Spring Petitions Related to MRI Services
March 1, 2023

Mission Hospital ("Mission") appreciates the opportunity to provide comments on fixed and mobile MRI services and their respective need. Mission applauds the work of the SHCC last year in approving Policy TE-3, which expanded the ability of hospital providers in both rural and urban communities who do not have an MRI unit to obtain a fixed MRI unit. This is a step in the right direction; however, more analysis and methodology changes are needed to fully allow for sufficient access to MRI as a basic imaging tool needed by all hospitals to provide routine care it their patients.

As will be discussed in detail below, the current MRI methodology continues to limit fixed MRI access in the state. MRI is the standard of care and has become as routine as other non-regulated services such as X-ray, Ultrasound, and CT scan. Yet, we continue to limit access to this basic service. This limitation has two effects:

- Patients in urban communities can wait weeks for an MRI appointment at major medical centers due to constraints and limitation of the approval of just 1 or 2 MRI units at a time in such counties.
- Patients in rural and smaller communities can wait days to weeks for scheduling on a mobile unit, sometimes with inferior image quality, endure an uncomfortable experience in a mobile trailer, and worry about continuity of care between the mobile provider and their local hospital provider.

It should be noted that in numerous other surrounding states with CON regulation, MRI regulation has been significantly curtailed with many state regulations containing no MRI need methodology. These states include Georgia, South Carolina, Tennessee, Kentucky, and Alabama.[1]

<u>Overview of MRI Need Methodology Concerns</u>

Mission believes the SHCC should address the need for hospital-located fixed MRI units and situations in which a location has sufficient demand for a fixed unit but is being served by one or more mobile providers. This speaks to the "big picture" of MRI planning that was not addressed by the SHCC last year as the MRI Workgroup simply made minor tweaks to the assumptions to prior methodology without a full evaluation of the actual methodology. There needs to be an overall assessment of how MRI is being offered in our state and how it should be offered. In fact,

[1] Georgia and South Carolina regulate MRI only by capital expenditure resulting in most MRI units seeking exemption. There is no need methodology. Tennessee only regulates MRI in smaller and rural communities. Kentucky requires only that an applicant demonstrated it will be accredited by ACR. Alabama only has capital expenditure thresholds set at a level that most MRI units are exempt.

the MRI Workgroup tweaks actually created a greater limitation on quantitative need for *fixed* MRI services with a higher threshold scan volume than the 2022 SMFP.

It seems reasonable to agree that where a fixed MRI can be well utilized, this is preferable from a technology, continuity, and patient care perspective than the use of multiple mobile vendors to meet demand. We hear from our hospital colleagues that they cannot get enough mobile days to meet demand, yet as will be shown, **there should be more than enough mobile capacity with 26 CON approved mobile units and the equivalent of 11 "legacy" or grandfathered mobile units to serve the state**. Now the 2023 SMFP identifies a need for 3 more mobile MRI units while numerous hospitals could likely justify a fixed unit. It is not to say that mobile MRIs are not important to serve low volume and rural communities, to bridge the gap when a fixed unit cannot meet all the demand at the host site, or to serve fixed sites temporarily when equipment is being replaced, for examples. Mission proposes that the goal of the planning methodology should be to offer fixed units where the demand exists to support a fixed unit and not limit need determinations so as to unnecessarily rely on mobile units. This goal is not furthered by the current methodology.

Options for MRI Planning

As demonstrated below, the complexity of reporting mobile capacity leads to numerous unintended issues and problems with the current methodology. The combination of mobile and fixed MRI units together also creates a less than clear picture of the full utilization and needs of hospitals, hospital systems, and other fixed and mobile MRI sites. Many of these issues and errors are discussed in detail below. With these concerns, and the "big picture" issues identified above, the SHCC and the Technology and Equipment Committee should consider the following options:

- Eliminate the MRI methodology
- Regulate MRI services through policies such as proposed TE-3.
- Develop a new methodology, within the framework of the larger view of MRI need, with varying approaches to be considered for:
    - Identifying separate planning approaches for Fixed and Mobile services (like the PET methodology);
    - Separate consideration of utilization of specific fixed sites such as hospitals (like the PET methodology); and
    - Separate considerations for the needs of hospitals or across health systems in a defined geographic area (similar to the OR methodology).

It is Mission's hope that the SHCC, Technology and Equipment Committee and the Agency will consider the significant issues with the current methodology, and particularly the impact of mobile units described in detail below and will undertake a broader evaluation of MRI regulation

and health planning goals even if this means delaying a year (planning cycle) for a more in-depth analysis.

Eliminate the Need Methodology

This approach follows the path taken by several other states including South Carolina and Georgia. MRI units are still regulated by Agency rule and a CON is required. Any provider can apply for an MRI unit and each applicant would still have to demonstrate that the general review criteria are met. This is the also the path that has occurred with CT scanners in North Carolina, for which a need methodology and SMFP chapter was eliminated and ultimately the performance standards sunsetted. MRI units are no less common or basic and a similar path should be strongly considered.

Develop a Policy to Address Hospital Fixed MRI Need at Minimum

Policy TE-3, added to the 2023 SMFP, is very helpful for the addition of fixed MRI units to hospitals that do not currently have a fixed MRI unit. However, this policy does not consider the number of hospitals that need additional MRI capacity (a second or third unit) but are prohibited by an area-wide surplus under the current methodology. Such providers have no other choice but to use mobile MRI units to supplement their need when they have more than sufficient volume to seek an additional unit. ***A new policy could be added that would allow any existing fixed provider with sufficient volume to meet the performance standards for a new fixed unit to apply for such, independent of a need determination in their area, and be found to meet the State Medical Facilities Plan – Criterion (1).*** This would be a simple way to address capacity limitations without revising the entire need methodology. Performance standards would still apply to each applicant.

In many urban and larger counties, the need for additional capacity is very clear but the annual need determinations fall far short of addressing this need. For example:

- Charlotte/Mecklenburg County
    - 28 fixed MRI units
    - **6 hospital fixed units operating at over 80% of capacity**
    - 4.65 mobile fixed equivalent units
    - **One (1) unit in the need determination**
- Wake County
    - 20 fixed equivalent units
    - **10 fixed units operating at over 80% of capacity including 5 hospital sites**
    - 7.26 mobile fixed equivalent units
    - **One (1) unit in the need determination**
- Forsyth County

    - 19 fixed MRI units
    - **3 hospital affiliated fixed units operating at over 80% of capacity**
    - 1.52 mobile fixed equivalent units
    - **No units in the need determination**
- Guilford County
    - 13 fixed equivalent units
    - **6 fixed units including 2 hospitals operating at over 80% of capacity**
    - 2.02 mobile fixed equivalent units
    - **NO units in the need determination**
- Buncombe County
    - 11 fixed units
    - **4 fixed units including 2 hospital affiliates operating at over 80% of capacity**
    - 1.03 mobile fixed equivalent units
    - **NO units in the need determination**
- Gaston County
    - 5 fixed MRI units
    - **1 hospital fixed unit operating at over 80% of capacity**
    - 1.28 mobile fixed equivalent units
    - **NO units in the need determination**

This is not an exhaustive list; however, these situations beg the question of why the recognized in the SMFP is so limited. Providers have no other choice but to supplement with mobile capacity, which does not address the true need.

Mobile units make sense when a rural community cannot support a full time fixed unit, when a provider wants to add an access point to expand geographic access. Mobile units should not be used instead of fixed capacity due to constraints imposed by the MRI Need Methodology and the North Carolina health planning process.

Based on the 2021 data considered in the 2023 SMFP, there were 30 hospitals that operated at over 80% of capacity. These providers collectively operated 72 units that average over 80% of capacity. In every size category below, there were hospitals operating at over 100% of capacity with a total of 10 hospitals operating at over 100 percent of capacity.

Analysis of Utilization Rate of Hospitals by Number of Fixed MRI Units

Units per Hospital/Site	Average % of Capacity (Current)	Providers over 80% of Capacity	Total Providers	% of Providers Over Capacity	Units Over 80% of Capacity
1 unit	52.0%	13	81	16.0%	13
2 units	67.4%	9	28	32.1%	18
3 units	84.4%	4	6	66.7%	16
4 units+	87.2%	4	5	80.0%	25
Total	**59.2%**	**30**	**120**	**25.0%**	**72**

Source: 2023 SMFP

Under a policy that recognizes the need for fixed MRI services at hospitals, these collective 30 hospital providers would have the opportunity to address their MRI capacity constraints without:

- waiting for a need determination in their county, which might take years to appear;
- applying and having another provider being approved to add competition, which does not address hospital capacity constraints;
- waiting additional time for CON submission, approval, and potential appeal; and
- then developing the capacity.

It should be questioned why the hospitals in North Carolina operating at over 80% of MRI capacity are in this situation and how that benefits the residents of the State.

Consider Separate Need Methodologies for Mobile and Fixed MRI (like PET/CT)

<u>Planning for Fixed MRI Units</u>

- As noted above, there are numerous fixed MRI providers operating above capacity. It is clear that the current methodology does not recognize or address the needs of these providers. It is also clear that average area utilization is clearly weighted downward based on the apparent underutilization of mobile MRIs in the current methodology. (Please see issues with planning mobile MRI units discussed below.)
- Analysis of the available data reveals:
  - The largest service areas (those with 4+ MRI units) represent the majority of highly utilized units.
  - There are over 30 hospital units and over 22 freestanding units operating at more than 80% of capacity. These providers collectively operate 94 MRI units that are on average operating at over 80% of capacity. This clearly indicates a need for more fixed MRI capacity in these markets.
  - The current and recommended methodologies limit need to 1 unit or even 2 in a service area, which does not address the fact that there may be many fixed providers in a large market operating at or well over capacity.
  - With this cap on need and a 4-to-5-year delay between data reporting, SMFP preparation, application, sometimes appeal, and then implementation, there is no way that sufficient fixed capacity can be brought online to address the large number of existing fixed providers operating at high levels of capacity.

- The largest hospitals with 4+ MRI units are clearly highly utilized, and their needs are not being met. If a single MRI is recognized as needed, then awarded to a freestanding provider under based on enhanced "competition" or "cost effectiveness", this leaves our major tertiary medical centers with ongoing limitations of MRI capacity for the most acutely ill patients.
- This perpetuates a situation in which the major tertiary medical centers cannot meet MRI demand. This should be considered in both policy and any type of future need methodology.

- **Important Observations available from the Agency's collected data indicate:**
  - There are 255 total fixed MRI units in North Carolina including approved and operational units.
  - These units are distributed more heavily towards hospitals.
  - Most freestanding fixed units are located in service areas with a large number of scanners.
  - There are a large number (more than 50) of highly utilized (over 80% of capacity) fixed units (both hospital and freestanding) many of those providers may need additional capacity.
  - Average area utilization is clearly weighted downward based on the apparent underutilization of mobile MRIs in the current and recommended methodology, which the highly utilized fixed providers have to rely upon to address capacity constraints.
  - A need methodology ONLY for fixed MRI units and an SMFP policy governing MRI need for hospitals, would address what appears to be a dire need for more fixed MRI units in the State.

- **With regard to Hospital-based fixed units:**
  - An analysis of hospital-based fixed units reveals that there are 185 fixed units either existing or approved in hospital locations across North Carolina. This includes 8 non-operational units. 177 units in 120 site locations reported volume in 2021.
  - There are a large number and percent of hospitals with only 1 unit. About 23.3% of hospitals have 2 units. Very few providers have 3 or more units on the hospital campus, according to their LRAs.

Summary of Number of Units by Hospital

Number of Fixed Units	Providers	% of Providers
1 unit*	81	67.5%
2 units	28	23.3%
3 units	6	5.0%
4 units	1	0.8%
5 units	1	0.8%
6 or more units	3	2.5%
Total	**120**	**100.0%**

**Includes approved but non-reporting hospitals.*

  - While the **average** utilization is below the thresholds, there are many units operating above the need utilization threshold, indicating that multiple hospitals may need more capacity. 30 hospital providers with 72 units in all service areas operate above 80% of the 2023 SMFP capacity.

Analysis of Utilization Rate of Hospitals by Number of Fixed MRI Units

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Total	**59.2%**	**30**	**120**	**25.0%**	**72**

Source: 2023 SMFP

- **There are 70 fixed units <u>existing and approved</u> in freestanding facilities operating fixed MRI units across North Carolina. This includes 11 units that are either not operational or not yet implemented (recent approvals) included in the 2021 data for the 2023 SMFP. This does not include the need determination place holders.**
  - Based on the current methodology, all of these units operate in planning areas with the highest capacity thresholds to generate need.
  - There are many units above threshold that could potentially need more capacity. 22 units are operating above 80% of capacity. This is far more than a collective need determination in any single SMFP.
  - Of the 22 units operating at over 80% capacity, 4 are operating at over 90% of capacity and 8 are operating at over 100% of capacity.
  - Like hospital fixed MRI units, these providers are limited in their ability to address capacity constraints given the minimal need determinations each year and the delays between identified need and implementation of any potentially approved project.

Conclusions Regarding Fixed MRI Need: With over 30 hospital units and 22 freestanding providers operating 94 MRI units at over 80% of capacity, there is clearly a need for more fixed MRI capacity in these markets. With the practice of limiting need to 1 unit or even 2 in a service area, and then a 4-to-5-year delay between data, SMFP preparation, application, sometimes appeal, and then implementation, there is no way that sufficient fixed capacity can be brought online to address the large number of existing fixed providers operating at high levels of capacity. Moreover, the largest hospitals with 3+ MRI units are clearly highly utilized, and their needs are not being met. When a major urban service area has multiple fixed locations, including large hospitals operating at high levels, and a single unit is recognized as needed every few years, and then that unit is approved for a freestanding provider, this perpetuates a situation in which the major tertiary medical centers cannot meet MRI demand. This should be considered in both policy and any type of future need methodology.

<u>Issues in Planning for Mobile MRI Need</u>

There are numerous issues involved in planning for mobile MRI services. In developing the 2023 SMFP, these issues were not considered and the SHCC simply granted petitions and determined a need for 3 mobile MRI units without a cohesive approach to analyzing and planning for mobile MRI services. There are numerous issues with mobile utilization data and planning that must be addressed.

- **Lack of "Big Picture" Information -** the tweaks made to the MRI need methodology in 2022 SMFP did not consider many shortcomings of this methodology including the following critical information about mobile use in the State. With the current methodology, it cannot easily be determined:
  - How many CON-authorized mobile units are operating in the state?
  - How many legacy units are operating in the state? How many are permitted to?
  - How well utilized is each individual unit as a whole (instead of focusing on its utilization levels only at individual sites)?
  - How much available mobile capacity is not being used currently?
  - Is it reasonable that mobile equipment has the same capacity as fixed equipment given that it must travel between sites, limiting the length of operational days and potentially the days per week of operation?
  - With mobile units serving providers with fixed units all over the state, does that indicate that perhaps there is a need for more fixed units and that limitations on need for fixed units has resulted in an overuse of mobile equipment for this basic and standard imaging modality?

- **Information available from the reported utilization (MRI Workgroup excel file 2020 data, which is included in the 2022 SMFP) reveals the following information:**
  - There are 26 reported CON authorized mobile units in NC.
    - Of these units, most are included in the methodology with less than 1 equivalent – not all authorized capacity is being used based on capacity definitions for mobile units.
    - It appears that the equivalent of only 16 fully utilized mobile units are included in the need methodology despite the fact that 26 units are authorized and serving the state.
    - If you ask hospitals, it is very hard to get additional mobile days. If you look at the utilization of each individual mobile unit as a whole, it seems there is available capacity based on the standard capacity (which is applied across all sites and types of equipment).
    - There are a handful of units that are calculated to have more than 1 equivalent. If a CON authorizes one unit, why should it be included with an equivalent of more than 1?

    See Appendix Table 1.

  - It is unclear how many Legacy units are authorized to operate in the state. It appears that perhaps a single authorized Legacy unit can report multiple different equipment IDs, which may be associated with replacement equipment. However, this is completely unclear with the current and recommended methodology and reporting process.
    - Across the state, there are 4 legal entities operating Legacy units. Entities operating Legacy mobile units include Insight Imaging, Alliance Imaging, Kings Medical, and Foundations Health.
    - Collectively these entities report 22 different pieces of equipment (Equipment ID #s), which represent approximately 11 equivalent units combined.
    - Combined, Alliance reports a total of 9.6 equivalent units across these legacy IDs. The Agency calculates 9.183 equivalent units in the need methodology. Is there any way to validate how

many legacy units Alliance is supposed to be operating? For example, in 2020 Alliance Healthcare operated legacy units with IDs #92, 121, 123, 124, 125, 126, 127, 128, 129, 130, 131, 133, 134, 136, 155, and 156.
    - How many legacy units does Alliance actually have authorization to operate?
  - Two providers (Kings Medical and Foundations) are counted as less than a unit even though they should be available full time.
  - Insight appears to have one unit, but it is counted as more than a full-time fixed equivalent.

  See Appendix Table 2.

- **The concept of mobile equivalents is not based on actual capacity and is flawed and inconsistent with how many days a mobile is available on site.**
  - When all of the equivalent units reported and calculated are added up for a single unit during a year, they can calculate to more than 1 full unit. A single CON-authorization should only equal 1 unit. As noted above 5 CON-authorized providers each report more than 1 equivalent. **(See Appendix Table 1)**
    - Example: Carolina Neurosurgery & Spine Assoc. ID #111 - F-006734-03 total reported and calculated equivalent units = 1.3
    - Example: EmergeOrtho J-008453-09 operated equipment IDs #106, 107, 108, 109, 110. Collectively, these units add up to an equivalent of 1.1 units.
  - Mobile equivalents are based on the threshold for the county/area and actual utilization as opposed to an allocation of a full-time unit across all locations.
    - Capacity should not be based on utilization but on the percent of time in each location. Setting capacity at actual utilization always shows an equivalent unit is well utilized.
    - As a result, often, when the total utilization of an authorized unit is summed, the **equivalent units is less than 1 even though the unit is authorized for full time use**. This is a function of different thresholds going into the equivalent units in different service areas. These units should be counted as 1 full unit collectively as that is what they were approved to operate.
    - Despite what seems to be limited available days of service for host sites in need of capacity, most mobile MRI units appear to be utilized at relatively low percentages of capacity.
  - If it is assumed that each authorized mobile has the capacity of a full unit, then the vast majority of mobile scanners are poorly utilized based on weighted scan volume / capacity as shown in **Appendix Table 3** under both the current and recommended ("Rec") methodology.
    - This reflects the fact that despite a mobile MRI provider scheduling most, if not all, days of service it has available, mobile units have built in scheduling inefficiencies and simply cannot operate at the same capacity as a fixed unit.
    - However, a mobile unit should be counted as a full-time unit if scheduled every day regardless of its utilization each day (one full equivalent).
    - These inefficiencies raise the question again as to whether more fixed units should be permitted to increase efficiency.

- **Complications in Reporting Leads to Errors -** During a given reporting year, mobile providers can make the following changes:
  - CON approved units can be replaced.
  - Legacy units can be replaced.
  - It appears that both CON approved and legacy units can:
    - Add site locations (even if they were not locations originally authorized in their CON)
    - Drop site locations
  - Serving the same site but with a different Equip ID (replace or move between units)
  - Serving the same site with:
    - Different CON authorized units, and/or
    - Different legacy units

  First, these changes do not appear to be consistent with the use for which mobile MRI units were approved.

  Second, these changes result in numerous errors impacting the inventory and need methodology. This information is not meant to criticize the Agency or any mobile vendor or host site and their reporting. It is simply a fact that given the complexities noted above, it is clearly an impossible task for the Agency to reconcile all mobile equipment utilization. Because units can change location during a year or the subsequent year, the mobile units may not be serving the same locations in a CON filing year as they were in the year in which need was identified. In other words, there may be more or less mobile units serving a county each year than anyone is aware of until after the fact.

Conclusions Regarding Mobile MRI Need: For these reasons, Mission strongly encourages the SHCC to consider separating mobile MRI units from fixed units in future planning efforts. Moreover, given the number of what appears to be underutilized mobile MRI units, a different approach should be taken with respect to determining mobile capacity.

Appendix
Mobile MRI Analysis

Table 1

Total Reported CON Equipment

CON Authorization	Legal Entity	Reported Equivalent Units	Calculated Equivalent Units	Eq. Units in Need Methodology	Unused Capacity (+) / Over-reported Capacity (-)
R-007623-06 Total	Sentara Albemarle Medical Center	0.31	0.270	0.270	0.730
G-00703804 Total	Alliance HealthCare Services	0.51	0.50	0.50	0.503
E-007066-04 Total	Blue Ridge Radiology	0.61	0.52	0.52	0.484
E-008230-80 Total	EmergeOrtho, PA	1.18	1.063	1.063	-0.063
F-006626-02 Total	Jacksonville Diagnostic Imaging	0.290	0.274	0.274	0.726
F-006734-03 Total	Carolina Neurosurgery & Spine Associates	1.30	1.30	1.30	-0.295
F-007040-04 Total	Carolinas Imaging Services, LLC	0.47	0.48	0.48	0.519
F-007164-04 Total	Presbyterian Mobile Imaging	0.920	0.892	0.892	0.108
F-007987-07 Total	OrthoCarolina, PA	1.050	1.020	1.020	-0.020
F-008000-07 Total	MRI Specialists of the Carolinas	0.40	0.40	0.40	0.603
G-006271-00 Total	Alliance HealthCare Services	0.73	0.71	0.71	0.288
G-007064-04 Total	High Point Regional Health System	0.260	0.245	0.245	0.755
G-007065-04 Total	Forsyth Medical Hospital	0.35	0.35	0.35	0.650
G-007723-06 Total	OrthoCarolina, PA	0.940	0.909	0.909	0.091
J-006665-02 Total	Cape Fear Mobile Imaging	0.690	0.667	0.667	0.333
J-007008-04 Total	Foundation Health Mobile Imaging, LLC	0.440	0.404	0.404	0.596
J-007012-04 Total	Wake Radiology	0.490	0.484	0.484	0.516
J-007756-06 Total	Raleigh Orthopaedic Clinic, PA	0.79	0.76	0.76	0.239
J-008453-09 Total	EmergeOrtho	1.100	1.010	1.010	-0.010
J-011291-17 Total	Wake Radiology	0.300	0.353	0.353	0.647
J-082608-08 Total	Pinnacle Health Service of North carolina, LLC	1.53	1.37	1.37	-0.366
M-006605-02 Total	Mobile Imaging of North Carolina, LLC	0.47	0.419	0.419	0.581
O-006434-01 Total	Cape Fear Diagnostic Imaging, LLC	0.440	0.372	0.372	0.628
O-007001-04 Total	Alliance HealthCare Services	0.270	0.309	0.309	0.691
O-007254-05 Total	Porter's Neck Imaging, LLC	0.71	0.68	0.68	0.320
Q-006884-03 Total	Alliance HealthCare Services	0.730	0.675	0.675	0.325
Total Reported CON Equipment		**17.280**	**16.419**	**16.419**	**9.581**
Count of Authorized CON Equipment		**26.000**			

Table 2

Equipment ID#	Legal Entity	Reported Equivalent Units	Calculated Equivalent Units	Eq. Units in Need Methodology	Total Units
Legacy #99	Insight Imaging	0.18	0.147	0.147	
Legacy #100	Insight Imaging	0.63	0.61	0.61	**1.062**
Legacy #104	Insight Imaging	0.280	0.309	0.309	
Legacy #113	Kings Medical Group	0.140	0.316	0.316	**0.752**
Legacy #114	Kings Medical Group	0.440	0.436	0.436	
Legacy #189	Foundations Health Mobile Imaging	0.570	0.551	0.551	**0.551**
Legacy #121	Alliance HealthCare Services	0.940	0.900	0.900	
Legacy #123	Alliance HealthCare Services	0.4	0.389	0.389	
Legacy #124	Alliance Healthcare Services	0.060	0.033	0.033	
Legacy #125	Alliance Healthcare Services	0.970	0.882	0.882	
Legacy #126	Alliance Healthcare Services	0.88	0.857	0.857	
Legacy #127	Alliance Healthcare Services	0.030	0.032	0.032	
Legacy #128	Alliance Healthcare Services	0.800	0.777	0.777	
Legacy #129	Alliance Healthcare Services	0.320	0.296	0.296	
Legacy #130	Alliance Healthcare Services	0.820	0.732	0.732	**9.183**
Legacy # 131	Alliance HealthCare Services	0.320	0.345	0.345	
Legacy #133	Alliance Healthcare Services	0.250	0.242	0.242	
Legacy #134	Alliance Healthcare Services	0.670	0.627	0.627	
Legacy #136	Alliance Healthcare Services	0.66	0.639	0.639	
Legacy #155	Alliance Healthcare Services	0.47	0.452	0.452	
Legacy #156	Alliance Healthcare Services	1.130	1.091	1.091	
Legacy #207	Alliance Healthcare Services	0.920	0.889	0.889	
Total All Reported Legacy Units		**11.880**	**11.549**	**11.549**	**11.549**

Table 3

Existing CON Authorized Units - Adjusted Scans as a % of Capacity			
CON Authorization	**Legal Entity**	**Rec Adjusted Scans as a % of Rec Capacity (6,240)**	**Current Adjusted Scans as a % of Current Capacity (6,864)**
F-007040-04 Total	Carolinas Imaging Services, LLC	16.99%	18.2%
R-007623-06 Total	Sentara Albemarle Medical Center	18.36%	20.0%
G-007064-04 Total	High Point Regional Health System	19.21%	20.3%
Q-006884-03 Total	Alliance HealthCare Services	21.47%	27.8%
J-007008-04 Total	Foundation Health Mobile Imaging, LLC	22.01%	23.3%
M-006605-02 Total	Mobile Imaging of North Carolina, LLC	25.11%	26.5%
F-006626-02 Total	Jacksonville Diagnostic Imaging	25.94%	23.1%
O-007001-04 Total	Alliance HealthCare Services	26.96%	26.8%
O-006434-01 Total	Cape Fear Diagnostic Imaging, LLC	27.35%	29.7%
G-007065-04 Total	Forsyth Medical Hospital	28.30%	29.4%
J-011291-17 Total	Wake Radiology	29.70%	30.3%
G-007038-04 Total	Alliance HealthCare Services	30.43%	31.0%
H-061004-99 Total	First Health of The Carolinas, Inc	32.05%	39.9%
F-008000-07 Total	MRI Specialists of the Carolinas	32.92%	33.8%
E-007066-04 Total	Blue Ridge Radiology	39.33%	41.4%
J-007012-04 Total	Wake Radiology	40.05%	41.2%
F-005723-97 Total	Insight Imaging	44.61%	62.4%
J-006665-02 Total	Cape Fear Mobile Imaging	51.83%	53.3%
G-006271-00 Total	Alliance HealthCare Services	52.88%	57.3%
J-007756-06 Total	Raleigh Orthopaedic Clinic, PA	54.81%	60.3%
G-007723-06 Total	OrthoCarolina, PA	66.98%	72.8%
O-007254-05 Total	Porter's Neck Imaging, LLC	67.91%	68.5%
CURRENT TOP THRESHOLD			**70.0%**
F-007164-04 Total	Presbyterian Mobile Imaging	70.86%	74.3%
J-008453-09 Total	EmergeOrtho	73.17%	79.4%
RECOMMENDED TOP THRESHOLD		**80.00%**	
F-007987-07 Total	OrthoCarolina, PA	75.20%	81.8%
E-008230-80 Total	EmergeOrtho, PA	76.68%	82.5%
J-082608-08 Total	Pinnacle Health Service of North carolina, LLC	107.29%	113.1%
F-006734-03 Total	Carolina Neurosurgery & Spine Associates	113.34%	119.9%
Average Utilization of All CON Authorized Mobile Units		**47.30%**	**50.29%**