Comments on WakeMed Cary's Vertical Expansion CON Application

submitted by

Rex Hospital, Inc. d/b/a UNC REX Healthcare

In accordance with N.C. GEN. STAT. § 131E-185(a1)(1), Rex Hospital, Inc. ("UNC REX") submits the following comments related to an application submitted by WakeMed to construct a 2-story addition at WakeMed Cary Hospital (WMC) and relocate 30 approved acute care beds and one existing shared surgical operating room from WakeMed Raleigh Campus (WMR) to WMC. UNC REX's 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*." *See* N.C. GEN. STAT. § 131E-185(a1)(1)(c). In order to facilitate the Agency's review of these comments, UNC REX has organized its discussion by issue, noting some of the general CON statutory review criteria and specific regulatory criteria and standards creating the non-conformity relative to each issue, as they relate to the following application:

- **WakeMed, Project ID # J-11428-17**

GENERAL COMMENTS

UNC REX believes there are several issues with WakeMed's application that indicate that the proposed project is not needed. One of the most concerning issues in WakeMed's application is the indication that it is "holding" other previously approved acute care beds, without a plan for developing them as proposed. This includes the 29 beds approved under the need determination in the *2011 SMFP*, as well as 21 beds to be converted back to acute care at WMR, per an approved 2013 application. As the Agency is aware, UNC REX opposed both of these previously-approved applications, and despite their eventual approval, UNC REX is now concerned that WakeMed apparently believes that it can hold the CON for these beds indefinitely, despite any representations in the applications, and develop a plan to bring these beds on line at an undetermined future date. This approach is also concerning given statements made by WakeMed executives during the appeal of the acute care bed applications proposed under the *2011 SMFP*, in which they testified that there was actually no need for the beds they had proposed. While UNC REX understands that projects may be delayed for various reasons, failing to implement a project simply because an approved applicant has not determined if the project is actually needed or whether to implement it is clearly inappropriate and contrary to the state's health planning process and the CON law. UNC REX believes these representations, summarized below, suggest that the Agency should more carefully scrutinize the WMC application, in light of WakeMed's intention to hold approved beds until sometime in the future.

Throughout its application, WakeMed claims that there is a need for additional acute care capacity at WMC based on its high and growing utilization. However, these claims are undermined by WakeMed's failure to timely develop 22 previously-approved acute care beds at WMC since the CON was issued in January 2014 pursuant to Project ID # J-8661-11. The proposed development schedule for Project # J-8661-11 was less than 12 months. Yet, WakeMed states that these beds are anticipated to be licensed on November 1, 2017, or 46 months after they were approved. This delay in implementation demonstrates the lack of need for additional capacity at WMC, since WMC was the sole party responsible for delaying the project once the CON was issued.

In its application, WakeMed states that "[w]*ith the exception of the 22 acute care beds approved for WakeMed Cary, WakeMed has not yet sought to develop* [the 50 beds previously approved for WMR]" (page 27). Later, WakeMed states it "*has chosen not to develop all of the 50 acute care beds approved in Project Nos. J-8660-11 and J-10165-13 for a number of reasons. First, developing all of these beds at WakeMed Raleigh will require a large capital expenditure that has not proven to be necessary up to this point. Second, while inpatient utilization at WakeMed Raleigh has been increasing, it has not grown at the same rate as WakeMed Cary. WakeMed leadership believe that relocation of 30 of the approved 50 approved beds, leaving Raleigh Campus with 20 remaining to develop, will be sufficient to meet the needs of that campus"* (pages 51-52). WakeMed provides vague statements about whether it intends to develop the remaining 20 beds (i.e. "*WakeMed Raleigh will continue to be licensed for 567 acute care beds, and will have 20 beds available for future development"* (page 28) and "*WakeMed Raleigh will have 20 remaining acute care beds available for development*" (page 53)). Based on these statements, it appears that WakeMed believes it can hold these CONs indefinitely until it decides where, how, or if to develop them. These statements are in contradiction to WakeMed's demonstration in each of these prior CON applications that it needed to develop additional acute care capacity at WMR on specific timelines. In this context, WakeMed's currently proposed project to develop additional acute care capacity should be viewed skeptically.

ISSUE-SPECIFIC COMMENTS

1. <u>The application fails to demonstrate the need for the proposed additional acute care beds</u>.

   WMC's argument that it needs additional acute care bed capacity is in contradiction to previous statements regarding its capacity needs. As noted in its application, the beds slated for relocation to WMC were originally approved for WMR in 2014 based on an application submitted in 2011. On page 40, WMC states that "*since this approval*, *inpatient utilization at WakeMed Cary Hospital exceeded the original projections, to the point where it is apparent that the 22 acute care beds approved in Project ID # J-8661-11 will not be sufficient to meet the needs of the local service area population."* <u>This statement is simply false</u>. As shown below, WMC has historically provided between 40,000 and 45,000 days of care.

Table C.11
WakeMed Cary Hospital
Acute Care Utilization and Average Daily Census, FYs 2014-2017

Fiscal Year	Licensed Acute Care Beds	Total Patient Days	Percent Occupancy	Average Daily Census
2014	156	41,510	72.9%	113.7
2015	156	42,937	75.4%	117.6
2016	156	40,516	71.0%	111.0
2017 (11 mos. annualized)	156	45,182	79.4%	123.8
Percent Change in Patient Days, 2014-17		8.9%		
Percent Change in Patient Days, 2016-17		11.5%		

Note: Excludes normal newborns
Source: WakeMed internal data, provided in Hospital License Renewal Applications for FYs 2014-2016, and data for FY 2017, 11 months' annualized.

   As shown in Attachment 1, excerpts from two prior acute care bed applications (J-8661-11 and J-10165-13) demonstrate that, in those applications, WMC projected acute care days in excess of 50,000 in the respective third project years. Clearly, inpatient utilization at WMC has not exceeded its original projections. Given the fact that historically WMC has demonstrated that

its existing and previously-approved acute care capacity (i.e. 178 acute care beds) was sufficient to support more than 50,000 acute care days, it appears unreasonable for WMC to argue in its current application that it needs additional capacity based on its historical utilization of 40,000 to 45,000 days, or 10 to 20 percent below what it projected.

WMC argues that its historical utilization demonstrates the need for additional capacity. However, UNC REX believes that WMC's historical utilization data indicates that its current and previously-approved capacity is more than adequate. As WMC notes in its application, it was approved in January 2014 to develop 22 additional beds pursuant to Project ID # J-8661-11. The proposed development schedule for Project # J-8661-11 was less than 12 months. Yet, WMC states that these beds are anticipated to be licensed November 1, 2017, or 46 months after they were approved. This delay in implementation suggests that WMC has not needed additional acute care capacity historically. In fact, if WMC had operated its 22 previously approved beds historically, based on the approved development schedule, its acute care bed occupancy rate would have been below the target threshold of 71.4 percent as shown below.

Fiscal Year	*Total Patient Days*	*Average Daily Census*	*Percent Occupancy Assuming Operation of 22 Previously Approved Beds*
2014	41,510	113.7	63.9%
2015	42,937	117.6	66.1%
2016	40,516	111.0	62.4%
2017 Annualized	45,182	123.8	69.5%

Thus, the "need" for additional capacity based on the historical occupancy percentages shown in the application fails to consider that WMC had a CON to develop a sufficient number of beds to lower its occupancy below the target threshold. As such, WMC fails to demonstrate the need to transfer additional undeveloped beds from WMR.

As shown in the table above, WMC's utilization has fluctuated significantly over this historical period and declined significant from 2015 to 2016, the two most recent full years. While WMC's most recent utilization in Fiscal Year 2017 year-to-date shows an increase over prior years, its acute care days remain below the historical projections in prior CON applications and below target occupancy given its previously approved capacity. Further, WMC's utilization in Fiscal Year 2017 year-to-date may be an anomaly as there is no other evidence of a trend in volume growth. In fact, WakeMed provides contradictory data for its operating room utilization in 2017. As shown below, on pages 50 and 164, WakeMed provides utilization for inpatient and outpatient surgical cases for the same 11 month time period in 2017 that differ by nearly five percent in total surgical hours.

	Inpatient Cases	*Outpatient Cases*	*Total Cases*	*Total Surgical Hours**
2017 (11 mos. annualized) pg 50	3,131	5,242	8,373	17,256
2017 (11 mos. annualized) pg 164	3,386	5,270	8,656	18,063
Difference	**8.1%**	**0.5%**	**3.4%**	**4.7%**

*Total surgical hours = 3.0 hours x inpatient cases + 1.5 hours x outpatient cases per the *2017 SMFP*.

WakeMed utilized the higher of the two sets of figures as the baseline for its operating room utilization projections as shown in Table Q.28 on page 164. In either case, surgeons who practice at both WMC and Rex Surgery Center of Cary, a freestanding ASC, report that WMC routinely schedules some of its operating rooms for use for only about one-half of each day. This level of downtime would indicate that WMC has more than sufficient existing operating room capacity and that the proposed additional operating room is not needed.

In order to demonstrate the need for the proposed additional acute care beds at WMC, WakeMed's utilization methodology makes several unreasonable assumptions.

WakeMed's assumes that acute care discharge use rates in WMC's service area will be equivalent to average use rates from 2014 to 2016. However, it is clear from data presented in WakeMed's application as well as data available from Hospital License Renewal Applications (HLRAs) that such use rates are generally declining. As shown in the table below based on data excerpted from Tables Q.7 to Q.10 in WakeMed's application, total service area use rates have declined for every age group, except Age 0-17.

Service Area Acute Care Discharge Use Rates per 1,000 Population

	2014	*2015*	*2016*	*CAGR**
Age 0-17	23.87	24.02	24.70	1.7%
Age 18-44	63.45	63.13	63.22	-0.2%
Age 45-64	76.78	74.48	74.76	-1.3%
Age 65+	237.94	234.62	227.20	-2.3%

*Compound annual growth rate.

To analyze these historical use rates over a longer time horizon, UNC REX calculated acute care discharge use rates per 1,000 population based on acute care discharge patient origin data from HLRAs and North Carolina Office of State Budget and Management (NC OSBM) population data. As shown below, acute care discharge use rates over the last five years have declined in each county in WMC's service area as well as statewide.

Service Area Acute Care Discharge Use Rates per 1,000 Population

	2012	*2013*	*2014*	*2015*	*2016*	*CAGR*
Harnett	92.77	86.35	85.40	82.48	83.21	-2.7%
Johnston	91.71	84.34	81.58	83.50	78.76	-3.7%
Wake	70.10	71.69	70.34	69.40	66.79	-1.2%
State	98.24	102.56	93.54	94.99	93.51	-1.2%

Source: HLRA and NC OSBM data.

Given this data, and without any other data to support its assumption, UNC REX believes WakeMed's assumption that use rates through 2022 will remain consistent with the 2014 to 2016 use rates is not supported.

In Step 5 of its methodology, WakeMed assumes that WMC's market share of Wake County will increase based on "*the expected impact of the increase 30 percent increase* [sic] *in acute care beds at WakeMed Cary between FY 2018 and FY 2020, as well as western and southern Wake County's population growth, which is outpacing Wake County overall*" (page 157). Later, WakeMed states that WMR's projected Wake County market share will decrease which "*takes into account future shifts in market share associated with the increases in bed capacity at WakeMed Cary . . . and WakeMed North*" (page 173). None of these cited factors indicate that WMC's share of Wake County inpatient utilization will increase. As noted throughout this application, the proposed beds to be added are not currently in operation. Thus, there is no associated volume with the beds that could possibly shift from WMR to WMC. Further, the development of additional beds does not result in increased market share. Similarly, population growth does not result in increased market share. While population growth may result in increased volume overall, there is no relationship between that growth and an increased share for a particular provider. Specifically, there is no evidence presented in the application to indicate that a higher percentage of the growing population would choose WMC in the future over other providers, as would be required to increase WMC's future market share. As such, WakeMed's assumed increase in market share at WMC is unsupported.

In Steps 8 and 9 of its methodology, WakeMed assumes that WMC's projected average length of stay (ALOS) will remain equivalent to its 2014 to 2016 average. However, data presented in WakeMed's application as well as data reported on its Hospital License Renewal Application indicates that WMC's ALOS is declining. As shown below, WMC's ALOS, as shown on page 159 of the application, has declined 4.3 percent since 2014 and 13.2 percent in the last year.

WMC ALOS

	2014	***2015***	***2016***	***2014 to 2016 CAGR***	***2015 to 2016 % Change***
ALOS	4.22	4.44	3.86	**-4.3%**	**-13.2%**

Data from WMC's HLRA also indicates that the facility's ALOS is declining and that the facility has only demonstrated an ALOS greater than 4.17, as assumed by WMC in its methodology, in a single year (2014).

WMC ALOS

	2012	***2013***	***2014***	***2015***	***2016***	***CAGR***
Discharges	10,136	9,948	9,837	10,335	10,565	1.0%
Days	41,929	41,278	41,510	42,937	40,516	-0.9%
ALOS	4.14	4.15	4.22	4.15	3.83	-1.9%

Source: HLRA and NC OSBM data.

Please note that WakeMed's application fails to include three full historical years of utilization in Form C, as requested in the CON application, which would have provided an additional source of comparison data for WMC's assumed ALOS.

Given this data, UNC REX believes the assumption that WMC's ALOS will be 4.17 through 2022 is not supported. Importantly, because WMC has overstated its ALOS, it fails to demonstrate the

need for the proposed project. Even if WMC achieves its projected acute care discharges, which are based on unreasonable use rate assumptions, it will not operate its facility above target occupancy rates if its ALOS is consistent with its most recent experience. As shown above, WMC states that its ALOS in 2016, based on Truven data, was 3.86 days. Assuming an ALOS of 3.86 days through 2022, which is conservative given WMC's declining ALOS, WMC will provide 52,454 total acute care days in the third project year and operate at 69 percent of its existing, approved, and proposed acute care beds, as shown below.

WMC Projected Utilization Based on Reasonable ALOS

	PY1 2020	***PY2 2021***	***PY3 2022***
Projected Discharges	12,434	13,001	13,589
Revised ALOS	3.86	3.86	3.86
Revised Total Days	47,995	50,184	52,454
Revised Average Daily Census (ADC)	131.5	137.5	143.7
Existing, Approved, and Proposed Beds	208	208	208
% Occupancy	63.2%	66.1%	69.1%

Source: HLRA and NC OSBM data.

As such, assuming a reasonable and supported projected ALOS for WMC, the proposed acute care beds will not operate above the target occupancy rate of 71.4 percent as set forth in the *SMFP* and the performance standards for acute care beds for facilities with an ADC of 100 to 200.

Based on the discussion above, it is clear that WMC's projected utilization is unreasonable and unsupported. As such, WMC's application is non-conforming with Criteria 3, 4, 5, 6, and the performance standards in the acute care bed rules (10A NCAC 14C .3803).

2. The application fails to account for the impact of UNC REX Holly Springs Hospital.

In 2013, UNC REX was approved to develop a separately licensed 50-bed acute care hospital in Holly Springs, UNC REX Holly Springs Hospital (Project ID # J-8669-11). UNC REX Holly Springs Hospital was the result of the 2011 Wake County Acute Care Bed Review which also resulted in the approval of the 22 acute care beds currently under development at WMC (Project ID # J-8661-11) and the 29 beds approved to be developed at WMR which WakeMed's currently proposed application will relocate to WMC (Project ID # J-8660-11). After the initial agency approval of UNC REX Holly Springs Hospital, WakeMed appealed the decision. During deposition testimony, WakeMed's expert witnesses stated that the development of UNC REX Holly Springs Hospital would reduce utilization at WMC (see Attachment 2). Despite taking this position historically when WakeMed was trying to prevent the approval of the Holly Springs Hospital, WakeMed's currently proposed application does not include any discussion of the impact of UNC REX Holly Springs Hospital.

As shown on UNC REX Holly Springs Hospital's most recent progress report, the facility is currently expected to be operational on June 1, 2020. WMC's proposed project is expected to be operational on October 1, 2019, just eight months prior to the expected opening of UNC REX Holly Springs Hospital. As such, UNC REX Holly Springs Hospital will open during the first project

year of WMC's proposed project and any impact from its opening on WMC will occur during each of WMC's proposed project's first three years of operation.

Based on WakeMed's prior opinions on the impact of UNC REX Holly Springs Hospital on WMC, it is unreasonable for its application to contain no discussion of the facility. In fact, WMC's application erroneously responds to Section G.1 which asks the applicant to "identify all existing and approved facilities that provide the same service component and are located in the service area" by failing to list the approved UNC REX Holly Springs Hospital.

As noted above, WakeMed erroneously assumes that the development of additional beds at WMC will lead to an increase in market share in Wake County. By that same logic, the development of 50 beds at UNC REX Holly Springs Hospital should lead to an increase in market share. Yet, WakeMed's application does not provide any discussion of this new facility or its impact on WMC.

Despite WakeMed's exclusion of this analysis, UNC REX believes the Agency should consider the development of UNC REX Holly Springs Hospital in its analysis of the proposed project's conformity with the review criteria.

Based on the discussion above, it is clear that WMC's projected utilization is unreasonable and unsupported. As such, WMC's application is non-conforming with Criteria 3, 4, 5, 6, and the performance standards in the acute care bed rules (10A NCAC 14C .3803).

3. Duplication of capital costs and beds

Under the currently proposed project, WakeMed will develop 30 acute care beds and one operating room for a total capital cost of over $59 million. WakeMed notes on page 27 that that project includes:

> 2. Relocation of 30 previously-approved, but heretofore undeveloped, acute care beds from WakeMed Raleigh Campus (located at 3000 New Bern Avenue, Raleigh, NC 27610) to WakeMed Cary, as follows:
>
> - All 29 beds approved in Project No. J-8660-11;
> - 1 of the 21 beds approved in Project No. J-10165-13;

However, WakeMed states that throughout its application that its proposed project is not a change in scope project and thus does not change the scope of Project ID # J-8660-11 or J-10165-13. Moreover, WakeMed does not propose to relinquish either Certificate for Project ID # J-8660-11 or J-10165-13 or reduce the approved capital costs for those projects. If the Agency approved WakeMed's currently proposed project without conditioning relinquishment or modifications to these previously approved projects, WakeMed would hold the Certificates permitting the development of 80 beds at a cost of over $124 million:

Project ID #	***# of Beds To Bed Developed***	***Capital Cost***
Previously Approved J-8660-11	29	$57,512,000
Previously Approved J-10165-13	21	$7,890,167
Previously Approved Total	**50**	**$65,402,167**

Proposed J-11428-17	30	$59,596,547
Revised Total	**80**	**$124,998,714**

Thus, approval of WakeMed's project as proposed would authorize the development of 30 additional acute care beds at a cost of over $59 million. The development of 30 additional acute care beds in Wake County would exceed the need that has been identified by the *SMFP*. WakeMed has not demonstrated the need for an additional 30 beds, nor has it demonstrated such beds would not unnecessarily duplicate existing or previously approved capacity.

While WakeMed may choose not to consider the proposed project a change in a previous project, by failing to do so, it is seeking a CON to spend an additional $60 million in capital costs to develop 30 acute care beds, while also retaining the right to spend $65 million in capital costs to develop only 20 of the approved 50 beds. It should also be noted that none of the beds from Project ID # J-8660-11 will be developed; thus the need to spend any of that capital is in question.

Based on the discussion above, it is clear that WakeMed's project is non-conforming with Criterion 1, 3, 5, 6 and 12.

4. WMC is unable to convert nursing beds back to acute care as proposed.

In 2014, WakeMed Raleigh was approved to reconvert 21 nursing facility beds located at WakeMed-Fuquay-Varina (WMFV) to acute care to be developed at WMR under Policy AC-4 (Project ID # J-10165-13). Policy AC-4, Reconversion to Acute Care, states:

"Facilities that have redistributed beds from acute care bed capacity to psychiatric, rehabilitation, nursing care, or long-term care hospital use, shall obtain a certificate of need to convert this capacity back to acute care. Applicants proposing to reconvert psychiatric, rehabilitation, nursing care, or long-term care hospital beds back to acute care beds shall demonstrate that the hospital's average annual utilization of licensed acute care beds as calculated using the most recent Truven Health Analytics Days of Care as provided to Healthcare Planning by The Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill, is equal to or greater than the target occupancies shown below, but shall not be evaluated against the acute care bed need determinations shown in Chapter 5 of the North Carolina State Medical Facilities Plan. In determining utilization rates and average daily census, only acute care bed "days of care" are counted.

Facility Average Daily Census	*Target Occupancy of Licensed Acute Care Beds*
1 – 99	*66.7%*
100 – 200	*71.4%*
Greater than 200	*75.2%"*

Emphasis added.

As noted above, Policy AC-4 applies to facilities that have redistributed beds from acute care bed capacity to other hospital use. As noted in its application, WakeMed has not implemented

Project ID # J-10165-13 and thus these beds remain unconverted. As WMR was previously approved to reconvert the 21 beds at WMFV, and since these beds were apparently originally redistributed to nursing beds prior to the development of WMC, it appears that WMR is the only facility that can convert the beds, not WMC, which is separately licensed from WMR. As it is not the facility the redistributed these beds, WMC cannot apply to reconvert these beds under Policy AC-4.

Further, even if WMC is allowed to convert these beds, it fails to demonstrate that its average annual utilization of licensed acute care beds exceeds its target occupancy rate. Under Policy AC-4, the hospital's average annual occupancy is calculated based on the most recent Truven Health Analytics Days of Care as provided to Healthcare Planning by The Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill. As shown in Attachment 3, the most recent Truven Health Analytics Days of Care show that WMC provided 37,623 days of care in 2016 or an average daily census of 103 patients. WMC is licensed for 156 acute care beds and was previously approved to develop 22 additional beds. As shown below, WMC's average annual utilization of its licensed beds using the most recent Truven Health Analytics Days of Care is 66.1 percent and fails to exceed its target occupancy rate under Policy AC-4.

	WMC
Truven Analytics Days of Care	37,623
Average Daily Census	103.1
Occupancy Rate of 156 Licensed Beds	**66.1%**
Occupancy Rate of 178 Beds (156 Licensed + 22 Previously Approved)	**57.9%**

While Policy AC-4 does not clearly state whether a facility's average annual utilization should be calculated including previously approved beds, it seems reasonable that undeveloped capacity should be included in order to appropriately evaluate the need for additional capacity. WMC's average annual utilization of its licensed and previously approved beds using the most recent Truven Health Analytics Days of Care is only 57.9 percent, which also fails to exceed its target occupancy rate under Policy AC-4. Thus, using only the currently licensed beds or both licensed and approved beds, WMC fails to meet this standard.

Based on the discussion above, it is clear that WakeMed's project is non-conforming with Policy AC-4 and Criteria 1 and 3.

Attachment 1

COPY
J-8661-11

WakeMed copy

WakeMed Cary Hospital 22 Acute Care Beds
Certificate of Need
Volume I - Application
April 15, 2011

IV. UTILIZATION

1. **Using the format of Table IV below, provide annual utilization data for the following time periods:**

   (a) Historical annual utilization data for the two full fiscal years prior to the submission of the application for each service component included in this application. Provide the dates for the fiscal years in the following format: Month/Date/Year to Month/Date/Year.

   (b) Projected annual utilization data for each fiscal year from the time the application was submitted through the fiscal year the project is complete for each service component included in this application.

   (c) Projected annual utilization data for each service component in this application, for the first three full fiscal years after completion of the proposed project.

Per the pre-application conference held with Mike McKillip, Project Analyst with the CON Section, on March 8, 2011, the service component of this project is defined as acute care beds.

Table IV.1.
WakeMed Cary Hospital Utilization

	Historical		Interim		Following Project Completion		
	FY 2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
Discharges	9,939	10,373	10,757	11,183	11,536	11,862	12,279
Pt Days	41,408	44,847	44,857	46,633	48,105	49,465	51,203
Beds	156	156	156	156	178	178	178

(d) Provide all assumptions and the specific methodology used for projected utilization for each service component in this application.

WakeMed utilized a use rate methodology to make its projections, using patient data from a Thomson Reuters database and population data from the Office of State Budget and Management. All assumptions and the specific methodology used are included in the response to 10A NCAC 14C .3803(b) in II.8.

2. **For each type of medical equipment proposed, provide the annual maximum capacity per unit if the SMFP or the certificate of need regulatory review criteria do NOT provide a standard. Provide all assumptions and the specific methodology used to determine the annual maximum capacity.**

Not applicable. The proposed project involves the renovation of existing space to accommodate additional acute care beds.

COPY

J-10165-13

WakeMed

Convert 21 NF Beds to Acute - Relocate to Raleigh

CERTIFICATE OF NEED

Application and Attachments 1-12 - Vol I

August 15, 2013

COPY

Table II.33
WakeMed Raleigh Campus Projected Inpatient Discharges & Patient Days
POST-Shift to WakeMed North

				Raleigh Campus Cases Post-North Shift		
	2013	2014	2015	2016	2017	2018
Discharges	35,113	36,145	37,178	34,862	35,265	35,989
Pt Days	171,116	176,145	181,180	174,769	177,190	181,053
ALOS	4.87	4.87	4.87	5.01	5.02	5.03
Days Per Year	365	366	365	366	365	365
Avg. Daily Census	468.8	481.3	496.4	477.5	485.5	496.0

For WakeMed Cary Hospital, the FY 2010-12 average ALOS was applied to the projected discharges in Table II.28, incorporating the projected shift of cases and patient days from Harnett County, to determine the patient days. Please see the following table.

Table II.34
WakeMed Cary Hospital Projected Inpatient Days & Patient Days

	2013	2014	2015	2016	2017	2018
Discharges	10,253	10,534	10,867	11,210	11,562	11,926
Patient Days	43,473	44,664	46,076	47,530	49,023	50,566
ALOS	4.24	4.24	4.24	4.24	4.24	4.24
Days Per Year	365	365	365	366	365	365
Avg. Daily Census	119.1	122.4	126.2	129.9	134.3	138.5

WakeMed North's projected utilization is based on a different methodology, given that this facility is slated to be developed as a dedicated women's hospital. Utilization at WakeMed North includes volume expected to shift from WakeMed Raleigh Campus, as well as incremental volume from the service area.

Table II.35
WakeMed North Projected Inpatient Days & Patient Days

	2013	2014	2015	2016	2017	2018
Discharges	0	0	0	3,810	4,483	4,999
Patient Days	0	0	0	14,039	17,012	19,245
ALOS	0.00	0.00	0.00	3.68	3.79	3.85
Days Per Year	365	365	365	366	365	365
Avg. Daily Census	n/a	n/a	n/a	38.4	46.5	52.7

History Note: ***Authority G.S. 131E-177(1); 131E-183;***
Temporary Adoption Eff. January 1, 2004;
Eff. August 1, 2004.

Attachment 2

Transcript of the Testimony of **W. Stanley Taylor**

Date: March 1, 2012
Volume: I

Case: Wake County Bed Review

Printed On: November 29, 2017

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STATE OF NORTH CAROLINA — IN THE OFFICE OF ADMINISTRATIVE HEARINGS

COUNTY OF WAKE

HOLLY SPRINGS HOSPITAL II, LLC, Petitioner, v. N.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF HEALTH SERVICE REGULATION, CERTIFICATE OF NEED SECTION, Respondent, and REX HOSPITAL, INC., HARNETT HEALTH SYSTEM, INC. and WAKEMED, Intervenors.	)	11 DHR 12727

(CAPTION CONTINUED ON NEXT Page)

DEPOSITION OF
W. STANLEY TAYLOR

THURSDAY, MARCH 1, 2012
9:33 A.M.

AT THE OFFICES OF
SMITH MOORE LEATHERWOOD LLP
234 FAYETTEVILLE STREET, SUITE 2800
RALEIGH, NORTH CAROLINA

VOLUME I

MR. TAYLOR--VOLUME I - 2 -

REX HOSPITAL, INC.,)
Petitioner,)
v.)
) 11 DHR 12794
N.C. DEPARTMENT OF HEALTH AND)
HUMAN SERVICES, DIVISION OF HEALTH)
SERVICE REGULATION, CERTIFICATE OF)
NEED SECTION,)
Respondent,)
and)
)
WAKEMED, HOLLY SPRINGS HOSPITAL)
II, LLC, and HARNETT HEALTH)
SYSTEM, INC.,)
Intervenors.)
_____)
HARNETT HEALTH SYSTEM, INC.,)
Petitioner,)
v.) 11 DHR 12795
)
N.C. DEPARTMENT OF HEALTH AND)
HUMAN SERVICES, DIVISION OF HEALTH)
SERVICE REGULATION, CERTIFICATE OF)
NEED SECTION,)
Respondent,)
and)
)
REX HOSPITAL, INC., HOLLY SPRINGS)
HOSPITAL II, LLC, and WAKEMED,)
Intervenors.)
_____)
WAKEMED,)
Petitioner,)
v.) 11 DHR 12796
)
N.C. DEPARTMENT OF HEALTH AND)
HUMAN SERVICES, DIVISION OF HEALTH)
SERVICE REGULATION, CERTIFICATE OF)
NEED SECTION,)
Respondent,)
and)
)
HOLLY SPRINGS HOSPITAL II, LLC,)
REX HOSPITAL, INC. and HARNETT)
HEALTH SYSTEM, INC.,)
Intervenors.)
)

MR. TAYLOR--VOLUME I - 3 -

A P P E A R A N C E S

ON BEHALF OF HOLLY SPRINGS HOSPITAL II, LLC:
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SMITH MOORE LEATHERWOOD LLP
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SPECIAL DEPUTY ATTORNEY GENERAL
SCOTT T. STROUD, ESQ.
ASSISTANT ATTORNEY GENERAL
POST OFFICE BOX 629
RALEIGH, NORTH CAROLINA 27603-0629

ALSO PRESENT: NATHAN MARVELLE
DAWN CARTER (VIA TELEPHONE)

MR. TAYLOR--VOLUME I - 4 -

T A B L E O F C O N T E N T S

MR. TAYLOR--VOLUME I - 5 -

S T I P U L A T I O N S

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

1. Said deposition shall be taken for the purpose of discovery or for use as evidence in the above-entitled action or for both purposes, as permitted according to law;

2. Any objections of any party hereto as to notice of the taking of said deposition or as to the time and place thereof or as to the competency of the person before whom the same shall be taken are hereby waived;

3. Objections to the questions and motions to strike answers need not be made during the taking of this deposition, but may be made for the first time during the progress of the trial of this case or any pre-trial hearing held before the judge for the purpose of ruling thereon or at any other hearing of said case at which said deposition might be used, except an objection as to the form of a question must be made at the time such question is asked or objection is waived as to the form of the question;

4. That all formalities and requirements of the statute with respect to any formalities not herein expressly waived are hereby waived, especially including the right to move for the rejection of this deposition before trial for any irregularities in the taking of the same, either in whole or in part or for any other cause;

5. That the undersigned notary-reporter shall personally deliver or mail by first-class mail the transcript of this deposition to the party taking the deposition or his attorney, who shall preserve it as the court's copy; and

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

counties and some even from out of state.
Q. Okay. Let's take a look for a minute at Exhibit 150.
A. Okay.
Q. Can you describe how this document impacts or what the relationship is to the Rex applications?
A. Certainly. I think the first bullet I described with Mr. Huffstetler that the--we were looking at 1982 versus 2011 and why his comment that Holly Springs had as much population as Cary had when Cary was approved was a rather absurd comment. The second block basically supports the fact that cardiac volumes are not growing in North Carolina.
Q. And is the cardiology data, what was that--was that North Carolina data?
A. Yes, that's from the State Medical Facility Plan, which is licensure reports that hospitals submit to the State.
Q. And under the diagnostic cardiac cath data, as you look down the years there, when has WakeMed last applied for cardiac cath equipment?
A. I don't recall. I think it would probably have been 2006 or '07.
Q. And how many cath units are at WakeMed-Raleigh

currently?
A. I believe there are nine cath units and two E.P. laboratories.
Q. And when was the last cath lab added at WakeMed-Raleigh?
A. I'm not sure. I know Rex won an application a year after we won an application, and that was five years ago. I think we've developed our cath lab since then. I don't think Rex has.
Q. And--but WakeMed would have applied last in what year, 2006 or 2007?
A. I'd need to go back and look at the application dates, but I believe that's correct.
Q. Okay. Would that have been a time when cardiac caths--what was the trend for cardiac caths at the time when WakeMed last applied in 2006 or 2007?
A. I believe that was the year where we saw a decline.
Q. Now, where it says "trend in cardiology utilization," just so I'm clear on that--
A. Actually, I don't--I think when we applied we had not seen a decline, because I think that the data based on the application is 2005, if 2006 is the correct year. So it was actually increasing at

that point.
Q. Where it says "trend in cardiology utilization," what is the heading under that, just so I understand exactly what this information is.
A. Total for diagnostic caths, percutaneous cardiovascular interventions, and open heart surgeries.
Q. And just so I understand the case numbers, what do these case numbers represent?
A. Patients.
Q. And the patients are patients of all of those combined?
A. Yes.
Q. Okay.
A. They're also broken out separately in the charts below.
Q. Okay. All right. So on the second page, it's diagnostic cardiac cath. And so, as of 2006, is where the trend line started diminishing for diagnostic cardiac cath?
A. Yes, but if the application was filed in 2006, which I think is correct, that data would not have been available.
Q. Has WakeMed-Raleigh done any renovations--when is

the last time that WakeMed-Raleigh did any renovations that involved the cardiac cath area?
A. We did one, a major renovation--one major renovation since 1993. I think it was in--they all bleed together. I think it was sometime around 2003 or 2004.
Q. Okay. And what did that entail?
A. It was called the heart center wedge project, which added observation capacity, office space for physicians and, I believe, space for an additional cath lab.
Q. And how about WakeMed-Cary, when is the last time the cardiac cath--any renovations or any work has been done to deal--that impacts upon cardiac cath at WakeMed-Cary?
A. I believe we are in the process of replacing or starting to replace a cath lab there now, but it's a replacement. It's not an addition.
Q. Okay. Let's look at the third page of Exhibit 150 for a minute. And when you say "harm done to WakeMed by CON decision" and where it says "hospital in Holly Springs"--
A. Yes.
Q. --and you say "duplication of Cary hospital," and

does that apply to both the Rex-Holly Springs and the Novant-Holly Springs proposal?

A. Yes.

Q. Okay. And under (g), where you're talking about "applicants projecting similar losses to WakeMed in all the primary service area" and you're talking about the net revenue there, is that the net revenue, as I understood it, for the loss that's assumed associated with Rex and Novant?

A. I am not--(i) is the amount associated with Rex, the $15.3 million, based on Rex's projections in their application. Item (ii) is the amount for Novant, which is 13.6 million.

Q. What types of patients are you assuming that WakeMed-Cary would lose to the Rex-Holly Springs proposal if Rex-Holly Springs were to be constructed?

A. I would assume that it would be a mix of patients. That loss is not Cary; it is for the WakeMed System. I 'm assuming it's a mix similar to what we get from that market today.

Q. How much of it--did you quantify how much of it would be WakeMed-Cary versus WakeMed-Raleigh?

A. No, I didn't.

Q. And did you quantify--you didn't quantify it by cardiac patients or other types of patients?

A. I just took an overall gross revenue snapshot of that market and quantified the loss to WakeMed, the system.

Q. Okay. And that wasn't broken down either by, for example, payor type. You didn't assume that a certain number would be Medicaid patients or anything like that?

A. No, it wasn't.

Q. Did you assume that a hundred percent of Rex's Holly Springs's volume would be a market share gain for Rex in these assumptions, or did you make any assumptions about how much would be market share gain for Rex?

A. I assumed that the gain to Rex would be proportional. I basically took what they said they would get from that market area, the 21 percent, and I assumed it would be proportionally taken from Rex and WakeMed and all the other providers that serve that market. Our market share is 57 percent, so I assumed that we would get 57 percent or 57 percent of that shift would be at the expense of the WakeMed system.

Q. Did you make any assumptions about whether or not or what impact the Wake Heart and Vascular physicians would have on any of these projections?

A. No, I assumed that Rex had already accounted for that in their market share projections. Rex had identified a market share that they would have for that facility. We're not talking about Rex-Main; we're just talking about the Rex-Holly Springs hospital. And Rex claimed that they would get 21.3 percent of that market. We currently have 57 percent of that market. So if they get a proportional amount of that from us, then that's a 12 percentage loss for the WakeMed system.

Q. Where you say under (h), and this is under 1(h), "given that the beds are not needed, this shift harm harms WakeMed-Cary Hospital." What did you mean by the statement where it says, "given that the beds are not needed"?

A. During the review, the 2012 draft Plan came out that showed that there was no longer a need for 101 beds in the market. And as such, it was my belief that the State should have looked at that in determining whether or not they award 101 beds.

Q. And at what point in time--at what point in time

did you become convinced that there was only a need for 29 beds?

A. When the 2012 draft Plan was published and when WakeMed looked at their own internal data and other data from around the state and saw the softness in patient days continue.

Q. And at what point in time was that; I mean, was that before the applications were filed?

A. No, it was not.

Q. Can you isolate a time during the year 2011 when you came to that realization?

A. Probably toward the end of 2011.

Q. Was it--so was it--

A. It's not something that I think about every day. It's something that, when we're sitting down looking at this, looking at what the State had done, and then looking back at what the Medical Facilities Planning Section had identified as a need, it's sort of is an "ah-ha.'' You know, if the State had been paying attention to this, they would have realized their own department indicated that there was no longer a need for 101 beds.

Q. So it was after the decision of the Agency, you would say?

A. I think that's fair to say.
Q. Okay. Was it before or after WakeMed filed its petition in this case?
A. It was probably around the same time.
Q. Probably around the same time as the petition?
A. I would imagine.
Q. Did WakeMed, at any point, consider withdrawing either of its applications?
A. No.
Q. Why not?
A. Regardless of whether something is needed, you always want it.
Q. Did--to your knowledge, did WakeMed--and I'm not talking about any attorney-client privilege conversations--but did WakeMed internally debate about whether or not to appeal any of the decisions?
A. I think we very quickly made a decision that we didn't feel like the decisions were correct and that we needed to appeal them, and that did not require much debate.
Q. Did not? I'm sorry. I didn't hear the last part.
A. Did not require much debate. I think that was a phone call to Dr. Atkinson who said we're going to

appeal it.
Q. So if you only came--are you faulting the Agency for issuing--for awarding more than 29 beds?
A. Yes.
Q. But you're faulting the Agency for awarding more than 29 beds, even though you had not come to a conclusion, it sounds like, that only 29 beds were needed until after the Agency decision?
MS. MURRAY: Object to the form.
A. Want to rephrase or?
Q. Do you understand the question?
A. No.
Q. Okay. You are faulting the Agency for awarding more than 29 beds even though you didn't come to a realization or you did not come to a conclusion on your own that only 29 beds were needed, rather than 101, until after the Agency decision was issued?
MS. MURRAY: Object to the form.
A. I think we questioned whether beds were needed all along. I think we believed that it was important for WakeMed to apply for these beds. We believe the patient need was there when we made the application, but we consistently had concerns

about the reimbursement system being able to finance these expansions.
Q. But is it fair to say that, at the time of the Agency decision, you still felt that there was a need for 101 beds?
MS. MURRAY: Object to the form.
A. We felt there was a need for 101 beds when we filed the application. So during the preceding or the ensuing year, we continued to see soft inpatient demand for services in our market and statewide. And I think, if that continues, then we're very concerned about an expansion of bed capacity when the need is not there. I think that hurts all the providers, the existing providers and any new providers.
Q. When did you--the 2012 data--the 2012 SMFP data is based on the 2010 Thompson Reuters data; is that correct?
A. I believe that's correct.
Q. And when would the 2010 Thompson Reuters data have been available to you?
A. In the Spring of 2011, but the growth rate that's applied for that with the Medical Facilities Planning Commission or the Medical Facilities

Planning Section does--was not available until the draft Plan was published.
Q. And when was that? Was that growth rate data the same data that was referenced in the earlier emails that we looked at--that you looked at with Mr. Huffstetler, or was that--
A. No. It's--
Q. Okay.
A. --different data.
Q. So when was the--when did WakeMed receive access to the growth rate data that would have been used in the--the same growth rate data that would have been used in the 2012 SMFP?
A. When the draft Plan was published.
Q. And when was that; do you recall?
A. It was--I think it was July--June or July of 2011. I don't--I don't--I'm not an expert on when those Plans are published, but I can certainly find out for you.
Q. And what--what data did you look at that caused you to conclude that only 29 beds were needed, in your view, instead of 101.
A. The 2012 draft of the Medical Facilities Plan.
Q. And it was the actual the Plan itself?

A. The draft.
Q. Okay. And when did you first look at that?
A. Probably within days of it being published.
Q. Okay. So you would have looked at it in the summer of 2011 roughly?
A. Yes.
Q. Okay. And that would have been during this review?
A. Yes.
Q. Okay. And at that point, did you discuss with anyone whether or not WakeMed might withdraw either of their applications?
A. No.
Q. And why not?
A. It's not our nature to withdraw an application before you even get a decision on it. It's not our nature to do that.
Q. Are you--is WakeMed, in your view, in this case challenging the need in the 2011 SMFP?
A. No.
Q. Is there anything that you've seen internally in writing at WakeMed that you've created or that you've seen where it is discussed that there's a need for only 29 beds in this review?

A. Probably--we've probably talked about that. I believe there was a summary document prepared when the draft Plan came out by one of the staff that looked at those issues and identified what was in the Plan.
Q. Okay. Do you know who would have done that?
A. Either Robbie Roberts or Bob Fitzgerald.
Q. And do you know whether that's a document that has been produced in this case?
A. I don't know.
Q. Okay. And do you recall seeing that document?
A. I recall seeing summaries from Robbie Roberts or Bob Fitzgerald of what was going on at SHCC and that process. I don't--I don't know that any of that was requested as part of this case.
Q. Do you recall what that document said about what WakeMed should do, if anything, about that?
A. I don't believe it said anything. It was not an analysis. It was a summary of what was in the Plan, what was going to be proposed for the next year. And I don't think anyone had been asked to make judgment calls on that, but it was distributed to executive staff probably via email so that they would be aware of what was coming up

for the next year.
COURT REPORTER: It's 159.
(DEPOSITION EXHIBIT NO. 159 WAS MARKED FOR IDENTIFICATION.)
Q. Have you seen this document before?
A. I'm sure I was emailed a copy. I don't know that I spent much time looking at it.
Q. Okay. If you look at--do you understand that it's the petition for contested case hearing that WakeMed filed in this case?
A. That's what it appears to be, yes.
Q. Okay. If you would look at Page 40 and 41 for a second.
A. I'm there.
Q. Okay. Do you see where it says WakeMed--I'm looking at the bottom of Page 40, the last two lines. It says, "WakeMed further requests that the Office of Administrative Hearings appoint an administrative law judge without delay and the administrative law judge recommend that," and then it has a few items there. And it says, Point Number 3 says, "The decision approving the WakeMed-Cary application be upheld." And then Item 5 says, "The WakeMed-Raleigh application be

approved for the full complement of 79 beds, and the CON Section's initial decision be reversed." Do you see that?
A. Yes.
Q. Why would--based on your understanding, why is WakeMed appealing the condition of the WakeMed-Raleigh application for 79 beds?
A. Because our application was for 79 beds, and it was conditioned for only 29 beds.
Q. But if WakeMed's position now is that there's only a need for 29 beds, why wouldn't WakeMed instead just defend whatever was approved and--well, strike that. Let me rephrase that.
If WakeMed's position now is that only 29 beds are needed, why is it asserting in its petition that WakeMed should have been awarded 101?
A. We were denied for an application. Just because they aren't needed, doesn't mean we don't want them.
Q. But the Agency was wrong to issue more than 29, first of all, right, in your view?
A. A lot of people want am-surg centers and apply for am-surg centers whenever there is an allocation,

but--I think you'd be foolish not to apply for one if it were available. It doesn't necessarily mean it's needed.

Q. But your position currently is that the Agency erred by--by awarding more than 29 beds; is that fair?

A. That's fair.

Q. Okay. But, at the same time, your position is that the Agency erred by not awarding WakeMed 101?

A. We had submitted two applications for 101 beds. Again, if you happen to see a resource out there that you can get through the regulatory process, you apply for everything. If that was what was denied, I think it would be a little bit foolish to position from a--yourself in a position of weakness in an appeal and give up something that would set the stage for all the other applicants to be approved.

Q. Why did the--well, let me ask you this. What would the Agency--what should the Agency do when dealing with a special need allocation, for example--a special need determination if--for example, if WakeMed has a special need determination put in the Plan for something--for

an item or beds, and then WakeMed files an application pursuant to that need determination, how should the Agency view that if, then, the next year's SMFP would show no need for such an item?

MS. MURRAY: Object to the form.

A. I think they should view it negatively if--I believe the CON criteria show that the State should assess the need. I've also had concerns about special need determinations which were not necessarily well founded. But I think if the State Medical Facility Plan said that in one year we need this allocation and the next year said we do not need this special need allocation, then I think the State should have paid attention to that. I don't think that's how special need determinations work.

Q. But isn't it, by definition, always the case with a special need determination that it's a special need determination because the methodology does not generate a need.

MS. MURRAY: Object to the form.

A. Not--not always. I think there are other things that go into a special need determination. Maybe a need for research.

Q. But you've seen special need determinations that WakeMed has applied for, for example, where the normal need methodology did not state a need, correct?

A. Correct.

Q. Okay. And in that situation, not even that year's Plan would show a need for pursuant to the methodology?

MS. MURRAY: Object to the form.

A. I can hardly see how it's analogous to this. I mean, there's a methodology every year that looks at the need for acute care beds. In a special need methodology, if the State said that we need a special need project in 2011 but in 2012 the State came back and said, oh, we made a mistake, we don't need this methodology, I think that would be grounds for the--we don't have this need. I think that would be grounds for the State to deny the application if it were still under review.

Q. So is it--is it your view that the 2012 SMFP negated the 2011 SMFP?

MS. MURRAY: Object to the form.

A. I believe the data in the 2012 SMFP indicated that there was not a need that the 2011 SMFP had

identified. You're making the analogy that if a special need determination is made one year and then the next year the SHCC said, you know, we don't need the special need determination. It shouldn't have been in the Plan. I think the State would have a responsibility to deny that special need determination if it was still under review.

Q. Let me go back for a second to--I'm jumping back and forth to cover some stuff, to the extent we can, this afternoon. Let's look back at Exhibit 150 for a minute. And what you have at the top of Page 150 where it says, when Holly Springs was approved versus Cary hospital approved--

A. Yes.

Q. --how--I want to go back to that for a second. How many beds were initially approved for WakeMed-Cary?

A. I believe it was 80.

Q. Okay. And so was it--when did WakeMed Cary come into operation then?

A. We opened December 17th, 1991.

Q. Okay. With 80 beds?

A. Yes.

Transcript of the Testimony of **W. Stanley Taylor**

Date: March 15, 2012
Volume: II

Case: Wake County Bed Review

Printed On: November 29, 2017

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STATE OF NORTH CAROLINA — IN THE OFFICE OF ADMINISTRATIVE HEARINGS

COUNTY OF WAKE

HOLLY SPRINGS HOSPITAL II, LLC, Petitioner, v. N.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF HEALTH SERVICE REGULATION, CERTIFICATE OF NEED SECTION, Respondent, and REX HOSPITAL, INC., HARNETT HEALTH SYSTEM, INC. and WAKEMED, Intervenors.	)	11 DHR 12727

(CAPTION CONTINUED ON NEXT PAGE)

DEPOSITION OF
W. STANLEY TAYLOR

THURSDAY, MARCH 15, 2012
9:04 A.M.

AT THE OFFICES OF
K&L GATES, LLP
430 DAVIS DRIVE, SUITE 400
MORRISVILLE, NORTH CAROLINA

VOLUME II

REX HOSPITAL, INC.,)
Petitioner,)
v.)
) 11 DHR 12794
N.C. DEPARTMENT OF HEALTH AND)
HUMAN SERVICES, DIVISION OF HEALTH)
SERVICE REGULATION, CERTIFICATE OF)
NEED SECTION,)
Respondent,)
and)
)
WAKEMED, HOLLY SPRINGS HOSPITAL)
II, LLC, and HARNETT HEALTH)
SYSTEM, INC.,)
Intervenors.)
_____)
HARNETT HEALTH SYSTEM, INC.,)
Petitioner,)
v.) 11 DHR 12795
)
N.C. DEPARTMENT OF HEALTH AND)
HUMAN SERVICES, DIVISION OF HEALTH)
SERVICE REGULATION, CERTIFICATE OF)
NEED SECTION,)
Respondent,)
and)
)
REX HOSPITAL, INC., HOLLY SPRINGS)
HOSPITAL II, LLC, and WAKEMED,)
Intervenors.)
_____)
WAKEMED,)
Petitioner,)
v.) 11 DHR 12796
)
N.C. DEPARTMENT OF HEALTH AND)
HUMAN SERVICES, DIVISION OF HEALTH)
SERVICE REGULATION, CERTIFICATE OF)
NEED SECTION,)
Respondent,)
and)
)
HOLLY SPRINGS HOSPITAL II, LLC,)
REX HOSPITAL, INC. and HARNETT)
HEALTH SYSTEM, INC.,)
Intervenors.)

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ALSO PRESENT: JUDY ORSER
NATHAN MARVELLE
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T A B L E O F C O N T E N T S

S T I P U L A T I O N S

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

1. Said deposition shall be taken for the purpose of discovery or for use as evidence in the above-entitled action or for both purposes, as permitted according to law;

2. Any objections of any party hereto as to notice of the taking of said deposition or as to the time and place thereof or as to the competency of the person before whom the same shall be taken are hereby waived;

3. Objections to the questions and motions to strike answers need not be made during the taking of this deposition, but may be made for the first time during the progress of the trial of this case or any pre-trial hearing held before the judge for the purpose of ruling thereon or at any other hearing of said case at which said deposition might be used, except an objection as to the form of a question must be made at the time such question is asked or objection is waived as to the form of the question;

4. That all formalities and requirements of the statute with respect to any formalities not herein expressly waived are hereby waived, especially including the right to move for the rejection of this deposition before trial for any irregularities in the taking of the same, either in whole or in part or for any other cause;

5. That the undersigned notary-reporter shall personally deliver or mail by first-class mail the transcript of this deposition to the party taking the deposition or his attorney, who shall preserve it as the court's copy; and

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

P R O C E E D I N G S

(WHEREUPON, W. STANLEY TAYLOR WAS CALLED AS A WITNESS, HAVING BEEN PREVIOUSLY DULY SWORN, AND TESTIFIED AS FOLLOWS:)

CONTINUED DIRECT EXAMINATION BY MR. QUALLS:

Q. Good morning, Mr. Taylor. We're back on the record in the acute care contested case. Let me ask you, since--since we were together last time for your deposition, have you reviewed the deposition transcript for Dawn Carter?

A. No, I have not.

Q. Okay. Or Daniel Carter?

A. Yes.

Q. Okay. Nathan Marvelle?

A. I printed it out but didn't get a chance to review it.

Q. Okay. To your knowledge, have you read any exhibits--have you reviewed any exhibits that were used by Dawn Carter, Daniel Carter, or Nathan Marvelle in their depositions?

A. I skimmed an exhibit that was used by Nathan Marvelle but did not spend much time on it.

Q. Okay. Do you remember what it pertained to generally?

A. I believe there were some tables of growth trends calculations.

Q. Okay. Have you developed any specific opinions that you plan to render in this case in response to those exhibits?

A. I have some opinions about that information. I haven't developed them in response.

Q. What are your opinions about that?

A. I--just in glancing at the tables, I--I think the--one opinion was that he was very careful about which year he picked to start his analysis. He picked a very low year, although the subsequent year was very high. It made a dramatic difference in growth rates that he was estimating.

Q. Okay. Well, we'll look at it. We may pull that out in one second. Have you reviewed the deposition transcript of Dan Sullivan?

A. No, I haven't.

Q. Okay. Have you reviewed any deposition exhibits that were used by Dan Sullivan in his exhibit--in his deposition?

A. I don't believe I have. I believe those were sent to me, but I don't believe I reviewed them.

Q. Okay. And then have you reviewed the deposition

transcript of Robbie Roberts?

A. No.

Q. Okay. Judy Orser?

A. I believe I did look at part of Judy Orser's.

Q. Okay. Was that in between the first time you were deposed?

A. No.

Q. Okay. That was before the first time?

A. Yes.

Q. Okay. I'll try to be careful not to go over anything that you went over--

MS. MURRAY: Gary, I'm sorry. Can I interrupt you? Allyson was going to call in, and I forgot to--

MR. QUALLS: Let's go off the record a second.

(OFF-THE-RECORD DISCUSSION)

Q. (By Mr. Qualls) As I was saying, Mr. Taylor, I'm going to try hard to not go over any territory that was gone over in your first day of deposition, so I may be skipping around a little bit. I'm going to try not to repeat anything that was already discussed there. You had talked about some in your exhibit where you discussed harm to

Rex--and you may want to pull that out in case you need to or want to refer to that. That is Exhibit 150, and so it should be, I'm guessing, either maybe in the second or third exhibit notebook. I apologize. There are many notebooks over there. And I've gotten mine pulled out of the notebook, so I'm not sure exactly which notebook that's in.

A. I'm there.

Q. Okay. And is Exhibit--Exhibit 150 a document which contains your opinions in this case?

A. Yes, it is.

Q. Okay. And one of the things that you were talking about in that document, and we briefly touched on last time before we quit, was that you believe that WakeMed is harmed by both the Rex-Main campus project and the Rex-Holly Springs project; is that correct?

A. WakeMed is harmed by those projects, yes.

Q. Okay. Are there any particular WakeMed projects, which the Rex-Holly Springs project would preclude WakeMed from developing?

A. Certainly.

Q. Which ones?

A. Projects at the Cary hospital that will be harmed

by the development of the Holly Springs hospital.
Q. Okay. And what specific projects, if you can identify any, would WakeMed be precluded from developing if Rex-Holly Springs were developed?
A. Anything that would relate to the volume trends in that market. The loss of volume that WakeMed would see at the Cary hospital is related to an unnecessary, duplicative project.
Q. Now, can you identify any that--any potential projects?
A. We have a capital budget. I believe the capital budget for that facility is in the range of $6 million a year, the odds and ends of projects. I don't work with that capital budget on a day-to-day basis, but I know, if the facility is harmed, then that budget will decrease.
Q. Will it--will the Rex-Holly Springs project preclude WakeMed from developing any beds at WakeMed-Cary in the future?
A. It could, certainly.
Q. And why would that be?
A. Because it's going to unnecessarily duplicate acute care beds in that part of the county.
Q. And it would--and therefore, it would deprive

WakeMed of funds to develop beds?
A. It would deprive WakeMed of the funds indirectly and patients directly.
Q. And what is--if--if Wake--if Rex-Holly Springs is developed, would WakeMed potentially, then, not apply for anymore bed need determinations for a while for WakeMed-Cary?
A. WakeMed would determine what its utilization rate is at that campus. If the expected drop in utilization occurs, it would grow much more slowly. And I'm sure, at some point in the future, we could apply for more beds, but it would certainly be harmed by the Holly Springs campus.
Q. If--see if you can fill in the blank for me in this question then. If WakeMed--if Rex-Holly Springs is developed and WakeMed's bed utilization reaches blank--excuse me--blank percent, WakeMed would not apply for more beds. What--what would be the blank?
A. If we're--if we're not utilizing beds, if we're not expected to see that utilization to grow, we wouldn't apply for beds. I--I can't tell you what that would be. It's more important what the trend would be, what the five-year trend in patient

volumes would look like, the past two or three years specifically, and whether or not that's growing or stable or declining, whether or not we're meeting the target thresholds that the State has determined are appropriate for expanding facilities.
Q. Which projects would the Rex-Main campus project prevent WakeMed from developing if the Rex-Main project at issue here were to be developed?
A. The Rex-Main project duplicates and--and builds a specialty hospital--a specialty heart hospital that already exists in the market. That is the most profitable, most--service for the WakeMed System. So there are certainly projects that would not be developed if the cash flow from cardiac services is unnecessarily shifted from one facility to another.
Q. Can you identify any WakeMed-Raleigh projects that have already been considered for WakeMed-Raleigh which would not be developed if the Rex-Main project were developed?
A. We make determinations of what we can develop based on our current financial status. I'm not going to speculate what project we would or

wouldn't develop. But I know that WakeMed would be harmed by taking the cash flow from cardiac services and picking it up from WakeMed and moving it five miles away to Rex. That's--that is going to be a tremendous harm to WakeMed, a tremendous financial harm, and is not needed. It's duplicative, and it's not needed in the market.
Q. And when you're talking about that, picking up those cases and moving them, you're talking about the shift of cardiovascular patients that were projected in the Rex-Main application?
A. That's correct.
Q. And that would be associated with the Wake Heart and Vascular physicians?
A. I believe it's associated with the development of the specialty hospital. I put very little credence in the shift that Rex talks about, in terms of the physician-based shift, because I just know, from my experience in healthcare, just because a physician is with you today doesn't mean he's going to be with you tomorrow. It's a very fluid market with physicians. I think that whole line of rationale in Rex's application is very questionable. But I do believe if you build a

When Holly Springs was approved versus Cary Hospital approved[i]:

- Utilization per 1000 in 1982[ii] – 6 ,384,449 days of care, population of 5,918,760 – days per 1000 = 1,078.7
- Utilization per 1000 in 1990[iii] – 5,883,907 days of care, population of 6,662,473 – days per 1000 = 883.1
- Utilization per 1000 in 2011 – 4,417,043 days of care, population of 9,735,890[iv] – days per 1000 = 453.7

Trend in Cardiology Utilization:

Total for DX Caths, PCI's and Open Heart:

Year	Cases	Growth
2001	116,291	--
2002	118,717	2.1%
2003	123,231	3.8%
2004	124,702	1.2%
2005	124,138	-0.5%
2006	112,728	-9.2%
2007	107,204	-4.9%
2008	106,559	-0.6%
2009	103,101	-3.2%
2010	102,529	-0.6%

Open Heart Surgery[v]

Year	Cases	Growth
1997	13,498	--
1998	13,365	-1.0%
1999	13,151	-1.6%
2000	13,210	0.4%
2001	12,870	-2.6%
2002	12,259	-4.7%
2003	12,041	-1.8%
2004	11,128	-7.6%
2005	10,817	-2.8%
2006	10,459	-3.3%
2007	9,449	-9.7%
2008	9,136	-3.3%
2009	8,762	-4.1%

2010	8,705	-0.7%

Diagnostic Cardiac Catheterizations

Year	Cases	Growth
1997	63,800	--
1998	67,757	6.2%
1999	69,733	2.9%
2000	73,425	5.3%
2001	78,296	6.6%
2002	79,168	1.1%
2003	81,161	2.5%
2004	82,803	2.0%
2005	84,662	2.2%
2006	74,556	-11.9%
2007	70,653	-5.2%
2008	69,709	-1.3%
2009	66,376	-4.8%
2010	64,856	-2.3%

Percutaneous Coronary Interventions

Year	Cases	Growth
2001	25,125	--
2002	27,290	8.6%
2003	30,029	10.0%
2004	30,771	2.5%
2005	28,659	-6.9%
2006	27,713	-3.3%
2007	27,102	-2.2%
2008	27,714	2.3%
2009	27,963	0.9%
2010	28,968	3.6%

Harm done to WakeMed by CON Decision:

1. Hospital in Holly Springs
   a. Duplication of Cary Hospital
   b. Unnecessary expansion of bed capacity will diminish Cary Hospital's revenue – we don't live in an era of "if you build it they will come".
   c. Market Share Currently in Holly Springs: 57%[vi] (54.1 in Rex's application for PSA)
   d. Market Share proposed by Rex: 21.3%
   e. Market Share proposed by Novant: PSA = 21.4% - Acute, 29.5% - OB,
   f. Financial harm of shift in only 1 ZIP Code (Holly Springs, 27540)
      i. .57 x .213 = loss of 12 percentage points, Rex, Total
      ii. .57 x .214 = loss of 12 percentage points, Novant, Acute
      iii. .57 x .295 = loss of 17 percentage points, Novant OB
      iv. Gross of $28,030,948, Net Revenue Estimated at 29.7% or $8.3 million
      v. 12/57ths of $8.3 million = $1.7 million in lost revenue
   g. Applicants project similar losses to WakeMed in all of Primary Service Area.
      i. Holly Springs[vii] is only 11% of the service area for Rex, so the total loss would be 9 times that in Holly Springs, or $15,300,000.
      ii. Holly Springs[viii] is only 12.5% of the service area for Novant, so the total loss would be 8 times that in Holly Springs, or $13,600,000.
   h. Given that the beds are not needed, this shift harms WakeMed Cary Hospital.

2. Rex Heart Tower Expansion
   a. Revenue lost
      i. Duplication of already adequate services that has a history of declining utilization.
         1. History and industry trends show that Rex does not need 4 catheterization laboratories. The State erred in not requiring Rex to downsize both their number of acute care beds and their number of catheterization laboratories as conditions to the project.
         2. Charts above show that the total volume of cardiovascular services is declining or stagnant at best. Therefore, allowing Rex to build additional resources serves no public purpose.
         3. Given the declining trend, Rex's low historical utilization and that the actual shift of cases by WHV is speculative, Rex should have been conditioned down on cardiac catheterization labs, and should also have been conditioned down on acute care beds.
         4. Rex demonstrated the need for no more than 3 catheterization laboratories. The State's failure to condition Rex down to replace only 3 cardiac catheterization laboratories harmed WakeMed.

5. If the State had required Rex to downsize its bed capacity by its surplus of 36 beds, then Rex would not be able to shift 9,881 patient days (36 x .752 x 365). At $2446 net revenue per patient day, that shift would amount to direct harm of at least $24,169,610.

ii. No evidence was presented to the CON Section of any problems with WakeMed's cardiac program and facilities. A change in physician employment does not justify unnecessary duplication of existing, appropriately utilized services and facilities. The primary purpose of the CON Act is not to allow development of resources that unnecessarily duplicate existing resources and cause the existing resources to be underutilized. Physicians are free to practice where they wish. Neither the physicians nor their employer, however, are entitled to develop new, duplicative resources just because they decide to practice at a different location.

3. Comments by Dr. Roper regarding intent to do harm to WakeMed:
   a. From News and Observer , 12/13/2011:
      i. Atkinson and Roper met again on April 5 [2011].
      ii. "Roper then shared with Atkinson his vision for the future: One day, WakeMed and UNC, similar in mission and history, would merge. Roper told Atkinson that work to this end could be the crowning achievement of both their careers. **Roper told Atkinson he'd rather do that than spend the next five years of his career trying to grind WakeMed into the dirt.**"
      iii. http://www.newsobserver.com/2011/12/13/1707473/hospital-ceos-argue-spur-fight.html#storylink=cpy
      iv. Clearly, Mr. Roper's intent is to either force WakeMed to merge or, through State action, "grind WakeMed into the dirt".

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[i] Although Cary Hospital (aka Western Wake Medical Center) was first approved in 1982 (5/28/1982, project # J-1621-82), the hospital did not open until December 17, 1991.

[ii] Health Facilities Data Book: Hospital Patient Origin Report 1982 Data; State Center For Health Statistics; NC Department of Human Resources, Division of Health Services.

[iii] Hospital Summary Report, 1990 Data, Department of Environment Health and Natural Resources; State Center for Health and Environmental Statistics.

[iv] http://www.osbm.state.nc.us/ncosbm/facts_and_figures/socioeconomic_data/population_estimates/demog/countytotals_2010_2019.html

[v] From State Medical Facilities Plan documents, 1997 through 2012 (draft)

[vi] 2010 Thomson Reuters Data

[vii] Rex Application page 155: 7,392 days in Holly Springs versus 66,214 in the Service Area.

[viii] Novant Application page 776: 7,152 days in Holly Springs versus 56,969 in the Service Area.

Attachment 3

Truven Health Analytics/Licensure Acute Care Days Comparison (2016 Data as of 08/14/2017)

Facility Name	County	Licensure	Truven	Lic.-Truven	%
H0037 Charles A. Cannon, Jr. Memorial Hospital	Avery	2,246	2,436	-190	-7.80%
H0154 Cape Fear Valley-Bladen County Hospital	Bladen	2,566	3,464	-898	-25.92%
H0027 Lexington Medical Center	Davidson	9,877	8,920	957	10.73%
H0287 FirstHealth Moore Regional Hospital - Hoke Campus	Hoke	1,370	1,280	90	7.03%
H0193 Highlands-Cashiers Hospital	Macon	423	1,494	-1,071	-71.69%
H0158 FirstHealth Richmond Memorial Hospital	Richmond	8,711	7,924	787	9.93%
H0067 Sampson Regional Medical Center	Sampson	11,777	12,557	-780	-6.21%
H0165 LifeBrite Community Hospital of Stokes	Stokes	768	1,454	-686	-47.18%
H0276 WakeMed Cary Hospital	Wake	40,516	37,623	2,893	7.69%