COMPETITIVE COMMENTS ON WAKE COUNTY 2018 OPERATING ROOM NEED DETERMINATION SUBMITTED BY ORTHONC ASC

OrthoNC ASC ("**OrthoNC**") (Project ID No. J-011561-18) proposes to develop a new ambulatory surgery center ("ASC") with one operating room ("OR") and one procedure room in North Raleigh/Wakefield. Eight additional applications were submitted in response to the need determination in the 2018 State Medical Facilities Plan ("SMFP") for six ORs in Wake County:

5. Green Level Ambulatory Surgical Center ("**Duke Green Level**") Project ID No. J-011557-18 Develop a new ASC with 4 ORs in Cary	80
6. Duke Raleigh Hospital ("**Duke Raleigh**") Project ID No. J-011558-18 Add 2 shared ORs to its existing hospital in Raleigh for a total of 17 ORs	87
7. WakeMed Surgery Center-North Raleigh ("**WakeMed-NR**") Project ID No. J-011564-18 Develop a new ASC with 2 ORs and 2 procedure rooms in North Raleigh	93
8. WakeMed Surgery Center-Cary ("**WakeMed-Cary**") Project ID No. J-011565-18 Develop a new ASC with 2 ORs in Cary	115

These comments are submitted in accordance with N.C. Gen. Stat. § 131E-185(a1)(1) to address the representations in the applications, including a comparative analysis and discussion as to whether the applications conform with the statutory and regulatory review criteria ("the Criteria") in N.C. Gen. Stat. §131E-183(a) and (b). **Other non-conformities in the competing applications may exist.**

Other abbreviations used in these comments include:

- UNC REX Holly Springs Hospital – UNC REX HSH
- UNC REX Surgery Center of Wakefield – UNC REX Wakefield
- UNC REX Surgery Center of Cary – UNC REX Cary
- Duke University Health System - DUHS

Note: Unless otherwise noted, "ORs" as used in these comments and attached tables should be understood to exclude dedicated C-Section and burn/trauma ORs and OR demonstration projects.

COMPARATIVE COMMENTS

Conformity to CON Review Criteria

Nine CON applications have been submitted seeking a total of 18 ORs. Based on the 2018 SMFP's need determination for only 6 ORs, not all applications can be approved. Only applicants demonstrating conformity with all applicable Criteria can be approved, and only the application submitted by **OrthoNC** demonstrates conformity to all Criteria:

Conformity of Proposed Facilities

Applicant	Project I.D.	Proposed New ORs	Conforming/Non-Conforming
RAC	J-011551-18	1	No
UNC REX Garner	J-011553-18	2	No
UNC Panther Creek	J-011554-18	2	No
UNC REX	J-011555-18	2	No
Duke Green Level	J-011557-18	4	No
Duke Raleigh	J-011558-18	2	No
OrthoNC	**J-011561-18**	**1**	**Yes**
WakeMed-NR	J-011564-18	2	No
WakeMed-Cary	J-011565-18	2	No
Total		18	

The **OrthoNC** application for a single OR is based on reasonable and supported volume projections premised on the historically-grounded estimates of the surgeons who will be owner/investors performing cases at **OrthoNC.** As discussed below, projections in the competing applications are based on unreasonable and unsupported assumptions; these and other issues result in one or more non-conformities with statutory and regulatory review Criteria. Therefore, **OrthoNC** is the most effective alternative on conformity with the Criteria.

Patient Access to a New Provider in the Service Area

This is the most important comparative factor in this batch review. The need determination for additional ORs represents a rare opportunity to establish a new ASC

owned and operated by a new surgical provider in Wake County. Only the applications submitted by **OrthoNC** and **RAC** would introduce a new surgical provider to the service area:

Market Status of Proposed Facilities

Applicant	Project I.D.	New Provider
RAC	J-011551-18	Yes
UNC REX Garner	J-011553-18	No
UNC Panther Creek	J-011554-18	No
UNC REX	J-011555-18	No
Duke Green Level	J-011557-18	No
Duke Raleigh	J-011558-18	No
OrthoNC	**J-011561-18**	**Yes**
WakeMed-NR	J-011564-18	No
WakeMed-Cary	J-011565-18	No

All but 10 of the 100 existing/approved ORs[1] (10%) in Wake County are owned by UNC, Duke or WakeMed. The project applications by **UNC REX Hospital**, **UNC REX Garner**, **UNC Panther Creek**, **WakeMed-Cary**, **WakeMed-NR**, **Duke Green Level**, and **Duke Raleigh** would simply add additional hospital-owned ORs to Wake County. Thus, these proposals are ineffective at improving patient access/choice and increasing competition.

Ownership of Proposed Facilities

Applicant	Project I.D.	Includes Ownership by Hospitals Already Serving Wake County
RAC	J-011551-18	No
UNC REX Garner	J-011553-18	Yes
UNC Panther Creek	J-011554-18	Yes
UNC REX	J-011555-18	Yes
Duke Green Level	J-011557-18	Yes
Duke Raleigh	J-011558-18	Yes
OrthoNC	**J-011561-18**	**No**
WakeMed-NR	J-011564-18	Yes
WakeMed-Cary	J-011565-18	Yes

[1] Does not include the 1 OR at SDSC (dental demonstration project) and the 2 ORs at Triangle Orthopedic (single-specialty demonstration project).

Only two applications—**OrthoNC** and **RAC**—have the potential to improve patient choice by offering a new provider in the service area and are the most effective alternatives. Relevant data is included in Tables 1 and 2, attached.

Geographic Accessibility

The ORs proposed by **UNC REX** and **Duke Raleigh** would be added to existing hospitals in *Central Wake County*. Multiple facilities exist in *Central Wake County* and these hospital OR additions would not improve geographic access to surgical services in Wake County. Therefore, these two applications are the least effective alternatives for improving geographic access. The remaining applications propose to locate ORs in new ASCs. Existing/approved freestanding ASCs in Wake County are located as follows:

Location/Utilization of Existing/Approved Wake County OR Facilities

Surgical Provider	Type	Wake County Location	Percent Utilization 2017
Triangle Ortho	Specialty	West	95.8%
REX Wakefield*	Multi-specialty	North	85.2%
Raleigh Orthopedic Surgery Center	Specialty	Central	77.7%
Raleigh Orthopedic West Cary	Specialty	West	New
Rex Surgery Center Cary	Multi-specialty	South	59.1%
Capital City	Multi-specialty	Central	34.7%
Blue Ridge Surgery Center	Multi-specialty	Central	32.1%
Raleigh Plastic Surg Ctr	Specialty	Central	29.8%
Holly Springs Surg Center (opened 2017)	Multi-specialty	South	9.5%
SCDP	Specialty	Central	New

Northern Wake County has only one freestanding ASC (UNC REX Wakefield), with two ORs which are highly utilized. The **OrthoNC** application is the only application proposing a location in northern Wake County which would alleviate capacity issues at UNC REX Wakefield as discussed in the **OrthoNC** application. **WakeMed-NR** is proposed as an ASC but will be immediately adjacent to the Hospital on the WakeMed North campus; utilization at WakeMed North is well under target and no new ORs are needed at that location. **OrthoNC** is a more effective alternative for a new location in northern Wake County.

Western Wake County has one freestanding ASC with one OR.

Eastern Wake County has no ASC.

Southern Wake County has two freestanding multi-specialty ASCs with seven ORs. Both facilities have available capacity to accept new surgeons and patients. Thus, the **WakeMed-Cary** proposal to add a new freestanding ASC in southern Wake County is not an effective alternative.

OrthoNC (northern Wake County), **UNC REX Garner** (eastern Wake County), **UNC REX Panther Creek** and **Duke Green Level** (western Wake County) are the most effective alternatives for improving geographic accessibility, as summarized below:

Locations for Proposed Facilities

Applicant	Project I.D.	Proposed Location	Improves Geographic Access
RAC	J-011551-18	New Bern Avenue near Wake Med – Central Wake County	No
UNC REX Garner	J-011553-18	Garner – Eastern Wake County	Yes
UNC Panther Creek	J-011554-18	West Cary – Western Wake County	Yes
UNC REX	J-011555-18	Existing Hospital Location – Central Wake County	No
Duke Green Level	J-011557-18	West Cary – Western Wake County	Yes
Duke Raleigh	J-011558-18	Existing Hospital Location – Central Wake County	No
OrthoNC	**J-011561-18**	**North Raleigh – North Wake County**	**Yes**
WakeMed-NR	J-011564-18	North Raleigh – North Wake County	Yes
WakeMed-Cary	J-011565-18	Cary – Southern Wake County	No

Adequacy of Physician Support

Physician Support

Applicant	Project I.D.	Adequate Physician Support
RAC	J-011551-18	Yes
UNC REX Garner	J-011553-18	No
UNC Panther Creek	J-011554-18	No
UNC REX	J-011555-18	Yes
Duke Green Level	J-011557-18	Yes
Duke Raleigh	J-011558-18	Yes
OrthoNC	**J-011561-18**	**Yes**
WakeMed-NR	J-011564-18	Yes
WakeMed-Cary	J-011565-18	Yes

OrthoNC provided specific letters of support from the Wake County orthopedic surgeons who will be owner/investors performing surgeries in the proposed **OrthoNC** ASC. These surgeons documented intent to perform a total of 1,337 OR cases annually at **OrthoNC**.

RAC demonstrated adequate physician support for an ASC dedicated to vascular surgery. **Duke Raleigh** and **Duke Green Level** (associated with Duke Health) and **WakeMed-Cary** and **WakeMed-NR** (associated with WakeMed) included wide physician support.

While **UNC REX** included wide physician support, **UNC REX Garner** and **UNC Panther Creek** presented inadequate physician support. **UNC REX Garner** describes general support from the larger UNC REX health system and an intent to recruit five surgeons but provides extremely limited documentation from existing Wake County surgeons intending to utilize the facility. Notably, only one percent (1%) of **UNC REX Garner's** projected utilization is based on volume from existing surgeons in Wake County. The remaining ninety-nine percent (99%) of **UNC REX Garner's** projected utilization is premised on recruitment of five new surgeons. Despite references to plans to recruit surgeons, nothing is included to document the need for additional surgeons in the market. **UNC REX Garner** includes letters from surgeons practicing at the Raleigh Orthopaedic Garner location stating their intent to seek privileges at the new facility which would improve access to their patients. However, none of these letters includes any projection of surgical volume

expected to be shifted to **UNC REX Garner**. Neither the assumptions for all UNC REX facilities in Wake County nor the projections for **UNC REX Garner** reflect any shift of the volume performed by these surgeons. (**UNC Rex Garner** App., Section Q. Form C Assumptions, pp. 3 – 23). Therefore, the Raleigh Orthopaedic letters provide no support for the **UNC REX Garner** utilization projections.

UNC Panther Creek also describes support from the larger UNC REX health system and plans to recruit surgeons for the project but provides extremely limited documentation from existing Wake County surgeons on intent to utilize the facility. Less than three percent (2.7%) of projected utilization is based on existing surgeons in Wake County. Over ninety-seven percent (97.3%) of projected utilization for **UNC Panther Creek** is based on recruitment of seven new surgeons. Despite references to plans to recruit surgeons, nothing is included to document the need for additional surgeons in the market.

UNC Panther Creek includes letters from six UNC affiliated surgeons "currently performing surgical cases in the area" but no surgical volume was projected to shift from other UNC Rex Health system facilities in Wake County associated with these six surgeons. Neither the assumptions for the UNC REX facilities in Wake County nor the projections for **UNC Panther Creek** reflect any shift of the volume performed by these surgeons. (**UNC Panther Creek** App., Section Q. Form C Assumptions, pp. 3-23). Therefore, these letters do not support the **UNC Panther Creek** projections. As to physician support, the **UNC Rex Garner** and **UNC Panther Creek** are the least effective alternatives.

Patient Access to ASC ORs

As shown in the following table, while nearly 60% of surgical hours in Wake County are for outpatient cases and 67 of the 103 existing/approved ORs, including demonstration

project ORs, are utilized for outpatient surgery; of the 103 ORs in Wake County, only 31.1% are in existing/approved freestanding ASCs.[2]

Outpatient Surgical Hours – Existing/Approved Wake County Facilities

Surgical Provider	Total Outpatient Cases	Outpt Surgical Hours	Total Surgical Hours	Outpatient Percent of Total Surgical Hours**	# of ORs	Estimated # Outpatient ORs
Rex Holly Springs Hospital	0	0	0	58.7%	3	1.8
Raleigh Orthopedic West Cary	0	0	0	100.0%	1	1.0
REX Wakefield*	1,955	3,324	3,324	100.0%	2	2.0
Raleigh Orthopedic Surgery Center	4,384	6,063	6,063	100.0%	3	3.0
Rex Surgery Center Cary	4,854	4,611	4,611	100.0%	4	4.0
UNC REX	10,681	24,744	50,113	49.4%	22	10.9
Capital City	5,388	5,412	5,412	100.0%	8	8.0
Wake Med	9,893	19,555	44,012	44.4%	23	10.2
WAKEMED-CARY	4,663	3,575	8,296	43.1%	9	3.9
Holly Springs Surgery Center	478	558	558	100.0%	3	3
Blue Ridge Surgery Center	7,043	3,757	3,757	100.0%	6	6.0
Raleigh Plastic Surgery Center	380	581	581	100.0%	1	1.0
Duke Raleigh	11,084	20,690	34,814	59.4%	15	8.9
Triangle Ortho***	2,437	0	0	100.0%	2	2.0
SCDP***	0	0	0	100.0%	1	1.0
Total Including Demo Projects	63,240	92,870	158,217	58.7%	103	66.6

* CON Approved conversion from HOPD to Freestanding; Data from REX 2018 LRA while HOPD

** REX HSH percent Outpt Hrs = Avg for all

*** Demonstration Projects

Yellow rows are orthopedic specialty ASC; green rows are multispecialty ASCs

Source: Proposed 2019 SMFP; 2018 LRAs attached Tables 3, 4 and 5

Freestanding ASCs provide excellent quality and better value for outpatient surgery, and also can improve access when located in densely populated areas away from other existing surgical facilities. The greater need in Wake County is for ORs in freestanding ASCs.

[2] Surgical providers in Wake County reported a total of 63,240 outpatient surgical cases equating to 92,870 outpatient surgical hours or 58.7% of total surgical hours in Wake County. Wake County's inventory of 103 existing/approved freestanding ASC ORs includes 3 specialty ASC ORs which are included above to reflect a more complete picture of need for additional orthopedic specialty ORs. (Source: Proposed 2019 SMFP as reported on 2018 LRAs).

UNC REX and **Duke Raleigh** propose hospital ORs. **WakeMed-NR** is described as a freestanding ASC but will be situated within the Wake Med North Raleigh hospital campus. These applicants are the least effective alternatives.

Patient Choice for Single-Specialty ASCs

In Wake County, sufficient hospital ORs and multi-specialty ASC ORs are available but single-specialty facilities are limited. Of the 32 existing/approved ASC ORs in Wake County, only 9 (28.1%) are offered in a single-specialty ASC with 23 (71.9%) offered as in a multi-specialty ASC.

Because nearly 72% of the ASC ORs in Wake County are multi-specialty and only 28% are single-specialty, the greater need in Wake County is for new single-specialty options, which can offer patients improved operational efficiencies with dedicated staff and equipment selected and devoted exclusively to a single specialty. Single-specialty ASCs are desirable options for patients seeking care in surgical centers dedicated to their specific needs.

In this Review, the most effective alternatives for expanding patient choice are **OrthoNC** and **RAC** because both propose new single-specialty ASCs:

Facility Type – Proposed Facilities

Applicant	Project I.D.	Type Facility
RAC	J-011551-18	Single Specialty ESRD Vascular Specialty ASC
UNC REX Garner	J-011553-18	Multi-specialty ASC
UNC Panther Creek	J-011554-18	Multi-specialty ASC
UNC REX	J-011555-18	Multi-specialty Shared Hospital ORs
Duke Green Level	J-011557-18	Multi-specialty ASC
Duke Raleigh	J-011558-18	Multi-specialty Shared Hospital ORs
OrthoNC	**J-011561-18**	**Single Specialty Orthopedic ASC**
WAKEMED-NR	J-011564-18	Multi-specialty ASC
WAKEMED-CARY	J-011565-18	Multi-specialty ASC

OrthoNC proposes a single-specialty orthopaedic ASC. Demand for outpatient orthopedic surgery in Wake County is high with surgical providers reporting a total of 19,241 outpatient orthopedic cases on their 2018 LRAs:

Orthopedic Outpatient Surgical Cases in 2018 – Wake County Providers

Surgical Provider	Outpatient Orthopedic Cases	Total Outpatient Cases	Percent Outpatient Cases
Rex Holly Springs Hospital	0	0	0.0%
Raleigh Orthopedic West Cary	0	0	100.0%
REX Wakefield*	759	1,955	38.8%
Raleigh Orthopedic Surgery Center	4,384	4,384	100.0%
Rex Surgery Center Cary	236	4,854	4.9%
UNC REX	953	10,681	8.9%
Capital City	3,954	5,388	73.4%
Wake Med	1,449	9,893	14.6%
WAKEMED-CARY	322	4,663	6.9%
Holly Springs Surgery Center	361	478	75.5%
Blue Ridge Surgery Center	1,145	7,043	16.3%
Raleigh Plastic Surgery Center	0	380	0.0%
Duke Raleigh	3,241	11,084	29.2%
Triangle Ortho	2,437	2,437	100.0%
SCDP	0	0	0.0%
Total Including Demo Projects	19,241	63,240	30.4%

* CON Approved convert from HOPD to Freestanding; this data is from REX 2018 LRA while HOPD
Source: Proposed 2019 SMFP; 2018 LRAs, attached Tables 3, 4 and 5

Orthopedic cases make up over 30% of total outpatient surgical cases performed in Wake County. Single-specialty orthopedic ASCs in Wake County are well-utilized, evidencing the strong demand for this ASC option. As shown in the following table, utilization of ORs at the two existing/approved orthopedic ASCs is considerably greater than all but one of the multi-specialty ASCs, with utilization exceeding the 75% utilization target used to determine Standard Hours per Operating Room in the 2018 SMFP Operating Room Need Methodology:

Percent Utilization in 2018 – Wake County Providers

Surgical Provider	Total Outpatient Cases	Total Surgical Hours	# of ORs	Total Surgical Hours @Capacity #ORs x 1,950	Percent Utilization 2017
Triangle Ortho	2,437	3,737	2	3,900	95.8%
REX Wakefield*	1,955	3,324	2	3,900	85.2%
Raleigh Orthopedic Surgery Center/ Raleigh Orthopedic West Cary**	4,384	6,063	4	7,800	77.7%
Rex Surgery Center Cary	4,854	4,611	4	7,800	59.1%
Capital City	5,388	5,412	8	15,600	34.7%
Blue Ridge Surgery Center	7,043	3,757	6	11,700	32.1%
Raleigh Plastic Surg Ctr	380	581	1	1,950	29.8%
Holly Springs Surg Center***	478	558	3	5,850	9.5%
SCDP	0	0	1	1,950	0.0%

*CON Approved convert from HOPD to Freestanding; this data is from REX 2018 LRA while HOPD
**Combined as Raleigh Orthopedic West not yet operational
***New facility, opened in FFY 2017
Source: Proposed 2019 SMFP; 2018 LRAs; attached Tables 3 and 4

OrthoNC meets the need for a single-specialty ASC for orthopedics, the single highest-volume surgical specialty most in demand in Wake County. Therefore, **OrthoNC** is the most effective alternative for a new ASC in Wake County.

Patient Access to Low Cost Alternative ASCs

Many outpatient surgical procedures currently performed in hospitals can be performed at much lower cost (to both patients and payors) in ASCs. Every application in this Review except **UNC REX** and **Duke Raleigh** proposes development of an ASC. **UNC REX** and **Duke Raleigh** would not increase patient access to low cost ASCs.

Access by Underserved Groups[3]

Charity Care

The following table shows the percent of charity care/self-pay patients projected for each of the applicants in Project Year 2 as reflected in Section L Question 3(a) and in Forms F.4 and F.5. Certain applications presented payor mix categories in Section L and Forms F.4 and F.5 inconsistent with the CON Section application form combining Charity Care and Self Pay. Therefore, the following table reflects combined Charity Care and Self Pay.

Applicant	Project I.D.	Inpatient Charity Care/Self Pay PY2	Outpatient Charity Care/Self Pay PY2
OrthoNC	**J-011561-18**	**NA**	**4.0%**
UNC Panther Creek	J-011554-18	NA	3.9%
UNC REX Garner	J-011553-18	NA	3.4%
WakeMed-Cary	J-011565-18	NA	2.9%
RAC	J-011551-18	NA	2.4%
UNC REX*	J-011555-18	2.3%	2.3%
Duke Green Level	J-011557-18	NA	1.6%
WakeMed-NR	J-011564-18	NA	1.6% or 1.8%
Duke Raleigh	J-011558-18	1.8%	1.4%

*REX UNC data combined inpatient and outpatient

**WakeMed-NR data in Section L inconsistent with data in Forms F.4 And F.5

The **OrthoNC** application is the most effective alternative with the highest charity care/self pay percentage (4.0%). The **UNC** ASC applications project the next highest charity care/self-pay percentages (over 3%). The **WakeMed-Cary, RAC, and UNC REX** applications are the next most effective charity care/self-pay alternatives (2.9%, 2.4% and 2.1% respectively). However, projected utilization for the **UNC** applications and **WakeMed applications** are unreasonable. **Duke Raleigh**, **Duke Green Level** and **Wake Med-NR** are the least effective alternatives, proposing less than 2% charity care/self-pay. Note that as indicated above, and in Criterion 5 discussion, the WakeMed-NC projected payor mix in Section L is different from the payor mix projected in Forms

[3] Certain applications presented payor mix categories in Forms F.4 and F.5 inconsistent with the CON Section application form as necessary to a demonstration of conformity with Criterion 5.

F.4 and F.5. Further, the proposed payor mix for **UNC REX Garner** and **UNC Panther Creek** are unreasonable.

OrthoNC is the most effective alternative for charity care/self-pay.

Medicare

The following table shows the percent of Medicare patients projected for each of the applicants in Project Year 2 as reflected in Section L Question 3(a) and in Forms F.4 and F.5.

Applicant	Project I.D.	Inpatient Medicare PY2	Outpatient Medicare PY2
RAC	J-011551-18	NA	56.9%
Duke Raleigh	J-011558-18	60.6%	45.7%
Duke Green Level	J-011557-18	NA	43.4%
UNC REX*	J-011555-18	41.0%	41.0%
UNC REX Garner	J-011553-18	NA	29.6%
OrthoNC	**J-011561-18**	NA	**25.0%**
WakeMed-Cary	J-011565-18	NA	16.8%
UNC Panther Creek	J-011554-18	NA	13.2%
WakeMed-NR**	J-011564-18	NA	14.1% or 13.3%

*REX UNC data combined inpatient and outpatient

**WakeMed-NR data in Section L inconsistent with data in Forms F.4 And F.5

WakeMed-Cary, UNC Panther Creek and WakeMed-NRare the least effective alternatives, proposing less than 20% Medicare. The **RAC, Duke and UNC REX** applications project the highest Medicare percentages (over 40%). The **OrthoNC** and **UNC Panther Creek** applications are the next most effective Medicare alternatives (29.6% and 25.0%, respectively). However, projected utilization for the **WakeMed** and **UNC** applications are unreasonable.

Medicaid

The following table shows the percent of Medicaid patients projected for each of the applicants in Project Year 2 as reflected in Section L Question 3(a) and in Forms F.4 and F.5.

Applicant	Project I.D.	Inpatient Medicaid PY3	Outpatient Medicaid PY3
UNC Panther Creek	J-011554-18	NA	13.2%
WakeMed-NR**	J-011564-18	NA	7.8% or 8.7%
RAC	J-011551-18	NA	6.1%
OrthoNC	**J-011561-18**	NA	**6.0%**
UNC REX Garner	J-011553-18	NA	6.0%
Duke Green Level	J-011557-18	NA	4.8%
WakeMed-Cary	J-011565-18	NA	4.2%
Duke Raleigh	J-011558-18	3.2%	3.9%
UNC REX*	J-011555-18	3.3%	3.3%

*REX UNC data combined inpatient and outpatient

**WakeMed-NR data in Section L inconsistent with data in Forms F.4 And F.5

UNC REX, Duke Raleigh, **WakeMed-Cary** and **Duke Green Level** are the least effective alternatives, proposing less than 5% Medicaid. The **UNC Panther Creek** application projects the highest Medicaid percentage (over 13%) and the **WakeMed-NR** is the second highest, but payor mix in Section L is inconsistent with payor mix in Forms F.4 and F.5. The **RAC, OrthoNC and UNC REX Garner** applications are the next most effective charity care/self-pay alternatives (6.1% and 6.0%, respectively). However, projected utilization for the **UNC** applications are unreasonable.

OrthoNC and RAC are the most effective alternatives for Medicaid.

Projected Gross Revenue per OR Case

Due to differences in the types of surgical services proposed by each of the applicants, it is not possible to make conclusive comparisons of gross revenue per surgical case. Thus, this comparative factor may be of little value.

Projected Net Revenue per OR Case

Due to differences in the types of surgical services proposed by each of the applicants, it is not possible to make conclusive comparisons of net revenue per surgical case. Thus, this comparative factor may be of little value.

Projected Expense per Total Cases and Procedures

Due to differences in the types of surgical services proposed by each of the applicants, it is not possible to make conclusive comparisons of operating expense per case.

Reasonableness of the Projected Timetable

Each applicant defines its own projected timeframe for completion of its proposed project. The following table reflects the date services will be operational as proposed in each application:

Proposed Project Timeframes

Applicant	Project I.D.	Operational Date
RAC	J-011551-18	1/2/2020
UNC REX Garner	J-011553-18	7/21/2021
UNC Panther Creek	J-011554-18	7/21/2021
UNC REX	J-011555-18	7/21/2021
Duke Green Level	J-011557-18	7/1/2021
Duke Raleigh	J-011558-18	12/1/2019
OrthoNC	**J-011561-18**	**10/1/2020**
WakeMed-NR	J-011564-18	10/1/2020
WakeMed-Cary	J-011565-18	10/1/2020

Given the 2018 SMFP's determination that six ORs are needed in 2020, **UNC REX Garner, UNC Panther Creek, UNC REX,** and **Duke Green Level** are the least effective alternatives for timely access to services for Wake County residents. The remaining applications are equally effective, as they propose operational dates that meet the need for ORs by 2020.

COMMENTS SPECIFIC TO RAC
PROJECT ID NO. J-011551-18

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

POLICY GEN-3: BASIC PRINCIPLES states:

"A certificate of need applicant applying to develop or offer a new institutional health service for which there is a need determination in the North Carolina State Medical Facilities Plan shall demonstrate how the project will promote safety and quality in the delivery of health care services while promoting equitable access and maximizing healthcare value for resources expended. A certificate of need applicant shall document its plans for providing access to services for patients with limited financial resources and demonstrate the availability of capacity to provide these services. A certificate of need applicant shall also document how its projected volumes incorporate these concepts in meeting the need identified in the State Medical Facilities Plan as well as addressing the needs of all residents in the proposed service area."

RAC fails to conform with Criterion 1 and Policy GEN-3 because its projected volumes are unreasonable and unsupported. See the discussion regarding projected utilization in Criterion 3.

Criterion 3 *"The applicant shall identify the population to be served by the proposed project and shall demonstrate the need that this population has for the services proposed, and the extent to which all residents of the area, and, in particular, low income persons, racial and ethnic minorities, women, handicapped persons, the*

elderly, and other underserved groups are likely to have access to the services proposed."

RAC's utilization projections and assumptions are unreasonable, causing the proposal to be non-conforming with Criterion 3. **RAC** indicates that it bases the need for the services proposed, in part, on historical vascular access procedure utilization. (**RAC** App., p. 30). **RAC** states that "the more medically complex procedures performed in the OR are growing significantly faster than the more routine procedure room appropriate procedures" and that "[t]he exponential growth of OR-appropriate procedures indicates that patient volume is shifting towards more medically complex cases." (**RAC** App., p. 31). However, these assumptions are unsupported. **RAC's** own data illustrates a decrease in OR cases at the Raleigh and Cary Vascular Access Centers ("VACs") (the primary referral sources for the proposed ASC) from 2016 to 2017. (**RAC** App., Table 4, p. 31). **RAC** annualizes 2018 OR cases for these VACs to show a large increase in OR cases from 2017 to 2018. However, **RAC** fails to provide any explanation for such a large variance and fails to account for the decrease in OR cases from 2016 to 2017. **RAC** does not adequately explain why it provided three years of data but chose to rely only on the one year (2018) that volume increased. Without more, **RAC** failed to demonstrate that 2018 is not an outlier year.

In addition, the data presented by **RAC** is inconsistent. **RAC** provides historical 2016, 2017 and projected 2018 OR cases for the Raleigh and Cary population served. (**RAC** App., Table 4, p. 31). Total patients for NC Nephrology are also presented. (**RAC** App., p. 31). The following table combines these two data sources to illustrate the disconnect between the data.

NC Nephrology Historical/Annualized Patients/OR Cases

	2015	2016	2017	Annualized 2018
NC Nephrology's ESRD Patients (Raleigh & Cary)	1,611	1,674	1,743	
Annual Growth in Patients		63	69	
OR Cases		1083	1042	1218
Annual Growth in OR Cases			-41	176

Source: RAC Application

The number of ESRD patients increased from 1,611 to 1,674 (63 additional patients) from 2015 to 2016, and from 1,674 to 1,743 (69 additional patients) from 2016 to 2017, a 2-Yr CAGR of just over 4%. If that level of growth continued from 2017 to 2018, one would expect to see a total of only approximately 1,813 ESRD patients (70 additional patients) in 2018. With respect to the number of OR cases, the applicant does not provide data for 2015, so one cannot calculate a corresponding 2-Yr CAGR for OR cases over the same period. Instead, RAC's own data shows a decrease in OR cases from 1,083 to 1,042 from 2016 to 2017 (41 fewer cases), and then shows it is on track for an increased number of OR cases from 2017 to 2018 (which is annualized in the chart above to show 176 additional OR cases). **RAC** does not adequately explain why it expects a nearly 17% increase in OR cases from 2017 to 2018, with a historical growth rate of only about 4% in ESRD patients.

RAC's failure to support the higher annualization of 2018 cases (as opposed to 2016 or 2017) poisons the entire need analysis. Without explaining a basis to expect such a trend (as opposed to the negative trend from 2016 to 2017), **RAC** failed to demonstrate its utilization projections are reasonable.

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."*

RAC does not demonstrate that projected surgical utilization is based on reasonable and adequately supported assumptions. **RAC** does not propose the least costly or most effective alternative and is non-conforming with Criterion 4.

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

Failure to Demonstrate Financial Feasibility

RAC does not demonstrate that projected surgical utilization is based on reasonable and supported assumptions and, thus, does not demonstrate the financial feasibility of its proposal. **RAC** is non-conforming with Criterion 5.

Failure to Demonstrate Availability of Funds

In Exhibit F-2.1, **RAC** provides a letter from Mark Fawcett, Senior Vice President and Treasurer of National Medical Care, Inc., which states that National Medical Care will provide Fresenius, a co-applicant for the proposed project, with a $2 million loan to fund the capital costs of the proposed project. However, **RAC** does not include a letter from an officer of the Fresenius co-applicant entity confirming that the loan proceeds will be committed to the proposed project. Therefore, **RAC** does not adequately demonstrate the availability of sufficient funds for the capital and working capital needs of the project. *See* Agency Findings, 2016 New Hanover County OR Review, p. 40. ("*In Exhibit 25, the*

applicant provides a letter from Rocky Rhodes, Senior Vice President of First Citizens Bank which states that First Citizens Bank will provide Surgical Care Affiliates, the sole member of Surgery Center of Wilmington, LLC, with $10.0 million for the capital costs and $1.0 million of the working capital costs to develop the proposed project. The letter in Exhibit 25 is addressed to Surgical Care Affiliates, the sole member of the applicant and the application does not contain a letter from an officer of Surgical Care Affiliates confirming how the money would be used or that it would go to the applicant and there is no letter from an officer of the applicant confirming how the money would be used. Therefore, the applicant does not adequately demonstrate the availability of sufficient funds for the capital and working capital needs of the project. See the N.C. Court of Appeals decisions in the working papers.")

Although the 2017 Annual Report for Fresenius Medical Care is provided, **RAC** confirms that "[n]o portion of the capital cost will be financed with accumulated reserves or owner's equity." (**RAC** App., p. 50).

RAC's failure to demonstrate the availability of funds does not end there. **RAC** fails to project any start up or working capital expenses. **RAC** states that "there is no initial operating expense or start-up expense" because "[c]o-applicant Fresenius Vascular Care Raleigh MSO, LLC is an existing operational entity." (**RAC** App., pp. 51-2). This is inaccurate. While Fresenius may be an existing operational entity, the proposed ASC—RAC Surgery Center—is not. **RAC** (through its MSA with Fresenius or otherwise) will need to employ staff to operationalize its OR and procedure rooms, which is a start-up expense. Fresenius Vascular has no existing ORs. It will need to train/orient staff, which is also a start-up expense. When the OR is operationalized, **RAC** will not realize proceeds for surgeries immediately. There will be up-front expenses associated with providing surgeries (staff costs, medical supplies, etc.) that **RAC** will be required to fund before receiving payment from commercial insurers, government payors, etc. As such, there will be initial operating expenses despite the applicants' claim to the contrary. **RAC's** failure to project any working capital expenses also renders it non-conforming with Criterion 5. In addition to failing to project working capital expenses, **RAC** fails to demonstrate the **availability** of funds for any working capital expenses. The loan proceeds from National

Medical Care are solely for proposed capital expenses, not working capital. Even those funds have not been sufficiently committed by the applicants to the project, and the applicants confirm that "[n]o portion of the capital cost will be financed with accumulated reserves or owner's equity." (**RAC** App., p. 50).

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."*

Based on the facts discussed above, **RAC** did not demonstrate conformity with Criterion 6.

Criterion 13c *"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."

RAC fails to conform with Criterion 13c because its projected utilization and payor percentages are based on highly speculative and unreasonable assumptions.

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

Based on the facts which result in **RAC** being non-conforming with Criteria 1, 3, 4, 5, 6 and 13c (and Policy GEN-3), it should also be found non-conforming with Criterion 18a. **RAC** did not adequately demonstrate the need the population projected to be served has for the proposed project and did not adequately demonstrate that its proposal would not result in the unnecessary duplication of surgical services in Wake County. **RAC** did not adequately demonstrate the availability of funds nor that the financial feasibility of the proposal was based on reasonable and supported assumptions.

10A NCAC 14C.2103 Performance Standards.

(e) The applicant shall document the assumptions and provide data supporting the methodology used for each projection in this Rule.

Based on the Criterion 3 discussion above, **RAC** is not conforming with this rule.

COMMENTS SPECIFIC TO UNC REX GARNER
PROJECT ID NO. J-11553-18

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

POLICY GEN-3: BASIC PRINCIPLES states:

"A certificate of need applicant applying to develop or offer a new institutional health service for which there is a need determination in the North Carolina State Medical Facilities Plan shall demonstrate how the project will promote safety and quality in the delivery of health care services while promoting equitable access and maximizing healthcare value for resources expended. A certificate of need applicant shall document its plans for providing access to services for patients with limited financial resources and demonstrate the availability of capacity to provide these services. A certificate of need applicant shall also document how its projected volumes incorporate these concepts in meeting the need identified in the State Medical Facilities Plan as well as addressing the needs of all residents in the proposed service area."

UNC REX Garner fails to conform with Criterion 1 and Policy GEN-3 because the projected volumes and payor mix assumptions are unreasonable and unsupported. See the discussions regarding Criteria 3 and 13.

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

Failure to Identify the Population to Be Served

UNC REX Garner states, "[i]n order to project patient origin, [**UNC REX Garner**] analyzed the historical patient origin by county for UNC REX Hospital outpatient surgery patients that originate from the ZIP codes in and around the proposed Garner location." (**UNC REX Garner** App., p. 26). However, **UNC REX Garner** failed to identify the "ZIP codes in and around the proposed Garner location." While the applicant provides a chart of "Wake County Population Growth by ZIP Code", it does not identify which zip codes the applicant proposes to serve. (**UNC REX Garner** App., p. 40-41; attached Table 26). Perhaps even more importantly, **UNC REX Garner** fails to document any connection between the historical patient origin at UNC REX and the population to be served by **UNC REX Garner**. All the applicant has done is identify the patients from Garner that underwent surgery at UNC REX. It did not explain why it would be reasonable to assume that such patients would shift to **UNC REX Garner**, taking into consideration the differences between hospital ORs and ASC ORs as well as differences in referring physicians/surgeons and the specialties offered at these facilities. Without identifying the "ZIP codes in and around the proposed Garner location" and explaining why UNC REX's historical patient origin is a reasonable proxy for the applicant**, UNC REX Garner** fails to identify the population to be served.

UNC REX Garner's population to be served also is questionable because it is unreasonable to project no shift of cases from UNC facilities other than perhaps 20 or 65 cases from UNC REX. If Raleigh Orthopedic surgeons support the proposed project and plan to utilize it, as stated in their letters, surgical volumes would undoubtedly shift from not only UNC REX but also from Raleigh Orthopedic Surgery Center. Yet, no historical

zip code-level patient origin data was considered from Raleigh Orthopedic Surgery Center, where many/most of the supporting surgeons perform cases, or any other UNC REX surgical locations. **UNC REX Garner** relies on an unreasonable assumption that nearly all utilization will be new surgical volume or market share from other providers such as WakeMed and Duke. Despite this assumption, **UNC REX Garner** provides no patient origin data for this volume which will be incremental to the UNC Health Care system (*i.e.,* market share shifting from other providers).

UNC REX Garner's application also contains conflicting data concerning the very modest volume it does project to shift from UNC REX to the proposed ASC. **UNC REX Garner** projects that by SFY24, 65 patients will "shift" to the proposed ASC. (**UNC REX Garner** App., Section Q, Form C Assumptions, pp. 5-6). However, elsewhere, **UNC REX Garner** lists only 20 total cases expected to shift in that period (the aggregate of the "projected operating room cases" for Drs. Lacin, Koleveld, Buttram, and Engler – 5 cases per physician for a total of 20 cases). (**UNC REX Garner** App., Section Q, Form C Assumptions, p. 13).

UNC REX Garner references a 15-minute drive time "analysis" which does nothing to cure the applicant's failure to identify the population to be served (which the applicant has specified are the zip codes in/around Garner, but which the applicant failed to identify). UNC REX Garner provided no definition of the service area included in the 15-minute drive time. (**UNC REX Garner** App., p. 51). **UNC REX Garner** has failed to adequately define the population to be served and the project is non-conforming to Criterion 3.

Failure to Demonstrate Need

The **UNC Rex Garner** utilization projections and assumptions are unreasonable because they are completely dependent on future physician recruitment efforts and do not consider existing volumes. Because the **UNC REX Garner** surgery projections and assumptions are unreasonable, its proposal is non-conforming with Criterion 3.

UNC REX Garner's projected utilization is not based on any solid data or information. Rather, 99% of the projected utilization is based on future recruitment of five new surgeons. (**UNC REX Garner** App., p. 13, Section Q). Vague statements about historical use of surgical services by specialty surgeons in an urban tertiary acute care facility (UNC REX) are used to estimate surgical volumes for these five surgeons in a freestanding ASC. These two surgical institutions are very different. Thus, projected utilization for **UNC REX Garner** is premised on unreasonable assumptions.

- **UNC REX Garner** provides minimal to no documentation in the application to support its projections or assumptions. **UNC REX Garner** states it "projected utilization for the proposed ASC based on discussions with physicians and administrators." (**UNC REX Garner** App., p. 13, Section Q). However, **UNC REX Garner** failed to divulge the substance of these discussions or identify the physicians and administrators with whom these discussions were undertaken. (See, *e.g.,* Final Decision, OAH Case No. 17 DHR 07277, p. 17, ¶ 54 ("This sentence does not provide substantiation for [the applicant's] projections . . . because it did not say why, or on what premise, [the applicant's] leadership believed it was necessary to increase the number of visits."). **UNC REX Garner** failed to describe *why* the assumptions underlying its utilization projections are reasonable and adequately supported. In addition, none of the letters of support provide any discussion of need for surgeons in the service area. (**UNC REX Garner** App., Exhibit I.2).

- Except for a mere 20 surgical cases from a small number of UNC REX-affiliated physicians, **UNC REX Garner** bases its projected surgery patient volumes exclusively on anticipated OR cases from five unidentified, yet-to-be-recruited surgeons. These highly speculative utilization projections are unreasonable: the **UNC REX Garner** utilization projections are entirely dependent on future recruitment efforts that may not be successful.

- **UNC REX Garner** provided 22 letters of support from orthopedic surgeons, 10 of whom reportedly currently see patients in the Raleigh Orthopedic Garner location.

(**UNC REX Garner** App., Exhibit I.2). However, while all these surgeons indicated an intent to seek privileges at the proposed facility, no surgical volumes were included for these surgeons. Further, no surgical cases for these surgeons were identified to be shifted from another UNC surgical facility, such as UNC REX or Raleigh Orthopedic Surgery Center, to **UNC REX Garner**.

- **UNC REX Garner** proposes development of a multispecialty ASC, but **none** of the three specialties to be performed at the proposed ASC (orthopedics, ENT, and general surgery) are supported by existing volumes from physicians who anticipate performing surgeries in the proposed ASC. Thus, not only do **UNC REX Garner's** utilization projections depend on its future recruitment efforts, its status as a "multispecialty ambulatory surgical program" under the CON Law is entirely dependent on future recruitment of all 3 specialties (orthopedics, ENT, and general surgery) to qualify as a multispecialty center.

- **UNC REX Garner** provides no documentation of the need for additional surgeons in the service area. No physician need assessment was conducted, and none of the letters regarding recruitment discuss need for additional surgeons.

- **UNC REX Garner** improperly relies on an "outpatient surgery utilization rate" which reflects total outpatient cases performed at all surgical locations in Wake County regardless of patient county of origin / per 1,000 Wake County population. The term "utilization rate" is distinct from "use rate."

    - First, this analysis is unreasonable as the rate is not age-adjusted. **UNC REX Garner** states "older residents utilized healthcare services at a higher rate." (**UNC REX Garner** App., p. 40). While utilization of surgical services is generally higher for older populations, it is not reasonable to use Wake County's rate without showing that such a rate is appropriate for the population to be served. Use of Wake County's outpatient surgery utilization rate assumes, without any demonstrated support, that the age distribution of the population within a 15-minute drive time is the same as that for all patients seeking outpatient surgery in Wake County, including all

in-migration from outside Wake County. Although Wake County itself has one of the lowest average median ages of all 100 North Carolina Counties as shown in the attached Table 13, its rate reflects service to a significant number of patients who in-migrate to Wake County for surgical services. In fact, nearly 25% of outpatient surgeries performed in Wake County are performed on residents of other counties with median ages *exceeding* that of Wake County (see attached Table 15). It is unreasonable to assume without support that the age range of the population in the service area defined by **UNC REX Garner** is necessarily comparable to that of the total outpatient surgical population, including in-migration, for all outpatient surgical cases performed in Wake County.

- Second, besides a small percentage of volume projected from Johnston County, no in-migration is projected for **UNC REX Garner**. (**UNC REX Garner** App., p. 26). Yet, **UNC REX Garner** unreasonably assumes its outpatient utilization rate will match that of Wake County. It is unreasonable to calculate **UNC REX Garner** surgical volumes using the Wake County outpatient utilization rate which includes thousands of residents from other counties.
- Third, **UNC REX Garner** would represent only 10% of proposed surgical capacity in the area, considering the outpatient OR capacity in the two existing surgical locations on the cusp of a 15-minute drive time of the proposed facility: WakeMed Raleigh and Capital City Surgery Center. (**UNC REX Garner** App., p. 50 (map)). Projecting utilization at **UNC REX Garner** to exceed 20% of the estimated outpatient surgical cases from the market is unreasonable, especially for a facility in which none of the proposed surgeons have a current share of the surgical market. As shown in the attached Table 16, the proposed ORs at **UNC REX Garner** would represent only 10% of the outpatient surgical capacity in the market.

- The reasonableness of the proposed project timetable also impacts the reasonableness of the projected utilization. (**UNC REX Garner** App., p. 113, Section P). **UNC REX Garner** assumes issuance of the CON in March 2019 with

services offered in July 2021. This is an unreasonably short timeframe of 29 months to acquire the property, build the new facility and recruit five additional surgeons to the market.

Further, the timeframe defined is considerably less than the actual time it took UNC REX to develop its two existing ASCs in Wake County: UNC REX Wakefield and the UNC REX Cary.

- UNC Rex Wakefield
- Project I.D. J-10280-14
- Reorganize a hospital-based ASC into a separately licensed ASC.
  - CON issued: 10/21/2014
  - Operational date on CON: 7/1/2016
  - Actual Operational date: 7/1/2018

  Although the application proposed a timeframe of 20 months, the actual timeframe was 48 months. This project did not involve any construction, only recruitment of surgeons. Attachment 1 includes progress reports for UNC REX Wakefield.

- UNC Rex Cary Surgery Center
- Project I.D. J-7878-07
- Reorganize a hospital-based ASC into a separately licensed ASC.
  - CON issued: 12/2007
  - Actual Operational date: FFY 2011

  The conversion to freestanding ASC was completed sometime in FFY 2011, so at a minimum development of the project, which did not involve any construction, only recruitment of surgeons, took 33 months.

UNC REX Garner involves both surgeon recruitment ***and*** construction of a new ASC facility. Considering UNC's poor track record for timely development of projects that involved only surgeon recruitment with no facility construction, the estimated operational date for **UNC REX Garner** is questionable.

- UNC REX HSH
- Project I.D. J-8669-11
  - CON issued: 1/22/2014
  - Operational Date on CON: 2/1/2017
  - Actual Operational Date: Not Yet Operational

  According to the most recent Progress Report included in Attachment 2, the delay in development of UNC REX HSH is due to the inability of UNC REX to develop two major projects concurrently. (Attachment 2, p. 60). In this Review, UNC projects to concurrently develop and simultaneously open **UNC REX Garner** and **UNC Panther Creek** while completing UNC REX HSH, raising a question on the reliability of the timetable for this project.

UNC REX has not completed CON projects involving ORs in accordance with the timeframes proposed in its CON applications. Therefore, the timeframe proposed by **UNC REX Garner** is not reasonable based on UNC REX's own experience and, as a result, the projections are unreasonable and likely to be inaccurate.

Equitable Access to Services by the Identified Population

Please see the discussion in Criterion 13 regarding **UNC REX Garner's** unreasonable Payor Mix assumptions.

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."*

UNC REX Garner does not demonstrate its projected surgical utilization is based on reasonable and adequately supported assumptions. **UNC REX Garner** is non-conforming with Criterion 4.

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

UNC REX Garner does not demonstrate its projected surgical utilization is based on reasonable and supported assumptions, and, thus, does not demonstrate the financial feasibility of its proposal. Thus, **UNC REX Garner** is non-conforming with Criterion 5.

In projecting a capital cost of $1 million for "Purchase Price of Land," **UNC REX Garner** indicates "Land costs are based on letter from the current owner included in Exhibit F.1." However, the letter from the current land owner states only that "a portion of the +/- 25 acre site" is available for purchase at an estimated $250,000 per acre. Nowhere does **UNC REX Garner** identify the acreage to be purchased, nor does the current land owner specify how much of the land he is willing to sell. No documentation establishes whether the land owner is willing to sell only 4 acres of the 25-acre parcel. Without additional documentation, as requested by the application, it is unclear how the applicant arrived at an estimate of $1 million, and the Agency cannot determine the applicant demonstrated sufficient funds for the project.

Payor mix assumptions for **UNC REX Garner** are not reasonable, calling into question the projected revenue and the financial feasibility of the project. Therefore, the project is non-conforming to Criterion 5.

Many expenses for **UNC REX Garner** are said to be based on UNC Health Care's historical experience. (**UNC REX Garner** App., Section Q, Form F.2 Assumptions). However, **UNC REX Garner** does not provide any documentation to show which locations were included in this "historical experience." There is no indication that the historical experience relied on includes facilities in comparable locations offering comparable surgical specialties. Therefore, insufficient information is provided to support the reasonableness of the assumptions. Consequently, the project is non-conforming to Criterion 5.

Financial pro forma information for UNC REX is omitted although UNC REX is a co-applicant incurring a $9 million capital obligation to build the building for the proposed ASC.

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."*

UNC REX Garner did not adequately demonstrate its proposal would not result in the unnecessary duplication of surgical services in Wake County. Specifically, **UNC REX Garner** did not adequately demonstrate its proposed ORs are needed and will not unnecessarily duplicate the ORs that UNC Health Care already owns in Wake County. See the discussion regarding projected utilization in Criterion 3 and in 10A NCAC 14C.2103 Performance Standards. Therefore, **UNC REX Garner** is non-conforming with Criterion 6.

Criterion 13c *"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."

UNC REX Garner fails to conform with Criterion 13c because the projected utilization and payor percentages are based on highly speculative and unreasonable assumptions. As discussed in Criterion 3, the projected utilization and assumptions are unreasonable.

UNC REX Garner states its payor mix is based on the historical payor mix for UNC REX outpatient surgery patients from the zip codes in the service area. (**UNC REX Garner** App., Section L, p. 98). However, **UNC REX Garner** never defines the zip codes in the service area. As discussed above, **UNC REX Garner** failed to identify the population to be served. Also, since only 1% of patients at UNC REX Garner will be shifted from UNC REX, this is an unreasonable assumption.

In addition, the **UNC REX Garner** application includes letters from Raleigh Orthopedic surgeons stating their intent to seek privileges and support the new facility. If this occurs, some volume will shift from Raleigh Orthopedic and potentially UNC REX Cary. Payor mix for Raleigh Orthopedic and UNC REX Cary differ significantly from the payor mix at UNC REX. As reflected in the 2018 LRAs for these surgical locations and in the attached Table 17, the freestanding ASCs treat fewer Medicare patients and more managed care and commercial patients. Therefore, the projected payor mix is unreasonable as the assumptions are unreasonable.

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

For the same reasons **UNC REX Garner** is non-conforming with Criteria 1, 3, 4, 5, 6, and 13c (and Policy GEN-3), it should also be found non-conforming with Criterion 18a. **UNC REX Garner** did not adequately demonstrate the need the population to be served has for the proposed project and did not adequately demonstrate its proposal would not result in the unnecessary duplication of surgical services in Wake County. **UNC REX Garner** did not adequately demonstrate the financial feasibility of the proposal because its projections were premised on unreasonable and unsupported assumptions.

Additionally, while **UNC REX Garner** proposes the development of an ASC, the applicant is owned by UNC REX. UNC REX currently owns 35 of the 100 existing ORs in Wake County, **or over 1/3 of the existing ORs in the service area**. If **UNC REX Garner's** application (or any of the UNC Health Care-affiliated applications) were approved, this dominance would only become more pronounced. Moreover, not only is UNC REX the largest aggregate controller of Wake County ORs, **UNC REX Garner** admits UNC Health Care "is the largest ASC provider in Wake County." (**UNC REX Garner** App., p. 38). Thus, **UNC REX Garner** will not have a positive impact on competition.

Because this is the first need determination for ORs in Wake County since 2012, the Agency should use this rare opportunity to increase competition by approving **OrthoNC** to become a new market provider rather than approving additional ORs for a large hospital system or its affiliates.

Criterion 20 "*An applicant already involves in the provision of health services shall provide evidence that quality care has been provided in the past."*

From past Reviews, it appears the Agency has concentrated its Criterion 20 analyses on Condition Level deficiencies. UNC Health Care has had multiple facilities out of compliance with Medicare Conditions of Participation during the 18-month look back period, including three (3) Condition Level deficiencies at Pardee Hospital.

10A NCAC 14C.2103 Performance Standards

(a) A proposal to establish a new ambulatory surgical facility, to establish a new campus of an existing facility, to establish a new hospital, to increase the number of operating rooms in an existing facility (excluding dedicated C-section operating rooms), to convert a specialty ambulatory surgical program to a multispecialty ambulatory surgical program, or to add a specialty to a specialty ambulatory surgical program shall demonstrate the need for the number of proposed operating rooms in the facility that is proposed to be developed or expanded in the third operating year of the project based on the Operating Room Need Methodology set forth in the 2018 State Medical Facilities Plan. The applicant is not required to use the population growth factor.

UNC REX Garner failed to document the need for its project. Therefore, its application is non-conforming to Criterion 3 and, as a result, non-conforming to this rule.

Further, the methodology utilized by **UNC REX Garner** is not based on the Operating Room Need Methodology in the 2018 SMFP Plan as required by this rule. The methodology used by **UNC REX Garner** does not identify a baseline projected surgical volume, nor does the methodology identify a projected growth rate for the projected surgical utilization. The application is non-conforming to Criterion 3 and this Rule.

(b) A proposal to increase the number of operating rooms (excluding dedicated C-section operating rooms) in a service area shall demonstrate the need for the number of proposed operating rooms in addition to the existing and approved operating rooms in the applicant's health system in the third operating year of the proposed project based on the Operating Room Need Methodology set forth in the 2018 State Medical Facilities Plan. The applicant is not required to use the population growth factor.

UNC REX Garner will be part of the UNC REX healthcare system in Wake County as defined in the 2018 SMFP. Therefore, in addition to justifying the new ORs proposed for **UNC REX Garner**, the applicant must justify ***all*** existing and proposed ORs owned/operated by UNC REX Healthcare. **UNC REX Garner** failed to justify all existing and proposed ORs as required and is non-conforming to this rule.

UNC REX Garner

Please see previous discussion under Criterion 3 and in 10 NCAC 14C .2103 above.

UNC REX

Please see discussion of **UNC REX** under Criterion 3. **UNC REX** failed to document the need for two additional ORs. Therefore, **UNC REX Garner** failed to document the need for all ORs in the system as required by this Rule.

UNC Panther Creek

Please see discussion of **UNC Panther Creek** under Criterion 3. **UNC Panther Creek** failed to document the need for two additional ORs. Therefore, **UNC REX Garner** failed to document the need for all ORs in the system as required by this Rule.

UNC REX HSH

UNC REX HSH is not yet open. In June 2017, the Agency sent a Notice of Intent to Consider Withdrawal of a Certificate of Need requesting a comprehensive progress report. The timetable for UNC REX HSH was extended to June 2020 based on information provided by UNC REX HSH. According to the **UNC REX** application, UNC REX HSH will open December 2020. (**UNC REX** App., p. 20). However,

according to the UNC REX HSH projections included in Section Q. Form C of the application, the project has been delayed, again, with a projected opening in July 2021, raising questions about the UNC REX HSH projected timetable and the reasonableness of the proposed projections and their impact on projected utilization for all **UNC REX** applications. Assumptions included in Section Q Form C for UNC REX HSH are unreasonable since the timeframe is unsupported based on UNC REX's experience in completing operating room projects in accordance with proposed timelines.

Further, considering the latest progress report for UNC REX HSH and the application, UNC REX has identified three different operational dates for UNC REX HSH. The opening of UNC REX HSH impacts the projections for **UNC REX**. Therefore, **UNC REX Garner** projections as presented in Section Q cannot be determined reasonable. UNC REX Healthcare growth rate analyses are included in the attached Tables 8-12.

UNC REX Cary

As discussed above, 22 Raleigh Orthopaedic surgeons provided letters of support for the proposed **UNC REX Garner** application, indicating their intent to utilize the facility. However, none of the projections for UNC REX Healthcare surgical facilities projected a shift of a significant number of patients associated with these physicians from any existing locations to **UNC REX Garner**. (App., Section Q. Form C). Therefore, it is unclear where these surgeons currently practice and from where they will shift patients, or how many patients will shift. Additional UNC REX Healthcare growth rate analyses are included in the attached Tables 8-12.

Therefore, projected utilization at UNC REX Cary cannot be determined reasonable.

UNC REX Wakefield

Projected utilization for UNC REX Wakefield is unreasonable and the proposed growth rate of "cases per operating room" is a fabricated number used to overstate projected utilization. (Section Q, Form C Assumptions, p. 16).

UNC REX Wakefield became a freestanding ASC in July 2018 in accordance with Project I.D. J-10280-14. The operational date for the project was more than two years later than originally projected. UNC REX Wakefield ceased operation for a short period prior to completion of the conversion. Further, during the development of the project, inventory for the new ASC was decreased from three to two ORs.

The following table provides historical utilization and CAGR for UNC REX Wakefield.

Historical Utilization – UNC REX Wakefield

Year	Outpt REX Wakefield
2012	1,595
2013	1,642
2014	1,430
2015	1,639
2016	1,424
2017	1,955
CAGR 2012-2017	4.2%
2018 (Wakefield annualized p16)	1,548
CAGR 2012-2018	-0.5%

Source: UNC REX Garner Section Q Form C page 16; attached Table 22

As shown above, UNC REX Wakefield reported a 4.2% CAGR from 2012 to 2017. UNC REX estimated utilization for 2018 based on ten months of utilization resulting in a much lower CAGR for 2012-2018, presumably based on its plans for conversion to an ASC. However, UNC REX should have used the 2012-2017 CAGR to project future utilization; they did not need to fabricate a discussion about "cases per OR." **UNC REX Garner** utilized a 2012-2017 CAGR in this application to project future inpatient surgical cases at UNC REX Hospital. The application does not discuss why this was a reasonable growth rate for UNC REX but not for UNC REX Wakefield.

The **UNC REX Garner** "cases per OR" analysis is unreasonable for many reasons. (**UNC REX Garner** App., Form C, p. 16). The most important fact is that, to date, utilization at UNC REX Wakefield has never required more than two ORs. This statement is supported by the data below and the fact that UNC REX shifted one of the three ORs originally at UNC REX Wakefield back to the UNC REX. The following table shows that UNC REX Wakefield never needed a third operating room.

Projected OR Need by Year – UNC REX Wakefield

Year	Outpt REX Wakefield	Time per Case	Outpt Surgical Hours	Target for One OR	OR Need
2012	1,595	90	2392.5	1312.5	1.8
2013	1,642	90	2463.0	1312.5	1.9
2014	1,430	90	2145.0	1312.5	1.6
2015	1,639	90	2458.5	1312.5	1.9
2016	1,424	90	2136.0	1312.5	1.6
2017	1,955	86	2802.2	1312.5	2.1
2018 (Wakefield annualized p16)	1,548	86	2218.8	1312.5	1.7

Source: Attached Table 220

As shown in the previous table OR need at UNC REX Wakefield has never exceeded 1.9 ORs even when using the new, more conservative surgical hours per OR target definition included in the 2018 SMFP. OR utilization at UNC REX Wakefield decreased from 2017 to 2018 due to the conversion of the facility to freestanding ASC status. Current utilization does not suggest that the facility is run efficiently nor that it equitably offers OR time to surgeons. *See* **OrthoNC** Application for discussion.

Using the same methodology used by **UNC REX Garner** to project future utilization for UNC REX Wakefield and using the more reasonable 5 Year CAGR 2012-2017, the existing inventory is sufficient to meet the projected needs through SFY 2024 which has a small deficit of 0.16 ORs in 2024 as shown below.

Projected OR Need – Proposed UNC REX Wakefield

SFY	2018	CAGR 2012-2017	2019	2020	2021	2022	2023	2024
Outpt	1,548	4.2%	1,612	1,679	1,749	1,822	1,897	1,976
Adjusted Outpat			1,612	1,679	1,749	1,822	1,897	1,976
Outpt Time Per Case			86.0	86.0	86.0	86.0	86.0	86.0
Outpatient Surgical Hours			2,311	2,407	2,507	2,611	2,720	2,833
Total Surgical Hours			2,311	2,407	2,507	2,611	2,720	2,833
Std Hrs Per OR			1,312.5	1,312.5	1,312.5	1,312.5	1,312.5	1,312.5
Projected OR Need			1.8	1.8	1.9	2.0	2.1	2.2
Licensed/CON Approved Inventory			2.0	2.0	2.0	2.0	2.0	2.0
Deficit(-)/Surplus(+)			0.24	0.17	0.09	0.01	-0.07	-0.16

Source: Attached Table 20

In addition, **UNC REX Garner** used a "time per case" of 86.0 minutes per case based on utilization while a hospital-based OR. However, UNC REX Wakefield is a **new** ASC and has been listed in the annual SMFP for several years as an ASC. Therefore, based on the methodology in the SMFP and the CON Application Form for Operating Rooms, projected time per case for **new** ASCs in Category 6 should be 68.6 minutes per case, which would further decrease the number of ORs needed to reflect a surplus.

Finally, as discussed above, 22 Raleigh Orthopaedic surgeons provided letters of support for the proposed **UNC REX Garner** application, indicating their intent to utilize the facility. However, none of the projections for UNC REX Healthcare surgical facilities indicated a shift of a significant number of patients associated with these physicians from any existing locations to **UNC REX Garner**. (App., Section Q. Form C). Therefore, it is unclear where these surgeons currently practice and from where they will shift patients, or how many patients will shift.

Additional UNC REX Healthcare growth rate analyses are included in the attached Tables 8-12. Therefore, projected utilization at UNC REX Surgery Center of Wakefield cannot be determined reasonable.

Raleigh Orthopaedic Surgery Center

As discussed above, 22 Raleigh Orthopaedic surgeons provided letters of support for **UNC REX Garner**, indicating their intent to utilize the facility. However, none of the projections for UNC REX Healthcare surgical facilities indicated a shift of a significant number of patients associated with these physicians from any existing locations to **UNC REX Garner**. (App., Section Q. Form C). Therefore, it is unclear where these surgeons currently practice and from where they will shift patients, or how many patients will shift. Additional UNC REX Healthcare growth rate analyses are included in the attached Tables 8-12. Therefore, projected utilization at Raleigh Orthopaedic Surgery Center cannot be determined reasonable.

Raleigh Orthopaedic Surgery Center – West Cary

As discussed above, 22 Raleigh Orthopaedic surgeons provided letters of support for **UNC REX Garner**, indicating their intent to utilize the facility. However, none of

the projections for UNC REX Healthcare surgical facilities indicated a shift of a significant number of patients associated with these physicians from any existing locations to **UNC REX Garner**. (App., Section Q. Form C). Therefore, it is unclear where these surgeons currently practice and from where they will shift patients, or how many patients will shift. Therefore, projected utilization at Raleigh Orthopaedic Surgery Center – West Cary cannot be determined reasonable.

The projections and assumptions for both the proposed facility and all other existing and proposed UNC REX surgical facilities in Wake County are overstated, unreasonable and undocumented. Additional UNC REX Healthcare growth rate analyses are included in the attached Tables 8-12. Therefore, **UNC REX Garner** failed to justify all existing and proposed ORs as required and is non-conforming to this Rule.

(e) The applicant shall document the assumptions and provide data supporting the methodology used for each projection in this Rule.

UNC REX Garner fails to document assumptions utilized in its application. Therefore, the methodologies for OR utilization for **UNC REX Garner** and all UNC REX surgical facilities are unreasonable and unsupported. **UNC REX Garner's** projected utilization is highly speculative—and therefore not reasonable and adequately supported—as it depends entirely on future recruitment efforts. See discussions of projected utilization, in Criterion 3 and in 10 NCAC 14C .2103(a) and (b). Additional UNC REX Healthcare growth rate analyses are included in the attached Tables 8-12. The **UNC REX Garner** application is not conforming with this Rule.

COMMENTS SPECIFIC TO UNC PANTHER CREEK
PROJECT ID NO. J-11554-18

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

POLICY GEN-3: BASIC PRINCIPLES states:

"A certificate of need applicant applying to develop or offer a new institutional health service for which there is a need determination in the North Carolina State Medical Facilities Plan shall demonstrate how the project will promote safety and quality in the delivery of health care services while promoting equitable access and maximizing healthcare value for resources expended. A certificate of need applicant shall document its plans for providing access to services for patients with limited financial resources and demonstrate the availability of capacity to provide these services. A certificate of need applicant shall also document how its projected volumes incorporate these concepts in meeting the need identified in the State Medical Facilities Plan as well as addressing the needs of all residents in the proposed service area."

UNC Panther Creek fails to conform with Criterion 1 and Policy GEN-3 because the projected volumes and payor mix assumptions are unreasonable and unsupported. See the discussions of Criteria 3 and 13.

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

Failure to Identify the Population to Be Served

UNC Panther Creek states, "[i]n order to project patient origin, [**UNC Panther Creek**] analyzed the historical patient origin by county for UNC Hospitals outpatient surgery patients that originate from the ZIP codes in and around the proposed Panther Creek location." (**UNC Panther Creek** App., p. 25). However, **UNC Panther Creek** failed to identify the "ZIP codes in and around the proposed Panther Creek location." While the applicant provides a chart outlining "Wake County Population Growth by ZIP Code", it does not identify which zip codes the applicant proposes to serve. (**UNC Panther Creek** App., p. 40). Perhaps even more importantly, **UNC Panther Creek** fails to document any connection between the historical patient origin at UNC REX and the population to be served by **UNC Panther Creek**. All the applicant does is identify the patients from the Panther Creek area that underwent surgery at UNC REX. It does **not** explain why it would be reasonable to assume that such patients would shift to **UNC Panther Creek** despite the differences between hospital ORs and ASC ORs as well as differences in referring physicians/surgeons and the specialties offered. Without identifying the "ZIP codes in and around the proposed Panther Creek location" and explaining why UNC REX's historical patient origin is a reasonable proxy for the proposed ASC, **UNC Panther Creek** fails to identify the population to be served.

UNC Panther Creek utilizes a 15-minute drive time "analysis" which does nothing to cure its failure to identify the population to be served (which the applicant has described as unnamed zip codes in/around Panther Creek). **UNC Panther Creek** fails to define the area depicted in the chart by zip code, census tract or otherwise and fails to support that

this ill-defined area is the area from which it can be expected to serve patients. While the map in the application includes a substantial part of Chatham County, the patient origin projections do not include any reference to Chatham County or to any in-migration to the facility. (**UNC Panther Creek** App., *cf.* pp. 25 and 45). Further, the zip code information only shows Wake County zip codes and only identifies one zip code, 27519, associated with the proposed facility. (**UNC Panther Creek** App., pp. 39-40).

UNC Panther Creek failed to adequately define the population to be served and the project is non-conforming to Criterion 3.

Failure to Demonstrate Need

The **UNC Panther Creek** surgery projections and assumptions for the proposed project are unreasonable, causing the proposal to be non-conforming with Criterion 3.

UNC Panther Creek states its "projected surgical utilization for the proposed ASC [is] based on a market analysis of surgical need in the market and on discussions with physicians and administrators." (**UNC Panther Creek** App., Section Q, Form C assumptions, p. 10). However, the applicant failed to describe the "market analysis" it undertook and how, if at all, it supports its projections. The application does not identify the substance of any discussions or how, if at all, these discussions support its projections. The application does not even identify the physicians and administrators involved in these discussions. (See, *e.g.,* Final Decision, OAH Case No. 17 DHR 07277, p. 17, ¶ 54 ("This sentence does not provide substantiation for [the applicant's] projections . . . because it did not say why, or on what premise, [the applicant's] leadership believed it was necessary to increase the number of visits."). **UNC Panther Creek** failed to describe *why* the assumptions underlying its utilization projections are reasonable and adequately supported.

Projected utilization for **UNC Panther Creek** is not based on any solid data or information. Rather, 97% of projected utilization is based on recruitment of new surgeons. (App., p.

10, Section Q, Form C Assumptions). Vague statements about historical use of surgical services by specialty surgeons are used to estimate surgical volumes for surgeons in a freestanding ASC. Thus, projected utilization for the proposed project is premised on unreasonable assumptions.

- The applicant provides minimal to no documentation in the application to support its projections or assumptions and no discussion of need for surgeons in the service area.

- Except for a mere 50 surgical cases from a single UNC Health Care-affiliated physician, **UNC Panther Creek** bases its projected surgery volumes exclusively on anticipated OR cases from seven unidentified, yet-to-be-recruited surgeons. Because **UNC Panther Creek's** utilization projections are entirely dependent on future recruitment efforts that may not be successful, the projections are highly speculative and, thus, unreasonable.

- **UNC Panther Creek** provided letters of support from UNC-affiliated surgeons who reportedly currently see patients and perform surgical cases in the service area. (**UNC Panther Creek** App., Ex. I.2). However, no surgical volumes were included for these surgeons. No surgical cases for these surgeons were identified to be shifted to **UNC Panther Creek** from another UNC REX surgical facility in the service area, such as UNC REX or UNC REX Cary.

- **UNC Panther Creek** proposes development of a multispecialty ASC, but **none** of the three specialties to be performed at the proposed ASC (ENT, plastics, and general surgery) are supported by existing volume from physicians who anticipate performing surgeries in the proposed ASC. Thus, not only do **UNC Panther Creek's** utilization projections depend on its future recruitment efforts, its status as a "multispecialty ambulatory surgical program" under the CON Law is dependent on future recruitment of all 3 specialties (ENT, plastics, and general surgery) to qualify as a multispecialty center.

- **UNC Panther Creek** provides no documentation of the need for additional surgeons in the service area. No physician need assessment was performed to document any additional need. In fact, none of the letters regarding recruitment discuss the need for additional surgeons.

- **UNC Panther Creek** relies on a Wake County "outpatient surgery utilization rate" which reflects total outpatient cases performed at all surgical locations in Wake County regardless of patient county of origin / per 1,000 Wake County population. The term "utilization rate" is distinct from "use rate."

    - First, this analysis is unreasonable as the rate is not age-adjusted. **UNC Panther Creek** states "older residents utilized healthcare services at a higher rate." (**UNC Panther Creek** App., p. 39). While utilization of surgical services is generally higher for older populations, it is not reasonable to use Wake County's rate without showing that such a rate is appropriate for the population to be served. Use of Wake County's outpatient surgery utilization rate assumes, without any demonstrated support, that the age distribution of the population within a 15-minute drive time is the same as that for all patients seeking outpatient surgery in Wake County, including all in-migration from outside Wake County. Although Wake County itself has one of the lowest average median ages of all 100 North Carolina Counties as shown in the attached Table 13, its rate reflects service to a significant number of patients who in-migrate to Wake County for surgical services. In fact, nearly 25% of outpatient surgeries performed in Wake County are performed on residents of other counties with median ages *exceeding* that of Wake County (see attached Table 15). It is unreasonable to assume without support that the age range of the population in the service area defined by **UNC Panther Creek** is necessarily comparable to that of the total outpatient surgical population, including in-migration, for all outpatient surgical cases performed in Wake County.
    - Second, besides a small percentage of volume projected from Johnston County, no in-migration is projected for **UNC Panther Creek**. (**UNC Panther Creek** App., p. 26). Yet, **UNC Panther Creek** unreasonably

assumes its outpatient utilization rate will match that of Wake County. It is unreasonable to calculate **UNC Panther Creek** surgical volumes using the Wake County outpatient utilization rate which includes thousands of residents from other counties.

- The reasonableness of the proposed project timetable also impacts the reasonableness of the projected utilization. (**UNC Panther Creek** App., Section P). **UNC Panther Creek** assumes issuance of the CON in March 2019 with services offered in July 2021. This is an unreasonably short timeframe of 29 months to acquire the property, build the new facility and recruit five additional surgeons to the market.

- Further, the timeframe defined is considerably less than the actual time it took UNC REX to develop its two existing ASCs in Wake County: UNC REX Wakefield and the UNC REX Cary.

  - UNC Rex Wakefield
  - Project I.D. J-10280-14
  - Reorganize a hospital-based ASC into a separately licensed ASC.
    - CON issued: 10/21/2014
    - Operational date on CON: 7/1/2016
    - Actual Operational date: 7/1/2018

  Although the application proposed a timeframe of 20 months, the actual timeframe was 48 months. This project did not involve any construction, only recruitment of surgeons. Attachment 1 includes progress reports for UNC REX Wakefield.

  - UNC Rex Cary Surgery Center
  - Project I.D. J-7878-07
  - Reorganize a hospital-based ASC into a separately licensed ASC.
    - CON issued: 12/2007
    - Actual Operational date: FFY 2011

The conversion to freestanding ASC was completed sometime in FFY 2011, so at a minimum, development of the project, which did not involve any construction, only recruitment of surgeons, took 33 months.

UNC Panther Creek involves both surgeon recruitment ***and*** construction of a new ASC facility. Considering UNC's poor track record for timely development of projects that involved only surgeon recruitment with no facility construction, the estimated operational date for **UNC Panther Creek** is questionable. The delay in development of UNC REX HSH also impacts this project.

- UNC REX HSH
- Project I.D. J-8669-11
  - CON issued: 1/22/2014
  - Operational Date on CON: 2/1/2017
  - Actual Operational Date: Not Yet Operational

According to the most recent Progress Report included in Attachment 2, the delay in development of UNC REX HSH is due to the inability of UNC REX to develop two major projects concurrently. (Attachment 2, p. 60). In this Review, UNC projects to concurrently develop and simultaneously open **UNC Panther Creek** and **UNC REX Garner** while completing UNC REX HSH, raising a question on the reliability of the timetable for this project.

UNC REX has not completed CON projects involving ORs in accordance with the timeframes proposed in its CON applications. Therefore, the timeframe proposed by **UNC Panther Creek** is not reasonable based on UNC REX's own experience and, as a result, the projections are unreasonable and likely to be inaccurate.

Equitable Access to Services by the Identified Population

Please see the discussion included in Criterion 13 regarding **UNC Panther Creek's** unreasonable Payor Mix assumptions.

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."*

UNC Panther Creek failed to consider the alternative of adding one or more ORs to its approved but undeveloped Raleigh Orthopaedic Surgery Center-West Cary project. While an applicant is not required to address every conceivable alternative, its failure to consider this option is particularly egregious, as it is an under-development project for similar services on the same campus that likely could easily (and more cost-effectively) be modified to accommodate additional ORs. **UNC Panther Creek's** omission of this alternative constitutes a failure to demonstrate that it has proposed the most effective alternative. Therefore, the application is non-conforming with Criterion 4.

Moreover, **UNC Panther Creek** does not demonstrate that projected surgical utilization is based on reasonable and adequately supported assumptions, which means it cannot be the most effective alternative.

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

UNC Panther Creek does not demonstrate that projected surgical utilization is based on reasonable and supported assumptions. Because **UNC Panther Creek** does not

reasonably project utilization of its facility, it does not demonstrate the financial feasibility of the proposal. Therefore, the application is non-conforming with Criterion 5.

As discussed below in Criterion 13, the payor mix assumptions for **UNC Panther Creek** are not reasonable calling into question projected revenue for the proposed project and the financial viability of the project. Therefore, the project is non-conforming to Criterion 5.

Many of the expenses for **UNC Panther Creek** are based on UNC Health Care's historical experience. (App., Section Q Form F.2 Assumptions). However, **UNC Panther Creek** does not provide any documentation, regarding the locations, or surgical specialties at the locations utilized, to support these assumptions. Therefore, the Agency cannot determine if the data is from a comparable location and if the assumptions are reasonable. Therefore, the project is non-conforming to Criterion 5.

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."*

UNC Panther Creek did not adequately demonstrate that its proposal would not result in the unnecessary duplication of surgical services in Wake County. Specifically, **UNC Panther Creek** did not adequately demonstrate in its application that the new ORs it proposes to develop are needed and will not unnecessarily duplicate the ORs that UNC Health Care already owns in Wake County. See the discussion regarding projected utilization in Criterion 3 and in 10A NCAC 14C.2103 Performance Standards. **UNC Panther Creek** is non-conforming with Criterion 6.

Criterion 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."

UNC Panther Creek fails to show that the cost, design, and means of construction proposed represent the most reasonable alternative. Specifically, **UNC Panther Creek** acknowledges that a CON-approved 3-story medical office building is currently under development in Panther Creek, which will house UNC Health Care's CON-approved (and under development) single-specialty, 1-OR ASC known as Raleigh Orthopaedic Surgery Center-West Cary. (**UNC Panther Creek** App., p. 21). **UNC Panther Creek** failed to include any discussion of why it is more reasonable to construct a separate building for the ASC proposed in this application, rather than upfitting a portion of the MOB now under construction and/or combining the project with its Raleigh Orthopaedic Surgery Center-West Cary project (CON-approved, but not yet developed). Consequently, **UNC Panther Creek** fails to demonstrate that the cost, design, and means of construction proposed represent the most reasonable alternative. **UNC Panther Creek** is non-conforming with Criterion 12.

Criterion 13c *"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."

UNC Panther Creek fails to conform with Criterion 13c because the projected utilization and payor percentages are based on highly speculative and unreasonable assumptions.

UNC Panther Creek's payor mix is said to be based on the historical payor mix for outpatient surgery patients from the zip codes in the service area. (**UNC Panther Creek** App, Section L, p. 98). However, **UNC Panther Creek** never defines the zip codes in the service area and thus fails to identify the population to be served. Also, since less than 3% of patients at **UNC Panther Creek** will be shifted from UNC REX, this is an unreasonable assumption. Therefore, the projected payor mix is unreasonable as the assumptions are unreasonable.

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

For the same reasons UNC Panther Creek is non-conforming with Criteria 1, 3, 4, 5, 6, 12, and 13c, it should also be found non-conforming with Criterion 18a. **UNC Panther Creek** did not adequately demonstrate the need the population projected to be served has for the proposed project and did not adequately demonstrate that its proposal would not result in the unnecessary duplication of surgical services in Wake County. **UNC Panther Creek** did not adequately demonstrate the financial feasibility premised on reasonable and supported assumptions.

Additionally, while **UNC Panther Creek** proposes the development of an ASC, the applicant is owned by UNC Health Care. UNC Health Care currently owns 35 of the 100 existing ORs in Wake County **or over 1/3 of the existing ORs in the service area**. If **UNC Panther Creek's** application (or any of the UNC Health Care-affiliated applications)

were approved, this dominance would only become more pronounced. Moreover, not only is UNC Health Care the largest aggregate controller of Wake County ORs, **UNC Panther Creek** admits that UNC Health Care "is the largest ASC provider in Wake County." **UNC Panther Creek** will not have a positive impact on competition. (**UNC Panther Creek** App., p. 37).

Because this is the first time since 2012 there has been a need determination for ORs in Wake County, the Agency should use this rare opportunity to increase competition by approving **OrthoNC** as a new market provider, rather than a large hospital system or its affiliates.

Criterion 20 "*An applicant already involves in the provision of health services shall provide evidence that quality care has been provided in the past."*

From past Reviews, it appears the Agency has concentrated its Criterion 20 analysis on Condition Level deficiencies. UNC Health Care has had multiple facilities out of compliance with Medicare Conditions of Participation during the 18-month look back period, including 3 Condition Level deficiencies at Pardee Hospital.

10A NCAC 14C.2103 Performance Standards.

(a) A proposal to establish a new ambulatory surgical facility, to establish a new campus of an existing facility, to establish a new hospital, to increase the number of operating rooms in an existing facility (excluding dedicated C-section operating rooms), to convert a specialty ambulatory surgical program to a multispecialty ambulatory surgical program, or to add a specialty to a specialty ambulatory surgical program shall demonstrate the need for the number of proposed operating rooms in the facility that is proposed to be developed or expanded in the third operating year of the project based on the Operating Room Need Methodology set

forth in the 2018 State Medical Facilities Plan. The applicant is not required to use the population growth factor.

UNC Panther Creek failed to document the need for the proposed project, is non-conforming to Criterion 3, and as a result, non-conforming to this rule.

The methodology utilized by **UNC Panther Creek** is not based on the Operating Room Need Methodology in the 2018 State Medical Facilities Plan as required by this Rule. The methodology utilized does not identify a baseline projected surgical volume, nor does the methodology identify a projected growth rate for the projected surgical utilization. The application is non-conforming to Criterion 3 and is non-conforming to this Rule.

(b) A proposal to increase the number of operating rooms (excluding dedicated C-section operating rooms) in a service area shall demonstrate the need for the number of proposed operating rooms in addition to the existing and approved operating rooms in the applicant's health system in the third operating year of the proposed project based on the Operating Room Need Methodology set forth in the 2018 State Medical Facilities Plan. The applicant is not required to use the population growth factor.

UNC Panther Creek will be part of the UNC Health Care system in Wake County as defined in the 2018 SMFP. Therefore, **UNC Panther Creek** must document not only the proposed new ORs at **UNC Panther Creek** but also ***all*** existing and proposed ORs owned/operated by UNC REX Healthcare. **UNC Panther Creek** has failed to justify all existing and proposed ORs as required and, as a result, is non-conforming to this rule.

UNC REX Panther Creek

Please see previous discussion under Criterion 3 and in 10 NCAC 14C .2103 above.

UNC REX Hospital

Please see discussion under Criterion 3 regarding the **UNC REX** application for two ORs. **UNC REX** failed to document the need for two additional ORs and, therefore,

UNC Panther Creek failed to document the need for all ORs in the system as required by this Rule.

UNC REX Garner

Please see discussion under Criterion 3 regarding the **UNC REX Garner** application for two ORs. **UNC REX Garner** failed to document the need for two additional ORs and, therefore, **UNC Panther Creek** failed to document the need for all ORs in the system as required by this Rule.

UNC REX Holly Springs Hospital

UNC REX Holly Springs Hospital (UNC REX HSH) is not yet open. In June 2017, the Agency sent a Notice of Intent to Consider Withdrawal of a Certificate of Need requesting a comprehensive progress report be completed. The timetable for UNC REX HSH was extended to June 2020 based on information provided by UNC REX HSH. According to the UNC REX application on page 20 UNC REX HSH will open December 2020. However, according to the UNC REX HSH projections included in the application, the project has again been delayed, opening in July 2021, raising questions about the UNC REX projected timetable and the reasonableness of the proposed projections. (Section Q. Form C). Assumptions for UNC REX HSH are unreasonable since the timeframe is unsupported based on UNC REX's experience in completing operating room projects in accordance with proposed timelines. (Section Q Form C).

Based on the latest progress report for UNC REX HSH, UNC REX has identified three different operational dates for UNC REX HSH. The opening of UNC REX HSH impacts the projections for **UNC REX**. Additional UNC REX Healthcare growth rate analyses are included in the attached Tables 8-12. Therefore, **UNC Panther Creek** projections as presented in Section Q are incorrect and cannot be determined reasonable.

UNC REX Surgery Center of Cary

Raleigh Orthopaedic surgeons provided letters of support for the proposed **UNC REX Garner** application but none of the projections for UNC REX Healthcare surgical

facilities projected a shift of a significant number of patients associated with these physicians from any existing locations to **UNC REX Garner**. (Section Q. Form C). Therefore, it is unclear where these surgeons currently practice and from where they will shift patients, or how many patients will shift. Additional UNC REX Healthcare growth rate analyses are included in the attached Tables 8-12. Therefore, projected utilization at UNC REX Surgery Center of Cary cannot be determined reasonable.

UNC REX Surgery Center of Wakefield

Projected utilization for UNC REX Wakefield is unreasonable and the proposed growth rate of "cases per operating room" is a fabricated number used to overstate projected utilization. (Section Q, Form C Assumptions, p. 16).

UNC REX Wakefield became a freestanding ASC in July 2018 in accordance with Project I.D. J-10280-14. The operational date for the project, to convert existing hospital-based ORs to an ASC, was more than two years later than originally projected. UNC REX Wakefield ceased operation for a short period prior to completion of the conversion. Further, during the development of the project, inventory for the new ASC was decreased from three to two ORs.

The following table provides historical utilization and CAGR for UNC REX Wakefield.

Historical Utilization – UNC REX Wakefield

Year	Outpt REX Wakefield
2012	1,595
2013	1,642
2014	1,430
2015	1,639
2016	1,424
2017	1,955
CAGR 2012-2017	4.2%
2018 (Wakefield annualized p16)	1,548
CAGR 2012-2018	-0.5%

Source: UNC Panther Creek Section Q Form C page 16

As shown above, UNC REX Wakefield reported a 4.2% CAGR from 2012 to 2017. UNC REX estimated utilization for 2018 based on ten months of utilization resulting

in a much lower CAGR for 2012-2018. UNC REX should have used the 2012-2017 CAGR to project future utilization; they did not need to fabricate a discussion about "cases per OR." **UNC Panther Creek** utilized a 2012-2017 CAGR in this application to project future inpatient surgical cases at UNC REX. The application does not discuss why this was a reasonable growth rate for UNC REX but not for UNC REX Wakefield.

The "cases per OR" analysis put forward by **UNC Panther Creek** is unreasonable for many reasons. (Form C Assumptions, p. 16). The most important fact is that to date, utilization at UNC REX Wakefield has never needed more than two ORs. This statement is supported by the data below and the fact that UNC REX shifted one of the three ORs originally at UNC REX Wakefield back to the UNC REX. The following table shows that UNC REX Wakefield never needed a third operating room.

Projected OR Need by Year – UNC REX Wakefield

Year	Outpt REX Wakefield	Time per Case	Outpt Surgical Hours	Target for One OR	OR Need
2012	1,595	90	2392.5	1312.5	1.8
2013	1,642	90	2463.0	1312.5	1.9
2014	1,430	90	2145.0	1312.5	1.6
2015	1,639	90	2458.5	1312.5	1.9
2016	1,424	90	2136.0	1312.5	1.6
2017	1,955	86	2802.2	1312.5	2.1
2018 (Wakefield annualized p16)	1,548	86	2218.8	1312.5	1.7

Source: Attached Table 22

As shown in the previous table OR need at UNC REX Wakefield has never exceeded 1.9 ORs even when using the new, more conservative surgical hours per OR target definition included in the 2018 SMFP. The capacity at UNC REX Wakefield does not suggest that the facility is run efficiently nor that it equitably offers OR time to surgeons. *See* **OrthoNC** Application for discussion.

Using the same methodology used by **UNC Panther Creek** to project future utilization for UNC REX Wakefield and using the more reasonable 5 Year CAGR

2012-2017 the existing inventory is sufficient to meet the projected needs through SFY 2024 which has a small deficit of 0.16 ORs in 2024 as shown below.

Projected OR Need – Proposed UNC Panther Creek

SFY	2018	CAGR 2012-2017	2019	2020	2021	2022	2023	2024
Outpt	1,548	4.2%	1,612	1,679	1,749	1,822	1,897	1,976
Adjusted Outpat			1,612	1,679	1,749	1,822	1,897	1,976
Outpt Time Per Case			86.0	86.0	86.0	86.0	86.0	86.0
Outpatient Surgical Hours			2,311	2,407	2,507	2,611	2,720	2,833
Total Surgical Hours			2,311	2,407	2,507	2,611	2,720	2,833
Std Hrs Per OR			1,312.5	1,312.5	1,312.5	1,312.5	1,312.5	1,312.5
Projected OR Need			1.8	1.8	1.9	2.0	2.1	2.2
Licensed/CON Approved Inventory			2.0	2.0	2.0	2.0	2.0	2.0
Deficit(-)/Surplus(+)			0.24	0.17	0.09	0.01	-0.07	-0.16

Source: Attached Table 20

UNC Panther Creek used a "time per case" of 86.0 minutes per case based on utilization while a hospital-based OR. However, UNC REX Wakefield is a **new** ASC and has been listed in the annual SMFP for several years as an ASC. Therefore, based on the methodology in the SMFP which is enumerated in the CON Application Form for Operating Rooms, projected time per case for new ASCs in Category 6 should be 68.6 minutes per case, which would further decrease the number of ORs needed to reflect a surplus.

Raleigh Orthopaedic surgeons provided letters of support for the proposed **UNC REX Garner** application but none of the projections for UNC REX Healthcare surgical facilities indicated a shift of a significant number of patients associated with these physicians from any existing locations to **UNC REX Garner**. (Section Q. Form C). Therefore, it is unclear where these surgeons currently practice and from where they will shift patients, or how many patients will shift.

Additional UNC REX Healthcare growth rate analyses are included in the attached Tables 8-12. Therefore, projected utilization at UNC REX Surgery Center of Wakefield cannot be determined reasonable.

Raleigh Orthopaedic Surgery Center

Raleigh Orthopaedic surgeons provided letters of support for the proposed **UNC REX Garner** application but none of the projections for UNC REX Healthcare surgical facilities projected a shift of a significant number of patients associated with these physicians from any existing locations to **UNC REX Garner**. (Section Q. Form C). Therefore, it is unclear where these surgeons currently practice and from where they will shift patients, or how many patients will shift. Additional UNC REX Healthcare growth rate analyses are included in the attached Tables 8-12. Therefore, projected utilization at Raleigh Orthopaedic Surgery Center cannot be determined reasonable.

Raleigh Orthopaedic Surgery Center – West

Raleigh Orthopaedic surgeons provided letters of support for the proposed **UNC REX Garner** application but none of the projections for UNC REX Healthcare surgical facilities projected a shift of a significant number of patients associated with these physicians from any existing locations to **UNC REX Garner**. (Section Q. Form C). Therefore, it is unclear where these surgeons currently practice and from where they will shift patients, or how many patients will shift. Additional UNC REX Healthcare growth rate analyses are included in the attached Tables 8-12. Therefore, projected utilization at Raleigh Orthopaedic Surgery Center – West Cary cannot be determined reasonable.

Projections and assumptions for both the proposed facility and all other existing and proposed UNC REX surgical facilities in Wake County, provided by **UNC Panther Creek** are overstated, unreasonable and undocumented. Therefore, **UNC Panther Creek** has failed to justify all existing and proposed ORs as required and is non-conforming to this Rule.

(e) The applicant shall document the assumptions and provide data supporting the methodology used for each projection in this Rule.

UNC Panther Creek fails to document assumptions utilized in its application. The methodologies utilized to project operating room projections for **UNC Panther Creek** and all UNC REX surgical facilities are unreasonable and unsupported. **UNC Panther Creek's** projected utilization is highly speculative—and therefore not reasonable and adequately supported—as it depends entirely on the success of future recruitment efforts. See discussions of projected utilization in Criterion 3 and in 10 NCAC 14C .2103(a) and (b). **UNC Panther Creek** is not conforming with this Rule.

10A NCAC 14C.3903 Performance Standards.

(b) An applicant proposing to establish a new licensed ambulatory surgical facility for performance of GI endoscopy procedures or develop a GI endoscopy room in an existing licensed health service facility shall reasonably project to perform an average of at least 1,500 GI endoscopy procedures only per GI endoscopy room in each licensed facility the applicant or a related entity owns in the proposed service area, during the second year of operation following completion of the project.

In Section Q Form C Assumptions on page 10 **UNC Panther Creek** references recruitment of a General/GI surgeon and projects 100 future "procedures" for this surgeon. **UNC Panther Creek's** fails to discuss the type of procedures to be provided by this type of specialist who routinely performs GI endoscopy procedures. Therefore, it is unclear if GI endoscopy procedures will be performed and it is unclear whether these rules should have been applicable. Failure to provide clarification regarding why these rules are not applicable should result in the application being determined to non-conforming with these Performance Standards.

(e) An applicant proposing to establish a new licensed ambulatory surgical facility for performance of GI endoscopy procedures or develop an additional GI endoscopy room

in an existing licensed health service facility shall describe all assumptions and the methodology used for each projection in the Rule.

UNC Panther Creek fails to document the assumptions or identify the type of GI procedures to be done in its procedure rule. One of the most common procedures performed by GI specialist is GI endoscopy. Moreover, **UNC Panther Creek's** projected utilization is highly speculative—and therefore not reasonable and adequately supported—as it depends entirely on the success of future recruitment efforts. See discussion of projected utilization in Criterion 3. **UNC Panther Creek** is not conforming with this rule.

COMMENTS SPECIFIC TO UNC REX
PROJECT ID NO. J-11555-18

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

POLICY GEN-3: BASIC PRINCIPLES states:

"A certificate of need applicant applying to develop or offer a new institutional health service for which there is a need determination in the North Carolina State Medical Facilities Plan shall demonstrate how the project will promote safety and quality in the delivery of health care services while promoting equitable access and maximizing healthcare value for resources expended. A certificate of need applicant shall document its plans for providing access to services for patients with limited financial resources and demonstrate the availability of capacity to provide these services. A certificate of need applicant shall also document how its projected volumes incorporate these concepts in meeting the need identified in the State Medical Facilities Plan as well as addressing the needs of all residents in the proposed service area."

UNC REX fails to conform with Criterion 1 and Policy GEN-3 because the projected volumes are unreasonable and unsupported. See the discussion regarding projected utilization in Criterion 3.

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

Failure to Demonstrate Need

The **UNC REX** surgery projections and assumptions are unreasonable, causing the proposal to be non-conforming with Criterion 3. Projected utilization for the proposed project is based on unreasonable growth assumptions.

- **UNC REX's** projected utilization is overstated and based on unreasonable growth rates. **UNC REX** presents historical surgical data for 2012 to 2018 from the annual SMFPs. (Section Q. p. 3 of the Form C Assumptions). From this data, **UNC REX** calculates a 5 Year CAGR to project future inpatient surgical volume. However, the data does not include 2018 surgical data, the most current data available. (Section Q. p. 3 of the Form C Assumptions). Further, this data does not distinguish UNC REX Wakefield outpatient surgical data from the total **UNC REX** outpatient surgical data, which results in historical growth at UNC REX appearing more favorable than actually experienced in the last year. The following table includes the omitted 2018 data, and separates **UNC REX** and UNC REX Wakefield outpatient data:

UNC REX Licensed Surgical Utilization 2012-2018

Year	Inpatient Cases	Outpt Cases @ UNC REX	Outpt Cases @ UNC REX Wakefield	Combined Total UNC REX OutPt Cases
2012	6,862	15,464	1,595	17,059
2013	7,269	14,351	1,642	15,993
2014	7,371	12,272	1,430	13,702
2015	7,984	11,577	1,639	13,216
2016	8,557	11,602	1,424	13,026
2017	8,453	10,681	1,955	12,636
5 Yr CAGR 2012-2017	4.3%	-7.1%	4.2%	-5.80%
2018*	8,418*	10,898		
2018^			1,548^	12,446
5 Yr CAGR 2013-2018	2.98%	-5.4%	-1.2%	-4.9%

* As reported in Section Q, p. 4 of the Form C Assumptions.
^ As reported in Section Q, p. 16 of the Form C Assumptions.
Source: Attached Table 7

When 2018 data is included, the most recent 5 Year CAGR is significantly less, approaching only 3.0% (instead of 4.3%). This is less than the Wake County inpatient surgical growth rate (3.6%) presented by **UNC REX.** (App., p. 28).

When the 2013-2018 5 Year CAGR (as opposed to the 2013-2017 5 Year CAGR used by **UNC REX**) is used to project future inpatient surgical cases at **UNC REX**, using the **UNC REX** methodology, the need for additional ORs at **UNC REX** decreases from a deficit of 1.7 additional ORs needed to a deficit of only 0.7 additional ORs needed. (Section Q, p. 7 of the Form C Assumptions). Note that the following methodology includes the shift of surgical volume to **UNC REX** and a very minimal shift to **UNC REX Garner**. **OrthoNC** believes these assumptions also are unreasonable as discussed and would result in decreasing the need to zero.

UNC REX Revised Utilization

	2018	CAGR 2013-2018	2019	2020	2021	2022	2023	2024
Inpt	8,418	2.98%	8,669	8,927	9,193	9,467	9,749	10,039
Shift to HSH						-359	-556	-766
UNC Hospital Shift						1,050	1,050	1,050
Adjusted Inpt	8,418		8,669	8,927	9,193	10,158	10,243	10,323
Inpt Time Per Case	154.0		154.0	154.0	154.0	154.0	154.0	154.0
Outpt	10,898		10,898	10,898	10,898	10,898	10,898	10,898
Shift to HSH						-630	-1,007	-1,400
Shift to Garner						-33	-49	-65
Adjusted Outpt	10,898		10,898	10,898	10,898	10,235	9,842	9,433
Outpt Time Per Case	113.3		113.3	113.3	113.3	113.3	113.3	113.3
Inpatient Surgical Hours	21,606		22,250	22,912	23,595	26,071	26,289	26,496
Outpatient Surgical Hours	20,579		20,579	20,579	20,579	19,327	18,585	17,813
Total Surgical Hours	42,185		42,829	43,492	44,174	45,398	44,874	44,308
Std Hrs Per OR			1,950	1,950	1,950	1,950	1,950	1,950
Projected OR Need			22.0	22.3	22.7	23.3	23.0	22.7
Licensed/CON Approved Inventory			22.0	22.0	22.0	22.0	22.0	22.0
Deficit(-)/Surplus(+)			0.0	-0.3	-0.7	-1.3	-1.0	-0.7

Source: Attached Tables 18, 19

UNC REX does not discuss in the application why it chose to use older data to project need when more current 2018 data was available. Additional growth rate analyses are included in attached Tables 7-12.

- **UNC REX's** utilization methodology is highly speculative and therefore unreasonable. The utilization projections are entirely dependent on shifts in volume to/from various facilities, one of which is an influx of cases from UNC Hospitals. (pp. 3-8, Form C Assumptions). **UNC REX** has been part of the UNC Health Care System for many years, and it is reasonable to assume that Wake County surgical volume that is more appropriate to be performed locally has been shifted from UNC Hospital to **UNC REX** during the past five years. The following table shows the changes in inpatient surgical

volume at **UNC REX** during this timeframe; at no point has inpatient surgical volume increased more than 1,000 cases per year:

UNC REX Inpatient Surgical Volume

	In	Annual Change
2012	6,862	
2013	7,269	407
2014	7,371	102
2015	7,984	613
2016	8,557	573
2017	8,453	-104
2018	8,418	-35

Source: Attached Table 14

In addition, the following table shows changes in inpatient surgery patient origin for residents of Wake County at UNC Hospitals and **UNC REX** during the last several years. This table shows that the Wake County inpatient surgical volume at UNC Hospitals has increased at a CAGR of 4.3% from 2012 to 2017 and **UNC REX** growth has been only 1.3% and annual change has not exceeded 300 in any year.

UNC Hospital and UNC REX Patient Origin - Wake County Surgical Cases

UNC Hospitals	2012	2013	2014	2015	2016	2017	CAGR 12-17
Inpt (includes CSection)	1,712	1,394	4,166	1,891	1,876	2,116	4.3%
Outpt	2,449	2,412	2,416	2,644	2,381	2,491	0.3%
UNC REX (includes Wakefield)	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**CAGR 12-17**
Inpt (includes CSection)	6,079	6,175	6,328	6,560	6,850	6,496	1.3%
Annual Change		96	153	232	290	-354	
Outpt	12,225	11,280	9,611	9,292	9,199	8,656	-6.7%

Source: Attached Table 14

The only documentation presented by **UNC REX** in its application from UNC Hospitals regarding a potential transfer of patients is from UNC Pediatrics. This letter indicates a potential of 550 new surgical cases, of which 250 are ENT. However, it does not provide any assumptions regarding inpatient or outpatient surgical split. Since over 90% of ENT cases are outpatient, the total potential inpatient surgical volume

documented from this letter is just over 300 cases which is nowhere near the projected 1,050 cases per year included in the assumption for **UNC REX**. Further, documentation in the **UNC Panther Creek** application indicates that the expansion of UNC Pediatrics would be at Panther Creek, not at **UNC REX**. No other documentation from UNC Hospitals regarding estimated cases to be shifted in the future is included in the application. Therefore, **UNC REX** failed to document its assumptions and the resulting projections are unreasonable.

- **UNC REX's** utilization methodology is highly speculative and therefore unreasonable. Utilization projections reflect a minimal shift in outpatient volume to **UNC REX Garner**. **UNC REX's** assumption that it will receive an influx of cases from UNC Hospitals is unreasonable and fails to account for physician support for the freestanding ASC. (pp. 3-8, Form C Assumptions). **Surgeons can only perform so many surgeries; thus, their volumes could support either UNC REX Hospital or the freestanding ASC – not both.** **UNC REX** provided letters of support for **UNC REX Garner**. (Exhibit I.2). Of these, 22 letters were from orthopedic surgeons, 10 of whom reportedly currently see patients in the Raleigh Orthopedic Garner location. However, no surgical volumes were included for these surgeons. Further, no surgical cases for these surgeons were identified to be shifted from **UNC REX** or any other another UNC REX surgical facility. As a result, projected outpatient volume at **UNC REX** should have reflected additional surgical volume shifted to **UNC REX Garner**. Therefore, the assumptions are unreasonable.

- **UNC REX** states its "need for additional operating room capacity is based in part by the fact that three ORs are slated to be relocated from UNC REX's hospital campus to UNC REX HSH, a previously approved project." (App., p. 18). **UNC REX** complains that it suffers from insufficient OR capacity as a result of this relocation project. (App., pp. 21-22, 33). However, projected utilization for UNC REX HSH reflects available surgical capacity at UNC REX HSH in 2024. (Section Q Form C). **UNC REX** could shift additional inpatient and outpatient surgical cases to that location. As stated in the assumptions, the projections for UNC REX HSH are dated and the UNC REX HSH service area represents one of the fastest growing areas in Wake County as

evidenced by **UNC REX's** own population data. (App., p. 38). **UNC REX chose** to relocate those ORs for competitive/business reasons, and now seeks Agency approval to replace the very ORs it outsourced. This reality is aptly demonstrated by **UNC REX's** projected deficit of 5.93 ORs for **UNC REX**, with surpluses of -3.00 and -2.00 ORs for REX HSHS and REX Surgery Center of Wakefield (approved but not yet operational as of the time of the Proposed 2019 Plan), respectively. (Table 6B, Proposed 2019 SMFP). **UNC REX** should not be allowed to cry foul about a "problem" it created for itself.

- In this Review, **UNC REX** has filed 2 other applications which collectively propose the development of 2 ASCs with a total of 4 ORs. Given the high likelihood that multiple applications are approved in this Review, it seems that if **UNC REX's** capacity woes were as pronounced as it depicts them to be, it would concentrate efforts on securing hospital ORs for its hospital rather than spreading itself thin by seeking to develop ASC ORs. Taking **UNC REX** at its word on insufficient capacity to accommodate the demands of its surgical patients, **OrthoNC** notes that its physicians currently hold credentials to perform surgery at **UNC REX**. When **OrthoNC's** application is approved, the resulting shift of surgeries will alleviate some of **UNC REX's** alleged capacity woes.

- **UNC REX** takes its "lack of capacity" argument a step further: it claims that hospitals in Wake County operate at an overall average of 100 percent of capacity. (App., pp. 29-30). To illustrate this claim, it divides total surgical hours by the aggregate number of standard hours per OR to arrive at a "percent utilization." (Table 6A of the SMFP). However, this approach fails to recognize that standard hours are a floor on utilization and represent 75% of the capacity of an operating room. (2018 SMFP, p. 58). Therefore, hospital ORs in Wake County are operating at only 75% of capacity.

  However, the flaw with **UNC REX's** argument does not end there. In representing that Wake County hospitals operated at 99% and 100% utilization in 2016 and 2017, respectively, **UNC REX** conspicuously failed to provide its own percent utilization over the same period:

UNC REX Hospital Operating Room Utilization

Year	Total Surgical Hours**	Standard OR Hours Total^	Total OR Hours @ Capacity as Defined in SMFP	Percent Utilization Based on Std Hours	Percent Utilization Based on Capacity
2016	46,560	52,650	70,200	88.4%	66.3%
2017	50,113	52,650	70,200	95.2%	71.4%
2018	42,185	52,650	70,200	80.1%	60.1%

**From Total Surgical Hours for Grouping per Table 6A in *SMFP*.
^From Standard Hours per OR per Year x OR Inventory per Table 6A in *SMFP* excluding any CON adjustments for future projects in order to accurately determine actual utilization in the years above.
Source: *2018 and Proposed 2018 SMFPs*.

UNC REX is not utilizing its ORs at full capacity, nor is **UNC REX** utilizing it ORs at the Wake County rate as shown in the previous table. Further, based on 2018 surgical data, provided by **UNC REX**, utilization has decreased significantly based on surgical case times in the 2018 SMFP. The standard 1,950 hours per OR (10 hours per day, 260 days per year) is merely a floor on utilization, and **UNC REX** is operating its ORs at 60.1% of capacity. Therefore, it would appear that **UNC REX** has alleviated any capacity "problem" **UNC REX** it was experiencing in previous years.

Because **UNC REX's** need argument is premised on the unfounded assumption that it has capacity constraints, and because **UNC REX's** utilization projections are based on unreasonable growth rates and highly speculative shifts of volume to/from various facilities, **UNC REX** fails to identify the population to be served and the need that population has for the services proposed. **UNC REX's** application is non-conforming with Criterion 3.

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."*

UNC REX does not demonstrate that projected surgical utilization is based on reasonable and adequately supported assumptions, which means it cannot be the most effective alternative. See the discussion under Criterion 3.

Also, **UNC REX** fails to comply with Criterion 4 because the application proposes to develop additional hospital-based OR capacity that is not an effective alternative given the heavy trend toward ASC surgical services, both in Wake County and statewide. Surgical growth in Wake County's freestanding ASCs has increased 17.5% from 2012 to 2017 while inpatient surgical cases have decreased -4.5%. (App., p. 28). Further, **UNC REX** OR utilization in 2017 was 71.4% which decreased in 2018 (based on surgical case times in the 2018 SMFP) to 60.1% in 2018.

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

UNC REX does not demonstrate that projected utilization is based on reasonable and supported assumptions. Because **UNC REX** does not reasonably project utilization, it does not demonstrate financial feasibility. Therefore, the application is non-conforming with Criterion 5.

Because of the lack of explanation furnished in the application as submitted, it is curious that **UNC REX** proposes $750,000 in capital cost for its proposal, when it is simply backfilling existing ORs currently licensed and operational (but which it will delicense when its UNC REX HSH project becomes operational). **UNC REX** fails to provide explanation as to why its proposal should involve **any** capital expenditure – the ORs proposed for backfill already exist and should not require any construction/renovation to be relicensed. **UNC REX** proposes a $550,000 medical equipment budget, along with a total of $200,000 in construction/renovation contracts and architect/engineering fees. (Form F.1a (Capital Costs)). A reference appears to "video integration." Beyond this, **UNC REX** offers **no** explanation of why new equipment or construction/renovation is needed for existing, operational ORs. There is no itemization of equipment, and no explanation of what construction/renovation is contemplated. Thus, the application lacks

the details and specificity necessary for the Agency to determine the reasonableness of the projected capital costs. As a result, the Agency also will be unable to ascertain that the applicant demonstrated the availability of funds for the capital and operating needs.

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."*

UNC REX did not adequately demonstrate that its proposal would not result in the unnecessary duplication of surgical services in Wake County. Specifically, **UNC REX** did not adequately demonstrate the new ORs it proposes to develop are needed and will not unnecessarily duplicate the ORs that UNC Health Care already owns in Wake County. See the discussion on projected utilization in Criterion 3 and in 10A NCAC 14C.2103 Performance Standards. **UNC REX** is non-conforming with Review Criterion 6.

Criterion 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."*

UNC REX does not explain whether its cost, design, and means of construction represent the most reasonable alternative. Specifically, **UNC REX** does not include any discussion of why new equipment or construction/renovation is needed for the existing, operational ORs it proposes to backfill. Consequently, the explanation by **UNC REX** is not sufficiently specific to show that the cost, design, and means of construction represent the most reasonable alternative.

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

For the same reasons **UNC REX** is non-conforming with Criteria 1, 3, 4, 5, 6, and 13c, it should also be found non-conforming with Criterion 18a. **UNC REX** did not adequately demonstrate the need the population projected to be served has for the proposed project and did not adequately demonstrate that its proposal would not result in the unnecessary duplication of surgical services in Wake County. **UNC REX** did not adequately demonstrate the financial feasibility of the proposal because its projections were premised on unreasonable and unsupported assumptions.

UNC REX currently owns 35 of the 100 existing ORs in Wake County **or over 1/3 of the existing ORs in the service area**. If **UNC REX's** application (or any of the UNC Health Care-affiliated applications) were approved, this dominance would only become more pronounced. **UNC REX** will not have a positive impact on competition.

Because this is the first time since 2012 there has been a need determination for ORs in Wake County, the Agency should use this rare opportunity to increase competition by approving **OrthoNC** to become a new market provider rather than a large hospital system or its affiliates.

Criterion 20 "*An applicant already involves in the provision of health services shall provide evidence that quality care has been provided in the past."*

From past Reviews, it appears the Agency has concentrated its Criterion 20 analyses on Condition Level deficiencies. UNC Health Care has had multiple facilities out of

compliance with Medicare Conditions of Participation during the 18-month look back period, including 3 Condition Level deficiencies at Pardee Hospital.

10A NCAC 14C.2103 Performance Standards.

(a) A proposal to establish a new ambulatory surgical facility, to establish a new campus of an existing facility, to establish a new hospital, to increase the number of operating rooms in an existing facility (excluding dedicated C-section operating rooms), to convert a specialty ambulatory surgical program to a multispecialty ambulatory surgical program, or to add a specialty to a specialty ambulatory surgical program shall demonstrate the need for the number of proposed operating rooms in the facility that is proposed to be developed or expanded in the third operating year of the project based on the Operating Room Need Methodology set forth in the 2018 State Medical Facilities Plan. The applicant is not required to use the population growth factor.

UNC REX failed to document the need for the proposed project. Therefore, the application is non-conforming to Criterion 3 and non-conforming to this Rule.

(b) A proposal to increase the number of operating rooms (excluding dedicated C-section operating rooms) in a service area shall demonstrate the need for the number of proposed operating rooms in addition to the existing and approved operating rooms in the applicant's health system in the third operating year of the proposed project based on the Operating Room Need Methodology set forth in the 2018 State Medical Facilities Plan. The applicant is not required to use the population growth factor.

UNC REX is part of the UNC REX Healthcare System in Wake County as defined in the 2018 SMFP. In addition to justifying the proposed new ORs at **UNC REX, UNC REX** must justify ***all*** existing and proposed ORs owned/operated by UNC REX Healthcare. **UNC REX** has failed to justify all existing and proposed ORs as required and as a result, is non-conforming to this rule.

UNC REX

Please see previous discussion under Criterion 3 and in 10 NCAC 14C .2103(a) above.

UNC REX Garner

Please see discussion under Criterion 3 regarding the **UNC REX Garner** application for two additional ORs. **UNC REX Garner** failed to document the need for two additional ORs; therefore, **UNC REX** failed to document the need for all ORs in the system as required by this Rule.

UNC Panther Creek

Please see discussion under Criterion 3 regarding the **UNC Panther Creek** application for two ORs. **UNC Panther Creek** failed to document the need for two additional ORs, therefore, **UNC REX** failed to document the need for all ORs in the system as required by this Rule.

UNC REX Holly Springs Hospital

UNC REX Holly Springs Hospital (UNC REX HSH) is not yet open. In June 2017, the Agency sent a Notice of Intent to Consider Withdrawal of a Certificate of Need requesting a comprehensive progress report be completed. The timetable for UNC REX HSH was extended to June 2020 based on information provided by UNC REX HSH. According to the **UNC REX** application on page 20, UNC REX HSH will open December 2020. However, according to the UNC REX HSH projections, the project has again been delayed, opening in July 2021, raising questions about the **UNC REX** projected timetable and the reasonableness of the proposed projections. (Section Q. Form C). Assumptions for UNC REX HSH are unreasonable since the timeframe is unsupported based on **UNC REX's** experience in completing OR projects in accordance with proposed timelines. (Section Q, Form C).

Further, according to the latest progress report for UNC REX HSH and this application, **UNC REX** has identified three different operational dates for UNC REX HSH. The opening of UNC REX HSH impacts the projections for **UNC REX**.

Therefore, **UNC REX** projections as presented in Section Q Form are incorrect and cannot be determined reasonable.

UNC REX Surgery Center of Cary

Raleigh Orthopaedic surgeons provided letters of support for the proposed UNC REX Garner application but none of the projections in Section Q Form C for UNC REX Healthcare surgical facilities projected a shift of a significant number of patients associated with these physicians from any existing locations to **UNC REX Garner**. Therefore, it is unclear where these surgeons currently practice and from where they will shift patients, or how many patients will shift. Therefore, projected utilization at UNC REX Surgery Center of Cary cannot be determined reasonable.

UNC REX Surgery Center of Wakefield

Projected utilization for UNC REX Surgery Center of Wakefield (UNC REX Wakefield) reflected in Section Q Form C Assumptions on page 16 is unreasonable and the proposed growth rate of "cases per operating room" is a fabricated number used to overstate projected utilization. UNC REX Wakefield became a freestanding ASC in July 2018 in accordance with CON Project I.D. J-10280-14. The operational date for the project, to convert existing hospital-based ORs to an ASC, was more than two years later than originally projected. UNC REX Wakefield ceased operation for a short period prior to completion of the conversion. Further, during the development of the project, inventory for the new ASC was decreased from three to two ORs. The following table provides historical utilization and CAGR for UNC REX Wakefield.

Historical Utilization – UNC REX Wakefield

Year	Outpt REX Wakefield
2012	1,595
2013	1,642
2014	1,430
2015	1,639
2016	1,424
2017	1,955
CAGR 2012-2017	4.2%
2018 (Wakefield annualized p16)	1,548
CAGR 2012-2018	-0.5%

Source: UNC Section Q Form C Assumptions page 16

As shown above, UNC REX Wakefield reported a 4.2% CAGR from 2012 to 2017. **UNC REX** estimated utilization for 2018 based on ten months of utilization resulting in a much lower CAGR for 2012-2018. **UNC REX** should have used the 2012-2017 CAGR to project future utilization; they did not need to fabricate a discussion about "cases per OR." **UNC REX** utilized a 2012-2017 CAGR in this application to project future inpatient surgical cases at **UNC REX**. The application does not discuss why this was a reasonable growth rate for UNC REX but not for UNC REX Wakefield.

The "cases per OR" analysis put forward by **UNC REX** is unreasonable for many reasons. (p. 16, Form C Assumptions). The most important fact is that to date, utilization at UNC REX Wakefield has never needed more than two ORs. This statement is supported by the data below and the fact that **UNC REX** shifted one of the three ORs originally at UNC REX Wakefield back to **UNC REX**. The following table shows that UNC REX Wakefield never needed a third OR.

Projected OR Need by Year – UNC REX Wakefield

Year	Outpt REX Wakefield	Time per Case	Outpt Surgical Hours	Target for One OR	OR Need
2012	1,595	90	2392.5	1312.5	1.8
2013	1,642	90	2463.0	1312.5	1.9
2014	1,430	90	2145.0	1312.5	1.6
2015	1,639	90	2458.5	1312.5	1.9
2016	1,424	90	2136.0	1312.5	1.6
2017	1,955	86	2802.2	1312.5	2.1
2018 (Wakefield annualized p16)	1,548	86	2218.8	1312.5	1.7

Source: Attached Table 22

OR need at UNC REX Wakefield has never exceeded 1.9 ORs even when using the new, more conservative surgical hours per OR target definition included in the 2018 SMFP.

Using the same methodology used by **UNC REX** to project future utilization for UNC REX Wakefield and using the more reasonable CAGR 2012-2017 the existing inventory is sufficient to meet the projected needs through SFY 2024. In Section Q Form C Assumptions page18 UNC REX projects a deficit of 0.6 (or one) for UNC Wakefield. As shown below when a more reasonable CAGR is used the deficit

decreased from 0.6 to a much smaller deficit of 0.16 (or zero) ORs in 2024 as shown below.

Projected OR Need – UNC REX Wakefield

SFY	2018	CAGR 2012-2017	2019	2020	2021	2022	2023	2024
Outpt	1,548	4.2%	1,612	1,679	1,749	1,822	1,897	1,976
Adjusted Outpat			1,612	1,679	1,749	1,822	1,897	1,976
Outpt Time Per Case			86.0	86.0	86.0	86.0	86.0	86.0
Outpatient Surgical Hours			2,311	2,407	2,507	2,611	2,720	2,833
Total Surgical Hours			2,311	2,407	2,507	2,611	2,720	2,833
Std Hrs Per OR			1,312.5	1,312.5	1,312.5	1,312.5	1,312.5	1,312.5
Projected OR Need			1.8	1.8	1.9	2.0	2.1	2.2
Licensed/CON Approved Inventory			2.0	2.0	2.0	2.0	2.0	2.0
Deficit(-)/Surplus(+)			0.24	0.17	0.09	0.01	-0.07	-0.16

Source: Attached Table 20

UNC REX used a "time per case" of 86.0 minutes per case based on utilization while a hospital-based OR. However, UNC REX Wakefield is a **new** ASC and has been listed in the annual SMFP for several years as an ASC. Therefore, based on the SMFP methodology in the CON Application Form for ORs, projected time per case for new ASCs in Category 6 should be 68.6 minutes per case, which would further decrease the number of ORs needed to reflect a surplus.

Raleigh Orthopaedic surgeons provided letters of support for the proposed **UNC REX Garner** application but none of the projections for UNC REX Healthcare surgical facilities indicated a shift of a significant number of patients associated with these physicians from any existing locations to **UNC REX Garner**. (Section Q Form C). Therefore, it is unclear where these surgeons currently practice and from where they will shift patients, or how many patients will shift. Therefore, projected utilization at UNC REX Wakefield cannot be determined reasonable.

Raleigh Orthopaedic Surgery Center

Raleigh Orthopaedic surgeons provided letters of support for **UNC REX Garner** but none of the projections for UNC REX Healthcare surgical facilities indicated a shift of a significant number of patients associated with these physicians from any existing locations to **UNC REX Garner**. (Section Q Form C). Therefore, it is unclear where

these surgeons currently practice and from where they will shift patients, or how many patients will shift. Therefore, projected utilization at Raleigh Orthopaedic Surgery Center cannot be determined reasonable.

Raleigh Orthopaedic Surgery Center – West Cary

Raleigh Orthopaedic surgeons provided letters of support for **UNC REX Garner** but none of the projections for UNC REX Healthcare surgical facilities indicated a shift of a significant number of patients associated with these physicians from any existing locations to **UNC REX Garner**. (Section Q Form C). Therefore, it is unclear where these surgeons currently practice and from where they will shift patients, or how many patients will shift. Therefore, projected utilization at Raleigh Orthopaedic Surgery Center – West Cary cannot be determined reasonable.

Projections and assumptions for both **UNC REX** and all other existing and proposed UNC REX surgical facilities in Wake County are overstated, unreasonable and undocumented. Therefore, **UNC REX** failed to justify all existing and proposed ORs as required and is non-conforming to this Rule.

(e) The applicant shall document the assumptions and provide data supporting the methodology used for each projection in this Rule.

UNC REX fails to document assumptions utilized in its application. Therefore, the methodologies used for OR projections for **UNC REX** and all UNC REX surgical facilities are unreasonable and unsupported. **UNC REX's** projected utilization is highly speculative—and therefore not reasonable and adequately supported—as it depends entirely on the success of future recruitment efforts. See discussions of projected utilization in Criterion (3) and in 10 NCAC 14C .2103(a) and (b). **UNC REX** is not conforming with this Rule.

COMMENTS SPECIFIC TO DUKE GREEN LEVEL (PROJECT ID NO. J-011557-18)

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

POLICY GEN-3: BASIC PRINCIPLES states:

"A certificate of need applicant applying to develop or offer a new institutional health service for which there is a need determination in the North Carolina State Medical Facilities Plan shall demonstrate how the project will promote safety and quality in the delivery of health care services while promoting equitable access and maximizing healthcare value for resources expended. A certificate of need applicant shall document its plans for providing access to services for patients with limited financial resources and demonstrate the availability of capacity to provide these services. A certificate of need applicant shall also document how its projected volumes incorporate these concepts in meeting the need identified in the State Medical Facilities Plan as well as addressing the needs of all residents in the proposed service area."

The **Duke Green Level** application fails to conform with Criterion 1 and Policy GEN-3 because the projected surgical patient volumes are unreasonable and unsupported. See the discussion regarding projected utilization in Criterion 3.

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

Duke Green Level proposes an ASC with four ORs and four procedure rooms at a cost of $34,300,000. The proposed address is in Cary, but **Duke Green Level** states the proposed location is less than one mile from the Apex zip code and refers to the location as an Apex location. A separate Duke University Health System (DUHS) proposal, under review as of August 15, 2018, is for a facility to be known as Arringdon ASC in Durham County. (Project ID #E-11508-18).

Overstated Compound Annual Growth Rate

Duke Green Level presents data intended to show growth in DUHS's outpatient surgical cases across Wake and Durham Counties, but then acknowledges that this "growth" was partly a "shift" of cases resulting from changes in the Medicare Inpatient-Only (IPO) list, which resulted in certain surgeries being moved from inpatient to outpatient facilities at DUHS facilities. (**Duke Green Level** App., pg. 121).

In Step 1 of its utilization methodology, **Duke Green Level** calculates a 4-Yr CAGR for DUHS's outpatient OR cases. (**Duke Green Level** App., pg. 120). However, the outpatient CAGR was heavily influenced by a significant jump in outpatient cases at the James E. Davis ASC (DASC) in Durham County between FY2017 (5,277 cases) and FY2018 (7,645 cases). If DASC is removed from the chart, the CAGR falls from 5.4% to just over 4%:

DUHS Outpatient Surgical Cases by Facility

	2014	2015	2016	2017	2018	CAGR 2014-2018
Duke Raleigh						
Outpatient	9,132	9,875	10,855	11,084	12,604	8.4%
Duke University Hospital Durham						
Outpatient	22,292	23,728	22,642	22,575	23,614	1.5%
Duke Regional Durham						
Outpatient	2,899	2,995	2,981	3,352	3,992	8.3%
DUHS Total (without Davis ASC)						
Outpatient	34,323	36,598	36,78	37,011	40,210	4.0%

Source: Attached Table 23

Unreasonable Assumptions Regarding Surgical Case Shifts

Duke Green Level goes to great lengths in its utilization methodology to illustrate the cases it expects will shift from existing DUHS facilities to the proposed ASC. However, in projecting such shifts, **Duke Green Level** fails to account for factors those patients selected DUHS for surgery in the first instance. Patients travel to Duke University Hospital for a variety of reasons, including the desire to undergo surgery in an academic medical center, the complexity of their surgery, and proximity to their homes. While data presented in the DUHS Application shows that the number of Wake County residents traveling to Duke University Hospital has grown, it is not clear what percentage of Wake County patients would opt to go to a Duke ASC in Apex instead of to Duke University Hospital.

Duke Green Level presents data in Steps 1 and 2 intended to show growth in inpatient and outpatient surgical cases across Wake and Durham Counties. On page 120 of the application a 4-Yr CAGR is calculated. However, as shown in the following table, the inpatient surgical CAGR trend reflects a decreasing CAGR for inpatient surgery at the four DUHS providing inpatient care is decreasing.

DUHS Inpatient Surgical Growth

	2014	2015	2016	2017	2018	CAGR 2014-2018	CAGR 2013-2018	CAGR 2016-2018	AGR 2017-2018
Duke Raleigh									
Inpatient	3,586	3,616	4,389	4,094	3,958	2.50%	3.06%	-5.0%	-3.3%
Duke University Hospital Durham									
Inpatient	16,920	17,344	17,151	17,989	17,312	0.57%	-0.06%	0.5%	-3.8%
Duke Regional Durham									
Inpatient	3,697	3,865	3,765	4,539	4,153	2.95%	2.42%	5.0%	-8.5%
Total DUHS									
Inpatient	24,203	24,825	25,305	26,622	25,423	1.24%	0.80%	0.2%	-4.5%

Source: Attached Table 23

Duke Green Level attempts to attribute the decrease in inpatient cases to the "loss of [an unnamed] community-based practice that shifted … cases to another facility" during FY 2017. While inpatient cases did go down between FY 2017 and FY 2018, the Application shows inpatient cases were already declining at **Duke Raleigh** between FY2016 and FY2017, before the "loss" of the community-based practice sometime in FY2017. Further, the trend from converting inpatient care to outpatient care will continue. Therefore, the CAGRs presented on pages 123 and 124 of the application are overstated.

As discussed in the 10 NCAC 14C .2100 Criteria and Standards for Surgical Services below, the unreasonable growth rates impact the need for both **Duke Green Level** and additional operating rooms at DRAH.

By combining data for jointly-owned facilities, **Duke Green Level** claims the need for new ORs in Wake County is "based solely" on DUHS utilization. However, data shown by **Duke Green Level** on page 74 indicates an OR need of 3.95 at REX Hospital and 3.47 at WakeMed.

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

Duke Green Level indicates all financial needs will be financed from DUHS's "cash reserves." (**Duke Green Level** App., p. 66). While DUHS has $181 million in cash, it will require at least $34 million for this project for the capital costs alone. The project is described as a part of a larger MOB building project that will include a variety of health care offerings. The ASC will occupy only 20% of this building. Although it is not clear whether DUHS will commit the funds for the entire building, it may very well do so. While DUHS has considerable cash on hand, **Duke Green Level** has failed to document the availability of that capital for the proposed ASC.

For the year ending June 30, 2012, DUHS reported $243 million in cash and cash equivalents. In 2013, DUHS received CON approval for a capital cost project estimated to cost $48.4 million. At that time, DUHS provided a letter signed by its Senior Vice President and Chief Financial Officer to "certify that Duke University Health System has as much as $50 million in accumulated reserves to devote to the Duke North Transformation project at Duke University Hospital, including infrastructure upgrade and renovation and upgrade of the cardiac critical care unit and nine operating rooms." No similar certification of availability of a portion of the FY 2017 DUHS $181 million in cash reserves was supplied in the **Duke Green Level** Application.

Duke Regional was recently approved for a $3 million CT scanner. (Duke Regional Hospital, Project I.D. #J-11505-18). DUHS is committing up to $32 million in accumulated reserves for Duke University Hospital to develop 90 additional acute care beds, approved in March 2018. (Duke University Hospital, Project ID #: J-11426-17). Although DUHS is a major hospital system with significant cash reserves, it also undertakes significant expenditures such as regular equipment acquisitions and the recently approved $32 million bed expansion project.

Notwithstanding the above, DUHS' Application provides nothing to identify the other projects that will rely on DUHS "cash reserves" and nothing to document that those reserves will be unrestricted and available for this project at the time needed. The Application Form in Section F specifically asks the applicant to "document" that the accumulated reserves to be used to finance the capital cost "are reasonably likely to be available when needed." (**Duke Green Level** App., p. 66). DUHS failed to do so; therefore, **Duke Green Level** has not documented the availability of funding for the project.

10A NCAC 14C.2103 Performance Standards.

(b) A proposal to increase the number of operating rooms (excluding dedicated C-section operating rooms) in a service area shall demonstrate the need for the number of proposed operating rooms in addition to the existing and approved operating rooms in the applicant's health system in the third operating year of the proposed project based on the Operating Room Need Methodology set forth in the 2018 State Medical Facilities Plan. The applicant is not required to use the population growth factor.

The proposed ASC would be part of DUHS in Wake County. Therefore, **Duke Green Level** must document that, in addition to justifying the proposed new ORs at its proposed ASC, ***all*** existing and proposed ORs owned/operated by DUHS in Wake County must be justified. As reflected in the following analysis, **Duke Green Level** has failed to justify all existing and proposed ORs as required and as a result, is non-conforming to this rule.

Duke Raleigh

As discussed above, the projected inpatient surgical growth rate utilized to project future surgical volume at Duke Raleigh is overstated. Therefore, projected inpatient utilization at Duke Raleigh is overstated.

Duke Raleigh – Inpatient Utilization by Year

	2014	2015	2016	2017	2018	CAGR 2014-2018	CAGR 2013-2018	CAGR 2016-2018	AGR 2017-2018	Average of Four CAGR/AGR
Duke Raleigh										
Inpatient	3,586	3,616	4,389	4,094	3,958	2.50%	3.06%	-5.0%	-3.3%	-0.7%

Source: Attached Table 23

As reflected above, Duke Raleigh used unreasonable and unsupported growth rates to project future inpatient surgical facilities in Wake County. Therefore, Duke Raleigh has failed to justify all existing and proposed ORs as required based upon reasonable assumptions and as a result, is non-conforming to this Rule.

(e) The applicant shall document the assumptions and provide data supporting the methodology used for each projection in this Rule.

As discussed above, the assumptions utilized to project inpatient cases for Duke Raleigh was unreasonable and unsupported. Therefore, the project is non-conforming to this Rule.

COMMENTS SPECIFIC TO DUKE RALEIGH (PROJECT ID NO. J-011558-18)

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

POLICY GEN-3: BASIC PRINCIPLES states:

"A certificate of need applicant applying to develop or offer a new institutional health service for which there is a need determination in the North Carolina State Medical Facilities Plan shall demonstrate how the project will promote safety and quality in the delivery of health care services while promoting equitable access and maximizing healthcare value for resources expended. A certificate of need applicant shall document its plans for providing access to services for patients with limited financial resources and demonstrate the availability of capacity to provide these services. A certificate of need applicant shall also document how its projected volumes incorporate these concepts in meeting the need identified in the State Medical Facilities Plan as well as addressing the needs of all residents in the proposed service area."

The **Duke Raleigh** application fails to conform with Criterion 1 and Policy GEN-3 because the projected surgical patient volumes are unreasonable and unsupported. See the discussion regarding projected utilization in Criterion 3.

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

Duke Raleigh proposes to develop two new shared operating rooms in the existing hospital. In addition, Duke University Health System (DUHS) has submitted another application in this batch review proposing the development of Duke Green Level, an ASC with four Ors.

Overstated Compound Annual Growth Rate

In Step 1 of its utilization methodology, **Duke Raleigh** calculates a 4-Yr CAGR for DUHS's OR cases. (**Duke Raleigh** App., pg. 120). However, as shown in the following table, the inpatient surgical CAGR reflects a decreasing trend for inpatient surgery at the four DUHS facilities providing inpatient care:

Duke University Health System
Inpatient Surgical Cases by Facility, FY2014 – FY2018

	2014	2015	2016	2017	2018	CAGR 2014-2018	CAGR 2013-2018	CAGR 2016-2018	AGR 2017-2018
Duke Raleigh									
Inpatient	3,586	3,616	4,389	4,094	3,958	2.50%	3.06%	-5.0%	-3.3%
Duke University Hospital Durham									
Inpatient	16,920	17,344	17,151	17,989	17,312	0.57%	-0.06%	0.5%	-3.8%
Duke Regional Durham									
Inpatient	3,697	3,865	3,765	4,539	4,153	2.95%	2.42%	5.0%	-8.5%
DUHS Total									
Inpatient	24,203	24,825	25,305	26,622	25,423	1.24%	0.80%	0.2%	-4.5%

Source: Attached Table 23

Duke Raleigh attempts to attribute a decrease in inpatient cases to the "loss of [an unnamed] community-based practice that shifted . . . cases to another facility" during FY2017. While inpatient cases did decrease between FY2017 and FY2018, the

Application shows inpatient cases were already declining at **Duke Raleigh** between FY2016 and FY2017, before the "loss" of the community-based practice sometime in FY2017. Further, the trend from converting inpatient care to outpatient care will continue. Therefore, the CAGRs presented on page 107 of the application is overstated.

As a result, **Duke Raleigh** has not projected future utilization based upon reasonable assumptions. Therefore, the project is non-conforming to Criterion 3.

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."*

As described above, **Duke Raleigh** does not demonstrate that projected surgical utilization is based on reasonable and adequately supported assumptions, which means it cannot be the most effective alternative. See the discussion under Criterion 3, which is incorporated by reference.

Further, as discussed previously in the comparative comments Wake County does not need additional inpatient/shared operating rooms. Additional freestanding ASC operating rooms with lower costs are the most effective alternative in Wake County.

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

Duke Raleigh indicates all financial needs will be financed from DUHS' "cash reserves." (**Duke Raleigh** App., p. 56). While DUHS has $181 million in cash, it will require $2 million for this project and $34 million for Green Level ASC, being proposed in this same review, for the capital costs alone.

For the year ended June 30, 2012, DUHS reported $243 million in cash and cash equivalents. In 2013, DUHS received CON approval for a capital cost project estimated to cost $48.4 million. At that time, DUHS provided a letter signed by its Senior Vice President and Chief Financial Officer to "certify that Duke University Health System has as much as $50 million in accumulated reserves to devote to the Duke North Transformation project at Duke University Hospital, including infrastructure upgrade and renovation and upgrade of the cardiac critical care unit and nine operating rooms." No similar certification of availability of a portion of the FY2017 DUHS $181 million in cash reserves was supplied in the DUHS Wake County OR Applications.

Duke Regional was recently approved for a $3 million CT scanner. (Duke Regional Hospital, Project I.D. #J-11505-18). DUHS is committing up to $32 million in accumulated reserves for Duke University Hospital to develop 90 additional acute care beds, approved in March 2018. (Duke University Hospital, Project ID #: J-11426-17). Although DUHS is a major hospital system with significant cash reserves, it also undertakes significant expenditures such as regular equipment acquisitions and the recently approved $32 million bed expansion project.

Notwithstanding the above, DUHS' Application provides nothing to identify the other projects that will rely on DUHS "cash reserves" and nothing to document that those reserves will be unrestricted and available for this project at the time needed. The Application Form in Section F specifically asks the applicant to "document" that the accumulated reserves to be used to finance the capital cost "are reasonably likely to be available when needed." (DUHS App., p. 66). **Duke Raleigh** has failed to do so, and thus has not documented the availability of funding for the project.

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."*

Duke Raleigh did not adequately demonstrate that its proposal would not result in the unnecessary duplication of surgical services in Wake County. Specifically, **Duke Raleigh** did not adequately demonstrate in its application that the new ORs it proposes to develop are needed, and that it will not unnecessarily duplicate the ORs that **Duke Raleigh** already owns in Wake County. See the discussion regarding projected utilization in Criterion 3 and in 10A NCAC 14C.2103 Performance Standards. Therefore, the **Duke Raleigh** application is non-conforming with Review Criterion 6.

10A NCAC 14C.2103 Performance Standards.

(b) A proposal to increase the number of operating rooms (excluding dedicated C-section operating rooms) in a service area shall demonstrate the need for the number of proposed operating rooms in addition to the existing and approved operating rooms in the applicant's health system in the third operating year of the proposed project based on the Operating Room Need Methodology set forth in the 2018 State Medical Facilities Plan. The applicant is not required to use the population growth factor.

Duke Raleigh is part of the DUHS in Wake County as defined in the 2018 SMFP. Therefore, in addition to justifying the proposed new ORs at **Duke Raleigh**, it must justify ***all*** existing and proposed ORs owned/operated by DUHS in Wake County. As reflected in the following analysis, **Duke Raleigh** has failed to justify all existing and proposed ORs as required and as a result, is non-conforming to this rule.

Duke Raleigh

As discussed above, the projected inpatient surgical growth rate utilized to project future surgical volume at **Duke Raleigh** is over stated. Therefore, projected inpatient utilization at **Duke Raleigh** is overstated.

Duke Raleigh – Inpatient Utilization by Year

	2014	2015	2016	2017	2018	CAGR 2014-2018	CAGR 2013-2018	CAGR 2016-2018	AGR 2017-2018	Average of Four CAGR/AGR
Duke Raleigh										
Inpatient	3,586	3,616	4,389	4,094	3,958	2.50%	3.06%	-5.0%	-3.3%	-0.7%

Source: Attached Table 23

As reflected above **Duke Raleigh** used unreasonable and unsupported growth rates to project future inpatient surgical facilities in Wake County. Therefore, **Duke Raleigh** has failed to justify all existing and proposed ORs as required based upon reasonable assumptions and as a result, is non-conforming to this Rule.

(e) The applicant shall document the assumptions and provide data supporting the methodology used for each projection in this Rule.

As discussed above, the assumptions utilized to project inpatient cases for **Duke Raleigh** was unreasonable and unsupported. Therefore, the project is non-conforming to this Rule.

COMMENTS SPECIFIC TO WAKEMED-NR (PROJECT ID NO. J-011564-18)

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

POLICY GEN-3: BASIC PRINCIPLES states:

"A certificate of need applicant applying to develop or offer a new institutional health service for which there is a need determination in the North Carolina State Medical Facilities Plan shall demonstrate how the project will promote safety and quality in the delivery of health care services while promoting equitable access and maximizing healthcare value for resources expended. A certificate of need applicant shall document its plans for providing access to services for patients with limited financial resources and demonstrate the availability of capacity to provide these services. A certificate of need applicant shall also document how its projected volumes incorporate these concepts in meeting the need identified in the State Medical Facilities Plan as well as addressing the needs of all residents in the proposed service area."

The **WakeMed-NR** application fails to conform with Criterion 1 and Policy GEN-3 because the projected surgical patient volumes are unreasonable and unsupported. See the discussion regarding projected utilization in Criterion 3.

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

WakeMed-NR proposes to develop a new freestanding ASC in North Raleigh with 2 ORs and 2 procedure rooms to be managed by Compass. WakeMed will own the building, and **WakeMed-NR** will upfit and equip the constructed space. **WakeMed-NR** is a joint venture between WakeMed and Compass.

Failure to Demonstrate Need

WakeMed-NR bases future surgical utilization at the proposed ASC on projected volumes for existing surgical locations within the WakeMed HealthCare system. The applicant projects a small percent of total WakeMed surgical volume will shift to the proposed ASC.

- **WakeMed-NR** calculated the CAGR for all Wake County surgical volumes, broken down by hospital inpatients, hospital outpatients, and freestanding ASC outpatients. (**WakeMed-NR** App, p. 120). The applicant neglected to include the comparable 2015-2017 CAGR for WakeMed surgical volumes in these categories, and instead erroneously used countywide CAGRs to project future surgical utilization at the proposed ASC. The following table shows that while WakeMed enjoyed modest growth in surgical volumes overall, the outpatient volumes in WakeMed's freestanding ASCs decreased precipitously:

CAGR 2015-2017

Surgical Case Location	All Wake County Providers	WakeMed Only
Hospital Surgical Inpatient	3.76%	3.5%
Hospital Surgical Outpatient	2.43%	4.2%
Freestanding ASC Outpatient	3.93%	-10.0%
Total Cases	3.21%	1.1%

Source: **WakeMed-NR** App., p. 120; Attached Table 24 and 25

Total surgical cases at WakeMed increased by only 1.1% from 2015-2017, compared to a countywide growth of 3.21% over the same period. WakeMed's system-wide surgical case growth (1.1%) trails the projected Wake County population growth from 2018-2023 (CAGR of 2.1%), as calculated on page 23 of **WakeMed-NR**'s application as reflected in attached Table 27. Therefore, it is unreasonable for WakeMed to project growth in its surgical volumes at any of its surgical locations using countywide growth rates. This especially so where, as here, actual rates for both WakeMed's surgical inpatient and freestanding ASC volumes were less than the countywide rates.

As shown in the following table, the CAGR at most surgical locations owned by WakeMed decreased from 2014 to 2017. Outpatient volumes were flat (-0.2%) from 2015 to 2017.

WakeMed Historical Surgical Utilization

	2014	2015	2016	2017	CAGR 2014-2017	CAGR 2015-2017	CAGR 2016-2017
Inpatient							
WakeMed	7,135	7,798	8,419	8,121	4.41%	2.1%	-3.5%
WakeMed North	0	21	81	63	0.00%	73.2%	-22.2%
WakeMed Cary	2,172	2,769	3,037	3,162	13.34%	6.9%	4.1%
Capital City	0	0	0	0	0.00%	0.0%	0.0%
Total Inpatient	9,307	10,588	11,537	11,346	6.83%	3.5%	-1.7%
Outpatient							
WakeMed	8,494	7,326	7,705	7,547	-3.86%	1.5%	-2.1%
WakeMed North	1,990	1,802	2,213	2,346	5.64%	14.1%	6.0%
WakeMed Cary	4,076	4,815	4,820	5,242	8.75%	4.3%	8.8%
Capital City	6,647	6,647	6,123	5,388	-6.76%	-10.0%	-12.0%
Total Outpatient	21,207	20,590	20,861	20,523	-1.09%	-0.2%	-1.6%
Total All Surgery	30,514	31,178	32,398	31,869	1.46%	1.1%	-1.6%

Source: Attached Table 24

WakeMed-NR did not provide any supporting information or documentation to suggest that the decreasing surgical growth trend at WakeMed will reverse. In fact, even though the application was submitted in the middle of August (at which time nearly 10

months of FFY 2018 data was available), WakeMed did not provide any assumptions for 2018 data. No positive 2017 to 2018 data, if any, was set forth as support for the aggressive growth rates projected in the **WakeMed-NR** application or to counter the decreasing surgical trends currently experienced by WakeMed.

The projected growth rates used by **WakeMed-NR** in the its application do not bear any resemblance to the actual experience at WakeMed and are overstated and unreasonable. Therefore, the proposed project is non-conforming to Criterion 3.

- **WakeMed-NR** identifies the shared experience between WakeMed and Compass at Capital City Surgery Center as a reason for approval, suggesting proximity to the hospital is a positive for the project. (**WakeMed-NR** App., p. 27). However, surgical utilization at WakeMed's only existing ASC's near a hospital, Capital City Surgery Center, has decreased dramatically since 2014. **WakeMed-NR** did not provide any documentation or data to show that this negative trend will reverse. As shown in the previous table, Capital City Surgery Center's utilization declined between 2015 and 2017 by 10.0%, and by 12.0% from 2016-2017. Proximity to the hospital has not supported an increase in utilization at Capital City Surgery Center, so it is unreasonable to assume that the proposed ASC's proximity to a hospital will benefit it from an efficiency or utilization standpoint.

  WakeMed is the majority investor in Capital City Surgery Center, opened in 2012, with 8 ORs and 3 procedure rooms. Compass manages Capital City Surgery Center. Because WakeMed is a majority investor and Compass is the manager of Capital City Surgery Center, the **WakeMed-NR** Application should have provided some explanation for the dramatic decline in surgical volumes at Capital City Surgery Center between 2015-2017. Without more, **WakeMed-NR** cannot demonstrate the need for additional ORs—it has ample capacity at Capital City Surgery Center.

- In Step 4 of its defined utilization methodology, **WakeMed-NR** projects surgical case growth by individual WakeMed facility in Wake County. (**WakeMed-NR** App., pp. 121-124).

- WakeMed Cary Hospital – WakeMed Cary Hospital has enjoyed significant growth in the last several years: the result of shifting surgical volumes from WakeMed to WakeMed Cary Hospital. However, **WakeMed-NR** did not provide any justification for using the countywide surgical CAGRs for future WakeMed Cary Hospital outpatient cases.

- WakeMed Main – The projected surgical utilization for WakeMed Main is unreasonable and unsupported. As discussed above, **WakeMed-NR** erroneously uses countywide CAGRs (2.43% for inpatient and 3.76% for outpatient) to project future growth, when its own system volumes were less than these growth rates. As shown in the following table, the CAGR for both inpatient and outpatient surgical utilization at WakeMed Main for 2015-2017 (2.1% and 1.5% respectively) is considerably less than the countywide growth rates used by **WakeMed-NR** to project future surgical volume. In addition, surgical volumes decreased significantly from 2016 to 2017.

WakeMed Main Only Historical Surgical Utilization

	2014	2015	2016	2017	CAGR 2014-2017	CAGR 2015-2017	AGR 2016-2017
Inpatient							
WakeMed	7,135	7,798	8,419	8,121	4.41%	2.1%	-3.5%
Outpatient							
WakeMed	8,494	7,326	7,705	7,547	-3.86%	1.5%	-2.1%

Source: Attached Table 24

WakeMed-NR projects future utilization for WakeMed Main and WakeMed North separately but uses a combined inpatient surgical CAGR for the two locations when projecting WakeMed Main future inpatient utilization, which is unreasonable.

WakeMed-NR did not provide any justification for using the countywide outpatient surgical CAGR for future WakeMed Main outpatient cases.

Finally, **WakeMed-NR** did not provide any supporting information or documentation to suggest that the decreasing surgical growth trend at WakeMed Main will reverse. In fact, even though the application was submitted in the middle of August, at which time nearly 10 months of FFY 2018 data was available, **WakeMed-NR** did not provide any assumptions for 2018 data for WakeMed Main. No data from 2017 to 2018 was included to support the aggressive growth rates or a change in the decreasing surgical trends currently experienced by WakeMed.

- WakeMed North – The methodology utilized by **WakeMed-NR** to calculate future surgical volumes at WakeMed North is unreasonable and unsupported. As shown in the following table, the CAGR for both inpatient and outpatient surgical utilization at WakeMed North for 2015-2017 is considerably less than those used by **WakeMed-NR**. In addition, surgical volumes decreased significantly from 2016 to 2017.

WakeMed North Historical Surgical Utilization

	2014	2015	2016	2017	CAGR 2014-2017	CAGR 2015-2017	AGR 2016-2017
Inpatient							
WakeMed North	0	21	81	63	0.00%	73.2%	-22.2%
Outpatient							
WakeMed North	1,990	1,802	2,213	2,346	5.64%	14.1%	6.0%

Source: Attached Table 24

On page 124, **WakeMed-NR** states the historic 2015-2017 CAGR for WakeMed North is 52.75%. However, no data is provided to support this. Data in the above table from annual WakeMed LRAs indicates that the four ORs at WakeMed North have enjoyed some outpatient surgical growth in the last several years but has not achieved the outpatient surgical levels experienced there in 2012. Essentially, there is no inpatient surgical volume performed at WakeMed North. As shown in the following table, WakeMed North has shown a surplus of more than 1.5 ORs since 2012.

WakeMed North Historical Operating Room Need

	2012	2013	2014	2015	2016	2017
Inpatient						
WakeMed North	0	0	0	21	81	63
Inpatient Case Time	0	0	0	105	105	105
Inpt Surgical Hours	0	0	0	36.8	141.8	110.3
Outpatient						
WakeMed North	3,486	2,106	1,990	1,802	2,213	2,346
Outpatient Case Time	65	65	65	65	65	65
Outpt Surgical Hours	3,776.5	2,281.5	2,155.8	1,952.2	2,397.4	2,541.5
Additional ORs Needed						
Total Surgical Hours	3,777	2,282	2,156	1,989	2,539	2,652
Std Hrs Per OR Category 4 (p58 2018 SMFP)	1500	1500	1500	1500	1500	1500
OR Need	2.5	1.5	1.4	1.3	1.7	1.8
OR Inventory	4	4	4	4	4	4
OR Surplus	1.5	2.5	2.6	2.7	2.3	2.2

Source: Attached Table 28

Finally, **WakeMed-NR** did not provide any supporting information or documentation that the inpatient surgical growth trend at WakeMed North would reverse. In fact, even though the application was submitted in the middle of August, at which time 10 months of FFY 2018 data was available, **WakeMed-NR** did not provide any assumptions for 2018 data for WakeMed North. No data from 2017 to 2018 was provided to support the aggressive growth rates or any potential change in the decreasing surgical trends currently experienced by WakeMed.

Therefore, the projected CAGRs utilized for WakeMed North are unreasonable and **WakeMed-NR** has not justified future operating room need at that WakeMed location.

- Capital City Surgery Center – The CAGR for outpatient surgical utilization at Capital City for 2015-2017 is negative and is considerably less than those used by **WakeMed-NR**. In addition, the CAGR from 2014-2017 is negative and surgical volumes decreased significantly from 2016 to 2017.

Capital City Historical Surgical Utilization

	2014	2015	2016	2017	CAGR 2014-2017	CAGR 2015-2017	AGR 2016-2017
Outpatient							
Capital City	6,647	6,647	6,123	5,388	-6.76%	-10.0%	-12.0%

Source: Attached Table 24

On page 122, **WakeMed-NR** does not discuss the historic 2015-2017 CAGR for Capital City nor does **WakeMed-NR** provide any discussion or documentation supporting the use of the countywide outpatient surgical growth rate for Capital City's projected utilization. Data in the above table shows that outpatient surgical volumes at Capital City have declined significantly since 2014.

Finally, **WakeMed-NR** did not provide any supporting information or documentation that the negative outpatient surgical growth trend at Capital City would reverse. In fact, even though the application was submitted in the middle of August, at which time 10 months of FFY 2018 data was available, **WakeMed-NR** did not provide any assumptions for 2018 data for Capital City. No data from 2017 to 2018 was provided to support the aggressive growth rates or any potential change in the decreasing surgical trends currently experienced by WakeMed.

Therefore, the projected CAGRs utilized for Capital City are unreasonable and **WakeMed-NR** has not justified future operating room need at that WakeMed location.

WakeMed-NR utilized unreasonable projections to project future surgical utilization at existing WakeMed surgical locations in Step 4. As a result, any future steps in the methodology based on the projections in Step 4 are also unreasonable. Therefore, **WakeMed-NR** has failed to document the need for the proposed project.

- In Step 5 of its defined utilization methodology, **WakeMed-NR** calculates outpatient surgical volume from existing surgical locations expected to shift to the proposed ASC, based on proximity of the existing facilities to the location of the proposed ASC and

physician patterns. (**WakeMed-NR** App., pp. 125-26). However, "proximity" is not defined, and **WakeMed-NR** does not provide any detail regarding physician practice patterns. Practice patterns are continually changing. For example, the type of cases that are appropriate to shift from inpatient to outpatient is constantly changing, as new, younger physicians are often more aggressive in moving patients to outpatient settings. No discussion or definitions on these points were provided by **WakeMed-NR**. Therefore, the assumptions are not supported.

- **WakeMed-NR** utilized unreasonable projections to shift projected surgical volumes from existing WakeMed surgical locations in Step 4. As a result, any future steps in the methodology based on the projections in Step 4 are also unreasonable. Therefore, **WakeMed-NR** has failed to document the need for the proposed project.

- In Step 6 of its defined utilization methodology, **WakeMed-NR** calculates the projected outpatient surgical volume shifts from existing surgical locations to the proposed **WakeMed-NR**. (**WakeMed-NR** App., p. 127). As previously discussed, Steps 4 and 5 are based on unreasonable and inadequately supported assumptions, and as a result, the projected utilization in Step 6 for **WakeMed-NR** is unreasonable and inadequately supported. Therefore, **WakeMed-NR** has failed to document the need for the proposed project.

- In Step 7 of its defined utilization methodology, **WakeMed-NR** calculates operating room need for the proposed **WakeMed-NR** and all other existing and proposed WakeMed ORs. (**WakeMed-NR** App., pp. 127-30). As previously discussed, Steps 4, 5 and 6 are based on unreasonable and inadequately supported assumptions, and as a result, the operating room need projections included in Step 7 for **WakeMed-NR** and other WakeMed locations are unreasonable and inadequately supported. Therefore, **WakeMed-NR** has failed to document the need for the proposed project.

- **WakeMed-NR** is proposed to be located on the WakeMed North Hospital campus. (**WakeMed-NR** App., p. 20). Patients often prefer to access outpatient surgery at non-hospital locations, which are often more convenient and welcoming than hospital sites.

In fact, in describing benefits of Capital City Surgery Center, **WakeMed-NR** states "Patients can conveniently access Capital City without having to enter the WakeMed Raleigh Campus." (**WakeMed-NR** App., p. 28). The **WakeMed-NR** proposal is neither a new facility nor one offering patients the convenience of accessing a true freestanding ASC facility, separate and apart from a hospital setting.

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."*

As described above, **WakeMed-NR** does not demonstrate that projected surgical utilization is based on reasonable and adequately supported assumptions. Therefore, the application is non-conforming with Criterion 4.

Also, because **WakeMed-NR** used aggressive projections and did not realistically examine the historical surgical volumes for other WakeMed surgical facilities, **WakeMed-NR** failed to address another potential alternative: relocating existing ORs to North Raleigh. Shifting underutilized ORs from Capital City Surgery Center or WakeMed North are two opportunities overlooked by the applicant.

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

Payor Mix

As discussed below in Criterion 13, the payor mix assumptions for **WakeMed-NR** are not reasonable, which calls into question the projected revenue for the proposed project and the financial viability of the project.

Further, as discussed in the Comparative Analysis, the payor mix reported by **WakeMed-NR** iAn Section L of the Application is different from the payor mix used in the financial statements included in Section Q Forms F.4 and F.5. Therefore, the project is non-conforming to Criterion 5.

Land Costs

Although WakeMed Property Services is a subsidiary of WakeMed, they are separate legal entities:

- WakeMed, Secretary of State ID # 0132946, was formed in 1965.
- WakeMed Property Services, Secretary of State ID # 0157075, was formed ten years later, in 1975.

On page 19, **WakeMed-NR** states that the proposed primary site is owned by WakeMed. However, on page 79, in response to Question K.5(b), the applicant states that WakeMed Property Services currently holds fee simple title to the proposed primary site (and corroborates this fact with an unsigned letter in Exhibit K.5.1).

The Application Form at page 79 requires that, if the applicant is not the current owner in fee simple, documentation is to be provided to show the site is available for acquisition by purchase, lease, donation or other comparable arrangement. Here, the **WakeMed-NR** Application is submitted in the name of two co-applicants, **WakeMed-NR** and WakeMed (WakeMed Property Services is ***not*** a co-applicant). Neither **WakeMed-NR** nor WakeMed holds fee simple title to the proposed primary site and no secondary site is

identified. The letter at Exhibit K.5.1 does not indicate that the site is available for acquisition by purchase, lease, donation or other comparable arrangement.

In 2017, WakeMed ***and*** WakeMed Property Services were co-applicants to expand the Emergency Department (ED) and acquire a second computerized tomography (CT) scanner at WakeMed North Family Health & Women's Hospital (WakeMed North). However, in this Review, WakeMed Property Services is ***not*** a co-applicant. As such, WakeMed Property Services did not sign a Certification Page or commit to carry out this project in material compliance with the representations in the Application.

In cases where a project is to be funded other than by the applicants, the application must contain evidence of a commitment to provide the funds by the funding entity. Without such a commitment, an applicant cannot adequately demonstrate availability of funds or the requisite financial feasibility. *Ret. Villages, Inc. v. N.C. Dep't of Human Res.*, 124 N.C. App. 495, 499, 477 S.E.2d 697, 699 (1996). The same principles apply to land. While it is permissible for an applicant (or co-applicants) to secure funding or land from a non-applicant entity, the non-applicant entity must commit to provide the funding, or in this case, the land.

It cannot be assumed, with no documentation, that WakeMed Property Services has committed to sell, lease or donate the land to its parent company, WakeMed, nor that it will or could do so at no cost to WakeMed or to **WakeMed-NR**, the LLC co-applicant.

In Form F.1a (Capital Costs, **WakeMed-NR** App., p. 133), no cost is included for either co-applicant to acquire the land by purchase, lease, donation or other arrangement. As such, the financial feasibility of the project is not based on reasonable cost assumptions as it artificially assumes zero land cost for the property in North Raleigh on which the proposed surgery center will be built.

WakeMed-NR is borrowing money to acquire fixed and movable equipment, and that value ($2,085,050 + $600,000 + $100,00) is shown on the Balance Sheet, Form F.2, as

an Asset. Notably, no value is shown for Land. (**WakeMed-NR** App., p. 135). The Applicants do not own the Land.

Even assuming WakeMed Property Services will agree to convey the land to its parent company, WakeMed, the cost of the Land has not been accounted for in the CON Application.

Financing Costs

The **WakeMed-NR** Application does not include any financing costs associated with the $1.5 million "revolving credit facility" to be provided by Wells Fargo at a variable rate based on a spread over Libor.

Charges

The **WakeMed-NR** Application does not explain the basis for its charges. The charges differ from those proposed in the WakeMed-Cary Application but, without explanation, the reasonableness of the charge projections cannot be evaluated. **WakeMed-NR** did not provide any assumptions for Forms F.4 and F.5; the assumptions included in the application are for the WakeMed-Cary project.

Initial Operating Expenses

Initial operating expenses and the projected start-up period are unreasonable. (**WakeMed-NR** App., p. 53). As discussed above, in Step 4 of its defined utilization methodology, **WakeMed-NR** utilized unreasonable projections to shift projected surgical volumes from existing WakeMed surgical locations. Further, in Steps 4 and 5, **WakeMed-NR** did not assume any ramp-up timeframe or gradual shifting of surgical volume for the proposed project. Instead, **WakeMed-NR** assumed 100% of such cases would shift to the proposed ASC in Project Year 1. This is not reasonable. As a result, the initial operating period of two months for the proposed project is understated, impacting the financial viability of the project and potential funding for the project.

ProForma Assumptions

The assumptions for proformas and staffing included in the **WakeMed-NR** application are for another project, not the **WakeMed-NR** project. (**WakeMed-NR** App., p. 142). Thus, **WakeMed-NR** failed to provide any assumptions for its proformas. Therefore, the Agency cannot determine if the projections are reasonable.

WakeMed-NR did not adequately demonstrate the financial feasibility of the project. Specifically, **WakeMed-NR** did not adequately demonstrate in its application that the new ORs it proposes to develop are needed. Therefore, the **WakeMed-NR** application is non-conforming with Criterion 5.

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."*

WakeMed-NR did not adequately demonstrate that its proposal would not result in the unnecessary duplication of surgical services in Wake County. Specifically, **WakeMed-NR** did not adequately demonstrate in its application that the new ORs it proposes to develop are needed, and that it will not unnecessarily duplicate the ORs that WakeMed already owns in Wake County. See the discussion regarding projected utilization in Criterion 3 and in 10A NCAC 14C.2103 Performance Standards. Therefore, the **WakeMed-NR** application is non-conforming with Criterion 6.

Criterion 13c *"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."

WakeMed-NR fails to conform with Criterion 13c because the proposed project did not document the provision of adequate access to low income persons, including Medicare patients. The proposed payor mix for the **WakeMed-NR** application is based upon unreasonable and unsupported assumptions. **WakeMed-NR** defines the service area based upon historical patient origin for WakeMed North surgical outpatients. (**WakeMed-NR** App., p. 29). **WakeMed-NR** projects that 72.5% of the patients expected to shift to the proposed ASC will be from WakeMed, with only 12.9% of patients expected to shift from WakeMed North. (**WakeMed-NR** App., p. 127). Around 10% of patients will come from Capital City and less than 4% from WakeMed Cary.

The following table shows 2017 outpatient surgical payor mix for all four WakeMed surgical locations:

2017 Outpatient Surgical Payor Mix – WakeMed Facilities

	WakeMed Main	WakeMed Cary	Capital City Surgery Center	WakeMed North
Self Pay/Charity	7.9%	2.4%	0.9%	1.3%
Medicare	16.3%	37.2%	31.2%	35.7%
Medicaid	31.4%	2.7%	6.3%	2.7%
Commercial	0.7%	0.6%	57.7%	0.9%
Managed Care	41.1%	55.5%	0.0%	57.2%
Other	2.6%	1.5%	3.9%	2.1%
Total	100.0%	100.0%	100.0%	100.0%

Source: 2018 LRAs

WakeMed Main has a considerably higher percentage of self-pay/charity patients and Medicaid patients than WakeMed North, Capital City Surgery Center, or WakeMed Cary. As discussed above, 72.5% of patients at **WakeMed-NR** will be shifted from WakeMed. Therefore, using only the WakeMed North payor mix is not reasonable and does not reflect the shift of patients as reflected in the utilization projections. The population of the WakeMed North service area is not homogeneous, and the market includes different socioeconomic groups. Therefore, the insurance coverage of patients seeking care at WakeMed is unlikely to be identical to those seeking care at WakeMed North. Therefore, the payor mix assumptions are unreasonable and **WakeMed-NR** has not shown that the medically underserve population will be served by the proposed project. Consequently, the project is not conforming with Criterion 13c.

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

Because the **WakeMed-NR** application is non-conforming with Criteria 1, 3, 4, 5, 6, and 13c, it should also be found non-conforming with Criterion 18a. **WakeMed-NR** did not

adequately demonstrate the need the population projected to be served has for the proposed project and did not adequately demonstrate that its proposal would not result in the unnecessary duplication of surgical services in Wake County. **WakeMed-NR** did not adequately demonstrate the financial feasibility of the proposal because its projections were premised on unreasonable and unsupported assumptions.

Additionally, while **WakeMed-NR** proposes the development of an ASC, the applicant is owned by WakeMed and Compass. WakeMed/Compass currently own/operate 43 of the 100 existing ORs in Wake County, **or over 40% of the existing ORs in the service area**. If **WakeMed-NR**'s application (or either of the WakeMed Health Care-affiliated applications) were approved, this dominance would only become more pronounced. Thus, the proposed WakeMed project will not have a positive impact on competition.

Because this is the first time since 2012 there has been a need determination for ORs in Wake County, the Agency should use this rare opportunity to increase competition by approving OrthoNC ASC to become a new market provider rather than a large hospital system or its affiliates.

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

WakeMed identifies only ***three*** hospitals (WakeMed Main, WakeMed Cary, WakeMed North) and ***one*** surgery center (Capital City Surgery Center) in response to Question 3(a). (**WakeMed-NR** App., p. 106) (requesting that the applicants "Identify all similar health care facilities located in NC that are owned, operated or managed by each applicant or any related entities.").

In the 2017 Agency Findings for the WakeMed North Project ID #J-11301-17, the Agency states:

> In Section O-3(a), pages 132-133, the applicants state that they currently own and operate ***seven*** hospitals/acute care health services facilities and owns/manages ***eight*** health services properties in North Carolina

(emphasis supplied).

The letter at Exhibit O.3 from WakeMed's President & CEO indicates "all WakeMed facilities" have been and continue to be in full compliance . . . with Medicare Conditions of Participation," but it is unclear whether the letter is intended to address the facilities identified on page 106 or the larger list of facilities described in the above-quoted 2017 Agency Findings.

On average, acute care hospitals are reassessed only every three to four years for their compliance with all the Conditions of Participation. By law, reports generated by accrediting organizations are not considered public records. CMS only releases deficiencies cited on complaint surveys.

10A NCAC 14C.2103 Performance Standards.

(a) A proposal to establish a new ambulatory surgical facility, to establish a new campus of an existing facility, to establish a new hospital, to increase the number of operating rooms in an existing facility (excluding dedicated C-section operating rooms), to convert a specialty ambulatory surgical program to a multispecialty ambulatory surgical program, or to add a specialty to a specialty ambulatory surgical program shall demonstrate the need for the number of proposed operating rooms in the facility that is proposed to be developed or expanded in the third operating year of the project based on the Operating Room Need Methodology set forth in the 2018 State Medical Facilities Plan. The applicant is not required to use the population growth factor.

As discussed in the above comments, **WakeMed-NR** failed to document the need for the proposed project. The discussions regarding analysis of need, including projected utilization, found in Criterion (3) above are incorporated herein by reference. Thus, the **WakeMed-NR** application is non-conforming to this Rule.

(b) A proposal to increase the number of operating rooms (excluding dedicated C-section operating rooms) in a service area shall demonstrate the need for the number of proposed operating rooms in addition to the existing and approved operating rooms in the applicant's health system in the third operating year of the proposed project based on the Operating Room Need Methodology set forth in the 2018 State Medical Facilities Plan. The applicant is not required to use the population growth factor.

The proposed **WakeMed-NR** is part of WakeMed Health System in Wake County as defined in the 2018 SMFP. Therefore, in addition to justifying the proposed new ORs, **WakeMed-NR** must justify ***all*** existing/approved ORs owned/operated by WakeMed. As discussed previously in the discussion of Criterion 3, **WakeMed-NR** has failed to justify all existing, approved, and proposed ORs as required, and as a result is non-conforming with this Rule.

WakeMed Historical Surgical Utilization

	2014	2015	2016	2017	CAGR 2014-2017	CAGR 2015-2017	AGR 2016-2017
Inpatient							
WakeMed	7,135	7,798	8,419	8,121	4.41%	2.1%	-3.5%
WakeMed North	0	21	81	63	0.00%	73.2%	-22.2%
WakeMed Cary	2,172	2,769	3,037	3,162	13.34%	6.9%	4.1%
Capital City	0	0	0	0	0.00%	0.0%	0.0%
Total Inpatient	9,307	10,588	11,537	11,346	6.83%	3.5%	-1.7%
Outpatient							
WakeMed	8,494	7,326	7,705	7,547	-3.86%	1.5%	-2.1%
WakeMed North	1,990	1,802	2,213	2,346	5.64%	14.1%	6.0%
WakeMed Cary	4,076	4,815	4,820	5,242	8.75%	4.3%	8.8%
Capital City	6,647	6,647	6,123	5,388	-6.76%	-10.0%	-12.0%
Total Outpatient	21,207	20,590	20,861	20,523	-1.09%	-0.2%	-1.6%
Total All Surgery	**30,514**	**31,178**	**32,398**	**31,869**	**1.46%**	**1.1%**	**-1.6%**

Source: Attached Table 24

As shown in the chart above, historical growth within the WakeMed Health System (all surgery) has experienced an overall decreasing growth rate from 2014 to 2017. Inpatient surgical growth has decreased by 1.7% over this same period, including a decrease from 2016 to 2017, the most recent years for which full data is available. **WakeMed-NR** did not provide any annualized 2018 data, which may have supported a positive growth trend. Outpatient surgical growth has decreased by 1.09% from 2014 to 2017, including a decrease from 2016 to 2017, the most recent years for which full data is available. **WakeMed-NR** did not provide any annualized 2018 data, which may have supported a positive growth trend.

WakeMed-NR used an overall CAGR of 2.23% to project inpatient surgical volumes from through 2023, which is the third project year for **WakeMed-NR**. While this may appear reasonable given the overall Wake County experience, it does not take into consideration the WakeMed Health System experience, which has shown only a 1.5% CAGR since 2014 (nearly a point less than Wake County as a whole). Also, outpatient surgical cases within WakeMed's Wake County surgical locations decreased from 2016 to 2017, the most recent years for which full data is available.

Further **WakeMed-NR** did not provide any data to suggest any changes were expected in the negative growth trend line for inpatient surgery at WakeMed.

WakeMed-NR used an overall CAGR of 2.07% for outpatient surgical volumes from through 2023, which is the third project year for **WakeMed-NR**. While this may appear reasonable given the overall Wake County experience, it does not take into consideration the WakeMed Health System experience, which has shown a -1.09% CAGR since 2014 (nearly three points less than Wake County as a whole). Also, outpatient surgical cases within WakeMed's Wake County surgical locations decreased from 2016 to 2017, the most recent years for which full data is available. Further **WakeMed-NR** did not provide any data to suggest any changes were expected in the negative growth trend line for outpatient surgery at WakeMed.

As shown in the attached Table 6, WakeMed used a CAGR of 2.24% to project future surgical volume for the combined WakeMed System. This is 8% greater than the actual population growth for the County, and 153.4% greater than the actual 2014-2017 CAGR for total surgical volume for WakeMed, as reflected in the previous table.

The Rule requires the applicant to use the Operating Room Need Methodology included in the 2018 SMFP to calculate future OR need. The following table shows that when the total growth rate for WakeMed is projected using the SMFP methodology, WakeMed fails to show a need for additional operating rooms.

Projected Surgical Growth - WakeMed

	2017 Total Surgical Hours - 2018 LRAs	WakeMed Total Surgical Hours Projected CAGR 2017-2023	Growth Factor	Projected Surgical Hours for 2023	Planning Threshold 2018 SMFP	OR Need	Inventory	Surplus (-) Deficit (+)
Capital Surgery Center	5,412	2.238%	13.4%	6,139	1,312.5	4.7	8	-3.3
WakeMed	44,012	2.238%	13.4%	49,921	1,950	25.6	23	2.6
WakeMed Cary	8,296	2.238%	13.4%	9,410	1,500	6.3	9	-2.7
WakeMed-Cary page 126 of application*						2.45	2	0.45
WakeMed-NR page 128 of application*						2.75	2	0.75
Total Projected Surplus						**41.8**	**44**	**-2.25**

* The above table assumes the projections for the two new applications were reasonable, which, as discussed previously is incorrect.

Source: WakeMed CAGR calculated in attached Table 29

The discussions regarding analysis of need, including projected utilization, found in Criterion (3) and in 10 NCAC 14C .2103(a) above are incorporated herein by reference. Thus, the **WakeMed-NR** application is non-conforming with this Rule.

(e) The applicant shall document the assumptions and provide data supporting the methodology used for each projection in this Rule.

WakeMed-NR fails to document the assumptions utilized in its application. Therefore, the methodologies utilized in the application to project OR utilization for **WakeMed-NR** and the WakeMed Health System as a whole are unreasonable and unsupported. See discussions regarding need, including projected utilization, in Criterion 3 and in 10 NCAC 14C.2103(a) and (b) above. Thus, the **WakeMed-NR** application is non-conforming to this Rule.

COMMENTS SPECIFIC TO WAKEMED-CARY (PROJECT ID NO. J-011565-18)

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

POLICY GEN-3: BASIC PRINCIPLES states:

"A certificate of need applicant applying to develop or offer a new institutional health service for which there is a need determination in the North Carolina State Medical Facilities Plan shall demonstrate how the project will promote safety and quality in the delivery of health care services while promoting equitable access and maximizing healthcare value for resources expended. A certificate of need applicant shall document its plans for providing access to services for patients with limited financial resources and demonstrate the availability of capacity to provide these services. A certificate of need applicant shall also document how its projected volumes incorporate these concepts in meeting the need identified in the State Medical Facilities Plan as well as addressing the needs of all residents in the proposed service area."

The **WakeMed-Cary** application fails to conform with Criterion 1 and Policy GEN-3 because the projected surgical patient volumes are unreasonable and unsupported. See the discussion regarding projected utilization in Criterion 3.

As discussed below in Criterion 13, the payor mix assumptions for **WakeMed-Cary** are not reasonable. **WakeMed-Cary** has not documented access to services for patients with limited financial resources and has not demonstrated the availability of capacity to provide these services. Therefore, the project is non-conforming with Criterion 1.

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

WakeMed-Cary proposes to develop a new freestanding ASC in North Raleigh with 2 ORs and 2 procedure rooms to be managed by Compass. WakeMed will own the building, and **WakeMed-Cary** will upfit and equip the constructed space. **WakeMed-Cary** is a joint venture between WakeMed and Compass.

Failure to Demonstrate the Need

WakeMed-Cary bases future surgical utilization at the proposed ASC on projected volumes for existing surgical locations within the WakeMed HealthCare system. The applicant projects that a small percent of the total WakeMed surgical volume will shift to the proposed ASC.

- **WakeMed-Cary** calculated the CAGR for all Wake County surgical volumes, broken down by hospital inpatients, hospital outpatients, and freestanding ASC outpatients. (**WakeMed-Cary** App, p. 120). The applicant neglected to include the comparable 2015-2017 CAGR for WakeMed surgical volumes in these categories, and instead erroneously used countywide CAGRs to project future surgical utilization at the proposed ASC. The following table shows that while WakeMed enjoyed modest growth in surgical volumes overall, the outpatient volumes in WakeMed's freestanding ASCs decreased precipitously.

CAGR 2015-2017

Surgical Case Location	All Wake County Providers	WakeMed Only
Hospital Surgical Inpatient	3.76%	3.5%
Hospital Surgical Outpatient	2.43%	4.2%
Freestanding ASC Outpatient	3.93%	-10.0%
Total Cases	3.21%	1.1%

Source: **WakeMed-Cary** App., p. 120; Attached Table 24

Total surgical cases at WakeMed increased by only 1.1% from 2015-2017, compared to a countywide growth of 3.21% over the same period. WakeMed's system-wide surgical case growth (1.1%) trails the projected Wake County population growth from 2018-2023 (CAGR of 2.1%), as calculated on page 23 of **WakeMed-Cary**'s application. Therefore, it is unreasonable for WakeMed to project growth in its surgical volumes at any of its surgical locations using countywide growth rates. This especially so where, as here, actual rates for both WakeMed's surgical inpatient and freestanding ASC volumes were less than the countywide rates.

As shown in the following table, the CAGR at most surgical locations owned by WakeMed decreased from 2014 to 2017. Outpatient volumes were flat (-0.2%) from 2015 to 2017.

WakeMed Historical Surgical Utilization

	2014	2015	2016	2017	CAGR 2014-2017	CAGR 2015-2017	AGR 2016-2017
Inpatient							
WakeMed	7,135	7,798	8,419	8,121	4.41%	2.1%	-3.5%
WakeMed North	0	21	81	63	0.00%	73.2%	-22.2%
WakeMed Cary	2,172	2,769	3,037	3,162	13.34%	6.9%	4.1%
Capital City	0	0	0	0	0.00%	0.0%	0.0%
Total Inpatient	9,307	10,588	11,537	11,346	6.83%	3.5%	-1.7%
Outpatient							
WakeMed	8,494	7,326	7,705	7,547	-3.86%	1.5%	-2.1%
WakeMed North	1,990	1,802	2,213	2,346	5.64%	14.1%	6.0%
WakeMed Cary	4,076	4,815	4,820	5,242	8.75%	4.3%	8.8%
Capital City	6,647	6,647	6,123	5,388	-6.76%	-10.0%	-12.0%
Total Outpatient	21,207	20,590	20,861	20,523	-1.09%	-0.2%	-1.6%
Total All Surgery	30,514	31,178	32,398	31,869	1.46%	1.1%	-1.6%

Source: Attached Table 24

WakeMed-Cary did not provide any supporting information or documentation to suggest that the decreasing surgical growth trend at WakeMed will reverse. In fact, even though the application was submitted in the middle of August (at which time nearly 10 months of FFY 2018 data was available), WakeMed did not provide any assumptions for 2018 data. No positive 2017 to 2018 data, if any, was set forth as support for the aggressive growth rates projected in the **WakeMed-Cary** application or to counter the decreasing surgical trends currently experienced by WakeMed.

The projected growth rates used by **WakeMed-Cary** in the its application do not bear any resemblance to the actual experience at WakeMed and are overstated and unreasonable. Therefore, the proposed project is non-conforming to Criterion 3.

- **WakeMed-Cary** identifies the shared experience between WakeMed and Compass at Capital City Surgery Center as a reason for approval, suggesting proximity to the hospital is a positive for the project. (**WakeMed-Cary** App., p. 27). However, surgical utilization at one of WakeMed's existing ASC's near a hospital, Capital City Surgery Center, has decreased dramatically since 2014. **WakeMed-Cary** did not provide any documentation or data to show that this negative trend will reverse. As shown in the

previous table, Capital City Surgery Center's utilization declined between 2015 and 2017 by 10.0%, and by 12.0% from 2016-2017. Proximity to the hospital has not supported an increase in utilization at Capital City Surgery Center, so it is unreasonable to assume that the proposed ASC's proximity to a hospital will be a benefit from an efficiency or utilization standpoint.

WakeMed is the majority investor in Capital City Surgery Center, opened in 2012, with 8 ORs and 3 procedure rooms. Compass manages Capital City Surgery Center. Because WakeMed is a majority investor and Compass is the manager of Capital City Surgery Center, the **WakeMed-Cary** Application should have provided some explanation for the dramatic decline in surgical volumes at Capital City Surgery Center between 2015-2017. Without more, **WakeMed-Cary** cannot demonstrate the need for additional ORs—it has ample capacity at Capital City Surgery Center.

- In Step 4 of its defined utilization methodology, **WakeMed-Cary** projects surgical case growth by individual WakeMed facility in Wake County. (**WakeMed-Cary** App., pp. 121-124).

  - WakeMed Cary Hospital – WakeMed Cary Hospital – WakeMed Cary Hospital has enjoyed significant growth in the last several years: the result of shifting surgical volumes from WakeMed to WakeMed Cary Hospital. However, **WakeMed-NR** did not provide any justification for using the countywide surgical CAGRs for future WakeMed Cary Hospital outpatient cases.

  - WakeMed Main – The projected surgical utilization for WakeMed Main is unreasonable and unsupported. As discussed above, **WakeMed-Cary** erroneously uses countywide CAGRs (2.43% for inpatient and 3.76% for outpatient) to project future growth, when its own system volumes were less than these growth rates. As shown in the following table, the CAGR for both inpatient and outpatient surgical utilization at WakeMed Main for 2015-2017 (2.1% and 1.5% respectively) is considerably less than the countywide growth rates used by

WakeMed-Cary to project future surgical volume. In addition, surgical volumes decreased significantly from 2016 to 2017.

WakeMed Main Historical Surgical Utilization

	2014	2015	2016	2017	CAGR 2014-2017	CAGR 2015-2017	AGR 2016-2017
Inpatient							
WakeMed	7,135	7,798	8,419	8,121	4.41%	2.1%	-3.5%
Outpatient							
WakeMed	8,494	7,326	7,705	7,547	-3.86%	1.5%	-2.1%

Source: Attached Table 24

WakeMed-Cary projects future utilization for WakeMed Main and WakeMed North separately but uses a combined inpatient surgical CAGR for the two locations when projecting WakeMed Main future inpatient utilization, which is unreasonable.

WakeMed-Cary did not provide any justification for using the countywide outpatient surgical CAGR for future WakeMed Main outpatient cases.

Finally, **WakeMed-Cary** did not provide any supporting information or documentation to suggest that the decreasing surgical growth trend at WakeMed Main will reverse. In fact, even though the application was submitted in the middle of August, at which time nearly 10 months of FFY 2018 data was available, **WakeMed-Cary** did not provide any assumptions for 2018 data for WakeMed Main. No data from 2017 to 2018 was included to support the aggressive growth rates or a change in the decreasing surgical trends currently experienced by WakeMed.

- WakeMed North – The methodology utilized by **WakeMed-Cary** to calculate future surgical volumes at WakeMed North is unreasonable and unsupported. As shown in the following table, the CAGR for both inpatient and outpatient surgical utilization at WakeMed North for 2015-2017 is considerably less than those used by **WakeMed-Cary**. In addition, surgical volumes decreased significantly from 2016 to 2017.

WakeMed North Historical Surgical Utilization

	2014	2015	2016	2017	CAGR 2014-2017	CAGR 2015-2017	AGR 2016-2017
Inpatient							
WakeMed North	0	21	81	63	0.00%	73.2%	-22.2%
Outpatient							
WakeMed North	1,990	1,802	2,213	2,346	5.64%	14.1%	6.0%

Source: Attached Table 24

On page 124, **WakeMed-Cary** states the historic 2015-2017 CAGR for WakeMed North is 52.75%. However, no data is provided to support this. Data in the above table from annual WakeMed LRAs indicates that the four ORs at WakeMed North have enjoyed some outpatient surgical growth in the last several years but has not achieved the outpatient surgical levels experienced there in 2012. Essentially, there is no inpatient surgical volume performed at WakeMed North. As shown in the following table, WakeMed North has shown a surplus of more than 1.5 ORs since 2012.

WakeMed North Historical Operating Room Need

	2012	2013	2014	2015	2016	2017
Inpatient						
WakeMed North	0	0	0	21	81	63
Inpatient Case Time	0	0	0	105	105	105
Inpt Surgical Hours	0	0	0	36.8	141.8	110.3
Outpatient						
WakeMed North	3,486	2,106	1,990	1,802	2,213	2,346
Outpatient Case Time	65	65	65	65	65	65
Outpt Surgical Hours	3,776.5	2,281.5	2,155.8	1,952.2	2,397.4	2,541.5
Additional ORs Needed						
Total Surgical Hours	3,777	2,282	2,156	1,989	2,539	2,652
Std Hrs Per OR Category 4 (p58 2018 SMFP)	1500	1500	1500	1500	1500	1500
OR Need	2.5	1.5	1.4	1.3	1.7	1.8
OR Inventory	4	4	4	4	4	4
OR Surplus	1.5	2.5	2.6	2.7	2.3	2.2

Source: Attached Table 28

Finally, **WakeMed-Cary** did not provide any supporting information or documentation that the inpatient surgical growth trend at WakeMed North would reverse. In fact, even though the application was submitted in the middle of August, at which time 10 months of FFY 2018 data was available, **WakeMed-Cary** did not provide any assumptions for 2018 data for WakeMed North. No data from 2017 to 2018 was provided to support the aggressive growth rates or any potential change in the decreasing surgical trends currently experienced by WakeMed.

Therefore, the projected CAGRs utilized for WakeMed North are unreasonable and **WakeMed-Cary** has not justified future operating room need at that WakeMed location.

o Capital City Surgery Center – The CAGR for outpatient surgical utilization at Capital City for 2015-2017 is negative and is considerably less than those used by **WakeMed-Cary**. In addition, the CAGR from 2014-2017 is negative and surgical volumes decreased significantly from 2016 to 2017.

Capital City Historical Surgical Utilization

	2014	2015	2016	2017	CAGR 2014-2017	CAGR 2015-2017	AGR 2016-2017
Outpatient							
Capital City	6,647	6,647	6,123	5,388	-6.76%	-10.0%	-12.0%

Source: Attached Table 24

On page 122, **WakeMed-Cary** does not discuss the historic 2015-2017 CAGR for Capital City nor does **WakeMed-Cary** provide any discussion or documentation supporting the use of the countywide outpatient surgical growth rate for Capital City's projected utilization. Data in the above table shows that outpatient surgical volumes at Capital City have declined significantly since 2014.

Finally, **WakeMed-Cary** did not provide any supporting information or documentation that the negative outpatient surgical growth trend at Capital City

would reverse. In fact, even though the application was submitted in the middle of August, at which time 10 months of FFY 2018 data was available, **WakeMed-Cary** did not provide any assumptions for 2018 data for Capital City. No data from 2017 to 2018 was provided to support the aggressive growth rates or any potential change in the decreasing surgical trends currently experienced by WakeMed.

Therefore, the projected CAGRs utilized for Capital City are unreasonable and **WakeMed-Cary** has not justified future operating room need at that WakeMed location.

WakeMed-Cary utilized unreasonable projections to project future surgical utilization at existing WakeMed surgical locations in Step 4. As a result, any future steps in the methodology based on the projections in Step 4 are also unreasonable. Therefore, **WakeMed-Cary** has failed to document the need for the proposed project.

- In Step 5 of its defined utilization methodology, **WakeMed-Cary** calculates outpatient surgical volume from existing surgical locations expected to shift to the proposed ASC, based on proximity of the existing facilities to the location of the proposed ASC and physician patterns. (**WakeMed-Cary** App., pp. 125-26). However, "proximity" is not defined, and **WakeMed-Cary** does not provide any detail regarding physician practice patterns. Practice patterns are continually changing. For example, the type of cases that are appropriate to shift from inpatient to outpatient is constantly changing, as new, younger physicians are often more aggressive in moving patients to outpatient settings. No discussion or definitions on these points were provided by **WakeMed-Cary**. Therefore, the assumptions are not supported.

- **WakeMed-Cary** utilized unreasonable projections to shift projected surgical volumes from existing WakeMed surgical locations in Step 4. As a result, any future steps in the methodology based on the projections in Step 4 are also unreasonable. Therefore, **WakeMed-Cary** has failed to document the need for the proposed project.

- In Step 6 of its defined utilization methodology, **WakeMed-Cary** calculates the projected outpatient surgical volume shifts from existing surgical locations to the proposed **WakeMed-Cary**. (**WakeMed-Cary** App., p. 127). As previously discussed, Steps 4 and 5 are based on unreasonable and inadequately supported assumptions, and as a result, the projected utilization in Step 6 for **WakeMed-Cary** is unreasonable and inadequately supported. Therefore, **WakeMed-Cary** has failed to document the need for the proposed project.

- In Step 7 of its defined utilization methodology, **WakeMed-Cary** calculates operating room need for the proposed **WakeMed-Cary** and all other existing and proposed WakeMed ORs. (**WakeMed-Cary** App., pp. 127-30). As previously discussed, Steps 4, 5 and 6 are based on unreasonable and inadequately supported assumptions, and as a result, the operating room need projections included in Step 7 for **WakeMed-Cary** and other WakeMed locations are unreasonable and inadequately supported. Therefore, **WakeMed-Cary** has failed to document the need for the proposed project.

- **WakeMed-Cary** is proposed to be located on the WakeMed North Hospital campus. (**WakeMed-Cary** App., p. 20). Patients often prefer to access outpatient surgery at non-hospital locations, which are often more convenient and welcoming than hospital sites. In fact, in describing benefits of Capital City Surgery Center, **WakeMed-Cary** states “Patients can conveniently access Capital City without having to enter the WakeMed Raleigh Campus.” (**WakeMed-Cary** App., p. 28). The **WakeMed-Cary** proposal is neither a new facility nor one offering patients the convenience of accessing a true freestanding ASC facility, separate and apart from a hospital setting.

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."*

As described above, **WakeMed-Cary** does not demonstrate that projected surgical utilization is based on reasonable and adequately supported assumptions. Therefore, the application is non-conforming with Criterion 4.

Also, because **WakeMed-Cary** used aggressive projections and did not look at its surgical volumes for other WakeMed surgical facilities realistically, they failed to address another potential alternative: relocating existing ORs to Cary. Shifting underutilized ORs from Capital City or WakeMed North are two opportunities overlooked by the applicant.

Criterion 5 *"Financial and operational projections for the project shall demonstrate the availability of funds for capital and operating needs as well as the immediate and longterm 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."*

Payor Mix

As discussed below in Criterion 13, the payor mix assumptions for **WakeMed-Cary** are not reasonable, which calls into question the projected revenue for the proposed project and the financial viability of the project. Therefore, the project is non-conforming with Criterion 5.

Charges

The **WakeMed-Cary** Application does not explain the basis for its charges. The charges differ from those proposed in its WakeMed-NR Application but, without explanation, the reasonableness of the charge projections cannot be evaluated.

Initial Operating Expenses

Initial operating expenses and the proposed start-up period are unreasonable. (**WakeMed-Cary** App., p. 53). As discussed above, **WakeMed-Cary** utilized unreasonable projections to shift projected surgical volumes from existing WakeMed surgical locations. Further, in Steps 4 and 5 of its utilization methodology, **WakeMed-Cary** did not assume any ramp-up timeframe or gradual shifting of surgical volume for the proposed project, instead assuming that 100% of cases expected to shift to the proposed ASC would do so in Project Year 1. This is not reasonable. As a result, the initial operating period of two months for the proposed project is understated, impacting the financial viability of the project and potential funding for the project.

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."*

WakeMed-Cary did not adequately demonstrate that its proposal would not result in the unnecessary duplication of surgical services in Wake County. Specifically, **WakeMed-Cary** did not adequately demonstrate in its application that the new ORs it proposes to develop are needed, and that it will not unnecessarily duplicate the ORs that WakeMed Health System already owns in Wake County. See the discussion regarding projected utilization in Criterion 3 and in 10A NCAC 14C.2103 Performance Standards. Therefore, the **WakeMed-Cary** application is non-conforming with Review Criterion 6.

Criterion 13c *"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."

WakeMed-Cary fails to conform with Criterion 13c because the proposed project will not provide adequate access to low income persons, including Medicare patients. The proposed payor mix for the **WakeMed-Cary** application is based upon unreasonable and unsupported assumptions. **WakeMed-Cary** defines the service area based upon historical patient origin for **WakeMed-Cary** outpatient surgical patients on page 22 of the application. Future utilization for **WakeMed-Cary** reflected on page 125 shows that 61.0% of the patients shifted to justify the projected utilization at **WakeMed-Cary** will be from WakeMed with only 32.2% of future patients from WakeMed Cary. Less than 5% of patients will come from Capital City and less than 2% from WakeMed North. The following table shows 2017 outpatient surgical payor mix for all four WakeMed surgical locations.

2017 Outpatient Surgical Payor Mix – WakeMed Facilities

	WakeMed	WakeMed Cary	Capital City	WakeMed No
Self Pay/Charity	7.9%	2.4%	0.9%	1.3%
Medicare	16.3%	37.2%	31.2%	35.7%
Medicaid	31.4%	2.7%	6.3%	2.7%
Commercial	0.7%	0.6%	57.7%	0.9%
Managed Care	41.1%	55.5%	0.0%	57.2%
Other	2.6%	1.5%	3.9%	2.1%
Total	100.0%	100.0%	100.0%	100.0%

Source: 2018 LRAs

As shown in the previous table WakeMed has considerably more self-pay/charity patients and Medicaid patients than WakeMed Cary, Capital City, or WakeMed North. As discussed above, 61% of patients at **WakeMed-Cary** will be shifted from WakeMed. Therefore, using an average of Wake Med Cary Payor mix and Capital City payor mix is not reasonable and does not reflect the patients to be shifted as reflected in the utilization projections. The population of the WakeMed Cary service area is not homogeneous and the market includes different socio-economic groups. Therefore, the insurance coverage of patients seeking care at WakeMed is more than likely not identical to those seeking care at WakeMed North. Therefore, the payor mix assumptions are unreasonable and **WakeMed-Cary** has not shown that the medically underserve population will be served by the proposed project. The project is not conforming to Criterion 13(c).

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

Because the **WakeMed-Cary** application is non-conforming with Criteria 1, 3, 4, 5, 6, and 13c, it should also be found non-conforming with Criterion 18a. **WakeMed-Cary** did not adequately demonstrate the need the population projected to be served has for the proposed project and did not adequately demonstrate that its proposal would not result in the unnecessary duplication of surgical services in Wake County. **WakeMed-Cary** did not adequately demonstrate the financial feasibility of the proposal because its projections were premised on unreasonable and unsupported assumptions.

Additionally, while **WakeMed-Cary** proposes the development of an ASC, the applicant is owned by WakeMed and Compass. WakeMed/Compass currently own/operate 43 of the 100 existing ORs in Wake County, **or over 40% of the existing ORs in the service**

area. If **WakeMed-Cary**'s application (or either of the WakeMed Health Care-affiliated applications) were approved, this dominance would only become more pronounced. Thus, the proposed WakeMed project will not have a positive impact on competition.

Because this is the first time since 2012 there has been a need determination for ORs in Wake County, the Agency should use this rare opportunity to increase competition by approving OrthoNC ASC to become a new market provider rather than a large hospital system or its affiliates.

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

At page 106, Question 3(a) states: "Identify all similar health care facilities located in NC that are owned, operated or managed by each applicant or any related entities."

In response, WakeMed identifies only ***three*** hospitals and ***one*** surgery center (WakeMed Raleigh Campus, WakeMed Cary Hospital, WakeMed North Family Health & Women's Hospital, and Capital City Surgery Center).

In the 2017 Agency Findings for the WakeMed North Project ID #J-11301-17, the Agency states:

> In Section O-3(a), pages 132-133, the applicants state that they currently own and operate ***seven*** hospitals/acute care health services facilities and owns/manages ***eight*** health services properties in North Carolina.

(Emphasis supplied).

The letter at Exhibit O.3 from WakeMed's President & CEO indicates "all WakeMed facilities" have been and continue to be in full compliance ... with Medicare Conditions of

Participation" but it is unclear whether the letter is intended to address the facilities identified on page 106 or the larger list of facilities described in the above-quoted 2017 Agency Findings.

On average, acute care hospitals are reassessed only every three to four years for their compliance with all the Conditions of Participation. By law, reports generated by accrediting organizations are not considered public records. CMS only releases deficiencies cited on complaint surveys.

10A NCAC 14C.2103 Performance Standards.

(a) A proposal to establish a new ambulatory surgical facility, to establish a new campus of an existing facility, to establish a new hospital, to increase the number of operating rooms in an existing facility (excluding dedicated C-section operating rooms), to convert a specialty ambulatory surgical program to a multispecialty ambulatory surgical program, or to add a specialty to a specialty ambulatory surgical program shall demonstrate the need for the number of proposed operating rooms in the facility that is proposed to be developed or expanded in the third operating year of the project based on the Operating Room Need Methodology set forth in the 2018 State Medical Facilities Plan. The applicant is not required to use the population growth factor.

As discussed in the above comments **WakeMed-Cary** failed to document the need for the proposed project. The discussions regarding analysis of need, including projected utilization, found in Criterion (3) above are incorporated herein by reference.
As discussed in the above comments, **WakeMed-Cary** failed to document the need for the proposed project. See discussions regarding need, including projected utilization, found in Criterion 3 above.

WakeMed-Cary is non-conforming to Criterion 3 and is non-conforming to this Rule.

(b) *A proposal to increase the number of operating rooms (excluding dedicated C-section operating rooms) in a service area shall demonstrate the need for the number of proposed operating rooms in addition to the existing and approved operating rooms in the applicant's health system in the third operating year of the proposed project based on the Operating Room Need Methodology set forth in the 2018 State Medical Facilities Plan. The applicant is not required to use the population growth factor.*

WakeMed-Cary is part of the WakeMed healthcare system in Wake County as defined in the 2018 SMFP. Therefore, in addition to justifying the proposed new ORs, **WakeMed-Cary** must justify ***all*** existing and proposed ORs owned/operated by WakeMed Healthcare. As discussed, **WakeMed-Cary** has failed to justify all existing and proposed ORs as required and as a result, is non-conforming to this Rule.

WakeMed Historical Surgical Utilization

	2014	2015	2016	2017	CAGR 2014-2017	CAGR 2015-2017	AGR 2016-2017
Inpatient							
WakeMed	7,135	7,798	8,419	8,121	4.41%	2.1%	-3.5%
WakeMed North	0	21	81	63	0.00%	73.2%	-22.2%
WakeMed Cary	2,172	2,769	3,037	3,162	13.34%	6.9%	4.1%
Capital City	0	0	0	0	0.00%	0.0%	0.0%
Total Inpatient	9,307	10,588	11,537	11,346	6.83%	3.5%	-1.7%
Outpatient							
WakeMed	8,494	7,326	7,705	7,547	-3.86%	1.5%	-2.1%
WakeMed North	1,990	1,802	2,213	2,346	5.64%	14.1%	6.0%
WakeMed Cary	4,076	4,815	4,820	5,242	8.75%	4.3%	8.8%
Capital City	6,647	6,647	6,123	5,388	-6.76%	-10.0%	-12.0%
Total Outpatient	21,207	20,590	20,861	20,523	-1.09%	-0.2%	-1.6%
Total All Surgery	30,514	31,178	32,398	31,869	1.46%	1.1%	-1.6%

Source: Attached Table 24

Historical growth within the WakeMed Healthcare System has experienced a decreasing CAGR since 2014 as shown in the previous table. Inpatient surgical growth reflected above shows a decreasing trend with negative change in the most current year for which data is available. **WakeMed-Cary** did not provide any 2018 data which could support a positive change in the above trend data. Inpatient and

outpatient surgical trend data reflected above shows a decreasing CAGR trend with negative change in the most current year for which data is available. **WakeMed-Cary** did not provide any 2018 data which could support a positive change in the above trend data.

WakeMed-Cary used an overall CAGR of 2.23% for inpatient surgical volumes from 2017 to 2023, which is the third project year for **WakeMed-Cary**. While this may appear reasonable given the overall Wake County experience it does not take into consideration the WakeMed experience which has been less than 1.5% since 2014. Further, it is greater than the Wake County population CAGR of 2.1% from 2017 to 2023. Also, inpatient surgical cases within the WakeMed Wake County surgical locations decreased in the most current year. Further **WakeMed-Cary** did not provide any data to suggest any changes were expected in the negative growth trend line for inpatient surgery at WakeMed.

WakeMed-Cary used an overall CAGR of 2.07% for outpatient surgical volumes from 2017 to 2023, which is the third project year for **WakeMed-Cary**. While this may appear reasonable given the overall Wake County experience it does not take into consideration the WakeMed experience. Inpatient surgical cases within the WakeMed Wake County surgical locations decreased in the most current year. Further **WakeMed-Cary** did not provide any data to suggest any changes were expected in the negative growth trend line for outpatient surgery at WakeMed.

As shown in the attached Table 6, WakeMed used a CAGR from 2017 to 2023 of 2.24% to project future surgical volume for the combined WakeMed System. This is 8% greater than the actual population growth for the County and 153.4% greater than the actual 2017-2017 CAGR total surgical volume for WakeMed reflected in the previous table.

The Rule requires the applicant to use the Operating Room Need Methodology included in the 2018 SMFP to calculate future OR need. The following table shows that when the total projected growth rate for WakeMed is used in the SMFP methodology WakeMed fails to show a need for additional operating rooms.

Projected OR Need - WakeMed

	2017 Total Surgical Hours - 2018 LRAs	WakeMed Total Surgical Hours Projected CAGR 2017-2023	Growth Factor	Projected Surgical Hours for 2023	Planning Threshold 2018 SMFP	OR Need	Inventory	Surplus (-) Deficit (+)
Capital Surgery Center	5,412	2.238%	13.4%	6,139	1,312.5	4.7	8	-3.3
WakeMed	44,012	2.238%	13.4%	49,921	1,950	25.6	23	2.6
WakeMed Cary	8,296	2.238%	13.4%	9,410	1,500	6.3	9	-2.7
WakeMed-Cary page 126 of application*						2.45	2	0.45
WSCNR page 128 of application*						2.75	2	0.75
Total Projected Surplus						**41.8**	**44**	**-2.25**

* The above table assumes the projections for the two new applications were reasonable, which, as discussed previously is incorrect.
Source: WakeMed CAGR calculated in attached Table 29

The discussions regarding analysis of need, including projected utilization, found in Criterion (3) and in 10 NCAC 14C .2103(a) above are incorporated herein by reference. Thus, the **WakeMed-Cary** application is non-conforming to this Rule.

(e) The applicant shall document the assumptions and provide data supporting the methodology used for each projection in this Rule.

WakeMed-Cary fails to document assumptions utilized in this application. Therefore, the methodologies utilized in the application to project operating room projections for **WakeMed-Cary** and all WakeMed surgical facilities are unreasonable and unsupported. **WakeMed-Cary**'s projected utilization is highly speculative—and therefore not reasonable and adequately supported—as it depends entirely upon the success of future recruitment efforts. The discussions regarding analysis of need, including projected

utilization, found in Criterion (3) and in 10 NCAC 14C .2103(a) and (b) above are incorporated herein by reference. Thus, the **WakeMed-Cary** application is non-conforming to this Rule.

Table 1
Inventory of Existing and Approved Wake County ORs

Owner	HOSP	ASC	Total	Notes
UNC				
REX	22		22	
REX Cary		4	4	
Rex Holly Springs	3		3	Not operational
Raleigh Ortho		3	3	
Raleigh Ortho West		1	1	Not operational
Rex Wakefield		2	2	
C-Section Rooms (1 HSH; 3 REX)	4		4	
UNC Total (Excluding C-Section)	25	10	35	
Wake Med				
Wake Med	23		23	Minus 1 to Cary
Wake Med	20			
Wake Med North	4			
Wake Med Cary	9		9	Plus 1 from Wake Med
Capital City Surgery Ctr		8	8	
Wake Med Total	32	8	40	
Duke				
Duke Raleigh	15		15	
Total Duke	15	0	15	
Others				
Blue Ridge Surgery Ctr		6	6	
Holly Springs Surgery Ctr (Compass Management)		3	3	
Raleigh Plastic		1	1	
Total Other Projects	0	10	10	
Demo Projects				
SCDP		1	1	
Triangle Ortho		2	2	
Total Excluding Demo Project	72	28	100	
Percent Hospital/ASC	72.0%	28.0%		
Subtotal HealthCare System (HSC) Owned	72	18	90	
Subtotal Non HCS	**0**	**10**	**10**	
Percent Non HSC			**10.0%**	
Proposed HSC ORs			14	
Proposed Non HSC ORs			2	

Source: SMFP

Table 2

Applicant	Abbreviation	Project ID#	Project	#ORs	ASC	HOSP	Proposed in a System	No System
1. RAC Surgery Center	RAC	J-011551-18	Proposes to develop a new ambulatory surgery center with one operating room and two procedure rooms in Raleigh.	1	ASC			NO
2. REX Surgery Center of Garner	UNC REX Garner	J-011553-18	Proposes to develop a new ambulatory surgery center with two operating rooms and two procedure rooms in Garner.	2	ASC		YES	
3. UNC Health Care Panther Creek Ambulatory Surgery Center	UNC Panther Creek	J-011554-18	Proposes to develop a new ambulatory surgery center with two operating rooms and two procedure rooms in Panther Creek/West Cary.	2	ASC		YES	
4. REX Hospital	UNC REX	J-011555-18	Proposes to add two shared operating rooms to its existing hospital in Raleigh for a total of 24 operating rooms.	2		HOSP	YES	
5. Green Level Ambulatory Surgical Center	Duke Green Level	J-011557-18	Proposes to develop a new ambulatory surgery center with four operating rooms in Cary.	4	ASC		YES	
6. Duke Raleigh Hospital	Duke Raleigh	J-011558-18	Proposes to add two shared operating rooms to its existing hospital in Raleigh for a total of 17 operating rooms.	2		HOSP	YES	
7. WakeMed Surgery Center-North Raleigh	WSCNR	J-011564-18	Proposes to develop a new ambulatory surgery center with two operating rooms and two procedure rooms in North Raleigh.	2	ASC		YES	
8. WakeMed Surgery Center-Cary	WakeMed-Cary	J-011565-18	Proposes to develop a new ambulatory surgery center with two operating rooms in Cary.	2	ASC		YES	
9. OrthoNC ASC	OrthoNC	J-011561-18	Proposes to develop a new ambulatory surgery center with one operating room and one procedure room in North Raleigh/Wakefield	1	ASC			NO
Total Number of ORs				18	14	4	16	2
Percent of Total					77.8%	22.2%	88.9%	11.1%

Source: Wake County OR CON Review applications

Table 3

Surgical Providers Including Demo ORs	Outpatient Orthopedic Cases	Total Outpatient Cases	Percent Outpatient Cases	Outpt Surgical Hours	Total Surgical Hours	Outpatient Percent of Total Surgical Hours**	# of Operating Rooms	Estimated # Outpatient Operating Rooms
Rex Holly Springs Hospital	0	0	0.0%	0	0	58.7%	3	1.8
Raleigh Orthopedic West Cary	0	0	100.0%	0	0	100.0%	1	1.0
REX Wakefield*	759	1,955	38.8%	3,324	3,324	100.0%	2	2.0
Raleigh Orthopedic Surgery Center	4,384	4,384	100.0%	6,063	6,063	100.0%	3	3.0
Rex Surgery Center Cary	236	4,854	4.9%	4,611	4,611	100.0%	4	4.0
UNC REX	953	10,681	8.9%	24,744	50,113	49.4%	22	10.9
Capital City	3,954	5,388	73.4%	5,412	5,412	100.0%	8	8.0
Wake Med	1,449	9,893	14.6%	19,555	44,012	44.4%	23	10.2
WakeMed-Cary	322	4,663	6.9%	3,575	8,296	43.1%	9	3.9
Holly Springs Surg Center	361	478	75.5%	558	558	100.0%	3	3
Blue Ridge Surgery Center	1,145	7,043	16.3%	3,757	3,757	100.0%	6	6.0
Raleigh Plastic Surg Ctr	0	380	0.0%	581	581	100.0%	1	1.0
Duke Raleigh	3,241	11,084	29.2%	20,690	34,814	59.4%	15	8.9
Triangle Ortho	2,437	2,437	100.0%	0	0	100.0%	2	2.0
SCDP	0	0	0.0%	0	0	100.0%	1	1.0
Volume Performed in Hospital Based OR	5,965	36,321	16.4%					
Volume Perfomed in Multispecialty ASC	6,455	19,718	32.7%					
Volume Perfomed in Ortho Specialty ASC	6,821	6,821	100.0%					
Total Including Demo Projects	19,241	63,240	30.4%	92,870	158,217	58.7%	103	66.6

*CON Approved convert from HOPD to Freestanding; this data is from REX 2018 LRA while HOPD

** REX HSH percent Outpt Hrs = Avg for all

Source: Proposed 2019 SMFP; 2018 LRAs

Table 4.

	# Outpatient Operating Rooms By Designation Including OR Demo	% Outpatient Operating Rooms By Designation
Total Wake County Operating Rooms including OR Demo ORs	103.0	
Number of Wake County ORs used for Outpt Surgical Cases	66.6	64.7%
Number of Wake County Freestanding ASC ORs	32.0	31.1%
Number of Wake County Outpt ORs Used for Ortho Cases	20.3	30.4%
Number of Ortho Specialty Freestanding ASC ORs	6.0	18.8%
Number of Freestanding Multispecialty ASC ORs	23.0	71.9%
Number of Freestanding Other Specialty ASC ORs	3.0	9.4%
Number of Total Freestanding ASC ORs	32.0	31.1%

Table 5

Surgical Provider	Total Outpatient Cases	Total Surgical Hours	# of Operating Rooms	Total Surgical Hours @Capacity #ORs x 1,950	Wake County Location	Percent Utilization 2017
Triangle Ortho	2,437	3,737	2	3900	West	95.8%
REX Wakefield*	1,955	3,324	2	3900	North	85.2%
Raleigh Orthopedic Surgery Center/Raleigh Orthopedic West Cary**	4,384	6,063	4	7800	West	77.7%
Raleigh Orthopedic Surgery Center/Raleigh Orthopedic West Cary**	4,384	6,063	4	7800	West	77.7%
Rex Surgery Center Cary	4,854	4,611	4	7800	South	59.1%
Capital City	5,388	5,412	8	15600	Central	34.7%
Blue Ridge Surgery Center	7,043	3,757	6	11700	Central	32.1%
Raleigh Plastic Surg Ctr	380	581	1	1950	Central	29.8%
Holly Springs Surg Center	478	558	3	5850	South	9.5%
SCDP	0	0	1	1950	Central	0.0%

*CON Approved convert from HOPD to Freestanding; this data is from REX 2018 LRA while HOPD

**Combined as ROSCWC not yet operational

Source: Proposed 2019 SMFP; 2018 LRAs

Table 6

Surgical Provider	Total inpatient Surgical Hours 2017	Total Outpt Surgical Hours 2017	Total Surgical Hours 2017	Total Outpt Surgical Hours 2018	Total Surgical Hours 2018	Total Outpt Surgical Hours 2020	Total Surgical Hours 2020	Total inpatient Surgical Hours 2021	Total Outpt Surgical Hours 2021	Total Surgical Hours 2021	Total inpatient Surgical Hours 2022	Total Outpt Surgical Hours 2022	Total Surgical Hours 2022	Total inpatient Surgical Hours 2023	Total Outpt Surgical Hours 2023	Total Surgical Hours 2023	Total inpatient Surgical Hours 2024	Total Outpt Surgical Hours 2024	Total Surgical Hours 2024	Inpt CAGR PY1-PY3	Outpt CAGR PY1-PY3	Total CAGR PY1-PY3	Inpt CAGR 2017-PY3	Outpt CAGR 2017-PY3	Total CAGR 2017-PY3
UNC REX																				**UNC REX 2 Yr CAGR SFY2021-2023 Rex Garner and UNC Panther Creek 2 Yr CAGR SFY2022-2024**			**7 Yr CAGR SFY 2017-2024**		
Rex Hospital	22,248	20,243	42,491					27181	20579	47760	27,302	19,328	46,630	27,883	18,585	46,468	28,478	17,812	46,290	1.28%	-4.97%	-1.36%	3.59%	-1.81%	1.23%
Rex Surgery Center Cary		4,738	4,738									4,569	4,569					4,569	4,569					-0.52%	-0.52%
REX Wakefield*		2,864	2,864									2,925	2,925					3,358	3,358					2.30%	2.30%
Raleigh Orthopedic Surgery Center		6,646	6,646									5,058	5,058					5,316	5,316					-3.14%	-3.14%
Raleigh Orthopedic West Cary		0	0									1,274	1,274					1,339	1,339						
Rex Holly Springs			0								767	855	1,622				1,635	1,901	3,536						
Rex Panther Creek			0									1,072	1,072					2,144	2,144		41.42%	41.42%			
Rex Garner			0									1,138	1,138					2,275	2,275		41.39%	41.39%			
Total UNC REX	**22,248**	**34,491**	**56,739**								**28,069**	**36,219**	**64,288**				**30,113**	**38,714**	**68,827**	**3.58%**	**3.39%**	**3.47%**	**4.42%**	**1.66%**	**2.80%**
WakeMed																				**2 Yr CAGR FFY2021-2023**			**6 Yr CAGR FFY2017-2023**		
Wake Med	27,119	23,846	50,965					29,743	20,087	49,830				31,157	18,848	50,005				2.35%	-3.13%	0.18%	2.34%	-3.84%	-0.32%
WakeMed-Cary	6,076	6,404	12,480					7,043	5,851	12,894				7,583	6,139	13,722				3.76%	2.43%	3.16%	3.76%	-0.70%	1.59%
Capital City		3,160	3,160						6,685	6,685					7,220	7,220					3.92%	3.92%		14.76%	14.76%
WSCC									2,439	2,439					2,754	3,215					6.27%	14.82%			
WSCNR									2,800	2,800					3,604	3,604					13.45%	13.45%			
Total WakeMed	**33,195**	**33,410**	**66,605**					**36,786**	**37,862**	**74,648**				**38,740**	**38,565**	**77,766**				**2.62%**	**0.92%**	**2.07%**	**2.23%**	**2.07%**	**2.24%**
								2.60%	**3.18%**	**2.89%**				**2.62%**	**0.92%**	**2.07%**									
Duke Health Care																				**DRAH - 2 Yr CAGR SFY2021-2023 Green Level - 2 Yr CAGR SFY2022-2024**			**7 Yr CAGR SFY 2017-2024**		
Duke Raleigh	14,124	20,690	34,814					14,633	26,756	41,389	14999	24002	39,001	15,374	23,320	38,694	15758	22925	38,683	2.50%	-6.64%	-3.31%	1.58%	1.48%	1.52%
Green Level			0						0	0		2,605	2,605					5453	5,453		44.68%	44.68%			
Total Duke	**14,124**	**20,690**	**34,814**					**14,633**	**26,756**	**41,389**	**14,999**	**26,607**	**41,606**				**15,758**	**28,378**	**44,136**	**2.50%**	**3.27%**	**3.00%**	**1.58%**	**4.62%**	**3.45%**
											2.50%	**-0.56%**	**0.52%**				**2.50%**	**3.27%**	**3.00%**						
RAC																				**2 Yr CAGR CY2020-2022**			**7 Yr CAGR CY 2017-2022**		
RAC						1,520	1,520					1,860	1,860												
Total Duke						**1,520**	**1,520**					**1,860**	**1,860**								**10.64%**	**10.64%**		**#DIV/0!**	**#DIV/0!**
												10.64%	**10.64%**												
OrthoNC																				**2 Yr CAGR FFY2021-2023**			**5 Yr CAGR FFY 2017-2023**		
OrthoNC				1,263	1,263				1,325	1,325					1,406	1,406									
Total OrthoNC				**1,263**	**1,263**				**1,325**	**1,325**					**1,406**	**1,406**					**3.01%**	**3.01%**		**2.17%**	**2.17%**
									1.61%	**1.61%**					**3.01%**	**3.01%**									

Source: Wake OR Applications Section Q Form C

Table 7

Section Q Form C page 3 of Assumptions

REX Only	In	Yr to Yr Chg	Annual Growth Rate	Outpt REX	Outpt REX Wakefield	Out	SubTotal REX Only In/Out w/Wakefield	UNC Outpatient /Including Rex	UNC Wake Total Inpt/Out
	A	B		C	D	E = C + D	F = A + E	G = page 3	H = A + G
2012	6,862			15,464	1,595	17,059	23,921	21,409	28,271
2013	7,269	407	5.9%	14,351	1,642	15,993	23,262	21,512	28,781
2014	7,371	102	1.4%	12,272	1,430	13,702	21,073	21,585	28,956
2015	7,984	613	8.3%	11,577	1,639	13,216	21,200	21,100	29,084
2016	8,557	573	7.2%	11,602	1,424	13,026	21,583	20,578	29,135
2017	8,453	-104	-1.2%	10,681	1,955	12,636	21,089	21,874	30,327
5 Yr CAGR 2012-2017	4.3%			-7.1%	4.2%	-5.80%	-2.50%	0.4%	1.4%
2018 (Rex p4/Wakefield p16)	8,418	-35	-0.4%	10,898	1,290	12,188	20,606		
2018 (Wakefield annualized p16)					1,548	12,446			
5 Yr CAGR 2013-2018	2.98%			-5.4%	-1.2%	-4.9%	-2.4%		

Table 8

Rolling CAGR REX Hospital License

Year	2012	2013	2014	2015	2016	2017	2018	CAGR 13-18	CAGR 14-18	CAGR 15-18	CAGR 16-18	AGR 17-18
Inpt	6,862	7,269	7,371	7,984	8,557	8,453	8,418	2.98%	3.38%	1.78%	-0.8%	-0.4%
Outpt w/o Wakefield	15,464	14,351	12,272	11,577	11,602	10,681	10,898	-5.4%	-2.9%	-2.0%	-3.1%	2.03%
Total w/o Wakefield	22,326	21,620	19,643	19,561	20,159	19,134	19,316	-2.2%	-0.4%	-0.4%	-2.1%	0.95%
Outpt w/ Wakefield	17,059	15,993	13,702	13,216	13,026	12,636	12,188	-5.3%	-2.9%	-2.7%	-3.3%	-3.5%
Total w/ Wakefield	23,921	23,262	21,073	21,200	21,583	21,089	20,606	-2.4%	-0.6%	-0.9%	-2.3%	-2.3%

Table 9

Rolling CAGR REX Surgery Center Cary

Year	2012	2013	2014	2015	2016	2017	CAGR 12-17	CAGR 13-17	CAGR 14-17	CAGR 15-17	CAGR 16-17
Outpt	4,350	5,108	4,735	4,145	3,786	4,854	2.2%	-1.3%	0.8%	8.2%	28.2%

Table 10

Rolling CAGR Raliegh Ortho

Year	2012	2013	2014	2015	2016	2017	CAGR 12-17	CAGR 13-17	CAGR 14-17	CAGR 15-17	CAGR 16-17
Outpt	0	411	3,148	3,739	3,766	4,384	0.0%	80.7%	11.7%	8.3%	16.4%

Table 11

Rolling CAGR UNC Rex Facilities in Wake County

Year	2012	2013	2014	2015	2016	2017	CAGR 12-17	CAGR 13-17	CAGR 14-17	CAGR 15-17	CAGR 16-17
Inpt	6,862	7,269	7,371	7,984	8,557	8,453	4.3%	3.8%	4.7%	2.9%	-1.2%
Outpt	21,409	21,512	21,585	21,100	20,578	21,874	0.4%	0.4%	0.4%	1.8%	6.3%

Table 12

Rolling CAGR UNC Rex Facilities in Wake County w/o ROC

Year	2012	2013	2014	2015	2016	2017	CAGR 12-17	CAGR 13-17	CAGR 14-17	CAGR 15-17	CAGR 16-17
Inpt	6,862	7,269	7,371	7,984	8,557	8,453	4.3%	3.8%	4.7%	2.9%	-1.2%
Outpt	21,409	21,101	18,437	17,361	16,812	17,490	-4.0%	-4.6%	-1.7%	0.4%	4.0%

Source: Tables 8-12 LRAs and CON Applications

Table 13.

2018		
	Population	Median Age
Onslow	197,455	25.80
Watauga	57,348	29.56
Pitt	176,920	32.77
Cumberland	329,653	33.13
Hoke	54,679	33.28
Durham	310,847	34.34
Harnett	133,065	34.78
Orange	143,873	35.76
Mecklenburg	1,099,382	35.93
Craven	103,800	36.20
Robeson	131,384	36.35
Pasquotank	40,805	36.92
Jackson	43,662	36.97
Wake	1,071,240	37.13
Wayne	125,509	37.26
Guilford	527,696	37.40
Forsyth	376,314	37.86
Lee	59,486	38.13
Cabarrus	209,736	38.39
New Hanover	230,919	38.46
Johnston	200,102	38.57
Union	232,425	38.58
Duplin	59,446	38.73
State	10,388,837	38.79
Vance	44,785	39.16
Alamance	163,041	39.54
Wilson	82,408	39.72
Sampson	62,821	39.97
Scotland	35,598	39.98
Rowan	142,862	40.04
Gaston	221,112	40.25
Richmond	44,812	40.40
Swain	15,142	40.53
Anson	25,628	40.54
Greene	21,520	40.56
Iredell	179,740	40.97

Table 13. (continued)

2018		
	Population	Median Age
Randolph	145,633	41.11
Columbus	56,904	41.12
Hertford	23,855	41.19
Catawba	157,424	41.23
Bladen	34,120	41.49
Franklin	67,586	41.49
Pender	62,551	41.75
Cleveland	98,862	41.77
Lenoir	57,366	41.79
Bertie	19,832	41.82
Montgomery	27,957	41.85
Stanly	63,069	42.06
Davidson	168,107	42.06
Buncombe	264,666	42.20
Nash	94,420	42.57
Camden	10,416	42.61
Granville	60,566	42.73
Edgecombe	52,149	42.88
Surry	72,844	42.89
Jones	10,356	43.04
Currituck	27,109	43.07
Person	39,997	43.16
Burke	90,865	43.25
Tyrrell	4,137	43.25
Yadkin	37,700	43.33
Lincoln	84,494	43.60
Gates	12,008	43.63
Caldwell	83,919	43.71
Rutherford	67,880	43.73
Halifax	51,468	43.73
Alexander	38,609	43.77
McDowell	45,915	44.03
Chowan	14,177	44.06
Rockingham	91,731	44.08
Hyde	5,630	44.10
Davie	43,244	44.36

Table 13. (continued)

2018		
	Population	Median Age
Wilkes	70,883	44.63
Caswell	23,692	44.91
Graham	8,862	44.97
Northampton	20,470	45.09
Warren	20,068	45.10
Avery	18,087	45.25
Mitchell	15,216	45.53
Stokes	46,708	45.53
Martin	23,412	45.57
Dare	37,172	45.63
Madison	22,504	45.87
Washington	12,272	45.95
Beaufort	47,444	46.19
Yancey	18,254	46.45
Moore	99,112	46.49
Alleghany	11,264	47.00
Ashe	27,262	47.48
Henderson	117,902	47.63
Haywood	62,780	47.73
Carteret	70,620	48.02
Perquimans	13,564	48.11
Chatham	76,383	48.20
Macon	35,779	48.84
Pamlico	13,288	50.24
Clay	11,654	50.78
Cherokee	29,853	50.89
Brunswick	135,464	50.89
Transylvania	34,814	51.10
Polk	21,273	51.68

Table 14.

Wake Providers - Historical Patient Origin from Wake County

UNC Patient Origin - Wake County											
	2012	**2013**	**2014**	**2015**	**2016**	**2017**	**CAGR 12-17**	**CAGR 13-17**	**CAGR 14-17**	**CAGR 15-17**	**CAGR 16-17**
Inpt (includes CSection)	1,712	1,394	4,166	1,891	1,876	2,116	4.3%	11.0%	-20.2%	5.8%	12.8%
Outpt	2,449	2,412	2,416	2,644	2,381	2,491	0.3%	0.8%	1.0%	-2.9%	4.6%
REX (w/Wakefield) Patient Origin - Wake County											
	2012	**2013**	**2014**	**2015**	**2016**	**2017**	**CAGR 12-17**	**CAGR 13-17**	**CAGR 14-17**	**CAGR 15-17**	**CAGR 16-17**
Inpt (includes CSection)	6,079	6,175	6,328	6,560	6,850	6,496	1.3%	1.3%	0.9%	-0.5%	-5.2%
		96	153	232	290	-354					
Total Inpts (includes C-Section	8,719	9,013	9,379	9,896	10,487	10,215	3.2%	3.2%	2.9%	1.6%	-2.6%
% of Total Inpt	69.7%	68.5%	67.5%	66.3%	65.3%	63.6%					
Outpt	12,225	11,280	9,611	9,292	9,199	8,656	-6.7%	-6.4%	-3.4%	-3.5%	-5.9%
Total Outpt	17,059	15,993	13,702	13,216	13,026	12,636	-5.8%	-5.7%	-2.7%	-2.2%	-3.0%
% of Total Outpt	71.7%	70.5%	70.1%	70.3%	70.6%	68.5%					
Rex Cary Patient Origin - Wake County											
	2012	**2013**	**2014**	**2015**	**2016**	**2017**	**CAGR 12-17**	**CAGR 13-17**	**CAGR 14-17**	**CAGR 15-17**	**CAGR 16-17**
Outpt	3,421	3,898	3,527	3,239	2,796	3,419	0.0%	-3.2%	-1.0%	2.7%	22.3%
Total Outpt	4,387	5,108	4,735	4,471	3,786	4,854	2.0%	-1.3%	0.8%	4.2%	28.2%
% of Total Outpt	78.0%	76.3%	74.5%	72.4%	73.9%	70.4%					
Raleigh Ortho Patient Origin - Wake County											
	2012	**2013**	**2014**	**2015**	**2016**	**2017**	**CAGR 12-17**	**CAGR 13-17**	**CAGR 14-17**	**CAGR 15-17**	**CAGR 16-17**
Outpt	0	0	2,276	2,724	2,696	3,211	0.0%	0.0%	12.2%	8.6%	19.1%
Total Outpt	0	0	3,148	3,739	3,766	4,384	0.0%	0.0%	11.7%	8.3%	16.4%
% of Total Outpt	0.0%	0.0%	72.3%	72.9%	71.6%	73.2%					
UNC Wake County Facilities Patient Origin - Wake County											
	2012	**2013**	**2014**	**2015**	**2016**	**2017**	**CAGR 12-17**	**CAGR 13-17**	**CAGR 14-17**	**CAGR 15-17**	**CAGR 16-17**
Inpt (includes CSection)	6,079	6,175	6,328	6,560	6,850	6,496	1.3%	1.3%	0.9%	-0.5%	-5.2%
Total Inpts (includes C-Section	8,719	9,013	9,379	9,896	10,487	10,215	3.2%	3.2%	2.9%	1.6%	-2.6%
% of Total Inpt	69.7%	68.5%	67.5%	66.3%	65.3%	63.6%					
Outpt	15,646	15,178	15,414	15,255	14,691	15,286	-0.5%	0.2%	-0.3%	0.1%	4.1%
Total Outpt	21,446	21,101	21,585	21,426	20,578	21,874	0.4%	0.9%	0.4%	1.0%	6.3%
% of Total Outpt	73.0%	71.9%	71.4%	71.2%	71.4%	69.9%					

Source: Licensure Renewal Applications 2013-2018

Table 15.

Wake County Ambulatory Surgery Patient Origin

	REX PO		WakeMed Cary		WakeMed		Capital		Duke Raleigh		REX Cary		Blue Ridge		ROSC		Total All		County
	# Pts	Percent	# Pts	Percent	# Pts	Percent	# Pts	Percent	# Pts	Percent	# Pts	Percent	# Pts	Percent	# Pts	Percent	# Pts	Percent	Median Age
Durham	144	1.1%	74	1.6%	183	1.8%	68	1.3%	449	4.5%	119	2.5%	345	4.0%	71	1.6%	1453	2.4%	34.34
Franklin	747	5.9%	19	0.4%	618	6.2%	150	2.8%	448	4.5%	37	0.8%	261	3.0%	78	1.8%	2358	3.9%	41.49
Harnett	380	3.0%	242	5.2%	311	3.1%	110	2.0%	201	2.0%	258	5.3%	214	2.5%	179	4.1%	1895	3.1%	34.78
Johnston	820	6.5%	188	4.0%	845	8.5%	288	5.3%	517	5.2%	308	6.3%	573	6.6%	296	6.8%	3835	6.3%	38.57
Nash	253	2.0%	15	0.3%	219	2.2%	40	0.7%	200	2.0%	30	0.6%	19	0.2%	43	1.0%	819	1.4%	42.57
Sampson	119	0.9%	45	1.0%	73	0.7%	22	0.4%	66	0.7%	43	0.9%	102	1.2%	52	1.2%	522	0.9%	39.97
Wake	8656	68.5%	3742	80.2%	6728	68.0%	4221	78.3%	6470	65.4%	3419	70.4%	6093	70.2%	3211	73.2%	42540	70.4%	37.13
Wayne	170	1.3%	1	0.0%	73	0.7%	43	0.8%	150	1.5%	39	0.8%	25	0.3%	31	0.7%	532	0.9%	37.26
Wilson	161	1.3%	9	0.2%	125	1.3%	41	0.8%	94	1.0%	0	0.0%	60	0.7%	45	1.0%	535	0.9%	39.72
Other	1186	9.4%	328	7.0%	718	7.3%	405	7.5%	1298	13.1%	601	12.4%	993	11.4%	378	8.6%	5907	9.8%	38.79
Total	12636	100.0%	4663	100.0%	9893	100.0%	5388	100.0%	9893	100.0%	4854	100.0%	8685	100.0%	4384	100.0%	60396	100.0%	
Percent from Counties with Greater Median Age																		24.0%	

Excludes single specialty and demo projects.

Source: 2018 LRA

Table 16

Outpatient ORs Located in REX Garner Service Area - Map page 50

Outpatient Surgical Providers 2018 SMFP	Total ORs (excluding C-Section)	Outpatient Hrs	Total Hrs	Percent Outpt HRs	Number Outpatient OR	Percent of Total
WakeMed Raleigh	23	20,332	47,498	42.8%	9.8	49.6%
Capital City Surgery Center	8	6,933	6,933	100.0%	8.0	40.3%
UNC REX Garner (Proposed)	2				2.0	10.1%
Total					19.8	

Source: SMFP

Table 17.

Payor Mix Comparison

	REX UNC	ROSC	REX Cary
Self Pay	2.4%	0.8%	7.0%
Medicare	27.5%	21.8%	15.6%
Medicaid	4.5%	0.6%	4.1%
Commercial/Mged Care	62.1%	67.9%	73.2%
Managed Care	61.5%	0.0%	0.0%
Other	3.5%	8.9%	0.0%
Total	161.5%	100.0%	100.0%

Table 18.

Rex Projections Revised

	2018	CAGR 2013-2018	2019	2020	2021	2022	2023	2024
Inpt	8,418	2.98%	8,669	8,927	9,193	9,467	9,749	10,039
Shift to HSH						-359	-556	-766
UNC Shift						1,050	1,050	1,050
Adjusted Inpt	8,418		8,669	8,927	9,193	10,158	10,243	10,323
Inpt Time Per Case	154.0		154.0	154.0	154.0	154.0	154.0	154.0
Outpt	10,898		10,898	10,898	10,898	10,898	10,898	10,898
						-630	-1,007	-1,400
						-33	-49	-65
Adjusted Outpat	10,898		10,898	10,898	10,898	10,235	9,842	9,433
Outpt Time Per Case	113.3		113.3	113.3	113.3	113.3	113.3	113.3
Inpatient Surgical Hours	21,606		22,250	22,912	23,595	26,071	26,289	26,496
Outpatient Surgical Hours	20,579		20,579	20,579	20,579	19,327	18,585	17,813
Total Surgical Hours	42,185		42,829	43,492	44,174	45,398	44,874	44,308
Std Hrs Per OR			1,950	1,950	1,950	1,950	1,950	1,950
Projected OR Need			22.0	22.3	22.7	23.3	23.0	22.7
Licensed/CON Approved Inventory			22.0	22.0	22.0	22.0	22.0	22.0
Deficit(-)/Surplus(+)			0.0	-0.3	-0.7	-1.3	-1.0	-0.7

Source: UNC REX Section Q Form C; Table 17

Table 19.

Rex Projections Revised - SMFP Methodology

	2017	CAGR 2013-2018	2018	2019	2020	2021	2022	2023	2024
Inpt	8,453	2.98%	8,705	8,964	9,231	9,506	9,789	10,081	10,430
Shift to HSH						-359	-556	-766	-766
UNC Shift						1,050	1,050	1,050	1,050
Adjusted Inpt	8,453		8,705	8,964	9,231	10,197	10,283	10,365	10,714
Inpt Time Per Case			154.0	154.0	154.0	154.0	154.0	154.0	154.0
Outpt	10,681	0%	10,681	10,681	10,681	10,681	10,681	10,681	10,681
						-630	-1,007	-1,400	-1,400
						-33	-49	-65	-65
Adjusted Outpat			10,681	10,681	10,681	10,018	9,625	9,216	9,216
Outpt Time Per Case			113.3	113.3	113.3	113.3	113.3	113.3	113.3
Inpatient Surgical Hours			22,342	23,008	23,693	26,172	26,393	26,603	27,499
Outpatient Surgical Hours			20,169	20,169	20,169	18,917	18,175	17,403	17,403
Total Surgical Hours			42,512	43,177	43,862	45,090	44,569	44,006	44,902
Std Hrs Per OR			1,950	1,950	1,950	1,950	1,950	1,950	1,950
Projected OR Need			21.8	22.1	22.5	23.1	22.9	22.6	23.03
Licensed/CON Approved Inventory			22.0	22.0	22.0	22.0	22.0	22.0	22.0
Deficit(-)/Surplus(+)			0.2	-0.1	-0.5	-1.1	-0.9	-0.6	-1.03

Table 20.

Rex Wakefield Projections Revised - 86 minutes

SFY	2018	CAGR 2012-2017	2019	2020	2021	2022	2023	2024
Outpt	1,548	4.2%	1,612	1,679	1,749	1,822	1,897	1,976
Adjusted Outpat			1,612	1,679	1,749	1,822	1,897	1,976
Outpt Time Per Case			86.0	86.0	86.0	86.0	86.0	86.0
Outpatient Surgical Hours			2,311	2,407	2,507	2,611	2,720	2,833
Total Surgical Hours			2,311	2,407	2,507	2,611	2,720	2,833
Std Hrs Per OR			1,312.5	1,312.5	1,312.5	1,312.5	1,312.5	1,312.5
Projected OR Need			1.8	1.8	1.9	2.0	2.1	2.2
Licensed/CON Approved Inventory			2.0	2.0	2.0	2.0	2.0	2.0
Deficit(-)/Surplus(+)			0.24	0.17	0.09	0.01	-0.07	-0.16

Source: REX Section Q Form C; Table 22

Table 21.

Rex Wakefield Projections Revised - 68.6 minutes

	2018	CAGR 2012-2017	2019	2020	2021	2022	2023	2024
Outpt	1,548	4.2%	1,612	1,679	1,749	1,822	1,897	1,976
Adjusted Outpat			1,612	1,679	1,749	1,822	1,897	1,976
Outpt Time Per Case			68.6	68.6	68.6	68.6	68.6	68.6
Outpatient Surgical Hours			1,843	1,920	2,000	2,083	2,169	2,259
Total Surgical Hours			1,843	1,920	2,000	2,083	2,169	2,259
Std Hrs Per OR			1,312.5	1,312.5	1,312.5	1,312.5	1,312.5	1,312.5
Projected OR Need			1.4	1.5	1.5	1.6	1.7	1.7
Licensed/CON Approved Inventory			2.0	2.0	2.0	2.0	2.0	2.0
Deficit(-)/Surplus(+)			0.60	0.54	0.48	0.41	0.35	0.28

Source: REX Section Q Form C; Table 22

Table 22.

Year	Outpt REX Wakefield	Time per Case	Outpt Surgical Hours	Target for One OR	OR Need
2012	1,595	90	2392.5	1312.5	1.8
2013	1,642	90	2463.0	1312.5	1.9
2014	1,430	90	2145.0	1312.5	1.6
2015	1,639	90	2458.5	1312.5	1.9
2016	1,424	90	2136.0	1312.5	1.6
2017	1,955	86	2802.2	1312.5	2.1
CAGR 2012-2017	4.20%				
2018 (Wakefield annualized p16)	1,548	86	2218.8	1312.5	1.7
CAGR 2012-2018	-0.50%				

Source: LRAs

Table 23.

Duke Historical Utilization page 22

	2014	2015	2016	2017	2018	CAGR 2014-2018	CAGR 2013-2018	CAGR 2016-2018	AGR 2017-2018	Average of Four CAGR/AGR
Duke Raleigh										
Inpatient	3,586	3,616	4,389	4,094	3,958	2.50%	3.06%	-5.0%	-3.3%	-0.7%
Outpatient	9,132	9,875	10,855	11,084	12,604	8.39%	8.47%	7.8%	13.7%	9.6%
Total	12,718	13,491	15,244	15,178	16,562	6.83%	7.08%	4.2%	9.1%	6.8%
Duke ASC Durham										
Inpatient	0	0	0	0	0	0.00%	0.00%	0.0%	0.0%	0.0%
Outpatient	4,406	4,869	5,164	5,277	7,645	14.77%	16.23%	21.7%	44.9%	24.4%
Total	4,406	4,869	5,164	5,277	7,645	14.77%	16.23%	21.7%	44.9%	24.4%
Duke University Hospital Durham										
Inpatient	16,920	17,344	17,151	17,989	17,312	0.57%	-0.06%	0.5%	-3.8%	-0.7%
Outpatient	22,292	23,728	22,642	22,575	23,614	1.45%	-0.16%	2.1%	4.6%	2.0%
Total	39,212	41,072	39,793	40,564	40,926	1.08%	-0.12%	1.4%	0.9%	0.8%
Duke Regional Durham										
Inpatient	3,697	3,865	3,765	4,539	4,153	2.95%	2.42%	5.0%	-8.5%	0.5%
Outpatient	2,899	2,995	2,981	3,352	3,992	8.33%	10.05%	15.7%	19.1%	13.3%
Total	6,596	6,860	6,746	7,891	8,145	5.42%	5.89%	9.9%	3.2%	6.1%
Duke Regional Durham										
Inpatient	24,203	24,825	25,305	26,622	25,423	1.24%	0.80%	0.2%	-4.5%	-0.6%
Outpatient	38,729	41,467	41,642	42,288	47,855	5.43%	4.89%	7.2%	13.2%	7.7%
Total	62,932	66,292	66,947	68,910	73,278	3.88%	3.40%	4.6%	6.3%	4.6%

Source: DUHS CON

Table 24.

WakeMed HealthSystem Historical Surgical Growth

	2012	2013	2014	2015	2016	2017	CAGR 2012-2017	CAGR 2013-2017	CAGR 2014-2017	CAGR 2015-2017	AGR 2016-2017
Inpatient											
WakeMed	7,292	6,902	7,135	7,798	8,419	8,121	2.18%	4.15%	4.41%	2.1%	-3.5%
WakeMed North	0	0	0	21	81	63	0.00%	0.00%	0.00%	73.2%	-22.2%
WakeMed Cary	1,909	2,042	2,172	2,769	3,037	3,162	10.62%	11.55%	13.34%	6.9%	4.1%
Capital City	0	0	0	0	0	0	0.00%	0.00%	0.00%	0.0%	0.0%
Total Inpatient	9,201	8,944	9,307	10,588	11,537	11,346	4.28%	6.13%	6.83%	3.5%	-1.7%
Outpatient											
WakeMed	10,210	9,335	8,494	7,326	7,705	7,547	-5.87%	-5.18%	-3.86%	1.5%	-2.1%
WakeMed North	3,486	2,106	1,990	1,802	2,213	2,346	-7.62%	2.73%	5.64%	14.1%	6.0%
WakeMed Cary	5,239	4,463	4,076	4,815	4,820	5,242	0.01%	4.10%	8.75%	4.3%	8.8%
Total Outpatient	18,935	15,904	14,560	13,943	14,738	15,135	-4.38%	-1.23%	1.30%	4.2%	2.7%
Freestanding ASC Outpatient											
Capital City	158	5,276	6,647	6,647	6,123	5,388	102.56%	0.53%	-6.76%	-10.0%	-12.0%
Total All Surgery	28,294	30,124	30,514	31,178	32,398	31,869	2.41%	1.42%	1.46%	1.1%	-1.6%

Source: LRA

Table 25.

WakeMed HealthSystem Historical Surgical Growth

	2012	2013	2014	2015	2016	2017	CAGR 2012-2017	CAGR 2013-2017	CAGR 2014-2017	CAGR 2015-2017	AGR 2016-2017
Inpatient											
WakeMed	7,292	6,902	7,135	7,798	8,419	8,121	2.18%	4.15%	4.41%	2.1%	-3.5%
WakeMed North	0	0	0	21	81	63	0.00%	0.00%	0.00%	73.2%	-22.2%
WakeMed Cary	1,909	2,042	2,172	2,769	3,037	3,162	10.62%	11.55%	13.34%	6.9%	4.1%
Capital City	0	0	0	0	0	0	0.00%	0.00%	0.00%	0.0%	0.0%
Total Inpatient	9,201	8,944	9,307	10,588	11,537	11,346	4.28%	6.13%	6.83%	3.5%	-1.7%
Outpatient											
WakeMed	10,210	9,335	8,494	7,326	7,705	7,547	-5.87%	-5.18%	-3.86%	1.5%	-2.1%
WakeMed North	3,486	2,106	1,990	1,802	2,213	2,346	-7.62%	2.73%	5.64%	14.1%	6.0%
WakeMed Cary	5,239	4,463	4,076	4,815	4,820	5,242	0.01%	4.10%	8.75%	4.3%	8.8%
Capital City	158	5,276	6,647	6,647	6,123	5,388	102.56%	0.53%	-6.76%	-10.0%	-12.0%
Total Outpatient	19,093	21,180	21,207	20,590	20,861	20,523	1.45%	-0.78%	-1.09%	-0.2%	-1.6%
Freestanding ASC Outpatient											
Total All Surgery	28,294	30,124	30,514	31,178	32,398	31,869	2.41%	1.42%	1.46%	1.1%	-1.6%

Source: LRA

Table 26

UNC REX Garner page 40-41 (Exhibit C.4-2)

Zip Code	Town	2018	2023	Growth
27587	Wake Forest	70,274	80,994	10,720
27519	Panther Creek/West Cary	58,262	68,341	10,079
27616	Raleigh	53,847	62,582	8,735
27526	Fuquay Varina	51,929	59,181	7,252
27540	Holly Springs	38,659	45,446	6,787
27610	Raleigh	74,990	81,645	6,655
27560	Morrisville	32,592	39,123	6,531
27502	Apex	41,830	48,219	6,389
27603	Raleigh	54,998	60,994	5,996
27529	Garner	51,923	57,728	5,805
27513	Cary	48,031	53,390	5,359
27609	Raleigh	38,860	46,363	7,503
27614	Raleigh	37,781	42,163	4,382
27604	Raleigh	47,641	51,777	4,136
27606	Raleigh	47,481	51,554	4,073
27545	Knightdale	29,642	33,701	4,059
27539	Apex	25,420	29,115	3,695
27612	Raleigh	39,235	42,749	3,514
27613	Raleigh	46,400	49,656	3,256
27615	Raleigh	45,759	48,680	2,921
27607	Raleigh	30,080	32,889	2,809
27591	Wendell	22,822	25,517	2,695
27597	Zebulon	24,729	27,401	2,672
27617	Raleigh	19,890	22,509	2,619
27518	Cary	23,017	25,482	2,465
27523	Apex	11,789	14,126	2,337
27511	Cary	34,099	36,183	2,084
27592	Willow Spring	17,028	18,818	1,790
27601	Raleigh'	12,151	13,553	1,402
27571	Rolesville	7,138	8,453	1,315
27608	Raleigh	11,536	12,439	903
27605	Raleigh	4,670	5,306	636
27562	New Hill	2,526	3,124	598

Source: UNC REX Garner page 40-41 (Exhibit C.4-2)

Table 27.

Wake County Population CAGRs

Year	Total	CAGR 2017-2023	CAGR 2017-2024	CAGR 2018-2023	CAGR 2018-2024
2017	1,048,771				
2018	1,071,240				
2019	1,093,987				
2020	1,116,912				
2021	1,139,953				
2022	1,163,066				
2023	1,186,223	2.074%		2.060%	
2024	1,209,408		2.057%		2.042%

Source: NC OSBM

Table 28.

WakeMed North OR Need

	2012	2013	2014	2015	2016	2017	CAGR 2012-2017	CAGR 2013-2017	CAGR 2014-2017	CAGR 2015-2017	AGR 2016-
Inpatient											
WakeMed North	0	0	0	21	81	63	0.00%	0.00%	0.00%	73.2%	-22.2%
Inpatient Case Time	0	0	0	105	105	105					
Inpt Surgical Hours	0	0	0	36.8	141.8	110.3					
Outpatient											
WakeMed North	3,486	2,106	1,990	1,802	2,213	2,346	-7.62%	2.73%	5.64%	14.1%	6.0%
Outpatient Case Time	65	65	65	65	65	65					
Outpt Surgical Hours	3,776.5	2,281.5	2,155.8	1,952.2	2,397.4	2,541.5					
Additional ORs Needed											
Total Surgical Hours	3,777	2,282	2,156	1,989	2,539	2,652					
Std Hrs Per OR Category 4 (p58 2018 SMFP)	1500	1500	1500	1500	1500	1500					
OR Need	2.5	1.5	1.4	1.3	1.7	1.8					
OR Inventory	4	4	4	4	4	4					
OR Surplus	1.5	2.5	2.6	2.7	2.3	2.2					

Source: CON applications; LRA data

Table 29.

WakeMed North OR Need- Revised Projections

	2017 Total Surgical Hours - 2018 LRAs	Wake Cty Pop CAGR 2017-2023	Growth Factor	Projected Surgical Hours for 2023	Planning Threshold 2018 SMFP	OR Need	Inventory	Surplus(-)
Capital Surgery Center	5,412	2.074%	12.4%	6,085	1,312.5	4.6	8	-3.36
WakeMed	44,012	2.074%	12.4%	49,488	1,950	25.4	23	2.38
WakeMed Cary	8,296	2.074%	12.4%	9,328	1,500	6.2	9	-2.78
WSCC page 126 of application						2.45	2	0.45
WSCNR page 128 of application						2.75	2	0.75
Total Projected Surplus						**41.4**	**44**	**-2.57**

Source: CON applications; LRA data

Table 30.

Capital City OR Need- Revised Projections

	2017 Total Surgical Hours - 2018 LRAs	Wake Cty Pop CAGR 2017-2023	Growth Factor	Projected Surgical Hours for 2023	Planning Threshold 2018 SMFP	OR Need	Inventory	Surplus(-)
Capital Surgery Center	5,412	2.238%	13.4%	6,139	1,312.5	4.7	8	-3.3
WakeMed	44,012	2.238%	13.4%	49,921	1,950	25.6	23	2.6
WakeMed Cary	8,296	2.238%	13.4%	9,410	1,500	6.3	9	-2.7
WSCC page 126 of application						2.45	2	0.45
WSCNR page 128 of application						2.75	2	0.75
Total Projected Surplus						**41.8**	**44**	**-2.25**

Source: CON applications; LRA data

Attachment 1

REX
UNC HEALTH CARE

James T. Hedrick Building
211 Friday Center Drive, Suite G015
Chapel Hill, NC 27517

July 15, 2015

Mr. Michael J. McKillip, Project Analyst
Healthcare Planning & Certificate of Need Section
Division of Health Service Regulation, DHHS
Mail Service Center 2704
Raleigh, NC 27699-2704

Mr. McKillip:

Attached you will find the Progress Report for CON Project I.D. # J-10280-14 and Facility I.D. # 110286. This project involves the conversion of an existing ambulatory surgery center operating under a hospital license to a separately licensed freestanding ambulatory surgical center at the same location.

Please call me at 984-974-1210 if you have any questions or require any additional information at this time.

Sincerely,

Dee Jay Zerman

Dee Jay Zerman, Director
Regulatory Planning
UNC HCS

CERTIFICATE OF NEED
PROGRESS REPORT FORM

County: Wake County
Facility: Rex Hospital, Inc., Rex Surgery Center of Wakefield, LLC
Project I.D. #: J-10280-14
Date of Progress Report: 7/15/2015
Facility I.D. #: 110286
Effective Date of Certificate: 10/21/2014
Project Description: Convert an existing ambulatory surgery center operating under a hospital license to a separately licensed freestanding ambulatory surgical center at the same location

A. Status of the Project

1. Describe in detail the steps taken to complete the project since the CON was issued or since the last progress report was submitted.

Response: The certificate of need was issued on October 21, 2014. Discussions are ongoing with potential surgeon investors. Reimbursement staff is determining the appropriate patient flow and signage to separate the LLC from the hospital based services.

2. Describe any of the previously approved changes which will impact this project:
   1. Cost Overruns and/or Changes of Scope (Include the Project I.D. numbers);
   2. Material Compliance determinations; and
   3. Declaratory Rulings

Response: Not applicable.

3. If the project is not going to be developed exactly as approved, describe all differences between the project as approved and the project as currently proposed. Such changes include, but are not limited to, changes in the:
   a. Site;
   b. Design of the facility;
   c. Number or type of beds to be developed;
   d. Medical equipment to be acquired;
   e. Proposed charges; and
   f. Capital cost of the project.

Response: Not applicable.

4. Pursuant to G.S. 131E-181(d), the Certificate of Need (CON) Section cannot determine that a project is complete **until** *"the health service or the health service facility for which the certificate of need was issued is licensed and certified and in material compliance with the representations made in the certificate of need application."* To document that new or replacement facilities, new or additional beds or dialysis stations, new or replacement equipment or new services have been licensed and certified, provide copies of correspondence from the appropriate section within the Division of Health Service Regulation and the Centers for Medicare and Medicaid Services (CMS).

Response: Not applicable.

B. Timetable

1. Complete the following table. The first column **must** include the timetable dates found on the certificate of need. If the CON Section has authorized an extension of the timetable in writing, you may substitute the dates from that letter.

PROJECT MILESTONES	Projected completion date from certificate	Actual completion date	Proposed completion date*
	Month/day/year	Month/day/year	Month/day/year
Completion of Final Drawings and Specifications	3/1/15		
Approval of Final Drawings and Specifications	6/31/15		
Contract Award	4/1/16		
25% Completion of Construction	4/23/16		
50% Completion of Construction	5/16/16		
75% Completion of Construction	6/7/16		
Completion of Construction	6/30/16		
Occupancy/Offering of Services	7/1/16		
Licensure of Facility	7/1/16		
Certification of Facility	7/1/16		

**Proposed completion dates are contingent upon CON approval*

2. If the project is experiencing delays in development, explain in detail the reasons for the delay.

Response: Not applicable. Activities are underway.

C. Medical Equipment Projects – If the project involves the acquisition of any of the following equipment: 1) major medical equipment as defined in NCGS §131E-176(14o); 2) the specific equipment listed in NCGS §131-176(16); or 3) equipment that creates a diagnostic center as defined in NCGS §131E-176(7a), provide the following information for each piece or unit of equipment: 1) manufacturer; 2) model; 3) serial number; and 4) date acquired.

Response: Not applicable.

D. Capital Expenditure

1. What is the total approved capital cost of the project indicated on the certificate of need? $466,000

2. Complete the table on the following page.
   a. Include all capital costs that have been paid to date as well as those that the applicant(s) are legally obligated to pay.
   b. If you have not already done so, provide copies of all executed contracts, including architect and engineering services (as applicable) and all final purchase orders for medical equipment costing more than $10,000 per unit.
   c. If the project involves renovation or construction, provide copies of the Contractors Application for Payment [AIA G702] with Schedule of Values [AIA G703].

	Capital Expense Since Last Report	Total Cumulative Capital Expenditure
Site Costs		
Purchase price of land		
Closing costs		
Site Inspection and Survey		
Legal fees		
Site preparation costs		
Other site costs (identify)		
Subtotal Site Costs		
Construction Contract		
Cost of materials		
Cost of Labor		
Other (Specify)		
Subtotal Construction Contract		
Miscellaneous Costs		
Building purchase		
Fixed equipment purchase/lease		
Moveable equipment purchase/lease		
Furniture		
Landscaping		
A&E and Consultant fees	$49,538	$49,538
Financing costs		
Interest during construction		
Other miscellaneous costs		
Subtotal Miscellaneous Costs	**$49,538**	**$49,538**
Total	**$49,538**	**$49,538**

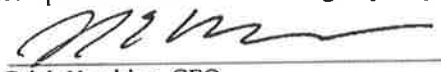
3. What is the projected remaining capital expenditure required to complete the project? $416,462

4. Will the total actual capital cost of the project exceed 115% of the approved capital expenditure on the certificate of need? If yes,

explain the reasons for the difference.

Response: No.

E. CERTIFICATION – The undersigned hereby certifies that the responses to the questions in this progress report and the attached documents are correct to the best of his or her knowledge and belief. In addition, I acknowledge that incomplete progress report forms **will not** be accepted and **must** be resubmitted upon notification from an Agency Project Analyst.

Signature of Officer: 
Name and Title of Responsible Officer: Erick Hawkins, CFO
Telephone Number of Responsible Officer: 919-784-3245

Attachment 1

REX
UNC HEALTH CARE

James T. Hedrick Building
211 Friday Center Drive, Suite G015
Chapel Hill, NC 27517

October 30, 2015

Mr. Michael J. McKillip, Project Analyst
Healthcare Planning & Certificate of Need Section
Division of Health Service Regulation, DHHS
Mail Service Center 2704
Raleigh, NC 27699-2704

Mr. McKillip:

Attached you will find the Progress Report for CON Project I.D. # J-10280-14 and Facility I.D. # 110286. This project involves the conversion of an existing ambulatory surgery center operating under a hospital license to a separately licensed freestanding ambulatory surgical center at the same location.

Please call me at 984-974-1210 if you have any questions or require any additional information at this time.

Sincerely,

Dee Jay Zerman

Dee Jay Zerman, Director
Regulatory Planning
UNC HCS

Attachment 1

CERTIFICATE OF NEED
PROGRESS REPORT FORM

County: Wake County
Facility: Rex Hospital, Inc., Rex Surgery Center of Wakefield, LLC
Project I.D. #: J-10280-14
Project Description: Convert an existing ambulatory surgery center operating under a hospital license to a separately licensed freestanding ambulatory surgical center at the same location

Date of Progress Report: 10/30/2015
Facility I.D. #: 110286
Effective Date of Certificate: 10/21/2014

A. Status of the Project

1. Describe in detail the steps taken to complete the project since the CON was issued or since the last progress report was submitted.

Response: The certificate of need was issued on October 21, 2014. Discussions are ongoing with potential surgeon investors. Reimbursement staff is determining the appropriate patient flow and signage to separate the LLC from the hospital based services.

2. Describe any of the previously approved changes which will impact this project:
   1. Cost Overruns and/or Changes of Scope (Include the Project I.D. numbers);
   2. Material Compliance determinations; and
   3. Declaratory Rulings

Response: Not applicable.

3. If the project is not going to be developed exactly as approved, describe all differences between the project as approved and the project as currently proposed. Such changes include, but are not limited to, changes in the:
   a. Site;
   b. Design of the facility;
   c. Number or type of beds to be developed;
   d. Medical equipment to be acquired;
   e. Proposed charges; and
   f. Capital cost of the project.

Response: Not applicable.

4. Pursuant to G.S. 131E-181(d), the Certificate of Need (CON) Section cannot determine that a project is complete **until** *"the health service or the health service facility for which the certificate of need was issued is licensed and certified and in material compliance with the representations made in the certificate of need application."* To document that new or replacement facilities, new or additional beds or dialysis stations, new or replacement equipment or new services have been licensed and certified, provide copies of correspondence from the appropriate section within the Division of Health Service Regulation and the Centers for Medicare and Medicaid Services (CMS).

Response: Not applicable.

B. Timetable

1. Complete the following table. The first column **must** include the timetable dates found on the certificate of need. If the CON Section has authorized an extension of the timetable in writing, you may substitute the dates from that letter.

PROJECT MILESTONES	Projected completion date from certificate	Actual completion date	Proposed completion date*
	Month/day/year	Month/day/year	Month/day/year
Completion of Final Drawings and Specifications	3/1/15		
Approval of Final Drawings and Specifications	6/31/15		
Contract Award	4/1/16		
25% Completion of Construction	4/23/16		
50% Completion of Construction	5/16/16		
75% Completion of Construction	6/7/16		
Completion of Construction	6/30/16		
Occupancy/Offering of Services	7/1/16		
Licensure of Facility	7/1/16		
Certification of Facility	7/1/16		

**Proposed completion dates are contingent upon CON approval*

2. If the project is experiencing delays in development, explain in detail the reasons for the delay.

Response: Not applicable. Activities are underway.

C. Medical Equipment Projects – If the project involves the acquisition of any of the following equipment: 1) major medical equipment as defined in NCGS §131E-176(14o); 2) the specific equipment listed in NCGS §131-176(16); or 3) equipment that creates a diagnostic center as defined in NCGS §131E-176(7a), provide the following information for each piece or unit of equipment: 1) manufacturer; 2) model; 3) serial number; and 4) date acquired.

Response: Not applicable.

D. Capital Expenditure

1. What is the total approved capital cost of the project indicated on the certificate of need? $466,000

2. Complete the table on the following page.
   a. Include all capital costs that have been paid to date as well as those that the applicant(s) are legally obligated to pay.
   b. If you have not already done so, provide copies of all executed contracts, including architect and engineering services (as applicable) and all final purchase orders for medical equipment costing more than $10,000 per unit.
   c. If the project involves renovation or construction, provide copies of the Contractors Application for Payment [AIA G702] with Schedule of Values [AIA G703].

	Capital Expense Since Last Report	Total Cumulative Capital Expenditure
Site Costs		
Purchase price of land		
Closing costs		
Site Inspection and Survey		
Legal fees		
Site preparation costs		
Other site costs (identify)		
Subtotal Site Costs		
Construction Contract		
Cost of materials		
Cost of Labor		
Other (Specify)		
Subtotal Construction Contract		
Miscellaneous Costs		
Building purchase		
Fixed equipment purchase/lease		
Moveable equipment purchase/lease		
Furniture		
Landscaping		
A&E and Consultant fees	$49,538	$49,538
Financing costs		
Interest during construction		
Other miscellaneous costs		
Subtotal Miscellaneous Costs	**$49,538**	**$49,538**
Total	**$49,538**	**$49,538**

3. What is the projected remaining capital expenditure required to complete the project? $416,462

4. Will the total actual capital cost of the project exceed 115% of the approved capital expenditure on the certificate of need? If yes,

explain the reasons for the difference.

Attachment 1

Response: No.

E. CERTIFICATION – The undersigned hereby certifies that the responses to the questions in this progress report and the attached documents are correct to the best of his or her knowledge and belief. In addition, I acknowledge that incomplete progress report forms **will not** be accepted and **must** be resubmitted upon notification from an Agency Project Analyst.

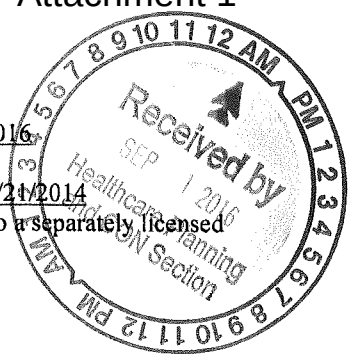
Signature of Officer: _____

Name and Title of Responsible Officer: Erick Hawkins, CFO

Telephone Number of Responsible Officer: 919-784-3245

Attachment 1

CERTIFICATE OF NEED
PROGRESS REPORT FORM



County: Wake County
Facility: Rex Hospital, Inc., Rex Surgery Center of Wakefield, LLC
Project I.D. #: J-10280-14
Date of Progress Report: 8/30/2016
Facility I.D. #: 110286
Effective Date of Certificate: 10/21/2014
Project Description: Convert an existing ambulatory surgery center operating under a hospital license to a separately licensed freestanding ambulatory surgical center at the same location

A. Status of the Project

1. Describe in detail the steps taken to complete the project since the CON was issued or since the last progress report was submitted.

Response: The certificate of need was issued on October 21, 2014. Discussions are ongoing with potential surgeon investors. Reimbursement staff is determining the appropriate patient flow and signage to separate the LLC from the hospital based services.

2. Describe any of the previously approved changes which will impact this project:
   1. Cost Overruns and/or Changes of Scope (Include the Project I.D. numbers);
   2. Material Compliance determinations; and
   3. Declaratory Rulings

Response: Not applicable.

3. If the project is not going to be developed exactly as approved, describe all differences between the project as approved and the project as currently proposed. Such changes include, but are not limited to, changes in the:
   a. Site;
   b. Design of the facility;
   c. Number or type of beds to be developed;
   d. Medical equipment to be acquired;
   e. Proposed charges; and
   f. Capital cost of the project.

Response: Not applicable.

4. Pursuant to G.S. 131E-181(d), the Certificate of Need (CON) Section cannot determine that a project is complete **until** *"the health service or the health service facility for which the certificate of need was issued is licensed and certified and in material compliance with the representations made in the certificate of need application."* To document that new or replacement facilities, new or additional beds or dialysis stations, new or replacement equipment or new services have been licensed and certified, provide copies of correspondence from the appropriate section within the Division of Health Service Regulation and the Centers for Medicare and Medicaid Services (CMS).

Response: Not applicable.

B. Timetable

1. Complete the following table. The first column **must** include the timetable dates found on the certificate of need. If the CON Section has authorized an extension of the timetable in writing, you may substitute the dates from that letter.

PROJECT MILESTONES	Projected completion date from certificate	Actual completion date	Proposed completion date*
	Month/day/year	Month/day/year	Month/day/year
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Approval of Final Drawings and Specifications	6/31/15		TBD
Contract Award	4/1/16		
25% Completion of Construction	4/23/16		
50% Completion of Construction	5/16/16		
75% Completion of Construction	6/7/16		
Completion of Construction	6/30/16		
Occupancy/Offering of Services	7/1/16		
Licensure of Facility	7/1/16		
Certification of Facility	7/1/16		

**Proposed completion dates are contingent upon CON approval*

2. If the project is experiencing delays in development, explain in detail the reasons for the delay.

Response: Activities are underway. Discussions with potential surgeon investors are ongoing.

C. Medical Equipment Projects – If the project involves the acquisition of any of the following equipment: 1) major medical equipment as defined in NCGS §131E-176(14o); 2) the specific equipment listed in NCGS §131-176(16); or 3) equipment that creates a diagnostic center as defined in NCGS §131E-176(7a), provide the following information for each piece or unit of equipment: 1) manufacturer; 2) model; 3) serial number; and 4) date acquired.

Response: Not applicable.

D. Capital Expenditure

1. What is the total approved capital cost of the project indicated on the certificate of need? $466,000

2. Complete the table on the following page.
   a. Include all capital costs that have been paid to date as well as those that the applicant(s) are legally obligated to pay.
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   c. If the project involves renovation or construction, provide copies of the Contractors Application for Payment [AIA G702] with Schedule of Values [AIA G703].

	Capital Expense Since Last Report	Total Cumulative Capital Expenditure
Site Costs		
Purchase price of land		
Closing costs		
Site Inspection and Survey		
Legal fees		
Site preparation costs		
Other site costs (identify)		
Subtotal Site Costs		
Construction Contract		
Cost of materials		
Cost of Labor		
Other (Specify)		
Subtotal Construction Contract		
Miscellaneous Costs		
Building purchase		
Fixed equipment purchase/lease		
Moveable equipment purchase/lease		
Furniture		
Landscaping		
A&E and Consultant fees		$49,538
Financing costs		
Interest during construction		
Other miscellaneous costs		
Subtotal Miscellaneous Costs		**$49,538**
Total		**$49,538**

3. What is the projected remaining capital expenditure required to complete the project? $416,462

4. Will the total actual capital cost of the project exceed 115% of the approved capital expenditure on the certificate of need? If yes,

explain the reasons for the difference.

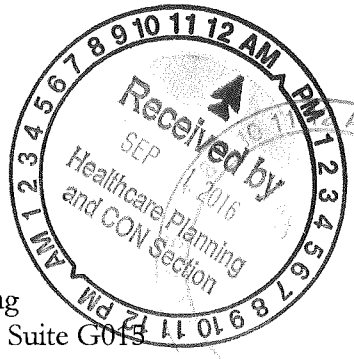
Response: No.

E. CERTIFICATION – The undersigned hereby certifies that the responses to the questions in this progress report and the attached documents are correct to the best of his or her knowledge and belief. In addition, I acknowledge that incomplete progress report forms **will not** be accepted and **must** be resubmitted upon notification from an Agency Project Analyst.

Signature of Officer: Andrew K. Zukowski
Name and Title of Responsible Officer Andrew Zukowski, CFO
Telephone Number of Responsible Officer 919-784-3245

Attachment 1

REX
UNC HEALTH CARE



James T. Hedrick Building
211 Friday Center Drive, Suite G015
Chapel Hill, NC 27517

August 30, 2016

Mr. Michael J. McKillip, Project Analyst
Healthcare Planning & Certificate of Need Section
Division of Health Service Regulation, DHHS
Mail Service Center 2704
Raleigh, NC 27699-2704

Mr. McKillip:

Attached you will find the Progress Report for CON Project I.D. # J-10280-14 and Facility I.D. # 110286. This project involves the conversion of an existing ambulatory surgery center operating under a hospital license to a separately licensed freestanding ambulatory surgical center at the same location.

On August 26, 2016 the CON Section approved CON Project ID # J-011198-16 to relocate one OR from Rex Surgery Center of Wakefield back to the hospital's main campus, which is a change in scope to Project I.D. # J-10280-14. The required appeal period is underway before the certificate can be issued.

Please call me at 984-974-1210 if you have any questions or require any additional information at this time.

Sincerely,

Dee Jay Zerman

Dee Jay Zerman, System Director
Regulatory Planning
UNC HCS

Attachment 1

REX
UNC HEALTH CARE

James T. Hedrick Building
211 Friday Center Drive, Suite G015
Chapel Hill, NC 27517

November 21, 2016

Mr. Michael J. McKillip, Project Analyst
Healthcare Planning & Certificate of Need Section
Division of Health Service Regulation, DHHS
Mail Service Center 2704
Raleigh, NC 27699-2704

Mr. McKillip:

Attached you will find the Progress Report for CON Project I.D. # J-10280-14 and Facility I.D. # 110286. This project involves the conversion of an existing ambulatory surgery center operating under a hospital license to a separately licensed freestanding ambulatory surgical center at the same location.

On August 26, 2016 the CON Section approved CON Project ID # J-011198-16 to relocate one OR from Rex Surgery Center of Wakefield back to the hospital's main campus, which is a change in scope to Project I.D. # J-10280-14. The Certificate of Need was issued on September 27, 2016.

Please call me at 984-974-1210 if you have any questions or require any additional information at this time.

Sincerely,

Dee Jay Zerman

Dee Jay Zerman, System Director
Regulatory Planning
UNC HCS

CERTIFICATE OF NEED
PROGRESS REPORT FORM

County: Wake County
Facility: Rex Hospital, Inc., Rex Surgery Center of Wakefield, LLC
Project I.D. #: J-10280-14
Project Description: Convert an existing ambulatory surgery center operating under a hospital license to a separately licensed freestanding ambulatory surgical center at the same location

Date of Progress Report: 11/21/2016
Facility I.D. #: 110286
Effective Date of Certificate: 10/21/2014

A. Status of the Project

1. Describe in detail the steps taken to complete the project since the CON was issued or since the last progress report was submitted.

Response: The certificate of need was issued on October 21, 2014. Discussions are ongoing with potential surgeon investors. Reimbursement staff is determining the appropriate patient flow and signage to separate the LLC from the hospital based services. Legal documents are in process and being reviewed.

2. Describe any of the previously approved changes which will impact this project:
   1. Cost Overruns and/or Changes of Scope (Include the Project I.D. numbers);
   2. Material Compliance determinations; and
   3. Declaratory Rulings

Response: Not applicable.

3. If the project is not going to be developed exactly as approved, describe all differences between the project as approved and the project as currently proposed. Such changes include, but are not limited to, changes in the:
   a. Site;
   b. Design of the facility;
   c. Number or type of beds to be developed;
   d. Medical equipment to be acquired;
   e. Proposed charges; and
   f. Capital cost of the project.

Response: Not applicable.

4. Pursuant to G.S. 131E-181(d), the Certificate of Need (CON) Section cannot determine that a project is complete **until** *"the health service or the health service facility for which the certificate of need was issued is licensed and certified and in material compliance with the representations made in the certificate of need application."* To document that new or replacement facilities, new or additional beds or dialysis stations, new or replacement equipment or new services have been licensed and certified, provide copies of correspondence from the appropriate section within the Division of Health Service Regulation and the Centers for Medicare and Medicaid Services (CMS).

Response: Not applicable.

B. Timetable

1. Complete the following table. The first column **must** include the timetable dates found on the certificate of need. If the CON Section has authorized an extension of the timetable in writing, you may substitute the dates from that letter.

PROJECT MILESTONES	Projected completion date from certificate	Actual completion date	Proposed completion date*
	Month/day/year	Month/day/year	Month/day/year
Completion of Final Drawings and Specifications	3/1/15		TBD
Approval of Final Drawings and Specifications	6/31/15		TBD
Contract Award	4/1/16		
25% Completion of Construction	4/23/16		
50% Completion of Construction	5/16/16		
75% Completion of Construction	6/7/16		
Completion of Construction	6/30/16		
Occupancy/Offering of Services	7/1/16		
Licensure of Facility	7/1/16		

Certification of Facility	7/1/16		*

**Proposed completion dates are contingent upon CON approval*

**Note: A very preliminary estimate for conversion to a stand-alone JV is approximately July 2017. Once this date can be finalized a timetable extension will be requested.

2. If the project is experiencing delays in development, explain in detail the reasons for the delay.

Response: Activities are underway. Discussions with potential surgeon investors are ongoing.

C. Medical Equipment Projects – If the project involves the acquisition of any of the following equipment: 1) major medical equipment as defined in NCGS §131E-176(14o); 2) the specific equipment listed in NCGS §131-176(16); or 3) equipment that creates a diagnostic center as defined in NCGS §131E-176(7a), provide the following information for each piece or unit of equipment: 1) manufacturer; 2) model; 3) serial number; and 4) date acquired.

Response: Not applicable.

D. Capital Expenditure

1. What is the total approved capital cost of the project indicated on the certificate of need? $466,000

2. Complete the table on the following page.
   a. Include all capital costs that have been paid to date as well as those that the applicant(s) are legally obligated to pay.
   b. If you have not already done so, provide copies of all executed contracts, including architect and engineering services (as applicable) and all final purchase orders for medical equipment costing more than $10,000 per unit.
   c. If the project involves renovation or construction, provide copies of the Contractors Application for Payment [AIA G702] with Schedule of Values [AIA G703].

	Capital Expense Since Last Report	Total Cumulative Capital Expenditure
Site Costs		
Purchase price of land		
Closing costs		
Site Inspection and Survey		
Legal fees		
Site preparation costs		
Other site costs (identify)		
Subtotal Site Costs		
Construction Contract		
Cost of materials		
Cost of Labor		
Other (Specify)		
Subtotal Construction Contract		
Miscellaneous Costs		
Building purchase		
Fixed equipment purchase/lease		
Moveable equipment purchase/lease		
Furniture		
Landscaping		
A&E and Consultant fees		$49,538
Financing costs		
Interest during construction		
Other miscellaneous costs		
Subtotal Miscellaneous Costs		**$49,538**
Total		**$49,538**

3. What is the projected remaining capital expenditure required to complete the project? $416,462

4. Will the total actual capital cost of the project exceed 115% of the approved capital expenditure on the certificate of need? If yes, explain the reasons for the difference.

Response: No.

E. CERTIFICATION – The undersigned hereby certifies that the responses to the questions in this progress report and the attached documents are correct to the best of his or her knowledge and belief. In addition, I acknowledge that incomplete progress report forms **will not** be accepted and **must** be resubmitted upon notification from an Agency Project Analyst.

Signature of Officer: Andrew K. Zukowski
Name and Title of Responsible Officer: Andrew Zukowski, CFO
Telephone Number of Responsible Officer: 919-784-3245

Attachment 1

REX
UNC HEALTH CARE

James T. Hedrick Building
211 Friday Center Drive, Suite G014
Chapel Hill, NC 27517

May 12, 2017

Mr. Michael J. McKillip, Project Analyst
Healthcare Planning & Certificate of Need Section
Division of Health Service Regulation, DHHS
Mail Service Center 2704
Raleigh, NC 27699-2704

Mr. McKillip:

Attached you will find the Progress Report for CON Project I.D. # J-10280-14 and Facility I.D. # 110286. This project involves the conversion of an existing ambulatory surgery center operating under a hospital license to a separately licensed freestanding ambulatory surgical center at the same location.

On August 26, 2016 the CON Section approved CON Project ID # J-011198-16 to relocate one OR from Rex Surgery Center of Wakefield back to the hospital's main campus, which is a change in scope to Project I.D. # J-10280-14. The Certificate of Need was issued on September 27, 2016.

Please call me at 984-974-1243 if you have any questions or require any additional information at this time.

Sincerely,

Dee Jay Zerman

Dee Jay Zerman, System Director
Regulatory Planning
UNC HCS

CERTIFICATE OF NEED
PROGRESS REPORT FORM

County: Wake County
Facility: Rex Hospital, Inc., Rex Surgery Center of Wakefield, LLC
Project I.D. #: J-10280-14
Project Description: Convert an existing ambulatory surgery center operating under a hospital license to a separately licensed freestanding ambulatory surgical center at the same location

Date of Progress Report: 5/11/2017
Facility I.D. #: 110286
Effective Date of Certificate: 10/21/2014

A. Status of the Project

1. Describe in detail the steps taken to complete the project since the CON was issued or since the last progress report was submitted.

Response: Legal documents have been completed. Subscription Agreement and other agreements should be finalized by the end of this month. The Operations team is working on Policy and Procedure conversion and Life Safety evaluation for the pending inspections. Target conversion date is September 1, 2017. This timing is to account for the necessary State and AAAHC inspections timeframe.

2. Describe any of the previously approved changes which will impact this project: (1) Cost Overruns and/or Changes of Scope (Include the Project I.D. numbers); (2) Material Compliance determinations; and (3) Declaratory Rulings

Response: On August 26, 2016 the CON Section approved CON Project ID # J-011198-16 to relocate one OR from Rex Surgery Center of Wakefield back to the hospital's main campus, which is a change in scope to Project I.D. # J-10280-14. The Certificate of Need was issued on September 27, 2016.

3. If the project is not going to be developed exactly as approved, describe all differences between the project as approved and the project as currently proposed. Such changes include, but are not limited to, changes in the:
   a. Site;
   b. Design of the facility;
   c. Number or type of beds to be developed;
   d. Medical equipment to be acquired;
   e. Proposed charges; and
   f. Capital cost of the project.

Response: Not applicable.

4. Pursuant to G.S. 131E-181(d), the Certificate of Need (CON) Section cannot determine that a project is complete **until** *"the health service or the health service facility for which the certificate of need was issued is licensed and certified and in material compliance with the representations made in the certificate of need application."* To document that new or replacement facilities, new or additional beds or dialysis stations, new or replacement equipment or new services have been licensed and certified, provide copies of correspondence from the appropriate section within the Division of Health Service Regulation and the Centers for Medicare and Medicaid Services (CMS).

Response: Not applicable.

B. Timetable

1. Complete the following table. The first column **must** include the timetable dates found on the certificate of need. If the CON Section has authorized an extension of the timetable in writing, you may substitute the dates from that letter.

PROJECT MILESTONES	Projected completion date from certificate Month/day/year	Actual completion date Month/day/year	Proposed completion date* Month/day/year
Completion of Final Drawings and Specifications	3/1/15	Not necessary^	TBD
Approval of Final Drawings and Specifications	6/31/15	Not necessary^	TBD
Contract Award	4/1/16	Not necessary^	
25% Completion of Construction	4/23/16	Not necessary^	
50% Completion of Construction	5/16/16	Not necessary^	
75% Completion of Construction	6/7/16	Not necessary^	
Completion of Construction	6/30/16	Door to be installed by	

		6/30/17	
Occupancy/Offering of Services	7/1/16		
Licensure of Facility	7/1/16	9/1/2017	
Certification of Facility	7/1/16	9/1/2017	**

**Proposed completion dates are contingent upon CON approval*

^ Note: It has been determined that the only alteration required is the addition of a door in the Central registration area. No drawings and specs are required.
**Note: Estimate for conversion to a stand-alone JV is expected September 2017.

2. If the project is experiencing delays in development, explain in detail the reasons for the delay.

Response: Legal documents have been completed. Subscription Agreement and other agreements should be finalized by the end of this month. The Operations team is working on Policy and Procedure conversion and Life Safety evaluation for the pending inspections. Target conversion date is September 1, 2017. This timing is to account for the necessary State and AAAHC inspections timeframe.

C. Medical Equipment Projects – If the project involves the acquisition of any of the following equipment: 1) major medical equipment as defined in NCGS §131E-176(14o); 2) the specific equipment listed in NCGS §131-176(16); or 3) equipment that creates a diagnostic center as defined in NCGS §131E-176(7a), provide the following information for each piece or unit of equipment: 1) manufacturer; 2) model; 3) serial number; and 4) date acquired.

Response: Not applicable.

D. Capital Expenditure

1. What is the total approved capital cost of the project indicated on the certificate of need? $466,000

2. Complete the table on the following page.
   a. Include all capital costs that have been paid to date as well as those that the applicant(s) are legally obligated to pay.
   b. If you have not already done so, provide copies of all executed contracts, including architect and engineering services (as applicable) and all final purchase orders for medical equipment costing more than $10,000 per unit.
   c. If the project involves renovation or construction, provide copies of the Contractors Application for Payment [AIA G702] with Schedule of Values [AIA G703].

	Capital Expense Since Last Report	Total Cumulative Capital Expenditure
Site Costs		
Purchase price of land		
Closing costs		
Site Inspection and Survey		
Legal fees		
Site preparation costs		
Other site costs (identify)		
Subtotal Site Costs		
Construction Contract		
Cost of materials		
Cost of Labor		
Other (Specify)		
Subtotal Construction Contract		
Miscellaneous Costs		
Building purchase		
Fixed equipment purchase/lease		
Moveable equipment purchase/lease		
Furniture		
Landscaping		
A&E and Consultant fees		$49,538

Financing costs		
Interest during construction		
Other miscellaneous costs		
Subtotal Miscellaneous Costs		**$49,538**
Total		**$49,538**

3. What is the projected remaining capital expenditure required to complete the project? $416,462

4. Will the total actual capital cost of the project exceed 115% of the approved capital expenditure on the certificate of need? If yes, explain the reasons for the difference.

Response: No.

E. CERTIFICATION – The undersigned hereby certifies that the responses to the questions in this progress report and the attached documents are correct to the best of his or her knowledge and belief. In addition, I acknowledge that incomplete progress report forms **will not** be accepted and **must** be resubmitted upon notification from an Agency Project Analyst.

Signature of Officer:
Name and Title of Responsible Officer: Andrew Zukowski, CFO
Telephone Number of Responsible Officer: 919-784-3245

Attachment 1

REX
UNC HEALTH CARE

James T. Hedrick Building
211 Friday Center Drive, Suite G014
Chapel Hill, NC 27517

September 29, 2017

Mr. Michael J. McKillip, Project Analyst
Healthcare Planning & Certificate of Need Section
Division of Health Service Regulation, DHHS
Mail Service Center 2704
Raleigh, NC 27699-2704

Mr. McKillip:

Attached you will find the Progress Report for CON Project I.D. # J-10280-14 and Facility I.D. # 110286. This project involves the conversion of an existing ambulatory surgery center operating under a hospital license to a separately licensed freestanding ambulatory surgical center at the same location.

On August 26, 2016 the CON Section approved CON Project ID # J-011198-16 to relocate one OR from Rex Surgery Center of Wakefield back to the hospital's main campus, which is a change in scope to Project I.D. # J-10280-14. The Certificate of Need was issued on September 27, 2016.

Please call me at 984-974-1243 if you have any questions or require any additional information at this time.

Sincerely,

Dee Jay Zerman

Dee Jay Zerman, System Director
Regulatory Planning
UNC HCS

CERTIFICATE OF NEED
PROGRESS REPORT FORM

County: Wake County
Facility: Rex Hospital, Inc., Rex Surgery Center of Wakefield, LLC
Project I.D. #: J-10280-14
Date of Progress Report: 9/29/2017
Facility I.D. #: 110286
Effective Date of Certificate: 10/21/2014
Project Description: Convert an existing ambulatory surgery center operating under a hospital license to a separately licensed freestanding ambulatory surgical center at the same location

A. Status of the Project

1. Describe in detail the steps taken to complete the project since the CON was issued or since the last progress report was submitted.

Response: Legal documents have been completed. The physicians have requested a time extension on submittal of the Subscription agreements. Target conversion date is now delayed a few months to provide the physicians additional time.

2. Describe any of the previously approved changes which will impact this project: (1) Cost Overruns and/or Changes of Scope (Include the Project I.D. numbers); (2) Material Compliance determinations; and (3) Declaratory Rulings

Response: On August 26, 2016 the CON Section approved CON Project ID # J-011198-16 to relocate one OR from Rex Surgery Center of Wakefield back to the hospital's main campus, which is a change in scope to Project I.D. # J-10280-14. The Certificate of Need was issued on September 27, 2016.

3. If the project is not going to be developed exactly as approved, describe all differences between the project as approved and the project as currently proposed. Such changes include, but are not limited to, changes in the:
   a. Site;
   b. Design of the facility;
   c. Number or type of beds to be developed;
   d. Medical equipment to be acquired;
   e. Proposed charges; and
   f. Capital cost of the project.

Response: Not applicable.

4. Pursuant to G.S. 131E-181(d), the Certificate of Need (CON) Section cannot determine that a project is complete until *"the health service or the health service facility for which the certificate of need was issued is licensed and certified and in material compliance with the representations made in the certificate of need application."* To document that new or replacement facilities, new or additional beds or dialysis stations, new or replacement equipment or new services have been licensed and certified, provide copies of correspondence from the appropriate section within the Division of Health Service Regulation and the Centers for Medicare and Medicaid Services (CMS).

Response: Not applicable.

B. Timetable

1. Complete the following table. The first column must include the timetable dates found on the certificate of need. If the CON Section has authorized an extension of the timetable in writing, you may substitute the dates from that letter.

PROJECT MILESTONES	Projected completion date from certificate	Actual completion date	Proposed completion date*
	Month/day/year	Month/day/year	Month/day/year
Completion of Final Drawings and Specifications	3/1/15	Not necessary^	TBD
Approval of Final Drawings and Specifications	6/31/15	Not necessary^	TBD
Contract Award	4/1/16	Not necessary^	
25% Completion of Construction	4/23/16	Not necessary^	
50% Completion of Construction	5/16/16	Not necessary^	
75% Completion of Construction	6/7/16	Not necessary^	
Completion of Construction	6/30/16	8/11/2017	
Occupancy/Offering of Services	7/1/16	11/30/2017	
Licensure of Facility	7/1/16	11/30/2017	
Certification of Facility	7/1/16	11/30/2017	**

**Proposed completion dates are contingent upon CON approval*

^ Note: It has been determined that the only alteration required is the addition of a door in the Central registration area. No drawings and specs are required for that activity.
**Note: Estimate for conversion to a stand-alone JV is expected during November 2017.

2. If the project is experiencing delays in development, explain in detail the reasons for the delay.

Response: Legal documents have been completed. The physicians have requested a time extension on submittal of the Subscription agreements. Target conversion date is now delayed a few months to provide the physicians additional time.

C. Medical Equipment Projects – If the project involves the acquisition of any of the following equipment: 1) major medical equipment as defined in NCGS §131E-176(14o); 2) the specific equipment listed in NCGS §131-176(16); or 3) equipment that creates a diagnostic center as defined in NCGS §131E-176(7a), provide the following information for each piece or unit of equipment: 1) manufacturer; 2) model; 3) serial number; and 4) date acquired.

Response: Not applicable.

D. Capital Expenditure

1. What is the total approved capital cost of the project indicated on the certificate of need? $466,000

2. Complete the table on the following page.
   a. Include all capital costs that have been paid to date as well as those that the applicant(s) are legally obligated to pay.
   b. If you have not already done so, provide copies of all executed contracts, including architect and engineering services (as applicable) and all final purchase orders for medical equipment costing more than $10,000 per unit.
   c. If the project involves renovation or construction, provide copies of the Contractors Application for Payment [AIA G702] with Schedule of Values [AIA G703].

	Capital Expense Since Last Report	Total Cumulative Capital Expenditure
Site Costs		
Purchase price of land		
Closing costs		
Site Inspection and Survey		
Legal fees		
Site preparation costs		
Other site costs (identify)		
Subtotal Site Costs		
Construction Contract		
Cost of materials		
Cost of Labor		
Other (Specify)		
Subtotal Construction Contract		
Miscellaneous Costs		
Building purchase		
Fixed equipment purchase/lease		
Moveable equipment purchase/lease		
Furniture		
Landscaping		
A&E and Consultant fees		$49,538
Financing costs		
Interest during construction		
Other miscellaneous costs		
Subtotal Miscellaneous Costs		**$49,538**

Total $49,538

3. What is the projected remaining capital expenditure required to complete the project? $416,462

4. Will the total actual capital cost of the project exceed 115% of the approved capital expenditure on the certificate of need? If yes, explain the reasons for the difference.

Response: No.

E. CERTIFICATION – The undersigned hereby certifies that the responses to the questions in this progress report and the attached documents are correct to the best of his or her knowledge and belief. In addition, I acknowledge that incomplete progress report forms **will not** be accepted and **must** be resubmitted upon notification from an Agency Project Analyst.

Signature of Officer:
Name and Title of Responsible Officer: Andrew Zukowski, CFO
Telephone Number of Responsible Officer: 919-784-3245

REX
UNC HEALTH CARE

James T. Hedrick Building
211 Friday Center Drive, Suite G014
Chapel Hill, NC 27517

January 30, 2018

Mr. Michael J. McKillip, Project Analyst
Healthcare Planning & Certificate of Need Section
Division of Health Service Regulation, DHHS
Mail Service Center 2704
Raleigh, NC 27699-2704

Mr. McKillip:

Attached you will find the Progress Report for CON Project I.D. # J-10280-14 and Facility I.D. # 110286. This project involves the conversion of an existing ambulatory surgery center operating under a hospital license to a separately licensed freestanding ambulatory surgical center at the same location.

Please call me at 984-974-1243 if you have any questions or require any additional information at this time.

Sincerely,

Dee Jay Zerman

Dee Jay Zerman, System Director
Regulatory Planning
UNC HCS

CERTIFICATE OF NEED
PROGRESS REPORT FORM

County: Wake County
Facility: Rex Hospital, Inc., Rex Surgery Center of Wakefield, LLC
Project I.D. #: J-10280-14
Project Description: Convert an existing ambulatory surgery center operating under a hospital license to a separately licensed freestanding ambulatory surgical center at the same location

Date of Progress Report: 1/30/2018
Facility I.D. #: 110286
Effective Date of Certificate: 10/21/2014

A. Status of the Project

1. Describe in detail the steps taken to complete the project since the CON was issued or since the last progress report was submitted.

Response: Legal documents have been completed. The physician offering was officially closed on December 28, 2017. The Governing Board of Directors has been formed and the first meeting was held on January 25th to approve policies, member, etc. The application to the State has been mailed. The State will then determine our timing of inspections, licensing, etc. We expect this to all occur within the next 60-90 days.

2. Describe any of the previously approved changes which will impact this project: (1) Cost Overruns and/or Changes of Scope (Include the Project I.D. numbers); (2) Material Compliance determinations; and (3) Declaratory Rulings

Response: On August 26, 2016 the CON Section approved CON Project ID # J-011198-16 to relocate one OR from Rex Surgery Center of Wakefield back to the hospital's main campus, which is a change in scope to Project I.D. # J-10280-14. The Certificate of Need was issued on September 27, 2016.

3. If the project is not going to be developed exactly as approved, describe all differences between the project as approved and the project as currently proposed. Such changes include, but are not limited to, changes in the:
   a. Site;
   b. Design of the facility;
   c. Number or type of beds to be developed;
   d. Medical equipment to be acquired;
   e. Proposed charges; and
   f. Capital cost of the project.

Response: Not applicable.

4. Pursuant to G.S. 131E-181(d), the Certificate of Need (CON) Section cannot determine that a project is complete until *"the health service or the health service facility for which the certificate of need was issued is licensed and certified and in material compliance with the representations made in the certificate of need application."* To document that new or replacement facilities, new or additional beds or dialysis stations, new or replacement equipment or new services have been licensed and certified, provide copies of correspondence from the appropriate section within the Division of Health Service Regulation and the Centers for Medicare and Medicaid Services (CMS).

Response: Not applicable.

B. Timetable

1. Complete the following table. The first column must include the timetable dates found on the certificate of need. If the CON Section has authorized an extension of the timetable in writing, you may substitute the dates from that letter.

PROJECT MILESTONES	Projected completion date from certificate	Actual completion date	Proposed completion date*
	Month/day/year	Month/day/year	Month/day/year
Completion of Final Drawings and Specifications	3/1/15	Not necessary^	TBD
Approval of Final Drawings and Specifications	6/31/15	Not necessary^	TBD
Contract Award	4/1/16	Not necessary^	
25% Completion of Construction	4/23/16	Not necessary^	
50% Completion of Construction	5/16/16	Not necessary^	
75% Completion of Construction	6/7/16	Not necessary^	
Completion of Construction	6/30/16	8/11/2017	
Occupancy/Offering of Services	7/1/16	*Awaiting State*	

Licensure of Facility	7/1/16	*Awaiting State*	
Certification of Facility	7/1/16	*Awaiting State*	**

**Proposed completion dates are contingent upon CON approval*

^ Note: It has been determined that the only alteration required is the addition of a door in the Central registration area. No drawings and specs are required for that activity.
**Note: See response to item A.1 above.

2. If the project is experiencing delays in development, explain in detail the reasons for the delay.

Response: Legal documents have been completed. The physician offering was officially closed on December 28, 2017. The Governing Board of Directors has been formed and the first meeting was held on January 25th to approve policies, member, etc. The application to the State has been mailed. The State will then determine our timing of inspections, licensing, etc. We expect this to all occur within the next 60-90 days.

C. Medical Equipment Projects – If the project involves the acquisition of any of the following equipment: 1) major medical equipment as defined in NCGS §131E-176(14o); 2) the specific equipment listed in NCGS §131-176(16); or 3) equipment that creates a diagnostic center as defined in NCGS §131E-176(7a), provide the following information for each piece or unit of equipment: 1) manufacturer; 2) model; 3) serial number; and 4) date acquired.

Response: Not applicable.

D. Capital Expenditure

1. What is the total approved capital cost of the project indicated on the certificate of need? $466,000

2. Complete the table on the following page.
   a. Include all capital costs that have been paid to date as well as those that the applicant(s) are legally obligated to pay.
   b. If you have not already done so, provide copies of all executed contracts, including architect and engineering services (as applicable) and all final purchase orders for medical equipment costing more than $10,000 per unit.
   c. If the project involves renovation or construction, provide copies of the Contractors Application for Payment [AIA G702] with Schedule of Values [AIA G703].

	Capital Expense Since Last Report	Total Cumulative Capital Expenditure
Site Costs		
Purchase price of land		
Closing costs		
Site Inspection and Survey		
Legal fees		
Site preparation costs		
Other site costs (identify)		
Subtotal Site Costs		
Construction Contract		
Cost of materials		
Cost of Labor		
Other (Specify)		
Subtotal Construction Contract		
Miscellaneous Costs		
Building purchase		
Fixed equipment purchase/lease		
Moveable equipment purchase/lease		
Furniture		
Landscaping		
A&E and Consultant fees	$83,060	$132,599
Financing costs		
Interest during construction		

Other miscellaneous costs		
Subtotal Miscellaneous Costs	**$83,060**	**$132,599**
Total	**$83,060**	**$132,599**

3. What is the projected remaining capital expenditure required to complete the project? Less than $333,401

4. Will the total actual capital cost of the project exceed 115% of the approved capital expenditure on the certificate of need? If yes, explain the reasons for the difference.

Response: No.

E. CERTIFICATION – The undersigned hereby certifies that the responses to the questions in this progress report and the attached documents are correct to the best of his or her knowledge and belief. In addition, I acknowledge that incomplete progress report forms **will not** be accepted and **must** be resubmitted upon notification from an Agency Project Analyst.

Signature of Officer: Andrew K. Zukowski
Name and Title of Responsible Officer Andrew Zukowski, CFO
Telephone Number of Responsible Officer 919-784-3245

Attachment 1

REX
UNC HEALTH CARE

James T. Hedrick Building
211 Friday Center Drive, Suite G014
Chapel Hill, NC 27517

June 1, 2018

Mr. Michael J. McKillip, Project Analyst
Healthcare Planning & Certificate of Need Section
Division of Health Service Regulation, DHHS
Mail Service Center 2704
Raleigh, NC 27699-2704

Mr. McKillip:

Attached you will find the Progress Report for CON Project I.D. # J-10280-14 and Facility I.D. # 110286. This project involves the conversion of an existing ambulatory surgery center operating under a hospital license to a separately licensed freestanding ambulatory surgical center at the same location.

Please call me at 984-974-1243 if you have any questions or require any additional information at this time.

Sincerely,

Dee Jay Zerman

Dee Jay Zerman, System Director
Regulatory Planning
UNC HCS

CERTIFICATE OF NEED
PROGRESS REPORT FORM

County: Wake County
Facility: Rex Hospital, Inc., Rex Surgery Center of Wakefield, LLC
Project I.D. #: J-10280-14
Date of Progress Report: 6/1/2018
Facility I.D. #: 110286
Effective Date of Certificate: 10/21/2014
Project Description: Convert an existing ambulatory surgery center operating under a hospital license to a separately licensed freestanding ambulatory surgical center at the same location

A. Status of the Project

1. Describe in detail the steps taken to complete the project since the CON was issued or since the last progress report was submitted.

Response: Legal documents have been completed. The physician offering was officially closed on December 28, 2017. The Governing Board of Directors has been formed and the first meeting was held on January 25th to approve policies, member, etc.

Fire alarm annunciator panel has been added. DHSR inspection was completed this week and the request for licensure has been submitted. We expect to receive the License at any time now. This will trigger the AAAHC inspection which could occur anytime during the next four weeks. We expect all to be completed within the next 30 days if not sooner.

2. Describe any of the previously approved changes which will impact this project: (1) Cost Overruns and/or Changes of Scope (Include the Project I.D. numbers); (2) Material Compliance determinations; and (3) Declaratory Rulings

Response: On August 26, 2016 the CON Section approved CON Project ID # J-011198-16 to relocate one OR from Rex Surgery Center of Wakefield back to the hospital's main campus, which is a change in scope to Project I.D. # J-10280-14. The Certificate of Need was issued on September 27, 2016.

3. If the project is not going to be developed exactly as approved, describe all differences between the project as approved and the project as currently proposed. Such changes include, but are not limited to, changes in the:
   a. Site;
   b. Design of the facility;
   c. Number or type of beds to be developed;
   d. Medical equipment to be acquired;
   e. Proposed charges; and
   f. Capital cost of the project.

Response: Not applicable.

4. Pursuant to G.S. 131E-181(d), the Certificate of Need (CON) Section cannot determine that a project is complete **until** *"the health service or the health service facility for which the certificate of need was issued is licensed and certified and in material compliance with the representations made in the certificate of need application."* To document that new or replacement facilities, new or additional beds or dialysis stations, new or replacement equipment or new services have been licensed and certified, provide copies of correspondence from the appropriate section within the Division of Health Service Regulation and the Centers for Medicare and Medicaid Services (CMS).

Response: Not applicable.

B. Timetable

1. Complete the following table. The first column **must** include the timetable dates found on the certificate of need. If the CON Section has authorized an extension of the timetable in writing, you may substitute the dates from that letter.

PROJECT MILESTONES	Projected completion date from certificate	Actual completion date	Proposed completion date*
	Month/day/year	Month/day/year	Month/day/year
Completion of Final Drawings and Specifications	3/1/15	Not necessary^	TBD
Approval of Final Drawings and Specifications	6/31/15	Not necessary^	TBD
Contract Award	4/1/16	Not necessary^	
25% Completion of Construction	4/23/16	Not necessary^	
50% Completion of Construction	5/16/16	Not necessary^	
75% Completion of Construction	6/7/16	Not necessary^	

Completion of Construction	6/30/16	8/11/2017	
Occupancy/Offering of Services	7/1/16	*Awaiting State**	
Licensure of Facility	7/1/16	*Awaiting State**	
Certification of Facility	7/1/16	*Awaiting State**	**

* We expect all to be completed within the next 30 days if not sooner.
**Note: See response to item A.1 above.

2. If the project is experiencing delays in development, explain in detail the reasons for the delay.

Response: Legal documents have been completed. The physician offering was officially closed on December 28, 2017. The Governing Board of Directors has been formed and the first meeting was held on January 25th to approve policies, member, etc. Fire alarm annunciator panel has been added. DHSR inspection was completed this week and the request for licensure has been submitted. We expect to receive the License at any time now. This will trigger the AAAHC inspection which could occur anytime during the next four weeks. We expect all to be completed within the next 30 days if not sooner.

C. Medical Equipment Projects – If the project involves the acquisition of any of the following equipment: 1) major medical equipment as defined in NCGS §131E-176(14o); 2) the specific equipment listed in NCGS §131-176(16); or 3) equipment that creates a diagnostic center as defined in NCGS §131E-176(7a), provide the following information for each piece or unit of equipment: 1) manufacturer; 2) model; 3) serial number; and 4) date acquired.

Response: Not applicable.

D. Capital Expenditure

1. What is the total approved capital cost of the project indicated on the certificate of need? $466,000

2. Complete the table on the following page.
   a. Include all capital costs that have been paid to date as well as those that the applicant(s) are legally obligated to pay.
   b. If you have not already done so, provide copies of all executed contracts, including architect and engineering services (as applicable) and all final purchase orders for medical equipment costing more than $10,000 per unit.
   c. If the project involves renovation or construction, provide copies of the Contractors Application for Payment [AIA G702] with Schedule of Values [AIA G703].

	Capital Expense Since Last Report	Total Cumulative Capital Expenditure
Site Costs		
Purchase price of land		
Closing costs		
Site Inspection and Survey		
Legal fees		
Site preparation costs		
Other site costs (identify)		
Subtotal Site Costs		
Construction Contract		
Cost of materials		
Cost of Labor		
Other (Specify)		
Subtotal Construction Contract		
Miscellaneous Costs		
Building purchase		
Fixed equipment purchase/lease		
Moveable equipment purchase/lease		
Furniture		
Landscaping		
A&E and Consultant fees		$132,599
Financing costs		

Interest during construction		
Other miscellaneous costs		
Subtotal Miscellaneous Costs		$132,599
Total		$132,599

3. What is the projected remaining capital expenditure required to complete the project? Less than $333,401

4. Will the total actual capital cost of the project exceed 115% of the approved capital expenditure on the certificate of need? If yes, explain the reasons for the difference.

Response: No.

E. CERTIFICATION – The undersigned hereby certifies that the responses to the questions in this progress report and the attached documents are correct to the best of his or her knowledge and belief. In addition, I acknowledge that incomplete progress report forms **will not** be accepted and **must** be resubmitted upon notification from an Agency Project Analyst.

Signature of Officer:
Name and Title of Responsible Officer: Andrew Zukowski, CFO
Telephone Number of Responsible Officer: 919-784-3245

Attachment 2

REX
UNC HEALTH CARE

James T. Hedrick Building
211 Friday Center Drive, Suite G015
Chapel Hill, NC 27517

June 1, 2014

Michael J. McKillip, Project Analyst
Certificate of Need Section
Division of Health Service Regulation, DHHS
2704 Mail Service Center
Raleigh, NC 27699-2704

Dear Mr. McKillip:

Attached you will find the Progress Report for CON Project I.D. # J-8669-11 and Facility I.D. # 070823. This project involves the development of a new separately licensed hospital in Holly Springs.

Please call me at 919-966-1129 if you have any questions or require any additional information at this time.

Sincerely,

Dee Jay Zerman

Dee Jay Zerman, Director
Regulatory Planning
UNC HCS

CERTIFICATE OF NEED
PROGRESS REPORT FORM

County: Wake County
Facility: Rex Hospital, Inc.
Project I.D. #: J-8669-11
Project Description: Develop a new separately licensed hospital in Holly Springs with no more than 50 licensed general acute care beds, 3 licensed shared ORs, 1 dedicated C-Section OR and 5 unlicensed observation beds

Date of Progress Report: 6/1/2014
Facility I.D. #: 070823
Effective Date of Certificate: 1/22/2014

A. Status of the Project:

1) Describe in **detail** the steps taken to complete the project since the CON was issued or since the last progress report was submitted.

Response: The certificate of need was issued on January 22, 2014. Internal meetings have begun with community relations, strategic planning and construction services.

2) Describe any of the previously approved changes which will impact this project:
   a. Cost Overruns and/or Changes in Scope (Include the Project I.D. numbers);
   b. Material Compliance determinations; and
   c. Declaratory Rulings.

Response: Not applicable.

3) If the project is not going to be developed exactly as proposed in the certificate of need application, describe all differences between the project as proposed in the application and the project as currently proposed. Such changes include, but are not limited to, changes in the:
   a. Design of the facility;
   b. Number or type of beds to be developed;
   c. Medical equipment to be acquired;
   d. Proposed charges; and
   e. Capital cost of the project.

Response: Not applicable.

4) Pursuant to G.S. 131E-181(d), the CON Section cannot determine that a project is complete **until** *"the health service or the health service facility for which the certificate of need was issued is licensed and certified and in material compliance with the representations made in the certificate of need application."* To document that new or replacement facilities, new or additional beds, new or replacement equipment or new services have been licensed and certified, provide copies of correspondence from the appropriate section within the Division of Health Service Regulation and the Centers for Medicare and Medicaid Services (CMS).

Response: Not applicable.

B. Timetable

1. Complete the following. The first column **must** include the timetable dates found on the certificate of need. If the CON Section has authorized an extension of the timetable in writing, you may substitute the dates from that letter.

PROJECT MILESTONES	Projected completion date from certificate	Actual completion date	Proposed completion date*
	Month/day/year	Month/day/year	Month/day/year
Completion of Final Drawings	12/1/14		
Site Approval	4/1/15		
25% Completion of construction	10/1/15		

50% Completion of construction	2/6/16		
75% Completion of construction	8/1/16		
Completion of construction	12/1/16		
Occupancy/Offering of Services	2/1/17		

**Proposed completion dates are contingent upon CON approval*

2. If the project is experiencing significant delays in development, explain the reasons for the delay.

Response: Not applicable.

C. Medical Equipment Projects – If the project involves the acquisition of any of the following equipment: 1) major medical equipment as defined in NCGS §131E-176(14f); 2) the specific equipment listed in NCGS §131-176(16); 3) equipment that creates an oncology treatment center as defined in NCGS §131-176(18a); or 4) equipment that creates a diagnostic center as defined in NCGS §131E-176(7a), provide the following information for each piece or unit of equipment: 1) Manufacturer; 2) Model; 3) Serial Number; and 4) Date acquired.

Response: Not yet applicable.

D. Capital Expenditure

1. What is the total approved capital cost of the project indicated on the certificate of need?

Response: $171,616,236

2. Complete the table on the following page.
   a. Include all capital costs that have been paid to date as well as those that the applicant(s) are legally obligated to pay.
   b. If you have not already done so, provide copies of the executed construction contracts, including the one for architect and engineering services (as applicable) and all final purchase orders for medical equipment costing more than $10,000/unit.
   c. If the project involves renovation or construction, provide copies of the Contractors Application for Payment [AIA G702] with Schedule of Values [AIA G703].

	Capital Expense Since Last Report	**Total Cumulative Capital Expenditure**
Site Costs		
Purchase price of land		
Closing costs		
Site inspection and survey		
Legal fees		
Site preparation costs		
Other site costs (identify)		
Subtotal Site Costs	**$0**	**$0**
Construction Costs		
Cost of materials		
Cost of labor		
Other (construction contract)		
Subtotal Construction Contract	**$0**	**$0**
Miscellaneous Costs		
Building Purchase		
Fixed equipment purchase/lease		
Moveable equipment purchase/lease		
Furniture		
Landscaping		
Consultant fees	$235,928.79	$235,928.79

Financing costs		
Interest during construction		
Other miscellaneous costs (legal fees)	$460,203.44	$460,203.44
Subtotal Miscellaneous Costs	**$696,132.23**	**$696,132.23**
Total	**$696,132.23**	**$696,132.23**

3. What do you project to be the remaining capital expenditure required to complete the project?

Response: $170,920,103.77

4. Will the total actual capital cost of the project exceed 115% of the approved capital expenditure on the certificate of need? If yes, explain the reasons for the difference.

Response: No.

E. CERTIFICATION – The undersigned hereby certifies that the responses to the questions in this progress report and the attached documents are correct to the best of his or her knowledge and belief.

Signature of Officer: Bernadette M Spong

Name and Title of Responsible Officer: Bernadette Spong, CFO

Telephone Number of Responsible Officer: 919-784-3245

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

Pat McCrory
Governor

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

Drexdal Pratt
Division Director

June 6, 2014

Dee Jay Zerman
211 Friday Center Drive, Suite G015
Chapel Hill, NC 27517

Acknowledgement of Receipt of Progress Report and Next Progress Report Due

Project I.D. #:	J-8669-11
Facility:	Rex Healthcare of Holly Springs
Project Description:	Develop a new separately licensed 50-bed hospital in Holly Springs
County:	Wake
FID #:	070823

Dear Ms. Zerman:

Thank you for your progress report dated June 1, 2014 on the above referenced project. Your next progress report will be due no later than September 1, 2014.

Please notify the Project Analyst as soon as possible if:

1. Development of the project may be delayed by more than three months; and/or
2. The total capital expenditure may exceed more than 115 percent of the approved capital expenditure.

The certificate of need holder must submit a written request for a timetable extension and the request must be approved by the Certificate of Need Section. If the total capital expenditure will exceed 115 percent of the approved capital expenditure, a new certificate of need will be required for the cost overrun.

Please do not hesitate to contact me if you have any questions regarding this project.

Please refer to the Project I.D.# and Facility I.D.# (FID) in all correspondence.

Sincerely,

Michael J. McKillip, Project Analyst
Certificate of Need Section

Attachment

Certificate of Need Section
www.ncdhhs.gov
Telephone: 919-855-3873 • Fax: 919-733-8139
Location: Edgerton Building • 809 Ruggles Drive • Raleigh, NC 27603
Mailing Address: 2704 Mail Service Center •Raleigh, NC 27699-2704
An Equal Opportunity/ Affirmative Action Employer

Attachment 2

REX
UNC HEALTH CARE

James T. Hedrick Building
211 Friday Center Drive, Suite G015
Chapel Hill, NC 27517

September 2, 2014

Michael J. McKillip, Project Analyst
Certificate of Need Section
Division of Health Service Regulation, DHHS
2704 Mail Service Center
Raleigh, NC 27699-2704

Dear Mr. McKillip:

Attached you will find the Progress Report for CON Project I.D. # J-8669-11 and Facility I.D. # 070823. This project involves the development of a new separately licensed hospital in Holly Springs.

Please call me at my new telephone number 984-974-1210 if you have any questions or require any additional information at this time.

Sincerely,

Dee Jay Zerman

Dee Jay Zerman, Director
Regulatory Planning
UNC HCS

CERTIFICATE OF NEED
PROGRESS REPORT FORM

County: Wake County
Facility: Rex Hospital, Inc.
Project I.D. #: J-8669-11
Project Description: Develop a new separately licensed hospital in Holly Springs with no more than 50 licensed general acute care beds, 3 licensed shared ORs, 1 dedicated C-Section OR and 5 unlicensed observation beds

Date of Progress Report: 9/2/2014
Facility I.D. #: 070823
Effective Date of Certificate: 1/22/2014

A. Status of the Project:

1) Describe in **detail** the steps taken to complete the project since the CON was issued or since the last progress report was submitted.

Response: The certificate of need was issued on January 22, 2014. Internal meetings have begun with community relations, strategic planning and construction services.

2) Describe any of the previously approved changes which will impact this project:
   a. Cost Overruns and/or Changes in Scope (Include the Project I.D. numbers);
   b. Material Compliance determinations; and
   c. Declaratory Rulings.

Response: Not applicable.

3) If the project is not going to be developed exactly as proposed in the certificate of need application, describe all differences between the project as proposed in the application and the project as currently proposed. Such changes include, but are not limited to, changes in the:
   a. Design of the facility;
   b. Number or type of beds to be developed;
   c. Medical equipment to be acquired;
   d. Proposed charges; and
   e. Capital cost of the project.

Response: Not applicable.

4) Pursuant to G.S. 131E-181(d), the CON Section cannot determine that a project is complete **until** *"the health service or the health service facility for which the certificate of need was issued is licensed and certified and in material compliance with the representations made in the certificate of need application."* To document that new or replacement facilities, new or additional beds, new or replacement equipment or new services have been licensed and certified, provide copies of correspondence from the appropriate section within the Division of Health Service Regulation and the Centers for Medicare and Medicaid Services (CMS).

Response: Not applicable.

B. Timetable

1. Complete the following. The first column **must** include the timetable dates found on the certificate of need. If the CON Section has authorized an extension of the timetable in writing, you may substitute the dates from that letter.

PROJECT MILESTONES	Projected completion date from certificate	Actual completion date	Proposed completion date*
	Month/day/year	Month/day/year	Month/day/year
Completion of Final Drawings	12/1/14		
Site Approval	4/1/15		
25% Completion of construction	10/1/15		

50% Completion of construction	2/6/16		
75% Completion of construction	8/1/16		
Completion of construction	12/1/16		
Occupancy/Offering of Services	2/1/17		

**Proposed completion dates are contingent upon CON approval*

2. If the project is experiencing significant delays in development, explain the reasons for the delay.

Response: Not applicable.

C. Medical Equipment Projects – If the project involves the acquisition of any of the following equipment: 1) major medical equipment as defined in NCGS §131E-176(14f); 2) the specific equipment listed in NCGS §131-176(16); 3) equipment that creates an oncology treatment center as defined in NCGS §131-176(18a); or 4) equipment that creates a diagnostic center as defined in NCGS §131E-176(7a), provide the following information for each piece or unit of equipment: 1) Manufacturer; 2) Model; 3) Serial Number; and 4) Date acquired.

Response: Not yet applicable.

D. Capital Expenditure

1. What is the total approved capital cost of the project indicated on the certificate of need?

Response: $171,616,236

2. Complete the table on the following page.
   a. Include all capital costs that have been paid to date as well as those that the applicant(s) are legally obligated to pay.
   b. If you have not already done so, provide copies of the executed construction contracts, including the one for architect and engineering services (as applicable) and all final purchase orders for medical equipment costing more than $10,000/unit.
   c. If the project involves renovation or construction, provide copies of the Contractors Application for Payment [AIA G702] with Schedule of Values [AIA G703].

	Capital Expense Since Last Report	**Total Cumulative Capital Expenditure**
Site Costs		
Purchase price of land		
Closing costs		
Site inspection and survey		
Legal fees		
Site preparation costs		
Other site costs (identify)		
Subtotal Site Costs	**$0**	**$0**
Construction Costs		
Cost of materials		
Cost of labor		
Other (construction contract)		
Subtotal Construction Contract	**$0**	**$0**
Miscellaneous Costs		
Building Purchase		
Fixed equipment purchase/lease		
Moveable equipment purchase/lease		
Furniture		
Landscaping		
Consultant fees		$235,928.79

Financing costs		
Interest during construction		
Other miscellaneous costs (legal fees)		$460,203.44
Subtotal Miscellaneous Costs	**$0**	**$696,132.23**
Total	**$0**	**$696,132.23**

3. What do you project to be the remaining capital expenditure required to complete the project?

Response: $170,920,103.77

4. Will the total actual capital cost of the project exceed 115% of the approved capital expenditure on the certificate of need? If yes, explain the reasons for the difference.

Response: No.

E. CERTIFICATION – The undersigned hereby certifies that the responses to the questions in this progress report and the attached documents are correct to the best of his or her knowledge and belief.

Signature of Officer:
Name and Title of Responsible Officer: Bernadette Spong, CFO
Telephone Number of Responsible Officer: 919-784-3245

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

Pat McCrory
Governor

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

Drexdal Pratt
Division Director

September 9, 2014

Dee Jay Zerman
211 Friday Center Drive, Suite G015
Chapel Hill, NC 27517

Acknowledgement of Receipt of Progress Report and Next Progress Report Due

Project I.D. #:	J-8669-11
Facility:	Rex Healthcare of Holly Springs
Project Description:	Develop a new separately licensed 50-bed hospital in Holly Springs
County:	Wake
FID #:	070823

Dear Ms. Zerman:

Thank you for your progress report dated September 2, 2014 on the above referenced project. Your next progress report will be due no later than December 1, 2014.

Please notify the Project Analyst as soon as possible if:

1. Development of the project may be delayed by more than three months; and/or
2. The total capital expenditure may exceed more than 115 percent of the approved capital expenditure.

The certificate of need holder must submit a written request for a timetable extension and the request must be approved by the Certificate of Need Section. If the total capital expenditure will exceed 115 percent of the approved capital expenditure, a new certificate of need will be required for the cost overrun.

Please do not hesitate to contact me if you have any questions regarding this project.

Please refer to the Project I.D. # and Facility I.D. # (FID) in all correspondence.

Sincerely,

Michael McKillip, Project Analyst
Certificate of Need Section

Attachment

Certificate of Need Section
www.ncdhhs.gov
Telephone: 919-855-3873 • Fax: 919-733-8139
Location: Edgerton Building • 809 Ruggles Drive • Raleigh, NC 27603
Mailing Address: 2704 Mail Service Center •Raleigh, NC 27699-2704
An Equal Opportunity/ Affirmative Action Employer

Attachment 2

REX
UNC HEALTH CARE

James T. Hedrick Building
211 Friday Center Drive, Suite G015
Chapel Hill, NC 27517

December 1, 2014

Michael J. McKillip, Project Analyst
Certificate of Need Section
Division of Health Service Regulation, DHHS
2704 Mail Service Center
Raleigh, NC 27699-2704

Dear Mr. McKillip:

Attached you will find the Progress Report for CON Project I.D. # J-8669-11 and Facility I.D. # 070823. This project involves the development of a new separately licensed hospital in Holly Springs.

Please call me at my new telephone number 984-974-1210 if you have any questions or require any additional information at this time.

Sincerely,

Dee Jay Zerman

Dee Jay Zerman, Director
Regulatory Planning
UNC HCS

CERTIFICATE OF NEED
PROGRESS REPORT FORM

County: Wake County
Facility: Rex Hospital, Inc.
Project I.D. #: J-8669-11
Project Description: Develop a new separately licensed hospital in Holly Springs with no more than 50 licensed general acute care beds, 3 licensed shared ORs, 1 dedicated C-Section OR and 5 unlicensed observation beds

Date of Progress Report: December 1, 2014
Facility I.D. #: 070823
Effective Date of Certificate: 1/22/2014

A. Status of the Project:

1) Describe in **detail** the steps taken to complete the project since the CON was issued or since the last progress report was submitted.

Response: The certificate of need was issued on January 22, 2014. Internal meetings continue regarding community relations, strategic planning and construction services.

2) Describe any of the previously approved changes which will impact this project:
   a. Cost Overruns and/or Changes in Scope (Include the Project I.D. numbers);
   b. Material Compliance determinations; and
   c. Declaratory Rulings.

Response: Not applicable.

3) If the project is not going to be developed exactly as proposed in the certificate of need application, describe all differences between the project as proposed in the application and the project as currently proposed. Such changes include, but are not limited to, changes in the:
   a. Design of the facility;
   b. Number or type of beds to be developed;
   c. Medical equipment to be acquired;
   d. Proposed charges; and
   e. Capital cost of the project.

Response: Not applicable.

4) Pursuant to G.S. 131E-181(d), the CON Section cannot determine that a project is complete **until** *"the health service or the health service facility for which the certificate of need was issued is licensed and certified and in material compliance with the representations made in the certificate of need application."* To document that new or replacement facilities, new or additional beds, new or replacement equipment or new services have been licensed and certified, provide copies of correspondence from the appropriate section within the Division of Health Service Regulation and the Centers for Medicare and Medicaid Services (CMS).

Response: Not applicable.

B. Timetable

1. Complete the following. The first column **must** include the timetable dates found on the certificate of need. If the CON Section has authorized an extension of the timetable in writing, you may substitute the dates from that letter.

PROJECT MILESTONES	Projected completion date from certificate	Actual completion date	Proposed completion date*
	Month/day/year	Month/day/year	Month/day/year
Completion of Final Drawings	12/1/14		
Site Approval	4/1/15		
25% Completion of construction	10/1/15		

Attachment 2

50% Completion of construction	2/6/16		
75% Completion of construction	8/1/16		
Completion of construction	12/1/16		
Occupancy/Offering of Services	2/1/17		

**Proposed completion dates are contingent upon CON approval*

2. If the project is experiencing significant delays in development, explain the reasons for the delay.

Response: Not applicable.

C. Medical Equipment Projects – If the project involves the acquisition of any of the following equipment: 1) major medical equipment as defined in NCGS §131E-176(14f); 2) the specific equipment listed in NCGS §131-176(16); 3) equipment that creates an oncology treatment center as defined in NCGS §131-176(18a); or 4) equipment that creates a diagnostic center as defined in NCGS §131E-176(7a), provide the following information for each piece or unit of equipment: 1) Manufacturer; 2) Model; 3) Serial Number; and 4) Date acquired.

Response: Not yet applicable.

D. Capital Expenditure

1. What is the total approved capital cost of the project indicated on the certificate of need?

Response: $171,616,236

2. Complete the table on the following page.
   a. Include all capital costs that have been paid to date as well as those that the applicant(s) are legally obligated to pay.
   b. If you have not already done so, provide copies of the executed construction contracts, including the one for architect and engineering services (as applicable) and all final purchase orders for medical equipment costing more than $10,000/unit.
   c. If the project involves renovation or construction, provide copies of the Contractors Application for Payment [AIA G702] with Schedule of Values [AIA G703].

	Capital Expense Since Last Report	**Total Cumulative Capital Expenditure**
Site Costs		
Purchase price of land		
Closing costs		
Site inspection and survey		
Legal fees		
Site preparation costs		
Other site costs (identify)		
Subtotal Site Costs	**$0**	**$0**
Construction Costs		
Cost of materials		
Cost of labor		
Other (construction contract)		
Subtotal Construction Contract	**$0**	**$0**
Miscellaneous Costs		
Building Purchase		
Fixed equipment purchase/lease		
Moveable equipment purchase/lease		
Furniture		
Landscaping		
Consultant fees		$235,928.79

Financing costs		
Interest during construction		
Other miscellaneous costs (legal fees)		$460,203.44
Subtotal Miscellaneous Costs	**$0**	**$696,132.23**
Total	**$0**	**$696,132.23**

3. What do you project to be the remaining capital expenditure required to complete the project?

Response: $170,920,103.77

4. Will the total actual capital cost of the project exceed 115% of the approved capital expenditure on the certificate of need? If yes, explain the reasons for the difference.

Response: No.

E. CERTIFICATION – The undersigned hereby certifies that the responses to the questions in this progress report and the attached documents are correct to the best of his or her knowledge and belief.

Signature of Officer:
Name and Title of Responsible Officer: Bernadette Spong, CFO
Telephone Number of Responsible Officer: 919-784-3245

Attachment 2

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

Pat McCrory
Governor

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

Drexdal Pratt
Division Director

December 29, 2014

Dee Jay Zerman
211 Friday Center Drive, Suite G015
Chapel Hill, NC 27517

Acknowledgement of Receipt of Progress Report and Next Progress Report Due

Project I.D. #:	J-8669-11
Facility:	Rex Healthcare of Holly Springs
Project Description:	Develop a new separately licensed 50-bed hospital in Holly Springs
County:	Wake
FID #:	070823

Dear Ms. Zerman:

Thank you for your progress report dated **December 1, 2014** on the above referenced project. Your next progress report will be due no later than **April 1, 2015**.

Please notify the Project Analyst as soon as possible if:

1. Development of the project may be delayed by more than three months; and/or
2. The total capital expenditure may exceed more than 115 percent of the approved capital expenditure.

The certificate of need holder must submit a written request for a timetable extension and the request must be approved by the Certificate of Need Section. If the total capital expenditure will exceed 115 percent of the approved capital expenditure, a new certificate of need will be required for the cost overrun.

Please do not hesitate to contact me if you have any questions regarding this project.

Please refer to the Project I.D. # and Facility I.D. # (FID) in all correspondence.

Sincerely,

Michael McKillip, Project Analyst
Certificate of Need Section

Attachment

Certificate of Need Section
www.ncdhhs.gov
Telephone: 919-855-3873 • Fax: 919-733-8139
Location: Edgerton Building • 809 Ruggles Drive • Raleigh, NC 27603
Mailing Address: 2704 Mail Service Center •Raleigh, NC 27699-2704
An Equal Opportunity/ Affirmative Action Employer

REX
UNC HEALTH CARE

James T. Hedrick Building
211 Friday Center Drive, Suite G015
Chapel Hill, NC 27517

March 31, 2015

Michael J. McKillip, Project Analyst
Certificate of Need Section
Division of Health Service Regulation, DHHS
2704 Mail Service Center
Raleigh, NC 27699-2704

Dear Mr. McKillip:

Attached you will find the Progress Report for CON Project I.D. # J-8669-11 and Facility I.D. # 070823. This project involves the development of a new separately licensed hospital in Holly Springs.

Please call me at 984-974-1210 if you have any questions or require any additional information at this time.

Sincerely,

Dee Jay Zerman

Dee Jay Zerman, Director
Regulatory Planning
UNC HCS

CERTIFICATE OF NEED
PROGRESS REPORT FORM

County: Wake County
Facility: Rex Hospital, Inc.
Project I.D. #: J-8669-11
Date of Progress Report: March 31, 2015
Facility I.D. #: 070823
Effective Date of Certificate: 1/22/2014
Project Description: Develop a new separately licensed hospital in Holly Springs with no more than 50 licensed general acute care beds, 3 licensed shared ORs, 1 dedicated C-Section OR and 5 unlicensed observation beds

A. Status of the Project:

1) Describe in **detail** the steps taken to complete the project since the CON was issued or since the last progress report was submitted.

Response: The certificate of need was issued on January 22, 2014. Internal meetings continue regarding community relations, strategic planning and construction services.

2) Describe any of the previously approved changes which will impact this project:
   a. Cost Overruns and/or Changes in Scope (Include the Project I.D. numbers);
   b. Material Compliance determinations; and
   c. Declaratory Rulings.

Response: Not applicable.

3) If the project is not going to be developed exactly as proposed in the certificate of need application, describe all differences between the project as proposed in the application and the project as currently proposed. Such changes include, but are not limited to, changes in the:
   a. Design of the facility;
   b. Number or type of beds to be developed;
   c. Medical equipment to be acquired;
   d. Proposed charges; and
   e. Capital cost of the project.

Response: Not applicable.

4) Pursuant to G.S. 131E-181(d), the CON Section cannot determine that a project is complete **until** *"the health service or the health service facility for which the certificate of need was issued is licensed and certified and in material compliance with the representations made in the certificate of need application."* To document that new or replacement facilities, new or additional beds, new or replacement equipment or new services have been licensed and certified, provide copies of correspondence from the appropriate section within the Division of Health Service Regulation and the Centers for Medicare and Medicaid Services (CMS).

Response: Not applicable.

B. Timetable

1. Complete the following. The first column **must** include the timetable dates found on the certificate of need. If the CON Section has authorized an extension of the timetable in writing, you may substitute the dates from that letter.

PROJECT MILESTONES	Projected completion date from certificate	Actual completion date	Proposed completion date*
	Month/day/year	Month/day/year	Month/day/year
Completion of Final Drawings	12/1/14		
Site Approval	4/1/15		
25% Completion of construction	10/1/15		

50% Completion of construction	2/6/16		
75% Completion of construction	8/1/16		
Completion of construction	12/1/16		
Occupancy/Offering of Services	2/1/17		

**Proposed completion dates are contingent upon CON approval*

2. If the project is experiencing significant delays in development, explain the reasons for the delay.

Response: Internal meetings continue regarding community relations, strategic planning and construction services. Once complete a revised timetable can be projected.

C. Medical Equipment Projects – If the project involves the acquisition of any of the following equipment: 1) major medical equipment as defined in NCGS §131E-176(14f); 2) the specific equipment listed in NCGS §131-176(16); 3) equipment that creates an oncology treatment center as defined in NCGS §131-176(18a); or 4) equipment that creates a diagnostic center as defined in NCGS §131E-176(7a), provide the following information for each piece or unit of equipment: 1) Manufacturer; 2) Model; 3) Serial Number; and 4) Date acquired.

Response: Not yet applicable.

D. Capital Expenditure

1. What is the total approved capital cost of the project indicated on the certificate of need?

Response: $171,616,236

2. Complete the table on the following page.
   a. Include all capital costs that have been paid to date as well as those that the applicant(s) are legally obligated to pay.
   b. If you have not already done so, provide copies of the executed construction contracts, including the one for architect and engineering services (as applicable) and all final purchase orders for medical equipment costing more than $10,000/unit.
   c. If the project involves renovation or construction, provide copies of the Contractors Application for Payment [AIA G702] with Schedule of Values [AIA G703].

	Capital Expense Since Last Report	**Total Cumulative Capital Expenditure**
Site Costs		
Purchase price of land	_____	_____
Closing costs	_____	_____
Site inspection and survey	_____	_____
Legal fees	_____	_____
Site preparation costs	_____	_____
Other site costs (identify)	_____	_____
Subtotal Site Costs	**$0**	**$0**
Construction Costs		
Cost of materials	_____	_____
Cost of labor	_____	_____
Other (construction contract)	_____	_____
Subtotal Construction Contract	**$0**	**$0**
Miscellaneous Costs		
Building Purchase	_____	_____
Fixed equipment purchase/lease	_____	_____
Moveable equipment purchase/lease	_____	_____
Furniture	_____	_____
Landscaping	_____	_____

Consultant fees		$235,928.79
Financing costs		
Interest during construction		
Other miscellaneous costs (legal fees)		$460,203.44
Subtotal Miscellaneous Costs	**$0**	**$696,132.23**
Total	**$0**	**$696,132.23**

3. What do you project to be the remaining capital expenditure required to complete the project?

Response: $170,920,103.77

4. Will the total actual capital cost of the project exceed 115% of the approved capital expenditure on the certificate of need? If yes, explain the reasons for the difference.

Response: No.

E. CERTIFICATION – The undersigned hereby certifies that the responses to the questions in this progress report and the attached documents are correct to the best of his or her knowledge and belief.

Signature of Officer: Bernadette M Spong
Name and Title of Responsible Officer: Bernadette Spong, CFO
Telephone Number of Responsible Officer: 919-784-3245

Attachment 2

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

Pat McCrory
Governor

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

Drexdal Pratt
Division Director

April 2, 2015

Dee Jay Zerman
211 Friday Center Drive, Suite G015
Chapel Hill, NC 27517

Acknowledgement of Receipt of Progress Report and Next Progress Report Due

Project I.D. #:	J-8669-11
Facility:	Rex Healthcare of Holly Springs
Project Description:	Develop a new separately licensed 50-bed hospital in Holly Springs
County:	Wake
FID #:	070823

Dear Ms. Zerman:

Thank you for your progress report dated **March 31, 2015** on the above referenced project. Your next progress report will be due no later than **July 1, 2015**.

Please notify the Project Analyst as soon as possible if:

1. Development of the project may be delayed by more than three months; and/or
2. The total capital expenditure may exceed more than 115 percent of the approved capital expenditure.

The certificate of need holder must submit a written request for a timetable extension and the request must be approved by the Certificate of Need Section. If the total capital expenditure will exceed 115 percent of the approved capital expenditure, a new certificate of need will be required for the cost overrun.

Please do not hesitate to contact me if you have any questions regarding this project.

Please refer to the Project I.D. # and Facility I.D. # (FID) in all correspondence.

Sincerely,

Michael McKillip, Project Analyst
Certificate of Need Section

Attachment

Certificate of Need Section
www.ncdhhs.gov
Telephone: 919-855-3873 • Fax: 919-733-8139
Location: Edgerton Building • 809 Ruggles Drive • Raleigh, NC 27603
Mailing Address: 2704 Mail Service Center •Raleigh, NC 27699-2704
An Equal Opportunity/ Affirmative Action Employer

REX
UNC HEALTH CARE

James T. Hedrick Building
211 Friday Center Drive, Suite G015
Chapel Hill, NC 27517

July 9, 2015

Michael J. McKillip, Project Analyst
Certificate of Need Section
Division of Health Service Regulation, DHHS
2704 Mail Service Center
Raleigh, NC 27699-2704

Dear Mr. McKillip:

Attached you will find the Progress Report for CON Project I.D. # J-8669-11 and Facility I.D. # 070823. This project involves the development of a new separately licensed hospital in Holly Springs.

Please call me at 984-974-1210 if you have any questions or require any additional information at this time.

Sincerely,

Dee Jay Zerman

Dee Jay Zerman, Director
Regulatory Planning
UNC HCS

CERTIFICATE OF NEED
PROGRESS REPORT FORM

County: Wake County
Facility: Rex Hospital, Inc.
Project I.D. #: J-8669-11
Date of Progress Report: 7/9/2015
Facility I.D. #: 070823
Effective Date of Certificate: 1/22/2014
Project Description: Develop a new separately licensed hospital in Holly Springs with no more than 50 licensed general acute care beds, 3 licensed shared ORs, 1 dedicated C-Section OR and 5 unlicensed observation beds

A. Status of the Project

1. Describe in detail the steps taken to complete the project since the CON was issued or since the last progress report was submitted.

Response: The certificate of need was issued on January 22, 2014. Internal meetings continue regarding community relations, strategic planning and construction services.

2. Describe any of the previously approved changes which will impact this project:
   1. Cost Overruns and/or Changes of Scope (Include the Project I.D. numbers);
   2. Material Compliance determinations; and
   3. Declaratory Rulings

Response: Not applicable.

3. If the project is not going to be developed exactly as approved, describe all differences between the project as approved and the project as currently proposed. Such changes include, but are not limited to, changes in the:
   a. Site;
   b. Design of the facility;
   c. Number or type of beds to be developed;
   d. Medical equipment to be acquired;
   e. Proposed charges; and
   f. Capital cost of the project.

Response: Not applicable.

4. Pursuant to G.S. 131E-181(d), the Certificate of Need (CON) Section cannot determine that a project is complete **until** *"the health service or the health service facility for which the certificate of need was issued is licensed and certified and in material compliance with the representations made in the certificate of need application."* To document that new or replacement facilities, new or additional beds or dialysis stations, new or replacement equipment or new services have been licensed and certified, provide copies of correspondence from the appropriate section within the Division of Health Service Regulation and the Centers for Medicare and Medicaid Services (CMS).

Response: Not applicable.

B. Timetable

1. Complete the following table. The first column **must** include the timetable dates found on the certificate of need. If the CON Section has authorized an extension of the timetable in writing, you may substitute the dates from that letter.

PROJECT MILESTONES	Projected completion date from certificate	Actual completion date	Proposed completion date*
	Month/day/year	Month/day/year	Month/day/year
Completion of Final Drawings	12/1/14		
Site Approval	4/1/15		
25% Completion of construction	10/1/15		
50% Completion of construction	2/6/16		
75% Completion of construction	8/1/16		
Completion of construction	12/1/16		
Occupancy/Offering of Services	2/1/17		

**Proposed completion dates are contingent upon CON approval*

2. If the project is experiencing delays in development, explain in detail the reasons for the delay.

Response: Internal meetings continue regarding community relations, strategic planning and construction services. Once complete a revised timetable can be projected.

C. Medical Equipment Projects – If the project involves the acquisition of any of the following equipment: 1) major medical equipment as defined in NCGS §131E-176(14o); 2) the specific equipment listed in NCGS §131-176(16); or 3) equipment that creates a diagnostic center as defined in NCGS §131E-176(7a), provide the following information for each piece or unit of equipment: 1) manufacturer; 2) model; 3) serial number; and 4) date acquired.

Response: Not applicable.

D. Capital Expenditure

1. What is the total approved capital cost of the project indicated on the certificate of need? $171,616,236

2. Complete the table on the following page.
   a. Include all capital costs that have been paid to date as well as those that the applicant(s) are legally obligated to pay.
   b. If you have not already done so, provide copies of all executed contracts, including architect and engineering services (as applicable) and all final purchase orders for medical equipment costing more than $10,000 per unit.
   c. If the project involves renovation or construction, provide copies of the Contractors Application for Payment [AIA G702] with Schedule of Values [AIA G703].

	Capital Expense Since Last Report	Total Cumulative Capital Expenditure
Site Costs		
Purchase price of land		
Closing costs		
Site Inspection and Survey		
Legal fees		
Site preparation costs		
Other site costs (identify)		
Subtotal Site Costs	**$0**	**$0**
Construction Contract		
Cost of materials		
Cost of Labor		
Other (Specify)		
Subtotal Construction Contract	**$0**	**$0**
Miscellaneous Costs		
Building purchase		
Fixed equipment purchase/lease		
Moveable equipment purchase/lease		
Furniture		
Landscaping		
Consultant fees		$235,928.79
Financing costs		
Interest during construction		
Other miscellaneous costs (Legal fees)		$460,203.44
Subtotal Miscellaneous Costs	**$0**	**$696,132.23**
Total	**$0**	**$696,132.23**

3. What is the projected remaining capital expenditure required to complete the project? $170,920,103.77

4. Will the total actual capital cost of the project exceed 115% of the approved capital expenditure on the certificate of need? If yes, explain the reasons for the difference.

Response: No.

E. CERTIFICATION – The undersigned hereby certifies that the responses to the questions in this progress report and the attached

documents are correct to the best of his or her knowledge and belief. In addition, I acknowledge that incomplete progress report forms **will not** be accepted and **must** be resubmitted upon notification from an Agency Project Analyst.

Signature of Officer:
Name and Title of Responsible Officer Bernadette Spong, CFO
Telephone Number of Responsible Officer 919-784-3245

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

Pat McCrory
Governor

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

Drexdal Pratt
Division Director

August 3, 2015

Dee Jay Zerman
211 Friday Center Drive, Suite G015
Chapel Hill, NC 27517

Acknowledgement of Receipt of Progress Report and Next Progress Report Due

Project I.D. #:	J-8669-11
Facility:	Rex Healthcare of Holly Springs
Project Description:	Develop a new separately licensed 50-bed hospital in Holly Springs
County:	Wake
FID #:	070823

Dear Ms. Zerman:

Thank you for your progress report dated **July 9, 2015** on the above referenced project. Your next progress report will be due no later than **November 1, 2015**.

Please notify the Project Analyst as soon as possible if:

1. Development of the project may be delayed by more than three months; and/or
2. The total capital expenditure may exceed more than 115 percent of the approved capital expenditure.

The certificate of need holder must submit a written request for a timetable extension and the request must be approved by the Certificate of Need Section. If the total capital expenditure will exceed 115 percent of the approved capital expenditure, a new certificate of need will be required for the cost overrun.

Please do not hesitate to contact me if you have any questions regarding this project.

Please refer to the Project I.D. # and Facility I.D. # (FID) in all correspondence.

Sincerely,

Michael McKillip, Project Analyst
Certificate of Need Section

Attachment

Certificate of Need Section
www.ncdhhs.gov
Telephone: 919-855-3873 • Fax: 919-733-8139
Location: Edgerton Building • 809 Ruggles Drive • Raleigh, NC 27603
Mailing Address: 2704 Mail Service Center •Raleigh, NC 27699-2704
An Equal Opportunity/ Affirmative Action Employer

Attachment 2

REX
UNC HEALTH CARE

James T. Hedrick Building
211 Friday Center Drive, Suite G015
Chapel Hill, NC 27517

October 30, 2015

Michael J. McKillip, Project Analyst
Certificate of Need Section
Division of Health Service Regulation, DHHS
2704 Mail Service Center
Raleigh, NC 27699-2704

Dear Mr. McKillip:

Attached you will find the Progress Report for CON Project I.D. # J-8669-11 and Facility I.D. # 070823. This project involves the development of a new separately licensed hospital in Holly Springs.

Please call me at 984-974-1210 if you have any questions or require any additional information at this time.

Sincerely,

Dee Jay Zerman

Dee Jay Zerman, Director
Regulatory Planning
UNC HCS

Attachment 2

CERTIFICATE OF NEED
PROGRESS REPORT FORM

County: Wake County
Facility: Rex Hospital, Inc.
Project I.D. #: J-8669-11
Date of Progress Report: 10/30/2015
Facility I.D. #: 070823
Effective Date of Certificate: 1/22/2014
Project Description: Develop a new separately licensed hospital in Holly Springs with no more than 50 licensed general acute care beds, 3 licensed shared ORs, 1 dedicated C-Section OR and 5 unlicensed observation beds

A. Status of the Project

1. Describe in detail the steps taken to complete the project since the CON was issued or since the last progress report was submitted.

Response: The certificate of need was issued on January 22, 2014. Internal meetings continue regarding community relations, strategic planning and construction services.

2. Describe any of the previously approved changes which will impact this project:
   1. Cost Overruns and/or Changes of Scope (Include the Project I.D. numbers);
   2. Material Compliance determinations; and
   3. Declaratory Rulings

Response: Not applicable.

3. If the project is not going to be developed exactly as approved, describe all differences between the project as approved and the project as currently proposed. Such changes include, but are not limited to, changes in the:
   a. Site;
   b. Design of the facility;
   c. Number or type of beds to be developed;
   d. Medical equipment to be acquired;
   e. Proposed charges; and
   f. Capital cost of the project.

Response: Not applicable.

4. Pursuant to G.S. 131E-181(d), the Certificate of Need (CON) Section cannot determine that a project is complete **until** *"the health service or the health service facility for which the certificate of need was issued is licensed and certified and in material compliance with the representations made in the certificate of need application."* To document that new or replacement facilities, new or additional beds or dialysis stations, new or replacement equipment or new services have been licensed and certified, provide copies of correspondence from the appropriate section within the Division of Health Service Regulation and the Centers for Medicare and Medicaid Services (CMS).

Response: Not applicable.

B. Timetable

1. Complete the following table. The first column **must** include the timetable dates found on the certificate of need. If the CON Section has authorized an extension of the timetable in writing, you may substitute the dates from that letter.

PROJECT MILESTONES	Projected completion date from certificate	Actual completion date	Proposed completion date*
	Month/day/year	Month/day/year	Month/day/year
Completion of Final Drawings	12/1/14		
Site Approval	4/1/15		
25% Completion of construction	10/1/15		
50% Completion of construction	2/6/16		
75% Completion of construction	8/1/16		
Completion of construction	12/1/16		
Occupancy/Offering of Services	2/1/17		

**Proposed completion dates are contingent upon CON approval*

2. If the project is experiencing delays in development, explain in detail the reasons for the delay.

Response: Internal meetings continue regarding community relations, strategic planning and construction services. Once complete a revised timetable can be projected.

C. Medical Equipment Projects – If the project involves the acquisition of any of the following equipment: 1) major medical equipment as defined in NCGS §131E-176(14o); 2) the specific equipment listed in NCGS §131-176(16); or 3) equipment that creates a diagnostic center as defined in NCGS §131E-176(7a), provide the following information for each piece or unit of equipment: 1) manufacturer; 2) model; 3) serial number; and 4) date acquired.

Response: Not applicable.

D. Capital Expenditure

1. What is the total approved capital cost of the project indicated on the certificate of need? $171,616,236

2. Complete the table on the following page.
   a. Include all capital costs that have been paid to date as well as those that the applicant(s) are legally obligated to pay.
   b. If you have not already done so, provide copies of all executed contracts, including architect and engineering services (as applicable) and all final purchase orders for medical equipment costing more than $10,000 per unit.
   c. If the project involves renovation or construction, provide copies of the Contractors Application for Payment [AIA G702] with Schedule of Values [AIA G703].

	Capital Expense Since Last Report	Total Cumulative Capital Expenditure
Site Costs		
Purchase price of land		
Closing costs		
Site Inspection and Survey		
Legal fees		
Site preparation costs		
Other site costs (identify)		
Subtotal Site Costs	**$0**	**$0**
Construction Contract		
Cost of materials		
Cost of Labor		
Other (Specify)		
Subtotal Construction Contract	**$0**	**$0**
Miscellaneous Costs		
Building purchase		
Fixed equipment purchase/lease		
Moveable equipment purchase/lease		
Furniture		
Landscaping		
Consultant fees		$235,928.79
Financing costs		
Interest during construction		
Other miscellaneous costs (Legal fees)		$460,203.44
Subtotal Miscellaneous Costs	**$0**	**$696,132.23**
Total	**$0**	**$696,132.23**

3. What is the projected remaining capital expenditure required to complete the project? $170,920,103.77

4. Will the total actual capital cost of the project exceed 115% of the approved capital expenditure on the certificate of need? If yes, explain the reasons for the difference.

Response: No.

E. CERTIFICATION – The undersigned hereby certifies that the responses to the questions in this progress report and the attached

documents are correct to the best of his or her knowledge and belief. In addition, I acknowledge that incomplete progress report forms **will not** be accepted and **must** be resubmitted upon notification from an Agency Project Analyst.

Attachment 2

Signature of Officer:
Name and Title of Responsible Officer Erick Hawkins, CFO
Telephone Number of Responsible Officer 919-784-3245

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

Pat McCrory
Governor

Richard O. Brajer
Secretary DHHS

Drexdal Pratt
Division Director

VIA EMAIL ONLY

December 17, 2015

Dee Jay Zerman, Director, Regulatory Planning
James T. Hedrick Building
211 Friday Center Drive, Suite G015
Chapel Hill NC 27517

Acknowledgement of Receipt of Progress Report and Next Progress Report Due

Project ID #:	J-8669-11
Facility:	Rex Hospital Holly Springs
Project Description:	Develop a 50-bed hospital in Holly Springs
County:	Wake
FID #:	070823

Dear Ms. Zerman:

Thank you for your progress report dated October 30, 2015 on the above referenced project. Your next progress report will be due on March 1, 2016.

Please notify the Project Analyst as soon as possible if development of the project may be delayed by more than three months, and/or the total capital expenditure may exceed more than 115 percent of the approved capital expenditure. If the total capital expenditure will exceed 115 percent of the approved capital expenditure, a new certificate of need will be required for the cost overrun.

Please do not hesitate to contact me if you have any questions regarding this project.

Sincerely,

Michael J. McKillip

Project Analyst, Certificate of Need

Attachment

Attachment 2

REX
UNC HEALTH CARE

James T. Hedrick Building
211 Friday Center Drive, Suite G015
Chapel Hill, NC 27517

March 1, 2016

Michael J. McKillip, Project Analyst
Certificate of Need Section
Division of Health Service Regulation, DHHS
2704 Mail Service Center
Raleigh, NC 27699-2704

Dear Mr. McKillip:

Attached you will find the Progress Report for CON Project I.D. # J-8669-11 and Facility I.D. # 070823. This project involves the development of a new separately licensed hospital in Holly Springs.

Please call me at 984-974-1210 if you have any questions or require any additional information at this time.

Sincerely,

Dee Jay Zerman

Dee Jay Zerman, System Director
Regulatory Planning
UNC HCS

CERTIFICATE OF NEED
PROGRESS REPORT FORM

County: Wake County
Facility: Rex Hospital, Inc.
Project I.D. #: J-8669-11
Date of Progress Report: 3/1/2016
Facility I.D. #: 070823
Effective Date of Certificate: 1/22/2014
Project Description: Develop a new separately licensed hospital in Holly Springs with no more than 50 licensed general acute care beds, 3 licensed shared ORs, 1 dedicated C-Section OR and 5 unlicensed observation beds

A. Status of the Project

1. Describe in detail the steps taken to complete the project since the CON was issued or since the last progress report was submitted.

Response: The certificate of need was issued on January 22, 2014. Internal meetings continue regarding community relations, strategic planning and construction services.

2. Describe any of the previously approved changes which will impact this project:
   1. Cost Overruns and/or Changes of Scope (Include the Project I.D. numbers);
   2. Material Compliance determinations; and
   3. Declaratory Rulings

Response: Not applicable.

3. If the project is not going to be developed exactly as approved, describe all differences between the project as approved and the project as currently proposed. Such changes include, but are not limited to, changes in the:
   a. Site;
   b. Design of the facility;
   c. Number or type of beds to be developed;
   d. Medical equipment to be acquired;
   e. Proposed charges; and
   f. Capital cost of the project.

Response: Not applicable.

4. Pursuant to G.S. 131E-181(d), the Certificate of Need (CON) Section cannot determine that a project is complete **until** *"the health service or the health service facility for which the certificate of need was issued is licensed and certified and in material compliance with the representations made in the certificate of need application."* To document that new or replacement facilities, new or additional beds or dialysis stations, new or replacement equipment or new services have been licensed and certified, provide copies of correspondence from the appropriate section within the Division of Health Service Regulation and the Centers for Medicare and Medicaid Services (CMS).

Response: Not applicable.

B. Timetable

1. Complete the following table. The first column **must** include the timetable dates found on the certificate of need. If the CON Section has authorized an extension of the timetable in writing, you may substitute the dates from that letter.

PROJECT MILESTONES	Projected completion date from certificate	Actual completion date	Proposed completion date*
	Month/day/year	Month/day/year	Month/day/year
Completion of Final Drawings	12/1/14		
Site Approval	4/1/15		
25% Completion of construction	10/1/15		
50% Completion of construction	2/6/16		
75% Completion of construction	8/1/16		
Completion of construction	12/1/16		
Occupancy/Offering of Services	2/1/17		

**Proposed completion dates are contingent upon CON approval*

2. If the project is experiencing delays in development, explain in detail the reasons for the delay.

Response: Internal meetings continue regarding community relations, strategic planning and construction services. Once complete a revised timetable can be projected.

C. **Medical Equipment Projects** – If the project involves the acquisition of any of the following equipment: 1) major medical equipment as defined in NCGS §131E-176(14o); 2) the specific equipment listed in NCGS §131-176(16); or 3) equipment that creates a diagnostic center as defined in NCGS §131E-176(7a), provide the following information for each piece or unit of equipment: 1) manufacturer; 2) model; 3) serial number; and 4) date acquired.

Response: Not applicable.

D. Capital Expenditure

1. What is the total approved capital cost of the project indicated on the certificate of need? $171,616,236

2. Complete the table on the following page.
   a. Include all capital costs that have been paid to date as well as those that the applicant(s) are legally obligated to pay.
   b. If you have not already done so, provide copies of all executed contracts, including architect and engineering services (as applicable) and all final purchase orders for medical equipment costing more than $10,000 per unit.
   c. If the project involves renovation or construction, provide copies of the Contractors Application for Payment [AIA G702] with Schedule of Values [AIA G703].

	Capital Expense Since Last Report	Total Cumulative Capital Expenditure
Site Costs		
Purchase price of land		
Closing costs		
Site Inspection and Survey		
Legal fees		
Site preparation costs		
Other site costs (identify)		
Subtotal Site Costs		
Construction Contract		
Cost of materials		
Cost of Labor		
Other (Specify)		
Subtotal Construction Contract		
Miscellaneous Costs		
Building purchase		
Fixed equipment purchase/lease		
Moveable equipment purchase/lease		
Furniture		
Landscaping		
Consultant fees		$235,928.79
Financing costs		
Interest during construction		
Other miscellaneous costs (Legal fees)		$460,203.44
Subtotal Miscellaneous Costs		**$696,132.23**
Total		**$696,132.23**

3. What is the projected remaining capital expenditure required to complete the project? $170,920,103.77

4. Will the total actual capital cost of the project exceed 115% of the approved capital expenditure on the certificate of need? If yes, explain the reasons for the difference. ***Response:*** No.

E. CERTIFICATION – The undersigned hereby certifies that the responses to the questions in this progress report and the attached documents are correct to the best of his or her knowledge and belief. In addition, I acknowledge that incomplete progress report forms **will not** be accepted and **must** be resubmitted upon notification from an Agency Project Analyst.

Signature of Officer: 2-26-16
Name and Title of Responsible Officer: Jeff LeGay, CFO
Telephone Number of Responsible Officer: 919-784-3245

Attachment 2

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

Pat McCrory
Governor

Richard O. Brajer
Secretary DHHS

Mark Payne
Assistant Secretary for Audit and
Health Service Regulation

VIA EMAIL ONLY

March 3, 2016

Dee Jay Zerman, Director, Regulatory Planning
James T. Hedrick Building
211 Friday Center Drive, Suite G015
Chapel Hill NC 27517

Acknowledgement of Receipt of Progress Report and Next Progress Report Due

Project ID #:	J-8669-11
Facility:	Rex Hospital Holly Springs
Project Description:	Develop a new separately licensed 50-bed hospital in Holly Springs
County:	Wake
FID #:	070823

Dear Ms. Zerman:

Thank you for your progress report dated March 1, 2016 on the above referenced project. Your next progress report will be due on July 1, 2016.

Please notify the Project Analyst as soon as possible if development of the project may be delayed by more than three months, and/or the total capital expenditure may exceed more than 115 percent of the approved capital expenditure. If the total capital expenditure will exceed 115 percent of the approved capital expenditure, a new certificate of need will be required for the cost overrun.

Please do not hesitate to contact me if you have any questions regarding this project.

Sincerely,

Michael J. McKillip

Project Analyst, Certificate of Need

Attachment

Healthcare Planning and Certificate of Need Section
www.ncdhhs.gov
Telephone: 919-855-3873 • Fax: 919-715-4413
Location: Edgerton Building • 809 Ruggles Drive • Raleigh, NC 27603
Mailing Address: 2704 Mail Service Center •Raleigh, NC 27699-2704
An Equal Opportunity/ Affirmative Action Employer

Attachment 2

REX
UNC HEALTH CARE

James T. Hedrick Building
211 Friday Center Drive, Suite G015
Chapel Hill, NC 27517

August 30, 2016

Michael J. McKillip, Project Analyst
Certificate of Need Section
Division of Health Service Regulation, DHHS
2704 Mail Service Center
Raleigh, NC 27699-2704

Dear Mr. McKillip:

Attached you will find the Progress Report for CON Project I.D. # J-8669-11 and Facility I.D. # 070823. This project involves the development of a new separately licensed hospital in Holly Springs.

Please call me at 984-974-1210 if you have any questions or require any additional information at this time.

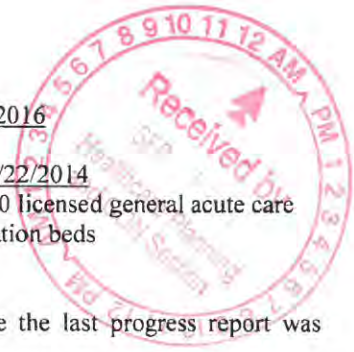
Sincerely,

Dee Jay Zerman

Dee Jay Zerman, System Director
Regulatory Planning
UNC HCS

Attachment 2

CERTIFICATE OF NEED
PROGRESS REPORT FORM



County: Wake County
Facility: Rex Hospital, Inc.
Project I.D. #: J-8669-11
Date of Progress Report: 8/30/2016
Facility I.D. #: 070823
Effective Date of Certificate: 1/22/2014
Project Description: Develop a new separately licensed hospital in Holly Springs with no more than 50 licensed general acute care beds, 3 licensed shared ORs, 1 dedicated C-Section OR and 5 unlicensed observation beds

A. Status of the Project

1. Describe in detail the steps taken to complete the project since the CON was issued or since the last progress report was submitted.

Response: The certificate of need was issued on January 22, 2014. Internal meetings continue regarding community relations, strategic planning and construction services.

2. Describe any of the previously approved changes which will impact this project:
   1. Cost Overruns and/or Changes of Scope (Include the Project I.D. numbers);
   2. Material Compliance determinations; and
   3. Declaratory Rulings

Response: Not applicable.

3. If the project is not going to be developed exactly as approved, describe all differences between the project as approved and the project as currently proposed. Such changes include, but are not limited to, changes in the:
   a. Site;
   b. Design of the facility;
   c. Number or type of beds to be developed;
   d. Medical equipment to be acquired;
   e. Proposed charges; and
   f. Capital cost of the project.

Response: Not applicable.

4. Pursuant to G.S. 131E-181(d), the Certificate of Need (CON) Section cannot determine that a project is complete **until** *"the health service or the health service facility for which the certificate of need was issued is licensed and certified and in material compliance with the representations made in the certificate of need application."* To document that new or replacement facilities, new or additional beds or dialysis stations, new or replacement equipment or new services have been licensed and certified, provide copies of correspondence from the appropriate section within the Division of Health Service Regulation and the Centers for Medicare and Medicaid Services (CMS).

Response: Not applicable.

B. Timetable

1. Complete the following table. The first column **must** include the timetable dates found on the certificate of need. If the CON Section has authorized an extension of the timetable in writing, you may substitute the dates from that letter.

PROJECT MILESTONES	Projected completion date from certificate	Actual completion date	Proposed completion date*
	Month/day/year	Month/day/year	Month/day/year
Completion of Final Drawings	12/1/14		
Site Approval	4/1/15		
25% Completion of construction	10/1/15		
50% Completion of construction	2/6/16		
75% Completion of construction	8/1/16		
Completion of construction	12/1/16		
Occupancy/Offering of Services	2/1/17		

**Proposed completion dates are contingent upon CON approval*

2. If the project is experiencing delays in development, explain in detail the reasons for the delay.

Response: Internal meetings continue regarding community relations, strategic planning and construction services. Once complete a revised timetable can be projected.

C. Medical Equipment Projects – If the project involves the acquisition of any of the following equipment: 1) major medical equipment as defined in NCGS §131E-176(14o); 2) the specific equipment listed in NCGS §131-176(16); or 3) equipment that creates a diagnostic center as defined in NCGS §131E-176(7a), provide the following information for each piece or unit of equipment: 1) manufacturer; 2) model; 3) serial number; and 4) date acquired.

Response: Not applicable.

D. Capital Expenditure

1. What is the total approved capital cost of the project indicated on the certificate of need? $171,616,236

2. Complete the table on the following page.
   a. Include all capital costs that have been paid to date as well as those that the applicant(s) are legally obligated to pay.
   b. If you have not already done so, provide copies of all executed contracts, including architect and engineering services (as applicable) and all final purchase orders for medical equipment costing more than $10,000 per unit.
   c. If the project involves renovation or construction, provide copies of the Contractors Application for Payment [AIA G702] with Schedule of Values [AIA G703].

	Capital Expense Since Last Report	Total Cumulative Capital Expenditure
Site Costs		
Purchase price of land		
Closing costs		
Site Inspection and Survey		
Legal fees		
Site preparation costs		
Other site costs (identify)		
Subtotal Site Costs		
Construction Contract		
Cost of materials		
Cost of Labor		
Other (Specify)		
Subtotal Construction Contract		
Miscellaneous Costs		
Building purchase		
Fixed equipment purchase/lease		
Moveable equipment purchase/lease		
Furniture		
Landscaping		
Consultant fees		$235,928.79
Financing costs		
Interest during construction		
Other miscellaneous costs (Legal fees)		$460,203.44
Subtotal Miscellaneous Costs		**$696,132.23**
Total		**$696,132.23**

3. What is the projected remaining capital expenditure required to complete the project? $170,920,103.77

4. Will the total actual capital cost of the project exceed 115% of the approved capital expenditure on the certificate of need? If yes, explain the reasons for the difference. ***Response:*** No.

E. CERTIFICATION – The undersigned hereby certifies that the responses to the questions in this progress report and the attached documents are correct to the best of his or her knowledge and belief. In addition, I acknowledge that incomplete progress report forms **will not** be accepted and **must** be resubmitted upon notification from an Agency Project Analyst.

Signature of Officer: Andrew K. Zukowski
Name and Title of Responsible Officer: Andrew Zukowski, CFO
Telephone Number of Responsible Officer: 919-784-3245

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

Pat McCrory
Governor

Richard O. Brajer
Secretary DHHS

Mark Payne
Assistant Secretary for Audit and
Health Service Regulation

VIA EMAIL ONLY

October 4, 2016

Dee Jay Zerman, System Director, Regulatory Planning
UNC HCS
James T. Hedrick Building
211 Friday Center Drive, Suite G015
Chapel Hill NC 27517

Acknowledgement of Receipt of Progress Report and Next Progress Report Due

Project ID #:	J-8669-11
Facility:	Rex Hospital Holly Springs
Project Description:	Develop a new separately licensed 50-bed hospital in Holly Springs
County:	Wake
FID #:	070823

Dear Ms. Zerman:

Thank you for your progress report dated August 30, 2016 on the above referenced project. Your next progress report will be due on February 1, 2017.

Please notify the Project Analyst as soon as possible if development of the project may be delayed by more than three months, and/or the total capital expenditure may exceed more than 115 percent of the approved capital expenditure. If the total capital expenditure will exceed 115 percent of the approved capital expenditure, a new certificate of need will be required for the cost overrun.

Please do not hesitate to contact me if you have any questions regarding this project.

Sincerely,

Michael J. McKillip

Project Analyst, Certificate of Need

Attachment

CERTIFICATE OF NEED
PROGRESS REPORT FORM

County: Wake County
Facility: Rex Hospital, Inc.
Project I.D. #: J-8669-11
Date of Progress Report: 11/21/2016
Facility I.D. #: 070823
Effective Date of Certificate: 1/22/2014
Project Description: Develop a new separately licensed hospital in Holly Springs with no more than 50 licensed general acute care beds, 3 licensed shared ORs, 1 dedicated C-Section OR and 5 unlicensed observation beds

A. Status of the Project

1. Describe in detail the steps taken to complete the project since the CON was issued or since the last progress report was submitted.

Response: The certificate of need was issued on January 22, 2014. Internal meetings continue regarding community relations, strategic planning and construction services.

2. Describe any of the previously approved changes which will impact this project:
   1. Cost Overruns and/or Changes of Scope (Include the Project I.D. numbers);
   2. Material Compliance determinations; and
   3. Declaratory Rulings

Response: Not applicable.

3. If the project is not going to be developed exactly as approved, describe all differences between the project as approved and the project as currently proposed. Such changes include, but are not limited to, changes in the:
   a. Site;
   b. Design of the facility;
   c. Number or type of beds to be developed;
   d. Medical equipment to be acquired;
   e. Proposed charges; and
   f. Capital cost of the project.

Response: Not applicable.

4. Pursuant to G.S. 131E-181(d), the Certificate of Need (CON) Section cannot determine that a project is complete **until** *"the health service or the health service facility for which the certificate of need was issued is licensed and certified and in material compliance with the representations made in the certificate of need application."* To document that new or replacement facilities, new or additional beds or dialysis stations, new or replacement equipment or new services have been licensed and certified, provide copies of correspondence from the appropriate section within the Division of Health Service Regulation and the Centers for Medicare and Medicaid Services (CMS).

Response: Not applicable.

B. Timetable

1. Complete the following table. The first column **must** include the timetable dates found on the certificate of need. If the CON Section has authorized an extension of the timetable in writing, you may substitute the dates from that letter.

PROJECT MILESTONES	Projected completion date from certificate	Actual completion date	Proposed completion date*
	Month/day/year	Month/day/year	Month/day/year
Completion of Final Drawings	12/1/14		
Site Approval	4/1/15		
25% Completion of construction	10/1/15		
50% Completion of construction	2/6/16		
75% Completion of construction	8/1/16		
Completion of construction	12/1/16		
Occupancy/Offering of Services	2/1/17		

**Proposed completion dates are contingent upon CON approval*

2. If the project is experiencing delays in development, explain in detail the reasons for the delay.

Response: Internal meetings continue regarding community relations, strategic planning and construction services. Once complete a revised timetable can be projected.

C. Medical Equipment Projects – If the project involves the acquisition of any of the following equipment: 1) major medical equipment as defined in NCGS §131E-176(14o); 2) the specific equipment listed in NCGS §131-176(16); or 3) equipment that creates a diagnostic center as defined in NCGS §131E-176(7a), provide the following information for each piece or unit of equipment: 1) manufacturer; 2) model; 3) serial number; and 4) date acquired.

Response: Not applicable.

D. Capital Expenditure

1. What is the total approved capital cost of the project indicated on the certificate of need? $171,616,236

2. Complete the table on the following page.
   a. Include all capital costs that have been paid to date as well as those that the applicant(s) are legally obligated to pay.
   b. If you have not already done so, provide copies of all executed contracts, including architect and engineering services (as applicable) and all final purchase orders for medical equipment costing more than $10,000 per unit.
   c. If the project involves renovation or construction, provide copies of the Contractors Application for Payment [AIA G702] with Schedule of Values [AIA G703].

	Capital Expense Since Last Report	Total Cumulative Capital Expenditure
Site Costs		
Purchase price of land		
Closing costs		
Site Inspection and Survey		
Legal fees		
Site preparation costs		
Other site costs (identify)		
Subtotal Site Costs		
Construction Contract		
Cost of materials		
Cost of Labor		
Other (Specify)		
Subtotal Construction Contract		
Miscellaneous Costs		
Building purchase		
Fixed equipment purchase/lease		
Moveable equipment purchase/lease		
Furniture		
Landscaping		
Consultant fees		$235,928.79
Financing costs		
Interest during construction		
Other miscellaneous costs (Legal fees)		$460,203.44
Subtotal Miscellaneous Costs		**$696,132.23**
Total		**$696,132.23**

3. What is the projected remaining capital expenditure required to complete the project? $170,920,103.77

4. Will the total actual capital cost of the project exceed 115% of the approved capital expenditure on the certificate of need? If yes, explain the reasons for the difference. ***Response:*** No.

E. CERTIFICATION – The undersigned hereby certifies that the responses to the questions in this progress report and the attached documents are correct to the best of his or her knowledge and belief. In addition, I acknowledge that incomplete progress report forms **will not** be accepted and **must** be resubmitted upon notification from an Agency Project Analyst.

Signature of Officer: Andrew K Zukowski
Name and Title of Responsible Officer: Andrew Zukowski, CFO
Telephone Number of Responsible Officer: 919-784-3245

Attachment 2

REX
UNC HEALTH CARE

James T. Hedrick Building
211 Friday Center Drive, Suite G015
Chapel Hill, NC 27517

November 21, 2016

Michael J. McKillip, Project Analyst
Certificate of Need Section
Division of Health Service Regulation, DHHS
2704 Mail Service Center
Raleigh, NC 27699-2704

Dear Mr. McKillip:

Attached you will find the Progress Report for CON Project I.D. # J-8669-11 and Facility I.D. # 070823. This project involves the development of a new separately licensed hospital in Holly Springs.

Please call me at 984-974-1210 if you have any questions or require any additional information at this time.

Sincerely,

Dee Jay Zerman

Dee Jay Zerman, System Director
Regulatory Planning
UNC HCS

CERTIFICATE OF NEED
PROGRESS REPORT FORM

County: Wake County
Facility: Rex Hospital, Inc.
Project I.D. #: J-8669-11
Date of Progress Report: 1/30/2017
Facility I.D. #: 070823
Effective Date of Certificate: 1/22/2014
Project Description: Develop a new separately licensed hospital in Holly Springs with no more than 50 licensed general acute care beds, 3 licensed shared ORs, 1 dedicated C-Section OR and 5 unlicensed observation beds

A. Status of the Project

1. Describe in detail the steps taken to complete the project since the CON was issued or since the last progress report was submitted.

Response: The certificate of need was issued on January 22, 2014. Internal meetings continue regarding community relations, strategic planning and construction services.

2. Describe any of the previously approved changes which will impact this project:
   1. Cost Overruns and/or Changes of Scope (Include the Project I.D. numbers);
   2. Material Compliance determinations; and
   3. Declaratory Rulings

Response: Not applicable.

3. If the project is not going to be developed exactly as approved, describe all differences between the project as approved and the project as currently proposed. Such changes include, but are not limited to, changes in the:
   a. Site;
   b. Design of the facility;
   c. Number or type of beds to be developed;
   d. Medical equipment to be acquired;
   e. Proposed charges; and
   f. Capital cost of the project.

Response: Not applicable.

4. Pursuant to G.S. 131E-181(d), the Certificate of Need (CON) Section cannot determine that a project is complete until *"the health service or the health service facility for which the certificate of need was issued is licensed and certified and in material compliance with the representations made in the certificate of need application."* To document that new or replacement facilities, new or additional beds or dialysis stations, new or replacement equipment or new services have been licensed and certified, provide copies of correspondence from the appropriate section within the Division of Health Service Regulation and the Centers for Medicare and Medicaid Services (CMS).

Response: Not applicable.

B. Timetable

1. Complete the following table. The first column **must** include the timetable dates found on the certificate of need. If the CON Section has authorized an extension of the timetable in writing, you may substitute the dates from that letter.

PROJECT MILESTONES	Projected completion date from certificate	Actual completion date	Proposed completion date*
	Month/day/year	Month/day/year	Month/day/year
Completion of Final Drawings	12/1/14		
Site Approval	4/1/15		
25% Completion of construction	10/1/15		
50% Completion of construction	2/6/16		
75% Completion of construction	8/1/16		
Completion of construction	12/1/16		
Occupancy/Offering of Services	2/1/17		

**Proposed completion dates are contingent upon CON approval*

2. If the project is experiencing delays in development, explain in detail the reasons for the delay.

Response: Internal meetings continue regarding community relations, strategic planning and construction services. Once complete a revised timetable can be projected.

C. Medical Equipment Projects – If the project involves the acquisition of any of the following equipment: 1) major medical equipment as defined in NCGS §131E-176(14o); 2) the specific equipment listed in NCGS §131-176(16); or 3) equipment that creates a diagnostic center as defined in NCGS §131E-176(7a), provide the following information for each piece or unit of equipment: 1) manufacturer; 2) model; 3) serial number; and 4) date acquired.

Response: Not applicable.

D. Capital Expenditure

1. What is the total approved capital cost of the project indicated on the certificate of need? $171,616,236

2. Complete the table on the following page.
   a. Include all capital costs that have been paid to date as well as those that the applicant(s) are legally obligated to pay.
   b. If you have not already done so, provide copies of all executed contracts, including architect and engineering services (as applicable) and all final purchase orders for medical equipment costing more than $10,000 per unit.
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	Capital Expense Since Last Report	Total Cumulative Capital Expenditure
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Cost of Labor		
Other (Specify)		
Subtotal Construction Contract		
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Moveable equipment purchase/lease		
Furniture		
Landscaping		
Consultant fees		$235,928.79
Financing costs		
Interest during construction		
Other miscellaneous costs (Legal fees)		$460,203.44
Subtotal Miscellaneous Costs		**$696,132.23**
Total		**$696,132.23**

3. What is the projected remaining capital expenditure required to complete the project? $170,920,103.77

4. Will the total actual capital cost of the project exceed 115% of the approved capital expenditure on the certificate of need? If yes, explain the reasons for the difference. ***Response:*** No.

E. CERTIFICATION – The undersigned hereby certifies that the responses to the questions in this progress report and the attached documents are correct to the best of his or her knowledge and belief. In addition, I acknowledge that incomplete progress report forms **will not** be accepted and **must** be resubmitted upon notification from an Agency Project Analyst.

Signature of Officer: Andrew K. Zukowski
Name and Title of Responsible Officer: Andrew Zukowski, CFO
Telephone Number of Responsible Officer: 919-784-3245

REX
UNC HEALTH CARE

James T. Hedrick Building
211 Friday Center Drive, Suite G015
Chapel Hill, NC 27517

January 31, 2017

Michael J. McKillip, Project Analyst
Certificate of Need Section
Division of Health Service Regulation, DHHS
2704 Mail Service Center
Raleigh, NC 27699-2704

Dear Mr. McKillip:

Attached you will find the Progress Report for CON Project I.D. # J-8669-11 and Facility I.D. # 070823. This project involves the development of a new separately licensed hospital in Holly Springs.

Please call me at 984-974-1210 if you have any questions or require any additional information at this time.

Sincerely,

Dee Jay Zerman

Dee Jay Zerman, System Director
Regulatory Planning
UNC HCS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH SERVICE REGULATION

ROY COOPER
GOVERNOR

MANDY COHEN, MD, MPH
SECRETARY

MARK PAYNE
DIRECTOR

CERTIFIED MAIL

June 13, 2017

Dee Jay Zerman, System Director, Regulatory Planning
UNC HCS
211 Friday Center Drive, G014
Chapel Hill NC 27517

Notice of Intent to Consider Withdrawal of a Certificate of Need

Project ID #:	J-8669-11
Facility:	Rex Hospital Holly Springs
Project Description:	Develop a new, separately licensed hospital in Holly Springs with 50 acute care beds, three shared operating rooms, one dedicated C-Section operating room, and five unlicensed observation beds
County:	Wake
FID #:	070823

Dear Ms. Zerman:

The Healthcare Planning and Certificate of Need Section, Division of Health Service Regulation (Agency) is hereby providing notice that it is considering the initiation of withdrawal proceedings on the project referenced above based on each of the reasons checked below:

- ☒ The project is significantly behind schedule with inadequate explanation for the delay.
- ☐ The applicant has failed to provide any progress reports or respond to any progress report request.
- ☐ The progress being made does not appear to be in material compliance with the representations in the certificate of need application.
- ☐ Progress reports are routinely submitted with little to no information.

In accordance with N.C. Gen. Stat. §131E-189(a) and 10A NCAC 14C .0209, the Agency is requesting a comprehensive progress report to document the progress that has been made to date in the development of the approved project. This report affords the holder of the certificate the opportunity to provide all evidence that demonstrates a good faith effort is being made to meet the timetable for the project and to develop the project as represented in the application.

Attachment 2

REX
UNC HEALTH CARE

James T. Hedrick Building
211 Friday Center Drive, Suite G014
Chapel Hill, NC 27517

July 14, 2017

Michael J. McKillip, Project Analyst
Certificate of Need Section
Division of Health Service Regulation, DHHS
2704 Mail Service Center
Raleigh, NC 27699-2704

Dear Mr. McKillip:

In response to your correspondence dated June 13, 2017 entitled "Notice of Intent to Consider Withdrawal of a Certificate of Need", attached you will find the Comprehensive Progress Report for CON Project I.D. # J-8669-11 to develop Holly Springs Hospital, and Facility I.D. # 70823.

Please call me at 984-974-1243 if you have any questions or require any additional information at this time.

Sincerely,

Dee Jay Zerman

Dee Jay Zerman, System Director
Regulatory Planning
UNC HCS

Certificate of Need
Comprehensive Progress Report Form

County: Wake
Facility: Rex Hospital Holly Springs
Project ID #: J-8669-11

Date of Progress Report: 7/14/2017
Facility ID #: 70823
Effective Date of Certificate: 1/22/2014

Project Description: Develop a new, separately licensed hospital in Holly Springs with 50 acute care beds, three shared operating rooms, one dedicated C-Section operating room, and five unlicensed observation beds

A. Status of the Project

1. Describe in <u>detail</u> the current status of the project.

Response: May and June have been busy months for Holly Springs Hospital development. In June, Rex engaged the services of a new design team, and held community forums to discuss the desire and needs for the community hospital. The design team and Rex staff have taken site visits to other similar sized hospital (in NC and CO), and additional benchmarking tours are being scheduled. When the Holly Springs MOB II opens in January 2018, the site work and underground construction can then begin for the hospital construction.

Rex Leadership met with the Holly Springs town council at a meeting on May 2nd to deliver the same message. Additionally, Rex hosted a Holly Springs Community Forum on June 28th to collect ideas and feedback from residents. Residents also have the option of submitting feedback via an online portal. The feedback is being collected to aid in the refinement of services to be provided at the hospital so to best fit the community's needs.

The hospital design effort currently underway, will take approximately 10-12 months. Once this design is completed, it will be followed by a review period with the Town officials before leading into the construction of the hospital itself.

Given the rising cost of construction (both in materials and labor), project coordination is a very important factor that when applicable will drive us to consolidate projects whenever possible. By designing, and constructing as a whole versus in parts, will not only reduce our overall spend, it will result in a more cohesive and efficient project.

Although not a part of this CON, Rex has been working on the Holly Springs campus since 2010 with the construction and occupancy of the Holly Springs MOB I. Rex moved into this building in late 2011 and it is highly utilized. Now, MOB II is currently under construction and is slated for completion by the end of the 2017 calendar. Holly Springs MOB II is going to be a 3 story, 45,000 sf building with tenants committed for all but 2,500 sf.

Committed practices going into the Phase II space are: Expansion of UNCPN Primary Care and Peds, Expansion of NC Heart & Vascular, Raleigh Orthopaedic Clinic - Ortho Urgent Care, Rehab and Ortho Clinic, Rex Sleep Lab, and Rex Vascular Specialists. We will also backfill the vacated space from Phase I of practices that are expanding into Phase II with: Rex Pulmonary Specialists, Digestive Healthcare, OB/GYN, Rex Pain Clinic, Urology and expanded time share suites for more specialty practices.

2. Describe in <u>detail</u> all activity taken by the applicant to achieve the milestones that have <u>not</u> yet been met. Examples: planning, construction, design, financing, zoning, licensure, and equipment purchase, etc. Be sure to include the dates.

Response: Programming activities are scheduled through July 2017. Following the programming activities, the schematic design phase will take place, running through the end of October 2017. The next phase, Design Development, will run through the end of January 2018. The target for submitting to the Town of Holly Springs for the site plan approval is slated to be submitted in January 2018. The Construction Document phase as well as the Permitting phase will then run from February to the end of August.

3. **Provide documentation to support the activities described in #2 above.**

Response: See copies of invoices and schedule contained in the attachments. The final design contract is currently being negotiated but a copy of the most recent draft is attached.

Also included is a copy of the press release for the public forum conducted in Holly Springs concerning the new holly Springs Hospital.

4. **Describe any changes to the project that have been previously approved by the Agency.**

Response: No changes have been proposed to the Agency.

B. Timetable

1. **Have you had any timetable extensions approved by the Agency? Yes___ No_X_ If you have had more than one timetable extension, state how many. Provide the dates that the Agency approved each timetable extension.**

2. **Complete the following table. The first column must include the timetable dates found on the certificate of need.**

Project Milestone	Original projected completion date from certificate	Projected completion date from most recently approved timetable extension	Actual completion date	Proposed completion date
	mm/dd/yy	mm/dd/yy	mm/dd/yy	mm/dd/yy
Obtained Funds for Project	NA			
Final Drawings and Specifications Sent to Construction Section, DHSR	NA			
Completion of Final Drawings	12/1/2014			6/29/2018
Acquisition of Land/Facility	NA			
Construction Contract Executed	NA			
25% Completion of Construction	10/1/2015			12/10/2018
50% Completion of Construction	2/1/2016			5/20/2019
75% Completion of Construction	8/1/2016			10/21/2019
Completion of Construction	12/1/2016			3/31/2019
Ordering of Medical Equipment	NA			
Operation of Medical Equipment	NA			
Occupancy/Offering of Services	2/1/2017			6/1/2020

Licensure	NA			
Certification	NA			

3. **Describe why the project's milestones have not been met or why the project has been significantly delayed. Please be specific.**

Response: We initially became delayed in beginning the Holly Springs hospital project due to opposition from another organization. While the CON application to develop this project was submitted in 2011, due to lengthy litigation the actual certificate of need was not issued until 2014. The opposition to the Holly Springs project caused us to proceed first with the heart hospital project. In order to ensure we did not take on too much debt at one time, as well as having the internal staff needed to manage a second large project, we held off beginning the Holly Springs project until the completion and opening of the heart hospital project. Now that the heart hospital is operational, we have hired an architect and begun planning for the Holly Springs hospital, with an expected opening in 2020.

4. **Describe in <u>detail</u> all activity that will be taken by the applicant to achieve <u>each of the unmet milestones</u> based on the most recent timetable approved by the agency.**

Response: Programming meetings with Rex end users have been scheduled, along with additional benchmarking site tours. Meetings between Rex Leadership and Town officials have taken place, include site visits to recently completed work for benchmarking ideas. Rex will be engaging a construction manager for preconstruction services in the coming month. This effort will aid in the cost and schedule tracking for the design team leading up to the start of the actual construction.

C. Changes to Project

If the project will not be developed as represented in the CON application, describe in <u>detail</u> any anticipated changes to the project or alternate plans being considered.

Response: The hospital is intended to be developed as described in the CON application.

D. Capital Expenditure

1. **List all capital costs that have been paid to date as well as those that the applicant(s) is legally obligated to pay.**

	Capital Expense Since Last Report	Total Cumulative Capital Expenditure
Site Costs		
Purchase Price of Land		
Closing Costs		
Site Inspection and Survey		
Legal Fees		
Site Preparation Costs		

Other Site Costs (Identify)	
Subtotal Site Costs	
Construction Contract	
Cost of Materials Cost of Labor	
Cost of Labor	
Other (Specify)	
Subtotal Construction Contract	
Miscellaneous Costs	
Building Purchase	
Fixed Equipment Purchase/Lease	
Moveable Equipment Purchase/Lease	
Furniture	
Landscaping	
Consultant Fees	$235,928.79
Financing Costs	
Interest During Construction	
Other Miscellaneous Costs (Specify)	$460,203.44
Subtotal Miscellaneous Costs	$696,132.23
Total	$696,132.23

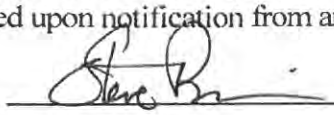
2. **Provide documentation of capital costs paid to date, including copies of all executed contracts, contractor's application for payment, and purchase orders for medical equipment over $10,000 each.**

Response: See copies of invoices and schedule contained in the attachments. The final design contract is currently being negotiated but a copy of the most recent draft is attached.

3. **Provide the remaining capital expenditure amount need to complete the project.** $170,920,103.77

[Note: approved total capital expenditure is $171,616,236]

E. CERTIFICATION - The undersigned hereby certifies that the responses to the questions in this progress report and the attached documents are correct to the best of his or her knowledge and belief. In addition, the undersigned acknowledges that an incomplete comprehensive progress report form will not be accepted and must be resubmitted upon notification from an Agency Project Analyst.

Signature: 

Name and Title: Steve Burriss, President UNC REX Healthcare

Telephone Number: 919-784-2244

UNC Health Care

UNC REX HEALTHCARE

Published on June 21, 2017

UNC REX Healthcare to Hold Community Forum for Holly Springs Community Hospital

Input from residents, employers and others needed as planning continues for 50-bed hospital

WHAT:

UNC REX Healthcare will hold a community forum on Weds., June 28, at the Holly Springs Town Hall to collect feedback on the new community hospital that's planned for Holly Springs. Input from residents of southern Wake County is crucial as planning accelerates for the new 50-bed hospital that will be built on UNC REX's Holly Springs campus at 781 Avent Ferry Road. The new hospital is expected to open in 2020.

WHY:

UNC REX is evaluating the needs of the fast-growing Holly Springs and southern Wake County communities. As construction continues on a second medical office building at UNC REX's Holly Springs campus, plans for the new hospital are being updated to take into account projected growth, changing demographics and additional services that need to be offered. Input from residents, employers, community leaders and others will help with the planning and design process.

"As we plan this important asset for the Holly Springs community, we want to hear from residents to determine the proper mix of services," said Tom Williams, vice president of ambulatory care at UNC REX. "We look forward to expanding the medical care available in this fast-growing regio

Top

WHO:

UNC REX executives and clinicians will join Holly Springs leaders to lead a discussion with the community. If residents are unable to attend the forum, they can provide feedback about the project online at www.rexhealth.com/hollysprings or by emailing tellmemore@unchealth.unc.edu.

WHEN:

Wednesday, June 28, 2017

5:30 to 6:30 p.m.

WHERE:

Holly Springs Town Hall (128 S. Main Street), Holleman Room

MEDIA NOTE

For more information, to arrange interviews or media assistance on the day of the event, contact Alan Wolf at (919) 218-7103.

Media Contact

For media inquiries and to arrange interviews, please contact:

Alan Wolf, UNC REX Healthcare
919-784-4467

Related News

- REX Blood Services to Hold 'Save Our Summer' Blood Drive on Friday, June 23 June 19, 2017
- UNC REX Healthcare presents run/walk to end prostate cancer June 9, 2017
- Conrad Shindler Wins 2017 REX Hospital Open June 4, 2017
- UNC REX Cancer Care to Honor Cancer Survivors with Celebration May 30, 2017
- REX Hospital Open Returns for 30th Annual Charity Tournament May 10, 2017

View More

Upcoming Events

Jul
13
Thur

Educational Talk
12:30 PM - 1:30 PM
Improve your knowledge on heart & vascular-related topics by attending a free educational talk in our state-of-the-art Heart & Vascular Hospital.

Top

NEWS RELEASE
FOR IMMEDIATE RELEASE
June 26, 2017

Contact: Alan M. Wolf
(919) 784-4467
alan.wolf@unchealth.unc.edu

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About UNC REX Healthcare
For more than 120 years, UNC REX Healthcare has provided expert care for the Wake County community and surrounding areas. With more than 6,400 co-workers, UNC REX is a private, not-for-profit health care system and is a member of UNC Health Care. UNC REX provides various health care services throughout Wake County with facilities in Apex, Cary, Garner, Holly Springs, Knightdale, Wakefield and downtown Raleigh. To learn more, click here.

WAKE COUNTY

JUNE 29, 2017 4:24 PM

At last, a hospital for Holly Springs comes into focus

BY HENRY GARGAN
hgargan@newsobserver.com

HOLLY SPRINGS — Since UNC REX Healthcare first considered building a hospital in Holly Springs more than a decade ago, the town's population has doubled to about 35,000 people. So hospital leaders have been making their rounds in southern Wake County this month to gauge which services are most in demand now.

At a forum Wednesday at Holly Springs Town Hall, some residents asked about the possibility of an oncology department to serve cancer patients. Others suggested a hospital bus system for geriatric patients or others who lack access to transportation.

Tom Williams, vice president of ambulatory care, said he expects the hospital will place a particular emphasis on OB-GYN services and labor and delivery.

"There are a lot of young families in southern Wake County," Williams said. "Everyone from this side of town has to go to Cary and Raleigh, and if you've driven up (N.C.) 55, you know what a hassle that is."

The $70 million, 145,000-square-foot hospital is set to open in late 2020 near REX's medical office buildings at the corner of N.C. 55 and Avent Ferry Road.

Residents have been waiting a long time for this.

Years ago, REX and Winston-Salem-based Novant Health both submitted applications to the state to build a hospital in Holly Springs, setting off a lengthy legal dispute. REX secured its certificate for a 50-bed hospital in 2014, nine years after the process began.

The project was sidetracked while REX turned its attention toward a $235 million heart and vascular center in Raleigh. In Holly Springs, traffic studies and other behind-the-scenes work took longer than expected, said hospital spokesman Alan Wolf.

The hospital held a community meeting in February 2014 to ask residents what services they wanted REX to provide, but "three years is a long time, especially in a fast-growing region like southern Wake County," Wolf said.

Medical needs vary from place to place, Williams said, and feedback from residents often pushes providers to make geographically specific investments.

"When we did open forums in Knightdale, one of the things we learned was there was a need for wound care and hyperbaric chambers," Williams said. "Most people from eastern Wake and Nash and Franklin counties were driving up to two hours for hyperbaric medicine, for wounds that wouldn't heal. So we put in two hyperbaric chambers, and they stay busy."

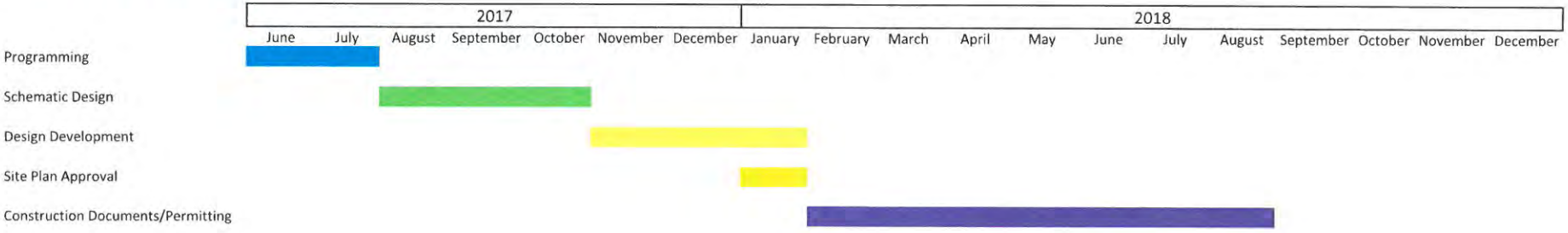
Speedy access to care has been a concern of some Holly Springs residents, who see the area's growth and the traffic that accompanies it as a potential health hazard. At public hearings about new developments, some have said they fear additional traffic will slow ambulance response times.

"We've been working very hard on one of the last remaining challenges in Holly Springs – to get to where you don't have to leave unless you want to," said Mayor Dick Sears. "That's very important to me, but the hospital has been a major challenge."

Gargan: 919-829-4807; @hgargan

UNC REX HEALTHCARE

UNC Rex Holly Springs Hospital



Attachment 2

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH SERVICE REGULATION

ROY COOPER
GOVERNOR

MANDY COHEN, MD, MPH
SECRETARY

MARK PAYNE
DIRECTOR

October 2, 2017

Dee Jay Zerman, System Director, Regulatory Planning
UNC HCS
James T. Hedrick Building
211 Friday Center Drive, Suite G015
Chapel Hill NC 27517

Extension of Timetable

Project ID #:	J-8669-11
Facility:	Rex Hospital Holly Springs
Project Description:	Develop a new separately licensed 50-bed hospital in Holly Springs
County:	Wake
FID #:	070823

Dear Ms. Zerman:

The Healthcare Planning and Certificate of Need Section, Division Health Service Regulation (Agency) has extended the timetable for the above referenced project pursuant to N.C. Gen. Stat. §131E-189. The decision not to withdraw the Certificate of Need at this time does not preclude the Agency from initiating withdrawal proceedings at a later date if the milestones are not completed in accordance with the new timetable. Documentation of the accomplishment of each of the milestones below (i.e., a completed progress report) must be provided to the Agency within **three weeks** following the specified completion dates. If documentation is not received by that date, the Agency may make a determination that the milestones have not been completed and may initiate withdrawal proceedings in accordance with 10A NCAC 14C .0502. The timetable for this project has been extended only for the period specified below.

Milestone	**Completion Date**
Drawings Completed	June 29, 2018
25% of Construction / Renovation Completed (25% of the cost is in place)	December 10, 2018
50% of Construction / Renovation Completed	May 20, 2019
75% of Construction / Renovation Completed	October 21, 2019
Construction / Renovation Completed	March 31, 2019
Services Offered	**June 1, 2020**

REX
UNC HEALTH CARE

James T. Hedrick Building
211 Friday Center Drive, Suite G015
Chapel Hill, NC 27517

July 12, 2018

Michael J. McKillip, Project Analyst
Certificate of Need Section
Division of Health Service Regulation, DHHS
2704 Mail Service Center
Raleigh, NC 27699-2704

Dear Mr. McKillip:

Attached you will find the Progress Report for CON Project I.D. # J-8669-11 and Facility I.D. # 070823. This project involves the development of a new separately licensed hospital in Holly Springs.

Please call me at 984-974-1243 if you have any questions or require any additional information at this time.

Sincerely,

Dee Jay Zerman

Dee Jay Zerman, System Director
Regulatory Planning
UNC HCS

CERTIFICATE OF NEED
PROGRESS REPORT FORM

County: Wake County
Facility: Rex Hospital, Inc.
Project I.D. #: J-8669-11
Date of Progress Report: 7/13/2018
Facility I.D. #: 070823
Effective Date of Certificate: 1/22/2014
Project Description: Develop a new separately licensed hospital in Holly Springs with no more than 50 licensed general acute care beds, 3 licensed shared ORs, 1 dedicated C-Section OR and 5 unlicensed observation beds

A. Status of the Project

1. Describe in detail the steps taken to complete the project since the CON was issued or since the last progress report was submitted.

Response: The project was initially delayed due to opposition from another organization, thus the actual certificate of need was not issued until 2014. This lengthy legal delay caused us to proceed first with the heart hospital project. In order to ensure we did not take on too much debt at one time, as well as having the internal staff needed to manage a second large project, we held off beginning the Holly Springs project until the completion and opening of the heart hospital project. Now that the heart hospital is operational, we have hired an architect and begun planning for the Holly Springs hospital, with an expected opening in 2020.

During June 2017, Rex engaged the services of a new design team, and held community forums to discuss the desire and needs for the community hospital. A comprehensive Progress Report was submitted on 7/15/2017 and a Timetable Extension was granted on 10/2/2017. The design team and Rex staff have taken site visits to other similar sized hospital (in NC and CO), and additional benchmarking tours are being scheduled. Additionally, Holly Springs Community Forums were hosted to collect ideas and feedback from residents. The hospital design efforts are actively underway and once this design is completed, it will be followed by a review period with the Town officials this fall, 2018.

Given the rising cost of construction (both in materials and labor), project coordination is a very important factor that when applicable will drive us to consolidate projects whenever possible. By designing, and constructing as a whole versus in parts, will not only reduce our overall spend, it will result in a more cohesive and efficient project. Due to market escalation in construction costs the team has launched more design time to reduce the costs of the project and maximize the project. Revised drawings are now expected to be completed late 2018. Once complete a revised timetable can be projected.

2. Describe any of the previously approved changes which will impact this project:
   1. Cost Overruns and/or Changes of Scope (Include the Project I.D. numbers);
   2. Material Compliance determinations; and
   3. Declaratory Rulings

Response: Not applicable.

3. If the project is not going to be developed exactly as approved, describe all differences between the project as approved and the project as currently proposed. Such changes include, but are not limited to, changes in the:
   a. Site;
   b. Design of the facility;
   c. Number or type of beds to be developed;
   d. Medical equipment to be acquired;
   e. Proposed charges; and
   f. Capital cost of the project.

Response: Not applicable.

4. Pursuant to G.S. 131E-181(d), the Certificate of Need (CON) Section cannot determine that a project is complete until *"the health service or the health service facility for which the certificate of need was issued is licensed and certified and in material compliance with the representations made in the certificate of need application."* To document that new or replacement facilities, new or additional beds or dialysis stations, new or replacement equipment or new services have been licensed and certified, provide copies of correspondence from the appropriate section within the Division of Health Service Regulation and the Centers for Medicare and Medicaid Services (CMS).

Response: Not applicable.

B. Timetable

1. Complete the following table. The first column must include the timetable dates found on the certificate of need. If the CON Section has authorized an extension of the timetable in writing, you may substitute the dates from that letter.

Project Milestone	Original projected completion date from certificate	Projected completion date from most recently approved timetable extension	Actual completion date	Proposed completion date
	1/22/2014	10/2/2017	mm/dd/yy	mm/dd/yy
Obtained Funds for Project	NA	NA	NA	NA
Final Drawings and Specifications Sent to Construction Section, DHSR	NA	NA	NA	NA
Completion of Final Drawings	12/1/2014	6/29/2018		TBD/ Late 2018
Acquisition of Land/Facility	NA	NA	NA	NA
Construction Contract Executed	NA	NA	NA	NA
25% Completion of Construction	10/1/2015	12/10/18		
50% Completion of Construction	2/1/2016	5/20/2019		
75% Completion of Construction	8/1/2016	10/21/2019		
Completion of Construction	12/1/2016	3/21/19		
Ordering of Medical Equipment	NA	NA	NA	NA
Operation of Medical Equipment	NA	NA	NA	NA
Occupancy/Offering of Services	2/1/2017	6/1/2020		
Licensure	NA	NA	NA	NA
Certification	NA	NA	NA	NA

**Proposed completion dates are contingent upon CON approval*

2. If the project is experiencing delays in development, explain in detail the reasons for the delay.

Response: As noted above in response to question A.1, given the rising cost of construction (both in materials and labor), project coordination is a very important factor that when applicable will drive us to consolidate projects whenever possible. By designing, and constructing as a whole versus in parts, will not only reduce our overall spend, it will result in a more cohesive and efficient project. Due to market escalation in construction costs the team has launched more design time to reduce the costs of the project and maximize the project. Revised drawings are now expected to be completed late 2018. Once complete a revised timetable can be projected.

C. **Medical Equipment Projects** – If the project involves the acquisition of any of the following equipment: 1) major medical equipment as defined in NCGS §131E-176(14o); 2) the specific equipment listed in NCGS §131-176(16); or 3) equipment that creates a diagnostic center as defined in NCGS §131E-176(7a), provide the following information for each piece or unit of equipment: 1) manufacturer; 2) model; 3) serial number; and 4) date acquired.

Response: Not applicable.

D. Capital Expenditure

1. What is the total approved capital cost of the project indicated on the certificate of need? $171,616,236

2. Complete the table on the following page.
   a. Include all capital costs that have been paid to date as well as those that the applicant(s) are legally obligated to pay.
   b. If you have not already done so, provide copies of all executed contracts, including architect and engineering services (as applicable) and all final purchase orders for medical equipment costing more than $10,000 per unit.
   c. If the project involves renovation or construction, provide copies of the Contractors Application for Payment [AIA G702] with Schedule of Values [AIA G703].

	Capital Expense Since Last Report	Total Cumulative Capital Expenditure
Site Costs		
Purchase price of land		
Closing costs		
Site Inspection and Survey		
Legal fees		
Site preparation costs		
Other site costs (identify)		
Subtotal Site Costs		
Construction Contract		
Cost of materials		

Cost of Labor		
Other (Specify)		
Subtotal Construction Contract		
Miscellaneous Costs		
Building purchase		
Fixed equipment purchase/lease		
Moveable equipment purchase/lease		
Furniture		
Landscaping		
Consultant fees	$2,088,650.64	$2,274,579.43
Financing costs		
Interest during construction		
Other miscellaneous costs (Legal fees)		$460,203.44
Subtotal Miscellaneous Costs	$2,088,650.64	$2,784,782.87
Total	$2,088,650.64	$2,784,782.87

3. What is the projected remaining capital expenditure required to complete the project? $168,881,453.13

4. Will the total actual capital cost of the project exceed 115% of the approved capital expenditure on the certificate of need? If yes, explain the reasons for the difference.

   Response: No.

E. **CERTIFICATION** – The undersigned hereby certifies that the responses to the questions in this progress report and the attached documents are correct to the best of his or her knowledge and belief. In addition, I acknowledge that incomplete progress report forms **will not** be accepted and **must** be resubmitted upon notification from an Agency Project Analyst.

Signature of Officer: Andrew K. Zukowski

Name and Title of Responsible Officer: Andrew Zukowski, CFO

Telephone Number of Responsible Officer: 919-784-3245