PETITION TO THE STATE HEALTH COORDINATING COUNCIL TO ADJUST THE DRAFT 2009 STATE MEDICAL FACILITIES PLAN'S NEED DETERMINATION TO INCLUDE TEN INPATIENT REHABILITATION BEDS AT THE ELIZABETH C. STANBACK REHABILITATION UNIT AT ROWAN REGIONAL MEDICAL CENTER IN ROWAN COUNTY

Novant Health, Inc. ("Novant"), Rowan Health Services Corporation ("RHSC") and Rowan Regional Medical Center, Inc. ("RRMC") (collectively "Petitioners") hereby petition the State Health Coordinating Council ("SHCC") to adjust the need determination in the Draft 2009 State Medical Facilities Plan ("SMFP") to include ten (10) inpatient rehabilitation beds at the Elizabeth C. Stanback Rehabilitation Unit ("Stanback Rehab") at RRMC in Rowan County. This request is made because The Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas HealthCare System ("CMHA"), the original CON applicant for these beds, is attempting to relocate them to another facility outside of Rowan County in the near future. These beds are licensed to RRMC and have been in continuous operation at RRMC since their development in 1999. There are no other inpatient rehabilitation beds in Rowan County. Petitioners do not believe that CMHA has the legal right to do this. Nevertheless, if CMHA does prevail, it is imperative that the citizens of Rowan County and surrounding areas continue to have access to inpatient rehabilitation beds at Stanback Rehab. The existing beds at Stanback Rehab are among the most highly-utilized rehabilitation beds in the State, and therefore removal of the beds without allowing their replacement and thus the continued operation of Stanback Rehab, will result in irreparable harm to the patients of Rowan County and surrounding communities.

IDENTIFICATION OF PETITIONERS

Each of the petitioners is a private, not-for-profit North Carolina corporation. Novant is located at 2085 Frontis Plaza Blvd, Winston-Salem, North Carolina 27103. RHSC is the sole member of RRMC. Effective 1 January 2008, Novant became the sole member of RHSC.

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Planning Section

RRMC operates a full-service community hospital with 268 licensed beds, including 10 rehabilitation beds, located at 612 Mocksville Ave, Salisbury, North Carolina 28144. Its main telephone number is 704-210-5000.

BACKGROUND FACTS REGARDING STANBACK REHAB

Stanback Rehab was developed pursuant to a certificate of need ("CON") awarded by the Department of Health and Human Services ("Department") on 1 February 1999 for Project I.D. No. F-4791-93.[1] That CON authorized the development of 10 rehabilitation beds to be located at either RRMC or Mercy Hospital in Charlotte, which at that time, had an existing rehabilitation unit. On 21 December 1998, RRMC and CMHA entered into a Management Agreement for the placement and management of the ten beds at Stanback Rehab in Rowan County. The ten Stanback Rehab beds have been licensed as a part of RRMC since 1999. Stanback Rehab is the only non-governmental inpatient rehabilitation facility in Rowan County. The closest inpatient rehabilitation facilities to Stanback Rehab are located in Albemarle (Stanly County), Charlotte (Mecklenburg County), Winston-Salem (Forsyth County), and High Point (Guilford County). On average, these facilities are over 40 miles and nearly 50 minutes away from Rowan County.[2]

Since its development in 1999, Stanback Rehab has become a tremendous resource for the Rowan County community.[3] Since 2002, the facility has consistently been among the top three or four most heavily utilized inpatient rehabilitation facilities in the State, with an average

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[1] *See* CON for Project I.D. No. F-4791-93, attached hereto as Exhibit A.

[2] Affidavit of David Smith, M.D. ("Dr. Smith Affidavit"), attached hereto as Exhibit B.

[3] *See* Affidavit of David R. Bean ("Bean Affidavit"), attached hereto as Exhibit C; Affidavit of Douglas B. Shellhorn, M.D. ("Dr. Shellhorn Affidavit"), attached hereto as Exhibit D; Affidavit of R. Christopher Agner, M.D. ("Dr. Agner Affidavit"), attached hereto as Exhibit E; Exhibit B, Dr. Smith Affidavit.

utilization rate of 82.1% in 2006, second only to Nash General Hospital.[4] According to data from the 2006-2008 SMFPs, the utilization of the Stanback Rehab inpatient rehabilitation unit has consistently been among the highest in the State, often exceeding the State's target occupancy:

	2008 SMFP FFY 2006 Data	**2007 SMFP FFY 2005 Data**	**2006 SMFP FFY 2004 Data**	**2005 SMFP FFY 2003 Data**	**2005 SMFP FFY 2003 Data**
RRMC Rehab Unit Utilization	82.1%	87.5%	87.8%	86.0%	81.5%
SMFP Target Utilization	80%	80%	80%	80%	80%

Throughout its operation, there has been a robust demand for inpatient rehabilitation services at Stanback Rehab and a real void will be left by CMHA's attempt to dismantle this unit.

Stanback Rehab provides services to patients with injuries and conditions ranging from joint replacement to injuries such as falls, to serious and debilitating strokes. Its rehabilitation services include physical therapy services, occupational therapy services, speech/language pathology services, psychology services, rehabilitation nursing, special services, vocational services, and respiratory therapy services among others. On average, a patient will spend approximately two weeks at Stanback Rehab receiving care and therapeutic treatment.[5] These patients require many hours of intensive rehabilitation in order to achieve even minimal normal function.

On June 30, 2008, CMHA, the original applicant for the CON authorizing the development of the rehabilitation beds at Stanback Rehab, essentially "removed" the beds from Stanback by discontinuing the admission of new patients into the rehabilitation facility. The

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[4] 2007 and 2008 State Medical Facilities Plans, Chapter 8, Inpatient Rehabilitation Beds, attached hereto as Exhibits F and G, respectively.

[5] Exhibit B, Dr. Smith Affidavit.

medical staff at Stanback Rehab, including the admitting physician, are employees of CMHA and were providing care to patients at Stanback pursuant to the parties' Management Agreement. This removal of beds was met with significant opposition from physicians and patients alike in Rowan County, who expressed their concern at losing such a valuable and heavily-utilized local health care resource.[6] RRMC sought a temporary restraining order to prevent the termination of the Management Agreement between RRMC and CMHA and the removal of the beds from Stanback. RRMC received a great deal of support from physicians in the community as well as from a former patient in an effort to prevent the closing of the rehab facility. However, RRMC's request for a temporary restraining order was ultimately denied and the parties privately negotiated a temporary resolution to their disagreement regarding the termination of the Management Agreement.[7]

Despite the support of the community for the continued operation of the rehabilitation facility, admissions were suspended as of June 30, 2008. However, Stanback did continue to operate and treat its existing patients through the week of July 21, 2008. Because the physicians and support staff at Stanback Rehab were employees of CMHA, they no longer provide services at Stanback Rehab, and have since left that facility.[8]

Petitioners are currently working to implement new physicians and staff at Stanback and anticipate reopening the facility for new admissions the week of August 4, 2008. However, the closure of this facility, even for a short period, is a tremendous blow to Rowan County. In the interim, patients in need of rehabilitation services in Rowan County have been

[6] *See* Exhibit C, Bean Affidavit; Exhibit D, Dr. Shellhorn Affidavit; Exhibit E, Dr. Agner Affidavit; Affidavit of Myron A. Goodman, M.D. ("Dr. Goodman Affidavit"), attached hereto as Exhibit H.
[7] The case referred to was filed in Rowan County Superior Court on June 26, 2008, case No. 08 CVS 2158. It was voluntarily dismissed without prejudice on July 2, 2008.
[8] Exhibit B, Affidavit of Dr. Smith.

forced to travel to other counties such as Stanly County, Mecklenburg County, Forsyth County, and Guilford County for inpatient rehabilitation therapy.[9] This presents a tremendous emotional and financial burden for the patients and their families during what is already a very stressful time for them. Because of the demonstrable need and high demand for these services in Rowan County, the community is left without a critical health care resource.[10]

Pursuant to the CON originally issued for these beds, CMHA can only relocate them to Mercy Hospital.[11] Thus, they cannot be relocated to another facility in Rowan County, and CMHA has expressed no intent to keep the beds operational in Rowan County. As reflected by the utilization data in the SMFP, there has been an excess of rehabilitation beds in Mecklenburg County for years.[12] Carolinas Rehabilitation Hospital has very low utilization, particularly in comparison to Stanback Rehab. Utilization was 58.7% and 58.4% in 2004 and 2005, respectively, and only 66.8% 64.2% in 2006 and 2007.[13] These low utilization rates show that there is no need in Mecklenburg County for inpatient rehabilitation beds.

If CMHA decides to relocate the beds to a location other than Mercy, which it has indicated it will likely do, it will be required to first obtain CON approval for the construction or upfit of a new facility and for any bed relocation. The beds could potentially remain

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[9] Exhibit B, Affidavit of Dr. Smith.

[10] CMHA has recently filed a CON application proposing a joint venture with Stanly Regional Medical Center to relocate 40 inpatient rehabilitation beds and develop a new rehabilitation facility in Concord, Cabarrus County to be known as Carolinas Rehabilitation—NorthEast, Project I.D. No. F-8161-08. However, there has been no demonstrated need for rehabilitation beds or a new rehabilitation facility in Cabarrus County, and such a facility will not alleviate the current need for an inpatient rehabilitation facility in Rowan County, where a need has been demonstrated and met by Stanback Rehab for the past nine years. Even if such a facility was approved by the CON Section, a facility in Cabarrus County would still require Rowan County patients and residents to travel over 20 miles, or nearly 30 minutes to Cabarrus County. This travel be particularly difficult for elderly drivers due not only to the added expense, but also due to the traffic they would face on Interstate 85, a very busy highway. It will also take years to implement this plan. CMHA's proposed date of offering services for the new facility, assuming the project is approved, there are no appeals, and construction is timely, is not until January 1, 2011. Therefore, this proposed project in no way fulfills the gap left by the removal of the Stanback Rehab beds.

[11] Exhibit A, CON.

[12] *See* Exhibit G, 2008 SMFP.

[13] Exhibit G, 2008 SMFP.

unutilized for years pending final CON approval and development.[14] This delay would mean a valuable health care resource that has already been approved by the Department nine years ago, and which is highly utilized by patients, will be wasted during the pendency of any action that CMHA may decide to take.

On June 26, 2008, Petitioners submitted a Declaratory Ruling Request to the Department to allow the continued operation of the ten rehabilitation beds comprising Stanback Rehab at RRMC, regardless of any actions by CMHA with respect to the original CON. Petitioners have argued that a CON is necessary only for the *development* of a new institutional health service, pursuant to N.C. Gen. Stat. § 131E-178. A CON is not needed, however, for the continued operation of an already developed project.[15] Furthermore, the rehabilitation beds are licensed under RRMC's hospital license and the Department lacks the authority to suspend or revoke the existing license pursuant to Chapter 131E, Article 5 of the General Statutes. The Department's rule at 10A N.C.A.C. 13B.3107(e) specifically sets forth the grounds upon which the Department can revoke a license, and because none of these grounds exists, the Department cannot act to delicense these beds. This Declaratory Ruling Request is currently under review by the Department, and because no decision has been made, Petitioners respectfully submit this request for a need determination in the 2009 SMFP. However the Department rules, appeals to the Superior Court as well as the Court of Appeals are likely.[16] CMHA has already indicated to the Department that it will oppose the Declaratory Ruling Request. Those appeals, which could take years to be resolved, would harm patients because they would effectively deny them access to the service at Stanback Rehab for an extended time.

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[14] *See* Affidavit of Barbara L. Freedy ("Freedy Affidavit"), attached hereto as Exhibit I.

[15] *See In re Total Care, Inc.*, 99 N.C. App. 517, 519, 393 S.E.2d 338, 340 (1990).

[16] *See* N.C. Gen. Stat. §§ 150B-4(a), 150B-43.

The present situation is an exceptional circumstance which justifies the SHCC including the requested need determination, in order to protect patient welfare.

DISCUSSION OF REASONS FOR PROPOSED ADJUSTMENT

The North Carolina CON Law prohibits the development or offering of a new institutional health service without prior approval from the CON Section of the Department in the form of a CON. *See* N.C. Gen. Stat. § 131E-178. Inpatient rehabilitation beds are among the new institutional health services that cannot be developed without a CON. There has not been a need determination for rehabilitation beds in any locality in North Carolina since 1999, and there is no need determination proposed in the current Draft 2009 SMFP.

A. Statement of the adverse effects on the population if inpatient rehabilitation services at Stanback Rehab are not continued.

The Rowan County community, including patients and physicians alike, regard the Stanback Rehab facility as a tremendous and essential asset to Rowan County, and have expressed great respect for the high level of care provided to patients and their families.[17] Former patients, such as David R. Bean of Rockwell, Rowan County, have expressed deep gratitude for the care received at Stanback Rehab, particularly with respect to the proximity of the facility to his family and home.[18] As stated by Mr. Bean in his Affidavit:

> I am glad that I did not have to relocate anywhere else for my rehabilitation. It was very important to me that my family could easily visit me while I was at Stanback Rehab receiving care, which also allowed them to participate in my care and recovery. Rowan County is very fortunate to have a rehabilitation unit where patients can rehabilitate close to home without traveling an hour or more away for care. Gas is so expensive now that it would be a real hardship for many people to travel.[19]

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[17] *See* Exhibit H, Dr. Goodman Affidavit.
[18] Exhibit C, Bean Affidavit.
[19] Exhibit C, Bean Affidavit, paragraph 5.

Ordinary general acute care hospitals do not provide the level of intensive rehabilitation that Stanback and other inpatient rehabilitation facilities provide. In fact, unlike general acute care hospitals, there are relatively few inpatient rehabilitation facilities in North Carolina. Currently, there are only 24 operational facilities located in the State, and as noted above, the closest rehabilitation facilities to Stanback Rehab are located in Albemarle (Stanly County), Charlotte (Mecklenburg County), Winston-Salem (Forsyth County), and High Point (Guilford County). On average, these facilities are over 40 miles and nearly 50 minutes away from Rowan County.[20]

Most of the patients in Rowan County recovering at Stanback Rehab are limited not only by their physical conditions, but also by their age and income levels. Stanback Rehab's patients are primarily elderly Medicare recipients and are often recovering from complex surgical procedures or debilitating conditions. They often live on a fixed Social Security income, and have very limited resources.[21] This is significant because an important part of the rehabilitation process is the involvement of family and caretakers in the patient's care. Because these patients receive long-term, intense treatment, the ability to receive visits and support from family and friends is an integral part of the healing and recovery process.[22] It is also essential to educate the caretakers on how to assist the patient once they are discharged from rehab and return home because most patients will need continued care and assistance. The financial burden on those families is no doubt already being felt due to the tremendous pressures of a long-term illness or injury. This pressure will only be exacerbated by the increase in expense that it will require for families to travel to distant rehabilitation facilities to

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[20] Exhibit B, Dr. Smith Affidavit.
[21] Exhibit B, Dr. Smith Affidavit.
[22] *See* Exhibit C, Bean Affidavit; Exhibit D, Dr. Shellhorn Affidavit; Exhibit E, Dr. Agner Affidavit; Exhibit H, Dr. Goodman Affidavit.

participate in the care and recovery of their loved one. As noted by Mr. Bean relating his own personal experiences in his affidavit, this concern is never more real than it is now with the cost of basic necessities increasing rapidly and soaring gas prices.

B. The continued operation of Stanback Rehab is necessary to meet the conclusive need for inpatient rehabilitation services in Rowan County.

Rowan County clearly has a need for ten inpatient rehabilitation beds, which has been demonstrated by the exceptionally high utilization of the beds at Stanback Rehab. The rehabilitation beds at Stanback Rehab have been well received by both patients and their families, as well as by referring physicians in Rowan and the surrounding counties. The need, impact, and success of Stanback Rehab has been conclusively proven by the sustained high utilization rates of this facility.

The utilization rate at Stanback Rehab has remained 81.5% or greater between 2002 and 2006, with steady increases in utilization each year.[23] This census is quite typical, as Stanback Rehab consistently experiences high occupancy rates. The utilization rate in 2007 was 73%, and was surpassed only by Wake Med, University of North Carolina Hospitals, and Nash General Hospital.[24] These rates typically do not vary depending on the seasons of the year, so it is expected that the occupancy rate will remain consistently high, as it has in years past.

The current inventory of operational inpatient rehabilitation beds in the State is 975, spread out among 24 different facilities. Stanback Rehab operates only ten of those beds (about 1%), yet its utilization is consistently in the top two, three, or four of all the inpatient

[23] Exhibit F, 2007 SMFP; Exhibit G, 2008 SMFP.

[24] Exhibit F, 2007 SMFP; Exhibit G, 2008 SMFP; Draft 2009 SMFP, attached hereto as Exhibit J.

rehabilitation beds in the State.[25] In 2002 and 2003, Stanback Rehab had the third highest utilization of all 24 facilities, following only Wake Med and Nash General Hospital. In 2004, Stanback Rehab boasted the second highest utilization rate in the State at 87.8%, and was third highest in the State in 2005 with a utilization rate of 87.5%. Again in 2006, Stanback's utilization was the second highest in the State among the 24 operational facilities, including several large university facilities, and it was fourth in 2007 of the 24 facilities. There is no denying the demand for the services provided at Stanback Rehab. This can be attributed to a combination of factors including the need for these services that Rowan County residents have, the superior quality of services and ancillary and support services provided at Stanback and RRMC, and the location of the facility close to those patients and families who need it most. Thus, Stanback Rehab has proven itself to be a successful operation providing efficient, effective, and quality patient care in Rowan County, and it would make no sense for this facility to close. In fact, if the Stanback Rehab unit were to close permanently, it would cause irreparable harm to the patients in that community with inpatient rehabilitation needs.

C. This request will not result in the unnecessary duplication of services.

A need determination for 10 inpatient rehabilitation beds at Stanback Rehab in Rowan County will not result in the unnecessary duplication of existing health services. As demonstrated in the 2008 SMFP, Stanback Rehab is the second busiest inpatient rehabilitation facility in the State. It has a proven track record of local accessibility for the medically underserved and of exceptional quality of care, and is thus likely to remain a heavily utilized service in Rowan County.

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[25] Exhibit G, 2008 SMFP; Exhibit J, Draft 2009 SMFP.

Furthermore, there is no possibility of duplication of services because there are no other inpatient rehabilitation beds located in Rowan County, and the closest facilities are prohibitively far from Stanback Rehab. As expressed in the attached affidavits, the permanent removal of Stanback Rehab will cause a tremendous burden on the patients and community that have grown dependent upon this facility over the last nine years. Thus, in order to continue to meet the need of Rowan County patients, these beds will need to be replaced without further delay.

D. Alternatives to the proposed adjustment were considered, but are not feasible.

Petitioners have considered other alternatives to the proposed adjustment. None of these alternatives is feasible, however, because they will not meet the need for inpatient rehabilitation services in Rowan County. Petitioners considered not reopening the Stanback facility after CMHA removed its employees. As demonstrated by the attached affidavits, this alternative would not serve the health care needs of the community and would result in irreparable harm to Rowan County and its residents. Petitioners have committed to providing health care services to this community, and cannot abandon this mission simply because of CMHA's actions. To do so would violate the trust and relationship Petitioners have established with this community, and would be a reckless abandonment of their duty to continue to provide the quality of health care services where they are needed most. As discussed in detail above, a clear need for inpatient rehabilitation services has been proven by the consistently high utilization of Stanback Rehab since its development nearly nine years ago.

Petitioners also considered closing down Stanback Rehab and constructing a new rehabilitation facility in another location. This alternative is not feasible because the true need for services exists in the community that Stanback Rehab has served for nine years—Rowan

County. In addition, there is currently no need for an inpatient rehabilitation facility in any other locality. Even if there was, any new construction or relocation of current equipment would be a tremendous waste of the existing facility. Any relocation would also require a large capital expenditure and would take a great deal of time in terms of both obtaining CON approval and actual construction. The Stanback Rehab facility also recently underwent upgrades and modifications this spring, so any new construction would be egregiously duplicative. The closing of the unit would mean that the improvements Petitioners made to Stanback Rehab would be wasted.

The most effective alternative, as demonstrated by this request, is to preserve the status quo. The status quo here is to allow Stanback Rehab to keep the rehabilitation beds it has operated for over nine years, and to remain operational, continuing to serve patients of Rowan County and surrounding communities. If action is not taken to maintain the status quo, patient care will suffer.

E. This request will ensure a fair and equitable geographic distribution of rehabilitation beds in the State.

Among the findings of fact made by the North Carolina General Assembly upon the enactment of the CON Law are the following:

> (3) That, if left to the market place to allocate health service facilities and healthcare services, geographical maldistribution of these facilities and services would occur and, further, less than equal access to all population groups, especially those that have traditionally been medically underserved, would result.
>
> (3a) That access to health care services and health care facilities is critical to the welfare of rural North Carolinians, and to the continued viability of rural communities, and that the needs of rural North Carolinians should be considered in the certificate of need review process.

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> (4) That the proliferation of unnecessary health service facilities results in costly duplication and underuse of facilities, with the availability of excess capacity leading to unnecessary use of expensive resources and overutilization of health care services.

N.C. Gen. Stat. § 131E-175(3), (3a), (4). Based on these findings, the North Carolina Court of Appeals recognized the "overriding legislative intent behind the CON process" to be the "regulation of major capital expenditures which may adversely impact the cost of healthcare services to the patient." *Cape Fear Memorial Hospital v. N.C. Dept. of Human Resources*, 121 N.C. App. 492, 494, 466 S.E.2d 299, 301 (1996). This Petition furthers the legislative intent by ensuring a fair and appropriate geographic distribution of rehabilitation beds in North Carolina.

There is arguably already a geographic maldistribution of inpatient rehabilitation beds in the State. CMHA already controls 172 rehabilitation beds, all of which are located in Mecklenburg County or just across the Gaston County border.[26] This petition concerns only 10 rehabilitation beds in a county that does not have any other rehabilitation beds. This is just the kind of geographic maldistribution the legislature is trying to protect against. The loss of the rehabilitation beds at Stanback Rehab has resulted in the loss of rehabilitation services in Rowan and surrounding counties, which has only further exacerbated this geographic discrepancy. The effect is that many rural North Carolinians are without rehabilitation services, which is a segment of the population about whom the Legislature was particularly concerned. The need for these services in Rowan County has been proven time and again over the last nine years, and therefore this Council should act to maintain the most effective geographic distribution of this service to ensure the services remain where they are most needed.

[26] *See* Exhibit G, 2008 SMFP.

F. This request will prevent one provider from having a monopoly over inpatient rehabilitation services in HSA III.

If the rehabilitation beds at Stanback Rehab were closed, one single provider would own or manage all of the 192 inpatient rehabilitation beds in HSA III, thereby creating a monopoly over the provision of such services in that health service area. The creation of such a monopoly is contrary to public policy in North Carolina.[27] By contrast, the amendment of the 2009 SMFP requested here would allow the continued operation of Stanback Rehab, which would be managed by a provider other than CMHA.

The creation of any monopoly in the provision of healthcare services is viewed with particular skepticism by our appellate courts. In *Iredell Digestive Disease Clinic, P.A. v. Petrozza*, 92 N.C. App. 21, 373 S.E.2d 449 (1988), the Court of Appeals refused to enforce a contract provision which would have eliminated competition in the relevant medical specialty in Iredell County. The Court noted that the creation of a monopoly in the provision of healthcare services is particular problematic.

> The creation of a monopoly also raises the issue of the public's interest in having some choice in the selection of a physician. The doctor-patient relationship is a personal one and we are extremely hesitant to deny the patient-consumer any choice whatsoever.[28]

To ensure that there will not be an effective monopoly over the provision of inpatient rehabilitation services in the relevant health service area, the amendment to the 2009 SMFP requested here is necessary.

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[27] *See* Constitution of North Carolina, Article I, § 34 ("monopolies are contrary to the genius of a free state and should not be allowed").

[28] 92 N.C. App. at 31, 373 S.E.2d at 455.

G. There is substantial precedent for the State acting to preserve access to a needed health care resource.

There is substantial precedent for the State taking action to ensure that access to a needed health care service is preserved and that a well utilized facility is kept open and operational, as is the case here. Attempts by competitors to put out of operation existing hospital equipment and facilities have been recognized as contrary to the purposes of the CON Law, and rebuffed by our Governors. On 23 July 1997, Governor Hunt directed that the 1997 SMFP be amended to permit the continued operation of an open heart surgery service at Catawba Memorial Hospital. Governor Hunt explained his rational as follows:

> I find that it is in the best interest of our citizens if valuable assets be used and not remain idle. I also believe that we should provide care close to home whenever we can.[29]

Similarly, Governor Easley amended the 2006 SMFP to permit the continued operation of Presbyterian Hospital Huntersville, notwithstanding an attempt by a competitor to seek a court order to close the hospital. Governor Easley explained:

> While expressing no opinion on the merits of the litigation, I am concerned about the potential hardship to the community and waste of valuable healthcare assets if the Hospital should be required to close. I believe that such a result would be contrary to the legislative intent underlying the Certificate of Need Law, as expressed N.C. Gen. Stat. § 131E-175.[30]

The Governor modified the proposed 2006 SMFP in light of these circumstances, and included a determination for the continued operation of the Presbyterian Hospital Huntersville. The current Petition shares many similarities with the Huntersville situation. The potential

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[29] *Frye Regional Medical Center, Inc. v. Hunt*, 350 N.C. 39, 40-41, 510 S.E.2d 159, 161 (1999).

[30] Memorandum from Michael F. Easley to Carmen Hooker Odom, dated 13 December 2005, attached hereto as Exhibit K.

closure and waste of well utilized resources would most certainly present a hardship to Rowan County, and would be directly contrary to the legislative intent expressed in the CON Law.

In 2004, the Governor also modified the proposed 2005 SMFP to include a need determination for a 50 bed hospital in central Harnett County with 3 additional operating rooms in response to the unique circumstances and need demonstrated in that County.[31] Part of the Governor's reasons for making this determination was the response of the community to the closure of Good Hope Hospital, expressing a need for a hospital facility. Here, that expression of need by the community is also very strong, and is illustrated by the affidavits attached to this Petition. Stanback Rehab has also been a fixture in Rowan County for nearly nine years, and to remove this well utilized and respected resource from this community now would certainly result in great hardship to the citizens who have depended on this care for so many years.

CONCLUSION

The removal of the Stanback Rehab beds by CMHA has left a large void in health care services in Rowan County. Because the utilization of Stanback Rehab has been so consistently high since it first began operating in 1999, and because that demand has continued through its last week of operation under CMHA management, it is reasonable to project that utilization of the same facility by the same referral network serving the same community of people, will continue at the same rate. There is an undeniable and proven need in Rowan County for the continued operation of the ten inpatient rehabilitation beds at Stanback Rehab, and the facility should remain open and operational with all ten inpatient rehabilitation beds.

[31] Memorandum from Michael F. Easley to Carmen Hooker Odom, dated 10 December 2004, attached hereto as Exhibit L.

REQUEST FOR RECUSAL

Petitioners respectfully request that the following Members of the State Health Coordinating Council recuse themselves from the consideration of this request due to a conflict of interest. Each of the following Members is affiliated with The Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas HealthCare System, and due to the relationship of this request to the recent litigation and pending Declaratory Ruling Request regarding CMHA and Petitioners, should not be involved in the consideration of this Petition:

Laurence C. Hinsdale

Mac McCrary

Michael C. Tarwater

Christopher G. Ullrich, M.D.

STATEMENT OF REQUESTED ADJUSTMENT

For all of the reasons set forth above, Petitioners respectfully request that the SHCC include the following adjusted need determination for Chapter 8, inpatient rehabilitation beds in the final 2009 SMFP:

> In response to a petition filed during public review of the Draft 2009 Plan, an adjusted need determination has been made for ten (10) inpatient rehabilitation units at the Elizabeth C. Stanback Rehabilitation Unit at Rowan Regional Medical Center in Rowan County as a result of the removal of the ten existing inpatient rehabilitation beds at that facility in June 2008. This need determination is for only ten inpatient rehabilitation beds to be located only at the Elizabeth C. Stanback Rehabilitation Unit at Rowan Regional Medical Center in Rowan County.

Respectfully submitted this the 1st day of August, 2008.

NELSON MULLINS RILEY &
SCARBOROUGH LLP

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ATTORNEYS FOR NOVANT HEALTH, INC., ROWAN HEALTH SERVICES CORPORATION, AND ROWAN REGIONAL MEDICAL CENTER, INC.

State of North Carolina

Department Of Health and Human Services
Division Of Facility Services
Certificate Of Need

Project Identification Number: F-4791-93 (Part II)
FID #923015
Effective Date: October 29, 1998

Issued to: The Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas Healthcare System and Mercy Hospital, [illegible] wholly owned subsidiary of CHS), (collectively referred to as "CHS"),

The North Carolina Department of Health and Human Services, pursuant to the North Carolina Health Planning and Resource Development Act of 1978, G.S. § 131-175, et seq., as amended and recodified, G.S. § 131E-175, et seq., hereby finds and certifies that the new institutional health service proposed by the person listed above is consistent with, or as conditioned is consistent with the plans, standards and criteria prescribed by the Act and the rules and regulations promulgated thereunder. The findings of the Department are attached hereto and incorporated by reference.

This Certificate affords the person listed above the opportunity to proceed with development of the proposed new institutional health service in a manner consistent with the plans, standards, and criteria prescribed by the Act and the rules and regulations promulgated thereunder. This Certificate includes [illegible]

SCOPE: See Reverse Side

CONDITIONS: See Reverse Side

PHYSICAL LOCATION: Mercy Hospital
2001 Vail Avenue
Charlotte, NC 28207

Rowan Regional Medical Center
612 Mocksville Avenue
Salisbury, NC 28144

MAXIMUM CAPITAL EXPENDITURE: $2,590,[illegible]

TIMETABLE: See Reverse Side

FIRST PROGRESS REPORT DUE: February 1, 1999

This Certificate is limited to the person listed above and is not transferable or assignable. This Certificate may be withdrawn as provided in G.S. § 131E-189, and the rules and regulations promulgated thereunder.

Issuance of this Certificate does not supplant provisions or requirements embodied in codes, ordinances, statutes other than G.S. § 131E-175, et seq., rules regulations or guidelines administered or enforced by municipal, state or federal agencies or the agent thereof.

Lee B. Hoffman
Chief, Certificate of Need Section
Division of Facility Services

DFS [illegible]

EXHIBIT

A

SCOPE:

CHS shall develop no more than ten inpatient rehabilitation beds at either Mercy Hospital ("Mercy") or Rowan Regional Medical Center ("Rowan"). In the event the project is developed at Rowan and is required to be licensed and certified as part of Rowan, the CON shall be transferred to Rowan for good cause for the duration of its Management Contract with CHS. However, upon termination of the above mentioned Management Contract, this CON shall authorize development of the ten inpatient rehabilitation beds at Mercy.

CON CONDITIONS

1. Carolinas Healthcare System shall materially comply with all of the representations made by it in the documents it submitted to the Certificate of Need Section on October 28, 1998.
2. Carolinas Healthcare System shall develop no more than ten inpatient rehabilitation beds.
3. At the request of the Certificate of Need Section, Carolinas Healthcare System shall provide documentation of the types of services provided to patients in the rehabilitation unit in accordance with the data format and reporting requirements that will be formulated by the Agency.
4. Carolinas Healthcare System's approved capital expenditure amount shall be $2,399,900.

TIMETABLE

Construction Contract Awarded	November 1, 1999
25% Construction Completed	December 27, 1999
50% Construction Completed	February 15, 2000
75% Construction Completed	March 28, 2000
Completion of Construction	May 15, 2000
Licensure of Facility	June 1, 12000
Occupancy/offering of services	June 1, 2000
Certification of Facility	June 1, 2000

AFFIDAVIT OF DAVID SMITH, M.D.

David Smith, M.D., being duly sworn, deposes and states as follows:

1. My name is Dr. David Smith. I am a resident of the State of North Carolina. I am over the age of twenty-one and make these statements of my own personal knowledge.

2. I am Board Certified in Internal Medicine and currently serve as the Vice President of Medical Affairs at Rowan Regional Medical Center ("RRMC"). I have worked at RRMC for over ten (10) years. I have also lived in Rowan County for over fifty (50) years. In my capacity as Vice President of Medical Affairs, I work closely with the physicians and staff at the Elizabeth C. Stanback Rehabilitation Unit ("Stanback Rehab"), and am very familiar with the operation and services we provide patients seeking inpatient rehabilitative care.

3. Stanback Rehab is the only non-governmental, inpatient rehabilitation facility in Rowan County. It is also one of the few inpatient rehabilitation facilities in all of North Carolina. Stanback Rehab's ten (10) inpatient rehabilitation beds are licensed to RRMC.

4. Stanback Rehab's ten inpatient rehabilitation beds have been very heavily utilized. Our average utilization rate has increased over the years. Stanback Rehab's utilization has typically been over 80% for the last several years. Our utilization rate in 2006, was the second highest of all rehabilitation beds in North Carolina, surpassed only by the Nash General Hospital facility.[1] This high utilization is a tribute to the dedication and outstanding services provided by our highly skilled staff, the commitment of RRMC to the patients and families served by Stanback Rehab, and the fact that there is no other option for inpatient rehabilitation in Rowan County.

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[1] This comparison is based upon the inventory and utilization of inpatient rehabilitation beds 2006 average annual utilization rates contained in the 2008 State Medical Facilities Plan.

5. Our patients at Stanback Rehab are treated for a wide range of injuries and illnesses, including joint replacement surgeries, hip fractures, and stroke. We provide physical therapy, occupational therapy, speech/language pathology therapy, psychology services, rehabilitation nursing, vocational services, respiratory therapy services, and other special services to address the wide range of physical, mental, and emotional impacts of our patients' illnesses and injuries. On average, patients spend two (2) weeks at our facility.

6. As a physician and administrator, I am extremely disturbed by the recent turn of events at Stanback Rehab. Despite our best efforts to keep Stanback up and running with no discontinuation of care to the community, on June 30, 2008, CMHA instructed its admitting physician to stop admitting patients at Stanback Rehab. We have admitted no patients since that date. The patients that were already receiving care at the facility as of that date remained in the facility to complete their care, and the last of those patients was discharged the week of July 21, 2008. Because the admitting physician and staff at Stanback Rehab were employees of CMHA, they also stopped providing services and left the facility at that time. At no time, however, has RRMC relinquished the license to the rehabilitation beds.

7. Since last week, Stanback Rehab has been closed and has not been providing care to the residents of Rowan County and the surrounding communities. This closure has been a tremendous blow to our health care system and community, particularly in light of the consistent high demand for the facility's services.

8. We have been working hard to put new physicians and staff in place at the facility so that it will be operational beginning the week of August 4, 2008. We are working to have physicians, a physician extender, and the necessary medical support personnel in place by that date. This is because of the strong demand for our high quality services here at Stanback Rehab.

9. Because there is no other inpatient rehabilitation facility in Rowan County, if the Stanback Rehab service is remains closed or is discontinued, patients will be forced to travel to Albemarle, downtown Charlotte, High Point, or even Winston-Salem to receive care. These facilities are over 40 miles and 50 minutes away from Rowan County. Receiving care at one of these remote facilities would require families to travel into heavily congested areas including downtown Charlotte, downtown Winston-Salem, and on Interstate 85, in order to visit their loved ones. This is not only an extremely stressful situation for families already worried about the health of their loved one, but also frankly a potentially dangerous situation, particularly for elderly drivers expected to traverse unfamiliar and heavily congested roads and parking garages. I-85, the main north-south artery in Rowan County, is very heavily traveled by eighteen wheeler trucks. This makes driving very challenging for everyone, and is especially difficult for elderly people who do not see well and whose reaction times may slower than a younger person's.

10. Most of our patients are elderly Medicare recipients. They are often limited by their age and income, in addition to any physical conditions or injuries from which they may be suffering and struggling to recoverIn some cases, it would be an insurmountable burden to expect the family members, particularly elderly spouses, to travel outside of Rowan County to take the patient for treatment or to visit their loved one receiving intensive rehabilitative therapy.

11. Practically speaking, the expense of this increased travel may be too much for many patients' families to bear. Gas prices now exceed $4.00 a gallon, and there is no relief in sight. Again, many patients who are in the Stanback Unit are elderly, and their loved ones are also elderly. Some of these people live on Social Security and have very limited resources.

12. For the elderly family members who do not drive, they must rely on other family members or friends who do drive. Already some of these family members and friends are

having to take time off from work to do the driving, and if the service at Stanback is discontinued, that means even more hardship for those family members or friends.

13. My concern for the burden on the families of our patients arises primarily from my role as a physician who understands the dramatic impact that the support of loved ones can have on a patient's successful recovery. It is also important for these family members to be involved throughout the rehabilitative and recovery process so that they will be better equipped to assist the patient with the many challenges and adjustments they will face once they return home. These patients may have trouble feeding themselves, dressing, bathing, sitting up and attending to other activities of daily living.

14. I am also deeply concerned about the lack of continuity of care that our patients will suffer from if the service at Stanback is discontinued. It has been very important to RRMC to be able to provide these patients with continued rehabilitation care at the same facility in which they are initially diagnosed and treated. Patients who come into the RRMC hospital suffering from a stroke or injured in a fall, for example, could normally remain at RRMC for their rehab therapy. This is not only more convenient for the patients and families, but ensures that physicians are communicating effectively within the same network to further the rehabilitation of these individuals, and is less confusing and traumatic for our elderly patients. Since the closure of Stanback Rehab, however, patients have been forced to leave RRMC for their long-term rehabilitative needs. I am very concerned as a resident of this community and physician, about the long-term impact the closure of Stanback Rehab will have on the community if services cannot be reinstated.

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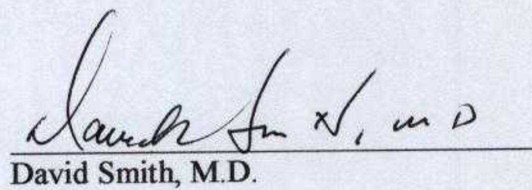
This is the 31st of July, 2008.



David Smith, M.D.

Sworn to and subscribed before me
this the 31st day of July, 2008.

Teressa C. Bebber
Notary Public
My Commission Expires: 8/21/2010

TERESSA C. BEBBER
NOTARY PUBLIC
Rowan County
North Carolina
My Commission Expires August 21, 2010

STATE OF NORTH CAROLINA

COUNTY OF ROWAN

IN THE GENERAL COURT OF JUSTICE
SUPERIOR COURT DIVISION
08 CVS 2158

ROWAN REGIONAL MEDICAL CENTER, INC.,

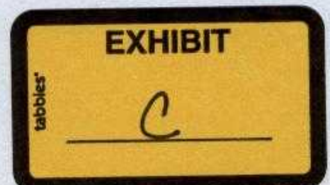
Plaintiffs,

vs.

THE CHARLOTTE-MECKLENBURG HOSPITAL AUTHORITY d/b/a CAROLINAS HEALTHCARE SYSTEM,

Defendant.

AFFIDAVIT OF DAVID R. BEAN



AFFIDAVIT OF DAVID R. BEAN

David R. Bean, being duly sworn, deposes and states as follows:

1. My name is David R. Bean. I am a resident of Rockwell, Rowan County, North Carolina. I am over the age of twenty-one and make these statements of my own personal knowledge.

2. I am a fifty-six (56) year old recipient of bilateral total knee replacement surgery. I would first like to take this opportunity to compliment and thank my physician Dr. Christopher Nagy, and all the staff at Rowan Regional Medical Center, particularly at the Stanback Rehabilitation Unit, who helped me along the way to a successful recovery.

3. Because of the severity of my condition, after surgery I received treatment at the Rowan Joynt Camp. All of the individuals who worked with me there (including Karen, James, Melvin, and Jan), from the physicians to the nurses, and even the housekeepers, were excellent. I felt like everyone was very positive and encouraging and entirely committed to helping me with my recovery.

4. I thought that after my brief stay at the Joynt Camp, that I would be ready to return home and would be physically back to my old self, but unfortunately, I wasn't. I had no idea that I would literally have to learn how to walk all over again. That is where the Stanback Rehabilitation Unit stepped in. My intensive therapy truly helped prepare me for the challenges that would be awaiting me when I returned home, including the basics of walking, bathing, and taking care of myself.

5. I am glad that I did not have to relocate anywhere else for my rehabilitation. It was very important to me that my family could easily visit me while I was at Stanback Rehab receiving care, which also allowed them to participate in my care and recovery. Rowan County

is very fortunate to have a rehabilitation unit where patients can rehabilitate close to home without traveling an hour or more away for care. Gas is so expensive now that it would be a real hardship for many people to travel.

6. I am doing great now, after having been treated at Stanback. The Stanback Rehab Unit truly helped me get ready for the outside world and ready to be home again. I am grateful to all of those individuals who were involved in the excellent care I received at Stanback.

7. I am very impressed with the Stanback Rehab Unit, including its staff from Dr. Agner, Debbie, Maureen, Lynn, Sharon, Jody, Kim, Amenia, and all the nurses and therapists whose names I can't remember. There were times when I felt like I just could not do something, but after the therapist explained it to me, and helped me get started, it seemed much easier.

8. I am grateful for the care I received at Stanback and hope that it will continue to provide services to the citizens of Rowan County and the surrounding areas for many years to come. It would be a real blow to this community if the services were no longer available in Rowan County.

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This is the 25th of June, 2008.

David R. Bean

David R. Bean

Sworn to and subscribed before me
this the 25th day of June, 2008.

Denise Koehn

Notary Public
My Commission Expires: 3-15-09

STATE OF NORTH CAROLINA

COUNTY OF ROWAN

IN THE GENERAL COURT OF JUSTICE
SUPERIOR COURT DIVISION
08 CVS 2158

ROWAN REGIONAL MEDICAL CENTER, INC.,

Plaintiffs,

vs.

THE CHARLOTTE-MECKLENBURG HOSPITAL AUTHORITY d/b/a CAROLINAS HEALTHCARE SYSTEM,

Defendant.

AFFIDAVIT OF DOUGLAS B. SHELLHORN, M.D.

AFFIDAVIT OF DOUGLAS B. SHELLHORN, M.D.

Douglas B. Shellhorn, M.D., being duly sworn, deposes and states as follows:

1. My name is Dr. Douglas B. Shellhorn. I am a resident of the State of North Carolina. I am over the age of twenty-one and make these statements of my own personal knowledge.

2. I am a Board certified Internist at Rowan Diagnostic Clinic, P.A., located in Salisbury, North Carolina. I have been practicing internal medicine in the Salisbury area for the last fourteen (14) years. I have also been a resident of that area for 39 years.

3. My practice includes the treatment of patients needing in-patient rehabilitative care for a variety of injuries and ailments. Throughout my fourteen years practicing in Salisbury, and as a resident of that area, I have seen firsthand the development and growth of the Elizabeth C. Stanback Rehabilitation Unit ("Stanback Rehab"), and have had the opportunity to work with many patients and the physicians and staff of the facility.

4. Stanback Rehab is a tremendous asset to the residents of Rowan County and the surrounding areas. Stanback Rehab is the only non-governmental, inpatient rehabiltation facility in Rowan County. It should be noted that there are relatively few inpatient rehabilitation facilities in North Carolina, and Stanback Rehab is among the busiest inpatient rehabilitation centers in North Carolina. I have seen firsthand the significant impact that having a state-of-the-art, local inpatient rehabilitation facility has on the treatment and recovery of its many patients, as well as on their families.

5. As a physician, I am particularly concerned about any efforts to pull the rehabilitation beds from the Stanback facility and move them to another location. The impact on

both the patients and families of having to travel great distances to visit loved ones who are essentially living in the rehab facility for a long period of time, will be a tremendous burden on the patients and their families, alike.

6. It is imperative for the recovery process of the patients, that family and friends be able to visit and provide support to patients recovering and receiving intense inpatient rehabilitation therapy. Loss of the ability to see and receive visits and support from family members, will only impede my patients' recovery process.

7. In addition, the financial burden on families already experiencing the tremendous financial pressures associated with severe injuries or illnesses requiring long-term care, will only be exacerbated by the increase in expenses to travel to distant rehabilitation facilities. This was never more true than now with the current exorbitant, $4.00 and higher, gas prices our economy is experiencing.

8. Stanback Rehab has made a significant positive impact on the lives of many individuals in our community. I have only the utmost respect and confidence in our physicians and staff running the rehab facility, regardless of their professional affiliations. It would be a tragedy not only for the patients and families currently receiving treatment at Stanback Rehab for the beds to be removed and relocated, but also for our community as a whole, which has become dependent upon the excellent care and treatment provided at the facility.

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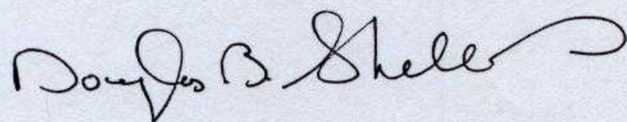
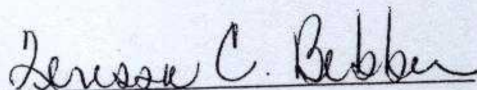
This is the 23 of June, 2008.



Douglas B. Shellhorn, M.D.

Sworn to and subscribed before me
this the 23rd day of June, 2008.



Notary Public
My Commission Expires: 8/21/2010

~Doc# 41169.1~

STATE OF NORTH CAROLINA

COUNTY OF ROWAN

IN THE GENERAL COURT OF JUSTICE
SUPERIOR COURT DIVISION
08 CVS 2158

ROWAN REGIONAL MEDICAL CENTER, INC.,

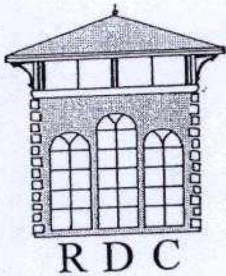
Plaintiffs,

vs.

THE CHARLOTTE-MECKLENBURG HOSPITAL AUTHORITY d/b/a CAROLINAS HEALTHCARE SYSTEM,

Defendant.

AFFIDAVIT OF R. CHRISTOPHER AGNER, M.D.



RDC

ROWAN DIAGNOSTIC CLINIC, PA
611 Mocksville Avenue Salisbury, NC 28144 Telephone 704-633-7220

Allergy
Jon E. Welch, MD, PhD

Endocrinology
Carey A. Robar, MD, FACE

Gastroenterology
Kiran Jagarlamudi, MD

Internal Medicine
R. Christopher Agner, MD
Frederick U. Goss, MD
Douglas B. Shellhorn, MD
Brent W. Seifert, MD
Sean I. Malone, MD, FACP
Donna R. Childress, MD
Amy E. Wilson, MD

Neurology
Shelia Smalls-Stokes, M.D.

Pulmonology
Neil V. Patel, MD, FCCP

Rheumatology
Rakesh C. Patel, DO
R. Gordon Senter, MD

Nurse Practitioner
Tracy Hildebran, ANP

Administrator
Paul A. Verhaeghe, CPA

June 23, 2008

Certificate of Need Authority
State of North Carolina

Gentleman:

It is my understanding that there is consideration of moving the Rehabilitation beds currently located at the Stanback Rehabilitation Unit at Rowan Regional Medical Center. I am an Internist practicing with Rowan Diagnostic Clinic now for almost 30 years. The addition of the Stanback Rehabilitation Unit has been a blessing to my patients and the surrounding community. Previously, families have had to travel long distances to receive the rehabilitation care required of their loved ones. Many of the spouses of these patients are elderly and find it quite onerous and indeed dangerous to travel to the larger congested cities. The utilization of the Stanback Rehab Unit speaks for itself. I strongly urge you to consider keeping the current rehabilitation beds at Rowan Regional Medical Center.

Sincerely,

R. Christopher Agner

R. Christopher Agner, MD

RCA/db

CC: David Smith, MD

Teresa C. Bebber
Notary Public
Commission expires 8/21/2010

2007

STATE MEDICAL FACILITIES PLAN

THE GREAT SEAL OF THE STATE OF NORTH CAROLINA
MAY 20, 1775
APRIL 12, 1776
★ ESSE QUAM VIDERI ★

NORTH CAROLINA STATE HEALTH COORDINATING COUNCIL
MEDICAL FACILITIES PLANNING SECTION
DIVISION OF FACILITY SERVICES
NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

CHAPTER 8
INPATIENT REHABILITATION SERVICES

Summary of Bed Supply and Utilization

As of June 2006, there were 989 inpatient rehabilitation beds in 26 facilties strategically located throughout North Carolina. From an historical perspective, although the "Days of Care" decreased between 2001 and 2002, the Average Annual Utilization Rate increased slightly due to a parallel decrease in the Total Planning Inventory. The "Days of Care" continued to decline in 2003, with the Average Annual Utilization Rate decreasing from 62.9% in 2002 to 60.6% in 2003. During data year 2004, the Average Annual Utilization Rate increased to 62.3%. For data year 2005, the average annual utilization rate decreased to 59.1%. Of the 25 facilities reporting days of care, five facilities indicated increased utilization and twenty facilities indicated decreased utilization.

Changes from Previous Plans

No substantive changes in the inpatient rehabilitation principles or methodology have been incorporated into the 2007 State Medical Facilities Plan. As in 2006, the inpatient rehabilitation bed need determination methodology is based on historic utilization of beds over a two-year period.

Basic Principles

The scope of services covered in this section of the State Medical Facilities Plan is limited to rehabilitation services provided to physically disabled persons. Physical rehabilitation services exclude mental health and substance abuse rehabilitation services, but include those mental health services needed by individuals primarily suffering from physical injury or disease, and rehabilitation services provided to persons who are cognitively disabled as a result of physical injury or disease.

The combination of component services required to meet the needs of the individual is provided using an interdisciplinary approach and continues as long as, within a reasonable period of time, significant and observable improvement toward established goals is taking place. Where necessary, these services are provided through a spectrum of care using a system of case management.

Inpatient rehabilitation beds include comprehensive (general), spinal cord, brain injury and pediatric beds.

Inpatient rehabilitation facilities units/beds should be located in general acute care or rehabilitation hospitals or in nursing facilities to ensure that there is available medical back-up for medical emergencies.

Basic Assumptions of the Method

- The Health Service Areas (HSAs) remain logical planning areas for inpatient rehabilitation beds even though many patients elect to enter rehabilitation facilities outside the region in which they reside. (*Note: An inpatient rehabilitation bed's service area is the rehabilitation bed planning area in which the bed is located. The inpatient rehabilitation planning areas are the six Health Service Areas which are identified in Appendix A.*)

- The bed need determination methodology is based upon the historic average annual utilization of inpatient rehabilitation beds.

Source of Data

Annual Hospital Licensure Applications – The numbers of inpatient rehabilitation bed days of care were compiled from the 2005 and 2006 "Hospital License Renewal Applications" as submitted to the Division of Facility Services of the North Carolina Department of Health and Human Services.

Inpatient Rehabilitation Bed Need Projection Methodology

Need for additional inpatient rehabilitation beds in any of the six Health Service Areas is determined when the total number of existing and CON approved inpatient rehabilitation beds in a Health Service Area report an overall average, annual occupancy rate of 80% or above during the two fiscal years prior to developing the Proposed State Medical Facilities Plan.

The determination of need (based on average annual occupancy rate) for additional inpatient rehabilitation beds or facilities in a Health Service Area for Plan Year 2007 is calculated by dividing the total number of rehabilitation bed days of care reported in FY 2003-04 in all units in the HSA by the total number of licensed and CON approved rehabilitation beds in these units multiplied by 366 days and the total number of rehabilitation bed days of care reported in FY 2004-05 in all units in the HSA by the total number of licensed and CON approved rehabilitation beds in these units multiplied by 365 days.

Table 8A: Inventory and Utilization of Inpatient Rehabilitation Beds

HSA/Facility	Current Inventory	CON Issued / Pending Develop-ment	Pending Review or Appeal	Total Planning Inventory	2003-2004 Days of Care	2004-2005 Days of Care	Average Annual Utilization Rate 2002	2003	2004	2005	Beds Needed
HSA I											
Catawba Valley Medical Center	20			20	5,079	4,137	78.0%	70.1%	69.4%	56.7%	
Care Partners Rehab Hospital	80			80	20,069	19,057	71.3%	65.9%	68.5%	65.3%	
Frye Regional Medical Center	29			29	4,575	4,153	53.0%	47.8%	43.1%	39.2%	
HSA I TOTAL	129	0	0	129	29,723	27,347	68.6%	62.9%	63.0%	58.1%	0
HSA II											
High Point Regional	16			16	3,641	4,320	0.0%	1.4%	62.2%	74.0%	
Hugh Chatham Mem. Hospital [1]	12			12	1,990	1,684	0.0%	40.2%	45.3%	38.4%	
N. C. Baptist Hospital	39			39	8,778	5,327	51.6%	51.6%	61.5%	37.4%	
Whitaker Rehab Center [2]	68			68	12,550	12,212	49.3%	47.7%	50.4%	49.2%	
Moses Cone Memorial Hospital	49			49	12,040	10,958	68.1%	66.5%	67.1%	61.3%	
HSA II TOTAL	184	0	0	184	38,999	34,501	53.5%	49.0%	57.9%	51.4%	0
HSA III											
Rowan Regional Medical Center	10			10	3,215	3,193	81.5%	86.0%	87.8%	87.5%	
Stanly Regional Medical Center	10			10	1,622	1,441	52.7%	51.8%	44.3%	39.5%	
Charlotte Institute of Rehabilitation	133	-53		80	28,483	28,371	59.7%	60.8%	64.9%	97.2%	
CMC-Levine Children's Hosp. [3]	0	13		13	n/a	n/a	0.0%	0.0%	0.0%	0.0%	
Carolinas Rehabilitation Hosp. [4]	0	40		40	n/a	n/a	0.0%	0.0%	0.0%	0.0%	
CMC-Mercy & Pineville [5]	39			39	11,987	11,775	66.3%	63.3%	84.0%	82.7%	
HSA III TOTAL	192	0	0	192	45,307	44,780	61.8%	62.2%	64.5%	63.9%	0
HSA IV											
Duke University Hospital [6]	24			24	0	0	0.0%	0.0%	0.0%	0.0%	
Durham Regional Hospital	30			30	7,372	6,783	71.4%	71.9%	67.1%	61.9%	
UNC Hospitals	30			30	6,744	8,007	62.5%	58.5%	61.4%	73.1%	
Wake Med	68			68	23,948	23,369	91.6%	93.4%	96.2%	94.2%	
Maria Parham Hospital	11			11	2,330	2,429	65.0%	55.4%	57.9%	60.5%	
HSA IV TOTAL	163	0	16	179	40,394	40,588	67.2%	66.7%	67.7%	62.1%	0
HSA V											
FirstHealth Moore Reg. Hospital	25			25	6,181	6,062	75.4%	73.1%	67.6%	66.4%	
New Hanover Reg. Med. Ctr.	60			60	11,358	12,423	53.8%	49.6%	51.7%	56.7%	
Scotland Memorial Hospital	7			7	1,450	1,302	26.5%	52.4%	56.6%	51.0%	
Southeastern Regional Rehab Ctr.	78			78	17,236	16,782	67.9%	65.1%	60.4%	58.9%	
HSA V TOTAL	170	0	0	170	36,225	36,569	62.3%	60.3%	58.2%	58.9%	0
HSA VI											
Nash General Hospital	23			23	7,239	6,905	92.7%	91.1%	86.0%	82.3%	
Lenoir Memorial Hospital	17			17	2,766	2,703	63.1%	49.9%	44.5%	43.6%	
Heritage Hospital	16			16	2,119	1,822	38.1%	36.2%	36.2%	31.2%	
Pitt Hospital Regional Rehab Ctr.	75			75	19,065	17,793	64.4%	64.0%	69.5%	65.0%	
Craven Regional Medical Center	20			20	3,813	3,618	65.8%	69.2%	52.1%	49.6%	
HSA VI TOTAL	151	0	0	151	35,002	32,841	66.0%	64.3%	63.3%	59.6%	0
STATE TOTAL	989	0	16	1,005	225,650	216,626	62.9%	60.6%	62.3%	59.1%	0

[1] A new 12-bed Inpatient Rehabilitation Unit at Hugh Chatham Memorial Hospital was licensed in September 2002.

[2] A certificate of need to relocate 12 inpatient rehabilitation beds from Whitaker Rehab Center to Presbyterian - Orthopaedic was relinquished in May 2002.

[3] A certificate of need to relocate 13 inpatient rehabilitation beds from Charlotte Institute of Rehabilitation to CMC-Levine was awarded in July 2004.

[4] A certificate of need to relocate 40 inpatient rehabilitation beds from Charlotte Institute of Rehabilitation to Carolinas Rehabilitation Hospital, Gaston Co. was awarded in January 2006.

[5] In October 2006, 39 beds transferred from **License** of CMC-Mercy & Pineville to Charlotte Institute of Rehabilitation; physical location of beds not changed.

[6] Duke University Hospital's 24 beds were delicensed in September 2006.

Need Determination

It is determined that there is no need for additional inpatient rehabilitation beds in any Health Service Area in the State and no reviews are scheduled.

Table 8B: Inpatient Rehabilitation Bed Need Determinations

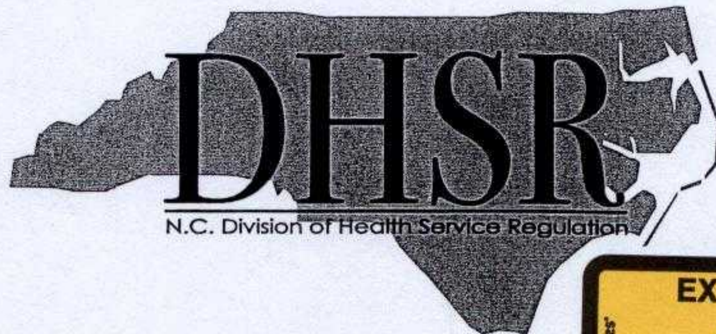
(Scheduled for Certificate of Need Review Commencing in 2007)

Health Service Area	Inpatient Rehabilitation Bed Need Determination	Certificate of Need Application Due Date	Certificate of Need Beginning Review Date
It is determined that there is no need for additional Inpatient Rehabilitation Beds anywhere in the State and no reviews are scheduled.			

2008

STATE HEALTH COORDINATING COUNCIL

State Medical Facilities Plan



North Carolina Department of Health and Human Services

CHAPTER 8
INPATIENT REHABILITATION SERVICES

Summary of Bed Supply and Utilization

As of Fall 2007, there were 975 inpatient rehabilitation beds in 24 facilties strategically located throughout North Carolina. From an historical perspective, although the "Days of Care" decreased between 2001 and 2002, the Average Annual Utilization Rate increased slightly due to a parallel decrease in the Total Planning Inventory. The "Days of Care" continued to decline in 2003, with the Average Annual Utilization Rate decreasing from 62.9 percent in 2002 to 60.6 percent in 2003. During data year 2004, the Average Annual Utilization Rate increased to 62.3 percent. For data year 2005, the Average Annual Utilization Rate decreased to 59.1 percent and for data year 2006, the Average Annual Utilization Rate increased slightly to 59.5 percent. Of the 24 facilities, eight facilities indicated increased utilization, fifteen facilities indicated decreased utilization, and one facility indicated that the utilization rate was unchagned compared to the previous year.

Changes from Previous Plans

No substantive changes in the inpatient rehabilitation principles or methodology have been incorporated into 2008 State Medical Facilities Plan. As in 2007, the inpatient rehabilitation bed need determination methodology is based on historic utilization of beds over a two-year period.

Basic Principles

The scope of services covered in this section of the State Medical Facilities Plan is limited to rehabilitation services provided to physically disabled persons. Physical rehabilitation services exclude mental health and substance abuse rehabilitation services, but include those mental health services needed by individuals primarily suffering from physical injury or disease, and rehabilitation services provided to persons who are cognitively disabled as a result of physical injury or disease.

The combination of component services required to meet the needs of the individual is provided using an interdisciplinary approach and continues as long as, within a reasonable period of time, significant and observable improvement toward established goals is taking place. Where necessary, these services are provided through a spectrum of care using a system of case management.

Inpatient rehabilitation beds include comprehensive (general), spinal cord, brain injury and pediatric beds.

Inpatient rehabilitation facilities units/beds should be located in general acute care or rehabilitation hospitals or in nursing facilities to ensure that there is available medical back-up for medical emergencies.

Basic Assumptions of the Method

- The Health Service Areas (HSAs) remain logical planning areas for inpatient rehabilitation beds even though many patients elect to enter rehabilitation facilities outside the region in which they reside.

- The bed need determination methodology is based upon the historic average annual utilization of inpatient rehabilitation beds.

Source of Data

Annual Hospital Licensure Applications – The numbers of inpatient rehabilitation bed days of care were compiled from the 2006 and 2007 "Hospital License Renewal Applications" as submitted to the Division of Health Service Regulation of the North Carolina Department of Health and Human Services.

Inpatient Rehabilitation Bed Need Projection Methodology

Need for additional inpatient rehabilitation beds in any of the six Health Service Areas is determined when the total number of existing and CON approved inpatient rehabilitation beds in a Health Service Area report an overall average, annual occupancy rate of 80 percent or above during the two fiscal years prior to developing the Proposed State Medical Facilities Plan.

The determination of need (based on average annual occupancy rate) for additional inpatient rehabilitation beds or facilities in a Health Service Area for Plan Year 2008 is calculated by dividing the total number of rehabilitation bed days of care reported in FY 2004-05 in all units in the HSA by the total number of licensed and CON approved rehabilitation beds in these units multiplied by 365 days <u>and</u> the total number of rehabilitation bed days of care reported in FY 2005-06 in all units in the HSA by the total number of licensed and CON approved rehabilitation beds in these units multiplied by 365 days.

Table 8A: Inventory and Utilization of Inpatient Rehabilitation Beds

HSA/Facility	Current Inventory	CON Issued / Pending Develop-ment	Pending Review or Appeal	Total Planning Inventory	2004-2005 Days of Care	2005-2006 Days of Care	Average Annual Utilization Rate				Beds Needed
							2003	2004	2005	2006	
HSA I											
Catawba Valley Medical Center	20			20	4,137	1,756	70.1%	69.4%	56.7%	24.1%	
Care Partners Rehab Hospital	80			80	19,057	16,931	65.9%	68.5%	65.3%	58.0%	
Frye Regional Medical Center	29			29	4,153	3,662	47.8%	43.1%	39.2%	34.6%	
HSA I TOTAL	129	0	0	129	27,347	22,349	62.9%	63.0%	58.1%	47.5%	0
HSA II											
High Point Regional	16			16	4,320	3,879	1.4%	62.2%	74.0%	66.4%	
Hugh Chatham Mem. Hospital [1]	12			12	1,684	2,243	40.2%	45.3%	38.4%	51.2%	
N. C. Baptist Hospital	39			39	5,327	6,439	51.6%	61.5%	37.4%	45.2%	
Whitaker Rehab Center [2]	68			68	12,212	13,190	47.7%	50.4%	49.2%	53.1%	
Moses Cone Memorial Hospital	49			49	10,958	8,473	66.5%	67.1%	61.3%	47.4%	
HSA II TOTAL	184	0	0	184	34,501	34,224	49.0%	57.9%	51.4%	51.0%	0
HSA III											
Rowan Regional Medical Center	10			10	3,193	2,995	86.0%	87.8%	87.5%	82.1%	
Stanly Regional Medical Center	10			10	1,441	1,237	51.8%	44.3%	39.5%	33.9%	
Carolinas Rehabilitation Hosp. [3]	172	-53		119	28,371	41,927	60.8%	58.7%	58.4%	66.8%	
CMC-Levine Children's Hosp. [4]	0	13		13	n/a	0	0.0%	0.0%	0.0%	0.0%	
Carolinas Rehab.Hosp Gaston Co. [5]	0	40		40	n/a	0	0.0%	0.0%	0.0%	0.0%	
HSA III TOTAL [6]	192	0	0	192	44,780	46,159	62.2%	64.5%	63.9%	65.9%	0
HSA IV											
Durham Regional Hospital	30			30	6,783	6,869	71.9%	67.1%	61.9%	62.7%	
UNC Hospitals	30			30	8,007	8,429	58.5%	61.4%	73.1%	77.0%	
Wake Med	78	6		84	23,369	24,036	93.4%	96.2%	94.2%	78.4%	
Maria Parham Hospital	11			11	2,429	2,084	55.4%	57.9%	60.5%	51.9%	
HSA IV TOTAL	149	6	0	155	40,588	41,418	66.7%	67.7%	62.1%	73.2%	0
HSA V											
FirstHealth Moore Reg. Hospital	25			25	6,062	5,568	73.1%	67.6%	66.4%	61.0%	
New Hanover Reg. Med. Ctr.	60			60	12,423	11,547	49.6%	51.7%	56.7%	52.7%	
Scotland Memorial Hospital	7			7	1,302	1,210	52.4%	56.6%	51.0%	47.4%	
Southeastern Regional Rehab Ctr.	78			78	16,782	19,489	65.1%	60.4%	58.9%	68.5%	
HSA V TOTAL	170	0	0	170	36,569	37,814	60.3%	58.2%	58.9%	60.9%	0
HSA VI											
Nash General Hospital	23			23	6,905	7,251	91.1%	86.0%	82.3%	86.4%	
Lenoir Memorial Hospital	17			17	2,703	2,508	49.9%	44.5%	43.6%	40.4%	
Heritage Hospital	16			16	1,822	1,489	36.2%	36.2%	31.2%	25.5%	
Pitt Hospital Regional Rehab Ctr.	75			75	17,793	16,255	64.0%	69.5%	65.0%	59.4%	
Craven Regional Medical Center	20			20	3,618	3,621	69.2%	52.1%	49.6%	49.6%	
HSA VI TOTAL	151	0	0	151	32,841	31,124	64.3%	63.3%	59.6%	56.5%	0
STATE TOTAL	975	6	0	981	216,626	213,088	60.6%	62.3%	59.1%	59.5%	0

[1] A new 12-bed Inpatient Rehabilitation Unit at Hugh Chatham Memorial Hospital was licensed in September 2002.

[2] A certificate of need to relocate 12 inpatient rehabilitation beds from Whitaker Rehab Center to Presbyterian - Orthopaedic was relinquished in May 2002.

[3] Formerly Charolotte Institue of Rehabilitation; in Oct. 2006, 39 beds transferred from License of CMC Mercy-Pineville to Carolinas Rehabilitation (phsyical location of beds not changed).

[4] A certificate of need to relocate 13 inpatient rehabilitation beds from Charlotte Institute of Rehabilitation (now Carolinas Rehab. Hospital) to CMC-Levine was awarded in July 2004.

[5] A certificate of need to relocate 40 inpatient rehabilitation beds from Charlotte Institute of Rehabilitation (now Carolinas Rehabilitation) to Carolinas Rehabilitation Hospital, Gaston Co. was awarded in January 2006.

[6] 44,780 days of care for 2004-2005 includes 11,775 days of care provided at CMC Mercy &Pineville.

Need Determination

It is determined that there is no need for additional inpatient rehabilitation beds in any Health Service Area in the State and no reviews are scheduled.

Table 8B: Inpatient Rehabilitation Bed Need Determination

(Scheduled for Certificate of Need Review Commencing in 2008)

HEALTH SERVICE AREA	INPATIENT REHABILITATION BED NEED DETERMINATION	CERTIFICATE OF NEED APPLICATION DUE DATE	CERTIFICATE OF NEED BEGINNING REVIEW DATE
It is determined that there is no need for additional inpatient rehabilitation beds anywhere in the state and no reviews are scheduled.			

STATE OF NORTH CAROLINA

COUNTY OF ROWAN

IN THE GENERAL COURT OF JUSTICE
SUPERIOR COURT DIVISION
08 CVS 2158

ROWAN REGIONAL MEDICAL CENTER, INC.,

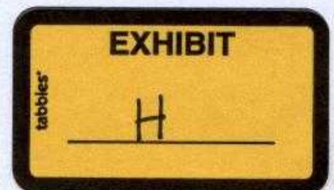
Plaintiffs,

vs.

THE CHARLOTTE-MECKLENBURG HOSPITAL AUTHORITY d/b/a CAROLINAS HEALTHCARE SYSTEM,

Defendant.

AFFIDAVIT OF MYRON A. GOODMAN, M.D.



MYRON A. GOODMAN, JR., M.D.

601 MOCKSVILLE AVENUE PHONE 633-4686 SALISBURY, N.C. 28144-2723

AFFIDAVIT OF MYRON A. GOODMAN, MD

1. I am Myron A. Goodman, MD, resident of Salisbury N.C. and have been on staff of the present Rowan Regional (formerly Rowan Memorial) for ~~forty~~ thirty-seven years as a board certified internist.

2. The Elizabeth Stanback Rehabilitation Unit has been of great service to numerous patients of mine and the care the patients receive there has been very outstanding. Having care in close proximity to specialists of all types and skills is also an asset to the unit and to our hospital. It is my understanding that the unit is very highly utilized and in that respect a tremendous asset to our community.

3. The Stanback Rehabilitation has been an especially meaningful organization to me personally as Mrs. Stanback was a very close personal friend to me from the time I was a child. She worked very close with me in my high school years on numerous church related projects. She, another high school student and I took very meaningful trips on church related projects. Her daughter Jean and I were classmates at Duke and shared transportation back and forth from Durham.
   As an aside, what I will never forget, is my approaching Mr. Fred Stanback, Elizabeth's husband, when I was a college student, to ask him for a recommendation for medical school. He greeted me warmly at his home and asked me to sit down. Instead of congratulating me as a young boy, over my reasons to enter medicine, he stated "Myron- you can support your family better if you go into business!"
   I often, in a kidding manner, relate this little conversation to others chuckling (I hope) to members of the family.

4. At any rate, the Stanback family has been extremely sincere and caring with their facility and resources to Salisbury. As stated above, Mrs. Stanback was, like Eleanor Roosevelt, not a mere figurehead but an active day to day worker, in the trenches, you might say, for numerous educational, medical, and other or

   Mr. Stanback and their son Fred also have been very involved with Salisbury projects. Fred Sr. and Elizabeth Stanback's daughter, Jean, while on a

MYRON A. GOODMAN, JR., M.D.

601 MOCKSVILLE AVENUE PHONE 633-4686 SALISBURY, N.C. 28144-2723

combination mission/ and holiday in Africa lost her life in a plane crash. This never deterred the Stanback family from their mission to help others.

Again, I would urge all involved to make every effort to keep the Stanback unit open. My patients have greatly benefited from the unit. Also, not to forget, David Agner, a most outstanding leader as the head physician in the unit and we appreciate his dedication and talents in the unit. The nursing and therapy staff in the unit are very caring and skillful. A highly spirited, positive unit it is.

Sincerely,

Myron A. Goodman, MD

Sworn to and subscribed before me
this the 23rd day of June, 2008

Teresa C. Bebber
Notary Public

8-21-2010
Commission Expires

STATE OF NORTH CAROLINA

COUNTY OF ROWAN

IN THE GENERAL COURT OF JUSTICE
SUPERIOR COURT DIVISION
08 CVS 2158

ROWAN REGIONAL MEDICAL CENTER, INC.,

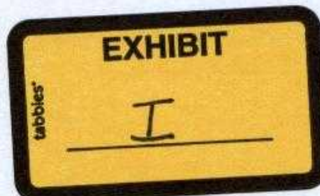
Plaintiffs,

vs.

THE CHARLOTTE-MECKLENBURG HOSPITAL AUTHORITY d/b/a CAROLINAS HEALTHCARE SYSTEM,

Defendant.

AFFIDAVIT OF BARBARA L. FREEDY



AFFIDAVIT OF BARBARA L. FREEDY

Barbara L. Freedy, being duly sworn, deposes and states as follows:

1. My name is Barbara L. Freedy. I am over the age of twenty-one and make these statements of my own personal knowledge. I am the Director of Certificate of Need—Financial Planning and Analysis for Novant Health, Inc. ("Novant"). In that capacity, I coordinate and supervise Novant's certificate of need ("CON") activities.

2. I hold a Juris Doctor degree from The Ohio State University College of Law, and a Master of Health Administration degree from Duke University. I have over eight years of experience working with North Carolina CON Law, and over eighteen years experience in the health care industry in North Carolina. During my tenure at Novant, I have assisted with and/or supervised the preparation of approximately 65-70 CON applications for nearly every variety of health care services. I have recently been qualified as an expert in the field of CON preparation and analysis and health care planning by the Office of Administrative Hearings in a CON contested case hearing.

3. Based on my education, training and work experience, I am very familiar with the CON program in North Carolina, including the requirements for adding inpatient rehabilitation beds.

4. I understand that The Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas HealthCare System ("CMHA") has stated that it will "remove" the ten (10) rehabilitation beds from the Elizabeth C. Stanback Rehabilitation Unit ("Stanback Rehab") at Rowan Regional Medical Center ("Rowan") on June 30, 2008. If that were to happen, Rowan, the patients in Stanback Rehab and the community at large will suffer greatly.

5. Stanback Rehab is the second most heavily utilized inpatient rehabilitation facility in the State, and is the only non-governmental rehabilitation facility located in Rowan County. Stanback Rehab treats patients who have had joint replacement surgery, such as hip replacements, bone fractures, and who are recovering from strokes. Many of the patients at Stanback Rehab are elderly Medicare recipients.

6. Unlike general acute care hospitals, there are relatively few inpatient rehabilitation facilities in North Carolina. An inpatient rehabilitation facility like Stanback Rehab provides a highly-specialized level of care for patients who are unable to perform many of the activities of daily life, such as walking, bathing and eating. Patients in a facility such as Stanback receive several hours of specialized inpatient rehabilitation therapy each day. An ordinary acute care hospital medical/surgical unit does not provide this kind of intensive therapy and is *not* a substitute for an inpatient rehabilitation unit.

7. If CMHA is permitted to "remove" the beds from Stanback Rehab, all of Stanback's current patients will be displaced, which will result in a substantial burden on the patients, their families and care givers, and the facility as well. New patients will not be admitted to Stanback Rehab. The nearest existing inpatient rehabilitation centers are in Charlotte, Winston-Salem and Stanly County, yet these are all at least an hour away from Salisbury.

8. Rowan has no immediate way to replace these beds if CMHA is allowed to "remove" them. New inpatient rehabilitation beds can only be added if there is a need for additional inpatient rehabilitation beds in the State Medical Facilities Plan ("SMFP"). There is no such need in the 2008 SMFP or in the draft 2009 SMFP. This means that if Rowan were to file a CON application for inpatient rehabilitation beds to replace those that CMHA is

attempting to remove, the CON application would be automatically denied because there is no need for additional inpatient rehabilitation beds. *See* N.C. Gen. Stat. § 131E-183(a)(1)(one of the review criteria for CON applications states that "[t]he 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 services, health service facility, health service facility beds, dialysis stations, operating rooms or home health offices that may be approved.").

9. The lack of need in the SMFP for additional inpatient rehabilitation beds also means that Rowan could not convert any of its existing acute care beds to inpatient rehabilitation beds, nor could another facility transfer its inpatient rehabilitation beds to Rowan.

10. Rowan's only option would be to file a "Special Petition" with the State Health Coordinating Council ("SHCC"), the body that develops the SMFP, seeking to add inpatient rehabilitation beds to Rowan. There is no way to know if such a petition would succeed. A competitor such as CMHA could work to defeat such a petition. The Chair of the Acute Care Services Committee of the SHCC, which is the Committee that has oversight responsibility for inpatient rehabilitation services, is Michael C. Tarwater, CEO of CMHA.

11. Even if such a petition succeeded, Rowan would still need to file a CON application. It can take several weeks to prepare a CON application. The CON Section charges several thousand dollars to file a CON application. This is addition to the time and money the applicant spends to prepare the application. A CON application for inpatient rehabilitation beds (Category E in the SMFP) can only be filed at certain times of the year. Currently, the only times a Category E application can be filed for the health service area that

includes Rowan County are March 15, July 15, and October 15. Once the CON application is filed, the CON Section can take up to 150 days to review the application. *See* N.C. Gen. Stat. § 131E-185. Even if the application is approved, a competitor such as CMHA could appeal the approval. *See* N.C. Gen. Stat. § 131E-188. It is not uncommon for CON contested case appeals to last several years. Some of these cases go all the way to the North Carolina Supreme Court. *See, e.g., Mooresville Hospital Management Associates, Inc. v. North Carolina Department of Health and Human Services,* 360 N.C. 156, 622 S.E.2d 621 (2005). In the meantime, the patients who need and deserve treatment at Stanback Rehab are out of luck.

12. It is my understanding that CMHA plans to relocate the rehabilitation beds from Stanback Rehab to a new health service facility which they will construct, possibly in a county other than Rowan. However, in order to do so, CMHA would be required to first obtain CON approval for the facility construction and any bed relocation. Even assuming for the sake of argument that CMHA submits an approvable application that is not appealed, the facility likely would not open for eighteen months to two years. This means that even if CMHA successfully removed Stanback Rehab's beds on June 30, 2008, the displaced patients could not be immediately moved into the new replacement facility that CMHA is planning. The beds would have to remain in storage pending CON approval of a new facility.

13. The CON was originally issued to CMHA and Mercy Hospital, Inc., and provides that if the Management Agreement with Rowan is terminated, the CON authorizes the development of the inpatient rehabilitation beds at Mercy Hospital in Charlotte. However, this raises at least three issues. First, CMHA has indicated that their plan is to construct a new rehabilitation facility to serve Cabarrus, Rowan, and Stanly counties (not Charlotte or

Mecklenburg County). Thus, CMHA's own statements indicate they do *not* plan to relocate the beds to Mercy Hospital as provided in the original CON. Second, there is no indication that there is anywhere to place these beds if they were located at Mercy. Thus, the beds could be warehoused for several years before anyone would use them. Third, even if the beds were installed at Mercy, that still does not help the disabled residents of Rowan County or the families who would bear the burden and expense of out of county travel to receive inpatient rehabilitation services.

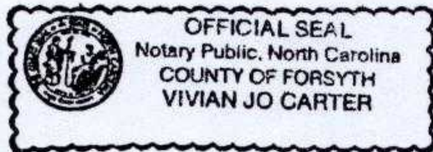
[REMAINDER OF PAGE INTENTIONALLY LEFT BLANK]

This is the 26 of June, 2008.

Barbara L. Freedy

Sworn to and subscribed before me
this the 26th day of June, 2008.

Notary Public
My Commission Expires: May 9, 2012



Proposed

2009

State Medical Facilities Plan

North Carolina State Health Coordinating Council • North Carolina Department of Health and Human Services • Division of Health Service Regulation • Medical Facilities Planning Section

IMPORTANT NOTICE: Recommendations for the final <u>2009 State Medical Facilities Plan</u> will be voted on in October 2008 and may include updated inventories, updated population projections, and other changes resulting from comments and petitions received during the public review period. Statewide revisions to population projections are not anticipated. Please contact the Medical Facilities Planning Section if you have questions.

tabbies
EXHIBIT
J

CHAPTER 8
INPATIENT REHABILITATION SERVICES

Summary of Bed Supply and Utilization

As of June 2008, there were 975 inpatient rehabilitation beds in 26 facilities strategically located throughout North Carolina. From an historical perspective, although the "Days of Care" decreased between 2001 and 2002, the Average Annual Utilization Rate increased slightly due to a parallel decrease in the Total Planning Inventory. The "Days of Care" continued to decline in 2003, with the Average Annual Utilization Rate decreasing from 62.9 percent in 2002 to 60.6 percent in 2003. During data year 2004, the Average Annual Utilization Rate increased to 62.3 percent. For data year 2005, the Average Annual Utilization Rate decreased to 59.1 percent, for data year 2006, the rate increased slightly to 59.5 percent, and for data year 2007 the rate decreased slightly to 59.2 percent. Of the 24 facilities providing services during the reporting period, 11 facilities indicated increased utilization and 13 facilities indicated decreased utilization.

Changes from Previous Plans

No substantive changes in the inpatient rehabilitation principles or methodology have been recommended for incorporation into the Proposed 2009 North Carolina State Medical Facilities Plan. As in 2008, the inpatient rehabilitation bed need determination methodology is based on historic utilization of beds over a two-year period.

Basic Principles

The scope of services covered in this section of the North Carolina State Medical Facilities Plan is limited to rehabilitation services provided to physically disabled people. Physical rehabilitation services exclude mental health and substance abuse rehabilitation services, but include those mental health services needed by individuals primarily suffering from physical injury or disease, and rehabilitation services provided to people who are cognitively disabled as a result of physical injury or disease.

The combination of component services required to meet the needs of the individual is provided using an interdisciplinary approach and continues as long as, within a reasonable period of time, significant and observable improvement toward established goals is taking place. Where necessary, these services are provided through a spectrum of care using a system of case management.

Inpatient rehabilitation beds include comprehensive (general), spinal cord, brain injury and pediatric beds.

Inpatient rehabilitation facilities units/beds should be located in general acute care or rehabilitation hospitals or in nursing facilities to ensure that there is available medical back-up for medical emergencies.

Basic Assumptions of the Method

- The Health Service Areas (HSAs) remain logical planning areas for inpatient rehabilitation beds even though many patients elect to enter rehabilitation facilities outside the region in which they reside.

- The bed need determination methodology is based upon the historic average annual utilization of inpatient rehabilitation beds.

Source of Data

Annual Hospital Licensure Applications – The numbers of inpatient rehabilitation bed days of care were compiled from the 2007 and 2008 "Hospital License Renewal Applications" as submitted to the Division of Health Service Regulation of the North Carolina Department of Health and Human Services.

Inpatient Rehabilitation Bed Need Projection Methodology

Need for additional inpatient rehabilitation beds in any of the six Health Service Areas is determined when the total number of existing and CON approved inpatient rehabilitation beds in a Health Service Area report an overall average, annual occupancy rate of 80 percent or higher during the two fiscal years prior to developing the North Carolina State Medical Facilities Plan.

The determination of need (based on average annual occupancy rate) for additional inpatient rehabilitation beds or facilities in a Health Service Area for Plan Year 2009 is calculated by dividing the total number of rehabilitation bed days of care reported in FY 2005-2006 in all units in the HSA by the total number of licensed and CON approved rehabilitation beds in these units multiplied by 365 days and the total number of rehabilitation bed days of care reported in FY 2006-2007 in all units in the HSA by the total number of licensed and CON approved rehabilitation beds in these units multiplied by 365 days.

Table 8A: Inventory and Utilization of Inpatient Rehabilitation Beds

		Inventory				Days of Care		Average Annual Utilization Rate		
HSA	Facility	Current	CON Issued / Pending Development	Pending Review or Appeal	Total Planning Inventory	2005-2006	2006-2007	2006	2007	Beds Needed
I	Catawba Valley Medical Center	20	0	0	20	1,756	1,526	24.1%	20.9%	
I	Care Partners Rehabilitation Hospital	80	0	0	80	16,931	16,980	58.0%	58.2%	
I	Frye Regional Medical Center	29	0	0	29	3,662	2,769	34.6%	26.2%	
I Total		**129**	**0**	**0**	**129**	**22,349**	**21,275**	**47.5%**	**45.2%**	**0**
II	High Point Regional	16	0	0	16	3,879	4,005	66.4%	68.6%	
II	Hugh Chatham Memorial Hospital	12	0	0	12	2,243	2,154	51.2%	49.2%	
II	North Carolina Baptist Hospital	39	0	0	39	6,439	6,724	45.2%	47.2%	
II	Whitaker Rehabilitation Center	68	0	0	68	13,190	13,408	53.1%	54.0%	
II	Moses Cone Memorial Hospital	49	0	0	49	8,473	8,333	47.4%	46.6%	
II Total		**184**	**0**	**0**	**184**	**34,224**	**34,624**	**51.0%**	**51.6%**	**0**
III	Rowan Regional Medical Center	10	0	0	10	2,995	2,665	82.1%	73.0%	
III	Stanly Regional Medical Center	10	0	0	10	1,237	743	33.9%	20.4%	
III	Carolinas Rehabilitation Hospital *	172	-53	0	119	41,927	40,315	66.8%	64.2%	
III	CMC-Levine Children's Hospital	0	13	0	13	0	0	0.0%	0.0%	
III	Carolinas Rehabilitation Hospital Gaston County	0	40	0	40	0	0	0.0%	0.0%	
III Total		**192**	**0**	**0**	**192**	**46,159**	**43,723**	**65.9%**	**62.4%**	**0**
IV	Durham Regional Hospital	30	0	0	30	6,869	6,758	62.7%	61.7%	
IV	University of North Carolina Hospitals	30	0	0	30	8,429	9,084	77.0%	83.0%	
IV	WakeMed	78	6	0	84	24,036	24,006	78.4%	78.3%	
IV	Maria Parham Hospital	11	0	0	11	2,084	2,588	51.9%	64.5%	
IV Total		**149**	**6**	**0**	**155**	**41,418**	**42,436**	**73.2%**	**75.0%**	**0**
V	FirstHealth Moore Regional Hospital	25	0	0	25	5,568	5,929	61.0%	65.0%	
V	New Hanover Regional Medical Center	60	0	0	60	11,547	10,904	52.7%	49.8%	
V	Scotland Memorial Hospital	7	0	0	7	1,210	1,322	47.4%	51.7%	
V	Southeastern Regional Rehabilitation Center	78	0	0	78	19,489	18,813	68.5%	66.1%	
V Total		**170**	**0**	**0**	**170**	**37,814**	**36,968**	**60.9%**	**59.6%**	**0**
VI	Nash General Hospital	23	0	0	23	7,251	7,140	86.4%	85.1%	
VI	Lenoir Memorial Hospital	17	0	0	17	2,508	2,554	40.4%	41.2%	
VI	Heritage Hospital	16	0	0	16	1,489	3,112	25.5%	53.3%	
VI	Pitt Hospital Regional Rehabilitation Center	75	0	0	75	16,255	16,657	59.4%	60.8%	
VI	Craven Regional Medical Center	20	0	0	20	3,621	3,393	49.6%	46.5%	
VI Total		**151**	**0**	**0**	**151**	**31,124**	**32,856**	**56.5%**	**59.6%**	**0**
Grand Total		**975**	**6**	**0**	**981**	**213,088**	**211,882**	**59.5%**	**59.2%**	**0**

* Utilization rates based on 172 beds in service at Hospital for reporting periods. Hospital transferred 30 beds 10.17.07 and 10 beds 1.8.08 to Carolinas Rehabilitation Hospital Gaston County and 13 beds 1.27.07 to Levine Children's Hospital.

Need Determination

It is determined that there is no need for additional inpatient rehabilitation beds in any Health Service Area in the State and no reviews are scheduled.

2006 STATE MEDICAL FACILITIES PLAN

North Carolina State Health Coordinating Council
Medical Facilities Planning Section
Division of Facility Services
North Carolina Department of Health and Human Services

EXHIBIT
K

MEMORANDUM

TO: Carmen Hooker Odom, Secretary
Department of Health and Human Services

FROM: Michael F. Easley

SUBJECT: Amendment to the 2006 State Medical Facilities Plan

DATE: December 13, 2005

I am approving the 2006 State Medical Facilities Plan as recommended to me by the North Carolina State Health Coordinating Council, with the following modification.

I am aware of litigation currently pending in the Supreme Court of North Carolina regarding Presbyterian Hospital Huntersville (the "Hospital"), which opened on November 8, 2004 pursuant to a certificate of need issued by the Department of Health and Human Services. In that litigation, the petitioner seeks an order requiring the closure of the Hospital, which was developed at a cost of more than fifty eight million dollars and which has been well utilized since its opening by the citizens of the Huntersville area. While expressing no opinion on the merits of the litigation, I am concerned about the potential hardship to the community and waste of valuable healthcare assets if the Hospital should be required to close. I believe that such a result would be contrary to the legislative intent underlying the Certificate of Need Law, as expressed in N.C. Gen. Stat. § 131E-175. I am also aware of the North Carolina General Assembly's recent enactment of 2005 Session Law 2005-276 § 10.40B, which provides that a licensed health care facility in operation on July 1, 2005, under a certificate of need issued by the Department of Health and Human Services prior to that date and subsequently invalidated based on a procedural defect in the awarding of the certificate of need, may remain in operation for the purpose of applying for a new certificate of need in accordance with Article 9 of Chapter 131E of the General Statutes.

In light of these unique circumstances, I am therefore modifying the proposed 2006 State Medical Facilities Plan to include a determination that there is need for the continued operation of the Hospital, such determination to be utilized only in the event that the Department of Health and Human Services' previous decision granting a certificate of need for the Hospital is remanded for reconsideration, or a new certificate of need is required for the continued operation of the Hospital. This determination shall not be interpreted to allow the development of any additional hospital facilities other than those previously approved by the Department of Health and Human Services in the above-referenced certificate of need.

I am pleased with the State Medical Facilities Plan that was submitted to me, and I thank the North Carolina State Health Coordinating Council and your staff for their diligence in producing this document.

cc: Dan A. Myers, M.D., Chairman
North Carolina State Health Coordinating Council

The 2005 State Medical Facilities Plan

North Carolina
State Health Coordinating Council
Medical Facilities Planning Section
Division of Facility Services
Department of Health and Human Services

MEMORANDUM

TO: Carmen Hooker Odom, Secretary
Department of Health and Human Services

FROM: Michael F. Easley

SUBJECT: 2005 State Medical Facilities Plan

DATE: December 10, 2004

I am approving the 2005 State Medical Facilities Plan as recommended to me by the North Carolina State Health Coordinating Council with the following two exceptions:

First, in addition to the Acute Care Bed Need shown by the standard methodology in Chapter 5, I am adding an adjusted need determination for a new hospital with not more than 50 acute care beds in the central part of Harnett County. I am aware of the continuing controversy regarding the desire for a hospital in the central part of Harnett County. The perceived need from the community's perspective is significant. Without expressing a preference for any particular provider, I have been persuaded that there is need for a new hospital in this area. The attached analysis supports the need for this adjustment in the 2005 State Medical Facilities Plan.

Second, I am directing that Chapter 6 regarding Operating Rooms be adjusted to include a need determination for 3 additional operating rooms for the new hospital, determined to be needed in Chapter 5, for the central part of Harnett County.

I am pleased with the State Medical Facilities Plan that was submitted to me, and I thank the Council and your staff for their diligence in producing this document.

MFE:jk

Attachment

cc: Dan A. Myers, M.D., Chairman
North Carolina State Health Coordinating Council

STATE OF NORTH CAROLINA
OFFICE OF THE GOVERNOR
20301 MAIL SERVICE CENTER • RALEIGH, NC 27699-0301

MICHAEL F. EASLEY
GOVERNOR

MEMORANDUM

TO: Carmen Hooker Odom, Secretary
Department of Health and Human Services

FROM: Michael F. Easley

SUBJECT: Clarification to 2005 State Medical Facilities Plan

DATE: December 30, 2004

The purpose of this memorandum is to clarify the intent of my December 10, 2004 memorandum in which I approved the 2005 State Medical Facilities Plan, with two exceptions.

First, I am aware that unique circumstances exist in Harnett County. The physical plant of one of the hospitals in Harnett County, Good Hope Hospital, is nearing the end of its useful life. In fact, the owners of Good Hope Hospital have represented to the Department that, based on a Plan of Correction submitted to and approved by the Federal Centers for Medicare and Medicaid Services, its present facilities cannot be used for patient care after November 2006. From the community's perspective, the perceived need for a new hospital in the central part of Harnett County is significant. These unique circumstances have persuaded me that a new hospital (the "New Hospital") containing not more than 50 acute care beds and not more than 3 operating rooms is needed in the central part of Harnett County.

Second, I have concluded that the certificate of need ("CON") application process to build the New Hospital should be open to any applicant and nothing herein is to be construed as favoritism toward, or bias against, any potential applicant. Applications for the New Hospital shall be filed in the CON review cycle that begins on October 1, 2005, shall be evaluated utilizing the review criteria set forth in N.C. Gen. Stat. § 131E-183 and the applicable rules of the Department, and shall be reviewed according to the process set forth in N.C. Gen. Stat. § 131E-185. Any applicant may propose, in its discretion, to construct less than 50 acute care beds and 3 operating rooms at the New Hospital. In no event, however, shall the New Hospital contain more than 50 acute care beds and 3 operating rooms.

LOCATION: 116 WEST JONES STREET • RALEIGH, NC • TELEPHONE: (919) 733-5811

Third, consistent with my understanding of the unique circumstances in Harnett County, and to avoid the proliferation of unnecessary health service facilities as referenced in N.C. Gen. Stat. §131E-175(4), I have concluded that any successful applicant for a CON to develop the New Hospital shall be required as a condition of its approval to relinquish any other CON which it holds to develop or replace acute care beds or operating rooms in Harnett County and to withdraw any other pending application or litigation concerning the development or replacement of such beds or rooms.

cc: Dan A. Myers, M.D., Chairman
North Carolina State Health Coordinating Council

Clarified Effective 12/30/04

(Please Insert in the 2005 SMFP)

CHAPTER 5
ACUTE CARE BEDS

Summary of Bed Supply and Utilization

Data reported on the "2004 Hospital License Renewal Applications" indicate that in 2003 there were 117 licensed acute care hospitals and 7 licensed long-term acute care hospitals in North Carolina which provided 4,259,963 days of care to patients in 20,482 licensed acute care beds. These numbers exclude beds in service for substance abuse, psychiatry, rehabilitation, hospice, and non-acute long-term care. Between 1991 and 1999, the average annual occupancy rate for acute care beds decreased 6.3 percentage points, from 60.7% in 1991 to 54.4% in 1999. More recently, the average annual occupancy rate has been gradually increasing, with a cumulative growth of 2.4 percentage points between 1999 and 2003. The change between 2002 and 2003 was an increase of 0.5 of a percentage point *(i.e., from 56.3% to 56.8%)*.

It is important to note that not all licensed beds were in service throughout the year. Some beds were more or less permanently idled, while others were temporarily taken out of service due to staff shortages or to accommodate renovation projects.

Changes from the Previous Plan

One change in acute care bed need methodology has been incorporated into the 2005 State Medical Facilities Plan. In the 2004 Plan, acute care beds in "Long-Term Acute Care Hospitals" (LTACHs) were identified in the inventory, but excluded from need projections for additional "acute care beds." Because all LTACH beds are licensed as "acute care beds" and because the majority of LTACH beds are "leased" to other entities for operation (but not "sold"), the number of "counted" acute care beds could change if a lease is amended during the year, causing fluctuations in the inventory that could affect projected need determinations.

For the 2005 Plan, "acute care beds" and the "days of care" reported by LTACHs affiliated with host hospitals providing general acute care services are included in the acute care bed need methodology. This action accounts for most "licensed acute care beds" and adds stability to the inventory. The only LTACH not counted in the acute care bed need methodology is Kindred Hospital-Greensboro, which is not affiliated with a general acute care hospital. To implement this change, a revision to Step 8 (a) regarding "common ownership" has also been incorporated into the 2005 Plan.

In addition, the Governor has made an adjusted need determination for a new hospital with not more than 50 acute care beds in the central part of Harnett County. Additional information regarding this adjusted need determination can be found with the Governor's Approval Letter on pages "c" and "d," prior to the Table of Contents**, and in the Governor's clarification memorandum dated December 30, 2004.**

Clarified Effective 12/30/04

(Please Insert in the 2005 SMFP)

Need Determination

Application of the methodology indicated need for an additional 94 acute care beds distributed across three single or multi-county service areas as shown in Table 5B. In addition, the Governor has included an adjusted need determination for a new hospital with not more than 50 acute care beds in the central part of Harnett County. **Any certificate of need issued pursuant to this adjusted need determination will be required to conform with the conditions provided in the Governor's clarification memorandum dated December 30, 2004.** This brings the total number of new acute care beds to 144 for review during 2005. It is further determined that there is no need for additional acute care beds anywhere else in the State and no other reviews are scheduled.

Table 5B: Acute Care Bed Need Determinations

(Scheduled for Certificate of Need Review Commencing in 2005)

It is determined that the counties listed in the table below need additional Acute Care Beds as specified:

Service Area	Acute Care Bed Need Determination *	Certificate of Need Application Due Date **	Certificate of Need Beginning Review Date
Pitt-Greene Counties	42	November 15, 2005	December 1, 2005
Richmond County	7	April 15, 2005	May 1, 2005
Wake County	45	August 15, 2005	September 1, 2005
Central Area of Harnett County	One New Hospital with Not More Than 50 Acute Care Beds	August 15, 2005	September 1, 2005

It is determined that there is no need for additional Acute Care Beds anywhere else in the State and no other reviews are scheduled.

* Need Determinations shown in this document may be increased or decreased during the year pursuant to Policy GEN-2 (see Chapter 4).

** Application Due Dates are absolute deadlines. The filing deadline is 5:30 p.m. on the Application Due Date. The filing deadline is absolute (see Chapter 3).

Clarified Effective 12/30/04

(Please Insert in the 2005 SMFP)

CHAPTER 6
OPERATING ROOMS

Summary of Operating Room Inventory and Utilization

As of October 2004, the combined inventory of operating rooms in hospitals and ambulatory surgical facilities consists of 151 dedicated inpatient surgery rooms (*including 47 dedicated open heart surgery rooms, 74 dedicated C-Section rooms, and 30 other inpatient operating rooms)*, 266 dedicated ambulatory surgery rooms and 819 shared operating rooms. Data from the "2004 License Renewal Applications" indicated that 24 surgical operating rooms were "not in use" during FY 2003 and that utilization of the shared operating rooms was split 61.1% for ambulatory cases and 38.9% for inpatient cases.

In addition, the inventory indicates a total of 321 endoscopy rooms in licensed facilities, with 278 endoscopy rooms in hospitals and 43 endoscopy rooms in licensed ambulatory surgical facilities.

Changes from the Previous Plan

No substantive changes to the Operating Room Need Methodology have been made for the 2005 State Medical Facilities Plan. The inventory and case data have been updated and references to dates have been advanced by one year. Data regarding hospitals and ambulatory surgical facilities have been combined into a unified "Table 6A," which provides County Totals for application of the methodology. The methodology is implemented in "Table 6B."

In addition, the "Note" regarding C-Section Rooms, which immediately follows the methodology, has been revised to address "conversion" of an existing operating room for use as a "Dedicated C-Section Operating Room."

(Note: While data are reported on the annual license renewal applications regarding dedicated C-Section rooms, data must be collected separately for the exclusions related to trauma centers and burn intensive care units. Last year, case data related to the trauma center and burn intensive care unit exclusions were requested individually from "facilities in counties with projected deficits." For purposes of the 2005 Plan, the trauma center and burn intensive care "rooms" are excluded in Table 6B, but the only Service Area with a projected deficit does not have either of these types of rooms; therefore, additional data on "cases" referred to excluded operating rooms by trauma centers and burn intensive care units have not been collected [excluding cases for service areas with "projected surpluses" would only increase the projected surpluses].)

In addition, the Governor has made an adjusted need determination for three additional operating rooms for the new hospital, determined to be needed in Chapter 5, for the central part of Harnett County. **Please note the Governor's Approval Letter on pages "c" and "d" prior to the Table of Contents and the Governor's clarification memorandum dated December 30, 2004.**

Clarified Effective 12/30/04

(Please Insert in the 2005 SMFP)

Need Determination

Application of the methodology indicated need for one additional operating room in Union County. In addition, the Governor has included an adjusted need determination for three additional operating rooms for the new hospital, determined to be needed in Chapter 5, for the central part of Harnett County. **Any certificate of need issued pursuant to this adjusted need determination will be required to conform with the conditions provided in the Governor's clarification memorandum dated December 30, 2004.** It is further determined that there is no need for additional operating rooms anywhere else in the State and no other reviews are scheduled. "Operating room" means an inpatient operating room, an outpatient or ambulatory surgical operating room, a shared operating room, or an endoscopy procedure room in a licensed health service facility. Any person, including a currently licensed hospital or ambulatory surgical facility, may apply for a certificate of need to develop a new operating room provided the new operating room is located in the Operating Room Service Area in which the need is determined.

Table 6C: Operating Room Need Determinations

(Scheduled for Certificate of Need Review Commencing in 2005)

It is determined that the counties listed in the table below need additional Operating Rooms as specified.

Operating Room Service Area	Operating Room Need Determination *	Certificate of Need Application Due Date **	Certificate of Need Beginning Review Date
Union County	1	July 15, 2005	August 1, 2005
Central Area of Harnett County	3 Operating Rooms for the New Hospital Identified in Chapter 5	August 15, 2005	September 1, 2005

It is determined that there is no need for additional Operating Rooms anywhere else in the State and no other reviews are scheduled.

* Need Determinations shown in this document may be increased or decreased during the year pursuant to Policy GEN-2 (see Chapter 4).

** Application Due Dates are absolute deadlines. The filing deadline is 5:30 p.m. on the Application Due Date. The filing deadline is absolute (see Chapter 3).