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.*
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> 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

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 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 relatively close proximity to the proposed Mission GI South campus – Park Ridge Hospital is approximately 5.15 miles[1]; 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 Exhibit O. 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).

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=DREFrmS-ZoU. 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 pro-competitive 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

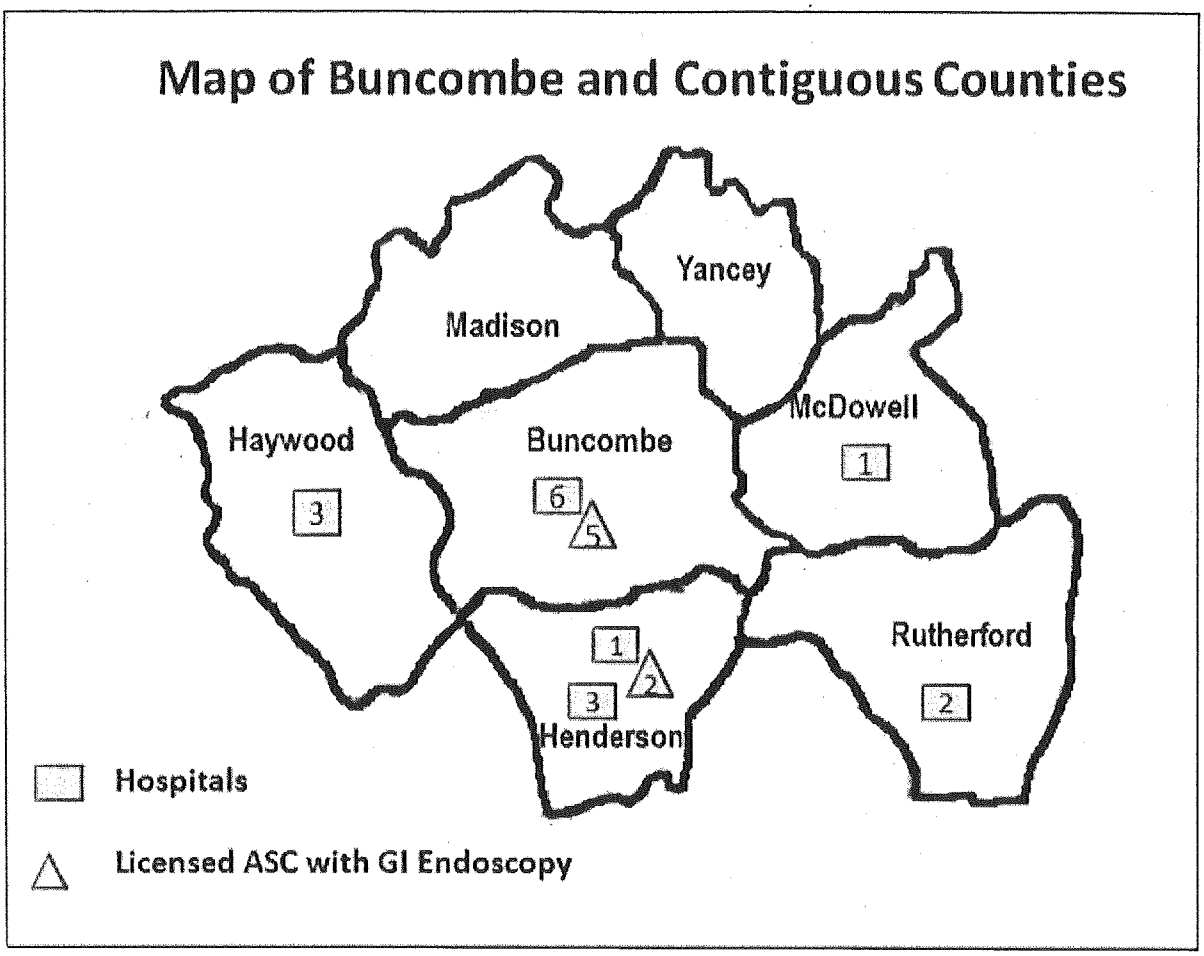
For the same period, the patient origin data demonstrates that fewer patients from Buncombe and Henderson Counties chose to obtain GI endoscopy at Mission. These statistics prove that decreasing numbers of patients from Buncombe and Henderson Counties obtain GI endoscopy performed at Mission.

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

existing facilities that provide GI endoscopy procedures.



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.

County	Licensed Facilities	Facility Type	Licensed Endosopy Rooms	2011 Population	2011 Population per Licensed GI Endoscopy Procedure Room
Buncombe	Mission Hospital / Asheville Surgery Center	Hospital	6	235,768	21,433
	The Endoscopy Center	GI ASC	5		
Haywood	Haywood Regional	Hospital	3	58,749	19,583
Henderson	Carolina Mountain GI Endoscopy Center	GI ASC	2	109,038	18,173
	Pardee Hospital	Hospital	3		
	Park Ridge Health	Hospital	1		
Madison	No Facility	NA	0	21,115	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 number of patients from Henderson and Buncombe Counties that obtain GI endoscopy procedures at Mission has not increased.

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

	Mission Hospital GI Endoscopy Patient Origin					Increase or (Decrease) Between LRA Periods	Increase or (Decrease) Between LRA Periods
	2006 LRA	2008 LRA		2012 LRA		2006 to 2012	2008 and 2012
Buncombe	4601	4561		3951		-650	-610
Henderson	517	509		506		-11	-3
Haywood	355	390		409		54	19
Madison	378	425		363		-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		100		-17	-22
	7421	7694		7073		-348	-621

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 nearest emergency services 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

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 (10/1/14-9/31/15) PROJECTED CASES AS PERCENT OF TOTAL CASES	
Self Pay/Indigent/Charity	4.1%
Medicare / Medicare Managed Care	50.1%
Medicaid	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 Total Reimbursement per Case			YR 1	YR 2	YR 3
Form D	10/01/10 to 09/30/11	Intervening Years	10/01/13 to 9/30/14	10/01/2014 to 9/30/15	10/01/2015 to 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:

Service	Facility Staff	Facility Paid Consultant/ Contractor	Contract Billed to Patient	Specify Staff Position Or Proposed Provider	Specify Date Service Available
Patient Care Areas: One Relocated Licensed GI Endoscopy Room					
Pre-Operative Services	X	N/A	N/A	RNs	10/1/2013
Procedural Area (Facility Component)	X	N/A	N/A	RNs, Endoscopy Technician	10/1/2013
Procedural Area (Professional Component)		N/A	X	Gastroenterologists, credentialed by Mission to practice at Mission GI South	10/1/2013
Post-Operative Area	X	N/A	N/A	RNs	10/1/2013
Anesthesia/Conscious Sedation	X		BLANK	BLANK	10/1/2013
Business Functions (Phone Coverage, Insurance Verification, Scheduling, Charge Entry – Existing Mission staff)	X	N/A	N/A	BLANK	10/1/2013
Business Functions (Reception, Registration)		X	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. Section VI Response to Question 14	**Page 115. Financial Section 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:

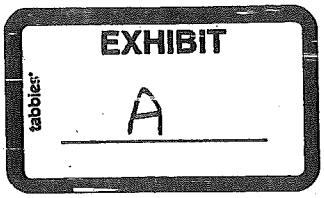
County	# Licensed Hospitals with GI Endoscopy Procedure Rooms	# Licensed Ambulatory Surgical Facilities with GI Endoscopy Procedure Rooms
Buncombe	1	1
Cabarrus	1	2
Cumberland	2	3

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

- 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)
Current and Projected Patient Origin

County	Current FY 2010	Project Year 2 CY 2014
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%
Macon	1.9%	1.9%
Cherokee	1.6%	1.6%
Burke	1.4%	1.4%
Swain	1.0%	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

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

	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.
**Totals may not foot due to rounding.

However, the applicant provides inconsistent information regarding projected in-migration 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.

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

	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	3,982	4,692
Total	6,826	8,694	6,752	8,812	6,513	8,661
GI Endo Rooms Needed at 1,500 procedures/yr		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

Buncombe County	FY 2008		FY 2009		FY 2010	
	Cases	Procedures	Cases	Procedures	Cases	Procedures
Mission Hospital IP GI Endoscopy	2,577	3,538	2,632	3,696	2,531	3,699
Mission Hospital OP GI Endoscopy	4,249	5,156	4,120	5,116	3,982	4,962
Total Mission Hospital	6,826	8,694	6,752	8,812	6,513	8,661
The Endoscopy Center OP GI Endoscopy	10,448	14,370	11,129	14,982	10,980	14,765
Total GI Endoscopy Performed in Buncombe County	17,274**	23,064**	17,881**	23,794**	17,493**	23,426**
GI Endoscopy Rooms Needed at 1,500 procedures/yr		15.4		15.9		15.6
2010 Licensed GI Endoscopy Inventory		11.0		11.0		11.0
Additional GI Endoscopy Rooms Needed		4.4		4.9		(4.6)

[Emphasis in original.]
Source: Exhibit 16, Table 7
**Mission has 6 licensed GI endoscopy rooms; The Endoscopy Center has 5 licensed GI endoscopy rooms*
***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.

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.

Buncombe and Henderson Counties Providers
GI Endoscopy Volume
October 2007 – September 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
The Endoscopy Center			
Cases	10,448	11,129	10,980
Procedures	14,370	14,982	14,765
Carolina Mountain Endoscopy Center			
Cases	3,541	2,551	3,283
Procedures	3,646	3,316	3,475
Pardee Hospital			
Cases	3,891	3,427	2,511
Procedures	4,562	4,289	4,090
Park Ridge Hospital			
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	20.8	20.7
Licensed GI Endoscopy Rooms	17	17	17
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

County	2010	2015	2010-2015 CAGR
Primary Service Area			
Buncombe	233,999	248,638	1.2%
Secondary Service Area			
Henderson	107,383	116,216	1.6%
McDowell	45,717	48,631	1.2%
Haywood	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	38,475	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 Area			
Henderson	38,729	42,937	2.1%
McDowell	13,177	14,343	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 – Mission Campus	6	6	6	6	5	5	5
# of GI Endoscopy Procedures	8,812	8,661	8,645	8,628	7,157	7,125	7,092
# of Dedicated GI Endoscopy Rooms – Mission GI South	0	0	0	0	1	1	1
# of Outpatient GI Endoscopy Procedures – Mission GI South	0	0	0	0	1,455	1,471	1,487
Total # of Dedicated GI Endoscopy Rooms – Mission Hospital and Mission GI South	6	6	6	6	6	6	6
Total # of GI Endoscopy Procedures – Mission Hospital and Mission GI South	8,812	8,661	8,645	8,628	8,612	8,595	8,579

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
January 2008 – December 2010

	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	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

	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	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

County	*2010-2015 CAGR*	*FY 2010 GI Endoscopy Services Patient Origin*	*GI Endoscopy Services Weighted Growth Rate*
Formula	*A=County Specific CAGR*	*B=County Percent of Total Patient Origin*	*C=AxB*
Primary Service Area			
Buncombe	*1.2%*	*56.8%*	*0.7%*
Secondary Service 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%*
Tertiary Service Area			
Yancey	*0.8%*	*3.4%*	*0.0%*
Transylvania	*0.8%*	*2.4%*	*0.0%*
Mitchell	*0.2%*	*2.2%*	*0.0%*
Jackson	*1.4%*	*2.1%*	*0.0%*
Macon	*1.6%*	*1.9%*	*0.0%*
Cherokee	*1.3%*	*1.6%*	*0.0%*
Burke	*1.1%*	*1.4%*	*0.0%*
Swain	*1.1%*	*1.0%*	*0.0%*
*North Carolina**	*1.7%*	*5.5%*	*0.1%*
Mission Hospital Weighted Population Growth Rate = Sum of Column C			*1.2%*

Source: Exhibit 16, Table 13
Methodology = Sum of Individual County Growth Rates x County Specific Patient Origin
**All Other In-migration grown at NC State Growth Rate*

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

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

County	2010-2015 CAGR	FY 2010 GI Endoscopy Services Patient Origin	GI Endoscopy Services Weighted Growth Rate
Formula	A=County Specific CAGR	B=County Percent of Total Patient Origin	C=AxB
Primary Service Area			
Buncombe	2.3%	56.8%	1.3%
Secondary Service Area			
Henderson	2.1%	6.9%	0.1%
McDowell	1.8%	5.2%	0.1%
Haywood	1.4%	5.0%	0.1%
Madison	1.7%	4.6%	0.1%
Tertiary Service Area			
Yancey	1.5%	3.4%	0.0%
Transylvania	1.8%	2.4%	0.0%
Mitchell	1.0%	2.2%	0.0%
Jackson	2.1%	2.1%	0.0%
Macon	1.9%	1.9%	0.0%
Cherokee	2.3%	1.6%	0.0%
Burke	1.7%	1.4%	0.0%
Swain	2.0%	1.0%	0.0%
North Carolina*	2.8%	5.5%	0.2%
Mission Hospital Weighted Population Growth Rate = Sum of Column C			2.1%

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 Endoscopy	*CY 2010*	*CY 2008-CY 2010 CAGR*	*CY 2011*	*CY 2012*	*CY 2013*	*CY 2014*	*CY 2015*
Procedures	*8,661*	*-0.2%*	*8,645*	*8,628*	*8,612*	*8,595*	*8,579*

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 Average Procedures per Case*	*CY 2011*	*CY 2012*	*PY 1: CY 2013*	*PY 2: CY 2014*	*PY 3: CY 2015*
Procedures	*8,661*	*1.33*	*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 per room	*5.8*		*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

Total GI Endoscopy	Buncombe	Henderson
FY 2007		
Cases	11,682	5,689
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 Zip 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.

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

Mission GI South	*2010*	*2011*	*2012*	*PY1: 2013*	*PY2: 2014*	*PY3: 2015*
Buncombe Zip Codes						
Zip Code Population	*80,717*	*81,536*	*82,363*	*83,199*	*84,043*	*84,896*
County GI Endoscopy Use Rate	*50.4*	*50.4*	*50.4*	*50.4*	*50.4*	*50.4*
Total Projected GI Endoscopy Cases	*4,071*	*4,112*	*4,154*	*4,196*	*4,239*	*4,282*
Henderson Zip Codes						
Zip Code Population	*70,396*	*71,413*	*72,444*	*73,490*	*74,551*	*75,628*
County GI Endoscopy Use Rate	*56.9*	*56.9*	*56.9*	*56.9*	*56.9*	*56.9*
Total Projected GI Endoscopy Cases	*4,009*	*4,067*	*4,125*	*4,185*	*4,245*	*4,307*

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

Buncombe County	*FY 2008*		*FY 2009*		*FY 2010*		*Three Year Avg Inpt/Outpt Split*	
	Cases	*Procedures*	*Cases*	*Procedures*	*Cases*	*Procedures*		
Mission Hospital IP GI Endoscopy	*2,577*	*3,538*	*2,632*	*3,696*	*2,531*	*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

Mission GI South	*2010*	*2011*	*2012*	*PY1: 2013*	*PY2: 2014*	*PY3: 2015*
Buncombe 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*	*3,508*	*3,543*	*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

Mission GI South	2010	2011	2012	PY1: 2013	PY2: 2014	PY3: 2015
Buncombe Zip 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
Henderson Zip Codes						
Projected OP GI Endoscopy Cases	3,385	3,434	3,484	3,534	3,585	3,637
Procedures per Case	1.33	1.33	1.33	1.33	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	2007		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

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

Mission GI South	*2010*	*2011*	*2012*	*PY1: 2013*	*PY2: 2014*	*PY3: 2015*
Buncombe Zip 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 – Mission GI South	*1,039*	*1,050*	*1,061*	*1,071*	*1,082*	*1,093*
Henderson Zip Codes						
Expected GI Endoscopy Procedures	*4501*	*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 – Mission GI South	*228*	*231*	*235*	*238*	*242*	*245*
Combined						
Projected OP GI Endoscopy Procedures – 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
(Inpatient and Outpatient)

County	# of Total GI Endoscopy Patients	% of Total GI Endoscopy Patients
Buncombe	3,730	56.8%
Henderson	452	6.9%
Sub-total	4,182	63.7%
Transylvania	158	2.4%
Jackson	135	2.1%
Macon	127	1.9%
Polk	27	0.4%
Rutherford	60	0.9%
Sub-total	508	7.7%
Total # Endoscopy Patients at 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 - 2015

Mission GI South	2010	2011	2012	PY1: 2013	PY2: 2014	PY3: 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 (10%)				145	147	149
Total Projected OP GI Endoscopy Procedures				1,455	1,471	1,487
GI Endoscopy Rooms Needed at Mission GI South				1	1	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 in-migration 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

Mission GI South	2010	2011	2012	PY1: 2013	PY2: 2014	PY3: 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	1

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	-

*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

	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 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[1] 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% in-migration 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 in-migration 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.

C

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. The 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.

NC

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.

NC

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

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

assume there will be no 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 Form 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)

Personnel	Annual Salary (A)	Full-Time Equivalents (FTEs) (B)	Salary Expense (A x 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
Total			$1,505,577

*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.

NC

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 inpatient 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 room[2] 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.

C

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.

Employee Category	# of Full-Time Equivalents (FTEs)		
	Mission Hospital (Current) (A)	Mission Hospital & Mission GI South Combined (Project Year 3) (B)	Mission GI South Only (Project Year 3) (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.
**Source: Sections VII.1 and VII.2.

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:

Functional Area	Type	# of FTE Positions
Administration	• RN Manager • RN Supervisor	1.00 1.00 **2.00**
Registration	• Unit Secretary	**3.00**
Pre-Procedure	• RNs • Endoscopy Technician	5.00 0.50 **5.50**
Post-Procedure	• RNs • Endoscopy Technician	5.00 0.50 **5.50**
GI Endoscopy Room	• RNs • Endoscopy Technician	8.00 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.

C

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 Asheville Gastroenterology Associates, P.A. and other physicians and 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.

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 (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.

NC

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;

C

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 DEPARTMENT LAST FULL FISCAL YEAR (10/1/09 – 9/30/10) CURRENT CASES AS PERCENT 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	16%	7%	16.7%
Henderson	13%	5%	17.6%
Statewide	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;

C

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

C

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	*1.31%*
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.

C

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.

C

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.

EXHIBIT
tabbies
B

Google

Directions to 100 Hospital Dr, Hendersonville, NC 28792
4.4 mi – about **9 mins**
Distance from Mission site to Park Ridge Health

A 2651 Hendersonville Rd, Arden, NC 28704

1.	Head **south** on **US-25 S/Hendersonville Rd** toward **Alliance Page Rd** About 1 min	go 1.2 mi total 1.2 mi
2.	Turn left onto **Co Rd 1006/Howard Gap Rd** About 6 mins	go 2.8 mi total 4.1 mi
3.	Turn right onto **Co Rd 1534/Naples Rd**	go 0.1 mi total 4.2 mi
4.	Take the 1st left onto **Hospital Dr**	go 312 ft total 4.3 mi
5.	Take the 1st right to stay on **Hospital Dr** Destination will be on the left	go 0.1 mi total 4.4 mi

B 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 route.

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

STATE OF NORTH CAROLINA — IN THE GENERAL COURT OF JUSTICE

SUPERIOR COURT DIVISION

COUNTY OF BUNCOMBE — 11 DHR 11636

MISSION HOSPITAL, INC;

Petitioner,

vs.

N.C DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF HEALTH SERVICE REGULATION, CERTIFICATE OF NEED SECTION,

Respondent

DEPOSITION

OF

GEBRETTE MILES

THURSDAY, JANUARY 5, 2012

10:03 A.M.

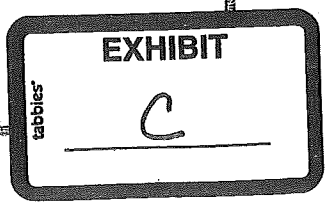
AT THE OFFICES OF

SMITH MOORE LEATHERWOOD LLP

434 FAYETTEVILLE STREET, TWO HANNOVER SQUARE SUITE 2800

RALEIGH, NC

VOLUME I



APPEARANCES

ON BEHALF OF THE MISSION HOSPITAL, INC:
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ALSO PRESENT: DENISE GUNTER, ESQ.
NANCY BRES MARTIN
CHRISTY SINK
BRIAN MOORE

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STIPULATIONS

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

1. 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 answers 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 irregularities in the taking of the same, either in whole or in part or for any other cause;

5. 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,

6. That the witness reserves the right to read and sign the transcript of this deposition prior to filing.

PROCEEDINGS

(WHEREUPON, GEBRETTE MILES WAS CALLED AS A WITNESS, DULY SWORN, AND TESTIFIED AS FOLLOWS:)

DIRECT EXAMINATION BY MS. HARRIS:

Q. Good morning, Ms. Miles. We've met off the record, and other times, I'm Terri Harris, and I'm representing Mission Hospital Incorporated in connection with an appeal of a decision by the CON Section related to an endoscopy relocation application. Will you state your full name, please?

A. Gebrette Miles.

Q. Okay. What is your business address?

A. 809 Ruggles. We just moved.

Q. All right. If we can go off the record for a second, I'll let Denise get settled.

(OFF-THE-RECORD DISCUSSION)

(MS. GUNTER JOINS)

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

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

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

A. Three years.

Q. Can you tell me a little bit about your job

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responsibilities?
A. As a certificate of need analyst, I'm responsible for reviewing certificate of need applications, reviewing them against the criterion and applicable rules. I'm also responsible for performing the public hearings as necessary, and also monitoring progress of projects that have been approved and are under development. I also respond to inquiries regarding projects that may be exempt from review or where the certificate of need law may not apply. And other general correspondence as necessary.
Q. Do you have responsibility for a particular area of the state, or type of service for which certificate of need applications are required?
A. Yes, I am assigned to HSA II--the western part of HSA II, which is Forsyth, Surry, Yadkin, Davidson and Davie Counties, I believe, if I'm not forgetting one.
Q. And I've been provided with a copy of a resume for you, but, if you could, tell me briefly your background with regard to health planning.
A. I don't have a health planning background. Most of my health planning experience is--has been involved with my current position as certificate of need

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analyst. I did work for--about three years for the Maryland Hospital Association -primarily with their financial advocacy team regarding the rate setting system in Maryland. Maryland's rates are regulated by the state, and so in an advocacy position on behalf of the hospitals, I worked in that capacity. But from a health planning standpoint, most of my experience has been gained as a certificate of need analyst.
Q. What degrees do you have?
A. I have an undergraduate from Delaware in Public Administration and a master's degree in Health Services Administration from the University of Michigan.
Q. Was your MSA -excuse me, Master's of Health Service Administration focused more on policy, would you say?
A. No, I would say it's--the subspecialty was Health Management and Policy, so it was a combination of management and policy. But I think primarily our training was more geared towards management and operations.
Q. Did you have any classes with regard to health planning?

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A. I don't recall. Possibly. I don't remember.
Q. And you did your administrative fellowship at Johns Hopkins; is that right?
A. Yes.
Q. Have you attended training programs or different educational sessions related to health planning since joining the Certificate of Need Section?
A. No.
Q. Your training is on the job; is that right?
A. Correct.
Q. Have you been in a deposition before?
A. Yes.
Q. How many times, do you think?
A. This may be my third or fourth time.
Q. You're doing a great job so far, but I'll remind you to let me finish my questions before you answer, and I'll try to make sure that I let you finish your answers before I ask another question. If you need a break, will you let me know?
A. I will.
Q. And if you don't understand one of my questions, will you let me know that?
A. Okay.
Q. Have you testified in a deposition involving a

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relocation of an existing service before?
A. Relocation. If you want to consider--if you want to consider the Gaston satellite ID--I mean, ED case as a relocation, that would be the closest to a relocation.
Q. And, just more generally, have you ever testified in a contested case hearing?
A. Yes.
Q. How many times?
A. Twice.
Q. What cases were those?
A. That was Wake Forest University Health Sciences development of a ambulatory surgical facility and the Gaston satellite ED case.
Q. The Wake Forest University Health Sciences amb surg center, was that a new ambulatory surgical center?
A. Yes.
Q. Did it involve transferring ownership of any existing operating rooms?
A. No, it was a development of new operating rooms.
Q. And did you initially disapprove the application?
A. Yes--no, I'm sorry. I approved that application.
Q. And then there was an appeal by a competing applicant?

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A. Intervenor, I believe. It was not competitive.
Q. Was the Agency's decision upheld through that appeal process?
A. That's--to my knowledge, it's still outstanding.
Q. Okay.
A. I'm not certain of the status.
Q. What was your initial decision with regard to the Gaston ED?
A. I approved that application.
Q. And was there an appeal by Carolinas Medical Center?
A. Yes.
Q. Does that case remain pending as well?
A. To my knowledge, yes.
Q. In regard to Mission's application, I typically refer to it as the GI or GI South application. Will you know what I mean if I use those shorthands?
A. Yes.
Q. Okay. Did you have a particular shorthand that you used?
A. I think I followed the applicant, which they used Mission GI South.
Q. How did you come to be the analyst for the Mission

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GI South application if you're typically assigned to another HSA?
A. I was assigned--I was assigned this particular application by leadership in the CON Section.
Q. Do you know if it was a question of workload or that they particularly wanted your expertise for this application?
A. I'm not sure.
Q. At what point did you become assigned to the application and review?
A. I don't--I don't remember.
Q. In terms of today's deposition, tell me what you did to prepare in terms of document review or discussions with others.
A. I reviewed the Agency file and spoke with counsel.
Q. Did you review the Mission GI South application again?
A. Yes--well, yes, it's part of the Agency file.
Q. We can mark them as exhibits. Probably, this is a good time to do that. I have in front of you witness copies of the Agency file. I have separate notebooks, one with the application itself and one with the Agency file materials. Let's mark the deposition--I mean, excuse me, the application as

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Exhibit 2, I've got 1 here, and the Agency file as Exhibit 3.
(DEPOSITION EXHIBIT NOS. 1, 2 AND 3 WERE MARKED FOR IDENTIFICATION.)
Q. And I'll hand you what I've marked at the beginning as Exhibit 1, which is a copy of the Agency's discovery responses, and we'll be referring to these exhibits throughout the deposition. I'll try to make sure I give you time and the page number to get where you need to go for my particular questions. Did you do anything else besides looking back through the application and Agency file and talking with counsel to prepare?
A. No.
Q. Did you locate any other documents that you thought might be responsive to discovery requests or that should have been included in the Agency's file?
A. No.
Q. What did you do to compile the Agency file for this case?
A. I simply went back through all of the documentation that I had gathered during the review from the--from the public hearing all the way to the final findings and organized them for the Agency file.

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Q. In the discovery responses that we've just marked and handed--I handed you as Exhibit 1, it reflects that you and Ms. Frisone were primarily responsible for providing information for these responses; is that correct?
A. Yes.
Q. 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 specific recollection of that, right?
A. That's correct.
Q. And Fatima Wilson, another project analyst, was present with you at the public hearing?
A. Yes.
Q. Did she have any other role in the review process?
A. No.
Q. Why did she attend the public hearing?
A. The public hearing--there were two applications under the public hearing. She was the project analyst for the other application, and it also required a public hearing, so we did them at the same time.
Q. When you became involved with the review of the Mission GI South application, was a public hearing

already scheduled?
A. No, I don't believe so. I believe I was assigned early in the process.
Q. Were you aware that Mission had requested an expedited review of its application?
A. I don't--I don't recall. I would not have checked this application in, because it's not in my HSA, and, typically, usually the person who either checks in the application when it comes into the Certificate of Need Section, is aware that there is an expedited review, or the project analyst who checks the application in for its completeness is aware that there's an expedited review. But I was not--neither of those people.
Q. What do you mean checking in an application?
A. When an application--when an applicant brings an application on application day, we check in the application. There are a few things that we need to make sure, or just ask if they are included. Whether or not that particular application--if the applicant has requested expedited review is one of the things that we need to check for.
Q. When an applicant requests an expedited review, what's the process for determining whether to grant

the request?
A. The Assistant Chief or the Chief has to approve the expedited review request.
Q. In this particular review, the decision was made not to expedite the review. Do you know who made that decision?
A. I believe I sent out the letter for the extension. I don't recall why. It could have been my workload at the time -prior to when this application came in that delayed my completion of this review.
Q. In terms of the denial of the expedited review, that came much earlier when it was decided to schedule the public hearing, did it not?
A. Let me look, because I don't recall if it was denied, or if it was accepted and then we had to extend it. I have to check.
Q. Are you looking at the Section I of the Agency file?
A. Yes. Okay. There was not an expedited--it was not approved for expedited review.
Q. And what--what are you referring to?
A. I'm looking at the completeness check form.
Q. Is that Page 5?
A. Yes, on Page 5. That was completed by another

project analyst.
Q. Do you know who completed it?
A. The analyst box up top says Les, so that's Les Brown.
Q. Did Les--
A. So there was no--it was not expedited.
Q. Right. If you look at the very first page of the Agency file though, it's actually Bates numbered 2, there was a request for an expedited review, correct?
A. Yes.
Q. And then going back to Page 5, there's a no under expedited approved--
A. That's correct.
Q. --and then supervisor's initials. Do you know whose those are?
A. I can't tell. It would be Craig Smith or Martha Frisone. I'm not sure whose initials those are.
Q. Is the--is there a letter sent to an applicant who requests expedited review and the request is denied, or how does an applicant obtain the decision on expedited review?
A. On Page 16, there is a letter dated May 2nd, which is a denial of expedited review. So we notified

the applicant in May that the request was denied.
Q. This letter on Page 16 of the Agency file to Mr. Moore says that the Certificate of Need Section has determined that a public hearing is in the public interest, and, therefore, an expedited review will not be granted.
A. Yes.
Q. And that letter is signed by yourself and by Ms. Frisone; is that right?
A. Yes.
Q. Did you discuss with Ms. Frisone whether to grant the expedited review request?
A. I don't recall, and I don't recall if it was Ms. Frisone or Mr. Smith that made that call.
Q. And do you know why it was determined that a public hearing would be in the public interest?
A. I don't recall.
Q. Did you agree with the decision?
A. That's their decision, so I didn't question it.
Q. Are you saying that you did not have any role in that decision, or that you just don't remember?
A. I would not have had a role in that decision.
Q. In a typical review that you perform, tell me how you go about conducting the review and the steps

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that you take.
A. I--I personally begin by reviewing the application. I read the application entirely through. When I'm finished with the application, I will then read any public comments that we've received and responses to public comments that we may have received, and then I begin with Criterion 1 and work my way through.
Q. Do you typically review the application in any depth before the public hearing?
A. No, many times I've not--most times I've not seen the application prior to the public hearing.
Q. And, likewise, do you just wait until after the public hearing to review the comments and responses to comments?
A. Yes.
Q. Do you recall if you read any of this application before the public hearing?
A. I did not.
Q. Going back to a more general question, have you--prior to the Mission GI South application, have you reviewed applications that involved endoscopy?
A. Yes.
Q. Can you tell me how many of those?

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A. Probably two or three.
Q. Do you recall the counties or the providers?
A. I believe they were all in Forsyth County. I think I've done two for Digestive Health Specialists and one for--well, they may all three have been Digestive Health Specialists.
Q. Were they competitive applications?
A. Actually, yes, one was deemed to be competitive. It was Digestive Health Specialists and Salem Gastroenterology in Kernersville.
Q. Did you make the determination that the two applications were competitive?
A. I don't recall if I made that determination, or if the Assistant Chief or Chief made that determination.
Q. What was the Agency's decision with regard to the competitive endo application?
A. I approved Digestive Health Specialists and disapproved Salem GI.
Q. Could you have approved both applications?
A. No, I didn't. I could not have approved both.
Q. Why not?
A. Oh, you mean in terms of whether they were--
Q. Right. In the general sense, not regarding the

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merits of each, but if they both met all the criteria, could you have approved both?
A. You know, I don't remember the details. I'm not sure.
Q. Was there an appeal related to your decision?
A. Yes.
Q. And Salem Gastroenterology appealed?
A. That's correct.
Q. Is that appeal still pending?
A. No, I believe there was a settlement.
Q. And who--did either applicant receive a certificate of need as part of the settlement?
A. Yes.
Q. Which one?
A. Well, initially--initially, Digestive Health Specialists received a certificate, and now, I think--I believe Salem GI may have received a certificate as well after--as part of the settlement, but I'd have to check.
Q. There's not a need determination process for the GI endoscopy rooms, right?
A. That's correct.
Q. Have you reviewed applications involving operating rooms, amb surg operating rooms?

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A. Yes.
Q. How many?
A. Well, there's just one that comes to mind that I--well, now, I shouldn't say that. There are two, and I believe they're both Wake Forest University Health Sciences applications.
Q. And I believe you told me about one of those already.
A. Yes, that was the ambulatory surgical facility in Winston-Salem, and the other was to relocate three OR's also in Forsyth County.
Q. Did you approve or deny the application to relocate three OR's?
A. That was denied.
Q. Did you refer back to the findings on that application to relocate three OR's in connection with the review of Mission GI South?
A. No.
Q. When you're reviewing the competitive comments or written comments by community members related to an application, how do you factor that into your decision then, and when do you review those as compared to the application?
A. Well, as I mentioned, I will read the application

first before I look at any comments, and I review the comments that are submitted, and I read them in conjunction with the response to comments, and I determine, or assess whether or not--whether or not I feel that there is any merit, in my mind, to either look more closely at a comment that has been made, or to dismiss a comment if I determine it's not relevant.

Q. Do you review those comments and the responses before or after you review the application against the criteria?

A. It's before I start the findings.

Q. And when you say before you start the findings, are you saying that you review an application and then write your findings with regard to Criterion 1, and then review more and write your findings?

A. No, I will review the whole application, and comments, and the response to comments before I start writing.

Q. In this particular case, the Mission GI case, there was a pre-application conference in February, 2011. Did you attend that public--pre-application conference?

A. I did not.

Q. Do you know who did?

A. I believe it was Ms. Frisone, Mr. Smith and Mr. Brown.

Q. Did you speak with any of the three about the pre-application conference and what was discussed?

A. The pre-application conference may have been discussed as part of the discussion about the location of the building, and I don't recall whether or not it was with Ms. Frisone or Mr. Smith, but I did not talk with Mr. Brown about this application at all.

Q. Did you get any notes or memos from Mr. Brown, Mr Smith or Ms. Frisone about the pre-application conference?

A. No.

Q. Did they make any notes, to your knowledge?

A. I don't know.

Q. What was discussed with regard to the relocation or the location?

A. I don't remember the specifics, and I wouldn't hazard a guess to restate what--what was said, because I don't remember it in full detail, but apparently in the pre-application, there was some discussion about the location of the building in

relation to the county line.

Q. What is your understanding of the issue that was discussed at the pre-application conference?

A. I--I don't recall. Something about the county line.

Q. Was it just that the project was located on the county line, or was there something specific with regard to the actual building?

A. I--I don't recall. You'd have to ask Ms. Frisone the specifics.

Q. Did any of the three who attended the pre-application conference say to you, Ms. Miles, you need to be aware of the fact that it's located here, or this is a concern for us, or we told the applicant that it could do a certain approach?

A. Not--not that I recall. It's clear from the application. I could see where the building was proposed to be located, but I didn't have any discussion, to my knowledge--that I recall about that.

Q. Do you know if any other sections of DHSR participated in that pre-application conference, such as Construction Section?

A. My understanding is -is that it was just--it was

just three representatives from the CON Section and then a few of the representatives for the applicant.

Q. Do you know if there were meetings that involved both the CON Section and Construction Section prior to the application being filed?

A. I don't know.

Q. Did you have any discussions personally with anybody in the Construction Section about the plans in the application, or the location?

A. No.

Q. Did you send any emails to or contact the Construction Section during the review?

A. No.

Q. What about the Licensure Section?

A. No. I'm sorry, yes. We did a standard quality check. I have to contact Licensure Section regarding the past services at the facility, and I did that.

Q. I believe that's reflected in the Agency file. That--

A. Yes.

Q. Is that the check that relates to whether there have been any quality or licensure issues?

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A. Yes.
Q. Did you contact Licensure Section at all with regard to the location of the building or the fact that it would be licensed as part of Mission Hospital?
A. No.
Q. You've told me that Ms. Frisone was the--was involved in the pre-application conference and may have made the decision not to expedite the review. What else did she do with regard to this review?
A. As the co-signor, she reviews the findings, my draft findings, and if I have any questions, she's there to answer any questions I may have.
Q. Do you know how much of the Mission GI South application Ms. Frisone reviewed herself?
A. I don't know.
Q. Did you have discussions with her at any point before you prepared your draft findings?
A. I don't recall. It's possible.
Q. Do you recall being--having any particular questions for Ms. Frisone during this review?
A. We had several discussions on a number of different topics. I can't categorize them or say specifically what they are, but we had a number of

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discussions.
Q. Can you give me any examples?
A. For example, about the discrepancy with the inmigration rate.
Q. We'll talk about that a lot more specifically, but what do you remember at this point about your discussion with Ms. Frisone about the inmigration rate?
A. I don't recall the discussion specifically, but I-- I noted and brought to her attention that there was a discrepancy, and we must have had some discussion about that, looking back at the application where the discrepancies are, but the details of our discussion, I don't--I don't specifically recall.
Q. When you say there's a discrepancy in the inmigration rate, what do you mean?
A. Well, in certain places, it's represented as 10 percent, and others it's represented as 15 percent.
Q. The discovery responses that we marked as Exhibit 1, Question 2 reflects that there was a discussion between yourself and Ms. Frisone and Mr. Smith about inmigration. It's on Page 4 in the response to Question 2.
A. Yes.

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Q. What in particular did you discuss with Mr. Smith about the inmigration?
A. From what I recall of that discussion, that was not regarding the discrepancy between the 10 and 15 percent. That was regarding the applicant's projected inmigration of 10 percent, and whether or not that was reasonable. I recall us looking at the licensing renewal application, the most recent one for endoscopy services, and looking at the service area where those patients were projected to come from, and also looking at a map of the State of North Carolina, looking at the counties and where they were projected to come from versus where one might expect them to come from.
Q. Does that relate to your finding that you didn't think that people would drive past Mission's current location to get to Mission GI South?
A. That relates to me determining that they overstated the inmigration.
Q. I believe there's some materials in Exhibit--in-- excuse me, behind Tab 4 of the Agency file that relate to the discussion. If you would, turn to those, and if you would let me know if I'm right about my guess on that. It begins with Page 568,

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the analyst's working papers and notes.
A. Okay.
Q. And, I believe, on 569, there begins the email exchange that we talked about with regard to quality.
A. Yes.
Q. Okay. And following the email exchange with Cecilia Boone at the Licensure Section, there is a series of maps and information. Tell me what--what you've got there.
A. On Page 571 and 572, I was just trying to get a picture in my mind of where the project was going to be located. I don't even recall what website I went to to find this information, but I was just trying to get a picture of where the building was supposed to be. On Page 573, I'm not sure off the top of my head what these two locations are. I did some research just about the Town of Fletcher on Page 574 to 575.
Q. And let me, if I might, go back to 571, please.
A. Sure.
Q. There's some handwritten numbers on 571. Is that your handwriting?
A. Yes.

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Q. What do the numbers reflect?
A. I think--if I can recall, I think they were street addresses that didn't come out on the print-out that were on the website. I think I was trying to get a grasp of, again, where the property was located. I think I may have had the address and was trying to figure some things out, and so those are just--I think they're street addresses.
Q. And if the address was given on Hendersonville Road for the project, is that right?
A. Yes.
Q. And that's in Buncombe County, correct?
A. Well, the building is in both counties, but the address is in--for in the application it's Buncombe County, yes.
Q. All right. And you were saying that you did some background information or research about Fletcher?
A. I was just looking up Fletcher, because I--I thought it straddled the county line, and so I just put it in here, because I had looked at that page, and I just wanted to acknowledge that I looked at that page. The zip code, I don't recall off the top of my head, but it may be the zip code for the project or the location.

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Q. The--the code on 576?
A. Yes, on Page 576, I put in 28732.
Q. If you look at Page 3 of the application, is that the zip code for the project?
A. Yes, and that's what I was just looking at the zip code to see what city came up. It said Fletcher. Page 577 was--again, I don't even recall the websites I was looking at, but this actually gave me sort of a satellite picture of the property.
Q. Did you have to enter the--the plat numbers or the address, or how did you get the overhead view?
A. You know, I don't remember. I don't remember off the top of my head how I got that.
Q. Is Page 578 a similar map?
A. I think it's another picture. It's hard to see.
Q. It looks like--this one on 578 looks like it was from Google Maps.
A. Yes. Yes, and 579 as well.
Q. Did you have a particular concern or just trying to visualize where the project would be located?
A. I was just trying to visualize where the project would be located.
Q. And what is the map on Page 580?
A. On Page 580, I was looking at--we received comments

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and letters of support from Pardee and Parkridge. They're also endoscopy providers in the area, and I was trying to see how close they were in proximity to the proposed project and to one another.
Q. So on your Legend, "A" is the Mission GI South, "B" is Pardee; is that right?
A. Yes.
Q. And "C" is Parkridge?
A. Yes. I believe that's what I've got down here.
Q. All right. And you have a note about 5.15 miles. What does that mean?
A. That's 5.515 miles from Mission GI South. Now, on 581, I've got Carolina Mountain, which isn't on the page before, so I'm not sure which one "C" is, but I was looking in general to see the proximity of other providers.
Q. That information was reflected in the application as well?
A. Yes.
Q. Both Pardee and Carolina Mountain Gastroenterology are in Hendersonville, right?
A. They're in Henderson County, yes.
Q. And actually in the Town of Hendersonville?
A. I'd have to double check. I can't recall off the

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top of my head.
Q. You were aware during the review that Pardee supported the application that Mission filed?
A. I believe we received a letter of support from Pardee.
Q. If you would, go on to 582.
A. 582, I think this was--I was trying to see the distance between Mission Hospital and the proposed Mission GI South.
Q. What did you determine?
A. I put in the addresses of each one, and it just said it was about 10 miles away, and I just wanted that for just general knowledge.
Q. It looks like you did some demographic research beginning on Page 583.
A. Yes, I did this--this is for Criterion, I believe, 13, and it's just new standard information we look at now.
Q. What's the source of the information?
A. It's not on the bottom there. It's public information. I'd have to look in the findings. I think I've cited the source in the findings under Criterion 13.
Q. Okay. But is it--does the source have it organized

in this way, or did you have to pull these tables together?
A. Oh, no, this--this is printed page print verbatim. I didn't pull together any tables.
Q. You determined that the application was conforming with Criterion 13, correct?
A. Let me look. Yes.
Q. And, going back to the working papers, you have the information gathered for both Buncombe and Henderson County?
A. Yes.
Q. And why did you look at the Henderson County information with regard to Criterion 13?
A. Well, the--the building was in both Henderson and Buncombe Counties, and so I pulled both.
Q. The--is it your understanding that the GI room will be in Buncombe County?
A. Well, there's a question about that. The diagram that is in the application shows that it's--I can't tell if the line is through the room or through the facility itself. It's unclear. It appears to me--I can't say if it's going through the exact room--or the room itself.
Q. And you're--the line you're talking about is the

county line?
A. Yes, based on the line drawing that we received.
Q. So, for purposes of your review, did you look at it both ways, or did you look at whether the room was solely in Buncombe County as stated?
A. I looked at it as the facility--the space being in both counties.
Q. What--the space for exactly what?
A. The GI endoscopy space.
Q. And you considered that to be in both counties?
A. Yes.
Q. What about with--what about just the endoscopy room where the procedures would be performed?
A. That I can't totally tell with 100 percent certainty from the line drawn, because it's not labeled.
Q. Did you ask anybody from Mission questions about the location during the review?
A. No.
Q. Could you have?
A. I'm not sure. I would have had--I'd have to ask Ms. Frisone.
Q. Did you ask--
A. I would have had to ask her. I did not ask her.

Q. If you would, turn to Page 587. Tell me what you--what we see on Page 587 of the Agency file.
A. This is GI utilization data for Buncombe and Henderson Counties. It's SMFP. It's State Medical Facilities Plan data.
Q. All right. Did you compile the data that we see on Page 587?
A. I received this from Ms. Frisone.
Q. Do you know if she compiled it herself or requested it from health planning?
A. I don't recall. I don't know.
Q. And, at the bottom, there's a footnote that said it was from the 2011 and 2012 proposed State Medical Facilities Plan?
A. Yes.
Q. Did you look back at the Plan yourself to verify any of the numbers?
A. Yes, through the review process, I looked at the Plan and the data tables that were in the application as well to make sure that they were all saying the same thing.
Q. Did you determine that they were all saying the same thing?
A. Yes.

Q. So, in other words, you did not find any discrepancies between the application and the SMFPs?
A. Not that I recall that ring a bell for me, no.
Q. And I would need to ask Ms. Frisone where she--how she obtained the--Page 587?
A. Yes.
Q. Is it correct that Pages 588 through 591 are actual tables--or 593, excuse me, are actual tables from the State Medical Facilities Plans that you reviewed?
A. Yes.
Q. Did you look at any other counties besides Buncombe or Henderson just as a comparison point?
A. No.
Q. Before the Mission GI South application, had you done any CON reviews for any type of service in Buncombe County?
A. No, I don't believe so.
Q. And what about Henderson County?
A. No.
Q. Have you done any since for either county?
A. No, I don't believe so.
Q. Who's normally assigned to that? Is that Mr.

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Brown?
A. Mr. Brown. I'm not sure if there's another analyst assigned to any other nearby counties, but Mr. Brown.
Q. If I'm not mistaken, the remainder of your working papers just is a copy of the 2011 renewal application for Mission?
A. Yes.
Q. Did you look at any other years besides 2011 licensure renewal applications?
A. No.
Q. Did you look at any other providers, such as Pardee or Parkridge license renewal applications?
A. Only in the context of what was provided in the SMFP, which is from the license renewal data.
Q. But you didn't go back to any of those actual license renewal applications?
A. No.
Q. We talked a minute ago about the fact that Pardee sent a letter of support. It's-- I believe it appears in the Agency file on Page 16, but I'd like for you to look at it and confirm. And I--it was actually Page 16.
A. 15.

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Q. 15. Okay. And you received it by fax on April 29, 2011; is that right?
A. Yes, that's what it says.
Q. Okay. Is that your handwriting?
A. No.
Q. Were there any--
A. I'm not sure who. It could have been the secretary. I'm not sure who put that there.
Q. Okay. Were there any letters or comments that were not timely received? Would they be in the Agency file that's stamped not considered?
A. Yes, everything would be in the Agency file.
Q. You don't recall receiving any that were not timely?
A. I don't recall, but if they are, they would be in here somewhere.
Q. Did you have any discussions with anyone from Pardee about the Mission application?
A. No, not that I recall.
Q. Okay. Other than at the public hearing, did you have any discussions with anyone representing Parkridge during the application review?
A. No.
Q. What about the Carolina Mountain Gastroenterology?

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A. No.
Q. At what point during the review did you determine that you would not approve the Mission GI South application?
A. I'm not sure, probably as I was--as I was writing it.
Q. When would that--was that in terms of time? I believe the review started in April, and the decision was made August 28.
A. Oh, I'm not sure, because I had it for a few--I had it for several months. I'm not sure when I started writing.
Q. When you wrote the letter that we looked at earlier on Page 16, and then the letter on Page 17 extending the review, had you made a determination whether to approve or deny the application?
A. No.
Q. And just while we're here, look at Page 19 of the Agency file. Did you prepare this letter notifying Mr. Moore at Mission that the application had been disapproved?
A. Yes.
Q. And the following letter starting on Page 22, is that the cover letter for your findings?

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A. Yes.
Q. And they were sent on the fifth day after the application--after the decision letter; is that right?
A. Yes, they were sent on September 2nd.
Q. Had you prepared the findings as of August 26, 2011?
A. I was still working on them.
Q. Had you shared them with Ms. Frisone in draft form prior to August 28th?
A. Yes.
Q. Do you recall what--not specific changes, but what areas Ms. Frisone focused on or just changed in general terms?
A. I don't recall as general--as general editing takes place. My decision wasn't changed, so there was nothing major like that, but I don't recall any specifics.
Q. Okay. So your initial draft findings included a determination that the application was not conforming with some of the criteria?
A. Yes.
Q. I'm going to go through each of the findings with you. Do you remember anything else about Ms.

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Frisone's review of your draft findings?
A. No, it was like another--another review I had done.
Q. Did you receive a directive at any point to disapprove the application from Ms. Frisone or Mr. Smith?
A. No.
Q. Before we talk about the specifics of your decision, will you look with me in the Agency file behind Tab 3? That's the section with the comments. You told me--or actually Section II is the comments. I'm sorry. Page 35.
A. Okay.
Q. There were extensive written comments submitted on behalf of Carolina Mountain Endoscopy and then on behalf of Parkridge, and you told me that you reviewed those comments during the review?
A. Yes.
Q. Included with both sets of comments is a copy of a report relating to the certificate of public advantage that Mission holds; do you recall that?
A. Yes.
Q. Did you review the report related to this particular public advantage?
A. Not in great detail.

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Q. Did you take that into consideration during your review?
A. No.
Q. Okay. Did you consider it relevant in any way to your review?
A. No.
Q. Is it fair to say you understood that both Carolina Mountain and Parkridge are competitors of Mission?
A. Yes.
Q. With regard to GI services, at least?
A. Yes.
Q. And you also said that you carefully reviewed the response to comments that was prepared and submitted by Mission at the public hearing?
A. Yes.
Q. And is it the document that begins on Page 524 of the Agency file?
A. Yes.
Q. As you're sitting here today, were there particular issues in the written comments by Parkridge and Carolina Mountain that you did not feel were addressed by Mission to your satisfaction, or that caused you to look at things more closely in the application?

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A. There was nothing in the comments--in the comments from the competitors that caused me to look at anything that I hadn't already thought was a potential sticking point.
Q. Okay. Was it a concern to you that the GI South application represented the first in a series of projects between--with Pardee and Mission on this joint health campus in Fletcher?
A. I had heard from the public hearing there was some kind of relationship or something with Mission and Pardee, but I didn't and still don't know the details of what that relationship is.
Q. Did you do anything as part of the review to get more information about what might be the relationship?
A. No.
Q. Did you consider that relevant at all to your review?
A. No.
Q. Let's go ahead and look at the Agency findings that you prepared. They're, as you know, behind Tab 5 of the Agency file.
A. Okay.
Q. On the first page of the findings, which is Page

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640 in this--the volume of the Agency file, you determined that the application did not propose any new endoscopy rooms, so it was--so Criterion 1 was nonapplicable; is that right?
A. Yes.
Q. And then the bulk of the findings, I believe, are contained under Criterion 3; is that right?
A. Yes, that's a large portion.
Q. Is that typically how you prepare your findings with the bulk of the discussion under Criterion 3?
A. It depends on the--it depends on the application, but many times Criterion 3 is the longest section.
Q. Okay. And as I looked at it, there are two sections within Section III. One, you addressed first the population to be served on Page 641; is that right?
A. Yes.
Q. And you determined that the applicant did not adequately identify the population to be served?
A. Yes, I state that on Page 644.
Q. I've read your findings, obviously, but tell me the main concern that you had with regard to why the applicant didn't identify the population to be served adequately in your view.

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A. Well, on 641, they--I quote that the applicant is talking about Mission Hospital's 13 county service area and included a table that was in the application on 642 outlining Mission Hospital's inpatient and outpatient GI endoscopy patient origin for the current year and also for Year 2 of the project. And then further down on 650--on 642, I quote the applicant as talking about the service area for Mission GI South, where the applicant stated 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, and on Page 643, I reproduced a chart that showed what the applicant's proposed service area was for Mission GI South. There are the zip codes that they included in that service area along with the corresponding counties.

Q. Okay. And it may help to--probably need to refer from time to time to the actual application.

A. Okay.

Q. And now would be a good time to look at Page 37.

A. Of the application?

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Q. Yes.

A. Yes.

Q. All right. And Page 37 is where Mission identified the nine--the nine zip code service area for Mission GI South; is that right?

A. Yes, that's where I got the table on the top of 643 from.

Q. You just abbreviated it?

A. Right.

Q. Okay.

A. And then the applicant provided their projected patient origin for Mission GI South for the three project years.

Q. Before you go on, if I could interrupt. I'm sorry. The zip codes that were defined in Buncombe and Henderson County didn't constitute all of those counties; is that right?

A. That's correct. These are zip codes within the counties, but they're not all the zip codes in the counties.

Q. All right.

A. So the Mission GI South projected patient origin chart, which was from Page 58 of the application, and it was also in Exhibit 16, Table 5, and in this

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chart, it states number of procedures and corresponding percentages of patients from Buncombe and Henderson County, and then provides projected inmigration of 10 percent to arrive at a total for each of those project years; but, below the table, I state 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 percent 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 proforma section of the application and also in Exhibit 16, Table 5, the applicant projects that inmigration at Mission GI South will be 15 percent. In the next paragraph, I go on to say that in Section III.1(a), Page 56, the applicant projects that 70 percent of Mission Hospital's existing GI endoscopy volume originating from Buncombe and Henderson Counties will shift to Mission GI South. In other words, 85 to 90 percent 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

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Mission Hospital who reside in Buncombe and Henderson Counties, but who are currently traveling to Mission Hospital in Asheville for GI endoscopy services. And on the top of Page 5 is where I state however, the applicant does not adequately identify where the patients included in either the 10 percent or 15 percent inmigration will come from, therefore, the applicant did not adequately identify the population to be served.

Q. With regard to the 10 percent versus 15 percent, you were aware from reading the response to comments that the 15 percent reference was left in some of the tables in error; is that right?

A. Yes.

Q. So did you understand during the review that Mission projected that 10 percent of its patients and procedures would come from other areas outside the defined zip code areas in Buncombe and Hendersonville--Henderson, excuse me?

A. Yes, that was throughout the methodology, but the proformas indicated 15 percent, so there was that discrepancy between the two.

Q. Right. But once you read the response to comments, did you still consider that to be a discrepancy?

A. It wasn't until I looked at the proformas. I understood it to be a discrepancy in Exhibit 16, I believe it is, Table 5, and I understood that error, and that wasn't an issue for me until 15 percent appeared in the proformas. Then it became an issue.
Q. And looking still at Page 643 and 44 of the findings in the Agency file, did you question or determine that the 70 percent of the existing GI volume shifting to Mission GI South was unreasonable?
A. No.
Q. And are you saying that Mission should have identified more specifically where patients who were projected to inmigrate would be coming from?
A. Yes, with regard to the 10 percent, I would have liked to have seen more specific information.
Q. Like what?
A. What zip codes those 10 percent were coming from.
Q. Is there any rule that requires more detail than was given?
A. No, there's no rule.
Q. If you were preparing this application, how would you know where folks would come from in terms of

other places?
MR. JOHNSON: Object to form.
A. Well, I didn't prepare the application.
Q. Right. I know.
A. So I wouldn't--I--I wouldn't--I don't know.
Q. I guess I'm asking if they had said we had--we're going to have six people from one particular zip code and 14 people from another, would you have considered that to be creditable?
A. I don't know. It would be more detail, but I don't know. I'd have to see what information was provided to make a decision.
Q. And you said that you looked back at the license renewal application; is that right?
A. Yes.
Q. And if I could direct you to the portion that contains the GI endoscopy patient origin. I think it's on Page 632 of the Agency file.
A. Okay.
Q. Do you have that?
A. Yes.
Q. All right. Am I correct that this is patient origin for all of Mission GI cases in the 2011 license renewal application?

A. Yes.
Q. And there's a range of counties from which patients were served, correct?
A. Yes.
Q. Some are close geographically to Buncombe County and some are not.
A. Yes.
Q. There--there were patients that particular year from both Georgia and South Carolina?
A. Yes.
Q. Okay. As well as Tennessee?
A. Yes.
Q. When you talked--I think you said you talked with Mr. Smith and Ms. Frisone about this particular page; is that right?
A. Yes.
Q. Do you remember anything else about your discussion?
A. Really, the results of our discussion is--is in the findings. Let me find it. It's in one of these on Page 667, and I think the discussion may start on 666, and the applicant references a table in Exhibit 16, Table 12, that lists counties in the secondary and tertiary areas, if I can recall off

the top of my head. We can certainly look at it, and they represented that that was--reflected inmigrations from the counties of Buncombe and Henderson to be over 34 percent. And some of those counties were represented to produce 10 percent of patients, or--or patients were coming from those counties in that 34 percent, and, as a result of our discussion, we determined that it wasn't reasonable for patients to be expected to come from all of those counties that were represented in that table. And from discussions with Ms. Frisone and Mr. Smith, the five counties in the table on 667 were the counties that were determined that the patients would likely come from.
Q. So, if I'm understanding you, you just didn't believe that people would come from some of the counties in the service area to this Mission GI South location?
A. We didn't believe that it was reasonable for patients to come from some of those counties that were listed in the Exhibit 16.
Q. And that's even--even looking at the patient origin information in the license renewal application?
A. Yes, I mean, there's always--you can always count

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some level--count on some level of inmigration, but in terms of estimating your inmigration based on your historical information, this is what was determined. In addition to the fact that these numbers that were in Exhibit 16 and also here in the table on 667 are inpatient and outpatient GI endoscopy patients, and they will only be performing outpatient endoscopy procedures at Mission GI South.

Q. Okay. And, likewise, the license renewal data is for inpatient and outpatient?

A. Yes.

Q. Do you know how patients determine where they will go for an endoscopy procedure?

A. It could be a number of reasons. It could be referral. It could be patient choice.

Q. Do the patients typically choose their--their GI physician first?

A. Well, I've never had an endoscopy, so I'm not sure. I'm sure there's a variety of different ways someone ends up in an endoscopy suite.

Q. Okay. Do you think somebody could just decide they needed an endoscopy and show up in an endoscopy suite?

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A. Technically, you maybe could, but I think usually they may have come through another physician. You don't use your endoscopy physician as your primary care physician.

Q. Right. So would you agree then that the choice of 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 assume 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.

Q. Beyond reading what was in the Mission GI South application about endoscopy procedures and the

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details of the procedures and conditions for which you might need an endoscopy procedure, did you do any research on endoscopy?

A. No, the information provided in the application regarding endoscopy was quite thorough, and I was generally familiar with endoscopy from the previous reviews I've done.

Q. In the previous reviews that you've done, were the providers in Forsyth County experiencing growth in terms of total numbers of procedures, or were they relatively flat?

A. That I don't recall.

Q. Going back to Page--to your--to your findings--to the--specifically with regard to the identification of--of patient population, if you had been given specific zip codes, for example, for the inmigration, you would have been more comfortable with the definition of the population to be served?

A. It would have been helpful. I don't know what my determination would have been, because I haven't seen it. I didn't have anything to look at, but--

Q. Okay. And looking at Page 643 of your findings, where you've got a line for--in the chart for inmigration.

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A. Yes.

Q. What number of procedures is projected in Project Year 3 to be coming from outside the main service area?

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 be patients from zip codes in Buncombe and Henderson County as well as outside Buncombe and Henderson County?

A. Well, the applicant said that--I quoted them there saying that 10 percent of the GI endoscopy procedures at Mission South will come from other Buncombe County and Henderson zip codes and other counties.

Q. Were you expecting a specific number from either zip code areas outside the primary service area in

terms of additional detail?
A. A specific number?
Q. Yeah.
A. No.
Q. So you didn't expect Mission to be able to say of that 10 percent inmigration, we expect a certain number of people to come from Polk County, for example?
A. Well, I would just liked to have seen more detailed information about--particularly with regard to the other counties that are referenced here.
Q. Not Buncombe or Henderson?
A. No, because they've said Buncombe and Henderson, other Buncombe and Henderson zip codes. It was the other counties that I would have liked to have more information on.
Q. I think this might be a good time to take a quick break.
(RECESS TAKEN FROM 11:20 A.M. UNTIL 11:34 A.M.)
Q. (By Ms. Harris) Ms. Miles, we talked a good bit already about inmigration. How do you define inmigration?
A. Let's see. How would I define inmigration? I would define inmigration as being, you know, any

patients coming from outside of your defined service area.
Q. And looking back at the GI endoscopy patient origin that we saw in the license renewal application on Page 632, and patients coming from any of the counties listed other than Buncombe are considered to be inmigrating to Mission; is that right?
A. I'm sorry. Could you repeat that?
Q. Sure. Do you have that gastrointestinal endoscopy case patient origin page?
A. Yes.
Q. All right. Under your definition, all the patients on this page outside Buncombe County are considered to have inmigrated to Buncombe County for GI services?
A. Well, for the review it's not necessarily how I defined inmigration, per say; the applicant has already kind of defined inmigration. In the population to be served section of the application, it lists where the patients are coming from, and I believe it said that Mission GI had 5.5 percent inmigration, which would be outside of those counties that are listed on that chart. I don't know what those counties are. I think they're

listed as "other," so I can't say specifically where--where they define that "other." But once--once this applicant defined their primary and secondary and tertiary service area, then anything else as inmigration would be in addition to that.
Q. All right. And--and just looking at history for Mission on Page 632 of the Agency file, it reflects 3,730 patients sought endoscopy procedures at Mission from Buncombe County?
A. Right.
Q. And if Buncombe County is the service area for Mission, then the rest of the patients reflected on this page are--are--inmigrated for their endoscopy here?
A. Well, not as defined as by the applicant. If I go to Exhibit 16 in the application, they tell me exactly what their primary, secondary, and tertiary service areas are.
Q. I think I'm--I need to ask a better question.
A. Okay.
Q. On Page 632, it just refers to Mission's current services?
A. Yes.
Q. So all the patients who came from outside Buncombe

County inmigrated for GI care historically to Mission; is that right?
A. Well, this table is just giving me every--every county.
Q. Right.
A. The applicant hasn't said what--from looking at this, I can't tell what the primary service area is, as defined by the applicant.
Q. Okay. But can you forget about the application for the moment?
A. Okay.
Q. And just look at Page 632, and I'm talking about inmigration generally. But would you agree that the patients from outside Buncombe County, from all these different places, inmigrated to Mission for their GI care?
A. Guess I wouldn't define it as inmigration per say, but yes. If Mission Hospital is in Buncombe County and all these patients are coming from counties outside of Buncombe County, then they have come into Buncombe County for services. Yes.
Q. Why wouldn't you call that inmigration?
A. Well, it's how the--the applicant has defined inmigration in their application as being something

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outside of their service area. Buncombe is part of their primary service area, but then they've identified a secondary and tertiary service area, and then an "other" service area.

Q. And when I interrupted you, you were taking me to table 16--or Exhibit 16.

A. I'm looking at Page 366. So they have identified Buncombe as being their primary service area, Henderson--well, actually, they've got Henderson and Buncombe as their primary service area, and then their secondary and their tertiary service area. And in the application, they have added up, I believe, the tertiary service area to describe their immigration as 34 percent. And then from that, they say they conservatively project that 10 percent of that will--will come to Mission GI South. And I--but they didn't say what counties that 10 percent would come from. But it's clear that it wouldn't be 34 percent, so of that 10 percent, I would like to know what counties they would come from so then we can determine whether or not we thought that those counties, geographically speaking, would be reasonable.

Q. But I--I think we're in agreement that they

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couldn't have used the 34 percent, which they had for the whole hospital, is that right, their whole service?

A. Right.

Q. And 10 percent is more conservative than 34 percent?

A. It is.

Q. And you referenced the 5.5 percent. Is that the number in the "All Other" column at the bottom of the chart on Page 366?

A. Yes. That's 5 percent here. I was picturing it--it's in a different chart somewhere else, but--

Q. Okay.

A. --I recall it being 5.5 percent.

Q. And so what does this 5.5 percent represent in your understanding?

A. That 5.5 percent is patients coming from outside of their service area.

Q. Outside, but both the primary, secondary, and tertiary?

A. Yes.

Q. Okay. What's the number of cases that--that represented that 5.5 percent? Just look at Year Three, as an example.

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A. Okay. On the Year 2015 on this chart, it's 472--472 cases.

Q. 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?

A. Generally.

Q. And then you would expect the procedures number to be higher than the patient number, at least in this review?

A. In this review, they provided historical data that showed that, yes, procedures were slightly higher than the number of cases.

Q. Have you--in other GI endoscopy reviews you've done, has there been a one-to-one relationship between patients and procedures?

A. I don't recall. I don't--I wouldn't--I wouldn't guess, off the top of my head, but I don't recall specifically.

Q. If you would, Ms. Miles, turn back to your findings, and specifically Criterion 3, Page 644. I'm going to ask you a series of questions about the need demonstration section of the findings. The--the discussion in the findings starts out with

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a series of quotations from the application regarding GI disorders, various clinical studies; do you see that?

A. Yes.

Q. Did you have any dispute with or disagreement with the discussion in Mission's application regarding the prevalence of GI disorders and the importance of cancer early detection through colon screening?

A. No.

Q. Did you dispute the validity of any of the studies mentioned?

A. No.

Q. The--there's a section of your findings discussing population growth as well as procedure volume growth that begins on Page 648.

A. Yes.

Q. As--as I read the discussion and the quotes from the application, is it correct to say that you accepted the representations made by Mission as valid with regard to population and procedure growth?

A. Yes.

Q. You have a footnote on Page 68 under the chart, reflects that you made some calculations and--and

got slightly different numbers?
A. On 648?
Q. Yes.
A. Yes.
Q. And your calculations were based on the 2009 through 2011 SMFPs?
A. Yes.
Q. The--the difference is--the differences in the numbers was not a significant difference, correct?
A. No.
Q. And the--
A. I simply noted it here--
Q. Okay.
A. --that it was different.
Q. And the chart at the top of Page 648 reflects that there are actually 15 endoscopy rooms needed in Buncombe County, based on the 1,500 procedure per year standard; is that right?
A. Yes.
Q. And the actual inventory for Buncombe County is 11 rooms?
A. Yes.
Q. So do you agree that the procedure volumes show a need for more licensed GI endoscopy rooms in

Buncombe County than exist?
A. The--based on this chart and the number of procedures and the 1,500 procedures per year standard that appears in the rules, there is sufficient volume for more rooms.
Q. And the--if you look at Page 649, the similar analysis appeared in Mission's application showing Buncombe and Henderson Counties combined?
A. Yes.
Q. And you would agree, based on the data, that there's a need--there's potentially a need for additional GI endoscopy rooms?
A. Yes.
Q. And the--the research that you did related to population growth was consistent with the information in Mission's application; is that correct?
A. I don't recall any specific research on population growth.
Q. You had some materials in the working papers where you just were checking on different things in the County. Did I misunderstand?
A. I--I--that was strictly for Criterion 13. I didn't look at it in relation to Criterion 3 at all.

Q. On Page 652, you note at the bottom that the applicant projected to perform less than 1,500 procedures per room in Year 2, but that's not an issue because the performance standards do not apply; is that right?
A. Right.
Q. And that's because Mission did not propose a new room?
A. They didn't propose a new ambulatory surgical facility that would be operated independently of the hospital, yes.
Q. And they also didn't propose a new GI endoscopy room?
A. That's correct.
Q. Beginning on Page 653 of your findings, there's a series of steps. It's the steps of the methodology used in the application. Do you see Step 1 on Page 653?
A. Yes.
Q. I'm going to ask you a few questions about each step to make sure I understand your findings. Step 1 is the step in which Mission determined the base volumes from which to make its projections, and you discussed its used of Trend Star data and

determined that that was reasonable; is that correct?
A. Yes.
Q. Step 2 has the growth rate for projecting future utilization. And as I read your findings, there were no negative findings regarding the growth rate assumptions that Mission made in the application?
A. That's correct.
Q. And likewise, you accepted the procedure per case assumptions?
A. Yes.
Q. On 654, why did you calculate the compound annual growth rate for that table?
A. Well, it wasn't included in the--in the information provided by the applicant, and I just thought it'd be interesting to see what those numbers look like.
Q. Did you make any conclusions based on your calculation?
A. No.
Q. And based on your calculations, there's a 2.3 percent compound annual growth rate for inpatient procedures, correct?
A. Yes.
Q. And then a -1.9 percent procedure growth rate for

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outpatient, and then the total was -0.2 percent?
A. Yes.
Q. And--and that -0.2 percent is, in fact, what Mission used as its--used to project its future volume; is that right?
A. Yes.
Q. On Page 655, there's a chart from the application, Exhibit 16, related to population growth rate. Would you agree that this 1.2 percent weighted population growth rate was a conservative way to project population growth?
MR. JOHNSON: Object to form.
A. I can't say whether or not it was conservative. This was the way the applicant chose to look at that information and I thought it was reasonable.
Q. The application reflects a higher weighted population growth rate for the over 55; is that right?
A. Yes. 2.1 versus 1.2.
Q. Did that assist you in determining that the 1.2 percent was reasonable?
A. No. They--they had the same methodology and way of looking at the population for--the total population and the population of 55 and over. I found it to

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be reasonable in both cases.
Q. Step 3 is on Page 657. And, in fact, they did use the compound annual growth rate that matched yours to project procedures correct?
A. Yes.
Q. All right. And you accepted that growth rate as reasonable?
A. Yes.
Q. In Step 4, the applicant applied the procedures and population growth numbers and growth rate to obtain a projected number of procedures and cases for the project years for the whole GI endoscopy service; is that right?
A. Yes.
Q. And you did not make any negative findings with regard to Step 4 of their methodology?
A. No.
Q. Step 5 involves a determination of use rates for Buncombe and Henderson Counties; do you see that?
A. Yes.
Q. On Page 658?
A. Yes.
Q. And you did not make any negative findings regarding the use rate calculations?

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A. No.
Q. Did you determine that the use rate used in the projections was reasonable?
A. Yes.
Q. Step 6 begins on Page 658, but most of the discussion is on the following page. You did not make any negative findings regarding the base population for the Mission GI South service area?
A. No.
Q. And you determined that the Mission GI South service--base service area was reasonable?
A. Yes.
Q. Step 7 begins on 659, and involves a projection of outpatient cases for Mission GI South. If you'll look, I think, mainly at Page 660, you determined ultimately that the projected total was reasonable; is that right?
A. Are you talking about the chart on the top of Page 660?
Q. I'm talking about that whole section, but if you need to refer to that to answer my question, that's fine.
A. Okay. Yes. I did.
Q. You have a "however" in your discussion Page 660

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What was your concern there?
A. 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.
Q. 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.
Q. And I think, if I'm understanding your findings correctly, on Page 662, you concluded that the use of Buncombe County outpatient GI endoscopy cases as 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 of the outpatient procedures in the GI South service area; is that right?
A. Yes.

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Q. Okay. And you did not have any negative findings regarding the number of outpatient procedures in the service area?
A. No.
Q. So you determined that the--the total projected outpatient procedure numbers were reasonable?
A. Yes. Their methodology for calculating that was reasonable.
Q. Moving on to Step 9, which is a market share calculation, the application demonstrated how and why it projected a certain market share; is that right?
A. Yes.
Q. And you determined that the market share calculations were reasonable?
A. Yes.
Q. And then Step 10 is the projection of outpatient procedures for Mission GI South, the last step of the methodology. The discussion in your findings begins on Page 664. I think this is where your discussion of inmigration comes up again; is that correct?
A. Yes.
Q. And did you determine that the total number of

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procedures projected for Mission GI South was reasonable?
A. I don't understand your question.
Q. Did you say you didn't--you weren't understanding my question?
A. Right.
Q. Okay.
A. If you could just rephrase it?
Q. Let me try it again. I think we've established that Steps 1 through 9 of the methodology you did not have a concern about; is that right?
A. Yes.
Q. What was your concern with regard to Step 10?
A. My concern with regard to Step 10 primarily had to do with the inmigration, and the use--that the applicant used Mission's 34 percent inmigration as a proxy for Mission South's inmigration, and then conservatively, as they've stated, projected that 10 percent of that would go to--would--10 percent would be reflected in Mission South's inmigration, but they didn't provide me any information as to what made up that 10 percent. and that's a detailed discussion here on Page 667, beginning on 666, of that.

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Q. And this is where--I think we touched on this earlier--you determined that it was not reasonable to expect patients from, for example, Madison, Yancey, and Mitchell to travel to Mission GI South; is that right?
A. Right. It was not reasonable to expect patients from all of these counties, on Page 336 of the application that the applicant provided, that all--that patients from all of those counties would travel to Mission GI South.
Q. Is it fair to say that the only issue you had with Mission's need methodology is the inmigration?
A. Let me just look here. (Witness reviews document.) It was the inmigration issue, and then around Page 670, I also discuss the volumes of other providers in the area.
Q. That's--that's a separate question from the methodology, though, correct?
A. From--out of the 10 steps of their methodology, correct. The inmigration was the major issue.
Q. Okay. And in your detailed discussion on 666 and 667, you include a chart on Page 667?
A. Yes.
Q. And that's a chart you created?

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A. Yes.
Q. And your source is the license renewal application?
A. Yes.
Q. Did--based on the chart and the discussion below, is it correct that you determined that it was reasonable to expect 508 endoscopy patients would come to Mission GI South out of the total 6,563?
A. Yes.
Q. And that 508 represents the five counties just above the subtotal of 508?
A. Yes.
Q. And so did you determine that 7.7 percent inmigration would have been reasonable?
A. Yes.
Q. And--
A. Well, I should say, 7.7 percent based on the information in this chart, but again, this is both inpatient and outpatient. I didn't take a step further to try to adjust and give you just an outpatient number. But it--in terms of patients going to Mission South, it would be reasonable to expect it to be lower than 7.7 percent once you removed inpatients from those--from those numbers.
Q. What was--what is the fact that you would use to

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remove inpatient based on the discussion in the application?

A. I--I would not have to think about it, but one way to perhaps do it would be to look at Mission's current inpatient/outpatient split as a proxy.

Q. Okay. If you did that, what--let me see if I can get you to the right page. There's a couple different places that you might want to look, and I think it's discussed in your findings. But if you look at Page 58 of the application--and 672 of your findings, actually, there's a table there that will help us--or not a table, but a discussion--at the bottom of the first full paragraph, you discuss that Mission's inpatient/outpatient split is 38.9 percent inpatient and 61.1 percent outpatient?

A. Yes.

Q. So would it be appropriate to apply that 61.1 percent to your 508 to get a total number of patients?

A. You could look at it that way.

Q. What--I have a calculator. What number do you come up with?

A. Well, half of 500 is 250. Around 300, just kind of off the top of my head.

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Q. Okay. Around 300 patients?

A. Uh-huh.

Q. Okay. So it would be reasonable to expect that approximately 300 patients would come from the counties that they had listed?

A. Outpatient. Uh-huh.

Q. All right.

A. That's a way of looking at it. Yes.

Q. So a--a total number of approximately 300 patients inmigrating from these five counties you listed would be--would have been a reasonable inmigration projection, in your view?

A. It'd be a way of looking at it. And I--you know, I may have considered it to be reasonable. It's the way that I would think about it. Applicants do different things, but that's the way I would think about it off the top of my head.

Q. If you have approximately 300 patients, how many procedures does that equate to using the 1.3 multiplier that was used in the application to convert cases to procedures? I'd be happy to share my calculator again. I get 390, just in round numbers.

A. Okay. 390 procedures.

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Q. Okay. And then look with me, if you will, on Page 668 of the findings. How many procedures did Mission project to perform for patients who inmigrated from outside the Buncombe and Henderson County zip code areas?

A. Well, they didn't give me for patients who inmigrated. The patients who inmigrated were 149.

Q. Isn't the 149 the inmigration?

A. Yes. That s the--I'm sorry. I may have misunderstood your question. 149 procedures. Yes.

Q. Right. Okay. So--

A. Inmigration.

Q. In Year Three, Mission projected that 149 procedures would be patients who inmigrated?

A. In Year Three, they projected 149 procedures.

Q. Okay. And 149 procedures is less than 390 that we just calculated?

A. It is.

Q. Based on this analysis, would you agree that the inmigration percentage used by Mission was reasonable?

MR. JOHNSON: Object to form.

A. No.

Q. Why not?

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A. Well, given the information that I have in the application--not what I've calculated here, in terms of not being able to look at it in relation to everything else--based on what they have given me, their calculation--the actual fundamentals of the calculation is fine. I just questioned the 10 percent as being unreasonable.

Q. We just calculated that--that your number of what was reasonable was higher than the 10 percent, so why is the number projected in the application not reasonable?

A. Well, actually, I'd have to sit and think as to why, you know, a number less than--why--why a number less than 10 percent would be higher than 10 percent. I'm not sure. I'd have to take a minute to look and figure out what's going on.

Q. Okay.

A. But if--if they were--based on this chart here, if their 10 percent is 149, if they were, say, projecting 5 percent, if you've got this chart and you substitute the 5 for the 10, it would be lower than 149.

Q. Can you say that again?

A. If they--if--if based on this chart--and--and what

I recall from the application is it gave me the first row, which is the outpatient procedures, and then you--there are a couple ways of look at it. One would be to get a total number and then back out what 10 percent of that would be. But my thought is--and we're talking right now--if this had been 5 percent of, say, 1,487, instead of 10 percent of 1,487, it would have been more like 70-some patients.

Q. Look at Page 58 of the application, if you will.

A. Which is--

Q. This volume right here. Is it correct that the table that you--that you have in the findings on Page 668 is--

A. Yes.

Q. --is identical or close to the chart on Page 58?

A. That's correct.

Q. And so the procedure numbers for inmigration are listed out separately in the application?

A. Yes. They're listed out separately. When I look at this chart--I don't know where that 10 percent comes from--so for when--when I look at it, I have to assume that the applicant got a total of, in Year Three, 1,487 and then took 10 percent of that

to get 149. Because I don't have a subtotal for inmigration, you know, where--what counties are included in that and how many procedures from each county to know where you got that 149 from, I have to assume that you--you reached a total and then back out at 10 percent inmigration to some degree. I mean, that's--that's--in looking at it and not having any information about what those counties are.

Q. Why does it matter if they did it that way, just for the sake of argument? Why--why would that matter?

A. Well, it didn't matter, per say, because I could look at it and figure out--10 percent is easy to look at and see where--where a number is in relation to. But you do it just to validate the applicant's assumptions. It--it's supportive. It helps.

Q. And--and then looking back at the charts on Page 667 and 668, the analysis that you did on 667--

A. Well, 667--

Q. --does--

A. I'm sorry. Go ahead.

Q. --it does validate the methodology that Mission

used; does it not?

A. Well, yes. But 667 is Mission Hospital total, and 668 is just Mission GI South. So I can't compare the 149 in Project Year on this table on Page 668 to that 390, because that's all Mission Hospital and this is just Mission GI South.

Q. Right.

A. And the reason why this is Mission Hospital as--as opposed to, say, Mission GI South, one, because I didn't have that information for Mission GI South, but because the applicant, in the application, states that, from that table on--from that Table 516, that they had 34 percent inmigration and that 10 percent--they--they were going to use 10 percent as a conservative basis for that.

Q. All right. Look with me back at Page 667.

A. Yes.

Q. What is 10 percent of the total endoscopy patients for Mission? What would that be?

A. 10 percent of the total patients would be about 656.

Q. What percent of the total patients is 149? In other words, if you divide 149 by 6563, what do you get?

A. Or--is that also--is--I'm not sure what year this chart here--667--if it's Project Year Three, 2015--

Q. It's actually based on historical data.

A. Okay. So it's like the current--current year.

Q. Look in the application.

A. Oh--oh, this is from the LRA, so--

Q. Yeah.

A. Okay. So the different years.

Q. But for the purpose of this question, I do want you to tell me what percentage of the total GI patients--6,563--149 would represent, even though I understand that they're different years.

A. I'm sorry. What percentage?

Q. I'm going to get you to do several calculations because what we're doing right now is comparing patients and procedures. But I still want you to do the calculation I asked, and then we'll--we'll be more specific. What percentage of patients on Page 667 does--if you use 149, what does that represent?

A. This is 149 procedures.

Q. Yeah. And actually, you--

A. This is patients.

Q. --you want to reduce the procedures to patients,

and that would make a better comparison?
A. Let's see. I think that that would be--if you've got 149 procedures--if I divided that by 1.3, I get 115.
Q. 115 patients?
A. 115 patients.
Q. Okay. And how does 115 patients compare to the 6,563 patients on 667?
A. Well, it's certainly a small amount. (Witness calculates.) That's about 1.8 percent.
Q. And let's do a similar calculation, but actually use the project Year Three procedures that are projected in the application.
A. 1,487? The outpatient procedures at Mission GI South?
Q. Actually, no. I want to use the total number for all of the Mission outpatient procedures. If you'll look with me at the application Exhibit 16, the one with all the tables, that's probably the best place to do it. And Table 3; do you see that?
A. Table 3 on Page 361?
Q. Uh-huh.
A. Uh-huh.
Q. For Calendar Year 2014, there's a total number of

GI endoscopy procedures for the combined Mission and South campuses; do you see that?
A. Yes.
Q. The last column, 8,579 procedures projected, and that would be with all six rooms. And then it reduces to 6,451 cases?
A. Yes.
Q. So I'd like for you to tell me what percentage of the total procedures 149 procedures represents for Project Year Three.
A. For procedures, you're talking about--
Q. Right.
A. --the 8,000 number?
Q. Yes. I'm not going to make you do the 1.3 calculation.
A. The--so you want the total procedures at Mission GI South from 668?
Q. I'd like for you to compare the--the inmigration number, the 149 procedures in Project Year Three, to the total GI endoscopy procedures for the entire system, which is 8,579.
A. Oh. I see. (Witness calculates.) That's 1.7.
Q. So looking at the--all of Mission GI services combined, the inmigration percentage projected for

Mission GI South is less than 2 percent?
A. When you're comparing those--this is--this, again, is just outpatient. This has got inpatient in it as well, because this is all of Mission's numbers.
Q. Right.
A. So--but yes, that--that calculation is correct, they're just not--
Q. Right.
A. --totally apples-to-apples, I don't think.
Q. I see what you're saying. Going back to the first calculation we did, as I'm not understanding some of your testimony. On 667 of the findings, another way to look at it, as we said, is to take the number of patients that you projected would be reasonable to expect to go to GI South from those other counties of 508; do you see that?
A. Yes.
Q. All right. And then you need to make a reduction for the outpatient percentage, correct?
A. Yes.
Q. And we looked at that earlier and it was around 60 percent?
A. Yes.
Q. So we can take 60 percent of 508 and what does that

give us?
A. (Witness calculates.) 305.
Q. Okay. And you would agree that--305 patients represents how many procedures?
A. (Witness calculates.) About 397.
Q. So that represents 397 procedures. So you have just calculated, based on the chart on Page 667, that 397 procedures would be a reasonable number to project to come from those five counties to Mission GI South; is that right?
A. Outpatient procedures, yes. That's--and that takes you down from 7.7 percent to about 4.6 percent.
Q. Of the total overall?
A. Of the total--that's 4.6 percent if you're looking at outpatient only.
Q. Okay. And the number, 397 procedures, is greater than 149 procedures projected in the application to come from those other counties?
A. 397 is greater. Yes.
Q. Just to make sure we're on the same page, you are agreeing that it would be reasonable to expect 397 procedures to be performed on patients from Transylvania, Jackson, Macon, Polk, and Rutherford County in Project Year Three?

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A. Roughly. Yes.
Q. So we're in agreement that the number of procedures projected in the application for Project Year Three to come from other counties is a reasonable number?
A. I'm not sure. There is obviously a disconnect between the numbers that we just calculated in this one. I can't say the difference is--what the difference is. I'm sure there's something I'm not --that I'm not thinking of or recognizing right now. So I can just validate that yes, these calculations that we've done are correct. But I also stand by these numbers that are here that the applicant has provided for me, the numbers that we calculated are greater. Yes.
Q. If you think about it further during the course of the deposition, will you let me know?
A. I will. Certainly.
Q. All right. When you did your analysis of the 10 percent inmigration, you did not look at procedure numbers; is that right?
A. When I did my analysis of inmigration?
Q. Yes.
A. That's correct.
Q. And if I'm understanding you correctly, it's not so

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much the 10 percent that you had a problem with, but that you didn't understand what made up the 10 percent?
A. That's correct. I mean, you want to make sure that the applicant is just not coming up with the number out of the blue.
Q. In the reviews that you did in Forsyth County involving endoscopy, do you recall the inmigration assumptions used there?
A. I don't recall.
Q. Have you prepared findings regarding any of the applications you have reviewed in which you determined that an inmigration percentage was unreasonable other than the one we're looking at today?
A. I don't recall. Certainly, there have been applications that had inmigration assumptions, but I don't--I don't recall specifically. I do recall from my other endoscopy applications, they were additional rooms based on historical volumes, so I don't know how much inmigration played into them, but I'd have to look at them.
Q. If you look at Page 669 of your findings, after the discussion of the methodology used in the

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application, you have a need analysis; do you see that heading?
A. Yes.
Q. And the need analysis section is where you looked at volumes from other providers in the area; is that right?
A. Yes.
Q. The--on Page 671 in particular, there's a discussion of the use in Henderson County?
A. Yes.
Q. We talked about this some earlier, but I want to make sure I understand. Did you make a determination that the endoscopy room proposed at Mission GI South itself would cross the county line or not?
A. I think I reference it in here specifically. Let me see how I phrased it.
Q. And if--if you--I can point you to the application as well, the pages there, if you want to look back there.
A. I--I really--let me see what I can find, because I think I did mention it.
Q. There's a mention on 672, and there's additional discussion under Criterion 4.

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A. (Witness reviews document.) I said a portion of the GI endoscopy suite would be located in Henderson County. That's the way it appeared in their line drawing.
Q. Okay. And is the line drawing that you're talking about in Exhibit 6 to the application?
A. Yes.
Q. Exhibit 6 is a floor plan of the building in which the endoscopy room would be located?
A. Yes. It looks to be the--a floor.
Q. And then it shows a larger version of the GI room and then a--where it--where it appears in the--in the overall facility at the top right; is that correct?
A. Right.
Q. Does this document form the basis of your conclusion that part of the facility crossed the county line?
A. Yes.
Q. Where is that county line represented?
A. That county line is the dotted line that goes through the building on the small chart, and it goes through a portion of the area of construction on the larger chart.

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Q. And that--you--okay. I just wanted to make sure we were looking at the same thing, that you have the same understanding.
A. It's not labeled "county line," but that's the county line as I interpreted it.
Q. Okay. Where in the--the more detailed drawing did you understand the endoscopy room was?
A. I don't know the location of the endoscopy room where the procedures will be done, but it would be somewhere, I assumed, in this square.
Q. And we talked earlier, you--you did not sit in on or hear anything about any communications with the construction section about the location of the room on the property?
A. That's correct.
Q. If you understood that a--that the endoscopy room itself was solely in Buncombe County, would that have resolved your concern about the location of the endoscopy suite?
A. Well, I think it--it would have been helpful if the whole building was in one county. But my understanding--again, I defer to Ms. Frisone and Mr. Smith--my understanding was that--that it could not come through this space indicated in Exhibit 6.

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Q. So you're understanding from talking to them is that if--if the county line went through one closet in the corner of the space, that that would be a problem from the CON Section's perspective?
A. I don't know the specifics, I just know that when we looked at this chart, they said--and I can't quote them or whatever, but this was not acceptable.
Q. And I'd need to talk to them, I guess, for the more--the more--the additional specifics?
A. The additional specifics, that's correct.
Q. Okay. Would you agree that you have to count--that--that the endoscopy room can't be located in two counties, it's either in one or the other, in terms of reporting requirements for licensure and planning?
A. Yes. I don't--yes.
Q. And throughout the application, Mission refers to the GI endoscopy room as being located in Buncombe County, correct?
A. Yes.
Q. So would it be fair to say you just didn't believe the representations made about being--it being located in Buncombe County?

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A. It was--I can't say I didn't believe them, but it's also close.
Q. Were you aware that Mission representatives asked questions about the location in pre-application conference and were told that the site was okay?
A. That was that conversation that--that we had earlier. There was a pre-app, and I think there was some location--some discussion about the county line, but I don't know the specifics of it because I wasn't there.
Q. Was there any discussion that you participated in after you determined that location was an issue that your--your findings might be inconsistent with what was told to Mission during the pre-application conference?
A. I don't recall there being any discussion about comparing what's in the application what's the pre-app. We--I know there was a pre-app, and again, there was some discussion about the location, probably other things. But in terms of my review for this application, I didn't compare what was in the application to what was discussed in the pre-app. I relied on Ms. Frisone and Mr. Smith since they were there, so I didn't question their

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thoughts on this exhibit.
Q. And they did not express any concern to you that they made inconsistent remarks in the pre-app versus the findings?
A. No. Not that I'm aware of.
Q. I think our lunch is here, but if we could do--look at Criterion 4 and then take a break, that'd be great. Is that all right with everybody?
MS. ?: Yeah.
Q. Before we do that, though, did you look at the findings for a GI endoscopy review in Macon County as part of this review, where a physician group moved their office and their endoscopy suites to a location that was right beside Angel Community Hospital?
A. No.
Q. Looking at the findings, starting on Page 673 under Criterion 4, you referred to this a few minutes ago in terms of the location, and I believe we've covered that issue. In the middle of Page 674, you state that, "If the entire proposed suite were located in Buncombe County, there would be no change in the inventory of operating rooms"; is that--is that your conclusion?

A. That's correct.
Q. And then you--you go on to discuss Exhibit 29, the cost estimate from the applicant; do you see that? On Page 674, your findings at the bottom.
A. Oh. At the bottom. Exhibit 29. Yes.
Q. Did you--how did you arrive at this concern expressed here, that there should have been more information, or the developer should have been identified as a co-applicant?
A. I did not understand or have enough information in that architect letter. I found it to be confusing.
Q. Let's look at that while we're talking about it in Exhibit 29. Is it correct to say you agree this represents a certified cost estimate?
A. Yes.
Q. But you have questions regarding what--what the costs are?
A. I had questions regarding how they were defining this ownership adjustment. It led me to believe that there would be a 60--a 60/40 ownership split, in which case, the developer would have to be an applicant, because I didn't have any additional information to clarify that point for me in the letter.

Q. Will you look back with me at Pages 3 and 5 of the application? And they're in Section I. Do you see at the bottom of Page 3, it says, "Mission Hospital will be leasing space in a medical office building to be developed at the proposed location," and it returns to a term sheet in Exhibit 34?
A. Yes.
Q. Did you understand from that that they would be leasing from another party?
A. Yes. That's what I understood it to say there.
Q. And likewise, on Page 5, under Question 13a, Mission represented that it would occupy leased space within a medical office building developed by a third party developer?
A. Yes.
Q. And then if you look again on Page 110 of the application, Section X. It's in Section XI, excuse me, the site information construction design section.
A. Yes.
Q. And in response to Question 2b, it reflects that--and 2a, for that matter--that the MOB Developer will file with the CON Section a request for an exemption from review?

A. Yes.
Q. And that Mission GI South will occupy leased space within that building?
A. Yes.
Q. Based on the sections of the application we just reviewed, would you agree that Mission did not propose to have any ownership interest in the medical office building?
A. That's what was represented in those sections, but the letter in Exhibit 29 cast doubt on that for me because I--it--it didn't explain--it didn't explain it for me. It--it--it raised a question. I needed more information, or explanation, I should say.
Q. Did you contact anybody at Mission to ask that question?
A. No.
Q. Did you discuss with Ms. Frisone or--
A. I did.
Q. And what did--what did your discussion--
A. She was equally confused. We both needed more information and explanation.
Q. Did you look at the exemption notice letter that was sent in to the CON Section related to the space in which the Mission GI South project would be

located?
A. I would not have received that exemption letter because that exemption letter would have gone to the person who was responsible for that HSA. So I have no idea of--if a letter was received, when it was received, what it said. I have not seen it.
Q. Did you ask Mr. Brown or any of the other staff members if a letter had been received as suggested in the application?
A. No.
Q. Why not?
A. It wasn't relative for me for this review. I was basing it on what we have in the application.
Q. Would it not have provided additional information to verify what Mission was saying with regard to the location?
A. I'm not sure. And I--I don't recall seeing a date in which the applicant said they were submitting that letter. I didn't--I didn't think much about it.
Q. I'm going to show you a copy of the letter, and we'll mark it as Deposition Exhibit 4.
(DEPOSITION EXHIBIT NUMBER 4 WAS MARKED FOR IDENTIFICATION.)

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Q. Would you take a minute to look at this letter? There are two pages to Exhibit 4.
A. Okay. (Witness reviews document.) Okay.
Q. What's the date on the letter to Mr. Smith from Keith Beuley of The Keith Corporation?
A. May 13th, 2011.
Q. What is the date of the CON Section's response?
A. May 24th, 2011.
Q. I misspoke. It's Kenneth Beuley. Is it correct that the letter to Mr. Smith reflects that Western North Carolina Health Care Innovators, LLC would construct a medical office building on Highway 25 on property that is located in both Buncombe and Henderson County?
A. Yes.
Q. And that it also reflects that the medical office building will be approximately 80,000 square feet?
A. Yes.
Q. And further, reflects that Mission Hospital will lease space in the building for its proposed GI Endoscopy South location?
A. Yes.
Q. And that application was submitted in February 2011?

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A. Yes.
Q. And the letter that you've just reviewed is consistent with the letter from the architect in Exhibit 29 in terms of the square footage; is it not?
A. Yes.
Q. The CON Section responded and determined that the construction of the medical office building was exempt from Certificate of Need review, correct?
A. Yes.
Q. And this is the first time you've seen the letter, today?
A. Yes.
Q. This letter was received by the CON Section during the review of the Mission GI South application, correct?
A. Yes. Yes.
Q. There's no rule or statute that prevented you from looking at the letter relating to the medical office building exemption, correct?
A. Correct.
Q. The application referred to the fact that this letter was--would be submitted; did it not?
A. It did.

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Q. Do you know if Ms. Frisone reviewed the exemption notice letter or response?
A. I would guess that she has not seen this letter. I cannot say for sure.
Q. But it's fair to say that Mr. Smith or Mr. Brown reviewed it and neither brought it to your attention?
A. Yes.
Q. Going back to your findings on Page 674, you concluded at the end of that discussion that, "The applicant did not adequately demonstrate the most effective alternative has been proposed"; do you see that?
A. Yes.
Q. Is your conclusion about the most effective alternative based on one, the location of the building, and two, the question you had about ownership?
A. That's one reason.
Q. Are there any other reasons?
A. And also regarding the demonstration of need in Criterion 3.
Q. Ms. Miles, would you also look with me at the response to comments that Mission submitted during

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the review? It's on Page--it begins on Page 524 of the Agency file, and there's a specific discussion on Page 535.
A. Okay.
Q. This is in response to an issue that was raised by Park Ridge in its comments. But Mission responded to state that it would be a tenant in the building and pay rent to the medical office building owner; do you see that?
A. Yes.
Q. Did that not clarify the issue for you in terms of whether the developer needed to be an applicant or not?
A. No. It--the--the letter that I was looking for from the architect to support it was still not clear. It is consistent with what was represented in other parts of the application that you directed me to, but the letter from the architect was not clear, so it raised a question.
Q. I think this will be a good place to stop for lunch.
(RECESS TAKEN FROM 12:50 P.M. UNTIL 1:23 P.M.
Q. (By Ms. Harris) Ms. Miles, in the findings--going back a little bit--under Criterion 3 in your need

analysis that starts on Page 669, you discuss declining GI procedure volume in Henderson County?
A. Yes.
Q. If you had determined that the Mission GI South project was entirely in Buncombe County, would you have been concerned at all about utilization in Henderson County?
MR. JOHNSON: Object to form.
A. I'm not sure. Henderson certainly is in Mission's service area, and I may still look at the location, but I'm not sure.
Q. Sort of a related question, you used the word "literally" on the county line several times in the findings?
A. Yes.
Q. Were you concerned that it--that the location was very close to another county, or just that the project itself was literally on the county line?
A. Well, both. I was concerned that the county line was going through the proposed space, and so there was a portion of the project that kind of lays in both counties.
Q. You can't say, though, if the project had been entirely in Buncombe, but just below the county

line, whether you would have had the same concerns?
A. I'm not sure. I--I would have talked to Ms. Frisone about it and looked to her for direction on that.
Q. 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?
A. Yes.
Q. And you determined that the costs were overstated; is that correct, or understated?
A. 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.
Q. So the actual cost calculated here for the project were $5,550 less than state on Page 99 of the application?
A. 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.
Q. You're looking at Page 99 of the application?
A. Yes. Yeah. On Page 99, the total miscellaneous project costs is $619,581. I calculated $614,031.

So it appeared that the applicant overstated.
Q. And an overstatement like that would not create an issue with financial feasibility, though, correct?
A. Well, it would have to be recognized in some way. It would not have created a huge issue, an insurmountable issue, I don't think. But I couldn't make heads or tails to make the numbers add up as they are totaled on Page 99, so I made note of it, there was something missing on that chart.
Q. And below the chart on Page 675, you go on to restate the concern you expressed under Criterion 4 with regard to the developer ownership portion versus Mission's ownership portion; is that right?
A. Yes.
Q. Assume with me that Mission included more costs than it was required to include here. Is that--would you agree that's more conservative than leaving out costs that you might incur?
A. Yes.
Q. And if you included extra capital costs, you would also have extra depreciation expense?
A. Possibly, yes, in the pro formas.
Q. And that would--if you took out the extra expense,

you would have a higher net revenue in the pro formas as it flows through?
A. All things being equal. Yes.
Q. 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?
A. 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.
Q. And that wouldn't have been--and the $5,550 wouldn t have been enough to--for a finding of nonconformity, correct?
A. Right.
Q. 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?
A. No. I wouldn't expect that. I would expect that to be borne by the developer.
Q. And additionally, if the land had already been

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purchased, you would not expect those costs to be included in the application?

A. That's correct.

Q. At the bottom of Page 675 and top of 676, there's a discussion to the start-up expenses or lack thereof; do you see that?

A. Yes.

Q. Will you turn with me to Page 106 of the application?

MR. JOHNSON: I'm sorry. What page?

MS. HARRIS: 106.

Q. How did Mission respond to section--the section on start-up on Page 106?

A. There is no--zero, essentially.

Q. Okay. And it noted that the--they will be relocating existing services and so no initial operating expenses are expected; do you see that?

A. Yes.

Q. So did you disagree that that section was not applicable?

A. Well, I wondered about--I understand that it's an existing room, but they're not just moving it to another part of the existing hospital. This is a new location, a new facility. I think they need

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some utilities, at the very least, that would--would need to be included, as an example.

Q. Is there a definition of start-up expenses in the CON rules or statutes?

A. Not to my knowledge.

Q. When you think of start-up expenses, how do you define such expenses?

A. Well, just as I mentioned, things like utilities, or insurance for that space, things that you would need to start a new location.

Q. And why do you consider those start-up as opposed to just normal operating expenses?

A. Because it's a different location.

Q. 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?

A. What letter is that?

Q. 1a.

A. Oh. Yes.

Q. The--the example that you gave of utilities or insurance isn't--isn't included there, is it?

A. No. It's not.

Q. And if, in fact, Mission did not need to have any

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staff training or inventory set up before it started operations, then it would not have had any start-up expenses, correct?

A. Well, that list of example operations, such as staffing, inventory, is not an exhaustive list. Certainly, if--if it was--if it was a brand new facility for which they don't have any existing service and they're just going to start a new location, you would need some staffing, training, inventory. They have all that at Mission, right now, in place. In this particular example of a new location, although it's not listed there under 1a, it's something that I would expect to see.

Q. Have you found applicants for other services nonconforming with Criterion 5 related to start-up and initial operating expenses?

A. I'm not sure.

Q. Did you discuss with Ms. Frisone or Mr. Smith whether Mission should have included any start-up expenses for the application here?

A. I don't recall if we discussed start-up expenses.

Q. Have you discussed with Mr. Smith or Ms. Frisone or other analysts what should be included in start-up and initial operating expenses at any point during

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your employment?

A. It's possible. I don't recall any specific conversations.

Q. Did you receive any--you know, any kind of accounting orientation at the CON Section?

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 the letter signed by the CFO Admission in Exhibit 26, and you found below the quote that the letter didn't adequately demonstrate the availability of

funds. Is it correct that you made this finding because you didn't understand the 60/40 information in the architect's letter?
A. That's correct.
Q. In terms of the application itself, the letter adequately documents the capital cost proposed in Section VIII?
A. Yes.
Q. Will you explain for me your concern on the performance, Page 21 and 25, that you list in the middle of Page 676?
A. Yes. And I--I think I've described it pretty well here. I say on this, speaking of revenues and expenses for Mission Hospital, which is on Page 121, "the applicant projects revenues will exceed operating costs in the first three years of the project." That's fine. "The project years are shown as fiscal years, October 1 to September 30, when in fact, the applicant's projected utilization is based on calendar years, which is January 1 to December 31st. In Section III.1(b), Page 45, the applicant states Calendar Year 2010 Trend Star data is the most current and reasonable data to use as the base to project future GI endoscopy

utilization. It is also consistent with the project years, which are calendar year based." And it's also--I noted some other sections there. "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 the number of cases performed in any given calendar year." So in several places, I noted the difference between the use of fiscal year versus calendar year, and I also noted the difference in the pro forma section versus some of the other sections where calendar year and fiscal year were interchanged.
Q. And did you determine, based on the references to fiscal versus calendar year, that the project--the projections were not reliable; is that what you said?
A. I said that they were unreliable because they were inconsistent.
Q. Did you consider whether, because the numbers were identical, that some of the columns just may have

been mislabeled?
A. It's possible that they could have been mislabeled. But as I mentioned, there were--I noted the use of calendar year versus fiscal year in other parts of the application--the pro formas and the--and Section III differed. I didn't know the source of the difference, I just noted that they were different. Typically, they are consistent. Your financials are based on the same time period as your utilization projections.
Q. You go on to express another concern in the last paragraph on Page 676?
A. Yes.
Q. And that concern is also related to fiscal versus calendar years; is that right?
A. Yes. I state here that the project years are shown as fiscal years on the pro formas, but the applicant's projected utilization is based on calendar years, as they state on Page 45, and as were labeled on the tables. And then I also note that the projected number of cases for the first three years of the project is inconsistent with the projected number of cases in the applicant's methodology.

Q. And that--the chart on top of Page 677 is based on calculations that you made?
A. Yes, because the information that is included in the pro formas were cases, and I needed to convert them to procedures. When I converted them to procedures, I noted that they were different than what was projected in the utilization projections.
Q. 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 conducting in the pro formas.
Q. Did you make an analysis of what--of whether the project was--was feasible if you made corrections for the calculations that you noted to be incorrect or inconsistent?
A. I did not go--make that determination.
Q. Is that something you've done before in reviews?
A. I'm not sure. It's possible. I don't recall which projects, if any, if I had a problem with their pro

formas and their projected utilization associated with them. I'm not sure.

Q. Have you ever performed a review in which you and the--Ms. Frisone or Mr. Smith conditioned an applicant to omit part of the project, for example, a certain number of beds?

A. I don't--I don't recall.

Q. Okay. Have you done a review of acute care beds?

A. I may have done one.

Q. Do you recall if you approved an applicant for all the beds requested?

A. I--I--yeah, I don't recall. I think I may have done one. I don't know what the circumstances were, though. That was a while ago.

Q. Are you aware that the Agency has, in the past, conditionally approved applicants in acute care bed reviews to construct and operate a smaller number of beds than originally applied for?

A. I'm generally aware that that happens sometimes.

Q. And that doing so would involve ensuring that the project would still be financially feasible, correct?

A. They would have done some type of analysis, I'm sure. I can't speak specifically.

Q. But in terms of your role as a project analyst, you are permitted to review and recalculate to verify the information in the application, are you not?

A. In this particular case, yes, I can verify the number of cases and procedures. I can't redo an applicant's pro formas, though.

Q. Could you have used the number that you determined was the correct number of procedures and followed that through the pro formas to see if you would still determine financial feasibility?

A. Well, I wouldn't be able to say how a change in procedures would affect any of those other line items, so I wouldn't have been comfortable doing that.

Q. Is it correct to say, then, that you occasionally make some recalculations during your reviews, but this was more than you were comfortable doing?

A. Well, I think what this came down to is when you look at these--it's tied into the--the discussion of the 10 percent inmigration versus the 15 percent inmigration, and these pro formas are based on 15 percent inmigration, not the 10 percent inmigration. And so the fact that the applicant has overstated its projections based on its

assumptions in the methodology, I had to find them nonconforming.

Q. With the numbers in the pro formas, the higher numbers in the pro formas of procedures, did you determine that those were unreasonable numbers of procedures to project, or just that a 15 percent inmigration was unreasonable?

A. I just determined that it was inconsistent with the methodology, and that it--it also supported the--the inconsistency of the 10 versus 15 percent. I didn't do a calculation to determine whether or not these numbers were reasonable. I just--I just determined that it was--their pro formas were based on higher utilization than what was in their assumptions and methodology.

Q. If you look at the next issue you raised in the finance, it was related to salary expense; do you see that?

A. Yes.

Q. And on Page 678, is it correct that you concluded that although it appeared the salary expenses were overestimated, that does not reflect negatively on the feasibility of the project?

A. That's correct.

Q. And in a general sense, overstating expenses is--does not negatively reflect on financial feasibility?

A. Overstating your expenses is less of an issue as if you had understated them. This was simply an anomaly that I saw that I didn't understand. It was very striking, and so on the heals of the--the overstated number of procedures, this is just another piece that I mentioned that I saw as an issue, but it did not negatively affect my thoughts on this particular salary expense piece.

Q. On that same page of the findings, under Criterion 6, you had a finding of nonconformity with Criterion 6; is that right?

A. Yes.

Q. And your finding on Criterion 6 is based on the observations that you made under Criterion 3; is that correct?

A. Yes. They are based on things that were also applicable to Criterion 3.

Q. In other words, the findings under Criterion 6 are a restatement of findings that you had under Criterion 3?

A. They are the same issues. I would not characterize

them as a restatement, but they are the same issues. Yes.

Q. Explain what you mean by your estimate of 7.7 percent immigration being overstated? I think we covered this earlier, but I want to make sure I understand.

A. We talked about the 7.7 percent being overstated because it's based on both inpatient and outpatient procedures, and Mission GI South will only conduct --only perform outpatient procedures. So it would be reasonable to assume that a smaller number than 7.7 would be outpatient procedures.

Q. This is where you suggested that their needs to be an adjustment made based on the percentage of inpatient procedures and outpatient; is that right?

A. That was back when we talked about an adjustment Yes.

Q. Okay. And would you--is it your view that the adjustment needs to be based on Mission's inpatient, outpatient split, or the service area inpatient, outpatient split?

A. An applicant, I suppose, could do it either way. I would have to see. When we talked about it earlier, we looked at a Mission adjustment. But an

applicant is free to develop a methodology however they see fit.

Q. If you would look with me at Criterion 12, which is 682 and 683.

A. Okay.

Q. Why did you determine Mission's application to be nonconforming with Criterion 12?

A. Well, the Criterion states, "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 to the person proposing the construction project," etcetera. The main point here reflected back on that architect's cost estimate and the lack of additional information or explanation that was provided.

Q. And we agreed when we talked about this before, that if the third party developer is truly developing the whole building, then the applicant, Mission, would not have needed to include any of the shell costs?

A. Yes.

Q. Explain to me why the 60/40 split issue caused you to say that the developer should have been a co-applicant?

A. Well, I--it was the conclusion that I drew based on the phrase, "60/40 ownership adjustment." I didn't know what that--what that meant. What that meant to me was that the developer was going to be owning 60 percent. And without any further explanation, I didn't know to--I didn't know what else to deduce from that information.

Q. Did you talk to Mr. Smith or Ms. Frisone about whether the developer should have been an applicant?

A. Yes. We talked about the 60/40 ownership adjustment. I talked with Ms. Frisone. I don't recall talking to Mr. Smith about it. She came to the same conclusion.

Q. Which was that it's unclear, or that the developer should have been an applicant?

A. That based on how we read it, how it was written, without any additional information, one would assume that the developer would be owning 60 percent, and should have been a co-applicant.

Q. And then--please clarify for me what -what you

think the developer would have been owning 60 percent of?

A. 60 percent of--it says -it says right--60 percent owner adjustment of this -of this site, shell, and core. The associated -excuse me--associated billing costs, essentially.

Q. Even if the building just owned 60 percent of the site, shell, and core, it--that does not make it an applicant for GI endoscopy services, does it?

A. I'm--I'm not sure. As I mentioned, I talked with Ms. Frisone about this section. We were both confused as to what the 60/40 ownership adjustment meant. We interpreted it as meaning that they would be owning 60 percent of it. I would have asked her that follow-up question.

Q. So I get to ask her now?

A. Correct.

Q. The last--the next to last sentence of that criterion says, "The applicant did not adequately demonstrate that the cost of construction represents the most reasonable alternative." Did you have a concern about the total cost or just who was paying?

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

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Q. You did not find that the construction costs were unreasonable?
A. That's correct.
Q. Please turn to the findings under Criterion 18a on 687.
A. Okay.
Q. You found Mission's application nonconforming with Criterion 18a based on your findings under Criteria 3, 4, 5, and 6; is that right?
A. Yes. There are similar issues as--as referenced in 3, 4, 5, and 6 regarding 18a. Yes.
Q. There weren't any new or separate grounds for finding the application nonconforming with Criterion 18a beyond what you've stated elsewhere?
MR. JOHNSON: Object to form.
A. If there were additional issues that weren't referenced, I would have stated them here.
Q. On the last page of -of your findings, it -it's-- there's an "N/A" under the 131E-188(b), and that is because there were no new endoscopy rooms or am/surg facilities proposed?
A. That's correct. This was an existing room.
Q. Before and after the project, Mission would have six GI endoscopy rooms?

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A. Yes.
Q. Would it be correct to say that a finding of conformity under Criterion 3 would have enabled you to find these--this application conforming with Criterion 6?
MR. JOHNSON: Object to form.
A. I don't know. If the applicant was conforming under 3, it's possible that they could be conforming under 6. But I'd have to look--still look at 6 independently, by itself.
Q. Have you thought of any additional reasons for disapproving Mission's application that you did not include in the Agency's findings?
A. No.
Q. So everything that you based your decision on is in--is in these findings?
A. Yes.
MS. HARRIS: I think I'm almost finished. If we could take a break, I'll look through my list and make sure.
(RECESS TAKEN FROM 2:02 P.M. UNTIL 2:17 P.M.)
Q. (By Ms. Harris) Ms. Miles, I believe I have asked you all my questions at this time. I appreciate your attendance. If you think of additional

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answers to my questions, you can let Mr. Johnson know and we can reconvene the deposition.
WITNESS: Okay.

(DEPOSITION ADJOURNED AT 2:17 P.M.)

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STATE OF NORTH CAROLINA
COUNTY OF WAKE

CERTIFICATE

I, Matthew Barbee, Notary Public-Reporter, do hereby certify that Gebrette Miles was duly sworn by me prior to the taking of the foregoing deposition and that said deposition was taken by me and transcribed under my direction and that the foregoing 128 pages constitute a true and correct transcript of the testimony of the witness.

I do further certify that I am not counsel for or in the employment of either of the parties to this action, nor am I interested in the results of this action.

I do further certify that the stipulations contained herein were entered into by counsel in my presence.

In witness whereof, I have hereunto set my hand, this 19th day of January, 2012.

MATTHEW BARBEE
NOTARY PUBLIC FOR THE
STATE OF NORTH CAROLINA
NOTARY PUBLIC NO. 2008358000116

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)

STATE OF

COUNTY OF

Subscribed and sworn to before me this day

of _____, 2012.

MY COMMISSION EXPIRES

NOTARY PUBLIC

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EXHIBIT

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CAROLINA REPORTING SERVICE

Transcript of the Testimony of **Martha Frisone**

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STATE OF NORTH CAROLINA — IN THE GENERAL COURT OF JUSTICE
SUPERIOR COURT DIVISION

COUNTY OF BUNCOMBE — 11 DHR 11636

MISSION HOSPITAL, INC;

Petitioner,

vs.

N.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF HEALTH SERVICE REGULATION, CERTIFICATE OF NEED SECTION,

Respondent

DEPOSITION

OF

MARTHA FRISONE

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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STIPULATIONS

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

1. 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 answers 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 irregularities in the taking of the same, either in whole or in part or for any other cause;

5. 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,

6. That the witness reserves the right to read and sign the transcript of this deposition prior to filing.

PROCEEDINGS

(WHEREUPON, MARTHA FRISONE WAS CALLED AS A WITNESS, DULY SWORN, AND TESTIFIED AS FOLLOWS:)

DIRECT EXAMINATION BY MS. HARRIS:

Q. Good morning, Ms. Frisone. I'm Terri Harris, and we've met a number of times. I'm here on behalf of Mission Hospital in connection with its application to relocate an endoscopy room to Mission GI South. If I use that shorthand, will you understand what I'm talking about?

A. Yes, ma'am.

Q. Great. Will you state your full name and business address, please?

A. Martha Frisone and 809 Ruggles Drive, Raleigh, North Carolina.

Q. That's the new address?

A. Yes. I hope it's 809, not 801. There's some confusion in the office. I had it right, and everyone else was calling it 801. And so now I doubt myself, but I think it's 809.

Q. When did you move to the new office?

A. Over the Memorial Day weekend last year in 2011.

Q. Was that during this review of Mission's application?

A. Since I don't recall off the top of my head what date the decision was--(Witness reviews document.) It was during the review, but we had already moved. We had been in our new location for two months before the date of the decision.
Q. What was the date of the decision while you've got that out in front of you?
A. Sorry. August 26, 2011.
Q. Were you one of the CON Section staff members who was responsible for making the decision on Mission's application?
A. Yes.
Q. And what position are you currently serving with the Certificate of Need Section?
A. I'm the Assistant Chief.
Q. How long have you served in that role?
A. Since March 1st, 2010.
Q. And prior to that, what was your title, if you will?
A. I was the team leader for the west team from January 16, 2008 until February 28, 2010.
Q. Can you tell me what you have included among your job responsibilities at this time?
A. As Assistant Chief, my job is to take care of the

day-to-day operations of the CON Section, to 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.
Q. Do you have particular geographic areas or types of services that you typically handle?
A. No.
Q. You don't divide up the duties in that way?
A. Not typically; certainly not geography. As for services, at this point in time, I think Mr. Smith has pretty much done all of the hospice inpatient, but that doesn't mean that down the road that I wouldn't do some.
Q. Is there a particular service that you reviewed all the findings in, like, the hospice inpatient for Craig Smith?
A. Up to now, because Ms. Hoffman is no longer the Chief of the section, Mr. Smith has done fewer satellite EDs than I have, but he's the one that's going to co-sign the two that are under review right now, so.

Q. Do either you or Mr. Smith review all the Agency decisions and findings that go out--one of the two of you review--
A. Since August 19th of 2011 when the team leader for the west position became vacant, yes. Prior to that, there were three of us reviewing them. So, at the time of this decision, Ms. Matthes was still with us. Well, no, at the time--at the date of the decision, she wasn't still with us, but she was with us for most of the review.
Q. Did she have any role in the review of Mission's application?
A. As direct supervisor, she may have had some conversations with Gebrette, but I don't--I'm not aware of any at this time.
Q. When did she announce that she was leaving her position as team leader, as compared to her departure date of August 19th?
A. About three weeks before that.
Q. How do you go about assigning analysts to reviews?
A. It's based on the analyst's workload, our workload, meaning, Mr. Smith and myself. When the applications come in, shortly after the application log is ready, we go through it, and we just look at

it. And based on what the analysts are already doing and their--whether we're trying to broaden the experience of new analysts by giving them things they haven't--types of services or types of facilities they haven't worked on before. Many factors go into it.
Q. Is it correct that Les Brown is typically the analyst that would cover Buncombe County?
A. Well, the assignment of analysts to a particular HSA and then to counties within the HSA is somewhat fluid. Since he joined us, he has always been assigned to HSA I, but actually he was not the analyst for Buncombe County until about--I think it was June of 2011 when we loaned Carol Hutchison to the Planning Section to assist them due to their staff shortfall. And, as a result of doing that, she was responsible for Mecklenburg County, but we couldn't leave Mecklenburg County without someone to take care of--to be responsible for it. So the team that had been doing the southern part of HSA I, and we moved the team into Mecklenburg County and--because the volume of applications and no reviews and exemptions from HSA I is lower than some of the other HSAs, even though it has possibly

the most counties in it. It doesn't necessarily generate the same volume of work, so we made the decision to have Les cover the whole of HSA I. So, as far as I know, the first time he's ever covered Buncombe County was starting in June of 2011. That's my recollection. It is fluid. Before Fatimah came to work for us, and when Ron had left, Les may have covered that part of HSA I for a brief period of time.

Q. When did Fatimah Wilson come to work at the CON Section?

A. She told me just this week she's been with us about 16 months.

Q. In terms of this application, if you'd like to look at the Agency file with me.

A. Okay.

Q. Les Brown is actually the analyst who checked in the application, if I'm reading the initials right, and you can tell that from Page 5 of the Agency file, which we marked as Deposition Exhibit 3 in the deposition the other day of Gebrette Miles.

A. Oh, okay, yeah. I'm having a little trouble reading it, but, yeah, that does say Les.

Q. Do you have any recollection of why he would have

checked it in if he was not then assigned to review applications for Buncombe County?

A. It's fluid. I don't have any idea--I mean, my recollection right now without--and I don't have any records to check on this, because it's fluid, and we update the analysts' assignment chart--we overwrite the previous versions. So I don't have any previous versions to look at, but what I'm recalling is that Fatimah was assigned--but maybe that's not right. Maybe Fatimah--maybe when Fatimah joined us 16 months ago, maybe she had the northern half and Les--maybe that's when Les was moved to the southern half, but he was the northern half at one time. And maybe he was the southern half. Now he's the whole thing.

Q. I believe Ms. Wilson reviewed an application for acute care beds that was pending the same time as this one. Were you the supervisor for the acute care bed?

A. No, I believe Mr. Smith signed that one.

Q. If you look at Page 7 of the Agency file, it shows that Ms. Wilson signed the public hearing notice with Ms. Miles.

A. That's because, on the agenda for the other public

hearing--it's not here--but that would have been the acute care--I assume--must have been--oh, I'm sorry. It's a double agenda. There were one public--well, in a technical sense, there was one public hearing, but in a technical sense, there were two. There were two projects. They each needed a public hearing. And Fatimah was assigned to the acute care bed and Gebrette to the GI endo project, and they both went--if I'm recalling correctly, they both went out and conducted two public hearings. It was one date, one start time, but--so, in that sense, it's one, but in another sense, it was two separate public hearings, one for each project.

Q. Did you review the Agency file that we were just looking at in preparation for your deposition today?

A. No.

Q. Did you review any documents to prepare for your deposition today?

A. The findings and some notes taken by my attorney from Gebrette's deposition.

Q. Did you review an actual transcript of Ms. Miles' deposition?

A. No.

Q. Did you talk with Ms. Miles about her deposition last week outside the presence of counsel?

A. No.

Q. Did you review the discovery responses that the Agency served?

A. No.

Q. Did you do anything else to prepare for your deposition today?

A. No.

Q. And you didn't talk with anyone else besides your counsel?

A. Nope.

Q. I believe in your role as analyst and then team leader and Assistant Chief, you've been deposed a number of times; is that right?

A. More than I can count.

Q. And, likewise, you've testified in more than one contested care hearing; is that true?

A. Oh, yes.

Q. What's the most recent contested case hearing you've been in or what type of service?

A. Okay. Since you said most recent, the most recent testimony was in, I believe, the Cabarrus ESRD

competitive review. Ms. Gunter called me as a witness in her case--well, yeah, I guess it was her case.

Q. When was that, if you recall?

A. Not the exact date, no. It was in 2011. It would have been--I don't know if it was October or November.

Q. Have you testified in a contested case hearing regarding services proposed to be provided in Buncombe or Henderson County in the past?

A. No.

Q. Have you reviewed other applications or supervised the review of other applications in Buncombe County in the last two or three years?

A. Well, reviewed would have been more than two or three years ago; supervised, yes, in the last two or three years.

Q. Were you ever assigned as an analyst to HSA I?

A. No.

Q. What types of applications have you reviewed for services in Buncombe County?

A. I believe I did their long-term acute care hospital within a hospital, and that would have been Mission. I did an MRI review. I did two of them.

The first one involved Asheville Open MRI. That was noncompetitive. That was a very long time ago. That was before we even had need determinations. And then there was a competitive review, and I believe Mission was involved in that, along with Mountain Neurological or something like that. It started with Mountain.

Q. Was that for an MRI as well?

A. That was also an MRI. It was competitive. It was also before the need determinations, and Asheville Open MRI I approved. The other two, I think I denied both. There may have been others in that area, but those are the ones I recall at this time.

Q. Have you reviewed or supervised the review of applications to relocate endoscopy rooms other than the Mission one we're talking about today?

A. Yes.

Q. What--which ones, if you can recall?

A. There was a Baptist proposal to relocate some GI endoscopy rooms. I've done other GIs. Now, your question, I want to make sure I recall it correctly, is limited to relocation of existing?

Q. Yes.

A. Okay. The only one I recall right now is Baptist

was definitely relocation of existing, I think.

Q. And that review was the proposal to create a new ambulatory surgery center with existing rooms or just to relocate?

A. That's what I'm recalling is that--and it definitely created a new ambulatory surgical facility. I'm pretty sure it was relocation of existing rooms, not new rooms.

Q. Do you recall if you reviewed other applications that involved relocating existing endoscopy rooms but not necessarily creating a new ambulatory surgical facility?

A. The only one I can say for certain right now that was--might have been existing rooms, I'm pretty sure Baptist was talking about existing rooms, not new rooms, which created a new facility. Otherwise, I think they were all new rooms.

Q. There was a review in Macon County for--

A. Oh, okay.

Q. --rooms to be relocated--

A. Yes, there was.

Q. Were you involved in that one?

A. Yes, I was.

Q. I've got a copy of those findings. I'll hand them

to you and mark them as Exhibit 5.

(DEPOSITION EXHIBIT NO. 5 WAS MARKED FOR IDENTIFICATION.)

A. Okay. To me, this is different from the Mission proposal. This isn't relocation of one room to create another satellite location or a new ambulatory surgical facility. This is relocation of the entire facility.

Q. In terms of the question I asked, though, this is responsive, because it's an application to relocate an existing room without creating a new facility.

A. Well, it does involve relocating an existing room, but it's a totally different type of proposal, because it's not just--it's relocating the whole facility. To me, that's different, very different from you have so many rooms, and you take some of them and create a new location to offer services at. That's how I was answering your question is in terms of you have so many rooms, say 10, and you take some of them, two, and you move them to a new location, and now you have two locations. So my answer was based on that premise not on the premise of moving the whole facility. That's a different type of proposal.

Q. Let's look at this Exhibit 5 we've just marked. The findings are dated February 5th, 2010; is that right?
A. Correct.
Q. And Les Brown was the project analyst?
A. Correct.
Q. You were the team leader?
A. Correct.
Q. And--and the applicant was Western Carolina Endoscopy Center, LLC and Western Carolina Medical Developers, LLC?
A. Correct.
Q. What was--what was the new institutional health service being reviewed for this application in Macon County? In other words, what triggered the need to file the CON application?
A. Do you happen to have a copy of the law handy, the SMFP?
Q. I have the SMFP.
A. That will work. I believe there are two definitions of new institutional health services that apply here.
Q. I'll hand you a copy of the 2011 SMFP and the CON Act is an exhibit.

A. 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 also over $2 million, so that definition also applied.

Q. So, if I'm understanding you correctly, even if a project cost had come in slightly under $2 million, it still would have required a certificate of need, because--
A. Correct.
Q. --it involved relocating an endoscopy room?
A. There are at least two definitions of a new institutional health service that applies to the Macon County project.
Q. Were there comments in opposition filed regarding the endoscopy center's application in Macon County?
A. That is my recollection that there were.
Q. Do you recall what entities filed comments opposing the application?
A. Not off the top of my head, no.
Q. If you look on Page 5 of the findings, under Criterion 3a, it reflects that the new facility would be more centrally located near Angel Medical Center and other physician office practices; do you see that sentence?
A. Yes.
Q. Did Angel Medical Center file comments in opposition?
A. I think so, yes.

Q. Did any other physician practices file comments in opposition?
A. I don't recall. I would have to go on the website and check to see what the website shows.
Q. 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?
A. Yes.
Q. In that patient origin chart, it has a number of counties listed and then an all other category of three percent of patients.
A. Yes.
Q. Did you require the applicant in that review to further define the all other category either by zip code or some other--
A. 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.
Q. Did they give you any zip codes within Haywood, Buncombe, Henderson Counties?

A. They didn't do a patient origin by zip code, as I recall. No one's required to do a zip code level patient origin.
Q. That was my next question. There's not a rule requiring that sort of an analysis when you're demonstrating your proposed patient origin?
A. There's not a rule that requires the applicant to provide patient origin by zip code. If the patient provides it by zip code, then that's what we will analyze.
Q. In Criterion 3, I did not see a discussion of whether the project would impact negatively the hospital, the Angel Medical Center, as part of the analysis of whether there was a need for the proposed service. Did I miss that discussion? You may want to take a moment to look.
A. This proposal involves picking up the existing facility in Franklin and moving it to another location in Franklin. Their current volumes in Calendar Year 2008 was 1,545. This is a totally different type of proposal, where whether we approve it or not, it's still going to be in Franklin. Their reasons, if I recall correctly, for moving was the physical plant they were in was

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 a--I 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 different--different issues.
Q. 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 facility and move it from one street in Franklin to another street in Franklin--
Q. Both--I'm sorry.

A. --that was about seven miles away. And it's a different--totally different review to decide to split your endoscopy service into two locations by moving one of your six rooms from Asheville to the Buncombe/Henderson County line. It requires a different analysis to determine whether it's conforming or not.
Q. Neither Mission nor this Western Carolina Endoscopy Center proposed to add any endo rooms; is that right?
A. That's correct.
Q. Will you look with me, Ms. Frisone, on the same findings, the Western Carolina Endoscopy Center findings, under Criterion 5?
A. Okay.
Q. The first section of Criterion 5 deals, I think, with an inconsistency in the capital costs; is that right?
A. They included the purchase price of the land, but they weren't supposed to, because they--that had been purchased in March of 2007.
Q. So they--they include more than they needed to?
A. In this particular case, yes.
Q. That wasn't a reason to disapprove, but you just

lowered the total capital expenditure; is that right?
A. That's correct.
Q. And there's a reference to a failure to include the other builder's fee; do you recall what that referred to?
A. No, where are you?
Q. In that same paragraph, I'm sorry, under Criterion 5.
A. 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.
Q. 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.
Q. 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 the applicant did not need to include the land cost, because it was already purchased several years before; is that right?

A. Correct, if I'm reading this correctly. And the 2,092,865, which is what we conditioned them to, does not appear to include the cost of the land. The very last part of that paragraph has the four dollar amounts that were added up to arrive at that number, and the cost of the land is not included in that.

Q. Why was the cost of the construction for the entire office building included?

A. I don't recall at this point in time why. They may have proposed it that way for all I know. I'd have to look at the application.

Q. Is there a difference between when and whether you include the cost of the medical office building or not, depending on the ownership of the entity?

A. If the applicant states or believes that some part of the building is exempt, then they're free to give us prior written notice of that and try to convince us that part of the medical office building should be exempt. Without reading the application, for all I know, without looking at the diagram of the building that Western Carolina Endo Center was proposing, they may have felt that the whole building should be included in the project

cost. If they don't ask for an exemption, I'm not going to exempt out some portion of it.

Q. You just review what was presented to you?

A. Well, I mean, there may have been situations where someone proposed something, and some part of it really should have been exempt. I don't know that we've ever--particularly in an expedited review situation, we may very well have talked to them and said, you know, really, that part should be exempt. Why don't you seek an exemption for it? I don't know. We could have. I can't recall any that I've done, but I may have.

In this particular case, with only the findings to go by, I can't tell you what they said in the application, but, apparently, they included the whole cost of the whole building, and we, after looking at it, decided that was appropriate in that case.

Q. And there--there are cases, though, where it's--an applicant or an entity applies for an exemption for a medical office building, correct?

A. There have been projects where the building included much more space than the space necessary for the service under review, yes.

Q. Okay. And in those cases, the applicant just needs to include the cost of upfitting its particular service and project?

A. The applicant bears the burden to demonstrate that they have included all of the costs that are necessary that fit the definition of the institutional health service.

Q. Is there any guidance in the rules regarding how you know what parts of a medical office building you would include or not include in an application for service going into a medical office building?

A. The guidance that I get comes from what I refer to as the Mission Asheville Hematology cases.

Q. And that's a Court of Appeals decision?

A. Well, actually, the best guidance comes from the final Agency decision that was upheld. There's more detail in there as to the cost. So, at this point in time, when I have questions about what should or shouldn't be included, that's what I usually turn to is the final Agency decision and the Court of Appeals decision.

Q. And before that decision, there weren't any particular rules that assisted in your determination?

A. Well, I don't think there have ever been any--when you say "rules," I'm assuming you mean something in the Administrative Code. I'm not aware of anything ever being in the Administrative Code on this subject. There have been, in the past, declaratory rulings. At one time, there was a--I want to say it was a Rex Wellness Center declaratory ruling everybody tended to turn to. Then, of course, we may have had some other things in between there and the Mission case, but, right now, the latest rulings we have would be the final Agency decision and the Court of Appeals decision upholding it in that Mission Asheville Hematology case.

Q. Looking back at the findings for Western Carolina Endoscopy Center, Ms. Frisone, there's a line also under Criterion 5a, just below the paragraph we were discussing.

A. 5a?

Q. On 5, where it says, see (a). I'm sorry.

A. Okay.

Q. I misspoke. The--it refers to the fact that in Section IX.1, Page 44, the applicants projected there will be no startup for initial operating expenses.

A. I see that.
Q. Did you find that reasonable, there would be no startup for operating--initial operating expenses for a relocation project?
MR. JOHNSON: Objection.
A. Without looking at the application, I cannot tell you what--I mean, if that's the findings in this particular case, Western Carolina Endo Center say what they say, and what's in the application, I do not recall, so I, you know, don't know what the basis was for a conclusion--well, that's not a conclusion. That's just a statement. But, clearly, based on these findings, we did not find that to be a problem in this particular case.
Q. How do you, in terms of reviewing applications or supervising reviews, define startup and initial operating expenses?
A. I don't have a definition. There's nothing in the law. Our application form gives examples of the sorts of things that might be expected--costs that might be expected to be incurred.
Q. The examples in the application form are the only guidance you're aware of for applicants to determine if they have startup or initial operating

expenses?
A. That's the only thing I can think of right now off the top of my head. There's no rule.
Q. The last question related to these findings in Macon County relates to the condition under Criterion 5.
A. Okay. Which one?
Q. The first condition. You conditioned the applicant to a capital expenditure amount that was recalculated to make the correct amount; is that right?
A. Correct.
Q. And the Agency is able to impose such conditions on applicants?
A. If the application is approvable, then we have that option, and we do consider that, when we're reviewing applications, when there are deficiencies, as to whether or not a condition would be appropriate and would correct the deficiency.
Q. How do you analyze--just--I'm not asking about a specific situation, but how do you analyze whether a deficiency is one that can be remedied through a condition or that cannot be?

A. Well, we have to take the whole application into account. We have to take our conclusions with regard to all of the statutory and regulatory review criteria into account. We do not, as a practice, condition past performance. So if someone has problems with quality of care track record we believe necessitates finding that applicant nonconforming with Criterion 20. We're not going to impose a condition, because I can't--it isn't even realistic or feasible for me to say, okay, you're going to provide quality care in the past. Well, I can expect them to provide it in the future, but I can't make them change what they did in the past. The past is over and done with. We don't usually impose--as a sort of general statement, when it comes to demonstrating need, we're not going to put a condition on someone asking them to correct the deficiencies, because we don't know if they can. Now, we may condition someone to develop less than what they've demonstrated a need for a portion of their project. For example, a slightly--if they've demonstrated the need for two ORs, but not three, we might condition them to develop just the two ORs. It's a

case-by-case decision as to whether or not these conditions can be imposed, and, as I say, you have to take into account an error that might require you to say, well, you need to demonstrate the availability of more funds than you did. That's a frequent condition. Is it going to be appropriate if you also have problems with Criterion 3 and 6 and can't condition those? So we're not going to impose a condition in Criterion 5 to correct a deficiency when we have deficiencies in other criteria that can't be corrected.
Q. As another example besides the ORs, you approved projects for fewer acute care beds than applied for at times; is that right?
A. Yes, we have--we have two appeals under way right now where we downsized a particular facility, both with respect to their ORs and their acute care beds.
Q. And when you--when you downsize a project or--or approve something slightly less than what's applied for, do you do an analysis of the financials with the downsized project?
A. That will depend on circumstances. The two that I just alluded involve a hospital. It's an ongoing

facility, ongoing operation, been in operation for many years. The proposals don't involve adding additional services--or services--or not providing or expanding existing services. They're a renovation project, so not approving as many--the OR project, which is the one I'm familiar with, involves new space to replace ORs, and we've told the applicant they can do that. They demonstrated the need for the new space but not for the number of ORs that they have now. So we downsized the number of ORs to, in our opinion, right size them to the number of ORs they need for the projected volumes that they projected. So that really shouldn't have any impact on their--so that's where I'm going with this is that you have to look at what the project is, what the impact of the downsizing would be. In the case of reducing the number of OR's, what we're saying is, with fewer OR's, you still have plenty of ORs to do the number of procedures you're projecting you're going to do. So why would that impact the financials? It wouldn't. Other cases, it might impact the financials, and that might be what causes us to not be able to downsize because of the uncertainty of

the impact on financials, because they really would need to redo the financials. So that--that can be one of the factors in deciding, no, we can't--we can't condition them.

Q. You might be--it might be more of an issue and less able to redo financials or downsize if it was a single service provider, for example, a hospice.

A. Well, I think the Mission GI--Mission GI South, whatever we decided to call it, would be a good example. It only involved a relocation of one room. If you decide that the one room is not necessary in that location, there's nothing really to downsize. If they had asked to move three rooms, and we said, well, one is okay, then we'd have to consider whether we could condition that. Because this is proposed to be basically a satellite location under the hospital license, it might have been possible in this case but for a brand new ambulatory surgical facility you would expect to be financially feasible on its own, particularly if you were dealing with separate ownership, then that might be a different story. You know, it really boils down to a case-by-case analysis of the specifics of the project, the

specifics of the deficiency, and the impact a condition might have on the potential financial feasibility of the project.

Q. Well, would it be fair to say if you had--if you had been convinced, under Criterion 3 and 6, that Mission needed to relocate that endoscopy room, then you may have been more likely to consider conditioning them on financials?

MR. JOHNSON: Object to form.

A. I haven't really given it a whole lot of thought, but, certainly, theoretically, if they had been found conforming with Criterion 3 and Criterion 6 and 4 and 12, then the problems in 5 might be something we'd certainly consider. But I think the problem in Criterion 5 is of a greater magnitude than that, and, quite possibly, my gut feel is that we would not have conditioned it. But we'd certainly consider it before we made a decision as to whether or not we had to find them nonconforming, even if that were the only area where there were concerns.

Q. And I'm definitely going to ask you about what the other--the issues that you just alluded to under Criterion 5, but first I wanted to ask if you had

looked at, in connection with this review or other reviews, some findings regarding a relocation of endoscopy rooms in Wilkes County in 2008?

A. Did I look at it?

Q. Yes.

A. I don't seem to recall it.

Q. The--I'm just going to hand it to you and ask you if you had any involvement or if you've ever reviewed it. We'll mark the findings as Exhibit 6.

(DEPOSITION EXHIBIT NO. 6 WAS MARKED FOR IDENTIFICATION.)

A. Let's just say it doesn't look familiar.

Q. The findings are dated June 24, 2008; is that right?

A. Correct.

Q. And they involve Wilkes Regional Medical Center's project to relocate two existing gastrointestinal endoscopy rooms to an existing outpatient facility licensed as part of the hospital?

A. Yes.

Q. You were not the analyst or the Assistant Chief reviewing that application, were you?

A. No, actually, I had just barely been promoted to team leader, and I think that was the month I

started co-signing decisions. This wasn't one of them.

Q. Have you ever reviewed these findings before?

A. I may have, but if I did, they're not really ringing a bell. There might have been a subsequent application involving this facility, a sort of change of scope for this, that perhaps I was involved in, but right here and now, this one's not ringing a whole lot of bells with me.

Q. Would you--just looking at--and you're welcome to take as much time as you want--consider this Wilkes Regional Medical Center project more similar to the project proposed by Mission than the Angel/Macon County case that we looked at a few minutes ago?

MR. JOHNSON: Object to form.

A. (Witness reviews document.) Well, Angel just had comments in opposition to it, but not the applicants, so the Macon County one--I don't--apparently, the outpatient care center already existed. I'm not sure how far away this outpatient care center is from the hospital, and it may say somewhere in the--nor have I found yet how many GI endo rooms they have in the hospital. And it may very well be a little more similar to the Mission

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 hospital or in the same town, and that I can't tell from these findings.

Q. And my understanding from your testimony about the Wilkes Regional and the Macon County application, that the relocation by Mission of one OR from Asheville to Fletcher was a significant concern or issue of the CON Section?

MR. JOHNSON: Object to form.

A. I wouldn't say it was a concern. It is a important factor, but we're not talking about relocating a GI endoscopy room to an outpatient center on the hospital campus in Asheville, particularly creating an ambulatory surgical center with different reimbursement. It matters that they're moving this service, the location where the service will be provided, to a different part of the county. It's a factor in our review and how we--you know, what would be important in the analysis. I cannot tell from these findings, unless there's something perhaps in one of these long quotes that gives me a

clue as to where the Westpark Outpatient Care Center is located in relationship to Wilkes Regional Medical Center. So that--without that knowledge, I can't tell you how similar or dissimilar the Wilkes project is from the Mission GI South project.

Q. When you're supervising a review of a CON application, do you typically suggest that the analyst look at other sets of findings?

A. Yes.

Q. And do you direct them to particular sets, or is there a way to search for similar services or similar types of projects?

A. Well, a couple of years ago, we started--got a folder on a share drive that the analyst can look at findings by service types. So, they're not all there, but it is certainly possible for an analyst to go to the S-drive to the folder for GI endoscopy proposals, and they are further sorted by new facilities and relocations, but this is not an exhaustive--sometimes we forget to put them there. It does not go back particularly far. It's not something we've done since the '90s, but the idea was to try to collect them in a place where the

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 they can't save to that drive. So someone else has to do it for them.

Q. And if you had directed Ms. Miles to a particular set of findings in this review of the Mission GI South application, you'd expect those findings to be in her working papers, wouldn't you?

A. If I had directed her to a specific one, I would have. I would have said this needs to be in the--in the working papers.

Q. Did you--do you recall directing her to any particular sets of findings in connection with the Mission GI South review?

A. I don't recall at this time. I don't even recall at this time if there are any other findings in our working papers.

Q. I don't recall seeing any findings in the working papers, but it's in Tab--behind Tab 4 of the Agency file notebook that we marked as Exhibit 3 in her

deposition.
A. Apparently, they're all findings that were attached to the written comments.
Q. Yes, that was my next question.
A. So, in that case, we would have looked at those, or she would have looked at those. Some of which have nothing to do with GI endo. I don't see any findings in her actual working papers.
Q. Okay. Well, while you've got the Agency file notebook open, there are--there are some findings that she said that were attached to the comments by Parkridge and Carolina Mountain.
A. Yes.
Q. Did you review any of the comments and their attachments or--
A. I reviewed the comments, and I may have skimmed through the attachments. I didn't necessarily read every page of every attachment.
Q. Starting on Page 223, which is an attachment to the Parkridge comments, there's a set of findings regarding Wake Forest Ambulatory Ventures, LLC.
A. Correct.
Q. Are those the--is that the review that you mentioned earlier you'd been involved with in

Forsyth County?
A. I don't remember actually mentioning this particular one.
Q. Okay. You looked at--you said one for Baptist, but this is not the one?
A. Okay. This is ORs for surgical procedures as opposed to--there's no GI endo in this one at all. I'm sorry, I shouldn't say that. The transcript won't be clear. For G-8608-10, which is one that Gebrette and I also did, this is not the one I was referring to. There was an earlier one that I did as an analyst where Baptist created a GI endoscopy am-surg in Winston-Salem. This project from--the decision was 2011--is the relocation of the chronically underutilized ORs from Plastic Surgery Center of North Carolina to Clemmons. And I knew this was attached, but I was familiar with this. So I--this would be one of those exhibits I've glanced at. I'm familiar with those. I know what the issues were there. I don't need to read it again.
Q. Were the issues in the Wake Forest Ambulatory Ventures, LLC relevant to the Mission GI South application, in your view?

A. Well, I guess, on a certain level, you could say they're similar in that Wake Forest Ambulatory Ventures, LLC didn't demonstrate the need to relocate the three ORs to Clemmons, but I think the particular problems were of a different nature. I don't recall there being a problem with Wake Forest Ambulatory Ventures with the identification of the population to be served. I think there were other issues with--well, for one thing, they were relying on referrals from an orthopaedic physician group which had withdrawn its support. And when you took those procedures or those cases out of their projected utilization, they couldn't meet their required targets. So it's different issues, because, in this particular case, the Wake Forest Ambulatory Ventures, there was a set of rules that applied. And once you took the cases out, the group that was not going to do cases there, after all, they didn't meet their target. So very different issues.
Q. You're talking about the target that requires a certain amount of procedures per year by the end of the third year?
A. Well, there were other problems besides that, but

that one--it is a performance standard rule. It is 2103(b), and they were required to show that they will--excuse me--that they needed at least 2.5 ORs based on taking the projected ambulatory cases times 1.5 hour per case to calculate the hours, and you divide by 1,872--1,872, and it showed 2.6; however, that projected utilization assumed that that orthopaedic group would actually do their surgical cases there, and they had withdrawn their support very explicitly in a letter addressed to us. So when you took that out, they didn't meet the standard.
Q. In the Mission GI South application, there's not a performance to be met, is that correct, because they're relocating--
A. The rules--the rules don't apply. We do use the standards as our guidance in evaluating, but, no, they were not required to show that they would do 1,500 procedures--GI endo cases, surgical--I get so confused, GI endo procedures at the GI South or, for that matter, because it's all one license, that the six were actually very close to that number. But they weren't specifically required to meet that target, because that rule didn't apply, because

they are proposing that it would be licensed as part of the hospital.

Q. Before I forget, the hospital that you mentioned where you downsized the number of ORs, which one is that?

A. High Point Regional.

Q. Okay. And that application or that appeal is still pending?

A. Yes, it is.

Q. You sort of alluded to this already, but when you--when you're supervising the review of the application, at what point do you get involved and what steps do you take, if you have a particular routine for each review?

A. Once it's assigned to the analyst, then the--when the analyst starts working on it, they're encouraged to, and they do frequently, bring issues to my attention. I seem to recall Gebrette, at some point, don't know exactly where in the process, but relatively early, bringing to my--to my attention the discrepancy between the 10 percent inmigration and the 15 percent inmigration, and we looked at the exhibit. I think it's Exhibit 16, Table 5, and we looked at the application and

talked about it and talked about the impact. At 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 at it. I think initially we thought, yes, and we looked at the response to written comments, and I think our initial thought was, well, it appears the only place where it says 15 percent is in the exhibit. But then, subsequently, as Gebrette worked on it further, she then brought to my attention that the pro formas--we couldn't figure out what the--had cases, and the number didn't match anything in Section IV or Section III or the exhibit that we could figure out, and we worked on that. So, as they find issues, if they're not able to resolve them on their own, they will--and Gebrette did on, at least, those issues, and I think we talked about the inmigration percentage and its reasonableness and the issue of not knowing precisely what counties that would come from. And we talked to Craig about it, because he has been the analyst for HSA I. He is very familiar with

the western part of the state, and we were looking at, well, where would it be reasonable for patients to come to this proposed facility. So we consulted with him on that issue.

Q. So is it fair to say this--this review proceeded in the normal way, from your perspective?

A. Yes, and that was a rather long answer, but to flesh it out further, then, at some point, the analyst will give me a first draft of the findings, and we will continue, as I look at what they've put in the draft findings, to talk to each other and look at things in the application and the comments and response to comments as we work out, you know, should this be conforming, should it not be conforming. And so it's a work in progress basically.

Q. When was the last time you reviewed an application cover to cover as an analyst?

A. I know the findings don't reflect this, but the replacement long-term care hospital in Mecklenburg County. Carol had started it, and she did do the bulk of the work on the findings. But she was--she was loaned out to the Planning Section, and so I finished that review. But we did decide that she

had done enough of it that I would co-sign as the 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, Angie was supposed to have been the analyst. She got swamped, and I took it away from her and did it. And it might have been in--could have been in 2008, could have been in 2009.

Q. You mentioned, and Ms. Miles mentioned also, talking to Craig Smith about the inmigration issue.

A. Yes.

Q. Was that early on when Gebrette first came to you about the 10 versus 15 percent or later in the process?

A. That's a different issue. It's not--there's two issues there. Theirs is it 10 percent or is it 15 percent. That's issue one. The second issue is--well, there's really three issues. The second issue is the 10 percent isn't defined adequately, because I believe all it says is other zip codes in Buncombe and Henderson Counties and other counties without ever specifying what those counties are. And the third issue is, is 10 percent reasonable

for this particular location and this facility. And it was that issue that we went to talk to Mr. Smith about, because we were looking at its geographic location. We don't know precisely what counties were intended to be included, so we were looking at, well, if you look at Mission's patient origin, which we had in the license renewal app, and the counties where they get their patients from now, which of those counties would it be reasonable for this facility to get patients from.

Q. And it was the third issue, the reasonableness for the location, that you talked to Craig Smith about?

A. I wouldn't phrase it quite that way. Yes, that's the third issue that I'm thinking of with respect to inmigration, and it's the one we talked to Craig about. But it's about we don't know where they're coming from, because they haven't told us enough about it. But of the counties currently served by Mission for this--for this service, which of those counties is it likely that people would come to the Mission GI South facility, as opposed to the Asheville location.

Q. Let's just go ahead and look at the findings with regard to Criterion 3, since we started talking

about the inmigration issue. The findings themselves start on Page 640 of the Agency file, and then Criterion 3 actually starts that same page as well.

A. Yes.

Q. In the findings, there's a section initially where you discuss the population to be served; do you see that?

A. Yes.

Q. I'm trying to understand your testimony about the different counties not being--or the other not being described. Did not the application have a listing of the counties where Mission currently sees patients coming from four endoscopy services?

A. No, I don't know whether it does or not. But going back to the language of Criterion 3, which starts on Page 640, it says the applicant shall identify the population to be served by the proposed project. So the issue isn't where does Mission get its patients for its existing GI endoscopy services. We have that data. Even if the applicant hadn't provided that data, we have it on file in the Division in the license renewal application. The issue is where are the patients

that are going to go to Mission GI South coming from.

Q. The application proposed to serve patients from the same areas where Mission currently gets GI patients, correct?

A. The Mission GI South has a different service area defined. That discussion starts on Page 642.

Q. Let me ask it this way. The application didn't propose to take patients who were typically seeing other providers in the area for endoscopy services, correct?

A. No, I don't know that that's an entirely correct statement either.

Q. If you need to refer to the application, it's there in front of you as well.

A. No, actually, it was something I saw this morning I'm looking for, which is in the findings. I didn't look at the application, so it has to be in the findings. (Witness reviews document.) I'm not finding it right now, but the--the statement regarding the patient origin from Mission GI South, we have--I guess maybe the first place it's discussed is--and there's a quote from the application, and this is on Page 642 of the Agency

file, and it's from Page 30 of the application. Mission analyzed historic 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. And then there's some text that we wrote, which introduces the table, which lists those zip codes. Then the projected patient origin was also provided on Page 58 of the application and in Exhibit 16, Table 5, and I think that's reproduced on Page 643. Now, this is not by zip code. It's just by county. And here inmigration--this is where the 10 percent comes in--but there's--that's actually from Page 58, because Table 5 shows 15 percent. And then after that table, it says, however, the applicant provides inconsistent information regarding projected inmigration for the Mission GI South campus. In Section III.1(b), Page 58, which is where the data came from in the table right above that, it says the applicant states it assumes that 10 percent of the GI endoscopy procedures at Mission GI South will come from other Buncombe County and Henderson zip codes and other counties.

That's not defined anywhere else. There's a problem of 10 percent and 15 percent. We don't know which it is, because Exhibit 16, Table 5 is one of the places where it's 15 percent, and the pro formas is another. But there's no further breakdown or discussion or anything. We don't know which counties. We don't even know which other zip codes in Buncombe and Henderson County are included in that either 10 percent or 15 percent.

Q. I think it might help to look at Page 58, if you would open the application, Ms. Frisone. I did not say this at the beginning, because I know you know that the rule is, if you need a break, you'll let me know, but just feel free to let me know if you need one at any time.

A. Sure.

Q. All right.

A. Okay.

Q. Page 58 in the application is referred to in the findings you just reviewed with me. Would you look at the bottom of the page? It says that Mission assumed that projected utilization at Mission GI South will shift from Mission Hospital in Asheville; do you see that?

A. I do, and that's discussed on the bottom of Page 643 of the findings.

Q. Did you determine that you did not think patients would shift from Mission?

A. No, no, the applicant assumes that 70 percent would shift, but of Mission's existing GI endoscopy patients, of which a substantial percentage are inpatients, some of the counties, it's not reasonable to assume that those patients would shift to Mission GI South. And because the--this is a--it's like each little piece taken alone might not be enough to find an applicant nonconforming, so it's--it's all of it taken together. Is it 10 percent? Is it 15 percent? 15 percent was used in the pro formas. Of the 10 or 15 percent, even if it's all supposed to be shifted from Mission, some of the patients currently using Mission are inpatients, a substantial portion, and some come from counties it's not reasonable to expect to use Mission GI South because of where those counties are located. So that's why, taking all of this together, all of the issues, we concluded that they didn't adequately identify the population to be served. And somewhere in this application, because

I found it in the findings this morning, there was a statement to the effect that patients currently utilizing some of the other providers might shift to Mission GI South. Yes, it's quoted on Page 665 in the Agency findings. It's a quote from the discussion of Step 10 in their methodology. 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 will 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. So it's not entirely clear to me that they're not counting on patients shifting from other providers, but that's not the reason they were found nonconforming.

Q. The discussion that you just read refers to a physician group that supported the application; is that correct?

A. That's correct.

Q. And there's not a discussion in the application regarding shifting patients from Parkridge or Carolina Mountain; is that correct?

A. That's correct. But the application is not conclusive enough as written for me to be assured that a hundred percent of the patients are expected to shift; but even if they are, the failure to define those other counties, you're still talking about patients potentially without defining it and limiting it to counties where it's logical for someone to go to Mission GI South, instead of a county that's north of Asheville where they would have to drive past the hospital to get to Mission GI South. That's not reasonable, and that's the problem that we found.

Q. Do you have an understanding of how patients select

a location for an endoscopy procedure?
A. Well, in my case, it was selected for me after the physician that I was referred to was selected.
Q. So you didn't have a choice as to where you went once you chose your physician?
A. No, because he didn't offer me but one alternative.
Q. Was it farther than you would have liked to have driven?
A. Since I was living in Johnston County, any place they would have sent me was far. Was it an ambulatory surgical facility, no. Unless someone tells me I have a medical reason why I need to have it done in a hospital-based outpatient setting, I would prefer the ambulatory surgical facility setting, because, you know, it costs me a lot less out of pocket.
Q. If you had wanted to go to a different endoscopy location, then it sounds like you would have had to select a different physician?
A. I would have had to, yes. And the gentleman has moved his office subsequently to where it's way farther away from my house, and he apparently does have an outpatient-only facility that he uses now. But unfortunately he moved out towards Wake Forest.

Q. Did you have--
A. I don't live out that way.
Q. Did you have to drive by other endoscopy procedure rooms to get to the one you went to?
A. Not from where I was coming from, no.
Q. Based on what you've just said, though, it may be reasonable to expect patients to drive past downtown Mission to get to GI South if that's the only choice their physician gives them, correct?
MR. JOHNSON: Object to form.
A. But the burden's on the applicant to identify the population to be served. So it might be in a given case that a given patient would drive, but it's up to the applicant to justify that and document that that's reasonable.
Q. How would you have expected Mission to document that?
A. Well, what I expected Mission to do is to adequately identify the population to be served, and if it's not including counties--this is not the first time where someone has done that. This is so much like what was done in FMC-Kernersville, where the inmigration was 20 percent, and it wasn't defined. And that's exactly what we said in those

findings was you haven't defined that 20 percent. We said Forsyth--other zip codes in Forsyth County and other counties, and you haven't limited it. And it was clear to us that someone was not likely to drive from Clemmons to Kernersville when they would have to drive past two hospitals to be admitted. So they were found nonconforming. We did subsequently settle. Kernersville is open. But the issue in the Mission GI South case is very, very similar to the FMC-Kernersville issue.
Q. So it's not the 10 or the 15 or the 20 percent, it's whether the information was in the application to convince you that the number that they chose is reasonable.
A. That's correct. This is also very similar to--I hate to even bring it up. It comes up at every deposition and hearing--the second Gaston ED review where we had a competitive review to develop a satellite ED in Mount Holly. And the Charlotte-Mecklenburg Hospital Authority application was denied, and we found that they did not adequately identify the population to be served. In the application, they said that their service area was a five-mile circle drawn around the location of the

proposed satellite ED, but at the hearing, they said it also included a 10-mile service area, a secondary service area. That was considered an amendment. What they said was that 70 percent of their patients would come from that five-mile circle, and 30 percent would come from outside it. And they said that included other zip codes in Gaston County. And, again, we said it's not reasonable to assume that patients living in the western part of Gaston County would drive past Gaston Memorial Hospital for an emergency department, and that decision was upheld last month by the Court of Appeals.
Q. Well, the emergency services are in a different category than endoscopy services, would you agree, in terms of where you might drive?
A. Yes, but the services to be offered at FMC-Kernersville, which decision preceded that Gaston ED, included all the services at FMC-Kernersville, which also included outpatient and scheduled type of things. So, yes, emergency services are different, but the issue is the same. And, you know, our decision here to find the Mission GI South application nonconforming with Criterion 3

for failure to adequately identify the population to be served, I think, is very consistent with our prior decisions on very similar situations.

Q. Going back to the 10 percent and the 15 percent, what do you understand the 10 percent inmigration to be from; in other words, 10 percent of what number?

A. Well, it's actually 10 percent of the total. So to get it, you--they came up with the projected utilization from the nine zip codes, and then--I would actually have to do this math to be sure this is right, but I believe what you do is you divide by .9 or by .85, and that gives you the total. And then the difference is either the 10 or the 15 percent.

Q. And the total is the number of procedures projected for the Mission GI South?

A. I believe it's the procedures, not the cases.

Q. Did you analyze the number, as opposed to the percent of procedures that would be projected to come from outside the zip code areas specified in Buncombe and Henderson County?

A. Well, I think Gebrette does do a comparison of--that's somewhere, I thought--

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 of 15 percent with different totals. And what she's doing is actually preparing the total--the

difference in the total procedures, depending on which inmigration factor was used. So that's the only comparison I know of in the findings. She doesn't actually talk about the difference between--let's just pick a year--Project Year 3, 149 patients at 10 percent, as opposed to 236 in 2015, but that's the only difference between them. So when she talks about the difference in totals in the text following the table on Page 669, that difference is the difference between a 15 percent inmigration and a 10 percent inmigration, because it's the only difference. The numbers in the first row, which is the projected utilization from the nine zip codes, those numbers remain the same in the two tables.

Q. Looking at the table on 668 and the number of 149 that you just mentioned for Year 3--

A. Uh-huh, yes.

Q. --that's 149 procedures; is that right?

A. Correct.

Q. And the actual number of patients would be less?

A. It would be that divided by--divided by 1.33, I think is the factor.

Q. That was the number of--the ratio of cases to

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 break.

THE WITNESS: Okay.

(RECESS TAKEN FROM 11:35 A.M. UNTIL 11:55 A.M.)

Q. (By Ms. Harris) Ms. Frisone, before we took a break, we were looking at the Agency findings and talking about the immigration issues that you outlined for me. And I'd like for you to look now at the table that Ms. Miles prepared on Page 667 of the Agency file.
A. Okay.
Q. Did you talk with her about this particular table?
A. I'm sure I did.
Q. Do you recall any of the discussions surrounding this table?
A. Well, what I do recall is that the inclusion of Transylvania, Jackson, Macon, Polk, and Rutherford Counties, I believe those are the ones that, in consulting with Mr. Smith--and it says in the text following it that these are the ones we thought, of the counties reported in Mission's license renewal app as counties from which Mission gets GI endoscopy patients, that these were the counties that it might be possible to expect patients using the Mission facility in Asheville to use the Mission GI South facility. So whether we really talked about the table, per se, I doubt it, but certainly the contents of the table is one of the

things--that is the very issue we were discussing with Mr. Smith is which of those counties that were in Mission's service area at the Asheville campus would be reasonable to include in the Mission GI South service area.
Q. And these five, you decided, would be reasonable to include?
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?
A. Well, I don't know that it's from that particular page, but it's from the license renewal app, I

believe, is what we were looking at for Mission's GI endoscopy services, which should look very similar to the list on Page 642. But I believe what we were actually looking a was their license renewal app. That's my recollection.
Q. And that is the footnote below the table on Page 667?
A. Well, that--yeah, that's the source cited for that table. There's no source--the source cited for the table on 642 in the application itself, Pages 70 and 71. (Witness reviews document.) Which then says that the source is Exhibit 16, Table 12. (Witness reviews document.) Which says the source is the 2011 license renewal app. But my recollection is we were actually looking at the license renewal app, not Table 12 or Page 70 and 71, and certainly not--at that point, I don't think I even had draft findings. So we weren't looking at the table on Page 642 in the Agency file. But that data in the table on Page 642 of the Agency file, if you follow the citations in the application, comes from the license renewal app. And I think that's what we actually had in our hand, because I think that's in the staff notes.

Q. It is. And I think--I think what you're saying is that you looked at the license renewal application and made a list of the counties you thought it would be reasonable to expect patients to travel from to Mission GI South for endoscopy rather than looking at Mission's application and--and crossing 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 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 Mission Hospital GI cases for the 2011 renewal application?
A. Correct. Which the application indicates is the

source for the table that's in the exhibit and then in the application that we created and made part of our findings.

Q. So, from what you said, I imagine that you and Mr. Smith and Ms. Miles looked at this Page 632 and said, here are the counties where we would believe patients would go to Mission GI South from?

A. Well, what we did is we went through each county that they're serving patients from and said, looking at a map--and that's based on Mr. Smith's knowledge of the counties and travel--not just a map, but the roads--that, okay, this county it would be reasonable to expect patients to go to Mission GI South. This county not so reasonable. So that's ultimately the source of the list on Page--

Q. 667 of the findings?

A. --yes.

Q. Did you look at maps or any documentation related to traffic patterns in western North Carolina?

A. I believe that Gebrette and I had a map. I'm not sure whether Craig needed a map, but I think Gebrette and I looked on a map.

Q. Is that map in the Agency file?

A. No, huh-uh.

Q. What map did you look at?

A. It could have been a North Carolina Department of Transportation map, or it could have been the map in the SMFP.

Q. Did you personally look at a map that had I-26 and I-40 and those routes specified?

A. I don't recall.

Q. You agree that the roads and traffic patterns are an important determining factor of where patients might reasonably be expected to go?

A. Certainly. Mr. Smith was cognizant of that and mentioned it all the time.

Q. Looking back at the chart on Page 667 of the findings.

A. Okay.

Q. Why did Ms. Miles prepare this chart?

A. To show that the percentage of patients currently utilizing Mission from these counties is only 7.7 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 on Page 666--in one part of the application, the inmigration for Mission GI endoscopy services as

currently provided in Asheville, the inmigration was said to be 5.5 percent, I believe, and that's reflected in the chart on Page 642. So somewhere in the application the applicant had chosen to be more explicit and to list the percentages for other counties besides Buncombe and Henderson. Then, in the quote that's reflected on Page 666, all Mission's counting as being somehow the service area is Mission--is Henderson and Buncombe Counties. And they're saying, well, the other 34 percent is inmigration. And so there's--the way we read the application was they were saying, well, if Mission in Asheville, if their inmigration is 34 percent, then 10 percent for Mission GI South is reasonable. And that's--that's sort of precisely the logic that Charlotte Mecklenburg Hospital Authority tried to use in the Gaston ED application, and we didn't find that acceptable. Because what they did is they specifically limited their primary and secondary service area down to a very tight geographic region and said all the rest of it was inmigration when, in fact, if you looked at historical utilization, they were routinely serving patients from outside that tight little

geographic area. So, here, to say inmigration is 34 percent and that it's more conservative if you say it's only 10 percent, that's not--that's what made no sense here. Because, earlier, they said inmigration's 5.5 percent. So clearly they believed, at some point in time, that some of these counties they routinely see patients from--it may not represent 10 percent of their total, but they routinely see patients from those counties. So we are--the term "inmigration" is something the applicants use. It's not really something the Agency uses. To us, the service area is everywhere you serve patients from. And so, in this particular case, what we're saying is, the assumption of 10 percent--and it could be 15 percent, so that problem still exists. You can't ignore it--isn't reasonable under these circumstances and here's why.

Q. If you look at Page 642 that you just referred to with the 5.5 percent inmigration--

A. Okay.

Q. --there the 5.5 percent refers to patients who come from counties other than the ones listed, correct?

A. Correct.

Q. So that could be--if you look at that license renewal application, that might be somebody from Georgia or South Carolina or somebody who was visiting from New Hanover County or however--
A. Correct.
Q. Okay.
A. But what I'm saying is, they're representing that inmigration is only 5.5 percent. They are breaking out their patient origin and listing these other counties and treating them as though they're part of their service area as they define it. But then, when it suits their purposes of trying to compare the 10 percent versus--now they're saying that inmigration's 34 percent, because they're treating those patients from those other counties listed in the table on Page 642 of the Agency file differently. And so we were not--we didn't find this notion that because--they were saying that the inmigration admissions in Asheville was 34 percent, that therefore 10 percent is reasonable--we're not accepting that. So that's all I'm trying to say here is that that--to just say, well, we'll compare the 34 percent to the 10. 10's less than 34. Therefore, it's reasonable. No, is the 10 percent

reasonable for Mission GI South. There are several problems. One, is it 10 percent, or is it 15 percent? And two, where are they coming from? And so there's--I told you, there are multiple issues involved here is the reason it should be found--that they didn't adequately identify the population to be served.
Q. Looking back at the chart on Page 667 of the findings, is it the Agency's finding that 7.7 percent inmigration from counties outside Buncombe and Henderson is a reasonable projection or would have been a reasonable projection?
A. No, because I believe we point out that--that that could be over--that is overstated, because the chart on Page 667, this total number of endoscopy patients, including the 508 from those counties, which represents 7.7 percent, that includes inpatients, as well as outpatients.
Q. What would you do to adjust and get to an outpatient number?
A. Well, you'd have to know what the percentage inpatient was, which I believe is somewhere reflected in the findings. (Witness reviews document.)

Q. I think the discussion you're thinking about is on Page 672.
A. It's in the methodology as well, so that's where I was looking.
Q. Okay. Wherever.
A. (Witness reviews document.) Yeah, she does mention that, based on a representation on Page 53, Fiscal Year 2010--this is on 672 of the Agency file--the findings state Mission Hospital had 2,531 inpatient cases and 3,982 outpatient cases. Thus, Mission Hospital's inpatient/outpatient split is 38.9 percent inpatient cases and 61.1 percent outpatient cases.
Q. You have to apply those percentages to the numbers on Page 667 to get to an outpatient number only, correct?
A. You could take that data and apply that outpatient/inpatient split to all of the counties represented there, and you could determine what the percentage of the total was for just outpatients from those counties.
Q. And so if you applied the 61 percent outpatient percentage to each of the counties as you've just said, you would get a number you would consider

reasonable in terms of inmigration?
A. This is--it's not about what I consider to be reasonable. This is about what the applicant failed to do. It's not my job--it's not our role to rewrite the application for them and come up with what is reasonable. What we're saying is, if you look at Mission's utilization by payor--by patient origin differently, and you look at the counties where it's reasonable to think patients--outpatients would utilize the Mission GI South facility, you don't get 10 percent. You get something less than that. You get--if you include the inpatients, you get 7.7 percent. If you did a different analysis, you'd get an even lower percent.
Q. In the Agency's analysis of the information in the application, there was no next step taken, in other words, to apply the outpatient percentage to the historical numbers to assess the reasonableness of the actual numbers in the application, correct?
A. Okay. I think I understand what you're saying. No, we didn't take this analysis further to further figure out what percentage of the total--and I mean total inpatient and outpatient--came from these

counties, because there are several--again, there are several issues with the immigration. First and foremost, is it 10 percent or 15 percent? We don't know. Where are they coming from? We don't know and if you base it on Mission's current patient origin for GI endoscopy services, it doesn't appear that 10 percent is reasonable.

Q. Based on what you've just said, then the analysis in the chart on Page 667 was not done to determine--to assess the reasonableness of the projections?

A. Okay. No, that's not what I'm saying. We're just illustrating that, if you look at Mission's total GI endoscopy patients, inpatient and outpatient, for the counties--it's a multi-step that you cannot take that one table in isolation. You have to look at the whole document, at the progression and the logic of all of our thoughts, not just this one table. First we've said, is it 10 percent or is it 15 percent? We don't know. We're not sure 10 percent's based on anything reasonable, because we don't know what the 10 percent consists of. But if we compare it to, and we analyze, Mission's current payor origin, and we analyze a map and roads, and

we look at and say, well, these counties that 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 list to--for Mission as a whole, there are other counties that it's not likely patients would go to Mission GI South. So when you look at only the utilization--this is historical, not projected. Maybe that's the problem. This table on Page 667 is not projected. It's historical, and it's historical for the whole hospital, all the patients it serves. We don't list the separate counties, but we do put the total number of procedures--cases here, patients. So it's about showing that, for those counties we've decided it might be reasonable, yes, they serve those counties; those patients could shift or 70 percent of them could shift; that doesn't add up to 10 percent. So it does--part of our analysis is we don't think the 10 percent's reasonable. We don't know what the 10 percent consists of. We don't know if it's 10

percent or is it 15 percent. And, furthermore, we don't think 10 percent, given the geography and the roads of where Mission's patients might be coming to Asheville but expected to shift to Fletcher, what percentage would that be, and we don't think it's 10 percent. It's certainly not 15 percent.

Q. If you look at the table on Page 668, could this whole issue have been avoided just by taking out those patients in the immigration categories? In other words--

A. Well, if the application didn't include a 10 percent or 15 percent immigration, it might have been a different outcome on this issue, but this isn't the only issue.

Q. Would you consider it reasonable to project all of your patients coming from Buncombe or Henderson zip codes for a project like this?

A. It certainly could be. I mean, this application was denied for a multitude of reasons. This is only one of them. The fact that we don't know whether it's 10 or 15 percent and the pro formas are based on 15 percent. If there had been no 10 percent immigration, if it was consistently 10 percent or it had been defined and where they were

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 inmigration; is that your understanding as well?

MR. JOHNSON: Object to the form.

A. My only recollection of this review is that--for example, the projected outpatient GI endoscopy procedures from the nine zip codes, I don't have a problem with those numbers. I don't recall having any problem with those numbers. So the assumptions and the methodology used, I don't recall any--it's when you get to the inmigration. And the combination of, is it 10 or 15 percent, and the pro formas are based on 15 percent--and I believe I've already testified at one point when we thought the only place in the application that said 15 percent was in the exhibit, we were initially thinking, well, that's just a typo. But then we get to the pro formas and, no, they're based on 15 percent. So--but then there are other issues as well that

don't have anything to do with the methodology or the assumptions, but they're described and discussed starting on 669 where we discuss some of this again. But all the other reasons are--basically start on 669 in Criterion 3.

Q. Okay. You're talking about Criterion 3 still only here. You're not talking about other issues; is that right?

A. Well, there's that, and there's also issues with Criterion 5 and Criterion 12 that we didn't believe were conditionable. So it's--when we're determining whether an application will be denied, we're looking at the whole application and all the review criteria. Each one is reviewed independently. Each one involves different issues, but they do impact each other. The issues raised in one may negatively impact our findings in another.

Q. The discussion that begins on Page 669 of the application is an analysis of need where you get into a discussion of Buncombe and Henderson County; is that right?

A. Correct. I believe, at the end of this, she may repeat some stuff about the inmigration, but

there's other issues discussed there involving the existing facilities in Henderson County and the utilization trends and so forth.

Q. Let's step back a little bit in time and talk about the pre-application conference before we talk about the discussion that begins on Page 669.

A. Okay.

Q. I understand that you attended one--at least one pre-application conference with Mission regarding this application; is that right?

A. There was a meeting regarding the building on the Henderson/Buncombe County line. I don't even recall whether GI endo was specifically mentioned or not. I do recall discussion about the satellite ED. I just don't recall if GI endo was specifically addressed in that meeting.

Q. That meeting was in 2010; is that correct?

A. I don't recall the date.

Q. You did not consider that a pre-application conference for the Mission South application though, right?

A. I--my memory of that meeting, I remember where we were. We moved a table especially in the room to hold it, because we couldn't use our break room

because of mold. Glad to get out of that building. I remember where we were. I remember some of the discussion. We may very well have discussed the GI endo application. I don't personally have, right now, any recollection of that. What I remember from that meeting is discussing a building that would be physically located on a piece of property that was in both Buncombe and Henderson Counties and discussing the satellite ED. That's what I remember from the meeting. That does not mean GI endo wasn't discussed. I just don't personally, right now, recall.

Q. In addition to that meeting that you just recalled, did you also participate in a pre-application conference regarding the Mission GI South application?

A. If I did, I have absolutely no recollection. All I recall--there may have been more than one meeting, but all I'm recalling is that meeting was in an anteroom where we had to turn the tables at an angle. And we had to move chairs, because you couldn't get the door open.

Q. Who--who attended the meeting that you remember?

A. I think Les was there. Craig may have been there.

Probably Brian Moore was there. But as to who else was there--there were a lot of people in the room, but I don't remember all their names.

Q. Were there representatives of the Construction or Licensure Section of DHSR there?

A. I don't recall.

Q. Do you recall ever participating in a meeting related to the GI South project that included members of the Construction Section?

A. I don't recall.

Q. What understanding did you take away from that meeting with--about the project that was discussed?

A. Mission and Pardee--Margaret R. Pardee Memorial Hospital were proposing to build a building on property already owned that was located--literally, part of the property is in Buncombe County and part of it is in Henderson County. And there was discussion about relocation of various services to that building. And what I'm recalling is the satellite ED, and I'm not sure which county it was 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 different county than the rest of the satellite ED,

and I said, unequivocally, no. I'm afraid that's all I recall of the meeting, other than where we were physically.

Q. At any point during the review of the GI South application, did you consult with the Construction Section or Licensure Section about the location of the project?

A. I don't believe I did. I don't know whether Ms. Miles did or not.

Q. Did you give Ms. Miles any guidance for her review of the application based on the discussions that you participated in regarding the location of the building on the county line?

A. I think you might have the cart before the horse. Ms. Miles brought to my attention that the drawings showed that the space for the GI endoscopy room, which would be licensed as part of the hospital, crossed over into another county, and so we discussed it.

Q. Before we talk about that, though, what I'm asking is whether you said to Ms. Miles at the beginning of the review, we've had these discussions with Mission about this location, here's what you need to know?

A. No, because any representations made at a pre-application conference or meeting, they're really not relevant to the review. What she has to review is the application that's submitted.

Q. There are references in the application to guidance received at the pre-application conference; did Ms. Miles bring any of those excerpts of the application to you to ask if they were accurate?

A. I don't recall her bringing any of those to my attention. It doesn't mean she didn't. I just don't recall at this time if she did or not.

Q. Why did you say emphatically that the ambulance entrance couldn't be in one county with the satellite ED in another?

A. Because there's a licensure rule that requires all the hospital--all the services that are under a hospital license to be in one county.

Q. I think you said you don't have any recollection at all of discussing the endoscopy process, correct, the application?

A. They may very well have mentioned the ORs and endoscopy rooms. We may even have talked about acute care beds, but what I remember is we were discussing sort of a joint venture, a building that

would span across county lines. And there was lots of discussion about that. And at some point there was some discussion about an ED--satellite ED. And somebody asked, I don't even know who, if the ambulance entrance could be physically located in a different county, and I said no based on my understanding of Licensure's rules.

Q. Just so I'm clear, you don't recall a second call or group coming to you as part of the pre-application conference for this particular project?

A. No. They may very well have. I just don't remember it.

Q. While we're kind of back at the beginning, I also wanted to ask you if you made the decision not to grant Mission's request for an expedited review?

A. That decision was made jointly by Mr. Smith and myself.

Q. Why did you decide not to expedite the review of Mission's application?

A. Because we were probably 99 percent certain that, if we had not scheduled a public hearing, that we would have been asked to schedule one.

Q. So you decided not to grant the expedited review request because you expected to receive a request

for a public hearing?

A. We expected to receive negative written comments, and we expected, if we hadn't scheduled a public hearing, that the people submitting--the facility submitting the negative written comments would also ask for a public hearing. So, if we were going to have to schedule one, it's a lot easier to schedule it from the beginning than to scramble to do it with very little time, particularly when it's got to be held in the far western part of the state.

Q. Why were you 99 percent certain that there would be parties who would request one?

A. It seemed pretty likely that Parkridge would object, which they did. And that is--this is not limited to this case. That is one of the things we consider when determining whether we will grant an expedited review. I believe the Macon one that you brought up the findings for, they may have asked for an expedited review, and we may have been totally willing to grant it. And I believe we were asked to hold a public hearing. And there have been others where we thought, well, we don't really feel the need to hold one, but I think we did one other recently where we decided we--Craig decided

we would just go ahead and schedule a public hearing and we would deny the request for expedited review, because we were pretty certain we would get a request for one.

Q. Had you had any discussions with any representatives of Parkridge at the time you made the determination to hold a public hearing?

A. No. This is one where I definitely consulted with Mr. Smith on to get his sense of whether we should just go ahead and schedule a public hearing.

Q. What--

A. And I usually do consult with him anyway on it. I don't--in other words, although technically it's supposed to be the Assistant Chief's responsibility to make the decision whether to deny or approve, I usually consult with him on all of them anyway.

Q. And what was the discussion surrounding whether Parkridge might oppose the--

A. I don't recall the discussion, just my recollection is the sense that, if I didn't believe it, that Mr. Smith believed that Parkridge would probably ask for a public hearing.

Q. Did Ms. Miles ever give you a draft of the findings that had a conditional approval?

A. Not to the best of my recollection.

Q. Did you talk with her about any conditions that would enable you to approve the application?

A. Ms. Miles tends to discuss with me at great lengths before she submits anything, so we would have already worked through all of the issues and concerns that she had spotted in the various review criteria before she ever submitted anything to me. So, in those discussions, we would have--if we had thought that conditioning anything was possible, we would have already discussed it then before she ever gave anything to me.

Q. Sitting here today, do you recall any discussions about conditions on approving this application?

A. This is not one, I believe, where we could have conditioned the applicant.

Q. And why is that?

A. They haven't demonstrated the need. They haven't demonstrated that the capital cost is the correct capital cost. They haven't--because of the way it's presented to us, it's not clear whether the developer will be incurring any costs that would make the developer need to be an applicant. I'm not sure if there may be some--in other words, by

looking at all of the issues and looking at all of the--some of them are things we just don't condition, because we don't know what they would present in response.

Q. We looked a little bit ago at some of the attachments to the comments by Parkridge and Carolina Mountain. They both attached documentation regarding Mission's certificate of public advantage and a study about that. Did you find that valid to the review of the application?

A. I was aware of what they had attached, because I'm the one who processes written comments when they come in. So I was the one who had to scan it all. I found some of it interesting. It's not--it's not the basis of the decision, any of the comments, with respect to the certificate of public advantage.

Q. You also went over Mission's response to those particular comments; is that right?

A. Yes.

Q. And did you go to the website referenced in Mission's response about the specific certificate of public advantage issue?

A. I'm not--right now, I don't recall what reference

you're talking about.

Q. Okay. Let me take you there. It is--it's the response to the comments on Page 540 in the Agency file.

A. I don't think I went to it. I don't know if Ms. Miles went to it.

Q. But the bottom line is, you said that discussion about the certificate of public advantage wasn't the basis of your decision to disapprove the application?

A. That's correct. The certificate of public advantage is a different statute from the CON law. And whatever issues there are with respect to that certificate are not issues to be resolved in a CON review. And if there--let me be clear. If there even are any issues, the CON review was not the forum to resolve those issues.

Q. And you're not saying there are or are not issues?

A. No, I mean that's not my law to--it's done by our Division. It's done by--it's the only--the only one that's ever been applied for, and it was actually done by Bob Fitzgerald, I think. He wasn't the Director at the time he did it, but I believe he was the one who was sort of the lead

person on that. I was--it occurred when I was a fairly wet-behind-the-ears project analyst. So all I have is hearsay from Mr. Smith that we--we, being, the CON Section--may have been consulted, but that would have probably been Lee Hoffman as Chief and perhaps Craig Smith as Assistant Chief. And I certainly wasn't involved in that.

Q. Let's look--let's go back now to the last part of the discussion under Criterion 3 in the findings. And as we said earlier, that begins on Page 669 of the Agency file.

A. (Witness complies.)

Q. As part of the analysis that starts on Page 669, Ms. Miles has findings regarding the existing rooms in Buncombe and Henderson Counties; is that right?

A. Correct.

Q. Was--why was the--why was the analyst and why were you concerned about utilization in Henderson County when the project was located in Buncombe County?

A. Well, part of it's located in Henderson County. Not a lot, but part of it is located physically in Henderson County. Because they're proposing to move this room literally to the county line. And there is a nexus between Criterion 3 and Criterion

6, and we were finding them nonconforming with Criterion 6. And so some of the same--if it--if 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 need and the impacts that each would have on the other.

Q. As part of the analysis of this aspect of Criterion 3, did you look at the information in Mission's application regarding the total number of procedures and rooms needed for Buncombe County?

A. Well, I didn't--I looked at portions of the Mission application. Don't recall right now what those are. So most of my time was focused on meeting with Gebrette, maybe looking at a page or two while we were doing so, and looking at her findings. So I don't know what part of the Mission application that you're talking about. If it's reflected in the findings, then definitely I--I looked at it. It may or may now be something where I actually looked at the source in the application.

Q. I will point you to those charts. It may be easier to look at Exhibit 16 in the application. Specifically, if you would, Ms. Frisone, look at Page 363 of the Mission application. It is Tables 7 and 8 to Exhibit 16. And particularly, did you look at Table 8 when you were conferring with Ms. Miles regarding the review?

A. I don't recall looking at that part. I think this is reflected--there are tables quoted in the findings that deal with Mission's representations

about--this is in one of the steps in the methodology.

Q. Uh-huh.

A. (Witness reviews document.) And I believe the table on Page 660, at the bottom, is from Table--is a quote from Table 7. So while I may not have looked at Table 7, I looked at the quote of Table 7 on Page 660--reflected on Page 660 of the Agency file.

Q. That is also on 648; is that right?

A. (Witness reviews document.) Yes, it is. Table 8 is on 649. So--

Q. To the extent they're in the findings, you did at least see them?

A. Yes.

Q. And if you're looking at the table on Page 649, Table 8.

A. Yes.

Q. Did you understand that table to determine that there is actually a deficit of endoscopy rooms based on volumes in Buncombe and Henderson Counties?

A. That's what the applicant concluded, yes.

Q. And did you disagree with the applicant's

conclusion based on the numbers in Table 8 from Exhibit 16?
A. Well, I don't know that we directly did so, but our analysis showed that utilization in Henderson County has decreased, and that the average number of procedures per room in Federal Fiscal Year 2010 was only 1,362. So I guess, to that extent, we don't agree with the conclusion drawn by the applicant as reflected in Table 8 from Exhibit 16 just quoted on Page 649 of the Agency findings--Agency file.
Q. That table takes into account the utilization for multiple years; does it not?
A. Which table are you talking about?
Q. The one we were just looking at, Table 8, that's on 649.
Q. Okay. You had deficits and surpluses calculated for '08, '09 and 2010, but that's for--based on the listed facilities, it has to be Henderson and Buncombe Counties combined. Our analysis looks at Buncombe County and then at Henderson County and shows that, if you don't combine them--now, in Buncombe County, the average utilization is 2,130 procedures per room, well above the target

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 surpluses--well, 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 room, an additional one in Henderson County, they--in addition to showing that there facility would be

at the target, then this would be certainly--this is the problem. The problem is they're moving the room to the Henderson County line. The suite actually crosses into Henderson County. And our analysis shows perhaps an outpatient-only room is needed, another one. There's already five in Asheville. But perhaps another one is needed, but perhaps it would be--the Henderson County line isn't the place for it is what we're really trying to say.
Q. If there had been no question in your mind that the entire endoscopy suite was in Buncombe County, sounds like you're still saying you would have had an issue?
A. Yes, ma'am. I need to stand corrected. You asked me if we'd ever considered a condition. We never drafted it, because other issues cropped up. But at one point we talked about whether it would be possible to condition--again, this is before we realized that there was the 15 percent inmigration used in the pro formas--we did talk about the possibility of conditioning an approval that the facility--the GI endo suite would have to be physically entirely located in Buncombe County. We

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.
Q. --storage and--
A. Yes.
Q. --bathrooms?
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 in 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 morning. I think the reason we were talking about

it is that there's something in the comments about it, but that we didn't necessarily agree with. I think we say something like arguably or something to that effect that--that it could be argued. I don't think we really believed that they really were proposing to increase the inventory in Henderson County, but it is certainly very, very close to the line. I would like to find where I-- it might be in Criterion 4. (Witness continues to review document.) Yes, Page 674 of the Agency file. It's in Criterion 4. It's the second full paragraph on that page. At the end of it, we do say the proposed project would arguably increase the inventory of licensed GI endo--endoscopy rooms in Henderson County. I don't think we were really convinced of that, but we could see where one could argue that.

Q. But it sounds like you're saying, even if there wasn't an argument to that effect, you still have a concern about locating this project on the county line?

A. I do. I do.

Q. Just in a general sense, not with regard to this Mission application, when you're reviewing a new GI

endoscopy room or an application for such a room, do you take into account utilization of existing providers?

A. I believe that we did so in the Davie County Digestive Health Specialists proposal, which I believe was reviewed by Ms. Miles and myself.

Q. Was the utilization of the existing provider a basis for denying that application?

A. We didn't deny it. We approved it.

Q. Was the existing provider's utilization below the target 1,500 per room?

A. Since it's the existing Davie County Hospital and they haven't built the replacement yet, yes. They only have a gastroenterologist about two days a week, half days at that, so. But, yes, we actually looked--if I'm recalling correctly, we actually looked at the projected utilization for the replacement facility, as opposed to looking at the historical. But we did take it into account. We reached a different conclusion, but we did take it into account. And it was also there were negative comments filed by Baptist. They did not ask for a public hearing. It remained expedited. And we had the applicant respond to the negative comments.

And so they provided information that showed that there was sufficient need in Davie County for one additional--one additional room. They only have one now. And based on their current volumes and they're projected volumes, that there was room for both.

Q. Was the new replacement hospital going to have one or more than one endoscopy room?

A. They weren't going to increase the number, but they were going to--we did grant them that replacing it, modernizing it, that they would be able to-- probably be able to keep a gastroenterologist there long enough or enough hours that they could actually do enough volume.

Q. Without that replacement hospital application, though, you couldn't have approved an additional room in the county?

A. I could have, because the applicant presented their data--it had a lot to do with how the applicant presented their data. In the Davie situation, they were able to provide enough data to show that there was enough potential volume for two rooms.

Q. Here, Mission's application shows an analysis that there's a need for additional rooms when you're

looking at Buncombe and Henderson County together--

A. But that's when you combine them.

Q. --but you didn't take that--

A. When you separate them, you see that Henderson doesn't need it. So the issue here is, do you need to move one of the Buncombe rooms closer to Henderson. And the answer is, based on our review of this, no, you don't. There's no need to move it closer to Henderson. It's still needed. It's not that there's an over supply of GI endo rooms when you--certainly if you look at them together. But when you break them apart, the need is in Buncombe County. And so you might have had a different result if the proposal had been to move one of them out of the hospital to become outpatient only but in a different location. So, here, a lot of it has to do with moving it closer to Henderson County.

Q. Why do you contend you must separate the analysis; you can't look at the Henderson County and Buncombe County combined in the way that Mission presented in its application?

A. Because when you separate it, you realize that you don't need to move another room--or one of the rooms--closer to Henderson County. If there is a

need when you combine them, you realize the need has to be in Buncombe County. It's not in Henderson County.

Q. Did you not find credible the representations in the application that the patients expected to be served would be closer to the location near the county line?

A. Well, the ones from the nine zip codes, I don't believe we had any question about that. The problem is on the inmigration, because they don't specify where they're--precisely where they're coming from. I think that's really what our analysis is saying is some of them don't live--if you just--if you're going by the Mission GI endoscopy current patient origin in Asheville, some of them don't live closer and aren't likely to utilize that facility.

MS. HARRIS: Off the record for a second.

(RECESS TAKEN FROM 1:01 P.M. UNTIL 1:43 P.M.)

Q. (By Ms. Harris) Ms. Frisone, continuing our discussion of the Agency findings regarding Mission GI South's application, we talked most of the morning about the Criterion 3 and the findings there. And I'm going to turn now to some questions

regarding Criterion 4.

A. Okay.

Q. And I believe some of it may flow into Criterion 5. The findings that we'll be mostly concerned about are on Page 674 and the next few pages.

A. Okay.

Q. Part of the analysis under Criterion 4 refers back to Criterion 3; isn't that correct? And specifically the very last paragraph on Page 675?

A. Okay. Well, that's just--the sentence says, "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." 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 under Criterion 4?

A. Criterion 4 deals with--what it says is "Where alternative methods of meeting the needs for the proposed project exist, the applicant shall demonstrate that the least costly or the most

effective alternative has been proposed." So our conclusion was that they didn't demonstrate that the proposal was the least costly or most effective alternative.

Q. You refer in the findings under Criterion 4 to the location of the room; is that correct?

A. You mean the location in Buncombe County?

Q. Yes. And--and I m looking--

A. Yeah.

Q. --at your findings on Page 674 at the top.

A. Right.

Q. So we're in agreement that one of the bases of your determination of nonconformity with Criterion 4 is the location of the project, correct?

A. That's probably a fair summary of those two paragraphs, yes.

Q. You said in the middle paragraph that, "If the entire project were located in Buncombe, there would be no change in inventory." And I believe we touched on that earlier as well; is that right?

A. Right. And this was kind of--that paragraph there is in response to the comments, which, if I'm recalling correctly, seemed to say that they were--that the application proposes an increase in the

inventory of GI endoscopy rooms in Henderson County. And we're explaining that, well, it is true, a portion of the suite does fall in Henderson County, and we could--you could argue that it would increase the inventory. I don't think we take that position, but one could argue that. And the reason I say we don't take that position is, if we had, we would have had to have found Criterion 1--I'm sorry--we--we would have mentioned it in 3.

Q. If a portion of the proposed GI endoscopy suite wasn't located in Henderson County, then the location wouldn't have necessarily been an issue under Criterion 4? I understand that it would have other places, but under--

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 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 is an issue in 4, it's moving it to that portion of Buncombe County. They haven't demonstrated the need to do that, and thus it's not an effective

alternative--the most effective alternative to propose to move it to that part of the county.

Q. One of the areas which Ms. Miles testified that she consulted with you related to the ownership and whether the developer should have been an applicant. Do you recall discussing that issue with Ms. Miles?

A. Yes, I do.

Q. And are the findings related to that issue at the bottom of Page 674?

A. This is one of the places where that shows up, yes.

Q. What was the concern that you had with regard to the ownership of the building and the developer?

A. I think we have to really start with Criterion 5 for that, or possibly 12. I'm not sure. I think it's good to start with 12, because 12 contains the quote from Exhibit 29. If I'm recalling correctly, there's a representation in the application--in the beginning of the application--and this is on Page 3 of the application; it's in Section I.

Q. The response to Question 10?

A. That's part of it, yeah. The representation here is that Mission Hospital will be leasing space for Mission GI South in a medical office building to be

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 of upfit costs at $100 a square foot. Then we subtract $92,500--or the architect subtracts it, we didn't. Then the architect subtracts $92,500 to come up with an interior upfit subtotal of $277,500. Okay. Not sure what that means either, what they mean by "less landlord tenant improvement allowance." But now we get to anticipated prorata share of site, shell, and core, and OB costs, 4.28 percent. Don't know what the basis for that is either, but that's reported to be $850,387. Then we get to "less 60 percent ownership adjustment-Mission 40 percent MOB ownership." And from the $850,387, they subtracted the $510,232 to come up with this associated building cost subtotal of

$340,155, for a total anticipated cost of $617,655. To the best of my knowledge, and to the best of--certainly based on what Gebrette told me, there is no explanation anywhere in the application--because I seem to recall she and I looking--that explains what that means. So what we're saying is, there isn't enough information regarding this 60/40 ownership adjustment between the developer and Mission. And because we don't know exactly what cost the developer is incurring, the applicant hasn't met its burden to demonstrate that the developer shouldn't have been identified as a co-applicant. Because they provided us with information we don't understand, and this is the only explanation we could find.

Q. Under what scenario would the developer need to be an applicant if it's not providing the endoscopy service?

A. If the developer is incurring any of the cost that would turn that space into space that can be licensed as part of the hospital for the performance of outpatient GI endoscopy services, then the developer has to be a co-applicant. We are not saying that the developer will be. What

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. At least our understanding of the statement on Page 3 was that Mission would be leasing it. Now, all of a sudden, there seems to be some owner. So we don't know how that capital cost that was said to be the cost of a new institutional health service, how was that derived? We don't know. We can't tell.

Q. Normally, a developer building a medical office building would bear the entire cost of the site shell core, correct?

A. Well, I don't know. What costs somebody incurs would depend on the agreement and the understanding between the parties. So the burden is on the applicant to tell us who is bearing what cost, and

then we decide, okay, the developer is not incurring any of the cost, what he's doing is something any developer could do, to build a building that would be occupied by insurance companies or lawyers.

Q. Did you review the exemption notice letter that the developer submitted to the CON Section during the review?

A. No, I did not.

Q. Did you look for that?

A. No, I wasn't aware of it.

Q. Did you understand from the application that a letter would be submitted?

A. If it said so in the application, and I--I don't know whether I was aware of it during the review or not. Apparently not.

Q. We marked the letter as Exhibit 4 in Ms. Miles' deposition. I believe you have a copy of it in front of you.

A. Yes.

Q. Did you get a chance to look at it before your deposition?

A. Yeah. Here, today. I did not look at it until today. It was already laying here, so I looked at

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 review?

A. No, I did not.

Q. Did you ask Ms. Miles to determine if a letter was submitted regarding the exempt medical office building?

A. I don't recall if I even knew that one had been submitted. So if I didn't know one was submitted, I would have had no reason to even ask Ms. Miles about it.

Q. Would you not expect an exemption notice to be provided for the medical office building involved here?

A. Well, if it's to be exempt, it does have to be provided by the developer in writing in order to be exempt. But people don't always submit those with the application or prior to an application. Sometimes they do; sometimes they don't.

Q. And what I'm trying to determine is whether you made any effort to determine if a letter had been submitted here to--to verify or--

A. No. No, I did not.

Q. Okay. Do you agree that the letter that we now see in Deposition Exhibit 4 is a letter determining that the medical office building on Highway 25 in both Buncombe and Henderson Counties is the office building in which the Mission GI project will be located?

A. I don't know that for certain. I didn't read the letter attached to it. I'm assuming that it is the same building, if that's what you're asking.

Q. Okay. Look with me, if you will, to the Mission GI South application on Page 110, which is in Section XI.

A. Okay.

Q. The response to Question 2(b) reads that, "Mission GI South will occupy leased space within a medical office building developed by a third-party developer. The MOB developer will file with the CON Section a request for an exemption from review to develop a medical office building." Did you review that answer during the review?

A. I don't recall, but probably, if we were looking for an explanation. But all it says is "will file"; it doesn't say they did file. And--

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--that Mission would be leasing space.

Q. Based on the information in the application and Exhibit 4 that we just reviewed, Mission was only required to include in its application the upfit costs for the space it was using, correct?

A. Mission was required to--I cannot agree with that. 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. Whether that's upfit costs or not, I can't say without more information. Because it appears from representations in the application that Mission will own the building, so that might be more than upfit costs. I don't know what that means when it talks about a 60/40 ownership adjustment. I don't know what that means. That's the problem. The application fails to explain what that means, and it appears to contradict the statement that Mission would be renting the space.

It sounds like Mission is going to own it, at least in part. And that the capital cost was somehow prorated based on this, and we don't know why or for what reason. This is--it isn't that the arrangement necessarily is wrong; it's just not adequately explained.

Q. There was information in the response to comments that related to this particular issue. Did you review--review that? And if you want to look back at it now, it would be in--around Page 535, 536 of the Agency file.

A. Yeah. But this doesn't--to answer your question, yes, we did look at this. And as far as we're concerned, this didn't explain the problem at all.

Q. Why not?

A. Well, if the developer owns 60 percent of the medical office building, then someone else owns 40 percent of it. And this does not tell us who is incurring the obligation to--to make that space licensable as a GI endoscopy suite as part of a hospital to do--it does not answer the question that we had.

Q. So you did not take from the information in the application and the response to comments that

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 center--or suite, excuse me?

A. I--I don't know what you're talking about. I mean, I know what it says here, and we did look at this, and this does not explain anything. Well, other than the 4.28 percent that I mentioned earlier and forgotten, that is explained, which is why you don't see anything in the findings about it. But I do not understand this $510,232 adjustment. Because it reduces the capital cost; it doesn't increase it. So I don't understand the basis for that at all.

Q. If you look at the top of Page 536, it references the name of the LLC that ultimately submitted the exemption request, correct?

A. Yes. Well, actually, no. The exemption request calls it the Keith Corporation.

Q. If you look at the letter to the CON Section, it references that Western North Carolina Healthcare Investors--Innovators, excuse me--LLC proposes to construct the building, and that's the same name that you see in the response to comments.

A. Okay. It's not worded the way I would have done it.

Q. The May 24 letter is not worded the way you--

A. Correct. If the proposed building is going to be built by Western North Carolina Healthcare Innovators LLC, then that's what should have appeared in the Re: line on the letter.

Q. But that looks like it was Mr. Brown's or Mr. Smith's error?

A. It was their choice. I won't even call it an error, how about that, since Mr. Smith is the Chief? It's just not how I would have done it.

Q. So you would not agree with the statement that the developer only needs to be an applicant if the developer is going to be offering the service?

A. No, the developer might have to be an applicant if the developer is going to incur some of the capital cost. It's not about who--it's not limited to who offers the service.

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.

Q. If, in fact, all the developer is doing is building the building, as represented, then the letter was correctly granted?

A. As long as he's not building the building and putting in the things that would make it a new institutional health service. I'm not saying he is; I'm saying that's what we would have to determine. That it's just a building, and that the cost to turn the space into a new institutional health service will be incurred by someone else. If he's--he or she--it--it's really an it--is going to incur any of that cost, then the potential exists that that entity needs to be an applicant. 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.

Q. The converse of that is, if the--Mission is the

only entity incurring the expenditures related to the health service, then Mission is the only entity that needs to be an applicant?

A. If the application satisfies us that Mission, identified as the only applicant, is the only entity incurring an obligation for a new institutional health service, then they're the only entity that has to be identified.

Q. Where do you look when evaluating that question in the CON law, or rules, or case law for guidance on what to include as a cost of the applicant versus the developer?

A. Well, in terms of what costs are incurred, I would now look to the Mission Asheville Hematology final Agency decision and the Court of Appeals decision. As for the authority that--or the proposition that anyone incurring an obligation--178A says no person shall offer or develop a new institutional health service without first obtaining a certificate of need from the Department. And the definition of new institutional health service in 176.16 says, new institutional health services means any of the following, including things such as 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. And it goes on and on. So what we're looking at is, who is incurring an obligation that meets one of these many definitions of new institutional health service. And I read the $2 million one--I don't think this project is $2 million, but then there's the relocation of a GI endo room.

Q. We talked about that earlier.

A. Right. So we're looking to see--what we want is to know that--who is incurring that obligation. And in this case, what the problem is is a statement that is not explained, some--which results in an adjustment, which we don't understand, does not explain, and we don't have sufficient documentation in the application to show that the developer won't be incurring an obligation for a new institutional health service.

Q. Ms Frisone, there is another discussion under Criterion 5 that's somewhat related that I want to take you to now. If--if you'd look at the findings under Criterion 5, the issue that we just discussed with regard to Exhibit 29 and the developer is

stated there, correct, under the table?

A. Yes, the first paragraph under the table on Page 675.

Q. And then you go--the--the next paragraph relates to the finding about start-up expenses?

A. Correct.

Q. And the--there's a conclusion that it's not reasonable to assume there will not be start-up expenses associated with the development of a new campus?

A. Correct.

Q. And utilities and insurance are given there as examples. Utilities and insurance are not typically considered start-up expenses, are they?

A. Well, they are by the CON Section. If you build a building, before you can get it licensed, before you can treat patient number one, you have to have electricity and water, and you have to pay for that. So I don't know who may have told you that the CON--certainly, the Assistant Chief considers it to be one of the start-up expenses.

Q. Okay. You didn't consider it to be a requirement in the review of the new replacement facility in Macon County?

A. And that may have been an error on our part. I don't know. I--remember, I told you I don't know what the application said.

Q. And utilities and insurance are not among the examples given on the CON application form for that section, though, correct?

A. That's correct. But that list in the CON application form is just an example of the types of things, the expenses that would be incurred before you can begin offering services. It's not meant to be exhaustive.

Q. Other than the application we're looking at today, the Mission GI South, has the CON Section ever found an applicant nonconforming with Criterion 5 for failure to include start-up expenses for relocation?

A. Well, I don't know about a relocation, but I--I believe I have found people nonconforming--well, I don't know if I've found them nonconforming. It has been an issue before. I just can't recall which review.

Q. Has it been an issue in reviews involving relocating existing services or just new services?

A. No, I'm thinking of relocations. I believe it has

been an issue.
Q. Can you give me an example?
A. No, I can't recall anything specific.
Q. There would not be start-up expenses, such as training of staff for relocation, correct?
A. There could be.
Q. If the staff is looking to moving from one place to another doing the same job, why would they need to be retrained?
A. You might have new staff you might have to train. I mean, I--we did not suggest that was one of the things omitted, but what I won't agree to is that it might never be. It could, under the right circumstances.
Q. We talked about this a little bit earlier, but there's not a definition anywhere of start-up expenses, right, other than what you include as examples in the application form?
A. Not in the CON law or rules, there's no definition.
Q. Is there an Agency decision holding that utilities or insurance constitute start-up expenses?
A. What do you mean by an Agency decision?
Q. A decision or findings or--
A. I--

Q. --declaratory 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 building up from scratch and--I don't--that's why I said I don't think it was nonconforming. I think someone alleged in litigation that these start-up expenses for a replacement facility were not sufficient, as in a nursing home. But we did look at start-up expenses. We did expect to see start-up expenses.
Q. In the nursing home case or here?
A. In the nursing home case. It was the New Hanover Bowden Nursing Home. If I'm recalling correctly, there were issues raised about start-up expenses.
Q. But you didn't make a determination of nonconformity?
A. Well, they do project some, and we found that it was sufficient.
Q. But are you saying categorically that representations like Mission made that it wouldn't have any is not believable?
A. Under these circumstances, it's not believable to

me. I mean, yes, it's an existing service in Asheville, but that building doesn't exist. So before they can--and it's going to be licensed as part of the hospital. So to have the Construction Section come in and look at it, it's going to have to have power and water. And to have power and water, it's got to be hooked up to those utilities, which means the deposits have to be paid, and you're incurring costs.
Q. Would you look with me at Section IX of the application, the start-up and initial expenses section that's on Page 106 of the application?
A. Okay.
Q. And the Question 1a asking for start-up expenses has in parenthesis underneath, "Expenses incurred prior to operation, such as staff training, inventory, et cetera"?
A. Yes.
Q. If Mission was bringing inventory supplies over from the main hospital to be available on the first day of operation, you would not expect there to be any inventory expense as a start-up cost, correct?
A. Those are examples. That's why we have "et cetera." In this case, the problem is how are--

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 the sorts of things one should be thinking about when you're creating a new location.
Q. How is it that an applicant is supposed to know what you'll count as start-up expenses?
A. It's up to them to present their information. We've given them examples. Other people have known exactly what we're talking about. If they don't, they can always ask us before they submit the application if they're not sure.
Q. When you do pre-application conferences, do you take notes?
A. No, I do not.
Q. Never?
A. Never.
Q. Does Mr. Smith take notes in pre-application conferences?
A. I have no idea.
Q. You've not seen him do so?
A. I haven't actually given it any thought or paid any

attention.
Q. Why don't you keep notes in those meetings in case you need them for the review?
A. I don't need them for the review, because anything they said in the pre-app--it's what's in the application, not what they said in the pre-app. And that cuts both ways. I don't use it against them either when they change something in the application. A lot of times, at the pre-app stage, they don't really know for sure all the details of what the project will look like.
Q. So if an applicant reflects in the application that it's doing what it understood it should be doing from the pre-app, then you just take them at face value?
A. Well, it depends on whether their understanding is correct, because I've seen people attribute statements to me in their applications that I know are not correct. It's not what I said.
Q. The discussion we had earlier with regard to the Exhibit 29 costs, you referenced Section--Criterion 12; is that right?
A. Yes.
Q. The Agency's finding of nonconformity with

Criterion 12 is based solely on this question you had about whether the developer should be an owner and whether all costs are included that needed to be included?
A. I wouldn't characterize it--yes, this is the issue. But the issue is, what is this 60/40 percent ownership adjustment. We don't know what it is. We don't have enough information about it. And we lack the information in the application that would assure us that the developer is not incurring any costs which are a new institutional health service.
Q. And--and that's not my question really. My question is, there's only one basis for your finding of nonconformity under Criterion 12?
A. You phrased it differently. There's--that--what I've just summarized is the basis. I don't know if you want to call that one or two. I mean, I don't want to quibble about it, but this is--what 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 about whether the developer is incurring an

obligation for a new institutional health service, because there's totally insufficient information to determine otherwise.
Q. If you'll turn with me now to Page 687 of the findings, Ms. Frisone, the last finding of nonconformity relates to Criterion 18a; is that correct?
A. Correct.
Q. The determination of nonconformity with Criterion 18a is based on the findings under Criteria 3, 4, 5, and 6, correct?
A. That's not how I would characterize that. Based on the finding that the proposal was--that the applicant did not adequately demonstrate the proposal was cost effective, and if you will--to learn more about why we believe that, then you have to go and look at all of what was said in Criteria 3, 4, 5, and 6. But the finding of nonconformity with respect to Criteria 3, 4, 5, and 6 is not the basis for finding it nonconforming with 18a. We find it nonconforming with 18a because we don't believe the applicant adequately demonstrated the proposal was cost effective.
Q. You didn't give any reasons other than to say "See

Criteria 3, 4, 5, and 6" though?
A. Well, we could have repeated all of what's in 3, 4, 5, and 6 here, but those same reasons are the reasons we believe the applicant didn't adequately demonstrate that it's cost effective.
Q. There are no new or different reasons given for the finding of nonconformity under Criterion 18a than provided elsewhere in the findings?
MR. JOHNSON: Object to form.
A. I have to disagree with you, because I don't believe that we ever say in any of those other criteria that the applicant didn't adequately demonstrate that it's a cost effective alternative. We actually say in 4 that it's not their most effective alternative. We don't actually say anything about cost. But the reasons given in those criteria are the same reasons why we're concluding that they don't adequately demonstrate that it would be cost effective.
Q. So I think I don't understand why you're disagreeing with me, I guess. Based on what you said, we're in agreement that the reasons that you gave under Criteria 3, 4, 5, and 6 are the same reasons that you determined nonconformity under

Criterion 18a?
A. I wouldn't express it that way. I would--the way I express it is we've made a--we're looking in 18a for the impact on competition in terms of cost effectiveness, quality, and access. We don't have any issues, that I can recall, with respect to quality or access. But we don't believe the project would have a favorable impact on cost effectiveness. And we say it sort of in an alternate way, that we don't--didn't adequately demonstrate the proposal is cost effective. If you want to know more about why we feel that way, why we concluded that, just look at what we said in Criteria 3, 4, 5, and 6. And arguably, we could have included 12.
Q. Your finding under Criterion 18a does not refer to competition at all, correct?
A. Our finding doesn't use the word "competition," but we're responding to what Criterion 18a requires an applicant to do. So even though we don't use the word, that's where we're coming from.
Q. So cost effectiveness and competition mean the same thing?
A. No. What Criterion 18a says is, including how any

enhanced competition will have a positive impact upon the cost effectiveness, quality, and access to the services, so that's how we evaluate that possible enhanced competition, in terms of cost effectiveness, quality, and access.
Q. Are there any additional reasons that the CON Section has for disapproving Mission's application that are not included in the Agency findings?
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 efficiently.
THE WITNESS: Sure.
(RECESS TAKEN FROM 2:29 P.M. UNTIL 2:56 P.M.)
Q. (By Ms. Harris) Ms. Frisone, following up on some of the questions and answers we've had regarding different costs to be incurred by the applicant as compared to a developer, I'm going to give you a couple of examples and just ask if I'm understanding your testimony correctly. When a

developer builds a medical office building, and for example, puts in an extra large air handler because the developer knows there will be a healthcare provider there, is that a cost that is a cost of the developer or the cost of the provider of the service?
A. That's not the issue as to whether it's a cost of the developer or a cost of the provider of the service. It's a question of--and I would have to look at the Mission Asheville Hematology final Agency decision before I would make any determination on it as to whether that--but--but for the new institutional health service, would you need that air handler, then some of that cost might be attributed to the--I don't know. I don't recall the specifics of the Mission Asheville Hematology final Agency decision well enough at this point. I would never try to make that decision without actually looking at that--at the--those two documents.
Q. I'm not trying to pin you down on the air handler versus something else. I was just trying to give a concrete example. But in that instance, the--the health service provider would not be paying for the

extra air handler directly.
A. And that's--that's--
Q. Is that part of your analysis?
A. But that's--I guess that's part of the problem with the approach you are taking. It's not about who the legal entity is who incurs the cost. It's not if you're a developer, you're never incurring an 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 we worry about who's incurring what. So I always start with, what are the costs and whether they should be considered necessary or essential and thus they become part of the new institutional health service, because you wouldn't incur that cost but for the new institutional health service. Then I look at who is incurring it, not the other way around.
Q. Do you also look at whether it's paid through an operating lease?
A. Some applicants will tell us in their application

clearly, concisely, and not with inconsistencies, that the developer will actually pay the subcontractors for the work, but that extra cost will be passed on to them in the lease payment. And I think we have found that to be an acceptable explanation, that in reality, yes, the developer is going to pay the bills because it's perhaps more effective for them to do it that way because they're the ones that have the contractual obligation between them and the subcontractor and not the eventual tenant. But the problem with the Mission GI South application is we don't have that level of detail to explain. I cannot stress enough I am not saying that the developer is developing a new institutional health service and should be an applicant. I'm saying we don't have enough information to determine that the developer is not. It's a lack of information that assures us that the developer's costs are just what you'd expect anyone developing a building that you're going to lease space in to incur--footings, foundation, roof, and so forth, and you will need HVAC. But we don't know enough about who is incurring what or--or even what the costs are to figure out if all of the

costs that amount to that new institutional health service have been included.

Q. Have you assessed whether an upfit allowance that's reflected in a lease from a--an office developer to a medical service provider is considered an operating cost or a cost that should be attributable to the provider's capital costs?

A. We evaluate each one based on all the information provided to us, so it kind of depends on what they say about it and how they describe it.

Q. So sitting here today, you don't have a position one way or the other about whether an upfit allowance should be considered an operating cost or a capital cost?

A. I don't know. It depends. I mean, I don't know--I have not--again, I come back to what's in the Mission GI South application is not sufficient for me to know who's incurring what costs and whether the developer is incurring--and whether--what it's done is it's cast doubt on that capital cost is that all of the costs necessary to make that space function as space licensable as a hospital for the performance of GI endoscopy services. I can't tell. There is insufficient information in that

application as submitted.

Q. If the--changing gears, if the Construction Section has--has said, or in the future says, it would approve plans where a bathroom or a closet for the endoscopy suite is across the county line, would you yield to--or defer to the Construction Section?

A. I--I don't believe that the Construction Section is even the appropriate section to make a decision about whether some portion of the space is across county lines. That's for Azzie Conley to decide, not for the Construction Section to decide.

Q. Well, if the Licensure Section and the Construction Section both said it was okay, would you yield to that and--and--

MR. JOHNSON: Object to form.

Q. --approve--I mean, approve the application, assuming all other issues were addressed?

A. If--if Azzie Conley were to say that that's okay, then, yes, I would defer--not yield, I guess that's probably why my counsel is objecting, that word--I certainly would defer to Ms. Conley, because it's not my rule to enforce; it's Ms. Conley's rule.

Q. Would you consider the Construction Section's input irrelevant?

A. On that particular issue, yes. They may be reviewing from the point of view of the bathroom can be across the hall, but it's not their rule to interpret or imply either. It's not a life safety issue. It's a licensure rule with respect to hospitals. It requires their services that are under their license to be in the same county.

Q. Did you check with Azzie Conley or anybody at the Licensure Section about the particular question you had about part of the space being over the county line?

A. No.

Q. Do you know if Ms. Miles did?

A. No, I don't know whether she did or not.

Q. Did you ask her to?

A. I don't recall asking her to.

MS. HARRIS: I believe those are all of my questions. Thank you for your time. Do you have any questions?

MR. JOHNSON: No.

(THE DEPOSITION ADJOURNED AT 3:06 P.M.)

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STATE OF NORTH CAROLINA
COUNTY OF WAKE

CERTIFICATE

I, Peggy F. Barbee, Notary Public-Reporter, do hereby certify that Martha Frisone was duly sworn by me prior to the taking of the foregoing deposition and that said deposition was taken by me and transcribed under my direction and that the foregoing 141 pages constitute a true and correct transcript of the testimony of the witness.

I do further certify that I am not counsel for or in the employment of either of the parties to this action, nor am I interested in the results of this action.

I do further certify that the stipulations contained herein were entered into by counsel in my presence.

In witness whereof, I have hereunto set my hand, this 26th day of January, 2012.

_____
PEGGY F. BARBEE
NOTARY PUBLIC FOR THE
STATE OF NORTH CAROLINA
NOTARY PUBLIC NO. 19953200118

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SIGNATURE

I have read the foregoing 141 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 MARTHA FRISONE)

STATE OF _____

COUNTY OF _____

Subscribed and sworn to before me this

day of _____, 2012

MY COMMISSION EXPIRES:

_____
NOTARY PUBLIC

Transcript of the Testimony of **Martha Frisone**

Date: January 26, 2012
Volume: I

Case: Mission Hospital, Inc. v. NCDHHS

Printed On: January 27, 2012

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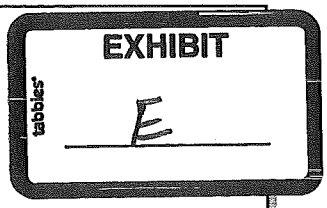

CAROLINA REPORTING SERVICE

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

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STATE OF NORTH CAROLINA

COUNTY OF BUNCOMBE

IN THE OFFICE OF ADMINISTRATIVE HEARINGS

11 DHR 11636

MISSION HOSPITAL, INC.,

Petitioners,

v.

N.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF HEALTH SERVICE REGULATION, CERTIFICATE OF NEED SECTION,

Respondent,

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.

DEPOSITION

OF

CRAIG R. SMITH

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

VOLUME I

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KRISTY SINK (VIA TELEPHONE)

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STIPULATIONS

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

1. 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 according to law;

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 answers 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 irregularities in the taking of the same, either in whole or in part or for any other cause;

5. 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

6. That the witness reserves the right to read and sign the transcript of this deposition prior to filing.

PROCEEDINGS

(WHEREUPON, CRAIG R. SMITH WAS CALLED AS A WITNESS, DULY SWORN, AND TESTIFIED AS FOLLOWS:)

DIRECT EXAMINATION BY MS. HARRIS:

Q. Good morning, Mr. Smith. We've met before. I'm here today to ask you questions related to the application we've been calling, as a shorthand, the Mission GI or Mission endoscopy application. Will you state your name and business address for the record, please?

A. Craig Richard Smith. And my business address is 2704 Mail Service Center, Raleigh, North Carolina 27699-2704.

Q. What is your current position?

A. I'm the Chief of the Certificate of Need Section.

Q. How long have you been the Chief of the Section?

A. A little over two years.

Q. And you've been employed with the CON Section for much longer than that?

A. Yes. I was Assistant Chief from 1994 to 2009 and a project analyst from '88 to 1994.

Q. Could you just briefly tell me your current job responsibilities and--and how you divided duties with the Assistant Chief, Ms. Frisone?

A. I'm responsible for the overall management of the certificate of need program in the State of North Carolina. And duties involve working with other sections of the Division with--when the questions come up that have mutual concern, working with the-- in particular, working with the Medical Planning branch in the implementation of the current State Medical Facilities Plan and the development of the next State Medical Facilities Plan. We have two team leader positions which are now vacant. Team leaders were envisioned to review most of the--or at least a significant portion of the decision findings. We no longer have that option, so we're back to the mode that we did for most of my tenure in the Section, where the Chief and the Assistant Chief divide up the reviews, and it's based on knowledge and availability. It's also based on other factors involving the workload, such as the current contested case schedules, depositions, other meetings.

Q. At the time the decision we're talking about today was made, were there--were there team leaders in place? That was in--

A. No.

Q. --August of 2011?

A. No.

Q. Do you typically--

A. Well, one was leaving in August or left either during August or shortly thereafter.

Q. Do you make the assignments of reviews to the analysts, or is that Ms. Frisone's job?

A. We usually collaborate.

Q. Did you have an opportunity to review either of the transcripts of depositions that we've taken thus far, Ms. Miles or Ms. Frisone, before your deposition today?

A. I reviewed a brief excerpt.

Q. Of both depositions or just one?

A. Ms. Frisone.

Q. What was that excerpt related to?

A. The--whether we had meetings prior to the application being submitted.

Q. And that--that was the only portion of Ms. Frisone's deposition you reviewed?

A. That's what I recall right now.

Q. Were you getting ready to say something else?

A. No, ma'am.

Q. Did you review any other documents or have any other conversations to prepare for your deposition other than with counsel?

A. The materials I reviewed were done in the presence of counsel.

Q. I won't ask you about your conversations with counsel, but I will ask what documents you reviewed other than the excerpts of Ms. Frisone's deposition?

A. I reviewed a letter from Ms. Gunter concerning the exemption that was granted for the medical office building.

Q. What's the date on the letter from Ms. Gunter?

A. I don't recall.

Q. Was it submitted during the review?

A. No, subsequent to the review.

Q. What was the substance of Ms. Gunter's letter?

A. Ms. Gunter believed the exemption may have been granted in error.

Q. Did she make a specific request in her letter to reconsider?

A. I believe she did.

Q. Was--did the letter show a copy to counsel for admission?

A. I--I didn't commit it to memory.

Q. Okay. Have you responded in any way to Ms. Gunter's letter?

A. Not at this time.

Q. Is it your intention to respond at some point?

A. We're contemplating it.

Q. Have you asked any additional information of the developer who submitted the letter?

A. That will be the first step should we proceed further.

Q. But you haven't done so yet?

A. No.

Q. I know you don't know the specific date, but was Ms. Frisone's letter--I mean, was Ms. Gunter's letter following Ms. Frisone's deposition in this case?

A. I don't know when Ms. Frisone's deposition was, but it was--the letter was generated as a result of this case, yes.

MS. HARRIS: Do you have a copy of the letter with you by any chance?

MR. JOHNSON: I think I actually do.

MS. HARRIS: Okay. When we take a break, I'd like to get a copy and may ask some further questions.

Q. (By Ms. Harris) So you told me that you reviewed Ms. Gunter's letter and the excerpts of Ms. Frisone's deposition. Did you look at the Agency file for the Mission GI application in preparation for your deposition?
A. I believe I may have looked at just the findings--portion of the findings.
Q. Do you recall the portion?
A. Criterion 3, I believe.
Q. Was there a particular concern or question that you had in reviewing the findings under Criterion 3?
A. I was just reviewing the portion of the analysis of the--the need conformity.
Q. I understand from discovery responses that you had some input into the discussion in the findings regarding the inmigration; is that correct?
A. They discussed their analysis with me.
Q. Did you contribute any edits or portions of the findings when they were being prepared?
A. I basically commented that I didn't have a problem with their--their decision on that particular issue.
Q. Do you know why they sought out your input on that particular issue?

A. Often, if there are issues that affect the conformity with the review criteria, I'll be consulted. Additionally, I was--my first assignment was, for those six years, was a project analyst in HSA I.
Q. So you were assigned to HSA I, which includes Buncombe and Henderson County in the--
A. Yes.
Q. --during the time you served as project analyst?
A. 1988 to 1994, yes.
Q. Have you served in any official role or been assigned to that area since 1994?
A. No.
Q. Have you been the reviewer or Assistant Chief or Chief assigned to review projects in HSA I in the last three years?
A. The assignments to review projects are not done based on geography, but I--I have reviewed projects in HSA I.
Q. What is the most recent project you think you reviewed in HSA I? And you don't have to give me the exact date obviously.
A. Well, we just--we just did a dialysis review in Shelby, and another dialysis review in Catawba

County, a nursing home review in Watauga County. Those are among the more recent.
Q. And you were the supervisor?
A. Yes.
Q. Okay. What about specifically in Buncombe or Henderson Counties, have you reviewed--
A. I may have been the one that reviewed the acute care beds that was submitted about the same time as this application.
Q. The public hearing for the acute care bed was held in conjunction with the GI application; is that right?
A. Yes.
Q. Did you attend that public hearing?
A. No.
Q. I didn't say this at the beginning, because I know you've been deposed many times, but if you need a break, will you let me know?
A. Sure thing.
Q. And if you don't understand one of my questions, will you ask me to repeat or rephrase?
A. Yes.
Q. Did your review of the acute care bed application for Mission in 2011 involve any study of traffic

patterns or how people may travel to particular services in the county?
A. My--my review did not.
Q. Do you recall supervising the review of any applications for services or equipment in Henderson County in the last three years?
A. Well, I'm currently reviewing a decision to relocate the nursing home from Fletcher Academy to a different site to the west of that area but still in northern Henderson County.
Q. I'm not familiar with that application. There's an applicant proposing to relocate an entire nursing home?
A. Yes.
Q. Okay. And is it from one side of Fletcher to the other or a different part of the county?
A. It's--it's leaving Fletcher and moving, I think, in the direction of Mills River. I'm not sure if it technically qualifies as Mills River or not, but--
Q. Who's the applicant in that review?
A. Well, Fletcher Academy is one--is the co-applicant, and that's the--the owner of the building. And it's the current operator that's working in conjunction with them.

Q. When is the deadline for rendering a decision in that review?
A. Next month.
Q. Is that the 90-day or 150-day?
A. 150-day.
Q. Did you conduct the public hearing for that application?
A. No, I did not.
Q. Who was the analyst on that review?
A. The analyst--the public hearing was actually conducted by Greg Yakaboski, but the review is being done by Bernetta Thorne-Williams.
Q. Are you evaluating roadways and traffic patterns as part of the review in that case?
A. The applicant has to discuss the impact of the relocation on the population that's currently being served and the population that--and the community as a whole. And since the--the decision is not final, I'd rather not discuss the specifics, because we don't like to give information that could be used in any way to forecast a decision.
Q. And you're expecting a decision to be issued at the end of March?

A. Middle--by the end of March. It could be issued sooner.
Q. And I'm--I'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.
A. Yes. 120-day application would have been filed in October.
Q. Are you familiar with the decision that was made with regard to moving a GI endoscopy room in Macon County from one location to another?
A. Yes.
Q. 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?
A. I was not.
Q. But you have reviewed the findings at one point or another?

A. I don't believe I reviewed the findings, but I believe we discussed the issue. I think the comments were filed.
Q. Comments were filed against the application?
A. I--I believe comments were filed and possibly a public hearing requested.
Q. Is it correct that the local hospital opposed and filed the comments regarding the relocation of the endoscopy center closer to the hospital?
A. I believe that's the case, but I--well, let's see. This is in '09. Let's see. The decision was made two years ago this month.
Q. So it's not fresh in your mind?
A. It's not fresh in my mind.
Q. Okay. If you'll look, Mr. Smith, on Page 5 of the findings in Exhibit 5 that you have in front of you, there's a finding of conformity with Criterion 3a, and a comment in the discussion under 3a that the new facility would be more centrally located near Angel Medical Center and other physician office practices?
A. Yes.
Q. I did not find in the Agency findings a discussion of how the relocation would impact Angel Medical

Center. Do you recall discussing the impact on the existing providers as part of the review or your consideration in 2009?
A. Well, they weren't planning to expand. They were 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 were--as 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.
Q. So it--it was a grandfathered room, as you--as you would say?
A. 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 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 things exist prior to there being any discussion in the law.

Q. Is that the procedure outlined in 2005 changes to the CON law or an earlier set of changes?
A. It was the 2007 procedures. Let's see. Do you have the law?
Q. I don't think I brought my SMFP with me today. I usually do. I looked the other day for another reason, and it seemed like it was longer ago than I realized.
A. It may have been. It may have just seemed--yeah, and it probably was.
Q. It was the procedure whereby--
A. Yes.
Q. --the party could submit an affidavit of--of using the room?
A. Yes.
Q. Okay. It's--the year is not the critical--
A. Right.
Q. --part for my question. All right. But if I'm understanding your testimony, when you're relocating an existing service that's already licensed, there's not a requirement to examine the impact on the existing providers?
MS. FRIEL: Object to form.

A. Not a requirement--nothing specifically in the law or the rules, no.
Q. Do you contend that it's within the Agency's discretion to examine the impact on existing providers for relocation of an existing licensed service?
MS. FRIEL: Object to form.
A. I'm trying to think of a specific example. I don't recall us doing that.
Q. For an application, then, to relocate an existing licensed service, your--you just typically review under Criterion 3 the need for the population proposed for the service in the new location; is that what you're looking at?
A. Well, yeah. We look to determine if the applicant has demonstrated the need for the facility in that location. And then we also look at the impact the relocation would have on the patients that currently use the facility, the community as a whole. And in--especially if there is a negative impact, if there--what that impact would be on the medically underserved. Typically, we discuss medically underserved under Criterion 13. I was going to say, you--most--most of our relocations have been adult

care homes, which are usually replacements of substandard facilities, a few nursing homes, mostly dialysis providers setting up satellite clinics as they outgrow their current location, as the nephrologists have done in the Buncombe County area.
Q. And I guess, based on what you said, you're looking to make sure that the patients or residents being served at the original location aren't disadvantaged--
A. Yes.
Q. --overly by having to go to a different location?
MS. FRIEL: Object to the form.
Q. Have you supervised the review of GI endoscopy applications that--
A. Yes.
Q. --applicants are seeking to relocate?
A. Oh. Seeking to relocate? Mostly, I've reviewed new ones.
Q. Have you reviewed applications for GI services in Buncombe or Henderson Counties?
A. No. Well, yes, the one that we did in 1993. The--I think it's the one with four or five rooms. It's located near Asheville. That was one of the first endoscopy reviews the CON Section did.

Q. You've got a good memory.
A. I don't--I don't recall whether I reviewed any subsequent to that.
Q. When you're supervising the review of an application, do you ever review the application cover to cover?
A. No. Well, rare--rare--I would say I may look at a large portion but usually some of the exhibits. The application itself, I may come close, especially if it's a thinner application. But usually, when it gets to the exhibits, I would only target one or two that are pertinent to the specific issues that have been raised.
Q. Do you rely on the analyst to raise particular issues with you?
A. Usually. Normally, unless there's something that might be aware of.
Q. Do you typically review the competitive comments when you're supervising the review of an application?
A. Typically.
Q. And you don't typically attend the public hearing, correct?

A. No. On one or two occasions, I have conducted the public hearing. It's usually--I did--there was a-- a health law seminar in Charlotte one year, and we had a public hearing we had to hold for a replacement nursing home. It was moving a couple blocks away--a couple miles away, excuse me. And it was the kind of hearing that we knew there would probably be about as many people as there are in this room at the hearing. It didn't make sense for us to--I had been asked to be on the program, so I-- I was going to Charlotte anyway. So I did the other hearing to save the State some money.

Q. That makes sense. Have--do you--how do you ask or instruct the analyst to take into account the competitive comments that are filed?

A. Well, you read them, try to understand them; you look at the responses; you look in the application to see if the matter was addressed in--as alleged in the comments; and then you make your decision based on the information available as it comports with the law and the rules.

Q. Is there any--

A. I mean, sometimes people want you to do things that you just can't do.

Q. Can you give me an example?

A. Well, I mean, the Macon one, I guess, we could have denied it. But, I mean, we would have had to--we would have been hard pressed, I think, to come up with a reason. You know, I mean, they--the reason they wanted us to deny it is because it didn't have a certificate of need, but they were clearly--they were licensed. They were clearly legal in the context of the requirements of the CON law in effect at the time they got their license.

Q. Do you ask the analyst that you supervise to review comments or--filed at the time of the public hearing, or is that typically done later in the process?

A. I don't understand your question.

Q. Sorry. It wasn't coming out quite the right way. When you are supervising analysts, do you instruct or ask them to review competitive comments before the public hearing?

A. No.

Q. Do you leave that up to them?

A. No, usually they don't. You know, ideally, it's nice if--if you could. But usually--sometimes your work schedule doesn't allow you, because there are

applications coming in every other month. Generally, that's about when you're wrapping--when you're doing the public hearing is about when you're trying to wrap up another review.

Q. How many analysts do you have on your staff at this point?

A. We have 12 slots. We have one vacancy that we're recruiting for.

Q. And do you--do you have to keep up with how many applications you typically review in a year; is that a statistic that you know?

A. Well, I just happened to fill out the AHPA report yesterday. And for the fiscal year that ended in July--June, we had 147 applications.

Q. And I guess that ebbs and flows each year, depending on what's in the Plan?

A. That's the lowest it's been in a long time. Well, yeah, the Plan has been generating less activity, with the exception of this year, in the 2012 fiscal year, with the 16 applications we got in Wake County for nursing home beds. And the--and the--and, of course, that's driven in part by the decreasing utilization of the--well, all health services--or not all--most health services, especially acute care

services, and to a somewhat lesser extent, long-term care services. I've not seen a decline in the dialysis volume.

Q. We--we've already talked a little bit about the Mission GI application, but I want to take you back in time a little bit. As I understand it, there was a meeting in 2010 where members of Mission staff, Pardee staff, the Certificate of Need Section, and the Construction Section met to discuss a project on the county line. Do you recall attending a meeting in 2010?

A. I think I did. But I checked my calendar yesterday, and unfortunately, the only thing on my calendar are Division staff meetings and the application day. For--I think, in a conversion, we may have lost some--I may have lost some data, because I had a considerable amount of sick leave that month. I mean, just a whole bunch of--there's nothing there. There's nothing in March. There's nothing in a good portion of the year. So I cannot confirm from my calendar that I did attend, but I believe it's likely that I would have been there.

Q. Do you have a specific recollection of attending a meeting that involved the Construction Section--

A. Well, there were two--I don't know specifically. I mean, the--the Construction Section, no, I don't have a specific recollection of that. I did find in early February last year we had a pre-application conference--
Q. And what do you recall about--
A --for the--this specific project. I recall it was in a different part of the building. We had to kind of gather in a room for--that--where the fire alarm center is.
Q. Was that because of the size of the crowd?
A. Partly because of the size of the crowd. partly because of the availability of rooms, partly because we had found mold in our section--part of our section of the building, and we'd moved staff out.
Q. You hadn't actually moved to the new building at that point?
A. We had not moved to the new building, no.
Q. That was later during the review of this application?
A. The--we moved to the new building effective June 1st. And that calendar notation says Nancy Bres Martin was in attendance, so.

Q. She's sitting where you are sitting today in another case. Do you recall if Mr. Moore, who's sitting with us, was at the meeting?
A. I believe he was.
Q. Okay. And were there other CON Section staff in attendance?
A. Yes.
Q. Who do you recall?
A. I don't specifically recall.
Q. Do you have any recollection of Ms. Frisone being there?
A. At this time, no.
Q. But she could have been, you just don't recall?
A. Right.
Q. What about Les Brown?
A. He may have been. It would have been likely for him to be there since he's the analyst that typically does HSA I projects.
Q. Speaking of that, he--he did not actually do the review of the Mission GI application?
A. Correct.
Q. Do you recall why?
A. At this time, I do not, but it may have been there were other projects that we assigned him to.

Q. I understand from Ms. Miles' testimony that she did not participate in the pre-application conference?
A. That would be likely.
Q. Did--were there any--well, let me ask this. Were there any other representatives of Pardee there, to your knowledge?
A. I don't remember.
Q. Do you recall discussing the GI application and what needed to be presented in terms of information?
A. At this time, no.
Q. Do you recall anything about the discussion?
A. Not specifically.
Q. Do you recall that there were questions regarding the space being on or near the county line?
A. Yes.
Q. Have you reviewed before a project like this one that was literally adjacent to the county line?
A. I don't think so.
Q. Was that a novel idea for you?
A. Well, it presents both opportunities and obstacles.
Q. What obstacles does it present, in your view?
A. The health service--the licensed health service facilities need to be in one county or the other. And if they are affiliated with another--and I'd say

health--not just health services--health 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 license--in this case, under the license of a facility in Henderson County, they need to be in Henderson County.
Q. And is that true of every square inch of the space or just the--for example, the licensed endoscopy room?
A. I'm not the one that actually enforces that statute, but I would think it would be the entire endoscopy suite, to include the rooms--the patient waiting areas. I mean, especially if it were set to be separately licensed. And--in other words, what could be--when I say what is separately licensed, but what could be--because when you are approving a project like this, one of the things you have to keep in mind is it could be sold at some point in time in the future. And for it to be sold and licensed or just licensed as a separate facility, it would, again, have to be intact in one county.

Q. And--and that's in the case of a freestanding licensed facility?
A. Well, I mean, if you're creating a separately licensed facility, it has to be in--in one county. And if you're creating space that is not separately licensed but licensed as part of a facility in--in a county, you know, I would think it would be the same--in my mind, it would be the same concept.
Q. You said earlier you weren't the Section that typically enforces that. Is that--is the Licensure Section--
A. That's my understanding, yes.
Q. Have you had any discussions with anyone from the Licensure Section regarding this Mission GI project and where it lies?
A. No.
Q. Do you know if anybody in your Section did so during the review of the application?
A. I do not know.
Q. You did not ask anybody to do so?
A. No.
Q. Since the decision on the Mission GI application, have you had any discussion with the Licensure

Section about whether it would permit a portion of the support space to be over the county line?
A. No, I have not.
Q. Have you had discussions with anybody in the Construction Section about the same question, whether it would be permissible, from its perspective, to have any of the support space across the county line from the licensed--
A. No, I have not.
Q. Are you aware of any decisions by the Construction Section or guidance from the Construction Section on that question?
A. No, I'm not.
Q. Once a project is approved, from your perspective, and a CON issued, do you or your analysts interact with the Construction Section at all as the project is being developed?
A. From time to time.
Q. What types of issues have you encountered?
A. Sometimes, when they're reviewing plans, they'll have questions, and they'll call us as they prepare a response to the--or to the submittal of the plans for clarification. And it may be number of rooms, size of rooms. It's a variety of issues.

Q. If the Construction Section doesn't have a concern about whether the project it's reviewing is consistent with the CON, then you don't get involved; is that right?
MS. FRIEL: Object to the form.
A. Well, sometimes we have issues with whether they are making substantial progress. So that would be one--we might contact the Construction Section to see if they've received the plans, or they received preliminary plans and that was six years ago and there hasn't been a submittal of anything else.
Q. Okay. And if the--if the answer to that question is no, then you might contact the CON holder to ask what's going on?
A. Yeah. Sometimes we contact them, because the CON holder is not necessarily responsive.
Q. There's not any sort of required reporting between your Sections on particular projects; is that right?
A. No.
Q. No, there's not any reporting, or, no, that's not right?
A. There's not any required reporting.
Q. If you have questions related to facility licensure, do those go to the Chief, Azzie Conley?

A. Usually.
Q. And is Ms. Conley still the Chief of the Licensure Section?
A. Yes.
Q. Going back to the pre-application conference that we referenced and you had on your calendar in February 2011, do you recall any discussion regarding how to allocate costs with a project involving a medical office building being developed by a third party?
A. It may have come up, but I don't recall specific guidance beyond, I think, we referred to a case where Mission had been involved in appealing a decision that I believe clarified--the Court of Appeals decision clarified what counts and what doesn't count.
Q. And that's the case that involved Mission and Asheville Hematology?
A. I believe that's the case, yes.
Q. So am I understanding correctly that you looked to the Court of Appeals decision to--
A. No. We told Mission that they needed to look at this case since they were intimately more familiar with the issues than we were.

Q. A couple times in her deposition, Ms. Frisone referred to that same case and said that she often looks at the final Agency decision for--for guidance on issues related to how a project is defined. Is that consistent with your understanding?

MS. FRIEL: Object to the form of the question.

A. In that particular case, the second final Agency decision--I believe it would be the second--in that case, the--there were two final Agency decisions.

Q. Yes.

A. Yes, that's what got me for a second there.

Q. Sorry. And included in the issues addressed in that case was what costs you count towards the projects versus--

A. Yes.

Q. --other projects; is that right?

A. Yes.

Q. Do you recall referring to or suggesting that Mission review the guidance that Jeff Horton issued on satellite projects for hospitals?

A. That would be likely that we did.

Q. You don't have a specific memory though?

A. No. I mean, it--it seems reasonable. I can't remember specifically telling anybody that, or--but that doesn't mean that it wasn't discussed. I would believe it would be--would have been appropriate for us to have discussed it. And--and 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.

Q. And--and some of those issues relate to the reimbursement on a federal level for satellite projects that are hospital-based?

A. I haven't looked at that probably since--assuming we--you know, probably since before this application was filed. So I have learned that, if I want to speak definitively on something, I track it down and read it.

Q. Do you recall having any specific concerns about the application that was described to you in the pre-application conference?

A. I don't understand the question. It's not specific enough.

Q. Sure. We spoke a minute ago about the fact that his project was on the county line, and it presented opportunities and obstacles from your perspective.

Maybe a better way to ask it is, did--did it--did you have concerns about other obstacles that the applicant might face beyond the--being in one county or another?

A. Well, we're aware of the relationship between Mission and Park Ridge. And so we knew--we felt--we didn't know, but we had a strong inclination that Park Ridge would be concerned about the project.

Q. And in fact, it did file comments opposing?

A. Yes.

Q. Does the fact that another provider has a history of opposing projects enter into your consideration in the review?

MS. FRIEL: Object to the form.

A. What it entered into was the decision to hold a public hearing.

Q. In the Agency file, there is, in fact, a request from Mission to have expedited review, and that's--there are documents in the Agency file, which I think is in front of you, marked as Exhibit 3, in the first section involving correspondence, I think Pages 5 through 16, not every page, but in that range, if you would like to look to refresh your recollection. Ms. Frisone recalled making a

decision in conjunction with you to set this case--this application for a public hearing. Do you recall discussing that issue with her?

A. Yes.

Q. And why did you decide to hold a public hearing and deny the request for an expedited review?

A. It was our belief that one would be requested, number one, by Park Ridge. And even if it weren't requested, we felt--well, we had to--I 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.

Q. Is it the CON Section's normal practice to schedule public hearings when opposition is anticipated, even if not required?

A. I think it would fall within the concept of within the public interest. And it--it's much easier to schedule the public hearing and give people notice well in advance because the--the--actually, the ad that's published in the paper, the notice that's published in the paper puts out the information, the public hearing, and a press release is sent out. And it beats trying to do that in just--in less than

three weeks if one is requested when the comments are filed. Then--then your--your work--you're trying to schedule a hearing, and then Party A pushed your scheduling forward and says, oh, I can't go; I'm on vacation. And then--so you try to change it, and then Party B says, well, I can't go. So, I mean--so we just try to schedule it up front. Logistically, it's much easier. Sometimes you can't find a suitable hall for when you want to hold one, because we like to hold the hearing as close to possible toward that 20th day, as specified in the law. And sometimes there's not a suitable venue to hold the hearing, so, I mean, that makes it a challenge also.

Q. I understand what you're trying to say about the practical considerations of scheduling a public hearing. Do you--was there anything unique about the relationship between Mission and Park Ridge that caused you to act differently in this case than you would normally?

A. No, I wouldn't say I acted differently. We--we had a GI endoscopy application in Halifax County that had been denied on two previous occasions, and they

applied again. And we've scheduled public hearings all three times.

Q. Is that application, the third one, under review now?

A. No, the third one was approved. It was appealed, but they settled.

Q. Was there a competitor involved in the appeal process?

A. It was not a competitive review, but the--the community hospital--it was more analogous to the Macon situation, except it did not involve the relocation but involved licensing a second room. There is--I--there is a grandfathered-in physician office, so it's not a licensed facility. But there is a physician office provider who wanted to become licensed.

Q. And when--when you said "they settled," you meant that the hospital and the GI practice reached some sort of agreement?

A. Yes, they did.

Q. I'm going to ask you some questions about the inmigration analysis in the findings. And we can turn to that now, but if anybody needs a break, we can do that now, too.

A. Sure.

Q. Are you okay to keep going or--

A. Well, I just need some more water.

Q. Okay. We'll take just a really short break.

(RECESS TAKEN FROM 11:02 A.M. UNTIL 11:13 A.M.)

Q. (By Ms. Harris) Mr. Smith, I'm going to ask you some questions about the Agency findings under Criterion 3. Do you have those in front of you?

A. Yes.

Q. Okay. And also in the--I don't know that you need to look at it, but you're welcome to--in the discovery responses, which are Deposition Exhibit 1, it was--it was revealed that you were consulted on the inmigration analysis. And I think I asked you that earlier. Is--is that consistent with your memory?

A. Yes.

Q. And did you have a particular experience with how to analyze an applicant's inmigration projections that you shared with Ms. Frisone and Ms. Miles?

A. I don't understand your question.

Q. I may not have understood the testimony correctly. But one or the other said that you had some particular experience, either with the area, or with

inmigration issues, or projections in general, that caused them to consult with you on whether Mission's inmigration percentage in this application was reasonable?

A. I have driven around the area on numerous occasions. That may have been what was the basis of some of their questions.

Q. I know you said earlier that you agreed with the decision to find the application nonconforming with Criterion 3. Were you focused in particular in your review on the percent of inmigration that Mission projected?

A. My understanding is that inconsistent data was provided with regard to patient origin.

Q. And was that the source of the--the source of the nonconformity in your understanding?

A. It was a component of it in my understanding.

Q. Did you have an objection to projecting 10 percent inmigration from areas outside the defined service area as--as a matter of principle, or was it just based on the information in this application?

A. It was based on the information in the application.

Q. So 10 percent is not, per se, unreasonable?

A. No. And I've testified in a recent deposition that the service area and inmigration are affected by the size of the service area. So the more narrowly drawn the service area, the primary service area, then the potentially larger the size of--the larger the amount of inmigration.
Q. What deposition did you give and--and address the inmigration and service area definition?
A. I said the small--are you asking me to restate what I just said?
Q. No, I'm asking you what case or what context?
A. Oh. That would have been in the--the Wake bed review.
Q. The acute care bed?
A. Yes. So it ultimately is a case by case, very fact dependent.
Q. Would you consider it reasonable to have zero inmigration?
MS. FRIEL: Object to form.
A. If you drew a large enough service area, I suppose, for some services.
Q. But--but, again, you'd have to look at the specific facts?
A. Right.

Q. I think that you've kind of addressed it, but just--would you define for me what--what you consider to be inmigration in the context of a CON application?
A. Well, it's really defined--it's also defined by the applicant, what they consider inmigration.
Q. Is it patients who are coming to the service from outside the defined service area?
A. Generally, yes.
Q. Were you aware that, in the Mission GI application, the defined service area did not include all of Buncombe County?
A. Yes.
Q. So some of the inmigration would have been from other parts of Buncombe County; is that right?
A. Potentially, yes.
Q. One of the objections that Ms. Miles and Ms. Frisone expressed in their depositions related to, I think, Mission not being specific enough about where the patients would be coming from in that--if--if they were coming from outside the defined service area. Did you discuss that specific issue with them?
A. I don't recall all the specifics of the discussion at this time.

Q. When you are supervising the review of applications in which an applicant proposes a certain percent of inmigration from outside the defined service area, do you require a specific definition of where those patients are coming from?
A. The more clearly defined it is, the easier it is to find an application conforming.
Q. Well, in terms of this application, where some of the inmigration was coming from parts of the county where the service would be located, would you expect a zip code specific description of the inmigration?
MS. FRIEL: Object to the form.
Q. That seemed to be what Ms. Frisone and Ms. Miles expected, and I'm trying to understand the Agency's position.
MR. JOHNSON: Object to form.
MS. FRIEL: Object to form.
A. It could be.
Q. Is there any rule or other guidance that an applicant could look at from--from the CON Section to understand how to describe adequately in their application where patients who inmigrate are coming from?

A. It--it's really very much application-specific. Some folks use--start by using a radius or a grouping of counties. And sometimes they narrow it down to zip codes within the radius of those counties.
Q. But there's not a requirement that you specify by zip code a specific segment of your anticipated patient origin?
A. It--it's usually based on the data that's available. The zip code is often used because that's tied to the person's mailing address and that's where you send the bill. So that's information you have about the patient that you can get with some degree of accuracy on a map. Those zip code maps are quite irregular, and they often cross county lines, which can compound. Or in some cases there are very few zip codes in a county, and they're--they're very large, so they don't give you additional specificity. So, I mean, you have to sort of work with what you--what you--you sort of have to work with what you've got.
Q. And if you--if you're in an area where there are rather large zip codes and not much specificity,

what--what else can an applicant do to further define the service area?
MS. FRIEL: Object to the form.
A. I believe I've seen some that are based on census tracks. But those are--those then use a demographic model--incident rates and demographic models.
Q. But you don't have a specification or a direction to applicants that you--you ask the applicants to explain?
A. No.
Q. Will you look with me on Page 666 of the Agency file, which is still within the discussion of conformity of Criterion 3; do you have that in front of you?
A. Yes.
Q. In the last paragraph on that page, there's a finding that, "It is unreasonable to assume that patients from certain counties would bypass Mission and travel to Mission GI South, particularly north of Buncombe County"; do you see that?
A. Yes.
Q. Was that finding based on input from you to Ms. Frisone and Ms. Miles?

A. It--I may have--I believe I did have some involvement in this discussion, yes.
Q. And why is it that you think that it would be unreasonable to assume that patients would bypass Mission and travel to Mission GI South where it was located on a highway?
A. It's for--it's further.
Q. Is that the only consideration that was given?
A. Those--those--that would have been a basis for my concurring with their logic.
Q. Would you agree that, in certain locations, patients 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't--I never thought Mission was that hard to get to from the highway.
Q. And--but my question was, would you agree that a patient might choose a healthcare location that was further away from his or her home if it was easier to get to on--on a particular highway--
MS. FRIEL: Same objection.
Q. --than the facility that was closer?
A. They--they might.

Q. You said earlier that you had driven around Asheville quite a bit. The--have you driven on the I-26, I-40 area?
A. Yes.
Q. Do you have an understanding about how a patient chooses a GI endoscopy provider?
A. They're usually referred by their primary care physician.
Q. So they're referred by their primary care physician to a GI specialist?
A. Yes.
Q. Does the GI specialist then typically govern which facility the patient goes to for the--an endoscopy procedure?
A. Well, if the physician has their own endoscopy center, we usually know where they're going to go. If the patient requires--I'm going to use the term "special handling," they usually go--end up going to the hospital.
Q. You would agree that a patient doesn't make the decision of the endoscopy facility on his or her own?
MR. JOHNSON: Object to the form.
MS. FRIEL: Object to the form.

A. No, but they--the physician may schedule it, may give them a choice. Would you rather have this done here or there? Because, in this case, this would present an opportunity for a choice. Right now, there is--if they're being referred specifically to Mission for a procedure, right now there's no choice of where to go within--within the Mission framework. There is the choice of the endoscopy center. And I'm going to just keep my discussion to Buncombe County.
Q. Just to make sure I understand, that all the Mission GI rooms are on the--the downtown campus?
A. Yeah.
Q. Given that reality, do you think it was unreasonable for Mission to seek to relocate an operating--I mean, a GI endoscopy room to a location that was outside its main campus and more accessible to certain patients?
A. No.
MR. JOHNSON: Object to form.
MS. FRIEL: Object to the form.
Q. Assuming that--well, let me ask you this. Hypothetically, if the application had been conforming with all the criteria in the Agency's

review, would there be any barrier to approving an application to relocate an operating room to the county line?

MR. JOHNSON: Object to form.

MS. FRIEL: Object to the form.

Q. So long as it was on the Buncombe County side?

A. If--if the application were conforming with all review criteria, it would have been approved.

Q. Mr. Smith, will you look with me now at the findings under Criterion 4?

A. (Witness complies.)

Q. And before I ask a specific question, are there--is there any other part of the Agency's findings under Criterion 3 that you recall discussing with Ms. Miles or Ms. Frisone that we haven't talked about this morning?

A. Not at this time.

Q. The findings under Criterion 4 begin on Page 673, but my questions are going to relate to Page 674 and 675. Did you have any discussions with Ms. Frisone or Ms. Miles about the location of the property as--as described in the findings on Page 674? Feel free to take a few minutes to review if you'd like.

A. (Witness reviews document.) I believe we discussed the information that starts with Exhibit 29 and 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.

Q. You're saying you talked about the information you had in that regard?

A. I--I said that I--my testimony is that I discussed that with Ms. Miles and Ms. Frisone.

Q. And we've also talked about that a little this morning, but am--am I correct in understanding that, because some of the space appeared to have been over the county line, the CON Section did not feel that it could approve the application?

A. Yes.

MS. FRIEL: Object to the form.

Q. And that's based on your understanding of the licensure rule regarding a hospital being licensed in only one county?

A. Yes. And then my--additionally, my understanding is that a facility can only be located in one county.

Q. And you define facility to include everything that's needed?

A. Well, in this case, it would be the endoscopy suite, because it has the potential for becoming a facility at some later date.

Q. And by endoscopy suite, do you mean the room itself plus the support space?

A. Yes.

Q. The--the second paragraph on Page 674 states at the end that the fact that a portion of the suite was over in Henderson County would arguably increase the inventory of licensed GI endoscopy rooms in Henderson County. Did you consider Mission's project to involve an increase in the inventory of licensed GI endoscopy rooms in Henderson County?

A. I wasn't focused on that part of the findings.

Q. By--by saying you were not focused, that means you didn't have involvement in that--

A. I don't--I don't recall discussing that specific comment that was made in these findings.

Q. Sitting here today, do you agree or disagree with the comment that it could increase the inventory in Henderson County?

A. I haven't given it any thought.

Q. The discussion under Criterion 4 continues in the last paragraph on Page 674 and refers to Exhibit 29, which is a cost estimate from the architect. Do you recall if you looked at the actual exhibit or just talked with Ms. Frisone or Ms. Miles about the MOB ownership?

A. I don't believe I've discussed that issue.

Q. Okay. So you're saying you did not discuss the MOB ownership or how the costs were allocated?

A. I don't recall the cost allocation or the MOB ownership being one of the things that we discussed.

Q. Would you agree that with projects to be located in a medical office building, an applicant to provide a health service regulated by the Certificate of Need Act would only need to count the upfit costs in terms of the CON application?

MS. FRIEL: Object to the form.

MR. JOHNSON: Object to the form.

A. Well, upfit, soft costs, equipment costs.

Q. So you're agreeing with me, as long as you define the upfit as soft costs and equipment costs?

MS. FRIEL: Object to form.

MR. JOHNSON: Object to form.

A. Yeah. It's--it's not just the upfit of the space. It's other--it's other aspects of the project as well.
Q. It's the aspects that make it possible to perform the health service there--to offer the health service there; is that right?
A. Yes.
MS. FRIEL: Object to form.
MR. JOHNSON: Object to form.
Q. And who bears the cost of the building shell and core itself when there's a medical office building?
A. The developer of the building.
Q. Does the ownership of the developer entity enter into your consideration of what costs the applicant should bear versus the developer?
A. I would have to go back and look at that case that we discussed, but there may be an issue if there's a related-party transaction.
Q. How do you define a related-party transaction?
A. Well, in this case, that if--if Mission were also an owner of the building.
Q. That would be--you would consider that a related-party transaction?
A. Yes.

Q. What about if Mission was an investor in the entity that owns the building?
MS. FRIEL: Object to form.
A. I'd have to look at the specifics.
Q. There was--in the same paragraph that we were just looking at in the findings, there is expressed a concern about whether the developer in this case should have been an applicant, but I think you're saying you did not discuss that issue with Ms. Frisone or Ms. Miles?
A. That is correct.
Q. We marked in an earlier deposition in this case the exemption notice and response letter from the CON Section for the medical office building in which the Mission GI project was proposed to be located. And it is in front of you in that notebook as Deposition Exhibit 4. I believe that you signed the letter?
A. Yes.
Q. Did you understand at the time that that medical office building discussed in the letter and your response was the building in which the Mission GI project would be located?
A. Yes.

Q. And how did you determine that it was the same medical office building?
A. The statement in the letter. It says, "In addition, Mission will lease space in the building for its proposed GI Endoscopy South location."
Q. The letter that you just referred to was dated May 13, 2011; is that right?
A. Yes.
Q. And then the response is May 24, 2011?
A. Yes.
Q. That was during the review of the Mission GI application, correct? If you need to look, the findings begin on Page 640 of the Agency file.
A. Yes.
Q. Did you send a copy of this exemption request in response to Ms. Miles or Ms. Frisone to make them aware?
A. No.
Q. Do you know if anybody else in the CON Section made them aware of the no review--or excuse me, the exemption request or response during the review?
A. I do not know that.

Q. Okay. And it is this no review or exemption determination that Ms. Gunter has asked you to reconsider; is that correct?
A. Yes. You know, it should be noted that the second paragraph clearly states, "It should be noted that the Agency's position is based solely on the facts represented by you. That any change of facts as represented will require further consideration by the Agency and a separate determination."
Q. Right. And that's a paragraph that you include in all your exemption notice letters?
A. That's right, because sometimes the project as conceived is not the project that is implemented. And we're not giving carte blanche.
Q. Do you contend that the facts are not as represented in the May 13, 2011 letter?
A. I don't know.
Q. When we looked at this during one of the earlier depositions, we determined that the reference in your regarding line on your May 24th, 2011 letter to the Keith Corporation should actually have been Western North Carolina Healthcare Innovators, LLC; is that right?

A. Yes. It was sent to the letterhead, not to the name on--of the company, not the specific entity that was being created for the development of the office building.
Q. But the exemption belongs to Western North Carolina Healthcare Innovators, LLC; is that right?
A. That's what was exempted, yes.
Q. Do you have an understanding at this point of what the basis for Ms. Gunter's allegation that the facts are not as represented, or is that something that you still need to look at?
A. We haven't conducted an investigation yet.
Q. If Western North Carolina Healthcare Innovators, LLC is the sole owner of the building, there would not be a need for it to be an applicant for the Mission GI service; is that correct?
MS. FRIEL: Object to the form.
A. I don't believe so, no.
Q. It would not have needed to be an applicant?
A. I said--I said that I didn't believe that it would.
Q. Okay. Mr. Smith, will you look with me now at Criterion 5?
A. (Witness complies.)

Q. One of the bases, as I read the findings, and specifically on Page 676, is that the applicant didn't demonstrate the availability of funds for startup costs, and that's because there were no startup costs projected in the application. And I can take you to the specific pages of the application, if that's helpful to you.
A. Oh. It's right there at the top. Okay.
Q. When an applicant is relocating an existing licensed service, would you agree that there aren't any startup costs to be incurred?
MR. JOHNSON: Object to form.
MS. FRIEL: Object to form.
A. It depends on the specifics of the situation.
Q. How do you evaluate whether a specific situation requires a projection of startup costs?
A. (Witness reviews document.) Well, we usually rely on the applicant to explain it sufficiently. But I don't know--because I did not--I don't believe I--I don't recall discussing this particular issue, and I don't--did not look at Section IX of the application. So I don't know what was explained or what wasn't explained. And it caused the finding to be as it was.

Q. Will you look back with me at the deposition exhibit that we looked at earlier, the findings involving the relocation of the endoscopy room in Macon County? I think we--I think it's Deposition Exhibit 5.
A. (Witness complies.)
Q. In those findings, under Criterion 5 on Page 6, it reflects that the applicants projected no startup or initial operating expenses; do you see that line?
A. Uh-huh.
Q. And that was not a basis of--
A. It was not a factor in this review.
Q. Both the Macon County review and the Mission GI review involved relocating an existing licensed endoscopy suite; is that right?
A. Yes.
Q. Why would it have been an issue--
A. Well--
Q. --in Buncombe and not Macon?
A. --I don't know. I didn't do the review. I did not look at the applications.
Q. Is there any guidance to applicants regarding how--how--whether and when to complete the startup and

initial operating expense section beyond what's actually in the application form?
A. If they have questions, they can always ask.
Q. How do--how do you, as the Chief of the CON Section, define operating--initial operating expenses and startup costs?
A. To new facilities, we typically look at the period of time before patients are served, where they'll be employing at least key staff and paying for such services as their actual hookup to the utilities, to the water, the cost of operations that are--of the utilities that occur before patients are seen.
Q. And before the revenue starts flowing?
A. Right. Before--yeah. There's no--there's no revenue coming in at that point in time. Also, a new facility typically has to stock supplies--supplies, food, depending on the services being offered.
Q. In this case, if Mission were able to turn the lights off and leave the endoscopy room that it currently uses and is relocating one day and then begin operating the new one the next day, would you agree that there aren't any startup--
MS. FRIEL: Object to the form.

MR. JOHNSON: Object to the form.
Q. --costs, as you define them?
A. There would be--there would be very few. I don't know if there would be none.
Q. Am--am I correct that there's not any sort of rule that says here's what you have to include for startup and initial operating expenses?
A. Right. There is no rule codified for any of the services that discusses a laundry list of services that should be included in initial operating costs or startup expenses.
Q. If an applicant determines that that section is not applicable because they don't expect any of those costs, do you expect the applicant to explain why they feel it's inapplicable?
A. Yes. We usually ask them to explain the N/A's.
MS. HARRIS: I think I'm getting close to the end of my questions. I'm going to take a short break and make sure so I can wrap it up efficiently.
(RECESS TAKEN FROM 11:57 A.M. UNTIL 12:18 P.M.)
Q. (By Ms. Harris) Mr. Smith, has our discussion this morning refreshed your recollection at all about the pre-application conference that I asked you about earlier?

A. No.
Q. And I believe you said that you did not have any discussions with Marjorie Acker or anybody from the 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 initial meeting, but you were unable to confirm that on your calendar?
A. Yes.
Q. And you don't have an independent recollection of a meeting involving Mission, Pardee, and the Construction Section?
A. I have a recollection of--of the meeting, but I don't recall all who attended.
Q. Right. And do you have a recollection of what was discussed at that meeting?
A. That would include the Construction Section?
Q. The 2010 meeting?
A. The 2010 meeting. Yes, I think it was the--kind of the conceptual plan at that point that Mission and Pardee had hoped to put on--on the site that they had selected.

Q. Were there reservations expressed from any of the Agency participants about the concept presented?
A. I think--I'm trying to think. We--we knew that there had been an issue in Gaston County with a satellite ED. Their initial application had been denied, and I believe there was an intervention by CHM--CMHA, and that--so that we knew that sometimes these things cause bad feelings. And we also knew that--I'm trying to think. That--that's probably all we may have known at that time.
Q. And when you say "sometimes these things cause bad feelings," you mean relocating closer to an existing provider?
A. Developing a service, just in--in a more general sense, whether it's relocation or--I think that meeting may have discussed as much the satellite emergency department that Mission and Pardee were contemplating.
Q. Because of the recent experience that you had with Gaston?
A. Yes. And, you know, I'm not sure exactly what form the--the project had--was at least sort of being proposed at the beginning. I think it may have been--Mission, I think, was trying to sort out the

phasing of the development of the project, so I'm not sure we--when we got the endoscopy center, we--we knew that that was going to be the first component, but I--I just can't remember now. But the--the first meeting was definitely a higher-level meeting.
Q. What do you mean by "higher-level"?
A. Like the 10,000-foot view. I mean, yeah.
Q. I think you used the word "conceptual" when you first started--
A. Yes, conceptual.
Q. Was there any sort of reaction by the Agency representatives at the meeting that this could never work--
MS. FRIEL: Object to form.
Q. --because of where it was located or the proximity to the county line?
MS. FRIEL: Same objection.
A. Well, there was a long time--I--I think we knew--we may have felt at that time that it would be--it would not be a smooth path.
Q. Did you anticipate it not being a smooth path because of opposition that you anticipated from other providers?

A. That would have been one of that--that would have probably been the primary reason, yes.
Q. Is opposition by a competing provider, in and of itself, a basis for finding an application nonconforming with Criterion 3 or 6?
A. No. But it certainly affects the speed at which a project can be developed should they get involved in a contested case hearing, and then the contested case hearing has to run its course.
Q. Do you recall anything else about the conceptual meeting that we've just been discussing in 2010?
A. No.

MS. HARRIS: I believe those are all my questions at this time. Thank you, Mr. Smith, for your time.

THE WITNESS: Thank you.

MS. FRIEL: I guess I have a couple very quick follow ups.

CROSS EXAMINATION BY MS. FRIEL:

Q. Mr. Smith, did I understand you correctly this morning, you've got about 23 years of experience with the CON Section in total; is that correct?
A. It'll be 24 years in June.

Q. Okay. And is it correct that, with respect to this Mission endoscopy room, that you did not supervise the review, either directly supervising the project analyst or the--the Assistant Chief in the review; is that correct?
A. Yes.

MS. FRIEL: Those are all my questions.

MR. JOHNSON: No questions.

MS. HARRIS: I don't have any other questions. Thank you.

(THE DEPOSITION ADJOURNED AT 12:27 P.M.)

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STATE OF NORTH CAROLINA
COUNTY OF WAKE

CERTIFICATE

I, Peggy F. Barbee, Notary Public-Reporter, do hereby certify that CRAIG R. SMITH was duly sworn by me prior to the taking of the foregoing deposition and that said deposition was taken by me and transcribed under my direction and that the foregoing 67 pages constitute a true and correct transcript of the testimony of the witness.

I do further certify that I am not counsel for or in the employment of either of the parties to this action, nor am I interested in the results of this action.

I do further certify that the stipulations contained herein were entered into by counsel in my presence.

In witness whereof, I have hereunto set my hand, this 30th day of April, 2012.

PEGGY F. BARBEE
NOTARY PUBLIC FOR THE
STATE OF NORTH CAROLINA
NOTARY PUBLIC NO. 19953200118

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SIGNATURE

I have read the foregoing 67 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 CRAIG R. SMITH)

STATE OF _____

COUNTY OF _____

Subscribed and sworn to before me this _____ day of _____, 2012.

MY COMMISSION EXPIRES:

_____
NOTARY PUBLIC

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

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EXHIBIT
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F

North Carolina Department of Health and Human Services
Division of Facility Services
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

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License # H0019 Medicare # 340023
Computer: 943388
PC LW Date 11/14/06

License Fee: $1,737.50

2007
HOSPITAL LICENSE
RENEWAL APPLICATION

Legal Identity of Applicant: **Fletcher Hospital, Incorporated**
(Full legal name of corporation, partnership, individual, or other legal entity owning the enterprise or service.)

Doing Business As
(d/b/a) name(s) under which the facility or services are advertised or presented to the public:

PRIMARY: **Park Ridge Hospital**
Other: _____
Other: _____

Facility Mailing Address: P O Box 1569
Fletcher, NC 28732

Facility Site Address: ~~Naples Rd~~ ~~Fletcher, NC 28732~~ 100 Hospital Drive Hendersonville, NC 28792

County: Henderson
Telephone: (828)684-8501
Fax: (828)687-0729

Administrator/Director: ~~Michael H. Schultz~~ Jimm Bunch
Title: Administrator
(Designated agent (individual) responsible to the governing body (owner) for the management of the licensed facility)

Chief Executive Officer: Jimm Bunch **Title:** President & CEO
(Designated agent (individual) responsible to the governing body (owner) for the management of the licensed facility)

Name of the person to contact for any questions regarding this form:

Name: Myriam L. Schulze **Telephone:** 828-681-2102

E-Mail: myriam.schulze@ahss.org

FEE PAID
Date 11 / 14 / 06
Amount $ 1,737.50
Check 237686 Cash Other

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.

Type of Health Care Facilities under the Hospital License

List Name(s) of facilities:	Address:	Type of Business / Service:

Please attach a separate sheet for additional listings

Ownership Disclosure (Please fill in any blanks and make changes where necessary.)

1. 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: Michael H. Schultz

   Is your facility part of a Health System? X Yes ___ No
   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 X Not For Profit

   b. Legal entity is: X Corporation ___ LLP ___ Partnership
      ___ 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:

2. Is the business operated under a management contract? ___ Yes X No

   If 'Yes', name and address of the management company.
   Name:
   Street/Box:
   City: State: Zip:
   Telephone: (___) ___

Ownership Disclosure *continued. . .*

3. Vice President of Nursing and Patient Care Services:
   Karen Owensby, RN, MSN, Vice President of Clinical Services

4. Director of Planning: Bruce Bergherm, Vice President of Business Development

Facility Data

A. **Reporting Period** All responses should pertain to the period **October 1, 2005 to September 30, 2006**. If otherwise, please indicate reporting period: _____

B. **General Information** (Please fill in any blanks and make changes where necessary.)

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	
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?		
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. 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, 2006	Staffed Beds as of September 30, 2006	Annual Census Inpt. Days 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)			**
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)			**
l. 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.
** Per C.O.N. rule definition. Refer to Section .1400 entitled Neonatal Services. (10A NCAC 14C)
*** Exclude swing-bed days. (See swing-bed information 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.

D. Beds by Service (Inpatient) *continued*

Number of Swing Beds *	**
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)

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

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 Surgery Cases
Charity Care**				
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				
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.

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

[2] Other Government includes Tricare and VA insurance programs.

[3] Cases which originate from the Emergency Department.

F. Services and Facilities

1. 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: 0

3. **Emergency Department Services** (cases equal visits to ED)

Number of cases/year: 13,987

Does this include fast track/urgent care ? ____ Yes __X__ No.

If "Yes," how many of these are urgent care? _____

	Hours of Operation		Hrs with physician on duty in ER suite	
	From	To	From	To
Monday		24 hours		24 hours
Tuesday		"		"
Wednesday		"		"
Thursday		"		"
Friday		"		"
Saturday		"		"
Sunday		"		"

4. **Medical Air Transport:** Owned or leased air ambulance service:

a. Does the facility operate an air ambulance service? __ Yes __X__ No
b. If "Yes", complete the following chart.

Type of Aircraft	Number of Aircraft	Number Owned	Number Leased	Number of Transports
Rotary				
Fixed Wing				

5. **Pathology and Medical Lab** (Check whether or not service is provided)

a. Blood Bank/Transfusion Services __X__ Yes __ No
b. Histopathology Laboratory __X__ Yes __ No
c. HIV Laboratory Testing __X__ Yes __ No
Number during month of September 2005
HIV Serology _____ **Screening test for employee exposures only.
HIV Culture _____
d. Organ Bank __ Yes __X__ No
e. Pap Smear Screening __X__ Yes __ No

6. **Transplantation Services** - Number of transplants

Type	Number	Type	Number
a. Bone Marrow-Allogenic		i. Kidney/Liver	
b. Bone Marrow-Autologous		j. Liver	
c. Cornea	2	k. Lung	
d. Heart		l. Pancreas	
e. Heart/Lung		m. Pancreas/Kidney	
f. Heart/Liver		n. Pancreas/Liver	
g. Heart/Kidney		o. Other	
h. Kidney			

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

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 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			
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**			

* One case is defined to be one visit or trip by a patient to an operating room or catheterization laboratory for a single or multiple procedures or catheterizations. Count each visit once regardless of 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 (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	
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 *Surgical Operating Rooms* 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.

(Campus – *If multiple sites*: _____)

Type of Room [A]	Number of Rooms [B]	Of the Rooms in Column [B], the number "Not in Use" [C]	Inpatient Cases [D]	Ambulatory Cases [E]
Dedicated Open Heart Surgery (from 7b)				
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 additional surgical operating rooms (i.e., not listed above) that are being developed pursuant to a Certificate of Need or pursuant to the exemption provided in Senate Bill 714? ____ Yes X No

If "Yes," please list the **Types of Rooms** and **Number of Rooms** being developed:

_____

b) Gastrointestinal Endoscopy Rooms and Cases

[1] Report the number of *Gastrointestinal Endoscopy Rooms* and the number of cases performed in these rooms during the reporting period. (*NOTE*: **Other procedure rooms** should be included in **Section 9** on **Page 10** of this application.) Count each patient as one case 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 [A]	Number Of Rooms [B]	Of the Rooms in Column [B], the number "Not in Use" [C]	Inpatient Cases [D]	Ambulatory Cases [E]	Total Number of Procedures [F]
Gastrointestinal Endoscopy Rooms & Cases	1	0	GI: 189	GI: 712	GI: 901
			Non GI: 8	Non GI: 103	Non GI: 111

[2] Does this facility have additional Gastrointestinal Endoscopy Rooms (i.e., not listed above) that are being developed pursuant to a Certificate of Need or pursuant to the exemption provided in Senate Bill 714? ____ Yes X No

If "Yes," please list the **Number of Rooms** being developed:

_____

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 Hours per Room per Day Routinely Scheduled for Use*)	Average "Case Time" ** in Minutes for Inpatient Cases	Average "Case Time" ** in Minutes for Ambulatory Cases
Surgical Operating Rooms	8	90	60
Gastrointestinal Endoscopy Rooms	4	30	30

* **"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 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.)

** **"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.*

d) Surgical Specialty - Of the cases in **Surgical Operating Rooms** (Item 8.a.[1]), enter the number of cases 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	176	146
Neurosurgery/Spine	199	392
Open Heart		
Ophthalmology	2	1,370
Oral Surgery		19
Orthopedics	379	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

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			

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							
Fixed Equipment (Exclude Research & Policy AC-3 Units)	Number of Units	No. of Procedures: Inpatient	Outpatient	Total	No. of MRI Procedures *: With Contrast or Sedation	Without Contrast or Sedation	Total
CT Scanner	1	1,908	6,391	8,299			
MRI Skyland	1		1,567	1,567	149	1,418	1,567
Open MRI Scanners included in row above							
Mammogram	1	2,815	29	2,844			
Other radiographic & fluoroscopic (See Note Below)							

Mobile Equipment Identify Vendor/Owner in space ( ) below:	Number of Units	No. of Procedures: Inpatient	Outpatient	Total	No. of MRI Procedures: With Contrast or Sedation	Without Contrast or Sedation	Total
MRI #1 (GE LX Echospeed)	1						
MRI #2 ( )							
CT Scan ( )							

Note: Totals of MRI inpatients and outpatients should equal MRI totals with and without contrast or sedation

Nuclear Medicine Fixed Equipment	Number of Units	No. of Procedures: Inpatient	Outpatient	Total
Dedicated PET Scanner				
Coincidence Camera				
SPECT				
Gamma Camera /Spect	1	726	1291	2,017

Mobile Equipment Identify Vendor/Owner in space () below:	Number of Units	No. of Procedures: Inpatient	Outpatient	Total
Dedicated PET Scanner (Alliance Imag	1		92	92
Coincidence Camera ( )				
SPECT ( )				
Gamma Camera ( )				

Policy AC-3 or Research Equipment	Number of Units	No. of Procedures: Inpatient	Outpatient	Total	No. of Procedures **: Clinical	Research	Total
MRI pursuant to Policy AC-3:							
Other Human Research MRI Scanner							
PET pursuant to Policy AC-3							
Other Human Research PET Scanner							

Lithotripsy [Identify Vendor/Owner in space ( ) below:]	Number of Units	No. of Procedures: Inpatient	Outpatient	Total
Fixed ( )				
Mobile (Prime Medical)		0	5	5

Note: Totals of MRI inpatients and outpatients should equal MRI totals for clinical and research procedures

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. *NOTE*: 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.

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

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	
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	
72156	MRI Cervical Spine w/o & with	41
72146	MRI Thoracic Spine w/o	69
72147	MRI Thoracic Spine with contrast	
72157	MRI Thoracic Spine w/o & with	32
72148	MRI Lumbar Spine w/o	379
72149	MRI Lumbar Spine with contrast	
72158	MRI Lumbar Spine w/o & with	107
72159	MRA Spinal Canal w/o OR with contrast	
72195	MRI Pelvis w/o	24
72196	MRI Pelvis with contrast	1
72197	MRI Pelvis w/o & with	30
72198	MRA Pelvis w/o OR with Contrast	1
73218	MRI Upper Ext, other than joint w/o	11
73219	MRI Upper Ext, other than joint with contrast	
73220	MRI Upper Ext, other than joint w/o & with	8
73221	MRI Upper Ext any joint w/o	168
73222	MRI Upper Ext any joint with contrast	36
73223	MRI Upper Ext any joint w/o & with	5
73225	MRA Upper Ext w/o OR with contrast	
	Subtotal	1,980

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

MRI Procedures by CPT Code		
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/o 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, bilateral 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	
	Total Number of Procedures	2,514

10b. MRI Procedures by CPT Codes SKYLAND FIXED MRI

MRI Procedures by CPT Code		
CPT Code	CPT Description	Number of Procedures
70336	MRI Temporomandibular Joint(s)	2
70540	MRI Orbit/Face/Neck w/o	
70542	MRI Orbit/Face/Neck with contrast	
70543	MRI Orbit/Face/Neck w/o & with	1
70544	MRA Head w/o	12
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	
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	
73223	MRI Upper Ext any joint w/o & with	
73225	MRA Upper Ext w/o OR with contrast	
	Subtotal	973

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

MRI Procedures by CPT Code		
CPT Code	CPT Description	Number of Procedures
73718	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	1
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	
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, 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 Procedures	1,567

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)		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 techniques, ESTV values are indicated below:					
77417	Additional field check radiographs		.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		
	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		
	Sub-Total				
	TOTALS:				

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

12. Radiation Oncology Treatment Data *continued*

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)	
c.	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? NO

13. Additional Services:

a) **Check if Service(s) is provided:**

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

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
Out of State										
Total All Ages										

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.
   Rebecca M. Mayer, R.N., Ph. D.

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 & 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 For Hospitals	Location of Services	Beds Assigned by Age				
		0-12	13-17	Subtotal 0-17	18 & up	Total Beds
.5200 Dedicated inpatient unit for individuals who have mental disorders	PRH				41	41

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						
.3600 Outpatient narcotic addiction treatment						
.3700 Day treatment facilities for individuals with substance abuse disorders						

Rule 10A NCAC 13B Licensure Rules For Hospitals	Location of Services	Beds Assigned by Age				
		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 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	80
4. Anson		40. Greene		76. Randolph	
5. Ashe		41. Guilford		77. Richmond	
6. Avery	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**	3,825

All responses should pertain to October 1, 2005 through September 30, 2006. If otherwise, indicate the actual reporting period used on Page 5 of this document.

Patient Origin – Inpatient 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 Inpatient Cases "Column D" in the Table under 8(a), page 8.

County	No. of Patients	County	No. of Patients	County	No. of Patients
1. Alamance		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. Iredell		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		
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**	1,348

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 E" in the Table under 8(a), page 8.

County	No. of Patients	County	No. of Patients	County	No. of Patients
1. Alamance	1	37. Gates		73. Person	
2. Alexander	7	38. Graham	19	74. Pitt	
3. 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		88. Transylvania	136
17. Caswell		53. Lee	1	89. Tyrrell	
18. Catawba	4	54. Lenoir		90. Union	1
19. Chatham		55. Lincoln		91. Vance	
20. Cherokee	23	56. Macon	50	92. Wake	
21. Chowan		57. Madison	37	93. Warren	
22. Clay		58. Martin	58	94. Washington	
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	5
33. Edgecombe	1	69. Pamlico		104. Virginia	
34. Forsyth		70. Pasquotank		105. Other States	26
35. Franklin	1	71. Pender		106. Other	40
36. Gaston		72. Perquimans		**Total No. of Patients**	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	County	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	
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**	1,012

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 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									
Alexander		1							
Alleghany									
Anson									
Ashe		1							
Avery		4							
Beaufort									
Bertie									
Bladen		1							
Brunswick		2							
Buncombe		327							
Burke		5							
Cabarrus		1							
Caldwell		1							
Camden									
Carteret									
Caswell									
Catawba		3							
Chatham									
Cherokee		17							
Chowan									
Clay		8							
Cleveland		17							
Columbus		3							
Craven									
Cumberland		1							
Currituck									
Dare									
Davidson									
Davie		2							
Duplin									
Durham		2							
Edgecombe									
Forsyth									
Franklin									
Gaston		7							
Gates									
Graham		3							
Granville									
Greene									
Guilford		2							
Halifax									
Harnett									
Haywood		86							
Henderson		280							
Hertford									
Hoke									
Hyde									
Iredell		5							
Jackson		30							
Johnston									

** 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: Henderson

(Continued from previous page)

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
Jones									
Lee									
Lenoir									
Lincoln			4						
Macon			24						
Madison			25						
Martin			24						
McDowell									
Mecklenburg			4						
Mitchell			8						
Montgomery									
Moore									
Nash									
New Hanover			3						
Northampton									
Onslow			3						
Orange			2						
Pamlico									
Pasquotank									
Pender			1						
Perquimans									
Person			1						
Pitt									
Polk			5						
Randolph									
Richmond									
Robeson			1						
Rockingham									
Rowan									
Rutherford			31						
Sampson									
Scotland									
Stanly									
Stokes									
Surry			1						
Swain			12						
Transylvania			68						
Tyrrell									
Union									
Vance									
Wake			2						
Warren									
Washington									
Watauga			4						
Wayne									
Wilkes									
Wilson									
Yadkin			2						
Yancey			22						
Out of State			46						
TOTALS			1,103						

** 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
1. Alamance		37. Gates		73. Person	
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		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	
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	
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	104. Virginia	8
34. Forsyth		70. Pasquotank		105. Other States	60
35. Franklin	1	71. Pender		106. Other	34
36. Gaston	5	72. Perquimans		**Total No. of Patients**	2,514

Mobile Services: **True** ___X___ **or False** _____

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	No. 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. 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	
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**	

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 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	No. 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	1
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	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	
15. Camden		51. Johnston		87. Swain	
16. Carteret		52. Jones		88. Transylvania	5
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	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		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	92

This application must be completed and submitted with ONE COPY 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 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: Jimm Bunch Date: 11-6-06

PRINT NAME OF APPROVING OFFICIAL Jimm Bunch

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

EXHIBIT
tabbies
G

Original

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 NS Date 12/30/07

License Fee: $1,737.50

2008
HOSPITAL LICENSE
RENEWAL APPLICATION

Legal Identity of Applicant: **Fletcher Hospital, Incorporated**
(Full legal name of corporation, partnership, individual, or other legal entity owning the enterprise or service.)

Doing Business As
(d/b/a) name(s) under which the facility or services are advertised or presented to the public:

PRIMARY: **Park Ridge Hospital**
Other: _____
Other: _____

Facility Mailing Address: P O Box 1569
Fletcher, NC 28732

Facility Site Address: Naples Rd
Fletcher, NC 28732
County: Henderson
Telephone: (828)684-8501
Fax: (828)687-0729

Administrator/Director: JIMM BUNCH
Title: CEO
(Designated agent (individual) responsible to the governing body (owner) for the management of the licensed facility)

Chief Executive Officer: Jimm Bunch **Title:** President & CEO
(Designated agent (individual) responsible to the governing body (owner) for the management of the licensed facility)

Name of the person to contact for any questions regarding this form:

Name: Myriam L. Schulze **Telephone:** 828.681.2102

E-Mail: myriam.schulze@ahss.org

PAID
CK. NO. 254389 - $1,737.50
DATE 11-26-07 (CV)

Type of Health Care Facilities under the Hospital License

List Name(s) of facilities:	Address:	Type of Business / Service:

Please attach a separate sheet for additional listings

Ownership Disclosure (Please fill in any blanks and make changes where necessary.)

1. 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: ~~Michael H. Schultz~~ JIMM BUNCH

   Is your facility part of a Health System? X Yes ___No
   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 X Not For Profit

   b. Legal entity is: X Corporation ___ LLP ___ Partnership
      ___ 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: _____

2. Is the business operated under a management contract? ___Yes X No

   If 'Yes', name and address of the management company.
   Name: _____
   Street/Box: _____
   City: _____ State: _____ Zip: _____
   Telephone: (___) _____

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, 2006 to September 30, 2007.**

B. **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.**	3,311	
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? ___ 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 the Joint Commission or AOA, specify the accrediting body Joint Commission and indicate the date of the last survey 05 / 19 / 06.
   AOA 4/30 - 5/2/07

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, 2007	Staffed Beds as of September 30, 2007	Annual Census Inpt. Days of Care
Intensive Care Units			
a. Burn *			*
b. Cardiac (Combined ICU/CCU/Telemetry)	14	14	3557
c. Cardiovascular Surgery			
d. Medical/Surgical			
e. Neonatal Beds Level IV ** (Not Normal Newborn)			**
f. Pediatric			
g. Respiratory Pulmonary			
h. Other (List)			
Other Units			
i. Gynecology			
j. Medical/Surgical ***	40	40	***8107
k. Neonatal Level III ** (Not Normal Newborn)			**
l. Neonatal Level II ** (Not Normal Newborn)			**
m. Obstetric (including LDRP)	8	8	1100
n. Oncology			
o. Orthopedics			
p. Pediatric			
q. 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	0		
4. Detoxification	0		
5. Substance Abuse / Chemical Dependency Treatment	0		
6. Psychiatry	41	36	11,854
7. Nursing Facility	0		
8. Adult Care (Home for the Aged)	0		
9. Other	0		
10. Totals (1 through 9)	103	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)

D. Beds by Service (Inpatient) *continued*

Number of Swing Beds *	2
Number of Skilled Nursing days in Swing Beds	200
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, item 3.d.)	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)
Charity Care [1]	0	0	0		
Commercial Ins. [2]	2,502	4,406	17,077	284	1,842
Medicaid (including HMO)	1,710	3,281	3,192	275	400
Medicare (including HMO)	7,836	2,843	14,837	480	1,940
Private Pay / Self Pay	638	4,906	1,402	60	209
Other Gov't. [3] (Champus)	77	187	769	9	58
All other			384		
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.

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

[3] Other Government includes Tricare and VA insurance programs.

F. Services and Facilities

1. Obstetrics	Enter Number
a. Live births (Vaginal Deliveries)	320
b. Live births (Cesarean Section)	139
c. Stillbirths	0

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 Department Services** (cases equal visits to ED)

a. Total Number of ED Treatment Rooms: (b.+c.) 12

b. #Trauma Rooms 1 c. #Fast Track Rooms 11

c. Total Number of ED visits for reporting period: 15,623

d. Total Number of admits from the ED for reporting period: 2,090

e. Total Number of Urgent Care visits for reporting period: 12,324

f. Does your ED provide services 24 hours a day 7 days per week? X Yes ___ No
If no, specify days/hours of operation:

g. Is a physician on duty in your ED 24 hours a day 7 days per week? X Yes ___ No
If no, specify days/hours physician is on duty:

4. **Medical Air Transport**: Owned or leased air ambulance service:

a. Does the facility operate an air ambulance service? ___ Yes X No
b. If "Yes", complete the following chart.

Type of Aircraft	Number of Aircraft	Number Owned	Number Leased	Number of Transports
Rotary				
Fixed Wing				

5. **Pathology and Medical Lab** (Check whether or not service is provided)

a. Blood Bank/Transfusion Services X Yes ___ No
b. Histopathology Laboratory X Yes ___ No
c. HIV Laboratory Testing ___ Yes X No
Number during reporting period
HIV Serology ___ Screening test for employee exposures only
HIV Culture ___
d. Organ Bank ___ Yes X No
e. Pap Smear Screening X Yes ___ No

6. **Transplantation Services** - Number of transplants

Type	Number	Type	Number	Type	Number
a. Bone Marrow-Allogeneic	0	i. Kidney/Liver	0	k. Lung	0
b. Bone Marrow-Autologous	0	j. Liver	0	l. Pancreas	0
c. Cornea	20	f. Heart/Liver	0	m. Pancreas/Kidney	0
d. Heart	0	g. Heart/Kidney	0	n. Pancreas/Liver	0
e. Heart/Lung	0	h. Kidney	0	o. Other	0

Do you perform living donor transplants ? ___ Yes X No.

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
1. Number of Units of Equipment			
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**			

* One case is defined to be one visit or trip by a patient to an operating room or catheterization laboratory for a single or multiple procedures or catheterizations. Count each visit once regardless of 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 Utilizing Heart-Lung Bypass Machine	
4. 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 & 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	6

[2] Does this facility have approval for additional surgical operating rooms (i.e., not listed 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	
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*

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.

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 * [a]	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

** **"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*

9. Gastrointestinal Endoscopy Rooms, Cases, and Procedures

[1] Report the number of *Gastrointestinal Endoscopy Rooms* and the number of cases and procedures performed in these rooms during the reporting period. (***NOTE***: **Other procedure rooms** should be included in **Section 10** below.) Count each patient as one case 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	330	1,215
	Total Number GI Endo Procedures [c]	Total Number Non-GI Endo Procedures [d]	Total Endo Procedures [c] + [d]
	935	330	1,265

[2] Does this facility have approval for additional GI Endoscopy rooms (i.e., **not** listed above) **that are being developed** pursuant to a Certificate of Need? ____ Yes __X__ No _____ # Rooms

[3] Does this facility have approval for additional GI Endoscopy rooms (i.e., **not** listed above) **that are being developed** pursuant to the exemption provided in Senate Bill 714? ____ Yes __X__ 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

b) Enter the number of Non-Surgical cases 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 of Units	No. of Procedures		Total	No. of MRI Procedures *		
		Inpatient	Outpatient		With Contrast or Sedation	Without Contrast or Sedation	Total
Magnetic Resonance Imaging							
Fixed MRI Scanners	1	364	2,120	2,484	1,186	1,298	2,484
Open MRI Scanners included in row above							
MRI pursuant to Policy AC-3:							
Other Human Research MRI Scanner							
MRI Mobile Equipment	Number of Units	No. of Procedures		Total	With Contrast or Sedation	Without Contrast or Sedation	Total
		Inpatient	Outpatient				
Identify Vendor/Owner in space ( ) below:							
MRI #1 (N/A)							
MRI #2 (N/A)							
CT Scanner (Fixed or Mobile)	1	1,887	6,693	8,580			
CT Scanner HECT Units							
Mammogram	1	61	2,875	2,936			
Fixed Other Radiographic&Fluoroscopic							
Nuclear Medicine	Number of Units	No. of Procedures		Total			
		Inpatient	Outpatient				
PET Scanners							
Dedicated Fixed PET Scanner	0						
Mobile PET Scanner Vendor (Alliance One)		2	212	214			
PET pursuant to Policy AC-3							
Other Human Research PET Scanner							
Other Nuclear Medicine							
Coincidence Camera							
Mobile Coincidence Camera Vendor ( )							
SPECT							
Mobile SPECT Vendor ( )							
Gamma Camera / Spect	1	875	1,368	2,243			
Mobile Gamma Camera Vendor ( )							
Lithotripsy [Identify Vendor/Owner in space ( ) below:]	Number of Units	No. of Procedures		Total			
		Inpatient	Outpatient				
Fixed							
Mobile (Healthtronics)			15	15			

Note: *Totals of MRI inpatients and and without contrast or sedation.

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. ***NOTE***: 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

MRI Procedures by CPT Code		
CPT Code	**CPT Description**	**Number of Procedures**
70336	MRI Temporomandibular Joint(s)	
70540	MRI Orbit/Face/Neck w/o	1
70542	MRI Orbit/Face/Neck with contrast	
70543	MRI Orbit/Face/Neck w/o & with	10
70544	MRA Head w/o	65
70545	MRA Head with contrast	
70546	MRA Head w/o & with	4
70547	MRA Neck w/o	1
70548	MRA Neck with contrast	1
70549	MRA Neck w/o & with	17
70551	MRI Brain w/o	206
70552	MRI Brain with contrast	2
70553	MRI Brain w/o & with	457
7055A	IAC Screening	
71550	MRI Chest w/o	1
71551	MRI Chest with contrast	
71552	MRI Chest w/o & with	5
71555	MRA Chest with OR without contrast	
72126	Cervical Spine Infusion only	
72141	MRI Cervical Spine w/o	365
72142	MRI Cervical Spine with contrast	1
72156	MRI Cervical Spine w/o & with	21
72146	MRI Thoracic Spine w/o	79
72147	MRI Thoracic Spine with contrast	1
72157	MRI Thoracic Spine w/o & with	23
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	
	Subtotal	1,983

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

MRI Procedures by CPT Code		
CPT Code	CPT Description	Number of Procedures
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	46
73719	MRI Lower Ext other than joint with contrast	
73720	MRI Lower Ext other than joint w/o & with	51
73721	MRI Lower Ext any joint w/o	232
73722	MRI Lower Ext any joint with contrast	4
73723	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	
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	
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 page	501
	Total Number of Procedures (both pages)	2,484

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)		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 techniques, ESTV values are indicated below:

77417	Additional field check radiographs		.50		
77418	Intensity modulated radiation treatment (IMRT)delivery		1.00		
77432	Stereotactic radiosurg. Treatment mgmt Linear Accelerator/CyberKnife		3.00		
77432	Stereotactic radiosurg. Treatment mgmt. Gamma Knife		3.00		
	Total body irradiation		2.50		
	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		
	Sub-Total				
	TOTALS:				

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

11. Radiation Oncology Treatment Data *continued*

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)	
c.	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? no

13. Additional Services:

a) **Check if Service(s) is provided:**

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

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
Out of State										
Total All Ages										

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 **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 & 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						
.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 For Hospitals	Location of Services	Beds Assigned by Age				
		0-12	13-17	Subtotal 0-17	18 & up	Total Beds
.5200 Dedicated inpatient unit for individuals who have mental disorders	PRH				X	36

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						
.3600 Outpatient narcotic addiction treatment						
.3700 Day treatment facilities for individuals with substance abuse disorders						

Rule 10A NCAC 13B Licensure Rules For Hospitals	Location of Services	Beds Assigned by Age				
		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 _____						

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	1	38. Graham	1	74. Pitt	
3. Alleghany		39. Granville		75. Polk	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		82. Sampson	
11. Buncombe	657	47. Hoke		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	
20. Cherokee	4	56. Macon	15	92. Wake	1
21. Chowan		57. Madison	4	93. Warren	
22. Clay	10	58. Martin	21	94. Washington	1
23. Cleveland	2	59. McDowell		95. Watauga	1
24. Columbus	3	60. Mecklenburg	5	96. Wayne	
25. Craven		61. Mitchell	1	97. Wilkes	
26. Cumberland		62. Montgomery		98. Wilson	
27. Currituck	1	63. Moore		99. Yadkin	
28. Dare		64. Nash		100. Yancey	15
29. Davidson		65. New Hanover	1		
30. Davie		66. Northampton		101. Georgia	1
31. Duplin		67. Onslow		102. South Carolina	11
32. Durham		68. Orange		103. Tennessee	4
33. Edgecombe		69. Pamlico	1	104. Virginia	
34. Forsyth		70. Pasquotank		105. Other States	4
35. Franklin		71. Pender		106. Other	114
36. Gaston	1	72. Perquimans		**Total No. of Patients**	3,727

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.

County	No. 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	21
5. Ashe	1	41. Guilford	1	77. Richmond	
6. Avery		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		49. Iredell		85. Stokes	
14. Caldwell	1	50. Jackson	6	86. Surry	
15. Camden		51. Johnston		87. Swain	6
16. Carteret		52. Jones		88. Transylvania	45
17. Caswell		53. Lee		89. Tyrrell	
18. Catawba	3	54. Lenoir		90. Union	
19. Chatham		55. Lincoln		91. Vance	
20. Cherokee	2	56. Macon	14	92. Wake	
21. Chowan		57. Madison	4	93. Warren	
22. Clay	4	58. Martin	12	94. Washington	
23. Cleveland	1	59. McDowell		95. Watauga	
24. Columbus	5	60. Mecklenburg	4	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	10
29. Davidson		65. New Hanover			
30. Davie		66. Northampton		101. Georgia	1
31. Duplin		67. Onslow		102. South Carolina	5
32. Durham		68. Orange		103. Tennessee	1
33. Edgecombe		69. Pamlico		104. Virginia	
34. Forsyth		70. Pasquotank		105. Other States	3
35. Franklin		71. Pender		106. Other	61
36. Gaston		72. Perquimans		**Total No. of Patients**	1,108

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	1	38. Graham	14	74. Pitt	
3. Alleghany		39. Granville		75. Polk	129
4. Anson	1	40. Greene		76. Randolph	
5. Ashe		41. Guilford	3	77. Richmond	
6. Avery	6	42. Halifax		78. Robeson	
7. Beaufort		43. Harnett	1	79. Rockingham	
8. Bertie		44. Haywood	174	80. Rowan	
9. Bladen		45. Henderson	2,349	81. Rutherford	54
10. Brunswick		46. Hertford		82. Sampson	
11. 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	1
21. Chowan		57. Madison	83	93. Warren	
22. Clay	4	58. Martin	72	94. Washington	
23. Cleveland	1	59. McDowell		95. Watauga	
24. Columbus		60. Mecklenburg	3	96. Wayne	
25. Craven		61. Mitchell	39	97. Wilkes	3
26. Cumberland	1	62. Montgomery		98. Wilson	
27. Currituck		63. Moore		99. Yadkin	1
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	1	68. Orange	4	103. Tennessee	6
33. Edgecombe		69. Pamlico		104. Virginia	
34. Forsyth		70. Pasquotank		105. Other States	4
35. Franklin		71. Pender		106. Other	72
36. Gaston	2	72. Perquimans		**Total No. of Patients**	4,449

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	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	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	6
16. Carteret		52. Jones		88. Transylvania	47
17. Caswell		53. Lee		89. Tyrrell	
18. Catawba	2	54. Lenoir		90. Union	
19. Chatham		55. Lincoln		91. Vance	
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	1
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		**Total No. of Patients**	1,215

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									
Alexander		3	3						
Alleghany									
Anson									
Ashe		2	2						
Avery		5	5						
Beaufort									
Bertie									
Bladen									
Brunswick									
Buncombe		309	309						
Burke		3	3						
Cabarrus		1	1						
Caldwell		2	2						
Camden									
Carteret									
Caswell									
Catawba		4	4						
Chatham									
Cherokee		17	17						
Chowan									
Clay		13	13						
Cleveland		16	16						
Columbus									
Craven		1	1						
Cumberland		2	2						
Currituck									
Dare									
Davidson									
Davie									
Duplin		1	1						
Durham									
Edgecombe									
Forsyth									
Franklin									
Gaston		4	4						
Gates									
Graham		8	8						
Granville									
Greene									
Guilford		1	1						
Halifax									
Harnett									
Haywood		90	90						
Henderson		262	262						
Hertford									
Hoke									
Hyde									
Iredell		2	2						
Jackson		18	18						
Johnston									

** 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 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
Jones									
Lee									
Lenoir									
Lincoln		1	1						
Macon		20	20						
Madison		31	31						
Martin		30	30						
McDowell									
Mecklenburg		5	5						
Mitchell		8	8						
Montgomery									
Moore									
Nash									
New Hanover									
Northampton									
Onslow		4	4						
Orange									
Pamlico									
Pasquotank									
Pender									
Perquimans									
Person									
Pitt									
Polk		8	8						
Randolph									
Richmond									
Robeson		3	3						
Rockingham									
Rowan									
Rutherford		31	31						
Sampson									
Scotland									
Stanly									
Stokes									
Surry		1	1						
Swain		11	11						
Transylvania		69	69						
Tyrrell									
Union		2	2						
Vance									
Wake		4	4						
Warren									
Washington									
Watauga		10	10						
Wayne									
Wilkes		1	1						
Wilson									
Yadkin									
Yancey		20	20						
Out of State		43	43						
TOTALS			1068						

** 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
1. 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		48. Hyde		84. Stanly	
13. Cabarrus		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	1	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	
34. Forsyth		70. Pasquotank		105. Other States	16
35. Franklin		71. Pender		106. Other	137
36. Gaston		72. Perquimans		Total No. of Patients	2,484

Mobile Services: **True _____ or False _____**

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	No. 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. 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	
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**	

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	No. 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	
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		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		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

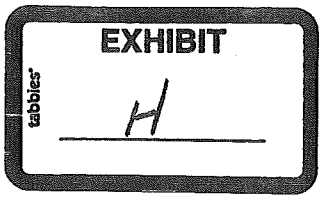
This application must be completed and submitted with ONE COPY to the Acute and Home Care Licensure and Certification Section, Division of Health Service Regulation prior to the issuance of a 2008 hospital license.

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: Jimm Bunch Date: 11-21-07

PRINT NAME OF APPROVING OFFICIAL Jimm Bunch

Please be advised, the license fee must accompany the completed application and be submitted to the Acute and Home Care Licensure and Certification Section, Division of Health Service Regulation, prior 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

Legal Identity of Applicant: **Fletcher Hospital, Incorporated**
(Full legal name of corporation, partnership, individual, or other legal entity owning the enterprise or service.)

Doing Business As
(d/b/a) name(s) under which the facility or services are advertised or presented to the public:

PRIMARY: **Park Ridge Hospital**
Other: _____
Other: _____

Facility Mailing Address: P O Box 1569
Fletcher, NC 28732

Facility Site Address: Naples Rd
Fletcher, NC 28732
County: Henderson
Telephone: (828)684-8501
Fax: (828)687-0729

Administrator/Director: JIMM BUNCH
Title: CEO
(Designated agent (individual) responsible to the governing body (owner) for the management of the licensed facility)

Chief Executive Officer: Jimm BUNCH **Title:** CEO/President
(Designated agent (individual) responsible to the governing body (owner) for the management of the licensed facility)

Name of the person to contact for any questions regarding this form:

Name: Myriam L. Schulze **Telephone:** 828-681-2102

E-Mail: myriam.schulze@ahss.org

PAID
CK. NO. 31019 - $ 1,737.50
DATE 12-1-09

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

Type of Health Care Facilities under the Hospital License

List Name(s) of facilities:	Address:	Type of Business / Service:

Please attach a separate sheet for additional listings

Ownership Disclosure (Please fill in any blanks and make changes where necessary:)

1. 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?]
Yes _____ No

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 X Not For Profit

b. Legal entity is: X Corporation ___ LLP ___ Partnership
___ 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:
_____

2. Is the business operated under a management contract? ___Yes X No

If 'Yes', name and address of the management company.
Name: _____
Street/Box: _____
City: _____ State: _____ Zip: _____
Telephone: (___) _____

Ownership Disclosure *continued. . . .*

3. Vice President of Nursing and Patient Care Services:
   Karen Owensby, Vice President of Clinical Services

4. Director of Planning: _____

Facility Data

A. **Reporting Period** All responses should pertain to the period **October 1, 2007 to September 30, 2008.**

B. **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.**	3,713	
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 responses to "2-9" on page 4; and exclude normal newborn bassinets.**	37	
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.	643	

C. Designation and Accreditation

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. If this facility is accredited by the Joint Commission or AOA, specify the accrediting body
   YES and indicate the date of the last survey 05 / 20 / 2006
   AOA – 4/30-5/2/07

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, 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)			**
f. Pediatric			
g. Respiratory Pulmonary			
h. Other (List)			
Other Units			
i. Gynecology			
j. Medical/Surgical ***	40	40	*** 8,665
k. Neonatal Level III ** (Not Normal Newborn)			**
l. Neonatal Level II ** (Not Normal Newborn)			**
m. Obstetric (including LDRP)	8	8	1,359
n. Oncology			
o. Orthopedics			
p. Pediatric			
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		
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)

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)					
TOTAL	13682	16191	81107	1302	4974

	$ 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%

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

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.

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)	197
c. Stillbirths	5

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 Department Services** (cases equal visits to ED)

a. Total Number of ED Exam Rooms: 12

a.1. #Trauma Rooms 1 a.2. #Fast Track Rooms 11

b. Total Number of ED visits for reporting period: 16,191

c. Total Number of admits from the ED for reporting period: 2,091

d. Total Number of Urgent Care visits for reporting period: 14,866

e. Does your ED provide services 24 hours a day 7 days per week? x Yes ___ No
If no, specify days/hours of operation:

f. Is a physician on duty in your ED 24 hours a day 7 days per week? x Yes ___ No
If no, specify days/hours physician is on duty:

4. **Medical Air Transport**: Owned or leased air ambulance service:

a. Does the facility operate an air ambulance service? ___ Yes x No
b. If "Yes", complete the following chart.

Type of Aircraft	Number of Aircraft	Number Owned	Number Leased	Number of Transports
Rotary				
Fixed Wing				

5. **Pathology and Medical Lab** (Check whether or not service is provided)

a. Blood Bank/Transfusion Services x Yes ___ No
b. Histopathology Laboratory x Yes ___ No
c. HIV Laboratory Testing ___ Yes x No
Number during reporting period
HIV Serology ___
HIV Culture ___
d. Organ Bank ___ Yes x No
e. Pap Smear Screening x Yes ___ No

6. **Transplantation Services** - Number of transplants

Type	Number	Type	Number	Type	Number
a. Bone Marrow-Allogeneic	0	i. Kidney/Liver	0	k. Lung	0
b. Bone Marrow-Autologous	0	j. Liver	0	l. Pancreas	0
c. Cornea	21	f. Heart/Liver	0	m. Pancreas/Kidney	0
d. Heart	0	g. Heart/Kidney	0	n. Pancreas/Liver	0
e. Heart/Lung	0	h. Kidney	0	o. Other	0

Do you perform living donor transplants ? ___ Yes x No.

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
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			

*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 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 total in #2**, Number of Procedures on Patients Age 14 & younger	
6. **Of total in #3**, Number of Procedures on Patients Age 14 & younger	

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	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 surgical operating rooms (i.e., **not** listed above) **that are being developed** 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 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)	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	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

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 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.

** **"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*

9. Gastrointestinal Endoscopy Rooms, Cases, and Procedures

[1] Report the number of *Gastrointestinal Endoscopy Rooms* and the number of cases and procedures performed in these rooms during the reporting period. (***NOTE*: Other procedure rooms** should be included in **Section 10** below.) Count each patient as one case 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	762	0	762
	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 additional GI Endoscopy rooms (i.e., **not** listed above) **that are being developed** pursuant to a Certificate of Need? _____ Yes __X__ 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

Note: Read the following instructions carefully

b) Enter the number of Non-Surgical cases by specialty area in the chart below. **Count all Non-Surgical 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.

Non-Surgical Specialty Area	Inpatient Cases	Ambulatory Cases
Pain Management	8	192
Cystoscopy	0	0
Non GI Endoscopies *(not reported in 9.)*	0	0
GI Endoscopies *(not reported in 9.)*	0	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

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	TOTAL Number of Procedures*: # 3410 procedures. Number **must** equal the sum of inpatient and outpatient procedures below.					
Fixed MRI Scanners-closed	1	Inpatient Procedures			Outpatient Procedures		
Fixed MRI Scanners-open		With Contrast or Sedation	Without Contrast or Sedation	TOTAL Inpatient	With Contrast or Sedation	Without 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)	1
70540	MRI Orbit/Face/Neck w/o	2
70542	MRI Orbit/Face/Neck with contrast	
70543	MRI Orbit/Face/Neck w/o & with	18
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	1
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	2372

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

CPT Code	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	
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	122
	Total Number of Procedures for all pages	3410

10c. Computed Tomography (CT)

How many fixed CT scanners does the hospital have? two

Does the hospital contract for mobile CT scanner services? ____ Yes _X_ No

If yes, identify the mobile CT vendor _____

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	X	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	X	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

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	=	
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		X	2.75	=	
8	Abscess drainage in addition to body scan with or without contrast		X	4.00	=	

10d. Other Imaging Equipment

	Number of Units	Number of Procedures		
		Inpatient	Outpatient	Total
Dedicated Fixed PET Scanner				
Mobile PET Scanner	1	2	199	201
PET pursuant to Policy AC-3				
Other Human Research PET Scanner				
Ultrasound equipment	3	1971	2387	4808
Bone Density Equipment	2	7	900	907
Fixed X-ray Equipment (excluding fluoroscopic)	4	5757	12812	18569
Fixed Fluoroscopic X-ray Equipment	2	1807	2121	3928
Special Procedures/ Angiography (neuro & vascular, but not including cardiac cath.)				
Coincidence Camera				
Mobile Coincidence Camera Vendor:				
SPECT	1	598	2248	2846
Mobile SPECT Vendor:				
Gamma Camera				
Mobile Gamma Camera 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 Units	Number of Procedures		
		Inpatient	Outpatient	Total
Fixed				
Mobile	1	0	40	40

Lithotripsy Vendor/Owner:
Health Tronics

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)		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 techniques, ESTV values are indicated 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 (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		
	Sub-Total				
	TOTALS:				

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

11. Radiation Oncology Treatment Data *continued*

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 (Outpatient)	X	5. Rehabilitation Outpatient Unit	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
Out of State										
Total All Ages										

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 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 & 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	Beds Assigned by Age				
		0-12	13-17	Subtotal 0-17	18 & up	Total Beds
.5200 Dedicated inpatient unit for individuals who have mental disorders	PRH				X	36

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						
.3600 Outpatient narcotic addiction treatment						
.3700 Day treatment facilities for individuals with substance abuse disorders						

Rule 10A NCAC 13B Licensure Rules For Hospitals	Location of Services	Beds Assigned by Age				
		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 _____						

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	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	
15. Camden		51. Johnston		87. Swain	7
16. Carteret		52. Jones		88. Transylvania	140
17. Caswell		53. Lee		89. Tyrrell	
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	95. Watauga	1
24. Columbus		60. Mecklenburg	7	96. Wayne	
25. Craven		61. Mitchell	2	97. Wilkes	
26. Cumberland	1	62. Montgomery		98. Wilson	
27. Currituck		63. Moore		99. Yadkin	
28. Dare		64. Nash		100. Yancey	14
29. Davidson		65. New Hanover	1		
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	2	70. Pasquotank		105. Other States	
35. Franklin		71. Pender		106. Other	162
36. Gaston	5	72. Perquimans		**Total No. of Patients**	4228

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.

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	
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	84. Stanly	
13. Cabarrus	1	49. Iredell	1	85. Stokes	
14. Caldwell	3	50. Jackson	11	86. Surry	
15. Camden		51. Johnston		87. Swain	4
16. Carteret		52. Jones		88. Transylvania	40
17. Caswell		53. Lee		89. Tyrrell	
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	
22. Clay	2	58. Martin	16	94. Washington	
23. Cleveland	3	59. McDowell		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	11
29. Davidson		65. New Hanover	1		
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	74
36. Gaston	1	72. Perquimans		**Total No. of Patients**	1302

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		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. Moore		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**	4974

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	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	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	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		95. Watauga	
24. Columbus		60. Mecklenburg	1	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	26
36. Gaston		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									
Alexander									
Alleghany		1	1						
Anson									
Ashe		6	6						
Avery		6	6						
Beaufort									
Bertie									
Bladen									
Brunswick									
Buncombe		324	324						
Burke		9	9						
Cabarrus		1	1						
Caldwell		1	1						
Camden									
Carteret									
Caswell									
Catawba		4	4						
Chatham									
Cherokee		18	18						
Chowan									
Clay		6	6						
Cleveland		15	15						
Columbus									
Craven									
Cumberland									
Currituck									
Dare									
Davidson		1	1						
Davie									
Duplin		1	1						
Durham									
Edgecombe									
Forsyth		2	2						
Franklin									
Gaston		10	10						
Gates									
Graham		6	6						
Granville									
Greene									
Guilford		1	1						
Halifax		1	1						
Harnett									
Haywood		70	70						
Henderson		309	309						
Hertford									
Hoke									
Hyde									
Iredell		2	2						
Jackson		31	31						
Johnston									

** 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 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
Jones									
Lee									
Lenoir									
Lincoln									
Macon		18	18						
Madison		25	25						
Martin		19	19						
McDowell									
Mecklenburg		10	10						
Mitchell		9	9						
Montgomery									
Moore									
Nash									
New Hanover									
Northampton									
Onslow		2	2						
Orange									
Pamlico									
Pasquotank									
Pender									
Perquimans									
Person									
Pitt									
Polk		14	14						
Randolph									
Richmond									
Robeson									
Rockingham									
Rowan									
Rutherford		28	28						
Sampson									
Scotland									
Stanly		1	1						
Stokes									
Surry									
Swain		14	14						
Transylvania		82	82						
Tyrrell									
Union									
Vance		2	2						
Wake		4	4						
Warren									
Washington		1	1						
Watauga		12	12						
Wayne									
Wilkes		2	2						
Wilson									
Yadkin									
Yancey		22	22						
Out of State		64	64						
TOTALS			1154						

** 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**). **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. Polk	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	
13. Cabarrus	8	49. Iredell		85. Stokes	
14. Caldwell	7	50. Jackson	19	86. Surry	
15. Camden		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		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		
30. Davie		66. Northampton		101. Georgia	
31. Duplin		67. Onslow	2	102. South Carolina	
32. Durham		68. Orange	1	103. Tennessee	
33. Edgecombe		69. Pamlico		104. Virginia	
34. Forsyth	4	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 services currently provided at your hospital? yes _____ no _____

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
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. 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	
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**	

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.**

County	No. 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	16
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	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		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	2
36. Gaston		72. Perquimans		**Total No. of Patients**	201

This application must be completed and submitted with ONE COPY to the Acute and Home Care Licensure and Certification Section, Division of Health Service Regulation prior to the issuance of a 2009 hospital license.

AUTHENTICATING SIGNATURE: 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: Jimm Bunch **Date:** 11-26-08

PRINT NAME OF APPROVING OFFICIAL Jimm Bunch

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

EXHIBIT
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North Carolina Department of Health and Human Services
Division of Health Service Regulation
Acute and Home Care Licensure and Certification Section
2705 Umstead Drive, 2719 Mail Service Center
Raleigh, North Carolina 27699-2719
Telephone: (919) 855-4620 Fax: (919) 715-3073

For Official Use Only
License #: H0019C Medicare #: 340023
Computer: 943388
PC Date

License Fee: $2,252.50

2010
HOSPITAL LICENSE
RENEWAL APPLICATION

Legal Identity of Applicant: **Fletcher Hospital, Incorporated**
(Full legal name of corporation, partnership, individual, or other legal entity owning the enterprise or service.)

Doing Business As
(d/b/a) name(s) under which the facility or services are advertised or presented to the public:

PRIMARY: **Park Ridge Hospital**
Other:
Other:

Facility Mailing Address: P O Box 1507
Fletcher, NC 28732

Facility Site Address: Naples Rd
Fletcher, NC 28732

County: Henderson
Telephone: (828) 684-8501
Fax: (828) 687-0729

Administrator/Director: JIMM BLNCH
Title: CEO
(Designated agent (individual) responsible to the governing body (owner) for the management of the licensed facility)

Chief Executive Officer: JOHN Bunch **Title** President & CEO
(Designated agent (individual) responsible to the governing body (owner) for the management of the licensed facility)

Name of the person to contact for any questions regarding this form:

Name: Myriam Schulze Telephone: (828) 681-2102

E-Mail: myriam.schulze@ahss.org

Type of Health Care facilities under the Hospital License

List Name(s) of facilities	Address	Type of Business / Service

Please attach a separate sheet for additional listings.

Ownership Disclosure (Please fill in any blanks and make changes where necessary.)

1. What is the name of the legal entity with ownership, responsibility and liability?
   Owner: Fletcher Hospital, Incorporated
   Federal Employer ID#: 56-05-3245
   Street/Box: P O Box 1569
   City: Fletcher State: NC Zip: 28732
   Telephone: (828)684-8501 Fax: (828)687-0729
   CEO: Jimmy 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?)
   Yes X No

   If Yes, name of Health System: Advent ist Health System
   (please attach a list of NC facilities that are part of your Health System)
   If Yes, name of CEO: Donald Jernigan, Pres/CEO

   a. Legal entity is: ___ For Profit X Not For Profit

   b. Legal entity is: X Corporation ___ LLP ___ Partnership
      ___ 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

2. Is the business operated under a management contract? ___ Yes X No

   If "Yes", name and address of the management company:
   Name
   Street/Box
   City State Zip
   Telephone: ( )

Ownership Disclosure *continued*

3. Vice President of Nursing and Patient Care Services:
Ronald Metcalf, RN, MaEd - Interim VP of Nursing

4. Director of Planning: Jason Wells

Facility Data

A. **Reporting Period**: All responses should pertain to the period October 1, 2008 to September 30, 2009.

B. **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.	2,226	
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.	2,208	
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.	39	
d. Was there a permanent change in the total number of licensed beds during the reporting period?	Yes	X 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.	826	

C. **Designation and Accreditation**

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. If this facility is accredited by the Joint Commission or AOA, specify the accrediting body:

JC and indicate the date of the last survey: 06 / 09 / 2009

All responses should pertain to October 1, 2008 through September 30, 2009

D. Beds by Service (Inpatient – Do Not Include Observation Beds or Days of Care)

[Please provide a Beds by Service (D. 1) 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, 2009	Staffed Beds as of September 30, 2009	Annual Census Inpt. Days of Care
Intensive Care Units			
a. Burn *			
b. Cardiac (combined, not just cardiac telemetry) *	14	14	5,226
c. Cardiovascular surgery *			
d. Medical/Surgical *			
e. Neonatal Beds (Level IV) * (Not Normal Newborn)			
f. Pediatric *			
g. Respiratory Pulmonary *			
h. Other (List) *			
Other Units			
i. Gynecology *			
j. Medical/Surgical *	40	40	14,502
k. Neonatal Level III * (Not Normal Newborn)			
l. Neonatal Level II * (Not Normal Newborn)			
m. Obstetric (including LDRP) *	8	8	1,589
n. Oncology *			
o. Orthopedics *			
p. Pediatric *			
q. Other (List) *			
1. Total General Acute Care Beds/Days (a through q)	62	62	21,317
2. Comprehensive In-Patient Rehabilitation	0		
3. Inpatient Hospice	0		
4. Detoxification	0		
5. Substance Abuse / Chemical Dependency Treatment	0		
6. Psychiatry	41	36	12,017
7. Nursing Facility **	0		
8. Adult Care Home **	0		
9. Other **	0		
10. Totals (1 through 9)	103	98	33,334

* Please report only Census Days of Care of DRG's 927, 928, 929, 935, 936 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)

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	1,182	5,450	3,084	35	115
Medicare & Medicare Managed Care	5,438	3,427	37,618	432	2,027
Medicaid	2,276	5,442	7,966	281	649
Commercial Insurance	52	232	600	74	2
Managed Care	2,969	4,725	30,788	350	2,029
Other (Specify)					
TOTAL	11,917	19,276	80,046	1,103	4,848

F. Services and Facilities

1. Obstetrics

	Enter Number of Infants
a. Live births (Vaginal Deliveries)	361
b. Live births (Cesarean Section)	162
c. Stillbirths	

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

All responses should pertain to October 1, 2008 through September 30, 2009.

3. **Emergency Department Services** (cases equal visits to ED)

a. Total Number of ED Exam Rooms: 32

a.1. # Trauma Rooms: 0 a.2. # Fast Track Rooms: 20

b. Total Number of ED visits for reporting period: 17,409

c. Total Number of admits from the ED for reporting period: 1,807

d. Total Number of Urgent Care visits for reporting period: 7,454

e. Does your ED provide services 24 hours a day 7 days per week? x Yes ___ No
If no, specify days/hours of operation: ___

f. Is a physician on duty in your ED 24 hours a day 7 days per week? x Yes ___ No
If no, specify days/hours physician is on duty: ___

4. **Medical Air Transport** - Owned or leased air ambulance service:

a. Does the facility operate an air ambulance service? ___ Yes x No

b. If "Yes", complete the following chart.

Type of Aircraft	Number of Aircraft	Number Owned	Number Leased	Number of Transports
Rotary				
Fixed Wing				

5. **Pathology and Medical Lab** - (Check whether or not service is provided)

a. Blood Bank/Transfusion Services x Yes ___ No
b. Histopathology/Laboratory x Yes ___ No
c. HIV Laboratory Testing x Yes ___ No
Number during reporting period:
HIV Serology: 95
HIV Culture: 0
d. Organ Bank ___ Yes x No
e. Pap Smear Screening x Yes ___ No

6. **Transplantation Services** - Number of Transplants:

Type	Number	Type	Number	Type	Number
a. Bone Marrow Allogeneic	0	i. Kidney/Liver	0	k. Lung	0
b. Bone Marrow Autologous	0	j. Liver	0	l. Pancreas	0
c. Cornea	13	k. Heart/Liver	0	m. Pancreas/Kidney	0
d. Heart	0	l. Heart/Kidney	0	n. Pancreas/Liver	0
e. Heart/Lung	0	m. Kidney	0	o. Other	0

Do you perform living donor transplants? ___ Yes x No

7. **Specialized Cardiac Services** (for questions, call 865-3865 [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	Electrophysiology 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 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 = 5 8-hour days per week; Monday, Wednesday, Saturday for 10 hours per day = 3 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 total in #2, Number of Procedures on Patients Age 14 & younger	
6. Of total in #3, Number of Procedures on Patients Age 14 & younger	

8. Surgical Operating Rooms, Procedure Rooms, Gastrointestinal Endoscopy Rooms, Surgical and Non-Surgical Cases and Procedures

NOTE: If this License includes more than one campus, please submit the Cumulative Totals and CON's and Submit a duplicate of pages 8 and 9 for each campus.

Campus – *If multiple sites*

a) Surgical Operating Rooms

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.

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

Number of additional CON approved surgical operating rooms pending development

CON Project ID Number(s)

b) Procedure Rooms (excluding Operating Rooms and Gastrointestinal Endoscopy Rooms)

Report rooms where are not equipped for or do not meet all the specifications of an operating room that are used for performance of procedures other than Gastrointestinal Endoscopy procedures.

Total Number of Procedure Rooms 0

c) 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 1

Number of additional CON approved GI Endoscopy Rooms pending development 0

CON Project ID Number(s)

	Number of Cases	Number of Procedures
GI Endoscopy	649	0
Non-GI Endoscopy		
Totals	649	0

Count each patient has one case, regardless of the number of procedures performed while the patient was in the GI endoscopy room.

As defined in 10A NCAC 14C .3903, "Gastrointestinal (GI) endoscopy procedures" means a single procedure identified by a CPT code or ICD-9-CM procedure code performed on a patient during a single visit to the facility for diagnostic or therapeutic purposes.

8. **Surgical Operating Rooms, Procedure Rooms, Gastrointestinal Endoscopy Rooms, Surgical and Non-Surgical Cases and Procedures** *(continued)*

(Campus – *If multiple sites:* _____ **)**

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 performed in procedure rooms or in any other location.**

Surgical Specialty Area	Inpatient Cases	Ambulatory Cases
Cardiothoracic (excluding Open Heart Surgery)		
Open Heart Surgery (from v. (b) 4.)	0	[redacted]
General Surgery	210	530
Neurosurgery	6	1
Obstetrics and GYN (excluding C-Sections)	102	340
Ophthalmology	0	1,180
Oral Surgery	0	3
Orthopedics	454	1,650
Otolaryngology	97	570
Plastic Surgery	14	172
Urology	70	392
Vascular	16	7
Other Surgeries (specify)	0	0
Other Surgeries (specify)	0	[redacted]
Number of C-Sections Performed in Dedicated C-Section ORs	52	
Number of C-Sections Performed in Other ORs	115	
Total Surgical Cases	1,035	4,846

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	5	106
Cystoscopy		
Non-GI Endoscopies *(not reported in 8.c)*		
GI Endoscopies *(not reported in 8.c)*		
YAG Laser		
Other (specify) Bronchoscopy		6
Other (specify) Bone Marrow Biopsy	7	
Other (specify)		
Total Non-Surgical Cases	12	117

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	116	64

* 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.

** **"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*

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	Inpatient Procedures			Outpatient Procedures			
Fixed MRI Scanners-closed	1							
Fixed MRI Scanners-open		With Contrast or Sedation	Without Contrast or Sedation	TOTAL Inpatient	With Contrast or Sedation	Without Contrast or Sedation	TOTAL Outpatient	TOTAL 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 Provider 2 Data								
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: _____

Name of Mobile MRI Provider 2: _____

10b. MRI Procedures by CPT Codes (duplicate CPT codes were removed)

CPT Code	CPT Description	Number of Procedures
70336	MRI Temporomandibular Joint(s)	4
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	
70553	MRI Brain w/o & with	459
7055A	IAC Screening	
	Subtotal for this page	791

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

CPT Code	CPT Description	Number of Procedures
71550	MRI Chest w/o	2
71551	MRI Chest with contrast	
71552	MRI Chest w/o & with	2
71555	MRA Chest with OR without contrast	
72126	Cervical Spine infusion only	
72141	MRI Cervical Spine w/o	354
72142	MRI Cervical Spine with contrast	
72156	MRI Cervical Spine w/o & with	49
72146	MRI Thoracic Spine w/o	98
72147	MRI Thoracic Spine with contrast	
72157	MRI Thoracic Spine w/o & with	21
72148	MRI Lumbar Spine w/o	436
72149	MRI Lumbar Spine with contrast	
72158	MRI Lumbar Spine w/o & with	101
72159	MRA Spinal Canal w/o OR with contrast	
72195	MRI Pelvis w/o	38
72196	MRI Pelvis with contrast	
72197	MRI Pelvis w/o & with	18
72198	MRA Pelvis w/o OR with Contrast	
73218	MRI Upper Ext. other than joint w/o	3
73219	MRI Upper Ext other than joint with contrast	
73220	MRI Upper Ext other than joint w/o & with	6
73221	MRI Upper Ext any joint w/o	258
73222	MRI Upper Ext any joint with contrast	46
73223	MRI Upper Ext any joint w/o & with	3
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	50
73721	MRI Lower Ext any joint w/o	128
73722	MRI Lower Ext any joint with contrast	1
73723	MRI Lower Ext any joint w/o & with	16
73725	MRA Lower Ext w/o OR with contrast	
74181	MRI Abdomen w/o	54
74182	MRI Abdomen with contrast	
	Subtotal for this page	2,097

10b. MRI Procedures by CPT Codes *continued*

CPT Code	CPT Description	Number of Procedures
74181	MRI Abdomen w/o & with	21
74185	MRA Abdomen w/o OR with contrast	2
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	1
76094	MRI Breast bilateral w/o and/or with contrast	95
76125	Cineradiography fo complement exam	
76390	MRI Spectroscopy	
76393	MRI Guidance for needle placement	
76394	MRI Guidance for tissue ablation	
76400	MRE Bone Marrow blood supply	
76497	MR functional imaging	
76498	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	119
	Total Number of Procedures for all pages	3,007

10c. Computed Tomography (CT)

How many fixed CT scanners does the hospital have? 2

Does the hospital contract for mobile CT scanner services? Yes X No

If yes, identify the mobile CT vendor

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 HPC CT Units)*

	Type of CT Scan	# of Scans		Conversion Factor		HPC CT Units
1	Head without contrast	1,955	X	1.00	=	1,955
2	Head with contrast	4	X	1.25	=	5
3	Head without and with contrast	150	X	1.75	=	262
4	Body without contrast	1,584	X	1.50	=	2,376
5	Body with contrast	3,049	X	1.75	=	5,336
6	Body without contrast and with contrast	486	X	2.75	=	1,336
7	Biopsy, head or neck or body scan with or without contrast	66	X	1.25	=	82
8	Abscess drainage in addition to body scan with or without contrast	31	X	4.00	=	124

All responses should pertain to October 1, 2008 through September 30, 2009.

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

	Type of CT Scan	# CT Scans		Conversion Factor	=	HECT Units
1	Head without contrast		X	1.00	=	
2	Head with contrast		X	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		X	2.75	=	
8	Abscess drainage in addition to body scan with or without contrast		X	4.00	=	

10d. Other Imaging Equipment

	Number of Units	Number of Procedures		
		Inpatient	Outpatient	Total
Dedicated Fixed PET Scanner	0			
Mobile PET Scanner	1	0	210	210
PET pursuant to Policy AC-3	0			
Other Human Research PET Scanner	0			
Ultrasound equipment	3	1,988	2,860	4,848
Mammography equipment	2	11	4,834	4,845
Bone Density Equipment	2	7	1,032	1,041
Fixed X-ray Equipment (excluding fluoroscopic)	2	2,717	1,628	4,345
Fixed Fluoroscopic X-ray Equipment	2	1,716	945	2,661
Special Procedures Angiography (neuro, vascular, but not including cardiac cath.)	0			
Coincidence Camera	0			
Mobile Coincidence Camera Vendor	0			
SPECT	0			
Mobile SPECT Vendor	0			
Gamma Camera	1			
Mobile Gamma Camera Vendor	1	65	1,013	1,078

* 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 Units	Number of Procedures			Lithotripsy Vendor/Owner
		Inpatient	Outpatient	Total	
Fixed	0	0	45	45	Health Images
Mobile	0	0	0	0	

All responses should pertain to October 1, 2008 through September 30, 2009.

11. Radiation Oncology Treatment Data

CPT Code	Description	# of Procedures
Simple Treatment Delivery		
77401	Radiation treatment delivery	
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 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 Treatment 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 Treatment Delivery Not Included Above		
77418	Intensity modulated radiation treatment (IMRT) delivery	
77371	Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session, multi-source Cobalt 60 based (Gamma Knife)	
77372	Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course 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, delivery including collimator changes and custom plan of one session or first fraction of fractionated treatment	
G0340	(Image guided) robotic linear accelerator based stereotactic radiosurgery, delivery including collimator changes and custom plan of one session or first fraction of 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 radiation	
	Hemibody irradiation	
	Total body irradiation	
Imaging Procedures Not Included Above		
77417	Additional field check radiographs	
	Total Procedures	0

11. Radiation Oncology Treatment Data *continued*

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.** patients
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 131E-176(24)))
e. 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? NO

13. Additional Services

a) **Check if Service(s) is provided (for dialysis stations, show number of stations)**

	Check		Check
1. Cardiac Rehab Program (Outpatient)	X	5. Rehabilitation Outpatient Unit	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
Out of State										
Total All Ages										

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 Behavioral Health Services and
Dr. Phillip Lartey, 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 .1700 Licensure Rules For Mental Health Facilities	Location of Services	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	Beds Assigned by Age				
		0-12	13-17	Subtotal 0-17	18 & up	Total Beds
.5200 Dedicated inpatient unit for individuals who have mental disorders	PRHC				X	

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	N/A					
.3200 Social setting detoxification for substance abusers	N/A					
.3300 Outpatient detoxification for substance abusers	N/A	[redacted]				
.3400 Residential treatment/rehabilitation for individuals with substance abuse disorders	N/A					
.3500 Outpatient facilities for individuals with substance abuse disorders	N/A	[redacted]				
.3600 Outpatient narcotic addiction treatment	N/A					
.3700 Day treatment facilities for individuals with substance abuse disorders	N/A					

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

All responses should pertain to October 1, 2008 through September 30, 2009

Patient Origin: General Acute Care Inpatient Services

Facility County: Henderson

In any 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		74. Pitt	1
3. Alleghany		39. Granville		75. Polk	65
4. Anson		40. Greene		76. Randolph	
5. Ashe		41. Guilford		77. Richmond	
6. Avery	3	42. Halifax		78. Robeson	
7. Beaufort		43. Harnett		79. Rockingham	
8. Bertie		44. Haywood	3	80. Rowan	2
9. Bladen		45. Henderson	2,413	81. Rutherford	34
10. Brunswick	1	46. Hertford		82. Sampson	
11. Buncombe	597	47. Hoke		83. Scotland	
12. Burke	11	48. Hyde		84. Stanly	1
13. Cabarrus		49. Iredell	1	85. Stokes	
14. Caldwell	2	50. Jackson	17	86. Surry	2
15. Camden		51. Johnston		87. Swain	4
16. Carteret		52. Jones		88. Transylvania	184
17. Caswell		53. Lee		89. Tyrrell	
18. Catawba	2	54. Lenoir		90. Union	1
19. Chatham		55. Lincoln		91. Vance	
20. Cherokee	4	56. Macon	23	92. Wake	
21. Chowan		57. Madison	8	93. Warren	
22. Clay	2	58. Martin	9	94. Washington	
23. Cleveland	6	59. McDowell	1	95. Watauga	3
24. Columbus		60. Mecklenburg	3	96. Wayne	1
25. Craven		61. Mitchell	8	97. Wilkes	1
26. Cumberland	1	62. Montgomery		98. Wilson	
27. Currituck		63. Moore		99. Yadkin	
28. Dare		64. Nash		100. Yancey	13
29. Davidson		65. New Hanover			
30. Davie		66. Northampton		101. Georgia	
31. Duplin		67. Onslow		102. South Carolina	
32. Durham	2	68. Orange		103. Tennessee	
33. Edgecombe		69. Pamlico		104. Virginia	
34. Forsyth	15	70. Pasquotank		105. Other States	106
35. Franklin	1	71. Pender		106. Other	
36. Gaston	1	72. Perquimans		Total No. of Patients	3,727

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 of a surgical 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 01.

County	No. of Patients	County	No. of Patients	County	No. of Patients
1. Alamance		37. Gates		73. Person	
2. Alexander		38. Graham		74. Pitt	1
3. Alleghany		39. Granville		75. Polk	34
4. Anson		40. Greene		76. Randolph	
5. Ashe		41. Guilford	2	77. Richmond	
6. Avery	2	42. Halifax	1	78. Robeson	
7. Beaufort		43. Harnett		79. Rockingham	
8. Bertie		44. Haywood	65	80. Rowan	
9. Bladen		45. Henderson	574	81. Rutherford	24
10. Brunswick		46. Hertford		82. Sampson	
11. Buncombe	229	47. Hoke		83. Scotland	
12. Burke	11	48. Hyde		84. Stanly	1
13. Cabarrus		49. Iredell	1	85. Stokes	
14. Caldwell	2	50. Jackson	10	86. Surry	
15. Camden		51. Johnston		87. Swain	3
16. Carteret		52. Jones		88. Transylvania	46
17. Caswell		53. Lee		89. Tyrrell	
18. Catawba		54. Lenoir		90. Union	1
19. Chatham		55. Lincoln		91. Vance	
20. Cherokee	4	56. Macon	1	92. Wake	
21. Chowan		57. Madison	8	93. Warren	
22. Clay	26	58. Martin		94. Washington	
23. Cleveland	3	59. McDowell		95. Watauga	1
24. Columbus		60. Mecklenburg	2	96. Wayne	1
25. Craven		61. Mitchell	6	97. Wilkes	
26. Cumberland		62. Montgomery		98. Wilson	
27. Currituck		63. Moore		99. Yadkin	
28. Dare		64. Nash		100. Yancey	2
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	1,172

All responses should pertain to: **October 1, 2008 through September 30, 2009**

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		38. Graham	109	74. Pitt	
3. Alleghany		39. Granville		75. Polk	55
4. Anson		40. Greene		76. Randolph	
5. Ashe	3	41. Guilford	21	77. Richmond	
6. Avery	6	42. Halifax	1	78. Robeson	
7. Beaufort		43. Harnett	1	79. Rockingham	
8. Bertie		44. Haywood	258	80. Rowan	
9. Bladen		45. Henderson	2,540	81. Rutherford	45
10. Brunswick	2	46. Hertford		82. Sampson	
11. Buncombe	1,090	47. Hoke		83. Scotland	
12. Burke		48. Hyde		84. Stanly	
13. Cabarrus		49. Iredell		85. Stokes	
14. Caldwell		50. Jackson	58	86. Surry	
15. Camden		51. Johnston		87. Swain	
16. Carteret		52. Jones		88. Transylvania	92
17. Caswell		53. Lee		89. Tyrrell	
18. Catawba		54. Lenoir		90. Union	
19. Chatham		55. Lincoln		91. Vance	
20. Cherokee	21	56. Macon	52	92. Wake	3
21. Chowan		57. Madison	667	93. Warren	
22. Clay	10	58. Martin	56	94. Washington	
23. Cleveland	4	59. McDowell		95. Watauga	
24. Columbus		60. Mecklenburg		96. Wayne	
25. Craven		61. Mitchell	25	97. Wilkes	
26. Cumberland		62. Montgomery		98. Wilson	
27. Currituck		63. Moore		99. Wilkin Ave	1
28. Dare		64. Nash		100. Yadkin	56
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	105
35. Franklin		71. Pender		106. Others	
36. Gaston		72. Perquimans		Total No. of Patients	

All responses should pertain to October 1st 2008 through September 30th 2009

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	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
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	1
9. Bladen		45. Henderson	46	81. Rutherford	4
10. Brunswick		46. Hertford		82. Sampson	
11. Buncombe	95	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	21
17. Caswell		53. Lee		89. Tyrrell	
18. Catawba	1	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		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	2	72. Perquimans		Total No. of Patients	646

2010 Renewal Application for Hospital:
Park Ridge Hospital

License No: **H0019**
Facility ID: **943388**

All responses should pertain to October 1, 2008 through September 30, 2009.

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 .4200.

County of Patient Origin	Psychiatric Treatment Days of Care			Sub-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	1						
Alexander									
Alleghany									
Anson									
Ashe		10	10						
Avery		12	12						
Beaufort									
Bertie									
Bladen									
Brunswick		2	2						
Buncombe		311	311						
Burke		5	5						
Cabarrus		3	3						
Caldwell		1	1						
Camden									
Carteret									
Caswell									
Catawba		2	2						
Chatham									
Cherokee		13	13						
Chowan									
Clay		6	6						
Cleveland		13	13						
Columbus									
Craven		1	1						
Cumberland		8	8						
Currituck									
Dare									
Davidson									
Davie									
Duplin									
Durham									
Edgecombe		1	1						
Forsyth									
Franklin									
Gaston		13	13						
Gates									
Graham		5	5						
Granville									
Greene									
Guilford		3	3						
Halifax									
Harnett									
Haywood		78	78						
Henderson		293	293						
Hertford									
Hoke									
Hyde									
Iredell		1	1						
Jackson		29	29						
Johnston									

Note: See counties Jones through Yancey (continue On-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 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
Jones									
Lee									
Lenoir									
Lincoln									
Macon		22	22						
Madison		32	32						
Martin		22	22						
McDowell		29	29						
Mecklenburg		7	7						
Mitchell		27	27						
Montgomery									
Moore									
Nash									
New Hanover		1	1						
Northampton									
Onslow		2	2						
Orange									
Pamlico									
Pasquotank									
Pender									
Perquimans									
Person									
Pitt		1	1						
Polk		10	10						
Randolph		1	1						
Richmond									
Robeson									
Rockingham									
Rowan		1	1						
Rutherford		25	25						
Sampson									
Scotland									
Stanly		2	2						
Stokes									
Surry		2	2						
Swain		9	9						
Transylvania		76	76						
Tyrrell									
Union		1	1						
Vance									
Wake		9	9						
Warren									
Washington									
Watauga		6	6						
Wayne									
Wilkes		2	2						
Wilson		1	1						
Yadkin									
Yancey		3	3						
Out of State		45	45						
TOTALS			0						

** 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). **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	1	37. Gates	4	73. Person	
2. Alexander		38. Graham		74. Pitt	3
3. Alleghany		39. Granville		75. Polk	60
4. Anson		40. Greene		76. Randolph	
5. Ashe	2	41. Guilford	5	77. Richmond	
6. Avery		42. Halifax		78. Robeson	
7. Beaufort		43. Harnett		79. Rockingham	25
8. Bertie		44. Haywood	55	80. Rowan	
9. Bladen		45. Henderson	718	81. Rutherford	27
10. Brunswick	1	46. Hertford		82. Sampson	
11. Buncombe	6918	47. Hoke		83. Scotland	
12. Burke	9	48. Hyde		84. Stanly	
13. Cabarrus		49. Iredell	2	85. Stokes	
14. Caldwell	4	50. Jackson	7	86. Surry	
15. Camden		51. Johnston	3	87. Swain	2
16. Carteret	1	52. Jones		88. Transylvania	112
17. Caswell		53. Lee		89. Tyrrell	
18. Catawba	1	54. Lenoir		90. Union	3
19. Chatham		55. Lincoln	3	91. Vance	
20. Cherokee	5	56. Macon	16	92. Wake	2
21. Chowan		57. Madison	24	93. Warren	
22. Clay	2	58. Martin	23	94. Washington	1
23. Cleveland	1	59. McDowell	4	95. Watauga	1
24. Columbus	1	60. Mecklenburg	10	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	13
29. Davidson	3	65. New Hanover			
30. Davie	7	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	1	70. Pasquotank	3	105. Other States	147
35. Franklin		71. Pender		106. Other	
36. Gaston	1	72. Perquimans		Total No. of Patients	3,005

Are mobile MRI services currently provided at your hospital? yes ____ no ____

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 I 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 II of this application.

County	No. 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. 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		101. Georgia	
30. Davie		66. Northampton		102. South Carolina	
31. Duplin		67. Onslow		103. Tennessee	
32. Durham		68. Orange		104. Virginia	
33. Edgecombe		69. Pamlico		105. Other States	
34. Forsyth		70. Pasquotank		106. Other	
35. Franklin		71. Pender		Total No. of Patients	
36. Gaston		72. Perquimans			

All responses should pertain to October 1, 2008 through September 30, 2009.

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.

County	No. of Patients	County	No. of Patients	County	No. of Patients
1. Alamance		37. Gaston		73. Person	
2. Alexander		38. Graham		74. Pitt	
3. Alleghany		39. Granville		75. Polk	19
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. Bladen		45. Henderson	133	81. Rutherford	5
10. Brunswick		46. Hertford		82. Sampson	
11. Buncombe	42	47. Hoke		83. Scotland	
12. Burke		48. Hyde		84. Stanly	
13. Cabarrus	2	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	2	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		101. Georgia	
30. Davie		66. Northampton		102. South Carolina	
31. Duplin		67. Onslow		103. Tennessee	
32. Durham		68. Orange		104. Virginia	
33. Edgecombe		69. Pamlico		105. Other States	
34. Forsyth		70. Pasquotank		106. Other	
35. Franklin		71. Pender		Total No. of Patients	210
36. Gaston		72. Perquimans			

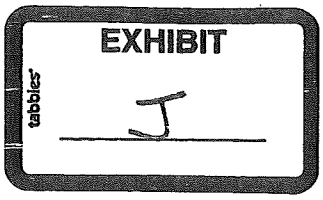
This application must be completed and submitted with ONE COPY to the Acute and Home Care Licensure and Certification Section, Division of Health Service Regulation prior to the issuance of a 2010 hospital license.

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 (10A NCAC 13B), and certifies the accuracy of this information.

Signature: _____ **Date:** _____

PRINT NAME OF APPROVING OFFICIAL Jimm Bunch

Please be advised, the license fee must accompany the completed application and be submitted to the Acute and Home Care Licensure and Certification Section, Division of Health Service Regulation prior 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: $2,252.50

2011
HOSPITAL LICENSE
RENEWAL APPLICATION

Legal Identity of Applicant: **Fletcher Hospital, Incorporated**
(Full legal name of corporation, partnership, individual, or other legal entity owning the enterprise or service.)

Doing Business As
(d/b/a) name(s) under which the facility or services are advertised or presented to the public:

PRIMARY: ~~Park Ridge Hospital~~
Other: Park. Ridge Health
Other:

Facility Mailing Address: ~~P O Box 1569~~ ~~Fletcher, NC 28732~~ 100 Hospital Drive Hendersonville, NC 28792

Facility Site Address: ~~Naples Rd~~ ~~Fletcher, NC 28732~~ 100 Hospital Drive Hendersonville, NC 28792

County: Henderson
Telephone: (828)684-8501
Fax: (828)687-0729

Administrator/Director: JIMM BUNCH
Title: CEO
(Designated agent (individual) responsible to the governing body (owner) for the management of the licensed facility)

Chief Executive Officer: [signature] **Title:** President and CEO
(Designated agent (individual) responsible to the governing body (owner) for the management of the licensed facility)

Name of the person to contact for any questions regarding this form:

Name: Colleen Ramsey **Telephone:** (828) 681. 2102

E-Mail: colleen. ramsey @ ahss. org

Type of Health Care Facilities under the Hospital License (please include offsite emergency departments)

List Name(s) of facilities:	Address:	Type of Business / Service:
See attached list		

Please attach a separate sheet for additional listings

Ownership Disclosure (Please fill in any blanks and make changes where necessary.)

1. 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~~ 100 Hospital Drive
City: ~~Fletcher~~ State: NC Zip: ~~28732~~ Hendersonville, NC 28792
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, offsite emergency departments, ambulatory surgical facilities, nursing homes, home health agencies, etc. owned by your hospital, a parent company or a related entity?] ____ Yes ✓ No ____

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, PhD

a. Legal entity is: ___ For Profit X Not For Profit

b. Legal entity is: X Corporation ___ LLP ___ Partnership
___ 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: _____

2. Is the business operated under a management contract? ___ Yes X No

If 'Yes', name and address of the management company.
Name: _____
Street/Box: _____
City: _____ State: _____ Zip: _____
Telephone: (___) _____

Ownership Disclosure *continued. . .*

3. Vice President of Nursing and Patient Care Services: Craig Lindsey
4. Director of Planning: Jason Wells

Facility Data

A. **Reporting Period** All responses should pertain to the period **October 1, 2009 to September 30, 2010.**

B. **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.**	30.65	
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?		
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.	716	

C. Designation and Accreditation

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 ___ No Expiration Date: Sept 2012
5. Is this facility DNV accredited? ___ Yes X No Expiration Date: ___
6. Is this facility AOA accredited? X Yes ___ No Expiration Date: 2013
7. Are you a Medicare deemed provider? X Yes ___ No

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, 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			
i. Gynecology			
j. Medical/Surgical ***	40	40	*** 6,940
k. Neonatal Level III ** (Not Normal Newborn)			**
l. Neonatal Level II ** (Not Normal Newborn)			**
m. Obstetric (including LDRP)	8	8	1,391
n. Oncology			
o. Orthopedics			
p. Pediatric			
q. 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)

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.)

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	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	650
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)	381
b. Live births (Cesarean Section)	151
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 "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)	12

2. Abortion Services

Number of procedures per Year 0

3. **Emergency Department Services** (cases equal visits to ED)

a. Total Number of ED Exam Rooms: 12

a.1. #Trauma Rooms 0 a.2. #Fast Track Rooms ____

b. Total Number of ED visits for reporting period: 19,486

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 duty in your ED 24 hours a day 7 days per week? ✓ Yes ____ No
If no, specify days/hours physician is on duty:

4. **Medical Air Transport**: Owned or leased air ambulance service:

a. Does the facility operate an air ambulance service? ____ Yes ✓ No
b. If "Yes", complete the following chart.

Type of Aircraft	Number of Aircraft	Number Owned	Number Leased	Number of Transports
Rotary				
Fixed Wing				

5. **Pathology and Medical Lab** (Check whether or not service is provided)

a. Blood Bank/Transfusion Services ✓ Yes ____ No
b. Histopathology Laboratory ✓ Yes ____ No
c. HIV Laboratory Testing ✓ Yes ____ No
Number during reporting period
HIV Serology 60
HIV Culture 0
d. Organ Bank ____ Yes ✓ No
e. Pap Smear Screening ✓ Yes ____ No

6. **Transplantation Services** - Number of transplants

Type	Number	Type	Number	Type	Number
a. Bone Marrow-Allogeneic	0	i. Kidney/Liver	0	k. Lung	0
b. Bone Marrow-Autologous	0	j. Liver	0	l. Pancreas	0
c. Cornea	9	f. Heart/Liver	0	m. Pancreas/Kidney	0
d. Heart	0	g. Heart/Kidney	0	n. Pancreas/Liver	0
e. Heart/Lung	0	h. Kidney	0	o. Other	0

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

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
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 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 total in #2**, Number of Procedures on Patients Age 14 & younger	
6. **Of total in #3**, Number of Procedures on Patients Age 14 & younger	

8. Surgical Operating Rooms, Procedure Rooms, Gastrointestinal Endoscopy Rooms, Surgical and Non-Surgical Cases and Procedures

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.

(Campus – *If multiple sites*: _____)

a) Surgical Operating Rooms

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.

Type of Room	Number of Rooms
Dedicated Open Heart Surgery	0
Dedicated C-Section	1
Other Dedicated Inpatient Surgery	0
Dedicated Ambulatory Surgery	0
Shared - Inpatient / Ambulatory Surgery	6
Total of Surgical Operating Rooms	7

Number of additional CON approved surgical operating rooms pending development: _____

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

c) 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: 1

Number of additional CON approved GI Endoscopy Rooms pending development: _____

CON Project ID Number(s) _____

	Number of Cases	Number of Procedures*
GI Endoscopy	676	
Non-GI Endoscopy		
Totals	676	

Count each 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.

8. **Surgical Operating Rooms, Procedure Rooms, Gastrointestinal Endoscopy Rooms, Surgical and Non-Surgical Cases and Procedures** *(continued)*

(Campus – *If multiple sites*: _____)

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		
Obstetrics and GYN (excluding C-Sections)	110	342
Ophthalmology	1	1,033
Oral Surgery	1	66
Orthopedics	361	1,518
Otolaryngology	11	648
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	815	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-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	7	187

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 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.

** **"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*

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.

Number of fixed MRI scanners-closed (*do not include any* Policy AC-3 scanners)	# Units	Inpatient Procedures*			Outpatient Procedures*			TOTAL Procedures
# of fixed MRI scanners-open (*do not include any* Policy AC-3 scanners)		With Contrast or Sedation	Without Contrast or Sedation	TOTAL Inpatient	With Contrast or Sedation	Without Contrast or Sedation	TOTAL Outpatient	
Number of Policy AC-3 MRI scanners used for general clinical purposes								
Total Fixed MRI Scanners	1	29	253	282	199	1,980	2,179	2,461
Procedures performed on mobile MRI scanners **only at this site**		0	0	0	6	429	435	435
Name(s) of Mobile MRI Provider(s): Alliance Imaging								
The total number of procedures performed on the MRI scanners listed above 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. Patients served on units listed in the next two rows should not be included in the MRI Patient Origin Table on page 25 of this application.								
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	0
70547	MRA Neck w/o	2
70548	MRA Neck with contrast	0
70549	MRA Neck w/o & with	21
70551	MRI Brain w/o	110
70552	MRI Brain with contrast	1
	Subtotal for this page	231

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	0
71552	MRI Chest w/o & with	3
71555	MRA Chest with OR without contrast	0
72126	Cervical Spine Infusion only	0
72141	MRI Cervical Spine w/o	245
72142	MRI Cervical Spine with contrast	0
72156	MRI Cervical Spine w/o & with	51
72146	MRI Thoracic Spine w/o	51
72147	MRI Thoracic Spine with contrast	0
72157	MRI Thoracic Spine w/o & with	20
72148	MRI Lumbar Spine w/o	503
72149	MRI Lumbar Spine with contrast	0
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 Pelvis w/o & with	0
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	0
73220	MRI Upper Ext, other than joint w/o & with	5
73221	MRI Upper Ext, any joint w/o	277
73222	MRI Upper Ext, any joint with contrast	92
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	63
73719	MRI Lower Ext other than joint with contrast	0
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	0
74181	MRI Abdomen w/o	73
74182	MRI Abdomen with contrast	0
	Subtotal for this page	2,586

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

CPT 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	0
75553	MRI Cardiac Morphology with contrast	0
75554	MRI Cardiac Function Complete	0
75555	MRI Cardiac Function Limited	0
75556	MRI Cardiac Velocity Flow Mapping	0
76093	MRI Breast, unilateral w/o and/or with contrast	2
76094	MRI Breast, bilateral w/o and/or with contrast	20
76125	Cineradiography to complement exam	0
76390	MRI Spectroscopy	0
76393	MRI Guidance for needle placement	0
76394	MRI Guidance for tissue ablation	0
76400	MRI Bone Marrow blood supply	0
7649A	MR functional imaging	0
7649D	MRI 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	79
	Total Number of Procedures for all pages	2,896

10c. Computed Tomography (CT)

How many fixed CT scanners does the hospital have? 2

Does the hospital contract for mobile CT scanner services? ___ Yes ✓ 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	2,590	X	1.00	=	2590
2	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	2,246	X	1.75	=	3930.50
6	Body without contrast and with contrast	998	X	2.75	=	2744.50
7	Biopsy in addition to body scan with or without contrast	33	X	2.75	=	90.75
8	Abscess drainage in addition to body scan with or without contrast	58	X	4.00	=	232

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	=	
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		X	2.75	=	
8	Abscess drainage in addition to body scan with or without contrast		X	4.00	=	

10d. Other Imaging Equipment

	Number of Units	Number of Procedures		
		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	5,235
Mammography equipment	6,384		6,384	6,384
Bone Density Equipment	957		957	957
Fixed X-ray Equipment (excluding fluoroscopic)	19,500	4,095	15,405	19,500
Fixed Fluoroscopic X-ray Equipment	718	288	430	718
Special Procedures/ Angiography Equipment (neuro & vascular, but not including cardiac cath.)				
Coincidence Camera				
Mobile Coincidence Camera Vendor:				
SPECT				
Mobile SPECT Vendor:				
Gamma Camera	1,873	917	956	1873
Mobile Gamma Camera 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 Units	Number of Procedures		
		Inpatient	Outpatient	Total
Fixed				
Mobile	1	2	31	33

Lithotripsy Vendor/Owner:
HealthTronics

11. Linear Accelerator Treatment Data (including Cyberknife® & Similar Equipment)

CPT Code	Description	# of Procedures
Simple Treatment Delivery		
77401	Radiation treatment delivery	
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 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 Treatment 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 Treatment Delivery Not Included Above		
77418	Intensity modulated radiation treatment (IMRT) delivery	
77372	Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course 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	
Imaging Procedures Not Included Above		
77417	Additional field check radiographs	
	Total Procedures – Linear Accelerators	
Gamma Knife® Procedures		
77371	Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; multisource Cobalt 60 based (Gamma Knife)	
	Total Procedures – Gamma Knife®	

11. Linear Accelerator Treatment Data *continued*

a. Number of unduplicated patients 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 131E-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:

a) **Check if Service(s) is provided: (for dialysis stations, show number of stations)**

	Check		Check
1. Cardiac Rehab Program (Outpatient)	✓	5. Rehabilitation Outpatient Unit	✓
2. Chemotherapy	✓	6. Podiatric Services	✓
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
Out of State										
Total All Ages										

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 Behavioral Health Services
   Dr. Philip Lartey, 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 & up	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					
.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	Beds Assigned by Age				
		0-12	13-17	Subtotal 0-17	18 & up	Total Beds
.5200 Dedicated inpatient unit for individuals who have mental disorders	Park Ridge Health				✓	36

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	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	N/A					
.3700 Day treatment facilities for individuals with substance abuse disorders	N/A					

Rule 10A NCAC 13B Licensure Rules For Hospitals	Location of Services	Beds Assigned by Age				
		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 _____	N/A					

All responses should pertain to October 1, 2009 through September 30, 2010.

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	2	41. Guilford	1	77. Richmond	
6. Avery	1	42. Halifax		78. Robeson	
7. Beaufort		43. Harnett	2	79. Rockingham	
8. Bertie		44. Haywood	09	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	19	86. Surry	
15. Camden		51. Johnston		87. Swain	8
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	16	94. Washington	
23. Cleveland	11	59. McDowell		95. Watauga	1
24. Columbus		60. Mecklenburg	3	96. Wayne	
25. Craven		61. Mitchell	5	97. Wilkes	
26. Cumberland		62. Montgomery		98. Wilson	
27. Currituck		63. Moore		99. Yadkin	
28. Dare		64. Nash		100. Yancey	2
29. Davidson		65. New-Hanover			
30. Davie		66. Northampton		101. Georgia	
31. Duplin	1	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

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	County	No. of Patients	County	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	
9. Bladen		45. Henderson	438	81. Rutherford	3
10. Brunswick		46. Hertford		82. Sampson	
11. Buncombe	166	47. Hoke		83. Scotland	
12. Burke	6	48. Hyde		84. Stanly	
13. Cabarrus		49. Iredell		85. Stokes	
14. Caldwell		50. Jackson	12	86. Surry	
15. Camden		51. Johnston		87. Swain	6
16. Carteret		52. Jones		88. Transylvania	45
17. Caswell		53. Lee		89. Tyrrell	
18. Catawba	1	54. Lenoir		90. Union	
19. Chatham		55. Lincoln		91. Vance	
20. Cherokee		56. Macon	7	92. Wake	
21. Chowan		57. Madison	4	93. Warren	
22. Clay		58. Martin	9	94. Washington	
23. Cleveland	4	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	1
29. Davidson		65. New Hanover			
30. Davie		66. Northampton		101. Georgia	
31. Duplin	1	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	21
36. Gaston	1	72. Perquimans		**Total No. of Patients**	815

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		38. Graham	19	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. Halifax		78. Robeson	
7. Beaufort		43. Harnett		79. Rockingham	
8. Bertie		44. Haywood	221	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	1
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	58. Martin	64	94. Washington	
23. Cleveland	2	59. McDowell		95. Watauga	1
24. Columbus		60. Mecklenburg	3	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	1	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		104. Virginia	
34. Forsyth	1	70. Pasquotank		105. Other States	5
35. Franklin		71. Pender		106. Other	120
36. Gaston		72. Perquimans		**Total No. of Patients**	4,739

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	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	454	81. Rutherford	3
10. Brunswick		46. Hertford		82. Sampson	
11. Buncombe	133	47. Hoke		83. Scotland	
12. Burke		48. Hyde		84. Stanly	
13. Cabarrus		49. Iredell		85. Stokes	
14. Caldwell		50. Jackson	2	86. Surry	
15. Camden		51. Johnston		87. Swain	
16. Carteret		52. Jones		88. Transylvania	32
17. Caswell		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. 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	15
36. Gaston		72. Perquimans		**Total No. of Patients**	676

All responses should pertain to October 1, 2009 through September 30, 2010.

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									
Alexander					1	1			
Alleghany									
Anson		1	1						
Ashe		1	1		3	3		1	1
Avery					3	3			
Beaufort									
Bertie									
Bladen									
Brunswick									
Buncombe		109	109		92	92		69	69
Burke		1	1		10	10		3	3
Cabarrus		3	3					1	1
Caldwell		2	2		6	6		1	1
Camden									
Carteret									
Caswell									
Catawba		1	1		1	1		1	1
Chatham									
Cherokee		8	8		2	2		4	4
Chowan									
Clay		2	2		1	1			
Cleveland		4	4		7	7		7	7
Columbus									
Craven									
Cumberland		2	2					1	1
Currituck									
Dare									
Davidson									
Davie								1	1
Duplin									
Durham								1	1
Edgecombe									
Forsyth									
Franklin									
Gaston		2	2		1	1		1	1
Gates									
Graham		2	2		4	4		3	3
Granville									
Greene									
Guilford		2	2					1	1
Halifax									
Harnett									
Haywood		23	23		23	23		13	13
Henderson		129	129		99	99		103	103
Hertford									
Hoke									
Hyde									
Iredell		2	2						
Jackson		8	8		3	3			
Johnston		1	1						

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

All responses should pertain to **October 1, 2009 through September 30, 2010.**

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

Facility County: Henderson

(Continued from previous page)

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
Jones									
Lee									
Lenoir									
Lincoln					1	1			
Macon		1	1		4	4		5	5
Madison		3	3		5	5		7	7
Martin		5	5		9	9		4	4
McDowell									
Mecklenburg		8	8		1	1			
Mitchell		6	6		6	6		10	10
Montgomery									
Moore									
Nash									
New Hanover		1	1						
Northampton									
Onslow									
Orange									
Pamlico									
Pasquotank									
Pender								2	2
Perquimans									
Person									
Pitt									
Polk		7	7		4	4		2	2
Randolph									
Richmond									
Robeson									
Rockingham		1	1						
Rowan					1	1			
Rutherford		12	12		14	14		11	11
Sampson									
Scotland									
Stanly									
Stokes									
Surry					1	1			
Swain		5	5					1	1
Transylvania		16	16		18	18		25	25
Tyrrell									
Union									
Vance									
Wake		3	3					1	1
Warren									
Washington									
Watauga		1	1		4	4		3	3
Wayne									
Wilkes		1	1		2	2			
Wilson									
Yadkin		1	1						
Yancey		4	4		5	5		6	6
Out of State		28	28		6	6		6	6
TOTALS			404			315			294

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

All responses should pertain to October 1, 2009 through September 30, 2010.

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	1	74. Pitt	
3. Alleghany		39. Granville		75. Polk	94
4. Anson	2	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	1,338	81. Rutherford	18
10. Brunswick		46. Hertford		82. Sampson	
11. Buncombe	666	47. Hoke		83. Scotland	
12. Burke	1	48. Hyde		84. Stanly	
13. Cabarrus		49. Iredell		85. Stokes	
14. Caldwell	1	50. Jackson	4	86. Surry	2
15. Camden		51. Johnston	1	87. Swain	2
16. Carteret		52. Jones		88. Transylvania	113
17. Caswell		53. Lee		89. Tyrrell	
18. Catawba	1	54. Lenoir		90. Union	2
19. Chatham		55. Lincoln		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	2
24. Columbus		60. Mecklenburg		96. Wayne	2
25. Craven		61. Mitchell	5	97. Wilkes	
26. Cumberland	1	62. Montgomery		98. Wilson	
27. Currituck		63. Moore		99. Yadkin	
28. Dare		64. Nash		100. Yancey	14
29. Davidson		65. New Hanover	1		
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	34
36. Gaston		72. Perquimans		**Total No. of Patients**	2,896

Are mobile MRI services currently provided at your hospital? yes ✓ no _____

Patient Origin – Linear Accelerator Treatment

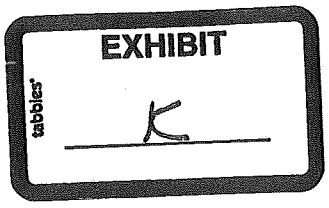
Facility County: Henderson

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	No. 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. 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	
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**	

Type of Health Care Facilities Under Park Ridge Health's Hospital License

Provider	Type of Business / Services	Office Address
Park Ridge Health	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
Hendersonville Podiatry	Podiatry Physician's Office	600 Fifth Avenue West, Hendersonville, NC 28739
Hendersonville Sports Medicine	Sports Medicine and Rehabilitation Services	204 King Street, Hendersonville, NC 28793
Laurel Park Medical Centre -- The Office of Drs. Robert Bailey, Clara Kim, Lorraine Neilson, James Thompson and Jennifer Wilhelm	Medical Building with Physician Offices, Radiology and Physical Therapy	1881 Pisgah Drive, Bldg. A , Hendersonville, NC 28791
Mountain View Dermatology	Dermatology	50 Hospital Drive, Suite 2C, Hendersonville, NC 28792
Mountain View Urological Associates	Urology	50 Hospital Drive, Suite 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
Park Ridge Audiology -- The Office of Kay and Kim Arado, Audiologists	Audiology	80 Doctors Drive, Suite 1, Hendersonville, NC 28792
Park Ridge Dermatology -- The Office of Dr. Timothy Highley, DO	Dermatology	2315 Asheville Highway, Suite 30, Hendersonville, NC 28791
Park Ridge ENT -- The Office of Drs. Michael Neuenschwander and Michael Stalford	Otolaryngology	81 Doctors Drive, Hendersonville, 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, Hendersonville, NC 28792
Park Ridge Geriatrics -- The Office of Drs. Albert Ford, Donald Culver and Clive Possinger	Geriatrics	132 Homestead Farm Circle, Hendersonville, NC 29792
Park Ridge Home Health	Howard Gap Road	Hendersonville, NC 28792
Park Ridge Infusion and Breast Center -- The Office of Dr. Mikhail Vinogradov	Hematology/Oncology	50 Hospital Drive, Suite 4-B, Hendersonville, NC 28792
Park Ridge Pediatrics -- The Office of Drs. Teresa Herbert, Charlotte Riddle and Mary Anne Uritis	Pediatrics	50 Hospital Drive, Suite 5-D, Hendersonville, NC 28792
Park Ridge Plastic Surgery -- The Office of Dr. William Young	Plastic & Reconstructive Surgery	One Town Square Blvd., Suite 225, Asheville, NC 28803
Park Ridge Psychiatry	Psychiatry	50 Hospital Drive, Suite 5-A, Hendersonville, NC 28792
Park Ridge Sleep Center -- The Office of Dr. Gary Prechter	Pulmonology & Sleep Center	50 Doctors Drive, Suite 1C, Hendersonville, NC 28792
Park Ridge Women's Services -- The Office of Drs. Jennifer Blattner and Justin Towle	OB/GYN	80 Doctors Drive, Suite 2, Hendersonville, NC 28792
PRMA Center for Mood Disorders -- The Office of Dr. William Simons	Psychiatry	50 Hospital Drive, Suite 3-C, Hendersonville, NC 28792
PRMA Office of Dr. Donna McGee	Family Medicine	50 Hospital Drive, Suite 5-B, Hendersonville, NC 28792
PRMA Office of Dr. James Bryant	Family Medicine	2315 Asheville Highway, Suite 20, Hendersonville, NC 28791
PRMA Office of Dr. Rebekah Robinson	Family Medicine	125 Vance Hill Drive, Mills River, NC 28759-4996
PRMA Office of Dr. Ronald Johnson	Family Medicine	One Town Square Blvd., Suite 220, Asheville, NC 28803
PRMA Office of Dr. Thomas Lugus	Family Medicine	207 Linda Vista Drive, Hendersonville, NC 28792
PRMA Office of Dr. Wade Grainger	Family Medicine	1998 Hendersonville Rd., Skyland Office Park, Suite 45, Asheville, NC 28803
PRMA Office of Drs. Christian Estes and Robert Francis	Orthopedic Surgery	2920 Haywood Road, Hendersonville, NC 28791
PRMA Office of Drs. Denise Ingram and John Lang	Family Medicine	7 Glenn Bridge Road, Unit H, Aden, NC 28704
Southeastern Sports Medicine	Podiatry and Orthopedic Services	21 Turtle Creek Drive, Asheville, NC 28803
Wound Therapy Center -- Office 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) 855-4620 Fax: (919) 715-3073

For Official Use Only
License # H0019 Medicare # 340023
Computer: 943388
PC _____ Date _____

License Fee: $2,252.50

2012
HOSPITAL LICENSE
RENEWAL APPLICATION

Legal Identity of Applicant: **Fletcher Hospital, Incorporated**
(Full legal name of corporation, partnership, individual, or other legal entity owning the enterprise or service.)

Doing Business As
(d/b/a) name(s) under which the facility or services are advertised or presented to the public:

PRIMARY: **Park Ridge Health**
Other: Park Ridge Hospital
Other: _____

Facility Mailing Address: 100 Hospital Drive
Hendersonville, NC 28792

Facility Site Address: 100 Hospital Drive
Hendersonville, NC 28792
County: Henderson
Telephone: (828)684-8501
Fax: (828)687-0729

Administrator/Director: JIMM BUNCH
Title: CEO
(Designated agent (individual) responsible to the governing body (owner) for the management of the licensed facility)

Chief Executive Officer: Jimm Bunch **Title:** President and CEO
(Designated agent (individual) responsible to the governing body (owner) for the management of the licensed facility)

Name of the person to contact for any questions regarding this form:

Name: Colleen Ramsey **Telephone:** (828) 681-2102

E-Mail: colleen.ramsey@ahss.org

Primary National Provider Identifier (NPI) registered at NPPES 1427075027

If facility has more than one "Primary" NPI, please provide _____

For questions regarding NPI contact Azzie Conley at (919) 855-4640.

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: $2,252.50

2012
HOSPITAL LICENSE RENEWAL APPLICATION

Legal Identity of Applicant: **Fletcher Hospital, Incorporated**
(Full legal name of corporation, partnership, individual, or other legal entity owning the enterprise or service.)

Doing Business As
(d/b/a) name(s) under which the facility or services are advertised or presented to the public:

PRIMARY: **Park Ridge Health**
Other: Park Ridge Hosptial
Other: _____

Facility Mailing Address: 100 Hospital Drive
Hendersonville, NC 28792

Facility Site Address: 100 Hospital Drive
Hendersonville, NC 28792
County: Henderson
Telephone: (828)684-8501
Fax: (828)687-0729

Administrator/Director: JIMM BUNCH
Title: CEO
(Designated agent (individual) responsible to the governing body (owner) for the management of the licensed facility)

Chief Executive Officer: Jimm Bunch **Title:** President and CEO
(Designated agent (individual) responsible to the governing body (owner) for the management of the licensed facility)

Name of the person to contact for any questions regarding this form:

Name: Colleen Ramsey **Telephone:** (828) 681-2102

E-Mail: colleen.ramsey@ahss.org

Primary National Provider Identifier (NPI) registered at NPPES 1427075027

If facility has more than one "Primary" NPI, please provide _____

For questions regarding NPI contact Azzie Conley at (919) 855-4646.

2012 Renewal Application for Hospital:
Park Ridge Health

License No: H0019
Facility ID: 943388

All responses should pertain to October 1, 2010 through September 30, 2011.

Type of Health Care Facilities under the Hospital License (please include offsite emergency departments)

List Name(s) of facilities:	Address:	Type of Business / Service:
See Attached Listing		

Please attach a separate sheet for additional listings

Ownership Disclosure (Please fill in any blanks and make changes where necessary.)

1. What is the name of the legal entity with ownership responsibility and liability?

Owner: Fletcher Hospital, Incorporated
Federal Employer ID# 56-0543246
Street/Box: 100 Hospital Drive
City: Hendersonville State: NC Zip: 28792
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, offsite emergency departments, ambulatory surgical facilities, nursing homes, home health agencies, etc. owned by your hospital, a parent company or a related entity?] Yes Yes _____ No _____

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, PhD

a. Legal entity is: ___ For Profit X Not For Profit

b. Legal entity is: X Corporation ___ LLP ___ Partnership
___ 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:

2. Is the business operated under a management contract? ___ Yes X No

If 'Yes', name and address of the management company.
Name: _____
Street/Box: _____
City: _____ State: _____ Zip: _____
Telephone: (___) _____

Ownership Disclosure *continued. . .*

3. Vice President of Nursing and Patient Care Services: Craig Lindsey

4. Director of Planning: Jason Wells

Facility Data

A. **Reporting Period** All responses should pertain to the period **October 1, 2010 to September 30, 2011.**

B. **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.	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	
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.	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 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.	638	

C. **Designation and Accreditation**

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 Date: June 2012
5. Is this facility DNV accredited? ____ Yes ____ No Expiration Date: ____
6. Is this facility AOA accredited? X Yes ____ No Expiration Date: 2013
7. Are you a Medicare deemed provider? X Yes ____ No

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 ICU/CCU/Telemetry	14	14	2,748
c. Cardiovascular Surgery			
d. Medical/Surgical			
e. Neonatal Beds Level IV ** (Not Normal Newborn)			**
f. Pediatric			
g. Respiratory Pulmonary			
h. Other (List)			
Other Units			
i. Gynecology			
j. Medical/Surgical ***	40	40	*** 6,779
k. Neonatal Level III ** (Not Normal Newborn)			**
l. Neonatal Level II ** (Not Normal Newborn)			**
m. Obstetric (including LDRP)	8	8	1,441
n. Oncology			
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)

D. Beds by Service (Inpatient) *continued*

Number of Swing Beds *	
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 (total should be the same as D.1.a – 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) Do not include with totals under the section entitled Beds by Service (Inpatient)	12

2. Abortion Services

Number of procedures per Year 0

3. **Emergency Department Services** (cases equal visits to ED)

a. Total Number of ED Exam Rooms: 12

a.1. #Trauma Rooms 0 a.2. #Fast Track Rooms 4

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 visits for reporting period: 0

e. Does your ED provide services 24 hours a day 7 days per week? X Yes ___ No
If no, specify days/hours of operation:

f. Is a physician on duty in your ED 24 hours a day 7 days per week? X Yes ___ No
If no, specify days/hours physician is on duty:

4. **Medical Air Transport**: Owned or leased air ambulance service:

a. Does the facility operate an air ambulance service?. ___ Yes X No
b. If "Yes", complete the following chart.

Type of Aircraft	Number of Aircraft	Number Owned	Number Leased	Number of Transports
Rotary				
Fixed Wing				

5. **Pathology and Medical Lab** (Check whether or not service is provided)

a. Blood Bank/Transfusion Services X Yes ___ No
b. Histopathology Laboratory X Yes ___ No
c. HIV Laboratory Testing X Yes ___ No
Number during reporting period
HIV Serology 62
HIV Culture 0
d. Organ Bank ___ Yes X No
e. Pap Smear Screening X Yes ___ No

6. **Transplantation Services** - Number of transplants

Type	Number	Type	Number	Type	Number
a. Bone Marrow-Allogeneic	0	f. Heart/Liver	0	k. Lung	0
b. Bone Marrow-Autologous	0	g. Heart/Kidney	0	l. Pancreas	0
c. Cornea	8	h. Kidney	0	m. Pancreas/Kidney	0
d. Heart	0	i. Kidney/Liver	0	n. Pancreas/Liver	0
e. Heart/Lung	0	j. Liver	0	o. Other	0

Do you perform living donor transplants ? ___ Yes X No.

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

(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
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 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 total in #2**, Number of Procedures on Patients Age 14 & younger	
6. **Of total in #3**, Number of Procedures on Patients Age 14 & younger	

8. Surgical Operating Rooms, Procedure Rooms, Gastrointestinal Endoscopy Rooms, Surgical and Non-Surgical Cases and Procedures

NOTE: If this License includes more than one campus, please copy pages 8 and 9 for each site. Submit the Cumulative Totals and submit a duplicate of pages 8 **and** 9 for each campus.

(**Campus** – *If multiple sites*: _____)

a) Surgical Operating Rooms

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.

Type of Room	Number of Rooms
Dedicated Open Heart Surgery	0
Dedicated C-Section	1
Other Dedicated Inpatient Surgery	0
Dedicated Ambulatory Surgery	0
Shared - Inpatient / Ambulatory Surgery	6
Total of Surgical Operating Rooms	7

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

c) 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: 1

Number of additional CON approved GI Endoscopy Rooms pending development: 0

CON Project ID Number(s). _____

	Number of Cases		Number of Procedures*	
	Inpatient	Outpatient	Inpatient	Outpatient
GI Endoscopy	148	460		
Non-GI Endoscopy				
Totals	148	460		

Count each 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.

8. Surgical Operating Rooms, Procedure Rooms, Gastrointestinal Endoscopy Rooms, Surgical and Non-Surgical Cases and Procedures *(continued)*

(Campus – *If multiple sites*: _____)

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		
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		

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 **Minutes** 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. *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.*

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:* _____

	# Units	Inpatient Procedures*			Outpatient Procedures*			
Number of fixed MRI scanners-closed (*do not include any* Policy AC-3 scanners)	1							
# of fixed MRI scanners-open (*do not include any* Policy AC-3 scanners)		With Contrast or Sedation	Without Contrast or Sedation	TOTAL Inpatient	With Contrast or Sedation	Without Contrast or Sedation	TOTAL Outpatient	TOTAL Procedures
Number of Policy AC-3 MRI scanners used for general clinical purposes								
Total Fixed MRI Scanners/Procedures	1	109	253	362	617	1,439	2,056	2,418
Procedures performed on mobile MRI scanners **only at this site**		0	0	0	93	824	917	917
Name(s) of Mobile MRI Provider(s):								
The total number of procedures performed on the MRI scanners listed above 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. Patients served on units listed in the next two rows should not be included in the MRI Patient Origin Table on page 25 of this application.								
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)	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	0
70548	MRA Neck with contrast	0
70549	MRA Neck w/o & with	21
70551	MRI Brain w/o	219
70552	MRI Brain with contrast	0
	Subtotal for this page	315

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

CPT Code	CPT Description	Number of Procedures
70553	MRI Brain w/o & with	422
7055A	IAC 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	0
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 Abdomen with contrast	0
	Subtotal for this page	2,953

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

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
75555	MRI Cardiac Function Limited	0
75556	MRI Cardiac Velocity Flow Mapping	0
76093	MRI 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 ablation	0
76400	MRI Bone Marrow blood supply	0
7649A	MR functional imaging	0
7649D	MRI 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

10c. Computed Tomography (CT)

How many fixed CT scanners does the hospital have? 2

Does the hospital contract for mobile CT scanner services? ___ 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	=	2,626.25
7	Biopsy in addition to body scan with or without contrast	44	X	2.75	=	121.0
8	Abscess drainage in addition to body scan with or without contrast	11	X	4.00	=	44.0

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	=	
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		X	2.75	=	
8	Abscess drainage in addition to body scan with or without contrast		X	4.00	=	

10d. Other Imaging Equipment

	Number of Units	Number of Procedures		
		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 Units	Number of Procedures		
		Inpatient	Outpatient	Total
Fixed				
Mobile	1			

Lithotripsy Vendor/Owner:
Healthtronics

11. Linear Accelerator Treatment Data (including Cyberknife® & Similar Equipment) N/A

CPT Code	Description	# of Procedures
Simple Treatment Delivery		
77401	Radiation treatment delivery	
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 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 Treatment 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 Treatment Delivery Not Included Above		
77418	Intensity modulated radiation treatment (IMRT) delivery	
77372	Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course 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	
Imaging Procedures Not Included Above		
77417	Additional field check radiographs	
	Total Procedures – Linear Accelerators	
Gamma Knife® 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®)	

11. Linear Accelerator Treatment Data *continued*

a. Number of patients 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 131E-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:

a) **Check if Service(s) is provided: (for dialysis stations, show number of stations)**

	Check		Check
1. Cardiac Rehab Program (Outpatient)	X	5. Rehabilitation Outpatient Unit	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
Out of State										
Total All Ages										

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 **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 & up	Total Beds
.1100 Partial hospitalization for individuals who are acutely mentally ill.	PRH PHP/IOP					
.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	Beds Assigned by Age				
		0-12	13-17	Subtotal 0-17	18 & up	Total Beds
.5200 Dedicated inpatient unit for individuals who have mental disorders	Park Ridge Health				X	36

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	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	N/A					
.3700 Day treatment facilities for individuals with substance abuse disorders	N/A					

Rule 10A NCAC 13B Licensure Rules For Hospitals	Location of Services	Beds Assigned by Age				
		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 _____	N/A					

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	2	37. Gates		73. Person	
2. Alexander		38. Graham	1	74. Pitt	
3. Alleghany	1	39. Granville		75. Polk	
4. Anson		40. Greene		76. Randolph	
5. Ashe		41. Guilford	1	77. Richmond	
6. Avery	2	42. Halifax		78. Robeson	
7. Beaufort		43. Harnett		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. Iredell		85. Stokes	
14. Caldwell		50. Jackson		86. Surry	
15. Camden		51. Johnston		87. Swain	6
16. Carteret		52. Jones		88. Transylvania	117
17. Caswell		53. Lee		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		57. Madison		93. Warren	
22. Clay		58. Martin		94. Washington	
23. Cleveland	3	59. McDowell	11	95. Watauga	2
24. Columbus		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		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	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	County	No. of Patients	County	No. of Patients
1. Alamance	1	37. Gates		73. Person	
2. Alexander		38. Graham	1	74. Pitt	
3. Alleghany		39. Granville		75. Polk	20
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	44	80. Rowan	
9. Bladen		45. Henderson	391	81. Rutherford	3
10. Brunswick		46. Hertford		82. Sampson	
11. Buncombe	176	47. Hoke		83. Scotland	
12. Burke	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. Clay		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

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	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. Buncombe	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. Catawba	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

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	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	19
4. Anson		40. Greene		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. Tyrrell	
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	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	
33. Edgecombe		69. Pamlico		104. Virginia	
34. Forsyth		70. Pasquotank		105. Other States	
35. Franklin		71. Pender		106. Other	7
36. Gaston	1	72. Perquimans		**Total No. of Patients**	608

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									
Alexander									
Alleghany		2	2						
Anson		3	3						
Ashe		6	6						
Avery		5	5						
Beaufort									
Bertie									
Bladen									
Brunswick									
Buncombe		302	302						
Burke		28	28						
Cabarrus		8	8						
Caldwell		7	7						
Camden									
Carteret									
Caswell									
Catawba		2	2						
Chatham		1	1						
Cherokee		9	9						
Chowan									
Clay		3	3						
Cleveland		19	19						
Columbus									
Craven									
Cumberland									
Currituck									
Dare									
Davidson									
Davie									
Duplin									
Durham		1	1						
Edgecombe									
Forsyth									
Franklin									
Gaston		7	7						
Gates									
Graham		15	15						
Granville									
Greene									
Guilford		3	3						
Halifax									
Harnett									
Haywood		69	69						
Henderson		314	314						
Hertford									
Hoke									
Hyde									
Iredell		4	4						
Jackson		20	20						
Johnston		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 page)

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
Jones									
Lee		1	1						
Lenoir									
Lincoln									
Macon		23	23						
Madison		34	34						
Martin		17	17						
McDowell									
Mecklenburg		7	7						
Mitchell		4	4						
Montgomery									
Moore									
Nash									
New Hanover									
Northampton									
Onslow									
Orange									
Pamlico									
Pasquotank									
Pender									
Perquimans									
Person									
Pitt									
Polk		11	11						
Randolph		3	3						
Richmond									
Robeson									
Rockingham		1	1						
Rowan									
Rutherford		36	36						
Sampson									
Scotland									
Stanly		1	1						
Stokes									
Surry		2	2						
Swain		11	11						
Transylvania		68	68						
Tyrrell									
Union		3	3						
Vance									
Wake		9	9						
Warren									
Washington									
Watauga		6	6						
Wayne									
Wilkes		4	4						
Wilson									
Yadkin									
Yancey		8	8						
Out of State		51	51						
TOTALS			1,129						

** 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. **The total number of patients reported here should be equal to or less than the total number of MRI procedures 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		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. Iredell	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. Tyrrell	
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	16	93. Warren	
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. Yadkin	
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 at your hospital? yes _____ no _____

Patient Origin – Linear Accelerator Treatment N/A

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	No. 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. 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	
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**	

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	County	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. Bladen		45. Henderson	129	81. Rutherford	
10. Brunswick		46. Hertford		82. Sampson	
11. Buncombe	14	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	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		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**	155

All responses should pertain to October 1, 2010 through September 30, 2011.

This application must be completed and submitted with ONE COPY to the Acute and Home Care Licensure and Certification Section, Division of Health Service Regulation prior to the issuance of a 2012 hospital license.

AUTHENTICATING SIGNATURE: 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.

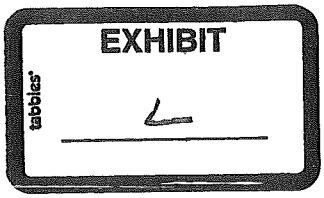
Signature: Jimm Bunch Date: November 30, 2011

PRINT NAME OF APPROVING OFFICIAL Jimm Bunch

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

Type of Health Care Facilities Under Park Ridge Health's Hospital License

Provider	Type of Business / Services	Office Address
Park Ridge Health	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, Suite 2-D, Hendersonville, NC 28792
Center for Pelvic Health	Pelvic Health / Physician Office	1881 Pisgah Drive, Bldg. A , Hendersonville, NC 28791
Family Medicine at Biltmore Park -- The Office of Drs. Sarah Danninger and Leah Swann	Family Medicine	One Town Square Blvd., Suite 220, Asheville, NC 28803
Mountain View Dermatology	Dermatology	50 Hospital Drive, Suite 2C, Hendersonville, NC 28792
Mountain View Urological Associates	Urology	50 Hospital Drive, Suite 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
Park Ridge Breast Health Center	Breast Health Services	50 Hospital Drive, Suite 4-B, Hendersonville, NC 28792
Park Ridge 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 Dermatology -- The Office of Dr. Timothy Highley, DO	Dermatology	2315 Asheville Highway, Suite 30, Hendersonville, NC 28791
Park Ridge ENT -- The Office of Drs. Michael Neuenschwander and Michael Stalford	Otolaryngology	81 Doctors Drive, Hendersonville, 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, Hendersonville, NC 28792
Park Ridge Geriatrics -- The Office of Drs. Albert Ford, Donald Culver, Julie Iacono, Margaret Anne Kirkley, Clive Possinger and Benjamin Pusser	Geriatrics	132 Homestead Farm Circle, Hendersonville, NC 29792
Park Ridge Health at Laurel Park -- The Office of Drs. Robert Bailey, Clara Kim, Meredith Richmond, James Thompson, Lorena Wade and Jennifer Wilhelm	Medical Building with Physician Offices, Radiology and Physical Therapy	1881 Pisgah Drive, Bldg. A , Hendersonville, NC 28791
Park Ridge Hearing and Balance-- The Office of Kay and Kim Arado, Audiologists	Audiology	80 Doctors Drive, Suite 1, Hendersonville, NC 28792
Park Ridge Home Health	Home Health	Howard Gap Road, Hendersonville, NC 28792
Park Ridge Oncology and Infusion Center -- The Office of Drs. Mikhail Vinogradov and Paul Schaefer	Hematology/Oncology	50 Hospital Drive, Suite 4-B, Hendersonville, NC 28792
Park Ridge Pediatrics -- The Office of Drs. Teresa Herbert, Charlotte Riddle and Mary Anne Urlis	Pediatrics	50 Hospital Drive, Suite 5-D, Hendersonville, NC 28792
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 Psychiatry	Psychiatry	50 Hospital Drive, Suite 5-A, Hendersonville, NC 28792
Park Ridge Pulmonology and Sleep Medicine -- The Office of Dr. Gary Prechter	Pulmonology & Sleep Center	50 Doctors Drive, Suite 1C, Hendersonville, NC 28792
Park Ridge Women's Services -- The Office of Drs. Jennifer Blattner and Justin Towle	OB/GYN	80 Doctors Drive, Suite 2, Hendersonville, NC 28792
Park Ridge Wound Care and Hyperbaric Medicine -- Office of Drs. Frederick Veser and Brian Stover	Wound Therapy	50 Hospital Drive, Suite 1-B, Hendersonville, NC 28792
PRMA Office of Drs. James Bryant and Lateef AbuMoussa	Family and Internal Medicine	2315 Asheville Highway, Suite 20, Hendersonville, NC 28791
PRMA Office of Drs. Wade Grainger and Ronald Johnson	Family Medicine	1998 Hendersonville Rd., Skyland Office Park, Suite 45, Asheville, NC 28803
PRMA Office of Drs. Denise Ingram and John Lang	Family Medicine	7 Glenn Bridge Road, Unit H, Aden, NC 28704
PRMA Office of Dr. Thomas Lugus	Family Medicine	207 Linda Vista Drive, Hendersonville, NC 28792
PRMA Office of Dr. Donna McGee	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 MRI	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, NC 28791



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

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/body.cfm?id=2133 and 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]

[1]Exhibit 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.

Reporting Periods	# of Procedure Rooms in Hospitals	# of Procedure Rooms in ASCs	Total # Procedures Performed in ASC plus Hospitals	# of Procedures Performed in ASC	% of Total Procedures Performed 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 inmigration assumptions. First, there is a discrepancy in the inmigration percentage, which in turn creates a discrepancy in the number of procedures. On page 58, the inmigration 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 in-migration 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 GI Endoscopy Procedures at Mission South	1,309	1,324	1,338
Other In-migration	231	234	236
Total Projected Procedures at Mission South GI Locatio	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 # GI Procedures	7,157	7,125	7,092
Mission South # Outpatient GI 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 GI 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.

EXHIBIT

A

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.

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.

(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
(FY 2015 and FY 2016)

County	Total Cases		% of Total Ambulatory 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%	1%
Watauga	2	4	1%	1%
Ashe	1	1	0%	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 cost-effective 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."*

<u>*Advances in Ambulatory Surgery and Regulatory Changes*</u>

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 ASC;*
- *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%	362,909	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 Year 1 (FY 2015)	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 inpatient 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 (compounded annual growth 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 inpatient 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.*

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 Cases	Inpatient Case Time	Total Inpatient Case Hours	Outpatient Cases	Outpatient Case Time	Total Outpatient Case Hours	Total Combined Hours	Hours per OR per Year	Projected ORs needed in 2017
Interim Years									
FY 2012	14,030	3.0	42,091	22,621	1.5	33,932	76,023	1,872	40.6
FY 2013	14,662	3.0	43,985	23,979	1.5	35,968	79,953	1,872	42.7
FY 2014	15,321	3.0	45,964	25,417	1.5	38,126	84,091	1,872	44.9
Project Years									
FY 2015	16,088	3.0	48,263	27,006	1.5	40,509	88,772	1,872	47.4
FY 2016	16,892	3.0	50,676	28,694	1.5	43,041	93,717	1,872	50.1
FY 2017	17,737	3.0	53,210	30,487	1.5	45,731	98,941	1,872	52.9

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 OP Cases*	*Projected Low 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*	*12,153*
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:

Interim Years	*Ambulatory Cases*	*Ambulatory Hours*	*Hours/OR*	*ORs*
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) (1) (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 Cases*	*Low Acuity Ambulatory Cases*	*Clemmons Medical Park ASC Low Acuity/Ambulatory Cases*
FY 2012	*22,621*	*10,180*	-
FY 2013	*23,979*	*10,790*	-
FY 2014	*25,417*	*11,438*	-
Project Years			
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 ORs 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 Mocksville 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	PY 3
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		
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.]

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 not "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:

	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
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 Room Volume*	*% Change from PY* [Previous Year]
2005	*1,032*	
2006	*1,344*	*30.23%*
2007	*1,992*	*48.21%*
2008	*2,798*	*40.46%*
2009	*3,217*	*14.97%*
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."*

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 urologic 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 CompRehab Procedures	# of West Campus Surgery Center Procedures	# of Clemmons ASC Procedures	Total Procedure Room Procedures
FY 2008	2,798	1,040	3	2,798	-	-	2,798
FY 2009	3,217	1,040	3	3,217	-	-	3,217
FY 2010	3,458	1,040	3	3,458	-	-	3,426
Interim Years							
FY 2011	3,717	1,040	4	3,717	-	-	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 Years							
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 inpatient 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 minorities, 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."

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.

NC

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.

C

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.

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 (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

The applicant proposes to construct a new 12,500 square foot building for the proposed facility. In Section XI.6(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;

NA

In Section VI.12, page 71, the applicant provides the payor mix for PSCNC, as illustrated in the following table.

PSCNC - Current Payor Mix	
Self Pay/Indigent/Charity	100.0%
Commercial	
Medicare/Medicare Managed Care	
Medicaid	
Managed Care	
Other	
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;

C

In Section VI.10(a), page 70, the applicant states, *"Clemmons Medical Park ASC is a new entitiy 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

C

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.

FY 2016 Clemmons Medical Park ORs	
Self Pay/Indigent/Charity	6.11%
Commercial Insurance/Managed Care	50.38%
Medicare/Medicare Managed Care	35.75%
Medicaid	7.76%
TOTAL	100.00%

FY 2016 Clemmons Medical Park Procedure Room	
Self Pay/Indigent/Charity	4.41%%
Commercial Insurance/Managed Care	35.47%
Medicare/Medicare Managed Care	12.63%
Medicaid	47.49%
TOTAL	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."*

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.

-C- 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
- 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);

-C- 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:

WFUHS Owned Facilities
Current Operating Room Inventory

Type	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);

-C- 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

Type	Clemmons Medical Park ASF
Dedicated Open Heart	
Other Dedicated Inpatient	
Shared Inpatient/Outpatient	
Dedicated Outpatient	3
Dedicated C-Section	
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

the operating rooms in each licensed facility listed in response to Subparagraphs (b)(1) and(b)(2) of this Rule:

-C- In Section II.10, page 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

Type	PSCNC
Inpatient	
Outpatient	165
Total	165

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

-C- In Section II.10, 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
FY 2015 – FY 2017

Type	Clemmons 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

Type	Clemmons Medical Park ASF
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;

-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, 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; and

-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.

-C- In Section II.10, page 20, the applicant identifies the providers of pre-operative 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);

-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.

(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;

-C- 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;

-C- 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

Type	Clemmons Medical Park ASC
Project Year 1 (FY 2015)	-
Project Year 2 (FY 2016)	-
Project Year 3 (FY 2017)	-

Projected Outpatient Surgical Cases
FY 2015 – FY 2017

Type	Clemmons 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;

-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, 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;

-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.

(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;

-C- 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 pre-operative 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

-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

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 inpatient cases for all the applicant's or related entities' facilities, excluding trauma cases report by Level I or II trauma centers, cases reported by designated burn intensive care units and cases performed in dedicated open heart and C-section rooms, times 3.0 hours) plus (Number of projected outpatient cases for all the applicant's or related entities' times 1.5 hours)] divided by 1,872 hours} minus the total number of existing and approved operating rooms and

operating rooms proposed in another pending application, excluding one operating room for Level I or II trauma centers, one operating room for facilities with designated burn intensive care units, and all dedicated open heart and C-section operating rooms in all of the applicant's or related entities' licensed facilities in the service area; 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.

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

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

.2103(e) *An applicant proposing to convert a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or to add a specialty to a specialty ambulatory surgical program shall:*

(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 inpatient cases, excluding open heart and C-sections performed in dedicated rooms times 3.0 hours) plus (Number of projected outpatient cases times 1.5 hours)] divided by the number of operating rooms, excluding dedicated open heart and C-Section operating rooms; and

-NC- The 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

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."*

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.*

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

.2106 *FACILITY*

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

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

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

-C- 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.

.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:*

(1) physicians;
(2) ancillary services;
(3) support services;
(4) medical equipment;
(5) surgical equipment;
(6) receiving/registering area;
(7) clinical support areas;
(8) medical records;
(9) waiting area;
(10) pre-operative area;
(11) operating rooms by type;
(12) recovery area; and
(13) observation area.

-NA- The applicant proposes to develop a new ambulatory surgical facility.

EXHIBIT
B

ATTACHMENT - REQUIRED STATE AGENCY FINDINGS

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
TEAM LEADER: Martha J. Frisone

PROJECT I.D. NUMBER: J-8529-10/ Duke University Health System d/b/a Duke Raleigh 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 Garner/ 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.

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

C – 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 Carolina 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 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 Garner. 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 Garner 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

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 VI.2, page 44, the applicant states:

"The services of Duke Raleigh Hospital are open to all area and non-area residents for inpatient, outpatient, and other healthcare services on a walk-in, emergency, referral, or emergency [sic] *basis."*

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 X.1, 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 during the renovation and installation process.*
> *3). Integrating the operation of the proposed MRI scanner with that of the existing MRI scanner.*
> *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 must 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 VI.2, 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 vendor 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:

"The provision of MRI services via WRDI's proposed fixed MRI scanner 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 vendor.

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 (1) 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:

County	FY2009 Percent of Total	FY2012-2013 Percent of Total
Wake	76.8%	76.8%
Johnston	5.0%	5.0%
Franklin	5.2%	5.2%
Harnett	1.7%	1.7%
Other NC Counties	9.8%	9.8%
Other States	1.5%	1.5%

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

County	2009	2010	2011	2012	2013	2014	CAGR
Wake	920,760	949,171	978,459	1,008,651	1,039,774	1,071,858	3.1%
Johnston	136,394	139,934	143,565	147,291	151,113	155.035	2.6%
Franklin	54,949	56,193	57,465	58,766	60,096	61,457	2.3%
Grand Total	1,112,103	1,145,298	1,179,490	1,214,708	1,250,984	1,288,350	3.0%

Source: Thomson Reuters

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.

2) 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	State
2007	65,582	821,829
2008	65,892	814,048
2009	72,036	822,853
% Change	9.8%	0.1%

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.

3) 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

Year	Unweighted Procedures	Weighted Procedures
FY2007	3,884	4,864
FY2008	4,071	5,212
FY2009	4,634	6,070
% Change	19.3%	24.8%

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,

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 (FY2011) 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 inpatient procedures increased 28%, and the number of ambulatory procedures grew 18%. Through the first 10 months of FY2010, the Hospital was providing inpatient 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 VII.6) 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.

6) *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

conservative."

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.

	Prior Full FY2007	Prior Full FY2008	Last Full FY2009	Interim Full FY2010	Interim Full FY2011	First Full FY2002	Second Full FY2013	Third Full FY2014
# of Fixed MRI Scanners	1	1	1	1	1	2	2	2
#of Procedures	3,884	4,071	4,634	5,476	5,880	6,654	7,269	8,034
# of Weighted Procedures	4,864	5,212	6,070	7,181	7,712	8,728	9,534	10,538
Average # of Weighted Procedures	4,864	5,212	6,070	7,181	7,712	4,364	4,767	5,269

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:*

	FY2010(Proj)	*FY2011*	*FY2012*	*FY2013*	*FY2014*
Inpatient	*897*	*958*	*981*	*1,009*	*1,041*
Outpatient	*4,579*	*4,853*	*5,185*	*5,534*	*5,902*
Total	*5,476*	*5,811*	*6,166*	*6,543*	*6,943*

2) *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 anecdotal 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 FY 2014:

	FY2010(Proj)	FY2011	FY2012	FY2013	FY2014
Total	315	334	355	376	399

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 FY2011 will be accommodated with the addition of the 3rd mobile MRI day.

3) 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

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

	FY2010(Proj)	FY2011	FY2012	FY2013	FY2014
1)	5,476	5,811	6,166	6,543	6,943
2)	—	69	355	376	399
3)	—	—	133	350	692
Unweighted	5,476	5,880	6,654	7,269	8,034
Weighted	7,181	7,712	8,728	9,534	10,538

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

	Unweighted MRI Scans	Weighted MRI Scans
FY2004	48,815	57,537
FY2005	53,122	62,174
FY2006	55,692	65,936
FY2007	65,582	77,172
FY2008	65,892	77,428
FY2009	72,036	86,533
04-09 CAGR	8.1%	8.5%

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. 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 Centre 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.

NCDI- Holly Springs Projected MRI Patient Origin

County	Number of Patients YR 1	Percentage of Total Patients YR 1	Number of Patients YR 2	Percentage of Total Patients YR 2
Wake	3,082	95.0%	3,522	95.0%
Johnston	32	1.0%	37	1.0%
Lee	32	1.0%	37	1.0%
Chatham	32	1.0%	37	1.0%
Other*	65	2.0%	74	2.0%
Total	3,243	100.0%	3,707	100.0%

*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 1 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

County	No. of Fixed MRI Scanners	2009 Population	Residents/ 1 Fixed Scanner
Buncombe	10	230,450	23,045
Cabarrus	7	174,294	24,899
Cumberland	7	321,121	45,874
Durham	14	266,189	19,014
Forsyth	17	355,640	20,920
Guilford	11	476,038	43,276
Mecklenburg	18	894,445	49,691
New Hanover	5	194,099	38,820
Orange	9	132,306	14,701
Pitt	7	158,575	22,654
Wake	13	892,607	68,662
North Carolina	224	9,382,610	41,887

Source: Population- NC OSBM; Scan Volume and fixed scanner numbers- Draft 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."*

* *"Availability 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 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 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-40 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-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.

NCDI- Holly Springs: Projected MRI Scanner Utilization

	First Full FY (CY 2012)	Second Full FY (CY 2013)	Third Full FY (CY 2014)
# of Units	1	1	1
# of Unweighted Procedures	3,600	4,115	4,661
Percent Change in Unweighted Procedures	-na-	14.3%	13.2%
# of Weighted Procedures	3,881	4,436	5,025
Percent Change in Weighted Procedures	-na-	14.3%	13.2%

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 scanner, 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]

Census Tract	*Town*	*2012*	*2013*	*2014*
532	*Holly Springs*	*39,671*	*41,582*	*43,586*
531.01	*Fuquay Varina*	*19,202*	*20,046*	*20,926*
531.03	*Wake County*	*9,643*	*9,781*	*9,922*
531.04	*Wake County*	*11,547*	*11,892*	*12,247*
534.04	*Holly Springs/Apex*	*21,581*	*22,533*	*23,236*
529	*Wake County*	*15,769*	*16,106.*	*16,450*
	Totals	*117,413*	*121,940*	*126,367*

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.

Wake County- Historical Use Rate (unweighted volume)

Time Period	Unweighted MRI Volume	Wake County Population	Use Rate Per 1,000
FFY 2005	53,122	757,346	70.1
FFY 2006	55,692	793,401	70.1
FFY 2007	65,582	831,537	78.9
FFY 2008	65,808	866,438	75.9
FFY 2009	72,036	892,607	80.7

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...

Wake County- Projected Use Rate (unweighted volume)

Time Period	Unweighted MRI Volume	Wake County Population	Use Rate Per 1,000
FFY 2005	53,122	757,346	70.1
FFY 2006	55,692	793,401	70.1
FFY 2007	65,582	831,537	78.9
FFY 2008	65,808	866,438	75.9
FFY 2009	72,036	892,607	80.7
FFY 2010	74,269	920,307	80.7
FFY 2011	76,504	948,001	80.7
FFY 2012	78,739	975,696	80.7
FFY 2013	80,973	1,003,389	80.7
FFY 2014	83,209	1,031,086	80.7

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.

Primary Service Area- Projected Unweighted Volume

Census Tract	CY 2012	CY 2013	CY 2014
532- Holly Springs	39,671	41,482	43,586
Use Rate/100	80.7	80.7	80.7
Projected Unweighted MRI Volume	3,209	3,356	3,517
531.01-Fuquay Varina	19,202	20,046	20,926
Use Rate/100	80.7	80.7	80.7
Projected Unweighted MRI Volume	1,550	1,618	1,689
531.03- Wake County	9,643	9,781	9,922
Use Rate/100	80.7	80.7	80.7
Projected Unweighted MRI Volume	778	789	801
531.04- Wake County	11,547	11,892	12,247
Use Rate/100	80.7	80.7	80.7
Projected Unweighted MRI Volume	932	960	988
534.04-Holly Springs/Apex	21,851	22,533	23,236
Use Rate/100	80.7	80.7	80.7
Projected Unweighted MRI Volume	1,763	1,818	1,875
529-Wake County	15,769	16,106	16,450
Use Rate/100	80.7	80.7	80.7
Projected Unweighted MRI Volume	1,272	1,300	1,328
Total Projected Unweighted Volume for Primary Service Area	9,504	9,841	10,198

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.

Census Tract	CY 2012	CY 2013	CY 2014
Census Tract 532	48%	53%	58%
Census Tract 531.01	30%	34%	38%
Census Tract 531.03	13%	15%	16%
Census Tract 531.04	30%	33%	36%
Census Tract 534.04	50%	53%	56%
Census Tract 529	12%	14%	16%

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.*
- *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 Area.*
- *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 Unweighted Volume by Census Tract

Census Tract	CY 2012	CY 2013	CY 2014
532- Holly Springs	3,209	3,356	3,517
Market Share Percentage	48%	53%	58%
Projected Unweighted MRI Volume for NCDI-Holly Springs	1,540	1,779	2,040
531.01-Fuquay Varina	1,550	1,618	1,689
Market Share Percentage	30%	34%	38%
Projected Unweighted MRI Volume for NCDI-Holly Springs	465	550	642
531.03- Wake County	778	789	801
Market Share Percentage	13%	15%	16%
Projected Unweighted MRI Volume for NCDI-Holly Springs	101	118	128
531.04- Wake County	932	960	988
Market Share Percentage	30%	33%	36%
Projected Unweighted MRI Volume for NCDI-Holly Springs	280	317	356
534.04-Holly Springs/Apex	1,763	1,818	1,875
Market Share Percentage	50%	53%	56%
Projected Unweighted MRI Volume for NCDI-Holly Springs	882	963	1,050
529-Wake County	1,272	1,300	1,328
Market Share Percentage	12%	14%	16%
Projected Unweighted MRI Volume for NCDI-Holly Springs	152	182	212
Total Projected Unweighted Volume for NCDI-Holly Springs (95% of total volume)	3,420	3,909	4,428

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 practice.
- 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

Attachment 30).

- *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.1(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 in-migration 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. ---

NCDI-Holly Springs Unweighted MRI Volume CY 2012 – CY 2014

Census Tract	Percent of Total	CY 2012	CY 2013	CY 2014
MRI Volume from NCDI-Holly Springs Service Area	95%	3,420	3,910	4,428
MRI Volume from Other Counties	5%	180	206	233
Total NCDI-Holly Springs Unweighted Volume	100%	3,600	4,116	4,661

Step 7: Convert Unweighted Procedures to Weighted Procedures [page 66]

After projecting the total number of unweighted MRI scans for the proposed fixed MRI scanner, 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 MedQuest-managed 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%.

Contrast Percentages for Other MedQuest Facilities

Facility Name	County	Total Scans	Contrast Scans	% Contrast
NCDI-Cary (Kings Medical Mobile)	Wake	388	76	19.5%
Durham Diagnostic Imaging	Durham	4,710*	1,622	34.4%
Triad Imaging	Guilford	5,663*	1,183	20.9%
Carolina Imaging	Cumberland	11,981*	2,087	17.45

**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.

Contrast Percentages for Outpatient Fixed MRI Facilities in Wake County

Facility Name	Fixed Magnets	Total Scans	Contrast Scans	% Contrast
Raleigh MRI Center	1	4,394	1,991	45.3%
Raleigh MRI Center	1	4,152	1,841	44.3%
Raleigh Neurology Associates	1	6,431	2,216	34.5%
Raleigh Radiology	1	2,743	894	32.5%
Raleigh Radiology at Cedarhurst	1	6,869	1,529	22.6%
Average Contrast Percentage				35.8%

Source: Draft 2011 SMFP

Step 8: Apply Contrast Percentage to Determine Weighted Volume [page 67]"

NCDI- Holly Springs Unweighted & Weighted MRI Volume

Census Tracts		2012	2013	2014
532	Holly Springs	1,540	1,779	2,040
531.01	Fuquay Varina	465	550	642
531.03	Wake County	101	118	128
531.04	Wake County	280	317	356
534.04	Holly Springs/ Apex	882	963	1,050
529	Wake County	152	182	212
Primary Service Area Unweighted		3,420	3,909	4,428
Plus-In-migration @ 5%		180	206	233
Total Unweighted Volume		3,600	4,115	4,661
19.5% Contrast	Contrast Scans	702	802	909
Outpatient Contrast Adjustment (Contrast Scans x 0.4)		281	321	364
Total Weighted volume (Unweighted Volume + Contrast Adjustment)		3,881	4,436	5,025

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

Census Tract	CY 2012	CY 2013	CY 2014
Census Tract 532	48%	53%	58%
Census Tract 531.01	30%	34%	38%
Census Tract 531.03	13%	15%	16%
Census Tract 531.04	30%	33%	36%
Census Tract 534.04	50%	53%	56%
Census Tract 529	12%	14%	16%

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.

- 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 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 Garner 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:

Wake Radiology's Projected Patient Origin for MRI Services

County	Current Percent of Total	FY2012-FY2014 Percent of Total
Wake	60.5%	60.5%
Johnston	33.9%	33.9%
Harnett	5.7%	5.7%
Total	100.0%	100.0%

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 Garner 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 scanner 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. ...

Primary Service Area Projected Population

Zip Code	Area	2009	2014	10-14 CAGR
27520	Clayton	34,341	40,352	4.1%
27526	Fuquay Varina	38,825	47,185	5.0%
27529	Garner	40,905	47,748	3.9%
27545	Knightdale	18,380	20,107	2.3%
27592	Willow Spring	13,601	15,876	3.9%
27603	Raleigh	40,026	45,127	3.0%
27606	Raleigh	49,436	54,897	2.7%
27610	Raleigh	60,654	70,115	3.7%
Total Primary SA		296,168	341,407	3.6%

Source: Claritas

C. *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

Year	Population	Unweighted MRI scans	MRI Procedure Rate (Per 1,000)
FY2004	725,334	48,815	67.3
FY2005	757,346	53,122	70.1
FY2006	793,401	55,692	70.2
FY2007	831,537	65,582	78.9
FY2008	866,438	65,892	76.0
FY2009	892,607	72,036	80.7
04-09 CAGR	4.2%	8.1%	3.7%

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.

Wake County Historical MRI Utilization FY2004 – FY2009

	Unweighted MRI Scans	Weighted MRI Scans
FY2004	48,815	57,537
FY2005	53,122	62,174
FY2006	55,692	65,936
FY2007	65,582	77,172
FY2008	65,892	77,428
FY2009	72,036	86,533
04-09 CAGR	8.1%	8.5%

Source: 2006-2010 SMFP, Draft 2011 SMFP data provided by SHCC Technology & Equipment Committee & DHSR Planning Section Totals may not foot due to rounding.

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

FY2008 Mobile MRI Utilization Top North Carolina Counties

County	Fixed Equivalent Total	Unweighted Mobile Scans
Mecklenburg	5.18	16,478
Guilford	3.37	16,232
Wake	3.87	15,298
New Hanover	2.44	11,726
Forsyth	1.94	9,361

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

scanner at Raleigh Radiology Cedarhurst, 18 miles from the fixed MRI scanner at WakeMed Cary Hospital, and 20 miles from the fixed MRI scanner at Rex 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

Municipality	2000	2008	% Growth
Garner	17,787	26,109	46.8%
Holly Springs	9,192	20,631	124.4%
Knightdale	5,958	10,967	84.1%
Fuquay-Varina	7,898	16,054	103.3%
Wendell	4,247	5,796	36.5%
Wake County	633,516	866,438	36.85
North Carolina	8,079,712	9,247,173	14.4%

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

	2009	2014	% Growth
Fuquay-Varina town	14,267	17,653	23.7%
Garner town	24,023	27,666	15.2%
Holly Springs town	18,063	22,763	26.0%
Knightdale town	7,305	8,181	12.0%
Wendell town	4,776	5,176	8.4%

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

Municipality	2009 Per Capita Income	2014 Per Capita Income
Cary	$39,069	$42,009
Morrisville	$38,343	$41,121
Apex	$36,649	$39,941
Wake Forest	$27,800	$29,893
Raleigh	$27,629	$29,219
Garner	$23,892	$25,159

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.

	2009 Population	Fixed & Mobile Magnets <5 miles	Ratio of pop/scanner
Raleigh city	371,092	13	28,546
Garner town	24,023	1	24,023
Cary town	126,832	11	11,530
Wake Forest town	25,307	3	8,436
Knightdale town	7,305	1	7,305
Apex town	30,480	6	5,080
Morrisville town	10,877	3	3,626
Holly Springs town	18,063	0	—
Fuquay-Varina town	14,267	0	—
Wendell town	4,776	0	—
Zebulon town	4,342	0	—

Source: Claritas, 2010 SMFP

Based on the current locations of fixed and mobile MRI scanners, Garner is significantly underserved by MRI scanners compared to other municipalities in Wake County. The Town of Wake Forest is similar in population to the Town of Garner; however, Wake Forest residents currently have access to mobile MRI scanners at 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 MRI 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 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.

	FY2008	FY2009	FY2010 - Interim (Oct-Sept)	FY2011- Interim (Oct-Sept)	FY2012 (Oct-Sept)	FY2013 (Oct-Sept)	FY2014 (Oct-Sept)
# of MRI Scanners							
Fixed					1	1	1
Mobile	1	1	1	1			
#of Procedures	2,483	2,323	2,417	2,515	3,298	3,851	4,444
#of Weighted Procedures	2,723	2,585	2,690	2,798	3,670	4,285	4,945
Percentage Change in Weighted Procedures	-na-	(-5.1%)	4.1%	4.1%	31.2%	16.75%	15.4%

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). To reach that volume, Wake Radiology assumes volume at WRGO will increase 4.1% each year before the fixed MRI scanner is operational. Between FY 2011 and FY 2012 (PY1), Wake Radiology assumes volume will increase 31.2%. Between PY1 and PY2, volume is projected to increase another 16.75%. Between PY2 and PY3, volume is projected to 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 = 0.913]. This, despite a 5.1% decrease between FY 2008 and FY 2009 at WRGO and decreases at Raleigh MRI, which is owned by Wake Radiology and has two existing fixed MRI scanners. See discussion below. The applicants do not adequately explain why utilization is expected to now start increasing.

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

Year	Unweighted MRI Scans
FY2004	48,815
FY2005	53,122
FY2006	55,692
FY2007	65,582
FY2008	65,892
FY2009	72,036
04-09 CAGR	8.1%

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 five-year 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 FY2008, 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 FY2009 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% ÷2= 4.0%) for MRI scans performed in Wake County.

Wake County Projected MRI Scans
FY2010-FY2014

Year	Unweighted MRI Scans
FY2010	74,951
FY2011	77,984
FY2012	81,140
FY2013	84,423
FY2014	87,840

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)

Wake County MRI Scans	WRGO Mobile MRI Scans	FY2009 Market Share
72,036	2,323	3.2%

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
Projected MRI Market Share

			PY1	PY2	PY3
	2010	2011	2012	2013	2014
MRI Market 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.

WRGO Projected Unweighted MRI Utilization
Proposed Fixed MRI Scanner

Project Year	Projected Wake County MRI Scans	WRGO Outpatient Market Share	Projected WRGO MRI Scans
FY2012	81,140	4.0%	3,246
FY2013	84,423	4.5%	3,799
FY2014	87,840	5.0%	4,392

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
Proposed Fixed MRI Scanner

	2012	2013	2014
Unweighted MRI Scans	3,246	3,799	4,392
MRI Scans Committed to Project Access	52	52	52
Total Unweighted MRI Scans	3,298	3,851	4,444
Weighted MRI scans	3,670	4,285	4,945

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].

[15- Based on FY2009 utilization provided on both WRDI's mobile MRI scanner 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%.

	FY2008- Actual (Oct-Sept)	FY2009- Actual (Oct-Sept)
#of MRI Procedures	2,483	2,323
#of Weighted MRI Procedures	2,723	2,585
Percentage Increase (Decrease) in Weighted Procedures	-na-	(5.1%)

The decrease in utilization at WRGO between FY2008 and FY2009 is in contrast to a 9.3% increase 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 Fixed MRI utilization (Historical and Projected)

	FY2005	FY2006	FY2007	FY2008	FY2009	FY 2010 Projected-Interim	FY 2011 Projected-Interim	FY1 FY 2012	FY2 FY 2013	FY3 FY 2014
Unweighted	11,852	10,576	10,009	9,842	8,546	8,731	8,919	9,112	9,309	9,511
Weighted	13,204	11,837	11,308	11,272	10,078	10,297	10,519	10,747	10,979	11,216
% change in weighted	-na-	<11.55%>	<4.7%>	<0.32%>	<11.85%>	2.2%	2.2%	2.2%	2.2%	2.2%

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 56.25%). In support of this projected growth, in Exhibit 18, the applicants submitted 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.*" [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 corridors from Johnston County to WRGO (the site of the proposed fixed MRI scanner) are I-40 and US 70. Johnston MRI, LLC 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.

Raleigh MRI Projected Utilization

	FY2009	FY 2010 Projected-Interim	FY 2011 Projected-Interim	PY1 FY 2012	PY2 FY 2013	PY3 FY 2014
Unweighted MRI Procedures	8,546	8,731	8,919	9,112	9,309	9,511
Weighted MRI Procedures	10,078	10,297	10,519	10,747	10,979	11,216
% change in weighted	<11.85%>	2.2%	2.2%	2.2%	2.2%	2.2%

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

	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.

	FY2012	FY2013	FY2014
Unweighted MRI procedures	7,864	8,061	8,263
Weighted MRI procedures	9,275	9,507	9,744

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 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

	2007	2008	2009	2010	2011	2012	2013	2014
Unweighted MRI Procedures	350	432	19	-na-	-na-	1,248	1,248	1,248
Weighted MRI Procedures						1,406	1,406	1,406

Wake Radiology Northwest Raleigh Office
Historical and Projected Mobile MRI Procedures FY2012-FY2014

	2008	2009	2010	2011	2012	2013	2014
Unweighted MRI Procedures	-na-	20*	—	—	728	832	936
Weighted MRI Procedures	-na-				815	932	1,048

*9/1/09—9/30/09 only. Total of 36 hours.

Wake Radiology Wake Forest Office
Historical and Projected Mobile MRI Procedures FY2012-FY2014

	2008	2009	2010	2011	2012	2013	2014
Unweighted MRI Procedures					728	832	936
Weighted MRI Procedures					801	915	1,030

*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

	2012	2013	2014
Total Unweighted MRI Procedures	2,704	2,912	3,120
Total Weighted MRI Procedures	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.

Furthermore, Wake Radiology did not provide the methodology and assumptions used to project utilization of the mobile MRI scanner 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.

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

NA – 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 Raleigh
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.

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	$ 292,100
Cost of Materials	$1,122,000
Cost of Labor	$ 918,000
Fixed Equipment	$2,049,000
Movable Equipment	$ 79,600
Furniture	$ 13,600
Architect & Engineering	$ 345,000
Independent Testing	$ 12,900
Other (Contingency)	$ 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

	Year 1- (7/1/11 -6/30/12)	Year 2- (7/1/12 – 6/30/13)	Year 3- (7/1/13 – 6/30/14)
Projected # of Unweighted Procedures	6,654	7,269	8,034
Projected Average Charge (Gross Patient Revenue / Projected # of Procedures)	$2,576.30	$2,730.95	$2,894.95
Gross Patient Revenue	$17,142,718	$19,851,292	$23,258,028
Deductions from Gross Patient Revenue	$11,681,400	$13,755,627	$16,334,823
Net Patient Revenue	$5,461,317	$6,095,665	$6,923,205
Total Expenses	$1,760,967	$1,988,733	$2,071,847
Net Income	$3,700,351	$4,106,892	$4,851,358

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

*Note: All $ are in 000's.	Year 1- (7/1/11 -6/30/12)	Year 2- (7/1/12 – 6/30/13)	Year 3- (7/1/13 – 6/30/14)
Total Operating Revenue	$2,333,141	$2,483,205	$2,726,652
Total Operating Expenses excluding Bad Debt	$2,168,050	$2,338,243	$2,588,607
Operating Income (Loss)	$165,091	$144,962	$138,045
Non-Operating Revenue	$61,540	$55,302	$58,417
Excess of Revenue over Expenses from Continuing Operations	$226,631	$200,264	$196,462

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	$ 409,304
Fixed Equipment	$1,590,565
Furniture	$ 25,000
Architect & Engineering	$ 25,000
Other (Contingency)	$ 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. 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- (1/1/12-12/31/12)	Year 2- (1/1/13-12/31/13)	Year 3- (1/1/14-12/31/14)
Projected # of Unweighted Procedures	3,600	4,115	4,661
Projected Average Charge (Gross Patient Revenue / Projected # of Procedures)	$2,046.18	$2,046.18	$2,046.18
Gross Patient Revenue	$7,366,232	$8,420,012	$9,537,224
Deductions from Gross Patient Revenue	$5,230,375	$5,978,610	$6,771,883
Net Patient Revenue	$2,135,856	$2,441,402	$2,765,341
Total Expenses	$1,564,969	$1,779,425	$1,875,820
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	$ 327,180
Fixed Equipment	$1,336,106
Movable Equipment	$ 37,158
Furniture	$ 3,000
Architect & Engineering	$ 33,500
Administrative & Legal	$ 41,750
Financing Costs	$ 18,500
Interest During Construction	$ 4,908
Other (freight, miscellaneous)	$ 17,000
Total	$1,819,102

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.

WRGO- Proposed fixed MRI service component

	Year 1- (10/1/11-9/30/12).	Year 2- (10/1/12-9/30/13)	Year 3- (10/1/13-9/30/14)
Projected # of Unweighted Procedures	3,600	4,115	4,661
Projected Average Charge (Gross Patient Revenue / Projected # of Procedures)	$1,988.71	$2,031.82	$2,070.00
Gross Patient Revenue	$7,159,352	$8,360,952	$9,648,264
Deductions from Gross Patient Revenue	$3,490,464	$4,099,147	$4,761,140
Net Patient Revenue	$3,68,888	$4,261,805	$4,887,124
Total Expenses	$2,253,997	$2,628,302	$2,884,476
Net Income	$1,414,891	$1,633,503	$2,002,648

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.

WRGO- Revenue and Expenses: Entire Facility

	Project Year 1	Project Year 2	Project Year 3
Total Revenue	$6,212,418	$6,363,667	$6,463,400
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:

1) 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 VII.1, 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 Technologists.*" The majority of the procedures are performed on a mobile MRI scanner 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 VII.8, 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, LLC 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

(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 (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.

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:

Duke Raleigh's Historical MRI Payor Mix

MRI Services Last Full Fiscal Year July 1, 2008 to June 30, 2009 Current Patient Days/ Procedure as Percent of Total Utilization	
Self Pay/Indigent/Charity	3.5%
Medicare/Medicare Managed Care	40.4%
Medicaid	5.8%
Commercial Insurance	47.7%
Managed Care	1.1%
Other (Specify)	1.4%
Total	100.0%

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 VI.13, 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 Percent of Total Utilization	
Self Pay/Indigent/Charity	0.3%
Medicare	26.4%
Medicaid	2.7%
Managed Care/ Commercial	15.6%
Blue Cross Blue Shield	44.4%
State Employees Health Plan	10.0%
Other (Workers Comp, TriCare)	0.7%
Total	100.0%

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 VI.10, 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, page105, 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.

(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 – 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 inpatient, outpatient, and other healthcare services on a walk-in, emergency, referral, or emergency basis."* In Section VI.15, 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 Projected Patient Days/ Procedure as Percent of Total Utilization	
Self Pay/Indigent/Charity	3.6%
Medicare/Medicare Managed Care	42.2%
Medicaid	8.6%
Commercial Insurance	43.1%
Managed Care	1.1%
Other (Specify)	1.4%
Total	**100.0%**

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 VI.2, 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 VI.15, 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 Projected Patient Days/ Procedure as Percent of Total Utilization	
Self Pay/Indigent/Charity	8.1%
Medicare/Medicare Managed Care	15.2%
Medicaid	4.8%
Commercial Insurance	6.5%
Managed Care	55.2%
Other – (Champus, Workers Compensation, Third Party Admin)	10.2%
Total	100.0 %

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) Current Patient Days/ Procedure as Percent of Total Utilization	
Self Pay/Indigent/Charity	0.3%
Medicare	26.4%
Medicaid	2.7%
Managed Care/ Commercial	15.6%
Blue Cross Blue Shield	44.4%
State Employees Health Plan	10.0%
Other (Workers Comp, TriCare)	0.7%
Total	100.0%

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- Holly 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

10A NCAC 14C .2702 INFORMATION REQUIRED OF APPLICANT

(a) *An applicant proposing to acquire an MRI scanner, including a mobile MRI scanner, shall use the Acute Care Facility/Medical Equipment application form.*

-C- All Applicants used the Acute Care Facility/Medical Equipment application form.

(b) *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 co-applicants in the application form.*

-C- **Duke Raleigh-** In Section II.8, page 13, the applicant, Duke Raleigh, states that it is both the applicant and the entity billing patients for MRI services.

-C- **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:*

(1) *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;*

-C- **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.*"

-C- **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 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;*

-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 patients 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;

-C- **Duke 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.

(9) *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 inpatient 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 inpatient 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 inpatients 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 inpatients 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 number 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 inpatients 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, tesla 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 WRDL. 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 scanners, 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 scanner, 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 scanner 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;

(B) 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 multi-position MRI scanner in any position;

(C) the number of doctors by specialty that referred patients for an MRI scan in an upright or nonstandard position;

(D) documentation to demonstrate compliance with the Basic Principles policy included in the State Medical Facilities Plan;

(E) 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

(F) the number of insured, underinsured, and uninsured patients served by type of payment category;

(2) provide the specific criteria that will be used to determine which patients will be examined in other than routine supine or prone imaging positions;

(3) project the number of exams by CPT code performed on the multi-position MRI scanner in an upright or nonstandard position;

(4) project the total number of examinations by CPT code performed on the multi-position MRI scanner in any position;

(5) 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 applicant's facility;

(6) 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 position; and

(7) 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 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.

-NA- None of the applicants propose to acquire a multi-position MRI scanner.

10A NCAC 14C .2703 PERFORMANCE STANDARDS

(a) An applicant proposing to acquire a mobile magnetic resonance imaging (MRI) scanner shall:

(1) 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 scanners.]; 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;

(2) 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 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.

-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 scanners 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 scanner 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.

-C- **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

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 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 scanners at Raleigh MRI.

Raleigh MRI Projected Utilization

	FY2009	FY 2010 Projected-Interim	FY 2011 Projected-Interim	PY1 FY 2012	PY2 FY 2013	PY3 FY 2014
Unweighted MRI Procedures	8,546	8,731	8,919	9,112	9,309	9,511
Weighted MRI Procedures	10,078	10,297	10,519	10,747	10,979	11,216
% change in weighted	<11.85%>	2.2%	2.2%	2.2%	2.2%	2.2%

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

	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.

	FY2012	FY2013	FY2014
Unweighted MRI procedures	7,864	8,061	8,263
Weighted MRI procedures	9,275	9,507	9,744

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 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 MRI.

Raleigh Fixed MRI Utilization (Historical and Projected)

	FY2005	FY2006	FY2007	FY2008	FY2009	FY 2010 Projected-Interim	FY 2011 Projected-Interim	FY1 FY 2012	FY2 FY 2013	FY3 FY 2014
Unweighted	11,852	10,576	10,009	9,842	8,546	8,731	8,919	9,112	9,309	9,511
Weighted	13,204	11,837	11,308	11,272	10,078	10,297	10,519	10,747	10,979	11,216
% change in weighted	-na-	<11.55%>	<4.7%>	<0.32%>	<11.85%>	2.2%	2.2%	2.2%	2.2%	2.2%

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.

(4) if the proposed MRI scanner will be located at a different site from any of the existing 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:

(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 scanner 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;

-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).

-NC- 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.

(5) demonstrate that annual utilization of each existing, approved and proposed mobile 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

	2007	2008	2009	2010	2011	2012	2013	2014
Unweighted MRI Procedures	350	432	19	-na-	-na-	1,248	1,248	1,248
Weighted MRI Procedures						1,406	1,406	1,406

Wake Radiology Northwest Raleigh Office
Historical and Projected Mobile MRI Procedures FY2012-FY2014

	2008	2009	2010	2011	2012	2013	2014
Unweighted MRI Procedures	-na-	20*	—	—	728	832	936
Weighted MRI Procedures	-na-				815	932	1,048

*9/1/09 – 9/30/09 only. Total of 36 hours.

Wake Radiology Wake Forest Office
Historical and Projected Mobile MRI Procedures FY2012-FY2014

	2008	2009	2010	2011	2012	2013	2014
Unweighted MRI Procedures					728	832	936
Weighted MRI Procedures					801	915	1,030

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

	2012	2013	2014
Total Unweighted MRI Procedures	2,704	2,912	3,120
Total Weighted MRI Procedures	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 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.

(c) *An applicant proposing to acquire a fixed dedicated breast magnetic resonance imaging (MRI) scanner for which the need determination in the State Medical Facilities Plan was based on an approved petition for an adjustment to the need determination shall:*

(1) 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 1 procedure per hour times 40 hours per week times 52 weeks per year; and

(2) 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 dedicated breast MRI scanner.

(d) *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 adjustment to the need determination shall:*

(1) 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

(2) 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 extremity MRI scanner.

(e) *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 demonstration project shall:*

(1) 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

(2) 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.

10A NCAC 14C .2704 SUPPORT SERVICES

(a) *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.*

NA- None of the applicants propose to acquire a mobile MRI scanner.

(b) *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 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.

-C- Duke Raleigh- The hospital is currently accredited by the Joint Commission. See Section II.8, page 23.

-C- 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.

10A NCAC 14C .2705 STAFFING AND STAFF TRAINING

(a) An applicant proposing to acquire an MRI scanner, including extremity and breast MRI scanners, shall demonstrate that one diagnostic radiologist certified by the American Board of Radiologists shall be available to interpret the images who has had:

(1) training in magnetic resonance imaging as an integral part of his or her residency training program; or

(2) six months of supervised MRI experience under the direction of a certified diagnostic radiologist; or

(3) at least six months of fellowship training, or its equivalent, in MRI; or

(4) a combination of MRI experience and fellowship training equivalent to Subparagraph (a)(1), (2) or (3) of this Rule.

-C- 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. 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.

-C- 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.

-C- 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 intention to serve as the MRI Medical Director.*" 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.

(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*

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 nurse 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:*

(1) *evidence that at least one licensed physician shall be on-site during the hours of operation of the proposed MRI scanner;*

(2) *a description of a research group for the project including a radiologist, orthopaedic surgeon, and research coordinator; and*

(3) *letters from the proposed members of the research group indicating their qualifications, experience and willingness to participate on the research team.*

-NA- None of the applicants propose to acquire an extremity MRI scanner.

(g) *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 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.*"

-C- 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 training 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. #J-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
Wake Radiology- Cary (Alliance)	Cary	1
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 Neurology	Raleigh	1
Raleigh Radiology Cedarhurst (Pinnacle)	Raleigh	1
Raleigh Radiology (Alliance)	Raleigh	1
Rex Hospital	Raleigh	2
Total		13

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

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.

Applicant	Percentage of Total Procedures to be Provided to Medicaid Recipients	Percentage of Total Procedures to be Provided to Medicare Recipients
Duke Raleigh	8.6%	42.2%
NCDI- Holly Springs	4.8%	15.2%
Wake Radiology	2.7%	26.4%

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 Medicare 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 MRI procedures. 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 Revenue	# of Unweighted MRI Procedures	Average Gross Revenue per Procedure	Professional Fees*	Gross Revenue less Professional Fees	Average Gross Revenue (less Professional Fee Component) per Procedure
Duke Raleigh	$23,258,028	8,034	$2,894.95	-na-	-na-	$2,894.95
NCDI-Holly Springs	$9,537,224	4,661	$2,046.18	$387,148	$9,150,076	$1,963.11
Wake Radiology	$9,648,264	4,444	$2,171.08	$1,243,102	$8,405,162	$1,891.35

* 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

Applicant	Net Revenue	# of Unweighted MRI Procedures	Average Net Revenue Per Procedure	Professional Fees and Bad Debt	Net Revenue Less Professional Fees and Bad Debt	Average Net Revenue (Less Professional Fee Component) Per Procedure
Duke Raleigh	$6,923,205	8,034	$861.74	-na-	-na-	$861.74
NCDI-Holly Springs	$2,765,341	4,661	$593.29	$387,148	$2,378,193	$510.23
Wake Radiology	$4,887,124	4,444	$1,099.71	$1,759,385	$3,127,739	$703.81

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 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, 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
Average Operating Cost per Unweighted Procedure

Applicant	# of Unweighted MRI Procedures	Total Operating Costs	Professional Fees and Bad Debt	Total Operating Cost less Professional Fee Expenses and Bad Debt	Average Cost Per Procedure (less Professional Fee Component per procedure)
Duke Raleigh	8,034	$2,071,847	-na-	$2,071,847	$257.88
NCDI-Holly Springs	4,661	$1,875,820	$387,148	$1,488,672	$319.39
Wake Radiology	4,444	$2,884,476	$1,759,385	$1,125,091	$253.17

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 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.

EXHIBIT

C

ATTACHMENT - REQUIRED STATE AGENCY FINDINGS

FINDINGS
C = Conforming
CA = 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

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

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.

(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

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

County	% of Patients
Macon	45.0%
Jackson	35.0%
Cherokee	7.0%
Swain	6.0%
Graham	2.0%
All Other*	4.5%
Total**	99.5%

* "All other" includes Haywood, Buncombe and Henderson Counties, Georgia and other states.
** Does not equal 100% due to rounding.

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:

"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:

Historical and Projected Utilization

	CY 2007	CY 2008	1/1/2009-8/31/09	Year 1 5/1/2010 – 4/30/2011	Year 1 5/1/2010 – 4/30/2011	Year 1 5/1/2010 – 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.**

2. **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.

C

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.

C

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
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;

C

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;

C

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 VI.9, 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.

C

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.

C

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.

EXHIBIT D

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 Gongloff NEW YORK (CNNfn) - If you're looking 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.

graphic

Money found the cities where people retire most often and then picked the ones "where a vigorous retirement is the norm."

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 11.7F, 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 20.5F. Those of us who would rather golf than shovel a driveway could live in Bradenton (average low a balmy 50.1F) 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.;

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

☐ Check the box to include the list of links referenced in the article.

Exhibit D, p. 3

CNNMoney.com

PRINT THIS

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Best places to retire June 14, 2000: 9:58 a.m. ET

Modern Maturity names the 50 most active places to live during retirement

*By Staff Writer Jennifer Karchmer*NEW 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.

graphic

"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."

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.

Boulder, 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.

Ex. D, p. 4

Austin, Texas

Maybe you've been thinking about taking a night class at the local university or a course on comparative literature?

graphic

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.

Ex. D, p 5

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.

Driving Directions from 2651 Hendersonville Rd, Arden, North Carolina to 100 Hospital

EXHIBIT E

mapquest

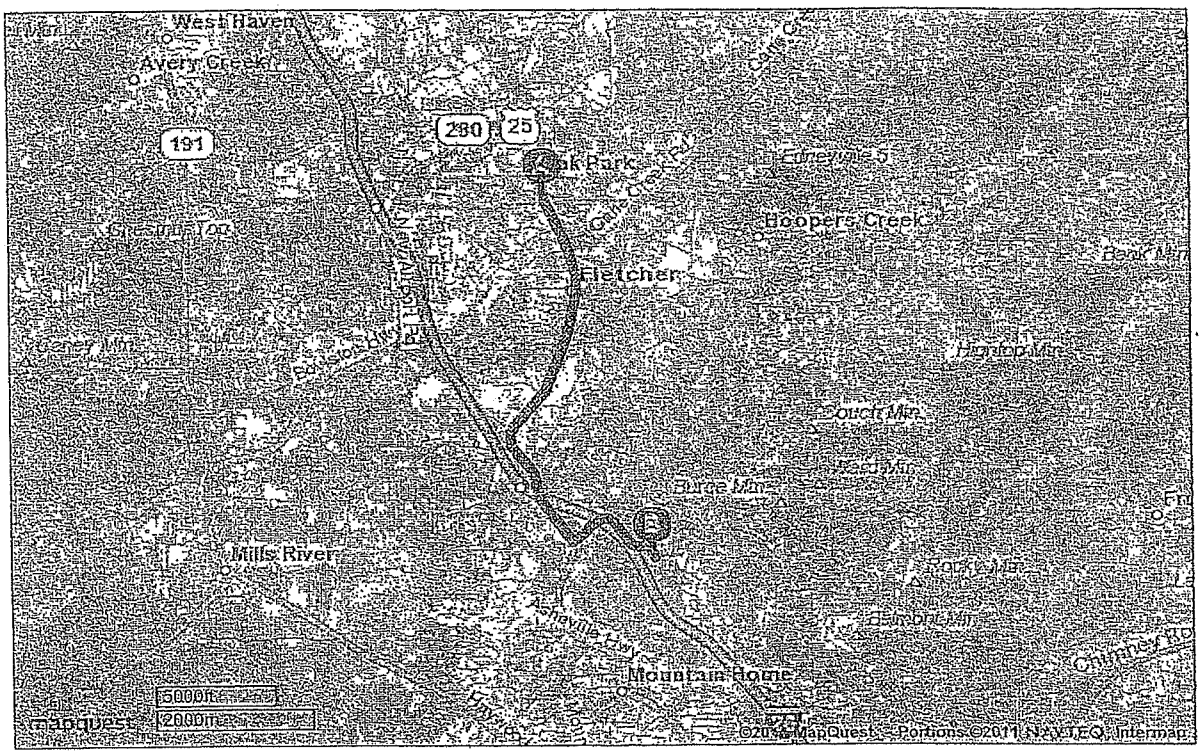
Notes

Mission GI South to Park Ridge

Trip to:
100 Hospital Dr
Hendersonville, NC 28792-5272
5.32 miles
10 minutes

		Miles Per Section	Miles Driven
	2651 Hendersonville Rd Arden, NC 28704-8527		
	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
	2. US-25 S becomes ASHEVILLE HWY / US-25-BR S.	**Go 0.5 Mi**	4.1 mi
	3. Turn 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 mi
	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 mi
	100 Hospital Dr Hendersonville, NC 28792-5272	**5.3 mi**	**5.3 mi**

Total Travel Estimate: **5.32 miles - about 10 minutes**



EXHIBIT

F

mapquest

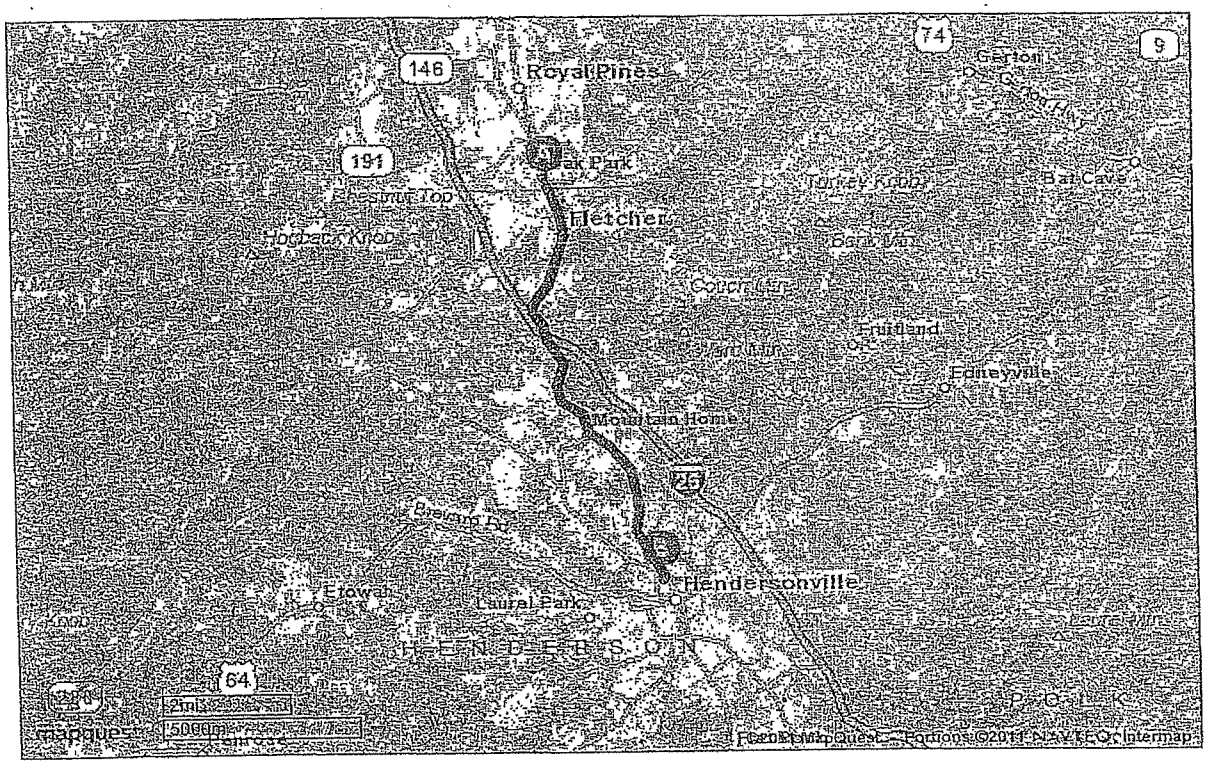
Notes

Mission GI Sath to Carolina Mountain Endoscopy

Trip to:
1032 Fleming St
Hendersonville, NC 28791-3532
9.82 miles
18 minutes

		Miles Per Section	Miles Driven
	2651 Hendersonville Rd Arden, NC 28704-8527		
	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
	2. US-25 S becomes ASHEVILLE HWY / US-25-BR S.	**Go 6.2 Mi**	9.7 mi
	3. Turn RIGHT onto FLEMING ST. *If you reach OAKLAND ST you've gone a little too far*	**Go 0.09 Mi**	9.8 mi
	4. 1032 FLEMING ST is on the LEFT. *Your destination is just past SHIPP ST* *If you reach PATTON ST you've gone a little too far*		9.8 mi
	1032 Fleming St Hendersonville, NC 28791-3532	**9.8 mi**	**9.8 mi**

Total Travel Estimate: **9.82 miles - about 18 minutes**



Driving Directions from 2651 Hendersonville Rd, Arden, North Carolina to 800 N Jus

EXHIBIT G

mapquest

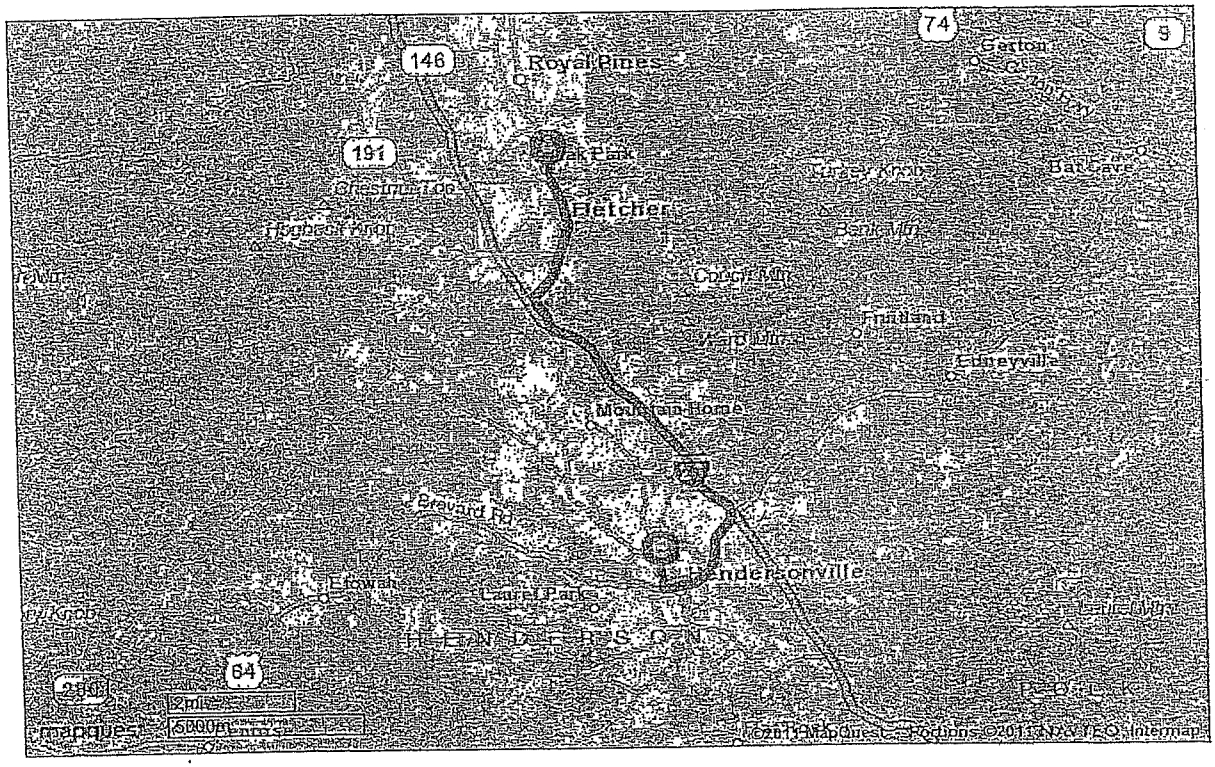
Notes

Mission GI. Sutn to Pardee

Trip to:
800 N Justice St
Hendersonville, NC 28791-3410
11.84 miles
18 minutes

		Miles Per Section	Miles Driven
	2651 Hendersonville Rd Arden, NC 28704-8527		
	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
	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
	3. Merge onto US-64 W via EXIT 49B toward HENDERSONVILLE.	Go 2.4 Mi	11.4 mi
	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
	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**



Driving Directions from 2651 Hendersonville Rd, Arden, North Carolina to 509 Biltmore ..

EXHIBIT

H

mapquest

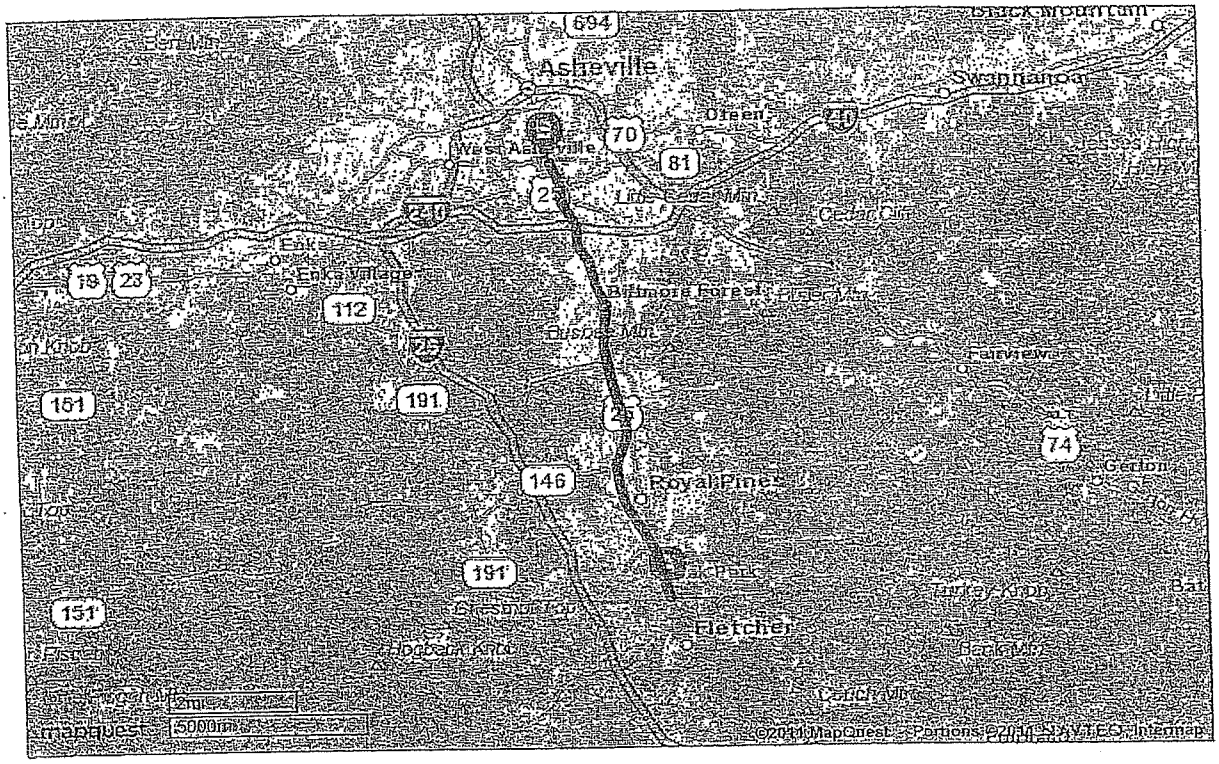
Trip to:
509 Biltmore Ave
Asheville, NC 28801-4601
9.93 miles
16 minutes

Notes

Mission GI
Sath to Mission

		Miles Per Section	Miles Driven
	2651 Hendersonville Rd Arden, NC 28704-8527		
	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
	2. Turn RIGHT onto US-25-ALT. *US-25-ALT is just past BOSTON WAY*	Go 0.04 Mi	9.1 mi
	3. Take the 1st LEFT onto BILTMORE AVE. *If you reach BILTMORE PLZ you've gone a little too far*	Go 0.8 Mi	9.9 mi
	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 mi	9.9 mi

Total Travel Estimate: **9.93 miles - about 16 minutes**



Driving Directions from 2651 Hendersonville Rd, Arden, North Carolina to 191 Biltmore ...

EXHIBIT

I

mapquest

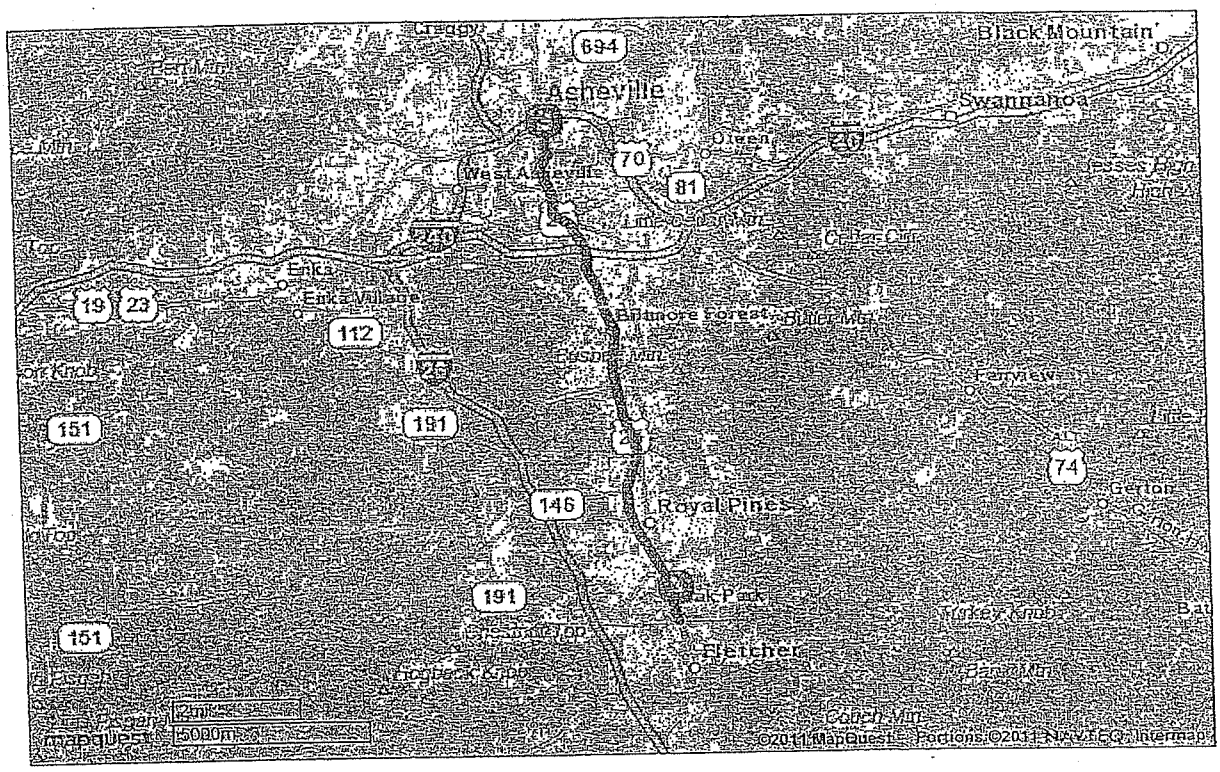
Trip to:
191 Biltmore Ave
Asheville, NC 28801-4109
10.90 miles
17 minutes

Notes

Mission GI South to Asheville Gastro - The Endoscopy Center

		Miles Per Section	Miles Driven
	2651 Hendersonville Rd Arden, NC 28704-8527		
	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
	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
	3. Turn LEFT onto BILTMORE AVE / US-25. *BILTMORE AVE is just past S LEXINGTON AVE*	Go 0.01 Mi	10.9 mi
	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 mi

Total Travel Estimate: **10.90 miles - about 17 minutes**



EXHIBIT

J

USDA United States Department of Agriculture
Economic Research Service
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2009 County-Level Poverty Rates for North Carolina

North Carolina Go

Percent Number

Go to the map to select a State
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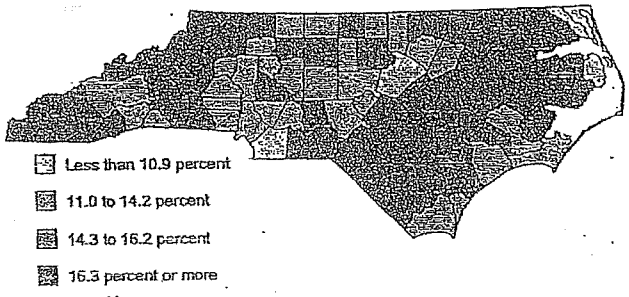
Percent of total population in poverty, 2009



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Click a column name to sort the table by that column.

				All people in poverty (2009)			Children ages 0-17 in poverty (2009)		
					90% confidence interval of estimate			90% confidence interval of estimate	
	FIPS*	Name	RUC Code[1]	Percent	Lower bound	Upper bound	Percent	Lower bound	Upper bound
1	37000	North Carolina		16.2	16.0	16.5	22.5	21.9	23.0
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

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	14.0	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	1	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	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	19.2	26.0	27.8	22.4	33.2
19	37035	Catawba County	2	14.4	12.6	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
21	37039	Cherokee County	9	17.8	13.6	21.9	31.5	24.4	38.7
22	37041	Chowan County	7	20.6	16.3	24.8	31.3	24.6	38.0
23	37043	Clay County	9	16.9	13.0	20.7	28.7	22.3	35.2
24	37045	Cleveland County	4	17.5	14.8	20.3	25.9	21.1	30.8
25	37047	Columbus County	6	25.4	21.7	29.0	38.2	33.0	43.4
26	37049	Craven County	5	16.1	14.0	18.2	25.7	21.8	29.7
27	37051	Cumberland County	2	17.0	15.0	19.0	24.4	20.5	28.3
28	37053	Currituck County	1	10.4	7.8	12.9	17.4	13.4	21.4
29	37055	Dare County	5	10.7	8.4	13.0	17.9	14.0	21.9
30	37057	Davidson County	4	14.6	12.6	16.6	22.4	18.7	26.0
31	37059	Davie County	2	11.7	9.4	14.0	17.9	14.5	21.3
32	37061	Duplin County	6	24.3	21.3	27.2	33.0	28.0	38.1
33	37063	Durham County	2	16.4	14.6	18.2	22.5	19.1	25.8
34	37065	Edgecombe County	3	25.7	22.0	29.3	34.8	28.6	41.0
35	37067	Forsyth County	2	16.5	15.0	18.0	23.6	20.8	26.3

36	37069	Franklin County	2	13.7	10.6	16.7	19.9	15.4	24.3
37	37071	Gaston County	1	15.6	13.5	17.6	21.7	18.1	25.4
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	28.3	31.4	24.7	38.1
42	37081	Guilford County	2	17.1	15.3	18.8	22.1	19.4	24.7
43	37083	Halifax County	4	26.8	23.1	30.6	35.6	29.3	42.0
44	37085	Harnett County	4	17.3	14.5	20.1	23.4	19.2	27.6
45	37087	Haywood County	2	15.2	12.4	18.1	24.9	19.6	30.3
46	37089	Henderson County	2	12.4	10.0	14.7	21.0	16.9	25.1
47	37091	Hertford County	7	24.9	20.0	29.8	34.6	27.7	41.5
48	37093	Hoke County	2	21.3	18.0	24.6	30.1	25.2	34.9
49	37095	Hyde County	9	24.0	18.6	29.5	29.6	23.0	36.3
50	37097	Iredell County	4	13.1	11.6	14.6	17.9	15.3	20.5
51	37099	Jackson County	6	20.5	16.7	24.3	26.3	20.6	32.0
52	37101	Johnston County	2	17.4	15.6	19.2	23.4	20.6	26.3
53	37103	Jones County	8	18.3	14.1	22.6	29.7	23.0	36.4
54	37105	Lee County	4	14.5	11.7	17.3	22.1	17.4	26.8
55	37107	Lenoir County	4	21.0	17.7	24.2	29.8	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	21.0	31.1
58	37113	Macon County	7	18.8	15.8	21.8	31.0	25.3	36.8
59	37115	Madison County	2	19.3	14.9	23.6	26.9	20.8	33.0
60	37117	Martin County	6	21.3	17.1	25.4	32.2	25.8	38.7
61	37119	Mecklenburg County	1	14.2	13.1	15.2	19.6	17.5	21.7
62	37121	Mitchell	9	18.3	14.6	22.0	26.5	20.8	32.1

		County							
63	37123	Montgomery County	6	21.3	17.2	25.3	31.2	24.9	37.6
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	27.3	26.7	23.2	30.3
76	37149	Polk County	8	15.3	12.3	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	31.1	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	20.4	28.1
82	37161	Rutherford County	4	21.8	18.9	24.7	30.6	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	6	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	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							
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.

[1]The 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.

For more information, contact: Kathleen Kassel

Web administration: webadmin@ers.usda.gov

Updated date: December 11, 2009

EXHIBIT

K

An Economic Analysis of the Certificate of Public Advantage (COPA) Agreement Between the State of North Carolina and Mission Health

February 10, 2011

Prepared by

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An Economic Analysis of the Certificate of Public Advantage Agreement Between the State of North Carolina and Mission Health

I. 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").[1] Due to concerns that the merger would significantly increase Mission Hospital's market power in one or more markets in Western North Carolina ("WNC"),[2] 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.[3] 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.[4] 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

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[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 1 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.

[3] 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.

4. *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.[5] 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.[6] 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 hospitals. 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.[7]

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.[8]

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.[9]

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

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[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.

[10] 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.[13] 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

[13]While 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).

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[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.

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[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-than-normal 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.[20] 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.[21] 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.

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[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

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[22] See Section 4.2 of the COPA.

[23] 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]

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[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.

[30] 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 the same individuals, and the contracts for MHS's different hospitals and services 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-

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[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 practices 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.

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 inpatient 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.[37] 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.

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[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.

[38] 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.[40] 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

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[40] This may, however, create certain problems relating to allocation of costs that are common to both inpatient 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.[43] 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).

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[42] 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.

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[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.[46] 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.[47] 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.

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[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

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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.

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[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.

[54] 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.[56] 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.

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[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 Carolina

	Total Patient Count in 2009*	Mission Hospital's Share of Patients					
		2005	2006	2007	2008	2009	1st Half 2010
Buncombe	26,045	86.3%	86.9%	87.3%	87.8%	89.6%	90.5%
Henderson	12,740	22.1%	22.7%	23.8%	25.3%	29.6%	36.4%
Burke	10,548	5.3%	5.7%	5.8%	6.1%	5.8%	5.8%
Rutherford	8,613	5.9%	6.3%	6.7%	8.0%	7.2%	7.2%
Haywood	8,298	28.7%	27.2%	28.4%	35.9%	33.5%	32.8%
McDowell	5,131	31.5%	33.3%	32.9%	34.4%	37.8%	35.8%
Jackson	3,807	17.5%	21.1%	21.5%	24.5%	27.3%	28.8%
Macon	3,734	27.5%	31.0%	27.8%	31.0%	29.3%	29.6%
Transylvania	3,523	32.1%	32.4%	32.0%	35.4%	34.6%	35.8%
Cherokee	2,671	18.8%	17.9%	20.0%	19.2%	18.5%	19.8%
Swain	2,494	22.7%	21.6%	24.4%	26.2%	26.8%	23.7%
Yancey	2,329	45.5%	49.4%	48.6%	47.5%	50.2%	49.5%
Madison	2,172	88.9%	89.9%	88.5%	89.7%	90.8%	91.2%
Mitchell	2,138	27.4%	29.1%	28.0%	25.7%	28.1%	29.6%
Polk	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

Hospital Name	County	City	Hospital Type	Beds	Average Patients Per Day	# of Physicians Actively Admitting Patients*	Distance in Miles from Mission Hospital
Mission Hospital	Buncombe	Asheville	Acute Care	726	522	342	0
The McDowell Hospital	McDowell	Marion	Acute Care	49	16	16	35
Blue Ridge Regional Hospital	Mitchell	Spruce Pine	Acute Care	49	22	28	51
Transylvania Community Hospital	Transylvania	Brevard	Critical Access	35	17	22	29
Pardee Hospital	Henderson	Hendersonville	Acute Care	216	72	58	27
Murphy Medical Center	Cherokee	Murphy	Acute Care	190	27	22	111
Grace Hospital	Burk	Morganton	Acute Care	184	59	56	58
Rutherford Hospital	Rutherford	Rutherfordton	Acute Care	143	53	42	57
Valdese Hospital	Burk	Connellys Springs	Acute Care	131	27	26	65
Haywood Regional Medical Center	Haywood	Clyde	Acute Care	121	62	37	27
Highlands-Cashiers Hospital	Macon	Highlands	Critical Access	104	7	7	67
Park Ridge Hospital	Henderson	Hendersonville	Acute Care	98	43	42	15
Harris Regional Hospital	Jackson	Sylva	Acute Care	86	43	33	47
Saint Luke's Hospital	Polk	Columbus	Critical Access	35	15	5	39
Angel Medical Center	Macon	Franklin	Critical Access	25	17	16	69
Swain County Hospital	Swain	Bryson City	Critical Access	24	6	6	66

Notes:

* 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.

Sources:

American Hospital Directory (ahd.com), November 8, 2010.

Thompson Reuters, Inpatient Data for North Carolina.

Table 3: The COPA's Cost Cap Methodology - Illustrative Example

Base Case

	Volume	"Price" per procedure	Total Revenue	Cost per Procedure	Total Cost
Inpatient Procedures	1,200	1,000	1,200,000	800	960,000
Outpatient Procedures	800	500	400,000	400	320,000
TOTAL			1,600,000		1,280,000
"Equivalent Outpatient Discharges"	400	1,000			
"Total Adjusted Discharges"	1,600				
"Cost/Adjusted Patient Discharge"	800				

20% Increase in Outpatient Price

	Volume	"Price" per procedure	Total Revenue	Cost per Procedure	Total Cost
Inpatient Procedures	1,200	1,000	1,200,000	800	960,000
Outpatient Procedures	800	600	480,000	400	320,000
TOTAL			1,680,000		1,280,000
"Equivalent Outpatient Discharges"	480	1,000			
"Total Adjusted Discharges"	1,680				
"Cost/Adjusted Patient Discharge"	762				

20% Increase in Outpatient Price and Volume

	Volume	"Price" per procedure	Total Revenue	Cost per Procedure	Total Cost
Inpatient Procedures	1,200	1,000	1,200,000	800	960,000
Outpatient Procedures	960	600	576,000	400	384,000
TOTAL			1,776,000		1,344,000
"Equivalent Outpatient Discharges"	576	1,000			
"Total Adjusted Discharges"	1,776				
"Cost/Adjusted Patient Discharge"	757				

Table 4: Mission Health System Operating Income
For the year ending September 30, 2009

	Total Revenue	Operating Income	Operating 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%
Other	19,161	660	3.4%

Source:
Mission Health System, Inc. and Affiliates, Combined Financial Statements and Schedules, September 30, 2009 and 2008, KPMG, page 32.

Appendix

CRA Charles River Associates

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/Benfield*). 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 Antitrust*, 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, DC.

- 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, Seattle.

- 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 Pendl 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]

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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 Otto Bock Healthcare, U.S. District Court, Southern District of California (Case 06-CV-1222 JAH (NLS)). Expert report submitted on behalf of Otto 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.

"Geographic Market Definition in Hospital Antitrust Analysis – Theory and Empirical Evidence." Federal Trade Commission/Department of Justice Joint Hearings on Health Care and Competition Law and Policy, Washington, DC, March 2003.

"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 Antitrust, 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)

EXHIBIT

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SECOND AMENDED CERTIFICATE OF PUBLIC ADVANTAGE

This Second Amended Certificate of Public Advantage is issued, pursuant to N.C. Gen. Stat. § 131 E-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.

I. 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. § 131E-192.4(b) lists the advantages and disadvantages which the Department must consider in reviewing a COPA application. Each 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) Enhancement of the quality of hospital and hospital-related care provided to North Carolina citizens.

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 (JCAHO).

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)(1)(A)-(c)(1)(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) Preservation of hospital facilities in geographical proximity to the communities 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 theHospitals 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 furnishing 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.

6.1 Except as provided herein, Mission Health shall not enter into any exclusive 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.

6.2 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.

6.4 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.

8.1 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.

8.3 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:

1) Annual utilization of beds, equipment, and services and any increases or decreases in utilization of beds, equipment, and services;

2) 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

3) 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.

11.3 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;

2) 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

3) 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.

11.4 The Department finds and concludes that: the proposed transaction has made 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) Compliance. 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.

13.1 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.

13.4 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) Legal Exposure. 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) Review and Amendment. 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) Binding Effect of COPA. 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.

This the 21st day of June, 2005.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Robert J. Fitzgerald
Director
Division of Facility Services

Agreed and Consented to:

MISSION HOSPITALS, INC.

Joseph F. Damore, President

Date: 6/22/05

MISSION HEALTH, INC.

Joseph F. Damore, President

Date: 6/22/05

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

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

April 27, 2011

Bruce Perlman, 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

THE MACULA CENTER
Of North Carolina

Diseases of the Retina Eye Surgery Laser Treatment

Robert P. Laborde, MD

709 5th Avenue West
Hendersonville, NC 28739
p 828.693.0747
f 828.693.0947
www.maculacenternc.com

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 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

~~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.

Sincerely,

Carlton A. Jenkins, MD

April 26, 2011

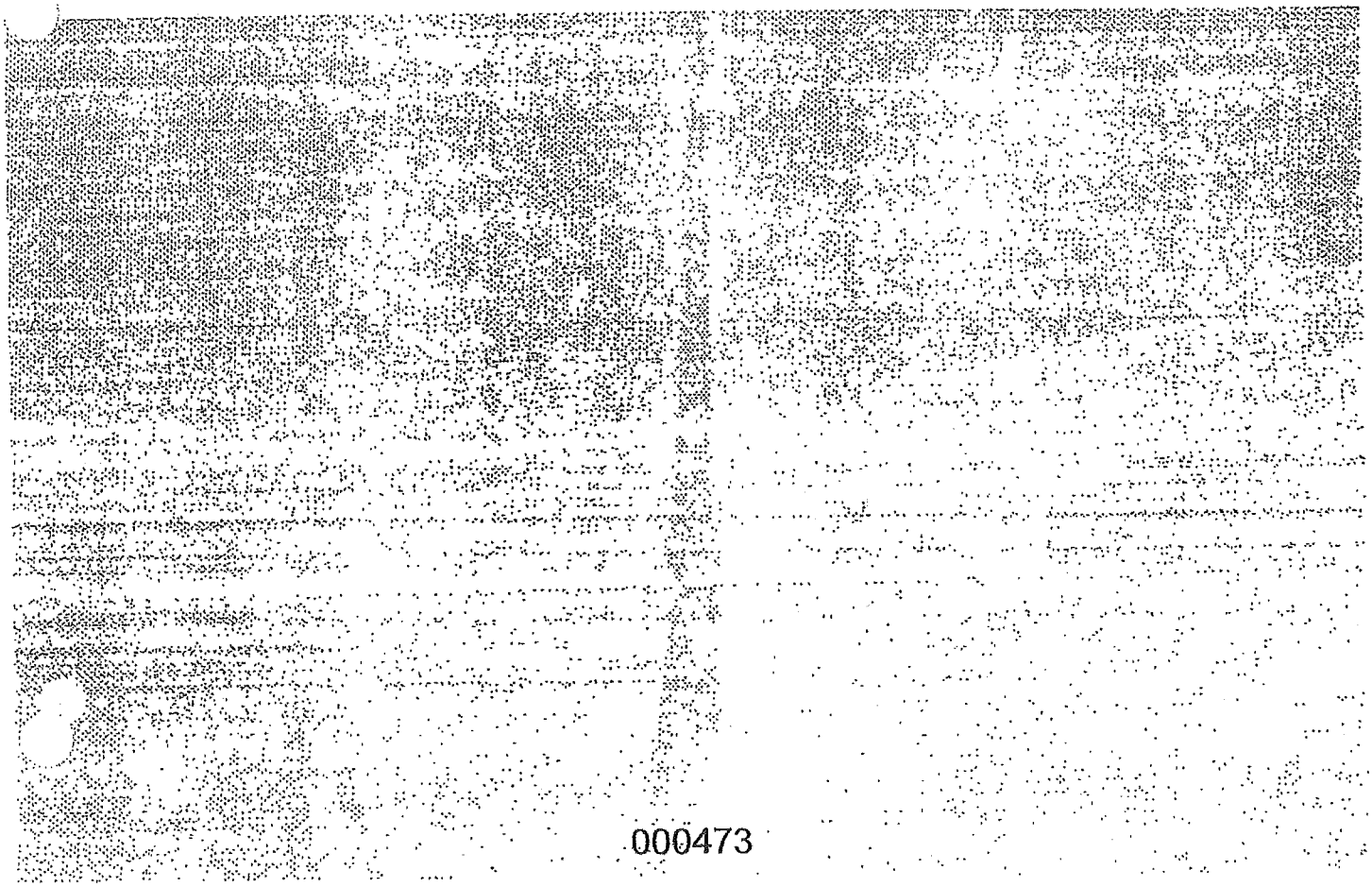
Received by the
CON Section

02 MAY 2011 9 : 50

Dear Ms. Miles,

I am writing to oppose the CON requested by Mission Hospital in Asheville regarding moving a G.I. Room. There is no need for this. There are already other providers serving this area. GI work volumes are declining. This is an unnecessary duplication of services that will have a negative impact on competition and hurt the other 3 serving entities.

Sincerely,
Donna McGee, MD
Family Physician
Hendersonville, NC



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,

RJohnson

Renae Johnson R.N.

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 against Mission Hospital's request to move one of their GI Procedure Rooms to the county line project.

Best regards,

Colleen C. Ramsey

Colleen C. Ramsey
44 Fox Trot Path
Fletcher, NC 28732

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 against Mission Hospital's request to move one of their GI Procedure Rooms to the county line project.

Sincerely,

Craig Lindsey

R. Craig Lindsey

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

Ronald Neimkin, MD

4/28/2011

To Whom it may Concern:

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 move in to destroy other health care facilities in WNC. As a Native of WNC I have watched Mission grow until it appears noone can say NO to the giant!

They serve a wonderful purpose where they are and taking care of Buncombe County - Please let them leave a few jobs for the rest of the Health Care field.

Sincerely,

Deborah Gentry

John Gentry

Gebrette Miles, Project Analyst

Certificate of Need Section

Division of Health Service Regulation

2704 Mail Service Center

Raleigh, North Carolina 27699-2704

Re: Project I.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 entities referenced above.

Thank you.

Sincerely,

Diane Sedgwick, RN

Diane Sedgwick, RN

102 Tartana Circle

Hendersonville, NC 28791

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 CON 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

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

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.

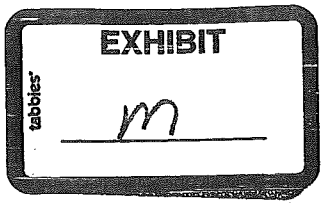
So, in summary, there is plenty of existing capacity in the service area. Also, there are already three different entities providing these services. Finally, we see this as a predatory advance into Henderson County. In fact, a recent 2011 report by Dr. Gregory Vistnes, commissioned by the State, has raised concern about Mission Health System's antitrust issues surrounding its Certificate of Public Advantage (COPA).

Sincerely,

Jeffrey Coston, DO

Dr. Jeffrey Coston
President

Dr. Stephen Bonney
Anesthesiology Department Section Chief



STATE OF NORTH CAROLINA

COUNTY OF BUNCOMBE

IN THE OFFICE OF ADMINISTRATIVE HEARINGS
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,

Respondent.

AFFIDAVIT OF JIMM BUNCH

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.[1] 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.

[REMAINDER OF PAGE LEFT INTENTIONALLY BLANK]

Jimm Bunch

JIMM BUNCH

STATE OF NORTH CAROLINA)
)
COUNTY OF HENDERSON)

Signed and sworn to before me this day by Jimm Bunch.

Date: December 15, 2011

Colleen C. Ramsey

Notary's Signature

Notary's Seal:

Colleen C. Ramsey

Notary's Name
(Printed or Typed)

My commission expires: October 16, 2015

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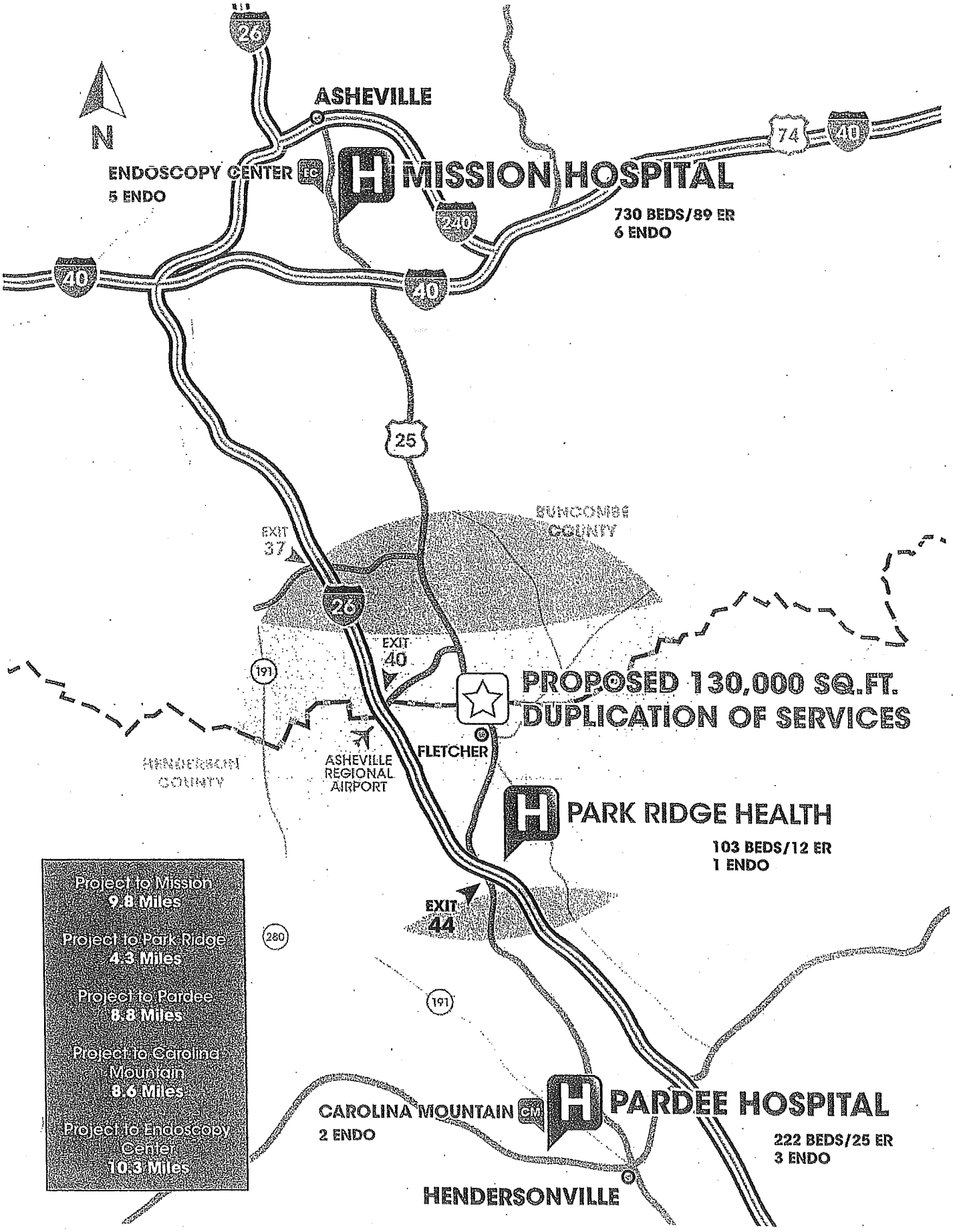
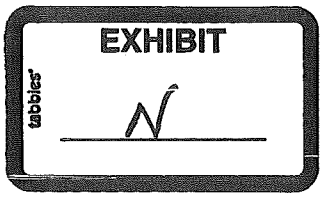

N
ASHEVILLE
ENDOSCOPY CENTER
5 ENDO
MISSION HOSPITAL
730 BEDS/89 ER
6 ENDO
26
40
74
240
25
BUNCOMBE COUNTY
EXIT 37
EXIT 40
191
PROPOSED 130,000 SQ.FT.
DUPLICATION OF SERVICES
FLETCHER
ASHEVILLE REGIONAL AIRPORT
HENDERSON COUNTY
PARK RIDGE HEALTH
103 BEDS/12 ER
1 ENDO
EXIT 44
280
CAROLINA MOUNTAIN
2 ENDO
PARDEE HOSPITAL
222 BEDS/25 ER
3 ENDO
HENDERSONVILLE
Project to Mission
9.8 Miles
Project to Park Ridge
4.3 Miles
Project to Pardee
8.8 Miles
Project to Carolina Mountain
8.6 Miles
Project to Endoscopy Center
10.3 Miles

Data supplied on hospital license renewal applications

[illegible]	[illegible]	[illegible]	[illegible]
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	2009	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

IN THE OFFICE OF
ADMINISTRATIVE HEARINGS
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,

Respondent.

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.[1] 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.

8. 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.

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[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.

11. This is not just ordinary competition. Rather, it is unfair competition. 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 endoscopy rooms. We cannot raise prices to our government payors to offset the revenue lost due to a decline in patient volumes, and managed care payors are also highly resistant to price increases. The population is not growing enough that it would be reasonable to expect an influx of new patients. The simple truth is that there are not enough patients to support 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.

14. While Carolina Mountain strongly supports the CON Section's decision to deny 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.

[REMAINDER OF PAGE LEFT INTENTIONALLY BLANK]

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.D.

Date:

Dawn Waters
Notary's Signature

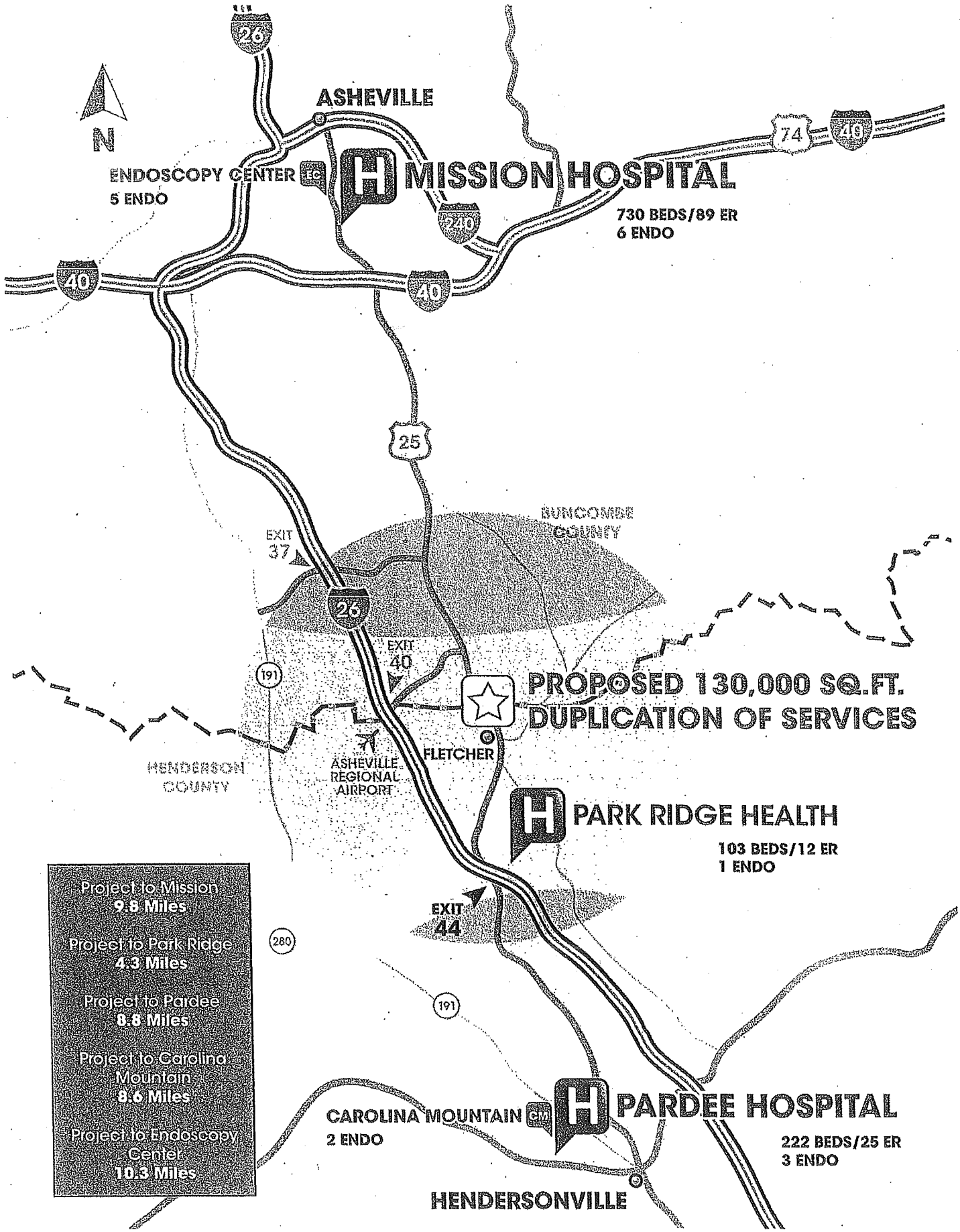
Dawn Waters
Notary's Name
(Printed or Typed)

Notary's Seal

DAWN WATERS
NOTARY
PUBLIC
HENDERSON COUNTY, NC

My commission expires: 07/05/15

~#4824-9611-1118 v.1 - 37136/01501~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8.6 Miles
Project to Endoscopy Center
10.3 Miles
CAROLINA MOUNTAIN
2 ENDO
PARDEE HOSPITAL
222 BEDS/25 ER
3 ENDO
HENDERSONVILLE

NORTH CAROLINA GENERAL ASSEMBLY

HOUSE SELECT COMMITTEE ON THE CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES

DRAFT

REPORT TO THE
2012 SESSION
of the
2011 GENERAL ASSEMBLY

APRIL 2012

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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. 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

of exceptions granted under policy AC-3 of the State Medical Facilities Plan as implemented by the Department of Health and Human Services.

(3) Issues relating to publicly owned hospitals, including determining the appropriate role of State-owned hospitals and the appropriate manner for public hospital authorities created under G.S. 131E-17 to operate beyond the boundaries of the local government that created the authority.

(4) Whether a hospital operating under a Certificate of Public Advantage should be required to comply with the same rules, policies, and limitations to each county in which it operates.

(5) The extent to which a publicly owned hospital should engage in business with an entity having a Certificate of Public Advantage or operating under an exemption under the CON laws of the State.

(6) Any other matter reasonably related to subdivisions (1) through (4) of this section, in the discretion of the Committee.

Section 4. The Committee shall meet upon the call of its Co-Chairs. A quorum of the Committee shall be a majority of its members.

Section 5. The Committee, while in the discharge of its official duties, may exercise all powers provided for under G.S. 120-19 and Article 5A of Chapter 120 of the General Statutes.

Section 6. Members of the Committee shall receive per diem, subsistence, and travel allowance as provided in G.S. 120-3.1.

Section 7. The expenses of the Committee including per diem, subsistence, travel allowances for Committee members, and contracts for professional or consultant services shall be paid upon the written approval of the Speaker of the House of Representatives pursuant to G.S. 120-32.02(c) and G.S. 120-35 from funds available to the House of Representatives for its operations.

Section 8. The Legislative Services Officer shall assign professional and clerical staff to assist the Committee in its work. The Director of Legislative Assistants of the House of Representatives shall assign clerical support staff to the Committee.

Section 9. The Committee may submit an interim report on the results of the study, including any proposed legislation, on or before May 1, 2012, by filing a copy of the report with the Office of the Speaker of the House of Representatives, the House Principal Clerk, and the Legislative Library. The Committee shall submit a final report on the results of its study, including any proposed legislation, to the members of the House of Representatives prior to the convening of the 2013 General Assembly by filing the final report with the Office of the Speaker of the House of Representatives, the House Principal Clerk, and the Legislative Library. The Committee terminates upon the convening of the 2013 General Assembly or upon the filing of its final report, whichever occurs first.

Effective this the 24th day of August, 2011

Thom Tillis
Speaker

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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.[1] 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.

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[1] G.S. 131E-177
[2] Article 9, Chapter 131E of the General Statutes
[3] 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 work can be found in 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 Noah Huffstetler III, Attorney and Partner at the firm Nelson Mullins. Mr. Huffstetler 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 WNC Agricultural Center in Fletcher, North Carolina, at 6:00 pm. Shawn Parker, Committee Counsel, gave a brief overview of the Committee's charge. The Committee heard two presentations regarding Certificate of Public 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 Goodman LLP. This presentation entailed a description of Mission's experience with its Certificate 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 future.

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 Coalition Member, Western North Carolina Community Heathcare Initiative. This presentation detailed areas in which the individuals felt the Certificate of Public Advantage would benefit from changes and requested further oversight of the Certificate of Public Advantage program. 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.

November 1, 2011

The House Select Committee on the Certificate of Need Process and Related Hospital Issues met Thursday, November 1, 2011, in the Council Chamber of the Citizens Center in Mount Holly, North Carolina 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. Carol Lovin, President, Management Company, Carolina HealthCare System, then addressed the Committee. Ms. Lovin explained why the Certificate of Need process is beneficial 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 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 Ms. Long detailed the positive aspects of the Certificate of Need regulations and discussed areas for improvement within the application and appeals process. 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.

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 Need Law to allow ophthalmic procedure rooms in licensed health services facilities in order to improve patients' access and choice. Next the Committee continued discussions on possible recommendations regarding the Certificate of Need law. After lunch citizens from Harnett County spoke on how the Certificate of Need law impacts health care, the economy, and overall well-being of their county. The speakers present from Harnett County were: Pat Cameron, Good Hope Hospital; Jim Burgin, Harnett County Commissioner; Dr. Linda Robinson, Family Practitioner; and Patsy Carson, Mayor of Erwin. 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.

STATE OF NORTH CAROLINA

COUNTY OF WAKE

IN THE OFFICE OF
ADMINISTRATIVE HEARINGS

HOLLY SPRINGS HOSPITAL II, LLC,

Petitioner,

v.

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.

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.

File No. 11 DHR 12795

WAKEMED,

Petitioner,

v.

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.

File No. 11 DHR 12796

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

> County and surrounding areas to support the reasonableness of its utilization projections for obstetrical services. 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.

23. With respect to each of these properly promulgated rules, the Agency found the 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

28. Novant contends that summary judgment should be entered against WakeMed 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 cost-effective [see Criteria (1), (3), (5) and (12) for additional discussion];
b) 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 cost-effective [see Criteria (1), (3), (5) and (12) for additional discussion];
> b) 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
> c) 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

Facility	Licensed Acute Care Beds	2010 Acute Care Days	Projected 2014 Acute Care Days	2014 Average Daily Census	2014 Beds Adjusted for Target Occupancy	Projected 2014 Deficit (Surplus)
Rex Hospital	439	103,206	110,509	303	403	(36)
WakeMed Cary	156	44,647	47,806	131	183	27
WakeMed Raleigh	628	167,712	179,579	492	630	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 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.

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 cost-effective [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 12 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 12th day of April, 2012.

Anne Hollowell

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APR 13 2012


EXHIBIT
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COPA
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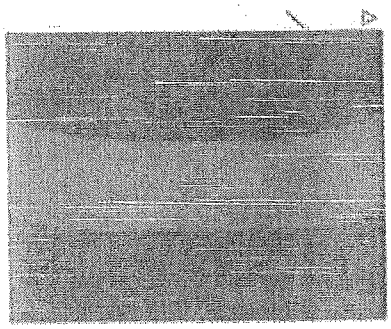
House Committee hears heated discussions on Mission's COPA agreement



By Mark Schulman
Times-News Staff Writer
Published Thursday, October 20, 2011 at 11:01 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 the crowd.

"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," Vinroot 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 eliminated.

"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.

Todd 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.

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.

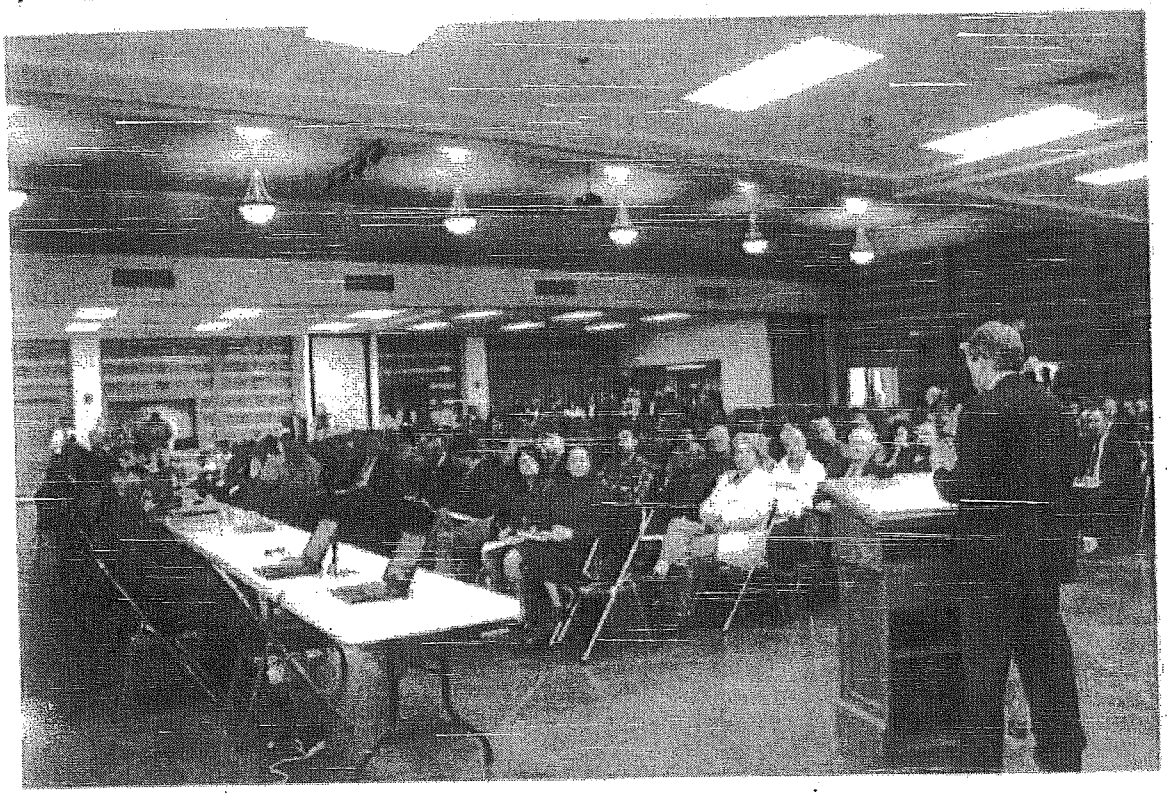
As hundreds of people listened to the sound bite, Janet Moore's voice came across the loud speakers. "There was a lot of talk about the fact that we are a monopoly, and we are," Moore said in the audio. "We're kinda the 500-pound gorilla in Western North Carolina."

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*.

CITIZEN-TIMES.com
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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D-Guilford; Jeff Collins, R-Nash; William Current Sr., R-Gaston, Rick Glazier, D-Cumberland; Mark Hollo, R-Alexander; and Shirley Randleman, R-Wilkes.

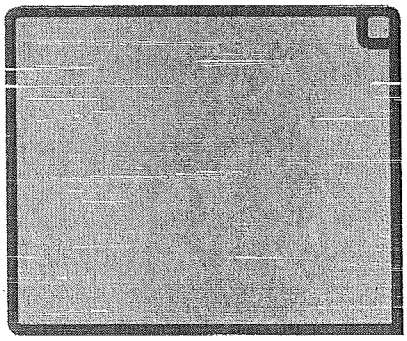
Related Links

Economists, officials duel over Mission in Asheville and 'monopoly' question

A Q&A with Ron Paulus, CEO of Mission Health in Asheville

BlueRidgeNow.com
Times-News Online

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.

EXHIBIT tabbies R

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Mission Health System on Mission and WNC

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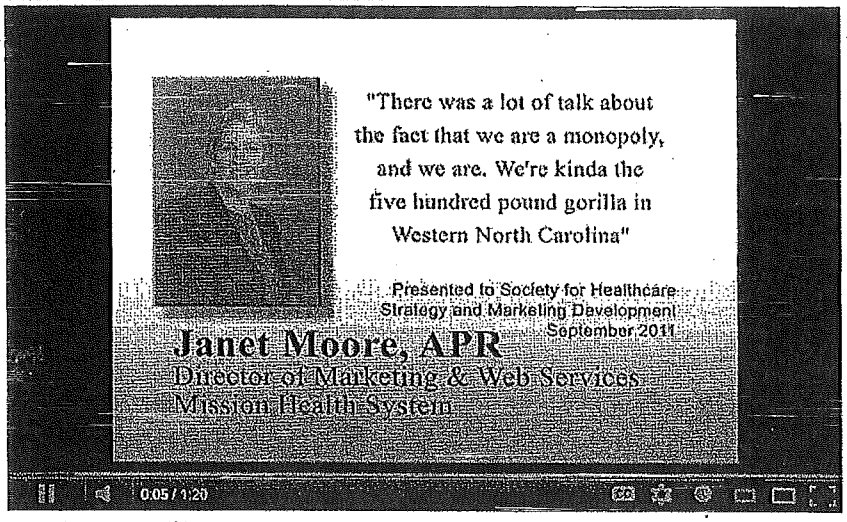

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Uploaded by WNCChoice on Oct 20, 2011

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 Gorilla and later demeaned the people of WNC. Listen for yourselves

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WOW! 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.

MrWncapples 6 months ago

WNCChoice also has posted Ms. Moore's full powerpoint presentation.

wncgrrl 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 youtube, can play such a powerful role in influencing public opinion.

wncgrrl 6 months ago

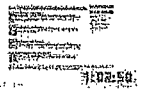
I am very offended by this video. She represents Mission? They must have reached all time low to let her represent their hospital. I have worked at Mission as an RN for years and was raised in Haywood County so am I just a back woods hillbilly?

militsrivermom 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!

Heat Exchanger Service
by frails25
1,895 views

Ad



Mission Marketing Presentation
by WNCChoice
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Nathan E. Williams, M.D. of HOPE - A
by WNCChoice
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Painting a Self Portrait by Canadian artist,
by artistjanetmoore
238 views

Ronald A Paulus, M D
by WNCChoice
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Portrait of theMPX by Canadian artist, Janet
by artistjanetmoore
277 views

Jason Wells of Park Ridge Health Shares
by WNCChoice
125 views

L2 hospital fire call
by mfd78
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Jimm Bunch, Pres. & CEO Park Ridge Health
by WNCChoice
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Funny Cats And Dogs :)
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Meet the New CEO & President for Mission
by MissionHealthSystem
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Hospital Fire With LAFD Water Drops
by RealManOfGenius
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by pmharrison2008
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by ywcaofasheville
80 views

carolinakaya55 6 months ago

1:54

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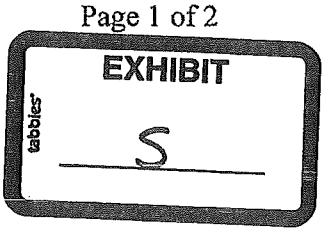


Sen. Apodaca expecting no change to county-line project

By Mark Schulman
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.

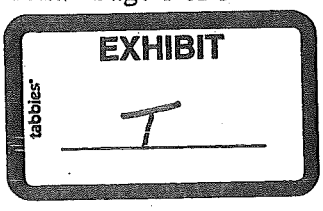
In addition, Park Ridge officials are requesting an audit of the COPA over the past 17 years and that the COPA be revised by expanding its anti-competitive laws throughout Western North Carolina.

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."

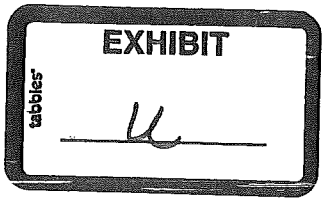
Reach Schulman at 828-694-7890 or mark.schulman@blueridgenow.com.



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 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.
- **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 GI South
Endoscopy Suite Lease Term Sheet
March 1, 2011

1.	**Landlord:**	Real Estate LLC – specific entity to be named at a later date
2.	**Tenant:**	Mission Hospital, Inc
3.	**Premises:**	Portion of medical office building to be constructed on 2651 Hendersonville Road, Buncombe County, NC
4.	**Use:**	Medical services and associated office operations
5.	**Term:**	10 years
6.	**Renewal Options:**	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.

EXHIBIT

tabbies

V

Market Share					
County/Detail	2007	2008	2009	2010	2011
PSA					
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%