PO Box 2568, Hickory NC 28603

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PETITION FOR ADJUSTMENT TO NEED DETERMINATION FOR ADDITIONAL ADULT CARE HOME BEDS IN HOKE COUNTY DUE TO COVID-19

ALG Senior LLC (the "Petitioner") hereby submits this petition (the "Petition") to adjust the need determination for adult care home ("ACH") beds in Hoke County in the 2022 State Medical Facilities Plan ("SMFP") due to the impact of the COVID-19 pandemic on the safety and quality, access, and value on ACH services.

Petitioner

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Statement of Requested Adjustment

Petitioner proposes that the need determination for ACH beds in Chapter 11 of the Proposed 2022 SMFP be adjusted to reflect a need determination for seventy (70) ACH beds in Hoke County due to impact of the COVID-19 pandemic.

Brief Statement of Reasons for Requested Adjustment

As set forth in the Proposed 2022 SMFP, ACH bed utilization statewide has declined substantially due to the COVID-19 pandemic. The negative impact of COVID-19 on ACH utilization statewide has essentially obliterated need determinations and deficiencies in the Proposed 2022 SMFP using current Agency methodology. This methodology was not designed to account for pandemic conditions in bed utilization. The majority of the census losses in long-term care settings may reasonably be expected to be temporary, even with the tragic deaths in the senior population and with some lasting changes to the senior housing market due to COVID-19.

Petitioner, a consultant for 85 ACH facilities throughout North Carolina, has continuous and updated access to ACH census data statewide. As a result, Petitioner can evaluate census and utilization trends of the communities it supports without having to wait for license renewal application ("LRA") data to become available for other ACH facilities. Utilizing data from 85 ACHs in North Carolina that had been operating for at least a year before March of 2020, Petitioner was able to calculate an overall portfolio total occupancy of 81% before the effects of COVID-19 heavily impacted bed utilization.

Overall portfolio census began to fall in April 2020 at a rate of between 0.2% and 3.7% per month, with the greatest sustained losses occurring between December 2020 and February 2021, as shown in the chart below:

Total Monthly Rate of Census Loss – April 2020 through June 2021 (85 ACH Facilities in North Carolina)

2020								
April	May	June	July	August	September	October	November	December
-1.3%	-1.1%	-1.0%	-1.5%	**-2.4%**	-1.9%	-1.2%	-1.0%	**-2.4%**

2021					
January	February	March	April	May	June
-3.7%	**-2.2%**	**-0.2%**	**-0.7%**	**-0.5%**	**-0.5%**

Petitioner notes that as of March 2021, the rate of census loss slowed considerably and has remained at only 0.5% during May and June of 2021. Petitioner and other industry experts expect that the trend of census loss will stop and reverse as we continue to make strides towards controlling COVID-19, vaccines are fully approved, and the pandemic subsides.

The wide-reaching negative effects of the COVID-19 pandemic on ACH providers and residents have been undeniable. However, much of this negative impact will likely be resolved as we move into a period during which effective vaccines are widely available, many existing residents and staff are vaccinated, transmission of COVID-19 is more localized, visitation and access to facilities are restored whenever possible, personal protective equipment (PPE) is widely available for use, and we better understand how to manage risks during localized outbreaks. Challenges remain, especially with the emergence of new strains of COVID-19, but the need for long-term care is not going away—especially as growth of our senior population continues. This is particularly true for affordable long-term care that is accessible to a wider range of the aging population.

COVID-19's Impact on the Safety and Quality of ACH Care

The COVID-19 pandemic has had a significant impact on the safety and quality of existing care, causing providers to have to rethink operations to improve infection control, care of residents, staffing, and also address the rapidly accelerating medicalization of assisted living.

When COVID-19 was first recognized in the United States, news of illness and death in congregate care settings spread quickly. Without a clear understanding of the virulence and transmission of this deadly novel coronavirus, access to immunizations and adequate PPE, long-term care providers struggled to contain the deadly illness.

Measures taken to keep residents and staff safe from COVID-19 included limiting contact of facility residents with outside visitors, enacting strict infection control procedures, implementing routine testing for residents and staff, utilizing screening tools designed to keep symptomatic staff out of facilities, and last but not least, undertaking a large scale campaign to immunize residents and staff. These important steps unfortunately also increased the isolation of residents, creating or exacerbating mental health challenges in residents, also demoralizing staff, families, and residents.

Additionally, as COVID-19 spread, most providers found it increasingly difficult to provide adequate staffing at facilities. ACH providers often had to create special COVID-19 treatment units when facing an outbreak. COVID-19 units typically had dedicated staff who could not work with healthy residents for days or weeks at a time. The need to fully staff multiple units increased the number of staff needed to meet regulatory minimums and, more importantly, to supply the actual needs of residents. It quickly became commonplace for care staff to need to work longer hours or to have to choose whether to work in COVID-19 units, potentially increasing risk of infection to those at home. Staff took on this responsibility while juggling child and family care needs, their own fears, financial impacts, supply shortages, and personal limitations from exposure to or illness from COVID-19. Over time, staffing challenges have persisted and new difficulties have arisen. Providers have found fewer individuals willing to work in healthcare jobs. The choice not to work has become increasingly feasible for some individuals due to the robust financial safety nets developed by the federal and state governments in response to COVID-19.

The effects of COVID-19 had broad negative impacts on the safety and quality of ACH care, created by supply chain disruptions reducing access to PPE and cleaning supplies, staffing shortages, stress and long hours suffered by remaining staff, and the health-compromising effects of resident isolation and pervasive fear. Tragically, COVID-19 has cost the lives of over half a million Americans, with as many as 40% of those deaths happening in long-term care settings (skilled nursing accounting for a large majority of that statistic).

Even as the hope that effective vaccines would be developed to protect people from COVID-19 became reality, supplies were limited, the rollout was fraught with logistical hurdles, and misinformation about the safety and efficacy of the vaccines has been pervasive. Now that supply of vaccines is surpassing demand, there has been a continuing lack of clarity about the ability of providers to “mandate” COVID-19 vaccination of residents and staff.

Some resident families responded to the fear, uncertainty, isolation, and risks posed by COVID-19 by pulling loved ones out of congregate care settings. Others delayed admission of their loved ones to ACHs. The decreasing census in turn created financial and operational issues impacting the value of and access to care.

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COVID-19 and the Impact on the Value of and Access to ACH Care

In most ACH settings, and especially those dedicated to providing affordable care, stable operations are achieved by having and maintaining good census at facilities. Losses of census to deaths, illness, and fear associated with COVID-19 has meant significant losses of revenue for ACH providers. Such revenue losses, if sustained for an undetermined period of time, may impact ACH providers' ability to provide affordable care and even to remain in business.

Many providers have had to make difficult choices as census has dropped. In some cases, rate increases have likely resulted, or will result, as providers aim to recover from the losses associated with COVID-19. Some facilities that went into COVID-19 in weak financial condition may struggle to recover and remain in business. We do not yet know the full impact of COVID-19 on ACH finances, but it is fair to assume that increasing costs and closed facilities will decrease the value of and access to ACH care over time.

Current Agency Need Determination Methodology Fails to Capture Actual Need for ACH Beds Now and in the Future

The SMFP need determination methodology, while instructive when utilization remains responsive to typical market pressures, was not designed to be responsive to catastrophic, temporary health crises like COVID-19. The methodology, due to its strong reliance on past utilization to determine future need, inadequately captures the impact of COVID-19 on utilization data when projecting need in the future. LRAs from 2022 (covering utilization from August 1, 2020 through July 31, 2021) and 2023 (August 1, 2021 through July 31, 2022) are likely to reflect utilization depressed by COVID-19. Given that there is a 5-year utilization look-back period included in the bed rate and need determinations, these temporarily depressed utilization numbers due to COVID-19 will likely be included in need calculations in SMFPs from 2022 (capturing the beginning of COVID-19's impact) through 2028, as shown by the chart below:

Projected Period of Impact of Depressed Utilization due to COVID-19 on Future Bed Rates and Need Determinations in the SMFP

2022 SMFP	2023 SMFP	2024 SMFP	2025 SMFP	2026 SMFP	2027 SMFP	2028 SMFP	
2016	2017	2018	2019	2020	2021	2022	Years of utilization included in bed rate and need determination calculation
2017	2018	2019	2020	2021	2022	2023	Years of utilization included in bed rate and need determination calculations **with** COVID-19-related depressed utilization
2018	2019	2020	2021	2022	2023	2024	
2019	2020	2021	2022	2023	2024	2025	
2020	2021	2022	2023	2024	2025	2026	

The impact of depressed utilization due to COVID-19 on the 2022 SMFP eliminated a 79-ACH bed deficit and an 80 ACH bed need determination that had been made for Hoke County in the 2021 SMFP for the year 2024. The calculations of bed deficits in the 2022 SMFP included

only about 3 months of utilization impacted by COVID-19. If three months of depressed utilization can eliminate an 80 ACH bed need determination, the effects of COVID-19 on the 2024, 2025, and 2026 SMFPs, when it is reasonable to expect that the entire impact of COVID-19 will be included in bed rates and need determinations, is likely obscure the actual growing need for ACH beds in Hoke County. The disastrous result of this aspect of current methodology will be tremendous unmet need for ACH beds in the future (i.e., a ballooning need for ACH beds all at once).

Petitioner has found that prospective residents of ACH settings and their families are become increasingly comfortable returning to congregate care settings. ACH bed utilization has not completely recovered from COVID-19's temporary depression as of June 2021, but census losses have slowed considerably, and Petitioner reasonably expects ACH census to recover to pre-COVID-19 levels within the next year.

Given the slowing losses of census and the likelihood of a return to utilization at pre-COVID-19 levels, Petitioner is concerned that unless corrections are made now that neutralize the impact of COVID-19 on need determinations for the future, the artificially depressed utilization, combined with the growth projected for senior populations, will create a critical shortage of ACH beds in the future. In short, COVID-19's effect on need determinations will likely last for years to come. Data from the low-utilization period caused by COVID-19 will contribute to an incorrect prediction that there is no need for ACH beds like we are already seeing in the Proposed 2022 SMFP.

Hoke County's Need for 70 ACH Beds

As will be illustrated more thoroughly in Attachment A, there is an actual need for 70 ACH beds in Hoke County that is not captured in the 2022 SMFP. This need can be illustrated by tying ACH bed need to projected growth in the senior population in Hoke County.

In addition to the impact of COVID-19, there are other factors likely depressing ACH bed utilization in Hoke County and pointing to actual bed need now and in the future. These factors include (1) regulatory issues at one of the two existing ACH facilities in Hoke County and (2) increasing demand for private beds (as opposed to roommate settings) due to the impact of COVID-19 and a desire to reduce risk of disease exposure.

1. There are currently two existing ACH facilities in Hoke County, both located in the city of Raeford[1]:

(i) *Open Arms Retirement Center* – HAL-047-014; 90 ACH beds (22 SCU); originally licensed in 2001. This facility changed ownership in 2019 and has experienced growing census since that time, even making small gains during the impact of

[1] There are also 8 ACH beds licensed at a skilled nursing facility in Hoke County, *Autumn Care of Raeford*.

COVID-19. *Open Arms Retirement Center* was apparently not serving residents during 2018, as SMFP utilization data for 2018 shows a total of 75 ACH residents, and there was no LRA data available for that year.

(ii) *Wickshire Creeks Crossing* – HAL-047-015; 75 ACH beds (0 SCU); f/k/a *The Crossings at Wayside* – HAL-047-011; originally licensed in 2015. This facility lost census at a greater rate than COVID-19 alone was likely to cause based on the Petitioner's COVID-19 data trends. The facility experienced a 16% loss of census, while COVID-19 is believed to have caused a loss of around 5% on average for the same period. Census losses at *Wickshire Creeks Crossing* were likely exacerbated by regulatory issues, as reflected by the facility's 0 star rating for the dates covered by the 2021 LRA period.

The census losses at *Wickshire Creeks Crossing* mean that county-wide, the actual loss of ACH bed days in Hoke County between 2020 and 2021 LRAs is the equivalent of just 10 ACH beds. The 2020 LRAs for Hoke County showed a total of 50,991 ACH bed days utilized. The 2021 LRAs for Hoke County showed a total of 47,368 ACH bed days utilized, which is a reduction of 3,623 bed days from the number in the 2020 LRAs (50,991 - 47,368 = 3,623). To calculate an ACH bed equivalency, the difference between the two years of 3,623 is divided by 365 (3,623 / 365 = 9.93). 9.93 rounded to a whole number is 10, making 10 the approximate number of ACH beds that were no longer utilized as of the 2021 LRAs.

The 70 ACH bed need determination adjustment proposed by Petitioner accounts for this loss. That said, correction of the regulatory problems at *Wickshire Creeks Crossing* would likely also increase ACH bed utilization in the future in Hoke County. Interestingly, the combination of COVID-19 and regulatory problems meant a significant loss of private payors from *Wickshire Creeks Crossing*, resulting in approximately a 24% reduction in private payor utilization in the facility's 2020 LRA. The rate of change is calculated by subtracting the number of private payor bed days for 2021 from the number of private payor bed days for 2020, and dividing the difference by the 2021 value (16,265 - 21,480 = -5,214; -5,214 / 21,480 = -0.2428). Then the quotient is multiplied by 100 to obtain the percentage (0.2428 x 100 = 24.28%, which rounds to 24%). Private payor residents are more likely to be able to afford other options, such as home-based care, when ACH placements become undesirable. COVID-19 and regulatory issues certainly contribute to making ACH placements undesirable. However, there are advantages of ACH placements to both residents and families that mean that much of the census loss due to both of these factors can be expected to reverse in future.

2. Petitioners expect growing and sustained demand for private rooms in future due to COVID-19. Residents and their families are likely to feel that the resident is safer from transmission of communicable diseases like COVID-19 without a roommate. To the extent that either of the existing Hoke County facilities have multiple ACH beds in a single room, the desirability of those rooms is likely to decrease. To compensate for reduced demand for semi-private rooms, the facilities may choose to fill only one bed per room, decreasing the number of licensed ACH beds actually available to the public (despite the number of licensed beds remaining the same). These beds that are only available "on paper" may further contribute to deceptively low utilization statistics, which will potentially further obscure actual ACH bed need, as determined by the current methodology.

The need determination of 80 ACH beds for Hoke County in the 2021 SMFP far more accurately captures the need for ACH beds in Hoke County than does the application of the current methodology to recent year utilization statistics as illustrated by the Proposed 2022 SMFP.

Alternatives Considered

Petitioner considered the possibility of (1) a smaller need adjustment and (2) no need adjustment.

1. Smaller Need Determination Adjustment

Petitioner dismissed the possibility of a smaller need adjustment for three primary reasons.

i. A need determination of fewer than 60 to 70 ACH beds would negatively impact the operational efficiency and revenue generation that a provider is likely to need to develop a standalone ACH facility. In other words, newly developed standalone ACH facilities smaller than 60 ACH beds may struggle to meet performance, operational, and financial metrics that justify their development. Given that the need determined in 2021 was for 80 ACH beds, Petitioner is proposing a need of 70, which is the high end of the ideal range for a newly developed ACH facility.

ii. It is unlikely that providers will apply for fewer beds to expand existing buildings, given (1) the very high cost to bring an entire wing or facility up to current code, (2) the current inflated costs of materials and labor, and (3) the current lower census numbers that are unlikely to meet the required threshold of utilization to add ACH beds to an existing facility (i.e., the 85% performance standard under current CON regulations).

iii. Developing any number of ACH beds as part of a combination skilled nursing facility in Hoke County is also not possible at this time due to the 51-skilled nursing bed surplus projected for Hoke County in the 2022 SMFP. Unless the need for skilled nursing beds is also adjusted, no combination facility may be developed

2. No Need Determination Adjustment

Petitioner dismissed the possibility of not adjusting the need because to do so would be to ignore the real need for ACH beds that is not captured by the current methodology in Hoke County. To ignore this need would have the catastrophic long-term effect of creating a ballooning need in the future for Hoke County that providers will not be able (or perhaps even willing) to meet timely. If corrections to the need determination for Hoke County are not made now, then in the future when bed rates and need determinations catch up to actual need (perhaps in the 2029 SMFP, as shown above), Hoke County will likely be only one of many ACH service areas with a substantial unmet need. Unfortunately, Hoke County is likely to continue to have unmet need, because this ballooning need will not be limited to Hoke County. Providers have limited resources, which means that providers will not likely develop ACH beds in multiple ACH service areas at once. Moreover, it is likely that providers will pick the ACH bed service areas in the most lucrative markets or closest to large population centers, to the detriment of more rural counties in North Carolina. This means that markets like Hoke, which have had need determinations that no providers have applied to fill in the past, are likely to again lose out to the more desirable ACH service areas. Not only would the need determination proposed for Hoke County meet the actual need in Hoke County, but it would also allow a provider that successfully applies to develop the beds to stagger development of new properties, allowing for resources to be freed up so that additional ACH beds can be developed in the future in different service areas.

PO Box 2568, Hickory NC 28603

400 2nd Avenue NW, Hickory, NC 28601

Attachment A

The planning inventory of 173 ACH beds for Hoke County has remained consistent from the 2021 SMFP to the Proposed 2022 SMFP, as shown by the table below.

Table 11A: Inventory of Adult Care Home (Assisted Living) Beds - Hoke County – 2021 SMFP and Proposed 2022 SMFP

Facility Name	License Number	Licensed Beds in Nursing Homes	Licensed Beds in Hospitals	Licensed Beds in Adult Care Facilities	Total Licensed Beds	CON Approved/ License Pending		Available in SMFP	Total Planning Inventory
						CON	CON Bed Transfer		
Autumn Care of Raeford	NH0438	8	0	0	8	0		0	8
Open Arms Retirement Center	HAL-047-014	0	0	90	90	0		0	90
The Crossings at Wayside	HAL-047-011	0	0	75	75	0		0	75
2021 SMFP - Hoke Totals		**8**	**0**	**165**	**173**	**0**	**0**	**0**	**173**
Autumn Care of Raeford	NH0438	8	0	0	8	0		0	8
Open Arms Retirement Center	HAL-047-014	0	0	90	90	0		0	90
Wickshire Creeks Crossing	HAL-047-015	0	0	75	75	0		0	75
Proposed 2022 SMFP - Hoke Totals		**8**	**0**	**165**	**173**	**0**	**0**	**0**	**173**

The bed rate, however, dropped precipitously from 4.1130 to 2.5468.

Table 11B: Hoke County Rate Calculations for Adult Care Home (Assisted Living) Bed Need Determination 2021 SMFP and Proposed 2022 SMFP

SMFP	Patients					Populations					Rates					Actual Average Annual Change Rate	Selected Change Rate (County or Adjusted County)	Bed Rate per 1,000
2021	2015	2016	2017	2018	2019	2015	2016	2017	2018	2019	2015	2016	2017	2018	2019			
	99	124	128	74	144	51,568	52,833	53,343	54,923	54,842	1.9198	2.3470	2.3996	1.3473	2.6257	0.1888	0.1888	4.1130
2022	2016	2017	2018	2019	2020	2016	2017	2018	2019	2020	2016	2017	2018	2019	2020			
	124	128	74	144	125	52,833	53,343	54,923	54,842	54,682	2.3470	2.3996	1.3473	2.6257	2.2859	0.1008	0.0380	2.5468

Hoke County's senior population accounts for the vast majority of all ACH beds used in ACH facilities in Hoke County, according to historical LRA data.

Historical ACH Bed Utilization in Hoke County in ACH Facilities, by Age

	18-64	**65-74**	**75-84**	**85+**	Total
2021 LRAs	4	29	39	46	**118**
2020 LRAs	4	39	36	58	**137**
2019 LRAs	1	19	21	26	**67**
Total	**9**	**87**	**96**	**130**	**322**
Percentage of Total	***2.8%***	***27.0%***	***29.8%***	***40.4%***	***100.0%***

65+	**97.2%**	75+	**70.2%**	85+	**40.37%**

Hoke County's senior population is expected to grow tremendously in the coming years. In fact, Hoke County ranks in the top 15% (and sometimes higher) of all North Carolina counties when looking at the growth as a percentage change in the senior population, as shown by the below statistics from the North Carolina Office of State Budget and Management ("OSBM"):

2010-2050 Population Growth Percentage - Ages 65+		
Net change	Percentage Change Age 65+	Percentage Change ALL Ages
8,183	**231.9%**	**35.2%**
Only 6 NC Counties are projected to have a greater percentage of growth in the 65+ population between 2010 and 2050 per the OSBM: (Chatham, 262.5%; Brunswick 281.3%; Mecklenburg, 306.8%; Union, 307.5%; Johnston, 310.6%; Wake, 367.1%)		

2010-2050 Population Growth Percentage - Ages 75+		
Net change	Percentage Change Ages 75+	Percentage Change ALL Ages
3,682	**265.7%**	**35.2%**
Only 11 NC counties are projected to have a greater percentage of growth in the 75+ population between 2010 and 2050 per the OSBM: (Cabarrus, 288.0%; Lincoln, 298.3%; Franklin, 319.1%; Orange, 322.6%; Currituck, 323.1%; Mecklenburg, 362.3%; Chatham, 367.8%; Johnston, 425.1%; Wake, 485.5%; Brunswick, 487.0%; Union, 499.0%)		

2020-2040 Population Growth Percentage - Ages 65+		
Net change	Percentage Change Ages 65+	Percentage Change ALL Ages
3,749	**66.7%**	**11.8%**
Only 12 NC counties are projected to have a greater percentage of growth in the 65+ population between 2020 and 2040, per the OSBM: (Iredell, 71.0%; Granville, 71.3%; Durham, 72.5%; Lincoln, 75.0%; Franklin, 75.3%; Chatham, 78.3%; Currituck, 79.8%; Cabarrus, 90.6%; Mecklenburg, 100.2%; Johnston, 106.0%; Wake, 118.4%; Union, 120.4%)		

2020-2040 Population Growth Percentage - Ages 75+		
Net change	Percentage Change Ages 75+	Percentage Change ALL Ages
2,448	**126.4%**	**11.8%**
Only 12 NC counties are projected to have a greater percentage of growth in the 65+ population between 2020 and 2040, per the OSBM: (Chatham,129.5%; Brunswick,129.5%; Franklin,129.8%; Durham,130.1%; Currituck,142.1%; Johnston,152.8%; Orange,155.5%; Mecklenburg,160.5%; Union,166.8%; Wake,190.3%)		

As demonstrated above, current Agency methodology fails to capture actual ACH bed need due to COVID-19 and other factors temporarily and artificially depressing ACH bed utilization. In order to illustrate the actual need in a simple, straightforward way, Petitioner has calculated projected bed need based on the senior population of individuals aged 65+, which account for 97.2% of the ACH bed usage in Hoke County for the past 3 years, and of individuals aged 75+, which account for 70.2% of actual ACH bed usage in Hoke County over the same period.

Using SMFP utilization data from the Proposed 2022 SMFP and OSBM population data, Petitioner calculated an average rate of bed utilization by age category for the 5 years considered by the 2022 SMFP. Data for 2018 was excluded from the calculation because of the lack of utilization data for *Open Arms Retirement Center*. With a sample size of two, the lack of data for more than half of all licensed beds in Hoke County would skew the average unreasonably.

	2016	**2017**	**2018**	**2019**	**2020**	**Average**
Residents (2022 SMFP data)	124	128	74	144	125	
Population (2022 SMFP data)	52,833	53,343	54,923	54,842	54,682	
Population 65+ (OSBM)	4,694	4,952	5,184	5,415	5,623	
Population 75+ (OSBM)	1,681	1,773	1,839	1,889	1,937	
1 bed per No. of 65+ (pop. / residents)	37.85	38.69	70.05	37.60	44.98	**39.78**
1 bed per No. of 75+ (pop. / residents)	13.56	13.85	24.85	13.12	15.50	**14.01**
			Excluded			

The average yields an approximate ratio of ACH beds to population segment. So, for instance, the ratio of ACH beds to individuals 65+ in the population is 1:39.78, which is to say that

PO Box 2568, Hickory NC 28603

400 2nd Avenue NW, Hickory, NC 28601

for every 39.78 seniors 65 and older, 1 ACH bed was used on average for the years 2016 through 2020 in Hoke County (adjusted to correct for the data irregularity in 2018). Using the ratio, it is then possible to calculate the approximate number of beds that would have been required if utilization had not been negatively impacted by COVID-19 and utilization remained at a relatively steady rate into the future.

Petitioner utilized OSBM population projections for the years in the table below, and calculated the corrected bed utilization, which points to corrected bed need. In this way, it is possible to see that by 2025, which is the year for which the Proposed 2022 SMFP has projected no deficit and no need in Hoke County, there is likely to be a deficit of 6 ACH beds.

This deficit calculation does not take into account any difference between the number of licensed beds and those that are actually available to the public. That is, the Petitioner's deficit calculation does not take into account the fact that some licensed beds in Hoke County, while available on paper as part of the SMFP inventory, are not being used at facilities (i.e., using semi-private rooms as private rooms, or otherwise unavailable). As a result, Petitioner's deficit number should be taken as a minimum deficit pointing to a bare minimum need in Hoke County. The actual need for ACH beds in Hoke County is likely to be greater.

By 2028, as shown in the table below, if there is no correction to the 2022 SMFP to allow for a need determination of ACH beds in Hoke County, the minimum deficit will likely have reached 66 beds.

SMFP Year Governing	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030
Need Determined for This Year	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**	**2027**	**2028**	**2029**	**2030**	**2031**	**2032**	**2033**
Projected Pop. 75+	2,001	2,120	2,270	2,391	2,504	2,630	2,760	2,909	3,046	3,190	3,343	3,494	3,633
1 bed per 14.01 of 75+	143	151	162	171	179	188	197	208	217	228	239	249	259
"Existing" beds, with no new development	173	173	173	173	173	173	173	173	173	173	173	173	173
Surplus or Deficit - 75+	30	22	11	2	-6	-15	-24	-35	-44	-55	-66	-76	-86

Current methodology likely to show no need during these SMFP years

These calendar years correspond to 2023 to 2025 SMFP years. No need will have been calculated, so there should be no new development.

PO Box 2568, Hickory NC 28603

400 2nd Avenue NW, Hickory, NC 28601

Given that beginning with the 2022 SMFP there are likely to be actual ACH bed deficits obscured by utilization data depressed by COVID-19, the best opportunity to recognize and meet the growing need for ACH beds in Hoke County is now. Utilization statistics during COVID-19's impact cannot be used to capture the real need for ACH beds in Hoke County. As the Petition demonstrates, not only will the granting of the Petition not create unnecessary duplication of ACH beds, but it would prevent Hoke County from suffering the deleterious effects into the future of relying exclusively on a methodology that relies heavily on utilization and obscures real need for ACH beds.