COMMENTS SUBMITTED BY PARK RIDGE HEALTH REGARDING PROJECT I.D. NO. B-8790-12

MISSION GI SOUTH RELOCATION OF ONE GI ENDOSCOPY ROOM

In accordance with N.C. Gen. Stat. § 131E-185, Park Ridge Health (Park Ridge) submits these comments in opposition to Mission Hospital, Inc.'s (Mission) March 15, 2012 CON application that proposes to locate one GI endoscopy room from Mission's campus in Asheville to a location on the border of Buncombe and Henderson Counties, about four miles from Park Ridge's front door. As these written comments demonstrate, the application fails to comply with numerous CON criteria. The application should be denied.

I. OVERVIEW

This is Mission's second time applying for a CON for this project. In March 2011, Mission filed the first version of this application. On August 26, 2011, the CON Section denied the application and on September 2, 2011, the CON Section issued a well-reasoned set of findings to support its decision. The CON Section correctly found Mission's application non-conforming with Criteria 3, 4, 5, 6, 12 and 18a. A copy of the CON Section's findings on the first application is attached as Exhibit A. Some highlights:

The number of GI endoscopy procedures has remained relatively flat not just at Mission Hospital, but for surrounding providers as well. In fact, the total number of procedures at the five GI endoscopy providers in Buncombe and Henderson counties has remained relatively flat or declined from FFY 2008 to FFY 2010. According to data in the 2009 to 2011 SMFPs, a total of 32,490 procedures were performed in Buncombe and Henderson counties in FFY 2008 and a total of 31,600 procedures were performed in FFY 2010. From FFY 2008 to FFY 2010, the CAGR in total procedures performed in Buncombe and Henderson Counties was -1.38%.

Findings, page 31.

Conversely, utilization in Henderson County has decreased, as the number of cases and procedures has decreased by 21.9% and 10.9%, respectively, over the same time period. In fact, the number of procedures performed per room in Henderson County's six GI endoscopy rooms in FFY 2010 – 1,362 procedures per room i—is well below the threshold in The

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Criteria and Standards for Gastrointestinal Endoscopy Procedure Rooms in Licensed Health Service Facilities (10A NCAC 14C .3900) that requires a licensed GI endoscopy room to perform a minimum of 1,500 procedures per room (By contrast, the number of procedures performed per room in Buncombe County's 11 GI endoscopy rooms in FFY 2010 was 2,130 procedures per room).

Findings, page 32.

Furthermore, while the applicant's utilization methodology assumes a -0.2% growth rate in the number of procedures through the project years, the growth in procedures in Henderson County has declined by 10.9% over the past two years. The applicant proposes to locate the proposed Mission GI South campus on the Buncombe/Henderson County line, where countywide, (Henderson County) GI endoscopy utilization is decreasing more rapidly than utilization in Buncombe County. Additionally the six GI endoscopy rooms in Henderson County are in relatively close proximity to the proposed Mission GI South campus - Park Ridge Hospital is approximately 5.15 miles¹; Carolina Mountain Gastroenterology Endoscopy Center is approximately 11.70 miles; and Margaret R. Pardee Memorial Hospital is approximately 11.80 miles. As can be seen in the previous table, Park Ridge Hospital (the facility in closest proximity to the proposed Mission GI South campus) performed the fewest number of GI endoscopy cases and procedures of the three Henderson County GI endoscopy providers. Park Ridge Hospital performed just 676 procedures per room in FFY 2010 well below the threshold in The Criteria and Standards for Gastrointestinal Endoscopy Procedure Rooms in Licensed Health Service Facilities (10A NCAC 14C .3900) that requires a licensed GI endoscopy room to perform a minimum of 1,500 procedures per room. Thus, there is existing capacity for additional GI endoscopy procedures in the Mission GI South service area. The applicant does not adequately demonstrate the need to locate of its six existing GI endoscopy rooms on the Buncombe/Henderson County line (literally).

Findings, pages 32 and 33.

¹ Google maps calculates the distance as 4.4 miles. See Exhibit B.

Mission appealed the denial of the first application. Park Ridge and another Henderson County endoscopy provider, Carolina Mountain, were allowed to intervene to support the Agency's decision. Mission briefly engaged in discovery, and when it became clear that the Agency stood behind its decision, Mission dropped the case. Mission soon thereafter refiled the application. Copies of the Agency's depositions from the appeal of the denial of the first application is attached as Exhibits C-E.

Given this history, the key question the Agency must ask is: has anything changed since 2011 that would warrant a different decision this time around?

The answer is no. The project has not changed. The location has not changed. The service area has not changed. Park Ridge is still about 4 miles from Mission's location. And Park Ridge's endoscopy room is still underutilized. Copies of Park Ridge's Hospital License Renewal Applications (LRA) from 2007 to 2012 are attached as Exhibits F-K.

The following chart depicts the combined number of inpatient and outpatient GI endoscopy cases performed at Park Ridge during the last several years:

Federal Fiscal Year	Number of GI Endo Cases
2006 (2007 LRA)	901
2007 (2008 LRA)	885
2008 (2009 LRA)	762
2009 (2010 LRA)	649
2010 (2011 LRA)	676
2011 (2012 LRA)	608

This represents a loss of 293 cases in a six year time period.

The number of GI endoscopy procedures at Park Ridge has also declined sharply:

Federal Fiscal Year	Number of GI Endo Procedures
2006	901
2007	935
2008	970
2009	826
2010	861
2011	774

See LRAs 2007-2009; see also Table 13 of Exhibit 16 of Application

As reflected on Table 13, Exhibit 16 of the Application, between 2008 and 2011, the number of GI endoscopy procedures at Pardee Hospital declined by 1,531.

Park Ridge has attached the comments it filed in 2011 as Exhibit L because those comments are as relevant today as they were in 2011. Park Ridge and other area providers are still harmed by this project, which is nothing more than an attempt to weaken smaller providers not associated with Mission. See Affidavits of Jimm Bunch and Carl Stamm, M.D. attached as Exhibits M and N. These affidavits were submitted in connection with the litigation over the first application, and they outline the substantial prejudice that Park Ridge and Carolina Mountain would suffer as a result of Mission's project.

There has, however, been one important development since the time of the last application which reinforces the correctness of the Agency's decision on the first application and would support an Agency decision to deny the second application. Since September 2011, the House Select Committee on the Certificate of Need Process and Related Hospital Issues has been studying, among other things, Mission's Certificate of Public Advantage (COPA). The COPA is an agreement between Mission and the State of North Carolina whereby Mission must agree to operate with certain conditions. The agreement resulted from Mission's takeover of its closest competitor, St. Joseph's Hospital, in 1995. This combination eliminated any competition for non-governmental, acute care hospital services in Buncombe County. The purpose of the COPA is to protect the citizens of Western North Carolina from Mission taking unfair advantage of its market dominance.

A copy of the Committee's draft report, which was distributed on April 19, 2012, is attached as <u>Exhibit O</u>. In the section entitled Findings and Recommendations, the Committee reports:

The Committee finds that in order to effectuate the purpose of a certificate of public advantage, which is to foster improvements in the quality health care services, moderate health care costs, and improve access to health care services in underserved areas, regulatory and judicial oversight of such agreements are necessary to ensure that the benefits of cooperative agreements outweigh the disadvantages and reduction in competition resulting from such agreements.

Exhibit O, page 13. This finding relates directly to Criterion 18a of the CON Law which requires the Agency to consider competition. When the Agency fails to consider competition, it commits legal error. See Exhibit P (order of Administrative Law Judge Beecher R. Gray granting partial summary judgment to petitioner because of the Agency's failure to consider competition).

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As the report also details, the Committee conducted a public hearing that took place in Fletcher in October 2011. The Committee heard from representatives of both Mission and Park Ridge, but even more important, it heard directly from area residents with no ties to either institution. These residents very clearly expressed their concern about Mission's existing monopoly in Buncombe County and its growing dominance throughout Western North Carolina. See Exhibit Q. At this hearing, the public heard Mission's then-Director of Marketing and Web Services refer to Mission as a "monopoly" and a "500 pound gorilla." See Exhibit R; see also YouTube video at http://www.youtube.com/watch?v=jV06W-xkUdc.

This application is a prime example of Mission acting like a 500 pound gorilla. Mission's status as a monopoly in Buncombe County is relevant to the CON consideration of the application because of Criterion 18a in the CON Law, which requires the Agency to consider competition. Criterion 18a therefore requires the Agency to consider both the procompetitive and anti-competitive aspects of a project.

This particular project offers nothing procompetitive, such as innovative services, increased access to healthcare, lower prices or higher quality. Rather, this project is anticompetitive because all it does is place an unnecessary endoscopy room on the border of Henderson County with the clear and obvious goal of taking patients away from the underutilized Henderson County providers. Two of the three Henderson County providers, Park Ridge and Carolina Mountain, are speaking out against this project; the third provider, Pardee Hospital, is in a joint venture with Mission concerning the very building which is planned to house the relocated endoscopy room, so it is obviously not in Pardee's economic interest to say anything against this endoscopy project. See Exhibit S. Yet Pardee's own declining endoscopy numbers (a loss of nearly 1,000 patients between FFY 2009-2011, and a loss of 1,531 procedures from FY 2008-FY 2011) speak volumes about the lack of need for Mission's project.²

As Park Ridge has said before in connection with this project, just because assets *can* be moved does not mean they *should* be moved. The provider seeking to move assets *must* demonstrate the need for the project in accordance with the CON Law. Mission has failed to do that, for the second time.

The CON Section must apply the law. When the law is applied, it is evident that this project cannot be approved and that this application must be denied, for the second time.

² Page 73 of the application and Mission's Exhibit table reference a letter of support from Pardee but no such letter is contained in Park Ridge's copy of the application.

II. THE APPLICATION FAILS TO SATISFY CRITERION 3.

Criterion 3 of the CON Law has both a qualitative and a quantitative component. Mission has demonstrated neither the qualitative need nor the quantitative need for its project. The first application was found nonconforming with Criterion 3, and the second application should also be found nonconforming with Criterion 3.

A. Qualitative factors do not demonstrate need.

In Section 3.1(a) of the application, Mission discusses the following qualitative factors in support of the need for the project:

- Prevalence of Gastrointestinal disorder;
- Importance of early detection of colorectal cancer;
- Patient Protection and Affordable Care Act of 2010 (PPACA);
- Mission GI South proposed service area;
- Additional rationale for site location;
- Utilization of Existing GI endoscopy resources;
- GI endoscopy use rates; and
- Population growth in Buncombe and Henderson Counties.

Most of these factors were recycled from first application, and none of these factors supports Mission's case for moving an endoscopy room approximately four miles away from a provider whose endoscopy utilization is declining.

While no one seriously challenges the prevalence of gastrointestinal disorder and the importance of early detection of colorectal cancer, these factors must be viewed in the context of the existing GI endoscopy resources in the area. The fact remains that there is significant endoscopy room capacity in Buncombe and Henderson Counties. Park Ridge and Pardee are particularly underutilized. See page 26 of the application. The CON Section should pay particular attention to Henderson County because part of the property Mission is using for this project is physically located in Henderson County. See Exhibit 28 to the application, pages 480-82.

As far as PPACA is concerned, Mission provides no statistical information to show how PPACA (if it survives Supreme Court challenge) will impact utilization of endoscopy resources in Buncombe and Henderson Counties. Even Medicare's coverage for colorectal cancer screening colonoscopies (effective January 1, 2011) had no impact on Park Ridge's endoscopy cases, which went down FFY 2010 v. FFY 2011. The same phenomenon occurred at Pardee, which saw a loss of 1,059 procedures between FFY 2010 and FFY 2011. See page 26 of the application.

With respect to its service area, Mission states on page 21 of the application that its proposed facility will be "proximate to three of the fastest growing zip codes in Henderson

County." Park Ridge is already located proximate to these zip codes, and its endoscopy utilization has declined, as has Pardee's. Further, Mission does not explain how many patients who now travel from these zip codes to Mission for endoscopy would be inclined to use Mission GI South. Mission provided no letters of support from patients, and the letter from the Asheville Gastroenterology Associates (AGA) physician, Dr. Garrett, which is found in Exhibit 10, is almost word-for-word identical to the AGA letter submitted in the first version, with two notable differences: (1) AGA has lost one gastroenterologist since 2011; and (2) only Dr. Garrett signed the letter this time, while last year, he and three of his partners signed the letter. As was the case with the 2011 letter, Dr. Garrett does not quantify the number of patients who would be likely to go to Mission GI South or the number of cases he or any of his partners would be likely to perform at Mission GI South. Thus, the AGA letter is not helpful to assess the need for this project.

The AGA letter is curious for three other reasons: (1) AGA owns its own five-room endoscopy center, called The Endoscopy Center, so it is questionable that it would perform many cases at a facility that could, at least in theory, cannibalize volume from The Endoscopy Center; (2) the number of patients seen at The Endoscopy Center has declined by 262 patients over the last two years; and (3) the number of procedures performed at The Endoscopy Center declined by 568 procedures in the last two years. *See* application, pages 26 and 339. The CON Section cannot assume that Dr. Garrett or any of the AGA doctors will perform any cases at Mission GI South.

Mission provides a travel time analysis on pages 21 and 22 of the application, but this information is not relevant because outpatient endoscopy is a non-emergent, scheduled procedure. There is no evidence in the application that any patient has had difficulty accessing outpatient endoscopy, nor is there any evidence in the application to establish that placing an endoscopy facility four miles from Park Ridge's front door would cause more people to have endoscopy procedures. Mission alludes to parking hassles and walking distances on its campus. But Mission offers valet parking so parking hassles and walking distances do not support the need to locate one of Mission's six endoscopy rooms offsite. *See* Mission's website, which states:

Valet Parking Service

Valet parking is available at the Patient/Outpatient Entrance on the Memorial Campus for a \$4 service charge. Our helpful valet attendants are available to assist guests between the hours of 7:00 a.m. and 5:00 p.m., Monday through Friday. Cars can be retrieved after 5:00 p.m. by calling the number provided on the claim. Expectant mothers and mothers with children visiting Women's Servcies [sic] can use valet services free of charge.

https://www.missionhospitals.org/body.cfm?id=2133. There is also a shuttle service. See https://www.missionhospitals.org/ShuttleService.

Moreover, to the extent that parking and walking distances play a role in a patient's choice of endoscopy provider, all three of the Henderson County providers have free surface parking. Park Ridge and Pardee also offer free valet services. The Endoscopy Center also offers free surface parking. Parking and walking distances are no impediment to endoscopy in this region.

Mission spends several pages discussing the growth in the area, including the fact the Town of Fletcher is "next to the busiest Ingles Supermarket in the region," but fails to draw any connection between this growth (which has been going on for some time) and the need for Mission GI South. The growth is nothing new, and yet endoscopy utilization in Henderson County declined by 853 procedures between FY 2008 and FY 2011, according to page 26 of Mission's application.

In its discussion of utilization of existing endoscopy resources in Buncombe and Henderson Counties, Mission fails to acknowledge the decline in cases and procedures at The Endoscopy Center. Instead, Mission adds its volume to that of The Endoscopy Center to show a modest increase in Buncombe County of 278 procedures between FY 2010 and FY 2011. Yet the fact remains that The Endoscopy Center is facing sharp volume decreases over the last two years, and overall, it procedure volume has grown by only 44 procedures since FY 2008. See page 26 of the application.

On page 27 of the application, in reference to the Henderson County providers, Mission states that "total volume has remained essentially flat, while volumes at Pardee Hospital and Park Ridge Hospital have decreased." Volumes have not remained flat – they have plummeted by 853 procedures between FY 2008 and FY 2011. See chart on page 26 of the application. The experience of these hospital based providers is especially relevant to Mission's project because Mission's project, although located on an outpatient campus, is proposed to be hospital based. See application, page 3.

While Mission saw an increase in volume in FY 2011 as compared to FY 2010, Mission is coming off two years of declining volume as compared to the "base year" of 2008. As shown on page 26 of the application, Mission's historical procedure volumes are as follows:

Fiscal Year	Procedures at Mission
2008	8,942
2009	8,535
2010	8,661
2011	9,290

One year of positive growth is not a trend. Further, in comparison to FY 2008, Mission's procedure volume in FY 2011 grew only very modestly (348 procedures). When allocated among the six endoscopy rooms at Mission, this is only 58 more procedures per room FY 2008 v. FY 2011.

Likewise, as reflected on page 35 of the application, Mission's number of cases has grown only very modestly:

Fiscal Year	Cases at Mission		
2008	7,064		
2009	6,741		
2010	6,563		
2011	7,073		

Thus, comparing FY 2008 to FY 2011, Mission has only added 9 cases. It is not reasonable to take a snapshot of 2010 and 2011 and suggest that there has been significant growth because one year is not a trend. Rather, the CON Section should look at utilization over a multi-year period. When the Agency does so, it is obvious that Mission's volumes are not growing.

Moreover, as shown on page 26, total procedure volume in Buncombe County is essentially flat. The difference in procedures between FY 2008 and FY 2011 is 392. When allocated among the eleven endoscopy rooms in Buncombe County, this is only 35.6 more procedures per room FY 2008 v. FY 2011.

Fiscal Year	Procedures in Buncombe County
2008	23,312
2009	23,517
2010	23,426
2011	23,704

These numbers are not indicative of an unmet need for endoscopy services in Fletcher.

Mission's discussion of endoscopy use rates on page 27 of the application shows declining use in Henderson County and no growth in Buncombe County. These facts do not support the need to relocate an endoscopy room to Fletcher.

Finally, with respect to population growth, Buncombe and Henderson Counties are projecting modest population growth overall and slightly higher population growth in the 55 and older age cohort. *See* application, pages 27-30. But Western North Carolina has always been a popular destination for retirees, and yet the endoscopy volumes in Henderson County have declined, and the outpatient endoscopy center in Asheville has lost significant volume. Again, Mission fails to reconcile these facts with its proposal to move an endoscopy room to a location about four miles from a severely underutilized endoscopy room that offers all of the "convenience" factors that Mission touts.

B. Quantitative factors do not demonstrate need.

In Section 3.1(b) of the application, the applicant is required to provide statistical data supporting the need for the project. Mission does not demonstrate the quantitative need for its

project because its utilization projections for the endoscopy room are unreliable and overstated and the patient origin projections are flawed and inaccurate.

As seen on page 35 of the application, Mission uses a short interval of historical GI endoscopy utilization between the years of 2008 and 2011 in order to contrive a positive growth rate for its methodology. Mission is mainly relying on a one-year increase in volume FY 2010 v. FY 2011 (see page 35 of the application, which states that "Mission decided to utilize fiscal year data from the 2012 Mission Hospital LRA as the base rate for projections..."). One year is not a trend, and is not an accurate base from which to measure future volume growth.

The historical data show that this positive growth rate is unreliable because Mission's longer term data for endoscopy from 2004-05 through 2010-11 more accurately shows declining utilization. The following table provides Mission's GI endoscopy utilization data showing the decline in the number of outpatient cases:

Mission Hospital	2004-05	2010-11	Change
Inpatient GI Endoscopy Cases	2,683	2,640	-1.60%
Ambulatory Endoscopy Cases	4,708	4,433	-5.84%
Total Cases	7,391	7,073	-4.30%

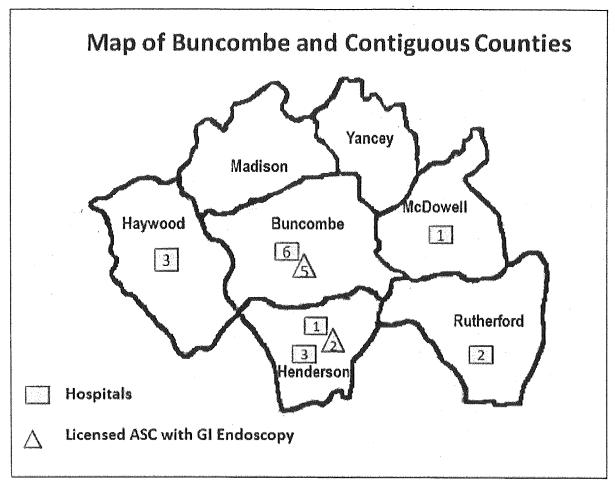
Sources: 2006 and 2012 Hospital License Renewal Applications

For the same period, the patient origin data demonstrates that fewer patients from Buncombe and Henderson Counties chose to obtain GI endoscopy at Mission. These statistics prove that decreasing numbers of patients from Buncombe and Henderson Counties obtain GI endoscopy performed at Mission.

Mission Hospital GI Endoscopy Cases	2004-05	2010-11	Change
Buncombe	4,601	3,951	-14.13%
Henderson	517	506	-2.13%

Sources: 2006 and 2012 Hospital License Renewal Applications

Patients from Buncombe and Henderson Counties have more abundant access to both hospital-based GI endoscopy procedure rooms and those in licensed ambulatory surgical facilities as compared to counties to the north contiguous to Buncombe. The following map shows the availability of GI endoscopy procedure rooms. There are no barriers to access at



The current geographic distribution of endoscopy procedure rooms allows convenient access for Buncombe and Henderson residents due to the concentration of 17 GI endoscopy procedure rooms at five licensed facilities. In contrast, Madison and Yancey Counties, both north of Buncombe, lack convenient access to endoscopy procedure rooms.

The following table also shows the comparable lack of access for residents of Madison and Yancey Counties as compared to the other counties in the region.

				-	2011 Population per	
			Licensed		Licensed GI	
			Endosopy	2011	Endoscopy	
County	Licensed Facilities	Facility Type	Rooms	Population	Procedure Room	
Buncombe	Mission Hospital / Asheville Surgery Center	Hospital	6	225 760	34 433	
Builcoilibe	The Endoscopy Center	GI ASC	5	235,768	21,433	
Haywood	Haywood Regional	Hospital	3	58,749	19,583	
•	Carolina Mountain GI Endoscopy Center	GI ASC	2		18,173	
Henderson	Pardee Hospital	Hospital	3	109,038		
	Park Ridge Health	Hospital	1	•		
Madison	No Facility	NA	0	21,115	NA NA	
McDowell	McDowel Hospital	Hospital	1	45,307	45,307	
Rutherford	Rutherford Hospital	Hospital	2	64,385	32,193	
Yancey	No Facility	NA	0	18,738	NA	
North Carolina	99 Hospitals and 67 ASC Endoscopy Centers		452	9,586,227	21,208	

Madison and Yancey Counties, with a combined population of nearly 40,000 persons, have sufficient demand to support one or more GI endoscopy procedure rooms. Clearly the proposed project does nothing to improve patient access for the Madison and Yancey populations as it proposes to take one room in Asheville and move it further away from Madison and Yancey Counties It must be noted that Buncombe, Madison and Yancey Counties are a multi-county service area for purposes of operating rooms and endoscopy rooms, so Mission does have the ability to relocate endoscopy rooms to Madison and Yancey Counties, where there are no existing endoscopy rooms. Yet, instead of reaching out to those communities, Mission is proposing to relocate an endoscopy room to a community that is surrounded by underutilized endoscopy resources. Thus, it is clear that the aim of Mission's project is to shift utilization away from the existing providers in Henderson County while ignoring the needs of patients in counties to the north where Mission has no competitors.

The application unreasonably forecasts to immediately begin performing 22 percent of its total hospital outpatient GI endoscopy procedures at Mission South GI even though the project relocates only 16.7 percent of its total endoscopy room capacity. This projection is unrealistic; page 9 of the application states that procedures will be performed only between 8 am and 3 pm, which limits access to fewer hours than procedure rooms at Mission Hospital's main campus.

Utilization projections for the project are inaccurate because the proposed single endoscopy procedure room would not support scheduling efficiency or high utilization for gastroenterologists because between each case the physician has to wait for the single procedure room to be cleaned and readied for the next patient. The American Gastroenterological Association advises:

Allow two procedure rooms per physician per session: to maximize physician time and the number of procedures that can be performed in a session, allowing the physician to move from ,

one room to another with no down time is critical. The patient should be prepped and ready for the procedure before the physician walks into the room. As soon as the procedure is finished, the physician should complete the procedure report and walk directly into the next room where the patient is waiting and ready for the next procedure. While the procedure is being performed, the first patient is taken from the procedure room into the recovery area, the scope is replaced, the room is cleaned and the next patient is brought into the procedure room. ³

See Exhibit T.

The historical utilization for Mission and The Endoscopy Center in Asheville has been performed with the availability of multiple GI endoscopy procedure rooms at each facility location to promote scheduling efficiency and physician productivity. No documentation is provided to explain how the one proposed GI procedure room at Mission GI South can safely perform 22 percent of the total outpatient volume of Mission.

Utilization projections for the single GI endoscopy room at Mission South GI are not substantiated by letters of support from gastroenterologists expressing their willingness to perform a specific numbers of procedures. The support letter from Asheville Gastroenterology Associates' CEO, John W. Garrett, MD, includes no estimates of the number of physicians that are committed to perform procedures in the proposed GI endoscopy room, or an estimate of procedures that these doctors would perform at Mission GI South. Asheville Gastroenterology Associates has offices in Asheville, Marion and Spruce Pine which means that all of these physicians would likely be driving greater distances to perform procedures at Mission GI South as compared to their current office locations. Therefore the overall productivity of any gastroenterologist will be diminished due to the time driving to and from Mission GI South. These physicians also have access to five of their own GI endo rooms. The applicant does not explain why the physicians would be willing to deprive their own practice of revenue (i.e., the facility fee) so that they could perform procedures at Mission GI South.

Patient origin projections are unreliable because, contrary to the applicant's projections, the actual <u>number of patients</u> from Henderson and Buncombe Counties that obtain GI endoscopy procedures at Mission has not increased.

³ www.gastro.org Maximizing Efficiency in Your ASC or Office Endoscopy Unit

						Increase or	Increase or
	Mission Hospital GI Endoscopy				(Decrease)	(Decrease).	
					Between LRA	Between LRA	
	Patient Origin				Periods	Periods	
,	2006 LRA	2008 LRA		2012 LRA		2006 to 2012	2008 and 2012
Buncombe	4601	4561		3951		-650	-610
Henderson	517	509		506	Ĕ,	-11	-3
Haywood	355	390		409		54	19
Madison	378	425	() () ()	363	iti ji	-15	-62
McDowell	323	351		362		39	11
Yancey	233	267		221		-12	-46
Translyvania	155	181		151		-4	-30
Mitchell	110	143		145		35	2
Macon	107	103		136		29	33
Jackson	102	111		127		25	16
Burke	84	120		116		32	-4
Cherokee	78	94		118		40	24
Swaim	60	65		79		19	14
Rutherford	36	73		95		59	22
Clay	31	11		24		-7	13
Graham	28	31		47		19	16
Polk	23	25		32		9	7
Avery	20	31		29		9	2
Catawba	13	13		8		-5	-5
Caldwell	11	21		16		5	-5
Other NC	39	47		38		-1	-9
Other States	117	122	C i.i. Sa i.i.	100		-17	-22
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The fact is that the number of patients who are having GI endoscopy is going down. This is true not just at Mission but also at Park Ridge, Pardee and The Endoscopy Center. For example, according to Park Ridge's 2010 LRA, 649 patients had endoscopy procedures at Park Ridge. That number rose modestly in the 2011 LRA to 676 patients, but then plummeted to 608 patients in the 2012 LRA. At Pardee, the number declined from 3,427 patients as reported in the 2010 LRA to 2,511 patients as reported in the 2011 LRA to 2,469 patients as reported in the 2012 LRA. This is a decline of 958 patients from FFY 2009-2011. According to its 2010 LRA, The Endoscopy Center served 11,129 patients, but that number declined to 10,980 patients in the 2011 LRA, and declined again to 10,867 patients in the 2012 LRA. This is a loss of 262 patients between FFY 209-2011. The applicant does not explain that it would be reasonable to expect these trends to reverse.

In the findings for the first version of the application, the Agency noted on page 31 that the number of endoscopy procedures in Buncombe and Henderson Counties FFY 2008 to FFY 2010. The 2012 LRAs report 31,329 procedures in the two counties for FFY 2011. Compared to FFY 2010, this is a decline of 271 procedures. The applicant does not explain how this trend will reverse itself.

Constructing a medical office building that straddles the county line between Buncombe and Henderson Counties could easily cause confusion for law enforcement, emergency services, and fire and rescue personnel. The Mission application fails to provide accurate distances and travel times to the <u>nearest emergency services</u> that would respond to emergencies at the facility. Furthermore, the application fails to explain whether an endoscopy patient experiencing a life threatening emergency should be transported seventeen miles back to Mission or to the nearest hospital emergency department at Park Ridge, approximately four miles away.

III. THE APPLICATION FAILS TO SATISFY CRITERION 3A.

This project proposes to move an endoscopy room from the campus of Mission, which is closer to Madison and Yancey Counties. These two counties have limited health care services and no endoscopy room. Instead of putting an endoscopy room in one of these two counties, or on the border of these two counties, to enhance access for these patients, Mission proposes to locate the endoscopy room at the border of Henderson County, which is saturated with excess endoscopy room capacity. Mission does not explain how the relocation will impact the residents of Madison and Yancey Counties, who are not likely to travel to southern Buncombe County to receive endoscopy services. Accordingly, the application should be found nonconforming with Criterion 3a.

IV. THE APPLICATION FAILS TO SATISFY CRITERION 4.

The first version of this application was found non-conforming with Criterion 4, and the second version should also be found non-conforming with Criterion 4.

The application fails to adequately demonstrate the need to relocate one of its six existing endoscopy procedure rooms to the Buncombe/Henderson County line. Thus, the applicant fails to demonstrate that it has chosen the least costly or most effective alternative, as required under Criterion 4. Based on the applicant's preliminary site plan in Exhibit 6, the parking lot, building entrance and common space that are required to access the proposed endoscopy room are located within Henderson County. See also Exhibit 28 to the application, which are the deeds to the property; one of the deeds was recorded in Henderson County. Exhibit 29 shows the county line slicing through the land and the MOB. Based on this configuration, the application fails to demonstrate that the proposed hospital-based endoscopy

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procedure room and all related space utilized by endoscopy patients will be entirely located within Buncombe County. Arguably, Mission is increasing endoscopy capacity in Henderson County, which was a problem identified in the first application. *See* Exhibit B, page 35.

Capital cost estimates for the proposed project are unreliable because the facility plans and allocation of space omit the patient registration area and a waiting area for the patients and family that will utilize the procedure room. Furthermore, as discussed in the comments related to Criterion 12, the application fails to adequately demonstrate that the proposed design is consistent with hospital licensure rules, construction standards and Medicare conditions of participation that require adequate separation from other building occupancies.

The application is not conforming to all applicable statutory and regulatory review criteria. *See* Criteria (1), (3), (5) and (6) and (12). Consequently the proposed project is also nonconforming to Criterion 4.

V. THE APPLICATION FAILS TO SATISFY CRITERION 5.

The first version of this application was found non-conforming with Criterion 5, and the second version should also be found non-conforming with Criterion 5.

The application fails to provide reasonable projections for capital costs:

According to the lease term sheet, Western North Carolina Healthcare Innovators LLC is committed to make tenant improvements for the endoscopy project. However, Western North Carolina Healthcare Innovators LLC is not listed as a CON co-applicant and the projected capital cost to be incurred by Western North Carolina Healthcare Innovators LLC is omitted.

Capital costs for the project are inaccurate because the facility plans fail to include the space needed for patient registration and patient waiting. As Ms. Frisone testified in the litigation involving the first version of this application: "Mission was required to include all costs which would make that space licensable as part of the hospital for the provision of GI endoscopy services." *See* Exhibit D, p. 117. This includes patient registration and patient waiting space.

The application provides inconsistent information for the projected payor percentages for outpatient GI endoscopy procedures to be performed at Mission South. Page 81 of the application provides the following information.

14. For the proposed project, provide the following information for the second year of operation following completion of the project. Provide all assumptions utilized in determining these figures.

ENDOSCOPY DEPARTMENT (10/1/1/1 PROJECTED CASES AS PERCENT OF TO	
Self Pay/Indigent/Charity	4.1%
Medicare / Medicare Managed Care	50.1%
Medicald	13.6%
Commercial Insurance	1.0%
Managed Care	27.8%
Other (Specify)*	3.4%
TOTAL	100.0%

^{*}Other includes Workers Comp & State Employee Benefit Health Plan

Form D on page 113 contains inconsistent payor percentages as compared to the above table:

Self Pay/Indigent/Charity	5.2%
Medicare/Medicare Managed Care	44.04%
Medicaid	9.79%
Commercial	0.71%
Managed Care	35.17%
NC State, Other, Workers	5.10%
Total	100.0%

The applicant fails to provide historical information or assumptions for payor percentages for the outpatient GI endoscopy procedures.

Revenue projections are inaccurate and overstated because the projected utilization is unreliable as discussed in the Criterion 3 comments.

Net revenue for this project is greatly overstated because the applicant unreasonably expects to receive ever increasing reimbursement. Page 116 of the application (incorrectly labeled as Form D) shows that by Year 3, Mission expects to be collecting 23 percent more revenue per case as compared to its 2011 reimbursement.

Projected 7	Γotal Reimbu	rsement per Case	YR 1	YR 2	YR 3
	10/01/10				10/01/2015
	to		10/01/13 to	10/01/2014	to
Form D	09/30/11	Intervening Years	9/30/14	to 9/30/15	9/30/2016
Total	1,870	Not shown	2,117.33	2,209.01	2,305.72
Percentage increase over 09/30/11 amount			13.2%	18.1%	23.3%

Operating expenses are inaccurate and understated because the anesthesia/conscious sedation staff and business office staff for the proposed project are omitted from the staffing tables and financial projections.

VI. THE APPLICATION FAILS TO SATISFY CRITERION 6.

The first version of this application was found non-conforming with Criterion 6, and the second version should also be found non-conforming with Criterion 6.

The applicant fails to demonstrate that the proposed project to be located on the Buncombe/Henderson County line would not unnecessarily duplicate existing GI endoscopy facilities.

Historical patient origin data demonstrates that fewer patients from Buncombe and Henderson Counties chose to obtain GI endoscopy at Mission.

Mission Hospital GI Endoscopy Cases	2004-05	2010-11	Change
Buncombe	4,601	3,951	-14.13%
Henderson	517	506	-2.13%

Sources: 2006 and 2012 Hospital License Renewal Applications

The proposed project is about four miles from Park Ridge (Henderson County) which has one underutilized GI endoscopy procedure room. During the previous year 608 endoscopy cases were performed at Park Ridge Hospital. Assuming at least one procedure per case, the endoscopy utilization at Park Ridge Hospital is far below the 1,500 annual procedures threshold as defined by 10A NCAC 14C.3900.

The proposed project is approximately 11.8 miles from Margaret R. Pardee Hospital and 11.7 miles from Carolina Mountain Gastroenterology Endoscopy Center. For the year ending September 20, 2011, endoscopy utilization in the 3 procedure rooms at Margaret R. Pardee Hospital totaled 3,031 procedures for an annual average of 1,010 procedures per room. Therefore these procedure rooms have available capacity. With underutilized GI procedure rooms at Park Ridge Hospital and Margaret R. Pardee Hospital, the proposed relocation of an endoscopy procedure room to the Buncombe/Henderson County line would unnecessarily duplicate existing GI endoscopy facilities.

VII. THE APPLICATION FAILS TO SATISFY CRITERION 7.

The scope of services table on page 7 of the Mission application is incomplete with four blanks as illustrated below:

Struica	: Facility Stati	Facility Paid Consultant/ Contractor	Contract Billed to: Patient	CONTRACTOR OF THE PROPERTY OF	Specify Dare Service Available
Pal	lent Care A	reas). One Relocat	ed Licensed	GI Endoscopy Room	4.00
Pre-Operative Services	. Х	N/A	N/A	RNs	10/1/2013
Procedural Area (Facility Component)	Х	N/A	N/A	RNs, Endoscopy Technician	10/1/2013
Procedural Area (Professional Component)		N/A	Х	Gastroenterologists, credentialed by Mission to practice at Mission GI South	10/1/2013
Post-Operative Area	Х	N/A	N/A	RNs	10/1/2013
Anesthesia/Conscious Sedation	х		BLANK	BLANK	10/1/2013
Business Functions (Phone Coverage, Insurance Verification, Scheduling, Charge Entry – Existing Mission staff)	×	N/A	N/A	BLANK	10/1/2013
Business Functions (Reception, Registration)		Х	N/A	BLANK	10/1/2013

The applicant is not permitted to amend the CON application by providing the omitted information to remedy this deficiency.

The proposed staffing for the project is shown on pages 82 and 83 of Section VII. Anesthesia/conscious sedation staff are also omitted from the staffing tables and financial projections for additional staff. However, the provision of anesthesia /conscious sedation is an essential clinical service that has been integral to the types of GI endoscopy procedures that have historically performed at the Mission campus. There is no evidence in the application explaining how this essential service will be provided at Mission GI South, *i.e.*, through CRNAs, the anesthesiology group that serves Mission, or someone else. A business office consultant position for reception and registration identified in the table on page 7 is omitted from the Section VII staffing tables on pages 82 and 83. No other staff positions for this function at Mission GI South re identified in the application.

Mission may try to explain away these discrepancies by stating that existing ancillary and support services and staff are in place to support the endoscopy service at the proposed new location. However, such an explanation is unsatisfactory because the CON application does not document that a specific number of staff are presently available to provide anesthesia / conscious sedation for GI endoscopy at Mission GI South and still provide sufficient coverage for the endoscopy procedure rooms at the main campus. Also, no information is provided in the application regarding the current availability of registration staff and a business consultant that are only partially described in the incomplete table on page 7.

VIII. THE APPLICATION FAILS TO SATISFY CRITERION 12.

The first version of this application was found non-conforming with Criterion 12, and the second version should also be found non-conforming with Criterion 12.

The application fails to provide sufficient plans to demonstrate that the proposed space conforms to the hospital licensure rules and construction standards for the provision of endoscopy procedures that involves conscious sedation and anesthesia. Specifically, the facility plans fail to adequately show how patients, family members and staff would be able to quickly exit the hospital-licensed portion of the medical office building in case of an emergency.

The endoscopy floor plans provided on page 190 of the application are deficient for multiple reasons:

- Omitted from the plan are the patient reception and registration and patient waiting areas that are specifically required for the patients obtaining hospital-based endoscopy service. The omissions of these spaces from the facility plans and the table on page 104 of the application cause the project construction costs and capital costs to be inaccurate and understated.
- Within the endoscopy suite there is one space labeled "ENDO PROC ROOM" that appears to be approximately 200 square feet. Immediately adjacent to this room is the mirror image space of approximately 200 square feet labeled "STORAGE" that is designed as a second endoscopy procedure room.
- The public areas and common areas of the medical office building that will be used by endoscopy patients and family have not been identified in the facility plans.
- Hospital licensure rules and CMS require that the endoscopy department have physical separation from other non-licensed space. The application contains no documentation of this.
- The application fails to demonstrate that the proposed hospital-based endoscopy procedure room and all related space utilized by endoscopy patients will be entirely located within Buncombe County.

Page 586 of the application provides the lease term sheet between the landlord, Western North Carolina Healthcare Innovators LLC and Mission Hospital, Inc. The lease term sheet contradicts the capital cost information on page 91 because some capital costs related to the endoscopy project will be the financial responsibility of Western North Carolina Healthcare Innovators LLC as follows:

"Landlord will perform tenant improvements based on the tenant's requirements."

"Landlord will provide a tenant an improvement allowance equal to 25% of the total cost of the premise improvements."

The landlord improvement allowance (equal to 25 percent of the total cost of the premise improvement) that is discussed in the term sheet contradicts the statement on page 90 B. b "Western North Carolina Healthcare Innovators LLC will not incur any capital expenditure associated with the development of the endoscopy suite."

Thus, this application appears to suffer from the same problem as the first application, i.e., the landlord appears to be incurring some expense related to a new institutional health service and therefore should have been included as a co-applicant.

Further, Mission has included in Exhibit 35 a request for exemption for the MOB in which the endoscopy room is proposed to be located. At her deposition in the litigation involving the first version of this application, Ms. Frisone testified:

- Q. If the medical office building itself is exempted from certificate of need review, then the developer would not need to be an applicant?
- A. The building is exempt to the extent that it doesn't include new institutional health services. And I guess I will go ahead and say this: Knowing what I know now, I question whether the exemption from review letter, which is based solely on this letter attached to it, whether we should have granted an exemption.

Exhibit D, pp. 120-121. See also page 121: "And what we're saying is, that the application, as submitted, contains insufficient information to assure ourselves that the developer is not incurring cost that would result in the offering of a new institutional health service."

Thus, a question remains whether the exemption for the MOB was properly granted, and whether the developer should have been a co-applicant. The second version of this application does not answer these questions.

Also not explained is why the applicant is increasing the square footage of the endoscopy suite by 1,100 square feet over the first version. Compare page 586 of the application to Exhibit U, which is the lease term sheet from the first version.

IX. THE APPLICATION FAILS TO CONFORM TO CRITERION 13C.

The application fails to conform to Criterion 13c due to inconsistent information regarding payor percentages and the omission of assumptions.

The Mission application provides inconsistent information regarding the payor percentages for the proposed project as shown in the following table:

Page 81.	v
Section VI	Page 115.
Response to	Financial Section
Question 14	Form D

Self Pay/Indigent/Charity	4.10%	5.20%
Medicare / Medicare Managed		
Care	50.10%	44.04%
Medicaid	13.60%	9.79%
Commercial Insurance	1.00%	0.71%
Managed Care	27.80%	35.17%
Workers Comp & State		
Employees	3.40%	5.10%
	100%	100%

No assumptions are provided for the payor percentages in Section VI of the application or in the financial information on pages 115 or page 117. Accordingly, the application should be found non-conforming with Criterion 13c.

X. THE APPLICATION FAILS TO SATISFY CRITERION 18A.

The first version of this application was found non-conforming with Criterion 18a, and the second version should also be found non-conforming with Criterion 18a.

Mission is an admitted monopolist in general acute care hospital services in Buncombe County. See Exhibit R. See also Exhibit V, which is Mission's market share report from its most recent COPA filing. It shows that Mission has a 90.5% market share in Buncombe County and a 28.2% market share in Henderson County.

Mission controls six of the eleven (55%) endoscopy rooms in Buncombe County. If the representations of Mission's application are to be believed, the owners of the only competing endoscopy service in Buncombe County, The Endoscopy Center, have capitulated to Mission's project, even though their own facility has suffered losses. Thus, Mission appears to have neutralized competition with The Endoscopy Center.

This project, which proposes to situate an endoscopy room on the border of Buncombe and Henderson Counties, seeks to expand Mission's dominance into Henderson County. Pardee, with its struggling endoscopy service, has capitulated and apparently supports Mission's project. *See also* page 64 of the application ("Together, Mission Hospital, The Endoscopy Center . . . and Pardee believe that this proposed solution is the best solution to meet future needs of the defined service area."). Thus, of the seventeen endoscopy rooms in Buncombe and Henderson Counties, Mission controls or has effectively neutralized competition with 14 of them, which equates to 82% of the total. The two independent providers of endoscopy, Park Ridge and Carolina Mountain, are squarely in Mission's line of fire.

On page 73 of the application, Mission provides the following discussion relative to Criterion 18a:

Throughout the planning process for the proposed project, Mission received input that additional outpatient services with better accessibility and ease of access were needed. In addition, the proposed project responds to market pressures to shift more and more services to outpatient settings. Therefore, the development of a new outpatient location which improves access to preventive care and early detection of disease responds to the needs of the community.

In addition, Mission has expanded and will continue to expand tertiary care services; as a result the main campus has become larger and more congested. Finding a parking place in one of Mission's parking decks and traversing the medical campus to outpatient admission can take an additional 20 minutes on average which negatively impacts patient satisfaction. The proposed Mission GI South location will allow parking that is much more accessible and user-friendly.

The proposed project is necessary to improve the delivery of outpatient GI endoscopy services by Mission to the population currently served by Mission. The proposed relocation of one licensed GI endoscopy room from the Mission Campus to Mission GI South will expand access and choice for residents of the rapidly growing population of southern Buncombe County who require outpatient GI endoscopy services and currently drive to the main Mission campus. Mission GI South in Southern Buncombe County will be desirable to healthcare consumers and physicians in the community because it will provide high quality patient care in a location that is convenient and easily accessible.

Application, page 73.

This answer is deficient for several reasons. First, and most obviously, it does not address competition at all. Second, there is no evidence in the application that accessibility, ease of access, parking or walking are issues in Buncombe or Henderson Counties regarding outpatient endoscopy services. Third, the notion that this project will expand choice for patients is false. This project is merely a reconfiguration of the monopolist's assets; the only "choice" the patient is being given is a choice where to receive *Mission's* services. This

project does not promote choice among providers in the broader sense. Park Ridge, which offers all of the conveniences Mission touts, is only four miles away and has plenty of endoscopy capacity. Fourth, there is no evidence in the application that allowing Mission to relocate an endoscopy room off campus to the border of Buncombe and Henderson Counties will improve quality or lower costs. Fifth, to the extent that this answer suggests that Mission will only serve "Mission's patients" the reader should not be mislead into thinking that Mission will not try to attract patients who might go to Park Ridge, Carolina Mountain, Pardee or The Endoscopy Center. The facility will be open to *all* endoscopy patients, and presumably, Mission will promote its services to *all* patients. There is no discrete class of "Mission patients." Mission presumably will not put up a sign on the door of the building warning those who are not "Mission patients" to stay away. Mission's choice of location, a mere four miles from Park Ridge, was not a coincidence.

As noted previously, the Agency is required to analyze Criterion 18a independently and to assess the impact of competition. See Exhibit P. The Agency correctly found the first version of the application nonconforming with Criterion 18a, and it should do so again with this second version. Apart from the deficiencies in the answer on page 73, the application fails to satisfy Criterion 18a because:

- Utilization projections for the project are unreasonable.
- Unreasonable utilization projections cause the financial projections to be incorrect.
- Financial projections are inaccurate due to the omission of anesthesia staff and business office positions.
- The applicant fails to demonstrate that it is reasonable to expect to achieve a 23 percent increase in reimbursement by the third year following completion of the project.
- The applicant, an admitted monopoly in its home county, is locating an endoscopy room about four miles from a smaller competitor in a county with significant declines in endoscopy volume.
- Mission's takeover of its closest competitor, St. Joseph's Hospital, in 1995 resulted in market dominance for hospital licensed services in Buncombe County including all six GI endoscopy procedure rooms under the combined hospital's license. The Endoscopy Center with five GI endoscopy procedure rooms is the only other provider in Buncombe County and has been providing outpatient services since 1991. In contrast to other counties of similar size, Buncombe County has few GI endoscopy providers:

County	# Licensed Hospitals with GI Endoscopy Procedure Rooms	# Licensed Ambulatory Surgical Facilities with GI Endoscopy
		Procedure Rooms
Buncombe	1	1
Cabarrus	1	2
Cumberland	2	3

Durham	2	1
Forsyth	2	4
Guilford	2	6
New	1	4
Hanover		

- With this comparative lack of competing facilities in Buncombe County, the proposed project to relocate an existing licensed GI endoscopy procedure room to Mission South is anti-competitive because the proposed project will not increase the number of licensed providers for endoscopy services within Buncombe County. Consequently the GI endoscopy market will still be divided between the same two licensed providers. Both the number of licensed GI endoscopy providers and the number of procedure rooms in Buncombe County will remain unchanged. Consequently the proposed project provides no competitive pressure for improved quality, no incentive to extend hours of operation, no new price competition that would allow patients to have access to more affordable healthcare.
- The application fails to show how relocating a single GI endoscopy room will result in cost effectiveness services. Instead of cost savings to patients, the applicant projects to increase its average reimbursement per case by 23 percent from the 2011 amount of \$1,870 to the projected 2016 amount of \$2,306.

X. CONCLUSION

For the reason set forth above, Mission has failed, for the second time, to demonstrate the need to relocate one of its endoscopy rooms to the Buncombe-Henderson border. Accordingly, the CON Section should deny this application for the second time.



ATTACHMENT - REQUIRED STATE AGENCY FINDINGS.

FINDINGS
C = Conforming

CA = Conditional

NC = Nonconforming

NA = Not Applicable

DECISION DATE:

August 26, 2011

FINDINGS DATE:

September 2, 2011

PROJECT ANALYST:

Gebrette Miles

ASSISTANT CHIEF:

Martha Frisone

PROJECT I.D. NUMBER:

B-8638-11 / Mission Hospital, Inc / Relocate one gastrointestinal

(GI) endoscopy room from the hospital's main campus in Asheville

to Fletcher / Buncombe County

REVIEW CRITERIA FOR NEW INSTITUTIONAL HEALTH SERVICES

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

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

NA

Mission Hospital, Inc. proposes to relocate one existing gastrointestinal (GI) endoscopy room from the hospital's main campus in Asheville to Fletcher (Buncombe County). The relocated GI endoscopy room will be licensed as part of the hospital. The applicant does not propose to increase the number of GI endoscopy rooms, increase the number of licensed beds in any category, add services, or acquire equipment for which there is a need determination in the 2011 State Medical Facilities Plan (SMFP). Consequently, there is no need determination in the 2011 SMFP applicable to the proposed project. Furthermore, there are no policies in the 2011 SMFP which are applicable to the proposal. Therefore, this criterion is not applicable to this review.

- (2) Repealed effective July 1, 1987.
- (3) The applicant shall identify the population to be served by the proposed project, and shall demonstrate the need that this population has for the services proposed, and the extent to

which all residents of the area, and, in particular, low income persons, racial and ethnic minorities, women, handicapped persons, the elderly, and other underserved groups are likely to have access to the services proposed.

NC

Mission Hospital, Inc. currently operates six licensed gastrointestinal (GI) endoscopy rooms on its main campus, located at 509 Biltmore Avenue in Asheville (Buncombe County). The applicant proposes to relocate one of the existing GI endoscopy rooms from the main campus in Asheville to a medical office building in Fletcher. The relocated GI endoscopy room, to be known as Mission GI South, will be licensed as part of the hospital. Consequently, the applicant does not propose to develop a new health service facility. Specifically, a new ambulatory surgical facility.

Population to Be Served

In Section III.5, page 69, the applicant states,

"Mission Hospital has a 13-county service area for GI endoscopy services consisting of Buncombe, Henderson, McDowell, Haywood, Madison, Yancey, Transylvania, Mitchell, Jackson, Macon, Cherokee, Burke, and Swain Counties. Mission's GI Endoscopy Service Area also includes 'Other In-Migration,' which are counties and states listed on page 37 of Mission's 2011 LRA included in Exhibit 8."

In Sections III.6 and III.7, pages 70 and 71, the applicant provides the current and projected patient origin for Mission Hospital GI endoscopy services (inpatient and outpatient). Because the GI endoscopy room proposed to be relocated will remain on the hospital's license, the applicant will continue to operate six GI endoscopy rooms upon completion of the proposed project. The projected patient origin for Mission Hospital, shown in the following table, is inclusive of the proposed Mission GI South location:

Mission Hospital GI Endoscopy Services (Inpatient and Outpatient)

County Current Project Year 2				
County		CY 2014		
·	FY 2010			
Buncombe	56.8%	56.8%		
Henderson	6.9%	6.9%		
McDowell	5.2%	5.2%		
Haywood	5.0%	5.0%		
Madison	4.6%	4.6%		
Yancey	. 3.4%	3.4%		
Transylvania	2.4%	2.4%		
Mitchell	2.2%	2.2%		
Jackson	2.1%	2:1%		
Масол	1.9%	1.9%		
Cherokee	1.6%	1.6%		
Burke	1.4%	1.4%		
Swain	1.00%	1.0%		
In-migration	5.5%	5.5%		
Total	100.0%	100.0%		

As shown in the table above, nearly 64% of Mission Hospital's current and projected endoscopy patients originate from Buncombe (56.8%) and Henderson (6.9%) counties. Also shown above, the applicant projects that 5.5% of its project patient origin will be the result of in-migration. As previously stated, the projected patient origin shown in the time table above for Mission Hospital includes both the Asheville campus and the proposed Mission GI South campus.

In Section III.1(a), page 30, the applicant states,

"Mission analyzed historical utilization of services at Mission from southern Buncombe County and Henderson County, as well as projected population growth in the region to determine the Mission GI South Zip Code Service Area."

In Section III.1(a), page 37, the applicant identifies the following nine-zip code service area for Mission GI South. [Note: The current and projected patient origin of Mission Hospital's GI endoscopy patients, as shown in the table above, is inclusive of the following nine zip codes. The existing Mission Hospital patients who live in these nine zip codes are currently traveling north to Mission Hospital for GI endoscopy services.]

> Mission GI South Service Area by Zip Code

by Exp Code				
Zip Code	County			
28704	Buncombe			
28803.	Buncombe			
28806	Buncombe			
28732	Henderson			
28742	Henderson			
· 28758*	Henderson			
28759	Henderson			
28791	Henderson			
. 28792 .	. Henderson			

^{*}This zip code is a P.O. Box.

In Section III.1(a), page 58 and Exhibit 16, Table 5, the applicant provides the projected patient origin for the Mission GI South campus, as illustrated in the table below.

Mission GI South
Projected Patient Origin

1 to joccod x terroit o xx						
	PY 1 (CY 2013)		PY 2 (CY 2014)		PY 3 (CY 2015)	
County	# of Procedures	% of Total	# of Procedures	% of Total	# of Procedures	% of Total
Buncombe	1,071	73.6%	1,082	73.6%	1,093	73.5%
Henderson	238	16.4%	242	16.5%	245	16.5%
Subtotal	1,309	90.0%	1,324	90-1%-	1,338	90.0%
In-migration	145	10.0%	147	10.0%	149	10.0%
Total	1,455	100.0%	1,471	100.1%	1,487	100.0%

^{*}Source: Section III.1(a), page 58, and Exhibit 16, Table 5.

However, the applicant provides inconsistent information regarding projected inmigration for the Mission GI South campus. In Section III.1(b), page 58, the applicant states it assumes that "...10% of the GI endoscopy procedures at Mission GI South will come from other Buncombe County and Henderson zip codes and other counties." But in the Pro Forma Section of the application, and also in Exhibit 16, Table 5, the applicant projects that in-migration at Mission GI South will be 15%. [See Utilization Assumptions and Methodology section of Criterion (3) and Criterion (5) for additional discussion, and Exhibit 16, Table 5 of the application.]

In Section III.1(a), page 56, the applicant projects that 70% of Mission Hospital's existing GI endoscopy volume originating from Buncombe and Henderson counties will shift to Mission GI South. In other words, 85-90% of the population that the applicant proposes to serve at the new Mission GI South campus represents a shift of existing GI endoscopy patients at Mission Hospital who reside in Buncombe and Henderson counties but who are currently traveling to Mission Hospital in Asheville for GI endoscopy services.

^{**}Totals may not foot due to rounding.

However, the applicant does not adequately indentify where the patients included in either the 10% or 15% in-migration will come from. Therefore, the applicant did not adequately identify the population to be served.

Demonstration of Need for the Proposed Project

Mission Hospital, Inc. operates six licensed GI endoscopy rooms on its main campus, located at 509 Biltmore Avenue in Asheville (Buncombe County). The applicant proposes to relocate one of its existing GI endoscopy rooms to a new medical office building in Fletcher. The relocated GI endoscopy room, to be known as Mission GI South, will be licensed as part of the hospital. Consequently, the applicant does not propose to develop a new health service facility. Specifically, a new ambulatory surgical facility.

Regarding the need for the proposed project, in Section II.6, page 12, the applicant states,

"The proposed relocation of one licensed GI endoscopy room from the Mission Campus to Mission GI South will expand access and choice for residents of the rapidly growing population of southern Buncombe County who require outpatient GI endoscopy services as well as all residents of Buncombe and surrounding counties that choose ease of service, parking, and access, provided by a convenient outpatient location. Currently, patients travel to downtown Asheville to receive outpatient GI endoscopy services on the Mission Campus. The Mission Campus is located in central Asheville in mountainous terrain. The existing campus is landlocked and has numerous parking decks and large facilities. Mission GI South in southern Buncombe County is desirable to health care consumers and physicians in the community because it will provide high quality patient care in a location that is convenient and easily accessible."

In Section III.1(a), pages 21-43, the applicant further describes the need for the proposed project. The applicant states,

"The proposed project involves the relocation of an existing licensed GI endoscopy room from the Memorial Building of Mission Hospital Asheville to Mission GI South in southern Buncombe County near the Town of Fletcher. The proposed project will establish a convenient, easily accessible, ambulatory setting in southern Buncombe County and is substantiated by the following reasons:

- Prevalence of Gastrointestinal Disorder
- Importance of Early Detection of Colorectal Cancer
- · Colon Cancer Screening Rates Room for Improvement
- Outpatient Colonoscopy Procedure Rates National Survey of Ambulatory Surgery, United States, 1996 and 2006
- Utilization of Existing GI Endoscopy Resources

- Population Growth in Buncombe and Surrounding Counties
- Growth and Development in Buncombe County
- Growth and Development in Fletcher, NC"

Prevalence of Gastrointestinal Disorder

On page 21, the applicant states,

"A 2005 national study reported in Clinical Gastroenterology and Hepatology Volume 3, Issue 6, Pages 543-552 (June 2005) concluded that 44.9% of US adults had gastrointestinal symptoms over a three month period...Outpatient GI endoscopy is a major tool in determining underlying disease issues for many of these GI disorders."

Importance of Early Detection of Colorectal Cancer

On page 23, the applicant states,

"Each year more than 145,000 people are diagnosed with colorectal cancer, often referred to as colon cancer, in the U.S. and almost 50,000 people die from it annually. The disease, however, is largely preventable with regular screening and is treatable with early detection."

Further, on pages 26-28, the applicant states,

"Screening can find non-cancerous colorectal polyps and remove them before they become cancerous. If colorectal cancer does occur, early detection and treatment dramatically increase chances of survival.

The relative 5-year survival rate for colorectal cancer when diagnosed at an early stage before it has spread is about 90%. But only about 4 out of 10 colorectal cancers are found at that early stage. Once the cancer has spread to nearby organs or lymph nodes, the 5-year relative survival rate goes down, and if cancer has spread to distant organs (like the liver or lung) the rate is about 11%.

Not only does colorectal cancer screening save lives, but it also is cost effective. Studies have shown that the cost-effectiveness of colorectal screening is consistent with many other kinds of preventive services and is lower than some common interventions. It is much less expensive to remove a polyp during screening than to try to treat advanced colorectal cancer. With sharp cost increases possible as new treatments become standards of care, screening is likely to become even more cost effective.

Colonoscopy, which provides the most comprehensive view of the colon, is the definitive test for colorectal cancer screening. Colonoscopies allow gastroenterologists to view the entire colon and rectum for polyps or cancer and during the same exam remove pre-cancerous polyps. It is the test most gastroenterologists recommend as the single best screening exam for colorectal cancer. It is the only method that combines both screening and prevention (by removal of pre-cancerous polyps)."

Colon Cancer Screening Rates

On page 29, the applicant states,

"More Americans are getting the message that colorectal cancer screening is important. Researchers from the National Cancer Institute and the University of Texas, Houston, say screening rates have increased among men and women over the past few years. But the rates still aren't where they need to be, experts say."

Outpatient Colonoscopy Procedure Rates — National Survey of Ambulatory Surgery, United States, 1996 and 2006

On page 29, the applicant states,

"The National Survey of Ambulatory Surgery, United States, 1996 and 2006 found that the majority of colonoscopies (up to 90% in 2006) take place in ambulatory settings compared with inpatient facilities. Mission GI South will provide an alternative ambulatory location for Mission patients in the southern market for GI endoscopies."

Utilization of Existing GI Endoscopy Resources

On page 31-34, the applicant states,

"Mission is the largest hospital in western North Carolina and serves as the tertiary care provider for the region. The following table shows Mission's GI endoscopy volume over the last three calendar years which is sufficient to justify all six of the existing licensed GI endoscopy rooms at Mission.

Mission Hospital GI Endoscopy Volume January 2008 – December 2010

		Junuary 2000	~			
	CY 2008		CY 2009		CY 2010	
·	Cases	Procedures	Cases	Procedures	Cases	Procedures
Inpatient	2,577	3,538	2,632	3,696	2,531	3,699
Outpatient	4,249	5,156	4,120	5,116	. <i>3,982</i>	4,692
Total	6,826	8,694	6,752	8.812	6,513	8,661
GI Endo Rooms Needed at 1,500 procedures/yr		er 6		6		6
Procedures per Case		1.27		1.31		1.33

Source: Exhibit 16, Table 2

Importantly, as shown in the previous table, GI endoscopy procedures have remained flat over the last three calendar years. Inpatient procedures at Mission are at a three-year high. Furthermore, procedure growth has resulted in a higher GI endoscopy procedure to case ratio at Mission.

GI endoscopy volumes provided by the two existing GI endoscopy providers in Buncombe County, Mission Hospital and The Endoscopy Center, are sufficient to support 15.6 GI endoscopy rooms, as shown in the following table.

Buncombe County Providers GI Endoscopy Volume October 2007 - September 2010

October 2007 – September 2010						
Buncombe County	FY 2008		FY 2009		FY 2010	
Building County	Cases	Procedures	Cases	Procedures	Cases	Procedures
Mission Hospital IP GI	2,577	3,538	2,632	3,696	2,531	3,699
Endoscopy			. 4 120	. 5,116	3,982	4,962
Mission Hospital OP GI	4,249	5,156	4,120	. 5,110	0,202	7,502
Endoscopy				0.072	(573	8,661
Total Mission Hospital	6,826	8,694	6,752	8,812	6,513	
The Endoscopy Center OP GI	10,448	14,370	11,129	14,982	10,980	14,765
Endoscopy			17 00124	23,794**	17,493**	23,426**
Total GI Endoscopy Performed	17,274**	23,064**	17,881**	23,794	17,793	25,420
in Buncombe County		15.4		15.9		15.6
GI Endoscopy Rooms Needed		13.7				
at 1,500 procedures/yr	<u> </u>	110		11.0		11.0
2010 Licensed GI Endoscopy		11.0		11.0	1	1
Inventory				1		. (4.6)
Additional GI Endoscopy		4.4		4.9		(4.0)
Rooms Needed					1	

[Emphasis in original.]

Source: Exhibit 16, Table 7

*Mission has 6 licensed GI endoscopy rooms; The Endoscopy Center has 5 licensed GI endoscopy rooms

As shown in the previous table, 4.6 additional GI endoscopy rooms could be developed in Buncombe County based upon FY 2010 GI endoscopy procedures provided in the county.

Mission GI South will provide improved access for the significant number of residents from south Buncombe County and Henderson County that currently choose to seek care at Mission and The Endoscopy Center in Buncombe County. Gastroenterologists associated with The Endoscopy Center are supportive of the proposed Mission GI South as reflected in letters of support in Exhibit 10.

Furthermore, the proposed relocated GI endoscopy room will not negatively impact existing GI endoscopy providers in either Buncombe or Henderson Counties as current GI endoscopy utilization in the two counties combined is sufficient to justify all seventeen licensed GI endoscopy rooms in each of the last three fiscal years. Even though GI endoscopy volumes have been flat current volume continues to justify all existing GI endoscopy rooms as shown in the following table.

^{**}The Project Analyst gets slightly different numbers for the total number of GI endoscopy cases and procedures performed in Buncombe County than what the applicant provided, based on data in the 2009 - 2011 State Medical Facilities Plans (SMFPs). The total number of cases and procedures provided by the applicant for Mission Hospital differs from the data in the 2009 - 2011 SMFPs. The total number of cases and procedures in Buncombe County, based on the SMFPs is as follows: FFY 2008: 17,512 cases and 23,312 procedures; FFY 2009: 17,870 cases and 23,517 procedures; FFY 2010: 17,643 cases. The total # of procedures in FFY 2010 matches what is provided in the 2011 SMFP.

Buncombe and Henderson Counties Providers GI Endoscopy Volume

Ov	ctober 2007 – Septer	nber 2010 -						
GI Endoscopy Provider	FY 2008	FY 2009	FY 2010					
Mission Hospital								
Cases	7,050	6,724	6,550					
Procedures	9,032	. 8,673	· 8,714 ·					
2,000	The Endoscopy C							
Cases	10,448	11,129	. 10,980					
Procedures	14,370	14,982	14,765					
Caro	lina Mountain Endo	scopy Center						
Cases	3,541	2,551	3,283					
Procedures	3,646	3,316	3,475					
1.000	Pardee Hospi	tal						
Cases	3,891	3,427	2,511					
Procedures	. 4,562	4,289	4,090					
	Park Ridge Hos	pital						
Cases	762	649	676					
Procedures.	970	No data	No data					
	Total							
Cases	25,692	24,480	· 24,000					
Procedures	32,580	31,260	31,044					
GI Endoscopy Rooms Needed								
at 1,500 Procedures/Year	21.7		20.7					
Licensed GI Endoscopy	17	17	17					
Rooms								
Surplus (+) / Deficit (-)	-4.7	-3.8	-3.7					

[Emphasis in original.]
Source: Exhibit 16, Table 8

There are 11 licensed GI endoscopy rooms in Buncombe County, and 6 licensed GI endoscopy rooms in Henderson County.

As shown in the previous table, there is sufficient GI endoscopy volume in the two county area for 3.7 additional GI endoscopy rooms in the most recent fiscal year."

Population Growth in Buncombe and Surrounding Counties

On pages 35-36, the applicant states,

"Population growth in Buncombe and surrounding counties, especially for the population over the age of 55, is experiencing steady growth. Total population by county and population for the age cohort of 55+ were obtained from the North Carolina Office of State Budget and Management (NC OSBM). Total projected population growth from 2010 to 2015 for counties in the Mission Hospital GI Endoscopy Service Area is shown in the following table.

Mission Hospital GI Endoscopy Service Area Projected Population All Ages 2010-2015

Frojecies	Projected Population An Ages 2010-2015					
·County	2010	2015	2010-2015			
	•		CAGR			
•	Primary Service	Area				
Buncombe	233,999	248,638	1.2%			
	Secondary Servic					
Henderson	107,383	116,216	1.6%			
McDowell	45,717	48,63 I	1.2%			
Наужоод	57,695	58,960	0.4%			
Madison	21,314	22,537	1.1%			
Subtotal	232,109	246,344	1.2%			
	Tertiary Service	Area				
Yancey	· 18,901	19,675	0.8%			
Transylvania	31,647	32,868	0.8%			
Mitchell	16,073	16,208	0.2%			
Jackson	38,096	40,859	1.4%			
Macon	35,468		1.6%			
Cherokee	27,874	29,733	1.3%			
Burke	91,355	96,599	.1.1%			
Swain	. 14,305	15,109	1.1%			
Subtotal	273,719	. 289,526	1.1%			
Total	739,827	784,508	1.2%			

Source: Exhibit 16, Table 13

As shown in the previous table, the population of Buncombe County is expected to grow at a compound annual rate of 1.2% between 2010 and 2015, from 233,999 residents to 248,638 residents by 2015. The population of the four Secondary Service Area counties is projected to grow from 232,109 residents in 2010 to 246,344 residents by 2015, a compound annual growth rate of 1.2%. The population of the Tertiary Service Area is expected to grow from 273,719 in 2010 to 289,526 in 2015. Total Service Area population is estimated to be 739,827 and is projected to be 784,508 by 2015, which is growing at a compound annual rate of 1.2%.

The segment of the population ages 55 and older is growing at a much faster rate than the total population. Population trends in that age cohort are significant, as the average age to develop colorectal cancer is 70 years, and 93% of cases occur in persons 50 years of age or older. Current recommendations are to begin screening at age 50 if there are no risk factors other than age for colorectal cancers. A person whose only risk factor is their age is said to be at average risk.

Total projected population growth for the 55+ population from 2010 to 2015 for counties in the Mission Hospital Service Area is shown in the following table.

Mission Hospital
GI Endoscopy Service Area

Projected Population Ages 55+2010-2015										
County	2010	2015	2010-2015 CAGR							
Primary Service Area										
Buncombe	68,644	76,986	. 2.3%							
	Secondary Service	e Area								
Henderson	38,729	42,937	2.1%							
McDowell	13,177	<i>14,343</i>	1.8%							
Haywood	20,914	22,434	1.4%							
Madison	6,707	. 7,285	1.7%							
Subtotal	79,467	86,999	1.8%							
	Tertiary Service	Area								
Yancey	6,670	7,176	1.5%							
Transylvania	12,482	13,630	1.8%							
Mitchell .	5,635	5,923	1.0%							
Jackson	11,527	12,813	2.1%							
Macon	14,072	15,492	1.9%							
Cherokee	11,255	12,613	2.3%							
Burke	25,701	28,013	1.7%							
Swain	4,267	4,720	2.0%							
Subtotal	91,609	100,380	1.8%							
.Total	239,720	264,365	2.0%							

Source: Exhibit 16, Table 14

As shown in the previous table, in the Primary Service Area, the 55+ population is expected to grow from 68,644 residents currently to 76,986 residents by 2015, a compound annual growth rate of 2.3%, more than twice the rate for the total projected population of Buncombe County. The Secondary and Tertiary Service Areas also are expected to experience growth in the 55+ population between 2010 and 2015, with the secondary service area growing at a compound annual rate of 1.8% and the Tertiary Service Area growing at a compound annual rate of 1.8%. The 55+ population of the entire Service Area is expected to increase from 239,720 in 2010 to 264,365 in 2015, representing an increase of 2.0% compounded annually. That trend reflects the general aging of the population seen nationally, as well as the fact that western North Carolina is a popular retirement destination. Those population estimates are conservative in that they do not include all retirees, who often have more than one residence."

Growth in Development in Buncombe County and Fletcher, NC

On pages 38-43, the applicant describes the attractiveness of Buncombe County and Fletcher, NC to prospective residents and businesses. Specifically, the applicant describes the following:

- Economic development
- Affordable housing
- Community transportation
- Planned infrastructure improvement

Utilization Assumptions and Methodology

The following table illustrates the historical and projected utilization for Mission Hospital GI endoscopy services through Project Year 3, as provided by the applicant in Section IV.1, page 76:

	Prior Full Year CY 2009	Last Full Year CY 2010	Interim Full Year CY 2011	Interim Full Year CY 2011	Project Year 1 CY 2013	Project Year 2 CY 2014	Project Year 3 CY 2015
# of Dedicated GI							
Endoscopy Rooms —				6	5	5	5
Mission Campus	6	6	6	0			ļ ————————————————————————————————————
# of GI Endoscopy				0.600	7157	7,125	7,092
Procedures	8,812	8,661	8,645	8,628	7,157	1,123	7,092
# of Dedicated GI							
Endoscopy Rooms —				,	,	1	1. 1
Mission GI South	0	0	0	0	1	 	
# of Outpatient GI							
Endoscopy Procedures					1 465	. 171	1,487
- Mission GI South	0	0	0	0	. 1,455	1,471	1,401
Total # of Dedicated GI						-	
Endoscopy Rooms -							-
Mission Hospital and						6	6
Mission GI South	6	6	6	6	6	- 0	1 . 0
Total # of GI							
Endoscopy Procedures							
- Mission Hospital and				5-600	0.610	0 505	8,579
Mission GI South	8,812	8,661	8,645	8,628	8,612	8,595	1 610

As illustrated in the table above, the applicant projects to perform a total of 8,595 procedures in six licensed GI endoscopy rooms, or 1,433 procedures per room (8,595 procedures / 6 rooms = 1,433 procedures) in Project Year 2 (CY 2014). While The Criteria and Standards for Gastrointestinal Endoscopy Procedure Rooms in Licensed Health Service Facilities [10A NCAC 14C 3900] requires a minimum performance threshold of 1,500 procedures per room, the Criteria and Standards are not applicable to this review because the applicant is not proposing to establish a new ambulatory surgical facility to be operated independently of the hospital. Rather, the applicant proposes to relocate one existing GI endoscopy room to another location and continue to operate it under Mission Hospital's license. Thus, the fact that the applicant projects to perform less than 1,500 procedures per room in Year 2 is not an issue for this application. (The applicant's use of the 1,500 procedures per room minimum performance threshold

throughout the application is for reference purposes only.) Mission Hospital already operates six licensed GI endoscopy rooms and is proposing to relocate one of the existing rooms from the main campus to another location in Fletcher, NC. In doing so, the applicant proposes to serve existing patients who live in southern Buncombe and northern Henderson Counties, and who are currently traveling to Mission Hospital for endoscopy services, thereby providing care to them closer to their homes.

In Section III.1(b), pages 44-59, the applicant provides the following methodology and assumptions used to project utilization:

Step 1: Determine Base Volume for Use in Projections

On page 45, the applicant provides historical utilization data for Mission Hospital's total GI endoscopy volume (inpatient and outpatient), as shown in the table below:

Mission Hospital
GI Endoscopy Volume
Innuary 2008 – December 2010

Junuary 2008 - December 2010											
	1 0	Y 2008	(CY 2009	CY 2010						
	Cases	Procedures	Cases	Procedures	Cases	Procedures					
Inpatient	2,577	3,538	2,632	3,696	2,531	3,699					
Outpatient	4,249	5,156	4,120	5,116	3,982	4,962					
Total	6,826	8,694	6,752	. 8,812	6,513	8,661					

Source: Exhibit 16, Table 2

The data provided in the table above is from the hospital's internal Trendstar database. The applicant states that Trendstar data was used because it is the most current. On page 45, the applicant provides a comparison of its Trendstar data with License Renewal Application (LRA) data to demonstrate consistency. Over the three years of data provided for comparison (FY 2008 – FY 2010), the largest variance in the number of cases was 0.3% in FY 2009 and the largest variance in the number of procedures was 1.6%, also in FY 2009. Thus, the applicant does demonstrate that the Trendstar data is generally consistent with the LRA data. More specifically, regarding the decision to use Trendstar data, on pages 44-45, the applicant states,

"Mission reviewed and compared internal Trendstar for the most recent fiscal three years with the data reported in the 2009-2011 LRAs to assure the reliability of the internal database.

...Mission's internal data is very consistent with the data reported on its Hospital License Renewal Applications in all three fiscal years. Therefore, Mission utilized the most current twelve months of data available as the base data for projections.

Calendar year 2010 Trendstar data is the most current and reasonable data to use as a base to project future GI endoscopy utilization. It is also consistent with the project years, which are calendar year-based."

Step 2: Determine the Growth Rate for Projecting Total GI Endoscopy Utilization

The applicant reviewed historical GI endoscopy growth at Mission Hospital, population growth, and market trends to project the growth rate for total GI endoscopy utilization.

On page 46, the applicant provides historical GI endoscopy utilization at Mission Hospital for CY 2008 to CY 2010, and calculates procedures per case and the two-year Compound Annual Growth Rate (CAGR) for total inpatient and outpatient procedures, as shown below:

Mission Hospital GI Endoscopy Volume January 2008 – December 2010

Junuary 2000 December 2022											
	C	CY 2008		CY 2009		CY 2010		CAGR CY08-CY10			
	Cases .	Procedures	Cases	Procedures	Cases	Procedures	Cases	Procedures			
Inpatient	2,577	3,538	2,632	3,696	2,531	3,699	-0.9%*	2.3%*			
Outpatient Outpatient	4,249	5,156	4,120	5,116	3,982	4,962	-3.2%*	-1.9%*			
Total .	6,826	8,694	6,752	8,812	6,513	8,661	-2.3%*	-0.2%			
Procedures per Case		1.27		1.31		1.33		·			

[Emphasis in original.]

Source: Exhibit 16, Table 2

*Calculated by the Project Analyst.

The applicant states,

"As shown in the previous table, procedures have remained flat, decreasing only slightly, during the last three calendar years. This is quite remarkable considering the development of freestanding outpatient GI endoscopy in North Carolina at the expense of hospital based GI endoscopy programs since the CON statute was amended to allow the development of freestanding GI centers in 2005. Inpatient GI endoscopy procedures at Mission Hospital reached a three-year high in CY 2010. Procedure growth at Mission has resulted in a higher GI endoscopy procedure to case ratio. ...

As previously discussed, Mission reasonably believes that GI endoscopy utilization has decreased due to the global economic crisis, beginning in December 2007, which gained intensity since September 2008. According to an

American Hospital Association survey the economic downturn is hitting hospitals hard as many patients struggle to pay their medial bills or put off care altogether. Nearly 60% of hospitals reported a moderate to significant decline in elective procedures compared with a year ago. Those numbers are similar to an Outpatient Surgery Magazine survey, also conducted in March 2009, in which 58% of readers said surgery volumes were down due to the struggling economy."

On page 47, the applicant provides patient origin data for total GI endoscopy services at Mission Hospital and calculates a weighted growth rate for GI endoscopy services, as shown in the table below:

Mission Hospital Total GI Endoscopy Service Area Weighted Population Growth Rate

Projected Population All Ages 2010-2015

Frojecieu i opumion interiges solo										
County	2010-2015	FY 2010	GI Endoscopy							
•	CAGR	. GI Endoscopy	Services Weighted							
		Services Patient	Growth Rate							
		Origin								
Formula	A=County	B=County Percent	C=AxB							
•	Specific CAGR ·	of Total Patient	•							
		Origin								
	Primary Ser		·							
Buncombe	1.2%	56.8%	0.7%							
	. Secondary Se	rvice Area								
Henderson	1.6%	6.9%	0.1%							
McDowell	1.2%	5.2%	0.1%							
Haywood	0.4%	5.0%	0.0%							
Madison	1.1%	4.6%	0.1%							
	Terțiary Sei									
Yancey .	0.8%	3.4%								
Transylvania	0.8%	2.4%	0.0%							
Mitchell	0.2%	2.2%	0.0%							
Jackson	1.4%	2.1%								
Macon	1.6%	1.9%	0.09							
Cherokee	1.3%	1.6%	0.09							
Burke	1.1%		0.09							
Swain	1.1%		0.09							
North Carolina*	1.7%		0.19							
Mission Hospital We	ighted Population Gr	owth Rate = Sum of	1.2%							
Column C	•									
24531141 4										

Source: Exhibit 16, Table 13

Methodology = Sum of Individual County Growth Rates x County Specific Patient Origin

The table above shows a total weighted population growth rate of 1.2% for total GI endoscopy services (inpatient and outpatient) at Mission Hospital.

^{*}All Other In-migration grown at NC State Growth Rafe

The applicant states,

"As discussed in Section III.1.(a) above, Mission reasonably expects that patients 55+ will continue to represent a greater percentage of GI endoscopy patients at Mission Hospital. Therefore, Mission also determined the weighted population growth rate for the 55+ population, as shown in the following table.

Mission Hospital
Total GI Endoscopy Service Area
Weighted Population Growth Rate
Projected Population Ages 55+ 2010-2015

	rojecteu i opumitani 22		
County	2010-2015	FY 2010 .	GI Endoscopy
OV 111-5	CAGR	GI Endoscopy	Services Weighted
		Services Patient	Growth Rate
•		Origin	
Formula	A=County	B=County Percent	C=AxB
	Specific CAGR	of Total Patient	•
		Origin	
	Primary Ser		
Випсотье	2.3%	56.8%	1:3%
DM100NOV.	Secondary Se	rvice Area	
Henderson	2.1%	6.9%	0.19
McDowell .	1.8%	. 5.2%	0.19
Наушоод	1.4%	5.0%	0.19
Madison	1.7%	4.6%	0,19
· · · ·	Tertiary Ser	vice Area	•
Yancey	1.5%	3.4%	0.09
Transylvania	1.8%	2.4%	0.09
Mitchell	1.0%	2.2%	0.09
Jackson	2.1%	2.1%	0.09
	1.9%	1.9%	0.0
Macon	2.3%		0.0
Cherokee .	1.7%		
Burke	2.0%		
Swain .	2.8%		
North Carolina*			2.1
B	eighted Population Gr	owin rine - Dain of	
Column C .		·	<u> </u>

Source: Exhibit 16, Table 14

Methodology = Sum of Individual County Growth Rates x County Specific Patient Origin

*All Other In-migration grown at NC State Growth Rate

As shown in the previous table, the segment of the population ages 55+ is growing at a faster rate than the total population. The previous table shows a total weighted population growth rate of 2.1% for GI Endoscopy Services at Mission for residents 55+."

Step 3: Project Total GI Endoscopy Procedures

Based on the applicant's weighted population growth analysis in Step 2, the applicant determined that it would use Mission Hospital's historical CAGR (CY 2008 to CY 2010) of -0.2% to project total GI endoscopy procedures (inpatient and outpatient) through Project Year 3 (CY 2015). On page 49, the applicant describes how it arrived at this conclusion. The applicant states,

"This rate is:

- Considerably less than the projected (2010-2015) 55+ weighted population growth rate of 2.1% in Mission GI Endoscopy Service Area counties which is the expected rate that GI endoscopy will grow once the economy recovers.
- Considerably less than the projected (2010-2015) weighted population growth rate of 1.2% in Mission GI Endoscopy Service Area counties."

On page 49, the applicant applied Mission Hospital's historical CAGR of -0.2% to the total number of GI endoscopy procedures performed at Mission Hospital in CY 2010 (from Step 1) and projected forward through Project Year 3 (CY 2015), as shown in the table below:

GI	CY 2010	CY 2008-	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015
Endoscopy		CY 201.0			·		
		CAGR					
Procedures	8,661	-0.2%	8,645	8,628	· 8,612	8,595	8,579
	_ •	Endoscopy	Endoscopy CY 2010 CAGR	Endoscopy CY 2010 CAGR	Endoscopy	Endoscopy	Endoscopy CY 2010 CAGR 8 612 8 595

Source: Exhibit 16, Table 3

Step 4: Project Total GI Endoscopy Cases

On page 50, the applicant applied the average procedures per case for CY 2010 (calculated in Step 2) to the projected number of procedures (calculated in Step 3) to determine the projected number of cases through Project Year 3 (CY 2015), as shown in the table below:

GI Endoscopy	CY 2010	CY 2010	CY 2011	CY 2012	PY 1:	PY 2:	PY 3:
		Average Procedures		. 1	CY 2013	CY 2014	CY 2015
		per Case		-		·	
Procedures	8.661	I.33	8,645	8,628	8,612	8,595	8,:579
Cases	6,513		6,501	6,488	6,476	6,464	6,451
GI Endoscopy							
Rooms Needed @						}	
1,500 procedures					- 0	- 0	= 0
per room	5.8	<u> </u>	5.8	5.8	5.8	5.8	5.8

Source: Exhibit 16, Table 3

The applicant states,

"As shown in the previous table, even though projected GI endoscopy volume at Mission is projected to remain relatively flat with a very slight reduction in cases and procedures, projected CY 2015 utilization reflects a continued need for all six of the existing GI endoscopy rooms in Buncombe County."

Step 5: Determine GI Endoscopy Use Rates for Buncombe and Henderson Counties

On page 51, the applicant used historical endoscopy utilization data from 2008 and 2011 License Renewal Applications and county population data to calculate endoscopy use rates for residents of Buncombe and Henderson counties, as shown in the following table:

Total GI Endoscopy Use Rates FY 2007 and FY 2010

FY 2007 and FY 2010										
Total GI Endoscopy	Buncombe	Henderson								
FY 2007										
Cases	11,682	<i>5,6</i> 89								
Population	225,555	102,079								
Use Rates	51.8	.55.7								
	FY 2010									
Cases	11,484	6,245								
Population	233,999	107,383								
Use Rate	· 49.1	. 58.2								
Four Year Average										
Use Rate	50.4	56.9								

[Emphasis in original.]
Source: Exhibit 16, Table 9

On page 51, the applicant states,

"In addition to 2007 and 2010 use rates, the previous table shows four year average use rates for each county. In Buncombe County GI utilization per 1,000 decreased slightly over the four year time frame. In Henderson County GI utilization per 1,000 increased slightly over the four year time frame. To adjust for anomalies across the timeframe, Mission utilized the county-specific four year average growth rate to project future GI utilization for Mission GI South zip service area."

Step 6: Base Population for Mission GI South Service Area

The applicant has defined Mission GI South's service area as a nine zip-code service area within southern Buncombe and northern Henderson counties. In Section III.1(a), page 37, the applicant identifies the following nine-zip code service area for Mission GI South:

Mission GI South Service Area by Zin Code

the state of the s							
Zip Code	County						
28704	Buncombe						
28803	Buncombe						
28806	Buncombe						
28732	Henderson						
28742	Henderson						
28758*	Henderson						
28759	Henderson						
28791	Henderson						
28792	Henderson						

^{*}This zip code is a P.O. Box.

On page 52, the applicant provides the projected population growth for the nine zip-code service area, as shown in the table below:

Mission GI South Service Area

	Projected Population All Ages 2010-2015										
County	2010	2011	2012	2013	2014	2015	CAGR 2010-2015				
Combined Buncombe Zips	80,717	81,536	82,363	83,199	84,043	84,896	1.0%				
Combined Henderson Zip[s]	70,396	71,413	72,444	73,490	74,551	75,628	1.4%				
Total	151,113	152,949	157,807	156,689	158,594 [,]	160,524	1.2%				

Source: Exhibit 16, Table 6

The applicant illustrates that the population in nine zip-code service area for all ages is projected to grow at a CAGR of 1.2% from CY 2010 to CY 2015.

Step 7: Project Outpatient GI Endoscopy Cases for Mission GI South Service Area

On page 53, the applicant projected the total number of GI endoscopy cases in the nine zip-code service area by multiplying the four-year average county-specific use rate (Step 5) by the projected population of the nine zip-code area (Step 6), as shown in the table below:

Mission GI South Projected Total GI Endoscopy Cases in Service Area 2010-2015

2020	OLD										
2010	2011	2012	PYI:	PY2:	PY3:						
			2013	2014	2015						
Buncombe Zip Codes											
80,717	81,536	82,363	· 83,199	84,043	<i>84,896</i>						
50.4	50.4	·50.4	50.4	. 50.4	50.4						
4,071	4,112	4,154	4,196	4,239	4,282						
Henderson	Zip Code:	5									
70,396	71,413	72,444	73,490	74,551	75,628						
56.9	56.9	56.9	56.9	56.9	56.9						
4,009	4,067	4,125	4,185	4,245	4,307						
	2010 Buncombe 80,717 50.4 4,071 Henderson 70,396 56.9	Buncombe Zip Codes 80,717	2010 2011 2012 Buncombe Zip Codes 80,717 81,536 82,363 50.4 50.4 50.4 4,071 4,112 4,154 Henderson Zip Codes 70,396 71,413 72,444 56.9 56.9 56.9	2010 2011 2012 PY1: 2013 Buncombe Zip Codes 80,717 81,536 82,363 83,199 50.4 50.4 50.4 50.4 4,071 4,112 4,154 4,196 Henderson Zip Codes 70,396 71,413 72,444 73,490 56.9 56.9 56.9 56.9	2010 2011 2012 PY1: 2013 PY2: 2014 Buncombe Zip Codes 80,717 81,536 82,363 83,199 84,043 50.4 50.4 50.4 50.4 50.4 4,071 4,112 4,154 4,196 4,239 Henderson Zip Codes 70,396 71,413 72,444 73,490 74,551 56.9 56.9 56.9 56.9 56.9						

Source: Exhibit 16, Table 5

In Step 5, the applicant calculated a use rate based on the total number of GI endoscopy cases at Mission Hospital, as reported on its License Renewal Application. As such, the projected number of cases in the table above includes inpatient and outpatient cases. However, the proposed project is for outpatient GI endoscopy services only. Thus, on page 53, the applicant calculates the percentage of inpatient and outpatient cases for the Mission GI South service area. The applicant states,

"Mission analyzed internal Trendstar inpatient and outpatient GI endoscopy data for FYs 2008, 2009, and 2010 and combined those volumes with the FYs 2008, 2009, and 2010 outpatient volume reported by The Endoscopy Center, the other GI endoscopy provider located in Buncombe County. The following table summarizes the historical inpatient and outpatient GI endoscopy split for Buncombe County providers and calculates the three-year average inpatient outpatient split.

Buncombe County
GI Endoscopy Cases – Inpatient and Outpatient Percentages
October 2007 – September 2010

October 2007 - September 2010								
Buncombe County	FY 2008		FY 2009		FY 2010		Three Year Avg	
	Cases	Procedures	Cases	Procedures	Cases	Procedures	Inpt/Outpt	Split
Mission Hospital IP GI Endoscopy	2,577	3,538	2,632	. 3,696	2,53 <i>I</i>	3,699	3,644	16%
Mission Hospital OP GI Endoscopy	4,249	5,156	4,120	5,116	3,982	4,962		
The Endoscopy Center OP GI Endoscopy	10,488	. 14,370	11,129	14,982	10,980	14,765	19,784	84%
Total GI Endoscopy	17,274	23,064	17,881	23,794	17,493	23,426	23,428	100%

[Emphasis in original.]
Source: Exhibit 16, Table 7

Mission determined that outpatient GI endoscopy cases represented an average of 84% of combined Mission Hospital and The Endoscopy Center cases over the last three fiscal years, as shown in the previous table."

It should be noted that while the applicant refers to cases when describing the three-year average split, the Project Analyst determined that three-year averages shown in the table above (3,644 for Mission inpatient cases, 19,784 for Mission and The Endoscopy Center outpatient cases, and 23,428 for total cases) are actually the average procedures, not cases. The Project Analyst calculated the three-year average number of cases as 2,580 for Mission inpatient cases, 14,969 for Mission and The Endoscopy Center outpatient cases, and 17,549 for total cases. This results in a three-year average split of 15% for inpatient cases, and 85% for outpatient cases. Thus, the fact that the applicant calculated the three-year average split based on procedures rather than cases does not pose an issue for the methodology.

There are two GI endoscopy providers in Asheville – Mission Hospital and The Endoscopy Center. Mission Hospital performs inpatient and outpatient GI endoscopy procedures, and The Endoscopy Center performs only outpatient procedures. Regarding the inclusion of The Endoscopy Center's outpatient cases and procedures along with Mission Hospital's outpatient cases and procedures, on page 54, the applicant states the following:

"Rather than using solely the Mission inpatient/outpatient GI endoscopy split, Mission believes that the combined average better reflects the total outpatient GI endoscopy volume in [the] Mission GI South Service Area since it will be an outpatient only location."

It is reasonable for the applicant to include both Mission Hospital's outpatient utilization data and The Endoscopy Center's utilization data because it provides a more complete picture of total outpatient GI endoscopy utilization in Buncombe County.

On page 54, the applicant then multiplied the projected total number of GI endoscopy cases (inpatient and outpatient) in the Buncombe and Henderson County zip code service area (calculated earlier in this Step) by 84% to calculate the projected number of outpatient GI endoscopy cases in the Mission GI South service area, as shown in the table below:

Mission GI South Service Area Projected Total Outpatient GI Endoscopy Cases 2010-2015

	20202	*****				
Mission GI South	2010	2011	2012	PYI:	PY2:	P73:
111111111111111111111111111111111111111				2013	2014	2015
	Зипсотье	Zip Codes				
Total Projected GI Endoscopy Cases	4,071	4,112	4,154	4;196	4,239	4,282
Percent OP GI Endoscopy	84%	84%	84%	84%	84%	84%
Projected OP GI Endoscopy Cases	3,438	3,473	<i>3,508</i>	<i>3,543</i>	3,579	3,616
Henderson Zip Codes						
Total Projected GI Endoscopy Cases	4,009	4,067	4,125	4,185	4,245	4,307
Percent OP GI Endoscopy	84%	84%	84%	84%	84%	84%
Projected OP GI Endoscopy Cases	3,385	3,434	. 3,484	3,534	3,585	3,637

Source: Exhibit 16, Table 5

As shown in the table above, the applicant projects a total of 7,253 outpatient endoscopy cases (3,616 + 3,637 = 7,253) in the Mission GI South service area by the third year of the project (CY 2015).

On page 54, the applicant states,

"The previous table reflects projected outpatient GI endoscopy cases in the Service Area zip codes in Buncombe and Henderson Counties for all residents of [the] Mission GI South Service Area. Because inpatient GI endoscopy data was not publically available for Henderson County, the Buncombe County inpatient/outpatient split was used as a proxy. Both counties are known as retirement locations with over 30% of the population aged 55 and over, and Henderson is rapidly becoming more urban as Asheville expands south."

The applicant correctly stated that inpatient GI endoscopy data was not publically available for Henderson County. The publicly-available License Renewal Application form does not separate inpatient and outpatient GI endoscopy procedures. Only the total number of GI endoscopy procedures is collected. Therefore, given the geographic proximity and demographic similarities of Buncombe and Henderson Counties, as noted by the applicant, the use of the Buncombe County outpatient GI endoscopy cases as a proxy for Henderson County GI endoscopy cases is reasonable.

Step 8: Calculate Outpatient GI Endoscopy Procedures in Mission GI South Service Area

Based on the historical experience of Mission Hospital, the applicant calculated that Mission Hospital performed 1.33 procedures per case in CY 2010 (see page 31 of the application). On page 55, the applicant multiplied the 1.33 procedures per case ratio by the total projected GI endoscopy cases in the Mission GI South service area (Step 7) to determine the projected number of procedures in Mission GI South service area, as shown in the following table:

Mission GI South Service Area Projected Outpatient GI Endoscopy Procedures 2010-2015

,	2020 200					
Mission GI South	2010	2011	2012	PYI:	PY2:	PY3:
		j		2013	2014	2015
Bı	uncombe 2	Lip Codes				
Projected OP GI Endoscopy Cases	3,438	3,473	3,508	· 3,543	3,579	3,616
Procedures per Case	1.33	1.33	1.33	1.33	1.33	1.33
Projected OP GI Endoscopy Procedures	4,571	4,618	4,665	4,712	4,760	4,808
H.	enderson I	Zip Codes				
Projected OP GI Endoscopy Cases	3,385	<i>3,434</i>	3,484	3,534	3,585	3,637
Procedures per Case	1.33	1.33	1.33	I.33	1,33	1.33
Projected OP GI Endoscopy Procedures	4,501	4,566	4,632	4,699	4,767	4,836

Source: Exhibit 16, Table 5

As shown in the table above, the applicant projects a total of 9,644 outpatient endoscopy procedures (4,808 + 4,836 = 9,644) in the Mission GI South service area by the third year of the project (CY 2015).

Step 9: Determine Mission Hospital Market Share of Total GI Endoscopy Cases in Buncombe and Henderson Counties

On pages 55 and 56, the applicant used 2008 and 2011 License Renewal Application (LRA) data to determine Mission Hospital's market share of total GI endoscopy cases (inpatient and outpatient) in Buncombe and Henderson counties, as shown in the following two tables:

Mission Hospital

Market Share of Total GI Endoscopy Cases in Buncombe County

FY 2007 and FY 2010

Provider	20	07	2010		
	Cases	Percent	Cases	Percent	
Margaret R. Pardee Memorial Hospital	113	1.0%	76	. 0.7%	
The Endoscopy Center	6,515	55.8%	6,958	60.6%	
Park Ridge Hospital	282	. 2.4%	133	1.2%	
Mission Hospital	4,561	39.0%	3730	32.5%	
Carolina Mountain Gastroenterology Endoscopy Center	9	0.1%	297	2.6%	
Transylvania Community Hospital and Bridgeway	5	0.0%	5	0.0%	
All Other	197	1.7%	285	2.5%	
Total	11,682	100.0%	11,484	100.0%	

[Emphasis in original.]

Source: Exhibit 16, Table 10

Mission Hospital Market Share of Total GI Endoscopy Cases in Henderson County FY 2007 and FY 2010

F1 2007 was 11 2010							
Provider .	2007		. 2010				
	Cases	Percent	Cases	Percent			
Margaret R. Pardee Memorial Hospital	3,283	57.7%	2,100	33.6%			
The Endoscopy Center	942	16.6%	1,003	16.1%			
Park Ridge Hospital	731	12.8%	454	7.3%			
Mission Hospital	509	. 8.9%	452	7.2%			
Carolina Mountain Gastroenterology Endoscopy Center	102	1.8%	2,063	. 33.0%			
Transylvania Community Hospital and Bridgeway	53	0.9%	49	0.8%			
All Other	69	1.2%	124	2.0%			
Total	5,689	100.0%	6,245	100.0%			

[Emphasis in original.]

Source: Exhibit 16, Table 11

Regarding Mission Hospital's market share in Buncombe County, on page 56, the applicant states,

"The previous table shows that Mission's market share of Buncombe County GI endoscopy decreased from FY 2007 and FY 2010 as a result of the shift in patients to The Endoscopy Center and the new outpatient GI center in Henderson County. In addition, GI endoscopy volume has declined due to an economic downturn and a shift in that volume to community settings as previously discussed."

Regarding Mission Hospital's market share in Henderson County, on page 56, the applicant states,

"The previous table shows that Mission has lost some market share in Henderson County from FY 2007 to FY 2010 as outpatient GI endoscopy volume has shifted to Carolina Mountain Gastroenterology Endoscopy Center, which entered the Henderson County market in FY 2007."

Step 10: Project Mission GI South Outpatient GI Endoscopy Procedures

The applicant assumes that Mission GI South will capture 70% of Mission Hospital's existing market share for Buncombe and Henderson counties in FY 2010, which was calculated in Step 9 to be 32.5% in Buncombe County and 7.2% in Henderson County. In other words, the applicant assumes 70% of its existing GI endoscopy patients from the Mission GI South service area will shift to the Mission GI South campus from the Asheville campus. On pages 56-57, the applicant states,

"While it is reasonable to assume that 100% of outpatient cases could shift to the new outpatient location for improved access in an outpatient setting, some cases may be more complex or patients could have co-morbidities [sic] may choose to go to the Mission campus in Asheville. However, over 80% of all cases reviewed were cases routinely performed in outpatient GI Centers. Therefore, a target of 70% was determined to be reasonable. Mission GI South's resulting market share of Mission GI South Service Area was calculated as follows:

- Service Area Zip Codes in Buncombe County: 70% of Buncombe County market share of 32.5% = 22.7%
- Service Area Zip Codes in Henderson County: 70% of Henderson County market share of 7.2% = 5.1%

For purposes of this Application, Mission assumes that the projected procedures performed at Mission GI South would be performed at Mission if the project were not developed. However, it is possible that cases from other providers in Buncombe County may shift to the proposed facility as the physicians associated with Asheville Gastroenterology Associates (AGA), who own and operate The Endoscopy Center, are very supportive of the proposed project as evidenced in the letters of support included in Exhibit 10. Furthermore, in 2010 over 1,000 patients from Henderson County received outpatient GI endoscopy procedures at The Endoscopy Center. Mission GI South would provide a more accessible alternative for these patients of AGA.

In addition, as the economy improves and GI endoscopy procedures begin to increase, some percent of cases at Mission GI South will result from the growth in the south Buncombe geographic area. As previously discussed this is one of the fastest growing areas in Buncombe and Henderson Counties. As a result, Mission believes the market share projections are reasonable to use in determining future volume performed at Mission GI South."

On page 57, the applicant projected the number of outpatient GI endoscopy procedures at Mission GI South through the third year of the project by multiplying the county-specific market share percentages described above by the projected number of outpatient GI endoscopy procedures at Mission GI South from Step 8, as shown below:

Mission GI South Projected Outpatient GI Endoscopy Procedures 2010-2015

	2010-201	. J				
Mission GI South	2010	2011	2012	PYI:	PY2:	PY3:
				2013	2014	2015
Bı	ancombe Z	ip Codes				
Expected GI Endoscopy Procedures	4,571	4,618	4,665	4,712	4,760	4,808
Projected Market Share – Mission GI						
South	22.7%	22.7%	22.7%	22.7%	22.7%	22.7%
Projected OP GI Endoscopy Procedures					* 000	****
– Mission GI South	1,039	1,050	1,061	1,071	1,082	^I,093
H	enderson Z	Zip Codes				
Expected GI Endoscopy Procedures	<i>4501</i>	4566	4632	4669	4767	8836
Projected Market Share – Mission GI						
South	5.1%	5.1%	5.1%	5.1%	5.1%	5.1%
Projected OP GI Endoscopy Procedures					0.12	2/-
- Mission GI South	228	231	235	238	242	245
Combined						
Projected OP GI Endoscopy Procedures				7 700	1 224	7 7 7 7 0
– Mission GI South	1,267	1,281	1,295	1,309	1,324	1,338

Source: Exhibit 16, Table 5

In addition to the projected outpatient GI endoscopy procedures calculated in the table above, the applicant also projects that approximately 10% of the procedures performed at Mission GI South will be as a result of "in-migration." On page 58, the applicant states,

"Mission is cognizant that some patients will choose to travel a bit further from their homes to Mission GI South in order to forgo a trip to Mission Hospital in downtown Asheville. Mission conservatively projects that 10% of GI endoscopy procedures at Mission GI South will come from other Buncombe and Henderson zip codes and other counties, as shown in the following table. That assumption is supported by the geographic accessibility of Mission GI South and Mission's historical patient origin which reflects in-migration from counties other than Buncombe and Henderson to be over 34% as reflected in Exhibit 16, Table 12."

Of the counties in Mission Hospital's secondary and tertiary service areas (see Exhibit 16, Table 2 and Section III.6, page 70), it is unreasonable to assume that patients from many of these counties would by-pass Mission Hospital and travel to Mission GI South, particularly counties that are north of Buncombe County, i.e. Madison, Yancey, and Mitchell. Moreover, the applicant does not specifically identify the counties and/or zip codes within Mission Hospital's existing service area from which it expects to see patients at Mission GI South. Thus, the project analyst could not validate the reasonableness of the applicant's 10% in-migration assumption (much less the 15% "in-migration" assumption) merely based on the fact that the in-migration rate at Mission Hospital from counties other than Buncombe and Henderson is 34%. "In-migration" at Mission Hospital includes inpatients as well as outpatients and Mission Hospital is a

tertiary hospital serving patients from a large geographic area. The service area for the proposed Mission GI South is not likely to be similar to the service area for Mission Hospital.

However, it is reasonable to assume that some patients from Mission Hospital's service area would travel to Mission GI South. The Project Analyst looked at Mission Hospital's patient origin by county for total GI endoscopy cases (inpatient and outpatient), as reported on its 2011 LRA, in conjunction with a map of the State of North Carolina. The Project Analyst determined that it is reasonable to assume that residents from the following counties (excluding Buncombe and Henderson counties) would seek outpatient GI endoscopy services at Mission GI South rather than traveling to Mission Hospital, based on geographic proximity to Mission GI South. (Note: Buncombe and Henderson counties are included here for reference purposes only.):

Mission Hospital
Total GI Endoscopy Patients
(Inputient and Outpatient)

(Inpatient and Outpatient)						
County	# of Total GI	% of Total GI				
	Endoscopy Patients	Endoscopy Patients				
Buncombe	3,730.	56.8%				
Henderson	452	6.9%				
Sub-total	4,182	63.7%				
	158	2.4%				
Transylvania	<u> </u>	2.1%				
Jackson	135	<u> </u>				
Macon	127	1.9%				
Polk	. 27	0.4%				
Rutherford	60	0.9%				
Sub-total .	508	, 7.7%				
		<u> </u>				
.Total # Endoscopy Patients at		100.00(
Mission Hospital	6,563	100.0%				

*Source: 2011 LRA, page 37.

As shown in the table above, based on geographic proximity and the non-emergent nature of GI endoscopy services projected to be performed at Mission GI South, the Project Analyst identified five counties from which residents are likely to travel to Mission GI South rather than Mission Hospital for GI endoscopy services: Transylvania, Jackson, Macon, Polk, and Rutherford. Thus, the Project Analyst estimates a total of 508 patients or 7.7% of patients residing in counties outside of Buncombe and Henderson counties can be expected to seek GI endoscopy services at Mission GI South, based on the current patient origin for total GI endoscopy services at Mission Hospital. It is also important to note that Mission Hospital's historical patient origin for GI endoscopy services includes both inpatient and outpatient cases. As such, the 508 patients from these counties includes both inpatient and outpatient cases. Therefore, the percentage of patients receiving outpatient GI endoscopy services would make up an even smaller percent of

patients seeking GI endoscopy services at Mission GI South. Nevertheless, based on the Project Analyst's determination, the applicant's assumption of 10% in-migration at Mission GI South from counties outside of Buncombe and Henderson Counties is overstated.

On page 58, after factoring in in-migration, the applicant projects the total number of outpatient procedures at Mission GI South through Project Year 3, as shown in the following table:

Mission GI South
Total Projected Outpatient GI Endoscopy Procedures

	2010 - 20	15				
Mission GI South	2010	2011	2012	PY1: 2013	PY2: - 2014	PY3: 2015
Projected OP GI Endoscopy Procedures — Combined Buncombe & Henderson Zip Codes In-migration (10%)	1,267	1,281	1,295	1,309 145	1,324 147	1,338 149
Total Projected OP GI Endoscopy Procedures		·		1,455	1,471	1,487
GI Endoscopy Rooms Needed at Mission GI South				1	11	1

Source: Section III.1(b), page 58.

As shown in the table above, the applicant projects to perform 1,455 outpatient GI endoscopy procedures at Mission GI South in Project Year 1, 1,471 in Project Year 2, and 1,487 in Project Year 3, assuming 10% in-migration. However, as previously noted in this section, projected in-migration for Mission GI South is overstated. Therefore, the projected number of procedures the applicant projects to perform at Mission GI South is overstated.

Additionally, the applicant provides inconsistent information regarding projected inmigration for Mission GI South. While the applicant states that 10% of the GI endoscopy procedures at Mission GI South will come from other Buncombe County and Henderson County zip codes and other counties, in the Pro Forma Section of the application, and also in Exhibit 16, Table 5, the applicant projects that in-migration at Mission GI South will be 15%. [See Criterion (5) for additional discussion.] Assuming 15% in-migration for Mission GI South results in the following projected utilization, as shown below:

Mission GI South Total Projected Outpatient GI Endoscopy Procedures 2010 – 2015

	2020 20					
Mission GI South	2010	2011	2012	PY1:	PY2:	PY3:
				2013	2014	2015
Projected OP GI Endoscopy Procedures		•				
- Combined Buncombe & Henderson						
Zip Codes	1,267.	1,281	1,295	1,309	1,324	1,338
In-migration (15%)				231	234	236
Total Projected OP GI Endoscopy						.
Procedures				1,540	1,558	1,574
GI Endoscopy Rooms Needed at					/ 	
Mission GI South				1	1	<u> </u>

Source: Exhibit 16, Table 5. Also see Pro Forma Section for Mission GI South's pro forma projections and the discussion in Criterion (5).

Thus, as shown in the two tables above, the in-migration information provided by the applicant for Mission GI South is inconsistent. The latter table shows that with 15% in-migration, the applicant projects to perform 1,540 outpatient GI endoscopy procedures in Project Year 1, 1,558 in Year 2, and 1,574 in Year 3, which is 85 more procedures in Project Year 1, 87 more in Year 2, and 87 in Year 3. Based on the differing information provided between the applicant's utilization and assumptions and the pro formas [Section II.1(b) of the application, Exhibit 16, Table 5, and the Pro Forma Section], the Project Analyst found the applicant's projected utilization assumptions to be unreliable. Therefore, projected utilization for Mission GI South is unreliable.

Need Analysis

Mission Hospital currently operates six licensed GI endoscopy rooms on its main campus in Asheville, in the northern portion of Buncombe County. The applicant proposes to relocate one of its existing GI endoscopy rooms to a new location in Fletcher, NC, in the southern portion of Buncombe County. The proposed new location will be called Mission GI South. The applicant does not propose to establish a new, separately licensed ambulatory surgical facility. Rather, the relocated GI endoscopy room will remain on the hospital's license. Indeed, Mission GI South can be thought of as a "satellite" GI endoscopy room of Mission Hospital. In Section III.1(b), the applicant states, "The proposed satellite GI endoscopy room at Mission GI South is projected to become operational in January 2013."

In Sections III.6 and III.7, pages 70 and 71, the applicant states that Buncombe and Henderson counties make up 63.7% of Mission Hospital's service area (Buncombe = 56.8% and Henderson = 6.9%). Within this service area, the applicant has identified a "sub-service area" for Mission GI South consisting of nine zip codes. The applicant states it proposes to serve existing Mission Hospital patients who live in the "sub-service area" and are currently traveling to the main campus in Asheville, thereby providing GI

endoscopy services to Mission's existing patients in a location closer to where they live.

In Section III.1(a), page 32, the applicant states, "Mission GI South will provide improved access for the significant number of residents from south Buncombe County and Henderson County that currently choose to seek care at Mission and The Endoscopy Center in Buncombe County." Additionally, in Section III.1(a), page 29, the applicant states, "Mission GI South will provide an alternative ambulatory location for Mission patients in the southern market for GI endoscopies."

As the relocated GI endoscopy room will remain on Mission Hospital's license and continue to be counted in the hospital's inventory of licensed GI endoscopy rooms, the applicant projected utilization at Mission GI South based on Mission Hospital's historical utilization of all six existing licensed GI endoscopy rooms. In Section III.1(b), page 46, the applicant illustrates that from CY 2008 to CY 2010, the total number of procedures (inpatient and outpatient) performed in the six existing licensed GI endoscopy rooms at Mission Hospital remained relatively flat, with a compound annual growth rate (CAGR) rate of -0.2% (or 0.0% when rounding) over the three-year period.

The number of GI endoscopy procedures has remained relatively flat not just at Mission Hospital, but for surrounding providers as well. In fact, the total number of procedures at the five existing GI endoscopy providers in Buncombe and Henderson counties has remained relatively flat or declined from FFY 2008 to FFY 2010. According to data in the 2009 to 2011 SMFPs, a total of 32,490 procedures were performed in Buncombe and Henderson counties in FFY 2008 and a total of 31,600 procedures were performed in FFY 2010. From FFY 2008 to FFY 2010, the CAGR in total procedures performed in Buncombe and Henderson counties was -1.38%.

There are 11 GI endoscopy rooms in Buncombe County. Mission Hospital has six rooms and The Endoscopy Center has five rooms, all of which are located in the northern portion of Buncombe County. Historical utilization of the 11 GI endoscopy rooms is illustrated below:

GI Endoscopy Room Utilization

Buncombe County						
	FFY 2008	FFY 2009	FFY 2010	% Increase (Decrease)		
# of Rooms	11	11	. 11			
# of Cases	17,512	17,870	17,643	0.7%		
# of Procedures	23,312	23,517	23,426	0.5%		
# of Procedures per Room	2,119	2,138	2,130	-		
	N C 12 1 12 - 2	7'4' - Dlana				

*Source: 2009, 2010, 2011 State Medical Facilities Plans.

There are six GI endoscopy rooms in Henderson County. Carolina Mountain Gastroenterology Endoscopy Center has two rooms, Margaret R. Pardee Memorial Hospital has three rooms, and Park Ridge Hospital one room. Historical utilization of the six endoscopy rooms is illustrated below:

GI Endoscopy Room Utilization Henderson County

Henderson County					
	FFY 2008	FFY 2009	FFY 2010	% Increase (Decrease)	
# of Rooms	.6	6	. 6	_	
# of Cases	8,194	6,627	6,403	(21.9%)	
# of Procedures .	9,178	8,254	8,174	(10.9%)	
# of Procedures per Room	1,530	1,376	1,362	·	

^{*}Source: 2009, 2010, 2011 State Medical Facilities Plans.

As shown in the tables above, utilization in Buncombe County has remained relatively flat, as the number of cases and procedures have increased by just 0.7% and 0.5%, respectively, from FFY 2008 to FFY 2010.

Conversely, utilization in Henderson County has decreased, as the number of cases and procedures has decreased by 21.9% and 10.9%, respectively, over the same time period. In fact, the number of procedures performed per room in Henderson County's six GI endoscopy rooms in FFY 2010—1,362 procedures per room—is well below the threshold in The Criteria and Standards for Gastrointestinal Endoscopy Procedure Rooms in Licensed Health Service Facilities (10A NCAC 14C .3900) that requires a licensed GI endoscopy room to perform a minimum of 1,500 procedures per room. (By contrast, the number of procedures performed per room in Buncombe County's 11 GI endoscopy rooms in FFY 2010 was 2,130 procedures per room.)

Furthermore, while the applicant's utilization methodology assumes a -0.2% growth rate in the number of procedures through the project years, the growth in procedures in Henderson County has declined by 10.9% over the past two years. The applicant proposes to locate the proposed Mission GI South campus on the Buncombe/Henderson County line, where county-wide (Henderson County) GI endoscopy utilization is decreasing more rapidly than utilization in Buncombe County. Additionally, the six GI endoscopy rooms in Henderson County are in relative close proximity to the proposed Mission GI South campus—Park Ridge Hospital is approximately 5.15 miles; Carolina Mountain Gastroenterology Endoscopy Center is approximately 11.70 miles; and Margarët R. Pardee Memorial Hospital is approximately 11.80 miles. As can be seen in the previous table, Park Ridge Hospital (the facility in closest proximity to the proposed Mission GI South campus) performed the fewest number of GI endoscopy cases and procedures of the three Henderson County GI endoscopy providers. Park Ridge Hospital performed just 676 procedures per room¹ in FFY 2010—well below the threshold in The Criteria and Standards for Gastrointestinal Endoscopy Procedure Rooms in Licensed Health Service Facilities (10A NCAC 14C .3900) that requires a licensed GI endoscopy room to perform a minimum of 1,500 procedures per room. Thus, there is existing capacity for additional GI endoscopy procedures in the Mission GI South service area.

¹ In the 2011 and 2012 (Proposed) State Medical Facilities Plans (FFYs 2009 and 2010, respectively), Park Ridge is reported as performing 0 procedures. The CON Section assumes Park Ridge performed at least one procedure per case.

The applicant does not adequately demonstrate the need to locate one of its six existing GI endoscopy rooms on the Buncombe/Henderson County line (literally).

The applicant assumes that 70% Mission Hospital's Buncombe and Henderson County market shares for outpatient GI endoscopy will shift to Mission GI South due to better geographic access and convenience. It is also reasonable to assume that some patients from other counties outside of Buncombe and Henderson counties may utilize services at Mission GI South. However, the applicant's assumption that 10% of Mission GI South's patients will come from other counties outside of Buncombe and Henderson counties is unsupported. The applicant does not identify the counties or zip codes associated with the 10% in-migration assumption. The Project Analyst examined Mission Hospital's current patient origin for total GI endoscopy cases as provided in the 2011 LRA, along with a map of the State of North Carolina. Based on the counties where patients currently live, the information provided indicates that it is reasonable to expect only 7.7% inmigration at Mission GI South to come from counties outside of Buncombe and Henderson counties [See Assumptions and Methodology in Criterion (3) for additional discussion.] In Section III.1(a), page 53, the applicant states that in FY 2010, Mission Hospital had 2,531 inpatient cases and 3,982 outpatient cases. Thus, Mission Hospital's inpatient/outpatient split is 38.9% inpatient cases and 61.1% outpatient cases. As such, only a portion of the patients included in the applicant's projected in-migration rate would be expected to seek care in an outpatient setting. Therefore, the applicant overstates the projected utilization at Mission GI South.

Finally, the applicant provided inconsistent assumptions with regard to projected inmigration at Mission GI South. While the applicant assumes a 10% in-migration rate throughout the methodology in Section III of the application, the supporting data (Exhibit 16, Table 5) assumes a 15% in-migration rate. This discrepancy in and of itself would not be problematic but for the fact that the applicant assumes a 15% in-migration rate in the Mission GI South pro formas. [See Pro Forma Section and Criterion (5) for additional discussion.]

In conclusion, the applicant's methodology and assumptions for projecting utilization at Mission GI South overstates the number of GI endoscopy procedures projected to be performed because its in-migration assumptions are unsupported. Additionally, the applicant's methodology and assumptions are unreliable because the applicant provides inconsistent assumptions with regard to varying in-migration rates between the assumptions in Section III.1(b), page 58, Exhibit 16, Table 5, and the Pro Forma Section [See Criterion (5) for additional discussion]. Furthermore, the applicant does not adequately demonstrate the need to locate one of its six existing GI endoscopy rooms on the Buncombe/Henderson County line (literally) given the declining utilization in Henderson County and the existence of sufficient capacity in Henderson County.

In summary, the applicant did not adequately identify the population to be served and did not demonstrate the need that the population has for proposal. Therefore, the application is nonconforming 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.

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The applicant proposes to relocate one of its existing six GI endoscopy rooms from Mission Hospital's main campus in Asheville to Fletcher, in Buncombe County. The relocated GI endoscopy room will be called Mission GI South, and will serve as a "satellite" location that will enable the applicant to provide care to patients who live in southern Buncombe County but are currently traveling to Mission Hospital. Buncombe and Henderson County patients projected to be served at the relocated GI endoscopy room represent a shift of existing patients from Mission's main campus in Asheville to the new location in Fletcher, thereby providing these patients easier geographic access to services. Furthermore, with five GI endoscopy rooms remaining on the Mission Hospital campus upon completion of the proposed project, the applicant will have sufficient capacity to continue to serve existing and projected patients in Asheville. In Section IV.1(c), page 76, the applicant states that in CY 2010, Mission Hospital performed 8,661 procedures in six GI endoscopy rooms at its main campus in Asheville or 1,444 procedures per room (8,661 procedures / 6 rooms = 1,444 procedures per room). In CY 2015 (Project Year 3), the applicant projects to perform 7,092 procedures in the remaining five rooms in Asheville or 1,418 procedures per room (7,092 procedures / 5 rooms = 1,418 procedures per room). Therefore, the relocation of one GI endoscopy room will not result in the overutilization of the five remaining rooms in Asheville. Thus, patients who will continue to use the Asheville campus will not be affected by the relocation of one GI endoscopy room to Fletcher. Consequently, the application is conforming to this criterion.

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

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In Section III.8, pages 71-72, the applicant describes the alternatives considered. The applicant considered developing a new GI endoscopy room rather than relocating one of the existing six rooms, but determined that it would be more reasonable to use existing resources. The applicant also considered relocating two rooms to southern Buncombe

County instead of one, but determined that the volume of existing cases originating from the southern portion of the county would not support two rooms.

The land and the MOB in which the relocated GI endoscopy room will operate straddle the Buncombe/Henderson County line. Exhibit 28 includes a copy of the warranty deed for the portion of the property in Buncombe County and a copy of the warranty deed for the portion of the property in Henderson County. Both deeds state the following, "This deed is one of two deeds describing the above property, one being recorded in Buncombe County and one in Henderson County." The majority of the property is located in Henderson County. Exhibit 28, page 508, includes an attachment to one of the warranty deeds describing the property as follows: "Lying in Buncombe and Henderson Counties, being a tract of 7.739 acres, of which 2.735 acres are located in Buncombe County and 5.004 acres are located in Henderson County..." Exhibit 29 includes a line drawing which shows that the county line crosses through the land and the MOB. Exhibit 6 includes a line drawing of the proposed GI endoscopy suite, which clearly shows that the county line cuts through the corner of the proposed space. Thus, as illustrated in the line drawings, the space in which the proposed relocated GI endoscopy room will be located is in both Buncombe and Henderson Counties.

In Section I.7 and I.8, the applicant states the physical address of the proposed relocated GI endoscopy room is 2651 Hendersonville Road in the Town of Fletcher, in Buncombe County. If the entire proposed GI endoscopy suite were located in Buncombe County there would be no change in the inventory of operating rooms in Buncombe County, as the GI endoscopy room being relocated is currently located in Buncombe County. However, due to the fact that a portion of the proposed GI endoscopy suite will be located in Henderson County, as illustrated in the line drawings provided by the applicant, the proposed project would arguably increase the inventory of licensed GI endoscopy rooms in Henderson County.

In Exhibit 29, the applicant provides a cost estimate from a registered architect for construction of the proposed project and related space in the medical office building (MOB). Mission Hospital already owns the land where the MOB will be located. The applicant states that a developer will own the building and Mission Hospital will lease space in the MOB for Mission GI South. However, the architect's cost estimate indicates there is a 60/40 ownership "adjustment" between the developer and Mission Hospital. However, the applicant does not provide enough information regarding the basis for determining that there will be a 60/40 ownership "adjustment" between the developer and Mission Hospital. Furthermore, it appears the developer should have been identified as a co-applicant in the application because the applicant does not adequately demonstrate that the developer will not be incurring an obligation for a capital expenditure which is a new institutional health service (i.e., developing space for a relocated GI endoscopy room in a licensed health service facility). Mission Hospital is the only applicant identified in the application. The applicant did not adequately demonstrate that the most effective alternative has been proposed to meet the need which the applicant states exists. See Criterion (3) for discussion regarding demonstration of need.

Furthermore, the application is not conforming to all other applicable statutory and regulatory review criteria. See Criteria (3), (5), (6), (12) and (18a). Therefore, the applicant did not adequately demonstrate that the proposal is its least costly or most effective alternative and the application is nonconforming with this criterion.

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

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In Section VIII, page 99, the applicant states that the total capital cost is projected be \$1,237,236, including \$617,655 for construction costs and \$619,581 for miscellaneous project costs, which consists of \$567,911 for fixed equipment, \$29,000 for furniture, and \$17,120 for architectural and engineering fees. However, construction costs, fixed equipment, movable equipment, and furniture only add up to \$614,031, as illustrated below:

Miscellaneous Project Costs	
Fixed Equipment	\$567,911
Furniture	\$29,000
Architectural and Engineering Fees	\$17,120
Total Miscellaneous Project Costs	\$614,031
Difference**	(\$5,550)

*Source: Section VIII, page 99.

Thus, in Section VIII, page 99, the applicant appears to overstate the total capital cost of the project by \$5,550. However, it appears the developer will incur an obligation for a capital expenditure which is a new institutional health service. The capital cost reported by the applicant in Section VIII, page 99, does not include the 60% to be incurred by the developer. [In the letter from the certified architect included in Exhibit 29, the architect states that total building costs for the Mission GI South portion of the building will be \$850,387, with the developer's ownership portion being 60% (or \$510,232) and Mission Hospital's ownership portion being 40% (or \$340,155).] If the developer's portion was included, the capital cost of the project would be \$1,747,468 (\$1,237,236 + \$510,232 = \$1,747,468). The applicant does not adequately demonstrate that the cost to be incurred by the developer should not be included. [See Criterion (4) for additional discussion.] Thus, the capital cost of the proposed project is understated.

In Section IX, page 106, the applicant projects there will be no start-up expenses associated with the project. While proposed to be licensed as part of the hospital, the relocated GI endoscopy room will be located on a new campus. It is not reasonable to

^{**}Difference calculated as follows: \$619,581 - \$614,031 = \$5,550.

assume there will be <u>no</u> start-up expenses associated with development of a new campus, such as utilities or insurance.

Exhibit 26 contains a letter signed by a Senior Vice President, Finance and Chief Financial Officer at Mission Hospital, which states,

"Mission Hospital is positioned financially to fund the project cost of \$1,237,236 through operations and/or accumulated cash reserves. Funds are available for this project, in addition to several other projects which have been approved or are under review by the Agency as reflected in Mission's 2010 Audited Financial Statements, which are included as part of this Application."

The applicant does not adequately demonstrate the availability of sufficient funds for the capital cost of the project given the developer appears to be incurring 60% of the cost to develop the new institutional health service. Furthermore, the applicant does not adequately demonstrate the availability of sufficient funds for start-up costs likely to be incurred prior to serving patients at the new campus.

In the Pro Forma Section, pages 121 and 125, the applicant provides a statement of revenues and expenses (Form C) for GI endoscopy services at Mission Hospital and Mission GI South. On the statement of revenues and expenses for Mission Hospital (page 121), the applicant projects revenues will exceed operating costs in the first three years of the project. The project years are shown as fiscal years (October 1 - September 30) when, in fact, the applicant's projected utilization is based on calendar years (January 1 - December 31). In Section III.1(b), page 45, the applicant states, "Calendar year 2010 Trendstar data is the most current and reasonable data to use as a base to project future GI endoscopy utilization. It is also consistent with the project years, which are calendar year-based." [Also see Section III.1(b), page 50 and Section IV, page 76]. Interestingly, the projected number of cases shown on Forin C, which are based on fiscal years, through Project Year 3 are the same as number of cases shown on page 50, which are based on calendar years. It is unusual that the number of cases performed in any given fiscal year would exactly match the number of cases performed in any given calendar year. Thus, the applicant's pro forma projections for GI endoscopy services at Mission Hospital are inconsistent with the methodology in Section III.1(b) and are, therefore, unreliable.

On the statement of revenues and expenses for Mission GI South (page 125), the applicant projects that revenues will exceed operating costs in the first three years of the project. Again, the project years are shown as fiscal years (October 1 – September 30) when, in fact, the applicant's projected utilization is based on calendar years (January 1 – December 31). [See Section IV, page 76 and various tables in Exhibit 16]. Additionally, the projected number of cases for the first three years of the proposed project is inconsistent with the projected number of cases in the applicant's methodology. The inconsistencies are illustrated below:

	Projected # of Procedures			
	Pro Forma (Form C)	Section IV (Page 76)		
Project Year 1	1,540*	1,455		
Project Year 2	1,557*	1,471		
Project Year 3	1,575*	1,487		

*Calculated by the Project Analyst. In the Pro Forma Section, the applicant provides the projected number of cases for each Project Year. In Section III.1(b), page 55, the applicant states the ratio of cases to procedures is 1.3. The Project Analyst multiplied the projected number of cases by 1.3 to determine the projected number of procedures for each Project Year. Project Year 1: 1,158 cases x 1.3 = 1,540 cases; Project Year 2: 1,171 x 1.3 cases = 1,557 cases; Project Year 3: 1,184 x 1.3 = 1,575 cases.

As shown in the table above, the projected number of cases in the pro formas is greater than the number of cases the applicant projects to perform it its utilization projections, as provided in Sections III and IV. Thus, the applicant's pro formas for Mission GI South are overstated. Projected revenues for GI endoscopy services at Mission GI South, which are based on projected utilization, are inconsistent with the assumptions and methodology in Section III.1(b) and the projected utilization in Section IV, and are, therefore, unreliable.

Additionally, on the applicant's statement of revenues and expenses (Form C), page 121, for GI endoscopy services at Mission Hospital and Mission GI South, salary expenses for clinical and other personnel are not in line with the salary expenses provided by the applicant in Section VII. In Project Year 3, salary expenses for GI endoscopy services at Mission Hospital and Mission GI South (combined), as provided on Form C, are shown in the table below:

Total Mission GI Endoscopy Salary Expenses . Project Year 3 (10/1/14 - 9/30/15)

Personnel ·	Salary Expense
Clinical	\$10,949,703
Other	\$7,450,692
Total	\$18,400,395

*Source: Form C, page 121.

However, salary expenses for GI endoscopy services at Mission Hospital and Mission GI South (combined) in Project Year 3, as provided in Section VII.2, page 93, are shown in the table below:

Total Mission GI Endoscopy Salary Expenses Project Year 3 (1/1/14 – 12/31/14)

	(1/1/14 11	, o z, z ·) · · · · · · · · · · · · · · · · ·	
Personnel	Annual Salary	Full-Time	Salary.Expense
		Equivalents	
		. (FTEs)	
	(A)	(B)	$(A \times B = C)$
Registered Nurse	\$62,519	17	\$1,062,823
Unit Secretary	\$31,917	. 3	\$95,751
Endoscopy Tech	\$35,169	. 3	\$105,507
RN - Supervisor	\$120,748	2	\$241,496
			\$1,505,577
Total	1		

*Source: Section VII.2, page 93.

As shown in the two proceeding tables, aside from the inconsistency of the project years, the applicant's salary expenses in the third year of the project differ significantly. Salary expenses on Form C are more than 12 times greater than that provided in Section VII of the application. The applicant does not explain why salary expenses differ so greatly in the assumptions provided in the Pro forma Section. Assuming the salary expenses provided in Section VII are accurate, the salary expenses in Form C are grossly overestimated. This, however, does not reflect negatively on the financial feasibility of the proposed project. However, the Project Analyst could not determine the source of the discrepancy, and the discrepancy is large enough to raise questions as to the reliability of the pro formas in general.

In summary, the applicant does not adequately demonstrate the availability of sufficient funds for the capital and working capital needs of the project and does not adequately demonstrate that the financial feasibility of the proposal is based upon reasonable projections of costs and revenues. Therefore, the application is not 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.

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Mission Hospital operates six licensed GI endoscopy rooms on its main campus in Asheville and proposes to relocate one of its existing GI endoscopy rooms to a new medical office building in Fletcher. The relocated GI endoscopy room will continue to be licensed as a part of the hospital. However, the applicant did not adequately demonstrate that the proposal would not result in the unnecessary duplication of existing or approved health service capabilities. The applicant identified nine zip codes in Buncombe and Henderson counties as the primary service area for Mission GI South. In Section III.1(a), page 58, the applicant projects to perform 1,455 procedures at Mission GI South in Project Year 1, 1,471 procedures in Project Year 2, and 1,487 procedures in Project Year

3. The applicant assumes a 10% in-migration rate from counties outside of Buncombe and Henderson counties. The applicant's in-migration assumption is based on the fact that Mission Hospital's historical patient origin consists of 34% in-migration rate from counties other than Buncombe and Henderson counties. However, Mission Hospital is a tertiary regional referral hospital and draws patients from a wide geographic area for a trauma and specialty care. Based on Mission Hospital's current patient origin for inpatient and outpatient GI endoscopy from counties other than Buncombe and Henderson counties [as reported on its 2011 License Renewal Application (LRA)], the Project Analyst estimates that a 7.7% in-migration is more reasonable. [See Criterion (3) for additional discussion.] Thus, the applicant's projected utilization for Mission GI South is overstated. Furthermore, the patient origin information reported on the LRA includes both inpatient and outpatient endoscopy procedures, but only outpatient procedures will be performed at the Mission GI South campus. As such, without making an adjustment for impatient GI endoscopy procedures, even the Project Analyst's estimate of 7.7% in-migration is overstated.

Additionally, the applicant proposes to locate the proposed Mission GI South on the Buncombe/Henderson County line (literally). From FFY 2008 to FFY 2010, Buncombe County experienced almost no growth in the number of GI endoscopy procedures performed, increasing by just 0.5% from FFY 2008 to FFY 2010. In contrast, Henderson County has experienced a decline in the number of GI endoscopy procedures, decreasing by 10.9% over the same time period. Additionally, the six GI endoscopy rooms in Henderson County are in relative close proximity to the proposed Mission GI South campus—Park Ridge Hospital is approximately 5.15 miles; Carolina Mountain Gastroenterology Endoscopy Center is approximately 11.70 miles; and Margaret R. Pardee Memorial Hospital is approximately 11.80 miles. As can be seen in the previous table, Park Ridge Hospital (the facility in closest proximity to the proposed Mission GI South campus) performed the fewest number of GI endoscopy cases and procedures of the three Henderson County GI endoscopy providers. Park Ridge Hospital performed just 676 procedures per room2 in FFY 2010—well below the threshold in The Criteria and Standards for Gastrointestinal Endoscopy Procedure Rooms in Licensed Health Service Facilities (10A NCAC 14C .3900) that requires a licensed GI endoscopy room to perform a minimum of 1,500 procedures per room. Given the decline in GI endoscopy utilization in Henderson County, with six GI endoscopy rooms in operation, there is sufficient GI endoscopy capacity in the Mission GI South service area already. Thus, relocating an additional GI endoscopy room to the Buncombe/Henderson County line would result in an unnecessary duplication of existing GI endoscopy services.

In summary, the applicant does not adequately demonstrate that the proposed Mission GI South would not unnecessarily duplicate existing and approved GI endoscopy facilities. Therefore, the application is nonconforming with the criterion.

² In the 2011 and 2012 (Proposed) State Medical Facilities Plans (FFYs 2009 and 2010, respectively), Park Ridge is reported as performing 0 procedures. The CON Section assumes Park Ridge performed at least one procedure per case.

(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.

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The following table illustrates the current and projected staffing for GI endoscopy services at Mission Hospital and the proposed Mission GI South campus, as reported by the applicant in Section VII, pages 93-94.

	# of F	ull-Time Equivaler		
Employee Category	Mission Hospital	Mission Hospital & Mission GI	Mission GI South Only	
	(Current)	South Combined (Project Year 3)	(Project Year 3)	
	(A)	(B)	(C)	
Registered Nurse	15	17	3	
Unit Secretary	2	. 3	1	
Endoscopy Tech	1	. 3	2	
RN Supervisor	2	2	n/a	
Applicant's Total	21	28	6	
Actual Total*	20	25	. 6	

^{*}Calculated by the Project Analyst.

As can be seen in the table above, there are some discrepancies in the projected staffing data as reported by the applicant. First, the applicant incorrectly added the number of existing full-time equivalents (FTEs) at Mission Hospital (Column A) and the projected number of FTEs for both the Mission Hospital campus and the Mission GI South campus combined in Project Year 3 (Column B). Additionally, while the applicant's table in Section VII.2, page 94, shows a total of six FTEs at the Mission GI South campus, the narrative in Section VII.3, page 94, states that there will be seven new FTEs on the Mission GI South campus after completion of the proposed project.

In Section VII.6(b), page 96, the applicant provides the projected staffing for Mission Hospital and Mission GI South by functional area in Project Year 3, shown in the table below:

^{**}Source: Sections VII.1 and VII.2.

Functional Area	• Туре	# of FTE
		Positions
Administration	RN Manager	1.00
	 RN Supervisor 	1.00
		2.00
Registration	 Unit Secretary 	3.00
Pre-Procedure	• RNs	.5.00
, '	 Endoscopy Technician 	<u>0.50</u>
		5.50
Post-Procedure	• ·RNs	5.00
	Endoscopy Technician	0.50
		5.50
GI Endoscopy Room	• RNs	8.00
	• Endoscopy Technician	4.00
		12.00
Total Staffing		28.00

As shown in the table above, the applicant projects a total of 28 FTEs on the Mission Hospital campus and the Mission GI South campus (combined) in Project Year 3. While the information in Sections VII.1 and VII.2 is inconsistent, the information provided with regard to the number of FTEs by functional area show that the applicant's staff projections are reasonable.

Exhibit 10 contains letters from the Chief Medical Officer and Senior Vice President of Medical Affairs, the Chief of Staff, and the Interim Vice President of Surgical Services at Mission Hospital, expressing their support for the proposed project. The relocated GI endoscopy room will continue to remain on the Mission Hospital license as one of its total complement of GI endoscopy rooms.

The applicant adequately demonstrates the availability of sufficient manpower and management personnel to provide the proposed GI endoscopy services. Therefore, the application is conforming to this criterion.

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

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As a provider of trauma and tertiary services, Mission Hospital already provides pathology services and other necessary ancillary support services. Exhibit 20 contains a list of facilities in the region with which Mission Hospital has existing transfer

agreements. A transfer agreement between the Mission GI South campus and Mission Hospital is not needed because the relocated GI endoscopy room on the Mission GI South campus will continue to be licensed as part of Mission Hospital. Exhibit 7 contains letters from the Vice President of Ambulatory and Ancillary Services and the Vice President of Support Services at Mission Hospital stating that the necessary ancillary and support services will be provided. Exhibit 22 contains letters from physicians at other physicians P.A. and Associates, Gastroenterology Asheville clinical/administrative staff at Mission Hospital stating their support for the proposed project. Consequently, the applicant adequately demonstrated that all necessary ancillary and support services will be available and that the service will 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.

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When applicable, the applicant shall show that the special needs of health maintenance organizations will be fulfilled by the project. Specifically, the applicant shall show that the project accommodates: (a) The needs of enrolled members and reasonably anticipated new members of the HMO for the health service to be provided by the organization; and (b) The availability of new health services from non-HMO providers or other HMOs in a reasonable and cost-effective manner which is consistent with the basic method of operation of the HMO. In assessing the availability of these health services from these providers, the applicant shall consider only whether the services from these providers: (i) would be available under a contract of at least 5 years duration; (ii) would be available and conveniently accessible through physicians and other health professionals associated with the HMO; (iii) would cost no more than if the services were provided by the HMO; and (iv) would be available in a manner which is administratively feasible to the HMO.

NA

- (11) Repealed effective July 1, 1987.
- (12) Applications involving construction shall demonstrate that the cost, design, and means of construction proposed represent the most reasonable alternative, and that the construction project will not unduly increase the costs of providing health services by the person proposing the construction project or the costs and charges to the public of providing health services by other persons, and that applicable energy saving features have been incorporated into the construction plans.

The applicant proposes to relocate one licensed GI endoscopy room from the main campus of Mission Hospital in Asheville to a new medical office building (MOB) in Fletcher. In Section XI.2, pages 110-111, the applicant states that the land is already owned by Mission Hospital but the MOB will be developed by a third party developer. The applicant states that Mission Hospital will lease space in the MOB for the proposed project. In Section XI.5, the applicant states the project will involve 3,700 square feet of interior construction. In Section XI.6(b), page 115, the applicant estimates construction costs of \$166.93 per square foot. In Section XI.8, pages 115-116, the applicant describes the methods to be used to maintain efficient energy operations.

Exhibit 29 contains a letter from a certified architect with a cost estimate for the proposed project. The architect breaks down the cost estimate as follows:

Anticipated site improvement cost	n/a	-
Anticipated upfit cost (\$100/sf)	\$370,000	
Less Landlord tenant improvement allowance (\$25/sf)	(\$92,500)	
Interior upfit subtotal		\$277,500
Anticipated prorate share of site, shell & core MOB cost (4.28%)	\$850,387	
Less 60% Ownership adjustment – Mission 40% MOB ownership	(\$510,232)	
Associated building cost subtotal		\$340,155
Total anticipated cost above		\$617,655

*Source: Exhibit 29.

The architect's cost estimate indicates there is a 60/40 ownership "adjustment" between the developer and Mission Hospital. However, the applicant does not provide enough information regarding the basis for determining that there will be a 60/40 ownership "adjustment" between the developer and Mission Hospital. Furthermore, it appears the developer should have been identified as a co-applicant in the application because the applicant does not adequately demonstrate that the developer will not be incurring an obligation for a capital expenditure which is a new institutional health service (i.e., developing space for a relocated GI endoscopy room in a licensed health service facility). Mission Hospital is the only applicant identified in the application. The applicant did not adequately demonstrate that the cost of construction represents the most reasonable alternative. Therefore, the application is nonconforming 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;

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The following table illustrates the current payor mix for the GI endoscopy department at Mission Hospital, as reported by the applicant in Section VI.13, page 91

ENDOSCOPY DEPART	
LAST FULL FISCAL YEAR (10/1/09 – 9/30/10)	
CURRENT CASES AS PERCENT C	OF TOTAL CASES
Self Pay / Indigent	5.24%
Medicare / Medicare Managed Care	. 50.42%
Medicaid	13.15%
Commercial Insurance	1.31%
Managed Care	27.69%
Other (Specify)*	2.19%
TOTAL	100.00%

^{*}Other includes. Workers Comp & State Employee Benefit Health Plan

The Division of Medical Assistance (DMA) maintains a website which offers information regarding the number of persons eligible for Medicaid assistance and estimates of the percentage of uninsured for each county in North Carolina. The following table illustrates those percentages as of June 2009 and CY 2005, respectively. The data in the table was obtained July 27, 2011. More current data, particularly with regard to the estimated uninsured percentages, was not available.

	Total # of Medicaid Eligibles as % of Total Population	Total # of Medicaid Eligibles Age 21 and older as % of Total Population	% Uninsured CY 2005 (Estimate by Cecil G. Sheps Center)
County Buncombe Henderson Statewide	16%	7%	16.7%
	13%	5%	17.6%
	16%	7%	17.2%

*Source: DMA Website: http://www.ncdhhs.gov/dma/pub/index.htm

The majority of Medicaid eligibles are children under the age of 21. This age group does not utilize the same health services at the same rate as older segments of the population, particularly the services offered by the endoscopy department at Mission Hospital.

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

The Office of State Budget & Management (OSBM) maintains a website which provides historical and projected population data for each county in North Carolina. However, as of July 27, 2011, no population data was available by age, race or gender. Even if the data were available, a direct comparison to the applicants' current payor mix would be of little value. The population data by age, race or gender does not include information on the number of elderly, minorities or women utilizing health services. Furthermore, OSBM's website does not include information on the number of handicapped persons.

The application is conforming to this criterion.

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

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Recipients of Hill-Burton funds were required to provide uncompensated care, community service and access by minorities and handicapped persons. In Section VI.2, page 85, the applicant states, "Mission provides and will continue to provide acute care inpatient and outpatient services to all persons regardless of race, sex, age, religion, creed, disability, national origin or ability to pay." In Section VI.10(a), page 90, the applicant states that it is not aware of any documented civil rights equal access complaints or violations filed against Mission Hospital in the last five years. The application is conforming to this criterion.

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

The following table illustrates the projected payor mix for Mission Hospital's GI endoscopy department during the second operating year of the proposed project, as reported by the applicant in Section VI.14, page 92.

ENDOSCOPY DEPARTMENT (1/	(1/14-12/31/14)
· PROJECTED CASES AS PERCENT	OF TOTAL CASES
Self Pay / Indigent	. 5.24%
Medicare / Medicare Managed Care	50.42%
Medicaid	13.15%
Commercial Insurance	1.3.1%
Managed Care	27.69%
Other (Specify)*	2.19%
TOTAL	100.00%

^{*}Other includes Workers Comp & State Employee Benefit Health Plan

In Section VI.6, pages 87-88, the applicant states,

"It is the policy of all Mission Hospital facilities to provide care to all who seek it, regardless of their ability to pay. Mission has policies and procedures in place to identify those patients who require financial assistance and to ensure that these patients receive the aid they need to access health services."

The applicant demonstrates that medically underserved populations will have adequate access to the proposed services and the application is conforming to 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.

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In Section VI.9(a), page 89, the applicant states, "GI endoscopy patients are referred to Mission from hospitals and physician practices in the region. Patients presenting in the Emergency Department are predominantly self-referral and will be admitted to acute care beds when clinically appropriate. It is also anticipated that the local physicians will directly refer patients for GI endoscopy services as necessary." The information provided is reasonable and credible and supports a finding of conformity with this criterion.

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

In Section V.1(a), the applicant describes the institutions with which Mission Hospital participates in professional training programs. Additionally, Exhibit 19 includes an affiliation agreement with the Mountain Area Health Education Center Family Practice Residency. The information provided is reasonable and credible and supports a finding of conformity with this criterion.

- (15) Repealed effective July 1, 1987.
- (16) Repealed effective July 1, 1987.
- (17) Repealed effective July 1, 1987.
- (18) Repealed effective July 1, 1987.
- (18a) The applicant shall demonstrate the expected effects of the proposed services on competition in the proposed service area, including how any enhanced competition will have a positive impact upon the cost effectiveness, quality, and access to the services proposed; and in the case of applications for services where competition between providers will not have a favorable impact on cost-effectiveness, quality, and access to the services proposed, the applicant shall demonstrate that its application is for a service on which competition will not have a favorable impact.

NC

The applicant did not adequately demonstrate that the proposal would have a positive impact on cost-effectiveness because the applicant did not adequately demonstrate that the proposal is cost-effective [see Criteria (3), (4), (5), and (6) for additional discussion]. Therefore, the application is nonconforming 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

Mission Hospital is accredited by The Joint Commission. In Section II.7, page 12, the applicant states, "The proposed project will meet all state and federal regulatory licensure requirements, including OSHA, Division of Health Services Regulation ("DHSR") licensure, and all health facility requirements of the Buncombe County Department of Health." According to the records in the Acute Home Care Licensure and Certification Section of the Division of Health Service Regulation, no incidents have occurred at Mission Hospital within the 18 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.

NA

The applicant does not propose to establish a new licensed ambulatory surgical facility for performance of GI endoscopy procedures or develop a new GI endoscopy room in an existing licensed health service facility (Mission Hospital would remain licensed for no more than six GI endoscopy rooms). Thus, the Criteria and Standards for Gastroenterology Endoscopy Procedure Rooms in Licensed Health Service Facilities, promulgated in 10A NCAC 14C 3900, are not applicable to this review.

Google

Directions to 100 Hospital Dr. Hendersonville, NC 28792 4.4 ml - about 9 mins Distance from Mission site to Park Ridge Health



2651 Hendersonville Rd, Arden, NC 28704

25) 1. Head south on US-25 S/Hendersonville Rd toward Alliance Page Rd	go 1.2 mi total 1.2 mi
About 1 min	go 2.8 mi
🗲 2. Turn left onto Go Rd 1006/Howard Gap Rd	total 4.1 mi
About 6 mins	go 0.1 mi
3. Turn right onto Co Rd 1534/Naples Rd	total 4.2 m
4 Take the 1st left onto Hospital Dr	go 312 f total 4 3 m
5. Take the 1st right to stay on Hospital Dr Destination will be on the left	go 0.1 m total 4.4 m
100 Hospital Dr, Hendersonville, NC 28792	

These directions are for planning purposes only. You may find that construction projects, traffic, weather, or other events may cause conditions to differ from the map results, and you should plan your route accordingly. You must obey all signs or notices regarding your

Directions weren't right? Please find your route on maps.google.com and click "Report a problem" at the bottom left.

IN THE GENERAL COURT OF JUSTICE STATE OF NORTH CAROLINA SUPERIOR COURT DIVISION ' 11 DHR 11636 COUNTY OF BUNCOMBE MISSION HOSPITAL, INC; DEPOSITION Petitioner, OF VS. N.C DEPARTMENT OF HEALTH AND) GEBRETTE MILES HUMAN SERVICES, DIVISION OF HEALTH SERVICE REGULATION, CERTIFICATE OF NEED SECTION, Respondent

THURSDAY, JANUARY 5, 2012

10:03 A.M.

AT THE OFFICES OF

SMITH MOORE LEATHERWOOD LLP

434 FAYETTEVILLE STREET, TWO HANNOVER SQUARE SUITE 2800

RALEIGH, NC

VOLUME I

EXHIBIT

APPEARANCES

ON BEHALF OF THE MISSION HOSPITAL, INC:
TERRILL JOHNSON HARRIS, ESQ.
SMITH MOORE LEATHERWOOD LLP
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RALEIGH, NORTH CAROLINA

ON BEHALF OF THE CERTIFICATE OF NEED SECTION

JOEL JOHNSON, ESQ.
ASSISTANT ATTORNEY GENERAL
NC DEPARTMENT OF JUSTICE
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RALEIGH, NORTH CAROLINA

ALSO PRESENT: DENISE GUNTER, ESQ.
NANCY BRES MARTIN
CHRISTY SDIK
BRIAN MOORE

Carolina Reporting Service (919) 661-2727

MS. MILES-VOLUME I

STIPULATIONS

PRIOR TO THE EXAMINATION OF THE WITNESS, COUNSEL FOR THE PARTIES STIPULATED AND AGREED AS FOLLOWS

- Said deposition shall be taken for the purpose of discovery or for use as evidence in the above-entitled action or for both purposes, as permitted by all applicable statutes and rules:
- 2. Any objections of any party hereto as to notice of the taking of said deposition or as to the time and place thereof or as to the competency of the person before whom the same shall be taken are hereby waived;
- 3. Objections to the questions and motions to strike enswers need not be made during the taking of this deposition, but may be made for the first time during the progress of the trial of this case or any pre-trial hearing held before the judge for the purpose of ruling thereon or at any other hearing of said case at which said deposition might be used, except an objection as to the form of a question must be made at the time such question; is asked or objection is waived as to the form of the question;
- 4. That all formalities and requirements of the statute with respect to any formalities not herein expressly waived are hereby waived, especially including the right to move for the rejection of this deposition before trial for any inregularities in the taking of the same, either in whole or in part or for any other cause;
- That the undersigned notary-reporter shall personally deliver or mail by first-class mail the transcript of this deposition to the party taking the deposition or his attorney, who shall preserve it as the court's copy, and,
- That the witness reserves the right to read and sign the transcript of this deposition prior to filing.

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PROCEEDINGS

(WHEREUPON, GEBRETTE MILES WAS CALLED AS A WITNESS,

3 DULY SWORN, AND TESTIFIED AS FOLLOWS:)

4 DIRECT EXAMINATION BY MS. HARRIS:

Q. Good morning, Ms. Miles. We've met off the record,

6 and other times, I'm Terri Harris, and I'm

representing Mission Hospital Incorporated in

8 connection with an appeal of a decision by the CON

Section related to an endoscopy relocation

10 application. Will you state your full name,

please?

11

16

2 A. Gebrette Miles.

13 Q. Okay. What is your business address?

14 A. 809 Ruggles. We just moved.

15 Q. All right. If we can go off the record for a

second, I'll let Denise get setfied.

17 (OFF-THE-RECORD DISCUSSION)

18 (MS. GUNTER JOINS)

Q. (By Ms. Harris) Ms. Miles, what is your current

20 position?

21 A. I'm a certificate of need project analyst.

22 Q. Okay. How long have you been in that position?

23 A. Three years.

24 O. Can you tell me a little bit about your job

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MS. HILES--VOLUME I -6-MS. HILES--VOLUME I 8 6 I don't recall. Possibly. I don't remember. A. responsibilities? 1 And you did your administrative fellowship at Johns As a certificate of need analyst, I'm responsible 2 Q. 2 A. Hopkins; is that right? 3 for reviewing certificate of need applications, 3 reviewing them against the criterion and applicable Δ A. 4 Have you attended training programs or different 5 Q. rules. I'm also responsible for performing the 5 educational sessions related to health planning 6 public hearings as necessary, and also monitoring 6 since joining the Certificate of Need Section? 7 progress of projects that have been approved and 7 are under development. I also respond to inquiries 8 A. 8 Your training is on the job; is that right? regarding projects that may be exempt from review 9 Q. 9 or where the certificate of need law may not apply. 10 A. Correct. 10 Have you been in a deposition before? 11 Q. And other general correspondence as necessary. 11 Yes. 12 A. Do you have responsibility for a particular area of 12 Q. How many times, do you think? 13 Q. . the state, or type of service for which certificate 13 This may be my third or fourth time. 14 A. of need applications are required? 14 You're doing a great job so far, but I'll remind Yes, I am assigned to HSA II--the western part of 15 O. 15 you to let me finish my questions before you 16 HSA II, which is Forsyth, Surry, Yadkin, Davidson 16 answer, and I'll try to make sure that I let you 17 and Davie Counties, I believe, if I'm not 17 finish your answers before I ask another question. 18 forgetting one. 18 If you need a break, will you let me know? And I've been provided with a copy of a resume for 19 19 Q. 20 you, but, if you could, tell me briefly your 20 And if you don't understand one of my questions, background with regard to health planning. 21 Q. 21 will you let me know that? 22 I don't have a health planning background. Most of 22 Okay. my health planning experience is—has been involved 23 A. 23 Have you testified in a deposition involving a 24 with my current position as certificate of need 24 Carolina Reporting Service (919) 661-2727 Carolina Reporting Service (919) 661-2727 MS. MILES—VOLUME I MS. MILES--VOLUME I 9 7 relocation of an existing service before? analyst. I did work for-about three years for the 1 1 Relocation. If you want to consider-if you want 2 Maryland Hospital Association -primarily with their 2 to consider the Gaston satellite ID-I mean, ED 3 financial advocacy team regarding the rate setting 3 case as a relocation, that would be the closest to 4 system in Maryland. Maryland's rates are regulated 4 a relocation. 5 by the state, and so in an advocacy position on 5 And, just more generally, have you ever testified 6 behalf of the hospitals, I worked in that capacity. 6 in a contested case hearing? 7 But from a health planning standpoint, most of my 7 experience has been gained as a certificate of need 8 ₿ How many times? 9 9 Twice. 10 What degrees do you have? 10 What cases were those? A. I have an undergraduate from Delaware in Public 11 Q. 11 That was Wake Forest University Health Sciences 12 Administration and a master's degree in Health 12 development of a ambulatory surgical facility and 13 Services Administration from the University of 13 the Gaston satellite ED case. 14 Michigan. 14 The Wake Forest University Health Sciences amb surg 15 Was your MSA -excuse me, Master's of Health Service 15 center, was that a new ambulatory surgical center? Administration focused more on policy, would you 16 16 17 A. 17 say? Did it involve transferring ownership of any No, I would say it's--the subspecialty was Health 18 Q. 18 existing operating rooms? 19 Management and Policy, so it was a combination of 19 No, it was a development of new operating rooms. 20 management and policy. But I think primarily our 20 And did you initially disapprove the application? training was more geared towards management and 21 Q. 21 Yes--no, I'm sorry. I approved that application.

22

23

24

22

23

24

operations.

planning?

Did you have any classes with regard to health

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Α.

Q.

applicant?

And then there was an appeal by a competing

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		. 10)			12
. .		Intervenor, I believe. It was not competitive.	1		E	xhibit 2, I've got 1 here, and the Agency file as
1 A		Was the Agency's decision upheld through that	2		E	xhibit 3.
2 Q			3		(DEPOSITION EXHIBIT NOS. 1, 2 AND 3 WER
3		appeal process? That's—to my knowledge, it's still outstanding.	4		•	MARKED FOR IDENTIFICATION.)
4 A			5	Q.		And I'll hand you what I've marked at the beginning
5 Q		Okay.	6	٧.		s Exhibit 1, which is a copy of the Agency's
6 A		I'm not certain of the status.	7			liscovery responses, and we'll be referring to
7 Ç		What was your initial decision with regard to the	8			hese exhibits throughout the deposition. I'll try
8	1	Gaston ED?	9			o make sure I give you time and the page number t
9 A	4.	I approved that application.	10			get where you need to go for my particular
0 (Q.	And was there an appeal by Carolinas Medical				questions. Did you do anything else besides
1		Center?	11			looking back through the application and Agency
12 A	A.	Yes.	. 12			file and talking with counsel to prepare?
13 (Q.' <i>'</i>	Does that case remain pending as well?	13			
14	A.	To my knowledge, yes.	14	Α.		No.
15 (Q.	In regard to Mission's application, I typically	15	Q		Did you locate any other documents that you thou
16		refer to it as the GI or GI South application.	16			might be responsive to discovery requests or that
17		Will you know what I mean if I use those	17			should have been included in the Agency's file?
18		shorthands?	18	A	•	No.
19	A.	Yes.	19	Q		What did you do to compile the Agency file for the
	Q.	Okay. Did you have a particular shorthand that	you 20			case?
21	٧,	used?	21	Α		I simply went back through all of the documentar
	Α.	I think I followed the applicant, which they use	1 22			that I had gathered during the review from the-
23	234	Mission GI South.	23			from the public hearing all the way to the final
24	Q.	How did you come to be the analyst for the Mis	sion 24			findings and organized them for the Agency file.
	-	•		arol	in	a Reporting Service (919) 661-2727
Caro	oliı	na Reporting Service (919) 661-2727				
MS. HI	iles	-volume I -11-	из	. HILE	:sV	YOLUME 1 -13-
			11			•
		or a I'm it - if mains trainally accioner	1 1		_	In the discovery responses that we've just mark
1			1 1 1	. (Q.	
. 5		GI South application if you're typically assigned			Q.	and handed-I handed you as Exhibit 1, it reflect
_		to another HSA?	2	?	Q.	and handed—I handed you as Exhibit 1, it reflect that you and Ms. Frisone were primarily respon
3	A.	to another HSA? I was assigned—I was assigned this particular	3	?	Q.	that you and Ms. Frisone were primarily respon
4		to another HSA? I was assigned—I was assigned this particular application by leadership in the CON Section.		? 3	Q.	that you and Ms. Frisone were primarily respon for providing information for these responses; is
	A. Q.	to another HSA? I was assigned—I was assigned this particular application by leadership in the CON Section. Do you know if it was a question of workload	or !	? 3 3		that you and Ms. Frisone were primarily respon for providing information for these responses; is that correct?
4		to another HSA? I was assigned—I was assigned this particular application by leadership in the CON Section. Do you know if it was a question of workload that they particularly wanted your expertise for	or s	2 3 1 5 6	A.	that you and Ms. Frisone were primarily respon for providing information for these responses; is that correct? Yes.
4 5		to another HSA? I was assigned—I was assigned this particular application by leadership in the CON Section. Do you know if it was a question of workload that they particularly wanted your expertise for this application?	OF S	? 3 1 5 6		that you and Ms. Frisone were primarily respon for providing information for these responses; is that correct? Yes. And, during the review, there may have been
4 5 6		to another HSA? I was assigned—I was assigned this particular application by leadership in the CON Section. Do you know if it was a question of workload that they particularly wanted your expertise for this application? I'm not sure.	or	2 3 1 5 6 7 8	A.	that you and Ms. Frisone were primarily responsor for providing information for these responses; is that correct? Yes. And, during the review, there may have been discussions with Craig Smith or others, but at the second sec
4 5 6 7	Q.	to another HSA? I was assigned—I was assigned this particular application by leadership in the CON Section. Do you know if it was a question of workload that they particularly wanted your expertise for this application? I'm not sure. At what point did you become assigned to the	or	2 3 1 5 6 7 8 9	A.	that you and Ms. Frisone were primarily responsor for providing information for these responses; is that correct? Yes. And, during the review, there may have been discussions with Craig Smith or others, but at the time you prepared these responses, you didn't have been discussions.
4 5 6 7 8	Q.	to another HSA? I was assigned—I was assigned this particular application by leadership in the CON Section. Do you know if it was a question of workload that they particularly wanted your expertise for this application? I'm not sure. At what point did you become assigned to the application and review?	or 1	? 3 1 5 6 7 8 9	A. Q.	that you and Ms. Frisone were primarily response for providing information for these responses; it that correct? Yes. And, during the review, there may have been discussions with Craig Smith or others, but at it time you prepared these responses, you didn't has specific recollection of that, right?
4 5 6 7 8 9	Q.	to another HSA? I was assigned—I was assigned this particular application by leadership in the CON Section. Do you know if it was a question of workload that they particularly wanted your expertise for this application? I'm not sure. At what point did you become assigned to the application and review? I don't—I don't remember.	or 1	? 3 3 5 6 7 8 9 0	A. Q.	that you and Ms. Frisone were primarily responsor for providing information for these responses; in that correct? Yes. And, during the review, there may have been discussions with Craig Smith or others, but at it time you prepared these responses, you didn't have specific recollection of that, right? That's correct.
4 5 6 7 8 9	Q. A. Q.	to another HSA? I was assigned—I was assigned this particular application by leadership in the CON Section. Do you know if it was a question of workload that they particularly wanted your expertise for this application? I'm not sure. At what point did you become assigned to the application and review? I don't—I don't remember. In terms of today's deposition, tell me what you	or 1 1 1 1 1 1 1 1 1	? 3 3 5 6 7 8 9 0 1	A. Q.	that you and Ms. Frisone were primarily response for providing information for these responses; it that correct? Yes. And, during the review, there may have been discussions with Craig Smith or others, but at it time you prepared these responses, you didn't have specific recollection of that, right? That's correct. And Fatima Wilson, another project analyst, we see that the second content of the second content
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4 5 6 7 8 9 10 11 12 13	Q. A. Q.	to another HSA? I was assigned—I was assigned this particular application by leadership in the CON Section. Do you know if it was a question of workload that they particularly wanted your expertise for this application? I'm not sure. At what point did you become assigned to the application and review? I don't—I don't remember. In terms of today's deposition, tell me what you did to prepare in terms of document review or discussions with others. I reviewed the Agency file and spoke with contractions application with contractions.	or 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	? 3 1 5 6 6 7 8 9 9 0 1 2 3 4 5	A. Q. A. Q. A. Q.	that you and Ms. Frisone were primarily responsor for providing information for these responses; is that correct? Yes. And, during the review, there may have been discussions with Craig Smith or others, but at it time you prepared these responses, you didn't his specific recollection of that, right? That's correct. And Fatima Wilson, another project analyst, we present with you at the public hearing? Yes. Did she have any other role in the review pro-
4 5 6 7 8 9 10 11 12 13 14 15	Q. A. Q. A	I was assigned—I was assigned this particular application by leadership in the CON Section. Do you know if it was a question of workload that they particularly wanted your expertise for this application? I'm not sure. At what point did you become assigned to the application and review? I don't—I don't remember. In terms of today's deposition, tell me what you did to prepare in terms of document review or discussions with others. I reviewed the Agency file and spoke with contractions application and spoke with contractions.	or 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	? 3 3 5 6 6 7 8 8 9 9 0 1 2 3 4	A. Q. A. Q. A. Q. A. Q. A.	that you and Ms. Frisone were primarily responsor for providing information for these responses; in that correct? Yes. And, during the review, there may have been discussions with Craig Smith or others, but at it time you prepared these responses, you didn't his specific recollection of that, right? That's correct. And Fatima Wilson, another project analyst, where the project with you at the public hearing? Yes. Did she have any other role in the review pronounce.
4 5 6 7 8 9 10 11 12 13 14 15 16	Q. A. Q. A	to another HSA? I was assigned—I was assigned this particular application by leadership in the CON Section. Do you know if it was a question of workload that they particularly wanted your expertise for this application? I'm not sure. At what point did you become assigned to the application and review? I don't—I don't remember. In terms of today's deposition, tell me what you did to prepare in terms of document review or discussions with others. I reviewed the Agency file and spoke with control of the properties of the pro	or 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	? 3 1 5 6 6 7 8 9 9 0 1 2 3 4 5	A. Q. A. Q. A. Q.	that you and Ms. Frisone were primarily responsor for providing information for these responses; in that correct? Yes. And, during the review, there may have been discussions with Craig Smith or others, but at it time you prepared these responses, you didn't his specific recollection of that, right? That's correct. And Fatima Wilson, another project analyst, we present with you at the public hearing? Yes. Did she have any other role in the review pronounce. Why did she attend the public hearing?
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4 5 6 7 8 9 10 11 12 13 14 15 16 17 18	Q. A. Q. A. Q. A. Q. A. Q. A. A. Q. A. A. A. Q. A. A. A. Q. A. A. A. Q. A. A. A. A. Q. A.	to another HSA? I was assigned—I was assigned this particular application by leadership in the CON Section. Do you know if it was a question of workload that they particularly wanted your expertise for this application? I'm not sure. At what point did you become assigned to the application and review? I don't—I don't remember. In terms of today's deposition, tell me what ye did to prepare in terms of document review or discussions with others. I reviewed the Agency file and spoke with complete the properties of the part of the properties o	or 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	2 3 3 5 5 6 6 7 8 8 9 9 0 1 2 3 4 5 6 6 7	A. Q. A. Q. A. Q. A. Q.	that you and Ms. Frisone were primarily responsor for providing information for these responses; is that correct? Yes. And, during the review, there may have been discussions with Craig Smith or others, but at a time you prepared these responses, you didn't his specific recollection of that, right? That's correct. And Fatima Wilson, another project analyst, a present with you at the public hearing? Yes. Did she have any other role in the review pronounce. Why did she attend the public hearing? The public hearing—there were two applications and the public hearing. She was the project
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MS. MILESVOIAND I -14-	16
14	4.4
1 already scheduled?	1 project analyst.
2 A. No, I don't believe so. I believe I was assigned	2 Q. Do you know who completed it?
3 early in the process.	3 A. The analyst box up top says Les, so that's Les
4 Q. Were you aware that Mission had requested an	4 Brown.
5 expedited review of its application?	5 Q. Did Les-
6 A. I don'tI don't recall. I would not have checked	6 A. So there was no-it was not expedited.
7 this application in, because it's not in my HSA,	7 Q. Right. If you look at the very first page of the
and, typically, usually the person who either	8 Agency file though, it's actually Bates numbered 2,
9 checks in the application when it comes into the	9 there was a request for an expedited review,
10 Certificate of Need Section, is aware that there is	10 correct?
an expedited review, or the project analyst who	11 A. Yes.
12 checks the application in for its completeness is	12 Q. And then going back to Page 5, there's a no under
aware that there's an expedited review. But I was	13 expedited approved—
14 not-neither of those people.	14 A. That's correct.
15 Q. What do you mean checking in an application?	15 Q. —and then supervisor's initials. Do you know
16 A. When an application-when an applicant brings a	16 whose those are?
application on application day, we check in the	17 A. I can't tell. It would be Craig Smith or Marina
application. There are a few things that we need	18 Frisone. I'm not sure whose initials those are.
19 to make sure, or just ask if they are included.	19 Q. Is the-is there a letter sent to an applicant who
20 Whether or not that particular application—if the	20 requests expedited review and the request is
21 applicant has requested expedited review is one of	21 denied, or how does an applicant obtain the
22 the things that we need to check for.	22 decision on expedited review?
23 Q. When an applicant requests an expedited review,	23 A. On Page 16, there is a letter dated May 2nd, which
24 what's the process for determining whether to gran	t 24 is a denial of expedited feview. So we nounted
Carolina Reporting Service (919) 661-2727	Carolina Reporting Service (919) 661~2727
	MS. MILESVOLUME I -17-
MS. NILESVOLUME I	17
	i i
the request?	
1 the request?	the applicant in May that the request was denied.
2 A. The Assistant Chief or the Chief has to approve the	ne 2 Q. This letter on Page 16 of the Agency file to Mr.
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-20-MS. MILES--VOIAME 1 -16-MS_ MILES--VOLUME I 20 18 merits of each, but if they both met all the 1 that you take. 1 criteria, could you have approved both? I-I personally begin by reviewing the application. 2 2 You know, I don't remember the details. I'm not 3 A. I read the application entirely through. When I'm 3 finished with the application, I will then read any 4 4 Was there an appeal related to your decision? 5 Q; public comments that we've received and responses 5 6 Α. to public comments that we may have received, and 6 7 Q. And Salem Gastroenterology appealed? then I begin with Criterion 1 and work my way 7 That's correct. 8 A. 8 through. 9 Is that appeal still pending? Do you typically review the application in any Q. 9 Q. No, I believe there was a settlement. 10 A. depth before the public hearing? 10 And who-did either applicant receive a certificate No, many times I've not-most times I've not seen 11 Q. 11 of need as part of the settlement? the application prior to the public hearing. 12 12 Yes. Q. And, likewise, do you just wait until after the 13 A. 13 Q. Which one? public hearing to review the comments and responses 14 14 Well, initially-initially, Digestive Health 15 A. to comments? 15 Specialists received a certificate, and-now, I 16 16 Yes. A. think-I believe Salem GI may have received a Do you recall if you read any of this application 17 17 Q. certificate as well after-as part of the 18 before the public hearing? 18 19 settlement, but I'd have to check. I did not. 19 Α. There's not a need determination process for the GI 20 Going back to a more general question, have you--20 endoscopy rooms, right? prior to the Mission Gl South application, have you 21 21 That's correct. 22 A. reviewed applications that involved endoscopy? 22 Have you reviewed applications involving operating 23 23 A. 24 rooms, amb surg operating rooms? Can you tell me how many of those? 24 Q. (919) 661-2727 Carolina Reporting Service Carolina Reporting Service (919) 661-2727 -21-MS. MILES--VOLUME I -19-MS. MILES--VOLUME I 21 19 Yes. 1 A. Probably two or three. Α. How many? 2 Do you recall the counties or the providers? Q. 2 Well, there's just one that comes to mind that I-I believe they were all in Forsyth County. I think 3 3 A. well, now, I shouldn't say that. There are two, 4 I've done two for Digestive Health Specialists and 4 and I believe they're both Wake Forest University 5 one for--well, they may all three have been 5 6 Health Sciences applications. Digestive Health Specialists. 6 Q. And I believe you told me about one of those 7 Were they competitive applications? 7 Q. 8 already. Actually, yes, one was deemed to be competitive. 8 Yes, that was the ambulatory surgical facility in 9 It was Digestive Health Specialists and Salem 9 Winston-Salem, and the other was to relocate three 10 Gastroenterology in Kernersville. 10 OR's also in Forsyth County. 11 Did you make the determination that the two 11 Did you approve or deny the application to relocate 12 Q. applications were competitive? 12 three OR's? I don't recall if I made that determination, or if 13 13 the Assistant Chief or Chief made that That was denied, 14 Α. 14 Did you refer back to the findings on that 15 determination. 15 application to relocate three OR's in connection What was the Agency's decision with regard to the 16 16 Q. with the review of Mission GI South? 17 competitive endo application? 17 I approved Digestive Health Specialists and 18 A. 18 Α. When you're reviewing the competitive comments or 19 Q. disapproved Salem GI. 19 written comments by community members related to an 20 Could you have approved both applications? 20 Q. application, how do you factor that into your 21 No, I didn't. I could not have approved both. 21 decision then, and when do you review those as 22 Why not? 22 Q. 23 compared to the application? Oh, you mean in terms of whether they were-23 Well, as I mentioned, I will read the application 24 Right. In the general sense, not regarding the 24 Q, Carolina Reporting Service (919) 661-2727 Carolina Reporting Service (919) 661-2727

MS. MILE	5~~V(OLINE I	-22-	MS. MII	esV	OLUME I	-24-
			22			•	24
7		first before I look at any comm	ents, and I review	. 1		relation to the county	line.
1 2		the comments that are submitte	and I read them in	2	Q.	What is your underst	anding of the issue that wa
		conjunction with the response		3		discussed at the pre-a	pplication conference?
3		determine, or assess whether o		4	A.		nething about the county
4		I feel that there is any merit, in		5		line.	
5		either look more closely at a c		6	Q.	Was it just that the r	roject was located on the
6		either look more closely at a c	if I determine it's	7	ζ.		ere something specific with
7		made, or to dismiss a commen	I II I determine to	8		regard to the actual b	
8	_	not relevant.	to and the recognition	9	Α.		u'd have to ask Ms. Frisone
	Q.	Do you review those commer		10		the specifics.	
1.0		before or after you review the	application against	11	Q.		who attended the pre-
11		the criteria?		12	٧.		e say to you, Ms. Miles, y
	Ą.	It's before I start the findings		13.			he fact that it's located
13	Q.	And when you say before yo		14			ern for us, or we told the
14		you saying that you review an	application and then	15			d do a certain approach?
15		write your findings with regar			Á		II. It's clear from the
16		then review more and write y		16	Α.		see where the building was
17	A.	No, I will review the whole	application, and	17			ed, but I didn't have any
18		comments, and the response t	o comments before I	18			owledge-that I recall abou
19		start writing.	_	19		_	iomicalec-martifican mod
20	Q.	In this particular case, the N	fission GI case, there	20	_	that.	and an acation of DUICD
21		was a pre-application conference		21	Q.		y other sections of DHSR
22		Did you attend that public-p	re-application	22			ore-application conference,
23		conference?		23		such as Construction	
24	A.	I did not.		2.4	A	-	is -is that it was justit wa
Car	oli	na Reporting Service	(919) 661-2727	Ca	rol:	ina Reporting Serv	rice (919) 661-2727
·		VOLARIE I	-23-	м5.	MILES		-25-
110. 11	2,000		23				:
						inef three representati	ives from the CON Section a
1	Q.			1		then a few of the rep	
2	A.	I believe it was Ms. Frisone,	Mr. Smith and Ivir.	2		-	COOLINE LOD YOU GIO
3		Brown.		3	_	applicant.	re were meetings that involve
4	Q.		he three about the pre-	4	(n and Construction Section
5		application conference and w	hat was discussed?	5			
6	A		nce may have been	6		to the application be	mg mea!
7		discussed as part of the discu	ssion about the	7		I don't know.	r.
8		location of the building, and		8	-(liscussions personally with
9		whether or not it was with M		9		• .	truction Section about the pl
10		Smith, but I did not talk with	Mr. Brown about this	10		in the application, or	the location?
11		application at all.		11		A. No.	
12	Ç		emos from Mr. Brown, I	Ar 12	•		emails to or contact the
13	*	Smith or Ms. Frisone about t	he pre-application	13		Construction Section	n during the review?
14		conference?	•	14		A. No.	
15	1	. No.		15	i '	Q. What about the Lie	
16		 Did they make any notes, t 	o your knowledge?	16	5		. We did a standard quality
17		L. I don't know.	- -	17	7		ntact Licensure Section
Ι,		 What was discussed with r 	egard to the relocation o	r 18	3	regarding the past s	ervices at the facility, and I
10	`	the location?		15	9	did that.	
18			fics, and I wouldn't	20			lected in the Agency file.
19		A. I don't remember the speci	at_what was said	2		That	
19 20	4	Lamend a assessment another ten	INC ALTINO ALINE DUTINE	1 ~			
19 20 21	4	hazard a guess to restate wh		2.	2	A. Yes.	
19 20 21 22		because I don't remember it	in full detail, but	2:		A. Yes.O. Is that the check t	hat relates to whether there
19 20 21 22 23		because I don't remember it apparently in the pre-applic	in full detail, but ation, there was some	2	3	Q. Is that the check t	hat relates to whether there
19 20 21 22 23 24		because I don't remember it	in full detail, but ation, there was some on of the building in	2	3 4	Q. Is that the check the have been any quality	hat relates to whether there lity or licensure issues? ervice (919) 661-272

22

23

24

about immigration. It's on Page 4 in the response

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22

23

24

A.

to Ouestion 2.

Yes.

There's some handwritten numbers on 571. Is that

(919) 661-2727

your handwriting?

Carolina Reporting Service

Yes.

-32-MS. MILES--VOLUME I -38-HS. HILES--VOLUME I 32 30 and letters of support from Pardee and Parkridge. 1 What do the numbers reflect? Q. 1 They're also endoscopy providers in the area, and I I think-if I can recall, I think they were street 2 A. was trying to see how close they were in proximity 3 addresses that didn't come out on the print-out 3 to the proposed project and to one another. that were on the website. I think I was trying to 4 So on your Legend, "A" is the Mission GI South, "B" 5 get a grasp of, again, where the property was 5 is Pardee; is that right? located. I think I may have had the address and 6 ĸ Yes. 7 A. was trying to figure some things out, and so those And "C" is Parkridge? 8 are just-I think they're street addresses. 8 Yes. I believe that's what I've got down here. And if the address was given on Hendersonville Road 9 9 All right. And you have a note about 5.15 miles. 10 for the project, is that right? 10 What does that mean? 11 11 A. That's 5.515 miles from Mission GI South. Now, on 12 And that's in Buncombe County, correct? 12 O. 581, I've got Carolina Mountain, which isn't on the 13 Well, the building is in both counties, but the 13 page before, so I'm not sure which one "C" is, but address is in-for in the application it's Buncombe 1.4 14. I was looking in general to see the proximity of 15 15 County, yes. other providers. All right. And you were saying that you did some 16 16 That information was reflected in the application 17 background information or research about Fletcher? 17 18 I was just looking up Fletcher, because I--I 18 19 thought it straddled the county line, and so I just 19 Both Pardee and Carolina Mountain Gastroenterology Q. put it in here, because I had looked at that page, 20 20 are in Hendersonville, right? and I just wanted to acknowledge that I looked at 21 21 They're in Henderson County, yes. that page. The zip code, I don't recall off the 22 A. 22 And actually in the Town of Hendersonville? 23 Q. top of my head, but it may be the zip code for the 23 I'd have to double check. I can't recall off the 24 project or the location. 24 Carolina Reporting Service (919) 661-2727 Carolina Reporting Service (919) 661-2727 HS. MILES-VOLUME I -31-MS. MILES--VOLUME I 33 31 top of my head. 1 The-the code on 576? Q. You were aware during the review that Pardee 2 Q. Yes, on Page 576, I put in 28732. 2 A. supported the application that Mission filed? 3 If you look at Page 3 of the application, is that 3 I believe we received a letter of support from A. 4 the zip code for the project? 4 Pardee. 5 Yes, and that's what I was just looking at the zip 5 If you would, go on to 582. Q. code to see what city came up. It said Fletcher. 6 6 582, I think this was--I was trying to see the 7 Page 577 was-again, I don't even recall the 7 distance between Mission Hospital and the proposed 8 websites I was looking at, but this actually gave . 8 Mission GI South. 9 me sort of a satellite picture of the property. 9 What did you determine? 10 Did you have to enter the-the plat numbers or the 10 I put in the addresses of each one, and it just address, or how did you get the overhead view? 11 11 said it was about 10 miles away, and I just wanted You know, I don't remember. I don't remember off 12 12 that for just general knowledge. 13 the top of my head how I got that. 13 It looks like you did some demographic research 14 Is Page 578 a similar map? 14 O. beginning on Page 583. 15 I think it's another picture. It's hard to see. 15 A. Yes, I did this-this is for Criterion, I believe, 16 It looks like--this one on 578 looks like it was 16 13, and it's just new standard information we look 17 from Google Maps. 17 18 Yes. Yes, and 579 as well. 18 Α. What's the source of the information? 19 Q. Did you have a particular concern or just trying to 19 It's not on the bottom there. It's public 20 visualize where the project would be located? A 20 information. I'd have to look in the findings. I 21 I was just trying to visualize where the project 21 think I've cited the source in the findings under 22 would be located. 22 23 Criterion 13. And what is the map on Page 580? 23 Q. Okay. But is it-does the source have it organized On Page 580, I was looking at-we received comments 24 Q, 24 Carolina Reporting Service (919) 661-2727

-36ms. Miles--volume i MS. MILES--VOLUME I 36 34 If you would, turn to Page 587. Tell me what youin this way, or did you have to pull these tables 1 1 what we see on Page 587 of the Agency file. 2 together? 2 This is GI utilization data for Buncombe and Oh, no, this-this is printed page print verbatim. 3 3 Henderson Counties. It's SMFP. It's State Medical 4 I didn't pull together any tables. Facilities Plan data. 5 You determined that the application was conforming 5 All right. Did you compile the data that we see on 6 O. with Criterion 13, correct? б Page 587? 7 Let me look. Yes. 7 I received this from Ms. Frisone. 8 And, going back to the working papers, you have the A. 8 Do you know if she compiled it herself or requested 9 information gathered for both Buncombe and 9 it from health planning? 10 10 Henderson County? I don't recall. I don't know. 11 A. Yes. 11 A. And, at the bottom, there's a footnote that said it And why did you look at the Henderson County 12 12 was from the 2011 and 2012 proposed State Medical 13 information with regard to Criterion 13? 13 Facilities Plan? Well, the--the building was in both Henderson and 14 14 15 A. Buncombe Counties, and so I pulled both. 15 Did you look back at the Plan yourself to verify The--is it your understanding that the GI room will 16 Q. 16 Q_r any of the numbers? 17 be in Buncombe County? 17 Yes, through the review process, I looked at the Well, there's a question about that. The diagram 18 Α. 18 Á. Plan and the data tables that were in the that is in the application shows that it's--I can't 19 19 application as well to make sure that they were all 20 tell if the line is through the room or through the 20 21 saying the same thing. facility itself. It's unclear. It appears to me-21 Did you determine that they were all saying the 22 I can't say if it's going through the exact room-22 23 same thing? or the room itself. 23 And you're-the line you're talking about is the Yes. 2.4 (919) 661-2727 Carolina Reporting Service Carolina Reporting Service (919) 661-2727 MS. MILES--VOLUME I -35-MS. MILES--VOLUME I 37 35 So, in other words, you did not find any 1 county line? discrepancies between the application and the Yes, based on the line drawing that we received. 2 2 A. SMFPs? 3 So, for purposes of your review, did you look at it 3 Not that I recall that ring a bell for me, no. both ways, or did you look at whether the room was 4 . And I would need to ask Ms. Frisone where she-how solely in Buncombe County as stated? 5 5 she obtained the-Page 587? 6 I looked at it as the facility—the space being in 6 A, Yes. A. both counties. 7 Is it correct that Pages 588 through 591 are actual 8 What-the space for exactly what? Q. 8 tables--or 593, excuse me, are actual tables from 9 The GI endoscopy space. 9 the State Medical Facilities Plans that you And you considered that to be in both counties? 10 10 Q. reviewed? 11 A. 11 What about with-what about just the endoscopy room 12 Α. 12 Did you look at any other counties besides Buncombe 13 Q. where the procedures would be performed? 13 or Henderson just as a comparison point? 14 That I can't totally tell with 100 percent 14 15 A. certainty from the line drawn, because it's not 15 Before the Mission GI South application, had you Q. 16 labeled. 16 done any CON reviews for any type of service in 17 Did you ask anybody from Mission questions about 17 Q. Buncombe County? the location during the review? 18 18 No, I don't believe so. 19 No. 19 A. And what about Henderson County? 20 Q. 20 Q. Could you have? I'm not sure. I would have had--I'd have to ask 21 A. 21 Have you done any since for either county? 22 Q. Ms. Frisone. 22 A. No. I don't believe so. 23 Did you ask--23 Q, Who's normally assigned to that? Is that Mr. I would have had to ask her. I did not ask her. 24 Q. 24 Carolina Reporting Service (919) 661-2727 Carolina Reporting Service (919) 661-2727

MS. KILES--VOLUME I -38-ME. MILES--VOLUME I 40 38 1 A. Brown? At what point during the review did you determine Mr. Brown. I'm not sure if there's another analyst Q. 2 A. that you would not approve the Mission GI South 3 assigned to any other nearby counties, but Mr. 3 application? 4 4 I'm not sure, probably as I was--as I was writing 5 A. If I'm not mistaken, the remainder of your working 5 Q. 6 papers just is a copy of the 2011 renewal 6 When would that-was that in terms of time? I 7 Q. application for Mission? 7 believe the review started in April, and the 8 8 À. decision was made August 28. Did you look at any other years besides 2011 9 9 Q. Oh, I'm not sure, because I had it for a few--I had 10 licensure renewal applications? 10 it for several months. I'm not sure when I started 11 11 A writing. Did you look at any other providers, such as Pardee 12 12 Q. When you wrote the letter that we looked at earlier 13 Q. or Parkridge license renewal applications? 13 on Page 16, and then the letter on Page 17 Only in the context of what was provided in the 14 14 Á. extending the review, had you made a determination SMFP, which is from the license renewal data. 15 15 whether to approve or deny the application? 16 But you didn't go back to any of those actual Q. 16 17 Α. license renewal applications? 17 And just while we're here, look at Page 19 of the 18 Q. No. 18 A. Agency file. Did you prepare this letter notifying 19 We talked a minute ago about the fact that Pardee 19 Q. Mr. Moore at Mission that the application had been sent a letter of support. It's- I believe it 20 20 appears in the Agency file on Page 16, but Fd like 21 disapproved? 21 22 Yes. for you to look at it and confirm. And I--it was 22 And the following letter starting on Page 22, is 23 Q. actually Page 16. 23 that the cover letter for your findings? 24 15. 24 Α. Carolina Reporting Service (919) 661-2727 (919) 661-2727 Carolina Reporting Service Ms. MILES--VOLUME I -39-MS. HILES--VOLUME I 41 39 15. Okay. And you received it by fax on April 29, A. 1 Q. And they were sent on the fifth day after the 2 2011; is that right? 2 application--after the decision letter; is that 3 Yes, that's what it says. 4 Okay. Is that your handwriting? Q. 4 Yes, they were sent on September 2nd. 5 No. 5 A. Had you prepared the findings as of August 26, 6 Were there any-6 7 2011? I'm not sure who. It could have been the I was still working on them. 8 secretary. I'm not sure who put that there. 8 Had you shared them with Ms. Frisone in draft form Okay. Were there any letters or comments that were 9 9 prior to August 28th? 10 not timely received? Would they be in the Agency 10 11 A. file that's stamped not considered? 11 Do you recall what-not specific changes, but what Yes, everything would be in the Agency file. 12 12 areas Ms. Frisone focused on or just changed in 13 You don't recall receiving any that were not 13 Q. general terms? 14 timely? 14 I don't recall as general-as general editing takes 15 I don't recall, but if they are, they would be in 15 A. place. My decision wasn't changed, so there was 16 here somewhere. 16 nothing major like that, but I don't recall any 17 Did you have any discussions with anyone from 17 18 specifics. Pardee about the Mission application? 18 Okay. So your initial draft findings included a 19 No, not that I recall. 19 A. determination that the application was not Okay. Other than at the public hearing, did you 20 20 conforming with some of the criteria? 21 have any discussions with anyone representing 21 22 A. Parkridge during the application review? 22 I'm going to go through each of the findings with 23 23 you. Do you remember anything else about Ms. What about the Carolina Mountain Gastroenterology 24 . Q. 24 Carolina Reporting Service (919) 661-2727 Carolina Reporting Service (919) 661-2727

-44-MS. MILES---VOLUME I MS. MILES--VOLUME I 44 42 There was nothing in the comments-in the comments 1. Frisone's review of your draft findings? 1 from the competitors that caused me to look at No, it was like another-another review I had done. 2 2 anything that I hadn't already thought was a 3 Did you receive a directive at any point to 3 0. potential sticking point. disapprove the application from Ms. Frisone or Mr. 4 Okay. Was it a concern to you that the GI South 5 Smith? 5 application represented the first in a series of 6 No. 6 Α. projects between--with Pardee and Mission on this 7 Before we talk about the specifics of your 7 ioint health campus in Fletcher? decision, will you look with me in the Agency file 8 8 I had heard from the public hearing there was some 9 behind Tab 3? That's the section with the 9 kind of relationship or something with Mission and comments. You told me-or actually Section II is 10 10 Pardee, but I didn't and still don't know the 11 the comments. I'm sorry. Page 35. 11 details of what that relationship is. 12 12 Okay. A. Did you do anything as part of the review to get 13 Q. There were extensive written comments submitted on 13 more information about what might be the behalf of Carolina Mountain Endoscopy and then on 14 14 15 relationship? behalf of Parkridge, and you told me that you 15 No. 16 A. reviewed those comments during the review? 16 Did you consider that relevant at all to your 17 Q. Yes. 17 A. review? Included with both sets of comments is a copy of a 18 Q. 18 19 A. report relating to the certificate of public 19 Let's go ahead and look at the Agency findings that 20 Q. advantage that Mission holds; do you recall that? 20 you prepared. They're, as you know, behind Tab 5 21 Yes. 21 A. of the Agency file. 22 Did you review the report related to this 22 Okay. 23 A. particular public advantage? 23 On the first page of the findings, which is Page 24 Not in great detail. 24 A. Carolina Reporting Service (919) 661-2727 Carolina Reporting Service (919) 661-2727 MS. MILES--VOLUME I -43-MS. MILES--VOLUME I 45 43 640 in this-the volume of the Agency file, you Did you take that into consideration during your 1 1 determined that the application did not propose any 2 review? 2 new endoscopy rooms, so it was-so Criterion 1 was 3 3 A. No. nonapplicable; is that right? Okay. Did you consider it relevant in any way to 4 Q. 4 5 Yes. A. your review? 5 And then the bulk of the findings, I believe, are 6 O. 6 A. contained under Criterion 3; is that right? 7 Is it fair to say you understood that both Carolina 7 Q. Yes, that's a large portion. 8 Mountain and Parkridge are competitors of Mission? A. 8 Is that typically how you prepare your findings 9 9 A. with the bulk of the discussion under Criterion 3? 10 With regard to GI services, at least? 10 Q. It depends on the--it depends on the application, 11 Α. 11 but many times Criterion 3 is the longest section. 12 And you also said that you carefully reviewed the 12 Okay. And as I looked at it, there are two 13 response to comments that was prepared and 13 sections within Section III. One, you addressed submitted by Mission at the public hearing? 14 14 first the population to be served on Page 641; is 15 15 A. that right? And is it the document that begins on Page 524 of 16 16 Q. 17 A. Yes. the Agency file? 17 And you determined that the applicant did not 18 Q. 18 A. adequately identify the population to be served? As you're sitting here today, were there particular 19 19 Yes, I state that on Page 644. issues in the written comments by Parkridge and 20 A. 20 I've read your findings, obviously, but tell me the 21 O. Carolina Mountain that you did not feel were 21 main concern that you had with regard to why the 22 addressed by Mission to your satisfaction, or that 22 applicant didn't identify the population to be 23 caused you to look at things more closely in the 23 served adequately in your view. 24 application? Carolina Reporting Service (919) 661-2727 Carolina Reporting Service (919) 661-2727

-48--46-MS. MILES--VOLUME I 48 46 chart, it states number of procedures and Weil, on 641, they-I quote that the applicant is 1 1 corresponding percentages of patients from Buncombel 2 talking about Mission Hospital's 13 county service 2 and Henderson County, and then provides projected 3 area and included a table that was in the 3 inmigration of 10 percent to arrive at a total for application on 642 outlining Mission Hospital's 4 4 each of those project years; but, below the table, 5 inpatient and outpatient GI endoscopy patient 5 I state however, the applicant provides 6 origin for the current year and also for Year 2 of 6 7 inconsistent information regarding projected the project. And then further down on 650-on 642, 7 inmigration for the Mission GI South campus. In 8 I quote the applicant as talking about the service R Section III.1(b), Page 58, the applicant states it area for Mission GI South, where the applicant 9 9 assumes that 10 percent of the GI endoscopy 10 stated Mission analyzed historical utilization of 10 procedures at Mission GI South will come from other services at Mission from southern Buncombe County 11 11 Buncombe County and Henderson zip codes and other 12 and Henderson County as well as projected 12 counties; but, in the proforma section of the population growth in the region to determine the 13 13 application and also in Exhibit 16, Table 5, the 14 Mission GI South zip code service area, and on Page 14 applicant projects that inmigration at Mission GI 643, I reproduced a chart that showed what the 15 15 South will be 15 percent. In the next paragraph, I applicant's proposed service area was for Mission 16 16 go on to say that in Section IIL1(a), Page 56, the 17 GI South. There are the zip codes that they 17 applicant projects that 70 percent of Mission 18 included in that service area along with the 18 Hospital's existing GI endoscopy volume originating 19 corresponding counties. 19 from Buncombe and Henderson Counties will shift to 20 Okay. And it may help to--probably need to refer 20 Q, Mission GI South. In other words, 85 to 90 percent 21 from time to time to the actual application. 21 of the population that the applicant proposes to 22 22 serve at the new Mission GI South campus represents And now would be a good time to look at Page 37. 23 23 Q. 24 a shift of existing GI endoscopy patients at Of the application? 24 Carolina Reporting Service (919) 661-2727 Carolina Reporting Service (919) 661-2727 -49-HS. MILES -- VOLUME I MS. HILES--VOLUME I 49 47 Mission Hospital who reside in Buncombe and 1 Q. Yes. 1 Henderson Counties, but who are currently traveling 2 Yes. 2 A. to Mission Hospital in Asheville for GI endoscopy All right. And Page 37 is where Mission identified 3 3 Q. 4 services. And on the top of Page 5 is where I the nine-the nine zip code service area for 4 state however, the applicant does not adequately 5 Mission GI South; is that right? 5 identify where the patients included in either the 6 Yes, that's where I got the table on the top of 643 6 A. 10 percent or 15 percent inmigration will come 7 7 from. from, therefore, the applicant did not adequately 8 You just abbreviated it? 8 Q. 9 identify the population to be served. 9 Right. A. With regard to the 10 percent versus 15 percent, 1Ò Q. 10 Q. you were aware from reading the response to 11 And then the applicant provided their projected 11 comments that the 15 percent reference was left in 12 patient origin for Mission GI South for the three 12 some of the tables in error, is that right? 13 project years. 13 Yes. Before you go on, if I could interrupt. I'm sorry. 14 A. 14 So did you understand during the review that Q. The zip codes that were defined in Buncombe and 15 15 Mission projected that 10 percent of its patients 16 Henderson County didn't constitute all of those 16 and procedures would come from other areas outside 17 counties; is that right? 17 the defined zip code areas in Buncombe and That's correct. These are zip codes within the 18 18 Hendersonville--Henderson, excuse me? counties, but they're not all the zip codes in the 19 19 Yes, that was throughout the methodology, but the 20 counties. 20 proformas indicated 15 percent, so there was that 21 All right. 21 Q. 22 discrepancy between the two. So the Mission GI South projected patient origin 22 Right. But once you read the response to comments chart, which was from Page 58 of the application, 23 23 did you still consider that to be a discrepancy?

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and it was also in Exhibit 16, Table 5, and in this

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-50-MS. MILES--VOLUME I HS, MILES--VOLUME I 52 50 Yes. It wasn't until I looked at the proformas. I 1 Α. 1 And there's a range of counties from which patients 2 understood it to be a discrepancy in Exhibit 16, I 2 were served, correct? believe it is, Table 5, and I understood that 3 3 4 A. error, and that wasn't an issue for me until 15 Some are close geographically to Buncombe County percent appeared in the proformas. Then it became 5 Q. and some are not. 6 an issue. 6 Yes. And looking still at Page 643 and 44 of the 7 A. 7 There—there were patients that particular year 8 Q. findings in the Agency file, did you question or 8 from both Georgia and South Carolina? determine that the 70 percent of the existing GI 9 9 10 A. volume shifting to Mission GI South was 10 Okay. As well as Tennessee? 11 Q. unreasonable? 11 12 A. No. 12 When you talked--I think you said you talked with 13 O. Q. And are you saying that Mission should have 13 Mr. Smith and Ms. Frisone about this particular identified more specifically where patients who 1.4 14 page; is that right? 15 were projected to inmigrate would be coming from? 15 Yes. Yes, with regard to the 10 percent, I would have 16 A. 16 Do you remember anything else about your 17 Q. liked to have seen more specific information. 17 discussion? 18 Like what? 18 Q. Really, the results of our discussion is-is in the What zip codes those 10 percent were coming from 19 19 A. findings. Let me find it. It's in one of these on Is there any rule that requires more detail than 20 20 Page 667, and I think the discussion may start on 21 was given? 21 666, and the applicant references a table in 22 No, there's no rule. 22 A. Exhibit 16, Table 12, that lists counties in the 23 If you were preparing this application, how would 23 secondary and tertiary areas, if I can recall off you know where folks would come from in terms of 24 24 Carolina Reporting Service (919) 661-2727 Carolina Reporting Service (919) 661-2727 MS. MILES--VOLUME I -51-MS. HILES--VOLUME I 53 51 the top of my head. We can certainly look at it, 1 other places? 1 and they represented that that was--reflected 2 MR. JOHNSON: Object to form. 2 inmigrations from the counties of Buncombe and 3 Well, I didn't prepare the application. 3 Α. Henderson to be over 34 percent. And some of those 4 Right. I know. 4 Q, counties were represented to produce 10 percent of So I wouldn't--I--I wouldn't--I don't know. 5 5 A. patients, or-or patients were coming from those I guess I'm asking if they had said we had-we're 6 6 Q. 7 counties in that 34 percent, and, as a result of going to have six people from one particular zip 7 our discussion, we determined that it wasn't 8 code and 14 people from another, would you have 8 , reasonable for patients to be expected to come from 9 considered that to be creditable? 9 all of those counties that were represented in that 10 I don't know. It would be more detail, but I don't 10 table. And from discussions with Ms. Frisone and know. I'd have to see what information was 11 11 Mr. Smith, the five counties in the table on 667 12 provided to make a decision. 12 were the counties that were determined that the 13 And you said that you looked back at the license 13 patients would likely come from. 14 renewal application; is that right? 14 So, if I'm understanding you, you just didn't 15 15 A. believe that people would come from some of the 16 And if I could direct you to the portion that 16 counties in the service area to this Mission GI contains the GI endoscopy patient origin. I think 17 17 South location? 18 it's on Page 632 of the Agency file. 18 We didn't believe that it was reasonable for 19 19 Ä. Okay. patients to come from some of those counties that 20 Do you have that? 20 Q. 21 were listed in the Exhibit 16. 21 A. Yes. 'And that's even--even looking at the patient origin All right. Am I correct that this is patient 22 22 information in the license renewal application? 23 origin for all of Mission GI cases in the 2011 23 Yes, I mean, there's always--you can always count 24 license renewal application? 24

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rp. nibb	54			5
_		1		details of the procedures and conditions for which
1	some level-count on some level of inmigration, but in terms of estimating your inmigration based on	2	٠.	you might need an endoscopy procedure, did you
2	your historical information, this is what was	3		any research on endoscopy?
3	determined. In addition to the fact that these	4	A.	No, the information provided in the application
4	numbers that were in Exhibit 16 and also here in	5		regarding endoscopy was quite thorough, and I was
5	the table on 667 are inpatient and outpatient GI	6		generally familiar with endoscopy from the previous
6 7	endoscopy patients, and they will only be	7		reviews I've done.
7	performing outpatient endoscopy procedures at	8	Q.	In the previous reviews that you've done, were the
8	Mission Gi South.	9	•	providers in Forsyth County experiencing growth
9 10 (t til t de l'anna namal data ia	10		terms of total numbers of procedures, or were the
11	Okay. And, likewise, the license renewal data is for inpatient and outpatient?	11		relatively flat?
	A. Yes.	12	A.	That I don't recall.
. 4	Q. Do you know how patients determine where they will	13	Q.	
14	go for an endoscopy procedure?	14	-	the-specifically with regard to the identification
	A. It could be a number of reasons. It could be	15		of-of patient population, if you had been given
15 7	referral. It could be patient choice.	16		specific zip codes, for example, for the
	Q. Do the patients typically choose their—their GI	17		inmigration, you would have been more comfort
18	physician first?	18		with the definition of the population to be served
	A. Well, I've never had an endoscopy, so I'm not sure.	19	A.	
20	I'm sure there's a variety of different ways	20		determination would have been, because I haven
21	someone ends up in an endoscopy suite.	21		seen it. I didn't have anything to look at, but-
	Q. Okay. Do you think somebody could just decide they	22	Q.	
23	needed an endoscopy and show up in an endoscopy	23		where you've got a line for-in the chart for
24	suite?	24		inmigration.
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MS. MI	LESVOLDME I -55- 55			
		1	,	. V.
1	A. Technically, you maybe could, but I think usually	1	A.	
2	they may have come through another physician. Yo		Q.	Year 3 to be coming from outside the main service
3	don't use your endoscopy physician as your primary			area?
4	care physician.	4		
5	a we we do not all array agency than that the chaice of	, =	٨	
-	Q. Right. So would you agree then that the choice of		A	A. 149.
6	endoscopy-of the location for an endoscopy	6	Q	A. 149. Q. And that is 10 percent of what number?
6 7	endoscopy—of the location for an endoscopy procedure is influenced strongly by the physician	6	Q	A. 149. Q. And that is 10 percent of what number? A. That's approximately 10 percent of the total of
7 8	endoscopy—of the location for an endoscopy procedure is influenced strongly by the physician who will perform the endoscopy?	6 7 8	Q A	 A. 149. Q. And that is 10 percent of what number? A. That's approximately 10 percent of the total of 1,487, I believe.
7 8 9	endoscopy—of the location for an endoscopy procedure is influenced strongly by the physician who will perform the endoscopy? A. I can't say—I can't say strongly, but certainly it	6 7 8 9	Q A	 A. 149. Q. And that is 10 percent of what number? A. That's approximately 10 percent of the total of 1,487, I believe. Q. And 1,487 is the total number of procedures
7 8 9 10	endoscopy—of the location for an endoscopy procedure is influenced strongly by the physician who will perform the endoscopy? A. I can't say—I can't say strongly, but certainly it could be influenced.	6 7 8 9 10	Q A	 A. 149. Q. And that is 10 percent of what number? A. That's approximately 10 percent of the total of 1,487, I believe. Q. And 1,487 is the total number of procedures projected to be performed at Mission GI South in
7 8 9 10 11	endoscopy—of the location for an endoscopy procedure is influenced strongly by the physician who will perform the endoscopy? A. I can't say—I can't say strongly, but certainly it could be influenced. Q. And if a—if a GI specialist says I can perform a	6 7 8 9 10 11	Q A Ç	 A. 149. Q. And that is 10 percent of what number? A. That's approximately 10 percent of the total of 1,487, I believe. Q. And 1,487 is the total number of procedures projected to be performed at Mission GI South in Year 3?
7 8 9 10 11 12	endoscopy—of the location for an endoscopy procedure is influenced strongly by the physician who will perform the endoscopy? A. I can't say—I can't say strongly, but certainly it could be influenced. Q. And if a—if a GI specialist says I can perform a procedure for you at Mission GI South next week,	6 7 8 9 10 11 12	Q A Q	 A. 149. Q. And that is 10 percent of what number? A. That's approximately 10 percent of the total of 1,487, I believe. Q. And 1,487 is the total number of procedures projected to be performed at Mission GI South in Year 3? A. Yes.
7 8 9 10 11 12 13	endoscopy—of the location for an endoscopy procedure is influenced strongly by the physician who will perform the endoscopy? A. I can't say—I can't say strongly, but certainly it could be influenced. Q. And if a—if a GI specialist says I can perform a procedure for you at Mission GI South next week, but if—but I can't do it at Mission downtown for	6 7 8 9 10 11 12 13	Q A C	 A. 149. Q. And that is 10 percent of what number? A. That's approximately 10 percent of the total of 1,487, I believe. Q. And 1,487 is the total number of procedures projected to be performed at Mission GI South in Year 3? A. Yes. Q. And were you aware during the review that the
7 8 9 10 11 12 13	endoscopy—of the location for an endoscopy procedure is influenced strongly by the physician who will perform the endoscopy? A. I can't say—I can't say strongly, but certainly it could be influenced. Q. And if a—if a GI specialist says I can perform a procedure for you at Mission GI South next week, but if—but I can't do it at Mission downtown for another month, which would you prefer?	6 7 8 9 10 11 12 13	Q A Q	 A. 149. Q. And that is 10 percent of what number? A. That's approximately 10 percent of the total of 1,487, I believe. Q. And 1,487 is the total number of procedures projected to be performed at Mission GI South in Year 3? A. Yes. Q. And were you aware during the review that the inmigration, that number, 149 procedures, would
7 8 9 10 11 12 13 14 15	endoscopy—of the location for an endoscopy procedure is influenced strongly by the physician who will perform the endoscopy? A. I can't say—I can't say strongly, but certainly it could be influenced. Q. And if a—if a GI specialist says I can perform a procedure for you at Mission GI South next week, but if—but I can't do it at Mission downtown for another month, which would you prefer? MR. JOHNSON: Object to form.	6 7 8 9 10 11 12 13 14 15	Q A Q	 A. 149. Q. And that is 10 percent of what number? A. That's approximately 10 percent of the total of 1,487, I believe. Q. And 1,487 is the total number of procedures projected to be performed at Mission GI South in Year 3? A. Yes. Q. And were you aware during the review that the inmigration, that number, 149 procedures, would patients from zip codes in Buncombe and Hende
7 8 9 10 11 12 13 14 15	endoscopy—of the location for an endoscopy procedure is influenced strongly by the physician who will perform the endoscopy? A. I can't say—I can't say strongly, but certainly it could be influenced. Q. And if a—if a GI specialist says I can perform a procedure for you at Mission GI South next week, but if—but I can't do it at Mission downtown for another month, which would you prefer? MR. JOHNSON: Object to form. Q. Can you see that discussion happening?	6 7 8 9 10 11 12 13 14 15 16	Q A Q	 A. 149. Q. And that is 10 percent of what number? A. That's approximately 10 percent of the total of 1,487, I believe. Q. And 1,487 is the total number of procedures projected to be performed at Mission GI South in Year 3? A. Yes. Q. And were you aware during the review that the inmigration, that number, 149 procedures, would patients from zip codes in Buncombe and Hende County as well as outside Buncombe and Hende
7 8 9 10 11 12 13 14 15 16	endoscopy—of the location for an endoscopy procedure is influenced strongly by the physician who will perform the endoscopy? A. I can't say—I can't say strongly, but certainly it could be influenced. Q. And if a—if a GI specialist says I can perform a procedure for you at Mission GI South next week, but if—but I can't do it at Mission downtown for another month, which would you prefer? MR. JOHNSON: Object to form. Q. Can you see that discussion happening? A. I could see that discussion happening.	6 7 8 9 10 11 12 13 14 15 16 17	Q A A C C C C C C C C C C C C C C C C C	 A. 149. Q. And that is 10 percent of what number? A. That's approximately 10 percent of the total of 1,487, I believe. Q. And 1,487 is the total number of procedures projected to be performed at Mission GI South in Year 3? A. Yes. Q. And were you aware during the review that the inmigration, that number, 149 procedures, would patients from zip codes in Buncombe and Hende County as well as outside Buncombe and Hende County?
7 8 9 10 11 12 13 14 15 16 17	endoscopy—of the location for an endoscopy procedure is influenced strongly by the physician who will perform the endoscopy? A. I can't say—I can't say strongly, but certainly it could be influenced. Q. And if a—if a GI specialist says I can perform a procedure for you at Mission GI South next week, but if—but I can't do it at Mission downtown for another month, which would you prefer? MR. JOHNSON: Object to form. Q. Can you see that discussion happening? A. I could see that discussion happening. Q. And, in that case, it would be reasonable to assure	6 7 8 9 10 11 12 13 14 15 166 17 me 18	Q A A C C C C C C C C C C C C C C C C C	 A. 149. Q. And that is 10 percent of what number? A. That's approximately 10 percent of the total of 1,487, I believe. Q. And 1,487 is the total number of procedures projected to be performed at Mission GI South in Year 3? A. Yes. Q. And were you aware during the review that the immigration, that number, 149 procedures, would patients from zip codes in Buncombe and Hende County as well as outside Buncombe and Hende County? A. Well, the applicant said that—I quoted them the
7 8 9 10 11 12 13 14 15 16 17 18	endoscopy—of the location for an endoscopy procedure is influenced strongly by the physician who will perform the endoscopy? A. I can't say—I can't say strongly, but certainly it could be influenced. Q. And if a—if a GI specialist says I can perform a procedure for you at Mission GI South next week, but if—but I can't do it at Mission downtown for another month, which would you prefer? MR. JOHNSON: Object to form. Q. Can you see that discussion happening? A. I could see that discussion happening. Q. And, in that case, it would be reasonable to assurt that the patient would choose Mission GI South,	6 7 8 9 10 11 12 13 14 15 16 17 me 19	Q A A Q Q A A A A A A A A A A A A A A A	 A. 149. Q. And that is 10 percent of what number? A. That's approximately 10 percent of the total of 1,487, I believe. Q. And 1,487 is the total number of procedures projected to be performed at Mission GI South in Year 3? A. Yes. Q. And were you aware during the review that the inmigration, that number, 149 procedures, would patients from zip codes in Buncombe and Hende County? A. Well, the applicant said that—I quoted them the saying that 10 percent of the GI endoscopy
7 8 9 10 11 12 13 14 15 16 17 18 19 20	endoscopy—of the location for an endoscopy procedure is influenced strongly by the physician who will perform the endoscopy? A. I can't say—I can't say strongly, but certainly it could be influenced. Q. And if a—if a GI specialist says I can perform a procedure for you at Mission GI South next week, but if—but I can't do it at Mission downtown for another month, which would you prefer? MR. JOHNSON: Object to form. Q. Can you see that discussion happening? A. I could see that discussion happening. Q. And, in that case, it would be reasonable to assure that the patient would choose Mission GI South, even driving further to get the procedure done	6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	Q A A C C C C C C C C C C C C C C C C C	 A. 149. Q. And that is 10 percent of what number? A. That's approximately 10 percent of the total of 1,487, I believe. Q. And 1,487 is the total number of procedures projected to be performed at Mission GI South in Year 3? A. Yes. Q. And were you aware during the review that the inmigration, that number, 149 procedures, would patients from zip codes in Buncombe and Hende County? A. Well, the applicant said that—I quoted them the saying that 10 percent of the GI endoscopy procedures at Mission South will come from other.
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	endoscopy—of the location for an endoscopy procedure is influenced strongly by the physician who will perform the endoscopy? A. I can't say—I can't say strongly, but certainly it could be influenced. Q. And if a—if a GI specialist says I can perform a procedure for you at Mission GI South next week, but if—but I can't do it at Mission downtown for another month, which would you prefer? MR. JOHNSON: Object to form. Q. Can you see that discussion happening? A. I could see that discussion happening. Q. And, in that case, it would be reasonable to assure that the patient would choose Mission GI South, even driving further to get the procedure done sooner?	6 7 8 9 10 11 12 13 14 15 16 17 18 15 20 21	Q A A (((((((((((((((((A. 149. Q. And that is 10 percent of what number? A. That's approximately 10 percent of the total of 1,487, I believe. Q. And 1,487 is the total number of procedures projected to be performed at Mission GI South in Year 3? A. Yes. Q. And were you aware during the review that the inmigration, that number, 149 procedures, would patients from zip codes in Buncombe and Hende County as well as outside Buncombe and Hende County? A. Well, the applicant said that—I quoted them the saying that 10 percent of the GI endoscopy procedures at Mission South will come from oth Buncombe County and Henderson zip codes and
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	endoscopy—of the location for an endoscopy procedure is influenced strongly by the physician who will perform the endoscopy? A. I can't say—I can't say strongly, but certainly it could be influenced. Q. And if a—if a GI specialist says I can perform a procedure for you at Mission GI South next week, but if—but I can't do it at Mission downtown for another month, which would you prefer? MR. JOHNSON: Object to form. Q. Can you see that discussion happening? A. I could see that discussion happening. Q. And, in that case, it would be reasonable to assure that the patient would choose Mission GI South, even driving further to get the procedure done sooner? A. I don't know. It's possible.	6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	Q A A Q Q A A A Q A A A A A A A A A A A	 A. 149. Q. And that is 10 percent of what number? A. That's approximately 10 percent of the total of 1,487, I believe. Q. And 1,487 is the total number of procedures projected to be performed at Mission GI South in Year 3? A. Yes. Q. And were you aware during the review that the inmigration, that number, 149 procedures, would patients from zip codes in Buncombe and Hende County as well as outside Buncombe and Hende County? A. Well, the applicant said that—I quoted them the saying that 10 percent of the GI endoscopy procedures at Mission South will come from oth Buncombe County and Henderson zip codes and counties.
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	endoscopy—of the location for an endoscopy procedure is influenced strongly by the physician who will perform the endoscopy? A. I can't say—I can't say strongly, but certainly it could be influenced. Q. And if a—if a GI specialist says I can perform a procedure for you at Mission GI South next week, but if—but I can't do it at Mission downtown for another month, which would you prefer? MR. JOHNSON: Object to form. Q. Can you see that discussion happening? A. I could see that discussion happening. Q. And, in that case, it would be reasonable to assurthat the patient would choose Mission GI South, even driving further to get the procedure done sooner? A. I don't know. It's possible. Q. Beyond reading what was in the Mission GI South	6 7 8 9 10 11 12 13 14 15 16 17 me 18 19 20 21 1th 2 2 2 1th	Q A A C C A A C C A A C C A A C C A A C C A A C C A C A C C	 A. 149. Q. And that is 10 percent of what number? A. That's approximately 10 percent of the total of 1,487, I believe. Q. And 1,487 is the total number of procedures projected to be performed at Mission GI South in Year 3? A. Yes. Q. And were you aware during the review that the inmigration, that number, 149 procedures, would patients from zip codes in Buncombe and Hende County as well as outside Buncombe and Hende County? A. Well, the applicant said that—I quoted them the saying that 10 percent of the GI endoscopy procedures at Mission South will come from oth Buncombe County and Henderson zip codes and counties. Q. Were you expecting a specific number from eigenstance.
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24	endoscopy—of the location for an endoscopy procedure is influenced strongly by the physician who will perform the endoscopy? A. I can't say—I can't say strongly, but certainly it could be influenced. Q. And if a—if a GI specialist says I can perform a procedure for you at Mission GI South next week, but if—but I can't do it at Mission downtown for another month, which would you prefer? MR. JOHNSON: Object to form. Q. Can you see that discussion happening? A. I could see that discussion happening. Q. And, in that case, it would be reasonable to assure that the patient would choose Mission GI South, even driving further to get the procedure done sooner? A. I don't know. It's possible.	6 7 8 9 10 11 12 13 14 15 16 17 me 18 19 20 21 1th 2 2 2	Q A A C C A A C C A A C C A A C C A A C C A C A C C A C A C	 A. 149. Q. And that is 10 percent of what number? A. That's approximately 10 percent of the total of 1,487, I believe. Q. And 1,487 is the total number of procedures projected to be performed at Mission GI South in Year 3? A. Yes. Q. And were you aware during the review that the inmigration, that number, 149 procedures, would patients from zip codes in Buncombe and Hende County as well as outside Buncombe and Hende County? A. Well, the applicant said that—I quoted them the saying that 10 percent of the GI endoscopy procedures at Mission South will come from oth Buncombe County and Henderson zip codes and counties.

-60--58~ MS. HILES--VOLUME I 60 58 1 listed as "other," so I can't say specifically terms of additional detail? 1 where-where they define that "other." But once-2 A specific number? once this applicant defined their primary and 3 3 Q. Yeah secondary and tertiary service area, then anything 4 A. No. else as inmigration would be in addition to that. 5 So you didn't expect Mission to be able to say of 5 All right. And-and just looking at history for 6 that 10 percent immigration, we expect a certain 6 Mission on Page 632 of the Agency file, it reflects 7 number of people to come from Polk County, for 7 3,730 patients sought endoscopy procedures at 8 В example? Mission from Buncombe County? 9 Well. I would just liked to have seen more detailed 9 information about-particularly with regard to the 10 A. 10 And if Buncombe County is the service area for Q. other counties that are referenced here. 11 11 Mission, then the rest of the patients reflected on Not Buncombe or Henderson? 12 12 this page are-are-inmigrated for their endoscopy A. No, because they've said Buncombe and Henderson, 13 13 other Buncombe and Henderson zip codes. It was the here? 14 14 Well, not as defined as by the applicant. If I go A. other counties that I would have liked to have more 15 15 to Exhibit 16 in the application, they tell me 16 information on. 16 exactly what their primary, secondary, and tertiary I think this might be a good time to take a quick 17 Q. 17 18 service areas are. 18 I think I'm-I need to ask a better question. (RECESS TAKEN FROM 11:20 A.M. UNTIL 11:34 A.M.) Q. 19 19 20, (By Ms. Harris) Ms. Miles, we talked a good bit A. 20 On Page 632, it just refers to Mission's current already about immigration. How do you define 21 21 services? 22 22 inmigration? Let's see. How would I define inmigration? I 23 Α. Yes. 23 24 Q. So all the patients who came from outside Buncombe would define immigration as being, you know, any 24 Carolina Reporting Service (919) 661-2727 Carolina Reporting Service (919) 661-2727 MS. MILES--VOLUME I MS. MILES--VOLUME I 61 59 County immigrated for GI care historically to 1 patients coming from outside of your defined 2 Mission; is that right? service area. 3 Well, this table is just giving me every--every And looking back at the GI endoscopy patient origin 4 county. that we saw in the license renewal application on 5 Q. Right. Page 632, and patients coming from any of the The applicant hasn't said what-from looking at 6 counties listed other than Buncombe are considered A. 6 7 this, I can't tell what the primary service area to be inmigrating to Mission; is that right? is, as defined by the applicant. 8 I'm sorry. Could you repeat that? 8 Okay. But can you forget about the application for 9 Sure. Do you have that gastrointestinal endoscopy 9 the moment? 10 case patient origin page? 10 11 Okay. A. 11 A. And just look at Page 632, and I'm talking about All right. Under your definition, all the patients 12 12 inmigration generally. But would you agree that on this page outside Buncombe County are considered 13 13 the patients from outside Buncombe County, from all to have inmigrated to Buncombe County for GI 14 14 these different places, inmigrated to Mission for 15 1.5 services? 16 their GI care? Well, for the review it's not necessarily how I 16 Guess I wouldn't define it as inmigration per say, defined inmigration, per say; the applicant has 17 17 but yes. If Mission Hospital is in Buncombe County 18 already kind of defined inmigration. In the 18 and all these patients are coming from counties population to be served section of the application, .19 19 outside of Buncombe County, then they have come 20 it lists where the patients are coming from, and I 20 into Buncombe County for services. Yes. 21 believe it said that Mission GI had 5.5 percent 21 Why wouldn't you call that inmigration? 22 Q. inmigration, which would be outside of those 22 Well, it's how the-the applicant has defined 23 counties that are listed on that chart. I don't 23 24 inmigration in their application as being something know what those counties are. I think they're 24

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MS. MII	LES\	TOLUME I	-62-	MS. MI	LES\	-VOLUME I64-	
			62				4
1		outside of their service area.	Buncombe is part of	1	A.	Okay. On the Year 2015 on this chart, it's 472	
2		their primary service area, bu	t then they've	2		472 cases.	
3		identified a secondary and ter	rtiary service area,	3	Q.	Cases. And I may have not been clear in some	
4		and then an "other" service a	rea.	4		earlier questions about whether I was talking about	
5	Q.	And when I interrupted you	you were taking me to	5		patients versus procedures, but I'll try to be more	
6	•	table 16-or Exhibit 16.		6		clear. Do you equate patients to cases?	
7	A.	I'm looking at Page 366. So	they have identified	7	A.	Generally.	
8		Buncombe as being their prin		8	Q.	472 cases. Cases. And I may have not been clear in some earlier questions about whether I was talking about patients versus procedures, but I'll try to be more clear. Do you equate patients to cases? Generally. And then you would expect the procedures number	rt
9		Henderson-well, actually, th	ey've got Henderson	9		be higher than the patient number, at least in this	
10		and Buncombe as their prim		10		review?	
11		then their secondary and the		11	A.		
12		area. And in the application	, they have added up,	12		showed that, yes, procedures were slightly higher	
13	.i	I believe, the tertiary service		13		than the number of cases.	
14		their inmigration as 34 perce		14	Q.	Have you-in other GI endoscopy reviews you've	
15		that, they say they conservat		15		done, has there been a one-to-one relationship	
16		percent of that will-will con	ne to Mission GI	16		between patients and procedures?	
17		South. And I-but they didn	't say what counties	17	A.		
18		that 10 percent would come	from. But it's clear	18		guess, off the top of my head, but I don't recall	
19-		that it wouldn't be 34 percer	nt, so of that 10	19		specifically.	
20		percent, I would like to kno		20	Q.		
21		would come from so then w	e can determine whether or	21		findings, and specifically Criterion 3, Page 644.	
22		not we thought that those co	ounties, geographically	22		I'm going to ask you a series of questions about	
23		speaking, would be reasona		23		the need demonstration section of the findings.	
24	Q.	But I-I think we're in agre	ement that they	24		The-the discussion in the findings starts out with	٠
Ca	rol:	ina Reporting Service	(919) 661-2727	Ca	roli	ina Reporting Service (919) 661-2727	7
		Volare 1	-63-	MS.	MILES	5VOLUNE I -65-	
			63				6
,		couldn't have used the 34	nercent which they had	1	•	a series of quotations from the application	
1		for the whole hospital, is		2		regarding GI disorders, various clinical studies;	
2		service?	man right, alon whole	3		do you see that?	
3	A	-		4	Α	A. Yes.	
4 5	A	•	conservative than 34	5		Q. Did you have any dispute with or disagreement	w
	Ç	`	OOIISOI TRATTO RAME ST	6	`	the discussion in Mission's application regarding	
6	٨	percent?		7		the prevalence of GI disorders and the important	
7 8	A		5.5 percent. Is that the	8		of cancer early detection through colon screening	
9	,		" column at the bottom of	9	A	A. No.	
ł		the chart on Page 366?		10		Q. Did you dispute the validity of any of the studi	e\$
10	,		ere. I was nicturing it-	11		mentioned?	
12	F	it's in a different chart so		12		A. No.	
13	,			13		Q. The-there's a section of your findings discussi	ing
14		Q. Okay. A. —I recall it being 5.5 pe	rcent.	14		population growth as well as procedure volume	
15			5.5 percent represent in yo	i		growth that begins on Page 648.	
16		understanding?	Francisco Comment	16		A. Yes.	
17			ents coming from outside	1		Q. As-as I read the discussion and the quotes fro	m
18		their service area.		18		the application, is it correct to say that you	
19			rimary, secondary, and	19		accepted the representations made by Mission a	1\$
20		Q. Outside, but both the p tertiary?	economy 2 am a commy 2 am m	.20		valid with regard to population and procedure	
1				23		growth?	
23			her of cases that—that	22		A. Yes.	
23		Q. Okay. What's the num represented that 5.5 per-		2:		Q. You have a footnote on Page 68 under the cha	art,
1 43	,	•		1			
24	1	Three, as an example.		2	4	reflects that you made some calculations and-	ano

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-56-	MS. MILESVOLUME I -68-
MS. MILESVOLUME I	68
	O O Day 652 you note at the hottom that the
1 got slightly different numbers?	1 Q. On Page 652, you note at the bottom that the 2 applicant projected to perform less than 1,500
2 A. On 648?	l ve o e e e e e e e e e e e e e e e e e
3 Q. Yes.	l some the state of the state o
4 A. Yes.	1
5 Q. And your calculations were based on the 2009	5 apply; is that right?
6 through 2011 SMFPs?	6 A. Right. 7 O. And that's because Mission did not propose a new a
7 A. Yes.	<u> </u>
8 Q. The-the difference is-the differences in the	8 room? 9 A. They didn't propose a new ambulatory surgical
9 numbers was not a significant difference, correct?	· · · · · · · · · · · · · · · · · · ·
10 A. No.	
11 Q. And the-	1 11 11 11 11 11 11 11 11 11 11 11 11 1
12 A. I simply noted it here-	No.
13 Q. Okay.	
14 A. —that it was different.	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
15 Q. And the chart at the top of Page 648 reflects that	15 Q. Beginning on Page 653 of your maings, there's a large 16 series of steps. It's the steps of the methodology
16 there are actually 15 endoscopy rooms needed in	
17 Buncombe County, based on the 1,500 procedure per	18 653?
18 year standard; is that right?	19 A. Yes.
19 A. Yes.	
20 Q. And the actual inventory for Buncombe County is 1	21 step to make sure I understand your findings. Step
21 rooms?	22 1 is the step in which Mission determined the base
22 A. Yes.	· · · · · · · · · · · · · · · · · · ·
23 Q. So do you agree that the procedure volumes show a	24 discussed its used of Trend Star data and
24 need for more licensed GI endoscopy rooms in	Carolina Reporting Service (919) 661-2727
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MS. MILESVOLUME I -67-	MS. MILESVOLAMS I -69-
67	7
1 Buncombe County than exist?	1 determined that that was reasonable; is that
	2 correct?
2 111	3 A. Yes.
procedures and the 1,500 procedures per year standard that appears in the rules, there is	4 Q. Step 2 has the growth rate for projecting future
5 sufficient volume for more rooms.	5 utilization. And as I read your findings, there
to the state of Days (40 the similar	6 were no negative findings regarding the growth rate
6 Q. And the—it you look at rage 649, the shintal 7 analysis appeared in Mission's application showing	7 assumptions that Mission made in the application?
8 Buncombe and Henderson Counties combined?	8 A. That's correct.
9 A. Yes.	9 Q. And likewise, you accepted the procedure per case
10 Q. And you would agree, based on the data, that	10 assumptions?
there's a need—there's potentially a need for	11 A. Yes.
12 additional GI endoscopy rooms?	12 Q. On 654, why did you calculate the compound annual
13 A. Yes.	13 growth rate for that table?
14 Q. And thethe research that you did related to	14 A. Well, it wasn't included in the information
15 population growth was consistent with the	15 provided by the applicant, and I just thought it'd
16 information in Mission's application; is that	16 be interesting to see what those numbers look like.
17 correct?	17 Q. Did you make any conclusions based on your
	18 calculation?
18 A. I don't recall any specific research on population	
18 A. I don't recall any specific research on population growth.	19 A. No.
19 growth.	vhere 20 Q. And based on your calculations, there's a 2.3
19 growth.20 Q. You had some materials in the working papers w	vhere 20 Q. And based on your calculations, there's a 2.3 21 percent compound annual growth rate for inpatient
19 growth. 20 Q. You had some materials in the working papers w 21 you just were checking on different things in the 22 County. Did I misunderstand?	where 20 Q. And based on your calculations, there's a 2.3 21 percent compound annual growth rate for inpatient 22 procedures, correct?
19 growth. 20 Q. You had some materials in the working papers w 21 you just were checking on different things in the	where 20 Q. And based on your calculations, there's a 2.3 21 percent compound annual growth rate for inpatient 22 procedures, correct? 23 A. Yes.
19 growth. 20 Q. You had some materials in the working papers w 21 you just were checking on different things in the 22 County. Did I misunderstand?	where 20 Q. And based on your calculations, there's a 2.3 21 percent compound annual growth rate for inpatient 22 procedures, correct?

	MS I -70-	MS. MI	LESV	OLIME I -72-
	70			1.2
1 01	tpatiens, and then the total was -0.2 percent?	1	A.	No.
	řes.	2	Q.	Did you determine that the use rate used in the
3 Q. A	and—and that -0.2 percent is, in fact, what	3		projections was reasonable?
	ission used as its-used to project its future	4	A.	Yes.
	lume; is that right?	5	Q.	Step 6 begins on Page 658, but most of the
	čes.	6		discussion is on the following page. You did not
	On Page 655, there's a chart from the application,	7		make any negative findings regarding the base
8 E	xhibit 16, related to population growth rate.	8		population for the Mission GI South service area?
	Yould you agree that this 1.2 percent weighted	9	A.	No.
	opulation growth rate was a conservative way to	10	Q.	And you determined that the Mission GI South
	roject population growth?	11		service—base service area was reasonable?
	MR. JOHNSON: Object to form.	12	A.	Yes.
	I can't say whether or not it was conservative.	13	Q.	Step 7 begins on 659, and involves a projection of
	his was the way the applicant chose to look at	14	ν.	outpatient cases for Mission GI South. If you'll
	nis was the way life applicant chose to foot at that information and I thought it was reasonable.	15		look, I think, mainly at Page 660, you determined
	The application reflects a higher weighted	16		ultimately that the projected total was reasonable;
	opulation growth rate for the over 55; is that	17		is that right?
-	•	18	A.	
	ight?	19	J 2.	660?
19 A.	Yes. 2.1 versus 1.2.	20	Q.	
20 Q.	Did that assist you in determining that the 1.2	21	٧.	need to refer to that to answer my question, that's
	percent was reasonable?			fine.
22 A.	No. They—they had the same methodology and way	23	A.	
	ocking at the population for—the total population	1		are a second of the second of These A
	and the population of 55 and over. I found it to	24	Q.	
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HS. HILESV	-71-	1		-73-
	OLUME I	MS.	MILES	
	7		HILES	VOLUME I
	7	1	MILES	
1	be reasonable in both cases.	1 1		What was your concern there?
1 2 Q.	be reasonable in both cases. Step 3 is on Page 657. And, in fact, they did use	1 1 2	miles A	What was your concern there? It wasn't a concern. I was just restating what was
1 2 Q. 3	be reasonable in both cases. Step 3 is on Page 657. And, in fact, they did use the compound annual growth rate that matched yo	1 1 2 ars 3		What was your concern there? It wasn't a concern. I was just restating what was in the applicant's methodology. The information—
1 2 Q. 3 4	be reasonable in both cases. Step 3 is on Page 657. And, in fact, they did use the compound annual growth rate that matched yo to project procedures correct?	1 2 2 3 4	A	What was your concern there? It wasn't a concern. I was just restating what was in the applicant's methodology. The information—the number of cases and procedures that the
1 2 Q. 3 4 5 A.	be reasonable in both cases. Step 3 is on Page 657. And, in fact, they did use the compound annual growth rate that matched yo to project procedures correct? Yes.	1 1 2 ars 3 4 5	A	What was your concern there? It wasn't a concern. I was just restating what was in the applicant's methodology. The information—the number of cases and procedures that the applicant was using up to this point were inpatient.
1 2 Q. 3 4	be reasonable in both cases. Step 3 is on Page 657. And, in fact, they did use the compound annual growth rate that matched yo to project procedures correct? Yes. All right. And you accepted that growth rate as	1 2 2 3 4 5 6	A	What was your concern there? It wasn't a concern. I was just restating what was in the applicant's methodology. The information—the number of cases and procedures that the applicant was using up to this point were inpatient and outpatient, and the applicant recognized that
1 2 Q. 3 4 5 A.	be reasonable in both cases. Step 3 is on Page 657. And, in fact, they did use the compound annual growth rate that matched yo to project procedures correct? Yes. All right. And you accepted that growth rate as reasonable?	1 2 3 4 5 6 7	A	What was your concern there? It wasn't a concern. I was just restating what was in the applicant's methodology. The information—the number of cases and procedures that the applicant was using up to this point were inpatient and outpatient, and the applicant recognized that here and provided a breakout of the inpatient and
1 Q. 3 4 5 A. 6 Q.	be reasonable in both cases. Step 3 is on Page 657. And, in fact, they did use the compound annual growth rate that matched yo to project procedures correct? Yes. All right. And you accepted that growth rate as reasonable? Yes.	1 1 2 3 4 5 6 7 8	A	What was your concern there? It wasn't a concern. I was just restating what was in the applicant's methodology. The information—the number of cases and procedures that the applicant was using up to this point were inpatient and outpatient, and the applicant recognized that here and provided a breakout of the inpatient and outpatient procedures.
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1 2 Q. 3 4 5 A. 6 Q. 7 8 A. 9 Q. 10 11 12 13 14 A. 15 Q. 16 17 A. 18 Q. 19 20 A. 21 Q.	be reasonable in both cases. Step 3 is on Page 657. And, in fact, they did use the compound annual growth rate that matched yo to project procedures correct? Yes. All right. And you accepted that growth rate as reasonable? Yes. In Step 4, the applicant applied the procedures a population growth numbers and growth rate to ob a projected number of procedures and cases for the project years for the whole GI endoscopy services is that right? Yes. And you did not make any negative findings with regard to Step 4 of their methodology? No. Step 5 involves a determination of use rates for Buncombe and Henderson Counties; do you see Yes. On Page 658?	1 1 2 3 3 4 4 5 6 6 7 8 8 nd 9 12 13 14 h 15 16 17 18 h 16 17 18 18 18 18 18 18 18 18 18 18 18 18 18	A A A A A A A A A A A A A A A A A A A	What was your concern there? It wasn't a concern. I was just restating what was in the applicant's methodology. The information—the number of cases and procedures that the applicant was using up to this point were inpatient and outpatient, and the applicant recognized that here and provided a breakout of the inpatient and outpatient procedures. And you determined on Page 661 that it was reasonable to—to include both Mission's and the endoscopy center's utilization data to get an outpatient percentage? A. Yes. It's reasonable. And I think, if I'm understanding your findings correctly, on Page 662, you concluded that the use of Buncombe County outpatient GI endoscopy ca a proxy for Henderson County was reasonable; is that right? A. Yes. Q. All right. If you'll move—move on to Step 8,
1 2 Q. 3 4 5 A. 6 Q. 7 8 A. 9 Q. 10 11 12 13 14 A. 15 Q. 16 17 A. 18 Q. 19 20 A. 21 Q. 22 A.	be reasonable in both cases. Step 3 is on Page 657. And, in fact, they did use the compound annual growth rate that matched yo to project procedures correct? Yes. All right. And you accepted that growth rate as reasonable? Yes. In Step 4, the applicant applied the procedures a population growth numbers and growth rate to ob a projected number of procedures and cases for the project years for the whole GI endoscopy service; is that right? Yes. And you did not make any negative findings wit regard to Step 4 of their methodology? No. Step 5 involves a determination of use rates for Buncombe and Henderson Counties; do you see Yes. On Page 658? Yes.	1 1 2 3 3 4 5 6 6 7 8 8 nd 9 11 12 13 14 h 15 14 15 hat 1 2 2	A A A A A A A A A A A A A A A A A A A	What was your concern there? It wasn't a concern. I was just restating what was in the applicant's methodology. The information—the number of cases and procedures that the applicant was using up to this point were inpatient and outpatient, and the applicant recognized that here and provided a breakout of the inpatient and outpatient procedures. And you determined on Page 661 that it was reasonable to—to include both Mission's and the endoscopy center's utilization data to get an outpatient percentage? A. Yes. It's reasonable. And I think, if I'm understanding your findings correctly, on Page 662, you concluded that the use of Buncombe County outpatient GI endoscopy ca a proxy for Henderson County was reasonable; is that right? A. Yes. Q. All right. If you'll move—move on to Step 8, which begins on Page 662, there's a calculation or
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-76--7 G-MS. MILES--VOLUME I 76 74 And this is where-I think we touched on this Q. Okay. And you did not have any negative findings 1 1 earlier-you determined that it was not reasonable 2 regarding the number of outpatient procedures in 2 to expect patients from, for example, Madison, 3 the service area? 3. Yancey, and Mitchell to travel to Mission GI South; 4 4 A. 5 is that right? So you determined that the-the total projected 5 Q. Right. It was not reasonable to expect patients 6 outpatient procedure numbers were reasonable? 6 7 from all of these counties, on Page 336 of the Yes. Their methodology for calculating that was 7 application that the applicant provided, that all-8 8 reasonable. 9 that patients from all of those counties would Moving on to Step 9, which is a market share 9 Q. travel to Mission GI South. 10 calculation, the application demonstrated how and 10 Is it fair to say that the only issue you had with why it projected a certain market share; is that Q, 11 11 Mission's need methodology is the inmigration? 12 12 right? Let me just look here. (Witness reviews document.) 13 13 Yes. It was the inmigration issue, and then around Page 14 And you determined that the market share 14 Q. 670, I also discuss the volumes of other providers 15 calculations were reasonable? 15 in the area. 16 16 Yes. A. That's-that's a separate question from the And then Step 10 is the projection of outpatient 17 Q. Q. 17 procedures for Mission GI South, the last step of 18 methodology, though, correct? 18 From-out of the 10 steps of their methodology, the methodology. The discussion in your findings 19 19 correct. The inmigration was the major issue. 20 begins on Page 664. I think this is where your 20 Okay. And in your detailed discussion on 666 and discussion of immigration comes up again; is that 21 21 667, you include a chart on Page 667? 22 correct? 22 23 A. Yes. 23 A. Yes. And did you determine that the total number of 24 Q. And that's a chart you created? Q. Carolina Reporting Service (919) 661-2727 Carolina Reporting Service (919) 661-2727 MS. MILES--VOLUME I MS. MILES--VOLUME I 77 75 1 A. procedures projected for Mission GI South was 1 And your source is the license renewal application? 2 Q. reasonable? 2 3 A. I don't understand your question. 3 A. Did-based on the chart and the discussion below, Did you say you didn't--you weren't understanding 4 Q. 4 Q. is it correct that you determined that it was 5 my question? 5 reasonable to expect 508 endoscopy patients would 6 Right. Α. come to Mission GI South out of the total 6,563? 7 7 Q. Okay. 8 A. If you could just rephrase it? 8 And that 508 represents the five counties just 9 Let me try it again. I think we've established O. 9 above the subtotal of 508? that Steps 1 through 9 of the methodology you did 10 10 11 Α. not have a concern about; is that right? 11 And so did you determine that 7.7 percent 12 Q. 12 A. Yes. inmigration would have been reasonable? What was your concern with regard to Step 10? 13 13 Q. Yes. My concern with regard to Step 10 primarily had to 14 A. 14 And-do with the immigration, and the use-that the 15 Q. 15 Well, I should say, 7.7 percent based on the 16 applicant used Mission's 34 percent inmigration as A. 16 information in this chart, but again, this is both 17 a proxy for Mission South's inmigration, and then 17 inpatient and outpatient. I didn't take a step conservatively, as they've stated, projected that 18 18 further to try to adjust and give you just an 19 10 percent of that would go to-would-10 percent 19 outpatient number. But it-in terms of patients would be reflected in Mission South's inmigration, 20 20 going to Mission South, it would be reasonable to but they didn't provide me any information as to 21 21 expect it to be lower than 7.7 percent once you 22 what made up that 10 percent. and that's a 22 removed inpatients from those-from those numbers. detailed discussion here on Page 667, beginning on 23 23 24 What was-what is the fact that you would use to 666, of that. 24 Carolina Reporting Service (919) 661-2727 Carolina Reporting Service (919) 661-2727

MS. MILES--VOLUME I -78-MS. MILES--VOLUME I 80 78 Okay. And then look with me, if you will, on Page 1 remove inpatient based on the discussion in the 1 668 of the findings. How many procedures did 2 application? 2 Mission project to perform for patients who I--I would not have to think about it, but one way 3 3 A. immigrated from outside the Buncombe and Henderson to perhaps do it would be to look at Mission's 5 County zip code areas? current inpatient/outpatient split as a proxy. 5 Well, they didn't give me for patients who 6 Okay. If you did that, what-let me see if I can А. 6 inmigrated. The patients who inmigrated were 149. 7 get you to the right page. There's a couple 7 Isn't the 149 the inmigration? Q. different places that you might want to look, and I 8 8 Yes. That's the-I'm sorry. I may have think it's discussed in your findings. But if you 9 9 misunderstood your question, 149 procedures. Yes. look at Page 58 of the application-and 672 of your 10 10 11 Q. Right, Okay. Sofindings, actually, there's a table there that will 11 Inmigration. help us--or not a table, but a discussion--at the 12 A. 12 In Year Three, Mission projected that 149 13 Q. bottom of the first full paragraph, you discuss 13 procedures would be patients who inmigrated? that Mission's inpatient/outpatient split is 38.9 14 14 In Year Three, they projected 149 procedures. percent inpatient and 61.1 percent outpatient? 15 A. 15 Okay. And 149 procedures is less than 390 that we 16 16 just calculated? So would it be appropriate to apply that 61.1 1.7 17 It is. A. percent to your 508 to get a total number of 18 18 Based on this analysis, would you agree that the 19 patients? 19 immigration percentage used by Mission was 20 You could look at it that way. 20 A. What-I have a calculator. What number do you come 21 reasonable? 21 22 MR. JOHNSON: Object to form. 22 No. Well, half of 500 is 250. Around 300, just kind of 23 A. 23 Why not? 24 Q. off the top of my head. 2.4 Carolina Reporting Service (919) 661-2727 (919) 661-2727 Carolina Reporting Service -81-MS. MILES--VOLUME I MS. MILES--VOLUME I -79-81 79 Well, given the information that I have in the A. Okay. Around 300 patients? 1 1 Q. application-not what I've calculated here, in 2 2 A. terms of not being able to look at it in relation Okay. So it would be reasonable to expect that 3 3 Q. to everything else-based on what they have given approximately 300 patients would come from the 4 me, their calculation-the actual fundamentals of 5 counties that they had listed? 5 the calculation is fine. I just questioned the 10 6 Outpatient. Uh-huh. 6 A. percent as being unreasonable. 7 All right. Q. We just calculated that-that your number of what 8 That's a way of looking at it. Yes. 8 A. was reasonable was higher than the 10 percent, so 9 So a--a total number of approximately 300 patients 9 why is the number projected in the application not 10 inmigrating from these five counties you listed 10 11 reasonable? would be-would have been a reasonable inmigration 11 Well, actually, I'd have to sit and think as to 12 A. projection, in your view? 12 why, you know, a number less than--why--why a 13 It'd be a way of looking at it. And I--you know, I 13 number less than 10 percent would be higher than 10 14 may have considered it to be reasonable. It's the 14 percent. I'm not sure. I'd have to take a minute 15 way that I would think about it. Applicants do 15 to look and figure out what's going on. 16 different things, but that's the way I would think 16 Okay. 17 Q. 17 about it off the top of my head. But if-if they were-based on this chart here, if If you have approximately 300 patients, how many 18 18 their 10 percent is 149, if they were, say, 19 procedures does that equate to using the 1.3 19 projecting 5 percent, if you've got this chart and 20 multiplier that was used in the application to 20 you substitute the 5 for the 10, it would be lower 21 convert cases to procedures? I'd be happy to share 21 than 149. 22 my calculator again. I get 390, just in round 22 23 Can you say that again? Q. numbers. 23 If they-if-if based on this chart-and-and what 24 Okay. 390 procedures. 24

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-84-MS. MILES--VOLUME I MS. MILES -- VOLUME I 84 82 used; does it not? I recall from the application is it gave me the 1 1 Well, yes. But 667 is Mission Hospital total, and 2 A. first row, which is the outpatient procedures, and 2 668 is just Mission GI South. So I can't compare then you-there are a couple ways of look at it. 3 3 the 149 in Project Year on this table on Page 668 One would be to get a total number and then back 4 4 to that 390, because that's all Mission Hospital 5 out what 10 percent of that would be. But my 5 and this is just Mission GI South. 6 thought is-and we're talking right now-if this 6 7 Right Q. had been 5 percent of, say, 1,487, instead of 10 7 And the reason why this is Mission Hospital as-as 8 A. percent of 1,487, it would have been more like 70-8 opposed to, say, Mission GI South, one, because I 9 9 some patients. didn't have that information for Mission GI South, 10 Look at Page 58 of the application, if you will. 10 Q. but because the applicant, in the application, 11 11 Which is-A. states that, from that table on-from that Table 12 This volume right here. Is it correct that the 12 516, that they had 34 percent immigration and that 13 table that you-that you have in the findings on 13 10 percent-they-they were going to use 10 percent 1.4 Page 668 is-14 as a conservative basis for that. 1.5 Yes. 15 A. All right. Look with me back at Page 667. Q. -is identical or close to the chart on Page 58? 16 16 17 Α, That's correct. 17 A. What is 10 percent of the total endoscopy patients And so the procedure numbers for inmigration are 18 Q. 18 for Mission? What would that be? listed out separately in the application? 19 19 10 percent of the total patients would be about Yes. They're listed out separately. When I look 20 A. 20 Α. 21 at this chart-I don't know where that 10 percent 21 What percent of the total patients is 149? In comes from-so for when-when I look at it, I have 22 Q. 22 other words, if you divide 149 by 6563, what do you 23 to assume that the applicant got a total of, in 23 Year Three, 1,487 and then took 10 percent of that 24 24 Carolina Reporting Service (919) 661-2727 Carolina Reporting Service (919) 661-2727 MS. MILES--VOIDME I -89-MS. MILES--VOLUME I 85 83 Or-is that also-is-I'm not sure what year this A. 1 to get 149. Because I don't have a subtotal for 1 chart here--667-if it's Project Year Three, 2015-inmigration, you know, where--what counties are 2 2 It's actually based on historical data. Q. included in that and how many procedures from each 3 3 Okay. So it's like the current-current year. county to know where you got that 149 from, I have 4 A. Look in the application. 5 Q. to assume that you--you reached a total and then Oh-oh, this is from the LRA, so--6 A. back out at 10 percent inmigration to some degree. 6 7 Q. Yeah. I mean, that's-that's-in looking at it and not 7 Okay. So the different years. 8 A. having any information about what those counties 8 But for the purpose of this question, I do want you 9 Q. 9 to tell me what percentage of the total GI 10 Why does it matter if they did it that way, just 10 Q. patients-6,563-149 would represent, even though I 11 for the sake of argument? Why-why would that 11 understand that they're different years. 12 matter? 12 I'm sorry. What percentage? 13 Well, it didn't matter, per say, because I could 13 . I'm going to get you to do several calculations 14 look at it and figure out-10 percent is easy to 14 because what we're doing right now is comparing 15 look at and see where-where a number is in 15 patients and procedures. But I still want you to 16 relation to. But you do it just to validate the 16 do the calculation I asked, and then we'll-we'll applicant's assumptions. It--it's supportive. It 17 17 be more specific. What percentage of patients on 1.8 18 Page 667 does--if you use 149, what does that And--and then looking back at the charts on Page 19 19 Q, 667 and 668, the analysis that you did on 667-20 represent? 20 This is 149 procedures. 21 Α. Well 667--21 A. Yeah. And actually, you--22 Q. -does-22 Q. 23 A. This is patients. I'm sorry. Go ahead. 23 A. -you want to reduce the procedures to patients, --it does validate the methodology that Mission 24 Q. 24 Q. Carolina Reporting Service (919) 661-2727

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			hattan sammariann?	1		Mission GI South	is less than 2 percent?	- Control
1	٠,	and that would make:	it that would be—if you've	2	А.		paring those-this is-this, again,	
2	À.		f I divided that by 1.3, I get	3			This has got inpatient in it	
3		- "	I I divided that by 1.0, 1 got	4			is is all of Mission's numbers.	
4	^	115.115 patients?		5	Q.	Right.		١
5	Q.	115 patients.		6	À.		-that calculation is correct,	
6	A.	Oleva And how do	es 115 patients compare to the	7		they're just not-		
. 7	Q.	6,563 patients on 667		8	Q.	Right.	,	
8 9			small amount. (Witness	9	À.	totally apples-to	-apples, I don't think.	
10	Α.	calculates.) That's al	· · · · · · · · · · · · · · · · · · ·	10	Q.	I see what you're	saying. Going back to the first	
11	Q.		ar calculation, but actually	11		calculation we did	l, as I'm not understanding some	
12	Q,		Three procedures that are	12		of your testimony.	On 667 of the findings, another	T
13	. <i>e</i> .	projected in the appl		13			as we said, is to take the	
14	A.		ent procedures at Mission GI	14			s that you projected would be	
15	1 1.	South?	<u>.</u>	15			ect to go to GI South from those	
16	Q.		nt to use the total number for	16		other counties of	508; do you see that?	
17	٧.		tpatient procedures. If	17	A.			
18		you'll look with me	at the application Exhibit 16,	18	Q.		hen you need to make a reductio	n
19		the one with all the	tables, that's probably the	19		for the outpatient	percentage, correct?	
20		best place to do it.	And Table 3; do you see that?	20	A.			
21	A.		-	21	Q,	And we looked	at that earlier and it was around	60
22	Q.			22		percent?		
23	À.			23	A.			
24	Q.	. For Calendar Year	2014, there's a total number of	24	Q.		60 percent of 508 and what does	
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İ	HILES		~e7~ 87		MILES	VOLUME I	-09-	89
	HILES		87		MILES		-05-	89
1		GI endoscopy proce	87 dures for the combined Mission	1		give us?		89
1 2			87 dures for the combined Mission	1 2	A	give us? . (Witness calcu	lates.) 305.	
ŀ		GI endoscopy proce and South campuses Yes.	87 dures for the combined Mission s; do you see that?	1 2 3		give us? . (Witness calcu	lates.) 305. u would agree that305 patients	
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3	A Ç	GI endoscopy proce and South campuses Yes. 2. The last column, 8 that would be with:	dures for the combined Mission s; do you see that? ,579 procedures projected, and all six rooms. And then it	1 2 3 4 5	A Q A	give us? . (Witness calculate) . Okay. And you represents how to the control of t	lates.) 305. u would agree that305 patients many procedures? lates.) About 397.	
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2 3 4 4 5 6 7 7 8 9 10 11 11 1 1 1 1 1 1 1 2 2 2 2 2 2 2	A Q Q Q A Q Q Q A Q Q Q Q A Q	GI endoscopy proce and South campuses Yes. 2. The last column, 8 that would be with reduces to 6,451 can Yes. 2. So I'd like for you the total procedures Project Year Three. 4. For procedures, you Right. 4. —the 8,000 number. 6. Yes. I'm not goin calculation. 7. I'd like for you want South from 668? 9. I'd like for you to number, the 149 puto the total GI endosystem, which is 8 a. 9. Oh. I see. (Witneys)	dures for the combined Mission s; do you see that? "579 procedures projected, and all six rooms. And then it ses? to tell me what percentage of 149 procedures represents for ou're talking about-er? gg to make you do the 1.3 the total procedures at Mission compare the—the inmigration rocedures in Project Year Three, oscopy procedures for the entire 5.579. ness calculates.) That's 1.7. —-all of Mission GI services	1 2 3 4 4 5 6 7 8 9 100 111 122 133 144 15 16 19 20 22 22 22 2	A Q A Q A Q A Q A A Q A A A A A A A A A	give us? (Witness calculated, Okay, And yo represents how a control of the total o	lates.) 305. u would agree that305 patients many procedures? lates.) About 397. Ints 397 procedures. So you have based on the chart on Page 667, ures would be a reasonable number from those five counties to Missist right? Interpreted to about 4.6 percent werall?	e ber sion kes kes eate n to
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MS. MILES--VOLUME I MS. MILES--VOLUME I 92 90 application, you have a need analysis; do you see 1 Roughly. Yes. 1 that heading? So we're in agreement that the number of procedures 2 2 3 projected in the application for Project Year Three A. 3 And the need analysis section is where you looked to come from other counties is a reasonable number? 4 Q. 4 at volumes from other providers in the area; is I'm not sure. There is obviously a disconnect 5 5 that right? between the numbers that we just calculated in this 6 6 7 Yes. one. I can't say the difference is-what the A. 7 The-on Page 671 in particular, there's a 8 difference is. I'm sure there's something I'm not 8 discussion of the use in Henderson County? 9 -that I'm not thinking of or recognizing right 9 10 A. now. So I can just validate that yes, these 10 We talked about this some earlier, but I want to calculations that we've done are correct. But I 11 Q. 11 make sure I understand. Did you make a 12 also stand by these numbers that are here that the 12 determination that the endoscopy room proposed at applicant has provided for me, the numbers that we 13 13 Mission GI South itself would cross the county line 14 14 calculated are greater. Yes. If you think about it further during the course of 15 15 I think I reference it in here specifically. Let 16 A. the deposition, will you let me know? 16 me see how I phrased it. 17 17 I will. Certainly. And if--if you-I can point you to the application All right. When you did your analysis of the 10 18 18 as well, the pages there, if you want to look back percent immigration, you did not look at procedure 19 19 20 numbers; is that right? 20 I-I really-let me see what I can find, because I 21 When I did my analysis of inmigration? 21 A. 22 think I did mention it. 22 Q. Yes, There's a mention on 672, and there's additional 23 23 That's correct. Α. discussion under Criterion 4. And if I'm understanding you correctly, it's not so 24 24 Carolina Reporting Service (919) 661-2727 Carolina Reporting Service (919) 661-2727 MS. MILES--VOLUME I MS. MILES--VOLUME I 93 (Witness reviews document.) I said a portion of much the 10 percent that you had a problem with, 1 1 the GI endoscopy suite would be located in but that you didn't understand what made up the 10 2 2 Henderson County. That's the way it appeared in 3 3 percent? their line drawing. That's correct. I mean, you want to make sure that 4 4 Okay. And is the line drawing that you're talking the applicant is just not coming up with the number 5 O. 5 about in Exhibit 6 to the application? 6 6 out of the blue. 7 A. In the reviews that you did in Forsyth County 7 Q. Exhibit 6 is a floor plan of the building in which involving endoscopy, do you recall the inmigration 8 8 the endoscopy room would be located? 9 assumptions used there? 9 Yes. It looks to be the--a floor. 10 I don't recall. 10 A. And then it shows a larger version of the GI room Have you prepared findings regarding any of the 11 11 and then a--where it--where it appears in the--in applications you have reviewed in which you 12 12 the overall facility at the top right; is that 13 determined that an inmigration percentage was 13 correct? unreasonable other than the one we're looking at 14 14 15 Right. Α. today? 15 Does this document form the basis of your 16 I don't recall. Certainly, there have been 16 conclusion that part of the facility crossed the applications that had inmigration assumptions, but 17 17 18 county line? I don't--I don't recall specifically. I do recall 18 from my other endoscopy applications, they were Yes. 19 A. 19 Where is that county line represented? 20 additional rooms based on historical volumes, so I O. 20 That county line is the dotted line that goes don't know how much inmigration played into them, 21 21 through the building on the small chart, and it 22 but I'd have to look at them. 22 goes through a portion of the area of construction If you look at Page 669 of your findings, after the 23 23 24 on the larger chart. discussion of the methodology used in the 24 Carolina Reporting Service (919) 661-2727 Carolina Reporting Service (919) 661-2727

-96-MS. MILES--VOLUME I MS. MILES--VOLUME I 96 94 It was-I can't say I didn't believe them, but it's And that-you-okay. I just wanted to make sure we 1 A. Q. 1 2 were looking at the same thing, that you have the 2 Were you aware that Mission representatives asked 3 Q, same understanding. 3 questions about the location in pre-application It's not labeled "county line," but that's the 4 4 A. conference and were told that the site was okay? 5 5 county line as I interpreted it. That was that conversation that—that we had Okay. Where in the-the more detailed drawing did 6 A. 6 Q. earlier. There was a pre-app, and I think there 7 you understand the endoscopy room was? 7 was some location-some discussion about the county R I don't know the location of the endoscopy room 8 line, but I don't know the specifics of it because where the procedures will be done, but it would be 9 9 10 I wasn't there. somewhere, I assumed, in this square. 10 Was there any discussion that you participated in 11 And we talked earlier, you-you did not sit in on 11 Q. after you determined that location was an issue or hear anything about any communications with the 12 12 that your-your findings might be inconsistent with 13 construction section about the location of the room 13 what was told to Mission during the pre-application 14 on the property? 14 15 15 That's correct. A. I don't recall there being any discussion about If you understood that a-that the endoscopy room 16 Α. 16 comparing what's in the application what's the pre-17 itself was solely in Buncombe County, would that 17 app. We--I know there was a pre-app, and again, have resolved your concern about the location of 18 18 there was some discussion about the location, 19 the endoscopy suite? 19 probably other things. But in terms of my review Well, I think it--it would have been helpful if the 20 20 for this application, I didn't compare what was in 21 whole building was in one county. But my 21 the application to what was discussed in the preunderstanding-again, I defer to Ms. Frisone and 22 22 app. I relied on Ms. Frisone and Mr. Smith since 23 Mr. Smith-my understanding was that-that it could 23 they were there, so I didn't question their not come through this space indicated in Exhibit 6. 24 24 Carolina Reporting Service (919) 661-2727 Carolina Reporting Service (919) 661-2727 MS. MILES--VOLUME I -95-MS. MILES--VOLUME I 97 95 thoughts on this exhibit. So you're understanding from talking to them is 1 .1 Q. And they did not express any concern to you that 2 Q. that if-if the county line went through one closet 2 they made inconsistent remarks in the pre-app 3 in the corner of the space, that that would be a 3 versus the findings? problem from the CON Section's perspective? 4 4 No. Not that I'm aware of. I don't know the specifics, I just know that when 5 A. 5 I think our lunch is here, but if we could do-look 6 we looked at this chart, they said-and I can't 6 7 at Criterion 4 and then take a break, that'd be quote them or whatever, but this was not 7 great. Is that all right with everybody? 8 acceptable. 8 MS. ?: Yeah. 9 And I'd need to talk to them, I guess, for the 9 Before we do that, though, did you look at the 10 more-the more-the additional specifics? 10 findings for a GI endoscopy review in Macon County The additional specifics, that's correct. 11 11 A. as part of this review, where a physician group 12 Okay. Would you agree that you have to count--12 moved their office and their endoscopy suites to a that—that the endoscopy room can't be located in 13 13 location that was right beside Angel Community 14 two counties, it's either in one or the other, in 14 terms of reporting requirements for licensure and 15 Hospital? 15 16 No. A. planning? 16 Looking at the findings, starting on Page 673 under 17 Q. Yes. I don't--yes. 17 Α. 18 Criterion 4, you referred to this a few minutes ago And throughout the application, Mission refers to 18 in terms of the location, and I believe we've 19 the GI endoscopy room as being located in Buncombe 19 covered that issue. In the middle of Page 674, you 20 County, correct? 20 state that, "If the entire proposed suite were 21 21 Yes. Α. located in Buncombe County, there would be no So would it be fair to say you just didn't believe 22 22 change in the inventory of operating rooms"; is 23 the representations made about being-it being 23 that--is that your conclusion? 24 located in Buncombe County? 24 Carolina Reporting Service (919) 661-2727 Carolina Reporting Service (919) 661-2727

MS. HILES--VOLUME I -98-100 98 Α., 1 That's correct. 1 Å. And that Mission GI South will occupy leased space And then you-you go on to discuss Exhibit 29, the 2 Q. 2 within that building? cost estimate from the applicant; do you see that? 3 3 A. Yes. On Page 674, your findings at the bottom. 4 4 Based on the sections of the application we just 5 Oh. At the bottom. Exhibit 29. Yes. 5 A. reviewed, would you agree that Mission did not Did you-how did you arrive at this concern 6 6 7 propose to have any ownership interest in the expressed here, that there should have been more 7 medical office building? information, or the developer should have been 8 8 That's what was represented in those sections, but 9 A. identified as a co-applicant? 9 the letter in Exhibit 29 cast doubt on that for me 10 I did not understand or have enough information in 10 because I-it-it didn't explain-it didn't explain 11 that architect letter. I found it to be confusing. 11 it for me. It--it--it raised a question. I needed Let's look at that while we're talking about it in 12 12 13 more information, or explanation, I should say. Exhibit 29. Is it correct to say you agree this 13 Did you contact anybody at Mission to ask that 14 . O. represents a certified cost estimate? 14 question? 15 15 A. 16 No. But you have questions regarding what-what the A. 16 Q. Did you discuss with Ms. Frisone or-17 Q. 17 costs are? I had questions regarding how they were defining 18 A. 18 Α. And what did--what did your discussion-this ownership adjustment. It led me to believe 19 Q. 19 She was equally confused. We both needed more 20 that there would be a 60-a 60/40 ownership split, 20 information and explanation. in which case, the developer would have to be an 21 21 Did you look at the exemption notice letter that 22 applicant, because I didn't have any additional 22. was sent in to the CON Section related to the space information to clarify that point for me in the 23 23 in which the Mission GI South project would be 24 24 letter. Carolina Reporting Service (919) 661-2727 Carolina Reporting Service (919) 661-2727 MS. MILES--VOLUME I -101-HS. HILES--VOLUME I 101 Will you look back with me at Pages 3 and 5 of the located? . 1 Q. application? And they're in Section I. Do you see 2 A. I would not have received that exemption letter 2 because that exemption letter would have gone to at the bottom of Page 3, it says, "Mission Hospital 3 the person who was responsible for that HSA. So I 4 will be leasing space in a medical office building 4 have no idea of-if a letter was received, when it to be developed at the proposed location," and it 5 was received, what it said. I have not seen it. 6 returns to a term sheet in Exhibit 34? O. Did you ask Mr. Brown or any of the other staff 7 Yes. A. 8 members if a letter had been received as suggested Did you understand from that that they would be 8 Q. 9 in the application? leasing from another party? 9 10 No. Yes. That's what I understood it to say there. Α. 10 A. Why not? And likewise, on Page 5, under Question 13a, 11 Q. 13 It wasn't relative for me for this review. I was Mission represented that it would occupy leased 12 12 basing it on what we have in the application. space within a medical office building developed by 13 13 Would it not have provided additional information 14 a third party developer? 14 to verify what Mission was saying with regard to 15 15 A. the location? And then if you look again on Page 110 of the 16 16 I'm not sure. And I-I don't recall seeing a date application, Section X. It's in Section XI, excuse 17 17 in which the applicant said they were submitting 18 me, the site information construction design 18 that letter. I didn't--I didn't think much about 19 section. 19 20 20 A. I'm going to show you a copy of the letter, and And in response to Question 2b, it reflects that-21 21 we'll mark it as Deposition Exhibit 4. and 2a, for that matter-that the MOB Developer 22 22 (DEPOSITION EXHIBIT NUMBER 4 WAS 23 will file with the CON Section a request for an 23 MARKED FOR IDENTIFICATION.) exemption from review? 24 Carolina Reporting Service (919) 661-2727 Carolina Reporting Service (919) 661-2727

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013. PA	. 200	102			104
	_		1	Q.	Do you know if Ms. Frisone reviewed the exemption
1	Q.	Would you take a minute to look at this letter?	2	Q.	notice letter or response?
2		There are two pages to Exhibit 4.	3	A.	I would guess that she has not seen this letter. I
3	A	Okay. (Witness reviews document.) Okay.	4	77.	cannot say for sure.
4	Q.	What's the date on the letter to Mr. Smith from	5	Q.	But it's fair to say that Mr. Smith or Mr. Brown
5		Keith Beuley of The Keith Corporation?	6	Ų.	reviewed it and neither brought it to your
6	Α.	May 13th, 2011.	7		attention?
7	Q.	What is the date of the CON Section's response?	8	A.	Yes.
8	Α.	May 24th, 2011. I misspoke. It's Kenneth Beuley. Is it correct	9	Q.	Going back to your findings on Page 674, you
9	Q.	that the letter to Mr. Smith reflects that Western	10		concluded at the end of that discussion that, "The
10		North Carolina Health Care Innovators, LLC would	11		applicant did not adequately demonstrate the most
11		construct a medical office building on Highway 25	12		effective alternative has been proposed"; do you
12 13		on property that is located in both Buncombe and	13		see that?
		Henderson County?	14	A.	Yes.
14 15	Α.	Yes.	15	Q.	Is your conclusion about the most effective
16	Q.	And that it also reflects that the medical office	16	•	alternative based on one, the location of the
17	٧٠	building will be approximately 80,000 square feet?	17		building, and two, the question you had about
18	Α.	Yes.	18		ownership?
19	Q.	And further, reflects that Mission Hospital will	19	A.	That's one reason.
20	٧.	lease space in the building for its proposed GI	20	Q.	Are there any other reasons?
21		Endoscopy South location?	21	A.	And also regarding the demonstration of need in
22	A.	Yes.	22		Criterion 3.
23	Q.	And that application was submitted in February	23	Q.	Ms. Miles, would you also look with me at the
24	~	2011?	24		response to comments that Mission submitted during
Ca	roli	na Reporting Service (919) 661-2727	Ca	roli	na Reporting Service (919) 661-2727
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MS.	MILES-	-volume z -103-	,,,,,	,11,1,100	105
		. 103			
1	A.		1		the review? It's on Page-it begins on Page 524 of
2	Q.		2		the Agency file, and there's a specific discussion
3		consistent with the letter from the architect in	3		on Page 535.
4		Exhibit 29 in terms of the square footage; is it	4	Α.	
5		not?	5	Q.	This is in response to an issue that was raised by Park Ridge in its comments. But Mission responded
-6	A		6		to state that it would be a tenant in the building
7	Q		1		and pay rent to the medical office building owner;
8		construction of the medical office building was	8		_
9		exempt from Certificate of Need review, correct?	9	Á	do you see that? Yes.
10			10	A Q	
11	`		12	V	whether the developer needed to be an applicant or
12		today?	13		not?
13			1	. A	
14	•		15		from the architect to support it was still not
1.5		the review of the Mission GI South application,	16		clear. It is consistent with what was represented
16		correct? Yes. Yes.	17		in other parts of the application that you directed
17			18		me to, but the letter from the architect was not
18		looking at the letter relating to the medical	19		clear, so it raised a question.
19		office building exemption, correct?	20	_	2. I think this will be a good place to stop for
20			21		lunch.
22		 Correct. The application referred to the fact that this 	22		(RECESS TAKEN FROM 12:50 P.M. UNTIL 1:23 P.M.
23		letter was-would be submitted; did it not?	23		Q. (By Ms. Harris) Ms. Miles, in the findings-going
: 24		A. It did.	24		back a little bit-under Criterion 3 in your need
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	valu.	THE VEROTOTIES SETATOR (242) AND MINE	Ι. ັ		

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		106			- 108 E
1		analysis that starts on Page 669, you discuss	1		So it appeared that the applicant overstated.
2		declining GI procedure volume in Henderson County?	2	Q.	And an overstatement like that would not create an
3	A.	·Yes.	3		issue with financial feasibility, though, correct?
4	Q.	If you had determined that the Mission GI South	4	A.	Well, it would have to be recognized in some way.
5		project was entirely in Buncombe County, would you	- 5		It would not have created a huge issue, an
6		have been concerned at all about utilization in	6		insurmountable issue, I don't think. But I
7		Henderson County?	7		couldn't make heads or tails to make the numbers
8		MR. JOHNSON: Object to form.	8		add up as they are totaled on Page 99, so I made
9	A.	I'm not sure. Henderson certainly is in Mission's	9		note of it, there was something missing on that
10	,	service area, and I may still look at the location,	10		chart.
11		but I'm not sure.	11	Q.	And below the chart on Page 675, you go on to
12	Q.	Sort of a related question, you used the word	12	-	restate the concern you expressed under Criterion 4
13		"literally" on the county line several times in the	13		with regard to the developer ownership portion
14		findings?	14		versus Mission's ownership portion; is that right?
15	A.	Yes.	15	A.	Yes.
16-	Q.	Were you concerned that it—that the location was	16	Q.	Assume with me that Mission included more costs
17	٧.	very close to another county, or just that the	17	-	than it was required to include here. Is that-
18		project itself was literally on the county line?	18		would you agree that's more conservative than
19	Α.	Well, both. I was concerned that the county line	19		leaving out costs that you might incur?
20		was going through the proposed space, and so there	20	A.	Yes.
21		was a portion of the project that kind of lays in	21	Q.	And if you included extra capital costs, you would
22		both counties.	22	•	also have extra depreciation expense?
23	Q.	You can't say, though, if the project had been	23	A.	Possibly, yes, in the pro formas.
24	٧,	entirely in Buncombe, but just below the county	24	Q.	And that wouldif you took out the extra expense,
	roli:	na Reporting Service (919) 661-2727	Ca	roli	na Reporting Service (919) 661-2727
- Ca		na, Reporting Services (1227, Ser 1227	 		
MS.	MILES-	-YOLUME I -107-	MS.	HILES-	volume 1 -109-
			1		ا ممس
		107			109
1					you would have a higher net revenue in the pro
1 2	Α.	line, whether you would have had the same concerns. I'm not sure. I-I would have talked to Ms.			
	A.	line, whether you would have had the same concerns	? 1	A	you would have a higher net revenue in the pro formas as it flows through?
2	A.	line, whether you would have had the same concerns. I'm not sure. II would have talked to Ms.	? 1 2	A. Q	you would have a higher net revenue in the proformas as it flows through? All things being equal, Yes.
2		line, whether you would have had the same concerns. I'm not sure. I—I would have talked to Ms. Frisone about it and looked to her for direction on that.	? 1 2 3 4		you would have a higher net revenue in the proformas as it flows through? All things being equal, Yes.
2 3 4	A. Q.	line, whether you would have had the same concerns. I'm not sure. II would have talked to Ms. Frisone about it and looked to her for direction on that. Will you look with me withat your findings unde	? 1 2 3 4		you would have a higher net revenue in the proformas as it flows through? All things being equal. Yes. If the architect's letter had not referenced the 60
2 3 4 5		line, whether you would have had the same concerns I'm not sure. II would have talked to Ms. Frisone about it and looked to her for direction on that. Will you look with me withat your findings unde Criterion 5? I think those are on Page 675 and	? 1 2 3 4 5		you would have a higher net revenue in the proformas as it flows through? All things being equal. Yes. If the architect's letter had not referenced the 60 percent and the third party developer is developing
2 3 4 5		line, whether you would have had the same concerns I'm not sure. II would have talked to Ms. Frisone about it and looked to her for direction on that. Will you look with me withat your findings unde Criterion 5? I think those are on Page 675 and subsequent pages. Did you prepare the chart on	? 1 2 3 4 5		you would have a higher net revenue in the proformas as it flows through? All things being equal. Yes. If the architect's letter had not referenced the 60 percent and the third party developer is developing the project as represented, should Mission have excluded any of the shell costs?
2 3 4 5 6 7		line, whether you would have had the same concerns. I'm not sure. II would have talked to Ms. Frisone about it and looked to her for direction on that. Will you look with me with-at your findings unde Criterion 5? I think those are on Page 675 and subsequent pages. Did you prepare the chart on 675?	? 1 2 3 4 5 6 7	Q	you would have a higher net revenue in the proformas as it flows through? All things being equal. Yes. If the architect's letter had not referenced the 60 percent and the third party developer is developing the project as represented, should Mission have excluded any of the shell costs?
2 3 4 5 6 7 8	Q.	line, whether you would have had the same concerns I'm not sure. I.—I would have talked to Ms. Frisone about it and looked to her for direction on that. Will you look with me with—at your findings unde Criterion 5? I think those are on Page 675 and subsequent pages. Did you prepare the chart on 675? Yes.	? 1 2 3 4 5 6 7 8 9	Q	you would have a higher net revenue in the proformas as it flows through? All things being equal. Yes. If the architect's letter had not referenced the 60 percent and the third party developer is developing the project as represented, should Mission have excluded any of the shell costs? I think that if the—the architect's letter was in
2 3 4 5 6 7 8 9	Q.	line, whether you would have had the same concerns I'm not sure. I.—I would have talked to Ms. Frisone about it and looked to her for direction on that. Will you look with me with—at your findings unde Criterion 5? I think those are on Page 675 and subsequent pages. Did you prepare the chart on 675? Yes.	? 1 2 3 4 5 6 7 8 9	Q	you would have a higher net revenue in the proformas as it flows through? All things being equal. Yes. If the architect's letter had not referenced the 60 percent and the third party developer is developing the project as represented, should Mission have excluded any of the shell costs? I think that if the—the architect's letter was in line with the other representations, then I would
2 3 4 5 6 7 8 9 10	Q. A. Q.	line, whether you would have had the same concerns. I'm not sure. I.—I would have talked to Ms. Frisone about it and looked to her for direction on that. Will you look with me with—at your findings unde Criterion 5? I think those are on Page 675 and subsequent pages. Did you prepare the chart on 675? Yes. And you determined that the costs were overstated is that correct, or understated?	? 1 2 3 4 5 6 7 8 9	Q	you would have a higher net revenue in the proformas as it flows through? All things being equal. Yes. If the architect's letter had not referenced the 60 percent and the third party developer is developing the project as represented, should Mission have excluded any of the shell costs? I think that if the—the architect's letter was in line with the other representations, then I would not have had an issue, but for the difference of \$5,550 that I could not account for.
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2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	Q. A. Q. A.	line, whether you would have had the same concerns. I'm not sure. II would have talked to Ms. Frisone about it and looked to her for direction on that. Will you look with me with—at your findings under Criterion 5? I think those are on Page 675 and subsequent pages. Did you prepare the chart on 675? Yes. And you determined that the costs were overstated is that correct, or understated? I think they were—I think they were—hold on, let me see if I say here. I think they were overstated by \$5,550. So the actual cost calculated here for the project were \$5,550 less than state on Page 99 of the application? I think I said that it's—I think I said that they overstated it by \$5,550, so that would be more than the cost in the application, but let me just look and see. You're looking at Page 99 of the application? Yes. Yeah. On Page 99, the total miscellaneous	? 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24	Q Q Q Q Q Q Q Q Q Q Q Q Q Q Q Q Q Q Q	you would have a higher net revenue in the proformas as it flows through? All things being equal. Yes. If the architect's letter had not referenced the 60 percent and the third party developer is developing the project as represented, should Mission have excluded any of the shell costs? I think that if the—the architect's letter was in line with the other representations, then I would not have had an issue, but for the difference of \$5,550 that I could not account for. And that wouldn't have been—and the \$5,550 wouldn t have been enough to—for a finding of nonconformity, correct? Right. Just thinking about it in general terms, not specific to this application, but in an application where a provider projects to lease space from a third party developer in a medical office building, would you expect the provider to include any of the shell costs? No. I wouldn't expect that. I would expect that to be borne by the developer.

	LESV	OLUME 1 -110-	MS. HIL	esv	-volume i -112-
		110			112
1		purchased, you would not expect those costs to be	1		staff training or inventory set up before it
2		included in the application?	2		started operations, then it would not have had any
3	A.	That's correct.	3 .		start-up expenses, correct?
4	Q.	At the bottom of Page 675 and top of 676, there's a	4	A.	Well, that list of example operations, such as
5	٧٠	discussion to the start-up expenses or lack	5		staffing, inventory, is not an exhaustive list.
6		thereof, do you see that?	6		Certainly, ifif it wasif it was a brand new
7	A.	Yes.	7		facility for which they don't have any existing
8	Q.	Will you turn with me to Page 106 of the	8		service and they're just going to start a new
. 9	Q.	application?	9		location, you would need some staffing, training,
10		MR. JOHNSON: I'm sorry. What page?	10		inventory. They have all that at Mission, right
11		MS. HARRIS: 106.	11		now, in place. In this particular example of a new
12	0	How did Mission respond to section—the section on	12		location, although it's not listed there under 1a,
13	Q.	start-up on Page 106?	13		it's something that I would expect to see.
		There is no-zero, essentially.	14	Q.	
14	Α.	Okay. And it noted that the—they will be	15		nonconforming with Criterion 5 related to start-up
15	Q.	relocating existing services and so no initial	16		and initial operating expenses?
16		operating expenses are expected; do you see that?	17	A.	
17		•	18	Q.	
18	A.	Yes. So did you disagree that that section was not	19	٧.	whether Mission should have included any start-up
19	Q.	applicable?	20		expenses for the application here?
. 20		Well, I wondered about—I understand that it's an	21	A.	
21	A.	· ·	22	Q.	
22		existing room, but they're not just moving it to	23	χ.	other analysts what should be included in start-up
23		another part of the existing hospital. This is a	24		and initial operating expenses at any point during
24		new location, a new facility. I think they need			ina Reporting Service (919) 661-2727
Ça	roli	na Reporting Service (919) 661-2727	Car	.011	ina Reporting Service (919) 001-2727
Ms.	MILES.	-111-	MS. 1	HILES-	svolue i -113-
		111			113
. 1		some utilities, at the very least, that would-	1		your employment?
1		would need to be included, as an example.	2	A	
2	0	and the second s	3		conversations.
3	Q	CON rules or statutes?	4	Q	
4			1 -		ξ. Σ.Ε., σ.Ε. του
5	A		5	~	accounting orientation at the CON Section?
_	_		5		accounting orientation at the CON Section?
6	Q	When you think of start-up expenses, how do you	6	A	A. No.
7		When you think of start-up expenses, how do you define such expenses?	6		A. No. Q. Is the absence of start-up expenses an issue
7 8	Q A	When you think of start-up expenses, how do you define such expenses? Well, just as I mentioned, things like utilities,	6 7 8	A	A. No. Q. Is the absence of start-up expenses an issue standing alone that would have caused you to
7 8 9		 When you think of start-up expenses, how do you define such expenses? Well, just as I mentioned, things like utilities, or insurance for that space, things that you would 	6 7 8 9	A	A. No. 2. Is the absence of start-up expenses an issue standing alone that would have caused you to determine the application nonconforming with
7 8 9 10	A	 When you think of start-up expenses, how do you define such expenses? Well, just as I mentioned, things like utilities, or insurance for that space, things that you would need to start a new location. 	6 7 8 9 10	A	A. No. Q. Is the absence of start-up expenses an issue standing alone that would have caused you to determine the application nonconforming with Criterion 5, or was it something that you just
7 8 9 10 11	A	 When you think of start-up expenses, how do you define such expenses? Well, just as I mentioned, things like utilities, or insurance for that space, things that you would need to start a new location. And why do you consider those start-up as oppose 	6 7 8 9 10 d 11	A Q	A. No. Q. Is the absence of start-up expenses an issue standing alone that would have caused you to determine the application nonconforming with Criterion 5, or was it something that you just noted?
7 8 9 10 11 12	A	When you think of start-up expenses, how do you define such expenses? Well, just as I mentioned, things like utilities, or insurance for that space, things that you would need to start a new location. And why do you consider those start-up as oppose to just normal operating expenses?	6 7 8 9 10 d 11 12	A Q	A. No. Q. Is the absence of start-up expenses an issue standing alone that would have caused you to determine the application nonconforming with Criterion 5, or was it something that you just noted? A. I don't—if you had an application and the only
7 8 9 10 11 12 13	A Q	When you think of start-up expenses, how do you define such expenses? Well, just as I mentioned, things like utilities, or insurance for that space, things that you would need to start a new location. And why do you consider those start-up as oppose to just normal operating expenses? Because it's a different location.	6 7 8 9 10 11 12 13	A Q	A. No. Q. Is the absence of start-up expenses an issue standing alone that would have caused you to determine the application nonconforming with Criterion 5, or was it something that you just noted? A. I don't—if you had an application and the only thing that was missing was start-up expenses and
7 8 9 10 11 12 13	A Q A	 When you think of start-up expenses, how do you define such expenses? Well, just as I mentioned, things like utilities, or insurance for that space, things that you would need to start a new location. And why do you consider those start-up as oppose to just normal operating expenses? Because it's a different location. The question in the application regarding total 	6 7 8 9 10 d 11 12 13 14	A Q	A. No. Q. Is the absence of start-up expenses an issue standing alone that would have caused you to determine the application nonconforming with Criterion 5, or was it something that you just noted? A. I don't—if you had an application and the only thing that was missing was start-up expenses and there was nothing else where you found them
7 8 9 10 11 12 13 14	A Q A	 When you think of start-up expenses, how do you define such expenses? Well, just as I mentioned, things like utilities, or insurance for that space, things that you would need to start a new location. And why do you consider those start-up as oppose to just normal operating expenses? Because it's a different location. The question in the application regarding total estimated start-up expenses uses as examples 	6 7 8 9 10 11 12 13 14 15	A Q	A. No. 2. Is the absence of start-up expenses an issue standing alone that would have caused you to determine the application nonconforming with Criterion 5, or was it something that you just noted? A. I don't—if you had an application and the only thing that was missing was start-up expenses and there was nothing else where you found them nonconforming, it's possible you could condition
7 8 9 10 11 12 13 14 15	A Q A	When you think of start-up expenses, how do you define such expenses? Well, just as I mentioned, things like utilities, or insurance for that space, things that you would need to start a new location. And why do you consider those start-up as oppose to just normal operating expenses? Because it's a different location. The question in the application regarding total estimated start-up expenses uses as examples expanses incurred before operation, like training	6 7 8 9 10 11 12 13 14 15 16	A Q	A. No. Q. Is the absence of start-up expenses an issue standing alone that would have caused you to determine the application nonconforming with Criterion 5, or was it something that you just noted? A. I don't—if you had an application and the only thing that was missing was start-up expenses and there was nothing else where you found them nonconforming, it's possible you could condition them on that.
7 8 9 10 11 12 13 14 15 16	A C	When you think of start-up expenses, how do you define such expenses? Well, just as I mentioned, things like utilities, or insurance for that space, things that you would need to start a new location. And why do you consider those start-up as oppose to just normal operating expenses? Because it's a different location. The question in the application regarding total estimated start-up expenses uses as examples expanses incurred before operation, like training or inventory; do you see that?	6 7 8 9 10 11 12 13 14 15 16 17	A Q	A. No. Q. Is the absence of start-up expenses an issue standing alone that would have caused you to determine the application nonconforming with Criterion 5, or was it something that you just noted? A. I don't—if you had an application and the only thing that was missing was start-up expenses and there was nothing else where you found them nonconforming, it's possible you could condition them on that. Q. You could condition them to either provide the
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7 8 9 10 11 12 13 14 15 16	A C	When you think of start-up expenses, how do you define such expenses? Well, just as I mentioned, things like utilities, or insurance for that space, things that you would need to start a new location. And why do you consider those start-up as oppose to just normal operating expenses? Because it's a different location. The question in the application regarding total estimated start-up expenses uses as examples expanses incurred before operation, like training or inventory; do you see that? What letter is that? 1a.	6 7 8 9 10 11 12 13 14 15 16 17 18 19	A A	A. No. Q. Is the absence of start-up expenses an issue standing alone that would have caused you to determine the application nonconforming with Criterion 5, or was it something that you just noted? A. I don't—if you had an application and the only thing that was missing was start-up expenses and there was nothing else where you found them nonconforming, it's possible you could condition them on that. Q. You could condition them to either provide the information or further explain why it's not relevant?
7 8 9 10 11 12 13 14 15 16	A C	When you think of start-up expenses, how do you define such expenses? Well, just as I mentioned, things like utilities, or insurance for that space, things that you would need to start a new location. And why do you consider those start-up as oppose to just normal operating expenses? Because it's a different location. The question in the application regarding total estimated start-up expenses uses as examples expanses incurred before operation, like training or inventory; do you see that? What letter is that? 1a. Oh. Yes.	6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	A A	A. No. Q. Is the absence of start-up expenses an issue standing alone that would have caused you to determine the application nonconforming with Criterion 5, or was it something that you just noted? A. I don't—if you had an application and the only thing that was missing was start-up expenses and there was nothing else where you found them nonconforming, it's possible you could condition them on that. Q. You could condition them to either provide the information or further explain why it's not relevant? A. Yes.
7 8 9 10 11 12 13 14 15 16 17	A A A A A A A A A A A A A A A A A A A	When you think of start-up expenses, how do you define such expenses? Well, just as I mentioned, things like utilities, or insurance for that space, things that you would need to start a new location. And why do you consider those start-up as oppose to just normal operating expenses? Because it's a different location. The question in the application regarding total estimated start-up expenses uses as examples expanses incurred before operation, like training or inventory; do you see that? What letter is that? 1a. Oh. Yes. The—the example that you gave of utilities or	6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	A A	A. No. Q. Is the absence of start-up expenses an issue standing alone that would have caused you to determine the application nonconforming with Criterion 5, or was it something that you just noted? A. I don't—if you had an application and the only thing that was missing was start-up expenses and there was nothing else where you found them nonconforming, it's possible you could condition them on that. Q. You could condition them to either provide the information or further explain why it's not relevant? A. Yes. Q. On Page 676 under Criterion 5, you quote from
7 8 9 10 11 12 13 14 15 16 17 18	A A C C C C C C C C C C C C C C C C C C	When you think of start-up expenses, how do you define such expenses? Well, just as I mentioned, things like utilities, or insurance for that space, things that you would need to start a new location. And why do you consider those start-up as oppose to just normal operating expenses? Because it's a different location. The question in the application regarding total estimated start-up expenses uses as examples expanses incurred before operation, like training or inventory; do you see that? What letter is that? 1a. Oh. Yes.	6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	A A	A. No. Q. Is the absence of start-up expenses an issue standing alone that would have caused you to determine the application nonconforming with Criterion 5, or was it something that you just noted? A. I don't—if you had an application and the only thing that was missing was start-up expenses and there was nothing else where you found them nonconforming, it's possible you could condition them on that. Q. You could condition them to either provide the information or further explain why it's not relevant? A. Yes. Q. On Page 676 under Criterion 5, you quote from letter signed by the CFO Admission in Exhibit 2.
7 8 9 10 11 12 13 14 15 16 17 18 20	A A C C A A C C C C C C C C C C C C C C	When you think of start-up expenses, how do you define such expenses? Well, just as I mentioned, things like utilities, or insurance for that space, things that you would need to start a new location. And why do you consider those start-up as oppose to just normal operating expenses? Because it's a different location. The question in the application regarding total estimated start-up expenses uses as examples expanses incurred before operation, like training or inventory; do you see that? What letter is that? 1a. Oh. Yes. The—the example that you gave of utilities or insurance isn't—isn't included there, is it? No. It's not.	6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	A A	A. No. Q. Is the absence of start-up expenses an issue standing alone that would have caused you to determine the application nonconforming with Criterion 5, or was it something that you just noted? A. I don't—if you had an application and the only thing that was missing was start-up expenses and there was nothing else where you found them nonconforming, it's possible you could condition them on that. Q. You could condition them to either provide the information or further explain why it's not relevant? A. Yes. Q. On Page 676 under Criterion 5, you quote from letter signed by the CFO Admission in Exhibit 2 and you found below the quote that the letter
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 21	A A A A A A A A A A A A A A A A A A A	When you think of start-up expenses, how do you define such expenses? Well, just as I mentioned, things like utilities, or insurance for that space, things that you would need to start a new location. And why do you consider those start-up as oppose to just normal operating expenses? Because it's a different location. The question in the application regarding total estimated start-up expenses uses as examples expanses incurred before operation, like training or inventory; do you see that? What letter is that? la. Oh. Yes. The—the example that you gave of utilities or insurance isn't—isn't included there, is it?	6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24	A A	A. No. Q. Is the absence of start-up expenses an issue standing alone that would have caused you to determine the application nonconforming with Criterion 5, or was it something that you just noted? A. I don't—if you had an application and the only thing that was missing was start-up expenses and there was nothing else where you found them nonconforming, it's possible you could condition them on that. Q. You could condition them to either provide the information or further explain why it's not relevant? A. Yes. Q. On Page 676 under Criterion 5, you quote from letter signed by the CFO Admission in Exhibit 2.

MS. MILES--VOLUME I MS. NTLES--VOLUME I 116 114 been mislabeled? funds. Is it correct that you made this finding 1 1 It's possible that they could have been mislabeled. because you didn't understand the 60/40 information 2 A. 2-But as I mentioned, there were-I noted the use of 3 in the architect's letter? 3 calendar year versus fiscal year in other parts of 4 4 A. That's correct. the application-the pro formas and the-and 5 In terms of the application itself, the letter 5 Section III differed. I didn't know the source of 6 adequately documents the capital cost proposed in 6 the difference, I just noted that they were 7 Section VIII? 7 8 different. Typically, they are consistent. Your 8 Yes. Á. financials are based on the same time period as 9 Will you explain for me your concern on the 9 Q. your utilization projections. 10 performance, Page 21 and 25, that you list in the 10 You go on to express another concern in the last 11 middle of Page 676? 11 paragraph on Page 676? Yes. And I--I think I've described it pretty well 12 12 13 A. here. I say on this, speaking of revenues and 13 And that concern is also related to fiscal versus 14 Q. expenses for Mission Hospital, which is on Page 14 calendar years; is that right? 15 121, "the applicant projects revenues will exceed 15 Yes. I state here that the project years are shown 16 A. operating costs in the first three-years of the 16 as fiscal years on the pro formas, but the 17 project." That's fine. "The project years are 17 shown as fiscal years, October 1 to September 30, applicant's projected utilization is based on 18 1.8 19 calendar years, as they state on Page 45, and as when in fact, the applicant's projected utilization 19 were labeled on the tables. And then I also note is based on calendar years, which is January 1 to 20 20 that the projected number of cases for the first 21 December 31st. In Section III.1(b), Page 45, the 21 three years of the project is inconsistent with the applicant states Calendar Year 2010 Trend Star data 22 22 projected number of cases in the applicant's 23 is the most current and reasonable data to use as 23 24 methodology. the base to project future GI endoscopy 24 (919) 661-2727 Carolina Reporting Service Carolina Reporting Service (919) 661-2727

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utilization. It is also consistent with the ٦ project years, which are calendar year based." And 2 it's also-I noted some other sections there. 3 "Interestingly, the projected number of cases shown on Form C, which are based on fiscal years through Project Year Three, are the same number of cases shown on Page 50, which are based on calendar years. And it's unusual that the number of cases performed in any given fiscal year exactly match G, the number of cases performed in any given calendar 10 year." So in several places, I noted the 11 difference between the use of fiscal year versus 12 calendar year, and I also noted the difference in 13 the pro forma section versus some of the other 14 sections where calendar year and fiscal year were 15 interchanged. 16 And did you determine, based on the references to 17 fiscal versus calendar year, that the project-the 18 projections were not reliable; is that what you 19

20 I said that they were unreliable because they were 21 A. 22

Did you consider whether, because the numbers were 23 identical, that some of the columns just may have 24

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MS. MILES--VOLUME I

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And that-the chart on top of Page 677 is based on calculations that you made? 2

3 Yes, because the information that is included in the pro formas were cases, and I needed to convert 4 them to procedures. When I converted them to 5 procedures, I noted that they were different than 6 what was projected in the utilization projections. 7 8

Did you determine that the differences were significant or insignificant?

A. I determined they were significant from the standpoint that they were a, inconsistent, and b, that they were then projecting a greater number of procedures than they had projected in-in their utilization projections, so they were overstating the number of procedures that they would be 15 conducting in the pro formas. 16

Did you make an analysis of what--of whether the 17 project was--was feasible if you made corrections 18 for the calculations that you noted to be incorrect 19 20 or inconsistent?

I did not go-make that determination. 21

· Is that something you've done before in reviews? 22

I'm not sure. It's possible. I don't recall which 23 projects, if any, if I had a problem with their pro 24

-120-MS, MILES--VOLUME I MS. MILES--VOLUME I -118~ 120 118 assumptions in the methodology, I had to find them formas and their projected utilization associated 1 1 2 nonconforming. 2 with them. I'm not sure. With the numbers in the pro formas, the higher 3 Q. Have you ever performed a review in which you and 3 Q. numbers in the pro formas of procedures, did you 4 the-Ms. Frisone or Mr. Smith conditioned an determine that those were unreasonable numbers of applicant to omit part of the project, for example, 5 5 6 procedures to project, or just that a 15 percent a certain number of beds? 6 inmigration was unreasonable? 7 I don't--I don't recall. 7 A. I just determined that it was inconsistent with the Gkay. Have you done a review of acute care beds? 8 8 Q. 9 methodology, and that it--it also supported the--9 I may have done one. A. the inconsistency of the 10 versus 15 percent. I Do you recall if you approved an applicant for all 10 10 didn't do a calculation to determine whether or not 11 the beds requested? 11 these numbers were reasonable. I just-I just 12 I--I--yeah, I don't recall. I think I may have 12 A. determined that it was-their pro formas were based done one. I don't know what the circumstances 13 13 on higher utilization than what was in their 14 were, though. That was a while ago. 14 assumptions and methodology. Are you aware that the Agency has, in the past, 15 15 If you look at the next issue you raised in the 16 conditionally approved applicants in acute care bed 16 finance, it was related to salary expense; do you 17 reviews to construct and operate a smaller number 17 see that? 18 18 of beds than originally applied for? I'm generally aware that that happens sometimes. 19 Yes. A. 19 And on Page 678, is it correct that you concluded 20 Q. And that doing so would involve ensuring that the 20 Q. that although it appeared the salary expenses were 21 project would still be financially feasible, 21 overestimated, that does not reflect negatively on 22 22 the feasibility of the project? 23 They would have done some type of analysis, I'm 23 That's correct. sure. I can't speak specifically. 24 24 (919) 661-2727 Carolina Reporting Service (919) 661-2727 Carolina Reporting Service HS. MILES--VOLUME I -119-MS. MILES--VOLUME I 121 119 And in a general sense, overstating expenses is-But in terms of your role as a project analyst, you 1 2 does not negatively reflect on financial are permitted to review and recalculate to verify 2 3 feasibility? the information in the application, are you not? 3 Overstating your expenses is less of an issue as if In this particular case, yes, I can verify the 4 Α. 4 you had understated them. This was simply an number of cases and procedures. I can't redo an 5 5 anomaly that I saw that I didn't understand. It applicant's pro formas, though. 6 6 7 was very striking, and so on the heals of the--the Could you have used the number that you determined 7 overstated number of procedures, this is just 8 was the correct number of procedures and followed 8 another piece that I mentioned that I saw as an 9 that through the pro formas to see if you would 9 issue, but it did not negatively affect my thoughts still determine financial feasibility? 10 10 on this particular salary expense piece. 11 Well, I wouldn't be able to say how a change in À. 1.1 procedures would affect any of those other line On that same page of the findings, under Criterion 12 12 6, you had a finding of nonconformity with 13 items, so I wouldn't have been comfortable doing 13 Criterion 6; is that right? 14 that. 14 15 A. Is it correct to say, then, that you occasionally 15 Q. And your finding on Criterion 6 is based on the make some recalculations during your reviews, but 16 16 17 observations that you made under Criterion 3; is this was more than you were comfortable doing? 17 Well, I think what this came down to is when you 18 that correct? 18 Yes. They are based on things that were also 19 look at these--it's tied into the--the discussion 19 applicable to Criterion 3. 20 of the 10 percent immigration versus the 15 percent 20 In other words, the findings under Criterion 6 are inmigration, and these pro formas are based on 15 21 21 22 a restatement of findings that you had under percent inmigration, not the 10 percent 22 inmigration. And so the fact that the applicant Criterion 3? 23 23 They are the same issues. I would not characterize 24 has overstated its projections based on its

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MS. MILES--VOLUME I -122-MS. MILES--VOLUME I 124 122 Explain to me why the 60/40 split issue caused you them as a restatement, but they are the same 1 1 to say that the developer should have been a 2 2 issues. Yes. Explain what you mean by your estimate of 7.7 3 co-applicant? 3 Q. Well, I-it was the conclusion that I drew based on percent inmigration being overstated? I think we 4 A. 4 the phrase, "60/40 ownership adjustment." I didn't covered this earlier, but I want to make sure I 5 5 6 know what that-what that meant. What that meant 6 to me was that the developer was going to be owning 7 We talked about the 7.7 percent being overstated 7 60 percent. And without any further explanation, I because it's based on both inpatient and outpatient 8 8 didn't know to--I didn't know what else to deduce procedures, and Mission GI South will only conduct 9 9 from that information. 10 -only perform outpatient procedures. So it would 10 Did you talk to Mr. Smith or Ms. Frisone about be reasonable to assume that a smaller number than 11 11 whether the developer should have been an 12 7.7 would be outpatient procedures. 12 Q. This is where you suggested that their needs to be 13 applicant? 13 Yes. We talked about the 60/40 ownership 14 A. an adjustment made based on the percentage of 14 adjustment. I talked with Ms. Frisone. I don't 15 inpatient procedures and outpatient; is that right? 1.5 recall talking to Mr. Smith about it. She came to That was back when we talked about an adjustment 16 16 A. the same conclusion. 17 17 Which was that it's unclear, or that the developer Okay. And would you-is it your view that the 18 Q. Q. 18 should have been an applicant? adjustment needs to be based on Mission's 19 19 That based on how we read it, how it was written, inpatient, outpatient split, or the service area 20 A. 20 without any additional information, one would 21 inpatient, outpatient split? 21 assume that the developer would be owning 60 An applicant, I suppose, could do it either way. I 22 22 percent, and should have been a co-applicant. 23 would have to see. When we talked about it 23 And then-please clarify for me what -what you 24 earlier, we looked at a Mission adjustment. But an 24 Carolina Reporting Service (919) 661-2727 Carolina Reporting Service (919) 661-2727 -125-HE, MILES--VOLUME I MS. MILES-VOLUME I 125 123 think the developer would have been owning 60 1 applicant is free to develop a methodology however 1 percent of? 2 they see fit. 2 60 percent of-it says -it says right--60 percent If you would look with me at Criterion 12, which is 3 A. 3 Q. owner adjustment of this -of this site, shell, and 4 682 and 683. 4 5 core. The associated -excuse me--associated 5 Okav. Α. billing costs, essentially. Why did you determine Mission's application to be 6 6 Q. Even if the building just owned 60 percent of the 7 7 nonconforming with Criterion 12? site, shell, and core, it-that does not make it an Well, the Criterion states, "applications involving 8 8 construction shall demonstrate that the cost, 9 applicant for GI endoscopy services, does it? 9 I'm-I'm not sure. As I mentioned, I talked with 10 design, and means of construction proposed 10 Ms. Frisone about this section. We were both 11 represent the most reasonable alternative, and that 11 confused as to what the 60/40 ownership adjustment the construction project will not unduly increase 12 12 meant. We interpreted it as meaning that they 13 the costs of providing health services to the 13 would be owning 60 percent of it. I would have person proposing the construction project," 14 14 etcetera. The main point here reflected back on 15 asked her that follow-up question. 15 Q. So I get to ask her now? 16 that architect's cost estimate and the lack of 16 additional information or explanation that was 17 A. · Correct. 17 The last-the next to last sentence of that 18 Q. provided. 18 criterion says, "The applicant did not adequately And we agreed when we talked about this before, 19 19 20 demonstrate that the cost of construction that if the third party developer is truly 20 represents the most reasonable alternative." Did developing the whole building, then the applicant, 21 21 22 you have a concern about the total cost or just who Mission, would not have needed to include any of 22

23

24

It was more of the ownership. It was the owner.

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23

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the shell costs?

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Yes.

A.

-128-MS. MILES--VOLUME I NS. MILES--VOLIDE -126-128 126 answers to my questions, you can let Mr. Johnson You did not find that the construction costs were O. 1 mreasonable? 2 know and we can reconvene the deposition. 3 That's correct. A. WITNESS: Okay. 3 Please turn to the findings under Criterion 18a on Q. 5 687. (DEPOSITION ADJOURNED AT 2:17 P.M.) 5 Okay. б A. You found Mission's application nonconforming with 7 Criterion 18a based on your findings under Criteria 8 3, 4, 5, and 6; is that right? 9 Yes. There are similar issues as-as referenced 10 in 3, 4, 5, and 6 regarding 18a. Yes. 11 There weren't any new or separate grounds for 12 finding the application nonconforming with 13 Criterion 18a beyond what you've stated elsewhere? 14 MR. JOHNSON: Object to form. 15 If there were additional issues that weren't 16 referenced, I would have stated them here. 17 On the last page of -of your findings, it -it's--18 there's an "N/A" under the 131E-188(b), and that is 19 because there were no new endoscopy rooms or 20 am/surg facilities proposed? 21 That's correct. This was an existing room. 22 A. Before and after the project, Mission would have 23 24 six GI endoscopy rooms? Carolina Reporting Service (919) 661-2727 Carolina Reporting Service (919) 661-2727 129 -127-MS. MILES--VOLUME I 127 -129-STATE OF NORTH CAROLINA Yes. 1 A. COUNTY OF WAKE Would it be correct to say that a finding of 2 Q. conformity under Criterion 3 would have enabled you 3 CERTIFICATE to find these-this application conforming with 4 I, Matthew Barbee, Notary Public-Reporter, do 5 Criterion 6? hereby certify that Gebrette Miles was duly sworn by me MR. JOHNSON: Object to form. 6 prior to the taking of the foregoing deposition and that I don't know. If the applicant was conforming 7 said deposition was taken by me and transcribed under my direction and that the foregoing 128 pages constitute a under 3, it's possible that they could be 8 true and correct transcript of the testimony of the 9 conforming under 6. But I'd have to look-still witness look at 6 independently, by itself. 10 I do further certify that I am not counsel for or Have you thought of any additional reasons for 11 in the employment of either of the parties to this action, disapproving Mission's application that you did not 12 nor am I interested in the results of this action. include in the Agency's findings? 13 I do further certify that the stipulations 14 A. contained herein were entered into by counsel in my So everything that you based your decision on is 15 in-is in these findings? 16 In witness whereof, I have hereunto set my hand, 17 Yes. this 19th day of January, 2012. A. MS. HARRIS: I think I'm almost finished. 18 If we could take a break, I'll look through my list 19 MATTHEW BARBEE and make sure. 20 NOTARY PUBLIC FOR THE (RECESS TAKEN FROM 2:02 P.M. UNTIL 2:17 P.M. 21 STATE OF NORTH CAROLINA (By Ms. Harris) Ms. Miles, I believe I have asked 22 NOTARY PUBLIC NO. 2008358000116 you all my questions at this time. I appreciate 23 your attendance. If you think of additional 24

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SIGNATURE

I have read the foregoing 128 pages which contain a correct transcript of the answers made by me to the questions herein recorded.

Signature is subject to corrections on attached errata sheet, if any.

(SIGNATURE OF GEBRETTE MILES)

STATELOF

COUNTY OF

Subscribed and sworn to before me this

day

of ,2012

MY COMMISSION EXPIRES
NOTARY PUBLIC
Carolina Reporting Service (919) 661-2727

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Transcript of the Testimony of Martha Frisone

Date: January 26, 2012 Volume: I

Case: Mission Hospital, Inc. v. NCDHHS

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STATE OF NORTH CAROLINA IN 3	THE GENE	RAL COURT OF JUSTICE
	SUPERIOR	R COURT DIVISION
COUNTY OF BUNCOMBE	11	DHR 11636
MISSION HOSPITAL, INC;)	
).	•
Petitioner,)	DEPOSITION
$C_{ij} = C_{ij}$)	
vs.)	OF
•)	
N.C. DEPARTMENT OF HEALTH AND)	MARTHA FRISONE
HUMAN SERVICES, DIVISION OF) .	
HEALTH SERVICE REGULATION,)	
CERTIFICATE OF NEED SECTION,)	•
)	
Respondent	.)	
)	

THURSDAY, JANUARY 12, 2012 10:02 A.M.

AT THE OFFICES OF

SMITH MOORE LEATHERWOOD LLP

434 FAYETTEVILLE STREET, SUITE 2800

RALEIGH, NORTH CAROLINA

VOLUME I

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	APPEARANCES		gi siyana i ya			IION OF THE WITNESS, COUNS ATED AND AGREED AS FOLLO
ONB	EHALF OF THE MISSION H	IOSPITAL, INC:	1		1. Said deposition shall be to	
	TERRILL JOHNSON HARR	US, ESQ.			of discovery or for use as evident action or for both purposes, as pe	x in the above-entitled maitted by all
	SMITH MOORE LEATHER	WOOD LLP	1		applicable statutes and rules; 2. Any objections of any par	tu hereto es ta
•	434 FAYETTEVILLE STRE	ET, SUTTE 2800			notice of the taking of said depos	átion or as to the time
·	RALEIGH, NORTH CAROL	.INA 28301			and place thereof or as to the con before whom the same shall be to	
					 Objections to the question strike answers need not be made 	
					deposition, but may be made for	the first time during the
ONB	SEHALF OF THE CERTIFICA	ATE OF NEED SE	CHON		progress of the trial of this case on the judge for	
. •			1		thereon or at any other hearing o	Ísaid case at which
	JOEL JOHNSON, ESQ.				said deposition might be used, ex the form of a question must be m	ude at the time such
	ASSISTANT ATTORNEY C	GENERAL			question is asked or objection is of the question;	waived as to the form
	NC DEPARTMENT OF JUS	STICE			 That all formalities and re 	
	114 WEST EDENTON STR	EET			statute with respect to any forms expressly waived are bereby wai	ved, especially including
	RALEIGH, NORTH CAROL	LINA 28603			the right to move for the rejection before trial for any irregularities	
					same, either in whole or in part	
					5. That the undersigned not	
					personally deliver or mail by first transcript of this deposition to the	
ALSO	O PRESENT: DENISE GUN				deposition or his attorney, who s	
	NANCY BRES MARTIN	1			court's copy; and,	
	CHRISTY SINK				 That the witness reserves and sign the transcript of this de 	
	BRIAN MOORE				filing. Caro	lina Reporting
Carolina Report	ing Service (919) 661-2727			ļ	Service (919) 661-2727	
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MS.	FRISONE-VOLUME I.			1	PROCEEDINGS	
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	NESS BRETTE MILES	PAGE		5 6	Q. Good morning, Ms. Frisone. I'm I we've met a number of times. I'm b	cari Harris, and
GEB	BRETTE MILES		5	1	-	eart Harris, and ere on behalf of
GEB			5	6	we've met a number of times. I'm b	ceri Harris, and ere on behalf of h its application
GEB	BRETTE MILES		5	6 7	we've met a number of times. I'm b	erri Harris, and ere on behalf of h its application dission GI South.
GEB	BRETTE MILES		5	6 7 8	we've met a number of times. I'm b Mission Hospital in connection wit to relocate an endoscopy room to N	erri Harris, and ere on behalf of h its application dission GI South.
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1	A.	Since I don't recall off the top of my head what	1	-	Do either you or Mr. Smith review all the Agency
2		date the decision was-(Witness reviews document.)	2		decisions and findings that go out-one of the two
3		It was during the review, but we had already moved.	3		of you review—
4		We had been in our new location for two months	4	A.	Since August 19th of 2011 when the team leader for
5		before the date of the decision.	5		the west position became vacant, yes. Prior to
6	Q.	What was the date of the decision while you've got	6		that, there were three of us reviewing them. So,
7		that out in front of you?	7		at the time of this decision, Ms. Matthes was still
8	A.	Sorry. August 26, 2011.	8		with us. Well, no, at the time-at the date of the
9	Q.	Were you one of the CON Section staff members who			decision, she wasn't still with us, but she was
10		was responsible for making the decision on	. 10		with us for most of the review.
11		Mission's application?	11	Q.	Did she have any role in the review of Mission's
12		Yes.	12		application?
13	Q.	And what position are you currently serving with	13	Α.	As direct supervisor, she may have had some
14		the Certificate of Need Section?	14		conversations with Gebrette, but I don'tI'm not
15	A.		15		aware of any at this time.
16	Q.	· · · · · · · · · · · · · · · · · · ·	16	Q.	When did she announce that she was leaving her
17	Α.,	•	17		position as team leader, as compared to her
18	Q.	And prior to that, what was your title, if you	18		departure date of August 19th?
19		will?	19	A.	About three weeks before that.
20	A.	I was the team leader for the west team from	20	Q.	How do you go about assigning analysts to reviews?
21		January 16, 2008 until February 28, 2010.	21	A.	It's based on the analyst's workload, our workload,
22	Q.		22		meaning, Mr. Smith and myself. When the
23		job responsibilities at this time?	23		applications come in, shortly after the application
24	A.	As Assistant Chief, my job is to take care of the	24		log is ready, we go through it, and we just look at
Martha	Fr	isoneVOLUME I January 26, 2012	Martha	Fri	isoneVOLUME I January 26, 2012
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1		7	1		
1 2		7 day-to-day operations of the CON Section, to supervise the 12 project analyst positions to	1 2		it. And based on what the analysts are already
2		supervise the 12 project analyst positions, to	2		it. And based on what the analysts are already doing and theirwhether we're trying to broaden
2		supervise the 12 project analyst positions, to assist in assigning reviews to the analysts when	2		it. And based on what the analysts are already doing and theirwhether we're trying to broaden the experience of new analysts by giving them
2 3 4		supervise the 12 project analyst positions, to assist in assigning reviews to the analysts when they come in-when the applications are submitted,	2 3 4	,	it. And based on what the analysts are already doing and theirwhether we're trying to broaden the experience of new analysts by giving them things they haven'ttypes of services or types of
2 3 4 5		supervise the 12 project analyst positions, to assist in assigning reviews to the analysts when they come in—when the applications are submitted, and to review the proposed decisions and findings	2 3 4 5		it. And based on what the analysts are already doing and theirwhether we're trying to broaden the experience of new analysts by giving them things they haven'ttypes of services or types of facilities they haven't worked on before. Many
2 3 4 5 6		supervise the 12 project analyst positions, to assist in assigning reviews to the analysts when they come inwhen the applications are submitted, and to review the proposed decisions and findings for approximately half of the reviews that we do in	2 3 4 5 6		it. And based on what the analysts are already doing and theirwhether we're trying to broaden the experience of new analysts by giving them things they haven'ttypes of services or types of facilities they haven't worked on before. Many factors go into it.
2 3 4 5 6 7	0	supervise the 12 project analyst positions, to assist in assigning reviews to the analysts when they come inwhen the applications are submitted, and to review the proposed decisions and findings for approximately half of the reviews that we do in a year.	2 3 4 5 6 7		it. And based on what the analysts are already doing and theirwhether we're trying to broaden the experience of new analysts by giving them things they haven'ttypes of services or types of facilities they haven't worked on before. Many factors go into it. Is it correct that Les Brown is typically the
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2 3 4 5 6 7 8		supervise the 12 project analyst positions, to assist in assigning reviews to the analysts when they come in—when the applications are submitted, and to review the proposed decisions and findings for approximately half of the reviews that we do in a year. Do you have particular geographic areas or types of services that you typically handle?	2 3 4 5 6 7 8 9		it. And based on what the analysts are already doing and theirwhether we're trying to broaden the experience of new analysts by giving them things they haven'ttypes of services or types of facilities they haven't worked on before. Many factors go into it. Is it correct that Les Brown is typically the analyst that would cover Buncombe County? Well, the assignment of analysts to a particular.
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1	the most counties in it. It doesn't necessarily	1	hearing-it's not here-but that would have been
2 ·	generate the same volume of work, so we made the	2	the acute care—I assumemust have beenoh, I'm
3	decision to have Les cover the whole of HSA I. So,	3	sorry. It's a double agenda. There were one
4	as far as I know, the first time he's ever covered	4	public-well, in a technical sense, there was one
5 .	Buncombe County was starting in June of 2011.	5	public hearing, but in a technical sense, there
. 6	That's my recollection. It is fluid. Before	6	were two. There were two projects. They each
7	Fatimah came to work for us, and when Ron had left,	7	needed a public hearing. And Fatimah was assigned
8	Les may have covered that part of HSA I for a brief	8	to the acute care bed and Gebrette to the GI endo
9	period of time.	9	project, and they both went-if I'm recalling
10	Q. When did Fatimah Wilson come to work at the CON	10	correctly, they both went out and conducted two
11	Section?	11	public hearings. It was one date, one start time,
12	A. She told me just this week she's been with us about	12	but-so, in that sense, it's one, but in another
13	16 months.	13	sense, it was two separate public hearings, one for
14	Q. In terms of this application, if you'd like to look	14	each project.
15	at the Agency file with me.	15	Q. Did you review the Agency file that we were just
16	A. Okay.	16	looking at in preparation for your deposition
17	Q. Les Brown is actually the analyst who checked in	17	today?
18	the application, if I'm reading the initials right,	18	A. No.
19	and you can tell that from Page 5 of the Agency	19	Q. Did you review any documents to prepare for your
20	file, which we marked as Deposition Exhibit 3 in	20	deposition today?
21	the deposition the other day of Gebrette Miles.	21	A. The findings and some notes taken by my attorney
22	A. Oh, okay, yeah. I'm having a little trouble	22	from Gebrette's deposition.
23	reading it, but, yeah, that does say Les.	23	Q. Did you review an actual transcript of Ms. Miles'
24	Q. Do you have any recollection of why he would have	24	deposition?
Martha	FrisoneVOLUME I January 26, 2012	Martha	FrisoneVOLUME I January 26, 2012
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-	checked it in if he was not then assigned to review	1	A. No.
1 2	checked it in if he was not then assigned to review	1 2	A. No. O. Did you talk with Ms. Miles about her deposition
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1.	competitive review. Ms. Gunter called me as a	1		was definitely relocation of existing, I think.
2	witness in her case-well, yeah, I guess it was her	2	Q.	And that review was the proposal to create a new
3	case.	3		ambulatory surgery center with existing rooms or
4	Q. When was that, if you recall?	4		just to relocate?
5	A. Not the exact date, no. It was in 2011. It would	5	A.	The state of the s
-6	have been-I don't know if it was October or	6		definitely created a new ambulatory surgical
7	November.	7		facility. I'm pretty sure it was relocation of
8	Q. Have you testified in a contested case hearing	8		existing rooms, not new rooms.
9	regarding services proposed to be provided in	9	Q.	Do you recall if you reviewed other applications
10	Buncombe or Henderson County in the past?	10		that involved relocating existing endoscopy rooms
11	A. No.	11		but not necessarily creating a new ambulatory
12	Q. Have you reviewed other applications or supervis			surgical facility?
13	the review of other applications in Buncombe Cou	1	A.	
14	in the last two or three years?	14		was-might have been existing rooms, I'm pretty
15	A. Well, reviewed would have been more than two o	l l		sure Baptist was talking about existing rooms, not
16	three years ago; supervised, yes, in the last two	1.6		new rooms, which created a new facility.
17	or three years.	17	_	Otherwise, I think they were all new rooms.
18	Q. Were you ever assigned as an analyst to HSA I?	18	Q.	
19	A. No.	19	A.	· · · ·
20	Q. What types of applications have you reviewed for	20	Q.	
21	services in Buncombe County? A. I believe I did their long-term acute care hospital	22	Α.	
22 23	within a hospital, and that would have been	23	Q. A.	
2.4	Mission. I did an MRI review. I did two of them.	24	Q.	
	Mission. I did an initial teriew. I did two of diene	23	Υ,	1 ve got a copy of these midnigs. In hand them
1				
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7.	The first one involved Asheville Open MRL. That	t 1 go. 2	a Fr	1.7 to you and mark them as Exhibit 5.
1 2	The first one involved Asheville Open MRI. That was a very long time a	t 1 go. 2	a Fr	to you and mark them as Exhibit 5. (DEPOSITION EXHIBIT NO. 5 WAS MARKED FOR IDENTIFICATION.)
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Martha	Fri	soneVOLUME I January 26, 2012	Martha	Fri	soneVOLUME I January 26, 2012
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1	Q.	Let's look at this Exhibit 5 we've just marked.	1	Q.	So, if I'm understanding you correctly, even if a
2		The findings are dated February 5th, 2010; is that	2		project cost had come in slightly under \$2 million,
3		right?	3		it still would have required a certificate of need,
4.	Α.	Correct.	4		because—
5	Q.	And Les Brown was the project analyst?	5	A.	Correct.
6	A.	Correct	6	Q.	-it involved relocating an endoscopy room?
7	Q.	You were the team leader?	7	A.	There are at least two definitions of a new
8	A.	Correct.	8		institutional health service that applies to the
9	Q.	•	9		Macon County project.
10		Endoscopy Center, LLC and Western Carolina Medical	10	Q.	Were there comments in opposition filed regarding
11		Developers, LLC?	11		the endoscopy center's application in Macon County?
12	Α.		12	Α.	
13	Q.		13	Q.	
14		service being reviewed for this application in	14		the application?
1.5		Macon County? In other words, what triggered the	15	A.	· * *
16		need to file the CON application?	16	Q.	•
17	A.	Do you happen to have a copy of the law handy, the	17		Criterion 3a, it reflects that the new facility
18		SMFP?	18		would be more centrally located near Angel Medical
19	Q	. I have the SMFP.	19		Center and other physician office practices; do you
20	A	. That will work. I believe there are two	20		see that sentence?
21		definitions of new institutional health services	21		Yes.
22		that apply here.	22	Q.	Did Angel Medical Center file comments in
23	Q	. I'll hand you a copy of the 2011 SMFP and the CON	23		opposition?
24		Act is an exhibit.	24	· A.	. I think so, yes.
		<u> </u>	<u> </u>		
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		19		a Fr	21
1		19 First, on Page 6, it indicates that the total	1	a Fr	21 Did any other physician practices file comments in
1 2		19 . First, on Page 6, it indicates that the total capital cost for the relocation was \$2.2 million.	1 2	a Fr Q	21 Did any other physician practices file comments in opposition?
1 2 3		19 . First, on Page 6, it indicates that the total capital cost for the relocation was \$2.2 million. So the definition of new institutional health	1 2 3	a Fr Q	21 Did any other physician practices file comments in
1 2 3 4		First, on Page 6, it indicates that the total capital cost for the relocation was \$2.2 million. So the definition of new institutional health service, this is 176.16(b), except as otherwise	1 2 3 4	Q.	Did any other physician practices file comments in opposition? I don't recall. I would have to go on the website and check to see what the website shows.
1 2 3 4 5		First, on Page 6, it indicates that the total capital cost for the relocation was \$2.2 million. So the definition of new institutional health service, this is 176.16(b), except as otherwise provided in G.S. 131.E-184(3), the obligation by	1 2 3 4 5	Q.	Did any other physician practices file comments in opposition? I don't recall. I would have to go on the website and check to see what the website shows. If you'll look back with me a page or two to
1 2 3 4 5		First, on Page 6, it indicates that the total capital cost for the relocation was \$2.2 million. So the definition of new institutional health service, this is 176.16(b), except as otherwise provided in G.S. 131.E-184(3), the obligation by any person of a capital expenditure exceeding \$2	1 2 3 4 5	Q.	Did any other physician practices file comments in opposition? I don't recall. I would have to go on the website and check to see what the website shows. If you'll look back with me a page or two to Criterion 3, there's a chart replicated, I think,
1 2 3 4 5 6		First, on Page 6, it indicates that the total capital cost for the relocation was \$2.2 million. So the definition of new institutional health service, this is 176.16(b), except as otherwise provided in G.S. 131.E-184(3), the obligation by any person of a capital expenditure exceeding \$2 million to develop or expand a health service or a	1 2 3 4 5 6	Q.	Did any other physician practices file comments in opposition? I don't recall. I would have to go on the website and check to see what the website shows. If you'll look back with me a page or two to Criterion 3, there's a chart replicated, I think, from the application, showing the projected patient
1 2 3 4 5 6 7 8		First, on Page 6, it indicates that the total capital cost for the relocation was \$2.2 million. So the definition of new institutional health service, this is 176.16(b), except as otherwise provided in G.S. 131.E-184(3), the obligation by any person of a capital expenditure exceeding \$2 million to develop or expand a health service or a health service facility or which relates to the	1 2 3 4 5 6 7	Q. A. Q.	Did any other physician practices file comments in opposition? I don't recall. I would have to go on the website and check to see what the website shows. If you'll look back with me a page or two to Criterion 3, there's a chart replicated, I think, from the application, showing the projected patient origin; do you see that?
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1 2 3 4 5 6 7 8 9		First, on Page 6, it indicates that the total capital cost for the relocation was \$2.2 million. So the definition of new institutional health service, this is 176.16(b), except as otherwise provided in G.S. 131.E-184(3), the obligation by any person of a capital expenditure exceeding \$2 million to develop or expand a health service or a health service facility or which relates to the provision of a health service. Then, in subpart (u), also of 176.16, it says the construction,	1 2 3 4 5 6 7 8 9	Q. A. Q.	Did any other physician practices file comments in opposition? I don't recall. I would have to go on the website and check to see what the website shows. If you'll look back with me a page or two to Criterion 3, there's a chart replicated, I think, from the application, showing the projected patient origin; do you see that? Yes. In that patient origin chart, it has a number of
1 2 3 4 5 6 7 8 9 10		First, on Page 6, it indicates that the total capital cost for the relocation was \$2.2 million. So the definition of new institutional health service, this is 176.16(b), except as otherwise provided in G.S. 131.E-184(3), the obligation by any person of a capital expenditure exceeding \$2 million to develop or expand a health service or a health service facility or which relates to the provision of a health service. Then, in subpart (u), also of 176.16, it says the construction, development, establishment, increasing the number,	1 2 3 4 5 6 7 8 9	Q A	Did any other physician practices file comments in opposition? I don't recall. I would have to go on the website and check to see what the website shows. If you'll look back with me a page or two to Criterion 3, there's a chart replicated, I think, from the application, showing the projected patient origin; do you see that? Yes. In that patient origin chart, it has a number of counties listed and then an all other category of
1 2 3 4 5 6 7 8 9 10 11		First, on Page 6, it indicates that the total capital cost for the relocation was \$2.2 million. So the definition of new institutional health service, this is 176.16(b), except as otherwise provided in G.S. 131.E-184(3), the obligation by any person of a capital expenditure exceeding \$2 million to develop or expand a health service or a health service facility or which relates to the provision of a health service. Then, in subpart (u), also of 176.16, it says the construction, development, establishment, increasing the number, or relocation of an operating room or	1 2 3 4 5 6 7 8 9 10 11 12	Q. A. Q. Q. Q.	Did any other physician practices file comments in opposition? I don't recall. I would have to go on the website and check to see what the website shows. If you'll look back with me a page or two to Criterion 3, there's a chart replicated, I think, from the application, showing the projected patient origin; do you see that? Yes. In that patient origin chart, it has a number of counties listed and then an all other category of three percent of patients.
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1 2 3 4 5 6 7 8 9 10 11 12 13 14 15		First, on Page 6, it indicates that the total capital cost for the relocation was \$2.2 million. So the definition of new institutional health service, this is 176.16(b), except as otherwise provided in G.S. 131.E-184(3), the obligation by any person of a capital expenditure exceeding \$2 million to develop or expand a health service or a health service facility or which relates to the provision of a health service. Then, in subpart (u), also of 176.16, it says the construction, development, establishment, increasing the number, or relocation of an operating room or gastrointestinal endoscopy room in a licensed health service facility, other than the relocation of an operating room or gastrointestinal endoscopy	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15	Q. A. Q. A. Q. A. A. Q. A. A. A. Q. A. A. Q. A. A. Q. A. A. Q. A. A. Q. A. A. Q. A. A. A. Q. A. A. A. Q. A. A. A. Q. A. A. A. A. A. A. A. A. A. A. A. A. A.	Did any other physician practices file comments in opposition? I don't recall. I would have to go on the website and check to see what the website shows. If you'll look back with me a page or two to Criterion 3, there's a chart replicated, I think, from the application, showing the projected patient origin; do you see that? Yes. In that patient origin chart, it has a number of counties listed and then an all other category of three percent of patients. Yes.
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1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19		First, on Page 6, it indicates that the total capital cost for the relocation was \$2.2 million. So the definition of new institutional health service, this is 176.16(b), except as otherwise provided in G.S. 131.E-184(3), the obligation by any person of a capital expenditure exceeding \$2 million to develop or expand a health service or a health service facility or which relates to the provision of a health service. Then, in subpart (u), also of 176.16, it says the construction, development, establishment, increasing the number, or relocation of an operating room or gastrointestinal endoscopy room in a licensed health service facility, other than the relocation of an operating room or gastrointestinal endoscopy room within the same building or on the same grounds, where the grounds are not separated by more than a public right-of-way adjacent to the grounds where the OR or the GI endo room is	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19	Q. A. Q. A. Q. A. Q.	Did any other physician practices file comments in opposition? I don't recall. I would have to go on the website and check to see what the website shows. If you'll look back with me a page or two to Criterion 3, there's a chart replicated, I think, from the application, showing the projected patient origin; do you see that? Yes. In that patient origin chart, it has a number of counties listed and then an all other category of three percent of patients. Yes. Did you require the applicant in that review to further define the all other category either by zip code or some other— I believe on the other page, on Page 3, under current patient origin, all other is defined to include Haywood, Buncombe and Henderson Counties,
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20		First, on Page 6, it indicates that the total capital cost for the relocation was \$2.2 million. So the definition of new institutional health service, this is 176.16(b), except as otherwise provided in G.S. 131.E-184(3), the obligation by any person of a capital expenditure exceeding \$2 million to develop or expand a health service or a health service facility or which relates to the provision of a health service. Then, in subpart (u), also of 176.16, it says the construction, development, establishment, increasing the number, or relocation of an operating room or gastrointestinal endoscopy room in a licensed health service facility, other than the relocation of an operating room or gastrointestinal endoscopy room within the same building or on the same grounds, where the grounds are not separated by more than a public right-of-way adjacent to the grounds where the OR or the GI endo room is currently located. It is the Agency's position	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	Q. A. Q. A. Q. A. Q.	Did any other physician practices file comments in opposition? I don't recall. I would have to go on the website and check to see what the website shows. If you'll look back with me a page or two to Criterion 3, there's a chart replicated, I think, from the application, showing the projected patient origin; do you see that? Yes. In that patient origin chart, it has a number of counties listed and then an all other category of three percent of patients. Yes. Did you require the applicant in that review to further define the all other category either by zip code or some other— I believe on the other page, on Page 3, under current patient origin, all other is defined to include Haywood, Buncombe and Henderson Counties, Georgia and other states. So they did provide us
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21		First, on Page 6, it indicates that the total capital cost for the relocation was \$2.2 million. So the definition of new institutional health service, this is 176.16(b), except as otherwise provided in G.S. 131.E-184(3), the obligation by any person of a capital expenditure exceeding \$2 million to develop or expand a health service or a health service facility or which relates to the provision of a health service. Then, in subpart (u), also of 176.16, it says the construction, development, establishment, increasing the number, or relocation of an operating room or gastrointestinal endoscopy room in a licensed health service facility, other than the relocation of an operating room or gastrointestinal endoscopy room within the same building or on the same grounds, where the grounds are not separated by more than a public right-of-way adjacent to the grounds where the OR or the GI endo room is currently located. It is the Agency's position that the relocation of an entire facility requires	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	Q. A. Q. A. Q. A. Q.	Did any other physician practices file comments in opposition? I don't recall. I would have to go on the website and check to see what the website shows. If you'll look back with me a page or two to Criterion 3, there's a chart replicated, I think, from the application, showing the projected patient origin; do you see that? Yes. In that patient origin chart, it has a number of counties listed and then an all other category of three percent of patients. Yes. Did you require the applicant in that review to further define the all other category either by zip code or some other— I believe on the other page, on Page 3, under current patient origin, all other is defined to include Haywood, Buncombe and Henderson Counties, Georgia and other states. So they did provide us sufficient information to tell us what that
1 2 3 4 5 6 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22		First, on Page 6, it indicates that the total capital cost for the relocation was \$2.2 million. So the definition of new institutional health service, this is 176.16(b), except as otherwise provided in G.S. 131.E-184(3), the obligation by any person of a capital expenditure exceeding \$2 million to develop or expand a health service or a health service facility or which relates to the provision of a health service. Then, in subpart (u), also of 176.16, it says the construction, development, establishment, increasing the number, or relocation of an operating room or gastrointestinal endoscopy room in a licensed health service facility, other than the relocation of an operating room or gastrointestinal endoscopy room within the same building or on the same grounds, where the grounds are not separated by more than a public right-of-way adjacent to the grounds where the OR or the GI endo room is currently located. It is the Agency's position that the relocation of an entire facility requires a CON regardless of cost. But this project was	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	Q A Q A A	Did any other physician practices file comments in opposition? I don't recall. I would have to go on the website and check to see what the website shows. If you'll look back with me a page or two to Criterion 3, there's a chart replicated, I think, from the application, showing the projected patient origin; do you see that? Yes. In that patient origin chart, it has a number of counties listed and then an all other category of three percent of patients. Yes. Did you require the applicant in that review to further define the all other category either by zip code or some other— I believe on the other page, on Page 3, under current patient origin, all other is defined to include Haywood, Buncombe and Henderson Counties, Georgia and other states. So they did provide us sufficient information to tell us what that consists of.
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21		First, on Page 6, it indicates that the total capital cost for the relocation was \$2.2 million. So the definition of new institutional health service, this is 176.16(b), except as otherwise provided in G.S. 131.E-184(3), the obligation by any person of a capital expenditure exceeding \$2 million to develop or expand a health service or a health service facility or which relates to the provision of a health service. Then, in subpart (u), also of 176.16, it says the construction, development, establishment, increasing the number, or relocation of an operating room or gastrointestinal endoscopy room in a licensed health service facility, other than the relocation of an operating room or gastrointestinal endoscopy room within the same building or on the same grounds, where the grounds are not separated by more than a public right-of-way adjacent to the grounds where the OR or the GI endo room is currently located. It is the Agency's position that the relocation of an entire facility requires	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	Q A Q A A	Did any other physician practices file comments in opposition? I don't recall. I would have to go on the website and check to see what the website shows. If you'll look back with me a page or two to Criterion 3, there's a chart replicated, I think, from the application, showing the projected patient origin; do you see that? Yes. In that patient origin chart, it has a number of counties listed and then an all other category of three percent of patients. Yes. Did you require the applicant in that review to further define the all other category either by zip code or some other— I believe on the other page, on Page 3, under current patient origin, all other is defined to include Haywood, Buncombe and Henderson Counties, Georgia and other states. So they did provide us sufficient information to tell us what that

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1	A.	They didn't do a patient origin by zip code, as I	1	A.	-that was about coven miles away. And it's a
2		recall. No one's required to do a zip code level	2		different-totally different review to decide to
3		patient origin.	3		split your endoscopy service into two locations by
4	Q.	That was my next question. There's not a rule	4		moving one of your six rooms from Asheville to the
5		requiring that sort of an analysis when you're	5		Buncombe/Henderson County line. It requires a
6		demonstrating your proposed patient origin?	6		different analysis to determine whether it's
7	A.	There's not a rule that requires the applicant to	7		conforming or not.
8		provide patient origin by zip code. If the patient	8	Q.	Neither Mission nor this Western Carolina Endoscopy
9		provides it by zip code, then that's what we will	9		Center proposed to add any endo rooms; is that
10		analyze.	10		right?
11	Q.	In Criterion 3, I did not see a discussion of	11	A.	That's correct.
12		whether the project would impact negatively the	12	Q.	Will you look with me, Ms. Frisone, on the same
13		hospital, the Angel Medical Center, as part of the	13		findings, the Western Carolina Endoscopy Center
14		analysis of whether there was a need for the	14		findings, under Criterion 5?
15		proposed service. Did I miss that discussion? You	15	A.	Okay.
16		may want to take a moment to look.	16	Q.	The first section of Criterion 5 deals, I think,
17	A	. This proposal involves picking up the existing	17		with an inconsistency in the capital costs; is that
18		facility in Franklin and moving it to another	18		right?
19		location in Franklin. Their current volumes in	19	·A.	. They included the purchase price of the land, but
20		Calendar Year 2008 was 1,545. This is a totally	20		they weren't supposed to, because they-flut had
21		different type of proposal, where whether we	21		been purchased in March of 2007.
22		approve it or not, it's still going to be in	22	Q.	. So they-they include more than they needed to?
23		Franklin. Their reasons, if I recall correctly,	23	A	. In this particular case, yes.
24		for moving was the physical plant they were in was	24	Q	. That wasn't a reason to disapprove, but you just
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marth	a Fi	23 inadequate. It is not the same thing as a proposal	1	a Fr	25 lowered the total capital expenditure; is that
1 2	a Fi	23 inadequate. It is not the same thing as a proposal to relocate a GI endo room from Asheville to the	1 2	•	lowered the total capital expenditure; is that right?
1	a Fi	inadequate. It is not the same thing as a proposal to relocate a GI endo room from Asheville to the county line. It requires a different analysis. So	1 2 3		lowered the total capital expenditure; is that right? That's correct.
1 2	a Fi	inadequate. It is not the same thing as a proposal to relocate a GI endo room from Asheville to the county line. It requires a different analysis. So whether or not there's aI don't recall an	1 2 3 4	•	lowered the total capital expenditure; is that right? That's correct. And there's a reference to a failure to include the
1 2 3	a Fi	inadequate. It is not the same thing as a proposal to relocate a GI endo room from Asheville to the county line. It requires a different analysis. So whether or not there's aI don't recall an analysis of the impact on Angel. I'm sure that we	1 2 3 4 5		lowered the total capital expenditure; is that right? That's correct. And there's a reference to a failure to include the other builder's fee; do you recall what that
1 2 3 4 5	a Fi	inadequate. It is not the same thing as a proposal to relocate a GI endo room from Asheville to the county line. It requires a different analysis. So whether or not there's aI don't recall an analysis of the impact on Angel. I'm sure that we considered that. It just isn't reflected in the	1 2 3 4 5 6	. Q	lowered the total capital expenditure; is that right? That's correct. And there's a reference to a failure to include the other builder's fee; do you recall what that referred to?
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1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21		inadequate. It is not the same thing as a proposal to relocate a GI endo room from Asheville to the county line. It requires a different analysis. So whether or not there's aI don't recall an analysis of the impact on Angel. I'm sure that we considered that. It just isn't reflected in the findings, but our consideration was an existing facility. If we don't approve it, they will continue to operate in Franklin where they're operating. All they want to do is get into a better building, because the building they're in is inadequate. So it's a differentdifferent issues. 2. You're saying it's different issues than the Mission application? A. That's correct, because the proposal is different The facts are different. It requires a different analysis. Q. There are some similarities though; do you agree that they're both moving rooms? A. In a very limited sense, they're moving a room, yes, but it is very different to pick up the entire	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	A A A	lowered the total capital expenditure; is that right? That's correct. And there's a reference to a failure to include the other builder's fee; do you recall what that referred to? No, where are you? In that same paragraph, I'm sorry, under Criterion 5. Well, they added up their miscellaneous costs incorrectly. If they didn't fail to include it—they obviously provided us with that information, because we know it's \$177,775. But they didn't add up correctly. Did you end up leaving in the cost of the land in the total approved capital expenditure? A. I don't recall. I'd—I'd have to study it and probably look at the application too. All right. I didn't bring that with me today, but for purposes of today, I guess I want to make sure I understand that essentially you are saying that

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		26	•			28
1	A.	Correct, if I'm reading this correctly. And the	1	Q.	Ckay. And in those cases, th	e applicant just needs
2		2,092,865, which is what we conditioned them to,	2		to include the cost of upfitting	its particular
3		does not appear to include the cost of the land.	3		service and project?	
4		The very last part of that paragraph has the four	4	A.	The applicant bears the burd	en to demonstrate that
5		dollar amounts that were added up to arrive at that	5 .		they have included all of the c	osts that are
6		number, and the cost of the land is not included in	6		necessary that fit the definition	n of the
7		that.	7		institutional health service.	
8	Q.		8	Q:	Is there any guidance in the	ules regarding how
9		office building included?	9	-	you know what parts of a med	lical office building
10	A.	I don't recall at this point in time why. They may	10		you would include or not incl	ude in an application
11		have proposed it that way for all I know. I'd have	11		for service going into a medic	al office building?
12		to look at the application.	12	A.	The guidance that I get come	s from what I refer to
13	Ó.	Is there a difference between when and whether you	13		as the Mission Asheville Hen	atology cases.
14	`	include the cost of the medical office building or	14	Q.	And that's a Court of Appea	ls decision?
15		not, depending on the ownership of the entity?	15	A.	Well, actually, the best guid	ance comes from the
16	A.		16		final Agency decision that wa	s upheld. There's
17		of the building is exempt, then they're free to	17		more detail in there as to the	ost. So, at this
18		give us prior written notice of that and try to	18		point in time, when I have qu	estions about what
19		convince us that part of the medical office	19		should or shouldn't be includ	ed, that's what I
20		building should be exempt. Without reading the	20		usually turn to is the final Ag	ency decision and
21		application, for all I know, without looking at the	21		the Court of Appeals decision	l.
22		diagram of the building that Western Carolina Endo	22	Q.	And before that decision, th	ere weren't any
23		Center was proposing, they may have feit that the	23		particular rules that assisted i	n your
24		whole building should be included in the project	24		determination?	
<u> </u>			Martha	. E+	isoneVOLUME İ	January 26, 2012
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		27				
1		cost. If they don't ask for an exemption, I'm not	1	A.		,
2		going to exempt out some portion of it.	2		you say "rules," I'm assuming	•
3	Q		3		the Administrative Code. I'm	
. 4	A	. Well, I mean, there may have been situations where	4		ever being in the Administrat	
5		someone proposed something, and some part of it	5		subject. There have been, in	•
6		really should have been exempt. I don't know that	6		rulings. At one time, there w	=
7		we've everparticularly in an expedited review	7		it was a Rex Wellness Center	· -
8		situation, we may very well have talked to them and	8		everybody tended to turn to.	
9		said, you know, really, that part should be exempt.	9		may have had some other thi	=
10		Why don't you seek an exemption for it? I don't	10		the Mission case, but, right n	
11		know. We could have. I can't recall any that I've	11		rulings we have would be the	- -
12		done, but I may have.	12		and the Court of Appeals dec	
13		In this particular case, with only the	13		that Mission Asheville Hema	
14		findings to go by, I can't tell you what they said	14	Ç		
15	•	in the application, but, apparently, they included	15		Endoscopy Center, Ms. Frisc	·
16		the whole cost of the whole building, and we, after	16		under Criterion 5a, just belo	w the paragraph we
17		looking at it, decided that was appropriate in that	17		were discussing.	
18		case.	18	A		
19	(Q. And there-there are cases, though, where it's-an	19	Ç	•	. I'm sorry.
20		applicant or an entity applies for an exemption for	20	A	a. Okay.	
21		a medical office building, correct?	21	(). I misspoke. Theit refers t	
22	1	A. There have been projects where the building	22		Section IX.1, Page 44, the a	
23		included much more space than the space necessary	23		there will be no startup for i	nitial operating
1 ^ -		C A A A	1 24		avnennen	•

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expenses.

for the service under review, yes.

January 26, 2012 Martha Frisone--VOLUME I Martha Frisone--VOLUME I January 26, 2012 30 1 Well, we have to take the whole application into A. I see that. 1 2 account. We have to take our conclusions with O. Did you find that reasonable, there would be no 2 regard to all of the statutory and regulatory 3 startup for operating-initial operating expenses 3 4 review criteria into account. We do not, as a for a relocation project? 4 5 practice, condition past performance. So if MR. JOHNSON: Objection. 5 someone has problems with quality of care track 6 Without looking at the application, I cannot tell 6 7 record we believe necessitates finding that you what-I mean, if that's the findings in this particular case, Western Carolina Endo Center say applicant nonconforming with Criterion 20. We're 8 8 not going to impose a condition, because I can't-what they say, and what's in the application, I do 9 9 it isn't even realistic or feasible for me to say, 10 not recall, so I, you know, don't know what the 10 okay, you're going to provide quality care in the 11 basis was for a conclusion-well, that's not a 11 past. Well, I can expect them to provide it in the conclusion. That's just a statement. But, 12 12 future, but I can't make them change what they did clearly, based on these findings, we did not find 13 13 in the past. The past is over and done with. We 14 14 that to be a problem in this particular case. don't usually impose--as a sort of general Q. How do you, in terms of reviewing applications or 15 15 statement, when it comes to demonstrating need, 16 supervising reviews, define startup and initial 16 we're not going to put a condition on someone 17 17 operating expenses? asking them to correct the deficiencies, because we 18 A. I don't have a definition. There's nothing in the 18 don't know if they can. Now, we may condition law. Our application form gives examples of the 19 19 someone to develop less than what they've 20 sorts of things that might be expected--costs that 20 demonstrated a need for a portion of their project. 21 might be expected to be incurred. 21 For example, a slightly--if they've demonstrated 22 Q. The examples in the application form are the only 22 23 the need for two ORs, but not three, we might guidance you're aware of for applicants to 23 condition them to develop just the two ORs. It's a determine if they have startup or initial operating 24 24 Martha Frisone--VOLUME I January 26, 2012 Martha Frisone--VOLUME I January 26, 2012 33 31 1 case-by-case decision as to whether or not these expenses? 2 conditions can be imposed, and, as I say, you have A. That's the only thing I can think of right now off 2 to take into account an error that might require 3 3 the top of my head. There's no rule. you to say, well, you need to demonstrate the Q. The last question related to these findings in 4 4 5 availability of more funds than you did. That's a Macon County relates to the condition under 5 6 frequent condition. Is it going to be appropriate Criterion 5. 6 if you also have problems with Criterion 3 and 6 7 7 A. Okay. Which one? 8 and can't condition those? So we're not going to Q. The first condition. You conditioned the applicant 8 impose a condition in Criterion 5 to correct a 9 9 to a capital expenditure amount that was recalculated to make the correct amount; is that 10 deficiency when we have deficiencies in other 10 11 criteria that can't be corrected. right? 11 Q. As another example besides the ORs, you approved 12 12 A. Correct. projects for fewer acute care beds than applied for And the Agency is able to impose such conditions on 13 13 at times; is that right? 14 14 A. Yes, we have-we have two appeals under way right 15 A. If the application is approvable, then we have that 15 now where we downsized a particular facility, both option, and we do consider that, when we're 16 16 17 with respect to their ORs and their acute care 17 reviewing applications, when there are deficiencies, as to whether or not a condition 18 18 would be appropriate and would correct the 19 Q. And when you-when you downsize a project or--or 19 20 approve something slightly less than what's applied 20 deficiency. 21 for, do you do an analysis of the financials with How do you analyze--just--I'm not asking about a 21 22 the downsized project? specific situation, but how do you analyze whether 22 23 A. That will depend on circumstances. The two that I

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just alluded involve a hospital. It's an ongoing

a deficiency is one that can be remedied through a

condition or that cannot be?

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1	facility, ongoing operation, been in operation for	1	specifics of the deficiency, and the impact a
2	many years. The proposals don't involve adding	2	condition might have on the potential financial
3	additional servicesor servicesor not providing	3	feasibility of the project.
4	or expanding existing services. They're a	4 (Q. Well, would it be fair to say if you had-if you
5	renovation project, so not approving as many-the	5	had been convinced, under Criterion 3 and 6, that
. 6	OR project, which is the one I'm familiar with,	6	Mission needed to relocate that cadoscopy room,
7	involves new space to replace ORs, and we've told	7	then you may have been more likely to consider
8	the applicant they can do that. They demonstrated	8	conditioning them on financials?
9	the need for the new space but not for the number	9	MR JOHNSON: Object to form.
10	of ORs that they have now. So we downsized the	10	A. I haven't really given it a whole lot of thought,
11	number of ORs to, in our opinion, right size them	11	but, certainly, theoretically, if they had been
12	to the number of ORs they need for the projected	12	found conforming with Criterion 3 and Criterion 6
13	volumes that they projected. So that really	13	and 4 and 12, then the problems in 5 might be
14	shouldn't have any impact on their-so that's where	14	something we'd certainly consider. But I think the
15	I'm going with this is that you have to look at	15	problem in Criterion 5 is of a greater magnitude
16	what the project is, what the impact of the	16	than that, and, quite possibly, my gut feel is that
17	downsizing would be. In the case of reducing the	17	we would not have conditioned it. But we'd
18	number of OR's, what we're saying is, with fewer	18	certainly consider it before we made a decision as
19	OR's, you still have plenty of ORs to do the number	19	to whether or not we had to find them
20	of procedures you're projecting you're going to do.	20	nonconforming, even if that were the only area .
21	So why would that impact the financials? It	21	where there were concerns.
22	wouldn't. Other cases, it might impact the	22	Q. And I'm definitely going to ask you about what the
23	financials, and that might be what causes us to not	23	otherthe issues that you just alluded to under
24	be able to downsize because of the uncertainty of	24	Criterion 5, but first I wanted to ask if you had
	35	1	37 looked at, in connection with this review or other
1	the impact on financials, because they really would need to redo the financials. So that—that can be	2	reviews, some findings regarding a relocation of
3	one of the factors in deciding, no, we can't—we	. 3	endoscopy rooms in Wilkes County in 2008?
4	can't condition them.	4	A. Did I look at it?
5	Q. You might be—it might be more of an issue and less	5	O. Yes.
6		6	A. I don't seem to recall it.
7		7	Q. The—I'm just going to hand it to you and ask you
	A. Well, I think the Mission GI-Mission GI Sout		if you had any involvement or if you've ever
	8	9	reviewed it. We'll mark the findings as Exhibit 6.
9	whatever we decided to call it, would be a good	10	(DEPOSITION EXHIBIT NO. 6 WAS
10	example. It only involved a relocation of one	11	MARKED FOR IDENTIFICATION.)
11	room. If you decide that the one room is not	12	A. Let's just say it doesn't look familiar.
12	· · · · · · · · · · · · · · · · · · ·	13	O. The findings are dated June 24, 2008; is that
13	to downsize. If they had asked to move three	14	right?
14	· · · · · · · · · · · · · · · · · · ·	15	A. Correct.
15		16	Q. And they involve Wilkes Regional Medical Center
16		17	project to relocate two existing gastrointestinal
17	•	18	endoscopy rooms to an existing outpatient facility
18	might have been possible in this case but for a	19	licensed as part of the hospital?
	time of many amplitudes an execution to all the contract of		
19		l l	
19 20	expect to be financially feasible on its own,	20	A. Yes.
19 20 21	expect to be financially feasible on its own, particularly if you were dealing with separate	20 21	A. Yes.Q. You were not the analyst or the Assistant Chief
19 20 21 22	expect to be financially feasible on its own, particularly if you were dealing with separate ownership, then that might be a different story.	20 21 22	A. Yes.Q. You were not the analyst or the Assistant Chief reviewing that application, were you?
19 20 21	expect to be financially feasible on its own, particularly if you were dealing with separate ownership, then that might be a different story.	20 21	A. Yes. Q. You were not the analyst or the Assistant Chief

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		38			40
1		started co-signing decisions. This wasn't one of	1		clue as to where the Westpark Outpatient Care
2		them.	2		Center is located in relationship to Wilkes
3	Q.	Have you ever reviewed these findings before?	3		Regional Medical Center. So that-without that
. 4	A.	*	4		knowledge, I can't tell you how similar or
· 5		ringing a bell. There might have been a subsequent	5		dissimilar the Wilkes project is from the Mission
6		application involving this facility, a sort of	6	_	GI South project.
7		change of scope for this, that perhaps I was	. 7	Q.	When you're supervising a review of a CON
8		involved in, but right here and now, this one's not	8		application, do you typically suggest that the
9	_	ringing a whole lot of bells with me.	.9		analyst look at other sets of findings?
10	Q.		10	A.	Yes.
11		take as much time as you want-consider this Wilkes	11	Q.	And do you direct them to particular sets, or is there a way to search for similar services or
12		Regional Medical Center project more similar to the	12		· · · · · · · · · · · · · · · · · · ·
13		project proposed by Mission than the Angel/Macon	13	_	similar types of projects? Well, a couple of years ago, we startedgot a
14		County case that we looked at a few minutes ago?	14 15	A.	folder on a share drive that the analyst can look
15	1	MR. JOHNSON: Object to form.	16		at findings by service types. So, they're not all
16	Α.	. (Witness reviews document.) Well, Angel just had	17		there, but it is certainly possible for an analyst
17		comments in opposition to it, but not the applicants, so the Macon County one-I don't-	18		to go to the S-drive to the folder for GI endoscopy
18 19		apparently, the outpatient care center already	19		proposals, and they are further sorted by new
l		existed. I'm not sure how far away this outpatient	20		facilities and relocations, but this is not an
20		care center is from the hospital, and it may say	21		exhaustive-sometimes we forget to put them there.
22		somewhere in thenor have I found yet how many GI	ł		It does not go back particularly far. It's not
23		endo rooms they have in the hospital. And it may	23		something we've done since the '90s, but the idea
24		very well be a little more similar to the Mission	24		was to try to collect them in a place where the
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Marth:	a Fi		Martha 1	ı Fri	\$41\$ analyst could go get them. They can also go get
	a Fi	. 39		a Fri	analyst could go get them. They can also go get them from each other, which is how we used to do
1	a Fr	one than, say, the Macon one, but I don't think	1	ı Fri	analyst could go get them. They can also go get them from each other, which is how we used to do it. But that was the idea was to have a share
1 2	a Fi	one than, say, the Macon one, but I don't think that it's entirely similar to the Mission one in	1 2 3	ı Fri	analyst could go get them. They can also go get them from each other, which is how we used to do it. But that was the idea was to have a share drive where everybody—they can't put them there.
1 2 3	a Fi	one than, say, the Macon one, but I don't think that it's entirely similar to the Mission one in that—particularly if the Westpark Outpatient Care	1 2 3 4 5	a Fri	analyst could go get them. They can also go get them from each other, which is how we used to do it. But that was the idea was to have a share drive where everybody—they can't put them there. That's part of the problem of getting them all on
1 2 3 4	a Fi	one than, say, the Macon one, but I don't think that it's entirely similar to the Mission one in that—particularly if the Westpark Outpatient Care Center is, like, across the street from the	1 2 3 4 5 6	a Fri	analyst could go get them. They can also go get them from each other, which is how we used to do it. But that was the idea was to have a share drive where everybody—they can't put them there. That's part of the problem of getting them all on there. They have to—they can look at them, but
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	26 2012	<u> </u>	Pas c	oneVOLUME I January 26, 2012
Martha	FrisoneVOLUME I January 26, 2012	Martha	Fris	
	42	•		44
1	deposition.	1		Well, I guess, on a certain level, you could say
2	A. Apparently, they're all findings that were attached	2		hey're similar in that Wake Forest Ambulatory
3	to the written comments.	3		Ventures, LLC didn't demonstrate the need to
4	Q. Yes, that was my next question.	4		relocate the three ORs to Clemmons, but I think the
5	A. So, in that case, we would have looked at those, or	5	-	particular problems were of a different nature. I
-6	she would have looked at those. Some of which have	6		don't recall there being a problem with Wake Forest
7	nothing to do with GI endo. I don't see any	7		Ambulatory Ventures with the identification of the
8	findings in her actual working papers.	8	-	population to be served. I think there were other
9	Q. Okay. Well, while you've got the Agency file	9		issues with—well, for one thing, they were relying
10	notebook open, there are—there are some findings	10		on referrals from an orthopaedic physician group which had withdrawn its support. And when you too
11	that she said that were attached to the comments by	11 12		which had withdrawn his support. What when you too those procedures or those cases out of their
12	Parkridge and Carolina Mountain.	13		projected utilization, they couldn't meet their
13	A. Yes.	14	-	required targets. So it's different issues,
14	Q. Did you review any of the comments and their	15		because, in this particular case, the Wake Forest
.15	attachments or—	16		Ambulatory Ventures, there was a set of rules that
16	A. I reviewed the comments, and I may have skimmed	17		applied. And once you took the cases out, the
17	through the attachments. I didn't necessarily read	18		group that was not going to do cases there, after
18	every page of every attachment. O. Starting on Page 223, which is an attachment to the	19		all, they didn't meet their target. So very
19 20	Q. Starting on Page 223, which is an attachment to the Parkridge comments, there's a set of findings	20		different issues.
21	regarding Wake Forest Ambulatory Ventures, LLC.	21		You're talking about the target that requires a
22	A. Correct.	22	_	certain amount of procedures per year by the end of
23	Q. Are those the—is that the review that you	23		the third year?
24	mentioned earlier you'd been involved with in	· 24	A.	Well, there were other problems besides that, but
23	Dictioned out its Jon a coord in total at			
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	46		· 48
-	they are proposing that it would be licensed as	1	the western part of the state, and we were looking
1 2	part of the hospital.	2	at, well, where would it be reasonable for patients
3	O. Before I forget, the hospital that you mentioned	3	to come to this proposed facility. So we consulted
4	where you downsized the number of ORs, which one is	4	with him on that issue.
5	that?	5	Q. So is it fair to say this-this review proceeded in
6	A. High Point Regional.	5	the normal way, from your perspective?
7	Q. Okay. And that application or that appeal is still	7	A. Yes, and that was a rather long answer, but to
8	pending?	8	flesh it out further, then, at some point, the
9	A. Yes, it is.	9	analyst will give me a first draft of the findings,
10	Q. You sort of alluded to this already, but when you	1.0	and we will continue, as I look at what they've put
11	when you're supervising the review of the	11	in the draft findings, to talk to each other and
12	application, at what point do you get involved and	12	look at things in the application and the comments
. 13	what steps do you take, if you have a particular	13	and response to comments as we work out, you know,
14	routine for each review?	14	should this be conforming, should it not be
15	A. Once it's assigned to the analyst, then the-when	15	conforming. And so it's a work in progress
16	the analyst starts working on it, they're	16	basically.
17	encouraged to, and they do frequently, bring issues	17	Q. When was the last time you reviewed an application
18	to my attention. I seem to recall Gebrette, at	18	cover to cover as an analyst?
19	some point, don't know exactly where in the	19	A. I know the findings don't reflect this, but the
20	process, but relatively early, bringing to my-to	20	replacement long-term care hospital in Mecklenburg
21	my attention the discrepancy between the 10 percent	21	County. Carol had started it, and she did do the
22	inmigration and the 15 percent inmigration, and we	. 22	bulk of the work on the findings. But she was—she
23	looked at the exhibit. I think it's Exhibit 16,	23	was loaned out to the Planning Section, and so I
24	Table 5, and we looked at the application and	24	finished that review. But we did decide that she
Martha	FrisoneVOLUME I January 26, 2012	Marth	a FrisoneVOLUME I January 26, 2012
	47		49
1			
2	talked about it and talked about the impact. At	1	had done enough of it that I would co-sign as the
	talked about it and talked about the impact. At	1 2	had done enough of it that I would co-sign as the Assistant Chief and not have Mr. Smith co-sign it.
3	that point, I think she was still fairly early in		
3.	that point, I think she was still fairly early in the process, and so we hadn't really made any	2	Assistant Chief and not have Mr. Smith co-sign it.
4	that point, I think she was still fairly early in the process, and so we hadn't really made any decisions at that point, even tentative, as to	2 3 4	Assistant Chief and not have Mr. Smith co-sign it. Prior to that, it would have been the Indian Trail
1	that point, I think she was still fairly early in the process, and so we hadn't really made any decisions at that point, even tentative, as to whether they were nonconforming with anything. In	2 3 4	Assistant Chief and not have Mr. Smith co-sign it. Prior to that, it would have been the Indian Trail Home Hemodialysis facility submitted by DaVita,
4 5 6	that point, I think she was still fairly early in the process, and so we hadn't really made any decisions at that point, even tentative, as to whether they were nonconforming with anything. It was just she brought it to my attention. We looked	2 3 4 5	Assistant Chief and not have Mr. Smith co-sign it. Prior to that, it would have been the Indian Trail Home Hemodialysis facility submitted by DaVita, which I denied, and that would have been-well,
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Martha	FrisoneVOLUME I January 26, 2012	Martha	FrisoneVOLUME I January 26, 2012
	50		52
1	for this particular location and this facility.	1	that are going to go to Mission GI South coming
2	And it was that issue that we went to talk to Mr.	2	from.
3	Smith about, because we were looking at its	3	Q. The application proposed to serve patients from the
4	geographic location. We don't know precisely what	4	same areas where Mission currently gets GI
5	counties were intended to be included, so we were	5	patients, correct?
6	looking at, well, if you look at Mission's patient	6	A. The Mission GI South has a different service area
7	origin, which we had in the license renewal app,	7	defined. That discussion starts on Page 642.
8	and the counties where they get their patients from	8	Q. Let me ask it this way. The application didn't
. 9	now, which of those counties would it be reasonable	9	propose to take patients who were typically seeing
10	for this facility to get patients from.	10	other providers in the area for endoscopy services,
11	Q. And it was the third issue, the reasonableness for	11	correct?
12	the location, that you talked to Craig Smith about?	12	A. No, I don't know that that's an entirely correct
13	A. I wouldn't phrase it quite that way. Yes, that's	13	statement either.
14	the third issue that I'm thinking of with respect	14	Q. If you need to refer to the application, it's there
15	to inmigration, and it's the one we talked to Craig	.15	in front of you as well.
16	about. But it's about we don't know where they're	16	A. No, actually, it was something I saw this morning
17	coming from, because they haven't told us enough	17	I'm looking for, which is in the findings. I
18	about it. But of the counties currently served by	18	didn't look at the application, so it has to be in
19	Mission for this-for this service, which of those	19	the findings. (Witness reviews document.) I'm not
20	counties is it likely that people would come to the	20	finding it right now, but the the statement
21	Mission GI South facility, as opposed to the	21	regarding the patient origin from Mission GI South, we have—I guess maybe the first place it's
21			We have—I guess maybe the mist place its
22	Asheville location.	22	·
l_	Q. Let's just go ahead and look at the findings with	23	discussed is-and there's a quote from the
22			•
22 23 24	Q. Let's just go ahead and look at the findings with	23 24	discussed is-and there's a quote from the
22 23 24	Q. Let's just go ahead and look at the findings with regard to Criterion 3, since we started talking	23 24	discussed is—and there's a quote from the application, and this is on Page 642 of the Agency
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Mar	tha		Martha	
		54		56
	1	That's not defined anywhere else. There's a	1	I found it in the findings this morning, there was
	2	problem of 10 percent and 15 percent. We don't	2	a statement to the effect that patients currently
	3	know which it is, because Exhibit 16, Table 5 is	3	utilizing some of the other providers might shift
	4	one of the places where it's 15 percent, and the	4	to Mission GI South. Yes, it's quoted on Page 665
	5	pro formas is another. But there's no further	5	in the Agency findings. It's a quote from the
	6	breakdown or discussion or anything. We don't know	6	discussion of Step 10 in their methodology. For
	7	which counties. We don't even know which other zip	7	purposes of this application, Mission assumes that
	8	codes in Buncombe and Henderson County are included	. 8	the projected procedures performed at Mission GI
	9	in that either 10 percent or 15 percent.	9	South would be performed at Mission if the project
:	10	Q. I think it might help to look at Page 58, if you	10	discussion of Step 10 in their methodology. For purposes of this application, Mission assumes that the projected procedures performed at Mission Gl South would be performed at Mission if the project were not developed. However, it is possible that cases from other providers in Buncombe County may
:	11	would open the application, Ms. Frisone. I did not	11	cases from other providers in Buncombe County may
	12	say this at the beginning, because I know you know	12	shift to the proposed facility as the physicians
1	13	that the rule is, if you need a break, you'll let	13	associated with Asheville Gastroenterology
1	14	me know, but just feel free to let me know if you	14	Associates, AGA, who own and operate the endoscopy
	15	need one at any time.	15	center are very supportive of the proposed project
	16	A. Sure.	16	as evidenced in the letters of support included in
	17	Q. All right.	17	Exhibit 10. Furthermore, in 2010, over L,000
	18	A. Okay.	18	patients from Henderson County received outpatient
	1.9	Q. Page 58 in the application is referred to in the	19	GI endoscopy procedures at the endoscopy center.
	20	findings you just reviewed with me. Would you look	20	Mission GI South will provide a more accessible
	21	at the bottom of the page? It says that Mission	21	alternative for these patients of AGA. In
	22	assumed that projected utilization at Mission GI	22	addition, as the economy improves and GI endoscopy
	23	South will shift from Mission Hospital in	23	procedures begin to increase, some percent of cases
	24	Asheville; do you see that?	24	at Mission GI South will result from the growth in
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	artha	a FrisoneVOLUME I January 26, 2012	Martha	FrisoneVOLUME I January 26, 2012,
	artha		Martha	FrisoneVOLUME I January 26, 2012,
	٠	55		57
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5 A. Not from where I was coming from, no. 5 their patients would come from the	t 70 percent of
	five-mile
. O C. Dabel on what you to hat and inording it may of 1 o bridge and 50 per the world both	
7 reasonable to expect patients to drive past 7 And they said that included other a	
8 downtown Mission to get to GI South if that's the 8 Gaston County. And, again, we say	
9 only choice their physician gives them, correct? 9 reasonable to assume that patients	
10 MR. JOHNSON: Object to form. 10 western part of Gaston County wo	d drive past
11 A. But the burden's on the applicant to identify the 11 Gaston Memorial Hospital for an	ergency
12 population to be served. So it might be in a given 12 department, and that decision was	pheld last mont
13 case that a given patient would drive, but it's up 13 by the Court of Appeals.	
to the applicant to justify that and document that 14 Q. Well, the emergency services are	a different
15 that's reasonable, 15 category than endoscopy services,	ould you agree
16 Q. How would you have expected Mission to document 16 in terms of where you might drive	
17 that? 17 A. Yes, but the services to be offere	at FMC-
18 A. Well, what I expected Mission to do is to 18 Kernersville, which decision prec	
19 adequately identify the population to be served, 19 ED, included all the services at FI	ed that Gaston
and if it's not including counties—this is not the 20 which also included outpatient an	
	C-Kernersville,
21 first time where someone has done that. This is so 21 of things. So, yes, emergency ser	C-Kernersville, scheduled type ces are
much like what was done in FMC-Kernersville, where 22 different, but the issue is the same	C-Kernersville, scheduled type ces are And, you
	C-Kernersville, scheduled type ces are And, you

Martha	12130110	Martha	FrisoneVOLUME I January 26, 2012
	62		64
1	for failure to adequately identify the population	1	difference in the total procedures, depending on
ż	to be served, I think, is very consistent with our	2	which inmigration factor was used. So that's the
3	prior decisions on very similar situations.	3	only comparison I know of in the findings. She
4	Q. Going back to the 10 percent and the 15 percent,	4	doesn't actually talk about the difference
5	what do you understand the 10 percent inmigration	5	betweenlet's just pick a yearProject Year 3,
6	to be from; in other words, 10 percent of what	6	149 patients at 10 percent, as opposed to 236 in
7	number?	7	2015, but that's the only difference between them.
.8	A. Well, it's actually 10 percent of the total. So to	8	So when she talks about the difference in totals in
9 .	get it, you-they came up with the projected	9	the text following the table on Page 669, that
10	utilization from the nine zip codes, and thenI	10	difference is the difference between a 15 percent
11	would actually have to do this math to be sure this	11	inmigration and a 10 percent inmigration, because
12	is right, but I believe what you do is you divide	12	it's the only difference. The numbers in the first
13	by .9 or by .85, and that gives you the total. And	13	row, which is the projected utilization from the
14	then the difference is either the 10 or the 15	14	nine zip codes, those numbers remain the same in
15	percent.	15	the two tables.
16	Q. And the total is the number of procedures projected	16	Q. Looking at the table on 668 and the number of 149
17	for the Mission GI South?	17	that you just mentioned for Year 3-
18	A. I believe it's the procedures, not the cases.	18	A. Uh-huh, yes.
19	Q. Did you analyze the number, as opposed to the	19	Qthat's 149 procedures; is that right?
20	percent of procedures that would be projected to	20	A. Correct.
21	come from outside the zip code areas specified in	21	Q. And the actual number of patients would be less?
22	Buncombe and Henderson County?	22	A. It would be that divided by-divided by 1.33, I
23	A. Well, I think Gebrette does do a comparison of-	23	think is the factor.
24	that's somewhere, I thought-	24	Q. That was the number of-the ratio of cases to
\(\frac{1}{2} = \frac{1}{2} \\ \frac{1}{2} frac{1}{2} \\ \frac{1}{2} = \frac{1}{2} \\ \frac{1}{2} = \fr	a FrisoneVOLUME I January 26, 2012	Martha	a Frisone—VOLUME 1 January 26, 2012
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1	63	_	65
1	Q. I'm not sure if it's what you're looking for, but	1	procedures, right?
1 2	Q. I'm not sure if it's what you're looking for, but there's a table on 654 and then tables on 667 and	2	procedures, right? A. Right
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2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	 Q. I'm not sure if it's what you're looking for, but there's a table on 654 and then tables on 667 and 668 that might help. A. Okay. The 643, she does discuss the issue a little bit, but that doesn't actually have—I was thinking they were somewhere in the text that she talked about the issue. Okay. What she was doing was the total utilization, not the actual 10 percent number or the 15 percent number. Q. Is that the table on Page 667 of the findings? A. No, that's not the table I'm thinking of. I'm looking at the tables on—this discussion starts with the table that's on Page 668, which is projected utilization assuming 10 percent inmigration, and that number is broken out in the table. But her discussion after the table, she notes the number of procedures projected to be performed in each year, states that's assuming 10 percent inmigration, but says that's overstated and then introduces the topic of whether it's 10 or 15 percent. So the next table on Page 669 has the—it's the same table, but now it shows inmigration 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	procedures, right? A. Right. Q. So are you saying that Mission should have told you where some number around a hundred patients should have come from specifically in order to find the 10 percent? A. Yes, in this particular case they should have. I mean, they also should have been consistent as to whether it was 10 percent or 15 percent. That's why I said, if you isolate each one of these little things by itself, whether that's enough to find them nonconforming, that you've got a combination of is it 10 or 15 percent.—I think initially we were thinking the only place it said 15 percent was in the exhibit, but then we found the pro formas are based on the 15 percent. So when we determined that, that's when we decided that the issue was serious enough, severe enough that it needed to be found nonconforming with Criterion 3. MS. HARRIS: Let's leave the application and the Agency file open where they are and take a

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1	Q. (By Ms. Harris) Ms. Frisone, before we took a	1.	believe, is what we were looking at for Mission's
2	break, we were looking at the Agency findings and	2	GI endoscopy services, which should look very
3	talking about the inmigration issues that you	3	similar to the list on Page 642. But I believe
4	outlined for me. And I'd like for you to look now	4	what we were actually looking a was their license
5	at the table that Ms. Miles prepared on Page 667 of	5	renewal app. That's my recollection.
6	the Agency file.	6	Q. And that is the footnote below the table on Page
7 .	A. Okay.	7	667?
8	Q. Did you talk with her about this particular table?	8	A. Well, that—yeah, that's the source cited for that
9	A. I'm sure I did.	9	table. There's no source—the source cited for the
10	Q. Do you recall any of the discussions surrounding	10	table on 642 in the application itself, Pages 70
11	this table?	11	and 71. (Witness reviews document.) Which then
12	A. Well, what I do recall is that the inclusion of	12	says that the source is Exhibit 16, Table 12.
13	Transylvania, Jackson, Macon, Polk, and Rutherford	13	(Witness reviews document.) Which says the source
14	Counties, I believe those are the ones that, in	14	is the 2011 license renewal app. But my
15	consulting with Mr. Smithand it says in the text	15	recollection is we were actually looking at the
16	following it that these are the ones we thought, of	16 17	license renewal app, not Table 12 or Page 70 and 71, and certainly not—at that point, I don't think
17	the counties reported in Mission's license renewal	18	· · · · · · · · · · · · · · · · · · ·
18	app as counties from which Mission gets GI	19	I even had draft findings. So we weren't looking at the table on Page 642 in the Agency file. But
19	endoscopy patients, that these were the counties	20	that data in the table on Page 642 of the Agency
20	that it might be possible to expect patients using	21	file, if you follow the citations in the
21 22	the Mission facility in Asheville to use the Mission GI South facility. So whether we really	22	application, comes from the license renewal app.
23	talked about the table, per se, I doubt it, but	23	And I think that's what we actually had in our
24	certainly the contents of the table is one of the	24	hand, because I think that's in the staff notes.
24	certainty the contents of the mole is one of the	 -	
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1	things-that is the very issue we were discussing	1	Q. It-is. And I think-I think what you're saying is
2	with Mr. Smith is which of those counties that were	2	that you looked at the license renewal application
3	in Mission's service area at the Asheville campus	. 3	and made a list of the counties you thought it
' 4	would be reasonable to include in the Mission GI	4	would be reasonable to expect patients to travel
5	South service area.	5	from to Mission GI South for endoscopy rather than
6	Q. And these five, you decided, would be reasonable to	6	
7		1	looking at Mission's application and-and crossing
	include?	7	counties off the list?
8	A. That patients from those counties might travel to	7 8	counties off the list? A. Well, we—we didn't make a list. I guess that's
9	A. That patients from those counties might travel to the GI South facility instead of the Asheville	7 8 9	counties off the list? A. Well, we-we didn't make a list. I guess that's part of my problem is that we would have looked
9 10	 A. That patients from those counties might travel to the GI South facility instead of the Asheville facility, yes. 	7 8 9 10	counties off the list? A. Well, we—we didn't make a list. I guess that's part of my problem is that we would have looked at—what we would have looked at is Page 632 of the
9 10 11	 A. That patients from those counties might travel to the GI South facility instead of the Asheville facility, yes. Q. And the counties like Macon or Polk—not Macon, 	7 8 9 10 11	counties off the list? A. Well, we—we didn't make a list. I guess that's part of my problem is that we would have looked at—what we would have looked at is Page 632 of th Agency file, which is a copy of Page 37 from the—I
9 10 11 12	 A. That patients from those counties might travel to the GI South facility instead of the Asheville facility, yes. Q. And the counties like Macon or Polk—not Macon, excuse me. I think it was—there were three 	7 8 9 10 11 12	counties off the list? A. Well, we—we didn't make a list. I guess that's part of my problem is that we would have looked at—what we would have looked at is Page 632 of th Agency file, which is a copy of Page 37 from the—I assume it's Mission—
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9 10 11 12 13 14 15	 A. That patients from those counties might travel to the GI South facility instead of the Asheville facility, yes. Q. And the counties like Macon or Polk—not Macon, excuse me. I think it was—there were three counties that you excluded; is that right? A. I don't recall. Q. I think you can look back at 642. 	7 8 9 10 11 12 13 14 15	counties off the list? A. Well, we—we didn't make a list. I guess that's part of my problem is that we would have looked at—what we would have looked at is Page 632 of th Agency file, which is a copy of Page 37 from the—I assume it's Mission— Q. It is. The first page starts on 594. A. Okay. Usually the name of the hospital appears of it, but it doesn't in this case.
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9 10 11 12 13 14 15 16 17 18 19 20 21	 A. That patients from those counties might travel to the GI South facility instead of the Asheville facility, yes. Q. And the counties like Macon or Polk—not Macon, excuse me. I think it was—there were three counties that you excluded; is that right? A. I don't recall. Q. I think you can look back at 642. A. Okay. (Witness reviews document.) I don't know exactly which ones or how many are not included, but obviously the list is longer on Page 642 than the list on Page 667. Q. Is it correct that you and Mr. Smith and Ms. Miles developed the list on page 667 from the list on 	7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	counties off the list? A. Well, we—we didn't make a list. I guess that's part of my problem is that we would have looked at—what we would have looked at is Page 632 of th Agency file, which is a copy of Page 37 from the—I assume it's Mission— Q. It is. The first page starts on 594. A. Okay. Usually the name of the hospital appears on it, but it doesn't in this case. Q. I think it just got cut off on the copy. A. So my recollection is we were actually looking at—I've already lost the page— Q. I think you just said Page 632. A. —632. Q. And that—Page 632 is the patient origin for
9 10 11 12 13 14 15 16 17 18 19 20 21 22	 A. That patients from those counties might travel to the GI South facility instead of the Asheville facility, yes. Q. And the counties like Macon or Polk—not Macon, excuse me. I think it was—there were three counties that you excluded; is that right? A. I don't recall. Q. I think you can look back at 642. A. Okay. (Witness reviews document.) I don't know exactly which ones or how many are not included, but obviously the list is longer on Page 642 than the list on Page 667. Q. Is it correct that you and Mr. Smith and Ms. Miles developed the list on page 667 from the list on Page 642? 	7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	counties off the list? A. Well, we—we didn't make a list. I guess that's part of my problem is that we would have looked at—what we would have looked at is Page 632 of th Agency file, which is a copy of Page 37 from the—I assume it's Mission— Q. It is. The first page starts on 594. A. Okay. Usually the name of the hospital appears of it, but it doesn't in this case. Q. I think it just got cut off on the copy. A. So my recollection is we were actually looking at—I've already lost the page— Q. I think you just said Page 632. A. —632. Q. And that—Page 632 is the patient origin for Mission Hospital GI cases for the 2011 renewal
9 10 11 12 13 14 15 16 17 18 19 20 21	 A. That patients from those counties might travel to the GI South facility instead of the Asheville facility, yes. Q. And the counties like Macon or Polk—not Macon, excuse me. I think it was—there were three counties that you excluded; is that right? A. I don't recall. Q. I think you can look back at 642. A. Okay. (Witness reviews document.) I don't know exactly which ones or how many are not included, but obviously the list is longer on Page 642 than the list on Page 667. Q. Is it correct that you and Mr. Smith and Ms. Miles developed the list on page 667 from the list on 	7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	counties off the list? A. Well, we—we didn't make a list. I guess that's part of my problem is that we would have looked at—what we would have looked at is Page 632 of th Agency file, which is a copy of Page 37 from the—I assume it's Mission— Q. It is. The first page starts on 594. A. Okay. Usually the name of the hospital appears on it, but it doesn't in this case. Q. I think it just got cut off on the copy. A. So my recollection is we were actually looking at—I've already lost the page— Q. I think you just said Page 632. A. —632. Q. And that—Page 632 is the patient origin for

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1	source for the table that's in the exhibit and then	1	currently provided in Asheville, the immigration
2	in the application that we created and made part of	2	was said to be 5.5 percent, I believe, and that's
3	our findings.	3	reflected in the chart on Page 642. So somewhere
4	Q. So, from what you said, I imagine that you and Mr.	4	in the application the applicant had chosen to be
5	Smith and Ms. Miles looked at this Page 632 and	5 6	more explicit and to list the percentages for other counties besides Buncombe and Henderson. Then, in
6	said, here are the counties where we would believe	. 7	the quote that's reflected on Page 666, all
7	patients would go to Mission GI South from?	8	Mission's counting as being somehow the service
8	A. Well, what we did is we went through each county	9	area is Mission—is Henderson and Buncombe
9	that they're serving patients from and said,	10	Counties. And they're saying, well, the other 34
10	looking at a map—and that's based on Mr. Smith's	11	percent is inmigration. And so there'sthe way we
11	knowledge of the counties and travel-not just a	12	read the application was they were saying, well, if
12	map, but the roads—that, okay, this county it	13	Mission in Asheville, if their inmigration is 34
13	would be reasonable to expect patients to go to	14	percent, then 10 percent for Mission GI South is
14	Mission GI South. This county not so reasonable.	15	reasonable. And that's—that's sort of precisely
1.5	So that's ultimately the source of the list on	16 .	the logic that Charlotte Mecklenburg Hospital
16	Page-	17	Authority tried to use in the Gaston ED
17	Q. 667-of the findings?	18	application, and we didn't find that acceptable.
18	Ayes.	19	Because what they did is they specifically limited
1.9	Q. Did you look at maps or any documentation related	20	their primary and secondary service area down to a
20	to traffic patterns in western North Carolina?	21	very tight geographic region and said all the rest
21	A. I believe that Gebrette and I had a map. I'm not	22	of it was inmigration when, in fact, if you looked
22	sure whether Craig needed a map, but I think	23	at historical utilization, they were routinely
23	Gebrette and I looked on a map.	24	serving patients from outside that tight little
24	Q. Is that map in the Agency file?		
Marth	a FrisoneVOLUME I January 26, 2012	Martha	FrisoneVOLUME I January 26, 2012
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1	A. No, huh-uh.	1	geographic area. So, here, to say immigration is
2	Q. What map did you look at?	2	34 percent and that it's more conservative if you
3	A. It could have been a North Carolina Department of	3	say it's only 10 percent, that's not-that's what
4	Transportation map, or it could have been the map	4	made no sense here. Because, earlier, they said
5	in the SMFP.	5	immigration's 5.5 percent. So clearly they
6	Q. Did you personally look at a map that had I-26 and	6	believed, at some point in time, that some of these
7	I-40 and those routes specified?	7	counties they routinely see patients fromit may
8	A. I don't recall.	8	not represent 10 percent of their total, but they
. 9	Q. You agree that the roads and traffic patterns are	9	routinely see patients from those counties. So we
10	an important determining factor of where patients	10	are-the term "inmigration" is something the
11	might reasonably be expected to go?	11	applicants use. It's not really something the
12	A. Certainly. Mr. Smith was cognizant of that and	12	Agency uses. To us, the service area is everywhere
13	mentioned it all the time.	13	you serve patients from. And so, in this
14	Q. Looking back at the chart on Page 667 of the	14	particular case, what we're saying is, the
15	findings.	15	assumption of 10 percentand it could be 15
16	A. Okay.	16	percent, so that problem still exists. You can't
17	Q. Why did Ms. Miles prepare this chart?	17	ignore itisn't reasonable under these
		18	circumstances and here's why.
18	· · · · · · · · · · · · · · · · · · ·	19	Q. If you look at Page 642 that you just referred to
18 19	utilizing Mission from these counties is only 7.7	•	
		20	with the 5.5 percent inmigration-
19	percent, not 10 percent, not 34 percent. And one	1	with the 5.5 percent inmigration A. Okay.
19 20	percent, not 10 percent, not 34 percent. And one of the statements, I believe, that was made in the	20	
19 20 21	percent, not 10 percent, not 34 percent. And one of the statements, I believe, that was made in the application—and I believe it's quoted. And it's	20 21	A. Okay.

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				74				76
1	Q.	So that could be-if	you look at that license		1	Q.	I think the discussion you're	thinking about is on
2	-		hat might be somebody from	om	2		Page 672.	Nimit.
3			olina or somebody who w		3	A.	It's in the methodology as w	ell, so that's where I
4		-	mover County or however		4		was looking.	Tangar Tangar
5	A.	Correct.			5	Q.	Okay. Wherever.	Esamax
6	Q.	Okay.			6.	A.	(Witness reviews document) Yeah, she does mention
7	A.	But what I'm saying	is, they're representing th	at	7		that, based on a representatio	12
8		inmigration is only 5	.5 percent. They are break	ding	8		Year 2010-this is on 672 of	i i
9		out their patient origi	n and listing these other		9		findings state Mission Hospi	· · · · · · · · · · · · · · · · · · ·
10			them as though they're pa		10		cases and 3,982 outpatient ca	19.
11			s they define it. But then,		11		Hospital's inpatient/outpatier	13
12	,		rposes of trying to compar	re	12		percent inpatient cases and 6	I.I percent outpatient
13	•		-now they're saying that		13	_	cases.	HANDE
14			ent, because they're treating		14	Q.	You have to apply those pe	12
15			hose other counties listed	in	15		on Page 667 to get to an outp	patient number only,
16		the table on Page 64		,	16		correct?	d and that
17			we were not-we didn't fin		17	Α.	You could take that data an	13
1.8			use-they were saying that		18		outpatient/inpatient split to a	i i
19		-	ons in Asheville was 34 pe		19 20		represented there, and you or percentage of the total was i	12
20			cent is reasonable—we're r	101	21		from those counties.	or just outpations
. 21			nat's all I'm trying to say		22	^		1 nement outpatient
22			ust say, well, we'll compa	ic.	23	Q.	percentage to each of the co	
23			10. 10's less than 34.	nt	24		said, you would get a numb	13.
24		I herefore, it's reason	nable. No, is the 10 perce				sma, you would got a maste	- Jackson - Jack
Marth	a Fr	isoneVOLUME I	January 26,	2012	Marth	a Fr	isoneVOLUME I	January 26, 2012
				75				77 📳
1. 1		reasonable for Miss	ion GI South. There are se	veral	1		reasonable in terms of inn	18
2		problems. One, is it	: 10 percent, or is it 15		2	А	. This isit's not about wh	nat I consider to be
3		percent? And two,	where are they coming from	m? Ar	nd 3		reasonable. This is about	12
4		so there'sI told you	i, there are multiple issues		- 4		failed to do. It's not my j	12
5			reason it should be found-		5		to rewrite the application	2
6		that they didn't adec	uately identify the populat	ion	6		with what is reasonable.	122
7		to be served.			7		you look at Mission's util	i n i lg
8	Ç	•	e chart on Page 667 of the	•	8		patient origin differently,	I S
9		- ·	gency's finding that 7.7		9		counties where it's reasor	i i
10			from counties outside Bur		1		outpatients would utilize	12
11			reasonable projection or w	ould	11		facility, you don't get 10	
12		have been a reasons			12		something less than that.	6
13	Æ		eve we point out that-that	that	13		the inpatients, you get 7.	Įž
14			is overstated, because the		14		different analysis, you'd	Ref Wil each lower.
15			this total number of endos		15	,	percent.	of the information in the
16		• -	the 508 from those countie	s,	16	(s of the information in the
17		-	7 percent, that includes		17		** **	next step taken, in other
18		inpatients, as well			18		words, to apply the outpo	· · · · · · · · · · · · · · · · · · ·
19		•	lo to adjust and get to an		19			ess the reasonableness of
20		outpatient number			20		the actual numbers in the	
21			to know what the percentage	ge	21		A. Okay. I think I underst	
22		•	ch I believe is somewhere		22		No, we didn't take this a	ge of the totaland I mean
23	5	reflected in the fin	dings. (Witness reviews		23	•	total innatient and outpa	-

total inpatient and outpatient--came from these

		LsongVOLUME I January 26, 2012	Martha	FrisoneVOLUME I January 26, 2012
Martha	Fri	LsoneVOLUME I January 26, 2012	Marcha	80
			4	percent or is it 15 percent. And, furthermore, we
1		counties, because there are several-again, there	1	don't think 10 percent, given the geography and the
2		are several issues with the inmigration. First and	2	
3		foremost, is it 10 percent or 15 percent? We don't	3	roads of where Mission's patients might be coming
4		know. Where are they coming from? We don't know	4	to Asheville but expected to shift to Fletcher,
5		and if you base it on Mission's current patient	5	what percentage would that be, and we don't think
6		origin for GI endoscopy services, it doesn't appear	6	it's 10 percent. It's certainly not 15 percent.
7		that 10 percent is reasonable.	7	Q. If you look at the table on Page 668, could this
8	Q.	İ	8	whole issue have been avoided just by taking out
9		in the chart on Page 667 was not done to	9	those patients in the inmigration categories? In
10		determineto assess the reasonableness of the	10	other words—
11		projections?	11	A. Well, if the application didn't include a 10
12	A	Okay. No, that's not what I'm saying. We're just	12	percent or 15 percent inmigration, it might have
13		illustrating that, if you look at Mission's total	13	been a different outcome on this issue, but this
14 .		GI endoscopy patients, inpatient and outpatient,	14	isn't the only issue.
15		for the counties-it's a multi-step that you cannot	15	Q. Would you consider it reasonable to project all of
16		take that one table in isolation. You have to look	16	your patients coming from Buncombe or Henderson zip
. 17		at the whole document, at the progression and the	17	codes for a project like this?
18		logic of all of our thoughts, not just this one	18	A. It certainly could be. I mean, this application
19		table. First we've said, is it 10 percent or is it	19	was denied for a multitude of reasons. This is
20		15 percent? We don't know. We're not sure 10	20	only one of them. The fact that we don't know
21		percent's based on anything reasonable, because we	21	whether it's 10 or 15 percent and the pro formas
22		don't know what the 10 percent consists of. But if	22	are based on 15 percent. If there had been no 10
23		we compare it to, and we analyze, Mission's current	23	percent inmigration, if it was consistently 10
24		payor origin, and we analyze a map and roads, and	24	percent or it had been defined and where they were
Marth	a F	risoneVOLUME I January 26, 2012	Marth	a FrisoneVOLUME I January 26, 2012
		.79		81
1			1	
		we look at and say well, these counties that	1	•
l		we look at and say, well, these counties that	1 2	coming from was reasonable, it could have been a
2		they're already serving, yeah, we could-besides	1 2 3	
2		they're already serving, yeah, we could-besides Buncombe and Henderson. There are some other	2	coming from was reasonable, it could have been a different outcome on this issue. But there are other issues.
2 3 4		they're already serving, yeah, we could—besides Buncombe and Henderson. There are some other counties where patients currently going to	2 3 4	coming from was reasonable, it could have been a different outcome on this issue. But there are other issues. Q. And when I spoke with Ms. Miles in her deposition
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2 3 4 5 6		they're already serving, yeah, we could—besides Buncombe and Henderson. There are some other counties where patients currently going to Asheville might very well go to Mission GI South instead of Asheville, but it's not all the counties	2 3 4 5 6	coming from was reasonable, it could have been a different outcome on this issue. But there are other issues. Q. And when I spoke with Ms. Miles in her deposition we went through each step of the methodologies that Mission used, and I believe she said the only issue
2 3 4 5 6 7		they're already serving, yeah, we could—besides Buncombe and Henderson. There are some other counties where patients currently going to Asheville might very well go to Mission GI South instead of Asheville, but it's not all the counties currently served by Mission. When you compare this	2 3 4 5 6 7	coming from was reasonable, it could have been a different outcome on this issue. But there are other issues. Q. And when I spoke with Ms. Miles in her deposition we went through each step of the methodologies that Mission used, and I believe she said the only issue with the methodology was with this Step 10 on the
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Martha	FrisoneVOLUME I January 26, 2012	Martha	FrisoneVOLUME I January 26, 2012
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1	don't have anything to do with the methodology or	1	because of mold. Glad to get out of that building.
2	the assumptions, but they're described and	2	I remember where we were. I remember some of the
3	discussed starting on 669 where we discuss some of	3	discussion. We may very well have discussed the G
4	this again. But all the other reasons are-	4	endo application. I don't personally have, right
5	basically start on 669 in Criterion 3.	5	now, any recollection of that. What I remember
6	Q. Okay. You're talking about Criterion 3 still only	6.	from that meeting is discussing a building that
7	here. You're not talking about other issues; is	7	would be physically located on a piece of property
8	that right?	8	that was in both Buncombe and Henderson Countie
9	A. Well, there's that, and there's also issues with	9	and discussing the satellite ED. That's what I
10	Criterion 5 and Criterion 12 that we didn't believe	10	remember from the meeting. That does not mean G
11	were conditionable. So it's—when we're	11	endo wasn't discussed. I just don't personally,
12	determining whether an application will be denied,	12	right now, recall.
13	we're looking at the whole application and all the	13	Q. In addition to that meeting that you just recalled,
14	review criteria. Each one is reviewed	14	did you also participate in a pre-application
15	independently. Each one involves different issues,	15	conference regarding the Mission GI South
16	but they do impact each other. The issues raised	16	application?
17	in one may negatively impact our findings in	17	A. If I did, I have absolutely no recollection. All I
18	another.	18	recallthere may have been more than one meeting
19	Q. The discussion that begins on Page 669 of the	19	but all I'm recalling is that meeting was in an
20	application is an analysis of need where you get	20	anteroom where we had to turn the tables at an
21	into a discussion of Buncombe and Henderson County;	21	angle. And we had to move chairs, because you
22	is that right?	22	couldn't get the door open.
23	A. Correct. I believe, at the end of this, she may	23	Q. Whowho attended the meeting that you rememb
24	repeat some stuff about the inmigration, but	24	A. I think Les was there. Craig may have been there
Marth	a FrisoneVOLUME I January 26, 2012	Martha	a FrisoneVOLUME I January 26, 20
March	83		
		1	Probably Brian Moore was there. But as to who
1	there's other issues discussed there involving the	2	was there—there were a lot of people in the room,
2	existing facilities in Henderson County and the	3	but I don't remember all their names.
3	utilization trends and so forth.	4	Q. Were there representatives of the Construction of
4	Q. Let's step back a little bit in time and talk about	5	Licensure Section of DHSR there?
5	the pre-application conference before we talk about	6	A. I don't recall.
9	the discussion that begins on Page 669.	7	Q. Do you recall ever participating in a meeting
7	A. Okay,	8	related to the GI South project that included
8	Q. I understand that you attended oneat least one pre-application conference with Mission regarding	9	members of the Construction Section?
9	this application; is that right?	10	A. I don't recall.
10		11	Q. What understanding did you take away from the
11		12	meeting with-about the project that was discussed
12		13	A. Mission and Pardee—Margaret R. Pardee Memo
14		14	Hospital were proposing to build a building on
15		15	property already owned that was located-literall
16	and the same of th	16	part of the property is in Buncombe County and
17		17	of it is in Henderson County. And there was
18		18	
, TO	1.70 Y MORE FOOTH MIN MINO.	1	
1	O You did not consider that a pre-application	1 19	
19		19	
19 20	conference for the Mission South application		satellite ED, and I'm not sure which county it was
19 20 21	conference for the Mission South application though, right?	20 21	satellite ED, and I'm not sure which county it we supposed to be in and which hospital wouldit
19 20 21 22	conference for the Mission South application though, right? A. I-my memory of that meeting, I remember where we	20 21	satellite ED, and I'm not sure which county it we supposed to be in and which hospital wouldit would be licensed under. But I do recall being
19 20 21	conference for the Mission South application though, right? A. Imy memory of that meeting, I remember where were. We moved a table especially in the room to	20 21 ve 22	satellite ED, and I'm not sure which county it we supposed to be in and which hospital would—it would be licensed under. But I do recall being asked if the ambulance entrance could be in a

Martha	FrisoneVOLUME I January 26, 2012	Martha	FrisoneVOLUME I January 26, 2012
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1	and I said, unequivocally, no. I'm afraid that's	1	would span across county lines. And there was lots
2	all I recall of the meeting, other than where we	2	of discussion about that. And at some point there
3	were physically.	3	was some discussion about an ED-satellite ED. And
4	Q. At any point during the review of the GI South	4	somebody asked, I don't even know who, if the
5	application, did you consult with the Construction	5	ambulance entrance could be physically located in a
6	Section or Licensure Section about the location of	6	different county, and I said no based on my
7	the project?	7	understanding of Licensure's rules.
8	A. I don't believe I did. I don't know whether Ms.	8	Q. Just so I'm clear, you don't recall a second call
9	Miles did or not.	9	or group coming to you as part of the pre-
10	Q. Did you give Ms. Miles any guidance for her review	10	application conference for this particular project?
11	of the application based on the discussions that	11	A. No. They may very well have. I just don't
12	you participated in regarding the location of the	12	remember it.
13	building on the county line?	13	Q. While we're kind of back at the beginning, I also
14	A. I think you might have the cart before the horse.	14	wanted to ask you if you made the decision not to
15	Ms. Miles brought to my attention that the drawings	. 15	grant Mission's request for an expedited review?
16	showed that the space for the GI endoscopy room,	16	A. That decision was made jointly by Mr. Smith and
17	which would be licensed as part of the hospital,	17	myself.
18	crossed over into another county, and so we	18	Q. Why did you decide not to expedite the review of
19	discussed it.	19	Mission's application?
20	Q. Before we talk about that, though, what I'm asking	20	A. Because we were probably 99 percent certain that,
21	is whether you said to Ms. Miles at the beginning	21	if we had not scheduled a public hearing, that we
22	of the review, we've had these discussions with	22	would have been asked to schedule one.
23	Mission about this location, here's what you need	23	Q. So you decided not to grant the expedited review
24	to know?	24	request because you expected to receive a request
		.[
Marth	FrisoneVOLUME I January 26, 2012	Martha	a FrisoneVOLUME I January 26, 2012
Marth	a Frisone—VOLUME I January 26, 2012	Martha	a FrisoneVOLUME I January 26, 2012
	. 87		89
1	A. No, because any representations made at a pre-	1	for a public hearing?
1 2	A. No, because any representations made at a pre- application conference or meeting, they're really	1 2	for a public hearing? A. We expected to receive negative written comments,
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Martha	Fr	isoneVOLUME I January 26, 2012	Martha	Fri	soneVOLUME I. January 26, 2012
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1		we would just go ahead and schedule a public	1		looking at all of the issues and looking at all of
2		hearing and we would deny the request for expedited	2		the-some of them are things we just don't
3		review, because we were pretty certain we would get	3		condition, because we don't know what they would
4		a request for one.	4		present in response.
5	. Q	7	5	Q.	We looked a little bit ago at some of the
6	`	representatives of Parkridge at the time you made	6		attachments to the comments by Parkridge and
-7		the determination to hold a public hearing?	7		Carolina Mountain. They both attached
В	A		8		documentation regarding Mission's certificate of
9		Mr. Smith on to get his sense of whether we should	9		public advantage and a study about that. Did you
10		just go ahead and schedule a public hearing.	10		find that valid to the review of the application?
11.	Q		11	Α.	I was aware of what they had attached, because I'm
12	A	. And I usually do consult with him anyway on it. I	12		the one who processes written comments when they
13	. 4	don't-in other words, although technically it's	13		come in. So I was the one who had to scan it all.
14		supposed to be the Assistant Chief's responsibility	14		I found some of it interesting. It's notit's not
15		to make the decision whether to deny or approve, I	15		the basis of the decision, any of the comments,
16		usually consult with him on all of them anyway.	16		with respect to the certificate of public
17	Ç	And what was the discussion surrounding whether	17		advantage.
18		Parkridge might oppose the-	18	Q.	You also went over Mission's response to those
19	A	I don't recall the discussion, just my recollection	19		particular comments; is that right?
20		is the sense that, if I didn't believe it, that Mr.	20	À.	Yes.
21		Smith believed that Parkridge would probably ask	21	, Q.	And did you go to the website referenced in
22		for a public hearing.	22		Mission's response about the specific certificate
23	Ç). Did Ms. Miles ever give you a draft of the findings	23		of public advantage issue?
24		that had a conditional approval?	24	A	. I'm not-right now, I don't recall what reference
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1	_	A. Not to the best of my recollection.	1	^	you're talking about,
2	(2. Did you talk with her about any conditions that	2	Q	Okay. Let me take you there. It is-it's the
3		would enable you to approve the application?	3		response to the comments on Page 540 in the Agency file.
4	. 1	A. Ms. Miles tends to discuss with me at great	5	٨	. I don't think I went to it. I don't know if Ms.
5		lengths before she submits anything, so we would have already worked through all of the issues and	6	Α.	Miles went to it.
6		•	7	Q	·
7		concerns that she had spotted in the various review criteria before she ever submitted anything to me.	8	V	about the certificate of public advantage wasn't
8		So, in those discussions, we would have—if we had	9		the basis of your decision to disapprove the
9		thought that conditioning anything was possible, we	1		application?
10		would have already discussed it then before she	11	Δ	That's correct. The certificate of public
12		ever gave anything to me.	12	,77	advantage is a different statute from the CON law.
13		Q. Sitting here today, do you recall any discussions	13		And whatever issues there are with respect to that
14		about conditions on approving this application?	14		certificate are not issues to be resolved in a CON
15		A. This is not one, I believe, where we could have	15		review. And if therelet me be clear. If there
16		conditioned the applicant.	16		even are any issues, the CON review was not the
17		Q. And why is that?	17		forum to resolve those issues.
18		A. They haven't demonstrated the need. They haven't	ı	C	2. And you're not saying there are or are not issues?
19		demonstrated that the capital cost is the correct	19		A. No, I mean that's not my law toit's done by our
20		capital cost. They haven'tbecause of the way	20	•	Division. It's done byit's the onlythe only
21		it's presented to us, it's not clear whether the	21		one that's ever been applied for, and it was
22		developer will be incurring any costs that would	22		actually doné by Bob Fitzgerald, I think. He
23		make the developer need to be an applicant. I'm	23		wasn't the Director at the time he did it, but I
		not sure if there may be somein other words, by	24		believe he was the one who was sort of the lead

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Martha		Martha	Fri	soneVOLUME I January 26, 2012
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1	person on that. I was-it occurred when I was a	1	Q.	As part of the analysis of this aspect of Criterion
2	fairly wet-behind-the-ears project analyst. So all	2		3, did you look at the information in Mission's
-3	I have is hearsay from Mr. Smith that wewe,	3		application regarding the total number of
4	being, the CON Section-may have been consulted,	4		procedures and rooms needed for Buncombe County?
5	but that would have probably been Lee Hoffman as	5	A.	Well, I didn'tI looked at portions of the Mission
6	Chief and perhaps Craig Smith as Assistant Chief.	. 6		application. Don't recall right now what those
7	And I certainly wasn't involved in that.	7		are. So most of my time was focused on meeting
8	Q. Let's looklet's go back now to the last part of	8		with Gebrette, maybe looking at a page or two while
9	the discussion under Criterion 3 in the findings.	9.		we were doing so, and looking at her findings. So
10	And as we said earlier, that begins on Page 669 of	10		I-don't know what part of the Mission application
11	the Agency file.	11		that you're talking about. If it's reflected in
12	A. (Witness complies.)	12		the findings, then definitely II looked at it.
13	Q. As part of the analysis that starts on Page 669,	13		It may or may now be something where I actually
14	Ms. Miles has findings regarding the existing rooms	14	^	looked at the source in the application. I will point you to those charts. It may be easier
15	in Buncombe and Henderson Counties; is that right?	15	Q.	to look at Exhibit 16 in the application.
16	Correct. Was—why was the—why was the analyst and why were	16 17		Specifically, if you would, Ms. Frisone, look at
17	· · · · · · · · · · · · · · · · · · ·	18		Page 363 of the Mission application. It is Tables
18 19	you concerned about utilization in Henderson County when the project was located in Buncombe County?	19		7 and 8 to Exhibit 16. And particularly, did you
20	A. Well, part of it's located in Henderson County.	20		look at Table 8 when you were conferring with Ms.
21	Not a lot, but part of it is located physically in	21		Miles regarding the review?
22	Henderson County. Because they're proposing to	22	Α.	
23	move this room literally to the county line. And	23		is reflected—there are tables quoted in the
24	there is a nexus between Criterion 3 and Criterion	24		findings that deal with Mission's representations
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	a FrisoneVOLUME I January 26, 2012	Marth	- Fr	isoneVOLUME I January 26, 2012
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1	6, and we were finding them nonconforming with	1		about-this is in one of the steps in the
2	Criterion 6. And so some of the same—if it—if	1 ~		45
		2	•	methodology.
3	you don't need it in that area because the existing	3	Q	. Uh-huh.
4	you don't need it in that area because the existing facilities have capacity, then they haven't	3 4	Q . A	. Uh-huh (Witness reviews document.) And I believe the
5	you don't need it in that area because the existing facilities have capacity, then they haven't demonstrated the need for the project as proposed,	3 4 5	,	. Uh-huh (Witness reviews document.) And I believe the table on Page 660, at the bottom, is from Table—i
4 5 6	you don't need it in that area because the existing facilities have capacity, then they haven't demonstrated the need for the project as proposed, which includes not just an outpatient-only GI endo	3 4 5 6	,	. Uh-huh (Witness reviews document.) And I believe the table on Page 660, at the bottom, is from Table—i a quote from Table 7. So while I may not have
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4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	you don't need it in that area because the existing facilities have capacity, then they haven't demonstrated the need for the project as proposed, which includes not just an outpatient-only GI endo room, but an outpatient GI endo room, to all intents and purposes, I assume that probably has a Fletcher mailing address, even though a good part of it might be in Buncombe County or at least the GI endo suite. But this is part of our analysis. I mean, it's nothing unique to this review. We've done similar things in other reviews, particularly involving Medical Park Hospital-Clemmons, Forsyth Medical Center-Clemmons, and various and sundry proposals by Davie County Hospital for a replacement. Davie County Hospital is going to be in Bermuda Run. The Clemmons facility will be Clemmons. And they're two different counties that are separated by a river, but they're only four miles apart. And we looked at utilization in—in those—both of those counties in evaluating the	3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	Q A A Q	. Uh-huh. (Witness reviews document.) And I believe the table on Page 660, at the bottom, is from Table—i a quote from Table 7. So while I may not have looked at Table 7, I looked at the quote of Table on Page 660—reflected on Page 660 of the Agence file. That is also on 648; is that right? (Witness reviews document.) Yes, it is. Table is on 649. So— To the extent they're in the findings, you did at least see them? Yes. And if you're looking at the table on Page 649, Table 8. Yes. Did you understand that table to determine that there is actually a deficit of endoscopy rooms based on volumes in Buncombe and Henderson Counties?
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Martha	Fri		Martha	FrisoneVOLUME I January 26, 2012
		98		100
1	•	conclusion based on the numbers in Table 8 from	1	at the target, then this would be certainlythis
2		Exhibit 167	2	is the problem. The problem is they're moving the
3	A.	Well, I don't know that we directly did so, but our	3	room to the Henderson County line. The suite
4		analysis showed that utilization in Henderson	4	actually crosses into Henderson County. And our
5		County has decreased, and that the average number	5	analysis shows perhaps an outpatient-only room is
6		of procedures per room in Federal Fiscal Year 2010	6	needed, another one. There's already five in
7		was only 1,362. So I guess, to that extent, we	7	Asheville. But perhaps another one is needed, but
8		don't agree with the conclusion drawn by the	8	perhaps it would be-the Henderson County line
9		applicant as reflected in Table 8 from Exhibit 16	9	isn't the place for it is what we're really trying
10		just quoted on Page 649 of the Agency findings-	10	to say.
11		Agency file.	11	Q. If there had been no question in your mind that the
12	Q	. That table takes into account the utilization for	12	entire endoscopy suite was in Buncombe County,
13		multiple years; does it not?	13	sounds like you're still saying you would have had
14	Α	. Which table are you talking about?	14	an issue?
15	Q	. The one we were just looking at, Table 8, that's on	15	A. Yes, ma'am. I need to stand corrected. You asked
16		649.	16	me if we'd ever considered a condition. We never
17	Q	. Okay. You had deficits and surpluses calculated	17	drafted it, because other issues cropped up. But
18		for '08, '09 and 2010, but that's for-based on the	18	at one point we talked about whether it would be
19		listed facilities, it has to be Henderson and	19	possible to condition-again, this is before we
20		Buncombe Counties combined. Our analysis looks at	20	realized that there was the 15 percent immigration
21		Buncombe County and then at Henderson County and	21	used in the pro formas-we did talk about the
22		shows that, if you don't combine them-now, in	22	possibility of conditioning an approval that the
23		Buncombe County, the average utilization is 2,130	23	facility-the GI endo suite would have to be
24		procedures per room, well above the target	24	physically entirely located in Buncombe County. We
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1		utilization. But when you isolate Henderson	1	didn't draft such a condition, but we talked about
2		utilization. But when you isolate Henderson County, the average in Henderson County is only	2	didn't draft such a condition, but we talked about whether it was feasible to-to do that to correct
1		utilization. But when you isolate Henderson County, the average in Henderson County is only 1,362 in Fiscal Year 2010. The applicant's	2	didn't draft such a condition, but we talked about whether it was feasible to—to do that to correct that one deficiency. Then we found other
2		utilization. But when you isolate Henderson County, the average in Henderson County is only 1,362 in Fiscal Year 2010. The applicant's analysis combined Buncombe and Henderson together	2 3 4	didn't draft such a condition, but we talked about whether it was feasible to—to do that to correct that one deficiency. Then we found other deficiencies, and we realized no conditions were
2		utilization. But when you isolate Henderson County, the average in Henderson County is only 1,362 in Fiscal Year 2010. The applicant's analysis combined Buncombe and Henderson together to come up with the surpluseswell, they come up	2 3 4 5	didn't draft such a condition, but we talked about whether it was feasible to—to do that to correct that one deficiency. Then we found other deficiencies, and we realized no conditions were going to be appropriate.
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2 3 4 5 6		utilization. But when you isolate Henderson County, the average in Henderson County is only 1,362 in Fiscal Year 2010. The applicant's analysis combined Buncombe and Henderson together to come up with the surpluseswell, they come up with deficits in Table 8. So it's a different way of looking at it. And when you break it apart, you realize that perhaps the preferred location would	2 3 4 5 6 7 8	didn't draft such a condition, but we talked about whether it was feasible to—to do that to correct that one deficiency. Then we found other deficiencies, and we realized no conditions were going to be appropriate. Q. And when you say "endo suite," you mean everything including closets and— A. Yes.
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2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18	<u>.</u>	utilization. But when you isolate Henderson County, the average in Henderson County is only 1,362 in Fiscal Year 2010. The applicant's analysis combined Buncombe and Henderson together to come up with the surpluseswell, they come up with deficits in Table 8. So it's a different way of looking at it. And when you break it apart, you realize that perhaps the preferred location would be Buncombe County and not on the Henderson County line. But perhaps more centrally located to serve all of Buncombe County. Q. Are you saying that the Federal Fiscal Year 2010 number of procedures per room for Henderson County of 1,362 is underutilized? A. Yeah, the target's 1,500. So what that shows us, and that's what we say in the findings, is that there's capacity in Henderson County for GI endo rooms.	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	didn't draft such a condition, but we talked about whether it was feasible to-to do that to correct that one deficiency. Then we found other deficiencies, and we realized no conditions were going to be appropriate. Q. And when you say "endo suite," you mean everything including closets and- A. Yes. Qstorage and A. Yes. Qbathrooms? A. Yes. I'm sorry. The discussion about that just jogged my memory, and I realized, oh, we did actually talk about whether we could do such a condition. We didn't draft one, but we did talk about whether we could. Q. Thank you for supplementing your answer. Are we agreement that Mission is not adding an endoscopy room to the inventory in Henderson County? A. Let me find what we said about that. (Witness
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2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	-	utilization. But when you isolate Henderson County, the average in Henderson County is only 1,362 in Fiscal Year 2010. The applicant's analysis combined Buncombe and Henderson together to come up with the surpluseswell, they come up with deficits in Table 8. So it's a different way of looking at it. And when you break it apart, you realize that perhaps the preferred location would be Buncombe County and not on the Henderson County line. But perhaps more centrally located to serve all of Buncombe County. Q. Are you saying that the Federal Fiscal Year 2010 number of procedures per room for Henderson County of 1,362 is underutilized? A. Yeah, the target's 1,500. So what that shows us, and that's what we say in the findings, is that there's capacity in Henderson County for GI endo rooms. Q. If they met the targets, then there would be the ability to demonstrate a need for an additional room, correct? A. If a provider wanted to develop a GI endoscopy	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	didn't draft such a condition, but we talked about whether it was feasible to-to do that to correct that one deficiency. Then we found other deficiencies, and we realized no conditions were going to be appropriate. Q. And when you say "endo suite," you mean everything including closets and A. Yes. Qstorage and A. Yes. Qbathrooms? A. Yes. I'm sorry. The discussion about that just jogged my memory, and I realized, oh, we did actually talk about whether we could do such a condition. We didn't draft one, but we did talk about whether we could. Q. Thank you for supplementing your answer. Are we agreement that Mission is not adding an endoscopy room to the inventory in Henderson County? A. Let me find what we said about that. (Witness reviews document.) We kind of went back and forth on that one. That is one we did talk about. I'm
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	•	utilization. But when you isolate Henderson County, the average in Henderson County is only 1,362 in Fiscal Year 2010. The applicant's analysis combined Buncombe and Henderson together to come up with the surpluseswell, they come up with deficits in Table 8. So it's a different way of looking at it. And when you break it apart, you realize that perhaps the preferred location would be Buncombe County and not on the Henderson County line. But perhaps more centrally located to serve all of Buncombe County. Q. Are you saying that the Federal Fiscal Year 2010 number of procedures per room for Henderson County of 1,362 is underutilized? A. Yeah, the target's 1,500. So what that shows us, and that's what we say in the findings, is that there's capacity in Henderson County for GI endo rooms. Q. If they met the targets, then there would be the ability to demonstrate a need for an additional room, correct?	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	didn't draft such a condition, but we talked about whether it was feasible to-to do that to correct that one deficiency. Then we found other deficiencies, and we realized no conditions were going to be appropriate. Q. And when you say "endo suite," you mean everything including closets and- A. Yes. Qstorage and A. Yes. Qbathrooms? A. Yes. I'm sorry. The discussion about that just jogged my memory, and I realized, oh, we did actually talk about whether we could do such a condition. We didn't draft one, but we did talk about whether we could. Q. Thank you for supplementing your answer. Are we agreement that Mission is not adding an endoscopy room to the inventory in Henderson County? A. Let me find what we said about that. (Witness reviews document.) We kind of went back and forth on that one. That is one we did talk about. I'm trying to-there is something that I saw this

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1	it is that there's something in the comments about	1	And so they provided information that showed that
2 .	it, but that we didn't necessarily agree with. I	2	there was sufficient need in Davie County for one
3	think we say something like arguably or something	3	additionalone additional room. They only have
4	to that effect thatthat it could be argued. I	4	one now. And based on their current volumes and
5	don't think we really believed that they really	. 5	they're projected volumes, that there was room for
6	were proposing to increase the inventory in	6	both.
7	Henderson County, but it is certainly very, very	7	Q. Was the new replacement hospital going to have or
8	close to the line. I would like to find where I	8	or more than one endoscopy room?
9	it might be in Criterion 4. (Witness continues to	9	A. They weren't going to increase the number, but the
10	review document.) Yes, Page 674 of the Agency	10	were going to-we did grant them that replacing it,
11	file. It's in Criterion 4. It's the second full	11	modernizing it, that they would be able to-
12	paragraph on that page. At the end of it, we do	12	probably be able to keep a gastroenterologist there
13	say the proposed project would arguably increase	13	long enough or enough hours that they could
14	the inventory of licensed GI endo-endoscopy rooms	14	actually do enough volume.
15	in Henderson County. I don't think we were really	15	Q. Without that replacement hospital application,
16	convinced of that, but we could see where one could	16	though, you couldn't have approved an additional
17	argue that.	17	room in the county?
18	Q. But it sounds like you're saying, even if there	18	A. I could have, because the applicant presented their
19	wasn't an argument to that effect, you still have a	19	data-it had a lot to do with how the applicant
20	concern about locating this project on the county	20	presented their data. In the Davie situation, they
21	line?	21	were able to provide enough data to show that there
22	A. I do. I do.	22	was enough potential volume for two rooms.
23	Q. Just in a general sense, not with regard to this	23	Q. Here, Mission's application shows an analysis that
24	Mission application, when you're reviewing a new GI	24	there's a need for additional rooms when you're
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1	endoscopy room or an application for such a room,	1	looking at Buncombe and Henderson County togethe
2	do you take into account utilization of existing	2	A. But that's when you combine them.
3	providers?	3	Qbut you didn't take that
4	A. I believe that we did so in the Davie County	4	A. When you separate them, you see that Henderson
5	Digestive Health Specialists proposal, which I	5	doesn't need it. So the issue here is, do you need
6	believe was reviewed by Ms. Miles and myself.	6	to move one of the Buncombe rooms closer to
7	Q. Was the utilization of the existing provider a.	7	Henderson. And the answer is, based on our review
8	basis for denying that application?	8	of this, no, you don't. There's no need to move it
9	A. We didn't deny it. We approved it.	9	closer to Henderson. It's still needed. It's not
10	Q. Was the existing provider's utilization below the	10	that there's an over supply of GI endo rooms when
11	target 1,500 per room?	11	youcertainly if you look at them together. But
12	A. Since it's the existing Davie County Hospital and	12	when you break them apart, the need is in Buncomb
13	they haven't built the replacement yet, yes. They	13	County. And so you might have had a different
14	only have a gastroenterologist about two days a	14	result if the proposal had been to move one of them
15	week, half days at that, so. But, yes, we actually	15	out of the hospital to become outpatient only but
16	lookedif I'm recalling correctly, we actually	16	in a different location. So, here, a lot of it has
17	looked at the projected utilization for the	17	to do with moving it closer to Henderson County.
18	replacement facility, as opposed to looking at the	18	Q. Why do you contend you must separate the analyst
19	historical. But we did take it into account. We	19	you can't look at the Henderson County and Buncon
20	reached a different conclusion, but we did take it	20	County combined in the way that Mission presented
21	into account. And it was also there were negative	21	in its application?
22	comments filed by Baptist. They did not ask for a	22	A. Because when you separate it, you realize that you
23		1 23	don't need to move another roomor one of the
24	the applicant respond to the negative comments.	24	roomscloser to Henderson County. If there is a
1 43	my appropriate to the negative same	_ 1	

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1		need when you combine them, you realize the need	1		effective alternative has been proposed." So our
2		has to be in Buncombe County. It's not in	2		conclusion was that they didn't demonstrate that the proposal was the least costly or most effective
3		Henderson County.	3		• •
4	Q.	Did you not find credible the representations in	4		alternative.
5		the application that the patients expected to be	5		You refer in the findings under Criterion 4 to the
6		served would be closer to the location near the	6		location of the room; is that correct?
7		county line?	7	Α.	You mean the location in Buncombe County?
8	A.		8	Q.	Yes. Andand I m looking
9		believe we had any question about that. The	9	Α.	Yeah.
10		problem is on the inmigration, because they don't	10	Q.	-at your findings on Page 674 at the top.
11		specify where they'reprecisely where they're	11	A.	Right.
12		coming from. I think that's really what our	12	Q.	So we're in agreement that one of the bases of your
13		analysis is saying is some of them don't live-if	13		determination of nonconformity with Criterion 4 is
14		you justif you're going by the Mission GI	14		the location of the project, correct?
15		endoscopy current patient origin in Asheville, some	15	A.	That's probably a fair summary of those two
16		of them don't live closer and aren't likely to	16	_	paragraphs, yes.
17		utilize that facility.	17	Q.	You said in the middle paragraph that, "If the
18		MS. HARRIS: Off the record for a second.	18		entire project were located in Buncombe, there
19		(RECESS TAKEN FROM 1:01 P.M. UNTIL 1:43 P.M.)			would be no change in inventory." And I believe we
20	Q	. (By Ms. Harris) Ms. Frisone, continuing our	20		touched on that earlier as well; is that right?
2,1		discussion of the Agency findings regarding Mission	21	A.	
22		GI South's application, we talked most of the	22		is in response to the comments, which, if I'm
23		morning about the Criterion 3 and the findings	23		recalling correctly, seemed to say that they were-
24		there. And I'm going to turn now to some questions	24		that the application proposes an increase in the
Marth	a F	risoneVOLUME I January 26, 2012	Marth	Fr.	isoneVOLUME I January 26, 2012
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1		regarding Criterion 4.	1		inventory of GI endoscopy rooms in Henderson
2	,	A. Okay.	2		County. And we're explaining that, well, it is
3		2. And I believe some of it may flow into Criterion 5.	. 3		true, a portion of the suite does fall in Henderson
4	`	The findings that we'll be mostly concerned about	-4		County, and we could-you could argue that it would
5		are on Page 674 and the next few pages.	5		increase the inventory. I don't think we take that
6		A. Okay.	6		position, but one could argue that. And the reason
7		Q. Part of the analysis under Criterion 4 refers back	7		I say we don't take that position is, if we had, we
8	•	to Criterion 3; isn't that correct? And	8		would have had to have found Criterion 1I'm
9		specifically the very last paragraph on Page 675?	9		sorrywewe would have mentioned it in 3.
10		A. Okay. Well, that's just—the sentence says, "The	10	Q	
11		applicant did not adequately demonstrate that the	11	•	wasn't located in Henderson County, then the
12		most effective alternative has been proposed to	12		location wouldn't have necessarily been an issue
ı		meet the need which the applicant states exists.	13		under Criterion 4? I understand that it would have
1 1 4			1		other places, but under-
13		See Unierion 3 for discussion regarding	14		
14		See Criterion 3 for discussion regarding	Ì	A	-
14 15		demonstration of need." So it's justhere, we're	15	A	Yes. No, it would still have been an issue under-
14 15 16		demonstration of need." So it's just-here, we're saying they don't demonstrate it's the most	15 16	A	 Yes. No, it would still have been an issue under- in other words, that's part of what's wrong inor
14 15 16 17		demonstration of need." So it's justhere, we're saying they don't demonstrate it's the most effective alternative. And you go to Criterion 3	15 16 17	A	Yes. No, it would still have been an issue under- in other words, that's part of what's wrong inor part of our conclusion with respect to Criterion 3
14 15 16 17 18		demonstration of need." So it's just-here, we're saying they don't demonstrate it's the most effective alternative. And you go to Criterion 3 for the discussion about demonstration of need.	15 16 17 18	A	Yes. No, it would still have been an issue under- in other words, that's part of what's wrong in-or part of our conclusion with respect to Criterion 3 is you don't need-you haven't demonstrated to us
14 15 16 17 18 19	,	demonstration of need." So it's just-here, we're saying they don't demonstrate it's the most effective alternative. And you go to Criterion 3 for the discussion about demonstration of need. Q. There's not any additional demonstration of need.	15 16 17 18 19	A	in other words, that's part of what's wrong inor part of our conclusion with respect to Criterion 3 is you don't needyou haven't demonstrated to us that you need to move it closer to Henderson
14 15 16 17 18 19 20	,	demonstration of need." So it's justhere, we're saying they don't demonstrate it's the most effective alternative. And you go to Criterion 3 for the discussion about demonstration of need. Q. There's not any additional demonstration of need under Criterion 4?	15 16 17 18 19 20	A	in other words, that's part of what's wrong inor part of our conclusion with respect to Criterion 3 is you don't needyou haven't demonstrated to us that you need to move it closer to Henderson County. So it's not that it overlaps into
14 15 16 17 18 19 20 21		demonstration of need." So it's justhere, we're saying they don't demonstrate it's the most effective alternative. And you go to Criterion 3 for the discussion about demonstration of need. Q. There's not any additional demonstration of need under Criterion 4? A. Criterion 4 deals withwhat it says is "Where	15 16 17 18 19 20 21	A	Yes. No, it would still have been an issue under- in other words, that's part of what's wrong inor part of our conclusion with respect to Criterion 3 is you don't needyou haven't demonstrated to us that you need to move it closer to Henderson County. So it's not that it overlaps into Henderson County that's the reason why the location
14 15 16 17 18 19 20 21		demonstration of need." So it's justhere, we're saying they don't demonstrate it's the most effective alternative. And you go to Criterion 3 for the discussion about demonstration of need. Q. There's not any additional demonstration of need under Criterion 4? A. Criterion 4 deals withwhat it says is "Where alternative methods of meeting the needs for the	15 16 17 18 19 20 21 22	A	Yes. No, it would still have been an issue under- in other words, that's part of what's wrong inor part of our conclusion with respect to Criterion 3 is you don't needyou haven't demonstrated to us that you need to move it closer to Henderson County. So it's not that it overlaps into Henderson County that's the reason why the locatic is an issue in 4, it's moving it to that portion of
14 15 16 17 18 19 20 21		demonstration of need." So it's justhere, we're saying they don't demonstrate it's the most effective alternative. And you go to Criterion 3 for the discussion about demonstration of need. Q. There's not any additional demonstration of need under Criterion 4? A. Criterion 4 deals withwhat it says is "Where	15 16 17 18 19 20 21	A	Yes. No, it would still have been an issue under- in other words, that's part of what's wrong inor part of our conclusion with respect to Criterion 3 is you don't needyou haven't demonstrated to us that you need to move it closer to Henderson County. So it's not that it overlaps into Henderson County that's the reason why the location

Martha	FrisoneVOLUME I January 26, 2012	Martha	FrisoneVOLUME I January 26, 2012
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1	alternative-the most effective alternative to	1	\$340,155, for a total anticipated cost of \$617,655.
2	propose to move it to that part of the county.	2	To the best of my knowledge, and to the best of-
3	Q. One of the areas which Ms. Miles testified that she	3	certainly based on what Gebrette told me, there is
4	consulted with you related to the ownership and	4	no explanation anywhere in the application-because
5	whether the developer should have been an	5	I seem to recall she and I looking-that explains
6	applicant. Do you recall discussing that issue	6	what that means. So what we're saying is, there
7	with Ms. Miles?	7	isn't enough information regarding this 60/40
8	A. Yes, I do.	ŝ	ownership adjustment between the developer and
9	Q. And are the findings related to that issue at the	9	Mission. And because we don't know exactly what
10	bottom of Page 674?	10	cost the developer is incurring, the applicant
11	A. This is one of the places where that shows up, yes.	11	hasn't met its burden to demonstrate that the
12	Q. What was the concern that you had with regard to	12	developer shouldn't have been identified as a co-
13	the ownership of the building and the developer?	13	applicant. Because they provided us with
14	A. I think we have to really start with Criterion 5	14	information we don't understand, and this is the
15	for that, or possibly 12. I'm not sure. I think	15	only explanation we could find.
16	it's good to start with 12, because 12 contains the	16	Q. Under what scenario would the developer need to
17	quote from Exhibit 29. If I'm recalling correctly,	17	an applicant if it's not providing the endoscopy
18.	there's a representation in the application—in the	18	service?
19	beginning of the application—and this is on Page 3	19	A. If the developer is incurring any of the cost that
20	of the application; it's in Section I.	20	would turn that space into space that can be
21	Q. The response to Question 10?	21	licensed as part of the hospital for the
22	A. That's part of it, yeah. The representation here	22	performance of outpatient GI endoscopy services,
23	is that Mission Hospital will be leasing space for	23	then the developer has to be a co-applicant. We
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24	Mission GI South in a medical office building to be	24	are not saying that the developer will be. What
	Mussion GI South in a medical office building to be a FrisoneVOLUME I January 26, 2012		are not saying that the developer will be. What FrisoneVOLUME I January 26, 201
			
Martha	FrisoneVOLUME I January 26, 2012	Martha	FrisoneVOLUME I January 26, 201
Martha	a FrisoneVOLUME I January 26, 2012 111 developed at the proposed location. Okay. Nothing	Martha	FrisoneVOLUME I January 26, 201 11 we're saying is, based on what was submitted to us,
Martha 1 2	a FrisoneVOLUME I January 26, 2012 111 developed at the proposed location. Okay. Nothing wrong with that. But then, when Gebrette gets to	Martha 1 2	FrisoneVOLUME I January 26, 201 11 we're saying is, based on what was submitted to us there was insufficient information to document that
Martha 1 2 3	developed at the proposed location. Okay. Nothing wrong with that. But then, when Gebrette gets to Exhibit 29 and she's looking for confirmation that	Martha 1 2 3	FrisoneVOLUME I January 26, 203 11 we're saying is, based on what was submitted to us, there was insufficient information to document that the developer won't be. Very important distinction
Martha 1 2 3	developed at the proposed location. Okay. Nothing wrong with that. But then, when Gebrette gets to Exhibit 29 and she's looking for confirmation that the construction costs that are reported in Section	Martha 1 2 3	FrisoneVOLUME I January 26, 201 11 we're saying is, based on what was submitted to us, there was insufficient information to document that the developer won't be. Very important distinction here. It's what's missing. The 60/40 split may be
1 2 3 4 5	developed at the proposed location. Okay. Nothing wrong with that. But then, when Gebrette gets to Exhibit 29 and she's looking for confirmation that the construction costs that are reported in Section VIII, that there's documentation to support that	Martha 1 2 3	refrisoneVOLUME I January 26, 203 11 we're saying is, based on what was submitted to us, there was insufficient information to document that the developer won't be. Very important distinction here. It's what's missing. The 60/40 split may be perfectly okay, except I don't know what it means.
1 2 3 4 5 6	developed at the proposed location. Okay. Nothing wrong with that. But then, when Gebrette gets to Exhibit 29 and she's looking for confirmation that the construction costs that are reported in Section VIII, that there's documentation to support that they're reasonable—and one way that's done is with	1 2 3 4 5 6	we're saying is, based on what was submitted to us, there was insufficient information to document that the developer won't be. Very important distinction here. It's what's missing. The 60/40 split may be perfectly okay, except I don't know what it means. I don't understand it. And there isn't anything
1 2 3 4 5 6 7	developed at the proposed location. Okay. Nothing wrong with that. But then, when Gebrette gets to Exhibit 29 and she's looking for confirmation that the construction costs that are reported in Section VIII, that there's documentation to support that they're reasonable—and one way that's done is with certified cost estimates. It's not a requirement,	1 2 3 4 5	we're saying is, based on what was submitted to us there was insufficient information to document that the developer won't be. Very important distinction here. It's what's missing. The 60/40 split may be perfectly okay, except I don't know what it means. I don't understand it. And there isn't anything else to explain it. And I don't know what cost is
1 2 3 4 5 6 7 8	developed at the proposed location. Okay. Nothing wrong with that. But then, when Gebrette gets to Exhibit 29 and she's looking for confirmation that the construction costs that are reported in Section VIII, that there's documentation to support that they're reasonable—and one way that's done is with certified cost estimates. It's not a requirement, but it is one of the typical ways it's done—and	1 2 3 4 5 6 7	we're saying is, based on what was submitted to us there was insufficient information to document that the developer won't be. Very important distinction here. It's what's missing. The 60/40 split may be perfectly okay, except I don't know what it means. I don't understand it. And there isn't anything else to explain it. And I don't know what cost is the developer incurring, what cost is Mission
1 2 3 4 5 6 7 8	developed at the proposed location. Okay. Nothing wrong with that. But then, when Gebrette gets to Exhibit 29 and she's looking for confirmation that the construction costs that are reported in Section VIII, that there's documentation to support that they're reasonable—and one way that's done is with certified cost estimates. It's not a requirement, but it is one of the typical ways it's done—and she's looking at this letter, and there's this	1 2 3 4 5 6 7 8	we're saying is, based on what was submitted to us there was insufficient information to document that the developer won't be. Very important distinction here. It's what's missing. The 60/40 split may be perfectly okay, except I don't know what it means. I don't understand it. And there isn't anything else to explain it. And I don't know what cost is the developer incurring, what cost is Mission incurring, and it seems to fly in the face of the
1 2 3 4 5 6 7 8	developed at the proposed location. Okay. Nothing wrong with that. But then, when Gebrette gets to Exhibit 29 and she's looking for confirmation that the construction costs that are reported in Section VIII, that there's documentation to support that they're reasonable—and one way that's done is with certified cost estimates. It's not a requirement, but it is one of the typical ways it's done—and she's looking at this letter, and there's this analysis, if you will, where we start with \$370,000	1 2 3 4 5 6 7 8 9	we're saying is, based on what was submitted to us there was insufficient information to document that the developer won't be. Very important distinction here. It's what's missing. The 60/40 split may be perfectly okay, except I don't know what it means. I don't understand it. And there isn't anything else to explain it. And I don't know what cost is the developer incurring, what cost is Mission incurring, and it seems to fly in the face of the statement that Mission will be leasing the space.
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Martha		Martna	FrisoneVOLUME I January 26, 2012
	114		116
1	then we decide, okay, the developer is not	1	A. No. No, I did not.
2	incurring any of the cost, what he's doing is	2	Q. Okay. Do you agree that the letter that we now see
. 3	something any developer could do, to build a	3	in Deposition Exhibit 4 is a letter determining
4	building that would be occupied by insurance	4	that the medical office building on Highway 25 in
5	companies or lawyers.	5	both Buncombe and Henderson Counties is the office
6	Q. Did you review the exemption notice letter that the	6	building in which the Mission GI project will be
7	developer submitted to the CON Section during the	7	located?
8	review?	8	A. I don't know that for certain. I didn't read the
9	A. No, I did not.	9	letter attached to it. I'm assuming that it is the
10	Q. Did you look for that?	10	same building, if that's what you're asking.
11	A. No, I wasn't aware of it.	11	Q. Okay. Look with me, if you will, to the Mission GI
12	Q. Did you understand from the application that a	12	South application on Page 110, which is in Section
13	letter would be submitted?	13	XI.
14	A. If it said so in the application, and II don't	14	A. Okay.
15	know whether I was aware of it during the review or	15	Q. The response to Question 2(b) reads that, "Mission
16	not. Apparently not.	16	GI South will occupy leased space within a medical
17	Q. We marked the letter as Exhibit 4 in Ms. Miles'	17	office building developed by a third-party
18	deposition. I believe you have a copy of it in	18	developer. The MOB developer will file with the
19	front of you.	19	CON Section a request for an exemption from review
20	A. Yes.	20	to develop a medical office building." Did you
21	Q. Did you get a chance to look at it before your	21	review that answer during the review?
22	deposition?	22	A. I don't recall, but probably, if we were looking
23	A. Yeah. Here, today. I did not look at it until	23	for an explanation. But all it says is "will
24	today. It was already laying here, so I looked at	24	file"; it doesn't say they did file. And-
Month		 . 	
	- Fricano-Indiane T January 26, 2012	Marth	a FrisoneVOLUME I January 26, 2012
March	a FrisoneVOLUME I January 26, 2012	Marth	a FrisoneVOLUME I January 26, 2012
PARCIN	a FrisoneVOLUME I January 26, 2012		117
1	115 it.	1	117 Q. Section X is—or XI, excuse me—that I just read is
	it. Q. That was my next question. You did not look at the	1 2	Q. Section X is-or XI, excuse me-that I just read is consistent with what you read in Section I earlier,
ı	it.Q. That was my next question. You did not look at the exempt from review request letter dated May 13,	1 2 3	Q. Section X is—or XI, excuse me—that I just read is consistent with what you read in Section I earlier, correct?
Ĭ 2	 it. Q. That was my next question. You did not look at the exempt from review request letter dated May 13, 2011 or response dated May 24, 2011 during the 	1 2 3 4	Q. Section X is—or XI, excuse me—that I just read is consistent with what you read in Section I earlier, correct? A. Well, I would read the two of them together to mean
1 2 3	it.Q. That was my next question. You did not look at the exempt from review request letter dated May 13,	1 2 3 4 5	Q. Section X is—or XI, excuse me—that I just read is consistent with what you read in Section I earlier, correct? A. Well, I would read the two of them together to mean that Mission GI South would occupy leased space—
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	118		120
1	It sounds like Mission is going to own it, at least	1	A. Okay. It's not worded the way I would have done
2	in part. And that the capital cost was somehow	2	it.
3	prorated based on this, and we don't know why or	3	Q. The May 24 letter is not worded the way you—
4	for what reason. This is-it isn't that the	4	A. Correct. If the proposed building is going to be
·5	arrangement necessarily is wrong; it's just not	5	built by Western North Carolina Healthcare
6	adequately explained.	6	Innovators LLC, then that's what should have
7	Q. There was information in the response to comments	7.	appeared in the Re: line on the letter.
8	that related to this particular issue. Did you	8	Q. But that looks like it was Mr. Brown's or Mr.
9	review-review that? And if you want to look back	9	Smith's error?
10	at it now, it would be in-around Page 535, 536 of	10	A. It was their choice. I won't even call it an
11	the Agency file.	11	error, how about that, since Mr. Smith is the
12	A. Yeah. But this doesn't-to answer your question,	12	Chief? It's just not how I would have done it.
13	yes, we did look at this. And as far as we're	13	Q. So you would not agree with the statement that the
14	concerned, this didn't explain the problem at all.	14	developer only needs to be an applicant if the
15	Q. Why not?	15	developer is going to be offering the service?
16	A. Well, if the developer owns 60 percent of the	16	A. No, the developer might have to be an applicant if
17	medical office building, then someone else owns 40	17	the developer is going to incur some of the capital
18	percent of it. And this does not tell us who is	18	cost. It's not about whoit's not limited to who
19	incurring the obligation to—to make that space	19	offers the service.
20	licensable as a GI endoscopy suite as part of a	20	Q. If the medical office building itself is exempted
21	hospital to do-it does not answer the question	21	from certificate of need review, then the developer
22	that we had.	22	would not need to be an applicant?
23	Q. So you did not take from the information in the	23	A. The building is exempt to the extent that it
24	application and the response to comments that	24	doesn't include new institutional health services.
		 	
Marth	a FrisoneVOLUME I January 26, 2012	Marth	a FrisoneVOLUME I January 26, 2012
Marth	a FrisoneVOLUME I January 26, 2012	Marth	a FrisoneVOLUME I January 26, 2012 121
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1 2	Mission included some of the building costs to be conservative, even though that was not necessary	1	121 And I guess I will go ahead and say this: Knowing
1 2 3	Mission included some of the building costs to be conservative, even though that was not necessary because of its plan to lease the space for the GI	1 2	121 And I guess I will go ahead and say this: Knowing what I know now, I question whether the exemption
1 2	Mission included some of the building costs to be conservative, even though that was not necessary because of its plan to lease the space for the GI endoscopy centeror suite, excuse me?	1 2 3 4	And I guess I will go ahead and say this: Knowing what I know now, I question whether the exemption from review letter, which is based solely on this
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		122				124
1	only entity incurring the exp	enditures related to	1		tated there, correct, under the	18
2	the health service, then Miss	sion is the only entity	2		Yes, the first paragraph under	er the table on Page
3	that needs to be an applicant		3		75.	
4	A. If the application satisfies t	us that Mission,		_	And then you go-the-the n	
5	identified as the only applica	1	5		he finding about start-up exp	enses?
6	, entity incurring an obligation				Correct	
7	institutional health service, t	i i		-	And the-there's a conclusio	I i
8	entity that has to be identified	3	8		easonable to assume there w	- 1
9	Q. Where do you look when e		9		expenses associated with the	development of a new
10	the CON law, or rules, or ca	E .	10		campus?	
11	what to include as a cost of	the applicant versus	11		Correct	
12	the developer?		12	~	And utilities and insurance	1
13	A. Well, in terms of what cos		13		examples. Utilities and insur	ŧ
14	now look to the Mission As	E .	14		typically considered start-up	· · · · ·
15-	Agency decision and the Co		15	Α.	Well, they are by the CON	i
16	As for the authority that—or	i	16		building, before you can get	
17	anyone incurring an obligat	l l	17		you can treat patient number	
18	shall offer or develop a new	i	18		electricity and water, and you	- :
19	service without first obtaini		19		that. So I don't know who m	
20	need from the Department.	1	20		the CON-certainly, the Assi	
21	new institutional health ser	•	21		it to be one of the start-up ex	-
22	new institutional health ser	l I	22	-	Okay. You didn't consider	· · ·
23	following, including things	3	23		in the review of the new repl	acement facility in
24	by any person of a capital e	expenditure exceeding \$2	24		Macon County?	
Marth	oa FrisoneVOLUME I	January 26, 2012	Martha	Fri	soneVOLUME I	January 26, 2012
Marth	oa FrisoneVOLUME I	January 26, 2012	Martha	Fri	soneVOLUME I	January 26, 2012 125
		123				125
. 1	million to develop or expan	123 nd a health service or a	1		And that may have been an	125 error on our part. I
1 2	million to develop or expan	123 nd a health service or a hich relates to the	1 2		And that may have been an don't know. Iremember, I	125 error on our part. I
1 2 3	million to develop or expanion health service facility or with provision of a health service.	123 and a health service or a hich relates to the ce. And it goes on and	1 2 3	A.	And that may have been an don't know. Iremember, I what the application said.	125 error on our part. I told you I don't know
1 2 3 4	million to develop or expanded health service facility or we provision of a health service on. So what we're looking	123 and a health service or a hich relates to the ce. And it goes on and at is, who is incurring	1 2 3		And that may have been an don't know. Iremember, I what the application said. And utilities and insurance	125 error on our part. I told you I don't know are not among the
1 2 3 4 5	million to develop or expansion health service facility or we provision of a health service on. So what we're looking an obligation that meets or	nd a health service or a hich relates to the ce. And it goes on and a at is, who is incurring the of these many	1 2 3 4 5	A.	And that may have been an don't know. Iremember, I what the application said. And utilities and insurance examples given on the CON	125 error on our part. I told you I don't know are not among the
1 2 3 4 5 6	million to develop or expanded health service facility or we provision of a health service on. So what we're looking an obligation that meets or definitions of new institutions.	nd a health service or a hich relates to the ce. And it goes on and a tis, who is incurring ne of these many ional health service.	1 2 3 4 5	A. Q.	And that may have been an don't know. Iremember, I what the application said. And utilities and insurance examples given on the CON section, though, correct?	error on our part. I told you I don't know are not among the application form for that
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1 2 3 4 5 6 7 8	million to develop or expanded health service facility or well provision of a health service on. So what we're looking an obligation that meets or definitions of new institutions of new institutions of the service of	nd a health service or a thich relates to the ce. And it goes on and g at is, who is incurring the of these many ional health service. one—I don't think this then there's the	1 2 3 4 5 6	A. Q.	And that may have been an don't know. Iremember, I what the application said. And utilities and insurance examples given on the CON section, though, correct?	error on our part. I told you I don't know are not among the application form for that in the CON example of the types of
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	2	Mantha	Fri.soneVOLUME I January 26, 2012
Martha		Martha	18
	126		128
1	been an issue.	1.1	me. I mean, yes, it's an existing service in
⁻ 2	Q. Can you give me an example?	2	Asheville, but that building doesn't exist. So
3	A. No, I can't recall anything specific.	3	before they can-and it's going to be licensed as
4	Q. There would not be start-up expenses, such as	4	part of the hospital. So to have the Construction
5	training of staff for relocation, correct?	5	Section come in and look at it, it's going to have
6	A. There could be.	6	to have power and water. And to have power and
7	Q. If the staff is looking to moving from one place to	7	water, it's got to be hooked up to those utilities,
8	another doing the same job, why would they need to	. 8	which means the deposits have to be paid, and
9	be retrained?	9	you're incurring costs.
10	A. You might have new staff you might have to train.	10	Q. Would you look with me at Section IX of the
11	I mean, I—we did not suggest that was one of the	11	application, the start-up and initial expenses
12	things omitted, but what I won't agree to is that	12	section that's on Page 106 of the application?
13	it might never be. It could, under the right	13	A. Okay.
14	circumstances.	14-	Q. And the Question 1a asking for start-up expenses
15	Q. We talked about this a little bit earlier, but	15	has in parenthesis underneath, "Expenses incurred
16	there's not a definition anywhere of start-up	16	prior to operation, such as staff training,
17	expenses, right, other than what you include as	17	inventory, et cetera"?
18	examples in the application form?	18	A. Yes.
19	A. Not in the CON law or rules, there's no definition.	19	Q. If Mission was bringing inventory supplies over
20	Q. Is there an Agency decision holding that utilities	20	from the main hospital to be available on the first
21	or insurance constitute start-up expenses?	21	day of operation, you would not expect there to be
22	A. What do you mean by an Agency decision?	22	any inventory expense as a start-up cost, correct?
23	Q. A decision or findings or-	23	A. Those are examples. That's why we have "et
24	A. I-	24	cetera." In this case, the problem is how are-
L			
Marth	FrisoneVOLUME T January 26, 2012	Marth	a FrisoneVOLUME I January 26, 2012
Marth	a FrisoneVOLUME I January 26, 2012	Martha	a FrisoneVOLUME I January 26, 2012
Marth	127		129
Marth:	Qdeclaratory ruling or	1	129 where's the money going to come from to pay for the
1 2	Qdeclaratory ruling or A. I don't know. I mean, I have looked at start-up	1 2	where's the money going to come from to pay for the electricity and the water that has to be present in
1	Qdeclaratory ruling or A. I don't know. I mean, I have looked at start-up costs before. I'm pretty sure anytime it was a new	1 2 3	where's the money going to come from to pay for the electricity and the water that has to be present in the building before it can be ever be passed off by
1 2	Qdeclaratory ruling or A. I don't know. I mean, I have looked at start-up costs before. I'm pretty sure anytime it was a new building that I've looked to see what was	1 2 3	where's the money going to come from to pay for the electricity and the water that has to be present in the building before it can be ever be passed off by Licensure. That is not a definition. It is not
1 2 3	Qdeclaratory ruling or A. I don't know. I mean, I have looked at start-up costs before. I'm pretty sure anytime it was a new building that I've looked to see what was projected. Because if you're going to start a	1 2 3 4 5	where's the money going to come from to pay for the electricity and the water that has to be present in the building before it can be ever be passed off by Licensure. That is not a definition. It is not meant to be an exhaustive list. It's an example of
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1	aftention.	1	obligation for a new institu	tional health service,
2	O. Why don't you keep notes in those meetings in case	2	because there's totally insur	fficient information to
3	you need them for the review?	3	determine otherwise.	ntasth
4	A. I don't need them for the review, because anything	4	Q. If you'll turn with me now	to Page 687 of the
5	they said in the pre-app-it's what's in the	5	findings, Ms. Frisone, the l	ast finding of
6	application, not what they said in the pre-app.	6	nonconformity relates to C	riterion 18a; is that
7	And that cuts both ways. I don't use it against	7	correct?	William Control of the Control of th
8	them either when they change something in the	8	A. Correct.	Elist Rea
9	application. A lot of times, at the pre-app stage,	9	Q. The determination of non	conformity with Criterion
10	they don't really know for sure all the details of	10	18a is based on the finding	s under Criteria 3, 4,
11	what the project will look like.	11	5, and 6, correct?	17. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18
12	Q. So if an applicant reflects in the application that	12	A. That's not how I would ci	naracterize that. Based on
13	it's doing what it understood it should be doing	13	the finding that the propos	al wasthat the
14	from the pre-app, then you just take them at face	14	applicant did not adequate	ly demonstrate the
15	value?	1,5	proposal was cost effective	e, and if you will—to
16	A. Well, it depends on whether their understanding is	16	learn more about why we	believe that, then you have
17	correct, because I've seen people attribute	17	to go and look at all of wh	at was said in Criteria
18	statements to me in their applications that I know	18	3, 4, 5, and 6. But the fine	ling of nonconformity
19	are not correct. It's not what I said.	19	with respect to Criteria 3,	4, 5, and 6 is not the
20	Q. The discussion we had earlier with regard to the	20	basis for finding it noncor	aforming with 18a. We
21	Exhibit 29 costs, you referenced Section-Criterion	21	find it nonconforming wit	h 18a because we don't
-22	12; is that right?	22	believe the applicant adeq	uately demonstrated the
23	A. Yes.	23	proposal was cost effective	e.
24	Q. The Agency's finding of nonconformity with	24	Q. You didn't give any reas	ons other than to say "See
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1	Criterion 12 is based solely on this question you	1	Criteria 3, 4, 5, and 6" the	5
2	had about whether the developer should be an owner	l	A. Well, we could have rep 5, and 6 here, but those se	eated all of what's in 3, 4,
3	and whether all costs are included that needed to	3	reasons we believe the ap	
4	be included?	5	demonstrate that it's cost	· · · · · · · · · · · · · · · · · · ·
5	A. I wouldn't characterize it—yes, this is the issue.	6		errent reasons given for the
6	But the issue is, what is this 60/40 percent	7	•	under Criterion 18a than
7	ownership adjustment. We don't know what it is.	i	provided elsewhere in the	
8	We don't have enough information about it. And we	9	MR. JOHNSON: Ob	
9	lack the information in the application that would	10	A. I have to disagree with	
10	assure us that the developer is not incurring any	11	believe that we ever say i	
11	costs which are a new institutional health service. O. And—and that's not my question really. My	12	criteria that the applicant	·
12		13	demonstrate that it's a co	· · · · · · · · · · · · · · · · · · ·
13	question is, there's only one basis for your	14	We actually say in 4 that	
14	finding of nonconformity under Criterion 12?	15	effective alternative. We	
15	A. You phrased it differently. There's-that-what	16	anything about cost. Bu	
1	The last managinal is the books. I don't be our if	1 40	those criteria are the sam	
16	~	177		e reasons why were
16 17	you want to call that one or two. I mean, I don't	17		
16 17 18	you want to call that one or two. I mean, I don't want to quibble about it, but this iswhat it says	18	concluding that they dor	't adequately demonstrate
16 17 18 19	you want to call that one or two. I mean, I don't want to quibble about it, but this iswhat it says here in 12, this is the basis. If you want to call	18 19	concluding that they dor that it would be cost effe	t't adequately demonstrate ective.
16 17 18 19 20	you want to call that one or two. I mean, I don't want to quibble about it, but this iswhat it says here in 12, this is the basis. If you want to call that one issue, okay, one issue with two subparts,	18 19 20	concluding that they dor that it would be cost effe Q. So I think I don't under	t adequately demonstrate active. stand why you're
16 17 18 19 20 21	you want to call that one or two. I mean, I don't want to quibble about it, but this iswhat it says here in 12, this is the basis. If you want to call that one issue, okay, one issue with two subparts, two issues. But, essentially, it boils down to the	18 19 20 21	concluding that they don that it would be cost effe Q. So I think I don't under disagreeing with me, I g	a't adequately demonstrate active. stand why you're uess. Based on what you
16 17 18 19 20 21 22	you want to call that one or two. I mean, I don't want to quibble about it, but this iswhat it says here in 12, this is the basis. If you want to call that one issue, okay, one issue with two subparts, two issues. But, essentially, it boils down to the costs were adjusted with this 40/60 percent split,	18 19 20 21 22	concluding that they dor that it would be cost effe Q. So I think I don't under disagreeing with me, I g said, we're in agreement	I't adequately demonstrate active. stand why you're uess. Based on what you that the reasons that you
16 17 18 19 20 21	you want to call that one or two. I mean, I don't want to quibble about it, but this iswhat it says here in 12, this is the basis. If you want to call that one issue, okay, one issue with two subparts, two issues. But, essentially, it boils down to the costs were adjusted with this 40/60 percent split, don't know what it means, and it raises questions	18 19 20 21	concluding that they dor that it would be cost effe Q. So I think I don't under disagreeing with me, I g said, we're in agreement gave under Criteria 3, 4,	I't adequately demonstrate active. stand why you're uess. Based on what you that the reasons that you

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1	Criterion 18a?	1	developer builds a medical office building, and for
2	A. I wouldn't express it that way. I would-the way I	2	example, puts in an extra large air handler because
3	express it is we've made a-we're looking in 18a	3	the developer knows there will be a healthcare
4	for the impact on competition in terms of cost	4	provider there, is that a cost that is a cost of
5	effectiveness, quality, and access. We don't have	5	the developer or the cost of the provider of the
6	any issues, that I can recall, with respect to	. 6	service?
7	quality or access. But we don't believe the	7	A. That's not the issue as to whether it's a cost of
8	project would have a favorable impact on cost	8	the developer or a cost of the provider of the
9	effectiveness. And we say it sort of in an	9	service. It's a question ofand I would have to
10	alternate way, that we don'tdidn't adequately	10	look at the Mission Asheville Hematology final
11	demonstrate the proposal is cost effective. If you	11	Agency decision before I would make any
12	want to know more about why we feel that way, why	12	determination on it as to whether that—but—but
13	we concluded that, just look at what we said in	13	for the new institutional health service, would you
14	Criteria 3, 4, 5, and 6. And arguably, we could	14	need that air handler, then some of that cost might
15	have included 12.	15	be attributed to the-I don't know. I don't recall
16	Q. Your finding under Criterion 18a does not refer to	16	the specifics of the Mission Asheville Hematology
17	competition at all, correct?	17	final Agency decision well enough at this point. I
18	A. Our finding doesn't use the word "competition," but	18	would never try to make that decision without
19	we're responding to what Criterion 18a requires an	19	actually looking at that-at thethose two
20	applicant to do. So even though we don't use the	20	documents.
21	word, that's where we're coming from.	21	Q. I'm not trying to pin you down on the air handler
22	Q. So cost effectiveness and competition mean the same	1	versus something else. I was just trying to give a
23	thing?	23	concrete example. But in that instance, thethe
24	A. No. What Criterion 18a says is, including how any	24	health service provider would not be paying for the
24		 	
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1	enhanced competition will have a positive impact	1	extra air handler directly.
2	upon the cost effectiveness, quality, and access to	2	A. And that'sthat's
3	the services, so that's how we evaluate that	3	Q. Is that part of your analysis?
4	possible enhanced competition, in terms of cost	4	A. But that's-I guess that's part of the problem with
5	effectiveness, quality, and access.	5	the approach you are taking. It's not about who
6	Q. Are there any additional reasons that the CON	6	the legal entity is who incurs the cost. It's not
7	Section has for disapproving Mission's application	7	if you're a developer, you're never incurring an
8			
9	that are not included in the Agency findings?	8	obligation for a new institutional health service,
	that are not included in the Agency findings? A. No, every reason we have has been provided in the	8 9	
ı	A. No, every reason we have has been provided in the	}	obligation for a new institutional health service,
10	 A. No, every reason we have has been provided in the findings. 	9	obligation for a new institutional health service, but if you're a provider, you always are. It's about whether the cost should be allocated to or-
10	A. No, every reason we have has been provided in the findings. MS. HARRIS: I think I'm getting close to the	9	obligation for a new institutional health service, but if you're a provider, you always are. It's
10 11 12	A. No, every reason we have has been provided in the findings. MS. HARRIS: I think I'm getting close to the end of my questions. I'll take a short break here	9 10 . 11	obligation for a new institutional health service, but if you're a provider, you always are. It's about whether the cost should be allocated to or- or counted as part of that new institutional health
10 11 12 13	A. No, every reason we have has been provided in the findings. MS. HARRIS: I think I'm getting close to the end of my questions. I'll take a short break here and—	9 10 . 11 . 12	obligation for a new institutional health service, but if you're a provider, you always are. It's about whether the cost should be allocated to or- or counted as part of that new institutional health service. That's the issue for us, is what costs
10 11 12 13 14	A. No, every reason we have has been provided in the findings. MS. HARRIS: I think I'm getting close to the end of my questions. I'll take a short break here and— THE WITNESS: Okay.	9 10 . 11 . 12 . 13	obligation for a new institutional health service, but if you're a provider, you always are. It's about whether the cost should be allocated to or- or counted as part of that new institutional health service. That's the issue for us, is what costs need to be counted and what costs don't. Then w
10 11 12 13 14 15	A. No, every reason we have has been provided in the findings. MS. HARRIS: I think I'm getting close to the end of my questions. I'll take a short break here and— THE WITNESS: Okay. MS. HARRIS: —make sure I can wrap it up	9 10 11 12 13 14	obligation for a new institutional health service, but if you're a provider, you always are. It's about whether the cost should be allocated to or-or counted as part of that new institutional health service. That's the issue for us, is what costs need to be counted and what costs don't. Then w worry about who's incurring what. So I always start with, what are the costs and whether they
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January 26, 2012 Martha Frisone--VOLUME I January 26, 2012 Martha Frisone--VOLUME I 140 138 clearly, concisely, and not with inconsistencies, 1 application as submitted. 1 2 Q. If the-changing gears, if the Construction Section 2 that the developer will actually pay the 3 has--has said, or in the future says, it would 3 subcontractors for the work, but that extra cost will be passed on to them in the lease payment. 4 approve plans where a bathroom or a closet for the 4 5 endoscopy suite is across the county line, would And I think we have found that to be an acceptable 5 6 you yield to--or defer to the Construction Section? explanation, that in reality, yes, the developer is 6 7 A. I--I don't believe that the Construction Section is going to pay the bills because it's perhaps more 7 8 even the appropriate section to make a decision effective for them to do it that way because 8 9 about whether some portion of the space is across 9 they're the ones that have the contractual county lines. That's for Azzle Conley to decide, obligation between them and the subcontractor and 10 10 not for the Construction Section to decide. not the eventual tenant. But the problem with the 11 11 12 Well, if the Licensure Section and the Construction Mission GI South application is we don't have that 12 level of detail to explain. I cannot stress enough 13 Section both said it was okay, would you yield to 13 14 that and--and--I am not saying that the developer is developing a 14 MR. JOHNSON: Object to form. 15 new institutional health service and should be an 15 applicant. I'm saying we don't have enough 16 --approve--I mean, approve the application, 16 assuming all other issues were addressed? 17 17 information to determine that the developer is not. 18 -A. If--if Azzie Conley were to say that that's okay, It's a lack of information that assures us that the 18 then, yes, I would defer--not yield, I guess that's developer's costs are just what you'd expect anyone 19 19 probably why my counsel is objecting, that word--I 20 developing a building that you're going to lease 20 certainly would defer to Ms. Conley, because it's space in to incur-footings, foundation, roof, and 21 21 22 not my rule to enforce; it's Ms. Conley's rule. so forth, and you will need HVAC. But we don't 22 23 Would you consider the Construction Section's input know enough about who is incurring what or-or even 23 24 irrelevant? 24 what the costs are to figure out if all of the Martha Frisone--VOLUME I January 26, 2012 January 26, 2012 Martha Frisone--VOLUME I 141 139 On that particular issue, yes. They may be costs that amount to that new institutional health 1 service have been included. reviewing from the point of view of the bathroom 2 Q. Have you assessed whether an upfit allowance that's can be across the hall, but it's not their rule to 3 3 4 reflected in a lease from a-an office developer to interpret or imply either. It's not a life safety a medical service provider is considered an 5 issue. It's a licensure rule with respect to 5 operating cost or a cost that should be 6 hospitals. It requires their services that are 7 attributable to the provider's capital costs? under their license to be in the same county. A. We evaluate each one based on all the information 8 Q. Did you check with Azzie Conley or anybody at the provided to us, so it kind of depends on what they 9 Licensure Section about the particular question you 9 say about it and how they describe it. 10 10 had about part of the space being over the county Q. So sitting here today, you don't have a position 11 line? 11 12 one way or the other about whether an upfit 12 A. No. allowance should be considered an operating cost or 13 Do you know if Ms. Miles did? 13 a capital cost? 14 14 A. No, I don't know whether she did or not. 15 A. I don't know. It depends. I mean, I don't know--I 15 Did you ask her to? 16 have not-again, I come back to what's in the I don't recall asking her to. 16 A. Mission GI South application is not sufficient for 17 MS. HARRIS: I believe those are all of my 17 me to know who's incurring what costs and whether 18 questions. Thank you for your time. Do you have 18 the developer is incurring-and whether--what it's 19 19 any questions? done is it's cast doubt on that capital cost is 20 20 MR. JOHNSON: No. 21 that all of the costs necessary to make that space 21 function as space licensable as a hospital for the 22 (THE DEPOSITION ADJOURNED AT 3:06 P.M.) 22 23 performance of GI endoscopy services. I can't 23 tell. There is insufficient information in that 24

attached errata sheet, if any.

(SIGNATURE OF MARTHA FRISONE)

STATE OF ______

COUNTY OF _____

Subscribed and sworn to before me this day of ______, 2012

MY COMMISSION EXPIRES:

NOTARY PUBLIC

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Transcript of the Testimony of Martha Frisone

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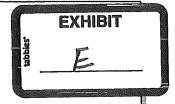
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Transcript of the Testimony of Craig Smith

Date: February 23, 2012 **Volume:** I

Case: Mission Hospital, Inc. v. NCDHHS, et al.

Printed On: April 30, 2012

Carolina Reporting Service

Phone: 919-661-2727

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Email: pbarbee@carolinareportingservice.com

	STATE OF NORTH CAROLINA		IN THE	OFFI	CE OF	
		ADM	INISTRAT	'IVE F	HEARING	3S
	COUNTY OF BUNCOMBE		11 DHF	1163	36	
	MISSION HOSPITAL, INC.,)				
	•)				
	Petitioners,)				
	v.)				
)				
Æ	N.C. DEPARTMENT OF HEALTH AND)				
	HUMAN SERVICES, DIVISION OF)	DEI	POSIT	ION	
	HEALTH SERVICE REGULATION,)				
	CERTIFICATE OF NEED SECTION,)		OF		
)				
	Respondent,),	CRAIG	R. SI	HTIM	
	and)				
)				
	HENDERSON COUNTY HOSPITAL)				
	CORPORATION d/b/a MARGARET R.	·)				
	PARDEE MEMORIAL HOSPITAL;)				
	FLETCHER HOSPITAL, INC. d/b/a)				
	PARK RIDGE HEALTH; and CAROLINA)				
	MOUNTAIN GASTROENTEROLOGY)				
	ENDOSCOPY CENTER, LLC,)				
)				
	Respondent-Intervenors	.)				

THURSDAY, FEBRUARY 23, 2012

10:02 A.M.

AT THE OFFICES OF

SMITH MOORE LEATHERWOOD LLP

434 FAYETTEVILLE STREET

TWO HANNOVER SQUARE, SUITE 2800

RALEIGH, NORTH CAROLINA

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	APPEARAN	CES				STIPULATIONS			
	ON BEHALF OF THE PETIT	ΓΙΟΝER:				PRIOR TO THE EXAMINATION	ON OF THE WITN	IESS, C	COUNSEL
	TERRILL JOHNSON SMITH MOORE LEA 300 N. GREENE STR GREENSBORO, NOF	ATHERWOOD LLP LEET, SUITE 1400			8	FOR THE PARTIES STIPULA 1. Said deposition shall be tak of discovery or for use as evidence action or for both purposes, as perm aw;	TED AND AGREE en for the purpose in the above-entitle hitted according to	ED AS	FOLLOW
	ON BEHALF OF THE RESP JOEL L. JOHNSON, ASSISTANT ATTOR NORTH CAROLINA 114 W. EDENTON S' RALEIGH, NORTH CON ON BEHALF OF THE RESP CANDACE S. FRIEL NELSON MULLINS 380 KNOLLWOOD S WINSTON-SALEM, ALSO PRESENT: BRIAN MOORE KRISTY SINK (VIA	ESQ. INEY GENERAL DEPARTMENT O TREET CAROLINA 27603 PONDENT-INTERV , ESQ. RILEY & SCARBO STREET, SUITE 53 NORTH CAROLIN TELEPHONE)	VENORS: OROUGH I 80 NA 27103		1	2. Any objections of any party notice of the taking of said deposition and place thereof or as to the compute of the taking of said deposition to the questions strike answers need not be made dustrike answers need not be made for the progress of the trial of this case or a hearing held before the judge for the thereon or at any other hearing of sideposition might be used, except ar form of a question must be made at is asked or objection is waived as to question; 4. That all formalities and registantly waived are hereby waive the right to move for the rejection observe trial for any irregularities in same, either in whole or in part or 5. That the undersigned notar personally deliver or mail by first-transcript of this deposition to the j deposition or his attorney, who sha court's copy; and 6. That the witness reserves the and sign the transcript of this deposition of his deposition or his attorney, who sha court's copy; and	on or as to the time etency of the person are hereby waive and motions to ring the taking of the first time during it may pre-trial e purpose of ruling aid case at which as a objection as to the the time such questo the form of the quirements of the ies not herein d, especially includ of this deposition the taking of the for any other cause; yy-reporter shall class mail the party taking the all preserve it as the the right to read	nd; nis the sid tion	
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1	Α.	I'm responsible for the overall management of the	1	Q.	Did you review any other documents or have any oth
2		pertificate of need program in the State of North	2 .		conversations to prepare for your deposition other
3		Carolina. And duties involve working with other	3	1	than with counsel?
4		ections of the Division withwhen the questions	4	A.	The materials I reviewed were done in the presence
5		come up that have mutual concern, working with the	- - 5		of counsel.
6		n particular, working with the Medical Planning	6	O.	I won't ask you about your conversations with
7		oranch in the implementation of the current State	7	`	counsel, but I will ask what documents you reviewed
8		Medical Facilities Plan and the development of the	8		other than the excerpts of Ms. Frisone's deposition?
9		next State Medical Facilities Plan. We have two	9		I reviewed a letter from Ms. Gunter concerning the
10		team leader positions which are now vacant. Team	10		exemption that was granted for the medical office
		eaders were envisioned to review most of theor at	11		building.
11	-	least a significant portion of the decision	12	Q.	What's the date on the letter from Ms. Gunter?
12		findings. We no longer have that option, so we're	13	A.	I don't recall.
13		back to the mode that we did for most of my tenure	14	Q.	Was it submitted during the review?
14		in the Section, where the Chief and the Assistant	15	Q. A.	
15		Chief divide up the reviews, and it's based on	16	Q.	What was the substance of Ms. Gunter's letter?
16		The state of the s	17	-	Ms. Gunter believed the exemption may have been
1.7		knowledge and availability. It's also based on other factors involving the workload, such as the	18	2 h.	granted in error.
18		current contested case schedules, depositions, other	19	0	Did she make a specific request in her letter to
19			20	ζ.	reconsider?
20		meetings. At the time the decision we're talking about today	21	Δ	I believe she did.
21		At the time the decision were talking about today	1 21	. 21.	
0.0			. 22	Ω	Was-rdid the letter show a conv to counsel for
22		was made, were therewere there team leaders in	22	Q.	Wasdid the letter show a copy to counsel for admission?
23		was made, were therewere there team leaders in place? That was in	22 23 24		Wasdid the letter show a copy to counsel for admission? II didn't commit it to memory.
23 24	Α.	was made, were therewere there team leaders in place? That was in No.	23 24	Α.	admission? II didn't commit it to memory.
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23 24	Α.	was made, were therewere there team leaders in place? That was in No. thVOLUME I February 23, 2012	23 24 Craig	A.	admission? II didn't commit it to memory. ithVOLUME I February 23, 2012 Okay. Have you responded in any way to Ms. Gunt
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1	Q.	(By Ms. Harris) So you told me that you review	ved Ms.	1		County, a nursing home review in Watauga County.
2		Gunter's letter and the excerpts of Ms. Frisone's	.	2	•	Those are among the more recent.
3		deposition. Did you look at the Agency file for	the	3	Q.	And you were the supervisor?
4		Mission GI application in preparation for your		4	A.	Yes.
5		deposition?		5	Q.	Okay. What about specifically in Buncombe or
6	A.	I believe I may have looked at just the findings		6		Henderson Counties, have you reviewed-
7		portion of the findings.		7		I may have been the one that reviewed the acute c
8	Q.	Do you recall the portion?		8		beds that was submitted about the same time as this
9	A.	Criterion 3, I believe.	İ	9		application.
10	Q.		you	10	-	The public hearing for the acute care bed was held
11		had in reviewing the findings under Criterion 3?	1	11		in conjunction with the GI application, is that
12	A.	I was just reviewing the portion of the analysis		12		right?
13		thethe need conformity.		13	Α.	Yes.
14	0	. I understand from discovery responses that you	u had	14	Q.	Did you attend that public hearing?
15	~.	some input into the discussion in the findings	1	15	A.	No.
16		regarding the inmigration; is that correct?		16	Q.	I didn't say this at the beginning, because I know
17	A		1	17		you've been deposed many times, but if you need a
18		Did you contribute any edits or portions of the		18		break, will you let me know?
19	Q	findings when they were being prepared?	.	19		Sure thing. And if you don't understand one of my questions,
20	٨	. I basically commented that I didn't have a prol	olem	20	Q.	
	А	with their-their decision on that particular issue	- 1	21	٨	will you ask me to repeat or rephrase? Yes.
21	_	Do you know why they sought out your input	- 1	22		Did your review of the acute care bed application
22 23	Q	particular issue?	on man	23 24	Ų.	for Mission in 2011 involve any study of traffic
						
Crai	g Si	mithVOLUME I February 23,	2012	Craig	Sm	ithVOLUME I February 23, 2012
			11			13
1	A	A. Often, if there are issues that affect the		1		patterns or how people may travel to particular
2		conformity with the review criteria, I'll be		2		services in the county?
3		consulted. Additionally, I wasmy first ass	ignment	3	A.	Mymy review did not.
4		was, for those six years, was a project analy	st in	4	Q.	
5		HSA I.		5		applications for services or equipment in Hender
6	(Q. So you were assigned to HSA I, which inc	ludes	6		County in the last three years?
7		Buncombe and Henderson County in the		7	A	
8	A	A. Yes.		8		the nursing home from Fletcher Academy to a
9	(Qduring the time you served as project and	alyst?	9		different site to the west of that area but still in
10	1	A. 1988 to 1994, yes.		10		northern Henderson County.
11	(Q. Have you served in any official role or been	en	11	Q	. I'm not familiar with that application. There's a
12		assigned to that area since 1994?	.	12		applicant proposing to relocate an entire nursing
13	٠.	A. No.		13		home?
1.4		Q. Have you been the reviewer or Assistant (14	A	
15		Chief assigned to review projects in HSA I	in the	15	Q	•
16		last three years?		16		other or a different part of the county?
17		A. The assignments to review projects are no		17	Α	-
18		based on geography, but II have reviewed	l project			the direction of Mills River. I'm not sure if it
19		in HSA I.	, 1	19		technically qualifies as Mills River or not, but-
20		Q. What is the most recent project you think		20	Ç	•
21		reviewed in HSA I? And you don't have to	give m		Α	Well, Fletcher Academy is oneis the co-appli
22		the exact date obviously.		22		and that's thethe owner of the building. And it
		A. Well, we justwe just did a dialysis revie	w in	23		the current operator that's working in conjunction
23		A. Well, we justwe just did a dialysis review in Cat		24		with them.

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		14			16
1	Q.	When is the deadline for rendering a decision in	1		I don't believe I reviewed the findings, but I
2		that review?	2		believe we discussed the issue. I think the
3	A.	Next month.	3		comments were filed.
4	Q.	Is that the 90-day or 150-day?	4	Q.	Comments were filed against the application?
5	A.	150-day.	5		II believe comments were filed and possibly a
6	Q.	Did you conduct the public hearing for that	6		public hearing requested.
7		application?	7	Q.	Is it correct that the local hospital opposed and
8	A.	No, I did not.	8		filed the comments regarding the relocation of the
9	Q.	Who was the analyst on that review?	9		endoscopy center closer to the hospital?
10	A.	The analystthe public hearing was actually	10	A.	I believe that's the case, but Iwell, let's see.
11		conducted by Greg Yakaboski, but the review is being	11 g		This is in '09. Let's see. The decision was made
12	ŧ	done by Bernetta Thorne-Williams.	12	_	two years ago this month.
13	0	Are you evaluating roadways and traffic patterns as	13	Q.	So it's not fresh in your mind?
14	۷.	part of the review in that case?	14	Α.	It's not fresh in my mind.
15	Ä.		15	Q.	Okay. If you'll look, Mr. Smith, on Page 5 of the
16	71.	relocation on the population that's currently being	16		findings in Exhibit 5 that you have in front of you
17		served and the population that-and the community a	17 s		there's a finding of conformity with Criterion 3a,
18		a whole. And since thethe decision is not final,			and a comment in the discussion under 3a that the
i		I'd rather not discuss the specifics, because we	19		new facility would be more centrally located near
19		don't like to give information that could be used in	20		Angel Medical Center and other physician office
20		any way to forecast a decision.	21		practices?
21	_		22	Α.	
22	Q	• •	1	Q.	
23		end of March?	24		of how the relocation would impact Angel Medic
Craig	יוי פי	withVOLUME I February 23, 2012	1		
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1		15	Craig	Sm:	
1 2		15 . Middleby the end of March. It could be issued		Sm:	17
2	A	15 . Middleby the end of March. It could be issued sooner.	1 2.	Sm.	17 Center. Do you recall discussing the impact on the
2 3		 15 Middleby the end of March. It could be issued sooner. And I'mI'm not asking about the decision that you 	1 2		Center. Do you recall discussing the impact on the existing providers as part of the review or your
2 3 4	A	15 . Middleby the end of March. It could be issued sooner And I'mI'm not asking about the decision that you expect to make in that case, I'm just trying to get	1 2 3		Center. Do you recall discussing the impact on the existing providers as part of the review or your consideration in 2009?
2 3 4 5	A	Middleby the end of March. It could be issued sooner. And I'mI'm not asking about the decision that you expect to make in that case, I'm just trying to get an idea of the considerations with regard to moving	1 2 3 4		Center. Do you recall discussing the impact on the existing providers as part of the review or your consideration in 2009? Well, they weren't planning to expand. They we
2 3 4 5 6	A	Middleby the end of March. It could be issued sooner. And I'mI'm not asking about the decision that you expect to make in that case, I'm just trying to get an idea of the considerations with regard to moving a service. Was the application to relocate the	1 2 3 4 5		Center. Do you recall discussing the impact on the existing providers as part of the review or your consideration in 2009? Well, they weren't planning to expand. They we just planning to move. And they're performing the required number of procedures. They're already licensed. I believe the gist of Angel's comments
2 3 4 5 6 7	A	Middleby the end of March. It could be issued sooner. And I'mI'm not asking about the decision that you expect to make in that case, I'm just trying to get an idea of the considerations with regard to moving a service. Was the application to relocate the nursing home in Fletcher filed after your decision	1 2 3 4 5 6		Center. Do you recall discussing the impact on the existing providers as part of the review or your consideration in 2009? Well, they weren't planning to expand. They we just planning to move. And they're performing the required number of procedures. They're already licensed. I believe the gist of Angel's comments wereas I recall now, was that they didn't want up to the second of the seco
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2 3 4 5 6 7 8 9	A Q	Middleby the end of March. It could be issued sooner. And I'mI'm not asking about the decision that you expect to make in that case, I'm just trying to get an idea of the considerations with regard to moving a service. Was the application to relocate the nursing home in Fletcher filed after your decision regarding the Mission GI application? I believe it would have been.	1 2 3 4 5 6 7 8 9		Center. Do you recall discussing the impact on the existing providers as part of the review or your consideration in 2009? Well, they weren't planning to expand. They we just planning to move. And they're performing the required number of procedures. They're already licensed. I believe the gist of Angel's comments wereas I recall now, was that they didn't want up to the second of the seco
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2 3 4 5 6 7 8 9 10	A	Middleby the end of March. It could be issued sooner. And I'mI'm not asking about the decision that you expect to make in that case, I'm just trying to get an idea of the considerations with regard to moving a service. Was the application to relocate the nursing home in Fletcher filed after your decision regarding the Mission GI application? I believe it would have been. Yes. 120-day application would have been filed in October.	1 2 3 4 5 6 7 8 9		Center. Do you recall discussing the impact on the existing providers as part of the review or your consideration in 2009? Well, they weren't planning to expand. They we just planning to move. And they're performing the required number of procedures. They're already licensed. I believe the gist of Angel's comments wereas I recall now, was that they didn't want us to approve it, because it didn't have a certificate of need initially before it got licensed. It was not required to because of the provisions in the law.
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2 3 4 5 6 7 8 9 10 11 12 13 14 15	A Q	Middleby the end of March. It could be issued sooner. And I'mI'm not asking about the decision that you expect to make in that case, I'm just trying to get an idea of the considerations with regard to moving a service. Was the application to relocate the nursing home in Fletcher filed after your decision regarding the Mission GI application? I believe it would have been. Yes. 120-day application would have been filed in October. Are you familiar with the decision that was made with regard to moving a GI endoscopy room in MacCounty from one location to another? Yes.	1 2 3 4 5 6 7 8 9 10 11 12 13 con 14 15 16	A. Q	Center. Do you recall discussing the impact on the existing providers as part of the review or your consideration in 2009? Well, they weren't planning to expand. They we just planning to move. And they're performing the required number of procedures. They're already licensed. I believe the gist of Angel's comments wereas I recall now, was that they didn't want us to approve it, because it didn't have a certificate of need initially before it got licensed. It was not required to because of the provisions in the law. So itit was a grandfathered room, as youas you would say? Well, it wasn't really grandfathered, per se, because it had a procedure that's in the CON law
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2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18	A Q	Middleby the end of March. It could be issued sooner. And I'mI'm not asking about the decision that you expect to make in that case, I'm just trying to get an idea of the considerations with regard to moving a service. Was the application to relocate the nursing home in Fletcher filed after your decision regarding the Mission GI application? I believe it would have been. Yes. 120-day application would have been filed in October. Are you familiar with the decision that was made with regard to moving a GI endoscopy room in Mac County from one location to another? Yes. Okay. I've got the deposition exhibits that we've marked in the previous depositions, if you'd like to look. That particular one we marked as Deposition	1 2 3 4 5 6 7 8 9 10 11 12 13 con 14 15 16 17 18 19	A. Q	Center. Do you recall discussing the impact on the existing providers as part of the review or your consideration in 2009? Well, they weren't planning to expand. They we just planning to move. And they're performing the required number of procedures. They're already licensed. I believe the gist of Angel's comments wereas I recall now, was that they didn't want us to approve it, because it didn't have a certificate of need initially before it got licensed. It was not required to because of the provisions in the law. So it—it was a grandfathered room, as youas you would say? Well, it wasn't really grandfathered, per se, because it had a procedure that's in the CON law that allowed them to get licensed, and they did not grant them a certificate of need. But it—it was a specific procedure, so, I mean, it—I guess you
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2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	A Q	Middleby the end of March. It could be issued sooner. And I'mI'm not asking about the decision that you expect to make in that case, I'm just trying to get an idea of the considerations with regard to moving a service. Was the application to relocate the nursing home in Fletcher filed after your decision regarding the Mission GI application? I believe it would have been. Yes. 120-day application would have been filed in October. Are you familiar with the decision that was made with regard to moving a GI endoscopy room in Mac County from one location to another? Yes. Okay. I've got the deposition exhibits that we've marked in the previous depositions, if you'd like to look. That particular one we marked as Deposition Exhibit 5. As I recall, you were not the supervisor for that review; is that right?	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	A. Q	Center. Do you recall discussing the impact on the existing providers as part of the review or your consideration in 2009? Well, they weren't planning to expand. They we just planning to move. And they're performing the required number of procedures. They're already licensed. I believe the gist of Angel's comments wereas I recall now, was that they didn't want us to approve it, because it didn't have a certificate of need initially before it got licensed. It was not required to because of the provisions in the law. So itit was a grandfathered room, as youas you would say? Well, it wasn't really grandfathered, per se, because it had a procedure that's in the CON law that allowed them to get licensed, and they did not grant them a certificate of need. But itit was a specific procedure, so, I mean, itI guess you could say it grandfathered in a very loose sense of the word, but it did follow a specific procedure.
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	A Q	Middleby the end of March. It could be issued sooner. And I'mI'm not asking about the decision that you expect to make in that case, I'm just trying to get an idea of the considerations with regard to moving a service. Was the application to relocate the nursing home in Fletcher filed after your decision regarding the Mission GI application? I believe it would have been. Yes. 120-day application would have been filed in October. Are you familiar with the decision that was made with regard to moving a GI endoscopy room in Mac County from one location to another? Yes. Okay. I've got the deposition exhibits that we've marked in the previous depositions, if you'd like to look. That particular one we marked as Deposition Exhibit 5. As I recall, you were not the supervisor for that review; is that right?	1 2 3 4 5 6 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	A. Q	Center. Do you recall discussing the impact on the existing providers as part of the review or your consideration in 2009? Well, they weren't planning to expand. They we just planning to move. And they're performing the required number of procedures. They're already licensed. I believe the gist of Angel's comments wereas I recall now, was that they didn't want us to approve it, because it didn't have a certificate of need initially before it got licensed. It was not required to because of the provisions in the law. So itit was a grandfathered room, as youas you would say? Well, it wasn't really grandfathered, per se, because it had a procedure that's in the CON law that allowed them to get licensed, and they did not grant them a certificate of need. But itit was a specific procedure, so, I mean, itI guess you could say it grandfathered in a very loose sense of the word, but it did follow a specific procedure that was outlined in the law. Most grandfathered.
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	A A C	Middleby the end of March. It could be issued sooner. And I'mI'm not asking about the decision that you expect to make in that case, I'm just trying to get an idea of the considerations with regard to moving a service. Was the application to relocate the nursing home in Fletcher filed after your decision regarding the Mission GI application? I believe it would have been. Yes. 120-day application would have been filed in October. Are you familiar with the decision that was made with regard to moving a GI endoscopy room in Mac County from one location to another? Yes. Okay. I've got the deposition exhibits that we've marked in the previous depositions, if you'd like to look. That particular one we marked as Deposition Exhibit 5. As I recall, you were not the supervisor for that review; is that right?	1 2 3 4 5 6 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	A. Q	Center. Do you recall discussing the impact on the existing providers as part of the review or your consideration in 2009? Well, they weren't planning to expand. They we just planning to move. And they're performing the required number of procedures. They're already licensed. I believe the gist of Angel's comments wereas I recall now, was that they didn't want us to approve it, because it didn't have a certificate of need initially before it got licensed. It was not required to because of the provisions in the law. So itit was a grandfathered room, as youas you would say? Well, it wasn't really grandfathered, per se, because it had a procedure that's in the CON law that allowed them to get licensed, and they did not grant them a certificate of need. But itit was a specific procedure, so, I mean, itI guess you could say it grandfathered in a very loose sense of the word, but it did follow a specific procedure.

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1	Q.	Is that the procedure outlined in 2005 changes to	1		care homes, which are usually replacements of
2	`	the CON law or an earlier set of changes?	2		substandard facilities, a few nursing homes, mostly
3	Α.	It was the 2007 procedures. Let's see. Do you have	3		dialysis providers setting up satellite clinics as
4		the law?	4		they outgrow their current location, as the
5	Q.	The state of the s	5		nephrologists have done in the Buncombe County are
6	۷.	usually do. I looked the other day for another	6	Q.	And I guess, based on what you said, you're looking
7		reason, and it seemed like it was longer ago than I	. 7		to make sure that the patients or residents being
8	1	realized.	8		served at the original location aren't
9	٨	It may have been. It may have just seemedyeah,	9		disadvantaged
10	A.	and it probably was.	10	A.	Yes.
	Λ	It was the procedure whereby	11	Q.	overly by having to go to a different location?
11	Q.	A STATE OF THE STA	12		MS. FRIEL: Object to the form.
12	Α.	44 4 1 0001 1 0 0 1	13	Q.	Have you supervised the review of GI endoscopy
13	Q.	* *	14		applications that
14		the room?	15	Α.,	Yes.
15	Α.		16	Q.	applicants are seeking to relocate?
16	Q.	•	17	A.	Oh. Seeking to relocate? Mostly, I've reviewed new
17	Α.		18		ones.
18	Q.		19	Q.	Have you reviewed applications for GI services in
19		understanding your testimony, when you're relocating	g 20		Buncombe or Henderson Counties?
20		an existing service that's already licensed, there's	21	A.	No. Well, yes, the one that we did in 1993. The
21		not a requirement to examine the impact on the	22		I think it's the one with four or five rooms. It's
22		existing providers?	23		located near Asheville. That was one of the first
23		MS. FRIEL: Object to form.	24		endoscopy reviews the CON Section did.
Craig	g Sm	ithVOLUME I February 23, 2012	Craig	Sm	ithVOLUME I February 23, 2012
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1	A	. Not a requirementnothing specifically in the law	1	Q.	You've got a good memory.
2		or the rules, no.	2	A.	
3	Q		3		subsequent to that.
4	V	discretion to examine the impact on existing	4	· .	
5		providers for relocation of an existing licensed	5	۷.	application, do you ever review the application
6		service?	6		cover to cover?
7		MS. FRIEL: Object to form.	7	A.	
8	Α	. I'm trying to think of a specific example. I don't	8	Α.	large portion but usually some of the exhibits. The
9		recall us doing that.	9		application itself, I may come close, especially if
10	Q		10		it's a thinner application. But usually, when it
11	`	licensed service, youryou just typically review	1		gets to the exhibits, I would only target one or two
12		under Criterion 3 the need for the population	11		that are pertinent to the specific issues that have
13		proposed for the service in the new location; is	i		•
14		that what you're looking at?	13	_	been raised.
15	A	Well, yeah. We look to determine if the applicant	14	Q	. Do you rely on the analyst to raise particular
16		has demonstrated the need for the facility in that	15		issues with you?
17		location. And then we also look at the impact the	16	Α	•
18		relocation would have on the patients that current	1 40	_	might be aware of.
19		use the facility, the community as a whole. And i	n- 18	Q	
20		-especially if there is a negative impact, if there-	19		when you're supervising the review of an
21		-what that impact would be on the medically	20		application?
22		underserved. Typically, we discuss medically	21	Α	
23		underserved under Criterion 13. I was going to s		Ç	
1		youmostmost of our relocations have been add	ıl 23		correct?

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1	A. No. On one or two occasions, I have conducted the	1		applications coming in every other month.
2	public hearing. It's usually-I didthere was a	2		Generally, that's about when you're wrappingwhen
3	a health law seminar in Charlotte one year, and we	3		you're doing the public hearing is about when you're
. 4	had a public hearing we had to hold for a	4		trying to wrap up another review.
5	replacement nursing home. It was moving a couple	5	Q.	How many analysts do you have on your staff at thi
6	blocks awaya couple miles away, excuse me. And	6		point?
7	was the kind of hearing that we knew there would	7	A.	We have 12 slots. We have one vacancy that we're
8	probably be about as many people as there are in	8		recruiting for.
9	this room at the hearing. It didn't make sense for	9	Q.	And do youdo you have to keep up with how man
10	us toI had been asked to be on the program, so I	10		applications you typically review in a year; is that
11	I was going to Charlotte anyway. So I did the other	11		a statistic that you know?
12	hearing to save the State some money.	12	A.	Well, I just happened to fill out the AHPA report
13	Q. That makes sense. Havedo youhow do you ask o	r 13		yesterday. And for the fiscal year that ended in
14	instruct the analyst to take into account the	14		JulyJune, we had 147 applications.
15	competitive comments that are filed?	15		And I guess that ebbs and flows each year, depend
16	A. Well, you read them, try to understand them; you	16	~	on what's in the Plan?
17	look at the responses; you look in the application	17	A.	That's the lowest it's been in a long time. Well,
18	to see if the matter was addressed inas alleged in	18		yeah, the Plan has been generating less activity,
19	the comments; and then you make your decision base			with the exception of this year, in the 2012 fiscal
	on the information available as it comports with the	20		year, with the 16 applications we got in Wake Cour
20		21		for nursing home beds. And theand theand, of
21	law and the rules.	22		course, that's driven in part by the decreasing
22	Q. Is there any-			utilization of thewell, all health servicesor
23	A. I mean, sometimes people want you to do things tha	24		not all-most health services, especially acute care
24	you just can't do.	24	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
Craic	g SmithVOLUME I February 23, 2012	Craic	g Sm:	ithVOLUME I February 23, 2012
	23			. 25
1	Q. Can you give me an example?	1		services, and to a somewhat lesser extent, long-te
2	A. Well, I mean, the Macon one, I guess, we could have	e 2		care services. I've not seen a decline in the
3	denied it. But, I mean, we would have had towe	3		dialysis volume.
4	would have been hard pressed, I think, to come up	4	Q.	
5	with a reason. You know, I mean, theythe reason	5		Mission GI application, but I want to take you ba
6	they wanted us to deny it is because it didn't have	6		in time a little bit. As I understand it, there was
7	a certificate of need, but they were clearlythey	7		a meeting in 2010 where members of Mission sta
l	were licensed. They were clearly legal in the	8		Pardee staff, the Certificate of Need Section, and
8		1		the Construction Section met to discuss a project
9	context of the requirements of the CON law in effect	10		the county line. Do you recall attending a meeting
10	at the time they got their license.	Į		in 2010?
11	Q. Do you ask the analyst that you supervise to review			
12	comments or-filed at the time of the public	12	A	
13	hearing, or is that typically done later in the	13		and unfortunately, the only thing on my calendar
14	process?	14		Division staff meetings and the application day.
15	A. I don't understand your question.	15		ForI think, in a conversion, we may have lost
16	•	16		someI may have lost some data, because I had
17	· · · · · · · · · · · · · · · · · · ·	1		considerable amount of sick leave that month. I
18		1		mean, just a whole bunch ofthere's nothing the
19	the public hearing?	19		There's nothing in March. There's nothing in a
20	A. No.	20		portion of the year. So I cannot confirm from m
21	Q. Do you leave that up to them?	21		calendar that I did attend, but I believe it's
22		22		likely that I would have been there.
23	nice ifif you could. But usuallysometimes your	23	Ç	•
		24		meeting that involved the Construction Section-

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1	A.	Well, there were twoI don't know specifically.	1	~	I understand from Ms. Miles' testimony that she did
2		mean, thethe Construction Section, no, I don't	2		not participate in the pre-application conference?
3		have a specific recollection of that. I did find in	3		That would be likely.
4		early February last year we had a pre-application	4		Didwere there anywell, let me ask this. Were there any other representatives of Pardee there, to
5		conference	5		your knowledge?
6	Q.	And what do you recall about	6	-	I don't remember.
7	Α	for thethis specific project. I recall it was	7 8	_	Do you recall discussing the GI application and wh
8		in a different part of the building. We had to kind		Q.	needed to be presented in terms of information?
9		of gather in a room forthatwhere the fire alarm	10	Α.	At this time, no.
10		center is.	11	Q.	Do you recall anything about the discussion?
11	Q.	Was that because of the size of the crowd?	12	A.	Not specifically.
12	A.	Partly because of the size of the crowd. partly	13	Q.	Do you recall that there were questions regarding
13		because of the availability of rooms, partly because	14	~	the space being on or near the county line?
14		we had found mold in our sectionpart of our	15	A.	Yes.
15		section of the building, and we'd moved staff out.	16		Have you reviewed before a project like this one
16	Q.	You hadn't actually moved to the new building a	17	-	that was literally adjacent to the county line?
17		that point?	1.8	A.	I don't think so.
18	A.	We had not moved to the new building, no.	19	Q.	Was that a novel idea for you?
19	Q.	That was later during the review of this	20	A.	Well, it presents both opportunities and obstacles.
20		application?	21	Q.	What obstacles does it present, in your view?
21	Α	. Thewe moved to the new building effective Ju-	ne 22	A.	The health servicethe licensed health service
22		1st. And that calendar notation says Nancy Bres	23		facilities need to be in one county or the other.
23		Martin was in attendance, so.	24		And if they are affiliated with anotherand I'd say
Craic	τ Sπ	nithVOLUME I February 23, 2012	Craig	Smi	thVOLUME I February 23, 2012
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1			1		29
2	Ω	She's sitting where you are sitting today in another	1		
	Q	÷ .	1 2		healthnot just health serviceshealth services,
	Q	case. Do you recall if Mr. Moore, who's sitting	1 2 3		healthnot just health serviceshealth services, not just health service facilities. And if they're
3		case. Do you recall if Mr. Moore, who's sitting with us, was at the meeting?	2		healthnot just health serviceshealth services, not just health service facilities. And if they're
3 4	A	case. Do you recall if Mr. Moore, who's sitting with us, was at the meeting? I believe he was.	2		healthnot just health serviceshealth services, not just health service facilities. And if they're affiliated with a provider from one of the counties, they need to be in the same county. If they're
3 4 5		case. Do you recall if Mr. Moore, who's sitting with us, was at the meeting? I believe he was. Okay. And were there other CON Section staff in	2 3 4		healthnot just health serviceshealth services, not just health service facilities. And if they're affiliated with a provider from one of the counties, they need to be in the same county. If they're
3 4	A	case. Do you recall if Mr. Moore, who's sitting with us, was at the meeting? I believe he was. Okay. And were there other CON Section staff in attendance?	2 3 4 5		healthnot just health serviceshealth services, not just health service facilities. And if they're affiliated with a provider from one of the counties, they need to be in the same county. If they're operating under the license of a Buncombe County
3 4 5 6	A Q	case. Do you recall if Mr. Moore, who's sitting with us, was at the meeting? I believe he was. Okay. And were there other CON Section staff in attendance? Yes.	2 3 4 5 6		healthnot just health serviceshealth services, not just health service facilities. And if they're affiliated with a provider from one of the counties, they need to be in the same county. If they're operating under the license of a Buncombe County facility, they should be in Buncombe County. If they're operating under the licensein this case,
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Craig	•	Craig	SmithVOLUME I February 23, 2012
	30		32
1	Q. Andand that's in the case of a freestanding	1	Q. If the Construction Section doesn't have a concern
2	licensed facility?	2	about whether the project it's reviewing is
3	A. Well, I mean, if you're creating a separately	3	consistent with the CON, then you don't get
4	licensed facility, it has to be inin one county.	4	involved; is that right?
5	And if you're creating space that is not separately	5	MS. FRIEL: Object to the form.
6	licensed but licensed as part of a facility inin a	6	A. Well, sometimes we have issues with whether they a
7	county, you know, I would think it would be the	7	making substantial progress. So that would be one
8	samein my mind, it would be the same concept.	8	we might contact the Construction Section to see if
9	Q. You said earlier you weren't the Section that	9	they've received the plans, or they received
10	typically enforces that. Is thatis the Licensure	10	preliminary plans and that was six years ago and
11	Section-	11	there hasn't been a submittal of anything else.
12	A. That's my understanding, yes.	12	Q. Okay. And if theif the answer to that question is
13	Q. Have you had any discussions with anyone from the	13	no, then you might contact the CON holder to ask
14	Licensure Section regarding this Mission GI project	14	what's going on?
15	and where it lies?	15	A. Yeah. Sometimes we contact them, because the CON
16	A. No.	16	holder is not necessarily responsive.
17	Q. Do you know if anybody in your Section did so during	17	Q. There's not any sort of required reporting between
	the review of the application?	10	your Sections on particular projects; is that right?
18		19	A. No.
19		20	Q. No, there's not any reporting, or, no, that's not
20	Q. You did not ask anybody to do so?	21	right?
21	A. No.	22	A. There's not any required reporting.
22	Q. Since the decision on the Mission GI application,	23	Q. If you have questions related to facility licensure,
23	have you had any discussion with the Licensure	24	do those go to the Chief, Azzie Conley?
Crai	SmithVOLUME I February 23, 2012	Craig	SmithVOLUME I February 23, 2012
	. 31		33
1	Section about whether it would permit a portion of	1	
2		,	A. Usually.
		2	A. Usually. Q. And is Ms. Conley still the Chief of the Licensure
3	the support space to be over the county line? A. No, I have not.	2	-
3 4	the support space to be over the county line?	1	Q. And is Ms. Conley still the Chief of the Licensure
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4	the support space to be over the county line? A. No, I have not. Q. Have you had discussions with anybody in the	2 3 4 5	Q. And is Ms. Conley still the Chief of the Licensure Section?A. Yes.Q. Going back to the pre-application conference that v
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1	Q.	A couple times in her deposition, Ms. Frisone	1		Maybe a better way to ask it is, diddid itdid
2		referred to that same case and said that she often	. 2		you have concerns about other obstacles that the
3.		looks at the final Agency decision forfor guidance	3		applicant might face beyond thebeing in one county
4		on issues related to how a project is defined. Is	4		or another?
5		that consistent with your understanding?	5	A.	Well, we're aware of the relationship between
6		MS. FRIEL: Object to the form of the	6		Mission and Park Ridge. And so we knewwe feltv
7		question.	7		didn't know, but we had a strong inclination that
8	A.	In that particular case, the second final Agency	8	_	Park Ridge would be concerned about the project.
9		decisionI believe it would be the secondin that	9	Q.	And in fact, it did file comments opposing?
10		case, thethere were two final Agency decisions.	10	Α.	Yes.
11	Q.		11	Q.	Does the fact that another provider has a history of
12	_	Yes, that's what got me for a second there.	12		opposing projects enter into your consideration in
13.	Q.		13 at		the review?
14		case was what costs you count towards the projects	14		MS. FRIEL: Object to the form.
15		versus	13	A.	What it entered into was the decision to hold a
16	Α		16	0	public hearing.
17	Q		17 18	Q.	In the Agency file, there is, in fact, a request from Mission to have expedited review, and that's
18	A		19		there are documents in the Agency file, which I
19	0		20		think is in front of you, marked as Exhibit 3, in
20	Q	Mission review the guidance that Jeff Horton issue	Ł		the first section involving correspondence, I think
21		on satellite projects for hospitals?	22		Pages 5 through 16, not every page, but in that
22	A		23		range, if you would like to look to refresh your
23	Q	10	24		recollection. Ms. Frisone recalled making a
		. Tou don't have a specific memory alough.	 		
Craig	j Sr	nithVOLUME I February 23, 2012	Craig	Sm	ithVOLUME I February 23, 2012
		35			. 37
1	Д	No. I mean, itit seems reasonable. I can't	1		decision in conjunction with you to set this case
2		remember specifically telling anybody that, orbut	2		this application for a public hearing. Do you
.3					
- 4		that doesn't mean that it wasn't discussed. I would	3		recall discussing that issue with her?
		that doesn't mean that it wasn't discussed. I would believe it would be-would have been appropriate to	1	A	
5			or 4	A. Q	. Yes.
5 6		believe it would bewould have been appropriate to	or 4 5	_	. Yes.
1		believe it would bewould have been appropriate to us to have discussed it. Andand I may have been	5 6	_	Yes. And why did you decide to hold a public hearing a deny the request for an expedited review?
6		believe it would bewould have been appropriate to us to have discussed it. Andand I may have been the one who brought it up, because I have attended some sessions with Mr. Horton trying to get clarity on some of these issues.	5 6	Q	 Yes. And why did you decide to hold a public hearing as deny the request for an expedited review? It was our belief that one would be requested, number one, by Park Ridge. And even if it weren't
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6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22		believe it would bewould have been appropriate to us to have discussed it. Andand I may have been the one who brought it up, because I have attended some sessions with Mr. Horton trying to get clarity on some of these issues. 2. Andand some of those issues relate to the reimbursement on a federal level for satellite projects that are hospital-based? 3. I haven't looked at that probably sinceassuming weyou know, probably since before this applicat was filed. So I have learned that, if I want to speak definitively on something, I track it down ar read it. 2. Do you recall having any specific concerns about application that was described to you in the preapplication conference? 4. I don't understand the question. It's not specific enough. 2. Sure. We spoke a minute ago about the fact that	or 4 5 6 7 8 9 10 11 12 on 13 14 dd 15 16 the 17 18 19 20 21 his 22	Q	And why did you decide to hold a public hearing at deny the request for an expedited review? It was our belief that one would be requested, number one, by Park Ridge. And even if it weren't requested, we feltwell, we had toI believe we had to hold one for the acute care beds. And we believed that it was in the public interest. And-and using our discretion, scheduled it to be at the same time. Is it the CON Section's normal practice to schedule public hearings when opposition is anticipated, ever if not required? I think it would fall within the concept of within the public interest. And itit's much easier to schedule the public hearing and give people notice well in advance because thetheactually, the ad that's published in the paper, the notice that's published in the paper puts out the information, the
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Craig Smith--VOLUME I February 23, 2012 February 23, 2012 Craig Smith--VOLUME I 40 38 Sure. A. three weeks if one is requested when the comments 1 Are you okay to keep going or-Q. 2 are filed. Then-then your-your work-you're Well, I just need some more water. trying to schedule a hearing, and then Party A 3 Okay. We'll take just a really short break. pushed your scheduling forward and says, oh, I can't 4 (RECESS TAKEN FROM 11:02 A.M. UNTIL 11:13 A.M.) 5 go; I'm on vacation. And then--so you try to change 5 Q. (By Ms. Harris) Mr. Smith, I'm going to ask you some it, and then Party B says, well, I can't go. So, I 6 questions about the Agency findings under Criterion 7 mean-so we just try to schedule it up front. 7 3. Do you have those in front of you? 8 Logistically, it's much easier. Sometimes you can't 8 9 A. Yes. find a suitable hall for when you want to hold one, 9 10 Okay. And also in the -- I don't know that you need because we like to hold the hearing as close to 10 to look at it, but you're welcome to--in the 11 possible toward that 20th day, as specified in the 11 discovery responses, which are Deposition Exhibit 1, 12 law. And sometimes there's not a suitable venue to 12 13 it was--it was revealed that you were consulted on 13 hold the hearing, so, I mean, that makes it a the inmigration analysis. And I think I asked you 14 14 challenge also. that earlier. Is--is that consistent with your 15 I understand what you're trying to say about the 15 16 memory? 16 practical considerations of scheduling a public 17 A. Yes. hearing. Do you--was there anything unique about 17 18 Q. And did you have a particular experience with how to the relationship between Mission and Park Ridge that 18 analyze an applicant's inmigration projections that 19 caused you to act differently in this case than you 19 20 you shared with Ms. Frisone and Ms. Miles? would normally? 20 21 I don't understand your question. A. No, I wouldn't say I acted differently. We--we had Q. I may not have understood the testimony correctly. 21 22 a GI endoscopy application in Halifax County that But one or the other said that you had some 22 23 23 had been denied on two previous occasions, and they 24 particular experience, either with the area, or with February 23, 2012 Craig Smith--VOLUME I Craig Smith--VOLUME I February 23, 2012 41 39 applied again. And we've scheduled public hearings 1 inmigration issues, or projections in general, that 1 caused them to consult with you on whether Mission' 2 2 all three times. inmigration percentage in this application was 3 Q. Is that application, the third one, under review 3 4 reasonable? 4 A. No, the third one was approved. It was appealed, A. I have driven around the area on numerous occasion 5 5 6 but they settled. That may have been what was the basis of some of 6 7 Was there a competitor involved in the appeal 7 their questions. 8 process? O. I know you said earlier that you agreed with the 8 9 A. It was not a competitive review, but the--the 9 decision to find the application nonconforming with community hospital--it was more analogous to the 10 10 Criterion 3. Were you focused in particular in your Macon situation, except it did not involve the 11 review on the percent of inmigration that Mission 11 relocation but involved licensing a second room. 12 12 projected? There is-I--there is a grandfathered-in physician 13 13 My understanding is that inconsistent data was office, so it's not a licensed facility. But there 14 1.4 provided with regard to patient origin. is a physician office provider who wanted to become 15 And was that the source of the--the source of the 15 16 licensed. 16 nonconformity in your understanding? Q. And when--when you said "they settled," you meant 17 It was a component of it in my understanding. 17 that the hospital and the GI practice reached some 18 Did you have an objection to projecting 10 percent 18 19 sort of agreement? 19 inmigration from areas outside the defined service 20 Yes, they did. 20 area as--as a matter of principle, or was it just 21 I'm going to ask you some questions about the based on the information in this application? 21 22 inmigration analysis in the findings. And we can 22 It was based on the information in the application. turn to that now, but if anybody needs a break, we 23 23 So 10 percent is not, per se, unreasonable? can do that now, too. 24

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Craig	Smi	thVOLUME I February 23, 2012	Craig	Sml	thVOLUME I February 23, 2012
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1	A.	No. And I've testified in a recent deposition that	1	Q.	When you are supervising the review of application
2		the service area and inmigration are affected by the	2		in which an applicant proposes a certain percent of
3		size of the service area. So the more narrowly	3		inmigration from outside the defined service area,
4		drawn the service area, the primary service area,	4		do you require a specific definition of where those
5		then the potentially larger the size ofthe larger	5		patients are coming from?
6		the amount of inmigration.	6	A.	The more clearly defined it is, the easier it is to
7	Q.	What deposition did you give andand address th	÷ 7		find an application conforming.
8		inmigration and service area definition?	8	Q.	Well, in terms of this application, where some of
9	A.	I said the smallare you asking me to restate wha	. 9		the inmigration was coming from parts of the county
10		I just said?	10		where the service would be located, would you expe
11	Q.	No, I'm asking you what case or what context?	11		a zip code specific description of the inmigration?
12	A.	Oh. That would have been in thethe Wake bed	12		MS. FRIEL: Object to the form.
13		review.	13	O.	That seemed to be what Ms. Frisone and Ms. Miles
14	Q.		14	`	expected, and I'm trying to understand the Agency's
15	A.	Yes. So it ultimately is a case by case, very fact	15		position.
16		dependent.	16		MR. JOHNSON: Object to form.
. 17	Q.	Would you consider it reasonable to have zero	17		MS. FRIEL: Object to form.
18		inmigration?	18	A.	
19		MS. FRIEL: Object to form.	10	Q.	
20	: A.	If you drew a large enough service area, I suppose	20	Q.	applicant could look at fromfrom the CON Section
21		for some services.			to understand how to describe adequately in their
22	Q	. Butbut, again, you'd have to look at the specific	22		application where patients who inmigrate are coming
23		facts?	23		from?
24	A	. Right.	23		noin:
Craig	g Sπ	ithVOLUME I February 23, 2012	Craig	Sm	ithVOLUME I February 23, 2012
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1	Q	. I think that you've kind of addressed it, but just	1	Α.	Itit's really very much application-specific.
2	Q	would you define for me what-what you consider to	1		Some folks usestart by using a radius or a
3		be inmigration in the context of a CON application?	3		grouping of counties. And sometimes they narrow
4	٨	were the state of the first to the state of the state of	4	•	down to zip codes within the radius of those
5	Α	applicant, what they consider inmigration.	5		counties.
1	0	v to at a 1 constructor to the country from	6	Q	
6	Q	Ta	7	Q	zip code a specific segment of your anticipated
7		outside the defined service area?	8		patient origin?
8	A	* * *	1	Α	
9	Ç	•	10	Α.	The zip code is often used because that's tied to
10		the defined service area did not include all of	1		the person's mailing address and that's where you
11		Buncombe County?	11		send the bill. So that's information you have about
12		x. Yes.	12		the patient that you can get with some degree of
13	Ç	2. So some of the inmigration would have been from	13		
14		other parts of Buncombe County; is that right?	14		accuracy on a map. Those zip code maps are quite
15		A. Potentially, yes.	15		irregular, and they often cross county lines, which
1	(Q. One of the objections that Ms. Miles and Ms. Frisc	1		can compound. Or in some cases there are very fe
16		expressed in their depositions related to, I think,	17		zip codes in a county, and they'rethey're very
1		·			
16		Mission not being specific enough about where the	18		large, so they don't give you additional
16 17		Mission not being specific enough about where the patients would be coming from in thatifif they	19		specificity. So, I mean, you have to sort of work
16 17 18		Mission not being specific enough about where the patients would be coming from in thatifif they were coming from outside the defined service area.	19 20		specificity. So, I mean, you have to sort of work with what youwhat youyou sort of have to wor
16 17 18 19		Mission not being specific enough about where the patients would be coming from in that—ifif they were coming from outside the defined service area. Did you discuss that specific issue with them?	19 20 21		specificity. So, I mean, you have to sort of work with what youwhat youyou sort of have to wor with what you've got.
16 17 18 19 20		Mission not being specific enough about where the patients would be coming from in thatifif they were coming from outside the defined service area.	19 20		specificity. So, I mean, you have to sort of work with what youwhat youyou sort of have to wor

		72. 22. 2012	Cmaia	Cmi	thVOLUME I February 23, 2012
Craig	Smi	thVOLUME I February 23, 2012 46	craig	PIIIT	48
				_	
1		whatwhat else can an applicant do to further		-	You said earlier that you had driven around
2		define the service area?	2		Asheville quite a bit. Thehave you driven on the
3		MS. FRIEL: Object to the form.	3		I-26, I-40 area?
4	A.	I believe I've seen some that are based on census	4		Yes. Do you have an understanding about how a patien
5		tracks. But those are-those then use a demographic	5	Q.	chooses a GI endoscopy provider?
6		modelincident rates and demographic models.	6	٨	They're usually referred by their primary care
7	Q.	But you don't have a specification or a direction to	7	A.	ii a
8		applicants that youyou ask the applicants to	8 9	0	physician. So they're referred by their primary care physician
9		explain?	10	Q.	to a GI specialist?
10	A.	No.	11	A.	Yes.
11	Q.	Will you look with me on Page 666 of the Agency	12	O.	Does the GI specialist then typically govern which
12	•	file, which is still within the discussion of	13	Q.	facility the patient goes to for thean endoscopy
13		conformity of Criterion 3; do you have that in front	14		procedure?
14		of you?	15	A.	
15	A.	Yes.	16		center, we usually know where they're going to go.
16	Q.	In the last paragraph on that page, there's a	17		If the patient requiresI'm going to use the term
17		finding that, "It is unreasonable to assume that	18	•	"special handling," they usually go-end up going to
18		patients from certain counties would bypass Missio			the hospital.
19		and travel to Mission GI South, particularly north	20	Ο.	You would agree that a patient doesn't make the
20		of Buncombe County"; do you see that?	21	`	decision of the endoscopy facility on his or her
21	Α		22		own?
22	O	. Was that finding based on input from you to Ms.	23		MR. JOHNSON: Object to the form.
23	`	Frisone and Ms. Miles?	24		MS. FRIEL: Object to the form.
	- C-	nithVOLUME I February 23, 2012	Craig	Sm	nithVOLUME I February 23, 2012
Crarc	a on	nithVOLUME I February 23, 2012			49
			1	٨	. No, but theythe physician may schedule it, may
1	Α	. It-I may have-I believe I did have some	2	л	give them a choice. Would you rather have this don
2	_	involvement in this discussion, yes. And why is it that you think that it would be	3		here or there? Because, in this case, this would
3	Ć	 And why is it that you think that it would be unreasonable to assume that patients would bypass 			present an opportunity for a choice. Right now,
4		Mission and travel to Mission GI South where it w			there isif they're being referred specifically to
5		located on a highway?	6		Mission for a procedure, right now there's no choice
7	,		7		of where to go withinwithin the Mission framewo
8		A. It's forit's further. Q. Is that the only consideration that was given?	8		There is the choice of the endoscopy center. And
9		A. Thosethosethat would have been a basis for m	1		I'm going to just keep my discussion to Buncombe
10	r	concurring with their logic.	10		County.
1 1			,		County
11	ſ		1	Ç	2. Just to make sure I understand, that all the Mission
11 12	(Would you agree that, in certain locations, patien	1	Ç	
12	(Would you agree that, in certain locations, patien might choose a location that's further away if it's 	ts 11		Just to make sure I understand, that all the Mission
12 13	(Q. Would you agree that, in certain locations, patien might choose a location that's further away if it's easier to access because of a highway?	ts 11 12	. 4	2. Just to make sure I understand, that all the Mission GI rooms are on thethe downtown campus?
12		 Would you agree that, in certain locations, patien might choose a location that's further away if it's 	ts 11 12 13	. 4	 Just to make sure I understand, that all the Mission GI rooms are on thethe downtown campus? Yeah.
12 13 14		Q. Would you agree that, in certain locations, patien might choose a location that's further away if it's easier to access because of a highway? MR. JOHNSON: Object to the form.	ts 11 12 13 14	. 4	 Just to make sure I understand, that all the Mission GI rooms are on thethe downtown campus? Yeah. Given that reality, do you think it was unreasonab
12 13 14 15		Q. Would you agree that, in certain locations, patien might choose a location that's further away if it's easier to access because of a highway? MR. JOHNSON: Object to the form. MS. FRIEL: Object to the form.	ts 11 12 13 14 15	. 4	 Just to make sure I understand, that all the Mission GI rooms are on thethe downtown campus? Yeah. Given that reality, do you think it was unreasonab for Mission to seek to relocate an operatingI
12 13 14 15 16		 Q. Would you agree that, in certain locations, patien might choose a location that's further away if it's easier to access because of a highway? MR. JOHNSON: Object to the form. MS. FRIEL: Object to the form. A. I don'tI never thought Mission was that hard to 	ts 11 12 13 14 15 16 17	. 4	 Just to make sure I understand, that all the Mission GI rooms are on thethe downtown campus? Yeah. Given that reality, do you think it was unreasonab for Mission to seek to relocate an operatingI mean, a GI endoscopy room to a location that was
12 13 14 15 16 17		 Q. Would you agree that, in certain locations, patien might choose a location that's further away if it's easier to access because of a highway? MR. JOHNSON: Object to the form. MS. FRIEL: Object to the form. A. I don'tI never thought Mission was that hard to get to from the highway. 	ts 11 12 13 14 15 16 17 18	A	 Just to make sure I understand, that all the Mission GI rooms are on thethe downtown campus? Yeah. Given that reality, do you think it was unreasonab for Mission to seek to relocate an operatingI mean, a GI endoscopy room to a location that was outside its main campus and more accessible to
12 13 14 15 16 17 18		 Q. Would you agree that, in certain locations, patien might choose a location that's further away if it's easier to access because of a highway? MR. JOHNSON: Object to the form. MS. FRIEL: Object to the form. A. I don'tI never thought Mission was that hard to get to from the highway. Q. Andbut my question was, would you agree that 	ts 11 12 13 14 15 16 17 18 s 19	A	 Just to make sure I understand, that all the Mission GI rooms are on thethe downtown campus? Yeah. Given that reality, do you think it was unreasonable for Mission to seek to relocate an operatingI mean, a GI endoscopy room to a location that was outside its main campus and more accessible to certain patients?
12 13 14 15 16 17 18 19		 Q. Would you agree that, in certain locations, patien might choose a location that's further away if it's easier to access because of a highway? MR. JOHNSON: Object to the form. MS. FRIEL: Object to the form. A. I don'tI never thought Mission was that hard to get to from the highway. Q. Andbut my question was, would you agree that patient might choose a healthcare location that was 	ts 11 12 13 14 15 16 17 18 s 19	A	 Just to make sure I understand, that all the Mission GI rooms are on thethe downtown campus? Yeah. Given that reality, do you think it was unreasonable for Mission to seek to relocate an operatingI mean, a GI endoscopy room to a location that was outside its main campus and more accessible to certain patients? No.
12 13 14 15 16 17 18 19		 Q. Would you agree that, in certain locations, patien might choose a location that's further away if it's easier to access because of a highway? MR. JOHNSON: Object to the form. MS. FRIEL: Object to the form. A. I don'tI never thought Mission was that hard to get to from the highway. Q. Andbut my question was, would you agree that patient might choose a healthcare location that wa further away from his or her home if it was easier 	ts 11 12 13 14 15 16 17 18 18 19 20	. A	 Just to make sure I understand, that all the Mission GI rooms are on thethe downtown campus? Yeah. Given that reality, do you think it was unreasonab for Mission to seek to relocate an operatingI mean, a GI endoscopy room to a location that was outside its main campus and more accessible to certain patients? No. MR. JOHNSON: Object to form.
12 13 14 15 16 17 18 19 20 21		 Q. Would you agree that, in certain locations, patien might choose a location that's further away if it's easier to access because of a highway? MR. JOHNSON: Object to the form. MS. FRIEL: Object to the form. A. I don'tI never thought Mission was that hard to get to from the highway. Q. Andbut my question was, would you agree that patient might choose a healthcare location that wa further away from his or her home if it was easier to get to onon a particular highway 	ts 11 12 13 14 15 16 17 18 s 19 20 21	A (Just to make sure I understand, that all the Mission GI rooms are on thethe downtown campus? Yeah. Given that reality, do you think it was unreasonab for Mission to seek to relocate an operatingI mean, a GI endoscopy room to a location that was outside its main campus and more accessible to certain patients? No. MR. JOHNSON: Object to form. MS. FRIEL: Object to the form.

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1		review, would there be any	barrier to approving an	1	Q.	And you define facility to include everything that's
2		application to relocate an o		2		needed?
3		county line?		3	A.	Well, in this case, it would be the endoscopy suite,
4		MR. JOHNSON: Obje	ct to form.	4		because it has the potential for becoming a facility
5		MS. FRIEL: Object to	the form.	5		at some later date.
6	Q.	a to the D		6	Q.	And by endoscopy suite, do you mean the room its
7	-	Ifif the application were		7		plus the support space?
8		review criteria, it would ha		8	A.	Yes.
9	Q.			s 9	Q.	
10		under Criterion 4?		10		end that the fact that a portion of the suite was
11	A.	(Witness complies.)		11		over in Henderson County would arguably increase
1.2	Q.		c question, are thereis	12		inventory of licensed GI endoscopy rooms in
13		there any other part of the		13	•	Henderson County. Did you consider Mission's
14		Criterion 3 that you recall		14		project to involve an increase in the inventory of licensed GI endoscopy rooms in Henderson County
15		Miles or Ms. Frisone that v		15 16	٨	I wasn't focused on that part of the findings.
16		this morning?		17		Byby saying you were not focused, that means y
17	Α.			18	Q.	didn't have involvement in that
18	Q.	. The findings under Criter	ion 4 begin on Page 673,	19	Δ	. I don'tI don't recall discussing that specific
19		but my questions are going		20	71.	comment that was made in these findings.
20		675. Did you have any dis		•	0	Sitting here today, do you agree or disagree with
21		or Ms. Miles about the loc		22	Q.	the comment that it could increase the inventory in
22		as described in the finding		23		Henderson County?
23		to take a few minutes to re		24	A	. I haven't given it any thought.
·						
Crai	g Sn	nithVOLUME I	February 23, 2012	Craig	SII	nithVOLUME I February 23, 201
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. 1,	A	(Witness reviews docume	ent.) I believe we discusse	d 1	Q	•
2		the information that starts		2		last paragraph on Page 674 and refers to Exhibit 29
3		includes a line drawing wl		. 3		which is a cost estimate from the architect. Do yo
4		line crosses through the la	nd and the MOB. Exhibit	4		recall if you looked at the actual exhibit or just
5		6 includes a line drawing		5		talked with Ms. Frisone or Ms. Miles about the Me
6		endoscopy suite, which cl	early shows that the county	6		ownership?
7		line cuts through the come	er of the proposed space.	7	A	•
8	Ç	You're saying you talked	about the information you	8	Q	Q. Okay. So you're saying you did not discuss the N
9		had in that regard?		9		ownership or how the costs were allocated?
10	A	A. II said that Imy testin	nony is that I discussed	10	Α	A. I don't recall the cost allocation or the MOB
11		that with Ms. Miles and N	1s. Frisone.	11		ownership being one of the things that we discuss
12	(And we've also talked at	out that a little this	12	Ç	Would you agree that with projects to be located
13		morning, but amam I co	rrect in understanding that	, 13		a medical office building, an applicant to provide
14		because some of the space	e appeared to have been ov	er 14		health service regulated by the Certificate of Need
15		the county line, the CON	Section did not feel that	15		Act would only need to count the upfit costs in
16		it could approve the appli	cation?	16		terms of the CON application?
17	1	A. Yes.		17		MS. FRIEL: Object to the form.
18		MS. FRIEL: Object t	o the form.	18		MR. JOHNSON: Object to the form.
19	(Q. And that's based on you	r understanding of the	19	A	A. Well, upfit, soft costs, equipment costs.
20		licensure rule regarding a	hospital being licensed	20	(Q. So you're agreeing with me, as long as you defin
21		in only one county?		21		the upfit as soft costs and equipment costs?
			سناه سمعسد بادار و و درو	g s 22		MS. FRIEL: Object to form.
22		A. Yes. And then myadd	itionally, my understandin	5 13		MB. I MED. Object to form.

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0	Cm.i	thVOLUME I February 23, 2012	Craig	SmithVOLUME I February 23, 2012
Craig	Smi	thvolume 1 replically 23, 2012	crarg	56
			1	Q. And how did you determine that it was the same
1	A.	Yeah. It'sit's not just the upfit of the space.		medical office building?
2		It's otherit's other aspects of the project as	2	
. 3	^	well.	3	A. The statement in the letter. It says, "In addition,
4	Q.	It's the aspects that make it possible to perform	4	Mission will lease space in the building for its
5		the health service thereto offer the health	5	proposed GI Endoscopy South location."
6		service there; is that right?	6	Q. The letter that you just referred to was dated May
7	A.		7	13, 2011; is that right?
8		MS. FRIEL: Object to form. MR. JOHNSON: Object to form.	8	A. Yes.
9		and the second of the second o	9	Q. And then the response is May 24, 2011?
10	Q.	core itself when there's a medical office building?	10	A. Yes.
11	À		11	Q. That was during the review of the Mission GI
12	Α.		12	application, correct? If you need to look, the
13	Q.	into your consideration of what costs the applican		findings begin on Page 640 of the Agency file.
14		should bear versus the developer?	14	A. Yes.
15		I would have to go back and look at that case that	1	Q. Did you send a copy of this exemption request in
16	Α.	we discussed, but there may be an issue if there's		
17			16	response to Ms. Miles or Ms. Frisone to make them
18	_	related-party transaction.	17	aware?
19		How do you define a related-party transaction? Well, in this case, that if—if Mission were also a	18	A. No.
20	A		19	Q. Do you know if anybody else in the CON Section ma
21	_	owner of the building. That would beyou would consider that a relate	20	them aware of the no reviewor excuse me, the
22	Q		21	exemption request or response during the review?
23		party transaction?	22	A. I do not know that.
24	A		 	
Craiq	g Sn	ithVOLUME I February 23, 2012	Craig	g SmithVOLUME I February 23, 2012
		55		57
1	Q	. What about if Mission was an investor in the enti	1	Q. Okay. And it is this no review or exemption
2	`	that owns the building?	2	determination that Ms. Gunter has asked you to
3		MS. FRIEL: Object to form.	3	reconsider; is that correct?
4	Α	****	4	A. Yes. You know, it should be noted that the secon
5	Ç		ıst 5	paragraph clearly states, "It should be noted that
6		looking at in the findings, there is expressed a	6	the Agency's position is based solely on the facts
. 7		concern about whether the developer in this case	7	represented by you. That any change of facts as
-8		should have been an applicant, but I think you're	8	represented will require further consideration by
l		saying you did not discuss that issue with Ms.	9	
9		Frisone or Ms. Miles?	10	
10			11	
11		that is correct.	1	
12	(). We marked in an earlier deposition in this case the	1	
13		exemption notice and response letter from the CO	1	
14		Section for the medical office building in which the	1	
15		Mission GI project was proposed to be located. A	3	
16		it is in front of you in that notebook as Deposition	1	•
17		Exhibit 4. I believe that you signed the letter?	17	
18	1	A. Yes.	18	7
19	(Did you understand at the time that that medical	\$	•
20		office building discussed in the letter and your	20	•
21		response was the building in which the Mission (I 21	-
22		project would be located?	22	
23	ł	A. Yes.	23	is that right?

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1	A. Yes. It was sent to the letterhead, not to the name	1	Q. Will you look back with me at the deposition exhib
2	onof the company, not the specific entity that was	2	that we looked at earlier, the findings involving
3	being created for the development of the office	3	the relocation of the endoscopy room in Macon
4	building.	4	County? I think weI think it's Deposition Exhibit
5	Q. But the exemption belongs to Western North Carolina	. 5	5.
6	Healthcare Innovators, LLC; is that right?	6,	A. (Witness complies.)
7	A. That's what was exempted, yes.	7	Q. In those findings, under Criterion 5 on Page 6, it
8	Q. Do you have an understanding at this point of what	8	reflects that the applicants projected no startup or
9	the basis for Ms. Gunter's allegation that the facts	9	initial operating expenses; do you see that line?
10	are not as represented, or is that something that	10	A. Uh-huh.
11	you still need to look at?	11	Q. And that was not a basis of
12	A. We haven't conducted an investigation yet.	12	A. It was not a factor in this review.
13	Q. If Western North Carolina Healthcare Innovators, LL	C 13	Q. Both the Macon County review and the Mission G
14	is the sole owner of the building, there would not	14	review involved relocating an existing licensed
15	be a need for it to be an applicant for the Mission	15	endoscopy suite; is that right?
16	GI service; is that correct?	16	A. Yes.
17	MS, FRIEL: Object to the form.	17	Q. Why would it have been an issue
18	A. I don't believe so, no.	18	A. Well
19	Q. It would not have needed to be an applicant?	19	Qin Buncombe and not Macon?
20	A. I saidI said that I didn't believe that it would.	20	AI don't know. I didn't do the review. I did not
21	Q. Okay. Mr. Smith, will you look with me now at	21	look at the applications.
22	Criterion 5?	22	Q. Is there any guidance to applicants regarding how
23	A. (Witness complies.)	23	howwhether and when to complete the startup and
		<u> </u>	
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	59		61
1	Q. One of the bases, as I read the findings, and	1	initial operating expense section beyond what's
2,	specifically on Page 676, is that the applicant	2	actually in the application form?
3	didn't demonstrate the availability of funds for	3.	A. If they have questions, they can always ask.
4	startup costs, and that's because there were no	4	Q. How do-how do you, as the Chief of the CON Section
5	startup costs projected in the application. And I	5	define operatinginitial operating expenses and
6	can take you to the specific pages of the	6	startup costs?
7	application, if that's helpful to you.	7	A. To new facilities, we typically look at the period
8	A. Oh. It's right there at the top. Okay.	8	of time before patients are served, where they'll be
9	Q. When an applicant is relocating an existing license	1	employing at least key staff and paying for such
10	service, would you agree that there aren't any	10	services as their actual hookup to the utilities, to
11	startup costs to be incurred?	11	the water, the cost of operations that areof the
12	MR. JOHNSON: Object to form.	12	utilities that occur before patients are seen.
13	MS. FRIEL: Object to form.	13	Q. And before the revenue starts flowing?
14	A. It depends on the specifics of the situation.	14	A. Right. Beforeyeah. There's nothere's no
15	Q. How do you evaluate whether a specific situation	3	revenue coming in at that point in time. Also, a
16	requires a projection of startup costs?	16	new facility typically has to stock supplies
17	A. (Witness reviews document.) Well, we usually re	1	supplies, food, depending on the services being
18	on the applicant to explain it sufficiently. But I	18	offered. Q. In this case, if Mission were able to turn the
19	· · · · · · · · · · · · · · · · · · ·	19	Q. In this case, if Mission were able to turn the lights off and leave the endoscopy room that it
20		20	currently uses and is relocating one day and then
21		1	begin operating the new one the next day, would you
22			agree that there aren't any startup
23		24	MS. FRIEL: Object to the form.
24	be as it was.	24	MD. I IGLE. Object to the form.

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1	MR. JOHNSON: Object to the form.	1	Q.	Were there reservations expressed from any of the
2	Qcosts, as you define them?	2		Agency participants about the concept presented?
3	A. There would bethere would be very few. I don't	, 3		I thinkI'm trying to think. Wewe knew that
4	know if there would be none.	4		there had been an issue in Gaston County with a
5	Q. Amam I correct that there's not any sort of rule	5		satellite ED. Their initial application had been
6	that says here's what you have to include for	6		denied, and I believe there was an intervention by
7	startup and initial operating expenses?	7		CHMCMHA, and thatso that we knew that sometime
8	A. Right. There is no rule codified for any of the	8		these things cause bad feelings. And we also knew
9 -	services that discusses a laundry list of services	9		thatI'm trying to think. Thatthat's probably
10	that should be included in initial operating costs	10	_	all we may have known at that time.
11	or startup expenses.	11	Q.	And when you say "sometimes these things cause bad
12	Q. If an applicant determines that that section is not	12		feelings," you mean relocating closer to an existing
13	applicable because they don't expect any of those	13		provider?
14	costs, do you expect the applicant to explain why	14	A.	Developing a service, just inin a more general
15	they feel it's inapplicable?	15		sense, whether it's relocation orI think that
16	A. Yes. We usually ask them to explain the N/A's.	16		meeting may have discussed as much the satellite
17	MS. HARRIS: I think I'm getting close to the	17		emergency department that Mission and Pardee were
18	end of my questions. I'm going to take a short	18	_	contemplating.
19	break and make sure so I can wrap it up efficiently.	19	Q.	Because of the recent experience that you had with
20	(RECESS TAKEN FROM 11:57 A.M. UNTIL 12:18 P.M.	1		Gaston?
21	Q. (By Ms. Harris) Mr. Smith, has our discussion this	21	A.	-
22	morning refreshed your recollection at all about the	22		thethe project hadwas at least sort of being
23	pre-application conference that I asked you about	23		proposed at the beginning. I think it may have
24	earlier?	24		beenMission, I think, was trying to sort out the
Craig	g SmithVOLUME I February 23, 2012	Craig	Sm	ithVOLUME I February 23, 2012
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1	A. No.	1		phasing of the development of the project, so I'm
2	0 4 171 11 11 11 11 11 11 11 11 11 11 11 11			phasing of the development of the project, so i in
3	O. And I believe you said that you did not have any	2		not sure wewhen we got the endoscopy center, we
	Q. And I believe you said that you did not have any discussions with Marjorie Acker or anybody from t	1		• •
1	discussions with Marjorie Acker or anybody from t	he 3		not sure wewhen we got the endoscopy center, we
4	discussions with Marjorie Acker or anybody from t Construction Section about the Mission GI project;	he 3		not sure wewhen we got the endoscopy center, we we knew that that was going to be the first
4 5	discussions with Marjorie Acker or anybody from t Construction Section about the Mission GI project; is that right?	he 3		not sure wewhen we got the endoscopy center, we we knew that that was going to be the first component, but II just can't remember now. But
4 5 6	discussions with Marjorie Acker or anybody from t Construction Section about the Mission GI project; is that right? A. That's correct.	he 3 4 5 6	Q	not sure wewhen we got the endoscopy center, we we knew that that was going to be the first component, but II just can't remember now. But thethe first meeting was definitely a higher-level meeting.
4 5 6 7	discussions with Marjorie Acker or anybody from t Construction Section about the Mission GI project; is that right? A. That's correct. Q. And did you say that she may have been in an init	he 3 4 5 6 7 ial	Q A	not sure wewhen we got the endoscopy center, we we knew that that was going to be the first component, but II just can't remember now. But thethe first meeting was definitely a higher-level meeting. What do you mean by "higher-level"?
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1	A. That would have bee	n and of that that way	ıld boya	•		- 68 -
1			na nave		STATE OF NORTH CAR	
2	probably been the prin		ndof		COUNTY OF WAKE	
3	Q. Is opposition by a co		na or			
4	itself, a basis for finding				CERTIFIC	i i i i i i i i i i i i i i i i i i i
5	nonconforming with C					, Notary Public-Reporter, do AIG R. SMITH was duly sworn by
6	A. No. But it certainly				, ,	of the foregoing deposition
7	project can be develop			1		n was taken by me and
8	a contested case heari		sted		transcribed under my	
9	case hearing has to run					nstitute a true and correct
10	Q. Do you recall anything	-			transcript of the testim	that I am not counsel for
11	meeting that we've jus	st been discussing in 2	010?			of either of the parties to
12	A. No.				,	nterested in the results of
13		pelieve those are all m			this action.	
14	•	Thank you, Mr. Smit	th, for			that the stipulations
15	your time.					entered into by counsel in my
16	THE WITNESS:	Thank you.			presence. In witness whereo	f, I have hereunto set my
17	MS. FRIEL: I gu	ess I have a couple ver	ry quick		hand, this 30th day of	
18	follow ups.				,	
19	CROSS EXAMINATION					
20	Q. Mr. Smith, did I und	lerstand you correctly	this			. BARBEE PUBLIC FOR THE
21	morning, you've got a	about 23 years of expe	rience			F NORTH CAROLINA
22	with the CON Section	n in total; is that correct	ct?			PUBLIC NO. 19953200118
23	A. It'll be 24 years in Ju	ine		Ì	Counting Donort	i Ci (010)661 2727
23	A. It if be 24 years in st	1110.		1	Caronna Report	ing Service (919)661-2727
			, 2012	Craic	SmithVOLUME I	February 23, 2012
	g SmithVOLUME I	February 23,		Craig		
Craig	g SmithVOLUME I	February 23,	, 2012 67	Craic		February 23, 2012
Craig	g SmithVOLUME I Q. Okay. And is it correct that	February 23,		Craic	SmithVOLUME I	February 23, 2012 69 -69-
Craig 1	g SmithVOLUME I Q. Okay. And is it correct the Mission endoscopy room, to	February 23, at, with respect to this hat you did not supervise		Craig	SmithVOLUME I SIGNA I have read the fore	February 23, 2012 69 -69- TURE going 67 pages
Craig 1 . 2	Q. Okay. And is it correct the Mission endoscopy room, the review, either directly s	February 23, at, with respect to this that you did not supervise upervising the project		Craic	SIGNA I have read the fore which contain a con	February 23, 2012 69 - 69 - TURE egoing 67 pages crect transcript of
Craig 1 . 2 . 3	Q. Okay. And is it correct the Mission endoscopy room, the review, either directly sanalyst or thethe Assistan	February 23, at, with respect to this that you did not supervise upervising the project		Craic	SIGNA I have read the fore which contain a con	February 23, 2012 69 -69- TURE going 67 pages
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2007 HOSPITAL LICENSE RENEWAL APPLICATION

Doing Business As (d/b/a) name(s) under which	the facility or service	are advertised or presented to the public:
PRIMARY: Park Ric	ige Hospital	
Facility Mailing Address:	P O Box 1569 Fletcher, NC 28	732
Pacility Site Address:	Naples Rd Fletcher, NC 28732	100 Hospital Drive Hendersonville, NC 28792
County: * Telephone: Fax:	Henderson (828)684-8501 (828)687-0729	
Administrator/Director: Title: <u>Administrator</u> (Designated agent (individual) r		JIMM Bunch body (owner) for the management of the licensed facility)
Chief Executive Officer:_ (Designated agent (individual) re	Jimm Bunch' esponsible to the governing	Title: President & CEO body (owner) for the management of the licensed facility)
Name of the person to cont	tact for any questions r	~ · · · ·
Name: Myriam L. Schul	ze .	Telephone: 828-681-2102
E-Mail: myriam.sc	hulze@ahss.org	Date // 14 / 00 Amount \$ 1,737.50
		Check 237686 Cish Other

"The N.C. Department of Health and Human Services does not discriminate on the basis of race, color, autional origin, religion, age, or disability in employment or the provision of services."

All responses should pertain to October 1, 2005 through September 30, 2006. If otherwise, indicate the actual reporting period used on Page 3 of this document.

List Name(s) of faciliti	es:	Address:	•		Type of SS / Service
					•
Janea attach a somewhat					
leașe attach a separate s	neet for aaattional	listings			
	A to the second				
wnership Disclosure (F	lease fill in any bla	nks and make	changes where nee	cessary.)	
What is the name of the Owner:	ne legal entity with	ownership res	ponsibility and liab	ility?	
Owner: Federal Employer ID#	Fletcher Hospita	-	ed.		
Street/Box:	P O Box 1569				
City:	Fletcher	State: NC	Zip: 28732		
Telephone:	(828)684-8501		(828)687-0729		
CEO:	Michael H. Sch		` ,		
Is your facility part of	a Health System?	XYes N	lo		
Is your facility part of If 'Yes', name of Hea * (please attach a list of If 'Yes', name of CE	alth System*: <u>Adve</u> of NC facilities that a	entist Healt re part of your	h System Health System)		•
If 'Yes', name of Heat' (please attach a list of If 'Yes', name of CE	alth System*: <u>Adve</u> of NC facilities that a	entist Healt re part of your nigan, Ph.D.	h System Health System)		
If 'Yes', name of Heat's (please attach a list of If 'Yes', name of CE's	alth System*: <u>Adve</u> of NC facilities that a O: <u>Donald Jerr</u> For Profit	entist Healt re part of your nigan, Ph.D.	th System Health System) Not For Profit	Partnership Governmen	
If 'Yes', name of Heat' (please attach a list of If 'Yes', name of CE' a. Legal entity is:	alth System*: _Adve of NC facilities that a O: Por Profit For Profit _X Corporation Proprietorsh ntity (partnership, c	entist Healt re part of your nigan, Ph.D. X	h System Health System) Not For Profit LLP LLC	Governmen	nt Unit
If 'Yes', name of Heat' (please attach a list of If 'Yes', name of CE a. Legal entity is: b. Legal entity is: c. Does the above e	alth System*: _Adve of NC facilities that a O: Por Profit For Profit Corporation Proprietorsh antity (partnership, c _Yes _X_ No	entist Healt re part of your nigan, Ph.D. X	h System Health System) Not For Profit LLP LLC	Governmen	nt Unit
if 'Yes', name of Heat' (please attach a list of If 'Yes', name of CE' a. Legal entity is: b. Legal entity is: c. Does the above e are offered? If "YES", name of be	alth System*: Advent NC facilities that a conclusion of NC facilities that a conclusion of NC facilities that a conclusion of NC facilities and NC facilities of NC facilities o	entist Healt re part of your nigan, Ph.D. X ip corporation, et	th System Health System) Not For Profit LLP LLC c.) LEASE the buil	Governmen	nt Unit
If 'Yes', name of Heat * (please attach a list of If 'Yes', name of CE a. Legal entity is: b. Legal entity is: c. Does the above eare offered? If "YES", name of but Is the business operate If 'Yes', name and ad	alth System*: _Adverse of NC facilities that a O: Por Profit For Profit X Corporation Proprietorship, coulding owner: Yes _X No wilding owner: ed under a manager	entist Healt re part of your nigan, Ph.D. X ip corporation, et	h System Health System) Not For Profit LLP LLC c.) LEASE the buil	Governmen	nt Unit
If 'Yes', name of Hea * (please attach a list of If 'Yes', name of CE a. Legal entity is: b. Legal entity is: c. Does the above e are offered? If "YES", name of bu Is the business operate	alth System*: _Adverse of NC facilities that a O: Por Profit For Profit X Corporation Proprietorship, coulding owner: Yes _X No wilding owner: ed under a manager	entist Healt re part of your nigan, Ph.D. X ip corporation, et	h System Health System) Not For Profit LLP LLC c.) LEASE the buil	Governmen	nt Unit

All responses should pertain to October 1, 2005 through September 30, 2006. If otherwise, indicate the zetual reporting period used on Page 3 of this document.

Эу	vnership Disclosure continued		
3.	Vice President of Nursing and Patient Care Services: Karen Owensby, RN, MSN, Vice President of Clinical Services		
ŀ.	Director of Planning: Bruce Bergherm, Vice President of Business De	velopment	
	Facility Data		
A. 20	Reporting Period All responses should pertain to the period October 1, 200 06. If otherwise, please indicate reporting period:	5 to Septen	nber 30,
В.	General Information (Please fill in any blanks and make changes where n	ecessary.)	
	a. Admissions to Licensed Acute Care Beds: include responses to "a - r" on page 4; exclude responses to "2-9" on page 4; and exclude normal newborn bassinets.	3,357	
	b. Discharges from Licensed Acute Care Beds: include responses to "a - r" on page 4; exclude responses to "2-9" on page 4; and exclude normal newborn bassinets.	3,291	i.
	c. Average Daily Census: include responses to "a-r" on page 4; exclude responses to "2-9" on page 4; and exclude normal newborn bassinets.	34	
	d. Was there a permanent change in the total number of licensed beds during the reporting period?	Yes	No X
	If 'Yes', what is the current number of licensed beds?	4"".	
	If 'Yes', please state reason(s) (such as additions, alterations, or conversions) which may have affected the change in bed complement:		
	e. Observations: Number of patients in observation status and not admitted as inpatients, excluding Emergency Department patients.	928	
C	Designation and Accreditation 1. Are you a designated trauma center? Yes _X No		•
	2. Are you a critical access hospital (CAH)? Yes X No	. •	-
	3. Are you a long term care hospital (LTCH)? Yes X No		
	4. If this facility is accredited by JCAHO or AOA, specify the accrediting body	JCAHO_	and
	indicate the date of the last survey 05 / 19 / 06. AOA: 04/21/04		

All responses should pertain to October 1, 2005 through September 30, 2006. If otherwise, indicate the actual reporting period used on Page 3 of this document,

D. <u>Beds by Service (Inpatient - Do Not Include Observation Beds or Days of Care)</u> [Please provide a <u>Beds by Service (p. 4)</u> for <u>each</u> hospital campus (see G.S. 131E-176(2c))]

Please indicate below the number of beds usually assigned (set up and staffed for use) to each of the following services and the number of census inpatient days of care rendered in each unit. NOTE: If your facility has a designated unit(s) for chemical dependency treatment and/or detoxification, please complete the patient origin sheet pertaining to Psychiatric and Substance Abuse Services. If your facility has a Nursing Facility unit and/or Adult Care Bed unit please complete the supplemental packet for Skilled Nursing Facility beds.

Licensed Acute Care (provide details below)	Licensed Beds as of September 30,	Staffed Beds as of	Annual Census Inpt. Days
Campus	2006	September 30, 2006	of Care
Intensive Care Units			
a. Burn *		•	*
b. Cardiac (Combined ICU/CCU/Telemetry)	14	14	3378
c. Cardiovascular Surgery			
d. Medical/Surgical			
e. Neonatal Beds Level IV ** (Not Normal Newborn)		•	भःभः
f. Pediatric		·	
g. Respiratory Pulmonary			
h. Other (List)			
Other Units			
i. Gynecology			
j. Medical/Surgical ***	40	40	*** 7751
k. Neonatal Level III ** (Not Normal Newborn)			**
I. Neonatal Level II ** (Not Normal Newborn)			**
m. Obstetric (including LDRP)	8	8	1281
n. Oncology			-
o. Orthopedics	·		
p. Pediatric			
q. Other (List)			
1. Total General Acute Care Beds (a through r)	62	62	12,410
2. Comprehensive In-Patient Rehabilitation	. 0		
3. Inpatient Hospice	0		
4. Detoxification	0		
5. Substance Abuse / Chemical Dependency Treatment	0		
6. Psychiatry	41	36	12,395
7. Nursing Facility	0		
8. Adult Care (Home for the Aged)	0		
9. Other	0		
10. Totals (1 through 9)	103	98	24,805

^{*} Please report only Census Days of Care of DRG's 504, 505, 506, 507, 508, 509, 510 and 511.

*** Exclude swing-bed days. (See swing-bed information next page)

^{**} Per C.O.N. rule definition. Refer to Section .1400 entitled Neonatal Services. (10A NCAC 14C)

All responses should pertain to October 1, 2005 through September 30, 2006. If otherwise, indicate the actual reporting period used on Page 3 of this document.

D. Beds by Service (Inpatient) continued

Number of Swing Beds *	rick
Number of Skilled Nursing days in Swing Beds	818
Number of unlicensed observation beds	

^{*} means a hospital designated as a swing-bed hospital by CMS (Centers for Medicare and Medicaid Services)

E. Reimbursement Source (For "Inpatient Days," show Acute Inpatient Days only, excluding normal newborns.)

Payer Source	Inpatient Days of Care	Emergency Cases	Outpatient Cases	Same Day
Charity Care**	Or Care	Cases	Cases	Surgery Cases
Commercial Ins. 1	2:348	4,585	15,576	2,103
Medicaid (including HMO)	1,608	3,242	3,034	419
Medicare (including HMO)	7,771	3,983	11,686	2,423
Private Pay / Self Pay	537	3,803	995	220
Other Gov't, 2	146	165	944	62
Bad Debt				- 02
All other				
TOTAL	12,410	15,778	32,235	5,227

^{**} Charity Care Definition; Health care services that never were expected to result in cash inflows. Charity care results from a provider's policy to provide health care services free of charge to individuals who meet certain financial criteria.

F. Services and Facilities

. Obstetrics	Enter Number
a. Live births (Vaginal Deliveries)	364
b. Live births (Cesarean Section)	192
c. Stillbirths	2

d. Delivery Rooms - Delivery Only (not Cesarean Section)	0
e. Delivery Rooms - Labor and Delivery, Recovery	4
f. Delivery Rooms - LDRP (include Item "n" on Page 4)	. 0
g. Normal newborn bassinets (Level I Neonatal Services)	
Do not include with totals under the section entitled Beds by Service (Inpatient)	8

2. Abortion Services Number of procedures per Year
--

^{**} There are 48 dual purpose beds, which include medical, surgical beds.

¹Commercial Insurance includes all forms of managed care except Medicaid and Medicare HMO's

²Other Government includes Tricare and VA insurance programs.

³Cases which originate from the Emergency Department.

All responses should pertain to October 1, 2005 through September 30, 2006. If otherwise, indicate the actual reporting period used on Page 3 of this document.

3. Emergency	Emergency Department Services (cases equal visits to ED)											
Number of	Number of cases/year: 13,987											
Does this in	Does this include fast track/urgent care? Yes _X No.											
	If "Yes," how many of these are urgent care?											
200,												
		s of Operation		Hrs		on duty in ER suite						
Monday	From		<u>Co</u>	_	From	Te						
Tuesday		24 hó	urs			24 hours						
Wednesday		**				11						
Thursday				1		11						
Friday		*1				· 1t						
Saturday		11				11						
Sunday						11						
4. Medical A	ir Transport:	Owned or lea	sed air a	mbulanc	e service:							
a. Does the b. If "Yes'	e facility operation, complete the	te an air ambu following cha	lance ser rt.	vice?	Yes _x No							
Type of A		···		0	Number Leased							
Rotary	derait Mann	per of August	Number	Ownea	Number Leased	Number of Transports						
Fixed Win	g				7,14							
5. Pathology	and Medical I	Lab (Check v	vhether c	r not sei	vice is provided)						
a. Blood B	Bank/Transfusio	on Services		Х үе	sNo							
	thology Labora			X Ye	s No							
	boratory Testin				s No							
Number	r during month	of September	2005									
· HI	IV Serology	•	かけれ	Screeni	ng test for e	mployee exposures						
d. Organ I	IV Culture			٧×	only. s <u>X</u> No							
_	near Screening				s <u>~ No</u>							
_	_	- NY1										
	tation Service		r transpia	nts	•							
Type		Number		rr. 1 0	Туре	Number						
a. Bone Marrow- b. Bone Marrow-				Kidney/	Liver							
c. Cornea	Autojogous	2		Liver	· ·							
d. Heart				Lung Pancreas	.							
e. Heart/Lung					Kidney							
f. Heart/Liver				Pancreas								
g. Heart/Kidney				Other								
h. Kidney												
Do you perform liv Revised 08/2006	Do you perform living donor transplants? Yes X No. Revised 08/2006											

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All responses should pertain to October 1, 2005 through September 30, 2006. If otherwise, indicate the actual reporting period used on Page 3 of this document.

7.	Specialized Cardiac Services	(for	questions,	call	855-3865	[Medical	Facilities	Planning])
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(a) Cardiac Catheterization	Diagnostic Cardiac Catheterization ICD-9 37.21, 37.22, 37.23, 37.25	Interventional Cardiac Catheferization- ICD-9 36.01, 36.02, 36.05, 36.06, 36.07, 36.09; 35.52, 35.71, 35.96	Electro-physiology 37.26, 37.27, 37.34, 37.70, 37.71, 37.72, 37.73, 37.74, 37.75, 37.76, 37.77, 37.79, 37.80, 37.81, 37.82, 37.83, 37.85, 37.86, 37.87, 37.89, 37.94, -37.95, 37.96, 37.97, 37.98, 37.99, 00.50, 00.51, 00.52, 00.53, 00.54
1. Number of Units of Equipment		,	
Total Annual Number of Cases* Of Total in #2, Number of Patients Age 14 & under			
4. Of Total in #2, Number of Cases Performed in Mobile Unit**			

	1 offormed in Modific Offic				
*	One case is defined to be one visit or trip by a patier laboratory for a single or multiple procedures or cat the number of diagnostic, interventional, and/or EP	heterizatio	ns. Count each vis	sit once regardl	ess o
**	Please report name of mobile vendor:	•			**************************************
ı	Number of operating hours per week on site:	· · · · · · · · · · · · · · · · · · ·	:		
	•	,			
(b)	Open Heart Surgery (utilizing heart/lung bypass machines)				
1.	Number of Dedicated Open Heart Surgery Operating Rooms				
2.	Number of Heart-Lung Bypass Machines	•	·		
3.	Total Annual Number of Procedures		3. · · ·		
4.	Of total in #3, Number of Procedures on Patients Age 14 & under				

All responses should pertain to October 1, 2005 through September 30, 2006. If otherwise, indicate the actual reporting period used on Page 3 of this document,

8. Surgical Operating Rooms and Gastrointestinal Endoscopy Rooms with Cases

a) Surgical Operating Rooms and Cases

[1] Please report <u>Surgical Operating Rooms</u> built to meet the specifications and standards for operating rooms required by the Construction Section of the Division of Facility Services, and which are fully equipped to perform surgical procedures. These surgical operating rooms include rooms located in Obstetrics and surgical suites. Please report the number of cases performed in these rooms during the reporting period. Count each patient undergoing surgery as one case regardless of the number of surgical procedures performed while the patient was in the operating room.

NOTE: If this License includes more than one campus, please submit the Cumulative Totals and COPY this sheet and Submit a duplicate of this page for each campus.

16 Samuel - Yet 1 Yet 1		
(Campus - If multiple sites:	•	```
Company of the contract of the		

Type of Room	Number of Rooms	Of the Rooms in Column[B], the number "Not in Use"	Inpatient Cases	Ambulatory Cases
[A]	[8]	[C]	[D]	(E)
Dedicated Open Heart Surgery (from 7b)			5. 4.	
Dedicated C-Section				
Other Dedicated Inpatient Surgery				
Dedicated Ambulatory Surgery				
Shared - Inpatient / Ambulatory Surgery	6	0	1,348	4,536
Total of Surgical Operating Rooms & Cases (Columns [D] & [E] should equal Totals in 8(d))	6	. 0	1,348	4,536

[2] Does this facility have <u>additional surgical operating rooms</u> (i.e., <u>not</u> listed above) that are being developed to a Certificate of Need or pursuant to the exemption provided in Senate Bill 714? Yes	
If "Yes," please list the Types of Rooms and Number of Rooms being developed:	V NO

b) Gastrointestinal Endoscopy Rooms and Cases

[1] Report the number of <u>Gastrointestinal Endoscopy Rooms</u> and the number of cases performed in these rooms during the reporting period. (<u>NOTE</u>: <u>Other procedure rooms</u> should be included in <u>Section 9 on Page 10</u> of this application.) Count <u>each patient as one case</u> regardless of the number of gastrointestinal procedures performed while patient was in the GI endoscopy room. For GI Endoscopy Rooms, please also report the Total Number of GI Procedures performed.

Type of Room	Number Of Rooms	Of the Rooms in Column [B], the number "Not in Use"	Inpatient Cases	Ambulatory Cases	Total Number of Procedures
[A]	[B]	[C]	[10]	[E]	[F]
Gastrointestinal Endoscopy Rooms & Cases	1	0	GI: 189	GI: 712	GI: 901
	1	l v	Non GI [*]	Non GI: 103	Non CI

		8	103	111
[2] Does this facility have additio developed pursuant to a Certificate	ual Gastrointestinal Endosco e of Need or pursuant to the e	py Rooms (i.e., not exemption provided	listed above) the	hat are being
Senate Bill 714?				X No
If "Yes," please list the Number o	f Rooms being developed:			
Revised 08/2006			· · · · · · · · · · · · · · · · · · ·	Dans 9

8. Surgical Operating Rooms and Gastrointestinal Endoscopy Rooms with Cases continued

c) Average Room Availability and Average Case Times:

Type of Room	"Resource Hours" * (Average <u>Hours</u> per Room per Day Routinely Scheduled for Use)	Average "Case Time" ** in <u>Minutes</u> for Inpatient Cases	Average "Case Time" ** in <u>Minutes</u> for Ambulatory Cases
Surgical Operating Rooms	8	90	60
Gastrointestinal Endoscopy Rooms	4	30	30

^{* &}quot;Resource Hours" = Average number of hours per Room per Day routinely scheduled to be available for performance of procedures. (Example: 2 rooms @ 8 hours per day <u>plus</u> 2 rooms @ 10 hours per day <u>equals</u> 36 hours per day; <u>divided</u> by 4 rooms <u>equals</u> an average of 9 hours / per room / per day.)

d) Surgical Specialty - Of the cases in <u>Surgical Operating Rooms</u> (Item 8.a.[1]), enter the number of <u>cases</u> by surgical specialty area in the chart below:

Specialty Area	Inpatient Cases	Ambulatory Cases
Cesarean Sections	192	
Cystoscopy		
Endoscopy (all endo types performed in Surgical Operating Room)		
General .	274	547
Gynecology	1;76	146
Neurosurgery/Spine	199	392
Open Heart		
Ophthalmology	2	1,370
Oral Surgery · · ·		19
Orthopedics	37 9 v	1,475
Otolaryngology	10	147
Plastic Surgery		
Podiatry	2	21
Thoracic (other than open heart)		3
Urology	94	374
Other (Specify) Cardiology/Oncology/vascular	20	45
Total Surgical Operating Room Cases (Totals should equal totals 8.a[1], columns D & E)	1,348	4,536

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^{** &}quot;Case Time" = Time from Room Set-up Start to Room Clean-up Finish. Definition 2.4 from the "Procedural Times Glossary" of the AACD, as approved by ASA, ACS, and AORN. NOTE: This definition includes all of the time for which a given procedure requires an OR/PR. It allows for the different duration of Room Set-up and Room Clean-up Times that occur because of the varying supply and equipment needs for a particular procedure. For purposes of scheduling and efficiency analysis, this definition is ideal because it includes all of the time that an OR/PR must be reserved for a given procedure.

All responses should pertain to October 1, 2005 through September 30, 2006. If otherwise, indicate the actual reporting period used on Page 3 of this document.

9. Non-Gastrointestinal Procedure Rooms and Cases

Please report only rooms or cases not reported in 8a or 8b: Other rooms not equipped or meeting all the specifications for an operating room, dedicated to the performance of procedures other than gastrointestinal endoscopy. (Do not list a room for more than one use). Please note: Any procedures performed in these rooms should not be billed as having occurred in an operating room or reported in 8 as procedures performed in an operating room. Cases: Count each patient as one case regardless of the number of procedures performed while patient was in the room.

Use	Number of Rooms	Inpatient Cases	Ambulatory Cases
Cast Procedures			
Cystoscopy			
Endoscopies (other than GI Endoscopies) unless they were performed in a surgical operating room		·	
Lithotripsy			
Special Procedures/Angiography (neuro & vascular but not including cardiac cath.)			
Sutures			
YAG Laser			
Other (Specify)			
Totals	,	1	

All responses should pertain to October 1, 2005 through September 30, 2006. If otherwise, indicate the actual reporting period used on Page 3 of this document.

10a. Diagnostic Imaging and Lithotripsy Data

Indicate the number of machines/instruments and the number of the following types of procedures performed during the 12-month reporting period at your facility. For Hospitals that operate medical equipment at multiple sites, please provide a separate page for each site.

Imaging		<u> </u>					
Fixed Equipment	Number	No. of Pro	ocedures		No. of MRI	Procedures *	
(Exclude Research & Policy AC-3 Units)	of Units	Inpatient	Outpatient	Total	With Contrast	Without Contrast	
CT Scanner	1	1,908	6,391	8,299	or Sedation	or Sedation	Total
MRI Skyland	1		1,567	1,567	149	1,418	1,567
Open MRI Scanners included in row above					10000		
Mammogram .	1	2,815	29	2,844			
Other radiographic & fluoroscopic (See Note Below)					No. of MR	Procedures	_
Mobile Equipment	Number	No. of Pr	ocedures		With Contrast	Without Contrast	
Identify Vendor/Owner in space () below:	of Units	Inpatient	Outpatient	Total	or Sedation	or Sedation	Total
MRI#1 (GE LX Echospeed)	1						
MRI 112 ()							
CT Soan (
Nuclear Medicine	Number	No. of Pr	ocedures		Note: Totals of	MRI inpatients and	
Fixed Equipment	of Units	Inpatient	Outpatient	Total	outpatients shou	ld equal MRI totals (with
Dedicated PET Scanner			-		and without cont		
Coincidence Camera				,			
SPECT			***************************************				
Gamma Camera / Spect.	1	726	1291	2,017			
Mobile Equipment	Number	No. of Pi	ocedures				
Identify Vendor/Owner in space () below:	of Units	Inpatient	Outpatient	Total			
Dedicated PET Scanner (Alliance Imag	. 1		92	92			
Coincidence Camera ()							
SPECT ()	7,100		·				
Gamma Camera ()							
	Number	No. of P	rocedures		No. of P	ocedures **	
Policy AC-3 or Research Equipment	of Units	Inpatient	Outpatient	Total	Clinical	Research	Total
MRI pursuant to Policy AC-3:						7777	
Other Human Research MRI Scanner							
PET pursuant to Policy AC-3							
Other Human Research PET Scanner							1
		No, of P	rocedures				
Lithotripsy	Number				Note: Totals of	MRI inpatients and	outpatients
[Identify Vendor/Owner in space () below:]	of Units	Inpatient	Outpatient	Total	sho	uld equal MRI totals	
Fixed (·)					for clinica	al and research proce	edures
Mobile (Prime Medical)		0	-5	5			
(L.,	-II	J		<u> </u>	1 000000000000000000000000000000000000		

MRI procedure is defined as a single discrete MRI study of one patient (single CPT coded procedure). An MRI study means one or more scans relative to a single diagnosis or symptom. <u>NOTE</u>: Please Report ALL Angiography procedures on page 10, in Table 9 under Special Procedures/Angiography Rooms.

PET procedure is defined as a single discrete PET scan of a patient (single CPT coded procedure), not counting other radiopharmaceutical or supply charge codes.

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10b. MRI Procedures by CPT Codes

•	MRI Procedures by CPT Code	
CPT Code	CPT Description	Number of Procedures
70336	MRI Temporomandibular Joint(s)	
70540	MRI Orbit/Face/Neck w/o	
70542	MRI Orbit/Face/Neck with contrast	
70543	MRI Orbit/Face/Neck w/o & with	
70544	MRA Head w/o	48
70545	MRA Head with contrast	200000000000000000000000000000000000000
70546	MRA Head w/o & with	2
70547	MRA Neck w/o	1
70548	MRA Neck with contrast	
70549	MRA Neck w/o & with	14
70551	MRI Brain w/o	160
70552	MRI Brain with contrast	
70553	MRI Brain w/o & with	459
7055A	IAC Screening	
71550	MRI Chest w/o	7
71551	MRI Chest with contrast	
71552	MRI Chest w/o & with	9
71555	MRA Chest with OR without contrast	
72126	Cervical Spine Infusion only	
72141	MRI Cervical Spine w/o	360
72142	MRI Cervical Spine with contrast	300
72156	MRI Cervical Spine w/o & with	41
72146	MRI Thoracic Spine w/o	69
72147	MRI Thoracic Spine with contrast	09
72157	MRI Thoracic Spine w/o & with	32
72148	MRI Lumbar Spine w/o	379
72149	MRI Lumbar Spine with contrast	3/2
72158	MRI Lumbar Spine w/o & with	107
72159	MRA Spinal Canal w/o OR with contrast	10/
72195	MRI Pelvis w/o	24
72196	MRI Pelvis with contrast	24
72197	MRI Pelvis w/o & with	30
72198	MRA Pelvis w/o OR with Contrast	
73218		1
73219	MRI Upper Ext, other than joint w/o MRI Upper Ext, other than joint with contrast	11
73220	MRI Upper Ext, other than joint w/o & with)
73220 73221.	MRI Upper Ext, other than joint w/o & with	8
73221.		168
	MRI Upper Ext any joint with contrast	36
73223 73225	MRI Upper Ext any joint w/o & with	5
There is an entry is a	MRA Upper Ext w/o OR with contrast	potential 1,980

All responses should pertain to October 1, 2005 through September 30, 2006. If otherwise, indicate the actual reporting period used on Page 3 of this document,

10b. MRI Procedures by CPT Codes continued....

	MRI Procedures by CPT Code	etre currenting angle dyndystation to the decision of the current as an a few first from the consecutive defendance of
CPT Code	CPT Description	Number of Procedures
73718	MRI Lower Ext other than joint w/o	33
73719	MRI Lower Ext other than joint with contrast	
73720	MRI Lower Ext other than joint w/o & with	43
73721	MRI Lower Ext any joint w/o	308
73722	MRI Lower Ext any joint with contrast	6
73723	MRI Lower Ext any joint w/o & with	15
73725	MRA Lower Ext w/o OR with contrast	1
74181	MRI Abdomen w/o	38
74182	MRI Abdomen with contrast	
74183	MRI Abdomen w/o & with	24
74185	MRA Abdomen w/c OR-with contrast	17
75552	MRI Cardiac Morphology w/o	
75553	MRI Cardiac Morphology with contrast	
75554	MRI Cardiac Function Complete	
75555	MRI Cardiac Function Limited	
75556	MRI Cardiac Velocity Flow Mapping	
76093	MRI Breast, unilateral w/o and/or with contrast	
76094	MRI Breast, bliateral w/o and/or with contrast	49
76125	Cineradiography to complement exam	
76375	MRI 3-D Reconstruction	
76390	MRI Spectroscopy	
76393	MRI Guidance for needle placement	
76394	MRI Guidance for tissue ablation	
76400	MRI Bone Marrow blood supply	
7649A	MR functional imaging	
7649D	MRI infant spine comp w/ & w/o contrast	
7649E	Spine (infants) w/o infusion	
7649H	MR functional imaging	
N/A	Clinical Research Scans	A CONTRACTOR OF THE CONTRACTOR
	. Total Number of Procedures	2,51.4

All responses should pertain to October 1, 2005 through September 30, 2006. If otherwise, indicate the actual reporting period used on Page 3 of this document.

10b. MRI Procedures by CPT Codes SKYLAND FIXED MRI

PT Code	CPT Description	Number of Procedures
0336	MRI Temporomandibular Joint(s)	2
0540	MRI Orbit/Face/Neck w/o	
0542	MRI Orbit/Face/Neck with contrast	
0543	MRI Orbit/Face/Neck w/o & with	1
0544	MRA Head w/o	12
0545	MRA Head with contrast	
70546	MRA Head w/o & with	
70547	MRA Neck w/o	
70548	MRA Neck with contrast	
70549	MRA Neck w/o & with	
70551	MRI Brain w/o	1.
70552	MRI Brain with contrast	38
70553	MRI Brain w/o & with	1
7055A	IAC Screening	27
71550	MRI Chest w/o	
71551	MRI Chest with contrast	2
71552	MRI Chest w/o & with	
71555	MRA Chest with OR without contrast	
72126	Cervical Spine Infusion only	
72141	MRI Cervical Spine w/o	163
72142	MRI Cervical Spine with contrast	1
72156	MRI Cervical Spine w/o & with	10
72146	MRI Thoracic Spine w/o	46
72147	MRI Thoracic Spine with contrast	
72157	MRI Thoracic Spine w/o & with	1
72148	MRI Lumbar Spine w/o	313
72149	MRI Lumbar Spine with contrast	
72158	MRI Lumbar Spine w/o & with	88
72159	MRA Spinal Canal w/o OR with contrast	
72195	MRI Pelvis w/o	26
72196	MRI Pelvis with contrast	
72197	MRI Pelvis w/o & with	3
72198	MRA Pelvis w/o OR with Contrast	
73218	MRI Upper Ext, other than joint w/o	13
73219	MRI Upper Ext, other than joint with contrast	1
73220	MRI Upper Ext, other than joint w/o & with	
73221	MRI Upper Ext any joint w/o	224
73222	MRI Upper Ext any joint with contrast	44-7
73223	MRI Upper Ext any joint w/o & with	
73225	MRA Upper Ext w/o OR with contrast	

License No: <u>H0019</u> Facility ID: <u>943388</u>

All responses should pertain to October 1, 2005 through September 30, 2006. If otherwise, indicate the actual reporting period used on Page 3 of this document.

10b. MRI Procedures by CPT Codes continued....

	MRI Procedures by CPT Code	
PT Code	CPT Description	Number of Procedures
'3718	MRI Lower Ext other than joint w/o	34 ·
73719	MRI Lower Ext other than joint with contrast	
73720	MRI Lower Ext other than joint w/o & with	7
73721	MRI Lower Ext any joint w/o	544
73722	MRI Lower Ext any joint with contrast	11
73723	MRI Lower Ext any joint w/o & with	5
73725	MRA Lower Ext w/o OR with contrast	
74181	MRI Abdomen w/o	1
74182	MRI Abdomen with contrast	
74183	MRI Abdomen w/o & with	1
74185	MRA Abdomen w/o OR with contrast	1
75552	MRI Cardiac Morphology w/o	
75553	MRI Cardiac Morphology with contrast	
75654	MRI Cardiac Function Complete	
75555	MRI Cardiac Function Limited	
75556	MRI Cardiac Velocity Flow Mapping	
76093	MRI Breast, unliateral w/o and/or with contrast	
76094	MRI Breast, bilateral w/o and/or with contrast	
76125 [.]	Cineradiography to complement exam	
76375	MRI 3-D Reconstruction	
76390	MRI Spectroscopy	
76393	MRI Guidance for needle placement	
76394	MRI Guidance for tissue ablation	
76400	MRI Bone Marrow blood supply	
7649A	MR functional imaging	·
7649D	MRI Infant spine comp w/ & w/o contrast	
7649E	Spine (infants) w/o infusion	
7649H	MR functional imaging	
N/A	Clinical Research Scans	
	Total Number of Procedure	1,567

All responses should pertain to October 1, 2005 through September 30, 2006. If otherwise, indicate the actual reporting period used on Page 3 of this document.

11. Radiation Oncology Treatment Data

CPT Code	Description	Number of Procedures	ESTVs/ Procedures Under ACR	Total ACR ESTVs	
	Simple Treatment Delivery:			- T. T. C.	
77401	Radiation treatment delivery		1.00		
77402	Radiation treatment delivery (<=5 MeV)		1.00	***************************************	
			1.00	······································	
77404	Radiation treatment delivery (11-19 MeV)		1.00	,	
77406	Radiation treatment delivery (>=20 MeV)		1.00	······································	
	Intermediate Treatment Delivery:				
77407	Radiation treatment delivery (<=5 MeV)		1.00		
77408	Radiation treatment delivery (6-10 MeV)		1.00		
77409			1.00	,	
77411	Radiation treatment delivery (>=20 MeV)		1.00		
	Complex Treatment Delivery:				
77412	Radiation treatment delivery (<=5 MeV)		1.00		
77413	Radiation treatment delivery (6-10 MeV)		1.00		1
77414			1.00		†
77416	Radiation treatment delivery (>= 20 MeV)	<u> </u>	1.00		
	Sub-Total				
For the	e increased time required for special techniqu	ies, ESTV valu	es are indicated	below:	<u> </u>
77417	Additional field check radiographs	T T	.50		
77418	Intensity modulated radiation treatment (IMRT)delivery		1.00		
77432	Stereotactic radiosurg, treatment mgmt Linear Accelerator		3.00		
77432	Stereotactic radiosurg. Treatment mgmt. Gamma Knife		3.00		
	Total body irradiation		2.50	ļ	
	Hemibody irradiation		2,00		
	Intraoperative radiation therapy (conducted by bringing the anesthetized patient down to the linac)		10.00	• .	
	Neutron and proton radiation therapy		2.00		
	Limb salvage irradiation		1.00		
	Pediatric Patient under anesthesia		1.50		T
	Sub-Total				
1	I CHO A CHAI				

Note: For special techniques, list procedures under both the treatment delivery and the special techniques sections.

All responses should pertain to October 1, 2005 through September 30, 2006. If otherwise, indicate the actual reporting period used on Page 3 of this document.

Number of unduplicated patients treatments (patients shall be coun of treatment)		nan once if they receive additional courses	
. Total number of Linear Accelerat	or(s)		
. Number of Linear Accelerators co	onfigured f	or stereotactic radiosurgery	
2. Telemedicine	madicina t	o have images read at another facility?	VRC
· ·			LUO
b. Does your facility read telen	aedicine in	nages? NO	
3. Additional Services:			
3. Additional Services:	- - - - - - - - - - -		
3. Additional Services: a) Check if Service(s) is provident		T	Chaok
a) Check if Service(s) is provide	ed:	5 Rehabilitation Outpatient Unit	Check
a) Check if Service(s) is provide Cardiac Rehab Program		5. Rehabilitation Outpatient Unit	Check
a) Check if Service(s) is provide Cardiac Rehab Program (Outpatient)	Check	Rehabilitation Outpatient Unit Podiatric Services	
a) Check if Service(s) is provide Cardiac Rehab Program (Outpatient) Chemotherapy	Check	6. Podiatric Services	X
a) Check if Service(s) is provide Cardiac Rehab Program (Outpatient)	Check	6. Podiatric Services	X
 a) Check if Service(s) is provided. 1. Cardiac Rehab Program (Outpatient) 2. Chemotherapy 3. Clinical Psychology Services 	Check	Podiatric Services Genetic Counseling Service	X
 a) Check if Service(s) is provided. 1. Cardiac Rehab Program (Outpatient) 2. Chemotherapy 3. Clinical Psychology Services 4. Dental Services 	Check X X	Podiatric Services Genetic Counseling Service Acute Dialysis	X
 a) Check if Service(s) is provided. 1. Cardiac Rehab Program (Outpatient) 2. Chemotherapy 3. Clinical Psychology Services 	Check X X	Podiatric Services Genetic Counseling Service Acute Dialysis	X
 a) Check if Service(s) is provided. 1. Cardiac Rehab Program (Outpatient) 2. Chemotherapy 3. Clinical Psychology Services 4. Dental Services 	Check X X ations	Podiatric Services Genetic Counseling Service Acute Dialysis	X

County of Residence	Age 0- 17	Age 18-40	Age 41-59	Age 60-64	Age 65-74	Age 75-84	Age 85+	Total Patients Served	Total Days of Care	Deaths
	· · · · · ·									
						,				
					 					
Out of State										
Total All Ages										

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All responses should pertain to October 1, 2005 through September 30, 2006. If otherwise, indicate the actual reporting period used on Page 3 of this document,

13. Additional Services: continued

c)	Me	ntal Health and Substance Abuse
	1.	If psychiatric care has a different name than the hospital, please indicate:

Hope Behavioral Health Services

2. If address is different than the hospital, please indicate:

3. Director of the above services, Rebecca M. Mayer, R.N., Ph. D.

Indicate the program/unit location in the <u>Service Categories</u> chart below. If it is in the hospital, include the room number. If it is located at another site, include the building name, program/unit name and address.

<u>Service Categories:</u> All applicants must complete the following table for all mental health services which are to be provided by the facility. If the service is not offered, leave the spaces blank.

Rule 10A NCAC 27G Licensure Rules For Mental Health Facilities	i i					
		0-12	13-17	Subtotal 0-17	18 & up	Total Beds
.1100 Partial hospitalization for individuals who are acutely mentally ill.	In-Patient				-	
.1200 Psychosocial rehabilitation facilities for individuals with severe and persistent mental illness						
.1300 Residential treatment facilities for children and adolescents who are emotionally disturbed or have a mental illness						
.1400 Day treatment for children and adolescents with emotional or behavioral disturbances						
.1500 Intensive residential treatment facilities for children & adolescents who are emotionally disturbed or who have a mental illness						

Rule 10A NCAC 13B Licensure Rules	Location of			ned by A		
For Hospitals	Services	0-12	13-17	Subtotal 0-17	18 & up	Total Beds
.5200 Dedicated inpatient unit for individuals who have mental disorders	PRH				41	41

All responses should pertain to October 1, 2005 through September 30, 2006. If otherwise, indicate the actual reporting period used on Page 3 of this document.

13. Additional Services: continued

c) Mental Health and Substance Abuse continued

13-17	Subtotal 0-17	18 & up	Total Bed:
	1		11
			<u> </u>
==			

Rule 10A NCAC 13B Licensure Rules	Location of	Bec	ds Assig	ned by A	Age	
For Hospitals	Services	0-12	13-17	Subtotal 0-17	18 & up	Total Beds
.5200 Dedicated inpatient hospital unit for individuals who have substance abuse disorders (specify type) # of Treatment beds						
# of Medical Detox beds						

All responses should pertain to October 1, 2005 through September 30, 2006. If otherwise, indicate the actual reporting period used on Page 3 of this document.

Patient Origin -General Acute Care Inpatient Services

Facility County: Henderson

In an effort to document patterns of utilization of General Acute Care Inpatient Services in North Carolina hospitals, please provide the county of residence for each patient admitted to your facility.

County	No. of	County	No. of	County	No. of
····	Admissions		Admissions	<u> </u>	Admissions
l. Alamance	, , , , , , , , , , , , , , , , , , ,	37. Gates		73. Person	
2. Alexander		38. Graham	2	74. Pitt	
3. Alleghany		39. Granville		75. Polk	80
4. Anson		40. Greene		76. Randolph	
5. Ashe		41. Guilford		77. Richmond	
б. Avery	1 1	42. Halifax		78. Robeson	
7. Beaufort		43. Harnett		79. Rockingham	
8. Bertie		44. Haywood	64	80. Rowan	2
9. Bladen		45. Henderson	2,462	81. Rutherford	55
10. Brunswick		46. Hertford		82. Sampson-	
11. Buncombe	840	47. Hoke		83. Scotland	
12. Burke	21	48. Hyde		84. Stanly	
13. Cabarrus	2	49. Iredell		85. Stokes	
14. Caldwell	3	50. Jackson	26	86. Surry	
15: Camden		51. Johnston		87. Swain	6
16. Carteret		52. Jones		88. Transylvania	75
17. Caswell		53. Lee		89. Tyrrell	
18. Catawba		54. Lenoir		90. Union	
19. Chatham		55. Lincoln		91. Vance	
20. Cherokee	3	56. Macon	18	92. Wake	
21. Chowan		57. Madison	5	93. Warren	
22. Clay	2	58. Martin	21	94. Washington	
23. Cleveland	5	59. McDowell		95. Watauga	
.24. Columbus	2	60. Mecklenburg	5	96. Wayne	
25. Craven		61. Mitchell	. 2	97. Wilkes	
26, Cumberland		62. Montgomery		98. Wilson	
27. Currituck		63. Moore		99. Yadkin	
28. Dare		64. Nash		100. Yancey	7
29. Davidson		65. New Hanover			
30. Davie		66. Northampton		101. Georgia	
31, Duplin		67. Onslow		102. South Carolina	27
32, Durham		68. Orange		103. Tennessee	3
33. Edgecombe		69. Pamlico		104. Virginia	2
34. Forsyth		70. Pasquotank		105. Other States	39
35. Franklin		71. Pender		106. Other	43
36. Gaston	2	72. Perquimans		Total No. of Patients	

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All responses should pertain to October 1, 2005 through September 30, 2006. If otherwise, indicate the actual reporting period used on Page 3 of this document.

Patient Origin - Impatient Surgical Cases - Excluding GI Endoscopy Cases (In Dedicated Inpatient or Shared Operating Rooms)

Facility County: Henderson

In an effort to document patterns of "Inpatient" utilization of Surgical Operating Rooms in North Carolina hospitals, please provide the county of residence for each inpatient surgical patient served in your facility. Count each inpatient "once" regardless of the number of surgical procedures performed while the patient was in the operating room. However, each admission as an inpatient operating room patient should be reported separately.

The "Total" from this chart should match the "Total" reported in the <u>Inpatient Cases</u> "Column D" in the Table under 8(a), page 8.

County	No. of Patients		No. of Patients		No. of Patients
1. Alamance	<u>'</u>	37. Gates	•	73. Person	
2. Alexander		38. Graham	2	74. Pitt	
3. Alleghany		39. Granville		75. Polk	26
4. Anson		40. Greene		76. Randolph	
5. Ashe	1	41. Guilford		77. Richmond	
6. Avery	2	42. Halifax		78. Robeson	
7. Beaufort		43. Harnett		79. Rockingham	
8. Bertie		44. Haywood	73	80. Rowan	1
9. Bladen	1	45. Henderson	700	81. Rutherford	29
10. Brunswick		46. Hertford		82. Sampson	
11. Buncombe	296	47. Hoke		83. Scotland	
12. Burke	. 29	48. Hyde		84. Stanly	
13. Cabarrus	1	49. Iredeil		85. Stokes	
14. Caldwell	5	50. Jackson	22	86. Surry	
15. Camden		51. Johnston		87. Swain	6
16. Carteret		52. Jones		88. Transylvania	28
17. Caswell		53. Lee		89. Tyrrell	
18. Catawba		54. Lenoir		90. Union	
19. Chatham		55. Lincoln		91. Vance	
20. Cherokee		56. Macon	11	92. Wake	
21. Chowan		57. Madison	5	93. Warren	
22, Clay	1	58. Martin	18	94. Washington	
23. Cleveland	4	59. McDowell		95. Watauga	
24. Columbus	2	60. Mecklenburg		96. Wayne	
25. Craven		61. Mitchell	2	97. Wilkes	
26, Cumberland		62. Montgomery	2	98. Wilson	
27. Currituck		63. Moore		99. Yadkin	
28. Dare		64. Nash		100. Yancey	3
29. Davidson		65. New Hanover	1		T
30. Davie		66. Northampton		101. Georgia	
31. Duplin		67. Onslow		102, South Carolina	20
32. Durham		68. Orange		103. Tennessee	3
33. Edgecombe		69. Pamlico		104. Virginia	2
34. Forsyth		70. Pasquotank		105. Other States	23
35. Franklin		71. Pender		106. Other	23
36. Gaston		72. Perquimans		Total No. of Patients	

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All responses should pertain to October 1, 2005 through September 30, 2006. If otherwise, indicate the actual reporting period used on Page 3 of this document.

Patient Origin - Ambulatory Surgical Cases - Excluding GI Endoscopy Cases (In Dedicated Ambulatory or Shared Operating Rooms)

Facility County: Henderson

In an effort to document patterns of "Ambulatory" utilization of Surgical Operating Rooms in North Carolina hospitals, please provide the county of residence for each ambulatory surgery patient served in your facility. Count each ambulatory patient "once" regardless of the number of procedures performed while the patient was in the operating room. However, each admission as an ambulatory operating room patient should be reported separately.

The "Total" from this chart should match the "Total" reported in the Ambulatory Cases, "Column B" in the Table under 8(a), page 8.

County	No. of Patients	County	No. of Patients	County	No. of Patients
1. Alamance	11	37. Gates		73. Person	
2. Alexander	77	38. Graham	1.9	74. Pitt	
Alleghany		39. Granville	1	75. Polk	110
4. Anson		40. Greene	1	76. Randolph	
5. Ashe		41. Guilford		77. Richmond	
6. Avery	13	42. Halifax		78. Robeson	1
7. Beaufort		43. Harnett	3	79. Rockingham	
8. Bertie		44. Haywood	211	80. Rowan	
9. Bladen		45. Henderson	2486	81. Rutherford	53
10. Brunswick		46. Hertford		82. Sampson	
11. Buncombe	998	47. Hoke		83. Scotland	
12. Burke	41	48. Hyde		84. Stanly	·
13. Cabarrus		49. Iredell	1	85. Stokes	
14. Caldwell	6	50. Jackson	52	86. Surry	***************************************
15. Camden		51. Johnston		87. Swain	35
16. Carteret		52. Jones	1	88. Transylvania	136
17. Caswell		53. Lee	1	89. Tyrrell	1
18. Catawba	4	54. Lenoir		90. Union	1
19. Chatham		55. Lincoln	10	91. Vance	<u> </u>
20. Cherokee	23	56. Macon	50	92. Wake	
21. Chowan		57. Madison	37	93, Warren	
22, Clay		58. Martin	58	94. Washington	<u> </u>
23. Cleveland		59. McDowell		95. Watauga	2
24. Columbus		60. Mecklenburg	1	96. Wayne	
25. Craven		61. Mitchell	24	97. Wilkes	
26. Cumberland		62. Montgomery		98. Wilson	
27. Currituck		63. Moore		99. Yadkin	2.
28. Dare		64. Nash		100. Yancey	36
29. Davidson		65. New Hanover			
30. Davie		66. Northampton		101. Georgia	3
31. Duplin		67. Onslow		102. South Carolina	. 42
32. Durham		68. Orange		103. Tennessee	1 5
33. Edgecombe	1	69. Pamlico		104. Virginia	
34. Forsyth		70. Pasquotank		105. Other States	26
35. Franklin	1 1	71. Pender		106. Other	40
36. Gaston		72. Perquimans		Total No. of Patient	s 4,536

All responses should pertain to October 1, 2005 through September 30, 2006. If otherwise, indicate the actual reporting period used on Page 3 of this document.

Patient Origin - Gastrointestinal Endoscopy (GI) Cases - (Performed In Gastrointestinal Endoscopy Rooms)

Facility County: Henderson

In an effort to document patterns of utilization of Gastrointestinal Endoscopy Rooms in North Carolina hospitals, please provide the county of residence for each GI Endoscopy patient served in your facility. Count each patient "once" regardless of the number of procedures performed while the patient was in the Gastrointestinal Endoscopy Room. However, each admission as a GI Endoscopy Room patient should be reported separately.

The "Total" from this chart should match the Combined Total reported as Gastrointestinal Endoscopy Cases, "Column D" plus "Column E" in the Table under 8(b), page 8.

County	No. of Patients		No. of Patients	County	No. of Patients
1. Alamance		37. Gates		73. Person	
2. Alexander		38. Graham	1	74. Pitt	
3. Alleghany		39. Granville		75. Polk	15
4. Anson		40. Greene		76. Randolph	
5. Ashe		41. Guilford		77. Richmond	
6. Avery		42. Halifax		78. Robeson	
7. Beaufort		43. Harnett		79. Rockingham	
8. Bertie		44. Haywood	14	80. Rowan	***************************************
9. Bladen		45. Henderson	744	81. Rutherford	8
10. Brunswick		46. Hertford		82. Sampson	
11. Buncombe	178	47. Hoke		83. Scotland	
12. Burke		48. Hyde		84. Stanly	
13. Cabarrus	1	49. Iredell		85. Stokes	
14. Caldwell		50. Jackson	1	86. Surry	***************************************
15. Camden		51. Johnston		87. Swain	
16. Carteret		52. Jones		88. Transylvania	21
17. Caswell		53. Lee		89. Tyrrell	
18. Catawba	1	54. Lenoir		90. Union	
19. Chatham		55. Lincoln		91. Vance	
20. Cherokee	1	56. Macon	2	92. Wake	
21. Chowan		57. Madison	2	93. Warren	
22. Clay		58. Martin	2	94. Washington	
23. Cleveland		59. McDowell	1	95. Watauga	1
24. Columbus		60. Mecklenburg		96. Wayne	
25. Craven		61. Mitchell		97. Wilkes	
26: Cumberland		62. Montgomery		98. Wilson	
27. Currituck		63. Moore		99. Yadkin	
28. Dare		64. Nash		100. Yancey	4
29. Davidson		65. New Hanover			
30. Davie	1	66. Northampton		101. Georgia	
31. Duplin		67. Onslow		102. South Carolina	4
32. Durham		68. Orange		103. Tennessee	1
33. Edgecombe		69. Pamlico		104. Virginia	
34. Forsyth		70. Pasquotank		105. Other States	5
35. Franklin		71. Pender		106. Other	4
36. Gaston		72. Perquimans		Total No. of Patients	

All responses should permin to October 1, 2005 through September 30, 2006. If otherwise, indicate the actual reporting period used on Page 3 of this document.

Patient Origin - Psychiatric and Substance Abuse Alamance through Johnston

Facility County: Henderson

Complete the following table below for inpatient Days of Care reported under Section .5200.

County of Patient Origin	Į.	luntric Treatmen Days of Care		Substance Abuse Treatment Days of Care			Day	Detoxification Days of Care		
	Age 0-17	Age 18+	Totals	Age 0-17	Age 18+	Totals	Age 0-17	Age 18+	Totals	
Alamance									1	
Alexander	i	1							1	
Alleghany										
Anson									1	
Ashe		1			1		-		 	
Avery	. (4							1	
Beaufort		T			1				1	
Bertie ·	1				1			 	1	
Bladen	1	1 1	<u> </u>			1			1	
Brunswick	1	2	 				,		1	
Buncombe	1	327	 	ļ				 	 	
Burke		6	1	1	1			 	 	
Cabarrus	1	1 7	1	l	· · · · · · · · · · · · · · · · · · ·				 	
Caldwell	1	1 1	1		<u> </u>	1		1	1	
Camden	1	1	1	1	1	1		1	+	
Carteret	1	1		1	†	<u> </u>			 	
Caswell	1	 	1		 	 		 	 	
Catawba		1 3	+	1		1	·	 		
Chatham		_		 		 		 	-} -	
Cherokee		17	 			 		 		
Chowan			+	 	-			 	- [
Clay	- 			- } -			ļ			
		8	-							
Cleveland ,			- 	<u> </u>						
Columbus		<u> </u>		 				ļ		
Crnven		 		_ <u> </u>			<u> </u>	 		
Cumberland	<u> </u>	_ 				 	ļ	<u> </u>		
Curituck	_					_	 			
Dare .				- 			<u> </u>			
Davidson							ļ <u>.</u>			
Davie.		2		<u> </u>			<u> </u>			
Duplin									_	
Durham	1	2		_						
Edgecombe										
Porsyth							1			
Franklin				·						
Gaston		/		_			<u></u>			
Gates								1		
Graham		3					1			
Granville										
Greene										
Guilford		2								
Halifax							1			
Harnett										
Haywood		86								
Henderson		280								
Hertford					**-		·			
Hoke			_				1	~		
Hydo				1			1			
Iredell		-1 "5					1	·		
Jackson	-	30		—			1	- 		
Johnston							1			

** Note: See counties: Jones through Yancey (including Out-of-State) on next page.

All responses should pertain to October 1, 2005 through September 30, 2006. If otherwise, indicate the actual reporting period used on Page 3 of this document.

Patient Origin - Psychiatric and Substance Abuse Jones through Yancey (including Out-of-State)

Facility County: <u>Henderson</u> (Continued from previous page)

County of Patient Origin	-	hiatric Treatm Days of Care		1	Substance Abuse Treatment Days of Care			Days of Care			Detoxification Days of Care		
	Age 0-17	Age 18+	Totais	Age 0-17	Age 18+	Totals	Age 0-17	Age 18+	T'otals				
ones .									1				
.cc									1				
cnoir					,				—				
incoln	1		4										
Macon			24	1					 				
Madison	d		25 24		1				1				
viartin.			24										
vicDowell									 				
Mecklenburg			4						1				
Mitchell		·	8										
Montgomery	L												
Moore													
Vash						1			i				
New Hanover		i .	3	1	1			T	1				
Northampton				1					1				
Onslow		1	3		T				 				
Orange			2	1	T	1		1	1				
Pamlico									 				
Pasquotank		1				T							
Pender			1		-				 				
Perquimans		1		1		-			·				
Person	-	 	1		1		ļ						
Pitt			 	1			 		 				
Polk		 	5				 						
Randolph			 			-	1						
Richmond		-					 						
Robeson		<u> </u>	1	-			 		 				
Rockingham			 	-1			1		-				
Rowan		 	 	1		 	1		 				
Rutherford		-	31.		1								
Sampson	_			_			 						
Scotland		 	 										
Stanly	-	 ~	1										
Stokes	·	 	 				1						
Surry			-				┨───						
Swain	-		1.2				 						
Transylvania			68	- 	 								
Tyrrell			 00				┨───						
Union			-				 		-				
Vance			+				1						
Wake			1-2				 						
Warren	-	-	 										
Washington						-	-		 				
Watauga		 	4				·						
Wayne			 										
Wilkes			 	_		-							
		- 					-		_				
Wilson		 		<u> </u>									
Yadkin													
Yancey Out of State			22			_							
TOTAL			1,103										

^{**} Note: See counties: Alamance through Johnston on previous page.

All responses should pertain to October 1, 2005 through September 30, 2006. If otherwise, indicate the actual reporting period used on Page 3 of this document.

Patient Origin - MRI Services

Facility County: Henderson

In an effort to document patterns of utilization of MRI Services in North Carolina, hospitals are asked to provide county of residence for each patient served in your facility. Patients served include patients receiving MRI procedures reported in Table 10a of this application (page 11),

County	No. of Patients	County	No. of Patients	County	No. of Patients
1. Alamance		37. Gates		73. Person	140. OF FALICIES
2. Alexander		38. Graham		74. Pitt	1
3. Alleghany		39. Granville		75. Polk	53
4. Anson		40. Greene		76. Randolph	
5. Ashe	1	41. Guilford	1	77. Richmond	
6. Avery	1	42. Halifax		78. Robeson	
7. Beaufort		43. Harnett		79. Rockingham	***************************************
8. Bertie		44. Haywood	46	80. Rowan	2
9. Bladen		45. Henderson	1,606	81. Rutherford	19
10. Brunswick		46. Hertford	1	82. Sampson.	
11. Buncombe	457	47. Hoke		83. Scotland	
12. Burke	9	48. Hyde		84. Stanly	
13. Cabarrus	3.	49. Iredell		85. Stokes	
14. Caldwell	2	50. Jackson	4 .	86. Surry	
15. Camden		51. Johnston	2	87. Swain	2
16. Carteret		52. Jones		88. Transylvania	72
17. Caswell		53. Lee		89. Tyrrell	. 12
18. Catawba	1	54. Lenoir	1	90. Union	
19. Chatham		55. Lincoln	3	91. Vance	
20. Cherokee	3	56. Macon	17	92. Wake	6
21. Chowan .		57. Madison	7	93. Warren	Ω
22. Clay		58. Martin	15	94. Washington	
23. Cleveland		59. McDowell		95. Watauga	
24. Columbus	5	60. Mecklenburg	. 2	96. Wayne	
25. Craven		61. Mitchell	1	97. Wilkes	
26. Cumberland	1	62. Montgomery		98. Wilson	
27. Currituck		63. Moore		99. Yadkin	
28. Dare		64. Nash		100. Yancey	2
29. Davidson	3	65. New Hanover			
30. Davie		66. Northampton		101. Georgia	13
31. Duplin		67. Onslow		102. South Carolina	39
32. Durham		68. Orange	1	103. Tennessee	3
33. Edgecombe		69. Pamlico	1:3	104. Virginia	8
34. Forsyth		70. Pasquotank	1	105. Other States	60
35. Franklin	1	71. Pender	1	106. Other	34
36. Gaston	5	72. Perquimans	j	Total No. of Patients	2,514

Mobile Services:	True	X	or False	
				

License No: <u>H0019</u> Facility ID: <u>943388</u>

All responses should pertain to October 1, 2005 through September 30, 2006. If otherwise, indicate the actual reporting period used on Page 3 of this document.

Patient Origin - Radiation Oncology Treatment

Facility County: Henderson

In an effort to document patterns of utilization of Radiation Oncology Treatment in North Carolina, hospitals are asked to provide county of residence for each patient served in your facility. This data should only reflect the number of patients, not number of treatments. Patients reported should be patients receiving [linac] procedures listed in Section 11 of this application. Please count each patient only once.

County N	o. of Patients	County	No. of Patients	County	NT. PTV. II
1. Alamance		37. Gates		73. Person	No. of Patients
2. Alexander		38. Graham		74. Pitt	
3. Alleghany.		39. Granville		75. Polk	
4. Anson		40. Greene		76. Randolph	
5. Ashe		41. Guilford		77. Richmond	
6. Avery		42. Halifax	-	78. Robeson	
7. Beaufort		43. Harnett	 	79. Rockingham	
8. Bertie		44. Haywood		80. Rowan	
9. Bladen		45. Henderson		81. Rutherford	[
10. Brunswick		46. Hertford		82. Sampson	
11. Buncombe		47. Hoke		83. Scotland	
12. Burke		48. Hyde	 	84. Stanly	
13. Cabarrus	·	49. ĭredell		85. Stokes	
14. Caldwell		50. Jackson		86. Surry	
15. Camden		51. Johnston		87. Swain	
16. Carteret	***	52. Jones		88. Transylvania	
17. Caswell	· · · · · · · · · · · · · · · · · · ·	53. Lec	 	89. Tyrrell	
18. Catawba		54. Lenoir		90. Union	
19. Chatham	***************************************	55. Lincoln	 	91. Vance	
20. Cherokee	······································	56. Macon		92. Wake	
21, Chowan		57. Madison		93. Warren	
22. Clay	······································	58. Martin		94. Washington	
23. Cleveland		59. McDowell	-	95. Watauga	
24. Columbus		60. Mecklenburg		96. Wayne	
25. Craven		61. Mitchell		97. Wilkes	
26. Cumberland		62. Montgomery	<u> </u>	98. Wilson	
27. Currituck	·	63. Moore		99. Yadkin	
28. Dare		64. Nash		100. Yancey	
29. Davidson		65. New Hanover		100, Lancey	
30Davie		66. Northampton		101. Georgia	
31. Duplin		67. Onslow		102. South Carolina	
32. Durham		68. Orange		103. Tennessee	<u></u>
33. Edgecombe		69. Pamlico		104. Virginia	ļ
34. Forsyth		70. Pasquotank		105. Other States	ļ
35. Franklin	· · · · · · · · · · · · · · · · · · ·	71. Pender		106. Other States	
36. Gaston	***************************************	72. Perquimans			
		T. v. z ordannans	1	Total No. of Patients	

All responses should pertain to October 1, 2005 through September 30, 2006. If otherwise, indicate the actual reporting period used on Page 3 of this document.

Patient Origin - PET Scanner

Facility County: Henderson

In an effort to document patterns of utilization of PET Scanner in North Carolina, hospitals are asked to provide county of residence for each patient served in your facility. This data should <u>only</u> reflect the number of <u>patients</u>, not number of scans and should not include other radiopharmaceutical or supply charge codes. Please count each patient only once.

County	No. of Patients	County	No. of Patients	County.	No. of Patients
1. Alamance		37. Gates		73. Person	2100 OF A RELOCATIO
2. Alexander		38. Graham		74. Pitt	* /
3. Alleghany		39. Granville - y		75. Polk	1
4. Anson		40. Greene		76. Randolph	
5. Ashe		41. Guilford		77. Richmond	
б. Avery-		42. Halifax		78. Robeson	
7. Beaufort		43. Harnett		79. Rockingham	
8. Bertie		44. Haywood		80. Rowan	
9. Bladen		45. Henderson	76	81. Rutherford	**************************************
10. Brunswick		46. Hertford		82. Sampson	
11. Buncombe	8	47. Hoke		83. Scotland	***************************************
12. Burke	. 1	48. Hyde		84. Stanly	
13. Cabarrus		49. Iredell		85. Stokes	· · · · · · · · · · · · · · · · · · ·
14. Caldwell		50. Jackson		86. Surry	,4
15. Camden		51. Johnston		87. Swain	
16. Carteret		52. Jones		88. Transylvania	5
17. Caswell		53. Lee		89. Tyrrell	<u> </u>
18. Catawba		54. Lenoir		90. Union	·
19. Chatham		55. Lincoln		91. Vance	
20. Cherokee		56. Macon	<u> </u>	92. Wake	
21. Chowan		57. Madison		93. Warren	
22. Clay		58. Martin	1	94. Washington	
23. Cleveland		59. McDowell		95. Watauga	
24. Columbus		60. Mecklenburg		96. Wayne	· · · · · · · · · · · · · · · · · · ·
25. Craven		61. Mitchell		97. Wilkes	,
26, Cumberland		62. Montgomery		98. Wilson	
27. Currituck		63. Moore		99, Yadkin	
28. Dare		64. Nash		100. Yancey	
29. Davidson		65. New Hanover			
30. Davie		66. Northampton		101. Georgia	
31. Duplin		67. Onslow	``	102. South Carolina	
32. Durham		68. Orange	1	103. Tennessee	
33. Edgecombe		69. Pamlico	1	104. Virginia	
34. Forsyth		70. Pasquotank	1	105. Other States	
35. Franklin		71. Pender		106. Other	
36. Gaston		72. Perquimans		Total No. of Patients	92

All responses should pertain to October 1, 2005 through September 30, 2006. If otherwise, indicate the actual reporting period used on Page 3 of this document.

This application must be completed and submitted with <u>ONE COPY</u> to the Acute and Home Care Licensure and Certification Section, Division of Facility Services prior to the issuance of a 2007 hospital license.

AUTHENTICATING SIGNATURE: The undersigned submits application for the year 2007 in accordance with Article 5, Chapter 131B of the General Statutes of North Carolina, and subject to the rules and codes adopted thereunder by the North Carolina Medical Care Commission (10A NCAC 13B), and certifies the accuracy of this information.

Signature:	Jums-	Burn		-6-06
PRINT NAME OF APPROVING OFFICIA	L Jimm I	Bunch	•	

<u>Please be advised</u>, the license fee <u>must</u> accompany the completed application and be submitted to the Acute and Home Care Licensure and Certification Section, Division of Facility Services, <u>prior</u> to the issuance of a hospital license.

North Carolina Department of Health and Human Services Division of Health Service Regulation Acute and Home Care Licensure and Certification Section 1205 Umstead Drive, 2712 Mail Service Center Raleigh, North Carolina 27699-2712
Telephone: (919) 855-4620 Fax: (919) 715-3073

EXHIBIT Medicare # 340023

For Official Use Only License # H0019 Computer: 943388 PC \rightarrow\frac{1}{\sqrt{2}}

License Fee:

\$1,737.50

2008 HOSPITAL LICENSE RENEWAL APPLICATION

Doing Business A (d/b/a) name(s) un	s der which	the facility or serv	vices are ac	lvertised or	presented to the p	public:	
PRIMARY: Other:	Park Rid	lge Hospital					
Facility Mailing	Address:	P O Box 1569 Fletcher, NC	28732				
Facility Site Add	ress:	Naples Rd Fletcher, NC 2	3732				•
County: Telephone: Fax:		Henderson (828)684-8501 (828)687-0729	,				
Administrator/I Title: <u>CEO</u> (Designated agent (JIMM BUNCH		owner) for the	management of the	licensed facility)	
Chief Executive (Designated agent (Officer:_individual) r	Jimm Bunch esponsible to the gove	rning body (owner) for the	Title: p	resident & (licensed facility)	SEO .
Name of the per	son to con	tact for any questic	ons regardi	ng this form	n:	•	
Name: Myr	iam L.	Schulze			Telephor	ne: 828,681.	2102
E-Mail: myr	iam.sch	nulze@ahss.or	ā.		CK. NO. 22 S	14389 - 81, 11-26-07	737.50

[&]quot;The N.C. Department of Health and Human Services does not discriminate on the basis of race, color, national origin, religion, age, or disability in employment or the provision of services."

ist Name(s) of facilitie	: Address:	,	Type of Business / Service
se attach a separate sl	eet for additional listings		
novchin Nicolosure (Pl	ease fill in any blanks and make cl	nanges where nece	ssary.)
•			•
	legal entity with ownership respo	nsibility and liabil	ity?
Owner:	Fletcher Hospital, Incorporated 56-0543246	•	
Federal Employer ID#	P O Box 1569		
Street/Box: City:	Fletcher State: NC	Zip: 28732	•
Telephone:	(828)684-8501 Fax: (8		
CEO:	Michael H. Schultz JIMM	BUNCH	•
If 'Yes', name of Hea	h Health System? X_YesNo th System*:Adventist	Health Syste	me me
If 'Yes', name of Hea	h Health System? X Yes No th System*: Adventist NC facilities that are part of your H Donald Jernigan, Ph	[ealth System]	me me
If 'Yes', name of Hea * (please attach a list of If 'Yes', name of CEC a Legal entity is:	th System*: Adventist NC facilities that are part of your H Donald Jernigan, Ph For Profit X	D. Not For Profit	em .
If 'Yes', name of Hea * (please attach a list of If 'Yes', name of CEC a Legal entity is:	th System*: Adventist NC facilities that are part of your H Donald Jernigan, Ph	D. Not For Profit	Partnership Government Unit
If 'Yes', name of Hea * (please attach a list of If 'Yes', name of CEO a. Legal entity is: b. Legal entity is:	th System*: Adventist NC facilities that are part of your H Donald Jernigan, Ph For Profit X Corporation Proprietorship tity (partnership, corporation, etc.	Not For Profit LLP LLC	Partnership Government Unit
If 'Yes', name of Hea * (please attach a list of If 'Yes', name of CEC a. Legal entity is: b. Legal entity is: c. Does the above e	th System*: Adventist NC facilities that are part of your H Donald Jernigan, Ph For Profit X Corporation Proprietorship tity (partnership, corporation, etc. Yes X No	Not For Profit LLP LLC	Partnership Government Unit
If 'Yes', name of Hea * (please attach a list of If 'Yes', name of CEC a. Legal entity is: b. Legal entity is: c. Does the above eare offered? If "YES", name of but	th System*: Adventist NC facilities that are part of your H Donald Jernigan, Ph For Profit X Corporation Proprietorship httity (partnership, corporation, etc. Yes X No illding owner:	Not For Profit LLP LLC) LEASE the build	Partnership Government Unit
If 'Yes', name of Hea * (please attach a list of If 'Yes', name of CEC a. Legal entity is: b. Legal entity is: c. Does the above eare offered? If "YES", name of but	th System*: Adventist NC facilities that are part of your H Donald Jernigan, Ph For Profit X Corporation Proprietorship tity (partnership, corporation, etc. Yes X No	Not For Profit LLP LLC) LEASE the build	Partnership Government Unit
If 'Yes', name of Hea * (please attach a list of If 'Yes', name of CEC a. Legal entity is: b. Legal entity is: c. Does the above effered? If "YES", name of but Is the business operat If 'Yes', name and ad	th System*: Adventist NC facilities that are part of your H Donald Jernigan, Ph For Profit X Corporation Proprietorship httity (partnership, corporation, etc. Yes X No illding owner:	Not For Profit LLP LLC LEASE the build Yes X No	Partnership Government Unit
If 'Yes', name of Hea * (please attach a list of If 'Yes', name of CEC a. Legal entity is: b. Legal entity is: c. Does the above effered? If "YES", name of but Is the business operat If 'Yes', name and ad Name:	th System*: Adventist NC facilities that are part of your H Donald Jernigan, Ph For Profit X Corporation Proprietorship Atity (partnership, corporation, etc., Yes X No Idding owner: Adventist Adventist X Local System*: Adventist Ad	Not For Profit LLP LLC LEASE the build Yes X No	Partnership Government Unit ing from which services
If 'Yes', name of Hea * (please attach a list of If 'Yes', name of CEC a. Legal entity is: b. Legal entity is: c. Does the above effered? If "YES", name of but Is the business operate If 'Yes', name and additional entity is: If 'Yes',	th System*: Adventist NC facilities that are part of your H Donald Jernigan, Ph For Profit X Corporation Proprietorship Atity (partnership, corporation, etc., Yes X No Idding owner: Adventist Adventist X Local System*: Adventist Ad	Not For Profit LLP LLC LEASE the build Yes X No	Partnership Government Unit

License	No:	H0019
Facility	D:	943388

All responses should pertain to October 1, 2006 through September 30, 2007.		
Ownership Disclosure continued		
3. Vice President of Nursing and Patient Care Services: Karen Owensby, Vice PresidentClinical Services	-	•
4. Director of Planning: Bruce Bergherm, Vice President		· · · · · · · · · · · · · · · · · · ·
Facility Data		
 A. Reporting Period All responses should pertain to the period October 1, 200 2007. B. General Information (Please fill in any blanks and make changes where responses to the period October 1, 200 		ber 30,
B. General Internation		·
a. Admissions to Licensed Acute Care Beds: include responses to "a - q" on page 4; exclude responses to "2-9" on page 4; and exclude normal newborn bassinets.	3,311	
b. Discharges from Licensed Acute Care Beds: include responses to "a - q" on page 4; exclude responses to "2-9" on page 4; and exclude normal newborn bassinets.	3,306	
c. Average Daily Census: include responses to " $a-q$ " on page 4; exclude responses to "2-9" on page 4; and exclude normal newborn bassinets.	35	
d. Was there a permanent change in the total number of licensed beds during the reporting period?	Yes	No X
If 'Yes', what is the current number of licensed beds?		
If 'Yes', please state reason(s) (such as additions, alterations, or conversions) which may have affected the change in bed complement:		***************************************
e. Observations: Number of patients in observation status and not admitted as inpatients, excluding Emergency Department patients.	597	
C. Designation and Accreditation 1. Are you a designated trauma center? YesX No		
2. Are you a critical access hospital (CAH)? Yes X No		
3. Are you a long term care hospital (LTCH)? Yes x No	, asst	ا
4. If this facility is accredited by the Joint Commission or AOA, specify the	accrediting bo	oay ·

Joint Commissiond indicate the date of the last survey 05 / 19 / 06.

AOA

4/30 - 5/2/07

License No: H0019 Facility ID: 943388

D. Beds by Service (Inpatient – Do Not Include Observation Beds or Days of Care) [Please provide a Beds by Service (p. 4) for each hospital campus (see G.S. 131E-176(2c))]

Please indicate below the number of beds usually assigned (set up and staffed for use) to each of the following services and the number of census inpatient days of care rendered in each unit. NOTE: If your facility has a designated unit(s) for chemical dependency treatment and/or detoxification, please complete the patient origin sheet pertaining to Psychiatric and Substance Abuse Services. If your facility has a Nursing Facility unit and/or Adult Care Bed unit please complete the supplemental packet for Skilled Nursing Facility beds.

Licensed Acute Care (provide details below) Campus	Licensed Reds as of September 30, 2007	Staffed Beds as of September 30, 2007	Annual Census Inpt. Days of Care
Intensive Care Units			
			*
a manufacture of the second	14	14	3557
***	<u> </u>	•	
c. Cardiovascular Surgery d. Medical/Surgical	to the same of the	•	
to the state of th			市本
e. Neonatal Beds Level IV *** (Not Normal Newborn) f. Pediatric			
g. Respiratory Pulmonary h. Other (List)			
Other Units			
i. Gynecology j. Medical/Surgical ***	4.0	40	*** 8107
k. Neonatal Level III ** (Not Normal Newborn)			**
Neonatal Level II ** (Not Normal Newborn)			**
m. Obstetric (including LDRP)	8	8 .	1100
n. Oncology			
o. Orthopedics			,
p. Pediatric		10000	
g. Other (List)			
1. Total General Acute Care Beds/Days (a through q)	62	62	12,764
2. Comprehensive In-Patient Rehabilitation	[0		
3. Inpatient Hospice			
A Detovification)	
5. Substance Abuse / Chemical Dependency Treatment			
6. Psychiatry	41		11,854
7. Nursing Facility	(
8. Adult Care (Home for the Aged))	<u> </u>
9. Other)	
10. Totals (1 through 9)	10:	3 98	24,618

^{*} Please report only Census Days of Care of DRG's 504, 505, 506, 507, 508, 509, 510 and 511.

Per C.O.N, rule definition. Refer to Section .1400 entitled Neonatal Services. (10A NCAC 14C)

^{***} Exclude Skilled Nursing swing-bed days. (See swing-bed information next page)

All responses should pertain to October 1, 2006 through September 30, 2007.

Beds by Service (Inpatient) continued

D. Beds by Service (inpatient) continu	isa — — — — — — — — — — — — — — — — — — —
Number of Swing Beds *	2
Number of Skilled Nursing days in Swing Bo	eds 200
Number of unlicensed observation beds	·
14thirton of miner	

^{*} means a hospital designated as a swing-bed hospital by CMS (Centers for Medicare and Medicaid Services)

E. Reimbursement Source (For "Inpatient Days," show Acute Inpatient Days only, excluding normal newborns.)

Primary Payer Source	Inpatient Days of Care (from p. 4, item D. 1.)	Emergency Visits (from p. 6, item 3.d.)	Outpatient Visits (excluding Emergency Visits and Swrgical Cases)	Inpatient Surgical Cases (from p.8, Table 8. b)	Ambulatory Surgical Cases (from p. 8, Table 8, b)
Charity Care 1	. 0	4,406	17,077	284	1,842
Commercial Ins. 2	2,502 1,710	3,281	3,192	275	400
Medicaid (including HMO)	7,836	2,843	14,837	480	1,940
Medicare (including HMO)	638	4,906	1,402	60	209
Private Pay / Seif Pay Other Gov't. 3 (Champus		187	769	9	58
All other			· 384		4 4 4 4 0
TOTAL	12,763	15,623	37,661	1,108	4,449

¹ Charity Care Definition: Health care services that never were expected to result in cash inflows. Charity care results from a provider's policy to provide health care services free of charge to individuals who meet certain financial criteria.

F. Services and Facilities

	•	•	,		
A 08 A 6.00				Enter Number	er .
1. Obstetrics	10 1	· · · · · · · · · · · · · · · · · · ·		320	
a. Live births (Vagin	at Denveries)	l district the same of the sam		139	•
b. Live births (Cesar	ean Section)			^	. 1
c. Stillbirths					الديبيسي
					
			-41	0	. 1

d. Delivery Rooms - Delivery Only (not Cesarean Section)	U
e. Delivery Rooms - Labor and Delivery, Recovery	• 4
e. Delivery Rooms - Labor and Delivery, Recovery	0
f. Delivery Rooms - LDRP (include Item "m" on Page 4)	
g. Normal newborn bassinets (Level I Neonatal Services)	
Do not include with totals under the section entitled Beds by Service (Inpatient)	
Do not morace	

2.	Abortion Services
hao	ADDI LIDIR DEL VICES

Number of procedures per Year

0	

² Commercial Insurance includes all forms of managed care except Medicaid and Medicare HMO's

³ Other Government includes Tricare and VA insurance programs.

-	-0-0							<i>f</i>
3.	Emergency Departme	nt Services (ca	ases	equal visits to E	D)			
	a. Total Number of ED Treatment Rooms: (b,+c.) 12							
	b. #Trauma Rooms —	1		c. #Fast Trac	k Rooms_	11		•
	c. Total Number of EI			g period: 15	623			
					~ ~	90		
	d. Total Number of ad						•	*
	e. Total Number of Un	gent Care visit	ts for	reporting perio	d: 12,32	4 .		
	f. Does your ED prov If no, specify days/hou	ide services 24 ars of operation	hou 1:	rs a day 7 days p	per week?	<u> </u>	Yes No	. ·
	g. Is a physician on d If no, specify days/ho	uty in your ED urs physician is	24 l s on	nours a day 7 day duty:	ys per week	7 <u>x</u>	Yes No	
i					a namiina:			
4.	Medical Air Transpo					~ *		
	a. Does the facility o	perate an air ar	nbul	ance service?	Yes _	X No		
•	b. If "Yes", complete	the following	cnar	l.			Number of Trans	norte
	Type of Aircraft	Number of Airer	aft	Number Owned	Number Li	easeu	Multiper of Trans.	h01 to
	Rotary							
	Fixed Wing		1		<u> </u>			
5.	Pathology and Med	cal Lab (Che	ck v	hether or not se	rvice is pro	vided)	
	a. Blood Bank/Trans			x Ye				
	b. Histopathology L				es _N	lo		
	c. HIV Laboratory	esting		Y	es XV	lo		•
	Number during re	porting period				Ψ,		
	HIV Serolog	y	S	creening te	st for e	*mp±	oyee exposur	es outa
•	HIV Culture				37.3	· •		
	d. Organ Bank	•		Y	es XN	NO To		
	e. Pap Smear Scree	ning	4	<u>X</u> X	es1	NO		
6.	Transplantation Se	rvices - Numb	er o	f transplants				
	Туре	Number		Туре	Number		Туре	Number
a. Bor	e Marrow-Allogeneic	0		Kidney/Liver	0.		ung	0
b. Bor	e Marrow-Autologous			Liver	0		Pancreas.	0
	c. Cornea 20 f. Heart/Liver 0 m. Fancreas/Ritiney 0							
	d Heart 0 g. Heart/Kidney 0 n. Pancreas/Liver 0							
	ut/Lung	0 -	h.	Kidney	0	10.	Other	<u> </u>
. Do 3	Do you perform living donor transplants? Yes X No.							

License No: <u>H0019</u> Facility ID: <u>943388</u>

		Specialized Cardiac S		call \$55,3865	Medical Facilit	ies Planningl)
77	•	Specialized Cardiac S	ervices (for questions,	CRIT 622-2005	Extractions & married	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,

(a) Cardiac Catheterization	•	•	Electro-physiology
(a) Cardiac Catherentam			37.26, 37.27, 37.34,
			37.70, 37.71, 37.72,
			37.73, 37.74, 37.75,
	i	Interventional	37.76, 37.77, 37.79,
		Cardiac	37.80, 37.81, 37.82,
	Diagnostic Cardiac	Catheterization-	37.83, 37.85, 37.86;
	Catheterization	ICD-9	37.87, 37.89, 37.94,
	· ICD-9	00.66, 99.10, 36.06,	37.95, 37.96, 37.97,
-	37.21, 37.22,	36.07, 36.09;	37.98, 37.99, 00.50,
•	37.23, 37.25	35.52, 35.71, 35.96	00.51, 00.52, 00.53, 00.54
. 1			
1. Number of Units of Equipment		T	<u></u>
2. Total Annual Number of Cases*	·		
3. Of Total in #2, Number of Patients		'	
Age 14 & under			
4. Of Total in #2, Number of Cases		•	
Performed in Mobile Unit**		- to the contract of the contr	l

t.	One case is defined to be one visit or trip by a patient to an operating room or catheterization	
-	One case is defined to be one visit of the property of the case is defined to be one regardless (Σf
	One case is defined to be one visit of hip by a partial to be one as a single or multiple procedures or catheterizations. Count each visit once regardless of laboratory for a single or multiple procedures or catheterizations. Count each visit once regardless of	٠.
	the number of diagnostic, interventional, and/or EP procedures performed within that visit.	

		•	•
**	Please report name of mobile vendor:		
	Number of operating hours per week on site:		

(b) Open Heart Surgery	Number of Rooms and Procedures
1. Number of Dedicated Open Heart Surgery Operating Rooms	
2 Number of Heart-Lung Bypass Machines	
3. Total Annual Number of Open Heart Surgery Procedures 14: Signar Heart-Lung Bypass Machine	
Total Annual Number of Open Heart Surgery Procedures done without utilizing a Heart-Lung Bypass Machine	
5 Total Open Heart Surgery Procedures (3, +4.)	
Procedures on Patients Age 14 and Under	
6. Of total in #3, Number of Procedures on Patients Age 14 &	
under 7. Of total in #4, Number of Procedures on Patients Age 14 &	
7. Of total in #4, Number of Procedures on Laterns Ago 11 to under	

8. Surgical Operating Rooms and Cases

a) Surgical Operating Rooms

[1] Report Surgical Operating Rooms built to meet the specifications and standards for operating rooms required by the Construction Section of the Division of Health Services Regulation, and which are fully equipped to perform surgical procedures. These surgical operating rooms include rooms located in Obstetrics and surgical suites.

NOTE: If this License includes more than one campus, please submit the Cumulative Totals and COPY this sheet and Submit a duplicate of this page for each campus.

(Campus - If multiple sites:

Type of Room	Number of Rooms
Dedicated Open Heart Surgery [from 7.(b) 1.]	
Dedicated C-Section	•
Other Dedicated Inpatient Surgery	
Dedicated Ambulatory Surgery	
Shared - Inpatient / Ambulatory Surgery	6
Total of Surgical Operating Rooms	<u> </u>

[2] Does this facility have approval for additional surgical operating rooms (i.e., not instead above) that are being developed pursuant to a Certificate of Need? Yes X No #Rooms
[3] Does this facility have approval for additional surgical operating rooms (i.e., not listed above) that are being
developed pursuant to the exemption provided in Senate Bill 714? Yes X No #Rooms

b) Surgical Cases by Specialty Area - Enter the number of surgical cases by surgical specialty area in the chart below. Count each patient undergoing surgery as one case regardless of the number of surgical procedures performed while the patient was having surgery. Categorize each case into one specialty area - Total Surgical Cases is an unduplicated count of surgical cases. Count all surgical cases, including cases performed in procedure rooms or in any other location.

Surgical Specialty Area	Inpatient Cases	Ambulatory Cases
Cardiothoracic (excluding Open Heart Surgery)	27	24
Open Heart Surgery (from 7.(b) 5.)	. 0	
General Surgery	249	664
Neurosurgery	159	125
Obstetrics and GYN (excluding C-Sections)	79	180
Ophthalmology	4	1301
Oral Surgery	0	34 -
Orthopedics	344	1355
Otolaryngology	13	323
Plastic Surgery	· 21	84
Urology	60	314 :
Vascular	3	<u> </u>
Other Surgeries (which do not fit into the above categories)	10	45
Number of C-Section's Performed in Dedicated C-Section OR's	0	
Number of C-Section's Performed in Other OR's	139	
Total Surgical Cases	1,108	4,449

8. Surgical Operating Rooms and Cases continued

e) Average Operating Room Availability and Average Case Times:

The Operating Room Methodology assumes that the average operating room is staffed 9 hours a day, for 260 days per year, and utilized at least 80% of the available time. This results in 1872 hours per OR per year.

Based on your hospital's experience, please complete the table below by showing the assumptions for the average operating room in your hospital.

	The state of the s	The state of the s	
Average Hours per Day Routinely Scheduled for Use *	Average Number of Days per Year Routinely Scheduled for Use [b]	Average Percent Availability [c]	Average Hours per OR per Year (Multiply [a] times [b] times [c])
. 9	260	90%	2,106

^{* (}Example: 2 rooms @ 8 hours per day plus 2 rooms @ 10 hours per day equals 36 hours per day; divided by 4 rooms equals an average of 9 hours / per room / per day.)

The Operating Room Methodology assumes 3 hours for each Inpatient Surgery and 1.5 hours for each Outpatient Surgery.

Based on your hospital's experience, please complete the table below by showing the Average Case Time in minutes for Inpatient and Outpatient cases performed in your hospital.

Average "Case Time" ** in Minutes for Inpatient Cases	Average "Case Time" ** in Minutes for Ambulatory Cases
86.7	. 40.5

^{** &}quot;Case Time" = Time from Room Set-up Start to Room Clean-up Finish. Definition 2.4 from the "Procedural Times Glossary" of the AACD, as approved by ASA, ACS, and AORN. NOTE: This definition includes all of the time for which a given procedure requires an OR/PR. It allows for the different duration of Room Set-up and Room Clean-up Times that occur because of the varying supply and equipment needs for a particular procedure

0	Castrointestinal	Endoscopy Room	ns, Cases,	and Procedu	ires

[1] Report the number of <u>Gastrointestinal Endoscopy Rooms</u> and the number of cases and procedures performed in these rooms during the reporting period. (<u>NOTE</u>: <u>Other procedure rooms</u> should be included in <u>Section 10</u> below.) Count <u>each patient as one case</u> regardless of the number of procedures performed while the patient was in the GI endoscopy room.

Number of GI Endo Rooms	Total Number GI Endo Cases [a]	Total Number Non-GI Endo Cases [b]	Total Endo Cases [a] + [b]
. 1	885 Total Number GI Endo Procedures [c]	330 Total Number Non-GI Endo Procedures [d]	1,215 Total Endo Procedures [c] + [d]
and the same of th	935	330	1,265

[2] Does this facility have approval for pursuant to a Certificate of Need?	·163	140		
[3] Does this facility have approval for	additional <u>GI Endoscopy</u>	<u>y rooms</u> (i.e., <u>not</u> liste	ed above) that are be	ing developed
pursuant to the exemption provided in S	Senate Bill 714?	Yes <u>X</u> No	# Rooms	

10. Non-Gastrointestinal Procedure Rooms and Cases

Please report only rooms and cases not reported in 8. or 9.: Report rooms not equipped or meeting all the specifications for an operating room, dedicated to the performance of procedures other than gastrointestinal endoscopy.

50017.1.				
·a).	Total Number of	of Procedure Rooms	: 0	

Enter the number of Non-Surgical <u>cases</u> by specialty area in the chart below. Count all cases, including cases performed in Operating Rooms. Count each patient undergoing a procedure or procedures as one case regardless of the number of procedures performed while the patient was in the room.

Specialty Area	Inpatient Cases	Ambulatory Cases
Pain Management		
Cystoscopy		
Non GI Endoscopies (not reported in 9.)		
GI Endoscopies (not reported in 9.)		
Special Procedures/Angiography (neuro & vascular but not including cardiac cath.)		
YAG Laser		
Other (specify)		
Other (specify)		
Other (unspecified)		
Total Non-Surgical Cases		

10a. Diagnostic Imaging and Lithotripsy Data

Indicate the number of machines/instruments and the number of the following types of procedures performed during the 12-month reporting period at your facility. For Hospitals that operate medical equipment at multiple sites, please provide a separate page for each site.

Imaging	Number	No. of Pro	cedures	-		Procedures *	
	of Units	Inpatient	Outpatient	Total	With Contrast	Without Contrast	
Magnetic Resonance Imaging	-			·	or Sedation	or Sedation	Total
Fixed MRI Scanners	1	364	2,120	2,484	1.186	1,298	2,48
Open MRI Scanners included in row above							น
MRI pursuant to Policy AC-3:				:			<u> </u>
Other Human Research MRI Scanner							<u> </u>
MRI Mobile Equipment	Number	No. of Pt	ocedures		With Contrast	Without Contrast	
Identify Vendor/Owner in space () below:	of Units	Inpatient	Outpatient	Total	or Sedation	or Sedation	Total
MRI#1 (N/A)							<u> </u>
MRI#2 (17/A)				**************************************	Water & Tatala at	MIST involvents and	<u> Д</u>
CT Scanner (Fixed or Mobile)	1	1,887	5,693	8,580	Note: "Totals of	MRI inpatients and	
CT Scanner HECT Units			.,				
Mammogram .	1 .	61	2,875	2,936	and without cont	rast of secalion,	
Fixed Other Radiographic&Fluoroscopic		<u> </u>			-18‱‱‱		*****
Nuclear Medicine	Number	No, of P	rocedures		1		****
PET Scanners	of Units	Inpatient	Outpatient	Total	J‱‱		*****
Dedicated Fixed PET Scanner	0				. ‱‱		*****
Mobile PET Scanner Vendor (Alliance	One)	2	212	214	_		
PET pursuant to Policy AC-3	1			<u> </u>	_ ‱		******
Other Human Research PET Scanner					⅃‱		
Other Nuclear Medicine	1				⅃‱		*****
Coincidence Camera					⅃‱		*****
Mobile Coincidence Camera Vendor (•)				_18888888888888888888888888888888888888		******
SPECT					_		*****
Mobile SPECT Vendor (T			_	_		*****
Gamma Camera / Spect	1	875	1,368	2,24	<u></u> 3∥‱‱		
Mobile Gamma Camera Vendor (•)			1	_ ***********		****
		No. of	Procedures		╗		*****
Lithotripsy	Numbe		1	-	¬‱‱		*******
[Identify Vendor/Owner in space () below:]		. 11	Outpatien	t Total			******
AND AS ASSESSMENT OF THE PARTY	-				- ‱‱		******
Fixed	_			1	-1		******
Mobile (Healthtronics)			15	15	100000000000000000000000000000000000000	**************************************	35XXXXXXX

MRI procedure is defined as a single discrete MRI study of one patient (single CPT coded procedure). An MRI study means one or more scans relative to a single diagnosis or symptom. <u>NOTE</u>: Please Report ALL Angiography procedures on page 10, in Table 9 under Special Procedures/Angiography Rooms.

PET procedure is defined as a single discrete PET scan of a patient (single CPT coded procedure), not counting other radiopharmaceutical or supply charge codes.

10b. MRI Procedures by CPT Codes

PT Code CPT Description Number of Procedures						
PT Code						
0336	MRI Temporomandibular Joint(s)	1				
0540	MRI Orbit/Face/Neck w/o					
0542	MRI Orbit/Face/Neck with contrast	10				
0543	MRI Orbit/Face/Neck w/o & with	65				
0544	MRA Head w/o					
0545	MRA Head with contrast	4				
70546	MRA Head w/o & with	1				
70547	MRA Neck w/o	. 1				
70548	MRA Neck with contrast	17				
70549	MRA Neck w/o & with	206				
70551	MRI Brain w/o	2				
70552	MRI Brain with contrast	457				
70553	MRI Brain w/o & with	421				
7055A	IAC Screening	<u> </u>				
7.1550	MRI Chest w/o					
7.1551	MRI Chest with contrast	5				
71552	MRI Chest w/o & with					
71555	MRA Chest with OR without contrast					
72126	Cervical Spine Infusion only	365				
72141	MRI Cervical Spine w/o	303				
72142	MRI Cervical Spine with contrast	21				
72156	MRI Cervical Spine w/o & with	21				
72146	MRI Thoracic Spine w/o	79				
72147	MRI Thoracic Spine with contrast	23				
72157	MRI Thoracic Spine w/o & with	The state of the s				
72148	MRI Lumbar Spine w/o	364				
72149	MRI Lumbar Spine with contrast	3				
72158	MRI Lumbar Spine w/o & with	88				
72159	MRA Spinal Canal w/o OR with contrast					
72195	MRI Pelvis w/o	18				
72196	MRI Pelvis with contrast	2				
72197	MRI Pelvis w/o & with	19				
72198	MRA Pelvis w/o OR with Contrast					
73218	MRI Upper Ext, other than joint w/o	14				
73219	MRI Upper Ext, other than joint with contrast					
73220	MRI Upper Ext, other than joint w/o & with	4				
73221	MRI Upper Ext any joint w/o	174				
73222	MRI Upper Ext any joint with contrast	• 34				
73223	MRI Upper Ext any joint w/o & with	5				
73225	MRA Upper Ext w/o OR with contrast	1				

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	MRI Procedures by CPT Code	
PT Code	CPT Description	Number of Procedures
3221	MRI Upper Ext, any joint w/o	
3222	MR) Upper Ext, any joint with contrast	
3223	MRI Upper Ext, any joint w/o & with	
3225	MRA Upper Ext, w/o OR with contrast	1.0
3718	MRI Lower Ext other than joint w/o	46
3719	MRI Lower Ext other than joint with contrast	51
3720	MRI Lower Ext other than joint w/o & with	
3721	MRI Lower Ext any joint w/o	232
3722	MRI Lower Ext any joint with contrast	
3723	MRI Lower Ext any joint w/o & with	39
73725 .	MRA Lower Ext w/o OR with contrast	2
74181	MRI Abdomen w/o	22
74182	MRI Abdomen with contrast	
74183	MRI Abdomen w/o & with	22
74185	MRA Abdomen w/o OR with contrast	7
75552	MRI Cardiac Morphology w/o	
75553	MRI Cardiac Morphology with contrast	<u> </u>
75554	MRI Cardiac Function Complete	
75555	MRI Cardiac Function Limited	
75556	MRI Cardiac Velocity Flow Mapping	
76093	MRI Breast, unilateral w/o and/or with contrast	6
76094	MRI Breast, bilateral w/o and/or with contrast	69
76125	Cineradiography to complement exam	
76390	MRI Spectroscopy	
76393	MRI Guidance for needle placement	1
76394	MRI Guidance for tissue ablation	
76400	MRI Bone Marrow blood supply	
7649A	MR functional imaging	
	MRI infant spine comp w/ & w/o contrast	
7649D	Spine (infants) w/o infusion	
7649E	MR functional imaging	
7649H	Clinical Research Scans	
N/A	Clinical Research Scans Subtotal for page 1997	ge 501
	Total Number of Procedures (both page	

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11. Radiation Oncology Treatment Data

CPT Code	Description	Number of Procedures	ESTVs/ Procedures Under ACR	Total ACR ESTVs	÷
·	Simple Treatment Delivery:			<u> </u>	
77401	Radiation treatment delivery		1.00		
77402	Radiation treatment delivery (<=5 MeV)		1.00		
77403	Radiation treatment delivery (6-10 MeV)		1.00		
77404	Radiation treatment delivery (11-19 MeV)		1.00		
77406	Radiation treatment delivery (>=20 MeV)		1.00		
	Intermediate Treatment Delivery:				T
77407	Radiation treatment delivery (<=5 MeV)		1.00		ļ
77408	Radiation treatment delivery (6-10 MeV)		1.00		ļ
77409	Radiation treatment delivery (11-19 MeV)		1.00		<u> </u>
77411	Radiation treatment delivery (>=20 MeV)		1.00		
	Complex Treatment Delivery:				
77412	Radiation treatment delivery (<=5 MeV)		1.00		
77413	Radiation treatment delivery (6-10 MeV)		1.00	<u> </u>	
77414	Radiation treatment delivery (11-19 MeV)		1.00		
77416		<u> </u>	1.00	<u> </u>	
	Sub-Total			<u> </u>	
	e increased time required for special techniq	ues. ESTV valu	ies are indicated	l below:	

	TOTALS:		<u> </u>	<u> </u>
	Sub-Total		 	
	Pediatric Patient under anesthesia	1.50	 	
	Limb salvage irradiation	1.00	<u> </u>	·
	Neutron and proton radiation therapy			<u> </u>
	patient down to the linac)	2.00		
••	(conducted by bringing the anesthetized			
	Intraoperative radiation therapy	10.00		
	Hemibody irradiation	2,00		
**************	Total body irradiation	2.50		
	Gamma Knife	2.50		
77432	Stereotactic radiosurg. Treatment mgmt.	3.00		
77432	Linear Accelerator/CyberKnife			
77432	Stereotactic radiosurg. Treatment mgmt	3.00		
//410	(IMRT)delivery			
77417	Intensity modulated radiation treatment	1.00		
77417	Additional field check radiographs	.50		

Note: For special techniques, list procedures under both the treatment delivery and the special techniques sections.

All responses should pertain to October 1, 2006 through September 30, 2007.

11.	Radiation Oncology Treatment Data	continued
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a,	Number of unduplicated patients who receive a course of radiation oncology	
	treatments (patients shall be counted more than once if they receive additional courses	
	of treatment)	
b.	Total number of Linear Accelerator(s)	<u> </u>
	Number of Linear Accelerators configured for stereotactic radiosurgery	

12. Telemedicine

- a. Does your facility utilize telemedicine to have images read at another facility? yes
- b. Does your facility read telemedicine images? <u>no</u>

13. Additional Services:

a) Check if Service(s) is provided:

a) Check if Service(s) in Service	Check		Check
Cardiac Rehab Program (Outpatient)	х	5. Rehabilitation Outpatient Unit	х.
2. Chemotherapy	x	6. Podiatric Services	X
3. Clinical Psychology Services		7. Genetic Counseling Service	
4. Dental Services		8. Acute Dialysis	

~ ~ ~	C A seeds T	Unternia O	tationa	
Number	of Acute D	naivsis o	lauvus	

b) Hospice Inpatient Unit Data:

Hospital-based hospice units with licensed hospice beds. List each county served and report all patients by county of residence. Use each patient's age on the admission day to the Licensed Hospice Inpatient

Facility. For age categories count each inpatient client only once.

County of Residence	Age 0-	Age 18-40	Age 41-59	Age 60-64	Age 65-74	Age 75-84	Age 85+	Total Patients Served	Total Days of Care	Deaths
				<u> </u>	- co-challeman - c		<u> </u>			
	<u> </u>			 						
	<u> </u>		ļ	ļ			<u> </u>			ļ
		ļ		ļ	<u></u>		-			·,
	ļ	<u> </u>	 	 	 	 		 		<u> </u>
Out of State	-	<u> </u>								
Total All		† ·					'			
Ages		<u> </u>	<u> L.:</u>	<u></u>	<u> </u>	<u></u>		1	1	

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13. Additional Services: continued

- c) Mental Health and Substance Abuse
 - 1. If psychiatric care has a different name than the hospital, please indicate:

Hope Behavioral Health Services

- 2. If address is different than the hospital, please indicate:
- 3. Director of the above services.

 David Manly, M.D.; Rebecca Mayer, RN, Ph. D.

Indicate the program/unit location in the <u>Service Categories</u> chart below. If it is in the hospital, include the room number. If it is located at another site, include the building name, program/unit name and address.

Service Categories: All applicants must complete the following table for all mental health services which are to be provided by the facility. If the service is not offered, leave the spaces blank.

Rule 10A NCAC 27G Licensure Rules For Mental Health Facilities	Location of Services	Beds Assigned by Age				
KOP Mental licatin Pacinics		0-12	13-17	Subtotal 0-17	18 & ир	Total Beds
.1100 Partial hospitalization for individuals who are acutely mentally ill.	Women's			i de la companya di salah di s		
1200 Psychosocial rehabilitation facilities for individuals with severe and persistent mental illness				<u> </u>		
.1300 Residential treatment facilities for children and adolescents who are emotionally disturbed or have a mental illness						
1400 Day treatment for children and adolescents with emotional or behavioral disturbances			P capital	10 1 30 10 10 10 10 10 10 10 10 10 10 10 10 10		
.1500 Intensive residential treatment facilities for children & adolescents who are emotionally disturbed or who have a mental illness						

Rule 10A NCAC 13B Licensure Rules For Hospitals	Location of Services	Bei 0-12	ls Assig 13-17	ned by A		Total Beds
.5200 Dedicated inpatient unit for individuals who have mental disorders	PRH				X	36

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13. Additional Services: continued

c) Mental Health and Substance Abuse continued

c) Mental Health and Substance Al	ouse continueu					
Rule 10A NCAC 27G Licensure Rules for Substance Abuse Facilities	Location of Services	Beds Assigned by Age				
101 Substance Abuse Pacintaes		0-12	13-17	Subtotal 0-17	18 & ap	Total Beds
.3100 Nonhospital medical detoxification for individuals who are substance abusers		·				
.3200 Social setting detoxification for substance abusers						
.3300 Outpatient detoxification for substance abusers	•				— — — — — — — — — — — — — — — — — — —	
.3400 Residential treatment/ rehabilitation for individuals with substance abuse disorders				·	•	
.3500 Outpatient facilities for individuals with substance abuse disorders						
.3600 Outpatient narcotic addiction treatment .3700 Day treatment facilities for individuals with				Page 1		
substance abuse disorders						
Rule 10A NCAC 13B Licensure Rules	Location of	1		gned by		1
For Hospitals	Services	0-12	13-17	Subtotal 0-17	18 & up	Total Bed
.5200 Dedicated inpatient hospital unit for individuals who have substance abuse disorders (specify type) # of Treatment beds						
# of Medical Detox beds				.		

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Patient Origin -General Acute Care Inpatient Services

Facility County: Henderson

In an effort to document patterns of utilization of General Acute Care Inpatient Services in North Carolina hospitals, please provide the county of residence for each patient admitted to your facility.

County	No. of	County	No. of	County	No. of Admissions
	Admissions .		Admissions	73. Person	Authrasiona
I. Alamance		37. Gates		74. Pitt	
2. Alexander	1	38. Graham	1	74. Pftt	
3. Alleghany		39, Granville .			88
4. Anson		40. Greene		76. Randolph	
5. Ashe	1	41. Guilford	1	77. Richmond	
6. Avery		42. Halifax		78. Robeson	
7. Beaufort		43. Harnett		79. Rockingham	
8. Bertie		44. Haywood	76	80. Rowan	
9. Bladen	1	45. Henderson	2,468	81. Rutherford	69
10. Brunswick	1	46. Hertford	1	82. Sampson	
11. Buncombe	657	47. Hoke	<u> </u>	83. Scotland	
12. Burke	4	48. Hyde		84. Stanly	
13. Cabarrus		49. Iredell	1	85. Stokes	
14, Caldwell	2	50. Jackson	13	86. Surry	·
15, Camden	· ·	51. Johnston		87. Swain	8
16. Carteret		52. Jones		88. Transylvania	105
17. Caswell		53. Lee		89. Tyrrell	2
18, Catawba	4	54. Lenoir		90. Union	
19. Chatham		55. Lincoln		91. Vance	
The state of the s	4	56. Macon	15	92. Wake	1
20. Cherokee 21. Chowan		57, Madison	4	93. Warren	
	10	58. Martin	21	94. Washington	11
22. Clay	$\frac{10}{2}$	59. McDowell		95. Watauga	-1
23. Cleveland	3	60. Mecklenburg	5	96. Wayne	
24. Columbus		61. Mitchell	1	97. Wilkes	
25. Craven		62. Montgomery		98. Wilson	
26. Cumberland	1	63. Moore		99. Yadkin	
27. Currituck		64. Nash		100. Yancey	15
28. Dare		65. New Hanover	1		
29. Davidson		66. Northampton		101. Georgia	1
30. Davie		67. Onslow		102. South Carolina	11
31. Duplin		68. Orange		103. Tennessee	4
32. Durham		69. Pamlico	1 1	104. Virginia	
33. Edgecombe		70. Pasquotank		105. Other States	4
34. Forsyth		71. Pender		106. Other	114
35. Franklin		/I. Penuer		Total No. of Patients	
36. Gaston	1.	72. Perquimans		1200011010101010	1 7 7 7 7 7

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Patient Origin - Inpatient Surgical Cases

Facility County: Henderson

In an effort to document patterns of "Inpatient" utilization of Surgical Services in North Carolina hospitals, please provide the county of residence for each inpatient surgical patient served in your facility. Count each inpatient "once" regardless of the number of surgical procedures performed while the patient was in the operating room. However, each admission as an inpatient operating room patient should be reported separately.

The "Total" from this chart should match the "Total" Inpatient Cases reported on the Surgical Cases by Specialty Area Table on page 8.

ounty	No. of Patients	County	No. of Patients		No. of Patients
. Alamance	A.W. V2.2	37. Gates		73. Person	
. Alexander		38. Graham		74. Pitt	
3. Alleghany		39. Granville		75, Polk	
4. Anson		40. Greene		76. Randolph	· 21
5. Ashe	1	41. Guilford	1	77. Richmond	<u> </u>
5. Avery	<u> </u>	42. Halifax		78. Robeson	
7. Beaufort		43. Harnett		79. Rockingham	
8. Bertie	· · · · · · · · · · · · · · · · · · ·	44. Haywood	61	80. Rowan	
9. Bladen	1	45. Henderson	579	81. Rutherford	29
10. Brunswick	1	46. Hertford		82. Sampson	
11. Buncombe	219	47. Hoke	· ·	83. Scotland	
12. Burke	6	48. Hyde	,	84. Stanly	
13. Cabarrus	- - 0	49. Iredell		85. Stokes	
14. Caldwell	1	50, Jackson	6	86. Surry	
15. Camden		51. Johnston	•	87. Swain	б
	 	52. Jones		88. Transylvania	45
16. Carteret		53. Lee		89. Tyrrell	
17. Caswell	3	54. Lenoir		90. Union	<u> </u>
18. Catawba		55. Lincoln		91. Vance	
19. Chatham	2	56. Macon	1.4	92, Wake	
20. Cherokee		57. Madison	4	93. Warren	,
21, Chowan	-4	58. Martin	1.2	94. Washington	
22. Clay	1 1	59. McDowell		95. Watauga	<u> </u>
23. Cleveland	5	60. Mecklenburg	4	96. Wayne	
24. Columbus		61. Mitchell	1	97. Wilkes	
25, Craven		62, Montgomery		98. Wilson	
26. Cumberland		63. Moore		99. Yadkin	
27. Currituck		64, Nash		100. Yancey	10
28. Dare		65. New Hanover			
29. Davidson		66. Northampton		101. Georgia	11_
30. Davie		67. Onslow		102. South Carolina	5
31, Duplin		68. Orange		103. Tennessee	11
32. Durham		69. Pamlico		104. Virginia	
33. Edgecombe		70. Pasquotank		. 105. Other States	3
34. Forsyth		71. Pender	•	106. Other	61
35. Franklin 36. Gaston		72. Perquimans		Total No. of Patient	s 1 108

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Patient Origin - Ambulatory Surgical Cases

Facility County: Henderson

In an effort to document patterns of "Ambulatory" utilization of Surgical Services in North Carolina hospitals, please provide the county of residence for each ambulatory surgery patient served in your facility. Count each ambulatory patient "once" regardless of the number of procedures performed while the patient was in the operating room. However, each admission as an ambulatory operating room patient should be reported separately.

The "Total" from this chart should match the "Total" Ambulatory Cases reported on the Surgical Cases by Specialty Area Table on page 8.

County	No. of Patients	County	No. of Patients		No. of Patients
. Alamance	•	37. Gates		73. Person	
. Alexander	1	38. Graham	14	74. Pitt	·
. Alleghany		39. Granville		75, Polk	129
. Anson	1	40. Greene		76. Randolph	
i. Ashe		41. Guilford	3	77. Richmond	
5. Avery	6	42. Halifax		78. Robeson	
7. Beaufort		43. Harnett	1	79, Rockingham	
Bertie		44. Haywood	174	80. Rowan	
). Bladen		45. Henderson	2,349	81. Rutherford	54
10. Brunswick		46. Hertford		82. Sampson	
Il. Buncombe	955	47. Hoke		83. Scotland	
12. Burke	32	48. Hyde		84. Stanly	
13. Cabarrus	-	49, Iredell	1	85. Stokes	
14. Caldwell	7	50. Jackson	61	86. Surry	
15. Camden		51, Johnston		87. Swain	41
16. Carteret		52. Jones		88. Transylvania	168
17. Caswell	_	53. Lee		89, Tyrrell	
18. Catawba	2	54. Lenoir		90. Union	
19. Chatham		55, Lincoln		91. Vance	
20, Cherokee	19	56. Macon	67	92. Wake	11
21. Chowan		57. Madison	83	93. Warren	<u> </u>
22. Clay	4	58. Martin	72	94. Washington	
23. Cleveland	1	59. McDowell		95. Watauga	
24. Columbus		60. Mecklenburg	3 39	96, Wayne	<u>'</u>
25, Craven		61. Mitchell	39	97. Wilkes	3
26, Cumberland	1	62. Montgomery		98. Wilson	
27. Currituck		63. Moore		. 99. Yadkin	11
28. Dare		64, Nash		100. Yancey	47
29. Davidson		65. New Hanover			
30. Davie		66. Northampton		101. Georgia	2
31. Duplin		67. Onslow		102. South Carolina	18
32. Durham		68. Orange	4	103. Tennessee	6
33. Edgecombe	<u> </u>	69. Pamlico		104. Virginia	
34. Forsyth		70. Pasquotank	4.50	105. Other States	. 4
35, Franklin		71. Pender		106. Other	72
36, Gaston	2	72. Perquimans		Total No. of Patient	s 4 449

License No: H0019 Facility ID: 943388

Patient Origin - Gastrointestinal Endoscopy (GI) Cases

Facility County: Henderson

In an effort to document patterns of utilization of Gastrointestinal Endoscopy Services in North Carolina hospitals, please provide the county of residence for each GI Endoscopy patient served in your facility. Count each patient once regardless of the number of procedures performed while the patient was receiving GI Endoscopy Services. However, each admission for GI Endoscopy services should be reported separately.

The "Total" from this chart should equal Item 9. [a] "Total Number GI Endo Cases" from the GI Endo Room Table on page 10, plus the total Inpatient and Ambulatory GI Endoscopies (not reported in 9.) from the Specialty Area Table at the bottom of page 10.

County ·	No. of Patients-		No. of Patients		No. of Patients
1. Alamance		37. Gates		73. Person	
2. Alexander		38. Graham		74. Pitt	
3. Alleghany		39. Granville		75. Polk	21 ·
4. Anson		40. Greene		76. Randolph	
5. Ashe	1	41. Guilford		77. Richmond	
6. Avery		42. Halifax		78. Robeson	,
7. Beaufort	· · · · · · · · · · · · · · · · · · ·	43. Harnett		79. Rockingham	
8. Bertie		44. Haywood	40	80. Rowan	
9. Bladen		45. Henderson	731	81. Rutherford	16
10. Brunswick		46. Hertford		82. Sampson	
11, Buncombe	282	47. Hoke		83. Scotland	
12. Burke	1	48. Hyde		84. Stanly	
13. Cabarrus	1:	49. Iredell		85, Stokes	
14, Caldwell		50. Jackson	4	86. Surry	
15. Camden		51. Johnston		87. Swain	66
16. Carteret		52. Jones		88. Transylvania	47
17, Caswell		53. Lee		89. Tyrrell	
18, Catawba	ż	54. Lenoir		90. Union	
19. Chatham		55. Lincoln		91. Vance	<u>'</u>
20. Cherokee	2	56. Macon	12	92. Wake	
21, Chowan		57. Madison	2	93. Warren	
22. Clay	6	58. Martin	. 8	94. Washington	
23, Cleveland		59. McDowell		95. Watauga	11
24. Columbus		60. Mecklenburg		96. Wayne	
25. Craven		61. Mitchell	3	97. Wilkes	1
26. Cumberland		62. Montgomery		98. Wilson	
27, Currituck	***************************************	63. Moore		99. Yadkin	
28. Dare		64. Nash		100. Yancey	4
29. Davidson		65. New Hanover			
30. Davie		66. Northampton		101. Georgia	
'31, Duplin		67. Onslow		102. South Carolina	3
32. Durham		68. Orange		103. Tennessee	
33. Edgecombe	.	69. Pamlico		104. Virginia	
34. Forsyth		70. Pasquotank		105. Other States	
35, Franklin	.	71. Pender		106. Other	21
36. Gaston		72. Perquimans	7	Total No. of Patient	1.215

All responses should pertain to October 1, 2006 through September 30, 2007.

Patient Origin - Psychiatric and Substance Abuse Alamance through Johnston

Facility County: Henderson

Complete the following table below for inpatient Days of Care reported under Section .5200.

Complete the fo County of Pattent Origin	Psycl	nlatric Treatmen Days of Care	t ·	Days of Care			Dete Day	xification s of Care	
I RUEIN OLIGIN	Age 0-17	Age 18+	Totals	Age 0-17	Age 18+	Totals	Age 0-17	Age 18+	Totals
Alamance	7,500 27							190	
Alexander		3	3						1
Alleghany				***************************************				`	
Anson	 								
Ashe :	1	2	2						
	 	2 5	<u>2</u> 5		1				
Avery Beaufort	 								
Bertie				-				1	
Bladen	}	<u> </u>		.,		1			
	 	 	l		 			1	
Brunswick	-	309-	309						
Buncombe			3						
Burke	-	3-	1		-	1		1.	T
Cabarrus		1 2			<u> </u>	+	1		T
Caldwell	-J	+	 			1	1	T	
Camden		 	 			-		1	1
Carteret		 	 				1	T	· · · · · · · · · · · · · · · · · · ·
Caşweli	<u> </u>	 4	[l	- 	
Catawba	<u> </u>	 	4			T	1		
Chatham		ļ					-		
Cherokee		17	17				1		
Chowan		 	1 4 2			- 	 	<u> </u>	
Clay		13	13					- 	
Cleveland		16	16				 		
Columbus			<u> </u>			- 	 	 	
Crayen		1 1					 		- ;
Cumberland			2.]			1		
Currituck				ļ			 	-	
Dare			<u> </u>	 					
Davidson				<u> </u>					
Davie				ļ					
Duplin-		11	1 1	<u> </u>					
Durham				<u> </u>					
Edgecombe				ļ					
Forsyth					<u> </u>				
Franklin		<u> </u>		<u> </u>					
Gaston		4 .	4	<u> </u>		- 			
Gates				<u> </u>					
Graham		8	8	1					
Granville									
Greene				1	<u> </u>				
Guilford		1	11_						
Halifax									
Harnett	1						_		
Haywood		90	90)				<u> </u>	
Henderson	_	90 262	267	2					
Hertford	· · · · · · · · · · · · · · · · · · ·			_l					
Hoke	_								
Hyde									
Iredell		3	2						
Jackson		. 18	1.8				_		
Johnston		- 					_1		

^{**} Note: See counties: Jones through Yancey (including Out-of-State) on next page.

Patient Origin - Psychiatric and Substance Abuse Jones through Yancey (including Out-of-State)

Facility County: <u>Henderson</u>

County of Patient Origin	Psyc	hiatric Treatmer Days of Care	at .	Substan	nce Abuse Trea Days of Care			Detoxification Days of Care	
HIEUR OTTEM	Age 0-17	Age 18+	Totals	Age 0-17	Age 18+	Totals	Age 0-17	Age 18+	Totals
lones	***************************************								1
et .								ļ	1
Lenoir		· · · · ·						<u> </u>	
Lincoln		1	1						
Maçon		20	20						
Madison		31	31		1				
Martin		30	30						
McDowell ·									
Mecklenburg	<u> </u>	5	5					1	
Mitchell		8	8						
Montgomery					1 .	1			<u> </u>
Moore									
Nash		· · · · ·							
New Hanover		1			1			·	
Northampton		1							
Motnismbion		4 1	4					.]	
Onslow		 							
Orange Pamileo						- · · ·			
Pasquotank								1	
Pender Pender	ļ	-							
Perquimans	 	 							
							•		
Person .	 								
* ***		8	8						
Polk	1								
Randolph	<u> </u>	-							
Richmond		1. 3	3	1					
Robeson		<u> </u>		1					
Rockingham	 		 						
Rowan ·	!	31	31	1					
Rutherford	ļ	-2	 	!					
Sampson	 		 						
Scotland			1.	╂					
Stanly	<u> </u>		 	╂		-	1		
Stokes			1			7.1			
Surry			11				·		
Swain	<u> </u>	11	69				1		
Transylvania		69	1 69						
Tyrreli			 						
Union		2	2	1					
Vance		- - a	4	-					
Wake		4	4 -						
Warren	_	-' 	 	1			1		
Washington		1 20	10				-1		
Watauga	4	10	 	<u> </u>			-1		·
Wayne	_	<u> </u>	1						
Wilkes	_	11							_
Wilson			4	_					
Yadkin									
Yancey	_	20 43	20	3					
Out of State	Ħ	4.3	4.	⊅ ∦					

^{**} Note: See counties: Alamance through Johnston on previous page.

Patient Origin - MRI Services

Facility County: Henderson

In an effort to document patterns of utilization of MRI Services in North Carolina, hospitals are asked to provide county of residence for each patient served in your facility. Patients served include patients receiving MRI procedures reported in Table 10a of this application (page 11).

County	No. of Patients	County	No. of Patients	County	No. of Patients
i. Alamance		37. Gates		73. Person	
2. Alexander		38. Graham	2	74. Pitt	
3. Alleghany		39. Granville		75. Polk	57
4. Anson		40. Greene		76. Randolph	
5. Ashe		41. Guilford	1	77. Richmond	
6. Avery		42. Halifax		78. Robeson	
7. Beaufort		43. Harnett	·	79. Rockingham	
8. Bertie		44. Haywood	40	80. Rowan	
9. Bladen		45. Henderson	1537 ·	81. Rutherford	39
10. Brunswick	2	46. Hertford		82. Sampson	
11. Buncombe	405	47. Hoke		83. Scotland .	
12. Burke	1	48. Hyde		84. Stanly	
13. Cabartus		49. Iredell		85. Stokes	
14. Caldwell	4	50. Jackson	. 8	86. Surry	
15. Camden		51. Johnston		87. Swain	1
16. Carteret		52. Jones		88. Transylvania	108
17. Caswell		53. Lee .		89. Tyrrell	
18, Catawba	11	54. Lenoir		90. Union	
19. Chatham		55. Lincoln		91. Vance	
20. Cherokee	. 4.	56. Macon	16	92, Wake	· .
21, Chowan	· · ·	57. Madison	16	93. Warren	
22, Clay .	7	58. Martin	29	94. Washington	
23. Cleveland	2	59. McDowell	·	95. Watauga	1
24. Columbus	4	60. Mecklenburg	4	96. Wayne	
25. Craven		61. Mitchell	11	97. Wilkes	
26. Cumberland		62. Montgomery		98. Wilson	
27. Currituck		63. Moore.		99. Yadkin	3
28, Dare		64. Nash		100. Yancey	7
29. Davidson		65. New Hanover	2		
30. Davie		66. Northampton		101, Georgia .	
31, Duplin		67. Onslow	•	102. South Carolina	16
32. Durham		68. Orange		103. Tennessee	4
33, Edgecombe		69. Pamlico		104. Virginia	A PARTICIPATION OF THE PARTICI
34. Forsyth		70. Pasquotank		105. Other States	16
35. Franklin		71. Pender		106. Other	137
36, Gaston		72. Perguimans		Total No. of Patients	2,484

Mobile Services:	True	or False	
IIAODATO CAR I I I I I I I I I I I I I I I I I I I			

License No: H0019
Facility ID: 943388

Patient Origin - Radiation Oncology Treatment

Facility County: Henderson

In an effort to document patterns of utilization of Radiation Oncology Treatment in North Carolina, hospitals are asked to provide county of residence for each patient served in your facility. This data should <u>only</u> reflect the number of <u>patients</u>, not number of treatments. Patients reported should be patients receiving [linac] procedures listed in Section 11 of this application. Please count each patient only once.

County	No. of Patients	County	No. of Patients	County	No. of Patients
I. Alamance		37. Gates		73. Person	
2. Alexander		38, Graham	<u> </u>	74. Pitt	
3. Alleghany		39, Granville		75. Polk	
4. Anson		40. Greene		76. Randolph	
5. Ashe		41. Guilford	-	77. Richmond	
6. Avery		42. Halifax		78. Robeson	
7. Beaufort		43. Harnett		79. Rockingham	
8. Bertie		44. Haywood		80. Rowan	
9. Bladen		45, Henderson		81. Rutherford	
10, Brunswick		46, Hertford		82. Sampson	
11. Buncombe		47. Hoke		83. Scotland	
12. Burke		48. Hyde		84. Stanly	
13. Cabarrus		49. Iredell		85. Stokes	
14. Caldwell		50. Jackson		86. Surry	
15. Camden		51. Johnston		87. Swain	
16. Carteret		52, Jones		88. Transylvania	
17. Caswell		53, Lee		89. Tyrrell	
18. Catawba		54. Lenoir	· ·	90. Union	
19. Chatham	<u> </u>	55, Lincoln		91. Vance	
20. Cherokee		56. Macon		92. Wake	
21. Chowan	<u> </u>	57. Madison		93. Warren	
22. Clay		58. Martin		94. Washington	
23. Cleveland	 	59. McDowell		95. Watauga	
24. Columbus		60. Mecklenburg		96. Wayne	
25. Craven	<u> </u>	61. Mitchell	•	97. Wilkes	
26. Cumberland		62. Montgomery	•	98. Wilson	
27. Currituck		63. Moore	<u></u>	99, Yadkin	
28. Dare		64. Nash		100. Yancey	
		65. New Hanover			
29. Davidson		66. Northampton		101. Georgia	
30. Davie		67. Onslow		102, South Carolina	
31. Duplin		68. Orange		103. Tennessee	
32, Durham	<u> </u>	69. Pamlico		104. Virginia	<u> </u>
33. Edgecombe		70. Pasquotank		105. Other States	
34. Forsyth		70. Pasquotank		106. Other	
35. Franklin 36. Gaston		72. Perquimans		Total No. of Patients	

License No: H0019 Facility ID: 943388

Patient Origin - PET Scanner

Facility County: Henderson

In an effort to document patterns of utilization of PET Scanner in North Carolina, hospitals are asked to provide county of residence for each patient served in your facility. This data should only reflect the number of patients, not number of scans and should not include other radiopharmaceutical or supply charge codes. Please count each patient only once.

County	lo. of Patients	County	No. of Patients	County	No. of Patients
1. Alamance		37. Gates		73. Person	
2, Alexander		38. Graham	3	74. Pitt	
3. Alleghany		39. Granville		75. Polk	11
4. Anson		40. Greene		76. Randolph	
5. Ashe		41. Guilford		77. Richmond	
6. Avery		42. Halifax		78. Robeson	17777011
7. Beaufort		43. Harnett		79. Rockingham ·	
8. Bertie		44. Haywood	1	80. Rowan	
9. Bladen		45. Henderson	159	81. Rutherford	5
10, Brunswick		46, Hertford		82. Sampson	
11. Buncombe	23	47. Hoke		83. Scotland	
12. Burke	tax	48. Hyde		84, Stanly	
13. Cabarrus		49. Iredell		85, Stokes	
14. Caldwell		50, Jackson		86. Surry	
15. Camden		51. Johnston		87. Swain	
16, Carteret		52, Jones		88, Transylvania	6
17. Caswell		53. Lee		89, Tyrrell	
18. Catawba		54. Lenoir		90, Union	
19. Chatham		55. Lincoln		91. Vance	
20. Cherokee	1	56. Macon		92. Wake	•
21. Chowan		57. Madison		93. Warren	
22. Clay		58, Martin		94, Washington	
23. Cleveland		59. McDowell		95. Watauga	
24. Columbus		60. Mecklenburg		96. Wayne	
25, Craven		61, Mitchell		97. Wilkes	
26. Cumberland		62. Montgomery		98. Wilson	
27. Currituck		63, Moore		99. Yadkin	
28, Dare		64. Nash		100. Yancey	
29. Davidson		65. New Hanover			
30. Davie		66. Northampton	 	101. Georgia	
31. Duplin		67. Onslow	1	102, South Carolina	
32. Durham		68. Orange		103. Tennessee	
33. Edgecombe		69. Pamlico		104. Virginia	
34. Forsyth		70. Pasquotank		105. Other States	
35. Franklin		71. Pender		106, Other .	3
36, Gaston		72. Perquimans		Total No. of Patients	212

All responses should pertain to October 1, 2006 through September 30, 2007.

This application must be completed and submitted with <u>ONE COPY</u> to the Acute and Home Care Licensure and Certification Section, Division of Health Service Regulation prior to the issuance of a 2008 hospital license.

AUTHENTICATING SIGNATURE: The undersigned submits application for the year 2008 in accordance with Article 5, Chapter 131E of the General Statutes of North Carolina, and subject to the rules and codes adopted thereunder by the North Carolina Medical Care Commission (10A NCAC 13B), and certifies the accuracy of this information.

Signature

Date: 11-21-07

PRINT NAME
OF APPROVING OFFICIAL

Jimm Bunch

<u>Please be advised</u>, the license fee <u>must</u> accompany the completed application and be submitted to the Acute and Home Care Licensure and Certification Section, Division of Health Service Regulation, <u>prior</u> to the issuance of a hospital license.



North Carolina Department of Health and Human Services Division of Health Service Regulation Acute and Home Care Licensure and Certification Section 1205 Umstead Drive, 2712 Mail Service Center Raleigh, North Carolina 27699-2712 Telephone: (919) 855-4620 Fax: (919) 715-3073 For Official Use Only
License # H0019 Medicare # 340023
Computer: 943388
PC Date
License Fee: \$1,737.50

2009 HOSPITAL LICENSE RENEWAL APPLICATION

		**************************************	AALEE ISE	A			
Legal Identity of Ap (Full legal name of	oplicant: <u>F</u> corporation	letcher Hospit 1, partnership, i	al, Incorpo	rated or other lega	ıl entity owning t	he enterprise or service.))
Doing Business As (d/b/a) name(s) und	er which tl	ne facility or ser	vices are ac	lvertised or	presented to the	public:	
PRIMARY: I	Park Ridge	e Hospital					
Other:	· · · · · · · · · · · · · · · · · · ·					-	
Facility Mailing Ac		P O Box 1569 Fletcher, NC	28732		• ,		
Facility Site Address County: Telephone: Fax:] ·]	Naples Rd Fletcher, NC 2 Henderson (828)684-8501 (828)687-0729	28732				
Administrator/Dir Title: <u>CEO</u> (Designated agent (inc		JIMM BUNCE		owner) for the	management of the	licensed facility)	
Chief Executive C (Designated agent (ind	Officer: lividual) resp	Jimm BUNG	CH erning body (c	owner) for the	Title:	CEO/President licensed facility)	-
Name of the person	•		ons regardi	ng this forn		ne: 828-681-2102	
-	lam L. S		· ·		reseptio	ne. 820-001-2102	<u></u>
E-Mail: myr	iam schu	ılze@ahss.o	rg		<u> </u>		
		•		·	CK. NO. 3)
•	•				DATE	12.1010	

wnership Disclosure (Please fill in any blanks and make changes where necessary.) What is the name of the legal entity with ownership responsibility and liability? Owner: Fletcher Hospital, Incorporated Federal Employer D# 56-0543246 Street/Box: P O Box 1569 City: Fletcher State: NC Zip: 28732 Telephone: (828)684-8501 Fax: (828)687-0729 CEO: Jimm Bunch Is your facility part of a Health System? [i.e., are there other hospitals, ambulatory surgical facilities, mursing homes, home health agencies, etc. owned by your hospital, a parent company or a related entity. YesNo If "Yes', name of Health System*: Adventist Health System * (please attach a list of NC facilities that are part of your Health System) If "Yes', name of CEO:	List Name(s) of facilities:	Address:	Type of Business / Service
What is the name of the legal entity with ownership responsibility and liability? Owner: Fletcher Hospital, Incorporated Federal Employer ID# 56-0543246 Street/Box: P O Box 1569 City: Fletcher State: NC Zip: 28732 Telephone: (828)684-8501 Fax: (828)687-0729 CEO: Jimm Bunch Is your facility part of a Health System? [i.e., are there other hospitals, ambulatory surgical facilities, nursing homes, home health agencies, etc. owned by your hospital, a parent company or a related entity. YesNo If "Yes', name of Health System*: Adventist Health System * (please attach a list of NC facilities that are part of your Health System) If "Yes', name of CEO:Donald Jernigan, Ph.D. a. Legal entity is: For Profit Not For Profit b. Legal entity is: For Profit Not For Profit c. Does the above entity (partnership, corporation, etc.) LEASE the building from which services are offered? Yes No If "YES", name of building owner: Is the business operated under a management contract? Yes No If "Yes', name and address of the management company. Name: Street/Box: State: No State: No Street/Box:		· · · · · · · · · · · · · · · · · · ·	
What is the name of the legal entity with ownership responsibility and liability? Owner: Fletcher Hospital, Incorporated Federal Employer ID# 56-0543246 Street/Box: P O Box 1569 City: Fletcher State: NC Zip: 28732 Telephone: (828)684-8501 Fax: (828)687-0729 CEO: Jimm Bunch Is your facility part of a Health System? [i.e., are there other hospitals, ambulatory surgical facilities, nursing homes, home health agencies, etc. owned by your hospital, a parent company or a related entity. YesNo If "Yes', name of Health System*: Adventist Health System * (please attach a list of NC facilities that are part of your Health System) If "Yes', name of CEO:Donald Jernigan, Ph.D. a. Legal entity is: For Profit Not For Profit b. Legal entity is: For Profit Not For Profit c. Does the above entity (partnership, corporation, etc.) LEASE the building from which services are offered? Yes No If "YES", name of building owner: Is the business operated under a management contract? Yes No If "Yes', name and address of the management company. Name: Street/Box: State: No State: No Street/Box:			
What is the name of the legal entity with ownership responsibility and liability? Owner: Fletcher Hospital, Incorporated Federal Employer ID# 56-0543246 Street/Box: P O Box 1569 City: Fletcher State: NC Zip: 28732 Telephone: (828)684-8501 Fax: (828)687-0729 CEO: Jimm Bunch Is your facility part of a Health System? [i.e., are there other hospitals, ambulatory surgical facilities, nursing homes, home health agencies, etc. owned by your hospital, a parent company or a related entity. YesNo If "Yes', name of Health System*: Adventist Health System * (please attach a list of NC facilities that are part of your Health System) If "Yes', name of CEO:Donald Jernigan, Ph.D. a. Legal entity is: For Profit Not For Profit b. Legal entity is: For Profit Not For Profit c. Does the above entity (partnership, corporation, etc.) LEASE the building from which services are offered? Yes No If "YES", name of building owner: Is the business operated under a management contract? Yes No If "Yes', name and address of the management company. Name: Street/Box: State: No State: No Street/Box:			
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Proprietorship LLC Government Unit c. Does the above entity (partnership, corporation, etc.) LEASE the building from which services are offered? Yes _X_No If "YES", name of building owner: Is the business operated under a management contract? Yes _X_No If 'Yes', name and address of the management company. Name: Street/Box:	nursing homes, home health agencie YesNo If 'Yes', name of Health System*: * (please attach a list of NC facilities	Adventist Health System s that are part of your Health System)	arent company or a related entity?
are offered?Yes _X_No If "YES", name of building owner: Is the business operated under a management contract?Yes _X_No If 'Yes', name and address of the management company. Name: Street/Box:	nursing homes, home health agencie YesNo If "Yes', name of Health System*: * (please attach a list of NC facilities If 'Yes', name of CEO:Don'	es, etc. owned by your hospital, a paragraph of Adventist Health System sthat are part of your Health System) hald Jernigan, Ph.D.	arent company or a related entity?
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Name: Street/Box:	nursing homes, home health agencies YesNo If 'Yes', name of Health System*: * (please attach a list of NC facilities If 'Yes', name of CEO:Dor. a. Legal entity is:For Properties b. Legal entity is: For Properties c. Does the above entity (partners are offered?Yes _X_ No)	Adventist Health System Sthat are part of your Health System) That are part of your Health System)	it Partnership Government Unit
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— n-j-	nursing homes, home health agencie YesNo If 'Yes', name of Health System*: * (please attach a list of NC facilities If 'Yes', name of CEO:Don a. Legal entity is:For Pro b. Legal entity is:Yorpor c. Does the above entity (partner are offered?Yes _X_No If "YES", name of building owner Is the business operated under a ma If 'Yes', name and address of the m Name:	Adventist Health System sthat are part of your Health System) hald Jernigan, Ph.D. ofit X Not For Profestoration LLP ietorship LLC ship, corporation, etc.) LEASE the before: anagement contract? Yes X Not For Profestoration Adventure Assets the before:	it Partnership Government Unit building from which services

License No: <u>H0019</u> Facility ID: <u>943388</u>

All responses should pertain to October 1, 2007 through September 30, 2008. \cdot

Ownership Disclosure continued	
. Vice President of Nursing and Patient Care Services: Karen Owensby, Vice President of Clinical Services	
Director of Planning:	
Facility Data	
A. Reporting Period All responses should pertain to the period October 1, 2008. B. General Information (Please fill in any blanks and make changes when	
B. General Information (Please fill in any blanks and make changes whe	io noossary.j.
a. Admissions to Licensed Acute Care Beds: include responses to "a - q" on page 4; exclude responses to "2-9" on page 4; and exclude normal newborn bassinets.	3,713
b. Discharges from Licensed Acute Care Beds: include responses to "a - q" on page 4; exclude responses to "2-9" on page 4; and exclude normal newborn bassinets.	3,697
c. Average Daily Census: include responses to "a - q" on page 4; exclude respons to "2-9" on page 4; and exclude normal newborn bassinets.	ses 37
d. Was there a permanent change in the total number of licensed beds durin the reporting period?	Yes No
If 'Yes', what is the current number of licensed beds?	
If 'Yes', please state reason(s) (such as additions, alterations, or conversions) which may have affected the change in bed complement:	
e. Observations: Number of patients in observation status and not admitted as inpatients, excluding Emergency Department patients.	643
C. Designation and Accreditation 1. Are you a designated trauma center? Yes (Designated Letter)	evel #) _x_ No
2. Are you a critical access hospital (CAH)? Yes X No	
3. Are you a long term care hospital (LTCH)? Yes X No	
4. If this facility is accredited by the Joint Commission or AOA, specify th	e accrediting body
YES and indicate the date of the last survey 05 / 20 / 2	2006
AOA - 4/30-5/2/07 Revised 08/2008	Pag

License No: H0019 Facility ID: 943388

D. <u>Beds by Service (Inpatient – Do Not Include Observation Beds or Days of Care)</u> [Please provide a <u>Beds by Service (p. 4)</u> for <u>each</u> hospital campus (see G.S. 131E-176(2c))]

Please indicate below the number of beds usually assigned (set up and staffed for use) to each of the following services and the number of census inpatient days of care rendered in each unit. NOTE: If your facility has a designated unit(s) for chemical dependency treatment and/or detoxification, please complete the patient origin sheet pertaining to Psychiatric and Substance Abuse Services. If your facility has a Nursing Facility unit and/or Adult Care Bed unit please complete the supplemental packet for Skilled Nursing Facility beds.

Licensed Acute Care (provide details below) Campus	Licensed Beds as of September 30, 2008	Staffed Beds as of September 30, 2008	Annual Census Inpt. Days of Care
Intensive Care Units			
a. Burn*			*
b. Cardiac (Combined ICU/CCU/Telemetry)	14	14	3,659
c. Cardiovascular Surgery	•	•	
d. Medical/Surgical		· ·	
e. Neonatal Beds Level IV ** (Not Normal Newborn)		<u> </u>	**
f. Pediatric		-	
g. Respiratory Pulmonary			<u> </u>
h. Other (List)			
Other Units			
i. Gynecology			·
j. Medical/Surgical ***	40	40 .	*** 8;665
k. Neonatal Level III ** (Not Normal Newborn)			**
Neonatal Level II ** (Not Normal Newborn)		et e balde likke aktivist i Fert Wales versom en skriven aktiva och och skrivet i fertiget i	**
m. Obstetric (including LDRP)	8	8	1,359
n. Oncology		- '	
o, Orthopedics			
p. Pediatric	4-00-14-14-14-14-14-14-14-14-14-14-14-14-14-		
q. Other (List)			
1. Total General Acute Care Beds/Days (a through q)	62	. 62	13,683
2. Comprehensive In-Patient Rehabilitation	. 0		
3. Inpatient Hospice	0		
4. Detoxification	0	***************************************	
5. Substance Abuse / Chemical Dependency Treatment	. 0	36	12,622
6. Psychiatry	41		
7. Nursing Facility	0		
8. Adult Care Home	0		
9. Other	0		<u> </u>
10. Totals (1 through 9)	103	98	26,305

^{*} Please report only Census Days of Care of DRG's 504, 505, 506, 507, 508, 509, 510 and 511.

^{**} Per C.O.N. rule definition. Refer to Section .1400 entitled Neonatal Services. (10A NCAC 14C)

^{***} Exclude Skilled Nursing swing-bed days. (See swing-bed information next page)

All responses should pertain to October 1, 2007 through September 30, 2008.

D. Beds by Service (Inpatient) continued

Number of Swing Beds *	2
Number of Skilled Nursing days in Swing Beds	,
Number of unlicensed observation beds	

^{*} means a hospital designated as a swing-bed hospital by CMS (Centers for Medicare and Medicaid Services)

E. Reimbursement Source (For "Inpatient Days," show Acute Inpatient Days only, excluding normal newborns.)

Primary Payer Source	Inpatient Days of Care (from p. 4, item D. 1.)	Emergency Visits (from p. 6)	Outpatient Visits (excluding Emergency Visits and Surgical Cases)	Inpatient Surgical Cases (from p.8, Table 8. b)	Ambulatory Surgical Cases (from p. 8, Table 8. b)
Self Pay/Indigent/Charity	698	4988	4345	49	178
Medicare & Medicare Managed Care	. 7278	2885	38894	562	2044
Medicaid	2586	3736	6624	289	567
Commercial Insurance	137	. 324	1193	20	85
Managed Care	2983	4258	30051	381	2100
Other (Specify)					And the second s
TOTAL	13682	16191	81107	1302	4974

	· · · · · · · · · · · · · · · · · · ·		Commence of the Commence of th
	\$ Amount	% of Total Costs	% of Net Revenues
Unreimbursed Medicaid Costs (1)	1.847.327	1.856%	
Unreimbursed Charity Care (1)	4,114,060	4.13%	· 4.7%
Bad Debt	5.704.426		6.52%

(I) Unreimbursed Medicaid costs and the unreimbursed charity care should come from the hospital's most recent Medicaid Cost

Charity Care Definition: Health care services that never were expected to result in cash inflows. Charity care results from a provider's policy to provide health care services free of charge to individuals who meet certain financial criteria.

policy to provide health care services free of charge to individuals who meet certain inflation of incine.

Bad Debt Definition: Health care services that were expected to result in cash inflows but written off after unsuccessful efforts to collect the amount owed.

F. Services and Facilities

1. Obstetrics	Enter Number of Infants
a. Live births (Vaginal Deliveries)	330
b. Live births (Cesarean Section)	1917
c. Stillbirths	5

	1
d. Delivery Rooms - Delivery Only (not Cesarean Section)	. 0 .
e. Delivery Rooms - Labor and Delivery, Recovery	4
f. Delivery Rooms - LDRP (include Item "m" on Page 4)	. 0
g. Normal newborn bassinets (Level I Neonatal Services)	·
Do not include with totals under the section entitled Beds by Service (Inpatient)	8

	•	
2.	Abortion	Services

Number of procedures per Year

_0___

3.	Emergency Departme	ent Services (cases equal visits to	ED)			
•	a. Total Number of El	Exam Room	ıs:	12	·		
	a.1. #Trauma Rooms_	1	a.2. #Fast	Track Room	s <u>11</u> .		
	b. Total Number of ED visits for reporting period: 16,191						
	c. Total Number of ac		•		•		
	d. Total Number of U					************	
	e. Does your ED prov If no, specify days/hor	ride services 2 urs of operation	4 hours a day 7 day on:	s per week?	x Yes No	·	
	f. Is a physician on di If no, specify days/ho	ity in your ED urs physician	0 24 hours a day 7 d is on duty:	ays per week	x? X Yes No		
4	Medical Air Transpo	ort: Owned o	r leased air ambula	nce service:			
	a. Does the facility of b. If "Yes", complete	perate an air a the following	mbulance service? g chart.	Yes x	No		
	Type of Aircraft	Number of Airc	raft Number Owner	d Number L	eased Number of Trans	ports	
	Rotary				·		
	Fixed Wing						
· 5 .	Pathology and Medi	cal Lab (Che	eck whether or not s	service is pro	vided)		
	a. Blood Bank/Trans	fusion Service	es x y	res N	lo,		
	b. Histopathology La	•	X	7es N	Vo.	• .	
	c. HIV Laboratory T			Zes <u>x</u> N	1 0		
	Number during re		.				
		у					
	HIV Culture					•	
	d. Organ Bank			Yes <u>x</u> 1 Yes1	No .		
	e. Pap Smear Screen	ning	. <u>X</u>	Yes : r	No	•	
6.	Transplantation Ser	rvices - Numl	per of transplants				
	Туре	Number	Туре	Number	Type	Number	
a. Bone	Marrow-Allogeneic	0	i. Kidney/Liver	0	k. Lung	0	
	e Marrow-Autologous	0	j. Liver	. 0	1. Pancreas	.0	
c. Corr		21	f. Heart/Liver	0	m. Pancreas/Kidney	0 .	
d. Hear		0	g. Heart/Kidney	0	n, Pancreas/Liver	. 0	
e. Hear	t/Lung	0	h. Kidney	. 0	o. Other	0	

Do you perform living donor transplants? ____ Yes __X No.

All responses should pertain to October 1, 2007 through September 30, 2008.

7. Specialized Cardiac Services (for questions, call 855-3865 [Medical Facilities Planning])

(a)	Cardiac Catheterization	Diagnostic Cardiae Catheterization ICD-9 37.21, 37.22, 37.23, 37.25	Interventional Cardiac Catheterization- ICD-9 00.66, 99.10, 36.06, 36.07, 36.09; 35.52, 35.71, 35.96	Electro-physiology 37.26, 37.27, 37.34, 37.70, 37.71, 37.72, 37.73, 37.74, 37.75, 37.76, 37.77, 37.79, 37.80, 37.81, 37.82, 37.83, 37.85, 37.86, 37.87, 37.89, 37.94, 37.95, 37.96, 37.97, 37.98, 37.99, 00.50, 00.51, 00.52, 00.53, 00.54
1.	Number of Units of Equipment		·	
2.	Number of Patients Age 14 and younger			
3.	Number of Patients Age 15 and older			
	Total # of Patients 10/1/07-9/30/08	·		
4.	Number of Procedures* Performed in Fixed Units	·		·
5.	Number of Procedures* Performed in Mobile Units			
	Total # of Procedures 10/1/07-9/30/08	17	LINGO	

*A procedure is defined to be one visit or trip by a patient to a catheterization laboratory for a single or multiple catheterizations. Count each visit once, regardless of the number of diagnostic, interventional, and/or EP catheterizations performed within that visit.

Name of Mobile Vendor:	
Number of 8-hour days per week the mobile unit is onsite;	8-hour days per week.
(Examples: Monday through Friday for 8 hours per day is 5 8-hours per day is 1.5 8-hour days per week)	ur days per week. Monday, Wednesday, & Friday for 4

(b)	Open Heart Surgery	Number of Machines/Procedures
1.	Number of Heart-Lung Bypass Machines	
2.	Total Annual Number of Open Heart Surgery Procedures	
	Utilizing Heart-Lung Bypass Machine	
3,	Total Annual Number of Open Heart Surgery Procedures done	
	without utilizing a Heart-Lung Bypass Machine	
4.	Total Open Heart Surgery Procedures (2. + 3.)	
	Procedures on Patients Age 14 and younger	
5.	Of total in #2, Number of Procedures on Patients Age 14 &	
	younger	
6.	Of total in #3, Number of Procedures on Patients Age 14 &	
	younger	

License No: H0019 Facility ID: 943388

8. Surgical Operating Rooms and Cases

a) Surgical Operating Rooms

[1] Report <u>Surgical Operating Rooms</u> built to meet the specifications and standards for operating rooms required by the Construction Section of the Division of Health Services Regulation, and which are fully equipped to perform surgical procedures. These surgical operating rooms include rooms located in Obstetrics and surgical suites.

NOTE: If this License includes more than one campus, please submit the Cumulative Totals and COPY this sheet and Submit a duplicate of this page for each campus.

(Campus – <i>If multip</i>	ole sites:
----------------------------	------------

Type of Room	Number of Rooms
Dedicated Open Heart Surgery	0
Dedicated C-Section	0
Other Dedicated Inpatient Surgery	0
Dedicated Ambulatory Surgery	0 "
Shared - Inpatient / Ambulatory Surgery	6
Total of Surgical Operating Rooms	6

Does this facility have approval for additional surgice	al operating	roon	<u>ıs</u> (i.e.,	not listed above) that are being develope
pursuant to a Certificate of Need?	Yes	X	No	# Rooms

b) Surgical Cases by Specialty Area

NOTE: Read the following instructions carefully.

Enter the number of surgical <u>cases</u> by surgical specialty area in the chart below. Count each patient undergoing surgery as one case regardless of the number of surgical procedures performed while the patient was having surgery. Categorize each case into one specialty area — Total Surgical Cases is an unduplicated count of surgical cases. Count all surgical cases, including cases performed in procedure rooms or in any other location.

Surgical Specialty Area	Inpatient Cases	Ambulatory Cases
Cardiothoracic (excluding Open Heart Surgery)	15 .	27
Open Heart Surgery (from 7.(b) 4.)	0	
General Surgery	218	543
Neurosurgery	83	4
Obstetrics and GYN (excluding C-Sections)	127	492
Ophthalmology	1	. 1263
Oral Surgery	1 1	23
Orthopedics	543	1645
Otolaryngology	13	490
Plastic Surgery	17	143
Urology	77	319
Vascular	6	· · 2
Other Surgeries (which do not fit into the above categories)	. 4	. 23
Number of C-Section's Performed in Dedicated C-Section ORs	. 0	
Number of C-Section's Performed in Other ORs	197	
Total Surgical Cases	1302	4974

PATK Range Mospital

All responses should pertain to October 1, 2007 through September 30, 2008.

License No: H0019 Facility ID: 943388

8. Surgical Operating Rooms and Cases continued

c) Average Operating Room Availability and Average Case Times:

The Operating Room Methodology assumes that the average operating room is staffed 9 hours a day, for 260 days per year, and utilized at least 80% of the available time. This results in 1872 hours per OR per year.

The Operating Room Methodology also assumes 3 hours for each Inpatient Surgery and 1.5 hours for each Outpatient Surgery.

Based on your hospital's experience, please complete the table below by showing the assumptions for the average operating room in your hospital.

Average Hours per Day Routinely Scheduled for Use *	Average Number of Days per Year Routinely Scheduled for Use	Average "Case Time" ** in Minutes for Inpatient Cases	Average "Case Time" ** in Minutes for Ambulatory Cases
9	.260	107	81

^{*} Use only Hours per Day **routinely** scheduled when determining. Example: 2 rooms @ 8 hours per day <u>plus</u> 2 rooms @ 10 hours per day <u>equals</u> 36 hours per day; <u>divided</u> by 4 rooms equals an average of 9 hours / per room / per day.

^{** &}quot;Case Time" = Time from Room Set-up Start to Room Clean-up Finish. Definition 2.4 from the "Procedural Times Glossary" of the AACD, as approved by ASA, ACS, and AORN. <u>NOTE</u>: This definition includes all of the time for which a given procedure requires an OR/PR. It allows for the different duration of Room Set-up and Room Clean-up Times that occur because of the varying supply and equipment needs for a particular procedure

License No: H0019
Facility ID: 943388

9. Gastrointestinal Endoscopy Rooms, Cases, and Procedures

[1] Report the number of <u>Gastrointestinal Endoscopy Rooms</u> and the number of cases and procedures performed in these rooms during the reporting period. (<u>NOTE</u>: <u>Other procedure rooms</u> should be included in Section 10 below.) Count <u>each patient as one case</u> regardless of the number of procedures performed while the patient was in the GI endoscopy room.

Number of GI Endo Rooms	Total Number GI Endo Cases [a]	Total Number Non-GI Endo Cases [b]	Total Endo Cases [a] + [b]
	762 _{se} -	0	762
1	Total Number GI Endo Procedures* [c]	Total Number Non-GI Endo Procedures [d]	Total Endo Procedures [c] + [d]
	970	0	970

*As defined in 10A NCAC 14C .3901 "Gastrointestinal (GI) endoscopy procedure" means a single procedure, identified by CPT code or ICD-9-CM procedure code, performed on a patient during a single visit to the facility for diagnostic or therapeutic purposes.

Does this facility have approval for addi	tional GI E	ndosco	py rooms	(i.e., not listed above)	that are being developed
pursuant to a Certificate of Need?	Yes	Х	No	# Rooms	`

10. Non-Gastrointestinal Procedure Rooms and Cases

Please report only rooms and cases not reported in 8. or 9.: Report rooms not equipped or meeting all the specifications for an operating room, dedicated to the performance of procedures other than gastrointestinal endoscopy.

a) Total Number of Procedure Rooms: 0			0 .		Rooms:	of Procedure	Number (Total	٠.	a)
---------------------------------------	--	--	-----	--	--------	--------------	----------	-------	----	----

Note: Read the following instructions carefully

b) Enter the number of Non-Surgical <u>cases</u> by specialty area in the chart below. Count all Non-Surgical <u>cases</u>, including <u>cases</u> performed in Operating Rooms. Count each patient undergoing a procedure or procedures as one case regardless of the number of procedures performed while the patient was in the room.

Non-Surgical Specialty Area	Inpatient Cases	Ambulatory Cases
Pain Management	8	192
Cystoscopy	· · O	0
Non GI Endoscopies (not reported in 9.)	0.	0
GI Endoscopies (not reported in 9.)	<u> </u>	0
YAG Laser	0 :	. 0
Other (specify) Bronchoscopy	. 10	11
Other (specify)	. 0 .	0
Other (unspecified) Bone Marrow bx	7	18
Total Non-Surgical Cases	25	221

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10a. Magnetic Resonance Imaging

Indicate the number of machines/instruments and the number of the following types of procedures performed during the 12-month reporting period at your facility. For Hospitals that operate medical equipment at multiple sites, please copy this and provide separate pages for each site.

	Number of Units		. Number of P		#3410 ient and outpa		dures. es below.
Fixed MRI · Scanners-closed	· 1		Inpatient Procedures Outpatient Pro				
(With	Without		With	Without .	•
Fixed MRI Scanners-open		Contrast or Sedation	Contrast_or Sedation	TOTAL Inpatient	Contrast or Sedation	Contrast or Sedation	TOTAL Outpatient
Total Fixed MRI Scanners	1	145	205	350	506	. 1828	2334
Mobile MRI Provider 1 Data	1				68	449	517 .
Mobile MRI Provider 2 Data	1				9	200	209
MRI pursuant to Policy AC-3:							
Other Human Research MRI Scanner						,	

^{*} An MRI procedure is defined as a single discrete MRI study of one patient (single CPT coded procedure). An MRI study means one or more scans relative to a single diagnosis or symptom. The total number of procedures should be equal to or more than the total number of patients reported on the MRI Patient Origin Table-on page 25 of this application.

Name of Mobile MRI Provider 1: Alliance Imaging

Name of Mobile MRI Provider 2: Insight Health

10b. MRI Procedures by CPT Codes

CPT Code	CPT Description	Number of Procedures
70336	MRI Temporomandibular Joint(s)	<u>. 1</u>
70540	MRI Orbit/Face/Neck w/o	2
70542	MRI Orbit/Face/Neck with contrast	
70543	MRI Orbit/Face/Neck w/o & with	<u>. 18</u> .
70544	MRA Head w/o	88
70545	MRA Head with contrast	1 ·
70546	MRA Head w/o & with	* ************************************
70547	MRA Neck w/o	
70548	MRA Neck with contrast	
70549	MRA Neck w/o & with	19
70551	MRI Brain w/o	263
70552	MRI Brain with contrast	2
70553	MRI Brain w/o & with	522
7055A	IAC Screening	
	Subtotal for this page	916

10b. MRI Procedures by CPT Codes continued....

CPT Code	CPT Description	Number of Procedures
71550	MRI Chest w/o	
71551	MRI Chest with contrast	,
71552	MRI Chest w/o & with	5
71555	MRA Chest with OR without contrast	1
72126	Cervical Spine Infusion only	
72141	MRI Cervical Spine w/o	469
72142	MRI Cervical Spine with contrast	<u> </u>
72156	MRI Cervical Spine w/o & with	35
72146	MRI Thoracic Spine w/o	121
72147 -	MRI Thoracic Spine with contrast	1
72157	MRI Thoracic Spine w/o & with	24
72148	MRI Lumbar Spine w/o	514
72149 :	MRI Lumbar Spine with contrast	2
72158	MRI Lumbar Spine w/o & with	100
72159	MRA Spinal Canal w/o OR with contrast	
72195	MRI Pelvis w/o	49
72196.	MRI Pelvis with contrast	
72197 [.]	MRI Pelvis w/o & with	. 25
72198	MRA Pelvis w/o OR with Contrast	•
73218	MRI Upper Ext, other than joint w/o	14
73219	MRI Upper Ext, other than joint with contrast	
73220	MRI Upper Ext, other than joint w/o & with	4
73221	MRI Upper Ext any joint w/o	288 ·
73222	MRI Upper Ext any joint with contrast	38
73223	MRI Upper Ext any joint w/o & with	8
73225	MRA Upper Ext w/o OR with contrast	,
73221	MRI Upper Ext, any joint w/o	
73222	MRI Upper Ext, any joint with contrast	
73223	MRI Upper Ext, any joint w/o & with	
73225	MRA Upper Ext, w/o OR with contrast	
73718	MRI Lower Ext other than joint w/o	83
73719	MRI Lower Ext other than joint with contrast	
73720	MRI Lower Ext other than joint w/o & with	27
73721 .	MRI Lower Ext any joint w/o	489
73722	MRI Lower Ext any joint with contrast	1
73723	MRI Lower Ext any joint w/o & with	22
73725	MRA Lower Ext w/o OR with contrast	. 1
74181	MRI Abdomen w/o	49
74182	MRI Abdomen with contrast	1
, , , , , ,	Subtotal for this page	

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CPT Code	s by CPT Codes continued CPT Description	Number of Procedures
74183	MRI Abdomen w/o & with	28
74185	MRA Abdomen w/o OR with contrast	6
75552	MRI Cardiac Morphology w/o	
75553	MRI Cardiac Morphology with contrast	
75554	MRI Cardiac Function Complete	
75555	MRI Cardiac Function Limited	
75556	MRI Cardiac Velocity Flow Mapping	
76093	MRI Breast, unilateral w/o and/or with contrast	. 5
76094	MRI Breast, bilateral w/o and/or with contrast	. 82
76125.	Cineradiography to complement exam	
76390	MRI Spectroscopy	
76393	MRI Guidance for needle placement	1
76394	MRI Guidance for tissue ablation	
76400	MRI Bone Marrow blood supply	<u>'</u>
7649A	MR functional imaging	
7649D	MRI infant spine comp w/ & w/o contrast	
7649E.	Spine (infants) w/o infusion	
7649H	MR functional imaging	
N/A	Clinical Research Scans	
	Subtotal for this page	
	Total Number of Procedures for all pages	3410

10c.	Computed	Tomography	(CT)
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How many fixed CT scanners does the hospital have?	two			-
Does the hospital contract for mobile CT scanner services?	·	Yes	<u>X</u>	No
If yes, identify the mobile CT vendor	•		<u></u>	

Complete the following tables (one for fixed CT scanners; one for mobile CT scanners).

Scans Performed on Fixed CT Scanners (Multiply # scans by Conversion Factor to get HECT Units)

	Type of CT Scan	# of Scans		Conversion Factor		HECT Units
1	Head without contrast	2389	X	· · 1,00	=	2389
2	Head with contrast	438	Х	. 1,25	=	547.50
3	Head without and with contrast	539	X	1.75	=	943.25
4	Body without contrast	2142	·X	1.50	=	3213
5	Body with contrast	2980	X	1.75	=	5215
6	Body without contrast and with contrast	1280	Х	2.75	=	. 3520
7	Biopsy in addition to body scan with or without contrast	55	X	2.75		151.25
8	Abscess drainage in addition to body scan with or without contrast	. 15	X.	4.00	=	60

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Scans Performed on Mobile CT Scanners (Multiply # scans by Conversion Factor to get HECT Units)

	Type of CT Scan	# of Scans		Conversion Factor		HECT Units
1	Head without contrast.		X	1.00	=	
2	Head with contrast		X	1.25 .	=	٠,
3	Head without and with contrast		X	1.75	=	
4	Body without contrast		X	1.50	=	
5	Body with contrast		X	1.75	=	
6	Body without contrast and with contrast		Х	2.75	=	
7	Biopsy in addition to body scan with or without contrast	es e	X	2.75	=	
8	Abscess drainage in addition to body scan with or without contrast		X	4.00	= :	

d. Other Imaging Equipment	Number of	Numb	er of Procedure	es
	Units .	Inpatient .	Outpatient	Total
Dedicated Fixed PET Scanner				
Mobile PET Scanner	1 1	2	199	201
PET pursuant to Policy AC-3				<u> </u>
Other Humani Research PET Scanner	·			<u></u>
Ultrasound equipment	. 3	1971 -	2387	4808
Bone Density Equipment	2	7	900	907
Fixed X-ray Equipment (excluding fluoroscopic)	4	5757	12812	185.69
Fixed Fluoroscopic X-ray Equipment	2	.1807	2121	3928
Special Procedures/ Angiography (neuro & vascular, but not including cardiac cath.)				
Coincidence Camera		!		<u> </u>
Mobile Coincidence Camera Vendor:				
SPECT	1	598	2248	2846
Mobile SPECT		·		
Vendor:				
Gamma Camera				1
Mobile Gamma Camera	•			
Vendor:	ationt involving or	<u> </u>	<u> </u>	

^{*} PET procedure means a single discrete study of one patient involving one or more PET scans. PET scan means an image-scanning sequence derived from a single administration of a PET radiopharmaceutical, equated with a single injection of the tracer. One or more PET scans comprise a PET procedure. The number of PET procedures in this table should match the number of patients reported on the PET Patient Origin Table on page 27.

10e. Lithotripsy

OC. LIEBUIL	Number of	Nu	mber of Procedu	res
,	Units	Inpatient	Outpatient	Total
Fixed				
Mobile	1	. 0	40	40

Lithotripsy Vendor/Owner:			
Health Tronics			

License No: <u>H0019</u> Facility ID: <u>943388</u>

11. Radiation Oncology Treatment Data

CPT Code	Description	Number of Procedures	ESTVs/ Procedures Under ACR	Total ACR ESTVs	
	Simple Treatment Delivery:				
77401	Radiation treatment delivery		1.00		·
77402	Radiation treatment delivery (<=5 MeV)		1.00		_
77403	Radiation treatment delivery (6-10 MeV)	4	1.00		
77404	Radiation treatment delivery (11-19 MeV)		1.00		
77406	Radiation treatment delivery (>=20 MeV)		1.00		
	Intermediate Treatment Delivery:				
77407	Radiation treatment delivery (<=5 MeV)	•	1.00		
77408	Radiation treatment delivery (6-10 MeV)	•	1.00	,	·
77409	Radiation treatment delivery (11-19 MeV)		1.00		
77411	Radiation treatment delivery (>=20 MeV)	·	1.00		
	Complex Treatment Delivery:				
77412	Radiation treatment delivery (<=5 MeV)		1.00		
77413	Radiation treatment delivery (6-10 MeV)		1.00		
77414	Radiation treatment delivery (11-19 MeV)		1.00		
77416	Radiation treatment delivery (>= 20 MeV)		. 1.00		
	Sub-Total			-	
For the	increased time required for special techniqu	ies, ESTV valu	es are indicated	l below:	
77417	Additional field check radiographs		.50		
77418	Intensity modulated radiation treatment (IMRT) delivery		1.00		
77432	Stereotactic radiosurg. treatment mgmt Linear Accelerator/CyberKnife or other	•	3.00		
77432	Stereotactic radiosurg. Treatment mgmt Gamma Knife		3.00		
	Total body irradiation	·	2.50		
	Hemibody irradiation		2.00		
	Intraoperative radiation therapy		10.00		
	(conducted by bringing the anesthetized	ŀ	1.		
	patient down to the linac)			<u> </u>	<u>,</u>
1.	Neutron and proton radiation therapy		2.00		ļ
	Limb salvage irradiation		1.00		
	Pediatric Patient under anesthesia		1.50		
	Sub-Total			<u> </u>	
	TOTALS:	1		<u> </u>	

Note: For special techniques, list procedures under both the treatment delivery and the special techniques sections.

1	1	Dadiation	Oncology Treatment Data continued	
3	٠.	MULHULL	Oucology I I cathere is at a continuent	

a.	Number of unduplicated patients who receive a course of radiation oncology treatments.	
· .	Patients shall be counted more than once if they receive additional courses of treatment.	
	For example, one patient who receives three courses of radiation oncology treatment	
	counts as three. The number of patients reported here should match the number of	
	patients reported in the Radiation Oncology Patient Origin Table on page 26.	
b.	Total number of Linear Accelerator(s)	
·C.	Number of Linear Accelerators configured for stereotactic radiosurgery	
d.	Number of CyberKnife® Systems, Gamma Knife, or other specialized Linear Accelerators.	
	Identify Manufacturer of Equipment	

12. Telemedicine

- a. Does your facility utilize telemedicine to have images read at another facility? Yes.
- b. Does your facility read telemedicine images? Yes

13. Additional Services:

a) Check if Service(s) is provided: (for dialysis stations, show number of stations)

_	Check		Check
1. Cardiac Rehab Program		5. Rehabilitation Outpatient Unit	.,,
(Outpatient)	, X	1	X
2. Chemotherapy	x	6. Podiatric Services	Lx
3. Clinical Psychology Services		7. Genetic Counseling Service	
4. Dental Services		8. Number of Acute Dialysis Stations	

b) Hospice Inpatient Unit Data:

Hospital-based hospice units with licensed hospice beds. List each county served and report all patients by county of residence. Use each patient's age on the admission day to the Licensed Hospice Inpatient Facility. For age categories count each inpatient client only once.

	County of Residence	Age 0- 17	Age 18-40	Age 41-59	Age 60-64	Age 65-74	Age 75-84	Age 85+	Total Patients Served	Total Days of Care	Deaths
	Annan and the state of the stat				***************************************			• '			
	•						·		·		
					,						
	•										
	,										,
L		,					·				
										. ,	
L	Out of State				<u> </u>		<u></u>	<u> </u>	<u> </u>	<u></u>	· .
Ħ	Total All Ages						 				

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13. Additional Services: continued

- c) Mental Health and Substance Abuse
 - 1. If psychiatric care has a different name than the hospital, please indicate:

Hope Behavioral Health Services

- 2. If address is different than the hospital, please indicate:
- 3. Director of the above services.

Dr. David Manly, Medical Director & Marilyn Jackson, RN, Director

Indicate the program/unit location in the <u>Service Categories</u> chart below. If it is in the hospital, include the room number. If it is located at another site, include the building name, program/unit name and address.

<u>Service Categories:</u> All applicants must complete the following table for all mental health services which are to be provided by the facility. If the service is not offered, leave the spaces blank,

Rule 10A NCAC 27G Licensure Rules For Mental Health Facilities	Location of Services	Ве	Beds Assigned by Age				
		0-12	13-17	Subtotal 0-17	18 & up	Total Beds	
.1100 Partial hospitalization for individuals who are acutely mentally ill.	Women's						
.1200 Psychosocial rehabilitation facilities for individuals with severe and persistent mental illness	N/A						
1300 Residential treatment facilities for children and adolescents who are emotionally disturbed or have a mental illness	n/a						
. 1400 Day treatment for children and adolescents with emotional or behavioral disturbances	n/a						
1500 Intensive residential treatment facilities for children & adolescents who are emotionally disturbed or who have a mental illness	n/a						
.5000 Facility Based Crisis Center	N/A						

Rule 10A NCAC 13B Licensure Rules For Hospitals	Location of Services	Be	ds Assig	ned by A	18 & up	Total Beds
.5200 Dedicated inpatient unit for individuals who have mental disorders	PRH			0-17	, X	. ·36

All responses should pertain to October 1, 2007 through September 30, 2008.

13. Additional Services: continued

c) Mental Health and Substance Abuse continued .

Rule 10A NCAC 27G Licensure Rules for Substance Abuse Facilities	Location of Services	Beds Assigned by Age					
	,	0-12	13-17	Subtotal 0-17	18 & up	Total Beds	
.3100 Nonhospital medical detoxification for individuals who are substance abusers							
.3200 Social setting detoxification for substance abusers							
.3300 Outpatient detoxification for substance abusers	•						
.3400 Residential treatment/ rehabilitation for individuals with substance abuse disorders							
.3500 Outpatient facilities for individuals with substance abuse disorders					3.2		
.3600 Outpatient narcotic addiction treatment		_					
.3700 Day treatment facilities for individuals with substance abuse disorders							

Rule 10A NCAC 13B Licensure Rules	Location of	Be Be	ds Assig	med by	Age		
For Hospitals	Services	0-12	13-17	Subtotal 0-17	18 & up	Total Beds	
The state of the s		7				***************************************	

Rule 10A NCAC 13B Licensure Rules	Location of	Be	ds Assig	ned by A	\ge	
For Hospitals	Services	0-12	13-17	Subtotal 0-17	18 & up	Total Beds
.5200 Dedicated inpatient hospital unit for individuals who have substance abuse disorders (specify type) # of Treatment beds						
# of Medical Detox beds						

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Patient Origin -General Acute Care Inpatient Services

Facility County: Henderson

In an effort to document patterns of utilization of General Acute Care Inpatient Services in North Carolina hospitals, please provide the county of residence for each patient admitted to your facility.

County	No. of	County	No. of	County	No. of
	Admissions		Admissions		Admissions
1. Alamance		37. Gates	2	73. Person	
2. Alexander		38, Graham	. 5	74. Pitt	
3. Alleghany		39. Granville	•	75. Polk	131
4. Anson		40. Greene		76. Randolph	
5. Ashe	2	41. Guilford	1	77. Richmond	. 1
6. Avery	2	42. Halifax		78. Robeson	
7. Beaufort		43. Harnett	•	79. Rockingham	1
8. Bertie		44. Haywood .	83	80. Rowan	1
9. Bladen		45. Henderson	2738	81. Rutherford	53
10. Brunswick		46, Hertford		82, Sampson	
11. Buncombe	763	47. Hoke		83. Scotland	
12. Burke	8	48. Hyde	. 1	84: Stanly	2
13. Cabarrus	2 .	49. Iredell	1	85. Stokes	
14. Caldwell	3	50. Jackson	16	86. Surry	Terrory Depression of the second seco
15, Camden	· .	51. Johnston		87. Swain	7
16. Carteret		52. Jones		88. Transylvania	140
17. Caswell		53. Lee		89. Tyrrell	140
18. Catawba	1	54. Lenoir		90. Union	1
19. Chatham		55. Lincoln		91. Vance	····
20. Cherokee	8	56. Macon	19	92. Wake	1
21. Chowan		57. Madison	6	93. Warren	
22. Clay	3	58. Martin	23	94. Washington	2
23. Cleveland	4	59. McDowell	1 1	95. Watauga	1
24. Columbus		60. Mecklenburg	7	96. Wayne	<u> </u>
25. Craven		61. Mitchell	2	97. Wilkes	
26. Cumberland	i	62. Montgomery		98. Wilson	
27. Currituck		63. Moore		99. Yadkin	
28; Dare		64. Nash		100. Yancey	14
29. Davidson		65. New Hanover	1		- 10
30. Davie	· · · · · ·	66. Northampton	1	101. Georgia	
31. Duplin		67. Onslow	1 1	102. South Carolina	
32. Durham	1	68. Orange	·	103. Tennessee	
33. Edgecombe		69. Pamlico		104. Virginia	
34. Forsyth	2	70. Pasquotank	- The state of the	105. Other States	
35. Franklin	1	71. Pender		106. Other	162
36, Gaston	5	72. Perquimans		Total No. of Patients	4228
		1	<u></u>	I worm riot or I amounts	4448

Patient Origin - Inpatient Surgical Cases

Facility County: Henderson

In an effort to document patterns of "Inpatient" utilization of Surgical Services in North Carolina hospitals, please provide the county of residence for each inpatient surgical patient served in your facility. Count each inpatient "once" regardless of the number of surgical procedures performed while the patient was in the operating room. However, each admission as an inpatient operating room patient should be reported separately.

The "Total" from this chart should match the "Total" Inpatient Cases reported on the $\underline{\text{Surgical Cases by Specialty}}$ Area Table on page 8.

County	No. of Patients	County	No. of Patients	County .	No. of Patients
1. Alamance		37. Gates	. 2	.73. Person	
2. Alexander		38. Graham	· 2·	74. Pitt	l
3. Alleghany		39. Granville		75. Polk	50
4. Anson		40. Greene		76. Randolph	
5. Ashe	2	41, Guilford		77. Richmond	
6. Avery	1 .	42. Halifax		78. Robeson	
7. Beaufort		43. Harnett		79. Rockingham	1
8. Bertie		44. Haywood	64	80, Rowan	1
9. Bladen		45. Henderson	679	81. Rutherford	17
10. Brunswick		46. Hertford		82. Sampson :	
11. Buncombe	268	47. Hoke		83, Scotland	
12. Burke	8	48. Hyde	1 . 1	84. Stanly	
13. Cabarrus	1	49. Iredell	1	85. Stokes	
14. Caldwell	. 3	50. Jackson	11	86. Surry	<u> </u>
15. Camden	707-0-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-	51. Johnston		87. Swain	. 4
16. Carteret		52. Jones	1.	88. Transylvania	40
17. Caswell		53. Lee		89. Tyrrell	7.0
18. Catawba	1	54. Lenoir		90. Union	
19. Chatham		55. Lincoln		91. Vance	· · · · · · · · · · · · · · · · · · ·
20. Cherokee	4	56. Macon	18	92. Wake	. 2
21. Chowan	-	57. Madison	5	93. Warren	<u> </u>
22. Clay	2	58. Martin	16	94. Washington	
23. Cleveland	. 3	59. McDowell	1	95. Watauga	1
24. Columbus		60. Mecklenburg	. 5	96. Wayne	
25. Craven		61. Mitchell		97. Wilkes	
26. Cumberland	1	62. Montgomery		98, Wilson	
27. Currituck	***************************************	63. Moore		99. Yadkin	
28. Dare		64. Nash		100, Yancey	1 11
29. Davidson		65. New Hanover .	1		
30. Davie	,	66. Northampton		101. Georgia	***************************************
31. Duplin		67. Onslow	1	102, South Carolina	
32, Durham	APPROX. A. C. C. C. C. C. C. C. C. C. C. C. C. C.	68. Orange	1	103. Tennessee	
33. Edgecombe		69. Pamlico		104. Virginia	
34. Forsyth	,	70. Pasquotank	T .	105. Other States	T
35. Franklin	The state of the s	71. Pender	T	106. Other	. 74
36. Gaston	1	72. Perquimans		Total No. of Patients	1302

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Patient Origin - Ambulatory Surgical Cases

Facility County: Henderson

In an effort to document patterns of "Ambulatory" utilization of Surgical Services in North Carolina hospitals, please provide the county of residence for each ambulatory surgery patient served in your facility. Count each ambulatory patient "once" regardless of the number of procedures performed while the patient was in the operating room. However, each admission as an ambulatory operating room patient should be reported separately.

The "Total" from this chart should match the "Total" Ambulatory Cases reported on the Surgical Cases by Specialty Area Table on page 8.

County ·	No. of Patients	County	No. of Patients	County	No. of Patients
1. Alamance		37. Gates		73. Person	
2. Alexander		38. Graham	11	74. Pitt	
3. Alleghany	-	39. Granville		75. Polk	159
4. Anson	i	40, Greene		76. Randolph	
5. Ashe	·	41. Guilford	. 5	77. Richmond	
6. Avery	8	42. Halifax		78. Robeson	
7. Beaufort	-	43. Harnett		79. Rockingham .	
8. Bertie		44. Haywood	288	80. Rowan	
9. Bladen		45. Henderson	2592	81. Rutherford	78
10. Brunswick		46. Hertford		82, Sampson	
11. Buncombe	991	47. Hoke		83. Scotland	
12. Burke	35	48. Hyde		84. Stanly	
13. Cabarrus	4	49. Iredell		85. Stokes	
14. Caldwell	3	50. Jackson	66	86. Surry	
15. Camden		51. Johnston		87. Swain	49
16. Carteret		52. Jones		88. Transylvania	199
17. Caswell		53. Lee	•	89. Tyrrell	
18. Catawba	1	54. Lenoir		90. Union	1
19. Chatham		55. Lincoln		91. Vance	
20. Cherokee	. 25	56, Macon	69	92. Wake	
21. Chowan		57. Madison	. 90	93. Warren	
22. Clay	15.	58. Martin	81	94. Washington	
23. Cleveland	4	59. McDowell		95. Watauga	1
24. Columbus	2	60. Mecklenburg	. 3	96. Wayne	
25. Craven		61: Mitchell	· 52	97. Wilkes	
26. Cumberland		62. Montgomery		98. Wilson	
27. Currituck	·	63. Мооте		99. Yadkin	
28. Dare ·		64. Nash	1	100. Yancey	63
29. Davidson		65. New Hanover			·
30. Davie	1	66. Northampton		101. Georgia	
31, Duplin		67. Onslow		102. South Carolina	
32, Durham	/	68. Orange	.1	103. Tennessee	
33. Edgecombe		69. Pamlico		104. Virginia	
34. Forsyth	1	70. Pasquotank	·	105. Other States	
35. Franklin		71. Pender		106. Other	88
36. Gaston		72. Perquimans		Total No. of Patients	

License No: H0019 Facility ID: 943388

Patient Origin - Gastrointestinal Endoscopy (GI) Cases

Facility County: Henderson

In an effort to document patterns of utilization of Gastrointestinal Endoscopy Services in North Carolina hospitals, please provide the county of residence for each GI Endoscopy patient served in your facility. Count each patient once regardless of the number of procedures performed while the patient was receiving GI Endoscopy Services. However, each admission for GI Endoscopy services should be reported separately.

The "Total" from this chart should equal Item 9. [a] "Total Number GI Endo Cases" from the GI Endo Room Table on page 10, plus the total Inpatient and Ambulatory GI Endoscopies (not reported in 9.) from the Specialty Area Table at the bottom of page 10.

County	No. of Patients		No. of Patients	County	No. of Patients
1. Alamance		37. Gates		73. Person	
2. Alexander	•	38. Graham		74. Pitt	
3. Alleghany		39. Granville		75. Polk	
4. Anson		40. Greene		76. Randolph	
5. Ashe	·	41. Guilford	1	77. Richmond	
6. Avery	•	42. Halifax		78. Robeson	18
7. Beaufort		43. Harnett		79. Rockingham	
8. Bertie		44. Haywood	10	80. Rowan	
9. Bladen		45. Henderson	517	81. Rutherford	7
10. Brunswick		46. Hertford		82. Sampson	
11. Buncombe	133	47. Hoke		83. Scotland	
12. Burke	1	48. Hyde		84. Stanly	
13. Cabarrus		49. Iredell		85. Stokes	
14. Caldwell		50. Jackson	3	86. Surry	
15. Camden		51. Johnston		87. Swain	
16. Carteret		52. Jones		88. Transylvania	38
17. Caswell		53. Lee		89. Tyrrell	
18. Catawba	,	54, Lenoir		90. Union	
19. Chatham		55. Lincoln	1 - 1 - 1 - 1	91. Vance	
20. Cherokee		56. Macon	1	92, Wake	
21. Chowan	,	57. Madison	2	93. Warren	•
22. Clay		58. Martin	. 2	94. Washington	
23. Cleveland		59. McDowell	<u> </u>	95. Watauga	
24. Columbus		60. Mecklenburg	1	96. Wayne	
25. Craven		61. Mitchell	1	97. Wilkes	
26. Cumberland		62. Montgomery		98. Wilson	, , , , , , , , , , , , , , , , , , , ,
27. Currituck .		63. Moore		99. Yadkin	
28. Dare		64. Nash		100. Yancey	
29. Davidson		65. New Hanover			
30. Davie	· · · · · · · · · · · · · · · · · · ·	66. Northampton		101. Georgia	
31. Duplin		67. Onslow	<u> </u>	102. South Carolina	
32. Durham		68. Orange		103. Tennessee	
33. Edgecombe		69. Pamlico		104. Virginia	· · · · · · · · · · · · · · · · · · ·
34. Forsyth		70. Pasquotank		105. Other States	
35. Franklin		71. Pender		106. Other	26
36. Gaston	1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1	72. Perquimans		Total No. of Patients	762

Patient Origin - Psychiatric and Substance Abuse Alamance through Johnston

Facility County: Henderson

Complete the following table below for inpatient Days of Care reported under Section, 5200

County of Patient Origin	Psychiatric Treatment Days of Care			Substance Abuse Treatment Days of Care			Detoxification Days of Care		
	Age 0-17	Age 18+	Totals	Age 0-17	Age 18+	Totals	Age 0-17 .	Age 18+	Totals
Alamance	•					1		11,50 101	1 dtais
Alexander					**************************************	 			
Alleghany		1	1		**********			***************************************	
Anson	,			· · · · · · · · · · · · · · · · · · ·	**************************************	·			
Ashe		6	6	·	· · · · · · · · · · · · · · · · · · ·	1			
Avery ·		6	6	10 m					
Beaufort		1	·						ļ
Bertie	1								
Bladen									
Brunswick	1		· .	·		 	···		
Buncombe		324	324			 			
Burke	1	9	324			 			
Cabarrus	1	1 1	7			t			
Caldwell	 	1				ļ			
Camden ·	1	 	-	,		<u></u>	<u> </u>		
Carteret	1	 				 			ļ
Caswell	1	 		<u>.</u>	· · · · · · · · · · · · · · · · · · ·	 			<u> </u>
Catawba	1	4	4			 		•	<u> </u>
Chatham	 	 	4					*	<u> </u>
Cherokee.	1	18	18						<u> </u>
Chowan	<u> </u>	· LO				 	<u> </u>		<u> </u>
Chay		6				 			
Cleveland	ļ	15	15						
Columbus		<u></u>	1.5		· · · · · · · · · · · · · · · · · · ·				
Craven		 	l						·
Cumberland	}	 	<u>-</u>	·		-			
Currituck	 	 	ļ	ļ					
Dare		ļ							<u> </u>
Davidson	ļ	<u> </u>		ļ					
Davieson Davie	 	. 1	1						
Duplin	<u> </u>	ļ		·		<u> </u>			
	1	11	1						•
Durham .	ļ	 			·				
Edgecombe		ļ	<u> </u>						
Forsyth.	 	2	. 2			ļ	•		
Franklin	<u> </u>	1-40-							
Gaston		10	10						
Gates	ļ								
Graham	<u> </u>	. 6	6	*					1
Granville	<u> </u>	<u> </u>							T
Greene ·	 		<u> </u>						1
Guilford		1	1				,	****	T
Halifax		11_	1	•					1
Harnett									1
Haywood		. 70	70						1
Henderson		309	309						·
Hertford						ÿ			
Hoke									
Hyde						T T	***************************************		1
Iredell	. ·	2	2		*************	1	7-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1		 -
Jackson		31	31	-		1			
Johnston .	1				*****	 		***************************************	

** Note: See counties: Jones through Yancey (including Out-of-State) on next page.

Patient Origin - Psychiatric and Substance Abuse Jones through Yancey (including Out-of-State)

Facility County: Henderson

(Continued from previous page)

County of Psychiatric Treatment Detoxification Days of Care Substance Abuse Treatment Patient Origin Days of Care Days of Care Totals Age 0-17 Age 18+ Age 18+ Age 0-17 Totals Age 18+ Totals Jones · Lee Lenoir Lincoln Macon. Madison 25 19 Martin 19 McDowell Mecklenburg 10 Mitchell Montgomery Moore Nash New Hanover Northampton Onslow Orange Pamlico Pasquotank Pender Perquimans Person Pitt Polk 14 Randolph Richmond Robeson Rockingham Rowan Rutherford ·28 28 Sampson Scotland Stokes Surry Swain. 14 Transylvania Tynrell Union

12

22

1.2

64

1154

TOTALS

Vance Wake Warren Washington Watauga

Wayne Wilkes Wilson Yadkin Yancey

Out of State

^{**} Note: See counties: Alamance through Johnston on previous page.

License No: H0019 Facility ID: 943388

Patient Origin - MRI Services

Facility County: Henderson

In an effort to document patterns of utilization of MRI Services in North Carolina, hospitals are asked to provide county of residence for each patient served in your facility. Patients served include patients receiving MRI procedures reported in Table 10a of this application (page 11). The total number of patients reported here should be equal to or less than the total number of MRI procedures reported in Table 10a.

County	No. of Patients	County	No. of Patients	County	No. of Patients	
1. Alamance	•	37. Gates	. 7	73. Person		
2. Alexander		38. Graham	. 4	74. Pitt		
3. Alleghany		39. Granville		75. Pólk	76	
4. Anson		40. Greene		76. Randolph		
5. Ashe	3	41. Guilford		77. Richmond	1	
6. Avery	•	42. Halifax		78. Robeson	· · · · · · · · · · · · · · · · · · ·	
7. Beaufort		43. Harnett		79. Rockingham	, 3	
8. Bertie		44. Haywood .	71.	80. Rowan	3	
9. Bladen		45. Henderson	1845	81. Rutherford	36	
10. Brunswick	6	46. Hertford		82. Sampson	,	
11. Buncombe	772	47. Hoke		83. Scotland		
12. Burke	8	48. Hyde		84. Stanly	110000000000000000000000000000000000000	
13. Cabarrus	8	49. Iredell		85. Stokes		
14. Caldwell	7	50. Jackson	19	86. Surry	***************************************	
15, Camden	i i	51. Johnston	2	87. Swain	. 4	
16. Carteret		52. Jones		88. Transylvania	146	
17. Caswell		53. Lee		89. Tyrrell	• • • •	
18. Catawba	12	54. Lenoir		90. Union		
19, Chatham		55. Lincoln	2	91. Vance		
20. Cherokee	1	56, Macon	36.	92. Wake	5	
21. Chowan		57. Madison	4	93. Warren		
22, Clay	1	58. Martin	41	94. Washington	`	
23. Cleveland	4	59. McDowell	7	95, Watauga	2	
24. Columbus		60. Mecklenburg	15	96. Wayne	2	
25. Craven		61. Mitchell	.2	97. Wilkes		
26. Cumberland		62. Montgomery		98. Wilson		
27. Currituck		63. Moore		99. Yadkin		
28. Dare . :	,	64, Nash		100; Yancey	. 13	
29. Davidson		65. New Hanover	1		1 7	
30. Davie		66. Northampton		101. Georgia		
31, Duplin		67. Onslow	2	102. South Carolina		
32, Durham		68. Orange	1 . 1	103. Tennessee	· ************************************	
33. Edgecombe		69. Pamlico		104. Virginia		
34. Forsyth	Δ	70. Pasquotank		105. Other States		
35. Franklin	1	71. Pender		106. Other	233	
36, Gaston	. 3	72. Perquimans		Total No. of Patients	3410	

Are mobile MRI s	services cur	rently provided	at your hospital?	ves	no
	,		TO JOHE HODISTONE	J 50	TAQ.

All responses should pertain to October 1, 2007 through September 30, 2008.

License No: H0019 Facility ID: 943388

Patient Origin - Radiation Oncology Treatment

Facility County: Henderson

In an effort to document patterns of utilization of Radiation Oncology Treatment in North Carolina, hospitals are asked to provide county of residence for each patient served in your facility. Report the number of unduplicated patients who receive a course of radiation oncology treatments. Patients reported should be receiving radiation oncology [linac] and stereotactic radiosurgery (SRS) procedures using equipment (Linac, CyberKnife, Gamma Knife) listed in Section 11 of this application. Patients should be counted more than once if they receive additional courses of treatment. (Example: one patient who receives three courses of radiation oncology treatment counts as three.) The number of patients reported should match the number of patients receiving radiation oncology procedures reported in Section 11 of this application.

County	No. of Patients	County	No. of Patients	County	No. of Patients
I. Alamance		37. Gates	-	73. Person	
2. Alexander .		38. Graham		74. Pitt	
3. Alleghany		39. Granville		75. Polk	
4. Anson		40. Greene		76. Randolph	
5. Ashe,		41. Guilford		77. Richmond	
6. Avery		42, Halifax		78: Robeson	
7. Beaufort		43. Harnett		79. Rockingham	
8. Bertie		44. Haywood		80. Rowan	
9. Bladen		45. Henderson		81. Rutherford	
10. Brunswick		46. Hertford		82. Sampson	
11. Buncombe		47. Hoke		83. Scotland	
12. Burke		48. Hyde	• •	84, Stanly	
13. Cabarrus	***************************************	49. Iredell		85. Stokes	
14. Caldwell		50. Jackson		86. Surry	
15. Camden		51. Johnston		87. Swain	The state of the s
16. Carteret		52. Jones		88. Transylvania	•
17. Caswell		53. Lee		89. Tyrrell	,
18. Catawba		54, Lenoir	*	90. Union	***************************************
19. Chatham		55, Lincoln		91. Vance	· · · · · · · · · · · · · · · · · · ·
20. Cherokee		56. Macon	٠.,	92. Wake	* '
21. Chowan		57. Madison		93. Warren	
22, Clay	•	58. Martin		94. Washington	
23. Cleveland		59. McDowell		95. Watauga	
24. Columbus	_	60. Mecklenburg		96. Wayne	
25. Craven		61. Mitchell		97. Wilkes	
26. Cumberland		62. Montgomery		98, Wilson	•
27. Currituck		63. Moore		99. Yadkin	**************************************
28. Dare	,	64. Nash	**************************************	100, Yancey	
29. Davidson		65. New Hanoyer		- Francisco - Fran	
30. Davie		66. Northampton		101, Georgia .	· · · · · · · · · · · · · · · · · · ·
31. Duplin		67. Onslow	•	102. South Carolina	
32. Durham		68. Orange		103. Tennessee	
33. Edgecombe		69. Pamlico		104. Virginia	
34. Forsyth		70. Pasquotank	***************************************	105. Other States	
35. Franklin		71. Pender		106. Other	
36. Gaston		72. Perquimans		Total No. of Patients	

Revised 08/2008 Page 26

All responses should pertain to October 1, 2007 through September 30, 2008.

License No: H0019 Facility ID: 943388

Patient Origin - PET Scanner

Facility County: Henderson

In an effort to document patterns of utilization of PET Scanner in North Carolina, hospitals are asked to provide county of residence for each patient served in your facility. This data should only reflect the number of patients, not number of scans and should not include other radiopharmaceutical or supply charge codes. Please count each patient only once. The number of patients in this table should match the number of PET procedures reported in Table 10d on page 14.

	No. of Patients		No. of Patients	County	No. of Patients
1. Alamance		37, Gates		73. Person	
2. Alexander		38. Graham	3	74. Pitt .	
3. Alleghany		39. Granville		75. Polk	16
4. Anson		40. Greene		76. Randolph	
5. Ashe		41. Guilford		77. Richmond	
6. Avery		42, Halifax		78. Robeson	
7. Beaufort		43. Harnett	Ţ	79. Rockingham	
8. Bertie		44. Haywood	4	80. Rowan	
9. Bladen		45. Henderson	119	81. Rutherford	. 9
10. Brunswick	'	46. Hertford		82. Sampson	
11. Buncombe	`42	47. Hoke		83. Scotland	
12. Burke	•	48. Hyde		84. Stanly	
13. Cabarrus		49. Iredell		85. Stokes	
14. Caldwell		50. Jackson		86. Surry	
15. Camden		51. Johnston		87. Swain	
16. Carteret		52. Jones		88. Transylvania	6
17. Caswell		53. Lee 89. Tyrrell			
18. Catawba		54. Lenoir	*	90. Union	
19. Chatham		55. Lincoln		91. Vance	· · · · · · · · · · · · · · · · · · ·
20. Cherokee .		56. Macon		92. Wake	
21. Chowan		57. Madison	,	93. Warren	
22. Clay		58. Martin		94. Washington	
23. Cleveland		59. McDowell		95. Watauga	
24. Columbus		60. Mecklenburg		96. Wayne	
25. Craven		61. Mitchell		97. Wilkes	
26. Cumberland		62. Montgomery	*	98. Wilson	
27. Currituck		63. Moore		99, Yadkin	
28. Dare		64. Nash		100, Yancey	**************************************
29. Davidson		65. New Hanover			
30. Davie	1	66. Northampton		101. Georgia	
31. Duplin		67. Onslow	The second of the second secon	102. South Carolina	,
32. Durham	, , , , , , , , , , , , , , , , , , ,	68. Orange		103. Tennessee	
33. Edgecombe		69. Pamlico		104. Virginia	
34. Forsyth		70. Pasquotank		105. Other States	
35. Franklin	***	71. Pender		106. Other	2
36. Gaston		72. Perquimans		Total No. of Patients.	201

Revised 08/2008

2009 Renewal Application for Hospital: Park Ridge Hospital

All responses should pertain to October 1, 2007 through September 30, 2008.

License No: H0019 Facility ID: 943388

This application must be completed and submitted with <u>ONE COPY</u> to the Acute and Home Care Licensure and Certification Section, Division of Health Service Regulation prior to the issuance of a 2009 hospital license.

<u>AUTHENTICATING SIGNATURE:</u> The undersigned submits application for the year 2009 in accordance with Article 5, Chapter 131E of the General Statutes of North Carolina, and subject to the rules and codes adopted thereunder by the North Carolina Medical Care Commission (10A NCAC 13B), and certifies the accuracy of this information.

Signature:

___Date

11-26-08

PRINT NAME

OF APPROVING OFFICIAL Jimm Bunch

<u>Please be advised</u>, the license fee <u>must</u> accompany the completed application and be submitted to the Acute and Home Care Licensure and Certification Section, Division of Health Service Regulation, <u>prior</u> to the issuance of a hospital license.



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-20105 HOSPITAL TICENSE RENEWAL APREICATION

Legal Identify of Applicants Eletcher Hespital Incorporation:

(Full legal name of corporation: partnership spolaridual to rother legal entity owning the enterprise

Doing Business As.
(d/b/a) name(s) ainder which the facility of services are advertised or presented to the public.

	Barlo Kidge Hospital				
Other					
Other					
Facility Mailing	dadices 120 Box 15				
	Plefelier N	C 4 28792			
Esantin Cifa, Ar	ldress - NaplesiRd-				
	Eletcher: N	C 28732			
County	Henderson				
lecephone	(MZO) m84-8	CONTRACTOR CONTRACTOR			
Faxo	0828)687-0				
Administrator	Director: Tivalence	WEET -			
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Type of Health Care Facilities under t			
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- Vice President of Nursing and Patient Care Services:

 Ronald Metealf, RN, Mattds Foter in VP of Nors

Lacility Data

- Reporting Periods All responses should perfant to the period October 1: 2008 to September 30. 20092
 - Ceneral Information. (Please: III: in an Aplanks and make: Clange

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\$ 7°	张·拉里,但对她说:"我是我们是不是我的话,我们就是她的话,我们就是我们的话,我们就是我们的话,我们就是我们的话,我们就是我们的话,我们就是这样的一个一个一个一
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٠. '	page 4; exclude responses to 29 on page 4; and exclude normal new round bassinets.
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- 3 a. Are you a long tempere liospital ATCH
- 43-11 this facility is accredited by the louitic ornmission of AWA specify the accr
 - and indicate the date of the Tast survey 06 / 09

All responses should pertain to October 142008 through Soprember 30, 2009

D. Beds by Service (Inputions - Do Not Include Observation Bedson Days of Care)

Please provide a Beasty-service of 4) for each hospital campus (see G.S.: 1/1E-176(2c))]

Please indicate below the miniber of fields us not least great (set up and staffed for use) to each of the following services and in another of sensus impatient days of eare tendered unsect unit. NOTE: If your facility has a descipated unit (so the mical dependency freatment and/or detoxification, please, complete the patient origin sheet portaining to Psychiatricated Substance Abuse Services. If your facility has a Busing Facility unit and/or Abuse Services are Red unit please complete the patient origin.

Licensed Acute Care	Vicensed Staffed Annual
(provide details below)	Beds as of Census September 30 September 30 Input Days:
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Pg: Respiratory Pulmonary	
TR (Other (Erst))	
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q. Other CLIST	
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Exclude Skilled Nursing swing bed days: (See swing bed information next page

Per Cio Numic definition (Refer to Section 1400 enniled Neonatal Services (1045) (CAC 140)

Park Ridge Hospital All responses should pertain to October 1, 2008 through September 19 2009. D: Beds by Service: (Enpatient) continued:

	Number of Swing Beds	2.2.2	
	Namber of Skilled Nuising deve in Swing Beds	其為類	
1	Number of indicensed observation beds 2.2.	ERANGE.	

Timeans amospital designated usur swing-Bedthospital by CMS (General Services)

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			Outpatient		
	Inputene Days	Emergency	(excluding?	Impatient Spreicel	Ambulatory Surgical
	of Care	Visits	Emergency Visits:	Cases	Cases
Primary Payer Source	(from p.4, item D. 1.)	(from p. 6);	and:Surgical Gases).	(from p.8, Table 8. b)	(from p. 8, Table 8::5)
Self Pay/Indigent/Charity	1,182	5,450	3,08年5点	354.43	2.1.1.1.1.5
Medicare & Medicare		1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	To Street Control	A CONTROL OF THE STATE OF THE S	
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Commercial Insurance.	T-10-1-18 2 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	232	22800		
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	d Deliver Rooms Deliver Only web cestican Section (Fig. 1997)	题
	e. Delivery Rooms. Laborand Delivery Recovery	
	f Delivery Rooms - LERB (include them in on Page 4)	
	g. Normalinewborn bassinets (Level I Neematal Services);	
. [Do not include with totals under the section entitled Beds by Service (topalient)	2320

4 : 7.43 5" J. L. J. J.	574 . V (174 \$ 50 - 2) - () - 14 54 54 5 1 1 1	there is a said the first the said the	Miles and the Company of the Company	アンドランとのできた。 まったが	the free of the same to the first the first of the same	- A Charles of the Charles of the Charles	了。
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4	Medical Air I	ransports Owne	dorleased.	air ambulance s	ervice:		
	a. Does the fac	ility operate an a	it antbulanc	e service?	Yes x No		

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Pathology and Medical Lab AChede whether or not service is provided

b. If Yes" complete the following chart.

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a Bone Manow Allogeheie	UNESDECTIVE ENDING ENDER PROPERTY OF THE PROPE	Kaling State	TERROLLE .
by Bone Marrow Autologous	学。SAE 可是LEWERTS 工作工具。	l Pancreas	10年60条件
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e_Heart/Lung	FINE RESIDENCE OF THE RESIDENCE OF THE PERSON OF THE PERSO	os omesay area	

Do you perform living donor transplants?

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(a) Cardine Catheterization	Dizgnostic Cardiae Interventional	Electro physiology
	Catheterization Cardiac RED 93	3#26_3727;34;34;31/70;37;71; 3772_3743;3774;3775;3776;7
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	36 17 36 09 35 57 35 70 35 96	3/19/A: 37/95 37/96 37/97 37/98 37/00: 00:50:00:50:00:50:00:50:50:50:50:50:50:5
		00.54
1. Number of Units of Fixed		
Equipment .		
2. Number of Procedures		
Performed in Fixed Units		
on Patients Age 14 and		
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A Number of Procedures to		
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-	(b) Open Heart Surgery	Number of
		Machines/Rrocedures
	1. Number of Heart Ling Bypass Machines	
-	2/ Total Affaual Number of Open Heart Surgery Procedures	
Š	Set Utilizing Heart-Lung Bapass Medicae	
£	3 - Total Ammar Mumber of Operall empoure procedures	done : The second
	wallion built zing at Eleant Cung Bypass Machine	
1,277	A Total Open Heart Surgery Prosedures 12.48	
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Ť	Of total in #2 Number of Brocenius con Patients Age 14	
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	ic cortotalini#5. Number of Procedures on Rauents Assura	
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Revised 08/2009

All responses should pertain to October 1, 2008 through September 50

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Campus *- It multipl*e sites: /___

A) Surgical Operating Rooms

Report Surgical Operating Rooms

Report Surgical Operating Rooms shifts in settlic specifications and standards for operating rooms required by the Construction Section of Historical Services Regulation; and which are full victuringed to perform surgical procedures. These surgical operating rooms include rooms detained by a factorical state of the services of the ser

٠,	<u> </u>		4 (1)	<u> </u>	<u>```</u>	. 4	1,15		10	10	-1.	(* · ·	. 1	44.	1,11	بترلند	<i>.</i>	v_{-i}		ΥĒ	12.3	- 15			×.	- 4	3.0	77/4	100				, C.	Š
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Number of additional Colling proyects surgical operating come pending development CPCONFEROIGE TORNIBULES (1)

in) Procedure Rooms (Freeholive experaints Rooms and Castromics masterioscopy Rooms

GE Gastrointestinal EndoscopseRooms: Cases: and Rinced Dress.
Report the number of Castrointestinal Endoscops rooms, and the Endoscops cases; and procedures performed in these rooms during the reporting period.

٠,	14.75 (2.5)	44.6	Profes of	4 3 4 7 5 6 4	1,72.7	C 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	44.7 m	S 4 6 6 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	3.00		Principle of the Control of the	and the second section	
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All responses should pertain to Corolier 1/2008 this cord Scripton Fer 30, 2009 c

Surgical Operating Rooms, Procedure Rooms, Castromfestinal Endoscopy Rooms, Surgical Cases and Procedures continued

		* . W. W		
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٠1	CHAILU	10 11/1	A PACAGON	たん・ はんりんつりょく

d). Surgical Cases by Specialty area Tables

Singles executives because the support of surgical sections of the number of surgical sections of surgical sections of the number of surgical sections of the number of surgical sections of the number of surgical sections of the number of surgical sections of the number of surgical sections of the number of surgical sections of the number of surgical sections of the number of surgical sections of the number of surgical sections of the number of surgical sections of the number of surgical sections of the number of surgical sections of the number of surgical sections of the number of surgical sections of su

Singical Specialty Area	Inpatient Cases: Ambulatory Cases
Cardiothoracio (excluding open flear, spigory)	
Open Heart Street without web; 421	
General Surgery 2007	A COLUMN TO THE PARTY OF THE PA
No more than the second of the	
Obstetries and GAN fexcluding C. Sections 10.	102 (4) (2)
iophibalinclogy was treating from the control of th	11 2 2 1 10 1 1 2 1 1 1 1 1 1 1 1 1 1 1
Oral Surgery	
Orthopedics	4546 4546 4 5 34 650
Otolaryngology	57.0
Plastic Surgery	
Urology	120.721.279127-104-56-5-10-3902-5-5
Vascular	作品。1996年第二人的第二人的第二人的第二人的第三人称单数
Other Surgeries (specify)	
Other Surgeries (speedly)	0.2
Number of C. Sections: Performed in Dedicated C. Section ORS of	
Policible of C. Scotion & Performed in Cinic ORS.	经验验的原则
Total Support Cases	

Non-Suegical Cases by Category Lable

Non-Surgical Cases by Caregory Lable

Enter the immiser of non-surgical cases by enterenging a subject of court cachipatients intergoing a subject of proceedings as one case regardless of the number of non-surgical cases is an extraction of the court case into one man surgical cases of the folding the folding cases is an extraction of the court of non-surgical cases. Count all non-surgical cases, including cases receiving services in operating rooms of many offici-location; except do not count cases having endoscopies in GI. Endoscopy rooms: Report cases having endoscopies in GEEndoscopy Rooms on page 8.

Non-Surgical Chiegory	Impatient Cases Ambulatory Cases
Pain Management	是是自己的。 第二十二十四十二十二十二十二十二十二十二十二十二十二十二十二十二十二十二十二十二
Cystoscopy Care 12: 12: 12: 12: 12: 12: 12: 12: 12: 12:	
Non-Gr Endoscopies ind reported in Section 2015	
GI/Endoscopies indure ported in Stol.	
YA-G-Laset	
Other (specify): Brondhiescopy.	
Other (specify) Borres Markown Brogery.	
Other (specify)	
Total Non-Surgical Cases	1952-15127-15400 14 LAM LAM LAME (17.89)

All responses should pertain to October 1, 2008 through September 30, 2009.

License No: H0019 Facility ID: 943368

9. Average Operating Room Availability and Average Case Times:

The Operating Room Methodology assumes that the average operating room is staffed 9 hours a day, for 260 days per year, and utilized at least 80% of the available time. This results in 1872 hours per OR per year.

The Operating Room Methodology also assumes 3 hours for each Inpatient Surgery and 1.5 hours for each Outpatient Surgery.

Based on your hospital's experience, please complete the table below by showing the assumptions for the average operating room in your hospital.

		. Average Number of	Average	Average
Average:Ho	urs per Day	Days per Year	"Case Time" ##	Case Time!
Routinely	Scheduled	Routinely Scheduled.	lo: '	in Minutes for
for t	∫se.*	for:Use	Inpatient Cases	Ambulatory Cases
	a ***	260	116	6.4.
.,, .,,	(* <u>180</u>			

^{*} Use only Hours per Day routinely scheduled when determining. Example: 2 rooms @ 8 hours per day plus 2 rooms @ 10 hours per day equals 36 hours per day; divided by 4 rooms equals an average of 9 hours / per room / per day.

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^{** &}quot;Case Time" = Time from Room Set-up Start to Room Clean-up Finish: Definition 2.4 from the "Procedural Times Glossary" of the AACD, as approved by ASA, ACS, and AORN. NOTE: This definition includes all of the time for which a given procedure requires an OR/PR. It allows for the different duration of Room Set-up and Room Clean-up Times that occur because of the varying supply and equipment needs for a particular procedure

All responses should pertain to October 1, 2008 through September 36, 2009;

10a. Magnetic Resonance Imaging

Indicate the number of machines/instruments (units) and the number of the following types of procedures performed during the 12-month reporting period at your facility. For Hospitals that operate medical equipment at multiple sites; please copy this and provide separate pages for each site.

	:.#-Units		· · · · · · · · · · · · · · · · · · ·				*	,
Fixed MRI	in the							
Scanners-closed	. 1	Inpa	ient:Procedu	res	Outp	ures.		
The second second	**	With.	Without		With	Without		· AFOLINA.
Fixed MRF		- Contrast			· Contrast	. Contrast or.	TOTAL	TOTAL
Scanners-open		or Sedation	·· Sedation	Inpatient	or Sedation	Sedation	Outpatient:	Procedures
·Total Fixed MRI		:	•					
· Scanners	. 1	. 265	203	468	868	1,192	2,060	2,528
Mobile MRI								
Provider 1 Data	1				0	13.	479	479.
Mobile MRI								1
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MRI pursuant to						3 1 1 1 1 1 1		
Policy AC-3		· · · · · · · · · · · · · · · · · · ·						
Other Human		· :		<u> </u>	· · · · ·	·	1. 1.	P
Research MRI				1.		[,		K' >
Scanner				, , , , , ,				

^{*} An MRI procedure is defined as a single discrete MRI study of one patient (single CPT coded procedure). An MRI study means one or more scans relative to a single diagnosis or symptom. The total number of procedures should be equal to or more than the total number of patients reported on the MRI Patient Origin Table on page 25 of this application.

Name of Mobile MRI Provider 1:	• • • • • • • • • • • • • • • • • • • •	·		•
	 •			
Name of Mobile MRI Provider 2:		•	•	; -
1 (41110.01 1/100110 1/1114 1 10 / 1401 14	 	•	· · · · · · · · · · · · · · · · · · ·	

10b. MRI Procedures by CPT Codes (duplicate CPT codes were removed)

CPT Code	CPT Description	Number of Procedures
.70336-	MRI Temporomandibular Joint(s)	(1) 20 (c) (4) 40 (c) (2) (c)
70540	MRI Orbit/Face/Neck.w/o	3
-70542 ·	MRI Orbit/Face/Neck with contrast	
· 70543·	MRI Orbit/Face/Neck w/o & with	7
·70544	MRA Head w/o	99
70545	MRA Head with contrast	,
70546	MRA Head w/o & with	
70547	MRA Neck w/o	
70548	MRA Neck with contrast	***
70549	MRA Neck w/o & with	23
70551	MRI Brain w/o	196
70552:	MRI Brain with contrast	建定位置 经改进证券
70553.	MRI Brain w/o & with	\$2.57.5459
:7055A: C	FAC Screening	March Sand Sand to the said to the
1	Subtotal for this page	791

Revised:08/2009

Page 11

All responses should perfain to October 1, 2008 through September 30, 2009.

10b-1918 Recedifies by CPT Codes continued

CPT Code	CPT Description	Number of Procedures
71550	MRI Chesswo	
H 1551	MRI Chest with contrast 2.5	
271552	MRT Chest woodewith	
71555	MRAChest with OR without contrasts 1999	
72126	Cervical Spine Infrasion only	
第2141	MRI Cervical Spines Vo.	207327854
72140	MRE Cervical Spine with contrast	
321567	MREGervicahe pine wo teawith	到了Experience
72146	MRITING AND STITE WILL	1.798
的aians以近	MECANIOMATICAS PROCESSION AND ASSESSION AND ASSESSION AND ASSESSION ASSESSIO	
加油蛋粉等	WRITTO racie Spine who we the	经编售等。20世界中国
72148	WRI Lumbar Spine was	1. THE VASSING TO SELECT
32344 SEE	EMECETIMENT OF THE PROPERTY OF	
72138	WRO Cumbat Spane web sowiths	
72150	WRASpinal Canalay/o OR with contrast	
72195	MRI Pelvis wlo	(5/125 1 38 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
72196-	MRIPelvie with some as	建筑是是不可以的
72197	MRI Pelvis wie cowih	是"是"之,这种"自己是是"。
721987	MRA Pelvis wo OR with Contrast.	。 1000年,1000年,1000年,1000年,1000年,1000年,1000年,1000年,1000年,1000年,1000年,1000年,1000年,1000年,1000年,1000年,1000年,1000年
73218	MRI UppenExt officestian goint w/o	
73212	MRI Upper Extender than joint with contract a second	
19920	MRE Upper Exceptification from Secretar 1995	
1784210	MRSHupper Excellent lumbwer 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	250
202220	MEDictipes Extransport with counsis	
30223	MPP Upper Extrany jointly/orce with	
78225	MRACIpperExt WOOR with contacts	
17877885	MRI Lowce Bat other than joint wice	
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10b MREProcedures by EPR Codes continued.

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75555	MRE Cardiac Function Finited	
£73556÷	MRE Gardine Velocity Flow Mapping	
7609353	MRIBreast unlateral worand or with contract	
76094	MRTBrease bilateral w/o and/or with contrasts	
76125	Cineradiography decomplement exam	
76390	MEC Specinoscopy	第27、三为秦帝,从今年 了
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7640022	TVIRE Bone Marrow, blood supply 19	
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NA COL	Clinical Presearch Seans	
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10c, Computed Fomography (CT)

Howmany fixed CT scanners does the hospital have

Does the hospital contract for mobile CT scamers en If yes, identify the mobile CF yendor.

Complete the following tables (one for fixed CTs canners one for mobile CII scanner

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^{*} PET procedure means a suggediscrete study of one parent involving one or more PET scars. PET scars means are image, scanning sequence derived from a single administration of a PET reducible armae current equality with a single import of the tracer. One or more PET scars combines a PET procedure. The number of PET procedures in this table should match the number of payents reported and the PET Ration (Origin Tableson page 27).

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11, Radiation Oncology Treatment Data

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FIL Radiation Offcology Treatment Data construc

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12. Telemedicine

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13 Additional Services

a) Cheek if Service(s) is provided: (for dialysissiations, show number of stations)

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b) Hospice Enparient Unit Data:

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Park Ridge Rospitals

All responses should pertain to October 1: 2008; through spirm by 303 7009;

14 Additional Services continued

c) Mental Health and Substance Abuse

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Hope-Benavioral Health Services

If address is different than the hespital please indicate.

32 Director of the above services?

Marzlym Jackson, RN | Director of Behavioral Health Services and a Dr. Phillip Lartey, Medical Director

Indicate the program/unit-location in the Service Categories chartoclow. It is is the lies such a include the program/unit-ber. If it is located at another site, include the building name, program/unit-name and address.

Service Categories: All applicants must complete the following table for all mental health convices which are to be provided by the facility. Tathe service is not offered leave the spaces plants.

Rule 104 NGAG 27G Lincensure Rules	Location of	Beds Assigned by Age	
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All responses should pertain to October 1, 2008; through September 30, 2009;

13: Additional Services: contained

c) Mental Health and Substance shuse continued

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Patient Origin - Ambulatory Surgical Cases

Facility County: <u>Penderson</u>

If an effort to document patterns of Ambulatory utilization of Suggical Services in North Carolina hospitals aplease provide the country of residence for each ambulatory sangery patterns erved in your facility. Countract ambulatory patterns one regardless of the alumber of procedures performed while the pattern was having surgery. However, each admission assumembulatory, surgery each solution reported separately.

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Patient Origin - Gastroin estinal Endoscopy (GI) Gases

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Patient Origin - Psychiatric and Substance Abuse Alamance through to huston

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Patient Origin—Psychiatric and Substance Abuse. Jones through Yancey. (including Out of State). Facility County: Henderson. (Continued from previous page)

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All responses should pertain to October 1, 2003 through Sentember 30, 2009

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Facility County: Henderson

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All responses should pertain to October 1 22008 through September 30, 2009

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All responses should pertain to October 1, 2008 through September 30, 2009.

This application must be completed and submitted with <u>ONE COPY</u> to the Acute and Home Care Licensure and Certification Section, Division of Health Service Regulation prior to the issuance of a 2010 hospital license.

AUTHENTICATING SIGNATURE: The undersigned submits application for the year 2010 in accordance with Article 5, Chapter 131E of the General Statutes of North Carolina and subject to the rules and codes adopted thereunder by the North Carolina Medical Care Commission (10% NCAC 13B), and certifies the accuracy of this information

Signature:		一位,这一个时间的	Date:		
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OF APPROVING	GOFFICIAL	Jimm Bunch	<u> </u>		•

Please be advised, the license fee must accompany the completed application and be submitted to the Acute and Home Care Licensure and Certification Sections Division of Health Service Regulation, prior to the issuance of a hospital license.

Revised 08/2009



North Carolina Department of Health and Human Services Division of Health Service Regulation Acute and Home Care Licensure and Certification Section 1205 Umstead Drive, 2712 Mail Service Center Raleigh, North Carolina 27699-2712 Telephone: (919) 855-4620 Fax: (919) 715-3073

For Official Use Only)		•
License # H0019		are # 340023	
Computer: 943388			
PC	Date		
License Fee:	•	\$2,252.50)

2011 HOSPITAL LICENSE RENEWAL APPLICATION

: Fletcher Hospital, Incorpor tion, partnership, individual, or	rated other legal entity owning the enterprise or service.)
n the facility or services are ad	vertised or presented to the public;
de Hospital Ridge Health	
PO Box 1569 Fletcher, NC 28732	ioo Hospital Drive Henderson ville, NC 28792
Naples-Rd Fletcher, NC 28732 Henderson (828)684-8501 (828)687-0729	100 Hospital Drive Hendersonville, NC 28792
JIMM BUNCH esponsible to the governing body (ov	vner) for the management of the licensed facility)
sponsible to the governing body (ow	Title: President and CEO mer) for the management of the licensed facility)
act for any questions regarding	this form:
n Ramsey n. ramsey @ at	Telephone: (828) 681, 2102
	tion, partnership, individual, or the facility or services are added Health POBOX 1569 Fletcher, NC 28732 Naples-Rd Fletcher, NC 28732 Henderson (828)684-8501 (828)687-0729 JIMM BUNCH esponsible to the governing body (over the content of the governing body) act for any questions regarding of Ramsey

[&]quot;The N.C. Department of Health and Human Services does not descriminate on the basis of race, color, national origin, religion, age, or disability in empinyment or the provision of services."

All responses should pertain to October 1, 2009 through September 30, 2010.

License No: <u>II0019</u> Facility ID: <u>943388</u>

List Name(s) of facilities:	Address:	Type of Business / Service
See attached list	, , , , , , , , , , , , , , , , , , , ,	A STANDARY OUT TACK
•		
lease attach a separate sheet for addi	itional listings	,
Ownership Disclosure (Please fill in a	ny blanks and make changes where	necessary.)
. What is the name of the legal entity	with ownership responsibility and	liability?
Owner: Fletcher H	Iospital, Incorporated	
Federal Employer ID# 50 Street/Box: P-O-Box-1	0-05:43246	170
City: Fletcher	569 100 (tospital Dri State: NC Zip: 28732 8501 Fax: (828)687-0729	- Hendersonville. NC 2
CEO: Jimm Bun	nch	
Is your facility part of a Health Syst	tem? [i.e., are there other hospitals,	offsite emergency departments,
ambulatory surgical facilities, nursicompany or a related entity?]	ng homes, home health agencies, etc. YesNo	c. owned by your hospital, a parent
company or a related entity?]	YesNo	-
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All responses should portain to October 1, 2009 through September 36, 2010.

License No: H0019
Facility ID: 943388

Page 3

<u>Ov</u>	vnership Disclosure continued					
3.	Vice President of Nursing and Patient Care Services: Craig Lindseu	•				
4.	Director of Planning: Jason Wells :					
	Facility Data					
A. 20	. Reporting Period All responses should pertain to the period October 1, 2009 to September 30, 010.					
в.	General Information (Please fill in any blanks and make changes where	necessary.)				
	a. Admissions to Licensed Acute Care Beds: include responses to "a - q" on page 4; exclude responses to "2-9" on page 4; and exclude normal newborn bassinets.	3,128				
•	b. Discharges from Licensed Acute Care Beds: include responses to "a - q" on page 4; exclude responses to "2-9" on page 4; and exclude normal newborn bassinets.	3,114.				
	c. Average Daily Census: include responses to "a - q" on page 4; exclude responses to "2-9" on page 4; and exclude normal newborn bassinets.					
	d. Was there a permanent change in the total number of licensed beds during the reporting period?	Yes	No /			
	If 'Yes', what is the current number of licensed beds?					
	lf 'Yes', please state reason(s) (such as additions, alterations, or conversions) which may have affected the change in bed complement:					
	e. Observations: Number of patients in observation status and not admitted as inpatients, excluding Emergency Department patients.	716				
C.	Designation and Accreditation					
	I. Are you a designated trauma center? Yes (Designated Level	#) <u>×</u>	No			
	2. Are you a critical access hospital (CAH)? Yes X No	-				
	3. Are you a long term care hospital (LTCH)? Yes X No					
	4. Is this facility TJC accredited? X Yes No Expiration I	Date: Sept	2012			
	5. Is this facility DNV accredited?YesXNo Expiration D	Date:				
	6. Is this facility AOA accredited? X Yes No Expiration D	Date: 2013	~			
	7. Are you a Medicare deemed provider? X Yes No					
Rev	vised 08/2010		Page 3			

License No: H0019 Facility ID: 943388

D. <u>Beds by Service (Inpatient - Do Not Include Observation Beds or Days of Care)</u> [Please provide a <u>Beds by Service (p. 4)</u> for <u>each</u> hospital campus (see G.S. 131E-176(2c))]

Please indicate below the number of beds usually assigned (set up and staffed for use) to each of the following services and the number of census inpatient days of care rendered in each unit. NOTE: If your facility has a designated unit(s) for chemical dependency treatment and/or detoxification, please complete the patient origin sheet pertaining to Psychiatric and Substance Abuse Services. If your facility has a Nursing Facility unit and/or Adult Care Bed unit please complete the supplemental packet for Skilled Nursing Facility beds.

Licensed Acute Care (provide details below) Campus	Licensed Beds as of September 30, 2010	Staffed Beds as of September 30, 2010	Annual Census Inpt. Days of Care
Intensive Care Units			
a. Burn *			*
b. Cardiac	14	14	2,858
c. Cardiovascular Surgery			·
d. Medical/Surgical			
e. Neonatal Beds Level IV ** (Not Normal Newborn)			**
f. Pediatric	•	-,	
g. Respiratory Pulmonary		, , , , , , , , , , , , , , , , , , , ,	
h. Other (List)		, , , , , , , , , , , , , , , , , , , ,	
Other Units	2 <u>-</u>	A 10 10 10 10 10 10 10 10 10 10 10 10 10	# (; ·
i. Gynccology			
j. Medical/Surgical ***	40	40	*** 6,940
k. Neonatal Level III ** (Not Normal Newborn)			**
Neonatal Level II ** (<u>Not</u> Normal Newborn)			**
m. Obstetric (including LDRP)	8	. 8	1,391
n. Oncology		, , , , , , , , , , , , , , , , , , ,	
o. Orthopedics			
p. Pediatric			
g. Other (List)			
1. Total General Acute Care Beds/Days (a through q)	62	62.	11,189
2. Comprehensive In-Patient Rehabilitation	0		
3. Inpatient Hospice	0		
4. Detoxification	0		
5. Substance Abuse / Chemical Dependency Treatment	0		
6. Psychiatry	41	36	10, 450
7. Nursing Facility	0		
8. Adult Care Home	0		
9. Other	0		
10. Totals (1 through 9)	·103	98	21,639

* Please report only Census Days of Care of DRG's 927, 928, 929, 933, 934 and 935.

** Per C.O.N. rule definition. Refer to Section .1400 entitled Neonatal Services. (10A NCAC 14C)

*** Exclude Skilled Nursing swing-bed days. (See swing-bed information next page)

License No: H0019 Facility ID: 943388

D. Beds by Service (Inpatient) continued

Number of Swing Beds *	0
Number of Skilled Nursing days in Swing Beds	0
Number of unlicensed observation beds	0 '

^{*} means a hospital designated as a swing-bed hospital by CMS (Centers for Medicare and Medicaid Services)

E. Reimbursement Source (For "Inpatient Days," show Acute Inpatient Days only, excluding normal newborns.)

	Inpatient Days of Care	Emergency Visits	Outpatient Visits (excluding Emergency Visits	Inpatient Surgical Cases	Ambulatory Surgical Cases
Primary Payer Source	(from p. 4, item D. 1.)	(from p. 6)	and Surgical Cases)	(from p.8, Table 8. b)	(from p. 8, Table 8. b)
Self Pay/Indigent/Charity	617	5,404	2,099	37	124
Medicare & Medicare Managed Care	6,772	3,781	36,539	460	1,914
Medicaid	1,505	5.485	7,799	97	G 50
Commercial Insurance	. 58	295	420	2.	12
Managed Care	2,237	4,521	29, 996	219	2,039
Other (Specify)	•				
TOTAL	11, 189	19,486	'76,853	. 815	4, 739

F. Services and Facilities

1. Obstetrics	Enter Number of Infants
a. Live births (Vaginal Deliveries)	38/
b. Live births (Cesarean Section)	. 151
c. Stillbirths	/

d. Delivery Rooms - Delivery Only (not Cesarean Section)	0
e. Delivery Rooms - Labor and Delivery, Recovery	L
f. Delivery Rooms - LDRP (include Item "m" on Page 4)	Ö
g. Normal newborn bassinets (Level I Neonatal Services)	10
Do not include with totals under the section entitled Beds by Service (Inpatient)	100

•			
2.	Abortion Services	Number of procedures per Year	

3.	Emergency Departs	nent Services	(cases equal visits t	to ED)			
	a. Total Number of l	BD Exam Roo	ms:	12	-		
	a.1. #Trauma Rooms	<u>, </u>	a.2. #Fas	t Track Rooi	ms		
	b. Total Number of	ED visits for re	eporting period:	19,48	36		
	c. Total Number of	dmits from th	e ED for reporting	period:	2,046		
c. Total Number of admits from the ED for reporting period: 2,046 d. Total Number of Urgent Care visits for reporting period:							
	e. Does your ED provide services 24 hours a day 7 days per week? Yes No If no, specify days/hours of operation:						
	f. Is a physician on of If no, specify days/he			days per wee	ek? <u>V</u> Yes <u>N</u>	.	
4.	Medical Air Transp	ort: Owned	or leased air ambula	ınce service:		•	
	a. Does the facility of b. If "Yes", complete	operate an air a	imbulance service?				
		Number of Airc	raft Number Owne	d Number	Leased Number of Tran	sports	
	Rotary	A. Alamiyini distant		(MEA/COS TANKA)			
,	Fixed Wing						
5.	Pathology and Med	ical Lab (Ch	eck whether or not	service is pro	ovided)		
	a. Blood Bank/Tranb. Histopathology Lc. HIV Laboratory TNumber during re	aboratory Testing Porting period		Yes Yes Yes	No No No		
	HIV Serolog	gy <u>60</u>					
	HIV Culture d. Organ Bank	·	`	Yes 🗸	No.		
	e. Pap Smear Scree	ning		Yes	No	•	
6.	Transplantation Se	rvices - Numb	per of transplants	_	•		
	Туре	Number	• Туре	Number	Type	Number	
	Marrow-Allogeneic	. 0	i. Kidney/Liver	0	k. Lung	0	
	Marrow-Autologous	0.	j. Liver	0	1. Pancreas	0	
. Come		9	f. Heart/Liver.	0	m. Pancreas/Kidney	0	
. Heart		0	g. Heart/Kidney	. 0	n. Pancreas/Liver	0	
. rieart	/Lung		h. Kidney	0	o: Other	0	
Do you	Do you perform living donor transplants? Yes V No.						

License No: H0019 Facility ID: 943388

7. Specialized Cardiac Services (for questions, call 855-3865 [Medical Facilities Planning])

(a)	Cardiac Catheterization	Diagnostic Cardiac Catheterization ICD-9 37.21, 37.22, 37.23, 37.25	Interventional Cardiac Catheterization- ICD-9 00.66, 99.10, 36.06, 36.07, 36.09; 35.52, 35.71, 35.96	Electro-physiology 37.26, 37.27, 37.34, 37.70, 37.71, 37.72, 37.73, 37.74, 37.75, 37.76, 37.77, 37.79, 37.80, 37.81, 37.82, 37.83, 37.85, 37.86, 37.87, 37.89, 37.94, 37.95, 37.96, 37.97, 37.98, 37.99, 00.50, 00.51, 00.52, 00.53, 00.54
I.	Number of Units of Fixed Equipment	ur.		
2.	Number of Procedures* Performed in Fixed Units on Patients Age 14 and younger			
3.	Number of Procedures* Performed in Fixed Units on Patients Age 15 and older			
4.	Number of Procedures* Performed in Mobile Units			
*^	procedure is defined to be one visi	it or trip by a patient to a	catheterization laboratory	for a single or multiple

catheterizations. Count each visit once, regardless of the number of diagnostic, interventional, and/or EP catheterizations performed within that visit.

Name of Mobile Vendor:

Number of 8-hour days per week the mobile unit is onsite:

8-hour days per week.

(Examples: Monday through Friday for 8 hours per day is 5 8-hour days per week. Monday, Wednesday, & Friday for 4 hours per day is 1.5 8-hour days per week)

(b)	Open Heart Surgery	Number of
·	•	Machines/Procedures
1.	Number of Heart-Lung Bypass Machines	•
2.	Total Annual Number of Open Heart Surgery Procedures	
l L.	Utilizing Heart-Lung Bypass Machine	1
3.	Total Annual Number of Open Heart Surgery Procedures done	
	without utilizing a Heart-Lung Bypass Machine	
4.	Total Open Heart Surgery Procedures (2. + 3.)	·
	Procedures on Patients Age 14 and younger	2008
5.	Of total in #2, Number of Procedures on Patients Age 14 &	
	younger	•
6.	Of total in #3, Number of Procedures on Patients Age 14 &	
	younger	

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8.		ating Rooms, Pr Cases and Proce	rocedure Rooms, Gastroin edures	testinal	Endoscopy Ro	oms, Surgical and			
	NOTE: If this License includes more than one campus, please submit the Cumulative Totals and COPY and Submit a duplicate of pages 8 and 9 for each campus.								
(C			,		,				
`	• •			The state of the s	70000 Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual				
<i>α</i> ;	A) Surgical Operating Rooms Report <u>Surgical Operating Rooms</u> built to meet the specifications and standards for operating rooms required by the Construction Section of the Division of Health Services Regulation, and which are fully equipped to perform surgical procedures. These surgical operating rooms include rooms located in Obstetrics and surgical suites.								
			•						
			Type of Room		Number of Rooms				
		Dedicated Open	Heart Surgery		0				
		Dedicated C-Sec			t				
	[Inpatient Surgery		0				
		Dedicated Ambi			0				
			ent / Ambulatory Surgery		6				
	•	Total of Surgic	al Operating Rooms		7	•.			
	Number of addit	ional CON approv	ved surgical operating rooms p	ending d	evelopment:	-			
	CON Projec	t ID Number(s) _	When the second			TTTT VIE TO BE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SE			
b)	Report rooms performance	s, which are not equi	Operating Rooms and Gastripped for or do not meet all the sp than Gastrointestinal Endoscopy ms:	ecification	ns for an operating				
c)	c) Gastrointestinal Endoscopy Rooms, Cases and Procedures: Report the number of Gastrointestinal Endoscopy rooms and the Endoscopy cases and procedures performed in thes rooms during the reporting period.								
	Total Number of	f existing Gastroir	ntestinal Endoscopy Rooms: _	<u> </u>		The state of the s			
	Number of addit	ilonal CON appro	ved GI Endoscopy Rooms pen	ding deve	elopment:				
	CON Projec	t ID Number(s)							
			Number of Cases		Number of Pro	ocedures*			
G)	Endoscopy	•	G176						
No	on-GI Endoscop	Y							

Count each patient as one case regardless of the number of procedures performed while the patient was in the GI endoscopy room.

670

*As defined in 10A NCAC 14C .3901 "Gastrointestinal (GI) endoscopy procedure" means a single procedure, identified by CPT code or ICD-9-CM procedure code, performed on a patient during a single visit to the facility for diagnostic or therapeutic purposes.

Totals

License No: <u>II0019</u> Facility ID: <u>943388</u>

8.	Surgical Operating Rooms, Procedure Rooms, Gastrointestinal Endoscopy Rooms, Surgical and Non-
	Surgical Cases and Procedures (continued)

,	Campus -	γ.	£ ! a !	ala altan	•
ŧ	Campus -	٠ ٨,	muu	pie sues:	

d) Surgical Cases by Specialty Area Table

Enter the number of surgical cases by surgical specialty area in the table below. Count each patient undergoing surgery as one case regardless of the number of surgical procedures performed while the patient was having surgery. Categorize each case into one specialty area — the total number of surgical cases is an unduplicated count of surgical cases. Count all surgical cases, including surgical cases operated on in procedure rooms or in any other location.

Surgical Specialty Area	Inpatient Cases	Ambulatory Cases
Cardiothoracic (excluding Open Heart Surgery)	18	39
Open Heart Surgery (from 7.(b) 4.)	·	
General Surgery	220	. 547
Neurosurgery		The state of the s
Obstetrics and GYN (excluding C-Sections)	110	342
Ophthalmology	1	1,033
Oral Surgery	1	66
Orthopedies	361	. 1,518
Otolaryngology	11	64.8
Plastic Surgery	3	127
Urology	62	392
Vascular	5	14
Other Surgeries (specify) ECT	23	13
Other Surgeries (specify)		
Number of C-Section's Performed in Dedicated C-Section ORs		
Number of C-Section's Performed in Other ORs		
Total Surgical Cases	\$15	4,739

e) Non-Surgical Cases by Category Table

Enter the number of non-surgical cases by category in the table below. Count each patient undergoing a procedure or procedures as one case regardless of the number of non-surgical procedures performed. Categorize each case into one non-surgical category—the total number of non-surgical cases is an unduplicated count of non-surgical cases. Count all non-surgical cases, including cases receiving services in operating rooms or in any other location, except do not count cases having endoscopies in GI Endoscopy rooms. Report cases having endoscopies in GI Endoscopy Rooms on page 8.

Non-Surgical Category	Inpatient Cases	Ambulatory Cases
Pain Management	. 4	168.
Cystoscopy	3 .	19
Non-G1 Endoscopies (not reported in 8. c)		· · · · · · · · · · · · · · · · · · ·
GI Endoscopies (not reported in 8, c)		
YAG Laser		
Other (specify)		
Other (specify)	, ,	
Other (specify)		
Total Non-Surgical Cases	1 7	189

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9. Average Operating Room Availability and Average Case Times:

The Operating Room Methodology assumes that the average operating room is staffed 9 hours a day, for 260 days per year, and utilized at least 80% of the available time. This results in 1872 hours per OR per year.

The Operating Room Methodology also assumes 3 hours for each Inpatient Surgery and 1.5 hours for each Outpatient Surgery.

Based on your hospital's experience, please complete the table below by showing the assumptions for the average operating room in your hospital.

Average Hours per Day Routinely Scheduled for Use *	Average Number of Days per Year Routinely Scheduled for Use	Average "Case Time" ** in Minutes for Inpatient Cases	Average "Case Time" ** in Minutes for Ambulatory Cases
9	260	144	91

^{*} Use only Hours per Day **routinely** scheduled when determining. Example: 2 rooms @ 8 hours per day <u>plus</u> 2 rooms @ 10 hours per day <u>equals</u> 36 hours per day; <u>divided</u> by 4 rooms <u>equals</u> an average of 9 hours / per room / per day.

Revised 08/2010

^{** &}quot;Case Time" = Time from Room Set-up Start to Room Clean-up Finish. Definition 2.4 from the "Procedural Times Glossary" of the AACD, as approved by ASA, ACS, and AORN. <u>NOTE</u>: This definition includes all of the time for which a given procedure requires an OR/PR. It allows for the different duration of Room Set-up and Room Clean-up Times that occur because of the varying supply and equipment needs for a particular procedure

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10a. Magnetic Resonance Imaging (MRI)

Indicate the number of scanners (units) and the number of procedures performed during the 12-month reporting period at your facility. For hospitals that operate medical equipment at multiple sites/campuses, please copy the MRI pages and provide separate data for each site/campus.

	0.44 4.							
Number of fixed MRI	# Units				•			
scanners-closed (do not include any Policy AC-3 scanners)	-tup _{ke}	Inpat	ient Proced	ures*	Outpa	itient Proce	dures*	
# of fixed MRI scanners- open (do not include any Policy AC-3 scanners)		With	Without		With	Without		
Number of Policy AC-3 MRI scanners used for general clinical purposes		Contrast or Sedation	Contrast or Sedation	TOTAL Inpatient	Contrast or Sedation	Contrast or Sedation	TOTAL Outpatient	TOTAL Procedures
Total Fixed MRI Scanners	1	29	253	282	199	1980	2,179	2,461
Procedures performed of MRI scanners only at		e	0	e	Ō	429	435	435
Name(s) of Mobile MRI P	rovider(s)	Allía	hce I	- - - - -	NG			
The total number of proced number of patients reporte listed in the next two rows s	d on the M	RI Patient (Origin Tabl	e on page 25	of this app	lication. Pa	tients served	on units
Policy AC-3 scanners used for dedicated or non-clinical purposes			,		,			,
Other Human Research MRI scanners							·	

^{*} An MRI procedure is defined as a single discrete MRI study of one patient (single CPT coded procedure). An MRI study means one or more scans relative to a single diagnosis or symptom.

10b. MRI Procedures by CPT Codes

CPT Code	CPT Description	Number of Procedures
70336	MRI Temporomandibular Joint(s)	. 4
70540	MRI Orbit/Face/Neck w/o	2.
70542	MRI Orbit/Face/Neck with contrast	2
70543	MRI Orbit/Face/Neck w/o & with	4
70544	MRA Head w/o	84
70545	MRA Head with contrast	1
70546	MRA Head w/o & with	-8
70547	MRA Neck w/o	2
70548	MRA Neck with contrast	Ø
70549	MRA Neck w/o & with	2-1
70551	MRI Brain w/o	110
70552	MRI Brain with contrast	ł
	Subtotal for this page	231

License No: <u>110019</u> Facility ID: <u>943388</u>

10b. MRI Procedures by CPT Codes continued....

CPT Code	CPT Description	Number of Procedures
70553	MRI Brain w/o & with	449
7055A	IAC Screening	.0
71550	MRI Chest w/o	5
71551	MRI Chest with contrast	e
71552	MRI Chest w/o & with	3
71555	MRA Chest with OR without contrast	8
72126	Cervical Spine Infusion only	-8
72141	MRI Cervical Spine w/o	245
72142	MRI Cervical Spine with contrast	¥
72156	MRI Cervical-Spine w/o & with	5/
72146	MRI Thoracic Spine w/o	5/
72147	MRI Thoracic Spine with contrast	8
72157	MRI Thoracic Spine w/o & with	2.0
72148	MRI Lumbar Spine-w/o	503
72149	MRI Lumbar Spine with contrast	Ø.
72158	MRI Lumbar Spine w/o & with	91
72159	MRA Spinal Canal w/o OR with contrast	.0
72195	MRI Pelvis w/o	41
72196	MRI Pelvis with contrast	20
72197	MRI Pelyis w/o & with	O
72198	MRA Pelvis w/o OR with Contrast	0
73218	MRI Upper Ext, other than joint w/o	13
73219	MRI Upper Ext, other than joint with contrast	Ø
73220	MRI Upper Ext, other than joint w/o & with	Ez
73221	MRI Upper Ext, any joint w/o	277
73222	MRI Upper Ext, any joint with contrast	72.
73223	MRI Upper Ext, any joint w/o & with	<i>c</i> ₁
73225	MRA Upper Ext, w/o OR with contrast	e
73718	MRI Lower Ext other than joint w/o	63
73719	MRI Lower Ext other than joint with contrast	8
73720	MRI Lower Ext other than joint w/o & with	40
73721	MRI Lower Ext any joint w/o	527
73722	MRI Lower Ext any joint with contrast	7
73723	MRI Lower Ext any joint w/o & with	21
73725	MRA Lower Ext w/o OR with contrast	.6
74181	MRI Abdomen w/o	
74182	MRI Abdomen with contrast	. 73
* ^ v // ba	Subtotal for this page	2,586

10b. MRI Procedures by CPT Codes continued....

CFT Code	CPT Description	Number of Procedures
74183	MRI Abdomen w/o & with	14
74185	MRA Abdomen w/o OR with contrast	3
75552	MRI Cardiac Morphology w/o	Ø
75553	MRI Cardiac Morphology with contrast	8
75554	MRI Cardiac Function Complete	
75555	MRI Cardiac Function Limited	Ö
75556	MRI Cardiac Velocity Flow Mapping	E E
76093	MRI Breast, unilateral w/o and/or with contrast	-2
76094	MRI Breast, bilateral w/o and/or with contrast	GO .
76125	Cineradiography to complement exam	-8
76390	MRI Spectroscopy	8
76393	MRI Guidance for needle placement	
76394	MRI Guidance for tissue ablation	e e
76400 ·	MRI Bone Marrow blood supply	Ø
7649A	- MR functional imaging	Ø
7649D	MRI infant spine comp w/ & w/o contrast	. 8
7649E	Spine (infants) w/o infusion	. 5
7649H	MR functional imaging	0
N/A	Clinical Research Scans	E
	Subtotal for this page	79
	Total Number of Procedures for all pages	2.896

100	Committee	Ta	maara	nhv	CT
8 8 P C .	COMBINE	3 4 61	пиога	TIES N	

How many fixed CT scanners does the hospital have?	2	
Does the hospital contract for mobile CT scanner services?	Yes/]	Νo
If yes, identify the mobile CT vendor NA		

Complete the following tables (one for fixed CT scanners; one for mobile CT scanners).

Scans Performed on Fixed CT Scanners (Multiply # scans by Conversion Factor to get HECT Units)

	Type of CT Scan	# of Scans		Conversion Factor	<u> </u>	HECT Units
1	Head without contrast	2,590	X	1.00	=	2590
3	Head with contrast	29	X	1.25	≈	36.25
3	Head without and with contrast	165	X	1.75	==	288,75
4	Body without contrast	2,913	X	1.50	=	4369.50
5	Body with contrast	1. 2.46.	X	1.75 . •	=	3930,50
6	Body without contrast and with contrast	998	Х	2.75	==	2744,50
7	Biopsy in addition to body scan with or without contrast	33	X	2.75	122	90,15
8	Abscess drainage in addition to body scan with or without contrast	58	X	4.00	=	232

License No: I10019

Pacility ID: 943388

Scans Performed on Mobile CT Scanners (Multiply # scans by Conversion Factor to get HECT Units)

				ALL 800	
Type of CT Scan	# of Scans		Conversion Factor		HECT Units
Head without contrast		X	1.00	=	
Head with contrast	ł .	X	1.25	=	
Head without and with contrast		X	1.75	=	
Body without contrast		X	1.50	=	
Body with contrast	·	X	1.75	=	
Body without contrast and with contrast		Х	2.75	13	
Biopsy in addition to body scan with or without contrast		Х	2,75	=	· ·
Abscess drainage in addition to body scan with or without contrast		Х	4.00	=	
	Type of CT Scan Head without contrast Head with contrast Head without and with contrast Body without contrast Body without contrast Body without contrast and with contrast Biopsy in addition to body scan with or without contrast Abscess drainage in addition to	Type of CT Scan # of Scans Head without contrast Head without and with contrast Body without contrast Body without contrast Body without contrast and with contrast Biopsy in addition to body scan with or without contrast Abscess drainage in addition to	Type of CT Scan # of Scans Head without contrast X Head with contrast X Head without and with contrast X Body without contrast X Body with contrast X Body without contrast X Body without contrast X Body without contrast A South Scans Sca	Type of CT Scan # of Scans Conversion Factor Head without contrast X 1.00 Head with contrast X 1.25 Head without and with contrast X 1.75 Body without contrast X 1.50 Body with contrast X 1.75 Body without contrast X 1.75 Body without contrast X 1.75 Body without contrast X 1.75 Body without contrast X 2.75 contrast X 2.75 contrast X 2.75 with or without contrast X 2.75 with or without contrast X 2.75 Abscess drainage in addition to X 4.00	Head without contrast X 1.00 = Head with contrast X 1.25 = Head without and with contrast X 1.75 = Body without contrast X 1.50 = Body with contrast X 1.75 = Body without contrast X 1.75 = Body without contrast X 2.75 = with or without contrast X 2.75 = with or without contrast X 2.75 = With or without Contrast X 2.75 = With or without Contrast X 2.75 = With or without Contrast X 2.75 = With or without X 2.75 = With or without Contrast X 2.75 = With or without Contrast X 2.75 = With or without Contrast X 2.75 = With or without Contrast X 2.75 = With or without X 2.75 = With or without X 2.75 = With or without X 2.75 = With or with Contrast X 2.75 = With or with Contrast X 2.75 = With or with Contrast X 2.75 = With Or With Contrast X 2.75 = With Contrast X 2.75 = With Contrast X 2.75 = With Contrast X 2.75 = With Contrast X 2.75 = With Contrast X 2.75

10d. Other Imaging Equipment

	Number of	Numl	per of Procedure	es
,	Units	Inpatient	Outpatient	Total
Dedicated Fixed PET Scanner				,,,,,,,,,
Mobile PET Scanner	143		143	143
PET pursuant to Policy AC-3				• • • • • • • • • • • • • • • • • • • •
Other Human Research PET Scanner				
Ultrasound equipment	5,235	942	4.293	5,23
Mammography equipment	6,384		6,384	6,38
Bone Density Equipment	957		957	957
Fixed X-ray Equipment (excluding fluoroscopic)	19,500	4,045	15,405	19,50
Fixed Fluoroscopic X-ray Equipment	718	288	4-30	718
Special Procedures/ Angiography Equipment (neuro & vascular, but not including cardiac cath.)				
Coincidence Camera	1			
Mobile Coincidence Camera				<u></u>
Vendor:				
SPECT		•		
Mobile SPECT				
Vendor:				,
Gamma Camera	1,873	917	956	1873
Mobile Gamma Camera			1	
Vendor:				

^{*} PET procedure means a single discrete study of one patient involving one or more PET scans. PET scan means an image-scanning sequence derived from a single administration of a PET radiopharmaceutical, equated with a single injection of the tracer. One or more PET scans comprise a PET procedure. The number of PET procedures in this table should match the number of patients reported on the PET Patient Origin Table on page 27.

10e. Lithotripsy

	Number of	Number of Procedures			
	Units	Inpatient	Outpatient	Total	
Fixed		· · · · · · · · · · · · · · · · · · ·			
Mobile	i	-2	31	33	

Lithotripsy Vendor/Owne	er:
Healthronic	<u>2S</u>

License No: H0019

Facility ID: 943388

License No: H0019
Facility ID: 943388

11. Linear Accelerator Treatment Data (including Cyberknife® & Similar Equipment)

CPT Code	Description	# of Procedures
Simple Trea	atment Delivery	
77401	Radiation treatment delivery	V. Children and A. Children an
77402	Radiation treatment delivery (<=5 MeV)	
77403	Radiation treatment delivery (6-10 MeV)	
77404	Radiation treatment delivery (11-19 MeV)	
77406	Radiation treatment delivery (>=20 MeV)	•
Intermediate	e Treatment-Delivery	
77407	Radiation treatment delivery (<=5 MeV)	
77408	Radiation treatment delivery (6-10 MeV)	
77409	Radiation treatment delivery (11-19 MeV)	
77411	Radiation treatment delivery (>=20 MeV)	
Complex Tr	reatment Delivery	
77412	Radiation treatment delivery (<=5 MeV)	
77413	Radiation treatment delivery (6-10 MeV)	
77414	Radiation treatment delivery (11-19 MeV)	
77416	Radiation treatment delivery (>= 20 MeV)	
Other Treat	ment Delivery Nột Included Aboye	
77418	Intensity modulated radiation treatment (IMRT) delivery	
77372	Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course	
	of treatment of cranial lesion(s) consisting of I session; linear accelerator	
77373	Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or	
	more lesions, including image guidance, entire course not to exceed 5 fractions	
G0339	(Image-guided) robotic linear accelerator-based stereotactic radiosurgery in	
	one session or first fraction	
G0340	(Image-guided) robotic linear accelerator-based stereotactic radiosurgery,	
,	fractionated treatment, 2nd-5th fraction	
	Intraoperative radiation therapy (conducted by bringing the anesthetized	
	patient down to the linac)	
, " ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Pediatric Patient under anesthesia	
	Neutron and proton radiation therapy	
	Limb salvage irradiation	4
	Hemibody irradiation	
	Total body irradiation	
	ocedures Not Included Above	
77417	Additional field check radiographs	
	Total Procedures - Linear Accelerators	
Gamma Kn	ife® Procedures	
77371	Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course	15.0.0
	of treatment of cranial lesion(s) consisting of 1 session; multisource Cobalt 60	
	based (Gamma Knife)	
	. Total Procedures – Gamma Knife®	

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11.	Linear	Accelerator	Treatment	Data	continued
	***************************************		The second secon	APRIL DESCRIPTION OF THE PROPERTY AND ADDRESS OF THE PROPERTY ADDRESS OF THE PROPERTY ADDRESS OF THE PROPERTY ADDRESS OF THE PROPERTY ADDRESS OF THE PROPERTY ADDRESS OF THE PROPERTY ADDRESS OF THE PROPERTY ADDRESS OF THE PROPERTY ADDRESS OF THE PROPERTY ADDRESS OF THE PROPERTY ADDRESS OF THE PROPERTY ADDRESS OF THE PROPERTY ADDRESS OF THE PROPERTY ADDRESS OF THE PROPERTY ADDRESS OF THE PROPERTY ADDRESS OF THE PROPERTY ADDRESS OF THE PROPERTY ADDRESS OF THE PROPERTY ADDRESS	

		Control of the contro	·
a. Number of unduplicated patients who	received a	course of radiation oncology treatments on lonce if they receive one course of treatment	inear accelerators
revolve additional correspont treatment	For evennl	e, one patient who receives one course of trea	and more it usey
one and any nations who receives three	control of t	reatment counts as three. # patients	uncia courts as
one, and one patient who receives three t	courses or t	the Linear Annalyses Butter Orling	(Ims number
		the Linear Accelerator Patient Origin Ta	bie on page 26.
b. Total number of Linear Accelerator(s		·	
c. Number of Linear Accelerators config			· -
d. Number of simulators (machine that)	produces hi	gh quality diagnostic radiographs and precise	ly reproduces the
geometric relationships of megavoltage	radiation th	erapy equipment to the patient."(GS 131E-17	(6(24b))
e. Number of CyberKnife ⁶⁶ System	s:	. Gamma Knife®	
Other specialized Linear Accelerator	rs	***************************************	•
Identify Manufacturer of Equipment	-	•	
	WHITE STATE OF THE		deconstruction of the second
12. <u>Telemedicine</u>			
a. Does your facility utilize telem	edicine to	have images read at another facility?	<u>Yes</u>
b. Does your facility read teleme	dicine ima	iges?NO	
13. Additional Services:			
a) Check if Service(s) is provide	ed: (for di	alysis stations, show number of stations	s)
· ·	Check		Check
1. Cardiac Rehab Program		5. Rehabilitation Outpatient Unit	
(Outpatient)	3/		· ·
			
2. Chemotherapy	V.	6. Podiatric Services	
3 Clinical Psychology Services	1	7 Genetic Counceling Service	

b) Hospice Inpatient Unit Data:

Hospital-based hospice units with licensed hospice beds. List each county served and report all patients by county of residence. Use each patient's age on the admission day to the Licensed Hospice Inpatient Facility. For age categories count each inpatient client only once.

Number of Acute Dialysis Stations

County of Residence	Age 0-17	Age 18-40	Age 41-59	Age 60-64	Age 65-74	Age 75-84	Age 85+	Total Patients Served	Total Days of Care	Deaths
	,.									
						,				
Out of State	<u> </u>	<u> </u>								
Total All Ages						٠				

Dental Services

License No: H0019 Facility ID: 943388

All responses should pertain to October 1, 2009 through September 30, 2010.

13. Additional Services: continued

c)	Mental	Health	and	Substance	Abuse

1. If psychiatric care has a different name than the hospital, please indicate:

Hope Behavioral Health Services
2. If address is different than the hospital, please indicate:

3. Director of the above services. Marilyn Jackson RN Director of Benavioral Health Sentices
Dr. Philip Lastey, Medical Director

Indicate the program/unit location in the Service Categories chart below. If it is in the hospital, include the room number. If it is located at another site, include the building name, program/unit name and address.

Service Categories: All applicants must complete the following table for all mental health services which are to be provided by the facility. If the service is not offered, leave the spaces blank.

Rule 10A NCAC 27G Licensure Rules For Mental Health Facilities	Location of Services	Beds Assigned by Age					
		- 0-12	13-17	Subtotal 0-17	18 & пр	Total Beds	
.1100 Partial hospitalization for individuals who are acutely mentally ill.	Women's PRH PHP/IOP						
.1200 Psychosocial rehabilitation facilities for individuals with severe and persistent mental illness	N/A	·	<u> </u>				
.1300 Residential treatment facilities for children and adolescents who are emotionally disturbed or have a mental illness	N/A						
.1400 Day treatment for children and adolescents with emotional or behavioral disturbances	N/H						
.1500 Intensive residential treatment facilities for children & adolescents who are emotionally disturbed or who have a mental illness	NA						
.5000 Facility Based Crisis Center	N/A ·			·			

Rule 10A NCAC 13B Licensure Rules	Location of			ned by A		
For Hospitals	Services	0-12	13-17	Subtotal 0-17	18 & up	Total Beds
.5200 Dedicated inpatient unit for individuals who have mental disorders	Park Ridge. Health				V	36

License No: <u>M0019</u> Facility ID: <u>943388</u>

13. Additional Services: continued

c) Mental Health and Substance Abuse continued

Rule 10A NCAC 27G Licensure Rules for Substance Abuse Facilities	Location of Services	Beds Assigned by Age			•	
		0-12	13-17	Subtotai 0-17	18 & up	Total Beds
.3100 Nonhospital medical detoxification for individuals who are substance abusers	N/A					
.3200 Social setting detoxification for substance abusers	N/A				,	
.3300 Outpatient detoxification for substance abusers	N/A					
.3400 Residential treatment/ rehabilitation for individuals with substance abuse disorders	N/A					
.3500 Outpatient facilities for individuals with substance abuse disorders	N/A		÷		<u>.</u>	
.3600 Outpatient narcotic addiction treatment	N/4					=
.3700 Day treatment facilities for individuals with substance abuse disorders	N/A					20 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2

Rule 10A NCAC 13B Licensure Rules	Location of		7	ned by A	\ ge	
For Hospitals	Services	0-12	13-17	Subtotal 0-17	18 & пр	Total Beds
5200 Dedicated inpatient hospital unit for individuals who have substance abuse disorders (specify type) # of Treatment beds # of Medical Detox beds	N/A	•			-	

License No: H0019 Facility ID: 943388

Patient Origin -General Acute Care Inpatient Services

Facility County: Henderson

In an effort to document patterns of utilization of General Acute Care Inpatient Services in North Carolina hospitals, please provide the county of residence for each patient admitted to your facility.

County	No. of Admissions	County	No. of Admissions	County	No. of Admissions
1. Alamance .		37. Gates		73. Person	
2. Alexander		38. Graham	2_	74. Pitt	
3. Alleghany		39. Granville		75. Polk	141
4. Anson		40. Greene		76. Randolph	
5. Ashe	7_	41. Guilford	1	77. Richmond	
6. Avery		42. Halifax		78. Robeson	
7. Beaufort		43. Harnett	2	79. Rockingham	
8. Bertie		44. Haywood	69	80. Rowan	
9. Bladen		45. Henderson	2,386	81. Rutherford	33
10. Brunswick		46. Hertford		82. Sampson	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
11. Buncombe	579	47. Hoke		83. Scotland	
12. Burke	6	48. Hyde		84. Stanly	
13. Cabarrus		49. Iredell		85. Stokes	
14. Caldwell		50. Jackson	17	86. Surry	
15. Camden		51. Johnston		87. Swain	ઇ
16, Carteret		52. Jones		88. Transylvania	190
17. Caswell		53. Lee	1	89. Tyrrell	
18. Catawba	2	54. Lenoir		90. Union	
19. Chatham		55. Lincoln ·		91. Vance	
20. Cherokee		56. Macon	12.	92. Wake	
21. Chowan		57. Madison	. 8	93. Warren	,
22. Clay		58. Martin	i6	94. Washington	
23. Cleveland	11	59. McDowell		95. Watauga	1
24. Columbus		60. Mecklenburg	3	96. Wayne	
25, Cravon		61. Mitchell	5	97. Wilkes	
26. Cumberland		62. Montgomery		98. Wilson	*
27. Currituck		63. Moore	1.	99, Yadkin	•
28. Dare		64. Nash		100. Yancey	2
29. Davidson		65. New-Hanover		The state of the s	The state of the s
30. Davie		66. Northampton		101. Georgia	**************************************
31. Duplin	T 7	67. Onslow	2	102. South Carolina	
32. Durham		68. Orange		103. Tennessee	
33. Edgecombe		69. Pamlico		104. Virginia	
34. Forsyth	3	70. Pasquotank		105. Other States	
35. Franklin		71. Pender	1	106. Other	89
36, Gaston	2	72. Perquimans		Total No. of Patients	3596

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Patient Origin - Inpatient Surgical Cases

Facility County: Henderson

In an effort to document patterns of Inpatient utilization of Surgical Services in North Carolina hospitals, please provide the county of residence for each inpatient surgical patient served in your facility. Count each inpatient surgical patient once regardless of the number of surgical procedures performed while the patient was having surgery. However, each admission as an inpatient surgical case should be reported separately.

The Total from this chart should match the Total Inpatient Cases reported on the "Surgical Cases by Specialty Area" Table on page 9.

County	No. of Patients		No. of Patients		No. of Patients
1. Alamance		37. Gates		73. Person	
2. Alexander		38. Graham	2	74. Pitt	
3. Alleghany		39. Granville		75. Polk	20
4. Anson		40. Greene		76. Randolph	
5. Ashe	1	41. Guilford		77. Richmond	
6. Avery		42. Halifax		78. Robeson	
7. Beaufort		43. Harnett	-	79. Rockingham	
8. Bertie		44. Haywood	65	80. Rowan	7
9. Bladen		45. Henderson	438	81. Rutherford	3
10. Brunswick		46. Hertford		82. Sampson	
11. Buncombe	160	47. Hoke		83. Scotland	
12. Burke	G	48. Hyde		84. Stanly	
13. Cabarrus		49. Iredell		85, Stokes	
14. Caldwell		50. Jackson	12	86. Surry	
15. Camden		51. Johnston		87. Swain	6
l'6. Carteret	•	52. Jones		88. Transylvania	45
1.7. Caswell.		53. Lee		89. Tyrrell .	- 12
18. Catawba	1 .	54. Lenoir		90. Union	
19. Chatham		55, Lincoln .		91. Vance	
20. Cherokee		56. Macon	7	92. Wake	T
21, Chowan		57. Madison	4	93. Warren	
22. Clay		58. Martin	q	94. Washington	
23. Cleveland	¥	59. McDowell		95. Watauga	
24. Columbus		60. Mecklenburg		96. Wayne	
25, Craven		61. Mitchell	2_	97. Wilkes	
26. Cumberland		62. Montgomery		98. Wilson	
27. Currituck		63. Moore		99. Yadkin	
28. Dare		64. Nash		100. Yancey	È
29. Davidson		65. New Hanover			
30. Davie		66. Northampton		101. Georgia	
31. Duplin	·i	67. Onslow	3	102. South Carolina	
32. Durham		68. Orange		103. Tennessee	
33. Edgecombe		69. Pamlico		104. Virginia	A STATE OF THE PARTY OF THE PAR
34, Forsyth		70. Pasquotank		105. Other States	<u> </u>
35. Franklin		71. Pender	İ	106. Other	21
36. Gaston		72. Perquimans		Total No. of Patients	875

License No: H0019 Facility ID: 943388

Patient Origin - Ambulatory Surgical Cases

Facility County: Henderson

In an effort to document patterns of Ambulatory utilization of Surgical Services in North Carolina hospitals, please provide the county of residence for each ambulatory surgery patient served in your facility. Count each ambulatory patient once regardless of the number of procedures performed while the patient was having surgery. However, each admission as an ambulatory surgery case should be reported separately.

The Total from this chart should match the Total Ambulatory Surgical Cases reported on the "Surgical Cases by Specialty Area" Table on page 9.

County	No. of Patients		No. of Patients		No. of Patients
1. Alamance		37. Gates		73. Person	
2. Alexander	•	38. Graham .	1 (2)	74. Pitt	
3. Alleghany		39. Granville		75. Polk	129
4. Anson		40. Greene		76. Randolph	
5. Ashe		41. Guilford	2	77. Richmond	
6. Avery	2_	42, Halifux •		78. Robeson	
7. Beaufort	٠.	43. Harnett		79. Rockingham	
8. Bertie		44. Haywood	721	80. Rowan	
9. Bladen		45. Henderson	. 2,605	81. Rutherford	40
10. Brunswick		46. Hertford	,	82. Sampson	-
11. Buncombe	1,038	47. Hoke		83. Scotland	<i>i</i>
12. Burke	17	48. Hyde		84. Stanly	
13. Cabarrus		49. Iredell		85. Stokes	
14. Caldwell	2	50. Jackson	41	86. Surry	
15. Camden		51. Johnston		87. Swain	35
16. Carteret		52. Jones		88. Transylvania	181
17. Caswell		53. Lee		89. Tyrrell	
18. Catawba	2	54: Lenoir		90. Union	· · · · · · · · · · · · · · · · · · ·
19. Chatham		55. Lincoln		91. Vance	
20. Cherokee	13	56, Macon	58	92. Wake	
21. Chowan	}	57. Madison	64	93. Warren	
22. Clay	4 2	58. Martin	64	94. Washington	
23. Cleveland	2	59. McDowell		95. Watauga	1
24. Columbus		60. Mecklenburg ·		96. Wayne	
25. Craven		61. Mitchell	28	97. Wilkes	
26. Cumberland		62. Montgomery		98. Wilson	
27. Currituck		63. Moore		99. Yadkin	
28. Dare		64. Nash		100. Yancey	40
29. Davidson	L t	65. New Hanover			
30. Davie		66. Northampton		101. Georgia	And the second s
31. Duplin		67. Onslow		102. South Carolina	
32. Durham		68. Orange	i	103. Tennessee	
33. Edgecombe		69. Pamlico		104, Virginia	
34. Forsyth	i	70. Pasquotank		105. Other States	5
35. Franklin		71. Pender	The state of the s	106. Other	5 120
36. Gaston		72. Perquimans		Total No. of Patients	: 4.739

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Patient Origin - Gastrointestinal Endoscopy (GI) Cases

Facility County: Henderson

In an effort to document patterns of utilization of Gastrointestinal Endoscopy Services in North Carolina hospitals, please provide the county of residence for each GI Endoscopy patient served in your facility. Count each patient once regardless of the number of procedures performed while the patient was receiving GI Endoscopy Services. However, each admission for GI Endoscopy services should be reported separately.

The Total from this chart should match the Total GI Endoscopy cases reported on the "Gastrointestinal Endoscopy Rooms, Cases and Procedures" Table on page 8 plus the total Inpatient and Ambulatory GI Endoscopy cases from the "Non-Surgical Cases by Category" Table on page 9.

County No	o. of Patients	County	No. of Patients	County	No. of Patients
1. Alamance	_	37. Gates		73. Person	
2. Alexander		38. Graham		74. Pitt	
3. Alleghany		39. Granville		75. Polk	25
4. Anson		40. Greene		76. Randolph	,
5. Ashe		41. Guilford	•	77. Richmond	
6. Avery		42. Halifax		78. Robeson	
7. Beaufort		43. Harnett		79. Rockingham	
8. Bertie		44. Haywood	5	80. Rowan	
9. Bladen		45. Henderson	458	81. Rutherford	3
10. Brunswick	, - t _{ure} , hi	46, Hertford		82. Sampson	1000
11. Buncombe	133.	47. Hoke		83. Scotland	
12. Burke		48. Hyde		84. Stanly	
13. Cabarrus		49. Iredell		85. Stokes	
14. Caldwell		SO. Jackson	2	86. Surry	
15. Camden		51. Johnston		87. Swain	
16. Carteret		52. Jones		88. Transylvania	32
17. Caswell	hkiri-i	53. Lee		89. Tyrrell	
18. Catawba		54. Lenoir		90. Union	
19, Chatham		55. Lincoln	,	91, Vance	
20. Cherokee		56. Macon	1	92. Wake .	
21. Chowan		57. Madison		93. Warren	
22. Clay		58. Martin	2	94. Washington	
23. Cleveland	2	59. McDowell		95. Watauga	
24. Columbus		60. Mecklenburg	1	96. Wayne	
25. Craven		61. Mitchell	1	97. Wilkes	
26. Cumberland		62. Montgomery		98. Wilson	
27. Currituck		63. Moore		99. Yadkin	
28. Darc		64. Nash		100. Yancey	
29. Davidson		65. New Hanover			**************************************
30. Davie		66. Northampton		101. Georgia	
31. Duplin		67. Onslow		102. South Carolina	
32. Durham		68. Orange		103. Tennessee	
33. Edgecombe		69. Pamlico		104. Virginia	
34. Forsyth		70. Pasquotank		105. Other States	
35. Franklin		71. Pender		106. Other	15
36. Gaston		72. Perquimans		Total No. of Patients	676

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Patient Origin - Psychiatric and Substance Abuse Alamance through Johnston

Facility County: Henderson

Complete the following table below for impatient Days of Care reported under Section .5200,

County of Patient Origin	Psychiatric Treatment Days of Care		nt	Substa	nce Abuse Treat Days of Care		Day	xification s of Care	
**************************************	Age 0-17	Age 18+	Totals	Age 0-17	Age 184	Totals	Age 0-17	Age 18+	Totals
Alamanee									
Alexander									
Alleghany									
Anson		i							}
Ashe		1	1		<u>3</u>	3 3	D1111111111111111111111111111111111111		i
Avery	. 24	1			3	3			
Beaufort							• •		
Bertie				•		-		The state of the s	
Bladen	1								
Brunswick				•		·			
Buncombe	1	109	104		42	72		64	64
Burke		7	1		10	10		"7	3
Cabarrus	<u> </u>	3	3					ſ	7
Culdwell	1	2	3 2		(ci	60		1	1
Camden	1 ::					l			
Cartoret	1							Ì	
Caswell							***************************************		1
Catawba	1	7		•	(1	*	7	1
Chatham		1	 		1				- -
Cherokee		প্ন	6	 	. 2	2		4	14
Chowan	1	 	1		1			<u> </u>	
Clay		7	2		i	1	- stryamoronogy	 	
Cleveland	 	Z	Z. 4		 	7		7	7
Columbus	1	 	1					 	
Craven	<u> </u>								
Cumberland	1	1 2	2	1.				Į.	
Currituck	1	 						1	
Dare			 	 				 	
Davidson		-	<u> </u>					 	
Davie		 	 	 				7	
Duplin	∦	 	·	1	†.			† .	
Durham	┨		 					,	· ,
Edgecombe	-		 			 		 	-
Forsyth		 	-	 	 	 			
Franklin		-			-	 		·	
Gaston		2	2	 	 	 	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		+
Gates			 	-	 		,		
Gates	1	2	2	1	4	4		3	.3
Granville		 		 	4	 		ļ	1-2
Greene	1							 	
Guilford	1	2	2		 	 		1	 , -
Halifax	-}		-	╣	-			 	1 1
Flarnott	-l	<u> </u>	 	-		 		 	+
Haywood		23	72	 	235	23		1	1
Henderson		127	127	 	77	77		13	103
Hertford		16-7	16/	 	111	 '''' 		103	102
Hoke	╢	 	ļ			 			1
Hyde	-		 		-			 	
fredell		+	+			<u> </u>		 	<u> </u>
Jackson	1	2 8	2.	1	3.	3		 	
20/2/111	<u> </u>	1 0	J U	4		1 7	<u></u>		I

** Note: See counties: <u>iones</u> through <u>Yancey</u> (including Out-of-State) on next page.

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Patient Origin - Psychiatric and Substance Abuse Jones through Yancey (including Out-of-State)

Facility County: Henderson (Continued from previous page)

County of Patient Origin	Psyc	chiatric Treatme Days of Care	ent	l e	ce Abuse Treat Days of Care			Detoxification Days of Care	
	Age 0-17	Age 18+	Totals	. Age 0-17	Age 18+	Totals	Age 0-17	Age 18+	Totals
lones					,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
Lee									
Lenoir	 								
Lincoln			•		ŧ	1			
Mucon		7	i	order	4	4	***************************************	5	5
Madison	-	3	- 3		5	4.		1	7
Martin	1	5	.3		9	9		4	5 7 4
McDowell	 	1			**************************************		· · · · · · · · · · · · · · · · · · ·	1	
Mecklenburg		Ś	8		7	1 1			
Mitchell		Ä	6		6	6	•	10	10
Montgoniery	1	1						1	1
Moore									
Nash				<u> </u>				 	
New Hanover	 	1	1	<u> </u>				1	
		 	*	- Warranting and the Warranting		1		<u> </u>	
Northampton Onslow	 			 		 		 	
Orange		-		1					
	 			ļ	 	 		-	-
Pamlico	<u> </u>	ļ			<u> </u>				
Pasquotank				ļ				2	12
Pender	 ,			<u> </u>				 	
Perquimans		ļ		<u> </u>	ļ	 			
Person									
Pitt		<u> </u>		 	4	ų.		1 2	2-
Polk		1. 7		I	ļ <u></u>	1 7			
Rundolph				<u> </u>	 			 	
Richmond:	J			 	 	ļ			ļ
Robeson				<u> </u>	ļ				ļ
Rockingham		////	1			<u> </u>			J
Rowan					1		<u> </u>		
Rutherford		12.	12	ļ,	14	14	ļ	111	- 11
Sampson	4			<u> </u>					
Scotland	_		<u> </u>	<u> </u>	 	ļ	ļ		ļ
Stanly					ļ	. .			_
Stokes					<u> </u>		1		
Surry						<u> </u>	<u> </u>		
Swain		16	55 10	<u> </u>	ļ			1	1
Transylvania		16	10	-	18	18		25	2.5
Tynell							1		
Union				1					
Vance					1				
Wake	1	.3	3					1	
Warren	7]
Washington									1
Watauga		1 L	\$		4	4		3	3
Wayne	•					7			
Wilkes		1	1		2	2_			
Wilson	1	1	1			1			1
Yadkin .	1	1	1						
Yimecy	-	4	5		5 6	5	-	6	₩
Out of State	1	28	29		6	(5) (6)		6	6
TOTALS			404	7		315	1 8		. 29

See counties: Alamance through Johnston on previous page.

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Patient Origin - MRI Services

Facility County: Henderson

In an effort to document patterns of utilization of MRI Services in North Carolina, hospitals are asked to provide county of residence for each patient served in your facility. The total number of patients reported here should be equal to or less than the total number of MRI procedures reported in Table 10a.

County	No. of Patients	County	No. of Patients	County	No. of Patients
1. Alamance		37. Gates		73. Person	
2. Alexander '		38. Graham	i	74. Pitt	
3. Alleghany		39. Granville		75. Polk	94
4. Anson	3	40. Greene		76. Randolph	
5. Ashe	3	41. Guilford		77. Richmond	
6. Avery		42. Halifax		78. Robeson	
7. Beaufort		43. Harnett	3_	79. Rockingham	
8. Bertie		44. Haywood	47	80. Rowan	
9. Bladen		45. Henderson	1.838	81. Rutherford	18
10. Brunswick		46. Hertford	-	82. Sampson	
11. Buncombe	666	47. Hoke		83. Scotland	
12, Burke		48. Hyde		84. Stanly	1
13. Cabarrus		49. Iredell		85. Stokes	275,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
14. Caldwell	1	50, Jackson	4	86. Surry	2
15. Camden		51. Johnston	· · · · · ·	87. Swain	2
16. Carteret		52. Jones		88. Transylvania	113
17. Caswell		53. Lee		89. Tyrrell	
18. Catawba	.	54. Lenoir		90. Union	2
19. Chatham		55. Lincoln	1	91. Vance	
20. Cherokee		56. Macon	11	92. Wake	1
21. Chowan		57. Madison	1	93. Warren	,
22. Clay	2	58, Martin	20	94. Washington	******************************
23. Cleveland	2	59. McDowell		95. Watauga	12
24. Columbus		60. Mecklenburg		96. Wayne	2
25. Craven		61. Mitchell	5	97. Wilkes	1.1
26. Cumberland	i	62. Montgomery		98. Wilson	44-y
27. Currituck		63. Moore		99. Yadkin	
28. Dare		64. Nash	, , , , , , , , , , , , , , , , , , , ,	100. Yancey	14
29. Davidson		65. New Hanover	1	,	
30. Davic		66. Northampton		101. Georgia	
31. Duplin		67. Onslow		102. South Carolina	
32. Durham		68, Orange		103. Tennessee	
33. Edgecombe		69. Pamlico		104. Virginia	
34. Forsyth		70. Pasquotank		105. Other States	
35. Franklin	100	71. Pender	· · · · · · · · · · · · · · · · · · ·	106. Other	34
36. Gaston		72. Perquimans		Total No. of Patients	2,896

	. /	
Are mobile MRI services currently provided at your hospital?	yes	no

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Patient Origin - Linear Accelerator Treatment

Facility County: Henderson

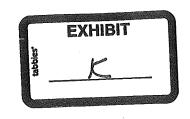
In an effort to document patterns of utilization of linear accelerators in North Carolina, hospitals are asked to provide the county of residence for patients served on linear accelerators in your facility. Report the number of unduplicated patients who receive radiation oncology treatment on equipment (linear accelerators, CyberKnife®, but not Gamma Knife®) listed in Section 11 of this application. Patients shall be counted once if they receive one course of treatment and more if they receive additional courses of treatment. For example, one patient who receives one course of treatment counts as one, and one patient who receives three courses of treatment counts as three. The number of patients reported here should match the number of patients reported in Section 11.a. of this application.

County N	lo. of Patients	County	No. of Patients	County	No. of Patients
1. Alamance		37. Gates		73. Person	
2. Alexander		38. Graham		74. Pitt	
3. Alleghany		39, Granville		75. Polk	
4. Anson		40, Greene		76. Randolph	
5. Ashe		41. Guilford		77. Richmond	,
6. Avery		42. Halifax		78. Robeson	
7. Beaufort		43. Harnett		79. Rockingham	
8. Bertie		44. Haywood		80. Rowan	
9. Bladen		45. Henderson		81. Rutherford	
10. Brunswick		46. Hertford		82. Sampson	
11. Buncombe		47, Hoke		83. Scotland	
12. Burke		48. Hyde		84. Stanly	
13. Cabarrus		49. Iredell		85. Stokes	
14. Caldwell		50. Jackson		86. Surry	
15. Camden		51. Johnston		87. Swain	
16. Carteret		52. Jones		88. Transylvania	
17. Caswell	<u> </u>	53. Lee		89. Tyrrell	, , , , , , , , , , , , , , , , , , ,
18. Catawba	4	54, Lenoir		90. Union	
19. Chatham		55. Lincoln		91. Vance	
20. Cherokee		56. Macon		92. Wake	
21, Chowan		57. Madison		93. Warren	
22. Clay		58. Martin		94. Washington	*
23. Cleveland		59. McDowell	1	95. Watauga	7.1.
24. Columbus		60. Mecklenburg		96. Wayne	
25. Craven		61. Mitchell		97. Wilkes	
26. Cumberland		62. Montgomery		98. Wilson	
27. Currituck	- Contrado de Cont	63. Moore		99. Yadkin	
28. Dare		64. Nash		100. Yancey	
29. Davidson		65. New Hanover	V342 1000388 010	,	4
30. Davie		66. Northampton		101. Georgia	
31. Duplin		67. Onslow		102. South Carolina	
32. Durham		68. Orange		103. Tennessee	
33. Edgecombe		69. Pamlico		104. Virginia	
34. Forsyth		70. Pasquotank		105. Other States	
35. Franklin		71. Pender		106. Other	
36. Gaston		72. Perquimans		Total No. of Patients	

Revised 08/2010 . Page 26

Type of Health Care Facilities Under Park Ridge Health's Hospital License

	Type of Dustiless / Sel vices	VILLO TAULI VOI
	Acute Care Hospital	100 Hospital Drive, Hendersonville, NC 28792
Carolinas Center for Advanced Management of Pain	Pain Management Physician Office	50 Hospital Drive, Suite 2-D, Hendersonville, NC 28792
	Podiatry Physician's Office	600 Fifth Avenue Wust. Hendersonville, NC 28739
ledicine	Sports Medicine and Rehabilitation Services	204 King Street, Hendersonville, NC 28793
he Office of Drs. Robert Bailey, Clara Kim,	Medical Building with Physician Offices, Radiology	1881 Pisgah Drive, Bidg. A., Hendersonville, NC 28791
npson and Jennifer Wilhelm	and Physical Therapy	
Monntain View Detnatology	Dermatology	50 Hospital Drive, Suite 2C, Hendersonville, NC 28792
sociates	Urology	50 Hospital Drive, Sulte 2A Hendersonville, NC 28792
New Beginnings OB/GYN The Office of Dr. Eileen Keppler	OB-GYN	50 Hospital Drive, Suite 2-B, Hendersonville, NC 28792
ogists	Audiology	80 Doctors Drive, Suite 1, Hendersonville, NC 28792
	Dermatology	2315 Asheville Highway, Suite 30, Hendersonville, NC 28791
i Michael	Otolaryngology	81 Doctors Drive, Hondersonville, NC 28792.
Park Ridge General Surgeons The Office of Drs. Thomas Eisenhauer, Allan Huffman and David Price	General, Vascular and Thoracic Surgery Physician's Office	80 Doctors Drive, Suite 1, Hendarsonville, NC 28792
he Office of Drs. Albert Ford, Donald Culver and Clive	Geriatrics	132 Homestead Farm Circle, Handersonville, NC 29792
a Lound Hanleh	Howard Gan Road	Hendersonville, NC 28792
Broast Center - The Office of Dr. Mikhail Vinogradov	11ematology/Oncology	50 Hospital Drive, Suite 4-B, Hendersonville, NC 28792
1	Pediatrics	50 Hospital Drive, Suite 5-D, Hendersouville, NC 28792
		C C C C C C C C C C C C C C C C C C C
gery The Office of Dr. William Young	Plastic & Reconstructive Surgery	One Tovyn Square Blyd., Suite 225, Asheville, NC 28803
	Psychiatry	50 Hospital Drive, Suite 5-A, Hendersonville, NC 28792.
	Pulmonology & Sleep Center	50 Doctors Drive, Suite 1C, Hendersonville, NC 28792
Blattner and Justin	OB/GYN	80 Doctors Drive, Sulte 2, Hendersonville, NC 28792
Center for Mood Disorders The Office of Dr. William Simons	Psychiatry	50 Hospital Drive, Suite 3-C, Hendersonville, NC 28792
	Family Medicine	50 Hospital Drive, Suite 5-B, Hendersonville, NC 28792
PRIMA Office of Dr. James Bryant	Family Medicine	2315 Asheville Highway, Suite 29, Hendersonville, NC 28791
PRMA Office of Dr. Rebekah Robinson	Family Medicine	125 Vance Hill Drive, Mills River, NC 28759-4996
	Family Medicine	Oue Town Square Blvd., Suite 220, Asheville, NC 28803
	Family Medicine	207 Linda Vista Drive, Hendersonville, NC 28792
PRMA Office of Dr. Wade Grainger	Family Medicine	1998 Hendersonville Rd., Skyland Office Park, Suile 45, Asheville, NC 28803
PRIMA Office of Drs. Christian Estes and Robert Francis	Orthopedic Surgery	2920 Haywood Road, Hendersonville, NC 28791
	Family Medicine	7 Glenn Bridgs Road, Unit H, Aden, NC 28704
	Podiatry and Orthopedic Services	21 Turtle Creck Drive, Asheville, NC 28803
icc of Drs. Frederick Veser and Brian Stover	Wound Therapy	50 Hospital Drive, Suite 1-B, Hendersonville, NC 28792



North Carolina Department of Health and Human Services Division of Health Service Regulation Acute and Home Care Licensure and Certification Section 1205 Umstead Drive, 2712 Mail Service Center Raleigh, North Carolina 27699-2712

Telephone: (919) 355-4620 Fax: (919) 715-3073

For Official Use Only License # H0019 Medicare # 340023 Computer: 943388 Date License Fee:

2012 **HOSPITAL LICENSE**

(Full legal name	Applicant of corpora	: <u>Fletcher Hospital, Inc</u> tion, partnership, individ	corporated ual, or other	legal entity	owning the enter	prise or service.)
Doing Business (d/b/a) name(s) t		h the facility or services	are advertis	ed or presente	ed to the public:	
PRIMARY: Other: Other;		dge Health ige Hosptial				
Facility Mailing	Address:	100 Hospital Drive Hendersonville, NC	28792	·		
Facility Site Add	iress:	100 Hospital Drive Hendersonville, NC	28792			
County: Telephone: Fax:		Henderson (828)684-8501 (828)687-0729		•		
Administrator/ Title: <u>CEO</u> (Designated agent		JIMM BUNCH responsible to the governing b	ody (owner) fa	or the manageme	ent of the licensed i	acility)
Chief Executive (Designated agent (e Officer:_ individual) re	Jimm Bunch esponsible to the governing bo	ody (owner) fo	T the manageme	itle: <u>Preside</u> nt of the licensed fi	nt and CEO
Name of the per	son to cont	act for any questions reg	arding this f	orm:		
Name: Col	<u>leen Ra</u>	msey		T	elephone: <u>(82</u>	8) 681-2102
E-Mail: col	<u>leen.ra</u>	msey@ahss.org				
Fb	wi Provide	er Identifier (NPI) regis	stered at NE	PPES 14	27075027	

For questions regarding N21 contact Acizic Contact at (910) GEC-4646.

[&]quot;The N.C. Department of Health and Human Services does an discriminate on the basis of race, color, national origin, religion, age, or desability in employment of the provision of services."

North Carolina Department of Health and Human Services Division of Health Service Regulation Acute and Home Care Licensure and Certification Section 1205 Umstead Drive, 2712 Mnil Service Center Raleigh, North Carolina 27699-2712 Telephone: (919) 855-4620 Fax: (919) 715-3073

For Official Use Only
License # i10019 Medicare # 346023
Computer: 943388
PC Date

License Fee: \$2,252.50

2012 HOSPITAL LICENSE RENEWAL APPLICATION

	: Fletcher Hospital, Incorporated tion, partnership, individual, or other legal entity owning the enterprise or service.)
Doing Business As (d/b/a) name(s) under whic	h the facility or services are advertised or presented to the public:
	ge Hosptial
Facility Mailing Address:	100 Hospital Drive Hendersonville, NC 28792
Facility Site Address: County: Telephone: Fax:	100 Hospital Drive Hendersonville, NC 28792 Henderson (828)684-8501 (828)687-0729
Administrator/Director: Title: <u>CEO</u> (Designated agent (individual) re	IIMM BUNCH esponsible to the governing body (owner) for the management of the licensed facility)
Chief Executive Officer:	Jimm Bunch Title: President and CEO sponsible to the governing body (cwner) for the management of the licensed facility)
Name of the person to conta	net for any questions regarding this form:
Name: Colleen Ra	Telephone: (828) 681-2102
E-Mail: <u>colleen.ra</u>	msey@ahss.org
	r Identifier (NPI) registered at NPPES 1427075027 ne "Primary" NPI, please provide
for questions regarding NP	contact Azzie Conlev at (919) 855-4646.

The N.C. Department of Benth and Human Services they are discriminate on the provision of services."

License No: <u>H0019</u> Facility ID: <u>943388</u>

List Name(s) of facilities	s: Add	ress:	Type of Business / Service
See Attached List	ing	WHITE COLUMN TO THE COLUMN TO	
1 			·
ease attach a separate sh	eet for additional listin	gs	
			Manus Comment
vnership Disclosure (Ple	ease fill in anv blanks ar	nd make changes where nec	essarv.)
1	•	ship responsibility and liab	• •
Owner:	Fletcher Hospital, Inc.		
Federal Employer ID#	56-0543246		
Street/Box:	100 Hospital Drive		•
		State: NC Zip: 28	792
CEO:	(828)684-8501 Jimm Bunch	rax; (828)081-0129	
	• •		site emergency departments,
ambulatory surgical fac company or a related en if 'Yes', name of Healti	ilities, nursing homes, h htity?] <u>Yes</u> Ye h System* <u>Advent</u>		wned by your hospital, a paren
ambulatory surgical fac company or a related en if 'Yes', name of Healti	ilities, mursing homes, h tity?] <u>Yes</u> Ye h System* <u>Advent</u> NC facilities that are par	ome health agencies, etc. or esNo ist Health System tof your Health System)	wned by your hospital, a paren
ambulatory surgical fac company or a related en if 'Yes', name of Healti * (please uttach a list of If 'Yes', name of CEO	illities, mursing homes, h httity?] Yes Ye h System* Advent NC facilities that are par Donald Jernig	ome health agencies, etc. or esNo ist Health System tof your Health System)	wned by your hospital, a paren
ambulatory surgical fac company or a related en If 'Yes', name of Healti * (please attach a list of If 'Yes', name of CEO a. Legal entity is:	illities, mursing homes, hatity?] Yes Yes h System* Advent NC facilities that are par Donald Jernig For Profit	ist Health System tof your Health System A. No X. Not For Profit	wned by your hospital, a paren
ambulatory surgical fac company or a related en if 'Yes', name of Healti * (please uttach a list of If 'Yes', name of CEO a. Legal entity is:	illities, mursing homes, h httity?] Yes Ye h System* Advent NC facilities that are par Donald Jernig	ist Health System tof your Health System A. No X. Not For Profit	wned by your hospital, a paren
ambulatory surgical fac company or a related en If 'Yes', name of Health * (please attach a list of If 'Yes', name of CEO a. Legal entity is: b. Legal entity is:	ilities, mursing homes, hatity?] Yes Yes Yes Yes Yes Yes Yes Yes Advent NC facilities that are party For Profit Yes Corporation Proprietorship corporation that (partnership, corporation)	ist Health System tof your Health System A. No X. Not For Profit	Partnership Government Unit
ambulatory surgical fac company or a related en If 'Yes', name of Healti * (please uttach a list of If 'Yes', name of CEO a. Legal entity is: b. Legal entity is: c. Does the above ent	illities, mursing homes, hatity?] Yes Yes h System* Advent NC facilities that are par Donald Jernig For Profit X Corporation Proprietorship hity (partnership, corporation) Yes X No	ist Health System tof your Health System) X Not For Profit LLP LLC	Partnership Government Unit
ambulatory surgical fac company or a related en if 'Yes', name of Healti * (please uttach a list of If 'Yes', name of CEO a. Legal entity is: b. Legal entity is: c. Does the above entare offered? If "YES", name of buil	illities, mursing homes, hatity?] Yes Yes Yes Yes Yes Yes Yes Yes Advent NC facilities that are party Por Profit Yes Yes X No Iding owner:	ist Health System tof your Health System) X Not For Profit LLP LLC	Partnership Government Unit
ambulatory surgical fac company or a related en if 'Yes', name of Health* (please attach a list of if 'Yes', name of CEO a. Legal entity is: b. Legal entity is: c. Does the above entare offered? If "YES", name of build is in the business operated if 'Yes', name and addragme:	illities, nursing homes, hatity?] Yes Yes Yes Yes Yes Yes Yes Yes Advent NC facilities that are participated and Jernig For Profit X Corporation Proprietorship hity (partnership, corporation Yes X No Iding owner:	ist Health System ist Health System i of your Health System) an, PhD X Not For Profit LLP LLC ation, etc.) LEASE the build	Partnership Government Unit
ambulatory surgical fac company or a related en if 'Yes', name of Healti * (please attach a list of if 'Yes', name of CEO a. Legal entity is: b. Legal entity is: c. Does the above entare offered? If "YES", name of builties the business operated if 'Yes', name and additionally and additionally surgical factors.	illities, nursing homes, hatity?] Yes Yes Yes Yes Yes Yes Yes Yes Advent NC facilities that are participated and Jernig For Profit X Corporation Proprietorship hity (partnership, corporation Yes X No Iding owner:	ist Health System ist Health System i of your Health System) an, PhD X Not For Profit LLP LLC ation, etc.) LEASE the build	Partnership Government Unit

License	No:	H0019	
acility	D:	943388	

Ow	ynership Disclosure continued						
3.	Vice President of Nursing and Patient Care Services: Craig Lindsey	-	<u> </u>				
4.	Director of Planning: Jason Wells						
	Facility Data						
A. 201	Reporting Period All responses should pertain to the period October 1, 2010 to September 30, 011.						
B.	General Information (Please fill in any blanks and make changes where i	necessary.)					
	a. Admissions to Licensed Acute Care Beds; include responses to "a - η" on page 4; exclude responses to "2-9" on page 4; and exclude normal newborn bassinets.	2,867	•				
	b. Discharges from Licensed Acute Care Beds: include responses to "a - q" on page 4; exclude responses to "2-9" on page 4; and exclude normal newborn bassinets.	2,866	,				
	6. Average Daily Census: include responses to "a - q" on page 4; exclude responses to "2-9" on page 4; and exclude normal newborn bassinets.	29.9					
	d. Was there a permanent change in the total number of licensed beds during the reporting period?	Yes	No X				
	If 'Yes', what is the current number of licensed heds!		· Jahrynny o vory a sous and a sou				
	If 'Yes', please state reason(s) (such as additions, alterations, or conversions) which may have affected the change in bed complement:		and the same and t				
	e. Observations: Number of patients in observation status and not admitted as inpatients, excluding Emergency Department patients.	638					
C.	Designation and Accreditation	A					
	1. Are you a designated trauma center? Yes (Designated Level	#)	X No				
	2. Are you a critical access hospital (CAH)? Yes X No						
	3. Are you a long term care hospital (LTCH)? Yes X No						
	4. Is this facility TJC accredited? X Yes =X= No Expiration I	Date: <u>June</u>	2012				
	5. Is this facility DNV accredited?YesYNoExpiration I						
	6. Is this facility AOA accredited? <u>x</u> Yes No Expiration I	Date: <u>2013</u>	3				
	7. Are you a Medicare deemed provider? X Yes No		•				

License No: H0019
Facility ID: 943388

D. Beds by Service (Inpatient - Do Not Include Observation Beds or Days of Care) [Please provide a Beds by Service (p. 4) for each hospital campus (see G.S. 131E-176(2c))]

Please indicate below the number of beds usually assigned (set up and staffed for use) to each of the following services and the number of census inpatient days of care rendered in each unit. NOTE: If your facility has a designated unit(s) for chemical dependency treatment and/or detoxification, please complete the patient origin sheet pertaining to Psychiatric and Substance Abuse Services. If your facility has a Nursing Facility unit and/or Adult Care Bed unit please complete the supplemental packet for Skilled Nursing Facility beds.

Licensed Acute Care (provide details below) Campus	Licensed Beds as of September 30, 2011	Staffed Beds as of September 30, 2011	Annual Census Inpt. Days of Care
Intensive Care Units			
1. General Acute Care Beds/Days			
a. Burn *			*
b. Cardiac Combined TCU/CCU/Telemetry	74	14	2,748
c. Cardiovascular Surgery			
d. Medical/Surgical	·		
e. Neonatal Beds Level IV ** (Not Normal Newborn)	,		**
f. Podiatrio			
g. Respiratory Pulmonary			
h. Other (List)			
Other Units			
i. Gynecology	•		
j. Medical/Surgical ***	40	40	*** 6.779
k. Neonatal Level III ** (Not Normal Newborn)			**
Neonatal Level II ** (Not Normal Newborn)			**
m. Obstetric (including LDRP)	8	8	1,441
n. Oncològy			
o. Orthopedics			
p. Pediatric			
q. Other (List)			
Total General Acute Care Beds/Days (a through q)	62	62	10,968
2. Comprehensive In-Patient Rehabilitation	0		
3. Inpatient Hospice	0		
4. Detoxification	. 0		
5. Substance Abuse / Chemical Dependency Treatment	0		
6. Psychiatry	41	36	10,966
7. Nursing Facility	0		
8. Adult Care Home	0		
9. Other	0		
10. Totals (1 through 9)	103	98	21,934

^{*} Please report only Census Days of Care of DRG's 927, 928, 929, 933, 934 and 935.

^{**} Per C.O.N. rule definition, Refer to Section .1400 entitled Neonatal Services. (10A NCAC 14C)

^{***} Exclude Skilled Nursing swing-bed days. (See swing-bed information next page)

License No: <u>H0019</u> Facility ID: <u>943388</u>

	D.	Beds b	v Service	(Inpatient)	continue
--	----	--------	-----------	-------------	----------

Number of Swing Beds *	
Number of Skilled Nursing days in S	Swing Beds
Number of unlicensed observation b	eds

^{*} means a hospital designated as a swing-bed hospital by CMS (Centers for Medicare and Medicaid Services)

Reimbursement Source (For "Inpatient Days," show Acute Inpatient Days only, excluding normal newborns.) E.

Primary Payer Source	Inputient Days . of Care (total should be the same as D.1.ā – q total on p 4)	Emergency Visits (total should be the same as F.3.b. on p. 6)	Outpatient Visits (excluding Emergency Visits and Surgical Cases)	Inpatient Surgical Cases (total should be same as F.8.d. Total Surgical Cases-Inpatient Cases on p. 9)	Ambulatory Surgical Cases (total should be same as F.8.d. Total Surgical Cases-Ambulatory Cases on p. 9)
Self Pay/Indigent/Charity	411	4,860	1,493	30	118
Medicare & Medicare . Managed Care	6,917	4,117	32,997	441	1;925
Medicaid	1,605	5,847	7,889	82	728
Commercial Insurance	129	477	463	11	17
Managed Care	1,906	4,613	22,670	220	1,814
Other (Specify)	•				
TOTAL	10,968	19,914	65,512	784	4,602

F. Services and Facilities

1. Obstetrics	Enter Number of Infants
a. Live births (Vaginal Deliveries)	394
b. Live births (Cesarean Section)	187
c. Stillbirths	1

d. Delivery Rooms - Delivery Only (not Cesarean Section)	0
e. Delivery Rooms - Labor and Delivery, Recovery	4
f. Delivery Rooms - LDRP (include Item "D.1.m" on Page 4)	0
g. Normal newborn bassinets (Level I Neonatal Services)	12
Do not include with totals under the section entitled Beds by Service (Inpatient)	

2.	Abortion Services	Number of procedures per Year	0
£4	Aboi don dei vices	ranifor of procedures per rear	

License	: No:	H00	19
Facility	ID:		

3.	Emergency Departs	nent Services	(case	s equal visits to	ED)				
•	a. Total Number of I	ED Exam Roo	ms:		12		_		
	à.1. #Trauma Rooms	3 0		a.2. #Fast	Track Roon	ns 4	1		
	b. Total Number of ED visits for reporting period: 19,914								
. •									
•	c. Total Number of admits from the ED for reporting period: 1,935								
	d. Total Number of	Urgent Care vi	isits f	or reporting per	iod:	0	The second of th	SECTOR Designation of	
•	e. Does your ED pro If no, specify days/h			ours a day 7 day	s per week?	X 7	Yes No)	
	f. Is a physician on o If no, specify days/h				ays per wee	k? <u>x</u>	Yes No)	
4,	Medical Air Transp	ort: Owned	or lea	sed air ambular	nce service:				
	a. Does the facility of b. If "Yes", complete				Yes	<u>X.</u> No			
ı	Type of Aircraft	Number of Aire	eraft	Number Owned	Number I	eased	Number of Tran	sports	
	Rotary	•							
	Fixed Wing								
5.	a. Blood Bank/Transfusion Services b. Histopathology Laboratory c. HIV Laboratory Testing Number during reporting period HIV Serology HIV Culture d. Organ Bank X Yes No X Yes No Yes X Yes No Yes X Yes No Yes X Yes No Yes X Yes No X Yes No Yes X No								
6. <u>Transplantation Services</u> - Number of transplants									
	Туре	Number		Туре	Number		Туре	Number	
	Marrow-Allogeneic	0		leart/Liver	0	k. Lu	A CONTRACTOR OF THE PARTY OF TH	0	
	Marrow-Autologous			Teart/Kidney	0		ncreas	0	
	Cornea 8 h. Kidney 0 m. Pancreas/Kidney 0								
. Heart		0		idney/Liver	0		ncreas/Liver	0	
. rieart	/Lung	0	<u>j.</u> L	iver	00	o. Ot	her	0	
Do you	Do you perform living donor transplants? Yes X No.								

License No: 140019 Facility ID: 943388

7.	Specialized Cardiac Services	(for questions,	call 855-3865	[Medical Facilities	s Planning])	N/À
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(a)	Cardiac Catheterization	Diagnostic Cardiac Catheterization ICD-9 37.21, 37.22, 37.23, 37.25	Interventional Cardiac Catheterization- ICD-9 00.66, 99.10, 36.06, 36.07, 36.09; 35.52, 35.71, 35.96	Electro-physiology 37.26, 37.27, 37.34, 37.70, 37.71, 37.72, 37.73, 37.74, 37.75, 37.76, 37.77, 37.79, 37.80, 37.81, 37.82, 37.83, 37.85, 37.86, 37.87, 37.89, 37.94, 37.95, 37.96, 37.97, 37.98, 37.99, 00.50, 00.51, 00.52, 00.53, 90.54
1.	Number of Units of Fixed Equipment			
2.	Number of Procedures* Performed in Fixed Units on Patients Age 14 and younger			
3.	Number of Procedures* Performed in Fixed Units on Patients Age 15 and older			
4.	Number of Procedures* Performed in Mobile Units			

*A procedure is defined to be one visit or trip by a patient to a catheterization laboratory for a single or multiple catheterizations. Count each visit once, regardless of the number of diagnostic, interventional, and/or EP catheterizations performed within that visit.

Name of Mobile Vendor:	
Number of 8-hour days per week the mobile unit is onsite:	8-hour days per week.
(Examples: Monday through Friday for 8 hours per day is 5 8-hour days per v	week. Monday, Wednesday, & Friday for 4
hours per day is 1.5 8-hour days per week)	

(b)	Open Heart Surgery	Number of Machines/Procedures
1.	Number of Heart-Lung Bypass Machines	
2.	Total Annual Number of Open Heart Surgery Procedures Utilizing Heart-Lung Bypass Machine	
3.	Total Annual Number of Open Heart Surgery Procedures done without utilizing a Heart-Lung Bypass Machine	
4.	Total Open Heart Surgery Procedures (2. + 3.)	
	Procedures on Patients Age 14 and younger	
5.	Of rotal in #2, Number of Procedures on Patients Age 14 & younger	
6.	Of total in #3, Number of Procedures on Patients Age 14 & younger	

Non-Surgio	cal Cases and Procedures		A
	nis License includes more than one campus, please cop Totals and submit a duplicate of pages 8 and 9 <u>for eac</u>		h site. Submit the
(Campus - If m	ultiple sites:		
Report <u>Surgice</u> Construction	perating Rooms al Operating Rooms built to meet the specifications and state Section of the Division of Health Services Regulation, and where surgical operating rooms include rooms located in Observations.	which are fully equipped to	perform surgical
	Type of Room	Number of Rooms	
	Dedicated Open Heart Surgery	O	
•	Dedicated C-Section	1	
	Other Dedicated Inpatient Surgery	0	
	Dedicated Ambulatory Surgery	0	
	Shared - Inpatient / Ambulatory Surgery	- i	•

8. Surgical Operating Rooms, Procedure Rooms, Gastrointestinal Endoscopy Rooms, Surgical and

	Number of additional CON approved surgical operating rooms pending development:0
	CON Project ID Number(s)
·b)	Procedure Rooms (Excluding Operating Rooms and Gastrointestinal Endoscopy Rooms) Report rooms, which are not equipped for or do not meet all the specifications for an operating room, that are used for performance of procedures other than Gastrointestinal Endoscopy procedures. Total Number of Procedure Rooms: 0.
e)	Gastrointestinal Endoscopy Rooms, Cases and Procedures: Report the number of Gastrointestinal Endoscopy rooms and the Endoscopy cases and procedures performed in these rooms during the reporting period.
	Total Number of existing Gastrointestinal Endoscopy Rooms:
	Number of additional COIV approved GI Endoscopy Rooms pending development: 0
	CON Project ID Number(s).

Total of Surgical Operating Rooms

		Number of Cases		Number of Prece	xlures*
		Inpatient	Outpatient	Inpatient ·	Outpatient
GI Endoscopy	,	148 : .	460		
Nen-GI Endoscopy .		•			
Totals		148	460		

Count cach patient as one case regardless of the number of procedures performed while the patient was in the GI endoscopy room.

^{*}As defined in 10A NCAC 14C .3901 "Gastrointestinal (GI) endoscopy procedure" means a single procedure, identified by CPT code or ICD-9-CM procedure code, performed on a patient during a single visit to the facility for diagnostic or therapeutic purposes.

License No: H0019
Facility ID: 943388

8.	Surgical Operating Rooms, Procedure Rooms, Gastrointestinal En	idoscopy Rooms,	Surgical and Non-
	Surgical Cases and Procedures (continued)		

						, -
	(A) T/	multiple sites:	•	· ·	•	,
ı		multine sites:				1
٦	CHERRY AT	111 Charleton DEPON				

d) Surgical Cases by Specialty Area Table

Enter the number of surgical cases by surgical specialty area in the table below. Count each patient undergoing surgery as one case regardless of the number of surgical procedures performed while the patient was having surgery. Categorize each case into one specialty area — the total number of surgical cases is an unduplicated count of surgical cases. Count all surgical cases, including surgical cases operated on in procedure rooms or in any other location.

. Surgical Specialty Area	Inpatient Cases	Ambulatory Cases
Cardiothoracic (excluding Open Heart Surgery)	12	26
Open Heart Surgery (from 7.(b) 4.)	0	
General Surgery	178	472
Neurosurgery	36	
Obstetrics and GYN (excluding C-Sections)	61_	411
Ophthalmology	1	928
Oral Surgery	1	46
Orthopedics	365	1,297
Otolaryngology	16	652 .
Plastic Surgery	3	113.
Urology	36 .	488
Vascular	4	5
Other Surgeries (specify) ECT	. 63	49
Other Surgeries (specify)		
Number of C-Section's Performed in Dedicated C-Section ORs		
Number of C-Section's Performed in Other ORs		2.77
Total Surgical Cases	776	4,487

e) Non-Surgical Cases by Category Table

Enter the number of non-surgical cases by category in the table below. Count each patient undergoing a procedure or procedures as one case regardless of the number of non-surgical procedures performed. Categorize each case into one non-surgical category—the total number of non-surgical cases is an unduplicated count of non-surgical cases. Count all non-surgical cases, including cases receiving services in operating rooms or in any other location, except do not count cases having endoscopies in Gi Endoscopy rooms. Report cases having endoscopies in Gi Endoscopy Rooms on page 8.

Non-Surgical Category	Inpatient Cases	Ambulatory Cases
Pain Management	6	126
Cystoscopy		
Non-GI Endoscopies (not reported in 8. c)		
GI Endoscopies (not reported in 8. c)		
YAG Laser		
Other (specify)		
Other (specify)		
Other (specify)		
Total Non-Surgical Cases		

Revised 08/2011

License No: H0019 Facility ID: 943388

9. Average Operating Room Availability and Average Case Times:

The Operating Room Methodology assumes that the average operating room is staffed 9 hours a day, for 260 days per year, and utilized at least 80% of the available time. This results in 1,872 hours per operating room per year.

The Operating Room Methodology also assumes an average of 3 hours for each Inpatient Surgery and an average of 1.5 hours for each Outpatient Surgery.

Based on your hospital's experience, please complete the table below by showing the assumptions for the average operating room in your hospital.

Average Hours per Day Routinely Scheduled for Use *	Average Number of "Days per Year Routinely Scheduled for Use.	Average "Case Time" ** in Minut es for Inpatient Cases	Average "Case Time" ** in Minutes for Ambulatory Cases
9	 260	150	89

^{*} Use only Hours per Day routinely scheduled when determining the answer.

Example for determining average hours per day routinely scheduled for use:

A hospital has two operating rooms routinely scheduled for use for 8 hours per day, and two other operating rooms routinely scheduled for use for 10 hours per day.

2 rooms X 8 hours = 16 hours per day

plus

2 rooms X 10 hours = 20 hours per day

equals 36 hours per day total

The average hours per day for the four operating rooms is calculated by dividing the total hours per day for all operating rooms by the total number of operating rooms. In this example, 36 hours divided by four operating rooms is 9 average hours per day for an operating room.

** "Case Time" = Time from Room Set-up Start to Room Clean-up Finish. Definition 2.4 from the "Procedural Times Glossary" of the AACD, as approved by ASA, ACS, and AORN. <u>NOTE</u>: This definition includes all of the time for which a given procedure requires an OR/PR. It allows for the different duration of Room Set-up and Room Clean-up Times that occur because of the varying supply and equipment needs for a particular procedure.

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10a. Magnetic Resonance Imaging (MRI)

Indicate the number of scanners (units) and the number of procedures performed during the 12-month reporting period at your facility. For hospitals that operate medical equipment at multiple sites/campuses, please copy the MRI pages and provide separate data for each site/campus. Campus – if multiple sites:

Number of fixed MRI	#Units	-						
scanners-closed (do not include any Policy AC-3 scanners)	1	Inpat	ient Proced	ures*	Outpa	atient Proce	×dures*	
# of fixed MRI scanners- open (do not include any Policy AC-3 scanners)		With	Without		With	Without		
Number of Policy AC-3 MRI scanners used for general clinical purposes		Contrast or Sedation	Contrast or Sedation	TOTAL Inpatient	Contrast or Sedation	Contrast or Sedation	TOTAL Outpatient	TOTAL Procedures
Total Fixed MRI Scanners/Procedures	1	109	253	362	617	1,439	2,056	2,418
Procedures performed of MRI scanners only a	·o	0	0	93	824	917	917	
Name(s) of Mobile MRI P	rovider(s)							
The total number of proceed number of patients reporte listed in the next two rows:	d on the M	RI Patient	Origin Tabl	e on page 25	of this app	lication. Pa	tients served	on units
Policy AC-3 scanners used for dedicated or non-clinical purposes		-		٠				
Other Human Research MRI scanners								

^{*} An MRI procedure is defined as a single discrete MRI study of one patient (single CPT coded procedure). An MRI study means one or more scans relative to a single diagnosis or symptom.

10b. MRI Procedures by CPT Codes

CPT Code	CPT Description	Number of Procedures
70336	MRI Temporomandibular Joint(s)	2 ·
70540	MRI Orbit/Face/Neck w/o	0
70542	MRI Orbit/Face/Neck with contrast	0
70543	MRI Orbit/Face/Neck w/o & with	20
. 70544	MRA Head w/o	53
70545	MRA Head with contrast	0
70546	MRA Head w/o & with	0
70547	MRA Neck w/o	Ò.
70548	MRA Neck with contrast	0
70549	MRA Neck w/o & with	· 21_
70551	MRI Brain w/o	219
70552	MRI Brain with contrast	00
	Subtotal for this page	315

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10b. MRI Procedures by CPT Codes continued. . . .

CPT Code	CPT Description	Number of Procedures
70553	MRI Brain w/o & with	422
7055A	1AC Screening	0
71550	MRI Chest w/o	0
71551	MRI Chest with contrast	0
71552	MRI Chest w/o & with	4
71555	MRA Chest with OR without contrast	Q
72126	Cervical Spine Infusion only	0
72141	MRI Cervical Spine w/o	342
72142	MRI Cervical Spine with contrast	4
72156	MRI Cervical Spine w/o & with	50
72146	MRI Thoracic Spine w/o	77
72147	MRI Thoracic Spine with contrast	0
72157	MRI Thoracic Spine w/o & with	. 14
72148	MRI Lumbar Spine w/o	560
72149	MRI Lumbar Spine with contrast	1
72158	MRI Lumbar Spine w/o & with	156
72159	MRA Spinal Canal w/o OR with contrast	0
72195	MRI Pelvis w/o	44
72196	MRI Pelvis with contrast	. 0
72197	MRI Pelvis w/o & with	14
72198	MRA Pelvis w/o OR with Contrast	0
73218	MRI Upper Ext, other than joint w/o	11
73219	MRI Upper Ext, other than joint with contrast	0
73220	MRI Upper Ext, other than joint w/o & with	5
73221	MRI Upper Ext, any joint w/o	361
73222	MRI Upper Ext, any joint with contrast	65
73223	MRI Upper Ext, any joint w/o & with	. 9
73225	MRA Upper Ext. w/o OR with contrast	0
73718	MRI Lower Ext other than joint w/o	73
73719	MRI Lower Ext other than joint with contrast	1
73720	MRI Lower Ext other than joint w/o & with	31
73721	MRI Lower Ext any joint w/o	643
73722	MRI Lower Ext any joint with contrast	6
73723	MRI Lower Ext any joint w/o & with	23
73725	MRA Lower Ext w/o OR with contrast	0
74181	MRI Abdomen w/o	. 37
74182	MRI Abdoinen with contrast	0
	Subtotal for this page	

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10b.	MRI	Procedures	by	CPT	Codes	continued	4 -

CPT Code	CPT Description	Number of Procedures
74183	MRI Abdomen w/o & with	22
74185	MRA Abdomen w/o OR with contrast	9
75552	MRI Cardiac Morphology w/o	0
75553	MRI Cardiac Morphology with contrast	0
75554	MRI Cardiac Function Complete	. 0
75\$55 ·	MRI Cardiac Function Limited	. 0
75556	MRI Cardiac Velocity Flow Mapping	0
76093	MR! Breast, unilateral w/o and/or with contrast	2
76094	MRI Breast, bilateral w/o and/or with contrast	34
76125	Cineradiography to complement exam	0
76390	MRI Spectroscopy	0
76393	MRI Guidance for needle placement	. 0
76394	MRI Guidance for tissue abiation	0
76400	MRI Bone Marrow blood supply	0
7649A	MR functional imaging	0
7649D	MFU infant spine comp w/ & w/o contrast	. 0
7649E	Spine (infants) w/o infusion	0
7649H	MR functional imaging	: 0
N/A	Clinical Research Scans	. 0
	Subtotal for this page	67
	Total Number of Procedures for all pages	3,335

100	Commutad	Tomograp	her (CT)
B 4 14".	W BESERVERS NAME OF STREET	B 4 5 7 5 8 8 8 9 8 7 8 8 8 9	81 V 19 X 1

How many fixed CT scanners does the	hospitai have?	2	
Does the hospital contract for mobile C	•	Yes	X No
If yes, identify the mobile CT vendor	N/A	•	

Complete the following tables (one for fixed CT scanners; one for mobile CT scanners).

Scans Performed on Fixed CT Scanners (Multiply # scans by Conversion Factor to get HECT Units)

	Type of CT Scan	# of Scans		Conversion Factor		HECT Units
1	Head without contrast	2 803	X	. 1.00	==	2,803.0
2	Head with contrast	17	X	1.25	=	21.25
3	Head without and with contrast	101	X	1.75	=	176,75
4	Body without contrast	2,223	X	1.50	=	3,334.5
5	Body with contrast	3,456	X	1.75	=	6,048.0
6	Body without contrast and with contrast	955	X	2.75	=	2,626.2
7	Biopsy in addition to body scan with or without contrast	44	Х	2,75	=	121.0
8	Abscess drainage in addition to body scan with or without contrast	11	X	4.00	=	44.0

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Scans Performed on Mobile CT Scanners (Multiply # scans by Conversion Factor to get HECT Units)

						-11202 011110/
	Type of CT Scan	# of Scans		Conversion Factor		HECT Units
1	Head without contrast		X	1.00	=	,
. 2	Head with contrast		Х	. 1.25	=	
3	Head without and with contrast		X	1.75	=	
4	Body without contrast		X	1.50	=	
5	Body with contrast		X	1.75	=	
6	Body without contrast and with contrast		X	2.75	=	
7	Biopsy in addition to body scan with or without contrast	Self	Х	2.75	=	
8	Abscess drainage in addition to body scan with or without contrast		X	4.00	=	

10d. Other Imaging Equipment

	Number of	Numt	er of Procedur	eş
	Units	Inpatient	Outpatient	Total
Dedicated Fixed PET Scanner	0			
Mobile PET Scanner	1		155	155
PET pursuant to Policy AC-3	0			
Other Human Research PET Scanner	0			
Ultrasound equipment	. 3	884	3.906	4.790
Mammography equipment	2	0	8,243	8,243
Bone Density Equipment	2		946	946
Fixed X-ray Equipment (excluding fluoroscopic)	2	3,653	17,854	21,507
Fixed Fluoroscopic X-ray Equipment	2	468	1,106	1,574
Special Procedures/ Angiography Equipment (neuro & vascular, but not including cardiac cath.)	0			
Coincidence Camera	0		•	
Mobile Coincidence Camera Vendor:				·
SPECT	1	224	151	375
Mobile SPECT Vendor:	. 0			
Gamma Camera	1	165	383	548
Mobile Gamma Camera Vendor:	0			

^{*}PET procedure means a single discrete study of one patient involving one or more PET scans. PET scan means an image-scanning sequence derived from a single administration of a PET radiopharmaceutical, equated with a single injection of the tracer. One or more PET scans comprise a PET procedure. The number of PET procedures in this table should match the number of patients reported on the PET Patient Origin Table on page 27.

10e. Lithotripsy

	Number of	Nut	nber of Procedu	res
	Units	Inpatient	Outpatient	Total
Fixed]	
Mobile	1		1	

Lithotripsy Vendor/Owner:
Healthtronics

11. Linear Accelerator Treatment Data (including Cyberknife® & Similar Equipment) N/

CPT Code	Description	# of Procedures
Simple Tre	atment Delivery	
77401	Radiation treatment delivery	
77402	Radiation treatment delivery (<=5 MeV)	
77403	Radiation treatment delivery (6-10 MeV)	
77404	Radiation treatment delivery (11-i9 MeV)	
77406	Radiation treatment delivery (>=20 MeV)	
Intermedia	te Treatment Delivery .	
77407	Radiation treatment delivery (<=5 MeV)	
77408	Radiation treatment delivery (6-10 MeV)	
77409	Radiation treatment delivery (11-19 MeV)	
77411	Radiation treatment delivery (>=20 MeV)	***************************************
Complex 'l	reatment Delivery	
77412	Radiation treatment delivery (<=5 MeV)	
77412 ·	Radiation treatment delivery (6-10 MeV)	
77414 .	Radiation treatment delivery (11-19 MeV)	· · · · · · · · · · · · · · · · · · ·
77416	Radiation treatment delivery (>= 20 MeV)	
	ttment Delivery Not Included Above	
	Intensity modulated radiation treatment (IMRT) delivery	
77418	Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course	
77372	of treatment of cranial lesion(s) consisting of 1 session; linear accelerator	
77373	Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or	
	more lesions, including image guidance, entire course not to exceed 5 fractions	
G0339	(Image-guided) robotic linear accelerator-based stereotactic radiosurgery in	
,,	one session or first fraction	
G0340	(Image-guided) robotic linear accelerator-based stereotactic radiosurgery,	
	fractionated treatment, 2nd-5th fraction	
	Intraoperative radiation therapy (conducted by bringing the anesthetized	
	patient down to the linac)	,
	Pediatric Patient under anesthesia	
	Neutron and proton radiation therapy	
	Limb salvage irradiation	
	Hemibody irradiation	
	Total body irradiation	ļ
Imaging P	rocedures Not Included Above	
77417	Additional field check radiographs	
•	Total Procedures - Linear Accelerators	
Gamma K	nife® Procedures	
77371	Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course	
	of treatment of cranial lesion(s) consisting of one session; multisource Cobalt 60 based (Gamma Knife®)	
	The I Proposition of Contract Contract	1

11. Linear Accelerator Treatment Data continued

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a. Number of <u>patients</u> who received a course of radiation oncology treatments on linear accelerators (not the Gamma Knife®). Patients shall be counted once if they receive one course of treatment and more if they receive
additional courses of treatment. For example, one patient who receives one course of treatment counts as one, and
one patient who receives three courses of treatment counts as three.
Patients (This number should match the number of patients reported in the Linear Accelerator
Patient Origin Table on page 26.)
b. Total number of Linear Accelerator(s)
c. Number of Linear Accelerators configured for stereotactic radiosurgery
d. Number of simulators ("machine that produces high quality diagnostic radiographs and precisely reproduces the
geometric relationships of megavoltage radiation therapy equipment to the patient."(GS 131B-176(24b)))
e. Number of CyberKnife® Systems:, Gamma Knife®
Other specialized Linear Accelerators
Identify Manufacturer of Equipment
12. Telemedicine
a: Does your facility utilize telemedicine to have images read at another facility? Yes
b. Does your facility read telemedicine images? No
13. Additional Services:

	Check		Check
1. Cardiac Rehab Program		5. Rehabilitation Outpatient Unit	
(Outpatient)	X		X
2. Chemotherapy	X	6. Podiatric Services	X
3. Clinical Psychology Services		7. Genetic Counseling Service	
4. Dental Services		8. Number of Acute Dialysis Stations	

b) Hospice Inpatient Unit Data:

Hospital-based hospice units with licensed hospice beds. List each county served and report all patients by county of residence. Use each patient's age on the admission day to the Licensed Hospice Inpatient Facility. For age categories count each inpatient client only once.

County of Residence	Age 0-17	Age 18-40	Age 41-59	Age 60-64	Age 65-74	Age 75-84	Age 85+	Total Patients Served	Total Days of Care	Deaths
	1.	<u> </u>								
					<u> </u>					
		<u> </u>			<u>i</u>					
					<u> </u>				•	
Out of State										
Total All	T	1	1		Ţ	1		[::		T
Ages	· · ·	1		i			ł	1	I	

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13. Additional Services: continued

c) Mental Health and Substance Abuse

1. If psychiatric care has a different name than the hospital, please indicate:

Hope Behavioral Health Services

2. If address is different than the hospital, please indicate:

3. Director of the above services.

Sandra Page, RN, Director of Behavioral Health Services

Dr. Philip Lartey, Medical Director

Indicate the program/unit location in the <u>Service Categories</u> chart below. If it is in the hospital, include the room number. If it is located at another site, include the building name, program/unit name and address.

<u>Service Categories:</u> All applicants must complete the following table for all mental health services which are to be provided by the facility. If the service is not offered, leave the spaces blank.

Rule 10A NCAC 27G Licensure Rules For Mental Health Facilities	Location of Services	Bec	Beds Assigned by Age					
		0-12	13-17	Subtotal 0-17	18 & up	Total Beds		
.1100 Partial hospitalization for individuals who are acutely mentally ill.	PRH PHP/TOP			 .				
.1200 Psychosocial rehabilitation facilities for individuals with severe and persistent mental illness	N/A_	,						
1300 Residential treatment facilities for children and adolescents who are emotionally disturbed or have a mental illness	n/a							
.1400 Day treatment for children and adolescents with emotional or behavioral disturbances	N/A							
.1500 Intensive residential treatment facilities for children & adolescents who are emotionally disturbed or who have a mental illness	n/a	-		,				
.5000 Facility Based Crisis Center	N/A							

Rule 10A NCAC 13B Licensure Rules For Hospitals	Location of Services	Beo	ds Assig	ned by A	\ge 18 & up	Total Beds
5200 Dedicated inpatient unit for individuals who have mental disorders	Park Ridge Health				х	36

All responses should pertain to October 1, 2010 through September 30, 2011.

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13. Additional Services: continued

c) Mental Health and Substance Abuse continued

Rule 10A NCAC 27G Licensure Rules for Substance Abuse Facilities	Location of Services	Bec	Beds Assigned by Age					
		0-12	13-17	Subtotal 0-17	18 & ap	Total Beds		
.3100 Nonhospital medical detoxification for individuals who are substance abusers	»» N/A				·			
.3200 Social setting detoxification for substance abusers	N/A							
.3300 Outpatient detoxification for substance abusers	N/A							
.3400 Residential treatment/ rehabilitation for individuals with substance abuse disorders	N/A							
3500 Outpatient facilities for individuals with substance abuse disorders	n/a							
3600 Outpatient narcotic addiction treatment .3700 Day treatment facilities for individuals with	A\n		- Service					
substance abuse disorders	N/A					<u> </u>		
Rule 10A NCAC 13B Licensure Rules	Location of	Be	ds Assig	ened by	Age			
For Hospitals	Services	0-12	13-17	Subtotal	18 & up	Toval Be		

Rule 10A NCAC 13B Licensure Rules	Location of	Be	Beds Assigned by Age					
For Hospitals	Services	0-12	L3-17	Subtotal 0-17.	18 & up	Total Beds		
.5200 Dedicated inpatient hospital unit for individuals who have substance abuse disorders	•							
(specify type) # of Treatment beds	N/A	j						
# of Medical Detox beds		•	:					

All responses should pertain to October 1, 2010 through September 30, 2011.

Patient Origin - General Acute Care Inpatient Services

Facility County: Henderson

In an effort to document patterns of utilization of General Acute Care Inpatient Services in North Carolina hospitals, please provide the county of residence for each patient admitted to your facility.

County	No. of	County	No. of	County	No. of
,	Admissions		Admissions		Admissions
I. Alamanec	2.	37. Gates		73. Person	
2. Alexander		38. Graham	1	74. Pitt	
3. Alleghany	11	39. Granville		75. Polk	
4. Anson		40. Greene		76. Randolph	
5. Ashe		41. Guilford	11	77. Richmond	
6. Avery	2	42. Halifax		78. Roboson	
7. Beaufort		43. Harnott		79. Rockingham	
8. Bertie		44. Haywood	47	80. Rowan	
9. Bladen		45. Henderson	1,890	81. Rutherford	28
10, Brunswick	· _	46. Hertford		82. Sampson	
11. Buncombe	498	47. Hoke		83. Scotland	
12. Burke	6	48. Hyde		84. Stanly	
13. Cabarrus	2 '	49. lredell		85. Stokes	
14. Caldwell	}	50. Jackson		86. Surry	
15. Carnden		51. Johnston	}	87. Swain	6
16, Carteret	-	52. Jones		88. Transylvania	117
17. Caswell	İ	53. Lcc		89. Tyrrell	
18. Catawba		54. Lenoir	·	90. Union	1
19, Chatham		55. Lincoln		91. Vance	
20. Cherokee	\	56. Macon	5	92. Wake	2
21. Chowan	<u> </u>	57. Madison		93. Warren	
22. Clay	İ	58. Martin		94, Washington	
23. Cleveland	3	59. McDowell	11	95. Watauga	_2
24. Columbus	1	60. Mecklenburg	3	96. Wayne	
25. Craven		61. Mitchell	1	97. Wilkes	
26. Cumberland		62. Montgomery		98. Wilson	•
27. Currituck		63. Moore		99. Yadkin	1
28. Dare		64. Nash		100. Yancey	5
29. Davidson	<u> </u>	65. New Hanover			
30. Davio	1	66. Northampton		101. Georgia	
31. Duplin	1	67. Onslow		102. South Carolina	
32. Durham		68. Orange		103. Tennessee	
33. Edgecombe	1	69. Pamlico		104. Virginia	
34. Forsyth	2	70. Pasquotank		105, Other States	230
35. Franklin		71. Pender		106. Other	
36. Gaston		72. Perquimans		Total No. of Patients	2,867

Patient Origin - Inpatient Surgical Cases

Facility County: Henderson

In an effort to document patterns of Inpatient utilization of Surgical Services in North Carolina hospitals, please provide the county of residence for each inpatient surgical patient served in your facility. Count each inpatient surgical patient once regardless of the number of surgical procedures performed while the patient was having surgery. However, each admission as an inpatient surgical case should be reported separately.

The Total from this chart should match the Total Inpatient Cases reported on the "Surgical Cases by Specialty Area" Table on page 9.

County	No. of Patients		No. of Patients	County	No. of Patients
I. Alamance	1	37. Gates		73. Person	
2. Alexander	٠	38. Graham	1	74. Pitt	
3. Alleghany		39. Granville		75. Polk	2.0
4. Anson		40. Стеепе		76. Randolph	7137
5. Ashe	•	41. Guiiford	1	77. Richmond	, , , , , , , , , , , , , , , , , , ,
6. Avery	. 3	42. Halifax		78. Robeson	
7. Beaufort		43. Hamen		79. Rockingham	
8. Bertie		44. Haywood	44	80. Rowan	
9. Bladen		45. Henderson	391	81. Rutherford	3
10. Brunswick	ı	46. Hertford		82. Sampson	
11. Buncombe	176	47. Hoke		83. Scotland	
12. Burkç	4	48. Hyde		84. Stanly	
13. Cabarrus	10	49. Iredell		85. Stokes	
14. Caldwell		50. Jackson	7	36. Surry	
15. Camden		51. Johnston		87. Swain	3
16. Carteret		52. Jones		88. Transylvania	29
17. Caswell		53. Lee		89: Tyrrell	
18. Catawba		54. Lenoir		90. Union	
19. Chatham		55, Lincoln	1	91. Vance	
20. Cherokee	1	56. Macon	7	92. Wake	1
21. Chowan .		57. Madison	4	93. Warren	
22. Ciay		58. Martin	25	94. Washington	
23. Cleveland	1	59. McDowell		95. Watauga	2
24. Columbus	•	60. Mecklenburg		96. Wayne	
25. Craven		61. Mitchell	1	97. Wilkes	
26. Cumberland		62. Montgomery.	1	98. Wilson	
27. Currituck		63. Moore		99. Yadkin	1
28. Dare		64. Nash		100. Yancey	4
29. Davidson		65, New Hanover			
30. Davie	1	66. Northampton		101. Georgia	
31, Duplin		67. Onslow		102, South Carolina	
32. Durham		68, Orange		103. Tennessee	
33. Edgecombe		69. Pamlico		104. Virginia	
34. Forsyth		70. Pasquotank		105. Other States	
35. Franklin		71. Pender		106, Other	33
36. Gaston		72. Perquimans		Total No. of Patients	776

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Patient Origin - Ambulatory Surgical Cases

Facility County: Henderson

In an effort to document patterns of Ambulatory utilization of Surgical Services in North Carolina hospitals, please provide the county of residence for each ambulatory surgery patient served in your facility. Count each ambulatory patient once regardless of the number of procedures performed while the patient was having surgery. However, each admission as an ambulatory surgery case should be reported separately.

The Total from this chart should match the Total Ambulatory Surgical Cases reported on the "Surgical Cases by Specialty Area" Table on page 9.

County	No. of Patients	County	No. of Patients	County	No. of Patients
1. Alamance		37. Gates		73. Person	
2. Alexander	2	38. Graham	1 -10-	74. Pitt	
3. Alleghany		39. Granville		75. Polk	159
4. Anson		40. Greene		76. Randolph	
5. Ashe		41. Guilford	1	77. Richmond	
6. Avery	3	42, Halifax		78. Robeson	
7. Beaufort		43. Harnett		79. Rockingham	
8. Bertie		44. Haywood	216	80. Rowan	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
9. Bladen		45, Henderson	2.541	81. Rutherford	37
10. Brunswick		46. Hertford		82. Sampson	
11. Bancombe	921	47. Hoke	·	83. Scotland	
12. Burke	16	48. Hyde		84. Stanly	
13. Cabarrus	1	49. Iredell		85. Stokes	
14. Caldwell	4	50. Jackson	58	86. Surry	
15. Camden		51. Johnston		87. Swain	21
16. Carteret		52. Jones		88. Transylvania	190
17. Caswell		53. Lee		89. Tyrrell	
18. Carawba	2	54. Lenoir		90. Union	2
19. Chatham		55. Lincoln		91. Vance	
20. Cherokee	13	56. Macon	53	92. Wake	1
21. Chowan		57. Madison	44	93. Warren	
22, Clay	2	58. Martin	49	94. Washington	
23. Cleveland	4	59. McDowell		95. Watauga	
24. Columbus		60. Mecklenburg	1	96. Wayne	
25. Craven	,	61. Mitchell	21	97. Wilkes	
26. Cumberland	1 .	62. Montgomery		98. Wilson	
27. Currituck		63. Moore		99, Yadkin	
28. Dare		64. Nash		100. Yancey	35
29. Davidson		65. New Hanover			
30. Davie		66. Northampton		101, Georgia	
31. Duplin		67. Onslow		102. South Carolina	
32. Durham		68. Orange		103. Tennessee	
33. Edgecombe		69. Pamlico		104. Virginia	{
34. Forsyth	2	70. Pasquotank		105. Other States	
35. Franklin		71. Pender	1	106. Other	76
36. Gaston		72. Perquimans		Total No. of Patients	4.487

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Patient Origin - Gastrointestinal Endoscopy (GI) Cases

Facility County: Henderson

In an effort to document patterns of utilization of Gastrointestinal Endoscopy Services in North Carolina hospitals, please provide the county of residence for each GI Endoscopy patient served in your facility. Count each patient once regardless of the number of procedures performed while the patient was receiving GI Endoscopy Services. However, each admission for GI Endoscopy services should be reported separately.

The Total from this chart should match the Total GI Endoscopy cases reported on the "Gastrointestinal Endoscopy Rooms, Cases and Procedures" Table on page 8 plus the total Inpatient and Ambulatory GI Endoscopy cases from the "Non-Surgical Cases by Category" Table on page 9.

County	No. of Patients		No. of Patients		No. of Patients
1. Alamance		37. Gates		73. Person	
2. Alexander		38. Graham		74. Pitt	
3. Alleghany		39. Granville		75. Polk	19
4. Anson		40. Greens		76. Randolph	
5. Ashe	2	41. Guilford		77. Richmond	
6. Avery		42. Halifax		78. Robeson	
7. Beaufort		43. Harnett		79. Rockingham	
8. Bertie		44. Haywood	7	80. Rowan	
9. Bladen		45. Henderson	438	81. Rutherford	5
10. Brunswick		46. Hertford		82. Sampson	
11. Buncombe	99	47. Hoke		83. Scotland	
12. Burke		48. Hyde		84. Stanly	
13. Cabarrus		49. Iredell		85. Stokes	
14. Caldwell		50. Jackson	1	86. Surry	
15. Camden		51. Johnston		87. Swain	
16. Carteret		52. Jones	:	88. Transylvania	23
17. Caswell		53. Lee		89. Tyrreli	
18. Catawba		54. Lenoir		90. Union	
19. Chatham		55. Lincoln		91. Vance	
20. Cherokee		56. Macon	1	92. Wake	
21. Chowan		57. Madison	1	93. Warren	
22, Clay		58. Martin	3	94. Washington	
23. Cleveland	1 1	59. McDowell		95. Watauga	
24. Columbus		60. Mecklenburg		96. Wayne	
25. Craven		61. Mitchell		97. Wilkes	
26. Cumberland		62. Montgomery		98. Wilson	
27. Currituck		63. Moore		99. Yadkin	
28. Dare		64. Nash		100. Yancey	
29. Davidson		65. New Hanover			
30. Davie		66. Northampton		101. Georgia	
31. Duplin		67. Onslow		102. South Carolina	
32. Durham		68. Orange		103. Tennessee	J
33. Edgecombe		69. Pamlico		104. Virginia	
34. Forsyth		70. Pasquotank		105. Other States	
35. Franklin		71. Pender		106. Other	. 7
36. Gaston	1 1	72. Perquimans		Total No. of Patients	608

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Patient Origin - Psychiatric and Substance Abuse Alamance through Johnston

Facility County: Henderson

Complete the following table below for inpatient Days of Care reported under Section .5200.

County of Patient Origin	1	hiatric Treatme Days of Care	1		nce Abuse Trea Days of Care	<u> </u>	Day	xification s of Care	
	Age 0-17	Age 18+	Totals	Age 0-17	Age 18+	Totals	Age 5-17	Age 18+	Totals
Alamance									
Alexander		1							1
Alleghany		2	2				·		
Anson		3	3						1
Ashe		6	6				***************************************		
Avery	 	5	6 5		1				!
Beaufort.						1			†
Bertie	 					1			1
Bladen	1	 			<u> </u>	1	A CONTRACTOR DESCRIPTION OF THE PARTY OF THE		1
Brunswick	1					 			
Buncombe	 	302	302		 	1			
Burke	 	28	28		 	1			
Cabarrus	╢───					1	· · · · · · · · · · · · · · · · · · ·		
Caldwell	 	 	8	<u> </u>	 	 			
Canden Canden	1	}	 		 	 			
Carterer	-	 	 		 	1		 	
		 	 	· · · · · ·	}	 		 	
Caswell		1	2	ļ	-	 	,		
Catawba		1-2-		<u> </u>		1			
Chatham	-	 	1 1			 	· .		
Cherokee	↓	9	9			ļ		ļ	
Chowan	.j	<u> </u>	ļ		- 	<u> </u>		<u> </u>	
Clay		3	3		<u> </u>				_
Cleveland	<u> </u>	1.9	19						
Columbus		}	<u> </u>	 	<u> </u>			<u> </u>	
Craven	·	1	<u> </u>			<u> </u>		1	
Cumbertand			<u> </u>	<u> </u>			ļ	\	
Currituck	1	1		ļ					
Dare		<u> </u>							
Davidson			<u> </u>	1	1	<u> </u>			1
Davic					<u> </u>	<u> </u>			
Duplin		,							
Durham	.)	1_1_	11_	1					
Edgcoombe				1					
Forsyth				J					
Franklin]					
Gaston		7	7						
Gates									
Graham		15	1.5						
Granville									
Greene					1				
Guilford		3	3			!			
Halifax				}]	
Harnett									T
Haywood	1	6.9	69	1			1	1	
Henderson		314	314	1	, , , , , , , , , , , , , , , , , , ,				
Henford			1	1					
Hoke		<u> </u>	1	1	<u> </u>		1	T	
Hydo	1		T	1	7	T			T
Irodell	1	1 1	1 7	1	·	1	 		
Jackson	1	20	$\frac{4}{20}$	1		1			
Johnston		 	1- 	1		1			

** Note: See counties; Jones through Yancey (including Out-of-State) on next page.

Patient Origin - Psychiatric and Substance Abuse Jones through Yancey (including Out-of-State)

Facility County: Henderson

(Continued from previous mage)

County of Patient Origin	Psyc	hiatric Treatm Days of Care	ent	• .	nce Abuse Treat Days of Care	tment		Detoxification : Days of Care			
	Age 0-17	Age 184	Totals	Age 0-17	Age 18+	Totals	Age 0-17	Age 18+	Totals		
Jones							,	1	1		
Lee		1	1			T :			1		
Lenoir						1	•	1			
Lincoln								1			
Macon		23	23 34						 		
Madison	.f	34	34	1997	1 .		· · · · · · · · · · · · · · · · · · ·	1			
Martin		17	17						1		
McDowell											
Mecklenburg		7	7	,	1			i	 		
Mitchell		4	Δ				<u></u>		 		
Montgomery							· · · · · · · · · · · · · · · · · · ·		 		
Moore			j						 		
Nash			1			T			1		
New Hanover					<u> </u>				1		
Northampton					1	1		T	 		
Onslow						1		-	 		
Orange						1	<u> </u>	1	1		
Pamlico					1			<u> </u>	 		
Pasquotank		1				 					
Pender						 		 			
Perquimans		1				 		**************************************			
Person		1									
Pitt		<u> </u>						 			
Polk	} <u>-</u>	1 11	1.1		<u> </u>			 	-		
Randolph		11 3	13								
Richmond		· · · · · · · · · · · · · · · · · · ·					· · · · · · · · · · · · · · · · · · ·	 			
Robeson								 	 		
Rockingham	<u> </u>	1	1					1			
Rowan		† — ·				1		1	-}		
Rutherford		3.6	36			1.		 			
Sampson	l	1	- 30-			\			 		
Scotland						 					
Stanly	 	1	1				<u> </u>		-		
Stokes	ļ	 			1	 	<u> </u>		 		
Surry	l	2	2_		 				 		
Swain	 	111	11		 	 					
Transylvanio	{ 	68	68		1		}	 			
Tyereli	 	1	00	<u> </u>		 	 				
Union	1	3	3			\	\ 	-			
Vance	 	 	-			 	 				
Wake	 	9	9		 	 	 		·		
Warren	 	 	7		 		<u> </u>	 			
Washington	1	 	i -			 	 	 	 		
Watauga	[6	6	<u> </u>		 	 	 			
Wayne	}	 	 		1	 	1	+			
Wilkes	 	4	4		 	 	 				
Wilson	∦ ·····	 			 		 				
Yadkin	1	 					 				
Yancey	 	1 .0	-		 		∯				
Out of State	 	51	8 51	 	 		\ 		4		
	1	T 3 !	1 7 7 7 7		,	 	1		-		
TOTALS			1,129			ML					

^{**} Note: See counties: <u>Alamance</u> through <u>Johnston</u> on previous page.

All responses should pertain to October 1, 2010 through September 30, 2011.

Patient Origin - MRI Services

Facility County: Henderson

In an effort to document patterns of utilization of MRI Services in North Carolina, hospitals are asked to provide county of residence for each patient served in your facility. The total number of patients reported here should be equal to or less than the total number of MRI precedures reported in Table 10a. on page 11.

County	No. of Patients	County	No. of Patients	County	No. of Patients
1. Alamance	3	37. Gates	2	73. Person	
2. Alexander		38. Graham		74. Pitt	
3. Alleghany		39. Granville		75. Polk	74
4. Anson	, and the second	40. Greene		76. Randolph	3
5. Ashe		41. Guilford	5	77. Richmond	
6. Avery		42. Halifax		78. Robeson	
7. Beaufort		43. Harnett		79. Rockingham	
8. Bertie		44. Haywood	39	80, Rowan	•
9. Bladen		45. Henderson	1.891	81. Rutherford	. 25
10. Brunswick		46. Hertford		82. Sampson	
11. Buncombe	859 •	47. Hoke		83. Scotland	
12. Burke	5	48. Hyde		84. Stanly	
13. Cabarrus	2	49. Iredeli	. 2	85. Stokes	
14. Caldwell		50. Jackson	9	86. Surry	
15. Camden		51. Johnston	3.	87. Swain	3
16, Carteret		52. Jones		88. Transylvania	101
17. Caswell		53. Lee		89. Tyrreli	
18, Catawba		54. Lenoir		90. Union	
19. Chatham		55. Lincoln		91. Vance	
20. Cherokee	5.	56. Macon	43	92. Wake	5
21. Chowan		57. Madison	1. 16	93. Warren	<u> </u>
22. Clay		58. Martin	51	94. Washington	
23. Cleveland	6	59. McDowell		95. Watauga	
24. Columbus		60. Mecklenburg	6	96. Wayne	
25, Craven		61. Mitchell	10	97. Wilkes	
26 Cumberland		62. Montgomery		98. Wilson	
27. Currituck		63. Moore	3	99. Yadkın	
28. Dare		64. Nash		100. Yancey	25
29. Davidson		65. New Hanover		, ,	
30. Davie		66. Northampton]	101, Georgia	,
31. Duplin		67. Onslow	1_	102. South Carolina	
32. Durham		68. Orange		103. Tennessee	
33. Edgecombe		69. Pamlico		104. Virginia	
34. Forsyth	3	70. Pasquotank		105. Other States	
35. Franklin		71. Pender	3	106. Other	131
36. Gaston	1	72. Perquimans		Total No. of Patients	3,335

Are mobile MRI	services	currently	provided a	t your	hospital?	yes_	no	
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All responses should pertain to October 1, 2010 through September 30, 2011.

License No: H0019 Facility ID: 943388

Patient Origin - Linear Accelerator Treatment

Facility County: Henderson

In an effort to document patterns of utilization of linear accelerators in North Carolina, hospitals are asked to provide the county of residence for patients served on linear accelerators in your facility. Report the number of patients who receive radiation oncology treatment on equipment (linear accelerators, CyberKnife®, but not Gamma Knife®) listed in Section 11 of this application. Patients shall be counted once if they receive one course of treatment and more if they receive additional courses of treatment. For example, one patient who receives one course of treatment counts as one, and one patient who receives three courses of treatment counts as three. The number of patients reported here should match the number of patients reported in Section 11.a. of this application.

County	o. of Patients	County	No. of Patients	County	No. of Patients
1. Alamance		37. Gates		73. Person ·	····
2. Alexander		38, Graham		74. Pitt	
3. Alleghany		39. Granville	,	75. Polk	
4. Anson		40. Greene		76. Randolph	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
.5. Ashe	•	41. Guilford		77. Richmond	
6. Avery		42, Halifax		78. Robeson	•
7. Beaufort.	•	43. Harnett		79. Rockingham	
8. Bertie		44. Haywood		80. Rowan	
9. Bladen		45. Henderson		81. Rutherford	
10. Brunswick		46. Hertford		82. Sampson	
11. Buncombe		47. Hoke		83. Scotland	
12. Burke		48. Hyde		84. Stanly	
13. Cabarrus		49. Iredell		85. Stokes	•
14. Caldwell		50. Jackson		86. Surry	
15. Camden		51. Johnston		87. Swain	
16. Carteret		52. Jones		88. Transylvania	
17. Caswell		53. Lee		89. Tyrrell	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
18. Catawba		54. Lenoir		90. Union	
19. Chatham		55. Lincoln		91. Vance	
20. Cherokee		56. Macon		92. Wake	
21. Chowan		57. Madison		93. Warren	· · · · · · · · · · · · · · · · · · ·
22. Clay		58. Martin		94. Washington	.,
23, Cleveland		59. McDoweli		95. Watauga	
24. Columbus		60. Mecklenburg		96. Wayne	
25. Craven		61. Mitchell		97. Wilkes	
26. Cumberland		62. Montgomery		98. Wilson	
27. Currituck		63. Moore		99. Yadkin	_
28. Dare		64. Nash		100. Yancey	
29. Davidson		65. New Hanover			
30, Davie		66. Northampton		101. Georgia	
31. Duplin		67. Onslow		102. South Carolina	
32. Durham		68. Orange		103. Tennessee	
33. Edgecombe		69. Pamlico		104. Virginia	,
34. Forsyth		70. Pasquotank		105. Other States	
35, Franklin		71. Pender		106. Other	
36. Gaston		72. Perquimans		Total No. of Patients	

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Patient Origin - PET Scanner

Facility County: Henderson

In an effort to document patterns of utilization of PET Scanners in North Carolina, hospitals are asked to provide county of residence for each patient served in your facility. This data should only reflect the number of patients, not number of scans and should not include other radiopharmaceutical or supply charge codes. Please count each patient only once. The number of patients in this table should match the number of PET procedures reported in Table 10d on page 14.

County	No. of Patients	County	No. of Patients		No. of Patients
1. Alamance		37. Gates		73. Person	
2. Alexander		38. Graham		74. Pitt .	
3. Alleghany		39. Granville		75. Polk	5
4. Anson		40. Greene		76. Randolph	
5. Ashe		41. Guilford		77. Richmond	
6. Avery		42. Halifax		78. Robeson	
7. Beaufort		43. Harnett		79. Rockingham	
8. Bertie		44. Haywood	1	80. Rowan	
9. Biaden		45. Henderson	129	81. Rutherford	
10. Brunswick		46. Hertford		82. Sampson	
11. Buncombe .	14 .	47. Hoke		83. Scotland	
12. Burke	The state of the s	48. Hyde		84. Stanly	
13. Cabarrus		49. Iredell		85. Stokes .	
14. Caldwell		50. Jackson	1	86. Surry	
15. Camden		51. Johnston		87. Swain	
16. Carteret		52. Jones		88. Transylvania	2
17. Caswell		53. Lee		89. Tyrrell	
18. Catawba		54. Lenoir		90. Union	
19. Chatham		55. Lincoln		91, Vance	
20. Cherokee		56. Macon		92. Wake	
21. Chowan		57. Madison		93. Warren	
22. Clay		58. Martin	3	94. Washington	
23. Cleveland	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	59. McDowell		95. Watauga	
24. Columbus		60. Mecklenburg		96. Wayne	
25. Craven		61. Mitchell		97. Wilkes	
26, Cumberland		62. Montgomery		98. Wilson	
27. Currituck		63. Moore		99. Yadkin	
28. Dare		64. Nash		100. Yancey	
29. Davidson		65. New Hanover			
30. Davie		66. Northampton	·	101. Georgia	
31. Duplin		67. Onslow		102, South Carolina	
32. Durham		58. Orange		103. Tennessee	·
33. Edgecombe		69. Pamlico	,	104. Virginia	
34. Forsyth		70. Pasquotank		105. Other States	
35. Franklin		71. Pender		106. Other	
36. Gaston		72. Perquimans		Total No. of Patients	155

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2012 Renewal	Application	for	Hospital:
Park Ridge H	ealth		

All responses should pertain to October 1, 2010 through September 30, 2011.

License No: H0019 Facility ID: 943388

This application must be completed and submitted with <u>ONE COPY</u> to the Acute and Home Care Licensure and Certification Section, Division of Health Service Regulation prior to the issuance of a 2012 hospital license.

<u>AUTHENTICATING SIGNATURE:</u> The undersigned submits application for the year 2012 in accordance with Article 5, Chapter 131E of the General Statutes of North Carolina, and subject to the rules and codes adopted thereunder by the North Carolina Medical Care Commission (10A NCAC 13B), and certifies the accuracy of this information.

Signature:	Jun	~ 151	wil	Date:	November	30,	2011	
							·	erace of
PRINT NAME OF APPROVING OFFICIAL	Jimm	Bunch					_	

<u>Please be advised</u>, the license fee <u>must</u> accompany the completed application and be submitted to the Acute and Home Care Licensure and Certification Section, Division of Health Service Regulation, <u>prior</u> to the Issuance of a hospital license.

Revised 08/2011

Type of Health Care Facilities Under Park Ridge Health's Hospital License

The state of the s	TO THE PARTY OF BIGHIBBS / SENSESS TO THE PARTY OF THE PA	The state of the s
	Acute Care Hospital	100 Hospital Drive, Hendersonville, NC 28792
Blue Ridge Headache Center	Headache/Pain Management Office	1998 Hendersonville Road, Suite 45, Asheville, NC 28803
Carolinas Center for Advanced Management of Pain	Pain Management Physician Office	50 Hospital Drive, Sulte 2-D, Hendersonville, NC 28792
Canter for Pelvic Health	Pelvio Health / Physician Office	1881 Pagah Drive, Bidg, A , Hendersonville, NC 28791
Family Medicine at Billmore Park The Office of Drs. Sarah Danninger and Leah Swann	Family Medicine	One Town Square Bivd., Suite 220, Asheville, NC 28803
Mountain View Dermatology	Dermatology	50 Hospital Drive, Sulte 2C, Hendersonville, NC 28792.
Mountain View Urological Associates	Urology	50 Hospital Drive, Suite 2A Handersonville, NC 28792
New Beginnings OB/GYN - The Office of Dr. Eileen Keppler	IOB-GYN	50 Hospital Drive, Suite 2-B, Hendersonville, NC 28792
Park Ridge Breast Health Center	Breast Health Services	50 Hospital Drive, Suite 4-B, Hendersonville, NC 28792
Park Ridus Cardiology	Cardiology Services	50 Hospital Drive, Suite 3B, Hendersonville, NC 28792
Park Ridge Center for Mood Disorders - The Office of Dr. William Simons	Psychiatry	50 Hospital Drive, Suite 3-C, Hendersonville, NC 28792
Park Ridge Dermatohogy - The Office of Dr. Timothy Highley, DO	Dermatology	12315 Asheville Highway, Suite 30, Hendersonville, NC 28791
Park Ridge ENT The Office of Drs. Michael Nevenschwander and Michael Stafford	Otolaryngology	81 Doctors Drive, Hendersonville, NC 28792
Park Ridge General Surgeons - The Office of Drs. Thomas Eisenhauer, Allan Huffman and	llan Huffman and General, Vascular and Thoracic Surgery Physician's Office	80 Dactors Drive, Suite 1, Hendersonville, NC 28792
Davis Black Oxidisting The Office of the Albert Earl Doseld Culture Italia factors	Geriatrics	1132 Homestead Farm Circle, Hendersonville, NC 29792
Park Ridne Health at Laurel Park - The Office of Drs. Robert Balley, Clara Kim, Meredith	Medical Building with Physician Offices, Radiology and	1881. Pisgah Drive, Bldg., A, Hendersonville, NC 28791
Richmond, James Thompson, Lorena Wade and Jennifer Wilhelm	Physical Therapy	
Park Ridge Hearing and Balance- The Office of Kay and Kim Arabo, Audiologists	Audiology	80 Doctors Drive, Sulle 1, Hendersonville, NC 28792
Park Ridge Home Health	Home Health	Howard Gap Road, Hendersonville, NC 28792
Infusion Center - The Office of Drs. Mikhail Vin	logradov and Paul Hematology/Oncology	50 Hospital Drive, Suite 4-B, Hendersonville, NC 28792
Dark Bland Dadiatrice _ The Office of Div Teresa Herhert Charlotte Riddle and Mary	Pediatrics	50 Hospital Drive, Suite 5-D, Hendersonville, NC 28792
Anne Utilis		
Park Ridge Plastic Surgery - The Office of Dr. William Young	Plastic & Reconstructive Surgery	1998 Hendersonville Rd., Skyland Office Park, Suite 45, Asheville, NC 28803
Park Ridge Psychlatry	Psychiatry	50 Hospital Drive, Suite 5-A, Hendersonville, NC 28792
Park Ridge Pulmondogy and Sleep Medicine - The Office of Dr. Gary Prechter	Pulmonology & Steep Center	50 Doctors Drive, Surle 1C, Hendersonville, NC 28792
Park Ridge Women's Services The Office of Dis. Jennifer Blather and Justin Towde	OB/GYN	80 Doctors Drive, Suite 2, Hendersonville, MC 28792
Park Ridge Wound Care and Hyperbarlo Medicine - Office of Drs. Frederick Veser and	Wound Therapy	50 Hospital Drive, Suite 1-B, Hendersonville, NC 28792
Brian Stover	(4- 7) (4- 7) (4- 7)	1994 Anha II Hadrowy Ditte 30 Unadamanilla NO 98701
PRMA Office of Drs. James Bryant and Lateef Abultioussa	tramity and Internal Medicine	2313 ASITEMIRE FIGURARY, DUITE ZU, THEIR THE INC. 2012 1
PRIMA Office of Drs. Wade Grainger and Ronald Johnson	Family Medicine	1998 Hendersonville Ha., Skyland Unice Park, Suite 45, Astreville, NC. 20003
PRMA Office of Drs. Denise Ingram and John Lang	Family Medicine	7 Glenn Bridge Road, Unit H, Aden, NC 28/04
PRMA Office of Dr. Thomas Lugus	Family Medicine	207 Linda Visia Drive, Hendersonville, NC 28792
PRMA Office of Dr. Donna MoGee	Family Medicine	50 Hospital Drive, Suite 5-B, Hendersonville, NC 28792
PRMA Office of Dr. Rebekah Robinson	Family Medicine	125 Vance Hill Drive, Mills River, NC 28759-4996
Skyland MR(MRI Services	1998 Hendersonville Rd., Skyland Office Park, Asheville, NC 28803
Southeastern Sports Medicine (Hendersonville Office)	Sports Medicine and Rehabilitation Services	204 King Street, Hendersonville, NC 28793
Southeastern Sports Medicine (Waynesville Office)	Sports Medicine and Rehabilitation Services	35 Valley View Terrace, Waynesville, NC
Southeastern Sports Medicine	Podiatry and Orthopedic Services	21 Turtle Creek Drive, Asheville, NC 28803
Southeastern Sports Medicine Office of Drs. Christian Estes and Robert Francis	Orthopedic Surgery	2920 Haywood Road, Hendersonville, N.C. 28/91



COMMENTS BY PARK RIDGE HEALTH ON THE CON APPLICATION FILED BY
MISSION HOSPITAL, INC. TO RELOCATE AN ENDOSCOPY ROOM TO
FLETCHER, NC

PROJECT I.D. NO. B-008638-11 Received by the

02 MAY 2311 62 : 43

Park Ridge Health ("Park Ridge") submits these comments on the CON application filed on March 15, 2011 by Mission Hospital, Inc. ("Mission") to relocate one GI endoscopy room from Mission's Asheville campus to a new medical office building ("MOB") located at 2651 Hendersonville Road in Fletcher, North Carolina. This location is on the border of Buncombe and Henderson Counties. The project is proposed to be called "Mission GI South."

According to the property deeds submitted in Exhibit 28 of the application, some of the and on which the MOB will sit is physically located in Henderson County, as two of the three deeds included in Exhibit 28 were recorded in Henderson County. According to the site plan in Exhibit 29, the Buncombe/Henderson county line actually goes right through the proposed MOB, with part of the building located in Buncombe County and part of the building, and most of the parking for the building, located in Henderson County. Although the drawings submitted with the application are not especially clear, it appears that the county line either goes through, or is inches away from, the endoscopy room itself. See Exhibits 6 and 29 to the application.

For the reasons stated below, the CON application should be denied because the project fails to meet several of the mandatory criteria in the CON Law. Failure to meet any one criterion in the CON Law means the project must be disapproved. See Presbyterian Orthopaedic Hospital v. NCDHR, 122 N.C. App. 529, 534, 470 S.E.2d 831, 834 (1996).

As the Agency reviews this application, it is important to keep in mind that an applicant proposing to relocate an existing endoscopy room must demonstrate conformity with all the review criteria, just as an applicant proposing a new endoscopy room must also demonstrate conformity with all the review criteria. A relocation application must be reviewed as rigorously as any other CON application; there are no "shortcuts" in CON review just because the applicant proposes to relocate an existing asset.

The fact that an endoscopy room is already in existence does not mean that the population proposed to be served needs the endoscopy room in a different location. The Agency made this point clear in the April 6, 2011 findings issued to Wake Forest Ambulatory Ventures, LLC, Project I.D. No. G-8608-10, a copy of which is attached to these comments as Exhibit A. There, the applicant proposed to relocate three existing underutilized operating rooms from Winston-Salem to Clemmons. The Agency disapproved the project because the applicant failed to demonstrate the need for the operating rooms in Clemmons. The failure to demonstrate need under Criterion 3 in turn caused the Agency to find the project non-conforming with Criteria 4, 5, 6, and 18a. The same results should apply here.

I. THE APPLICATION FAILS TO SATISFY CRITERION 3.

Criterion 3 of the CON Law requires the applicant to document the population proposed to be served by the project and the need that population has for the services proposed. The first ten pages of the need section of the application are spent discussing the prevalence of gastrointestinal disorders, the importance of early detection of colorectal cancer, colon cancer screening rates and outpatient colonoscopy procedure rates. See application, pages 21-30. By page 31, however, the application reveals a fundamental problem with the Mission GI South project: Mission's outpatient endoscopy volumes are declining. See application, page 31. Outpatient endoscopy is the service proposed in the Mission GI South application. See page 31 of the application, showing that between CY 2008 and CY 2010, Mission's outpatient endoscopy volumes declined by 267 cases and 194 procedures, respectively. Applying the 1,500 procedures per room standard in 10A NCAC 14C.3903. Mission's volume declines show that Mission barely has enough volume to support the six endoscopy rooms it now has. See, e.g., CY 2010 volumes on page 31 (8,661/1,500 = 5.77 rooms). According to Tables 2 and 3, Exhibit 16 in the application, the compound annual growth rate (CAGR) for CY08-CY10 for all endoscopy procedures at Mission is negative 0.2%.

The endoscopy use rate has also declined sharply in Buncombe County. See application, page 34 and Table 9, Exhibit 16, showing that in FY 2007, the endoscopy use rate in Buncombe County was 51.8. In FY 2010, it declined to 49.1. In Henderson County, the use rate increased from 55.7 to 58.2, but even when the two counties are combined, the combined 2010 use rate is still below the combined 2007 use rate.

Mission "reasonably believes" the economic downturn is responsible for the decline in the utilization of outpatient endoscopy. See application, page 34. While the economy may have played a role in Mission's volume declines, it seems unlikely that the economy bears all the responsibility for Mission's volume declines. That is because Mission's competitor, The Endoscopy Center, which operates five outpatient only endoscopy rooms less than a mile from Mission, has maintained its high procedure volumes of more than 14,000 procedures annually during the three year period FY 2008 through FY 2010. See application, page 32. While The Endoscopy Center experienced a slight drop in volume in FY 2010 when compared to FY 2009, its FY 2010 volume is still significantly higher than its FY 2008 volume. And The Endoscopy Center's FY 2009 volume, which was higher than both FY 2007 and FY 2010, occurred at a time when the economic downturn was at its worst. The Endoscopy Center operates in the same economy in which Mission operates, so if the economy caused a decline in Mission's volumes, one would reasonably expect to see The Endoscopy Center's volume also decline. Yet the Endoscopy Center experienced robust volumes.

In fact, Mission relies on The Endoscopy Center's robust volumes to support the proposition that Buncombe County needs an additional 4.6 endoscopy rooms. See application, page 32. But The Endoscopy Center is not the applicant here, so Mission cannot leverage The Endoscopy Center's robust volumes to prop up its declining volumes.

In the Wake Forest Ambulatory Ventures, LLC findings, the Agency cited the decline in inpatient surgery at North Carolina Baptist Hospital, and the applicant's failure to explain why those volumes were going down, as a reason to deny the application under Criterion 3. The decline in volume casts doubt on future growth. See Exhibit A, pages 12, 13 and 24. Likewise, in the 2010 Wake County MRI review, the Agency cited Wake Radiology's declining MRI volumes as a reason to disapprove Wake Radiology's CON application for an MRI scanner in Garner. See Exhibit B, page 34. The same concerns exist here.

Mission states that the project will result in "improved" access. See page 32 of the application. Yet Mission does not provide any evidence to support the notion that access to outpatient endoscopy in the Asheville area needs to be "improved." In fact, in the nine zip code service area defined by the applicant, there are already six endoscopy rooms: Carolina Mountain Endoscopy Center (2 rooms in zip code 28791), Pardee Hospital (3 rooms in zip code 28791) and Park Ridge (1 room in zip code 28792).

On page 12 of the application, Mission states that "[c]urrently, patients travel to downtown Asheville to receive outpatient GI endoscopy services on the Mission Campus. The Mission Campus is located in central Asheville in mountainous terrain. The existing campus is landlocked and has numerous parking decks and large facilities."

Visiting the Mission campus is not nearly as challenging as this description suggests. Central Asheville is not plagued with traffic. Mission's campus is not mountainous. According to its website, Mission offers free parking and shuttle services, and valet parking on the Memorial campus for \$4.00. See http://www.missionhospitals.org/ShuttleService.

There are no letters from any patient indicating any challenges accessing Mission's endoscopy services. None of the physician letters included in Exhibit 10 of the application indicates that any patient has complained about access. There is nothing in the application to substantiate the proposition that terrain, parking decks and the number of buildings on the Mission campus has anything to do with Mission's declining outpatient endoscopy volumes, or that this trend will be reversed if Mission relocates an endoscopy room to the Buncombe/Henderson border.

Moreover, several other facilities in the area provide convenient access to outpatient endoscopy for residents of Buncombe and Henderson Counties. The Endoscopy Center, located at 191 Biltmore Avenue in Asheville, less than a mile from Mission, has five endoscopy rooms. The Endoscopy Center offers free parking, does not have any parking decks and is focused solely on outpatient endoscopy. Both Mission and The Endoscopy Center are in zip code 28801, which is adjacent to two of the zip codes in the service area: 28806 and 28803. Mission does not explain why it would be reasonable to expect patients in zip codes 28806 and 28803 to drive to the Buncombe/Henderson border when they can easily get to Mission or The Endoscopy Center.

There are also three other providers of outpatient endoscopy in nearby Henderson County, which includes two of the zip codes in the proposed service area for Mission GI

South: Carolina Mountain Endoscopy Center (2 rooms), Pardee Hospital (3 rooms) and Park Ridge (1 room). Each of these facilities is easy-to-navigate and offers free parking. Park Ridge has recently spent \$26,000,000 to build a 20-bed outpatient surgery center and created state of the art operating rooms where it provides high-quality endoscopy services to residents of Buncombe and Henderson Counties. Mission does not explain why it would be reasonable to expect patients living in zip codes 28791 and 28792 to bypass these existing providers and go to Mission GI South.

Access to outpatient endoscopy is clearly not a problem in the Buncombe/Henderson area.

The applicant's definition of the service area for the project includes nine zip codes that straddle Henderson and Buncombe Counties; this zip code region is inconsistent with the service area definition contained in 10A NCAC 14C .3901(6) that is based specifically on county boundaries. Also, the 2011 State Medical Facilities Plan shows that counties are used to describe the geographical service areas for endoscopy rooms.

It is unreasonable for Mission to project that its patient origin percentages will remain unchanged with the proposed relocation of one GI endoscopy room to a medical office building 10 miles to the south of the current facility. See application, pages 70 and 71. This is because Mission's self-defined service area for this one GI endoscopy procedure room is comprised of nine zip codes which is a different service area Mission's Hospitals service area definition that has been comprised of 13 counties. Since this endoscopy room is moving to the Buncombe/Henderson border, one can reasonably expect that the facility will attempt to attract more Henderson County patients.

Mission states that the physicians associated with The Endoscopy Center support the Mission GI South project. See page 32 of the application. In Exhibit 10, there is a letter of from four of the eighteen gastroenterologists at Asheville Gastroenterology Associates, P.A. ("AGA"). AGA owns The Endoscopy Center. The letter in Exhibit 10 is a self-described "expression of interest" by the four undersigned physicians. The physicians do not, however, commit to perform any number of procedures at Mission GI South. Therefore, the Agency cannot determine that the "interest" of these four physicians will translate into procedure volume at Mission GI South. Further, as owners of The Endoscopy Center (for which they receive both facility fee income and professional fee income), one wonders how serious the "interest" of these physicians in using Mission GI South really is, as Mission GI South would take facility fee revenue away from The Endoscopy Center. In the findings for Wake Forest Ambulatory Ventures, LLC, the Agency noted that the applicant failed to provide letters of support from any community physicians indicating the number of surgical cases they expect to perform at the applicant's proposed facility. See Exhibit A, page 25. One also wonders if these physicians may have been promised something in return for their support, such as a joint venture opportunity, which is not disclosed in the application.¹

¹Exhibit 34, which is the lease term sheet, indicates that the landlord is a "real estate LLC" that will be named at a later date. It is reasonable to ask whether the landlord is AGA.

The physicians' "expression of interest" states that "the proposed relocation will expand access and choice for residents of the rapidly growing population of southern Buncombe County who require outpatient GI endoscopy services. The Mission GI South Location in southern Buncombe County is desirable to health care consumers and physicians in our community because it will provide high quality patient care in a location that is convenient and easily accessible." See Exhibit 10 to the application.

There are several noteworthy points about this letter. First, while the letter talks about "expand[ed] access," there is nothing in the letter or in the application otherwise to show that access is a problem at all, and that access to outpatient endoscopy needs to be "expanded" through Mission GI South. As previously noted, there are already six endoscopy rooms in the service area proposed by the applicant, and eleven more endoscopy rooms in an adjacent zip code (28801). Second, while the letter states that the location is "desirable" to health care consumers, no patient filed a letter of support for this project. Third, the letter states that the Mission GI South project will "expand choice" for residents, but the letter fails to mention that there are three other providers in the southern Buncombe/Henderson County area that already offer this choice in convenient, easily-accessible settings, in addition to AGA's own five-room endoscopy center. There is no indication in the application that any of these providers (The Endoscopy Center, Carolina Mountain Endoscopy Center, Pardee or Park Ridge) is unable to accommodate the needs of patients. Patients already have abundant access to, and significant choice of, endoscopy providers in the Buncombe/Henderson area, so Mission GI South does not bring anything new or needed to the table. Fourth, the according to the deeds and drawings submitted with the application, part of the property on which Mission GI South will be located is actually in Henderson County, not Buncombe County, so it is incorrect to imply, as Mission does, that this project is wholly inside Buncombe County. Mission GI South is strategically positioned so that Mission can attempt to attract more Henderson County patients. See Exhibits 6; 28 and 29 to the application.

Given its own declining outpatient volumes, Mission itself has capacity to accommodate more endoscopy patients. Thus, the situation here is very different from the findings cited on page 19 of the Mission application, Western Carolina Endoscopy Center, LLC and Western Carolina Medical Developers, LLC, in which the Agency noted waiting times for appointments ranging from six to nine weeks. See Exhibit C, page 4.

Mission then proceeds to discuss population growth in Buncombe and surrounding counties, noting the fact that the Asheville area is a popular place for retirees. See application, page 37. This is not new information; Asheville has been popular with retirees for many years. The articles that Mission cites from Modern Maturity and Money magazines date from the year 2000. Yet, despite the influx of retirees, Mission's outpatient endoscopy volume is not growing; in fact, it is declining. See application, page 32. See also Exhibit D (references to the dates on which these articles were published).

On pages 38-43 of the application, Mission provides extensive discussion about the growth and development in Buncombe County and in Fletcher, specifically. This information does not demonstrate that Mission needs to relocate an endoscopy room to the Buncombe/Henderson border. Mission does not make any connection between new business

coming into the area, the number of endoscopy cases that may result from the employees working in these businesses and whether Mission GI South would capture any particular number of any endoscopy cases that comes as a result of this growth.

The Town of Fletcher, where Mission proposes to establish Mission GI South, is physically located in Henderson County. Additionally, the deed to the property on which MI GI South will be located is actually in Henderson County. See Exhibit 28 to the application, reflecting that the site is located in Henderson County and the deed was recorded in Henderson County. There are already three existing providers of outpatient endoscopy in Henderson County: Carolina Mountain Endoscopy Center, Pardee or Park Ridge. Park Ridge is just a few miles from Mission's proposed site. See Mapquest map at Exhibit E. Carolina Mountain Endoscopy is approximately 10 miles from Mission's proposed site. See Exhibit F. Pardee is also about 10 miles from Mission's proposed site. See Exhibit G. Outpatient endoscopy is a non-emergent, scheduled outpatient procedure. There is nothing about Henderson County geography or traffic conditions that would make it unreasonably difficult for patients to get to these three locations. Likewise, Mission and The Endoscopy Center are about 10 miles from the proposed Mission GI South. See Exhibits H and I. There is no information in the application to substantiate that it is unreasonably difficult for patients to travel to Asheville for endoscopy.

On page 43 of the application, Mission optimistically states that "[w]hen the economy improves and national health reform is implemented, the demand for GI endoscopy services will grow once again, particularly with the impact of the growing 65+ population." The problem with this assertion is that no one knows when the economy will improve. The future of health care reform is also unknown. Further, Mission does not even attempt to quantify how improvements in the economy or implementation of health care reform will lead to increased utilization of Mission's outpatient endoscopy services. The CON process requires documentation and demonstration of need, not speculation about circumstances that are well beyond the applicant's control.

Mission next presents a 10-step methodology to demonstrate the need for this project. Step 1 of the methodology compares Mission's internal data (Trendstar) to the data it reports on its annual Hospital License Renewal application. As the first chart on page 45 shows, there is a significant variation in the number of cases and procedures reported in Trendstar versus the number of cases and procedures reported in the annual Hospital License Renewal Application. The internal data is not "very consistent" with the data Mission reports on its Hospital License Renewal application, as Mission claims. Mission states that it elected to use the Trendstar data for its projections. The Trendstar data, as depicted in the second table on page 45 of the application, clearly shows that Mission's outpatient endoscopy volume has declined significantly from CY 2008 to CY 2010, and that its combined inpatient and outpatient endoscopy volume has also declined from CY 2008 to CY 2010.

In Step 2 of the methodology, Mission develops its growth rate of negative 0.2%. See application, page 48. While Mission proclaims that its growth rate is "conservative," the Agency must ask why, in the face of declining volumes and a negative growth rate, it should award a CON to Mission to spend more than a million dollars to move an endoscopy room to

an area that is already well-served by endoscopy providers. CON is intended to promote cost control, not wastefulness or unnecessary duplication of services. See N.C. Gen. Stat. § 131E-175(4).

As Step 3 of the methodology and the chart on page 49 of the application shows, Mission projects to perform fewer endoscopy procedures and cases in 2015 (Project Year 3) than it performed in 2010. CONs are to be awarded only where there is a demonstrated need for a project. Declining volumes and a negative growth rate are certainly not indicative of a need for a project; rather, they indicate exactly the opposite, i.e., the project is not needed. The declining volumes and negative growth rate also undermine the preceding pages of the application where Mission speaks of the growth in the Asheville area and its optimism that once the economy improves and health care reform is implemented, more people will have endoscopies. As previously noted, the application does not offer any reasonable explanation that the endoscopy room will be better utilized if the endoscopy room is moved to Fletcher. In fact, the application shows just the opposite – Mission projects that its volumes will go down if the room is moved to Fletcher.

In Step 4 of the methodology, Mission tries to minimize the volume decline by calling it "a very slight reduction." See application, page 50. A reduction is a reduction, and a reduction does not indicate a need for a CON. Moreover, this reduction is not "very slight." The volume is going down every year from CY 2011 to CY 2015. Measured cumulatively from CY 2010 to CY 2015, Mission's procedure volume is going down by 246 procedures or 189 cases. The question is not whether Mission continues to show a need for 6 endoscopy rooms, as Mission states on page 50 of the application – the question is whether Mission has shown a need to relocate a room to Fletcher. The answer to that question is no.

In Step 5 of the methodology, Mission again discusses the use rate for endoscopy in Buncombe and Henderson Counties. As previously noted, the use rate in Buncombe County, which is the county from which Mission GI South projects to derive a substantial majority (56.8%) of its patients, is going down.

In Step 6, 7 and 8 of the methodology, Mission projects the base population for the Mission GI South service area, and the projected number of endoscopy cases and procedures in the service area for the first three project years. These calculations do not help Mission because, as noted in Step 3, Mission's own growth is negative and its volumes are projected to go down.

In Step 9, Mission provides its market share of the total endoscopy cases in Buncombe County for 2007 and 2010. The table on page 55 shows that Mission's market share has decreased significantly (by 6.5 basis points), while the market share for The Endoscopy Center has increased substantially (by 4.8 basis points). Carolina Mountain Endoscopy Center has also experienced a significant market share increase (2.5 basis points).

On page 56 of the application, Mission performs the same exercise for Henderson County, and again, Mission's market share of the endoscopy cases in Henderson County,

which was in the single digits in 2007, has declined (by 1.9 basis points). Carolina Mountain Endoscopy Center experienced a significant market share increase (31.2 basis points).

Using all this data, Mission arrives at Step 10 of the methodology on page 56 of the application. Mission states on page 56 that it "reasonably assumed" that Mission GI South would capture 70% of Mission's FY 2010 county-specific market share in Step 9. Mission does not explain how it selected this percentage. Given that Mission's market share of GI endoscopy cases in Buncombe and Henderson Counties is steadily going down, it does not seem reasonable for Mission to assume that it would steadily capture 70% of its 2010 county-specific market share in all three project years. Rather, the trend line over the past several years has been that the market share is declining. Given that Mission has not provided any information to explain how this trend would be reversed, it is not reasonable to expect a consistent market share going forward.

Mission Hospitals' historical data demonstrates a decline in outpatient utilization due to market share loss to the freestanding ASCs with GI endoscopy rooms. This data shows that more patients are choosing to obtain colonoscopy procedures at freestanding GI endoscopy centers where patient charges are substantially lower as compared to the hospital-based charges. Across North Carolina, licensed freestanding ambulatory surgery centers with GI procedure rooms are being used to perform an increasing percentage of the total GI endoscopy demand.

The total number of endoscopy procedures performed in licensed ambulatory surgical centers in North Carolina increased from 98,588 procedures in the 2005-06 annual period to 270,181 procedures in the most recent 2008-09 annual period.

	,		Total #		
			Procedures	# of	% of Total
	# of Procedure	# of Procedure	Performed in	Procedures	Procedures
Reporting	Rooms in	Rooms in	ASC plus	Performed in	Performed
Periods	Hospitals	ASCs	Hospitals	ASC ·	· in ASC
2005-06	285	119	489,899	98,588	20.12%
2006-07	289	144	551,484	165,337	29.98%
2007-08	286	164	585,024	233,740	39.95%
2008-09	284	169	591,693	270,181	45.66%

Sources: North Carolina State Medical Facilities Plans (2008 to 2011)

Contrary to statewide trends and local market share data, the Mission application fails to project forward the highly probable market share gains for The Endoscopy Center in Buncombe County and Carolina Mountain Gastroenterology Endoscopy Center in Henderson County.

Mission's market share projections are based on the unreasonable assumption that the proposed project will immediately capture and hold 22.7% of the GI endoscopy market share

from the Buncombe zip codes and 5.1% of the market share from the Henderson zip codes. These market share assumptions are unreliable because:

- Mission fails to provide a list of the types of outpatient GI endoscopy procedures by CPT code that the proposed project will be able to accommodate. Without this underlying data, it is impossible to evaluate the reasonableness of the market share assumptions.
- No ramp-up in volume is projected in Year 1 even though it will take considerable time for both patients and physicians to change established referral and practice patterns.
- The application fails to demonstrate the average number of physicians that will utilize the one GI room facility on a daily or weekly basis.
- Mission fails to demonstrate that a single GI endoscopy procedure room located in a medical office building can operate as efficiently as multiple endoscopy procedure rooms in existing facilities.

At the bottom of page 57, Mission provides a chart showing that by PY 3, 1,338 endoscopy procedures will be performed at Mission GI South. This number is well below the planning metric of 1,500 procedures per year per room. In an attempt to salvage this situation, Mission projects 10% inmigration on page 58 of the application, which generates an additional 149 procedures by PY 3. Mission does not explain how it arrived at 10% inmigration. Mission says that this 10% will come from "other Buncombe and Henderson zip codes" and "other counties." See application, page 58.

There are several problems with Mission's immigration assumptions. First, there is a discrepancy in the immigration percentage, which in turn creates a discrepancy in the number of procedures. On page 58, the immigration percentage is represented to be 10%. In Exhibit 15, Table 5, it is represented to be 15%. This changes the procedure volumes and also cases further doubt on Mission's representation that the patient origin at Mission GI South will be "the same" as it is at Mission's main campus. See application, pages 70 and 71.

The application fails to explain the discrepancies in the projected numbers of inmigration procedures. Page 58 is based on an assumption of 10% in-migration; Exhibit 16, Table 5 is based on approximately 15 percent. Based on these conflicting representations, the utilization projections are inaccurate and unreasonable.

Page 58	PY 1: 2013	PY 2: 2014	PY 3: 2015
Buncombe-Henderson Zip Codes - OP GI Endoscopy			
Procedures	1,309	1,324	1,338
In-migration (10%)	145	147	149
Total Projected OP GI Endoscopy Procedures	1,455	1,471	1,487
Exhibit 16. Table 5.	2013	2014	2015
Combined Buncombe-Henderson Gl Endoscopy			
Procedures at Mission South	1,309	1 ,324	1,338
Other In-migration	231	234	. 236
Total Projected Procedures at Mission South Gl Location	1,540	1,557	1,574

The utilization projections provided in Section IV, Table IV on page 76 are also inconsistent with the utilization projections provided in Exhibit 16, Table 16 as follows:

Table IV GI Endoscopy	CY 2013	CY 2014	CY 2015
Mission Campus # Gl Procedures	7,157	7,125	7,092
Mission South # Outpatient Gl Procedures	1,455	1,471	1,487
Total #GI Procedures	8,612	8,596	8,579
Exhibit 16. Table 16.	CY 2013	CY 2014	CY 2015
Mission GI South	1,540	1,557	1,574
Mission Hospital	7,687	7,867	8,052
Total Mission Gl Procedures	9,227	9,424	9,626

Based on these conflicting projections the applicant fails to demonstrate that the utilization projections are based on reasonable assumptions.

Second, according to Exhibit 16, Table 12, Mission inpatient and outpatient endoscopy services have attracted patients from a range of counties in Western North Carolina, but Mission does not provide a breakdown of how many of these patients were inpatients or outpatients. Mission does not specifically identify the "other Buncombe and Henderson zip codes" or the "other counties" from which the inmigration would come.

Third, Mission does not provide any information in the application to explain why it would be reasonable to expect patients in "other Buncombe and Henderson zip codes" to go to Mission GI South, given the other options available (e.g., Mission, The Endoscopy Center, Carolina Mountain, Pardee and Park Ridge). In some cases, residents in these "other" zip codes would actually have to drive past an existing provider to get to Mission GI South, and there is no information in the application to explain why a patient in these "other" zip codes would be willing to drive past an existing provider to go to Mission GI South. For example, zip code 28739 is adjacent to the service area, but to get to Mission GI South, a resident of that zip code would have to drive past five endoscopy rooms at Pardee and Carolina Mountain before reaching Mission GI South.

Fourth, Mission's claim that patients from other counties would be likely to travel to the Buncombe/Henderson border for outpatient endoscopy is even less plausible. Mission does not explain, for example, why it would be reasonable to expect a patient from McDowell County to drive an hour to have outpatient endoscopy on the Buncombe/Henderson border, when that patient could just as easily get to McDowell Hospital, Mission or The Endoscopy Center for the same service. Nor does Mission explain why it would be reasonable for a patient in Haywood County, for example, to travel anywhere from 35 minutes to an hour to get an outpatient endoscopy on the Buncombe/Henderson border, when the patient could have the procedure done at Haywood Regional Medical Center, Mission, or The Endoscopy Center. And if patients really are inclined to travel that far, there are already three choices for the service near the Buncombe/Henderson border: Carolina Mountain, Pardee and Park Ridge.

Fifth, the immigration percentage is further called into question by the fact that outpatient endoscopy is a non-emergent, scheduled procedure. It is not like other services, e.g., emergency department visits, where it is reasonable to expect that some patients who do not live in or near the service area may use the applicant's facility because of a random event, e.g., an accident or the sudden onset of illness.

The unavoidable facts are that Mission's outpatient endoscopy volume is going down and there are numerous other convenient choices in the market for outpatient endoscopy. Just as the applicant in the recent Wake Forest Ambulatory Ventures findings failed to demonstrate the need for the relocation of the operating rooms, Mission has likewise failed to demonstrate the need to relocate an endoscopy room and the project should be disapproved under Criterion 3.

II. THE APPLICATION FAILS TO SATISFY CRITERION 3A.

Criterion 3a of the CON Law specifically applies in relocation projects such as this one. It requires the applicant to demonstrate that the needs of the population presently served will be met, and to explain the effect that reduction in service will have on medically underserved populations. Page 61 of the application asks the applicant to demonstrate

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.

The application is nonconforming to Criterion 3a due to the applicant's failure to evaluate how the project will reduce access to patients from Yancey and Madison Counties (with a combined population of approximately 40,000). 17.8% of Yancey County's residents live below the poverty line, and 19.3% of Madison County's residents live below the poverty line. See Exhibit J. Both of these counties are included with Buncombe County in the acute care service area controlled by Mission. As seen in the table on page 73 of the Mission application, neither Yancey nor Madison County has a hospital or a freestanding ambulatory surgical facility with GI endoscopy procedure rooms. The proposed project by Mission shifts one of its six GI endoscopy procedure rooms to be further away from the populations of

Madison and Yancey Counties. This reduction in GI endoscopy capacity in Asheville will certainly have a negative impact access for patients from these counties. In contrast to the populations in southern Buncombe and northern Henderson, patients from Yancey and Madison Counties are geographically isolated and have limited access to GI Endoscopy procedure rooms.

III. THE APPLICATION FAILS TO SATISFY CRITERION 4.

Criterion 4 of the CON Law requires the applicant to demonstrate that it has chosen the least costly or most effective alternative. An applicant that is found non-conforming with Criterion 3, is usually also found non-conforming with Criterion 4. See Exhibit A. Since Mission has failed to demonstrate the need for the Mission GI South project under Criterion 3, it should also be found non-conforming under Criterion 4 for failing to demonstrate that its proposal is the least costly or most effective alternative.

IV. THE APPLICATION FAILS TO SATISFY CRITERION 5.

Criterion 5 of the CON Law requires the applicant to demonstrate that the availability and commitment of funds for the project, and that the project will be financially feasible. The Mission application fails both prongs of Criterion 5.

Exhibit 26 to the application is a CFO funding letter dated March 15, 2010 for the addition of nine acute care beds. The amount indicated in the letter is \$245,000. The letter is obviously not for the endoscopy project. There is no other letter in the application evidencing the availability and commitment of funds for the endoscopy project. The Agency cannot speculate whether Mission has the funds for the endoscopy project. It is the applicant's responsibility, not the Agency's, to demonstrate the availability and commitment of funds. See N.C. Gen. Stat. § 131E-183(a)(5).

In addition, and as discussed above with regard to Criterion 3, projected utilization is unreasonable. Thus, costs and revenues that are based on this projected utilization are also unreliable. See Exhibit A.

Capital costs also appear to be understated. In Section XI of the application, page 110, Mission represents that it owns the land upon which the medical office building will be located. See also Exhibit 28 to the application. Mission states it will lease the land to the developer of the MOB. See application, page 111. Yet no land cost was included in the Section VIII capital cost form. See application, page 99. Since Mission is the entity incurring the cost for the land, the land cost needs to be reflected in the capital cost form.

The application does not conform to Criterion 5 because the capital cost projections are unreliable and the operational projections are inaccurate. The project capital cost includes the conceptual cost estimate that is provided in Exhibit 29. This conceptual cost letter is unreliable because:

- The application fails to demonstrate that the Exhibit 29 "conceptual cost estimate" is an acceptable substitute for a certified construction cost estimate.
- The proposed facility plans fail to include areas for endoscopy waiting, registration and reception. Therefore, the omission of these spaces cause the construction cost to be unreliable.
- Exhibit 29 shows that the architect's cost certification includes unsubstantiated deductions for a landlord /tenant improvements allowance. This allowance is unsupported because no landlord legal entity yet exists as seen in lease terms sheet in Exhibit 34.
- The architect letter unreasonably assumes that the project will have a pro rata share of the site, shell & core Medical Office Building ("MOB") of 4.28%. This assumption is unreliable because the remaining 95.72% of the MOB has not been adequately described in the project application.
- The cost estimate fails to adequately explain the basis for the 60% Ownership adjustment amount of \$<510,232>.

Operational projections for the project are unreliable as discussed in the Criterion 3 comments. Consequently, the financial projections for the project are unreasonable because these are based on unreliable volume projections. Mission fails to explain the basis for its projected average charge per GI endoscopy case. The financial statements, worksheet and assumptions fail to include the charge per procedure for the outpatient GI endoscopy procedures that are proposed to be shifted to the proposed project.

Expenses for the proposed project are understated and inaccurate due to the omission of staff positions as described in the Criterion 7 comments regarding anesthesia, business office, reception and registration personnel.

Mission fails to describe any start-up costs associated with the new service location. It is most unreasonable to project no start-up costs because the proposed location will incur new and additional utilities costs, lease expenses and initial inventory costs that are not being incurred at present.

Therefore, the project is non-conforming under Criterion 5. See also Exhibit A (Wake Forest Ambulatory Ventures findings).

V. THE APPLICATION FAILS TO SATISFY CRITERION 6.

Criterion 6 of the CON Law requires the applicant to demonstrate that its project will not result in the unnecessary duplication of existing or approved health service capabilities or facilities. As discussed above, there are already abundant resources available in Buncombe and Henderson Counties for outpatient endoscopy, including Mission's own facilities in Asheville. Park Ridge, which recently spent \$26 million upgrading its surgical services, offers outpatient endoscopy in a state of the art-facility, is only a few miles from Mission's proposed location in Fletcher. See Exhibit E.

On page 73 of the application, the State asks Mission to

Explain and provide specific documentation of the inadequacy or inability of existing providers to meet the need identified by the applicant.

In response to this question, Mission does not discuss the inadequacy or inability of existing providers to meet the need identified by the applicant. Instead, Mission says the project will provide "better geographic access to services by Mission." See application, page 73. As discussed above, there is no evidence in the application demonstrating that patients have difficulty accessing endoscopy services where they are presently located, including at Mission, so Mission's claim that Mission GI South will provide "better access" to Mission's services is unsubstantiated. In fact, as noted above, two of Mission's service area zip codes, 28806 and 28803, are adjacent to 28801, where Mission is located.

Mission GI South unnecessarily duplicates other facilities that offer outpatient endoscopy. Thus, the application is non-conforming with Criterion 6. See also Exhibit A (Wake Forest Ambulatory Ventures findings).

VI. THE APPLICATION FAILS TO SATISFY CRITERION 7.

The application fails to conform to Criterion 7 because the staffing is incomplete. Page 9 of the application states Mission GI South will have anesthesia conscious sedation, business office functions, reception and on-site registration. But the staffing tables in Section VII of the application omit these positions.

VII. THE APPLICATION FAILS TO SATISFY CRITERION 12.

The application fails to conform to Criterion 12 because the line drawings in Exhibit 6 are unlabeled and incomplete. Within the "Area of Construction" shown in Exhibit 6, Mission shows a "black box" that may be the endoscopy room, but since nothing is labeled, it is impossible to know for sure. Nor is it possible to tell what is inside the "black box." The line drawings show no entrance from the building exterior, no patient waiting area and no registration area. The line drawings in Exhibit 6 and the "conceptual cost estimate" in Exhibit 29 fail to demonstrate that the proposed GI endoscopy procedure room will be constructed to meet hospital licensure rules and construction requirements.

On page 110 of the application, Mission refers to an MOB exemption letter to be filed by an unknown property developer. In Exhibit 29, the architect refers to an "80,000 sf two story MOB, developed by PMR, dated 3/09/11." Exhibit 29 contains an unclear site plan, so it is not possible to know what else is in the MOB. It appears that the "conceptual cost estimate" is based on certain amounts being allocated to the MOB and not to the endoscopy room. Since the architect's letter does not explain the basis for the allocation, it is impossible to know if this "conceptual cost estimate" is accurate.

VIII. THE APPLICATION FAILS TO SATISFY CRITERION 18a.

Criterion 18a of the CON Law requires the applicant to demonstrate the effects of its proposal on competition. A project that is not needed, like this one, does not have a positive impact on competition. Typically, when an application is non-conforming with Criterion 3, it will also be found non-conforming with Criterion 18a. See Exhibit A (Wake Forest Ambulatory Ventures findings).

On page 84 of the application, the applicant is asked to

Describe how the proposed project will foster competition.

Mission answers that the project is necessary to improve the delivery of GI endoscopy services by Mission. Mission also repeats many of the statements it made previously about expanding access and choice, population growth and travel to downtown Asheville. Mission then states:

Mission will equal or surpass other providers in the region in terms of promoting cost effectiveness, quality and access to care. These efforts will allow Mission to remain competitive in the western North Carolina health care market. Mission aims to improve the health of the people of western North Carolina.

Mission fails to tell the Agency that on March 1, 2011, the State of North Carolina published a study by Gregory S. Vistnes, Ph.D., an economist hired by DHSR and the Attorney General's Office to analyze Mission's behavior under its Certificate of Public Advantage (COPA) that was issued to Mission in 1998. The COPA, which allowed Mission to merge with its formal rival, St. Joseph's Hospital, places certain limitations on Mission's activities. The report, entitled An Economic Analysis of the Certificate of Public Advantage (COPA) Agreement Between the State of North Carolina and Mission Health, is attached as Exhibit K. A copy of the COPA is found in Exhibit L.

In the report, Dr. Vistnes describes numerous problems with the COPA, and noted that the COPA gives Mission incentives to raise outpatient prices. The report also acknowledges that the COPA may give Mission an unfair advantage relative to other providers. Dr. Vistnes makes several recommendations in the report about modifications to the COPA. DHSR and the Attorney General's Office are the process of reviewing the Vistnes report and the comments submitted on the report. Presumably, these Agencies will decide whether to modify the COPA in the near future.

While the CON Section is not an antitrust regulatory body, it is important to consider the Vistnes report in the context of this application. The fact that Mission is seeking to move an endoscopy room to the Buncombe/Henderson border, when there clearly is no community need to do so, suggests that Mission's goal is twofold: (1) to shift volume from existing

providers of outpatient endoscopy services, including Park Ridge; and (2) establish a presence in Henderson County so that it can increase its market share in Henderson County, not only for outpatient endoscopy but also for other services. It is no coincidence that the location chosen for Mission GI South is about five miles from Park Ridge's front door. While Mission states that the project will be in Buncombe County, the deed to the property shows that part of the property on which Mission GI South is located is actually in Henderson County. See Exhibit 28 to the application.

While Mission steadfastly maintains it is only planning on shifting some of its own volume from Mission's main campus to Mission GI South, and that this project will not negatively impact other providers, see, e.g., application pages 32 and 58, this claim is contradicted by the fact that Mission's outpatient endoscopy volumes are declining. Since its own endoscopy volumes are going down, Mission cannot keep this endoscopy room busy if it does not attempt to shift volumes from other providers, including Park Ridge, which recently spent \$26 million upgrading its own facilities. Loss of patients in turn means lost revenue for these other providers, including Park Ridge. The Henderson County line location of Mission GI South gives Mission another opportunity to increase its Henderson County market share, which has been climbing steadily since 2005. See Table 1 to Vistnes Report in Exhibit D. The fact that Mission is proposing to move this endoscopy room to the Buncombe/Henderson border (see Exhibits 6, 28 and 29 to the application) further indicates that its patient origin at Mission GI South is not going to be "the same" as it is today. See application, pages 70 and 71.

Mission also has much bigger plans for Fletcher than simply the relocation of one endoscopy room. The attached email from Ron Paulus, M.D., CEO of Mission, shows that Mission plans a "Fletcher health campus." See Exhibit M. The endoscopy room relocation is apparently the first step toward developing this "campus," just a few miles from Park Ridge's front door. The application, of course, does not discuss the "campus."

This is not just ordinary competition at work. As the Vistnes report notes, Mission is a monopolist that has substantial incentives under the COPA to engage in regulatory evasion through the expansion of outpatient services in other geographies, *i.e.*, Mission has strong motives to find ways to get around the COPA so that it can exercise market power to the detriment of health care consumers and other providers in Western North Carolina. This project, which certainly cannot be justified on the basis of community need or Mission's own volumes, does nothing to foster competition.

Thus, the application is non-conforming with Criterion 18a. See also Exhibit A (Wake Forest Ambulatory Ventures findings).

CONCLUSION

For the reasons stated above, the Mission GI South CON application is non-conforming with multiple review criteria and should be denied.

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ATTACHMENT - REQUIRED STATE AGENCY FINDINGS

FINDINGS

C = Conforming

CA = Conditional

NC = Nonconforming

NA = Not Applicable

DECISION DATE:

March 30, 2011

FINDINGS DATE:

April 6, 2011

PROJECT ANALYST:

Gebrette Miles

ASSISTANT CHIEF:

Martha Frisone

PROJECT I.D. NUMBER:

G-8608-10 / Wake Forest Ambulatory Ventures, LLC / Relocate ambulatory surgical facility (ASF) with 3 ORs from Winston-Salem to

Clemmons and convert the ASF from single specialty to

multispecialty/ Forsyth County

REVIEW CRITERIA FOR NEW INSTITUTIONAL HEALTH SERVICES

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

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

NA

Wake Forest Ambulatory Ventures, LLC, a wholly-owned subsidiary of Wake Forest University Health Sciences (WFUHS), proposes to relocate an existing ambulatory surgical facility (ASF) with three operating rooms (ORs) from Maplewood Avenue in Winston-Salem to Clemmons, convert the ASF from single specialty (plastic surgery) to multi-specialty, and develop one new procedure room. The applicant does not propose to increase the total number of ORs in Forsyth County. There are no policies or need determinations in the 2010 State Medical Facilities Plan (SMFP) applicable to this review. Therefore, this criterion is not applicable to this review.

- (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.

Wake Forest Ambulatory Ventures, LLC Project ID # G-8608-10 Page 2

NC

Wake Forest Ambulatory Ventures, LLC, a wholly-owned subsidiary of Wake Forest University Health Sciences (WFUHS), proposes to relocate an existing ambulatory surgical facility (ASF) with three operating rooms (ORs) from 2901 Maplewood Avenue in Winston-Salem to a new facility in Clemmons, convert the ASF from single specialty (plastic surgery) to multi-specialty, and develop one new procedure room. The ASF, formerly known as the Plastic Surgery Center of North Carolina (PSCNC) was acquired by WFUHS in June 2009. The ORs are not currently in use. The proposed multi-specialty ASF, to be known as the Clemmons Medical Park Ambulatory Surgery Center, will include the following specialties:

- · Orthopaedics
- General Surgery
- Obstetrics/Gynecology
- · Plastic Surgery
- Otolaryngology

Population to be Served

The following table illustrates patient origin for the ambulatory surgical cases performed at PSCNC, as reported in Section III.7, page 57:

PSCNC Current Patient Origin FFY 2009

County	% of Total
	Ambulatory
	Surgical Cases
Forsyth.	64%
Davie	8%
Surry	8%
Davidson	5%
Stokes	3%
Guildford	2%
Yadkin	- 2%
Ashe	. 1%
Burke	1%
. Virginia	1%
Henderson	1%
Iredell	1%
Mecklenburg	1%
Wilkes	1%
South Carolina	1%
Rockingham	1%
Total	101%

^{*}Totals do not foot due to rounding.

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(Note: WFUHS acquired PSCNC in June 2009. Thus, the current patient origin reflects that of PSCNC prior to WFUHS' acquisition of the facility.)

The following table illustrates projected patient origin for ambulatory surgical cases and procedure cases to be performed at the proposed ASF, as reported in Section III.6, pages 55-56:

Projected Patient Origin Ambulatory Surgical Cases Project Years 1 and 2 (FY 2015 and FY 2016)

County	Total	Cases	% of Total Ambulatory		
	:		Surgical Cases		
	FY 2015	FY 2016	FY 2015	FY 2016	
Forsyth	1,614	1,718	57%	57%	
Davidson	244	259	9%	9%	
Stokes	163	174	. 6%	6%	
Surry	143	152	5%	5%	
Wilkes .	144	154	5%	. 5%	
Davie	124	133	4%	4%,	
Yadkin	92	98	3%	3%	
Catawba.	65	69	. 2%	2%	
Iredell	61	65	2%	2%	
Alexander	,21	22	1%	1%	
Alleghany	25	26	1%	1%	
Ashe	23	.24	1%	1%	
Burke	23	25	1%	1%	
Caldwell ·	32	34	1%	1%	
Watauga	35	37	1%	1%	
Cabarrus	12	12	0%	. 0%	
Total	. 2,821	3,001	100%	100%	

Projected Patient Origin Procedure Room Cases Project Years 1 and 2 (FV 2015 and FV 2016)

	(FY 2015 and FY 2016)						
County	Total	Cases	% of Total A				
				Surgical Cases			
	FY 2015	FY 2016	FY 2015	FY 2016			
Forsyth	146	270	54%	54%			
Davidson	25	46	9%	9%			
Davie	15	28	6%	6%			
Stokes	15	28	6%	6%			
Surry	15	28	6%	6%			
Yadkin	14	26	5%	5%.			
Wilkes	11	20	4%	4%			
Catawba	7	13	3%	3%			
Iredell	8	14	3%	3%			
Alleghany	2	3	1%	. 1%			
Burke	4	. 7	1%	1%			
Cabarrus	2	4	1%	1%			
Caldwell	2	4	1%	•			
Watauga	. 2	4	1%	1%			
Ashe	1	1	0%				
Total	270	499	100%	100%			

The applicant adequately identified the population proposed to be served.

Demonstration of Need

Proposed Operating Rooms

In Section III.1(b), page 34, the applicant states,

"The need for the proposed freestanding ambulatory surgical facility, with three surgical operating rooms and one minor procedure room, relates to multiple factors that are outlined as follows:

- The proposed ASC is needed to support the specialties that will be participating in the new Clemmons Medical Park medical office building
- National Healthcare Trends—Market Shift to Outpatient Setting

 Trends within ambulatory surgery demonstrate that the utilization of freestanding ambulatory surgery centers will continue to increase dramatically

Healthcare reform will bring large volumes of newly insured patients into the market, and reduce the number of uninsured Americans by as many as 28 million by 2019. A stated goal of the legislation is to encourage investment in infrastructure and redesigned care processes for high quality and efficient service delivery. Ambulatory surgery centers (ASCs) will represent exactly the type of value-based delivery paradigm the government desires healthcare providers to embrace

 Advances in surgical technologies and anesthesia techniques promote increased demand for ambulatory surgery

 Demographic data for Wake Forest Ambulatory Ventures LLC's 16-county outpatient service area show that the growth in the population will increase demand for healthcare services, including ambulatory surgery procedures

Physician letters of support demonstrate that the proposed project is necessary to provide additional surgical capacity"

In Section III.1(b), pages 35-41, the applicant discusses each of these factors separately.

Development of a Clemmons Medical Office Building

On page 35, the applicant states,

"The current Plastic Surgery Center of North Carolina (PSCNC) operating rooms are antiquated and do not meet modern operating room standards. The rooms are outdated and too small to accommodate the modern equipment that is necessary to provide exceptional patient care. WFUHS faculty surgeons consider the current condition of the PSCNC operating rooms to be inadequate and are opposed to utilizing the rooms without renovation. Because the building housing the PSCNC operating rooms is owned by a third party, WFUHS has ceased using the PSCNC operating rooms while Clemmons Medical Park ASC is being developed, unless the CON Section approves their use at another location in the interim. Relocation of the PSCNC ambulatory surgery facility to the Clemmons Medical Park location will provide an opportunity to expand and enhance those operating room assets to improve patient safety as well as operating room efficiency and utilization.

In addition to the modernization of antiquated operating rooms, the new location of the ambulatory surgery center will enhance patient care through the co-location of complementary services. Clemmons Medical Park, LLC, a separate legal entity, has proposed to develop a Medical Office Building (MOB) on the property directly adjacent to the proposed site of Clemmons Medical Park ASC. This MOB will be a major medical and surgical multispecialty outpost designed to enhance quality through the co-location of multiple offerings of complementary clinical and ancillary services. In fact, of the five services planned to utilize Clemmons Medical Park ASC operating rooms, three will have clinic at the Clemmons MOB — Orthopedic Surgery,

Obstetrics & Gynecology, and Otolaryngology. The resulting ambulatory surgery outpost with a full complement of clinic [sic] and ancillary support services will enhance patient convenience and bring a novel healthcare delivery model to the citizens of WFUBMC's 16-county outpatient service area."

Market Shift to the Outpatient Setting

On page 35, the applicant states,

"Increasingly complex procedures are continuing to transition from the inpatient to the outpatient setting as new technology enters the marketplace each year. Patients and payors prefer the outpatient setting due to convenience and because of the increased savings associated with providing care in a lower cost setting and improved access to services.

Sg2, a nationally recognized healthcare consulting firm, forecasts a substantially greater increase in outpatient volumes compared to inpatient. In fact, Sg2 data indicates a decline of 12% in inpatient use rates and a growth of 17% in outpatient use rates over the next ten years."

Trends in Ambulatory Surgery

On page 36, the applicant states,

"The 2006 National Survey of Ambulatory Surgery is the principal source for national data on the characteristics of visits to hospital-based and freestanding ambulatory surgery centers. The 2006 National Survey of Ambulatory Surgery includes ambulatory surgery performed on an outpatient basis in hospitals and in freestanding ASCs as well as in specialized rooms such as endoscopy suites and cardiac catheterization laboratories. Data from the 2006 Survey provides important information regarding the types of facilities, services rendered and patient characteristics.

The national total of ambulatory surgery visits increased 66.7 percent during the ten year period, growing from 20,838,000 visits in 1996 to 34,728,000 visits in 2006. Visits to freestanding ambulatory surgery centers ("ASCs") increased 348.8 percent.

For the ten year period, the increase in the number of visits to freestanding ACSs far exceeded the growth in visits to hospital-based ambulatory surgery locations. Advances in surgical technology and changes in payment arrangements have supported the growth of freestanding ambulatory surgery centers."

Increased Demand for Healthcare Due to Healthcare Reform

On page 37, the applicant states,

"Coverage expansion will play a significant role in the demand for healthcare services when the full law is implemented in 2013. As of September 2010, insurers must allow parents to keep an adult child up to age 26 on their health plan and those young adults can't be charged more than any other dependent. Beginning in 2014, individuals with income up to 133% of the federal poverty level will qualify for Medicaid. And those individuals with income below 400% of the federal poverty level will qualify for subsidies to purchase health insurance coverage on newly created state insurance exchanges. And, of course, the legislation mandates the purchase of insurance.

ASCs provide a low-cost, convenient alternative to traditional inpatient care. According to Tracy K. Johnson, Vice President of Health Strategies & Solutions, 'healthcare reform will likely accelerate growth in ambulatory services.' Organizations that begin to implement ambulatory strategies with a focus on costeffective and patient-centered care will enhance their competitive advantage as the market adapts to the effects of healthcare reform. As the movement towards accountable care organizations gains momentum, healthcare organizations with comprehensive, accessible and coordinated ambulatory services will succeed in addressing the needs of the newly insured. The increase in the number of insured patients will require healthcare organizations to adapt to the increased outpatient volumes. Reform will reward those providers that can manage and coordinate services more cost effectively while improving the quality of care. Wake Forest University Baptist Medical Center views this ambulatory surgery center as a means to establishing the proper continuum of care while addressing the increased need of outpatient services expected with the increase [in] the insured population."

Advances in Ambulatory Surgery and Regulatory Changes

On page 38, the applicant states,

"Changes in surgical technologies and anesthesia techniques support the continued shift of surgical procedures to the ambulatory setting. Miniaturization of surgical instruments and implants is making it possible to perform an ever-widening variety of surgical procedures on an outpatient basis, thereby avoiding a costly hospital admission. Many procedures that once required an incision are now performed percutaneously.

Along with tremendous changes in surgery technology and anesthesia techniques, the reimbursement for ASC procedures has expanded. In recent years the Centers for Medicare and Medicaid Services (CMS) provided updated and expanded lists of ASC-reimbursed procedures. The ASC procedures are limited to those that do not exceed 90 minutes' operating time and a total of 4 hours of recovery / convalescent time.

Anesthesia must be local or regional, or general of not more than 90 minutes. The regulations also exclude procedures that generally result in major blood loss, prolonged invasion of the body cavity or involve major arteries. The ASC procedures included are:

- Commonly performed on an inpatient basis but may safely be performed in an
- Not of a type that are commonly performed or that may be safely performed in a physician's office;
- Limited to procedures requiring a dedicated operating room or surgical suite and generally requiring a post-operative recovery room or short-term (not overnight) convalescent room; and
- Not otherwise excluded from Medicare coverage

With these changes in surgical procedures and reimbursement regulations, thousands of surgical procedures can now be safely and more cost effectively performed in an ambulatory surgical center. ASCs can improve the quality of care received by the patients and delivered by the physicians.

The surgeons and anesthesiologist that are committed to perform ambulatory surgery cases at Clemmons Medical Park ASC have extensive experience in the use of innovative surgical technologies and anesthesia."

Cost Savings for Ambulatory Surgery Centers (ASCs) as Compared to Hospital Outpatient Surgery

On pages 38-39, the applicant states,

"There are huge cost savings related to ambulatory surgery procedures performed in freestanding ASCs as compared to those in hospital outpatient surgery. For all types of surgical procedures, it was estimated that ASCs provided 1.7 billion dollars in Medicare savings in 2008.

CMS has continued to expand the range of services for which ASCs will be paid a facility fee. CMS currently pays ASCs approximately 60% of the outpatient procedure fees paid to hospitals. Medicare currently reimburses the ASC providers less than the hospital provider because ASCs do not have the overhead related to ancillary services, such as Emergency Departments. Also, Medicare co-payment rates are also significantly lower for ASCs as compared to hospital facilities, saving the ASC patient 45 to 60 percent."

Demographic Data

On page 39, the applicant states,

"Given the approximate location of the Clemmons Medical Park ASC to WFUBMC, the WFUBMC 16-county service area was used to project future demand. The following table summarizes growth projections for the WFUBMC outpatient service area as provided by Thomson-Reuters Healthcare.

Population - WFUBMC 16-County Outpatient Service Area						
Age Group	Actual Population 2000	Estimated Population 2010	2000-2010 Average Annual Growth	Projected Population 2015	2010-2015 Average Annual Growth	
0-17	324,284	349,433	0.8%	<i>362</i> ,909	0.8%	
18-44	536,343	536,928	0.0%	534,495	(0.1%)	
45-64	323,373	407,936	2.6%	429,700	1.1%	
65+	178,293	219,154	· 2.3%	258,209.	3.6%	
Total	1,362,293	1,513,451	1.1%	1,585,313	0.9%	

Source: Thomson-Reuters Healthcare Market Planner Plus

The service area population has grown at a consistent rate of 1.1% per year in the past decade and is expected to continue growing by 0.9% per year through 2015. 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 older age groups represent the segment of the population that will most likely utilize the ORs proposed in this project. Those age groups were estimated to grow 2.6% per year and 2.3% per year respectively for the period 2000-2010. These two cohorts are expected to experience continued growth at a rate of 1.1% for ages 45-64 and 3.6% for those aged 65 and higher between 2010 and 2015.

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 17 and older. With a total net gain of 71,862 residents, the population in the service area will have increased demand for healthcare services including ambulatory surgery."

Physician Support

On pages 39, the applicant states,

"The need for the proposed project is consistent with the high demand for ambulatory surgical procedures and the widespread support from numerous surgeons who practice in Forsyth County. These surgeons are members of large General Surgery and Orthopedic physicians groups that have documented their intent to recruit additional surgeons.

In addition to the above surgical cases that are to be performed in the three operating rooms, community physicians have specific recruitment plans. New surgeons will be recruited and encouraged to perform surgical cases at the proposed facility. These newly recruited surgeons are expected to obtain privileges at the facility and at least one hospital in the service area. The applicant expects that these surgeons will perform a total of 3,197 ambulatory surgical cases by project year 3 at the proposed facility."

Proposed Procedure Room

In Section III.1(b), page 41, the applicant discusses the need for the proposed procedure room. 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 inpatient OR (such as open heart), while other procedures (such as partial knee replacements) do not need to be performed in an inpatient OR. Further, there are many procedures 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.

The applicant believes that the benefit of having an adequate supply of procedure rooms is valuable for both the proposed facility and the community."

Projected Utilization—Operating Rooms

In Section IV, page 63, the applicant provides the projected OR utilization at the proposed ASF through the third operating year of the proposed project, as shown in the following table:

Surgical Operating Rooms	Project ?		Project Year 2 (FY 2016)	Project Year 3 (FY 2017)
# of Dedicated Inpatient ORs	,	0	0	. 0
# of Dedicated Outpatient ORs		0	. 0	0
# of Dedicated Ambulatory ORs		3	3	3
# of Outpatient Surgical Cases		2,821	3,001	3,197

As shown in the table above, the applicant projects to perform 3,197 outpatient surgical cases in three ORs by Project Year 3.

In Section III.1(b), pages 41-47, the applicant provides the methodology and assumptions used to project utilization of the proposed operating rooms. On page 41-42, the applicant states,

"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 16-county service area and the growth rates reported in recently submitted Certificate of Need applications were considered as well. The projections were vetted through senior leadership and growth rates that reflect all of these variables were developed."

Step 1

In Step 1, the applicant defines the patient population to be served. On page 42, the applicant states,

"In order to project future demand for surgical services, the applicant began by identifying all impatient and outpatient patient status cases performed at the Inpatient, Outpatient, and Pediatric Surgical Center sites that are on NCBH's license in the date range July 1, 2005 through June 30, 2010 for all surgical specialties. Currently NCBH is licensed for 40 ORs, all of which are located in Ardmore Tower."

Note: On June 10, 2010, North Carolina Baptist Hospital (NCBH) was approved to construct a new building (to be known as the West Campus Surgery Center) to house eight operating rooms (seven additional and one relocated), two procedure rooms, one robotic surgery training room, and one simulation operating room (Project I.D. #G-8460-10). Thus, upon completion of that project, NCBH will be licensed for 47 ORs. That decision is currently under appeal.

Step 2

On page 42, the applicant determined the historical growth in inpatient and outpatient surgical case volumes at NCBH from FY 2006 to FY 2010, as shown in the following table:

Year				Cumulative Growth Rate	IP Growth Rate	OP Growth Rate
	IP .	OP	Total			
FY 2006	11,435	16,029	27,464	-	-	_
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%
FY 2010	12,848	20,133	32,981	2.65%	-4.45%	7.76%
CAGR (con	npounded a	nnual grow	tIı rate)	4.7%	. 3,0%	5.9%

On page 42, the applicant states,

"WFUBMC has experienced a 4.7% total increase in the number of surgical case volumes between Fiscal Years 2006 and 2010, with a CAGR of a CAGR of 4.7%. Inpatient surgical case volumes had a CAGR of 3.0% and outpatient surgical case volumes, which grew at a rate higher than that of impatient surgeries, increased, on average, by 5.9% annually.

It is important to note, OR case volumes in FY 2006 were negatively impacted by the 2005 Blue Cross and Blue Shield of North Carolina (BCBSNC) Contract Negotiations, which resulted in a contract termination of June 4, 2005 followed by a renewal on October 7, 2005. Despite public offers by NCBH to continue to treat BCBSNC patients on terms equivalent to the previous contract and even though the Wake Forest University Health Sciences (WFUHS) BCBSNC contract remained intact, the patients and referring providers were confused by press coverage of the issue. The NCBH cancellation caused significant disruption in referral patterns resulting in BCBSNC patients seeking care from other BCBSNC providers. Without the BCBSNC disruption, it is likely that the first half of FY 2006 utilization could have been much higher than what was actually experienced during and after that time period. It should be noted that the slow growth between FY 2006 and FY 2007 can also be attributed to significant surgeon turnover."

As the chart above illustrates, inpatient surgical cases at NCBH increased in each of the last three years. In FY 2010, inpatient surgical cases decreased by 4.45%. However, the applicant provides no explanation as to why this decrease occurred, as was provided for FY 2006 and FY 2007.

Step 3

The applicant used the historical growth rates to estimate future growth rates for inpatient and outpatient surgical cases. On page 43, the applicant states,

"Using the historical growth rates along with assumptions for future growth including service area population, trends in ambulatory surgery and the increased demand for healthcare services due to Healthcare Reform, the applicant calculated inpatient and outpatient surgical case volumes for FY 2012 through FY 2014 in the following table utilizing an inpatient growth rate of 4.5% for the interim years and an outpatient growth rate of 6.0% for the same time period.

The applicant chose to project future operating room utilization using conservative annual growth rates of 5.0% for inpatient surgeries and 6.25% for outpatient surgeries during the interim years.

Wake Forest Ambulatory Ventures, LLC Project ID # G-8608-10 Page 13

Achievable CAGR	-	
,	IP]	OP
Interim Years	4.50%	6.00%
Project Years	5.00%	6.25%

Interim Years	IP .	OP	TOTAL
FY 2012	14,030	22,621	36,652
FY 2013	14,662	23,979	38,640
FY 2014	15,321	25,417	40,739
Project Years	-		
FY 2015	16,088	27,006	43,094
FY 2016	16,892	28,694	45,586
FY 2017	17,737	30,487	48,224"

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 on page 42, the CAGR for inpatient surgical cases from FY 2006 to FY 2010 was 3.0%. Information reported on NCBH's license renewal applications (LRAs) from 2006 to 2010 (which uses federal fiscal year data) shows that NCBH performed 11,847 inpatient surgical cases in FFY 2006 and 13,357 inpatient surgical cases in FFY 2010, also resulting in a CAGR of 3.0%. The number of inpatient surgical cases decreased by 4.45% between FY 2009 and FY 2010. However, the applicant provides no explanation as to why this decrease occurred. Furthermore, information reported on NCBH's 2011 LRA (the most recent data available) also shows that inpatient surgical cases declined from FFY 2009 to FFY 2010. In FFY 2009, NCBH performed 13,357 inpatient surgical cases and in FFY 2010, NCBH performed 12,658 inpatient surgical cases, which is a decrease of 5.2% (12,658 - 13,357 = -699 / 13,357 = -5.2%). Thus, the applicant's projected growth rates for inpatient surgical cases of 4.5% during the interim years and 5.0% during the project years are unsupported. Not only are the projected growth rates higher than the CAGR over the past four years, but the number of inpatient surgical cases is decreasing, not increasing. And, unlike the earlier decrease, the applicant provides no explanation to support its assumption that the number of inpatient surgical cases will increase in the future despite the recent decrease.

Step 4

On page 44, the applicant used the projected growth rates in Step 3 and the methodology used to project the need for additional ORs from the 2010 SMFP to determine the number of ORs needed at NCBH through the third year of the proposed project, as shown in the table below:

Year	Inpatient	Inpatient	Total	Outpatient	Outpatient	Total	Total	Hours	Projected
1 CAL	Cases	Case	Inpatient	Cases	Case Time	Outpatient	Combined	per OR	ORs
		Time	Case			Case Hours	Hours	per	needed in
	į		Hours		-		•	Year	2017
Interim Y	Zears								
FY	14,030	3.0	42,091	22,621	1.5	33,932	76,023	1,872	40.6
2012									
FY	14,662	3.0	43,985	23,979	1.5	35,968	79,953	1,872	42.7
2013									
FY	15,321	3.0	45,964	25,417	1.5	_38,126	84,091	1,872	44.9
2014					<u> </u>		l	l	l
Project ?	Years .			·			T	·	
FY	16,088	. 3.0	48,263	27,006	1.5	40,509	88,772	1,872	47.4
2015				<u> </u>				ļ	ļ
FY	16,892	3.0	50,676	28,694	1.5	43,041	93,717	1,872	1 50.1
2016		.}		<u> </u>				ļ	ļ
FY	17,737	3.0	53,210	30,487	1.5	45,731	98,941	1,872	52.9
2017		<u> </u>	1	<u> </u>		<u> </u>	<u> </u>	1	<u> </u>

As shown in the table above, the applicant states NCBH will need 53 ORs by FY 2017. NCBH is currently licensed for 40 ORs. Thus, the applicant states there will be a deficit of 13 ORs by 2017 (53-40=13). However, on June 10, 2010, NCBH was approved to develop seven new ORs (Project I.D. #G-8460-10). Upon completion of that project, NCBH would be licensed for 47 ORs. Thus, based on the applicant's assumptions, a deficit of six ORs is projected by 2017 (53-47=6). On page 44, the applicant states,

"Although the above need methodology reveals a system deficit of -12.9 operating rooms, the proposed project does not request approval for incremental ORs. The current project proposes the relocation of 3 existing operating rooms that will allow for a shift of clinically appropriate ambulatory procedures from WFUBMC to the Clemmons Medical Park ASC location."

However, the applicant's projected need for 53 ORs at NCBH in FY 2017 is overstated because the projected number of inpatient surgical cases is overstated based on unsupported growth rates in the interim and project years. (See Step 3 for discussion.)

Steps 5 and 6

In Step 5, the applicant determined the number of ambulatory surgical cases that would shift from NCBH to the proposed facility in Clemmons. On pages 44-45, the applicant states,

"The applicant established criteria to determine what patient population would be appropriate to shift from WFUBMC [i.e. NCBH]. First, the applicant identified all outpatient status cases performed at the Inpatient, Outpatient, and Pediatric Surgical Center Sites in the date range July 1, 2009 through June 30, 2010 for all surgical

specialties. Outpatient status cases were then further filtered to include only adult cases, which was defined as 17 years of age or older at the time of surgery. All pediatric surgical cases will continue to be performed in the pediatric operating rooms at Brenner Children's Hospital.

Further selection refinement was accomplished on this subset of patients by analyzing the types of outpatient surgical procedures that would be appropriate to shift to an off-site location. A comprehensive list of all outpatient surgical procedures that was performed in FY 2010 was created, and OR leadership, with input from a number of surgeons, abbreviated the list to include only low acuity outpatient surgical procedures. The number of cases was determined by reviewing not only the appropriate cases with OR staff, but also takes into consideration the anticipated increases in ambulatory surgical case volumes that will result from the recruitment of additional surgical faculty. Furthermore, the anticipated increases in surgical demand as a result of Healthcare Reform were also considered. Therefore, of the total 20,133, the number of ambulatory surgical cases that fit the aforementioned criteria for FY 2010 was 9,060 cases."

Ratio of Low Acuity/Adult Only Ambulatory Cases Divided into	
Total Ambulatory Cases FY 10 WFUBMC Ambulatory OR Volumes	20,133
FY 10 West Campus Volumes	. 9,060
FY 10 Percentage	45%

Step 7

On page 45, the applicant applies the percentage of low acuity ambulatory cases calculated in Step 6 (45%) to the projected number of outpatient surgical cases from Step 3 to determine the number of cases to be shifted to the proposed facility in Clemmons, as shown in the table below:

Interim Years	Projected	Projected Low
,	OP Cases	Acuity OP Cases
		to be Shifted
FY 2012	22,621	10,180
FY 2013	23,979	10,790
FY 2014	25,417	11,438
Project Years		
FY 2015	27,006	
FY 2016	. 28,694	12,912
FY 2017	.30,487	13,719

The applicant states it expects the 45% shift of outpatient cases from NCBH to the proposed facility to remain constant through Project Year 3.

Step 8

On page 46, the applicant applied the methodology used to project the need for additional ORs from the 2010 SMFP to determine the number of ORs needed at NCBH for low acuity outpatient surgical cases through the third year of the proposed project, as shown in the table below:

T	4774	Ambulatory	Hours/OR	ORs
Interim Years	Ambulatory Cases	Hours	LIVE S/OIL	V.G
FY 2012	10,180	15,269	1,872	8.2
FY 2013	10,790	16,186	1,872	8.6
FY 2014	11,438	17,157	1,872	9.2
Project Years				
FY 2015	12,153	18,229	1,872	9.7
FY 2016	12,912	19,368	1,872	10.3
FY 2017	13,719	20,579	1,872	11.0

On page 46, the applicant states,

"This analysis resulted in an operating room need of 11.0 ORs by FY 2017 (Project Year 3) to accommodate demand. As specified in this Question (a) (I) (A), for a positive difference of 0.5 or greater, the need is the next highest whole number for fractions of 0.5 or greater. Therefore, a total of 11 operating rooms are needed to accommodate the projected demand for this sub-set of surgical patients."

Step 9

On page 46, the applicant states,

"Based upon the volumes projected in Step 7, the applicant determined the surgical case volumes for select surgical specialties that would shift along with projected incremental growth from the main campus. Those volumes account for 61% of the total Clemmons Medical Park ASC volumes and the remaining 39% will be performed by surgeons from the community. Please see letters from the community surgeons included in Exhibit 12, in which these surgeons state their intention to utilize the new Clemmons Medical Park ASC. The projected Clemmons Medical Park ASC low acuity ambulatory case volumes are presented in the following table.

Interim Years	Ambulatory	Low Acuity	Clemmons Medical
	Cases	Ambulatory	Park ASC Low .
		Cases	Acuity/Ambulatory
			Cases
FY 2012	22,621	10,180	_
FY 2013	23,979	10,790	
FY 2014	25,417	11,438	
Project Years	No.		•
FY 2015	27,006	12,153	2,821
FY 2016	28,694	12,912	3,001
FY 2017 .	30,487	13,719	. 3,197

^{*}The proposed Clemmons Medical Park ASC is projected to be operational in July 2014.

On page 47, the applicant states,

"It is important to note that the projected surgical volumes for this project were adjusted to reflect the projected ambulatory surgical cases and hours represented in [the] Davie Certificate of Need (CON ID# G-8078-08). FMC/Clemmons Medical Center Certificate of Need (CON ID# G-8165-08) and NCBH — Policy AC-3 OR Certificate of Need (CON ID# G-8460-10). Furthermore, surgical cases projected in the West Campus CON are inclusive of all surgical specialties (Dentistry, Otolaryngology, General Surgery, General Pediatrics, General Vascular, Gynecology, Neurosurgery, Ophthalmology, Orthopedics, Physiatry, Plastics and Urology), whereas, the surgical specialties slated for the proposed Clemmons ASC reflects only a small subset (Orthopedics, General Surgery, Obstetrics/Gynecology, Otolaryngology and Plastics). [Emphasis added.]

As previously discussed, select surgical specialties were indentified to shift to Clemmons Medical Park ASC and the percentage of total ASC volumes by specialty are outlined in the table below.

Clemmons ASC Surgical Service Mix	Percent of Total
Orthopedics	42%
General Surgery	22%
Obstetrics/Gynecology	17%
Otolaryngology	11%
Plastics	8%".

The applicant says it adjusted volumes to account for three recently approved projects involving ORs in Forsyth and Davie counties. However, the applicant fails to provide any explanation of how it "adjusted" volumes to reflect the development of the replacement Davie County Hospital, the Clemmons campus of Forsyth Medical Center, or the approval of seven additional dedicated outpatient ORs at NCBH. The FMC Clemmons Medical Center

project includes the relocation of five shared CRs from Winston-Salem to Clemmons. Like the proposed ASF in Clemmons, the FMC Clemmons Medical Center will also provide outpatient surgical services and will be located less than three miles from the proposed ASF. The replacement Davie County Hospital project includes the relocation of two shared ORs from Mocksyille to Bermuda Run, approximately 9.5 miles from the proposed ASF. The West Campus Surgery Center project includes the development of seven additional dedicated ambulatory ORs and will be located on the campus of NCBH, approximately 8.7 miles from the proposed ASF. Some of the same WFUHS surgeons who will utilize the proposed ASF in Clemmons are expected to utilize the new ORs at NCBH. All three of these facilities will perform outpatient surgical cases in the replacement/new ORs. Given that there is no explanation of how volumes were adjusted, the applicant does not adequately demonstrate that it took these recently approved projects into account when it proposed to relocate the PSCNC ORs to Clemmons and to convert them from single specialty to multi-specialty.

In Section III.1(b), page 40, the applicant provides a table listing the physicians, by specialty, projected to utilize the three ORs at the proposed facility in Clemmons, and the number of cases projected to be performed, by physician, in each of the project years. Letters of support from the physicians listed on page 40 are included in Exhibit 12. The following table summarizes the number of cases, by specialty, projected to be performed:

	# of Surgical Cases		
Specialty -	PY 1	PY 2	PY3
Orthopaedic Surgery	801	1,077	1,376
ENT	159	183	208
General Surgery	331	377	430
OB/GYN	186	213	237
Plastic Surgery	122	140	160
"Additional Recruitment"	. 1,222	1,011	786
Total	2,821	3,001.	3,197

However, prior to the beginning of the review of this project, an orthopaedic physician group consisting of four physicians withdrew its support for the proposed project, including the estimated number of cases projected to be performed by the physician group at the proposed facility. The physician group had projected to perform a total of 180 cases in Project Year 1, 355 cases in Project Year 2, and 545 cases in Project Year 3. Thus, the number of surgical cases projected to be performed is overstated by 180 cases in Project Year 1 (801 – 621 = 180), 355 cases in Project Year 2 (1,077 – 722 = 355), and 545 cases in Project Year 3 (1,376 – 831 = 545). The following table summarizes the number of cases, by specialty, projected to be performed minus the cases that were projected to be performed by the physician group that withdrew its support for the proposed project:

	# of Surgical Cases		ises
Specialty	PY 1	PY 2	PY 3
Orthopaedic Surgery	· 621	722	831
ENT	159	183	208
General Surgery	331	377	430
OB/GYN	186	213	237
Plastic Surgery	122	140	160
"Additional Recruitment"	1,222	1,011	786
Total	2,641	2,646	2,652

Additionally, in Section III.1(b), pages 40-41, the applicant states,

"In addition to the above surgical cases that are to be performed in the three operating rooms, community physicians have specific recruitment plans. New surgeons will be recruited and encouraged to perform surgical cases at the proposed facility. These newly recruited surgeons are expected to obtain privileges at the facility and at least one hospital in the service area. The applicant expects that these surgeons will perform a total of 3,197 ambulatory surgical cases by project year 3 at the proposed facility. Please see Exhibit 13 for documentation regarding physician recruitment." [Emphasis added.]

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11.

Exhibit 13 includes letters from 5 Wake Forest University Department Chairs which describe WFUHS' planned recruitment of the following:

- 9 additional Orthopaedic Surgery faculty members
- 4 additional Otolaryngology faculty members
- 6 additional General Surgery faculty members
- 3 additional Obstetrics and Gynecology faculty members
- 6 additional Plastic and Reconstructive Surgery faculty members

However, the new physicians listed above are <u>not</u> "community physicians." These will be faculty members of WFUHS.

Exhibit 13 also includes a letter from the Executive Director of WFU Physicians and Vice President of Regional Business Development for WFUBMC, which states,

"As the Executive Director of Wake Forest University Physicians and Vice President of Regional Business Development for Wake Forest University Baptist Medical Center, I am actively recruiting physicians from the surrounding communities to utilize the proposed Clemmons Medical Park Ambulatory Surgery Center (ASC). At present, several individual physicians and physician groups have expressed a strong interest in operating at Clemmons Medical Park ASC given that there are currently

no other multispecialty ASC options available in Forsyth County. I am certain that we will have adequate support for the operating rooms by Project Year 1.

In addition to the physicians that have presently expressed a strong interest in Clemmons Medical Park ASC, I plan to continue physician recruitment efforts during the four year span between Clemmons Medical Park ASC CON approval and Project Year 1. The additional recruitment combined with the current interest in operating at Clemmons Medical Park ASC will result in case volumes necessary to support the three operating rooms." [Emphasis added.]

However, the applicant does not provide any letters of support from any community physicians or physician groups regarding their willingness to utilize the ORs at the proposed facility, the number of surgical cases they expect to perform, or the number of additional physicians they expect to recruit. [The orthopaedic physicians that withdrew their support were the only community physicians (i.e. not faculty members of WFUHS) to provide letters.] Therefore, the applicant does not adequately demonstrate that projected utilization based on its assumptions that "community physicians" will utilize the proposed ASF and recruit additional "community physicians" is reasonable and supported.

Furthermore, the applicant does not discuss the potential impact on existing and approved ORs in Forsyth and Davie counties of shifting patients from other facilities which is likely if "community physicians" are expected to perform 39% of the total number of cases to be performed at the proposed ASF. Additionally, the applicant fails to explain why that number is expected to decline from 1,222 cases in Project Year 1 to only 786 cases in Project Year 3.

In summary, the number of surgical cases projected to be performed in the first three project years based on utilization by "community physicians" is unsupported. As a result, the projected number of surgical cases to be performed in the first three operating years that the applicant attributes to "additional recruitment" (1,222 cases in Project Year 1, 1,011 cases in Project Year 2, and 786 cases in Project Year 3) is also overstated.

Step 10

On page 47, the applicant applied the methodology used in the 2010 SMFP to determine the number of ORs needed at the proposed ASF, as shown in the following table:

	Projected Ambulatory Cases	Ambulatory Case Time	Ambulatory Hours	Hours/ORs	Projected Ambulatory ORs Needed
					in FY2017
FY2015	2,821	1.5	4,231	1,872	2.3
FY2016	3,001	1.5	4,502	1,872	2.4
FY2017	3,197	1.5	4,796	1,872	2.6

As shown in the table above, the applicant projects a need for 2.6 or, rounding to the next whole number, 3 ORs in Project Year 3. However, after adjusting for the projected number of cases to be performed by the orthopaedic physician group that withdrew its support for the proposed project and the number of cases attributed to "additional recruitment," the applicant demonstrates a need for only two ORs in the third year of proposed project, as illustrated in the table below:

4		Projected Ambulatory Cases	Ambulatory Case Time	Ambulatory Hours	Hours/ORs	Projected Ambulatory ORs Needed in FY2017
	FY2015	1,419	1.5.	· 2,129	1,872	. 1.1
Ì	FY2016	1,653	1.5	2,480	1,872	1.3
	FY2017	1,866	1.5	2,799	1,872	1.5

Thus, the applicant's projected OR need by Project Year 3 is overstated by at least one OR. Projected Utilization—Procedure Room

The applicant proposes to develop one procedure room at the proposed facility. In Section IV, page 63, the applicant provides the projected utilization of the proposed procedure room through the third operating year of the proposed project, as shown in the following table:

Procedure Room	Project Year 1 (2015)	Project Year 2 (2016)	Project Year 3 (2017)
# of Procedure Rooms	1	1	. 1
# of Procedure Room Cases	270	499	750

As shown in the table above, the applicant projects to perform 750 procedure room cases in one procedure room by Project Year 3.

In Section III.1(b), pages 48-50, the applicant provides the methodology and assumptions used to project utilization of the proposed procedure room.

Step 1

In this step, the applicant analyzed the growth in the number of procedure room cases performed by WFUHS physicians at NCBH. On page 48, the applicant states,

"The applicant reviewed historical data for Fiscal Years 2005 through 2010 in order to determine volume growth and trends occurring specifically to surgical procedures performed in its [sic, the rooms are part of NCBH, which is not the applicant] procedure rooms located in CompRehab Plaza. It must be noted that procedures performed in the six Interventional Radiology (IR) rooms and five Cardiac Cath room [sic] were excluded as neither the rooms nor the cases would be appropriate in the methodology calculations. Both the IR rooms and the Cardiac Cath rooms require

very specific equipment and faculty who perform the procedures, and in the case of the six IR rooms, radiologists perform the procedures not the surgeons.

An analysis of WFUBMC patient records was further conducted for the last six fiscal years to identify patient cases that would be eligible to be performed in a procedure room. The analysis excluded emergency room patients, all endoscopy patients, all interventional radiology patients, all cardiac cath patients and all patients whose procedure [sic] 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 increase in the number of cases by over 200% in the last six years.

Fiscal Year	Cases Performed in a Procedure	% Change from PY [Previous Year]
	Room Volume	[LICVIOUS XCAL]
2005	1,032	
2006	1,344	30.23%
2007	1,992	48.21%
2008	2,798	40.46%
2009	3,217	. 14.97%
2010	3,458	7.49%

^{*}CompRehab Procedure Room opened in 2005.

Step 2

The applicant states the hours of operation at CompRehab are 6:45 am - 5:00 pm, Monday through Friday. On page 49, the applicant states,

"The capacity of each procedure rooms [sic] depends on several factors, such as complexity of the procedure, patient condition and urgency of procedure." However, for 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."

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Step 3

On pages 49-50, the applicants discuss the historical growth in the number of procedures at CompRehab. On page 49, the applicant states,

"Since 2005, the volume of outpatient procedure cases has grown by over 200%.

Based on its own 4 year historical growth rate, the applicant chose to utilize a conservative 7.5% growth rate for the three project years. Wake Forest Ambulatory Ventures, LLC believes this a [sic] 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, FY 09 and FY 10 change.
- * WFUHS has recruited additional physicians that will continue to contribute to the increase in procedure case volumes at WFUBMC. These faculty recruits are anticipated to increase the volume of implantable pain devices as well as the number of wologic cases referred for prostate biopsies and other treatment."

The applicant states that projected procedure room volumes will be split between CompRehab, the West Campus Surgery Center (NCBH was approved to develop two procedure rooms as part of Project I.D. # G-8460-10), and the proposed ASF facility in Clemmons. The applicant's methodology and assumptions results in the need for a total of six procedure rooms in Project Year 3, as illustrated in the following table:

Year	# of Procedures	Procedure Room Capacity	Total # of Procedure Rooms Needed	# of CompReh2b Procedures	# of West Campus Surgery · Center	# of Clemmons ASC´ Procedures	Total Procedure Room Procedures
					Procedures		2,798
FY 2008	2,798	1,040	3	2,798	<u> </u>		
FY 2009	3,217	1,040	3	3,217			3,217
FY 2010	3,458	1,040	3 ·	3,458			3,426
Interim Y	ears				;		T
FY 2011	3,717	. 1,040	4 .	3,717	· <u>-</u>	-	3,649
FY 2012	3,996	1,040	4	3,996	-		3,886
FY 2013	4,296	1,040	4	2,802	1,494	- :	- 4,139
FY 2014	4,618	1,040	4	3,013	1,605		4,408
Project Y	ears					<u></u>	1
FY 2015	4,964	1,040	5	3,062	1,632	270	4,694
FY 2016	5,337	1,040	5	3,084	1,754	499	5,337
FY 2017	5,737	1,040	6	3,102	1,885	750	5,737

As shown in the table above, the applicant projects the need for six procedure rooms by Project Year 3. However, the projected number of cases to be performed in the procedure room is not based on reasonable and supported assumptions. One, four orthopaedic surgeons withdrew their support. Two, the applicant's assumptions regarding utilization by other "community physicians" are not adequately documented. See discussion above. Thus, the applicant did not adequately demonstrate the need for the proposed procedure room.

The three PSCNC ORs to be relocated have been chronically underutilized for many years. At present, they are not being utilized. The applicant does not adequately demonstrate the need to construct a replacement facility in Clemmons and to convert PSCNC from a single specialty program to a multi-specialty program for the following reasons:

- Based on historical data for NCBH, the CAGR for inpatient surgical cases from FY 2006 to FY 2010 was 3.0%. However, the number of inpatient surgical cases decreased by 4.45% between FY 2009 to FY 2010. Additionally, LRA data for NCBH shows a decrease of 5.2% from FFY 2009 to FFY 2010. The applicant does not provide an explanation for this decrease or explain why it would be reasonable to assume that impatient surgical cases will increase in the near future. Thus, the applicant's projected growth rates for inpatient surgical cases of 4.5% and 5.0% during the interim and project years, respectively, are unsupported. Consequently, the applicant's conclusion that NCBH will need 53 ORs by 2017 is also unsupported.
- The applicant does not explain how it "adjusted" volumes to reflect the development of the replacement Davie County Hospital, the Clemmons campus of Forsyth Medical Center, or the approval of seven additional ORs at NCBH. Specifically, the applicant did not provide any data to support its assumptions regarding the potential impact that those existing or approved ORs will have on projected utilization and market shifts in the proposed service area. The approved ORs are all located within 10 miles of the proposed ASF.
- Prior to the beginning of the review of this project, an orthopaedic physician group consisting of four physicians withdrew its support for the proposed project, including the estimated number of cases projected to be performed by the physician group at the proposed facility. The physician group had projected to perform a total of 180 cases in Project Year 1, 355 cases in Project Year 2, and 545 cases in Project Year 3. Thus, the number of outpatient surgical cases projected to be performed is overstated by 180 cases in Project Year 1, 355 cases in Project Year 2, and 545 cases in Project Year 3.

The applicant assumes 39% of all cases will be performed by "community physicians." Presumably, by this, the applicant means these physicians are not faculty members of WFUHS and do not currently perform surgery at NCBH. Instead, they perform surgery at Forsyth Medical Center, Davie County Hospital, Medical Park Hospital, and other community hospitals. The applicant does not adequately demonstrate that any "community physicians" will utilize the proposed ASF. As discussed above, four orthopaedic surgeons withdrew their support for the proposal and indicated they will not be performing surgery in the facility after all. When the cases they were expected to perform are subtracted, the applicant only demonstrates a need for two ORs, not three. Furthermore, the applicant does not address the impact on other facilities, particularly the replacement Davie County Hospital and the Clemmons campus of Forsyth Medical Center, if existing "community physicians" were to shift their surgical cases to the proposed ASF.

The applicant states physicians will be recruited "from the surrounding communities to utilize the proposed Clemmons Medical Park Ambulatory Surgery Center." However, the applicant does not provide any letters of support from any "community physicians" or physician groups regarding their willingness to utilize the ORs at the proposed facility, the number of surgical cases they expect to perform, or the number of additional physicians they expect to recruit. In addition, when the cases projected to be performed as a result of "additional recruitment" are subtracted, the applicant only demonstrates a need for two ORs, not three.

Therefore, the applicant does not adequately demonstrate the need for the proposed multispecialty ASF with three ORs in Clemmons.

In summary, the applicant adequately identified the population to be served but did not adequately demonstrate the need that the population has for proposal. Therefore, the application is nonconforming 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.

C

The applicant proposes to relocate the three ORs formerly known as PSCNC from Winston-Salem to Clemmons. The applicant acquired PSCNC in June 2009. In FFY 2009, only 148 surgical procedures were performed at PSCNC. Currently, the three ORs at PSCNC are not in use. In Section III.1(b), page 35, the applicant states,

"The current Plastic Surgery Center of North Carolina (PSCNC) operating rooms are antiquated and do not meet modern operating room standards. The rooms are outdated and too small to accommodate the modern equipment that is necessary to provide exceptional patient care. WFUHS faculty surgeons consider the current condition of the PSCNC operating rooms to be inadequate and are opposed to utilizing the rooms without renovation. Because the building housing the PSCNC operating rooms is owned by a third party, WFUHS has ceased using the PSCNC operation rooms while Clemmons Medical park ASC is being developed, unless the CON Section approves their use at another location in the interim. Relocation of the PSCNC ambulatory surgery facility to the Clemmons Medical Park location will provide an opportunity to expand and enhance those operating room assets to improve patient safety as well as operating room efficiency and utilization."

Because the ORs to be relocated are currently not being utilized, no patients will be impacted as a result of the proposed project. The three ORs at PSCNC are located approximately 7.5

miles away from the proposed ASF in Clemmons. Thus, the replacement facility would be geographically accessible to the same population formerly served at the PSCNC. The relocation and replacement of the ORs would have a positive effect on the ability of low income persons, racial and ethnic minerities, women, handicapped persons, and other underserved groups and the elderly to obtain needed health care. Consequently, the application is conforming to this criterion.

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

NC

In Section III.8, pages 57-58, the applicant describes the alternatives considered:

- Maintain the status quo
- Relocate the ORs to the NCBH campus
- Develop a freestanding ambulatory surgical center in Winston-Salem
- Develop a freestanding ambulatory surgical center in Clemmons

However, the application is not conforming to all other applicable statutory and regulatory review criteria. See Criteria (3), (5), (6), (18a), and the Criteria and Standards for Surgical Services and Operating Rooms, promulgated in 10A NCAC 14C .2100. Therefore, the applicant did not adequately demonstrate that the proposal is its least costly or most effective alternative and the application is nonconforming to this criterion.

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

NC

In Section VIII, pages 83-84, the applicant projects the total capital expenditure for the project will be \$8,553,928, which includes \$1,024,925 for land purchase and site preparation costs; \$3,242,500 for construction costs; \$3,468,684 for movable equipment; \$60,000 for furniture; \$365,700 for consulting fees and engineering fees; and \$392,119 for other miscellaneous costs. In Section IX, page 87, the applicant projects start-up expenses of \$158,198 and initial operating expenses of \$374,270, for a total working capital of \$532,468.

The applicant proposes to finance the capital and working capital costs with the accumulated reserves of WFUHS. Wake Forest Ambulatory Ventures LLC is a wholly owned subsidiary of WFUHS. Exhibit 21 contains a letter from the Executive Vice President for Finance and Chief Financial Officer of WFUHS, which states,

"Wake Forest University Health Sciences agrees to make available from its accumulated reserves a total of \$8,553,928 for the capital costs incurred in the development of the aforementioned project.

As Treasurer for Wake Forest University Health Sciences, I can attest to the availability of funds for this purpose. These funds will be made available from the accumulated reserves of Wake Forest University Health Sciences. Please reference our audited financial statements, particularly our balance sheet, for evidence that funds are available for this purpose."

Exhibit 21 contains a second letter from the Executive Vice President for Finance and Chief Financial Officer of WFUHS, which states,

"Consistent with the information in the CON application, a total of \$532,468 has been identified to provide the working capital necessary to fund the operating expenses expected during the initial operating period. In the event that the initial capital requirements are exceeded by unforeseen circumstances such as those defined in NCGS 131E-176(16e), WFUHS will provide the funds necessary to ensure development of the proposed project."

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Exhibit 22 contains the audited financial statements for WFUHS. As of June 30, 2010, WFUHS had \$9,877,000 in cash and cash equivalents, \$1,102,285,000 in total assets, and \$559,199,000 in net assets (total assets less total liabilities). The applicant adequately demonstrated the availability of sufficient funds for the capital and working capital needs of the project.

In the pro forma revenue and expense statements, the applicant projects that revenues will exceed operating costs for the entire facility in each of the first three full operating years of the proposed project. The assumptions used by the applicant are in Section XIII (financial statements). However, the applicant's projected utilization is unsupported and unreliable. Thus, costs and revenues that are based on this projected utilization are also not reliable. See Criterion (3) for discussion of projected utilization. Therefore, the applicant did not adequately demonstrate that the financial feasibility of the proposal is based upon reasonable projections of costs and revenues. Therefore, the application is nonconforming 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.

The applicant did not adequately demonstrate that the proposal would not result in the unnecessary duplication of existing or approved health service capabilities for the following reasons: First, the applicant's projected growth rates for inpatient surgical cases are unsupported and unreliable. Thus, the applicant overstates the need for ORs at NCBH. Second, the applicant's assumptions regarding the number of orthopaedic physicians projected to utilize the proposed facility are unsupported and unreliable. Third, the applicant relies on unsupported and unreliable assumptions regarding the number of "community physicians" expected to utilize the proposed ASF. Thus, the number of surgical cases and procedures projected to be performed at the proposed ASF is overstated. Consequently, the number of ORs and procedure rooms needed is overstated. Fourth, the applicant states it made adjustments for the replacement Davie County Hospital, the seven additional ambulatory surgical ORs to be developed at NCBH and the Clemmons campus of Forsyth Medical Center. However, the applicant fails to explain or document how it took these existing and approved ORs into account. See Criterion (3) for additional discussion. Therefore, the application is nonconforming 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.

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In Section VII.2, page 74, the applicant provides the projected staffing for the proposed facility. The applicant projects that the proposed facility will be staffed with 24.10 full-time equivalent (FTE) positions in the second year of the project. In Section VII.3(a), page 74, the applicant states that all of these positions are new positions. In Section VII.3(b), pages 74-75, the applicant describes the methods it will use to recruit staff for the new positions. In Section V.3, page 65, the applicant identifies Andrea Fernandez, M.D., as having expressed interest in serving as the medical director for the proposed facility. 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.1, page 10, the applicant provides a list of the necessary ancillary and support services which will be available at the proposed facility. Additionally, in Section II.2(a), page 11, the applicant states that the following professional, ancillary, and support services will be provided by Wake Forest University Baptist Medical Center (WFUBMC):

- 1. Anesthesiology and CRNA Services
- 2. Pathology Professional Services
- 3. Laboratory Services
- 4. Pharmacy Consulting

In Section V.2(a), page 64, the applicant states it is willing to establish a transfer agreement with WFUBMC. Exhibit 4 contains a copy of a draft transfer agreement between the applicant and WFUBMC. Exhibit 12 includes copies of letters from WFUHS physicians supporting the proposed ASF.

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.

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When applicable, the applicant shall show that the special needs of health maintenance organizations will be fulfilled by the project. Specifically, the applicant shall show that the project accommodates: (a) The needs of enrolled members and reasonably anticipated new members of the HMO for the health service to be provided by the organization; and (b) The availability of new health services from non-HMO providers or other HMOs in a reasonable and cost-effective manner which is consistent with the basic method of operation of the HMO. In assessing the availability of these health services from these providers, the applicant shall consider only whether the services from these providers: (i) would be available under a contract of at least 5 years duration; (ii) would be available and conveniently accessible through physicians and other health professionals associated with the HMO; (iii) would cost no more than if the services were provided by the HMO; and (iv)would be available in a manner which is administratively feasible to the HMO.

NA

- (11) Repealed effective July 1, 1987.
- 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 12,500 square foot building for the proposed facility. In Section XL6(a), the applicant provides details of the square footage allocation, as shown in the table below:

***	Total Square
•	Footage / New
	Construction
Pre/Post-Operative	2,040
Operating and Procedure Rooms	1,890
Administration -	460
Support	8,110
Total	12,500

The certified estimate of construction costs from the architect, included in Exhibit 10, is consistent with the construction costs reported by the applicant in Section VIII, page 83. In Section XI.6(b), page 124, the applicant estimates construction costs of \$684 per square foot. In Section XI.8, page 94, 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 project as proposed 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;

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In Section VI.12, page 71, the applicant provides the payor mix for PSCNC, as illustrated in the following table.

PSCNC - Current Payor Mix (1983)	
Self Pay/Indigent/Charity	100.0%
Commercial	
Medicare/Medicare Managed Care	<u> </u>
Medicaid	
Managed Care	1
Other	ļ
TOTAL	100.0%

However, the applicant does not indicate the time period for the table above. The Project Analyst concluded that the payor mix shown in the table above reflects the payor mix of the plastic surgery practice prior to WFUHS' acquisition of the ORs at PSCNC. In Section II.10, page 19, the applicant provides a list of the 20 procedures performed at PSCNC in the 12 months preceding submittal of the application. It appears many of the procedures performed at PSCNC would not have been reimbursed by Medicare or Medicaid, thereby limiting the extent to which medically underserved populations had access to services at the facility. Furthermore, in Section III.(b), page 35, the applicant states that the three ORs at the PSCNC are currently not in use. The applicant states, "Because the building housing the PSCNC operating rooms is owned by a third party, WFUHS has ceased using the PSCNC operating rooms while Clemmons Medical Park ASC is being developed..." Therefore, this criterion is not applicable to this application.

(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;

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In Section VI.10(a), page 70, the applicant states, "Clemmons Medical Park ASC is a new entity and has no civil rights equal access complaints on file. No civil rights equal access complaints have been filed against WFUHS or any facilities or services owned by WFUHS in North Carolina 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

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In Section VI.14, pages 71-72, the applicant projects the following payor mix for the proposed facility in Project Year 2, as illustrated in the following tables.

- Contractor	FY 2016 30 P	
Ì	Clemnions Medical Paris ORs	行。直接完整法。
	Self Pay/Indigent/Charity	6.11%
Ì	Commercial Insurance/Managed Care	50.38%
	Medicare/Medicare Managed Care	35.75%
	Medicaid	. 7.76%
	TOTAL	100.00%

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omeses
4.41%%
35.47%
12.63%
47.49%
100.00%

In Section VI.14, page 72, the applicant states that the projected payor mix for the proposed services are based on WFUBMC's historical experience. The applicant demonstrates that medically underserved groups would 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 70, the applicant states,

"Physicians with privileges at the facility may refer and schedule patients for procedures. Clemmons Medical Park ASC physicians are expected to receive patient referrals from a large base of primary care physicians in the region."

The applicant adequately demonstrated that would offer a range of means by which patients would 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.

NC

In Section V.1(a), page 64, the applicant states,

"As an academic medical center that has been providing services for more than 85 years, WFUBMC [this is not the applicant] has established relationships with many clinical training programs in the southeast and continues to provide teaching opportunities for these schools. The clinical staff at Clemmons Medical Park ASC will be provided the same access to the existing clinical training programs at WFUBMC. As an academic medical center with recognized national and international expertise in surgery, WFUBMC is one of only a few hospitals in the state that could promulgate its expertise to a freestanding ambulatory surgery center. Please see Exhibit 15 for a list of educational programs that use WFUBMC's facilities for clinical training."

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The applicant states the staff of the proposed ASF will have access to WFUBMC clinical training programs. However, this criterion requires the applicant to demonstrate that the proposed ASF will serve as a clinical training site as applicable. In Section V.1(b), page 64, the applicant states it "has offered to serve as a clinical training site for health professional students." However, the applicant does not provide documentation, such as a letter addressed to an area health professional training program offering the proposed ASF as a clinical training site. Therefore, the applicant does not adequately demonstrate that the proposed ASF would accommodate the clinical needs of area health professional training programs. Thus, the application is nonconforming 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.

NC

The applicant did not adequately demonstrate that the proposal would have a positive impact on cost-effectiveness, quality and access for the following reasons:

1) the applicant did not adequately demonstrate that the proposal is cost-effective [see Criteria (3) and (5) for additional discussion];

2) the applicant did not adequately demonstrate that the proposal will not result in unnecessary duplication of existing or approved health service capabilities or facilities [see Criteria (3) and (6) for additional discussion]; and

3) the applicant did not adequately document the expected effects of the proposed services on competition in the proposed service area [see Criteria (3) and (6) for additional discussion].

Therefore, the application is nonconforming 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.

NA

Although PSCNC is an existing ASF, WFUHS acquired it in June 2009. At present, the facility is not in use. See Section III.1(b), page 35.

- (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.

NC

The Criteria and Standards for Surgical Services and Operating Rooms, promulgated in 10A NCAC 14C .2100, are applicable to this review. However, the application is not 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.

The applicant proposes to convert a single specialty ambulatory surgical program to a multi-specialty ambulatory surgical program. In Section II.10, page 16, the applicant states the following specialty areas will be provided in the facility:

- Orthopedics
- Obstetrics/Gynecology
- Otolaryngology
- Plastics

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- General Surgery
- .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);
 - In Section II.10, page 17, the applicant provides information regarding the number of ORs in each licensed facility owned by WFUMBC. NCBH and WFUHS, separate legal entities, do business as WFUBMC pursuant to an integration agreement. However, the ORs at PSCNC are the only ORs owned by WFUHS in Forsyth County and NCBH does not own a controlling interest in PSCNC. The following table illustrates the number and type of ORs in which WFUHS owns a controlling interest in Forsyth County:

-C-

WFUHS Owned Facilities

Current Operating Roo	m Inventory
Туре	PSCNC
Dedicated Open Heart	
Other Dedicated Inpatient	
Shared	
Inpatient/Outpatient	
Dedicated Outpatient	3
Dedicated C-Section	
Total	3

(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);

In Section II.10, page 17, the applicant provides information regarding the number of operating rooms to be located in each licensed facility owned by NCBH or WFUHS. However, the ORs at PSCNC are the only ORs owned by WFUHS in Forsyth County and NCBH does not own a controlling interest in PSCNC. The following table illustrates the number and type of ORs to be located in the proposed ASF upon completion of the proposed project in which WFUHS owns a controlling interest in Forsyth County:

WFUHS Owned Facilities
Projected Operating Room Inventory

Projected Operating Room Inventory	
Туре	Clemmons Medical Park ASF
Dedicated Open Heart	
Other Dedicated Inpatient	
Shared	}
Inpatient/Outpatient	
Dedicated Outpatient	3
Dedicated C-Section	<u> </u>
Total	3

(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

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the operating rooms in each licensed facility listed in response to Subparagraphs (b)(1) and (b)(2) of this Rule:

In Section II.10, page 18, the applicant provides 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 owned by NCBH or WFUHS. However, the ORs at PSCNC are the only ORs owned by WFUHS in Forsyth County and NCBH does not own a controlling interest in PSCNC. The following table illustrates the number surgical cases performed in the most recent 12 month period at PSCNC:

WFUHS Owned Facilities Total Surgical Cases July 2009 – June 2010

Туре	PSCNC
Inpatient	
Outpatient	165
Total	165

(4) The number of impatient 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;

In Section II.10, page 18, the applicant provides 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 owned by NCBH or WFUHS. However, the ORs at PSCNC are the only ORs owned by WFUHS in Forsyth County and NCBH does not own a controlling interest in PSCNC. The following table illustrates the number of inpatient and outpatient surgical cases to be performed in each of the first three operating years at the proposed ASF:

WFUHS Owned Facilities
Total Projected Inpatient Surgical Cases
WY 2015 - WY 2017

E J. 2013 - E I 2017	
	Clemmons
' Туре	Medical
	Park ASF
Project Year 1 (FY 2015)	n/a
Project Year 2 (FY 2016)	n/a
Project Year 3 (FY 2017)	n/a

WFUHS Owned Facilities
Total Projected Outpatient Surgical Cases
FY 2015 - FY 2017

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Туре	Clemmons Medical Park ASF	
Project Year I (FY 2015)	2,821	
Project Year 2 (FY 2016)	3,001	
Project Year 3 (FY 2017)	3,197	

However, see Criterion (3) for discussion regarding the reasonableness of projected utilization.

- (5) A detailed description of and documentation to support the assumptions and methodology used in the development of the projections required by this Rule:
- In Section III.1(b), pages 34-50, the applicant provides a detailed description of the assumptions and methodology used in the development of the projections required by this Rule. However, the assumptions and methodology used to project the number outpatient surgical cases to be performed at the proposed ASF in Clemmons are unreasonable and unsupported. See Criterion (3) for discussion. Therefore, the application is nonconforming to this Rule.
 - (6) The hours of operation of the proposed operating rooms;
 - C. In Section II.10, page 19, the applicant states the hours of operation of the proposed ASF will be 7:00 am to 5:00 pm, Monday through Friday.
 - (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 19, the applicant provides the average reimbursement per procedure for the 20 surgical procedures most commonly performed at

PSCNC during the preceding 12 months. WFUHS received an exemption from the Certificate of Need Section to acquire PSCNC in June 2009. The applicant is a wholly-owned subsidiary of WFUHS.

- (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;
- -C- In Section II.10, page 20, the applicant provides the projected average reimbursement per procedure for the 20 surgical procedures which the applicant projects will be performed most often in the proposed ASF.
 - (9) identification of providers of pre-operative services and procedures which will not be included in the facility's charge.

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- -C- In Section II.10, page 20, the applicant identifies the providers of preoperative services and procedures which will not be included in the ASF's charge. They are: Anesthesia/CRNA (WFUBMC Anesthesia Department), Pathology (WFUBMC Pathology), and Pharmacy Consulting (WFUBMC Pharmacist).
- .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);
 - PSCNC is currently licensed for three ORs. Upon project completion, the name of the facility and its location within the service area (Forsyth County) will change but the existing ASF would continue to be licensed for three ORs.
 - (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);
 - -C- PSCNC is currently licensed for three ORs. Upon project completion, the name of the facility and its location within the service area (Forsyth County) will change but the existing ASF would continue to be licensed for three ORs.
 - (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;

In Section II.10, page 22, the applicant provides the number of inpatient surgical cases and outpatient surgical cases performed in the most recent 12 month period in the operating rooms in each facility listed in Subparagraphs (c)(1) and (c)(2) of this Rule:

Type	PSCNC
Inpatient .	n/a
Outpatient	165
Total	165

(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;

In Section II.10, page 22, the applicant provides the number of inpatient surgical cases and 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:

Projected Inpatient Surgical Cases
FY 2015 - FY 2017

A A A V A	
Туре	Clemmons Medical
	Park ASC
Project Year 1 (FY 2015)	-
Project Year 2 (FY 2016)	-
Project Year 3 (FY 2017)	<u>i</u>

Projected Outpatient Surgical Cases FY 2015 - FY 2017

FI HOLD XX AVX						
	Clemmons'					
Туре	Medical					
	Park ASC					
Project Year 1 (FY 2015)	2,821					
Project Year 2 (FY 2016)	3,001					
Project Year 3 (FY 2017)	3,197					

However, see Criterion (3) for discussion regarding the reasonableness of projected utilization.

- (5) a detailed description of and documentation to support the assumptions and methodology used in the development of the projections required by this Rule;
- In Section III.1(b), pages 34-50, the applicant provides a detailed description of the assumptions and methodology used in the development of the projections required by this Rule. However, the assumptions used to project the number of outpatient surgical cases at the proposed ASF in Clemmons are unreasonable and unsupported. See Criterion (3) for discussion. Therefore, the application is nonconforming to this Rule.
 - (6) the hours of operation of the facility to be expanded;
- In Section II.10, page 23, the applicant states that the proposed ASF's hours of operation will be 7:00 am to 5:00 pm, Monday through Friday.
 - (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;
 - In Section II.10, page 23, the applicant provides the average reimbursement per procedure for the 20 surgical procedures most commonly performed at PSCNC during the preceding 12 months. WFUHS received an exemption from the Certificate of Need Section to acquire PSCNC in June 2009. The applicant is a wholly-owned subsidiary of WFUHS. The ORs are not currently in use. Thus, it is assumed that the 20 procedures most commonly performed were those performed before WFUHS acquired the facility.
 - (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
 - -C- In Section II.10, page 24, the applicant provides 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 relocated facility.
 - 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 20, the applicant identifies the providers of preoperative services and procedures which will not be included in the ASF's charge. They are: Anesthesia/CRNA (WFUBMC Anesthesia Department), Pathology (WFUBMC Pathology), and Pharmacy Consulting (WFUBMC Pharmacist):
- .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 23, the applicant states that the proposed ASF's hours of operation will be 7:00 am to 5:00 pm, Monday through Friday.
- .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:
 - (1) demonstrate 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 traima centers, one operating room for facilities with designated burn intensive care units, and all dedicated open heart and C-section operating rooms or demonstrate 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;" and
 - (2) 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 6 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

-MC-

The service area (Forsyth County) has more than 10 ORs. In Section II.10, page 26, the applicant states it needs three ORs at the proposed facility, as shown in the table below.

		Projected Ambulatory Cases	Ambulatory Case Time	Ambulatory Hours	Hours/ORs	Projected Ambulatory ORs Needed in FY2017
	FY2015	2,821	1.5	4,231	1,872	2.3
	FY2016	3,001	1.5	4,502	1,872	2.4
ı	FY2017	3,197	1.5	4,796	1,872	2.6

However, projected utilization is not based on reasonable and supported assumptions. See Criterion (3) for discussion. Therefore, the applicant does not adequately demonstrate the need for three ORs and the application is nonconforming to this Rule.

.2103(c)

A proposal to increase the number of operating rooms (excluding dedicated C-Sections operating rooms) in a service area shall:

(1) demonstrate 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 impatient 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; and

- (2) 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 or a positive number less than 0.5, the need is zero;
 - (B) in a service area which has 6 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 if the difference is a negative number or a positive number less than 0.2, the need is zero.
- -NA- The applicant does not propose to increase the number of operating rooms in the service area.
- 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:

(1) 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 impatient 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; and

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- -NCThe applicant states that plastic surgery will be one of the specialties at the proposed multi-specialty ASF. PSCNC is the only existing ambulatory surgical program in the service area (Forsyth County). It is a single specialty ambulatory surgical program. The applicant did not provide documentation to show that the three ORs at PSCNC are currently utilized an average of at least 1,872 hours per operating room per year. In fact, in the 2010 SMFP, the facility identified is identified as "chronically underutilized." See page 74 in the 2010 SMFP. Therefore, the application is nonconforming to this Rule.
 - (2) demonstrate the need 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.
 - -NC- The service area (Forsyth County) has more than 10 ORs. In Section II.10, page 26, the applicant states it needs three ORs at the proposed facility, as shown in the table below.

	Projected Ambulatory Cases	Ambulatory Case Time	Ambulatory . Hours	Hours/ORs	Projected Ambulatory ORs Needed in FY2017
FY2015	2,821	1.5	4,231	1,872	2.3
FY2016	3,001	1.5	4,502	1,872	2.4
FY2017	3,197	1.5	4,796	1,872	2.6

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However, projected utilization is not based on reasonable and supported assumptions. See Criterion (3) for discussion. Therefore, the applicant does not adequately demonstrate the need for three ORs and the application is nonconforming to this Rule.

- .2103(f) The applicant shall document the assumptions and provide data supporting the methodology used for each projection in this Rule.
 - -NC- In Section III.1(b), pages 34-50, the applicant provides a detailed description of the assumptions and methodology used in the development of the projections required by this Rule. However, projected utilization is not based on reasonable and supported assumptions. See Criterion (3) for discussion. Therefore, the application is nonconforming to this Rule.

.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- The applicant proposes to relocate an existing ASF, change its name and convert it from single specialty to multi-specialty. This Rule is not applicable.
- .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- The applicant proposes to relocate an existing ASF, change its name and convert it from single specialty to multi-specialty. This Rule is not applicable.

.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 Section VII.2, page 74, the applicant provides documentation of the availability of the 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), pages 104-105, the applicant provides the number of WFUHS physicians expected to utilize the proposed facility. On page 104, the applicant states,

"The projected number of active medical staff is based on the list of physicians that have expressed willingness to perform procedures and professional services at the new facility. These and additional physicians will have the opportunity to apply for medical staff privileges and perform services at the proposed facility in accordance with the medical staff by-laws and their individual scope of privileges and in compliance with the Certificate of Need operating room regulations."

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Additionally, Exhibit 9 contains a copy of the physician credentialing criteria. In Section III.1(b), page 35, the applicant states there are no physicians currently utilizing PSCNC.

- .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- Exhibit 16 contains a letter from Andrea S. Fernandez, M.D., medical director for the proposed facility, that states,

"As the Medical Director for Clemmons Medical Park ASC, I have responsibility for ensuring that the physicians with privileges to practice in the facility are active members in good standing at a general acute care hospital or will have written referral procedures

with a physician who is an active member in good standing at a general acute care hospital in the ambulatory surgical service area."

The WFUHS surgeons are members of NCBH's medical staff. NCBH is an acute care hospital located in the service area (Forsyth County).

- .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.
 - -NAThe 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- The applicant states the proposed ASF will seek accreditation from the Accreditation Association for Ambulatory Health Care (AAAHC) once operational.
- .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 10 contains a letter from Tabor Architecture, the architects for the proposed project, which documents that the physical environment will conform to the requirements of federal, state, and local regulatory bodies.

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- .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.
 - -C- In Exhibit 11, the applicants provide a copy of the floor plan for the proposed facility, which identifies the specific areas required by this Rule.
 - .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:
 - 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 proposes to develop a new ambulatory surgical facility.

ATTACHMENT - REQUIRED STATE AGENCY FINDINGS

EXHIBIT

FINDINGS

C = Conforming

CA = Conditional

NC = Nonconforming

NA = Not Applicable

DECISION DATE:

November 24, 2010

FINDINGS DATE:

December 2, 2010

PROJECT ANALYST:

Gregory F. Yakaboski

Martha J. Frisone TEAM LEADER:

J-8529-10/ Duke University Health System d/b/a Duke Raleigh PROJECT LD. NUMBER-

Hospital/ Acquire a second fixed MRI scanner to be located in the

hospital in Raleigh/ Wake County

J-8537-10/ North State Imaging, LLC d/b/a North Carolina Diagnostic Imaging-Holly Springs/ Acquire a fixed MRI scanner to be located in

a new diagnostic center in Holly Springs/ Wake County

J-8534-10/ Wake Radiology Diagnostic Imaging, Inc. and Wake Radiology Services, LLC/ Acquire a fixed MRI scanner to be located

in an existing diagnostic center in Gamer/ Wake County

REVIEW CRITERIA FOR NEW INSTITUTIONAL HEALTH SERVICES

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

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 (1)beds, dialysis stations, operating rooms, or home health offices that may be approved.

C-Duke Raleigh NC- NCDI-Holly Springs NC: Wake Radiology

The 2010 State Medical Facilities Plan (2010 SMFP) provides a methodology for determining the need for additional fixed MRI scanners in North Carolina by service area. Application of the need methodology in the 2010 SMFP identified a need for one additional fixed MRI scanner in Wake County. Three applications were submitted to the Certificate of Need Section, each proposing to acquire a fixed MRI scanner for Wake County. Each proposal is briefly described below.

Duke University Health System d/b/a Duke Raleigh Hospital ("Duke Raleigh") currently owns and operates one (1) fixed MRI scanner on the Duke Raleigh Hospital campus. In addition, Duke Raleigh offers mobile MRI services through a contract with Alliance HealthCare Services ("Alliance") 36 hours per week. The applicant states the contract for mobile MRI services would be terminated if the proposal is approved. The applicant proposes to acquire no more than one fixed MRI scanner to be located in Wake County. Consequently, the application is conforming to the need determination in the 2010 SMFP.

North State Imaging, LLC d/b/a North Carelina Diagnostic Imaging-Holly Springs ("NCDI-Holly Springs") proposes to acquire a fixed MRI scanner and develop a new diagnostic center in leased space at 190 Rosewood Centre Drive in Holly Springs. The applicant proposes to acquire no more than one fixed MRI scanner to be located in Wake applicant proposes to acquire no more than one fixed MRI scanner to be located in Wake County. Consequently, the application is conforming to the need determination in the 2010 SMFP.

Wake Radiology Diagnostic Imaging, Inc. ("WRDI") and Wake Radiology Services, LLC ("WRS") together ("Wake Radiology") Wake Radiology proposes to acquire a fixed MRI scanner and locate it in an existing diagnostic center in Gamer. WRS would acquire and install the proposed fixed MRI scanner and WRDI would operate the proposed fixed MRI scanner. Wake Radiology currently offers mobile MRI services at Wake Radiology Gamer Office ("WRGO") through contracts with Alliance and Wake Radiology Diagnostic Imaging (one of the co-applicants). The applicants state the contracts for mobile MRI services would be terminated if the proposal is approved. The applicants propose to acquire no more than one fixed MRI scanner to be located in Wake County. Consequently, the application is conforming to the need determination in the 2010 SMFP.

In addition, Policy GEN-3 in the 2010 SMFP is applicable to the review of these proposals. Policy GEN-3 states:

"A CON applicant applying to develop or offer a new institutional health service for which there is a need determination in the North Carolina State Medical Facilities Plan (SMFP) shall demonstrate how the project will promote safety and quality in the delivery of health care services while promoting equitable access and maximizing healthcare value for resources expended. A CON applicant shall document its plans for providing access to services for patients, with limited financial resources and demonstrate the availability of capacity to provide these services. A CON applicant shall also document how its projected volumes incorporate these concepts in meeting the need identified in the SMFP as well as addressing the needs of all residents in the proposed service area."

The applicants responded to Policy GEN-3 as follows:

Duke Raleigh — Promote Safety and Quality

000609 000275 In Section II.7(a), pages 9-10, the applicant describes the methods to be used to promote safety and quality care as follows:

"Quality Management Program

The DRAH quality management program emphasizes a customer-oriented perspective that is used by each department to determine the needs of patients, physicians and others that use the hospital's services. Each department strives to meet or exceed customer's expectations.

Direction for Quality Improvement comes from the Performance Improvement Council (PIC), which identifies PI projects for DRAH. The PIC consists of members of the DRAH medical staff, department directors and administrative staff. The goal of using the FOCUS PDCA methodology has been to standardize the quality improvement process throughout DRAH, joining clinical and non-clinical quality efforts with a process that can be easily implemented, measured and maintained Please see Exhibit II.7 for copies of the following documents relating to DRAH's efforts to ensure quality care:

- FY2010 Organizational Performance Improvement Plan and Patient Safety Plan
- Utilization Management Plan

Patient Satisfaction Research

DRAH understands the importance of soliciting, analyzing, and understanding customer feedback regarding the provision of healthcare services. Since 1999 DRAH has contracted with Press-Ganey to conduct random patient satisfaction surveys. Patients who use inpatient, outpatient, surgical and ED services are surveyed post-discharge. Results from these patient satisfaction surveys are shared with all managers and employees of DRAH to assist in improving services. Moreover, survey results provide invaluable feedback on all aspects of hospital services, both clinical and operational, and they are used in staff and manager performance evaluations and in determining merit increases."

Duke Raleigh adequately demonstrates that it will promote safety and quality in the delivery of the proposed services.

Promote Equitable Access

In Section VI2, page 44, the applicant states:

"The services of Duke Raleigh Hospital are open to all area and non-area residents for impatient, outpatient, and other healthcare services on a walk-in, emergency, referral, or emergency [sic] basis"

000610 000276 See Criterion (13) for additional discussion. Duke Raleigh adequately demonstrates it will promote equitable access to the proposed services for patients with limited financial resources and other medically underserved persons.

Maximize Healthcare Value

In Section X1, page 71, the applicant states:

"The project proposed in this application has been designed to reduce to a minimum the cost of developing and operating the MRI scanner proposed in this application by:

1)	The exercise of tight control over the renovation plans. (See the response to Section VIII.1 (b) for additional information.)"
2)	Minimizing the disruption of existing services auring the
•	renovation and installation process. Integrating the operation of the proposed MRI scanner with
3).	I - File misting MRI sconner.
4)	Completing the project as quickly as possible to allow the earliest possible termination of the mobile scanner service."

The applicant adequately demonstrates the need the population to be served has for the proposed fixed MRI scanner. See Criterion (3) for discussion. Therefore, the applicant adequately demonstrates that the proposal would maximize healthcare value. Furthermore, the applicant adequately documents how its projected volumes incorporate these concepts in meeting the need identified in the 2010 SMFP as well as addressing the needs of all residents of the service area.

In summary, the application is consistent with Policy GEN-3 and conforming to the need determination in the 2010 SMFP. Consequently, the application is conforming to this criterion.

NCDI- Holly Springs - Promote Safety and Quality

In Section II.7(a), pages 18-19, the applicant describes the methods to be used to promote safety and quality care as follows:

"NCDI-Holly Springs will use several methods to ensure and maintain quality care at its facility. All facilities managed by MedQuest are required to adhere to the company's quality assurance plan, which includes continuous quality improvement.

NCDI-Holly Springs will seek and obtain accreditation for the proposed equipment. This ensures that quality images are produced by the unit for all types of scans.

- NCDI-Holly Springs will have preventive maintenance recommended by the manufacturer performed on the unit pursuant to original equipment manufacturer ("OEM") specifications.
- All radiologists who interpret scans for NCDI-Holly Springs will be board-certified. These radiologists will set protocols for scans performed by NCDI-Holly Springs. They also will follow ACR guidelines for communication in issuing reports.
- NCDI-Holly Springs's technologists will be certified by the American Registry of Radiologic Technologists (ARRTS) or will be required to obtain ARRT certification within one year of their employment with NCDI-Holly Springs. Any technologists who have not received certification will work under the supervision of a registered technologist. All NCDI-Holly Springs technologists will be required to receive ongoing continuing medical education to stay current on relevant clinical issues. All NCDI-Holly Springs technologists will also be trained in CPR.
 - NCDI-Holly Springs will provide 24 to 48 hour radiology report turnaround to referring physicians to ensure that treatment and the cycle of care are not delayed.
 - NCDI-Holly Springs representatives will meet with referring physicians to obtain feedback on image quality, radiology report quality, convenience of scheduling and accessibility, and patient experience. NCDI-Holly Springs will react to this feedback quickly to ensure that the needs of referring physicians are met. NCDI-Holly Springs will also survey a sample of patients on a monthly basis to obtain feedback on patient experiences at the facility.
 - NCDI-Holly Springs will be regularly inspected by Medicare and musi pass Medicare inspection, including applicable IDTF regulations, in order to participate in the Medicare program.

The MedQuest Quality Assurance Plan is provided as Attachment 9.

In addition to the quality controls set forth by MedQuest, NCDI-Holly Springs will provide high clinical quality through its relationship with its Medical Director, Dr. David Wiener. Dr. Wiener is a board-certified radiologist and maintains all continuing medical education requirements. As Medical Director, Dr. Wiener will be responsible for all clinical decisions affecting the care provided to patients. Please see Attachment 10 for Dr. Wiener's curriculum vitae and Attachment 11 for a letter expressing Dr. Wiener's willingness to serve as Medical Director. Dr. Wiener and his associates at Durham Radiology will provide interpretation services for NCDI-Holly Springs."

NCDI-Holly Springs adequately demonstrates that it will promote safety and quality in the delivery of the proposed services.

Promote Equitable Access

In Section VI2, page 91, the applicant states "NCDI- Holly Springs will not discriminate based on race, creed, color, sex, age, religion, national origin, mental or physical handicap, or ability to pay. NCDI-Holly Springs will be committed to providing necessary medical care to any individual regardless of that person's ability to pay." See Criterion (13) for additional discussion. NCDI- Holly Springs adequately demonstrates it will promote equitable access to the proposed services for patients with limited financial resources and other medically underserved persons.

Maximize Healthcare Value

In Section X.1, page 123, the applicant states:

"Special efforts by NCDI-Holly Springs to contain the costs of offering the proposed outpatient imaging services include, but are not limited to:

NCDI-Holly Springs is working closely with the equipment yendor to secure the most cost effective pricing for the proposed equipment.

NCDI- Holly Springs is leasing space in an existing building, instead of

building a new building.

NCDI- Holly Springs is proposing to renovate space in an existing facility rather than to construct a new facility for the proposed MRI scanner.

However, NCDI-Holly Springs did not adequately demonstrate the need the population to be served has for the proposed fixed MRI scanner. See Criterion (3) for discussion. Therefore, NCDI-Holly Springs did not adequately demonstrate that the proposal would maximize healthcare value.

In summary, the application is not consistent with Policy GEN-3. Consequently, the application is nonconforming to this criterion.

Wake Radiology - Promote Safety and Quality

In Section II.7(a), pages 25-26, the applicants describe the methods to be used to promote safety and quality care as follows:

"Providing quality patient care and rendering services in an effective and efficient manner is the goal of WRDI's ongoing performance improvement process. This quality assurance process is designed to objectively measure and improve patient care activities and services in order to identify opportunities for improvement.

Consistent with the existing fixed MRI scanners at Raleigh MRI and the mobile MRI scanner operated by WRDI, the proposed fixed MRI scanner will be accredited by the American College of Radiology (ACR). The ACR awards accreditation to facilities for the achievement of high practice standards after a peer-review evaluation of the practice. Evaluations are conducted by board-certified physicians and medical physicists who are experts in the field. They assess the qualifications of the personnel and the adequacy of facility equipment. WRDI's existing accreditations are indications of the ongoing commitment to quality. Please refer to Exhibit 17 for copies of current ACR accreditation certificates.

WRDI seeks to provide an optimal, uniform level of care by reducing and/or eliminating unnecessary and correctable risks, hazards, and expense. Thus, WRDI has an established Risk Management plan. The program includes activities designed to ensure patient safety, reduce accidents, and conserve financial resources.

WRDI also has an established Medical Review Committee to monitor the quality of care provided by Radiologists and staff, and to make recommendations to improve the quality, cost, appropriateness or necessity of health care services. Please refer to Exhibit 5 for policies and procedures of the Medical Review Committee.

A Radiologist Peer Review Policy is also in place as part of the Medical Review Committee. This process encompasses ultrasound, MRI, CT, nuclear medicine, bone density and mammography/breast MRI pathology. The process meets all ACR requirements. Please refer to Exhibit 5 for copies of WRDI's Peer Review Policy."

Wake Radiology adequately demonstrates that it will promote safety and quality in the delivery of the proposed services.

Promote Equitable Access

In Section VI.2, page 109, the applicants state:

"WRDI will continue to have a policy to provide all services to all patients regardless of income, racial/ethnic origin, gender, physical or mental conditions, age, ability to pay or any other factor that would classify a patient as underserved. Diagnostic imaging services at WRDI's Garner MRI facility will continue to be available to and accessible by any patient having a clinical need for those services."

See Criterion (13) for additional discussion. Wake Radiology adequately demonstrates it will promote equitable access to the proposed services for patients with limited financial resources and other medically underserved persons.

Maximize Healthcare Value

In Section X.1, page 129, the applicants state:

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"The provision of MRI services via WRDI's proposed fixed MRI scamper will provide a more cost effective way to bring services closer to the WRDI patients and other residents of the service area who utilize them. The location of MRI services in the Garner Office facility is more cost effective than diagnostic imaging services provided in a hospital setting in Wake County. The operations of the fixed MRI scanner also will be less costly than the current mobile MRI service because WRDI will reduce equipment rental costs associated with a third-party mobile equipment yendor.

WRDI is committed to and will be actively involved in efforts to contain costs in its facility. WRDI will develop the project in the most cost-effective manner. Examples of cost-saving measures include:

- The proposed new imaging system is modern technology and will improve scan speed, image quality and capabilities. This enhanced capacity will enable more procedures per day, ultimately reducing the cost per scan.
- Because the proposed project is located at an existing medical clinic, staffing and operational costs are minimal, as WRDI will utilize staff and space quite efficiently.

For CON purposes, WRS and WRDI estimated the capital costs conservatively to avoid a project cost overrun. Actual costs may be less. WRS will obtain competitive vendor quotations for the proposed new fixed MRI scanner."

However, Wake Radiology did not adequately demonstrate the need the population to be served has for the proposed fixed MRI scanner. See Criterion (3) for discussion. Therefore, Wake Radiology did not adequately demonstrate that the proposal would maximize healthcare value.

In summary, the application is not consistent with Policy GEN-3. Consequently, the application is nonconforming to this criterion.

One fixed MRI scanner is the limit on the number of MRI scanners that may be approved for this review. See the Comparative Analysis section for the decision regarding development of an additional fixed MRI scanner in Wake County.

- (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 — Duke Raleigh NC- NCDI-Holly Springs NC- Wake Radiology

Duke Raleigh currently owns and operates one (I) fixed MRI scanner on the Duke Raleigh Hospital campus. The applicant proposes to acquire a second fixed MRI scanner which will be located on the Duke Raleigh Hospital Campus.

Population to Be Served

In Section III.5(a), page 32, the applicant states "As recent experience appears the best predictor of future patterns, we project the same geographic service area for future MRI services as our current service area." In Section III.4(b), page 31, the applicant provides the current and projected patient origin for the MRI services provided at Duke Raleigh Hospital, as shown in the table below:

F		FY2009	FY2012-2013
9	County .	Percent of Total	Percent of Total
Ì		76.8%	76.8%
	Wake Johnston Franklin Harnett	5.0%	5.0%
		5.2%	5.2%
		1.7%	1 70/
		9.8%	2 20/
	Other NC Counties	1.5%	1.5%
	Other States	ottell and the state of the sta	

The applicant adequately identified the population proposed to be served.

Need Analysis

Duke Raleigh has one (1) existing fixed MRI scanner. In Section III.1, pages 27-29, the applicant states that the need for the proposed second fixed MRI scanner at Duke Raleigh Hospital is based on the following factors:

"The urgent need for the additional fixed MRI scanner proposed in this application is documented in the following places:

1) Thomson Reuters' population projections. The primary service area for MRI services at Duke Raleigh Hospital is Wake County, with nearly 77% of patients originating within the county. The secondary service area includes Franklin and Johnston counties, each with approximately 5% of the total MRI volume. Population within these counties is expected to increase significantly between 2009 and 2014 as illustrated below.

Service Area	, Population	Projections		2072	2013	2014	CAGR
County	2009	2010	2011 978,459	2012 1,008,651	1,039,774	1,071,858	3.1%
Wake	920,760	949,171 139,934	143,565	147,291	151,113	155.035 61,457	2.6%
Johnston	136,394 54,949	56,193	57,465	58,766	60,096 1,250,984		
Franklin Grand Total	111 11 11 12 12	1,145,298	1,179,490	1,214,708	1,200,000		

Thomson Resters Source

Moreover, Wake County's population is aging rapidly. Projections provided by Thomson Reuters suggest that between 2009 and 2014 the population age 65+ will grow more than 40%, and the population age 45-64 will grow more than 20%. People in these age groups are far more likely to be referred for MRI scans than people in younger age groups.

The 2010 State Medical Facilities Plan, which finds need for an additional fixed MRI scanner in Wake County. That finding results from the fact that the number of unweighted procedures provided in Wake County increased nearly 10% over the last 3 years, while the total provided in the entire state remained virtually unchanged-

Unweighted Procedures Provided in Wake County

Year	Wake County	SILLE
2007	65,582	821,829
	65,892	814,048
2008	72,036	822,853
2009	9.8%	0.1%
% Change	9.070	

We believe that the difference reflects both the growth and aging of the Wake County population and the growing migration of acute care patients from the rural counties where they live to the largest urban counties for treatment, especially for specialty and inpatient care. During FY2009, the MRI scanners at Duke Raleigh provided procedures for residents of 70 of the state's 100 counties. We believe that both trends will continue.

The 25% increase in the volume of weighted MRI procedures provided at Duke Raleigh over the last 3 years:

MRI Scans Provided at Duke Raleigh Hospital

TADT Com	s Provided at Duke Kaleigh	HUBPELLE
WINI DUM	Unweighted Procedures	Weighted Procedures
Year	Unweighten I Toccum Co	4,864
FY2007	3,884	
	4,071	5,212
FY2008	4,634	6,070
FY2009		24.8%
	19.3%	24.070
% Change		

The growth reflects the recruitment of additional physicians, especially subspecialists from Duke University Medical Center supporting the Duke Raleigh Hospital's service lines in neuroscience, musculoskeletal, oncology,

000617 000283

and cardiac services. Their impact is reflected in the growth in admissions, patient days, outpatient visits to the campus, surgical procedures, and other services as well as MRI services.

As the new physicians continue to ramp up their practices on the campus, their MRI referrals are sure to increase. (See the letters of support in Exhibit V.3.) Despite the addition of a third mobile day, current capacity will not be able to accommodate growth at the rates of the last two years. Thus the growth rate projected for the interim year (FI2011) is a modest 7.4% [sic]

- 4) The continuing increase in the number of surgical procedures performed at Duke Raleigh. Between FY2008 and FY2009, the number of impatient procedures increased 28%, and the number of ambulatory procedures grew 18%. Through the first 10 months of FY2010, the Hospital was providing impatient procedures at the rate of 3,462 per year, an increase of 15.2% over FY2009, and ambulatory procedures at the rate of 11,402 per year, an increase of 5.4% over FY2009.
- 5) A physician recruitment plan that projects the Hospital bringing on 25 specialists, including 14 additional surgeons, between July 1, 2010 and June 30, 2015. Those totals do not include Raleigh surgeons now applying for privileges for the first time, and the recruitment schedule (See Exhibit VIL6) underestimates the speed with which recruits are being identified and brought on board. For instance, the neurosurgeon slated to begin practicing in FY2013 will begin in FY2011.

As surgeons are especially likely to order MRI procedures, their recruitment will certainly increase the utilization of the Hospital's MRI scanners.

- The current backlog of patients awaiting MRI procedures. Even though the Hospital's existing fixed MRI scanner is staffed and available 106.5 hours per week and the mobile scanner provides service 3 full days (36 hours) each week, non-emergent patients, especially those needing scans of the quality provided by the fixed MRI scanner, are frequently obliged to wait a week or more for their MRI procedures.
- 7) The projections provided by Sg2, a national health care consulting firm that uses current data, trends, and sophisticated models to project county-specific utilization rates. Sg2 anticipates that the demand for MRI procedures will increase 28.1% in Wake County between 2010 and 2014, or approximately 6.1% per year.

Given those facts and the fact that the Hospital is on track to exceed virtually all its utilization projections for the current year, our projection that the number of procedures provided by the Hospital's MRI scanners will increase by an average of less than 10% per year over the years from FY2010 through FY2014 appears

Historical and Projected Utilization

In Section IV, pages 35-37, the applicant provides historical and projected MRI scanner utilization, as illustrated in the table below.

• •			7			·	rt 7	5-1-17
	Prior Full FY2007	Prior Full FY2008	Last Full FY2009	Interim Full FY2010	Interim Full FYZ011	First Full FY2002	Second FnH FY2013	Third Full FY2014
# of Fixed MRI	1	.1	1	1	1	2	2	2
Scanners	3,884	4.071	4,634	5,476	5,880	6,654	7,269	8,034
#of Procedures # of Weighted	4,864	5,212	6,070	7,181	7,712	8,728	9,534	10,538
Procedures Average # of	4,864	5,212	6,070	7,181	7,712	4,364	4,767	5,269
Weighted Procedures								1

As shown in the table above, during FY2009, the existing fixed MRI scanner and the mobile MRI scanner performed a total of 6,070 weighted MRI procedures. During the third project year, the applicant projects that the two fixed MRI scanners will perform an average of 5,269 weighted MRI procedures per scanner, which exceeds the 4,805 required by 10A NCAC 2703(b)(3).

In Section IV.1(d), pages 36-37, the applicant provides the assumptions and methodology used to project utilization for MRI services and states

"The substitution of a second fixed MRI scanner operating 70 hours per week (or more, as necessary) for a mobile scanner operating 36 hours per week will give the Hospital 34 hours of additional scan time each week. How will that capacity be used?

1) First, to accommodate growth attributable to the projected increase in MRI utilization. Sg2, a national health care consulting firm specializing in the analysis of technology utilization, predicts that MRI utilization in Wake County will increase, on average, 6.1% per year through FY 2014. Growth at that rate would increase the annual volume at Duke Raleigh from a projected 5,476 unweighted procedures in FY 2010 to a projected 6,943 unweighted procedures in FY 2014.

Т		FY2010(Proj)	FY2011	FY2012	FY2013	FY2014
		897	958	981	1,009	1,041
ļ	Inpatient		4,853	5,185	5,534	5,902
	Outpatient	4,579			6,543	6,943
	Total	5,476	5,811	6,166	0,343	0,545

 Second, to accommodate patients that physicians practicing on the Hospital campus now send to fixed MRI scanners elsewhere to avoid the delays (of as much as a week or more) resulting from the intensive utilization of the fixed MRI scanner at the Hospital. It is not possible to determine with certainty the number of patients now referred elsewhere, but unecdotal evidence suggests about 6 per week If the Hospital's MRI service were to continue with a single fixed MRI scanner and a mobile MRI 36 hours per week, that number would. also grow 6.1% per year through FI 2014:

-			YZZZZZZZ	FY2014
FY2010(Proj)	FY2011	FY2012	FY2013	300
275	334	355	3/0	399
Total 1				•

While the Hospital will not pick up this volume until FY2012, when the new fixed MRI scanner would become operational, we project a small portion of this volume in FY20II will be accommodated with the addition of the 3rd mobile MRI day.

- Third, to accommodate the additional procedures that we can safely predict that the 31 physicians to be recruited will order. To calculate the totals below, we assumed that:
 - The physicians would all begin practice on the first day of the fiscal year that they are scheduled to start;
 - Their order rates would increase 50% per year over four years.
 - In the fourth year of their practice on the campus, their order rates would be the same as those for physicians in the same subspecialties now well established at the Hospital (as many as 290 per year for a neurologist to as few as 5 for a pulmonologist); and
 - For recruits in subspecialties not yet well established on the campus (e.g., oncologic surgery), the order rates would be the same as the order rates of physicians in the same subspecialties practicing at Duke.

	FY2011	FY2012 ·	FY2013	FY2014	
Total	221	487	727	1,092	_
10141	1				

Finally, to derive the total procedures to be provided each year, we subtracted from the procedures attributable to the recruits the procedures attributable to the growth attributable to the projected increase in MRI utilization. That is reflected in the table below, which shows on line 3 the procedures over and above those attributable to population growth that the recruits will order.

Duke Raleigh MRI Volume Projections

	Duke Raleigh MRI Volume Projections FY2013 FY2014					
	Dτ	ire Kaleigh 1911	T / OEDA//T	FY2012	FY2013	FY2014
Γ		FY2010(Proj)	FY2011		6,543	6,943
1		5,476	5,811	6,166		399
. [1)	3,770	69	355	376	
-	2)		- 07	133	350	692
-	3)				7,269	8,034
	77.7	5.476	5,880	6,654		
	Unweighted		7,712	8,728	9,534	10,538
	Weighted	7,181	1,722			

In the public hearing on the Hospital's two additional operating rooms, the President of Duke Raleigh noted that the number of surgeons practicing at the Hospital is continuing to increase because of applications for privileges from physicians already established in Raleigh. The projections provided here do not include any additional MRI procedures, over and above those attributable to the growth in projected MRI utilization, attributable to those additional physicians."

To determine projected utilization, the applicant used FY2010 as the base year and applied an annual growth rate of 6.1%. As illustrated in the table below, between 2004 and 2009, the compound annual growth rate ("CAGR") for unweighted MRI procedures performed in Wake County was 8.1%. In FY2009 and FY2010, the number of unweighted MRI procedures performed at Duke Raleigh Hospital increased 13.8% [4,634 FY09/4,071 FY08 = 1.138 or 13.8% growth] and 18.2% [5,476 FY10 / 4,634 FY09 = 1.181 or 18.1% growth], respectively.

Wake County Historical MRI Utilization FY2004-FY2009

Water County	Historical WIRI Unicated)IL I. XXXV
PYARE COLLECT	Unweighted MRI Scans	Weighted MRI Scans
	Unweighted Marci Beans 48,815	57,537
FY2004		. 62,174
	53,122	
FY2005	55,692	65,936
FY2006	65,582	77,172
FY2007	65,892	77,428
FY2008		T DC 577 I
FY2009	72,036	0.50/
F12007	8.1%	. 0.2/0]
04-09 CAGR		-

The applicant used a lower rate (6.1%) than the Wake County CAGR from 2004-2009 (8.1%) or the percentage increases at Duke Raleigh Hospital (13.8% and 18.2%). Next, the applicant determined the annual number of MRI procedures that would have been performed at Duke Raleigh Hospital if an appointment had been available in a timely manner (i.e., the ordering Physician sent the patient elsewhere), which the applicant states is approximately 6 per week physician sent the patient elsewhere), which the applicant states is approximately 6 per week. This number is also increased 6.1% per year. Finally, the applicant determined the annual number of MRI procedures attributed to physician recruitment. To avoid double counting, the applicant states it subtracted projected MRI procedures ordered by physicians already practicing in Raleigh and the increases attributed to the projected 6.1% growth.

Based on these assumptions, the applicant projects it will perform 10,538 weighted MRI procedures in the third project year, which exceeds the 9,610 weighted procedures (4,805 x 2 fixed MRI scanners = 9,610) required by 10A NCAC 14C 2703(b)(3). Projected utilization is based on reasonable and supported assumptions. Therefore, the applicant adequately demonstrates the need to acquire the proposed MRI scanner.

In summary, the applicant adequately identified the population to be served and adequately demonstrated the need the population to be served has for the proposed MRI scanner. Consequently, the application is conforming to this criterion.

NCDI-Holly Springs

NCDI-Holly Springs proposes to acquire a fixed MRI scanner and develop a new diagnostic center at 190 Rosewood Cenire Drive in Holly Springs.

Population to Be Served

In Section III.5(b), page 77, the applicant provides projected patient origin for the MRI services to be provided at NCDI-Holly Springs in Project Years 1 and 2, as illustrated in the table below.

DI-Holly Springs Projected MRI Patient Origin

	TOTAL	Patient Origin		
NCDI-Holly Springs	Projecten marc	af Total	Number of	Percentage of Total
	Vimminer Of i	7 01000	Patients YR 2	Patients YR 2
County	Patients YR 1	Torronna Taca	3,522	95.0%
	3,082	95.0%		1.0%
Wake	32	1.0%	37	
Johnston		1.0%	37	1.0%
	32			1.0%
Lee	32	1.0%		2.0%
Chaffiam.	·	2.0%	74	1
Other*	65	700.00/	3.707	100.0%
X	3,243	100.076	77	ce, Warren, Person, other NC
Total		- C-meers Deplus N	ash, Crayco, Wayne, Van	CC Waterd, I would -

The applicant states "Other" includes: Durham, Orange, Sampson, Duplin, Nash, Craven, Wayne, Vance, Warren, Person, other NC counties and other states.

In Section III.5(c), page 77, the applicant states:

"NCDI- Holly Springs is a proposed new facility. NCDI-Holly Springs reviewed the patient data for the mobile MRI host site at NCDI-Cary, which receives services from Kings Medical, an independent third party provider. The majority of patients served at NCDI-Cary originate from Wake County. NCDI-Holly Springs also considered the proximity to other counties near the southern border of Wake County in determining the percentages of patients from other counties. The patient to scan ratio at NCDI-Cary was 1.11 scans per patient. NCDI- Holly Springs utilized this ratio to : determine the total number of patients for Years I and 2."

The applicant identifies the population it proposes to serve. However, see discussion below regarding the reasonableness of projecting that residents of Durham, Orange, Sampson, Duplin, Nash, Craven, Wayne, Vance and Person counties would utilize a fixed MRI scanner located in Holly Springs in Wake County given that the proposed facility does not yet exist and the presence of existing fixed and mobile MRI scanners in those counties.

Need Analysis

In Section III.1(a), pages 41-57, the applicant states that the need for the proposed fixed MRI scanner in Holly Springs is based on the following factors:

"NCDI- Holly Springs will meet the need for:

Additional fixed MRI capacity based on current and projected demand for MRI services in Wake County;"

In Section III, page 47, the applicant states "The population explosion in Wake County is generating increased demand for healthcare services. On a per resident basis, Wake County is greatly underserved considering it is the most populated county in North Carolina. Counting the 2010 need determination for one fixed MRI scanner, there are over 68,000 residents per every one fixed MRI scanner in Wake County. The following chart provides an analysis of the number of residents per fixed MRI scanner in the more populated counties in North Carolina. The average number of residents per fixed MRI scanner in North Carolina is 41,887. The high ratio of residents to fixed MRI scanners could signal a potential issue regarding accessibility to care for patients in Wake County.

Fixed MRI Scanners Per Residents by County-FY 2009

Fixed	MRI Sconners Per Reside	2009 Population	Residents/1 Fixed
County	No-of Fixed MRI	LOOD I OP	Scanner
	Scanners	230,450	23,045
Винсотье	10	174,294	24,899
Cabarrus	1	321,121	45,874
Cumberland	7	266,189	19,014
Durham	14	355,640	20,920
Forsyth	17	476,038	43,276
Guilford	11	894,445	49,691
Mecklenburg ·	18	194,099	38,820
New Hanover	5	132,306	14,701
Orange	9.	- 158,575	22,654
Pitt		892,607	68,662
Wake	13	9 382-610	41,887
North Carolina :Source: Population-NC	OSBM; Scan Volume and fixed scan	ner monbers-Druft 2011 SMFP-	Table 9k

"Improved access to MRI services for Southern Wake County residents;"

In Section III, page 47, the applicant states "The population of the NCDI-Holly Springs Service Area currently exceeds 100,000 persons and is projected to increase by nearly 30,000 persons from 2009 to 2016. The NCDI-Holly Springs Service Area currently represents 11.9% of the total Wake County population and currently none of the 13 existing fixed MRI scanners in Wake County are located there."

"Ayailability of a fixed MRI in a convenient outpatient setting;"

In Section III, page 53, the applicant states "Located in southwest Wake County on N.C. Highway 55, Holly Springs is accessible from U.S. Highway 1, US Highway 64 and US Highway 401. The new N.C. 55 Highway Bypass is a four

lane median divided, limited access highway that provides direct access to the 400 acre Holly Springs Business Park

The \$21 billion North Carolina General Assembly's spending plan includes \$25 million a year for the North Carolina Turnpike Authority's Triangle Expressway project, which would be the state's first toll road and the first phase will open in 2011. The toll road will connect N.C. Highway 147 to N.C. Highway 540, and extend N.C. Highway 540 to Holly Springs (12.6 mile Highway 540, and extend N.C. Highway 540 to Holly Springs (12.6 mile Western Wake Freeway) as shown in the following map. The site for the Holly Springs Surgical Center is strategically located within one mile of the proposed Springs Surgical Center is strategically located within one mile of the proposed I-540 interchange with Highway 55 Bypass. Construction on the Triangle Expressway in Wake and Durham counties is underway. This 18.8-mile toll road system is a new roadway from the NC 55 Bypass near Holly Springs to I-70 at NC 147 and is comprised of two projects—the Western Wake Freeway and the Triangle Parkway."

- Lower costs and charges associated with a cost-effective outpatient provider;
 and
- Quality imaging services as provided by Novant and MedQuest for residents
 of Wake County and the surrounding counties."

In Section III.1(a), page 43, the applicant states:

"The primary focus for this project is creating improved geographic access to MRI services for residents in southern Wake County and the surrounding areas. Novant and MedQuest are committed to improving the quality and accessibility of healthcare services for the residents of southern Wake County as demonstrated by the numerous CON applications filed by Novant for an acute care facility and operating rooms for this specific area. The proposed NCDI-Holly Springs facility will result in a community-this specific area. The proposed NCDI-Holly Springs facility will result in a community-based, locally accessible site for outpatient diagnostic MRI imaging services and brings these services much closer to a population that is underserved in Wake County. If approved, it will be the first fixed MRI scanner in Holly Springs. This is an important consideration in this review, as most fixed MRI scanners in Wake County are clustered in Raleigh or Cary."

Projected Utilization

In Section IV.1, page 82, the applicant provides projected utilization for the proposed fixed MRI scanner through the first three project years, as illustrated in the table below.

d WRI Scanner Utilization

	TO THE A TOTAL	anner Utilization	The state of the s
NCDI-Holly Springs	Projected mark	Second Full FY	Third Full FY
	HITSTEHLEL		· (CY 2814)
لأتكار	(CY 2012)	· (CY 2013)	7
	1	. 1	4,661
# of Units	3,600	4,115	· 4,001
# of Unweighted	, ,,,,,,,,,		
Procedures		14.3%	13.2%
Percent Change in	-na-	14070	
Policini China	,		1
Unweighted		-	5,025
Procedures	3,881	4,436	5,023
# of Weighted	5,651		
Procedures		14.3%	13.2%
Percent Change in	-ma-	113/	
Weighted			
Procedures			•

As shown in the table above, NCDI-Holly Springs projects that the proposed fixed MRI scanner will perform 5,025 weighted MRI procedures during Project Year 3, which exceeds the 4,805 weighted MRI procedures required by 10A NCAC 14C .2703(b)(3).

In Section III.1, pages 58-68, the applicant provides the assumptions and methodology used to project utilization, as follows:

"As a proposed new provider of fixed MRI services in Wake County, NCDI-Holly Springs considered several factors in developing a need methodology for the medically underserved area of southern Wake County. In light of the geographic distribution of MRI scanners in Wake County, NCDI-Holly Springs determined that a location in Holly Springs would increase accessibility to health care services for southern Wake County residents by offering full-time fixed MRI services. After determining that an unmet need existed in southern Wake County and identifying Holly Springs as the most effective location in Wake County for a new fixed MRI scarmer, NCDI-Holly Springs developed a need methodology based on population growth and Wake County MRI utilization rates to reasonably project the estimated number of unweighted and weighted MRI scanners [sic] for the proposed facility.

Step 1: Identify the population to be served [page 58]

	2012	2013	2014
		41.582	43,586
Holly Springs			20,926
Fuquay Varina			9,922
			12,247
			23,236
			16,450
			126,367
Totals	117,415	1	
	Town Holly Springs Fuquay Varina Wake County Wake County Holly Springs/Apex Wake County Totals	Holly Springs 39,671	Town 2012 141,582 Holly Springs 39,671 41,582 Fuquay Varina 19,202 20,046 Fuquay Varina 9,643 9,781 Wake County 11,547 11,892 Wake County 11,547 22,533 Holly Springs/Apex 21,581 22,533 Wake-County 117,413 121,940

NCDI-Holly Springs selected a site in Holly Springs for numerous reasons. A site in Holly Springs would be easily accessible for the specific census tracts listed above based on its position off of Highway 55. In the defined primary service area, Holly Springs is the most populated area and is projected to continue growing at an accelerated pace. There are currently no fixed MRI scanners located in the primary service area."

Step 2: Determine Wake County Use Rate for MRI Services [pages 59-60]

NCDI-Holly Springs reviewed the annual unweighted volume from FFY 2005 through FFY 2009 to determine the historical MRI use rate per 1,000 population for Wake County:

Rate (inveronted volume)

·	The same of the sa	tod volume)	
Wake County-Hist	orical Use Rate (unweigh	Wake County	Use Rate Per 1,000
Time Period	Onweighter 1600	Population	
1	Volume	757,346	.70.1
FFY 2005	53,122	793,401	70.1
FF1 2005	55,692	831,537	78.9
FFY 2006	65,582		75.9
FFY 2007	65,808	866,438	50.7
FFY 2008	72,036	7	30.7
FFY 2009	,)2,030		

During FFY 2008, the MRI use rate experienced a slight decrease compared to the previous year. While the growth of MRI utilization has slowed slightly in the FFY 2007-08 time period, NCDI-Holly Springs does not anticipate a continued decrease in MRI utilization as is supported by the FFY 2009 data, which shows an increase in volume of 9.5%. ... For the purposes of the projections contained in this application, NCDI-Holly Springs has held the Wake County use rate constant, at 80.7, for the first three project years....

ake County-Projected Use Rate (unweighted volume)

	I Trace Rate (1771We12)	HEU YOLANIC)	
Wake County-Project	cted Use Rate (unweigh	Wake County	Use Rate Per
Time Period	Outherdinerry	Population	1,000
111111111111111111111111111111111111111	Volume	757,346	70.1
2005	53,122		70.1
FFY 2005	55,692	793,401	
FFY 2006	65,582	831,537	78.9
FFY 2007			75.9
FFY 2008	65,808	007 607	80.7
FFY 2009	72,036	020 707	
	74,269	920,307	90.0
FFY 2010	76,504	948,001	50.5
FFY 2011	78,739		80.7
FFY 2012			80.7
FFY 2013	80,973	7 03 T 00	
	83,20	9 1,031,000	<u> </u>
FFY 2014			•

By maintaining the same FFY 2009 use rate of 80.7 scans per thousand population, the Wake County compound annual growth rate for FFY 2010-2014 will decrease 2.3%. This growth rate is considerably lower than Wake County's experience in the prior five year period from FFY 2005-FFY 2009 at 6.28%.

Step 3: Apply Wake County Use Rate to the Primary Service Area Population in Project volume [page 61]

NCDI-Holly Springs utilized the FY 2009 Wake County MRI use rate per 1,000 of 80.7 and applied it to the population projections for each census tract. The result was the projected unweighted MRI volume for each project year. As indicated below, the total estimated unweighted volume for the primary service area is expected to exceed 10,000 scans by the third year of operation.

Projected Unweighted Volume

7 Duration for	a Timperonted Vo	lume	
imary Service Area-Projecte	CY 2012	CY 2013	CY 2014
Census Tract	39,671	41,482	43,586
532- Holly Springs	80.7	- 80.7	- 80.7
Tice Rate/100	3,209	3,356	3,517
Projected Unweighted MRI	3,203	·	
Volume	10.707	20,046	20,926
531.01-Fuquay Varina	19,202 80.7	80.7	80.7
Tien Rate/100		1,618	1,689
Projected Unweighted MRI	1,550		1
Volume	9,643	9,781	9,922
531.03- Wake County	80.7	80.7	80.7
Tire Rate/100	778	789	
Projected Univerghted MRI	770		
Volume	11,547	11,892	12,247
531.04- Wake County	80.7	80.7	
The Rate/100	932	960	988
Projected Unweighted MRI	932		
Volume	21 251	22,53	3 23,236
534_04-Holly Springs/Apex	21,851 80.7	80.	~~~
Tisa Rate/100		1,81	
Projected Unweighted MRI	1,763	1,02	
Volume.	15,769	16;10	6 16,450
529-Wake County	1,703		
Tice Rate/100		7 77	1,328
Projected Unweighted MRI	1,272	1	
Volume	9,50	9,8	41 . 10,19
Total Projected Unweighted	9,30	* -	
Volume for Primary Service	1	1	
Area	<u> </u>		

Step 4: Estimate Market Share Percentages for the Project [pages 62-63]

The following percent market share was used to project outpatient MRI volume for NCDI-Holly Springs. NCDI-Holly Springs proposes to reach the target market share in year three of operation. The following projections reflect the year to year rate of growth for market share in each census tract.

	CY 2012	CY 2013	CY 2014
Census Tract .	48%	53%	58%
Census Tract 532	30%	34%	38%
Census Tract 531.01	13%	15%	16%
Census Tract 531.03.		33%	36%
Census Tract 531.04	. 30%	1	56%
Census Tract 534.04	50%	7 (0)	16%
Census Tract 529	12%	1478	

Market share assumptions were projected at the census tract level to address the proximity of the proposed outpatient imaging center to each population group and the proximity of other providers to the population. Market share assumptions were ramped up gradually over the projected timeframe. The total projected unweighted MRI volume at NCDI-Holly Springs as calculated below in Step 5, based upon these market share assumptions, is less than 6% of total unweighted MRI volume projected to be performed in Wake County in Project Year Three as reflected in Step 2 above. There are several factors that support the projected market share percentages, including but not limited to the following:

- NCDI-Holly Springs Service Area population represents almost 12% of the total
 Wake County population.

 The service Area population represents almost 1/14 or 7% of the
- NCDI-Holly Spring's one fixed MRI scanner would represent 1/14, or 7% of the total fixed MRI scanners in Wake County.
- The estimated unweighted MRI volume for NCDI-Holly Springs represents less than 6% of total Wake County unweighted MRI volume as projected in Step 2.
- There are no existing fixed MRI scanners in the NCDI-Holly Springs Service
- Novant Medical Group primary care physician offices with local access are planned for development in Holly Springs in and near the medical plaza where NCDI-Holly Springs and the proposed Novant Holly Springs Surgery Center will be located.

Step 5: Apply Estimated Market Share Percentages to Projected Volume [page 64]

NCDI-Holly Springs- Projected	CTT 2012	CY 2013	C	7 2014
Cerisus Traci	CY 2012 3,209	3,356		3,517
32- Holly Springs		53%		58%
1-1-t Share Percentage	48%	.1,779		2,040
Projected Universited MICI	1,540	2,7		
Volume for NCDI-Holly				
Springs		1,618		1,689
531.01-Fuquay Varina	1,550	34%	†	38%
Market Share Percentage	3.0%	550	1	642
Projected Unweighted MRI	465	, ,		
Projected Office State Foliane for NCDI-Holly	1			į.
		. 789	-	801
Springs .	778			16%
531_03- Wake County	13%	. 15%		128
Market Share Percentage MRT	101	.118	;]	120
Projected Unweighted MRI			1	
Volume for NCDI-Holly				988
Springs	932	96		36%
531.04- Wake County	30%	. 335		
Market Share Percentage	280	3.	17	356
Projected Unweighted MRI			1	
Volume for NCDI-Holly				
Springs	1,763	1,8	18	1,875
53.4.04-Holly Springs/Apex	50%	-T	3%	56%
16 Just Charg Percentage	882		63	1,050
Designed Thrweighted MKI	002			
Volume for NCDI-Holly	1			
Springs	1,27.	7 1.	300	. I,32
529-Wake County	1,27		4%	. 169
T. C. Lat Charge Rescentage		8	182	21
Projected Threeighted MKG	15	4		
Volume for NCDI-Holly	· }	'		•
7 Opmires		3	,909	4,42
Total Projected Unweighted	3,43	201	, , ,	
Total 170 for NCDI-Holls	,	1		

NCDI-Holly

Volume

Springs (95% of total volume) The chart above details the amount of unweighted MRI volume that NCDI-Holly Springs anticipates from the primary service area. ...

The Novant Medical Group of general surgeons is exploring a satellite office location in Holly Springs, near the NCDI-Holly Springs location.

Novant Medical Group's positive reputation with local physicians and the steady growth of the Novant Medical Group-Triangle, which has grown from seven practice locations with 34 physicians and surgeons in 2008 to fourteen practice locations with 42 physicians and surgeons in 2010, including one new surgical

• Letters of support from local providers indicating willingness to refer patients to

the proposed facility which are included in Attachment 29.

Congestion and traffic to Research Triangle Park, Cary, and downtown Raleigh continues to increase as population grows (Please see traffic/travel study in

The proposed location of NCDI-Holly Springs adjacent to the new Western Wake Freeway will result in ease of access to the existing population in the defined zip code service area. The NCDI-Holly Springs site is strategically located in northern Holly Springs, between Highway 55 and Highway 55 Bypass, and is located within one mile of the proposed I-540 interchange with Highway 55 Bypass. (See discussion in response to Question III.I (a)).

The new Western Wake Freeway will result in population growth in the defined zip code service area.

Projected population growth in the defined NCDI-Holly Springs Service Area is projected to exceed 28% between 2009 and 2016.

These qualitative and quantitative reasons all support the proposed market share. assumptions reflected in the previous table for NCDI-Holly Springs.

Step 6: Other In-migration Assumption [page 65]

While not part of the defined NCDI-Holly Springs Service Area, NCDI-Holly Springs recognizes that patients from other areas may choose to travel to receive services at NCDI-Holly Springs as a result of convenience or patient choice.

As a result, NCDI-Holly Springs assumes that 5% of the total projected utilization in each of the project years will be from other areas or in-migration. The estimate of inmigration is consistent with the experience of other MedQuest facilities in North Carolina as to the fact that each facility generally sees patients from multiple counties and sometimes other states. ...

Holly Springs Unweighted MRI Volume CY 2012 — CY 2014

	TT Totad MKIV	กกสทย 61 20.	LA OL DOL'	
NCDI-Holly Spring	S Unweighter with 1	CY 2012	CY 2013	CY 2014
Census Tract	Percent of Louis	3,420	3,910	4,428
MRI Volume from	95%	.3,420	2,,,,,	,
NCDI-Holly Springs.				
Service Area	50/	180	206	233
MRI Volume from	. 370	1		
Other Counties	1000/	3,600	4,116	. 4,661
Total NCDI-Holly	100%	3,000		
Springs Unweighted		1		
· Volume	<u> </u>	J		-

Step 7: Convert Unweighted Procedures to Weighted Procedures [page 66]

After projecting the total number of unweighted MRI scans for the proposed fixed MRI scarner, NCDI- Holly Springs determined a reasonable contrast percentage to apply to the unweighted MRI volume. NCDI-Holly Springs reviewed the contrast percentages for the mobile service provided at NCDI-Cary during FY 2009, which was 19.5%. NCDI-Holly Springs also reviewed the contrast percentages for other MedQuestmanaged facilities near Wake County. Considering these data sources, the 19.5 percentage for contrast is reasonable in light of experience of other MedQuest facilities located in North Carolina near Wake County. The average for the four facilities was 23.1%

entages for Other MedQuest Facilities

Contrast Percentage	s for Other Med	dQuest Facilin	es	7/ 7
Contrast Fercesting	Character	Total Scans	Contrast	% Contrast
Facility Name	Сошију	1	Scans	
1.		700	76	19.5%
NCDI-Cary (Kings	Wake	388	. •	
Medical Mobile)		1210=	1,622	34.4%
Durham Diagnostic	Durham	4,710*	1,000	
Imaging		C (62±	1,183	20.9%
Triad Imaging	Guilford '	5,663*		17.45
Carolina Imaging	Cumberland .	11,981*	1	

*Includes fixed and mobile volumes

NCDI-Holly Springs also considered the contrast percentages performed by other freestanding fixed MRI centers in Wake County based on data from the Draft 2011 SMFP.

st Percentages for Outpatient Fixed MRI Facilities in Wake County

- · · · · · · · · · · · · · · · · · · ·	- For Ordinations	TXEA BULL FOR	Philippin 1	
Contrast Percentage	S JOI Omputer 2	Total Scans	Contrast Scans	% Contrast
Facility Name	Fixed Magnets	4,394	1.991	45_3%
Raleigh MRI Center	1		1,841	44.3%
Raleigh MRI Center	<u> </u>	. 4,152	2,216	34.5%
Rateigh With Common Page	1	6,431	2,210	
Raleigh Neurology			1	32,5%
Associates	7	2,743	894	
Raleigh Radiology	7	6.869	7 700	22.6%
Raleigh Radiology at	.1	,,,,,		
Cedarhurst				35.8%
Average Comrast	: \			
Percentage			<u> </u>	

Source: Draft 2011 SMFP

Step 8; Apply Contrast Percentage to Determine Weighted Volume [page 67]"

ings Unweighted & Weighted MRI Volume

	- TI- IR WOTE	shied MKL YOU	11112	
NCDI- Holly Springs	Unweighted & Heis	2072	2013	2014
Consus Tracts		1,540	1,779	2,040
-22	Holly Springs	465	550	642
531.01	Fuquay Varina	101	118	128
531.03	Wake County	280	317	356
531.04	Wake County	· 882	963	1,050
534.04	Holly Springs Apex	152	182	212
529	Wake County	}	3,909	4,428
Primary Service Area		3,420	3,707	
Unweighted		700	206	233
Phys-In-migration @		180		1
.	age.	2 (00	4,115	4,661
5% Total Unweighted	•	3,600		'
1 '		503	803	909
Volume	Contrast Scans	702		7.7
19.5% Contrast		281	32.	
Outpatient Contrast				
Adjustment (Contrast				6 5,025
Scars x 0.4)	7	3,88	1 4,43	0 5,025
Total Weighted	¹ .		-	
volume (Unweighter	7	1	1	
Volume + Contras	T			
Adjustment)	1			

· NCDI-Holly Springs reviewed a variety of options and determined that the development of the proposed project is the most effective alternative to meet the current and future imaging needs of the residents of Wake County and in particular, the residents of southern Wake County, including the Town of Holly Springs. The proposed outpatient imaging center will be located in one of the most populous and fastest growing areas of Wake County and within one mile of the Holly Springs interchange with the Western Wake Freeway. The proposed project will result in greater convenience and expanded state-of-the-art imaging services in a comfortable, pleasant environment for residents of southern Wake County."

However, projected utilization is not based on reasonable and supported assumptions. In Step 4, the applicant makes the following assumptions regarding the projected market share for the proposed fixed MRI scanner:

"NCDI-Holly Springs Outpatient Imaging Center Projected

Market Share: CY 2012 - CY 2014

2 . cd CV 2017	-1 / ////		
Market Share: CY 2012	CY 2012	CY 2013	CY 2014
Census Tract	48%	53%	58%
Census Tract 532	30%	34%	38%
Census Tract 531.01	13%	15%	16%
Census Tract 531_03		33%	36%
Census Tract 531.04	30%	5206	56%
Census Tract 534.04	50%	1.10/	16%
Census Tract 529	" 12%	1470	1

ģá

4. .

However, the applicant does not adequately demonstrate that the assumptions shown in the table above are reasonable for the following reasons:

- In Attachment 29, the applicant provided letters from physicians which include estimates of the number of referrals to the proposed fixed MRI scanner. These estimates total only 117 referrals in PY1, 127 in PY2 and 134 in PY3. These estimated referrals are substantially below the levels needed to support the projected utilization in the first three operating years.
- ² In each project year, 15 of the estimated referrals are from a physician practice whose address is listed as Wake Forest which is located in the exact opposite corner of Wake County from the proposed facility. According to Google Maps, the distance between Holly Springs and Wake Forest is around 35-47 miles depending on the route taken. The applicant does not adequately demonstrate that it would be reasonable to assume that a physician practice located in Wake Forest would serve many residents of Holly Springs.
 - In Step 4, the applicant states "Novant Medical Group primary care physician offices with local access are planned for development in Holly Springs in and near the medical plaza." In addition, the applicant states in Step 5 "The Novant Medical Group of general surgeons is exploring a satellite office location in Holly Springs." However, the applicant did not provide any details such as when the practices would open, how many physicians would be associated with these practices would open, how many physicians would be associated with these primary care physician offices or the projected number of referrals for MRI primary care physician offices or the projected number of referrals for MRI services. None of the reasons cited by the applicant on page 62 adequately support the projected market share assumptions. (See page 21 of the findings for the applicant's reasons.) For example, the applicant does not explain why its projected market share is positively correlated with the population of Holly Springs as a percentage of the total Wake County population. Even if it is, the population of Holly Springs represents only 12% of the total population of Wake County, yet the applicant projects a market share of 58% for one of the Holly Springs census tracts.
 - In Step 5, the applicant applies the projected market share percentages from Step 4 to total projected unweighted MRI procedure volume by census tract. However, the applicant did not adequately demonstrate that its projected market share percentages are based on reasonable and supported assumptions. None of the reasons cited by the applicant on page 63 adequately support the projected market share assumptions. (See pages 22-23 of the findings for the applicant's reasons.)
 - Therefore, projected utilization which is based on these market share assumptions is not based on reasonable and supported assumptions and is questionable.

Furthermore, the applicant projects that 2% of its MRI patients will be residents of Durham, Orange, Sampson, Nash, Craven, Wayne, Vance and Person counties. However, the applicant does not adequately demonstrate that it is reasonable to assume residents of those

counties would utilize the proposed MRI-scanner in Holly Springs. Particularly since there are existing fixed and mobile MRi scanners in those counties, the facility does not yet exist and it would be located in Holly Springs, a community of less than 22,000 people.

In summary, the applicant did not adequately demonstrate the need the population to be served has for the proposed MRI scanner. Consequently, the application is nonconforming to this criterion.

Wake Radiology currently offers MRI services at its Gamer office, an existing diagnostic center, through two different vendors, Alliance and Wake Radiology Diagnostic Imaging (one of the co-applicants). Wake Radiology plans to place the proposed fixed MRI scanner at its Garner office located at 300 Health Park Drive. The applicants state the mobile MRI scanner services would be discontinued at the Garner office.

Population to Be Served

In Section III.5(a), page 94, the applicants state "The primary service area for the proposed fixed MRI scanner includes the following zip codes 27529, 27520, 27603, 27606, 27610, 27526, 27592, and 27545. The secondary service area for includes the remainder of Wake County not included by the primary service area zip codes. The rationale for establishing this service area is based on historical patient origin for MRI patients at WRGO."

In Section III.5(c), page 95, the applicant provides the current and projected patient origin for the first two years of operation following completion of the proposed project as shown in the table below:

cted Patient Origin for MRI Services

	Carred Patient Origin for	MIKT SELAICES
	Projected Patient Origin for Current	
County	Percent of Total	Percent of Total
	60.5%	60.5%
Wake	33.9%	33.9%
Johnston	5.7%	5.7%
Harnetti .	100-0%	100.0%
Total		

In Section III.5(d), pages 95-96, the applicants state "The projected patient origin is consistent with WRGO's historical experience providing mobile MRI services. The applicants do not anticipate a significant change in patient origin as a result of providing fixed MRI services." The applicants adequately identified the population proposed to be served.

Need Analysis

In Section III.I, pages 59-75, the applicants state the need for the proposed fixed MRI scanner in Gamer is based on the following:

"The proposed project is consistent with the unmet need, identified in the 2010 SMFP for one additional fixed MRI scanner in Wake County. To meet the identified need, WRS proposes to acquire and install a fixed MRI scanner to be placed at WRGO. The

proposed fixed MRI scarmer will be operated by WRDI. In evaluating the unmet need for the proposed MRI scanner, WRDI reviewed service area population growth trends, MRI growth in Wake County and at WRDI, and physician referral patterns. This need analysis is described below.

A 2010 SMFP Need Methodology [pages 59-60 of the application]

Based on the 2010 SMFP Need Methodology, the State has determined a need for one additional fixed MRI scanner in Wake County in 2010.

In addition to the State's need determination, Wake Radiology recognizes that there are additional characteristics and data in Wake County that further support the need for an additional fixed MRI scanner in Wake County.

B. Population [pages 60-63 of the application]

The State-defined MRI scanner Service Area is Wake County. ... According to the NCOSBM, Wake County is expected to become the most populous county in North Carolina by 2013 and host more than one million residents. ... [T]he county population is expected to increase by approximately 110,779 people, or 12% percent during the next four years. ...

As described previously, the applicants propose to locate the fixed MRI scanner at the WRGO facility in Garner. Garner is a rapidly growing community within Wake County. ---

The primary service area for the proposed fixed MRI scanner includes the following zip codes: 27529, 27520, 27603, 27606, 27610, 27526, 27592 and 27545. The secondary service area includes the remainder of Wake County not included by the primary service area zip codes. ...

The rationale for establishing this service area is based on the historical patient origin for MRI patients at WRGO. Currently, 67.5% of WRGO patients originate from the service area. ...

- Compies Are	a Projected Populati	071	2014	10-14 CAGR
Primary Service 211,	Area	2009	40,352	4.1%
Zip Code	Clayton	34,341	47,185	5.0%
27520	Fuquay Yarina	38,825		3.9%
27526.	Garner	40,905		
27529	Kraghtdale	18,380	15,876	7 00/4 1
27545	Willow Spring	13,601		
27592	Raleigh	40,026	7 4 005	2.7%
27603	Raleigh	49,436		3.7%
27606	Raleigh	60,654 296,168		2 207
27610 Total Primary SA	, , , , , , , , , , , , , , , , , , , ,	290,100	7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	

Source: Claritas

MRI Utilization [pages 63-67 of the application]

MRI utilization rates for Wake County continue to trend upward ... Based on population data from NCOSBM and FY2009 MRI utilization from DHSR Planning Section, the Wake County MRI utilization rate was 80.7 procedures per 1,000 population in 2009. From 2004 to 2009, the Wake County MRI use rate experienced a compound annual growth rate of 3.7%.

Wake County MRI Use Rate per 1,000 Population FY 2004-FY2009

- TOTT	Tian Data nor 1 111	O FUDULIATION X X	
Wake County MRI	Use Kuis per 1,00	Universited MRI	MRI Procedure
Year	РориІлбоп	DIE!	Rate (Per 1,000)
1		2 COURTS	67.3
	725,334	48,815	
FY2004		53,122	70.1
FY2005	757,346	55,692	70.2
	793,401		78:9
FY2006	831,537	65,582	500
FY2007 ·			76.0
FY2008 -	. 866,438		80.7
	892,607		2 70/
FY2009	4.2%	1 8 176	
04-09 CAGR	7.270	D- # 2011 SMFP da	ta provided by SHCC

Source: NCOSBM, 2006-2010 SMFP, Draft 2011 SMFP data provided by SHCC Technology & Equipment Committee & DHSR Planning Section Totals may not foot due to rounding.

Wake County MRI Utilization

Wake County has also experienced substantial growth in MRI utilization.

County Historical MRI Utilization FY2004 - FY2009

	NART THISZATION F 14	104-11200
Wake County Hist	orical MRI Utilization F120	Weighted MRI Scans
	I Impropried But both	27 537
	48,815	C7 774
FY2004	53,122	65,936
FY2005	55,692	
FY2006	65,582	77,172
FY2007	1	77,428
FY2008	65,892	86,533
	72,036	8.5%
F12009	8.1%	
DA DO CAGR		" sided by SHCC Technology

Source: 2006-2010 SMFP, Draft 2011 SMFP data provided by SHCC Technology & Equipment Committee & DHSR Planning Section Totals may not foot due to roundīng.

Unweighted MRI utilization in Wake County experienced a five-year compound annual growth rate of 8.1% from FY2004 to FY2009. Weighted MRI utilization increased 8.5% annually during the same time period. Based on historical growth rates combined with rapid population growth estimates, Wake County is likely to continue to utilize MRI services at increasing rates.

According to the 2010 SMFP, over 87% of MRI scans performed in Wake County are outpatient MRI procedures. Wake County inpatients and emergency patients are currently adequately served by six existing fixed MRI scanners located at Wake County hospitals. Thus, WRDI's proposal to establish a dedicated outpatient MRI scanner is an effective alternative.

Mobile MRI Utilization

377008 Mobile MRI Utilization Top North Carolina Counties

TOTALL MANTER MIKE	Utilization Lop Worth C	JEH O'STATE
	Fixed Equivalent Total	Unweighted Mobile Scans
. County	5.18	16.478
Mecklenburg ·		16,232
Guilford	3.37	
	3.87	. 15,298
Wake	2.44	11,726
New Honover		9.361
Forsyth	1.94	

Source: 2010 SMFP

Wake County mobile MRI scanners average 3,953 unweighted scans per fixed equivalent magnet (4,218: weighted scans per fixed equivalent), which are both far above the 3,328 weighted scan State-defined mobile MRI capacity threshold. This demonstrates that mobile MRI scanners in Wake County are operating well above capacity. Furthermore, during the most recent fiscal year ending September 30, 2009, WRDI's mobile MRI scanner performed 3,560 weighted MRI procedures, which also exceeds the State-defined mobile MRI capacity threshold.

In summary, Wake County has historically experienced steady MRI growth, and based on projected population growth rates, the demand for MRI services will continue to increase. Furthermore, given that the majority of MRI scans are performed on an outpatient basis, Wake County residents would benefit most from a facility dedicated to providing outpatient MRI services. Thus, to meet the growing demand for outpatient MRI services in Wake County, the applicants propose to install a new fixed MRI scanner at the WRGO facility in Garner.

D. Geographic Need [pages 68-75 of the application]

There are thirteen existing fixed MRI scanners in the Wake County MRI Service Area. Ten fixed MRI scanners are located in Raleigh, and three fixed MRI scanners are located in Cary. There are currently no fixed MRI scanners located in Garner. ...

WRDI's proposed location at 300 Health Park Drive in Garner is more than 10 miles from the two fixed MRI scanners located at WakeMed Raleigh Hospital, 13 miles from the fixed scanner at Duke Raleigh Hospital, 14 miles from two fixed MRI scanners at the Raleigh MRI location on Merton Drive, 14 miles from one fixed MRI

scarner at Raleigh Radiology Cedarharst, 18 miles from the fixed MRI scarner at WakeMed Cary Hospital, and 20 miles from the fixed MRI scanner at Kex Healthcare of Cary.

According to North Carolina Office of State Budget & Management (NCOSBM) population estimates, the communities in southeastern Wake County (Garner and the surrounding area) have experienced significant population growth in recent years.

Southeast Wake County
2008 Municipal Estimates by Municipality

ን <i>ስ</i> በዩ <i>ሽብ</i>	unicipal Estimai	es by leithfulps	
	2000	2008	20 GIDBUL
Municipality		26,109	46.8%
Garner	17,787	20,631	124.4%
Holly Springs	9,192		84.1%
	5,958	10,967	
Knightdale	7.898	16,054	103.3%
Fuquay-Varina	4,247	5,796	36.5%
Wendell		866,438	36.85
Wake County	633,516		14.4%
North Carolina	. 8,079,712	9,247,173	

Source: NC Office of State Budget & Management

... Municipal population projections are not available on the NCOSBM website; however, WRDI obtained the following population projections from Claritas which demonstrate continued growth for the municipalities in southeast Wake County during the next five years. ...

Southeast Wake County
Claritas Population Projections by Municipality

Claritas Popului		2014	% Growth
	2009	17,653	23.7%
Fuguay-Varina town	24,023	• 27,666	15.2%
Garner town	18,063	22,763	26.0%
Holly Springs town	7,305		12.0%
Krightdale town	4,776	5,176	8.4%
Wendell town	4,770		

Source: Claritas

... Out of the municipalities listed, Garner has the lowest per capita income currently and also five years from now, at \$23,892 and \$25,159 respectively. A lower per capita income average traditionally results in difficulties in obtaining equal access to health services. Therefore, the proposed fixed MRI scanner at WRGO will ensure access to MRI services for underserved populations.

Municipalities in Wake County Per Capita Income 2009–2014

	Per Capita Littonie 20	- C: . Y
	2009 Per Capita Income	2014 Per Capita Income
Municipality	\$39,069	\$42,009
		\$41.121
Cary	\$38,343	
Morrisville	\$36,649	\$39,941
Apex	1	\$29,893
Wake Forest	\$27,800	\$29,219
	\$27,629	
Raleigh .	\$23,892	\$25,159
Garner	\$25,032	

Fixed & Mobile MRI Access

Wake County hosts several mobile MRI sites, including WRGO. Based on FY2008 data reported in the 2010 SMFP, Wake County has the third highest utilization of mobile MRI services in North Carolina, behind Mecklenburg and Guilford counties. Despite numerous mobile MRI scanners located in Wake County, Garner remains underserved with regard to MRI access. The applicants then determined the number of either fixed or mobile MRI sites within a five-mile radius of each municipality.

The following table provides Claritas population estimates for Wake County municipalities including the number of fixed and/ or mobile MRI host sites within a 5-mile radius of each municipality.

		10 36-Lila :	· Ratio of
	2009 Population	- Fixed & Mobile Magnets <5 miles	pop/scarner
	277 002	13	28,546
Raleigh city	371,092	1	24,023
Garner town	24,023	11	11,530
Cary town	126,832	3	8,436
Wake Forest town	. 25,307	7	7,305
Knightdale town	7,305	6	5,080
Apex town	30,480	2	3,626
Morrisville town	10,877	7	- ·
Holly Springs town	18,063	1	
Fuquay-Varina town	14,267	1 0	1
Friquity-) in the town	4,776	di di	
Wendell town Zebulon town	4,342	. 0	1

Based on the current locations of fixed and mobile MRI scanners, Garner is significantly underserved by MRI scanners compared to other municipalities in Wake significantly underserved by MRI scanners compared to other municipalities in Wake significantly underserved by MRI scanners compared to other municipalities in Wake significantly underserved by MRI scanners at however, Wake Forest residents currently have access to mobile MRI scanners at however, wake Forest residents currently have access to mobile MRI services three different host sites. Garner residents only have access to mobile MRI services

at WRGO. Furthermore, Morrisville has less than half the population of Garner yet still has access to mobile MRI scanners at three different host sites.

In summary, Garner is currently underserved with regard to MRI services. WRGO is an established MRI provider in the service area that has long-standing relationships with local referring physicians. Thus, the proposed fixed MRI scanner at WRGO will greatly increase geographic access to fixed MRI services in Wake County for a rapidly growing market

E. Physician Referrals [page 75 of the application]

Radiologists do not refer patients for iMRI scans. Rather, local physicians in Wake County and surrounding communities are the primary source of referrals to the existing and proposed MRI services at WRGO. WRDI is a well-established and existing and provider of MRI services in Wake County. As such, WRDI has long-trusted local provider of MRI services in Wake County. As such, WRDI has long-standing relationships with local referring physicians. In fact, the applicants have received over 175 letters of support from local physicians who refer patients to WRGO. Based on the referral estimates provided in these letters of support, local physicians have indicated their intent to refer over 4,300 MRI patients to the proposed fixed MRI scanner located at WRGO. This is further evidence of the need for the proposed service at WRGO's facility in Garner. The proposed fixed MRI scanner at will be available to all physicians and their patients, regardless of the patient's ability to pay. Please refer to Exhibit 18 for letters of support for the proposed fixed MRI scanner."

Historical and Projected Utilization

In Section IV.1, pages 99-101, the applicants provide historical and projected utilization for the existing mobile MRI services and the proposed fixed MRI scanner at WRGO through the first three project years, as illustrated in the table below.

tt	nee project yea	is, as musuc	2002 200					-
		FY2008	FY2009	FY2010 Interim (Oct-	FY2011- Interim (Oct- Sept)	FY2012 (Oct- Sept)	FY2013 (Oct- Sept)	FY2014 (Oct- Sept)
	# of MRI	•		Sept)		-		
	Scanners		·	-		. 1	. 1	
	Fixed .			1	1			1 111
	Mobile	100	2,323	- 2,417	2,515	3,298		4,444
	#of Procedures #of Weighted	2,483 2,723	2,585		2,798	3,670		
	Procedures Percentage	-na-	(-5.1%)	4.1%	4.1%	31.2%	16.75%	15.49
	Change in							
	Weighted Procedures							1

As shown in the table above, in FY2009, 2,585 weighted MRI procedures were performed on the mobile MRI scanners at WRGO, a 5.1% decrease from the year before. In the third project year, the applicants project the proposed fixed MRI scanner will perform 4,945 weighted MRI procedures, which exceeds the 4,805 required by 10A NCAC 14C .2703(b)(3). weighted MRI procedures, which exceeds the 4,805 required by 10A NCAC 14C .2703(b)(3). weighted MRI procedures, which exceeds the 4,805 required by 10A NCAC 14C .2703(b)(3). weighted MRI procedures, which exceeds the 4,805 required by 10A NCAC 14C .2703(b)(3). weighted MRI scanner is operational. Between FY 2011 and FY 2012 (PY1), year before the fixed MRI scanner is operational. Between FY 2011 and FY 2012 (PY1), wake Radiology assumes volume will increase 31.2%. Between PY2 and PY3, volume is projected to projected to increase another 16.75%. Between PY2 and PY3, volume will increase 91.3% increase another 15.4%. All together, Wake Radiology projects volume will increase 91.3% between FY 2009 and PY3 (FY 2014) (a 5-year period) [4,945 - 2,585 = 2,360; 2,360/2,585 between FY 2009 and PY3 (FY 2014) (a 5-year period) [4,945 - 2,585 = 2,360; 2,360/2,585 between FY 2009 and PY3 (FY 2014) (a 5-year period) [4,945 - 2,585 = 2,360; 2,360/2,585 between FY 2009 and PY3 (FY 2014) (a 5-year period) [4,945 - 2,585 = 2,360; 2,360/2,585 between FY 2009 and PY3 (FY 2014) (a 5-year period) [4,945 - 2,585 = 2,360; 2,360/2,585 between FY 2009 and PY3 (FY 2014) (a 5-year period) [4,945 - 2,585 = 2,360; 2,360/2,585 between FY 2009 and PY3 (FY 2014) (a 5-year period) [4,945 - 2,585 = 2,360; 2,360/2,585 between FY 2009 and PY3 (FY 2014) (a 5-year period) [4,945 - 2,585 = 2,360; 2,360/2,585 between FY 2009 and PY3 (FY 2014) (a 5-year period) [4,945 - 2,585 = 2,360; 2,360/2,585 between FY 2009 and PY3 (FY 2014) (a 5-year period) [4,945 - 2,585 = 2,360; 2,360/2,585 between FY 2009 and FY 2009 at WRGO and ecreases at Raleigh MRI, which is owned by Wake Radiology and has two existing fixed MRI sca

In Section III.1, pages 76-83, the applicants provide the assumptions and methodology used to project utilization at the proposed fixed MRI scanner at WRGO, as follows:

"Specific Methodology for Projecting MRI Utilization at WRGO

The following provides the specific methodology used to project MRI utilization for the proposed fixed MRI scanner that will be located at WRGO.

Step 1: Identify Historical Wake County MRI Utilization

The following table provides historical MRI utilization for Wake County.

Wake County Historical MRI Scans FY2004 - FY2009

	r I.	2004 - 1 1 2 2000
Г	Year	Unweighted MRI Scans
1		48,815
٠ \	FY2004	53,122
1	FY2005	55,692
	· FYZ006	
	FY2007	65,582
	FY2008	65,892
		72,036
	FY2009	8.1%
	04-09 CAGR	7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7

Source: State Medical Facilities Plan (2006-2010), Draft 2011 SMFP data provided by SHCC Technology & Equipment Committee & DHSR Planning Section. Totals may not foot due to rounding.

The number of unweighted MRI scans performed in Wake County experienced a fiveyear compound annual growth rate of 8.1% from FY2004 to FY2009. Despite recent economic distress (experienced at its height during FY2008), the number of MRI scans in Wake County have continued to increase. While most counties saw a decrease in MRI scans during FI2008, the total number of MRI scans performed in Wake County actually increased As a sign of economic recovery, Wake County MRI procedures increased 9.3% during FI2009 compared to the previous year.

Step 2: Project Future Wake County MRI Utilization

To project Wake County MRI utilization from FY2010 to FY2014, the applicants utilized one-half of the FY2004-FY2009 compound annual growth rate $(8.1\% \div 2=4.0\%)$ for MRI scans performed in Wake County.

Wake County Projected MRI Scans FY2010-FY2014

		1.7.70	<i>,</i> \cup \perp \cup			
Ī	Year		Un	weigl	nted M	IRI Scans
	FY2010				•	74,951
١	FY2011					77,984
	FY2012		-			81,140
			├─			84,423
	FY2013		\vdash			87.840
	FY2014		1			07,070

Totals may not foot due to rounding.

The projected annual growth rate of 4.0% is reasonable and conservative based on the historical utilization for MRI services in Wake County. As stated previously, the most recent five-year compound annual growth rate for Wake County was 8.1% from FY2004 to FY2009, and the most recent one-year annual increase was 9.3% from FY2008 to FY2009.

Step 3: Determine Reasonable MRI Market Share Assumptions

To project reasonable market share assumptions for the proposed Garner fixed MRI scanner, Wake Radiology first determined WRGO's current market share in Wake County. During the most recent fiscal year ending September 30, 2009 (FY2009), WRGO performed a total 2,323 unweighted mobile MRI scans on the WRDI mobile MRI scanner and the Alliance MRI scanner combined. Based on the total number of MRI scans performed in Wake County during FY2009, WRGO's current market share is approximately 3.2%.

Wake Radiology Garner Office FY2009 MRI Market Share (Based on Mobile MRI Utilization)

	(Ras	ed on Modile Blue Villiant	
1		TOY	FY2009 Market Share
1	Wake County MRI Scans		3.2%
	72,036	2,323	J.270
	12,000		54. 8 DITTE DIGWENT Section

Source: 2011 SMFP data provided by SHCC Technology & Equipment Committee & DHSR Planning Section, Wake Radiology Internal Data. Totals may not foot due to rounding:

To remain conservative, the applicants project WRGO's Wake County market share to remain constant until the first year of the proposed project. Upon implementation of the

proposed project, the applicants project WRGO's market share to increase to 4.0% during Project Year 1, 4.5% during Project Year 2 and 5.0% during Project Year 3.

Wake Radiology Garner Office

	PTO: ECTE!! INIX! INIX! ESTER E								
Γ				PYI.	PY2	PY3			
+		2010	2011	2012	20.13	2014			
-	MRI Markei Share	3.2%	3_2%	4.0%	4.5%	5.0%			

The projected MRI market shares are reasonable and conservative. First, WRGO's MRI market share is projected to remain constant until the first year of the proposed project. WRGO has provided mobile MRI services at its facility in Garner for six years, and has long-standing, established relationships with local referring physicians. Thus, it is reasonable to project that WRGO's MRI market share will remain constant until FY2012. The applicants project modest market share increases during the first three project years based on the written commitment of local physicians to refer patients to the proposed fixed MRI scanner in Garner. Based on the referral estimates provided in these letters of support, local physicians have indicated their intent to refer over 4,300 MRI patients to the proposed fixed MRI scanner located at WRGO. This is much greater compared to WRGO's most recent mobile MRI utilization of 2,323 unweighted MRI scans during FY2009. Additionally, the projected market shares are supported by the following factors:

* The proposed project will increase MRI access at WRGO from 40 hours to 66 hours each week, an increase in availability of 65%.

WRS and WRDI will establish the first freestanding, dedicated outpatient 1.5T

fixed MRI scanner owned by local physicians in Garner.

* As described in Section II, the proposed project will increase access to MRI services for obese and claustrophobic patients.

WRS and WRDI have received over 175 letters of support representing indicating their intent to refer at over 4,300 patients to the proposed fixed MRI scanner. Please refer to Exhibit 18.

* WRGO will establish a new, free-standing non-hospital based fixed MRI service with a lower charge structure compared to existing hospital-based MRI services in Wake County. Currently, the hospital-based MRI scanners at WakeMed are the closest in proximity to Garner-area residents.

Step 4: Project MRI Scans at WRGO

The applicants applied market share projections in Project Years 1 through 3 to the projected Wake County MRI utilization.

Proposed Fixed MRI Sconner

	Proposed LD	en hun premiu		·
Project Year		WRGO Outpatient	Projected	WRGO
Project real		Market Share	MRI Şcans	
T777077	81,140	4.0%		. 3,246
FY2012	84,423	4.5%		3,799
FY2013	87,840	5.0%		4,392
FY2014	07,040			

Totals may not foot due to rounding

If awarded a fixed MRI scanner, the applicants have offered to partner with Project Access, a program of the Wake County Medical Society, to provide one free MRI scan each week to local patients who are uninsured or underinsured. The agreement will provide 52 charitable scans each year in the local community. Please refer to Exhibit 8 for correspondence between Project Access and WRS/WRDI regarding this agreement. These are patients who otherwise would not receive MRI services; thus, the projected 52 scans each year are in addition to the projected MRI utilization based on market share. Therefore, the applicants project the following MRI procedures in the first three years of the proposed project.

WRGO Projected MRI Utilization

., 0,00		
sed Fixed MRIS	conner	
	2013	2014
3,246	3,799	4,392
52	52	52
	2.057	4.444
3,298	3,851	4,444
	/205	1016
3,670	4,283	4,945
	2012 3,246	sed Fixed MRI Scanner 2012 2013 3,246 3,799 52 52 3,298 3,851

Totals may not foot due to rounding.

Utilization for the proposed fixed MRI scanner is projected to be 4,444 unweighted MRI procedures during the third year of the proposed project (FY2014). The applicants project weighted MRI procedures based on the historical contrast utilization at WRGO. Based on FY2009 data, WRGO's MRI procedure mix was 28.2% contrast and 71.8% non-contrast.

[15-Based on FT2009 utilization provided on both WRDI's mobile MRI scarner and a mobile MRI contract with Alliance Imaging, WRGO provided 655 outpatient MRI procedures with contrast and 1,668 without contrast for a total 2,323 mobile MRI procedures.]

Physician Referrals

As described previously, physicians are the primary source of referrals to the proposed fixed MRI service. WRS and WRDI received over 175 letters of support from local physicians who refer patient for MRI services in Wake County. ...

The proposed fixed MRI scanner at WRGO will be available to all physicians and their patients, regardless of the patient's ability to pay. Please refer to Exhibit 18 for letters of support from physicians indicating their intent to refer to the proposed fixed MRI scanner.

In summary, WRGO has provided mobile MRI services to the residents of Wake County and surrounding communities for six years. Currently, a mobile MRI scanner is on-site five days each week (Monday-Friday 8:00am-5:00pm). WRDI's proposed fixed MRI scanner will:

- > expand MRI access at WRGO to six days (66 hours) week.
- > improve physical access to MRI services for patients,
- reduce the cost of providing MRI services at WRDI,
- increase access to uninsured and underinsured patients via agreement with Project Access of Wake County,
- > insure continuing access to Medicare and Medicaid patients, and
- > increase access to obese and claustrophobic patients."

However, projected utilization of the proposed fixed MRI scanner at WRGO is not based on reasonable and supported assumptions. In Step 4 of the methodology, the applicants project their market share will increase from the current 3.2% of all unweighted MRI procedures performed in Wake County to 4.0%, 4.5% and 5.0%, respectfully. As illustrated in the table below, between FY2008 and FY2009, the number of unweighted MRI procedures performed at WRGO decreased by 5.1%.

	1-00-7-1-1-7		FY2008- Actual (Oct-Sept)	FY2009- Actual (Oct-Sept)
#of MRI Prod	edure	s	2,483.	2,323
#of Weighter			2,723	2,585
Percentage	LAILLA	Increase	-Da-	(5.1%)
(Decrease)	in	Weighted	, ,	
Procedures		·		

The <u>decrease</u> in utilization at WRGO between FY2008 and FY2009 is in contrast to a 9.3% <u>increase</u> in the total number of unweighted MRI procedures performed in Wake County at all locations, including WRGO, between FY2008 and FY2009. The applicants do not adequately explain this decrease in their application.

Furthermore, the applicants do not adequately explain decreases in utilization at Raleigh MRI. The table below illustrates historical and projected utilization of the two fixed MRI scanners at Raleigh MRI.

Raleigh Fi	zed MR	(utilizatio	a (Histor	ical and	Projected) FY2009	FY 2010	FY 2011	· IYI	PYZ	PY3
n.	FY2005	FY2006	FY2007	FY2008	1 1,000	Projected-	Projectica-	FY 2012	FY 2013	FY 2014
i,						Literina	Interim			
1				9.842	8.546	8,731	8,919	9,112	9,309	9,511
Unweighten	11,852	10,576	10,009	1,	10_078	10,297	10,519	10,747	10,979	11,216
Weighted	13,204	11,837	11,308	11,272		22%	2.2%	2.2%	2.2%	2.2%
% change in	-na-	<11.55%>	<4.7%>	<0.32%>	<11.8570~			1		1
	1		1 _			-	1		and the second s	The second secon
Weighted		-							•	

As shown above, for each year from FY2005 to FY2009, the number of MRI procedures performed on the two fixed MRI scanners at Raleigh MRI has decreased. The applicants do not provide an explanation for this other than to state that the economy was difficult in FY2008. Furthermore, the applicants do not adequately document that it is reasonable to assume volume at Raleigh MRI will increase except to state in Section II.8, page 35, "During FY2009, WRDI performed 8,546 unweighted MRI scans on the two fixed MRI scanners located at Raleigh MRI. To project MRI utilization at Raleigh MRI through FY2014, WRDI conservatively applied three-fourths of the projected population growth rate for Wake County (2.9% x .75 = 2.2%) to its most recent historical MRI utilization." The applicants tied MRI growth at Raleigh MRI to population growth. However, as shown in Section III.1, page 64, the population of Wake County increased at a compound annual growth rate ("CAGR") of 4.2% from FY2004 to FY2009, the same years during which utilization of the two fixed MRI scanners at Raleigh MRI declined every year.

In FY2008, the applicants "market share" of the total number of unweighted MRI procedures performed anywhere in Wake County was 3.8% (2,483 procedures/ 65,892 Wake County procedures = .03768 or 3.8%). In contrast, in FY2009, the applicants "market share" of the total number of unweighted MRI procedures performed anywhere in Wake County declined from 3.8% to 3.2% (2,323 procedures/ 72,036 Wake County procedures = 0.03224 or 3.2%). By projecting a 5.0% "market share" in FY2014 at WRGO, the applicants project a 56.25% increase in "market share" in a five (5) year period (5.0% / 3.2% = 1.5625 or In support of this projected growth, in Exhibit 18, the applicants submitted over 56.25%). 175 letters of support from "Iocal physicians who refer patients to WRGO. Based on the referral estimates provided in these letters of support, local physicians have indicated their intent to refer over 4,300 MRI patients to the proposed fixed MRI scanner located at WRGO." [See page 75 of application.] If these physicians were to refer 4,300 patients to WRGO for an MRI procedure, it would be an 85% increase in the number of referrals (4300/ 2323 = 1.851. or 85.1%). However, the applicants do not adequately explain what will change to cause these physicians to increase their referrals to WRGO by 85.1%.

In the interim years before the proposed fixed MRI scanner is operational, the applicants project volume on the mobile MRI scanners at WRGO will increase 4.1% annually. However, the applicants do not adequately demonstrate that this assumption is reasonable and supported given the 5.1% decrease at WRGO between FY2008 and FY2009. The applicants do not adequately explain what will change to cause volume to increase before the proposed fixed MRI scanner would be operational.

Between FY 2011 and FY2012 (Year 1), the applicants project the number of weighted MRI procedures performed at WRGO will increase 31.2%. The applicants state what would be different at WRGO between FY2011 and FY2012 (Year 1) to explain the projected increase in the number of weighted MRI procedures to be performed at WRGO between FY2011 and Year 1. That is, WRGO's hours of operation will increase 65% once the proposed fixed MRI scanner begins operating [66.40 = 26; 26/40 = 0.65].

Between FY 2012 and FY2013 (Years 1 and 2) the applicants project the number of weighted MRI procedures performed at WRGO will increase 16.75% Furthermore, between FY2013 and FY2014 (Years 2 and 3) the applicants project the number of weighted MRI procedures performed at WRGO will increase 15.4%. However, the applicants do not adequately demonstrate that it is reasonable to assume that utilization will increase 16.75% at WRGO between Years 1 and 2 and 15.4% between Years 2 and 3 given the 5.1% decrease in the number of weighted MRI procedures performed at WRGO between FY 2008 and FY2009. Furthermore, according to the applicants (see Section III.1, page 66), between FY2004 and FY 2009, the CAGR for unweighted MRI procedures performed in Wake County was only 8.1%, roughly half of the percentage increase projected by the applicants between Years 1 and 2 and Years 2 and 3.

Moreover, the applicants do not state what would be different at WRGO between Years 1 and 2 or Years 2 and 3. Physician referrals for an MRI procedure have decreased recently. Thus, the physician's referral practices would have to change somehow if the number of referrals is going to increase 16.75% between Years 1 and 2 and 15.4% between Years 2 and 3. The applicants do not adequately explain how the physician's referral practices would change such that referrals would increase 16.75% and 15.4% respectively or provide documentation to support such an assumption.

Furthermore, in support of the proposed fixed MRI scanner the applicants state that it would be able to accommodate obese and claustrophobic patients. However, there is nothing in the application or the physician letters of support regarding the number of obese or claustrophobic patients who would normally be referred to WRGO but instead are being referred elsewhere. In addition, the applicants do not provide projected estimates of the number of MRI procedures which would be performed at WRGO on the proposed fixed MRI scanner on obese or claustrophobic patients. Neither the applicants nor the physicians state that the proposed fixed MRI scanner is capable of performing certain types of procedures which the mobile scanners are not capable of performing.

In addition, the applicants state on page 93 of the application that 33.1% of WRGO's 2009 MRI patients originated from Johnston County. Based on 2,323 unweighted MRI procedures that means that, in 2009, approximately 769 patients originated from Johnston County (2,323 x 0.331% = 768.91). On page 95, the applicants project that during FY2012-2014, 33.9% of its patients would originate from Johnston County. Based on the applicants estimate of 4,444 unweighted MRI procedures during FY2014 that means the applicants project approximately 1,507 patients will be residents of Johnston County. [4,444 x 33.9% = 1,506.5] Therefore, the applicants are projecting a 95.9% increase in the number of residents of Johnston County who will have an MRI procedure at WRGO (1,506.5 / 768.9 = 1.9592 or 95.9%). Of the 175

letters from physicians in Exhibit 18, 14 are from physicians located in Johnston County projecting a total of 615 referrals. The two main travel comidors from Johnston County to WRGO (the site of the proposed fixed MRI scanner) are I-40 and US 70. Johnston MRI, ILC was approved for and developed a new fixed MRI scanner which was operational as of September 2009 located in Clayton, adjacent to US 70 and located between the bulk of Johnston County and WRGO. Pinnacle Health Services of North Carolina, LLC d/b/a Raleigh Radiology at Cedarhurst ("Pinnacle") received CON approval to acquire a 1.5 Tesla open mobile MRI scanner to serve a host site at 300 Guy Road, Clayton. [Project ID #J-8268-08. Under appeal by Wake Radiology.] The host site is adjacent to US-70 and close to I-40. Pinnacle described the approved open mobile MRI scanner as follows

"Siemens mobile MRI systems are designed and equipped to provide the same diagnostic performance as that of the fixed Magnetom systems delivering leading applications, superb patient comfort, and efficient workflow to any place.

The proposed Siemens Magnetom Espree's unique Open Bore design can accommodate more types of patients than other 1.5T systems on the market today, in particular the growing population of obese patients. The power of 1.5T combined with "TIM" technology boosts signal-to-noise, which is necessary to adequately image obese patients.

The proposed MRI system is also designed for an improved patient experience for claustrophobic patients." See page 8 of the Findings for Project ID #J-8268-08.

The type of fixed MRI scanner that Wake Radiology is proposing to acquire is a Siemens 1.5T Magnetom Avanto MRI System equipped with "TIM" (Total Imaging Matrix).

The applicants do not adequately demonstrate that it is reasonable to assume a 95.9% increase in the number of Johnston County patients who will utilize WRGO once it has a fixed MRI scanner given the development of one new fixed MRI scanner and the approval of a new. Open Bore Mobile MRI Scanner designed to accommodate both obese and claustrophobic patients at an existing host site in the same general area.

The applicants will have a total of three existing, approved and proposed fixed MRI scanners by the third operating year of this project. In Section II.8, page 34, the applicants project the average annual utilization of the existing, approved and proposed fixed MRI scanners (2 existing at Raleigh MRI and 1 proposed at WRGO) will be 4,896 weighted MRI procedures (4,945 on proposed fixed MRI scanner at WRGO + 9,744 on the two existing MRI scanners at Raleigh MRI = 14,689/3 MRI scanners = 4,896) in the third operating year.

However, the applicants did not adequately demonstrate that the two fixed MRI scanners at Raleigh MRI would reasonably perform 9,744 weighted MRI procedures in the third project year. The applicants used the following assumptions and methodology to project utilization of the two existing fixed MRI scanners at Raleigh MRI and the existing mobile MRI scanner (owned by WRS and operated by WRDI):

First, the applicants started with the actual number of MRI procedures performed in FY2009 on the two fixed MRI scanners located at Raleigh MRI and projected a 2.2% increase in unweighted MRI procedures for each year from FY2010 through FY2014. (See Section II.8, pages 35-36). The table below illustrates the historical and projected unweighted and weighted MRI procedures for the two fixed MRI scanners at Raleigh MRI.

Date of MRT Projected Utilization

Raleigh MRI Projected Unitzation										
T	FY2009	FY 2010	FY 2011	PYI	PY2	PY3				
Ì		Projected-	Projected-	FY 2012	FY 2013	FY				
	•	Interim	Interim			2014				
Unweighted MRI	8,546	8,731	8,919	9,112	9,309	9,511				
Procedures		10.007	10,519	10,747	10,979	11,216				
Weighted MRI	10,078	10,297	10,319	10,747	10,577	11,000				
· Procedures		- 506	2.2%	2.2%	2.2%	2.2%				
% change in	<11.85%>-	2.2%	2.270	22/0	1 22/8	2.276				
weighted.						<u></u>				

Second, the applicants then stated that WRDI would locate its mobile MRI scanner at Raleigh MRI for three days per week and assumed 1,248 of those unweighted MRI procedures would be performed on the mobile, as illustrated in the table below. (See Section II.8, pages 36-37.)

Raleigh MRI Projected Utilization

, Introduction and the	FY2012	FY2013	FY2014
Fixed MRI procedures	7,864	8,061	8,263
Mobile MRI procedures	1,248	1,248	1,248
Total unweighted MRI procedures	9,112	9,309	9,511

Third, the applicants then converted the unweighted fixed MRI procedures not allocated to the mobile MRI scanner to weighted MRI procedures as shown in the table below.

		Secretary of the second second second second second second second second second second second second second se	
	FY2012	FY2013	FY2014
Unweighted MRI procedures	7,864	8,061	8,263
Weighted MRI procedures	9.275	9,507	9,744
Melaurer Miles brocking	L. Company of the Com		

The applicants assume the two existing fixed MRI scanners at Raleigh MRI will perform 9,744 weighted MRI procedures in Year 3, which is an average of 4,872 weighted MRI procedures per scanner. [9,744/2=4,872 weighted MRI procedures per MRI scanner]. As noted above, the proposed fixed MRI scanner at WRGO is projected to perform 4,945 weighted MRI procedures in year 3. Thus, the three fixed MRI scanners (2 at Raleigh MRI and one proposed at WRGO) are projected to average 4,896 weighted MRI procedures.

However, Wake Radiology did not adequately demonstrate that projected utilization of the proposed fixed MRI scanner at WRGO is based on reasonable and supported assumptions. See discussion above.

Furthermore, the applicants did not adequately demonstrate that projected utilization of the two existing fixed MRI scanners at Raleigh MRI is based on reasonable and supported assumptions. See discussion above.

In Section II.8, page 47, the applicants state that WRS owns and WRDI operates one mobile MRI scanner in the MRI service area (Wake County). In Section II.8, pages 39-41, the applicants project the mobile MRI scanner will perform 3,484 weighted procedures in Year 3. In Section II.8, pages 39-41, the applicants provide "projected unweighted and weighted MRI utilization by site for WRDI's existing mobile MRI scarmer. For information purposes, mobile MRI services are currently offered at each of the sites identified in the following tables." See the following tables.

rojected Mobile MRI Procedures FY2012-FY2014

Raleigh MRI-Historical and Projected Mobile MRI Procedures V12012 2013 2014									
Raleigh MIKI-HISTOFICAL	31117 7 7 7	, Licitor .		0.70	2011	2012	2013	2014	
	2007	2008	2009	2010	2011	JAN JOH	~~~		
		422	19	-na-	-na-	1,248	1,248	1,248	
Unweighted MRI	350	432	1			•	1	1	
	Į.	١,		·		<u> </u>		7 (00	
Procedures	}			T	Į.	1,406	1,406	1,406	
Weighted MRI Procedures				<u> </u>	L	Line Comme			

Wake Radiology Northwest Raleigh Office

Historical and Projected Mobile MRI Procedures FY2012-FY2014

Historical and Projected Monne Mitt Project 1 2013 2013 2014							
Historical and r	t b) cccca xix			1705	2012	2013 ·	2014
Facility of the second	2008	2009	2010	.7011	2014		1
	2000				728.	832	936
Timeralited MRI	-na-	20≠			,		\ . \ \
Unweighted MKI		1	Į.		\	1	
The androrer	1	<u> </u>		ļ	27.5	020	1,048
Procedures		1	1	ł	815	932	1,040
Weighted MRI Procedures	- <u>ma</u> -	1			· Lagrantia de la const		
Well-invitation and							

*9/1/09-9/30/09 only. Total of 36 hours.

Wake Radiology Wake Forest Office

Historical and Projected Mobile MRI Procedures FY2012-FY2014

	Historical and Projected Mobile Mrd 1 locality 1 2013 2014							
	Historical and L	T		2010	2011	2012	2013	2014
Ĭ		2008	2009	2010	2011	728	832	936
1	Througinhted MRI					120	مرده	1
- 1	Unweighted MKI			-	-	1		
-	Procedures .	<u> </u>		-		- 801-	915	1,030
-	Weighted MRI Procedures]	<u> </u>	1		
	THE CALL CONTRACTOR OF THE CALL CONTRACTOR OF					•		

*No data for 2008-2011.

The table below illustrates the total projected unweighted and weighted MRI procedures for FY2012-FY2014 for all three of the listed host sites.

> Total-All Three Projected Host Sites Projected Mobile MRI Procedures FY2012-FY2014

Projected Mobile Wiki Floccula Co.						
		2012	2013	2014		
Total Unweighted	MRI	2,704	2,912	3,120		
Procedures Total Weighted MRI Procedu	res	3,022	3,253	3,484		

However, projected utilization of the mobile MRI scanner at Raleigh MRI is based on projected utilization of the fixed MRI scanners at Raleigh MRI. Projected utilization of the fixed MRI scanners at Raleigh MRI is not based on reasonable and supported assumptions. See discussion in 10A NCAC 14C .2703(b)(3). Therefore, projected utilization of the mobile MRI scanner is also questionable.

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Furthermore, Wake Radiology did not provide the methodology and assumptions used to project utilization of the mobile MRI scaimer at two other host sites: the Northwest Raleigh Office and the Wake Forest Office other than to state "For information purposes, mobile MRI services are currently offered at each of the sites identified in the following tables." [See Section II.8, pages 39-41.] In Section II.8, page 47, the applicants did state that for the 12-month period ending September 30, 2009, 20 unweighted/22 weighted MRI procedures were performed at the Northwest Raleigh Office. Wake Radiology did not supply any year-to-date information as to the number of MRI procedures (either unweighted or weighted) performed at either the Northwest Raleigh Office or the Wake Forest Office after September 30, 2009. This application was submitted on June 15, 2010.

In summary, the applicants did not adequately demonstrate that projected utilization of the proposed fixed MRI scanner at WRGO, the two existing fixed MRI scanners at Raleigh MRI or the existing mobile MRI scanner owned by Wake Radiology is based on reasonable and supported assumptions. Consequently, the applicants did not adequately demonstrate the need the population to be served has for the proposed fixed MRI scanner at WRGO. Therefore, the application is nonconforming to this criterion.

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 - All Applications

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

C –Duke Kaleigh NC- NCDI–Holly Springs NC- Wake Radiology

Duke Raleigh In Section III.3, pages 30-31, the applicant describes the alternatives it considered. 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 10A NCAC 14C 2700 for discussion. Therefore, the applicant adequately demonstrated that the proposal is its least costly or most effective alternative and the application is conforming to this criterion.

NCDI-Holly Springs In Section III.3, pages 75-76, the applicant describes the alternatives it considered. However, the application is not conforming to all other applicable statutory and regulatory review criteria. See Criteria (1), (3), (5), (6), (18a) and 10A NCAC 14C 2700 for discussion. Therefore, the applicant did not adequately demonstrate that the proposal is its least costly or most effective alternative and the application is nonconforming to this criterion.

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Wake Radiology In Section III.3, pages 89-92, the applicants describe the alternatives they considered. However, the application is not conforming to all other applicable statutory and regulatory review criteria. See Criteria (1), (3), (5), (6), (18a) and 10A NCAC 14C 2700 for discussion. Therefore, the applicants did not adequately demonstrate that the proposal is their least costly or most effective alternative and the application is nonconforming to this criterion.

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

. C – Duke Raleigh NC – NCDI-Holly Springs NC- Wake Radiology

Duke Raleigh In Section VIII, page 65, the applicant states that the total capital cost of the proposed project is \$4,972,700, which includes:

Site Costs Cost of Materials Cost of Labor Fixed Equipment Movable Equipment Furniture Architect & Engineering Independent Testing Other (Contingency)	\$ 292,100 \$1,122,000 \$ 918,000 \$2,049,000 \$ 79,600 \$ 13,600 \$ 345,000 \$ 12,900 \$ 140,500
Total	\$4,972,700

In Section IX.1, page 70, the applicant states that there will be no startup expenses or initial operating expenses. In Section VIII.3, page 66, and in Section VIII.8, page 67, the applicant states that the capital costs of the proposed project will be financed through the accumulated reserves of Duke University Health System.

Exhibit VIII.6 contains a copy of a letter dated May 13, 2010 from the Senior Vice President, Chief Financial Officer and Treasurer of the Duke University Health System, which states:

"This letter is to certify that Duke University Health System has as much as \$6 million in accumulated reserves to fund the acquisition of a second fixed MRI scanner and the new construction and renovations essential to its installation and efficient operation."

Exhibit VIII.9 contains a copy of the audited financial statements for Duke University Health System, Inc. and Affiliates for the year ending June 30, 2009. As of June 30, 2009, Duke

University Health System, Inc. and Affiliates had cash and cash equivalents of \$98,925,000, unrestricted net assets of \$1,348,045,000 and total net assets of \$1,392,169,000. The applicant adequately demonstrated the availability of funds for the capital needs of the project.

The following table illustrates projected revenues, expenses and average charge per unweighted MRI procedure as reported by the applicant in Form C and Form D. Note: the charges include only the technical component.

Duke Raleigh-MRI Service Component

Duke Raleigh-MRI Service Component				
	Year 1-	Year 2-	Year 3-	
	(7/1/11 -6/30/12)	(7/1/12 - 6/30/13)	(7/1/13 - 6/30/14)	
10 077	6,654	7,269	8,034	
Projected # of Unweighted	0,00			
Procedures	, mo cac 20	· \$2,730.95	\$2,894.95	
Projected Average Charge	\$2,576.30	\$2,73000	4-3	
(Gross Patient Revenue-/			1	
Projected # of Procedures)			POZ 050 000	
Gross Patient Revenue	\$17,142,718	\$19,851,292	\$23,258,028	
Deductions from Gross	\$11,681,400	\$13,755,627	\$16,334,823	
Demending Train				
Patient Revenue	\$5,461,317	\$6,095,665	\$6,923,205	
Net Patient Revenue	\$1,760,967			
Total Expenses		C DOO		
Net Income	\$3,700,351	54,100,002	1 4 1503 1503	

As illustrated in the table above, the applicant projects that net revenues for the MRI service component will exceed expenses during each of the first three operating years. The following table illustrates projected revenues and expenses for Duke University Health System as reported by the applicant in Form B.

Duke University Health System

Revenues and Expenses for Entire Health System

Revenues and expenses to	n ranno monta or		
*Note: All.\$ are in 000's.	Year 1-	Year 2-	Year 3-
"INOTE" WITH ME III GOO BY	(7/1/11-6/30/12)	(7/1/12 - 6/30/13)	(7/1/13 ~ 6/30/14)
	\$2,333,141	\$2,483,205	\$2,726,652
Total Operating Revenue		\$2,338,243	\$2,588,607
Total Operating Expenses	\$2,168,050	ود مرد در مرد و	4-3-5-3,047
excluding Bad Debt			6128 DAF
Operating Income (Loss)	\$165,091	\$144,962	\$138,045
Non-Operating Revenue	\$61,540	\$55,302	\$58,417
Non-Obergring Kevenine		\$200,264	\$196,462
Excess of Revenue over	1	4.2.5	
Expenses from Continuing			1 .
Operations		1	
			· ·

The applicant projects revenues will exceed expenses for the entire health system in each of the first three project years following completion of the proposed project.

The assumptions are reasonable, including projected utilization, costs and charges. See the Proforma Section for the proformas and assumptions. See Criterion (3) for discussion of utilization projections. Therefore, the applicant adequately demonstrates that the financial

feasibility of the proposal is based upon reasonable projections of costs and charges. Consequently, the application is conforming to this criterion.

NCDI- Holly Springs In Section VIII, page 114, the applicant states that the total capital cost of the proposed project is \$2,099,869, which includes:

Construction Contract Fixed Equipment Furniture Architect & Engineering Other (Contingency)	\$ 409,304 \$1,590,565 \$ 25,000 \$ 25,000 \$ 50,000
Total	\$2,099,869

In Section IX, page 118, the applicant states that the total working capital required is \$345,515 (\$84,687 in start-up expenses + \$260,828 in initial operating expenses = \$345,515). In Section VIII, page 115, the applicant states that the capital costs will be funded with the accumulated reserves of Novant Health, Inc. In Attachment 20 the applicant states that the working capital costs will be funded by the reserves of Novant Health, MedQuest, Inc. and MedQuest Inc.'s line of credit with Novant Health.

Attachment 20 contains a copy of a letter dated June 9, 2010 from the Chief Financial Officer of Novant Health, Inc., which states:

"As the Chief Financial Officer for Novant Health, Inc., I have the authority to obligate funds from accumulated reserves of Novant Health for projects undertaken by MedQuest, Inc. and North State Imaging, LLC d/b/a North Carolina Diagnostic Imaging—Holly Springs ("NCDI-Holly Springs"), both affiliates of Novant Health, Inc. is the not-for-profit parent company of Medquest and the ultimate parent company of North State Imaging, LLC d/b/a North Carolina Diagnostic Imaging—Holly Springs. I am familiar with the CON application in which NCDI—Holly Springs proposes to develop a new outpatient imaging center with a fixed MRI scanner in northern Wake County.

I can and will commit Novant's reserves to cover all of the capital costs associated with this project, including the project capital cost of \$2,099,869 and start-up and initial operating expenses of \$345,315."

Attachment 20 also contains a copy of a letter dated June 9, 2010 from the Chief Accounting Officer of MedQuest, which states:

"This letter confirms the availability of funds for North State Imaging, LLC d/b/a North Carolina Diagnostic Imaging- Holly Springs ("NCDI- Holly Springs") to support the capital expenditures required for the acquisition of the fixed MRI as proposed in NCDI-Holly Spring's CON application...

MedQuest, Inc., an affiliate of NCDI-Holly Springs, will make available all funds—necessary to finance the proposed project and required working capital, as well as any unforeseen expenses related to the CON application."

Attachment 21 contains audited financial statements for Novant Health, Inc. and Affiliates for the year ended December 31, 2009. As of December 31, 2009, Novant Health, Inc. had cash and cash equivalents of \$768,805,000 and total unrestricted net assets of \$1,775,542,000. The applicant adequately demonstrated the availability of funds for the capital and working capital needs of the project.

The following table illustrates projected revenues, expenses and average charge per unweighted MRI procedure, as reported by the applicant in Form C and Form D. The facility does not yet exist and the applicant does not propose any service other than MRI. Therefore, the revenues and expenses in Form C (service component) are identical to those in Form B (entire facility). In Section II, page 24, the applicant states:

"NCDI- Holly Springs has not assumed any inflation in its charges during the first three years of operation following implementation. These are global charges which include both the technical component and the radiologist's professional fee. NCDI-Holly Springs will pay the radiologists, which is reflected in the expenses for the proposed project in the financial pro formas under Indirect Expenses-Professional Fees."

	•		
	Year 1-	Year 2-	Year 3-
	(1/1/12-12/31/12)	(1/1/13-12/31/13)	(1/1/14-12/31/14)
Projected # of Unweighted	. 3,600	4,115	4,661
Procedures		22.046.10	\$2,046.18
Projected Average Charge	\$2,046.18	\$2,046.18	\$2,040.10
(Gross Patient Revenue /			
Projected # of Procedures)		\$8,420,012	\$9,537,224
Gross Patient Revenue	\$7,366,232		\$6,771,883
Deductions from Gross	\$5,230 <i>,37</i> 5	\$5,978,610	\$0,111,000
Patient Revenue	1 2 2 2 2 2	\$2,441,402	\$2,765,341
Net Patient Revenue	\$2,135,856		
Total Expenses	\$1,564,969	\$1,779,425	
Net Income	\$570,887	\$661,978	\$889,521

As shown in the table above, the applicant projects that net revenues will exceed expenses during each of the first three operating years. The assumptions used by the applicant in preparation of the pro formas are in with the pro formas behind Section 12 of the application. However, the applicant's utilization projections are unsupported and unreliable. See Criterion (3) for discussion. Consequently, costs and revenues that are based on this projected utilization are also not reliable. Therefore, the applicant did not adequately demonstrate that the financial feasibility of the proposal is based upon reasonable projections of costs and charges. Consequently, the application is nonconforming with this criterion.

Wake Radiology In Section VIII, page 120, the applicants state that the total capital cost of the proposed project is \$1,819,102, which includes:

Construction Contract Fixed Equipment Movable Equipment Functine Architect & Engineering Administrative & Legal Financing Costs Interest During Construction		327,180 336,106 37,158 3,000 33,500 41,750 18,500 4,908	
Other (freight, miscellaneo	as) \$	<u>17,000</u>	
Total		,819,102	

In Section IX, page 118, the applicants state that there will be no startup expenses or initial operating expenses. In Section VIII, page 123, the applicants state that the capital cost will be funded with a conventional loan in the amount of \$482,996 and a vendor equipment lease in the amount of \$1,336,106, which total \$1,819,102.

Exhibit 14 contains a copy of a letter dated June 8, 2010 from the Senior Vice President of Wells Fargo, The Private Bank, which states:

"We are pleased to issue this letter regarding our willingness to provide financing associated with the proposed acquisition of a fixed MRI scanner in Wake County by Wake Radiology Services, LLC, and Wake Radiology Diagnostic Imaging, Inc... Specific to this project, the Bank has examined the financial position of Wake Radiology Services, LLC and found it adequate to support the proposal. Based upon this review, the Bank is willing to provide up to \$500,000 for this project, specifically to fund the leasehold improvements, contrast injector, and miscellaneous project capital costs."

A copy of a capital lease proposal between Siemens and Wake Radiology Services, LLC dated June 4, 2010 for an Avanto RS Proven Excellence System is also contained in Exhibit 14...

Exhibit 14 also contains a copy of an asset and liability report for Wake Radiology Services as of December 31, 2009. As of December 31, 2009 Wake Radiology Services had total assets of \$21,202,392.03, total liabilities of \$8,175,230.00 and net assets of \$13,027,163. The applicant adequately demonstrated the availability of funds for the capital and working capital needs of the project.

The following table illustrates projected revenues, expenses and average charge per unweighted MRI procedure, as reported by the applicants in Form C and Form D.

TIDGO Proposed fixed MRT service component

WRGO. Proposed fixed MRI service component				
	Year I-	Year 2-	Year 3-	
	(10/1/11-9/30/12).	(10/1/12-9/30/13)	(10/1/13-9/30/14)	
Projected # of Unweighted	3,600	4,115	4,661	
Procedures	27.000.67	\$2,031.82	\$2,070.00	
Projected Average Charge	\$1,988.71	\$2,00 Laz	. SE,070.00	
(Gross Patient Revenue /				
Projected # of Procedures)		70.000.000	\$9,648,264	
Gross Patient Revenue	\$7,159,352	\$8,360,952		
Deductions from Gross	\$3,490,464	\$4,099,147	\$4,761,140	
Patient Revenue	20 60 000	\$4,261,805	. \$4,887,124	
Net Patient Revenue	\$3,68,888	4-7-4-00		
Total Expenses	\$2,253,997	12 500 500		
Net Income	\$1,414,891	\$1,633,503	\$2,002,046	

As shown in the table above, the applicants project that net revenue for the MRI service component will exceed expenses during each of the first three operating years. The following table illustrates projected revenues and expenses for all services provided at WRGO as reported by the applicants in Form B.

XRGO-Revenue and Expenses: Entire Facility

WRGO- Kevenue and Ex	Denses. Diffic Laci	1117	
	Project Year 1	Project Year 2	Project Year 3
	\$6,212,418	\$6,363,667	\$6,463,400
Total Revenue Total Projected Expenses	\$5,075,582	\$5,295,100	\$5,384,047
Net Operating Income	\$1,136,837	-\$1,041,566	\$1,079,353

As shown in the first table above, the applicants project that net revenues for the MRI service component will exceed expenses during each of the first three operating years. In addition, in the second table, the applicants project that revenues for all services provided at WRGO will exceed expenses in each of the first three operating years. The assumptions used by the applicants in preparation of the pro formas are in Section 13 of the application. However, the applicants utilization projections are unsupported and unreliable. See Criterion (3) for discussion. Consequently, costs and revenues that are based on this projected utilization are also not reliable. Therefore, the applicants did not adequately demonstrate that the financial feasibility of the proposal is based upon reasonable projections of costs and charges. Consequently, the application is nonconforming with 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 – Duke Raleigh NC- NCDI- Holly Springs NC- Wake Radiology

Duke Raleigh Duke Raleigh adequately demonstrates that the proposal would not result in unnecessary duplication of existing or approved MRI services for the following reasons:

- The 2010 SMFP identifies a need for one fixed MRI scanner in Wake County and the applicant proposes to acquire only one fixed MRI scanner to be located in Wake County. See Criterion (1) for additional discussion.
- 2) The applicant adequately demonstrates the need for a second fixed MRI scanner at Duke Raleigh Hospital. See Criterion (3) for additional discussion.

Consequently, the application is conforming to this criterion.

NCDI- Holly Springs The 2010 SMFP identifies a need for one fixed magnetic resonance imaging (MRI) scanner in Wake County and the applicant proposes to acquire only one fixed MRI scanner to be located in Wake County. See Criterion (1) for discussion. However, NCDI- Holly Springs did not adequately demonstrate that the proposed project would not result in the unnecessary duplication of existing or approved MRI services because the applicant did not adequately demonstrate that projected utilization was based on reasonable and supported assumptions regarding projected market share. See Criterion (3) for additional discussion. Consequently, the application is nonconforming to this criterion.

Wake Radiology The 2010 SMFP identifies a need for one fixed magnetic resonance imaging (MRI) scanner in Wake County and the applicants propose to acquire only one fixed MRI scanner to be located in Wake County. See Criterion (1) for discussion. However, Wake Radiology did not adequately demonstrate that the proposed project would not result in the unnecessary duplication of existing or approved MRI services because the applicants did not adequately demonstrate that projected utilization was based on reasonable and supported assumptions regarding projected growth between Project Years 1 and 2 and Project Years 2 and 3. See Criterion (3) for additional discussion. Consequently, the application is nonconforming 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 - All Applicants

Duke Raleigh In Section VII.1, pages 53-57, the applicant provides current and projected staffing for the existing and proposed MRI scanners. The applicant projects staffing will increase from 7.26 full-time equivalent (FTE) positions to 11.53 FTE positions at the beginning of the second year (FY2012) (.53 FTE RN positions and 3.74 FTE MR technologist positions). In Section VII.6, pages 59-61, the applicant describes its experience in the recruitment and retention of staff. In Section VII.8, page 62, the applicant identifies Josiah Carr, M.D. as the Chief of Staff/Medical director. Dr. Carr is the President of the Medical Staff and board certified in Family Medicine. The applicant also identifies Ted Kunstling, M.D. as the Chief Medical Officer for Duke Raleigh Hospital. Dr. Kunstling is board-certified in Internal Medicine and Pulmonary Disease. In Section II.8, page 24, the applicant states MRI scans are interpreted by radiologists with training and/or experience in interpreting MRI scans. The applicant demonstrates the availability of adequate health manpower and management personnel to provide the proposed services and is conforming with this criterion.

NCDI- Holly Springs In Section VII.1, pages 103-106, the applicant provides projected staffing for the proposed MRI scanner. The applicant projects a total of 5.0 FTE positions at the beginning of the second year (FY2013) (0 FTE RN positions, 5.0 FTE MR technologist positions, 1.0 clerical, 0.25 administrator, 1.0 clerical administration, 25 marketing). In Section VII.6, page 109, the applicant describes its experience in the recruitment and retention of staff. In Section II.8, page 37, the applicant identifies David Wiener, M.D. as the proposed medical director of the proposed project. Exhibit 10 contains documentation that Dr. Wiener is board-certified in radiology. Exhibit 11 contains a letter from Dr. Wiener indicating his willingness to serve as the Medical Director. The applicant demonstrates the availability of adequate health manpower and management personnel to provide the proposed services and is conforming with this criterion.

Wake Radiology In Section VII.1, pages 111-112, the applicants provide current staffing for the existing mobile MRI service and projected staffing for the proposed fixed MRI scanner. In Section VIL1, page 111, the applicants note that "WRDI currently contracts with Alliance (the mobile MRI provider) for the MRI Technologists. Therefore, this table does not include MRI The majority of the procedures are performed on a mobile MRI scanner Technologists." owned by one of the applicants. The applicants did not provide the existing number of MRI technologists who support the mobile MRI scanner owned by one of the co-applicants. The applicants project a total of 4.5 FTE positions at the beginning of the second year (FY2013) 2.0 existing support and administrative positions, 2.0 FTE MRI technologist positions and 0.5 of an additional FTE support staff position. In Section VII.6, page 116, the applicants describe their experience in the recruitment and retention of staff. In Section VIL8, page 118, the applicants identify G. Glenn Coates, M.D. as the medical director of the proposed project. Dr. Coates is board-certified in radiology. The applicants demonstrate the availability of adequate health manpower and management personnel to provide the proposed services and are 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-All Applicants

Duke Raleigh In Section II.2(a-c), page 8, the applicant describes the ancillary and support services to be provided. In Exhibit V.3, the applicant provides letters of support from referring physicians indicating their intent to refer patients to the proposed MRI scanner. The applicant adequately demonstrates that the necessary ancillary and support services will be provided and that the proposed service will be coordinated with the existing health care system. Therefore, the application is conforming with this criterion.

NCDI-Holly Springs In Section II.2(a-c), page 16, the applicant describes the ancillary and support services to be provided. In Attachment 7, the applicant provides a letter from MedQuest Associates, Inc. documenting that the "necessary ancillary and support services

will be provided by MedQuest, as well as its parent company Novant Health, Inc." In Attachment 29, the applicant provides letters of support from referring physicians indicating their intent to refer patients to the proposed MRI scanner. The applicant adequately demonstrates that the necessary ancillary and support services will be provided and that the proposed service will be coordinated with the existing health care system. Therefore, the application is conforming with this criterion.

Wake Radiology in Section II.2(a-c), pages 16-17, the applicants describe the ancillary and support services to be provided. In Exhibit 22, the applicants provide a copy of a management agreement with Wake Radiology Services, ILC to provide the ancillary and support services. In Exhibit 18, the applicants provide letters of support from referring physicians indicating their intent to refer patients to the proposed MRI scanner. The applicants adequately demonstrate that the necessary ancillary and support services will be provided and that the proposed service will be coordinated with the existing health care system. Therefore, the application is conforming with 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-All Applicants

When applicable, the applicant shall show that the special needs of health maintenance organizations will be fulfilled by the project. Specifically, the applicant shall show that the project accommodates: (a) The needs of enrolled members and reasonably anticipated new members of the HMO for the health service to be provided by the organization; and (b) The availability of new health services from non-HMO providers or other HMOs in a reasonable and cost-effective manner which is consistent with the basic method of operation of the HMO. In assessing the availability of these health services from these providers, the applicant shall consider only whether the services from these providers: (i) would be available under a contract of at least 5 years duration; (ii) would be available and conveniently accessible through physicians and other health professionals associated with the HMO; (iii) would cost no more than if the services were provided by the HMO; and (iv) would be available in a manner which is administratively feasible to the HMO.

NA - All Applicants

- (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.

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C- Duke Raleigh NA -- NCDI- Holly Springs NA- Wake Radiology

Duke Raleigh- To accommodate the proposed new fixed MRI scanner, the applicant proposes to construct 2,875 square feet of new space and renovate 499 square feet. See Exhibit XI.5(d) which contains a copy of the site plan. Exhibit XI.5(a) contains the architect's certified cost estimate of \$2,040,000 which is consistent with the applicant's projected costs in Section VIII, page 65. In Section XI.7, page 78, the applicant states that coordinated efforts where made between the architects, engineers, and contractors to "maintain efficient energy operations to contain the cost of utilities." The applicant adequately demonstrated that the cost, design and means of construction represent the most reasonable alternative, and that the construction costs will not unduly increase costs and charges for health services. See Criterion (5) for discussion of costs and charges. The application is conforming with 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 — Duke Raleigh C- Wake Radiology NA- NCDI- Holly Springs

Duke Raleigh. In Section VI.13, pages 99-100, the applicant provides the payor mix for MRI services during FY 2009 (7/1/2008 – 6/30/2009), as shown in the following table:

Dale Deleigh's Historical MRI Payor Mix

Duke Raleigh's Historical MRI Payor MIA					
MRI Services					
Last Full Fiscal Y	ear				
Tule 1 2008 to Tone 3	to_2009				
Procedure as Percent of Total Utilization					
Self Pay/Indigent/Charity	2270				
Sell Fay/Illington Change	40.4%				
Medicare/Medicare Managed Care	5.8%				
Medicaid	47.7%				
Commercial Insurance	1.1%				
Managed Care	1.4%				
Other (Specify)	. 100.0%				
Total	1 100.078				

Note-"Other" includes out-of-state Medicaid, Tricare, and other government.

The applicant demonstrates that medically underserved populations currently have adequate access to the applicant's existing MRI services and the application is conforming to this criterion.

Wake Radiology-In Section VI13, page 107, the applicants provide the payor mix for the mobile MRI services provided at WRGO during FY 2009 (October 2008 – September 2009), as shown in the following table:

· Wake Radiology's Historical MRI Payor Mix		
MRI Services		
Last Full Fiscal Year		
October 2008 to September, 2009		
Current Patient Days/ Procedure as Pe	reent of Total Utilization	
Self Pay/Indigent/Charity		
Medicare	26.4%	
Medicaid	. 2.7%	
Managed Care/ Commercial	15.6%	
Manager Card Commission	. 44.4%	
Blue Cross Blue Shield	10.0%	
State Employees Health Plan	0.7%	
Other (Workers Comp, TriCare)	100.0%	
Total		

The applicants demonstrate that medically underserved populations currently have adequate access to the applicants' existing mobile MRI services and the application is conforming to this criterion.

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

C — Duke Raleigh C- Wake Radiology NA-NCDI-Holly Springs Duke Raleigh In Section VIIC, page 49, the applicant states that "to the best of our knowledge, no civil rights or equal access complaints have been filed by patients against Duke University Health System or any of the facilities comprising Duke University Health System in the last five years." The application is conforming to this criterion:

Wake Radiology In Section VI.10, page 105, the applicants state that "neither WRS nor WRDI has had any civil rights complaints filed against it during the last five years." The application is conforming to this criterion.

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 (c) these groups is expected to utilize the proposed services; and

C-All Applicants

Duke Raleigh In Section VI.2, page 44, the applicant states, "The services of Duke Raleigh Hospital are open to all area and non-area residents for impatient, outpatient, and other healthcare services on a walk-in, emergency, referral, or emergency basis." In Section VL15, pages 51-52, the applicant projects the following payor mix for the proposed MRI services in the second project year.

Duke Raleigh's Projected MRI Payor Mix		
MRI Services		
July 1, 2011 to June 30, 2012		
The Ford Procedure as Percent of Lotal Univarion		
Projection Factors	· · · · · · · · · · · · · · · · · · ·	
Self Pay/Indigent/Charity	42.2%	
Medicare/Medicare Managed Care	8.6%	
Medicaid	. 43.1%	
Commercial Insurance	1.1%	
Managed Care	1.4%	
Other (Specify)	100,0%	
Total	1 the government	
Note: "Other" includes out-of-state Medicaid, TriCare and other government.		

In Section VI.15, page 52, the applicant states

"Our assumption is that the payor mix for MRI services, will change in the following ways:

The Medicare percentage will increase each year, with the aging of the population and the Hospital's development of services to meet their needs.

The Medicaid percentage will also increase.

The Managed Care percentage will go down each year as baby boomers retire and become eligible for Medicare.

The commercial insurance, self-pay/indigent/charity, and other percentages will stay the same.".

The applicant demonstrates that medically underserved populations will have adequate access to the proposed services and the application is conforming to this criterion.

NCDI- Holly Springs In Section VI2, page 91, the applicant states, "NCDI- Holly Springs will not discriminate based on race, creed, color, sex, age, religion, national origin, mental or physical handicap, or ability to pay. NCDI- Holly Springs will be committed to providing necessary medical care to any individual regardless of that person's ability to pay." In Section VII5, page 102, the applicant projects the following payor mix for the proposed MRI services in the second project year.

NCDI-Holly Spring's Projected Payor Mix		
MRI Services		
Second Full Fiscal Year		
01/01/2013 — 12/31/2013		
ONULATE PROJECTED Patient Days/ Procedure as Percent of Total Utilization 8.1%		
Projected Patient Days 118ctatus 2.	8.1%	
Self Pay/Indigent/Charity	15.2%	
Medicare/Medicare Managed Care		
	4.8%	
Medicaid	6.5%	
Commercial Insurance	. 55.2%	
Managed Care		
Other - (Champus, Workers Compensation,	10.2%	
Other - (Champie, Workers Octob		
Third Party Admin)	100.0 %	
Total	1 . Local ye	

Note: "Percentage allocation for each payor is based on historical payor mix for MedQuest sites in the region."

In Section VI.15, page 102, the applicant states "Percentage allocation for each payor is based on historical payor mix for MedQuest sites in the region." The applicant does not identify the MedQuest sites in the region. However, the Agency notes that Novant Health, Inc. has an imaging facility in Cary which offers MRI services through an agreement with Kings Medical Company.

The applicant demonstrates that medically underserved populations will have adequate access to the proposed services and the application is conforming to this criterion.

Wake Radiology- In Section VI.2, the applicants state, "WRDI will continue to have a policy to provide all services to all patients regardless of income, racial/ethnic origin, gender, physical or mental conditions, age, ability to pay or any other factor that would classify a patient as underserved." In Section VI.15, the applicants project the following payor mix for the proposed MRI services in the second project year.

Wake Radiology's Historical MRI Payor Mix		
MRI Services		
Second Full Fiscal Year		
FY2013 (October 2012 to September, 2013)		
Corrent Patient Days/ Procedure as Percent of Total Utilization		
Self Pay/Indigent/Charity	0376	
Medicare	26.4%	
Medicaid	2.7%	
Managed Care/ Commercial	15.6%	
Blue Cross Blue Shield	44.4%	
State Employees Health Plan	10.0%	
Ofher (Workers Comp, TriCare)	0.7%	
	100.0%	
Total		

In Section VI.15, the applicants state "WRDI projects the MRI payor mix for the first three project years based on the assumptions described in Section VI.14 above. In other words, WRDI projects the MRI payor mix based on the actual Garner MRI payor mix during FY2009. This table does not reflect the WRDI offer to annually provide 52 free MRI scans to Project Access patients. These "no charge" scans are reflected in the charity care section." The applicants demonstrate that medically underserved populations will have adequate access to the proposed services and the application is conforming to 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-All Applicants

Duke Raleigh In Section VI.9 (a-c), pages 48-49, the applicant describes the range of means by which patients will have access to the proposed services. The information provided in Section VI.9 is reasonable and credible and supports a finding of conformity with this criterion.

NCDI- Holly Springs In Section VI.9 (a-c), pages 97-98, the applicant describes the range of means by which patients will have access to the proposed services. The information provided in Section VI.9 is reasonable and credible and supports a finding of conformity with this criterion.

Wake Radiology In Section VI.9 (a-c), page 115, the applicants describe the range of means by which patients will have access to the proposed services. The information provided in Section VI.9 is reasonable and credible and supports a finding of conformity with this criterion.

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

C- All Applicants .

Duke Raleigh- See Section V.1 (a-c), pages 39-40, for documentation that Duke Raleigh Hospital will continue to accommodate the clinical needs of area health professional training programs. The information provided is reasonable and credible and supports a finding of conformity with this criterion.

NCDI- Holly Springs- See Section V.1 (a-c), page 85, for documentation that NCDI- Holly Springs will accommodate the clinical needs of area health professional training programs. The information provided is reasonable and credible and supports a finding of conformity with this criterion.

Wake Radiology- See Section V.1 (a-c), page 102, for documentation that the applicants will continue to accommodate the clinical needs of area health professional training programs. The information provided is reasonable and credible and supports a finding of conformity with this criterion.

- (15) Repealed effective July 1, 1987.
- (16) Repealed effective July 1, 1987.
- (17) Repealed effective July 1, 1987.
- (18) Repealed effective July 1, 1987.
- (18a) The applicant shall demonstrate the expected effects of the proposed services on competition in the proposed service area, including how any enhanced competition will have a positive impact upon the cost effectiveness, quality, and access to the services proposed; and in the case of applications for services where competition between providers will not have a favorable impact on cost-effectiveness, quality, and access to the services proposed, the applicant shall demonstrate that its application is for a service on which competition will not have a favorable impact.

C — Duke Raleigh NC — NCDI- Holly Springs NC — Wake Radiology

Duke Raleigh- The applicant adequately demonstrated that the proposal would have a positive impact on the cost effectiveness, quality, and access to the proposed services for the following reasons: 1) the applicant adequately demonstrates the proposal is cost-effective [See Criteria (1), (3) and (5) for additional discussion]; 2) the applicant demonstrates it will provide adequate access to the proposed services [See Criterion (13) for additional discussion]; and 3) the applicant adequately demonstrates it has and will continue to provide quality MRI services [See Criteria (7), (8), and (20) for additional discussion]. Therefore, the application is conforming to this criterion.

NCDI-Holly Springs- The applicant did not adequately demonstrate that the proposal is cost effective because the applicants projected utilization is not based on reasonable and supported assumptions. Therefore, the applicant's costs and revenue are unreliable and the applicant did not adequately demonstrate the proposal would maximize healthcare value.

See Criteria (1), (3) and (5) for additional discussion. Therefore the application is nonconforming to this criterion.

Wake Radiology- The applicants did not adequately demonstrate that the proposal is cost effective because the applicants projected utilization is not based on reasonable and supported assumptions. Therefore, the applicants' costs and revenue are unreliable and the applicants did not adequately demonstrate the proposal would maximize healthcare value. See Criteria (1), (3) and (5) for additional discussion. Therefore the application is nonconforming 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- Duke Raleigh
NA.—NCDI- Holly Springs
NA- Wake Radiology

Duke Raleigh—Duke Raleigh Hospital is accredited by the Joint Commission and certified for Medicare and Medicaid participation. According to the Acute and Home Care Licensure and Certification Section, DHSR, 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 with 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 – Duke Raleigh NC-NCDI-Holly Springs NC- Wake Radiology

Duke Raleigh The proposal is conforming to all Criteria and Standards for Magnetic Resonance Imaging Scanners, promulgated in 10A NCAC 14C .2700. The specific criteria are discussed below.

NCDI- Helly Springs The proposal is not conforming to all Criteria and Standards for Magnetic Resonance Imaging Scanners, promulgated in 10A NCAC 14C 2700. The specific criteria are discussed below.

Wake Radiology The proposal is not conforming to all Criteria and Standards for Magnetic Resonance Imaging Scanners, promulgated in 10A NCAC 14C .2700. The specific criteria are discussed below.

SECTION 2700 - CRITERIA AND STANDARDS FOR MAGNETIC RESONANCE IMAGING SCANNER

INFORMATION REQUIRED OF APPLICANT

- 10A NCAC 14C .2702 An applicant proposing to acquire an MRI scanner, including a mobile MRI scanner, shall use the Acute Care Facility/Medical Equipment application form
- All Applicants used the Acute Care Facility/Medical Equipment application form. -C-
- Except for proposals to acquire mobile MRI scanners that serve two or more host facilities, both the applicant and the person billing the patients for the MRI service shall be named as (b) co-applicants in the application form.
- Duke Raleigh- In Section II.8, page 13, the applicant, Duke Raleigh, states that it is both the -Capplicant and the entity billing patients for MRI services.
- NCDI-Holly Springs- In Section II.8, page 23, the applicant, NCDI-Holly Springs, states that it is both the applicant and the entity billing patients for MRI services. -C-
- Wake Radiology- In Section II.8, page 29, the applicants state that one of the applicants, WRDI, will be the entity billing patients for MRI services. -C-
- An applicant proposing to acquire a magnetic resonance imaging scanner, including a mobile MRI scanner, shall provide the following information: (c)
 - documentation that the proposed fixed MRI scanner, excluding fixed extremity and breast MRI scanners, will be available and staffed for use at least 66 hours per week,
- Duke Raleigh- In Section II.4, pages 8-9, the applicant states that the proposed fixed MRI scanner will be staffed and operated a total of 70 hours each week (8am-10pm on weekdays). -C-
- NCDI-Holly Springs- In Section II.8, page 23, the applicant states "NCDI-Holly Springs will ensure that the proposed MRI scanner will be available and staffed at least 66 hours per week. The proposed unit will operate Monday through Friday 8:00am to 8:00pm and Saturday from 8:00am to 4:00pm for a total of 68 hours per week."
- Wake Radiology- In Section II.8, page 30, the applicant states "The proposed MRI scanner will be staffed from 7:00 am to 7:00 pm Monday through Friday and Saturday 8:00am to -C-2:00pm (66 hours) each week"

- (2) documentation that the proposed mobile MRI scanner will be available and staffed for use at least 40 hours per week;
- -NA- None of the applicants propose to acquire a mobile MRI scanner.
 - (3) documentation that the proposed fixed extremity or dedicated breast MRI scanner shall be available and staffed for use at least 40 hours per week,
 - -NA- None of the applicants propose to acquire either a fixed extremity or a dedicated breast MRI scanner.
 - (4) the average charge to the patient, regardless of who bills the patient, for each of the 20 most frequent MRI procedures to be performed for each of the first three years of operation after completion of the project and a description of items included in the charge; if the professional fee is included in the charge, provide the dollar amount for the professional fee;
 - -C- Duke Raleigh- In Section II.8, page 13, and Exhibit II.8A, the applicant provides the projected charges for the 20 MRI procedures to be performed most frequently during the first three years of operation. The applicant states that the charges do not include the professional fees, which are billed separately.
 - -C- NCDI-Holly Springs- In Section II.8, pages 24-25, the applicant provides the projected charges for the 20 MRI procedures to be performed most frequently during the first three years of operation. The applicant states that "these are global charges which include both the technical component and the radiologist's professional fee." The applicant provides the dollar amount of the professional fee in Section II.8, page 25.
 - -C- Wake Radiology- In Section II.8, pages 30-31, the applicants provide the projected charges for the 20 MRI procedures to be performed most frequently during the first three years of operation. On page 31, the applicants provide both the projected global charge and the dollar amount of the professional fee.
 - (5) if the proposed MRI service will be provided pursuant to a service agreement, the dollar amount of the service contract fee billed by the applicant to the contracting party for each of the first three years of operation;
 - -NA- None of the applicants propose to provide the MRI services pursuant to a service agreement.
 - (6) letters from physicians indicating their intent to refer patients to the proposed magnetic resonance imaging scanner and their estimate of the number of patients proposed to be referred per year, which is based on the physicians' historical number of referrals;

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- C- Duke Raleigh- Exhibit V.3 contains letters from physicians indicating their intent to refer patients to the proposed fixed MRI scanner and their estimate of the number of proposed to be referred per year, which is based on the physicians' historical number of referrals for MRI studies.
- -C- NCDI-Holly Springs- Attachment 29 contains letters from physicians indicating their intent to refer patients to the proposed fixed MRI scanner and their estimate of the number of patients proposed to be referred per year, which is based on the physicians' historical number of referrals for MRI studies.
- -C- Wake Radiology- Exhibit 18 contains letters from physicians indicating their intent to refer patients to the proposed fixed MRI scanner and their estimate of the number of patients proposed to be referred per year, the physicians' historical number of referrals for MRI studies.
 - (7) for each location in the MRI service area at which the applicant or a related entity will provide MRI services, utilizing existing, approved, or proposed fixed MRI scanners, the number of fixed MRI scanners operated or to be operated at each location;
 - C- Duke Raleigh Hospital- In Section II.8, page 14, the applicant states that the only location in the MRI service area (Wake County) at which Duke University Health System or a related entity will provide MRI services utilizing a fixed MRI scanner is on the campus of Duke Raleigh Hospital. Duke University Health System currently has one fixed MRI scanner located on the Duke Raleigh Hospital campus. The proposed MRI scanner would also be located on the Duke Raleigh Hospital campus:
 - -C- NCDI- Holly Springs- In Section II.8, page 26, the applicant states that NCDI- Holly Springs, MedQuest, and Novant do not currently operate any fixed MRI scanners in the MRI service area (Wake County). NCDI- Holly Springs proposes to operate one fixed MRI scanner at 190 Rosewood Centre Drive in Holly Springs.
 - C- Wake Radiology- In Section II.8, page 32, WRDI (a co-applicant) states that it currently operates two (2) fixed MRI scanners at Raleigh MRI located on Merton Drive in Raleigh. The proposed fixed MRI would be operated at the WRGO facility in Garner. Both locations are in Wake County. In addition, the applicants state "For information purposes, the applicants provide MRI services at the Wake Radiology-Cary office via a fixed MRI scanner owned by Alliance. The applicants do not have any ownership interest in this fixed MRI scanner, thus it is not subject to this rule. This was confirmed via telephone call with CON Project Analyst Mike McKillip on June 10, 2010."
 - (8) for each location in the MRI service area at which the applicant or a related entity will provide MRI services, utilizing existing, approved, or proposed fixed MRI scanners, projections of the annual number of unweighted MRI procedures to be

performed for each of the four types of MRI procedures, as identified in the SMFP, for each of the first three years of operation after completion of the project;

- Onke Raleigh Hospital- In Section IV.1, page 35 and Exhibit IV.1, the applicant provides projections of the number of unweighted MRI procedures for each of the four types of MRI procedures to be performed on the existing fixed MRI scanner and on the proposed fixed MRI scanner for the first three years following completion of the project. See Criterion (3) for discussion of reasonableness of projections.
- -C- NCDI- Holly Springs- In Section II.8, page 26, the applicant provides projections of the number of unweighted MRI procedures for each of the two types of MRI procedures to be performed on the proposed fixed MRI scanner for the first three years following completion of the project. The applicant does not propose to perform MRI procedures on inpatients. See Criterion (3) for discussion of reasonableness of projections.
- -C- Wake Radiology- In Section II.8, pages 32-33, the applicants provide projections of the number of unweighted MRI procedures for each of the two types of MRI procedures to be performed on the proposed fixed MRI scanner for the first three years following completion of the project. The applicant does not propose to perform MRI procedures on inpatients. See Criterion (3) for discussion of reasonableness of projections.
 - for each location in the MRI service area at which the applicant or a related entity will provide services, utilizing existing, approved, or proposed fixed MRI scanners, projections of the annual number of weighted MRI procedures to be performed for each of the four types of MRI procedures, as identified in the SMFP, for each of the first three years of operation after completion of the project;
 - -C- Duke Raleigh Hospital- In Section IV.1, page 35 and Exhibit IV.1, the applicant provides projections of the number of weighted MRI procedures for each of the four types of MRI procedures to be performed on the existing fixed MRI scanner and on the proposed fixed MRI scanner for the first three years following completion of the project. See Criterion (3) for discussion of reasonableness of projections.
 - -C- NCDI- Holly Springs- In Section II.8, page 27, the applicant provides projections of the number of weighted MRI procedures for each of the two types of MRI procedures to be performed on the proposed fixed MRI scanner for the first three years following completion of the project. The applicant does not propose to perform MRI procedures on inpatients. See Criterion (3) for discussion of reasonableness of projections.
 - -C- Wake Radiology In Section II.8, pages 34-35, the applicants provide projections of the number of unweighted MRI procedures for each of the two types of MRI procedures to be performed on the proposed fixed MRI scanner for the first three years following completion of the project. The applicants do not propose to perform MRI procedures on inpatients. See Criterion (3) for discussion of reasonableness of projections.

- (10) a detailed description of the methodology and assumptions used to project the number of unweighted MRI procedures to be performed at each location, including the number of contrast versus non-contrast procedures, sedation versus non-sedation procedures, and impatient versus outpatient procedures;
- C- Duke Raleigh Hospital- The applicant's methodology and assumptions used to project the number of unweighted MRI procedures, including the number of contrast versus non-contrast procedures, sedation versus non-sedation procedures and impatient versus outpatient procedures, are described in Section II.8, page 15, Section III.1, pages 27-29, and Exhibit IV.1. See Criterion (3) for discussion of reasonableness of projections.
- -C- NCDI- Holly Springs- The applicant's methodology and assumptions used to project the number of unweighted MRI procedures, including the number of contrast versus non-contrast procedures, are described in Section II.8, page 27, and Section III.1, pages 40-71. The applicant does not propose to provide MRI procedures to impatients or use sedation. See Criterion (3) for discussion of reasonableness of projections.
- -C- Wake Radiology- The applicants' methodology and assumptions used to project the number of unweighted MRI procedures, including the number of contrast versus non-contrast procedures, are described in Section II.8, pages 35-37, Section III.1, pages 59-86, and Section IV.1, pages 99-100. The applicants do not propose to provide MRI procedures to impatients or use sedation. See Criterion (3) for discussion of reasonableness of projections.
 - (11) a detailed description of the methodology and assumptions used to project the rnamber of weighted MRI procedures to be performed at each location;
 - -C- Duke Raleigh Hospital- The applicant's methodology and assumptions used to project the number of weighted MRI procedures are described in Section II.8, page 16, Section III.1, pages 27-29, and Exhibit IV.1. See Criterion (3) for discussion of reasonableness of projections.
 - -C- NCDI- Holly Springs- The applicant's methodology and assumptions used to project the number of weighted MRI procedures are described in Section II.8, page 27, Section III.1, pages 40-71. The applicant does not propose to provide MRI procedures to impatients or use sedation. See Criterion (3) for discussion of reasonableness of projections.
 - -C- Wake Radiology- The applicants' methodology and assumptions used to project the number of weighted MRI procedures are described in Section II.8, page 38, Section III.1, pages 59-86, and Section IV.1, pages 99-100. The applicants do not propose to provide MRI procedures to inpatients or use sedation. See Criterion (3) for discussion of reasonableness of projections.
 - (12) for each existing, approved or proposed mobile MRI scanner owned by the applicant or a related entity and operated in North Carolina in the month the application is submitted, the vendor, tesla strength, serial number or vehicle identification number, CON project identification number, and host sites;

CA- Duke Raleigh- In Section II.8, pages 16-17, the applicant states "The only mobile scanner owned by DUHS or a related entity is sited at Lenox Baker at Duke Hospital. Pursuant to an agreement with the Certificate of Need Section, it is moved only one week per year, and the procedures it provides are reported with those of the other clinical scanners operated by the Department of Radiology at Duke Hospital." However, the applicant does not provide the tesla strength, serial number or VIN, and host sites. The tesla strength and serial number are available in publicly available files in the Division of Health Service Regulation. However, those files do not show the host sites at the time the application was submitted. Therefore, the application is conforming to this rule subject to the following condition:

Prior to issuance of the Certificate of Need, Duke University Health System d/b/a Duke Raleigh Hospital shall provide the Certificate of Need Section with the host sites for the mobile scanner owned by Duke University Health System.

- -C- NCDI- Holly Springs. In Section II.8, page 28, the applicant provides a list of the existing, and approved mobile MRI scanners owned by the applicant or a related entity and operated in North Carolina which list includes the vendor, testa strength, serial number, CON project identification number and host sites.
- -NC- Wake Radiology- In Section II.8, page 39, the applicant states that WRS owns a mobile MRI which is operated by WRDI. The vendor is Siemens; Tesla- 1.5T; Serial Number 25432; and CON Project ID# J-7012-04. However, the applicants did not provide the host sites at the time the application was submitted and this information is not available in publicly available files in the Division of Health Service Regulation. Therefore, the application is nonconforming to this rule.
 - (13) for each host site in the mobile MRI region in which the applicant or a related entity will provide the proposed mobile MRI services, utilizing existing, approved, or proposed mobile MRI scamers, projections of the annual number of unweighted and weighted MRI procedures to be performed for each of the four types of MRI procedures, as identified in the SMFP, for each of the first three years of operation after completion of the project;
 - -NA- None of the applicants propose to acquire a mobile MRI scanner.
 - (14) if proposing to acquire a mobile MRI scanner, an explanation of the basis for selection of the proposed host sites if the host sites are not located in MRI service areas that lack a fixed MRI scanner; and
 - -NA- None of the applicants propose to acquire a mobile MRI scanner.
 - (15) identity of the accreditation authority the applicant proposes to use.

- -C- Duke Raleigh- In Section II.8, page 17, the applicant states "Duke Raleigh Hospital is accredited by the Joint Commission."
- -C- NCDI-Holly Springs- In Section II.8, page 29, the applicant states "NCDI-Holly Springs will seek American College of Radiology (ACR) accreditation for the proposed MRI scanner."
- -C- Wake Radiology- In Section II.8, page 42, the applicants state "Relevant to the proposed fixed MRI scarner, Wake Radiology will seek MRI accreditation from the American College of Radiology during the first year of the proposed project."
- (d) An applicant proposing to acquire a mobile MRI scanner shall provide copies of letters of intent from, and proposed contracts with, all of the proposed host facilities of the new MRI scanner.
- -NA- None of the applicants propose to acquire a mobile MRI scanner.
- (e) An applicant proposing to acquire a dedicated fixed breast MRI scanner shall demonstrate that:
 - (1) it has an existing and ongoing working relationship with a breast-imaging radiologist or radiology practice group that has experience interpreting breast images provided by mammography, ultrasound, and MRI scanner equipment, and that is trained to interpret images produced by a MRI scanner configured exclusively for mammographic studies;
 - (2) for the last 12 months it has performed the following services, without interruption in the provision of these services: breast MRI procedures on a fixed MRI scanner with a breast coil, mammograms, breast ultrasound procedures, breast needle core biopsies, breast cyst aspirations, and pre-surgical breast needle localizations;
 - (3) its existing mammography equipment, breast ultrasound equipment, and the proposed dedicated breast MRI scanner is in compliance with the federal Mammography Quality Standards Act;
 - (4) it is part of an existing healthcare system that provides comprehensive cancer care, including radiation oncology, medical oncology, surgical oncology and an established breast cancer treatment program that is based in the geographic area proposed to be served by the applicant; and,
 - (5) it has an existing relationship with an established collaborative team for the treatment of breast cancer that includes, radiologists, pathologists, radiation oncologists, hematologists/oncologists, surgeons, obstetricians/gynecologists, and primary care providers.
 - -NA- None of the applicants propose to acquire a dedicated fixed breast MRI scanner.
 - (f) An applicant proposing to acquire an extremity MRI scanner, pursuant to a need determination in the State Medical Facilities Plan for a demonstration project, shall:

(1) provide a detailed description of the scope of the research studies that will be conducted to demonstrate the convenience, cost effectiveness and improved access resulting from utilization of extremity MRI scanning;

(2) provide projections of estimated cost savings from utilization of an extremity MRI-scamer based on comparison of "total dollars received per procedure" performed on the proposed scanner in comparison to "total dollars received per procedure" performed on whole body scanners;-

(3) provide projections of estimated cost savings to the patient from utilization of an extremity MRI scanner;

(4) commit to prepare an annual report at the end of each of the first three operating years, to be submitted to the Medical Facilities Planning Section and the Certificate of Need Section, that will include:

(A) a detailed description of the research studies completed;

(Β) a description of the results of the studies;

(C) the cost per procedure to the patient and billing entity,

- (D) the cost savings to the patient attributed to utilization of an extremity MRI scanner:
- (E) an analysis of "total dollars received per procedure" performed on the extremity MRI scanner in comparison to "total dollars received per procedure" performed on whole body scanners; and
- (F) the annual volume of unweighted and weighted MRI procedures performed, by CPT code:

(5) identify the operating hours of the proposed scanner;

(6) provide a description of the capabilities of the proposed scanner;

(7) provide documentation of the capacity of the proposed scanner based on the number of days to be operated each week, the number of days to be operated each year, the number of hours to be operated each day, and the average number of unweighted MRI procedures the scanner is capable of performing each hour;

(8) identify the types of MRI procedures by CPT code that are appropriate to be performed on an extremity MRI scanner as opposed to a whole body MRI scanner;

- (9) provide copies of the operational and safety requirements set by the manufacturer; and
- (10) describe the criteria and methodology to be implemented for utilization review to ensure the medical necessity of the procedures performed.

-NA- None of the applicants propose to acquire an extremity MRI scanner

(g) An applicant proposing to acquire a multi-position MRI scanner, pursuant to a need determination in the State Medical Facilities Plan for a demonstration project, shall:

(1) commit to prepare an annual report at the end of each of the first three operating years, to be submitted to the Medical Facilities Planning Section and the Certificate of Need Section, that will include:

 (A) the number of exams by CPT code performed on the multi-position MRI scanner in an upright or nonstandard position;

(B) the total number of examinations by CPT code performed on the multiposition MRI scanner in any position;

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the number of doctors by specialty that referred patients for an MRI scan in an upright or nonstandard position;

documentation to demonstrate compliance with the Basic Principles policy (D) included in the State Medical Facilities Plan;

a detailed description of the unique information that was acquired only by use of the multi-position capability of the multi-position MRI scanner, and (E)

the number of insured, underinsured, and uninsured patients served by type of (F)payment category,

provide the specific criteria that will be used to determine which patients will be examined in other than routine supine or prone imaging positions;

project the number of exams by CPT code performed on the multi-position MRI (3) scanner in an upright or nonstandard position;

project the total number of examinations by CPT code performed on the multi-(4) position MRI scanner in any position;

demonstrate that access to the multi-position MRI scanner will be made available to all spine surgeons in the proposed service area, regardless of ownership in the (5) applicant's facility;

demonstrate that at least 50 percent of the patients to be served on the multi-position MRI scanner will be spine patients who are examined in an upright or nonstandard (6)

position; and provide documentation of the capacity of the proposed fixed multi-position MRI scanner based on the number of days to be operated each week, the number of days to (7) be operated each year, the number of hours to be operated each day, and the average number of unweighted MRI procedures the scanner is capable of performing each

-NA- None of the applicants propose to acquire a multi-position MRI scanner.

PERFORMANCE STANDARDS 10A NCAC 14C .2703

An applicant proposing to acquire a mobile magnetic resonance imaging (MRI) scanner (a)shall:

demonstrate that each existing mobile MRI scanner which the applicant or a related entity owns a controlling interest in and operates in the mobile MRI region in which the proposed equipment will be located, except temporary MRI scanners, performed 3,328 weighted MRI procedures in the most recent 12 month period for which the applicant has data [Note: This is not the average number of weighted MRI procedures performed on all of the applicant's mobile MRI scarners.]; with the exception that in the event an existing mobile MRI scanner has been in operation less than 12 months at the time the application is filed, the applicant shall demonstrate that this mobile MRI scanner performed an average of at least 277 weighted MRI procedures per month for the period in which it has been in operation;

demonstrate annual utilization in the third year of operation is reasonably projected to be at least 3328 weighted MRI procedures on each of the existing, approved and (2)proposed mobile MRI scanners owned by the applicant or a related entity to be operated in the mobile MRI region in which the proposed equipment will be located

[Note: This is not the average number of weighted MRI procedures performed on all of the applicant's mobile MRI scanners.]; and

(3) document the assumptions and provide data supporting the methodology used for each projection required in this Rule.

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-NA- None of the applicants propose to acquire a mobile MRI scanner.

(b) An applicant proposing to acquire a fixed magnetic resonance imaging (MRI) scanner, except for fixed MRI scanners described in Paragraphs (c) and (d) of this Rule, shall:

- (1) demonstrate that the existing fixed MRI scanners which the applicant or a related entity owns a controlling interest in and locates in the proposed MRI service area performed an average of 3,328 weighted MRI procedures in the most recent 12 month period for which the applicant has data;
- -C- Duke Raleigh- In Section II.8, page 20, the applicant states that the one existing fixed MRI scanner at Duke Raleigh performed 6,893 weighted procedures for the 12 months ending May 31, 2010.
- -NA- NCDI- Holly Springs- In Section II.8, pages 33-34, the applicant states neither NCDI-Holly Springs nor a related entity own an existing fixed MRI scanner in Wake County.
- -C- Wake Radiology- In Section II.8, pages 46-47, the applicant states that Raleigh MRI, a related entity, operated two (2) fixed MRI scanners in the MRI service area (Wake County) which performed a total of 10,079 weighted MRI procedures during the 12 months ending September 30, 2009, which is an average of 5,039 weighted MRI procedures per scanner.
 - (2) demonstrate that each existing mobile MRI scanner which the applicant or a related entity owns a controlling interest in and operates in the proposed MRI service area except temporary MRI scanners, performed 3,328 weighted MRI procedures in the most recent 12 month period for which the applicant has data [Note: This is not the average number of weighted MRI procedures performed on all of the applicant's mobile MRI scanners.];
 - -NA- Duke Raleigh- In Section II.8, page 21, the applicant states that neither Duke University. Health System nor a related entity owns a controlling interest in a mobile MRI scanner that operates in the MRI service area (Wake County).
 - -NA- NCDI- Holly Springs- In Section II.8, pages 33-34, the applicants states "Novant Health, Inc. owns North Carolina Diagnostic Imaging-Cary, which is currently receiving mobile MRI services from Kings Medical Company, an independent third party provider. Neither Novant Health, Inc., nor any of its related entities including MedQuest and NCDI-Holly Springs, has any ownership interest in Kings Medical Company or its MRI scanners. There are no Novant-owned mobile MRI scanners operating in Wake County at this time of this filing."

- -C- Wake Radiology- In Section II.8, page 47, the applicant's state that WRS owns and WRDI operates one mobile MRI scanner in the MRI service area which performed 3,560 weighted MRI procedures during the 12 months ending September 30, 2009.
 - (3) demonstrate that the average annual utilization of the existing, approved and proposed fixed MRI scamers which the applicant or a related entity owns a controlling interest in and locates in the proposed MRI service area are reasonably expected to perform the following number of weighted MRI procedures, whichever is applicable, in the third year of operation following completion of the proposed project:

(A) 1,716 weighted MRI procedures in MRI service areas in which the SMFP shows no fixed MRI scanners are located,

(B) 3,775 weighted MRI procedures in MRI service areas in which the SMFP shows one fixed MRI scamer is located,

(C) 4,118 weighted MRI procedures in MRI service areas in which the SMFP shows two fixed MRI scanners are located,

(D) 4,462 weighted MRI procedures in MRI service areas in which the SMFP shows three fixed MRI scanners are located, or

(E) 4,805 weighted MRI procedures in MRI service areas in which the SMFP shows four or more fixed MRI scanners are located;

The 2010 SMFP shows more than four (4) fixed MRI scanners located in the MRI service area, which consists of Wake County. Therefore, each applicant must demonstrate that the average annual utilization for the existing, approved and proposed MRI scanners which the applicant or a related entity owns and locates in Wake County is reasonably expected to perform 4,805 weighted MRI procedures per scanner in the third operating year.

- Duke Raleigh- The applicant will have a total of two existing, approved and proposed fixed MRI scanners located in Wake County by the third operating year of this project. In Section II.8, page 21, and Table IV, page 35, the applicant projects to perform 8,034 unweighted MRI procedures in the third operating year, which the applicant states equals 10,538 weighted procedures. This results in an average annual utilization of 5,269 weighted procedures per MRI scanner in the third year. The applicant adequately demonstrates that its projections are based on reasonable and supported assumptions. See Criterion (3) for discussion.
- -NC- NCDI- Holly Springs- The applicant will have a total of one existing, approved and proposed fixed MRI scanner by the third operating year of this project. In Section II.8, page 34, the applicant projects to perform 5,025 weighted procedures in the third operating year. However, the applicant did not adequately demonstrate that its projections are based on reasonable and supported assumptions. See Criterion (3) for discussion. Therefore, the application is nonconforming to this rule.
- -NC- Wake Radiology- The applicants will have a total of three existing and proposed fixed MRI scanners by the third operating year of this project (Wake Radiology does not have any approved fixed MRI scanners). In Section II.8, page 34, the applicants project the average annual utilization of the existing and proposed fixed MRI scanners (2 existing at Raleigh

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MRI and I proposed at WRGO) will be 4,896 weighted MRI procedures (4,945 on proposed fixed MRI scanner at WRGO + 9,744 on the two existing MRI scanners at Raleigh MRI = 14,689/3 MRI scanners = 4,896) in the third operating year.

However, the applicants did not adequately demonstrate that the existing and proposed fixed MRI scanners would reasonably perform an average of at least 4,805 weighted MRI procedures in the third operating year.

The applicants used the following assumptions and methodology to project utilization of the two existing fixed MRI scanners at Raleigh MRI.

First, the applicants started with the actual number of MRI procedures performed in FY2009 on the two fixed MRI scanners located at Raleigh MRI and projected a 2.2% increase in unweighted MRI procedures for each year from FY2010 through FY2014. (See Section II.8, pages 35-36). The table below illustrates the historical and projected unweighted and weighted MRI procedures for the two fixed MRI scamers at Raleigh MRI.

Raleigh MRI Projected Titilization

Raleigh MRI Projected Utilization										
TOTOTO	FY2009	FY 2010	FY 2011	PAI	PY2	PY3				
	112005	Projected-	Projected-	FY 2012	FY 2013	FΥ				
		Interior.	Interim			2014				
	9.546	8,731	8,919	9,112	9,309	9,511				
Unweighted MRI	. 8,546	0,751	1							
Procedures		10 207	10,519	10,747	10.979	11,216				
Weighted MRI	10,078	10,297	. 10,212	23,7						
Procedures			2.2%	2.2%	2.2%	2.2%				
% change in	<11.85%>.	2.2%	2.270	2278	2.270	22,0				
weighted		<u> </u>		1	1	<u>.L</u>				

Second, the applicants then stated that WRDI would locate its mobile MRI scanner at Raleigh MRI for three days per week and assume 1,248 of those unweighted MRI procedures would be performed on the mobile MRI scanner, as illustrated in the table below. (See Section II.8, pages 36-37.)

Raleigh MRI Projected Utilization

Raleigh MKL Projected Ot	mzanon				
Muoigu mina 2-3	FY2012	FY2013	FY2014		
	7.864	8,061	8,263		
Fixed MRI procedures	1,248	1,248	1,248		
Mobile MRI procedures		9.309	- 9,511		
Total unweighted MRI procedures					

Third, the applicants then converted the unweighted fixed MRI procedures not allocated to the mobile MRI scanner to weighted MRI procedures as shown in the table below.

	FY2012	FY2013	FY2014
Unweighted MRI procedures	7.864	8,061	8,263
Unweighted Mike procedures	9,275	9,507	9,744
Weighted MRI procedures	1		

The applicants assume the two existing fixed MRI scanners at Raleigh MRI will perform 9,744 weighted MRI procedures in Year 3, which is an average of 4,872 weighted MRI 000345 procedures per scanner [9,744/2 = 4,872 weighted MRI procedures per MRI scanner]. noted above, the proposed fixed MRI scanner at WRGO is projected to perform 4,945 weighted MRI procedures in year 3. Thus, the three fixed MRI scanners (2 at Raleigh MRI and one proposed at WRGO) are projected to average 4,896 weighted MRI procedures.

However, Wake Radiology did not adequately demonstrate that projected utilization of the proposed fixed MRI scanner at WRGO is based on reasonable and supported assumptions. See discussion in Criterion (3).

Furthermore, the applicants did not adequately demonstrate that it is reasonable to assume volume at Raleigh MRI would increase 2.2% per year from FY 2010 to FY2014. The table below illustrates historical and projected utilization of the two fixed MRI scanners at Raleigh MRL

d MRT Utilization (Historical and Projected)

	- 4 - 7 17%	TON # 5	THilizatio	n (Histo	rical and	KIDJecrea)						
	Raleigh Fi	SECT WITH	Commi	11 (222)		777000	FY 2010	FY 2011	PY1	PYZ (PY3	
ţ		FY2005	FY2006 .	FY2007	FY2008	FY2009	Projected-	Projected-	FY 2012	FY 2013	FY.2014	
٠,		* *****										į.
-		i i			_		Interna	Interior		ļ		į
Ě					2 2 42	8,546	8,731	8,919	9,112	9,309	9,511	k
1	TT	.11,852	10,576	10,009	9,842	1		10.519	10,747	10,979	11,216	ģ
ş	Unweighted		11,837	11,308	11.272	10,078	10,297				22%	ķ.
1	Weighted	13,204			<0.32%>	<11.85%>.	2.2%	2.2%	2.2%	2.2%	2270	1
	% change in	-na-	<11.55%>	<4.7%>	40.3270	11100700	l	1	1	1 .		١.
		1	1	1	1		1		1		denomination and the second	-
	weighted.	1		<u> </u>								

As shown above, for each year from FY2005 to FY2009, the number of MRI procedures performed on the two fixed MRI scanners at Raleigh MRI has decreased. The applicants do not provide an explanation for this other than to state that the economy was difficult in FY2008. Furthermore, the applicants do not adequately document that it is reasonable to assume volume at Raleigh MRI will increase except to state in Section II.8, page 35, "During FY2009, WRDI performed 8,546 unweighted MRI scans on the two fixed MRI scanners located at Raleigh MRI To project MRI utilization at Raleigh MRI through FY2014, WRDI conservatively applied three-fourths of the projected population growth rate for Wake County (2.9% x .75 = 2.2%) to its most recent historical MRI utilization." The applicants tied MRI growth at Raleigh MRI to population growth. However, as shown in Section III.1, page 64, the population of Wake County increased at a compound annual growth rate ("CAGR") of 4.2% from FY2004 to FY2009, the same years during which utilization of the two fixed MRI scanners at Raleigh MRI declined every year.

In addition, as shown in Section III.1, page 65, the overall number of weighted MRI procedures performed in Wake County (on both fixed and mobile MRI scanners) increased by 9.3% between FY2008 and FY2009 while the number of weighted MRI procedures performed on the two fixed MRI scanners at Raleigh MRI decreased by 11.85% from FY2008 to FY2009:

In summary, Wake Radiology did not adequately demonstrate that its existing and proposed fixed MRI scanners are reasonably expected to perform an average of at least 4,805 weighted MRI procedures per scanner in the third operating year.

Therefore, the application is nonconforming to this rule.

if the proposed MRI scanner will be located at a different site from any of the existing . (4) or approved MRI scanners owned by the applicant or a related entity, demonstrate that the annual utilization of the proposed fixed MRI scanner is reasonably expected to perform the following number of weighted MRI procedures, whichever is applicable, in the third year of operation following completion of the proposed project:

1,716 weighted MRI procedures in MRI service areas in which the SMFP (A)

shows no fixed MRI scanners are located,

3,775 weighted MRI procedures in MRI service areas in which the SMFP shows one fixed MRI scanner is located,

4,118 weighted MRI procedures in MRI service areas in which the SMFP (C)

shows two fixed MRI scanners are located,

4,462 weighted MRI procedures in MRI service areas in which the SMFP (D) shows three fixed MRI scarners are located, or

4,805 weighted MRI procedures in MRI service areas in which the SMFP (E) shows four or more fixed MRI scanners are located;

- -NA- Duke Raleigh- In Section II.8, page 22, the applicant states that the proposed MRI scanner will not be located at a different site from any of the existing or approved MRI scanners. owned by the applicant or a related entity which are located in the MRI service area (Wake County).
- -NA- NCDI-Holly Springs- In Section II.8, page 35, the applicant states that the proposed MRI scanner would be the only MRI scanner owned by the applicant or a related entity in the MRI service area (Wake County).
 - Wake Radiology- In Section II.8, page 34, the applicants state they will have a total of three existing, approved and proposed fixed MRI scanners by the third operating year of this project, which are located in the MRI service area (Wake County) (2 existing fixed MRI scanners at Raleigh MRI and proposed fixed MRI scanner at WRGO). In Section II.8, page 34, the applicants project the annual utilization of the proposed fixed MRI scanner at WRGO would be 4,945 weighted procedures in the third project year. However, the applicants did not adequately demonstrate that projected utilization of the proposed fixed MRI scanner at WRGO is based on reasonable and supported assumptions. See Criterion (3) for discussion. Therefore, the application is nonconforming to this rule.
 - demonstrate that annual utilization of each existing, approved and proposed mobile (5)MRI scanner which the applicant or a related entity owns a controlling interest in and locates in the proposed MRI service area is reasonably expected to perform 3,328 weighted MRI procedures in the third year of operation following completion of the proposed project [Note: This is not the average number of weighted MRI procedures to be performed on all of the applicant's mobile MRI scanners.]; and

- -NA- Duke Raleigh- In Section II.8, page 22, the applicant states that "neither Duke University Health System nor a related entity owns a controlling interest in a mobile MRI scanner operated in the service area."
- -NA- NCDI- Holly Springs- In Section II.8, pages 33-34, the applicant states "Novant Health,"
 Inc. owns North Carolina Diagnostic Imaging-Cary, which is currently receiving mobile
 MRI services from Kings Medical Company, an independent third party provider. Neither
 Novant Health, Inc., nor any of its related entities including MedQuest and NCDI-Holly
 Springs, has any ownership interest in Kings Medical Company or its MRI scanners. There
 are no Novant-owned mobile MRI scanners operating in Wake County at this time of this
 filing."
- -NC- Wake Radiology- In Section II.8, page 47, the applicants state that WRS owns and WRDI operates one mobile MRI scanner in the MRI service area (Wake County). In Section II.8, pages 39-41, the applicants project the mobile MRI scanner will perform 3,484 weighted procedures in Year 3. In Section II.8, pages 39-41, the applicants provide "projected unweighted and weighted MRI utilization by site for WRDI's existing mobile MRI scanner. For information purposes, mobile MRI services are currently offered at each of the sites identified in the following tables." See the following tables.

Raleigh MRI- Historical and Projected Mobile MRI Procedures FY2012-FY2014

	Raleigh MRI- Historical	anderi					2 7 7 0 0		
5		2007	2008	2009	2010	2011	2012	2013	2014
ŀ					70	-na-	1,248	1,248	1.248
, de	Unweighted MRI	350	432	19	-na-	-110-	1,52.70	1,2.0	
	Procedures	<u> </u>	 			<u> </u>	1,406	1,406	1,406
	Weighted MRI Procedures	<u> </u>	1	<u> </u>	1	1			

Wake Radiology Northwest Raleigh Office

Historical and Projected Mobile MRI Procedures FY2012-FY2014

H	Historical and Projected House Hart 2011 2012 2013 2014									
F		2008	2009	2010	2011	2012	2013	7074		
§		2000				728	832	936		
Unweighted	MRI	-na-	20*.		-	120.	032			
Procedures				 		815	. 932	1,048		
Weighted M	RI Procedures	-na-	<u></u>]			• • • • • • • • • • • • • • • • • • • •			

*9/1/09 - 9/30/09 only. Total of 36 hours.

Wake Radiology Wake Forest Office

Historical and Projected Mobile MRI Procedures FY2012-FY2014 2014 2011 2013 2009 2010 2008 936 832 728 Unweighted Procedures 1,030 801 915 Weighted MRI Procedures

No Data for 2008-2011.

The table below illustrates the total projected unweighted and weighted MRI procedures for FY2012-FY2014 for all three of the listed host sites.

Total-All Three Projected Host Sites
Projected Mobile MRI Procedures FY2012-FY2014

	· Pro	Jecten Tato	2,2000000	- voters		ğ.	
	-	4	The same of the sa	2012	2013	2014	
٠		weighted	MRI	2,704	2,912	3,120	
	Procedures	11 CDT D	- domest	3,022	3.253	3,484	A Paris
1	Total Weighte	d MKI PIOU	CHITTES	J. J. J. J. J. J. J. J. J. J. J. J. J. J			-11

However, projected utilization of the mobile MRI scanner at Raleigh MRI is based on projected utilization of the fixed MRI scanners at Raleigh MRI. Projected utilization of the fixed MRI scanners at Raleigh MRI is not based on reasonable and supported assumptions. See discussion in 10A NCAC 14C 2703(b)(3). Therefore, projected utilization of the mobile MRI scanner at Raleigh MRI is also questionable.

Furthermore, Wake Radiology did not provide the methodology and assumptions used to project utilization of the mobile MRI scanner at the two other host sites: Northwest Raleigh Office and Wake Forest Office other than to state "For information purposes, mobile MRI services are currently offered at each of the sites identified in the following tables." [See Section II.8, pages 39-41.] In Section II.8, page 47, the applicants did state that for the 12-month period ending September 30, 2009, 20 unweighted/ 22 weighted MRI procedures were performed at the Northwest Raleigh Office. Wake Radiology did not supply any year-to-date information as to the number of MRI procedures (either unweighted or weighted) performed at either the Northwest Raleigh Office or the Wake Forest Office after September 30, 2009. This application was submitted on June 15, 2010, almost nine months later.

The applicants do not adequately demonstrate projected utilization of the existing mobile MRI scanner is based on reasonable and supported assumptions. Consequently, the applicants did not adequately demonstrate that the mobile MRI scanner is reasonably expected to perform 3,328 weighted MRI procedures in Year 3. Therefore, the application is nonconforming with this rule.

- (6) document the assumptions and provide data supporting the methodology used for each projection required in this Rule.
- -C- Duke Raleigh- The applicant adequately documented the assumptions and provided data supporting the methodology used for each projection required in this rule. See Criterion (3) for discussion.
- -NC- NCDI- Holly Springs- The applicant did not adequately document the assumptions and provide data supporting the methodology used for each projection required by this rule. See Criterion (3) for discussion. Therefore, the application is nonconforming with this rule.
- -NC- Wake Radiology- The applicants did not adequately document the assumptions and provide data supporting the methodology used for each projection required by this rule. See Criterion (3) for discussion. See also discussion in 10A NCAC 14C .2703 (b)(3)) and 10A NCAC 14C .2703 (b)(5). Therefore, the application is nonconforming with this rule.

An applicant proposing to acquire a fixed dedicated breast magnetic resonance imaging (MRI) scamer for which the need determination in the State Medical Facilities Plan was (c) based on an approved petition for an adjustment to the need determination shall:

demonstrate annual utilization of the proposed MRI scanner in the third year of operation is reasonably projected to be at least 1,664 weighted MRI procedures which is .80 times I procedure per hour times 40 hours per week times 52 weeks per

document the assumptions and provide data supporting the methodology used for (2)

each projection required in this Rule.

-NA- None of the applicants propose to acquire a fixed dedicated breast MRI scanner.

An applicant proposing to acquire a fixed extremity MRI scanner for which the need determination in the State Medical Facilities Plan was based on an approved petition for an (d) adjustment to the need determination shall:

demonstrate annual utilization of the proposed MRI scanner in the third year of operation is reasonably projected to be at least 80 percent of the capacity defined by

the applicant in response to 10A NCAC 14C .2702(f)(7); and

document the assumptions and provide data supporting the methodology used for: (2) each projection required in this Rule.

-NA- None of the applicants propose to acquire a fixed extremity MRI scanner.

An applicant proposing to acquire a fixed multi-position MRI scanner for which the need determination in the State Medical Facilities Plan was based on an approved petition for a (e) demonstration project shall:

demonstrate annual utilization of the proposed multi-position MRI scanner in the third year of operation is reasonably projected to be at least 80 percent of the capacity defined by the applicant in response to 10A NCAC 14C .2702(g)(7); and

document the assumptions and provide data supporting the methodology used for each projection required in this Rule.

-NA- None of the applicants propose to acquire a fixed multi-position MRI scanner.

SUPPORT SERVICES

- 10A NCAC Ï4C .2704 An applicant proposing to acquire a mobile MRI scanner shall provide referral agreements between each host site and at least one other provider of MRI services in the geographic area to be served by the host site, to document the availability of MRI services if patients require them when the mobile unit is not in service at that host site.
- None of the applicants propose to acquire a mobile MRI scanner. NA-
- An applicant proposing to acquire a fixed or mobile MRI scanner shall obtain accreditation from the Joint Commission for the Accreditation of Healthcare Organizations, the American *(b)* College of Radiology or a comparable accreditation authority, as determined by the

Certificate of Need Section, for magnetic resonance imaging within two years following operation of the proposed MRI scanner.

- Duke Raleigh-The hospital is currently accredited by the Joint Commission. See Section -C-IL8, page 23.
- NCDI- Holly Springs- In Section II.8, page 37, the applicant states NCDI-Holly Springs will obtain accreditation from the American College of Radiology for the proposed MRI services. -C-
- . Wake Radiology- In Section II.8, page 56, the applicants state that they will seek MRI. accreditation from the American College of Radiology during the first year of the proposed project

STAFFING AND STAFF TRAINING

10A NCAC 14C .2705 An applicant proposing to acquire an MRI scanner, including extremity and breast MRI scariners, shall demonstrate that one diagnostic radiologist certified by the American Board of Radiologists shall be available to interpret the images who has had:

training in magnetic resonance imaging as an integral part of his or her residency

training program; or

six months of supervised MRI experience under the direction of a certified diagnostic radiologist; or

at least six months of fellowship training, or its equivalent, in MRI; or

a combination of MRI experience and fellowship training equivalent to Subparagraph (3) (a)(1), (2) or (3) of this Rule.

- Duke Raleigh- In Section II.8, page 24, the applicant states "The radiologists interpreting MRI scans at Duke Raleigh Hospital all meet the listed requirements. -C-The radiologists include both members of Duke Radiology of Raleigh, who hold consulting appointments on the faculty of the Department of Radiology of the Duke University School of Medicine, and regular rank faculty members." Exhibit II.8 B contains copies of the curriculum vitae of a member of Duke Radiology of Raleigh and a faculty member which document that both physicians are board-certified radiologists with the training and experience required by this Rule.
- NCDI- Holly Springs- In Section II.8, page 37, the applicant states "Radiology coverage for NCDI-Holly Springs will be provided by Durham Radiology. Durham Radiology currently has an established working relationship with Novant/MedQuest and provides profession [sic] coverage at other existing MedQuest Imaging Centers, including NCDI-Cary. Dr. David Wiener, who is a board-certified radiologist with specialty training in MRI, will serve as Medical Director:" Attachment 10 contains a copy of the curriculum vitae of Dr. Wiener which documents that he is a board-certified radiologist with the training and experience required by this Rule.
- Wake Radiology-In Section II.8, page 56, the applicants state "Please refer to Exhibit 3 for a letter from Dr. Coates documenting compliance with the above criterion, and indicating his -Cintention to serve as the MRI Medical Director." Exhibit 3 contains a copy of the curriculum

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vitae of Dr. Coates which documents that he is a board-certified radiologist with the training and experience required by this Rule.

(b) An applicant proposing to acquire a dedicated breast MRI scanner shall provide documentation that:

(1) the radiologist. is trained and has expertise in breast imaging, including mammography, breast ultrasound and breast MRI procedures; and

- (2), two full time MRI technologists or two mammography technologists are available with training in breast MRI imaging and that one of these technologists shall be present during the hours operation of the dedicated breast MRI scanner.
- -NA- None of the applicants propose to acquire a dedicated breast MRI scanner.
- (c) An applicant proposing to acquire a MRI scanner, including extremity but excluding dedicated breast MRI scanners, shall provide evidence of the availability of two full-time MRI technologist-radiographers and that one of these technologists shall be present during the hours of operation of the MRI scanner.
- -C- Duke Raleigh- In Section II.8, page 24, the applicant proposes a total of 9.47 FTE MRI technologist positions. The applicant states that at least one of the technologists will be present during all the hours of operation of the MRI scanner.
- -C- NCDI- Holly Springs- In Section II.8, page 38, the applicant proposes 2.5 FTE MRI technologist positions. The applicants state that at least one technologist will be present during all hours of operation of the MRI scanner.
- -C- Wake Radiology- In Section II.8, page 57, the applicants propose 2.0 FTE MRI technologist positions. The applicants state that at least one MRI technologist will be present during all hours of operation.
- (d) An applicant proposing to acquire an MRI scanner, including extremity and breast MRI scanners, shall demonstrate that the following staff training is provided:

(1) American Red Cross or American Heart Association certification in cardiopulmonary resuscitation (CPR) and basic cardiac life support; and

- -C- Duke Raleigh- In Section II.8, page 25, the applicant states "All Duke Raleigh Hospital's technologists are required by the Hospital and the Joint Commission to receive American Heart Association certification in Cardiopulmonary Resuscitation (CPR) training and basic cardiac life support... Nursing personnel have completed an AMA nurse training program and have taken and passed the respective boards."
- -C- NCDI- Holly Springs- In Section II. 8, pages 38-39, the applicant states "NCDI-Holly Springs will require that its entire clinical staff have and maintain current certification in cardiopulmonary resuscitation and basic cardiac life support and will ensure that appropriate opportunities to obtain such training are available to all staff. All staff education and training will be provided by MedQuest Associates, Inc. MedQuest Associates

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Inc. has an established training program that is implemented in each of its managed facilities which includes all of the above training." Attachment 12 includes documentation regarding the availability of staff education and training programs.

- -C- Wake Radiology- In Section II.8, page 57, that applicants state that they will "continue to provide continuing education programs for Garner staff including CPR and BCLS training for appropriate clinical staff." Exhibit 6 contains copies of the applicants Orientation, Continuing Education Policy and CPR certification.
 - (2) the availability of an organized program of staff education and training which is integral to the services program and ensures improvement in technique and the proper training of new personnel.
- C- Duke Raleigh- In Section II.8, page 25, the applicant states "All Duke Raleigh Hospital MRI technologists have completed the AMA radiologists training program and have taken and passed the American Registry of Technologists (AART) national boards. In addition, the technologists are required to take and pass the Advanced Level Certification (ALC) in Magnetic Resonance Imaging by the AART. Nursing personnel have completed an AMA murse training program and have taken and passed the respective boards. A minimum of one year's experience in a clinical care unit is also required." Exhibit II.7 contains a copy of Duke Raleigh Hospital's "FY10 Organizational Performance Improvement and Patient Safety Plan" which documents that Duke Raleigh Hospital has an organized program of staff educations and training.
 - -C- NCDI-Holly Springs- In Section II. 8, pages 38-39, the applicant states "All staff education and training will be provided by MedQuest Associates, Inc. MedQuest Associates Inc. has an established training program that is implemented in each of its managed facilities which includes all of the above training." Attachment 12 includes documentation regarding the availability of staff education and training programs.
 - -C- Wake Radiology- In Section II.8, page 57, that applicants state that they will "continue to provide continuing education programs for Garner staff including CPR and BCLS training for appropriate clinical staff." Exhibit 6 contains copies of the applicants Orientation, Continuing Education Policy and CPR certification.
 - (e) An applicant proposing to acquire a mobile MRI scanner shall document that the requirements in Paragraph (a) of this Rule shall be met at each host facility, and that one full time MRI technologist-radiographer shall be present at each host facility during all hours of operation of the proposed mobile MRI scanner.
 - -NA- None of the applicants propose to acquire a mobile MRI scanner.
 - (f) An applicant proposing to acquire an extremity MRI scanner, pursuant to a need determination in the State Medical Facilities Plan for a demonstration project, also shall provide:

evidence that at least one licensed physician shall be on-site during the hours of (I)operation of the proposed MRI scanner;

a description of a research group for the project including a radiologist, orthopaedic

surgeon, and research coordinator; and

(2)

- letters from the proposed members of the research group indicating their qualifications, experience and willingness to participate on the research team. (3)
- None of the applicants propose to acquire an extremity MRI scanner.
- An applicant proposing to perform cardiac MRI procedures shall provide documentation of the availability of a radiologist, certified by the American Board of Radiology, with training (2) and experience in interpreting images produced by an MRI scanner configured to perform cardiac MRI studies.
- -NA- Duke Raleigh- In Section II.8, page 26, the applicant states that "This application does not propose the provision of cardiac MRI services."
- -NA- NCDI- Holly Springs- In Section II.8, page 39, the applicant states that "NCDI-Holly Springs does not anticipate performing cardiac MRI procedures."
- Wake Radiology-In Section II.8, page 58, the applicant states "Dr: Coates; the MRI Medical Director for the proposed project, is certified by the American Board of Radiology, with -Ctraining and experience in interpreting images produced by an MRI scanner configured to perform cardiac MRI studies." Exhibit 3 contains a copy of the curriculum vitae of Dr. Coates which documents that he is a board-certified radiologist with the training and experience required by this Rule.

COMPARATIVE ANALYSIS

Pursuant to G.S. 131E-183(a)(1) and the 2010 State Medical Facilities Plan, no more than one additional fixed MRI scanner may be approved in this review for Wake County. Because the three applications in this review collectively propose to acquire three additional fixed MRI scanners, only one of the applications can be approved. Therefore, after considering all of the information in each application and reviewing each application individually against all applicable review criteria, the analyst conducted a comparative analysis of the proposals to decide which proposal should be approved. For the reasons set forth below and in the rest of the findings, the application submitted by Duke University Health System d/b/a Duke Raleigh Hospital, Project I.D. #I-8529-10, is approved and the two other applications are denied.

Geographic Distribution

The 2010 SMFP identifies the need for one fixed MRI scanner in Wake County. The following table identifies the location of the existing and approved fixed MRI scanners in Wake County.

Facility	City/Town	# of Existing and Approved Fixed MRI Units
		TIACGINICE CHICS
Wake Radiology- Cary (Alliance)	Cary	<u> </u>
Rex Healthcare of Cary	Cary	1
WakeMed Cary Hospital	Cary	1
WakeMed Raleigh Hospital	Raleigh	2
Raleigh MRI Center (Wake Radiology)	Raleigh	2
Duke Health Raleigh Hospital	Raleigh	1
	Raleigh	1
Raleigh Neurology		1
Raleigh Radiology Cedarhurst (Pinnacle)	Raleigh	
Raleigh Radiology (Alliance)	Raleigh	
Rex Hospital	Raleigh	
		13
Total	<u></u>	

As shown in the table above, there are 13 existing and approved fixed MRI scanners located in Wake County. Ten are located in Raleigh and three are located in Cary. There are no fixed MRI scanners located in Garner or Holly Springs.

Duke Raleigh proposes to locate an additional fixed MRI scanner at Duke Health Raleigh Hospital in Raleigh; NCDI-Holly Springs proposes to locate a fixed MRI scanner in Holly Springs; and Wake Radiology proposes to locate a fixed MRI scanner in Garner. Thus, with respect to geographic distribution, the proposals submitted by NCDI-Holly Springs and Wake Radiology are the more effective alternatives.

Demonstration of Need

Duke Raleigh adequately demonstrated that projected utilization of the existing and proposed MRI scanners is based on reasonable and supported assumptions. Therefore, Duke Raleigh adequately demonstrated the need the population it projects to serve has for the proposed fixed MRI scanner. See Criterion (3) for discussion. However, neither NCDI-Holly Springs nor Wake Radiology adequately

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demonstrated that projected utilization of the respective proposed fixed MRI scanner is based on reasonable and supported assumptions. Therefore, neither NCDI-Holly Springs nor Wake Radiology adequately demonstrated the need the respective populations they projected to serve had for the proposed MRI scanner. See Criterion (3) for discussion. Therefore, the proposal submitted by Duke Raleigh is the more effective alternative with regard to demonstration of need.

Access by Underserved Groups

The applicants provided the following information regarding the percentage of their respective MRI patients projected to be Medicaid and Medicare recipients in Project Year 2, as stated by the applicants in Section VI:15 of the respective applications.

	•	
i i	Percentage of Total Procedures to be Provided to Medicaid Recipients	Percentage of Total Procedures to be Provided to Medicare Recipients
Дррист	be Provided to Ivientian Recipions	42.2%
Duke Raleigh	4.8%	15.2%
NCDI-Holly Springs	2.7%	26.4%
Wake Radiology		

The percentages for Duke Raleigh are based on its historic payor mix for MRI services currently provided at its existing facility. The percentages for NCDI-Holly Springs are based on the historical payor mix for MedQuest sites in the region. The percentages for Wake Radiology are based on its historic payor mix for mobile MRI services currently provided at its existing facility. As illustrated in the table above, Duke Raleigh proposes to serve the highest percentage of both Medicaid and Medicare recipients. NCDI-Holly Springs proposes to serve the lowest percentage of Medicaid recipients. See recipients. Wake Radiology proposes to serve the lowest percentage of Medicaid recipients. See Criterion (13c) for additional discussion. Therefore, the proposal submitted by Duke Raleigh is the more effective alternative with regard to access by Medicaid and Medicare recipients.

Revenues

The third full fiscal year of operation (Project Year 3) for Duke Raleigh is July 1, 2013 to June 30, 2014. Project Year 3 for NCDI-Holly Springs is January 1, 2014 to December 31, 2014. Project Year 3 for Wake Radiology is October 1, 2013 to September 30, 2014.

Gross revenue projections for Duke Raleigh do not include professional fees (i.e. charges for interpretation of the images by a radiologist). Gross revenue projections for both NCDI-Holly Springs and Wake Radiology do include professional fees. Neither NCDI-Holly Springs nor Wake Radiology provided the total dollar amount to be charged for professional fees or the weighted average professional fee component. Rather, in response to a rule, they provide the dollar amount charged for the professional fee component for each of the 20 procedures performed most often. The analyst used the cost of obtaining professional interpretation services as a proxy for the total gross revenue attributed to professional fees which could be greater than the cost. If the gross revenue attributed to professional fees was greater than the cost, the average gross revenue (less professional fee component) per procedure would be lower.

The average gross revenue per procedure during Project Year 3 was calculated by dividing total gross revenue by total unweighted MPL recedures. Gross revenue is from Form C and projected

unweighted MRI procedures are from Form D and Sections III and IV of the respective applications. See the following table.

· Project Year 3

	Average Gross Revenue per Unweighted MRI procedure										
Applicant	Total Gross	# of	Average Gross	Professional	Gross Revenue	Average Gross					
Арри	Revenue -	Unweighted	Revenue per	Fees*	Iess	Revenue (Jess					
		MRI	Procedure	_	Professional	Professional					
-		Procedures			Fees	Fee					
]					Component)					
		•				per Procedure					
Duke Raleigh	\$23,258,028	8,034	.\$2,894.95	-102-	-na-	\$2,894.95					
: NCDL-Holly	\$9,537,224	4,661	. \$2,046.18	\$387,148	\$9,150,076	\$1,963.11					
Springs			67 171 00	\$1,243,102	\$8,405,162	\$1,891.35					
Wake .	\$9,648,264	4,444	- \$2,171_08	\$1,240,102	403,402,102						
Radiology				<u> </u>							

[₹] These dollar amounts represent the cost of having a radiologist read and interpret the MRI images.

As shown in the table above, Wake Radiology projects the lowest average gross revenue (less professional fee component) per unweighted MRI procedure and NCDI-Holly Springs projects the second lowest gross revenue (less professional fee component) per unweighted MRI procedure. However, neither NCDI-Holly Springs nor Wake Radiology adequately demonstrated that projected revenues are based on reasonable and supported assumptions regarding projected utilization. See Criteria (3) and (5) for discussion. Therefore, the average gross revenue (less professional fee component) per procedure for Wake Radiology and NCDI-Holly Springs is also questionable. Duke Raleigh serves both inpatients and outpatients while NCDI-Holly Springs and Wake Radiology would serve only outpatients. Duke Raleigh also serves patients with a higher acuity than the outpatients to be served by either NCDI-Holly Springs or Wake Radiology. Thus, a higher average gross revenue per procedure is to be expected for Duke Raleigh.

Net revenue is from Form C. Duke Raleigh does not deduct either charity care or bad debt from gross revenue. NCDI-Raleigh deducts both charity care and bad debt from gross revenue. Wake Radiology deducts charity care from gross revenue but not bad debt. Wake Radiology includes bad debt as an operating cost. The following table shows the average net revenue per unweighted MRI procedure before and after deducting professional fees (NCDI-Holly Springs and Wake Radiology) and bad debt (Wake Radiology) for Project Year 3 for each applicant.

Project Year 3

	Average Net Revenue per Unweighted MRI Procedure									
T. Terret	Net Revenue	Average Net								
Applicant	Net Revenue	# of Unweighted	Average Net	Fees and	Less	Revenue				
	Weating.	MRI	Revenue	Bad Debt	Professional	(Less				
		Procedures	Per		Fees and	Professional				
		110000000	Procedure		Bad Debt	Fee				
					•	Component)				
f .	-					Per				
		super-				Procedure				
	\$6,923,205	8,034	\$861.74	-na-	-па-	\$861.74				
Duke Raleigh	\$2,765,341	4,661	\$593.29	\$387,148	\$2,378,193	\$510.23				
NCDI-Holly	\$2,100,541	3,002								
Springs		4,444	\$1,099.71	\$1,759,385	\$3,127,739	\$703.81				
Wake	\$4,887,124	45444	\$1,033.11							
Radiology	1		<u>}</u>	<u> </u>		1				

As shown in the table above, NCDI-Holly Springs projects the lowest average net revenue (less professional fee component) per unweighted MRI procedure and Wake Radiology projects the second lowest average net revenue (less professional fee component) per unweighted MRI procedure. However, neither NCDI-Holly Springs nor Wake Radiology adequately demonstrated that projected revenues are based on reasonable and supported assumptions regarding projected utilization. See Criteria (3) and (5) for discussion. Therefore, the average net revenue (less professional fee component) per procedure for NCDI-Holly Springs and Wake Radiology is also questionable. Duke Raleigh serves both impatients and outpatients while NCDI-Holly Springs and Wake Radiology would serve only outpatients. Duke Raleigh also serves patients with a higher acuity than the outpatients to be served by either NCDI-Holly Springs or Wake Radiology. Thus, higher average charges are to be expected for Duke Raleigh.

Operating Costs

Duke Raleigh's charges do not include a professional fee component, and thus, Duke Raleigh does not report any professional fee expense in Form C. NCDI-Holly Springs and Wake Radiology both state that their charges include a professional fee component. The average operating cost per procedure for Project Year 3 was calculated by dividing total operating expenses (less professional fee expense) by total unweighted MRI procedures.

Project Year 3

Project Year 3

Project Year 3

	Average Operating Cost per Unweighted 1 totelling										
F		# of	Total	Professional	Total Operating	Average Cost Per					
Ì	1 Years	Unweighted	Operating	Fees and Bad	Cost	Procedure					
9	Applicant	MRI Costs		Debt	less Professional	(less Professional					
9		Procedures	0002		Fee Expenses and	Fee Component					
		110ccmm			Bad Debt	per procedure)					
Į	D. L. Daloich	8,034	\$2,071,847 .	-na-	\$2,071,847	* \$257.88					
	Duke Raleigh	<u> </u>		\$387,148	\$1,488,672	\$319.39					
1	NCDI-Holly	4,661	\$1,875,820	٠٠٠٠ ١٩٥٥	Ψ1,400,012						
ı	Springs				41 10C 007	\$253.17					
	Wake	- 4,444	\$2,884,476	\$1,759,385	\$1,125,091	\$233.17					
	Radiology					<u> L</u>					

As shown in the table above, Duke Raleigh and Wake Radiology project the lowest average operating cost (less professional fee component) per unweighted MRI procedure. However, Wake Radiology did not adequately demonstrate that projected operating costs are based on reasonable and supported assumptions regarding projected utilization. See Criteria (3) and (5) for discussion. Therefore, the average operating cost (less professional fee component) per unweighted MRI procedure for Wake Radiology is also questionable. Furthermore, NCDI-Holly Springs did not adequately demonstrate that projected operating costs are based on reasonable and supported assumptions regarding projected utilization. See Criteria (3) and (5) for discussion.

. . .

SUMMARY

The following is a summary of the reasons the application submitted by Duke Raleigh is determined to be the most effective alternative in this review:

Duke Raleigh

adequately demonstrates the need the population to be served has for the proposed fixed MRI scanner. See Criterion (3) for discussion.

adequately demonstrates that the financial feasibility of the proposal is based upon reasonable projections of costs and charges. See Criterion (5) for discussion.

proposes the highest percentage of total procedures to be provided to Medicaid and Medicare recipients. See Comparative Analysis for discussion.

The following is a summary of the reasons the applications submitted by NCDI-Holly Springs is found to be a less effective alternative than the application submitted by Duke University Health System d/b/a Duke Raleigh Hospital.

NCDI-Holly Springs

- did not adequately demonstrate the need the population to be served has for the proposed fixed MRI scanner. See Comparative Analysis for discussion.
- did not adequately demonstrate that the financial feasibility of the proposed project is based upon reasonable projections of costs and charges. See Criterion (5) for discussion.
- proposes a lower percentage of total procedures to be provided to Medicaid and Medicare recipients. See Comparative Analysis for discussion.

The following is a summary of the reasons the applications submitted by Wake Radiology is found to be a less effective alternative than the application submitted by Duke University Health System d/b/a Duke Raleigh Hospital

Wake Radiology

- did not adequately demonstrate the need the population to be served has for the proposed fixed MRI scanner. See Comparative Analysis for discussion.
- did not adequately demonstrate that the financial feasibility of the proposed project is based upon reasonable projections of costs and charges. See Criterion (5) for discussion.

 proposes a lower percentage of total procedures to be provided to Medicaid and Medicare recipients. See Comparative Analysis for discussion.

CONCLUSION

G.S. 131E-183(a)(1) states that the need determination in the SMFP is the determinative limit on the number of fixed MRI scanners that can be approved by the CON Section. The CON Section determined that the application submitted by Duke University Health System d/b/a Duke Raleigh Hospital is the most effective alternative proposed in this review for an additional fixed MRI scanner for Wake County and is approved. The approval of any other application would result in the approval of MRI scanners in excess of the need determination in the 2010 SMFP and therefore, the applications submitted by North State Imaging, LLC d/b/a North Carolina Diagnostic Imaging-Holly Springs and Wake Radiology Diagnostic Imaging, Inc. and Wake Radiology Services, LLC are denied.

The application submitted by Duke University Health System d/b/a Duke Raleigh Hospital is approved subject to the following conditions.

- 1. Duke University Health System d/b/a Duke Raleigh Hospital shall materially comply with all representations made in its certificate of need application.
- 2. Duke University Health System d/b/a Duke Raleigh 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.
- 3. Duke University Health System d/b/a Duke Raleigh Hospital shall acquire no more than one fixed MRI scanner for a total of no more than two fixed MRI scanners.
- 4. Duke University Health System d/b/a Duke Raleigh 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.

 proposes a lower percentage of total procedures to be provided to Medicard and Medicare recipients. See Comparative Analysis for discussion.

CONCLUSION

G.S. 131E-183(a)(1) states that the need determination in the SMFP is the determinative limit on the number of fixed MRI scanners that can be approved by the CON Section. The CON Section determined that the application submitted by Duke University Health System d/b/a Duke Raleigh Hospital is the most effective alternative proposed in this review for an additional fixed MRI scanner for Wake County and is approved. The approval of any other application would result in the approval of MRI scanners in excess of the need determination in the 2010 SMFP and therefore, the applications submitted by North State Imaging, LLC d/b/a North Carolina Diagnostic Imaging-Holly Springs and Wake Radiology Diagnostic Imaging, Inc. and Wake Radiology Services, LLC are denied.

The application submitted by Duke University Health System d/b/a Duke Raleigh Hospital is approved subject to the following conditions.

- 1. Duke University Health System d/b/a Duke Raleigh Hospital shall materially comply with all representations made in its certificate of need application.
- 2. Duke University Health System d/b/a Duke Raleigh 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.
- 3. Duke University Health System d/b/a Duke Raleigh Hospital shall acquire no more than one fixed MRI scanner for a total of no more than two fixed MRI scanners.
- 4. Duke University Health System d/b/a Duke Raleigh 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.

ATTACHMENT - REQUIRED STATE AGENCY FINDINGS

FINDINGS C = ConformingCA = Conditional NC = Nonconforming NA = Not Applicable

DATE:

February 5, 2010

PROJECT ANALYST:

Les Brown

TEAM LEADER:

Martha J. Frisone

PROJECT I.D. NUMBER:

A-8430-09 / Western Carolina Endoscopy Center, LLC and Western Carolina Medical Developers, LLC / Relocate one existing ambulatory surgical facility with one licensed gastrointestinal endoscopy room from its present location at 2730 Georgia Road to 211 Riverview Street in Franklin / Macon County

RÉVIEW CRITERIA FOR NEW INSTITUTIONAL HEALTH SERVICES

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

The proposed project shall be consistent with applicable policies and need determinations (1)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.

NA

Western Carolina Endoscopy Center, LLC (WCEC) (Lessee) and Western Carolina Medical Developers, LLC (WCMD) (Lessor) propose to relocate an existing ambulatory surgical facility with one licensed gastrointestinal (GI) endoscopy procedure room from its current location in a medical office building at 2730 Georgia Road to another medical office building at 211 Riverview Street in Franklin. The offices of the related gastroenterology medical practice, Western Carolina Digestive Consultants, PA, will be relocated to space adjoining the ambulatory surgical facility. There are no policies or need determinations in the 2009 State Medical Facilities Plan applicable to the review of this application. Therefore, this criterion is not applicable in this review. .

Repealed effective July 1, 1987. (2)

(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

WCEC and WCMD propose to relocate an existing ambulatory surgical facility with one licensed GI endoscopy procedure room from the existing medical office building on Georgia Road to another medical office building on Riverview Street in Franklin. The relocated ambulatory surgical facility will occupy 4,526 square feet of space on the third floor of the building, which will contain a total of 25,460 square feet of space. WCEC will lease the space from WCMD.

Population to be Served

In Section III.6, page 19, the applicants state that the service area for the existing GI endoscopy procedure room is Macon, Jackson, Cherokee, Swain and Graham Counties, and provide projected patient origin for the first two years of operation, as illustrated in the following table.

Projected Patient Origin - Years 1 & 2				
County	% of Patients			
Macon	47.0%			
Jackson	35.0%			
Cherokee	7.0%			
Swain	6.0%			
Graham	2.0%			
All Other	3.0%			
Total	. 100.0%			

In Section III.7, page 20, the applicants provide the current patient origin, which was used by the applicants as a basis for the projected patient origin, as illustrated in the following table.

Current Patient Origin

% of Patients	
45.0%	
35.0%	
7.0%	
6.0%	
2.0%	
4.5%	
99.5%	

^{* &}quot;All other" includes Haywood, Buncombe and Henderson Counties, Georgia and other states,

The applicants adequately identify the population proposed to be served.

Need for the Proposed Service

Regarding the need to relocate the existing ambulatory surgical facility to another location in Franklin, in Section III.1, page 15, the applicants state:

"Our current location is 1800 square feet of leased space. We are limited by physical space and are only able to provide one service at a time. We stop the Endoscopy schedule by 2:00 pm in order to allow time for office visits. Due to limited office visit availability our current wait for an office visit is an average of 9 weeks in our Franklin location. We are offering patients an appointment in our Sylva office (Jackson County) to expedite their consultation. Our current wait time for an appointment in the Sylva office is 6 weeks,"

In Section III.9, page 21, the applicants state:

"The current location is physically inadequate. The new facility will provide faster access to office consultations as our scheduling block time now for consultations is extremely limited in Franklin. Majority of our patients are currently driving to Sylva for their office consults. There will be a physical distinct separation of Western Carolina Digestive Consultants, PA for the practice from Western Carolina Endoscopy Center, LLC for procedures. The current location has a shared waiting room that is very small with limited privacy. The new location will be 5 miles closer to the center of town and more conveniently located. The physicians will own the building."

In Section III.8, page 20, the applicants state:

^{**} Does not equal 100% due to rounding.

"The option of adding to our existing leased space was considered. The tenant next to us is under a 3 year lease and plans to stay on the property long term. Our current location is at the end of the building and borders parking lot and property line. After these options were considered, the most effective solution is to be more centrally located in town and near other medical facilities. The new location is located in what is considered the "medical park" of Franklin. The physicians would also like to own their own property vs. leasing. In the new facility there will be separate office space from Endoscopy. We will then be able to see office patients 5 days/week in Franklin and patients would not be asked to drive to our Sylva office for their office visit. The Endoscopy schedule will also be able to run 5 days/week."

The applicants adequately demonstrate the need to relocate the existing ambulatory surgical facility to a larger space.

On page 22, the applicants provide the following historical and projected utilization:

				Year 1	Year 1	Year 1
			1/1/2009-	5/1/2010	5/1/2010	5/1/2010
	CY 2007	CY 2008	8/31/09	4/30/2011	4/30/2011	4/30/2011
. GI Endoscopy			·.			
Procedures	1,511	1,545	1,061	1,680	1,764	1,852

The applicants propose to increase the hours of operation from 26 hours per week to 47.5 hours per week after completion of the project, allowing for increased capability to perform more procedures. In Section III.1, page 15, the applicants state: "Our current wait for an office visit is an average of 9 weeks in our Franklin location. ... Our current wait time for an appointment in the Sylva office is 6 weeks." The applicants are currently performing over 1,500 GI endoscopy procedures per year, which exceeds the 1,500 procedures required by 10A NCAC 14C .3903(b). The applicants adequately demonstrate projected utilization is based on reasonable and supported assumptions.

The applicants adequately demonstrate the need the population to be served has for the proposed project. Consequently, the application is conforming with this criterion.

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

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

C

The applicants propose to relocate the existing ambulatory surgical facility with one licensed GI endoscopy procedure room from a medical office building in Franklin to another medical office building in Franklin, approximately 7 miles away. The new facility would be more centrally located near Angel Medical Center and other physician office practices. The proposed patient origin is similar to the current patient origin. The applicants adequately demonstrate that the needs of the population presently served by WCEC would be met adequately following the proposed relocation of the ambulatory surgical facility. Consequently, the application is conforming with this criterion.

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

CA

In Section III.8, page 20, the applicants discuss the alternatives considered prior to submission of this application and the basis for selection of the proposed project. Furthermore, the application is conforming with all applicable statutory review criteria. See Criteria (3), (5), (6), (7), (8), (12), (13), (14), (18a) and (20). Therefore, the applicants adequately demonstrate that the proposed project is their least costly or most effective alternative, and the application is conforming with this criterion subject to the following conditions:

- 1. Western Carolina Endoscopy Center, LLC and Western Carolina Medical Developers, LLC shall materially comply with all representations made in the certificate of need application.
- 2. Western Carolina Endoscopy Center, LLC and Western Carolina Medical Developers, LLC shall relocate the existing ambulatory surgical facility with one licensed gastrointestinal endoscopy room to a new location in Franklin which shall not be licensed for more than one gastrointestinal endoscopy room in the new location.
- 3. The facility fee charged per procedure by Western Carolina Endoscopy Center, LLC shall be no more than \$1,011 in

operating year one, \$1,204 in operating year two and \$1,376 in operating year three.

- 4. Western Carolina Endoscopy Center, LLC and Western Carolina Medical Developers, LLC shall prohibit the exclusion of services to any patient on the basis of age, race, religion, disability or the patient's ability to pay.
- 5. Western Carolina Endoscopy Center, LLC and Western Carolina Medical Developers, LLC 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.

CA

In Section VIII.1, page 42, the applicants project that the total capital cost will be \$2,210,090, including \$295,000 for land acquisition, \$256,810 for site preparation, \$1,423,780 for construction costs and \$234,500 for miscellaneous costs. However, the actual miscellaneous costs in the application amount to \$412,275 because the applicant failed to include the "Other Builders Fee" of \$177,775 (\$234,500 + \$177,775 = \$412,275). The applicants also include \$295,000 for the purchase price of the land. However, the applicants state the land was purchased in March, 2007 and thus, should not be included in the projected capital costs. The total capital cost for the project, which includes the cost of the entire medical office building, not just the ambulatory surgical facility, is \$2,092,865 (\$256,810 + \$1,423,780 + \$234,500 + \$177,775 = \$2,092,865).

In Section IX.1, page 44, the applicants project that there will be no start-up or initial operating expenses.

In Section VIII.2, page 42, the applicants state that 95% of the capital cost will be financed with a conventional loan. Exhibit 10 contains a September 23, 2009 e-mail from Rob McFarland of First Citizens Bank, which states that the loan request is being reviewed by the "credit officer." Also in Section VIII.2, page 42, the applicants state that the remaining 5% of the capital cost would come from accumulated reserves. However, Form A Balance Sheet in

the pro forma financial statements shows that WCEC only had \$29,747 in cash and cash equivalents as of August 31, 2009.

In Form D the applicants state that the average facility charge per procedure during the first three operating years will be \$1,011 in Year 1, \$1,204 in Year 2 and \$1,376 in Year 3. In Form B the applicants project that revenues will exceed operating costs in each of the first three operating years. The assumptions used by the applicants in preparation of the pro formas are reasonable, including projected utilization, costs and charges. See Criterion (3) for discussion of utilization projections. Therefore, the applicants adequately demonstrated that the financial feasibility of the proposal is based upon reasonable projections of costs and revenues, and the application is conforming with this criterion subject to the following conditions:

- 1. The total capital cost for the project shall be \$2,092,865, which includes the cost of construction for the entire physician office building.
- Prior to issuance of the certificate of need, Western Carolina Endoscopy Center, LLC and Western Carolina Medical Developers, LLC shall provide the Certificate of Need Section with documentation of funding for the total capital expenditure.
- (6) The applicant shall demonstrate that the proposed project will not result in unnecessary duplication of existing or approved health service capabilities or facilities.

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The applicants adequately demonstrate the need to relocate the existing ambulatory surgical facility with one licensed GI endoscopy room from Georgia Road to Riverview Street in Franklin. See Criterion (3) for discussion. Consequently, the applicants adequately demonstrate that the proposal would not result in unnecessary duplication of existing or approved health service capabilities or facilities. Therefore, the application is conforming with 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.

The following table illustrates current and projected staffing at WCEC during the second operating year, as reported by the applicants in Sections VII.1 and VII.2, pages 34-35.

Position	# OF FULL TIME EQUIVALENT POSITIONS (FTES)			
	CURRENT	YEAR TWO		
	Agree N			
Administrator	0.75	0.75		
Registered Nurses (RNs)	1.75	1.75		
Nursing Aides	2.00	. 2.00		
GI Endoscopy Technician	1.00	1.00		
Total	5.50	5.50		

In Section VII, page 38, the applicants state that Philip Stack, MD, gastroenterologist and managing partner, is the Medical Director of the facility. In Section VII.9, page 39, the applicants state that a total of three gastroenterologists will perform GI endoscopy procedures at the proposed facility. The applicants demonstrated the availability of adequate health manpower and management personnel for the provision of the proposed services. Therefore, the application 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, the applicant state:

"The following ancillary and support services are currently provided at our existing facility by outside vendors: Housekeeping, Linen, Biohazard/Waste, Biomedical Equipment Inspection, Pharmacy Inspection, and Maintenance.

Our current letters of agreement and services will continue at the new location."

Exhibit 7 contains letters from physicians that state their support for the proposed project and their intent to refer patients to the proposed facility. Exhibit 5 contains e-mail correspondence with Angel Medical Center requesting that a transfer agreement be arranged between WCEC and the

hospital. It also contains a letter from Macon County Emergency Services explaining the procedures for requesting emergency services when necessary.

The applicants adequately demonstrate that the necessary ancillary and support services will continue to be available and that the services would continue to be coordinated with the existing health care system. Consequently, the application is conforming with this criterion.

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

.NA

- (10) When applicable, the applicant shall show that the special needs of health maintenance organizations will be fulfilled by the project. Specifically, the applicant shall show that the project accommodates:
 - (a) The needs of enrolled members and reasonably anticipated new members of the HMO for the health service to be provided by the organization; and

NA

- (b) The availability of new health services from non-HMO providers or other HMOs in a reasonable and cost-effective manner which is consistent with the basic method of operation of the HMO. In assessing the availability of these health services from these providers, the applicant shall consider only whether the services from these providers:
 - (i) would be available under a contract of at least 5 years duration;
 - (ii) would be available and conveniently accessible through physicians and other health professionals associated with the HMO;
 - (iii) would cost no more than if the services were provided by the HMO; and
 - (iv) would be available in a manner which is administratively feasible to the HMO.

NA

- (11) Repealed effective July 1, 1987.
- (12) Applications involving construction shall demonstrate that the cost, design, and means of construction proposed represent the most reasonable alternative, and that the construction project will not unduly increase the costs of providing health services by the person

proposing the construction project or the costs and charges to the public of providing health services by other persons, and that applicable energy saving features have been incorporated into the construction plans.

C

WCMD proposes to construct a medical office building in Franklin and lease 4,526 square feet to WCEC for the relocated ambulatory surgical facility. In Section VIII.1, page 41, the applicants project construction costs of \$1,423,780 for the entire 25,460 square foot medical office building. The architect's estimate of costs for construction of the GI endoscopy suite provided in Exhibit 14 is \$869,414, including the prorated cost for site development, 5% contingency and 4.6% for architectural and engineering fees. In Exhibit 13, the applicants provide a letter from the architect which describes the energy saving features which have been incorporated into the construction plans. The applicants 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. Therefore, the application is conforming with 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;

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The following table illustrates the payor mix for GI endoscopy services provided by WCEC during CY 2008, as reported by the applicants in Section VI.12, page 32.

PAYOR CATEGORY	PERCENT OF TOTAL
Self Pay / Indigent / Charity Care	21.1%
Commercial Insurance	45.3%
Medicare	29,6%
Managed Care	4.0%
Total	. 100.0%

As shown in the table above, 21.1% of WCEC's patients are self-pay, indigent or charity care. The applicants demonstrate that medically underserved populations currently have adequate access to the existing GI endoscopy services provided at WCEC 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;

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In Sections VI.10 and VI.11, pages 31-32, concerning civil rights complaints and government obligations for uncompensated care, the applicants state "NA." In Section VI.8, page 30, the applicants state that during January – August 2009, WCEC provided charity care in the amount of \$120,676, or 25% of net revenue. Therefore, 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

The following table illustrates the projected payor mix for WCEC during the second operating year, as reported by the applicants in Section VI.14, page 33.

PAYOR CATEGORY	PERCENT OF TOTAL
Self Pay / Indigent / Charity Care	22,4%
Commercial Insurance	46.1%
Medicare	21.0%
Managed Care	10.5%
Total .	100.0%

The applicants propose to increase the percentage of patients who are self pay, indigent or charity care by Year 2 of the project. The applicants demonstrate that medically underserved populations will have adequate access to the proposed services and therefore, the application is conforming with this criterion.

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

C

In Section VL9, page 31, the applicants state that the "facility operated by physician referral." The information provided is reasonable and credible and supports a finding of conformity with this criterion.

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

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Exhibit 4 contains a letter from Western Carolina University expressing appreciation to WCEC for allowing students in the Nursing and Nutrition Program to observe procedures at WCEC. In Section V.1, page 23, the applicants state that the new facility will allow WCEC to accommodate more students from Western Carolina University, as well as students from Southwestern Community College. Thus, WCEC currently accommodates the clinical needs of health professional training programs in the area and the applicants state that the new facility will do the same. The information provided is reasonable and credible and supports a finding of conformity with this criterion.

- (15) Repealed effective July 1, 1987.
- (16) Repealed effective July 1, 1987.
- (17) Repealed effective July 1, 1987.
- (18) Repealed effective July 1, 1987.
- (18a) The applicant shall demonstrate the expected effects of the proposed services on competition in the proposed service area, including how any enhanced competition will have a positive impact upon the cost effectiveness, quality, and access to the services proposed; and in the case of applications for services where competition between providers will not have a favorable impact on cost-effectiveness, quality, and access to the services proposed, the applicant shall demonstrate that its application is for a service on which competition will not have a favorable impact.

C

The applicants adequately demonstrate that the proposal would have a positive impact on the cost effectiveness, quality and access to the services proposed. See Criteria (3), (3a), (5), (7), (8), (12), (13) and (20) for discussion. Therefore, the application is conforming with 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.

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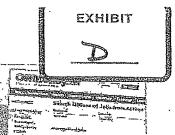
The facility is accredited by AAAHC [Accreditation Association for Ambulatory Health Care] as an ambulatory surgery center. According to the records in the Acute and Home Care Licensure and Certification Section of the Division of Health Service Regulation, no incidents have occurred at WCEC within the 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 with this criterion.

- (21) Repealed effective July 1, 1987.
- (b) The Department is authorized to adopt rules for the review of particular types of applications that will be used in addition to those criteria outlined in subsection (a) of this section and may vary according to the purpose for which a particular review is being conducted or the type of health service reviewed. No such rule adopted by the Department shall require an academic medical center teaching hospital, as defined by the State Medical Facilities Plan, to demonstrate that any facility or service at another hospital is being appropriately utilized in order for that academic medical center teaching hospital to be approved for the issuance of a certificate of need to develop any similar facility or service.

NA

The applicants are relocating an existing ambulatory surgical facility with one licensed GI endoscopy procedure room to another location and do not propose to add any new GI endoscopy procedure rooms to the facility. They are not establishing a new ambulatory surgical facility. Therefore, the Criteria and Standards for Gastrointestinal Endoscopy Procedure Rooms in Licensed Health Service Facilities promulgated in 10A NCAC 14C .3900 are not applicable to this review.







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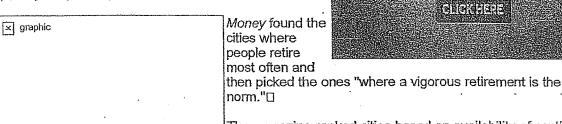
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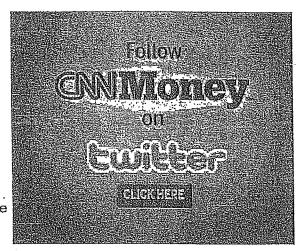
The best retirement cities June 9, 2000: 12:41 p.m. ET

Money magazine ranks the best places to have an active retirement

By staff writer Mark GongloffNEW YORK (CNNfn) - If you're jooking for a stimulating retirement spot, Money magazine has made the search a little easier, naming five cities with a wealth of activities for retirees.

In its July issue, Money named Bradenton, Fla.; Fort Collins, Colo.; Bend, Ore.; Asheville, N.C.; and Brunswick, Me., as the five best U.S. towns in which to spend your golden years.





The magazine ranked cities based on availability of continuing education, outdoor and cultural activities, accessibility of medical care and transportation, cost of living, taxes and home prices.

Though many retirees prefer temperate locales like Florida or the Southwest, weather was less important to Money when picking its winners. Brunswick, for example, has an average low temperature of 11.7 DF, but Money likes it for its museums, theaters, and restaurants; the availability of golfing, sailing and other outdoor activities; its proximity to Boston, and the presence of Bowdoin College.

In fact, Fort Collins, Bend, Asheville and Brunswick together have an average low temperature of 20.5 F. Those of us who would rather golf than shovel a driveway could live in Bradenton (average low a balmy 50.10F) or go to Money's retirement-locale web site, where you can search for retirement locations that match your personal criteria for livability.

Do you like a place that's "cultured and outdoorsy at the same time," as Money put it? Fort Collins, Asheville or Bend may be for you. Do you want to recover from a lifetime of work by gorging on golf and baseball? Bradenton, with 24 golf courses, is where eight major-league teams hold spring training. Do you want to be far from the madding crowd?□ Asheville is two hours by car from the nearest big city (Charlotte), and Bend is a three-hour drive from Portland, Ore.

As Money writer Patricia Skalka pointed out, "There is no one formula for picking the best place to settle down." Find a place that suits you best.

Money also named five runners-up: Santa Fe, N.M.; Hot Springs, Ark.; San Luis Obispo, Calif.;

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Money's top retirement spots - Jun. 9, 2000

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Ex.D p.2

Madison, Wis.; and Amherst, Mass.

Click here to read more of Money's best retirement places.

Find this article at: http://money.cnn.com/2000/06/09/senior_living/q_retire_places

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Best places to retirejune 14, 2000: 9:58 a.m. ET

Modern Maturity names the 50 most active places to live during retirement

By Staff Writer Jennifer KarchmerNEW YORK (CNNfn) - If you think retirement means riding ATVs on the beach, watching a Shakespeare play at night and starting your own consulting firm after saying goodbye to corporate America, then a new survey will help you find the perfect town to have it all.

Modern Maturity magazine has come out for the first time with a list of the most active places to live in the country if you're over 50 and preparing to retire.

"Retirement is coming to have a different meaning than it used to," said Modern Maturity senior editor Gabrielle deGroot Redford. "(Baby) Boomers are going to retire differently than their parents did."

|xi| graphic



Relaxing on the front porch of the retirement home or playing a round of golf is being replaced with world-wide traveling, rock climbing and hiking, and opening a new business, she added. It's no secret Americans are living longer and stronger.

So Modern Maturity judged places based on transportation, restaurants, health care, crime rates, recreational and cultural activities; and availability of continuing education and affordability. A team of researchers spent six months studying the cities to come up with the following winners: Boulder, Colo., Austin, Texas, Boston, Mass., Asheville, N.C., and Sonoma County, Calif.

Boulder, Colo.

<u>Boulder</u>, Colo., took the top spot in the magazine's **Green and Clean** category because of the town's abundance of outdoor and recreational activities, access to top-level health care, proximity to University of Colorado in Boulder, low crime rate, and walkability factor.

Modern Maturity named Bend, Ore., and Annapolis, Md., as runner-up cities based on fresh air and outdoor activities.

http://cnnmoney.printthis.clickability.com/pt/cpt?expire=&title=Modern+Maturity+rates+t... 4/20/2011

Page 2 of 3.

Austin, Texas

Maybe you've been thinking about taking a night class at the local university or a course on comparative literature?

More and more retirees are finding time to expand their knowledge and master new hobbies and skills. Modern Maturity named Austin, Texas, its top pick for College Towns.

"The city offers unique things for seniors, lifelong classes, seniors can take classes for free or a nominal fee — woodworking to history," Redford said.

Adding to Austin's attractiveness for an older, but active crowd, is the city's progressiveness, its environmentally friendly attitude, and hiking and biking trails.

"The Baby Boomer generation is very active and aware of exercise in terms of health and longevity," Redford said.

Charlottesville, Va., home of the University of Virginia, and Columbia, Mo., home of the University of Missouri, were named as runner-up cities for college towns.

Click here to find out how Modern Maturity rates each of the cities

Boston, Mass.

Boston, Mass., certainly isn't the biggest city out there, but *Modern Maturity* rated it the best Big City for retirement, thanks to its abundance of colleges and universities and quaint neighborhoods.

"Boston has a high vitality quotient with a lot of culture, lectures, and concerts," Redford said. "It's a town of niches," home to Harvard University, Boston University, Boston College, and Emerson College, among other schools.

And it's no secret that older Americans are shying away from typical warm climates, opting for more culture and outdoor activities.

"The new generation of retirees is not necessarily going to move to Florida; either they're staying put or moving to be near family or they're moving back to where their alma mater is, but it's away from moving to the Sun Belt." she said.

Runner-up cities were San Francisco and Sarasota, Fla.

Asheville, N.C.

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Asheville, N.C., which is two hours by car from Charlotte - the nearest big city - got high marks for its cultural atmosphere, orchestra, concerts and theatre, according to Redford. In addition, it's situated in the Blue Ridge Mountains.

With a population of 68,000, Asheville is considered the best Small Town on Modern Maturity's list. Money also chose Asheville as one of its top retirement cities.

Ashland, Ore., and Silver City, N.M., were named as runner-up cities.

Sonoma County, Calif.

Because of its unique mix of natural beauty, wineries, ranches, and progressive politics, the magazine named Sonoma County, Calif. the best Quirky city. Sonoma boasts organic food, a center for alternative medicine, and a low crime rate.

"Health care has always been important, but Baby Boomers may be more interested in alternative health care," Redford said. "I don't necessarily think 10 years ago people were too terribly concerned about outdoor recreation and vitality."

Key West, Fla., and Reno, Nev., are runner-up cities for the Quirky category.

"I think people are doing homework on retirement cities," Redford added.

"There are books out, places rated. They're big sellers." @

-- Staff Writer Jennifer Karchmer covers retirement news for CNNfn.com. Click here to send her e-mail.

Find this article at: http://money.cnn.com/2000/06/14/senior_living/q_retire_cities

Check the box to include the list of links referenced in the article.

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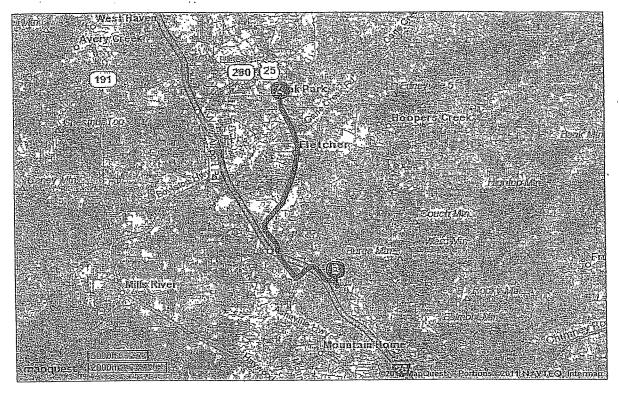


Trip to:
100 Hospital Dr
Hendersonville, NC 28792-5272
5.32 miles
10 minutes

Mission GI South to Park Ridge

	2651 Hendersonville Rd Arden, NC 28704-8527	Miles Per Section	Miles Driven
	Start out going SOUTH on HENDERSONVILLE RD / US-25 toward ALLIANCE PAGE RD. Continue to follow US-25 S.	Go 3.6 MI	3.6 mi
	2. US-25 S becomes ASHEVILLE HWY / US-25-BR S.	Go 0.5 Mi-	4.1 mi
4	3. Tum LEFT onto S NAPLES RD. S NAPLES RD is 0.2 miles past NAPLES RD	Go 0.2 Mi	4.3 mi
*	4. Turn RIGHT onto NAPLES RD.	Go 0.8 Mi	5.1 mì
F	5. Take the 2nd RIGHT onto HOSPITAL DR. If you reach HOMESTEAD FARM CIR you've gone a little too far	Go 0.2 Mi	5.3 mi
	6. 100 HOSPITAL DR. Your destination is 0.1 miles past DOCTORS DR		5.3 ml
P	100 Hospital Dr Hendersonville, NC 28792-5272	5.3 mi	5.3 mi

Total Travel Estimate: 5.32 miles - about 10 minutes



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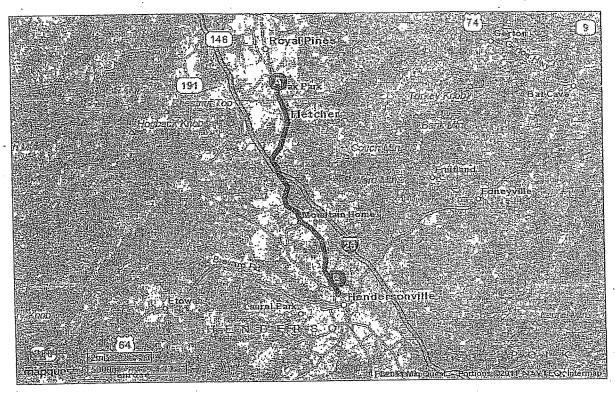
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Trip to: 1032 Fleming St Hendersonville, NC 28791-3532 9.82 miles 18 minutes

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1	(255) (255)	. US-25 S becomes ASHEVILLE HWY / US-25-BR S.	Go 6.2 Mi	9.7 ml
P	3	B. Turn RIGHT onto FLEMING ST. If you reach OAKLAND ST you've gone a little too far	Go 0.09 Mi	9,8 mi
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		1032 Fleming St Hendersonville, NC 28791-3532	9.8 mi	9.8 mi

Total Travel Estimate: 9.82 miles - about 18 minutes



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Driving Directions from 2651 Hendersonville Rd, Arden, North Carolina to 800 N Jus

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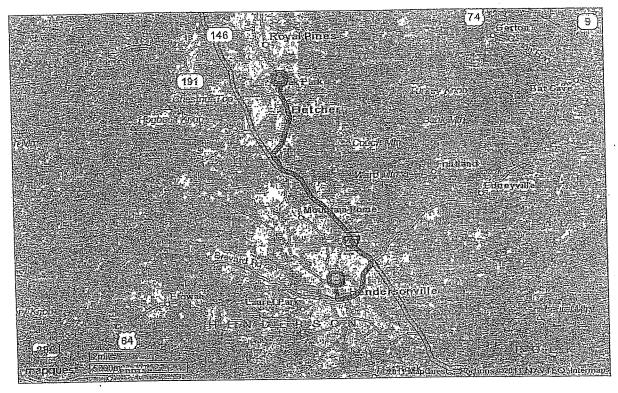
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Trip to: 800 N Justice St Hendersonville, NC 28791-3410 11.84 miles 18 minutes Mission GI. Swtn Derdel

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	. €	1. Start out going SOUTH on HENDERSONVILLE RD / US-25 toward ALLIANCE PAGE RD. Continue to follow US-25 S.	Go 3.6 Mi	3.6 mi
13		2. Merge onto I-26 E / US-25 S / US-74 E via the ramp on the LEFT. If you reach S CURETON PL you've gone about 0.1 miles too far	Go 5.5 MI	9,0 mi
E 51E		3. Merge onto US-64 W via EXIT 49B toward HENDERSONVILLE.	Go 2.4 Mi	11.4 mi
4	THE STATE OF THE S	4. Turn LEFT onto BUNCOMBE ST / US-64 W.	Go 0.04 Mi	11.5 mi
***		5. Take the 1st RIGHT onto 6TH AVE W / US-64. If you reach 5TH AVE W you've gone about 0.1 miles too far	Go 0.3 Mi	11.7 mi
7		6. Take the 3rd RIGHT onto N JUSTICE ST. If you reach N OAK ST you've gone about 0.1 miles too far	Go 0.1 Mi	11.8 mi
	•	7. 800 N JUSTICE ST is on the RIGHT. If you reach CONNOR AVE you've gone a little too far		11.8 mi
		800 N Justice St Hendersonville, NC 28791-3410	11.8 mi	11.8 mi

Total Travel Estimate: 11.84 miles - about 18 minutes



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Driving Directions from 2651 Hendersonville Rd, Arden, North Carolina to 509 Biltmore ..

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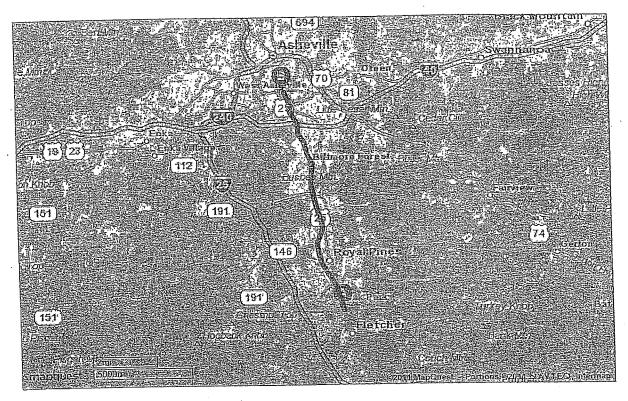
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Trip to: 509 Biltmore Ave Asheville, NC 28801-4601 9.93 miles 16 minutes Notes
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		2651 Hendersonville Rd Arden, NC 28704-8527	Miles Per Section	Miles Driven
· 🌼 .	8	1. Start out going NORTH on HENDERSONVILLE RD / US-25 toward SHARP SOLUTIONS DR. Continue to follow US-25.	Go 9.1 Mi	9.1 mi
	圖	2. Turn RIGHT onto US-25-ALT. US-25-ALT is just past BOSTON WAY	Go 0.04 Mi	9.1 ml
4		3. Take the 1st LEFT onto BILTMORE AVE. If you reach BILTMORE PLZ you've gone a little too far	Go 0.8 Mī	9.9 mi
<u></u>		4. 509 BILTMORE AVE is on the LEFT. Your destination is just past FOREST HILL DR If you reach GRANBY ST you've gone a little too far		9.9 mi
		509 Biltmore Ave Asheville, NC 28801-4601	9.9 mî	9.9 mi

Total Travel Estimate: 9.93 miles - about 16 minutes



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Driving Directions from 2651 Hendersonville Rd, Arden, North Carolina to 191 Biltmore ...

Notes

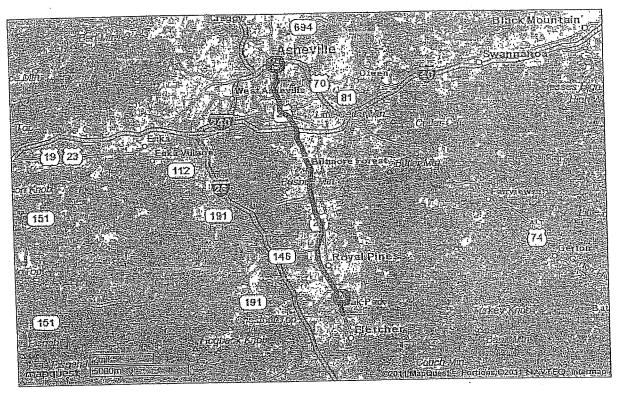
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Trip to: 191 Biltmore Ave Asheville, NC 28801-4109 10.90 miles 17 minutes Hyssian GI south to Asheville Gastro -The Endoscopy Center

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			2651 Hendersonville Rd Arden, NC 28704-8527	Miles Per Section	Miles Driven
,			1. Start out going NORTH on HENDERSONVILLE RD / US-25 toward SHARP SOLUTIONS DR. Continue to follow US-25.	Go 10.5 Mi	10.5 mi
	P		2. Turn SLIGHT RIGHT onto SOUTHSIDE AVE / US-25. SOUTHSIDE AVE is 0.1 miles past CHOCTAW ST	Go 0.4 Mi	10.9 mi
	42		3. Turn LEFT onto BILTMORE AVE / US-25. BILTMORE AVE is just past S LEXINGTON AVE	Go 0.01 Mi	10.9 mì
		*	4. 191 BILTMORE AVE is on the LEFT. If you reach CARROLL AVE you've gone a little too far		10.9 mi
			191 Biltmore Ave Asheville, NC 28801-4109	10.9 mi	10.9 mī

Total Travel Estimate: 10.90 miles - about 17 minutes



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Economic Research Service

Economics of Food, Farming, Natural Resources, and Hurid America

Data Sets



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2009 County-Level Poverty Rates for North Carolina

North Carolina

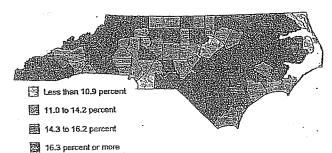
Percent

Number

Go to the map to select a State

Go to North Carolina State Fact Sheet

Percent of total population in poverty, 2009



Get this map as a JPG image or a PNG image.

Click a column name to sort the table by that column.

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2	37001	Alamance County	3	15.2	13.2	17.2	20.1	16.2	23.9						
3	37003	Alexander County	2	14.9	12.1	17.7	22.1	17.5	26.7						
4	37005	Alleghany County	9	19.3	14.8	23.9	31.5	24.5	38.6						
5	37007	Anson County	1	24.1	18.9	29.4	32.1	25.1	39.1						
6	37009	Ashe County	9	18.1	14.7	21.6	26.4	20.4	32.4						
7	37011	Avery County	8	18.9	14.5	23.2	27,3	21.1	33.4						
8	37013	Beaufort County	. 6	19.3	16.0	22.6	31.2	25.9	36.5						
9	37015	Bertie County	9	24.3	18.9	29.7	34.9	27.2	42.6						

o Animal Products o Countries & Regions o Crops o Diet, Health, & Safety o Farm Economy o Farm Practices &

Management o Food & Nutrition Assistance

o Food Sector

o Natural Resources & Environment

o Policy Topics

o Research & Productivity

o Rural Economy

o Trade & International Markets

10	37017	Bladen County	. 6	23.3	19.	.4	27.2	30.5	24.7	36.3
11	37019	Brunswick County	2	14.6	12	.1	17.2	26.0	20.6	31.3
12	37021 .	Buncombe County	2	16.2	14	:D	18.4	22.4	18.6	26.2
13	37023	Burke County	2	17,4	14	.7	20.1	23.5	18.8	28.2
14	37025	Cabarrus County .	4 L.	11.4	9	.8	13.0	16.4	13.6	19.1
15	37027	Caldwell County	2	16.7	14	.1	19.3	25.2	20.4	30.1
16	37029	Camden County	8	8.9	6	8,6	11.0	12.8	10.0	15.7
17	37031	Carteret County	4	. 13.1	10).4	15.8	22.5	17.7	27.3
18	37033	Caswell County	. 8	22.6	19	9.2	26.0	27.8	22.4	33.2
19	37035	Catawba County	2	14.4	1	2.6	16.2	20.9	17.5	24.3
-20	37037	Chatham County	- 2	11.0)	8.7	13.2	17.6	13.9	21.3
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38	37073	Gates County	8	17.5	14.1	21	.0	24.1	19.2	28.9
39	37075 [.]	Graham County	9	19.6	14.8	24	.4	33.9	26.3	41.5
40	37077	Granville County	6	14.8	11.9	17	.6	18.5	14.7	22.4
41	37079	Greene County	3	23.0	17.8	28	1.3	31,4	24.7	38.1
42	37081	Guilford County	2	17.1	15.3	18	3.8	22.1	19,4	24.7
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45	37087	Haywood County	2	15.2	12.	4 1	3.1	24.9	19.6	30.3
46	37089	Henderson County	2	12.4	10.	0 1	4.7	21.0	16.9	25.1
47	37091	Hertford · County	7	24.9	20.	0 2	9.8	34.6	27.7	41.5
48	37093	Hoke County	2	21.3	18.	0 2	4.6	30.1	25.2	34.9
49	37095	Hyde County	9	24.0	18.	6 2	9.5	29.6	23.0	36.3
50	37097	Iredell County	4	13.1	11.	6 1	4.6	17.9	15.3	20.5
51	37099	Jackson County	6	20.5	5 16.	.7 2	4.3	26.3	20.6	32.0
52	37101	Johnston County	2	17.	1 15	.6 1	9.2	23,4	20.6	26.3
53	37103	Jones County	8	18.	3 14	,1 2	22.6	29.7	23.0	36.4
54	37105	Lee County	4	14.	5 11	.7	17.3	22.5	17.4	26.8
55	37107	Lenoir County	4	21.	0 17	.7	24.2	29.8	3 24.0	35.7
56	37109	Lincoln County	4	14.	3 12	.2	16.3	20.	1 16.	5 23.7
57	37111	McDowell County	6	17.	8 14	.9	20.8	26.	1 21.	31.1
58	37113	Macon County		7 18.	.8 15	5.8	21.8	31.	0 25.	36.8
59	37115	Madison County	7	2 19	.3 14	1.9	23.6	26.	9 20.	8 33.0
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64	37125	Moore County	4	13.3	11.0	15.6	21.9	17.9	25.9
65	37127	Nash County	3	15.6	12.8	18.3	22.7	18.1	27.4
66	37129	New Hanover County	. 2	16.0	14.2	17.7	. 21.2	17.9	24,6
67	37131	Northampton County	9	24.9	20.1	29.7	35.1	27.6	42.7
68	37133 ·	Onslow County	3	15.1	12.4	17.9	21.0	17.1	24.8
69	37135	Orange County	2	16.9	15.2	18.6	14.7	12.3	17.0
70	37137	Pamlico . County	. 9	18.6	14.6	22.5	30.3	23.7	36.8
71	37139	Pasquotank County	7	17.7	13.8	21.6	25,3	19.9	30.7
72	37141	Pender County	2	18.1	15.5	20.7	24.1	19.9	28.4
73	37143	Perquimans County	9	17.2	13,5	20.9	28.3	21.8	34,7
74	37145	Person County	2	14.6	11.3	17.8	20.7	16.1	25,4
75	37147	Pitt County	3	25,5	23.7	7 27,3	26.7	23.2	30.3
76	37149	Polk County	8	15.3	12.3	3 18.4	25.1	20.3	30.0
77	37151	Randolph County	2	16.0	14.0	18.1	23,6	19.8	27.4
78	37153	Richmond County	4	30.0	26.	6 33.4	38.4	33.1	43.8
79	37155	Robeson County	4	31.3	27.	6 34.6	43.8	38.2	49.3
80	37157	Rockingham County	2	14.9	12.	3 17.	4 22.3	17.7	26.9
81	37159	Rowan County	4	16.	7 14.	5 18.	9 24.3	3 20.4	28.1
82	37161	Rutherford County	4	21.	8 18.	9 24.	7 30.0	5 25.7	35.4
83	37163	Sampson County	6	21.	7 18.	.5 24.	8 28.	4 23.0	33.9
84	37165	Scotland County	6	29.	6 25	.7 33.	5 42.	6 36.1	49.1
85	37167	Stanly County	(5 14.	1 11	.4 16.	7 21.	2 16.8	25.6
86	37169	Stokes County		2 11.	2 8	.4 13.	.9 18.	1 13.9	22.4
87	7 37171	Surry County		4 17.	.4 14	.5 20	.4 24.	7 19.	7 29.7
88	37173	Swain		8 17	.6 13	.9 21	.3 26.	6 20.	7 32.6

		County			I			,	
89	37175	Transylvania County	6	19.9	17.3	22.6	35.2	30.0	40.4
90	37177	Tyrrell County	'9	28.9	21.9	35.9	41.1	31.6	50.5
91	37179	Union County	1.	10.9	9.5	12.3	14.5	12.3	16.7
92	37181	Vance County	4	32.3	28.8	35,8	48.0	42.3	53.8
93	37183	Wake County	2	10.2	9.4	11.0	12.1	10.4	13.9
94	37185	Warren County	8	26.1	21.3	31.0	37.0	29.7	44.2
, 95 .	37187	Washington County	7	23.3	18.3	28.4	37.1	29.1	45.1
96	37189	Watauga County	6	21.2	18.1	24.3	18.4	14.2	22.5
97	37191 ·	Wayne County	3	20.0	17.8	22.3	29,0	25.4	32.6
98	37193	Wilkes County	6	18.5	16.0	21.1	30.0	25.4	34.5
99	37195	Wilson County	4	20.3	17.5	23,1	29.3	24.3	34.2
100	37197	Yadkin County	2	13.4	10.5	16.2	20.5	15.9	25,0
101	37199	Yancey County	8	17.8	13.5	22.0	28.8	22.2	35.3

See the county-level poverty rates from the 1990 and 2000 Census of Population.

Download the State- and county-level data in Excel format.

See important notes about intercensal model-based poverty estimates.

¹The 2003 rural-urban continuum codes classify metropolitan counties (codes 1 through 3) by size of the Metropolitan Statistical Area (MSA), and nonmetropolitan counties (codes 4 through 9) by degree of urbanization and proximity to metro areas. See rural-urban continuum codes for precise definitions of each code.

Source: Bureau of the Census, Small Area Income and Poverty Estimates.

*See the Census Bureau web site for a description of FIPS codes.

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An Economic Analysis of the Certificate of Public Advantage (COPA) Agreement Between the State of North Carolina and Mission Health

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L. EXECUTIVE SUMMARY

In late 1995, the only two acute-care hospitals in Asheville, North Carolina, merged to form Mission Hospital, an entity owned and operated by Mission Health Systems ("MHS"). Due to concerns that the merger would significantly increase Mission Hospital's market power in one or more markets in Western North Carolina ("WNC"), the State of North Carolina entered into a Certificate of Public Advantage ("COPA") agreement with the hospitals as a condition for allowing the merger to go forward. The regulatory requirements embodied in the COPA were designed to provide an offset to the competitive discipline being eliminated by the merger, thus helping to ensure that consumers would not face higher prices or reduced quality of care as a result of the merger.

In the years since the initial COPA agreement was entered into, health care markets have changed considerably. In recognition of this, the State of North Carolina commissioned this economic study to assess whether the existing Second Amended COPA (hereafter, simply "the COPA") should be modified in any way to better protect consumers against the loss of competition that resulted from the 1995 merger. In assessing whether such modifications were warranted, I was asked to focus solely on competitive issues, and not to consider whether the COPA should be modified to better address policy issues such as access to care, the financial impact of the COPA on MHS or other entities, or the COPA's impact on physicians' incentives to practice in the WNC region.

The assessment of what, if any, modifications to the COPA are warranted is a very fact-specific one. In conducting this study, I collected and assessed information from a variety of sources, including interviews (both in-person and over the telephone) with individuals at MHS and other area hospitals, with health insurance plans operating in the WNC region, and with local physicians. I also reviewed and analyzed regulatory filings and data, public documents relating to competition in the WNC region, public data relating to physician admitting practices and

¹ Memorial Mission Hospital and St. Joseph's Hospital signed a cooperative agreement in December 1995 to manage and operate the two hospitals as an integrated entity. Three years later, Memorial Mission Hospital acquired St. Joseph's Hospital under the ownership of Mission-St. Joseph's Health System, Inc. In December 2003, Mission-St. Joseph's Health System, Inc. was renamed Mission Health, Inc. and the merged hospitals were renamed Mission Hospital. In the remainder of this report I refer to the initial integration of the two hospitals, and their subsequent merger, simply as the 1995 merger. See the Second Amended Certificate of Public Advantage at pages' I and 2.

² For the purposes of this report, I define the WNC region as the Service Area defined under the COPA (Section I Definitions): the 17 county region consisting of Buncombe, Burke, Cherokee, Clay, Graham, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Rutherford, Swain, Transylvania, and Yancey. For the purposes of this report, I define MHS's Primary Service Area ("PSA") as Buncombe and Madison counties.

See the initial COPA agreement dated December 21, 1995. The COPA agreement was subsequently amended on October 8, 1998 to account for the formal merger of the two hospitals and again in June 2005 "to reflect changes in facts and circumstances, including the accomplishment or expiration of certain provisions of the COPA, and to provide better tools and mechanisms for oversight by the State." See Second Amended COPA at page 1.

⁴ The two entities within the State that commissioned this study were the North Carolina Department of Health and Human Services and the Office of the Attorney General for North Carolina.

patient hospital choice, and confidential business data and documents. More generally, I drew upon my experience conducting similar types of economic analyses, especially in the area of hospital mergers, over the last 20 years as a private economic consultant at Charles River Associates and while serving in senior positions at the Antitrust Division of the U.S. Department of Justice and at the Federal Trade Commission's Bureau of Economics.

In assessing whether modifications to the COPA are warranted, I have adopted the following critical assumption: that the regulatory scope of the COPA should be limited to addressing competitive problems that arose as a result of the 1995 merger, and that the COPA should not seek to regulate conduct or markets that were unlikely to have been impacted by that merger. Rather, any problems that exist but that are unrelated to the 1995 merger should instead be addressed through other means such as existing state or federal antitrust laws, or existing Certificate of Need laws.

The motivating justification for the COPA's restrictions likely remains valid today: the 1995 merger likely resulted in a significant and enduring reduction in competition in one or more markets. Thus, the COPA's regulatory restrictions to replace that lost competitive discipline remain appropriate. Certain modifications of those regulations, however, are warranted as a means of increasing the regulatory protection that the COPA offers while simultaneously ensuring that the COPA is targeted solely on those areas where the merger likely reduced competition.

The four principal conclusions and recommendations from this study are summarized below.

1. The COPA's Margin Cap creates an incentive and opportunity for MHS to evade the intent of the COPA: by expanding into other markets (with respect to either geography or service), MHS can increase prices and realize higher margins than the COPA seeks to allow.

The COPA regulates MHS's average margin across all services and geographies. By expanding into lower-margin markets, MHS can reduce its average margin, thus allowing MHS to raise price without violating the Margin Cap. MHS can also lower its average margin, thus allow it to increase price, by incurring additional expenses that are not covered by the COPA's Cost Cap. Finally, although the Margin Cap is intended to protect commercial payers from incurring excessive rate increases, by looking at MHS's margin across both commercial and government payers, MHS may be able to impose excessive rate increases.

To address these problems, I recommend that:

- The existing Margin Cap should be replaced with a Price Cap so that MHS cannot
 meet its margin cap by incurring additional costs relating to services outside the
 scope of the Cost Cap.
- The Price Cap should only be applied to those markets originally affected by the merger, and a separate Price Cap should be calculated for each of those markets.
- The Price Cap should be limited to regulating prices to commercial payers, not to government payers or other payers for whom prices are unlikely to depend significantly on hospital competition.
- 2. The COPA's Cost Cap offers only limited regulatory protection for consumers, yet it creates undesirable incentives for MHS to increase outpatient prices and volumes.

The COPA's Cost Cap regulates Mission Hospital's inpatient and outpatient expenses, but does not prevent MHS from incurring excessive expenses relating to other markets or services (e.g., the cost of acquiring physician practices). As a result, it provides only limited protection to consumers. Moreover, if the COPA's Margin Cap is replaced by a Price Cap, then there may be little need for a Cost Cap. Finally, the methodology by which the COPA Cost Cap is calculated also creates an incentive for MHS to reduce the COPA's measure of expenses by increasing outpatient prices and, in some cases, by increasing outpatient volume.

To address these issues, I recommend that:

- The State should consider eliminating the COPA's Cost Cap. The greater the State's confidence in the effectiveness of a new Price Cap (to replace the existing Margin Cap), the greater the justification for eliminating that Cost Cap.
- If the State retains the Cost Cap, then the COPA should address incentive problems relating to the Cost Cap methodology by adopting a separate Cost Cap for inpatient services and for outpatient services, and change the methodology by which "Equivalent Outpatient Discharges" are calculated.

3. The COPA creates an incentive and opportunity for MHS to engage in "Regulatory Evasion" by which MHS can evade price (or margin) regulation in one market by instead imposing price increases in a related, but unregulated, market.

MHS has an incentive to evade price (or margin) caps by tying the sale of its regulated services to other unregulated services, and then raising the price of that unregulated service. Although the COPA currently prevents MHS from tying with respect to physician services, I recommend that the scope of the COPA's restrictions on tying be expanded to also cover any other services that MHS offers.

The State may also wish to also provide additional protection against Regulatory Evasion by requiring MHS to adopt contracting firewalls requiring MHS to contract separately, and with distinct contracting teams, for services in markets affected by the 1995 merger and for services in all other markets. In determining whether contracting firewalls are warranted, the State should balance what may be limited incremental benefits from these contracting firewalls with possible costs associated with impeding legitimate efforts by MHS to more fully integrate the provision of care between distinct contracting entities, and thus lower costs and improve quality.

 The COPA's Physician Employment Cap may be unnecessary to address competitive concerns attributable to the 1995 merger.

The 1995 merger did not result in any significant reduction in competition between the two Asheville hospitals with respect to physician services, and thus the COPA's Physician Employment Cap is unnecessary to counter any merger-related increase in MHS's market power associated with physician services.

An alternative merger-related justification for the COPA's physician restrictions is that the merger may have increased the risk that MHS could foreclose competition with rival hospitals by employing physicians that might otherwise split their practice between MHS and those rival hospitals. The evidence suggests, however, that the COPA's Physician Employment Cap may have limited value in preventing such a problem. On the other hand, the Physician Employment Cap may cause harm by preventing MHS from pursuing legitimate efforts to integrate care, and thus lower costs and improve quality. Thus, the State should consider dropping the COPA's restrictions on MHS's employment of physicians and instead let MHS's acquisitions of physician practices be governed by the same laws and regulations that govern other hospitals.

II. QUALIFICATIONS

I am an economist with a specialty in the fields of industrial organization and the economics of competition. I hold a Ph.D. in economics from Stanford University and a B.A. in economics from the University of California at Berkeley. I have published, made professional presentations, testified, and consulted in the areas of industrial organization, competition, and antitrust economics for approximately 20 years. A copy of my curriculum vitae is provided in Appendix 1.

During my professional career, I served as Deputy Director for Antitrust in the U.S. Federal Trade Commission's ("FTC's") Bureau of Economics. In that position, I was responsible for directing the economic analysis of all antitrust matters before the FTC and overseeing its staff of approximately 40 Ph.D. economists. Prior to that, I held several positions in the Economic Analysis Group of the U.S. Department of Justice's ("DOJ's") Antitrust Division, including Assistant Chief of the Economic Regulatory Section. In all of these positions, my antitrust analyses have focused on assessing competition and evaluating the likely competitive effects of firms' conduct.

I am currently a Vice President in the Washington, DC office of Charles River Associates ("CRA"), an economics and business consulting firm. At CRA, my work has focused almost exclusively on issues relating to competition, with a substantial portion of that work relating to both merger and non-merger matters before the FTC and the Antitrust Division of the DOJ, including matters in which I have been retained by the government to serve as an expert witness on its behalf.

Both while I was with the DOJ and FTC, and since joining CRA, I have been actively involved in analyzing competition in the healthcare industry. While at the DOJ, I was a member of the small working group that wrote, and subsequently updated, the DOJ/FTC Statements of Antitrust Enforcement Policy in Health Care. I also served during that period as a member of President Clinton's Health Care Task Force, and as a member of President Bush's Interagency Task Force on Information in the Health Care Industry. Since joining CRA, I have testified at the Federal Trade Commission/Department of Justice Joint Hearings on Health Care and Competition Law and Policy, and have been retained by private parties, and both state and federal antitrust agencies, to provide analysis and expert testimony regarding competitive issues in the health care sector. Finally, I have made presentations and published articles in peer-reviewed journals regarding competition in the health care industry.

III. BACKGROUND

The 1995 merger likely provided Mission Hospital with substantial market power with respect to inpatient services and possibly with respect to outpatient services. The COPA addresses that market power through three principal regulatory constraints: a Cost Cap; a Price Cap; and a Physician Employment Cap.

A. Regulatory scope of the COPA

When analyzing competition, economists typically consider whether a firm enjoys significant market power, where market power can be thought of as a firm's ability to increase price above competitive levels. Here, the relevant question is whether the 1995 merger of Memorial Mission and St. Joseph in Asheville, the event which led to the original COPA agreement between the State and the hospitals, likely created significant market power in any relevant market. If so, then regulatory efforts to offset or reverse the effects of that increased market power may be appropriate.

However tempting it may be, the COPA should not be viewed as a vehicle for addressing competitive problems or healthcare policy issues that are unrelated to the merger. Rather, the regulatory scope of the COPA should be limited to addressing competitive problems that can be attributed to the 1995 merger. Problems unrelated to the 1995 merger, to the extent they exist, should instead be addressed through existing state or federal antitrust laws and regulations (e.g., North Carolina's Certificate of Need laws).

B. The impact of the 1995 merger

The proper scope of the COPA depends on an assessment of where the merger likely created substantial market power. As discussed below, the 1995 merger likely only created significant market power regarding inpatient, and possibly outpatient, services.

1. Merger-related market power in inpatient hospital services

In assessing what, if any, modifications to the COPA are warranted, I have not been asked to address whether the 1995 merger resulted in substantially increased market power with respect to inpatient hospital services, and thus warranted regulatory restrictions: such an inquiry would go well beyond the scope of this study and require a much more fact-intensive inquiry. Instead, I

⁵ References to inpatient and outpatient services in this report should be understood to refer to acute care and related medical services, not psychiatric, rehabilitation, substance abuse or other types of services.

⁶ Regardless of any philosophical considerations about the proper scope for regulation, this limitation on the scope of the COPA is necessary purely from a practical perspective: unless the scope of the COPA is limited to merger-related issues, there is no clear boundary for how far-reaching the COPA's regulations should be. Absent those boundaries, there is no way in which to assess whether further modifications to the COPA are warranted so as to achieve those broader (but undefined) goals.

have assessed the COPA given the assumption of a merger-related increase in inpatient hospital services market power.

Yet, while I do not independently seek to assess whether Mission Hospital has market power relating to inpatient hospital services that stems from the 1995 merger, the evidence I have seen is fully consistent with that assumption. Prior to the merger, Memorial Mission and St. Joseph likely provided significant competition to each other. These two hospitals were located only blocks away from each other, and were both viewed as large, full-service hospitals. Consistent with what I have learned from health insurers operating in the area, those two hospitals appear to have provided important competitive discipline to each other. In contrast, other hospitals in the WNC region appear to have provided, and continue to provide, substantially less competitive discipline to the Asheville hespitals. Thus, by merging Memorial Mission and St. Joseph, the most important competitive discipline facing these hospitals appears to have been lost, thereby creating substantial market power.

The facts are generally consistent with this assumption that Mission Hospital realized significant market power from the merger. While potentially a very imperfect proxy for market power, Mission Hospital's share of inpatient discharges in several counties in WNC is consistent with the assumption that Mission Hospital enjoys substantial market power with respect to inpatient hospital services. As shown in Table 1, Mission Hospital's share of discharges from several counties in WNC is not only quite high (e.g., Mission Hospital accounts for approximately 90 percent of all hospitalizations of patients living in Buncombe County), it has been growing over time.

Mission Hospital is also significantly different in several regards from neighboring hospitals, thus likely reducing payers' willingness to substitute from Mission Hospital to those other hospitals. As shown in Table 2, Mission Hospital is substantially larger than other hospitals, both in terms of bed capacity and patient census. For example, Mission Hospital averaged approximately 522 patients/day in 2009, with the next largest hospital in WNC (Pardee Memorial Hospital in Henderson County) averaging only 72 patients/day. Mission Hospital is also substantially larger than other area hospitals in terms of the number of physicians actively admitting to the hospital: Mission has over 300 actively admitting physicians on its staff, while the next largest hospital in WNC has only 58.

Mission Hospital also offers a broader, and more specialized, scope of services than do the other hospitals in WNC. For example, Mission Hospital is the only hospital in the WNC region offering Level II trauma care and is the recognized center for specialized care in the region. Consistent with this, other hospitals in the area generally recognize that Mission Hospital is an

⁷ For the purposes of counting actively admitting physicians, I considered physicians with at least 12 admissions in the 12 month period ending June 30, 2010 (based on the State Inpatient data provided by Thompson Reuters). Alternative means of counting physicians (including counting only physicians that are not employed by a hospital) would not affect the conclusion that MHS has a much larger physician staff than any other local hospital.

important partner in providing healthcare services to the local community by offering services that those smaller hospitals cannot provide themselves. This difference in scope of services would make it difficult for payers to substitute away from Mission Hospital to those other hospitals in the region.

Geographic location also matters. In contrast to the two merging hospitals that now make up Mission Hospital and which were located only blocks away from each other, other hospitals in the WNC region are located many miles away from Asheville where managed care plans seek hospital coverage. The largest neighboring hospital (Pardee Memorial Hospital) that competes with Mission Hospital is approximately 25 miles away, while other hospitals in the WNC region are 15 to 110 miles away.

These data, as well as the information that I learned while interviewing physicians, health insurance providers and hospitals, are all consistent with the premise that Mission Hospital continues to enjoy substantial market power with respect to inpatient hospital services, and that this market power likely increased significantly as a result of the 1995 merger.

2. Merger-related market power in outpatient hospital services

I understand that both Memorial Mission and St. Joseph offered competing outpatient services at the time of the merger. Thus, the merger would have eliminated any competition between those two providers with respect to outpatient hospital services.

I have not sought to determine the extent to which Mission Hospital faces significant competition in the provision of those services. This competition could have come from physician clinics and offices, outpatient clinics or facilities, or other hospitals' outpatient facilities. Thus, I do not have a basis to conclude whether the merger likely created significant market power with respect to outpatient hospital services at the time of the merger or whether any such increased market power in outpatient hospital services remains today. Inasmuch as the COPA regulatory restrictions do cover outpatient services provided by Mission Hospital, however, I assume for the purposes of my study that the merger did create significant market power that endures today.

3. Merger-related market power and physician services

I have seen no evidence suggesting that the creation of Mission Health resulted in a significant increase in market power with respect to physician services. In particular, I understand that neither of the merged hospitals employed any significant number of physicians prior to the

⁸ If this assumption can be shown invalid, it may be appropriate to drop regulations in the COPA that relate to those outpatient services.

merger. Thus, the 1995 merger does not appear to have resulted in a significant increase in physician market power that warrants offsetting regulatory restrictions.

C. The COPA imposes three principal regulatory constraints

I focus on three key regulations in the COPA: a Cost Cap; a Margin Cap; and a Physician Employment Cap. ¹⁰ A general description of those constraints is provided below.

1. The COPA's Cost Cap

Under the COPA, the rate at which Mission Hospital's "cost per adjusted patient discharge" ("CAPD") increases must not exceed the rate of increase in the producer price index for general medical and surgical hospitals in the U.S. 11

The CAPD as defined by the COPA measures MHS's costs over both inpatient and outpatient operations, but only for the two merged Asheville hospitals. Thus, the scope of the COPA's Cost Cap regulation is appropriately limited to just those services and geographies for which the 1995 merger likely significantly increased MHS's market power.

2. The COPA's Margin Cap

Under the COPA, the operating margin of MHS over any three-year period shall not exceed by more than one percent the mean of the median operating margin of comparable hospitals (provided that this cap will not fall below three percent).¹²

The COPA's Margin Cap covers MHS's margins across its entire scope of operations: inpatient and outpatient, hospital and physician services, and all the geographic regions in which MHS operates. Thus, the scope of this regulation extends well beyond those services and geographies in which the 1995 merger likely significantly increased MHS's market power.

3. The COPA's Physician Employment Cap

Under the COPA, MHS is not permitted to employ, or enter into exclusive contracts with, more than 20 percent of the physicians practicing in Buncombe and Madison counties. This restriction

⁹ As discussed below, I have also considered whether the 1995 merger was likely to have increased concerns that MHS could engage in a vertical foreclosure strategy that might warrant regulatory restrictions relating to physician services.

Although the COPA also includes other regulatory restrictions, I have seen no evidence suggesting that modifications to any of those restrictions is warranted.

¹¹ See Section 4.1 of the COPA.

¹² See Section 4.2 of the COPA.

applies to primary care physicians in each of the three following areas: family practice/internal medicine; general pediatrics; and obstetrics/gynecology.

D. The interplay between cost and margin caps

There exists an important interplay between the COPA's Cost and Margin caps in preventing problems that might otherwise emerge following the creation of significant market power following the 1995 merger. This interplay means that changes to one aspect of the COPA's regulatory structure cannot necessarily be done without regard to how, or whether, other aspects of the COPA's regulatory structure is changed.

The COPA's margin cap helps prevent post-merger price increases that might otherwise result from increased market power. Regulators often use margin caps, rather than price caps, in situations where the regulated firm's costs are likely to change over time in ways that the regulator cannot readily observe: since changes in costs normally warrant changes in a regulated price cap, the lack of cost observability can make a price cap difficult to implement. A margin cap, however, offers the promise of automatically compensating for changes in costs: higher costs allow the regulated firm to impose a comparable price increase while leaving margins unchanged.

A margin cap by itself, however, can be of limited effectiveness in regulating a monopolist. Absent additional regulation, a monopolist can meet its margin cap by simultaneously increasing both prices and costs. Moreover, while this strategy of spending any merger-related revenue increase may at first seem unattractive, in fact such a strategy may be quite attractive – especially for non-profit firms such as Mission Hospital. For example, a non-profit hospital might have an incentive to increase post-merger prices to fund extensive architectural renovations that have little impact on quality of care, increased salaries that may (or may not) allow the hospitals to attract higher-quality employees, or investments in new medical technologies that yield significant consumer benefits (e.g., new operating rooms or new capital equipment). A regulated monopolist hospital may also respond to increased market power by raising prices so that it can fund an expanded scope of services (e.g., expanded outpatient services, offering a new transplant program, or acquiring physician practices) or to extend the geographic region in which it operates.

This incentive for a regulated monopolist to increase costs as a way of relaxing a margin cap can be addressed by imposing a cost cap along with the margin cap. Note, however, that in order to be fully effective, the cost cap needs to be broad enough in scope that it covers all areas that are covered by the margin cap. For example, if the margin cap covers all geographies and services

¹³While I use the economic terminology "monopolist" throughout this report to describe certain economic phenomenon that are relevant to understanding MHS's incentives and the COPA, and while I believe that MHS likely enjoys substantial market power in certain markets, I do *not* mean to suggest that MHS is a monopolist facing absolutely no competition.

(as is the case with the COPA Margin Cap), then a cost cap that is limited to costs relating to inpatient and outpatient services in a particular geography (as is the case with the COPA Cost Cap) will still allow the monopolist to increase inpatient and outpatient prices, yet still meet the margin cap by increasing expenditures relating to physician services or by opening or acquiring facilities in other geographies outside the scope of the Cost Cap.

IV. INCENTIVE PROBLEMS UNDER THE EXISTING COPA REGULATIONS

Economists have long recognized the difficulties of regulating monopolists and how regulation, no matter how carefully crafted and implemented, can inadvertently create undesirable incentive problems. Not surprisingly, some of these incentive problems emerge with respect to the COPA's regulation of MHS.¹⁴ These problems are described below, with recommendations on how the COPA can be modified to address those problems provided in the next section.

A. Incentive problems created by the Cost Cap

The COPA's Cost Cap suffers from two problems. First, the mechanics of how Mission Hospital's costs are calculated creates an incentive (whether or not it is acted upon) for MHS to game the system: by increasing outpatient prices, MHS makes it easier to meet its Cost Cap. Second, the scope of the Cost Cap is too narrow to adequately prevent MHS from raising prices with respect to inpatient or outpatient services at Mission Hospital, and then using those merger-related revenues to expand into other services or geographies.

1. Incentives to raise outpatient prices and expand outpatient services

The COPA's Cost Cap limits Mission Hospital's "cost per adjusted patient discharge" ("CAPD"). The manner in which the COPA defines the CAPD, however, has the effect that Mission Hospital can increase its number of effective calculated outpatient discharges, thus lower the CAPD, by increasing outpatient prices. This can be seen by looking at the specifics by which the CAPD is calculated.¹⁵

- 1) Calculate Mission Hospital's "case mix adjusted discharges" by multiplying its inpatient discharges by its case mix index.
- 2) Calculate Mission Hospital's "revenue per inpatient discharge" by dividing its inpatient revenue by its case mix adjusted discharges (as calculated in (1) above).

¹⁴ It should be stressed that although some of MHS's conduct appears to be consistent with the incentive problems I identify below, I offer no opinion as to whether MHS has actually acted on those incentives. Addressing that question would likely require an extremely fact-intensive investigation.

¹⁵ See Section 4.1 of the COPA.

- 3) Calculate Mission Hospital's "equivalent outpatient discharges" by dividing its outpatient revenue by its revenue per inpatient discharge (as calculated in (2) above).
- 4) Calculate Mission Hospital's "total adjusted discharges" by adding its case mix adjusted discharges and its equivalent outpatient discharges (as calculated in (3) above).
- 5) Calculate Mission Hospital's "cost per adjusted patient discharge " (CAPD) by dividing its operating expenses by total adjusted discharges (as calculated in (4) above).

In essence, the COPA calculates the CAPD by first defining a common measure of volume across both inpatient and outpatient services. The COPA does this by defining a unit of outpatient service (the "equivalent outpatient discharges") as the volume of outpatient services that ends up equalizing inpatient revenue per unit and outpatient revenue per unit. This is illustrated in the Base Case in Table 3 which provides a hypothetical example in which the hospital is assumed to do 1,200 inpatient procedures at a price of \$1,000/procedure, and 800 outpatient procedures at a price of \$800/procedure. Here, the "equivalent outpatient discharges" is calculated so that the price per procedure is equalized at \$1,000 for both inpatient and outpatient procedures. Once outpatient volume is calculated in this way, Table 3 shows how it is straightforward to then calculate the hospital's "cost per adjusted patient discharge" (based on the hospital's assumed costs).

Calculating Mission Hospital's CAPD in this way, however, creates a serious incentive problem. As illustrated in the middle block of Table 3, Mission Hospital can increase outpatient revenue by increasing outpatient prices. That increased outpatient revenue in turn increases the number of "equivalent outpatient discharges" that are calculated according to the COPA methodology. ¹⁶ That increased number of equivalent outpatient discharges will, in turn, increase total adjusted discharges, and thus reduce the calculated CAPD: as illustrated in Table 3, the assumed 20 percent outpatient price increase lowers the CAPD from \$800 to \$762, a reduction of almost 5 percent. Thus, the COPA creates an incentive for Mission Hospital to lower its CAPD, and make it easier to meet the Cost Cap, by raising outpatient prices. ¹⁷

The COPA Cost Cap may also create an incentive for Mission Hospital to increase outpatient volume as a means of lowering the calculated CAPD. Just like an increase in outpatient prices, increased outpatient volumes increase equivalent outpatient discharges. Increased outpatient volume, however, will also increase Mission Hospital's operating expenses. Whether that increase in outpatient volume increases, or reduces, the CAPD will depend how much the increase in outpatient volume increases total expenses. This effect is illustrated in the bottom

¹⁶ In essence, the COPA defines a unit of outpatient services to be equal to \$1,000 worth of outpatient services. If the prices for all individual outpatient services increase, then the actual volume of outpatient services associated with that \$1,000 of outpatient care has to fall. Thus, even with no change in the actual amount of outpatient care, the measured volume of outpatient care (i.e., a package of \$1,000 of outpatient care) will increase.

¹⁷ As discussed in more detail below, the COPA's Margin Cap cannot be relied upon to prevent this increase in outpatient prices.

block of Table 3 which shows how increasing outpatient volume by 20 percent in addition to increasing outpatient prices by 20 percent can further reduce the CAPD.¹⁸

2. Differing scope of the Cost Cap and the Margin Cap

The principal purpose of the Cost Cap is to prevent MHS from meeting its Margin Cap by pairing price increases with an accompanying increase in costs, and thus keeping margins unchanged. Yet, the Cost Cap can only prevent this form of regulatory evasion if the scope of the Cost Cap is as broad as the scope of the Margin Cap.

The COPA's Cost Cap, however, only covers inpatient and outpatient services provided by MHS's Mission Hospital. Thus, while the Cost Cap prevents MHS from spending money relating to post-merger price increases on inpatient and outpatient services in Asheville, the Cost Cap does not prevent MHS from satisfying the Margin Cap by spending merger-related revenues in other areas, e.g., expanding its geographic reach outside Mission Hospital's PSA, or expanding the scope of services it provides in Mission Hospital's PSA.

B. Incentive problems created by the Margin Cap

The COPA's Margin Cap creates several undesirable incentives that should be addressed.

1. The COPA creates incentives for MHS to increases its costs

As discussed, MHS has an incentive to evade the Margin Cap by pairing price increases in markets where it enjoys market power with accompanying cost increases. Moreover, the COPA's Cost Cap cannot be relied upon to prevent these cost increases since the Cost Cap does not cover all services or geographies.

2. The COPA may create an unfair competitive advantage for MHS

The COPA's Margin Cap creates an incentive for MHS to engage in cross-subsidization across markets whereby it raises price in those markets where it has market power, and uses those revenues to subsidize its operations in other more competitive markets. Thus, the Margin Cap creates an incentive for MHS to offer particularly low prices when expanding into new geographic regions (e.g., offering outpatient services in counties other than its PSA) or offering new services. This willingness to offer particularly low prices, while benefitting consumers in the short run, could lead to market distortions and create what might be viewed as an unfair advantage for MHS relative to other competitors.

¹⁸ Mission Hospital has, in fact, been increasing its outpatient revenues more rapidly over time than its inpatient revenues. From 2004 to 2009, Mission Hospital's inpatient gross revenues increased by approximately 57 percent, while its outpatient gross revenues increased by approximately 77 percent. As a result, outpatient services increased from approximately 30 percent of Mission Hospital's gross revenue to 33 percent.

The Margin Cap also creates an incentive for MHS to lower its margin by paying higher-thannormal prices for certain inputs. This might take the form of MHS being willing to pay more than others in competitive bidding for hospitals, for empty land on which to build new facilities, or to outbid rivals when purchasing physician practices.

3. The COPA creates incentives for MHS to expand into low margin markets

The COPA's Margin Cap requires that MHS's average margin across all services and all geographies not exceed a specified margin. MHS, however, can reduce its average margin, and thus make it easier to meet the Margin Cap, by expanding into new services and geographies in which MHS anticipates realizing a lower-than-average margin.¹⁹

The incentive for MHS to expand operations to lower-margin markets is consistent with the observation that, by adding McDowell Hospital and Blue Ridge Hospital to its system, MHS has reduced its average margin subject to the COPA's Margin CAP: as shown in Table 4, by expanding its scope of operations beyond just Mission Hospital, MHS's operating margin falls from approximately 5.1 percent to 4.5 percent. Similarly, the margins at two other hospitals with which MHS is in the process of affiliating (Transylvania Community Hospital and Angel Medical Center) are also likely to be lower than the margin at Mission Hospital. Thus, if either of those two hospitals were eventually acquired by MHS it would likely further reduce the average margin that is currently subject to the Margin Cap.

4. The Margin Cap may provide limited relief for commercial payers

Because Medicare and Medicaid payments to hospitals are largely unaffected by competition, the principal category of payers requiring protection from the reduced competition resulting from the 1995 merger are commercial health plans and their enrollees. The COPA Margin Cap, however, does not distinguish between MHS's margin on commercial accounts versus its margin relating to other patients (e.g., Medicare, Medicaid and self-pay/uninsured). To the extent that Medicare and Medicaid patients represent lower margin business (as generally believed to be the case), then MHS's margin on commercial patients can exceed the Margin Cap, even though MHS's average margin will still meet that Margin Cap.

¹⁹ The COPA's Cost Cap cannot be relied upon to prevent this type of expansion into low-margin services and geographies: as noted above, the COPA's Cost Cap only covers Mission Hospital's inpatient and outpatient services, and would not prevent MHS from expanding into other services (e.g., employing more physicians) or into other geographies.

²⁰ I do not address whether MHS's expansion into these low-margin markets serves some other important public policy goal, e.g. the infusion of necessary capital or helping to ensure that a hospital can remain open.

²¹ Although I do not have data confirming these relative margins, small rural hospitals such as Transylvania Community Hospital and Angel Medical Center frequently face significant financial difficulties, with those financial difficulties oftentimes a reason for why those hospitals seek a relationship with a financially stronger partner.

The greater MHS's share of Medicare and Medicaid patients (or more generally, the greater the share of non-commercial pay patients with low margins), the more that MHS's margin on commercial patients can exceed the regulated Margin Cap. With the COPA's regulated margin cap based on margins at comparable hospitals, ²² then if MHS's payer mix becomes more heavily weighted towards Medicare and Medicaid than those comparable hospitals, MHS will be able to increase prices to commercial payers without exceeding the regulated Margin Cap. ²³

C. The COPA creates incentives for Regulatory Evasion

The COPA creates an incentive for MHS to engage in what economists often refer to as "Regulatory Evasion," a situation in which a regulated monopolist responds to price regulation in one market by instead raising prices in a second unregulated market.²⁴ In the context of the COPA, this evasion can arise if MHS, unable to increase inpatient or outpatient prices because of regulation, instead increases the price it charges for unregulated services such as physician services or services at another facility. If MHS can condition the sale of its regulated inpatient or outpatient services (where it likely has significant market power) on a health insurers' willingness to also purchase its higher-priced unregulated service, then MHS essentially "shifts" the market in which it extracts its higher price.²⁵

The traditional approach to preventing Regulatory Evasion is to attempt to prevent the monopolist from tying its regulated product to some other unregulated problem. If those ties can be prevented, then the monopolist can no longer impose a price increase in the secondary market since consumers no longer need to purchase that higher-priced product as a condition to purchasing the regulated product.

The COPA currently incorporates language that limits MHS's ability to engage in a tie by requiring that MHS "shall not require managed-care plans to contract with its employed doctors

²² See Section 4.2 of the COPA.

According to data provided by MHS, Medicare and Medicaid accounted for approximately 63 percent of its gross revenue in 2008 (increasing slightly to 65 percent in 2010). This is slightly higher than the nationwide average across community hospitals in which Medicare and Medicaid accounted for approximately 56 percent of gross revenue in 2007. (See "The Economic Downturn and Its Impact on Hospitals," The American Hospital Association, January 2009; page 4). It is also higher than the average for hospitals rated by Moody's Investors Service as Aa2 and Aa3 in which Medicare and Medicaid accounted for approximately 48 percent and 50 percent of gross revenue, respectively. These Moody's credit rated hospitals are particularly relevant because the operating margins at these hospitals are used in part to determine the operating margin benchmark specified by Section 4.2 of the COPA. (See "Moody's U.S. Public Finance — Not-for-Profit Hospital Medians for Fiscal Year 2008," Moody's Investors Service, August 2009, page 21).

²⁴ Regulatory evasion can also occur when the second market is regulated, as long as the second market is somehow "less" regulated.

²⁵ It may seem that the solution to Regulatory Evasion is to expand the scope of regulation by extending price (or margin) caps to those secondary markets. Expanding the scope of regulation, however, can create a slippery slope of increased regulatory entanglement in which price (or margin) caps end up being applied to an increasing number of otherwise competitive secondary markets in an effort to prevent the monopolist from finding a market in which it can shift its price increase.

as a precondition to contracting with it or its constituent hospitals."²⁶ This language, however, only succeeds in preventing MHS from tying physician services to its sale of hospital services, while failing to prevent possible ties between Mission Hospital and other MHS services such as outpatient services in other geographies, or inpatient services provided at other MHS hospitals.

D. MHS conduct appears to be consistent with incentive problems

The incentive problems associated with the COPA regulation appear to be consistent with MHS's observed conduct and complaints about MHS's conduct that have been voiced by certain parties.²⁷

1. MHS expansion into other geographies and services

The COPA creates a variety of incentives for MHS to expand its operations into other services and into new geographies. These incentives are consistent with MHS's historical conduct, as well as its possible plans for the future:

- MHS historically expanded its hospital network with the acquisition of Blue Ridge Regional Hospital in Mitchell county and the McDowell Hospital in McDowell county;
- MHS further expanded its hospital network by recently agreeing to manage the operations of Transylvania Community Hospital in Transylvania county;²⁸
- MHS has plans to further expand its hospital network to include Angel Medical Center in Macon county;²⁹
- MHS attempted to expand its scope of hospital operations by bidding to manage the operations of Haywood Regional Medical Center in Haywood county and the WestCare Health System with hospitals in Swain and Jackson counties;³⁰

²⁶ See Section 5.2 of the COPA.

²⁷ It is worth repeating that, while the above-mentioned conduct is consistent with the previously discussed incentive problems created by the COPA, I have not sought to determine the extent to which the COPA likely caused any of that conduct. Yet, even without showing that MHS is necessarily acting on these incentives to any significant degree, it would be prudent to seek to reduce or eliminate those incentive problems.

²⁸ MHS recently announced that it will manage Transylvania Community Hospital and its affiliates as of January 1, 2010. See Mission Health System press release dated December 27, 2010.

²⁹ According to a recent publication, "[o]n May 13, Angel Medical Center's Board of Trustees decided to actively begin exploring a potential partnership with the Asheville-based Mission Health System." See "Angel Medical Center and Mission Health System consider partnership," The Macon County News, May 27, 2010.

³⁶ Press release: "HRMC, WestCare move forward together with Carolinas HealthCare System," Haywood Regional Medical Center (http://www.haymed.org/about/news-and-events/43-main-news/63-hrmc-westcare-move-forward-together-with-carolinas-healthcare-system.html).

- Concerns have been expressed that MHS plans to further expand its scope of employed physicians;
- MHS has plans to engage in a joint venture with Pardee Hospital to construct a new outpatient facility on the Buncombe/Henderson county line;³¹

2. MHS expansion into lower margin services

Consistent with MHS's incentive to expand into lower margin services as a means of lowering its average margin and thus relaxing the margin constraint, MHS continues to expand its relationships with rural hospitals that enjoy lower margins than the rest of MHS's operations.³² This comparison of margins is shown in Table 4.

3. Joint contracting across services and geographies

Regulatory Evasion could be achieved by MHS tying the sale of Mission Hospital's inpatient and outpatient services to the sale of some other more competitively provided service. 'This is consistent with what I understand MHS's contracting practice to be. In particularly, I understand that, while MHS typically enters into separate contracts at separate rates for its different services (e.g., it does not charge the same rates for Mission Hospital as it does for its Blue Ridge hospital), there is at least some degree of informal linkage between these contracts. I also understand that the contracting personnel at MHS and at the managed care plans are generally negotiated concurrently.

4. Concerns about "unfair competition"

In the course of my interviews, some providers have expressed concerns that, as MHS has expanded the geographic scope of the services it offers, those providers will be at a competitive disadvantage. To some extent, this concern may simply reflect a competitor's normal concern that, as a new rival comes to town, there will be some loss of business.³³

Concerns about MHS's entry into new geographic or service markets, however, are also consistent with the fear that MHS is competing on an unequal competitive footing. In particular, concerns about competing with MHS may stem from MHS's potential incentive to cross-

³¹ Press release: "Mission and Pardee Announce Collaboration to Expand Healthcare Services," Mission News, July 1, 2010 (http://www.missionhospitals.org/ body.cfm?id=111&action=detail&ref=141).

³² Policymakers will have to decide whether they view this incentive effect of the COPA as a good, or a bad, thing. While MHS's incentive to acquire those hospitals may reflect a market distortion caused by the COPA, policymakers may ultimately conclude that the benefits of the financial support that MHS provides those hospitals outweighs any harm from that market distortion.

³³ This concern would be heightened if the entrant came to town with a reputation for high quality service and the ability to offer certain services that the incumbent was less capable of offering.

subsidize services and offer lower-than-normal prices on new services so as to avoid exceeding the Margin Cap, or to offer higher-than-normal prices when competing to acquire physician oractices or existing healthcare facilities.

V. ADDRESSING THE INCENTIVE PROBLEMS CREATED BY THE COPA

To address the previously discussed incentive problems, I recommend several modifications to the COPA.

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A. Changing the Margin Cap to a market-specific Price Cap

I recommend that the COPA replace its existing Margin Cap with a Price Cap that limits the annual amount by which an aggregated measure of price can increase. Perhaps the most important reason for recommending this change is that the usual reasons for relying on a margin cap rather than a price cap do not apply here. As previously discussed, economists typically rely on margin caps when a price cap is not workable. This is most often the case when there are likely to be significant unobservable cost changes over time that would otherwise necessitate changes in the price cap. Absent a means to either observe underlying cost changes, or to observe how prices should be changing by looking at other (competitive) markets, a price cap may be impractical. Those impediments to a price cap, however, do not exist here. In particular, price changes over time can be regulated to ensure they do not exceed price increases at comparable hospitals in competitive markets.

Switching from a margin cap to a price cap should improve regulation in several ways. First, a price growth cap is a more direct means of addressing the concern that the 1995 merger created market power that allows MHS to raise price. Second, a price cap eliminates MHS's ability to evade the margin cap by inflating expenses along with prices. Third, a price cap eliminates the incentives that a margin cap can create for cross-subsidization, creating unfair competition, and creating distorting incentives by promoting MHS entry into low-margin markets. Fourth, switching from the Margin Cap to a price cap will make it easier for regulators to focus the regulation on those markets originally affected by the 1995 merger: inpatient and outpatient services at Mission Hospital.³⁴

In designing a new Price Cap for the COPA, the following considerations should apply:

- The Price Cap should regulate rates of change over time, not absolute levels.³⁵
- There should be separate Price Caps that apply to impatient and to outpatient services.

³⁴ This focus would be much more difficult to achieve with a Margin Cap given the difficulties that would arise in allocating costs that were common across a variety of services or different geographies.

³⁵ This approach, unfortunately, locks in any excessive rates that Mission Hospital may already be charging.

- The Price Cap should apply only to those markets originally affected by the merger: inpatient and outpatient services in Mission Hospital's PSA.
- The Price Cap should only apply to, and be calculated with respect to, commercial payers.³⁶ This focus on commercial payers is consistent with the view that the original merger only affected competition for commercial contracts, and thus the regulation should only be directed at controlling price increases to that payer segment.

Calculating Mission Hospital's price for use in a price cap will involve three steps. First, a measure of Mission Hospital's case-weighted output should be defined, separately for inpatient and for outpatient services. Second, Mission Hospital's net patient revenue should be determined, separately for inpatient and for outpatient services. Third, net patient revenue should be divided by case-weighted output to obtain an average case-mix adjusted price across all inpatient services, and across all outpatient services. Increases in these case-mix adjusted prices can then be restricted to not exceed increases of a suitably defined index. 38

Should the State replace the Margin Cap with a Price Cap, the State needs to decide whether that Price Cap should encompass the services that MHS hopes to offer at its proposed joint venture facility to be located on the Buncombe/Henderson county line. ³⁹ As discussed below, a decision not to extend the Price Cap to cover those joint venture services may create strong incentives for MHS to engage in regulatory evasion whereby it seeks to force payers to purchase services from the joint venture but pay prices that exceed competitive levels. Thus, the State's decision not to extend the Price Cap to those services should depend on its comfort that it can prevent such Regulatory Evasion. Ultimately, however, I believe that the State can sufficiently limit concerns regarding Regulatory Evasion so that it is *not* necessary to extend the Price Cap to cover the joint venture's services.

³⁶ I recommend that the Price Cap apply to MHS's net revenues across all commercial payers rather than having the cap apply to each individual payer. A payer-specific Price Cap may be impractical and undesirable for several reasons. First, a payer-specific cap would leave open the question of how much MHS could charge a new payer. If no restrictions applied, the MHS would have strong incentives to charge a very high initial price so that subsequent growth would leave the Price Cap at a very high level. Such incentives would also reduce the likelihood that new payers would seek to enter the Asheville area, an undesirable outcome given the apparently very high payer concentration in the Asheville region. Second, a payer-specific cap would be more difficult to practically implement given that hospital rates to payers typically depend significantly on payer volume.

³⁷ For inpatient services, this can be done in the same way that case-mix adjusted discharges are calculated for purposes of the COPA's Cost Cap (see Section 4.1 of the COPA). For outpatient services, a comparable approach can be used; such approaches are used, for example, by the Centers for Medicare and Medicaid Services for use in the Outpatient Prospective Payment System.

¹⁸ The COPA already uses a Producer Price Index for general medical and surgical hospitals, as well as an index of comparable hospitals (see Section 4.1 of the COPA) in calculating acceptable cost changes.

³⁹ See note 31.

B. Dropping, or revising, the Cost Cap

The principal motivation for the COPA's Cost Cap is to prevent MHS from increasing expenditures as a means of satisfying the Margin Cap. Once the Margin Cap is replaced by a Price Cap, however, the Cost Cap is largely relegated to providing "backup regulation" in the event that the Price Cap is imperfect. Accordingly, as long as the State replaces the COPA's Margin Cap with a Price Cap, the State should consider dropping the COPA's Cost Cap entirely.

Should the State choose to retain the Cost Cap as a type of regulatory backup to the Price Cap, that Cost Cap should be revised to eliminate the incentive that it currently gives Mission Hospital to increase outpatient prices, and possibly expand outpatient volume, as a means of reducing the estimated cost per adjusted patient discharge. As previously noted, this problem stems from how the COPA calculates equivalent outpatient discharges, and it can be addressed by adopting the following two changes.

- Adopt a separate Cost Cap for inpatient services and for outpatient services. Separating the Cost Cap for inpatient and outpatient services means that it is no longer necessary to find a common output measure for both inpatient and outpatient procedures. As previously discussed, this need to find a common measure of output created the incentive for MHS to increase outpatient prices and possibly outpatient volumes.
- Calculate Case-Weighted Outpatient Discharges. Case-weighted outpatient discharges should be calculated in the same way that outpatient volume is calculated when estimating an average outpatient price for use in a new Price Cap.⁴¹

C. Reducing Regulatory Evasion concerns

Replacing the Margin Cap with a Price Cap, and then limiting that Price Cap to just Mission Hospital's inpatient and outpatient services, increases incentives for MHS to engage in Regulatory Evasion in which it would instead raise prices in unregulated secondary markets such as physician services. As mentioned above, this concern may be particularly acute with respect to MHS's proposed joint venture with Pardee Memorial Hospital.

The cleanest means of preventing Regulatory Evasion is to prevent tying, explicit or otherwise. Accordingly, the COPA's existing language prohibiting tying of physician services should be extended to prevent MHS from requiring managed care plans to contract with any of its

This may, however, create certain problems relating to allocation of costs that are common to both impatient and outpatient services, e.g., certain corporate costs, certain facilities costs, and certain capital costs associated with technology that is used for both inpatient and outpatient procedures.

⁴¹ See note 37 above.

employed physicians or any other MHS service provider as a precondition to contracting with Mission Hospital.⁴²

Imposing a regulatory prohibition on tying, however, may be insufficient to completely solve the Regulatory Evasion problem: firms often have a variety of ways of imposing ties that are not clearly in violation of regulatory language. Accordingly, the State should be vigilant in guarding against such tying, whether explicit or implicit, and particularly with respect to the proposed joint venture with Pardee Memorial Hospital where incentives to engage in Regulatory Evasion might be particularly strong.

Should the State become concerned that that a "no tying" restriction will be insufficient to protect against Regulatory Evasion, the State may wish to add language in the COPA that gives the State the option of making such tying more difficult by requiring a contracting firewall between MHS's inpatient and outpatient services at Mission Hospital and the other services it provides. This contracting firewall could include the following elements:

- That the COPA require MHS to establish distinct contracting teams: one of which focuses on MHS's contracts relating to Mission Hospital in Asheville and its operations, the other of which focuses on all other services and geographies (including all physician-related contracts and contracts with McDowell Hospital and Blue Ridge Regional Hospital);
- That the two MHS contracting teams maintain an information firewall to prevent communications or coordination across contracting;
- That MHS does not engage in simultaneous contracting for Mission Hospital and any other MHS service provider (e.g., McDowell Hospital).

The joint venture may also create strong incentives to engage in another form of Regulatory Evasion: substitution of where MHS offers its services: if services offered at Mission Hospital are covered by the price cap, but similar services offered at the joint venture are not covered by the price cap, then MHS has incentives to shift patients from the regulated Mission Hospital to the unregulated joint venture (presuming that MHS can tie the sale of those joint venture services in a way that allows it to realize higher-than-competitive prices at the joint venture). In fact, I understand that an express goal of MHS is to shift the location where it treats many of its patients from Mission Hospital to the new joint venture facility. I note, however, that Mission Hospital argues that such shifting is an important means of improving healthcare quality and access to care given its concern that Mission Hospital has little slack capacity. Thus, by shifting patients, MHS has indicated that it hopes to better serve the community by focusing on more complex care at Mission Hospital while shifting less complex care to other sites that may be closer to where patients actually live. If, however, tying between Mission Hospital and the joint venture can be prevented, then MHS can pursue its goal of shifting patients, and thus benefitting consumers, without raising any concomitant concerns about Regulatory Evasion.

⁴³. The alternative regulatory approach of trying to prevent regulatory evasion by extending price (or margin) regulation into otherwise unregulated secondary markets, however, seems even less attractive and less beneficial to consumers.

The value of a contracting firewall, however, is unclear. In particular, a contracting firewall is a cumbersome regulatory obligation that may create inefficiencies for both payers and MHS. 44 Moreover, even contracting firewalls often fail to operate as cleanly and as effectively as might be wished. As a result, I recommend that, even if the State opts to include language in the COPA regarding contracting firewalls, those firewalls only be imposed if the State concludes that tying is occurring in a way that cannot otherwise be prevented through the "no tying" language of the COPA.

VI. THE COPA'S RESTRICTIONS ON PHYSICIAN EMPLOYMENT

The COPA's restrictions on physician employment do not appear necessary to address concerns that the 1995 merger reduced competition relating to physician services. Those restrictions also appear to be of limited value in preventing a merger-related problem associated with MHS foreclosing competition with rival hospitals by restricting those rival hospitals' access to physicians. As a result, I recommend that the State consider dropping the COPA's Physician Employment Cap, and instead let MHS's acquisitions of physician practices be governed by the same laws and regulations that govern other hospitals.

A. The 1995 merger did not significantly reduce physician competition

At the time of the 1995 merger, neither of the merging Asheville hospitals employed a significant number of physicians. As a result, the merger did not significantly increase Mission Hospital's market power with respect to physician services. It follows that COPA regulation of physician services is not necessary to counter any merger-related creation of market power.⁴⁵

B. The 1995 merger and foreclosure concerns

Physician employment by MHS creates a potential foreclosure concern involving MHS employing physicians as a means of harming rival hospitals. To the extent such foreclosure is deemed possible, and that the 1995 merger increased the either likelihood of, or effects from, such foreclosure, the COPA's Physician Employment Cap may be warranted. As discussed below, however, I have seen little evidence that such foreclosure concerns are sufficiently likely to warrant restrictions on how many physicians MHS can employ.

⁴⁴ My discussions with payers, however, indicate that, despite the inefficiencies that firewalls and sequential contracting will likely create, they tend to either support, or be neutral towards, requiring such a firewall.

⁴⁵ I have also considered whether the merger might have resulted in buy-side market power (typically referred to by economists as "monopsony power"). Yet, even if the merger had created buy-side market power (a supposition for which I have seen no evidence), a cap on physician employment would not be the proper regulatory solution.

1. Foreclosure concerns and rationale for a Physician Employment Cap

In the course of my interviews with different health care providers in WNC, several MHS rivals have expressed a variant of the following type of foreclosure concern. By employing physicians, MHS may be able to cause those physicians to shift their admissions from rival hospitals to MHS (their new employer). By employing enough physicians, MHS might reduce admissions at rival hospitals by so much that those rival hospitals become financially, and thus compressively, weakened. In addition, by employing enough physicians who previously admitted at rival hospitals, MHS might increase the importance of MHS, and reduce the importance of those rival hospitals, to managed care plans. This, in turn, would make it more difficult for those managed care plans to drop MHS hospitals from their network, and thus result in reduced competition. Thus, a cap on the number of physicians that MHS can employ might be necessary to prevent such foreclosure.

The foregoing foreclosure concern is also generally consistent with the COPA's existing Nondiscrimination restrictions. Those restrictions prevent MHS from requiring physicians to render services only at MHS hospitals, consistent with an underlying foreclosure concern. The COPA's nondiscrimination restrictions do not, however, apply to MHS's employed physicians. Thus, the COPA's Physician Employment Cap can be viewed as a complement to the Nondiscrimination restriction by helping to ensure that MHS does not control too many physicians' admitting decisions, and thus cannot put rival hospitals at too much at risk of having MHS cut off their access to the physicians that they rely upon for patients.

2. The likelihood of successful foreclosure by MHS

In order for the foreclosure concern to be appropriately addressed by the COPA (rather than other antitrust or competition laws that address foreclosure concerns), the foreclosure concern should be related to the 1995 merger. The evidence, however, provides little support for the belief that the 1995 merger increased the likelihood that such a foreclosure by MHS would be successful.

The most likely means by which the 1995 merger might have increased foreclosure concerns is that the merger may have given MHS the ability to "force" physicians into employment contracts that they otherwise would rejected.⁴⁸ The evidence, however, suggests that MHS is not in a position where it can force such employment contracts on physicians.

⁴⁶ Whether or not this shift in admitting patterns would occur in reality is unclear. I understand that MHS claims that, for physicians located outside of Buncombe County, it does not necessarily seek to change that physician's admitting patterns. At this point, the empirical evidence relating to such practice acquisitions is too sparse to properly evaluate this issue.

⁴⁷ See Section 6.1 of the COPA.

⁴⁸ Perhaps the only other possible linkage between the 1995 merger and the foreclosure concern is that the 1995 merger likely increased the harm that would likely result from foreclosure (if, in fact, MHS successfully engaged in

- MHS's employment of a physician will have the greatest impact on a rival hospital when that physician admits a significant number of patients to the rival hospital.⁴⁹ Yet physicians that already rely heavily on a rival hospital would be the least vulnerable to pressure from MHS. Conversely, those physicians that are most vulnerable to MHS pressure would be the ones that admit most of their patients to Mission Hospital, meaning that rival hospitals would lose little if those physicians began admitting exclusively to Mission Hospital.⁵⁰
- There have been instances in which MHS has sought to employ a physician, yet that
 physician has turned down MHS's offer and instead remained unaffiliated or else
 affiliated with a different organization.
- One of the factors behind the recent departure of MHS's CEO is that local physicians were unhappy with what they perceived to be excessive pressure from MHS regarding the nature of their affiliation with MHS.⁵¹ Thus, MHS's ability to force employment contracts on local physicians appears quite limited.

C. Restrictions on physician employment may harm consumers

In assessing whether to eliminate the COPA's restrictions on physician employment, the State should consider what, if any, consumer harm may result from those restrictions. Such harm should be balanced against what the previous discussion suggests are limited benefits from those restrictions.

The Physician Employment Cap may cause harm in several ways. First, unnecessarily regulating MHS with respect to physician services may effectively handicap MHS in its ability to compete

a foreclosure strategy). The 1995 merger increases the harm from foreclosure since, by significantly reducing competition for inpatient hospital services, further reductions in competition due to foreclosure would likely be even more problematic. This linkage between the 1995 merger and the foreclosure concern, however, appears to be a relatively tenuous basis for using the COPA to guard against foreclosure rather than existing antitrust laws that would also prohibit such conduct.

⁴⁹ This suggests, however, that the COPA's Physician Employment Cap may be targeting the wrong physicians: rather than limit MHS's employment of primary care physicians in Buncombe and Madison counties — physicians that are already typically admitting almost exclusively to Mission Hospital — the cap should perhaps apply instead to physicians in the outlying counties that are more likely to otherwise be admitting to Mission Hospital's rival hospitals.

⁵⁰ Consider, for example, data on the admitting patterns for the top 50 physicians at one of Mission Hospital's local hospital rivals. These physicians, who collectively accounted for approximately 99 percent of all inpatient admissions at that hospital, made *no* admissions to Mission Hospital. Absent admissions to Mission Hospital, MHS is unlikely to have significant leverage over those physicians.

⁵¹ See "Trauma Center," Business North Carolina, April 2010 and "Mission Exit Reflects Trend," Asheville Citizen-Times, November 1, 2009.

with other health care providers.⁵² At least one payer I spoke to indicated that many physician practices in the WNC region were likely to be acquired in the future – either by a larger physician group, another hospital, or another health system (e.g., Novant Health or the Carolinas Healthcare System). A view was expressed that, of all these possible suitors for a physician practice, MHS might be the most desirable.

Second, preventing MHS from acquiring certain physician practices will reduce physicians' options. In some cases, this may mean that physicians leave the region (or decide not to come to the region in the first place). For physicians intent on selling their practice, the elimination of MHS as a potential bidder for that practice may significantly reduce the value that physicians receive for their practice.

Third, the Physician Employment Cap may preclude MHS from bringing new physicians to town. Bringing new physicians to town, however, is the type of output expansion that is likely to be procompetitive. The current Physician Employment Cap, however, would prohibit such recruitment of new physicians if it ended up pushing MHS over the 20 percent cap.⁵³

Perhaps most important, to the extent that MHS can successfully integrate its acquired physicians in a way that will lower overall healthcare costs and increase quality, then preventing MHS from acquiring those physician practices could end up denying consumers the benefits of lower prices and better outcomes.⁵⁴

D. Balancing likely benefits and harm from the Physician Employment Cap

Balancing the potentially significant downsides to the Physician Employment Cap against the weak merger-related justifications, I recommend that the Physician Employment Cap be dropped from the COPA.

⁵² According to the American Hospital Association, 65 percent of community hospitals are making efforts to increase the number of employed physicians. See "The State of America's Hospitals — Taking the Pulse, Results of AHA Survey of Hospital Leaders," March/April 2010, The American Hospital Association.

⁵³ The COPA contains provisions by which MHS can appeal the cap (see Section 8.3 of the COPA). Yet, even if an appeal were possible, the need to go through the appeal process likely constitutes a significant disincentive to pursue such physician recruitment.

See, for example, articles co-authored by MHS's new CEO, Ronald A. Paulus, M.D., that describe benefits that he helped to achieve at the Geisenger Clinic which pursued an active strategy of physician integration ("Continuous Innovation In Health Care: Implications Of The Geisinger Experience," Ronald A. Paulus, Karen Davis, and Glenn D. Steele, Health Affairs, Volume 27, Number 5, September/October 2008, pages 1235 to 1245; "How Geisinger's Advanced Medical Home Model Argues The Case For Rapid-Cycle Innovation," Ronald A. Paulus et al., Health Affairs, November 2009, pages 2047 to 2053; "ProvenCare - A Provider-Driven Pay-for-Performance Program for Acute Episodic Cardiac Surgical Care," Ronald A. Paulus et al., Annals of Surgery, Volume 246, Number 4, October 2007, pages 613 to 623; "The Electronic Health Record and Care Reengineering: Performance Improvement Redefined, Ronald A. Paulus et al., Redesigning the Clinical Effectiveness Research Paradigm: Innovation and Practice-Based Approaches: Workshop Summary, National Academy of Sciences, 2010, pages 221 to 265; "Value and the Medical Home: Effects of Transformed Primary Care," Ronald A. Paulus et al., The American Journal of Managed Care, Volume 16, Number 8, August 2010, pages 607 to 615.).

Should the Physician Employment Cap be retained, however, the State should consider adjusting that cap in a number of regards, including expanding the scope (both with respect to covered specialties and covered geographies), and allowing for exceptions relating to single-practice physician groups or for physicians that move into the Asheville area. The State should also require additional documentation by which MHS demonstrates its compliance with this aspect of the COPA regulation.

E. Other laws limit hospitals' ability to employ physicians

Dropping the Physician Employment Cap from the COPA will not leave MHS free to acquire as many physician practices as it likes. Rather, even though no longer subject to the COPA's restrictions, MHS will be subject to the same regulatory and legal constraints facing any other party with respect to acquiring competing physician practices.⁵⁵

The extent to which MHS can acquire more physician practices without running afoul of existing antitrust laws will depend on the extent to which MHS can show that the likely benefits of such acquisitions will outweigh the likely competitive harm. MHS can then decide for itself whether to increase its share of physicians above 20 percent of the market, with that decision based in part on whether it believes such acquisitions will prompt an antitrust investigation and its expectations about the likely outcome of any such investigation.

⁵⁵ I assume that MHS will not be able to avoid such constraints by claiming some type of State Action exemption.

⁵⁶ See, for example, The U.S. Department of Justice/Federal Trade Commission 1996 Statements of Antitrust Enforcement Policy in Health Care. The potential costs and benefits of allowing greater physician concentration are also actively being debated in the context of policy discussions about Accountable Care Organizations ("ACOs") See, for example, the October, 2010 volume of Competition Policy International, including the following articles: Braun, C., "Clinical Integration: The Balancing of Competition and Health Care Policies;" Fischer, A. and Marx, D., "Antitrust Implications of Clinically-Integrated Managed Care Contracting Networks and Accountable Care Organizations;" and Vistnes, G., "The Interplay Between Competition and Clinical Integration: Why the Antitrust Agencies Care About Medical Care."

Table 1: Mission Hospital County-Level Market Shares Over, Time in Western North Carblina

	Total Patient	•	Mission	Hospital's Sh	Mission Hospital's Share of Patients	S	21.11.1
٠	Count	2005	2006	2007	2008	2009	1st Half 2010
o-quadratic d	76.045	86.3%	86.9%	87.3%	87.8%	89.6%	%3,06
	12.740	22.1%	22.7%	23.8%	25,3%	29,6%	36.4%
Heriderson	10.548	5.3%	6,7%	5.8%	6.1%	5.8%	2.8%
Durke	8,613	5.9%	6.3%	6.7%	8.0%	7.2%	7,2%
Take to the second	8,298	28.7%	27.2%	28.4%	35,9%	33,5%	32.8%
Monowall	5,131	31.5%	33,3%	32.9%	34,4%	37,8%	35.8%
יי מאסטריו	3,807	17.5%	21.1%	21.5%	24,5%	27.3%	28.8%
Jackson Jackso	3.734	27,5%	31.0%	27.8%	31.0%	. 29.3%	29.6%
Transvivania	3,523	32.1%	32.4%	32,0%	35.4%	34,6%	35.8%
) Laileyivaina	2,671	18.8%	17.9%	20.0%	19.2%	18,5%	19.8%
Ciletonea Ciletonea	767 6	22.7%	21.6%	24.4%	26.2%	26.8%	23.7%
owall Zanov	2.329	45.5%	49,4%	48.6%	47.5%	50.2%	49.5%
rancey	2.172	88.9%	89,9%	88.5%	89.7%	80.8%	91.2%
Madiodil	2,138	27,4%	29.1%	28,0%	25.7%	28.1%	29.6%
וופורל: אלי ה	1.790	11.9%	15.7%	14.5%	17.2%	16.6%	18.0%
Graham	1,116	22.3%	26.6%	24.4%	26.4%	27.5%	29.2%
Clay	916	20.8%	20,4%	20,2%	19.7%	21.4%	21.6%

Note: * Total Patient Count represents the number of patients that reside in the county.

Sources:

Patient Shares 2005 to 2008: Second Amended and Restated Certificate of Public Advantage Periodic Report, September 30, 2009, Mission Hospital, Inc.

Patient Shares 2009 to June 2010; Thompson Reuters, Inpatient Data for North Carolina.

Table 2: Short-Term Acute Care and Critical Access Hospitals in Western North Carolina

Average Patients Activating Activating Activations Activation Activations Hospital Type Beds Patients Activations Buildownibe Aşheville Acute Care 49 16 16 16 NocDowell Marion Acute Care 49 22 28 28 y Hospital Transylvania Brevard Critical Access 35 17 22 28 y Hospital Transylvania Brevard Critical Access 35 17 22 28 y Hospital Transylvania Brevard Critical Access 35 17 22 28 y Hospital Transylvania Acute Care 184 59 58 58 42 <t< th=""><th></th><th></th><th>į</th><th></th><th></th><th></th><th># of Physicians</th><th>Distance in Miles</th></t<>			į				# of Physicians	Distance in Miles
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Introduction Acute Care 49 16 16 MotDowell Marion Acute Care 49 22 28 spital Transylvania Brevard Critical Access 35 17 22 spital Transylvania Brevard Critical Access 35 17 22 Cherokee Murphy Acute Care 184 59 56 Cherokee Murphy Acute Care 143 63 42 Burk Connellys Springs Acute Care 131 27 26 Burk Connellys Springs Acute Care 131 27 26 Burk Connellys Springs Acute Care 121 62 37 Acute Care 131 27 26 37 Macon Highlands Critical Access 16 43 42 Henderson Hendersonwille Acute Care 86 43 42 Polk Columbus Critical Access <t< td=""><td>Jospital-Name</td><td>Gounty</td><td>Asheville</td><td>Acute Care</td><td>728</td><td>522</td><td>. 342</td><td>0 .</td></t<>	Jospital-Name	Gounty	Asheville	Acute Care	728	522	. 342	0 .
pittal Transylvania Brevard Critical Access 35 17 22 spital Transylvania Brevard Critical Access 35 17 22 Henderson Henderson Hendersonville Acute Care 190 27 58 Cherokee Murphy Acute Care 190 27 22 Burk Morganton Acute Care 143 63 42 Rutherford Rutherford Rutherfordon Acute Care 131 27 26 Burk Connellys Springs Acute Care 131 27 26 Burk Connellys Springs Acute Care 121 62 37 Jackson Highlands Chilical Access 104 7 7 7 Henderson Ville Acute Care 86 43 42 Handerson Sylva Acute Care 86 43 6 Polik Columbus Critical Access 25 17 16 Cun	Mission Hospital	Mar Dawell	Marion	Acute Care	48	16	16	35
pital Transylvania Brevard Critical Access 35 17 22 Cherokee Murphy Acute Care 190 27 22 Cherokee Murphy Acute Care 190 27 22 Cherokee Murphy Acute Care 184 59 56 Burk Conneilys Springs Acute Care 143 63 42 Rutherford Rutherford Acute Care 131 27 26 Burk Conneilys Springs Acute Care 121 62 37 Jenier Hendersonville Acute Care 98 43 42 Henderson Hendersonville Acute Care 96 43 42 Jackson Sylva Acute Care 66 43 33 Jackson Franklin Critical Access 25 15 6 Acute Franklin Critical Access 24 6 6	The McDowell Hospital	Michell	Sunice Pine	Acute Care	. 49	22	28	51
Henderson Hendersonville Acute Care 216 72 58 Charokee Murphy Acute Care 190 27 22 Charokee Murphy Acute Care 184 59 56 Burk Morganton Acute Care 143 63 42 Ruthèrford Rutherfordton Acute Care 131 27 26 Burk Connellys Springs Acute Care 131 27 26 Jenier Haywood Cylde Acute Care 121 62 37 Henderson Highlands Critical Access 104 7 7 7 Henderson Mile Acute Care 98 43 33 33 Jackson Sylva Acute Care 86 43 33 Macon Franklin Critical Access 25 15 6 Acvie Brysan City Critical Access 24 6 6	Slue Ridge Regional Hospital	Transvivania	Brevard	Crilloal Access	35	17	22	29
Cherokee Murphy Acute Care 190 27 22 Burk Morganton Acute Care 184 59 56 Rutherford Rutherfordson Acute Care 131 27 26 Burk Connellys Springs Acute Care 131 27 26 Jenter Haywood Cylde Acute Care 121 62 37 Henderson Highlands Critical Access 104 7 7 7 Henderson Highlands Critical Access 98 43 42 Jackson Sylva Acute Care 96 43 33 Jackson Sylva Acute Care 86 43 33 Macon Franklin Critical Access 25 17 16 Acvel Franklin Critical Access 24 6 6	וייין אייין אייין אייין אייין אייין אייין אייין אייין אייין אייין אייין אייין אייין אייין אייין אייין אייין אייי	Henderson	Hendersonville	Aoute Care	216 .	72	58.	27
Burk Morganton Acute Care 184 59 56 Rutherford Rutherfordton Acute Care 143 53 42 Burk Connellys Springs Acute Care 131 27 26 Jenlar Haywood Cylde Acute Care 121 62 37 Henderson Highlands Critical Access 104 7 7 7 Henderson Hendersonville Acute Care 98 43 42 Jackson Sylva Acute Care 86 43 33 Jackson Critical Access 35 15 5 Macon Franklin Critical Access 25 17 16 Sweln Bryson City Critical Access 24 6 6	Jaroee mospilal Jumbiy Modfool Confor	Cherokee	Murphy	Acute Care	. 190	27	. 22	111
Rutherford Rutherford Care 143 63 42 Burk Connellys Springs Acute Care 131 27 26 Jenler Haywood Cylde Acute Care 121 62 37 Henderson Highlands Critical Access 104 7 7 7 Henderson Highlands Critical Access 98 43 42 Jackson Sylva Acute Care 86 43 33 Jackson Sylva Acute Care 86 43 33 Poik Columbus Critical Access 35 15 5 Macon Franklin Critical Access 25 17 16 Sweln Bryson Cily Critical Access 24 6 6	Murphy Medical Collect	Birrk	Morganton	Acute Care	184	59	56	. 58
Burk Connellys Springs Acute Care 131 27 26 Jenier Haywood Cylde Acute Care 124 62 37 Macon Highlands Critioal Access 104 7 7 7 Henderson Highlands Critioal Access 98 43 42 Jackson Sylva Acute Care 86 43 33 Jackson Sylva Acute Care 86 43 33 Macon Franklin Critical Access 35 15 5 Acvelin Bryson City Critical Access 24 6 6	stace nospijal	Rutherford	Rutherfordton	Acule Care	143	. 63	42	57
Jenter Haywood Cylde Acute Care 121 62 37 Macon Highlands Critical Access 104 7 7 Henderson Hendersonville Acute Care 98 43 42 Jackson Sylva Acute Care 86 43 33 Polik Columbus Critical Access 35 15 5 Macon Franklin Critical Access 25 17 16 Sweln Bryson City Critical Access 24 6 6	Aumenora-nospiral	Burk	Connellys Springs	Acufe Care	131	27	. 56	. 65
Macon Highlands Chilloal Access 104 7 7 Henderson Henderson Highlands Chilloal Access 98 43 42 Jackson Sylva Acute Care 86 43 33 Polk Columbus Critical Access 35 15 5 Macon Franklin Critical Access 25 17 16 Sweln Bryson City Critical Access 24 6 6	Valdese ribspiral	Hessmood	Cylde	Acute Care	121	62	37	. 27
Henderson Henderson Wills Acute Care 98 42 42 Jackson Sylva Acute Care 86 43 33 Polk Columbus Critical Access 35 15 5 Macon Franklin Critical Access 25 17 16 Sweln Bryson Cily Critical Access 24 6 6	Haywood Kaglonal Medical Certical	Macon	Highlands	Critical Access	104	2	7	67
Jackson Sylva Acute Care 86 43 33 Polik Columbus Critical Access 35 17 16 Macon Franklin Critical Access 25 17 16 Couling Critical Access 24 6	igniands-casmiels nospital .	Henderson	Hendersonville	Acule Care	86	. 43	42	- 15
Polk Columbus Critical Access 35 15 5 Macon Franklin Critical Access 25 17 16 Swaln Bryson Cilv Critical Access 24 6	Jark Kloge Hospital	Jackson	Sylva	Acute Care	99	43	. 33	47
Macon Franklin Critical Access 25 17 16	Halfis Regional Hospital	. Alod	Columbus	Crilical Access	35	7	5	66
Swah Bryson Cily Critical Access 24 6	Salli Luna & Hospital	Macon	Franklin	Critical Access	25	17	.91	. 69
Ostani	Swein County Hospital .	Swaln	Brysan City	Critical Access	24	ප	9	99

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American Hospital Directory (ahd.com), November 8, 2010. Thompson Reuters, Inpatient Data for North Carolina.

^{*} An active physician is defined as any physician with at least 12 admissions in the 12-month period ending June 30, 2010 based on State Inpatient data provided by Thompson Reuters.
The Asheville VA Medical Center and the Cherokee Indian Hospital have been excluded from the table because these facilities are primarily government funded.

Table 3: The COPA's Cost Cap Methodology - Illustrative Example

Volume procedure Revenue Procedure Inpatient Procedures 1,200 1,200,000 800 Outpatient Procedures 800 600 480,000 400 "Equivalent Outpatient Discharges" 480 1,000 1,680,000 "Total Adjusted Discharges" 1,680 1,000 1,000
20% Increase in Outpatient Price and Volume "Price" per Total Cost per Volume Procedure Revenue Procedure B00 1,200,000 800 800 Outpatient Procedures 960 600 576,000 400 TOTAL TOTAL 1,776,000 1,776,000 1,776,000 1,776,000 1,776,000 1,776,000 1,776,000 1,776,000 1,776,000 1,776,000 1,776

Table 4: Mission Health System Operating Income For the year ending September 30, 2009

	Total	Operating	
	Revenue	Income	Income Margin
	(\$000)	(000\$)	
Mission Health Inc.	897,742	40,391	4.5%
Individual Components of Mission Health Inc.:			
Mission Hospital, Inc.	. 805,191	41,281	. 5.1%
McDowell Hospital. Inc.	33,980	(2,080)	(6.1%)
Blue Ridge Regional Hospital, Inc.	39,410	. 530	1.3%
	19,161	099	3.4%

Source:

Mission Health System, Inc. and Affiliates, Combined Financial Statements and Schedules, September 30, 2009 and 2008, KPMG, page 32.

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Appendix

GREGORY S. VISTNES

Vice President

Ph.D. Economics, Stanford University

M.A. Economics, Stanford University

B.A. Economics, University of California at Berkeley (with High Honors)

Dr. Vistnes is an antitrust and industrial organization economist who works in a broad array of industries, including financial services, insurance, defense and aerospace, medical equipment, chemicals, software, energy, pharmaceuticals, steel, and various retail and industrial products. Dr. Vistnes is also an expert in the healthcare industry where he has frequently testified, published, and spoken at professional conferences.

In the course of his work, Dr. Vistnes regularly presents his analyses to the U.S. Department of Justice (DOJ) and the U.S. Federal Trade Commission (FTC). He also provides economic analyses for clients involved in private antitrust litigation, for clients involved in matters before state attorney generals, and for firms interested in anticipating the competitive implications of alternative strategies. Dr. Vistnes has also provided expert testimony in a variety of antitrust matters, both on behalf of private sector firms and government antitrust agencies.

Prior to joining CRA International, Dr. Vistnes was the Deputy Director for Antitrust in the Federal Trade Commission's Bureau of Economics. In that position, he supervised the FTC's staff of approximately 40 Ph.D.-level antitrust economists and directed the economic analysis of all antitrust matters before the FTC. Before that, he served as an Assistant Chief in the Antitrust Division of the U.S. Department of Justice. At both the FTC and DOJ, Dr. Vistnes headed analytical teams responsible for investigating pending mergers and acquisitions or alleged anticompetitive behavior. As part of his duties, he regularly advised key agency decision makers, including FTC commissioners and the Assistant Attorney General for Antitrust.

REPRESENTATIVE PROJECTS AND INDUSTRY EXPERTISE

- Real Estate. Dr. Vistnes served as the testifying expert for the DOJ in their multi-year litigation U.S. v. National Association of Realtors (NAR) regarding NAR's rules on how real estate brokers could use the Internet to compete. Dr. Vistnes has also testified before several states regarding competition the title insurance industry, and worked on several mergers (e.g., Fidelity/LandAmerica) involving title insurance providers.
- Aftermarkets. Dr. Vistnes testified before a jury in the Static Control Components v. Lexmark International litigation relating to replacement toner cartridges for laser printers. The jury agreed with Dr. Vistnes' opinion that the evidence showed that the aftermarket of replacement toner cartridges was the appropriate relevant market.

- Insurance and Financial Services. Dr. Vistnes has testified and provided analyses to both state and federal competition authorities regarding mergers of both insurance carriers (e.g., MetLife/Travelers) and insurance brokers (e.g., Aon/Bentield). Dr. Vistnes has also analyzed price fixing claims regarding initial public offerings (IPOs) and private equity firms.
- Healthcare and Medical Products and Equipment. Dr. Vistnes has provided court testimony
 and economic analyses relating to hospital mergers, hospital certificate of need
 applications, health plan mergers, and physician conduct. He has also provided analyses
 and testimony related to mergers and conduct issues relating to MRI providers, medical
 products and equipment, and medical technology.
- Computer Software and Technology. Dr. Vistnes has provided economic analyses in several software mergers that helped the merging parties avoid a second request by the government. Examples include matters involving software that provides security for internet websites; billing software used by large health plans; and the provision of electronic business-to-business services between trading partners.
- Energy. Dr. Vistnes has provided economic analyses of several antitrust matters in
 different sectors of the energy industry, including the oil, electricity, gas pipelines and gas
 storage sectors. In addition to overseeing the FTC's economic analyses of mergers such
 as BP/Arco and Mobil/Exxon, Dr. Vistnes has also presented his analyses to the
 Department of Justice regarding price fixing claims in this industry.
- Price Fixing Cases. Dr. Vistnes has provided analyses and reports regarding price fixing cases in the chemicals industry. Dr. Vistnes' work in these matters helped to determine the relevant scope of products affected by the alleged conspiracy, the time periods over which price effects may have arisen, and the magnitude of any damages associated with the conspiracy. Dr. Vistnes' work in this area has been used both in presentations to the Department of Justice and in private litigation.

PROFESSIONAL EXPERIENCE

2000-Present Vice President, CRA International, Washington, D.C.

Dr. Vistnes' work focuses on analyzing antitrust and competition issues such as:

- · Horizontal and vertical mergers;
- Contractual provisions such as exclusivity provisions, most favored customer clauses, bundling provisions, and price discount schedules;
- Intellectual property and antitrust;
- Price fixing and conspiracy allegations;
- · Class action litigation.

1997-2000

Deputy Director for Antifrust, Bureau of Economics, U.S. Federal Trade Commission, Washington, D.C.

- · Directed the economic analyses of all antitrust matters before the Commission.
- Briefed Commissioners and the Director of the Bureau of Economics regarding all antitrust matters before the Commission, including mergers, vertical restraints, and joint ventures.
- Advised the Commission on whether to challenge mergers or other anticompetitive activities.
- Developed strategies for the investigation and litigation of antitrust matters before the Commission.
- Directed the FTC's antitrust staff of 55 Ph.D. economists, managers, and support staff.

1996-1997

Assistant Chief, Economic Regulatory Section, Antitrust Division, U.S. Department of Justice, Washington, DC.

- Directed economic analyses at the Antitrust Division in the health care and telecommunications industries;
- Briefed the Assistant Attorney General and Deputies on the economic aspects of health care and telecommunications matters;
- Played a key role in writing the 1996 Department of Justice/Federal Trade Commission's Statements of Antitrust Enforcement Policy in the Health Care Area;
- Led the Antitrust Division's economic analyses of hospital and HMO mergers and/or joint ventures in the health care industry;
- Directed the economic analyses of Bell Operating Company mergers;
- Headed DOJ's economic assessment of the conditions under which Bell Operating Companies should be allowed to enter into long-distance markets;
- Directed the economic analyses of the wave of radio station mergers following passage of the 1996 Telecommunications Act.

1995-1996

Manager, Health Care Issues Antitrust Division, U.S. Department of Justice, Washington, DG.

Directed the economic analyses of all health care matters at the Division.

1990-1995

Staff Economist, Antitrust Division, U.S. Department of Justice, Washington, DC.

- Analyzed antitrust and competition-related matters in the health care, entertainment, natural resources, and industrial machinery industries;
- Designated as the Antitrust Division's economic testifying expert in numerous hospital mergers;
- Analyzed hospital and HMO mergers, physician joint ventures, healthcare information exchanges, and physician/hospital affiliations and mergers;
- Played a key role in writing the 1993 and 1994 Department of Justice/Federal Trade Commission's Statements of Antitrust Enforcement Policy in the Health Care Area;
- Designated as DOJ's Economic Representative to President Clinton's 1993
 White House Task Force on Health Care Reform.

1988-1990

Economic Consultant, Putnam, Hayes and Bartlett, Washington, DC.

- · Analyzed health care matters;
- Wrote strategy reports for clients interested in directing the course of health care reform at the local and federal levels;
- Developed pricing methodologies to promote competition in the electric utility industry.

1987-1988

Visiting Professor, Department of Economics, University of Washington, Sealtle.

 Taught graduate and undergraduate health care economics, industrial organization & strategic firm behavior, and intermediate price theory.

SELECTED INDUSTRY EXPERTISE

- Healthcare
- Chemicals
- Insurance
- Software
- Financial Markets
- Pharmaceuticals
- Supermarkets
- Aerospace and Defense
- Medical Equipment and Services
- Energy

ORAL TESTIMONY

Wendy Fleischman, et al. v. Albany Medical Center, et al., U.S. District Court, Northern District of New York (Case No. 06-CV-0765/TJM/DRH), July 2009 and January 2010. [Deposition testimony on behalf of plaintiff class]

Pat Cason-Merenda et al. v. Detroit Medical Center, et al., Eastern District of Michigan, Southern Division (Case No. 06-15601), April 2009. [Deposition testimony on behalf of plaintiff class]

Munich Reinsurance Group Application for the Acquisition of Control of Hartford Steam Boiler. Testimony before the Commissioner of Insurance of the State of Connecticut, March 2009. [Oral hearing testimony on behalf of Munich Reinsurance Group]

United States of America v. National Association of Realtors. U.S. District Court (Northern District of Illinois – Eastern Division), July 2007 and December 2007. [Deposition testimony on behalf of the U.S. Department of Justice]

Funeral Consumers Alliance, Inc., et al. v. Service Corporation International, et al.. U.S. District Court (Southern District of Texas), Civil Action 3H-05-3394, July 2007. [Deposition testimony on behalf of Funeral Consumers Alliance, Inc.]

Static Control Components v. Lexmark International. U.S. District Court (Eastern District of Kentucky at Lexington), June 2007. [Trial and deposition testimony on behalf of Static Control Components, Wazana Brothers International and Pendi Companies]

Saint Alphonsus Diversified Care, Inc. v. MRI Associates, LLP; and MRI Associates, LLP v. Saint Alphonsus Diversified Care, Inc. and Saint Alphonsus Regional Medical Center. District Court for the Fourth Judicial District of the State of Idaho, May 2007. [Deposition testimony on behalf of Saint Alphonsus Regional Medical Center]

Louisiana Municipal Police Employees' Retirement System, et al., v. Crawford, et al., and Express Scripts, Inc. v. Crawford, et al. Del. Ch., C.A., No. 2635-N and 2663-N, February 2007. [Deposition testimony on behalf of Caremark Rx, Inc.]

MetLife, Inc. Application for the Acquisition of Control of The Travelers Insurance Company. Testimony before the Commissioner of Insurance of the State of Connecticut, June 2005. [Oral hearing testimony on behalf of MetLife]

Group Hospitalization and Medical Services, Inc. (GHMSI)/CareFirst Hearing. Testimony before the Department of Insurance, Securities and Banking, Washington, DC, March 2005. [Oral hearing testimony and written report on behalf of GHMSI]

Holmes Regional Medical Center, Inc. v. Agency for Health Care Administration and Wuesthoff Memorial Hospital, Inc., State of Florida Division of Administrative Hearings, Tallahassee, FL, December 2004. [Trial and deposition testimony on behalf of Holmes Regional Medical Center]

Application of The St. Paul Companies for the Acquisition of Control of Travelers Property and Casualty Corp. Testimony before the Commissioner of Insurance of the State of Connecticut, February 2004. [Oral hearing testimony on behalf of The St. Paul Companies and Travelers]

Anheuser-Busch Companies, Inc. Metal Container Corporation, and Anheuser-Busch, Inc. v. Crown Cork & Seal Technologies Corporation. U.S. District Court (Western District of Wisconsin), October 2003. [Deposition testimony on behalf of Crown Cork & Seal]

Wal-Mart Stores v. the Secretary of Justice of the Commonwealth of Puerto Rico. U.S. District Court (District of Puerto Rico), December 2002. [Trial testimony on behalf of Wal-Mart]

United States v. North Shore Health System and Long Island Jewish Medical Center. U.S. District Court (Eastern District of New York), August 1997. [Trial and deposition testimony on behalf of the U.S. Department of Justice]

SELECTED EXPERT REPORTS AND WRITTEN TESTIMONY

Yakima Valley Memorial Hospital v. Washington State Department of Health, U.S. District Court, Eastern District of Washington (Case CV-09-3032-EFS). Expert report submitted on behalf of Yakima Valley Memorial Hospitals, April 2010.

DAW Industries, Inc. v. Hanger Orthopedic Group and Offo Bock Healthcare, U.S. District Court, Southern District of California (Case 06-CV-1222 JAH (NLS)). Expert report submitted on behalf of Ofto Bock Healthcare, May 2009.

Hometown Health Plan, et al., vs. Aultman Health Foundation, et al., Court of Common Pleas, Tuscarawas County, OH (Case No. 2006 CV 06 0350). Expert report submitted on behalf of Hometown Health Plan, March 2008.

Texas Title Insurance Biennial Hearing, Docket Nos. 2668 and 2669. Pre-filed direct testimony on behalf of Fidelity National Financial, Inc., January 2, 2008.

An Economic Analysis of Competition in the Title Insurance Industry. Report on behalf of Fidelity National Financial, Inc., submitted to the US GAO, March 20, 2006.

The St. Paul Companies/Travelers Property and Casualty Corp Merger. Expert report on behalf of St. Paul and Travelers, submitted to the California Department of Insurance, February 2004.

Granite Stone Business International (aka Eurimex) v. Rock of Ages Corporation. International Court of Arbitration, ICC Arbitration No. 11502/KGA/MS. Expert reports submitted on behalf of Granite Stone Business International, October 2002 and March 2003.

General Electric/Honeywell Merger. Expert reports (co-authored with Carl Shapiro and Patrick Rey) on behalf of General Electric, submitted to the U.S. Department of Justice and the European Commission, 2001.

United States and State of Florida v. Morton Plant Health System, Inc., and Trustees of Mease Hospital. U.S. District Court (Middle District of Florida – Tampa Division). Expert report on behalf of the U.S. Department of Justice, May 1994.

SELECTED PRESENTATIONS

"Interpreting Evidence Regarding Price Effects in Consummated Mergers," ABA Spring Meetings, Washington, DC, April 2010.

"Are There Different Rule of Reason Tests for Vertical and Horizontal Conduct?" ABA Joint Conduct Committee, teleconference presentation, June 2009.

"The Economics of Information Sharing and Competition," ABA Section on Business Law, Vancouver, BC, April 2009.

"United States versus the National Association of Realtors: The Economic Arguments and Implications for Trade Associations," ABA Spring Meetings, Washington, DC, March 2009.

"The Use of Price Effects Evidence in Consummated Merger Analysis," ABA Section of Antitrust Law, teleconference presentation, February 2009.

"Competition in the Title Insurance Industry – An Economic Analysis." National Association of Insurance Commissioners, Washington, DC, June 2006.

"Antitrust Issues in the BioTech Industry." Biotech Industry Organization BIO 2005 International Meetings, Philadelphia, June 2005.

"Cartels and Price Fixing - Ensuring Consistency Between Theory and the Facts." The Use of Economics in Competition Law, Brussels, January 2005.

"Intellectual Property and Antitrust in High-Tech Industries." ABA Section on Business Law, Atlanta, August 2004.

"Antitrust, Intellectual Property and Innovation." Biotech Industry Organization BIO 2004 International Meetings, San Francisco, June 2004.

"Quality, Healthcare and Antitrust." Petris Center/UC Berkeley Conference on Antitrust and Healthcare, University of California at Berkeley, April 2004.

"Unilateral Effects - Be Careful What You Wish For." Second Annual Merger Control Conference, The British Institute of International and Comparative Law, London, December 2003.

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"Trade Barriers and Antitrust: Foreign Firms - Down But Not Out." Antitrust Issues in Today's Economy, The Conference Board, New York City, March 2003.

"Bundling and Tying: Antitrust Analyses in Markets with Intellectual Property." Department of Justice/Federal Trade Commission Joint Hearings on Intellectual Property and Antitrust, Washington, DC, May 2002.

"Practical Issues in Intellectual Property Investigations: Balancing Rules versus Discretion." Department of Justice/Federal Trade Commission Joint Hearings on Intellectual Property and Antifrust, Washington, DC, May 2002.

"Bundling and Tying: Recent Theories and Applications." Antitrust Section of the American Bar Association Meeting, Washington, DC, April 2002.

"Antitrust Issues in the Pharmaceutical Industry: The Hatch-Waxman Cases." ABA Healthcare and Intellectual Property Sections Brownbag, Washington, DC, February 2002.

"The GE/Honeywell Deal: Is Europe Raising the Yellow Flag on Efficiencies?" CRA Conference on Current Topics in Merger and Antitrust Enforcement, Washington, DC, October 2001.

"Marching to the Sounds of the Cannon: Antitrust Battlegrounds of the Future." National Association of Attorneys General Conference, San Diego, October 2000.

"The Joint Venture Guidelines: Navigating Outside the Safety Zones." The 8th Annual Golden State Antitrust and Unfair Competition Law Institute, Los Angeles, October 2000.

"Strategic Behavior in the Pharmaceutical Industry: The Hatch-Waxman Act and Blockading Entry." Antitrust Section of the American Bar Association Meeting, Washington, DC, April 2000.

"Working With Economic Experts." Antitrust Common Ground Conference, Chicago, IL, December 1999.

"Merger Enforcement Trends." CRA Conference on Current Topics in Merger and Antitrust Enforcement, Washington, DC, December 1998.

"Hot Topics in Health Care Antitrust." Antitrust Fundamentals for the Health Care Provider, Sponsored by the Wisconsin Field Office of the Federal Trade Commission, the US Department of Justice, and Marquette University Law School, Milwaukee, WI, December 1998.

"Federal Antitrust Enforcement in the Health Care Industry: New Directions." Fourth Annual Health Care Antitrust Forum, Northwestern University, September 1998.

"Hospital Competition in HMO Networks." American Economic Association Meetings, San Francisco (1996) and Chicago (1998).

"Creating Competitive Markets Amidst Barriers to Entry." Weeklong Presentation to the Russian State Committee of Antimonopoly Policy, Volgograd, Russia, January 1997.

"The Economics of Antitrust Law." Maine Bar Association, January 1995.

"The Competitive Impact of Differentiation Across Hospitals." Fourth Annual Health Economics Conference, Chicago, 1993.

"Multi-Firm Systems, Strategic Alliances, and Provider Integration." Pennsylvania State University, the University of California at Santa Barbara, and the Johns Hopkins School of Public Health, 1992 and 1993.

PUBLICATIONS

"Presumptions, Assumptions and the Evolution of U.S. Antitrust Policy." With Andrew Dick. *Trade-Practices Law Journal*, December 2005.

"Commentary: Is Managed Care Leading to Consolidation in Health Care Markets?" Health Services Research, June 2002.

"Employer Contribution Methods and Health Insurance Premiums: Does Managed Competition Work?" With Jessica Vistnes and Phillip Cooper. The International Journal of Health Care Finance and Economics, 2001.

"Hospital Competition in HMO Networks: An Empirical Analysis of Hospital Pricing Behavior." With Robert Town. The Journal of Health Economics, September 2001.

"Hospitals, Mergers, and Two-Stage Competition." The Antitrust Law Journal, January 2000.

"Defining Geographic Markets for Hospital Mergers." Antitrust, Spring 1999.

"The Role of Third Party Views in Antitrust Analysis: Trust But Verify." Government Antitrust Litigation Advisory, American Bar Association, July 1998.

"Hospital Mergers and Antitrust Enforcement." The Journal of Health Politics, Policy and Law, Spring 1995.

"An Empirical Investigation of Procurement Contract Structures." The Rand Journal of Economics, Summer 1994.

PROFESSIONAL ACTIVITIES

Referee for:

- The American Economic Review
- · The Antitrust Law Journal
- · Health Services Research
- Inquiry
- The Journal of Industrial Economics
- · The Rand Journal of Economics
- The Review of Industrial Organization

Grant Reviewer for:

- Robert Wood Johnson Foundation/Academy Health
- The Alpha Center
- Agency for Health Care Policy and Research

Honors And Awards

- Named one of Global Competition Review's 2006 "Top Young Economists" (identifying the top 22 antitrust economists in the U.S. and Europe under the age of 45)
- Assistant Attorney General's Merit Award (1994), Antitrust Division, U.S. Department of Justice
- Distinguished Teaching Fellowship (1986), Department of Economics, Stanford University
- Academic Fellowship (1983–1984), Department of Economics, Stanford University
- Phi Beta Kappa (1983)

SECOND AMENDED CERTIFICATE OF PUBLIC ADVANTAGE

This Second Amended Certificate of Public Advantage is issued, pursuant to N.C. Gen. Stat. § 131 B-192.5, to applicants Mission Hospitals, Inc. and Mission Health, Inc. The stated purpose for which the applicants seek a second amended Certificate of Public Advantage, or COPA, is to update the COPA to reflect changes in facts and circumstances, including the accomplishment or expiration of certain provisions of the COPA, and to provide better tools and mechanisms for oversight by the State.

BACKGROUND: On December 21, 1995, pursuant to N.C. Gen. Stat. § 131E-192.5, the North Carolina Department of Health and Human Services, with the consent of the North Carolina Attorney General, issued a revised Certificate of Public Advantage. That initial COPA concerned a cooperative agreement between Memorial Mission Hospital, Inc. and St. Joseph's Hospital to form Mission-St. Joseph's Health System, Inc. to serve as the "managing member" of both hospitals and to manage and operate the two hospitals as integrated entities.

The Hospitals and their managing member, Mission-St. Joseph's Health System, Inc., operated under the initial COPA for more than two and one-half years, with the active supervision of the Department and the Attorney General and in full compliance with the terms and conditions of the COPA, achieving the efficiencies, savings, and other benefits that the COPA contemplated. In 1998, the parties determined that it was in the best interests of the communities they served for Memorial Mission Hospital, Inc. to acquire St. Joseph's Hospital in a statutory merger of St. Joseph's Hospital with and into Memorial Mission Hospital, Inc. Following the transaction, the Mission-St. Joseph's Health System, Inc. became the sole owner and corporate member of Memorial Mission Hospital, Inc. that operated on the Mission and St. Joseph's campuses, on a fully integrated basis.

The First Amended COPA, issued on October 8, 1998, reflecting the conclusions of the Department of Health and Human Services, in consultation with the Attorney General, about the applicants' requested amendments, permitted the referenced merger.

As of December 1, 2003, Memorial Mission Hospital, Inc. changed its name to Mission Hospitals, Inc. and Mission-St. Joseph's Health System, Inc. changed its name to Mission Health, Inc.

L Definitions

- 1. "Mission Health, Inc." refers to Mission Health, Inc., the successor in title to Mission St. Joseph's Health System, Inc., the entity created by Memorial Mission Hospital, Inc., and St. Joseph's Hospital to provide common management to both facilities, and later merged with and into Memorial Mission Medical Center, Inc., the name of which was then changed to Mission-St. Joseph's Health System, Inc.
- 2. "Attorney General" means the North Carolina Department of Justice, Attorney General's Office.
- 3. "Department" means the North Carolina Department of Health and Human Services.
- 4. "Service area" means and includes the area of Western North Carolina encompassing the following 17 counties: Buncombe, Burke, Cherokee, Clay, Graham, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Rutherford, Swain, Transylvania, and Yancey.
- 5. "State Agencies" means the Department of Health and Human Services and the Attorney General's Office.
- 6. "Mission Hospitals, Inc." is a tax-exempt nonprofit charitable organization that owns the Memorial and St. Joseph's hospital facilities in Asheville.

II. Advantages and Disadvantages of the Transaction

N.C. Gen. Stat. § 131B-192.4(b) lists the advantages and disadvantages which the Department must consider in reviewing a COPA application. Bach statutory criterion is set forth below, and is followed by the Department's determination regarding it. In making its determinations regarding these criteria, and in establishing the conditions of this COPA (see Part III, below), the Department consulted with the Attorney General, and considered the application and materials submitted by the parties and all oral and written comments provided by others.

Potential Benefits

(1) <u>Buhancement of the quality of hospital and hospital-related care provided to North Carolina citizens.</u>

Mission Hospitals, Inc. is licensed and certified for participation in Title XVIII and XIX by the Division of Facility Services and accredited by the Joint Commission for the Accreditation of Healthcare Organizations (ICAHO).

10 NCAC 3C.109, entitled "Licensure Surveys," provides at subsection (c):

Hospitals that are accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) shall choose one of the following options:

- (1) accredited hospitals may agree to provide the division with:
 - (A) JCAHO Accreditation Certificate
 - (B) JCAHO Statement of Construction
 - (C) JCAHO Report and Recommendations
 - (D) JCAHO Interim Self-Survey Reports, and
 - (E) permission to participate in any regular survey conducted by the JCAHO.

If a review of the information listed in Subparagraphs (c)(l)(A)-(c)(l)(D) indicates deficiencies with or exceptions to licensure regulations contained in this subchapter then the Division may conduct surveys or partial surveys with special emphasis on deficiencies noted,

The JCAHO accreditation process includes surveys that evaluate and rank the quality of care in several areas of hospital operations, including patient care. The JCAHO surveys are conducted at intervals of three years. Memorial Mission Hospital, Inc. was surveyed on June 16 through 20, 2003 and received accreditation for a three year period. All recommendations for improvement have been cleared.

Mission Hospitals, Inc. currently offers high-quality services according to the surveys and measurements available for assessing quality. In order to assure that the quality of hospital services are maintained the State Agencies will require, as more fully shown below, that there be no deterioration in quality according to surveys to be conducted by the Joint Commission on Accreditation of Healthcare Organizations.

Therefore, it is found that the quality of hospital and hospital related care provided to North Carolina citizens would likely be maintained or enhanced if the Terms and Conditions of this Second Amended Certificate of Public Advantage are met.

Potential Benefits

(2) <u>Preservation of hospital facilities in geographical proximity to the communities</u> traditionally served by those facilities.

For the purposes of determining the impact of the proposed agreement, the Western North Carolina region for determining geographic proximity includes the following 17 counties: Buncombe, Burke, Cherokee, Clay, Graham, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Rutherford, Swain, Transylvania, and Yancey. Of these 17 counties, Clay, Graham, Madison, and Yancey have no acute care hospital within their borders. Within this region there are 16 acute care general hospitals one rehabilitation hospital and one long-term acute care hospital. There is also a Veterans Administration Hospital and healthcare facility in Asheville and a U.S. Public Health Service Hospital on the Cherokee Indian Reservation. The Mission Hospitals facility is the largest hospital in the region. The basis for including all 17 counties is that at least 38.4% percent of persons hospitalized for acute care services from these counties use Mission Health for acute care.

Mission Health dominates the market share in two counties. 93.8% of Madison County admissions and 90.6% of Buncombe County admissions are at Mission Hospitals' facilities, which are located in Buncombe County. Madison County, which has no hospital, is closer to Mission Hospitals in Asheville than to any other acute care hospital.

The State Agencies will conduct ongoing monitoring of hospital utilization and patient origin data throughout the area in order to determine if particular communities may experience a loss of geographical access to needed services. The State Agencies will then assess whether such a potential loss is related to the operation or activities of Mission Hospitals, Inc.

It is found that under the Second Amended COPA, Mission Health and Mission Hospitals will likely preserve hospital facilities in their dominant market and, will not likely cause a loss of hospitals in geographical proximity to the communities in the remainder of the service area, and will optimize the resources of Mission Health.

Potential Benefits

(3) Lower costs of or gains in the efficiency of delivering hospital services.

The original application for the Certificate of Public Advantage proposed cost savings as the primary benefit of the combination of hospital operations. Through the elimination of planned capital expenditures and a reduction of operating costs the Hospitals determined that at least \$74.2 million could be saved over the first five years of operation.

In addition, the Hospitals proposed a cap on increases in charges. The cap would be based on an appropriate medical inflation index.

The savings proposed in the application demonstrated a substantial benefit of the combined operation and provided a basis for granting the COPA. The projected savings were arrived at through a study of the Hospitals by Arthur Andersen & Co.

Because the Hospitals did not want to be held to every recommendation made in the Arthur Andersen study, an ability to substitute items that would not diminish the total savings

was approved. In order to document the savings in such an environment, an independent consultant was employed to verify the savings on an annual basis over the five-year period.

It is important that the Hospitals both contain their costs and keep their operating margins reasonable when compared to other similar hospitals in North Carolina. To that end the Department will seek to limit and control the costs and operating margins of the hospital operations of the applicant.

It is therefore found that the savings accomplished by the Hospitals and the monitoring and supervision by the State Agencies of costs and operating margins as provided in the Terms and Conditions of this Second Amended COPA will likely lead to a lowering of costs and increased efficiency of hospital services delivered in the area as a result of the combination.

Potential Benefits

(4) Improvements in the utilization of hospital resources and equipment

Mission Hospitals, Inc. has 735 licensed acute care beds, including 57 psychiatric beds. Mission Hospitals is the only provider of open-heart surgery services in Buncombe County and the 17 county region in Western North Carolina. It is also the only hospital that has an in-patient dialysis unit in the region. Mission Hospitals is part owner of both Asheville Specialty Hospital, a long-term acute care facility, and the Asheville MRI Center. Mission Hospitals and the Asheville MRI Center both operate MRI scanners. Mission Hospitals has radiation therapy equipment (linear accelerators).

Under the initial COPA and the First Amended COPA, Mission Hospitals and Mission Health (and their predecessor entities) demonstrated improvements in the utilization of hospital resources and equipment, and it is found that the Second Amended COPA will permit the preservation and continuation of such improvements.

Potential Benefits

(5) Avoidance of duplication of hospital resources.

The initial agreement involved the consolidation of services that was to result in an estimated five-year net savings of \$74,215,848. Savings were accomplished in four areas: (1) avoidance of capital expenditures, such as duplication of obstetric services and urology services, (2) reduction of positions, (3) employee benefits, and (4) efficiencies in operations. The total five year gross saving was projected to be \$81.6 million. After deducting the cost of implementing the consolidation, the five-year net saving was projected to be about \$74.2 million. Of the 167.5 positions identified for elimination between the two Hospitals, about 36% are management, 19% clerical, and 45% other hospital staff. As a result of the First Amended COPA the Hospitals committed to save an additional \$2 million by the end of the five year period due to increased efficiencies Patient services to be consolidated included outpatient imaging, emergency/trauma services, and oncology services.

The initial agreement also involved making operations more efficient by consolidating duplicate functions in the areas of Administration, Accounting/Finance, Business Office, Human Resources, Planning and Communications, Information Services, Materials Management/Purchasing, Nursing Administration, Laboratory, and Outpatient Services. In other areas only management was consolidated, including Medical Records, Plant Services, Housekeeping, Dietary/Cafeteria/Vending, Quality Assurance, Cardio/Respiratory Services, Pharmacy, and Rehabilitation Services. Other types of collaboration strategies were proposed in the areas of Medical/Surgical Floors, Intensive/Critical Care, Surgical Services, Emergency Services, Primary Care Network, and Radiology.

The proposed savings were accomplished and it is therefore found that the Hospitals adequately demonstrated that the proposed merger allowed the two facilities to avoid unnecessary duplication of hospital resources.

Potential Benefits

(6) The extent to which medically underserved populations are expected to utilize the proposed services.

The initial application from the Hospitals did not suggest that any restriction of services to Medicare or Medicaid patients was under consideration. Indeed, at present Mission Hospitals relies on these programs to provide payment for most of its patients. Slightly more than 68% of the inpatient gross revenue and approximately 43% of the outpatient gross revenue for Mission Hospitals comes from these programs.

Mission Health provides significant amounts of care to uninsured and underinsured patients. It has well-established policies for providing such care, with patients determined eligible for free or reduced price care based on their income and policies for writing off debt as uncollectible. Care represented by such debt is then counted in calculating total amounts of charity care.

Mission Hospitals issued a 2004 Community Benefits Report that shows dollars invested in community benefits having increased from \$42,723,492 in 1997 to \$69,714,024 in 2003. These figures include charity care, donations to community services, free health services like screenings and immunizations, costs the government does not cover treating Medicare and Medicaid patients, and other non-cash reimbursed services.

Nothing in the application for a second amended COPA suggests any attempt to eliminate or reduce the amount of care provided to uninsured, underinsured, and otherwise indigent patients. Mission Hospitals helps to support a clinic to provide medical care to indigent patients in an underserved neighborhood and supports The Asheville Buncombe Community Christian Ministry Clinic to provide additional services.

Merging hospital operations has provided increased capacity to serve the underserved population with no reduction in the commitment to do so. In the past it has been pursuit of a mission, not competition that has led to Mission Health's providing care to the underserved. Under the conditions of this Second Amended COPA, the merged entity should provide continued access to care by underserved populations.

It is therefore found that medically underserved populations are likely to continue to benefit from the proposed merger.

Potential Disadvantages

(1) The extent to which the agreement may increase costs or prices of health care at a hospital which is party to the cooperative agreement.

The stated purpose of the initial proposal to combine operation of the two Hospitals was to reduce costs and contain charges. Because reduced competition could have the opposite effect, the State Agencies established a method to monitor and supervise the costs and operating margins of the Hospitals to assure that they do not exceed those of comparable hospitals.

The entity will be required to show that its increase in cost per adjusted patient discharge is no more than the Producer Price Index for general medical and surgical hospitals and that its operating margin does not exceed the mean of the selected other comparable institutions over any three-year period.

It is therefore found that as conditioned elsewhere in this Agreement the proposed merger of the Hospitals will not likely have an adverse effect on costs or prices of health care.

Potential Disadvantages

(2) The extent to which the agreement may have an adverse impact on patients in the quality, availability, and price of health care services.

Conditions and terms of this Second Amended COPA are specifically designed to address the quality, availability and prices of health care service provided at the applicant institutions.

The stated purpose of both the initial application and the applications for amendment is to reduce costs which will in turn affect the price of services. While some duplication of services will continue to be eliminated, there are no stated plans to eliminate any services. Mission Hospitals is explicitly required to maintain quality as part of the conditions of this agreement.

It is therefore found that as conditioned the merger of the Hospitals will not likely have an adverse impact on patients in the quality, availability and price of health care services.

Potential Disadvantages

(3) The extent to which the agreement may reduce competition among the parties to the agreement and the likely effects thereof

The combination of operations of Memorial Mission and St. Joseph's Hospitals, the two largest acute care facilities in Asheville and its surrounding environs, has reduced competition. While the two Hospitals did not compete in all areas of services, there was substantial overlap of the services they provide.

The effects of the reduced competition, however, were designed to lower costs and maintain the availability of services presently offered. While there has been some consolidation of services and a reduction of duplication, no services have been eliminated.

Maintenance of services at lower costs should not adversely impact the patient population served by the Hospitals even though there is reduced competition. The terms and conditions of the Certificate of Public Advantage, the First Amended Certificate of Public Advantage and now the Second Amended Certificate of Public Advantage are designed to assure that the beneficial effects of the arrangement will materialize.

It is therefore found that the reduced competition brought about by the proposed merger, within the framework of the terms and conditions of this Second Amended Certificate of Public Advantage, will likely benefit the consumers of hospital services in the area.

Potential Disadvantages

(4) The extent to which the agreement may have an adverse impact on the ability of health maintenance organizations, preferred providers organizations, managed health care service agents, or other health care payors to negotiate optimal payment and service

arrangements with hospitals, physicians, allied health care professionals, or other health care-providers.

The merger, as conditioned by the First Amended COPA, should not significantly impact the ability of managed care providers and payors to negotiate optimal arrangements for several reasons:

- 1) The Hospitals did not effectively compete with one another before issuance of the COPA for such contracts because St. Joseph's did not offer enough services to make exclusive contracting practical.
- 2) Competition for tertiary care services currently exists and will continue to exist from points around Asheville such as Charlotte; Johnson City, Tenn.; Greenville/Spartanburg S.C.; and Atlanta, Ga.
- 3) The primary objective of the merger and the main focus of state supervision is a reduction of costs. In addition, supervision will assure that operating margins are reasonable.

The ability of managed care providers and payors to contract with physicians, allied health professionals and other health care providers will not be changed as a result of the proposed merger so long as the merged facility does not establish employment or exclusive dealing arrangements with physicians and allied health professionals in the primary service area above the limits established in this Second Amended COPA.

This finding therefore concludes that the merger does not significantly affect the ability of managed care providers to negotiate with Mission Hospitals and that the terms and conditions of the Second Amended COPA will adequately protect the ability of managed care providers and payors to negotiate reasonable arrangements.

Potential Disadvantages

(5) The extent to which the agreement may result in a reduction in competition among physicians, allied health professionals, other health care providers, or other persons finnishing goods or services to, or in competition with hospitals.

There seems to be no basis to conclude that competition among physicians, allied health professionals or other health care providers will be significantly different as a result of this Second Amended COPA

The State Agencies have reviewed and conditioned the exclusive physician provider contracts of Mission Hospitals and will continue to monitor the terms of such contracts.

Others furnishing goods or services to Mission Hospitals will continue to compete with one another on the basis of cost, quality and service.

This finding therefore concludes that the Second Amended COPA under consideration in this application is not likely, on balance, to result in a disadvantage due to reduced competition among various health care providers or other persons furnishing goods and services to or in competition with them.

Potential Disadvantages

(6) The availability of arrangements that are less restrictive to competition and achieve the same benefits or a more favorable balance of benefits over disadvantages attributable to and reduction in competition.

. The Second Amended COPA does not raise any potential disadvantages not already considered in the COPA or the First Amended COPA.

III. Terms and Conditions of Second Amended COPA

Following are the terms and conditions upon which this Second Amended COPA is issued:

- (1) Accreditation of Mission Hospitals, Inc. Mission Hospitals, Inc. shall:
 - 1.1 Remain accredited by the Joint Commission for accreditation of Healthcare Organizations (JCAHO).
 - 1.2 Not become conditionally accredited by the JCAHO.
 - 1.3 Correct any requirements for improvement and/or supplemental findings from JCAHO surveys within the time frame set by the JCAHO.
 - 1.4 Promptly provide to the State Agencies an explanation of requirements for improvement received in surveys, submit action plans to improve such deficiencies as part of the Interim or Periodic Report to the State Agencies, and attach copies of any focused survey results received from JCAHO.
 - 1.5 Maintain a three-year JCAHO survey schedule for JCAHO surveys.

(2) Charity and Indigent Care.

- 2.1 The general policy of Mission Health, Inc. to provide needed health care services to those requiring such care regardless of their ability to pay shall be continued.
- 2.2 Medicare and Medicaid patients shall continue to enjoy access to all needed health services of the combined entity on the same basis as patients represented by any other payor.
- 2.3 The policy for the provision of charity care currently in effect at Mission Health,

 Inc. shall be used as the policy for providing such care.
- (3) Purchase of Equipment and Supplies by Competitive Bidding. The purchase of equipment and supplies used at Mission Hospitals shall be made on a competitive basis to effectuate the lowest cost possible consistent with required quality, compatibility and efficiency.

(4) Controls on Costs and Margins.

4.1 Following the end of each fiscal year Mission Hospitals, Inc. shall provide to the State Agencies, in addition to its audited financial statements, the following accounting and statistical information: net in-patient revenue, net out-patient revenue, in-patient discharges, and the case-mix index for all acute care hospital in-patients. In addition, further breakouts of information contained in the audited financial statements shall be provided to the State Agencies or their designee upon request.

The Department of Health and Human Services or its designee will use the above information to develop a cost per adjusted patient discharge for Mission Hospitals, Inc. Cost per adjusted patient discharge shall be calculated as follows:

1) multiply inpatient discharges by case mix index to obtain case mix adjusted discharges; 2) divide inpatient revenue by case mix adjusted discharges to obtain revenue per inpatient discharge; 3) divide outpatient revenue by revenue per inpatient discharge to obtain equivalent outpatient discharges; 4) add case mix adjusted discharges and equivalent outpatient discharges to obtain total adjusted discharges; 5) divide operating expenses by total adjusted discharges to obtain cost per adjusted patient discharge.

Mission Hospitals, Inc. shall keep its cost per adjusted patient discharge to no more than the amount for the previous year, plus the product of that amount multiplied by the percentage increase, in the relevant year, in the Producer Price Index for general medical and surgical hospitals (PPI) as published by the United States Department of Labor. The following and each successive year the Hospital shall keep its cost per adjusted patient discharge to no more than the lesser of the above calculation or \$6,000 multiplied by the 2004 Producer Price Index and in each successive year thereafter the product from the preceding year multiplied by the PPI for the relevant year.

A failure of Mission Hospitals, Inc. to keep its cost per adjusted patient discharge at or below the requirement set out in the previous paragraph for two consecutive years shall result in Mission Hospital Inc. employing a management consultant approved by the Department to study and recommend actions to reduce its costs to the required level. The State Agencies will provide Mission Hospital, Inc. the opportunity to comment on the consultant's recommendations, before making final recommendations to Mission Hospitals, Inc. Mission Hospitals, Inc. shall implement the recommendations made by the State Agencies.

The cost per adjusted discharge of Mission Hospitals, Inc. shall also be compared with similarly calculated costs of comparable hospitals. Comparable hospitals may be a selected group of hospitals of 300 beds or more excluding academic medical center teaching hospitals such as Duke University Health System, The North Carolina Baptist Hospitals, Inc., UNC Hospitals, and Pitt County Memorial Hospital, Inc. This comparison will be used by the state agencies to help them determine if the PPI seems to be an appropriate standard.

4.2 The Department of Health and Human Services will calculate the operating margin in fiscal years subsequent to 2003 of Mission Health, Inc. derived by dividing the excess of operating revenues over operating expenses by operating revenues.

The operating margin, expressed in percentage terms, of Mission Health, Inc. shall not exceed by more than one percent the mean of the median operating margins of hospitals rated in the AA, category by Standard and Poor's, the Aa category of Moody's Investor Service, and the AA category of Fitch Ratings over any three-year period, provided that in no event shall Mission Health, Inc. be required to have an operating margin of less than three percent. For purposes of applying this test the Hospital's excess for 2003 of \$3,175,690 will be carried over into the Second Amended COPA for future calculations of the allowable margin for a three-year period.

To the extent that operating margins exceed the amounts set forth above, over any three-year period the total dollar difference between the amount realized and the amount allowed shall be deposited, according to a schedule established by the State Agencies, in a separate fund established by Mission Health, Inc. and directed by the State Agencies, provided that the State Agencies also determine that any required transfer in a given year will not result in either Mission Hospitals, Inc. or Mission Health, Inc. failing to meet financial ratios established by covenants for bonds issued on their behalf by the North Carolina Medical Care Commission. Mission Hospitals, Inc. and Mission Health, Inc. shall be jointly and severally liable for such amount. Money in this fund shall be used to support or provide low-cost or no-cost health-care services to residents of western North Carolina such as child immunizations, mammograms, drug and alcohol abuse treatment programs, or other health-care services needed by the community for which adequate resources are not available. The State Agencies may select, after receiving any input from Mission Health, Inc. one or more charitable organizations to utilize these funds. The selected organization(s) shall submit quarterly reports to the State Agencies on the expenditure of the funds. In the event of a settlement and deposit of funds representing excess margin as described above, a new three-year measurement period shall begin.

The operating margin of Mission Hospitals, Inc. will also be compared with similarly calculated operating margins of comparable hospitals selected by the Department in consultation with the Attorney General. Comparable hospitals may be a selected group of hospitals of 300 beds or more excluding academic medical center teaching hospitals such as Duke University Health System, The North Carolina Baptist Hospitals, Inc., UNC Hospitals, and Pitt County Memorial Hospital, Inc. This comparison will be used by the State Agencies to help them determine the appropriateness of the comparison with the median of AA rated facilities. The manner in which extraordinary items will be considered or adjusted will be determined on a case-by-case basis by Mission Health and the State Agencies.

- 4.3 The parties to this Second Amended COPA further stipulate and agree that the Department may, in its discretion and with the approval of the Attorney General, establish an alternative methodology or incentive designed to reflect competitive conditions to control Mission Hospitals, Inc. costs or operating margins following its review of the Periodic or Interim Reports described in subparagraphs 11.1 and 11.3 of this document.
- 4.4 Subparagraphs 4.1 through 4.3 shall apply only during those fiscal years when the State of North Carolina or the federal government does not substantially regulate hospital rates.

(5) Nonexclusivity.

- 5.1 Mission Health shall not enter into any provider contract with any health plan on terms that prohibit it from entering into a provider contract for any services it offers with any other health plan.
- 5.2 Mission Health shall not require managed-care plans to contract with its employed doctors as a precondition to contracting with it or its constituent hospitals.
- 5.3 Mission Health shall not restrict an independent physician's provision of services or procedures outside the member hospitals, unless performance of duties outside the member hospitals would impair or interfere with the safe and effective treatment of a patient.
- 5.4 Mission Health shall not prohibit independent physicians who are members in any Mission Health physician-hospital network from participating in any other physician-hospital network, health plan, or integrated delivery system.

(6) Nondiscrimination.

- Except as provided herein, Mission Health shall not enter into any exclusive 6.1 contract with any physician or group of physicians by which it requires that physician or group of physicians to render services only at Mission Hospitals, or by which it requires only one physician or group of physicians to provide particular services at Mission Hospitals. However, Mission Health may enter into exclusive contracts with anesthesiologists; radiologists; nuclear medicine physicians; pathologists; psychiatrists; emergency-room physicians; infectious disease physicians; neonatologists; nephrologists; pediatric subspecialists (e.g., pediatric cardiologists); perinatologists; pulmonologists; radiation oncologists; trauma surgeons; cardiologists; cardiovascular surgeons; neurologists; and physicians providing services in Mission Health's community access clinics. This provision, however, shall not require Mission Health to terminate any existing contracts, and Mission Health may continue to require its employed physicians to render services only at Mission Hospitals. Mission Health may also petition the State Agencies for approval to enter into exclusive contracts with physicians in specialties other than those above.
- Other than as provided in Paragraph 8.1, and except as restrictions on granting certain medical privileges are necessary to maintain physicians' qualifications, including clinical competency, Mission Hospitals shall provide an open staff, ensuring equal access to all qualified physicians in, and in reasonable proximity to, Buncombe County, according to the criteria of the JCAHO and the medical staff by-laws.
- 6.3 Mission Health shall negotiate in good faith with all health plans with a service area or proposed service area within or including western North Carolina that approach it seeking a provider contract. This provision, however, shall not be construed to require Mission Health to enter into a provider contract with any particular health plan.

- Mission Health shall not enter into a provider contract with any licensed health plan operated by Mission Health itself, in existence now or which may be created, on terms available to that plan solely because it is wholly-or-partially-owned, controlled or sponsored by Mission Health, where doing so would place other comparable licensed health plans at a competitive disadvantage because of any market power Mission Health may have rather than from efficiencies resulting from its integration with its health plan. However, this subsection 6.4 shall not apply to the provision of hospital services to employees of Mission Health or its affiliates.
- 6.5 With respect to any managed-care plan affiliated with or proposed by Mission Health or any other group or alliance of hospitals, Mission Health shall participate in such plan only on nonexclusive terms. Further, Mission Health shall not engage in any "most-favored-nation" pricing with respect to such a plan vis-a-vis other competing managed-care plans in its market, and shall not cross-subsidize any such plan through the operating revenues of Mission Health in a manner that would facilitate predatory pricing or other anticompetitive conduct.

(7) Health Plans

- 7.1 Mission Health shall not unreasonably terminate any provider contracts to which it or one of its member hospitals is party as of the date of issuance of the Second Amended COPA.
- 7.2 Mission Health shall attempt, in good faith, to contract with all health plans operating in its service area that offer commercially-reasonable terms on a fully-capitated basis, a percentage of premium revenue basis, or on other terms that require Mission Health to assume risk. Mission Health shall not refuse to contract with a health plan solely because such plan proposes a risk bearing or capitated contractual reimbursement methodology. This provision, however, does not require Mission Health to enter into a provider contract with any particular health plan or with all health plans.

(8) Employment of or Contracting with Physicians.

- Notwithstanding Section 6.1, above, Mission Health may employ or enter into exclusive contracts with no more than 20% of the physicians in its primary service area of Buncombe and Madison Counties, practicing in any of the following areas: family practice/internal medicine, general pediatrics, or obstetrics/gynecology. This percentage limit shall apply to each such area of practice: In calculating this percentage, full-time residency faculty members employed by Mission Health and residents employed by MAHEC shall be included, and physicians whose primary employment is at Mission Health's community access clinics shall be excluded.
- 8.2 Mission Health shall not solicit the employment of any physician or group practice within its primary service area of Buncombe and Madison Counties if such employment would exceed the limitations imposed by Subparagraph 8.1.
- Mission Health may petition the State Agencies in writing for an exception to Subparagraph 8.1 if market conditions warrant employing physicians in any of the enumerated categories above the 20% level. Market conditions potentially justifying an exception include providing physicians to an underserved area.

(9) "Most-Favored-Nation" Provisions in Contracts with Health Plans.

Mission Health shall not enter into any provider contract with any health plan on terms which include a "most-favored-nation" clause to the benefit of Mission Health or any health care plan. A "most-favored-nation" clause is any term in a provider contract that guarantees either party that it will receive the benefit of any better price, term or condition than the other party to the contract allows to a third person for the same service.

(10) Ancillary Services.

10.1 Patient referrals for durable medical equipment, home health services, or home infusion services made by Mission Health, its employees, contractors and medical staff shall provide for patient choice among the competitors in those markets and

- shall be on a non-discriminatory basis without regard to whether Mission Health owns or operates the provider of such services.
- 10.2 Mission Health shall document that each patient referral for such services has been made in compliance with the preceding subparagraph 10.1.
- 10.3 If providers of ancillary services not affiliated with Mission Health cannot or do not provide such goods or services in a manner that would permit Mission Health to contain costs in the context of risk-bearing contracts, I Mission Health may petition the State Agencies for an exception to subparagraphs 10.1 and 10.2.

(11) Reports

- 11.1 Within four months from the close of the second fiscal year of each biennium during which the COPA and now the Second Amended COPA is in effect, Mission Health shall submit to the State Agencies a Periodic Report accompanied by an officer's compliance certificate describing its compliance with this COPA. The Periodic Reports shall address in detail:
 - Annual utilization of beds, equipment, and services and any increases or decreases in utilization of beds, equipment, and services;
 - Acute care hospital utilization for the 17-county Western North Carolina region. If a report, or the Department's own determination, indicates that the future survival of any one of the other general acute care hospitals in the region is in jeopardy, Mission Health will be requested to evaluate the situation and report to the Division of Facility Services whether the ability of persons to maintain access to general acute care services is in jeopardy. If persons in the region are in jeopardy of losing access to general acute care services, Mission Heath will be requested to present the Division of Facility Services with alternatives to address the needs of these persons; and

- All funds that were provided during the preceding fiscal year by Mission Health to any managed care plan owned or controlled by it.
- 11.2 Mission Health shall notify the Division of Facility Services in advance if it is proposing to add or delete a health service.
- Within four months from the close of each fiscal year during which first the COPA and now the Second Amended COPA is in effect, and in which Mission Health is not required to submit a Periodic report, Mission Health shall submit to the State Agencies an Interim Report accompanied by an officer's compliance certificate certifying its compliance with this Second Amended COPA. The next Interim Report shall be filed no later than January 31, 2006. This report shall address in detail:
 - 1) The methods used to insure competitive prices of its purchases of equipment and supplies;
 - Acute care hospital utilization for the 17-county Western North Carolina region. If a report, or the Department's own determination, indicates that the future survival of any one of the other general acute care hospitals in the region is in jeopardy, Mission Health will be requested to evaluate the situation and report to the Division of Facility Services whether the ability of persons to maintain access to general acute care services is in jeopardy. If persons in the region are in jeopardy of losing access to general acute care services, Mission Health will be requested to present the Division of Facility Services with alternatives to address the needs of these persons; and
 - All funds that were provided during the preceding fiscal year by Mission Health to any managed care plan owned or controlled by it.
 - It is also stipulated and agreed that following their review of the Interim Report, the State Agencies shall have the same discretion to modify or

revoke the Second Amended COPA as the statute provides them with respect to the Periodic Report in N.C. Gen. Stat. § 131E-192.9.

- The Department finds and concludes that: the proposed transaction has made 11.4 more permanent and difficult to dissolve the combination of two complex organizations; that verification of the benefits of this Second Amended COPA to the public (and in particular the stated cost savings) is critical to assuring that the public benefits of this Second Amended COPA in fact exceed the public detriments due to the reduction in competition; and that the Department cannot include adequate "conditions to control prices of health care services provided under the [COPA]," N.C. Gen. Stat. § 131E-192.5, nor supervise compliance with these conditions sufficient to achieve for the merged entity the immunity that the General Assembly intended, N.C. Gen. Stat. § 131E-192.13(a), while also assuring that the costs of its oversight of the Second Amended COPA are fully supported by COPA application fees and periodic report fees, per N.C. Gen. Stat. § 131E-192.11. Therefore, in order to carry out the General Assembly's intent of assuring that the public interest is served, and of providing the merged entity immunity for conduct that serves the public interest, the Department can grant this Second Amended COPA only if Mission Health agrees, by consenting to this Second Amended COPA (per paragraph 18, below), to pay the Department, the Attorney General, or their designee(s), for annual expenses, including any expert fees, incurred in analyzing and verifying its Periodic and Interim Reports, in an amount not to exceed \$25,000 per year (to be paid within thirty days of receiving the invoice(s) therefor).
 - 11.5 Mission Health shall cooperate with the Department of Health and Human Services, the Attorney General, and any expert engaged by either agency or by Mission Health pursuant to this the COPA and now to this Second Amended COPA. Such cooperation shall include but not be limited to providing any additional requested information reasonably necessary to complete the analysis and verification of the compliance reports.

- (12) <u>Compliance</u>. To determine or secure compliance with this Second Amended COPA, any duly authorized representative of the State Agencies, including any expert engaged by either of them, shall be permitted:
 - 12.1 Upon reasonable notice, access during normal business hours to all nonprivileged books, ledgers, accounts, correspondence, memoranda, reports, accountant's work papers and other records, and documents, in the possession or under the control of Mission Health or its independent auditors, relating to any matters contained in the COPA, the First Amended COPA or this Second Amended COPA;
 - 12.2 Upon reasonable notice, access during normal business hours to interview directors, officers, managers, or employees regarding any matters contained in the COPA, the First Amended COPA or this Second Amended COPA; and
 - 12.3 Upon reasonable notice, to call a special meeting of the Board of Directors of Mission Health.
 - 12.4 The State Agencies will endeavor to provide notice to Mission Health of any concerns raised by the Periodic Report, the Interim Report, or any other information tending to show that Mission Health may not be in compliance with any of the conditions of the COPA; the First Amended COPA or the Second Amended COPA, within a reasonable time after its receipt. Mission Health, and its board of directors, shall meet with the Department of Health and Human Services and/or the Attorney General, upon request, to attempt to resolve any such concerns.

(13) Board of Directors.

An important element of assuring that the granting of this Second Amended COPA will be in the public interest is that the Boards of Directors of Mission Health, Inc. and Mission Hospitals, Inc. will be composed primarily of members of the community who have an interest in low-cost medical care and who have no ties to either entity. Accordingly, the Boards of Directors of Mission Health, Inc.

and Mission Hospitals, Inc. which may be composed of the same members, shall be composed as follows:

The Boards of Directors shall consist of twelve (12) to nineteen (19) persons selected through the consideration of appropriate competency-based criteria to (1) regard and protect the interests of recipients and purchasers of hospital-based health care services, and (2) help assure that Mission Hospitals provides cost-effective, efficient, and high-quality health services. The selection process should include a specific effort to assure that the interests of large and small employers; racial and ethnic minorities; women and men; and economically disadvantaged citizens are represented on the Boards. The Boards may also include physicians having medical staff membership and other persons having clinical practice privileges at Mission Health's facilities.

At least one member of the Board shall be affiliated with a private employer that employs more than 200 employees in the service area and at least one member shall be affiliated with a private employer that employs more than 300 employees in the service area.

- 13.2 Mission Hospitals' Chief Executive Officer may serve as an ex-officio member of its Board of Directors, with vote; Mission Health's Chief Executive Officer shall be an ex-officio member of its Board of Directors, with vote; the Immediate Past Chair of each entity may serve as an ex-officio member with vote, and the Chairman of Mission Healthcare Foundation, Inc. shall be an ex-officio member with vote, but these ex-officio members are in addition to the twelve-to-nineteen-member figure referred to in ¶ 13.1 above.
- 13.3 All Board members of Mission Health other than the ex-officio members shall serve on the same conditions, shall be removed only for cause upon the affirmative vote of a majority of the remaining members of the Board, and shall

be limited to serving three consecutive terms of three years (or nine consecutive years) including time previously served on the Memorial Mission Medical Center board or the Mission-St. Joseph's Health System board. Members of the Board of Mission Hospitals shall be appointed by the Board of Mission Health and may be removed at any time by the Mission Health Board with or without cause.

Membership on the current Boards consists of 18 persons including four physicians on the medical staff. This number does not include the ex officio members. This kind of representation appears to provide medical and administrative expertise while preserving public interest through a membership of broad based community representatives, who have no ties to Mission Health, and whose primary interest would seem to be low-cost, high-quality medical care. If and when the overall mix, composition, or size of the membership of the Boards is to be changed, Mission Health shall submit the proposed changes in advance to the State Agencies, and shall implement the changes only if the State Agencies do not object within thirty days. Any future reduction in the number of Board members shall begin with one of the positions reserved for physicians.

The above requirement is established because of the economic nature of a Certificate of Public Advantage. In terms of an economic relationship, the patients and consumers of health services at Mission Health have interests that can be in conflict with the economic interests of physicians, other clinicians and administrators.

(14) Change of Legal Status or Sale.

- 14.1 Mission Health and its constituent hospitals shall retain their status as non-profit entities. Any sale or transfer of control of Mission Health, or either of its constituent hospitals, shall take place only with the prior written approval of the State Agencies. Such approval may be upon conditions.
- 14.2 The State Agencies' approval shall not be required in the case of the sale or transfer of control to another not-for-profit entity or organization which has a

mission and vision for the delivery of cost-effective and quality health care services consistent with that of Mission Health, and the acquiring entity provides the State Agencies its agreement in writing that it is subject to this Second Amended COPA.

- (15) <u>Legal Exposure</u>. No provision of this Second Amended COPA shall be interpreted or construed to require Mission Health to take any action, or to prohibit Mission Health from taking any action, if that requirement or prohibition would expose Mission Health to significant risk of liability for any type of negligence (including negligent credentialing or negligence in making referrals) or malpractice.
- (16) Averment of Truth. By consenting to and signing this Second Amended COPA, Mission Health and Mission Hospitals aver that the information they have provided to the State Agencies in connection with first the COPA, the First Amended COPA and the Second Amended COPA to the best of their knowledge, is true and represents the most recent and comprehensive data available, and that no material information has been withheld.
- (17) <u>Review and Amendment.</u> The State Agencies, Mission Health and Mission Hospitals agree to review this Second Amended COPA at least every two years and to consider appropriate amendments by the written agreement of the parties.
- (18) <u>Binding Effect of COPA</u>. The terms of this Second Amended COPA are binding on Mission Health, Mission Hospitals, their successors and assigns, directors and officers, and all persons and entities in active concert or participation with any of them.
- (19) Effective Date of Second Amended COPA. This Second Amended COPA shall become effective upon the consent of Mission Health and Mission Hospitals to the terms and conditions contained herein, as reflected by depositing in the U.S. Mail, by, a copy signed by the respective officers shown below, with first class postage affixed thereto, and addressed to the Department. Section (4) of the Terms and Conditions of this Agreement shall be applied in determining compliance with the cost and operating margin limitations for 2004 and subsequent years.

This document may be executed in multiple counterparts.

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			Division of Facility Services	
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	MISSION HOSPITALS, INC.			
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	Joseph F. Damore, President			
	Date: 622/05		•	
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	Joseph F. Damore, President			
	Joseph F. Damore, President			
	Date: 6/22/05	•		
	Date: 622/05			

Sent: Tuesday, April 12, 2011 8:59 AM Subject: message on behalf of Ron Paulus

As you know, a complex set of dynamics impacting the delivery of healthcare services has existed in our region for some time. Close to home, those dynamics include those related to the joint development of the Mission-Pardee ambulatory health campus on the County line in Fletcher. This morning Pardee's medical staff was informed that "the Henderson County Board of Commissioners has initiated discussions with University of North Carolina Healthcare System (UNC-Chapel Hill)...to explore a possible relationship." Press releases from Pardee and UNC Health Care will be forthcoming later this morning, but I wanted you to know as soon as the Pardee medical staff knew. Once the press release is available, I will share that with you.

As you also know, Mission has well established, collaborative relationships with both UNC and Pardee. Each has kept us aware (subject to confidentiality agreements) of the evolution of certain elements of the UNC-Pardee discussion. As stated in the release, the nature of any relationship that might actually develop between UNC and Pardee is yet to be defined. Similarly, how the UNC-Pardee discussions or possible relationship might impact our own relationships with UNC and/or Pardee is also yet to be defined.

What is clear at this time is that Mission and Pardee will continue to move forward developing the Fletcher health campus, an innovative project that will increase access to needed services in one of the fastest growing areas in Henderson and Buncombe Counties. UNC has been briefed on the project and indicated to us that it supports the ongoing project with Mission. We look forward to continuing dialogue in this regard.

Of course, we will carefully monitor and assess the progress of these discussions and our relationships to determine what course of action is in the best interest of our region's patients, physicians and Mission Health System.

As the situation develops, we will keep you informed to the fullest extent possible.

Best Regards,

Ron

Ronald A. Paulus, MD President and CEO Mission Health System 509 Biltmore Avenue . 4

Asheville, NC 28801 Ron.Paulus@msj.org www.msj.org

Assistant: Velinda Fisher Velinda. Fisher@msj.org
Tel: 828-213-1144
Fax: 828-213-0196

Received by the CON Section 28 APR 2011 1 1 2000.

April 27, 2011

Bruce Periman, M.D.

178 Bradford Terrace Lane

Hendersonville, NC 28792

Gebrette Miles, Project Analyst

Certificate of Need Section

Division of Health Services Regulation

I am an Internal Medicine Physician in the Hendersonville area. I am against issuance of a CON for Mission Hospital to build a GI lab near the county line. At present there is more than enough capacity in our community for the type of procedures that would be done in that lab. After building the lab, Mission Hospital would the feel the need to make it profitable. Since there is excess capacity as it is, the only way to show a profit is to do unnecessary testing or increase their billing for the procedures. Either way it is the citizens of the area that are shouldering the responsibility for making an un-needed lab profitable. In my experience, if this lab dilutes the business of pre-existing physicians then they will also be forced to look for added ways to remain profitable. Again, this is not in the best interest of our citizens.

It would seem that if Mission Hospital has excess money to spend, then that money should go back to the citizens who have subsidized the hospital, not the expansion which will only increase the resumes of the hospital administrators.

Sincerely,

Bruce Perlman M.D

Internal Medicine

Received by the CON Section

29 APR 2011 1-1 2020

THE MACULA CENTER
Of North Carolina

Diseases of the Retina Eye Surgery Laser Treatment

Robert P. Laborde, MB-

709 5th Avenue West Hendersonville, NC 28739 p 828.693.0747 f 828.693.0947 www.maculacenternc.com

Gebrette Miles, Project Analyst Certificate of Need Section Division of Health Service Regulation 2704 Mail Service Center Raleigh NC 27699-2704 April 27, 2011

Re: Project I.D. No. B-8638-11

Dear Sirs,

I am writing to express strong opposition to the proposed expansion of Mission Hospital into Henderson County and to oppose the application of CON for a GI room as part of their proposed expansion project.

As a physician who has practiced in Henderson County for twenty years, I have grave concern that Mission's move will adversely impact health care providers and patients in Henderson County. Pardee Hopsital, Park Ridge Hospital, and Carolina Mountain GI provide more than sufficient GI room access for patients in our area. I believe Mission's expansion into the Henderson County area is not needed and is not in the best interest of patients in Western NC.

I urge you to carefully consider and reject the proposed expansion of Mission outside of Buncombe County and to reject this proposed request for CON application.

Sincerely.

Robert P. Laborde, MD

Received by the **CON Section**

29 APR 2011 1 7 2020

Post Office Box 1590 Flat Rock, North Carolina 28731 April 28, 2011

Ms.Gebrette Miles, Project Analyst Certificate of Need Section Division of Health Service Regulation 2704 Mail Service Center Raleigh, NC 27699-2704

Dear Ms. Miles:

This letter is in reference to Project ID B-8638-11.

I am a physician living and working in Henderson County. I oppose the requested CON by Mission Hospital to move a GI room to Henderson County. There are already three centers that provide excellent services for the patients of Henderson County and elsewhere in Western North Carolina. They are not fully utilized at this time; I feel this would be an unnecessary duplication of services.

Thank you for the opportunity to express my opinion.

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through he are mention stock in the contract with

en grant transfer for the second

Sincerely,

Carlton A. Jenkins, MD

Received by the CON Section

02 MAY 2011 9: 5 G

Dear Ms. Miles,

I am writing to oppose the:

CON requested by mission

Hespital in Asherie reporting moving a & I ROOM. There wilk red about this. There are already:

Other providers serving this area.

GI work volumes are declaring. This is an unaccessory duplication of services that will have a regative impact and competition and hurt the other 3 serving entities.

Sixerely, Danna Matterno Family Physician Hendersonville, NC

CON Section

02 MAY 2011 9 : 30

Gebrette Miles, Project Analyst Certificate of Need Section Division of Health Service Regulation 2704 Mail Service Center Raleigh, NC 27699-2704

April 28, 2011

I am writing to express my concern over Project I.D. No. B-8638-11.

First, there is no need for a GI room in this location. There are three providers in close proximity to the proposed location- Pardee Hospital, Carolina Mountain Gastroenterology and Park Ridge Health.

Second, the application shows declining volumes for GI work.

Third, as indicated in my first point, this is a duplication of services. There are three options for people seeking Gastroenterology services for this area. This type of unnecessary duplication of services drives up the cost of healthcare.

Fourth, a negative impact will be felt by the competition. All three of the above entities will be hurt in this maneuver.

Finally, there remains plenty of unused capacity in all three of the entities referenced above.

Thank you for you time in noting my concerns for this Certificate of Need.

Sincerely,

Renae Johnson R.N.

02 MAY 2011 9 : 3

April 28, 2011

Gebrette Miles, Project Analyst Certificate of Need Section Division of Health Service Regulation 2704 Mail Service Center Raleigh NC 27699-2704

REFERENCE: Project I.D. No. B-8638-11

Dear Gebrette,

As a citizen who lives in Henderson County, North Carolina, and works in the healthcare field, I am writing as a concerned citizen regarding Mission Hospital's application to the Certificate of Need Office for the relocation of one of their GI rooms to the area of the Buncombe - Henderson County line project which is being planned for 2013. I believe relocation of one of Mission's GI Proecedure rooms in unnecessary and their only reason for this request is to gain a stronghold in the Henderson County market, which is currently well served by the three existing providers of endoscopy services — Pardee Hospital, Park Ridge Health and Carolina Mountain Gastroenterology.

Allowing Mission to relocate their GI Procedure Room to this area will decrease the volumes the current providers are handling and would create an unnecessary duplication of services which, in the end, drives up the cost of health care to the consumer. I am all for competition — but not when it has a negative impact on those healthcare providers who have served in Henderson County through the years.

I urge you to vote <u>against</u> Mission Hospital's request to move one of their GI Procedure Rooms to the county line project.

Best regards,

Colleen C. Ramsey 44 Fox Trot Path

Colleen C. Ranser

Fletcher, NC 28732

Received by the CON Section

02 HAY 2011 9 : 30

R. Craig Lindsey 10 Sabrina Drive Arden, NC 28704

April 28, 2011

Gebrette Miles, Project Analyst Certificate of Need Section Division of Health Service Regulation 2704 Mail Service Center Raleigh NC 27699-2704

REFERENCE: Project I.D. No. B-8638-11

Dear Gebrette,

As a concerned citizen who works in the healthcare field, I am writing regarding Mission Hospital's application to the Certificate of Need Office for the relocation of one of their GI rooms to the area of the Buncombe - Henderson County line project which is being planned for 2013. I believe relocation of one of Mission's GI Proecedure rooms in unnecessary, as the Henderson County market is currently well served by the three existing providers of endoscopy services — Pardee Hospital, Park Ridge Health and Carolina Mountain Gastroenterology.

Allowing Mission to relocate their GI Procedure Room to this area will decrease the volumes the current providers are handling and would create an unnecessary duplication of services which, in the end, drives up the cost of health care to the consumer. This will have a negative impact on those healthcare providers who have served in Henderson County through the years.

I urge you to vote <u>against</u> Mission Hospital's request to move one of their GI Procedure Rooms to the county line project.

Sincerely,

R. Craig Lindsey

02 MAY 2011 9 : 3 C

Ronald Neimkin, MD 6 Dry Ridge Road Asheville, NC 28804

April 28, 2011

Gebrette Miles, Project Analyst Certificate of Need Section Division of Health Service Regulation 2704 Mail Service Center Raleigh NC 27699-2704

REFERENCE: Project I.D. No. B-8638-11

Dear Gebrette,

I am writing as a concerned citizen and physician of Buncombe County. Mission Hospital System has applied for a Certificate of Need for relocation of one of their GI rooms to the area of the Buncombe County-Henderson County line. I do not believe that this is necessary. There are rooms available for this purpose at Pardee Hospital, Park Ridge Health and Carolina. Mountain Gastroenterology.

Allowing Mission to relocate their GI Procedure Room to this area will just add to the monopoly of health care that Mission Hospital has in this region. This will have a negative effect on the other providers in the area with the decreasing volume of GI procedures needed at this time. By being larger, Mission could sustain financial losses which the other competitors cannot, and therefore forcing the smaller providers to close their doors. Thus, Mission's monopoly just continues to thrive at the other hospitals' expense.

Sincerely yours,

Ronald Neimkin, MD

Rouald Mainkin

4/28/20// Received by the CON Section

To whom it may Concern:

U 2 MAY 2011

I am writing in reference to Project

I.D. No. B-8638-11, I am totally against Mission Hospital being allowed to buy up and more in to destroy other health care facilities in WNC. as a Native of WNC & Rane Watched Mission grow until it appears noone can say mo

to the grant!

They serve a wonderful purpose where they are and taking core of Buncombe Country-Please let them leave a few John for the rost of the health con field.

John Gentry

Received by the CON Section

0 2 MAY 2011 9: 30

Gebrette Miles, Project Analyst

Certificate of Need Section

Division of Health Service Regulation

2704 Mail Service Center

Raleigh, North Carolina 27699-2704

Re: Project L.D. No. B-8638-11

April 29, 2011

Dear Ms Miles,

I am writing to express my concerns regarding the Certificate of Need for which Mission Hospitals has applied, in order to move one of their GI rooms from their campus to a location on the Buncombe/Henderson county line.

- There is no identified need that has been shown to the public. There are already three providers in close proximity to the proposed center: Park Ridge Health, Pardee, and Carolina Mountain Gastroenterology.
- The application itself shows declining volumes for GI work.
- This would be an unnecessary duplication of services. There are plenty of alternatives for those of us seeking these services. This type of duplication drives up our cost of healthcare.
- It would have a negative impact on competition. It will hurt all three of the entities mentioned above.
- There is plenty of unused capacity in all three of the entitles referenced above.

Thank you.

Sincerely,

Diane Sedgwick, R

102 Tartana Circle

Hendersonville, NC 28791

02 MAY 2011 9 . 3

April 28, 2011

Gebrette Miles, Project Analyst Certificate of Need Section 2704 Mail Service Center Raleigh, North Carolina 27699-2704

Project ID No. B-8638-11

To Whom it may Concern:

I'd like to voice my strong opposition to the approval of a CON for a GI Room by Mission Health System on the Henderson & Buncombe county line. Following are some of the reasons this CON does not make any sense and should be denied:

- There are two other hospitals and one independent GI services provider all within a few minutes
 of each other and the proposed location for the new GI facility. There is capacity for additional
 volumes at all of these providers making another facility unnecessary and redundant.
- This unnecessary duplication of services drives up cost and makes it more difficult for the
 existing providers to maintain the volumes they have. This will clearly hurt the existing
 providers and thus negatively impact their ability to serve their community.
- This negative and completely unnecessary impact will simply hurt the healthcare consumers in western North Carolina.
- The application indicates a declining demand for GI services in the area. A GON by definition states it is for a "NEED". The facts clearly do not support a need and in fact will cause damage to the delivery of healthcare in this two county area to physicians, independent DI providers, and to both Pardee Hospital and Park Ridge Health.
- Knowing something about the COPA issue under review, as well as this CON, it appears that this is a predatory move by Mission Health System designed to create a monopoly in western North Carolina. This is absolutely not in the best interest of patients needing services since monopolies always end up driving up the costs of goods and services.

Sincerely,

Gary Carlson

02 MAY 2011 9 : 36

April 28, 2011

David T. Manly, M.D. 5 Sharon Drive Fairview, NC 28730

Gebrette Miles
Project Analyst
Certificate of Need Section
Division of Health Service Regulation
2704 Mail Service Center
Raleigh, NC 27699-2704

RE: Project ID# B-8638-11

Dear Ms. Miles,

I am a physician practicing in Henderson County, N.C. I am writing to express my concern about the recent Certificate of Need (CON) application by Mission Hospital to move a GI procedure room from the Mission main campus south to the Buncombe-Henderson County line.

With careful review of the data, one can see there is already plenty of capacity now in Henderson County. In fact, the existing procedure rooms at Pardee Hospital and Park Ridge Hospital are underutilized. Adding this GI suite will only serve to hurt the providers already in Henderson County. This is an unnecessary duplication of service since there are already three nearby providers of GI procedures: Pardee Hospital, Park Ridge Hospital and Carolina Mountain Gastroenterology. There is already plenty of capacity to meet the current and future demand.

I strongly oppose this CON and encourage you to carefully consider the potential negative impact of this proposal.

Thank you.

Sincerely,

David T. Manly, M.D.

Park Ridge Anesthesiology Services, PA

P.O. Box 279 • Naples, NC 28760 www.parkridgeanesthesia.com

> Office: (828) 329-5550 Fax: (828) 681-2747

Received by the CON Section

02 MAY 2011 9:30

April 27, 2011

Gebrette Miles, Project Analyst Certificate of Need Section Division of Health Service Regulation 2704 Mail Service Center Raleigh NC 27699-2704

RE: Project I.D. No. B-8638-11

Dear Ms. Miles:

We are writing in opposition to the Certificate of Need that Mission Hospital System has recently put before the North Carolina Division of Health Service Regulation.

Our group practice is in the unique position of working with many physicians from both hospitals in Henderson County. We cannot recall a time recently when any of the surgeons or GI specialists who do endoscopies have said there is a need for more endoscopy suites.

The proposed project is to be built literally on the Buncombe/Henderson county line and only two miles from Park Ridge Health. It appears to us this is a purely predatory move.

Practice demographics from our Anesthesiology Department show a decline in these types of procedures at this point in time. It is our understanding that there are declining volumes around the entire service area. Why approve another endoscopy suite? It would be a duplication of services.

So, in summary, there is plenty of existing capacity in the service area. Also, there are already three different entities providing these services. Finally, we see this as a predatory advance into Henderson County. In fact, a recent 2011 report by Dr. Gregory Vistnes, commissioned by the State, has raised concern about Mission Health System's antitrust issues surrounding its Certificate of Public Advantage (COPA).

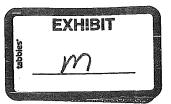
Sincerely,

Dr. Jeffrey Coston

President

Dr. Stephen Bonney

Anesthesiology Department Section Chief



STATE OF NORTH CAROLINA

IN THE OFFICE OF ADMINISTRATIVE HEARINGS

COUNTY OF BUNCOMBE	11 DHR 11636
MISSION HOSPITAL, INC.)
Petitioner,)
v. N.C. DEPT. OF HEALTH AND HUMAN SERVICES, DIVISION OF HEALTH SERVICE REGULATION, CERTIFICATE) OF NEED SECTION,	AFFIDAVIT OF DIMM BUNCH
Respondent.)))

The undersigned, Jimm Bunch, first being duly sworn, deposes and says as follows:

- 1. I am the President and Chief Executive Officer of Fletcher Hospital, Incorporated d/b/a Park Ridge Health ("Park Ridge"). Park Ridge is a 103-bed hospital located in Fletcher, Henderson County, North Carolina. We have served our community for more than 100 years.
- 2. Park Ridge has one endoscopy room and provides all types of outpatient endoscopy procedures to its patients.
- 3. I am familiar with the CON Application filed by Mission Hospital, Inc. and its proposal to move one of its existing endoscopy rooms currently being utilized at its Asheville hospital, to a medical office building in Fletcher. Mission calls its project "Mission GI South." The proposed location of Mission GI South straddles the Henderson and Buncombe County line, and is only 4.3 miles from Park Ridge. See Map of Proposed Project, attached to my affidavit.
- 4. We provide endoscopy services to patients residing in Henderson and Buncombe Counties. Specifically, we provide outpatient endoscopy services to patients who live in each of the nine zip codes Mission stated in its CON Application that it wants to serve. In fact, between October 1, 2010 and September 30, 2011, we provided outpatient endoscopy services to 267 patients residing in those nine zip codes. For both inpatient and outpatient endoscopy services in the same time period, we provided services to 350 patients residing in the nine zip codes proposed to be served by Mission.

¹ Those zip codes are: Henderson County: 28732, 28742, 28758, 28759, 28791, and 28792; Buncombe County: 28704, 28803, and 28806.

- 5. As the Agency noted in its findings, Park Ridge's procedure volume is well below the minimum standard (1,500 procedures) used to determine the need for a new endoscopy room. In fact, as the Agency pointed out on page 32 of its findings, in Federal Fiscal Year 2010, Park Ridge performed just 676 endoscopy procedures. The Agency also noted on page 32 that Park Ridge is the facility in closest proximity to the proposed Mission GI South campus.
- 6. Park Ridge submitted detailed comments opposing the Mission CON Application, and we also spoke at the public hearing in May 2011. By moving an endoscopy room so close to Park Ridge, it is evident that Mission will seek to attract patients away from Park Ridge's endoscopy room and to Mission's endoscopy room. There is no reason for Mission to move the room from Asheville to the Buncombe/Henderson County Line (a distance of approximately 10 miles) if Mission is simply planning on serving the same patients it has always served.
- 7. As the Agency's findings made clear, endoscopy utilization is flat in Buncombe County, and declining in Henderson County. In fact, according to page 32 of the Agency's findings, between 2008 and 2010, the number of endoscopy cases in Henderson County declined by 21.9%. During that same period, the number of endoscopy procedures in Henderson County declined by 10.9%. These are dramatic decreases. What this means in practical terms is that fewer people are having endoscopy. There are not enough patients to keep the existing endoscopy rooms in the area busy.
- 8. As the Agency also noted in its findings, Mission is arguably increasing the inventory of endoscopy rooms in Henderson County because part of the room that Mission proposes to build is actually located in Henderson County. So, Mission would be increasing endoscopy rooms in a county where there is absolutely no need for more endoscopy rooms. This is something that Mission, with six endoscopy rooms, can seek to do, while Park Ridge, which has only one endoscopy room, cannot do. We would not take our one endoscopy room, and try to move it to Buncombe County. Nor could we apply to add an additional endoscopy room. As the Agency noted in its findings, our endoscopy volume is well below the minimum standard for adding another endoscopy room.
- 9. As the Agency's findings show, the endoscopy volumes in Henderson County do not justify adding another endoscopy room in such close proximity to Park Ridge. While adding unnecessary excess capacity harms Park Ridge's endoscopy program, it is important to look at the bigger picture to see how the unnecessary duplication impacts Park Ridge as a whole, and how the unnecessary duplication impacts the CON program.
- 10. As a not-for-profit entity, all the money that Park Ridge makes, after paying its expenses, is returned to the facility so we can maintain and grow what we have. Any revenues after expenses on endoscopy help support services we typically do not make money on, like the emergency department and psychiatric services. Lost patients in any service line means lost revenue to the organization as a whole.
- 11. Replacing these lost revenues is not a simple matter of trying to gain more endoscopy patients to offset these losses, because the pool of endoscopy patients is shrinking. Nor is it a matter of raising rates in another area to try to offset a loss of revenue in a particular

service line. A substantial part of our revenues comes from Medicare and Medicaid. The government will not raise rates upon our request. Managed care payors are also extremely restrictive in their reimbursement. So, once the revenue is lost because of this unnecessary duplication of services, it is likely lost for good. The impact that this will have on some of our services we do not make money on, like psychiatric services, will be significant.

- 12. The CON Law is designed in part to avoid over-investment in medical services. By over-investment, I mean building facilities that the community does not need. This drives up costs, since those facilities have to be paid for in some way and contributes to over-capacity. This is wasteful and increases medical costs for everyone. Mission's proposal is an excellent example of over-building because declining endoscopy volumes do not support the need for more endoscopy services in this area.
- 13. There is no issue whatsoever with patients being able to access convenient, high-quality endoscopy services in Buncombe and Henderson Counties. Park Ridge invested more than \$25 million a few years ago to refurbish and enhance our surgery center which contains our endoscopy room. This is a state-of-the-art center that is conveniently located for patients, and it is less than five miles from where Mission proposes to build its facility. Carolina Mountain has two outpatient endoscopy rooms which are also conveniently located nearby in Hendersonville. Mission itself has six endoscopy rooms in Asheville, and the Endoscopy Center, which focuses exclusively on outpatient endoscopy, has five endoscopy rooms in Asheville. Pardee Hospital, which is near the Carolina Mountain facility in Hendersonville, has three endoscopy rooms.
- 14. The Agency's decision to deny Mission's endoscopy room does not prevent Mission from using its endoscopy room in its current location, so patients are not being deprived of the services offered in this room.
- 15. It is my understanding that under the CON Law, Park Ridge is an "affected person" because it provides services, similar to the services under review by the Agency, to residents of the service area proposed to be served by the applicant. It is also my understanding that an "affected person" who has a statutory right to intervene cannot be limited in its intervention. Park Ridge wishes to exercise its rights and to participate in this case as a party.
- 16. While Park Ridge absolutely agrees with the Agency's decision to deny Mission's application, the Agency does not represent Park Ridge. Park Ridge has first-hand knowledge, which the Agency does not have, about the harm Mission's project would cause Park Ridge. Park Ridge can also speak, on a first-hand basis, to the unnecessary duplication that Mission's project would cause, and to the investment that Park Ridge has made in developing its endoscopy services. Park Ridge actually participates in this market as a healthcare provider so it has more direct knowledge about the delivery of outpatient endoscopy services in this area than the Agency does. Park Ridge also has greater resources to defend the Agency's decision. For example, the Agency, due to financial constraints, would be unlikely to depose Mission witnesses or to hire an expert witness to help defend its decision. Park Ridge can depose these witnesses and hire an expert. I would expect Mission to defend its proposal vigorously, and unless someone, i.e., Park Ridge and Carolina Mountain, can question Mission's assertions, those

assertions may go unchallenged. The Agency, by consenting to Park Ridge's intervention, recognized that Park Ridge can help the Agency defend its decision.

17. Filing a brief will not adequately protect Park Ridge's interests. Park Ridge, as an "affected person," is entitled to review documents, question witnesses at deposition and at trial, appear at mediation, and argue the case in front of the Administrative Law Judge and Final Agency Decisionmaker. We cannot adequately defend our rights as someone who is directly and immediately impacted by Mission GI South by just filing a brief.

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June Burch

STATE OF NORTH CAROLINA)
)
COUNTY OF HENDERSON	•

Signed and sworn to before me this day by Jimm Bunch.

Date: December 15, 2011

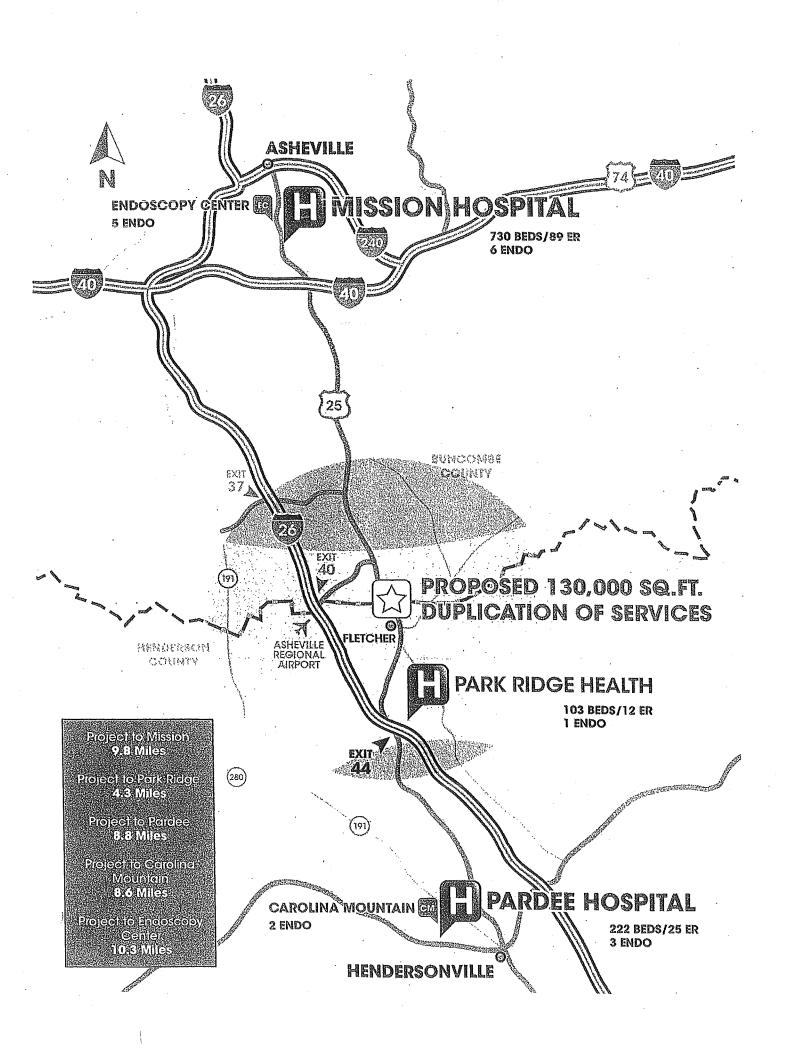
Collew C. Ramsey Notary's Signature

Notary's Seal:

Colleen C. Ramsey
Notary's Name
(Printed or Typed)

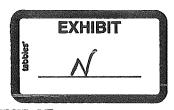
My commission expires: October 16, 2015

-#4818-4291-3806 v.1 - 37136/01501~



Data supplied on hospital license renewal applications

week with the ball	पूर्वभाष । -	14.00	The second of th
Total Beds	730	730	730
Total Admissions	37,221	38,104	38,559
ER Rooms	75	75	89
ER Visits	100,453	100,061	100,299
ER Admissions	18,122	19,554	20,421
OR Rooms	43	43	43
Endoscopy Rooms	6	6	6
Endoscopy Cases (GI)	7,064	6,741	6,563
ParkRidgeHealth	2009	2010	2011
Total Beds	103	103	103
Total Admissions	3,713	3,226	3,128
ER Rooms	12	12	12
ER Visits	16,191	17,409	19,486
ER Admissions	2,091	1,807	2,046
OR Rooms	6	6	6
Endoscopy Rooms	1	1	. 1
Endoscopy Cases (GI)	762	649	676
Pardee Hospital	2007	2010	2011
Total Beds	222	222	222
Total Admissions	6,649	6,369	6,557
ER Rooms	25	25	25
ER Visits	30,682	32,225	32,209
ER Admissions	5,606	5,837	5,695
OR Rooms	10	10	10
Endoscopy Rooms	3	3	3
Endoscopy Cases (GI)	3,891	3,344	2,444



STATE OF NORTH CAROLINA

COUNTY OF BUNCOMBE

MISSION HOSPITAL, INC.

Petitioner,

٧.

N.C. DEPT. OF HEALTH AND HUMAN SERVICES, DIVISION OF HEALTH SERVICE REGULATION, CERTIFICATE OF NEED SECTION,

Respondent.

IN THE OFFICE OF ADMINISTRATIVE HEARINGS 11 DHR 11636

AFFIDAVIT OF CARL P. STAMM, M.D

The undersigned, Carl P. Stamm, M.D., first being duly sworn, deposes and says as follows:

- 1. I am a physician licensed to practice in North Carolina. I am board certified in gastroenterology and internal medicine. I am one of the founding members of Carolina Mountain Gastroenterology, P.A., a physician practice in Hendersonville, North Carolina that focuses on the evaluation and treatment of illnesses of the gastrointestinal tract. In 2007, our practice established an outpatient endoscopy center in Hendersonville with two endoscopy rooms that we call Carolina Mountain Gastroenterology Endoscopy Center, LLC ("Carolina Mountain"). We provide all types of outpatient endoscopy procedures to our patients.
- 2. I have practiced gastroenterology in the Henderson and Buncombe County area since 1995 and am personally very familiar with our patient base.
- 3. Carolina Mountain has four physicians and four physician extenders (physician's assistants and family nurse practitioners) who serve patients. We also have several staff members.

- 4. I am familiar with the CON Application filed by Mission Hospital, Inc. and its proposal to move one of its existing endoscopy rooms currently being utilized at its Asheville hospital, to an office building in Fletcher. Mission calls its proposal "Mission GI South." The proposed location for Mission GI South straddles the Henderson County and Buncombe County line. This proposed location is less than 9 miles from Carolina Mountain. See Map of Proposed Project, attached to my affidavit.
- 5. I and my partners and staff at Carolina Mountain are deeply concerned about Mission's proposed relocation so close to our facility.
- 6. Our primary patient base is Henderson, Buncombe and Transylvania Counties. Specifically, we provide outpatient endoscopy services to patients who live in each of the nine zip codes Mission stated in its CON Application that it wants to serve. In fact, between April 2010 and March 2011, we provided outpatient endoscopy services to nearly 1,300 patients residing in those nine zip codes.
- 7. It is my understanding that under the CON Law, Carolina Mountain is an "affected person" because it provides services similar to the service under review to people who reside in the service area proposed to be served by the applicant. It is also my understanding that an "affected person" has an absolute right to intervene as a party in CON litigation. Carolina Mountain wishes to exercise its right to intervene as a party to support the CON Section in these proceedings.
- During the CON review process, Carolina Mountain filed extensive comments opposing the Mission CON Application. We also spoke at the public hearing in May 2011. We did so because it was clear to us that this proposed relocation was not needed. Patients in the Buncombe County and Henderson County service area are already being adequately served by Carolina Mountain and other existing providers like Park Ridge. We knew this to be the case because we currently have existing capacity in our two rooms and since 2008, have experienced dramatic decreases in the number of endoscopy cases and procedures at our center. Between 2008 and 2009, the number of cases at our facility decreased by 990 cases.² Due to this dramatic decrease and shrinking pool of patients, our endoscopy rooms are significantly underutilized and could easily accommodate a 30% to 40% increase above our current volumes. There is just no need for another endoscopy room in this market.

¹ Those zip codes are: Henderson County: 28732, 28742, 28758, 28759, 28791, and 28792; Buncombe County: 28704, 28803, and 28806.

² See Table 6E 2010 SMFP; Table 6E 2011 SMFP; Carolina Mountain Comments in Opposition, p. 7.

- 9. As the CON Section noted in its findings, part of the room that Mission proposes to develop in the Mission GI South project is actually located in Henderson County, so Mission is arguably seeking to increase endoscopy room inventory in Henderson County, which is already saturated with excess endoscopy room capacity.
- 10. By seeking to relocate one of its six endoscopy rooms to the Buncombe/Henderson border, it is evident that Mission wants to attract patients who now go to the existing endoscopy providers in Henderson County, including Carolina Mountain. If Mission were intending to serve only the patients it now serves, then it would leave the endoscopy room where it is in Asheville.
- Rather, it is unfair competition. This is not just ordinary competition. 11. Mission, which already has six endoscopy rooms, is seeking to move its inventory around so that it can capture patients from providers like Carolina Mountain who are already struggling with declining endoscopy room utilization. Carolina Mountain, a physician practice, certainly cannot compete with Mission's resources. We are also not in position to move either or both of our existing endoscopy rooms to Buncombe County, nor are we in a position to add more We cannot raise prices to our government payors to offset the revenue endoscopy rooms. lost due to a decline in patient volumes, and managed care payors are also highly resistant to The population is not growing enough that it would be reasonable to expect The simple truth is that there are not enough patients to support an influx of new patients. the endoscopy rooms that exist now in Henderson County, and adding another one at the Buncombe/Henderson border is completely unnecessary.
- 12. The bottom line is that if Mission is allowed to build Mission GI South, we are in danger of having to close one or both of our existing endoscopy rooms. This is not just a matter of lost revenue and a lost investment. It may mean we will have to lay off staff and the community will lose an option for care. If Mission were to relocate its endoscopy room as proposed, Carolina Mountain would face volume losses of 40% per month which would equate to approximately \$112,000.00 in lost revenues each month.
- 13. Patients in this area already have excellent access to endoscopy room services. Patients can choose between our facility, which has two state-of-the-art endoscopy rooms; Park Ridge Health; Pardee Hospital; The Endoscopy Center in Asheville and Mission itself. With six endoscopy rooms, Mission has more endoscopy rooms than anyone else in this region. Even though its CON application was denied, Mission can still keep using all six of its endoscopy rooms at its Asheville campus.

the Mission GI South application, the CON Section does not represent our interests. Only Carolina Mountain can represent Carolina Mountain's interests. Only Carolina Mountain can explain how the Mission GI South project impacts Carolina Mountain. Only Carolina Mountain can explain, from a first-hand perspective, how the Mission GI South project unnecessarily duplicates Carolina Mountain's services. As an actual participant in the delivery of outpatient endoscopy services in this region, Carolina Mountain knows a great deal more about outpatient endoscopy services in this region than does the CON Section. Limiting Carolina Mountain just to filing a brief does not allow Carolina Mountain to review documents, take depositions, cross examine witnesses and attend mediation. Carolina Mountain cannot effectively participate in defending the Agency's decision when all it can do is file a brief.

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December 15, 2011.

Carl P. Stamm, M.D.

STATE OF NORTH CAROLINA)

COUNTY OF HENDERSON

Signed and sworn to before me this day by Carl P. Stamm, M.

Date:

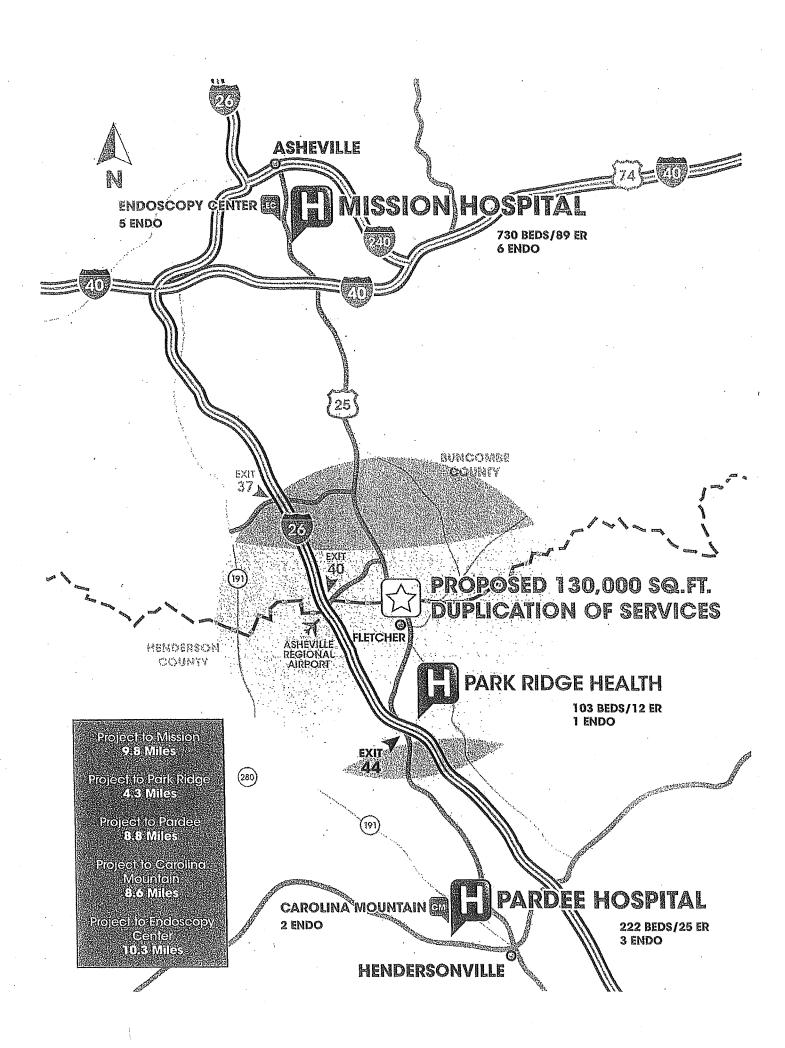
Notary's Signature

Dawn Waters.

Notary's Name (Printed or Typed) Notary's Seal

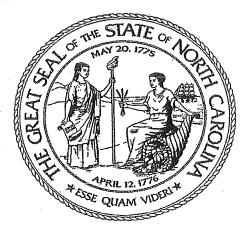
My commission expires: 07 05

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NORTH CAROLINA GENERAL ASSEMBLY



HOUSE SELECT COMMITTEE ON THE CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES

REPORT TO THE
2012 SESSION
of the
2011 GENERAL ASSEMBLY

APRIL 2012

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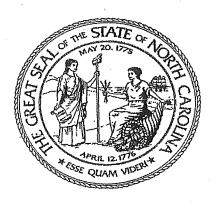
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TRANSMITTAL LETTER

STATE OF NORTH CAROLINA

HOUSE SELECT COMMITTEE ON THE CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES



April 19, 2012

TO THE MEMBERS OF THE 2012 HOUSE OF REPRESENTATIVES:

Attached for your consideration is the interim report of the House Select Committee on the Certificate of Need Process and Related Hospital Issues established by the Speaker of the House of Representatives pursuant to G.S. 120-19.6(a1) and Rule 26 of the Rules of the House of Representatives of the 2011 General Assembly.

Respectfully submitted,

Representative Fred Steen Co-Chair Representative John Torbett Co-Chair

COMMITTEE AUTHORIZATION



Office of Speaker Thom Tillis North Carolina House of Representatives Raleigh, North Carolina 27601-1096

HOUSE SELECT COMMITTEE ON THE CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES.

TO THE HONORABLE MEMBERS OF THE NORTH CAROLINA HOUSE OF REPRESENTATIVES

Section 1. The House Select Committee on the Certificate of Need Process and Related Hospital Issues (hereinafter "Committee") is established by the Speaker of the House of Representatives pursuant to G.S. 120-19.6(a1) and Rule 26 of the Rules of the House of Representatives of the 2011 General Assembly.

Section 2. The Committee consists of the 11 members listed below, appointed by the Speaker of the House of Representatives. Members serve at the pleasure of the Speaker of the House of Representatives may dissolve the

Committee at any time.

Representative Fred Steen, Co-Chair
Representative John Torbett, Co-Chair
Representative Jamie Boles
Representative Mark Hollo
Representative Bill Current
Representative Marilyn Avila
Representative Jeff Collins
Representative Shirley Randleman
Representative Rick Glazier
Representative Martha Alexander
Representative Marcus Brandon

Section 3. The Committee may study all of the following:

(1) The provisions of House Bill 743, First Edition, 2011 Regular Session and House Bill 812, First Edition, 2011 Regular Session.

(2) The legal requirements and process governing Department of Health and Human Services determinations on applications for CON, including an analysis

Issues relating to publicly owned hospitals, including determining the implemented by the Department of Health and Human Services. of exceptions granted under policy AC-3 of the State Medical Facilities Plan as

hospital authorities created under G.S. 131E-17 to operate beyond the boundaries appropriate role of State-owned hospitals and the appropriate manner for public

required to comply with the same rules, policies, and limitations to each county Whether a hospital operating under a Certificate of Public Advantage should be (ħ) of the local government that created the authority.

entity having a Certificate of Public Advantage or operating under an exemption The extent to which a publicly owned hospital should engage in business with an (g)

Any other matter reasonably related to subdivisions (I) another was the property of the state of (9)under the CON laws of the State.

Section 4. The Committee shall meet upon the call of its Co-Chairs. A quorum of the section, in the discretion of the Committee.

powers provided for under G.S. 120-19 and Article 5A of Chapter 120 of the General Statutes. Section 5. The Committee, while in the discharge of its official duties, may exercise all Committee shall be a majority of its members.

Section 6. Members of the Committee shall receive per diem, subsistence, and travel

allowances for Committee members, and contracts for professional or consultant services shall Section 7. The expenses of the Committee including per diem, subsistence, travel allowance as provided in G.S. 120-3.1.

G.S. 120-32.02(c) and G.S. 120-35 from funds available to the House of Representatives for its be paid upon the written approval of the Speaker of the House of Representatives pursuant to

assist the Committee in its work. The Director of Legislative Assistants of the House of Section 8. The Legislative Services Officer shall assign professional and clerical staff to operations.

Section 9. The Committee may submit an interim report on the results of the study, Representatives shall assign clerical support staff to the Committee.

its final report, whichever occurs first. Committee terminates upon the convening of the 2013 General Assembly or upon the filling of of the House of Representatives, the House Principal Clerk, and the Legislative Library. The convening of the 2013 General Assembly by filling the final report with the Office of the Speaker including any proposed legislation, to the members of the House of Representatives prior to the Legislative Library. The Committee shall submit a final report on the results of its study, the Office of the Speaker of the House of Representatives, the House Principal Clerk, and the including any proposed legislation, on or before May I, 2012, by filing a copy of the report with

Effective this the 24th day of August, 2011

Speaker silliT modT

(5)

COMMITTEE MEMBERSHIP

Representative Fred Steen, Co-Chair Fred.Steen@ncleg.net

O 919-733-5881

Representative Martha Alexander

Martha.Alexander@ncleg.net O 919-733-5807

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Representative Mark Hollo

Mark. Hollo@ncleg.net O 919-733-8361

STAFF:

Committee Clerk (919) 733 5868

Viddia Torbett - torbettla@ncleg.net

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Lisa Hollowell - Lisa.hollowell@ncleg.net

PREFACE

The development of health care facilities and provision of health care services in North Carolina has been subject to State-level regulation and determinations of need since the late 1970's. This health care planning process seeks to ensure that rural areas and underserved populations have adequate access to health care, to encourage safety and high quality in the health care services provided, and to reduce health care costs through the elimination of unnecessarily duplicative expensive facilities, equipment and services. To accomplish these goals, the statutes require the development of annual projections of need for various types of health care facilities and services. The resulting document is known as the State Medical Facilities Plan (SMFP). To implement the SMFP, the General Assembly enacted the Certificate of Need Law,2 which provides the process by which persons may apply for a license to construct or expand health care facilities or to provide services in accordance with the determined need.

In addition to the SMFP and the CON law, the State has also taken steps to enhance the availability of quality health care services by allowing hospitals and other persons to enter into cooperative agreements for the provision of health care that would otherwise be subject to State antitrust scrutiny.3 Such agreements are subject to the issuance by the State of a Certificate of Public Advantage (COPA). The COPA spells out conditions of operation on the parties to the agreement that, in theory, should counterbalance any competitive advantage gained in the health care marketplace under the cooperative agreement. Only one COPA has issued since the enactment of the statute in 1993.

Although the Certificate of Need law has been amended several times since enacted, it has been a number of years since the General Assembly undertook a serious review of the program.⁴ Further, there is concern that our certificate of public advantage law has not adequately offset the competitive advantage gained under the cooperative agreement and it is unclear if Article 9A provides a definitive process to initiate the termination of an agreement.

The House Select Committee on the Certificate of Need Process and Related Hospital Issues was created and charged with the review of the State health planning process, including the State's CON program and the implementation of the COPA law, to determine whether these programs are adequately serving their intended purpose of ensuring the availability of quality, cost effective health care services to North Carolina citizens. The Committee began its work in September of 2011 and after soliciting input from citizens in all regions of the State has determined, based on the depth and complexity of the information received, further examination is warranted prior to any action.

G.S. 131E-177

Article 9, Chapter 131E of the General Statutes

Article 9A, Chapter 131E of the General Statutes.

⁴ 1991, Legislative Research Commission: Committee on Care Provided by Rest Homes, Intermediate Care Facilities, and Skilled Nursing Homes; Necessity for Certificates of Need; and Continuing Care Issues.

COMMITTEE PROCEEDINGS

Below is a brief summary of the Committee's proceedings. A more detailed record of the Committee's notebook, located in the Legislative Library.

September 14, 2011

The House Select Committee on the Certificate of Need Process and Related Hospital Issues met Wednesday, September 14, 2011, in Room 544 of the Legislative Office Building at 10:00 am. Shawn Parker, Committee Counsel, was called upon to give a review of the Committee Charge. Committee Counsel, Barbara Riley, Amy Jo Johnson, and Jan Paul, gave an overview of North Carolina Certificate of Need Law. This presentation included a review of the North Carolina State Coordinating Council, the State Medical Facilities Plan, and the State Health Planning Process. Also discussed were facilities, services, and equipment subject to the Certificate of Need laws, the application process, and the process by which to appeal a decision regarding Certificate of Need. Following the presentation on Certificate of Need, Shawn Parker gave an overview regarding Certificate of Public Advantage, including its purpose, the legislative history, and the application process. At this time, there is only one Certificate of Public Advantage in the State and Mr. Parker reviewed the details of Mission Health System's Certificate of Public Advantage. The Committee engaged in discussion and requested additional information be provided at the next meeting.

October 6, 2011

The House Select Committee on the Certificate of Need Process and Related Hospital Issues met Thursday, October 6, 2011, in Room 544 of the Legislative Office Building at 10:00 am. The Chair recognized Shawn Parker, Committee Counsel, to go over the Committee charge and address questions remaining from the previous meeting. Drexel Pratt, Director, Division of Health Service Regulation, Department of Health and Human Services spoke briefly on Policy Acute Care 3 (AC3), which allows Academic Medical Center Teaching Hospitals to request additional capacity and equipment to address educational and academic research needs, even if the State Medical Facilities Plan indicates "no need determination" based on the projected need for the general population. Mr. Pratt indicated that the upcoming 2012 State Facilities Medical Plan would include compromise language surrounding AC3 due to the Hospital Associations work with stakeholders and explained the compromise language. Jeff Horton, Chief Operating Officer, Division of Health Service Regulation, Department of Health and Human Services, gave an overview and inventory of facilities regulated by the Certificate of Need Process, as well as a review of the Certificate of Need application and appeal process. Mr. Horton also provided various statistics surrounding Certificate of Need in North Carolina.

Following the presentations by the Division of Health Services Regulation, the Committee heard from Hugh Tilson, Senior Vice President, North Carolina Hospital Association. Mr. Tilson explained the economics of health care and challenges facing hospitals in the State. The final

presentation was given by Moah Huffsteder III, Attorney and Partner at the firm Nelson Mullins. Mr. Huffsteder discussed Certificate of Need regulation from a legal practioner's point of view, including areas in which the Certificate of Need law presents opportunities for improvement.

October 20, 2011

The House Select Committee on the Certificate of Need Process and Related Hospital Issues met Thursday, October 20, 2011, in the Boone Building at the WMC Agricultural Center in Fletcher, Morth Carolina, at 6:00 pm. Shawn Parker, Committee Counsel, gave a brief overview of the Committee's charge. The first presentation was made by the following individuals: Dr. Ron Paulus, Chief Advantage. The first presentation was made by the following individuals: Dr. Ron Paulus, Chief Executive Officer, Mission Health System, Richard Vinroot, Legal Counsel, Mission Health System, Dr. Tom McCarthy, Economist, and Brandon Sutherland, Senior Manager, Dixon Hughes Dr. Tom McCarthy, Economist, and Brandon Sutherland, Senior Manager, Dixon Hughes of Public Advantage on the hospital's of Public Advantage, the effectiveness of the Certificate of Public Advantage on the hospital's performance, and a request that Mission be released from the Certificate of Public Advantage in the Public Robins Dr. Tom McCarthy.

The second presentation was made by the following individuals: Jim Bunch, President and Chief Executive Officer, Park Ridge Hospital, Graham Fields, Assistant to the Presented for External Relations, Park Ridge Hospital, Dr. Brian Quaranta, Physician, 21st Century Oncology, Gail Cummings, Regional Administrator, 21st Center Oncology, and Dr. Nathan Williams, Physician and detailed areas in which the individuals felt the Certificate of Public Advantage program. Following changes and requested further oversight of the Certificate of Public Advantage program. Following the presentations, the Chair recognized individuals from the public Advantage program. Following the presentations, the Chair recognized individuals from the public Advantage program. Following the presentations, the Chair recognized individuals from the public Advantage program. Following the presentations, the Chair recognized individuals from the public Advantage or Committee on issues related to Certificate of Need and Certificate of Public Advantage.

November 1, 2011

The House Select Committee on the Certificate of Meed Process and Related Hospital Issues met Thursday, November 1, 2011, in the Council Chamber of the Citizens Center in Mount Holly, Morth Catolina at 6:00 pm. Shawn Parker, Committee Counsel, gave a brief overview of the Committee's charge. Darise D. Caldwell, President of Rowan Regional Medical Center presented information regarding the AC3 policy in the State Medical Facilities Plan and suggestions for further changes to that policy. Catol Lovin, President, Management Company, Catolina HealthCate System, then addressed the Committee. Ms. Lovin explained wby the Certificate of Need regulations, which in her opinion involve the application and appeals process, as well as the AC3 policy. The final pereficial and discussed the challenges facing the Certificate of Need regulations, which in her opinion involve the application and appeals process, as well as the AC3 policy. The final monitor involve the application and appeals process, as well as the AC3 policy. The final presentation was made by Doug Luckett, Acting Chief Executive Officer, CaroMont Health and Maria Long, Executive Vice President and Chief Legal Officer, CaroMont Health. Mr. Luckett and Maria Long, Executive Vice President and Chief Legal Officer, CaroMont Health and improvement within the application and appeals process. Pollowing the presentations, the Chair improvement within the application and appeals process. Pollowing the presentations, the Chair

recognized individuals from the public to address the Committee on issues related to Certificate of Need and Certificate of Public Advantage.

November 17, 2011

The House Select Committee on the Certificate of Need Process and Related Hospital Issues met Tuesday, November 17, 2011, at Cape Fear Community College in Wilmington, North Carolina at 6:00 pm. The first presentation was made to the Committee by Denise Mihal, President, Brunswick Novant Medical Center regarding the benefits of Certificate of Need regulations to Novant Health's facilities. The Committee then heard from Dennis Coffey, Chief Financial Officer, Dosher Memorial Hospital, who spoke in support of Certificate of Need regulation and offered suggestions for improving the regulations, particularly with regards to smaller hospitals. The third presentation was made by the following individuals: Sue Collier, Vice President, University Health Systems of Eastern Carolina, Dr. Herbert Garrison, Vice President, Medical Affairs, Pitt County Memorial Hospital and Professor of Medicine, Department of Emergency Medicine, the Brody School of Medicine, and Dr. Brian Kuszyk, Chief of Staff, Department of Radiology, Pitt County Memorial Hospital. This presentation discussed the virtues of the AC3 policy and the benefits this policy provides to the State. The final presentation was made by John Gizdic, Vice President of Strategic Services and Business Development, New Hanover Regional Medical Center, who spoke in support of the process. He detailed the benefits that the Certificate of Need Regulations have had on New Hanover Regional Medical Center's facilities. Following the presentations, the Chair recognized individuals from the public to address the Committee on issues related to Certificate of Need and Certificate of Public Advantage.

January 19, 2012

The House Select Committee on the Certificate of Need Process and Related Hospital Issues met Thursday, January 19, 2012, in Room 544 of the Legislative Office Building at 10:00 am. Representative Torbett presided and gave a brief recap of the previous meetings held across the State. The Chair then recognized Amy Jo Johnson, Committee Counsel, to present topics for discussion regarding the Certificate of Need. The presentation included a chart containing issues and possible solutions that Research staff complied from presentations heard by the Committee and comments from public (see minutes). The Chair opened the floor for discussion and Committee members made various changes and additions to the recommendations. Staff was directed to follow-up on several questions raised by the Committee.

February 15, 2012

The House Select Committee on the Certificate of Need Process and Related Hospital Issues met Wednesday, February 15, 2012, in Room 421 of the Legislative Office Building at 9:00 am. Shawn Parker, Committee Counsel, began with a review of the items pertaining to the Certificate of Public Advantage. The presentation was followed by extensive Committee discussion.

March 15, 2012

The House Select Committee on the Certificate of Need Process and Related Hospital Issues met Thursday, March 15, 2012, in Room 544 of the Legislative Office Building at 10:00 am. The first presentation of the day was made by Jonathan Christenbury, MD regarding amending the Certificate of Meed Law to allow ophthalmic procedure rooms in licensed health services facilities in possible recommendations regarding the Certificate of Meed law. After lunch citizens from Harnett County spoke on how the Certificate of Meed law impacts health care, the economy, and overall well-being of their county. The speakers present from Harnett County were: Pat Cameron, Good Practitioner; and Patsy Carson, Mayor of Etwin. The Chair then opened the floor for discussion. At the end of the meeting, the Chair directed staff to start assembling a draft interim report for the Committee's consideration at a future meeting.

April 19, 2012

The House Select Committee on the Certificate of Need Process and Related Hospital Issues met Thursday, April 19, 2012, in Room 544 of the Legislative Office Building at 10:00 am. The Committee discussed a draft of the interim report.

FINDINGS AND RECOMMENDATIONS

Having clear and open processes enables the stakeholders, as well as the public, to fully participate in the programs and encourages more thorough oversight of the Certificate or Need and Certificate of Public Advantage programs. The Committee believes that maintaining the utmost integrity of these programs is vital. The Division of Health Service Regulation should continue to expand upon its procedures to create more expeditious and transparent processes within the Certificate of Need and Certificate of Public Advantage programs.

The Committee finds that in order to effectuate the purpose of a certificate of public advantage, which is to foster improvements in the quality health care services, moderate health care costs, and improve access to health services in underserved areas, regulatory and judicial oversight of such agreements are necessary to ensure that the benefits of cooperative agreements outweigh the disadvantages and reduction in competition resulting from such agreements.

The Committee concludes there is a need for more transparency and accountability by the State Health Coordinating Council for decisions it makes in the development of the State Medical Facilities Plan. The Committee finds, while it is necessary for the State Health Coordinating Council members to have certain experience and expertise in the health care industry, there is concern of public perception of impropriety based on potential conflicts of interest and the potential of undue influence by a single individual based on the current appointing process. While exemptions to the provisions of need determinations of the North Carolina State Medical Facilities Plan may be necessary, fairness dictates exemptions should be limited to the greatest extent possible so that all applicants of a particular type of health services are subject to the same requirements.

The Committee heard concerns that the specified capital expenditure amounts for certain projects and activities needed to be adjusted based on inflation or necessity and that Certificate of Need review and regulation is no longer needed for specified equipment acquisitions and services. Further the length and volume of appeals cause delays in the provision of needed facilities and/or services. It is in the best interest of the State that the Certificate of Need process be as expeditious as possible and that unnecessary delays be deterred and there should be an expedited process for appellate review in order to shorten the overall Certificate of Need determination process.

The House Select Committee on the Certificate of Need Process and Related Hospital Issues shall continue its in depth review of health care service regulation in North Carolina and shall, after prudent deliberation, recommend changes that are equitable and effective.

Filed

STATE OF NORTH CAROLINA

2012 APR 12 AM 11: ABMINISTRATIVE HEARINGS

COUNTY OF WAKE

Office of

HOLLY SPRINGS HOSPITAL II, LLA diministrative) Hearings

Petitioner,

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File No. 11 DHR 12727

N.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF HEALTH SERVICE REGULATION, CERTIFICATE OF NEED SECTION,

Respondent, and

REX HOSPITAL, INC., HARNETT HEALTH SYSTEM, INC. and WAKEMED,

Intervenors.

REX HOSPITAL, INC.,

Petitioner,

v.

File No. 11 DHR 12794

N.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF HEALTH SERVICE REGULATION, CERTIFICATE OF NEED SECTION,

Respondent, and

WAKEMED, HOLLY SPRINGS HOSPITAL II, LLC, and HARNETT HEALTH SYSTEM, INC.

Intervenors.

HARNETT HEALTH SYSTEM, INC.,	
Petitioner,	
v.) File No. 11 DHR 12795
N.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF HEALTH SERVICE REGULATION, CERTIFICATE OF NEED SECTION,))))
Respondent, and	
REX HOSPITAL, INC., HOLLY SPRINGS HOSPITAL II, LLC, and WAKEMED,	
Intervenors.	
WAKEMED,	
Petitioner,	\}
v.)) File No. 11 DHR 12796
N.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF HEALTH SERVICE REGULATION, CERTIFICATE OF NEED SECTION,	
Respondent, and	
HOLLY SPRINGS HOSPITAL II, LLC, REX HOSPITAL, INC., and HARNETT HEALTH SYSTEM, INC.	
Intervenors.	

RECOMMENDED DECISION ON NOVANT'S MOTION FOR PARTIAL SUMMARY JUDGMENT

THIS CAUSE came before the undersigned Administrative Law Judge upon Petitioner Holly Springs Hospital II, LLC's ("Novant") Motion for Partial Summary Judgment (the "Motion") filed March 19, 2012. The Motion seeks partial summary judgment as follows:

1. Against WakeMed with respect to WakeMed's appeal of the denial of its certificate of need ("CON") application for 79 new acute care beds in Project I.D. No. J-8660-

11 and the North Carolina Department of Health and Human Services, Division of Health Service Regulation, Certificate of Need Section's (the "Agency") conditional approval of 29 new acute care beds in Project I.D. No. J-8660-11 (the "WakeMed Raleigh Application");

- 2. Against Rex Hospital, Inc. ("Rex") with respect to the Agency's conditional approval of Rex's CON application for a 50-bed hospital in Holly Springs, Project I.D. No. J-8669-11 (the "Rex Holly Springs Application");
- 3. Against Rex with respect to Rex's appeal of the Agency's denial of Rex's CON application for a 40-bed hospital in Wakefield, Project I.D. No. J-8670-11 (the "Rex Wakefield Application");
- 4. Against the Agency with respect to the Agency's disapproval of the Novant's CON Application for a 50-bed hospital in Holly Springs, Project I.D. No. J-8673-11 (the "Novant Holly Springs Application"); and
- 5. Against the Agency with respect to all of the applications in this review on the basis of Criterion (18a) of the CON Law, N.C. Gen. Stat. § 131E-183(a)(18a).
 - 6. Novant contends as follows:
 - a. the Agency erred as a matter of law by applying an unpromulgated rule with respect to the Novant Holly Springs Application. Specifically, Novant contends that the Agency impermissibly denied the Novant Holly Springs Application because Novant did not have letters of support from obstetricians practicing in Wake County, when no such requirement exists in the CON Law or applicable administrative rules;
 - b. the Agency erred as a matter of law with respect to its application of Criterion (18a) of the CON Law, N.C. Gen. Stat. § 131E-183(a)(18a) for each of the applicants in this review;
 - c. Summary judgment should be entered against WakeMed Raleigh because its witnesses admitted at deposition that WakeMed Raleigh does not need the 79 beds for it applied or the 29 beds for which it was approved in the 2011 Wake County Bed Review;
 - d. Summary judgment should be entered against Rex Holly Springs because the draft 2012 SMFP showed that Rex has a surplus of 36 beds and therefore, Rex cannot demonstrate the need for 50 additional beds; and
 - e. Summary judgment should be entered against Rex Wakefield in its appeal of the denial of the Rex Wakefield Application for the same reasons set forth above with respect to the Rex Holly Springs Application.

- 7. Petitioner Harnett Health System, Inc. joined in the Motion with respect to the Rex Holly Springs Application and the Criterion (18a) argument.
- 8. Having considered Novant's Motion, the Memoranda of Law and supporting documentation filed by all parties and the arguments of counsel at a hearing conducted on April 2, 2012, the Undersigned enters this Recommended Decision granting in part and denying in part Novant's Motion for Partial Summary Judgment. Specifically, the Motion is granted as to Novant's contentions 6a. (unpromulgated rule) and 6b. (Criterion(18a)) above. The Court does not reach and accordingly denies the Motion with respect to Novant's contentions 6c. through 6e. above. This Recommended Decision does not make any ruling with respect to Project I.D. J-8667-11, the Rex Main Application. WakeMed has made a motion for summary judgment on the Rex Main Application, which will be heard and decided separately.

I. SUMMARY OF UNDISPUTED FACTS

- 1. The 2011 State Medical Facilities Plan ("SMFP") contained a determination that 101 additional acute care beds were needed in Wake County. Exhibit 35 to the Motion, p. 1513. See also Exhibit 42 to the Motion.
- 2. On April 15, 2011, Rex filed three applications proposing to develop all 101 beds as follows:

J-8667-11/Rex Hospital, Inc./Add 11 acute care beds and construct a new beds tower to replace 115 acute care beds in a change of scope for Project I.D. # J-8532-10 (heart and vascular renovation and expansion project)/Wake County (the "Rex Main Application")

J-8669-11/Rex Hospital, Inc./Develop a new separately licensed 50-bed hospital in Holly Springs/Wake County

J-8670-11/Rex Hospital, Inc./Develop a new separately licensed 40-bed hospital in Wakefield/Wake County

3. On April 15, 2011, WakeMed filed two applications proposing to develop all 101 beds as follows:

J-8660-11/WakeMed/Add 79 acute care beds on the WakeMed Raleigh Campus/Wake County

J-8661-11/WakeMed/Add 22 acute care beds at WakeMed Cary Hospital/Wake County (the "WakeMed Cary Application")

4. On April 15, 2011, Novant filed one application proposing to develop 50 of the 101 beds in a new hospital to be located in the Town of Holly Springs as follows:

J-8673-11/Holly Springs Hospital II, LLC/Develop a new 50-bed hospital in Holly Springs/Wake County

- 5. Since the applications in the 2011 Wake County bed review in total proposed to develop 252 new acute care beds, and since the SMFP contained a determinative limitation of 101 new acute care beds, all of the applications could not be approved. Exhibit 35 to the Motion, pp. 1778-1779.
- 6. The Agency conditionally approved the WakeMed Raleigh Application for 29 of the 79 beds for which it applied, Exhibit 35 to the Motion, p. 1780-1781.
- 7. The Agency conditionally approved the WakeMed Cary Application for all 22 beds for it applied. Exhibit 35 to the Motion, p. 1780.
- 8. The Agency conditionally approved the Rex Holly Springs Application for all 50 beds for which it applied. Exhibit 35 to the Motion, pp. 1779-1780.
- 9. The Agency denied the Rex Wakefield Application. Exhibit 35 to the Motion, p. 1779.
- 10. The Agency denied that portion of the Rex Main Application that sought 11 new acute care beds and conditionally approved the remainder of that application. Exhibit 35 to the Motion, p. 1781-1782.
- 11. The Agency denied the Novant Holly Springs Application. Exhibit 35, p. 1779.

- 12. Novant was the only applicant for those beds which was not an existing provider of acute care services in Wake County. Exhibit 35 to the Motion, p. 1626.
- 13. The Agency made its decision on the 2011 Wake County bed review on September 27, 2011, and issued its findings on October 4, 2011.

A. Novant Holly Springs Application

- 14. Novant contends that the Agency applied an unpromulgated rule to its Novant Holly Springs Application, and it also contends that the Agency erred in its application of Criterion (18a) with respect to all of the applications in this review.
- 15. Michael J. McKillip, a CON Section Project Analyst, was charged with reviewing the CON applications received for the 2011 Wake County Bed Review.
- 16. In early September 2011, Mr. McKillip prepared draft findings which indicated that the Novant Holly Springs Application was conforming with Criteria (1), (3), (4), (5), (6), (8), and (18a) and the administrative rules applicable to new acute care beds, with the plan to discuss with Mr. Smith the extent of support from obstetricians for the Novant Holly Springs Application. See Exhibit 10 to the Motion, pp. 12-20.
- 17. Subsequently, however, Mr. McKillip discussed his draft with Mr. Smith, the CON Section Chief. See Exhibit 10 to the Motion, pp. 20-22. Mr. Smith and Mr. McKillip discussed the competitive comments that Rex and WakeMed had filed during the review process, in which they criticized Novant's support from local obstetricians, and reviewed Novant's response to such comments. The CON Section then determined that the Novant Application should be found non-conforming with Criteria (1), (3), (4), (5), (6), (8), and (18a) and the administrative rules applicable to new acute care beds. See Exhibit 10 to the Motion, pp. 20-22; see also Exhibit 35 to the Motion.
- 18. The Required State Agency Findings issued on October 4, 2011 state as follows:

However, the applicant did not provide sufficient documentation from obstetricians practicing in Wake

surrounding areas support and to County reasonableness of its utilization projections for obstetrical The applicant states it 'will achieve a market share of 40% of total births in the Primary Service Area' by the second and third year of operations (2016 and 2017). However, Exhibit 14 [which contains Novant's letters of support from physicians does not contain any letters of support from obstetricians practicing in the applicant's proposed service area, or from any other Wake County obstetricians. Exhibit 14 contains only one letter an obstetrician in the local area expressing support for the proposed hospital, and that obstetrician practices in Durham. Exhibit 14 also contains a letter of support from the obstetrician who the applicant identifies as the medical director for obstetrical services, however, that physician practices in Winston-Salem. In Section V.3(b), page 228, the applicant provides a list of physicians by medical and surgical specialty that support the proposed hospital, but the list does not include obstetricians. Similarly, in Section V.4, page 229, the applicant provides a list of the Novant Medical Group 'Triangle physician network' physicians by medical and surgical specialty that support the proposed hospital, but the list does not include obstetricians.

Exhibit 35 to the Motion, p. 1641 (emphasis in original)

- 19. The perceived lack of sufficient documentation from obstetricians practicing in Wake County and surrounding areas caused the Agency to find Novant non-conforming with Criterion (3), N.C. Gen. Stat. § 131E-183(a)(3). *Id.*, pp. 1641-1642. The finding of non-conformity on Criterion (3) in turn caused the Agency to find Novant non-conforming with Criteria (1), (4), (5), (6), (8) and (18a), and the administrative rules applicable to new acute care beds and CT scanners. *See id.*, pp. 1532; 1662; 1669; 1671; 1675; 1692-1693; 1709-1710; 1755.
- 20. The sole reason for the findings of non-conformity with these criteria and administrative rules was the perceived lack of "sufficient documentation from obstetricians in Wake County and surrounding areas." *Id.*, p. 1641; Exhibit 10 to the Motion, pp. 46-47; 81-82; 143; 150; 154-155; 166-168; 180.
- 21. The properly adopted administrative criteria for the review of the applications in question are discussed in the Agency's findings. Exhibit 35 to the Motion, pp. 1694-1768.

- 22. Several of those rules require an applicant to include correspondence from physicians in its application. See Exhibit 35 to the Motion, p. 1707, 1714, 1715 and 1717.
- Novant Application conforming. For example, the Department's rule promulgated as 10A N.C.A.C. 14C.3802, entitled "Information Required of Applicant," requires the inclusion of "correspondence from physicians and other referral sources that documents their willingness to refer or admit patients to the proposed new hospital or new campus." Exhibit 35 to the Motion, p. 1707. The Agency found the Novant Application conforming with that rule, noting that it "contains copies of correspondence from physicians and other referral sources documenting their willingness to refer or admit patients to the proposed new hospital." *Id*.
- 24. By contrast, none of the properly promulgated rules applicable to the Novant Application required it to submit any minimum number of physician support letters in any practice specialty, nor did they establish the relative number of such letters as a factor for the comparative analysis of applications. Exhibit 35 to the Motion, pp. 1694-1768.
 - 25. Criterion (18a) of the CON Law states:

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.

See N.C. Gen. Stat. § 131E-183(18a).

26. With respect to the Novant Holly Springs Application, the Agency made the following findings under Criterion (18a):

NC Novant Holly Springs

Novant Holly Springs. See Section II.6, page 42, Section II.7, pages 42-46, Section III.2, pages 199-207, and Section VI, pages 242-263. However, the applicant does not adequately demonstrate that its proposed project would have

a positive impact on the cost-effectiveness of the proposed services for the following reasons:

a) the applicant does not adequately demonstrate the need for its proposal [see

Criterion (3) for additional discussion]; and

b) the applicant does not adequately demonstrate the financial feasibility of the proposal is based on reasonable assumptions regarding revenues and expenses [see Criterion (5) for additional discussion]. and

c) the applicant did not adequately demonstrate that Novant Holly Springs will

provide quality services [see Criterion (8) for additional discussion].

Therefore, the application is nonconforming with this criterion.

See Exhibit 35 to the Motion, pp. 1692-1693.

27. The Agency's findings with respect to Criterion (18a) and the Novant Holly Springs Application do not discuss competition.

B. WakeMed Raleigh Application

- Raleigh because its witnesses admitted on deposition that WakeMed Raleigh does not need the 79 beds for which it applied or the 29 beds for which it was approved. *See, e.g.*, Exhibit 4 to the Motion, pp. 11, 49, 124; Exhibit 6 to the Motion, pp. 27; 40; 269-270; Exhibit 7 to the Motion, pp. 109-110; Exhibit 8 to the Motion, pp. 29-33; 47; 49; 300; Exhibit 9 to the Motion, pp. 6-7; p. 146; and Exhibit 34 the Motion, p. 79.
- 29. WakeMed disputes Novant's characterization of statements by its witnesses in depositions and contends that the only applicant that should have been approved in the 2011 Wake County Bed Review is WakeMed Cary, and that all the other applicants should have been denied. See WakeMed's Response in Opposition to the Motion.
- 30. With respect to the WakeMed Raleigh Application, the Agency made the following findings under Criterion (18a):

WakeMed Raleigh. See Section II.6, page 21, Section II.7, pages 21-30, Section III.2, pages 77-78, and Section VI, pages 108-130. The applicant adequately demonstrates that its proposal would have a positive impact upon the cost effectiveness, quality, and access to the proposed services for the following reasons:

a) the applicant adequately demonstrates that its proposal would be costeffective [see Criteria (1), (3), (5) and (12) for additional discussion];

the applicant demonstrates that WakeMed Raleigh provides adequate access to the proposed services by the medically underserved [see Criteria (1) and (13) for additional discussion]; and

c) the applicant adequately demonstrates that WakeMed Raleigh provides quality services [see Criteria (1), (7), and (8) for additional discussion].

Therefore, the application is conforming to this criterion.

Exhibit 35 to the Motion, p. 1691.

- 31. The Agency's findings with respect to Criterion (18a) and the WakeMed Raleigh Application do not discuss competition.
 - C. WakeMed Cary Application
- 32. With respect to the WakeMed Cary Application, the Agency made the following findings under Criterion (18a):

WakeMed Cary. See Section II.6, page 18, Section II.7, pages 18-28, Section III.2, pages 65-66, and Section VI, pages 98-118. The applicant adequately demonstrates that its proposal would have a positive impact upon the cost effectiveness, quality, and access to the proposed services for the following reasons:

- a) the applicant adequately demonstrates that its proposal would be costeffective [see Criteria (1), (3), (5) and (12) for additional discussion];
- the applicant demonstrates that WakeMed Cary provides adequate access to the proposed services by the medically underserved [see Criteria (1) and (13) for additional discussion]; and

the applicant adequately demonstrates that WakeMed Cary provides quality services [see Criteria (1), (7), and (8) for additional discussion].

Therefore, the application is conforming to this criterion.

Exhibit 35, to the Motion, p. 1691.

- 33. The Agency's findings with respect to Criterion (18a) and the WakeMed Cary Application do not discuss competition.
 - D. Rex Holly Springs Application

34. Novant contends that summary judgment should be entered against Rex Holly Springs because Rex has a surplus of 36 beds as set forth in the draft 2012 SMFP. The draft 2012 SMFP became available during the course of the 2011 Wake County Bed Review. The draft 2012 SMFP contained updated bed utilization data. The Agency discussed this in the context of its Comparative Analysis of the Applications, under the heading "Utilization and Need for Acute Care Beds at Existing Hospitals":

Proposed 2012 SMFP, Table 5A Acute Care Bed Need Projections

						The second secon
	Licensed					
	Acute Care	Acute	2014	Average	Adjusted	2014
	Beds	Care	Acute	Daily	for Target	Deficit
		Days _	Care	Census	Occupancy	(Surplus)
	1000		Days			走上。
Rex Hospital	439	103,206	110,509	303	403	(36)
WakeMed Cary	156	44,647	47,806	131	183	27
WakeMed		167,712	179,579		630	-
Raleigh	628	,		492		2

Based on the 2010 acute care patient days, on an average day, Rex Hospital had 156 vacant beds (439 - (103,206/365) = 156), WakeMed Raleigh had 169 vacant beds [(628 - (167,712/365) = 169], and WakeMed Cary had 34 vacant beds [(156 - (44,647/365) = 34]. As a smaller hospital, WakeMed Cary Hospital has fewer placement options as their occupancy rates increase. Also, between 2009 and 2010, WakeMed Cary's projected bed deficit increased from 21 to 27 beds. In contrast, the projected bed deficits for Rex Hospital and WakeMed Raleigh decreased over the same time period. In fact, Table 5A of the Proposed 2012 SMFP projects a surplus of acute care beds for Rex Hospital by 2014. Therefore, of the applications proposing to develop additional acute care beds at existing hospitals, the application submitted by WakeMed Cary is the most effective alternative for addressing the need for additional acute care beds, and the application submitted by Rex Hospital is the least effective alternative for addressing the need for additional acute care beds, in Wake County.

Exhibit 35 to the Motion, pp. 1772-1773.

35. In response to the Motion, the Agency offered the Affidavit of Martha J. Frisone, Assistant Chief of the CON Section. In her Affidavit, Ms. Frisone cited the example of the 2006 Dare County Acute Care bed review, in which the Agency was able to approve the sole applicant, The Outer Banks Hospital, for 2 additional beds, even though the 2007 SMFP, which was published during the 2006 Dare County Acute Care bed review, showed that Dare County had a surplus of 2 beds. *See* Exhibit 1 to Agency's Notice of Filing.

36. With respect to the Rex Holly Springs Application, the Agency made the following findings under Criterion (18a):

Rex Holly Springs. See Section II.6, page 44, Section II.7, pages 44-47, Section III.2, pages 240-244, and Section VI, pages 283-305. The applicant adequately demonstrates that its proposal would have a positive impact upon the cost effectiveness, quality, and access to the proposed services for the following reasons:

a) the applicant adequately demonstrates that its proposal would be costeffective [see Criteria (1), (3), (5) and (12) for additional discussion];

the applicant demonstrates that Rex Holly Springs will provide adequate access to the proposed services by the medically underserved [see Criteria (1) and (13) for additional discussion]; and

the applicant adequately demonstrates that Rex Holly Springs will provide quality services [see Criteria (1), (7), and (8) for additional discussion].

Therefore, the application is conforming to this criterion.

Exhibit 35 to the Motion, p. 1692.

37. The Agency's findings with respect to Criterion (18a) and the Rex Holly Springs Application do not discuss competition.

E. Rex Wakefield Application

- 38. Novant contends that partial summary judgment should be entered against Rex's appeal of the denial of the Rex Wakefield Application for the same reasons Novant contends that the Agency should have denied the Rex Holly Springs Application.
- 39. The Agency found that the Rex Wakefield Application was conforming with all the applicable CON criteria and administrative rules. In the comparative analysis, however, the Agency found that the Rex Wakefield Application was a less effective alternative compared to the Rex Holly Springs Application, WakeMed Raleigh Application and the WakeMed Cary Application because:
 - Rex Wakefield projects the lowest percentage of total services to be provided to Medicaid recipients of all the applicants.
 - Rex Wakefield projects the highest gross revenue per adjusted patient day in the third year of operation of the three applicants proposing to develop new acute care hospitals.
 - Rex Wakefield proposes a location for the acute care beds that is less effective with regard to improving geographic accessibility.

Exhibit 35. p. 1778.

40. With respect to the Rex Wakefield Application, the Agency made the following findings under Criterion (18a):

Rex Wakefield. See Section II.6, page 44, Section II.7, pages 44-47, Section III.2, pages 209-212, and Section VI, pages 248-269. The applicant adequately demonstrates that its proposal would have a positive impact upon the cost effectiveness, quality, and access to the proposed services for the following reasons:

- a) the applicant adequately demonstrates that its proposal would be costeffective [see Criteria (1), (3), (5) and (12) for additional discussion];
- b) the applicant demonstrates that Rex Wakefield will provide adequate access to the proposed services by the medically underserved [see Criteria (1) and (13) for additional discussion]; and
- c) the applicant adequately demonstrates that Rex Wakefield will provide quality services [see Criteria (1), (7), and (8) for additional discussion].

Therefore, the application is conforming to this criterion.

Exhibit 35 to the Motion, p. 1692.

41. The Agency's findings with respect to Criterion (18a) and the Rex Wakefield Application do not discuss competition.

II. CONCLUSIONS OF LAW

Based on all the foregoing undisputed facts, the undersigned concludes as follows.

- 1. The Office of Administrative Hearings has jurisdiction over the parties and the subject matter of this case. N.C. Gen. Stat. §§ 131E-188(a); 150B-23(a).
- 2. N.C. Gen. Stat. § 150B-33(b)(3a) authorizes an Administrative Law Judge to "[r]ule on all prehearing motions that are authorized by G.S. 1A-1, the Rules of Civil Procedure." The rules include North Carolina Rule of Civil Procedure 56(c) governing summary judgment. Rule 56(c) provides that summary judgment "shall be rendered forthwith if the pleadings, depositions, answers to interrogatories, and admissions on file, together with affidavits, if any, show that there is no genuine issue of material fact and that any party is entitled to judgment as a matter of law." There is no genuine issue of material fact regarding the Motion with respect to the Agency's use of an unpromulgated rule to deny the Novant

Holly Springs Application and the Agency's misapplication of Criterion (18a) to all the applicants in this review. Accordingly, Novant is entitled to judgment as a matter of law.

- 3. To obtain a CON for a proposed project, an applicant must satisfy *all* of the review criteria set forth in N.C. Gen. Stat. § 131E-183(a). If an application fails to conform with any one of these criteria, then the applicant is not entitled to a CON for the proposed project as a matter of law. *See Presbyterian-Orthopaedic Hospital v. N.C. Dept. of Human Resources*, 122 N.C. App. 529, 534-35, 470 S.E.2d 831, 834 (1996)(holding that "an application must comply with *all* review criteria" and that the failure to comply with one review criterion supports entry of summary judgment against the applicant)(emphasis in original).
- 4. In a recent decision, the Court of Appeals explained the procedures for review of a CON application as follows:

N.C. Gen. Stat. § 131E-183(a) charges the Agency with reviewing all CON applications utilizing a series of criteria set forth in the statute. The application must either be consistent with or not in conflict with these criteria before a certificate of need for the proposed project shall be issued. A certificate of need may not be granted which would allow more medical facilities or equipment than are needed to serve the public. Each CON application must conform to all applicable review criteria or the CON will not be granted. The burden rests with the applicant to demonstrate that the CON review criteria are met.

Parkway Urology v. N.C. Dept. of Health and Human Services, ____, N.C. App. ____, ____, 696 S.E.2d 187, 191-92 (2010). Accord Good Hope Health System, L.L.C. v. N.C. Dept. of Health and Human Services, 189 N.C. App. 534, 549, 659 S.E.2d 456, 466 (2008).

5. N.C. Gen. Stat. § 150B-23(a) sets forth five grounds upon which a decision of the Agency after such a review may be reversed, including that the Agency "[e]xceeded its authority or jurisdiction," "[a]cted erroneously," or "[f]ailed to use proper procedure." "In cases appealed from administrative agencies, [q]uestions of law receive *de novo* review, whereas fact-intensive issues such as sufficiency of the evidence to support [the] decision are

reviewed under the whole-record test." N.C. Dept. of Revenue v. Bill Davis Racing, 201 N.C. App. 35, 43, 684 S.E.2d 914, 920 (2009).

- 6. Thus, questions of whether the Agency exceeded its authority, acted erroneously or failed to use proper procedure are subject to *de novo* review. *See Good Hope Hospital v. N.C. Dept. of Health and Human Services*, 175 N.C. App. 309, 311, 623 S.E.2d 315, 317 (2006)("In determining whether an agency erred in interpreting a statute, this Court employs a *de novo* standard of review."); *Parkway Urology*, ___ N.C. App. at ____, 696 S.E.2d at 192; *Total Renal Care of N.C., LLC v. N.C. Dept. of Health and Human Services*, 171 N.C. App. 734, 739, 615 S.E.2d 81, 84 (2005).
- 7. Here, Novant submits that the Agency exceeded its statutory authority, misinterpreted and misapplied relevant review criteria and failed to follow proper procedure in its review of the competing applications. Because of the nature of the errors alleged, the Agency's decision is subject to *de novo* review by the Administrative Law Judge. *Id*.
- 8. The Court of Appeals' decision in Living Centers-Southeast, Inc. v. N.C. Dept. of Health & Human Services, 138 N.C. App. 572, 581-82, 532 S.E.2d 192, 197 (2000)("The CON statute...does not contemplate the preclusion of a full contested case hearing in a certificate of need case due to a recommended decision of summary judgment by the ALJ.") does not preclude the Administrative Law Judge entering a Recommended Decision of partial summary judgment. The Undersigned further finds that the facts of Living Centers are distinguishable from the facts of the present case and that Living Centers cannot be read to preclude entry of a recommended decision granting partial summary judgment in every CON case involving a competitive review. In addition, the Undersigned notes that the HCA Crossroads case, discussed below, came to the North Carolina Supreme Court in the context of an ALJ's recommended decision awarding summary judgment. See 327 N.C. 573, 576, 398 S.E.2d 466, 468 (1990).

A. Novant Holly Springs Application

1. Unpromulgated Rule

- 9. The CON Law and the administrative code regulations applicable to CON applications do not define or illustrate what would be "sufficient documentation" from obstetricians practicing in Wake County and surrounding areas to support the reasonableness of utilization projections for obstetrical services in the Novant Holly Springs Application.
- 10. The CON Law and the administrative code regulations applicable to CON applications do not require an applicant proposing to develop a new hospital to have a certain number of letters of support from obstetricians practicing in the county or in the area surrounding the county in which the applicant proposes to locate its hospital.
- 11. The Agency used an unpromulgated rule, *i.e.*, that Novant needed to have a certain number of letters of support from obstetricians in Wake County and surrounding areas in its application.
- 12. An "administrative agency is a creature of the statute creating it and has only those powers expressly granted to it or those powers included by necessary implication from the legislative grant of authority." In re Williams, 58 N.C. App. 273, 279-80, 293 S.E.2d 680, 685 (1982)(quoting Matter of Broad & Gales Creek Community Ass'n, 300 N.C. 267, 280, 266 S.E.2d 645, 654 (1980)).

Express powers delegated by statute and implied powers reasonably necessary for its proper functioning are the only powers which an administrative agency possesses. . . . Thus, it is clear that administrative agencies must find within the statutes justification for any authority which they purport to exercise.

Charlotte Liberty Mut. Ins. Co. v. State ex rel. Lanier, 16 N.C. App. 381, 384, 192 S.E.2d 57, 58 (1972).

13. The Agency's powers are specifically delineated in N.C. Gen. Stat. § 131E-177. Because the CON Law is in derogation of providers' fundamental right to carry out their otherwise lawful business, the provisions of Section 177 must be strictly construed against the Agency. See Hall v. Toreros, II, Inc., 176 N.C. App. 309, 626 S.E.2d 861, 869 (2006).

- 14. Additionally, the Agency's ability "to exercise powers granted it by the legislature in the CON Act may not supersede other express requirements and limitations placed upon its exercise of those powers." Mooresville Hosp Management Associates, Inc., 169 N.C. App. at 648, 611 S.E.2d at 437.
- 15. Considering N.C. Gen. Stat. § 131E-177 together with other relevant provisions of the CON Law, it is clear that the Agency's application of standards and criteria which are not contained in any statute or rule exceeded its statutory authority.
- 16. The Agency is empowered "to adopt rules pursuant to Chapter 150B of the General Statutes, to carry out the purposes and provisions of [the CON Law]," to "[d]efine, by rule, procedures for submission of periodic reports by persons or health service facilities subject to Agency review," and to "[i]mplement, by rule, criteria for project review." N.C. Gen. Stat. § 131E-177 (emphasis added).
- 17. Nevertheless, the Agency "has no power to promulgate rules and regulations which alter or add to the law which it was set up to administer or which have the effect of substantive law." *Hall*, 176 N.C. App. at 319, 626 S.E.2d at 868.
- 18. Even assuming, however, that the Agency could adopt criteria specifying the number and type of physician support letters necessary for approval of an application, it has not done so.
- 19. In Duke University Medical Center v. Bruton, 134 N.C. App. 39, 51, 516 S.E.2d 633, 641 (1999), the Division of Medical Assistance of the Department, a sister division to the Agency, attempted to deny Medicaid payments for hospital services rendered to recipients who were otherwise eligible, but had failed to also file for Medicare benefits. The Court of Appeals invalidated that requirement:
 - ... DMA's policy is also unauthorized because it involves the application of an unpromulgated legislative rule. An administrative agency may not act outside the mandates of the NCAPA... specifically, 'a rule is not valid unless it is adopted in substantial compliance with this Article.'

Duke University Medical Center v. Bruton, 134 N.C. App. 39, 51, 516 S.E.2d 633, 641 (1999). N.C. Gen. Stat. § 150B-18.

- 20. Likewise, the Agency's attempt in this case to invent criteria and standards which do not appear in any statute, court decision or promulgated rule - and then use them to disapprove the Novant Holly Springs Application - was beyond its statutory authority and erroneous as a matter of law.
- 21. The Undersigned concludes as a matter of law that the Agency applied an unpromulgated rule to the Novant Holly Springs Application and therefore, the Agency's conclusion that the Novant Holly Springs Application was nonconforming with Criteria (1), (3), (4), (5), (6), (8) and (18a) and the administrative rules applicable to new acute care beds and CT scanners was erroneous as a matter of law.

2. Criterion (18a)

22. The language of Criterion 18a is clear and unambiguous, and the legislative intent in amending N.C. Gen. Stat. § 131E-183(a) to add this provision is not difficult to ascertain.

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.

N.C. Gen. Stat. § 131E-183(a)(18a)(emphasis added).

23. In the present case, the Agency followed its consistently erroneous practice of failing to make any meaningful analysis of the applications under Criterion (18a), but rather making its determinations of conformity with respect that criterion based on its determinations concerning other criteria. For example, in approving the Rex Holly Springs Application the Agency made the following finding with respect to Criterion (18a):

The applicant adequately demonstrates that its proposal would have a positive impact upon the cost effectiveness, quality, and access to the proposed services for the following reasons:

- a) The applicant adequately demonstrates that its proposal would be cost-effective [see Criteria (1), (3), (5) and (12) for additional discussion];
- b) The applicant demonstrates that Rex Holly Springs will provide adequate access to the proposed services by the medically underserved [see Criteria (1) and (13) for additional discussion]; and
- c) The applicant adequately demonstrates that Rex Holly Springs will provide quality services [see Criteria (1), (7), and (8) for additional discussion].

Therefore, the application is conforming to this criterion.

Exhibit 35 to the Motion, p. 1692.

- 24. However, the North Carolina Appellate Courts have not hesitated to correct even longstanding, consistent practices of the Agency, where the Agency has been consistently wrong. See, e.g., HCA Crossroads Residential Ctrs. v. N.C. Dept. of Human Resources, 327 N.C. 573, 398 S.E.2d 466 (1990)(holding that the Agency cannot ignore with impunity the time limits for making a decision); Britthaven, Inc. v. N.C. Dept. of Human Resources, 118 N.C. App. 379, 455 S.E.2d 455 (1995)(holding that the Agency must review each competing application independently against the statutory review criteria before reviewing them comparatively).
- 25. With respect to the Novant Application and the same criterion the Agency found:

However, the applicant does not adequately demonstrate that is proposed project would have a positive impact on the cost-effectiveness of the proposed services for the following reasons:

- a) The applicant does not adequately demonstrate the need for its proposal [see Criterion (3) for additional discussion]; and
- b) The applicant does not adequately demonstrate the financial feasibility of the proposal is based on reasonable assumptions regarding revenues and expenses [see Criterion (5) for additional discussion] and
- c) The applicant did not adequately demonstrate that Novant Holly Springs will provide quality services [see Criterion (8) for additional discussion].

Therefore, the application is nonconforming to this criterion. Exhibit 35 to the Motion, pp. 1692-1693.

- 26. The Agency's findings on the other applications in this review concerning Criterion 18a are similarly derived from findings on the other criteria. See Exhibit 35 to the Motion, pp. 1690-1693. In none of these findings does the Agency even mention the word "competition," much less does it analyze whether the approval of any application would enhance competition in the area and, if so, whether such enhanced competition would be beneficial. In practical affect, the Agency analyzed these applications as if Criterion (18a) added nothing to the other statutory review criteria.
- 27. Under controlling authority from our Supreme Court, such an interpretation of the CON Law is not possible. Interpreting the provisions of the CON Law placing a time limit on the Agency's review of applications, the Supreme Court held:

The only other conceivable interpretation of the language of N.C.G.S. § 131E-185(b) is that it merely reiterates the time limits specified in N.C.G.S. § 131E-185(a1)(c) without doing anything more. Under such an interpretation, N.C.G.S. § 131E-185(b) would be entirely redundant and meaningless. Such statutory construction is not permitted, because a statute must be construed, if possible, to give meaning and effect to all of its provisions.

HCA Crossroads, 327 N.C. at 578, 398 S.E.2d at 470.

28. More recently, our Court of Appeals dealt specifically with a case in which the Agency, as it did here, made its decision on one of the statutory criteria dependent upon its findings on other criteria.

The Agency has determined that Criteria 1, 3 and 6 address need-related issues which overlap and which should be analyzed together and consistently. Consequently, the Agency analyzes Criteria 1, 3, and 6 together and if the Agency determines that the need is identified in the SMFP for the service of equipment proposed in the application, and that an application is consistent with the need determination in the SMFP and demonstrates that the population it proposes to serve needs the services it proposes to provide, then to be consistent, the Agency also will determine that the application does not unnecessarily duplicate existing or approved services.

Standing alone, this finding by NCDHHS is problematic. Each criterion contained in N.C. Gen. Stat. § 131E183(a) must be separately analyzed by NCDHHS.

Parkway Urology _____ N.C. App. at ____, 696 S.E.2d at 194. (emphasis by the Court, citing HCA Crossroads).

- 29. A review of the Agency findings here shows that it followed precisely the same erroneous course in applying Criterion (18a) to each of the applications in the 2011 Wake County Bed Review. To reach the conclusion that approving a new competitor in the market would not enhance competition and thereby benefit patients, but that approving additional beds for the incumbent providers would do so, the Agency simply ignored the intent of the General Assembly, and analyzed the applications as if Criterion (18a) added nothing to the statute.¹
- 30. With regard to its decision and findings on the applications under Criterion (18a), the Agency acted erroneously and failed to follow proper procedure in its decision on all the applications before it. Based on the undisputed facts, Novant is entitled to summary judgment as a matter of law.
- 31. Because an applicant must be found conforming or conditionally conforming with respect to all applicable statutory criteria and applicable administrative rules before the Agency can issue a CON, see Presbyterian-Orthopaedic Hospital v. N.C. Dept. of Human Resources, 122 N.C. App. 529, 534-35, 470 S.E.2d 831, 834 (1996), and because the Agency erred in its application of Criterion (18a) with respect to each of the applications in this review, the Agency's decision to conditionally approve the WakeMed Raleigh, WakeMed Cary, and Rex Holly Springs Applications was erroneous as a matter of law. The Agency's decision to deny the Novant Holly Springs Application was erroneous as a matter of law.
 - B. Other Arguments Related to The WakeMed Raleigh/Rex Holly Springs/Rex Wakefield Applications.

¹ Testimony from Mr. McKillip indicates that comments filed by the incumbent providers (Rex and WakeMed) concerning a perceived lack of support from obstetricians for the Novant Holly Springs project played a major role in the Agency's decision to deny the Novant application. See Exhibit 10 to the Motion, pp. 16-19.

32. In view of the foregoing conclusions, it is not necessary to reach Novant's other arguments on these applications, the Undersigned makes no findings concerning such arguments and accordingly, the Undersigned recommends that the remainder of the Motion be denied. Specifically, the Motion is granted as to Novant's contentions 6a. (unpromulgated rule) and 6b. (Criterion(18a)) above. The Court does not reach and accordingly denies the Motion with respect to Novant's contentions 6c. through 6e. above. This Recommended Decision does not make any ruling with respect to Project I.D. J-8667-11, the Rex Main Application. WakeMed has made a motion for summary judgment on the Rex Main Application, which will be heard and decided separately.

RECOMMENDED DECISION

Based on the foregoing undisputed facts and conclusions of law, the undersigned Administrative Law Judge holds, as a matter of law, that:

- 1. The Agency erred as a matter of law because it relied on an unpromulgated rule to deny the Novant Holly Springs Application in Project I.D. No. J-8673-11. Therefore, the Agency's decision to find the Novant Holly Springs Application non-conforming with Criteria (1), (3), (4), (5), (6), (8) and (18a) and the administrative rules applicable to new acute care beds and CT scanners is erroneous as a matter of law; and
- 2. The Agency erred as a matter of law in its application of N.C. Gen. Stat. § 131E-183(a)(18a) to each of the applications in this review. Accordingly, the Agency's decision to conditionally approve the WakeMed Raleigh, WakeMed Cary, and Rex Holly Springs Applications was erroneous as a matter of law. The Agency's decision to deny the Novant Holly Springs Application was erroneous as a matter of law.

SO ORDERED this <u>/2</u> day of April, 2012.

Beecher R. Gray

Administrative Law Judge

NOTICE

The decision of the Administrative Law Judge in this contested case will be reviewed by the agency making the final decision according to the standards found in G.S. 150B 36(b), (b1) and (b2). The agency making the final decision is required to give each party an opportunity to file exceptions to the decision of the Administrative Law Judge and to present written arguments to those in the agency who will make the final decision. G.S. 150B-36(a). The Agency is required by N.C. Gen. Stat. § 150B-36(b) to serve a copy of the final decision on all parties and to furnish a copy to the parties' attorneys of record and to the Office of Administrative Hearings. The agency that will make the final decision in this contested case is the North Carolina Department of Health and Human Services.

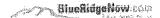
A copy of the foregoing has been mailed to:

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This the day of April, 2012.

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House Committee hears heated discussions on Mission's COPA agreement

Bu Mark Scholmon Times-News Stoff Writer Published: Thursday, October vo., bout at 11 an p.m.

FLETCHER - Mission Hospital has seen substantial growth over the past 15 years, and as health care continues to change, Mission officials say the hospital's regulatory agreement with the state is no longer needed.

More than 300 people crowded into the Virginia C. Boone Mountain Heritage Building at the WNC Ag Center Thursday night for a hearing conducted by the N.C. House of Representatives Select Committee on Certificate of Need and Related Hospital Issues. Lawmakers came to the area to listen to hospital officials and the public express their views on Mission's Certificate of Public Advantage.

What they heard were conflicting stories from competing interests. Mission officials advocated for an end to the COPA restrictions, saying the health care climate has changed, and Park Ridge Health officials clamored for more state oversight, saying Mission is trying to monopolize the market and drive the smaller hospitals out.

The purpose of the Mission COPA, established in 1995, was to allow Mission and St. Joseph's hospital to join and to monitor competition that may have been reduced as a result of the joint operation. The state of North Carolina has a duty to regulate on the quality of care, health care costs and access to care and to keep smaller rural hospitals open.

Mission CEO Ron Paulus said his hospital has kept its costs, profit margins and charges in line with peer hospitals across the state and has increased access to care and quality of care.

"Since 1995, Mission has complied fully with the COPA each and every year, as independent experts hired by the state have attested," Paulus said.

But now, Paulus is looking at a different approach in determining the hospital's future.

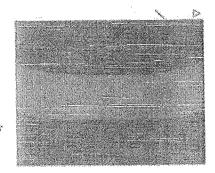
He wants Mission to freely compete for patients like their competitors, Paulus told

Bottom line, it means letting patients and physicians choose where to go, who to align with and letting performance on quality, efficiency and service determine the winners and losers, not the government," Paulus said.

Park Ridge Health officials say that Mission has created a monopoly and the state has failed to regulate the hospital under its COPA. They hope the House Committee reviews the COPA and finds there is a lack of oversight by the state.

"Mission suggested that you consider scrapping the COPA altogether," said Graham Fields, assistant to Park Ridge's CEO.

*Should any of us be surprised that a monopoly would ask for nothing short of everything?" Fields said. "Instead of thoughtfully exploring ways to collaborate with other providers, Mission has devoted its considerable resources ensuring that it is never changed."



Fields also spoke on behalf of a group of grass roots physicians who say they have been negatively affected by Mission's actions and, in Fields' words, "the state's lack of oversight."

He added, "The COPA is vital to protecting patients, physicians and hospitals in the area,"

There are only three hospital systems in the country that have operated under a state -regulated COPA -- one in Montana, one in Columbia, S.C., and Mission, according to Richard Vinroot, legal counsel for Mission. The hospital in Montana does not operate under the state's regulations now, while the South Carolina hospital is being phased out of the COPA agreement, he said.

"Mission is the last most regulated COPA in the country," Vincoot said. "It has outlived its usefulness."

He said it is time for Mission's agreement with the state to be phased out as bigger hospitals are increasingly affiliating with other hospitals and medical facilities.

Park Ridge Vice President Jason Wells said Mission has used the COPA to undermine local providers, acquire physicians and limit patient choice.

"In other words, Mission wants to keep its monopoly in many North Carolina. counties, and expand it elsewhere, and have antitrust immunity and not to be bothered by what it considers to be intrusive regulation," Wells said.

Last spring, Mission hired economist Tom McCarthy to analyze the COPA, and he said Mission has operated fully under the agreement.

McCarthy said that there is a trend toward the integration of health care services, which includes acquisitions of smaller stand-alone hospitals, growth of outpatient services outpacing inpatient service growth, a growing number of hospitals employing physicians, and providers bearing more of the risk for services they provide for patients.

Jimm Bunch, CEO of Park Ridge Health, said that the COPA does not protect the citizens of Western North Carolina, but he urged that it not be climinated.

"Under the circumstances in which we find ourselves, the COPA is the right vehicle," Bunch said. "It simply needs to be changed to reflect the realities of our current health care environment."

He said that Mission has strangled health care throughout the region and funneled more care into Buncombe County.

The House Committee that listened to all sides of the issue is charged to study and evaluate the system of state regulation of health care services, facilities and equipment and its impact on health care costs.

Nearly 80 people signed up to speak for and against Mission's COPA agreement and the hospital's growth in the region.

Toold Guffey said he has worked at Transylvania Regional Hospital, which is in the Mission Health System, Pardee Hospital, which is affiliating with Mission, and now currently works for Park Ridge.

"We knew our limits, and Mission could provide needed care," Guffey said about his time at Transylvania Regional, However, he said Mission's growth is decreasing choices for patients in the region.

"I want to make sure my kids have a choice to choose a doctor," he said.

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Jennifer Bock, a cancer patient, said her chemotherapy provider was in the medical building that caught fire in Asheville in July, taking a fireman's life.

The fire happened three days before her appointment.

"But before the flames were out, Mission set up a place for cancer care onto their campus," Bock said.

Her treatment continued on schedule and supports Mission's work in the community.

Reach Schulman at 828-694-7890 or mark schulman@blueridgenow.com.

Facts (sidebar to Times-News COPA article 10-21-11)

Health officials go on the offensive

Park Ridge Health officials went on the offensive at Thursday's hearing before a legislative committee that is reviewing hospitals' delivery of health care in North Carolina.

During Park Ridge's presentation, they played an audio clip Mission's communications director referring her own hospital is in fact, a monopoly.

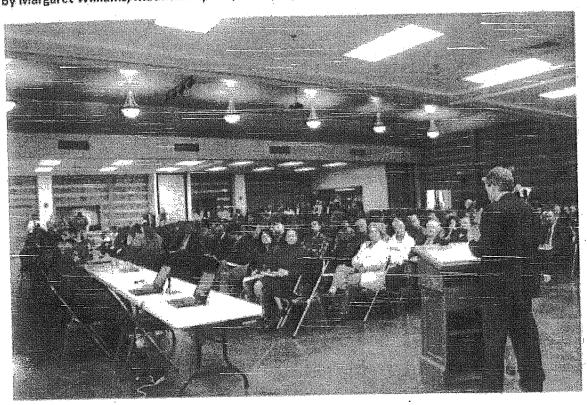
As hundreds of people listened to the sound bite, Janet Moore's voice came across the loud speakers. "There was a lot of talk about the fact that we are a monopoly, and we are," Moore said in the audio. "We're kinda the 500-pound gorilla in Western North Carolina."

Moore said the quote was taken out of context. She was speaking at an American Hospital Association meeting last month about using social networking as a tool in the hospital's operations. She was given a case study and set the situation in perspective by saying Mission was a monopoly prior to the COPA established 15 years ago.

However, Vice President Jason Wells with Park Ridge, said that is not the case.

"We invite people to listen to the whole clip (beginning Friday) at www.wncchoice.com," Wells said.

KEEP PATIENTS IN MIND, SOME SPEAKERS TELL LEGISLATIVE COMMITTEE AT PUBLIC MEETING By Margaret Williams, Mountain Xpress, on 10/20/2011 10:11 PM



For three hours on the evening of Oct. 20, a litany of area residents, doctors, health-care professionals and a few patients spoke out about competition and choice, giving a state legislative committee plenty to think about. The general topic was health-care needs in North Carolina, but there's no mistaking that the main item on the agenda was Mission Health System. Is it too big? Are its competitors getting a fair shake? Is Mission? Are patients?

The answers depended on your point of view.

The evening's meeting was one of several being held by the recently convened North Carolina House Select Committee on Certificate of Need and Related Hospital Issues. Held at the Western North Carolina Agricultural Center, the committee meeting featured presentations by Mission Health System, Park Ridge Health and the WNC Community Healthcare Initiative (which includes Park Ridge, 21st Century Oncology and HOPE Cancer Center physician Dr. Nathan Williams).

At issue: the 1995 agreement that allowed Mission and St. Joseph's Hospital to merge. Park Ridge and WNC CHI say that agreement — a Certificate of Public Advantage — turned Mission into a monopoly that has been aggressively expanding and pressuring doctors, medical practices and small hospitals to partner with it. Mission counters that it has honored all aspects of the COPA, which is monitored by the

state and is meant to "mimic competition," an economist told committee members.

Mission wants the COPA to be modified and possibly ended (Mission is one of just three hospitals in the country operating under such an anti-trust agreement; the two other ones are either inactive or have been allowed to sunset).

Park Ridge and WNC CHI want the COPA rules tightened, saying that Mission has grown too large. They point to a county-line project spearheaded by Mission that seeks to partner with Henderson County's Pardee Hospital and place a new endoscopy center just a few miles from Park Ridge. Dr. Nathan Williams of the cancer-treatment group, the Hope Center, accuses Mission of trying to force his affiliation or shut him down (Mission is building a new cancer center).

Mission counters that in the realities of the modern health-care industries, small hospitals must partner with larger ones to survive, and in their view, Mission is the smaller entity operating in WNC (Park Ridge, a faith-based provider that has a 100-year history in WNC and just about 100 beds at its Fletcher location, is affiliated with Adventist Health, a 44-hospital system; three MedWest hospitals are affiliated with Carolinas Healthcare, a two-state system that includes about 30 hospitals; Mission, which either owns or is affiliated with such small hospitals as Angel in Franklin, has about 1,100 total beds — about a quarter the number of either of the larger systems).

Many speakers noted that they appreciate Mission but are worried about the potential lack of choice. Some decried what one woman called Mission's "Pac Man" expansion practices. Others lauded Mission's pediatric care.

But Mission's Chief of Staff, Dr. William Hathaway, called on all sides to end the quarreling about competition and expansion and get back to focusing on patient care. A cardiologist, Hathaway noted that all the hospitals in WNC can offer good care. "But there's been little talk of patient care [here tonight], and that's distressing." He told committee members — and only a handful of the 11-member group was present — that he didn't want the state telling him or any hospital how to provide care.

Committee member Rep. Jeff Collins said he didn't want the state doing that, either. But finding a way to make sure Mission feels it can compete fairly, Park Ridge doesn't feel threatened, practices like Dr. Williams' don't feel pressured, and patients get good care ... "It's a dilemma," he acknowledged.

Several hundred people attended the hearing. The 11-member committee is comprised of eight Republicans and three Democrats. There are no Buncombe County representatives on the House committee, but Rep. Ray Rapp (Democrat) of Mars Hill attended.

Stay tuned for a report in the Oct. 26 issue of Mountain Xpress.

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ASHEVILLE CITIZEN-TIMES • VOICE OF THE MOUNTAINS

Asheville's Mission Hospital asks state to ease restrictions on competition

FLETCHER — After 16 years working under the state-monitored Certificate of Public Advantage, Mission Health officials said Thursday the system's debt has been paid and it should be released from the document.

Mission made its case Thursday night before the 11-member House Select Committee on the Certificate of Need Process and Related Hospital Issues, which held one of three public hearings at the WNC Agricultural Center. About 300 people attended the meeting, many of them questioning Mission's market dominance in the mountains.

"I came here with an open mind tonight, but as the evening went on I became more and more fearful of a monopoly," said local resident Debbie Wooten. "If there's any doubt in anyone's mind now, I'm afraid you're not listening tonight."

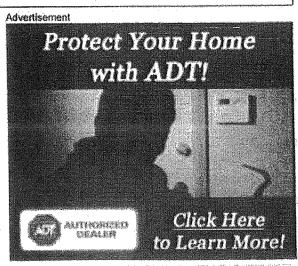
The COPA restricts Mission's profit margin and was designed to ensure that the merger of Memorial Mission and St. Joseph's hospitals in 1995 would not significantly increase the hospital's market power, cause higher prices or reduce quality for consumers.

Mission Health President and CEO Ron Paulus told the committee that Mission has complied with every demand of the COPA and is the most regulated hospital in the state.

By releasing Mission from the COPA, he said, the state would allow the health system to compete with other big players in the mountain market such as Carolinas HealthCare, which operates four hospitals in the mountains, and the Adventist Health System, the parent company of Park Ridge Hospital in northern Henderson.

The bottom line, Paulus said, "is it means letting patients and physicians choose where they go and who they align with, and performance determines winners and losers."

Several doctors and patients, as well as some of Mission's critics, spoke highly of Mission, which has alliances with four mountain hospitals. The hospital provides care other hospitals simply cannot, and its reputation helps bring in top-notch



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physicians.

But critics say Mission should be regulated more closely, not allowed to shuck the bounds of the COPA.

"Should any of us be surprised a monopoly should ask for anything short of everything?" said Graham Fields, special assistant to the president for external affairs at Park Ridge Hospital.

Park Ridge contends that Mission has gobbled up market share in the mountains ever since the COPA went into effect, increasing its patient market share in mountain counties by 15 percentage points over the past five years alone.

Mission attorney Richard Vinroot noted that only three other COPAs exist nationwide, a nd one of those, in Montana, is being phased out. Market conditions have changed considerably in 16 years, and antitrust laws can ensure Mission does not engage in misconduct if the COPA is lifted, Vinroot said.

"I think the time has come to start thinking about phasing out this COPA as well," Vinroot said.

The Republican-controlled committee is examining spheres of influence held by health care providers and whether the certificate of need process or the agreement that Mission Health operates under interferes with free-market expansion in the health care industry. It will issue a report to the General Assembly

next year.

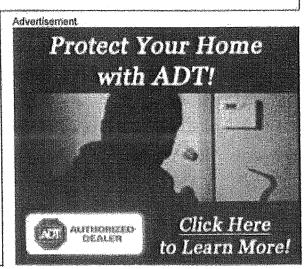
Park Ridge has been particularly upset with a planned joint-venture outpatient center between Mission and Hendersonville's Pardee Memorial Hospital. Officials from both hospitals broke ground earlier this month on the \$45 million project on the Buncombe-Henderson county line.

At the meeting, Park Ridge Vice President Jason Wells called it "the most predatory action ever taken in the history of health care in Western North Carolina."

Several Henderson County residents said the move is unnecessary and made them question Mission's motives.

The committee consists of eight Republicans and three Democrats and is co-chaired by Rep. Fred Steen, R-Rowan, and Rep. John Torbett, R-Gaston.

Other members include Martha Alexander, D-Mecklenburg; Marilyn Avila, R-Wake; J ames Boles Jr., R-Moore; Marcus Brandon,



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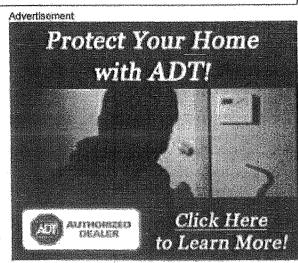
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D-Guilford; Jeff Collins, R-Nash; William Current Sr., R-Gaston, Rick Glazier, D-Cumberland; Mark Hollo, R-Alexander; and Shirley Randleman, R-Wilkes.

Related Links

Economists, officials duel over Mission in Asheville and 'monopoly' question

A Q&A with Ron'Paulus, CEO of Mission Health in Asheville



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Mission continues to build its monopoly

Mary Sloop Be Our Guest Published: Sunday, October 30, 2011 at 4:30 a.m.

I worked as a registered nurse at Mission Hospital for 14 years. While in new employee orientation in 1982, I heard a young female employee speak about the greatness of Mission Hospital and the plans it had for its future growth. I was pleased to be going to work for a progressive medical facility where I could use the skills that I had acquired while working in Charlotte Memorial's intensive care unit.

However, I was somewhat astounded by a statement this speaker made that just didn't sound ethical. I didn't know exactly what the statement implied, but I have remembered it for more than 28 years and have recalled it many times during those years as Mission Hospital has indeed lived up to the goal she shared that day.

The statement she made with pride was that Mission Hospital was growing, would continue to do so and would eventually take over all the smaller hospitals in the area and put them out of business.

As an example, she named specifically one of the hospitals — Fletcher Hospital, the "little hospital out there" that "doesn't have a chance to survive."

As time went by, I was pleased to see that Fletcher Hospital not only survived but grew and built a beautiful new facility and renamed it Park Ridge Health. I have had, and still have, great respect for the values of this hospital and the work it does to benefit the people of the area it serves.

My profession is that of a nurse. I am not a business professional or politician. However, I have discernment for honor, justice and right. I observed the first thing about which Mission was not entirely truthful and which was its first subtle step in taking over St. Joseph's Hospital. It was when it announced that the two hospitals would share a combined laundry facility. After this, they announced several so-called "joint ventures," each time reassuring in print that these changes were not a merger of the two hospitals at that time, nor would they become so in the future.

History has proven its dishonesty as Mission not only merged with St. Joseph's but eventually took possession of it. There is no longer a St. Joseph's Hospital in Asheville. Even the name it used to wean the public, Mission-St. Joseph's, has been changed to Mission Health System, leaving all memories of St. Joseph's behind.

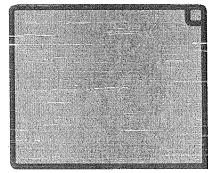
I have no doubt that Mission Health System has a plan to create a monopoly in this area. Its efforts to do so should have been recognized 28 years ago when Bob Burgin was making his frequent trips to Washington, D.C., presenting his deceptive reasons why Western North Carolina would be better served if Mission were allowed an exemption from anti-trust laws. This exemption allowed the joint venture with St. Joseph's Hospital and was part of the Mission plan to become the only provider of health care in the area.

Certainly now that all the facts are before us and Mission's plans to destroy any competition and to take complete control of health care in Western North Carolina have been exposed, those who have the authority to do so will put a stop to its selfish plans that do not benefit the people but do somehow, in a way that is beyond my knowledge and understanding, benefit only a few money- and power-hungry executives. Unless this plan is halted, Pardee Hospital and Park Ridge Health will no longer exist. Pardee and Park Ridge will soon be forgotten in the same manner as St. Joseph's in Asheville.

When making decisions concerning Mission, the "employer monopoly" should be the main concern. There are organizations that monitor health care to assure that providers give good care. There are incentives for doing so, such as loss of reimbursement if Joint Commission standards are not met. Also, the present facilities when taken over by Mission are likely to remain open, making health care as accessible as it is now.

However, there are no laws in North Carolina to protect employees. Mission Hospital prides itself on being the largest employer in Western North Carolina. If allowed to move forward with its plans for a monopoly, it will be the only employer of health care workers in the area except for the Veterans Affairs Hospital.

This will give Mission control of wages and allow it to treat its employees as it so desires. If an employee is dismissed from Mission, he or she will have nowhere else to seek employment in the area. This should be a concern for all health care workers in the area, even those who wear the stickers provided by their employer that state their support of Mission.



I support decisions that would keep Mission Hospital from taking possession of any more health care facilities in Western North Carolina. These decisions would support the present facilities, thereby giving patients and employees the choice to receive health care and employment somewhere other than Mission.

Mary Sloop is a Horse Shoe resident.

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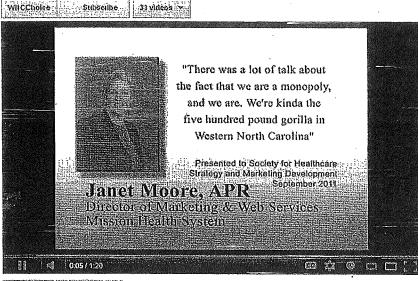
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Mission Health System on Mission and WNC



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1,306

2 likes, 5 dislikes

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Uploaded by WNCChoice on Oct 20, 2011

Mission Health System's spokesperson Janet Moore recently (September 2011) shared these thoughts on Mission Health System and the people of Western North Carolina at a national marketing convention in Phoenix, AZ, She-called Mission a 500 pound Sorilla and later demeaned the people of MANC. Listen for corrections

All Comments (5)

see ali

Add a channel now to post a comment

WOWI How embarrassing our region was represented in this manner, parody or not. Good job "marketing" Western North Carolina to the rest of the world. It's unfortunate that Ms. Moore had so much fun MIMICKING Western North Carolina "assumptions," It's even more of a shame that she was fired from Mission for having the courage to call it what it is - a monopoly.

MrWhcapples 6 months ago

WNCChoice also has posted Ms. Moore's full powerpoint presentation, wheath 6 months ago

Ms. Moore's comments were taken out of context. She is actually MIMICKING assumptions that outsiders make about Western North Carolinians, and it is actually not Ms. Moore herself who is making the assumptions. Her comments are excerpted from a powerpoint that she delivered to a group of health care marketers, talking about how social media, such as facebook and youlube, can play such a powerful role in influencing public opinion.

I am very offended by this video. She represents Mission? They must have reached all time low to let her represent their hospital. I have worked at Mission as an RN for years and was raised in Haywood County so am I just a back woods hillbilly?

militarivermom 6 months ago

This is suppose to be a leader of Mission Hospitals insulting the people of WNC? They need to get rid of her!



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Englishment Financial Control of the

Mission Marketing Presentation by WNCChoice 1,654 views



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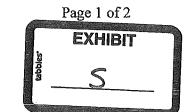
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Sen. Apodaca expecting no change to countyline project

By <u>Mark Schulman</u> Times-News Staff Writer Published: Saturday, January 28, 2012 at 8:54 a.m.

While a House select committee studies health regulations that affect the reach of Mission Hospital, a powerful state senator says it's unlikely that the General Assembly will alter the hospital's Certificate of Public Advantage.

The COPA has become a flashpoint in the debate over Pardee Hospital's plan to partner with Mission in an outpatient facility in Fletcher, the 10-acre Mission Pardee Health Campus.

During an October public hearing, representatives of Park Ridge Health asked the select committee to strengthen state oversight of Mission, saying Mission is engaging in predatory business practices in Henderson County.

At the same meeting, Mission's CEO made a case for eliminating the COPA restrictions altogether.

The select committee is scheduled to discuss the issue at a Feb. 15 meeting in Raleigh. Those discussions could lead to recommendations for new legislation, but state Sen. Tom Apodaca, R-Hendersonville, said this week that any House action on the COPA is likely to die in the Senate.

"I don't think there's a need in the Senate to do anything with it (the COPA recommendations)," Apodaca said. "There doesn't seem to be anything wrong with it."

Mission entered into the COPA agreement with the state in 1995, when Mission acquired St. Joseph's Hospital and eliminated its competition in Buncombe County. The COPA states that Mission may employ or place under exclusive contract no more than 30 percent of the physicians in Buncombe and Madison counties.

"The predatory county-line project that Mission has proposed in Fletcher clearly violates the spirit of the COPA," said Graham Fields, assistant to the president for external relations at Park Ridge. "We hope the committee will ultimately decide to strengthen the COPA and extend its protection to Mission's true service area."

Fields said Apodaca's stance on COPA legislation is not surprising because last summer Apodaca removed language in the House study bill that would have authorized the select committee to examine Mission's operations outside Buncombe County.

"We all hope that the good senator sees the light on this issue," Fields said.

Park Ridge officials have said the Mission Pardee Health Campus would create an unnecessary duplication of services in northern Henderson County and erode Park Ridge's market share. The site is about 4 miles from Park Ridge's main campus.

Park Ridge officials are asking the committee to prohibit the joint venture in light of the COPA.

While the House select committee will consider requests to change the COPA, Rep. John Torbett, the committee's co-chairman, said the Pardee-Mission project probably would be protected by a grandfather clause if new legislation is passed.

Pardee CEO Jay Kirby said his hospital and medical staff have been planning the county-line project for four years, and it's difficult for him to predict what will result from the committee's discussions.

The project took another step forward this week when Pardee's board of directors signed a letter of understanding with Mission that details an even division of ownership in the project.

"Although I read with interest updates from the committee's review of Mission's COPA, I think any speculation on what the committee will or will not recommend and how it may or may not impact the county-line project is premature at best," Kirby said.

In a written statement, Mission officials said they respect and support Apodaca, Fields said he would like to see legislation limit entities that operate under, or are managed by a COPA, from constructing, developing or owning a facility within a 10-mile radius of an existing health care facility or service within the 18 counties in Western North Carolina.

In addition, Park Ridge officials are requesting an audit of the COPA over the past 17 years and that the COPA be revised by expanding its anti-competitive laws throughout Western North Carolina,

And no matter what the decision is with COPA, they will remain steadfast in their "role as the region's safety net health care organization."

But Park Ridge officials argue that Mission's safety net is instead a noose around the necks of its competitors.

"This whole project is predicated on fear," Fields said of the Pardee Mission HealthCampus."AndIdon't believe that Mission should be allowed to dictate to our community what the future of health care will look like in Henderson County."

Reach Schulman at 828-694-7890 or mark.schulman@blueridgenow.com.

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Maximizing Efficiency in Your ASC or Office Endoscopy Unit • American Gastroenterol... Page 1 of 1

Maximizing Efficiency in Your ASC or Office Endoscopy Unit



As facility fees for ambulatory surgery centers (ASCs) continue to fall, it is more important than ever that the facility operate at maximum efficiency. This includes minimizing turnaround time in procedure rooms and maximizing the use of space, equipment, supplies and staff time. The following are some suggestions for meeting this goal:

- Allow two procedure rooms per physician per session: to maximize physician time and the number of procedures that can be performed in a session, allowing the physician
 to move from one room to another with no down time is critical. The patient should be prepped and ready for the procedure before the physician walks into the room. As soon as
 the procedure is finished, the physician should complete the procedure report and walk directly into the next room where the performed, the grady for the next procedure.
 While the procedure is being performed, the first patient is taken from the procedure room into the recovery area, the scope is replaced, the room is cleaned and the next patient
 is brought into the procedure room.
- Assign staff to specific functions: the same people should be performing the same function for the entire session. For example, one nurse should be assisting the physician in
 the procedure room, one nurse should prepare the patient and bring the patient into the procedure room, one nurse should take the patient out of the procedure room and into
 recovery and one tech should be responsible for cleaning the scopes.
- Schedule patients for the full day: though patients may prefer to have their procedures performed in the morning, leaving the unit empty in the afternoon does not make full use of the facility. Colonoscopies can be scheduled for the morning and upper endoscopies in the afternoon so the patients don't have to fast a full day.
- · Fill the entire schedule: If you do not have enough patients in your practice to fill the ASC schedule, consider opening up your facility to other physicians in the community.
- Have enough equipment and supplies: nothing is worse than having to wait for a scope to be cleaned before the procedure can begin or running out of forceps. Inventory of supplies should be taken on a regular basis and scopes should be checked daily to ensure that they are functioning properly. Always have a back-up scope in case one malfunctions.



Mission Hospital - Mission Gl South **Endoscopy Suite Lease Term Sheet** March 1, 2011

Landlord: 1.

Real Estate LLC - specific entity to be named at a later

date

Tenant: 2.

Mission Hospital, Inc.

Premises: 3.

Portion of medical office building to be constructed on

2651 Hendersonville Road, Buncombe County, NC

Use: 4.

Medical services and associated office operations

Term: 5.

10 years

Renewal Options: 6.

Two renewal options at five years each

7. Rentable Square Feet: 3700 sf

8. Rent Commencement: Upon issuance of a substantial completion certificate

9. Base Rent: \$35.22/sf

10. Rent Inflation Factor: 3.5%/year

11.

Expense Responsibility: \$8/sf is included in the base rent for taxes, insurance

and maintenance

12.

Premise Improvements: Tenant will perform tenant improvements based on

tenant's requirements.

13.

Tenant Upfit Allowance: Landlord will provide a tenant an improvement

allowance equal to 25% of the total cost of the premise

improvements.

Mission Hospital preliminarily agrees to the terms of this lease pending finalization of specifications, design and lease terms.

	Man	ket Share			
GountyDetail	2007	2008	2009	2010	2011
PSA					versament esternic
Buncombe	89.3%	89.9%	90.4%	90.7%	90.5%
		***************************************			**************************************
SSA					
Haywood	28.2%	36.7%	34.0%	33.0%	33.8%
Henderson	23.5%	26.4%	28.3%	27.3%	28.2%
Madison	90.5%	91.6%	92.7%	92.3%	93.7%
Mcdowell	34.5%	34.9%	39.1%	37.9%	39.7%
SSA Total	31.3%	35.6%	36.7%	35.7%	37.2%
TSA					
Avery	8.8%	8.4%	8.4%	7.7%	9.7%
Burke	5.8%	6.2%	5,9%	6.2%	7.2%
Cherokee	20.1%	19.2%	19.2%	20.7%	21.8%
Clay	20.3%	19,9%	21.7%	22.6%	22.6%
Graham	25.3%	26,3%	28.2%	28.8%	31.3%
Jackson	22.1%	25.0% ·	28.1%	29.4%	27.6%
Macon	28.0%	30.8%	31.7%	31.3%	32.4%
Mitchell	28.8%	25.9%	27.8%	29.5%	31.7%
Polk	14.5%	18.0%	16.5%	15.8%	18.9%
Rutherford	6.7%	7.9%	7.7%	7.9%	9.8%
Swain	24.9%	26.4%	29.0%	27.4%	29,6%
Transylvania	32.1%	35.8%	34,9%	34.0%	31.4%
Yancey	49.4%	48.6%	50.2%	50,2%	50.3%
TSA Total	21.8%	23.3%	24.0%	24.2%	25.7%
Total Market	38.5%	41.3%	42,2%	42.4%	43.3%

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