WILMINGTON ASC, LLC

January 2, 2018 **DELIVERED VIA EMAIL 1/02/18**

Ms. Lisa Pittman, Assistant Section Chief
Greg Yakaboski, Project Analyst
Health Planning and Certificate of Need Section
Division of Health Service Regulation
2704 Mail Service Center
Raleigh, NC 27699-2704

Re: Comments on Competing Applications for a Certificate of Need for one operating room in New Hanover County, Health Service Area V; CON Project ID Numbers:

- ***Wilmington ASC, LLC application for a new multi-specialty ambulatory surgery center with one operating room and three procedure rooms, Project ID O-11441-17***
- ***Wilmington Surgery Center, LP application for one new operating room, Project ID# O-11437-17***
- ***New Hanover Surgery Center, LLC, application for a new single-specialty ambulatory surgery center with one operating room and two procedure rooms, Project ID# O-11444-17***
- ***New Hanover Regional Medical Center, LLC, application for one shared operating room, Project ID# O-11434-17***

Dear Mr. Yakaboski and Ms. Pittman:

On behalf of Wilmington ASC, LLC ("WASC"), Project ID# O-11441-17, thank you for the opportunity to comment on the above referenced applications for one additional operating room in New Hanover County. During your review of the projects, I trust that you will consider the comments presented herein.

We recognize that the State's Certificate of Need (CON) award for the proposed operating room will be based upon the State's CON health planning objectives, as outlined in G.S. 131E-183. Specifically, we request that the CON Section give careful consideration to the extent to which each applicant:

- Encourages and supports the State's Basic Principles of Quality, Access, and Value;
- Supports the CMS Triple Aim of Low Cost, High Quality, and Positive Patient Experience; and,
- Provides a sustainable program that responds to true need in the community.

In this review, the four applicants propose very different uses for the one operating room. Although this difference makes traditional comparison metrics difficult to apply, it also opens the review to consideration of which surgical program offering will have the biggest and most positive impact on the community. For example, the statute requires a review of enhanced competitive effects of proposed services and encourages competition where competition would have beneficial impact on cost effectiveness, quality, and access to the services proposed.

- U.S. Census forecasts that in the Wilmington Metro Area (New Hanover and Pender counties) will have a population of 294,000 people; it ranked second in the state in rate of growth (1.99 percent annually, see Attachment 7).
- New Hanover County acts as a tertiary center for a much larger service area that includes Pender, Columbus, Brunswick, and Duplin counties. According to NCOSBM, the combined population of the five counties in 2017 is 536,440 and, in 2022, it will be 576,551.

Table 1: Population Estimates and Projections by County by Year

County	2017	2022
Brunswick	131,726	147,577
Columbus	56,941	56,903
Duplin	59,513	59,214
New Hanover	227,261	245,544
Pender	60,999	67,313
TOTAL	***536,440***	***576,551***

Source: North Carolina Office of State Budget and Management; Data accessed December 27, 2017; https://www.osbm.nc.gov/demog/county-projections

- New Hanover has the tertiary medical community to meet the service challenge. However, it has only one facility and four operating rooms that offer the freestanding ambulatory surgery center option.
- Two applicants, WASC and New Hanover Surgery Center propose a new freestanding ambulatory surgery center. Some of the cases proposed by each will represent an alternative site of care. That is, if the applicant is approved, cases that might have been done at New Hanover Regional Medical Center ("NHRMC") at hospital-based rates can be done at costs to the payor that are as much as 60 percent lower. The alternative site will have the added benefit of increasing NHRMC capacity to accommodate more complex inpatient and outpatient cases. Approval of one of these two would produce a double benefit for the service area.

The application from WASC is conforming to all statutory review criteria and special rules. We believe that the proposal by WASC offers the state a unique, one-time opportunity to gain the positive impact of a multi-specialty freestanding ambulatory surgery center in addition to improved competition in this tertiary health care referral market. WASC provides:

- The only truly new regional competitor among the applicants;
- The only application proposing a new multi-specialty ambulatory surgery center;
- The most efficient cost, design, and means of construction for keeping surgical services costs approachable for consumers and payors in the region;
- A service that enjoys strong community support and, associated with it visibility that will be accountable to the community for years to come;

- A service fully integrated with Wilmington Health and its community-based Accountable Care Organization, Physicians Healthcare Collaborative (That ACO ranked first in the nation in Medicare quality of care scoring in 2013 and sustains high quality scoring[1].);
- A facility that enjoys broad support from the community; in addition to the 36 letters of support provided in the application, another 93 letters have been submitted by persons who are aware of the options and express a preference for this application;
    - It has the endorsement and support of two of the largest organizations representing independent physicians in New Hanover County – Coastal Physicians Alliance and Wilmington Health. The practices in these organizations include physicians who will use the center for cases and those who will refer patients to physicians who will use the center;
    - It was designed on the basis of hundreds of hours of conversations with the community;
- A facility with access to two sites that are convenient to the patients to be served and close to both the offices of specialists who propose to perform cases in the center and to the hospital;
- A facility that will be certified by Medicare and Medicaid, accredited by AAAHC, and its management services company's access to national contracts with insurance companies can expedite access to the facility for persons who have private insurance;
- A generous charity policy, and through its management services company, an organized program for diversity in hiring, and it will have language and cultural assistance to remove access barriers for medically underserved groups;
- A construction management team that has experience with design and development of hundreds of ambulatory surgery centers;
- It has access to the capital required for the project;
- Improved efficiency and access to services of existing resources. Specifically it will relocate three existing licensed multi-specialty / GI endoscopy procedure rooms that are currently in a facility that restricts their use because of its age and design constraints. WASC proposes to bring the multispecialty ambulatory procedure rooms to current code with better support. This will permit expanded use of the rooms for both GI procedures and other procedures;
- The only freestanding surgery center certified as a spine center of excellence;
- A proposed payor mix that is well grounded in experience with ambulatory surgery facilities in this region that provide the types of services proposed;
- The only freestanding surgery center offering oral surgery procedures;
- The only freestanding surgery center with staff identified to provide overnight services;
- Essential equipment, such as the Femtosecond laser which is not currently available in any freestanding surgery center in New Hanover County, and a balance sheet showing commitment to refresh equipment annually;
- An achievable timetable to be available in 2019; and,

[1] Physicians Health Collaborative website http://www.physicianshealthcarecollaborative.com/quality.html
Wilmington Health website: https://www.wilmingtonhealth.com/news/wilmington-health-recognized-as-the-1-accountable-care-organization-in-the

- Organization and structure that respond to the CMS goals for an Accountable Care Organization to provide the highest quality services with the best patient satisfaction at the lowest reasonable cost.

The following tables also highlight reasons why WASC is competitively superior on a combination of individual metrics. A few metrics are missing for individual applications. To adjust for missing values, the second table has a standardized score based on the applicant's actual score compared to the maximum it could achieve.

Table 2: Recommended Comparative Analysis

Raw Data

Competitive Enhancement	Metric	Applicants				Source
		WASC	New Hanover Surgery Center, LLC	New Hanover Regional Medical Center, LLC	Wilmington Surgery Center, LP	
Access	Year 3 OR Cases	1,357	1,704	1,274	1,256	Form D
Access	Medicare and Medicaid Patients served Year 2	8,017	550	n/a	7,835	Section VI and IV
Access	Medicare and Medicaid over 50 percent of payor mix	53%	23%	57%	59%	Form D
Access	Charity % of Gross Year 02	1.00%	0.70%	3.98%	0.08%	Form B
Value, Cost effective	Total expense/ case Year 2	$1,141	$1,626	$3,933	$1,392	Form B
Value, Cost effective	Capital cost per Year 2 case	$ 980	$3,388	n/a	n/a	Section VIII.1 and IV
Value, Cost effective	Offers freestanding pricing	yes	yes	no	yes	
Value, Cost effective	Adds multi-specialty competitor	yes	no	no	no	Section I
Value, Cost effective	Available by SMFP Need Date 2019	yes	yes	yes	no	Section XII
Quality	Year 2 RN + LPN FTEs / Surgical Room	4.38	1.67	3.37	2.95	Section VII.2
Quality	Year 2 Total FTE/ Surgical Room	9.28	4.00	8.73	7.14	Section VII.2
Quality	Pre / Post recovery per OR + Proc Rm	6.2	2	0.9	2.9	Floor Plan
Quality	Letters of support	131	15	4	41	Exhibits, Section VI

Weighted Scores (4 = Maximum)

Competitive Enhancement	Metric	Applicants			
		WASC	New Hanover Surgery Center, LLC	New Hanover Regional Medical Center, LLC	Wilmington Surgery Center, LP
Access	Year 3 OR Cases	3	4	2	1
Access	Medicare + Medicaid Patients Year 2	4	2	0	3
Access	Medicare / Medicaid over 50% payor mix	4	1	4	4
Access	Charity % of Gross Year 02	3	2	4	1
Value, Cost effective	Total expense / case Year 02	4	2	1	3
Value, Cost effective	Capital cost per Year 2 case	4	3	0	0
Value, Cost effective	Offers freestanding pricing	4	4	1	4
Value, Cost effective	Adds multi-specialty competitor	4	1	1	1
Value, Cost effective	Available by SMFP Need Date 2019	4	4	4	1
Quality	Year 2 RN + LPN FTEs / Surgical Room	4	1	3	2
Quality	Year 2 Total FTE/ Surgical Room	4	1	3	2
Quality	Pre / Post recovery per OR + Proc Rm	4	2	1	3
Quality	Letters of support	4	2	1	3
	Total	**50**	**29**	**25**	**28**
	Maximum Possible (w/o n/a)	*52*	*52*	*44*	*48*
	Percent of Maximum	**96.2%**	**55.8%**	**56.8%**	**58.3%**

Scores from prior table are rank ordered with 4=best. Items not applicable are adjusted out by using the percent of maximum score.

Although percentage is a consideration in payor mix, the impact on the community is better measured in number of patients who benefit from the program. WASC clearly stands out in this regard. North Carolina requires that a facility have an operating room to obtain an ambulatory surgery license, with exceptions for GI and demonstration dental-only facilities. Yet the statute and rules permit use of appropriately designed procedure rooms for surgical procedures. Hence, the number of patients served should be a consideration in this review.

Adequate pre-and post-procedure support are essential to efficiency and to good patient care. When the facility has sufficient space and staffing to support patient instruction and pre-screening, opportunities for error both in the facility and later at home decrease. NHRMC did not provide enough information to evaluate the number of new Medicare and Medicaid patients associated with the new room.

Medicare and Medicaid are among the underserved groups mentioned in the statute. Setting the benchmark at 50 percent allows for differences in case mix and for service to other underserved groups like medically indigent.

Existing facilities, NHRMC and Wilmington SurgCare, propose additions or renovations to existing space. The application does not provide enough information to assess the existing capital cost associated with the space proposed for renovation.

For reasons described in the attached documents, other applications do not meet all statutory criteria.

Thank you for your time and consideration. Please do not hesitate to call me if you have any questions.

Sincerely,

Cory Hess
Manager, Wilmington, ASC, LLC
Regional Vice President of Operations, SCA

Attachments

Attachment 1

Competitive Review of New Hanover Surgery Center, LLC
Project ID# O-1144-17

Competitive Review of –
New Hanover Surgery Center, LLC
Application for New Operating Rooms, New Hanover County
Project ID# O-11444-17

OVERVIEW

New Hanover Surgery Center, LLC's ("NHSC") application to develop a one operating room (OR), two-procedure room, single specialty orthopedic ambulatory surgery center (ASC) is non-conforming with statutory review criteria: 4, 5, 12, and 13c. It offers a limited service and the application has errors in critical calculations.

CON REVIEW 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.

Most Effective Alternative

Page 62 of NHSC's application contains a discussion of four alternatives: 1) maintain the status quo and do nothing; 2) develop the proposed ASC in another location; 3) develop an ASC without procedure rooms; and, 4) develop a multi-specialty ASC with procedure rooms. The application indicates that alternative 3 is less effective by arguing that a multi-specialty ASC with procedure rooms would unduly increase project capital cost and decrease the facility's efficiency. However, the application provides no documentation to support either statement.

Table 3 below summarizes the number of historical ambulatory cases by specialty in New Hanover County. Although, the sum of all ambulatory orthopedic cases is increasing in New Hanover County, so are other types of surgery. The patterns by surgical specialty show the impact of a population that is aging.

Table 3: Historical Ambulatory Cases by Specialty in New Hanover County, 2012-2016

	2012	2013	2014	2015	2016	CAGR	Case increase 2015-2016
Cardiothoracic	666	641	526	535	622	-1.7%	87
Open Heart	-	-	-	-	-	-	0
General Surgery	2,396	3,172	2,855	2,946	1,977	-4.7%	-969
Neurosurgery	727	929	951	1,103	1,090	10.7%	-13
OBGYN	1,193	1,330	1,208	1,089	1,368	3.5%	279
Ophthalmology	5,779	6,991	7,777	8,873	9,727	13.9%	854
Oral Surgery	822	844	891	871	931	3.2%	60
Orthopedics	6,077	6,892	7,427	6,997	7,374	5.0%	377
Otolaryngology	1,747	2,352	2,070	2,084	2,338	7.6%	254
Plastic Surgery	1,897	2,380	2,451	2,514	2,376	5.8%	-138
Urology	1,343	1,371	1,462	1,350	2,275	14.1%	925
Vascular	163	278	-	-	422	26.8%	422
Other Surgeries	1,909	1,803	1,521	1,708	2,771	9.8%	1,063
Total	***24,719***	***28,983***	***29,139***	***30,070***	***33,271***		***3,201***

Source: 2013-2017 Hospital and Ambulatory Surgery Center License Renewal Applications

For example, Ophthalmology (eye) surgery is growing almost three times faster than orthopedics, accounting for more than twice as many cases added between 2015 and 2016. The same is true for Urology. A new multi-specialty freestanding surgical center is clearly a more responsive alternative to NHSC's proposal to develop a single specialty ASC with procedure rooms. Development of a facility that caters only to orthopedic surgery limits access for patients requiring other types of surgery. Moreover, the application proposes to serve only a small portion of outpatient ambulatory surgery that has historically occurred in New Hanover County. The application proposes 1,704 cases in 2022 compared to 7,374 orthopedic cases that occurred in 2016 in Table 3 above.

Because the application did not provide supporting documentation for its chosen alternative NHSC's application is nonconforming with CON Criterion 4.

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.

In addition to mathematical errors in its pro formas, NHSC provides an unsupported payor mix projection for the entire facility. The combination creates unreasonable projections of the total revenue projections associated with providing the proposed health services.

Errors in Revenue and Income Forecast

Analysis of the applicant's pro forma reveals errors that impact the proposed facility's gross revenue and net operating income during the first three years of operation. Table 4 is a condensed version of the application's Form B that shows the missing Medicaid contractual allowance. It also shows the corrected math for the sum of revenue from each payor source in the application's Form B. Values in red are from the application, and values just above them in black are re-calculated based on the actual information in the pro forma.

Table 4: Re-calculated NHSC Pro Forma Income Statement

	CY 2020	CY 2021	CY 2022
REVENUES			
Gross Patient Revenue			
Self-Pay/ Indigent/ Charity	$226,153	$260,415	$297,260
Medicare	$887,889	$1,017,242	$1,156,282
Medicaid	$823,013	$931,693	$1,048,381
BCBS	$2,619,860	$3,014,706	$3,439,280
Commercial/Managed Care	$1,614,894	$1,852,839	$2,108,637
Other	$668,737	$766,437	$871,457
Gross Revenue	**$6,840,546**	**$7,843,332**	**$8,921,297**
Deductions from Gross Patient Revenue			
Charity Care	$47,884	$54,903	$62,449
Write down for Self-Pay	$164,420	$189,330	$216,116
Contractual Allowances Medicare	$634,007	$726,373	$825,656
Contractual Allowances Medicaid	**No data**	**No data**	**No data**
Contractual Allowances BCBS	$1,119,853	$1,288,630	$1,470,113
Contractual Allowances Comm/Mgd Care	$829,669	$951,916	$1,083,335
Contractual Allowances Other	$321,748	$368,754	$419,282
Total Deductions from Patient Revenue	**$3,117,581**	**$3,579,906**	**$4,076,951**
Net Patient Revenue	**$3,722,965**	**$4,263,426**	**$4,844,346**
Other Revenue			
Total Revenue After Re-calculation	**$3,722,965**	**$4,263,426**	**$4,844,346**
Total Revenue Form B Before Re-calculation	**$3,153,158**	**$3,618,377**	**$4,118,507**
EXPENSES			
Direct Expenses	$1,729,883	$1,889,335	$2,067,380
Total Indirect Expenses	$1,063,971	$1,079,232	$1,003,887
Total Expenses	**$2,793,854**	**$2,968,567**	**$3,071,267**
Net Income After Re-Calculation	**$929,111**	**$1,294,859**	**$1,773,079**
Net Income Form B Before Re-Calculation	**$359,304**	**$649,811**	**$955,322**
Difference Before and After Re-Calculation	**$569,807**	**$645,048**	**$817,757**

Source: NHSC Application Form B

With the arithmetic corrected, net income is much higher than shown in the application's Form C pro forma, by approximately $600,000 to $800,000. However, the assumptions do not provide enough information to evaluate the net revenue. These differences raise questions about the validity of the projections. The missing Medicaid contractuals add more questions about the assumptions, including charges used in the pro forma income statement. A review of other orthopedic-only surgery centers reinforces the questions.

Unsupported Payor Mix

Justification for the proposed project year 02 payor mix for the entire facility begins on page 85. Table 5 below compares NHSC's project year 02 Medicaid projection to actual 2016 information from License Renewal Application forms for four other orthopedic-only ASC's in North Carolina. It shows that NHSC's Medicaid projection is much higher than similar facilities currently in operation.

Table 5: Comparison of NHSC Project Year 02 Payor Mix Projection to Similar Facilities in North Carolina

Payor	Proposed New Hanover Surgery Center	Triangle Orthopedics Surgery Center	Mallard Creek Surgery Center	Raleigh Orthopedic Surgery Center	Orthopedic Surgery Center of Asheville
Self-Pay/Indigent/Charity	3.4%	2.4%	7.5%	0.5%	0.2%
Medicare / Medicare Mgd. Care	12.9%	12.5%	11.9%	19.0%	36.2%
Medicaid	**10.5%**	4.2%	7.7%	0.0%	5.1%
Commercial Insurance	23.8%	65.5%	8.5%	69.2%	1.9%
Managed Care (BCBS*)	39.7%	0.7%	53.5%	0.0%	12.3%
Other	9.7%	14.6%	10.8%	11.2%	44.3%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
Total Cases	**1,515**	**2,261**	**2,313**	**4,181**	**3,092**

**Labeled as BCBS in NHSC Application*

Source: Page 85 of application and 2017 License Renewal Applications

Table 5 shows NHSC's projected Medicaid percent is at least twice as high as Triangle Orthopedics Surgery Center and the Orthopedic Surgery Center of Asheville. It is also higher than Mallard Creek Surgery Center in Charlotte.

The application provides no description of any planned initiatives that would cause it to reach 10.5 percent Medicaid. Moreover, information provided in the application shows evidence that the applicant overstated its Medicaid percentage. Table 6 presents data from application page 87; and shows that 76 percent of outpatient surgical services provided to Medicaid beneficiaries by applicant members, EmergeOrtho surgeons, took place in a hospital-based facility. The application includes all EmergeOrtho outpatient cases. It does not make allowance for cases that were not appropriate for a freestanding center.

Table 6: FY 2016 EmergeOrtho Hospital-based Cases as Percent of Total

Payor	NHRMC Cases (Hospital)	Wilmington SurgCare (ASC)	Combined Total	(Hospital) Cases as % of Combined Total
	A	B	C	D
Self-Pay	811	96	907	89%
Medicare	10,740	4,679	15,419	70%
Medicaid	2,443	751	3,194	76%
Commercial/Managed Care	7,659	68	7,727	99%
BCBS	1,449	2,825	4,274	34%
Other	1,585	622	2,207	72%
Total	**24,687**	**9,041**	**33,728**	**73%**

Source: Data from NHSC application page 87

Notes: A. Hospital-based orthopedic cases

B. Freestanding ASC-based orthopedic cases

C. A + B

D. A / C

All cases in Table 6 are ambulatory cases, with 76 percent of the Medicaid cases performed in a hospital-based environment. The applicant provides no evidence that all hospital-based cases would have been appropriate for a freestanding ASC. NHSC's payor mix would change if the table adjusted to include only cases appropriate for a freestanding ASC. The Medicaid cases completed in the ASC represented a much smaller proportion of the total (8.3 percent). All of the payor mix is affected by the approach used in the application.

Considering the information above, the application provides unreasonable assumptions which would affect both the cost and the quantity of service proposed and the resulting income statement and is therefore non-conforming to Criterion 5.

12. Applications involving construction shall demonstrate that the cost, design, and means of construction proposed represent the most reasonable alternative, and that the construction project will not unduly increase the costs of providing health services by the person proposing the construction project or the costs and charges to the public of providing health services by other persons, and that applicable energy saving features have been incorporated into the construction plans.

The NHSC application proposes the highest cost per case among the four applications in this competitive review. Table 7 below shows NHSC making a significant capital expenditure in relation to the number of cases it proposes to serve by project year 02. A high capital cost to case ratio will unduly increase the cost of services for patients.

Comparisons of cost per case with the two facilities proposing renovations or additions would be inappropriate, because the application does not provide sufficient information to consider the fully allocated cost of existing space.

Table 7: Cost per Case among Applications for New Facilities in Competitive Review

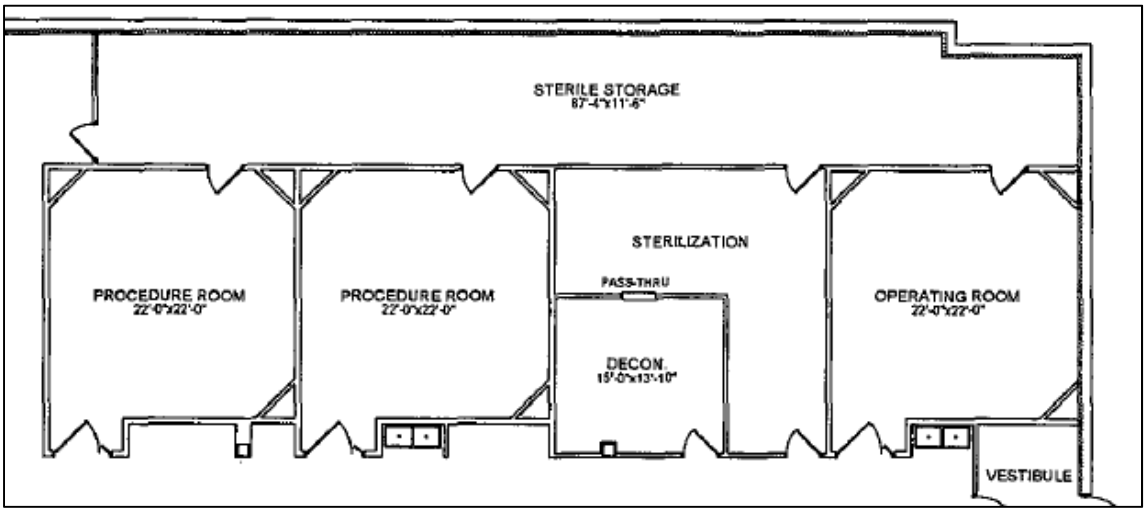
Facility	Total Capital Cost	Number of PY 02 Cases	Cost per Case
	A	B	C
Wilmington ASC	$13,387,950	13,668	$980
New Hanover Surgery Center	$6,187,265	1,515	$4,084

Table 8: Incremental Cost per case Among Facilities Proposing Additions or Renovations

NHRMC	$1,300,000	11,267	$115
Wilmington SurgCare	$1,097,511	13,270	$83

Figure 1 below is a screenshot of the proposed floor plan provided in Exhibit 12 of the NHSC application. It shows that both proposed procedure rooms are the exact same size as the operating room. Yet the application indicated that NHSC will perform only pain cases in those two rooms.

Figure 1: Screenshot of NHSC Proposed Floor Plan



The application provides no justification for the capital expenditure required to build such large procedure rooms to accommodate only a relatively small number of pain cases.

Considering the information above, the applicant does not demonstrate that the cost, design, and means of construction proposed represent the most reasonable alternative and will not unduly increase the cost of providing health services; therefore, the application does not conform to Criterion 12.

13. The applicant shall demonstrate the contribution of the proposed service in meeting the health-related needs of the elderly and of members of medically underserved groups, such as medically indigent or low income persons, Medicaid and Medicare recipients, racial and ethnic minorities, women, and handicapped persons, which have traditionally experienced difficulties in obtaining equal access to the proposed services, particularly those needs identified in the State Health Plan as deserving of priority. For the purpose of determining the extent to which the proposed service will be accessible, the applicant shall show:

(c.) That the elderly and the medically underserved groups identified in this subdivision will be served by the applicant's proposed services and the extent to which each of these groups is expected to utilize the proposed services; and

Page 76 of the application provides an explanation of the availability of proposed services to the elderly and medically underserved individuals in the proposed service area, in terms of orthopedic surgery. But, the application provides no demonstration of need in these groups for surgical services other than orthopedics and pain. Restricting to a single surgical specialty, orthopedics, the only new operating room that will likely be added to New Hanover County for several years, will severely limit access to elderly individuals and those in medically underserved groups.

Given the information above, the applicant is non-conforming to Criterion 13c.

Attachment 2

Competitive Review of New Hanover Regional Medical Center, LLC
Project ID# O-11434-17

Competitive Review of –
New Hanover Regional Medical Center, LLC
Application for One Additional Operating Room, New Hanover County
Project ID# O-11434-17

OVERVIEW

The applicant, New Hanover Regional Medical Center ("NHRMC") fails to conform to statutory review criteria 3, 4, and 18a. NHRMC's proposal will provide no added competition to New Hanover County and will only increase the number of operating rooms ("OR") that charge patients at hospital rates. Approval of this application will deny New Hanover County residents a new surgery provider that can positively impact competition and cost-effectiveness of the services proposed. In addition, the applicant provides no documentation to show why it needs a shared OR over a dedicated ambulatory surgery OR.

CON REVIEW CRITERIA

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.

The applicant does not demonstrate the need for a shared OR verses a dedicated ambulatory surgery OR. Starting on page 27 the application describes need for the additional shared OR due to an increase in population, physician group growth, new NHRMC services – which do not necessarily concern surgery – and surgery utilization [at NHRMC]. However, there is no mention of why the hospital needs an additional shared OR. Because shared rooms are subject to inpatient scheduling unpredictability, they are less efficient for outpatients and surgeons. Data in Table 9 are from page 33 of the application and show outpatient cases are increasing as a percent of total hospital surgery cases. With outpatient almost three-quarters of NHRMC surgery, a dedicated ambulatory surgery OR would appear more responsive to community need. According to the NHRMC license renewal application ("LRA") for 2017, the hospital dedicates only four of its total 38 operating rooms to ambulatory surgery (page 11).

Table 9: NHRMC Outpatient Cases as Percent of Total

Fiscal Year	IP Cases	OP Cases	Total	OP as % of Total
2012	8,341	15,928	24,269	65.6%
2013	8,688	19,526	28,214	69.2%
2014	9,717	21,666	31,383	69.0%
2015	9,299	21,944	31,243	70.2%
2016	9,936	23,421	33,357	70.2%
2017	9,273	25,574	34,847	73.4%

Source: Page 33 of NHRMC application.

Moreover, the application does not discuss the need for a hospital-based rather than a freestanding OR. Finally, the hospital appears to have excess surgery capacity; for, neither the application, nor the 2017 LRA form discusses how NHRMC accounts for the surgical procedures performed in the three procedure rooms, referenced in item 9.b) on page 11 of the 2017 LRA. This item specifically asks to identify procedure rooms that are not ORs or GI rooms, but can be used for surgical procedures. See Attachment 4 for a copy of NHRMC's 2017 LRA.

Therefore, the application does not demonstrate the need for the proposed shared OR and is non-conforming to Criterion 3.

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.

The NHRMC Application discusses alternatives. However, it excludes an obvious and critical alternative: adding capacity for surgical procedures by developing a procedure room that meets the construction and staffing requirements essential to perform surgical procedures. North Carolina interprets its statute and regulations to permit such development. NHRMC could do it without the cost and time delay associated with a Certificate of Need (CON) application.

In fact, failure to consider this alternative suggests that the focus of the application may be on maintaining market position as one of only two competitors, rather than on increasing its surgical capacity.

Because the application fails to address this, its consideration of least costly or most effective alternative is incomplete and does not conform to Criterion 4.

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 the service for which competition will not have a favorable impact.

No Enhanced Competition

The applicant's proposal will provide no favorable competition enhancement among surgery providers in New Hanover County. NC Office of State Budget and Management population forecast for New Hanover County in 2022 is close 245,000. The five-county health care service area is more than twice that. Yet, New Hanover County has only two options when it comes to surgical facility owners, NHRMC and Wilmington SurgCare. The county has not added a new surgery provider since the establishment of Wilmington SurgCare in 1992 – over 25 years.[2]

On page 27 the application states NHRMC has "*never been awarded an OR in a competitive revie*w." However, NHRMC owns 84 percent (38 / 45 = 0.84) of all operating rooms in the county, all of which charge patients at hospital rates. Over the years, NHRMC has been able to increase OR capacity through other means like the acquisition of Atlantic Surgicenter, which took a freestanding, four-OR ASC and made it part of the hospital. NHRMC was also able to acquire two ORs included in the 2006 SMFP. The State initially awarded the ORs in the 2006 SMFP to Same Day Surgery Center to become a freestanding ASC, but the ORs instead divested to NHRMC. The hospital finally developed the ORs in the hospital in 2014, thus eliminating competition in the county.

A third surgery provider in a health care region with almost 600,000 people would bring important competitive elements. A second freestanding ASC in New Hanover County, the center of that region, would provide the dual benefits of competition and capacity relief for NHRMC. A freestanding center could absorb lower acuity cases leaving the hospital with more capacity for the higher acuity cases.

[2] http://www.surgcare.com/about.html. Accessed December 19, 2017

Cost to Payors

Although the application presents a case for competition with other hospital facilities, it does not address the value of competition for the same surgical procedure in the service area. Adding an OR to NHRMC will not have a positive impact on the cost effectiveness of surgery in the proposed service area. One more OR at NHRMC will bring to 39 the number of ORs in New Hanover County that bill patients at hospital rates. Presently only seven operating rooms in the county bill at ASC rates, which are traditionally lower compared to hospitals. One source reports a 45-60 percent difference in payor cost between hospital and freestanding settings.[3] Reported patient satisfaction tends to be higher in the freestanding setting, as well.[4]

Efficiency

Review of the 2017 LRA for NHRMC illustrates the efficiency of a dedicated ambulatory OR even in the NHRMC system. The Atlantic Surgicenter average case time in minutes is less than half of the average ambulatory surgery case time at NHRMC-Main Campus and NHRMC Orthopedic Hospital. In the latter setting ambulatory cases share the same schedule with inpatient cases. See Table 10.

Table 10: Average Ambulatory Surgery Case Time by NHRMC Facility 2017 LRA (in minutes)

Main Campus	Ortho. Hospital	Atlantic Surgicenter
115	119	52

Source: NHRMC 2017 LRA

In 2017, the CON Section decided in favor of NHRMC's 2016 request to impact the cost effectiveness of surgery in New Hanover County with a new freestanding ambulatory surgery center. In November 2016, NHRMC applied, in a proposed joint venture with Wilmington Health, PPLC, and New Hanover Ambulatory Surgery, LLC, for a six-OR, three-multispecialty-GI/endoscopy-procedure room facility in New Hanover County (Project ID# 0-111275-16). The State approved the project for the design and capital cost proposed, but the decision restrained NHRMC from labelling three of the surgical procedure rooms as operating rooms. However, in fall 2017, NHRMC chose not to develop the project as approved. Instead, NHRMC decided to relinquish the CON, and stated on page 42 of this application, "*the CON application for the development of the joint venture project was not approved for the entire project making the joint venture unfeasible.*"

[3] Surgery Center Network 2017 https://www.surgerycenternetwork.com/hospitals-vs-ascs
[4] IBID

The current application for one shared operating room, states the joint venture was "unfeasible." However, the application provides no documentation to support this statement. By contrast, the North Carolina SMFP and license renewal application data contain evidence of at least 15 freestanding ambulatory surgery centers that have three or fewer ORs. See Attachment 6. All have been in the SMFP and reporting procedures for at least three years. The Plans show an additional 18+ facilities with three or fewer GI endoscopy rooms. These data provide clear evidence that others can feasibly operate facilities similar to what the Agency approved in 2017.

There is a significant difference in the average charge per case between the 2016 application and the 2017. The average cost per OR case in the 2016 application was less than half of the proposed outpatient charge in this application.

Access to capital cannot be the issue. Exhibit 20, NHRMC's audited financial statement, shows NHRMC has about $80 million in cash, added approximately $10 million to its cash flow from 2015 to 2016, and had a 2016 profit of $90 million. In light of this information, and without further explanation from the applicant, it is difficult to discern what NHRMC means when it says the joint venture was unfeasible. NHRMC's balance sheet suggests the not-for-profit, tax-exempt corporation, could make a contribution to New Hanover's healthcare costs by offering a freestanding surgery alternative.

Because competition has a documented a favorable effect on cost-effectiveness among providers of surgical services and because the application does not demonstrate the effects of the proposed project on cost-effectiveness, it is non-conforming to Criterion 18a.

Attachment 3

Competitive Review of Wilmington Surgery Center, LP
Project ID# O-11437-17

Competitive Review of –
Wilmington Surgery Center, LP
Application for New Operating Room, New Hanover County
Project ID# O-11437-17

OVERVIEW

As discussed in detail below the applicant, Wilmington Surgery Center, L.P. fails to meet CON review Criteria 3, 4, 5, and 12. Specifically, the application filed by Wilmington Surgery Center, L.P. (the "SurgCare Application") does not propose to meet the need in 2019, the threshold set in the 2017 State Medical Facilities Plan ("SMFP"), which identified a need for one additional operating room ("OR") in New Hanover County. Moreover, the SurgCare Application's surgical case volume projections are unsupported and unreasonable. In fact, the historical surgical case volume trends reported for the facility, Wilmington SurgCare, clearly show that the facility does not need an additional operating room ("OR") at present and will not need one in the future. It is consistent with other Agency Certificate of Need ("CON") Findings to deny applications that contain need and utilization projections that are not consistent with an applicant's historical volume trends, as is the case with the SurgCare Application.

The SurgCare Application refers to need for additional capacity but all of its arguments for additional capacity point back to its flawed projections. If an ambulatory surgery facility is truly at capacity, it will show demonstrable impacts such as long wait times, difficulty with both scheduling surgeons requesting block time and bringing on new surgeons to perform surgery in the facility. SurgCare's Application does not describe any of these impacts, and it is clear that SurgCare does not suffer from limited capacity, contrary to indications otherwise. In fact, the SurgCare Application makes repeated reference to having on-boarded additional physicians in recent years, suggesting that there is, indeed, available capacity to support these new surgeons. Additionally, Wilmington SurgCare has not extended the hours it performs surgeries. On a typical day Wilmington SurgCare stops providing services at 3:30. If capacity were an issue it would only be reasonable for it to have extended its surgery times to alleviate this issue.

In addition, the entire SurgCare Application assumes that Wilmington SurgCare has been awarded a CON for all three operating rooms from the need determination in the 2016 SMFP for three additional ORs in New Hanover County. However, no CON for those three ORs has been awarded, as the Agency' decision regarding those three ORs is under appeal. The current SurgCare Application provides no explanation of how the proposal would change if Wilmington Surgery Center, LP is not ultimately awarded the three ORs for Wilmington SurgCare, pursuant to the 2016 SMFP. The application should have explored the possibility of SurgCare not being awarded the three ORs and then explained how its assumptions, plans, and proposal would change. It did not.

The flaws in the SurgCare Application suggest that its true intent is to protect its position as the only ASC in New Hanover County by preventing new market entry and to preserve appeal rights, rather than to obtain a CON for one additional OR.

The following discussion and calculations demonstrate why the Agency should not approve the SurgCare Application per NC G.S. 131E-183 and 10A NCAC 14C .2103.

CON REVIEW CRITERIA

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.

Growth Projections for Wilmington SurgCare are Unreasonable

Beginning on page 46, the SurgCare Application shows alternative calculations with the intent of proving a need for 11 ORs by 2023, the proposed third year of operation.

The SurgCare Application does not show need for an additional OR until 2023. Its need methodology hinges on use of a 5.0 percent annual growth rate. This growth rate is unreasonable and unsupported based on SurgCare's historical growth trends. The timeline on which the 5.0 percent annual growth rate is based is too long; recent trends do not support it.

The SurgCare Application presents historical surgical case growth rates for extended time periods as justification for the 5.0 percent.

The first is a 20-year growth trend going all the way back to 1995. Figure 2, obtained from page 33 of the SurgCare Application, shows the annual case volumes in 1995 and 2016.

Figure 2: 1995 and 2016 Wilmington SurgCare Case Volumes

	1995	2016	% Change
Wilmington SurgCare OR Cases	2,175	8,584	294.67%

Sources 1998 SMFP and Wilmington SurgCare 2017 LRA

Source: SurgCare App. Pg. 33

After presenting this table, SurgCare explains that the compound annual growth rate ("CAGR") during this period was 5.92 percent. SurgCare opened in 1992. Reaching all the way back to 1995, during the startup phase of the center, is not reasonable for a facility that has been in operation this long, nor is it common or accepted practice in healthcare planning. Moreover, 20 years was long time ago. Healthcare has changed significantly in 20 years. Using that span to calculate a CAGR (which relies on the first and last points only) is particularly unreasonable because the rate has not sustained, even when Wilmington SurgCare added capacity. For example, data show that Wilmington SurgCare performed only 163 more cases in 2016 than it did in 2004 when it had only 6 ORs (compare 2005 LRA (8,421) v. 2017 LRA (8,584)). A far more reasonable approach would consider more recent trends, such as three-or five-year trends or to consider Wilmington SurgCare's case growth during a period of time when it operated 7 ORs (10-year trend). All of these timeframes show annual growth to be far less than 5 percent

Generously considering Wilmington SurgCare's multi-year growth rate in the last six years demonstrates why the SurgCare Application avoided using this information Table 11 contains annual cases reported on Wilmington SurgCare's last six License Renewal Applications ("LRAs") and page 51 of the SurgCare Application and the calculated CAGR and average annual change in cases over those years.

Table 11: Annual Surgical Case Volumes for Wilmington SurgCare, FY 2011-2017

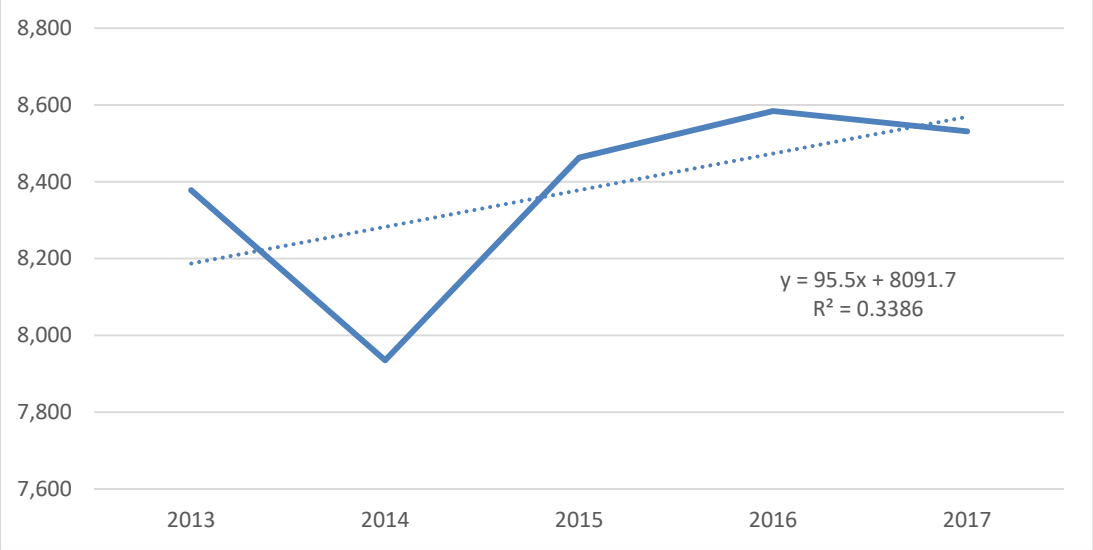
Federal Fiscal Year (Oct - Sep)	2012	2013	2014	2015	2016	2017	6-Year CAGR 2012- 2016	Average Annual Change 2021-2016
Wilmington SurgCare Cases	7,728	8,378	7,935	8,463	8,584	**8,531**	2.00%	
Change from Prior Year	-137	650	-443	528	121	**-53**		111

Source: Wilmington SurgCare 2011 – 2016 LRAs. Note that License Renewal Application data are for the prior fiscal year Oct 1 – Sept 30.

The average annual change in surgical cases in the six-years 2012–2017 was only 111, yet the SurgCare Application proposes an average annual increase of 880 surgical cases, for the period 2017-2023. See page 68 of the SurgCare Application, (13,813 minus 8,531)/6 =880. The five-year picture is better for average annual change in cases (144) but the CAGR is worse (0.45%).

As illustrated in Table 11, the 6-year CAGR for Wilmington SurgCare cases was only 2.00 percent between 2012 and 2016 (the most recently available data). Figure 3 shows a linear trend for the same data. The linear trend suggests Wilmington SurgCare case volume should increase by only 95.5 cases a year (see factor for "x" in the equation in Figure 3). As such, even a 2.0 percent annual growth rate would be generous.

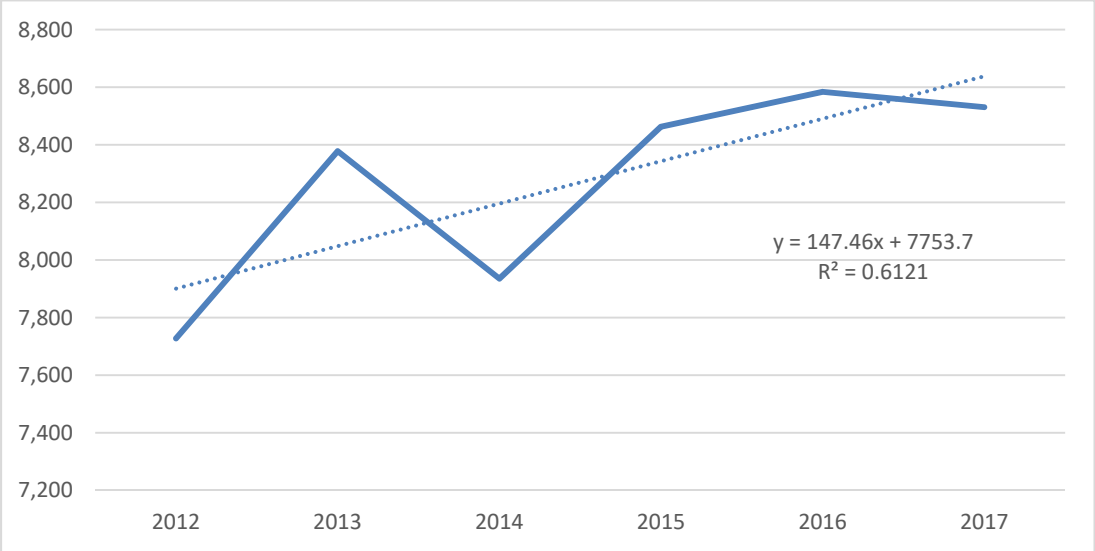
Figure 3: Five-Linear Year Case Trend for Wilmington SurgCare, 2012-2016



Source: Wilmington SurgCare LRAs: 2012 to 2017 and SurgCare Application p 51

The 6-year trend is slightly more generous and has a better R^2, but does not change the conclusion that the proposed growth rate is too high. See Figure 4 below.

Figure 4: Six-Year Linear Growth Trend Wilmington SurgCare Cases



Source: LRAs and page 51 SurgCare Application

The SurgCare Application attempted to justify a 5.0 percent growth in other ways. Exhibit 48 contains an analysis of two other NC freestanding ambulatory surgery centers ("ASCs"); Fayetteville Ambulatory Surgery Center in Cumberland County and Vidant SurgiCenter in Pitt County. Both facilities experienced one-year (2014-2015) growth rates above 6 percent and market shares like those that the SurgCare Application proposes. The SurgCare Application makes a blanket statement that, if these two ASCs can experience those growth rates and market shares, then all of the SurgCare Application's forecasting assumptions needed to justify Wilmington SurgCare's 11 ORs are reasonable. Neither of these ASCs share a management company with SurgCare, nor do they accommodate the same surgeons or specialties. The three ASCs are in completely different markets and SurgCare makes no comparison of surgical specialties offered among the three facilities. Moreover, the data are for one year only and not for the most current period. They are not sustained patterns. Overall, the comparison has no merit and should be afforded little weight.

The SurgCare Application also analyzes inpatient and outpatient surgery growth trends for all New Hanover County from 2012-2016. Using inpatient and outpatient data from SurgCare and New Hanover Regional Medical Center ("NHRMC"), the SurgCare Application shows the CAGR from 2012-2016 for the combined surgeries was above 6 percent and concludes, "*having confirmed that the CAGR exceeds 6 percent for both inpatient and ambulatory operating room utilization, the applicant projects future years' ambulatory surgery cases using a 5.5 percent annual growth assumption that is more conservative than the CAGR.*" See page 46 of the SurgCare Application. This analysis does not explain why, with better pricing and unused capacity, SurgCare's own cases did not keep pace with increase demand in the market. Most of the growth is attributable to cases at NHRMC.

Clearly SurgCare has unused capacity, otherwise it could not continue to absorb the proposed additional 2300+ cases in the interim years while the facility is under construction for both the assumed 2016 operating rooms and the proposed new 2017 OR.

Another major flaw in the OR utilization and projection methodology on pages 46-49 of the SurgCare Application, is the assumption SurgCare will receive a CON for all three ORs from the 2016 SMFP need determination. At the time of submission of these comments, the decision relative to the 2016 SMFP need determination is under appeal, with a hearing that will not begin until January 2018 and until Wilmington Surgery Center, L.P. has a CON in hand for the three ORs at Wilmington SurgCare, hence, an assumption of ownership with no discussion of alternatives is unreasonable.

With only eight, not 11, operating rooms, by its own assumptions, Wilmington SurgCare could not absorb the high number of cases forecasts in the current SurgCare Application.

SurgCare Does Not Fully Utilize its Existing Seven Operating Rooms

Based on data provided by its last six LRAs, Wilmington SurgCare does not fully utilize its existing operating rooms. According to its 2012 through 2016 LRAs, Wilmington SurgCare averaged between 47 and 51 minutes per procedure, including room turnover. Using these data, Wilmington SurgCare's annual utilization data for the same time period, and assumptions found in the SMFP, one can show that SurgCare used no more than 3.7 of its operating rooms in the last six years, assuming 1,872 available hours per OR from the 2017 SMFP. In 2017, it needed only 3.5 operating to accommodate its volumes at 100 percent efficiency.

Table 12 shows the calculations. At 85 percent efficiency it needed only 4.2 operating rooms.

SurgCare does not provide any information suggesting its case times would increase because of the proposed project. Therefore, in this instance, case times matter.

Table 12: SurgCare Operating Room Utilization and Need, 2011-2016

Notes	Federal Fiscal Year (Oct - Sep)	2012	2013	2014	2015	2016	2017
a	Wilm SurgCare Cases	7,728	8,378	7,935	8,463	8,584	8,531
b	Wilm SurgCare Case Time	50.92	49.56	49.18	47.7	46.6	46.6
c	Total Case Hours	6,558	6,920	6,504	6,728	6,667	6,626
d	Available Hours per OR	1,872	1,872	1,872	1,872	1,872	1,873
e	ORs Needed	3.5	3.7	3.5	3.6	3.6	3.5
f	ORs Available	7.0	7.0	7.0	7.0	8	8
g	Surplus	3.5	3.3	3.5	3.4	4.4	4.5

Notes: a: Wilmington SurgCare 2012 – 2017 LRAs and SurgCare Application page 51

b: Wilmington SurgCare 2012 – 2017 LRAs, includes room turnover time Assume no change in 2017

*c: a * b / 60*

d: Operating Room Methodology in 2017 SMFP (and previous SMFPs)

e: c / d

f: Wilmington SurgCare 2011 – 2016 LRAs

g: f – e

Not only does SurgCare have more licensed operating rooms than it needs, utilization of those rooms has remained very stable in the last five years, further suggesting errors in the CON application's calculation of future growth. SurgCare has excess capacity of at least three operating rooms and certainly does not need three *additional* operating rooms.

SurgCare Does Not Need Additional Operating Rooms

As discussed, SurgCare's volume projections are substantially overstated. Rather than using its incorrect assumptions of 5.0 percent growth, for comparison, we used a much more reasonable 2.0 percent growth rate. Table 13 shows the re-calculated future surgical cases using a 2.0 percent growth rate.

Table 13: Wilmington SurgCare Surgical Case Volume and OR Need at 2 Percent CAGR

Notes	Federal Fiscal Year (Oct - Sep)	2016	2017	2018	2019	2020	2021	2022	2023
a	Wilm SurgCare Cases	8,584	8,755	8,930	9,109	9,290	9,476	9,665	9,858
b	Wilm SurgCare Case Time (minutes)	50.92	50.92	50.92	50.92	50.92	50.92	50.92	50.92
c	Total Case Hours	7,285	7,430	7,579	7,730	7,884	8,042	8,203	8,333
d	Available Hours per OR	1,872	1,872	1,872	1,872	1,872	1,872	1,872	1,872
e	Total ORs Needed at 100 % efficiency	3.9	4.0	4.0	4.1	4.2	4.3	4.4	4.5
f	OR's Needed at 85%	4.6	4.7	4.8	4.9	5.0	5.1	5.2	5.2

Notes: a: Wilmington SurgCare's FFY 2015 surgical case volume (8,463) increased at 2% annually

b: 50.92 is the highest, and therefore most conservative, case time reported on Wilmington SurgCare 2012 – 2017 LRAs; includes turnover time

*c: a * b / 60*

d: Operating Room Methodology in 2017 SMFP (and previous SMFPs)

e: c / d

f. e / 0.85

As Table 13 shows, with a CAGR of 2.0 percent, SurgCare will need 5.1 operating rooms by 2021. This 2017 CON proposal would bring its proposed inventory to 11 ORs (assuming SurgCare obtains the CON for three ORs from 2016 SMFP need determination). The table shows that Wilmington SurgCare does not need even half of its proposed operating inventory. Note that Table 13 projections are by Federal Fiscal Year (Oct. to Sep) and require conversion to Calendar Year to match Wilmington SurgCare's operating years, but the difference is insignificant to this point.

In summary, Wilmington SurgCare's need and utilization projections are unreasonable and unsupported. It does not fully utilize its existing ORs and a reasonable forecast suggests it will not need additional ORs in the coming years.

Consequently, the SurgCare Application is nonconforming to Criterion 3

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.

The SurgCare Application discusses alternatives. However, it the option of adding capacity for surgical procedures by developing a procedure room that meets the construction and staffing requirements essential to perform surgical procedures. North Carolina interprets its statute and regulations to permit such development. ASC's around the state are examining whether the addition of procedures rooms can help to meet their needs. SurgCare should have at least considered the addition of procedure rooms in its application and explained why it believes the addition of a procedure rooms could not meet its needs. It failed to do so.

Because this present SurgCare Application fails to address either, its consideration of least costly or most effective alternative is incomplete and the SurgCare Application does not conform to Criterion 4.

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.

Availability of Funds

The SurgCare Application fails to demonstrate how funds from the parent company will transfer to the applicant for development of the proposed project. The SurgCare Application indicates that Wilmington Surgery Center, L.P.'s is a partnership between Surgery Partners LLC and more than twenty physician owners. Surgery Partners, LLC's "parent company" is Surgery Partners, Inc. ("Surgery Partners, Inc."). See Section I of the SurgCare Application. While Surgery Partners is the parent company of Wilmington Surgery Center, L.P., the SurgCare Application fails to provide sufficient information regarding the applicant, Wilmington Surgery Center, L.P. Of note, the applicant is a partnership with many partners, not just one.

As indicated in Exhibit 1 of the SurgCare Application, individual physician investors own approximately 28.5 percent of the ownership interests in Wilmington SurgCare, L.P. Exhibit 38 contains a funding letter from Teresa Sparks, CFO, Surgery Partners, Inc. The letter states that Surgery Partners, Inc. "has cash and cash equivalents." The letter says that Surgery Partners, Inc. is committed to fund the project capital cost. However, the letter does not identify Surgery Partner's source of funds for the project. This may be an issue, given recent investor notes about Surgery Partners, Inc. cash. See Attachment 8 of these comments.

Moreover, there is no letter stating or other information indicating that the applicant, Wilmington Surgery Center, L.P., discussed the capital required to fund the project with its partners. The SurgCare Application does not even contemplate that Wilmington Surgery Center, L.P. (which is a partnership of Surgery Partners, LLC) and over twenty physician owners will have to repay the funds provided by the parent company Surgery Partners, Inc. It is unreasonable to assume that the parent company will provide funding for this project without expecting Wilmington Surgery Center, L.P. and its partners to repay these funds either through a capital call or through a reduction in draw by the partners. The SurgCare Application provides no information about the impact of a capital call or reduced draw on ownership that funding this project by Surgical Partners, Inc. would have on ownership of the applicant entity. A disproportionate investment by Surgical Partners Inc. without any investment by physician owners would raise Anti-kickback concerns.

Further, as stated above, it is reasonable to believe that the physician owners of Wilmington Surgery Center, L.P. will ultimately be required to either repay the funds provided by Surgery Partners, Inc., or dilute their ownership interest in proportion to the proposed Surgery Partners, Inc. investment in this project. This was not discussed in the SurgCare Application.

The absence of this information makes it difficult to understand what the source of funds is for the project proposed in the SurgCare Application.

If Surgery Partners, Inc. is planning to loan the money to the Wilmington Surgery Center, L.P., the applicant, there is no evidence of such a loan and the pro forma does not contain any line item that would represent a loan payment to Surgery Partners, Inc.

The Project is Not Financially Feasible

As noted above in the discussion under Criterion 3, SurgCare's growth projections are overstated. A much more reasonable annual growth rate of 2.0 percent should be applied to calendar year ("CY") projections.

Table 14 converts those projections, based on LRA data reported by FFY, to calendar year projections.

Table 14: Converting Updated FFY Wilmington SurgCare Projections to CY

Notes		FFY 2021	CY 2021	FFY 2022	CY 2022	FFY 2023	CY 2024	FFY 2024
a	Wilmington SurgCare OR Cases (Updated FFY Projections)	9,476		9,665		9,858		10,055
b	Wilmington SurgCare OR Cases (Converted to CY Projections)		9,523		9,713		9,907	

Notes: a. Wilmington SurgCare's FFY 2016 surgical case volume (8,548) grown at 2% annually

*b. Calendar year values equal (3/4 * preceding FFY) + (1/4 * following FFY)*

These more realistic forecasts mean that the SurgCare Application overstates project revenue; hence, the income statement earnings projections are not reasonable. With more reasonable utilization, applied to revenue the proposal is not financially viable.

Table 15 is a condensed income statement which borrows data from SurgCare FORM B, but updates it using the new case projections.

Table 15: Updated SurgCare Pro Forma Income Statement

Notes	Metric	2021	2022	2023
a	Projected OR Cases	9,523	9,713	9,907
b	Projected GI Cases	198	190	182
c	Total OR Cases	9,721	9,903	10,089
d	Net Revenue per Total Case	$1,529	$1,541	$1,549
e	Net Revenue After Adjustment	$14,863,790	$15,261,155	$15,628,430
f	Variable Expenses per Case	$676	$696	$731
g	Variable Expenses	$6,572,909	$6,891,929	$7,378,062
h	Non-Variable Expenses	$8,849,349.00	$9,208,043.00	$9,486,271.00
i	Total Expenses	$15,422,258	$16,099,972	$16,864,333
j	**Net Income After Adjustment**	**($558,468.29)**	**($838,817.63)**	**($1,235,902.99)**
k	Net Income Before Adjustment	$1,560,062	$2,000,861	$2,372,095

Notes: *a: Table 14*

b: SurgCare Application FORM B

c: a + b

d: SurgCare Application FORM B

*e: d * c*

f: Calculated from SurgCare Application FORM B; identified variable expense categories[5] from SurgCare pro forma assumptions, then divided by original SurgCare case projections to calculate variable expenses per case.

*g: f * c*

h: Calculated from SurgCare Application FORM B; identified non-variable expense categories from SurgCare pro forma assumptions

i: g + h

j: e – i

k: SurgCare Application FORM B

[5] Variable expense categories include Medical Supplies, Pro Fees, Medical Related Fees, and Management Fee. Non-variable expenses included all other expense categories.

Clearly, the proposed Wilmington SurgCare project is not viable. In all years of operation, it will have negative net incomes and require working capital that is not committed. Without the unrealistic case volumes proposed in the SurgCare Application, the facility will generate insufficient income. Essentially, the marginal increase in operating room cases SurgCare can realistically expect is not enough to offset the substantial increase in rent and depreciation from project-related expenditures (combined into non-Variable expenses in Table 15). SurgCare's application does not adequately demonstrate financial feasibility and does not make reasonable projections. Consequently, SurgCare's application fails to conform to statutory Criterion 5.

12. Applications involving construction shall demonstrate that the cost, design, and means of construction proposed represent the most reasonable alternative, and that the construction project will not unduly increase the costs of providing health services by the person proposing the construction project or the costs and charges to the public of providing health services by other persons, and that applicable energy saving features have been incorporated into the construction plans.

The SurgCare Application fails to demonstrate that the cost and design of the proposed project represents the most reasonable alternative. The renovation plan proposed by this application is based on the unsupported assumption that Wilmington Surgery Center, L.P. will ultimately be awarded the three operating rooms from the 2016 SMFP need determination for New Hanover County. The Agency's decision approved the 2016 application for Wilmington SurgCare, however, Wilmington Surgery Center, L.P. has yet be awarded the CON, as the Agency decision regarding the three additional ORs identified in the 2016 SMFP is currently under appeal.

According to the floor plan provided in Exhibit 44 of the SurgCare's application, the eleventh OR will be an extension to a wing of the existing facility that does not yet exist. If Wilmington Surgery Center, L.P. does not ultimately obtain the CON for the three additional ORs identified in the 2016 SMFP, the construction plans for the proposed project will have to change. This in turn will lead to a certain change in capital expenditure. SurgCare provides no alternative solution or even discusses what would need to take place if it does not obtain the CON for the three ORs identified in the 2016 SMFP.

Further, with the case forecast adjusted to reflect recent history, the proposed capital cost cannot be supported. See discussion in Criterion 5 above.

Therefore, the SurgCare Application does not demonstrate that the cost, design, and means of construction represent the most reasonable alternative and the application does not conform to Criterion 12.

Attachment 4

New Hanover Regional Medical Center 2017
Hospital License Renewal Application

Attachment 4

New Hanover Regional Medical Center 2017
Hospital License Renewal Application

RECD DEC 30 2016

North Carolina Department of Health and Human Services
Division of Health Service Regulation
Acute and Home Care Licensure and Certification Section
Regular Mail: 2712 Mail Service Center
Raleigh, North Carolina 27699-2712
Overnight UPS and FedEx only: 1205 Umstead Drive
Raleigh, North Carolina 27603
Telephone: (919) 855-4620 Fax: (919) 715-3073

For Official Use Only
License # H0221 Medicare # **340141**
FID #: 943372
PC 25 Date 1/13/17

License Fee: **$14,407.50**

2017
HOSPITAL LICENSE
RENEWAL APPLICATION

Legal Identity of Applicant: **New Hanover Regional Medical Center**
(Full legal name of corporation, partnership, individual, or other legal entity owning the enterprise or service.)

Doing Business As
(d/b/a) name(s) under which the facility or services are advertised or presented to the public:

PRIMARY: **New Hanover Regional Medical Center**
Other: NHRMC Orthopedic Hospital
Other: NHRMC Behavioral Health Hospital
NHRMC Rehabilitation Hospital

Facility Mailing Address: 2131 S. 17th Street
NHRMC-Business Analysis & Planning
Wilmington, NC 28401

Facility Site Address: 2131 S. 17th St
Wilmington, NC 28401
County: New Hanover
Telephone: (910)667-7040
Fax: (910)667-5819

51805
1-6-17
$14,407.50

Administrator/Director: ~~Jack Barto~~ John Gizdic
Title: President & CEO
(Designated agent (individual) responsible to the governing body (owner) for the management of the licensed facility)

* **Chief Executive Officer:** John Gizdic **Title:** Chief Executive Officer
(Designated agent (individual) responsible to the governing body (owner) for the management of the licensed facility)

Name of the person to contact for any questions regarding this form:

Name: Laura Rackley, Manager of Business and Strategic Plng **Telephone:** (910)667-5277

E-Mail: Laura.Rackley@nhrmc.org

* Mr. Gizdic's tenure as CEO officially begins 1/1/2017

For questions regarding this page, please contact Azzie Conley at (919) 855-4646.

In accordance with Session Law 2013-382 and 10NCAC 13B .3502(e) on an annual basis, on the license renewal application provided by the Division, the facility shall provide to the Division the direct website address to the facility's financial assistance policy. This Rule applies only to facilities required to file a Schedule H, federal form 990. Please use Form 990 Schedule B and / or Schedule H as a reference.

1) Please provide the main website address for the facility:

www.nhrmc.org

2) In accordance with 131E-214.4(a) DHSR can no longer post a link to internet Websites to demonstrate compliance with this statute.

   A) Please provide the website address and / or link to access the facility's charity care policy and financial assistance policy:

https://www.nhrmc.org/patients/admissions/insurance-billing/assistance

   B) **Also, please attach a copy of the facility's charity care policy and financial assistance policy:** Feel free to email the copy of the facility's charity care policy to: DHHS.DHSR.Hospital.CharityCare.Policy@dhhs.nc.gov.

3) Please provide the following financial assistance data. All responses can be located on Form 990 and / or Form 990 Schedule H.

Contribution, Gifts, Grants and other similar Amounts *(Form 990; Part VIII 1(h)*	**Annual Financial Assistance at Cost** *(Form 990; Schedule H Part I, 7(a)(c)*	**Bad Debt Expense** *(Form 990; Schedule H Part III, Section A(2)*	**Bad Debt Expense Attributable to Patients eligible under the organization's financial assistance policy** *(Form 990; Schedule H Part III, Section A(3)*
*	*	*	*

* As a government non-profit, NHRMC is not required to file Form 990

AUTHENTICATING SIGNATURE: this attestation statement is to validate compliance with GS 131E-91 as evidenced through 10A NCAC 13B .3502 and all requirements set forth to assure compliance with fair billing and collection practices.

Signature: _____ **Date**: _____

PRINT NAME OF APPROVING OFFICIAL _____

For questions regarding NPI contact Azzie Conley at (919) 855-4646.

Primary National Provider Identifier (NPI) registered at NPPES _____

If facility has more than one "Primary" NPI, please provide _____

Acute Care (MC # 340141) NPI # 1548216880
Psychiatric (MC # 345141) NPI # 1538239397
Rehabilitation (MC# 34T141) NPI # 1003985375

List all campuses (as defined in NCGS 131E-176(2c) under the hospital license. Please include offsite emergency departments)

* See attached page

Name(s) of Campus:	Address:	Services Offered:

Please attach a separate sheet for additional listings

ITEMIZED CHARGES: Licensure Rule 10A NCAC 13B .3110 requires the Applicant to provide itemized billing. Indicate which method is used:

_____ a. The facility provides a detailed statement of charges to all patients.

__X__ b. Patients are advised that such detailed statements are available upon request.

List all campuses (as defined in NCGS 131E-176(2c) under the hospital license. Please include offsite emergency departments)

Name(s) of Campus:	Address:	Services Offered:
New Hanover Regional Medical Center	2131 S. 17th St, Wilmington, NC 28401	Acute Care Hospital
NHRMC Orthopedic Hospital	5301 Wrightsville Ave., Wilmington, NC 28403	Acute Care Hospital
NHRMC Behavioral Health Hospital	2131 S. 17th St, Wilmington, NC 28401	Inpatient Psychiatric Hospital
NHRMC Rehabilitation Hospital	2131 S. 17th St, Wilmington, NC 28401	Inpatient Rehab Hospital
Coastal Family Medicine	2523 Delaney Ave., Wilmington, NC 28403	Provider Based
Independence Rehabilitation Center	2800 Ashton Dr., Wilmington, NC 28412	Provider Based
NHRMC Medical Mall	2243 South 17th St, Wilmington, NC 28401	Provider Based
NHRMC H+D - Brunswick Forest	1333 S. Dickinson Dr., Leland, NC 28451	Provider Based
NHRMC H+D - Military Cutoff	1135 Military Cutoff Rd., Wilmington, NC 28405	Provider Based
NHRMC H+D - North	151 Scotts Hill Medical Drive Wilmington, NC 28411	Provider Based
Oleander Rehabilitation Center	5220 Oleander Drive, Wilmington, NC 28403	Provider Based
NHRMC Atlantic Surgicenter	9104 Market St, Wilmington, NC 28411	Provider Based
NHRMC Heart Center - Outpatient Services	1415 Physicians Dr, Wilmington, NC 28401	Provider Based
NHRMC Physician Specialists	1725 New Hanover Medical Park Wilmington, NC 28401	Provider Based
NHRMC Physician Specialists - OB/GYN	2150 Shipyard Blvd. Wilmington, NC 28112	Provider Based
NHRMC ED North	151 Scotts Hill Medical Drive, Wilmington, NC	Provider Based

Ownership Disclosure (Please fill in any blanks and make changes where necessary.)

1. What is the name of the legal entity with ownership responsibility and liability?

Owner:	New Hanover Regional Medical Center		
Street/Box:	2131 South Seventeenth St		
City:	Wilmington	State: NC	Zip: 28401
Telephone:	(910)343-7040	Fax: (910)343-7220	
CEO:	~~Jack Barto~~ John Gizdic (effective 1/1/2017)		

Is your facility part of a Health System? [i.e., are there other hospitals, offsite emergency departments, ambulatory surgical facilities, nursing homes, home health agencies, etc. owned by your hospital, a parent company or a related entity?] ____Yes __X__No

If 'Yes', name of Health System*: _____

* (***please attach a list of NC facilities that are part of your Health System***)

If 'Yes', name of CEO: _____

a. Legal entity is: ___ For Profit __X__ Not For Profit

b. Legal entity is: ___ Corporation ___ LLP ___ Partnership
___ Proprietorship ___ LLC __X__ Government Unit

c. Does the above entity (partnership, corporation, etc.) **LEASE** the building from which services are offered? __X__ Yes ___ No

If "**YES**", name of building owner:
New Hanover County

2. Is the business operated under a management contract? ___Yes __X__No

If 'Yes', name and address of the management company.

Name: _____
Street/Box: _____

City: _____ State: _____ Zip: _____
Telephone: (___) _____

3. Vice President of Nursing and Patient Care Services:
Mary Ellen Bonczek, Chief Nursing Executive

4. Director of Planning: Vacant as of 12/2016

Facility Data

A. Reporting Period All responses should pertain to the period **October 1, 2015 to September 30, 2016.**

B. General Information (Please fill in any blanks and make changes where necessary.)

a. Admissions to Licensed Acute Care Beds: **include responses to "a – q" on page 6; exclude responses to "2-9" on page 6; and exclude normal newborn bassinets.**	37,152	
b. Discharges from Licensed Acute Care Beds: **include responses to "a – q" on page 6; exclude responses to "2-9" on page 6; and exclude normal newborn bassinets.**	37,167	
c. Average Daily Census: **include responses to "a – q" on page 6; exclude responses to "2-9" on page 6; and exclude normal newborn bassinets.**	467	
d. Was there a permanent change in the total number of licensed beds during the reporting period?	Yes ✓	No
If 'Yes', what is the current number of licensed beds?	769 800	
If 'Yes', please state reason(s) (such as additions, alterations, or conversions) which may have affected the change in bed complement:	31 beds approved in 10/2015 (CON Proj # O-011042-15	
e. Observations: Number of patients in observation status and not admitted as inpatients, excluding Emergency Department patients.	8,745	
f. Number of unlicensed Observation Beds	0	

Not in use

C. Designation and Accreditation

1. Are you a designated trauma center? X Yes ___ No
   Designated Level # 2
2. Are you a critical access hospital (CAH)? ___ Yes X No
3. Are you a long term care hospital (LTCH)? ___ Yes X No
4. Is this facility TJC accredited? X Yes ___ No Expiration Date: 8/21/2018
5. Is this facility DNV accredited? ___ Yes X No Expiration Date: ___
6. Is this facility AOA accredited? ___ Yes X No Expiration Date: ___
7. Are you a Medicare deemed provider? X Yes ___ No

D. Beds by Service (Inpatient – Do Not Include Observation Beds or Days of Care)

[Please provide a Beds by Service (p. 6) for each hospital campus (see G.S. 131E-176(2c))]

Please indicate below the number of beds usually assigned (set up and staffed for use) to each of the following services and the number of census inpatient days of care rendered in each unit. If your facility has a Nursing Facility unit and/or Adult Care Bed unit please complete the supplemental packet for Skilled Nursing Facility beds.

Licensed Acute Care (provide details below) *Campus* All Sites Combined	**Licensed Beds as of September 30, 2016**	**Operational Beds as of September 30, 2016**	**Annual Census Inpt. Days of Care**
Intensive Care Units			
1. General Acute Care Beds/Days			
a. Burn *			*
b. Cardiac	16	16	4,434
c. Cardiovascular Surgery	14	14	2,505
d. Medical/Surgical	31	24	7,835
e. Neonatal Beds Level IV ** (Not Normal Newborn)	23	23	**5,167
f. Pediatric	6	6	1,303
g. Respiratory Pulmonary			
h. Other (List)			
Other Units			
i. Gynecology	20	20	2,936
j. Medical/Surgical ***	363	298	***87,021
k. Neonatal Level III ** (Not Normal Newborn)	22	22	** 9,487
l. Neonatal Level II ** (Not Normal Newborn)			** 139
m. Obstetric (including LDRP)	48	48	12,413
n. Oncology	43	43	13,175
o. Orthopedics	31	31	7,040
p. Pediatric	17 ~~15~~	17	3,532
q. Other (List) Progressive Care Unit	44 ~~647~~	42	13,371
Total General Acute Care Beds/Days (a through q)	678 ~~647~~	604	170,358
2. Comprehensive In-Patient Rehabilitation	60	36	12,696
3. Inpatient Hospice	0		
4. Detoxification	0		
5. Substance Abuse / Chemical Dependency Treatment	0		
6. Psychiatry	62	45	15,745
7. Nursing Facility	0		
8. Adult Care Home	0		
9. Other	0		
10. Totals (1 through 9) 2J 769	800 ~~769~~	685	198,799

* Please report only Census Days of Care of DRG's 927, 928, 929, 933, 934 and 935.
** As defined in 10A NCAC 14C .1401.
*** Exclude Skilled Nursing swing-bed days. (See swing-bed information next page)

D. Beds by Service (Inpatient – Do Not Include Observation Beds or Days of Care)
[Please provide a Beds by Service (p. 6) for each hospital campus (see G.S. 131E-176(2c))]

Please indicate below the number of beds usually assigned (set up and staffed for use) to each of the following services and the number of census inpatient days of care rendered in each unit. If your facility has a Nursing Facility unit and/or Adult Care Bed unit please complete the supplemental packet for Skilled Nursing Facility beds.

Licensed Acute Care (provide details below) *Campus* NHRMC Main Campus	**Licensed Beds as of September 30, 2016**	**Operational Beds as of September 30, 2016**	**Annual Census Inpt. Days of Care**
Intensive Care Units			
1. General Acute Care Beds/Days			
a. Burn *			*
b. Cardiac	16	16	4,434
c. Cardiovascular Surgery	14	14	2,505
d. Medical/Surgical	24	24	7,616
e. Neonatal Beds Level IV ** (Not Normal Newborn)	23	23	**5,167
f. Pediatric	6	6	1,303
g. Respiratory Pulmonary			
h. Other (List)			
Other Units			
i. Gynecology	20	20	2,936
j. Medical/Surgical ***	326	273	***87,003
k. Neonatal Level III ** (Not Normal Newborn)	22	22	** 9,487
l. Neonatal Level II ** (Not Normal Newborn)			** 139
m. Obstetric (including LDRP)	48	48	12,413
n. Oncology	43	43	13,175
o. Orthopedics			
p. Pediatric	17	17	3,532
q. Other (List) Progressive Care Unit	44	42	13,371
Total General Acute Care Beds/Days (a through q)	603	548	163,081
2. Comprehensive In-Patient Rehabilitation	60	36	12,696
3. Inpatient Hospice	0		
4. Detoxification	0		
5. Substance Abuse / Chemical Dependency Treatment	0		
6. Psychiatry	62	45	15,745
7. Nursing Facility	0		
8. Adult Care Home	0		
9. Other	0		
10. Totals (1 through 9)	725	629	191,522

* Please report only Census Days of Care of DRG's 927, 928, 929, 933, 934 and 935.
** As defined in 10A NCAC 14C .1401.
*** Exclude Skilled Nursing swing-bed days. (See swing-bed information next page)

D. Beds by Service (Inpatient – Do Not Include Observation Beds or Days of Care) [Please provide a Beds by Service (p. 6) for each hospital campus (see G.S. 131E-176(2c))]

Please indicate below the number of beds usually assigned (set up and staffed for use) to each of the following services and the number of census inpatient days of care rendered in each unit. If your facility has a Nursing Facility unit and/or Adult Care Bed unit please complete the supplemental packet for Skilled Nursing Facility beds.

Licensed Acute Care (provide details below) *Campus* NHRMC Orthopedic Hospital	**Licensed Beds as of September 30, 2016**	**Operational Beds as of September 30, 2016**	**Annual Census Inpt. Days of Care**
Intensive Care Units			
1. General Acute Care Beds/Days			
a. Burn *			*
b. Cardiac			
c. Cardiovascular Surgery			
d. Medical/Surgical	7	0	219
e. Neonatal Beds Level IV ** (Not Normal Newborn)			**
f. Pediatric			
g. Respiratory Pulmonary			
h. Other (List)			
Other Units			
i. Gynecology			
j. Medical/Surgical ***	37	25	*** 18
k. Neonatal Level III ** (Not Normal Newborn)			**
l. Neonatal Level II ** (Not Normal Newborn)			**
m. Obstetric (including LDRP)			
n. Oncology			
o. Orthopedics	31	31	7,040
p. Pediatric			
q. Other (List)			
Total General Acute Care Beds/Days (a through q)	75 ~~647~~	56	7,277
2. Comprehensive In-Patient Rehabilitation	0 ~~60~~		
3. Inpatient Hospice	0		
4. Detoxification	0		
5. Substance Abuse / Chemical Dependency Treatment	0		
6. Psychiatry	0 ~~62~~		
7. Nursing Facility	0		
8. Adult Care Home	0		
9. Other	0		
10. Totals (1 through 9)	75 ~~769~~	56	7,277

* Please report only Census Days of Care of DRG's 927, 928, 929, 933, 934 and 935.
** As defined in 10A NCAC 14C .1401.
*** Exclude Skilled Nursing swing-bed days. (See swing-bed information next page)

E. Swing Beds

Number of Swing Beds *	0
Number of Skilled Nursing days in Swing Beds	0

* in a hospital designated **as a swing-bed hospital** by CMS (Centers for Medicare & Medicaid Services)

F. Reimbursement Source (For "Inpatient Days," show Acute Inpatient Days only, excluding normal newborns.)

Campus – *If multiple sites*: NHRMC, All Sites Combined

Primary Payer Source	Inpatient Days of Care (total should be the same as D.1.a – q total on p. 6)	Emergency Visits (total should be the same as G.3.b. on p. 8)	Outpatient Visits (excluding Emergency Visits and Surgical Cases)	Inpatient Surgical Cases (total should be same as 9.d. Total Surgical Cases-Inpatient Cases on p. 12)	Ambulatory Surgical Cases (total should be same as 9.d. Total Surgical Cases-Ambulatory Cases on p. 12)
Self Pay/Indigent/Charity	8,788	27,465	116,531	542	811
Medicare & Medicare Managed Care	88,060	40,164	83,555	6,520	10,740
Medicaid	34,239	32,944	48,674	1,492	2,443
Commercial Insurance	25,987	27,797	62,418	2,949	7,659
Managed Care	4,790	5,598	11,783	505	1,449
Other (Specify)	8,494	7,999	21,074	807	1,585
TOTAL	170,358	141,967	244,035	12,815	24,687

G. Services and Facilities

1. Obstetrics	Enter Number of Infants
a. Live births (Vaginal Deliveries)	2,854
b. Live births (Cesarean Section)	1,162
c. Stillbirths	40

d. Delivery Rooms - Delivery Only (not Cesarean Section)	0
e. Delivery Rooms - Labor and Delivery, Recovery	14
f. Delivery Rooms – LDRP (include Item **"D.1.m"** on Page 6)	0
g. Normal newborn bassinets (Level I Neonatal Services) Do not include with totals under the section entitled Beds by Service (Inpatient)	43

2. Abortion Services Number of procedures per Year 0

(Feel free to footnote the type of abortion procedures reported)

3. Emergency Department Services

a. Total Number of ED Exam Rooms: 81.

Of this total, how many are:

a.1. # Trauma Rooms 2

a.2 # Fast Track Rooms 0

a.3 # Urgent Care Rooms 0

b. Total Number of ED visits for reporting period: 141,967

c. Total Number of admits from the ED for reporting period: 21,663

d. Total Number of Urgent Care visits for reporting period: 0

e. Does your ED provide services 24 hours a day 7 days per week? X Yes ___ No

If no, specify days/hours of operation:

f. Is a physician on duty in your ED 24 hours a day 7 days per week? X Yes ___ No
If no, specify days/hours physician is on duty:

4. Medical Air Transport: Owned or leased air ambulance service:

a. Does the facility operate an air ambulance service? X Yes __ No

b. If "Yes", complete the following chart.

Type of Aircraft	Number of Aircraft	Number Owned	Number Leased	Number of Transports
Rotary	2	0	0	800
Fixed Wing	0	0	0	0

5. Pathology and Medical Lab (Check whether or not service is provided)

a. Blood Bank/Transfusion Services X Yes __ No

b. Histopathology Laboratory X Yes __ No

c. HIV Laboratory Testing X Yes __ No
Number during reporting period

HIV Serology 3,832

HIV Culture 0

d. Organ Bank __ Yes X No

*e. Pap Smear Screening X Yes __ No

* Service began 12/21/15.

6. Transplantation Services - Number of transplants

Type	Number	Type	Number	Type	Number
a. Bone Marrow-Allogeneic		f. Kidney/Liver		k. Lung	
b. Bone Marrow-Autologous		g. Liver		l. Pancreas	
c. Cornea		h. Heart/Liver		m. Pancreas/Kidney	
d. Heart		i. Heart/Kidney		n. Pancreas/Liver	
e. Heart/Lung		j. Kidney		o. Other	

Do you perform living donor transplants ? ____ Yes X No.

7. Telemedicine

a. Does your facility utilize telemedicine to have images read at another facility? Yes

b. Does your facility read telemedicine images? Yes

8. Specialized Cardiac Services (for questions, call Healthcare Planning at 919-855-3865)

(a) Open Heart Surgery	Number of Machines/Procedures
1. Number of Heart-Lung Bypass Machines	3
2. Total Annual Number of Open Heart Surgery Procedures Utilizing Heart-Lung Bypass Machine	494
3. Total Annual Number of Open Heart Surgery Procedures done without utilizing a Heart-Lung Bypass Machine	185
4. Total Open Heart Surgery Procedures (2. + 3.)	679

8. **Specialized Cardiac Services** ***continued*** (for questions, call Healthcare Planning at 919-855-3865)

(b) Cardiac Catheterization and Electrophysiology

Cardiac Catheterization, as defined in NCGS 131E-176(2g)	**Diagnostic Cardiac Catheterization ICD-10 / CPT Codes [1]**	**Interventional Cardiac Catheterization ICD-10 / CPT Codes [2]**
1. Number of Units of Fixed Equipment	5	
2. Number of Procedures* Performed in Fixed Units on Patients Age 14 and younger	0	0
3. Number of Procedures* Performed in Fixed Units on Patients Age 15 and older	2,772	1,838
4. Number of Procedures* Performed in Mobile Units	0	0
Dedicated Electrophysiology (EP) Equipment		
5. Number of Units of Fixed Equipment	2	
6. Number of Procedures on Dedicated EP Equipment	1,642	

*A **procedure** is defined to be one visit or trip by a patient to a catheterization laboratory for a single or multiple catheterizations. Count each visit once, regardless of the number of diagnostic, interventional, and/or EP catheterizations performed within that visit. For example, if a patient has both a diagnostic and an interventional procedure in one visit, count only the interventional procedure.

Name of Mobile Vendor: N/A

Number of 8-hour days per week the mobile unit is onsite: _____ 8-hour days per week.
(Examples: Monday through Friday for 8 hours per day is 5 8-hour days per week. Monday, Wednesday, & Friday for 4 hours per day is 1.5 8-hour days per week)

[1] Diagnostic Cardiac Catheterizations

ICD-10 PCS: 02B_3ZX, 02B_4ZX, 4A020N6, 4A020N7, 4A020N8, 4A023N6, 4A023N7, 4A023N8, B21_ _ ZZ

CPT Codes: 93451, 93452, 93453, 93454, 93455, 93456, 93457, 93458, 93459, 93460, 93461, 93462, 93530, 93531, 93532, 93533

[2] Interventional Cardiac Catheterizations

ICD-10 PCS: 02B_3ZZ, 02B_4ZZ, 02B_3ZK, 02B_4ZK, 02L73DK, 02Q53ZZ, 02Q54ZZ, 02RF0_Z, 02RF3_Z, 02RF37Z, 02RF38Z, 02RF3JH, 02RF3JZ, 02RF3KZ, 02RH3_H, 02RH3_Z, 02U53JZ, 02U54JZ, 02UG3JZ 5A1221Z

CPT Codes: 92920, +92921, 92924, +92925, 92928, +92929, 92933, +92934, 92937, +92938, 92941, 92943, +92944, +92973, 92986, 92987, 92990, 93580, 93581, 93582, 93583, C9600, +C9601, C9602, +C9603, C9604, +C9605, C9606, C9607, +C9608

Note: Due to the large total number of potential codes in the ICD-10-PCS system, the codes noted above are not fully comprehensive. The "_" symbol, while not a character within the ICD-10-PCS system, serves as a wild card character and indicates where any other recognized character would be used. For example, in the code 027_34Z for a coronary drug-eluting stent procedure, "_" could be a 2 for three sites treated.

9. Surgical Operating Rooms, Procedure Rooms, Gastrointestinal Endoscopy Rooms, Surgical and Non-Surgical Cases and Procedures

NOTE: If this License includes more than one campus, please copy pages 11-14 (through Section 9) for each site. Submit the Cumulative Totals and submit a duplicate of pages 11-14 for each campus.

(**Campus – *If multiple sites*:** All Sites Combined)

a) Surgical Operating Rooms

Report *Surgical Operating Rooms* built to meet the specifications and standards for operating rooms required by the Construction Section of the Division of Health Services Regulation, and which are fully equipped to perform surgical procedures. These surgical operating rooms include rooms located in Obstetrics and surgical suites.

Type of Room	Number of Rooms
Dedicated Open Heart Surgery	2
Dedicated C-Section	3
Other Dedicated Inpatient Surgery ***(Do not include dedicated Open Heart or C-Section rooms)***	0
Dedicated Ambulatory Surgery	4
Shared - Inpatient / Ambulatory Surgery	29
Total of Surgical Operating Rooms	38

Of the **Total of Surgical Operating Rooms**, above, how many are equipped with advanced medical imaging devices (excluding mobile C-arms) or radiation equipment for the performance of endovascular, cardiovascular, neuro-interventional procedures, and/or intraoperative cancer treatments? Your facility may or may not refer to such rooms as "hybrid ORs."	2

b) Procedure Rooms (Excluding Operating Rooms and Gastrointestinal Endoscopy Rooms)

Report rooms, which are not equipped for or do not meet all the specifications for an operating room, that are used for performance of surgical procedures other than Gastrointestinal Endoscopy procedures.

Total Number of Procedure Rooms: 3

c) Gastrointestinal Endoscopy Rooms, Cases and Procedures:

Report the number of Gastrointestinal Endoscopy rooms and the Endoscopy cases and surgical procedures **performed only in these rooms** during the reporting period.

Total Number of existing Gastrointestinal Endoscopy Rooms: 5

	Number of Cases Performed In GI Endoscopy Rooms		Number of Procedures* Performed in GI Endoscopy Rooms	
	Inpatient	Outpatient	Inpatient	Outpatient
GI Endoscopy	3,167	4,997	4,857	6,659
Non-GI Endoscopy				

Count each patient as one case regardless of the number of procedures performed while the patient was in the GI endoscopy room.

*As defined in 10A NCAC 14C .3901 " 'Gastrointestinal (GI) endoscopy procedure' means a single procedure, identified by CPT code or ICD-9-CM [ICD-10-CM] procedure code, performed on a patient during a single visit to the facility for diagnostic or therapeutic purposes."

9. Surgical Operating Rooms, Procedure Rooms, Gastrointestinal Endoscopy Rooms, Surgical and Non-Surgical Cases and Procedures *(continued)*

(Campus – *If multiple sites*: All Sites Combined **)**

d) Surgical Cases by Specialty Area Table

Enter the number of surgical cases performed only in licensed operating rooms by surgical specialty area in the table below. Count each patient undergoing surgery as one case regardless of the number of surgical procedures performed while the patient was having surgery. Categorize each case into one specialty area – the total number of surgical cases is an unduplicated count of surgical cases. **Count all surgical cases performed only in licensed operating rooms. The total number of surgical cases should match the total number of patients listed in the Patient Origin Tables on pages 27 and 28.**

Surgical Specialty Area	Inpatient Cases	Ambulatory Cases
Cardiothoracic (excluding Open Heart Surgery)	908	622
Open Heart Surgery (from 8.(a) 4. on page 9)	679	
General Surgery	2248	1,519
Neurosurgery	300	1,000
Obstetrics and GYN (excluding C-Sections)	331	1,342
Ophthalmology	21	5,175
Oral Surgery	8	931
Orthopedics	5,442	5,597
Otolaryngology	7	1,225
Plastic Surgery	420	2,146
Urology	669	2,151
Vascular	0	422
* Other Surgeries (specify) Laparoscopy	632	2,535
* Other Surgeries (specify) Other	37	22
Number of C-Sections Performed in Dedicated C-Section ORs	1,099	
Number of C-Sections Performed in Other ORs	14	
Total Surgical Cases Performed Only in Licensed ORs	12,815	24,687

* Due to change to ICD-10, surgical categories became more precise in definition.

e) Non-Surgical Cases by Category Table

Enter the number of non-surgical cases by category in the table below. Count each patient undergoing a procedure or procedures as one case regardless of the number of non-surgical procedures performed. Categorize each case into one non-surgical category – the total number of non-surgical cases is an unduplicated count of non-surgical cases. **Count all non-surgical cases, including cases receiving services in operating rooms or in any other location, *except* do not count cases having endoscopies in GI Endoscopy rooms. Report cases having endoscopies in GI Endoscopy Rooms on page 11.**

Non-Surgical Category	Inpatient Cases	Ambulatory Cases
Pain Management	0	0
Cystoscopy	0	0
Non-GI Endoscopies *(not reported in 9. C on page 11)*	0	0
GI Endoscopies *(not reported in 9. C on page 11)*	5	466
YAG Laser	0	0
Other (specify) Non-Invasive Vascular Lab	2,526	1,071
Other (specify)	0	0
Other (specify)	0	0
Total Non-Surgical Cases	2,531	1,537

20 Most Common Outpatient Surgical Cases Table - Enter the number of surgical cases performed only in licensed operating rooms and / or licensed endoscopy room by the top 20 most common outpatient surgical cases in the table below by CPT code. Count each patient undergoing surgery as one case regardless of the number of surgical procedures performed while the patient was having surgery.

CPT Code	Description	Cases
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair	267
29880	Arthroscopy, knee, surgical; with meniscectomy (medial and lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed	208
29881	Arthroscopy, knee, surgical; with meniscectomy (medial or lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed	361
42820	Tonsillectomy and adenoidectomy; younger than age 12	192
42830	Adenoidectomy, primary; younger than age 12	111
43235	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	397
43239	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with biopsy, single or multiple	1,561
43248	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with insertion of guide wire followed by dilation of esophagus over guide wire	180
43249	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with balloon dilation of esophagus (less than 30 mm diameter)	148
45378	Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)	541
45380	Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple	707
45384	Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery	46
45385	Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	548
62311	Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; lumbar or sacral (caudal)	78
64483	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or computed tomography); lumbar or sacral, single level	85
64721	Neuroplasty and/or transposition; median nerve at carpal tunnel	501
66821	Discission of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid); laser surgery (e.g., YAG laser) (one or more stages)	0
66982	Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (e.g., iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage	240
66984	Extracapsular cataract removal with insertion of intraocular lens prosthesis (stage one procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification)	3,567
69436	Tympanostomy (requiring insertion of ventilating tube), general anesthesia	406

(Campus – *If multiple sites:* NHRMC All Sites Combined)

9f. Average Operating Room Availability and Average Case Times:
The Operating Room Methodology assumes that the average operating room is staffed 9 hours a day, for 260 days per year, and utilized at least 80% of the available time. This results in 1,872 hours per operating room per year.

The Operating Room Methodology also assumes an average of 3 hours for each Inpatient Surgery and an average of 1.5 hours for each Outpatient Surgery.

Based on your hospital's experience, please complete the table below by showing the assumptions for the average operating room in your hospital.

Average Hours per Day **Routinely** Scheduled for Use *	Average Number of Days per Year **Routinely** Scheduled for Use	Average "Case Time" ** in **Minutes** for Inpatient Cases	Average "Case Time" ** in **Minutes** for Ambulatory Cases
9.75	260	160	100

* Use only Hours per Day **routinely** scheduled when determining the answer. Example:

A facility has 3 ORs: 2 are routinely scheduled for use 8 hours per day, and 1 is routinely scheduled for use 9 hours per day.

2 rooms	x	8 hours	=	16 hours
1 room	x	9 hours	=	9 hours
		Total hours per day		25 hours

25 hours divided by 3 ORs
= **8.3 Average Hours per day Routinely Scheduled for Use**

** **"Case Time" = Time from Room Set-up Start to Room Clean-up Finish**. Definition 2.4 from the "Procedural Times Glossary" of the AACD, as approved by ASA, ACS, and AORN. *NOTE: This definition includes all of the time for which a given procedure requires an OR/PR. It allows for the different duration of Room Set-up and Room Clean-up Times that occur because of the varying supply and equipment needs for a particular procedure.*

9. Surgical Operating Rooms, Procedure Rooms, Gastrointestinal Endoscopy Rooms, Surgical and Non-Surgical Cases and Procedures

NOTE: If this License includes more than one campus, please copy pages 11-14 (through Section 9) for each site. Submit the Cumulative Totals and submit a duplicate of pages 11-14 for each campus.

(Campus – *If multiple sites*: NHRMC Main Campus)

a) Surgical Operating Rooms

Report *Surgical Operating Rooms* built to meet the specifications and standards for operating rooms required by the Construction Section of the Division of Health Services Regulation, and which are fully equipped to perform surgical procedures. These surgical operating rooms include rooms located in Obstetrics and surgical suites.

Type of Room	Number of Rooms
Dedicated Open Heart Surgery	2
Dedicated C-Section	3
Other Dedicated Inpatient Surgery ***(Do not include dedicated Open Heart or C-Section rooms)***	0
Dedicated Ambulatory Surgery	0
Shared - Inpatient / Ambulatory Surgery	21
Total of Surgical Operating Rooms	26

Of the **Total of Surgical Operating Rooms**, above, how many are equipped with advanced medical imaging devices (excluding mobile C-arms) or radiation equipment for the performance of endovascular, cardiovascular, neuro-interventional procedures, and/or intraoperative cancer treatments? Your facility may or may not refer to such rooms as "hybrid ORs."	2

b) Procedure Rooms (Excluding Operating Rooms and Gastrointestinal Endoscopy Rooms)

Report rooms, which are not equipped for or do not meet all the specifications for an operating room, that are used for performance of surgical procedures other than Gastrointestinal Endoscopy procedures.

Total Number of Procedure Rooms: 2

c) Gastrointestinal Endoscopy Rooms, Cases and Procedures:

Report the number of Gastrointestinal Endoscopy rooms and the Endoscopy cases and surgical procedures **performed only in these rooms** during the reporting period.

Total Number of existing Gastrointestinal Endoscopy Rooms: 5

	Number of Cases Performed In GI Endoscopy Rooms		Number of Procedures* Performed in GI Endoscopy Rooms	
	Inpatient	Outpatient	Inpatient	Outpatient
GI Endoscopy	3,167	4,997	4,857	6,659
Non-GI Endoscopy	0	0	0	0

Count each patient as one case regardless of the number of procedures performed while the patient was in the GI endoscopy room.

*As defined in 10A NCAC 14C .3901 " 'Gastrointestinal (GI) endoscopy procedure' means a single procedure, identified by CPT code or ICD-9-CM [ICD-10-CM] procedure code, performed on a patient during a single visit to the facility for diagnostic or therapeutic purposes."

9. Surgical Operating Rooms, Procedure Rooms, Gastrointestinal Endoscopy Rooms, Surgical and Non-Surgical Cases and Procedures *(continued)*

(Campus – *If multiple sites*: NHRMC Main Campus)

d) Surgical Cases by Specialty Area Table

Enter the number of surgical cases performed only in licensed operating rooms by surgical specialty area in the table below. Count each patient undergoing surgery as one case regardless of the number of surgical procedures performed while the patient was having surgery. Categorize each case into one specialty area – the total number of surgical cases is an unduplicated count of surgical cases. **Count all surgical cases performed only in licensed operating rooms. The total number of surgical cases should match the total number of patients listed in the Patient Origin Tables on pages 27 and 28.**

Surgical Specialty Area	Inpatient Cases	Ambulatory Cases
Cardiothoracic (excluding Open Heart Surgery)	901	613
Open Heart Surgery (from 8.(a) 4. on page 9)	679	
General Surgery	2,242	1,350
Neurosurgery	294	982
Obstetrics and GYN (excluding C-Sections)	331	1,341
Ophthalmology	19	1,334
Oral Surgery	8	931
Orthopedics	2,441	579
Otolaryngology	7	946
Plastic Surgery	388	1,192
Urology	669	2,149
Vascular	0	421
Other Surgeries (specify) Laparoscopy	631	2,316
Other Surgeries (specify) Other	36	22
Number of C-Sections Performed in Dedicated C-Section ORs	1,099	
Number of C-Sections Performed in Other ORs	14	
Total Surgical Cases Performed Only in Licensed ORs	9,759	14,176

e) Non-Surgical Cases by Category Table

Enter the number of non-surgical cases by category in the table below. Count each patient undergoing a procedure or procedures as one case regardless of the number of non-surgical procedures performed. Categorize each case into one non-surgical category – the total number of non-surgical cases is an unduplicated count of non-surgical cases. **Count all non-surgical cases, including cases receiving services in operating rooms or in any other location, *except* do not count cases having endoscopies in GI Endoscopy rooms. Report cases having endoscopies in GI Endoscopy Rooms on page 11.**

Non-Surgical Category	Inpatient Cases	Ambulatory Cases
Pain Management		
Cystoscopy		
Non-GI Endoscopies *(not reported in 9. C on page 11)*		
GI Endoscopies *(not reported in 9. C on page 11)*	5	3
YAG Laser		
Other (specify) Non-Invasive Vascular Lab	2,526	1,071
Other (specify)		
Other (specify)		
Total Non-Surgical Cases	2,530	1,074

20 Most Common Outpatient Surgical Cases Table - Enter the number of surgical cases performed only in licensed operating rooms and / or licensed endoscopy room by the top 20 most common outpatient surgical cases in the table below by CPT code. Count each patient undergoing surgery as one case regardless of the number of surgical procedures performed while the patient was having surgery.

CPT Code	Description	Cases
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair	1
29880	Arthroscopy, knee, surgical; with meniscectomy (medial and lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed	0
29881	Arthroscopy, knee, surgical; with meniscectomy (medial or lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed	0
42820	Tonsillectomy and adenoidectomy; younger than age 12	137
42830	Adenoidectomy, primary; younger than age 12	75
43235	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	368
43239	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with biopsy, single or multiple	1,420
43248	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with insertion of guide wire followed by dilation of esophagus over guide wire	178
43249	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with balloon dilation of esophagus (less than 30 mm diameter)	146
45378	Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)	422
45380	Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple	628
45384	Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery	7
45385	Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	495
62311	Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; lumbar or sacral (caudal)	1
64483	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or computed tomography); lumbar or sacral, single level	3
64721	Neuroplasty and/or transposition; median nerve at carpal tunnel	20
66821	Discission of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid); laser surgery (e.g., YAG laser) (one or more stages)	0
66982	Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (e.g., iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage	12
66984	Extracapsular cataract removal with insertion of intraocular lens prosthesis (stage one procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification)	101
69436	Tympanostomy (requiring insertion of ventilating tube), general anesthesia	300

(Campus – *If multiple sites:* NHRMC Main Campus **)**

9f. Average Operating Room Availability and Average Case Times:
The Operating Room Methodology assumes that the average operating room is staffed 9 hours a day, for 260 days per year, and utilized at least 80% of the available time. This results in 1,872 hours per operating room per year.

The Operating Room Methodology also assumes an average of 3 hours for each Inpatient Surgery and an average of 1.5 hours for each Outpatient Surgery.

Based on your hospital's experience, please complete the table below by showing the assumptions for the average operating room in your hospital.

Average Hours per Day **Routinely** Scheduled for Use *	Average Number of Days per Year **Routinely** Scheduled for Use	Average "Case Time" ** in **Minutes** for Inpatient Cases	Average "Case Time" ** in **Minutes** for Ambulatory Cases
9.75	260	162	115

* Use only Hours per Day **routinely** scheduled when determining the answer. Example:

A facility has 3 ORs: 2 are routinely scheduled for use 8 hours per day, and 1 is routinely scheduled for use 9 hours per day.

2 rooms	x	8 hours	=	16 hours
1 room	x	9 hours	=	9 hours
		Total hours per day		25 hours

25 hours divided by 3 ORs
= **8.3 Average Hours per day Routinely Scheduled for Use**

**** "Case Time" = Time from Room Set-up Start to Room Clean-up Finish.** Definition 2.4 from the "Procedural Times Glossary" of the AACD, as approved by ASA, ACS, and AORN. *NOTE: This definition includes all of the time for which a given procedure requires an OR/PR. It allows for the different duration of Room Set-up and Room Clean-up Times that occur because of the varying supply and equipment needs for a particular procedure.*

9. Surgical Operating Rooms, Procedure Rooms, Gastrointestinal Endoscopy Rooms, Surgical and Non-Surgical Cases and Procedures

NOTE: If this License includes more than one campus, please copy pages 11-14 (through Section 9) for each site. Submit the Cumulative Totals and submit a duplicate of pages 11-14 for each campus.

(**Campus – *If multiple sites*:** NHRMC Orthopedic Hospital)

a) Surgical Operating Rooms

Report *Surgical Operating Rooms* built to meet the specifications and standards for operating rooms required by the Construction Section of the Division of Health Services Regulation, and which are fully equipped to perform surgical procedures. These surgical operating rooms include rooms located in Obstetrics and surgical suites.

Type of Room	Number of Rooms
Dedicated Open Heart Surgery	0
Dedicated C-Section	0
Other Dedicated Inpatient Surgery ***(Do not include dedicated Open Heart or C-Section rooms)***	0
Dedicated Ambulatory Surgery	0
Shared - Inpatient / Ambulatory Surgery	8
Total of Surgical Operating Rooms	8

Of the **Total of Surgical Operating Rooms**, above, how many are equipped with advanced medical imaging devices (excluding mobile C-arms) or radiation equipment for the performance of endovascular, cardiovascular, neuro-interventional procedures, and/or intraoperative cancer treatments? Your facility may or may not refer to such rooms as "hybrid ORs."	0

b) Procedure Rooms (Excluding Operating Rooms and Gastrointestinal Endoscopy Rooms)

Report rooms, which are not equipped for or do not meet all the specifications for an operating room, that are used for performance of surgical procedures other than Gastrointestinal Endoscopy procedures.

Total Number of Procedure Rooms: 1

c) Gastrointestinal Endoscopy Rooms, Cases and Procedures:

Report the number of Gastrointestinal Endoscopy rooms and the Endoscopy cases and surgical procedures **performed only in these rooms** during the reporting period.

Total Number of existing Gastrointestinal Endoscopy Rooms: 0

	Number of Cases Performed In GI Endoscopy Rooms		Number of Procedures* Performed in GI Endoscopy Rooms	
	Inpatient	Outpatient	Inpatient	Outpatient
GI Endoscopy				
Non-GI Endoscopy				

Count each patient as one case regardless of the number of procedures performed while the patient was in the GI endoscopy room.

*As defined in 10A NCAC 14C .3901 " 'Gastrointestinal (GI) endoscopy procedure' means a single procedure, identified by CPT code or ICD-9-CM [ICD-10-CM] procedure code, performed on a patient during a single visit to the facility for diagnostic or therapeutic purposes."

9. Surgical Operating Rooms, Procedure Rooms, Gastrointestinal Endoscopy Rooms, Surgical and Non-Surgical Cases and Procedures *(continued)*

(Campus – *If multiple sites*: NHRMC Orthopedic Hospital)

d) Surgical Cases by Specialty Area Table

Enter the number of surgical cases performed only in licensed operating rooms by surgical specialty area in the table below. Count each patient undergoing surgery as one case regardless of the number of surgical procedures performed while the patient was having surgery. Categorize each case into one specialty area – the total number of surgical cases is an unduplicated count of surgical cases. **Count all surgical cases performed only in licensed operating rooms. The total number of surgical cases should match the total number of patients listed in the Patient Origin Tables on pages 27 and 28.**

Surgical Specialty Area	Inpatient Cases	Ambulatory Cases
Cardiothoracic (excluding Open Heart Surgery)	7	1
Open Heart Surgery (from 8.(a) 4. on page 9)	0	
General Surgery	5	1
Neurosurgery	6	12
Obstetrics and GYN (excluding C-Sections)	0	0
Ophthalmology	0	1
Oral Surgery	0	0
Orthopedics	3,001	4,184
Otolaryngology	0	0
Plastic Surgery	32	507
Urology	0	0
Vascular	0	1
Other Surgeries (specify) ~~Vapors~~ Other	1	0
Other Surgeries (specify)	0	0
Number of C-Sections Performed in Dedicated C-Section ORs	0	
Number of C-Sections Performed in Other ORs	0	
Total Surgical Cases Performed Only in Licensed ORs	3,052	4,707

e) Non-Surgical Cases by Category Table

Enter the number of non-surgical cases by category in the table below. Count each patient undergoing a procedure or procedures as one case regardless of the number of non-surgical procedures performed. Categorize each case into one non-surgical category – the total number of non-surgical cases is an unduplicated count of non-surgical cases. **Count all non-surgical cases, including cases receiving services in operating rooms or in any other location, *except* do not count cases having endoscopies in GI Endoscopy rooms. Report cases having endoscopies in GI Endoscopy Rooms on page 11.**

Non-Surgical Category	Inpatient Cases	Ambulatory Cases
Pain Management		
Cystoscopy		
Non-GI Endoscopies *(not reported in 9. C on page 11)*		
GI Endoscopies *(not reported in 9. C on page 11)*		
YAG Laser		
Other (specify)		
Other (specify)		
Other (specify)		
Total Non-Surgical Cases		

20 Most Common Outpatient Surgical Cases Table - Enter the number of surgical cases performed only in licensed operating rooms and / or licensed endoscopy room by the top 20 most common outpatient surgical cases in the table below by CPT code. Count each patient undergoing surgery as one case regardless of the number of surgical procedures performed while the patient was having surgery.

CPT Code	Description	Cases
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair	246
29880	Arthroscopy, knee, surgical; with meniscectomy (medial and lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed	207
29881	Arthroscopy, knee, surgical; with meniscectomy (medial or lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed	353
42820	Tonsillectomy and adenoidectomy; younger than age 12	0
42830	Adenoidectomy, primary; younger than age 12	0
43235	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	0
43239	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with biopsy, single or multiple	0
43248	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with insertion of guide wire followed by dilation of esophagus over guide wire	0
43249	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with balloon dilation of esophagus (less than 30 mm diameter)	0
45378	Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)	0
45380	Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple	0
45384	Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery	0
45385	Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	0
62311	Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; lumbar or sacral (caudal)	77
64483	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or computed tomography); lumbar or sacral, single level	82
64721	Neuroplasty and/or transposition; median nerve at carpal tunnel	303
66821	Discission of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid); laser surgery (e.g., YAG laser) (one or more stages)	0
66982	Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (e.g., iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage	0
66984	Extracapsular cataract removal with insertion of intraocular lens prosthesis (stage one procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification)	1
69436	Tympanostomy (requiring insertion of ventilating tube), general anesthesia	0

(Campus – *If multiple sites:* NHRMC Orthopedic Hospital **)**

9f. Average Operating Room Availability and Average Case Times:
The Operating Room Methodology assumes that the average operating room is staffed 9 hours a day, for 260 days per year, and utilized at least 80% of the available time. This results in 1,872 hours per operating room per year.

The Operating Room Methodology also assumes an average of 3 hours for each Inpatient Surgery and an average of 1.5 hours for each Outpatient Surgery.

Based on your hospital's experience, please complete the table below by showing the assumptions for the average operating room in your hospital.

Average Hours per Day **Routinely** Scheduled for Use *	Average Number of Days per Year **Routinely** Scheduled for Use	Average "Case Time" ** in **Minutes** for Inpatient Cases	Average "Case Time" ** in **Minutes** for Ambulatory Cases
9.75	260	153	119

* Use only Hours per Day **routinely** scheduled when determining the answer. Example:

A facility has 3 ORs: 2 are routinely scheduled for use 8 hours per day, and 1 is routinely scheduled for use 9 hours per day.

2 rooms	x	8 hours	=	16 hours
1 room	x	9 hours	=	9 hours
		Total hours per day		25 hours

25 hours divided by 3 ORs
= **8.3 Average Hours per day Routinely Scheduled for Use**

** **"Case Time" = Time from Room Set-up Start to Room Clean-up Finish.** Definition 2.4 from the "Procedural Times Glossary" of the AACD, as approved by ASA, ACS, and AORN. *NOTE: This definition includes all of the time for which a given procedure requires an OR/PR. It allows for the different duration of Room Set-up and Room Clean-up Times that occur because of the varying supply and equipment needs for a particular procedure.*

9. Surgical Operating Rooms, Procedure Rooms, Gastrointestinal Endoscopy Rooms, Surgical and Non-Surgical Cases and Procedures

NOTE: If this License includes more than one campus, please copy pages 11-14 (through Section 9) for each site. Submit the Cumulative Totals and submit a duplicate of pages 11-14 for each campus.

(Campus – *If multiple sites*: NHRMC Atlantic Surgicenter **)**

a) Surgical Operating Rooms

Report *Surgical Operating Rooms* built to meet the specifications and standards for operating rooms required by the Construction Section of the Division of Health Services Regulation, and which are fully equipped to perform surgical procedures. These surgical operating rooms include rooms located in Obstetrics and surgical suites.

Type of Room	Number of Rooms
Dedicated Open Heart Surgery	0
Dedicated C-Section	0
Other Dedicated Inpatient Surgery ***(Do not include dedicated Open Heart or C-Section rooms)***	0
Dedicated Ambulatory Surgery	4
Shared - Inpatient / Ambulatory Surgery	0
Total of Surgical Operating Rooms	4

Of the **Total of Surgical Operating Rooms**, above, how many are equipped with advanced medical imaging devices (excluding mobile C-arms) or radiation equipment for the performance of endovascular, cardiovascular, neuro-interventional procedures, and/or intraoperative cancer treatments? Your facility may or may not refer to such rooms as "hybrid ORs."	0

b) Procedure Rooms (Excluding Operating Rooms and Gastrointestinal Endoscopy Rooms)

Report rooms, which are not equipped for or do not meet all the specifications for an operating room, that are used for performance of surgical procedures other than Gastrointestinal Endoscopy procedures.

Total Number of Procedure Rooms: _____

c) Gastrointestinal Endoscopy Rooms, Cases and Procedures:

Report the number of Gastrointestinal Endoscopy rooms and the Endoscopy cases and surgical procedures **performed only in these rooms** during the reporting period.

Total Number of existing Gastrointestinal Endoscopy Rooms: _____

	Number of Cases Performed In GI Endoscopy Rooms		Number of Procedures* Performed in GI Endoscopy Rooms	
	Inpatient	Outpatient	Inpatient	Outpatient
GI Endoscopy				
Non-GI Endoscopy				

Count each patient as one case regardless of the number of procedures performed while the patient was in the GI endoscopy room.

*As defined in 10A NCAC 14C .3901 " 'Gastrointestinal (GI) endoscopy procedure' means a single procedure, identified by CPT code or ICD-9-CM [ICD-10-CM] procedure code, performed on a patient during a single visit to the facility for diagnostic or therapeutic purposes."

9. Surgical Operating Rooms, Procedure Rooms, Gastrointestinal Endoscopy Rooms, Surgical and Non-Surgical Cases and Procedures *(continued)*

(Campus – *If multiple sites*: NHRMC Atlantic Surgicenter)

d) Surgical Cases by Specialty Area Table

Enter the number of surgical cases performed only in licensed operating rooms by surgical specialty area in the table below. Count each patient undergoing surgery as one case regardless of the number of surgical procedures performed while the patient was having surgery. Categorize each case into one specialty area – the total number of surgical cases is an unduplicated count of surgical cases. **Count all surgical cases performed only in licensed operating rooms. The total number of surgical cases should match the total number of patients listed in the Patient Origin Tables on pages 27 and 28.**

Surgical Specialty Area	Inpatient Cases	Ambulatory Cases
Cardiothoracic (excluding Open Heart Surgery)		7
Open Heart Surgery (from 8.(a) 4. on page 9)		
General Surgery		169
Neurosurgery		5
Obstetrics and GYN (excluding C-Sections)		1
Ophthalmology		3,840
Oral Surgery		0
Orthopedics		834
Otolaryngology		279
Plastic Surgery		447
Urology		2
Vascular		0
Other Surgeries (specify)		220
Other Surgeries (specify)		0
Number of C-Sections Performed in Dedicated C-Section ORs		
Number of C-Sections Performed in Other ORs		
Total Surgical Cases Performed Only in Licensed ORs		5,804

e) Non-Surgical Cases by Category Table

Enter the number of non-surgical cases by category in the table below. Count each patient undergoing a procedure or procedures as one case regardless of the number of non-surgical procedures performed. Categorize each case into one non-surgical category – the total number of non-surgical cases is an unduplicated count of non-surgical cases. **Count all non-surgical cases, including cases receiving services in operating rooms or in any other location, *except* do not count cases having endoscopies in GI Endoscopy rooms. Report cases having endoscopies in GI Endoscopy Rooms on page 11.**

Non-Surgical Category	Inpatient Cases	Ambulatory Cases
Pain Management		
Cystoscopy		
Non-GI Endoscopies *(not reported in 9. C on page 11)*		
GI Endoscopies *(not reported in 9. C on page 11)*	0	463
YAG Laser		
Other (specify)		
Other (specify)		
Other (specify)		
Total Non-Surgical Cases	0	463

20 Most Common Outpatient Surgical Cases Table - Enter the number of surgical cases performed only in licensed operating rooms and / or licensed endoscopy room by the top 20 most common outpatient surgical cases in the table below by CPT code. Count each patient undergoing surgery as one case regardless of the number of surgical procedures performed while the patient was having surgery.

CPT Code	Description	Cases
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair	20
29880	Arthroscopy, knee, surgical; with meniscectomy (medial and lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed	1
29881	Arthroscopy, knee, surgical; with meniscectomy (medial or lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed	8
42820	Tonsillectomy and adenoidectomy; younger than age 12	55
42830	Adenoidectomy, primary; younger than age 12	36
43235	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	29
43239	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with biopsy, single or multiple	141
43248	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with insertion of guide wire followed by dilation of esophagus over guide wire	2
43249	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with balloon dilation of esophagus (less than 30 mm diameter)	2
45378	Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)	119
45380	Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple	79
45384	Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery	39
45385	Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	53
62311	Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; lumbar or sacral (caudal)	0
64483	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or computed tomography); lumbar or sacral, single level	0
64721	Neuroplasty and/or transposition; median nerve at carpal tunnel	178
66821	Discission of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid); laser surgery (e.g., YAG laser) (one or more stages)	0
66982	Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (e.g., iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage	228
66984	Extracapsular cataract removal with insertion of intraocular lens prosthesis (stage one procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification)	3,465
69436	Tympanostomy (requiring insertion of ventilating tube), general anesthesia	106

(Campus – *If multiple sites:* NHRMC Atlantic Surgicenter)

9f. Average Operating Room Availability and Average Case Times:
The Operating Room Methodology assumes that the average operating room is staffed 9 hours a day, for 260 days per year, and utilized at least 80% of the available time. This results in 1,872 hours per operating room per year.

The Operating Room Methodology also assumes an average of 3 hours for each Inpatient Surgery and an average of 1.5 hours for each Outpatient Surgery.

Based on your hospital's experience, please complete the table below by showing the assumptions for the average operating room in your hospital.

Average Hours per Day **Routinely** Scheduled for Use *	Average Number of Days per Year **Routinely** Scheduled for Use	Average "Case Time" ** in **Minutes** for Inpatient Cases	Average "Case Time" ** in **Minutes** for Ambulatory Cases
9.75	260	~~0~~	52

* Use only Hours per Day **routinely** scheduled when determining the answer. Example:

A facility has 3 ORs: 2 are routinely scheduled for use 8 hours per day, and 1 is routinely scheduled for use 9 hours per day.

2 rooms	x	8 hours	=	16 hours
1 room	x	9 hours	=	9 hours
		Total hours per day		25 hours

25 hours divided by 3 ORs
= **8.3 Average Hours per day Routinely Scheduled for Use**

** **"Case Time" = Time from Room Set-up Start to Room Clean-up Finish**. Definition 2.4 from the "Procedural Times Glossary" of the AACD, as approved by ASA, ACS, and AORN. *NOTE: This definition includes all of the time for which a given procedure requires an OR/PR. It allows for the different duration of Room Set-up and Room Clean-up Times that occur because of the varying supply and equipment needs for a particular procedure.*

Imaging Procedures

20 Most Common Outpatient Imaging Procedures Table - Enter the number of the top 20 common imaging procedures performed in the ambulatory setting or outpatient department in the table below by CPT code.

CPT Code	Description	Procedures
70450	Computed tomography, head or brain; without contrast material	11,038
70486	Computed tomography, facial bone; without contrast material	1,441
70551	Magnetic resonance (e.g., proton) imaging, brain (including brain stem); without contrast material	635
70553	Magnetic resonance (e.g., proton) imaging, brain (including brain stem); without contrast material followed by contrast material(s) and further sequences	2,454
71020	Radiologic examination, chest; two views, frontal and lateral	14,512
71250	Computed tomography, thorax; without contrast material(s)	1,239
71260	Computed tomography, thorax; with contrast material(s)	3,661
71275	Computed tomographic angiography, chest (noncoronary), with contrast material(s), including noncontrast images, if performed, and image postprocessing	2,130
72100	Radiologic examination, spine, lumbosacral; two or three views	3,232
72110	Radiologic examination, spine, lumbosacral; minimum of four views	390
72125	Computed tomography, cervical spine; without contrast material	3,672
72141	Magnetic resonance (e.g., proton) imaging, spine cervical without contrast material	1,005
72148	Magnetic resonance (e.g., proton) imaging, spine lumbar without contrast material	2,059
73221	Magnetic resonance (e.g., proton) imaging, upper joint (e.g. shoulder, elbow, wrist) extremity without contrast material	611
73630	Radiologic examination, foot; complete, minimum of three views	2,980
73721	Magnetic resonance (e.g., proton) imaging, lower joint (e.g. knee, ankle, mid-hind foot, hip) extremity without contrast material	751
74000	Radiologic examination, abdomen; single anteroposterior view	1,770
74176	Computed tomography, abdomen and pelvis; without contrast material	4,267
74177	Computed tomography, abdomen and pelvis; with contrast material(s)	8,060
74178	Computed tomography, abdomen and pelvis; with contrast material(s) followed by contrast material	536

Instructions for Hospitals with multiple campuses: For MRI Services, (Sections 10a-10e, pp 16-19), do not provide cumulative/combined data for all campuses. Provide data for individual campuses only.

10a. Magnetic Resonance Imaging (MRI) Procedures by CPT Codes

Indicate the number of procedures performed during the 12-month reporting period at your facility. For hospitals that operate medical equipment at multiple sites/campuses, please copy the MRI pages and provide separate data for each site/campus. Campus – *if multiple sites:* NHRMC Main Campus

CPT Code	CPT Description	Inpatient Procedures	Outpatient Procedures	Total Number of Procedures
70336	MRI Temporomandibular Joint(s)		1	1
70540	MRI Orbit/Face/Neck w/o	4	6	10
70542	MRI Orbit/Face/Neck with contrast			
70543	MRI Orbit/Face/Neck w/o & with	17	102	119
70544	MRA Head w/o	298	91	389
70545	MRA Head with contrast			
70546	MRA Head w/o & with			
70547	MRA Neck w/o	26	9	35
70548	MRA Neck with contrast			
70549	MRA Neck w/o & with	157	65	222
70551	MRI Brain w/o	1,409	413	1,822
70552	MRI Brain with contrast	47	7	54
70553	MRI Brain w/o & with	722	1,164	1,886
70554	MR functional imaging, w/o physician admin			
70555	MR functional imaging, with physician admin			
71550	MRI Chest w/o	2	2	4
71551	MRI Chest with contrast			
71552	MRI Chest w/o & with	10	11	21
71555	MRA Chest with OR without contrast		7	7
72141	MRI Cervical Spine w/o	182	469	651
72142	MRI Cervical Spine with contrast		1	1
72156	MRI Cervical Spine w/o & with	90	160	250
72146	MRI Thoracic Spine w/o	121	162	283
72147	MRI Thoracic Spine with contrast		1	1
72157	MRI Thoracic Spine w/o & with	101	123	224
72148	MRI Lumbar Spine w/o	223	950	1,173
72149	MRI Lumbar Spine with contrast	3	8	11
72158	MRI Lumbar Spine w/o & with	189	399	588
72159	MRA Spinal Canal w/o OR with contrast		1	1
72195	MRI Pelvis w/o	23	32	55
72196	MRI Pelvis with contrast		1	1
72197	MRI Pelvis w/o & with	38	93	131
72198	MRA Pelvis w/o OR with contrast	2	2	4
	Subtotals for this page	3,664	4,280	7,944

10a. MRI Procedures by CPT Codes *continued*

CPT Code	CPT Description	Inpatient Procedures	Outpatient Procedures	Total Number of Procedures
73218	MRI Upper Ext, other than joint w/o	24	28	52
73219	MRI Upper Ext, other than joint with contrast		1	1
73220	MRI Upper Ext, other than joint w/o & with	22	27	49
73221	MRI Upper Ext, any joint w/o	30	280	310
73222	MRI Upper Ext, any joint with contrast	2	36	38
73223	MRI Upper Ext, any joint w/o & with	29	23	52
73225	MRA Upper Ext, w/o OR with contrast			
73718	MRI Lower Ext other than joint w/o	93	23	116
73719	MRI Lower Ext other than joint with contrast			
73720	MRI Lower Ext other than joint w/o & with	116	40	156
73721	MRI Lower Ext any joint w/o	44	252	296
73722	MRI Lower Ext any joint with contrast	1	3	4
73723	MRI Lower Ext any joint w/o & with	33	34	67
73725	MRA Lower Ext w/o OR with contrast		2	2
74181	MRI Abdomen w/o	235	39	274
74182	MRI Abdomen with contrast	1	1	2
74183	MRI Abdomen w/o & with	73	188	261
74185	MRA Abdomen w/o OR with contrast	4	5	9
75557	MRI Cardiac Morphology w/o	3	3	6
75561	MRI Cardiac Morphology with contrast	7	9	16
75565	MRI Cardiac Velocity Flow Mapping			
76125	Cineradiography to complement exam			
76390	MRI Spectroscopy			
77021	MRI Guidance for needle placement			
77022	MRI Guidance for tissue ablation			
77058	MRI Breast, unilateral w/o and/or with contrast	1		1
77059	MRI Breast, bilateral w/o and/or with contrast		1	1
77084	MRI Bone Marrow blood supply			
N/A	Clinical Research Scans			
	Subtotal for this page	718	995	1,713
	Total Number of Procedures for all pages*	4382	5275	9657

*Totals must match totals in summary Table 10b and must be greater than or equal to the totals in the MRI Patient Origin Table on page 33 of this application.

10b. MRI CPT Code Procedure Summary (Summary of CPT Codes in Table 10a)

Indicate the number of procedures performed on MRI scanners (units) operated during the 12-month reporting period at your facility. For hospitals that use equipment at multiple sites/campuses, please copy the MRI pages and provide separate data for each site/campus.

Campus – *if multiple sites:* NHRMC Main Campus

Procedures	Inpatient Procedures*			Outpatient Procedures*			TOTAL Procedures
	With Contrast or Sedation	Without Contrast or Sedation	TOTAL Inpatient	With Contrast or Sedation	Without Contrast or Sedation	TOTAL Outpatient	
Fixed	1691	2691	4382	2,523	2,752	5,275	9,657
Mobile (Scans on mobile MRI performed **only at this site**)	0	0	0	0	0	0	0
TOTAL**	1,691	2,691	4,382	2,523	2,752	5,275	9,657

* An **MRI procedure** is defined as a single discrete MRI study of one patient (single CPT-coded procedure). An MRI study means one or more scans relative to a single diagnosis or symptom.
** Totals must match totals in Table 10a on page 17 and must be greater than or equal to the totals in the MRI Patient Origin Table on page 33 of this application.

10c. Fixed MRI Scanners

Indicate the number of MRI scanners (units) operated during the 12-month reporting period at your facility. For hospitals that operate medical equipment at multiple sites/campuses, please copy the MRI pages and provide separate data for each site/campus. Campus – *if multiple sites:* NHRMC Main Campus

Fixed Scanners	Number of Units
Number of fixed MRI scanners-closed (*do not include any* Policy AC-3 scanners)	1
# of fixed MRI scanners-open (*do not include any* Policy AC-3 scanners)	1
Number of Policy AC-3 MRI scanners used for general clinical purposes	0
Total Fixed MRI Scanners	2

10d. Mobile MRI Services:

During the reporting period,

1. Did the facility own one or more mobile MRI scanners? ____ Yes ___X___ No
   If Yes, how many? _____

2. Did the facility contract for mobile MRI services? ___X___ Yes ____ No
   If Yes, name of vendor/contractor: Alliance Imaging

10e. Other MRI

Patients served on units listed in the next table should not be included in the MRI Patient Origin Table on page 33 of this application. For hospitals that operate medical equipment at multiple sites/campuses, please copy the MRI pages and provide separate data for each site/campus. Campus – *if multiple sites:* _____

Other Scanners	Units	Inpatient Procedures*			Outpatient Procedures*			TOTAL Procedures
		With Contrast or Sedation	Without Contrast or Sedation	TOTAL Inpatient	With Contrast or Sedation	Without Contrast or Sedation	TOTAL Outpatient	
Other Human Research MRI scanners	0							
Intraoperative MRI (iMRI)	0							

***** An **MRI procedure** is defined as a single discrete MRI study of one patient (single CPT coded procedure). An MRI study means one or more scans relative to a single diagnosis or symptom.

10f. Lithotripsy Following MRI Breakouts

	Number of Units	Number of Procedures		
		Inpatient	Outpatient	Total
Fixed				
Mobile				

Lithotripsy Vendor/Owner: _____

10g. Computed Tomography (CT)

How many fixed CT scanners does the hospital have? _____

Does the hospital contract for mobile CT scanner services? ____ Yes ____ No

If yes, identify the mobile CT vendor _____

Complete the following tables (one for fixed CT scanners; one for mobile CT scanners).

Scans Performed on Fixed CT Scanners *(Multiply # scans by Conversion Factor to get HECT Units)*

	Type of CT Scan	# of Scans		Conversion Factor		HECT Units
1	Head without contrast		X	1.00	=	
2	Head with contrast		X	1.25	=	
3	Head without and with contrast		X	1.75	=	
4	Body without contrast		X	1.50	=	
5	Body with contrast		X	1.75	=	
6	Body without contrast and with contrast		X	2.75	=	
7	Biopsy in addition to body scan with or without contrast		X	2.75	=	
8	Abscess drainage in addition to body scan with or without contrast		X	4.00	=	
	Total					

Instructions for Hospitals with multiple campuses: For MRI Services, (Sections 10a-10e, pp 16-19), do not provide cumulative/combined data for all campuses. Provide data for individual campuses only.

10a. Magnetic Resonance Imaging (MRI) Procedures by CPT Codes

Indicate the number of procedures performed during the 12-month reporting period at your facility. For hospitals that operate medical equipment at multiple sites/campuses, please copy the MRI pages and provide separate data for each site/campus. Campus – *if multiple sites:* NHRMC Orthopedic Hospital

CPT Code	CPT Description	Inpatient Procedures	Outpatient Procedures	Total Number of Procedures
70336	MRI Temporomandibular Joint(s)			
70540	MRI Orbit/Face/Neck w/o		2	2
70542	MRI Orbit/Face/Neck with contrast			
70543	MRI Orbit/Face/Neck w/o & with		20	20
70544	MRA Head w/o	1	25	26
70545	MRA Head with contrast			
70546	MRA Head w/o & with			
70547	MRA Neck w/o		1	1
70548	MRA Neck with contrast			
70549	MRA Neck w/o & with		9	9
70551	MRI Brain w/o	2	57	59
70552	MRI Brain with contrast		1	1
70553	MRI Brain w/o & with	1	220	221
70554	MR functional imaging, w/o physician admin			
70555	MR functional imaging, with physician admin			
71550	MRI Chest w/o		1	1
71551	MRI Chest with contrast			
71552	MRI Chest w/o & with		4	4
71555	MRA Chest with OR without contrast		1	1
72141	MRI Cervical Spine w/o		143	143
72142	MRI Cervical Spine with contrast		1	1
72156	MRI Cervical Spine w/o & with		49	49
72146	MRI Thoracic Spine w/o		35	35
72147	MRI Thoracic Spine with contrast			
72157	MRI Thoracic Spine w/o & with		39	39
72148	MRI Lumbar Spine w/o	2	302	304
72149	MRI Lumbar Spine with contrast		1	1
72158	MRI Lumbar Spine w/o & with	2	107	109
72159	MRA Spinal Canal w/o OR with contrast			
72195	MRI Pelvis w/o	2	9	11
72196	MRI Pelvis with contrast			
72197	MRI Pelvis w/o & with		16	16
72198	MRA Pelvis w/o OR with contrast			
	Subtotals for this page	10	1,043	1,053

10a. MRI Procedures by CPT Codes *continued*

CPT Code	CPT Description	Inpatient Procedures	Outpatient Procedures	Total Number of Procedures
73218	MRI Upper Ext, other than joint w/o	3	5	8
73219	MRI Upper Ext, other than joint with contrast			
73220	MRI Upper Ext, other than joint w/o & with	4	2	6
73221	MRI Upper Ext, any joint w/o	3	80	83
73222	MRI Upper Ext, any joint with contrast		80	80
73223	MRI Upper Ext, any joint w/o & with	4	2	6
73225	MRA Upper Ext, w/o OR with contrast			
73718	MRI Lower Ext other than joint w/o	2	7	9
73719	MRI Lower Ext other than joint with contrast			
73720	MRI Lower Ext other than joint w/o & with		6	6
73721	MRI Lower Ext any joint w/o	8	104	112
73722	MRI Lower Ext any joint with contrast		23	23
73723	MRI Lower Ext any joint w/o & with	1	14	15
73725	MRA Lower Ext w/o OR with contrast		2	2
74181	MRI Abdomen w/o		13	13
74182	MRI Abdomen with contrast			
74183	MRI Abdomen w/o & with		48	48
74185	MRA Abdomen w/o OR with contrast		1	1
75557	MRI Cardiac Morphology w/o			
75561	MRI Cardiac Morphology with contrast		1	1
75565	MRI Cardiac Velocity Flow Mapping			
76125	Cineradiography to complement exam			
76390	MRI Spectroscopy			
77021	MRI Guidance for needle placement			
77022	MRI Guidance for tissue ablation			
77058	MRI Breast, unilateral w/o and/or with contrast		1	1
77059	MRI Breast, bilateral w/o and/or with contrast		4	4
77084	MRI Bone Marrow blood supply			
N/A	Clinical Research Scans			
	Subtotal for this page	25	393	418
	Total Number of Procedures for all pages*	35	1,436	1,471

*Totals must match totals in summary Table 10b and must be greater than or equal to the totals in the MRI Patient Origin Table on page 33 of this application.

10b. MRI CPT Code Procedure Summary (Summary of CPT Codes in Table 10a)

Indicate the number of procedures performed on MRI scanners (units) operated during the 12-month reporting period at your facility. For hospitals that use equipment at multiple sites/campuses, please copy the MRI pages and provide separate data for each site/campus.

Campus – *if multiple sites:* NHRMC Orthopedic Hospital

Procedures	Inpatient Procedures*			Outpatient Procedures*			TOTAL Procedures
	With Contrast or Sedation	Without Contrast or Sedation	TOTAL Inpatient	With Contrast or Sedation	Without Contrast or Sedation	TOTAL Outpatient	
Fixed	12	23	35	649	787	1,436	1,471
Mobile (Scans on mobile MRI performed **only at this site**)	0	0	0	0	0	0	0
TOTAL**	12	23	35	649	787	1,436	1,471

* An **MRI procedure** is defined as a single discrete MRI study of one patient (single CPT-coded procedure). An MRI study means one or more scans relative to a single diagnosis or symptom.
** Totals must match totals in Table 10a on page 17 and must be greater than or equal to the totals in the MRI Patient Origin Table on page 33 of this application.

10c. Fixed MRI Scanners

Indicate the number of MRI scanners (units) operated during the 12-month reporting period at your facility. For hospitals that operate medical equipment at multiple sites/campuses, please copy the MRI pages and provide separate data for each site/campus. Campus – *if multiple sites:* NHRMC Orthopedic Hospital

Fixed Scanners	Number of Units
Number of fixed MRI scanners-closed (*do not include any* Policy AC-3 scanners)	1
# of fixed MRI scanners-open (*do not include any* Policy AC-3 scanners)	0
Number of Policy AC-3 MRI scanners used for general clinical purposes	0
Total Fixed MRI Scanners	1

10d. Mobile MRI Services:

During the reporting period,

1. Did the facility own one or more mobile MRI scanners? ____ Yes X No
   If Yes, how many? _____

2. Did the facility contract for mobile MRI services? ____ Yes X No
   If Yes, name of vendor/contractor: _____

10e. Other MRI

Patients served on units listed in the next table should not be included in the MRI Patient Origin Table on page 33 of this application. For hospitals that operate medical equipment at multiple sites/campuses, please copy the MRI pages and provide separate data for each site/campus. Campus – *if multiple sites:* NHRMC Orthopedic Hospital

Other Scanners	Units	Inpatient Procedures*			Outpatient Procedures*			TOTAL Procedures
		With Contrast or Sedation	Without Contrast or Sedation	TOTAL Inpatient	With Contrast or Sedation	Without Contrast or Sedation	TOTAL Outpatient	
Other Human Research MRI scanners	0							
Intraoperative MRI (iMRI)	0							

* An **MRI procedure** is defined as a single discrete MRI study of one patient (single CPT coded procedure). An MRI study means one or more scans relative to a single diagnosis or symptom.

Following MRI Breakout

10f. Lithotripsy

	Number of Units	Number of Procedures		
		Inpatient	Outpatient	Total
Fixed				
Mobile				

Lithotripsy Vendor/Owner: _____

10g. Computed Tomography (CT)

How many fixed CT scanners does the hospital have? _____

Does the hospital contract for mobile CT scanner services? ____ Yes ____ No

If yes, identify the mobile CT vendor _____

Complete the following tables (one for fixed CT scanners; one for mobile CT scanners).

Scans Performed on Fixed CT Scanners *(Multiply # scans by Conversion Factor to get HECT Units)*

	Type of CT Scan	# of Scans		Conversion Factor		HECT Units
1	Head without contrast		X	1.00	=	
2	Head with contrast		X	1.25	=	
3	Head without and with contrast		X	1.75	=	
4	Body without contrast		X	1.50	=	
5	Body with contrast		X	1.75	=	
6	Body without contrast and with contrast		X	2.75	=	
7	Biopsy in addition to body scan with or without contrast		X	2.75	=	
8	Abscess drainage in addition to body scan with or without contrast		X	4.00	=	
	Total					

Instructions for Hospitals with multiple campuses: For MRI Services, (Sections 10a-10e, pp 16-19), do not provide cumulative/combined data for all campuses. Provide data for individual campuses only.

10a. Magnetic Resonance Imaging (MRI) Procedures by CPT Codes

Indicate the number of procedures performed during the 12-month reporting period at your facility. For hospitals that operate medical equipment at multiple sites/campuses, please copy the MRI pages and provide separate data for each site/campus. Campus – *if multiple sites:* NHRMC Medical Mall

CPT Code	CPT Description	Inpatient Procedures	Outpatient Procedures	Total Number of Procedures
70336	MRI Temporomandibular Joint(s)			
70540	MRI Orbit/Face/Neck w/o		1	1
70542	MRI Orbit/Face/Neck with contrast			
70543	MRI Orbit/Face/Neck w/o & with		27	27
70544	MRA Head w/o		19	19
70545	MRA Head with contrast			
70546	MRA Head w/o & with			
70547	MRA Neck w/o		1	1
70548	MRA Neck with contrast			
70549	MRA Neck w/o & with		15	15
70551	MRI Brain w/o		62	62
70552	MRI Brain with contrast		3	3
70553	MRI Brain w/o & with		381	381
70554	MR functional imaging, w/o physician admin			
70555	MR functional imaging, with physician admin			
71550	MRI Chest w/o			
71551	MRI Chest with contrast			
71552	MRI Chest w/o & with		5	5
71555	MRA Chest with OR without contrast			
72141	MRI Cervical Spine w/o		139	139
72142	MRI Cervical Spine with contrast			
72156	MRI Cervical Spine w/o & with		41	41
72146	MRI Thoracic Spine w/o		40	40
72147	MRI Thoracic Spine with contrast			
72157	MRI Thoracic Spine w/o & with		14	14
72148	MRI Lumbar Spine w/o		299	299
72149	MRI Lumbar Spine with contrast			
72158	MRI Lumbar Spine w/o & with		73	73
72159	MRA Spinal Canal w/o OR with contrast			
72195	MRI Pelvis w/o		93	93
72196	MRI Pelvis with contrast			
72197	MRI Pelvis w/o & with		32	32
72198	MRA Pelvis w/o OR with contrast		1	1
	Subtotals for this page	0	1,246	1,246

10a. MRI Procedures by CPT Codes *continued*

CPT Code	CPT Description	Inpatient Procedures	Outpatient Procedures	Total Number of Procedures
73218	MRI Upper Ext, other than joint w/o		11	11
73219	MRI Upper Ext, other than joint with contrast			
73220	MRI Upper Ext, other than joint w/o & with		2	2
73221	MRI Upper Ext, any joint w/o		70	70
73222	MRI Upper Ext, any joint with contrast		196	196
73223	MRI Upper Ext, any joint w/o & with		8	8
73225	MRA Upper Ext, w/o OR with contrast			
73718	MRI Lower Ext other than joint w/o		13	13
73719	MRI Lower Ext other than joint with contrast			
73720	MRI Lower Ext other than joint w/o & with		14	14
73721	MRI Lower Ext any joint w/o		152	152
73722	MRI Lower Ext any joint with contrast		34	34
73723	MRI Lower Ext any joint w/o & with		4	4
73725	MRA Lower Ext w/o OR with contrast			
74181	MRI Abdomen w/o		22	22
74182	MRI Abdomen with contrast			
74183	MRI Abdomen w/o & with		63	63
74185	MRA Abdomen w/o OR with contrast		6	6
75557	MRI Cardiac Morphology w/o			
75561	MRI Cardiac Morphology with contrast			
75565	MRI Cardiac Velocity Flow Mapping			
76125	Cineradiography to complement exam			
76390	MRI Spectroscopy			
77021	MRI Guidance for needle placement			
77022	MRI Guidance for tissue ablation			
77058	MRI Breast, unilateral w/o and/or with contrast		21	21
77059	MRI Breast, bilateral w/o and/or with contrast		142	142
77084	MRI Bone Marrow blood supply			
N/A	Clinical Research Scans			
Subtotal for this page		0	758	758
Total Number of Procedures for all pages*		0	2,004	2,004

*Totals must match totals in summary Table 10b and must be greater than or equal to the totals in the MRI Patient Origin Table on page 33 of this application.

10b. MRI CPT Code Procedure Summary (Summary of CPT Codes in Table 10a)

Indicate the number of procedures performed on MRI scanners (units) operated during the 12-month reporting period at your facility. For hospitals that use equipment at multiple sites/campuses, please copy the MRI pages and provide separate data for each site/campus.

Campus – *if multiple sites:* NHRMC Medical Mall

Procedures	Inpatient Procedures*			Outpatient Procedures*			TOTAL Procedures
	With Contrast or Sedation	Without Contrast or Sedation	TOTAL Inpatient	With Contrast or Sedation	Without Contrast or Sedation	TOTAL Outpatient	
Fixed	0	0	0	941	1,063	2,004	2,004
Mobile (Scans on mobile MRI performed **only at this site**)	0	0	0	0	0	0	0
TOTAL**	0	0	0	941	1,063	2,004	2,004

* An **MRI procedure** is defined as a single discrete MRI study of one patient (single CPT-coded procedure). An MRI study means one or more scans relative to a single diagnosis or symptom.
** Totals must match totals in Table 10a on page 17 and must be greater than or equal to the totals in the MRI Patient Origin Table on page 33 of this application.

10c. Fixed MRI Scanners

Indicate the number of MRI scanners (units) operated during the 12-month reporting period at your facility. For hospitals that operate medical equipment at multiple sites/campuses, please copy the MRI pages and provide separate data for each site/campus. Campus – *if multiple sites:* NHRMC Medical Mall

Fixed Scanners	Number of Units
Number of fixed MRI scanners-closed (*do not include any* Policy AC-3 scanners)	1
# of fixed MRI scanners-open (*do not include any* Policy AC-3 scanners)	0
Number of Policy AC-3 MRI scanners used for general clinical purposes	0
Total Fixed MRI Scanners	1

10d. Mobile MRI Services:

During the reporting period,

1. Did the facility own one or more mobile MRI scanners? ____ Yes X No
   If Yes, how many? _____
2. Did the facility contract for mobile MRI services? ____ Yes X No
   If Yes, name of vendor/contractor: _____

10e. Other MRI

Patients served on units listed in the next table should not be included in the MRI Patient Origin Table on page 33 of this application. For hospitals that operate medical equipment at multiple sites/campuses, please copy the MRI pages and provide separate data for each site/campus. Campus – *if multiple sites:* NHRMC Medical Mall

Other Scanners	Units	Inpatient Procedures*			Outpatient Procedures*			TOTAL Procedures
		With Contrast or Sedation	Without Contrast or Sedation	TOTAL Inpatient	With Contrast or Sedation	Without Contrast or Sedation	TOTAL Outpatient	
Other Human Research MRI scanners	0							
Intraoperative MRI (iMRI)	0							

* An **MRI procedure** is defined as a single discrete MRI study of one patient (single CPT coded procedure). An MRI study means one or more scans relative to a single diagnosis or symptom.

Following MRI Breakout

10f. Lithotripsy

	Number of Units	Number of Procedures		
		Inpatient	Outpatient	Total
Fixed				
Mobile				

Lithotripsy Vendor/Owner: _____

10g. Computed Tomography (CT)

How many fixed CT scanners does the hospital have? _____

Does the hospital contract for mobile CT scanner services? ____ Yes ____ No

If yes, identify the mobile CT vendor _____

Complete the following tables (one for fixed CT scanners; one for mobile CT scanners).

Scans Performed on Fixed CT Scanners *(Multiply # scans by Conversion Factor to get HECT Units)*

	Type of CT Scan	# of Scans		Conversion Factor		HECT Units
1	Head without contrast		X	1.00	=	
2	Head with contrast		X	1.25	=	
3	Head without and with contrast		X	1.75	=	
4	Body without contrast		X	1.50	=	
5	Body with contrast		X	1.75	=	
6	Body without contrast and with contrast		X	2.75	=	
7	Biopsy in addition to body scan with or without contrast		X	2.75	=	
8	Abscess drainage in addition to body scan with or without contrast		X	4.00	=	
	Total					

Instructions for Hospitals with multiple campuses: For MRI Services, (Sections 10a-10e, pp 16-19), do not provide cumulative/combined data for all campuses. Provide data for individual campuses only.

10a. Magnetic Resonance Imaging (MRI) Procedures by CPT Codes

Indicate the number of procedures performed during the 12-month reporting period at your facility. For hospitals that operate medical equipment at multiple sites/campuses, please copy the MRI pages and provide separate data for each site/campus. Campus – *if multiple sites:* NHRMC North Campus

CPT Code	CPT Description	Inpatient Procedures	Outpatient Procedures	Total Number of Procedures
70336	MRI Temporomandibular Joint(s)			
70540	MRI Orbit/Face/Neck w/o			
70542	MRI Orbit/Face/Neck with contrast			
70543	MRI Orbit/Face/Neck w/o & with		28	28
70544	MRA Head w/o		16	16
70545	MRA Head with contrast			
70546	MRA Head w/o & with			
70547	MRA Neck w/o		7	7
70548	MRA Neck with contrast			
70549	MRA Neck w/o & with		9	9
70551	MRI Brain w/o		34	34
70552	MRI Brain with contrast		2	2
70553	MRI Brain w/o & with		286	286
70554	MR functional imaging, w/o physician admin			
70555	MR functional imaging, with physician admin			
71550	MRI Chest w/o		2	2
71551	MRI Chest with contrast			
71552	MRI Chest w/o & with		4	4
71555	MRA Chest with OR without contrast		5	5
72141	MRI Cervical Spine w/o		78	78
72142	MRI Cervical Spine with contrast		1	1
72156	MRI Cervical Spine w/o & with		54	54
72146	MRI Thoracic Spine w/o		20	20
72147	MRI Thoracic Spine with contrast			
72157	MRI Thoracic Spine w/o & with		34	34
72148	MRI Lumbar Spine w/o		177	177
72149	MRI Lumbar Spine with contrast		2	2
72158	MRI Lumbar Spine w/o & with		95	95
72159	MRA Spinal Canal w/o OR with contrast			
72195	MRI Pelvis w/o		6	6
72196	MRI Pelvis with contrast			
72197	MRI Pelvis w/o & with		25	25
72198	MRA Pelvis w/o OR with contrast			
	Subtotals for this page	0	885	885

10a. MRI Procedures by CPT Codes *continued*

CPT Code	CPT Description	Inpatient Procedures	Outpatient Procedures	Total Number of Procedures
73218	MRI Upper Ext, other than joint w/o		6	6
73219	MRI Upper Ext, other than joint with contrast			
73220	MRI Upper Ext, other than joint w/o & with		7	7
73221	MRI Upper Ext, any joint w/o		55	55
73222	MRI Upper Ext, any joint with contrast		1	1
73223	MRI Upper Ext, any joint w/o & with		10	10
73225	MRA Upper Ext, w/o OR with contrast			
73718	MRI Lower Ext other than joint w/o		16	16
73719	MRI Lower Ext other than joint with contrast			
73720	MRI Lower Ext other than joint w/o & with		15	15
73721	MRI Lower Ext any joint w/o		87	87
73722	MRI Lower Ext any joint with contrast			
73723	MRI Lower Ext any joint w/o & with		12	12
73725	MRA Lower Ext w/o OR with contrast			
74181	MRI Abdomen w/o		9	9
74182	MRI Abdomen with contrast			
74183	MRI Abdomen w/o & with		75	75
74185	MRA Abdomen w/o OR with contrast			
75557	MRI Cardiac Morphology w/o			
75561	MRI Cardiac Morphology with contrast			
75565	MRI Cardiac Velocity Flow Mapping			
76125	Cineradiography to complement exam			
76390	MRI Spectroscopy			
77021	MRI Guidance for needle placement			
77022	MRI Guidance for tissue ablation			
77058	MRI Breast, unilateral w/o and/or with contrast			
77059	MRI Breast, bilateral w/o and/or with contrast			
77084	MRI Bone Marrow blood supply			
N/A	Clinical Research Scans			
	Subtotal for this page	0	293	293
	Total Number of Procedures for all pages*	0	1,178	1,178

*Totals must match totals in summary Table 10b and must be greater than or equal to the totals in the MRI Patient Origin Table on page 33 of this application.

10b. MRI CPT Code Procedure Summary (Summary of CPT Codes in Table 10a)

Indicate the number of procedures performed on MRI scanners (units) operated during the 12-month reporting period at your facility. For hospitals that use equipment at multiple sites/campuses, please copy the MRI pages and provide separate data for each site/campus.

Campus – *if multiple sites:* NHRMC North Campus

Procedures	Inpatient Procedures*			Outpatient Procedures*			TOTAL Procedures
	With Contrast or Sedation	Without Contrast or Sedation	TOTAL Inpatient	With Contrast or Sedation	Without Contrast or Sedation	TOTAL Outpatient	
Fixed	0	0	0	0	0	0	0
Mobile (Scans on mobile MRI performed **only at this site**)	0	0	0	672	506	1,178	1,178
TOTAL**	0	0	0	672	506	1,178	1,178

* An **MRI procedure** is defined as a single discrete MRI study of one patient (single CPT-coded procedure). An MRI study means one or more scans relative to a single diagnosis or symptom.
** Totals must match totals in Table 10a on page 17 and must be greater than or equal to the totals in the MRI Patient Origin Table on page 33 of this application.

10c. Fixed MRI Scanners

Indicate the number of MRI scanners (units) operated during the 12-month reporting period at your facility. For hospitals that operate medical equipment at multiple sites/campuses, please copy the MRI pages and provide separate data for each site/campus. Campus – *if multiple sites:* NHRMC North Campus

Fixed Scanners	Number of Units
Number of fixed MRI scanners-closed (*do not include any* Policy AC-3 scanners)	0
# of fixed MRI scanners-open (*do not include any* Policy AC-3 scanners)	0
Number of Policy AC-3 MRI scanners used for general clinical purposes	0
Total Fixed MRI Scanners	0

10d. Mobile MRI Services:

During the reporting period,

1. Did the facility own one or more mobile MRI scanners? ____ Yes X No
   If Yes, how many? _____

2. Did the facility contract for mobile MRI services? X Yes ____ No
   If Yes, name of vendor/contractor: Alliance Imaging

10e. Other MRI

Patients served on units listed in the next table should not be included in the MRI Patient Origin Table on page 33 of this application. For hospitals that operate medical equipment at multiple sites/campuses, please copy the MRI pages and provide separate data for each site/campus. Campus – *if multiple sites:* NHRMC North Campus

Other Scanners	Units	Inpatient Procedures*			Outpatient Procedures*			TOTAL Procedures
		With Contrast or Sedation	Without Contrast or Sedation	TOTAL Inpatient	With Contrast or Sedation	Without Contrast or Sedation	TOTAL Outpatient	
Other Human Research MRI scanners	0							
Intraoperative MRI (iMRI)	0							

* An **MRI procedure** is defined as a single discrete MRI study of one patient (single CPT coded procedure). An MRI study means one or more scans relative to a single diagnosis or symptom.

Follows MRI Breakout

10f. Lithotripsy

	Number of Units	Number of Procedures		
		Inpatient	Outpatient	Total
Fixed				
Mobile				

Lithotripsy Vendor/Owner: _____

10g. Computed Tomography (CT)

How many fixed CT scanners does the hospital have? _____

Does the hospital contract for mobile CT scanner services? ____ Yes ____ No

If yes, identify the mobile CT vendor _____

Complete the following tables (one for fixed CT scanners; one for mobile CT scanners).

Scans Performed on Fixed CT Scanners *(Multiply # scans by Conversion Factor to get HECT Units)*

	Type of CT Scan	# of Scans		Conversion Factor		HECT Units
1	Head without contrast		X	1.00	=	
2	Head with contrast		X	1.25	=	
3	Head without and with contrast		X	1.75	=	
4	Body without contrast		X	1.50	=	
5	Body with contrast		X	1.75	=	
6	Body without contrast and with contrast		X	2.75	=	
7	Biopsy in addition to body scan with or without contrast		X	2.75	=	
8	Abscess drainage in addition to body scan with or without contrast		X	4.00	=	
	Total					

Instructions for Hospitals with multiple campuses: For MRI Services, (Sections 10a-10e, pp 16-19), do not provide cumulative/combined data for all campuses. Provide data for individual campuses only.

10a. Magnetic Resonance Imaging (MRI) Procedures by CPT Codes

Indicate the number of procedures performed during the 12-month reporting period at your facility. For hospitals that operate medical equipment at multiple sites/campuses, please copy the MRI pages and provide separate data for each site/campus. Campus – *if multiple sites:* NHRMC Military Cutoff H+D

CPT Code	CPT Description	Inpatient Procedures	Outpatient Procedures	Total Number of Procedures
70336	MRI Temporomandibular Joint(s)			
70540	MRI Orbit/Face/Neck w/o		2	2
70542	MRI Orbit/Face/Neck with contrast			
70543	MRI Orbit/Face/Neck w/o & with		12	12
70544	MRA Head w/o		17	17
70545	MRA Head with contrast			
70546	MRA Head w/o & with			
70547	MRA Neck w/o		2	2
70548	MRA Neck with contrast		1	1
70549	MRA Neck w/o & with		6	6
70551	MRI Brain w/o		37	37
70552	MRI Brain with contrast			
70553	MRI Brain w/o & with		195	195
70554	MR functional imaging, w/o physician admin			
70555	MR functional imaging, with physician admin			
71550	MRI Chest w/o		1	1
71551	MRI Chest with contrast			
71552	MRI Chest w/o & with		3	3
71555	MRA Chest with OR without contrast			
72141	MRI Cervical Spine w/o		95	95
72142	MRI Cervical Spine with contrast			
72156	MRI Cervical Spine w/o & with		38	38
72146	MRI Thoracic Spine w/o		23	23
72147	MRI Thoracic Spine with contrast			
72157	MRI Thoracic Spine w/o & with		23	23
72148	MRI Lumbar Spine w/o		176	176
72149	MRI Lumbar Spine with contrast			
72158	MRI Lumbar Spine w/o & with		47	47
72159	MRA Spinal Canal w/o OR with contrast			
72195	MRI Pelvis w/o		10	10
72196	MRI Pelvis with contrast		1	1
72197	MRI Pelvis w/o & with		25	25
72198	MRA Pelvis w/o OR with contrast			
	Subtotals for this page	0	714	714

10a. MRI Procedures by CPT Codes *continued*

CPT Code	CPT Description	Inpatient Procedures	Outpatient Procedures	Total Number of Procedures
73218	MRI Upper Ext, other than joint w/o		7	7
73219	MRI Upper Ext, other than joint with contrast			
73220	MRI Upper Ext, other than joint w/o & with		4	4
73221	MRI Upper Ext, any joint w/o		55	55
73222	MRI Upper Ext, any joint with contrast			
73223	MRI Upper Ext, any joint w/o & with		13	13
73225	MRA Upper Ext, w/o OR with contrast			
73718	MRI Lower Ext other than joint w/o		19	19
73719	MRI Lower Ext other than joint with contrast			
73720	MRI Lower Ext other than joint w/o & with		11	11
73721	MRI Lower Ext any joint w/o		83	83
73722	MRI Lower Ext any joint with contrast			
73723	MRI Lower Ext any joint w/o & with		7	7
73725	MRA Lower Ext w/o OR with contrast			
74181	MRI Abdomen w/o		14	14
74182	MRI Abdomen with contrast			
74183	MRI Abdomen w/o & with		55	55
74185	MRA Abdomen w/o OR with contrast			
75557	MRI Cardiac Morphology w/o			
75561	MRI Cardiac Morphology with contrast			
75565	MRI Cardiac Velocity Flow Mapping			
76125	Cineradiography to complement exam			
76390	MRI Spectroscopy			
77021	MRI Guidance for needle placement			
77022	MRI Guidance for tissue ablation			
77058	MRI Breast, unilateral w/o and/or with contrast			
77059	MRI Breast, bilateral w/o and/or with contrast			
77084	MRI Bone Marrow blood supply			
N/A	Clinical Research Scans			
	Subtotal for this page	0	268	268
	Total Number of Procedures for all pages*	0	982	982

*Totals must match totals in summary Table 10b and must be greater than or equal to the totals in the MRI Patient Origin Table on page 33 of this application.

10b. MRI CPT Code Procedure Summary (Summary of CPT Codes in Table 10a)

Indicate the number of procedures performed on MRI scanners (units) operated during the 12-month reporting period at your facility. For hospitals that use equipment at multiple sites/campuses, please copy the MRI pages and provide separate data for each site/campus.

Campus – *if multiple sites:* NHRMC Military Cutoff H&D

Procedures	Inpatient Procedures*			Outpatient Procedures*			TOTAL Procedures
	With Contrast or Sedation	Without Contrast or Sedation	TOTAL Inpatient	With Contrast or Sedation	Without Contrast or Sedation	TOTAL Outpatient	
Fixed	0	0	0	0	0	0	0
Mobile (Scans on mobile MRI performed **only at this site**)	0	0	0	443	539	982	982
TOTAL**	0	0	0	443	539	982	982

* An **MRI procedure** is defined as a single discrete MRI study of one patient (single CPT-coded procedure). An MRI study means one or more scans relative to a single diagnosis or symptom.
** Totals must match totals in Table 10a on page 17 and must be greater than or equal to the totals in the MRI Patient Origin Table on page 33 of this application.

10c. Fixed MRI Scanners

Indicate the number of MRI scanners (units) operated during the 12-month reporting period at your facility. For hospitals that operate medical equipment at multiple sites/campuses, please copy the MRI pages and provide separate data for each site/campus. Campus – *if multiple sites:* NHRMC Military Cutoff H&D

Fixed Scanners	Number of Units
Number of fixed MRI scanners-closed (*do not include any* Policy AC-3 scanners)	0
# of fixed MRI scanners-open (*do not include any* Policy AC-3 scanners)	0
Number of Policy AC-3 MRI scanners used for general clinical purposes	0
Total Fixed MRI Scanners	0

10d. Mobile MRI Services:

During the reporting period,

1. Did the facility own one or more mobile MRI scanners? ____ Yes X No
   If Yes, how many? _____

2. Did the facility contract for mobile MRI services? X Yes ____ No
   If Yes, name of vendor/contractor: Alliance Imaging

10e. Other MRI

Patients served on units listed in the next table should not be included in the MRI Patient Origin Table on page 33 of this application. For hospitals that operate medical equipment at multiple sites/campuses, please copy the MRI pages and provide separate data for each site/campus. Campus – *if multiple sites:* NHRMC Military Cutoff MED

Other Scanners	Units	Inpatient Procedures*			Outpatient Procedures*			TOTAL Procedures
		With Contrast or Sedation	Without Contrast or Sedation	TOTAL Inpatient	With Contrast or Sedation	Without Contrast or Sedation	TOTAL Outpatient	
Other Human Research MRI scanners	0							
Intraoperative MRI (iMRI)	0							

* An **MRI procedure** is defined as a single discrete MRI study of one patient (single CPT coded procedure). An MRI study means one or more scans relative to a single diagnosis or symptom.

Following MRI Breakout

10f. Lithotripsy

	Number of Units	Number of Procedures		
		Inpatient	Outpatient	Total
Fixed				
Mobile				

Lithotripsy Vendor/Owner: _____

10g. Computed Tomography (CT)

How many fixed CT scanners does the hospital have? _____

Does the hospital contract for mobile CT scanner services? ____ Yes ____ No

If yes, identify the mobile CT vendor _____

Complete the following tables (one for fixed CT scanners; one for mobile CT scanners).

Scans Performed on Fixed CT Scanners *(Multiply # scans by Conversion Factor to get HECT Units)*

	Type of CT Scan	# of Scans		Conversion Factor		HECT Units
1	Head without contrast		X	1.00	=	
2	Head with contrast		X	1.25	=	
3	Head without and with contrast		X	1.75	=	
4	Body without contrast		X	1.50	=	
5	Body with contrast		X	1.75	=	
6	Body without contrast and with contrast		X	2.75	=	
7	Biopsy in addition to body scan with or without contrast		X	2.75	=	
8	Abscess drainage in addition to body scan with or without contrast		X	4.00	=	
	Total					

Instructions for Hospitals with multiple campuses: For MRI Services, (Sections 10a-10e, pp 16-19), do not provide cumulative/combined data for all campuses. Provide data for individual campuses only.

10a. Magnetic Resonance Imaging (MRI) Procedures by CPT Codes

Indicate the number of procedures performed during the 12-month reporting period at your facility. For hospitals that operate medical equipment at multiple sites/campuses, please copy the MRI pages and provide separate data for each site/campus. Campus – *if multiple sites:* NHRMC Brunswick Forest HSD

CPT Code	CPT Description	Inpatient Procedures	Outpatient Procedures	Total Number of Procedures
70336	MRI Temporomandibular Joint(s)			
70540	MRI Orbit/Face/Neck w/o			
70542	MRI Orbit/Face/Neck with contrast			
70543	MRI Orbit/Face/Neck w/o & with		16	16
70544	MRA Head w/o		17	17
70545	MRA Head with contrast			
70546	MRA Head w/o & with			
70547	MRA Neck w/o		3	3
70548	MRA Neck with contrast			
70549	MRA Neck w/o & with		5	5
70551	MRI Brain w/o		32	32
70552	MRI Brain with contrast			
70553	MRI Brain w/o & with		208	208
70554	MR functional imaging, w/o physician admin			
70555	MR functional imaging, with physician admin			
71550	MRI Chest w/o		1	1
71551	MRI Chest with contrast			
71552	MRI Chest w/o & with		3	3
71555	MRA Chest with OR without contrast			
72141	MRI Cervical Spine w/o		81	81
72142	MRI Cervical Spine with contrast			
72156	MRI Cervical Spine w/o & with		34	34
72146	MRI Thoracic Spine w/o		21	21
72147	MRI Thoracic Spine with contrast			
72157	MRI Thoracic Spine w/o & with		20	20
72148	MRI Lumbar Spine w/o		155	155
72149	MRI Lumbar Spine with contrast			
72158	MRI Lumbar Spine w/o & with		58	58
72159	MRA Spinal Canal w/o OR with contrast			
72195	MRI Pelvis w/o		3	3
72196	MRI Pelvis with contrast			
72197	MRI Pelvis w/o & with		9	9
72198	MRA Pelvis w/o OR with contrast			
	Subtotals for this page	0	666	666

10a. MRI Procedures by CPT Codes *continued*

CPT Code	CPT Description	Inpatient Procedures	Outpatient Procedures	Total Number of Procedures
73218	MRI Upper Ext, other than joint w/o		6	6
73219	MRI Upper Ext, other than joint with contrast			
73220	MRI Upper Ext, other than joint w/o & with		3	3
73221	MRI Upper Ext, any joint w/o		71	71
73222	MRI Upper Ext, any joint with contrast		1	1
73223	MRI Upper Ext, any joint w/o & with		4	4
73225	MRA Upper Ext, w/o OR with contrast			
73718	MRI Lower Ext other than joint w/o		5	5
73719	MRI Lower Ext other than joint with contrast			
73720	MRI Lower Ext other than joint w/o & with		11	11
73721	MRI Lower Ext any joint w/o		73	73
73722	MRI Lower Ext any joint with contrast			
73723	MRI Lower Ext any joint w/o & with		6	6
73725	MRA Lower Ext w/o OR with contrast			
74181	MRI Abdomen w/o		10	10
74182	MRI Abdomen with contrast			
74183	MRI Abdomen w/o & with		55	55
74185	MRA Abdomen w/o OR with contrast		4	4
75557	MRI Cardiac Morphology w/o			
75561	MRI Cardiac Morphology with contrast			
75565	MRI Cardiac Velocity Flow Mapping			
76125	Cineradiography to complement exam			
76390	MRI Spectroscopy			
77021	MRI Guidance for needle placement			
77022	MRI Guidance for tissue ablation			
77058	MRI Breast, unilateral w/o and/or with contrast			
77059	MRI Breast, bilateral w/o and/or with contrast			
77084	MRI Bone Marrow blood supply			
N/A	Clinical Research Scans			
	Subtotal for this page	0	249	249
	Total Number of Procedures for all pages*	0	915	915

*Totals must match totals in summary Table 10b and must be greater than or equal to the totals in the MRI Patient Origin Table on page 33 of this application.

10b. MRI CPT Code Procedure Summary (Summary of CPT Codes in Table 10a)

Indicate the number of procedures performed on MRI scanners (units) operated during the 12-month reporting period at your facility. For hospitals that use equipment at multiple sites/campuses, please copy the MRI pages and provide separate data for each site/campus.

Campus – *if multiple sites:* NHRMC Brunswick Forest HoD

Procedures	Inpatient Procedures*			Outpatient Procedures*			TOTAL Procedures
	With Contrast or Sedation	Without Contrast or Sedation	TOTAL Inpatient	With Contrast or Sedation	Without Contrast or Sedation	TOTAL Outpatient	
Fixed	0	0	0	0	0	0	0
Mobile (Scans on mobile MRI performed **only at this site**)	0	0	0	440	475	915	915
TOTAL**	0	0	0	440	475	915	915

* An **MRI procedure** is defined as a single discrete MRI study of one patient (single CPT-coded procedure). An MRI study means one or more scans relative to a single diagnosis or symptom.
** Totals must match totals in Table 10a on page 17 and must be greater than or equal to the totals in the MRI Patient Origin Table on page 33 of this application.

10c. Fixed MRI Scanners

Indicate the number of MRI scanners (units) operated during the 12-month reporting period at your facility. For hospitals that operate medical equipment at multiple sites/campuses, please copy the MRI pages and provide separate data for each site/campus. Campus – *if multiple sites:* NHRMC Brunswick Forest HoD

Fixed Scanners	Number of Units
Number of fixed MRI scanners-closed (*do not include any* Policy AC-3 scanners)	0
# of fixed MRI scanners-open (*do not include any* Policy AC-3 scanners)	0
Number of Policy AC-3 MRI scanners used for general clinical purposes	0
Total Fixed MRI Scanners	0

10d. Mobile MRI Services:

During the reporting period,

1. Did the facility own one or more mobile MRI scanners? ____ Yes X No
   If Yes, how many? _____

2. Did the facility contract for mobile MRI services? X Yes ____ No
   If Yes, name of vendor/contractor: Alliance Imaging

10e. Other MRI

Patients served on units listed in the next table should not be included in the MRI Patient Origin Table on page 33 of this application. For hospitals that operate medical equipment at multiple sites/campuses, please copy the MRI pages and provide separate data for each site/campus. Campus – *if multiple sites:* NHRMC Brunswick Forest H&D

Other Scanners	Units	Inpatient Procedures*			Outpatient Procedures*			TOTAL Procedures
		With Contrast or Sedation	Without Contrast or Sedation	TOTAL Inpatient	With Contrast or Sedation	Without Contrast or Sedation	TOTAL Outpatient	
Other Human Research MRI scanners	0							
Intraoperative MRI (iMRI)	0							

* An **MRI procedure** is defined as a single discrete MRI study of one patient (single CPT coded procedure). An MRI study means one or more scans relative to a single diagnosis or symptom.

10f. Lithotripsy

	Number of Units	Number of Procedures		
		Inpatient	Outpatient	Total
Fixed	0	0	0	0
Mobile	1	0	129	129

Lithotripsy Vendor/Owner: Carolina Lithotripsy

10g. Computed Tomography (CT)

How many fixed CT scanners does the hospital have? 9

Does the hospital contract for mobile CT scanner services? ___ Yes X No

If yes, identify the mobile CT vendor n/a

Complete the following tables (one for fixed CT scanners; one for mobile CT scanners).

Scans Performed on Fixed CT Scanners *(Multiply # scans by Conversion Factor to get HECT Units)*

	Type of CT Scan	# of Scans		Conversion Factor		HECT Units
1	Head without contrast	18,423	X	1.00	=	18,423.00
2	Head with contrast	43	X	1.25	=	53.75
3	Head without and with contrast	181	X	1.75	=	316.75
4	Body without contrast	20,110	X	1.50	=	30,165.00
5	Body with contrast	20,988	X	1.75	=	36,729.00
6	Body without contrast and with contrast	7,148	X	2.75	=	19,657.00
7	Biopsy in addition to body scan with or without contrast	0	X	2.75	=	0
8	Abscess drainage in addition to body scan with or without contrast	0	X	4.00	=	0
	Total	66,893				105,344.50

10g. Computed Tomography (CT) *continued*

Scans Performed on Mobile CT Scanners *(Multiply # scans by Conversion Factor to get HECT Units)*

	Type of CT Scan	# of Scans		Conversion Factor		HECT Units
1	Head without contrast		X	1.00	=	
2	Head with contrast		X	1.25	=	
3	Head without and with contrast		X	1.75	=	
4	Body without contrast		X	1.50	=	
5	Body with contrast		X	1.75	=	
6	Body without and with contrast		X	2.75	=	
7	Biopsy in addition to body scan with or without contrast		X	2.75	=	
8	Abscess drainage in addition to body scan with or without contrast		X	4.00	=	
	Total					

10h. Positron Emission Tomography (PET)

	Number of Units	Number of Procedures*		
		Inpatient	Outpatient	Total
Dedicated Fixed PET Scanner	1	16	1,831	1,847
Mobile PET Scanner	0	0	0	0
PET pursuant to Policy AC-3	0	0	0	0
Other PET Scanners used for Human Research only	0	0	0	0

*** PET procedure** means a single discrete study of one patient involving one or more PET scans. PET **scan** means an image-scanning sequence derived from a single administration of a PET radiopharmaceutical, equated with a single injection of the tracer. One or more PET scans comprise a PET procedure. **The number of PET procedures in this table should match the number of patients reported on the PET Patient Origin Table on page 35.**

Name of Mobile Provider: n/a

10i. Other Imaging Equipment

	Number of Units	Number of Procedures		
		Inpatient	Outpatient	Total
Ultrasound equipment	12	7,242	20,502	27,926
Mammography equipment	6	94	19,950	20,044
Bone Density Equipment	4	0	2,114	2,114
Fixed X-ray Equipment (excluding fluoroscopic)	10	54,614	70,698	125,582
Fixed Fluoroscopic X-ray Equipment	7	4,670	4,104	8,774
Special Procedures/ Angiography Equipment (neuro & vascular, but not including cardiac cath.)	5	601	1,398	1,999
Coincidence Camera	0			
Mobile Coincidence Camera. Vendor:	0			
SPECT	4	1,035	1,421	2,456
Mobile SPECT. Vendor:	0			
Gamma Camera	2	891	3,263	4,154
Mobile Gamma Camera. Vendor:	0			

11. Linear Accelerator Treatment Data (including Cyberknife® & Similar Equipment)

CPT Code	Description	# of Procedures
	Simple Treatment Delivery	
77401	Radiation treatment delivery	
77402	Radiation treatment delivery (<=5 MeV)	55
77403	Radiation treatment delivery (6-10 MeV)	
77404	Radiation treatment delivery (11-19 MeV)	
77406	Radiation treatment delivery (>=20 MeV)	
	Intermediate Treatment Delivery	
77407	Radiation treatment delivery (<=5 MeV)	
77408	Radiation treatment delivery (6-10 MeV)	
77409	Radiation treatment delivery (11-19 MeV)	
77411	Radiation treatment delivery (>=20 MeV)	
	Complex Treatment Delivery	
77412	Radiation treatment delivery (<=5 MeV)	4,017
77413	Radiation treatment delivery (6-10 MeV)	
77414	Radiation treatment delivery (11-19 MeV)	
77416	Radiation treatment delivery (>= 20 MeV)	
	Other Treatment Delivery Not Included Above	
77418	Intensity modulated radiation treatment (IMRT) delivery and/or CPT codes 77385 and/or 77386	
77372	Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; linear accelerator	
77373	Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions	
G0339	(Image-guided) robotic linear accelerator-based stereotactic radiosurgery in one session or first fraction	
G0340	(Image-guided) robotic linear accelerator-based stereotactic radiosurgery, fractionated treatment, 2nd-5th fraction	
	Intraoperative radiation therapy (conducted by bringing the anesthetized patient down to the LINAC)	
	Pediatric Patient under anesthesia	
	Neutron and proton radiation therapy	
	Limb salvage irradiation	
	Hemibody irradiation	
	Total body irradiation	
Imaging Procedures Not Included Above		
77417	Additional field check radiographs	963
	Total Procedures – Linear Accelerators	5,035
	Gamma Knife® Procedures	
77371	Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of one session; multisource Cobalt 60 based (Gamma Knife®)	
	Total Procedures – Gamma Knife®	0

11. Linear Accelerator Treatment Data *continued*

a. Number of patients who received a course of radiation oncology treatments on linear accelerators (not the Gamma Knife®). Patients shall be counted once if they receive one course of treatment and more if they receive additional courses of treatment. For example, one patient who receives one course of treatment counts as one, and one patient who receives three courses of treatment counts as three.
Patients 634 **(This number should match the number of patients reported in the Linear Accelerator Patient Origin Table on page 34.)**

b. Linear Accelerators
1. TOTAL number of Linear Accelerator(s) 1
2. Of the TOTAL number above, number of Linear Accelerators configured for stereotactic radiosurgery 0
3. Of the TOTAL number above, Number of CyberKnife® Systems: 0
4. Of the TOTAL number above, -other specialized linear accelerators 0

c. Number of Gamma Knife® units 0

d.

e. Number of treatment simulators ("machine that produces high quality diagnostic radiographs and precisely reproduces the geometric relationships of megavoltage radiation therapy equipment to the patient."(GS 131E-176(24b))) 2

12. Additional Services:

a) **Check if Service(s) is provided: (for dialysis stations, show number of stations)**

	Check		Check
1. Cardiac Rehab Program (Outpatient)	✓	5. Rehabilitation Outpatient Unit	✓
2. Chemotherapy	✓	6. Podiatric Services	
3. Clinical Psychology Services	✓	7. Genetic Counseling Service	
4. Dental Services		7. Inpatient Dialysis Services. If checked, number of stations: 15	✓

12. Additional Services: ***continued***

b) **Hospice Inpatient Unit Data:**
Hospital-based hospice units with licensed hospice beds. List each county served and report **all patients by county of residence**. Use each patient's age on the admission day to the Licensed Hospice Inpatient Facility. **For age categories count each inpatient client only once.**

County of Residence	Age 0-17	Age 18-40	Age 41-59	Age 60-64	Age 65-74	Age 75-84	Age 85+	Total Patients Served	Total Days of Care	Deaths
Out of State										
Total All Ages										

c) **Mental Health and Substance Abuse**

1. If psychiatric care has a different name than the hospital, please indicate:
   NHRMC Behavioral Health Hospital
2. If address is different than the hospital, please indicate:

3. Director of the above services.
   Karen Pleva, AVP/Administrator - Behavioral Health Hospital

12. Additional Services: *continued*

c) Mental Health and Substance Abuse *(continued)*

Indicate the program/unit location in the **Service Categories** chart below. If it is in the hospital, include the room number. If it is located at another site, include the building name, program/unit name and address.

Service Categories: All applicants must complete the following table for all mental health services which are to be provided by the facility. If the service is not offered, leave the spaces blank.

Rule 10A NCAC 27G Licensure Rules for Mental Health Facilities	Location of Services	Beds Assigned by Age					
		< 6	6-12	13-17	Total 0-17	18 & up	Total Beds
.1100 Partial hospitalization for individuals who are acutely mentally ill.							
.1200 Psychosocial rehabilitation facilities for individuals with severe and persistent mental illness							
.1300 Residential treatment facilities for children and adolescents who are emotionally disturbed or have a mental illness							
.1400 Day treatment for children and adolescents with emotional or behavioral disturbances							
.1500 Intensive residential treatment facilities for children & adolescents who are emotionally disturbed or who have a mental illness							
.5000 Facility Based Crisis Center							

Rule 10A NCAC 13B Licensure Rules for Hospitals	Location of Services	Beds Assigned by Age					
		< 6	6-12	13-17	Total 0-17	18 & up	Total Beds
.5200 Dedicated inpatient unit for individuals who have mental disorders	NHRMC Behavioral Health Hospital					62	62

12. Additional Services: *continued*

c) Mental Health and Substance Abuse *continued*

Rule 10A NCAC 27G Licensure Rules for Substance Abuse Facilities	Location of Services	Beds Assigned by Age					
		< 6	6-12	13-17	Total 0-17	18 & up	Total Beds
.3100 Nonhospital medical detoxification for individuals who are substance abusers							
.3200 Social setting detoxification for substance abusers							
.3300 Outpatient detoxification for substance abusers							
.3400 Residential treatment/ rehabilitation for individuals with substance abuse disorders							
.3500 Outpatient facilities for individuals with substance abuse disorders							
.3600 Outpatient narcotic addiction treatment							
.3700 Day treatment facilities for individuals with substance abuse disorders							

Rule 10A NCAC 13B Licensure Rules for Hospitals	Location of Services	Beds Assigned by Age					
		< 6	6-12	13-17	Total 0-17	18 & up	Total Beds
.5200 Dedicated inpatient hospital unit for individuals who have substance abuse disorders (specify type) # of Treatment beds _____							

Patient Origin - General Acute Care Inpatient Services

Facility County: New Hanover

In an effort to document patterns of utilization of General Acute Care Inpatient Services in North Carolina hospitals, please provide the county of residence for each patient admitted to your facility. **Must match number of admissions on page 5, Section B-a.**

County	No. of Admissions	County	No. of Admissions	County	No. of Admissions
1. Alamance	20	37. Gates		73. Person	5
2. Alexander		38. Graham		74. Pitt	16
3. Alleghany	1	39. Granville	4	75. Polk	1
4. Anson		40. Greene	2	76. Randolph	9
5. Ashe	3	41. Guilford	20	77. Richmond	3
6. Avery	3	42. Halifax	8	78. Robeson	156
7. Beaufort	14	43. Harnett	13	79. Rockingham	1
8. Bertie	1	44. Haywood	2	80. Rowan	5
9. Bladen	549	45. Henderson	2	81. Rutherford	
10. Brunswick	6,359	46. Hertford	1	82. Sampson	340
11. Buncombe	7	47. Hoke		83. Scotland	3
12. Burke	1	48. Hyde		84. Stanly	2
13. Cabarrus	3	49. Iredell	9	85. Stokes	3
14. Caldwell	2	50. Jackson	2	86. Surry	5
15. Camden		51. Johnston	13	87. Swain	
16. Carteret	93	52. Jones	32	88. Transylvania	1
17. Caswell	1	53. Lee	7	89. Tyrrell	
18. Catawba	4	54. Lenoir	36	90. Union	11
19. Chatham	6	55. Lincoln	7	91. Vance	1
20. Cherokee	1	56. Macon	1	92. Wake	96
21. Chowan		57. Madison	1	93. Warren	
22. Clay		58. Martin	4	94. Washington	3
23. Cleveland	4	59. McDowell	6	95. Watauga	3
24. Columbus	1,925	60. Mecklenburg	42	96. Wayne	50
25. Craven	56	61. Mitchell		97. Wilkes	1
26. Cumberland	48	62. Montgomery	2	98. Wilson	4
27. Currituck		63. Moore	8	99. Yadkin	2
28. Dare	3	64. Nash	6	100. Yancey	1
29. Davidson	6	65. New Hanover	17,678		
30. Davie	1	66. Northampton	1	101. Georgia	37
31. Duplin	1,252	67. Onslow	2,654	102. South Carolina	163
32. Durham	15	68. Orange	12	103. Tennessee	16
33. Edgecombe	2	69. Pamlico	6	104. Virginia	98
34. Forsyth	19	70. Pasquotank	4	105. Other States	433
35. Franklin	1	71. Pender	4,688	106. Other	
36. Gaston	11	72. Perquimans	1	**Total No. of Patients**	37,152

Patient Origin – Inpatient Surgical Cases

Facility County: New Hanover

In an effort to document patterns of Inpatient utilization of Surgical Services in North Carolina hospitals, please provide the county of residence for each inpatient surgical patient served in your facility. Count each inpatient surgical patient once regardless of the number of surgical procedures performed while the patient was having surgery. However, each admission as an inpatient surgical case should be reported separately.

The Total from this chart should match the Total Inpatient Cases reported on the "Surgical Cases by Specialty Area" Table on page 12.

County	No. of Patients	County	No. of Patients	County	No. of Patients
1. Alamance	9	37. Gates		73. Person	1
2. Alexander		38. Graham		74. Pitt	11
3. Alleghany		39. Granville		75. Polk	
4. Anson		40. Greene	1	76. Randolph	5
5. Ashe		41. Guilford	9	77. Richmond	4
6. Avery	1	42. Halifax	1	78. Robeson	71
7. Beaufort	12	43. Harnett	11	79. Rockingham	1
8. Bertie	1	44. Haywood	3	80. Rowan	2
9. Bladen	210	45. Henderson		81. Rutherford	
10. Brunswick	2,519	46. Hertford		82. Sampson	150
11. Buncombe	1	47. Hoke		83. Scotland	2
12. Burke		48. Hyde		84. Stanly	
13. Cabarrus		49. Iredell		85. Stokes	1
14. Caldwell		50. Jackson		86. Surry	1
15. Camden	1	51. Johnston	8	87. Swain	
16. Carteret	50	52. Jones	14	88. Transylvania	
17. Caswell		53. Lee	1	89. Tyrrell	
18. Catawba	1	54. Lenoir	24	90. Union	2
19. Chatham	3	55. Lincoln	1	91. Vance	
20. Cherokee	1	56. Macon		92. Wake	30
21. Chowan		57. Madison	2	93. Warren	
22. Clay		58. Martin	1	94. Washington	1
23. Cleveland		59. McDowell		95. Watauga	3
24. Columbus	721	60. Mecklenburg	13	96. Wayne	30
25. Craven	32	61. Mitchell		97. Wilkes	
26. Cumberland	25	62. Montgomery	2	98. Wilson	1
27. Currituck		63. Moore	3	99. Yadkin	
28. Dare	2	64. Nash	1	100. Yancey	
29. Davidson	1	65. New Hanover	5,376		
30. Davie		66. Northampton		101. Georgia	8
31. Duplin	489	67. Onslow	1,162	102. South Carolina	81
32. Durham	4	68. Orange		103. Tennessee	10
33. Edgecombe		69. Pamlico	2	104. Virginia	39
34. Forsyth	3	70. Pasquotank	1	105. Other States	121
35. Franklin	1	71. Pender	1,511	106. Other	
36. Gaston	5	72. Perquimans	1	**Total No. of Patients**	12,815

Patient Origin – Ambulatory Surgical Cases

Facility County: New Hanover

In an effort to document patterns of Ambulatory utilization of Surgical Services in North Carolina hospitals, please provide the county of residence for each ambulatory surgery patient served in your facility. Count each ambulatory patient once regardless of the number of procedures performed while the patient was having surgery. However, each admission as an ambulatory surgery case should be reported separately.

The Total from this chart should match the Total Ambulatory Surgical Cases reported on the "Surgical Cases by Specialty Area" Table on page 12.

County	No. of Patients	County	No. of Patients	County	No. of Patients
1. Alamance	9	37. Gates		73. Person	2
2. Alexander	1	38. Graham		74. Pitt	37
3. Alleghany		39. Granville	1	75. Polk	1
4. Anson	1	40. Greene	2	76. Randolph	
5. Ashe	1	41. Guilford	9	77. Richmond	4
6. Avery		42. Halifax	4	78. Robeson	76
7. Beaufort	11	43. Harnett	18	79. Rockingham	4
8. Bertie		44. Haywood	1	80. Rowan	4
9. Bladen	320	45. Henderson	1	81. Rutherford	
10. Brunswick	4,594	46. Hertford	2	82. Sampson	205
11. Buncombe		47. Hoke	7	83. Scotland	5
12. Burke	1	48. Hyde	2	84. Stanly	
13. Cabarrus	4	49. Iredell	5	85. Stokes	
14. Caldwell		50. Jackson		86. Surry	2
15. Camden		51. Johnston	9	87. Swain	1
16. Carteret	141	52. Jones	51	88. Transylvania	1
17. Caswell		53. Lee	3	89. Tyrrell	
18. Catawba	1	54. Lenoir	35	90. Union	4
19. Chatham	2	55. Lincoln	3	91. Vance	1
20. Cherokee		56. Macon		92. Wake	34
21. Chowan		57. Madison		93. Warren	
22. Clay		58. Martin		94. Washington	2
23. Cleveland	2	59. McDowell	1	95. Watauga	2
24. Columbus	1,238	60. Mecklenburg	10	96. Wayne	30
25. Craven	72	61. Mitchell		97. Wilkes	3
26. Cumberland	49	62. Montgomery	1	98. Wilson	4
27. Currituck	1	63. Moore	3	99. Yadkin	
28. Dare	1	64. Nash	7	100. Yancey	2
29. Davidson	4	65. New Hanover	10,947		
30. Davie		66. Northampton		101. Georgia	16
31. Duplin	890	67. Onslow	2,362	102. South Carolina	221
32. Durham	5	68. Orange	5	103. Tennessee	12
33. Edgecombe	2	69. Pamlico	13	104. Virginia	29
34. Forsyth	5	70. Pasquotank	1	105. Other States	192
35. Franklin		71. Pender	2,933	106. Other	
36. Gaston	2	72. Perquimans		**Total No. of Patients**	24,687

Patient Origin – Gastrointestinal Endoscopy (GI) Cases

Facility County: New Hanover

In an effort to document patterns of utilization of Gastrointestinal Endoscopy Services in North Carolina hospitals, please provide the county of residence for each GI Endoscopy patient served in your facility. Count each patient once regardless of the number of procedures performed while the patient was receiving GI Endoscopy Services. However, each admission for GI Endoscopy services should be reported separately.

The Total from this chart should match the GI Endoscopy cases reported on the "Gastrointestinal Endoscopy Rooms, Cases and Procedures" Table on page 11 plus the Inpatient and Ambulatory GI Endoscopy cases from the "Non-Surgical Cases by Category" Table on page 12. Do not include patients from the "Non-GI Endoscopy Cases" fields on page 12.

County	No. of Patients	County	No. of Patients	County	No. of Patients
1. Alamance	2	37. Gates		73. Person	1
2. Alexander		38. Graham		74. Pitt	10
3. Alleghany		39. Granville	1	75. Polk	
4. Anson		40. Greene	1	76. Randolph	3
5. Ashe		41. Guilford	5	77. Richmond	1
6. Avery		42. Halifax	1	78. Robeson	45
7. Beaufort	1	43. Harnett	2	79. Rockingham	
8. Bertie	1	44. Haywood		80. Rowan	2
9. Bladen	117	45. Henderson		81. Rutherford	
10. Brunswick	1,541	46. Hertford		82. Sampson	67
11. Buncombe	1	47. Hoke	2	83. Scotland	1
12. Burke		48. Hyde		84. Stanly	2
13. Cabarrus		49. Iredell	2	85. Stokes	1
14. Caldwell		50. Jackson		86. Surry	1
15. Camden		51. Johnston	2	87. Swain	
16. Carteret	18	52. Jones	5	88. Transylvania	
17. Caswell		53. Lee	1	89. Tyrrell	
18. Catawba		54. Lenoir	21	90. Union	2
19. Chatham	1	55. Lincoln	3	91. Vance	
20. Cherokee		56. Macon	1	92. Wake	15
21. Chowan		57. Madison		93. Warren	
22. Clay		58. Martin		94. Washington	
23. Cleveland		59. McDowell		95. Watauga	1
24. Columbus	436	60. Mecklenburg		96. Wayne	10
25. Craven	14	61. Mitchell		97. Wilkes	
26. Cumberland	18	62. Montgomery		98. Wilson	
27. Currituck		63. Moore		99. Yadkin	
28. Dare	2	64. Nash	1	100. Yancey	
29. Davidson	1	65. New Hanover	4,138		
30. Davie		66. Northampton		101. Georgia	1
31. Duplin	312	67. Onslow	606	102. South Carolina	31
32. Durham	2	68. Orange	4	103. Tennessee	3
33. Edgecombe		69. Pamlico	1	104. Virginia	16
34. Forsyth	3	70. Pasquotank		105. Other States	57
35. Franklin		71. Pender	1,095	106. Other	
36. Gaston	3	72. Perquimans		**Total No. of Patients**	8,635

Patient Origin - Psychiatric and Substance Abuse

Facility County: New Hanover

Complete the following table below for inpatient Days of Care reported under Section .5200 on page 24-25.

County of Patient Origin	Psychiatric Treatment Days of Care					Substance Abuse Treatment Days of Care				
	Age < 6	Age 6-12	Age 13-17	Age 18 +	Total	Age < 6	Age 6-12	Age 13-17	Age 18 +	Total
Example: Wake		5	8	30	43			10	2	12
1. Alamance				10	10					
2. Alexander										
3. Alleghany										
4. Anson										
5. Ashe										
6. Avery										
7. Beaufort				6	6					
8. Bertie										
9. Bladen				44	44					
10. Brunswick				2,148	2,148					
11. Buncombe				12	12					
12. Burke										
13. Cabarrus				9	9					
14. Caldwell										
15. Camden										
16. Carteret				33	33					
17. Caswell										
18. Catawba				17	17					
19. Chatham				1	1					
20. Cherokee										
21. Chowan										
22. Clay										
23. Cleveland										
24. Columbus				508	508					
25. Craven				4	4					
26. Cumberland				27	27					
27. Currituck										
28. Dare				6	6					
29. Davidson				9	9					
30. Davie										
31. Duplin				108	108					
32. Durham				23	23					
33. Edgecombe										
34. Forsyth				23	23					
35. Franklin				3	3					
36. Gaston				35	35					
37. Gates										
38. Graham										
39. Granville										
40. Greene				2	2					
41. Guilford				27	27					
42. Halifax				18	18					
43. Harnett				13	13					

Continued on next page

All responses should pertain to **October 1, 2015 through September 30, 2016.**

County of Patient Origin	Psychiatric Treatment Days of Care					Substance Abuse Treatment Days of Care				
	Age < 6	Age 6-12	Age 13-17	Age 18 +	Total	Age < 6	Age 6-12	Age 13-17	Age 18 +	Total
44. Haywood										
45. Henderson										
46. Hertford										
47. Hoke										
48. Hyde										
49. Iredell				8	8					
50. Jackson										
51. Johnston				15	15					
52. Jones				135	135					
53. Lee				1	1					
54. Lenoir										
55. Lincoln				5	5					
56. Macon										
57. Madison										
58. Martin										
59. McDowell										
60. Mecklenburg				63	63					
61. Mitchell										
62. Montgomery										
63. Moore				3	3					
64. Nash				7	7					
65. New Hanover				10,123	10,123					
66. Northampton										
67. Onslow				288	288					
68. Orange				13	13					
69. Pamlico										
70. Pasquotank										
71. Pender				1,275	1,275					
72. Perquimans										
73. Person										
74. Pitt				8	8					
75. Polk				5	5					
76. Randolph										
77. Richmond				3	3					
78. Robeson				28	28					
79. Rockingham				21	21					
80. Rowan										
81. Rutherford										
82. Sampson				74	74					
83. Scotland										
84. Stanly										
85. Stokes				15	15					
86. Surry				13	13					
87. Swain										
88. Transylvania										
89. Tyrrell										
90. Union				8	8					
91. Vance										
92. Wake				72	72					

Continued on next page

All responses should pertain to **October 1, 2015 through September 30, 2016.**

County of Patient Origin	Psychiatric Treatment Days of Care					Substance Abuse Treatment Days of Care				
	Age < 6	Age 6-12	Age 13-17	Age 18 +	Total	Age < 6	Age 6-12	Age 13-17	Age 18 +	Total
93. Warren										
94. Washington										
95. Watauga										
96. Wayne				6	6					
97. Wilkes										
98. Wilson				47	47					
99. Yadkin										
100. Yancey										
101. Out of State				423	423					
TOTAL					15,745					

All responses should pertain to **October 1, 2015 through September 30, 2016.**

Patient Origin - MRI Services

Facility County: New Hanover

In an effort to document patterns of utilization of MRI Services in North Carolina, hospitals are asked to provide county of residence for each patient served in your facility. **The total number of patients reported here should be equal to or less than the total number of MRI procedures reported in Table 10a. on page 17.**

County	No. of Patients	County	No. of Patients	County	No. of Patients
1. Alamance	8	37. Gates		73. Person	1
2. Alexander		38. Graham		74. Pitt	5
3. Alleghany	2	39. Granville		75. Polk	
4. Anson		40. Greene	1	76. Randolph	1
5. Ashe	1	41. Guilford	8	77. Richmond	1
6. Avery		42. Halifax	5	78. Robeson	46
7. Beaufort	3	43. Harnett	6	79. Rockingham	
8. Bertie		44. Haywood	2	80. Rowan	
9. Bladen	167	45. Henderson	1	81. Rutherford	
10. Brunswick	2,796	46. Hertford		82. Sampson	96
11. Buncombe		47. Hoke		83. Scotland	
12. Burke		48. Hyde		84. Stanly	
13. Cabarrus	4	49. Iredell	1	85. Stokes	1
14. Caldwell		50. Jackson		86. Surry	2
15. Camden		51. Johnston	5	87. Swain	
16. Carteret	30	52. Jones	6	88. Transylvania	
17. Caswell		53. Lee	3	89. Tyrrell	
18. Catawba	3	54. Lenoir	9	90. Union	1
19. Chatham	3	55. Lincoln		91. Vance	
20. Cherokee		56. Macon	2	92. Wake	26
21. Chowan		57. Madison	1	93. Warren	
22. Clay		58. Martin		94. Washington	1
23. Cleveland	1	59. McDowell		95. Watauga	1
24. Columbus	633	60. Mecklenburg	11	96. Wayne	11
25. Craven	12	61. Mitchell		97. Wilkes	1
26. Cumberland	8	62. Montgomery		98. Wilson	
27. Currituck		63. Moore	3	99. Yadkin	1
28. Dare		64. Nash	2	100. Yancey	
29. Davidson	1	65. New Hanover	6,748		
30. Davie		66. Northampton		101. Georgia	11
31. Duplin	360	67. Onslow	737	102. South Carolina	45
32. Durham	4	68. Orange	5	103. Tennessee	4
33. Edgecombe		69. Pamlico	1	104. Virginia	20
34. Forsyth	5	70. Pasquotank		105. Other States	124
35. Franklin		71. Pender	1,699	106. Other	1
36. Gaston	1	72. Perquimans		**Total No. of Patients**	13,698

All responses should pertain to **October 1, 2015 through September 30, 2016.**

Patient Origin – Linear Accelerator Treatment

Facility County: New Hanover

In an effort to document patterns of utilization of linear accelerators in North Carolina, hospitals are asked to provide the county of residence for patients served on linear accelerators in your facility. Report the number of patients who receive radiation oncology treatment on equipment (linear accelerators, CyberKnife®, but not Gamma Knife®) listed in Section 11 of this application. Patients shall be counted once if they receive one course of treatment and more if they receive additional courses of treatment. For example, one patient who receives one course of treatment counts as one, and one patient who receives three courses of treatment counts as three. **The number of patients reported here should match the number of patients reported in Section 11.a. on page 22 of this application.**

County	No. of Patients	County	No. of Patients	County	No. of Patients
1. Alamance		37. Gates		73. Person	
2. Alexander		38. Graham		74. Pitt	
3. Alleghany		39. Granville		75. Polk	
4. Anson		40. Greene		76. Randolph	
5. Ashe		41. Guilford		77. Richmond	
6. Avery		42. Halifax		78. Robeson	1
7. Beaufort		43. Harnett		79. Rockingham	
8. Bertie		44. Haywood		80. Rowan	
9. Bladen	11	45. Henderson		81. Rutherford	
10. Brunswick	94	46. Hertford		82. Sampson	1
11. Buncombe		47. Hoke		83. Scotland	
12. Burke		48. Hyde		84. Stanly	
13. Cabarrus		49. Iredell		85. Stokes	
14. Caldwell		50. Jackson		86. Surry	
15. Camden		51. Johnston		87. Swain	
16. Carteret		52. Jones		88. Transylvania	
17. Caswell		53. Lee		89. Tyrrell	
18. Catawba		54. Lenoir	1	90. Union	
19. Chatham		55. Lincoln		91. Vance	
20. Cherokee		56. Macon		92. Wake	
21. Chowan		57. Madison		93. Warren	
22. Clay		58. Martin		94. Washington	
23. Cleveland		59. McDowell		95. Watauga	
24. Columbus	65	60. Mecklenburg		96. Wayne	
25. Craven		61. Mitchell		97. Wilkes	
26. Cumberland		62. Montgomery		98. Wilson	
27. Currituck		63. Moore		99. Yadkin	
28. Dare	1	64. Nash		100. Yancey	
29. Davidson		65. New Hanover	295		
30. Davie		66. Northampton		101. Georgia	
31. Duplin	20	67. Onslow	32	102. South Carolina	3
32. Durham		68. Orange		103. Tennessee	
33. Edgecombe		69. Pamlico		104. Virginia	
34. Forsyth		70. Pasquotank		105. Other States	6
35. Franklin		71. Pender	104	106. Other	
36. Gaston		72. Perquimans		**Total No. of Patients**	634

Patient Origin – PET Scanner

Facility County: New Hanover

In an effort to document patterns of utilization of PET Scanners in North Carolina, hospitals are asked to provide county of residence for each patient served in your facility. This data should only reflect the number of patients, not number of scans and should not include other radiopharmaceutical or supply charge codes. **Please count each patient only once. The number of patients in this table should match the number of PET procedures reported in Table 10h on page 20.**

County	No. of Patients	County	No. of Patients	County	No. of Patients
1. Alamance		37. Gates		73. Person	
2. Alexander		38. Graham		74. Pitt	1
3. Alleghany		39. Granville		75. Polk	
4. Anson		40. Greene		76. Randolph	
5. Ashe		41. Guilford	2	77. Richmond	
6. Avery		42. Halifax		78. Robeson	
7. Beaufort		43. Harnett	1	79. Rockingham	1
8. Bertie		44. Haywood		80. Rowan	
9. Bladen	23	45. Henderson		81. Rutherford	
10. Brunswick	510	46. Hertford		82. Sampson	11
11. Buncombe		47. Hoke		83. Scotland	
12. Burke		48. Hyde		84. Stanly	
13. Cabarrus		49. Iredell		85. Stokes	
14. Caldwell		50. Jackson		86. Surry	
15. Camden		51. Johnston		87. Swain	
16. Carteret	8	52. Jones	1	88. Transylvania	
17. Caswell		53. Lee		89. Tyrrell	
18. Catawba		54. Lenoir	1	90. Union	
19. Chatham		55. Lincoln		91. Vance	
20. Cherokee		56. Macon		92. Wake	
21. Chowan		57. Madison		93. Warren	
22. Clay		58. Martin		94. Washington	
23. Cleveland		59. McDowell		95. Watauga	
24. Columbus	119	60. Mecklenburg		96. Wayne	1
25. Craven	3	61. Mitchell		97. Wilkes	
26. Cumberland	4	62. Montgomery		98. Wilson	
27. Currituck		63. Moore		99. Yadkin	
28. Dare		64. Nash		100. Yancey	
29. Davidson		65. New Hanover	763		
30. Davie		66. Northampton		101. Georgia	
31. Duplin	52	67. Onslow	136	102. South Carolina	10
32. Durham	1	68. Orange		103. Tennessee	
33. Edgecombe		69. Pamlico		104. Virginia	7
34. Forsyth		70. Pasquotank		105. Other States	9
35. Franklin		71. Pender	183	106. Other	
36. Gaston		72. Perquimans		**Total No. of Patients**	1,847

All responses should pertain to **October 1, 2015 through September 30, 2016.**

Patient Origin – Emergency Department Services

Facility County: New Hanover

In an effort to document the patterns of utilization of Emergency Department Services in North Carolina hospitals, please provide the county of residence for all patients served by your Emergency Department. The total number of patients from this chart must match the number of Emergency Department visits provided in Section F.(3)(b) : Emergency Department Services, Page 8.

County	No. of Visits	County	No. of Visits	County	No. of Visits
1. Alamance	110	37. Gates	10	73. Person	25
2. Alexander	4	38. Graham		74. Pitt	97
3. Alleghany	2	39. Granville	21	75. Polk	11
4. Anson	10	40. Greene	7	76. Randolph	48
5. Ashe	13	41. Guilford	261	77. Richmond	19
6. Avery	6	42. Halifax	31	78. Robeson	167
7. Beaufort	26	43. Harnett	100	79. Rockingham	21
8. Bertie	5	44. Haywood	21	80. Rowan	38
9. Bladen	692	45. Henderson	13	81. Rutherford	6
10. Brunswick	16,219	46. Hertford	4	82. Sampson	546
11. Buncombe	40	47. Hoke	13	83. Scotland	14
12. Burke	11	48. Hyde	2	84. Stanly	19
13. Cabarrus	80	49. Iredell	67	85. Stokes	30
14. Caldwell	17	50. Jackson	10	86. Surry	30
15. Camden	2	51. Johnston	123	87. Swain	1
16. Carteret	139	52. Jones	31	88. Transylvania	7
17. Caswell	4	53. Lee	64	89. Tyrrell	3
18. Catawba	50	54. Lenoir	61	90. Union	113
19. Chatham	29	55. Lincoln	30	91. Vance	26
20. Cherokee	3	56. Macon	3	92. Wake	806
21. Chowan	4	57. Madison	6	93. Warren	1
22. Clay	3	58. Martin	14	94. Washington	7
23. Cleveland	28	59. McDowell	10	95. Watauga	15
24. Columbus	4,258	60. Mecklenburg	330	96. Wayne	138
25. Craven	107	61. Mitchell		97. Wilkes	15
26. Cumberland	283	62. Montgomery	16	98. Wilson	34
27. Currituck	5	63. Moore	65	99. Yadkin	11
28. Dare	25	64. Nash	51	100. Yancey	3
29. Davidson	50	65. New Hanover	86,651		
30. Davie	10	66. Northampton	1	101. Georgia	245
31. Duplin	1,596	67. Onslow	5,985	102. South Carolina	517
32. Durham	128	68. Orange	93	103. Tennessee	119
33. Edgecombe	15	69. Pamlico	7	104. Virginia	568
34. Forsyth	144	70. Pasquotank	10	105. Other States	2,834
35. Franklin	36	71. Pender	17,063	106. Other	43
36. Gaston	60	72. Perquimans	2	**Total No. of Patients**	141,967

All responses should pertain to **October 1, 2015 through September 30, 2016**.

This application must be completed and submitted to the Acute and Home Care Licensure and Certification Section, Division of Health Service Regulation prior to the issuance of a 2017 hospital license.

AUTHENTICATING SIGNATURE: The undersigned submits application for the year 2017 in accordance with Article 5, Chapter 131E of the General Statutes of North Carolina, and subject to the rules and codes adopted thereunder by the North Carolina Medical Care Commission (10A NCAC 13B), and certifies the accuracy of this information.

Signature: _____ **Date:** 12/16/16

PRINT NAME OF APPROVING OFFICIAL _____

Please be advised, the license fee must accompany the completed application and be submitted to the Acute and Home Care Licensure and Certification Section, Division of Health Service Regulation, prior to the issuance of a hospital license.

Attachment 5

New Hanover Regional Medical Center Project ID# O-11189-16, Issued CON and Findings

STATE OF NORTH CAROLINA

Department of Health and Human Services
Division of Health Service Regulation

CERTIFICATE OF NEED

for

Project ID #: O-11189-16
FID #: 943372

ISSUED TO: **New Hanover Regional Medical Center**
2131 S. 17th Street
Wilmington, NC 28402

Pursuant to G.S. 131E-175, the North Carolina Department of Health and Human Services hereby authorizes the person or persons named above (the "certificate holder") to develop the certificate of need project identified above. The certificate holder shall develop the project in a manner consistent with the representations in the project application and with the conditions contained herein and shall make good faith efforts to meet the timetable contained herein, as documented by the periodic progress reports required by 10A NCAC 14C .0209. The certificate holder shall not exceed the maximum capital expenditure amount specified herein during the development of this project, except as provided by G.S. 131E-176(16)e. The certificate holder shall not transfer or assign this certificate to any other person except as provided in G.S. 131E-189(c). This certificate is valid only for the scope, physical location, and person(s) described herein. The Department may withdraw this certificate pursuant to G.S. 131E-189 for any of the reasons provided in that law.

SCOPE: **Construct additional floors on top of the existing Surgical Pavilion, relocate 68 acute care beds from NHRMC Orthopedic Hospital, and relocate five operating rooms from NHRMC Orthopedic Hospital, which results in a change of scope for Project I.D. #O-11042-15 (add 31 acute care beds and relocate nine acute care beds) / New Hanover County**

CONDITIONS: **See Reverse Side**

PHYSICAL LOCATION: **New Hanover Regional Medical Center**
2131 S. 17th Street
Wilmington, NC 28402

MAXIMUM CAPITAL EXPENDITURE: **$86,878,371**

TIMETABLE: **See Reverse Side**

FIRST PROGRESS REPORT DUE: **August 1, 2017**

This certificate is effective as of the 17th day of December, 2016

Martha J. Frisone, Assistant Chief

CONDITIONS:

1. **New Hanover Regional Medical Center shall materially comply with all representations made in the certificate of need application and in clarifying information received October 31, 2016.**

2. **New Hanover Regional Medical Center shall materially comply with all the conditions of approval on the certificate of need for Project I.D. #O-11042-15, except as specifically modified by the conditions of approval for this application, Project I.D. #O-11189-16.**

3. **New Hanover Regional Medical Center shall develop a 108-bed patient tower over the existing Surgical Pavilion by relocating 68 existing acute care beds and five operating rooms from the NHRMC Orthopedic Hospital to the NHRMC 17th Street campus as well as by including the acute care beds approved in Project I.D. #O-11042-15.**

4. **New Hanover Regional Medical Center shall de-license 68 acute care beds and five operating rooms at NHRMC Orthopedic Hospital. Following completion of this project and Project I.D. #O-11042-15, New Hanover Regional Medical Center shall be licensed for no more than 38 operating rooms, including 29 shared operating rooms, four dedicated ambulatory surgery operating rooms, three dedicated C-section operating rooms, and two dedicated open heart surgery operating rooms, and for no more than 678 general acute care beds.**

5. **New Hanover Regional Medical Center shall not acquire, as part of this project, any equipment that is not included in the project's proposed capital expenditures in Section VIII of the application and that would otherwise require a certificate of need.**

6. **New Hanover Regional Medical Center shall develop and implement an Energy Efficiency and Sustainability Plan for the project that conforms to or exceeds energy efficiency and water conservation standards incorporated in the latest editions of the North Carolina State Building Codes.**

7. **New Hanover Regional Medical Center shall acknowledge acceptance of and agree to comply with all conditions stated herein to the Certificate of Need Section in writing prior to issuance of the certificate of need.**

A letter acknowledging acceptance of and agreeing to comply with all conditions stated in the conditional approval letter was received by the Agency on December 19, 2016.

TIMETABLE:

Final Drawings and Specifications to the Construction Section, DHSR	**July 15, 2017**
Construction Contract Executed/Contract Award	**December 1, 2017**
25% Completion of Construction	**July 1, 2018**
50% Completion of Construction	**December 1, 2018**
75% Completion of Construction	**April 1, 2019**
Completion of Construction	**September 1, 2019**
Occupancy/offering of Service	**October 1, 2019**

ATTACHMENT - REQUIRED STATE AGENCY FINDINGS

FINDINGS
C = Conforming
CA = Conditional
NC = Nonconforming
NA = Not Applicable

Decision Date: November 16, 2016
Findings Date: November 16, 2016

Project Analyst: Julie Halatek
Team Leader: Fatimah Wilson

Project ID #: O-11189-16
Facility: New Hanover Regional Medical Center
FID #: 943372
County: New Hanover
Applicant: New Hanover Regional Medical Center
Project: Construct additional floors on top of the existing Surgical Pavilion, relocate 68 acute care beds from NHRMC Orthopedic Hospital, and relocate five operating rooms from NHRMC Orthopedic Hospital, which results in a change of scope for Project I.D. #O-11042-15 (add 31 acute care beds and relocate nine acute care beds)

REVIEW CRITERIA FOR NEW INSTITUTIONAL HEALTH SERVICES

G.S. 131E-183(a) The Department shall review all applications utilizing the criteria outlined in this subsection and shall determine that an application is either consistent with or not in conflict with these criteria before a certificate of need for the proposed project shall be issued.

(1) The proposed project shall be consistent with applicable policies and need determinations in the State Medical Facilities Plan, the need determination of which constitutes a determinative limitation on the provision of any health service, health service facility, health service facility beds, dialysis stations, operating rooms, or home health offices that may be approved.

C

New Hanover Regional Medical Center (NHRMC) proposes to relocate 68 existing acute care beds as well as five operating rooms from the existing NHRMC Orthopedic Hospital (Orthopedic Hospital) to the Surgical Pavilion on the 17th Street campus and to construct a 108-bed tower above the Surgical Pavilion. This project also involves a change of scope for Project I.D. #O-11042-15 (add 31 acute care beds and relocate nine existing acute care beds) by including those beds in the 108-bed tower.

Need Determination

The proposed project does not involve the addition of any new health service facility beds, services, or equipment for which there is a need determination in the 2016 State Medical Facilities Plan (SMFP). Therefore, there are no need determinations applicable to this review.

Policies

There are is one policy in the 2016 SMFP which is applicable to this review: Policy GEN-4: Energy Efficiency and Sustainability for Health Service Facilities.

Policy GEN-4 states:

> *"Any person proposing a capital expenditure greater than $2 million to develop, replace, renovate or add to a health service facility pursuant to G.S. 131E-178 shall include in its certificate of need application a written statement describing the project's plan to assure improved energy efficiency and water conservation.*
>
> *In approving a certificate of need proposing an expenditure greater than $5 million to develop, replace, renovate or add to a health service facility pursuant to G.S. 131E-178, the Certificate of Need Section shall impose a condition requiring the applicant to develop and implement an Energy Efficiency and Sustainability Plan for the project that conforms to or exceeds energy efficiency and water conservation standards incorporated in the latest editions of the North Carolina State Building Codes. The plan must be consistent with the applicant's representation in the written statement as described in paragraph one of Policy GEN-4.*
>
> *Any person awarded a certificate of need for a project or an exemption from review pursuant to G.S. 131E-184 are required to submit a plan of energy efficiency and water conservation that conforms to the rules, codes and standards implemented by the Construction Section of the Division of Health Service Regulation. The plan must be consistent with the applicant's representation in the written statement as described in paragraph one of Policy GEN-4. The plan shall not adversely affect patient or resident health, safety or infection control."*

The proposed capital expenditure for this project is greater than $5 million. In Section X.1, pages 133-134, and Section XI.7, page 142, the applicant provides a written statement describing the proposed project's plan to assure improved energy efficiency and water conservation. Therefore, the application is consistent with Policy GEN-4.

Conclusion

In summary, the application is consistent with Policy GEN-4. Consequently, the application is conforming to this criterion.

(2) Repealed effective July 1, 1987.

(3) The applicant shall identify the population to be served by the proposed project, and shall demonstrate the need that this population has for the services proposed, and the extent to which all residents of the area, and, in particular, low income persons, racial and ethnic minorities, women, handicapped persons, the elderly, and other underserved groups are likely to have access to the services proposed.

C

The applicant proposes to relocate 68 existing acute care beds as well as five operating rooms from the existing Orthopedic Hospital to the Surgical Pavilion on the 17th Street campus and to construct a 108-bed tower above the Surgical Pavilion. This project also involves a change of scope for Project I.D. #O-11042-15 (add 31 acute care beds and relocate nine existing acute care beds) by including those beds in the 108-bed tower.

In Section II.1, pages 16-17 and page 24, the applicant describes the current status of the Orthopedic Hospital, which was formerly Cape Fear Hospital before it was acquired by the applicant in 1998. The Orthopedic Hospital is described as a collection of buildings, building expansions, and building renovations that have been constructed or renovated over the last 70 years. Each particular project was constructed or renovated to the building code standard at the time it was constructed or renovated. The applicant states that during a review of the facility, it was determined that the collection of buildings needed considerable renovations or complete demolition and redevelopment to be viable for the level of healthcare delivery provided by the applicant.

The applicant states that after numerous meetings with varying stakeholders, the best alternative that emerged was to relocate the inpatient orthopedic services (both acute care beds and operating rooms) from the Orthopedic Hospital to a 108-bed tower built over the top of the existing Surgical Pavilion. To make the development of the 108-bed tower feasible, the 40 acute care beds to be developed or relocated as part of Project I.D. #O-11042-15 were included in the plans for the 108-bed tower. Renovations within the Surgical Pavilion will allow for the relocation of the inpatient operating rooms. Additionally, Project I.D. #O-11190-16 (relocate one GI endoscopy procedure room) and a future letter of exemption to be submitted that will allow for renovation of existing space to accommodate the four remaining GI endoscopy procedure rooms are also part of the master facility renovation plan. The outpatient operating rooms at the Orthopedic Hospital will be addressed through an application that the applicant plans to submit to the Agency in November 2016 for the December 1, 2016 review cycle.

Patient Origin

On page 48, the 2016 SMFP defines the service area for acute care bed services by county (or multicounty service area for counties without a hospital). On page 67, the 2016 SMFP defines the service area for operating room services by county (or multicounty service area for counties without a hospital). NHRMC is located in New Hanover County. Thus, the service area for this facility consists of New Hanover County. Facilities may also serve residents of counties not included in their service area.

In Section III.5(a), page 68, the applicant states that patients originating from Brunswick, Columbus, New Hanover, Onslow, and Pender counties comprise more than 86 percent of its orthopedic days of care and surgical cases in FY 2015. In Sections III.4 and III.5, pages 67-71, the applicant provides its current and projected patient origin by county for orthopedic days of care as well as orthopedic surgical cases, as shown in the table below.

NHRMC Historical and Projected Patient Origin by County
Orthopedic Surgical Procedures and Days of Care – FY 2015 & FY 2020-2021

County	FY 2015		FY 2020		FY 2021	
	Ortho DoC	Ortho Surg.	Ortho DoC	Ortho Surg.	Ortho DoC	Ortho Surg.
New Hanover	46.2%	43.5%	46.2%	43.5%	46.2%	43.5%
Brunswick	16.2%	18.7%	16.2%	18.7%	16.2%	18.7%
Pender	10.2%	10.0%	10.2%	10.0%	10.2%	10.0%
Columbus	7.3%	6.9%	7.3%	6.9%	7.3%	6.9%
Onslow	6.3%	8.2%	6.3%	8.2%	6.3%	8.2%
Other*	13.8%	12.8%	13.8%	12.8%	13.8%	12.8%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

*The applicant provides a patient origin list by county or state of residence for the entire facility, including orthopedic services, on page 66. On page 68, the applicant states that it serves other North Carolina counties as well as South Carolina counties.

On page 71, the applicant states that it expects its patient origin to remain relatively consistent through FY 2022.

The applicant adequately identifies the population to be served.

Analysis of Need

In Section III.1(a) of the application, the applicant states the identified need is to relocate 68 existing acute care beds from the Orthopedic Hospital to a proposed 108-bed tower to be built above the existing Surgical Pavilion as well as relocation of the inpatient operating rooms from the Orthopedic Hospital to the Surgical Pavilion, due to the outdated condition of the existing Orthopedic Hospital and the potential costs associated with renovation. Throughout Section III, the applicant describes the factors which it states result in the need for the proposed project, including:

- Population growth trends for New Hanover County as well as Brunswick, Columbus, Onslow, and Pender counties (pages 54-57).
- NHRMC Physician Group has continued to expand and add to its physician network, thereby increasing the number of referrals to NHRMC facilities (page 58).
- The development of a new Accountable Care Organization (Physician Quality Partners) by NHRMC and a corresponding increase in NHRMC's market share (pages 59-60).
- Continued increases in NHRMC utilization, including monthly Code Lavender days (when inpatient medical-surgical units exceed 95 percent of their capacity) (page 61).
- Concerns about the cost of renovation to bring the Orthopedic Hospital up to code, as well as determining the useful life of the building and proximity to services, along with a lack of other viable options (pages 64-65).

In Section III.3, page 64, the applicant states:

> *"The existing NHRMC Orthopedic Hospital is a collection of individual buildings, building expansions, and building renovations that have constructed/renovated* [sic] *since before 1957.*
>
> *Each of the buildings, expansions, and renovations occurred under the building codes and healthcare delivery models of the time. This collection of buildings currently warrants considerable renovations or complete demolition and reconstruction to be viable facilities for the level of healthcare delivery expected from NHRMC in the future. These issues and concerns were identified and assessed through a series of facility and healthcare service line reviews. The costs to just bring the building to current code exceeds $20.0 million."*

Exhibit 4 contains a review done by Navigant Consulting, Inc., of the aforementioned needs and the costs to accomplish those needs at the Orthopedic Hospital. According to the Infrastructure Upgrade Summary and Budget Assessment, the low end and high end of the budget just to bring the building up to code is $17.5 million to $22.2 million, respectively. In Section III.3, page 64, the applicant states some of the concerns that were considered along the way were related to the provision of ancillary and support services, ease of patient access, support of medical staff for call and consult coverage, and the overhead costs of running two facilities instead of just one.

In Section II.1, pages 16-17, the applicant states that the proposed project will result in a change of scope for Project I.D. #O-11042-15, which was approved to develop a 40-bed acute care bed unit by developing 31 new acute care beds and converting nine existing semi-private rooms into private rooms. The capital expenditure for that project which will now be included in the capital expenditure for this project is $39,234,000.

In clarifying information received October 31, 2016, the applicant states that the costs listed in the application as those necessary to bring buildings up to code do not include costs such as equipment or furniture and do not include costs to demolish and replace buildings constructed prior to 1972 in order to continue operating the Orthopedic Hospital's operating rooms and beds.

The applicant's representations regarding the need to develop a new bed tower and to relocate the acute care beds and operating rooms to serve existing and projected patients are reasonable and adequately supported.

Projected Utilization

In Section IV.1, page 74, the applicant projects orthopedic inpatient days of care and orthopedic inpatient surgical utilization at NHRMC for the interim years and the first three fiscal years after completion of the project, as shown in the table below.

NHRMC Historical, Interim, & Projected Orthopedic Service Utilization									
	Historical		Interim				Projected		
	FFY 2014	FFY 2015	FFY 2016	FFY 2017	FFY 2018	FFY 2019	FFY 2020	FFY 2021	FFY 2022
Ortho Days of Care	11,524	11,866	12,208	12,562	12,930	13,311	13,706	14,078	14,464
Annual Change		342	342	354	368	381	395	372	386
Annual Change Rate		3.0%	2.9%	2.9%	2.9%	2.9%	3.0%	2.7%	2.7%
Ortho IP Surgical Cases	3,321	3,381	3,483	3,585	3,691	3,801	3,915	4,023	4,135
Annual Change		60	102	102	106	110	114	108	112
Annual Change Rate		1.8%	3.0%	3.0%	3.0%	3.0%	3.0%	2.8%	2.8%

In Section IV, pages 74-86, the applicant states that it hired Navigant Consulting (Navigant), a consulting firm that specializes in highly regulated industry sectors like healthcare, to assist in developing its strategic plan, which includes utilization projections. On page 76, the applicant states:

> *"Many of Navigant's analytical tools are proprietary models, which does not permit Navigant to supply each and every assumption that was utilized in the development of the service line volume projections. However, it is important to remember that Navigant's service line projections are individually modeled for each service line using the most current national, regional, state, and local data available, which may result in service line projections that mimic or are dramatically different from either simple trend lines or service area population growth."*

In Section IV, page 79, the applicant lists the following assumptions and methodologies that were used by Navigant to develop the utilization projections:

- The baseline year for forecasting inpatient volumes was FFY 2015.
- Market share from the seven counties with the highest NHRMC utilization was combined with age cohort data from Claritas to determine 2015 inpatient use rates (discharges per 1,000 population).
- Actual NHRMC FFY 2015 orthopedic market share and in-migration rates were used and assumed to remain constant during the entire projection period.
- Population estimates from Claritas for 2015 and 2020 were used to calculate estimates for five-year market volumes, and then average growth rates were applied to the interim years to develop interim year estimates.
- Elements in determining future inpatient market share included variables such as demographic changes, economic shifts, changes in disease incidence and technological/standard of care changes, service line strategies, actions of competitors, effects of new or renovated facilities, and reduction of in-migration due to added capacity.

The explanation of the utilization projections can be found on pages 80-86. Exhibit 9 contains additional data used by Navigant in projecting utilization.

In Section II.1, pages 16-17, Section III.3, pages 64-65, and in clarifying information received October 31, 2016, the applicant states that the purpose of the relocation of the beds and operating rooms is to consolidate services at one campus as well as avoid the excessive costs

that would be associated with the renovation of the existing Orthopedic Hospital campus. There are no Regulatory Review Criteria that are applicable to this project; therefore, there are no performance standards for utilization that must be met. The applicant's projections of the orthopedic surgeries and days of care following the relocation of existing beds and operating rooms and development of the new bed tower is based on reasonable and adequately supported assumptions. Therefore, the applicant adequately demonstrates the need to relocate 68 existing acute care beds and five operating rooms from the existing Orthopedic Hospital campus to the 17th Street campus, and to develop a 108-bed tower above the Surgical Pavilion to house those beds as well as beds approved as part of Project I.D. #O-11042-15.

Access

In Section VI.2, pages 110-111, the applicant states that it will provide services to all persons regardless of income, race, age, color, creed, religion, national origin, disability, or the level of care required. In Section VI.15, page 119, the applicant projects that 65.4 percent of its orthopedic inpatient service recipients and 66.6 percent of its medical/surgical inpatient service recipients will have some or all of their services paid for by Medicare and 4.3 percent of its orthopedic inpatient service recipients and 10.1 percent of its medical/surgical inpatient service recipients will have some or all of their services paid for by Medicaid during the second full operating year (FFY 2021). On pages 118-119, the applicant states that it based its projected payor mix on its FFY 2016 payor mix. The applicant adequately demonstrates the extent to which all residents of the area, including the medically underserved, are likely to have access to the proposed services.

Conclusion

In summary, the applicant adequately identifies the population to be served, adequately demonstrates the need that this population has for the proposed project and adequately demonstrates the extent to which all residents, including underserved groups, will have access to the proposed services. Therefore, the application is conforming to this criterion.

(3a) In the case of a reduction or elimination of a service, including the relocation of a facility or a service, the applicant shall demonstrate that the needs of the population presently served will be met adequately by the proposed relocation or by alternative arrangements, and the effect of the reduction, elimination or relocation of the service on the ability of low income persons, racial and ethnic minorities, women, handicapped persons, and other underserved groups and the elderly to obtain needed health care.

C

The applicant proposes to relocate 68 existing acute care beds and five operating rooms from the Orthopedic Hospital to its existing main campus. The geographic distance from the Orthopedic Hospital, located at 5301 Wrightsville Avenue in Wilmington, to the existing 17th Street campus in Wilmington, is approximately 5.5 miles. In Section II.1, pages 16-17, Section III.3, pages 64-65, and in clarifying information received October 31, 2016, the applicant provides the reasons it believes it is not feasible to continue to maintain and operate the acute care beds and operating rooms in their current location. The applicant provides reasonable and

adequately supported projections for the use of the operating rooms after relocation. The discussion regarding need and projected utilization found in Criterion (3) is incorporated herein by reference.

The applicant adequately demonstrates that the needs of the population presently served at the Orthopedic Hospital will be adequately met by the proposed relocation and that the proposal will not adversely affect the ability of medically underserved groups to obtain needed health care. Therefore, the application is conforming to this criterion.

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

CA

In Section III.3, pages 64-65, the applicant discusses the alternatives considered prior to the submission of this application, which include:

- Maintain the Status Quo – The applicant states that maintaining the status quo would involve costly renovation as well as complete demolition and reconstruction of the facility in order to maintain the level of healthcare delivery expected from NHRMC in the future. The applicant states in clarifying information received October 31, 2016 that the costs associated beyond just the renovation as well as continued costs of operating two separate campuses would be unreasonable. Therefore, this alternative was rejected.
- Pursue a Joint Venture – The applicant states that the project is specific to NHRMC's needs and all renovations and relocations will take place among physical NHRMC locations. Therefore, this alternative was rejected.
- Develop a New Hospital Campus – The applicant states that developing a freestanding, separately licensed hospital or a satellite outpatient and inpatient department campus of NHRMC is feasible to accomplish; however, the estimated construction costs of $65 million to $125 million is not reasonable to accomplish the goals of the project. Therefore, this alternative was rejected.
- Develop Orthopedic Beds on the NHRMC Campus – the applicant states that constructing a 108-bed tower above the existing surgical pavilion would be the most cost-effective and reasonable alternative.

After considering the above alternatives, the applicant states the proposed alternative represents the most effective alternative to meet the identified need.

Furthermore, the application is conforming to all other statutory and regulatory review criteria, and thus, is approvable. A project that cannot be approved cannot be an effective alternative.

In summary, the applicant adequately demonstrates that the proposal is the least costly or most effective alternative to meet the identified need. Therefore, the application is conforming to this criterion, subject to the following conditions:

1. **New Hanover Regional Medical Center shall materially comply with all representations made in the certificate of need application and in clarifying information received October 31, 2016.**

2. **New Hanover Regional Medical Center shall materially comply with all the conditions of approval on the certificate of need for Project I.D. #O-11042-15, except as specifically modified by the conditions of approval for this application, Project I.D. #O-11189-16.**

3. **New Hanover Regional Medical Center shall develop a 108-bed patient tower over the existing Surgical Pavilion by relocating 68 existing acute care beds and five operating rooms from the NHRMC Orthopedic Hospital to the NHRMC 17th Street campus as well as by including the acute care beds approved in Project I.D. #O-11042-15.**

4. **New Hanover Regional Medical Center shall de-license 68 acute care beds and five operating rooms at NHRMC Orthopedic Hospital. Following completion of this project and Project I.D. #O-11042-15, New Hanover Regional Medical Center shall be licensed for no more than 38 operating rooms, including 29 shared operating rooms, four dedicated ambulatory surgery operating rooms, three dedicated C-section operating rooms, and two dedicated open heart surgery operating rooms, and for no more than 678 general acute care beds.**

5. **New Hanover Regional Medical Center shall not acquire, as part of this project, any equipment that is not included in the project's proposed capital expenditures in Section VIII of the application and that would otherwise require a certificate of need.**

6. **New Hanover Regional Medical Center shall develop and implement an Energy Efficiency and Sustainability Plan for the project that conforms to or exceeds energy efficiency and water conservation standards incorporated in the latest editions of the North Carolina State Building Codes.**

7. **New Hanover Regional Medical Center shall acknowledge acceptance of and agree to comply with all conditions stated herein to the Certificate of Need Section in writing prior to issuance of the certificate of need.**

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

C

The applicant proposes to relocate 68 existing acute care beds and five operating rooms from the Orthopedic Hospital to the 17th Street campus and construct a 108-bed tower above the existing Surgical Pavilion, which will also include the acute care beds approved in Project I.D. #O-11042-15.

Capital and Working Capital Costs

In Section VIII, page 127, the applicant projects the total capital cost of the proposed project will be $86,878,371, which will include the following items:

NHRMC Acute Care Bed/OR Relocation	
Description	**Cost**
Site Preparation Costs	$1,400,000
Construction Costs (Labor & Parking)	$64,687,026
Equipment/Furniture	$13,291,345
Consultant Fees	$6,150,000
Contingency	$1,350,000
Total	**$86,878,371**

In Section IX.1, page 132, the applicant states there will be no start-up expenses and no initial operating expenses associated with the project.

Availability of Funds

In Section VIII.3, page 128, the applicant states that the total capital cost will be funded with $86,878,371 in NHRMC accumulated reserves. Exhibit 20 contains a letter from the Chief Financial Officer of NHRMC which documents its commitment to fund the proposed project and the availability of funds. Exhibit 21 contains the audited financial reports for NHRMC for the years ending September 30, 2015 and 2014. According to the financial statements, as of September 30, 2015, NHRMC had $126,588,000 in cash and cash equivalents, $1,141,261,000 in total assets, and $695,977,000 in total net assets (total assets less total liabilities). The applicant adequately demonstrates the availability of sufficient funds for the capital and working capital needs of the project.

Financial Feasibility

In the pro forma financial statements for NHRMC's proposed service components (Form C), the applicant projects that revenues will exceed operating expenses in each of the first three operating years of the project, as shown in the table below.

NHRMC – Acute Care Bed/OR Relocation Projected Revenue/Expenses – Project Years 1-3			
	Project Year 1 FFY 2020	**Project Year 2 FFY 2021**	**Project Year 3 FFY 2022**
Projected # IP Orthopedic Days of Care	13,706	14,078	14,464
Projected # IP Orthopedic Surgeries	3,915	4,023	4,135
Projected # IP Med/Surg Days of Care	9,855	10,541	11,169
Gross Patient Revenue	$307,065,948	$332,194,552	$358,863,321
Deductions from Gross Patient Revenue	$221,483,023	$242,753,642	$265,587,216
Net Patient Revenue	$85,582,925	$89,440,910	$93,276,106
Total Expenses	$49,677,269	$51,851,303	$54,103,642
Net Income	$35,905,655	$37,589,607	$39,172,464

The assumptions used by the applicant in preparation of the pro forma financial statements are reasonable, including projected utilization, costs, and charges. See the financial section of the application for the assumptions used regarding costs and charges. The discussion regarding utilization projections for relocated acute care beds and operating rooms found in Criterion (3) is incorporated herein by reference. The discussion regarding staffing found in Criterion (7) is incorporated herein by reference. The applicant adequately demonstrates the availability of sufficient funds for the operating needs of the project and that the financial feasibility of the proposal is based upon reasonable and adequately supported assumptions regarding projected utilization, revenues (charges), and operating costs.

Conclusion

In summary, the applicant adequately demonstrates the availability of sufficient funds for the capital and working capital needs of the project. Furthermore, the applicant adequately demonstrates the availability of sufficient funds for the operating needs of the project and that the financial feasibility of the proposal is based upon reasonable and adequately supported assumptions regarding projected utilization, revenues (charges), and operating costs. Therefore, the application is conforming to this criterion.

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

C

The applicant proposes to relocate 68 acute care beds as well as five operating rooms from the existing Orthopedic Hospital to the Surgical Pavilion on the 17th Street campus and to construct a 108-bed tower above the Surgical Pavilion. This project also involves a change of scope for Project I.D. #O-11042-15 (add 31 acute care beds and relocate nine existing acute care beds) by including those beds in the 108-bed tower.

On page 48, the 2016 SMFP defines the service area for acute care bed services by county (or multicounty service area for counties without a hospital). On page 67, the 2016 SMFP defines the service area for operating room services by county (or multicounty service area for counties without a hospital). NHRMC is located in New Hanover County. Thus, the service area for this facility consists of New Hanover County. Facilities may also serve residents of counties not included in their service area.

The following table summarizes the existing and approved operating room inventories for New Hanover County, as shown in Table 6A of the Proposed 2017 SMFP.

Operating Room Inventory – New Hanover County					
	Inpatient ORs	**Ambulatory ORs**	**Shared ORs**	**CON Adjustments**	**Total**
NHRMC*	5	4	29	0	**38**
Wilmington SurgCare	0	7	0	0	**7**
Total	**5**	**11**	**29**	**0**	**45**

*Includes NHRMC Orthopedic Hospital inventory

NHRMC proposes to relocate existing acute care beds and existing operating rooms from the Orthopedic Hospital to the 17th Street campus and to develop a 108-bed tower above the Surgical Pavilion. According to Table 5A in the Proposed 2017 SMFP, the applicant is the only provider of acute care bed services in New Hanover County. Therefore, the applicant does not propose to increase the inventory of operating rooms or acute care beds in the service area. The applicant adequately demonstrates the need to relocate the existing acute care beds and operating rooms, and adequately demonstrates that the projected utilization is based on reasonable and adequately supported assumptions. The discussion regarding projected utilization found in Criterion (3) is incorporated herein by reference.

The applicant adequately demonstrates that the proposal would not result in an unnecessary duplication of existing or approved acute care beds or operating rooms in New Hanover County. Therefore, the application is conforming to this criterion.

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

C

In Section VII and Exhibit 17, the applicant provides NHRMC's current and projected surgical and med/surg unit staffing for the second operating year, as shown in the following table.

NHRMC Acute Care Bed/OR Relocation – Staffing		
Employee Category	**Current Staff FFY 2016**	**Projected Staff FFY 2021**
	Total #FTE Positions	**Total #FTE Positions**
Orthopedic Unit		
Nurses/Aides	45.39	45.39
Clinical Personnel (other)	13.50	13.50
Non-Clinical Personnel	0.20	0.20
Total	**59.09**	**59.09**
Orthopedic Surgery		
Clinical OR Personnel	31.80	31.80
Clinical PACU Personnel	7.80	7.80
Clinical Anesthesia Personnel	12.30	12.30
Clinical Ambulatory Surgery Personnel	9.50	9.50
Clinical Pre-Admission Testing Personnel	5.20	5.20
Clinical Personnel (others)	0.60	0.60
Non-Clinical Personnel	16.20	16.20
Total	**83.40**	**83.40**
Med/Surg Unit		
Nurses/Aides	0.00	45.04
Clinical Personnel (other)	0.00	10.50
Non-Clinical Personnel	0.00	7.10
Total	**0.00**	**62.64**
Total Staff	**142.49**	**205.13**

The applicant proposes to add 62.64 FTE unit staff for the med/surg unit by the end of the second operating year and adequately budgeted for the expense of hiring that staff in its pro formas. The discussion regarding projected costs and charges found in Criterion (5) is incorporated herein by reference. In Section VII.3, page 122, and Section VII.7, pages 123-124, the applicant describes its experience and process for recruiting and retaining staff. Exhibit 13 contains a copy of a letter from Scott Q. Hannum, M.D., expressing his interest in continuing to serve as the Medical Director for NHRMC Orthopedic Services. The applicant adequately demonstrates the availability of sufficient health manpower and management personnel to provide the proposed services. Therefore, the application is conforming to this criterion.

(8) The applicant shall demonstrate that the provider of the proposed services will make available, or otherwise make arrangements for, the provision of the necessary ancillary and support services. The applicant shall also demonstrate that the proposed service will be coordinated with the existing health care system.

C

In Sections II.1 and II.2, pages 39-41, the applicant describes the manner in which it will provide the necessary ancillary and support services. Exhibit 24 of the application contains copies of letters from area physicians and surgeons expressing support for the proposed project. The applicant adequately demonstrates that necessary ancillary and support services are available and that the proposed services will be coordinated with the existing healthcare system. Therefore, the application is conforming to this criterion.

(9) An applicant proposing to provide a substantial portion of the project's services to individuals not residing in the health service area in which the project is located, or in adjacent health service areas, shall document the special needs and circumstances that warrant service to these individuals.

NA

(10) When applicable, the applicant shall show that the special needs of health maintenance organizations will be fulfilled by the project. Specifically, the applicant shall show that the project accommodates: (a) The needs of enrolled members and reasonably anticipated new members of the HMO for the health service to be provided by the organization; and (b) The availability of new health services from non-HMO providers or other HMOs in a reasonable and cost-effective manner which is consistent with the basic method of operation of the HMO. In assessing the availability of these health services from these providers, the applicant shall consider only whether the services from these providers: (i) would be available under a contract of at least 5 years duration; (ii) would be available and conveniently accessible through physicians and other health professionals associated with the HMO; (iii) would cost no more than if the services were provided by the HMO; and (iv) would be available in a manner which is administratively feasible to the HMO.

NA

(11) Repealed effective July 1, 1987.

(12) Applications involving construction shall demonstrate that the cost, design, and means of construction proposed represent the most reasonable alternative, and that the construction project will not unduly increase the costs of providing health services by the person proposing the construction project or the costs and charges to the public of providing health services by other persons, and that applicable energy saving features have been incorporated into the construction plans.

C

The applicant proposes to relocate 68 existing acute care beds and five operating rooms from the Orthopedic Hospital and develop a 108-bed tower above the existing Surgical Pavilion, which will include the 31 new acute care beds and nine relocated acute care beds from Project I.D. #O-11042-15. Exhibit 23 contains a certified cost estimate from an architect that estimates construction costs that are consistent with the project capital cost projections provided by the applicant in Section VIII.1 (page 127) of the application. In Section XI.7, page 142, and Exhibit 10, the applicant describes the methods that will be used by the facility to maintain efficient energy operations and contain the costs of utilities. The discussion regarding costs and charges found in Criterion (5) is incorporated herein by reference. The applicant adequately demonstrates that the cost, design, and means of construction represent the most reasonable alternative, and that the construction cost will not unduly increase costs and charges for health services. Therefore, the application is conforming to this criterion.

(13) The applicant shall demonstrate the contribution of the proposed service in meeting the health-related needs of the elderly and of members of medically underserved groups, such as medically indigent or low income persons, Medicaid and Medicare recipients, racial and ethnic minorities, women, and handicapped persons, which have traditionally experienced difficulties in obtaining equal access to the proposed services, particularly those needs identified in the State Health Plan as deserving of priority. For the purpose of determining the extent to which the proposed service will be accessible, the applicant shall show:

(a) The extent to which medically underserved populations currently use the applicant's existing services in comparison to the percentage of the population in the applicant's service area which is medically underserved;

C

In Sections VI.12 and VI.13, pages 117-118, the applicant provides the payor mix during FFY 2016 for all of NHRMC as well as the orthopedic inpatient service component and med/surg patient component for NHRMC, as illustrated in the tables below:

NHRMC Historical Payor Mix Orthopedic IP Services – FFY 2016	
Self-Pay/Charity	2.0%
Medicare/Medicare Managed Care	65.4%
Medicaid	4.3%
Managed Care/Commercial	23.4%
Other (Government)	3.5%
Other	1.4%
Total	**100.0%**

NHRMC Historical Payor Mix Med/Surg IP Services – FFY 2016	
Self-Pay/Charity	6.3%
Medicare/Medicare Managed Care	66.6%
Medicaid	10.1%
Managed Care/Commercial	13.6%
Other	3.4%
Total	**100.0%**

NHRMC Historical Payor Mix Entire Facility – FFY 2016	
Self-Pay/Charity/Other	10.7%
Medicare/Medicare Managed Care	51.5%
Medicaid	19.6%
Managed Care/Commercial	18.2%
Total	**100.0%**

The United States Census Bureau provides demographic data for North Carolina and all counties in North Carolina. The following table contains relevant demographic statistics for the applicant's service area (New Hanover County).

Percent of Population						
County	**% 65+**	**% Female**	**% Racial & Ethnic Minority***	**% Persons in Poverty****	**% < Age 65 with a Disability**	**% < Age 65 without Health Insurance****
New Hanover	16%	52%	23%	18%	9%	19%
Statewide	15%	51%	36%	17%	10%	15%

Source: http://www.census.gov/quickfacts/table, 2014 Estimate as of December 22, 2015.
*Excludes *"White alone"* who are *"not Hispanic or Latino"*
***"This geographic level of poverty and health estimates are not comparable to other geographic levels of these estimates. Some estimates presented here come from sample data, and thus have sampling errors that may render some apparent differences between geographies statistically indistinguishable…The vintage year (e.g., V2015) refers to the final year of the series (2010 thru 2015). Different vintage years of estimates are not comparable."*

However, a direct comparison to the applicant's current payor mix would be of little value. The population data by age, race, or gender does not include information on the number of elderly, minorities, women or handicapped persons utilizing health services.

The applicant demonstrates that it currently provides adequate access to medically underserved populations. Therefore, the application is conforming to this criterion.

(b) Its past performance in meeting its obligation, if any, under any applicable regulations requiring provision of uncompensated care, community service, or access by minorities and handicapped persons to programs receiving federal assistance, including the existence of any civil rights access complaints against the applicant;

C

Recipients of Hill-Burton funds were required to provide uncompensated care, community service and access by minorities and handicapped persons. In Section VI.11, page 116, the applicant states:

> *"NHRMC fulfilled its Hill-Burton obligation and does not have any related obligation under any applicable federal regulations to provide uncompensated care, community service, or access by minorities and the handicapped."*

The applicant states it is dedicated to providing care to all members of the community, regardless of ability to pay, and provides charity care. See Exhibit 16 for a copy of the NHRMC community benefits report, documenting some of its charity care. In Section VI.10, page 116, the applicant states that no civil rights access complaints have been filed against NHRMC in the last five years. The application is conforming to this criterion.

(c) That the elderly and the medically underserved groups identified in this subdivision will be served by the applicant's proposed services and the extent to which each of these groups is expected to utilize the proposed services; and

C

In Sections VI.14 and VI.15, pages 118-119, the applicant provides the projected payor mix for the second full fiscal year following project completion (FFY 2021) for all of NHRMC as well as the orthopedic inpatient service component and med/surg patient component for NHRMC, as illustrated in the tables below:

NHRMC Projected Payor Mix Orthopedic IP Services – FFY 2021	
Self-Pay/Charity	2.0%
Medicare/Medicare Managed Care	65.4%
Medicaid	4.3%
Managed Care/Commercial	23.4%
Other (Government)	3.5%
Other	1.4%
Total	**100.0%**

NHRMC Projected Payor Mix Med/Surg IP Services – FFY 2021	
Self-Pay/Charity	6.3%
Medicare/Medicare Managed Care	66.6%
Medicaid	10.1%
Managed Care/Commercial	13.6%
Other	3.4%
Total	**100.0%**

NHRMC Projected Payor Mix Entire Facility – FFY 2021	
Self-Pay/Charity/Other	10.7%
Medicare/Medicare Managed Care	51.5%
Medicaid	19.6%
Managed Care/Commercial	18.2%
Total	**100.0%**

On pages 118-119, the applicant states that it based its projected payor mix on its FFY 2016 payor mix. The applicant demonstrates that medically underserved populations will have adequate access to the proposed services. Therefore, the application is conforming to this criterion.

(d) That the applicant offers a range of means by which a person will have access to its services. Examples of a range of means are outpatient services, admission by house staff, and admission by personal physicians.

C

In Section VI.9, page 115, the applicant describes the range of means by which a person will have access to NHRMC's orthopedic surgical services and med/surg inpatient services. The applicant adequately demonstrates that the facility will offer a range of means by which patients will have access to the proposed services. Therefore, the application is conforming to this criterion.

(14) The applicant shall demonstrate that the proposed health services accommodate the clinical needs of health professional training programs in the area, as applicable.

C

In Section V.1, page 88, the applicant documents that NHRMC accommodates the clinical needs of health professional training programs in the service area and that it will continue to do so. Exhibit 11 contains a list of the health professional training programs that currently utilize the training opportunities at NHRMC. The information provided is reasonable and supports a finding of conformity with this criterion.

(15) Repealed effective July 1, 1987.
(16) Repealed effective July 1, 1987.

(17) Repealed effective July 1, 1987.
(18) Repealed effective July 1, 1987.

(18a) The applicant shall demonstrate the expected effects of the proposed services on competition in the proposed service area, including how any enhanced competition will have a positive impact upon the cost effectiveness, quality, and access to the services proposed; and in the case of applications for services where competition between providers will not have a favorable impact on cost-effectiveness, quality, and access to the services proposed, the applicant shall demonstrate that its application is for a service on which competition will not have a favorable impact.

C

The applicant proposes to relocate 68 acute care beds as well as five operating rooms from the existing Orthopedic Hospital to the Surgical Pavilion on the 17th Street campus and to construct a 108-bed tower above the Surgical Pavilion. This project also involves a change of scope for Project I.D. #O-11042-15 (add 31 acute care beds and relocate nine existing acute care beds) by including those beds in the 108-bed tower.

On page 48, the 2016 SMFP defines the service area for acute care bed services by county (or multicounty service area for counties without a hospital). On page 67, the 2016 SMFP defines the service area for operating room services by county (or multicounty service area for counties without a hospital). NHRMC is located in New Hanover County. Thus, the service area for this facility consists of New Hanover County. Facilities may also serve residents of counties not included in their service area.

The following table summarizes the existing and approved operating room inventories for New Hanover County, as shown in Table 6A of the Proposed 2017 SMFP.

Operating Room Inventory – New Hanover County					
	Inpatient ORs	**Ambulatory ORs**	**Shared ORs**	**CON Adjustments**	**Total**
NHRMC*	5	4	29	0	**38**
Wilmington SurgCare	0	7	0	0	**7**
Total	**5**	**11**	**29**	**0**	**45**

*Includes NHRMC Orthopedic Hospital inventory

NHRMC proposes to relocate existing acute care beds and existing operating rooms from the Orthopedic Hospital to the 17th Street campus and to develop a 108-bed tower above the Surgical Pavilion. According to Table 5A in the Proposed 2017 SMFP, the applicant is the only provider of acute care bed services in New Hanover County. Therefore, the applicant does not propose to increase the inventory of operating rooms or acute care beds in the service area.

In Section V.7, pages 93-107, the applicant discusses how any enhanced competition in the service area will have a positive impact on the cost-effectiveness, quality, and access to the proposed services. On page 93, the applicant states:

"This project will foster competition. NHRMC competes not only with other hospitals in the service area, but also with much larger system both inside and outside of North Carolina. NHRMC recognizes that patients have a choice of where to receive their care, and it strives to earn the loyalty of its patients every day."

See also Sections II, III, V, VI, and VII where the applicant discusses the impact of the project on cost-effectiveness, quality, and access.

The information in the application is reasonable and adequately demonstrates that any enhanced competition in the service area includes a positive impact on the cost-effectiveness, quality, and access to the proposed services. This determination is based on the information in the application and the following analysis:

- The applicant adequately demonstrates the need for the project and that it is a cost-effective alternative. The discussions regarding the analysis of need and alternatives found in Criteria (3) and (4), respectively, are incorporated herein by reference.
- The applicant adequately demonstrates it will provide quality services. The discussion regarding quality found in Criterion (20) is incorporated herein by reference.
- The applicant demonstrates that it will provide adequate access to medically underserved populations. The discussion regarding access found in Criteria (3), (3a), and (13) is incorporated herein by reference.

Therefore, the application is conforming to this criterion.

(19) Repealed effective July 1, 1987.

(20) An applicant already involved in the provision of health services shall provide evidence that quality care has been provided in the past.

C

Section I.12, pages 10-12, contains a list of NHRMC-owned or operated health care facilities. According to the files in the Acute and Home Care Licensure and Certification Section, DHSR, there were two instances where NHRMC or an affiliated facility was out of compliance with Medicare conditions of participation within the last 18 months. The problems have since been corrected and at this time, all of the facilities are in compliance with all Medicare conditions of participation. Additionally, an incident is under investigation by the Centers for Medicare and Medicaid Services for potential violations with no timetable for any decision or outcome. After reviewing and considering information provided by the applicant and by the Acute and Home Care Licensure and Certification Section and considering the quality of care provided at both facilities, the applicant provides sufficient evidence that quality care has been provided in the past. Therefore, the application is conforming to this criterion.

(21) Repealed effective July 1, 1987.

(b) The Department is authorized to adopt rules for the review of particular types of applications that will be used in addition to those criteria outlined in subsection (a) of this section and may vary according to the purpose for which a particular review is being conducted or the type of health service reviewed. No such rule adopted by the Department shall require an academic medical center teaching hospital, as defined by the State Medical Facilities Plan, to demonstrate that any facility or service at another hospital is being appropriately utilized in order for that academic medical center teaching hospital to be approved for the issuance of a certificate of need to develop any similar facility or service.

NA

The Criteria and Standards for Surgical Services and Operating Rooms, and Acute Care Beds, promulgated in 10A NCAC 14C .2100 and 10A NCAC 14C .3800, respectively, are not applicable to this review because the applicant is not proposing to develop new operating rooms, surgical services, or acute care beds. The applicant is proposing to relocate operating rooms and acute care beds to an existing campus with newly developed and newly renovated space.

Attachment 6

North Carolina Freestanding Ambulatory Surgical Facilities with Three or Less Operating Rooms, and / or Three or Less Procedure Rooms

North Carolina Freestanding Ambulatory Surgical Facilities with Three or Less Operating Rooms

Total Surgical ORs	County	Facility Name	License Number
3	Buncombe	Orthopaedic Surgery Center of Asheville	AS0038
3	Catawba	Viewmont Surgery Center	AS0101
3	Forsyth	Plastic Surgery Center of North Carolina	AS0021
3	Guilford	Greensboro Specialty Surgical Center	AS0009
3	Moore	The Eye Surgery Center of the Carolinas	AS0022
2	Burke	Surgery Center of Morganton Eye Physicians	AS0040
2	Cabarrus	Eye Surgery Center and Laser Clinic	AS0019
2	Carteret	The Surgical Center of Morehead City	AS0061
2	Catawba	Graystone Eye Surgery Center	AS0036
2	Cleveland	Eye Surgery Center of Shelby	AS0049
2	Dare	Sentara Kitty Hawk Ambulatory Surgery Center	AS0053
2	Forsyth	Piedmont Outpatient Surgery Center	AS0134
2	Guilford	Premier Surgery Center	AS0152
2	Guilford	Piedmont Surgical Center	AS0063
2	Mecklenburg	Carolina Center for Specialty Surgery	AS0058
2	Mecklenburg	Novant Health Huntersville Outpatient Surgery	AS0124
2	Mecklenburg	Novant Health Ballantyne Outpatient Surgery	AS0098
2	Mecklenburg	Matthews Surgery Center	AS0136
2	Mecklenburg	Mallard Creek Surgery Center	AS0148
2	Union	Union West Surgery Center	AS0132
2	Wake	Triangle Orthopaedics Surgery Center	AS0142
1	Buncombe	Asheville Eye Surgery Center	AS0065
1	Iredell	Iredell Head Neck and Ear Ambulatory Surgery Center	AS0042
1	Wake	Raleigh Plastic Surgery Center	AS0034
1	Wilson	Wilson OB-GYN	AS0007
Total Number of Freestanding Facilities with 3 or less Operating Rooms			***25***

Source *NCDHSR Medical Facilities Access Database*
2016 Planning Data from 2017 Ambulatory Surgical Facility License Renewal Applications
Database downloaded July 2017

North Carolina Freestanding Ambulatory Surgical Facilities with Three or Less GI Endoscopy Rooms

GI Endo Rooms	County	Facility Name	License Number
3	Pitt	Carolinas Endoscopy Center	AS0117
3	Craven	CarolinaEast Internal Medicine	AS0096
3	Guilford	LeBauer Endoscopy Center	AS0052
3	Iredell	Piedmont HealthCare Endoscopy Center	AS0126
3	Cabarrus	Northeast Digestive Health Center	AS0104
3	New Hanover	Wilmington SurgCare	AS0055
3	Guilford	High Point Endoscopy Center	AS0059
3	Wake	Center for Digestive Diseases & Cary Endoscopy Center	AS0072
3	Catawba	Gastroenterology Associates, Hickory	AS0077
3	Craven	CCHC Endoscopy Center	AS0078
3	Wake	Raleigh Endoscopy Center-North	AS0082
3	Cumberland	Fayetteville Ambulatory Surgery Center	AS0006
3	New Hanover	Wilmington Health	AS0045
2	Watauga	Appalachian Gastroenterology	AS0095
2	Pitt	Carolina Digestive Diseases	AS0118
2	Pitt	East Carolina Endoscopy Center	AS0119
2	Lenoir	Park Endoscopy Center	AS0121
2	Lenoir	Kinston Medical Specialists, PA Endoscopy Center	AS0122
2	Cumberland	Digestive Health Endoscopy Center	AS0123

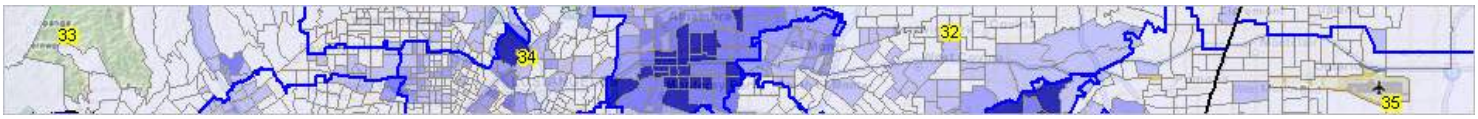
North Carolina Freestanding Ambulatory Surgical Facilities with Three or Less Operating Rooms

Total Surgical ORs	County	Facility Name	License Number
2	Forsyth	Wake Forest Baptist Health Outpatient Endoscopy	AS0125
2	Forsyth	Digestive Health Specialists, P.A.	AS0099
2	New Hanover	Endoscopy Center NHRMC Physician Group	AS0100
2	Nash	Boice-Willis Clinic Endoscopy Center	AS0105
2	Wilson	Wilson Digestive Diseases Center	AS0130
2	Henderson	Carolina Mountain Gastroenterology Endoscopy Center	AS0106
2	Wake	W. F. Endoscopy Center, LLC	AS0131
2	Mecklenburg	Carolina Endoscopy Center-Huntersville	AS0108
2	Gaston	CaroMont Endoscopy Center	AS0135
2	Mecklenburg	Charlotte Gastroenterology & Hepatology	AS0110
2	Wilson	CGS Endoscopy Center	AS0112
2	Guilford	Guilford Endoscopy Center	AS0113
2	Wake	GastroIntestinal Healthcare	AS0116
2	Halifax	Halifax Gastroenterology	AS0141
2	Forsyth	Digestive Health Endoscopy Center of Kernersville	AS0144
2	Burke	Carolina Digestive Care	AS0145
2	Davidson	Digestive Health Specialists	AS0146
2	Guilford	Bethany Medical Endoscopy Center	AS0076
2	Robeson	The Surgery Center at Southeastern Health Park	AS0150
2	Mecklenburg	Carolinas Gastroenterology Center-Medical Center Plaza	AS0080
2	Gaston	Greater Gaston Endoscopy Center	AS0151
2	Cabarrus	Gateway Surgery Center	AS0070
2	Pitt	Atlantic Gastroenterology Endoscopy Center	AS0086
2	Mecklenburg	Carolina Endoscopy Center-Pineville	AS0088
2	Mecklenburg	Carolina Endoscopy Center-University	AS0089
2	Guilford	Greensboro Specialty Surgical Center	AS0009
2	Union	Carolina Endoscopy Center-Monroe	AS0090
2	Mecklenburg	Carolina Digestive Endoscopy Center	AS0092
2	Wake	Triangle Gastroenterology	AS0093
2	Lee	Mid Carolina Endoscopy Center	AS0094
2	Johnston	Clayton Endoscopy	AS0153
2	Mecklenburg	Endoscopy Center of Lake Norman	AS0084
1	Macon	Western Carolina Endoscopy Center	AS0097
1	Mecklenburg	Novant Health Ballantyne Outpatient Surgery	AS0098
1	Edgecombe	Vidant Endoscopy Center	AS0127
1	Alamance	Pioneer Ambulatory Surgery Center	AS0128
1	Randolph	Randolph Health Endoscopy Center	AS0054
1	Robeson	Southeastern Gastroenterology Endoscopy Center	AS0107
1	Wake	Kurt G. Vernon, MD PA	AS0138
1	Davie	Digestive Health Specialists PA	AS0139
1	Carteret	The Surgical Center of Morehead City	AS0061
1	Robeson	Robeson Digestive Diseases, Inc.	AS0147
1	Onslow	East Carolina Gastroenterology Endoscopy Center	AS0079
1	Surry	Rockford Digestive Health Endoscopy Center	AS0154
Total Number of Freestanding Facilities with 3 or less GI Endo Rooms			***63***

Source *NCDHSR Medical Facilities Access Database*
2016 Planning Data from 2017 Ambulatory Surgical Facility License Renewal Applications
Database downloaded July 2017

Attachment 7

Metropolitan Statistical Area Population Data, US Census



Metropolitan Area Situation & Outlook Report

Wilmington, NC Metropolitan Statistical Area (CBSA 48900)
Geographic-Demographic-Economic Characteristics -- access other metros
Updated 03/07/17 ... see what has been updated.

This document is the Personal Use Edition. It is not authorized for commercial, consulting or professional advice use. The Personal Use Edition is for User Group members. See about Personal versus Business Use Editions. Join User Group now .. receive e-mail updates when Reports are updated.

The "S&O Metro Analytics" joins "S&O Metro Reports" (this page). "S&O Metro Analytics" provides access to raw data and extended scope data. S&O Metro Analytics data are packaged in ready-to-use CVGIS projects and Tableau projects. The no fee versions of each product creates visually enahanced (charts and presentation formats) metro reports. More advanced users can create additional analytics and integrate other data. See this section for more about these developments.

New additions:
- Updated demographic projections to 2060 by county & metro .. Washington DC metro example.
- Extended monthly building permits by metro, county, city interactive table - includes 2016 by month.
- Jobs-to-Housing Ratio & related Employment, Housing, Income by metro, county, city interactive table.
- Characteristics of urban areas intersecting with the metro.
- Consumer expenditure patterns by product and service.
- Improving Competitive Advantage Workshops -- using these and related data.

Join us in the weekly web sessions (Tuesdays, 3:00 pm ET) where we review metro demographic-economic characteristics and patterns and related topics. No fee, no registration, see connectivity details.

Contents of this Report
This document is organized into these sections:

Metropolitan Statistical Areas (MSAs) - larger metros
The nation's MSAs contained 275.3 million people in 2015, an increase of about 2.5 million from 2014. Most (285 of the 381) MSAs nationwide gained population between 2014 and 2015. Four of the 20 fastest-growing MSAs between 2014 and 2015 were in the Mountain states: Greeley and Fort Collins in Colorado and St. George and Provo-Orem in Utah.

Micropolitan Statistical Areas (MISAs) - smaller metros
The nation's MISAS contained about 27.3 million people in 2015, an increase of approximately 27,000 from 2014. Nearly half the U.S. MISAs (261 of the 536) gained population between 2014 and 2015.

Use the interactive table (includes all counties) to examine metro by county demographic change 2010-2015, the how and why of change and what these patterns suggest about the future.

1. Recent Trends & Outlook
Summary of recent business, demographic, economic trends; year-ahead & 5-year outlook.
- the Recent Trends & Outlook section, updated quarterly, covers topics about this metro such as .. assessing the implications of next jobs report .. impact of Fed"s interest rate action .. which sectors are expanding or contracting .. housing market conditions .. insights to help your planning and decision-making. The Recent Trends & Outlook section is available in business edition.

2. Overview & Update
The total population of the Wilmington, NC MSA metro changed from 255,648 in 2010 to 272,671 in 2015, a change of 22,321 (8.7%). Among all 917 metros, this metro was ranked number 176 in 2010 and 171 in 2015, based on total population. Annual net migration was 2,904 (2011), 3,073 (2012), 4,551 (2013), 3,623 (2014), 3,623 (2015). View annual population estimates and components of change table. See more about population characteristics below.

This metro is projected to have a total population in 2020 of 294,310. The projected population change from 2010 to 2020 is 38,576 (15.1%). The population ages 65 years and over is projected to change from 37,199 (2010) to 57,792 (2020), a change of 20,593 (55.4%). See more about population projections.

Based on per capita personal income (PCPI), this metro was ranked number 288 in 2008 and 418 in 2014. among the 917 metros for which personal income was estimated.The PCPI changed from $36,029 in 2008 to $38,278 in 2014, a change of $2,249 (6.2%). Per capita personal income (PCPI) is a comprehensive measure of individual economic well-being. Use the interactive table to compare PCPI in this metro to other metros. See more about PCPI in Economic Characteristics section below.

282 metropolitan statistical areas, of the total 381, experienced an increase in real Gross Domestic Product (GDP) between 2009 and 2014. This metro ranked number 168 among the 381 metros based on 2014 GDP. The GDP (millions of current dollars) changed from $10,776 in 2009 to $12,995 in 2014 a change of $2,219 (20.59%). Real GDP (millions of real, inflation adjusted, dollars) changed from $10,776 in 2009 to $11,807 in 2014, a change of $1,031 (9.57%). GDP is the most comprehensive measure of metro economic activity. GDP is the sum of the GDP originating in all industries in the metro. See more about GDP in Economic Characteristics section below.

Attributes of driil-down, small area geography within the metro ... metros account for 65,744 of the national scope 73,056 census tracts (others are in non-metro areas). This metro is comprised of 61 tracts covering the metro wall-to-wall. View, rank, compare demographic-economic attributes of these tracts using the interactive tables. Use the CBSA code 48900; see table usage details below the table.

Updated: 03/07/17 ... this document updates frequently. Register to receive update notifications.
- Housing Price Index (section 5.4) updated 01/14/17.
- Establishments, employment & earnings (section 6.6) updated 01/12/17.
- Economic profile and personal income (section 6.1) updated 12/07/16.
- Labor market situation (section 6.7) updated 10/29/16.
- Residential construction; units authorized & value (section 5.3.) updated 9/3/16.
- Population by county; annual series 2010-2015 (section 4.2.) updated 7/23/16.
- Population by county; links for individual counties (section 4.2.) updated 7/23/16.
  -- includes annual data 2010-2015.
  -- includes components of change; race/origin; single year of age; age group summaries.
- RDEMS county sections added 6/16.
- Total population and components of change 3/24/16.
- Census tracts added in overview section 1/16.
- General Demographics section updated/extended 12/15.
- Gross Domestic Product section updated 12/15.
- Higher education institutions updated 12/15.
- Overview lead narrative on population components of change updated 12/15.
- Metro & county demographic component detailed annual estimates updated 5/15.
- School districts in metro & K-12 enrollment updated 12/14.

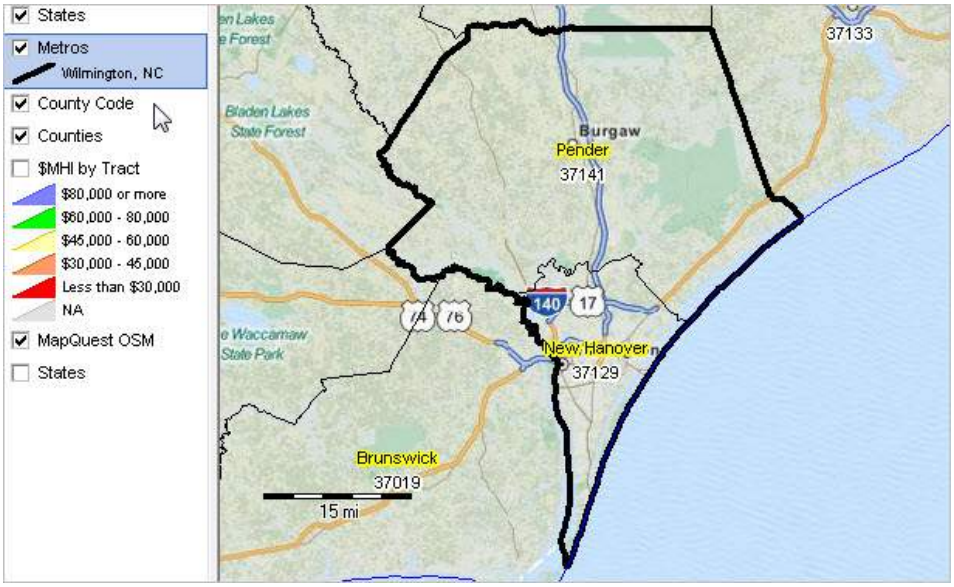
More about schedule and upcoming events ... Calendar ... Upcoming Events ... Find Event

3. Lay of the Land & Neighborhood Patterns of Economic Prosperity ▲

3.1. Lay of the Land ▲
Lay of the Land. The following map shows the metro with bold boundary.
Counties are labeled with county name and state-county FIPS code.

Select a Different Metro
... click a link below or use table

10100 Aberdeen, SD MISA
10140 Aberdeen, WA MISA
10180 Abilene, TX MSA
10220 Ada, OK MISA
10300 Adrian, MI MISA
10420 Akron, OH MSA
10460 Alamogordo, NM MISA
10500 Albany, GA MSA
10540 Albany, OR MSA
10580 Albany-Schenectady-Troy, NY MSA
10620 Albemarle, NC MISA
10660 Albert Lea, MN MISA
10700 Albertville, AL MISA
10740 Albuquerque, NM MSA
10780 Alexandria, LA MSA
10820 Alexandria, MN MISA
10860 Alice, TX MISA
10900 Allentown-Bethlehem-Easton, PA-
10940 Alma, MI MISA
10980 Alpena, MI MISA
11020 Altoona, PA MSA

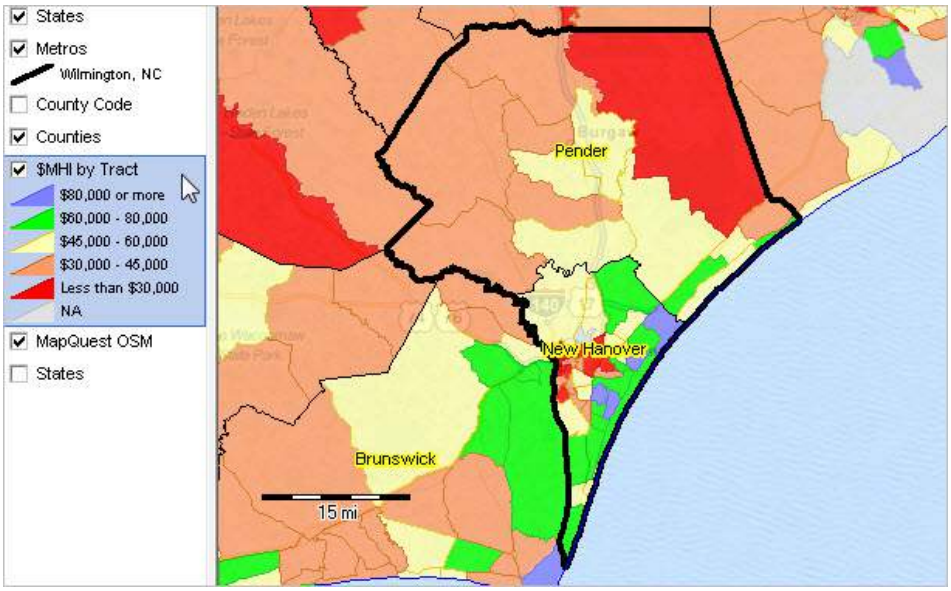


View developed with CV XE GIS software. See this section to learn about making custom metro maps.

11060 Altus, OK MISA
11100 Amarillo, TX MSA
11140 Americus, GA MISA
11180 Ames, IA MSA
11220 Amsterdam, NY MISA
11260 Anchorage, AK MSA
11380 Andrews, TX MISA
11420 Angola, IN MISA
11460 Ann Arbor, MI MSA
11500 Anniston-Oxford-Jacksonville, AL
11540 Appleton, WI MSA
11580 Arcadia, FL MISA
11620 Ardmore, OK MISA
11660 Arkadelphia, AR MISA
11680 Arkansas City-Winfield, KS MISA
11700 Asheville, NC MSA
11740 Ashland, OH MISA
11780 Ashtabula, OH MISA
11820 Astoria, OR MISA
11860 Atchison, KS MISA
11900 Athens, OH MISA
11940 Athens, TN MISA
11980 Athens, TX MISA
12020 Athens-Clarke County, GA MSA
12060 Atlanta-Sandy Springs-Roswell, G
12100 Atlantic City-Hammonton, NJ MSA
12140 Auburn, IN MISA
12180 Auburn, NY MISA
12220 Auburn-Opelika, AL MSA
12260 Augusta-Richmond County, GA-SC
12300 Augusta-Waterville, ME MISA
12380 Austin, MN MISA
12420 Austin-Round Rock, TX MSA
12460 Bainbridge, GA MISA
12540 Bakersfield, CA MSA
12580 Baltimore-Columbia-Towson, MD
12620 Bangor, ME MSA
12660 Baraboo, WI MISA
12680 Bardstown, KY MISA

3.2. Patterns of Economic Prosperity by Neighborhood ▲

Median household income by census tract (see color/data legend at left of map).



View developed with CV XE GIS software. See this section to learn about making custom metro maps.

4. Population Characteristics & Trends ▲

Updated monthly, quarterly, annually. Housing market conditions and extended detail available in business edition.

4.1. Component City Characteristics ▲

Principal Cities (about principal cities); Click link to view city profile.

- Wilmington

Cities 10,000 population and over; click link to view city profile.

Area	Census 2010	July 1 2010	July 1 2011	July 1 2012	July 1 2013	July 1 2014	Change 2010-14	%Change 2010-14
Wilmington, NC (3774440)	106,476	106,820	108,244	109,826	111,987	113,657	6,837	6.40

All places interactive tables General Demographics | Social | Economic | Housing
All places time series population estimates interactive table.

4.2. Component County Characteristics ▲

Updated periodically, annually. General demographics, social characteristics and extended detail available in business edition.

Metropolitan areas are defined as one or more contiguous counties based on a set of demographic-economic criteria. Counties comprising the metro are shown below. For multi-county metros, this section provides insights into how the population is changing by county. Many metros changed geographic composition (counties included in the metro) between the Census 2010 vintage and the current vintage. These changes, if any, are also shown below (county is marked with **). See projections in related section.Click county

Attachment 8

Article: Why Surgery Partners Inc. Is Plunging Today

Why Surgery Partners Inc. Is Plunging Today

Shares drop after management preannounces disappointing earnings.

Brian Feroldi (TMFTypeoh)
Nov 1, 2017 at 4:13PM

What happened

In response to the company preannouncing disappointing earnings, shares of **Surgery Partners** (NASDAQ:SGRY), a business focused on surgical services, fell 15% as of 3:30 p.m. EDT on Wednesday.

So what

Here's a review of the preannounced numbers:

- Revenue is expected to grow 8% to approximately $306.3 million. Wall Street had expected revenue of $303 million.
- Net loss is expected to be $21.9 million, a sharp reversal from the $12.6 million in net income that was reported in the year-ago period. By contrast, market-watchers were projecting a net loss of roughly $1 million.

Management blamed the poor results on Hurricanes Harvey and Irma. In total, management estimates that the two hurricanes will cost the company $7 million to $9 million in lost revenue and $4 million to $6 million in adjusted EBITDA (earnings before interest, taxes, depreciation, and amortization). The majority of these expenses will take place in the third quarter.

What's more, the company also stated that it incurred nonrecurring adjustments to revenue of $15.6 million and to adjusted EBITDA of $14.9 million, attributable to "an increase in reserves for certain accounts receivable."

Given the updates, it isn't surprising to see that shares took a hit today.

IMAGE SOURCE: GETTY IMAGES.

Now what

Management also provided investors with some normalized numbers in the release that were more upbeat. Same facility revenue is expected to grow 2.9% year over year. Also, adjusted EBITDA excluding the hurricanes and charges is expected to be approximately $43.1 million. While that's down 3% when compared to the year-ago period, it does show that the business is still making money.

Turning to guidance, full-year revenue is expected to be in the range of $1.30 billion to $1.33 billion, while adjusted EBITDA is expected to land between $178 million and $185 million. These figures include normalization for the impact of hurricanes and the reserve adjustment.

Interim CEO Clifford Adlerz likely knew that the market wasn't going to take this update well, so he did his best to put a positive spin on the challenges facing the company:

> While we experienced some unique challenges in the quarter, our normalized same facility revenue growth demonstrates the underlying market demand for outpatient surgical procedures at our facilities. ... Additionally, the integration of NSH is going well and we are focused on achieving synergies and the scale benefits of a larger organization. Our leadership is dedicated to quickly addressing and resolving any near-term issues that have impacted the Company's performance and have launched specific initiatives to accelerate same facility cases, act on accretive surgical facility tuck-in acquisitions, and implement procurement optimization initiatives to improve margins. We are moving forward with a stronger, more diversified platform to support our short stay surgical procedure growth objectives, and delivering significant value to patients, providers, and payors.

That all sounds great, but the company is currently searching for a new CEO, is in the middle of digesting an acquisition, and has a balance sheet loaded with $1.8 billion in debt and only $57 million in cash. That's far too much risk for this Fool, so I plan on avoiding this stock like the plague.

Brian Feroldi has no position in any of the stocks mentioned. The Motley Fool has no position in any of the stocks mentioned. The Motley Fool has a disclosure policy.

More from The Motley Fool

Here's Why Surgery Partners Inc. Is Sinking Today

Cory Renauer | Aug 9, 2017

A disappointing second-quarter earnings report is taking a toll on the healthcare services stock.

Fast-forward to today, and someone finally has figured it out… yes, Bill Gates' wish has come true. And experts say the market opportunity is now far, far greater than 10 Microsofts.

Jeff Bezos, the founder of Amazon, has even said that he thinks this new technology is the key to Amazon's future...

Learn more

AUTHOR

Brian Feroldi
(TMFTypeoh)

Brian Feroldi has been covering the healthcare industry for the Motley Fool since 2015. Brian's investing goal is to find the highest quality companies that he can find, buy them, and then to sit back and let compounding work its magic. See all of his articles here and make sure you follow him on Twitter.

Follow @brianferoldi 2,602 followers

ARTICLE INFO

Nov 1, 2017 at 4:13PM

Health Care

STOCKS

SGRY

Surgery Partners
NASDAQ:SGRY
$12.70 $1.55 (13.90%)

COMPARE BROKERS

Attachment 9

Additional Letters of Support

WASC Additional Letters of Support from Referring Physicians

Provider Name	Suffix	Specialty
Suzanne Smith	MD	Pediatrics
Danny Ott	MD	Pediatrics
Kelly Capobianco	NP-C	Pediatrics
Pamela Taylor	DO	Pediatrics
Erin Whitehead	NP-C	Pediatrics
Caryn Bowden	FNP-C	Pediatrics
Noah Archer	MD	Pediatrics
Sam Armani	MD	Radiology
Kathryn Monroe	NP-C	Cardiology
Carlos Arrieta	MD	Cardiology
Matt Janik	MD	Cardiology
Gail Robinson	FNP-C	Urology
Michael McGarrity	MD	Endocrinology
Seth Braunstein	MD	Endocrinology
Michael Favorito	MD	Endocrinology
Michale Lee	MD	Pulmonary
Alfred Demarra	MD	Neurology
Jill Finnegan	PA-C	Internal Medicine
Jonathan Hines	MD	Internal Medicine
Jeaninne Jones-Guion	PA-C	Internal Medicine
Craig Webb	PA-C	Internal Medicine
Sharon Speed	MD	Urgent Care
Gina Berthold	MD	Infectious Disease
David Kraebber	MD	Urology
Paul Payne	MD	Cardiology
Tor Ljung	MD	Plastic Surgery
Catherine Hawley	FNP	Family Medicine
Linda Ferrand	PA-C	Family Medicine
Cyril Abrams	MD	Cardiology
Troy Earhart	MD	Family Medicine
Arlene Hallegado	MD	Family Medicine
Joseph Gallagher	MD	Gastroenterology
John Parker	MD	Endocrinology
Patrick Bruff	NP-C	Spinal Intervention
Michale Stavovy	PA-C	Surgery Vascular
David Schultz	MD	Hospitalist
Victor Tucker	FNP-C	Pediatrics
Robert Johnson	MD	Family Medicine
Kira Alatar	MD	Family Medicine
Kristin Nomides	FNP-C	Family Medicine
Jenna Bennett	NP	Internal Medicine
Susan Brandt	NP	Pediatrics
Patrick Tester	MD	Internal Medicine
Elizabeth Benfield	PA-C	Rheumatology
Ronald George	MD	Rheumatology
Lawrence Landingram	PA-C	Rheumatology
Heather Favorito	MD	Rheumatology

Provider Name	Suffix	Specialty
Anna Caitlin Paylor	FNP	Pulmonary
Kevin O'Neil	MD	Pulmonary
Maria Mastoras	NP-C	Pulmonary
Paula Babiss	MD	Internal Medicine
Megan Kinney	MD	Dermatology
Susannah Aylesworth	MD	Pediatrics
Jessica Burkett	MD	Family Medicine
J'nelle Ruscetti	PA-C	Family Medicine
Robert Grove	PA-C	Cardiology
Jeremy Holdsworth	MD	Family Medicine
Scott Visser	MD	Family Medicine
Matthew Sincock	MD	Infectious Disease
Negin Misaghian-Xantho	MD	Endocrinology
George Stamatoros	DO	Endocrinology
Sarah Falk	FNP-C	Endocrinology
Kathy Lewis	NP-C	Endocrinology
Susan Thomas	GNP-BC	Internal Medicine
Linda Leck	FNP-C	Internal Medicine
Catherine Daum	MD	Internal Medicine
Brian Webster	MD	Internal Medicine
Jonathan Staub	MD	Internal Medicine
Emily Murtha	FNP-C	Infectious Disease
Paul Kamitsuka	MD	Infectious Disease
Rose Coady	MD	Family Medicine
Heather Anderson	MD	Family Medicine
Howard Ruscetti	MD	Family Medicine
Michelle Jones	MD	Family Medicine
Laura Tanner	MD	Dermatology
Rebecca Maphis	FNP	Dermatology
Emily Poczontek	NP-C	Internal Medicine
Nicole Caroll	MD	OBGYN
Sarah Gore	DO	OBGYN
David Joseph	MD	OBGYN
Barbara Klein	WHNP-BC	OBGYN
Margeret McElroy	DO	OBGYN
Rachel McLean	DO	OBGYN
Alison Parker	MD	OBGYN
George Stewart	MD	OBGYN
Joshua Vogel	MD	OBGYN
Gregory Woodfill	DO	OBGYN
Pamela Rogers	FNP-C	Pediatrics
Jeffrey Culp	MD	Allergy
Lauren Jones	WHNP-BC	OBGYN
David Green	MD	Pulmonary
Ashley Schuman	FNP	Convenient Care
James McGrath	MD	Oncology

Totals by Speciality

Allergy	1
Cardiology	6
Convenient Care	1
Dermatology	3
Endocrinology	8
Family Medicine	15
Gastroenterology	1
Hospitalist	1
Internal Medicine	13
Infectious Disease	4
Neurology	1
OBGYN	11
Oncology	1
Pediatrics	11
Plastic Surgery	1
Pulmonary	5
Radiology	1
Rheumatology	4
Spinal Intervention	1
Surgery Vascular	1
Urgent Care	1
Urology	2

Totals by Provider Type

DO	6
FNP	4
FNP-C	8
GNP-BC	1
MD	54
NP	2
NP-C	7
PA-C	9
WHNP-BC	2

January 2, 2018

WILMINGTON HEALTH

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

RE: Letter in support of proposed Wilmington ASC, LLC ambulatory surgical facility in New Hanover County, North Carolina

Dear Ms. Frisone,

I am writing this letter to express support for the certificate of need submitted by Wilmington ASC, LLC (WASC) for a freestanding ambulatory surgical center (ASC) in New Hanover County. I understand this application was submitted as a cooperative venture between Surgical Care Affiliates, LLC, and Wilmington Health, PLLC.

New Hanover County has some excellent medical resources, although its surgical facility options are limited. What patients are expected to pay for services at the hospital-owned facilities is high, and scheduling at both the hospital and the one freestanding facility is occasionally difficult. Patients in our service area juggle transportation, caregiver support and work schedules to accommodate surgeries. Predictability is important to them. The proposed new WASC will expand access at affordable rates in a safe and convenient setting.

Changes associated with the CON decisions in 2016 will increase the number of freestanding operating rooms, by three. However, the Agency decision will not improve our options much. At the end of the day, patients and their surgeons will have only two choices of facility owners. A referral area as large as New Hanover, needs more options to maintain the positive nature of competition.

Moreover, it is my understanding WASC's application stands out because it proposes to offer:

- The most comprehensive list of surgical specialties of all freestanding ASC proposals;
- A low-cost structure;
- A generous charity care policy, regardless of insurance provider;
- A convenient, modern, and well-designed facility located in a developing area of Wilmington that is accessible to the hospital and patients;
- The only Femtosecond laser in a New Hanover County freestanding ASC; and,
- The only joint cooperative between the nation's largest independent ASC management company and New Hanover County's largest Independently Owned Multispecialty Practice and Physician Led Accountable Care Organization.

Wilmington Health
1202 Medical Center Drive
Wilmington, NC 28401
Phone: 910.341.3300
Fax: 910.341.3419
wilmingtonhealth.com

WILMINGTON HEALTH

Having met with representatives of WASC, and had time to consider their other operations, I am pleased with what I know of SCA and Wilmington Health in terms of quality and willingness to take patients from all payor sources. Moreover, the providers who intend to care for patients in the proposed WASC are among the finest in the Lower Cape Fear Region. In short, the proposed new freestanding ASC would be good for my patients and good for the community. Both SCA and Wilmington Health have reputations for efficient operations, reasonable charges, and good quality control standards.

I urge the DHHS Division of Health Service Regulation to approve the certificate of need application from the SCA-related applicant as soon as possible. They are the best choice among the four competitors in this review.

Sincerely,

MD

Suzanne Smith, MD
Pediatrics

Wilmington Health
1202 Medical Center Drive
Wilmington, NC 28401
Phone: 910.341.3300
Fax: 910.341.3419
wilmingtonhealth.com

January 2, 2018

WILMINGTON HEALTH

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

RE: Letter in support of proposed Wilmington ASC, LLC ambulatory surgical facility in New Hanover County, North Carolina

Dear Ms. Frisone,

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Wilmington Health
1202 Medical Center Drive
Wilmington, NC 28401
Phone: 910.341.3300
Fax: 910.341.3419
wilmingtonhealth.com

WILMINGTON HEALTH

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Sincerely,

Danny Ott, MD
Pediatrics

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1202 Medical Center Drive
Wilmington, NC 28401
Phone: 910.341.3300
Fax: 910.341.3419
wilmingtonhealth.com

January 2, 2018

WILMINGTON HEALTH

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Department of Health Service Regulation
Healthcare Planning and Certificate of Need Section
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Sincerely,

Kelly Capobianco, NP-C
Pediatrics

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Sincerely,

Pamela Taylor, DO
Pediatrics

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Sincerely,

Erin Whitehead, NP-C
Pediatrics

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Sincerely,

Caryn A Bowden FNP

Caryn Bowden, FNP-C
Pediatrics

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Sincerely,

Noah Archer, MD

Noah Archer, MD
Pediatrics

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Sincerely,

Sam Armani, MD
Radiology

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Sincerely,

Tor Ljung, MD
Plastic Surgery

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January 2, 2018

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Sincerely,

Catherine Hawley FNP

Catherine Hawley, FNP
Family Medicine

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Sincerely,

Linda Ferrand

Linda Ferrand, PA-C
Family Medicine

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Wilmington Health
1202 Medical Center Drive
Wilmington, NC 28401

Phone: 910.341.3390
Fax: 910.341.3419

wilmingtonhealth.com

WILMINGTON HEALTH

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Sincerely,

Cyril Abrams MD FACC

Cyril Abrams, MD
Cardiology

Wilmington Health
1202 Medical Center Drive
Wilmington, NC 28401

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Fax: 910.341.3419

wilmingtonhealth.com

January 2, 2018

WILMINGTON HEALTH

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

RE: Letter in support of proposed Wilmington ASC, LLC ambulatory surgical facility in New Hanover County, North Carolina

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Sincerely,

Troy Ehrhart, MD
Family Medicine

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1202 Medical Center Drive
Wilmington, NC 28401

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Fax: 910.341.3419

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January 2, 2018

WILMINGTON HEALTH

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Healthcare Planning and Certificate of Need Section
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Sincerely,

Arlene Hallegado, MD
Family Medicine

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Wilmington, NC 28401

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January 2, 2018

WILMINGTON HEALTH

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Healthcare Planning and Certificate of Need Section
2704 Mail Service Center
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Sincerely,

Joseph Gallagher, MD
Gastroenterology

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Wilmington, NC 28401

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January 2, 2018

WILMINGTON HEALTH

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Sincerely,

John Parker, MD
Endocrinology

Wilmington Health
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January 2, 2018

WILMINGTON HEALTH

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2704 Mail Service Center
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Sincerely,

Patrick Bruff, NP-C
Spinal Intervention

Wilmington Health
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Wilmington, NC 28401
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January 2, 2018

WILMINGTON HEALTH

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Sincerely,

Michele Stavovy, PA-C
Surgery Vascular

Wilmington Health
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Wilmington, NC 28401
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wilmingtonhealth.com

January 2, 2018

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Sincerely,

David Schultz, MD
Hospitalist

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Wilmington, NC 28401

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January 2, 2018

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Sincerely,

Vickie Tucker

Vickie Tucker, FNP-C
Pediatrics

Wilmington Health
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January 2, 2018

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Robert Johnson, MD
Family Medicine

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January 2, 2018

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Phone: 910.341.3300
Fax: 910.341.3419
wilmingtonhealth.com

WILMINGTON HEALTH

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Sincerely,

Kira Alatar, MD
Family Medicine

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1202 Medical Center Drive
Wilmington, NC 28401
Phone: 910.341.3300
Fax: 910.341.3419
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January 2, 2018

WILMINGTON HEALTH

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

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Kristin Nomides, FNP-C
Family Medicine

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Sincerely,

Jenna Bennett, NP
Internal Medicine

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January 2, 2018

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Sincerely,

Susan Brandt, NP
Pediatrics

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Sincerely,

Patrick Tester, MD
Internal Medicine

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Sincerely,

Elizabeth Benfield, PA-C
Rheumatology

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Ronald George, MD
Rheumatology

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Lawrence Landrigan, PA-C
Rheumatology

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Heather Favorito

Heather Favorito, MD
Rheumatology

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James McGrath, MD
Oncology

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1202 Medical Center Drive
Wilmington, NC 28401
Phone: 910.341.3300
Fax: 910.341.3419
wilmingtonhealth.com

WILMINGTON HEALTH

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Sincerely,

Anna Caitlin Paylor, FNP

Anna Caitlin Paylor, FNP
Pulmonary

Wilmington Health
1202 Medical Center Drive
Wilmington, NC 28401
Phone: 910.341.3300
Fax: 910.341.3419
wilmingtonhealth.com

January 2, 2018

WILMINGTON HEALTH

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

RE: Letter in support of proposed Wilmington ASC, LLC ambulatory surgical facility in New Hanover County, North Carolina

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Sincerely,

Kevin O'Neil, MD
Pulmonary

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1202 Medical Center Drive
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Fax: 910.341.3419
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January 2, 2018

WILMINGTON HEALTH

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Sincerely,

Maria Mastoras, NP-C
Pulmonary

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wilmingtonhealth.com

January 2, 2018

WILMINGTON HEALTH

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Healthcare Planning and Certificate of Need Section
2704 Mail Service Center
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Sincerely, Paula Babiss

Paula Babiss, MD
Internal Medicine

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1202 Medical Center Drive
Wilmington, NC 28401
Phone: 910.341.3300
Fax: 910.341.3419
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January 2, 2018

WILMINGTON HEALTH

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Department of Health Service Regulation
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Sincerely,

Megan Kinney, MD
Dermatology

Wilmington Health
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Wilmington, NC 28401
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January 2, 2018

WILMINGTON HEALTH

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Sincerely,

Susannah Aylesworth, MD
Pediatrics

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January 2, 2018

WILMINGTON HEALTH

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Sincerely,

Jessica Burkett, MD
Family Medicine

Wilmington Health
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Wilmington, NC 28401

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Fax: 910.341.3419

wilmingtonhealth.com

January 2, 2018

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Jrielle Ruscetti, PA-C
Family Medicine

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Wilmington, NC 28401
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January 2, 2018

WILMINGTON HEALTH

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Department of Health Service Regulation
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Rose Coady, MD
Family Medicine

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January 2, 2018

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Heather Anderson, MD
Family Medicine

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January 2, 2018

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Wilmington Health
1202 Medical Center Drive
Wilmington, NC 28401
Phone: 910.341.3300
Fax: 910.341.3419
wilmingtonhealth.com

WILMINGTON HEALTH

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Sincerely,

Howard Rascetti, MD
Family Medicine

Wilmington Health
1202 Medical Center Drive
Wilmington, NC 28401
Phone: 910.341.3300
Fax: 910.341.3419
wilmingtonhealth.com

WILMINGTON HEALTH

January 2, 2018

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

RE: Letter in support of proposed Wilmington ASC, LLC ambulatory surgical facility in New Hanover County, North Carolina

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Wilmington Health
[illegible]
Phone: 910.341.3000
Fax: 910.341.3419
wilmingtonhealth.com

WILMINGTON HEALTH

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Sincerely,

Michelle Jones, MD
Family Medicine

Wilmington Health
[illegible]
Phone: 910.341.3000
Fax: 910.341.3419
wilmingtonhealth.com

January 2, 2018

WILMINGTON HEALTH

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Department of Health Service Regulation
Healthcare Planning and Certificate of Need Section
2704 Mail Service Center
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Sincerely,

Laura Tanner, MD
Dermatology

Wilmington Health
1202 Medical Center Drive
Wilmington, NC 28401
Phone: 910.341.3300
Fax: 910.341.3419
wilmingtonhealth.com

January 2, 2018

WILMINGTON HEALTH

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Healthcare Planning and Certificate of Need Section
2704 Mail Service Center
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Sincerely,

Rebecca Maphis FNP-C

Rebecca Maphis, FNP
Dermatology

Wilmington Health
1202 Medical Center Drive
Wilmington, NC 28401

Phone: 910.341.3300
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wilmingtonhealth.com

January 2, 2018

WILMINGTON HEALTH

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Department of Health Service Regulation
Healthcare Planning and Certificate of Need Section
2704 Mail Service Center
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1202 Medical Center Drive
Wilmington, NC 28401
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Sincerely,

Emily Poczontek, NP-C

Emily Poczontek, NP-C
Internal Medicine

Wilmington Health
1202 Medical Center Drive
Wilmington, NC 28401
Phone: 910.341.3300
Fax: 910.341.3419
wilmingtonhealth.com

January 2, 2018

WILMINGTON HEALTH

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Healthcare Planning and Certificate of Need Section
2704 Mail Service Center
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Sincerely,

Nicole Carroll, MD
OBGYN

Wilmington Health
1202 Medical Center Drive
Wilmington, NC 28401
Phone: 910 343 3300
Fax: 910.341.3479
wilmingtonhealth.com

January 2, 2018

WILMINGTON HEALTH

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Department of Health Service Regulation
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2704 Mail Service Center
Raleigh, NC 27699

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Sarah M. Gore DO

Sarah Gore, DO
OBGYN

Wilmington Health
1202 Medical Center Drive
Wilmington, NC 28401
Phone: 910.341.3300
Fax: 910.341.3419
wilmingtonhealth.com

January 2, 2018

WILMINGTON HEALTH

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Department of Health Service Regulation
Healthcare Planning and Certificate of Need Section
2704 Mail Service Center
Raleigh, NC 27699

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Wilmington, NC 28401

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Fax: 910.341.3419

wilmingtonhealth.com

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David Joseph, MD
OBGYN

Wilmington Health
1202 Medical Center Drive
Wilmington, NC 28401

Phone: 910.341.3300
Fax: 910.341.3419

wilmingtonhealth.com

January 2, 2018

WILMINGTON HEALTH

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Sincerely,

Barbara Klein, WHNP-BC
OBGYN

Wilmington Health
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Wilmington, NC 28401
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Fax: 910.341.3419
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January 2, 2018

WILMINGTON HEALTH

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Margaret McElroy, DO
OBGYN

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1202 Medical Center Drive
Wilmington, NC 28401
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Wilmington Health
1202 Medical Center Drive
Wilmington, NC 28401
Phone: 910.341.3300
Fax: 910.341.3419
wilmingtonhealth.com

WILMINGTON HEALTH

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Sincerely,

Rachel McLean, DO
OBGYN

Wilmington Health
1202 Medical Center Drive
Wilmington, NC 28401
Phone: 910.341.3300
Fax: 910.341.3419
wilmingtonhealth.com

January 2, 2018

WILMINGTON HEALTH

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

RE: Letter in support of proposed Wilmington ASC, LLC ambulatory surgical facility in New Hanover County, North Carolina

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Sincerely,

Alison Parker, MD
OBGYN

Wilmington Health
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Wilmington, NC 28401
Phone: 910.341.3300
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wilmingtonhealth.com

January 2, 2018

WILMINGTON HEALTH

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2704 Mail Service Center
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Sincerely,

George Stewart, MD
OBGYN

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January 2, 2018

WILMINGTON HEALTH

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Healthcare Planning and Certificate of Need Section
2704 Mail Service Center
Raleigh, NC 27699

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Sincerely,

Joshua Vogel, MD
OBGYN

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Wilmington, NC 28401
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January 2, 2018

WILMINGTON HEALTH

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Department of Health Service Regulation
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Sincerely,

Gregory Woodfill, DO
OBGYN

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Wilmington, NC 28401
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Fax: 910.341.3419
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January 2, 2018

WILMINGTON HEALTH

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2704 Mail Service Center
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Sincerely,

Pamela Rogers, FNP-C
Pediatrics

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Wilmington, NC 28401
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January 2, 2018

WILMINGTON HEALTH

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Department of Health Service Regulation
Healthcare Planning and Certificate of Need Section
2704 Mail Service Center
Raleigh, NC 27699

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Wilmington Health
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Wilmington, NC 28401
Phone: 910.341.3360
Fax: 910.341.3419
wilmingtonhealth.com

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Sincerely,

Jeffrey Culp, MD
Allergy

Wilmington Health
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Phone: 910.341.3360
Fax: 910.341.3419
wilmingtonhealth.com

January 2, 2018

WILMINGTON HEALTH

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Department of Health Service Regulation
Healthcare Planning and Certificate of Need Section
2704 Mail Service Center
Raleigh, NC 27699

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Lauren Jones, WHNP-BC
OBGYN

Wilmington Health
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Wilmington, NC 28401
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January 2, 2018

WILMINGTON HEALTH

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Department of Health Service Regulation
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Sincerely,

David Green, MD
Pulmonary

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Phone: 910.341.3300
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January 2, 2018

WILMINGTON HEALTH

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Ashley Schuman, FNP-C

Ashley Schuman, FNP
Convenient Care

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Wilmington, NC 28401
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January 2, 2018

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1202 Medical Center Drive
Wilmington, NC 28401
Phone: 910.341.3300
Fax: 910.341.3419
wilmingtonhealth.com

WILMINGTON HEALTH

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Sincerely,

Michael McGarrity, MD
Endocrinology

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1202 Medical Center Drive
Wilmington, NC 28401
Phone: 910.341.3300
Fax: 910.341.3419
wilmingtonhealth.com

January 2, 2018

WILMINGTON HEALTH

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

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Negin Misaghian-Xanthos, MD
Endocrinology

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Sincerely,

Seth Braunstein, MD
Endocrinology

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Sincerely,

George Stamatoros, DO
Endocrinology

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Michael Favorito, MD
Endocrinology

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Sarah Falk, FNP-C
Endocrinology

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January 2, 2018

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Sincerely,

Kathy Lewis, NP-C

Kathy Lewis, NP-C
Endocrinology

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January 2, 2018

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Sincerely,

Mitchell Lee, MD
Pulmonary

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January 2, 2018

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Sincerely,

Alfred Demaria, MD
Neurology

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Sincerely,

Susan Thomas

Susan Thomas, GNP-BC
Internal Medicine

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Wilmington Health
1202 Medical Center Drive
Wilmington, NC 28401

Phone: 910.341.3300
Fax: 910.341.3419

wilmingtonhealth.com

WILMINGTON HEALTH

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Sincerely,

Jill Finnegan, PA-C
Internal Medicine

Wilmington Health
1202 Medical Center Drive
Wilmington, NC 28401

Phone: 910 341 3300
Fax: 910.341.3419

wilmingtonhealth.com

January 2, 2018

WILMINGTON HEALTH

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

RE: Letter in support of proposed Wilmington ASC, LLC ambulatory surgical facility in New Hanover County, North Carolina

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Sincerely,

Linda Leck

Linda Leck, FNP-C
Internal Medicine

Wilmington Health
1202 Medical Center Drive
Wilmington, NC 28401
Phone: 910.341.3300
Fax: 910.341.3419
wilmingtonhealth.com

January 2, 2018

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Sincerely,

Jonathan Hines, MD
Internal Medicine

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Phone: 910.341.3300
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wilmingtonhealth.com

January 2, 2018

WILMINGTON HEALTH

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Healthcare Planning and Certificate of Need Section
2704 Mail Service Center
Raleigh, NC 27699

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Sincerely,

Catherine Daum, MD
Internal Medicine

Wilmington Health
1202 Medical Center Drive
Wilmington, NC 28401
Phone: 910.341.3300
Fax: 910.341.3419
wilmingtonhealth.com

January 2, 2018

WILMINGTON HEALTH

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2704 Mail Service Center
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Sincerely,

Jeannine Jones-Guion, PA-C
Internal Medicine

Wilmington Health
1202 Medical Center Drive
Wilmington, NC 28401
Phone: 910.341.3300
Fax: 910.341.3419
wilmingtonhealth.com

January 2, 2018

WILMINGTON HEALTH

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Department of Health Service Regulation
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2704 Mail Service Center
Raleigh, NC 27699

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Brian Webster, MD
Internal Medicine

Wilmington Health
1202 Medical Center Drive
Wilmington, NC 28401

Phone: 910.341.3300
Fax: 910.341.3419

wilmingtonhealth.com

January 2, 2018

WILMINGTON HEALTH

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Department of Health Service Regulation
Healthcare Planning and Certificate of Need Section
2704 Mail Service Center
Raleigh, NC 27699

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Phone: 910.341.3300
Fax: 910.341.3419

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Craig Webb, PA-C
Internal Medicine

Wilmington Health
1202 Medical Center Drive
Wilmington, NC 28401

Phone: 910.341.3300
Fax: 910.341.3419

wilmingtonhealth.com

January 2, 2018

WILMINGTON HEALTH

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Department of Health Service Regulation
Healthcare Planning and Certificate of Need Section
2704 Mail Service Center
Raleigh, NC 27699

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Sincerely,

Jonathan Staub, MD
Internal Medicine

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1202 Medical Center Drive
Wilmington, NC 28401

Phone: 910.341.3300
Fax: 910.341.3419

wilmingtonhealth.com

January 2, 2018

WILMINGTON HEALTH

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Department of Health Service Regulation
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Sincerely,

Sharon Speed MD

Sharon Speed, MD
Urgent Care

Wilmington Health
1202 Medical Center Drive
Wilmington, NC 28401

Phone: 910.341.3300
Fax: 910.341.3419

wilmingtonhealth.com

January 2, 2018

WILMINGTON HEALTH

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Department of Health Service Regulation
Healthcare Planning and Certificate of Need Section
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Sincerely,

Emily Murtha, FNP-C
Infectious Disease/Internal Medicine

Wilmington Health
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Wilmington, NC 28401
Phone: 910.341.3300
Fax: 910.341.3419
wilmingtonhealth.com

January 2, 2018

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1202 Medical Center Drive
Wilmington, NC 28401
Phone: 910.341.3300
Fax: 910.341.3419
wilmingtonhealth.com

WILMINGTON HEALTH

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I urge the DHHS Division of Health Service Regulation to approve the certificate of need application from the SCA-related applicant as soon as possible. They are the best choice among the four competitors in this review.

Sincerely,

Gina Berthold, MD
Infectious Disease

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1202 Medical Center Drive
Wilmington, NC 28401
Phone: 910.341.3300
Fax: 910.341.3419
wilmingtonhealth.com

January 2, 2018

WILMINGTON HEALTH

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

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Paul Kamitsuka, MD
Infectious Disease

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Sincerely,

Kathryn "Kate" Monroe, NP-C
Cardiology

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Wilmington, NC 28401
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wilmingtonhealth.com

January 2, 2018

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Healthcare Planning and Certificate of Need Section
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Sincerely,

Carlos (Garcia) Arrieta, MD
Cardiology

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Sincerely,

Matt Janik, MD
Cardiology

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Wilmington, NC 28401

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Fax: 910.341.3419

wilmingtonhealth.com

January 2, 2018

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G Robinson FNP-BC
Gail Robinson, FNP-BC
Urology

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David Kraebber, MD
Urology

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Paul Payne, MD
Cardiology

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January 2, 2018

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Robert Grove, PA-C
Cardiology

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January 2, 2018

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Sincerely,

Jeremy Holdsworth, MD
Family Medicine

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Phone: 910.341.3300
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January 2, 2018

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Changes associated with the CON decisions in 2016 will increase the number of freestanding operating rooms, by three. However, the Agency decision will not improve our options much. At the end of the day, patients and their surgeons will have only two choices of facility owners. A referral area as large as New Hanover, needs more options to maintain the positive nature of competition.

Moreover, it is my understanding WASC's application stands out because it proposes to offer:

- The most comprehensive list of surgical specialties of all freestanding ASC proposals;
- A low-cost structure;
- A generous charity care policy, regardless of insurance provider;
- A convenient, modern, and well-designed facility located in a developing area of Wilmington that is accessible to the hospital and patients;
- The only Femtosecond laser in a New Hanover County freestanding ASC; and,
- The only joint cooperative between the nation's largest independent ASC management company and New Hanover County's largest Independently Owned Multispecialty Practice and Physician Led Accountable Care Organization.

Wilmington Health
1202 Medical Center Drive
Wilmington, NC 28401
Phone: 910.341.3300
Fax: 910.341.3419
wilmingtonhealth.com

WILMINGTON HEALTH

Having met with representatives of WASC, and had time to consider their other operations, I am pleased with what I know of SCA and Wilmington Health in terms of quality and willingness to take patients from all payor sources. Moreover, the providers who intend to care for patients in the proposed WASC are among the finest in the Lower Cape Fear Region. In short, the proposed new freestanding ASC would be good for my patients and good for the community. Both SCA and Wilmington Health have reputations for efficient operations, reasonable charges, and good quality control standards.

I urge the DHHS Division of Health Service Regulation to approve the certificate of need application from the SCA-related applicant as soon as possible. They are the best choice among the four competitors in this review.

Sincerely,

Scott Visser

Scott Visser, MD
Family Medicine

Wilmington Health
1202 Medical Center Drive
Wilmington, NC 28401
Phone: 910.341.3300
Fax: 910.341.3419
wilmingtonhealth.com

January 2, 2018

WILMINGTON HEALTH

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

RE: Letter in support of proposed Wilmington ASC, LLC ambulatory surgical facility in New Hanover County, North Carolina

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Wilmington Health
1202 Medical Center Drive
Wilmington, NC 28401

Phone: 910.341.3300
Fax: 910.341.3479

wilmingtonhealth.com

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Sincerely,

Matthew Sincock, MD
Infectious Disease

Wilmington Health
1202 Medical Center Drive
Wilmington, NC 28401

Phone: 910.341.3300
Fax: 910.341.3479

wilmingtonhealth.com