Strategic Healthcare Consultants

November 30, 2017

Ms. Martha Frisone, Chief
Health Planning and Certificate of Need Section
2704 Mail Service Center
Raleigh, NC 27699-2704

RE: Comments Regarding Duke University Hospital CON Project ID # J-11426-17

Dear Ms. Frisone:

I am writing on behalf of North Carolina Specialty Hospital to submit comments regarding Duke University Hospital CON Project ID # J-11426-17. These comments are submitted in accordance with G.S.131 E-185(a1)(1).

Thank you for your consideration of this information.

Sincerely,

David J. French
Consultant

Phone: 336-349-6250
Djfrench45@gmail.com

Mailing Address
Post Office Box 2154
Reidsville, NC 27323-2154

North Carolina Specialty Hospital Comments Regarding Duke University Hospital CON Project ID # J-11426-17

The following table provides comparative data for the two competing CON applications:

Comparative Factors	**NCSH CON # J-11422-17**	**DUH CON # J-11426-17**
Conformity to Statutory and Regulatory Criteria	Yes conforms to all criteria	No, nonconforming to multiple criteria
Enhances Competition	Yes, NCSH offers patients and physicians an alternate facility choice.	No, Duke controls 98.6 percent of all acute care beds in the service area.
Access to Existing Licensed Beds	Yes, NCSH staffs and operates its total capacity of licensed beds	No, DUH staffs and operates less than its total capacity of licensed beds
Operational Dates for Proposed Additional Beds	1/1/2019 (all 6 beds proposed)	7/1/2018 (initial 22 of 96 beds) 7/1/2023 (all 96 beds)
Gross Revenue per Patient Day	$14,700 For 2021 (Year 3)	$13,142 For FY2024 (Year 1)
Net Revenue per Patient Day	$6,909 For 2021 (Year 3)	$4,194 For FY2024 (Year 1)
Expense per Patient Day	$5,953 For 2021 (Year 3)	$4,326 For 2024 (Year 1)
Medicare % of Total Inpatient Acute	43.0%	47.1%
Medicaid % of Total Inpatient Patients	2.8%	18.8%
Durham County % Patient Origin	34.61 % Durham	29.1% Durham
HSA IV Patient Origin	76.5% HSA IV	72.5% HSA IV
Adequate Physician Letters of Support	Yes	Yes
Total Capital Cost and Capital Cost per Bed	$100,000 / 6 = $16,667 per bed	$29,100,000 / 96 = 303,125 per bed

Conformity to Statutory and Regulatory Criteria – The NCSH application conforms to all applicable CON review criteria and regulatory performance standards. In contrast the DUH application fails to conform to CON Review Criteria 1, 3, 4, 5, 6, 7,18a and performance standard 10A NCAC 14C .3803. Therefore the NCSH is comparatively superior regarding this factor.

Enhances Competition – The NCSH proposal seeks to add 6 licensed acute care beds to its existing 18 licensed beds; this will enable patients and physicians in Durham County to have the opportunity to utilize an excellent quality, physician-owned specialty hospital. If approved, NCSH will have 24 licensed acute care beds representing approximately 1.75 percent of the total acute care capacity for the service area. NCSH documents that its proposed project will help contain costs and improve quality for all of the licensed acute care beds it owns and operates in the service area. Duke University Hospital (DUH) has a total of 938 licensed acute care beds, including 14 beds that were obtained in accordance with Policy AC-3. Duke Health System leases and manages Duke Regional Hospital (DRH) with a total licensed capacity of 316 acute care beds. The DUH application documents that its proposed project will helps contain costs and improve quality care but only for the acute care beds at DUH. The application includes no documentation that the proposed project will enhance competition by helping to contain costs and improve quality for the licensed acute care beds at DRH. Duke Health System (DUH and DRH) currently controls 98.6 percent of the total bed capacity in the service area. If DUH is approved to add 96 beds, then Duke Health System would increase its control to 98.7 percent of total bed capacity while NCSH would be reduced to 1.3 percent. The NCSH application is comparatively superior regarding this factor because its proposal to add 6 acute care beds enhances competition, helps contain costs and improves quality for <u>all</u> of the acute care beds that it operates in the service area.

Access to Existing Licensed Beds – NCSH utilizes its total acute care bed capacity because all of its licensed beds are staffed and operational. As reported in its 2017 License Renewal Application, DUH has not been staffing and operating all of its 938 licensed beds. Also, not all of the licensed acute care beds at Duke Regional Hospital (DRH) are staffed. Durham County residents have restricted access to acute care beds at both DUH and DRH. Thus, the NCSH application is comparatively superior regarding access to existing licensed beds.

Operational Dates for Proposed Additional Beds - NCSH projects that its proposal to develop 6 additional acute care beds will be completed and operational by January 1, 2019. This completion date is consistent with the projected 2019 need determination in the 2017 SMFP. DUH proposes to develop its proposed acute care beds with an initial 22 beds to become operational July 1, 2018; the remaining beds will be completed in phases with the total 96 beds to be operational by July 1, 2023. The staggered completion dates for the DUH project are inconsistent with the projected 2019 need determination because the majority of the proposed additional bed capacity at DUH are expected to be operational four years after the indicated date when the beds are needed. The DUH proposal also makes no projections regarding when the existing licensed beds at DRH will be staffed or when any improvements to the DRH facility will occur. Therefore the NCSH is comparatively superior because all of the licensed beds are currently operational and its project schedule fully comports to the need determination in the 2017 SMFP.

Financial Comparisons – NCSH and DUH differ in several characteristics that could affect the average gross and net patient revenue per adjusted patient day including differences in patient acuities and the types of medical and surgical subspecialty services provided. The NCSH financial section includes financial assumptions for all of the worksheets including F.4 Revenues and Expenses for Each Service Component. The DUH financial proforma fails to include the specific financial assumptions for F.4 Revenues and Expenses for Each Service Component. The schedules for NCSH and DUH differ and none of the first three years of the NCSH project overlap with the later

three years of DUH. The majority of the patients served by NCSH are surgical cases while DUH provides a broad scope of both medical and surgical services. Consequently the financial comparison for these differing applications is not conclusive.

Medicare Percentage of Total Inpatient Acute – For the overall scope of services NCSH and DUH provide inpatient acute care services to high percentages of Medicare patients based on each hospital's scope of service. However, NCSH and DUH differ in several characteristics that could affect the payer percentages, including differences in patient acuities and the types of medical and surgical subspecialty services provided. Consequently the comparison of Medicare percentages for these applications is not conclusive.

Medicaid Percentage of Total Inpatient Patients – DUH's 2017 License Renewal Application shows that the facility's inpatient acute care services include Obstetrics (44 beds), ICU Neonatal Level IV (45 beds), Neonatal Level III (15 beds), Neonatal II (7 beds), ICU Pediatric (45 beds) and Pediatric (74 beds). Consequently a large portion of the DUH facility serves Obstetrics, Neonatal and Pediatric patients which contributes to a high percentage of Medicaid patients. NCSH has no Obstetrics beds and no dedicated Pediatric or Neonatal units. DUH and NCSH differ greatly in their scopes of services that relate to Medicaid inpatients. Consequently, the comparison of Medicaid percentages for the two facilities is not conclusive.

Durham County % Patient Origin - NCSH projects that 34.61 percent of its patients will originate from Durham County in the second year following completion of its project. DUH projects that 29.1 percent of its patients will originate from Durham County in the second year following completion of its project. Therefore the NCSH proposal is comparatively superior because its project will serve a higher percentage of patients originating from Durham County.

HSA IV Patient Origin - NCSH projects that 76.5 percent of its total patients will originate from Health Service Area (HSA) IV in the second year following completion of

its project. DUH projects that 72.5 percent of its patients will originate from HSA IV in the second year following completion of its project. Therefore the NCSH proposal is comparatively superior because its project will serve a higher percentage of patients originating from HSA IV.

Total Capital Cost and Capital Cost per Bed – Chapter 5 of the 2017 SMFP includes the Acute Care Hospital Goal 5 which is intended to ensure that substantial capital expenditures for the construction or renovation of health care facilities are based on demonstrated need. On a per-square-foot basis, acute care projects can be among the most costly types of CON-regulated health services to construct and implement. Facility design and energy efficiency are important factors that are addressed by the Acute Care Hospital Goal 5 as well as Policy GEN-4 and CON Review Criterion 12. The following table provides comparative data regarding the NCSH and the DUH facility designs:

	Total Capital Cost	Proposed Additional Beds	Total Cost / Added Bed
NCSH	**$100,000**	**6**	**$16,667**
DUH	**$29,100,000**	**96**	**$303,125**

The cost of renovating existing space at DUH is extraordinarily high at $921 per square foot because the application indicates that the scope of renovation totals 31,601 square feet. The DUH application fails to explain why it is necessary to renovate space for all 96 beds because DUH has 11 existing observation beds (as seen in the 2017 LRA). Some or all of these observation beds could easily become licensed beds without diminishing access because DUH already uses its licensed inpatient beds for observation patients. In addition to the existing 11 observation beds, DUH has a "Clinical Observation Unit" in its Emergency Department. In contrast to the DUH application, NCSH proposes to convert existing observation beds to licensed inpatient acute care beds with no renovation costs. The $100,000 total capital cost includes contingency amounts for equipment and building repairs. NCSH's total capital cost and

capital cost per bed is far less than the amounts proposed by DUH. Consequently the NCSH is comparatively superior regarding this factor.

Physician Letters of Support - DUH has a very large medical staff made up of 1,968 physicians and dentists. The DUH Exhibits include a large number of physician letters of support for its proposed project; some of the DUH physician support letters are provided on behalf of multiple physicians. NCSH has a medical staff of 154 physicians. The NCSH application includes a sizable number of physician support letters for its proposed project to add 6 acute care beds; none of the NCSH physician support letter are provided on behalf of multiple physicians. Based on the differences in the sizes of the medical staffs at DUH and NCSH as well as variation in the structure of the physician support letters, both applications provide adequate documentation of physician support for their respective projects.

Comments Regarding CON Review Criteria

Criterion 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 DUH project application is submitted in response to the need determination for 96 acute care beds in the 2017 State Medical Facilities Plan. The DUH application indicates that Policies GEN-3 and GEN-4 are applicable and that their proposed project is conforming to these Policies.

Regarding Policy GEN-3, the DUH application fails to adequately demonstrate that its utilization projections are based on reasonable assumptions regarding the project schedule; the schedule delays the development of most of the requested acute care beds to several years past 2019 – when the SMFP shows a need for additional

capacity. DUH unreasonably projects that all 96 beds are needed for non-ICU capacity and no additional ICU level beds will be needed. DUH also erroneously predicts that the average length of stay remains unchanged, contrary to the declining trend that has occurred in the past three years. As explained in more detail in the comments below, the DUH application fails to conform to Criterion 3. A proposal that lacks reasonable utilization projections does not demonstrate that it will promote equitable access and maximize healthcare value. Therefore the project application also fails to demonstrate conformity to Policy GEN-3. For these reasons the DUH application fails to conform to Policy GEN-3 and CON Review Criterion 1.

Criterion 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."*

Table 51 of the 2017 State Medical Facilities Plan shows a 2019 need determination for 96 acute care beds based on the projected demand. The acute care methodology projects increased acute care days of care based on the Durham County growth rate multiplier that is applied to the 2015 days of care for each of the hospitals in the County. Consequently the projected increase in acute care days in the SMFP methodology does not favor one hospital over another in terms of the outcome of the competitive review of the CON applications.

The 2017 State Medical Facilities Plan acknowledges that Duke University Hospital is licensed for 14 acute care beds under Policy AC-3 in addition to the 924 beds that are reflected in Table 5A. Policy AC-3 acute care beds are used for teaching and research and are not counted when determining acute care bed need. Because Policy AC-3 is only applicable to academic medical centers, DUH has the option to submit a Policy AC-3 CON request to obtain additional bed capacity in addition to its CON application for 96 acute care beds. As the Policy AC-3 opportunity will likely extend to future years, DUH

will maintain a continual competitive advantage (with its present extra beds plus the opportunity to acquire more) over North Carolina Specialty Hospital and Duke Regional Hospital. DUH also lacks a compelling need for all of the 96 acute beds that are allocated in the 2017 SMFP because it has failed to staff and operate all 938 of its current licensed acute care beds.

The DUH application fails to conform to CON Review Criterion 3 for multiple reasons. DUH has no genuine need for additional bed capacity as demonstrated by the delayed schedule for the development of the proposed project which will not be completed until 2023. As seen in their 2017 License Renewal Application, DUH has not staffed its full licensed bed capacity during the previous year. Given that DUH already has the 14 "extra" AC-3 beds, the applicant proposes to increase its acute care bed capacity gradually from the current 938 beds (924 acute care beds plus 14 AC-3 beds) in several stages with the total 1,034 total acute care beds becoming operational in 2023, approximately 4 years after the 2019 need determination. The historical underutilized capacity combined with the extra AC-3 beds and the delayed implementation of the 96 proposed additional beds demonstrates excess capacity at DUH.

The DUH application also fails to adequately demonstrate that all 96 acute care beds are needed as a consequence of growth in patient demand solely at an academic medical center with no growth in demand for admissions and acute care days at both NCSH and DRH. The basic premise of the DUH methodology is that acute care utilization will increase whenever beds are added at the hospital. DUH contends that regardless of the number of beds that will be added and staffed in each phase of the project, the days of care for these incremental beds promptly ramps up to 80 percent occupancy within the subsequent six months.

DUH expects to gain hospital admissions while limiting DRH bed capacity by deferring needed renovations that would be exempt from CON review. Facility improvements at DRH could improve access to its licensed beds as well as improve patient satisfaction. Furthermore, DUH opposed the full replacement of all 24 inpatient acute care beds at

North Carolina Specialty Hospital in 2004 and forced a settlement agreement that has limited NCSH's licensed acute care capacity at 18 acute care beds. For these reasons the historic growth in acute care utilization for hospitals in Durham County reflects the bed capacity constraints that have been imposed by DUH on both DRH and NCSH. Consequently future growth projections for DUH are based on intentional restrictions of patient access to other hospital facilities in Durham County.

In recent years DUH has added significant capacity by staffing licensed beds to provide ICU level care with minimal increases in bed capacity for its non-ICU level units:

DUH 2014 and 2017 LRA	2013 Beds	2016 Beds	% Change
Cardiac	16	40	150.00%
Cardiovascular Surgery	16	32	100.00%
Medical/Surgical	48	86	79.17%
Neonatal Beds Level IV	45	45	0.00%
Pediatric	45	48	6.67%
Respiratory Pulmonary	16	24	50.00%
Total ICU Beds	186	275	47.85%
Non-ICU Beds	616	632	2.60%
Total DUH Staffed Beds	802	907	13.09%

Between 2013 and 2016 DUH increased ICU capacity by 89 beds for a 47.85 percent increase in capacity. For the same time period DUH added 16 non-ICU beds for only a 2.6 percent capacity increase.

As seen in its 2017 License Renewal Application, DUH staffed only 907 of its 938 licensed acute care beds. Not staffing all of its licensed beds restricts access and causes some patient transfer requests from other hospitals to likely be denied. Because DUH has been unwilling or unable to staff its total licensed bed capacity in the past five years, there is no reason to believe it will make use of all of the proposed additional 96 beds.

The DUH application fails to explain why it is reasonable to add all 96 beds for general medical surgical (non-ICU) beds when the highest occupancy units are the Cardiac, Medical Surgical and Respiratory Pulmonary ICUs as seen in the following:

DUH 2017 LRA	Beds	Days of Care	ADC	Occupancy
Cardiac	40	12,995	35.6	89.01%
Cardiovascular Surgery	32	9,678	26.5	82.86%
Medical/Surgical	86	27,491	75.3	87.58%
Neonatal Beds Level IV	45	14,003	38.4	85.25%
Pediatric	48	10,816	29.6	61.74%
Respiratory Pulmonary	24	8,110	22.2	92.58%
Total ICU Beds	275	83,093	227.7	82.78%
Non-ICU Beds	632	190,485	521.9	82.58%
Total DUH Staffed Beds	907	273,578	749.5	82.64%

In 2017, approximately 30 percent of the staffed beds at DUH were staffed and operated for ICU level nursing care and the remaining 70 percent are non-ICU beds. The proposed project to add 96 non-ICU beds would change the mix to approximately 20 percent ICU beds and 80 percent non-ICU beds. Consequently, the proposed project would increase DUH bed capacity to provide care to low and moderate acuity patients that may not need admission to an academic medical center; in addition, these patients would generally have shorter average lengths of stay. If there are no increases in ICU level beds at DUH over the next four years then the overall growth projections are false because most of the ICU nursing units are already operating near maximum practical capacity.

The DUH methodology and assumptions for the utilization projections included in Section Q are unreasonable as follows:

1) DUH omits data for the Duke Regional beds even though DRH's utilization and ongoing requests for patient transfers to DUH are integral to the applicant's arguments regarding the need for the proposed project. The application makes

multiple statements that DUH needs additional bed capacity to accommodate transfers from other hospitals, including Duke Regional. However, the ramp-up of utilization at DUH is unreliable because the applicant has made no projections regarding the bed availability at Duke Regional Hospital for the period from 2018 through 2023. If the need for additional beds at DUH is due in part to accommodate transfers from Duke Regional, then the bed capacity and utilization projections for Duke Regional are essential to evaluate the applicant's projections.

2) The utilization projections and assumptions beginning on page 114 of Section Q are inaccurate because DUH does not staff and operate all of its existing licensed inpatient beds. On page 115 DUH admits that it utilizes some of its beds for observation and other clinical services. Nowhere in the application does DUH document the specific date it will staff and operate all 938 of its current licensed acute care beds. Absent this information, all of the future years' utilization and occupancy projections are unsupported.
3) Pages 115 to 118 of Section Q include the illogical assumption that whenever DUH adds incremental bed capacity the ramp-up to 80% occupancy will occur over the following six months. When 22 beds become operational beginning in July 2018, the ramp-up to 80 percent will occur with 2,731 incremental days of care (July to December 2018). When 34 beds are projected to be operational in January 2022 the ramp-up to 80 percent occurs over the following six months with 4,157 incremental days of care. These ramp-up projections and days of care exceed the annual growth in DUH total days of care in FY2015 and FY2016 that occurred while the hospital had unstaffed licensed beds.
4) It is unreasonable for DUH to maintain 6.61 days as the Average Length of Stay (ALOS) through FY2026 because their ALOS has decreased by 2.52% over the past two years. Given the statement in the application that DUH is not planning to add any ICU beds, the ALOS would not remain the same as the current because the hospital-proposed 96 beds are non-ICU beds which serve lower acuity patients. Therefore, increasing the availability of non-ICU beds at DUH would most likely decrease overall ALOS over the next 7 years. A more

reasonable assumption that is consistent with the ALOS trend would be to forecast a continuing annual ALOS decrease of 1.26 percent. Therefore the average length of stay and resulting acute care days of care in the first three years following project completion will be substantially less than the applicant's projections. Please see the utilization projections on the following page based on the declining DUH ALOS trend.

	ALOS	% Change From Previous Year	ALOS Assumption based on DUH Actual Data for FY2015 to FY2017 and Statements in the Application regarding 96 Beds
FY2015	**6.78**	NA	
FY2016	**6.68**	-1.47%	
FY2017	**6.61**	-1.05%	-1.26% Two Year Average
FY2018	**6.53**	-1.26%	
FY2019	**6.44**	-1.26%	ALOS reduced because none of the 96 beds to be added will provide ICU level services. Consequently overall acuity and ALOS should be decreasing.
FY2020	**6.36**	-1.26%	
FY2021	**6.28**	-1.26%	
FY2022	**6.19**	-1.26%	
FY2023	**6.11**	-1.26%	
FY2024	**6.03**	-1.26%	
FY2025	**5.94**	-1.26%	
FY2026	**5.86**	-1.26%	

Page 210 DUH Methodology Summary	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026
Days of Care	281,394	287,311	287,818	287,818	291,975	302,318	308,896	310,440	311,993
Discharges	42,547	43,442	43,518	43,518	44,147	45,711	46,705	46,939	47,174
ALOS	6.61	6.61	6.61	6.61	6.61	6.61	6.61	6.61	6.61
ADC	771	787	789	789	800	828	846	851	855
Licensed Beds							1034	1034	1034
% Occupancy							81.85%	82.26%	82.67%

Methodology Sumary with ALOS Declining	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026
Discharges	42,547	43,442	43,518	43,518	44,147	45,711	46,705	46,939	47,174
ALOS	**6.53**	**6.44**	**6.36**	**6.28**	**6.19**	**6.11**	**6.03**	**5.94**	**5.86**
Days of Care	**277,688**	**279,907**	**276,768**	**273,140**	**273,407**	**279,281**	**281,460**	**278,957**	**276,420**
ADC	**761**	**767**	**758**	**748**	**749**	**765**	**771**	**764**	**757**
Licensed Beds							**1,034**	**1,034**	**1,034**
% Occupancy							**74.58%**	**73.91%**	**73.24%**

As seen on the previous page, the declining ALOS trend (-1.26% annual decrease) causes forecasts for utilization and resulting occupancy percentages to be less than 75.2 percent (performance standard) in all three years following the completion of the project. The utilization projections for the DUH proposal to add 96 non-ICU acute care beds are not based on reasonable assumptions regarding the future ALOS and the unsupported ramp-up of the incremental bed additions.

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

DUH fails to adequately demonstrate that the proposed project is the least costly or most effective alternative because there are currently underutilized acute care beds at Duke Regional Hospital (DRH) that are "restricted by semi-private beds and facility limitations" as documented on page 76 of the DUH application. Rather than improve the acute care beds and facility limitations at Duke Regional to enhance patient privacy and improve satisfaction scores, DUH seeks approval to expand its flagship hospital. The future of Duke Regional remains uncertain because page 77 of the application states, "If and when DUHS renovates Duke Regional to put additional beds into service, DUHS anticipates that acute care utilization will increase commensurate to the expanded access at DRH."

Most of the ICU level beds designated by DUH have very high utilization based on the data in the 2017 LRA. However, DUH failed to explain why it did not increase its bed capacity for ICU beds in proportion to its non-ICU bed capacity as an effective alternative to promote equitable patient access.

The DUH 2017 LRA reports 11 observation beds at the facility in addition to the "Clinical Observation Unit" in its Emergency Department. Some or all of these 11 observation beds could be converted to licensed beds without diminishing access because DUH also uses licensed inpatient beds for observation patients. However, DUH failed to

explain why converting some of its existing observation beds would not represent a less costly and more effective alternative that could be implemented by 2019.

The DUH application is not conforming to all other CON review criteria. Please see the comments regarding Criteria 1, 3, 18a. An application must be conforming or conditionally conforming to all review criteria to be an effective alternative. Therefore, DUH did not adequately demonstrate that its proposal is the least costly or most effective alternative.

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

The DUH application fails to conform to CON Review Criterion 5 due to unreasonable utilization projections:

- the applicant proposes to delay the development of most of the acute care beds to 2024, even when the SMFP shows a need for additional capacity in 2019.
- the projection that all 96 beds are needed for non-ICU capacity and no additional ICU level beds will be needed at DUH.
- the applicant unreasonably assumes the average length of stay remains unchanged, contrary to the most recent declining trend with FY 2015 ALOS at 6.78, FY2016 at 6.68, and FY2017 at 6.61.
- The DUH ramp-up and incremental patient days are based on an arbitrary 80 percent occupancy assumption for each phase of the additional acute care beds regardless of the timing and the number of beds that are being added; the applicant fails to provide a rationale for the 80 percent assumption.
- The DUH ramp-ups and occupancy assumptions for the proposed additional beds shown on pages 115 through 120 of the application are not reasonable

because the projected days of care and occupancy for both the existing ICU beds and non-ICU beds are omitted.

- The timeline for the proposed DUH project to add 96 beds appears to overlap with the Bed Tower Addition project (exempt from CON review) that will relocate 350 existing acute care beds from Duke North to newly constructed spaces in January 2022. If this CON exempt project is not completed on schedule in early January 2022, then the occupancy and ramp-up assumptions and projections shown on page 117 cannot be achieved.

Financial projections are unreliable as follows:

- Form H Current Staff FTE values and salaries are not adequately explained because the total FTEs of 114.59 does not relate to the existing 938 licensed acute care beds. In fact, the Current Staff on Form H appears to represent an existing nursing unit but the number of licensed beds, days of care, and average length of stay are omitted.
- The Form H staffing projections for the first three fiscal years unreasonably show the exact same numbers of FTEs for all positions including the RNs and Nursing Assistants; thus, even though utilization is projected to continuously increase, the staffing levels remain unchanged.
- The DUH financial proforma fails to include all of the financial assumptions for F.4 Revenues and Expenses for Each Service Component.
- The financial proforma assumptions do not define "margin improvement initiatives" to the extent that this is a meaningful mathematical assumption.
- Direct and Indirect Expenses for the Form F.4 Additional Acute Care Beds are not defined by the applicant. Therefore it is impossible to determine the reasonableness of these expenses.
- The proposed project involves the incremental addition of beds beginning July 1, 2018 with later bed additions in 2022 and 2024. However, the projected expenses are inconsistent with the "ramp up and occupancy" described on pages 115 to 119. The financial proforma erroneously show no additional equipment will be acquired and no capitalized expenses will be spent until FY2024.

- The Consolidated Balance Sheet fails to reflect the increases in Property Plant and Equipment and the Depreciation for the Bed Tower Addition project that is discussed in the CON narrative.
- The Consolidated Balance Sheet fails to reflect the increases in Total Indebtedness for the Bed Tower Addition project that is discussed in the CON narrative.

Criterion 6 *"The applicant shall demonstrate that the proposed project will not result in unnecessary duplication of existing or approved health service capabilities or facilities."*

The DUH application fails to conform to CON Review Criterion 3; consequently the application is nonconforming to Criterion 6. The DUH application fails to adequately demonstrate that the proposed project will not result in unnecessary duplication of existing beds and healthcare services at Duke Regional Hospital. Rather than improve acute care beds and facility limitations at DRH to enhance patient privacy and improve satisfaction scores, DUH seeks approval to expand its flagship hospital. The future of DRH remains uncertain because page 77 of the application states "If and when DUHS renovates Duke Regional to put additional beds into service, DUHS anticipates that acute care utilization will increase commensurate to the expanded access at DRH."

Criterion 7 *"The applicant shall show evidence of the availability of resources, including health manpower and management personnel, for the provision of the services proposed to be provided."*

The DUH application is nonconforming to CON Review Criterion 7 because the staffing projections are unreliable as follows:

- Form H Current Staff FTE are not adequately explained because the total FTEs of 114.59 does not relate to the existing 938 licensed acute care beds. In fact, the Current Staff on Form H appears to represent an existing nursing unit but the number of licensed beds and days of care are omitted.

- DUH fails to demonstrate the adequacy of staff during the initial phases of the project when licensed acute care beds are added in 2018 and 2022.
- The Form H staffing projections for the first three fiscal years unreasonably show the exact same numbers of FTEs for all positions including the RNs and Nursing Assistants. Even though utilization is projected to continually increase, the staffing levels remain unchanged. Therefore the staffing projections show no growth in Full Time-Equivalents, which is inconsistent with the written assumption. "Salaries (Line 7) are projected based on anticipated growth in Full Time-Equivalents, changes to current compensation and the estimated benefit of margin improvement initiatives."

Criterion 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."*

The DUH application is nonconforming to CON Criteria 18a because the application does not conform to Criteria 3, 4 and 5. The DUH application fails to adequately demonstrate that its utilization projections are based on reasonable assumptions regarding the project schedule that delays the development of most of the acute care beds until four years after the SMFP shows a need for additional capacity (2019). DUH unreasonably assumes that all 96 beds are needed for non-ICU capacity and no additional ICU level beds will be needed. Further, the average length of stay is projected to remain unchanged; this is contrary to the declining DUH ALOS as seen in their License Renewal Applications. The project application omits discussion of when the facility deficiencies at DRH that limit its bed capacity and likely contribute to low patient satisfaction survey results might be remedied.

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 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.

The DUH application is nonconforming to 10A NCAC 14.C.3803 (a) and (b) because the utilization projections are not based on reasonable assumptions. Therefore the application fails to demonstrate that the projected average daily census is reasonably projected to be at least 75.2 percent in the third year following completion of the proposed project. DUH fails to demonstrate when it will staff and operate all of its current 938 licensed acute care beds. The applicant projects incremental bed additions with a ramp-up to 80 percent occupancy within six months regardless of the number of beds that are added. The ramp-up assumptions are not credible because the incremental days of care for these bed additions exceed the historical annual growth in total DUH utilization for the current 938 licensed beds while the applicant had available capacity and unstaffed beds. DUH unreasonably forecasts that the overall average length of stay will remain unchanged even though all 96 additional beds will be used for non-ICU nursing care. In conclusion, the DUH application is not approvable.