December 1, 2021

COMMENTS IN OPPOSITION FROM NOVANT HEALTH INC.

Regarding Atrium Health Applications for Acute Care Beds in Mecklenburg County

Filed October 15, 2021

Atrium Health Carolinas Medical Center Project I.D. #F-**012149-21:** Add 75 acute care beds at Carolinas Medical Center (CMC) pursuant to the need determination in the 2021 State Medical Facilities Plan.

Atrium Health Pineville Medical Center Project I.D. #F-**012147-21:** Add 36 acute care beds at AH Pineville pursuant to the need determination in the 2021 State Medical Facilities Plan.

Atrium Health University City Project I.D. #F-**012146-21:** Add 12 acute care beds at AH University City pursuant to the need determination in the 2021 State Medical Facilities Plan.

Executive Summary

The 2021 SMFP contains a need for 123 acute care beds in Mecklenburg County. As shown above, Atrium Health (AH) applied for all 123 acute care beds. Novant Health (NH) applied for 22 additional acute care beds at NH Presbyterian Medical Center (NH Presbyterian) in Project I.D. #F-012144-21.

For each AH application these comments include "discussion and argument regarding whether, in light of the material contained in the application and other relevant factual material, the application complies with the relevant review criteria, plans and standards."[1] Due to the significant overlap in the AH applications, appearing as largely duplicative sections in all three applications, these comments are organized by comments applicable to all AH applications and then comments applicable to specific AH applications. These comments show:

- AH's version of the "History" of Acute Care Bed Need in Mecklenburg County is incomplete, draws inaccurate conclusions, and is irrelevant in analyzing the need for each specific AH application with respect to Criterion (3).

- AH's past occupancy rates on licensed beds, and any concerns related to capacity, are irrelevant to analyzing future need at the specific AH Mecklenburg facilities requesting beds. The past occupancy rates do not account for volume AH has acknowledged will shift to other hospitals, nor do they account for recent AH acute care bed approvals that will increase capacity as they become operational. AH has not demonstrated in the applications as filed that the current or past perceived capacity issues raised in its applications will exist in the future.

[1] See N.C. GEN. STAT. § 131E-185(a1)(1)(c).

- In addition to having the same irrelevance as past occupancy rates, AH's current (2021) occupancy rates are only based on a partial year impacted by COVID-19. Further, AH does not demonstrate why an unadjusted seven months of CY 2021, annualized, is reasonable to use as the base year to project future acute care days of care, particularly in light of the discussion in the application regarding the impact of COVID-19 and the publicly available information on the impact of COVID-19, which is ongoing.

- For all three AH applications, projected utilization and occupancy rates for acute care beds are not reasonable and not adequately supported. These comments show publicly available data calls the projected growth rates chosen by the applicant into question because AH's growth rates are based solely on past acute care day growth. For each hospital, AH assumed acute care discharges would growth at the same rate as acute care days, which is not supported by past growth trends in acute care discharges. Further, the applicant's own statements regarding capacity limitations do not support a projected annual increase in utilization at CMC.

- The CMC application is non-conforming with CON Review Criteria (1), (3), (5), (6), and (18a), and the performance standards for acute care beds.

- The AH Pineville application is non-conforming with CON Review Criteria (1), (3), (4), (5), (6), (12), and (18a), and the performance standards for acute care beds.

- The AH University application is non-conforming with CON Review Criteria (1), (3), (5), (6), and (18a), and the performance standards for acute care beds.

The Agency cannot approve a non-conforming application. Based on these comments, NH respectfully urges the Agency to deny the CMC, AH Pineville and AH University City applications as non-conforming with CON Review Criteria. These comments also compare the NH Presbyterian acute care bed application to the three AH applications and show it is more effective than the AH Pineville and AH University City applications. If the Agency finds the AH applications conforming with all CON criteria and performance standards, the AH Pineville and AH University applications are less effective proposals than the NH Presbyterian application and should be denied or partially approved on that basis.

Atrium Health's History of Acute Care Bed Need in Mecklenburg County

The three AH applications have a nearly identical 11-page narrative in Section C called, "History of Acute Care Bed Need in Mecklenburg County."

Page References for Sections Titled, "History of Acute Care Bed Need in Mecklenburg County"

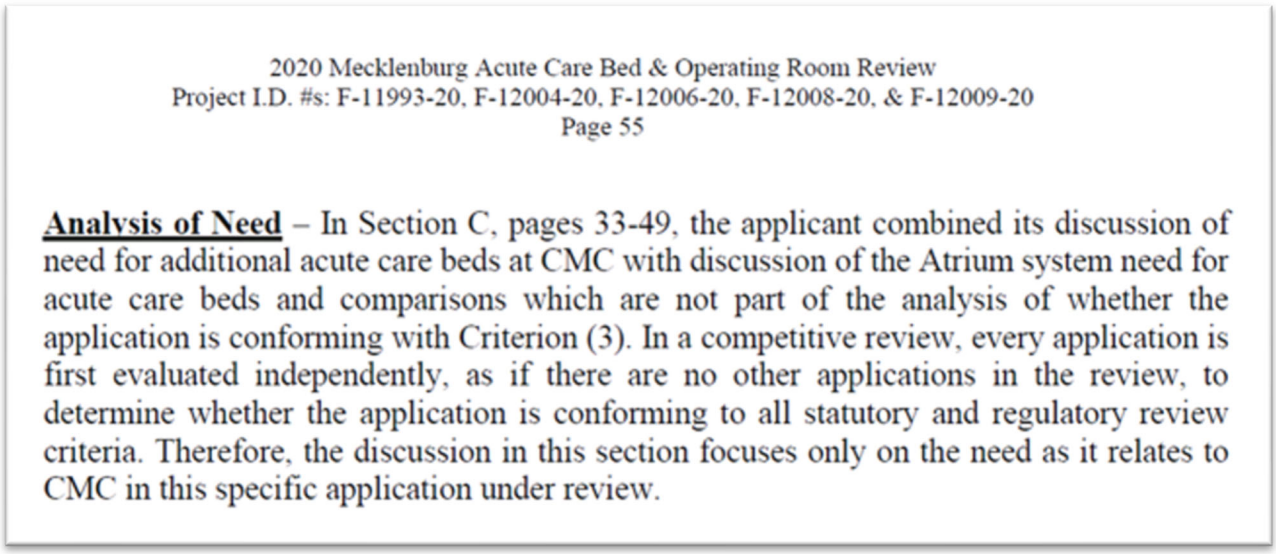
Applicant Hospital	Project I.D.	Introductory Paragraph	Entire Section
CMC	#F-012149-21	Page 43	Pages 44-54
AH Pineville	#F-012147-21	Page 42	Pages 42-52
AH University	#F-012146-21	Page 40	Pages 41-51

Relevance to Conformity with Criterion (3)

Each statutory review criterion is addressed in a separate section of the application form and the language of the statutory review criterion is provided at the beginning of the section. AH's history lesson appears in Section C – Criterion (3) of all three applications. AH admits in the introductory paragraphs these sections describe market demand "[P]rior to demonstrating the need patients have for the proposed project…" While these 11-page sections give AH's version of SMFP history, AH perceived system need, and comparisons to other North Carolina health systems, they do not inform the Agency why the specific projects in the applications conform to Criterion (3). These self-serving narratives are irrelevant to the statutory criteria and should be given no weight in determining whether the applications are conforming to Criterion (3).

AH also says the narratives "provide a brief overview of the negative impacts that result from an inadequate supply of acute care beds at Atrium Health hospitals…" AH alleges negative impacts to the AH system but not to the specific hospitals where the projects are proposed. The impacts address: AH hospitals (collectively) in Mecklenburg County; AH EDs and FSEDs (collectively) in Mecklenburg County, AH PACUs (collectively) in Mecklenburg County, and the Carolinas Hospitalist Group which practices at all AH hospitals. None of these system-wide issues demonstrate conformity with Criterion (3) for the specific applications under review.

Most of AH's version of history appeared in past AH acute care bed applications. As shown in the excerpt below from the 2020 Mecklenburg Acute Care Bed Review, system need and system comparisons *are not* part of the Agency's analysis of whether a specific application is conforming with Criterion (3).



2020 Mecklenburg Acute Care Bed & Operating Room Review
Project I.D. #s: F-11993-20, F-12004-20, F-12006-20, F-12008-20, & F-12009-20
Page 55

Analysis of Need – In Section C, pages 33-49, the applicant combined its discussion of need for additional acute care beds at CMC with discussion of the Atrium system need for acute care beds and comparisons which are not part of the analysis of whether the application is conforming with Criterion (3). In a competitive review, every application is first evaluated independently, as if there are no other applications in the review, to determine whether the application is conforming to all statutory and regulatory review criteria. Therefore, the discussion in this section focuses only on the need as it relates to CMC in this specific application under review.

The Agency has not found AH's "history lesson" persuasive before, and it should not find it persuasive now. However, because Atrium has used this section to exaggerate its own historical bed need in Mecklenburg County, NH provides other relevant factual material below to set the record straight.

AH is not Entitled to Any Beds

In these sections AH admits "…a provider that generates the need for additional capacity is not entitled to that need." In the 2019 and 2020 Mecklenburg Acute Care Bed and OR Reviews, the Agency agreed and clearly stated[2,3] an applicant must justify each project, based on the information in the application and Agency file, and show it satisfies the CON review criteria and performance standards.

However, despite the admission, AH devotes several pages to discussing which Mecklenburg provider generated the SMFP acute care bed need as far back as 2009 and which provider was awarded beds. All three applications state:

- "Atrium Health has been chronically under-bedded **as a result** of not being awarded additional acute care beds for which it generated the need." (*emphasis added)*

- "CMHA continues to be seriously constrained in its ability to meet patient demand **as a result** of not being awarded a sufficient number of beds to dramatically reduce its bed deficit." (*emphasis added*)

- Each section concludes with the identical statement, "Patients, physicians, nurses, and operators suffer when acute care beds needed at Atrium Health facilities repeatedly go to other providers in Mecklenburg County."

As NH is the only other acute care provider in Mecklenburg County, "other providers" refers to NH. AH implies that because the Agency approved past NH applications and partially approved or denied past AH applications, the Agency endangered patients and their healthcare providers. This false narrative of entitlement is only possible because AH's history lesson is incomplete and inaccurate. Thus, AH argues that whenever there is a bed need in Mecklenburg County, it should be awarded all the beds, all the time, and that the Agency is wrong to approve anyone other than AH. But AH is not entitled to any beds, and the Agency does not owe AH anything.

AH focuses only on the outcome of each Review Cycle and ignores reasons NH beds were approved and specific AH bed applications were partially approved or denied:

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[2] 2019 Mecklenburg Acute Care Bed and OR Review Findings, p. 38. "Anyone may apply to meet the need, not just Atrium. Atrium has the burden of demonstrating the need for the proposed acute care beds and ORs in its applications as submitted"

[3] 2020 Mecklenburg Acute Care Bed and OR Review Findings, p. 90. "… Atrium states the need for 126 acute care beds in Mecklenburg County was generated entirely by Atrium hospitals. However, anyone may apply to meet the need, not just Atrium. Atrium has the burden of demonstrating the need for the proposed acute care beds in its applications as submitted."

- In the 2018 Mecklenburg Acute Care Bed and OR Review the Agency found the NH Huntersville bed application a more effective alternative than the AH Pineville bed application.

- In the 2019 Mecklenburg Acute Care Bed and OR Review the AH Lake Norman application could not be approved because it was found non-conforming to the CON Criteria.

- In the 2020 Mecklenburg Acute Care Bed and OR Review the Agency found the NH Steele Creek application was a more effective alternative than the CMC application.[4]

AH's allegation that any current occupancy constraints result from past denials is false, because AH assumes that if the beds were awarded to AH, they would be in operation today. In 2017, AH was awarded all the beds it requested and those beds are operational. Since then, the table below shows AH has been denied or partially approved three times. All three projects had first project years *after* 2021. Therefore, even if AH had been awarded all beds it applied for in the last four cycles, its occupancy rates on licensed beds from 2019 – 2021 would be exactly the same.

Facility Name	SMFP	Project I.D.	Beds Requested	Beds Approved	Beds Denied	Project Years 1-3*
CMC	2017	F-11362-17	45	45	0	CY 2019-2021
AH Pineville	2017	F-11361-17	15	15	0	CY 2019-2021
AH Pineville	2018	F-11622-18	50	38	12	CY 2022-2024
CMC	2019	F-11811-19	18	18	0	CY 2022-2024
AH Pineville	2019	F-11813-19	12	12	0	CY 2022-2024
AH University City	2019	F-11812-19	16	16	0	CY 2022-2024
AH Lake Norman	2019	F-11810-19	30	0	30	CY 2023-2025
CMC	2020	F-12006-20	119	87	32	CY 2028-2030
AH Pineville	2020	F-12009-20	7	7	0	CY 2022-2024
Total			312	238	74	

* First full fiscal year of project

The table shows that since 2017, AH has been approved for 76% of the beds available in the SMFP. There is no denying that AH has been extremely successful with its bed applications. Moreover, when AH was not awarded all the beds it requested the Agency awarded AH enough acute care beds the following year to more than offset the previous denials. The excerpt below from its recent 2021 AH Steele Creek application shows AH is well aware of these opportunities in subsequent Review Cycles.[5]

[4] 2020 Mecklenburg Acute Care Bed and OR Findings, p. 191.
[5] AH Steele Creek Medical Center Acute Bed Application, Project I.D. No. F-012084-21, p. 53.

Allowing patients to shift away from the Atrium Health Pineville campus to Atrium Health Steele Creek will be beneficial, as demonstrated previously. Additionally, given the time horizon of the proposed project and need identified in the *2021 SMFP* for additional acute care beds in Mecklenburg County, as well as the historical and projected growth in utilization of CMHA facilities in Mecklenburg County, CMHA reasonably believes that it will have an opportunity to apply for additional capacity in the near-term and future *SMFPs* will identify the need for additional acute care beds in the county. Furthermore, of

The following table summarizes the Agency's approval of acute beds for each system in the past five review cycles:

Mecklenburg County SMFP Acute Care Bed Approval by System, 2017 - 2021

		Atrium Health			Novant Health		
SMFP Year	SMFP Need Determination	Beds Requested	Beds Awarded	AH% of Awarded	Beds Requested	Beds Awarded	NH% of Awarded
2017	60	60	60	100%	18	0	0%
2018	50	50	38	76%	12	12	24%
2019*	76	76	46	70%	20	20	30%
2020	126	126	94	75%	32	32	25%
2021	123	123	*(TBD)*	*(TBD)*	22	*(TBD)*	*(TBD)*
2022	65						

** NOTE: The Agency awarded 66 of the maximum 76 beds in the 2019 review cycle.*

The Agency's annual awards of new acute care beds to AH contradict AH's allegation it cannot "dramatically decrease its bed deficit." The Agency awarded AH the vast majority (76 percent) of the beds it requested in the 2017-2020 review cycles. The previously denied AH beds would not yet be operational in 2021. If there is a perceived capacity problem at AH hospitals now, it is not because the Agency did not award AH enough beds in years past. As discussed in these comments, AH has tools at its disposal to manage capacity constraints, and AH has definitely used those tools.

Atrium Health's False Portrayal of Bed Need and Bed Deficits

All three applications present two graphs falsely titled "Atrium Health and Novant Health Acute Care Bed Need."[6] The graphs actually show the results of Step 8 of the SMFP Acute Care Bed Need Methodology. This step is intended to project **future** hospital and system acute care bed surpluses and deficits in a service area **before adjusting the service area by subtracting from that number any beds for prior year need determinations for which a CON has not yet been issued** in Step 9 of the SMFP Acute Care Bed

[6] CMC Acute Bed Application, Project I.D. No. F-012149-21, pp. 44 and 47; AH Pineville Acute Bed Application, Project I.D. No. F-012147-21, pp. 43 and 45; AH University Acute Bed Application, Project I.D. No. F-012146-21, pp. 41 and 44.

Need Methodology. The role of the SMFP in the CON process is to set the upper limit on the new assets the Agency may approve in a review. It does not prove "need" for an application by any provider or health system.

AH's graphic portrayal of bed need based on past SMFP deficits is grossly exaggerated because it makes no adjustments for prior year need determinations in which it was awarded acute care beds. Months before AH filed its applications, acute care bed CON approvals were final in all past Mecklenburg Review Cycles, yet AH continues to depict the SMFP published bed deficit in these charts, unadjusted for final CON approvals, as its own "need".

Atrium Health's Unlicensed Acute Care Capacity[7]

The only mention of occupancy at specific hospitals appears in the bulleted sections on pages 53, 51, and 50 of the CMC, AH Pineville, and AH University applications, respectively. While **historically** accurate, none of these occupancy rates establishes **future** bed need at any of the hospitals. The entire paragraph is misleading with regard to establishing need for the projects as proposed because (1) the occupancy rates are based on 2019 patient days and 2019 licensed beds; (2) AH fails to mention the CON approvals for an additional 136 acute care beds at its Mecklenburg hospitals; and (3) AH does not show that those beds when implemented will not reduce occupancy levels. Further, AH fails to consider the observation beds and temporary beds that were in place in 2019, which increased operational capacity and lowered operational occupancy.[8]

- Not only do Atrium Health facilities have the highest occupancy rates in Mecklenburg County, but Atrium Health Pineville also had the highest occupancy rate (89.2 percent) of any hospital in the entire state in FFY 2019 according to the *2021 SMFP* and all three of Atrium Health's Mecklenburg County facilities had occupancy rates in the top 10 in the state (CMC/Atrium Health Mercy and Atrium Health University City operated at 83.6 and 76.3 percent occupancy, respectively). Notably, none of Novant Health's Mecklenburg County facilities operated in the state's top 10 hospitals with regard to occupancy rate. Moreover, from a system level (defined as hospitals under common ownership in the same county as presented in the *SMFP*), the Atrium Health system in Mecklenburg County had the highest occupancy rate overall of any system in the state (84 percent) while Novant Health's Mecklenburg County system had the second lowest (70.2 percent) followed only by Community Health Systems in Iredell County (25.8 percent). Please see Exhibit C.4-1.

AH claims that AH's Mecklenburg hospital inpatient units have sustained high licensed occupancy rates and can only handle growth in demand if the Agency approves all 123 additional beds it requested. This is false. In failing to mention the 136 acute care bed approvals in determining what licensed occupancy

[7] CMC Application, p. 53; AH Pineville Application, p. 51; AH University Application, p. 50.

[8] Pursuant to Project ID #s F-11622-18, F-11813-19, and F-12009-20, Atrium Health Pineville was approved to develop a total of 57 additional acute care beds. Twelve additional beds were operational as of November 2021. The 45 additional acute care beds approved will be developed in CY 2022. (AH Pineville Application, Form C Assumptions and Methodology, p. 12.)

rates it can sustain, AH failed to consider the full complement and capacity of licensed beds it will have in the future.

AH argues in its applications that the daily census figures at its Mecklenburg hospitals are effectively higher than those reported in the SMFP because of patients being admitted in the morning, before the majority of its daily discharges have occurred.[9] There is a constant "turnover" of patients being admitted and discharged from a hospital during midday. These routine variations in admission volume are the reason hospitals operate a supply of temporary and observation beds. Using observation beds is one method used by hospitals to manage this turnover, including AH hospitals.[10]

There are several ways AH increased its operational capacity above licensed capacity without increasing the number of permanently licensed beds:

- In its 2021 License Renewal Applications, AH's three Mecklenburg hospitals reported 160 observation beds. Observation beds are not limited to use by observation patients only. They are also available to admitted acute care patients, so long as the total number of admitted acute care patients does not exceed licensed capacity, including temporary increases. The Agency has interpreted the CON law to allow a hospital to use all physical beds for inpatients so long as the midnight census does not exceed the number of licensed beds.[11]

- AH continuously uses the provision in North Carolina Administrative Code 10A NCAC 13B.3111 to temporarily increase its licensed bed capacity by up to 10 percent. A temporary increase lasts 60 days but can be renewed indefinitely. A hospital qualifies for a temporary increase if its census is at least 90 percent of its permanent licensed bed capacity. The hospital must also explain what triggered the need for a temporary increase. Justifications may include but are not limited to: natural disaster, catastrophic event, or disease epidemic. AH used this provision routinely to increase bed capacity at CMC and AH Pineville well before the coronavirus pandemic.

- AH Pineville and CMC received approval for 102 "temporary" licensed beds that can accommodate many types of admitted patients. These temporary beds have been renewed for many years. They are not tied to additional beds needed for COVID-19 patients.

    - Since March 2018 AH Pineville has consistently had 20 to 22 additional licensed beds.[12] Letters to the Agency say, "Atrium Health Pineville plans to utilize existing observation

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[10] Licensable bed spaces can be acute care beds or observation beds on any day, so long as the number of beds in use at midnight does not exceed the number of permanent and temporary licensed beds *See*: Payne, Mark. Email Correspondence RE: Declaratory Ruling by the Charlotte-Mecklenburg Hospital Authority FID# 943092, May 18, 2017.

[11] See **Exhibit 7** for a copy of this letter.

[12] AH received seven approvals from the Agency to temporarily operate 20 additional acute care beds from March 2018 to June 2019. Due to an increase in total bed count at AH Pineville, AH received approval for 22 additional acute care beds from June 2019 to April 2020.

beds to achieve this temporary increase."[13] (The cited correspondence is included in **Exhibit 1** that accompanies these comments.) This statement proves AH has enough unlicensed beds to handle the overflow. The Division of Health Service Regulation approved 20 temporary beds at AH Pineville on March 20, 2018. This increase in beds was extended through bimonthly requests approved through June 15, 2019. In April 2019, AH Pineville applied for and was approved to operate 22 temporary inpatient beds. These temporary beds received extensions through April 2020.

- CMC used this same process to increase its licensed bed capacity. Beginning on January 13, 2015, CMC was approved for an additional 80 temporary beds by the Department of Health Service Regulation. This expanded capacity was extended through bimonthly requests to DHSR that were approved through April 2020.[14]
- Both of these bed sources provide additional capacity that lowered the effective inpatient occupancy rate at AH hospitals.

- Beds at CMC and AH Pineville that are delicensed when beds are transferred to a new hospital like AH Lake Norman or AH Steele Creek still physically exist and can be used to manage the inpatient census. Beds at these hospitals that are delicensed when beds are relocated to a new bed tower may also still physically exist.

AH cites high occupancy challenges at its Mecklenburg hospitals as a trigger for reaching critical capacity activation status on multiple occasions in 2020.[15] AH asserts that during these events normal operational processes related to patient care are disrupted, e.g., the need for ambulance diversions and delaying or canceling surgeries. Such instances were not unique to AH hospitals in 2020 due to the unanticipated strain on hospital resources during the COVID-19 pandemic. AH does not specify the volume of COVID-19 patients during these surges, but it seems likely that patients infected with COVID-19 and requiring hospitalization contributed to the high occupancy levels at AH's hospitals.

DHSR also offered North Carolina hospitals an option for adding temporary beds during the pandemic. This emergency waiver suspended the usual qualification criteria in 10A-NCAC-13B.3111.[16] (See **Exhibit 2** for the DHSR memorandum dated March 20, 2020). AH applied for and was approved for 173 COVID-19 expansion beds at AH Pineville and 379 beds at CMC, although according to Atrium none of these beds

[13] Christopher Hummer, correspondence with Azzie Conley, RE: Request for Temporary Operation Above Licensed Bed Capacity, March 20, 2018.
[14] CMC received 31 approvals from the Agency to temporarily operate 80 additional acute care beds from January 2015 to April 2020.
[15] AH Pineville Application, pp. 71-72; AH University City Application, p. 71.
[16] Mark Payne, North Carolina Department of Health and Human Services Memorandum to North Carolina Hospital CEOs RE: Request for Temporary Waiver of 10A NCAC 13B.3111 to Provide Services to Patients That May Be Stricken by COVID-19, March 12, 2020.

were in use at the time of the 2021 LRA submission.[17] These beds were available in the first half of 2021 to manage the patient census AH cites in its applications and would have mitigated many of these operational difficulties without requiring a CON approval. AH did not implement these beds as of September 30, 2020,[18] presumably because it did not need them.

All three AH applications limit all occupancy rates to licensed beds. AH did not quantify the actual number of physical bed spaces it had available to manage its inpatient census in recent years, but the following table shows the reported inventory of licensed, unlicensed, and approved beds at AH's Mecklenburg hospitals.

2021 Atrium Health Mecklenburg Reported Acute Care Bed Inventory

Hospital	Licensed Beds	Observation Beds	Temporary Beds*	Temporary COVID-19 Beds	CON Approved Beds
CMC/Mercy	1,055	110	80	379	87
AH Pineville	233	31	22	173	45
AH University City	100	19	0	N/A	4
Total	1,388	160	102	552	136

*Approved temporary beds as of April 15, 2020. Beginning in 2020, additional COVID-19 temporary beds were approved but not in use at the time of AH's 2021 HLRA submissions.

AH's unlicensed and temporarily licensed beds increased the inpatient capacity of its Mecklenburg hospitals by 19 percent in 2021. AH does not count the observation beds or temporarily licensed beds in its occupancy calculations, and thus understates its physical capacity to manage its inpatient census. It also exaggerates its physical occupancy rate. Beyond limited reference to the total not being enough, AH also does not address why the recent CON bed approvals which are not yet operational, will not address any current occupancy constraints.

There is no urgency for the beds AH requests. AH will continue constructing the Pineville bed tower whether or not any beds are awarded in this cycle. It can, and most likely will, build out floors with unlicensed observation beds that do not require CON approval. AH does not need all 123 beds requested.

Atrium Health's False Assertions about NH's Increased Market Share[19]

AH falsely claims NH's patient days and market share grew in recent years because AH was turning away patients due to lack of licensed beds. The truth is NH's inpatient acute care discharges, patient days, and market share in Mecklenburg County grew because of the growth and expansion of NH's medical group, its investment in service line development and its ability to attract independent physicians. In other words,

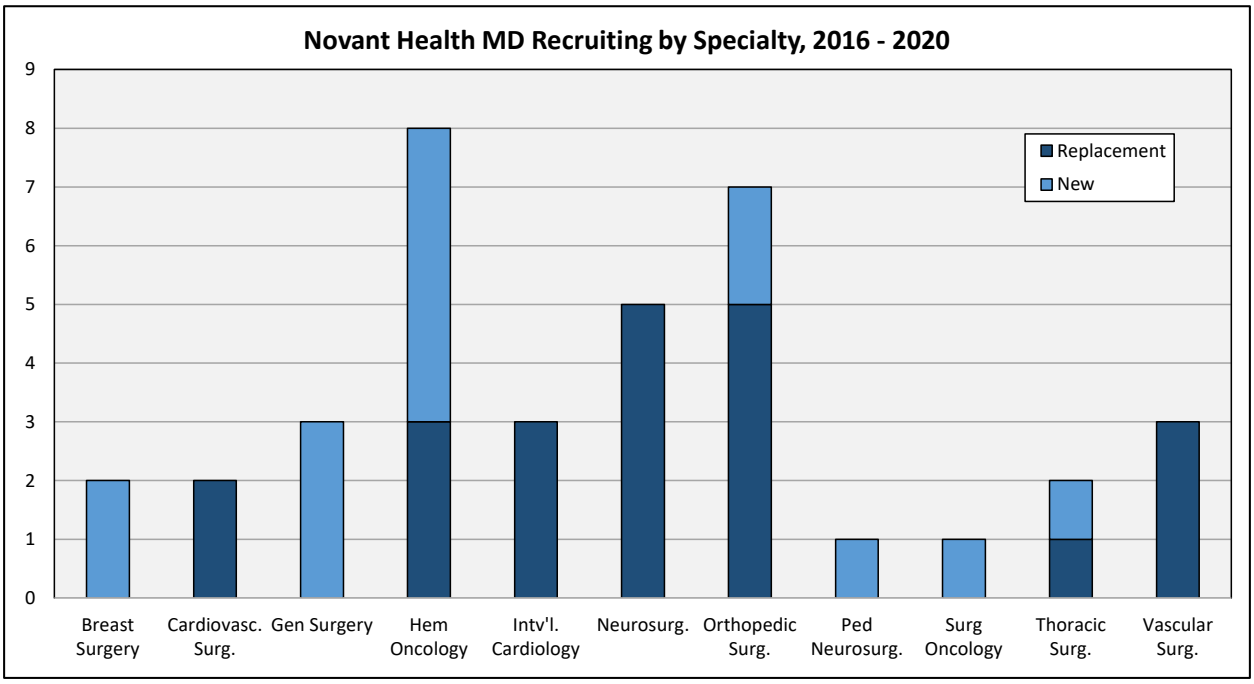
[17] 2021 CMC and AH Pineville Hospital License Renewal Applications, COVID-19 Addendum. Atrium had not implemented any of the approved beds under the waiver for the service dates from October 1, 2020 through September 30, 2021 at the time of submission.
[18] Ibid.
[19] CMC Application, p. 57; AH Pineville Application, p. 55; AH University Application, p. 54.

NH competed for the privilege to serve patients and patients increasingly *chose* NH physicians and facilities. They were not driven from AH due to a so-called lack of licensed beds at AH. NH predicted this decrease in AH market share and increase in NH market share in its Response to Comments in the 2018 Mecklenburg County Acute Care Bed Review. (See **Exhibit 4**.)

AH was the first Mecklenburg County health system to increase its employed physician roster. AH began a massive acquisition of physician practices about ten years ago. Over the last decade, AH has added locations and medical providers to expand specialty care programs such as the Sanger Heart and Vascular Institute. NH did not respond immediately with equivalent acquisitions of physician practices, and the result was a dramatic shift in patient volumes from NH to AH, as reflected in the SMFP.

Since 2016, NH has successfully acquired practices and recruited new physicians to its Mecklenburg medical group. NH has developed service line institute models for specialties that include Heart and Vascular, Cancer, Neurosciences, and Orthopedics & Sports Medicine. In 2020, the Novant Health Medical Group employed over 5,000 team members, including nearly 1,400 physicians and extenders, in the Greater Charlotte market.[20]

Expanding the NH Medical Group increased the number of medical and surgical specialists that admit patients to NH's Mecklenburg hospitals. NH added over 37 new specialists to the Greater Charlotte market between 2016 and 2020, with significant additions in Oncology, Orthopedics, Neurosciences and Thoracic/Cardiovascular Surgery.

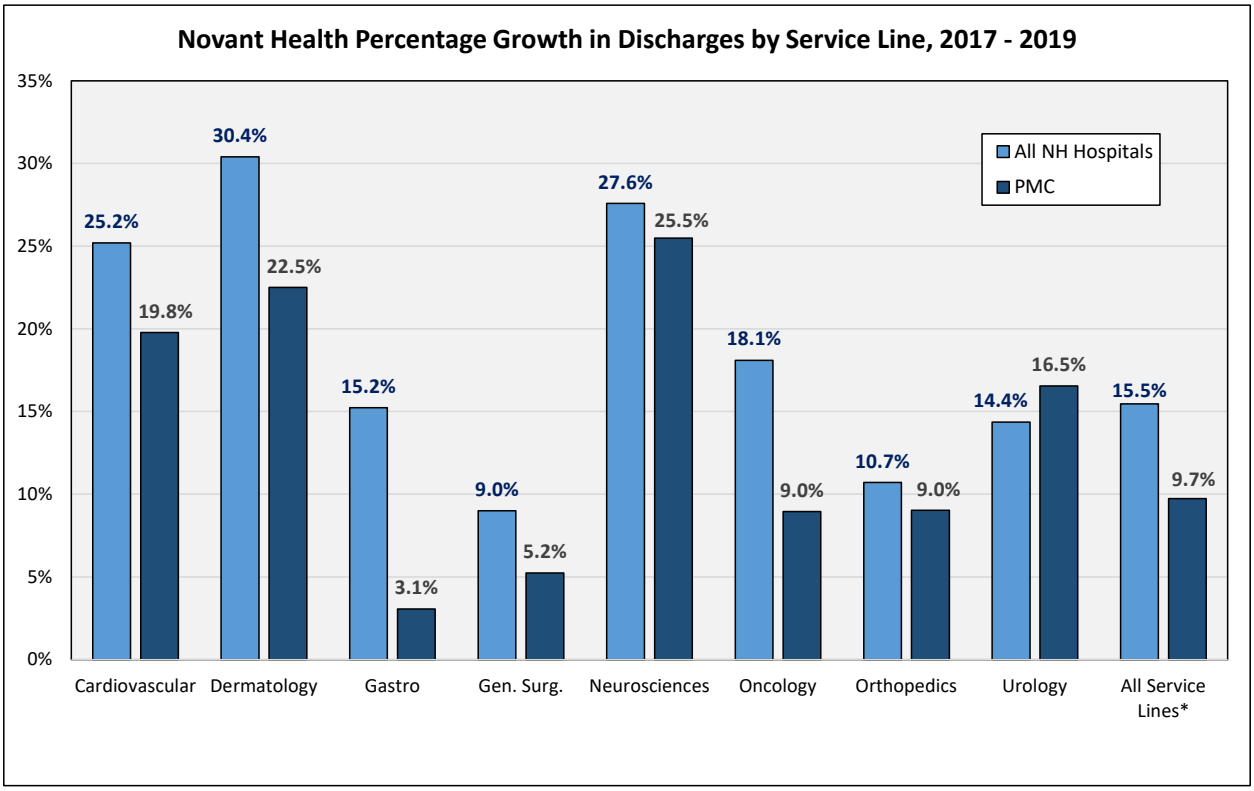


Source: NH internal data.

[20] Novant Health Medical Group 2020 Annual Report, p. 3.

This response to AH's strategy has reversed NH's previous losses in market share. NH experienced significant growth in inpatient discharges for these targeted specialties from 2017 to 2019 before COVID-19. The chart below shows conspicuous gains in the service lines NH identified as recruiting priorities. Orthopedics discharges grew 10.7%, Oncology increased 18.1%, Cardiovascular grew 25.2% and Neurosciences increased 27.6%. This growth over just two years is far more than one would expect from patients being diverted from AH hospitals operating at capacity. Rather, the growth is attributable to hard work, remarkable patient care, and investing in the communities NH serves.

Growth in NH's inpatient volume and market share will likely continue to increase as these employed specialists continue building their practices and become better known in Mecklenburg County and the surrounding communities. It is reasonable to assume that patients will follow NH specialists to the hospitals where they admit patients. This includes growth projected for new NH hospitals in Mint Hill, Ballantyne and Steele Creek. The volume projections for these NH hospitals accepted in the Agency's reviews include market share growth resulting from the capture of additional patients in these markets.



Source: NH internal data.

AH's need analysis and utilization projections fail to account for volume and market share shifts to recently approved NH hospitals in Mecklenburg County. The Agency approved NH's application for a 36-bed acute care hospital in Ballantyne (Project I.D. # F-011625-18) that is scheduled to open in 2022, and approved the application for a 32-bed hospital in Steele Creek (Project I.D. # F-11193-20) that will begin operations in 2025. Both of these facilities will draw patients from existing acute care providers in Mecklenburg County, including AH Pineville.

NH Ballantyne will have over 1,600 acute discharges in CY 2023, the first full year of operation. This figure will grow by 800 discharges by 2025. In NH Steele Creek's first full operating year (CY 2026), NH projected nearly 1,400 discharges of patients from Mecklenburg County zip codes. This will increase to over 2,100 discharges by CY 2028. For both projects, the Agency determined that "the projected utilization is reasonable and adequately supported."[21,22]

NH's program development and investment in service lines and provider resources is also reflected in its growth in acute patient days of care. NH increased its share of patient days of care relative to AH from 2017 to 2021, despite AH receiving the majority of available acute care beds in the Agency's decisions during this period. In the 2022 SMFP, NH hospitals have a COVID-19-adjusted total of 225,109 patient days of care, representing 34.6% of patient days for Mecklenburg County hospitals. This is an increase of 1.6 percent compared to 2017, despite NH having a smaller share of licensed and approved beds.

	% of Licensed + Approved Beds	% of Licensed + Approved Beds	% of Patient Days of Care	% of Patient Days of Care
SMFP Year	AH System	NH System	AH System	NH System
2017	61.2%	38.8%	67.0%	33.0%
2018	61.2%	38.8%	67.7%	32.3%
2019	61.8%	38.2%	68.1%	31.9%
2020	60.8%	39.2%	68.0%	32.0%
2021	61.9%	38.1%	66.0%	34.0%
2022*	62.1%	37.9%	65.4%	34.6%

Source: SMFP.

** NOTE: Bed percentages do not include the Agency's pending 2021 award decision.*

AH's Overview of Unmet Need and 2021 SMFP Acute Care Bed Need Methodology

All three AH applications also contain lengthy, nearly identical sections called, "*Overview of Unmet Need" and "2021 SMFP Acute Care Bed Need Methodology*."

Page References for Sections Titled,
"Overview of Unmet Need" and "2021 SMFP Acute Care Bed Need Methodology"

Applicant Hospital	Project I.D.	Overview of Unmet Need	2021 SMFP Acute Care Bed Need Methodology
CMC	#F-012149-21	Pages 54-55	Pages 56-66
AH Pineville	#F-012147-21	Pages 52-53	Pages 54-65
AH University	#F-012146-21	Pages 51-52	Pages 52-65

[21] 2018 Mecklenburg Acute Care and OR Competitive Review Findings, p. 74.
[22] 2020 Mecklenburg Acute Care and OR Review Findings, p. 28.

For the brief "Overview of Unmet Need" section in each application, AH says two factors support the specific need for the proposed project.

> The overall need for the proposed project is based on the need for additional acute care beds in Mecklenburg County as identified by the *2021 SMFP.* The specific need for the project proposed in this application is comprised of the following factors:
>
> - The need for additional capacity at Atrium Health [Applicant Hospital], and
> - The dynamic population growth in the region served by Mecklenburg County providers, including the growth in the population over age 65.
>
> Each of these factors will be discussed in turn below. A detailed analysis of the quantitative need for the proposed project is discussed in the assumptions and methodology for Form C and is incorporated herein by reference.

Relevance to Conformity with Criterion (3)

AH states these factors will be discussed "in turn below". However, in the next 10-page sections titled, "2021 SMFP Acute Care Bed Need Methodology," AH again discusses the 2021 SMFP, AH System deficits, and the comparison of the AH System to other providers in North Carolina. Repeating the same irrelevant argument is not helpful to AH's cause. The discussion above about the irrelevance of this information to the analysis of the applications with conformity with Criterion (3) is incorporated herein. This section of the application also discusses what AH calls its "Superior Need" which appears to be provided in anticipation of other co-batched applications. The discussion of the AH system need for acute care beds and these comparisons do not show the individual applications are conforming with Criterion (3).

2020 SMFP Mecklenburg County Growth Rate Multiplier

In all three AH applications, AH shows the calculation of the 2020 SMFP Mecklenburg County Growth Rate Multiplier (CGRM) and then admits, "Of note, Novant Health's total days increased at a faster rate from 2015 to 2019 than did Atrium Health's over the same period of time…" The following table breaks down the 2020 CGRM by health system, showing AH's CGRM is lower than NH's CGRM and the service area CGRM.

Mecklenburg County Acute Care Growth Rate Multiplier 2020 SMFP

Mecklenburg Total	FFY 2015	FFY 2016	FFY 2017	FFY 2018	FFY 2019	CGRM*
Acute Care Bed Days	562,638	565,440	581,200	596,723	638,866	1.0325
Difference from Previous Year		2,802	15,760	15,523	42,143	
Percent Change		0.5%	2.8%	2.7%	7.1%	

Novant Health	FFY 2015	FFY 2016	FFY 2017	FFY 2018	FFY 2019	CGRM*
Acute Care Bed Days	185,521	182,594	185,596	190,746	217,163	1.0417
Difference from Previous Year		-2,927	3,002	5,150	26,417	
Percent Change		-1.6%	1.6%	2.8%	13.8%	

Atrium Health	FFY 2015	FFY 2016	FFY 2017	FFY 2018	FFY 2019	CGRM*
Acute Care Bed Days	377,117	382,846	395,604	405,977	421,703	1.0284
Difference from Previous Year		5,729	12,758	10,373	15,726	
Percent Change		1.5%	3.3%	2.6%	3.9%	

** 1 + Four Year Average Percent Change.*
Source: 2017 – 2021 SMFPs

AH states its system growth "is curtailed solely by capacity constraints experienced at CMC"[23] and "Atrium Health as a Mecklenburg County system is facing such significant capacity constraints and bed deficits that it simply has not had the ability to grow over the last four years at the same rate of the Novant Health system that has underutilized beds and adequate capacity to grow."[24] AH blatantly ignores competition as a factor.

The table below shows AH's annual acute care day growth. Compared to previous years, Atrium's system growth has been among the highest in the last three years when it claims the system, "simply has not had the ability to grow at the rate of the Novant system..."

[23] CMC Application, p. 58.
[24] CMC Application, p. 59.

Atrium Health Mecklenburg Facility Acute Care Patient Day Growth

SMFP Year	FFY Data Period	Acute Care Days	Annual Change	Growth Rank
2013	2011	346,410		
2014	2012	344,089	-0.7%	8
2015	2013	352,853	2.5%	5
2016	2014	347,252	-1.6%	9
2017	2015	377,117	8.6%	1
2018	2016	382,846	1.5%	6
2019	2017	395,604	3.3%	3
2020	2018	405,977	2.6%	4
2021	2019	421,703	3.9%	2
2022	2020*	425,778	1.0%	7

Source: SMFPs

For years AH has stated in its acute care bed applications that it has a proven ability to shift patients between its Mecklenburg County and Union County facilities and that it has actively shifted acute care patients from CMC to its other hospitals. In its CMC Application, AH states it has, "developed strategies over many years to manage utilization at CMC. CMHA has sought to decompress capacity at CMC by adding beds at, and shifting patients to, Atrium Health Mercy, Atrium Health University City, and Atrium Health Pineville."[25] The growth at AH's other Mecklenburg hospitals would appear to be a direct result of AH shifting system utilization from CMC to those hospitals. AH provides no reasonable basis to assume that its system wide growth rate would be any higher than it was in the years that contribute to the SMFP CGRM.

Comments on Quantitative Need Applicable to All AH Applications

In all three applications, AH states, "A detailed analysis of the quantitative need for the proposed project is discussed in the assumptions and methodology for Form C." [26] All three AH applications contain nearly identical Form C - Assumptions and Methodology (Form C A&M) which begins page renumbering at 1.

The foundation of Atrium's quantitative need analysis is the idea that absent the opening of approved but not yet operational hospitals, "Baseline" acute care patient days will grow at either the historical CMC growth rate or the 2020 Mecklenburg CGRM, as shown in the table below from the CMC Application Form C A&Ms, Page 6. AH then adjusts for projected shifts of acute care patients from its existing hospitals to selected approved hospitals in the future.

[25] CMC Application, p. 33.
[26] CMC Application, p. 55; AH Pineville Application, p. 53; AH University Application, p. 52.

Assumed Projected Growth Rates

	16-21 CAGR	*22-26 Projected CAGR*	*27-30 Projected CAGR*	*Assumption*
Atrium Health Pineville	6.03%	3.25%	3.25%	3.25% is the Mecklenburg County Growth Rate Multiplier used in the *2021 SMFP.*
Atrium Health University City	7.67%	3.25%	3.25%	3.25% is the Mecklenburg County Growth Rate Multiplier used in the *2021 SMFP.*
CMC	1.61%	1.61%	3.25%	1.61% is CMC's historical CY 16-21 CAGR. 3.25% is the Mecklenburg County Growth Rate Multiplier used in the *2021 SMFP.*
Atrium Health Mercy	7.17%	3.25%	1.61%	3.25% is the Mecklenburg County Growth Rate Multiplier used in the *2021 SMFP.* 1.61% is CMC's historical CY 16-21 CAGR.
Atrium Health Total	**3.33%**	NA	NA	NA

AH relied on its Mecklenburg system's past acute care patient day growth since 2016 as the reasonableness for its acute care utilization projections. According to the Form Cs, AH assumes the acute care average length of stay (ALOS) at each of its facilities will remain constant at its CY 2020 experience and acute care discharges at each facility will grow at the same rate as acute care days.

AH provides no support for its assumptions on patient days and ALOS in the applications as filed. The Agency will find AH did not disclose any data on past acute care patient discharges or ALOS or provide any discussion of these trends in any of the three AH applications. Other than its presence on Form C, the only mention of ALOS in all three application is the single sentence, "With shorter lengths of stay in today's healthcare environment, physicians find it necessary to consolidate a significant volume of clinical care to patients before discharge."[27]

AH also failed to explain the primary reason for its past growth in acute care days because doing so would make clear to the Agency that the growth was substantially due to an increasing average length of stay. Publicly available LRA data show AH's Mecklenburg system discharges declined from 2016 – 2019 and 2016 – 2020. This reason alone makes the utilization projections for all three AH applications unreasonable and without adequate support.

However, the Agency will also find AH failed to adequately quantify the impact of approved new hospitals in Mecklenburg and adjacent counties and significantly understated the shift of acute care utilization from AH Pineville to Piedmont Fort Mill.

As shown in the comments below, AH also does not demonstrate why an unadjusted seven months of CY 2021, annualized, is reasonable to use as the base year to project future acute care days of care, particularly in light of the discussion in the application regarding the impact of COVID-19 and the publicly available information on the impact of COVID-19, which is ongoing.

[27] CMC Application, p. 72; AH Pineville Application, p. 70; AH University City, p. 69.

Atrium Health's Growth Rates

For hospitals that are projected to grow at CGRM, the only support Atrium provides is the statement, "CMHA believes use of the Mecklenburg County Growth Rate Multiplier from the 2021 SMFP acute care bed need methodology is a reasonable basis to project future acute care days for Atrium Health facilities in Mecklenburg County. This projected growth rate of 3.25 percent is conservative relative to Atrium Health's system-wide historical experience..."

AH assumes the acute care average length of stay (ALOS) at each of its facilities will remain constant at its 2020 experience and acute care discharges at each facility will grow at the same rate as acute care days. According to its LRAs, AH's Mecklenburg System acute care discharges actually *declined* 3.2 percent from FFY 2016 to FFY 2019. AH did not provide actual acute care discharges in 2021 from which growth could be measured.[28]

Atrium Health Mecklenburg System Acute Care Discharges

LRA:	2017	2018	2019	2020	2021
FFY Data:	FFY 2016	FFY 2017	FFY 2018	FFY 2019	FFY 2020
CMC/Mercy	61,312	61,064	56,105	55,753	52,279
AH Pineville	15,310	16,362	16,855	17,288	16,229
AH University	6,059	6,442	6,970	6,999	6,741
Total	82,681	83,868	79,930	80,040	75,249

The CMC application provides the following support for the growth rates at CMC and Mercy (Form C A&M, Page 6):

[28] On the Form Cs for all existing AH facilities, AH calculated an estimated number of 2021 acute care discharges by dividing annualized 2021 patient days (Jan – July) by CY 2020 ALOS for each facility. Actual 2021 patient discharges, days, and ALOS for the period January – July 2021 are not provided in the applications as filed.

The *2021 SMFP* Mecklenburg County Growth Rate Multiplier was applied to historical acute care days to project future utilization for each facility through CY 2030, the third full fiscal year of the CMC project, with two exceptions. Growth at CMC has been severely restricted due to occupancy levels in excess of 90 percent for three out of the last five years with no ability to develop any significant number of additional acute care beds for several more years. Until CMC has significant additional acute care bed capacity, its growth will continue to be constrained. As such, CMHA reasonably projects that CMC's acute care days will grow at its historical CY 2016 to 2021 CAGR of 1.61 percent through CY 2026 prior to the opening of a new patient tower on the CMC campus in CY 2027 at which time 87 previously approved beds from the 2020 acute care bed review and 66 of the 75 additional beds proposed in CMC's application in response to the need identified for Mecklenburg County in the *2021 SMFP* become operational. Beginning in CY 2027 through CY 2030, the third full fiscal year of the CMC project, CMHA assumes that CMC's acute care days will grow at the Mecklenburg County Growth Rate Multiplier rate of 3.25 percent annually. Similarly, CMHA projects that Atrium Health Mercy's acute care days will grow at 3.25 percent annually through CY 2026 as it continues to offer relief to CMC, with which it shares a license. With Atrium Health Mercy's projected occupancy rate after CY 2026, its growth will be forced to slow. The development of additional acute care bed capacity at CMC beginning in CY 2027 will allow CMC room to grow, at which time CMHA assumes that Atrium Health Mercy will grow at CMC's historical, capacity-restricted growth rate of 1.61 percent, as shown in the table above.

CMC and Mercy are reported as a combined licensed facility on the LRAs. Acute care discharges have decreased every year at CMC/Mercy since 2016. The only reason acute care days at CMC grew during this time was because of an increasing ALOS. AH failed to explain this increasing ALOS, and further, assumed there would be no increase in the ALOS at any AH Mecklenburg facility at any time in the future as projected in the three applications.

AH did not explain the reasons for the decline or the factors that will or will not stop or reverse the decline in future years. The impact of COVID-19 does not explain the declining discharges because the steady decline in discharges between FFY 2016 and FFY 2019 occurred *before* any cases of COVID-19 were detected. AH assumed baseline growth in acute care days (and thus discharges) at its Mecklenburg hospitals 2.59 percent per year through 2030. The growth per year in discharges is not supported by historical growth trends.

Atrium Health Mecklenburg County Facilities Projected Baseline Utilization

	CY21*	CY22	CY23	CY24	CY25	CY26	CY27	CY28	CY29	CY30	Resulting CAGR
Atrium Health Pineville**	81,874	84,535	87,282	90,119	93,048	96,072	99,194	102,418	105,746	109,183	3.25%
Atrium Health University City	32,574	33,633	34,726	35,854	37,020	38,223	39,465	40,748	42,072	43,439	3.25%
CMC^	286,864	291,471	296,151	300,907	305,739	310,649	320,745	331,169	341,932	353,045	2.33%
Atrium Health Mercy^^	55,054	56,844	58,691	60,598	62,568	64,601	65,639	66,693	67,764	68,852	2.52%
Total Days	456,366	466,482	476,850	487,479	498,374	509,545	525,043	541,028	557,514	574,520	2.59%

AH admits that the past 2016-2021 acute care days CAGR of 1.61 percent at CMC was only possible because CMC added additional bed capacity of 45 beds in late 2018.[29]

> A detailed analysis of Atrium Health's growth and occupancy rates by facility/campus, demonstrates that its growth is curtailed solely by capacity constraints experienced at CMC. The growth CMC experienced from CY 2018 to CY 2019 is clearly indicative of the practical capacity limits CMC has reached when operating at 90 percent occupancy throughout the year. As demonstrated in the table below, from CY 2016 to CY 2018, CMC's occupancy hovered around 90 percent and it experienced limited growth over those years. In CY 2019, after 45 additional beds became operational in late CY 2018, it immediately filled those beds—continuing to operate at 90 percent capacity over the course of CY 2019—but the additional bed capacity permitted CMC to grow by nearly five percent that year, though it still had to turn away some patients because of capacity limits.

This contradicts AH's assumption that CMC will grow at its past 2016-2021 CAGR from 2021 through 2026 when CMC is only expected to make nine additional beds operational (2022). In justifying its assumed CMC growth rate in the following excerpt, the applicant's own statements do not support a projected annual increase in acute care patient days or discharges at any growth rate at CMC before at least CY 2027.[30]

[29] CMC Application, p. 58.

[30] CMC Application, Form C Assumptions and Methodology p. 6. Similar language appears in the AH Pineville and AH University applications, Form C Assumptions and Methodology, also on page 6.

The *2021 SMFP* Mecklenburg County Growth Rate Multiplier was applied to historical acute care days to project future utilization for each facility through CY 2030, the third full fiscal year of the CMC project, with two exceptions. Growth at CMC has been severely restricted due to occupancy levels in excess of 90 percent for three out of the last five years with no ability to develop any significant number of additional acute care beds for several more years. Until CMC has significant additional acute care bed capacity, its growth will continue to be constrained. As such, CMHA reasonably projects that CMC's acute care days will grow at its historical CY 2016 to 2021 CAGR of 1.61 percent through CY 2026 prior to the opening of a new patient tower on the CMC campus in CY 2027 at which time 87 previously approved beds from the 2020 acute care bed review and 66 of the 75 additional beds proposed in CMC's application in response to the need identified for Mecklenburg County in the *2021 SMFP* become operational. Beginning in CY 2027 through CY 2030, the third full fiscal year of the CMC project, CMHA assumes that CMC's acute care days will grow at the Mecklenburg County Growth Rate Multiplier rate of 3.25 percent annually. Similarly, CMHA projects that Atrium Health Mercy's acute care days will grow at 3.25 percent annually through CY 2026 as it continues to offer relief to CMC, with which it shares a license. With Atrium Health Mercy's projected occupancy rate after CY 2026, its growth will be forced to slow. The development of additional acute care bed capacity at CMC beginning in CY 2027 will allow CMC room to grow, at which time CMHA assumes that Atrium Health Mercy will grow at CMC's historical, capacity-restricted growth rate of 1.61 percent, as shown in the table above.

The AH applications indicate AH Mecklenburg hospitals reach practical operational capacity at 90 percent occupancy on licensed beds. However, AH projects future acute care occupancy as projected on Form C to exceed 90 percent at CMC, Mercy, AH Lake Norman, and AH University City.

Shifts to Other Hospitals[31]

AH's utilization projections did not adequately account for the impact of new hospitals, particularly on AH Pineville. AH's CMC-Fort Mill application was filed more than 10 years ago and its hospital was projected to be operational January 1, 2015. Since that time, Piedmont's Fort Mill hospital received final approval and its hospital will now be operational in late 2022 with a first full project year of CY 2023. AH is unreasonably assuming the same absolute patient day impact it projected in early 2011 in its Fort Mill application (See Form C Assumptions & Methodology, Page 8 and the tables below.)[32]

[31] CMC Application, Form C Assumptions and Methodology, p.8; AH Pineville Application, Form C Assumptions and Methodology, p. 7; AH University Application, Form C Assumptions and Methodology, p. 7.

[32] Reduced to account for the ownership change from Atrium to Tenet by only shifting those expected to be admitted through the ER (Form C Assumptions and Methodology, pp. 8-9).

Originally Proposed Shifts of Acute Care Days to CMC-Fort Mill

	CY24	CY25	CY26
Atrium Health Pineville	-7,276	-7,482	-7,693
Atrium Health University City	-85	-88	-90
CMC	-5,257	-5,403	-5,553
Atrium Health Mercy	-946	-973	-1,000
Total Days to Shift	**-13,565**	**-13,945**	**-14,336**

Source: CMC-Fort Mill application and Project ID #s F-10215-13, F-10221-13, F-11361-17, F-11362-17, and F-11622-18.

Adjusted Shifts of Acute Care Days to Piedmont Fort Mill Medical Center by Facility of Origin

	CY23	CY24	CY25	CY26	CAGR
Atrium Health Pineville	-4,996	-5,137	-5,282	-5,431	2.8%
Atrium Health University City	-57	-58	-60	-62	2.8%
CMC	-2,475	-2,543	-2,614	-2,687	2.8%
Atrium Health Mercy	-493	-506	-521	-535	2.8%
Adjusted Total Days to Shift	**-8,021**	**-8,244**	**-8,477**	**-8,715**	**2.8%**

In all AH applications, the only support provided for the assumed Piedmont Fort Mill shifts is that the projected shift of acute care days to Piedmont Fort Mill is consistent with AH's projections in these previous acute care bed applications:

Application Project IDs	Application Year
CMC Fort Mill Application	2011
#F-10215-13, #F10221-13	2013
#F-11361-17, #F-11362-17	2017
#F-11622-18	2018
#F-012147-21	2021

The excerpt below is from the original 2011 CMC-Fort Mill application regarding the impact of its proposed hospital on AH Pineville. This excerpt was taken from an attachment to the #F-10215-13 application and is provided with these comments as **Exhibit 5**.

2. *Shift of Discharges from other CHS facilities.*

CHS calculated the historic market share for CHS Mecklenburg facilities for each of the three submarkets. CHS assumed that a portion of its existing market share for each of the three submarkets would shift to CMC-Fort Mill:

- CHS projected to shift 75 percent of the 2009 Northern York County market share held by CHS Mecklenburg facilities to CMC-Fort Mill.
- CHS projected to shift 80 percent of the 2009 Rock Hill market share held by CHS Mecklenburg facilities to CMC-Fort Mill.
- CHS projected to shift 50 percent of the 2009 Western York County market share held by CHS Mecklenburg facilities to CMC-Fort Mill.

While over the years AH has the data available to update and recalculate future impact using the same assumptions it used in 2011, it has instead held the absolute volume impact on patient days constant. Since the Agency first accepted AH's impact projections in a 2013 North Carolina application, York County population, AH Pineville's total acute care utilization, and the number of acute care patients at AH Pineville from York County has increased significantly.

AH's projections of impact from a new Fort Mill hospital, regardless of ownership, are now out of date and understated. The table below shows that when the agency first accepted the impact projections in a 2013 North Carolina application, AH projected about 15 percent of AH Pineville's acute care days would shift to CMC Fort Mill. In the current Pineville application, the assumed shift to an Atrium-owned Fort Mill hospital now amounts to only 8 percent of AH Pineville's acute care days. These days are further reduced by AH since the hospital in Fort Mill will be owned by Piedmont.

In 2013 Applications	AH Pineville Total Acute Care Days	To AH Fort Mill	Percent of AH Pineville Patient Days
2015	51,380	7,276	14%
2016	52,078	7,482	14%
2017	52,785	7,693	15%

In 2021 AH Pineville Application	AH Pineville Baseline Acute Care Days	To AH Fort Mill	Percent of AH Pineville Patient Days
2023	87,282	7,276	8%
2024	90,119	7,482	8%
2025	93,048	7,693	8%

The table below shows AH Pineville's projected year three volume has nearly doubled and AH Pineville is more reliant on patients from South Carolina now than it was when AH filed its CMC-Fort Mill application in 2011, yet AH's projected shift of patient days from AH Pineville has decreased.

Application Project ID	CMC- Fort Mill	#F-012147-21
Application Date	2011	2021
Approved York County Hospital	CMC-Fort Mill 64 Beds	Piedmont Fort Mill Medical Center 100 Beds
Proposed Hospital Year 3	CY 2017	CY 2025
Projected AH Pineville Total Acute Care Days (before shift)	52,785	93,048
Acute Care Days Shifted from AH Pineville	7,693	5,282
% of Total Pineville Days Shifted	14.6%	5.7%
AH Pineville LRA:	2011 LRA	2021 LRA
Most Recent Year of Data	FFY 2009	FFY 2020
Acute Care Discharges	7,957	16,229
Acute Care Days	34,218	69,521
Acute Care Discharges from South Carolina	3,040	7,391
% from South Carolina	38.2%	45.5%

This does not make sense. If AH Pineville is more reliant on South Carolina patients now than it was in 2011, then the days and percent shifted from AH Pineville to Fort Mill should be higher, not lower.

AH also did not account for impact on AH Pineville from these approved new hospitals:

- CaroMont Belmont (Gaston County)
- NH Ballantyne
- NH Steele Creek

CaroMont and NH projected, and the Agency accepted, the new hospitals would change acute care market share patterns in southern Mecklenburg County. NH also showed how NH Steele Creek will affect EMS patterns between NH and AH. While not addressed in the NH Ballantyne application, NH Ballantyne will also affect EMS patterns to reduce transports to AH Pineville. AH only addresses the approved hospitals relative to the acute care bed performance standards (page 18 A&M) and based on projected utilization found on Form C. However, NH's comments show AH's Form C utilization projections are unreasonable and inadequately supported. The reduction of future acute care volume at AH Pineville due to the opening of new acute care hospitals is a critical piece of analyzing the future quantitative need for the proposed AH Pineville project. For all these reasons the AH Pineville application should be found non-conforming with Criterion (3).

Atrium Health's Inappropriate Use of Data

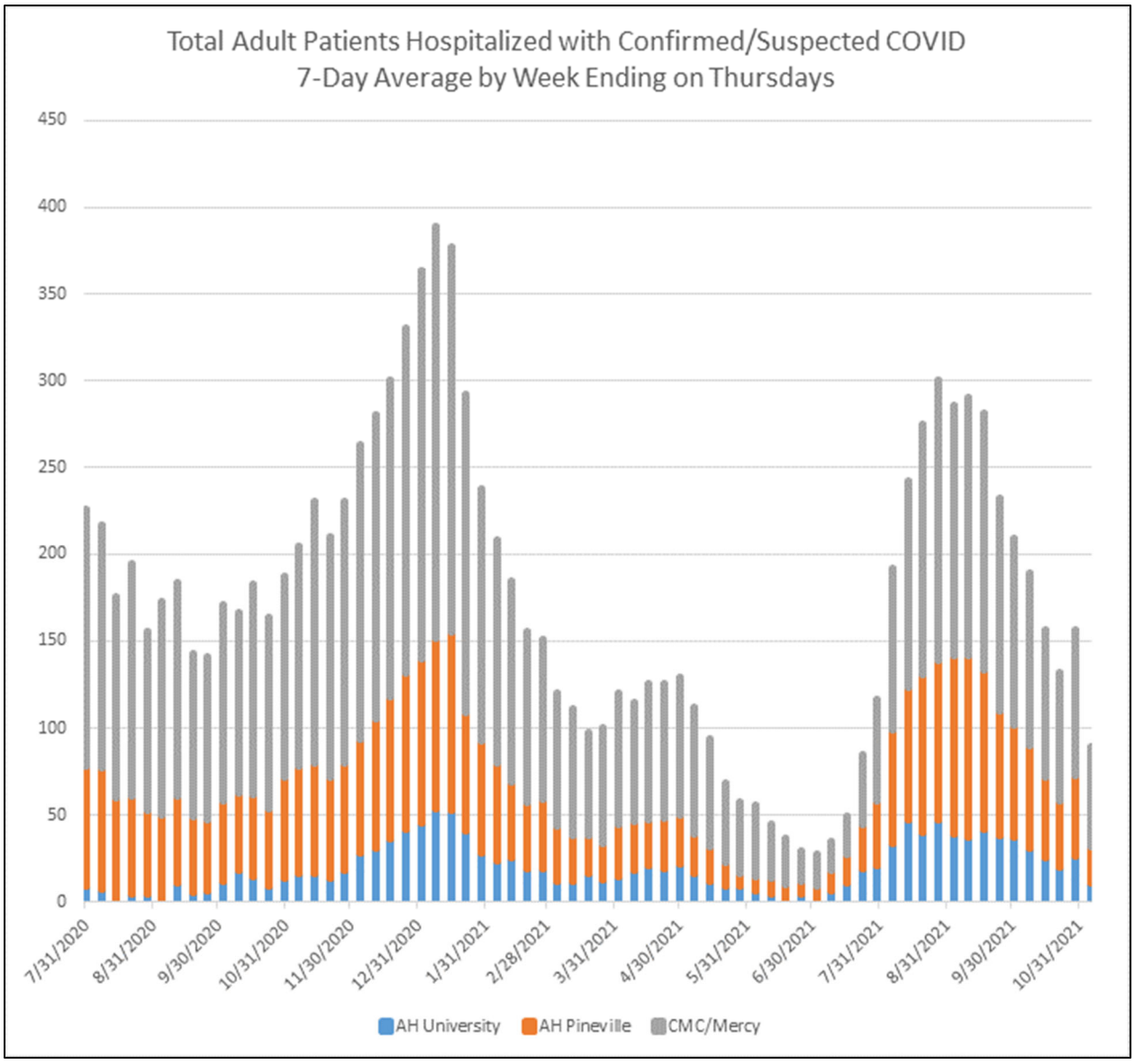
AH used misleading data to support its need analysis and utilization projections in all three applications. The Agency and the State Health Coordinating Council (SHCC) recognized the variances in acute care utilization that began in 2020 due to the COVID-19 pandemic, and issued recommendations for normalizing the data. (See **Exhibit 6** for the SHCC acute adjusted patient days methodology.) The utilization projections in the AH applications ignored these significant variances. AH used its annualized inpatient utilization data from January – July 2021 as a base year for projections and to calculate the past growth rates for its Mecklenburg hospitals.[33] The first quarter of 2021 coincided with the residual surge of COVID-19 hospitalizations from the previous winter, while the subsequent surge in North Carolina due to the Delta variant began in early summer. AH made no adjustment to its census or occupancy rate for the effects of COVID-19 in 2021. AH did not explain how COVID-19 impacted its 2021 utilization. AH's use of unadjusted, annualized, internal data for the first half of 2021 makes the need analysis and utilization projections in the three applications unreasonable and inadequately supported.

The need analysis in the AH Pineville application has other major flaws. AH relied on anecdotal information about capacity issues on one day: September 1, 2021.[34] Public data shows this was the peak of the Delta variant surge at AH Pineville.[35] Even if the Agency accepts at face value AH's description of operational difficulties on September 1, 2021, it is not a description of normal demand or the expected demand in 2023 and later years. High bed demand due largely to COVID-19 patients on a single day is not reasonable support of the future need for additional beds.

The following chart shows the 7-day average census of adult COVID-19 patients at AH Mecklenburg hospitals for each week from August 2020 through October 2021.[36] The three AH hospitals had a

[33] AH Pineville Application, Form C Assumptions and Methodology, p. 3.
[34] AH Pineville Application, Form C Assumptions and Methodology, p. 41.
[35] Source: U.S. Department of Health and Human Services, COVID-19 Reported Patient Impact and Hospital Capacity by Facility. Viewed Nov. 17, 2021. https://catalog.data.gov/dataset/COVID-19-reported-patient-impact-and-hospital-capacity-by-facility-raw
[36] Seven-day average total adult patients hospitalized with confirmed or suspected COVID-19 at CMC/Mercy, AH Pineville, and AH University (300.6). Source: U.S. Department of Health and Human Services. COVID-19- Reported

combined average census of 300 adult COVID-19 patients for the week beginning August 27, 2021 and ending September 2, 2021. Since data collection began in the summer of 2020, this was the highest weekly average adult COVID-19 patient census after the January 2021 peak. The COVID-19 census at AH Mecklenburg hospitals has steadily declined since that peak. It was not a representative week and should not be used for health planning purposes. These COVID-19 patients were 21 percent of the total average adult inpatient census at AH hospitals during the week ending September 2, 2021.[37]



Patient Impact and Hospital Capacity by Facility, Updated: November 16, 2021. https://catalog.data.gov/dataset/COVID-19-reported-patient-impact-and-hospital-capacity-by-facility-raw

[37] Seven-day average total adult hospital inpatient beds occupied at CMC/Mercy, AH Pineville, and AH University (1,411.9). Source: U.S. Department of Health and Human Services. COVID-19 Reported Patient Impact and Hospital Capacity by Facility, Updated: November 16, 2021. https://catalog.data.gov/dataset/COVID-19-reported-patient-impact-and-hospital-capacity-by-facility-raw

Source: U.S. Department of Health and Human Services.

Basing the need for additional beds on the September 1, 2021 census is unreasonable without adjusting for the large number of COVID-19 cases at AH hospitals. The census with COVID-19 cases is not adequate support for the need for beds in future years. AH had the data to make the adjustment but chose to present data for only this one date, without adjusting for the COVID-19 census. If AH needed additional beds for COVID-19 patients it had a COVID-19 exemption to add more beds. It did not see the need to do so. It is true that some normal admissions were deferred due to COVID-19. NH's experience was admissions deferred due to COVID-19 in fall 2021 were much less than the COVID-19 cases. AH presented no data on admissions deferred to show its situation was different.

Quantitative Need Comments Specific to AH Pineville

Need for Additional Capacity at Atrium Health Pineville (Pages 65-74)

On pages 65-74, AH explains why it believes the AH Pineville project is needed. Atrium argues AH Pineville operated at nearly 83 percent occupancy in CY 2020 and is expected to operate above 95 percent occupancy this year, more than demonstrating its urgent need for additional bed capacity (p. 67). This past occupancy rate is not relevant to the future bed need at AH Pineville. 2020 and 2021 are periods with substantial patient days due to COVID-19. It is misleading because (1) AH makes no adjustment for COVID-19 and (2) AH fails to mention the additional 57 licensed acute care beds AH Pineville is approved to implement by 2022.[38]

AH then argues AH Pineville's high utilization levels already support the need for 62 more beds today, more than one and a half times the proposed 36 additional acute care beds (p. 68). The table at the top of page 68 ignores the approved beds not yet operational. As AH acknowledges in the next sentence, "assuming Atrium Health Pineville's bed inventory was increased by the proposed 36 beds in addition to 45 previously approved beds that have not yet been developed, its occupancy rate in CY 2021, not accounting for any future growth, would be approximately 71 percent." Occupancy calculated on 2021 volume and licensed beds is irrelevant to analyzing future need at AH Pineville because it does not account for volume AH has acknowledged will shift to other hospitals and recent AH acute care bed approvals that will increase capacity as they become operational. Regardless, this 70.7% rate is below the threshold rate of 75.2% for hospitals with >200 ADC.

When the COVID-19 bed waiver is no longer available, AH argues AH Pineville will again need to rely on temporary bed overflow status to meet demand while operating at reasonable occupancy levels (p. 69). If this is true, it is not a problem. AH has been very successful in obtaining temporary bed increases, and should have no concerns about obtaining them in the future. AH Pineville operated above 90% capacity every single day in January of 2021 (p. 70). In the application AH never projects AH Pineville will have an

[38] Pursuant to Project ID #s F-11622-18, F-11813-19, and F-12009-20, Atrium Health Pineville was approved to develop a total of 57 additional acute care beds. 12 additional beds were operational as of November 2020. The 45 additional acute care beds approved will be developed in CY 2022. (AH Pineville Application, Form C Assumptions and Methodology, p. 12)

occupancy rate of 90 percent or more when all approved beds are operational (Form C), even without the 36 beds. The occupancy rate is even lower with the 22 non-COVID-19 temporary licensed beds.

All statistics and charts in Section C.4 are based on the 221 licensed beds at AH Pineville in 2019 or the 233 licensed beds in 2020 and 2021. By project year 3, 45 more approved beds (F-11622-18, F-12009-20) will be developed in the new AH Pineville patient tower under development and will become operational in CY 2022. AH has not demonstrated in the application as submitted that any current capacity constraints at AH Pineville may exist in the future, when occupancy is reduced by shifts of patients to other hospitals (further discussed below) and the approved beds that will become operational in 2022. AH also bases its need on annualized 2021 patient utilization data, when there were multiple surges of hospitalized COVID-19 patients placing unusually high demand on hospitals. This additional demand cannot reasonably be expected to continue in calculations of future need.

In summary, the above reasons do not adequately explain why the population to be served needs the 36 acute care beds as proposed at AH Pineville in the future.

CON Criteria and Acute Care Bed Performance Standards

The proposed projects by NH and AH must be reviewed according to criteria described in G.S. 131E-183(a). This review process does not grade the applicant relative to competing applications; it is a binary analysis of whether the application is conforming or non-conforming with the specific criterion.

Based on these requirements, all three of the AH applications are non-conforming with Criteria (1), (3), (5), (6) and (18a). In addition, the AH Pineville application is non-conforming with Criteria (4) and (12). The following discussion of these review criteria describes the reasons AH's applications do not conform with these criteria.

Criterion (1)

Criterion (1): NCGS § 131E-183(a)(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.

The information AH presents under Criterion (1) is not relevant to that criterion. The need determination in the 2021 SMFP allows the Agency to approve up to 123 acute care beds. The Agency is not required to award *all* the beds. It cannot approve all four applications as proposed, as AH applied for 75 beds at CMC, 12 beds at AH University City and 36 beds at AH Pineville, while NH applied for 22 beds at NH Presbyterian.

The Agency can approve all four acute care applications if it approves 101 or fewer of the beds AH requested.[39]

AH argues all its 2021 applications should be approved because AH hospitals generated the acute care bed need in Mecklenburg County. The role of the SMFP in the CON process is to limit the number of new assets the Agency can award in a review cycle. The SMFP does not indicate which applications should be approved. The SMFP clarifies that "[A]ny person can apply to meet the need, not just the health service hospital or hospitals that generated the need."[40] The Agency supported this in its Findings on the 2019 Mecklenburg Bed and OR Review, stating that "anyone may apply to meet the need, not just AH. Atrium has the burden of demonstrating the need for the proposed acute care beds and ORs in its applications as submitted."[41] An applicant must justify each project, based on the information in the application and Agency file, and show it satisfies the CON review criteria and performance standards. AH's refrain it generated the need is entitled to no weight.

Granting approval to these projects contradicts the Agency's objectives within Policy GEN-3: Basic Principles. AH does not demonstrate that it will "maximize value for resources expended." "Maximizing healthcare value" in the 2021 review cycle should mean the Agency takes a balanced approach that allows both systems to compete in ways that benefit the population. It will not be accomplished by denying any new assets to either system. It would not maximize health care value to approve an application awarding additional beds to a hospital that has not operationalized all approved beds. The three AH hospitals have a combined total of 136 approved but not yet operational beds (87 at CMC, 45 at AH Pineville, 4 at AH University City).[42] They do not require additional licensed beds to manage the census at their hospitals.

AH's projects will stockpile unnecessary beds at a cost of more than $158 million. The table below shows the cost per bed for the applications AH submitted in this review cycle. AH Pineville's cost per new bed is the second-highest of the four applications. The more cost-effective alternative at AH Pineville is to license existing temporary beds now in operation.

	Total Capital Expenditure	Requested Beds	Cost per Bed
NH Presbyterian	$289,369	22	$13,153
CMC-Main	$120,474,107	75	$1,606,321
AH Pineville	$32,575,000	36	$904,861
AH University City	$5,016,500	12	$418,041

Source: AH Acute Care Beds Applications, Form F.1a

[39] By making this comment, NH does not intend to suggest that Atrium's applications conform with all applicable criteria and rules. Rather, it is NH's position that the AH applications are non-approvable. If, however, the Agency decides otherwise, NH is merely noting that there is a way to approve the AH applications for the majority of the assets they seek, while also approving NH's more modest request.

[40] 2022 Proposed North Carolina State Medical Hospitals Plan, Chapter 5, p. 48.

[41] 2019 Mecklenburg Acute Care Bed and OR Review Findings, p. 38.

[42] 2022 SMFP Final Draft, Table 5A: Acute Care Bed Need Projections.

For these and other reasons the Agency may discern, the Agency should find the CMC, AH Pineville and AH University City applications are non-conforming with Criterion (1).

Criterion (3)

Criterion (3): NCGS § 131E-183(a)(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.

Section C.4 of the AH applications discuss the qualitative need for the proposed additional acute care beds. The comments above show AH did not adequately explain why the population to be served needs the services proposed. In summary:

- AH's inventory of Agency-approved and temporary licensed beds and unlicensed observation beds provides sufficient capacity for future inpatient demand
- AH relies on anecdotal information from September 2021, during the height of the Delta variant-fueled surge in hospitalized COVID-19 patients, to illustrate its operational challenges resulting from high patient census
- AH wrongly concludes that NH's increase in inpatient discharges and market share results from patients being redirected from AH hospitals at full capacity. NH has expanded its employed medical group and developed specialty service lines in Mecklenburg County that account for this growth, and any diversion of AH patients to NH facilities is minimal

In Form C Assumptions and Methodology, AH presents the quantitative need for the proposed additional acute care beds. The above comments (see "Comments on Quantitative Need Applicable to all AH Applications", beginning on page 16) show utilization projections are not reasonable nor adequately supported. In summary:

- AH bases future growth rates on unadjusted data from the first half of 2021 that coincides with abnormally high surges of hospitalized COVID-19 patients
- AH's growth rates are unreasonable and not adequately supported
- AH uses outdated assumptions about market share shifts to Piedmont Fort Mill hospital in South Carolina, understating the acute care volume that will move to the new facility
- AH does not incorporate Agency-approved market share growth assumptions at new NH hospitals in Ballantyne and Steele Creek

For these and other reasons the Agency may discern, the Agency should find the CMC, AH Pineville, and AH University acute care bed applications non-conforming with Criterion (3).

Criterion (4)

Criterion (4) NCGS §131E-183(a)(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.

AH presented three alternatives in the AH Pineville application: (1) Maintain the status quo; (2) Develop the requested beds in existing space at AH Pineville; and (3) Develop a different number of beds at AH Pineville.[43] AH failed to fully consider Alternative #2 for AH Pineville. AH failed to consider permanently licensing the 22 temporarily licensed bed spaces. Building out an entire floor of the CON-exempt Pineville patient tower for new patient rooms and support space instead of permanently licensing patient rooms that already exist and are operational is not the least costly or most effective alternative.

AH also failed to consider Alternative #3 for AH Pineville. The Applicant reasoned that developing fewer than 36 beds would prevent AH Pineville from accommodating growth, but developing over 36 beds would prevent CMC and AH University from increasing capacity for growth as proposed in the concurrent applications. This contradicts Form C of the AH applications, which project significantly higher occupancy rates at CMC and AH University than AH Pineville. Furthermore, the utilization projections are not reasonable and not adequately supported.

For these and other reasons the Agency may discern, the Agency should find the AH Pineville application to be non-conforming with Criterion (4).

Criterion (5)

Criterion (5) NCGS §131E-185(a)(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

AH's projections of acute care bed days and utilization are not reasonable, reliable, or adequately supported. The projections in its three applications are based on several unreasonable assumptions, including incorporating COVID-19-affected 2021 data as the base year, growth rates based on patient days with no consideration of historical trends in discharge volumes, average lengths of stay not validated by historical trends, and failure to consider volume shifts to competing hospitals. Please see the discussion under Criterion (3). With unreliable utilization projections, all projections of operating revenues and expense are also unreliable. The applications do not show the long-term financial feasibility of the project.

[43] AH Pineville Application, p. 97.

As discussed in Criterion (3) of this document, AH can admit all projected Mecklenburg patients without the 123 acute care beds in its applications. It will have more than enough acute care beds if the Agency awards NH 22 beds and awards AH part or all of the remainder.

For the above-stated reasons, plus any additional reasons the Agency may discern as it reviews the AH applications, the CMC, AH Pineville and AH University City applications are non-conforming with Criterion (5).

Criterion (6)

Criterion (6) NCGS § 131E-183(a)(6): The applicant shall demonstrate that the proposed project will not result in unnecessary duplication of existing or approved health service capabilities or facilities.

AH is applying for 123 beds when it already has 136 approved beds that have not been developed.[44] For all three AH applications, projected utilization and occupancy rates for acute care beds are not reasonable and not adequately supported. AH has not demonstrated in the applications as filed that the current or past capacity issues raised in its applications will exist in the future.

The AH Pineville application also fails to consider permanently licensing the 22 bedspaces in use as temporary licensed beds instead of constructing new bed spaces. Since March 2018, AH Pineville has consistently operated an additional 20 to 22 temporarily licensed bed spaces.[45] Building new patient rooms and support space in its CON-exempt bed tower instead of permanently licensing existing patient rooms is an unnecessary duplication of existing health care services.

For these and other reasons the Agency may discern, the Agency should find the CMC, AH Pineville and AH University City applications to be non-conforming with Criterion (6).

Criterion (12)

Criterion (12) NCGS §131E-183(a)(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 savings features have been incorporated into the construction plans.

[44] While NH also has approved but not yet operational beds, it accounted for these beds in its discussion of need for the proposed beds at NH Presbyterian. AH did not account for its approved beds in the arguments regarding 2020 and 2021 occupancy rates presented in its applications for additional acute care beds.

[45] AH received seven approvals from the Agency to temporarily operate 20 additional acute care beds from March 2018 to June 2019. Due to an increase in total bed count at AH Pineville, AH received approval for 22 additional acute care beds from June 2019 to April 2020.

The AH Pineville application failed to consider permanently licensing the bedspaces in use as temporarily licensed beds. Since April 2018, AH Pineville has consistently operated an additional 20 to 22 bed spaces.[46] Construction and upfitting new patient rooms and support space in the bed tower instead of permanently licensing existing patient rooms will result in greater project costs. AH's commitment of nonessential construction projects at three facilities with approved yet undeveloped projects will require unnecessary costs.

The proposed beds at AH Pineville will not be placed into service until July 2023. This is an unnecessarily protracted timeline if there are immediate bed capacity challenges as the applicant describes. AH can develop observation beds that can be placed into service without CON review and approval on a much shorter completion schedule.

For these and other reasons the Agency may discern, the Agency should find the AH Pineville bed application as non-conforming with Criterion (12).

Criterion (18a)

Criterion (18a) NCGS § 131E-183(a)(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.

Competitive Balance and the Public Interest

The legislative findings on the CON statute note the importance of the program using competition and regulation to improve access and quality and to control costs. The first finding states: "the financing of health care . . . limits the effects of free market competition and government regulation is therefore necessary to control costs, utilization and distribution of new health service facilities and the bed complements of these health service facilities."[47] One purpose of the CON program is to ensure that the distribution of beds in a health care market is optimized for market competition. The Agency should exercise its ability to use CON awards to improve the competitive balance of the acute care bed distribution in Mecklenburg County.

The service area defined by the SMFP is Mecklenburg County. The AH and NH hospitals in Mecklenburg County serve the same populations of Mecklenburg County residents. Both health systems are equally accessible to all residents of the service area and, in particular, low-income persons, racial and ethnic minorities, women, handicapped persons, the elderly, and other underserved groups. NH's charity and

[46] Ibid.
[47] N.C. Gen. Stat. § 131E-175, Findings of Fact.

financial assistance policies for uninsured and low-income residents are more generous than AH's policies.[48] Both health systems have expanded virtual access to care programs through telehealth and remote monitoring programs. NH will maintain the increased virtual access after the U.S. Department of Health and Human Service's COVID-19 Public Health Emergency expires.

In deciding which conforming applications to approve or partially approve, the Agency should consider the public interest in maintaining competitive balance in the largest health care market in North Carolina. There is a public interest in creating, maintaining, and improving competitive balance to keep AH from becoming even more dominant and enabling Atrium to dictate rates to commercial, Medicare, and Medicaid managed care organizations. The only policy tool the Agency has to improve competitive balance in Mecklenburg County is its CON decisions. Absent a compelling public benefit, the Agency should avoid approving AH applications to the detriment of competitors like NH, and to the detriment of health care consumers and payors.

Impact of AH and NH Projects on Competitive Balance

None of the applications for acute care beds in Mecklenburg County are for services by a new provider in Mecklenburg County. AH has a dominant market share and the most inpatient assets in the county. NH is its only inpatient competitor in the county. With its approved beds and with the acute care beds in the CMC, Pineville and University City applications, AH has all the licensed beds it needs to compete. Awarding all beds to AH will increase its market dominance and tilt the competitive balance the wrong way.

The following table shows each system's licensed acute care bed inventory and how the competitive balance will change based on the Agency's decisions on these applications. AH has over 62% of the licensed and approved beds for Mecklenburg County. The competitive balance will still tilt to Atrium if NH Presbyterian's application is approved and AH receives the remaining beds in the 2021 need determination, but this disparity will be less than AH's bed share if NH's application is denied. Improving competitive balance in Mecklenburg County, or not unnecessarily worsening competitive imbalance, will maximize healthcare value by incentivizing high quality care, lowering costs, and expanding patient choice. As NH's improved market share over time shows, competition works to the benefit of patients and payors, who increasingly choose NH physicians and facilities in Mecklenburg County. The most effective alternative is for the Agency to deny AH's applications as nonconforming and approve the NH Presbyterian application.

[48] NH Presbyterian Acute Care Beds Application CON Project I.D. No. F-012144-21, Exhibit L-4.1; AH Pineville Application, Exhibit L-4.1.

			NH Approved and AH Pineville Denied			All AH Approved and NH Denied		
	2021 Licensed and Approved Beds	***Percent of Beds***	***2021 CON Award***	***Total Beds***	***Percent of Beds***	***2021 CON Award***	***Total Beds***	***Percent of Beds***
Atrium Health	1,554	62.7%	87	1,641	63.4%	123	1,677	64.4%
Novant Health	926	37.3%	22	948	36.6%	0	926	35.6%

Source: 2022 SMFP Final Draft.

Impact of AH and NH Projects on Cost Effectiveness

There is a wide variance in the estimated projected costs for the AH and NH applications. The CMC and AH Pineville projects include construction and build out of additional floors of bed towers. The NH and AH University City projects would renovate existing space to expand licensed bed capacity. NH's application offers by far the most cost-effective option, with an average cost per bed over 31 times lower than the cost per bed of CMC's least-expensive proposed project at AH University City.

AH declares in its applications that its hospitals, "as part of the larger CMHA system, (benefit) from the significant cost savings measures through the consolidation of multiple services and large economies of scale."[49] While there may be unit cost savings, the overall combined costs for AH's projects total more than $158 million. AH does not explain how the proposed projects would consolidate services to result in cost savings. The AH applications cannot adequately demonstrate a favorable impact on cost-effectiveness.

Approval of the AH Pineville application would continue the trend of developing acute care resources in the southern region of Mecklenburg County while the central area remains unchanged. The downtown Charlotte hospitals, and in particular, NH Presbyterian, should be awarded additional beds while the previously approved beds in the southern and northern regions of the county are implemented.

For these and other reasons the Agency may discern, the Agency should find the CMC, AH Pineville and AH University City applications as non-conforming with Criterion (18a).

Section .3800 - Criteria and Standards for Acute Care Beds

10A NCAC 14C .3803 (a) Performance Standard: An applicant proposing to develop new acute care beds shall demonstrate that the projected average daily census (ADC) of the total number of licensed acute care beds proposed to be licensed within the service area, under common ownership with the applicant, divided by the total number of those licensed acute care beds is reasonably projected to be at least 66.7 percent when the projected ADC is less than 100 patients, 71.4 percent when the projected ADC is 100 to 200 patients, and 75.2 percent when the projected ADC is greater than 200 patients, in

[49] CMC Application, Section B.20, p. 30; AH Pineville Application, Section B.20, p. 30; AH University City Application, Section B.20, p. 30.

the third operating year following completion of the proposed project or in the year for which the need determination is identified in the State Medical Facilities Plan, whichever is later.

10A NCAC 14C .3803 (b) Performance Standard: An applicant proposing to develop new acute care beds shall provide all assumptions and data used to develop the projection required in this rule and demonstrate that they support the projected inpatient utilization and average daily census.

The Agency should find AH applications non-conforming with this rule because AH does not adequately demonstrate the need for the proposed projects or that its assumptions and methodology support the projected inpatient utilization. Please see the discussion under Criterion (3).

Atrium Health's Assertions of Superior Need

All three AH applications contain nearly identical sections called, "*Atrium Health Demonstrates Superior Need.*"

Page References for Sections Titled, "Atrium Health Demonstrates Superior Need"

Applicant Hospital	Project I.D.	Overview of Unmet Need
CMC	#F-012149-21	Pages 62-65
AH Pineville	#F-012147-21	Pages 60-63
AH University	#F-012146-21	Pages 60-63

AH draws comparisons between its applications and other facilities in asserting its need for bed capacity. In its three applications AH includes a section describing its "superior need" that attempts to differentiate AH's bed need beyond standard review measures. AH alleges that three of NH's five Mecklenburg hospitals violate North Carolina's CON statute as outlined in § 131E-175, Findings of Fact (4) and (6). These Findings conclude that excess capacity results in "the unnecessary use of expensive resources and overutilization of health services"[50], and "places an enormous economic burden on the public who pay for the construction and operation of these facilities."[51] Under the Performance Standards evaluation criteria in 10A-NCAC-14C-.3803, NH does not have to meet capacity thresholds at individual facilities. The rule requires NH to meet or exceed a systemwide occupancy rate of 75.2% for its Mecklenburg facilities, the standard for an average daily census exceeding 200 acute patients. NH has shown that it meets this standard.

AH then reverses direction and contends that the Agency should consider bed need for competing systems. AH argues that "it is the system-based deficits/surpluses that determine whether or not

[50] CMC Application, p. 62.
[51] Ibid.

additional beds are needed."[52] This argument is false. The SMFP calculates aggregate bed need at the county level, and does not distinguish need attributable to providers or systems. To do so would harm competition by preventing new entrants from offering services and reinforcing the accumulation of beds by dominant market providers. Any qualified applicant can apply to meet the need. The beds are not "reserved" for any particular provider or system. NH projects a bed deficit and has identified a rational, cost-effective plan for developing these beds.

AH also dismisses the Agency's previous inclusion of other comparative factors such as Impact on Competition. The Agency consistently used this factor in its acute bed application reviews in 2018, 2019 and 2020, and it should do so in 2021. AH concludes this factor should not be applied in the 2021 review process and is "contrary to the purpose of the CON statute… and should not be applied in this manner."[53] This argument is false. AH seems to believe it is acceptable for a dominant provider to be awarded beds solely because its own facilities generated need. It is already established that any competitor can apply for beds when there is demonstrated need, regardless of which facility or system generated the need. (See previous discussion on page 4 of these comments.)

Comparative Analysis of Conforming Applications

A comparative review is required as part of the Agency findings only when the total beds ("assets") in applications found conforming with CON criteria and performance standards exceed the number the SMFP allows the Agency to approve. The Agency must then comparatively review the applications and select applications that together request assets fewer than or equal to the number the SMFP allows the Agency to approve. To fit its approvals within the SMFP's constraints, the Agency may conditionally approve a conforming application for fewer assets than requested.

The NH Presbyterian Application is conforming with CON Review Criteria and rules, and is approvable. Because they base their need arguments and utilization projections on 2021 annualized data without adjustments for COVID-19, none of the AH applications are conforming with Criterion (3) and are not approvable. For additional reasons the AH Pineville Application is non-conforming with CON Review Criteria and rules, and is not approvable. This section of the comments addresses comparative review factors other than conformity with CON Review Criteria if the Agency finds any of the AH applications are approvable.

NH recognizes the Agency has discretion to select the comparative factors in each review. We draw the Agency's attention to issues with several review factors, should the Agency decide to use them. As there are four applications, NH scores each application from 1 to 4 in order of effectiveness. When applications are equally effective, we assign each hospital an average rank score.[54]

Scope of Services

[52] Ibid.
[53] CMC Application, p. 63.
[54] For example, if the equally effective hospitals would rank 1 and 2, each receives a rank score of 1.5.

Carolinas Medical Center and NH Presbyterian each represent the flagship hospital in Mecklenburg County for their respective health systems. AH University City and AH Pineville are existing acute care hospitals that provide numerous types of medical services, but offer a lesser range of services with lower average acuity levels than patients treated at NH Presbyterian and CMC.

Scope of Services	NH PMC	AH CMC	AH Pineville	AH University
Rank	2	1	3	4

Geographic Accessibility (Distribution of Beds in Mecklenburg County)

The Agency has approved several acute care expansion projects as Mecklenburg County's population has grown and consecutive SMFP need determinations have added to the bed inventory in the county. The most recently approved projects are primarily in communities in the southern part of the county, and secondarily to communities in the northern part.

- In the southern part of Mecklenburg County, the Agency has approved new hospitals in the southern communities of Steele Creek (2), Mint Hill, and Ballantyne. The Agency has approved bed expansions in Pineville and Matthews in south Mecklenburg, and the northern community of Huntersville. Adjacent to southern Mecklenburg County the Agency has approved new hospitals in Union County and in Cabarrus County. The South Carolina CON agency and courts gave final approval to the Fort Mill hospital in York County.

- In the northern part of Mecklenburg County, the Agency approved one new hospital in Cornelius, and bed expansions in Huntersville and University City.

- Both Mecklenburg health systems have pursued a strategy of developing acute care resources outside the central city. In the downtown Charlotte market, only CMC has been approved for a sizable number of additional beds. NH will experience a decrease of licensed beds in the central city due to transferring beds to other hospitals, as summarized in the following table:

Hospital Name	Hospital Location in County	CON Bed Adjustments
AH CMC/Mercy	Central/Downtown Charlotte	87
AH Pineville	Suburban	45
AH University City	Suburban	4
AH Lake Norman	Suburban	30
AH Steele Creek	Suburban	26
NH Ballantyne	Suburban	36
NH Huntersville	Suburban	12
NH Matthews	Suburban	20
NH Mint Hill	Suburban	36
NH Presbyterian	Central/Downtown Charlotte	(22)
NH Steele Creek	Suburban	32

Source: 2022 SMFP Final Draft.

The suburban hospitals will increase accessibility, convenience and improve the patient experience for residents of these communities. However, there is a concurrent need for the growth and development of inpatient capacity at the flagship hospitals in the central city. Much of the growth in specialty services for both the NH and Atrium Health systems has been at their respective flagship campuses, NH Presbyterian and CMC. These hospitals provide highly specialized care that typically is not available at suburban community hospitals. Awarding beds to the downtown hospitals in the 2021 review cycle will improve their ability to grow clinical programs and provide care for a more resource-intensive mix of patients. The Agency has recently awarded a large number of additional beds in the suburban areas of Mecklenburg County. While those projects are implemented, the Agency should focus on meeting the needs of patients accessing the downtown flagship hospitals.

The 2022 SMFP makes 65 new acute care beds available for Mecklenburg County. Additional acute care bed need is likely in subsequent SMFP need determinations. Atrium Health will have future opportunities to request additional beds. There is no need to give AH all 123 beds now to have these beds available in 2024 through building out floors in bed towers.

The AH Pineville bed application will add acute beds in the southern part of Mecklenburg County, which has received a disproportionate amount of new and additional bed approvals in recent years. While this area is experiencing growth, allocating beds for expansion in the central region of the county represents a better alternative for access by a greater share of Mecklenburg residents. In its AH Pineville application, Atrium estimates that nearly 47% of its inpatients will come from South Carolina, with only 41% from Mecklenburg County.[55] This is lower than the other acute care applications, and 28% lower than NH Presbyterian's percentage of inpatients from Mecklenburg County. AH's proposed Pineville expansion is the least effective alternative to enhance the geographic accessibility of services for residents of Mecklenburg County.

Geographic Accessibility	**NH PMC**	**AH CMC**	**AH Pineville**	**AH University**
Rank	1.5	1.5	4	3

Competitive Balance

None of the applicants for acute care beds is a new provider in Mecklenburg County. NH has the lower percentage of existing assets in the county. Approval of the three AH applications will further diminish competition and patient choice. NH has shown that AH Pineville can accommodate its projected patient days without the approval of a CON application. Awarding all SMFP assets to AH will increase its market dominance and harm competitive balance, to the detriment of patients and payors.

The table below shows the distribution of acute care beds and how the competitive balance will change, with or without approval of NH's or the AH Pineville applications. If the AH applications are approved for

[55] AH Pineville Application, p. 38.

123 total beds, the competitive balance will still tilt to AH, but to a lesser extent than if NH Presbyterian is approved and Pineville is denied. Improving competitive balance in Mecklenburg County, or not unnecessarily worsening competitive imbalance, will maximize healthcare value by incentivizing high quality care, lowering costs, and expanding patient choice. The most effective alternative is for the Agency to deny the AH Pineville application as nonconforming and approve the NH Presbyterian application.

			NH Approved and AH Pineville Denied			***All AH Approved and NH Denied***		
	2021 Licensed and Approved Beds	***Percent of Beds***	***2021 CON Award***	***Total Beds***	***Percent of Beds***	***2021 CON Award***	***Total Beds***	***Percent of Beds***
Atrium Health	1,554	62.7%	87	1,641	63.4%	123	1,677	64.4%
Novant Health	926	37.3%	22	948	36.6%	0	926	35.6%

Source: 2022 SMFP Final Draft.

Competitive Balance	**NH PMC**	**AH CMC**	**AH Pineville**	**AH University**
Rank	1	3	3	3

Access by Underserved Groups

The Agency usually compares applicants on the payor mix percentages of Charity Care, Medicaid, and Medicare patients in the service area. The Agency has determined it is not possible to make comparisons of gross revenue by payer type because of "differences in how each applicant categorizes charity care and the differences in presentation of pro forma financial statements."[56] However, these projections for each applicants' projects are based on data provided within the applicants' submissions.

[56] 2020 Mecklenburg Acute Care Bed and OR Review, pp. 187-188.

Access by Underserved Groups - Project Year 3

	NH Presbyterian	AH CMC	AH Pineville	AH Univ City
# Of Total Charity Care Patients[57]	25,330	23,977	8,431	12,772
Charity Care Patients/Bed (Total)[58]	48.8	23.5	29.3	110.1
Charity Care % of Total Patients[59]	7.6%	2.7%	5.6%	10.0%
# Of Medicaid Patients	5,676	15,434	2,131	1,506
Medicaid Patients/Bed	10.9	15.1	7.4	13.0
Medicaid % of Total Patients	17.3%	30.7%	10.9%	18.2%
# Of Medicare Patients	11,548	16,087	10,989	3,369
Medicare Patients/Bed	22.3	15.8	38.2	29.0
Medicare % of Total Patients	35.2%	32.0%	56.2%	40.7%

Source: 2021 Acute Care Beds Applications, Section L and Form C.

NH Presbyterian compares favorably for the care of underserved groups. NH Presbyterian ranks first for total charity care patients served by the project in Year 3. NH Presbyterian ranks second for percentage of total Charity Care patients and average number of Charity Care patients per bed. NH Presbyterian also ranks second for total Medicaid patients in Year 3 of the project, and ranks second for total Medicare patients in project Year 3.

Charity Care	NH PMC	AH CMC	AH Pineville	AH University
Charity Care as % Patients	7.6%	2.7%	5.6%	10.0%
Rank	2	4	3	1

NH Presbyterian ranks third for the average number of Medicaid patients per bed and percentage of Medicaid patients, ahead of AH Pineville.

Medicaid	NH PMC	AH CMC	AH Pineville	AH University
Medicaid as % Patients	17.3%	30.7%	10.9%	18.2%
Rank	3	1	4	2

NH Presbyterian also ranks third in percent of total Medicare patients and the average number of Medicare patients per bed. Usage of particular hospitals by certain groups does not completely show the accessibility of health systems to those groups. Utilization is affected by MEDIC protocols, locations of

[57] Charity Care calculations are based on total Charity Care patients for each hospital, including all inpatient and outpatient utilization. Atrium Health did not submit figures for acute patients only, so this metric is the only directly comparable measure.
[58] Ibid.
[59] Ibid.

clinics, referral patterns of employed physicians, and patient choice. NH and AH are equally accessible by Medicare and Medicaid patients and there are no barriers to enrollees in either program using either health system.

Medicare	NH PMC	AH CMC	AH Pineville	AH University
Medicare as % Patients	35.2%	32.0%	56.2%	40.7%
Rank	3	4	1	2

Net Revenue and Net Operating Expense Comparisons

The Agency does not specify how applicants shall present revenues and costs in CON applications. AH and NH present revenue and expense data differently in their applications. NH presents the total revenue and total expense for patients served, including all direct care revenue codes/cost centers and all allocated cost for non-direct care cost centers. In its acute care bed applications, AH presents only the revenues and costs associated with the nursing unit, and omits any revenues or costs from the other direct care departments that would serve a patient. AH does not distribute the costs of non-direct care cost centers to the direct care cost centers. Because of the differences in presentation, the AH revenues and costs as presented will appear lower than the NH revenues and expenses.

The AH and NH revenues and costs in CON applications are not comparable. Until the Agency adopts standards for reporting revenues and expenses in CON applications, any comparisons must be inconclusive.

The following table summarizes comparable data for the applications and may assist with conclusions about the relative merits for each factor. The Agency has computed Historical Utilization in previous reviews by using acute care days to calculate average daily census and then dividing by only licensed beds (not approved) for the most recent SMFP reporting period. The occupancy rates in the values section below use this methodology and 2022 SMFP data.

Agency Comparative Factor	NH PMC	AH CMC	AH Pineville	AH University
Conformity with Review Criteria	Yes	No	No	No
Scope of Services	More Effective	More Effective	Less Effective	Less Effective
Geographic Accessibility	n/a	n/a	n/a	n/a
Historical Utilization	78.3%	84.4%	85.2%	77.0%
Competitive Balance (% of existing + approved beds by system)	37.3%	63.7%	63.7%	63.7%
Access by Service Area Residents	69.0%	51.3%	40.7%	74.3%
Charity Care % of Total Patients*	7.6%	2.7%	5.6%	10.0%
Medicaid % of Total Patients	17.3%	30.7%	10.9%	18.2%
Medicare % of Total Patients	35.2%	32.0%	56.2%	40.7%
Projected Avg. Net Rev/Patient	$19,774	$10,167	$4,027	$4,317
Projected Avg. Oper. Cost/Patient	$19,607	$7,991	$3,648	$4,306

Additional Comparative Factors

In addition to comparative factors used in previous Agency reviews, we are including these additional elements that may assist with evaluating the applications:

- Project Cost per Bed supports the evaluation of each project's ability to maximize healthcare value, one of the Criterion (4) objectives. NH Presbyterian will expand access to services and ensure high value by completing its proposed project at a lower relative cost than AH's projects.

Maximize Healthcare Value	NH PMC	AH CMC	AH Pineville	AH University
Project Cost per Bed	$13,153	$1,606,321	$904,861	$418,041
Rank	1	4	3	2

- Case Mix Index (CMI) provides complementary data for the Scope of Services factor. A higher CMI score reflects the more complex cases seen by a hospital and ability to treat a wider spectrum of patients with specialized care needs.

  The two downtown Charlotte hospitals serve patients with a much higher acuity level than the suburban community hospitals. AH provides data on the case mix of Medicare patients at Mecklenburg County hospitals in its AH Pineville application.[60]

  The Case Mix Index scores indicate that the two downtown Charlotte hospitals serve a higher overall level of clinically complex patients that require additional care resources. Based on this information, the Agency should approve the NH Presbyterian and CMC applications because of their unique abilities to care for more clinically complex patients.

Case Mix Index	NH PMC	AH CMC	AH Pineville	AH University
CMI[61]	2.14	2.28	1.70	1.49
Rank	2	1	3	4

- The Future Utilization estimates of Project Year 3 occupancy rates account for licensed beds and approved beds that will be operational by CY 2026, while also including shifts of licensed beds to other facilities/campuses. These calculations incorporate Agency-approved changes to bed inventory that will occur. The third project year for the CMC application is CY 2030, so it is not included in this comparison.

Future Utilization	NH PMC	AH CMC	AH Pineville	AH University
With Project Approval	89.0%	n/a	78.3%	93.7%
Rank	2	n/a	3	1

[60] AH Pineville Application, p. 66.
[61] Source: American Hospital Directory.

The following table provides a ranking of the quantitative data included in the comparative analysis factors. NH Presbyterian ranks favorably compared to other applications. It should be noted that it is not possible to directly compare NH Presbyterian's and AH's net revenue and operating expense per case, as there are significant differences in each system's reporting methodology, described in the Form F cost assumptions.[62]

Comparative Analysis Factors – Ranking Summary

Agency Comparative Factor	NH PMC	AH CMC	AH Pineville	AH University
Conformity with Review Criteria	Yes	No	No	No
Scope of Services	2	1	3	4
Geographic Accessibility	1.5	1.5	4	3
Historical Utilization	3	2	1	4
Competitive Balance (% of existing + approved beds by system)	1	3	3	3
Access by Service Area Residents	2	3	4	1
Charity Care % of Total Patients*	2	4	3	1
Medicaid % of Total Patients	3	1	4	2
Medicare % of Total Patients	3	4	1	2
Projected Avg. Net Rev/Patient	n/a	n/a	n/a	n/a
Projected Avg. Oper. Cost/Patient	n/a	n/a	n/a	n/a
Maximize Healthcare Value	1	4	3	2
Case Mix Index	2	1	3	4
Future Utilization – With Approval	2	n/a	3	1
Average Ranking Score	2.14	2.45	3.0	2.55

Conclusion

The NH Presbyterian application conforms with all review criteria. For reasons discussed above, the AH applications do not. As shown in these comments:

- AH's acute care bed application for CMC is non-conforming with CON Review Criteria (1), (3), (5), (6), and (18a), and the performance standards for acute care beds. The Agency should find it non-approvable.

- AH's acute care bed application for AH Pineville is non-conforming with CON Review Criteria (1), (3), (4), (5), (6), (12), and (18a), and the performance standards for acute care beds. The Agency should find it non-approvable.

- AH's acute care bed application for AH University City is non-conforming with CON Review Criteria (1), (3), (5), (6), and (18a), and the performance standards for acute care beds. The Agency should find it non-approvable.

[62] AH Pineville Application, Form F.2 assumptions, p. 19.

If the Agency finds all of AH's applications approvable, it should approve AH for a maximum of 101 beds so it may also approve NH's 22-bed application. Approving the NH Presbyterian application and AH's conforming applications is a more effective alternative than full approval of the AH applications and denial of the NH application.

Full approval of the AH applications or denial of the NH Presbyterian application will unnecessarily increase the competitive imbalance in Mecklenburg County. It will increase AH's already dominant market share in Mecklenburg County while impeding competition and threatening consumer choice. The most effective alternative for the Agency is to deny the AH Pineville application as nonconforming and approve the other AH applications and NH Presbyterian application. Approval of the other AH acute care bed applications will increase the competitive imbalance, but to a lesser degree. Fostering competitive balance in Mecklenburg County, or not unnecessarily worsening competitive imbalance, will maximize healthcare value by incentivizing high quality care, lowering costs, and expanding patient choice.

Exhibit 1

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH SERVICE REGULATION

ROY COOPER
GOVERNOR

MANDY COHEN, MD, MPH
SECRETARY

MARK PAYNE
DIRECTOR

April 5, 2018

Mr. Christopher Hummer, CEO
Carolinas Health Care System Pineville
10628 Park Rd
Charlotte, NC 28210

RE: Approval for Temporary Increase in Licensed Acute Care Beds

Dear Mr. Hummer:

This letter is in response to your correspondence of March 20, 2018 requesting a temporary bed increase of a total of 20 beds. Based on review of the information you submitted, the request to temporarily activate the sum total of **20 beds** is approved effective **March 20, 2018** through **May 19, 2018.**

It should be noted that this determination is based solely on the facts represented by you and that any change in the facts as represented would require further consideration by this Agency and a separate determination. Should you have questions, please do not hesitate to contact me at the above number.

Sincerely,

Azzie Y. Conley

Azzie Y. Conley, RN,

cc: Section Chief, Certificate of Need (via email)

/AYC

ACUTE AND HOME CARE LICENSURE AND CERTIFICATION SECTION
WWW.NCDHHS.GOV/DHSR
TEL 919-855-4620 • FAX 919-715-3073
LOCATION: 1205 UMSTEAD DRIVE • LINEBERGER BUILDING • RALEIGH, NC 27603
MAILING ADDRESS: 2712 MAIL SERVICE CENTER • RALEIGH, NC 27699-2712

NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Division of Health Service Regulation

ROY COOPER · Governor
MANDY COHEN, MD, MPH · Secretary
MARK PAYNE · Director

May 17, 2018

Mr. Christopher Hummer, CEO
Carolinas Health Care System Pineville
10628 Park Rd
Charlotte, NC 28210

RE: Approval for Temporary Increase in Licensed Acute Care Beds

Dear Mr. Hummer:

This letter is in response to your correspondence of May 15, 2018 requesting a temporary bed increase of a total of 20 beds. Based on review of the information you submitted, the request to temporarily activate the sum total of **20 beds** is approved effective **May 20, 2018** through **July 19, 2018.**

It should be noted that this determination is based solely on the facts represented by you and that any change in the facts as represented would require further consideration by this Agency and a separate determination. Should you have questions, please do not hesitate to contact me at the above number.

Sincerely,

Azzie Y. Conley

Azzie Y. Conley, RN,

cc: Section Chief, Certificate of Need (via email)

/AYC

NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Division of Health Service Regulation

ROY COOPER · Governor
MANDY COHEN, MD, MPH · Secretary
MARK PAYNE · Director

July 19, 2018

Mr. Christopher Hummer, CEO
Carolinas Health Care System Pineville
10628 Park Rd
Charlotte, NC 28210

RE: Approval for Temporary Increase in Licensed Acute Care Beds

Dear Mr. Hummer:

This letter is in response to your correspondence of July 17, 2018 requesting a temporary bed increase of a total of 20 beds. Based on review of the information you submitted, the request to temporarily activate the sum total of **20 beds** is approved effective **July 20, 2018** through **September 18, 2018.**

It should be noted that this determination is based solely on the facts represented by you and that any change in the facts as represented would require further consideration by this Agency and a separate determination. Should you have questions, please do not hesitate to contact me at the above number.

Sincerely,

Azzie Y. Conley

Azzie Y. Conley, RN,

cc: Section Chief, Certificate of Need (via email)

/AYC

NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Division of Health Service Regulation

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director

September 12, 2018

Mr. Christopher Hummer, CEO
Carolinas Health Care System Pineville
10628 Park Rd
Charlotte, NC 28210

RE: Approval for Temporary Increase in Licensed Acute Care Beds

Dear Mr. Hummer:

This letter is in response to your correspondence of September 12, 2018 requesting a temporary bed increase of a total of 20 beds. Based on review of the information you submitted, the request to temporarily activate the sum total of **20 beds** is approved effective **September 19, 2018** through **November 18, 2018.**

It should be noted that this determination is based solely on the facts represented by you and that any change in the facts as represented would require further consideration by this Agency and a separate determination. Should you have questions, please do not hesitate to contact me at the above number.

Sincerely,

Azzie Y. Conley

Azzie Y. Conley, RN,

cc: Section Chief, Certificate of Need (via email)

/AYC

NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Division of Health Service Regulation

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director

November 30, 2018

Mr. Christopher Hummer, CEO
Carolinas Health Care System Pineville
10628 Park Rd
Charlotte, NC 28210

RE: Approval for Temporary Increase in Licensed Acute Care Beds

Dear Mr. Hummer:

This letter is in response to your correspondence of November 21, 2018 requesting a temporary bed increase of a total of 20 beds. Based on review of the information you submitted, the request to temporarily activate the sum total of **20 beds** is approved effective **November 19, 2018** through **January 18, 2018.**

It should be noted that this determination is based solely on the facts represented by you and that any change in the facts as represented would require further consideration by this Agency and a separate determination. Should you have questions, please do not hesitate to contact me at the above number.

Sincerely,

Azzie Y. Conley

Azzie Y. Conley, RN,

cc: Section Chief, Certificate of Need (via email)

/AYC

NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Division of Health Service Regulation

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director

February 28, 2019

Mr. Christopher Hummer, CEO
Carolinas Health Care System Pineville
10628 Park Rd
Charlotte, NC 28210

RE: Approval for Temporary Increase in Licensed Acute Care Beds

Dear Mr. Hummer:

This letter is in response to your correspondence of February 13, 2019 requesting a temporary bed increase of a total of 20 beds. Based on review of the information you submitted, the request to temporarily activate the sum total of **20 beds** is approved effective **February 14, 2019** through **April 15, 2019.**

It should be noted that this determination is based solely on the facts represented by you and that any change in the facts as represented would require further consideration by this Agency and a separate determination. Should you have questions, please do not hesitate to contact me at the above number.

Sincerely,

Azzie Y. Conley

Azzie Y. Conley, RN,

cc: Section Chief, Certificate of Need (via email)

/AYC

NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Division of Health Service Regulation

ROY COOPER · Governor
MANDY COHEN, MD, MPH · Secretary
MARK PAYNE · Director

April 22, 2019

Mr. Christopher Hummer, CEO
Carolinas Health Care System Pineville
10628 Park Rd
Charlotte, NC 28210

RE: Approval for Temporary Increase in Licensed Acute Care Beds

Dear Mr. Hummer:

This letter is in response to your correspondence of April 16, 2019 requesting a temporary bed increase of a total of 20 beds. Based on review of the information you submitted, the request to temporarily activate the sum total of **20 beds** is approved effective **April 16, 2019** through **June 15, 2019.**

It should be noted that this determination is based solely on the facts represented by you and that any change in the facts as represented would require further consideration by this Agency and a separate determination. Should you have questions, please do not hesitate to contact me at the above number.

Sincerely,

Azzie Y. Conley

Azzie Y. Conley, RN,

cc: Section Chief, Certificate of Need (via email)

/AYC

NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Division of Health Service Regulation

ROY COOPER · Governor
MANDY COHEN, MD, MPH · Secretary
MARK PAYNE · Director

June 11, 2019

Mr. Christopher Hummer, CEO
Atrium Health Pineville
10628 Park Rd
Charlotte, NC 28210

RE: Approval for Temporary Increase in Licensed Acute Care Beds

Dear Mr. Hummer:

This letter is in response to your correspondence of April 16, 2019 requesting a temporary bed increase of a total of 20 beds. Based on review of the information you submitted, the request to temporarily activate the sum total of **22 beds** is approved effective **June 16, 2019** through **August 15, 2019.**

It should be noted that this determination is based solely on the facts represented by you and that any change in the facts as represented would require further consideration by this Agency and a separate determination. Should you have questions, please do not hesitate to contact me at the above number.

Sincerely,

Azzie Y. Conley

Azzie Y. Conley, RN,

cc: Section Chief, Certificate of Need (via email)

/AYC

NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Division of Health Service Regulation

ROY COOPER · Governor
MANDY COHEN, MD, MPH · Secretary
MARK PAYNE · Director

August 13, 2019

Mr. Michael J. Lutes, Senior Vice President
Atrium Health Pineville
10628 Park Rd
Charlotte, NC 28210

RE: Approval for Temporary Increase in Licensed Acute Care Beds

Dear Mr. Lutes:

This letter is in response to your correspondence of August 12, 2019 requesting a temporary bed increase of a total of 22 beds. Based on review of the information you submitted, the request to temporarily activate the sum total of **22 beds** is approved effective **August 16, 2019** through **October 15, 2019.**

It should be noted that this determination is based solely on the facts represented by you and that any change in the facts as represented would require further consideration by this Agency and a separate determination. Should you have questions, please do not hesitate to contact me at the above number.

Sincerely,

Azzie Y. Conley

Azzie Y. Conley, RN,

cc: Section Chief, Certificate of Need (via email)

/AYC

NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Division of Health Service Regulation

ROY COOPER · Governor
MANDY COHEN, MD, MPH · Secretary
MARK PAYNE · Director

October 15, 2019

Mr. Michael J. Lutes, Senior Vice President
Atrium Health Pineville
10628 Park Rd
Charlotte, NC 28210

RE: Approval for Temporary Increase in Licensed Acute Care Beds

Dear Mr. Lutes:

This letter is in response to your correspondence of August 12, 2019 requesting a temporary bed increase of a total of 22 beds. Based on review of the information you submitted, the request to temporarily activate the sum total of **22 beds** is approved effective **OCTOBER 16, 2019** through **December 15, 2019.**

It should be noted that this determination is based solely on the facts represented by you and that any change in the facts as represented would require further consideration by this Agency and a separate determination. Should you have questions, please do not hesitate to contact me at the above number.

Sincerely,

Azzie Y. Conley

Azzie Y. Conley, RN,

cc: Section Chief, Certificate of Need (via email)

/AYC

NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Division of Health Service Regulation

ROY COOPER · Governor
MANDY COHEN, MD, MPH · Secretary
MARK PAYNE · Director

December 15, 2019

Mr. Michael J. Lutes, Senior Vice President
Atrium Health Pineville
10628 Park Rd
Charlotte, NC 28210

RE: Approval for Temporary Increase in Licensed Acute Care Beds

Dear Mr. Lutes:

This letter is in response to your correspondence of **December 10, 2019** requesting a temporary bed increase of a total of 22 beds. Based on review of the information you submitted, the request to temporarily activate the sum total of **22 beds** is approved effective **December 16, 2019** through **February 14, 2020.**

It should be noted that this determination is based solely on the facts represented by you and that any change in the facts as represented would require further consideration by this Agency and a separate determination. Should you have questions, please do not hesitate to contact me at the above number.

Sincerely,

Azzie Y. Conley

Azzie Y. Conley, RN,

cc: Section Chief, Certificate of Need (via email)

/AYC

NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Division of Health Service Regulation

ROY COOPER · Governor
MANDY COHEN, MD, MPH · Secretary
MARK PAYNE · Director

February 27, 2019

Ms. Alicia R. Campbell, Vice President
Atrium Health Pineville
10628 Park Rd
Charlotte, NC 28210

RE: Approval for Temporary Increase in Licensed Acute Care Beds

Dear Ms. Campbell:

This letter is in response to your correspondence of **February 7, 2020** requesting a temporary bed increase of a total of 22 beds. Based on review of the information you submitted, the request to temporarily activate the sum total of **22 beds** is approved effective **February 15, 2020** through **April 15, 2020.**

It should be noted that this determination is based solely on the facts represented by you and that any change in the facts as represented would require further consideration by this Agency and a separate determination. Should you have questions, please do not hesitate to contact me at the above number.

Sincerely,

Azzie Y. Conley

Azzie Y. Conley, RN,

cc: Section Chief, Certificate of Need (via email)

/AYC

North Carolina Department of Health and Human Services
Division of Health Service Regulation

Pat McCrory
Governor

Aldona Z. Wos, M.D.
Ambassador (Ret.)
Secretary DHHS

Drexdal Pratt, Director

January 13, 2015

Mr. Spencer Lilly, CEO
Carolinas Medical Center
PO Box 32861
Charlotte, NC 28232

RE: Approval for Temporary Increase in Licensed Acute Care Beds

Dear Mr. Lilly:

This letter is in response to your correspondence of January 8, 2015 requesting a temporary bed increase of a total of 80 beds. Based on review of the information you submitted, the request to temporarily activate the sum total of **80 beds** is approved effective **January 11, 2015,** through **March 12, 2015.**

It should be noted that this determination is based solely on the facts represented by you and that any change in the facts as represented would require further consideration by this Agency and a separate determination. Should you have questions, please do not hesitate to contact me at the above number.

Sincerely,

Azzie Y. Conley

Azzie Y. Conley, RN,

cc: Section Chief, Certificate of Need (via email)

/AYC

North Carolina Department of Health and Human Services
Division of Health Service Regulation

Pat McCrory
Governor

Aldona Z. Wos, M.D.
Ambassador (Ret.)
Secretary DHHS

Drexdal Pratt, Director

March 9, 2015

Mr. Spencer Lilly, CEO
Carolinas Medical Center
PO Box 32861
Charlotte, NC 28232

RE: Approval for Temporary Increase in Licensed Acute Care Beds

Dear Mr. Lilly:

This letter is in response to your correspondence of March 9, 2015 requesting a temporary bed increase of a total of 80 beds. Based on review of the information you submitted, the request to temporarily activate the sum total of **80 beds** is approved effective **March 13, 2015,** through **May 12, 2015.**

It should be noted that this determination is based solely on the facts represented by you and that any change in the facts as represented would require further consideration by this Agency and a separate determination. Should you have questions, please do not hesitate to contact me at the above number.

Sincerely,

Azzie Y. Conley

Azzie Y. Conley, RN,

cc: Section Chief, Certificate of Need (via email)

/AYC

North Carolina Department of Health and Human Services
Division of Health Service Regulation

Pat McCrory
Governor

Aldona Z. Wos, M.D.
Ambassador (Ret.)
Secretary DHHS

Drexdal Pratt, Director

May 14, 2015

Mr. Spencer Lilly, CEO
Carolinas Medical Center
PO Box 32861
Charlotte, NC 28232

RE: Approval for Temporary Increase in Licensed Acute Care Beds

Dear Mr. Lilly:

This letter is in response to your correspondence of May 7, 2015 requesting a temporary bed increase of a total of 80 beds. Based on review of the information you submitted, the request to temporarily activate the sum total of **80 beds** is approved effective **May 13, 2015,** through **July 12, 2015.**

It should be noted that this determination is based solely on the facts represented by you and that any change in the facts as represented would require further consideration by this Agency and a separate determination. Should you have questions, please do not hesitate to contact me at the above number.

Sincerely,

Azzie Y. Conley

Azzie Y. Conley, RN,

cc: Section Chief, Certificate of Need (via email)

/AYC

North Carolina Department of Health and Human Services
Division of Health Service Regulation

Pat McCrory
Governor

Aldona Z. Wos, M.D.
Ambassador (Ret.)
Secretary DHHS

Drexdal Pratt, Director

July 8, 2015

Mr. Spencer Lilly, CEO
Carolinas Medical Center
PO Box 32861
Charlotte, NC 28232

RE: Approval for Temporary Increase in Licensed Acute Care Beds

Dear Mr. Lilly:

This letter is in response to your correspondence of July 7, 2015 requesting a temporary bed increase of a total of 80 beds. Based on review of the information you submitted, the request to temporarily activate the sum total of **80 beds** is approved effective **July 13, 2015,** through **September 11, 2015.**

It should be noted that this determination is based solely on the facts represented by you and that any change in the facts as represented would require further consideration by this Agency and a separate determination. Should you have questions, please do not hesitate to contact me at the above number.

Sincerely,

Azzie Y. Conley

Azzie Y. Conley, RN,

cc: Section Chief, Certificate of Need (via email)

/AYC

North Carolina Department of Health and Human Services
Division of Health Service Regulation

Pat McCrory
Governor

Aldona Z. Wos, M.D.
Ambassador (Ret.)
Secretary DHHS

Drexdal Pratt, Director

September 16, 2015

Mr. Spencer Lilly, CEO
Carolinas Medical Center
PO Box 32861
Charlotte, NC 28232

RE: Approval for Temporary Increase in Licensed Acute Care Beds

Dear Mr. Lilly:

This letter is in response to your correspondence of September 4, 2015 requesting a temporary bed increase of a total of 80 beds. Based on review of the information you submitted, the request to temporarily activate the sum total of **80 beds** is approved effective **September 12, 2015,** through **November 11, 2015.**

It should be noted that this determination is based solely on the facts represented by you and that any change in the facts as represented would require further consideration by this Agency and a separate determination. Should you have questions, please do not hesitate to contact me at the above number.

Sincerely,

Azzie Y. Conley

Azzie Y. Conley, RN,

cc: Section Chief, Certificate of Need (via email)

/AYC

North Carolina Department of Health and Human Services
Division of Health Service Regulation

Pat McCrory
Governor

Aldona Z. Wos, M.D.
Ambassador (Ret.)
Secretary DHHS

Drexdal Pratt, Director

November 20, 2015

Mr. Spencer Lilly, CEO
Carolinas Medical Center
PO Box 32861
Charlotte, NC 28232

RE: Approval for Temporary Increase in Licensed Acute Care Beds

Dear Mr. Lilly:

This letter is in response to your correspondence of November 5, 2015 requesting a temporary bed increase of a total of 80 beds. Based on review of the information you submitted, the request to temporarily activate the sum total of **80 beds** is approved effective **November 12, 2015,** through **January 11, 2016.**

It should be noted that this determination is based solely on the facts represented by you and that any change in the facts as represented would require further consideration by this Agency and a separate determination. Should you have questions, please do not hesitate to contact me at the above number.

Sincerely,

Azzie Y. Conley

Azzie Y. Conley, RN,

cc: Section Chief, Certificate of Need (via email)

/AYC

North Carolina Department of Health and Human Services
Division of Health Service Regulation

Pat McCrory
Governor

Richard O. Brajer
Secretary

Mark Payne
Assistant Secretary for Audit and
Health Service Regulation

January 8, 2016

Mr. Spencer Lilly, CEO
Carolinas Medical Center
PO Box 32861
Charlotte, NC 28232

RE: Approval for Temporary Increase in Licensed Acute Care Beds

Dear Mr. Lilly:

This letter is in response to your correspondence of January 7, 2016 requesting a temporary bed increase of a total of 80 beds. Based on review of the information you submitted, the request to temporarily activate the sum total of **80 beds** is approved effective **January 12, 2016** through **March 12, 2016**

It should be noted that this determination is based solely on the facts represented by you and that any change in the facts as represented would require further consideration by this Agency and a separate determination. Should you have questions, please do not hesitate to contact me at the above number.

Sincerely,

Azzie Y. Conley

Azzie Y. Conley, RN,

cc: Section Chief, Certificate of Need (via email)

/AYC

North Carolina Department of Health and Human Services
Division of Health Service Regulation

Pat McCrory
Governor

Richard O. Brajer
Secretary

Mark Payne
Assistant Secretary for Audit and
Health Service Regulation

February 10, 2016

Mr. Spencer Lilly, CEO
Carolinas Medical Center
PO Box 32861
Charlotte, NC 28232

RE: Approval for Temporary Increase in Licensed Acute Care Beds

Dear Mr. Lilly:

This letter is in response to your correspondence of March 4, 2016 requesting a temporary bed increase of a total of 80 beds. Based on review of the information you submitted, the request to temporarily activate the sum total of **80 beds** is approved effective **March 13, 2016** through **May 12, 2016.**

It should be noted that this determination is based solely on the facts represented by you and that any change in the facts as represented would require further consideration by this Agency and a separate determination. Should you have questions, please do not hesitate to contact me at the above number.

Sincerely,

Azzie Y. Conley

Azzie Y. Conley, RN,

cc: Section Chief, Certificate of Need (via email)

/AYC

North Carolina Department of Health and Human Services
Division of Health Service Regulation

Pat McCrory
Governor

Richard O. Brajer
Secretary

Mark Payne
Assistant Secretary for Audit and
Health Service Regulation

May 18, 2016

Mr. Spencer Lilly, CEO
Carolinas Medical Center
PO Box 32861
Charlotte, NC 28232

RE: Approval for Temporary Increase in Licensed Acute Care Beds

Dear Mr. Lilly:

This letter is in response to your correspondence of May 4, 2016 requesting a temporary bed increase of a total of 80 beds. Based on review of the information you submitted, the request to temporarily activate the sum total of **80 beds** is approved effective **May 13, 2016** through **July 12, 2016.**

It should be noted that this determination is based solely on the facts represented by you and that any change in the facts as represented would require further consideration by this Agency and a separate determination. Should you have questions, please do not hesitate to contact me at the above number.

Sincerely,

Azzie Y. Conley

Azzie Y. Conley, RN,

cc: Section Chief, Certificate of Need (via email)

/AYC

North Carolina Department of Health and Human Services
Division of Health Service Regulation

Pat McCrory
Governor

Richard O. Brajer
Secretary

Mark Payne
Assistant Secretary for Audit and
Health Service Regulation

August 2, 2016

Mr. Spencer Lilly, CEO
Carolinas Medical Center
PO Box 32861
Charlotte, NC 28232

RE: Approval for Temporary Increase in Licensed Acute Care Beds

Dear Mr. Lilly:

This letter is in response to your correspondence of July 7, 2016 requesting a temporary bed increase of a total of 80 beds. Based on review of the information you submitted, the request to temporarily activate the sum total of **80 beds** is approved effective **July 13, 2016** through **October 12, 2016.**

It should be noted that this determination is based solely on the facts represented by you and that any change in the facts as represented would require further consideration by this Agency and a separate determination. Should you have questions, please do not hesitate to contact me at the above number.

Sincerely,

Azzie Y. Conley

Azzie Y. Conley, RN,

cc: Section Chief, Certificate of Need (via email)

/AYC

North Carolina Department of Health and Human Services
Division of Health Service Regulation

Pat McCrory
Governor

Richard O. Brajer
Secretary

Mark Payne
Assistant Secretary for Audit and
Health Service Regulation

October 11, 2016

Mr. Spencer Lilly, CEO
Carolinas Medical Center
PO Box 32861
Charlotte, NC 28232

RE: Approval for Temporary Increase in Licensed Acute Care Beds

Dear Mr. Lilly:

This letter is in response to your correspondence of October 10, 2016 requesting a temporary bed increase of a total of 80 beds. Based on review of the information you submitted, the request to temporarily activate the sum total of **80 beds** is approved effective **October 13, 2016** through **December 12, 2016.**

It should be noted that this determination is based solely on the facts represented by you and that any change in the facts as represented would require further consideration by this Agency and a separate determination. Should you have questions, please do not hesitate to contact me at the above number.

Sincerely,

Azzie Y. Conley

Azzie Y. Conley, RN,

cc: Section Chief, Certificate of Need (via email)

/AYC

North Carolina Department of Health and Human Services
Division of Health Service Regulation

Pat McCrory
Governor

Richard O. Brajer
Secretary

Mark Payne
Assistant Secretary for Audit and
Health Service Regulation

December 12, 2016

Mr. Spencer Lilly, CEO
Carolinas Medical Center
PO Box 32861
Charlotte, NC 28232

RE: Approval for Temporary Increase in Licensed Acute Care Beds

Dear Mr. Lilly:

This letter is in response to your correspondence of December 12, 2016 requesting a temporary bed increase of a total of 80 beds. Based on review of the information you submitted, the request to temporarily activate the sum total of **80 beds** is approved effective **December 13, 2016** through **February 11, 2017.**

It should be noted that this determination is based solely on the facts represented by you and that any change in the facts as represented would require further consideration by this Agency and a separate determination. Should you have questions, please do not hesitate to contact me at the above number.

Sincerely,

Azzie Y. Conley

Azzie Y. Conley, RN,

cc: Section Chief, Certificate of Need (via email)

/AYC

North Carolina Department of Health and Human Services
Division of Health Service Regulation

Pat McCrory
Governor

Richard O. Brajer
Secretary

Mark Payne
Assistant Secretary for Audit and
Health Service Regulation

February 9, 2017

Mr. Spencer Lilly, CEO
Carolinas Medical Center
PO Box 32861
Charlotte, NC 28232

RE: Approval for Temporary Increase in Licensed Acute Care Beds

Dear Mr. Lilly:

This letter is in response to your correspondence of February 8, 2017 requesting a temporary bed increase of a total of 80 beds. Based on review of the information you submitted, the request to temporarily activate the sum total of **80 beds** is approved effective **February 12, 2017** through **April 13, 2017**

It should be noted that this determination is based solely on the facts represented by you and that any change in the facts as represented would require further consideration by this Agency and a separate determination. Should you have questions, please do not hesitate to contact me at the above number.

Sincerely,

Azzie Y. Conley

Azzie Y. Conley, RN,

cc: Section Chief, Certificate of Need (via email)

/AYC

North Carolina Department of Health and Human Services
Division of Health Service Regulation

Pat McCrory
Governor

Richard O. Brajer
Secretary

Mark Payne
Assistant Secretary for Audit and
Health Service Regulation

April 18, 2017

Mr. Spencer Lilly, CEO
Carolinas Medical Center
PO Box 32861
Charlotte, NC 28232

RE: Approval for Temporary Increase in Licensed Acute Care Beds

Dear Mr. Lilly:

This letter is in response to your correspondence of April 11, 2017 requesting a temporary bed increase of a total of 80 beds. Based on review of the information you submitted, the request to temporarily activate the sum total of **80 beds** is approved effective **April 14, 2017** through **June 14, 2017**

It should be noted that this determination is based solely on the facts represented by you and that any change in the facts as represented would require further consideration by this Agency and a separate determination. Should you have questions, please do not hesitate to contact me at the above number.

Sincerely,

Azzie Y. Conley

Azzie Y. Conley, RN,

cc: Section Chief, Certificate of Need (via email)

/AYC

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH SERVICE REGULATION

ROY COOPER
GOVERNOR

MANDY COHEN, MD, MPH
SECRETARY

MARK PAYNE
DIRECTOR

June 15, 2017

Mr. Spencer Lilly, CEO
Carolinas Medical Center
PO Box 32861
Charlotte, NC 28232

RE: Approval for Temporary Increase in Licensed Acute Care Beds

Dear Mr. Lilly:

This letter is in response to your correspondence of June 9, 2017 requesting a temporary bed increase of a total of 80 beds. Based on review of the information you submitted, the request to temporarily activate the sum total of **80 beds** is approved effective **June 15, 2017** through **August 14, 2017**

It should be noted that this determination is based solely on the facts represented by you and that any change in the facts as represented would require further consideration by this Agency and a separate determination. Should you have questions, please do not hesitate to contact me at the above number.

Sincerely,

Azzie Y. Conley

Azzie Y. Conley, RN,

cc: Section Chief, Certificate of Need (via email)

/AYC

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH SERVICE REGULATION

ROY COOPER
GOVERNOR

MANDY COHEN, MD, MPH
SECRETARY

MARK PAYNE
DIRECTOR

August 16, 2017

Mr. Spencer Lilly, CEO
Carolinas Medical Center
PO Box 32861
Charlotte, NC 28232

RE: Approval for Temporary Increase in Licensed Acute Care Beds

Dear Mr. Lilly:

This letter is in response to your correspondence of August 4, 2017 requesting a temporary bed increase of a total of 80 beds. Based on review of the information you submitted, the request to temporarily activate the sum total of **80 beds** is approved effective **August 15, 2017** through **October 14, 2017.**

It should be noted that this determination is based solely on the facts represented by you and that any change in the facts as represented would require further consideration by this Agency and a separate determination. Should you have questions, please do not hesitate to contact me at the above number.

Sincerely,

Azzie Y. Conley

Azzie Y. Conley, RN,

cc: Section Chief, Certificate of Need (via email)

/AYC

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH SERVICE REGULATION

ROY COOPER
GOVERNOR

MANDY COHEN, MD, MPH
SECRETARY

MARK PAYNE
DIRECTOR

October 12, 2017

Mr. Spencer Lilly, CEO
Carolinas Medical Center
PO Box 32861
Charlotte, NC 28232

RE: Approval for Temporary Increase in Licensed Acute Care Beds

Dear Mr. Lilly:

This letter is in response to your correspondence of October 9, 2017 requesting a temporary bed increase of a total of 80 beds. Based on review of the information you submitted, the request to temporarily activate the sum total of **80 beds** is approved effective **October 15, 2017** through **December 14, 2017.**

It should be noted that this determination is based solely on the facts represented by you and that any change in the facts as represented would require further consideration by this Agency and a separate determination. Should you have questions, please do not hesitate to contact me at the above number.

Sincerely,

Azzie Y. Conley

Azzie Y. Conley, RN,

cc: Section Chief, Certificate of Need (via email)

/AYC

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH SERVICE REGULATION

ROY COOPER
GOVERNOR

MANDY COHEN, MD, MPH
SECRETARY

MARK PAYNE
DIRECTOR

December 15, 2017

Mr. Spencer Lilly, CEO
Carolinas Medical Center
PO Box 32861
Charlotte, NC 28232

RE: Approval for Temporary Increase in Licensed Acute Care Beds

Dear Mr. Lilly:

This letter is in response to your correspondence of October 9, 2017 requesting a temporary bed increase of a total of 80 beds. Based on review of the information you submitted, the request to temporarily activate the sum total of **80 beds** is approved effective **December 15, 2017** through **February 13, 2017.**

It should be noted that this determination is based solely on the facts represented by you and that any change in the facts as represented would require further consideration by this Agency and a separate determination. Should you have questions, please do not hesitate to contact me at the above number.

Sincerely,

Azzie Y. Conley

Azzie Y. Conley, RN,

cc: Section Chief, Certificate of Need (via email)

/AYC

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH SERVICE REGULATION

ROY COOPER
GOVERNOR

MANDY COHEN, MD, MPH
SECRETARY

MARK PAYNE
DIRECTOR

February 19, 2018

Mr. Spencer Lilly, CEO
Carolinas Medical Center
PO Box 32861
Charlotte, NC 28232

RE: Approval for Temporary Increase in Licensed Acute Care Beds

Dear Mr. Lilly:

This letter is in response to your correspondence of October 9, 2017 requesting a temporary bed increase of a total of 80 beds. Based on review of the information you submitted, the request to temporarily activate the sum total of **80 beds** is approved effective **February 14, 2018**through **April 15, 2018.**

It should be noted that this determination is based solely on the facts represented by you and that any change in the facts as represented would require further consideration by this Agency and a separate determination. Should you have questions, please do not hesitate to contact me at the above number.

Sincerely,

Azzie Y. Conley

Azzie Y. Conley, RN,

cc: Section Chief, Certificate of Need (via email)

/AYC

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH SERVICE REGULATION

ROY COOPER
GOVERNOR

MANDY COHEN, MD, MPH
SECRETARY

MARK PAYNE
DIRECTOR

April 19, 2018

Mr. Christopher Bowe, CEO
Carolinas Medical Center
PO Box 32861
Charlotte, NC 28232

RE: Approval for Temporary Increase in Licensed Acute Care Beds

Dear Mr. Bowe:

This letter is in response to your correspondence of April 12, 2018 requesting a temporary bed increase of a total of 80 beds. Based on review of the information you submitted, the request to temporarily activate the sum total of **80 beds** is approved effective **April 16, 2018** through **June 15, 2018.**

It should be noted that this determination is based solely on the facts represented by you and that any change in the facts as represented would require further consideration by this Agency and a separate determination. Should you have questions, please do not hesitate to contact me at the above number.

Sincerely,

Azzie Y. Conley

Azzie Y. Conley, RN,

cc: Section Chief, Certificate of Need (via email)

/AYC

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH SERVICE REGULATION

ROY COOPER
GOVERNOR

MANDY COHEN, MD, MPH
SECRETARY

MARK PAYNE
DIRECTOR

June 19, 2018

Mr. Christopher Bowe, CEO
Carolinas Medical Center
PO Box 32861
Charlotte, NC 28232

RE: Approval for Temporary Increase in Licensed Acute Care Beds

Dear Mr. Bowe:

This letter is in response to your correspondence of June 15, 2018 requesting a temporary bed increase of a total of 80 beds. Based on review of the information you submitted, the request to temporarily activate the sum total of **80 beds** is approved effective **June 16, 2018** through **August 15, 2018.**

It should be noted that this determination is based solely on the facts represented by you and that any change in the facts as represented would require further consideration by this Agency and a separate determination. Should you have questions, please do not hesitate to contact me at the above number.

Sincerely,

Azzie Y. Conley

Azzie Y. Conley, RN,

cc: Section Chief, Certificate of Need (via email)

/AYC

NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Division of Health Service Regulation

ROY COOPER · Governor
MANDY COHEN, MD, MPH · Secretary
MARK PAYNE · Director

August 30, 2018

Mr. Christopher Bowe, CEO
Carolinas Medical Center
PO Box 32861
Charlotte, NC 28232

RE: Approval for Temporary Increase in Licensed Acute Care Beds

Dear Mr. Bowe:

This letter is in response to your correspondence of August 28, 2018 requesting a temporary bed increase of a total of 80 beds. Based on review of the information you submitted, the request to temporarily activate the sum total of **80 beds** is approved effective **August 16, 2018** through **October 15, 2018.**

It should be noted that this determination is based solely on the facts represented by you and that any change in the facts as represented would require further consideration by this Agency and a separate determination. Should you have questions, please do not hesitate to contact me at the above number.

Sincerely,

Azzie Y. Conley

Azzie Y. Conley, RN,

cc: Section Chief, Certificate of Need (via email)

/AYC

NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Division of Health Service Regulation

ROY COOPER · Governor
MANDY COHEN, MD, MPH · Secretary
MARK PAYNE · Director

October 10, 2018

Mr. Christopher Bowe, CEO
Carolinas Medical Center
PO Box 32861
Charlotte, NC 28232

RE: Approval for Temporary Increase in Licensed Acute Care Beds

Dear Mr. Bowe:

This letter is in response to your correspondence of August 28, 2018 requesting a temporary bed increase of a total of 80 beds. Based on review of the information you submitted, the request to temporarily activate the sum total of **80 beds** is approved effective **October 16, 2018** through **December 15, 2018.**

It should be noted that this determination is based solely on the facts represented by you and that any change in the facts as represented would require further consideration by this Agency and a separate determination. Should you have questions, please do not hesitate to contact me at the above number.

Sincerely,

Azzie Y. Conley

Azzie Y. Conley, RN,

cc: Section Chief, Certificate of Need (via email)

/AYC

NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Division of Health Service Regulation

ROY COOPER · Governor
MANDY COHEN, MD, MPH · Secretary
MARK PAYNE · Director

December 11, 2018

Mr. Christopher Bowe, CEO
Carolinas Medical Center
PO Box 32861
Charlotte, NC 28232

RE: Approval for Temporary Increase in Licensed Acute Care Beds

Dear Mr. Bowe:

This letter is in response to your correspondence of December 9, 2018 requesting a temporary bed increase of a total of 80 beds. Based on review of the information you submitted, the request to temporarily activate the sum total of **80 beds** is approved effective **December 16, 2018** through **February 13, 2018.**

It should be noted that this determination is based solely on the facts represented by you and that any change in the facts as represented would require further consideration by this Agency and a separate determination. Should you have questions, please do not hesitate to contact me at the above number.

Sincerely,

Azzie Y. Conley

Azzie Y. Conley, RN,

cc: Section Chief, Certificate of Need (via email)

/AYC

NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Division of Health Service Regulation

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director

February 11, 2019

Mr. Christopher Bowe, CEO
Carolinas Medical Center
PO Box 32861
Charlotte, NC 28232

RE: Approval for Temporary Increase in Licensed Acute Care Beds

Dear Mr. Bowe:

This letter is in response to your correspondence of February 6, 2019 requesting a temporary bed increase of a total of 80 beds. Based on review of the information you submitted, the request to temporarily activate the sum total of **80 beds** is approved effective **February 14, 2019** through **April 15, 2019.**

It should be noted that this determination is based solely on the facts represented by you and that any change in the facts as represented would require further consideration by this Agency and a separate determination. Should you have questions, please do not hesitate to contact me at the above number.

Sincerely,

Azzie Y. Conley

Azzie Y. Conley, RN,

cc: Section Chief, Certificate of Need (via email)

/AYC

NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Division of Health Service Regulation

ROY COOPER · Governor
MANDY COHEN, MD, MPH · Secretary
MARK PAYNE · Director

April 17, 2019

Mr. Christopher Bowe, CEO
Carolinas Medical Center
PO Box 32861
Charlotte, NC 28232

RE: Approval for Temporary Increase in Licensed Acute Care Beds

Dear Mr. Bowe:

This letter is in response to your correspondence of April 1, 2019 requesting a temporary bed increase of a total of 80 beds. Based on review of the information you submitted, the request to temporarily activate the sum total of **80 beds** is approved effective **April 16, 2019** through **June 15, 2019.**

It should be noted that this determination is based solely on the facts represented by you and that any change in the facts as represented would require further consideration by this Agency and a separate determination. Should you have questions, please do not hesitate to contact me at the above number.

Sincerely,

Azzie Y. Conley

Azzie Y. Conley, RN,

cc: Section Chief, Certificate of Need (via email)

/AYC

NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Division of Health Service Regulation

ROY COOPER · Governor
MANDY COHEN, MD, MPH · Secretary
MARK PAYNE · Director

June 11, 2019

Mr. Christopher Bowe, CEO
Carolinas Medical Center
PO Box 32861
Charlotte, NC 28232

RE: Approval for Temporary Increase in Licensed Acute Care Beds

Dear Mr. Bowe:

This letter is in response to your correspondence of June 11, 2019 requesting a temporary bed increase of a total of 80 beds. Based on review of the information you submitted, the request to temporarily activate the sum total of **80 beds** is approved effective **June 16, 2019** through **August 15, 2019.**

It should be noted that this determination is based solely on the facts represented by you and that any change in the facts as represented would require further consideration by this Agency and a separate determination. Should you have questions, please do not hesitate to contact me at the above number.

Sincerely,

Azzie Y. Conley

Azzie Y. Conley, RN,

cc: Section Chief, Certificate of Need (via email)

/AYC

NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Division of Health Service Regulation

ROY COOPER · Governor
MANDY COHEN, MD, MPH · Secretary
MARK PAYNE · Director

August 13, 2019

Mr. Christopher Bowe, CEO
Carolinas Medical Center
PO Box 32861
Charlotte, NC 28232

RE: Approval for Temporary Increase in Licensed Acute Care Beds

Dear Mr. Bowe:

This letter is in response to your correspondence of August 12, 2019 requesting a temporary bed increase of a total of 80 beds. Based on review of the information you submitted, the request to temporarily activate the sum total of **80 beds** is approved effective **August 16, 2019** through **October 15, 2019.**

It should be noted that this determination is based solely on the facts represented by you and that any change in the facts as represented would require further consideration by this Agency and a separate determination. Should you have questions, please do not hesitate to contact me at the above number.

Sincerely,

Azzie Y. Conley

Azzie Y. Conley, RN,

cc: Section Chief, Certificate of Need (via email)

/AYC

NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Division of Health Service Regulation

ROY COOPER · Governor
MANDY COHEN, MD, MPH · Secretary
MARK PAYNE · Director

October 14, 2019

Mr. Christopher Bowe, CEO
Carolinas Medical Center
PO Box 32861
Charlotte, NC 28232

RE: Approval for Temporary Increase in Licensed Acute Care Beds

Dear Mr. Bowe:

This letter is in response to your correspondence of October 7, 2019 requesting a temporary bed increase of a total of 80 beds. Based on review of the information you submitted, the request to temporarily activate the sum total of **80 beds** is approved effective **October 16, 2019** through **December 15, 2019.**

It should be noted that this determination is based solely on the facts represented by you and that any change in the facts as represented would require further consideration by this Agency and a separate determination. Should you have questions, please do not hesitate to contact me at the above number.

Sincerely,

Azzie Y. Conley

Azzie Y. Conley, RN,

cc: Section Chief, Certificate of Need (via email)

/AYC

NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Division of Health Service Regulation

ROY COOPER · Governor
MANDY COHEN, MD, MPH · Secretary
MARK PAYNE · Director

January 24, 2020

Mr. Christopher Bowe, CEO
Carolinas Medical Center
PO Box 32861
Charlotte, NC 28232

RE: Approval for Temporary Increase in Licensed Acute Care Beds

Dear Mr. Bowe:

This letter is in response to your correspondence of December 5, 2019 requesting a temporary bed increase of a total of 80 beds. Based on review of the information you submitted, the request to temporarily activate the sum total of **80 beds** is approved effective **December 16, 2019** through **February 14, 2020.**

It should be noted that this determination is based solely on the facts represented by you and that any change in the facts as represented would require further consideration by this Agency and a separate determination. Should you have questions, please do not hesitate to contact me at the above number.

Sincerely,

Azzie Y. Conley

Azzie Y. Conley, RN,

cc: Section Chief, Certificate of Need (via email)

/AYC

NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Division of Health Service Regulation

ROY COOPER · Governor
MANDY COHEN, MD, MPH · Secretary
MARK PAYNE · Director

February 28, 2020

Mr. Christopher Bowe, CEO
Carolinas Medical Center
PO Box 32861
Charlotte, NC 28232

RE: Approval for Temporary Increase in Licensed Acute Care Beds

Dear Mr. Bowe:

This letter is in response to your correspondence of February 17, 2020 requesting a temporary bed increase of a total of 80 beds. Based on review of the information you submitted, the request to temporarily activate the sum total of **80 beds** is approved effective **February 15, 2020** through **April 15, 2020.**

It should be noted that this determination is based solely on the facts represented by you and that any change in the facts as represented would require further consideration by this Agency and a separate determination. Should you have questions, please do not hesitate to contact me at the above number.

Sincerely,

Azzie Y. Conley

Azzie Y. Conley, RN,

cc: Section Chief, Certificate of Need (via email)

/AYC

Exhibit 2

NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Division of Health Service Regulation

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director

MEMORANDUM

TO: North Carolina Hospital CEOs

FROM: Mark Payne

DATE: March 12, 2020

RE: Requests for Temporary Waiver of 10A NCAC 13B.3111 to Provide Services to Patients That May Be Stricken by COVID-19

On Tuesday, March 10th, Governor Cooper issued an Executive Order declaring a State of Emergency to coordinate response to the spread of COVID-19. Pursuant to his Executive Order and General Statute 131E-84, the North Carolina Emergency Management Director, Mike Sprayberry, and Department of Health and Human Services (DHHS) Secretary Dr. Mandy Cohen have directed the Division of Health Service Regulation (DHSR) to temporarily waive certain hospital rules approved by the North Carolina Medical Care Commission to the extent necessary to allow the hospital to provide temporary shelter and temporary services to adequately care for patients that may be stricken by COVID-19.

At this time, DHSR will waive the limitations found in 10A NCAC 13B.3111 (for example, the limitation on increasing beds to 10% above licensed bed capacity when census exceeds 90%, the limitation on utilization of observation beds only, and the limitation for a period not greater than 60 consecutive days) to the extent necessary to allow a hospital to provide temporary services to adequately care for patients that may be stricken by COVID-19 based on the following parameters:

1. A hospital may temporarily increase its acute care bed capacity over its licensed bed capacity and temporarily relocate existing licensed acute care beds into physical space that meets federal life safety requirements, unless any of those requirements are waived by the Centers for Medicare and Medicaid Services (CMS) for inpatients, for the purposes of accommodating patients:
    a. receiving treatment for COVID-19;
    b. awaiting results of testing for COVID-19; or
    c. relocated to accommodate other patients treated for COVID-19 elsewhere in the facility or community;

    for the period of consecutive days specified in the approval of the DHSR. Such physical space may include clinical or non-clinical space within the hospital facility, including space used for other categories of licensed beds, or in other facilities or space operated as a campus of the hospital.

2. DHSR may approve a temporary increase in licensed bed capacity or temporary relocation of inpatient beds if:
    a. the hospital has submitted such request in writing, including, but not limited to, the number of additional beds, description of the physical space to be utilized and how it will be utilized, and the anticipated duration;
    b. DHSR has determined that the request has met the requirements of paragraph 1 above; and
    c. the hospital administrator provides an explanation and certifies that:
        i. the increase in bed capacity is necessary for public health and safety in the geographic area served;
        ii. physical facilities to be used are adequate to safeguard the health and safety of patients and will be operated in accordance with CMS hospital conditions of participation and any applicable temporary CMS requirements for inpatient care; and
        iii. all hospital patients will receive appropriate care and their health and safety safeguarded.

This approval will be revoked if DHSR determines that these conditions are not met or safeguards are not adequate to safeguard the health and safety of patients.

A hospital may address its request to temporarily increase its acute care bed capacity to adequately care for patients that may be stricken by COVID-19 to DHSR's Acute and Home Care Licensure and Certification Section Chief, Azzie Conley, via email (azzie.conley@dhhs.nc.gov).

Cc: NC Hospital Director of Facility Plant Engineering

Exhibit 3

Table 5A: Acute Care Bed Need Projections

A	B	C	D	E	F	G	H	I	J	K	L
Service Area	License Number	Facility Name	Licensed Acute Care Beds	Adjustments for CONs/ Previous Need	Inpatient Days of Care	County Growth Rate Multiplier	Projected Days of Care	2024 Projected Average Daily Census (ADC)	2024 Beds Adjusted for Target Occupancy	Projected 2024 Deficit or Surplus (surplus shows as a "-")	2024 Need Determination
		Community Health Systems Total	225	0	20,877		21,432	59	88	-137.0	
Iredell	H0164	Iredell Memorial Hospital	199	0	35,651	1.0066	36,599	100	140	-58.7	
Iredell Total			**424**	**0**							**0**
Jackson	H0087	Harris Regional Hospital	86	0	13,030	1.0066	13,378	37	55	-31.1	
Jackson Total			**86**	**0**							**0**
Johnston	H0151	Johnston Health	179	0	35,545	1.0174	38,078	104	146	-33.0	
Johnston Total			**179**	**0**							**0**
Lee	H0243	Central Carolina Hospital	127	0	13,514	-1.0347	13,514	37	55	-71.5	
Lee Total			**127**	**0**							**0**
Lenoir	H0043	UNC Lenoir Health Care	182	0	22,930	-1.0109	22,930	63	94	-87.8	
Lenoir Total			**182**	**0**							**0**
Lincoln	H0225	Atrium Health Lincoln	101	0	19,208	1.0328	21,858	60	90	-11.2	
Lincoln Total			**101**	**0**							**0**
Macon	H0034	Angel Medical Center	59	-29	5,166	-1.0066	5,166	14	21	-8.8	
Macon	H0193	Highlands-Cashiers Hospital	24	0	2,008	-1.0066	2,008	5	8	-15.8	
Macon Total			**83**	**-29**							**0**
Martin	H0078	Martin General Hospital	49	0	4,467	1.0406	5,237	14	22	-27.5	
Martin Total			**49**	**0**							**0**
McDowell	H0097	Mission Hospital McDowell	65	0	7,370	1.0046	7,505	21	31	-34.2	
McDowell Total			**65**	**0**							**0**
Mecklenburg		2021 Acute Care Bed Need Determination	0	123	0	1.0331	0	0	0	-123.0	
Mecklenburg		Atrium Health Lake Norman	0	30	0	1.0331	0	0	0	-30.0	
Mecklenburg	H0042	Atrium Health Pineville	233	45	72,498	1.0331	82,570	226	301	22.7	
Mecklenburg	H0255	Atrium Health University City	100	4	28,116	1.0331	32,023	88	132	27.5	
Mecklenburg	H0071	Carolinas Medical Center/Center for Mental Health	1,055	87	325,164	1.0331	370,341	1,014	1,298	155.8	
		Atrium Health Total	1,388	166	425,778		484,934	1,328	1,730	176.0	
Mecklenburg		Novant Health Ballantyne Medical Center	0	36	0	1.0331	0	0	0	-36.0	
Mecklenburg	H0282	Novant Health Huntersville Medical Center	139	12	27,955	1.0331	31,839	87	131	-20.2	
Mecklenburg	H0270	Novant Health Matthews Medical Center	154	20	41,291	1.0331	47,028	129	180	6.3	
Mecklenburg	H0290	Novant Health Mint Hill Medical Center†††	36	0	7,530	1.0331	8,576	23	35	-0.8	
Mecklenburg	H0010	Novant Health Presbyterian Medical Center	519	-22	148,333	1.0331	168,942	463	592	95.0	
Mecklenburg		Novant Health Steele Creek Medical Center	0	32	0	1.0331	0	0	0	-32.0	

Exhibit 4

Novant Health's Response to Written Comments Submitted by Atrium Health

Regarding

CON Application #F-011624-18

Add 12 acute care beds and one operating room pursuant to the 2018 SMFP need determination and change of scope for Project I.D. #F-11110-15 (add 48 beds and 1 OR) for a total of 151 acute care beds and 8 ORs

DECEMBER 17, 2018

Novant Health, Inc. and The Presbyterian Hospital d/b/a Novant Health Huntersville Medical Center (collectively, "Novant Health") file this response to the Written Comments filed on December 3, 2018 by Atrium Health (hereafter "the Atrium Comments"). On October 15, 2018, Novant Health filed a CON application (the "Application") to add 12 acute care beds and one operating room at Novant Health Huntersville Medical Center ("NHHMC") under the 2018 State Medical Facilities Plan ("SMFP") need determination. The Application was a scope change for the approved project #F-11110-15 (add 48 beds and 1 OR) at NHHMC.

As part of this response, Novant Health prepared a Revised Section Q, Form C (Attachment A) that accounts for Atrium criticisms of data and calculations in the Application. In this response we explain why many of Atrium's criticisms are not valid. When we determined there was an error in the Application, it is corrected in Attachment A. The Attachment is not offered as an amendment to the application and the Agency should not view it as such. The Attachment is offered solely as a response to comments to show that Atrium's criticisms, individually and cumulatively, are not material. Taking them into account, the Application conforms to all CON Review Criteria and Policies.

General Comments

Atrium's comments begin with an eye-opening table that shows the great disparity in the number of beds licensed by the only two health systems in Mecklenburg County. See Atrium Comments, page 2. This table, entitled "Mecklenburg County Acute Care Beds" shows that currently Atrium has 1,316 acute care beds and Novant has 862 acute care beds, a difference of 454 beds. This difference is greater than the total acute care bed inventory of most North Carolina hospitals, including several tertiary level hospitals, such as:

- Duke Regional (316 acute care beds)
- CaroMont Regional Medical Center (372 acute care beds)
- High Point Regional Health (307 acute care beds)
- FirstHealth Moore Regional Hospital (325 acute care beds)
- Rex Hospital (433 acute care beds)[1]

By proposing to add 50 more beds to its Pineville facility, which received a CON to add 15 beds in June 2018, Atrium is asking the Agency to widen the disparity even more. This disparity ultimately hurts the residents of Mecklenburg County and surrounding areas by concentrating

[1] Source: 2018 SMFP, Table 5A, Column D.

market power in Atrium. With so many beds under its control, Atrium is able to extract higher prices from payors, which results in higher insurance premiums for patients. The United States Department of Justice Antitrust Division and the State of North Carolina have been working for years to contain Atrium's market power and recently announced a settlement with Atrium. Awarding more beds and ORs to the Atrium system only undermines their work and hurts the very people the CON law is intended to protect.

Atrium's desire to squelch competition and claim every available asset for itself stands in contrast to Novant Health's measured proposal to add 12 of the 50 available acute care beds and one of the six available ORs to meet the growing needs of patients in northern Mecklenburg County.

The Atrium Comments allege Novant Health's total days have declined in each of the last four years while Atrium's total days have increased. See Atrium Comments, pages 2-3. However, Atrium defined "the last four years" as the FFY ending September 30, 2016. Atrium erroneously omits two of the last four years, despite having publicly available LRA data for FY 2017 for all facilities, 2018 data for Novant Health facilities in the Application, and its own internal data for 2018. The picture the 2015 – 2018 data presents is quite different. By contrast, Atrium gives its Pineville hospital the benefit of more current data which extends to CY 2018. See Table on page 3 of Atrium Comments entitled "CHS Pineville Acute Care Bed Utilization Assuming 50 Proposed Beds." Atrium's attempt to compare the Novant system against Atrium Pineville is neither fair nor accurate.

By focusing on a time period that goes back six years, Atrium does not reflect the effects of investments Novant Health made in physicians and facilities in Mecklenburg County beginning in 2015. These investments are only beginning to be reflected in the data. From CY 2017 to CY 2018, Novant Health's total days at its Mecklenburg facilities increased 4 percent and total days at NHHMC increased 10 percent.

Acute Care Days	CY 2015	CY 2016	CY 2017	2018 Annualized	2017 to 2018 % Growth
NHPMC	128,953	128,356	126,319	130,817	3.6%
NHMMC	36,771	36,401	36,688	38,484	4.9%
NHHMC	23,273	21,165	23,312	25,634	10.0%
Subtotal	317,950	314,278	312,638	325,752	4.2%

Source: Trendstar. Jan – July 2018 Annualized

Growth rates for all Novant Health hospitals will be higher and growth rates all Atrium hospitals in Mecklenburg County and surrounding counties will be lower in future years due to:

1. Reductions in Atrium's ability to abuse its market power in contracts with health plans due to the settlement agreement with the Department of Justice and the State of North Carolina.

2. Novant Health's increased investments beginning in 2015 in primary care practitioners and facilities to balance Atrium's earlier acquisition of physician practices.

3. Exit of many physicians from Atrium employment agreements to join Novant Health Medical Group or to form independent practices able to admit patients to Novant Health facilities.

4. The opening in October 2018 of Novant Health Mint Hill Medical Center (NHMHMC).

Atrium's growth rates and market share in Mecklenburg County will be lower in future years due to these factors, while Novant Health's growth rates and market share will be higher. This continues a trend shown in the tables below that began in 2015 that is not reflected in the 2018 SMFP or the tables in the Atrium Comments.

Inpatient Days for Mecklenburg County Residents

	Mecklenburg County Residents				
System	**2015**	**2016**	**2017**	**2018Q1**	**2018 Annualized**
Atrium	229,965	240,655	248,940	63,492	253,968
Novant	135,486	133,090	132,491	36,559	146,236
Other	11,855	13,266	13,690	3,649	14,596
Total	377,306	387,011	395,121	103,700	414,800
Atrium Growth Rate		4.6%	3.4%		2.0%
Novant Health Growth Rate		-1.8%	-0.5%		10.4%

*Source: Truven CY Discharge Data *Based on Annualized 2018Q1 Data. Excludes Normal Newborns and Non-Acute Neonates. Excludes LTACH, Rehab, and Behavioral Health Hospitals*

This trend is due in part to the significant investments Novant Health has made in the Charlotte market in recent years to recruit physicians and advanced nurse practitioners (ANPs) shown in the table below. The number of physicians and ANPs Novant Health employs in the Charlotte market has nearly doubled since 2014, with most of the increase after 2016. The impact of these practitioners on utilization of Novant Health hospitals and surgical facilities will increase in future years. Novant Health plans further increases in the number of employed physicians.

Addition of Providers to Novant Health Medical Staff in the Charlotte Market

Specialty	2014 Baseline	2015 Additions	2016 Additions	2017 Additions	2018 Projected Additions	Total Added 2015-2018
Primary Care	233	28	26	16	23	93
OB/GYN	-	69 (baseline)	20	3	18	41
Pediatrics	62	22	10	15	53	100
Orthopedics	34	0	4	8	8	20
Neurosciences	33	0	0	23	11	34
Cardiology	49	6	9	17	5	37
Oncology	6	1	4	10	24	39
Behavioral Health	21	-2	26	13	9	46
Total	**438**	**55**	**99**	**105**	**151**	**410**

Source: Novant Health Medical Group internal data.

This expansion of the Novant Health employed medical staff has been complemented by development of the new clinics and urgent care centers shown in the table below.

Besides outpatient facilities, NHMHMC opened in October 2018. The hospital is in zip code 28215 and the service area consists of four additional zip codes. Besides shifting existing Novant Health patients to the new facility, Novant Health projected in the application gaining 15 percentage points of market share in zip code 28215 and gaining 10 percentage points of market share in the other service area zip codes. Novant Health continues to see the market share gains as reasonable. The gains will come primarily from Atrium University and Atrium CMC/Mercy. This equals a reduction in Atrium's annual patient days of 3,010 in 2021, NHMHMC's third year of operation.[2]

[2] Project I.D. # F-7648-06 Exhibit 20 Table 67 shows the expected impact on Atrium hospitals was 4,210 patient days in project year three. NHMHMC opened in October 2018 with 36 beds, therefore we reduced this impact by 28.3%, or 1,191 days to 3,010.

New and Expanded Novant Health Outpatient Facilities in the Charlotte Market

Type Facility	Town or Area	Year Opened or Expanded
Pediatrics	Waxhaw	2015
Pediatrics	Arboretum	2015
Urgent Care & Physical Therapy	Midtown/Center City	2016
Primary Care/Midwifery	Langtree	2016
Cancer	Ballantyne	2016
Urgent Care	Quail Corners	2016
Primary Care/Pediatrics	Mint Hill	2016
Orthopedics	Ballantyne	2016
Physical Therapy/EXOS	Huntersville	2016
Neurosurgery	Center City	2016
Pulmonary	Huntersville	2017
Primary Care	Cornelius	2017
Primary Care	South Boulevard	2017
Pediatrics/OB-GYN	South Boulevard	2017
Spine Specialists/Neurology/Pediatrics	Huntersville	2018
Urgent Care & Pulmonary	Harrisburg	2018
Rehab & EXOS	Arboretum	2018
Primary Care	University	2018
Primary Care/HVI	Steele Creek	2018
Primary Care/Urgent Care/OB-GYN/Orthopedics/Physical Therapy	Denver	2018
Psychiatry	Concord	2018
Urgent Care	Huntersville	2018
Pediatrics	Plaza Midwood	2018
Primary Care & Endocrinology	Carmel Road	2018
Primary Care & OB-GYN	Concord	2018
Primary Care/OB-GYN/Pediatrics	Wesley Chapel	2018
Pediatrics	SouthPark	2018
Pediatrics	Highland Creek	2018

Two other factors will reduce Atrium's growth rates and market share in Mecklenburg and Union Counties: (1) litigation to reduce Atrium's abuse of its market power; and, (2) dissatisfied physicians leaving Atrium.

The U.S. Department of Justice and State of North Carolina Settlement Agreement, Attachment C to this response, should reduce Atrium's ability to abuse its market power in contracts with health plans. Atrium used its market power to restrict health insurers from encouraging consumers to choose non-Atrium providers in the Charlotte market that offer better value. The provider offering better value would likely be Novant Health. With this settlement agreement, health insurers can include both Atrium and Novant Health in their networks and can inform their insureds which system provides the better value based on price or outcomes. Novant Health expects allowing health insurers to steer patients to the higher value provider will decrease Atrium's growth rates and market share. Two class action suits are pending against Atrium whose outcomes may increase Novant Health's ability to compete in the Charlotte market.[3] Atrium's historical practice of forcing patients to stay within its system (a practice which has obviously helped its utilization) has been seriously threatened. Therefore, the overly-optimistic growth rates in the Atrium Applications premised on its past bad conduct are not reasonable.

Physicians by Specialty Moving from Atrium Medical Group to Novant Health Medical Group in Last Twelve Months

Specialty	Number
Dermatology	2
Hematology	1
Internal Medicine	2
Neurosurgery	2
Oncology	1
Orthopedics	1
Pediatrics	29
Rheumatology	3
OB/GYN	3
Total	**44**

Source: Novant Health Medical Group internal data.

The Atrium Medical Group has lost many physicians in the last twelve months. Forty-two physicians and two mid-level providers left the Atrium Medical Group to join the Novant Health Medical Group. The table above shows the distribution of these physicians by specialty.

Charlotte-area physicians are also leaving the Atrium Medical Group to form independent practice groups. In July 2018, a group of 88 physicians in the Mecklenburg Medical Group left to form Tryon Medical Partners and open eight offices around the county. Atrium acquired the

[3] *Benitez v. The Charlotte-Mecklenburg Hospital Authority*, 3:2018cv00095 (WDNC); *DiCesare v. The Charlotte-Mecklenburg Hospital Authority*, 16cvs16404 (Mecklenburg County Superior Court).

Mecklenburg Medical Group in 1993.[4] Other physicians have also chosen to leave Atrium Medical Group for independent practice.[5] These physicians can now practice at Novant Health facilities and Atrium facilities. While the Novant Health Medical Group has normal physician turnover, it has not experienced similar mass departures.

In summary, actions by Novant Health, actions by the U.S. Department of Justice and the North Carolina Attorney General and actions by 100 – 200 Charlotte physicians formerly with Atrium Medical Group will reduce the growth rate and market share of Atrium hospitals and other surgical facilities in Mecklenburg and Union Counties. Assuming a continuation of current or past growth rates is not a reasonable assumption.

Based on these factors and Novant Health's increasing growth rates and increasing market share, the growth rates in the Application are reasonable.

On page 3 of the Atrium Comments, Atrium states, "assuming NHHMC's bed inventory increased by its previously approved 48 beds and the proposed 12 beds, its occupancy rate in the last three years would never have exceeded its historical target occupancy rate of 66.7 percent as defined in the performance standards for acute care beds." This comment is erroneous for at least four reasons: (1) the 48 previously approved beds and the 12 beds proposed in the current application were not licensed and in service at NHHMC "in the last three years" so the denominator Atrium is using is wrong; (2) NHHMC is not required to demonstrate that it was at target occupancy "in the last three years;" (3) for multi-hospital systems, of which NHHMC is a part, target occupancy under 10A NCAC 14C. 3803 is evaluated against the total number of the applicant's licensed acute care beds in the service area, not at the individual hospital level; and (4) target occupancy is a forward-looking concept; target occupancy is not evaluated on "the last three years" or any number of years in the past. The language of 10A NCAC 14C.3803 is produced below:

> *10A NCAC 14C .3803 PERFORMANCE STANDARDS*
>
> *(a) An applicant proposing to develop new acute care beds shall demonstrate that the projected average daily census (ADC) of the total number of licensed acute care beds proposed to be licensed within the service area, under common ownership with the applicant, divided by the total number of those licensed acute care beds is reasonably projected to be at least 66.7 percent when the projected ADC is less than 100 patients, 71.4 percent when the projected ADC is 100 to 200 patients, and 75.2 percent when the projected ADC is greater than 200 patients, in the third operating year following completion of the proposed project or in the year for*

[4] Atrium will release Mecklenburg Medical Group from contract. Charlotte Business Journal. April 25, 2018. Available at https://www.bizjournals.com/charlotte/news/2018/04/25/atrium-health-will-release-mecklenburg-medical.html

[5] As nearly 100 doctors abandon Atrium, some experts see the start of a trend. The Charlotte Observer. May 25, 2018. Available at https://www.charlotteobserver.com/latest-news/article211322954.html

which the need determination is identified in the State Medical Facilities Plan, whichever is later.

(b) An applicant proposing to develop new acute care beds shall provide all assumptions and data used to develop the projections required in this rule and demonstrate that they support the projected inpatient utilization and average daily census.

Based on its erroneous understanding of target occupancy, Atrium then presents an erroneous table at the top of page 4 of its comments. This table, entitled "NHHMC Acute Care Bed Utilization Assuming Approved and Proposed Beds" calculates occupancy at NHHMC using actual historical utilization 2015 - 2018, but using the wrong number of beds. Atrium's table uses 151 beds which were not yet licensed, or even built, in those years. When the table is corrected with the *actual* licensed beds, NHHMC occupancy rates are rapidly increasing and are well above 66.7 percent.

NHHMC Acute Care Bed Utilization

	CY16 per CON	***CY17 per CON***	***CY18 per CON***
NHHMC Days	21,165	23,312	25,634
ADC	58	64	70
Licensed Beds	91	91	91
Occupancy	63.7%	70.2%	77.2%

Source: Atrium Comments, Page 4. Licensed Acute Care Beds from NHHMC 2018 LRA.

On page four of its comments, Atrium invites the Agency to conclude that based on the SMFP, NHHMC cannot successfully apply for more beds. This is a false invitation the Agency should reject. CON applications are reviewed based on the entirety of the information that the applicant presents in its application; if CON reviews were simply a matter of looking at the Projected Deficit/Surplus column in the SMFP, then there would be no reason to consider any of the information the applicant presents, and no reason to evaluate the information against the CON criteria in N.C. Gen. Stat. § 131E-183. CON reviews must be conducted according to the statute, and the statute does not permit the Agency to base its decision on the SMFP Projected/Deficit Surplus column.

Atrium's characterization of Novant Health's recently opened Novant Health Mint Hill Medical Center is also incorrect. Novant Health was approved to relocate 50 beds from Charlotte to Mint Hill. With the Agency's knowledge and approval, Novant opened the Mint Hill hospital with 36 beds. Novant Health received permission to open the remaining 14 beds by 2023. Those beds would go to Mint Hill; they have no bearing on the proposal to license 12 LDRP beds at Huntersville.

Specific Comments

The Atrium Comments unsuccessfully attempt to paint the Application as not conforming with several CON criteria and standards. Novant has addressed any criticisms by Atrium Health in these comments and corrected when necessary. Attachment A is a partial revised Section Q for NHHMC taking into account all issues raised by Atrium Health.[6] Nothing in these comments or Attachment A is intended to amend or modify the Novant Health application. The purpose of Attachment A is to show Atrium's criticisms are not material separately or cumulatively. When Section Q is adjusted for all Atrium criticisms, the Application still conforms to all CON criteria. The criticisms are not material and should not affect the Agency's comparative analysis of the competing applications.

Atrium grouped its criticisms into these six categories:

(1) Overstatement of acute care utilization

(2) Issues with NHHMC patient origin.

(3) Issues with utilization at NHHMC.

(4) Issues with utilization at Novant Health Ballantyne Medical Center (NHBMC)

(5) Issues with operating room utilization

(6) Issues with financial statements

Each criticism in each category is addressed below. This response shows none of the criticisms is material, and when all criticisms are addressed, the Application is conforming to all criteria and standards.

(1) Overstatement of acute care utilization

Atrium alleges the Application overstates historical utilization for Novant Health hospitals as compared to the LRAs and Table 5 of the 2018 SMFP. The allegation is false regarding NHHMC and NHMMC. The data for calendar years in the Application for NHHMC and NHMMC are correct and differences from FFY LRA or SMFP data are due to different time periods or data element definitions.[7]

[6] Attachment 1 includes Revised Forms C and D and all supporting tables from the Assumptions and Methodology as well as Form F.4 ICU

[7] Andrea Emanuel, Planner, Division of Health Service Regulation, Healthcare Planning and Certificate of Need Section, confirmed that the SMFP acute care days exclude patients with substance use disorders, psychiatry, and rehabilitation diagnoses even if those services were provided in an acute care bed. NHHMC and NHMMC do not have rehabilitation or behavioral health beds so any patients with these diagnoses are in acute care beds at these hospitals.

Novant Health acknowledges an error in the calculation of historical utilization for NHPMC on page 109 of the Application. Counts of NHPMC acute care days and discharges excluded counts for Novant Health Charlotte Orthopedic Hospital (NHCOH); part of the NHPMC license, and included behavioral health patient days and discharges should have been excluded.

The data were used to calculate the CAGRs and ALOS at each hospital, which are assumed to be each facility's projected growth rate and ALOS. For NHPMC this correction results in a revised growth rate (2.1% instead of 2.6%) and a revised ALOS (4.9 instead of 5.9 days). These revisions are shown in **Revised Section Q, Form C: Table System.1.** The resulting projected discharges and days for NHPMC are shown in **Section Q, Form C: Table System.2** and the **Revised Form Cs.**

For completeness, Novant Health also corrected the growth rate formula error Atrium pointed out in 2024 and 2025. However, these two years are after the third year of the NHHMC Application and are irrelevant to the Agency's findings on the Application.

On page 13 of its comments, Atrium also says the Application omitted Table System.3. Atrium alleges, "Without this table, it is impossible to determine Novant's projected acute care utilization for all of its hospitals in Mecklenburg County." While Table System.3 was omitted from Section Q, it appeared on page 46 of the Application in response to *10A NCAC 14C .3803 PERFORMANCE STANDARDS*. Further, all data on that table appear on previous tables in Section Q of the Application. Therefore, the Agency has all the data it needs to "to determine Novant's projected acute care utilization for all of its hospitals in Mecklenburg County." Corrections for patient days just discussed, and the resulting growth rate and ALOS assumptions, are shown in **Revised Section Q, Form C: Table System.3 and the Revised Form Cs.** The system occupancy percentage in project year 3 is 75.5%, which satisfies the performance standard of 75.2% occupancy for hospitals (health systems) with an ADC above 200.

(2) Issues with NHHMC patient origin

On pages 27 and 28 of the Application, Novant provided CY 2017 patient origin data for "Acute Care Inpatient Services", "NICU Services", "Inpatient Surgical Services", and "Outpatient Surgical Services." On page 13 of the Atrium Comments, Atrium notes that for each service, Novant's reported utilization in the patient origin tables differs from the utilization reported in the remainder of the application. Atrium's criticism is irrelevant. As noted in the source notes of the tables in the Application, the patient origin data came from Truven and not Trendstar, which explains any minor differences in acute care and NICU cases.

Data used to compute patient origin percentages for inpatient and outpatient surgical services is also Truven data. As noted, the counts are for all records with a surgical revenue code, which likely include procedure room cases. The tables are intended to show the percentage of patients from each county, not the counts. The percentages accurately identify the historical distribution of

Historical Patient Origin
Novant Health Huntersville Medical Center
Inpatient Surgical Services

	Truven CY17[1]		LRA Data FY17 [2]	
County of Residence	**Number of Patients**	**% of Total**	**Number of Patients**	**% of Total**
Mecklenburg	2,431	63.1%	1,054	61.5%
Iredell	433	11.2%	194	11.3%
Lincoln	347	9.0%	158	9.2%
Gaston	182	4.7%	91	5.3%
Cabarrus	242	6.3%	100	5.8%
All Other	217	5.6%	118	6.9%
Total	**3,852**	**100.0%**	**1,715**	**100.0%**

[1]As submitted in the Application. Source: 2017 Truven Hospital Inpatient Data, All Discharges with Surgical Charges (Revenue Codes 360-379, 710-729) Excluding C-Section (DRGs 765 and 766) [2]2018 Licensed Renewal Application Access Database (FY17 data)

Historical Patient Origin
Novant Health Huntersville Medical Center
Outpatient Surgical Services

	Truven CY17[1]		LRA Data FY17 [3]	
County of Residence	**Number of Patients**	**% of Total**	**Number of Patients**	**% of Total**
Mecklenburg	5,335	54.1%	2,093	56.7%
Iredell	1,557	15.8%	514	13.9%
Lincoln	910	9.2%	373	10.1%
Gaston	548	5.6%	173	4.7%
Cabarrus	592	6.0%	231	6.3%
All Other	921	9.3%	305	8.3%
Total	**9,863**	**100.0%**	**3,689**	**100.0%**

[1]As submitted in the Application. Source: 2017 Truven Hospital Inpatient Data, All Cases with Surgical Charges (Revenue Codes 360-379, 710-729) [2]2018 Licensed Renewal Application Access Database (FY17 data)

surgical patients at NHHMC by service component. The tables above show the percentages provided in the Application compared to the percentages as calculated from the most recent 2018 LRAs (FFY 2017 data). The difference is not material. No correction is necessary.

(3) Issues with utilization at NHHMC

On page 14 of its Comments, Atrium alleges "Novant's failure to include 2015 and actual year-to-date 2018 data, despite clear instructions in the CON form to provide, and its misrepresentation of the data it did provide undermines the ability of the Agency to determine the reasonableness of Novant's assumptions." The allegation is false. Novant provides the Agency sufficient data to determine the reasonableness of Novant Health's assumptions. Novant Health documented the method used to annualize the first seven months of CY 2018 data to a full year as [(Jan – July) / 7] * 12. The Agency has 2015 data from multiple sources including LRAs, Truven Analytics, and past CON applications. For NHHMC, January – July 2018 data were provided in the Application on Section Q, Form C: Table NHBMC.7. In this Response we provide actual CY 2015 and YTD 2018 data on all **Revised Form Cs** attached to this response in Attachment A. As this is actual historical data, it is not an amendment to the application.

On page 15 of the Atrium Comments, Atrium alleges NHHMC fails to demonstrate the need for its proposed project according to the 2018 SMFP and the performance standards for acute care beds (at 10A NCAC 14C .3803) because NHHMC's projected occupancy rate in its third project year is 67.9 percent.

Section C, Question 12 contains the rules which apply to proposals submitted on the Acute Care Services and Medical Equipment application form. Only two rules apply to this Application: 10A NCAC 14C .3800 Criteria and Standards for Acute Care Beds and 10A NCAC 14C .2100 Criteria and Standards for Surgical Services and Operating Rooms.

Other than definitions, the only performance standard for acute care beds is:

> *10A NCAC 14C .3803*
>
> *An applicant proposing to develop new acute care beds shall demonstrate that the projected average daily census (ADC) of the* ***total number of licensed acute care beds proposed to be licensed within the service area, under common ownership with the applicant,*** *divided by the total number of those licensed acute care beds is reasonably projected to be at least 66.7 percent when the projected ADC is less than 100 patients, 71.4 percent when the projected ADC is 100 to 200 patients, and 75.2 percent when the projected ADC is greater than 200 patients, in the third operating year following completion of the proposed project or in the year for which the need determination is identified in the State Medical Facilities Plan, whichever is later.* (emphasis added)

The target occupancy rate is for "*the total number of licensed acute care beds proposed to be licensed within the service area, under common ownership with the applicant,*" *not* the rate for an individual facility. Novant Health demonstrates it meets this performance standard, with a projected occupancy rate of 75.5 for the system in the third year of the project after all of Atrium's comments are addressed. There are no acute care bed performance standards that set a threshold occupancy rate for an individual facility that is part of a larger health system in the service area. Further, the acute care bed performance standards do not require the applicant to project need using the method from the SMFP as do the operating room performance standards. The only other policy with an occupancy threshold is Policy AC-5, Replacement of Acute Care Bed Capacity, which is not applicable to the Application. The Application conforms to all rules and performance standards for acute care beds.

Atrium alleges on page 15 of its Comments Novant Health provides contradictory information on the number of ICU beds and NICU beds it will operate. Novant Health recognizes typos in the text of the application on pages 126 and 127. To clarify: as approved in Project I.D. F-11110-15, and also as it appeared correctly on Form C, Novant Health will operate eight ICU beds and four NICU beds.

On page 16 of its Comments, Atrium alleges Novant's projected utilization of over 100 percent capacity of NICU beds is unreasonable as it will not have NICU capacity to serve its projected patient days. This allegation is false. As the Application explained on page 127, "[t]he projected occupancy for NICU is high. NICU beds are licensed acute care beds. If needed, NHHMC can designate more acute care beds as NICU beds. As long as NICU guidelines are met, approval for the conversion is granted through written notification to the Acute and Home Care Licensure and Certification Section of North Carolina' s Department of Health and Human Services."

Atrium further alleges, "Given the facility and unit requirements, the development of additional NICU beds is likely to require a capital expense that is not insignificant. As Novant has stated that it may add NICU beds given its projected utilization, it appears as though the proposed project has failed to include all necessary capital expense, specifically any capital expense associated with the development of additional NICU beds." This allegation is false. NICU beds are not an integral part of this project, which is a proposal to convert LDRs to LDRPs. If Novant Health finds it necessary to add NICU beds by changing the designation within its count of licensed acute care beds, it will not be a CON reviewable expense as it will be below the capital expenditure threshold.

(4) Issues with utilization at NHBMC

Before turning to Atrium's specific comments, Novant has some general responses to Atrium's comments on the Novant Health Ballantyne Medical Center (NHBMC) application. The application at issue is NHHMC, not NHBMC. NHBMC is not in this competitive batch. Any Atrium comments about NHBMC are irrelevant to approval of the NHHMC Application. The Agency should not be distracted by a critique of an application that is not in this batch review and

for which Atrium did not file comments. The NHBMC application is a non-competitive bed and OR relocation project that is not subject to any performance standard. It would be inappropriate for the Agency to make any findings on the NHBMC application based on comments on the NHHMC application.

Turning to Atrium's specific comments:

On page 17 of its Comments, Atrium alleges the NHBMC methodology for projecting utilization does not account for the lack of ICU services at NHBMC, nor does it appropriately limit those patients that would require other services not offered at NHBMC. This allegation is false. On page 18 Atrium lists DRGs it claims NHBMC would not serve. Novant Health agrees it does not anticipate serving these patients at NHBMC and as we demonstrate below the analysis of the NHBMC inpatient market was limited appropriately for intermediate care beds, and excluded patients requiring services not offered at NHBMC.

The Application's market analysis applied a two-tiered method to identify patients inappropriate for NHBMC and exclude them from all utilization projections. The first step was to exclude patients not part of NHBMC's scope of services as defined in the Application. The next step was to exclude all patients with a FY 2018 DRG case weight of 2.0 or more.

In the Application, Section Q, Form C: Table NHBMC.2 includes counts of inpatient cases by age group for medical/surgical and obstetric patients, included in the Novant Health Ballantyne Service Area. For 2017, we included 10,331 medical/surgical and 2,628 obstetrics cases based on data from both North Carolina and South Carolina hospitals. The data are from Truven Analytics and SC Revenue and Fiscal Affairs Office, which means the data includes patients from the service area that went to a North Carolina or South Carolina hospital in 2017. Attachment B to this response shows these cases by DRG.[8]

Atrium alleges on page 18 of its Comments, the "NHHMC application has approximated the services at NHBMC with a patient pool that includes thoracic surgery, electrophysiology, interventional cardiology, carotid procedures, peripheral vascular, trauma surgery, brain procedures, peripheral and cranial diseases, advanced care neonates, minor care newborns, general pediatrics, and pediatric subspecialties. As Attachment B shows, that allegation is false.

Atrium criticizes the assumed ALOS for NHBMC, which was based on the experience at NHHMC and NHMMC in CY 2017. Atrium argues on page 19 of its Comments, *"[b]oth NHHMC and NHMMC serve patients with weights of 2.0 or greater and serve ICU patients, who have significantly longer lengths of stay than non-ICU patients. The NHHMC application fails to demonstrate the reasonableness of using the ALOS from its facilities that serve a broader range*

[8] Medical/surgical cases in the Application (10,331) and Attachment B (10,328) differ by 3 cases which were FY 2017 DRGs no longer valid in FY 2018.

of patients as the basis for NHBMC." The criticism is not valid. The ALOS for NHBMC was based on patients and patient days already limited to the services provided at NHBMC, therefore the ALOS is reasonable.

NHBMC will have Intermediate Care beds instead of ICU beds. There is no state definition of intermediate care beds. As Novant defines them, there are few differences between ICU and Intermediate Care. Staffing would be 4:1 in an Intermediate Care setting versus 2:1 in an ICU setting. The Intermediate Care Unit will have hardwired monitors with telemetry capability, so there is not a significant difference in equipment. For physician coverage, an Intermediate Care Unit does not require intensivist coverage. A hospitalist service will provide medical coverage with consults from any specialist that may be on call for the hospital or through a telemedicine consult.

On page 19 of its Comments, Atrium discussed Wake Forest Baptist Davie and Cape Fear Valley Hoke. Wake Forest Baptist Davie and Cape Fear Valley Hoke are not "comparable" to NHBMC. Hoke County is a rural county in central NC, population of 54,116. Davie County is also a rural county in the Piedmont area of NC, population 42,456. The experience of these hospitals is not even comparable to each other – see the chart on page 20 of the Atrium Comments. They both have very different days, discharges and ALOS. There is no basis for benchmarking NHBMC against either of these hospitals, neither of which is a Novant Health hospital, and neither of which is in a large urban county, population 1,076,837. Novant reasonably relied on its experience with its hospitals in Mecklenburg County. Atrium arbitrarily picked two hospitals in very different markets and declared them comparable. This is a false and flawed comparison and should be disregarded.

Atrium alleges on page 20 of its Comments, "*…the NHHMC application assumes that inpatient and outpatient surgical utilization at NHBMC will be consistent with the experience of NHHMC and NHMMC. Again, the NHHMC application fails to demonstrate the reasonableness of using the experience of NHHMC and NHMMC, both of which serve patients with weights of 2.0 or greater and ICU patients, as the basis for operating room utilization at NHBMC."* In the Application, we based projected surgeries at NHBMC on the historical 3-year composite ratio of surgery to acute care discharges at NHHMC and NHMMC. Those figures from the Application Section Q, Form C: Table NHBMC.7, which we still believe to be reasonable, are re-produced below for inpatient surgery. In response to Atrium's criticism, we performed a more in-depth analysis.

The table below also shows the inpatient discharges and inpatient surgical cases for the last 3 years of publicly available Truven data, limited to only the services NHBMC will provide. There is no material difference in the composite ratios as both would produce the need for two operating rooms at NHBMC. The denominator for the ratio for both the inpatient and outpatient surgery was acute care patients. While the denominator would be reduced for services not expected to be provided at

NHBMC, very few outpatient surgical cases would be performed at Novant Health's other community hospitals and not NHBMC. This means a NHBMC limited services ratio would produce an even higher outpatient surgery to acute care patient ratio. Atrium's criticisms are not valid. The in-depth analysis shows the reasonableness of the assumption in the Application.

	Cases and Ratios per Application [1]				**NHBMC Limited Cases and Ratios**			
	CY 2016	**CY 2017**	**CY 2018A**	**Avg**	**CY 2015**	**CY 2016**	**CY 2017**	**Avg**
Acute Care Cases								
NHHMC	6,262	6,867	7,490		5,354	5,057	5,530	
NHMMC	9,455	9,941	10,646		7,956	7,768	7,935	
Composite	15,717	16,808	18,135		13,310	12,825	13,465	
IP Surgical Cases								
NHHMC	1,261	1,352	1,452		949	827	863	
NHMMC	1,392	1,542	1,503		1,190	1,139	1,250	
Composite	2,653	2,894	2,955		2,139	1,966	2,113	
Ratio	0.17	0.17	0.16	0.17	0.16	0.15	0.16	0.16

[1] NHHMC Application, Section Q, Form C: Table NHBMC.7
[2] Truven Analytics Data. Limited to DRGs at NHBMC, excluding normal newborns and non-acute neonates. IP Surgical Cases further exclude C-sections.

On page 21 of the Atrium Comments, Atrium alleges, "*The NHHMC application projects that NHBMC will serve more med/surg patients from this service area than Novant's entire system does currently.*" Novant Health agrees. The Application reasonably assumes NHBMC will increase Novant Health market shares by 5 to 10 percent in each service area ZIP Code.

On page 21 of its Comments, Atrium further alleges, "*The NHHMC application provides no justification for its ability to shift physicians or patients from Atrium Health facilities*," This allegation is false. Atrium rejects the idea that NHBMC could shift patients from Atrium facilities. This assumes that Atrium is simply immune from competition, and basically owns its patients and the physicians, which is alarming on many levels. The Application discusses the current lack of choice for physicians and patients in south Mecklenburg County, the limits traffic congestion create for patients and how creating a competitive alternative will shift patients and physicians. The Application identified the nearest competitor hospitals from which patients and physicians can reasonably be expected to shift. Additional evidence that physicians and patients will leave Atrium, given a reasonable choice is recent physician and market share shifts in Mecklenburg County discussed on pages 2-8 of this response.

Atrium alleges on pages 22-24 of its Comments, *"[t]he NHHMC application does not provide enough information to determine how many discharges and days will be shifted from each Novant facility to NHBMC under a corrected impact analysis.*" However, Atrium provides a table with correct impact for CY 2025 on page 23 of its comments, showing there was sufficient information. However, Atrium included only service area cases in its recalculation of impact. Novant shows the correct impact analysis for all three years of the project in the **Revised Section Q, Form C: Table NHBMC.9**. Novant Health included cases from outside the hospital's service area that account for 10% of the total cases at NHBMC.

(5) Issues with operating room utilization

The 2018 SMFP operating room need determination for six ORs in Mecklenburg County represents the community need for all surgery facilities in Mecklenburg County. Novant Health applied for only one OR. The Novant Health application shows with reasonable and supported assumptions and calculations the need for an additional OR at NHHMC.

On pages 25 and 26 of its Comments Atrium alleges, "Novant unreasonably assumes that all of its cases and locations will grow equally" at 2.7 percent. That allegation is not a valid criticism. It is undisputed Novant Health surgical volumes in Mecklenburg County grew at a 2.7 percent CAGR from 2016 to 2018. Atrium concedes on page 25 of its Comments, "NHHMC's total operating room cases have grown at a higher rate than its system- wide CAGR."

There is no requirement that the 2.7% CAGR be experienced equally across Novant Health's Mecklenburg County facilities. The reason to use a CAGR is to smooth out differences between years and facilities. The criteria in 10A NCAC 14C .2103(a), permit an applicant to choose the data and method to calculate the growth rate. The burden is on the applicant to show its growth rate is well supported and is a reasonable expectation of growth. Novant Health has met this burden.

On pages 26 and 27 of its Comments, Atrium criticizes Novant Health's calculation of surgical impact on existing facilities due to the opening of NHBMC and NHMHMC. Novant Health corrects these issues in the **Revised Section Q, Form C: Table NHBMC.8b** and **Section Q, Form C: Table System.7.** For completeness, Novant Health also corrected the surgical cases and OR counts Atrium pointed out in 2024 and 2025 on Form C (Atrium Comments page 27). However, these two years are after the third year of the NHHMC Application and are irrelevant to the Agency's findings on the Application.

On page 28, Atrium alleges an error in the Application's count of ORs stating, "… on page 186 (as well as page 41), Novant states that NHPMC has 34 operating rooms in its analysis of the need for additional operating rooms at NHPMC which is the basis for its demonstration of conformity with the operating room performance standard excerpted below." Novant Health recognizes a

miscount of operating rooms after all CON approved and CON exempt projects are complete. The OR counts have been corrected in the Revised Section Q tables.

According the 2018 LRAs, NHPMC was licensed for 45 operating rooms, three of which are dedicated C-section ORs, as of September 30, 2017. The CON for the NHMHMC Project I.D. #F-7648-06 allows five shared ORs to be relocated from NHCOH (now a part of NHPMC). On October 1, 2018, NHPMC transferred four shared ORs to NHMHMC to be licensed as three shared ORs and one dedicated C-section OR at NHMHMC per the Material Compliance Determination Request dated May 25, 2018. In 2023, NHPMC will relocate one shared OR from the NHPMC license to NHMHMC for a total of five ORs (four shared and one C-section) at NHMHMC. The CON for NHHMC Project I.D. #F-11110-15 (add 48 beds and 1 OR) allows one shared OR to be relocated from NHPMC and that is scheduled to occur July 2019. At the completion of these approved projects, NHPMC will have a total of 39 ORs (three of those C-section). C-section ORs are excluded from the SMFP need calculation. Therefore, NHPMC will have 36 ORs in the third project year after excluding C-section ORs. Total need for the Novant Health system, adjusted for correct OR counts, is 5.4 ORs in 2023, project year 3. The need at NHHMC for one OR is not affected by this revision in OR counts. Please see the **Revised Section Q, Form Cs, Revised Section Q, Form C: Table System.7 for NHPMC** and **Revised Section Q, Form C: Table System.8**. Attachment D is a table showing the shift of ORs at Novant Health's Mecklenburg surgical locations.

(6) Issues with financial statements

On page 29 and 30 of its comments, Atrium alleges the growth rate for Surgical Services between project year one and project year three is slightly higher than Novant says it assumed. Novant's stated growth rate assumption on page 205 of the Application is 2.0%. The growth between project year one and project year two is 2%. The growth between project year two and project year three is about 2.7%. The growth rate of 2.7% was used in error and should have been 2%. The error is not material and using the correct growth rate does not cause the Application to be non-conforming. Using the correct growth rate reduces net revenue in project year three by 0.16%, a sixteenth of one percent. Using the correct growth rate, net income in project year 3 is $163,207,323 and the proposed project remains financially feasible and conforming with CON Review Criterion (5).

On page 31 of its comments, Atrium alleges the Payor Mix for Acute Care Beds, on page 211 of Huntersville CON narrative is inconsistent with the Payor Mix for Acute Care Beds shown on Forms F.4 and F.5. Any inconsistency is not material. The Payor Mix, percentages as presented on Forms F.4 and F.5, and used in the Acute Care Beds calculations are correct. There are typographical errors in the chart on page 211 of the application. The erroneous numbers in the chart on page 211 of the application are not used in any calculation and the errors are not material.

On page 32 of its comments, Atrium notes an inconsistency between Forms F.5 and F.6. The largest difference between the payor categories on the two forms is three-tenths of one percent. The differences are not material. The is no difference in total dollars on F.5 and F.6 as revenue was calculated by multiplying Patient Days times Average Charge and Patient Days times Average Reimbursement.

On page 32 of its comments, Atrium notes an inconsistency in Payor Mix percentages between project years one, two and three. The differences are due to rounding and are not material. The largest difference between years in the Payor Mix categories is four-hundredths of one percent (0.04%).

On page 33 of its comments, Atrium notes that Form F.6, in one instance is mislabeled as "Gross Revenue" instead of "Net Revenue." This typographical error did not affect any calculations and is not material. In addition, Form F.4 for ICU Beds assumptions was inadvertently omitted due to a production error. Please see **Revised Section Q, Form F.4 ICU Beds** in Attachment A to this Response**.**

Conclusion

Atrium's criticisms of the application are either false or not material. Attachment A shows the criticisms individually and cumulatively do not show the Application does not conform to the CON Review Criteria, Policies, and Performance Standards. The Application is fully conforming. As stated in Novant Health's comments in opposition to the Atrium applications, the NHHMC Application is also comparatively superior to the Atrium applications. Novant Health respectfully asks the Agency to approve its Application for 12 of 50 additional acute care beds and one of the six additional ORs available in the 2018 SMFP.

Exhibit 5

EXHIBIT 17

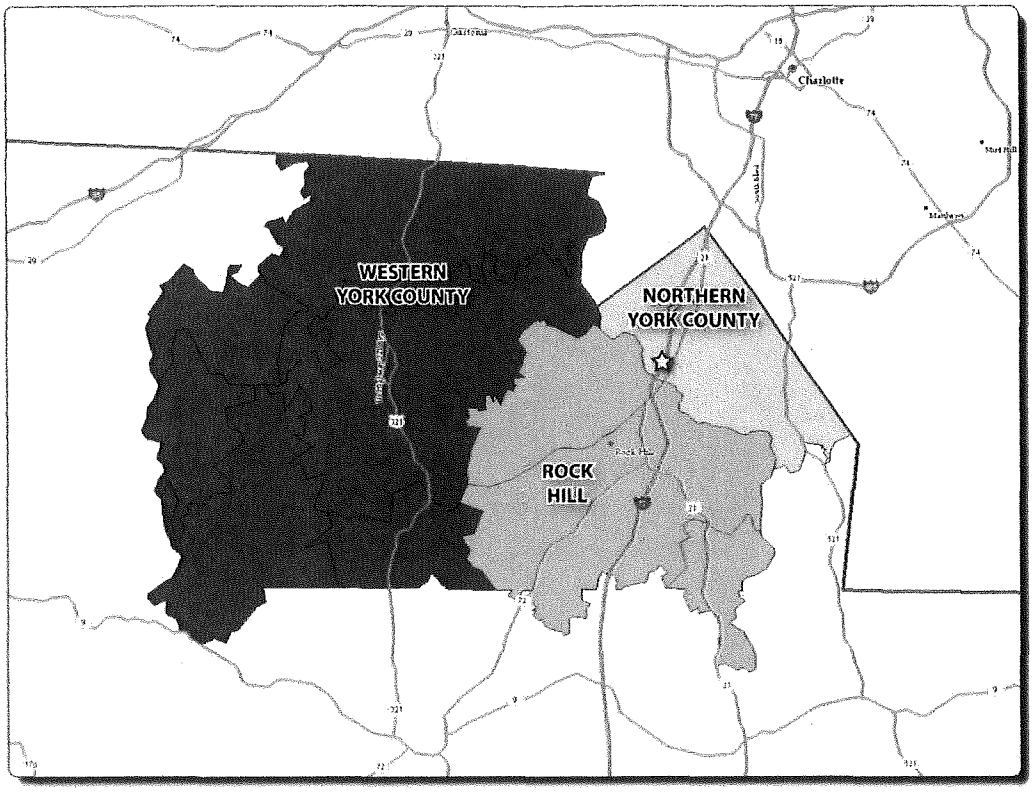
CMC-FORT MILL
PROJECTED ACUTE CARE BED METHODOLOGY

In September 2011, CHS was approved to develop a new 64-bed acute care hospital in Fort Mill, South Carolina. CMC-Fort Mill is projected to be operational on January 1, 2015, though it is currently under appeal. Inpatient discharges at CMC-Fort Mill will be derived from York County patients currently seeking care at CHS hospitals in North Carolina (now given a choice to receive care at a CHS facility closer to home). The residents of York County have continued to seek care at CHS facilities, even though it currently requires traveling to North Carolina for inpatient care. CHS does not project any additional market share shift from Piedmont Medical Center or from Novant Mecklenburg facilities.

The following steps summarize the CMC-Fort Mill projection methodology, which has been approved by the South Carolina Department of Health and Environmental Control. The detailed methodology tables are included in this exhibit.

1. *Calculate historic use rate and project future utilization by submarket.*

CHS identified CMC-Fort Mill's primary (Northern York County and Rock Hill submarkets) and secondary (Western York County submarket) service areas, as shown in the map and table below.



☆ **CMC-Fort Mill**

Northern York County	*Rock Hill*	*Western York County*
Fort Mill – 29715	Rock Hill – 29730	Clover – 29710
Fort Mill – 29707	Rock Hill – 29732	Hickory Grove – 29717
Tega Cay – 29708	Catawba – 29704	McConnells – 29726
		Sharon – 29742
		Smyrna – 29743
		York – 29745

For each submarket, CHS calculated the historic discharge use rate per 1,000 population. CHS included only primary and secondary level discharges as CMC-Fort Mill will provide primary and secondary level services only and not tertiary or quaternary inpatient services.

Northern York County	*2003*	*2004*	*2005*	*2006*	*2007*	*2008*	*2009*
Population	36,224	38,227	40,347	42,591	44,968	47,485	50,151
Discharge use rate per 1,000 population^	65.0	63.2	63.1	66.6	66.0	68.0	67.3
Total area discharges	2,356	2,415	2,544	2,837	2,966	3,230	3,373

Source: Claritas and Thomson data.
^Primary and secondary level discharges only.

Rock Hill	*2003*	*2004*	*2005*	*2006*	*2007*	*2008*	*2009*
Population	97,471	100,585	103,804	107,129	110,565	114,116	117,786
Discharge use rate per 1,000 population^	76.5	76.5	77.7	72.0	70.7	65.0	59.5
Total area discharges	7,458	7,690	8,068	7,710	7,812	7,423	7,010

Source: Claritas and Thomson data.
^Primary and secondary level discharges only.

Western York County	*2003*	*2004*	*2005*	*2006*	*2007*	*2008*	*2009*
Population	55,299	56,828	58,401	60,018	61,681	63,392	65,151
Discharge use rate per 1,000 population^	75.7	77.5	79.4	74.2	68.7	65.8	64.2
Total area discharges	4,188	4,406	4,635	4,455	4,238	4,174	4,183

Source: Claritas and Thomson data
^Primary and secondary level discharges only.

CHS projected future submarket discharges by applying the 2009 use rate to the projected population through 2017, the third project year. While the historic use rates for these submarkets have fluctuated, CHS believes it is reasonable to assume the 2009 use rate going forward.

Northern York County	*2015*	*2016*	*2017*
Population	61,502	63,366	65,287
Discharge use rate per 1,000 population^	67.3	67.3	67.3
Total area discharges	4,136	4,262	4,391

Source: Claritas.
^Primary and secondary level discharges only.

Rock Hill	*2015*	*2016*	*2017*
Population	138,171	141,754	145,430
Discharge use rate per 1,000 population^	59.5	59.5	59.5
Total area discharges	8,223	8,436	8,655

Source: Claritas.
^Primary and secondary level discharges only.

Western York County	*2015*	*2016*	*2017*
Population	76,023	77,979	79,985
Discharge use rate per 1,000 population^	64.2	64.2	64.2
Total area discharges	4,881	5,007	5,135

Source: Claritas.
^Primary and secondary level discharges only.

Projected Discharges by Submarket Summary

Submarket	*2015*	*2016*	*2017*
Northern York County	4,136	4,262	4,391
Rock Hill	8,223	8,436	8,655
Western York County	4,881	5,007	5,135

2. *Shift of Discharges from other CHS facilities.*

CHS calculated the historic market share for CHS Mecklenburg facilities for each of the three submarkets. CHS assumed that a portion of its existing market share for each of the three submarkets would shift to CMC-Fort Mill:

- CHS projected to shift 75 percent of the 2009 Northern York County market share held by CHS Mecklenburg facilities to CMC-Fort Mill.
- CHS projected to shift 80 percent of the 2009 Rock Hill market share held by CHS Mecklenburg facilities to CMC-Fort Mill.
- CHS projected to shift 50 percent of the 2009 Western York County market share held by CHS Mecklenburg facilities to CMC-Fort Mill.

Percentage of CMC-Pineville Market Share to Shift to CMC-Fort Mill

Submarket	*2009 Thomson Market Share*	*Percent of Market Share to Shift*	*Percent Shift*
	A	*B*	*C = A x B*
Northern York County	30.9%	75%	23.1%
Rock Hill	10.1%	80%	8.1%
Western York County	8.1%	50%	4.0%

Percentage of CMC Market Share to Shift to CMC-Fort Mill

Submarket	*2009 Thomson Market Share*	*Percent of Market Share to Shift*	*Percent Shift*
	A	*B*	*C = A x B*
Northern York County	18.1%	75%	13.6%
Rock Hill	8.2%	80%	6.5%
Western York County	8.7%	50%	4.4%

Percentage of CMC-Mercy Market Share to Shift to CMC-Fort Mill

Submarket	*2009 Thomson Market Share*	*Percent of Market Share to Shift*	*Percent Shift*
	A	*B*	*C = A x B*
Northern York County	3.6%	75%	2.7%
Rock Hill	1.3%	80%	1.1%
Western York County	1.5%	50%	0.7%

Percentage of CMC-University Market Share to Shift to CMC-Fort Mill

Submarket	*2009 Thomson Market Share*	*Percent of Market Share to Shift*	*Percent Shift*
	A	*B*	*C = A x B*
Northern York County	0.3%	75%	0.2%
Rock Hill	0.1%	80%	0.1%
Western York County	0.2%	50%	0.1%

Based on these assumptions, CHS calculated the number of discharges that would be shifted from CHS Mecklenburg facilities to CMC-Fort Mill by submarket. For example, CHS projected to shift 75 percent of CMC-Pineville's 30.9 percent market share of Northern York County, or 23.1 percent, to CMC-Fort Mill. Thus, in 2015, CMC-Pineville will shift 957 discharges to CMC-Fort Mill (957 discharges = 23.1 percent x 4,136 submarket discharges from Step 1. Totals do not foot due to computer rounding).

CMC-Pineville Discharges to Shift to CMC-Fort Mill

Submarket	*2015*	*2016*	*2017*
Northern York County	957	986	1,016
Rock Hill	664	682	699
Western York County	197	202	207
Total	**1,819**	**1,870**	**1,923**

CMC Discharges to Shift to CMC-Fort Mill

Submarket	*2015*	*2016*	*2017*
Northern York County	563	580	598
Rock Hill	538	552	566
Western York County	214	219	225
Total	**1,314**	**1,351**	**1,388**

CMC-Mercy Discharges to Shift to CMC-Fort Mill

Submarket	*2015*	*2016*	*2017*
Northern York County	113	117	120
Rock Hill	87	90	92
Western York County	36	37	38
Total	**237**	**243**	**250**

CMC-University Discharges to Shift to CMC-Fort Mill

Submarket	*2015*	*2016*	*2017*
Northern York County	9	9	10
Rock Hill	8	8	8
Western York County	5	5	5
Total	**21**	**22**	**23**

3. *Summary of Utilization.*

The following table summarizes the discharges by submarket projected above for CMC-Fort Mill.

Summary of CMC-Fort Mill Discharges by Submarket

Submarket	*2015*	*2016*	*2017*
Northern York County	1,643	1,692	1,744
Rock Hill	1,297	1,331	1,365
Western York County	452	463	475
Total	**3,391**	**3,486**	**3,584**

In addition, CHS projected that CMC-Fort Mill will serve some patients from South Carolina ZIP Codes outside of the proposed service area. CHS projected that these discharges will equal ten percent of the proposed service area discharges. Historical average length of stay data were obtained from similar hospitals operated by CHS (CMC-Pineville and CMC-University). An average length of stay of four days was projected for CMC-Fort Mill and applied to projected discharges in order to calculate projected patient days. The following table summarizes CMC-Fort Mill projected utilization.

	2015	*2016*	*2017*
Submarket Discharges	3,391	3,486	3,584
Inmigration Discharges (10.0% of Submarket Discharges)	339	349	358
Total Discharges	3,730	3,835	3,942
Average Length of Stay	4.0	4.0	4.0
Total Patient Days	14,921	15,340	15,770
Average Daily Census	41	42	43
Licensed Beds	64	64	64
Percent Occupancy	**63.9%**	**65.7%**	**67.5%**

As demonstrated above, CMC-Fort Mill is projected to operate at 67.5 percent occupancy in the third project year of the proposed CMC-University and CMC-Mercy bed additions.

PROJECTED OBSTETRICS BED METHODOLOGY

CMC-Fort Mill provided a separate obstetrics bed utilization methodology which was identical in its approach to its total acute care bed methodology except that it applied to obstetrics utilization only. The obstetrics bed utilization shown below is a component of the total acute care bed utilization shown above. The following steps summarize the previously approved CMC-Fort Mill obstetrics bed projection methodology. The detailed methodology tables are included in this exhibit.

1. *Calculate historic obstetrics use rate and project future utilization by submarket.*

For each submarket, CHS calculated the historic obstetrics discharge use rate per 1,000 of the female child bearing population aged 15 to 44.

Northern York County	*2003*	*2004*	*2005*	*2006*	*2007*	*2008*	*2009*
Female 15-44 Population	7,560	7,896	8,246	8,612	8,994	9,393	9,810
Obstetrics discharge use rate per 1,000 population	62.7	65.3	76.2	81.0	88.3	94.8	95.0
Total area obstetrics discharges	474	516	628	698	794	890	932

Source: Claritas and Thomson data.

Rock Hill	*2003*	*2004*	*2005*	*2006*	*2007*	*2008*	*2009*
Female 15-44 Population	23,132	23,661	24,203	24,756	25,322	25,902	26,494
Obstetrics discharge use rate per 1,000 population	62.8	58.9	58.6	64.5	68.0	66.4	60.5
Total area obstetrics discharges	1,452	1,393	1,419	1,596	1,721	1,720	1,604

Source: Claritas and Thomson data.

Western York County	*2003*	*2004*	*2005*	*2006*	*2007*	*2008*	*2009*
Female 15-44 Population	11,581	11,802	12,028	12,259	12,493	12,733	12,977
Obstetrics discharge use rate per 1,000 population	64.2	60.1	67.8	63.1	64.1	64.9	64.4
Total area obstetrics discharges	743	709	816	774	801	826	836

Source: Claritas and Thomson data.

CHS projected future submarket obstetrics discharges by applying the 2009 use rate to the projected population through 2017, the third project year. While the historic use rates for these submarkets have fluctuated, CHS believes it is reasonable to assume the 2009 use rate going forward.

Northern York County	*2015*	*2016*	*2017*
Female 15-44 Population	11,096	11,275	11,456
Obstetrics discharge use rate per 1,000 population	95.0	95.0	95.0
Total area obstetrics discharges	1,054	1,071	1,088

Source: Claritas.

Rock Hill	*2015*	*2016*	*2017*
Female 15-44 Population	29,136	29,561	29,993
Obstetrics discharge use rate per 1,000 population	60.5	60.5	60.5
Total area obstetrics discharges	1,764	1,790	1,816

Source: Claritas.

Western York County	*2015*	*2016*	*2017*
Female 15-44 Population	14,184	14,384	14,587
Obstetrics discharge use rate per 1,000 population	64.4	64.4	64.4
Total area obstetrics discharges	914	927	940

Source: Claritas.

Projected Obstetrics Discharges by Submarket Summary

Submarket	*2015*	*2016*	*2017*
Northern York County	1,054	1,071	1,088
Rock Hill	1,764	1,790	1,816
Western York County	914	927	940

2. *Shift of Discharges from other CHS facilities.*

CHS calculated the historic obstetrics market share for CHS Mecklenburg facilities for each of the three submarkets. Please note that CMC-Mercy does not currently offer obstetrics services; thus, no obstetric discharges will shift from CMC-Mercy. CHS assumed that a portion of its existing market share for each of the three submarkets would shift to CMC-Fort Mill:

- CHS projected to shift 75 percent of the 2009 Northern York County obstetrics market share held by CHS Mecklenburg facilities to CMC-Fort Mill.
- CHS projected to shift 80 percent of the 2009 Rock Hill obstetrics market share held by CHS Mecklenburg facilities to CMC-Fort Mill.
- CHS projected to shift 50 percent of the 2009 Western York County obstetrics market share held by CHS Mecklenburg facilities to CMC-Fort Mill.

Percentage of CMC-Pineville
Obstetrics Market Share to Shift to CMC-Fort Mill

Submarket	*2009 Thomson Market Share*	*Percent of Market Share to Shift*	*Percent Shift*
	A	*B*	*C = A x B*
Northern York County	34.9%	75.0%	26.2%
Rock Hill	19.8%	80.0%	15.9%
Western York County	16.4%	50.0%	8.2%

Percentage of CMC
Obstetrics Market Share to Shift to CMC-Fort Mill

Submarket	*2009 Thomson Market Share*	*Percent of Market Share to Shift*	*Percent Shift*
	A	*B*	*C = A x B*
Northern York County	14.5%	75.0%	10.9%
Rock Hill	3.0%	80.0%	2.4%
Western York County	3.9%	50.0%	2.0%

Percentage of CMC-University
Obstetrics Market Share to Shift to CMC-Fort Mill

Submarket	*2009 Thomson Market Share*	*Percent of Market Share to Shift*	*Percent Shift*
	A	*B*	*C = A x B*
Northern York County	0.4%	75.0%	0.3%
Rock Hill	0.2%	80.0%	0.1%
Western York County	0.1%	50.0%	0.1%

Based on these assumptions, CHS calculated the number of obstetrics discharges that would be shifted from CHS Mecklenburg facilities to CMC-Fort Mill by submarket. For example, CHS projected to shift 75 percent of CMC-Pineville's 34.9 percent obstetrics market share of Northern York County, or 26.2 percent, to CMC-Fort Mill. Thus, in 2015, CMC-Pineville will shift 276 obstetrics discharges to CMC-Fort Mill (276 discharges = 26.2 percent x 1,054 submarket obstetrics discharges from Step 1).

CMC-Pineville Obstetrics Discharges to Shift to CMC-Fort Mill

Submarket	*2015*	*2016*	*2017*
Northern York County	276	280	285
Rock Hill	280	284	288
Western York County	75	76	77
Total	**630**	**640**	**650**

CMC Obstetrics Discharges to Shift to CMC-Fort Mill

Submarket	*2015*	*2016*	*2017*
Northern York County	115	116	118
Rock Hill	42	43	43
Western York County	18	18	19
Total	**175**	**178**	**180**

CMC-University Obstetrics Discharges to Shift to CMC-Fort Mill

Submarket	*2015*	*2016*	*2017*
Northern York County	3	3	4
Rock Hill	3	3	3
Western York County	1	1	1
Total	**7**	**7**	**7**

3. *Summary of Utilization.*

The following table summarizes the obstetrics discharges by submarket projected above for CMC-Fort Mill.

Summary of CMC-Fort Mill Obstetrics Discharges by Submarket

Submarket	*2015*	*2016*	*2017*
Northern York County	394	400	406
Rock Hill	325	329	334
Western York County	93	95	96
Total	**812**	**824**	**837**

In addition, CHS projected that CMC-Fort Mill will serve some obstetrics patients from South Carolina ZIP Codes outside of the proposed service area. CHS projected that these discharges will equal ten percent of the proposed service area obstetrics discharges. Historical average length of stay data were obtained from similar hospitals operated by CHS (CMC-Pineville and CMC-University). An average length of stay of 2.6 was projected for CMC-Fort Mill and applied to projected discharges in order to calculate projected obstetrics patient days. The following table summarizes CMC-Fort Mill projected obstetrics utilization.

	2015	*2016*	*2017*
Submarket Obstetrics Discharges	812	824	837
Inmigration Discharges (10.0% of Submarket Discharges)	81	82	84
Total Obstetrics Discharges	893	907	920
Average Length of Stay	2.6	2.6	2.6
Total Obstetrics Patient Days	2,321	2,357	2,393
Average Daily Census	6.4	6.5	6.6
Obstetrics Beds	8	8	8
Percent Occupancy	**79.5%**	**80.7%**	**81.9%**

As demonstrated above, CMC-Fort Mill is projected to operate its obstetrics beds at 81.9 percent occupancy in the third project year of the proposed CMC and CMC-Mercy bed additions.

The detailed methodology tables are presented on the following pages.

CMC-Fort Mill CON
Inpatient Utilization Projection

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Primary and Secondary Discharges Only															
Northern York County															
CMC-Pineville	588	681	735	811	920	1,034	1,041								
Carolinas Medical Center	310	308	340	447	432	485	612								
CMC-Mercy	42	50	55	51	62	91	123								
CMC-University	4	9	3	7	17	9	10								
CHS Mecklenburg Subtotal	944	1,048	1,133	1,316	1,431	1,619	1,786								
Presbyterian Hospital	218	246	281	351	373	419	479								
Presbyterian Hosp Matthews	40	22	40	55	81	97	85								
Presbyterian Hosp Huntersville	-	-	-	2	2	2	2								
Novant Mecklenburg Subtotal	258	268	321	408	456	518	566								
SC Facilities	1,115	1,064	1,052	1,077	1,041	1,052	969								
All Others	39	35	38	36	38	41	52								
Total Northern York County	2,356	2,415	2,544	2,837	2,966	3,230	3,373								
STEP ONE															
Population (Claritas)	36,224	38,227	40,347	42,591	44,968	47,485	50,151	52,975	54,580	56,233	57,937	59,693	61,502	63,366	65,287
Discharge use rate per 1,000 population	65.0	63.2	63.1	66.6	66.0	68.0	67.3	67.3	67.3	67.3	67.3	67.3	67.3	67.3	67.3
Total area P&S discharges	2,356	2,415	2,544	2,837	2,966	3,230	3,373	3,563	3,671	3,782	3,897	4,015	4,136	4,262	4,391
STEP TWO															
Market Share															
CMC-Pineville	25.0%	28.2%	28.9%	28.6%	31.0%	32.0%	30.9%								
Carolinas Medical Center	13.2%	12.8%	13.4%	15.8%	14.6%	15.0%	18.1%								
CMC-Mercy	1.8%	2.1%	2.2%	1.8%	2.1%	2.8%	3.6%								
CMC-University	0.2%	0.4%	0.1%	0.2%	0.6%	0.3%	0.3%								
Subtotal **(A)**	40.1%	43.4%	44.5%	46.4%	48.2%	50.1%	52.9%								
Shift in share to CMC-Fort Mill **(A x 0.75)** **75.0%**							39.7%						39.7%	39.7%	39.7%
Gain in share by CMC-Fort Mill							0.0%						0.0%	0.0%	0.0%
CMC-Fort Mill discharges													1,643	1,692	1,744

CMC-Pineville discharges shifted to CMC-Fort Mill	957	986	1,016
Carolinas Medical Center discharges shifted to CMC-Fort Mill	563	580	598
CMC-Mercy discharges shifted to CMC-Fort Mill	113	117	120
CMC-University discharges shifted to CMC-Fort Mill	9	9	10
Total CHS discharges shifted to CMC-Fort Mill	1,643	1,692	1,744

CMC-Fort Mill CON
Inpatient Utilization Projection

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Primary and Secondary Discharges Only															
Rock Hill															
CMC-Pineville	460	573	482	569	618	706	708								
Carolinas Medical Center	334	356	357	347	440	481	573								
CMC-Mercy	59	45	45	54	64	86	93								
CMC-University	6	8	8	6	12	13	8								
CHS Mecklenburg Subtotal	859	982	892	976	1,134	1,286	1,382								
Presbyterian Hospital	169	191	199	237	247	305	238								
Presbyterian Hosp Matthews	12	16	9	25	29	28	24								
Presbyterian Hosp Huntersville	-	-	1	2	2	6	-								
Novant Mecklenburg Subtotal	181	207	209	264	278	339	262								
SC Facilities	6,355	6,448	6,900	6,410	6,328	5,732	5,303								
All Others	63	53	67	60	72	66	63								
Total Rock Hill	7,458	7,690	8,068	7,710	7,812	7,423	7,010								
STEP ONE															
Population (Claritas)	97,471	100,585	103,804	107,129	110,565	114,116	117,786	121,579	124,729	127,961	131,277	134,679	138,171	141,754	145,430
Discharge use rate per 1,000 population	76.5	76.5	77.7	72.0	70.7	65.0	59.5	59.5	59.5	59.5	59.5	59.5	59.5	59.5	59.5
Total area discharges	7,458	7,690	8,068	7,710	7,812	7,423	7,010	7,236	7,423	7,616	7,813	8,015	8,223	8,436	8,655
STEP TWO															
Market Share															
CMC-Pineville	6.2%	7.5%	6.0%	7.4%	7.9%	9.5%	10.1%								
Carolinas Medical Center	4.5%	4.6%	4.4%	4.5%	5.6%	6.5%	8.2%								
CMC-Mercy	0.8%	0.6%	0.6%	0.7%	0.8%	1.2%	1.3%								
CMC-University	0.1%	0.1%	0.1%	0.1%	0.2%	0.2%	0.1%								
Subtotal **(A)**	11.5%	12.8%	11.1%	12.7%	14.5%	17.3%	19.7%								
Shift in share to CMC-Fort Mill **(A x 0.80)** **80%**							15.8%						15.8%	15.8%	15.8%
Gain in share by CMC-Fort Mill							0.0%						0.0%	0.0%	0.0%
CMC-Fort Mill discharges													1,297	1,331	1,365

CMC-Pineville discharges shifted to CMC-Fort Mill	664	682	699
Carolinas Medical Center discharges shifted to CMC-Fort Mill	538	552	566
CMC-Mercy discharges shifted to CMC-Fort Mill	87	90	92
CMC-University discharges shifted to CMC-Fort Mill	8	8	8
Total CHS discharges shifted to CMC-Fort Mill	1,297	1,331	1,365

CMC-Fort Mill CON
Inpatient Utilization Projection

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Primary and Secondary Discharges Only															
Western York County															
CMC-Pineville	218	249	295	278	315	339	338								
Carolinas Medical Center	260	269	275	286	290	280	366								
CMC-Mercy	35	35	43	52	28	59	62								
CMC-University	5	5	4	3	13	6	8								
CHS Mecklenburg Subtotal	518	558	617	619	646	684	774								
Presbyterian Hospital	180	190	196	241	232	224	231								
Presbyterian Hosp Matthew	8	5	12	22	13	11	11								
Presbyterian Hosp Huntersville	-	-	4	7	8	5	8								
Novant Mecklenburg Subtotal	188	195	212	270	253	240	250								
Gaston Memorial Hospital	606	683	709	662	670	602	659								
SC Facilities	2,788	2,865	2,979	2,772	2,566	2,560	2,389								
All Others	88	105	118	132	103	88	111								
Total Western York County	4,188	4,406	4,635	4,455	4,238	4,174	4,183								
STEP ONE															
Population (Claritas)	55,299	56,828	58,401	60,018	61,681	63,392	65,151	66,960	68,681	70,447	72,258	74,117	76,023	77,979	79,985
Discharge use rate per 1,000 population	75.7	77.5	79.4	74.2	68.7	65.8	64.2	64.2	64.2	64.2	64.2	64.2	64.2	64.2	64.2
Total area discharges	4,188	4,406	4,635	4,455	4,238	4,174	4,183	4,299	4,410	4,523	4,639	4,759	4,881	5,007	5,135
STEP TWO															
Market Share															
CMC-Pineville	5.2%	5.7%	6.4%	6.2%	7.4%	8.1%	8.1%								
Carolinas Medical Center	6.2%	6.1%	5.9%	6.4%	6.8%	6.7%	8.7%								
CMC-Mercy	0.8%	0.8%	0.9%	1.2%	0.7%	1.4%	1.5%								
CMC-University	0.1%	0.1%	0.1%	0.1%	0.3%	0.1%	0.2%								
Subtotal **(A)**	12.4%	12.7%	13.3%	13.9%	15.2%	16.4%	18.5%								
Shift in share to CMC-Fort Mill **(A x 0.5)** 50%							9.3%						9.3%	9.3%	9.3%
Gain in share by CMC-Fort Mill							0.0%						0.0%	0.0%	0.0%
CMC-Fort Mill discharges													452	463	475

CMC-Pineville discharges shifted to CMC-Fort Mill	197	202	207
Carolinas Medical Center discharges shifted to CMC-Fort Mill	214	219	225
CMC-Mercy discharges shifted to CMC-Fort Mill	36	37	38
CMC-University discharges shifted to CMC-Fort Mill	5	5	5
Total CHS discharges shifted to CMC-Fort Mill	452	463	475

CMC-Fort Mill CON
Inpatient Utilization Projection

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017

Primary and Secondary Discharges Only

STEP THREE

CMC-Fort Mill Utilization

Discharges		Year 1	Year 2	Year 3
Northern York		1,643	1,692	1,744
Rock Hill		1,297	1,331	1,365
Western York		452	463	475
Subtotal **(A)**		3,391	3,486	3,584
Other discharges **(A x 0.10)**	**10%**	339	349	358
Total discharges		3,730	3,835	3,942
Average length of stay	**4.0**	4.0	4.0	4.0
Total patient days		14,921	15,340	15,770
Average daily census		41	42	43
Licensed beds		64	64	64
Percent occupancy		**63.9%**	**65.7%**	**67.5%**

Sources: **(1) Thomson Healthcare.**
(2) SC Office of Research and Statistics.
(3) CHS internal data.
(4) Claritas, Inc.

Notes: **(1) Numbers may not add exactly due to immaterial computer rounding.**
(2) All discharges represent market-wide primary and secondary services (the types of hospital services to be provided at CMC-Fort Mill).
(3) Discharges exclude normal newborns, behavioral health and rehabilitation.

Total York County CMC-Pineville discharges shifted to CMC-Fort Mill	1,819	1,870	1,923
Total York County Carolinas Medical Center discharges shifted to CMC-Fort Mill	1,314	1,351	1,388
Total York County CMC-Mercy discharges shifted to CMC-Fort Mill	237	243	250
Total York County CMC-University discharges shifted to CMC-Fort Mill	21	22	23
Total CHS York County discharges shifted to CMC-Fort Mill	3,391	3,486	3,584

CMC-Fort Mill CON
Inpatient Obstetrical Utilization Projection

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Obstetrical Discharges Only															
Northern York County															
CMC-Pineville	187	194	231	261	278	295	325								
Carolinas Medical Center	70	74	100	100	102	111	135								
CMC-Mercy	1	-	-	-	-	-	-								
CMC-University	1	3	1	3	8	4	4								
CHS Mecklenburg Subtotal	259	271	332	364	388	410	464								
Presbyterian Hospital	47	69	87	95	124	148	164								
Presbyterian Hosp Matthews	10	6	15	22	27	39	28								
Presbyterian Hosp Huntersville	-	-	-	1	-	1	1								
Novant Mecklenburg Subtotal	57	75	102	118	151	188	193								
SC Facilities	155	160	188	211	249	286	267								
All Others	3	10	6	5	6	6	8								
Total Northern York County	474	516	628	698	794	890	932								
STEP ONE															
Population (Females 15-44) (Claritas)	7,560	7,896	8,246	8,612	8,994	9,393	9,810	10,245	10,410	10,577	10,747	10,920	11,096	11,275	11,456
Discharge use rate per 1,000 population	62.7	65.3	76.2	81.0	88.3	94.8	95.0	95.0	95.0	95.0	95.0	95.0	95.0	95.0	95.0
Total discharges	474	516	628	698	794	890	932	973	989	1,005	1,021	1,037	1,054	1,071	1,088
STEP TWO															
Market Share															
CMC-Pineville	39.5%	37.6%	36.8%	37.4%	35.0%	33.1%	34.9%								
Carolinas Medical Center	14.8%	14.3%	15.9%	14.3%	12.8%	12.5%	14.5%								
CMC-Mercy	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%								
CMC-University	0.2%	0.6%	0.2%	0.4%	1.0%	0.4%	0.4%								
Subtotal (A)	54.6%	52.5%	52.9%	52.1%	48.9%	46.1%	49.8%								
Shift in share to CMC-Fort Mill (A x 0.75) 75.0%							37.3%						37.3%	37.3%	37.3%
CMC-Fort Mill discharges													394	400	406

CMC-Pineville discharges shifted to CMC-Fort Mill	276	280	285
Carolinas Medical Center discharges shifted to CMC-Fort Mill	115	116	118
CMC-Mercy discharges shifted to CMC-Fort Mill	0	0	0
CMC-University discharges shifted to CMC-Fort Mill	3	3	4
Total CHS OB discharges shifted to CMC-Fort Mill	394	400	406

CMC-Fort Mill CON
Inpatient Obstetrical Utilization Projection

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Obstetrical Discharges Only															
Rock Hill															
CMC-Pineville	179	221	181	260	280	323	318								
Carolinas Medical Center	47	50	45	49	39	40	48								
CMC-Mercy	-	-	-	-	1	-	-								
CMC-University	-	3	2	1	4	6	3								
CHS Mecklenburg Subtotal	226	274	228	310	324	369	369								
Presbyterian Hospital	24	26	24	44	56	74	44								
Presbyterian Hosp Matthews	2	7	3	2	9	12	10								
Presbyterian Hosp Huntersville	-	-	-	-	-	1	-								
Novant Mecklenburg Subtotal	26	33	27	46	65	87	54								
SC Facilities	1,191	1,079	1,159	1,232	1,325	1,258	1,176								
All Others	9	7	5	8	7	6	5								
Total Rock Hill	1,452	1,393	1,419	1,596	1,721	1,720	1,604								
STEP ONE															
Population (Females 15-44) (Claritas)	23,132	23,661	24,203	24,756	25,322	25,902	26,494	27,100	27,495	27,897	28,304	28,717	29,136	29,561	29,993
Discharge use rate per 1,000 population	62.8	58.9	58.6	64.5	68.0	66.4	60.5	60.5	60.5	60.5	60.5	60.5	60.5	60.5	60.5
Total discharges	1,452	1,393	1,419	1,596	1,721	1,720	1,604	1,641	1,665	1,689	1,714	1,739	1,764	1,790	1,816
STEP TWO															
Market Share															
CMC-Pineville	12.3%	15.9%	12.8%	16.3%	16.3%	18.8%	19.8%								
Carolinas Medical Center	3.2%	3.6%	3.2%	3.1%	2.3%	2.3%	3.0%								
CMC-Mercy	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%	0.0%								
CMC-University	0.0%	0.2%	0.1%	0.1%	0.2%	0.3%	0.2%								
Subtotal (A)	15.6%	19.7%	16.1%	19.4%	18.8%	21.5%	23.0%								
Shift in share to CMC-Fort Mill (A x 0.80)	80.0%						18.4%						18.4%	18.4%	18.4%
CMC-Fort Mill discharges													325	329	334

CMC-Pineville discharges shifted to CMC-Fort Mill	280	284	288
Carolinas Medical Center discharges shifted to CMC-Fort Mill	42	43	43
CMC-Mercy discharges shifted to CMC-Fort Mill	0	0	0
CMC-University discharges shifted to CMC-Fort Mill	3	3	3
Total CHS OB discharges shifted to CMC-Fort Mill	325	329	334

CMC-Fort Mill CON
Inpatient Obstetrical Utilization Projection

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Obstetrical Discharges Only															
Western York County															
CMC-Pineville	76	86	97	108	104	128	137								
Carolinas Medical Center	33	24	34	38	36	30	33								
CMC-University	2	2	2	1	2	3	1								
CHS Mecklenburg Subtotal	111	112	133	147	142	161	171								
Presbyterian Hospital	33	23	28	38	41	38	50								
Presbyterian Hosp Matthews	-	3	4	7	3	4	4								
Presbyterian Hosp Huntersville	-	-	-	-	-	1	1								
Novant Mecklenburg Subtotal	33	26	32	45	44	43	55								
SC Facilities	511	474	548	521	518	530	508								
All Others	88	97	103	61	97	92	102								
Total Western York County	743	709	816	774	801	826	836								
STEP ONE															
Population (Females 15-44) (Claritas)	11,581	11,802	12,028	12,259	12,493	12,733	12,977	13,225	13,411	13,601	13,792	13,987	14,184	14,384	14,587
Discharge use rate per 1,000 population	64.2	60.1	67.8	63.1	64.1	64.9	64.4	64.4	64.4	64.4	64.4	64.4	64.4	64.4	64.4
Total discharges	743	709	816	774	801	826	836	852	864	876	889	901	914	927	940
STEP TWO															
Market Share															
CMC-Pineville	10.2%	12.1%	11.9%	14.0%	13.0%	15.5%	16.4%								
Carolinas Medical Center	4.4%	3.4%	4.2%	4.9%	4.5%	3.6%	3.9%								
CMC-University	0.3%	0.3%	0.2%	0.1%	0.2%	0.4%	0.1%								
Subtotal (A)	14.9%	15.8%	16.3%	19.0%	17.7%	19.5%	20.5%								
Shift in share to CMC-Fort Mill (A x 0.50) 50.0%							10.2%						10.2%	10.2%	10.2%
CMC-Fort Mill discharges													93	95	96

CMC-Pineville discharges shifted to CMC-Fort Mill	75	76	77
Carolinas Medical Center discharges shifted to CMC-Fort Mill	18	18	19
CMC-University discharges shifted to CMC-Fort Mill	1	1	1
Total CHS OB discharges shifted to CMC-Fort Mill	93	95	96

CMC-Fort Mill CON
Inpatient Obstetrical Utilization Projection

		2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Obstetrical Discharges Only																
STEP THREE																
CMC-Fort Mill Utilization																
Discharges																
Northern York														394	400	406
Rock Hill														325	329	334
Western York														93	95	96
Subtotal														812	824	837
Other discharges	10.0%													81	82	84
Total discharges														893	907	920
Average Length of Stay														2.6	2.6	2.6
Total Patient Days														2,321	2,357	2,393
Average Daily Census														6.4	6.5	6.6
Licensed Beds														8	8	8
Percent Occupancy														79.5%	80.7%	81.9%

Sources: (1) Thomson Healthcare.
(2) SC Office of Research and Statistics.
(3) CHS internal data.
(4) Claritas, Inc.

Notes: (1) Numbers may not add exactly due to immaterial computer rounding.

EXHIBIT 20

CMC-PINEVILLE
PROJECTED ACUTE CARE METHODOLOGY

CHS performed the following steps to project inpatient acute care days for CMC-Pineville.

Step	Description
1	Examine CMC-Pineville's *Historical Acute Care Bed Utilization and Projected Population.*
2	Determine the *Projected Acute Care Bed Patient Days Prior to Shifts.*
3	Determine the *Impact of CMC-Fort Mill.*
4	Demonstrate the *Summary of Utilization* for CMC-Pineville.

Each step is described in detail below.

1. *Historical Acute Care Bed Utilization and Projected Population.*

Internal hospital license renewal data is available for CMC-Pineville through June 2013. Between CY 2010 and CY 2013 annualized (January 2013 to June 2013 data annualized), CMC-Pineville's patient days have grown at a compound annual growth rate (CAGR) of 16.0 percent annually, as shown in the following table.

CY	*Patient Days*	*ADC*	*Beds*	*Occupancy*
2010	32,003	87.7	110	79.7%
2011	33,921	92.9	120	77.4%
2012	42,850	117.4	120	97.8%
2013 Annualized*	50,012	137.0	206	66.5%
CAGR	**16.0%**	**NA**	**NA**	**NA**

*January 2013 to June 2013 days annualized.
Source: CMC-Pineville internal data used to prepare HLRAs.

CMC-Pineville has experienced significant growth in inpatient days since CY 2010.

CMC-Pineville's service area includes five submarkets (South Mecklenburg County, York County (SC), Lancaster County (SC), East Gaston County, and Union County). The following table defines these submarkets by ZIP code.

South Mecklenburg County	*York County*	*Lancaster County*	*East Gaston County*	*Union County*
28105	29710	29720	28032	28103
28134	29715		28120	28174
28210	29708		28012	28110
28226	29704			28112
28270	29730			28104
28277	29732			28079
28278	29717			28173
28273	29726			
	29742			
	29743			
	29745			

The population residing in CMC-Pineville's service area is projected to grow 1.4 percent annually from 2013 to 2018. Population CAGR was based on 2013 to 2018 data, rather than 2013 to 2017 (the third project year) due to limitations in ZIP code level population data.

CMC-Pineville Service Area 2013 to 2018 Population Projections

	2013	*2018*	*Population CAGR*
Total Service Area	825,192	882,780	1.4%

Source: Claritas.

2. *Projected Acute Care Bed Patient Days Prior to Shifts.*

Based on the growth rate of 1.4 percent determined in step one, CHS has projected patient days through CY 2017, as shown below.

CY	*Projected Patient Days*
2014	50,691
2015	51,380
2016	52,078
2017	52,785
CAGR	**1.4%**

Prior to volume shifts to CMC-Fort Mill, CHS projects that CMC-Pineville will provide 52,785 inpatient days of care in CY 2017.

3. *Impact of CMC-Fort Mill.*

In September 2011, CHS was approved to develop a new acute care hospital in Fort Mill, South Carolina. CMC-Fort Mill is projected to be operational on January 1, 2015, though it is currently under appeal. Inpatient discharges at CMC-Fort Mill will be derived from York County patients currently seeking care at CHS hospitals in North Carolina (now given a choice to receive care at a CHS facility closer to home), including CMC-Pineville. CHS has calculated the projected impact of CMC-Fort Mill on total discharges for CHS facilities as shown in the CMC-Fort Mill Projections exhibit. These projections are based on the approved projections for this project filed in October 2010. Based on that submission, CMC-Fort Mill will begin operation in January 2015.

Calendar Year	*Shift of Total Discharges from CMC-Pineville to CMC-Fort Mill*
2015	(1,819)
2016	(1,870)
2017	(1,923)

Please see the CMC-Fort Mill exhibit for the detailed analysis of CMC-Fort Mill's impact on CMC-Pineville and other CHS facilities, which is the source of the data provided above.

In order to determine the patient days associated with the discharges to be shifted from CMC-Pineville to CMC-Fort Mill, CHS assumed that the average length of stay for the shifted discharges was four days based on CMC-Fort Mill's projected average length of stay as demonstrated in the CMC-Fort Mill exhibit.

Calendar Year	*Shift of Total Discharges from CMC-Pineville to CMC-Fort Mill*	*Average Length of Stay*	*Shift of Total Days from CMC-Pineville to CMC-Fort Mill*
2015	(1,819)	4.0	(7,276)
2016	(1,870)	4.0	(7,482)
2017	(1,923)	4.0	(7,693)

4. *Summary of Utilization.*

The following table summarizes the patient days projected above for CMC-Pineville.

Calendar Year	*CMC-Pineville Patient Days (from Step 2)*	*Shift to CMC-Fort Mill (from Step 3)*	*Final Projected Patient Days*	*ADC*	*Beds*	*Occupancy*
2014	50,691	-	50,691	138.9	206	67.4%
2015	51,380	(7,276)	44,104	120.8	206	58.7%
2016	52,078	(7,482)	44,596	122.2	206	59.3%
2017	52,785	(7,693)	45,092	123.5	206	60.0%

As demonstrated, CMC-Pineville is projected to operate at 60.0 percent occupancy in the third project year of the CMC-Mercy and CMC-University bed additions.

Exhibit 6

Test 4

- Use weighted average by facility
- Substitute weighted DOC for each month (March, April, May, June 2020) across 3 previous years and apply result to same month in 2020. The total of the weights = 1 (or 100%)

Formula for March 2020

Step 1: Calculate the average DOC weight for March 2017, March 2018, and March 2019.

w1 = Mar17DOC / (Mar17DOC + Mar18DOC + Mar19DOC)
w2 = Mar18DOC / (Mar17DOC + Mar18DOC + Mar19DOC)
w3 = Mar19DOC / (Mar17DOC + Mar18DOC + Mar19DOC)

Step 2: Multiply each weight by the actual March DOC for each of the 3 years to calculate March 2020 DOC

(w1 x Mar17DOC) + (w2 x Mar18DOC) + (w3 x Mar19DOC)

Next: Repeat the process for April, May, and June

Calculation for March 2020

Step 1:

w1 = 1,288 / (1,288 + 1,119 + 1,229) = **.35424**
w2 = 1,119 / (1,288 + 1,119 + 1,229) = **.30776**
w3 = 1,229 / (1,288 + 1,119 + 1,229) = **.33801**

Step 2:

(1,288 x .35424) + (1,119 x .30776) + (1,229 x .33801) = **1,216.05**

Exhibit 7

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH SERVICE REGULATION

ROY COOPER
GOVERNOR

MANDY COHEN, MD, MPH
SECRETARY

MARK PAYNE
DIRECTOR

MEMORANDUM

TO: Mark Payne, Director
Division of Health Service Regulation (DHSR)

FROM: Martha J. Frisone
Assistant Chief Certificate of Need
Healthcare Planning and Certificate of Need Section

DATE: March 16, 2017

SUBJECT: Declaratory Ruling Request
REQUESTOR: The Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas Rehabilitation
DESCRIPTION: Operate the 70 licensed rehabilitation beds in any of the 117 available and *"licensure-compliant spaces"* without having to file a new bed plan
COUNTY: Mecklenburg
FID#: 943092

BACKGROUND

Gary S. Qualls, representing The Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas Rehabilitation (CR), requests a declaratory ruling regarding the applicability of Chapter 131E, Article 9 (Certificate of Need Law) and the Department's rules to a proposal to operate CR's 70 licensed rehabilitation beds in any of the 117 available and *"licensure-compliant spaces"* without having to file a new bed plan each time the hospital desires to use a different complement of bed spaces.

ANALYSIS

CR is located at 1100 Blythe Boulevard in Charlotte and is currently licensed for 70 rehabilitation beds. The request states that the hospital has been licensed for as many as 133 rehabilitation beds. According to the Master Facility File, CR has been licensed for as many as 143 rehabilitation beds at some point in time. See the attached screen shot.

The request states that the 70 beds are currently located in 54 rooms – 41 private, 12 semi-private and one 4-bed ward. Note: that only adds up to 69 beds, not 70 (12 x 2 = 24 + 4 + 41 = 69). The request also states that there are 62 *"licensure-compliant spaces"* on the A Wing, 25 *"licensure-compliant*

spaces" on the B Wing, and 30 *"licensure-compliant spaces"* on the C Wing. What is not clear is what is meant by a "licensure-compliant space." It is not clear if the word "space" means a room or something else. What is not provided in the request is the number of rooms on each wing and how many rooms on each wing are large enough to accommodate two beds although at least one room is apparently large enough for four beds. The request also does not include sufficient information to determine how many rooms on each wing are currently being used for the 70 licensed beds.

Nevertheless, pursuant to N.C. Gen. Stat. § 131E-178(a), a certificate of need would only be required if the proposal results in the development or offering of a "new institutional health service." "New institutional health service" is defined in N.C. Gen. Stat. § 131E-176(16). The proposal would not result in the development of a new health service facility. Assuming that no more than 70 beds are in use at any one time, the proposal would not result in an increase in the number of rehabilitation beds. Although, ensuring compliance with the limit on the total number of beds that can be in use at any one time could be problematic. The request appears to imply that there is no capital cost associated with the proposal. And even if there is a capital cost for renovations, the cost of renovations could be exempt from review. It appears that the proposal to operate the 70 licensed rehabilitation beds in any of the 117 available and *"licensure-compliant spaces"* does not meet any of the definitions of "new institutional health service." Consequently, a certificate of need is not required.

RECOMMENDATION

The Healthcare Planning and Certificate of Need Section recommends that the Director conclude that the proposal is not a new institutional health service which requires a certificate of need.