-Section: 1
Shared Inpatient/Ambulatory Surgery: 4
Endoscopy: 2

Annie Penn Hospital
618 South Main St.; Reidsville, NC 27320
County: ROCKINGHAM Phone: (336)951-4000
Licensee: The Moses H. Cone Memorial Hospital Operating Corp.
License No: H0023
HOSPITAL BEDS: General: 110

Operating Room(s):
Shared Inpatient/Ambulatory Surgery: 4
Endoscopy: 2

Ashe Memorial Hospital, Inc.
200 Hospital Ave.; Jefferson, NC 28640
County: ASHE Phone: (336)846-7101
Licensee: Ashe Memorial Hospital, Inc.
License No: H0099
HOSPITAL BEDS: General: 76
NURSING HOME BEDS: General: 60

Operating Room(s):
Shared Inpatient/Ambulatory Surgery: 2
Endoscopy: 1

Asheville Specialty Hospital
428 Biltmore Ave; Asheville, NC 28801
County: BUNCOMBE Phone: (828)213-5400
Licensee: MSJHS And CCP Joint Development Company, LLC
License No: H0279
HOSPITAL BEDS: General: 34

Betsy Johnson Hospital
P O Dwr 1706; Dunn, NC 28335
County: HARNETT Phone: (910)892-7161
Licensee: Harnett Health System, Inc
License No: H0224
HOSPITAL BEDS: General: 151

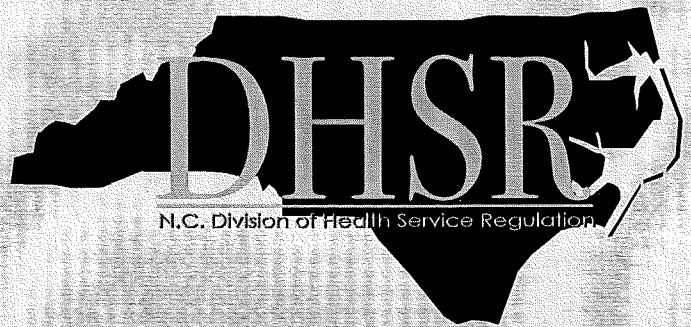
Operating Room(s):
Shared Inpatient/Ambulatory Surgery: 7
Endoscopy: 2

Blue Ridge Regional Hospital, Inc
P O Drawer 9; Spruce Pine, NC 28777
County: MITCHELL Phone: (828)765-4201
Licensee: Blue Ridge Regional Hospital, Inc.
License No: H0169
HOSPITAL BEDS: General: 46

Operating Room(s):
Shared Inpatient/Ambulatory Surgery: 3
Endoscopy: 1

STATE HEALTH COORDINATING COUNCIL

2014 STATE MEDICAL FACILITIES PLAN



North Carolina Department of Health and Human Services

CONTRACT BETWEEN SMOKY MOUNTAIN LOCAL MANAGEMENT ENTITY/ MANAGED CARE ORGANIZATION ("LME/MCO") AND ALEXANDER HOSPITAL INVESTORS, LLC, AND MBHS OF NORTH CAROLINA, LLC

WHEREAS, Alexander Hospital, located at 326 Third Street South West in Taylorsville, Alexander County, has twenty-five existing acute care beds; and

WHEREAS, Alexander Hospital Investors, LLC and MBHS of North Carolina, LLC, a provider of Mental Health, Intellectual/ Developmental Disability, and/or Substance Abuse ("MH/IDD/SA") services, (hereinafter collectively "Provider" or "Contractor") intend to convert the twenty-five licensed acute care beds at Alexander Hospital to inpatient psychiatric beds; and

WHEREAS, Contractor intends to submit an exemption request to the North Carolina Department of Health and Human Services, Division of Health Service Regulation, Certificate of Need Section, pursuant to N.C. Gen. Stat. § 131E-184(c); and

WHEREAS, in order to be eligible for the exemption, Contractor is required to execute a contract with one or more Area Authorities created under Chapter 122C of the N.C. General Statutes to provide psychiatric beds to patients referred by the Area Authority; and

WHEREAS, Smoky Mountain LME/MCO (hereinafter "Smoky" or "LME/MCO") is the Area Authority created under Chapter 122C responsible for a 23-county catchment area that includes Alexander County; and

WHEREAS, the Parties desire to enter into this Contract in order for Contractor to provide up to thirteen (13) psychiatric beds to patients referred by the LME/MCO, for the purpose of providing medically necessary MH/IDD/SA services to the LME/MCO's Enrollee(s).

WHEREAS, this Contract sets forth the requirements under which LME/MCO will make referrals to Alexander Hospital for the provision of such publicly-funded MH/IDD/SA services; and

NOW, THEREFORE, for and in consideration of mutual covenants herein and the mutual benefits to result therefrom, the Parties hereby agree as follows:

DEFINITIONS

A. "Alexander Hospital" means an inpatient acute care hospital in Alexander County that intends to license and operate twenty-five inpatient psychiatric beds.
B. "Catchment area" of the Local Management Entity/Managed Care Organization (LME/MCO) means the geographic part of the State served by Smoky.
C. "Clean Claim" means as defined in 42 C.F.R. § 447.45(b).

D. "Contract" means this Contract between Contractor and the LME/MCO.
E. "Contractor" means Alexander Hospital Investors, LLC and MBHS of North Carolina, LLC, including all staff and employees of Contractor.
F. "Department" means the North Carolina Department of Health and Human Services and its Divisions, including but not limited to the Division of Medical Assistance (DMA), Division of Health Service Regulation (DHSR), and Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS).
G. "Emergency services" means as defined in 42 CFR §422.113 and §438.114.
H. "Enrollee" means an individual with a Medicaid county of residence located within the LME/MCO catchment area enrolled with LME/MCO.
I. "Local Management Entity/Managed Care Organization" (LME/MCO) means as defined at N.C. Gen. Stat. § 122C-3(20c). The LME/MCO is responsible for authorizing, managing and reimbursing providers for all Medicaid and State-funded mental health, substance abuse, and developmental disability services pursuant to contracts with the Department for those Enrollees within the LME/MCO's defined catchment area.
J. "Notice" means a written communication between the parties delivered by trackable mail, electronic means, facsimile or by hand.

ARTICLE I
RIGHTS AND OBLIGATIONS OF THE LOCAL MANAGEMENT ENTITY

1.0 Operations Manual. The LME/MCO shall post on its website an "Operations Manual" which is hereby incorporated by reference. If the terms of this Contract conflict with information contained in the Operations Manual, the terms of the Contract shall control. Provider may download and print copies of the manual from the SMC website at: www.smokymountaincenter.com.

1.1 Screening, Triage and Referral. LME/MCO agrees to make appropriate referrals of Enrollees to Contractor effective upon execution of a Procurement Contract with LME/MCO for the provision of inpatient services. TTY capability, for persons who have a hearing impairment, and foreign language interpretation will be provided to the person making the referral or to the individual seeking service for the purposes of receipt of appropriate information for referral of services at no cost when necessary.

ARTICLE II
RIGHTS AND OBLIGATIONS OF PROVIDER

2.0 Scope of Work. Contractor agrees to make up to thirteen (13) beds of inpatient hospitalization available for referrals of LME/MCO adult enrollees dually diagnosed with I/DD and mental health disorders ("dual diagnosed enrollees"). Contractor agrees to make a minimum of twelve (12) beds of facility-based crisis available for referrals of dual diagnosed adult enrollees in a facility separate from the Alexander Hospital facility. The Parties agree that LME/MCO will be intricately involved in the development and implementation of processes and procedures governing the operation of each of the facilities and a best practice clinical model for both identified facilities. LME/MCO must approve the best practice clinical model and policies governing entrance and discharge

criteria, restrictive interventions and other policies and procedures affecting service delivery. Contractor will employ qualified staff to meet the unique needs of the dual diagnosed I/DD population. Acceptance of referrals for inpatient admission is contingent upon the approval and signed order of a physician authorized to admit enrollees to the inpatient unit. Upon acceptance of referrals, all services will be delivered in accordance with all requirements set forth or referenced in Federal and State laws, rules, and regulations, and NCDHHS implementation updates, bulletins, manuals, Clinical Coverage Policies, State Service Definitions, and the Operations Manual and all subsequent revisions.

2.1 Maintenance of Facility Licensure, Accreditation and Credentialing. Provider accepting referrals under this Contract shall obtain and maintain in good standing all applicable accreditation(s), licenses and certificates required by DHHS policy or State law, including but not limited to licensure required by all appropriate agencies and/or Boards. The Provider and its agents providing services on the Provider's behalf under this Contract shall continuously, during the term of this Contract, meet all licensure, credentialing and privileging/competency standards as described in this Contract, the Operations Manual or as required by law, policy or regulation. Provider shall meet all Certificate of Need requirements and further agree and understand that rates are based on a midnight census.

2.2 Service Record Compliance. Upon acceptance of referrals, Provider shall maintain a Service Record for each individual served in accordance with the standards set forth in Federal and State laws, rules, and regulations, and DHHS implementation updates, bulletins, manuals, Clinical Coverage Policies, and State Service Definitions, including but not limited to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services ("DMH/DD/SAS") Records Management and Documentation Manual - APSM 45-2 (effective April 1, 2009). The original Service Record related to services provided in accordance with this Contract shall be accessible upon request for review for the purpose of Quality Assurance, Utilization Management, monitoring services rendered, financial audits by third party payers and research and evaluation. Service records shall be retained for the duration and the format prescribed by the LME/MCO and by State and Federal law, rules, regulation and policy. Upon request, Provider shall provide data about individuals for the research and study to the LME/MCO as permitted or required by DHHS and applicable Federal law. Contractor shall provide the LME/MCO with all necessary clinical information for the LME/MCO's utilization management process.

2.3 Rights of Individuals. Provider shall conduct activities in a manner that shall deter, prevent, and avoid abuse, neglect, and/or exploitation of individuals in its care and to ensure compliance with all DHHS and Federal requirements and in accordance with the policies of the LME/MCO, including but not limited to the DMH/DD/SAS Confidentiality Rules APSM 45-1 (1/05), Treatment of Confidential Information Under N.C.G.S. § 122C (Special Medicaid Bulletin, July 2012), and Client Rights Rules in Community Mental Health, Developmental Disabilities & Substance Abuse Services APSM 95-2 (7/03). The Provider agrees to maintain policies, procedures and monitoring as required in the DHHS Client Right's policy, the Operations Manual and the policies of the LME/MCO. When a restrictive intervention is used, Contractor shall follow all applicable Controlling Authority

governing seclusion and restraint for behavior management, including but not limited to 42 C.F.R. §482.12, N.C. Gen. Stat. §122C-60, and 10A N.C.A.C. 13B .1924.

2.4 Adverse Selection. Provider shall be prohibited from arbitrarily declining, refusing to serve or ejecting consumers referred by the LME/MCO under this Agreement except that Provider shall serve only those Enrollees for which it has capacity or staff appropriate to treat the Enrollee at the time the Enrollee presents for treatment. In the event that Provider declines a referral, refuses to serve or ejects a specific consumer, Provider shall provide a detailed written specific reason for the decline, refusal or denial to Smoky via email (Provider.Info@smokymountaincenter.com). In all cases of adverse selection, Provider must provide timely reasons, and where applicable, notice to ensure that continuity of care can be optimized. Refusal to accept a referral based upon the individual's source of reimbursement may constitute adverse selection. The LME/MCO may consider information regarding adverse selection in its evaluation of Provider.

2.5 Service Coordination. All individuals referred by LME/MCO shall receive Continuity of care. In an effort to improve the coordination of supports and services within the LME/MCO's community of providers, Provider agrees to use good faith efforts to coordinate supports and services with other Provider participants, Carolina Access and other primary care providers for all individuals served under this Contract. Provider shall coordinate interpretation services as necessary, including but not limited to TTY/TTD or other similar services for the deaf and hard of hearing. Provider shall obtain appropriate client authorizations and consents to release or exchange information. The Provider shall participate in team meetings and/or community collaborations and communicate regularly with other providers regarding mutual cases. A pattern of failure to coordinate services in a timely manner, without demonstrated corrections, may result in contract termination.

2.6 Quality Management. Facilities and/or Programs that are accredited by accrediting agencies accepted by the Centers for Medicare and Medicaid Services (CMS) shall be considered in compliance with Quality Assurance/ Quality Improvement requirements. Contractor shall provide a copy of its QA/QI Plan upon written request by the LME/MCO.

2.7 Incident Reporting. Provider shall report and respond to all client incidents as required under Federal and State laws, rules, and regulations, and DHHS implementation updates, bulletins, manuals, Clinical Coverage Policies and State Service Definitions. Incidents shall be reported in the manner prescribed and on a form provided by DHHS.

2.8 Reports of Regulatory Authorities. Copies of surveys, reviews and/or audits performed by accrediting or regulatory authorities of Provider, including but not limited to the Centers for Medicare & Medicaid Services ("CMS"), DHHS, DMH/DD/SAS, the Division of Medical Assistance ("DMA") and the Division of Health Service Regulation ("DHSR"), shall be provided to the LME/MCO within five (5) business days of receipt by the Provider.

2.9 Exclusion, Suspension or Debarment. Provider certifies by signing this Contract that neither it nor its agents have been excluded, suspended or debarred by any applicable

governmental authority from conducting any business or activities contemplated by this Contract whether under current corporate name or any additional name or former name, including the current or former name of a division, department, program or subsidiary.

2.10 Insurance. Provider shall purchase and maintain insurance as listed below from a company, or a self insurance program which is licensed and authorized to do business in the State of North Carolina by the North Carolina Department of Insurance. Self insurance policies shall not be eliminated or reduced in coverage or limits below the stated minimums without thirty (30) days prior notice to the LME/MCO. Additional coverage and requirements may apply for approval of credentialing and/or execution of a Procurement Contract.

a. Professional Liability: Contractor shall purchase and maintain professional liability insurance protecting the Contractor and any employee performing work under the Contract for an amount of not less than $1,000,000.00 per occurrence and proof of coverage at or exceeding $3,000,000.00 in the annual aggregate.

b. Comprehensive General Liability: Bodily Injury and Property Damage Liability Insurance shall protect the Contractor and any employee performing work under the Contract from claims of Bodily Injury or Property Damage, which may arise from operations under the Contract. The amounts of such insurance shall not be less than $1,000,000.00 per Occurrence/$3,000,000.00 per Aggregate/$1,000,000.00 Personal and Advertising Injury/$50,000.00 Fire Damage. The insurance shall not include exclusion for contractual liability.

c. Automobile Liability: Automobile Bodily Injury and Property Damage Liability Insurance covering all owned, non-owned, and hired automobiles for limits of not less than $1,000,000.00 each person and $1,000,000.00 each occurrence of Bodily Injury Liability and $1,000,000.00 each occurrence of Property Damage Liability. Policies written on a combined single limit basis should have a limit of not less than $1,000,000.00.

d. Workers' Compensation and Occupational Disease Insurance: Insurance Coverage must meet the statutory requirements of the State of North Carolina; and Employer's Liability Insurance for an amount of not less than: Bodily Injury by Accident $100,000.00 each Accident, Bodily Injury by Disease $100,000.00 each Employee, and Bodily Injury by Disease $500,000.00 Policy Limit.

e. Certificate of Coverage: Contractor shall permit the LME/MCO to inspect Certificates of Insurance Coverage consistent with the Contract upon advance written request. Notwithstanding anything to the contrary herein, the Contractor shall have the right to self-insure so long as the Contractor's self insurance program is licensed by the Department of Insurance of the State of North Carolina and is actuarially determined sufficient to pay the insurance limits required in this paragraph.

2.11 Federal Requirements. Provider by signing this contract agrees to comply with all

governmental requirements applicable to the services being provided and to its operations, including, but not limited to the Certification Regarding Environmental Tobacco Smoke; Certification Regarding Lobbying; Certification Regarding Drug-Free Workplace Requirements; and Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion-Lower Tier Covered Transactions (See Appendices A through D).

2.12 Utilization Management Requirements. The LME/MCO can only authorize medically necessary services within available funding. Authorization requests shall comply with established clinical guidelines, evidence based practices where applicable, the Operations Manual, the LME/MCO state funded benefit plan, Federal and State laws, rules, and regulations, and NCDHHS implementation updates, bulletins, manuals, Clinical Coverage Policies and State Service Definitions.

2.13 Admission and Discharge Requirements. As shall be more fully described in the Procurement Contract between the Parties, Contractor shall immediately notify LME/MCO electronically upon an Enrollee's inpatient admission and in advance of discharge, and shall coordinate any discharge planning meetings with LME/MCO and the Enrollee's behavioral health provider.

2.14 Preservation of DHHS Public Funds. Provider shall demonstrate good faith efforts to seek alternative and/or supplemental sources of financing so as to reduce dependency on government monies.

2.15 Coordination of Benefits. Provider agrees to assist in the coordination of each individual's health care benefits so as to avoid undue delay in the provision of service and to ensure that public funds shall be used only if and when other sources of first and third Party payment have been exhausted. Provider shall make every reasonable effort to verify all insurance and other third Party benefit plan details during first contact, so that persons are directed to appropriate Providers, and to comply with North Carolina law. Where available, Provider is required to bill a consumer's private insurance. During an emergency, Provider shall provide the necessary services and then assist to coordinate payment.

2.16 Mergers, Name Changes and Acquisitions and Changes in Ownership or Control. The Provider shall notify the LME/MCO in writing regarding any merger, name change, acquisition of another company, change in ownership or control or change in address or site location prior to the effective date of such change. LME/MCO is not required to approve the credentialing or contract with the surviving entity. The surviving entity shall be bound by all the terms and conditions of this Contract.

ARTICLE III
MUTUAL RIGHTS AND OBLIGATIONS OF BOTH PARTIES

3.0 Health Insurance Portability and Accountability Act (HIPAA). The Parties shall comply with any and all laws relating to privacy and/or security of healthcare information, including but not limited to 42 CFR Part 2 and the Health Insurance Portability and Accountability Act of 1996 (45 CFR Parts 160, 162 & 164), as further expanded by the

Health Information Technology for Economic and Clinical Health Act (HITECH Act), which was adopted as part of the American Recovery and Reinvestment Act of 2009, commonly known as "ARRA" (Public Law 111-5) and any subsequent modifications thereof. Pursuant to 45 C.F.R. § 164.506, the Parties may share an individual's protected health information ("PHI") for the purposes of treatment, payment, or health care operations without the individual's consent unless as otherwise proscribed by Federal law.

3.1 Confidentiality. The Parties shall protect the confidentiality of any and all individuals and will not discuss, transmit, or narrate in any form other information, medical or otherwise, received in the course of providing services hereunder, except as authorized by the individual, his legally responsible person, or as otherwise permitted or required by law. The Parties shall, in addition, meet all confidentiality requirements promulgated by any applicable governmental authority.

3.2 Compliance with Civil Rights and Disability Law. The Parties shall comply with Title VI and VII of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990 (ADA), the North Carolina Persons with Disabilities Protection Act, and all requirements imposed by Federal and State laws, rules, regulations and guidelines issued pursuant to these laws for both personnel employed and individuals served.

3.3 Governing Laws. The laws of the State of North Carolina shall govern the validity and interpretation of the provisions, terms, and conditions of this Contract. Venue for all legal actions upon this Contract shall be in the State Courts of Buncombe County or the U.S. District Court for the Western District of North Carolina, Asheville Division. By signing this Contract, Provider explicitly acknowledges, agrees and understands that disputes based on this Contract are not subject to review by the DMH/DD/SAS Appeals Panel or the NC Office of Administrative Hearings.

3.4 Entire Contract. This Contract, along with the Operations Manual and other standards or documents specifically incorporated herein, constitutes the entire understanding of the Parties and this Contract shall not be altered, amended, or modified except by an Amendment in writing, properly executed by the duly authorized officials of both Parties. This contract to provide psychiatric beds to patients referred by the LME/MCO meets the requirements established in N.C.G.S. §131E-184(c)(1) and (2).

3.5 Invalid Provisions. If any term, provision, or condition of this Contract is found to be illegal, void, or unenforceable by a court of competent jurisdiction, the rest of this Contract shall remain in full force and effect. The invalidity or unenforceability of any term or provision of this Contract shall in no way affect the validity or enforceability of any other term or provision.

3.6 Hold Harmless. The LME/MCO and Provider agree to each be solely responsible for their own acts or omissions in the performance of each of their individual duties hereunder, and shall be financially and legally responsible for all liabilities, costs, damages, expenses and attorney fees resulting from, or attributable to any and all of their individual acts or

omissions. No Party shall have any obligation to indemnify the other, and/or its agents, employees and representatives.

3.7 Independent Contractor. This Contract is not intended and shall not be construed to create the relationship of agent, servant, employee, partnership, joint venture, or association between Provider and LME/MCO, their employees, partners, or agents, but rather is a Contract by and among independent contractors. Neither party shall be considered an employee or agent of the other for any purpose including but not limited to, compensation for services, employee welfare and pension benefits, workers' compensation insurance, or any other fringe benefits of employment.

3.8 Subcontracting. Provider must obtain written permission from the LME/MCO prior to any subcontract or assignment any of the services contemplated under this Contract. In the event that LME/MCO approves the subcontracting or assignment any of the services contemplated under this Contract, the services shall be subject to all conditions of this Contract. The LME/MCO may assign its rights and obligations under this Contract without approval of providers.

3.9 Non-Exclusivity. This Contract is not exclusive. The LME/MCO and Provider have the right to enter into a similar Contract with any other LME/MCO and/or other providers at any time.

3.10 Conflict of Interest. Provider and LME/MCO will comply with all applicable laws regarding Conflict of Interest.

3.11 No Third Party Contract Rights Conferred: Nothing in this Contract shall be construed as creating or justifying any liability, claim or cause of action, however alleged or arising, by any third party, against LME/MCO or Provider.

3.12 Notice. All notices, reports, records, or other communications which are required or permitted to be given to the parties under the terms of this Contract shall be sufficient in all respects if given in writing and delivered in person, by confirmed facsimile transmission, by overnight courier, or by registered or certified mail, postage prepaid, return receipt requested, to the receiving party at the following address:

If to SMC:	Smoky Mountain LME/MCO Office of General Counsel 356 Biltmore Avenue Asheville, NC 28801
If to Provider:	MBHS OF NORTH CAROLINA, LLC ALEXANDER HOSPITAL INVESTORS, LLC 19821 NW ~~2nd~~ Avenue Suite 396 Miami Gardens, Fl 33169

Either Party may at any time change its address for notification purposes by mailing a notice to the other Party at the address designated by that Party. The new address shall be effective on the date specified in such notice, or if no date is specified, on the tenth (10th) day following the date such notice is received.

ARTICLE IV
TERM AND TERMINATION

4.0 Term. The term of this Contract shall commence upon execution by all Parties and shall continue until the effective date of Procurement Contract(s) between the Parties allowing for reimbursement of claims submitted by Contractor to LME/MCO for inpatient psychiatric services. The Parties agree, acknowledge and understand that Contractor shall be required to meet all credentialing criteria required by the Division of Medical Assistance and the LME/MCO accrediting body prior to the execution of a Procurement Contract, and that credentialing approval is contingent upon approval of Contractor's license to operate Alexander Hospital as a psychiatric hospital by the State of North Carolina.

4.1 Termination Without Cause. In accordance with 10A NCAC 27A .0106, this contract may be terminated at any time by mutual consent of both parties or 30 days after either Party gives written notice of termination to the other Party.

4.2 Availability of Funding. Either party may terminate the Contract if Federal, State or local funds allocated to LME/MCO are revoked or terminated in a manner beyond the control of LME/MCO for any part of the Contract period. The parties explicitly acknowledge, agree and understand that this Contract and any other contractual relationship between the parties is dependent upon and subject to the appropriation, allocation or availability of funds for this purpose by the State of North Carolina to LME/MCO. In the event that LME/MCO, in its sole discretion, determines, in view of its total operations, that available funding is insufficient to continue this Contract, it may choose to terminate the Contract by providing written notice of said termination to CMT, and the Contract shall terminate upon such notice without any further liability to LME/MCO.

4.3 Termination for Cause. Either party may terminate the Contract with cause upon thirty (30) days notice to the other party; cause shall be documented in writing detailing the grounds for the termination. Cause for termination of the Contract may include, but is not limited to:

i. Either party has failed to attain or maintain required facility or professional NC Medicaid enrollment, licensure, accreditation or certification; and/or

ii. The conduct of either party or either party's employees or agents or the standard of services provided threatens to place the health or safety of any Enrollee in jeopardy. Conduct of the either party's employee(s) or agent(s) that threatens to place the health or safety of any Enrollee in jeopardy shall not constitute grounds for termination of the entire Contract provided the party takes appropriate action toward said employee(s) or agent(s). Either party maintains its right to terminate this

Contract should the other party fail to take appropriate action toward employees or agents whose conduct threatens to place the health or safety of any Enrollee in jeopardy; and/or

iii. Any other material breach of this Contract.

REQUIRED APPENDICES/ATTACHMENTS:

_____	Appendix A	CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION-LOWER TIER COVERED TRANSACTIONS
_____	Appendix B	CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS
_____	Appendix C	CERTIFICATION REGARDING LOBBYING
_____	Appendix D	CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

IN WITNESS WHEREOF:

IN WITNESS WHEREOF, each party has caused this agreement to be executed in multiple copies, each of which shall be deemed an original, as the act of said party. Each individual signing below certifies that he or she has been granted the authority to bind said Party to the terms of this Contract and any Addendums or Attachments thereto.

SMOKY MOUNTAIN LME/MCO

DocuSigned by:
Brian Ingraham
Brian Ingraham
Chief Executive Officer

10/15/2014
Date

ALEXANDER HOSPITAL INVESTORS, LLC

By: _____, Manager
Charles E. Trefzger, Jr.
Manager

9/29/14
Date

MBHS OF NORTH CAROLINA, LLC

DocuSigned by:

Wes Mason
President

9/23/2014
Date

APPENDIX A

CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION-LOWER TIER COVERED TRANSACTIONS

(Note: The phrase "prospective lower tier participant" means providers under contract with the Division.)

Department of Health and Human Services
Division of Mental Health, Developmental Disabilities and Substance Abuse Services

Instructions for Certification

1. By signing and submitting this Contract, the prospective lower tier participant is providing the certification set out below.

2. The certification in this clause is a material representation of the fact upon which reliance was placed when this transaction was entered into. If it is later determined that the prospective lower tier participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government, the department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.

3. The prospective lower tier participant will provide immediate written notice to LME/MCO if at any time the prospective lower tier participant learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.

4. The terms "covered transaction," "debarred," "suspended," "ineligible," "lower tier covered transaction," "participant," "person," "primary covered transaction," "principal," "proposal," and "voluntarily excluded," as used in this clause, have the meanings set out in the Definitions and Coverage sections of rules implementing Executive Order 12549, 45 CFR Part 76.

5. The prospective lower tier participant agrees by submitting this proposal that, should the proposed covered transaction be entered into, it shall not knowingly enter any lower tier covered transaction with a person who is debarred, suspended, determined ineligible or voluntarily excluded from participation in this covered transaction unless authorized by the department or agency with which this transaction originated.

6. The prospective lower tier participant further agrees by signing this Contract that it will include this clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion - Lower Tier Covered Transaction," without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

7. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not debarred, suspended, ineligible, or voluntarily excluded from covered transaction, unless it knows that the certification is erroneous. A participant may decide the method and frequency of which it determines the eligibility of its principals. Each participant may, but is not required to, check the Non procurement List.

8. Nothing contained in the foregoing shall be construed to required establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

9. Except for transactions authorized in paragraph 5 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal Government, the department or agency with which this transaction originated may pursue available remedies, including suspension, and/or debarment.

Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion - Lower Tier Covered Transactions

(1) The prospective lower tier participant certifies, by signing this Contract, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency.

(2) Where the prospective lower tier participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal.

By: Manager — MANAGER
Charles E. Trefzger, Jr. — Title

9/29/14
Alexander Hospital Investors, LLC — Date

DocuSigned by:
Wes Wilson
Wes Wilson — President
Title

9/23/2014
MBHS of North Carolina, LLC — Date

APPENDIX B

CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

Department of Health and Human Services
Division of Mental Health, Developmental Disabilities and Substance Abuse Services

I. By execution of this Agreement the Contractor certifies that it will provide a drug-free workplace by:

A. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the Contractor's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

B. Establishing a drug-free awareness program to inform employees about:

(1) The dangers of drug abuse in the workplace;

(2) The Contractor's policy of maintaining a drug-free workplace;

(3) Any available drug counseling, rehabilitation, and employee assistance programs; and

(4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

C. Making it a requirement that each employee be engaged in the performance of the agreement be given a copy of the statement required by paragraph A;

D. Notifying the employee in the statement required by paragraph A that, as a condition of employment under the agreement, the employee will:

(1) Abide by the terms of the statement; and

(2) Notify the employer of any criminal drug statute conviction for a violation occurring in the workplace no later than five days after such conviction;

E. Notifying the Department within ten days after receiving notice under subparagraph D(2) from an employee or otherwise receiving actual notice of such conviction;

F. Taking one of the following actions, within 30 days of receiving notice under subparagraph D(2), with respect to any employee who is so convicted:

(1) Taking appropriate personnel action against such an employee, up to and including termination; or

(2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency; and

(3) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs A, B, C, D, E, and F.

II. The site(s) for the performance of work done in connection with the specific agreement is:

Alexander Hospital
326 Third Street SW
Taylorsville, NC 28681

Contractor will seek credentialing for and request written amendment from LME/MCO to add any additional sites for performance of work under this agreement.

False certification or violation of the certification shall be grounds for suspension of payment, suspension or termination of grants, or government-wide Federal suspension or debarment, 45 C.F.R. §82.510.

Charles E. Trefzger, Jr. — Manager — Title

Alexander Hospital Investors, LLC — 9/29/14 — Date

DocuSigned by:
Wes Mason — President — Title

MBHS of North Carolina, LLC — 9/23/2014 — Date

APPENDIX C

Certification Regarding Lobbying
Department of Health and Human Services
Division of Mental Health, Developmental Disabilities and Substance Abuse Services

Certification for Contracts, Grants, Loans and Cooperative Agreements

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any Federal, state or local government agency, a Member of Congress, a Member of the General Assembly, an officer or employee of Congress, an officer or employee of the General Assembly, an employee of a Member of Congress, or an employee of a Member of the General Assembly in connection with the awarding of any Federal or state contract, the making of any Federal or state grant, the making of any Federal or state loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal or state contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any Federal, state or local government agency, a Member of Congress, a Member of the General Assembly, an officer or employee of Congress, an officer or employee of the General Assembly, an employee of a Member of Congress, or an employee of a Member of the General Assembly in connection with the awarding of any Federal or state contract, the making of any Federal or state grant, the making of any Federal or state loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal or state contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly.

(4) This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Notwithstanding other provisions of federal OMB Circulars A-122 and A-87, costs associated with the following activities are unallowable:

Paragraph A.

(1) Attempts to influence the outcomes of any Federal, State, or local election, referendum, initiative, or similar procedure, through in kind or cash contributions, endorsements, publicity, or similar activity;

(2) Establishing, administering, contributing to, or paying the expenses of a political party, campaign, political action committee, or other organization established for the purpose of influencing the outcomes of elections;

(3) Any attempt to influence: (i) The introduction of Federal or State legislation; or (ii) the enactment or modification of any pending Federal or State legislation through communication with any

member or employee of the Congress or State legislature (including efforts to influence State or local officials to engage in similar lobbying activity), or with any Government official or employee in connection with a decision to sign or veto enrolled legislation;

(4) Any attempt to influence: (i) The introduction of Federal or State legislation; or (ii) the enactment or modification of any pending Federal or State legislation by preparing, distributing or using publicity or propaganda, or by urging members of the general public or any segment thereof to contribute to or participate in any mass demonstration, march, rally, fundraising drive, lobbying campaign or letter writing or telephone campaign; or

(5) Legislative liaison activities, including attendance at legislative sessions or committee hearings, gathering information regarding legislation, and analyzing the effect of legislation, when such activities are carried on in support of or in knowing preparation for an effort to engage in unallowable lobbying.

The following activities as enumerated in Paragraph B are excepted from the coverage of Paragraph A:

Paragraph B.

(1) Providing a technical and factual presentation of information on a topic directly related to the performance of a grant, contract or other agreement through hearing testimony, statements or letters to the Congress or a State legislature, or subdivision, member, or cognizant staff member thereof, in response to a documented request (including a Congressional Record notice requesting testimony or statements for the record at a regularly scheduled hearing) made by the recipient member, legislative body or subdivision, or a cognizant staff member thereof; provided such information is readily obtainable and can be readily put in deliverable form; and further provided that costs under this section for travel, lodging or meals are unallowable unless incurred to offer testimony at a regularly scheduled Congressional hearing pursuant to a written request for such presentation made by the Chairman or Ranking Minority Member of the Committee or Subcommittee conducting such hearing.

(2) Any lobbying made unallowable by subparagraph A(3) to influence State legislation in order to directly reduce the cost, or to avoid material impairment of the organization's authority to perform the grant, contract, or other agreement.

(3) Any activity specifically authorized by statute to be undertaken with funds from the grant, contract, or other agreement.

Paragraph C.

(1) When an organization seeks reimbursement for indirect costs, total lobbying costs shall be separately identified in the indirect cost rate proposal, and thereafter treated as other unallowable activity costs in accordance with the procedures of subparagraph B(3).

(2) Organizations shall submit, as part of the annual indirect cost rate proposal, a certification that the requirements and standards of this paragraph have been complied with.

(3) Organizations shall maintain adequate records to demonstrate that the determination of costs as being allowable or unallowable pursuant to this section complies with the requirements of this Circular.

(4) Time logs, calendars, or similar records shall not be required to be created for purposes of complying with this paragraph during any particular calendar month when: (i) the employee engages in lobbying (as defined in subparagraphs A & B) 25 percent or less of the employee's compensated hours of employment during that calendar month, and (ii) within the preceding five-year period, the organization has not materially misstated allowable or unallowable costs of any nature, including legislative lobbying costs. When conditions (i) and (ii) are met, organizations are not required to establish records to support the allow ability of claimed costs in addition to records already required or maintained. Also, when conditions (i) and (ii) are met, the absence of

time logs, calendars, or similar records will not serve as a basis for disallowing costs by contesting estimates of lobbying time spent by employees during a calendar month.

(5) Agencies shall establish procedures for resolving in advance, in consultation with OMB, any significant questions or disagreements concerning the interpretation or application of this section. Any such advance resolution shall be binding in any subsequent settlements, audits or investigations with respect to that grant or contract for purposes of interpretation of this Circular; provided, however, that this shall not be construed to prevent a contractor or grantee from contesting the lawfulness of such a determination.

Paragraph D.

Executive lobbying costs. Costs incurred in attempting to improperly influence either directly or indirectly, an employee or officer of the Executive Branch of the Federal Government to give consideration or to act regarding a sponsored agreement or a regulatory matter are unallowable. Improper influence means any influence that induces or tends to induce a Federal employee or officer to give consideration or to act regarding a federally sponsored agreement or regulatory matter on any basis other than the merits of the matter.

By: Manager Charles E. Trefzger, Jr.	Manager Title
Alexander Hospital Investors, LLC	9/29/14 Date
DocuSigned by: [signature] Wes Mason	President Title
MBHS of North Carolina, LLC	9/23/2014 Date

APPENDIX D

CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Department of Health and Human Services
Division of Mental Health, Developmental Disabilities and Substance Abuse Services

Certification for Contracts, Grants, Loans and Cooperative Agreements

Public Law 103-227, Part C-Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, education, or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law does not apply to children's services provided in private residences, facilities funded solely by Medicare or Medicaid funds, and portions of facilities used for inpatient drug or alcohol treatment. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 per day and/or the imposition of an administrative compliance order on the responsible entity.

By signing and submitting this certification, the Contractor certifies that it will comply with the requirements of the Act. The Contractor further agrees that it will require the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-grantees shall certify accordingly.

by: _____ MANAGER

Charles E. Trefzger, Jr. — Title

9/29/14

Alexander Hospital Investors, LLC — Date

DocuSigned by:
_____
Wes Mason

President

Title

9/23/2014

MBHS of North Carolina, LLC — Date

N.C. Department of Health and Human Services

For Those We Serve

Facility-Based Crisis (Professional Treatment Services in Facility-Based Crisis Program)

This service provides an alternative to hospitalization for adults who have a mental illness,substance abuse disorder or intellectual/developmental disability and are in crisis. Services are provided in a 24-hour residential facility and include short-term intensive evaluation, and treatment intervention or behavioral management to stabilize acute or crisis situations. Before contacting the local Facility-Based Crisis provider, it is recommended that you **first contact your current mental health, substance abuse, or developmental disabilities service provider, if you have one, or your Local Management Entity's access/crisis line.**

- LME 24-Hour Access/Crisis Contact Information
- Facility-Based Crisis Programs (4/14)

North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services

PROFESSIONAL TREATMENT SERVICES IN FACILITY-BASED CRISIS PROGRAMS

April 30, 2014

Admission of persons with Intellectual/Developmental Disabilities to any of these programs depends on the acuity of the individual.

County	Name	Address	Phone Number
Alamance	Hall Avenue Facility - Residential Treatment Services of Alamance, Inc.	136 Hall Ave., Burlington, NC 27215	336-227-7417
Beaufort	PORT Human Services - Ray G. Silverthorne Crisis Center	1379 Cowell Farm Rd., Washington, NC 27889	252-975-8852
Buncombe	Neil Dobbins Center - ARP Phoenix, Inc.	277 Biltmore Ave., Asheville, NC 28801	828-253-6306
Cabarrus	Crisis Recovery Center at Kannapolis - Daymark Recovery Services, Inc.	1309 S. Cannon Blvd., Kannapolis, NC 28083	704-933-3212
Cleveland	Cleveland Crisis and Recovery Center – Phoenix Counseling Center	609 North Washington St., Shelby, NC 28150	704-751-3693
Cumberland	Roxie Ave. Center - Cape Fear Valley Health System	1724 Roxie Ave., Fayetteville, NC 28304	910- 609-6656
Durham	Durham Center Access - Freedom House Recovery Center, Inc.	309 Crutchfield St., Durham, NC 27704	919-560-7305
Forsythe	Addiction	1931 Union Cross	336-784-9470

	Recovery Care Association (ARCA), Inc.	Rd. Winston-Salem, NC 27107	
Gaston	Phoenix Counseling Center	2505 Court Drive, Gastonia, NC 28054	704-854-4830
Haywood	Balsam Center Adult Recovery Unit - Appalachian Community Services, Inc.	91 Timberlane Rd. Waynesville, NC 28786	828-454-9242
Hertford	Port Human Services – Roanoke/Chowan	144C Community College Rd., Ahoskie, NC 27910	252- 332-4598
Iredell	Daymark Recovery C.R.C. Statesville – Daymark Recovery Services, Inc.	524 Signal Hill Drive Extension, Statesville, NC 28625	704-871-9605
Mecklenburg	Carolinas Healthcare System – CMC Randolph	447 Billingsley Rd., Charlotte, NC 28211	704- 336-5386
New Hanover	The Harbor – RHA Health Services, Inc.	2023 1A South 17th St. Wilmington, NC 28401	910-632-2191
Orange	Facility Based Crisis Services - Freedom House Recovery Center, Inc.	110 New Stateside Dr., Chapel Hill, NC 27516	919-942-2803
Pitt	PORT Human Services, Inc.	203 Government Circle, Greenville, NC 27834	252-413-1637
Polk	Pavillon International	241 Pavillon Place, Mill Spring, NC 28756	828-694-2300
Robeson	Tanglewood Arbor - Monarch	207 W. 29th St., Lumberton, NC 28358	910-618-5606

Union	Monroe Crisis Recovery Center - Daymark Recovery Services, Inc.	1408 E. Franklin St., Monroe, NC 28112	704-635-2080
Vance	Recovery Innovations Inc. Recovery Response Center	300 Parkview Dr. West, Henderson, NC 27536	252-438-4145
Wake	UNC Health Care Facility Based Crisis at Wakebrook	107 Sunnybrook Rd., Raleigh, NC 27610	919-882-3481
Wilkes	Synergy Recovery at the Bundy Center – Synergy Recovery, Inc.	118 Peace St., North Wilkesboro, NC 28659	336-667-7191