EXHIBITS FOR NOVANT HEALTH, INC.'S PETITION TO THE STATE HEALTH COORDINATING COUNCIL REGARDING POLICY AC-3

Exhibit	Name
A	Policy B.5 from 1983 SMFP
B	Table 9E from 2011 SMFP
C	Pitt County Memorial Hospital's 2007 Operating Room Petition
D	Excerpts from NCBH Application, Project I.D. No. G-8460-10
E	Agency Findings on Project I.D. No. G-8460-10
F	Comments in Opposition to Project I.D. No. G-8460-10
G	Excerpts from 2010 SMFP
H	Excerpts from 2011 SMFP
I	Excerpts from 2009 SMFP
J	Excerpts from 2008 SMFP

EXHIBIT A TO NOVANT HEALTH'S PETITION TO THE SHCC REGARDING POLICY AC-3

1983

according to their size. Some of these hospitals may be experiencing difficulty in competing for patients with nearby larger community hospitals due to their small size, age, or other conditions. A few of these hospitals with low occupancy are located in counties close to large medical centers and some residents apparently are traveling to those large medical centers for care which normally could be provided by local community hospitals.

Reasons for low occupancy and bed need vary with the circumstances of a particular area. In areas where the number of licensed beds considerably exceeds the number of beds projected as needed within the next five years, consideration should be given to alternative or more efficient uses of these beds, including closing them permanently. In other areas, improved utilization of these beds would prevent the need to build additional beds elsewhere. This statement applies to the case involving other hospitals in the same county and to the situation in which patients are going to other counties, particularly large referral centers, for secondary care. A particularly opportune time for reduction of acute care bed capacity, where indicated, may be the time when renovation or replacement of a facility is being considered.

B.5. — SPECIAL CONSIDERATION FOR ACADEMIC MEDICAL CENTER TEACHING HOSPITALS

A hospital that has been designated an Academic Medical Center Teaching Hospital may receive a special exemption from the State Medical Facilities Plan, if justified. Requests for additional resources made by a formally designated Academic Medical Center Teaching Hospital which are subject to Certificate of Need review will be evaluated in the context of the overall requirements of the academic medical center and in the context of the special characteristics which distinguish the academic medical center teaching hospital from other acute care facilities.

Definition

An academic medical center teaching hospital is defined as a tertiary care facility which serves as the primary site for university-based teaching activities for the health sciences. The hospital associated with such an academic medical center would be engaged in the tripartite mission of education, research, and

patient care. Educational activities would include training programs for various levels of health professional students such as undergraduate, graduate, and professional programs in nursing, allied health, dentistry, pharmacy, health administration and others. Patient care would be offered on a broad spectrum, from primary care (including serving the patient care needs in the local community) to providing highly specialized treatment centers (including serving patients on a statewide, national, and perhaps even international basis). In terms of research, such a facility would serve to facilitate the development of new health care treatment modalities, as well as serving as a vanguard institution in developing new methods of diagnosis, disease prevention and health maintenance. In addition to clinical research, these institutions would be actively engaged in basic research in the health-related sciences and act as testing sites for development and refinement of new medical equipment and pharmaceuticals.

Characteristics of an Academic Medical Center Teaching Hospital

The major characteristics which distinguish the academic medical center teaching hospital from other hospitals is that it possesses all nine of the characteristics listed below:

(1) The presence of an academic health science center* within close proximity to the hospital and the use of that hospital as a primary teaching site for health professional students.

(2) The presence of a broad range of health science students at multiple levels of training.

(3) The existence of broad-based continuing education programs for health professionals.

(4) The presence of continuous and ongoing research programs, both basic and clinical, directed at the development of new modalities of diagnosis and treatment, disease prevention, health maintenance as well as the development and clinical evaluation of new medical equipment, pharmaceuticals and diagnostic/therapeutic procedures.

(5) The inclusion of individuals in the hospital's patient population who are being followed for specific research purposes.

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*Academic Health Science Center includes a school of medicine and at least one other health professional school or division.

(6) The presence of state and federally designated centers for the diagnosis and treatment of special conditions such as burns, cancer, trauma, perinatal disease, etc. within the hospital's programs.

(7) A patient population which reflects treatment of patients referred from extended geographical service areas within and outside the State of North Carolina for the treatment of unique and distinctive clinical conditions that require access to facilities that are uniquely equipped to treat such conditions.

(8) The provision of a broad spectrum of care ranging from primary to highly specialized levels, across a broad range of clinical specialties and in sufficient volume to meet the educational needs of the hospital's health science students.

(9) The presence of long-range plans which describes the anticipated future development and growth of the academic health science teaching hospital and its related health science programs.

Special Considerations

The Department of Human Resources in developing its Medical Facilities Plan did not attempt to take into account all of the special needs which may arise in the academic medical center teaching hospital resulting from the unique characteristics they possess which differentiate them from other types of acute care facilities. These characteristics should be taken into consideration in the evaluation of Certificate of Need applications from academic medical center teaching hospitals.

Designation Process

A hospital must be formally designated as an academic medical center teaching hospital by the Health Planning Section within the Division of Facility Services in order for this policy to be applicable. While some hospitals may engage in one or more of the activities described above, a hospital must submit evidence to demonstrate that it possesses all of the characteristics described in Items 1 through 9 in order to be designated as an academic medical center teaching hospital. A hospital desiring

this designation should submit its request along with appropriate evidence to:

Health Planning Section
Division of Facility Services
Department of Human Resources
P.O. Box 12200
Raleigh, North Carolina 27605-2200

After an application is reviewed, the applicant will be notified about its special designation status as an academic medical center teaching hospital. Once a hospital receives this status, the Certificate of Need Section will recognize this status and may allow for special exemptions from the State Medical Facilities Plan, if justified, for the formerly designated Academic Medical Center Teaching Hospital.

Once a facility receives this special designation, it can continue to maintain this status as long as the facility certifies each year that it continues to possess these characteristics. A statement on the annual licensure application form will be used to continue to monitor this designation. The State Medical Facilities Plan will contain a listing of hospitals which have been designated as academic medical center teaching hospitals.

B.6. — USE OF SWING BEDS

The Department of Human Resources supports the use of swing beds in providing long-term care services in rural acute care hospitals.

According to Public Law 96-499 (The Omnibus Reconciliation Act of 1980), Section 904, (the Swing Bed Provision), certain small rural hospitals may use their inpatient facilities to furnish skilled nursing facility (SNF) services to Medicare and Medicaid beneficiaries and intermediate care facility (ICF) services to Medicaid beneficiaries. The hospital will be reimbursed at rates appropriate for these services, which are generally lower than hospital rates.

Although there has been State legislative action to contain the growth of long-term care beds, there is some evidence to support the need for additional long-term care beds in certain rural areas.

EXHIBIT B TO NOVANT HEALTH'S PETITION TO THE SHCC REGARDING POLICY AC-3

Table 9E: Hospital and Free-Standing Linear Accelerators and Radiation Oncology Procedures					
Facility Name	Service Area #	County	Number of Linear Accelerators	Number of Procedures (ESTVs) 10/1/2008-9/30/2009	Average # of Procedures per Unit
Murphy Medical Center	1	Cherokee	1*	0	0
Harris Regional Hospital	1	Jackson	1	4,338	4,338
NC Radiation Therapy - Franklin	1	Macon	1	633	633
Mission Hospitals (S) (b)	2	Buncombe	3	20,042	6,681
NC Radiation Therapy - Asheville	2	Buncombe	2	7,993	3,997
NC Radiation Therapy - Clyde	2	Haywood	1	4,090	4,090
NC Radiation Therapy - Marion	2	McDowell	1	1,605	1,605
Watauga Hospital	3	Watauga	1	4,169	4,169
Margaret Pardee Memorial Hospital	4	Henderson	1	6,791	6,791
NC Radiation Therapy - Brevard	4	Transylvania	1	2,580	2,580
NC Radiation Therapy - Hendersonville	4	Henderson	1	127	127
Catawba Valley Medical Center	5	Catawba	2	15,372	7,686
Frye Regional Medical Center	5	Catawba	1	689	689
Valdese General Hospital	5	Burke	2	6,325	3,163
Caldwell Memorial Hospital	5	Caldwell	1	2,651	2,651
Cleveland Regional Medical Center	6	Cleveland	1	6,217	6,217
Gaston Memorial Hospital (h)	6	Gaston	3	14,110	4,703
Lincoln Radiation Oncology Associates (s)	6	Lincoln	will be transferred	NR	NR
NC Radiation Therapy - Forest City	6	Rutherford	1	4,951	4,951
Pineville Radiation Therapy Center (n)	7	Mecklenburg	1	6,972	6,972
Carolinas Medical Center (S)	7	Mecklenburg	3**	17,268	5,756
CMC-Union (i)	7	Union	1	7,619	7,619
Matthews Radiation Oncology	7	Mecklenburg	1	11,443	11,443
Presbyterian Hospital	7	Mecklenburg	4	12,688	3,172
University Radiation Oncology	7	Mecklenburg	1	6,271	6,271
Iredell Memorial Hospital	8	Iredell	2	7,197	3,599
Lake Norman Radiation Oncology Center	8	Iredell	1	10,680	10,680
Rowan Regional Medical Center	8	Rowan	1	5,396	5,396
CMC-NorthEast Medical Center	9	Cabarrus	2	12,386	6,193
Stanly Regional Medical Center	9	Stanly	1	3,994	3,994
Forsyth Memorial Hospital	10	Forsyth	4	27,566	6,892
Hugh Chatham Memorial Hospital (d)	10	Surry	1	5,777	5,777
N. C. Baptist Hospitals (S)	10	Forsyth	4	18,597	4,649
Cancer Center of Davidson County (o)	11	Davidson	1	226	226
High Point Regional Health System	12	Guilford	2	8,442	4,221
Morehead Memorial Hospital	12	Rockingham	1	5,811	5,811
Moses Cone Health System	12	Guilford	4	24,654	6,164
Randolph Cancer Center (m)	13	Randolph	1	3,803	3,803
UNC Hospitals (S)	14	Orange	4	25,953	6,488
Alamance Regional Medical Center (j)	15	Alamance	2	9,592	4,796
Duke University Hospital (S)	16	Durham	8	36,721	4,590
Durham Regional Hospital	16	Durham	1	3,924	3,924
Maria Parham Hospital (e)	16	Vance	1	5,444	5,444
FirstHealth Moore Regional	17	Moore	2	18,953	9,477
Scotland Memorial Hospital (l)	17	Scotland	1	4,943	4,943
Cape Fear Valley Medical Center (a)	18	Cumberland	5	18,220	3,644

Table 9E: Hospital and Free-Standing Linear Accelerators and Radiation Oncology Procedures					
Facility Name	Service Area #	County	Number of Linear Accelerators	Number of Procedures (ESTVs) 10/1/2008-9/30/2009	Average # of Procedures per Unit
Southeastern Regional Medical Center (v)	18	Robeson	1	7,404	7,404
Sampson Regional Medical Center	18	Sampson	1	2,519	2,519
New Hanover Radiation Oncology	19	New Hanover	2	21,634	10,817
New Hanover Regional Medical Center	19	New Hanover	1	6,954	6,954
South Atlantic Radiation Oncology (c)	19	Brunswick	1	7,640	7,640
Raleigh Hematology Oncology Associates/Cancer Centers of NC (u)	20	Wake	2	11,923	5,962
Duke Raleigh Hospital	20	Wake	1	7,268	7,268
Rex Hospital	20	Wake	4	16,932	4,233
Wake Radiology / Oncology Services	20	Wake	1	4,718	4,718
Rex Healthcare (Smithfield Radiation Oncology)	21	Johnston	1	2,432	2,432
Johnston Memorial Hospital Authority (t)	21	Johnston	1	NR	NR
Lenoir Memorial	22	Lenoir	1	5,860	5,860
Goldsboro Radiation Therapy Services dba Wayne Radiation Oncology Center	22	Wayne	1	4,799	4,799
Carteret General Hospital (g)	23	Carteret	1	119	119
CarolinaEast Medical Center	23	Craven	2	12,036	6,018
Onslow Radiation Oncology	24	Onslow	1	NR	NR
Nash Day Hospital	25	Nash	2	8,491	4,246
Roanoke Valley Cancer Center	25	Halifax	1	3,996	3,996
Wilson Medical Center	25	Wilson	1	5,178	5,178
Beaufort County Hospital	26	Beaufort	1	4,308	4,308
Ahoskie Cancer Center	26	Hertford	1	1,758	1,758
NC Radiation Therapy Management Services (prev Carolina Radiation Medicine, P.A.) (f) (S)	26	Pitt	1	8,228	8,228
ECU Brody School of Medicine (S)	26	Pitt	3	18,786	6,262
Albemarle Hospital	27	Pasquotank	1	5,276	5,276
Alliance Oncology dba Outer Banks Cancer Center	27	Dare	1	2,049	2,049
TOTALS (71 Facilities, including Murphy Medical Center)			**119**	**593,531**	**4,988**

* Murphy Medical Center stopped operating, and decommissioned, this linear accelerator on May 20, 2009.

** CMC will move one linear accelerator to CMC-Union per CON F-007525-06

(a) Cape Fear Valley Health System received a CON in May 2004 for the fourth linear accelerator, and CON M-008133-08 on 12/18/2009 to retain a linear accelerator, for a total of five, including a CyberKnife.

(b) Mission Hospitals received a CON in September 2004 for a CyberKnife linear accelerator; operational in October 2005.

(c) South Atlantic Radiation Oncology received a CON in August 2005 for a linear accelerator; operational in May 2007.

(d) Hugh Chatham Memorial Hospital became operational in March 2000 with a leased linear accelerator from NC Baptist Hospitals.

(e) Maria Parham Hospital received a CON in July 2001 to lease and install one linear accelerator.

(f) Carolina Radiation Medicine, P.A. became operational in July 1998.

(g) Carteret General Hospital received a no review in June 1999 to replace a linear accelerator and purchase a simulator. Also received a no-review for a replacement linear accelerator in 2009.

(h) Gaston Memorial Hospital received a CON in August 1999 to add one linear accelerator.

Table 9E: Hospital and Free-Standing Linear Accelerators and Radiation Oncology Procedures					
Facility Name	Service Area #	County	Number of Linear Accelerators	Number of Procedures (ESTVs) 10/1/2008-9/30/2009	Average # of Procedures per Unit

footnotes, continued:

(i) Union Regional Medical Center received a CON in April 2000 to acquire one linear accelerator.

(j) Alamance Regional Medical Center received a CON in August 2002 to add one linear accelerator.

(k) Forsyth Medical Center received a CON in August 2002 to add one linear accelerator; operational in October 2004.

(l) Scotland Memorial Hospital became operational in August 2003.

(m) Randolph Cancer Center received a CON in June 2006 for a linear accelerator.

(n) Pineville Radiation Therapy Center received a CON in June 2007 for a linear accelerator.

(o) Cancer Center of Davidson County, LLC received a CON in July 2007 for a linear accelerator.

(p) East Carolina University Brody School of Medicine received a CON in December 2007 to replace an existing linear accelerator with a CyberKnife linear accelerator.

(q) UNC Hospitals received a CON in October 2006 to replace an existing linear accelerator with a CyberKnife linear accelerator.

(r) Carolinas Medical Center - NorthEast received a CON in February 2006 to acquire a CyberKnife linear accelerator.

(s) Lincoln Radiation Oncology Associates received CON 10/27/08 to acquire existing linear accelerator through ownership transfer from Gaston Memorial Hospital, replace the linear accelerator and relocate to Lincoln Radiation Oncology Center.

(t) Johnston Memorial Hospital Authority received CON # J-8188-08 on 2/24/09.

(u) Raleigh Hematology Oncology Associates, PC d/b/a Cancer Centers of NC received CON #J-007941-07 in July 2009 for a second linear accelerator.

(v) Southeastern Regional Medical Center received CON #N-004919-93 on 2/2/94.

NA - Not Applicable, not in operation for appropriate time frame.

NR - No report

S - Has at least one linear accelerator configured for stereotactic radiosurgery

EXHIBIT C TO NOVANT HEALTH'S PETITION TO THE SHCC REGARDING POLICY AC-3

PETITION FOR ADJUSTMENT TO NEED DETERMINATION TO ADD SIX OPERATING ROOMS TO THE PITT-GREENE OPERATING ROOM SERVICE AREA

Submitted To:
Mr. Michael C. Tarwater, Chair
Acute Care Services Committee
c/o Medical Facilities Planning Section
Division of Health Service Regulation
2714 Mail Service Center
Raleigh, NC 27699-2714

Petitioner
Pitt County Memorial Hospital
2100 Stantonsburg Road
P. O. Box 6028
Greenville, NC 27835-6028

Stephen J. Lawler, President
(252) 847-4451

I. Request

Pitt County Memorial Hospital, Inc. (PCMH) petitions for a special need determination in the 2008 State Medical Facilities Plan (SMFP) for six operating rooms (OR) in the Pitt-Greene Operating Room Service Area (P-G ORSA). The proposed 2008 SMFP shows a need for only 0.25 ORs in the P-G ORSA. A comprehensive analysis of the unique and special attributes of the geographic area and providers in the service area demonstrate the need for six or more operating rooms by 2010.

II. Rationale for the Proposed Adjustment

Background Information Regarding Petitioner

PCMH is a private, not-for-profit hospital that serves as the tertiary, regional referral hospital for eastern North Carolina. PCMH has over 750 acute care beds and has CON approval to build and operate over 100 additional acute care beds. PCMH has the only licensed inpatient and shared operating rooms in Pitt and Greene Counties. SSOP Services of Pitt, Inc. (SSOP) is an 8-bed freestanding ambulatory surgery center and a controlled affiliate of PCMH. SSOP operates the only licensed dedicated ambulatory surgery operating rooms in Pitt and Greene Counties. PCMH's Level I Trauma Center, Cardiovascular Center, Cancer Center, Children's Hospital, and Regional Rehabilitation Center are just a few examples of the highly specialized services that have been developed and expanded over the past 20 years in direct response to the primary/community care needs of Pitt and Greene Counties and the tertiary healthcare needs of the entire HSA VI region. PCMH's commitment to continue to provide

these specialized services and to sustain specialty designations such as the sole Level I Trauma Center and Level IV Neonatal unit in the eastern part of NC has impacted:

- the percentage growth of surgery cases at PCMH and SSOP relative to underlying population served,
- the number and mix of surgical case hours delivered by PCMH and SSOP,
- the average case time for inpatients and outpatients, and
- the capacity of existing operating rooms to manage a highly complex mix of surgical patients

These impacts are the basis for the evidence that the resource requirements for the Pitt-Greene OR service area differ from the requirements resulting from the application of the standard planning methodology for operating rooms.

PCMH & SSOP Are Sole Providers In The Pitt-Greene Operating Room Service Area

PCMH is the only tertiary regional referral center in NC located in a two-county OR Service Area. PCMH is also the sole provider of inpatient and shared operating rooms in the P-G ORSA. This attribute results in PCMH fulfilling a unique role as a community and specialized services hospital for Pitt and Greene Counties and a tertiary regional referral center for the entire HSA VI region. Greene County does not have a licensed facility providing operating rooms. Greene County is grouped with Pitt County to form the P-G ORSA since PCMH, the sole provider in Pitt County, serves the greatest number of surgical patients originating from Greene County. The majority of operating room service areas across NC has multiple providers of inpatient, shared and dedicated outpatient operating rooms. The majority of providers can therefore address any growth in surgical services demand and adjust to periodic constraints in capacity. The P-G ORSA has limited or no capacity to meet immediate or future needs for operating rooms because:

1) P-G ORSA has only one hospital and one free-standing dedicated ambulatory surgery facility,
2) The providers in the P-G ORSA historically, currently, and in the near term must serve not only as the sole primary care provider in these counties but also as the regional referral hospital for the 29 counties in HSA VI, and
3) There is no tertiary regional referral center located adjacent to the P-G ORSA that can address the demand for comprehensive surgical services that can only be met by the sole providers in the P-G ORSA.

The unique characteristics of the P-G ORSA geography and the sole providers in this OR service area make it impossible for PCMH to effectively manage the constraints in OR capacity without compromising the patients' access to timely, high quality, safe and cost effective care.

The SSOP, as the sole provider of licensed dedicated ambulatory surgery operating rooms in Pitt and Greene Counties, uses the American Society of Anesthesiologist classifications of physical status to assure surgical patients receive services in the appropriate

setting. Currently, additional specific criteria set by Medicare/Medicaid must be met in order for the provider to be reimbursed by Medicare/Medicaid. PCMH and SSOP continuously review the outpatient cases performed at the hospital to assure as many outpatients as possible and as appropriate are performed at the SSOP facility. These efforts have been especially intense in the past few years given the OR capacity constraints at PCMH. PCMH expects to see fewer gains in OR capacity using this approach since the majority of benefits in OR capacity due to this shift have already been realized.

Additionally, SSOP historical utilization data has demonstrated that this facility also serves more complex outpatients that any ambulatory surgery center in adjacent counties and in some cases in the entire region. Since SSOP is the sole provider of dedicated outpatient ORs in the P-G ORSA, it is limited in the type and complexity of patients it can serve.

PCMH & SSOP Serves Surgery Patients Beyond Pitt-Greene OR Service Area

The sole providers of licensed operating room services in the P-G ORSA have historically served a much broader service area than Pitt and Greene Counties. The table below compares the FY 2006 PCMH percent of patient origin from the P-G ORSA against the PCMH percent of patient origin from outside the P-G ORSA for acute care and surgery patients.

	Pitt & Greene Counties	Outside Pitt & Greene Counties
PCMH Patient Origin Inpatient & Outpatient Acute Care Admissions	41.9 %	58.1 %
PCMH Patient Origin Inpatient Surgery Cases	30.8 %	69.2 %
PCMH Patient Origin Outpatient Surgery Cases	41.5 %	58.5 %
PCMH Patient Origin Total Surgery Cases	35.8 %	63.2 %

The data above clearly shows that over 50% of PCMH's acute care admissions, inpatient surgery and outpatient surgery cases originate from outside Pitt and Greene Counties. PCMH, as the only tertiary regional referral center in eastern NC, serves all 29 counties of eastern NC and beyond, not just Pitt and Greene Counties. Even if other HSA VI counties have underutilized ORs, PCMH is still the only acute care provider in HSA VI who has the unique mix and availability of specialists and sub-specialist physicians, advanced centers of emphasis in cardiovascular, cancer, children's and surgical services and comprehensive services and technology to meet the demand for complex surgery services. Additionally,

PCMH is the only Level IV Neonatal facility and the only Level I Trauma Center in eastern NC. PCMH is also the only hospital that has a comprehensive Cardiovascular Center designed to address the unmet need for advanced cardiovascular care in a region with one of the nation's highest incidence of cardiac disease and mortality.

It is clear that the standard methodology used by the state to project future OR need does not recognize the unique attributes of PCMH in the P-G ORSA. The standard formula assumes that the number of surgical hours will increase or decrease in direct proportion to the change in the general population of the OR Service Area. This approach does not take into account the special role PCMH plays in eastern NC as the only tertiary, regional referral facility in HSA VI. Assuming surgical hours performed by PCMH using only Pitt and Greene Counties' general population change underestimates the volume and complexity of patients PCMH serves outside the P-G ORSA and severely underestimates projected growth.

Additionally, SSOP's historical and projected patient origin demonstrates that the SSOP serves a much broader region than just the P-G ORSA. The data table below clearly shows that over 54% of SSOP's cases originate from outside Pitt and Greene Counties. SSOP, as the only freestanding ambulatory surgery facility in the P-G ORSA, has provided services to every county in HSA VI and has served patients in 27 other counties in NC and patients from other states. Even if other HSA VI counties have underutilized dedicated ambulatory surgery ORs, SSOP has a unique and comprehensive mix of specialty surgery services. SSOP is the only freestanding ambulatory surgery center in eastern NC that offers all of the following specialty surgical services: dental, general surgery, gynecology, neurology, ophthalmology, oral, orthopedic, otolaryngology, plastics, podiatry, and urology. This comprehensive mix of surgical services makes SSOP a unique provider not only in the P-G ORSA but also in the eastern part of the state.

	Pitt & Greene Counties	Outside Pitt & Greene Counties
SSOP Patient Origin Outpatient Surgery Cases	45.7 %	54.3 %

The need for operating rooms in the P-G ORSA must consider the unique and special attributes of the geographic area served by PCMH and SSOP and the unique and special attributes associated with the services provided by the sole providers in the P-G ORSA. These attributes are not reflected in the standard methodology used to determine OR need.

Demand for ORs Exceeds Current and Projected OR Capacity In P-G ORSA

The unique and special attributes of the P-G ORSA geographic area and providers are the basis for the need for more operating rooms by 2010 in this service area. PCMH conducted an extensive analysis of the historical and projected utilization of sixteen service lines and

found that the demand for ORs in the P-G ORSA exceeds current and projected OR capacity. Current and projected OR need in the P-G ORSA is impacted by the following:

- Growth in OR volumes based on a service area beyond Pitt and Greene Counties,
- Growth in hours per case due to a unique population of surgery patients, and
- Operational capacity needed to serve a comprehensive mix of specialized surgical patients.

Wider Service Area

PCMH and SSOP both serve patients beyond the P-G ORSA. In order to recognize the impact of serving a wider service area, the population change rate used in the standard methodology must be adjusted. Using the overall population growth rate of eastern NC counties changes the P-G ORSA growth factor to no less than 0.80 % per year, which is higher than the 2-county service area population change rate used in the standard methodology. Assuming no other changes to the standard methodology, the OR need in the P-G ORSA would be over two ORs for this unique variable alone. However, additional variables must be considered before determining total OR need for the P-G ORSA. Below are the additional variables for consideration and statistics that support the need for six new ORs in the P-G ORSA in the 2008 SMFP.

Unique Population and Growth

The sole providers in the P-G ORSA serve a unique population of surgery patients, namely, surgery patients that originate from a region that state statistics clearly document has some of the highest rates of poverty, illiteracy, infant mortality rates, heart disease, cancer, diabetes, and pulmonary disease than any other region in the state. The growth in surgery cases and the length of time to complete more complex surgery cases at PCMH are directly impacted by the unique health status attributes of eastern NC. These differences have driven growth in surgery volumes at PCMH and SSOP at a rate nearly 50% higher than local and regional population growth. Other unique attributes of the geographic area include the presence of military bases, the double-digit growth in tourism and retirement communities in the eastern counties that are not fully represented in population statistics, and the fact that the eastern counties are aging at a faster rate than any other region in the state. These unique variables increase the numbers of surgical cases, the types of surgical cases, the OR hours needed to serve current and future patients, and the capacity needed to address a comprehensive mix of surgical patients.

Additionally, patients and physicians are demanding access to ORs during the week and during the early hours of the day. Operationally that means that the hospital must have sufficient OR capacity to do the majority of elective and non-elective cases Monday through Friday. Historical growth in surgical case volumes and surgical case times have exceeded current OR capacity. PCMH leadership is unable to meet the patients' and physicians' requests for OR time during the weekdays and on day shift. For the past three years PCMH has seen the number of routine, elective and scheduled cases that must be performed after 3pm climb to nearly 25% of the total number of surgical cases performed at PCMH. The

hospital has been forced to staff an average of seven ORs during the eight hours from 3pm-11pm every day just to meet the demand for routine, elective cases. Included in these numbers is one OR that must be staffed and available at all times in order for PCMH to meet its commitment as a Level I Trauma Center. Additionally, PCMH routinely staffs 3 ORs plus 1 trauma OR on Saturdays and additional ORs on Sundays to meet the demand for emergency and trauma cases, and in some cases, elective surgeries.

Capacity Needed to Address Demand Growth and Unique Mix of Surgical Patients

PCMH, due to its unique attributes as a sole provider of inpatient and shared ORs in the P-G ORSA, must have sufficient capacity to address the volume and unique mix of surgical patients both now and in the future. The standard methodology for determining OR need uses an occupancy rate of 80%. This occupancy rate does not recognize the unique factors impacting PCMH's need for additional OR capacity. PCMH provides a different level of surgical specialization that requires a different number, mix and type of ORs, staff, equipment, and supplies. These differences are needed to address the special attributes of tertiary and complex inpatients and outpatients who receive care in PCMH's ORs. There is less predictability in scheduling patients when a provider such as PCMH serves a wide range of specialty surgical services (e.g. cardiothoracic, ENT, GI, general surgery, gynecology, oncology, nephrology and transplant, orthopedics, reconstructive plastics, urology and vascular) and a broad range of patient acuity (simple, elective outpatient to extensive, unstable, complex trauma patient).

The current special rules for ORs assumes that inpatient ORs, operating at 80% capacity, can serve 2.4 inpatient cases per room per 9-hour day for 260 days per year and shared ORs can serve 3.2 cases per room per 9-hour day. Over 50% of PCMH's surgical cases are inpatients, which in and of itself is a unique factor for the majority of hospital-based ORs in NC. Based on the last 12 months of data, PCMH performed 10,161 inpatient surgery cases and 9,043 outpatient surgery cases and operated at over 85% capacity in its current 25 operating rooms. Additionally, during FY 2006 and in the last 12-month period, PCMH's average case time for outpatient surgery patients was greater than two hours. Operating at greater than 80% capacity, while at the same time providing care to ambulatory surgery patients whose average case times are 30% higher than the case time used in the standard formula for OR need, are direct indications of lack of sufficient OR capacity to meet current, much less future, needs.

PCMH's ORs are already operating above desired capacity. Additional attributes that make use of an 80% capacity assumption inappropriate for the providers in the P-G ORSA include:

- PCMH has over 140 active and consulting MDs with OR privileges. Additional capacity is needed to serve a large number of physicians providing specialized services.
- PCMH has twenty-four surgery residents and one surgery fellow. Insufficient OR capacity can severely limit opportunities for surgical medical education and research.

- The number of complex and highly specialized surgical cases at PCMH requires expanded OR capacity to manage turnaround times between complex, highly specialized cases and to separate contaminated cases from clean cases.
- By 2010, PCMH will have added over 100 new acute care medical-surgical beds. Since there is no OR need in the 2008 SMFP for the P-G ORSA, it is likely that PCMH will add these beds without being able to add a single operating room. Surgery patients' account for over 20% of PCMH's total patient admissions. Adding 100 new acute care beds without adding any ORs will result in significant gaps in services and will make it impossible for PCMH to sufficiently meet the needs of the P-G ORSA, much less the needs of a broader region.

Proposed Adjustment

The number and types of special attributes of the P-G ORSA and its providers demonstrate the need for additional ORs by 2010. Instead of attempting to associate OR need for each attribute, the petitioner recommends the following adjustments:

- Adjust growth factor to 0.080 for the P-G ORSA to reflect the population and demand growth of the wider region and the unique health status factors in PCMH's and SSOP's service areas. These factors drove historical volumes and will drive future demand.
- Adjust capacity assumption for the P-G ORSA to 75% to reflect the complexity and mix unique to this OR Service Area and the sole providers in the P-G ORSA.
- Adjust hours per outpatient case for PCMH's ambulatory surgeries to 2.0 hours per case to reflect current (and projected) average hours per ambulatory surgery case at PCMH.

These adjustments acknowledge the unique role played by the sole providers in this service area. The standard formula for projecting OR need cannot reflect the attributes unique to PCMH and SSOP. These attributes include population growth beyond the two-county service area, volume growth unique to a region with high incidence of chronic disease and mortality, the operational capacity necessary to serve the mix and complexity of surgical patients PCMH and SSOP serve, and OR hours needed to care for the large number of specialized and complex ambulatory surgeries at PCMH.

Applying the recommended adjustments above changes the OR need for P-G ORSA in the 2008 SMFP to six additional ORs using the following assumptions:

- PCMH inpatient surgery hours = 28,851.00 (unchanged)
- PCMH ambulatory surgery hours = 17,878 (2.0 hours/case x 8,939 cases)
- SSOP outpatient hours = 14,407.50 (unchanged)
- Total surgery hours for P-G ORSA = 61,136.5
- Projected surgical hours for 2010 (using new growth rate of 0.08) = 66,027.42
- Standard hours per OR per year = 1,755 (assumes 9hrs/day, 260 days/year, 75% capacity)
- Projected ORs in 2010 for P-G ORSA = 37.62
- Current OR in P-G ORSA after adjustments = 32
- Project ORs needed = 5.62 (Rounded = 6.0)

III. Adverse Effects if Requested Changes Are Not Made

The following list describes some of the adverse effects on the population of patients served by the sole providers in the P-G ORSA if additional ORs are not included in the 2008 SMFP:

- Patients will experience increased delays in access to the specialized services provided solely by PCMH as the regional referral facility for HSA VI. These delays could impact patient morbidity and mortality.
- Limited or no access to complex, high acuity tertiary surgical services due to limited OR capacity may result in patient's not receiving surgery care at all or patient's being forced to travel long distances to access similar services at other regional referral facilities.
- Physician recruitment has already been severely affected by the lack of OR capacity at PCMH and SSOP. Hours of operation have been extended to increase the number of hours of available OR time since PCMH continues to operate above reasonable OR capacity. As a result of this operational change, physician dissatisfaction has increased. Key physicians who provide highly specialized surgical services have left the facility. Physician recruitment, especially in the areas of surgical subspecialties needed at PCMH and for eastern NC to support the 24/7 demands of a Level I Trauma Center, has been extremely difficult. The obvious lack of OR capacity to handle current, much less future surgery demand, is severely affecting the delivery of vital surgical services at PCMH and SSOP.
- Extended hours of operation to manage the demand in surgical services has increased human resources, utilities and support services costs. Staff expenses such as shift differential and overtime have continued to rise in order to accommodate surgical case demand during the 3pm to11pm shift.
- Routine and elective patients who remain without food or water prior to surgery risk having their case cancelled due to the lack of OR hours (capacity) available during the day shift to handle routine and emergent case volumes. A number of healthcare research groups are currently analyzing the impact on quality and safety for patients who have surgical procedures performed late in the day versus on day shift.
- Patients must remain in the hospital overnight because their elective or routine surgical procedure was performed late in the day or early evening due to limited OR capacity. This results in higher costs for the patient and hospital.
- PCMH will open and operate over 100 new acute care beds before 2010. If the 2008 SMFP does not include the need for more ORs, PCMH will be unable to support the increased surgical volume associated with the operation of such a large number of new acute care beds.

Continued application of the standard formula for determining OR need will not address the unique and special attributes of the P-G ORSA or its sole providers.

IV. Alternatives Considered But Not Feasible

Alternative # 1 – Modify existing resources
PCMH and SSOP cannot modify existing resources without continuing to compromise the availability and functioning of existing ORs. Procedures' volumes cannot be safely shifted to any other procedures' rooms without compromising patient safety or jeopardizing the delivery of other vital hospital services. The addition of operating rooms is contingent on CON approval and current SMFP shows no need for ORs in the P-G ORSA.

Alternative #2 - Reduce the number of ORs needed in the P-G ORSA
A need of less than six ORs in the P-G ORSA in the 2008 SMFP will significantly hinder the ability of both PCMH and SSOP to continue to serve the surgical patients who have historically used these facilities. Constructing or operating less than six more ORs will only increase the adverse effects noted above and may very well compromise the hospital's ability to sustain long-term its position as a regional referral center.

Alternative #3 - Wait until changes are made in the standard methodology
Future changes proposed by a special task force will not fully address the unique and special needs of PCMH and SSOP. Waiting until the changes are made in the 2009 SMFP will delay the construction or operation of additional ORs in the P-G ORSA and will severely compromise PCMH's ability to address the projected demand for surgery cases associated with the addition of over 100 new acute care beds beginning early 2009 through early 2010.

V. Evidence Proposed Change Would Not Result in Unnecessary Duplication of Health Resources

PCMH and SSOP are the sole providers in the P-G ORSA. Evidence presented in this petition demonstrates there is an unmet need today for ORs in the P-G ORSA given its unique attributes. No other provider in HSA VI can duplicate the scope and complexity of surgical services offered by PCMH or by SSOP. Patient waiting lists, extended operating room hours, and a growing volume of chronic health care issues in the P-G ORSA and beyond reflect an unmet need now and in the future. New ORs will address unmet need and not result in the unnecessary duplication of health resources. Projections of need presented in this petition and the proposed minor adjustments to the standard methodology do not result in any duplication of existing OR capacity.

EXHIBIT D TO NOVANT HEALTH'S PETITION TO THE SHCC REGARDING POLICY AC-3

(8) the projected average reimbursement to be received per procedure for the 20 surgical procedures which the applicant projects will be performed most often in the facility and a list of all services and items included in the reimbursement; and

OP Principal CPT Procedure Code	OP Principal CPT Procedure Name	FY 2013	FY 2014	FY 2015
66984	CATARACT SURG W/IOL, 1 S	$ 2,142	$ 2,194	$ 2,247
29881	KNEE ARTHROSCOPY/SURGERY	$ 3,763	$ 3,853	$ 3,945
52353	CYSTOURETHROSCOPY W/URETERO AND/OR PYELO;WITH LITHO	$ 5,698	$ 5,834	$ 5,974
58340	CATHETER FOR SIS OR HSG	$ 871	$ 892	$ 914
20680	REMOVAL OF SUPPORT IMPLANT	$ 2,895	$ 2,964	$ 3,035
47562	LAPAAROSCOPIC CHOLECYSTECTOMY	$ 4,952	$ 5,071	$ 5,193
52332	CYSTOSCOPY AND TREATMENT	$ 2,731	$ 2,796	$ 2,863
29877	KNEE ARTHROSCOPY/SURGERY	$ 3,293	$ 3,372	$ 3,453
19125	EXCISION OF BREAST LESION	$ 3,912	$ 4,006	$ 4,102
58558	HYSTEROSCOPIC BIOPSY	$ 2,335	$ 2,391	$ 2,449
65730	CORNEAL TRANSPLANT	$ 5,244	$ 5,370	$ 5,499
49505	PRP I/HERN INIT REDUC >5	$ 2,914	$ 2,984	$ 3,055
29880	KNEE ARTHROSCOPY/SURGERY	$ 3,595	$ 3,681	$ 3,769
20670	REMOVE SUPERFICIAL WIRE,PIN,ROD	$ 1,421	$ 1,455	$ 1,490
15823	UP BLEPHAROPLAS&FAT HERN	$ 3,441	$ 3,523	$ 3,608
36561	INSERTION OF TUNNELED CVAD, W/SUBQ PORT, 5+Y	$ 4,069	$ 4,167	$ 4,267
69433	CREATE EARDRUM OPENING	$ 464	$ 476	$ 487
29888	KNEE ARTHROSCOPY/SURGERY	$ 11,931	$ 12,218	$ 12,511
47563	LAPAROSCOPIC CHOLECYSTECTOMY WITH CHOLANGIOGRAPHY	$ 5,751	$ 5,889	$ 6,030
42826	REMOVAL OF TONSILS	$ 3,470	$ 3,553	$ 3,638

These projected rates per case include the pre-operative assessment clinic services, the surgery or procedure facility charges, anesthesia used during the surgery or procedure, necessary drugs, supplies and devices and recovery. Surgeon and anesthesiologist professional fees will be billed separately by the providers.

The procedure case volumes depicted above adequately justify two incremental procedure rooms on the NCBH campus. The procedure case projections are very conservative and excess volume in excess of the modeled number of cases will be accommodated between both the CompRehab Plaza and West Campus locations. NCBH is confident that all five procedure rooms will be well utilized and will support NCBH's ability to continue to provide and expand pain management and other less invasive procedures for our patients.

2. **Document that the facility is needed at the proposed site as opposed to another area of the service area.**

Given the combination of facilities and services required to provide the surgical services, simulation operating rooms, training facilities, equipment, and the fact that the resources are already in place at NCBH, the clinical model the Surgical Services department has developed, and the deep involvement of Wake Forest University researchers, NCBH has concluded that expanded the campus to accommodate the outpatient surgery center on the NCBH campus would benefit our patients and their families, our clinicians, and our researchers far more than establishing the expanded OR and training capacity at another off-campus location. Since all Wake Forest University Faculty provide clinics and have their offices housed on the NCBH campus it would not make sense to relocate services off campus away from where faculty currently practice.

3. **If an existing facility proposes to relocate operating rooms to a new site, the applicant shall demonstrate:**

(a) **the necessity for relocation of operating rooms such as, physical inadequacy of existing facility or geographic accessibility of services;**

As previously discussed NCBH is operating its ORs to the fullest capacity and currently all 40 licensed ORs are currently located in Ardmore Tower. The surgery department in Ardmore Tower is landlocked and cannot be expanded without significant cost and disruption to the displacement of beds. Furthermore, renovation of existing ORs can occur only by sequentially closing groups of ORs temporarily. Given the high utilization of surgical services at NCBH, this is an ineffective alternative that would create major OR capacity constraints during the renovations.

(d) **that the relocation will not have a negative impact on the patients served in terms of any changes in services, costs to the patient, or level of access by medically underserved populations.**

NCBH believes the proposed project will have a positive impact on the provision of surgical services for NCBH patients. The ORs will be located on the NCBH campus and will be utilized by surgeons who already perform surgical cases there. Surgical services will be more easily accessed by patients given the proposed location will have its own parking accessed directly from Medical Center Blvd. and directly visible from Business I-40. NCBH will continue to serve a high number of medically underserved and this project will not change NCBH' s commitment to continue that.

4. **Describe how the project is consistent with each applicable policy in the State Medical Facilities Plan, including Policy Gen-3, Basic Principles.**

The need determinations of the 2010 State Medical Facilities Plan are not applicable because this application is filed under Policy AC-3 of the Plan, which provides that:

Exemption from the provision of need determinations of the North Carolina State Medical Facilities Plan shall be granted to projects submitted by Academic Medical Center Teaching Hospitals designated prior to January 1, 1990 provided the projects comply with one of the following conditions:

A. Necessary to complement a specified and approved expansion of the number or types of students, residents or faculty, as certified by the head of the relevant associated professional school; or
B. Necessary to accommodate patients, staff or equipment for a specified and approved expansion of research activities, as certified by the head of the entity sponsoring the research; or
C. Necessary to accommodate changes in requirements of specialty education accrediting bodies, as evidenced by copies of documents issued by such bodies.

As the letter from William B. Applegate MD, president of Wake Forest University Health Sciences and dean of Wake Forest University School of Medicine demonstrates in Exhibit 8 and certifies, this CON application and its exhibit documents, comply with condition A. It should also be noted that the need determination for additional ORs will likely not be included in future iterations of

the State Medical Facilities Plan due to the surplus of ORs experienced by other Forsyth County market providers. Due to the level of faculty growth, the need to enhance and expand surgical training opportunities and the fact that NCBH ORs are operating at over 100% of capacity is important and timely that NCBH apply for incremental ORs for the NCBH campus.

Consistency with Policies

The only Acute Care Policy that is applicable to this application is Policy AC-3. As noted above, the Policy requires that the necessity for the proposed project be certified by the "head of the relevant associated professional school" and "head of the entity sponsoring research". The certification is provided in the letter from William B. Applegate, MD, president of Wake Forest University Health Sciences and dean of Wake Forest University School of Medicine and included in Exhibit 8. This application is therefore consistent with Policy AC-3.

This application is also consistent with Policy Gen-3: Basic Principles because its implementation will allow us to:

-Develop and provide clinical services that improve the cost effectiveness of surgical services. One measure of that effort is to continually refine procedures that are less invasive, reducing the need and expenditures for inpatient surgeries and stays. Expanding outpatient surgical capacity for less acute patients will enable NCBH to treat more patients efficiently and cost-effectively than can be accomplished in the current facilities.

-Expand health care services to the medically underserved. Even though NCBH must contribute substantially to the support of the education and research programs of Wake Forest University School of Medicine, NCBH also contributes substantially to the care of medically underserved including the indigent, racial and ethnic minorities, the disabled and Medicaid and Medicare patients, as well as patients who cannot find the treatment they require elsewhere in the state or region.

-Provide the clinical equipment and facilities essential to the efficient operation of the multidisciplinary teams that diagnose and treat NCBH's surgical patients.

5. **Describe the geographic boundaries of the proposed service area (i.e., area in which patients to be served reside) for the facility and explain the rationale for establishing**

EXHIBIT E TO NOVANT HEALTH'S PETITION TO THE SHCC REGARDING POLICY AC-3

ATTACHMENT - REQUIRED STATE AGENCY FINDINGS

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

DECISION DATE: June 10, 2010
PROJECT ANALYST: Gebrette Miles
ASSISTANT CHIEF: Martha Frisone

PROJECT I.D. NUMBER: G-8460-10 / North Carolina Baptist Hospital / Construct a new building to house eight operating rooms (seven additional and one relocated), two procedure rooms, one robotic surgery training room, and one simulation operating room / Forsyth County

REVIEW CRITERIA FOR REPLACEMENT INSTITUTIONAL HEALTH SERVICES

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

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

C

North Carolina Baptist Hospital (NCBH) proposes to construct a new building to house eight operating rooms (seven additional operating rooms and one relocated operating room), two procedure rooms, one simulation operating room and one robotic surgery training room. There is no need determination for additional operating rooms in Forsyth County in the 2010 State Medical Facilities Plan. However, NCBH proposes to develop the seven additional operating rooms pursuant to *Policy AC-3: Exemption from Plan Provisions for Certain Academic Medical Center Teaching Hospital Projects* in the 2010 SMFP. Policy AC-3 states,

> *"Exemption from the provisions of need determinations of the North Carolina State Medical Facilities Plan shall be granted to projects submitted by Academic Medical Center Teaching Hospitals designated prior to January 1, 1990 provided the projects comply with one of the following conditions:*

1. *Necessary to complement a specified and approved expansion of the number or types of students, residents or faculty, as certified by the head of the relevant associated professional school; or*

2. *Necessary to accommodate patients, staff or equipment for a specified and approved expansion of research activities, as certified by the head of the entity sponsoring the research; or*

3. *Necessary to accommodate changes in requirements of specialty education accrediting bodies, as evidenced by copies of documents issued by such bodies.*

A project submitted by an Academic Medical Center Teaching Hospital under this Policy that meets one of the above conditions shall also demonstrate that the Academic Medical Center Teaching Hospital's teaching or research need for the proposed project cannot be achieved effectively at any non-Academic Medical Center Teaching Hospital provider which currently offers the service for which the exemption is requested and which is within 20 miles of the Academic Center Teaching Hospital."

NCBH was designated an Academic Medical Center Teaching Hospital by the Medical Facilities Planning Section on February 17, 1983.

In Exhibit 8, the applicant provides a letter from William B. Applegate, MD, president of Wake Forest University Health Sciences (WFUHS) and Dean of the Wake Forest School of Medicine, which states,

"The purpose of this letter is to certify that the expansion of ambulatory care surgical facilities on the North Carolina Baptist Hospital West Campus proposed in a certificate of need application to be submitted by North Carolina Baptist Hospital on January 15, 2010 is:

> *'Necessary to complement a specified and approved expansion of the number of types of students, residents, or faculty'*

With the support of North Carolina Baptist Hospital, the Wake Forest University School of Medicine and Wake Forest Health Sciences has begun an expansion of the clinical and research faculty within the Division of Surgical Sciences. The expansion is driven by four factors:

- *The increasing specialization of clinical and surgical practices at academic medical centers*

- *The increasing involvement of faculty research, especially clinical trials involving new diagnostic, surgical and therapeutic tools and techniques*
- *The increasing demand for surgical services*
- *The changing paradigms for surgical training*

Over the last three years, we have successfully recruited 36 new clinical faculty within the Division of Surgical Sciences, which has largely contributed to the operating room capacity issues on the NCBH campus. The current number of surgeons practicing within the Division is 113; however, we now project to add a total of 51 faculty in the Division of Surgical Sciences, including 39 clinical FTEs by 2020. It is anticipated that by 2020 there will be a total of 193 surgical faculty within the Division of Surgical Services.

...

The expansion of the ambulatory surgery capacity and facilities on the NCBH West Campus will also allow the Wake Forest University School of Medicine to enhance the training and education of our medical students, faculty and fellows. The simulation and robotics training rooms proposed on the West Campus will simulate high-acuity conditions and utilize scenarios and associated instructor feedback to provide a safe yet lifelike learning environment for students and faculty to acquire essential skills required in surgical care. There is a great need to expand our teaching facilities for our surgical residents and medical students to ensure they have an appropriate environment to practice the fundamental skills of operating outside the clinical field in a laboratory setting where operations can be simulated.

...

The expansion of the surgical capacity on the West Campus proposed in the certificate of need application to be submitted January 15, 2010 is essential to the recruitment and retention of these new faculty as well as our existing faculty. I therefore certify the proposed project as 'Necessary to complement a specified and approved expansion' of the faculty of the Wake Forest University Health Sciences."

NCBH adequately demonstrates that the seven additional ORs are necessary to complement a specified and approved expansion of 39 clinical faculty in the Division of Surgical Sciences. See Criterion (3) for the Agency's analysis and discussion regarding the need for the additional ORs at NCBH.

Regarding NCBH's need to demonstrate that its "*teaching or research need for the proposed project cannot be achieved effectively at any non-Academic Medical Center Teaching Hospital provider which currently offers the service for which the exemption is requested and which is*

within 20 miles of the Academic Center Teaching Hospital," in Section III.2, page 64, the applicant states,

> *"Given the combination of facilities and services required to provide the surgical services, simulation operating rooms, training facilities, equipment, and the fact that the resources are already in place at NCBH, the clinical model the Surgical Services department has developed, and the deep involvement of Wake Forest University reasearchers, NCBH has concluded that expanding the campus to accommodate the outpatient surgery center on the NCBH campus would benefit our patients and their families, our clinicians, and our researchers far more than establishing the expanded OR and training capacity at another off-campus location. Since all Wake Forest University Faculty provide clinics and have their offices housed on the NCBH campus it would not make sense to relocate services off campus away from where faculty currently practice."*

The applicant adequately demonstrates that developing seven additional ORs on the hospital campus would be more effective as the faculty, residents and students will be able to remain on campus rather than have to travel to an offsite location. Therefore, the applicant adequately demonstrates that the teaching need for surgical services cannot be achieved effectively at a non-academic medical center teaching hospital located within 20 miles of NCBH. The proposal is consistent with Policy AC-3 in the 2010 SMFP.

There are no other policies in the 2010 SMFP that are applicable to this review. Therefore, the application is conforming with this criterion.

(2) Repealed effective July 1, 1987.

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

C

North Carolina Baptist Hospital (NCBH) proposes to construct a new 72,300 square foot building on its campus, to be called the West Campus Surgery Center (WCSC). The building will house eight operating rooms (ORs), two procedure rooms, one simulation operating room and one robotic surgery training room. Of the eight proposed ORs, seven will be new (or incremental) ORs and one OR will be relocated from the existing surgical suite in Ardmore Tower. NCBH is currently licensed for 40 ORs (36 shared and four dedicated inpatient). The seven additional ORs and the relocated OR will be dedicated outpatient ORs. Therefore, upon

completion of the proposed project, NCBH will be licensed for a total of 47 ORs (35 shared, 4 dedicated inpatient and 8 dedicated outpatient).

Population to Be Served

The following table illustrates current patient origin for surgical services provided at NCBH, as reported in Section III.7, pages 75-77:

2009 NCBH Patient Origin
Inpatient and Outpatient Surgical Cases
Performed in the Surgical Suite in Ardmore Tower

County	% of Total Inpatient and Outpatient Surgical Cases
Caldwell	2%
Catawba	3%
Davidson	7%
Davie	3%
Forsyth	29%
Guilford	10%
Iredell	2%
Randolph	2%
Rockingham	3%
Stokes	3%
Surry	4%
Wilkes	4%
Yadkin	2%
Subtotal*	**74%**
Other NC Counties	15%
All Other States	11%
Total	**100%**

*Includes only those counties where the percentage of the total is 2% or greater. All other counties are included in "Other NC Counties."

In Section III.6, page 74, the applicant states,

> *"Historical patient origin is often the best indicator of future patient origin, and as such the fiscal year 2009 proportions from each county were applied to Project Years 1 and 2*

utilization projections with minor adjustment provided by surgical faculty leadership. NCBH anticipates that any changes to patient origin in the future will be insignificant."

In Section III.6, pages 68-70, the applicant provides the projected patient origin for outpatient surgical cases to be performed in the proposed WCSC.

Project Year 2 (2014) Patient Origin
Proposed West Campus Surgery Center
Percent of Total Surgical Cases Performed in ORs

County	% of Total Outpatient Surgical Cases Performed in ORs
Catawba	2%
Davidson	6%
Davie	3%
Forsyth	42%
Guilford	10%
Iredell	2%
Randolph	2%
Rockingham	2%
Stokes	4%
Surry	4%
Wilkes	4%
Yadkin	2%
Subtotal*	**83%**
Other NC Counties	11%
All Other States	6%
Total	**100%**

*Includes only those counties where the percentage of the total is 2% or greater. All other counties are included in "Other NC Counties."

In Section III.6, pages 73-74, the applicant provides the projected patient origin for the procedures to be performed in the two proposed procedure rooms:

Project Year 2 (2014) Patient Origin
Proposed West Campus Surgery Center
Percent of Total Procedures Performed in Procedure Rooms

County	% of Total Procedures Performed in Procedure Rooms
Catawba	2%
Davidson	7%
Davie	4%
Forsyth	40%
Guilford	10%
Iredell	2%
Rockingham	2%
Stokes	4%
Surry	4%
Wilkes	3%
Yadkin	4%
Subtotal*	**82%**
Other NC Counties	10%
All Other States	8%
Total	**100%**

*Includes only those counties where the percentage of the total is 2% or greater. All other counties are included in "Other NC Counties."

The applicant adequately identified the population proposed to be served.

Need for the Proposed Project

In Section II.1(a), page 12, the applicant states,

> *"Expansion of outpatient surgical services and the surgical training capabilities will enable NCBH to accomplish the following: 1) provide adequate space to meet the current and projected block scheduling demands for outpatient and inpatient surgeries caused by the current and planned growth in surgical faculty and referrals for surgery; 2) to improve the efficiency and utilization of all NCBH's operating rooms through substantial improvements by expanding ambulatory surgery capacity in the proposed West Campus surgery center; 3) Allow NCBH to continue to recruit and attract new surgical faculty; and 4) enhance research and training abilities*

through the addition of an additional simulation OR and new robotics training room."

In Section II.1, page 14, the applicant states,

"As a tertiary, quaternary academic medical center, NCBH is at the forefront of technology and education. NCBH proposes to include an additional simulation OR and a new robotics training room as part of the proposed project. As simulation OR is a requirement by the Council on Graduate Medical Education (GME) as well as an important training tool for existing faculty community surgeons and NCBH's OR nurses.

Wake Forest University School of Medicine has established the Center for Applied Learning, a major new initiative to enhance patient care and safety through immersive learning. The Center utilizes advanced instructional technologies to increase the clinical capacities and skills of health care providers. In addition to the laparoscopic and endoscopic surgical skills training, the Simulation Lab experience includes regularly scheduled sessions and experience in Crew Resource Management in a multidisciplinary environment.

The Center combines faculty expertise from across clinical disciplines and brings together innovative resources for clinical education from a host of diverse training facilities. Among the resources are high-fidelity patient simulation laboratories, a surgery academy, an anatomical training center, a program in medical ultrasound, and standardized patient assessment examination rooms."

In Section III.1(a), page 44, the applicant states,

"The unmet need that prompted the development of the proposed project is the continued and increasing demand for OR block time due to high growth in current and future faculty recruitment of 80+ surgeons at NCBH, the continued increase in the volume of ambulatory surgery and procedures performed at NCBH, and the need to expand training programs for surgical faculty, residents, fellows and nurses."

Furthermore, the applicant states that each of the following factors supports the need for the proposed project:

- *Need in the State Medical Facilities Plan (SMFP)*
- *Need to Accommodate Current and Planned Faculty Growth in Surgical Sciences*
- *Need to Support the Innovations and Research of NCBH as an Academic, Tertiary/Quaternary Hospital*
- *Increase in the Amount of Minimally Invasive Surgical Procedures*

- *Need to Accommodate Increasing Patient Demand*
- *NCBH Campus—Ardmore Tower—Growth in Demand Exhausts Capacity*
- *Need to Address Capacity Enhancement*

Each factor will be discussed separately below.

Need in the State Medical Facilities Plan (SMFP)

Based on data reported in the 2010 SMFP, the ORs at NCBH are currently operating at full capacity (see chart below). However, in Section III.1(a), page 45, the applicant states that because of the higher acuity patients seen at NCBH, both inpatient and outpatient cases take longer than the average case times of 3.00 hours and 1.50 hours for inpatient and outpatient cases, respectively, used in the 2010 SMFP methodology. In Exhibit 7, the applicant provides data for FY 2005 to FY 2009, which shows that the average case time at NCBH was 3.17 hours for inpatient cases and 1.79 hours for outpatient cases. The applicant states,

> *"When applying the NCBH average case lengths to the State's need determination formula, NCBH will be operating at 110% capacity by 2012. These figures suggest NCBH needs four additional ORs by 2012 just to keep pace with Forsyth County population growth alone. Thus, the need for additional ORs included in this application on the NCBH campus is imperative."*

The following chart compares projected OR need in 2012 using the methodology in the 2010 SMFP and projected OR need using the same methodology and assumptions except for substituting NCBH's five-year average inpatient and outpatient case times. See Section III.1, pages 44-45.

	NCBH Projected OR Need—Case Length from 2010 SMFP	NCBH Projected OR Need—NCBH Average Five-Year Case Length
Inpatient Cases* (FFY 2008)	13,251	13,251
Inpatient Case Time	3.00	3.12
Total Inpatient Hours	39,753	41,343
Outpatient Cases (FFY 2008)	17,999	17,999
Outpatient Case Time	1.50	1.79
Total Outpatient Case Hours	26,998.50	32,218.21
Total Combined Hours	66,751.50	73,651.33
Growth Factor	5.99	5.99
Projected Hours	70,749.91	77,967.65
Hours per OR per Year	1,872.00	1,872.00
Projected ORs Needed in 2012	37.79	41.65
2010 Adjusted Planning Inventory**	38	38
Projected OR Deficit or Surplus	**0**	**4**

*NCBH does not have any dedicated C-Section ORs and only performs a few emergency C-sections in a year (less than 10).
**Two of NCBH's ORs are excluded because NCBH is both a burn and a trauma center.

Need to Accommodate Current and Planned Faculty Growth in Surgical Sciences

In Section III.1(a), page 46, the applicant states,

> *"In response to population growth in Forsyth County and the patient demands of the 19 county market we serve, NCBH has recruited and employed 36 incremental surgeons in the Division of Surgical Sciences bringing the total surgical faculty to 113 surgeons in just the last three years. (This does not include surgical faculty growth in ER, OB/GYN and Dermatology). As a result we have seen significant growth in inpatient and outpatient surgeries, which has resulted in the number of surgical cases in the last two fiscal years growing by 5.52% for inpatient cases and 5.83% for ambulatory cases.*
>
> *As previously demonstrated, this increase in faculty has pushed NCBH OR case load to its maximum capacity earlier than anticipated. Wake Forest University Health Sciences (WFUHS) intends to continue to add incremental surgeons to meet patient demands and has recently released surgical faculty projections through 2020. The projections are derived from an annual assessment of faculty recruitment plans and the NCBH strategic facilities plans, which includes the expected addition of clinical faculty over the next ten years. As all surgical practices are located within the Academic Medical Center, all surgical time will be spent on the NCBH campus."*

In Exhibit 8, the applicant provides a letter from William B. Applegate, MD, President, Wake Forest University Health Sciences and Dean of the Wake Forest University School of Medicine, which includes the following chart illustrating the current and projected number of clinical and research faculty in the Division of Surgical Sciences.

Specialty	Current Faculty—Jan 2010			Projected Additional Faculty – 2010 to 2020			Projected Total Faculty—2020		
	Clinical	Research	Total	Clinical	Research	Total	Clinical	Research	Total
Cadiothoracic Surgery	9	1	10	2	0	2	11	1	12
Emergency	23	4	27	6	0	6	29	4	33
General	25	4	29	6	0	6	31	4	35
Hypertension	0	8	8	0	2	2	0	10	10
Neurosurgery	7	4	11	6	4	10	13	8	21
Ophthalmology	16	0	16	4	0	4	20	0	20
ENT	11	1	12	3	1	4	14	2	16
Plastics	6	4	10	3	3	6	9	7	16
Urology	8	3	11	6	2	8	14	5	19
Vascular	8	0	8	3	0	3	11	0	11
Total	**113**	29	142	**39**	12	**51**	152	41	**193**

As shown in the table above, WFUHS projects to add 39 clinical and 12 research faculty to the Division of Surgical Services over the next 10 years, for a total of 193 clinical and research faculty by 2020, or an increase of 34.5% in clinical faculty and 41.4% in research faculty. The overall increase is 35.9% over the 10-year period. The existing and proposed clinical faculty will perform both inpatient and outpatient surgical procedures in the existing surgical suite in Ardmore Tower and outpatient surgical procedures in the proposed WCSC.

Need to Support the Innovations and Research of NCBH as an Academic, Tertiary/Quaternary Hospital

In Section III.1(a), pages 50-51, the applicant states,

> *"NCBH's patients experience a much higher acuity level than other health care providers within the region. In fact, according to the North Carolina Hospital Association, in FFY 2008 NCBH's acuity level was the second highest amongst the state's other academic medical centers and statewide.*

Facility	*North Carolina Baptist Hospital*	*Duke University Hospital*	*Pitt County Memorial Hospital*	*UNC Hospitals*
Case Mix Factor	*1.71*	*1.77*	*1.66*	*1.49*
Rank Among AMC's	*2*	*1*	*3*	*4*

**Source: North Carolina Hospital Association*

These high acuity levels provide insight into the type of patients that NCBH treats. In essence, it means that the patients seen at NCBH are sicker on average than any other provider's patient cohort in the state. These patients require more complex [sic] *and more health care services. They require subspecialties and treatments that are not offered by most providers. Thus, the needs of these types of patients, and the resulting demand on their providers, such as NCBH, Duke, Pitt, or UNC, are not comparable to other patients and community-based providers within the state."*

Furthermore, on page 50, the applicant states,

"The State Health Coordinating Council's (SHCC) Acute Care Committee State Planning methodology does not appropriately account for patient acuity and the longer case times required for higher acuity patients. As previously discussed, the 5 year average inpatient case time is 3.12 and 1.79 for ambulatory cases. Therefore, the State formula does not allow NCBH to accurately reflect its true capacity.

Absent additional capacity, NCBH will find it increasingly difficult to meet the needs of these complex patients referred have [sic] *that originate within the service area and beyond. As the only tertiary and academic medical center within western North Carolina, NCBH must be allowed the capacity and capabilities to continue to support this important need and its function as a teaching facility and tertiary, quaternary referral center.*

Currently, NCBH experiences significant wait times and/or inconvenient block scheduling with surgeries now scheduled as late at 8:00 p.m. Additional OR capacity will reduce wait times and inconvenient scheduling for patients and surgeons which impacts clinic availability. For high acuity patients in particular, the delay in treating their illness when surgery is part of the plan of care can impact their health and future prognosis. Without the proposed incremental ORs, patient-waiting time will continue to increase."

Increase in the Amount of Minimally Invasive Surgical Procedures

In Section III.1(a), pages 47-48, the applicant states,

> *"As an academic teaching hospital, NCBH is at the forefront of care delivery and as such will continue to adapt its techniques to both speed the recovery process and to enhance the outcome from surgery itself. In the last several years, NCBH surgeons have received advanced training in techniques such as laparoscopy and robotics. As a result, NCBH surgeons estimate that as much as 20 percent of the current surgeries performed use one of the minimally invasive techniques. Projections suggest that we will continue to see an increase in these laparoscopic and robotic techniques to perform surgeries because of the benefits to the patients: smaller incision, minimization of patient pain, fewer complications and a shorter recovery time. With smaller incisions and shorter recovery surgeries, NCBH expects that many surgical procedures will continue to migrate from the inpatient setting to the outpatient setting.*
>
> ...
>
> *Because of* [sic] *potential of such surgical interventions and the quality of the outcomes we have also seen an increase in the number of surgeons being trained on this and* [sic] *equipment and performing these services."*
>
> *This increase in the number of robotic assisted surgeries has also precipitated the need for the enhanced Robotics Training Institute mentioned earlier in the application. NCBH's goal* [sic] *is to become a world class multi-specialty surgical program comprised of leading urologic, gynecologic, colorectal, and cardiac physicians dedicated to providing superior patient outcomes through the use of robot assisted laparoscopic technology."*

Need to Accommodate Increasing Patient Demand

In Section III.1(a), page 49, the applicant states,

> *"Between 2009 and 2014, the average annual growth rate is projected to be 1.4%. Currently, 56% of the population who receive surgery are ages 45 and over. Therefore, this trend was taken into consideration in our analysis based on the expectation that the 45-64 and 65 and higher age groups represent the segment of the population that will most likely utilize the ORs proposed in this project...These two cohorts are expected to experience continued growth at a rate of 1.6% for ages 46-64 and 3.3% for those aged 65 and higher between 2009 and 2014. Pediatric information is included in order to provide a complete picture of the age distribution; however, all of the ORs in the proposed project are expected to be utilized by patients ages 18 and older."*

NCBH Campus—Ardmore Tower—Growth in Demand Exhausts Capacity

In Section III.1(a), pages 51-52, the applicant states,

> *"For NCBH's surgical services, the growth in demand has forced NCBH to extend operating case times well beyond the 7 am to 5 pm weekday period that is strongly preferred by surgeons and their patients. Currently NCBH schedules surgeries from 7 am to 9 pm and schedules six ORs on Saturdays as well. Between FY 2005 and FY 2009, Surgical Services experienced a 25 percent increase in the number of surgical hours. While this increase in hours has provided a temporary solution, it is unworkable in the long term to extend surgery hours from 7:30 am to 11:00 pm, which is currently planned. It should be noted, of NCBH's 32,129 current operating room cases, about 2,000 cases are now performed on nights and weekends to accommodate the increase in volume.*
>
> *Currently, wait times can exceed 2-3 hours and there is up to a two month back log for certain types of procedures such as orthopaedics/bone and joint, hip scopes, ophthalmology, and urologic robotics cases. ORs are also open on holidays to accommodate the current backlog of schedule surgeries.*
>
> *Scheduling surgeries in the evening and on weekends create inconveniences and dissatisfaction for the referring physicians, the surgeons, patients and their families. Moreover, this demand crunch in the surgical suite creates inefficiencies for patient flow, and challenges for finding, training and retaining qualified staff to fill positions ranging from RNs, surgical techs, patient transporters, lab techs and other support personnel.*
>
> *NCBH's ability to currently accommodate the growing demand is increasingly challenged. In order to develop and offer adequate capacity, both for the current level of demand and for the anticipated higher levels to come, NCBH has determined that this project is a priority for NCBH."*

Need to Address Capacity Enhancement

In Section III.1(a), page 52, the applicant states,

> *"A major complicating factor for NCBH is that its 36 shared ORs serve a wide variety of patients, including inpatient, outpatient and elective cases and as a result, patient acuity and risks also vary. As a result, OR cases comingled in our 40 ORs vary from 30 minutes to 8 hours or more, depending on the surgical specialty and patient needs creating challenges for staffing appropriately.*
>
> *NCBH currently experiences a mix of approximately 42% inpatient surgical cases and 58% outpatient surgical cases. The needs and circumstances of these two groups can be substantially different. For the less complex and lower acuity cases including certain*

ophthalmology, orthopedics, ENT, and some plastics, the surgical cases are often less complex and can take less time, NCBH feels a model that would remove these patients from the Ardmore Tower location would allow faculty to utilize ORs and equipment located in Ardmore Tower to more efficiently perform the higher acuity, more complex case."

Need for Additional Procedure Room Capacity

In Section III.1(a), pages 52-53, the applicant states,

"Over the past several decades, the healthcare system and the advent of new technology and innovation has made frequent changes to how various surgical procedures are performed. Currently, some procedures must be performed in an OR (such as open heart), but other procedures (such as sutures or partial knee replacements) do not need to be performed in an OR. Further, there are many patients who need a procedure that could be performed in either an operating room or procedure rooms. The determination about which of those rooms is most appropriate depends on the specific procedure and the circumstantial needs that are specific to an individual patient. The types of individual patient needs is based on medical judgment and include co-morbidities, complications, the patient's age, patient weight, anesthesia needs and other factors.

...

NCBH believes that the benefit of having an adequate supply of procedure rooms is valuable for both the hospital and the community. As previously described, NCBH must create additional surgical services capacity to meet current and future demand. Currently, the NCBH campus does not have any available physical space to develop additional procedure rooms, and therefore, two procedure rooms are service components in the proposed project."

Projected Utilization—ORs

In Section IV, pages 82-84, the applicant provides historical and projected OR through the third fiscal year after completion of the proposed project, as shown in the following table.

Location	Historical Years		Interim Years			Project Years		
	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
# of Dedicated Inpatient ORs	4	4	4	4	4	4	4	4
# of Inpatient Surgical Cases*	12,743	13,446	14,091	14,683	15,344	16,111	16,917	17,763
# of Shared ORs	36	36	36	36	36	35	35	35
# of Dedicated Outpatient ORs	0	0	0	0	0	8	8	8
# of Outpatient Surgical Cases at NCBH (all locations)	17,654	18,683	19,617	20,598	19,805	20,894	22,043	23,256
Total Surgical Cases	30,397	32,129	33,708	35,281	35,149	37,005	38,960	41,019

*Includes Open Heart and C-Section cases.

NCBH proposes to shift a portion of outpatient surgical cases from the existing surgical suite in Ardmore Tower to the proposed WCSC. In Section III.1(b), page 58, the applicant states,

> *"Step 6: Calculate the percentage of FY 2009 West Campus volumes to the total outpatient surgical cases for FY 2009, which are presented in Table 13.*

Ratio of Low Acuity/Adult Only Ambulatory Cases Divided into Total Ambulatory Cases	
FY 09 NCBH Ambulatory OR Volumes	*18,683*
FY 09 West Campus Volumes	*7,473*
FY 09 Percentage	*40%*

> *For FY 2009, the criteria test discussed above resulted in* [sic] *the determination that 40% of NCBH's ambulatory case volumes would be appropriate to shift to West Campus."*

The number of outpatient surgical cases to be performed in the proposed WCSC and in the existing surgical suite in Ardmore Tower in the first three years of the project is illustrated in the following table:

Location	Project Years		
	FY 2013	FY 2014	FY 2015
# of Outpatient Surgical Cases to be Performed in Existing Surgical Suite in Ardmore Tower	12,536	13,226	13,954
# of Outpatient Surgical Cases to be Performed in the Proposed WCSC	8,358	8,817	9,302
Total # of Outpatient Surgical Cases at NCBH	**20,894**	**22,043**	**23,256**

In Section III.1(b), page 54, the applicant states,

> *"NCBH engaged in a broad based planning discussions that have evolved over time to address the issues the Division of Surgical Sciences was experiencing as it relates to current OR capacity, block scheduling, the increased number of faculty and planned recruitment efforts. The planning process included a review of historical growth rates for surgical case volumes, assessment of current and future capacity constraints and proposed growth methodologies to project future OR demand. Population growth of our 19-county service area and the growth rates reported in the Pediatric ED and Cancer Center Expansion Certificate of Need applications were considered as well. The projections were vetted through senior leadership and growth rates that reflected all of these variable were developed."*

In Section III.1(b), pages 54-64, the applicant provides the assumptions and methodology used to project OR utilization through the third project year. The applicant first determined the historical growth in inpatient and outpatient surgical case volumes at NCBH from FY 2005 to FY 2009, as shown in the following table:

Year				***Growth Rate***	***IP Growth Rate***	***OP Growth Rate***
	IP	*OP*	*Total*			
FY 2005	*12,732*	*15,637*	*28,009*	-	-	-
FY 2006	*11,435*	*16,029*	*27,464*	*-1.95%*	*-7.57%*	*2.51%*
FY 2007	*12,428*	*16,165*	*28,593*	*4.11%*	*8.68%*	*0.85%*
FY 2008	*12,743*	*17,654*	*30,397*	*6.31%*	*2.53%*	*9.21%*
FY 2009	*13,446*	*18,683*	*32,129*	*5.70%*	*5.52%*	*5.83%*
CAGR (compounded annual growth rate)				***3.49%***	***2.10%***	***4.55%***

As shown in the above table, NCBH experienced a 14.7% growth in total surgical cases between FY 2005 and FY 2009, and a compound average growth rate (CAGR) of 3.49%. Inpatient surgical cases grew by 5.77%, resulting in a CAGR of 2.10%. Outpatient surgical cases grew by a larger rate of 19.47%, resulting in a CAGR of 4.55%.

Based on these historical growth rates and the addition of 39 clinical faculty in the Division of Surgical Services (a 34.5% increase in 10 years or approximately 3.5% per year), the applicant assumes inpatient surgical cases will increase 4.5% per year and outpatient surgical cases will increase 5.0% per year in the interim years and 5.0% and 5.5%, respectively, in the project years. In Section III.1(b), pages 55-56, the applicant states,

> *"Using the historical growth rates along with assumptions for future growth including primarily faculty recruitment, NCBH calculated inpatient and outpatient surgical case volumes for FY 2010 through FY 2015 in the following table utilizing an inpatient growth rate of 5% for the project years and an outpatient growth rate of 5.5% for the project years.*

GROWTH RATE		
	Inpatient	***Outpatient***
Interim Years	*4.50%*	*5.00%*
Project Years	*5.00%*	*5.50%*

INTERIM YEARS	***Inpatient***	***Outpatient***	***TOTAL***
FY 2010	*14,051*	*19,617*	*33,668*
FY 2011	*14,683*	*20,598*	*35,281*
FY 2012	*15,344*	*19,805*	*35,149*
PROJECT YEARS			
FY 2013	*16,111*	*20,894*	*37,005*
FY 2014	*16,917*	*22,043*	*38,960*
FY 2015	*17,763*	*23,256*	*41,018*

> *NCBH chose to project future operating room utilization using conservative annual growth rates of 4.5% for inpatient surgeries and 5.0% for outpatient surgeries during the interim years. NCBH's operating rooms maximum capacity of 36,500 cases was taken in consideration when determining the growth rates for the interim years. This capacity calculation is based on the existing block hours, the existing staff, and utilizing NCBH's average case length and an average turnover for all cases. During the three project years, the annual growth rates were increased by 0.50% for both inpatient and outpatient volumes, resulting in a 5.0% increase in surgical cases and an 5.5% increase in outpatient volumes.*
>
> *Surgical volumes in Davie Certificate of Need (CON ID # G-8078-08) were taken into consideration when developing the project surgical volumes in the proposed project."*

In Section III.1(b), page 57, the applicant used the above projected growth rates and the methodology for projecting OR need in the 2010 SMFP, to determine the number of ORs needed at NCBH in Project Year 3. The result is shown in the following table:

Year	Inpatient Cases	Inpatient Case Time	Total Inpatient Case Hours	Outpatient Cases	Outpatient Case Time	Total Outpatient Case Hours	Total Combined Hours	Hours per OR per Year	Projected ORs needed in 2015
Interim Years									
FY 2010	14,051	3.0	42,153	19,617	1.5	29,426	71,579	1,872	38.2
FY 2011	14,683	3.0	44,050	20,598	1.5	30,897	74,947	1,872	40.0
FY 2012	15,344	3.0	46,032	20,482	1.5	30,723	76,755	1,872	41.0
Project Years									
FY 2013	16,111	3.0	48,334	20,894	1.5	31,341	79,675	1,872	42.6
FY 2014	16,917	3.0	50,751	22,043	1.5	33,065	83,816	1,872	44.8
FY 2015	17,763	3.0	53,288	23,256	1.5	34,884	88,172	1,872	47.1

The table above shows that NCBH will need a total of 47.1 ORs in 2015, without excluding any ORs for burn and trauma services. NCBH is both a Burn and a Trauma Center. Pursuant to the need methodology in the 2010 SMFP, two ORs would be excluded, one for each service. NCBH currently has 40 ORs. Therefore, NCBH projects a need for seven incremental ORs by Project Year 3.

The applicant determined that 40% of NCBH's outpatient cases would be appropriate to shift to the proposed WCSC. See previous discussion. In Section III.1(b), page 59, the applicant states, *"For this projection methodology, the percentage of 40% is assumed to remain constant across all years, FY 2010 through FY 2015."*

Based on the applicant's projected total outpatient surgical volumes and the percentage of cases projected to shift to the proposed WCSC, the applicant used the methodology in the 2010 SMFP to determine the number of ORs needed at the proposed WCSC. In Section III.1(b), page 60, the applicant projects the number of ORs needed at WCSC as follows:

Year	*Outpatient Cases*	*Outpatient Case Time*	*Total Outpatient Case Hours*	*Hours per OR per Year*	*Projected ORs needed in 2015*
Interim Year					
FY 2010	*7,847*	*1.5*	*11,770*	*1,872*	*6.3*
FY 2011	*8,239*	*1.5*	*12,359*	*1,872*	*6.6*
FY 2012	*7,922*	*1.5*	*11,883*	*1,872*	*6.3*
Project Years					
FY 2013	*8,358*	*1.5*	*12,536*	*1,872*	*6.7*
FY 2014	*8,817*	*1.5*	*13,226*	*1,872*	*7.1*
FY 2015	*9,302*	*1.5*	*13,953*	*1,872*	*7.5*

As shown in the table above, 8 of the 47.1 ORs are needed in the proposed WCSC. Thus, the applicant proposes to add seven incremental ORs and relocate one shared OR from the existing surgical suite in Ardmore Tower to the proposed WCSC for a total of eight ORs.

Projected Utilization—Procedure Rooms

The applicant states that the proposed WCSC will also address NCBH's need for additional procedure room capacity. In Section III.1(a), page 53, the applicant states,

> *"NCBH believes that the benefit of having an adequate supply of procedure rooms is valuable for both the hospital and the community. As previously described, NCBH must create additional surgical services capacity to meet current and future demand. Currently, the NCBH campus does not have any available physical space to develop additional procedure rooms, and therefore, two procedure rooms are service components in the proposed project."*

In Section IV, page 85, the applicant provides projected utilization of the proposed procedure rooms in the WCSC, as shown in the following table.

	Project Years		
	FY 2013	**FY 2014**	**FY 2015**
# of Procedure Rooms	2	2	2
# of Procedures/Treatments	1,439	1,532	1,632

In Section III.1(b), pages 60-64, the applicant describes the methodology and assumptions used to project utilization of the proposed procedure rooms. The applicant used historical utilization of the three existing procedure rooms in the CompRehab Plaza to project utilization at the proposed WCSC. With the addition of the two proposed procedure rooms, NCBH would have a total of five procedure rooms upon project completion. Procedures are also performed in the six

Interventional Radiology (IR) and five Cardiac Catherization rooms at CompRehab. The applicant states that the procedures performed in these rooms were excluded because only specific procedures can be performed in these rooms, such as cardiac catheterization and IR or angiography procedures, which require specialized equipment. Moreover, the IR procedures are performed by radiologists not surgeons.

In Section III.1(b), page 61, the applicant states that procedures related to pain/physiatry, OB/GYN, plastics, and ENT are performed in the three procedure rooms in the CompRehab Plaza. The applicant reviewed the Top 20 procedures performed in the CompRehab Plaza procedure rooms, as well as NCBH patient records to identify procedures that would be eligible to be performed in a procedure room at the proposed WCSC. On page 61, the applicant states,

> *"The analysis excluded emergency room patients, all endoscopy patients, all interventional radiology patients, all cardiac cath patients and all patients whose procedure*[s] *were done in an operating room. The data in the table below indicates that, overall, the number of procedures performed at CompRehab has experienced an overall increase in the number of cases by over 200% in the last five years.*

Fiscal Year	***Cases Performed in a Procedure Room Volume***	***% Change from Previous Year***
2005	*1,032*	
2006	*1,344*	*30.23%*
2007	*1,992*	*48.21%*
2008	*2,798*	*40.46%*
2009	*3,217*	*14.97%*

The applicant states it assumed volumes would increase 6.5% per year through the third project year. The CAGR between 2005 and 2009 was 32.87%. Furthermore, in Section III.1(b), pages 62-63, the applicant states,

> *"NCBH believes this* 6.5% *growth rate is supportable based on the following assumptions:*
>
> - *Historical growth in cases performed in procedure rooms are expected to continue growing at a slower pace than the preceding five years. The slowdown in growth can be seen in the FY 08 to FY 09 change.*
> - *NCBH has recruited additional physicians that will continue to contribute to the increase in procedure case volumes at NCBH. NCBH will be adding an additional urologist and a physiatrist in Orthopaedics and Neurosurgery in 2010. Both of these faculty recruits are anticipated to increase the volume of pain*

management procedures and implantable pain devices as well as the number of urologic cases referred for prostate biopsies and other treatment."

The applicant states that projected procedure room volumes will be split between CompRehab and the proposed WCSC, thereby decompressing procedure room volumes at CompRehab. The applicant's methodology and assumptions results in the need for a total of five procedure rooms in Project Year 3, as illustrated in the following table:

Year	# of Procedures	Procedure Room Capacity*	Total # of Procedure Rooms Needed	# of CompRehab Procedures	# of West Campus Surgery Center Procedures	Total Procedure Room Procedures
Historical Years						
FY 2007	1,992	1040	2	1,992	-	1,992
FY 2008	2,798	1040	3	2,798	-	2,798
FY 2009	3,217	1040	3	3,217	-	3,217
Interim Years						
FY 2010	3,410	1040	3	3,426	-	3,426
FY 2011	3,649	1040	4	3,649	-	3,649
FY 2012	3,886	1040	4	3,886	-	3,886
Project Years						
FY 2013	4,139	1040	4	2,700	1,439	4,139
FY 2015	4,408	1040	4	2,876	1,532	4,408
FY 2016	4,694	1040	5	3,062	1,632	4,694

*On page 62, the applicant states, *"...for the purposes of this CON application the capacity for each procedure room is determined to be 4 cases per day for 260 days per year, for a total annual capacity of 1,040 cases per procedure room, and a total annual capacity for the three rooms of 3,120."*

Need Analysis

Based on projected faculty recruitment to expand teaching, research, and training within the Division of Surgical Sciences at the Wake Forest School of Medicine and the current utilization of NCBH's existing ORs, NCBH does not have the capacity to accommodate the projected increase in surgeons without additional OR capacity. WFUHS projects to hire an additional 39 clinical and 12 research faculty for the Division of Surgical Sciences over the next 10 years, for a total of 193 clinical and research faculty by 2020, or an increase of 34.5% in clinical faculty and 41.4% in research faculty. The overall increase is 35.9% in the Division of Surgical Sciences faculty over the 10-year period. This represents an average increase of 3.9 clinical faculty members per year (39 new clinical faculty / 10 years), or 3.5% per year (34.5% increase in clinical faculty / 10 years = 3.5%). The total complement of existing and proposed ORs in the existing surgical suite in Ardmore Tower and the proposed WCSC will be utilized by the existing and future clinical and research faculty.

The applicant projects inpatient surgical cases will grow at a rate of 4.5% during the interim years and 5.0% during the project years. Based on historical information provided by the applicant, the CAGR for inpatient surgical cases from FY 2005 to FY 2009 was 2.1%. Information reported on NCBH's license renewal applications (LRAs) from 2005 to 2009 (which uses federal fiscal year data) shows that NCBH performed 11,847 inpatient surgical cases in FFY 2005 and 13,357 inpatient surgical cases in FFY 2009, resulting in a CAGR of 3.0%. Although the projected growth rate for the interim and project years is greater than the CAGR for the past four years, the actual growth rate from FY 2008 to FY 2009 was 5.52%. While the CAGR for outpatient surgical cases was from FY 2005 to FY 2009 was 4.55%, the applicant's projected growth rate of 5.0% and 5.5% for the interim and project years is less than the actual growth in outpatient surgical procedures at NCBH in recent years. Between FY 2007 and FY 2008, outpatient surgical cases grew by 9.21%, and between FY 2008 and FY 2009 by 5.83%. The applicant's assumptions regarding projected growth in surgical cases are reasonable, given current utilization, historical growth and the addition of 39 clinical Division of Surgical Services faculty. The applicant anticipates a 34.5% increase in clinical surgeons by 2020 (39 / 113 = 0.345).

Furthermore, NCBH's case length exceeds the case lengths used in the SMFP methodology for projecting OR need, which is 3.0 hours for inpatient cases and 1.5 hours for outpatient cases. The applicant states that NCBH's five year average case length from FY 2005 to FY 2009 was 3.17 for inpatient cases and 1.79 for outpatient cases. However, NCBH's 2010 LRA shows an average case length of 4.17 hours for inpatient cases and 2.13 hours for outpatient cases. This supports the applicant's assumption that patient acuity is a factor driving the need for additional OR capacity at NCBH.

The applicant adequately demonstrates the need to develop seven additional ORs pursuant to Policy AC-3 [See Criterion (1) for discussion] and to relocate one existing shared OR to a new building on campus which will house eight dedicated outpatient ORs, two procedure rooms, a robotic training room and a simulation OR.

In addition to increasing the OR capacity for current and future clinical and research faculty, the proposed WCSC will house a simulation OR and robotics training room. The simulation OR will provide students, nurses and faculty with a variety of training experiences in a real-life setting. The purpose of the robotics training room is to train surgeons interested in laparoscopic surgery and other minimally invasive procedures utilizing the da Vinci Surgical Robot. The applicant adequately demonstrates that co-locating the simulation OR and robotics training room in the same building will support the training needs of surgeons, surgical residents, fellows and medical students, and will also allow for increased operational efficiencies.

In summary, the applicant adequately identified the population to be served and demonstrated the need that the population has for proposal. Therefore, the application is conforming to this criterion.

(3a) In the case of a reduction or elimination of a service, including the relocation of a facility or a service, the applicant shall demonstrate that the needs of the population presently served will be met adequately by the proposed relocation or by alternative arrangements, and the effect of the reduction, elimination or relocation of the service on the ability of low income persons, racial and ethnic minorities, women, handicapped persons, and other underserved groups and the elderly to obtain needed health care.

NA

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

CA

In Section III.8, pages 77-79, the applicant describes the alternatives considered. Further, the application is conforming to all other applicable statutory and regulatory review criteria. See Criteria (1) (3), (5), (6), (7), (8), (12), (13), (14), (18a), (20) and the Criteria and Standards for Surgical Services and Operating Rooms, promulgated in 10A NCAC 14C .2100. Therefore, the applicant adequately demonstrated that the proposal is its least costly or most effective alternative and the application is conforming to this criterion and approved subject to the following conditions.

1. **North Carolina Baptist Hospital shall materially comply with all representations made in the certificate of need application.**

2. **North Carolina Baptist Hospital shall develop no more than 7 additional operating rooms pursuant to Policy AC-3 in the 2010 SMFP and relocate 1 existing shared operating room to the new West Campus Surgery Center (licensed as part of the hospital), which shall be utilized for outpatient surgical services. The West Campus Surgery Center shall include no more than 8 operating rooms, 1 robotics training room, a simulation operating room (unlicensed) and 2 procedure rooms.**

3. **Upon completion of the project, North Carolina Baptist Hospital shall be licensed for a total of no more than 47 operating rooms (35 shared operating rooms, 4 dedicated inpatient operating rooms, and 8 dedicated outpatient operating rooms).**

4. **North Carolina Baptist Hospital shall not acquire, as part of this project, any equipment that is not included in the project's proposed capital expenditure**

in Section VIII of the application or that would otherwise require a certificate of need.

5. **Prior to issuance of the certificate of need, North Carolina Baptist Hospital shall acknowledge acceptance of and agree to comply with all conditions stated herein to the Certificate of Need Section in writing prior to issuance of the certificate of need.**

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

C

In Section VIII, page 108, the applicant projects the total capital expenditure for the project will be $38,709,009, which includes $4,008,285 for site preparation costs; $18,198,034 for construction costs; $4,331,077 for fixed equipment; $4,083,446 for movable equipment; $344,403 for furniture; $4,067,385 for consulting fees and interest during construction; $2,220,632 for contingency; and other costs of $1,455,748. In Section IX, page 113, the applicant projects working capital will not be required since the project is an expansion of existing surgical services. The applicant proposes to finance the capital cost with the accumulated reserves of NCBH. Exhibit 16 contains a letter from the Vice-Treasurer of NCBH, which states,

> *"North Carolina Baptist Hospital agrees to make available from its accumulated reserves a total of $38,709,009 for the capital costs incurred in the development of the aforementioned project."*

Additionally, Exhibit 17 contains the audited financial statements for North Carolina Baptist Hospital and Affiliates. As of June 30, 2009, NCBH had $44,061,000 in cash and cash equivalents, $1,308,427,000 in total assets, and $714,802,000 in net assets (total assets less total liabilities). The applicant adequately demonstrated the availability of sufficient funds for the capital needs of the project.

In the pro forma revenue and operating cost statements, the applicant projects that the hospital's revenues will exceed operating costs in each of the first three full operating years. See Form B. The applicant also projects that WCSC's revenues will exceed operating costs in each of the first three full operating years. See Form C. The assumptions used by the applicant in preparation of the pro formas are reasonable, including projected utilization. See Criterion (3) for discussion of projected utilization.

In summary, the applicant adequately demonstrated the availability of funds for the capital needs of the project and that the financial feasibility of the proposal is based upon reasonable assumptions regarding projected revenues and operating costs. Therefore, the application is conforming to this criterion.

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

C

The applicant adequately demonstrated the need to construct a new building on campus to house eight operating rooms (seven incremental operating rooms pursuant to Policy AC-3 and one existing to be relocated), two procedure rooms, one simulation operating room and one robotics training room. See Criterion (3) for discussion. Therefore, the applicant adequately demonstrated the proposed project would not result in unnecessary duplication of existing or approved health service capabilities or facilities, and the application is conforming to this criterion.

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

C

In Section VII, pages 99-100, the applicant provides the current staffing for surgical services at NCBH, as well as the projected staffing for the proposed WCSC. The applicant projects that the WCSC will be staffed with 86.8 full-time equivalent (FTE) positions in the second year of the project. In Section VII.3(a), page 100, the applicant states that none of these positions are new positions. In Section V.4, pages 87-88, the applicant identifies Joseph R. Tobin, M.D., as having expressed interest in serving as the medical director for the WCSC. The applicant demonstrates the availability of adequate health manpower and management personnel to provide the proposed services and is conforming with this criterion.

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

C

In Section II.2(b), the applicant states,

> *"The West Campus Surgery Center will be operated as a department of NCBH and located on the same campus. The West Campus Surgery Center will include the ancillary*

services that are necessary to support the surgical cases and minor procedures that will be performed including Basic Imaging, Pharmacy, Sterile Processing, Post Anesthesia Care, Recovery, Pre-admission Testing and Bio-medical Engineering services. The staffing information in Section VII includes the on-site staff to provide these services. Other support services such as Facility Services and Environmental Services will be provided through the existing NCBH support departments as is done for other existing departments."

In Section VI.9(b), page 95, the applicant states,

"As an academic medical center with a teaching hospital and a regional referral center for tertiary care, NCBH routinely accepts referrals from hospitals across North Carolina."

Exhibit 12 includes copies of letters from WFUHS physicians supporting the proposed WCSC. The applicant adequately demonstrated the availability of the necessary ancillary and support services and that the proposed services would be coordinated with the existing health care system. Therefore, the application is conforming to this criterion.

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

NA

(10) When applicable, the applicant shall show that the special needs of health maintenance organizations will be fulfilled by the project. Specifically, the applicant shall show that the project accommodates:

(a) The needs of enrolled members and reasonably anticipated replacement members of the HMO for the health service to be provided by the organization; and

NA

(b) The availability of replacement health services from non-HMO providers or other HMOs in a reasonable and cost-effective manner which is consistent with the basic method of operation of the HMO. In assessing the availability of these health services from these providers, the applicant shall consider only whether the services from these providers:

(i) would be available under a contract of at least 5 years duration;
(ii) would be available and conveniently accessible through physicians and other health professionals associated with the HMO;

(iii) would cost no more than if the services were provided by the HMO; and
(iv) would be available in a manner which is administratively feasible to the HMO.

NA

(11) Repealed effective July 1, 1987.

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

C

The applicant proposes to construct a new 72,300 square foot building on the hospital campus. The certified estimate of construction costs from the architect, included in Exhibit 21, is consistent with the construction costs reported by the applicant in Section VIII, page 108. In Section XI.6(b), page 124, the applicant estimates construction costs of $252 per square foot. In Section XI.8, page 125, the applicant describes the methods to be used to maintain efficient energy operations. The applicant adequately demonstrated that the cost, design, and means of construction represent the most reasonable alternative for the proposed project and that the construction project will not unduly increase the costs and charges of providing health services. See Criterion (5) for discussion of costs and charges. Therefore, the application is conforming to this criterion.

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

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

C

In Section VI.12 and VI.13, pages 96-97, the applicant provides the current payor mix for the entire hospital, surgical services and the existing procedure rooms, as illustrated in the following tables.

NCBH—Entire Facility (includes inpatients)	
Self Pay/Indigent/Charity	5.7%
Commercial	1.5%
Medicare/Medicare Managed Care	39.4%
Medicaid	21.6%
Managed Care	28.8%
Other	3.0%
TOTAL	**100.0%**

NCBH—Surgical Services (includes inpatients)	
Self Pay/Indigent/Charity	5.5%
Commercial	1.7%
Medicare/Medicare Managed Care	31.6%
Medicaid	17.8%
Managed Care	39.5%
Other	3.9%
TOTAL	**100.0%**

NCBH—Procedure Rooms	
Self Pay/Indigent/Charity	5.8%
Commercial	0.5%
Medicare/Medicare Managed Care	33.5%
Medicaid	12.4%
Managed Care	42.9%
Other	4.9%
TOTAL	**100.0%**

The applicant demonstrates that it currently provides adequate access to medically underserved populations, and the application is conforming with this criterion.

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

In Section VI.10(a), page 95, the applicant states that no civil rights access complaints have been filed against NCBH in the last five years. The application is conforming with this criterion.

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

C

In Section VI.14, pages 97-98, the applicant projects the following payor mix for the proposed WCSC in Project Year 2, as illustrated in the following tables.

WCSC—ORs (outpatients only) FY 2014	
Self Pay/Indigent/Charity	6.1%
Commercial	0.9%
Medicare/Medicare Managed Care	35.7%
Medicaid	7.7%
Managed Care	46.0%
Other	3.6%
TOTAL	**100.0%**

WCSC—Procedure Rooms FY 2014	
Self Pay/Indigent/Charity	4.4%
Commercial	0.6%
Medicare/Medicare Managed Care	35.5%
Medicaid	12.7%
Managed Care	43.6%
Other	3.2%
TOTAL	**100.0%**

In the assumptions following the pro formas and a footnote on page 98, NCBH states the projected payor mix for services to be provided in the WCSC is based on historical experience. The applicant demonstrates that medically underserved groups will have adequate access to the proposed services, and the application is conforming with this criterion.

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

C

In Section VI.9(a), page 94, the applicant states,

> *"Patients have access to surgical services primarily through Wake Forest University physician referrals, community physician referrals, and admissions by physicians who have privileges at the hospital. As a tertiary, quaternary hospital, NCBH also admits and treats patients referred from other facilities. Patients are also admitted and treated through the Emergency Department."*

The applicant adequately demonstrated that it offers a range of means by which patients have access to the proposed services. The application is conforming to this criterion.

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

C

In Section V.1(a), page 86, the applicant states,

> *"As an acute care facility that has been providing services for more than 85 years, NCBH has established relationships with many clinical training programs in the Southeast and continues to provide teaching opportunities for these schools. With the incremental ORs, NCBH will be able to continue to provide training support to the numerous clinical programs utilizing educational opportunities at the hospital by providing more space to accommodate students and new opportunities for learning experiences in an integrated inpatient and outpatient environment."*

A list of training programs and affiliates is included in Exhibit 10. NCBH is an "academic medical center teaching hospital," as that term is defined in the 2010 SMFP. Thus, the hospital serves as the primary teaching site for WFUHS and at least one other health professional school. The application is conforming with this criterion.

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

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

on cost-effectiveness, quality, and access to the services proposed, the applicant shall demonstrate that its application is for a service on which competition will not have a favorable impact.

C

The applicant adequately demonstrated that its proposal will have a positive impact upon the cost effectiveness, quality and access to the proposed services. See Criteria (3), (5), (7), (8), (12), (13) and (20). Therefore, the application is conforming to this criterion.

(19) Repealed effective July 1, 1987.

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

C

NCBH is accredited by the Joint Commission and certified for Medicare and Medicaid participation. According to the files in the North Carolina Department of Health and Human Services, Division of Health Service Regulation, Acute and Home Care Licensure and Certification Section, no incidents occurred within the eighteen months immediately preceding the date of this decision, for which any sanctions or penalties related to quality of care were imposed by the State. Therefore, the application is conforming to this criterion.

(21) Repealed effective July 1, 1987.

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

C

NCBH, an "academic medical center teaching hospital," as defined in the 2010 SMFP, proposes to develop seven incremental ORs pursuant to Policy AC-3 in the 2010 SMFP as part of the proposed project. Therefore, the Criteria and Standards for Surgical Services and Operating Rooms, promulgated in 10A NCAC 14C .2100, are applicable to this review. The application is

conforming, to all applicable Criteria and Standards for Surgical Services and Operating Rooms. The specific criteria are discussed below.

SECTION .2100 – CRITERIA AND STANDARDS FOR SURGICAL SERVICES AND OPERATING ROOMS

.2102 INFORMATION REQUIRED OF APPLICANT

.2102(a) *An applicant proposing to establish a new ambulatory surgical facility, to establish a new campus of an existing facility, to establish a new hospital, to convert a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or to add a specialty to a specialty ambulatory surgical program shall identify each of the following specialty areas that will be provided in the facility:*

(1) gynecology;
(2) otolaryngology;
(3) plastic surgery;
(4) general surgery;
(5) ophthalmology;
(6) orthopedic;
(7) oral surgery; and
(8) other specialty area identified by the applicant.

-NA- NCBH proposes to add the seven incremental ORs to its license and locate them on the existing campus. Therefore, this rule is not applicable.

.2102(b) *An applicant proposing to increase the number of operating rooms in a service area, to convert a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or to add a specialty to a specialty ambulatory surgical program shall provide the following information:*

(1) the number and type of operating rooms in each licensed facility which the applicant or a related entity owns a controlling interest in and is located in the service area (separately identifying the number of dedicated open heart and dedicated C-Section rooms);

-C- In Section II.10, page 25, the applicant provides the following information regarding the number of ORs in each licensed facility which NCBH owns a controlling interest in the service area.

NCBH Owned Facilities
Current Operating Room Inventory

Type	NCBH	Davie County Hospital	Lexington Memorial Hospital	Total
Dedicated Open Heart				
Other Dedicated Inpatient	4			4
Shared Inpatient/Outpatient	36	2	4	42
Dedicated Ambulatory Surgical Center				
Dedicated C-Section				
Total	40	2	4	46

(2) the number and type of operating rooms to be located in each licensed facility which the applicant or a related entity owns a controlling interest in and is located in the service area after completion of the proposed project and all previously approved projects related to these facilities (separately identifying the number of dedicated open heart and dedicated C-Section rooms);

-C- In Section II.10, page 26, the applicant provides the following information regarding the number of operating rooms to be located in each licensed facility which NCBH owns a controlling interest in the service area.

NCBH Owned Facilities
Projected Operating Room Inventory

Type	NCBH	Davie County Hospital	Lexington Memorial Hospital	Total
Dedicated Open Heart				
Other Dedicated Inpatient	4			4
Shared Inpatient/Outpatient	35	2	4	41
Dedicated Ambulatory Surgical Center	8			8
Dedicated C-Section				
Total	47	2	4	53

(3) The number of inpatient surgical cases, excluding trauma cases reported by Level I, II and III trauma centers, cases reported by designated burn intensive care units, and cases performed in dedicated open heart and dedicated C-Section rooms, and the number of outpatient surgical cases performed in the most recent

12 month period for which data is available, in the operating rooms in each licensed facility listed in response to Subparagraphs (b)(1) and(b)(2) of this Rule:

-C- In Section II.10, page 27, the applicant provides the following information regarding the number of inpatient surgical cases (excludes trauma cases, burn center cases, and cases performed in dedicated open heart and dedicated C-Section rooms) and the number of outpatient surgical cases performed in the most recent 12 month period in the ORs in each licensed facility listed in response to Subparagraphs (b)(1) and(b)(2) of this Rule.

NCBH Owned Facilities
Total Inpatient and Outpatient Surgical Cases and
July 2008 – June 2009

Type	NCBH	Davie County Hospital	Lexington Memorial Hospital	Total
Inpatient	13,446	8	832	14,286
Outpatient	18,683	119	2,508	21,310
Total	32,129	127	3,340	35,596

(4) The number of inpatient surgical cases, excluding trauma cases reported by Level I, II and III trauma centers, cases reported by designated burn intensive care units, and cases performed in dedicated open heart and dedicated C-Section rooms, and the number of outpatient surgical cases projected to be performed in each of the first three operating years of the proposed project, in each licensed facility listed in response to Subparagraphs (b)(1) and (b)(2) of this Rule;

-C- In Section II.10, pages 27-28, the applicant provides the following information regarding the number of inpatient surgical cases (excludes trauma cases, burn center cases, and cases performed in dedicated open heart and dedicated C-Section rooms) and the number of outpatient surgical cases projected to be performed in each of the first three operating years of the proposed project in the operating rooms in each licensed facility listed in response to Subparagraphs (b)(1) and (b)(2) of this Rule.

NCBH Owned Facilities
Total Projected Inpatient Surgical Cases
FY 2013 – FY 2015

Type	NCBH	Davie County Hospital*	Lexington Memorial Hospital	Total
Project Year 1 (FY 2013)	16,111	9	866	16,986
Project Year 2 (FY 2014)	16,917	9	874	17,800
Project Year 3 (FY 2015)	17,763	10	883	18,656

*The applicant states the replacement hospital will not offer inpatient services until 2017 (Project I.D. # G-8078-08). Thus, the number of inpatient surgeries are not anticipated to increase until the project is complete and the replacement acute care beds become operational.

NCBH Owned Facilities
Total Projected Outpatient Surgical Cases
FY 2013 – FY 2015

Type	NCBH	Davie County Hospital	Lexington Memorial Hospital	Total
Project Year 1 (FY 2013)	20,894	2,411	2,651	25,956
Project Year 2 (FY 2014)	22,043	2,508	2,689	27,240
Project Year 3 (FY 2015)	23,256	2,608	2,726	28,590

(5) A detailed description of and documentation to support the assumptions and methodology used in the development of the projections required by this Rule

-C- In Section III.1(b), pages 53-64, the applicant provides a detailed description of and documentation to support the assumptions and methodology used in the development of the projections required by this Rule. See Criterion (3) for discussion.

(6) The hours of operation of the proposed operating rooms;

-C- In Section II.10, page 28, the applicants states,

> "[The] *NCBH West Campus Surgery location will operate the same as the NCBH Ardmore Tower location for outpatient surgeries, Monday through Friday from 6:00 am to 6:00 pm."*

(7) If the applicant is an existing facility, the average reimbursement received per procedure for the 20 surgical procedures most commonly performed in the facility during the preceding 12 months and a list of all services and items included in the reimbursement;

-C- In Section II.10, page 29, the applicant provides the average reimbursement per procedure for the 20 surgical procedures most commonly performed at NCBH during the preceding 12 months. On page 28, the applicant states,

> *"Current surgical services included inpatients and outpatients, therefore these reimbursement rates included an inpatient stay where necessary. In addition, the reimbursement rates include the preoperative assessment clinic."*

(8) the projected average reimbursement to be received per procedure for the 20 surgical procedures which the applicant projects will be performed most often in the facility and a list of all services and items in the reimbursement; and

-C- In Section II.10, page 30, the applicant provides the average reimbursement per procedure for the 20 surgical procedures which the applicant projects will be performed in the proposed WCSC. On page 30, the applicant states,

> *"These projected rates per case include the per-operative assessment clinic services, the surgery or procedure facility charges, anesthesia used during the surgery or procedure, necessary drugs, supplies and devices and recovery. Surgeon and anesthesiologist professional fees will be billed separately by the providers."*

(9) identification of providers of pre-operative services and procedures which will not be included in the facility's charge.

-C- In Section II.10, page 31, the applicant states,

> *"The traditional pre-operative assessment tests such as laboratory procedures and pharmacy medication reconciliations are included in the charge data, however any physician visits or other services incurred by the patients prior to the surgery or procedure are not included."*

.2102(c) An applicant proposing to relocate existing or approved operating rooms within the same service area shall provide the following information:

(1) the number and type of existing and approved operating rooms in each facility in which the number of operating rooms will increase or decrease (separately identifying the number of dedicated open heart and dedicated C-Section rooms);

(2) the number and type of operating rooms to be located in each affected facility

after completion of the proposed project and all previously approved projects related to these facilities (separately identifying the number of dedicated open heart and dedicated C-Section rooms);

(3) the number of inpatient surgical cases, excluding trauma cases reported by Level I, II, or III trauma centers, cases reported by designated burn intensive care units, and cases performed in dedicated open heart and dedicated C-section rooms, and the number of outpatient surgical cases performed in the most recent 12 month period for which data is available, in the operating rooms in each facility listed in response to Subparagraphs (c)(1) and (c)(2) of this Rule;

(4) the number of inpatient surgical cases, excluding trauma cases reported by level I, II, or III trauma centers, cases reported by designated burn intensive care units and cases performed in dedicated open heart and dedicated C-section rooms, and the number of outpatient surgical cases projected to be performed in each of the first three operating years of the proposed project, in each facility listed in response to Subparagraphs (c)(1) and (c)(2) of this Rule;

(5) a detailed description of and documentation to support the assumptions and methodology used in the development of the projections required by this Rule;

(6) the hours of operation of the facility to be expanded;

(7) the average reimbursement received per procedure for the 20 surgical procedures most commonly performed in each affected facility during the preceding 12 months and a list of all services and items included in the reimbursement;

(8) the projected average reimbursement to be received per procedure for the 20 surgical procedures which the applicant projects will be performed most often in the facility to be expanded and a list of all services and items included in the reimbursement; and

(9) identification of providers of pre-operative services and procedures which will not be included in the facility's charge.

-NA- The applicant does not propose to relocate existing operating rooms between existing licensed facilities in the same service area.

.2102(d) *An applicant proposing to establish a new single specialty separately licensed ambulatory surgical facility pursuant to the demonstration project in the 2010 State Medical Facilities Plan shall provide:*

(1) the single surgical specialty area in which procedures will be performed in the proposed ambulatory surgical facility;

(2) a description of the ownership interests of physicians in the proposed ambulatory surgical facility;
(3) a commitment that the Medicare allowable amount for self pay and Medicaid surgical cases minus all revenue collected from self-pay and Medicaid surgical cases shall be at least seven percent of the total revenue collected for all surgical cases performed in the proposed facility;

(4) for each of the first three full fiscal years of operation, the projected number of self-pay surgical cases;

(5) for each of the first three full fiscal years of operation, the projected number of Medicaid surgical cases;

(6) for each of the first three full fiscal years of operation, the total projected Medicare allowable amount for the self pay surgical cases to be served in the proposed facility, i.e. provide the projected Medicare allowable amount per self-pay surgical case and multiply that amount by the projected number of self pay surgical cases;

(7) for each of the first three full fiscal years of operation, the total projected Medicare allowable amount for the Medicaid surgical cases to be served in the facility, i.e. provide the projected Medicare allowable amount per Medicaid surgical case and multiply that amount by the projected number of Medicaid surgical cases;

(8) for each of the first three full fiscal years of operation, the projected revenue to be collected from the projected number of self-pay surgical cases;

(9) for each of the first three full fiscal years of operation, the projected revenue to be collected from the projected number of Medicaid surgical cases;

(10) for each of the first three full fiscal years of operation, the projected total revenue to be collected for all surgical cases performed in the proposed facility;

(11) a commitment to report utilization and payment data for services provided in the proposed ambulatory surgical facility to the statewide data processor, as required by G.S. 131E-214.2;

(12) a description of the system the proposed ambulatory surgical facility will use to measure and report patient outcomes for the purpose of monitoring the quality of care provided in the facility;

(13) descriptions of currently available patient outcome measures for the surgical specialty to be provided in the proposed facility, if any exist;

(14) if patient outcome measures are not currently available for the surgical specialty area, the applicant shall develop its own patient outcome measures to be used for monitoring and reporting the quality of care provided in the proposed facility, and shall provide in its application a description of the measures it developed;

(15) a description of the system the proposed ambulatory surgical facility will use to enhance communication and ease data collection, e.g. electronic medical records;

(16) a description of the proposed ambulatory surgical facility's open access policy for physicians, if one is proposed;

(17) a commitment to provide to the Agency annual reports at the end of each of the first five full years of operation regarding:

(A) patient payment data submitted to the statewide data processor as required by G.S. 131E-214.2;

(B) patient outcome results for each of the applicant's patient outcome measures;

(C) the extent to which the physicians owning the proposed facility maintained their hospital staff privileges and provided Emergency Department coverage, e.g. number of nights each physician is on call at a hospital; and

(D) the extent to which the facility is operating in compliance with the representations the applicant made in its application relative to the single specialty ambulatory surgical facility demonstration project in the 2010 State Medical Facilities Plan.

-NA- The applicant does not propose to establish a new single specialty separately licensed ambulatory surgical facility pursuant to the demonstration project in the 2010 State Medical Facilities Plan.

.2103 PERFORMANCE STANDARDS

.2103(a) *In projecting utilization, the operating rooms shall be considered to be available for use five days per week and 52 weeks per year.*

-C- In Section II.10, page 32, the applicant states,

> *"NCBH based the utilization projection of the eight multispecialty surgical operating rooms for West Campus on 5 days per week, 52 weeks a year."*

.2103(b) *A proposal to establish a new ambulatory surgical facility, to establish a new campus of an existing facility, to establish a new hospital, to increase the number of operating rooms in an existing facility (excluding dedicated C-section operating rooms), to convert a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or to add a specialty to a specialty ambulatory surgical program shall not be approved unless:*

(1) the applicant reasonably demonstrates the need for the number of proposed operating rooms in the facility, which is proposed to be developed or expanded, in the third operating year of the project is based on the following formula: {[(Number of facility projected inpatient cases, excluding trauma cases reported by Level I or II trauma centers, cases reported by designated burn intensive care units and cases performed in dedicated open heart and C-Section rooms, times 3.0 hours) plus (Number of facilities projected outpatient cases times 1.5 hours) plus (Number of facility's projected outpatient cases times 1.5 hours)] divided by 1,872 hours} minus the facility's total number of existing and approved operating rooms and operating rooms proposed in another pending application, excluding one operating room for level I or II trauma centers, one operating room for facilities with designated burn intensive care units, and all dedicated open heart and C-section operating rooms. The number of rooms needed is determined as follows:

> *(A) in a service area which has more than 10 operating rooms, if the difference is a positive number greater than or equal to 0.5, then the need is the next highest whole number for fractions of 0.5 or greater and the next lowest whole number for fractions less than 0.5; and if the difference is a negative number less than 0.5, then the need is zero;*

> *(B) in a service area which has six to 10 operating rooms, if the difference is a positive number greater than or equal to 0.3, then the need is the next highest whole number for fractions of 0.3 or greater and the next lowest whole number for fractions less than 0.3, and if the difference*

is a negative number or a positive number less than 0.3, the need is zero; and

(C) in a service area which has five or fewer operating rooms, if the difference is a positive number greater than or equal to 0.2, then the need is the next highest whole number for fractions of 0.2 or greater and the next lowest whole number for fractions of less than 0.2; and the difference is a negative number or a positive number less than 0.2, the need is zero; or

(2) the applicant demonstrates conformance of the proposed project to Policy AC-3 in the State Medical Facilities Plan titled "Exemption From Plan Provisions for Certain Academic Medical Center Teaching Hospital Projects."

-C- The applicant demonstrates conformance of the proposed project to Policy AC-3 in the 2010 SMFP. See Criterion (1) for discussion. The applicant also demonstrates the need for the number of ORs proposed for NCBH. See Criterion (3) for discussion.

.2103(c) *A proposal to increase the number of operating rooms (excluding dedicated C-Sections operating rooms) in a service area shall not be approved unless the applicant reasonably demonstrates the need for the number of proposed operating rooms in addition to the rooms in all of the licensed facilities identified in response to 10A NCAC 14C .2102(b)(2) in the third operating year of the proposed project based on the following formula: {[(Number of projected inpatient cases for all the applicant's or related entities' facilities, excluding trauma cases report by Level I or II trauma centers, cases reported by designated burn intensive care units and cases performed in dedicated open heart and C-section rooms, times 3.0 hours) plus (Number of projected outpatient cases for all the applicant's or related entities' times 1.5 hours)] divided by 1,872 hours} minus the total number of existing and approved operating rooms and operating rooms proposed in another pending application, excluding one operating room for Level I or II trauma centers, one operating room for facilities with designated burn intensive care units, and all dedicated open heart and C-section operating rooms in all of the applicant's or related entities' licensed facilities in the service area. The number of rooms needed is determined as follows:*

(1) in a service area which has more than 10 operating rooms, if the difference is a positive number greater than or equal to 0.5, then the need is the next highest whole number for fractions of 0.5 or greater and the next lowest whole number for fractions less than 0.5; and if the difference is a negative number or a positive number less than 0.5, the need is zero;

(2) in a service area which has six to 10 operating rooms, if the difference is a positive number greater than or equal to 0.3, then the need is the next highest whole number for fractions of 0.3 or greater and the next lowest whole number for fractions less than 0.3, and if the difference is a negative number or a positive number less than 0.3, the need is zero; and

(3) in a service area which has five or fewer operating rooms, if the difference is a positive number greater than or equal to 0.2, then the need is the next highest whole number for fractions of 0.2 or greater and the next lowest whole number for fractions of less than 0.2; and if the difference is a negative number or a positive number less than 0.2, the need is zero.

-NA- NCBH is an academic medical center teaching hospital as that term is defined in the 2010 SMFP. Pursuant to G.S. 131E-183(b), the Agency is not authorized to require NCBH to demonstrate that any facility or service at another hospital is being fully utilized in order to be approved.

.2103(d) *An applicant that has one or more existing or approved dedicated C-section operating rooms and is proposing to develop an additional dedicated C-section operating room in the same facility shall demonstrate that an average of at least 365 C-sections per room were performed in the facility's existing dedicated C-section operating rooms in the previous 12 months and are projected to be performed in the facility's existing, approved and proposed dedicated C-section rooms during the third year of operation following completion of the project.*

-NA- The applicant does not propose to develop an additional dedicated C-section room.

.2103(e) *An applicant proposing to convert a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or to add a specialty to a specialty ambulatory surgical program shall provide documentation to show that each existing ambulatory surgery program in the service area that performs ambulatory surgery in the same specialty area as proposed in the application is currently utilized an average of at least 1,872 hours per operating room per year, excluding dedicated open heart and C-Section operating rooms. The hours utilized per operating room shall be calculated as follows: [(Number of projected inpatient cases, excluding open heart and C-sections performed in dedicated rooms times 3.0 hours) plus (Number of projected outpatient cases times 1.5 hours)] divided by the number of operating rooms, excluding dedicated open heart and C-Section operating rooms.*

-NA- The applicant does not propose to convert a specialty ambulatory surgery program to a multispecialty ambulatory surgery program or to add a specialty to a specialty ambulatory surgical program.

.2103(f) *An applicant proposing to convert a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or to add a specialty to a specialty ambulatory surgery program shall reasonably demonstrate the need for the conversion in the third operating year of the project based on the following formula: [Total number of projected outpatient cases for all ambulatory surgery programs in the service area times 1.5 hours) divided by 1,872 hours] minus the total number of existing, approved and proposed outpatient or ambulatory surgical operating rooms and shared operating rooms in the service area. The need for the conversion is demonstrated if the difference is a positive number greater than or equal to one, after the number is rounded to the next highest number for fractions of 0.50 or greater.*

-NA- The applicant does not propose to convert a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or to add a specialty to a specialty ambulatory surgical program.

.2103(g) *The applicant shall document the assumptions and provide data supporting the methodology used for each projection in this Rule.*

-C- In Section III.1(b), pages 53-64, the applicant provides a detailed description of and documentation to support the assumptions and methodology used in the development of the projections required by this Rule. See Criterion (3) for discussion.

.2104 SUPPORT SERVICES

.2104(a) *An applicant proposing to establish a new ambulatory surgical facility, a new campus of an existing facility, or a new hospital shall provide copies of the written policies and procedures that will be used by the proposed facility for patient referral, transfer, and follow-up.*

-NA- NCBH is proposing to add ORs to its license and locate them on the existing campus. Therefore, this rule is not applicable to this review.

.2104(b) *An applicant proposing to establish a new ambulatory surgical facility, a new campus of an existing facility, or a new hospital shall provide documentation showing the proximity of the proposed facility to the following services:*

(1) emergency services;

(2) support services;

(3) ancillary services; and
(4) public transportation.

-NA- NCBH is proposing to add 7 ORs to its license and locate them on the existing campus. Therefore, this rule is not applicable to this review.

.2105 STAFFING AND STAFF TRAINING

.2105(a) *An applicant proposing to establish a new ambulatory surgical facility, to establish a new campus of an existing facility, to establish a new hospital, to increase the number of operating rooms in a facility, to convert a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or to add a specialty to a specialty ambulatory surgical program shall identify, justify and document the availability of the number of current and proposed staff to be utilized in the following areas:*

(1) administration;
(2) pre-operative;
(3) post-operative;
(4) operating room; and
(5) other.

-C- In Sections VII.1 and VII.2, pages 99-100, and Sections VII.6(a) and (b), page 101-102, the applicant provides documentation of the availability of current and proposed staff to be utilized in each of the areas listed in this Rule.

.2105(b) *The applicant shall identify the number of physicians who currently utilize the facility and estimate the number of physicians expected to utilize the facility and the criteria to be used by the facility in extending surgical and anesthesia privileges to medical personnel.*

-C- In Section VII.9(b), page 104, the applicant provides the number of physicians on the NCBH medical staff by specialty. In Section II.10, page 40, the applicant states,

> *"All of the NCBH medical staff who currently perform surgeries on the NCBH campus will be eligible to perform surgery in the West Campus building."*

In Section VII.8(a), page 103, the applicant states,

> *"Counting fellows and residents as well as faculty, the number of surgeons expected to utilize the West Campus Surgery Center will exceed 42 initially, all of which* [sic] *perform surgical services."*

Additionally, Exhibit 15 contains a copy of NCBH's physician credentialing policies and procedures, which outline the criteria used in extending privileges.

.2105(c) *The applicant shall provide documentation that physicians with privileges to practice in the facility will be active members in good standing at a general acute care hospital within the service area in which the facility is, or will be, located or documentation of contacts the applicant made with hospitals in the service area in an effort to establish staff privileges.*

-C- In Section VII.8(a), page 103, the applicant states,

> *"Privileges to practice at NCBH are limited to physicians with appointments to the faculty at Wake Forest University School of Medicine whose credentials have been approved by the Executive Committee of the Medical Staff of NCBH."*

The applicant states that these physicians are expected to remain in good standing.

.2105(d) *The applicant shall provide documentation that physicians owning the proposed single specialty demonstration facility will meet Emergency Department coverage responsibilities in at least one hospital within the service area, or documentation of contacts the applicant made with hospitals in the service area in an effort to commit its physicians to assume Emergency Department coverage responsibilities.*

-NA- The applicant does not propose to establish a new single specialty separately licensed ambulatory surgical facility pursuant to the demonstration project in the 2010 State Medical Facilities Plan.

.2106 FACILITY

.2106(a) *An applicant proposing to establish a licensed ambulatory surgical facility that will be physically located in a physician's or dentist's office or within a general acute care hospital shall demonstrate that reporting and accounting mechanisms exist and can be used to confirm that the licensed ambulatory surgery facility is a separately identifiable entity physically and administratively, and is financially independent and distinct from other operations of the facility in which it is located.*

-NA- The applicant does not propose to establish a licensed ambulatory surgical facility that will be physically located in a physician's or dentist's office or within a general acute care hospital.

.2106(b) *An applicant proposing a licensed ambulatory surgical facility or a new hospital shall receive accreditation from the Joint Commission for the Accreditation of Healthcare Organizations, the Accreditation Association for Ambulatory Health Care or a comparable accreditation authority within two years of completion of the facility.*

-C- NCBH is already accredited by the Joint Commission.

.2106(c) *All applicants shall document that the physical environment of the facility to be developed or expanded conforms to the requirements of federal, state, and local regulatory bodies.*

-C- Exhibit 5 contains a letter from HKS, the architects for the proposed project, which documents that the physical environment will conform to the requirements of federal, state, and local regulatory bodies.

.2106(d) *An applicant proposing to establish a new ambulatory surgical facility, a new campus of an existing facility or a new hospital shall provide a provide a floor plan of the proposed facility identifying the following areas:*

(1) receiving/registering area;
(2) waiting area;
(3) pre-operative area;
(4) operating room by type;
(5) recovery area; and
(6) observation area.

-NA- NCBH is proposing to add 7 ORS to its existing license and locate them on the existing campus. Therefore, this rule is not applicable to this review.

.2106(e) *An applicant proposing to expand by converting a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or by adding a specialty to a specialty ambulatory surgical program that does not propose to add physical space to the existing ambulatory surgical facility shall demonstrate the capability of the existing ambulatory surgical program to provide the following for each additional specialty area:*

(1) physicians;
(2) ancillary services;
(3) support services;
(4) medical equipment;
(5) surgical equipment;
(6) receiving/registering area;
(7) clinical support areas;

(8) medical records;
(9) waiting area;
(10) pre-operative area;
(11) operating rooms by type;
(12) recovery area; and
(13) observation area.

-NA- The applicant is not proposing to expand by converting a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or by adding a specialty to a specialty ambulatory surgical program.

EXHIBIT F TO NOVANT HEALTH'S PETITION TO THE SHCC REGARDING POLICY AC-3

Original

March 3, 2010
Comments Submitted by Novant Health
Regarding the January 15, 2010
NCBH CON Application for a New $38 Million
Ambulatory Surgery Center with Seven New ORs
Pursuant to SMFP Policy AC-3
(Project I.D. # G-8460-10)

NCBH Does Not Meet the Criteria to Qualify for Special Consideration and Exemption from the Forsyth County OR Need Determination Under SMFP Policy AC-3 "Exemption From Plan Provisions for Certain Academic Medical Center Teaching Hospital Projects"

Overview

In its January 15, 2010 CON Application, NCBH is seeking the state's approval to add seven new ORs in Forsyth County, even though the 2010 SMFP shows for Forsyth County the need for no new ORs in Forsyth County in Table 6 C of the 2010 SMFP. In fact, the 2010 SMFP in Table 6B shows a projected surplus of 5.52 operating rooms in Forsyth County, more than half of which is associates with ORs that are part of the NCBH/Wake Forest Health Sciences (including the recent acquisition of Plastic Surgery Center of North Carolina) operating room inventory. NCBH/WFU Health Sciences did not address the 2.65 surplus ORs at Plastic Surgery Center of NC in seeking approval for seven new ORs in its 8-OR Ambulatory Surgery Center. NCBH proposes to spend $38.7 Million to construct a 72,300 Square Foot Ambulatory Surgery Center ("the West Campus Surgery Center") with:

- 8 operating rooms (7 new ORs and 1 relocated OR from NCBH's existing surgical suites)
- 2 procedure rooms
- 1 simulation operating room (to provide a safe and lifelike learning environment for medical students, residents, fellows, nurses, and faculty to acquire essential skills required in clinical care)[1]
- 1 robotics training operating room (to train surgeons interested in laparoscopic surgery and other minimally invasive procedures using the DaVinci robot)[2]
- Sterile Processing in the ASC
- 23 Prep/Recovery Bays plus one patient isolation room
- 10 PACU Bays NCBH .
- 8 Short-Stay Recovery Rooms, including one Isolation Recovery Room

Under the special status afforded only to Academic Medical Centers under SMFP Policy AC-3, the applicant has a especially important burden of showing the need for new ORs in a County where a surplus of existing ORs already exists. SMFP Policy AC-3: "Exemption From Plan Provisions for Certain Academic Medical Center Teaching Hospital Projects" states:

"Projects for which certificates of need are sought by academic medical center teaching hospitals may qualify for exemption from the need determinations of this document. The Medical Facilities Planning Section shall designate as an Academic Medical Teaching

[1] NCBH CON Application page 14.
[2] NCBH CON Application page 15.

Hospital any facility whose application for such designation demonstrates the following characteristics of the hospital:

1. Serves as a primary teaching site for a school of medicine and at least one other health professional school, providing undergraduate, graduate, and postgraduate education.

2. Houses extensive basic medical science and clinical research programs, patients, and equipment.

3. Serves the treatment needs of patients from a broad geographic area through multiple medical specialists.

Exemption from the provisions of need determinations of the North Carolina State Medical Facilities Plan shall be granted to projects submitted by Academic Medical Center Teaching Hospitals designated prior to January, 1, 1990 provided the projects comply with one of the following conditions:

1. *Necessary to complement a specified and approved expansion of the number or types of students, residents or faculty, as certified by the head of the relevant associated professional school.*

2. *Necessary to accommodate patients, staff or equipment for a specified and approved expansion of research activities, as certified by the head of the entity sponsoring the research; or*

3. *Necessary to accommodate changes in requirements of specialty education accrediting bodies, as evidenced by copies of documents issued by such bodies.*

A project submitted by an Academic Medical Center Teaching Hospital under this policy that meets one of the above conditions shall also demonstrate that the Academic Medical Center Teaching Hospital's teaching or research need for the proposed project cannot be achieved effectively at any non-Academic Medical Center Teaching Hospital provider which currently offers the service for which the exemption is requested and which is within 20 miles of the Academic Medical Center Teaching Hospital." [Emphasis Added]

NCBH Provides Insufficient Documentation and Explanation Needed to Demonstrate Compliance with the SMFP Policy AC-3 Requirement for the Necessity to Support an Expansion of Students, Residents or Faculty

In its CON application for an 8-OR Ambulatory Surgery Center, with seven new ORs, NCBH is seeking to quality for Policy AC-3 Exemption from SMFP Provisions for New OR Need Determinations in Forsyth County, using Criterion #1 above: "*Necessary to complement a specified and approved expansion of the number or types of students, residents or faculty, as certified by the head of the relevant associated professional school.*"

At pages 66-67 in Section II of the 8-OR ASC CON Application, NCBH briefly addresses the provisions of SMFP Policy AC-3, under which it is seeking an exemption from the finite limits of an OR Need Determination in Forsyth County, where such exemption is only available to Academic Medical Centers. Since SMFP Policy AC-3 grants a unique privilege to a handful of North Carolina hospitals that are Academic Medical Centers, it is imperative that the Academic Medical Center is diligent and through in demonstrating compliance with all the requirements of SFMP Policy AC-3 in order to qualify for this exemption, which is a unique exception, available to a chosen few hospitals, in the standard SMFP Need Determination process.

In its Policy AC-3 documentation, NCBH relies on a letter included in CON Application Exhibit #8 from Dr. Applegate, President Wake Forest University Health Sciences & Dean, Wake Forest University School of Medicine. This letter notes as justification for the Policy AC-3 Exemption:

- WFUHS projects to add 39 clinical FTEs to the Division of Surgical Sciences by 2020 (over the next ten years);

The faculty recruiting plan represents the addition of approximately 3.9 FTE clinical staff per year for the Division of Surgical Sciences for each of the next ten years. This seems like a modest and manageable rate of growth in surgical faculty that may also be offset by future retirements of surgical faculty, which were not discussed as part of WFUHS Surgeon Recruiting Plan. However, it is unclear whether the projected 12 additional "research" FTEs in the Division of Surgical Sciences would require access to the proposed operating rooms in the West Campus ASC.[3]

- 2 of the 39 new Clinical FTEs in the Division of Surgical Sciences are identified as "Cardiothoracic Surgery," so it is unlikely that these surgeons will perform surgical cases in the proposed West Campus 8-OR surgery center.

- 6 of the 39 new Clinical FTEs in the Division of Surgical Sciences are identified as "Emergency"; it is unclear whether these are "emergency" surgeons or whether these 6 FTEs are Emergency Department physicians; if these 6 FTEs are Emergency Room physicians it is very unlikely that they would be performing surgery in the proposed 8-OR West Campus ASC.

- 6 of the 39 new Clinical FTEs in the Division of Surgical Sciences are identified as Neurosurgeons. It is not likely that neurosurgeons would be performing surgical cases on a regular basis in the proposed West Campus 8-OR ASC.

If you assume that fourteen (2 Cardiothoracic Surgery, 6 Emergency, and 6 Neurosurgery) of the 39 Clinical FTEs to be recruited for the Division of Surgical Sciences during the next ten years (2010- 2020) will not use the West Campus Surgery Center ORs, then WFUHS is proposing to add only 25 clinical FTEs to the Division of

[3] See the table in Dr. Applegate's letter at page 2. See CON application Exhibit #8 for a copy of this letter.

Surgical Sciences over the next ten years who could be reasonably expected to use the eight ORs at the West Campus surgery center. This represents the modest addition of approximately 2.5 FTE clinical surgical staff per year added to the Division of Surgical Sciences, who would require access to the eight ORs of outpatient surgical capacity proposed at the West Campus ASC.

These 25 FTEs of new clinical surgery FTEs to be recruited to the Division of Surgical Sciences over the next ten years include surgeons specializing in: General Surgery, Ophthalmology, ENT, Plastic Surgery, Urology, and Vascular Surgery. The most recent Medical Group Mangers Association "Physician Compensation and Production Survey: Based on 2008 Data" shows that at the 75 Percentile of annual surgical case productivity:

- Each Plastic Surgeon performs 598 surgical cases per year
- Each General Surgeon performs 832 surgical cases per year
- Each Vascular Surgeon performs 685 surgical cases per year
- Each Urological Surgeon performs 2,043 cases per year
- Each ENT Surgeon performs 1,141 cases per year

In total, one each of these five types of surgeons, if working at the highly productive 75th percentile, would generate about 5,300 outpatient surgical cases per year.[4] The MGMA Table is provided as Attachment 1. Applying the SMFP OR Need Method Weighting Factor of 1.5 Hours Per Outpatient Surgery, would result in 7,949 hours of ambulatory surgery cases per year; dividing this by the SMFP defined capacity for annual OR hours per year per OR of 1,872, shows, at best, a need for only 4 ORs[5], rather than the 7, for which NCBH is seeking approval. With only 2.5 FTEs of surgeons added on average each year over the next ten years, if those surgeons are going to use only the West Campus surgery center (which seems unlikely), these 2.5 FTE new surgeons might add 2,650 outpatient OR cases per year. These 2,650 outpatient cases would occupy about two ORs during the course of a year[6], so an initial request for 7 new ORs seems to be overstated for the proposed West Campus ASC. This is not enough outpatient OR case volume to suggest that as many as eight ORs are needed right now.

If these surgeons, functioned at only the MGMA Median Percentile of annual surgical case productivity, due to the added complexity of Academic Medical Center patients as discussed in the NCBH CON application, then the annual cases for the above five surgeon types would total only 3,671. This level of annual outpatient OR volume would utilize the capacity of about 3 outpatient ORs[7], based on the elements of the SMFP OR Need Method. Again, seven new ORs for the NCBH West Campus ASC, seems excessive at this point in time.

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[4] Calculation: 598 + 832 + 685 + 2,043 + 1,141 = 5,299 cases per year

[5] Calculation: (5,299 outpt OR cases X 1.5 Hours/Case)/1,872 Hours Per OR Per Year = 4.2 ORs

[6] Calculation: 2.5 FTE Surgeons generate half the annual outpatient OR cases that 5 surgeons would = 5,299/2 = 2,650 outpatient OR cases/year. Estimate OR capacity utilized: (2,650 outpatient OR cases X 1.5 hours per OR case)/1,872 hours per OR per year = 2.1 ORs

[7] Calculation: (3,671 outpatient OR cases/year X 1.5 hours per OR case)/1,872 hours per OR per year = 2.99 ORs

A lesser number of ORs at the proposed ASC would meet the needs in the near-term and would not run the risk of saturating the OR inventory in Forsyth County that already shows a surplus of 5.5 operating rooms in the 2010 SMFP. Also, an affiliate of NCBH, Wake Forest University Health Sciences, has notified the Agency of the exempt acquisition of a 3-OR Plastic Surgery Center in Forsyth County (Plastic Surgery Center of NC), which is licensed for three ORs, 2.65 of which are currently identified in the 2010 SMFP as underutilized ORs. It is puzzling that NCBH did not seek to relocate one or two of these operating rooms to the proposed 8-OR ASC, in order to put them to better, more productive use. In addition, two more operating rooms may well be added to the OR inventory in Forsyth County pursuant to the Triad (Forsyth and Guilford) Need Determination for two new Demonstration Project single specialty ambulatory surgery ORs in the 2010 SMFP. The CON Application deadline for these Demonstration Project ASC ORs is March 15, 2010. Given the above factors, adding seven new ORs to the Forsyth County OR inventory, which are projected to be operational in 2012, would simply compound the surplus of OR capacity in Forsyth County now and for the foreseeable future. Unnecessary Duplication is a statutory Review Criterion[8] which the Agency will apply in its consideration of NCBH's 8-OR ASC CON application.

NCBH's Application Fails to Discuss the Mandatory SMFP Policy AC-3 Provision Requiring the Academic Medical Center to Show that its Teaching Need for the Project Cannot be Achieved at Any Non-AMC Currently Offering the Service and Located within 20 miles of NCBH

The above criterion, as stated in SMFP Policy AC-3 is a mandatory requirement *("shall also demonstrate")* which must be discussed by NCBH in its SMFP Policy AC-3 CON Application for the new 8-OR Ambulatory Surgery Center. Neither the CON application narrative nor the CON Application Exhibits provided by NCBH address this requirement. The NCBH application is silent on this point.

The Agency should note that there are other Non-Academic Medical Center providers of ambulatory surgical services within a twenty-mile radius of NCBH. These surgical services providers include:

- Forsyth Medical Center, Winston-Salem, NC (including FMC's Hawthorne Surgery Center, with 6 ORs)
- Medical Park Hospital, Winston-Salem, NC
- Kernersville Medical Center, Kernersville NC (under development and slated to open prior to the 2010 opening date for NCBH's proposed 8-OR ASC)
- Davie County Hospital Replacement Facility, Advance, NC
- Clemmons Medical Center, Clemmons, NC

NCBH's CON application is devoid of any discussion of these options and thus, fails to meet this mandatory requirement to qualify for an SMFP Policy AC-3 exemption from the OR Need Determination in Forsyth County, which is zero new ORs in the 2010

[8] North Carolina General Statutes Section 131E-183(a)(6).

SMFP. Thus, the Agency should find NCBH non-conforming under CON statutory Review Criterion (1)[9], which requires the applicant to demonstrate that "the project is consistent with applicable policies [including SMFP Policy AC-3]...in the State Medical Facilities Plan."

Simulation Operating Room and Robotics Training Operating Room

Novant does not oppose the portion of NCBH's proposal that seeks approval for one simulation operating room and one robotics training operating room. Novant would note that many area hospital facilities and surgeons already have in use DaVinci robotic surgical technology (to be addresses in the NCBH Robotics Training OR), which is in use today at operating rooms at Forsyth Medical Center, Medical Park Hospital, High Point Regional Medical Center, and Moses Cone Hospital. A few years ago NCBH announced an enhanced clinical training agreement between NCBH and MCH.

[9]North Carolina General Statutes Section 131E-183(a)(6).

NCBH Overstates the Need for Additional Operating Rooms in its Quantitative Need Method in CON Application Section III

Review of NCBH AC-3 OR Need Methodology

1. The following analysis reflects a review of only the need for **total** operating rooms at NCBH. The need methodology for the West Campus Outpatient Surgery Center was not analyzed, only NCBH's total need for ORs.

2. For FFY 2005-FFY 2009, the NCBH annual inpatient surgical growth rate of 0.8% and annual outpatient surgical growth rate of 3.9%, as calculated in the following table, are significantly less than the NCBH reported inpatient surgery growth rate of 5.52% and the outpatient surgery growth rate of 5.83% reflected on page 55, Section III of the Application for 2008 to 2009, based upon a July to June timeframe.

NCBH Annual Surgical Growth

NCBH	FFY 2005	FFY 2006	FFY 2007	FFY 2008	FFY 2009	AGR FFY 2008 FFY 2009
Inpatient Cases	11,847	11,900	12,208	13,251	13,357	0.8%
Annual Growth Rate		0.4%	2.6%	8.5%	0.8%	
Ambulatory Cases	15,656	15,842	16,717	17,999	18,693	3.9%
Annual Growth Rate		1.2%	5.5%	7.7%	3.9%	

Source: Table 2; LRAs

NCBH's narrative on CON Application page 55, is addressing the CON Application Question III.1(b), which requires the applicant to *"provide statistical data that substantiates the existence of an unmet need for each project component and the proposed services..."* This is the most basic threshold which every applicant must demonstrate in its Certificate of Need Application to establish the most fundamental level of "need" for the project: the applicant must first and foremost demonstrate the "quantitative need" for the 8-OR ambulatory surgery center as measured by the Agency under CON Statutory Review Criterion 3 ("Need").[10]

Two years of data, such as that used by NCBH on pages 46 and 55 of its application, is not typically enough to establish a trend or a reliable growth rate for use in estimating future surgical cases that justify 8 ORs at the proposed surgery center. It seems that the annual percent growth rates for NCBH OR cases may be overstated, which if applied to base year data would suggest a need for more new ORs than can be supported in the future.

3. The NCBH annual growth rate for the last fiscal year as reported on page 55, Section III of the Application, is inconsistent and overstated when compared to LRA[11] data

[10] NCGS Section 131E-183(a)(3).
[11] LRA = Annual Hospital Licensure Renewal Application

for the timeframe FFY 2008 to FFY 2009 as shown in the following table. Note that NCBH uses a July to June Fiscal Year in the Application, rather than an October to September Fiscal Year (timeframe in LRAs). The data reported in the 2010 LRA is the most current data available which NCBH elected not to consider in its projections of OR cases to demonstrate the need for its existing ORs and the seven proposed new ASC ORs.

Comparison NCBH Surgical Growth Rates

	Actual One Year Growth Rates 2008-2009	
	LRA Data FFY 2008 and FFY 2009 October 2007 – September 2009	NCBH Reported SFY 2008 and SFY 2009 July 2007 – June 2009 Page 55
Inpatient Cases	0.8%	5.52%
Ambulatory Cases	3.9%	5.83%

Source: Table 2; LRAs and page 55

4. Based upon NCBH's own data reported by NCBH in these two documents the only conclusion to be made is that the rate of inpatient surgical growth dropped precipitously in the last quarter of FFY 2009 (July 1, 2009 – Sept. 30, 2009). Annual growth for the twelve months from July 2008 to June of 2009 was 5.52% which decreased to 0.8% (less than 1%) for the twelve months from October 2008 to September 2009. Likewise, NCBH outpatient surgical growth dropped during the last quarter of FFY2009, from 5.83% for the twelve months from July 2008 to June of 2009, to 3.9% for the twelve months from October 2008 to September 2009. This rapid decrease in growth in only three months was not discussed by NCBH nor was it taken into consideration in the application when determining the projected growth rate used in calculating future surgical utilization to justify the need for all existing and new ORs.

5. The high growth rates utilized by NCBH in Step 3 of its Quantitative Need Method in Section III.1(b) of the application on page 56 were based upon the growth experience of NCBH referenced on page 55. However, the historical growth rates reflected in the NCBH Annual Surgical Growth table included in #2 above, which also are more current growth rates than those presented on page 55 of the Application, reflect a much lower growth rate than that which was used to in the projections.

6. The compound annual growth rates for NCBH as calculated: (a) using the LRA data (see table in #2 above); (b) as reported on page 55 of the application; and (c) those utilized in the projections are reflected in the following table.

NCBH Reported CAGRs (Compound Annual Growth Rates)
For OR Cases

	NCBH Reported SFY 2005-SFY2009 July 2004-June2009 Page 55	NCBH Interim Growth Rates Page 56	NCBH Project Year Growth Rates Page 56
Inpatient Cases	2.1%	4.5%	5.0%
Ambulatory Cases	4.55%	5.0%	5.5%

Source: Table 2; 2010 LRA and page 55

7. As shown in the previous table, the 4.5% interim time period inpatient NCBH annual OR case growth rate and the 5.0% Project Year inpatient annual growth rate used in Step 4 on page 57 of the Application is over twice the actual CAGR rate reported by NCBH on page 55. The 5.0% interim period NCBH outpatient OR case annual growth rate and the 5.5% Project Year outpatient annual OR case growth rate used in Step 4 on page 57 of the Application are half of a percent to one percent greater than the actual CAGR rate reported by NCBH on page 55. Both annual OR case growth rates utilized by NCBH in its projections are significantly greater than the more current LRA annual growth rates discussed in #1 above.

8. The projected growth rates utilized in Step 4 of the application on page 57 are contradictory to the most current historical growth rates reported in LRA and the CAGR reflected on 55 of the Application. Overstated growth rates result in overstated utilization. Therefore, the projected need for new operating rooms is overstated.

9. NCBH fails to acknowledge the recent purchase of Plastic Surgery Center of North Carolina by Wake Forest University Health Sciences, which is the teaching/research arm of the organization. North Carolina Baptist Hospital and Wake Forest University Health Sciences are "related entities" as that term is defined in the CON Surgical Services and Operating Room Regulations at 10A NCAC 14C.2101((9)[12]. As a result of this recent acquisition, the teaching and research arm of the institution now has three operating rooms which can be utilized for teaching, so it is not clear why seven additional operation rooms, or 10 overall (7 + 3), are needed for teaching at NCBH and Wake Forest Health Sciences. The PSCNC operating rooms are chronically underutilized operating rooms as listed in Chapter 6 of the SMFP and should be relocated to the proposed West Campus ASC, as part of the project.

10. Novant calculated revised number of operating rooms need at NCBH using the LRA 2005-2009 CAGR included in Table 7. The result is a need for only four additional ORs at NCBH when the Plastic Surgery Center of North Carolina (PSCNC) surplus

[12] The definition of "related entity" states: "...or a company that shares common ownership with the applicant (i.e., the applicant [NCBH] and another company [Wake Forest University Health Sciences] are owned by some of the same persons."

of 2.65 out of 3 ORs into consideration. In late 2009 Wake Forest University Health Sciences, a "related entity" and affiliate of NCBH sought and received confirmation from the CON Agency for the CON exemption acquisition of PSCNC. This is shown in the following table and in Table 7. Note that the following projections do not take into consideration any shift in NCBH surgical volume to the new Davie County Hospital, which was described in the Davie County Replacement Hospital CON Application filed in March 2008 by NCBH. This project was approved, a Certificate of Need was issued by the Agency following settlement, which projects the DCH ORs to become operational anytime between now and 2014.

	FFY 2010	FFY 2011	FFY 2012	PY1 FFY 2013	PY2 FFY 2014	PY3 FFY 2015
Inpatient Cases	13,764	14,183	14,615	15,059	15,518	15,990
Annual Growth Rate	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%
Weighted Inpatient Cases NCBH LRA 3.0 hrs/case	41,291	42,548	43,844	45,178	46,554	47,971
Ambulatory Cases	19,540	20,426	21,351	22,319	23,331	24,388
Annual Growth Rate	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%
Weighted Ambulatory Cases at NCBH LRA 1.5 hrs/case	29,310	30,639	32,027	33,479	34,996	36,582
Total Weighted Cases	70,601	73,187	75,871	78,657	81,550	84,553
Licensed ORs needed at 1,872 cases/year	38	39	41	42	44	45
Planning Inventory	38	38	38	38	38	38
Surplus/Deficit	0	-1	-3	-4	-6	-7
NCBH Deficit Less Surplus at PSCNC	3.0	1.7	0.2	-1.3	-2.8	**-4.4**

11. Novant also calculated revised operating room need at NCBH using a weighted population growth rate for 45+ population based upon NCBH discussion on CON Application page 49, Section III and current NCBH surgical patient origin as calculated in the attached Table 8. This methodology results in a need for only 1.5 or 2.0 additional ORs at NCBH (includes PSCNC surplus) as shown in the following table and in the attached Table 6. The result is a need for only four additional ORs at NCBH (taking the PSCNC surplus into consideration) as shown in the following table and in Table 6. Note that the following projections do not take into consideration any shift in surgical volume to the new Davie County Hospital operating rooms, which can open anytime between now and 2014.

	FFY 2010	FFY 2011	FFY 2012	PY1 FFY 2013	PY2 FFY 2014	PY3 FFY 2015
Inpatient Cases	13,695	14,041	14,397	14,761	15,134	15,517
Annual Growth Rate	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%
Weighted Inpatient Cases NCBH LRA 3.0 hrs/case	41,085	42,124	43,190	44,282	45,403	46,551
Ambulatory Cases	19,166	19,651	20,148	20,658	21,180	21,716
Annual Growth Rate	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%
Weighted Ambulatory Cases at 1.5 hrs/case	28,749	29,476	30,222	30,986	31,770	32,574
Total Weighted Cases	69,834	71,600	73,412	75,269	77,173	79,125
Licensed ORs needed at 1,872 cases/year	37	38	39	40	41	42
NCBH Planning Inventory	38	38	38	38	38	38
Surplus/Deficit	0.7	-0.2	-1.2	-2.2	-3.2	-4.3
NCBH Deficit Less Surplus at PSCNC	3.4	2.5	1.5	0.5	-0.5	**-1.5**

12. NCBH July 2008-June 2009 does not appear to subtract trauma/burn cases but does subtract trauma/burn ORs from planning inventory. This will cause the need for existing and new ORs to be overstated.

13. The 2010 SMFP does not indicate that NCBH's existing operating rooms are currently operating at capacity as suggested on page 44 of the NCBH CON Application. In fact, the 2010 SMFP shows only that NCBH's operating rooms are not projected to be at planning capacity (80% of total capacity) until 2012.

14. Based upon surgical data included in Table 6A of the 2010 SMFP, NCBH and Plastic Surgery Center of NC have a current surplus of 4.5 operating rooms in 2010. Based upon the projected growth rate in the 2010 SMFP, the projected surplus in 2012 for NCBH plus Plastic Surgery Center decreases to 2.0 operating rooms. The proposed additional seven operating rooms in this Application are projected to be operational in July 2012 as reflected in Section XII of the Application, which will result in a combined surplus of 9.0 operating rooms in 2012 if the proposed Application is approved.

Conclusion

In May 2003, NCBH has filed an SMFP Policy AC-3 CON Application that was ultimately successful, for one MRI Scanner and one PET/CT Scanner for placement in the NCBH Cancer Center (CON Project I.D. #G-6816-03). In that case the project involved medical equipment only and capital cost for the MRI scanner was $3.1Million and the capital cost for the PET/CT Scanner was $2.96 Million, for a total of $6 Million in projects exempt from the SMFP need determinations. By contrast, NCBH's Jan. 15, 2010 CON application, seeks approval to spend $38 Million for seven new ORs, the relocation of one existing OR, a simulation OR, and a robotics training OR, plus all

associated support space in a 72,600 Square Foot facility. Given the magnitude of the proposed capital expenditure and the large number of new ORs, requested over and above the existing surplus of operating rooms in Forsyth County per the 2010 SMFP OR Need Determination, the Agency should give careful consideration to the scope and capital intensity of this project under the requirements of SMFP Policy AC-3. Seven new ORs in a county that currently has 84 ORs (excluding dedicated c-section ORs) is a substantial, practical increase in operating room capacity (+8%) in a County that has consistently for the past five years of Forsyth County OR 2006-2010 SMPF data shown a surplus of operating rooms ranging from 5.5 to 10.3 ORs[13]. The FFY 2009 OR case data (10/1/2008-9/30/2009) that will populate the 2011 SMFP, will be the first data to reflect the time period when the effects of the economic downturn were in full force and perhaps reflected in hospital volumes, including OR cases. Taken in that context, including the historical pattern some ongoing excess OR capacity in Forsyth County, NCBH's request for seven new ORs is too much, too soon. A less costly project, with a significantly smaller compliment of new ORs and greater relocation of existing ORs seems the more reasonable course at this point in time.

File: NCBH AC-3 OR Application analysis 3 3 2010.FINAL.doc

[13] Forsyth County OR Surpluses in annual State Medical Facilities Plans, Chapter 6: 2006 SMFP = 8.7 ORs; 2007 SMFP = 8.47 ORs; 2008 SMFP = 10.3 ORs; 2009 SMFP = 8.42 ORs; and 2010 SMFP = 5.5 ORs.

le 53: Physician Surgery/Anesthesia Cases (NPP Excluded) (continued)

	Phys	Med Pracs	Mean	Std. Dev.	25th %tile	Median	75th %tile	90th %tile
hinolaryngology	203	69	801	549	301	755	1,141	1,478
hinolaryngology: Pediatric	3	3	*	*	*	*	*	*
n Management: Nonanesthesia	9	7	*	*	*	*	*	*
hology: Anatomic & Clinical	5	1	*	*	*	*	*	*
hology: Anatomic	1	1	*	*	*	*	*	*
ology: Clinical	0	*	*	*	*	*	*	*
iatrics: General	827	100	149	177	48	92	176	332
diatrics: Adolescent Medicine	7	3	*	*	*	*	*	*
diatrics: Cardiology	6	3	*	*	*	*	*	*
diatrics: Child Development	0	*	*	*	*	*	*	*
diatrics: Critical Care/Intensivist	8	4	*	*	*	*	*	*
diatrics: Emergency Medicine	1	1	*	*	*	*	*	*
diatrics: Endocrinology	4	4	*	*	*	*	*	*
diatrics: Gastroenterology	6	4	*	*	*	*	*	*
diatrics: Genetics	0	*	*	*	*	*	*	*
diatrics: Hematology/Oncology	7	3	*	*	*	*	*	*
diatrics: Infectious Disease	2	2	*	*	*	*	*	*
diatrics: Neonatal Medicine	25	8	19	20	6	8	28	64
diatrics: Nephrology	2	2	*	*	*	*	*	*
diatrics: Neurology	4	3	*	*	*	*	*	*
diatrics: Pulmonology	5	4	*	*	*	*	*	*
diatrics: Urgent Care	0	*	*	*	*	*	*	*
Physiatry (Phys Med & Rehab)	66	33	644	661	58	287	724	1,620
Podiatry: General	62	33	1,752	993	1,031	1,748	2,304	2,004
Podiatry: Surg-Foot & Ankle	40	15	1,012	794	236	916	1,551	2,034
Podiatry: Surg-Forefoot Only	2	2	*	*	*	*	*	*
Psychiatry: General	9	7	*	*	*	*	*	*
Psychiatry: Child & Adolescent	3	2	*	*	*	*	*	*
Pulmonary Medicine	82	40	180	163	76	135	228	302
Pulmonary Medicine: Critical Care	32	10	176	110	78	146	248	345
Pulmonary Med: Gen & Crit Care	45	11	224	185	64	132	390	519
Radiation Oncology	17	7	12	17	1	3	20	48
Radiology: Diagnostic-Invasive	44	12	494	375	176	396	788	1,124
Radiology: Diagnostic-Noninvasive	176	23	220	271	34	91	316	650
Radiology: Nuclear Medicine	1	1	*	*	*	*	*	*
Rheumatology	104	52	543	576	198	398	645	1,126
Sleep Medicine	3	3	*	*	*	*	*	*
Surgery: General	449	117	644	342	399	600	832	1,134
Surgery: Bariatric	11	6	560	189	446	634	753	777
Surgery: Cardiovascular	121	33	300	164	202	265	350	477
Surgery: Cardiovascular-Pediatric	0	*	*	*	*	*	*	*
Surgery: Colon & Rectal	25	14	1,249	594	624	1,336	1,695	1,999
Surgery: Neurological	108	35	346	272	184	274	408	606
Surgery: Oncology	9	7	*	*	*	*	*	*
Surgery: Oral	7	2	*	*	*	*	*	*
Surgery: Pediatric	10	6	462	223	257	479	683	747
Surgery: Plastic & Reconstruction	55	27	614	431	212	438	590	1,162
Surgery: Thoracic (primary)	12	8	402	240	226	363	578	836
Surgery: Transplant	2	2	*	*	*	*	*	*
Surgery: Trauma	31	9	412	593	146	233	340	1,609
Surgery: Vascular (primary)	71	29	532	239	356	466	666	876
Urgent Care	231	36	245	179	102	209	373	477
Urology	298	66	1,427	825	815	1,413	2,043	2,432
Urology: Pediatric	4	2	*	*	*	*	*	*

53 Community Mental Health Facility
54 Intermediate Care Facility for Mentally Retarded
55 Residential Substance Abuse Treatment Facility
56 Psychiatric Residential Treatment Center
62 Comprehensive Outpatient Rehabilitation Facility
65 End-stage Renal Disease Treatment Facility
71 State or Local Public Health Clinic
72 Rural Health Clinic
81 Independent Laboratory

Important: If ambulatory encounters are reported in question 20, respondents must complete question 26.

Question 21 – Hospital encounters

Report the total number of encounters, using the previous definition, with the following CMS place of service codes:

21 Inpatient Hospital
25 Birthing Center
26 Military Treatment Facility
51 Inpatient Psychiatric Facility
61 Comprehensive Inpatient Rehabilitation Facility

Question 22 – Surgery/anesthesia cases

Report the total surgery/anesthesia cases performed annually by each provider. A surgery/anesthesia case is a case between a provider and a patient where at least one procedure performed is a procedure from the surgery chapter (CPT codes 10021-69979) or anesthesia chapter (CPT codes 00100-01999) of the *Current Procedural Terminology, Fourth Edition,* copyrighted by the American Medical Association (AMA).

Note that the number of cases, not procedures, should be counted since a case may consist of multiple procedures. Surgery/anesthesia cases include cases performed on an inpatient or outpatient basis, regardless of facility or site. For anesthesia care teams or an anesthesiologist who supervises one or more CRNAs, include total care team cases.

Questions 23 and 24 – RVUs

Report the RVUs, as measured by the RBRVS, not weighted by a conversion factor, attributed to all professional services. An RVU is a nonmonetary standard unit of measure that indicates the value of services provided by physicians, nonphysician providers, and other health care professionals. The RVU system is explained in detail in the November 27, 2007 *Federal Register*, pages 66,222 to 66,578. Addendum B: Relative Value Units (RVUs) and Related Information presents a table of RVUs by CPT code. Your billing system vendor should be able to load these RVUs into your system if you are not yet using RVUs for management analysis. When answering this question, note the following:

- The RVUs published in the November 27, 2007, *Federal Register*, effective for calendar year 2008, should be used; and
- The total RVUs for a given procedure consist of three components:
  - Physician work RVUs;
  - Practice expense (PE) RVUs; and
  - Malpractice RVUs.

Thus, Total RVUs = Physician Work RVUs + Practice Expense RVUs + Malpractice RVUs.

For 2008, there were two different types of practice expense RVUs:

1. Fully implemented nonfacility practice expense RVUs; and
2. Fully implemented facility practice expense RVUs.

"Nonfacility" refers to RVUs associated with a medical practice that is not affiliated with a hospital and does not utilize a split billing system that itemizes facility (hospital) charges and professional charges. "Nonfacility" also applies to services performed in settings other than a hospital, skilled nursing facility, or ambulatory surgery center. You should report total RVUs in question 23 that are a function of "nonfacility" practice expense RVUs.

"Facility" refers to RVUs associated with a hospital affiliated medical practice that utilizes a split billing fee schedule where facility (hospital) charges and professional charges are billed separately. "Facility" also refers to services performed in a hospital, skilled nursing facility, or ambulatory surgery center. Do not report total RVUs in question 23 that are a function of "facility" practice expense RVUs. If you are a hospital affiliated medical practice that utilizes a split billing fee schedule, you should report your total RVUs in question 23 as if you were a medical practice not affiliated with a hospital.

Table 1: **NCBH OR Inventory FFY 2007-FFY 2009**

	OR Inventory
Inpatient	4
Shared	36
Ambulatory	0
Total	40
Excluded ORs (Trauma Burn)	-2
OR Planning Invenotry	38

Souce: 2008-2010 LRAs

Table 2: **NCBH OR Utilization and Need FFY 2005 - FFY 2009**

	FFY 2005	FFY 2006	FFY 2007	FFY 2008	FFY 2009	CAGR FFY 2005 - FFY 2009	AGR FFY 2008 - FFY 2009
Inpatient Cases	11,847	11,900	12,208	13,251	13,357	3.0%	0.8%
Annual Growth Rate		0.4%	2.6%	8.5%	0.8%		
Weighted Inpatient Cases at 3 hrs/case	35,541	35,700	36,624	39,753	40,071		
Ambulatory Cases	15,656	15,842	16,717	17,999	18,693	4.5%	3.9%
Annual Growth Rate		1.2%	5.5%	7.7%	3.9%		
Weighted Ambulatory Cases at 1.5 hrs/case	23,484	23,763	25,076	26,999	28,040		
Total Weighted Cases	59,025	59,463	61,700	66,752	68,111		
Planning Inventory	38	38	38	38	38		
Licensed ORs needed at 1,872 cases/year	32	32	33	36	36		
Surplus/Deficit	6	6	5	2	2		

Souce: 2006-2010 LRAs

Table 3: **NCBH OR Utilization**

	FFY 2007	FFY 2008	FFY 2009
Inpatient Cases	12,208	13,251	13,357
Weighted Inpatient Cases	36,624	39,753	40,071
Ambulatory Cases	16,717	17,999	18,693
Weighted Ambulatory Cases	25,076	26,999	28,040
Total Weighted Cases	61,700	66,752	68,111
Licensed ORs needed at 1,872 cases/year	33	36	36
OR Planning Inventory	38	38	38
NCBH Surplus (+) / Deficit (-)	5.0	2.3	1.6

Source: Tables 2; SMFP OR Need Methodology

Table 4: **Plastic Surgery Center of NC OR Utilization**

	FFY 2007	FFY 2008	FFY 2009	Future Surplus Used in Tables 6, 7
Ambulatory Cases	447	411	148	
Weighted Cases at 1.5 hrs/case	670.5	616.5	222	
Ambulatory ORs needed at 1,872 cases/year	0.36	0.33	0.12	
Licensed Ambulatory ORs	3	3	3	
PSCNC Surplus (+) / Deficit (-)	2.64	2.67	2.88	2.75
Combined NCBH and PSCNC Surplus (+) / Deficit (-)	7.68	5.01	4.50	

Souce: 2008-2010 LRAs; SMFP OR Need Methodology

Note: On 6/5/2009, CON Section issued Exempt from Review letter approving the acquisition of Plastic Surgery Center of NC, Inc. by Wake Forest Health Sciences

Table 5: **NCBH OR Utilization and Projected Need in CON Application**

	SFY 2009	SFY 2010 Jul2009-Jun2010	SFY 2011	SFY 2012	PY1 SFY 2013	PY2 SFY 2014	PY3 SFY 2015
Inpatient Cases	13,446	14,051	14,683	15,344	16,111	16,917	17,763
Weighted Inpatient Cases at 3 hrs/case	40,338	42,153	44,049	46,032	48,333	50,751	53,289
Ambulatory Cases	18,683	19,617	20,598	20,482	20,894	22,043	23,256
Weighted Ambulatory Cases at 1.5 hrs/case	28,025	29,426	30,897	30,723	31,341	33,065	34,884
Total Weighted Cases	68,363	71,579	74,946	76,755	79,674	83,816	88,173
Licensed ORs needed at 1,872 cases/year	37	38	40	41	43	45	47
Planning Inventory	38	38	38	38	38	38	38
Surplus/Deficit	1	0	-2	-3	-5	-7	-9

Table 6: Revised Projections **NCBH OR Utilization and Projected Need Using 2009-2015 Weighted Population Growth Rate** (Table 8)

	Actual			Projected						Weighted Population 45+ Growth Rate
	FFY 2007	FFY 2008	FFY 2009	FFY 2010	FFY 2011	FFY 2012	PY1 FFY 2013	PY2 FFY 2014	PY3 FFY 2015	
Inpatient Cases	12,208	13,251	13,357	13,695	14,041	14,397	14,761	15,134	15,517	2.5%
Annual Growth Rate		8.5%	0.8%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	
Weighted Inpatient Cases NCBH LRA 3.0 hrs/case	36,624	39,753	40,071	41,085	42,124	43,190	44,282	45,403	46,551	
Ambulatory Cases	16,717	17,999	18,693	19,166	19,651	20,148	20,658	21,180	21,716	2.5%
Annual Growth Rate		7.7%	3.9%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	
Weighted Ambulatory Cases at 1.5 hrs/case	25,076	26,999	28,040	28,749	29,476	30,222	30,986	31,770	32,574	
Total Weighted Cases	61,700	66,752	68,111	69,834	71,600	73,412	75,269	77,173	79,125	
Licensed ORs needed at 1,872 cases/year	33	36	36	37	38	39	40	41	42	
NCBH Planning Inventory	38	38	38	38	38	38	38	38	38	
Surplus/Deficit	5.0	2.3	1.6	0.7	-0.2	-1.2	-2.2	-3.2	-4.3	
NCBH Deficit Less Surplus at PSCNC	7.8	5.1	4.4	3.4	2.5	1.5	0.5	-0.5	**-1.5**	

Table 7: Revised Projections **NCBH OR Utilization and Projected Need Using NCBH CAGR 2005-2009**

	Actual			Projected						CAGR
	FFY 2007	FFY 2008	FFY 2009	FFY 2010	FFY 2011	FFY 2012	PY1 FFY 2013	PY2 FFY 2014	PY3 FFY 2015	FFY 2005 - FFY 2009
Inpatient Cases	12,208	13,251	13,357	13,764	14,183	14,615	15,059	15,518	15,990	3.0%
Annual Growth Rate		8.5%	0.8%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	
Weighted Inpatient Cases NCBH LRA 3.0 hrs/case	36,624	39,753	40,071	41,291	42,548	43,844	45,178	46,554	47,971	
Ambulatory Cases	16,717	17,999	18,693	19,540	20,426	21,351	22,319	23,331	24,388	4.5%
Annual Growth Rate		7.7%	3.9%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	
Weighted Ambulatory Cases at NCBH LRA 1.5 hrs/case	25,076	26,999	28,040	29,310	30,639	32,027	33,479	34,996	36,582	
Total Weighted Cases	61,700	66,752	68,111	70,601	73,187	75,871	78,657	81,550	84,553	
Licensed ORs needed at 1,872 cases/year	33	36	36	38	39	41	42	44	45	
Planning Inventory	38	38	38	38	38	38	38	38	38	
Surplus/Deficit	5	2	2	0	-1	-3	-4	-6	-7	
NCBH Deficit Less Surplus at PSCNC	7.8	5.1	4.4	3.0	1.7	0.2	-1.3	-2.8	-4.4	

Table 8. **NCBH Surgical Weighted Population 45+ Growth Rate**

County	45-54	55-59	60-64	65-74	75-84	85-94	95+	45+	Total
2009									
DAVIDSON	25,004	10,397	9,610	12,882	7,109	2,387	218	67,607	160,917
DAVIE	6,433	2,879	2,552	3,442	1,877	674	67	17,924	41,668
FORSYTH	52,052	22,364	18,984	24,287	14,854	5,282	581	138,404	349,405
GUILFORD	70,164	30,140	25,388	32,202	18,944	7,118	828	184,784	476,642
STATE	1,380,324	583,777	497,297	656,941	371,605	130,155	12,889	3,632,988	9,397,548
2015									
DAVIDSON	26,478	12,551	10,553	16,506	7,906	2,685	261	76,940	176,383
DAVIE	6,680	3,291	2,975	4,422	2,193	740	77	20,378	45,856
FORSYTH	54,791	26,069	22,713	32,355	15,542	6,064	670	158,204	383,608
GUILFORD	76,722	35,445	30,661	44,105	20,352	8,038	1,013	216,336	526,426
STATE	1,487,394	694,884	597,553	862,242	409,772	144,932	15,990	4,212,767	10,424,250

	Annual Growth		Patient Origin	Weighted Pop Growth Rate
DAVIDSON	2.3%		6%	0.14%
DAVIE	2.3%		3%	0.07%
FORSYTH	2.4%		42%	1.00%
GUILFORD	2.8%		10%	0.28%
STATE	2.7%		39%	1.04%
				2.53%

Table 9: **Forsyth County OR Utilization and OR Need FFY 2008 Data - 2010 SMFP**

NCBH		PSCNC		FMC		Medical Park		Total	
Inpatient Cases	13,357	Inpatient Cases	0	Inpatient Cases - C-Section	10,361	Inpatient Cases	1,085	Inpatient Cases	24,803
Weighted Inpatient Cases at 3 hrs/case	40,071	Weighted Inpatient Cases at 3 hrs/case	0	Weighted Inpatient Cases at 3 hrs/case	31,083	Weighted Inpatient Cases at 3 hrs/case	3,255	Weighted Inpatient Cases at 3 hrs/case	74,409
Ambulatory Cases	18,693	Ambulatory Cases	148	Ambulatory Cases	12,676	Ambulatory Cases	10,531	Ambulatory Cases	42,048
Weighted Ambulatory Cases at 1.5 hrs/case	28,040	Weighted Ambulatory Cases at 1.5 hrs/case	222	Weighted Ambulatory Cases at 1.5 hrs/case	19,014	Weighted Ambulatory Cases at 1.5 hrs/case	15,797	Weighted Ambulatory Cases at 1.5 hrs/case	63,072
Total Weighted Hours	68,111	Total Weighted Hours	222	Total Weighted Hours	50,097	Total Weighted Hours	19,052	Total Weighted Hours	137,481
OR Planning Inventory*	38	OR Planning Inventory	3	OR Planning Inventory**	32	OR Planning Inventory	13	OR Planning Inventory	86
Licensed ORs needed at 1,872 cases/year	36.4	Licensed ORs needed at 1,872 cases/year	0.1	Licensed ORs needed at 1,872 cases/year	26.8	Licensed ORs needed at 1,872 cases/year	10.2	Licensed ORs needed at 1,872 cases/year	73.4
Surplus/Deficit (-)	**1.6**	**Surplus/Deficit (-)**	**2.9**	**Surplus/Deficit (-)**	**5.2**	**Surplus/Deficit (-)**	**2.8**	**Surplus/Deficit (-)**	**12.6**

Souce: 2010 LRA

**Excludes one trauma and one burn OR*

***Excludes two C-Section ORs*

Table 9: **Forsyth County OR Utilization and OR Need FFY 2008 Data - 2010 SMFP - Combined System OR Surplus**

NCBH + PSCNC		FMC + MPH		Total	
Inpatient Cases	13,357	Inpatient Cases	11,446	Inpatient Cases	24,803
Weighted Inpatient Cases at 3 hrs/case	40,071	Weighted Inpatient Cases at 3 hrs/case	34,338	Weighted Inpatient Cases at 3 hrs/case	74,409
Ambulatory Cases	18,841	Ambulatory Cases	23,207	Ambulatory Cases	42,048
Weighted Ambulatory Cases at 1.5 hrs/case	28,262	Weighted Ambulatory Cases at 1.5 hrs/case	34,811	Weighted Ambulatory Cases at 1.5 hrs/case	63,072
Total Weighted Hours	68,333	Total Weighted Hours	69,149	Total Weighted Hours	137,481
OR Planning Inventory*	41	OR Planning Inventory**	45	OR Planning Inventory	86
Licensed ORs needed at 1,872 cases/year	36.5	Licensed ORs needed at 1,872 cases/year	36.9	Licensed ORs needed at 1,872 cases/year	73.4
Surplus/Deficit (-)	**4.5**	**Surplus/Deficit (-)**	**8.1**	**Surplus/Deficit (-)**	**12.6**

Souce: 2010 LRA

**Excludes one trauma and one burn OR*

***Excludes two C-Section ORs*

Table 11: **Forsyth County OR Utilization and OR Need 2012 - 2010 SMFP**

NCBH		FSCNC		FMC		Medical Park		Total	
Inpatient Cases	14,256	Inpatient Cases	0	Inpatient Cases - C-Section	11,058	Inpatient Cases	1,158	Inpatient Cases	26,472
Weighted Inpatient Cases at 3 hrs/case	42,768	Weighted Inpatient Cases at 3 hrs/case	0	Weighted Inpatient Cases at 3 hrs/case	33,175	Weighted Inpatient Cases at 3 hrs/case	3,474	Weighted Inpatient Cases at 3 hrs/case	79,417
Ambulatory Cases	19,951	Ambulatory Cases	158	Ambulatory Cases	13,529	Ambulatory Cases	11,240	Ambulatory Cases	44,878
Weighted Ambulatory Cases at 1.5 hrs/case	29,927	Weighted Ambulatory Cases at 1.5 hrs/case	237	Weighted Ambulatory Cases at 1.5 hrs/case	20,294	Weighted Ambulatory Cases at 1.5 hrs/case	16,860	Weighted Ambulatory Cases at 1.5 hrs/case	67,317
Total Weighted Hours	72,694	Total Weighted Hours	237	Total Weighted Hours	53,469	Total Weighted Hours	20,334	Total Weighted Hours	146,733
OR Planning Inventory*	38	OR Planning Inventory	3	OR Planning Inventory**	32	OR Planning Inventory	13	OR Planning Inventory	86
Licensed ORs needed at 1,872 cases/year	38.8	Licensed ORs needed at 1,872 cases/year	0.1	Licensed ORs needed at 1,872 cases/year	28.6	Licensed ORs needed at 1,872 cases/year	10.9	Licensed ORs needed at 1,872 cases/year	78.4
Surplus/Deficit (-)	**-0.8**	**Surplus/Deficit (-)**	**2.9**	**Surplus/Deficit (-)**	**3.4**	**Surplus/Deficit (-)**	**2.1**	**Surplus/Deficit (-)**	**7.6**

Souce: 2010 LRA

**Excludes one trauma and one burn OR*

***Excludes two C-Section ORs*

Table 12: **Forsyth County OR Utilization and OR Need 2012 - 2010 SMFP - Combined System OR Surplus**

NCBH + FSCNC		FMC + MPH		Total	
Inpatient Cases	14,256	Inpatient Cases	12,216	Inpatient Cases	26,472
Weighted Inpatient Cases at 3 hrs/case	42,768	Weighted Inpatient Cases at 3 hrs/case	36,649	Weighted Inpatient Cases at 3 hrs/case	79,417
Ambulatory Cases	20,109	Ambulatory Cases	24,769	Ambulatory Cases	44,878
Weighted Ambulatory Cases at 1.5 hrs/case	30,163	Weighted Ambulatory Cases at 1.5 hrs/case	37,153	Weighted Ambulatory Cases at 1.5 hrs/case	67,317
Total Weighted Hours	72,931	Total Weighted Hours	73,802	Total Weighted Hours	146,733
OR Planning Inventory*	41	OR Planning Inventory**	45	OR Planning Inventory	86
Licensed ORs needed at 1,872 cases/year	39.0	Licensed ORs needed at 1,872 cases/year	39.4	Licensed ORs needed at 1,872 cases/year	78.4
Surplus/Deficit (-)	**2.0**	**Surplus/Deficit (-)**	**5.6**	**Surplus/Deficit (-)**	**7.6**

Souce: 2010 LRA

**Excludes one trauma and one burn OR*

***Excludes two C-Section ORs*

North Carolina Department of Health and Human Services
Division of Health Service Regulation
Certificate of Need Section
2704 Mail Service Center ▪ Raleigh, North Carolina 27699-2704

Beverly Eaves Perdue, Governor
Lanier M. Cansler, Secretary

www.ncdhhs.gov/dhsr

Lee Hoffman, Section Chief
Phone: 919-855-3873
Fax: 919-733-8139

June 15, 2009

S. Todd Hemphill
Bode, Call & Stroupe, LLP
3105 Glenwood Avenue, Suite 300
Raleigh, NC 27612

RE: Exempt from Review / Acquisition of Plastic Surgery Center of North Carolina, Inc. by Wake Forest University Health Sciences (WFUHS) / Forsyth County
FID # 953413

Dear Mr. Hemphill:

In response to your letter of May 22, 2009, the above referenced proposal is exempt from certificate of need review in accordance with N.C.G.S 131E-184(a)(8). Therefore, Wake Forest University Health Sciences (WFUHS) may proceed to acquire the above referenced health service facility without first obtaining a certificate of need. However, you need to contact the Acute and Home Care Licensure and Certification Section of the Division of Health Service Regulation to obtain instructions for changing ownership of the existing facility. Note that pursuant to N.C.G.S. §131E-181(b): "*A recipient of a certificate of need, or any person who may subsequently acquire, in any manner whatsoever permitted by law, the service for which that certificate of need was issued, is required to materially comply with the representations made in its application for that certificate of need.*"

It should be noted that this Agency's position is based solely on the facts represented by you and that any change in facts as represented would require further consideration by this Agency and a separate determination. If you have any questions concerning this matter, please feel free to contact this office.

Sincerely,

Gebrette Miles
Project Analyst

Lee B. Hoffman, Chief
Certificate of Need Section

cc: Acute and Home Care Licensure and Certification Section, DHSR

BODE, CALL & STROUPE, L.L.P.
ATTORNEYS AT LAW
3105 GLENWOOD AVENUE, SUITE 300
RALEIGH, NORTH CAROLINA 27612

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JOHN V. HUNTER III
RETIRED

MAILING ADDRESS
POST OFFICE BOX 6338
RALEIGH, NORTH CAROLINA
27628-6338

May 22, 2009

Received by the
CON Section

22 MAY 2009 09:01

Via Hand Delivery
Lee B. Hoffman, Chief
Gebrette Miles, Project Analyst
Certificate of Need Section
Division of Facility Services
701 Barbour Drive
Raleigh, North Carolina 27603

Re: Plastic Surgery Center of North Carolina, Inc. Ambulatory Surgical Facility / Acquisition by Wake Forest University Health Sciences /Winston-Salem, Forsyth County, North Carolina

Dear Ms. Hoffman and Ms. Miles:

This letter is submitted on behalf of our client, Wake Forest University Health Sciences ("WFUHS"). WFUHS intends to acquire from Plastic Surgery Center of North Carolina, Inc. ("PSCNC"), the ambulatory surgical facility, as that term is defined in G.S. §131E-176(1b), owned by PSCNC (hereinafter, the "Facility"). When the transaction is completed, PSCNC will have no interest in the Facility, and WFUHS will have no interest in PSCNC.

The Facility is located in the lower level of the medical building located at 2901 Maplewood Avenue, Winston-Salem, Forsyth County, North Carolina, and consists of three (3) ambulatory surgery operating rooms and support space, as identified in the 2009 SMFP. The parties have entered into a Purchase Agreement, which provides that the purchase is contingent upon our client obtaining confirmation from the CON Section that it does not need to obtain a certificate of need to acquire the Facility.

The medical office building in which PSCNC is located is owned by John Paul & Associates, LLC ("JPA"). PSCNC leases its space from JPA. WFUHS will enter into a new lease with JPA for the space which constitutes the Facility. WFUHS will not lease any other space in the building and will have no interest in JPA.

By this letter, we are providing notice to the CON Section, pursuant to G.S. §131E-184(a) of this transaction. Because this project involves the acquisition of an interest in an existing health service facility, we believe the acquisition of the Facility is exempt from CON review pursuant to G.S. §131E-184(a)(8). We would appreciate your office reviewing this information and advising us that our analysis is correct and that this acquisition is not subject to CON review.

The parties intend to close on this transaction by no later than the end of June, 2009, so your prompt attention to this request would be very much appreciated. Should you have any questions, please do not hesitate to contact me.

Very truly yours,

BODE, CALL & STROUPE, L.L.P.

S. Todd Hemphill

STH:sh
cc: Brian McGinn

EXHIBIT G TO NOVANT HEALTH'S PETITION TO THE SHCC REGARDING POLICY AC-3

Table 6A: Operating Room Inventory (Combined Data for Hospitals and Ambulatory Surgical Facilities)

Case Data for 10/01/07 through 9/30/08 as reported on the 2009 Hospital and Ambulatory Surgical Facility License Renewal Applications.

Counties with one facility shown first, followed by counties with more than one facility.

Lic #	Facility Name	County	Inpatient Cases (Dedicated C-Section OR Cases Excluded)	Ambulatory Cases	Inpatient ORs	Ambulatory ORs	Shared ORs	Excluded C-Section ORs	Excluded Trauma/Burn ORs	CON Adjustments	CON Adjustments for Dedicated C-Section OR
H0015	Duke University Hospital	Durham	16,166	19,055	4	9	32	0	-1	4	0
	(In addition to a CON Adjustment for 4 ORs, Duke University Hospital has a CON for 16 additional ORs under Policy AC-3. These 16 ORs are not counted when determining OR need.)										
H0233	Durham Regional Hospital	Durham	4,276	3,238	3	0	12	-2	0	0	0
AS0041	James E. Davis Ambulatory Surgical Center	Durham	0	5,299	0	8	0	0	0	0	0
H0075	North Carolina Specialty Hospital	Durham	1,276	5,600	0	0	4	0	0	0	0
		Durham Total	21,718	33,192	7	17	48	-2	-1	4	0
H0209	Forsyth Medical Center	Forsyth	10,361	12,676	5	6	19	-2	0	10	0
H0229	Medical Park Hospital	Forsyth	1,085	10,531	0	0	13	0	0	-6	0
H0011	North Carolina Baptist Hospitals	Forsyth	13,251	17,999	4	0	36	0	-2	0	0
AS0021	Plastic Surgery Center Of North Carolina	Forsyth	0	411	0	3	0	0	0	0	0
		Forsyth Total	24,697	41,617	9	9	68	-2	-2	4	0
H0261	Franklin Regional Medical Center	Franklin	923	1,422	0	0	3	0	0	0	0
	2009 Franklin SMFP Need Determination	Franklin	0	0	0	0	0	0	0	1	
		Franklin Total	923	1,422	0	0	3	0	0	1	0
AS0037	CaroMont Specialty Surgery	Gaston	0	4,073	0	6	0	0	0	0	0
H0105	Gaston Memorial Hospital	Gaston	4,055	10,160	5	8	9	-4	0	0	0
		Gaston Total	4,055	14,233	5	14	9	-4	0	0	0
AS0015	Carolina Birth Center	Guilford	0	545	0	1	0	0	0	0	0
AS0009	HEALTHSOUTH Greensboro Specialty Surgical Center	Guilford	0	1,888	0	3	0	0	0	0	0
AS0018	HEALTHSOUTH Surgical Center of Greensboro	Guilford	0	13,984	0	13	0	0	0	0	0
H0052	High Point Regional Health System	Guilford	3,621	3,935	3	0	9	-1	0	-1	0
AS0047	High Point Surgery Center	Guilford	0	4,888	0	6	0	0	0	0	0
H0073	Kindred Hospital - Greensboro	Guilford	929	46	0	0	1	0	0	0	0
H0159	Moses Cone Health System	Guilford	13,723	20,083	4	13	37	0	-1	-2	0
	Triad Neurosurgery	Guilford	0	0	0	0	0	0	0	2	0
AS0063	Piedmont Surgical Center	Guilford	0	1,012	0	2	0	0	0	0	0
	Premier Surgery Center	Guilford	0	0	0	0	0	0	0	2	0
AS0033	Surgical Eye Center	Guilford	0	3,019	0	4	0	0	0	0	0
		Guilford Total	18,273	49,400	7	42	47	-1	-1	1	0

OR = Operating Room

Table 6A: Operating Room Inventory (Combined Data for Hospitals and Ambulatory Surgical Facilities)

Case Data for 10/01/07 through 9/30/08 as reported on the 2009 Hospital and Ambulatory Surgical Facility License Renewal Applications.

Counties with one facility shown first, followed by counties with more than one facility.

Lic #	Facility Name	County	Inpatient Cases (Dedicated C-Section OR Cases Excluded)	Ambulatory Cases	Inpatient ORs	Ambulatory ORs	Shared ORs	Excluded C-Section ORs	Excluded Trauma/Burn ORs	CON Adjustments	CON Adjustments for Dedicated C-Section OR
H0153	Wilkes Regional Medical Center	Wilkes	1,005	1,933	1	0	4	-1	0	0	0
AS0046	Wilkes Regional Medical Center Ambulatory Surgery Facility	Wilkes	0	442	0	1	0	0	0	0	0
		Wilkes Total	1,005	2,375	1	1	4	-1	0	0	0
AS0005	Eastern Regional Surgical Center (X HealthSouth Surgecenter of Wilson)	Wilson	0	1,320	0	4	0	0	0	0	0
H0210	Wilson Medical Center	Wilson	1,759	3,184	1	0	9	-1	0	0	0
AS0007	Wilson OB-GYN	Wilson	0	450	0	1	0	0	0	0	0
		Wilson Total	1,759	4,954	1	5	9	-1	0	0	0
		Grand Total	267,187	657,748	155	284	861	-84	-11	51	9

Underutilized Facilities:

Excluded from Need Determinations

Lic #	Facility Name	County
H0002	Pungo District Hospital Corporation	Beaufort
AS0062	Cleveland Ambulatory Services	Cleveland
AS0021	Plastic Surgery Center Of North Carolina	Forsyth
AS0050	Iredell Surgical Center	Iredell
H0193	Highlands-Cashiers Hospital	Macon
AS0098	Same Day Surgery Center at Ballantyne	Mecklenburg
AS0010	Chapel Hill Surgical Center	Orange
H0069	Swain County Hospital	Swain
AS0034	Raleigh Plastic Surgery Center	Wake
AS0048	Southern Eye Associates Ophthalmic Surgery Center	Wake
H0160	Blowing Rock Hospital	Watauga
AS0005	Eastern Regional Surgical Center (X HealthSouth Surgecenter of Wilson)	Wilson
AS0007	Wilson OB-GYN	Wilson

OR = Operating Room

Table 6B: Projected Operating Room Need for 2012

A	M	N	O	P	Q	R	S	T	U
Operating Room Service Areas (Multi-County Groupings and Single Counties. Multi-County Groupings First, Followed by Single Counties.)	*Number of Inpatient Operating Rooms*	*Number of Ambulatory Operating Rooms*	*Number of Shared Operating Rooms*	*Excluded Dedicated C-Section Rooms*	*Exclusion of One Operating Room for each Level I and II Trauma Center and Burn Unit*	*Adjustments: CONs Issued, Settlement Agreements, Previous Need*	*Adjusted Planning Inventory*	*Projected Operating Room Deficit or Surplus (Surplus shows as a "-")*	*Projected Need for New Operating Rooms*
Alexander	0	0	2	0	0	0	2	-2.00	0
Alleghany	0	0	2	0	0	0	2	-1.76	0
Anson	0	0	2	0	0	0	2	-1.39	0
Ashe	0	0	2	0	0	0	2	-1.19	0
Avery	0	0	2	0	0	0	2	-1.54	0
Bertie	0	0	2	0	0	0	2	-1.29	0
Bladen	0	0	2	0	0	0	2	-1.21	0
Brunswick	1	0	5	-1	0	1	6	-0.36	0
Burke	1	2	9	-1	0	0	11	-2.59	0
Cabarrus	4	6	17	-2	0	0	25	-0.88	0
Caldwell	1	3	4	-1	0	0	7	-2.33	0
Carteret	1	2	5	-1	0	0	7	-0.98	0
Catawba	3	8	27	-1	0	0	37	-10.13	0
Chatham	0	0	2	0	0	0	2	-1.69	0
Cleveland	1	2	8	-1	0	0	10	-0.78	0
Columbus	1	0	4	-1	0	1	5	0.19	0
Dare	1	2	2	-1	0	0	4	-2.19	0
Davidson	1	0	9	-1	0	0	9	-2.23	0
Davie	0	0	2	0	0	0	2	-1.95	0
Duplin	0	0	3	0	0	0	3	-0.74	0
Durham	7	17	48	-2	-1	4	73	-4.98	0
Edgecombe	1	0	5	-1	0	0	5	-2.80	0
Forsyth	9	6	68	-2	-2	4	83	-5.52	0
Franklin	0	0	3	0	0	1	4	-1.19	0
Gaston	5	14	9	-4	0	0	24	-4.52	0
Granville	0	0	3	0	0	0	3	-0.46	0
Guilford	7	42	47	-1	-1	1	95	-21.20	0
Harnett	0	0	4	0	0	6	10	-5.15	0
Haywood	0	0	7	0	0	0	7	-3.18	0
Henderson	0	0	16	0	0	0	16	-1.87	0
Hertford	1	0	5	-1	0	0	5	-2.35	0
Iredell	3	3	22	-3	0	0	25	-5.37	0
Johnston	1	2	5	-1	0	1	8	-0.39	0
Lee	1	0	5	-1	0	2	7	-3.22	0
Lenoir	1	0	9	-1	0	0	9	-3.46	0
Lincoln	0	0	4	0	0	0	4	-1.17	0
Macon	1	0	4	-1	0	0	4	-2.44	0
Martin	0	0	2	0	0	0	2	-0.82	0
McDowell	1	0	3	-1	0	0	3	-0.77	0
Mecklenburg	23	41	99	-13	-1	0	149	-19.63	0
Mitchell	0	0	3	0	0	0	3	-1.74	0
Montgomery	0	0	2	0	0	0	2	-1.44	0
Nash	1	0	13	-1	0	0	13	-2.95	0
New Hanover	5	16	20	-3	-1	4	41	0.46	0
Onslow	1	4	5	-1	0	0	9	-4.04	0
Orange	6	4	29	-3	-2	4	38	-7.53	0
Pender	0	0	2	0	0	0	2	-1.62	0
Person	1	0	4	-1	0	0	4	-1.45	0
Polk	0	0	3	0	0	0	3	-1.68	0
Randolph	1	0	5	-1	0	2	7	-1.89	0
Richmond	1	0	6	-1	0	0	6	-2.49	0
Robeson	1	0	9	0	0	0	10	-2.66	0
Rockingham	1	0	9	-1	0	0	9	-3.26	0
Rowan	2	3	8	-2	0	0	11	-1.87	0
Rutherford	0	0	5	0	0	0	5	-0.91	0

EXHIBIT H TO NOVANT HEALTH'S PETITION TO THE SHCC REGARDING POLICY AC-3

Table 6A: Operating Room Inventory (Combined Data for Hospitals and Ambulatory Surgical Facilities)

Case Data for 10/01/08 through 9/30/09 as reported on the 2010 Hospital and Ambulatory Surgical Facility License Renewal Applications.

Counties with one facility shown first, followed by counties with more than one facility.

Lic #	Facility Name	County	Inpatient Cases (Dedicated C-Section OR Cases Excluded)	Ambulatory Cases	Inpatient ORs	Ambulatory ORs	Shared ORs	Excluded C-Section ORs	Excluded Trauma/Burn ORs	CON Adjustments	CON Adjustments for Dedicated C-Section OR
		Cleveland Total	2,220	7,810	1	6	8	-1	0	0	0
H0213	Cape Fear Valley Medical Center	Cumberland	6,509	5,804	5	0	13	-3	0	1	0
AS0006	Fayetteville Ambulatory Surgery Center	Cumberland	0	14,210	0	11	0	0	0	0	0
H0275	Highsmith-Rainey Memorial Hospital	Cumberland	72	2,511	0	0	4	0	0	0	0
		Cumberland Total	6,581	22,525	5	11	17	-3	0	1	0
AS0053	RMS Surgery Center	Dare	0	559	0	2	0	0	0	0	0
H0273	The Outer Banks Hospital	Dare	243	917	1	0	2	-1	0	0	0
		Dare Total	243	1,476	1	2	2	-1	0	0	0
H0027	Lexington Memorial Hospital	Davidson	837	2,565	0	0	4	0	0	0	0
H0112	Thomasville Medical Center	Davidson	555	2,861	1	0	5	-1	0	0	0
		Davidson Total	1,392	5,426	1	0	9	-1	0	0	0
H0015	Duke University Hospital	Durham	16,766	19,343	4	9	32	0	-1	4	0
	(In addition to a CON Adjustment for 4 ORs, Duke University Hospital has a CON for 16 additional ORs under Policy AC-3. These 16 ORs are not counted when determining OR need.)										
H0233	Durham Regional Hospital	Durham	4,149	3,234	3	0	12	-2	0	0	0
AS0041	James E. Davis Ambulatory Surgical Center	Durham	0	4,477	0	8	0	0	0	0	0
H0075	North Carolina Specialty Hospital	Durham	1,395	6,285	0	0	4	0	0	0	0
		Durham Total	22,310	33,339	7	17	48	-2	-1	4	0
H0209	Forsyth Medical Center	Forsyth	10,431	12,968	5	6	19	-2	0	10	0
H0229	Medical Park Hospital	Forsyth	844	10,523	0	0	13	0	0	-6	0
H0011	North Carolina Baptist Hospitals	Forsyth	13,357	18,693	4	0	36	0	-2	0	0
AS0021	Plastic Surgery Center Of North Carolina	Forsyth	0	148	0	3	0	0	0	0	0
		Forsyth Total	24,632	42,332	9	9	68	-2	-2	4	0
H0261	Franklin Regional Medical Center	Franklin	151	834	0	0	3	0	0	0	0
	Same Day Surgery Center Franklin	Franklin	0	0	0	0	0	0	0	1	0
		Franklin Total	151	834	0	0	3	0	0	1	0

OR = Operating Room

Table 6A: Operating Room Inventory (Combined Data for Hospitals and Ambulatory Surgical Facilities)

Case Data for 10/01/08 through 9/30/09 as reported on the 2010 Hospital and Ambulatory Surgical Facility License Renewal Applications.

Counties with one facility shown first, followed by counties with more than one facility.

Lic #	Facility Name	County	Inpatient Cases (Dedicated C-Section OR Cases Excluded)	Ambulatory Cases	Inpatient ORs	Ambulatory ORs	Shared ORs	Excluded C-Section ORs	Excluded Trauma/Burn ORs	CON Adjustments	CON Adjustments for Dedicated C-Section OR
AS0005	Eastern Regional Surgical Center (formerly HealthSouth Surgecenter of Wilson)	Wilson	0	1,453	0	4	0	0	0	0	0
H0210	Wilson Medical Center	Wilson	1,551	2,764	1	0	9	-1	0	0	0
AS0007	Wilson OB-GYN	Wilson	0	400	0	1	0	0	0	0	0
		Wilson Total	1,551	4,617	1	5	9	-1	0	0	0
		Grand Total	263,195	653,627	160	289	862	-89	-11	50	4

Underutilized Facilities:

Excluded from Need Determinations

H0002	Pungo District Hospital Corporation	Beaufort
AS0062	Cleveland Ambulatory Services	Cleveland
AS0053	RMS Surgery Center	Dare
AS0021	Plastic Surgery Center Of North Carolina	Forsyth
AS0050	Iredell Surgical Center	Iredell
H0034	Angel Medical Center	Macon
H0193	Highlands Cashiers Hospital	Macon
AS0010	Chapel Hill Surgical Center	Orange
H0069	Swain County Hospital	Swain
AS0034	Raleigh Plastic Surgery Center	Wake
AS0048	Southern Eye Associates Ophthalmic Surgery Center	Wake
H0160	Blowing Rock Hospital	Watauga
AS0046	Wilkes Regional Medical Center Ambulatory Surgery Facility	Wilkes
AS0005	Surgecenter of Wilson (X HealthSouth Surgecenter of Wilson)	Wilson
AS0007	Wilson OB-GYN	Wilson

OR = Operating Room

Table 6B: Projected Operating Room Need for 2013

A	M	N	O	P	Q	R	S	T	U
Operating Room Service Areas (Multi-County Groupings and Single Counties. Multi-County Groupings First, Followed by Single Counties.)	*Number of Inpatient Operating Rooms*	*Number of Ambulatory Operating Rooms*	*Number of Shared Operating Rooms*	*Excluded Dedicated C-Section Rooms*	*Exclusion of One Operating Room for each Level I and II Trauma Center and Burn Unit*	*Adjustments: CONs Issued, Settlement Agreements, Previous Need*	*Adjusted Planning Inventory*	*Projected Operating Room Deficit or Surplus (Surplus shows as a "-")*	*Projected Need for New Operating Rooms*
Alamance	2	3	9	-2	0	0	12	-2.45	0
Alexander	0	0	2	0	0	0	2	-2.00	0
Alleghany	0	0	2	0	0	0	2	-1.71	0
Anson	0	0	2	0	0	0	2	-1.53	0
Ashe	0	0	2	0	0	0	2	-1.22	0
Avery	0	0	2	0	0	0	2	-1.40	0
Bertie	0	0	2	0	0	0	2	-1.35	0
Bladen	0	0	2	0	0	0	2	-1.22	0
Brunswick	1	0	5	-1	0	1	6	-0.02	0
Burke	1	2	9	-1	0	0	11	-2.92	0
Cabarrus	4	6	17	-2	0	0	25	-2.27	0
Caldwell	1	3	4	-1	0	0	7	-2.27	0
Carteret	1	2	5	-1	0	0	7	-0.72	0
Catawba	3	8	27	-1	0	0	37	-9.73	0
Chatham	0	0	2	0	0	0	2	-1.68	0
Cleveland	1	2	8	-1	0	0	10	-1.30	0
Columbus	1	0	4	-1	0	1	5	-0.15	1
Dare	1	0	2	-1	0	0	2	-0.90	0
Davidson	1	0	9	-1	0	0	9	-2.13	0
Davie	0	0	2	0	0	0	2	-1.83	0
Duplin	0	0	3	0	0	0	3	-1.07	0
Durham	7	17	48	-2	-1	4	73	-5.36	0
Edgecombe	1	0	5	-1	0	0	5	-2.80	0
Forsyth	9	6	68	-2	-2	4	83	-4.95	0
Franklin	0	0	3	0	0	1	4	-3.02	0
Gaston	5	14	9	-4	0	0	24	-5.61	0
Granville	0	0	3	0	0	0	3	-0.33	0
Guilford	7	42	47	-1	-1	1	95	-26.49	0
Harnett	0	0	4	0	0	6	10	-5.20	0
Haywood	0	0	7	0	0	0	7	-2.07	0
Henderson	0	0	16	0	0	0	16	-2.47	0
Hertford	1	0	5	-1	0	0	5	-2.32	0
Iredell	3	3	22	-3	0	0	25	-6.74	0
Johnston	1	2	5	-1	0	1	8	-0.80	0
Lee	1	0	5	-1	0	2	7	-2.76	0
Lenoir	1	0	9	-1	0	0	9	-3.85	0
Lincoln	1	0	4	-1	0	0	4	-1.20	0
Macon	0	0	0	0	0	0	0	0.00	0
Martin	0	0	2	0	0	0	2	-0.71	0
McDowell	1	0	3	-1	0	0	3	-1.03	0
Mecklenburg	23	44	99	-13	-1	-3	149	-23.31	0
Mitchell	0	0	3	0	0	0	3	-1.76	0
Montgomery	0	0	2	0	0	0	2	-1.83	0
Nash	1	0	13	-1	0	0	13	-3.15	0
New Hanover	5	16	20	-3	-1	4	41	-1.04	0
Onslow	1	4	5	-1	0	0	9	-3.46	0
Orange	6	4	29	-3	-2	4	38	-6.75	0
Pender	0	0	2	0	0	0	2	-1.58	0
Polk	0	0	3	0	0	0	3	-1.84	0
Randolph	1	0	5	-1	0	2	7	-2.42	0
Richmond	1	0	6	-1	0	0	6	-3.50	0
Robeson	1	0	9	0	0	0	10	-2.82	0
Rockingham	1	0	9	-1	0	0	9	-4.14	0
Rowan	2	3	8	-2	0	0	11	0.89	1
Rutherford	0	0	5	0	0	0	5	-0.86	0

EXHIBIT I TO NOVANT HEALTH'S PETITION TO THE SHCC REGARDING POLICY AC-3

Table 6A: Operating Room Inventory (Combined Data for Hospitals and Ambulatory Surgical Facilities)

(Case Data for 10/01/06 through 9/30/07 as reported on the 2008 Hospital and Ambulatory Surgical Facility License Renewal Applications)

Facility Name	County	Inpatient Cases (Dedicated C-Section OR Cases Excluded)	Ambulatory Cases	Inpatient Rooms	Ambulatory Rooms	Shared Rooms	Excluded C-Section Rooms	Excluded Trauma/Burn Rooms	Adjustments for CON Non Dedicated C-Section OR	Adjustments for CON Dedicated C-Section OR
Eastern Regional Surgical Center (X HealthSouth Surgecenter of Wilson)	Wilson	0	882	0	4	0	0	0	0	0
Wilson Medical Center	Wilson	2,075	3,464	1	0	9	-1	0	0	0
Wilson OB-GYN	Wilson	0	413	0	1	0	0	0	0	0
	Wilson Total	2,075	4,759	1	5	9	-1	0	0	0
Hoots Memorial Hospital	Yadkin	2	252	0	0	2	0	0	0	0
	Yadkin Total	2	252	0	0	2	0	0	0	0
	Grand Total	267,754	634,399	151	281	863	-82	-11	51	10

Underutilized Facilities - Excluded from Need Determinations

Facility	County
Pungo District Hospital Corporation	Beaufort
Cleveland Ambulatory Services	Cleveland
Plastic Surgery Center Of North Carolina	Forsyth
Piedmont Surgical Center	Guilford
Iredell Surgical Center	Iredell
Highlands-Cashiers Hospital	Macon
Carolina Center for Specialty Surgery	Mecklenburg
Chapel Hill Surgical Center	Orange
Swain County Hospital	Swain
Raleigh Plastic Surgery Center	Wake
Southern Eye Associates Ophthalmic Surgery	Wake
Blowing Rock Hospital	Watauga
Eastern Regional Surgical Center	Wilson

EXHIBIT J TO NOVANT HEALTH'S PETITION TO THE SHCC REGARDING POLICY AC-3

Table 6A: Operating Room Inventory (Combined Data for Hospitals and Ambulatory Surgical Facilities)

(Case Data for 10/01/05 through 9/30/06 as reported on the 2007 Hospital and Ambulatory Surgical Facility License Renewal Applications)

Facility Name	County	Inpt.- C-Sec.	Amb. Cases	Inpat. Rms.	Amb. Rms.	Shared Rms.	Exclu. C-Sec.	Exclu. Tra/Bur	Adj.CON
Murphy Medical Center, Inc.	Cherokee	358	1,873	0	0	4	0	0	0
Chowan Hospital	Chowan	614	1,117	0	0	3	0	0	0
Cleveland Ambulatory Services *	Cleveland		1,745		4				0
Cleveland Regional Medical Center	Cleveland	2,295	3,691	1	0	6	-1	-1	0
Eye Surgery Center of Shelby	Cleveland		1,711		2				0
Kings Mountain Hospital	Cleveland	271	1,212	0	0	2	0		0
Totals for:	**Cleveland**	**2,566**	**8,359**	**1**	**6**	**8**	**-1**	**-1**	**0**
Columbus Regional Healthcare System	Columbus	1,510	3,527	1	0	4	-1	0	0
Columbus Regional Same Day Surgery, LLC	Columbus		0		0				1
Totals for:	**Columbus**	**1,510**	**3,527**	**1**	**0**	**4**	**-1**	**0**	**1**
Craven Regional Medical Center	Craven	3,669	9,527	3	6	9	-1	0	0
Cape Fear Valley Medical Center	Cumberland	7,252	7,040	5	0	13	-3	0	0
Fayetteville Ambulatory Surgery Center	Cumberland		10,372		11				0
Highsmith-Rainey Memorial Hospital	Cumberland	171	2,895	0	0	4	0	0	0
2006 SMFP Need Determination	Cumberland								1
Totals for:	**Cumberland**	**7,423**	**20,307**	**5**	**11**	**17**	**-3**	**0**	**1**
RMS Surgery Center	Dare		2,308		2				0
The Outer Banks Hospital, Inc.	Dare	284	720	1	0	2	-1	0	0
Totals for:	**Dare**	**284**	**3,028**	**1**	**2**	**2**	**-1**	**0**	**0**
Lexington Memorial Hospital	Davidson	1,010	2,620	0	0	4	0	0	0
Thomasville Medical Center	Davidson	792	2,350	1	0	5	-1	0	0
Totals for:	**Davidson**	**1,802**	**4,970**	**1**	**0**	**9**	**-1**	**0**	**0**
Davie County Hospital	Davie	8	62	0	0	2	0	0	0
Duplin General Hospital, Inc.	Duplin	728	1,319	0	0	3	0	0	0
Duke University Hospital	Durham	15,281	18,216	4	8	33	0	-1	4
Durham Regional Hospital	Durham	4,619	3,546	3	0	12	-2	0	0
James E. Davis Ambulatory Surgical Center	Durham		7,575		8				0
North Carolina Specialty Hospital, LLC	Durham	810	4,557	0	0	4	0	0	0
Totals for:	**Durham**	**20,710**	**33,894**	**7**	**16**	**49**	**-2**	**-1**	**4**
Heritage Hospital	Edgecombe	664	1,441	1	0	5	-1	0	0
Forsyth Medical Center	Forsyth	10,153	6,109	5	2	19	-2	0	3
Hawthorne Surgical Center	Forsyth		6,933		4				2
Medical Park Hospital, Inc.	Forsyth	1,170	10,242	0	0	13	0	0	-1
North Carolina Baptist Hospitals, Inc.	Forsyth	11,900	15,842	4	0	36	0	-2	0
Plastic Surgery Center Of North Carolina, Inc. *	Forsyth		328		3				0
Totals for:	**Forsyth**	**23,223**	**39,454**	**9**	**9**	**68**	**-2**	**-2**	**4**

* Chronically underutilized facility; operating rooms in these facilities are excluded from Need Determination calculations.