December 2, 2019

COMMENTS IN OPPOSITION FROM NOVANT HEALTH, INC.

Regarding Atrium Health's CON Applications Filed October 15, 2019:

Atrium Health Lake Norman ("AHLN") Project I.D. #F-011810-19: Develop a new satellite hospital campus of Atrium Health University City with 30 acute care beds and 2 ORs in Cornelius, NC. Total project cost is $147,090,166.

Atrium Health University City ("AH University City") Project I.D. #F-011812-19: Add 16 acute care beds. Total project cost is $3,766,000.

Carolinas Medical Center ("CMC")

- **Project I.D. #F-011811-19:** Add 18 acute care beds. Total project cost is $10,527,737.
- **Project I.D. #F-011815-19:** Add two (2) ORs. Total project cost is $7,974,633.

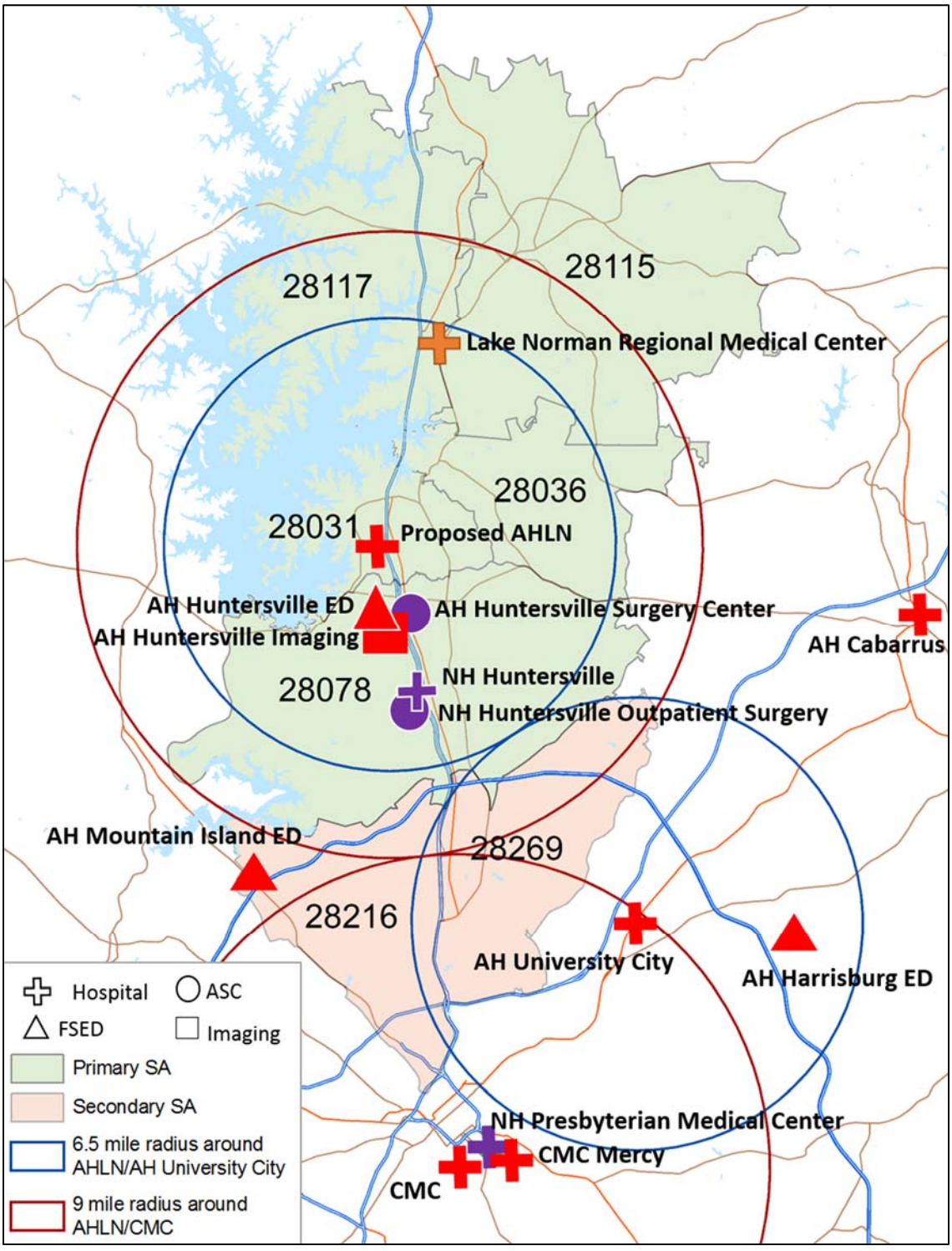
Atrium Health Pineville ("AH Pineville")

- **Project I.D. #F-011813-19:** Add 12 acute care beds. Total project cost is $7,231,102.
- **Project I.D. #F-011814-19:** Add two (2) ORs. Total project cost is $15,695,524.

The 2019 SMFP contains a need for 76 acute care beds and six (6) ORs in Mecklenburg County. Atrium Health applied for all 76 acute care beds and six (6) ORs. Novant Health filed two applications: one application for 20 additional acute care beds at Novant Health Matthews Medical Center ("NH Matthews") in Project I.D. #F-011808-19 and one application for one (1) additional OR at NH Matthews in Project I.D. #F-011807-19. Because AHLN is proposed as a satellite hospital under the AH University City license, Atrium Health is asking for 46 new acute care beds and two (2) ORs under that license. These comments analyze the AHLN acute care hospital campus application and compare the NH Matthews acute care bed and OR applications to AHLN and the other Atrium Health-sponsored applications.

The AHLN Application did not provide a map of the AHLN service area showing the location of existing providers. There may be two reasons they did not. First, a map makes it apparent the AHLN service area is not reasonable. Second, the map shows there is a plethora of healthcare options in the AHLN service area. NH Huntersville and Lake Norman Regional Medical Center ("LNRMC") are within a 6.5-mile geographic radius of AHLN and 5.1 and 7.2 driving miles, respectively, from AHLN. For reference, the map below shows the proposed AHLN location, the proposed AHLN service area, and the location of existing facilities in and near the AHLN service area.

AHLN Service Area and Existing Providers



The AHLN application did not analyze distance or drive times from service area ZIP Codes to AHLN or existing facilities. The geographic midpoints between AHLN and AH University City and between AHLN and CMC are 6.5 miles and 9.0 miles, respectively. The map shows these distances as circles

to demonstrate which portions of the service area are closer to AHLN or an existing Atrium Health hospital. A list of facilities offering one or more of the proposed AHLN service components is included below with driving distances and drive times on Wednesdays at peak morning travel (8 am). Residents of the service area have reasonable access to all health services AHLN would provide.

Travel Distance and Time from AHLN to

Existing and Approved Facilities Providing AHLN Service Components in the AHLN Service Area

From AHLN to:				Driving Miles	Driving Minutes	
Type	**System**	**Name**	**Zip**		**Low**	**High**
Hospital	Novant	NH Huntersville	28078	5.1	9	16
Hospital	Other*	Lake Norman Regional Medical Center	28117	7.2	10	16
FSED	Atrium	AH Huntersville Emergency Dept.	28078	2	4	8
FSED	Atrium	AH Mountain Island Emergency Dept.	28216	14.9	18	30
ASC	Novant	NH Huntersville Outpatient Surgery	28078	5.1	9	16
ASC	Atrium	AH Huntersville Surgery Center	28078	2	4	8
Imaging	Atrium	AH Carolinas Imaging Services - Huntersville	28078	2	4	8

Source: 2020 SMFP, NC Facility Licensure, Google Maps Wednesday 8 am Start. Lake Norman Regional Medical Center is part of Community Health Systems

Because the total number of acute care beds and ORs proposed in these eight applications exceeds the number of acute care beds and ORs that can be approved under the SMFP, it is not possible for the Agency to approve all eight applications. The Monthly Application Log indicates that the Agency intends to review the eight applications competitively, as approval of some combination of these applications will require the denial of other applications. The Agency is not required to award all 76 acute care beds and six (6) ORs available in Mecklenburg County under the 2019 SMFP.

As explained in these comments, approval of the AHLN Application is not possible because the AHLN application is non-conforming with CON Review Criteria (1), (3), (4), (5), (6), (12), (13) and (18a). Novant Health respectfully urges the Agency to approve the NH Matthews Applications and deny the AHLN Application. Novant Health notes that if the Agency denies the AHLN Application, the Agency can approve all other applications in this review cycle, which have a combined project cost lower than the AHLN Application alone.[1]

[1] Nothing in these comments should be deemed to suggest that Novant Health agrees with the approval of the other Atrium Health CON applications submitted in this review cycle.

Conformity with CON Statutory Review Criteria

Executive Summary

As explained in these comments, approval of the AHLN Application is not possible because the AHLN application is non-conforming with CON Review Criteria (1), (3), (4), (5), (6), (12), (13) and (18a) because:

1. The Applicant failed to demonstrate that its proposal maximizes healthcare value for resources expended. The Applicant proposes to spend $147 million to build AHLN, a hospital that will serve fewer than three additional patients per day from the proposed service area than Atrium already served in CY 2018. Accordingly, the application is nonconforming with Criterion (1) and Policy GEN-3.

2. The Applicant's assumption it will only serve patients who have historically received care at Atrium Health facilities in Mecklenburg County is unreasonable. The proposed location for AHLN is between LNRMC and NH Huntersville. Both hospitals are within a 6.5-mile geographic radius and 7.2 driving miles of AHLN. Clearly, AHLN chose this location to take patients and market share from LNRMC and NH Huntersville.

3. The Applicant failed to identify by DRG, or any other diagnosis code or description, which acute care patients at existing Atrium Health hospitals are appropriate for AHLN. These patients are the basis for all utilization projections. Therefore, the Applicant did not adequately identify the population to be served and is non-conforming with Criterion (3). Because the Applicant failed to provide adequate support for the assumptions and methodology used to project utilization, the Application is non-conforming with Criterion (3).

4. Including two Charlotte ZIP Codes in the AHLN service area and the assumption that more that 43 percent of projected acute care patients and 45 percent of projected acute care patient days will come from those two ZIP Codes is unreasonable.[2] The Applicant failed to provide adequate support for why it is reasonable to include Charlotte ZIP Codes in the service area when these two ZIP Codes are as close or closer to existing Atrium Health hospitals. AHLN does not improve access to Atrium Health services for patients in the two Charlotte ZIP Codes. The Applicant documented no connection between those ZIP Codes and the Lake Norman area that would provide a reasonable basis for believing that patients in these ZIP Codes would go to AHLN instead of the Atrium Health hospitals in Charlotte they went to historically. At best, residents of these ZIP Codes represent in-migration to the service area; therefore, the

[2] AHLN Application, Form C – Assumptions and Methodology, Page 6. CY 2025 Discharges from SSA (922) divided by Total Discharges (2,144) = 43 percent. CY 2025 Patient Days from SSA (3,576) divided by Total Patient Days (7,930) = 45 percent.

assumption they would account for over 40% of any service line is unreasonable. Because the Applicant does not demonstrate the utilization projections are based on reasonable and adequately supported assumptions, the Application is non-conforming with Criterion (3).

5. Because over 40 percent of projected patients will come from Charlotte, the population proposed to be served in the narrative (i.e., residents of the Lake Norman area) does not align with the proposed service area or the Applicant's utilization projections and therefore the Application is non-conforming with Criteria (1) and (3).

6. AHLN is an unnecessary duplication of Atrium Health ancillary and support facilities and is not the least costly or most effective alternative to meet needs of the residents of the service area the Applicant designated. Residents of all service area ZIP Codes have reasonable access to Atrium inpatient hospitals as shown by Atrium's market shares in each ZIP Code. A more cost-effective alternative is to add beds and ORs to AH University City and CMC/CMC-Mercy. Much of the cost of AHLN is the unnecessary duplication of ancillary and support facilities and equipment already present in Atrium Health outpatient facilities in the Lake Norman area, at AH University City, and at CMC/CMC-Mercy. Because the Applicant does not demonstrate it has proposed the least costly or most effective alternative, the Application is non-conforming with Criterion (4).

7. The Application overstates utilization. Without the Charlotte ZIP Codes, which were unreasonably included, the total volume projections for AHLN is much lower. Assuming (1) AHLN can shift the acute care days it projects from the PSA, (2) the PSA is 75 percent of total AHLN acute care days, and (3) the remaining 25 percent come from ZIP Codes all around the periphery, total acute care days in year three would be 5,805 (15.9 ADC), not 7,930 (21.7 ADC).[3] This equates to an acute care occupancy rate of 53 percent on 30 beds. Because the utilization projections are unreasonable, the project is not financially feasible and is not conforming with Criterion (5).

8. From a community need perspective, AHLN is an unnecessary duplication of other Lake Norman area facilities, including Atrium's own freestanding ED, ASC, and imaging center. The Applicant provided no evidence of lack of access to services in the Application. NH Huntersville and LNRMC are barely mentioned in the Application and not shown on any maps. Both are within a 6.5 mile geographic radius and 7.2 drvings miles of the proposed AHLN. The Lake Norman area has existing and approved hospitals, ASCs, FSEDs, and an Atrium Health imaging center. NH Huntersville added 48 acute care beds and one (1) OR in 2019 and will add 12 additional acute care beds and one OR in 2021. LNRMC has low occupancy and excess capacity. The Application

[3] 4,354 PSA / 75% = 5,805

does not demonstrate the proposed AHLN is not a duplication of existing Atrium Health services and is therefore non-conforming under Criterion (6).

9. The Applicant did not adequately document how the square footage in AHLN will be used. Therefore, the Applicant did not demonstrate the cost of design and construction is reasonable. The AHLN Application fails to demonstrate that its project will not unduly increase the costs of providing health services or the costs and charges to the public and is non-conforming with Criterion (12).

10. AHLN does not increase access for underserved groups and is non-conforming with Criterion (13). Atrium's assumption is everyone who would be served at AHLN is already being served at other Atrium hospitals, so the proposal provides no increase in access for these groups. The PSA ZIP Codes are areas with above average income and below average minority populations. Most of the underserved population resides in the two Charlotte ZIP Codes and residents in those ZIP Codes have equal or better geographic access to existing Atrium Health hospitals. The Applicant provides no statistical or anecdotal evidence the underserved groups do not have access to NH Huntersville and LNRMC. Atrium Health's existing and proposed FSEDs provide access to Atrium Health emergency services. The application does not demonstrate residents of the proposed service area do not have reasonable geographic and financial access to the services AHLN would provide now and in 2025. Therefore, the Applicant fails to adequately demonstrate how the proposed project will maximize healthcare value for resources expended in meeting the need identified in the 2019 SMFP and is also non-conforming with Criterion (1).

11. If the Applicant's assumption of no change of market share is reasonable, AHLN does not benefit competition; it just shifts patients from one Atrium Health hospital to another. If AHLN affects competition, it will increase the Atrium Health market share in Mecklenburg County. Atrium Health already has a dominant market share and increasing its market power in managed care negotiation could increase negotiated rates. The Applicant does not demonstrate it will enhance competition and is therefore non-conforming with Criterion (18a).

Criterion (1)

Criterion (1): NCGS § 131E-183(a)(1): The proposed project shall be consistent with applicable policies and need determinations in the State Medical Facilities Plan, the need determination of which constitutes a determinative limitation on any health service, health service facility, health service facility beds, dialysis stations, or home health offices that may be approved.

Policy GEN-3 applies to the AHLN Application. 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 AHLN Application does not comply with Policy GEN-3 for several reasons. First, the Application did not propose to address the needs of ***all residents*** in the proposed service area. The Applicant proposed to serve ***only*** Atrium's existing patients already being served at existing Atrium hospitals.[4]

> *"… as demonstrated in Form C Methodology and Assumptions, Atrium Health proposes to serve **only** patients from the Lake Norman area that have historically accessed Atrium Health hospitals in Mecklenburg County."*[5] *(emphasis added)*

The assumption that AHLN will serve only "Atrium Health" patients is implausible. However, should the Agency accept the Applicant's assumptions and methodology for projecting utilization as reasonable and adequately supported, the Agency should determine the Applicant has not documented that its projected volumes address the needs of ***all residents*** in the proposed service area. Therefore, the Agency should find the application non-conforming with Criterion (1).

When Atrium said it will serve patients from its service area who chose an Atrium facility in CY 2018, it means Atrium assumed there will be no shift in market share because of opening AHLN. Despite proposing to locate a new Atrium hospital approximately seven (7) driving miles from two acute care hospitals, NH Huntersville and LNRMC, in an area it repeatedly points out has no Atrium Health inpatient services, Atrium assumed it will not increase its market share for:

- acute care (med/surg, OB, ICU) patient discharges or days;
- emergency department visits;
- inpatient and outpatient surgical cases;
- observation days;
- procedure room volumes; and
- imaging and ancillary services.

[4] AHLN Application, Form C - Assumptions and Methodology, Page 3
[5] AHLN Application, Page 49 (emphasis added)

This is an unreasonable assumption. By spending $147 million to place a new hospital in close proximity to other hospitals, Atrium Health expects to take market share away from those hospitals. Yet Atrium Health claimed this is not the case and gave the Agency no other assumptions to support its utilization projections. The sole identified source of patients for the proposed new hospital are the patients who have historically used Atrium facilities in Mecklenburg County. The Applicant's assumptions and methodology for projecting utilization should be found unreasonable and lacking adequate support and the application should be non-conforming with Criterion (3) for these reasons.

Second, Atrium described the patients to be served at AHLN on Form C Methodology Page 3 and in the excerpt from page 3 below:

> *To determine the projected number of days to be served at Atrium Health Lake Norman, Atrium Health conducted an analysis of the potential patients to be served at the proposed facility. First, Atrium Health assumed that any patient days related to services that are not proposed to be provided at Atrium Health Lake Norman such as invasive/surgical cardiology, neurosurgery, pediatrics, and minor or advanced neonatal services would continue to be provided at existing Atrium Health facilities and not at Atrium Health Lake Norman. Second, Atrium Health assumed that Atrium Health Lake Norman would serve only patients with a Primary or Secondary Acuity Level MS-DRG,* ***as defined by Atrium Health****. The acute care days associated with services proposed to be provided at Atrium Health Lake Norman and with either a Primary or Secondary Acuity Level are hereafter referred to as "Atrium Health Lake Norman appropriate" acute care utilization. (emphasis added)*

The "Atrium Health Lake Norman appropriate" patients were selected using a black box methodology, "defined by Atrium Health." There is no generally accepted health care definition of "Primary or Secondary Acuity Level MS-DRGs." Atrium Health coined this term, but provided no definition of "Primary or Secondary Acuity Level MS-DRGs" and provided no list of the MS-DRGs, diagnosis codes, or procedure codes. Atrium did not provide the weights of the MS-DRGs or the product lines of the MS-DRGs it defined as appropriate. There is no way the Agency or competing applicants can analyze the reasonableness of Atrium's utilization projections because, although both parties have access to Truven Analytics data, Atrium did not list the DRGs it used to identify the potential patients at AHLN. Whether or not the Agency accepts the Applicant's market share assumption, because the Applicant failed to adequately describe the assumptions and methodology used to identify the population to be served and to project utilization, the application is non-conforming to Criteria (1) and (3) and should be denied.

Third, AHLN did not adequately demonstrate any community need for AHLN, which is further discussed under Criteria (3) and (6). The application did not demonstrate residents of the proposed service area lack reasonable geographic and financial access to the services AHLN would provide now and in 2025. Therefore, the Applicant failed to adequately demonstrate how the

proposed project will maximize healthcare value for resources expended in meeting the need identified in the 2019 SMFP.

The application did not address the needs identified in the SMFP. Its proposal is contrary to the explicit language in Policy GEN-3 that "[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." (emphasis added).* As shown in the table below, the Applicant proposed to spend $147 million for AHLN to serve less than three (3) more patients per day from the service area than were served in CY 2018 at Atrium's Mecklenburg County hospitals. The table below shows the base year 2018 appropriate acute care patient days (already being served at Atrium hospitals historically) compared to the AHLN acute care patient days in project year 3 (CY 2025).[6] Atrium attributes the difference to population growth. [7] Atrium did not justify spending $147 million to serve fewer than three (3) additional patients per day from the proposed service area at AHLN.

	2018 Potential Acute Care Volumes to be Served at AHLN[8]	**2025 Projected Acute Care Volumes to be Served at AHLN[9]**	**Difference (Service Area Population Growth)**
AHLN PSA Days	3,737	4,354	617
AHLN SSA Days	3,190	3,576	386
Total Days	6,927	7,930	1,003
ADC	19.0	21.7	2.7

Source: AHLN Application, Form C – Assumptions and Methodology Page 5

The Applicant assumed the CY 2018 identified patient days for AHLN will grow by the projected annual population growth rate for the PSA and SSA shown below.[10]

Projected Population Growth

	2018	*2024*	*CAGR*
PSA Population	204,826	228,464	2.21%
SSA Population	140,208	152,127	1.65%

Source: Esri.

[6] AHLN Application, Form C – Assumptions and Methodology, Page 5
[7] AHLN Application, Form C – Assumptions and Methodology, Page 5
[8] AHLN Appropriate patients historically served at AH Mecklenburg County facilities. AHLN Application, Form C – Assumptions and Methodology, Page 5
[9] AHLN Appropriate patients historically served at AH Mecklenburg County facilities. AHLN Application, Form C – Assumptions and Methodology, Page 5
[10] AHLN Application, Form C – Assumptions and Methodology, Page 5

Assuming all acute care patient days in the service area grow at these population growth rates, the table below shows population growth will increase the average daily census (ADC) of acute care patients in the total service area by 37 as compared to CY 2018.

CY 2018 – CY 2025 Acute Care Days in AHLN Service Area

AHLN Service Area ZIP Code	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023	CY 2024	CY 2025	CAGR
28031-Cornelius	6,955	7,109	7,266	7,426	7,591	7,758	7,930	8,105	2.21%
28036-Davidson (w/ 28035 PO Box)	4,133	4,224	4,318	4,413	4,511	4,610	4,712	4,816	2.21%
28078-Huntersville (w/ 28070 PO Box)	15,146	15,481	15,823	16,173	16,530	16,895	17,269	17,650	2.21%
28115-Mooresville (w/28123 PO Box)	12,776	13,058	13,347	13,642	13,943	14,252	14,567	14,888	2.21%
28117-Mooresville	9,080	9,281	9,486	9,695	9,910	10,129	10,353	10,581	2.21%
28216-Charlotte	24,091	24,489	24,893	25,303	25,721	26,145	26,577	27,015	1.65%
28269-Charlotte	22,414	22,784	23,160	23,542	23,930	24,325	24,727	25,135	1.65%
Service Area Total	94,595	96,425	98,291	100,195	102,135	104,114	106,133	108,191	
Difference (Days) from CY 2018		1,830	3,696	5,600	7,540	9,519	11,538	13,596	
Difference (ADC) from CY 2018								37.2	

Source: Total Acute Care Days from Truven Analytics, CY 2018. Acute Care Days calculated by applying the Sheps Center methodology used in the SMFP. CAGR from Esri (as provided in the AHLN Application, Form C Assumptions and Methodology, Page 5

Atrium Health is proposing a $147 million hospital to serve fewer than three of these additional patients at AHLN. A proposal that claims to be focused on serving one health system's patients, and would only serve fewer than three more of these patients does not meet the requirements of Policy GEN-3 that the proposal address the needs of all residents of the service area.

The claim that AHLN will "help to decompress the highly utilized Atrium Health hospitals" in Mecklenburg County is unsubstantiated because the Applicant did not provide adequate support for the assumption AHLN will not increase Atrium's market share.[11] Further, since it is unrealistic to expect residents of the two Charlotte ZIP Codes, who comprise over 40 percent of AHLN's projected patients, to switch from Atrium's Charlotte hospitals to AHLN, it is unreasonable to expect AHLN will reduce the ADC at Atrium's existing hospitals.

The PSA has relatively high household incomes. The most current publicly available Census data report median income of $86,027 in AHLN's home ZIP Code 28031, and $92,707 for Huntersville

[11] AHLN Application, Page 47

ZIP Code 28078, compared to $49,440 and $63,097 for the SSA ZIP Codes 28216 and 28269, respectively.[12]

AHLN will not improve access to services for uninsured, Medicare or Medicaid populations. AHLN's projected payor mix for each service is based on Atrium Health Mecklenburg facilities' CY 2018 payor mix for Atrium Health Lake Norman-appropriate patients from the PSA and SSA identified in the Form C Methodology and Assumptions for the services to be provided at the proposed facility.[13] AHLN's payor mix is heavily weighted to the SSA, due to the unreasonable distribution of patients from the SSA, as further discussed under Criterion (3). The table below compares the percentages of total acute care patient days in the PSA and SSA in CY 2018 compared to AHLN's questionable payor mix.[14]

Acute Care Payor Mix for AHLN and AHLN Service Area, CY 2018

	Med/Surg and ICU Days			Obstetrics Days		
Payor	CY 2018 PSA	CY 2018 SSA	AHLN	CY 2018 PSA	CY 2018 SSA	AHLN
Insurance	28.0%	18.9%	19.5%	77.1%	48.6%	54.8%
Medicaid	8.7%	13.8%	17.9%	19.7%	44.8%	42.5%
Medicare	38.2%	37.5%	52.7%	0.1%	0.7%	0.7%
Other / Gov't	2.8%	3.0%	2.5%	1.3%	1.3%	0.4%
Self Pay	2.9%	5.9%	7.5%	1.8%	4.6%	1.5%

Source: Service Area Total Acute Care Days from Truven Analytics, CY 2018. Acute Care Days calculated by applying the Sheps Center methodology used in the SMFP. Obstetrics identified as Truven service line "Obstetrics". Med/Surg = Total Acute Care less Obstetrics. AHLN payor mix from AHLN Application, Page 124. AHLN projects the same payor mix percentages for Med/Surg and ICU.

While Atrium argues it generated the need determination for beds and ORs in the SMFP, that does not entitle it to any additional assets. Rather, it must demonstrate, through reasonable and supported assumptions, there is a need for the projects it proposed. As explained in these comments, the AHLN Application failed to do so. The Agency should not approve a non-confirming application because a health system shows a deficit of assets in the SMFP.

For the above-stated reasons, plus any additional reasons the Agency may discern as it reviews the AHLN Application, the AHLN Application is non-conforming with Criterion (1) and should be denied.

Criterion (3)

Criterion (3): NCGS § 131E-183(a)(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

[12] American Fact Finder. https://factfinder.census.gov/faces/nav/jsf/pages/community_facts.xhtml
[13] AHLN Application, Page 125
[14] AHLN Application, Page 124

proposed and the extent to which all residents of the service area, and, in particular, low income persons, racial and ethnic minorities, women, handicapped persons, the elderly, and other underserved groups likely to have access to the services proposed.

The AHLN Application is nonconforming with Criterion (3) because the Applicant:

1. Did not adequately identify the population to be served

    a. The Applicant failed to provide adequate support for the reasonableness of its service area.

    b. The population proposed to be served in the narrative (Lake Norman area) does not align with the proposed service area or the Applicant's utilization projections.

    c. The Applicant failed to provide adequate support for the assumptions and methodology used to identify the population to be served and project utilization.

2. Did not demonstrate all residents of the service area will have access to the services proposed

3. Did not demonstrate the need for the services proposed by residents of the service area

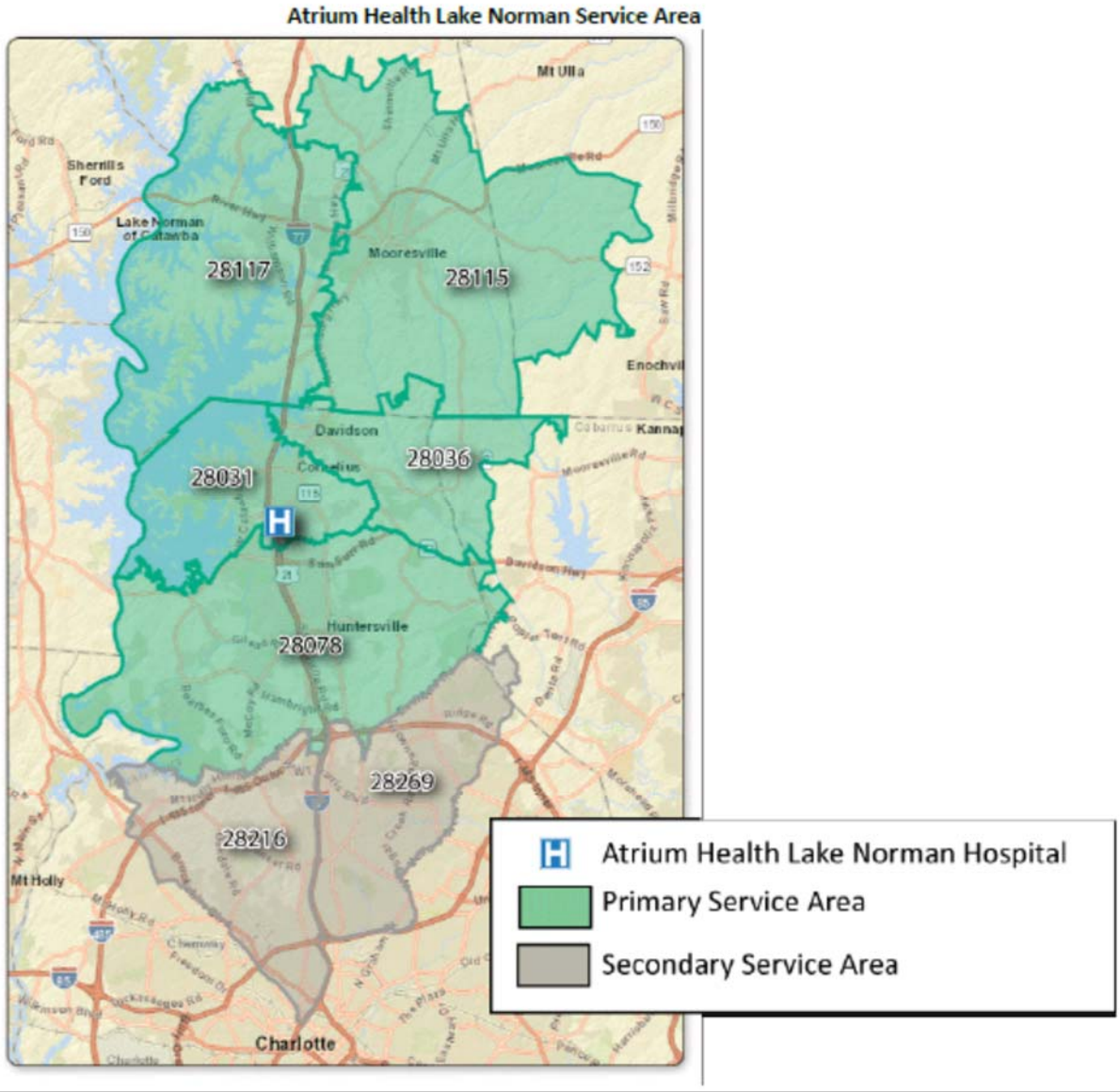
<u>The Applicant did not adequately identify the population to be served</u>

The Applicant failed to provide adequate support for the reasonableness of its service area

There is no explanation in the Application how Atrium determined its service area based on generally accepted health planning principles. The text by which the Applicant defined its service area in Section C of the Application is limited to a single sentence and a map, reproduced below.[15]

[15] AHLN Application, Page 40

The map below shows the proposed primary service area (PSA) and secondary service area (SSA) and corresponding ZIP codes from which Atrium Health Lake Norman projects to draw its patients.



In the Assumptions and Methodology following Form C the Applicant stated, "Based on the geography of the Lake Norman area and expected patient travel patterns, Atrium Health considered its historical utilization originating from only certain geographies as identified in the table below" and then lists the PSA and SSA ZIP Codes.[16] However, there is no support or exhibits provided for what "geography" and "expected travel patterns" the Applicant used to define the service area. The application has a section on planned public roadway improvements in the Lake Norman area, but acknowledged these projects which "will allow for faster travel both north and south," would actually reduce travel times of PSA residents accessing Atrium's existing

[16] AHLN Application, Form C - Assumptions and Methodology, Page 2

Mecklenburg County hospitals.[17] The planned road improvements would also reduce travel times for PSA residents accessing NH Huntersville and LNRMC.

The Agency approved Atrium to develop Atrium Health Mountain Island, a freestanding emergency department ("FSED") in the Mountain Island area (Project ID # F-11658-19).[18] According to its application, Atrium Health Mountain Island will open in 2021. That application, excerpted in the AHLN Application and the Agency Findings, defined Atrium Health Mountain Island's proposed service area by a 15-minute drive time radius.[19] Atrium provided no such analysis for the AHLN project.

AHLN's PSA, which contains the entire Lake Norman area, is expected to generate only 55 percent of its patient days (4,354 / [4,354 + 3,576]).[20] The remaining 45 percent of AHLN's projected acute care days are expected to come from the Charlotte ZIP Codes. Atrium did not provide adequate support for its assumption that residents from the Charlotte ZIP Codes would drive to Cornelius for their hospital care when there are multiple closer hospitals in Charlotte as shown on the map on page 2 of these comments.

Projected Atrium Health Lake Norman Total Inpatient Utilization

	CY23	*CY24*	*CY25*
PSA Days of Care	2,084	3,195	4,354
PSA ALOS	3.56	3.56	3.56
PSA Discharges	585	897	1,222
SSA Days of Care	1,730	2,638	3,576
SSA ALOS	3.88	3.88	3.88
SSA Discharges	446	680	922
Total Discharges	1,031	1,577	2,144

Atrium claims, "[the] impetus for the proposed project is to locate Atrium Health inpatient services closer to patients in the Lake Norman area that have historically accessed existing Atrium Health hospitals in Mecklenburg County…"[21] In summary, the Applicant's service area is unreasonable because it is not adequately supported and it contradicts the "impetus" for AHLN.

The population proposed to be served in the narrative (Lake Norman area) does not align with the proposed service area or the Applicant's utilization projections.

The Applicant describes the population to be served as residents of the Lake Norman area:

[17] AHLN Application, Pages 41-43
[18] AHLN Application, Form C – Assumptions and Methodology Page 14
[19] AHLN Application, Form C – Assumptions and Methodology, Page 14. AHLN Application, Exhibit C.12-1
[20] AHLN Application, Form C – Assumptions and Methodology, Page 6
[21] AHLN Application, Page 47

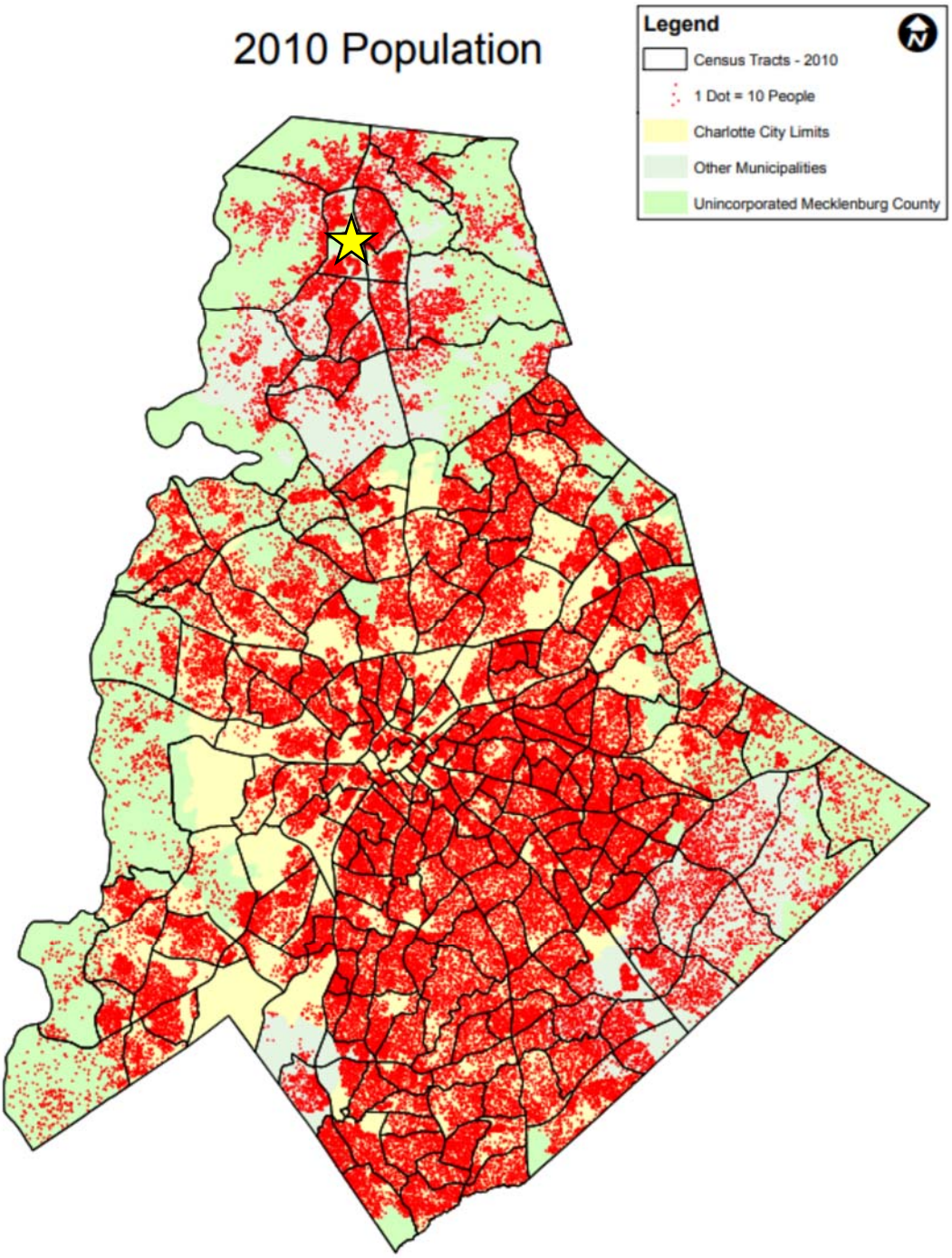
> *Atrium Health proposes to develop a new acute care hospital campus (as a remote location of Atrium Health University City) in Cornelius, North Carolina in order to bring high quality, convenient access to care for the residents of the Lake Norman area.*[22]

In describing the Lake Norman area, the applicant states:

> *The Lake Norman area's proximity to the city of Charlotte as well as the allure of access to a large body of water capable of supporting a wide variety of recreational activities, including boating and freshwater fishing, has contributed to the population growth in the area. As a result of these factors, the population of the Lake Norman area has grown to a density similar to other well populated areas of Mecklenburg County, as shown in the figure below.*[23]

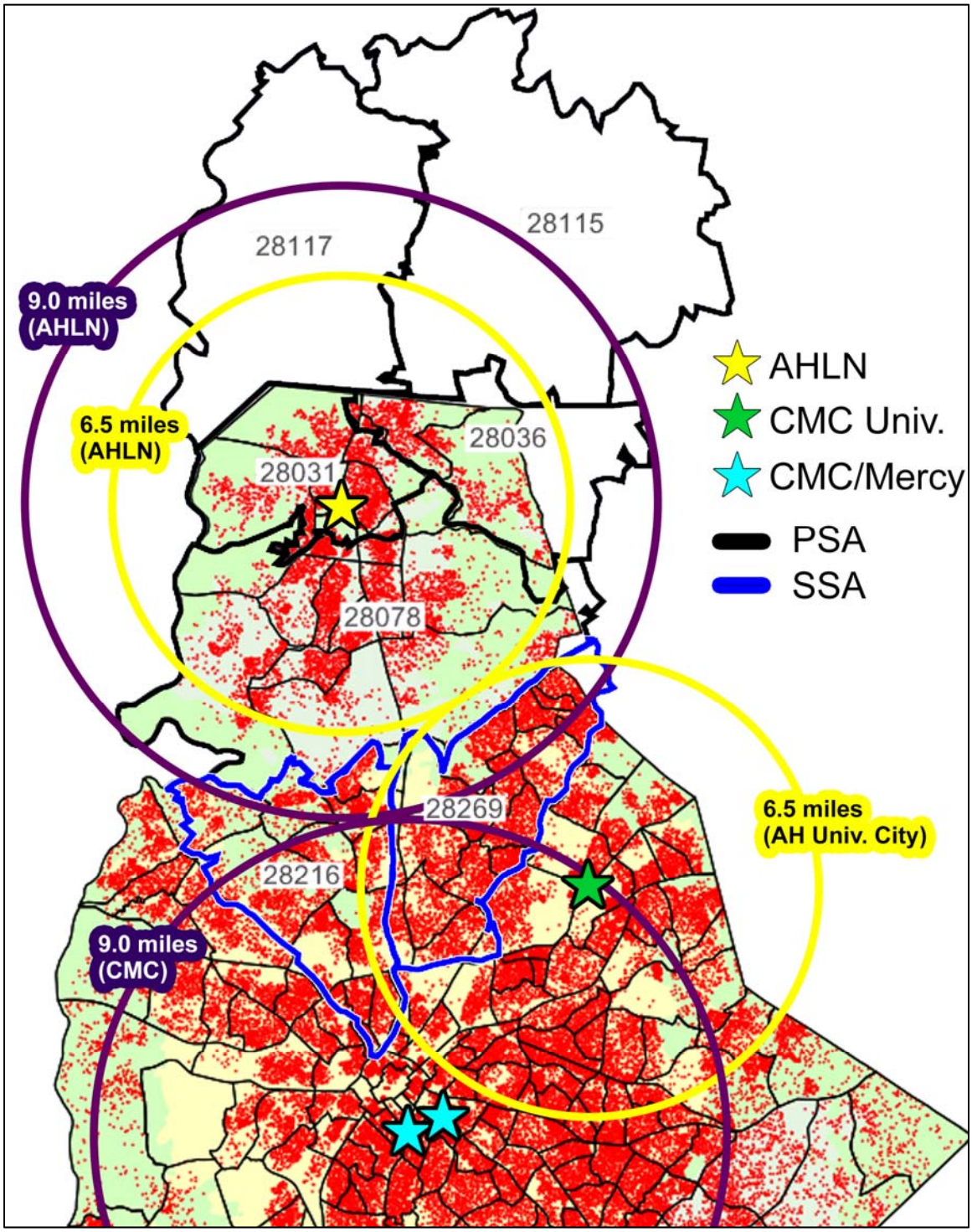
The referenced figure, for 2010, is reproduced below and clearly shows the dense area the applicant calls "the Lake Norman area," in the northern most portion of Mecklenburg County, distinctly separate from the Charlotte City limits.

[22] AHLN Application, Page 36
[23] AHLN Application, page 38



The map on the next page overlays the AHLN service area onto the Applicant's 2010 population density map. The Applicant's service area directly contradicts its claims to serve the Lake Norman area. The AHLN service area extends far beyond the population density of the Lake Norman area and well into the Charlotte city limits (ZIP Codes 28216 and 28269) as well as Iredell County. The geographic midpoints between AHLN and AH University City and between AHLN and CMC are 6.5 miles and 9.0 miles, respectively. The map shows a 6.5-mile radius around AHLN and AH University City in yellow and a 9.0-mile radius around AHLN and CMC in dark purple. Geographically, no

residents in ZIP Code 28269 would be closer to AHLN than to AH University City. The most population dense portions of the SSA (ZIP Codes 28216 and 28269) are much closer to the existing Atrium hospitals in Mecklenburg County from which the Applicant proposes to shift patients.



The Applicant failed to provide adequate support for the assumptions and methodology used to identify the population to be served and project utilization

The Applicant must demonstrate in the application as submitted that projected utilization is based on reasonable and adequately supported assumptions. These assumptions and methods to project utilization for AHLN are unreasonable and/or not adequately supported:

- The assumption there will be no change in Atrium market share by ZIP Code is unreasonable and not adequately supported
- Atrium overstated the target patients from the service area currently being served at Atrium Mecklenburg County hospitals
- The assumed shift of Atrium patients from Mecklenburg County hospitals to AHLN is unreasonable and not adequately supported
- The distribution of projected days from the PSA and SSA are unreasonable
- The average length of stay is unreasonable
- Atrium provided inadequate support for its projected surgical services
- Atrium provided inadequate support for its projected other services
- AHLN is not comparable to AH Union West
- Atrium did not demonstrate the need for the services proposed by residents of the service area

Each issue is discussed below.

The assumption there will be no change in Atrium market share by ZIP Code is unreasonable and not adequately supported

AHLN proposed to exclusively serve current Atrium acute care, obstetrics, ICU, emergency department, or imaging patients and not divert any patients from non-Atrium facilities. When Atrium says it will serve patients from its service area who chose an Atrium facility in CY 2018, it does not mean the actual individuals it served. It means Atrium assumed opening AHLN will not increase its market share. The assumption AHLN will not increase its market share is unreasonable and not adequately supported. Atrium provided no evidence showing the opening of a new hospital would not increase its market shares in that hospital's service area. Atrium's assumption contradicts its past assumptions and arguments about the impact of new facilities on existing facilities.

Market Share Contradiction 1: NH Huntersville Medical Center

Atrium Health submitted comments in opposition on Rowan Regional Medical Center – South's ("RRMC-S") CON application for a new acute care hospital in Rowan County (Attachment 1).[24] The Agency findings denied that application (Attachment 2). Based on market share shifts when NH Huntersville opened, Atrium Health argued it would lose market share if RRMC-S was approved. Atrium argued in its RRMC-S comments:

[24] Rowan Regional Medical Center – South Project ID# F-7994-07

In the case of Presbyterian-Huntersville, the hospital's CON application on page 53 of Exhibit 17 projected "862 Discharges Lost to PHN [Presbyterian-Huntersville]" from Presbyterian Hospital in the third year of the project. Furthermore, the application argued on page 107 that "the proposed addition of beds in the Huntersville service area, which will be accomplished by the relocation of beds and services from the downtown Charlotte area, not only meets the needs of the residents of Huntersville, but also adequately meets the needs of resident and patients who receive care at Presbyterian Hospital." However, in reality, no volume shifted from Presbyterian Hospital to Huntersville; Presbyterian Hospital's volume from the Huntersville service area increased from 5,385 in 2003 (the year prior to the hospital's opening) to 6,119 in 2005 (the first full year following the hospital's opening). In contrast, even if all new service area growth is attributed to Presbyterian-Huntersville (instead of shared with Presbyterian Hospital), approximately 75 percent of Presbyterian-Huntersville's volume came from competitor hospitals, while additional volume shifted from competitors to Presbyterian Hospital.

Presbyterian-Huntersville Competitive Shift

	2003 Volume	*New Area Growth*	*Competitive Shift*	*2005 Volume*
Presbyterian-Huntersville and Presbyterian Hospital Combined	5,385	608	2,705	8,698
% of Total	**62%**	**7%**	**31%**	**100%**
Presbyterian-Huntersville Only	0	608	1,971	2,579
% of Total	**0%**	**24%**	**76%**	**100%**

Source: Presbyterian-Huntersville analysis conducted by CMC-NorthEast, see Exhibit 6.

As a result of the development of Presbyterian-Huntersville, from 2003 to 2005:

- Presbyterian Hospital/Presbyterian-Huntersville combined gained eight points of share
- Lake Norman Regional Medical Center lost two points of share
- CMC and CMC-University combined lost five points of share
- Occupancy at CMC-University declined by 6.7 points from ***2003 to 2005 alone;*** of that 6.2 points is attributable to the 807 discharges lost to Presbyterian Huntersville[9]

Atrium's comment on the RRMC-S application demonstrates the unreasonableness of its assumption that AHLN will not increase Atrium's market share in the proposed service area. The only distinction between the NH Huntersville example and AHLN is that NH Huntersville was farther from LNRMC (12 miles) and from AH University City (12 – 15 miles), than the driving miles from AHLN to NH Huntersville (5.1 miles) and LNRMC (7.2 miles). From another perspective, if no market share shifted from Presbyterian Hospital when NH Huntersville opened, it is not reasonable to expect all of AHLN's patients to shift from Atrium's Mecklenburg County hospitals to AHLN as it claims:

> *The impetus for the proposed project is to locate Atrium Health inpatient services closer to patients in the Lake Norman area that have historically accessed existing Atrium Health hospitals in Mecklenburg County; which, in turn, will help to decompress the highly utilized Atrium Health hospitals in the county.*[25]

Based on Atrium's own analysis of NH Huntersville, AHLN will take market share from hospitals in the service area with unused capacity, i.e., NH Huntersville and LNRMC.

Market Share Contradiction 2: AH Mountain Island Lake Emergency Department

AHLN proposes an emergency department. However, AHLN's projected emergency department visits are composed entirely of visits historically served by Atrium Health Mecklenburg hospitals.[26] First, AHLN will have a small ED compared to existing Level I Trauma Center ED at CMC. The proposed mobile MRI means there may be times MRI will not be available for ED patients. The Applicant stated AHLN will have limited availability of MRI service compared to Atrium Health fixed scanners in Charlotte.[27] Atrium's assumption that patients closer to a higher level ED would instead go to a lower level ED further away is unreasonable.

Second, this assumption contradicts assumptions Atrium made in the Mountain Island Lake Application. In that application, Atrium projected its impact on existing emergency departments, including non-Atrium Health facilities, based on existing hospitals' proportional market share of Atrium Health Mountain Island's proposed service area. [28] Atrium gave no reason Mountain Island would impact all existing providers while AHLN' would only impact Atrium facilities, when AHLN is located between two hospitals with emergency departments. A hospital ED will have equal or greater impact on existing hospitals than an FSED. Further, Atrium unreasonably projected no impact from AHLN on its own Huntersville FSED located only two miles from AHLN.

[25] AHLN Application, Assumptions and Methodology, Page 3
[26] AHLN Application, Form C – Assumptions and Methodology Page 13
[27] AHLN Application, Form C – Assumptions and Methodology Page 18
[28] AHLN Application, Form C – Assumptions and Methodology Page 15

Market Share Contradiction 3: Piedmont Medical Center Fort Mill

The Applicant's assumptions for AHLN contradict its own assumptions and method for projecting the shift of patients from Atrium hospitals in Mecklenburg County to the proposed Piedmont Medical Center in Fort Mill, SC. The Applicant stated: "Atrium Health believes it is reasonable to assume that a York County patient who has a scheduled inpatient admission and is cared for by a physician who admits patients at Atrium Health facilities would continue to be served by Atrium Health facilities. However, patients who are admitted through the emergency room may be more likely to shift their site of care to a new hospital closer to home."[29] Atrium projected over 5,000 acute care patient days would shift from AH Pineville to Piedmont Medical Center Fort Mill, yet zero will shift from other non-Atrium hospitals to AHLN.[30]

Just as Atrium assumed in its AH Mountain Island FSED application, AHLN's ED volumes and emergency impatient admissions would affect ***all*** existing providers. Just as AHLN's ED will capture market share from NH Huntersville and LNRMC, it is reasonable to assume other services at AHLN will increase Atrium's market share.

The Applicant overstates the target patients at Atrium Mecklenburg County hospitals

The Applicant claims the project will target patients from the proposed primary and secondary service areas who have historically accessed Atrium Mecklenburg County hospitals, as shown in the excerpt below.[31]

[29] AHLN Application, Exhibit C-4.1, Concurrent Acute Care Bed Form C Methodology Page 5
[30] Piedmont Fort Mill proposed location is Sutton Rd and I-77.
https://www.bizjournals.com/charlotte/news/2019/02/21/after-15-years-piedmont-medical-gets-go-ahead-over.html as viewed on October 29, 2019.
[31] AHLN Application, Page 47

The impetus for the proposed project is to locate Atrium Health inpatient services closer to patients in the Lake Norman area that have historically accessed existing Atrium Health hospitals in Mecklenburg County, which in turn, will help to decompress the highly utilized Atrium Health hospitals in the county. The table below provides the number of acute care days provided at an Atrium Health hospital to patients from the PSA and SSA from 2016 to 2018.

Historical Number of Acute Care Days Provided at an Atrium Health Hospital to Patients from PSA and SSA

All Patients	*2016*	*2017*	*2018*	*CAGR*
PSA Days	14,224	14,725	15,398	4.0%
SSA Days	27,185	28,782	28,949	3.2%
PSA ADC*	39	40	42	4.0%
SSA ADC	74	79	79	3.2%
PSA + SSA ADC	**113**	**119**	**121**	**3.5%**

Source: Atrium Health internal data.
*Average Daily Census.

The table above shows that patients from the PSA and SSA accounted for an ADC of 121 patients in 2018, which means that 121 acute care beds at an Atrium Health hospital were occupied every day by patients from the PSA/SSA. Further, as shown above, the ADC of residents from the PSA/SSA in Atrium Health hospitals in Mecklenburg County increased by 3.5 percent annually from 2016 to 2018.

The impetus for the project references only patients served in Mecklenburg hospitals. The text referring to the table indicates the ADC is shown for "residents from the Atrium Health Lake Norman PSA/SSA in Atrium Health hospitals in Mecklenburg County." The table below shows acute care days from the service area in CY 2018 at Atrium Health hospitals in Mecklenburg County from Truven Analytics. The actual number of acute care patient days at Atrium's Mecklenburg County hospitals is 14 percent lower than the Applicant claimed, as shown in the table below.[32] The Applicant misrepresented and overstated the residents from the service area in Atrium's Mecklenburg County hospitals. It appears from the Truven data the Applicant used AH Cabarrus, and perhaps other Atrium hospitals in North Carolina, to boost its total acute care patient days in Mecklenburg County from the service area. Although more patients from the service area receive their acute care services at AH Cabarrus than AH University City, the Applicant did not assume a shift of any patients from AH Cabarrus to AHLN.[33]

[32] Truven Analytics reports 38,146 acute care patient days from the PSA and SSA were provided at Atrium Health Mecklenburg County Hospitals while the AHLN Application claims 44,347 acute care patient days (15,398 PSA + 28,949 SSA = 44,347. (38,146 – 44,347)/44,347 = -14%

[33] AHLN Application, Form C – Assumptions and Methodology, Pages 6 and 7

CY 2018 Total Acute Care Days Provided at a Mecklenburg County Atrium Health Hospital to Patients from PSA and SSA

ZIP Code	AH University City	CMC Main / CMC Mercy	AH Pineville	Atrium Health Mecklenburg County Total	AH Cabarrus	Other Atrium Health Hospitals	Total with AH Cabarrus and Other Atrium Hospitals	AHLN Application
28031-Cornelius	337	1,440	25	1,802	302	12	2,116	
28036-Davidson (w/ 28035 PO Box)	168	635	18	821	883	2	1,706	
28078-Huntersville (w/ 28070 PO Box)	895	4,091	86	5,072	718	38	5,828	**
28115-Mooresville (w/28123 PO Box)	113	2,020	53	2,186	1,057	5	3,248	
28117-Mooresville	63	1,763	17	1,843	256	14	2,113	
PSA Subtotal	1,576	9,949	199	11,724	3,216	71	15,011	15,398
28216-Charlotte	1,394	12,410	228	14,032	540	217	14,789	**
28269-Charlotte	4,665	7,500	225	12,390	1,456	46	13,892	
SSA Subtotal	6,059	19,910	453	26,422	1,996	263	28,681	28,949
Total	7,635	29,859	652	38,146	5,212	334	43,692	44,347
PSA ADC	4	27	1	32	9	0	41	42
SSA ADC	17	55	1	72	5	1	79	79
Total ADC	21	82	2	105	14	1	120	121

*Source Notes: ** Historical acute care days by ZIP Code not provided by the Applicant*
Acute Care Days by Hospital: CY 2018 Atrium Health Mecklenburg Total Acute Care Days from Truven Analytics, CY 2018. Acute Care Days calculated by applying the Sheps Center methodology used in the SMFP
Other Atrium Hospitals: Kings Mountain Hospital, CMC – Lincoln, Cleveland Regional Medical Center, Stanly Regional Medical Center, Union Regional Medical Center
AHLN Application, Page 46

The Applicant stated many patients, an ADC of 121, bypass Novant Health Huntersville Medical Center for care at an Atrium Health facility. However, because the Applicant did not identify the types of services these patients needed, other than that they allegedly occupied acute care beds at an Atrium facility, we don't know why these patients went to an Atrium facility and we can't conclude that they would be likely to seek services at AHLN.

Assumed shift of Atrium patients from Mecklenburg County hospitals to AHLN is unreasonable and not adequately supported

The Applicant assumed:

> *Patients in the PSA would be closer to Atrium Health Lake Norman than to any other Atrium Health Mecklenburg County hospital; thus, 80 percent of those patients are assumed to be served at Atrium Health Lake Norman. Some patients in the SSA are closer to Atrium Health Lake Norman and some are closer to existing Atrium Health Mecklenburg County hospitals; thus, 20 percent of those patients are assumed to be served at Atrium Health Lake Norman.*[34]

Other than vague geographic proximity to AHLN described above as "closer", the Applicant did not say how it determined these percentages. The Applicant provided no documentation of geographic distance, driving distance, or travel times between AHLN or the service area ZIP Codes and other existing hospitals in the service area or Mecklenburg County. The analysis shows that the Applicant's acute care patient day shift assumptions are based on incorrect facts and unreasonable percentages.

The maps on page 2 and 17 of these comments show no residents in ZIP Code 28269 would be closer to AHLN than to AH University City. The map on page 17 shows the most population dense portions of the SSA (ZIP Codes 28216 and 28269) are much closer to the existing Atrium hospitals in Mecklenburg County. Atrium provided no reasonable basis to expect any substantial number of patients from ZIP Codes 28216 and 28269 to use AHLN. Atrium included them in the service area because without them it cannot justify need for the project without assuming a substantial increase in Atrium's market share in the primary service area.

Atrium based the number of base year CY 2018 acute care patient days served by AHLN in future years on unsupported assumed shift percentages. [35]

Days of Care to be Served at Atrium Health Lake Norman

	CY 2018 Potential Days	*Percentage Served*	*Potential Days to be Served at Atrium Health Lake Norman*
PSA	4,671	80%	3,737
SSA	15,948	20%	3,190
Total	20,619		6,926

The Applicant's proposal to bring "convenient access to care for the residents of the Lake Norman area" is misleading because:

- The service area extends to the south far beyond the Lake Norman area

[34] AHLN Application, Form C - Assumptions and Methodology, Page 5
[35] AHLN Application, Form – C Assumptions and Methodology, Page 5. Patient days are limited to the Atrium Lake Norman Appropriate DRGs, as defined by the Applicant.

- The secondary service area comprises two Charlotte ZIP Codes (28216 and 28269), the majority of which are significantly closer to other Atrium hospitals were they receive their inpatient services.
- Despite its claims to serve the residents of the Lake Norman area, almost half (46%) of the CY 2018 base year patient days are expected to come from the two Charlotte ZIP Codes in the SSA, which are closer to Charlotte hospitals.[36]

The orientation of the SSA's residents to Charlotte hospitals is evident in their commuting patterns. Census data show over 60 percent of the residents in the SSA work in Charlotte. Only 2.8% of the residents in ZIP Codes 28216 and 28269 commute to Huntersville. Of note, less than one percent of the SSA residents commute to Cornelius.

Work Destination Report - Where Workers are Employed Who Live in the Selection Area

	AHLN Primary Service Area					AHLN Secondary Service Area	
	28117	**28115**	**28031**	**28036**	**28078**	**28216**	**28269**
Charlotte	17.3%	15.6%	38.6%	36.3%	47.9%	62.1%	61.3%
Concord	2.9%	4.1%	3.3%	6.5%	3.7%	2.8%	4.7%
Cornelius	2.7%	2.6%	9.1%	3.3%	3.4%	*	*
Davidson	3.2%	3.4%	4.4%	10.6%	2.4%	*	*
Gastonia	*	*	1.0%	*	1.1%	1.6%	1.1%
Greensboro	1.5%	*	1.0%	1.2%	1.0%	1.1%	1.2%
Huntersville	3.9%	3.9%	7.6%	4.7%	10.2%	2.8%	2.8%
Kannapolis	*	*	*	2.1%	*	*	*
Matthews	*	*	*	*	*	1.0%	1.0%
Mooresville	22.7%	24.3%	6.2%	6.5%	4.0%	1.2%	1.2%
Pineville	*	*	*			1.1%	0.9%
Raleigh	1.7%	1.6%	1.9%	2.1%	1.7%	1.7%	1.9%
Salisbury	*	2.4%	*	*	*	*	*
Statesville	6.1%	4.9%	*	*	*	*	*
Winston-Salem	2.0%	1.9%	0.9%	1.0%	0.9%	1.0%	1.0%
Other location	35.9%	35.4%	25.9%	25.7%	23.6%	23.6%	23.0%

** For locations having < 1 percent, Census data are not available.*
Source: U.S. Census Bureau, OnTheMap Application, http://onthemap.ces.census.gov

The distribution of projected days from the PSA and SSA is unreasonable

AHLN's proposed project is not feasible without significant shifts of patients from Charlotte ZIP Codes, and it is unreasonable to assume that Charlotte residents will drive farther to reach AHLN.

[36] AHLN Application, Form C – Methodology and Assumptions, page 5. 3,190/6,926 = 46%.

Atrium showed all utilization projections by primary and secondary service areas and not by ZIP Codes to mislead the Agency. Because of the black box methodology it used to define "AHLN Appropriate" patients, the Agency, and competitors cannot determine the number of acute care patient days projected by ZIP Code.

However, we do have access to total acute care days by ZIP Code and hospital from Truven Analytics. The Applicant based its utilization projections on base year CY 2018 patient days it assumed could be shifted to AHLN in future years.[37] Based on the distribution of total acute care days at Atrium County Mecklenburg County hospitals in CY 2018 from the ZIP Codes in the PSA and SSA, the table below estimates the distribution of projected days in the base year.

[37] AHLN Application, Form C – Assumptions and Methodology, Pages 4 and 5

CY 2018 Acute Care Days Potentially Served at AHLN, Estimated by ZIP Code

	Column A	*Column B*	*Column C*	*Column D*	*Column E*
ZIP Code	**CY 2018 Atrium Health Mecklenburg Total Acute Care Days**	**Percent of PSA / SSA Service Area**	**CY 2018 Potential Days to be Served at AHLN (by PSA / SSA)**	**CY 2018 Potential Days to be Served at AHLN (by ZIP Code)**	**CY 2018 AHLN Patient Origin Percentage**
28031-Cornelius	1,802	15.4%	**	575	8.3%
28036-Davidson (w/ 28035 PO Box)	821	7.0%		262	3.8%
28078-Huntersville (w/ 28070 PO Box)	5,072	43.3%		1,618	23.4%
28115-Mooresville (w/28123 PO Box)	2,173	18.5%		691	10.0%
28117-Mooresville	1,843	15.7%		587	8.5%
28123-Mooresville	13	0.1%		4	0.1%
PSA Subtotal	11,724	100.0%	3,737	3,737	53.9%
28216-Charlotte	14,032	53.1%	**	1,694	24.5%
28269-Charlotte	12,390	46.9%		1,496	21.6%
SSA Subtotal	26,422	100.0%	3,190	3,190	46.1%
Total	38,146		6,927	6,927	100.0%

*** Historical acute care days by ZIP Code not provided by the Applicant*
Sources and calculations:

Column A: CY 2018 Atrium Health Mecklenburg Total Acute Care Days from Truven Analytics, CY 2018. Acute Care Days calculated by applying the Sheps Center methodology used in the SMFP

Column B: Column A ZIP Code / Column A Subtotal (PSA and SSA separately)
*Column C: AHLN Application, Form C - Assumptions and Methodology, Page 5. * Days by ZIP Code not provided by Applicant*

*Column D: Column B ZIP Code Percent * Column C Subtotal (PSA and SSA Separately)*

Column E: Column D ZIP Code / Column D Total

Based on this analysis, only 575 of the acute care patient days in the base year would come from the hospital's home ZIP Code, compared to 1,496 patient days expected to come from ZIP Code 28269, the entirety of which is closer to AH University City than the proposed AHLN, and 1,694 patient days from ZIP Code 28216, the overwhelming majority of which is closer to CMC-Main and CMC-Mercy. The proposed hospital would not provide improved geographic access to the ZIP Codes from which the Applicant proposed to generate nearly half its patient days.

With none of the residents of ZIP Code 28269 closer to AHLN, the geographic area of residents in the SSA proposed to shift to AHLN is reduced to a sliver of the northern portion of ZIP Code 28216. This sliver of ZIP Code 28216 was shown on Atrium's population density map (page 17 of these comments) as a sparsely populated area, mostly identified as unincorporated Mecklenburg

County. It is entirely unreasonable to assume nearly half of the patients at the proposed AHLN will come from this small area.

AHLN will be a small 30-bed satellite hospital campus for AH University City. AH University City offers significantly more services than will be offered at the new 30-bed hospital. The Applicant's basis for why patients from ZIP Code 28269 would shift to AHLN is solely distance, but none of these patients would be closer to AHLN than to AH University City. Atrium not adequately demonstrate in its application it is reasonable for any residents of ZIP Code 28269 to drive to northern Mecklenburg County for acute care services when a closer Atrium hospital offers more services.

The table below is found in AHLN's response to Section C, Question 11. It shows the projected percentage of minorities AHLN proposes to serve.[38]

Atrium Health Lake Norman	Third Full Fiscal Year					
	Med/Surg & ICU Beds	Obstetrics Beds	Surgical Services	ED	Imaging	Lab/PT/OT/ST Other
Low income persons						
Racial and ethnic minorities	70.9%	64.6%	53.7%	74.1%	62.6%	71.2%
Women	64.6%	99.9%	61.1%	58.1%	66.5%	55.1%
Handicapped persons						
The elderly	32.6%	0.0%	29.5%	11.1%	21.8%	7.4%
Medicare beneficiaries	52.7%	0.7%	38.2%	19.4%	25.7%	10.9%
Medicaid recipients	17.9%	42.5%	6.4%	25.4%	16.5%	45.3%

Atrium stated the percentages was "based on CY 2018 percentages for the patient population proposed to be served as identified in Form C Methodology and Assumptions."[39] Atrium used Esri data for its population growth.[40] Current-year (2019) estimates of minority population by ZIP Code are also available from Esri.[41] "Minority" equals the total population minus the white non-Hispanic population. Percent minority for AHLN's service area is presented in the table below by ZIP Code and PSA/SSA Totals.

[38] AHLN Application, Page 86
[39] AHLN Application, Page 86
[40] AHLN Application, Form C – Assumptions and Methodology, Page 5
Esri data are in line with the US Census Bureau Quick Facts which reports the percent minority population in the PSA to be approximately 19 percent. See page 56 of these comments.

AHLN Service Area ZIP Code	2019 Minority Population	2019 Total Population	Percent Minority
28031 (Cornelius)	5,884	31,049	19.0%
28036 (Davidson)	3,449	18,554	18.6%
28078 (Huntersville)	18,793	66,079	28.4%
28115 (Mooresville)	9,329	41,536	22.5%
28117 (Mooresville)	7,546	47,608	15.9%
*Primary Service Area Subtotal**	*45,001*	*204,826*	*22.0%*
28216 (Charlotte)	45,578	58,744	77.6%
28269 (Charlotte)	53,932	81,464	66.2%
Secondary Service Area Subtotal	*99,510*	*140,208*	71.0%
Total	**144,511**	**345,034**	**41.9%**

Source: Esri
**ZIP Codes 28035, 28070 and 28123 are excluded from this table since they are PO box ZIP Codes and therefore unavailable in ESRI.*

Compared to actual census data for residents of the service area, the AHLN patients (~70 percent minority) are expected to look far more like the SSA (71 percent minority) than the PSA (22 percent minority). This is further demonstration the AHLN projections are heavily weighted to the SSA, which is closer to CMC and AH University City. AHLN's utilization projections are unreasonable for a hospital located in the PSA and focused on the Lake Norman area. Patients in the SSA are not likely to drive farther to receive services at AHLN.

Average Length of Stay is unreasonable

Atrium provided no support for the reasonableness of its acute care ALOS assumption, only what it is assumed to be, as shown in the excerpt below.[42] Because the Applicant did not list the DRGs it included as Atrium Health Lake Norman Appropriate, we cannot verify the current ALOS for those DRGs at Atrium hospitals from Truven data.

[42] AHLN Application, Form C – Assumptions and Methodology, Page 6

In order to calculate projected total discharges, Atrium Health Lake Norman assumed that its average length of stay (ALOS) would be consistent with the CY 2018 ALOS for Atrium Health Lake Norman-appropriate inpatients in the PSA and SSA, 3.56 and 3.88 days, respectively. The table below provides projected acute care utilization at Atrium Health Lake Norman based on this assumption.

Projected Atrium Health Lake Norman Total Inpatient Utilization

	CY23	CY24	CY25
PSA Days of Care	2,084	3,195	4,354
PSA ALOS	3.56	3.56	3.56
PSA Discharges	**585**	**897**	**1,222**
SSA Days of Care	1,730	2,638	3,576
SSA ALOS	3.88	3.88	3.88
SSA Discharges	**446**	**680**	**922**
Total Discharges	**1,031**	**1,577**	**2,144**

Atrium assumed an obstetrics ALOS of 2.73 days.[43] Projected acute care and obstetrics days and discharges are shown in the table below for AHLN project year three. Subtracting obstetrics volume from total acute care volume shows Atrium projected an ALOS of 4.1 days for AHLN med/surg patients.

	Days	Discharges	ALOS
Total Acute Care	7,930	2,144	3.70
Obstetrics	1,674	613	2.73
Med/Surg	6,256	1,531	4.09

Source: AHLN Application, Form C – Assumptions and Methodology, Page 6 and Page 13

Based on data Atrium provided for its other acute care hospitals in Mecklenburg County, the medical/surgical ALOS at AHLN will be higher than the CY 2018 ALOS at AH Pineville (3.86 days) and at AH University City (3.81 days).[44] The AHLN ALOS is unreasonable and unsupported for a 30-bed hospital with limited services, even with an ICU unit.

Further, Atrium's projected obstetrics ALOS for AHLN is significantly higher than at its existing community hospitals. The Applicant did not indicate which obstetrics DRGs are "Atrium Health Lake Norman appropriate". However, the table below shows ALOS for obstetric DRGs at AH Pineville and AH University City combined in CY 2018.

[43] AHLN Application, Form C – Utilization Assumptions and Methodology Page 13

[44] Exhibit C-4.2, Page 11: "In order to calculate projected discharges, Atrium Health assumed that Atrium Health University City's average length of stay (ALOS) will be equivalent to 3.93 days for its total acute care beds and 3.81
days for its medical/surgical beds based on its CY 2018 experience."
Exhibit C-4.2, Page 10: "To calculate projected discharges, Atrium Health assumed that Atrium Health Pineville's average length of stay (ALOS) will be equivalent to 4.03 days for its total acute care beds and 3.86 days for its medical/surgical beds based on its CY 2018 experience."

CY 2018 Obstetrics ALOS at AH Pineville and AH University City Combined

DRG	Description	Days	Discharges	ALOS
765	CESAREAN SECTION W CC/MCC	1,261	373	3.4
766	CESAREAN SECTION W/O CC/MCC	1,232	465	2.6
767	VAGINAL DELIVERY W STERILIZATION &/OR D&C	198	88	2.3
768	VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	123	52	2.4
769	POSTPARTUM & POST ABORTION DIAG W O.R. PROC	58	22	2.6
770	ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	15	11	1.4
774	VAGINAL DELIVERY W COMPLICATING DIAG	634	287	2.2
775	VAGINAL DELIVERY W/O COMPLICATING DIAG	3,577	1,726	2.1
776	POSTPARTUM & POST ABORTION DIAG W/O O.R. PROC	91	39	2.3
777	ECTOPIC PREGNANCY	7	5	1.4
778	THREATENED ABORTION	43	22	2.0
779	ABORTION W/O D&C	18	12	1.5
780	FALSE LABOR	12	5	2.4
781	OTHER ANTEPARTUM DIAG W MEDICAL COMPLICATIONS	265	100	2.7
782	OTHER ANTEPARTUM DIAG W/O MEDICAL COMPLICATIONS	10	6	1.7
797*	VAGINAL DELIVERY W STERILIZATION/D&C W CC	5	2	2.5
798*	VAGINAL DELIVERY W STERILIZATION/D&C WO CC/MCC	24	11	2.2
805*	VAGINAL DELIVERY W/O STERILIZATION/D&C W MCC	67	25	2.7
806*	VAGINAL DELIVERY W/O STERILIZATION/D&C W CC	208	100	2.1
807*	VAGINAL DELIVERY W/O STERILIZATION/D&C W/O CC/MCC	948	485	2.0
817*	OTHER ANTEPARTUM DIAG W O.R. PROC W MCC	3	1	3.0
818*	OTHER ANTEPARTUM DIAG W O.R. PROC W CC	4	1	4.0
831*	OTHER ANTEPARTUM DIAG W/O O.R. PROC W MCC	14	5	2.8
832*	OTHER ANTEPARTUM DIAG W/O O.R. PROC W CC	33	16	2.1
833*	OTHER ANTEPARTUM DIAG W/O O.R. PROC W/O CC/MCC	51	24	2.1
Total		8,901	3,883	2.3

*Source: Truven Analytics *New FFY 2019 DRG*

There is no reason to expect more complicated obstetrics patients with higher average lengths of stay at AHLN than AH Pineville and AH University City. To the extent the obstetrics ALOS at AHLN is lower than projected, the med/surg ALOS needed to achieve the Applicant's utilization projections would be even higher than 4.1, and more unreasonable.

The Applicant provided inadequate support for its projected surgical services

Inpatient surgical cases at AHLN are based on projected acute care utilization, which is unreasonable. Because of the black box methodology used to project acute care patients, the Applicant did not identify which surgeries would be done at AHLN.

In the Application, Exhibit C-4.8, Page 10, the Applicant states "Atrium Health has assumed the planned shift of OR cases to AHLN will occur as noted in the tables below and detailed in Exhibit C.7-2." However, there was no Exhibit C.7.2 in the application. Absent this exhibit, we relied on the shift of OR cases in the Assumptions and Methodology following AHLN Form C.

The Applicant's demonstration of need for two operating rooms at AHLN is based on unreasonable and unsupported assumptions. The Applicant states it applied the Operating Room Methodology in the 2019 SMFP to AHLN separately from AH University City. However, that is not true. To prove the need for its two operating rooms at AHLN separately from AH University City, the Applicant should have used the Group 4 average case times for "hospitals reporting less than 15,000 surgical hours." The Applicant used AH University City's final case times from the 2019 SMFP with no support for why those final case times at a 100 bed hospital offering more services apply to the proposed 30 bed hospital offering a limited subset of services, other than the fact that it will be a satellite campus of AH University City.

> As noted throughout this application, the proposed Atrium Health Lake Norman will be licensed as part of Atrium Health University City. As such, the Operating Room Methodology in the *SMFP* will not distinguish between the two campuses but will evaluate their utilization in total. However, for purposes of demonstrating the need for the proposed operating rooms, Atrium Health has applied the Operating Room Methodology in the *SMFP* to Atrium Health Lake Norman separately from Atrium Health University City. According to Table 6B of the *2019 SMFP*, Atrium Health University City's final inpatient case time is 112.6 minutes and its final outpatient case time is 74.1 minutes. Using those case times to project estimated surgical hours, Atrium Health projects the following surgical hours through the project years for Atrium Health Lake Norman.

Based on AH University City's case times, the Applicant demonstrated its need for two operating rooms in the tables below, reproduced from the AHLN Application.[45] The tables in the AHLN application reproduced below show data for CY24, CY25, and CY26. We assume this was a typo and the intended years were CY23, CY24, and CY25 which are the first three operating years at AHLN.

Projected Total Surgical Hours at Atrium Health Lake Norman

	CY24	*CY25*	*CY26*
Inpatient Surgical Cases	145	222	302
Outpatient Surgical Cases	665	1,018	1,385
Final Inpatient Case Time	112.6	112.6	112.6
Final Outpatient Case Time	74.1	74.1	74.1
Total Surgical Hours	**1,093**	**1,673**	**2,277**

[45] AHLN Applications, Form C – Assumptions and Methodology, Page 11

Projected Operating Room Utilization at Atrium Health Lake Norman

	CY24	*CY25*	*CY26*
Total Surgical Hours	1,093	1,673	2,277
Standard Hours per OR per Year	1,500	1,500	1,500
Total Surgical Hours / Standard Hours per OR per Year	**0.73**	**1.12**	**1.52**
OR Capacity	2	2	2

Because the Applicant used AH University City's case times without applying the methodology to the entire AH University City License, the utilization projections and demonstration of need are unreasonable. Applying the Group 4 average case times in the 2019 SMFP, AHLN does not demonstrate a need for two operating rooms. Note the SMFP only rounds projected fractional deficits of 0.50 or greater, to the next highest whole number.

Projected Total Surgical Hours at Atrium Health Lake Norman

	CY23	*CY24*	*CY25*
Inpatient Surgical Cases	145	222	302
Outpatient Surgical Cases	665	1,018	1,385
Group 4 Inpatient Case Time from 2019 SMFP	112.5	112.5	112.5
Group 4 Outpatient Case Time from 2019 SMFP	71.7	71.7	71.7
Total Surgical Hours	1,067	1,633	2,221
Standard Hours per OR per Year	1,500	1,500	1,500
Total Surgical Hours / Standard Hours per OR per Year	0.71	1.09	1.48
OR Need	1	1	1

For the Applicant to properly demonstrate need using the 2019 SMFP Methodology and AH University City's case times, the calculations would have to be shown for the licensed facility (both campuses combined). Atrium Health projected AH University City will have a surplus of two ORs in AHLN's third project year.[46]

[46] AHLN Application, Exhibit C-4.3, Page 17

Projected Atrium Health University City Operating Room Utilization

	CY20	CY21	CY22	CY23	CY24	CY25
Total Surgical Hours	7,489	7,582	7,671	7,506	7,491	7,478
Standard Hours per OR per Year	1,500	1,500	1,500	1,500	1,500	1,500
Total Surgical Hours/Standard Hours per OR per Year	5.0	5.1	5.1	5.0	5.0	5.0
Existing and Approved OR Capacity	7	7	7	7	7	7
OR Deficit/(Surplus)	**(2.0)**	**(1.9)**	**(1.9)**	**(2.0)**	**(2.0)**	**(2.0)**

Using Form C for AHLN and AH University City, the Applicant did not demonstrate that the AH University City License would have a need for two (2) ORs. There is a surplus of .5 ORs in CY 2025.

Projected Total Surgical Hours at Atrium Health University City (Proposed License with AHLN)

	CY23	CY24	CY25
AHLN City Inpatient Surgical Cases	145	222	302
AHLN City Outpatient Surgical Cases	665	1,018	1,385
AH Univ. City Inpatient Surgical Cases	971	968	965
AH Univ. City Outpatient Surgical Cases	4,602	4,595	4,588
Group 4 Inpatient Case Time	112.6	112.6	112.6
Group 4 Outpatient Case Time	74.1	74.1	74.1
Total Surgical Hours	8,599	9,165	9,754
Standard Hours per OR per Year	1,500	1,500	1,500
Total Surgical Hours / Standard Hours per OR per Year	5.73	6.11	6.50
Adjusted ORs (without AHLN)	7	7	7
Surplus (without AHLN)	1.27	0.89	0.50

Source: AHLN Application, Form Cs. 2019 SMFP Final Case Times.

The Applicant did not adequately explain the need for additional outpatient operating room capacity on the AH University City License when the AH University City License is projected to have a surplus and Atrium operates AH Huntersville Surgery just 2 miles away from the proposed AHLN. Surgical utilization for the Atrium System is also unreasonable because the Applicant projected no impact on AH Huntersville Surgery Center.

In 2015, Atrium Health and its joint venture partners were approved to develop Randolph Surgery Center, a six operating room freestanding ASC in Charlotte (Project ID # F-11106-15).[47] Randolph Surgery Center's operating rooms are being relocated from these facilities. [48] Atrium Health is relocating two (2) ORs from AH University City and one (1) OR from AH Huntersville Surgery, which was under the AH University City License at the time of the application. Even after these relocations, Atrium is projecting a surplus of ORs at AH University City with or without AHLN.

[47] AHLN Application, Exhibit C-4.2, Page 11
[48] AHLN Application, Exhibit C-4.2, Page 11

These relocations further support the above analysis that Atrium does not need additional operating rooms at AH University City or in the AHLN service area. We note AH University City did not itself apply for any ORs under the 2019 SMFP.

	Randolph Surgery Center (Project ID # F-11106-15)
Relocated from Charlotte Surgery Center	1
Relocated from CMC	2
Relocated from Atrium Health University City	2
Relocated from Atrium Health Huntersville Surgery	1
Total	6

The Applicant provided inadequate support for its projected other services

All other services are driven by acute care days, surgeries, or ED visits, which as explained are unreasonable and not adequately supported. Therefore, those projections are also unreasonable and unsupported.

AHLN is not comparable to AH Union West

In the application, Atrium suggests its utilization projection assumptions and methodology are reasonable because they are "consistent with Atrium Union West."[49] The Agency's approval of AH Union West provides no precedent for approval of AHLN or its methodology and assumptions. The AHLN application differs from the AHUW in several ways.

First, AHLN is a response to need determinations identified in the 2019 SMFP for acute care beds and operating rooms in Mecklenburg County. In the AH Union West application, CHS Union proposed the relocation of acute care beds and operating rooms within the same health system and the same SMFP service area.

Second, in the AHUW application, both CHS Union and AHUW had the same service area and Atrium Health was the "only provider of acute care beds, dedicated C-Section rooms, CT equipment, or emergency department services in Union County."[50] In the proposed AHLN service area there are two acute care hospitals, two ambulatory surgery centers, two freestanding emergency departments, and an imaging center.[51] Atrium Health owns one of the ASCs, both of the FSEDs, and the imaging center.

[49] AHLN Application, Form C – Utilization Assumptions and Methodology, Page 1
[50] AHUW Application, Page 101
[51] See discussion of existing providers under Criterion (6).

The Applicant did not demonstrate the need for the services proposed by residents of the service area

Although Atrium said it was focused on serving the Lake Norman area, the application failed to demonstrate any need all Lake Norman residents have for the proposed hospital. The Application had no hospital utilization analysis of the PSA or SSA; rather, it focuses on historical Atrium patients alone.

Although Atrium has access to total market data for the service area, it offered no analysis for all service area patients showing residents of the proposed service area do not have reasonable geographic and financial access to the services AHLN would provide now and in 2025. The table below shows service area residents have access to multiple health systems, and patients in the service area already have reasonable access to Atrium's inpatient services:

- The PSA is already served by three health systems (Atrium, Novant Health and Community Health Systems, the owner of LNRMC)
- Atrium already has over 30 percent of the market share in the PSA
- Atrium is already the dominant provider of acute care patient days in the secondary service area with over 60 percent market share.

AHLN Service Area Acute Care Days, CY 2018

	CY 2018 Acute Care Days				CY 2018 Market Share		
AHLN Service Area ZIP Code	**Atrium**	**Novant Health**	**Other**	**Total**	**Atrium Health**	**Novant Health**	**Other**
28031-Cornelius	2,116	4,183	656	6,955	30.4%	60.1%	9.4%
28036-Davidson (w/ 28035 PO Box)	1,706	1,694	733	4,133	41.3%	41.0%	17.7%
28078-Huntersville (w/ 28070 PO Box)	5,828	8,728	590	15,146	38.5%	57.6%	3.9%
28115-Mooresville (w/28123 PO Box)	3,248	2,276	7,252	12,776	25.4%	17.8%	56.8%
28117-Mooresville	2,113	2,295	4,672	9,080	23.3%	25.3%	51.5%
28216-Charlotte	14,789	8,526	776	24,091	61.4%	35.4%	3.2%
28269-Charlotte	13,892	7,765	757	22,414	62.0%	34.6%	3.4%
PSA Subtotal	15,011	19,176	13,903	48,090	31.2%	39.9%	28.9%
SSA Subtotal	28,681	16,291	1,533	46,505	61.7%	35.0%	3.3%
Service Area Total	43,692	35,467	15,436	94,595	46.2%	37.5%	16.3%

Acute Care Days by Hospital: CY 2018 Atrium Health Mecklenburg Total Acute Care Days from Truven Analytics, CY 2018. Acute Care Days calculated by applying the Sheps Center methodology used in the SMFP

The Applicant did not demonstrate all residents of the service area will have access to the services proposed

The Lake Norman area is now, and has been well-served by NH Huntersville, LNRMC, and even Atrium Health. Please refer to the discussion under Criterion (6).

In summary, the applicant did not provide adequate support for its service area or address the needs of the entire service area. Atrium not only failed to demonstrate need for the population it proposed to serve, it also failed to consistently identify the population to be served by the project (narratively it indicates Lake Norman, while statistically it indicates Charlotte). Almost half of the patient days are projected to come from two Charlotte ZIP Codes closer to other Atrium Health facilities than AHLN. The Applicant failed to adequately demonstrate that projected utilization of AHLN is based on reasonable and supported assumptions. Key assumptions in the Application contradict assumptions and arguments Atrium has made in recent years. The Applicant relied on the SMFP OR Methodology to demonstrate need for two ORs, but when applied correctly this methodology does not justify two ORs. Further, the applicant failed to demonstrate that the existing acute care beds at NH Huntersville and LNRMC lack sufficient capacity to meet the needs of the Lake Norman Area.

For these reasons, plus any additional reasons the Agency may discern as it reviews the AHLN Application, the AHLN Application is non-conforming with Criterion (3) and should be disapproved.

Criterion (4)

Criterion (4) NCGS § 131E-183(a)(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.

AHLN fails to demonstrate that the least costly or most effective alternative has been proposed.

As discussed under Criterion (3), AHLN is not proposing the most effective alternative to serve the patient population it claims to serve. Rather, AHLN proposes to spend $147 million to develop a facility to serve mostly patients from outside the Lake Norman area in Iredell County and Charlotte. Atrium has not justified the need to spend $147 million to serve fewer than three (3) additional patients per day from the proposed service area at AHLN. It has not demonstrated the proposed project is needed by the population of the service area, that sufficient capacity does not already exist to serve these patients in the Lake Norman area, and that patients do not currently have adequate access to the proposed services. Please refer to the discussions under Criteria (1), (3) and (6).

The table below shows the cost per bed and OR for the applications Atrium Health submitted in this review cycle. Based on the Applicant's assumption that Atrium patients currently going to

other Atrium facilities are the only patients who will go to AHLN (highly unlikely), the more cost-effective alternative is to add additional beds at the existing Atrium hospitals, which Atrium is proposing to expand in this review cycle.

	Total Capital Expenditure	Requested ORs	Cost per OR	Requested Beds	Cost per Bed
AHLN	$147,090,166	2	$73,545,083	30	$4,903,006
AH Pineville Beds	$7,231,102			12	$602,592
AH University City Beds	$3,766,000			16	$235,375
AH Pineville ORs	$15,695,524	2	$7,847,762		
CMC Beds	$10,527,737			18	$584,874
CMC ORs	$7,974,633	2	$3,987,317		

For the above-stated reasons, plus any additional reasons the Agency may discern as it reviews the AHLN Application, the AHLN Application is non-conforming with Criterion (4) and should be disapproved.

Criterion (5)

Criterion (5) NCGS § 131E-185(a)(5): ***Financial and operational projections for the project shall demonstrate the availability of funds for capital and operating needs as well as the immediate and long-term financial feasibility of the proposal, based upon reasonable projections of the costs of and charges for providing health services by the person proposing the service.***

The Application does not demonstrate the need for AHLN. Atrium's assumptions in the financial pro formas are not reasonable and not adequately supported because projected utilization is not reasonable. Since projected revenues and expenses are based at least in part on projected utilization, projected revenues and expenses are unreasonable.

The Application overstates utilization. Without the Charlotte ZIP Codes, which were unreasonably included, the total volume projections for AHLN would be significantly lower. Assuming (1) Atrium can shift to AHLN the acute care days it projects from the PSA, (2) the PSA is 75 percent of total AHLN acute care days, and (3) the remaining 25 percent come from ZIP Codes all around the periphery, total acute care days in year three would be 5,805 (15.9 ADC), not 7,930 (21.7 ADC).[52] This equates to an acute care occupancy rate of 53 percent on 30 beds. Because the utilization

[52] 4,354 PSA / 75% = 5,805

projections are unreasonable, the project is not financially feasible and is not conforming with Criterion (5).

Atrium's financial statements also have inconsistencies and errors, which make it impossible to determine the financial feasibility of its project even with the utilization as projected by the Applicant.

AHLN Net Income by Service Component

A snapshot of net income by service component in the Atrium Lake Norman proposed hospital application shows heavy losses related to Med/Surg, ICU and OB beds through the third project year as presented in the table below.

Atrium Health Lake Norman - Net Income by Service Component

Service Component	Project Year One	Project Year Two	Project Year Three
Med/Surg Beds	($3,389,105)	($3,773,882)	($3,156,774)
ICU Beds	($3,466,816)	($3,625,484)	($3,671,287)
OB Beds	($3,409,129)	($3,031,834)	($2,483,403)
Beds Subtotal	***($10,265,050)***	***($10,431,200)***	***($9,311,464)***
Operating Rooms	$1,162,448	$3,032,609	$4,989,675
Procedure Room	$581,223	$1,516,302	$2,494,837
Emergency Department	($1,212,037)	$187,044	$1,426,776
Imaging	($241,059)	$1,807,954	$3,969,824
Lab & Other	($1,377,564)	$249,464	$1,922,741
Other Services Subtotal	***($1,086,989)***	***$6,793,373***	***$14,803,853***
Total Proposed Hospital	**($11,352,039)**	**($3,637,827)**	**$5,492,389**

Source: AHLN Application, Form F.2

The Applicant's financial projections seem to indicate this project is financially unfeasible. The approximately $9.3 million to $10.4 million in annual losses on beds is unnecessary when all the other service components, which do generate a profit, are already being offered in the service area by Atrium Health. Atrium owns and operates a freestanding emergency department, imaging services, and an ambulatory surgery center.

AHLN Gross Revenue for Med/Surg Beds

In Atrium's application for the proposed Lake Norman hospital they indicate in their Form F.2 Assumptions that gross revenue is based on Atrium University City's average charge:

Form F.2 Assumptions

a Patient Services Gross Revenue is based on Atrium Health University City's CY 2018 average charge for each proposed service through the project years. Projected payor mix for each service is based on Atrium Health Mecklenburg facilities' CY 2018 payor mix for Atrium Health Lake Norman appropriate patients from the PSA and SSA identified in the Form C Methodology and Assumptions. While Atrium Health expects payor mix shifts in the coming years, there remains considerable uncertainty given healthcare reform, Medicaid expansion, and other policy initiatives as to how much shift will occur (in NC) and from what payor categories to others. Furthermore, those changes will occur with or without the development of the proposed project. Therefore, until greater clarity to guide reasonable assumptions, Atrium Health has assumed for the purposes of these projections that the payor mix will be consistent with the historical payor mix of the patients proposed to be served.

Atrium applied for acute care beds, specifically medical/surgical beds, at AH University City in the current review cycle (Project I.D. #F-011812-19). In the AH University City application, the Form F.2 Assumptions reads:

Form F.2 Assumptions

a Patient Services Gross Revenue is based on CY 2018 payor mix and average charge for the service through the project years. Percent of total days is based on CY 2018 payor mix for the service. While Atrium Health expects payor mix shifts in the coming years, there remains considerable uncertainty given healthcare reform, Medicaid expansion, and other policy initiatives as to how much shift will occur (in NC) and from what payor categories to others. Furthermore, those changes will occur with or without the development of the proposed project. Therefore, until greater clarity to guide reasonable assumptions, Atrium Health has assumed for the purposes of these projections that the payor mix will be consistent with the historical payor mix.

Unlike payor mix, the AHLN assumption for average charge does not indicate Atrium is using a subset of University City's patients such as those from the service area or patients in a limited set of DRGs. Although both applications assume the exact same assumption for average charge per med/surg day, the actual average charges on the Form F2s are very different.

Third Project Year - Med/Surg Beds

	AHLN	AH University City	$ Difference	% Difference
Gross Revenue	$16,563,341	$77,853,732		
Patient Days	5,563	21,868		
Gross Revenue per Patient Day	**$2,977**	**$3,560**	**$ (583)**	**-20%**

As Atrium is adopting its AH University City average charge in its proposed AHLN hospital revenue projections for med/surg beds, it is unclear why AHLN's gross revenue per patient day is 20% lower than AH University City.

Payor Mix is unreasonable

As shown in the excerpt above, AHLN's projected payor mix for each service was based on Atrium Health Mecklenburg facilities' CY 2018 payor mix for Atrium Health Lake Norman appropriate patients from the PSA and SSA. While the utilization projections assumed AHLN will shift only 20 percent of the SSA acute are days to AHLN, the Applicant provided no indication that the payor mix from the PSA and the SSA were given different weights. As discussed under Criterion (3) above, the payor mix for the PSA and SSA is very different. The table below from the AHLN Application shows that 77 percent of these patient days from which Atrium based its payor mix on are actually from the SSA. Therefore, the payor mix was heavily weighted to the SSA and did not reasonably represent the PSA.[53]

Potential Days of Care Appropriate at Atrium Health Lake Norman by Geography

	CY 2018 Atrium Health Lake Norman-Appropriate Days
PSA	4,671
SSA	15,948
Total Days	20,619
Total ADC	**56**

Other Intercompany Expenses - Med/Surg Beds

Atrium assumed, as reproduced below, that the proposed Lake Norman facility's intercompany expenses were based on University City's CY 2018 experience as a percentage of net revenue.

AHLN Form F.3 Assumptions:

j	Intercompany Expense is based on the Atrium Health University City's CY 2018 expense as a percentage of net revenue. Intercompany expense includes buildings & ground maintenance, insurance, taxes, registration, scheduling, billing, courier services, intercompany work orders, corporate overhead, and all other costs necessary to provide the proposed service.

The AH University City application, filed concurrently with the AHLN application, assumed AH University City's intercompany expense was 5% of net revenue based on their CY 2018 experience.

[53] AHLN Application, Form C – Utilization Assumptions and Methodology, Page 4

AH University City Form F.3 Assumptions:

> i Intercompany Expense is assumed to be 5.0 percent of net patient revenue based on the Atrium Health CY 2018 experience. Intercompany expense includes dietary, housekeeping/laundry, buildings & ground maintenance, insurance, taxes, registration, scheduling, billing, courier services, intercompany work orders, corporate overhead, and all other costs necessary to provide the proposed service.

Our calculation of intercompany expenses as a percentage of net revenue on AH University City's Form F.3 is 5 percent of net revenue in year three as described in the AH University assumptions. However, Atrium calculated AHLN's intercompany expenses in year three as 22 percent of net revenue. In addition, the intercompany expenses expressed as dollars works out to be $170 per patient day, which is 370 percent higher than AH University City. AHLN's intercompany expenses for all other service components are also 22 percent of net revenue.

Project Year 3 Intercompany Expenses for Med/Surg Beds

Third Project Year - Med/Surg Beds	**AHLN Application**	**AH University City Application**
Other Expenses (Intercompany)	$944,310	$1,008,145
as % of **net** revenue	**22%**	5%
cost per patient day	**$170**	$46

Source: AHLN Form F.3, AH University City (Project I.D. #F-011812-19) Form F.3

For the above-stated reasons, plus any additional reasons the Agency may discern as it reviews the AHLN Application, the AHLN Application is non-conforming with Criterion (5) and should be disapproved. Because of the inconsistencies or errors indicated above, any comparative reviews based on AHLN's financial pro formas are not meaningful.

Criterion (6)

Criterion (6) NCGS § 131E-183(a)(6): The applicant shall demonstrate that the proposed project will not result in unnecessary duplication of existing or approved health service capabilities or facilities.

Although the CON application form requires applicants to identify all existing and approved facilities that provide the same service components proposed in this application and are in the proposed service area, Atrium listed no facilities.[54] Instead, Atrium referred the Agency to the SMFP:

[54] AHLN Application, Section G, Question 1, Page 108

1.	**Identify all existing and approved facilities that provide the same service components proposed in this application and are located in the proposed service area.** Please see Exhibit G.1 for Table 5A and 6B of the *Proposed 2020 SMFP* which includes all existing and approved acute care facilities and facilities with operating rooms in the proposed service area.

In its response, the Applicant only addressed two of its service components (acute care beds and operating rooms) and failed to refer to the freestanding emergency departments or outpatient imaging centers in its service area. A complete list of facilities offering one or more of the proposed AHLN service components is included below with driving distances and drive times on Wednesdays at peak morning travel (8 am). A map of these facilities is shown on page 2 of these comments.

Travel Distance and Time from AHLN to

Existing and Approved Facilities Providing AHLN Service Components in the AHLN Service Area

From AHLN to:				Driving Miles	Driving Minutes	
Type	**System**	**Name**	**Zip**		**Low**	**High**
Hospital	Novant	NH Huntersville	28078	5.1	9	16
Hospital	Other*	Lake Norman Regional Medical Center	28117	7.2	10	16
FSED	Atrium	AH Huntersville Emergency Dept.	28078	2	4	8
FSED	Atrium	AH Mountain Island Emergency Dept.	28216	14.9	18	30
ASC	Novant	NH Huntersville Outpatient Surgery	28078	5.1	9	16
ASC	Atrium	AH Huntersville Surgery Center	28078	2	4	8
Imaging	Atrium	AH Carolinas Imaging Services - Huntersville	28078	2	4	8

Source: 2020 SMFP, NC Facility Licensure, Google Maps Wednesday 8 am Start.
**Lake Norman Regional Medical Center is part of Community Health Systems*

The Applicant quotes the NC CON Statute on Page 73 of the Application:

North Carolina CON statute. Findings of Fact 4 and 6 state:

4) "That the proliferation of unnecessary health service facilities results in costly duplication and underuse of facilities, with the availability of excess capacity leading to unnecessary use of expensive resources and overutilization of health care services."

(6) "That excess capacity of health service facilities places an enormous economic burden on the public who pay for the construction and operation of these facilities as patients, health insurance subscribers, health plan contributors, and taxpayers."
See § 131E-175. Findings of Fact

NH Huntersville has existing underutilized capacity to serve the growing population in the proposed service area. Recently, the Agency has responded to the needs of the Lake Norman Area by approving multiple projects at NH Huntersville at a combined cost of $52.8 million.

Recently Approved NH Huntersville Projects

Project I.D. #	Project Description	Total Capital Cost
Project I.D. F-11110-15	Relocate 48 acute care beds 1 OR from NHPMC License, Operational in 2019	$45,661,870.00
Project I.D. F-011624-18	Add 12 acute care beds (LDRPs) and 1 OR from SMFP Need Determinations, proposed to be operational in 2021	$7,110,815.00
Total	60 acute care beds and 2 ORs	$52,772,685.00

According to the 2020 Proposed SMFP, using FFY 2018 data from Truven Analytics, NH Huntersville is currently operating at approximately 45.4% of the capacity of its existing and approved licensed acute care beds (25,022 acute care days / 365 = 68.6 ADC/ 151 = 0.454). NH Huntersville demonstrated in its recently approved CON applications its need for the additional approved beds and operating rooms.

LNRMC also has existing underutilized capacity to serve the growing population in the proposed service area. According to the 2020 Proposed SMFP, using FFY 2018 data from Truven Analytics, LNRMC is currently operating at approximately 32.8% of the capacity of its licensed acute care beds (14,753 acute care days / 365 = 40.4 ADC/ 123 = 0.328).

The AHLN projected utilization is not reasonable if the Charlotte ZIP Codes are excluded because the Charlotte population is a key driver of proposed project's utilization. The Applicant has not provided support for why these Charlotte patients would shift to AHLN. Atrium's assumption that its proposed hospital will not divert even one patient from NH Huntersville or LNRMC is unreasonable. If the Agency approves AHLN, it will directly conflict with the North Carolina CON statute and a duplication of project costs already approved in the service area.

For the above-stated reasons, plus any additional reasons the Agency may discern as it reviews the AHLN Application, the AHLN Application is non-conforming with Criterion (6) and should be disapproved.

Criterion (12)

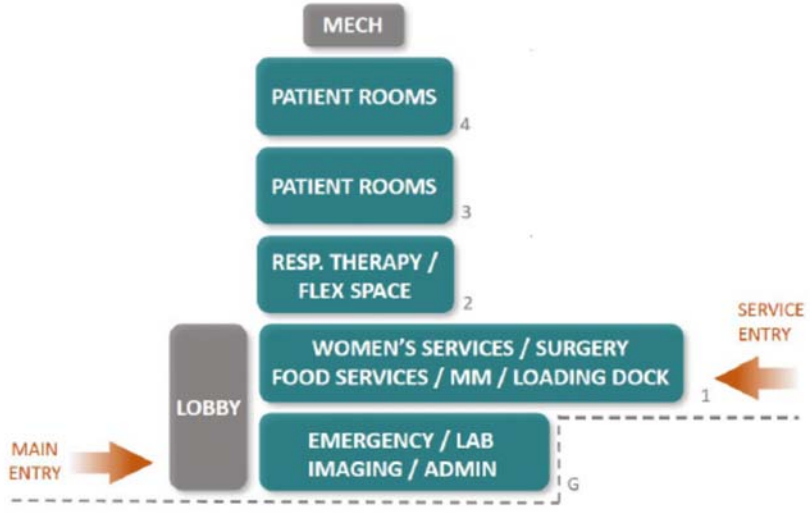
Criterion (12) NCGS § 131E-183(a)(12): Applications involving construction shall demonstrate that the cost, design, and means of construction proposed represent the most reasonable alternative, and that the construction project will not unduly increase the costs of providing health services by the person proposing the construction project or the costs and charges to the

public of providing health services by other persons, and that applicable energy savings features have been incorporated into the construction plans.

The Application has project costs of $147 million for unneeded beds and ORs. As stated under the discussion related to Criterion (4), Atrium could save millions of dollars by placing the beds at its existing hospitals.

The Application failed to demonstrate AHLN will not unduly increase the costs of providing health services or the costs and charges to the public of providing health services. With unexplained spaces in of the hospital, the Applicant did not demonstrate the cost of design and construction is reasonable. The second floor of the hospital is mentioned only once in the Application in a diagram on page 32:

The following stacking diagram summarizes the beds and services proposed for Atrium Health Lake Norman by floor. Please see Exhibit C.1 for detailed line drawings.



The second floor of the hospital is designated for respiratory therapy. Beyond a small space designated for respiratory therapy, the entire floor is called "flex space" and the floor plans in Exhibit C.1 show only conference rooms, offices, staff lounge, and storage. The "flex space" is really shell space for future bed expansions. The uses in the floor plan duplicate spaces shown on the first, second, and third floors of the hospital according to the floor plans.

AHLN Second Floor Plan

Atrium also proposed the addition of eight observation beds, even though it projects to have an average daily census of only 3 observation patients (1,131 observation days / 365 days per year = 3.1 ADC).[55]

Projected Atrium Health Lake Norman Observation Patients

	CY23	CY24	CY25
Observation Days	544	832	1,131
Observation ALOS	1.39	1.39	1.39
Observation Patients	**393**	**601**	**816**

Assuming a target occupancy rate of 66.7%, the applicant only demonstrated a need for five observation beds (3.1 beds / 66.7% = 4.6 beds). There is no other support provided for the need to construct space for eight observation beds, therefore the applicant did not adequately demonstrate the need for eight unlicensed observation beds at the proposed new facility.

While Atrium did not adequately demonstrate the need for eight observation beds, its proposal for eight beds instead indicates Atrium expects to have the need for these observation beds. AHLN assumes that its observation days will have a ratio of 0.14 to its acute care days.[56] Assuming a 66.7 percent target occupancy rate, the request for eight observation beds actually indicates Atrium believes it will have the need for 57 acute care beds. The calculations are shown below:

a. 8 beds * 365 days * 66.7% occupancy = 1,948 observation days

[55] AHLN Application, Methodology Page 9
[56] AHLN Application, Methodology Page 9

b. 1,948 observation days / .14 ratio = 13,914 acute care days
c. 13,914 acute care days / 365 = 38.1 ADC
d. 38.1 ADC / 66.7% target occupancy rate = 57 acute care bed need

If Atrium believes it needs 57 acute care beds, 27 more than requested, it is fair to assume those beds would only be needed through an increase in market share in the service area which contradicts the utilization projection assumptions in the Application. As shown on the floor plans for the third and fourth floors, the second floor of the hospital has sufficient space to be converted to 16 additional acute care beds. Filling the 30 proposed beds or any number beyond 30 is not feasible without significant shifts of market share from NH Huntersville and LNRMC.

For the above-stated reasons, plus any additional reasons the Agency may discern as it reviews the AHLN Application, the AHLN Application is non-conforming with Criterion (12) and should be disapproved.

Criterion (13)

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

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

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

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

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

Atrium's assumption is everyone who would be served at AHLN is already being served at other Atrium hospitals, so the proposal provides for no increase in access. The PSA ZIP Codes are areas with above average household income and below average minority and elderly populations. The population in the two Charlotte ZIP Codes is more underserved and residents in those ZIP Codes have equal or better geographic access to existing Atrium Health hospitals. The Applicant provides no indication the underserved groups do not have access to NH Huntersville and LNRMC. Atrium Health's existing and proposed FSEDs provide access to Atrium Health emergency services. AHLN fails to comply with Criterion (13c) because the projected utilization and payor percentages are not based on reasonable assumptions.

For the above-stated reasons, plus any additional reasons the Agency may discern as it reviews the AHLN Application, the AHLN Application is non-conforming with Criterion (13) and should be disapproved.

Criterion (18a)

Criterion (18a) NCGS § 131E-183(a)(18a): The applicant shall demonstrate that the 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 for a services on which competition would not have a favorable impact.

AHLN is nonconforming with Criterion 18(a) because competition already exists to provide services AHLN would provide to service area residents. The Atrium proposal does not positively enhance competition in the service area because Atrium is only proposing to serve patients that already go to Atrium. Any statements the Applicant made regarding a favorable impact on competition contradict its main assumption for projecting utilization at the hospital.

The table below shows the base year 2018 Atrium Health Lake Norman appropriate acute care patient days (already being served at Atrium hospitals historically) compared to AHLN projected acute care patient days.[57] The difference is attributed to population growth.

[57] AHLN Application, Form C – Assumptions and Methodology, Page 5

	2018 Potential Acute Care Volumes to be Served at AHLN	2025 Projected Acute Care Volumes to be Served at AHLN	Difference (New Service Area Growth)
PSA Days	3,737	4,354	617
SSA Days	3,190	3,576	386
Total Days	6,927	7,930	1,003
ADC	19.0	21.7	2.7
PSA ALOS	3.56	3.56	
SSA ALOS	3.88	3.88	
PSA Discharges	1,050	1,223	173
SSA Discharges	822	922	100
Total Discharges	1,872	2,145	273

Source: AHLN Application, Form C – Assumptions and Methodology Pages 5 and 6

At the Applicant's assumed ALOS, this equates to an additional 273 patients for Atrium Health in the third project year from developing AHLN, or an ADC of 2.7 new Atrium patients. If Atrium does not intend to increase its market share, as it claims, it has not justified the need to spend $147 million to serve fewer than three (3) additional patients per day.

AHLN looks less like a strategy to respond to the need determinations and more like a strategy to increase Atrium Health market share. This project actually hinders competition because when one properly disregards the unreasonable assumption that the entire hospital will be filled with Atrium's existing patients, the project mainly reduces the number of patients going to other health systems in Mecklenburg County and Iredell County.

The tables below show patient destination from the AHLN ZIP Codes for the inpatient medical/surgical and obstetric discharges. There is already competition between health systems to provide the services AHLN would provide. Even without AHLN, the tables below show that Atrium has a strong market share in the proposed service area and needs no new hospital to improve competitive balance. Atrium makes no argument that the quality of care at AHLN would be better than existing facilities for the services it would provide.

AHLN Service Area Acute Care Days and Market Share by Health System, CY 2018

	CY 2018 Acute Care Days				CY 2018 Market Share		
AHLN Service Area ZIP Code	**Atrium**	**Novant Health**	**Other**	**Total**	**Atrium Health**	**Novant Health**	**Other**
28031-Cornelius	6,715	11,571	2,064	20,350	33.0%	56.9%	10.1%
28036-Davidson (w/ 28035 PO Box)	5,288	4,473	1,953	11,714	45.1%	38.2%	16.7%
28078-Huntersville (w/ 28070 PO Box)	15,620	24,133	2,400	42,153	37.1%	57.3%	5.7%
28115-Mooresville (w/28123 PO Box)	9,254	6,199	21,303	36,756	25.2%	16.9%	58.0%
28117-Mooresville	6,049	6,293	14,796	27,138	22.3%	23.2%	54.5%
28123-Mooresville	83	34	112	229	36.2%	14.8%	48.9%
28216-Charlotte	43,542	26,158	3,011	72,711	59.9%	36.0%	4.1%
28269-Charlotte	41,228	22,458	2,183	65,869	62.6%	34.1%	3.3%
PSA Subtotal	43,009	52,703	42,628	138,340	31.1%	38.1%	30.8%
SSA Subtotal	84,770	48,616	5,194	138,580	61.2%	35.1%	3.7%
Service Area Total	127,779	101,319	47,822	276,920	46.1%	36.6%	17.3%

Source: Total Acute Care Days from Truven Analytics, CY 2018. Acute Care Days calculated by applying the Sheps Center methodology used in the SMFP.

The table below shows CMC / CMC-Mercy already have the most market share in the entire service area.

Hospital	**Health System**	**PSA**	**SSA**	**Total Service Area**	**PSA %**	**SSA %**	**Total %**
CMC / CMC-Mercy	Atrium	9,949	19,910	29,859	20.7%	42.8%	31.6%
NHPMC License	Novant	7,432	10,679	18,111	15.5%	23.0%	19.1%
NH Huntersville	Novant	11,214	5,191	16,405	23.3%	11.2%	17.3%
LNRMC	Other	9,830	131	9,961	20.4%	0.3%	10.5%
AH University City	Atrium	1,576	6,059	7,635	3.3%	13.0%	8.1%
CMC - Northeast	Atrium	3,216	1,996	5,212	6.7%	4.3%	5.5%
Wake Forest Baptist Medical Center	Other	1,279	425	1,704	2.7%	0.9%	1.8%
Iredell Health System	Other	1,295	0	1,295	2.7%	0.0%	1.4%
Duke University Medical Center	Other	653	266	919	1.4%	0.6%	1.0%
Other Hospitals	Other	1,646	1,848	3,494	3.4%	4.0%	3.7%
Total Service Area Acute Care Days		48,090	46,505	94,595			

Source: Total Acute Care Days from Truven Analytics, CY 2018. Acute Care Days calculated by applying the Sheps Center methodology used in the SMFP.

Atrium has formed a set of unreasonable assumptions designed to mislead the Agency. Atrium's business objectives to increase market share should not be confused with a need for a third hospital in the Lake Norman area.

For the foregoing reasons, plus any additional reasons the Agency may discern as it reviews the AHLN Application, the AHLN Application is nonconforming with Criterion (18a) and should be disapproved.

Role of the SMFP in the Review of CON Applications

Under Criterion (1), the role of the SMFP in the review of CON applications for acute care beds and operating rooms is to set the upper limit on the number of acute care beds and operating rooms the Agency can approve in a service area. The Agency does not have to approve this upper limit. The SMFP does not establish a need for any specific application or applicant. Whether an applicant claims to have generated a need for acute care beds or ORs in a service area is irrelevant to the review of a CON application under the statutory review criteria in G.S. § 131E-183(a). Each applicant must establish the specific need for a proposed project under Criterion (3). The SMFP also does not contain a need determination for hospitals; rather, the need is for acute care beds and ORs. If an applicant proposes a hospital, the applicant must demonstrate the need for the entire project, including the beds and ORs.

The SMFP does not say where in the service area defined by the SMFP new beds or ORs should be located. The AHLN application hardly mentions Lake Norman Regional Medical Center or other facilities in its service area located in Iredell County. It would not be sound health planning for the Agency to ignore these facilities when applying Criteria (3) and (6) to the review of the AHLN application.

The SMFP does not consider how a health system grew its volume and whether those means were in the public interest. Early in this decade Atrium Health began a massive acquisition of physician practices. Many of those physicians had privileges at both Atrium and Novant Health facilities and could allow their patients to choose the facility. Once acquired, those physicians, as Atrium employees, had no effective choice but to refer and admit their patients to Atrium facilities. Novant Health initially did not respond with equivalent acquisition of physician practices, and the result was a dramatic shift of patient volumes from Novant Health to Atrium reflected in the SMFP. Novant Health had no choice but to increase its staff of employed physicians by acquisition and recruitment, and has partially regained volume and market share.

The SMFP does not consider the "anti-steering" clauses that Atrium Health had in its managed care contracts that prevented payors from directing business away from Atrium Health. The United States Department of Justice and the State of North Carolina sued Atrium Health on antitrust grounds for this conduct. The Department and the State alleged that Atrium Health, the dominant hospital system in the Charlotte area, used its market power to restrict health insurers

from encouraging consumers to choose healthcare providers that offer better overall value. The restrictions also constrained insurers from providing consumers and employers with information regarding the cost and quality of alternative health benefit plans.[58] Even though Atrium Health had to stop using these clauses as part of a settlement with the Department and the State, their effect likely contributed to volume shifts that lead to need determinations in Mecklenburg County.[59]

The primary function of the CON statute is to regulate competition among healthcare providers in a way that controls costs, improves quality and improves geographic and financial access to services. Managing competition requires managing the competitive balance in health care markets in the state. However, the SMFP formulas do not take account of the state of competitive balance in a health care market. In applying Criterion (18a), the Agency can recognize the public interest in creating and maintaining competitive balance to keep one health system from becoming so dominant it can dictate rates to commercial, Medicare and Medicaid managed care organizations.

Atrium Health Lake Norman: Fantasy versus Reality

Novant has shown with reasonable certainty that Atrium has not defined a realistic service area in its AHLN application. The two ZIP Codes in Charlotte, 28216 and 28269, that make up AHLN's secondary service area, and almost half of the patient days for AHLN, are closer to AH University City and to CMC/Mercy than to the proposed hospital. Atrium presents no plausible case that 20% of the acute care patient days for residents of these SSA ZIP Codes currently served at Atrium Health's Mecklenburg County hospitals will leave Charlotte to travel to Cornelius to a smaller hospital with fewer services than the Atrium hospitals they now use. The five ZIP Codes Atrium identified as its primary service area are the reasonable service area from which AHLN will obtain 75% or more of its patients. The remainder will come from surrounding ZIP Codes on all sides and not predominantly from the Charlotte ZIP Codes.

Atrium proposed an unreasonable service area to support the fantasy the AHLN would not increase Atrium's market share in its primary service area. Atrium's market share of total acute care days in the PSA is a substantial 31.2 percent, but it is lower than its market share in the rest of the county. Its current substantial market share shows residents of the PSA have reasonable access to Atrium hospitals now. Atrium's real purpose in spending $147 million on a new hospital, with ample shell space to add beds and ORs, is to increase its market share. If its real purpose was only to accommodate census growth from population growth at AH University City and

[58] https://www.justice.gov/opa/pr/atrium-health-agrees-settle-antitrust-lawsuit-and-eliminate-anticompetitive-steering

[59] Atrium Health has also recently announced a strategic combination with Wake Forest Baptist Health and Wake Forest University. While many details about this combination are unknown, published reports indicate that the parties intend to establish a medical school in Charlotte. https://atriumhealth.org/campaigns/bestcareforall.

CMC/Mercy, it could do so at much less cost by adding slightly more beds at those facilities than it applied for in this batching cycle.

The socioeconomic characteristics of the two Charlotte ZIP Codes differ greatly from the five PSA ZIP Codes. The Charlotte ZIP Codes have much higher percentages of minority population and have a payor mix with much higher Medicaid, Medicare, self-pay, and charity care than the PSA. Including the Charlotte ZIP Codes distorts several comparative review factors the Agency has previously used in Atrium's favor. Atrium would have the Agency believe the patient characteristics and payor mix at AHLN would be dramatically different from those of NH Huntersville, five miles to the south and Lake Norman Regional Medical Center, seven miles to the north. The Agency should not indulge Atrium's fantasy. Novant Health will not indulge the fantasy in the AHLN application in this comparative review section. We will compare the NH Matthews applications to the AHLN PSA, its real service area.

Conformity with Review Criteria

For the reasons stated in these comments, the AHLN Application is non-conforming with multiple review criteria. Accordingly, it is not an effective alternative with respect to this factor.

Geographic Accessibility

None of the applications in this batching cycle improves geographic accessibility to acute care beds or ORs. The CMC/Mercy, AH Pineville, AH University City, and NH Matthews applications are to expand existing hospitals and do not create new points of service. Approval of the NH Matthews acute care bed application will reduce the probability patients will be denied access to NH Matthews because of capacity constraints and be referred to a different Novant Health hospital.

AHLN will not improve access to acute care beds or ORs substantially for residents of its PSA or of the two Charlotte ZIP Codes in the SSA. There are existing hospitals with unused capacity on I-77 seven miles to the north and five miles to the south of the proposed location. There are ambulatory surgery facilities, outpatient imaging facilities, and freestanding emergency departments within a 6.5-mile radius of the proposed location. Residents of the two Charlotte ZIP Codes in the SSA are closer to existing Atrium and Novant Health hospitals than to the proposed location.

All applications except for AHLN are equally effective on this factor.

Patient Access to a New Provider

None of the applications give Mecklenburg County residents access to a new provider. The applications are equally effective on this factor.

Patient Access to Lower Cost Surgical Services

None of the applications will give patients access to lower cost surgical services as all ORs will be under hospital licenses and not as freestanding ASCs. The applications are equally effective on this factor.

Patient Access to New Services

None of the applications will give patients access to new services not currently available in Mecklenburg County. All applications except AHLN increase access to full-service hospitals by increasing physical capacity. The AHLN application is less effective because it would create a limited service hospital with a lesser range of services than NH Matthews or the existing Atrium hospitals.

Access by Underserved Groups

"Underserved groups" is defined in G.S. 131E-183(a)(13) as follows:

> *"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."*

The fantasy service area for AHLN and Atrium's failure to disclose the definition of appropriate patients distorts all these comparisons. Atrium says it bases the projected payor mix on the current payor mix at Atrium hospitals. The table below shows the resident payor mix for each ZIP Code based on Truven data. The payor mix for the PSA and the two Charlotte ZIP Codes are very different. The same is true of the percentage of racial and ethnic minorities. The Agency should consider the statistics for the PSA as the realistic statistics in assessing how the application affects access by underserved groups.

Acute Care Payor Mix for AHLN and AHLN Service Area, CY 2018

	Med/Surg and ICU Days			Obstetrics Days		
Payor	CY 2018 PSA	CY 2018 SSA	AHLN	CY 2018 PSA	CY 2018 SSA	AHLN
Insurance	28.0%	18.9%	19.5%	77.1%	48.6%	54.8%
Medicaid	8.7%	13.8%	17.9%	19.7%	44.8%	42.5%
Medicare	38.2%	37.5%	52.7%	0.1%	0.7%	0.7%
Other / Gov't	2.8%	3.0%	2.5%	1.3%	1.3%	0.4%
Self Pay	2.9%	5.9%	7.5%	1.8%	4.6%	1.5%

Source: Service Area Total Acute Care Days from Truven Analytics, CY 2018. Acute Care Days calculated by applying the Sheps Center methodology used in the SMFP. Obstetrics identified as Truven service line "Obstetrics". Med/Surg = Total Acute Care less Obstetrics. AHLN payor mix from AHLN Application, Page 124. AHLN projects the same payor mix percentages for Med/Surg and ICU.

If the Agency accepts Atrium's unreasonable assumption that AHLN will not change the Atrium market share, all the patients Atrium projects coming to AHLN would have come to an existing Atrium hospital. Approval of the application results in no increased charity care or services to Medicare and Medicaid enrollees. Atrium has offered no evidence any persons projected at AHLN would not be seen at an existing Atrium facility due to lack of capacity.

The service area for the existing Novant Health and Atrium hospitals is Mecklenburg County as established by the SMFP. However, for AHLN, the service area is a set of ZIP Codes. The reasonable service area for the proposed hospital is the five PSA ZIP Codes. The census data in the table below shows these ZIP Codes have minority population percentages substantially below the average for Mecklenburg County. Census data also shows the median household income for these ZIP Codes is substantially above the county average. As regards the percentage of minority population in the service area, the AHLN application is the least effective and the other applications are equally effective.

	Percent Racial Minority	Median Household Income
28031 (Cornelius)	17.5%	$86,027
28036 (Davidson)	16.3%	$114,641
28078 (Huntersville)	22.8%	$92,707
28115 (Mooresville)	20.9%	$60,256
28117 (Mooresville)	14.8%	$85,376
*Primary Service Area Subtotal**	*19.3%*	*$87,801*
Mecklenburg County	53.6%	$61,695

Source: United States Census Bureau's QuickFacts accessed on November 18. 2019 at: https://www.census.gov/quickfacts/fact/table/US/PST045218

Projected Average Net Revenue per Bed or OR case

Generally, the Agency finds the application proposing the lowest average net revenue is the more effective alternative for this comparative factor. However, as explained AHLN's financial statements and payor mix are based on unreasonable assumptions and contain multiple inconsistencies. Thus, any analysis of AHLN to other applications should be determined to be inconclusive. The same is true for any analysis of operating cost.

Due to differences in the existing hospitals and differences in the applications, the comparatives above may be of less value and result in less than definitive outcomes than if all applications were for like facilities of like size, proposing like services and reporting in like formats.

Competitive Balance in Mecklenburg County

Competition was appropriately used as a comparative factor in the 2018 Mecklenburg County Bed and OR Review, and it should be used again in this review. Novant Health respectfully urges the Agency to give competition the most weight of the comparative factors in this review. As shown in the 2020 Proposed SMFP, Atrium controls through full or partial ownership 1,380 acute care beds and 91 ORs in Mecklenburg County.[60] Atrium has a 68 percent market share of acute care patient days in Mecklenburg County hospitals and a 54 percent market share of surgeries in Mecklenburg County surgical facilities.[61] Novant Health controls through full or partial ownership 874 acute care beds and 65 ORs in Mecklenburg County[62]. Novant Health has a 32% market share of acute care patient days in Mecklenburg County hospitals and a 46% market share of surgeries in Mecklenburg County surgical facilities.[63]

Atrium acquired these dominant market shares through means legal and possibly illegal. Early in this decade Atrium Health began a massive acquisition of physician practices. Many of those physicians had privileges at both Atrium and Novant Health facilities and could allow their patients to choose the facility. Once acquired, those physicians, as Atrium employees, had no effective choice but to refer and admit their patients to Atrium facilities. Novant Health initially did not respond with equivalent acquisition of physician practices, and the result was a dramatic shift of patient volumes from Novant Health to Atrium reflected in the SMFP. Novant Health had no choice but to increase its staff of employed physicians by acquisition and recruitment, and has partially regained volume and market share.

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[60] Includes adjustments for approved ORs. Excludes facilities that are part of demonstration projects and the ORs not included in the SMFP need determination. Excludes C-section, Trauma, and Burn ORs. Atrium Health is a part owner of Charlotte Surgery Center and Randolph Surgery Center.

[61] Excludes facilities that are part of demonstration projects and the ORs not included in the SMFP need determination.

[62] The Proposed 2020 SMFP incorrectly shows an adjustment for two ORs at NH Huntersville. The correct adjustment is one.

[63] Includes adjustments for approved ORs. Excludes facilities that are part of demonstration projects and the ORs not included in the SMFP need determination. Excludes C-section, Trauma, and Burn ORs.

Atrium Health had "anti-steering" clauses in its managed care contracts that prevented payors from directing business away from Atrium Health. The United States Department of Justice and the State of North Carolina sued Atrium Health on antitrust grounds for this conduct. The Department and the State alleged that Atrium Health, the dominant hospital system in the Charlotte area, used its market power to restrict health insurers from encouraging consumers to choose healthcare providers that offer better overall value. The restrictions also constrained insurers from providing consumers and employers with information regarding the cost and quality of alternative health benefit plans.[64] Even though Atrium Health had to stop using these clauses as part of a settlement with the Department and the State, their effect likely contributed to volume shifts that subsequently lead to need determinations in Mecklenburg County.[65]

Atrium was awarded all 60 beds in the 2017 Mecklenburg County Acute Care Bed Review. These CONs were issued in June 2018. Atrium was awarded 38 beds of the 50 beds in the 2018 Mecklenburg County Acute Care Bed Review and Novant Health was awarded 12. These CONs were issued in March 2019. Approving Atrium for another 76 beds in the 2019 Mecklenburg County Acute Care Bed Review equals 174 new acute care beds awarded to Atrium during two years compared to the 12 awarded to Novant Health. This is highly unusual and equates to more beds for Atrium Health than the entire bed inventory of some hospitals in North Carolina.

Atrium requests approval to build out 18 acute care beds at CMC, 12 acute care beds at AH Pineville, 16 acute care beds at AH University City, and 30 acute care beds at AHLN. The proposed new beds at CMC are besides the 45 new acute care beds awarded to CMC in Project I.D. #F-011362-17. The proposed new beds at AH Pineville are besides the fifteen beds for which AH Pineville was approved under Project I.D. #F-011361-17 and the 38 beds AH Pineville was awarded in Project I.D. #F-11622-18. Atrium also requests approval to build out two ORs at AH Pineville besides the two undeveloped ORs it was awarded in March of 2019 in Project I.D. #F-11621-18. Atrium's CMC OR application requests two ORs besides the two undeveloped ORs awarded in Project I.D. F-11620-18. Since all of Atrium's approved acute care beds and ORs have not yet been developed, they have no utilization to demonstrate that they will be fully utilized and that Atrium will need the additional requested assets.

The Agency should recognize the public interest in creating and maintaining competitive balance to keep Atrium from becoming even more dominant and enabling Atrium to dictate rates to commercial, Medicare, and Medicaid managed care organizations. The only policy tool the Agency has to improve competitive balance in Mecklenburg County is its CON decisions. Absent a compelling public benefit, it should avoid approving Atrium applications that will increase its market share to the detriment of competitors like Novant Health, and to the detriment of health

[64] https://www.justice.gov/opa/pr/atrium-health-agrees-settle-antitrust-lawsuit-and-eliminate-anticompetitive-steering

[65] Atrium Health has also recently announced a strategic combination with Wake Forest Baptist Health and Wake Forest University. While many details about this combination are unknown, published reports indicate that the parties intend to establish a medical school in Charlotte. https://atriumhealth.org/campaigns/bestcareforall.

care consumers. There will be no compelling public benefit from approval of the AHLN application. Denying the NH Matthews applications to approve all the Atrium applications will harm the competitive balance by increasing the number and percentage of acute care beds and ORs Atrium controls and by increasing its market share in Mecklenburg County. To maintain and improve competitive balance in Mecklenburg County, the Agency should deny the AHLN application and approve the NH Mathews applications, besides whatever decisions it makes on the other Atrium applications.

The NH Matthews applications are more effective on this factor and the Atrium applications are less effective.

Summary

The NH Matthews applications conform with all review criteria. For reasons discussed above, the AHLN application does not. To summarize major flaws in the AHLN Application and the criteria with which those flaws make the application non-conforming:

- The definition of the service area and the population to be served is not reasonable because it includes two Charlotte ZIP Codes that cannot reasonably be expected to supply 43 percent of the hospital's acute care patient days.[66]

- Atrium did not define the patients the proposed hospital will treat by DRG, APC, CPT code, or ICD code and thus did not identify the population to be served or adequately document the basis for its volume and financial projections.

- The Atrium acute care patient day and surgical case market shares from the PSA and SSA show residents of these ZIP Codes have reasonable access to Atrium Health services without a new hospital.

- The $147 million project to construct a new hospital to shift patients other Atrium hospitals is far more costly and a less effective alternative than adding acute care beds to AH University City and CMC/Mercy.

- If AHLN draws 75% of patients from the PSA, and does not increase the Atrium market share as Atrium assumes, the hospital is not financially feasible in the third project year.

- With Atrium's assumptions of no increase in market share, AHLN will not increase access to care for Medicare, Medicaid, or self-pay/charity patients relative to doing nothing or relative to adding acute care beds to AH University and CMC/Mercy.

[66] AHLN Application, Form C – Assumptions and Methodology, Page 6

In reality, AHLN will harm competition and consumers by increasing Atrium's market share in Mecklenburg County by giving it a new point of service for emergency admissions that would otherwise go to the next closest hospitals, NH Huntersville or LNRMC.

Approval of the other Atrium acute care bed and OR applications will increase the competitive imbalance, but full approval of the AHLN Application or denial of the NH Matthews Applications will unnecessarily increase the imbalance more. The most effective alternative is for the Agency to deny the AHLN Application as nonconforming and approve the NH Matthews Applications. Improving competitive balance in Mecklenburg County, or not unnecessarily worsening competitive imbalance, will maximize healthcare value by incentivizing high quality care, lowering costs, and expanding patient choice.

COMMENTS IN OPPOSITION FROM NOVANT HEALTH, INC.

Regarding Atrium Health's CON Applications Filed October 15, 2019

Attachment 1

Comments Submitted on Rowan Regional Medical Center – South's Proposal to Construct a 50-bed Hospital in Kannapolis, North Carolina

submitted by

Carolinas Medical Center – NorthEast

December 3, 2007

In accordance with NCGS 131E-185(a1)(1), Carolinas Medical Center - NorthEast ("CMC-NorthEast") submits the following comments related to Rowan Regional Medical Center - South's ("RRMC-South") proposal to build a 50-bed hospital in Kannapolis, North Carolina. CMC-NorthEast's comments include "discussion and argument regarding whether, in light of the material contained in the application and other relevant factual material, the application complies with the relevant review criteria, plans and standards" [NCGS 131E-185(a1)(1)(c)]. As such, CMC-NorthEast's comments are organized by the general CON statutory review criteria and specific regulatory criteria and standards, as they relate to the following application:

Rowan Regional Medical Center - South ("RRMC-South") – Project ID # F-7994-07

EXECUTIVE SUMMARY

RRMC-South's application should not be approved as it fails to conform with statutory review criteria and regulatory criteria and standards. The following document discusses the numerous deficiencies in RRMC-South's application. Key among these are:

- A new hospital in Kannapolis is not needed. More than 60 percent of RRMC-South's projected patients are ***currently*** being served by existing hospitals including RRMC. Without RRMC-South, 83 percent of the ***projected*** volume would be served by competitor hospitals.
- Though RRMC-South professes that the proposed hospital is in response to its mission to serve Rowan County residents, RRMC-South is proposing a new hospital primarily to serve Cabarrus County, not Rowan. Of its defined service area patients (Rowan and Cabarrus counties), ***58 percent are projected to be from Cabarrus County.***
- To attempt to demonstrate the feasibility of the proposed hospital, which is clearly not needed by the population it proposes to serve, RRMC-South relies on tremendous increases in market share, ***some greater than 3,000 percent,*** for which it provides no reasonable basis.
- Contrary to RRMC-South's assertion, the proposed hospital will not add competition in the area. ***Competition already exists in the area.*** CMC-NorthEast's success in the area is not the result of a geographic monopoly - if so, the facility would have experienced the same relative market share over time – but rather the result of CMC-NorthEast's focused efforts on developing high quality clinical services, recruiting and retaining highly specialized physicians, and providing its patients with exceptionally satisfying service.
- Patients in the area already have a choice, demonstrated by those from Salisbury (who travel farther than the proposed service area residents) to seek care at CMC-NorthEast.
- RRMC-South's proposed facility will not enhance competition by improving cost-effectiveness of services. In fact, ***RRMC-South's proposed charges are higher than all other providers in the region,*** except its parent, RRMC.
- RRMC-South's argument regarding the need for competition will result in unnecessary duplication, not only in this area, but also across the state. The

application of RRMC-South's rationale across North Carolina ***would result in the "need" for at least 22 additional hospitals.***

In summary, the proposed project has nothing to do with the needs of the patient population RRMC-South proposes to serve. Rather, the proposed project is RRMC-South's attempt to reduce the competition that already exists in the area between its existing facility in Salisbury and CMC-NorthEast. It seeks to reverse the choice that patients have already been exercising – that of CMC-NorthEast. As stated in the RRMC-South application on page 99, the CON law has not been established to ensure the long-term viability or success of any individual facility, but rather to ensure that the health care needs of the state's population are well-served. As such, RRMC-South's application should not be approved as the proposed service area population is well-served and demonstrates no need for the proposed project.

APPLICATION AMENDMENT

RRMC-South has publicly amended its application, which renders the application unapprovable as a matter of law, violating 10A NCAC 14C .0204, controlling appellate authority, and all applicable review criteria.

On page 178 of the application, RRMC-South states that its primary site for the proposed hospital is Moose Road, Kannapolis. In response to a request for information on possible additional sites, page 179 states, "Not applicable. Only one site is being considered." However, just two weeks after filing the application in which RRMC-South stated that no other sites were being considered, it publicly stated the following at a community forum in Rowan County, "We need your support for the state so we can get permission to build it...Along the way, we can work with you on another site." Representatives also indicated that other sites were considered and that RRMC-South "will probably revisit those sites."[1] (See Exhibit 1 for related news articles.)

The law is clear that applicants are prohibited from amending their CON applications after the filing date. The rules governing the review of CON applications provide that "[a]n applicant may not amend an application." 10A N.C.A.C. 14C.0204. This rule has been applied by the Agency and the Courts in prior cases, which have established that, if an applicant makes a material change to the project proposed in its application, such an application is not approvable. The leading case addressing this issue is *Presbyterian-Orthopaedic Hosp. v. N.C. Dept. of Human Resources*, 122 N.C. App. 529, 470 S.E.2d 831 (1996). In *Presbyterian*, the Agency decided to award Stanly Memorial Hospital a CON for a ten-bed rehabilitation project. A competing applicant, Presbyterian-Orthopaedic Hospital, argued that Stanly could not be approved for its CON because Stanly had impermissibly amended its CON application by changing management companies during the CON review period. The Court agreed, reasoning as follows:

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1 "Rowan Looks at Proposed Hospital," *Concord & Kannapolis Independent Tribune*, October 31, 2007. Attached in Exhibit 1.

> . . . Presbyterian contends that Stanly's actions constituted an impermissible material amendment of its application because all of the information in Stanly's application listed Milestone as Stanly's prospective management company and the project analyst relied on Stanly's representations in its application in deciding to award a certificate of need to Stanly. We agree.
>
> An applicant may not amend an application for a certificate of need once the application is deemed complete. N.C. Admin. Code tit. 10, r. 3R.0306 (Dec.1994); *In re Application of Wake Kidney Clinic*, 85 N.C. App. 639, 643, 355 S.E.2d 788, 790-91, *disc. review denied*, 320 N.C. 793, 361 S.E.2d 89 (1987). Here, all of Stanly's logistical and financial data in its completed certificate of need application was based on having Milestone as Stanly's management company. Yet, the record contains a letter dated 14 July 1993 from the president of Milestone expressing his disappointment in Milestone not being chosen by Stanly as its management company for the ten bed rehabilitation project. John Sullivan, Stanly's President and Chief Operating Officer, testified that he telephoned Milestone's president before 14 July 1993 and told him that Stanly would probably be working with a management company closer to Stanly "if and when [Stanly was] allowed to develop the beds." We conclude that the combination of the 14 July 1993 letter and Mr. Sullivan's telephone conversation with Milestone's president that occurred prior to the 14 July 1993 letter, taken in context, is sufficient evidence to show that **Stanly had decided not to use Milestone as its management company before Stanly's certificate of need application was approved and that Stanly's actions constituted a material amendment to its application.**
>
> * * *
>
> . . . **We reverse the portion of the final agency decision that awarded Stanly a certificate of need because Stanly materially changed its application** after its application was completed in violation of the North Carolina Administrative Code, N.C. Admin. Code tit. 10, r. 3R.0306 (Dec.1994).[2]

Presbyterian, 122 N.C. App. at 537, 470 S.E.2d at 835-36 (emphasis added).

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[2] The language of this rule cited by the Presbyterian Court is the same as the current amendment rule, 10A N.C.A.C. 14C.0204. It has simply been re-numbered.

Likewise, in this situation, RRMC-South has decided to "change sites" while its application is under review. Thus, this amendment to the RRMC-South application renders the application unapprovable as a matter of law.

Moreover, the Agency has followed the precedent from *Presbyterian* in its own findings. In a 2002 review for new operating rooms, the Agency was faced with a situation in which an applicant had submitted its application on the wrong application form. (Exhibit 2, p. 59) The Agency directed the applicant, HealthSouth Holding, to resubmit the application on the correct application form prior to the start of the review period. HealthSouth Holding did so, but also changed some of the information in the application that it submitted on the correct form. In its Findings, the Agency reviewed all of the changes made by HealthSouth Holding's second application and determined that changes made to the financial statements constituted an impermissible amendment to the application, such that the application could not be approved. The Agency explained as follows:

> [T]he changes made in the financial statements in Form A of the second application package . . . constituted an amendment to the application. These changes are amendments because they were not requested by the CON Section and differed materially from the information originally submitted in the first application. . . . Consequently, **regardless of the other findings contained in this document, the CON Section determined that the application submitted by HealthSouth Holding cannot be approved, standing alone, because an applicant cannot amend its application.**

(Exhibit 2, p. 60)

The changes in the HealthSouth Holding application that were deemed an impermissible amendment to the application were found in the Form A, Income Statement, and resulted in increases in the total assets for the first three years of the project of approximately $250,000, $600,000, and $1.0 million. These increased assets resulted in the project showing smaller losses and greater profits during the first three years of the project. (Exhibit 2, p. 67)

Similarly, by leaving the site issue wide open to speculation, numerous RRMC-South representations (a sampling of which are listed below) are materially altered and are rendered indeterminable. Just as in the HealthSouth Holding case, this change in the RRMC-South application constitutes an impermissible amendment that renders the application unapprovable as a matter of law.

The announcement that RRMC-South would look for other sites is material to numerous representations made in the application including, but not limited to, the following:

- The application's qualitative arguments are largely based on Kannapolis as the location for the proposed hospital.

  "As described elsewhere in this application, Kannapolis is a growing suburban community located in southern Rowan County and northern Cabarrus County. It has a substantial population base and is positioned for future growth as a result of its I-85 corridor location and serving as a bedroom community for Charlotte." (page 21)

  "Through this development in downtown, Kannapolis will truly become a new city for a new century. The proposed [RRMC-South] hospital and a planned adjacent medical office building will add modern medical care capabilities and facilities to Kannapolis at a time when the city is benefiting from significant investments and growth in research facilities which will attract academic, scientific and health care professionals to the community." (page 22)

  "[T]he location is highly accessible. The proposed location for [RRMC-South] is on the North side of Moose Road adjacent to I-85N in Kannapolis. It is less than one mile from the Rowan-Cabarrus County border and is centrally located in the proposed [RRMC-South] service area. The location is readily accessible to the residents of both northern Cabarrus county...and southern Rowan County." (page 23)

  "If RRMC did not seek to redeploy these acute bed assets, it would simply perpetuate the bed surplus which masks the need for new acute beds at the proposed Kannapolis acute care hospital...Second, as the projections show, there is a need for acute care beds in Kannapolis. Thus, if the applicant did nothing, it would not be responding to a need that Kannapolis residents have for their own community hospital." (page 25)

  "For the reasons stated below, this is no longer acceptable; the time has come for Kannapolis to have a community hospital." (page 38)

- RRMC-South does not have the support of southern Rowan communities for the project it has proposed in this application. According to China Grove Mayor Don Bringle, "Exit 63 [near the location of the proposed hospital], that's Kannapolis ... that's not southern Rowan."[3] James Furr, an alderman in Landis, was reported as saying, "If this is going to be a South Rowan hospital, let's build it in South Rowan. This (property) is practically in northern Cabarrus County."[4] The Landis Board of Aldermen wrote a letter of support but only, "with the

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3 "Rowan Regional makes case for southern Rowan," *Salisbury Post*, October 31, 2007. Attached in Exhibit 1.

4 Ibid.

strong recommendation that Rowan Regional considers another site further north, closer to Landis and China Grove."[5]

- As discussed under Criterion 3 below, the proposed project is heavily dependent on Concord patients choosing to bypass their existing hospital, CMC-NorthEast, and travel to a smaller hospital offering fewer services in Kannapolis. If that hospital is moved farther north, as requested by other residents in southern Rowan County and on which their support is dependent, the ability of RRMC-South to attract Concord patients is even more remote. Moreover, it is impossible for RRMC-South to make the requisite Criterion 3 need showing when the site and resulting surrounding service area are undetermined. Specifically, with an undetermined site, RRMC-South cannot possibly demonstrate "the extent to which all residents of the area . . . are likely to have access to the services proposed." See Criterion 3. Finally, this Criterion 3 nonconformity results in nonconformities under Criteria 4, 5, 6, and 18a based on the Agency's traditional analysis.

CRITERION-SPECIFIC COMMENTS

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

RRMC-South's application directly contradicts the directives of Policy AC-5.

The proposed project is not consistent with applicable policies of the 2007 SMFP. Specifically, Policy AC-5 states in part, "Any hospital proposing replacement of acute care beds must clearly demonstrate the need for maintaining the acute care bed capacity proposed within the application." RRMC-South's response to Policy AC-5 does not address the policy directive. It states simply, "The proposed project utilizes the appropriate target occupancy rates specified in The State Medical Facilities Plan Acute Care Bed Need Methodology for facilities with an average daily census less than 100 patients to determine future bed need for [RRMC-South] (66.7%)." RRMC-South fails to discuss anywhere in the application the need for RRMC to replace its existing bed capacity, when its current occupancy is less than 50 percent (see page 86 of the application), compared to its target occupancy of 71.4 percent.

Furthermore, RRMC-South fails to even address, much less reconcile, the response to Policy AC-5 in RRMC's bed tower applications[6] with its response

5 "Landis officials like hospital, not site," *Concord & Kannapolis Independent Tribune*, November 6, 2007. Attached in Exhibit 1.

and projections in the RRMC-South application. According to page 13 of the most recent application filed for the bed tower project, RRMC agreed to reduce its acute care bed capacity in order to comply with Policy AC-5. With the reduction in bed capacity to 223 beds, RRMC projected to be at 79.8 percent capacity by the end of FY 2008, the third operational year of the project. Thus, the previous applications were approved for bed replacement based on projections that RRMC would be above target occupancy by 2008. Instead, RRMC is currently below 50 percent utilization, yet argues that it needs to <u>again</u> **partially replace its acute care bed capacity even though it has just completed a replacement of 56 percent of its acute care bed capacity (125/223 beds), more than it is currently using.**

In addition to incurring the capital costs of two projects (bed tower and RRMC-South to replace chronically underutilized existing acute care beds), RRMC-South's own projections indicate that the proposed project will undermine CMC-NorthEast's ability to increase its occupancy toward its target. On page 73 of the application, RRMC-South estimates that without the proposed hospital, CMC-NorthEast would achieve 65.8 percent occupancy in CY 2013. However, with the proposed project, RRMC-South estimates that CMC-NorthEast would remain at its current occupancy levels, approximately 58.7 percent.

As discussed in response to Criterion 3, at the very least nearly two-thirds of RRMC-South's projected volume will be shifted from existing facilities, primarily RRMC and CMC-NorthEast, neither of which is currently operating at target occupancy. Without this shifted volume, RRMC-South would not be projected to reach target occupancy rates. Thus, the proposed project directly contradicts the principles of Policy AC-5: it proposes to expend capital to replace existing beds that are not being used, at least some of which were replaced as recently as two years ago; it proposes to expend capital to replace existing beds to serve a majority of patients that are already being served at an existing facility; it proposes to expend capital to replace existing beds, shift existing patients from CMC-NorthEast, and undermine the ability of CMC-NorthEast to increase its occupancy.

(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.*

<u>RRMC-South does not demonstrate the need for the proposed project. RRMC-South is proposing a hospital to serve Cabarrus County, not Rowan County.</u>

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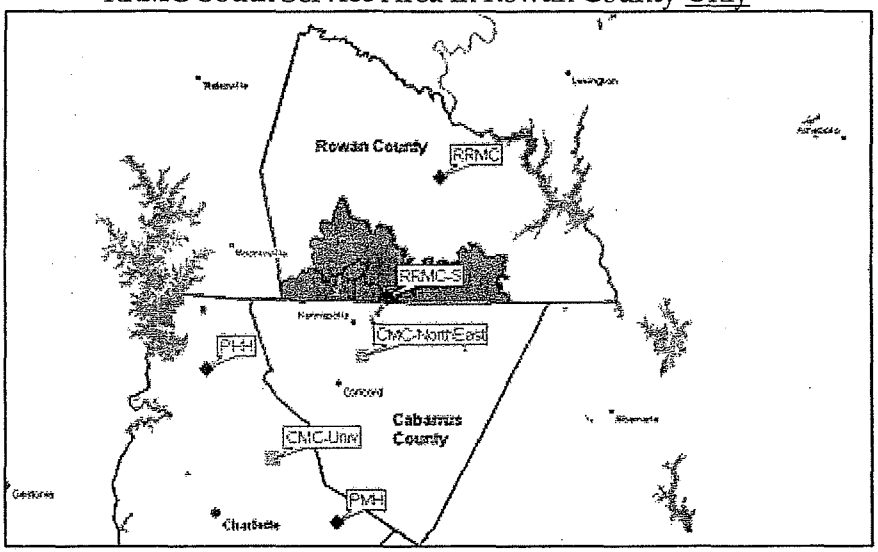
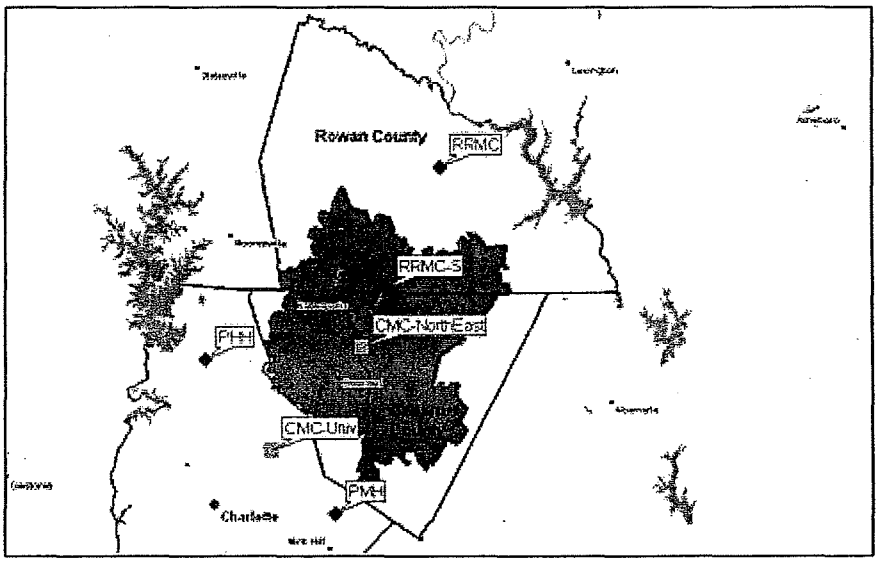
6 RRMC filed three CON applications for the bed tower: the original application, Project ID # F-6687-02, and two cost overrun applications, Project ID # F-6865-03 and Project ID # F-7055-04.

RRMC-South states on page viii that, "RRMC has a responsibility to provide hospital services for all the people of Rowan County." In almost identical statements on pages 30 and 100, RRMC-South continues to claim that it is proposing a new hospital in order to meet its mission of providing hospital services to Rowan County. However, the two maps below demonstrate that the proposed service area for RRMC-South encompasses most of Cabarrus County, while proposing to serve a much smaller portion of Rowan County.

RRMC-South Service Area in Rowan County Only

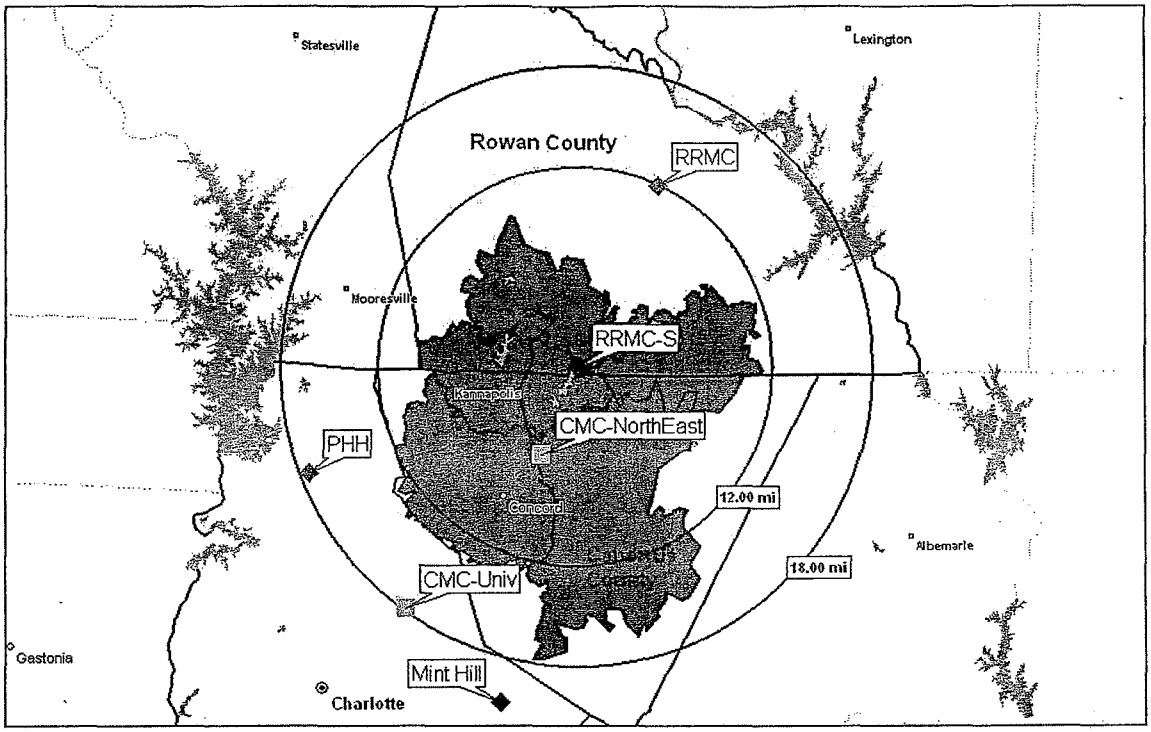


RRMC-South Service Area



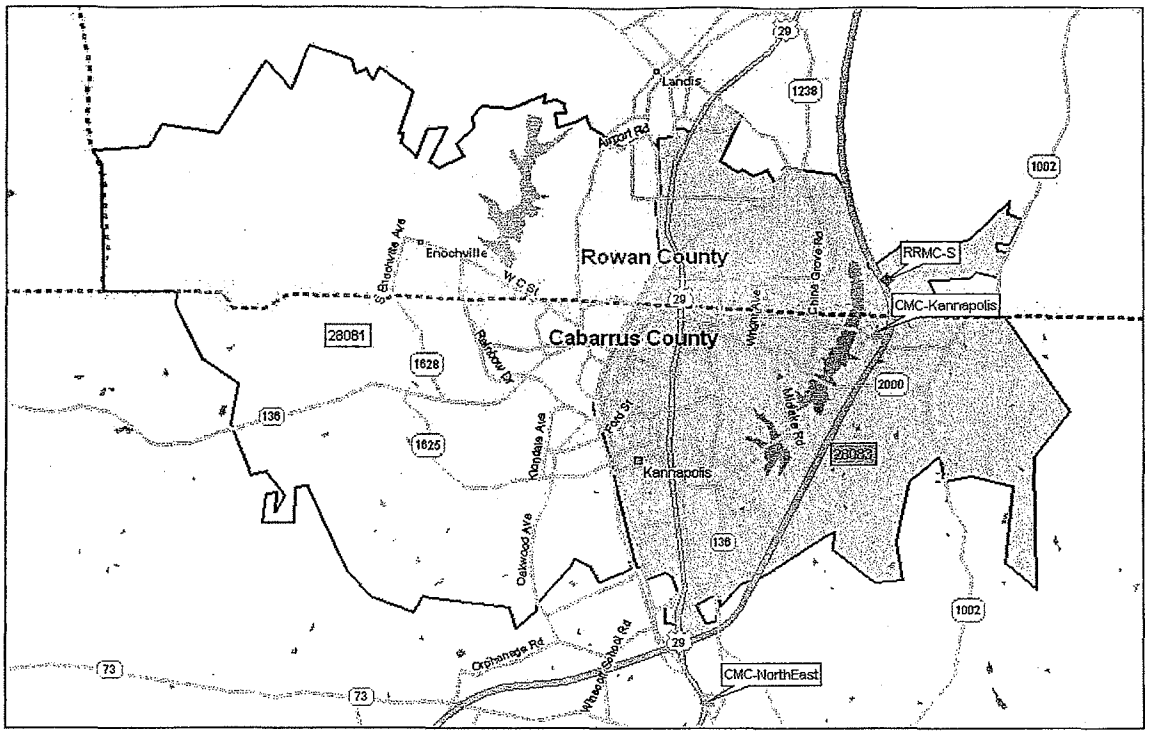
RRMC-South is proposing a service area that includes Concord zip codes 28025 and 28027, portions of which are 18 miles away from the proposed site. However, RRMC-South is **not** proposing a service area that extends a similar distance into Rowan County. As the map below demonstrates, RRMC-South is

only proposing to serve Rowan County patients as far as 12 miles away (with the northern area towards Salisbury much less than 12 miles).



As the map demonstrates there is a large area inside the 18 mile ring within Rowan County, and yet, RRMC-South is not proposing to serve patients in that area. Instead, RRMC-South is proposing to serve Cabarrus County patients who are already well-served by CMC-NorthEast.

RRMC-South's proposal to serve Kannapolis as part of its mission as a Rowan County provider is also misleading because Kannapolis and its citizens are largely based in Cabarrus County and heavily oriented to Concord. As the map below illustrates, the Kannapolis zip codes of 28081 and 28083 are more geographically located in Cabarrus County than Rowan County.



In addition, over two-thirds of the population of these two zip codes is located in Cabarrus County, as shown in the table below.

Kannapolis Population by County

	Cabarrus County	*Rowan County*	*Kannapolis Total*
28081	15,227	10,687	25,914
28083	17,553	5,398	22,951
Total	**32,780**	**16,085**	**48,865**
% of Total	***67%***	***33%***	***100%***

Source: Claritas 2007 Population data, see Exhibit 3.

Another indicator of Kannapolis' orientation towards Concord and Cabarrus County is newspaper readership. As demonstrated in the table below, over twice as many households in Kannapolis read the Concord-based *Concord and Kannapolis Independent Tribune* as read the *Salisbury Post*. (Please note the name of the *Independent Tribune* is the *Concord and Kannapolis Independent Tribune*, further signifying the long-standing shared interests of these communities.)

Kannapolis Households by Newspaper Circulation

	Independent Tribune	*Salisbury Post*	*Kannapolis Households*
28081	2,375	1,235	9,921
28083	2,851	929	8,743

Total	5,226	2,164	18,664
% of Total	*28%*	*12%*	*100%*

Source: Claritas 2007 Population data, see Exhibit 3; *Concord & Kannapolis Independent Tribune; Salisbury Post,* see Exhibit 4.

Moreover, Kannapolis is now, and has in the past, been well-served by CMC-NorthEast. In fact, the former Cabarrus Memorial Hospital, which is now CMC-NorthEast, was originally established in Concord for the very purpose of providing health care services to the workers of Cannon Mills, located in Kannapolis. The heritage of Cannon Mills and the Cannon family shared between Concord and Kannapolis has drawn these communities together to share resources, including CMC-NorthEast, which is widely considered among Kannapolis residents to be "their" hospital. Contrary to RRMC-South's assertions regarding a geographic monopoly, it is this community-to-community relationship, combined with high clinical quality and service delivery that has resulted in more than 80 percent of Kannapolis residents choosing CMC-NorthEast for their hospital needs.

RRMC-South discusses throughout its application the development of the North Carolina Research Campus in Kannapolis and the need and support the proposed hospital will bring to that endeavor. In contrast to RRMC-South's recent interest in this project, CMC-NorthEast has been intimately involved in the planning for the campus development, dating back to Spring of 2005. As a result of its long-held interest in the project, its commitment to Kannapolis, and its capabilities, quality and service reputation, CMC-NorthEast has been granted exclusive rights to be the hospital service provider on the campus.

Although RRMC-South proposes in its narrative to be focused on serving Kannapolis, the application fails to demonstrate the need Kannapolis residents have for the proposed hospital. As shown on the prior map, much of the heart of downtown Kannapolis and its residents are actually closer to CMC-NorthEast and CMC-NorthEast is much more accessible to these residents via Highway 29 than RRMC-South will be on the eastern side of I-85, particularly without access to the interstate at its location.

Although RRMC-South claims in its narrative that the proposed project will serve Kannapolis and Rowan County, its utilization projections are based largely on serving Cabarrus County residents, not Rowan residents, a population that is already well-served by CMC-NorthEast. Approximately 58 percent of RRMC-South's patients from its defined service area are projected to reside in Cabarrus County, as demonstrated below. Therefore, not only has RRMC-South failed to demonstrate the need the population it proposes to serve has for the project, it has also failed to consistently identify the population to be served by the project (narratively it indicates Rowan, while statistically it indicates Cabarrus) and is therefore non-conforming with Criterion 3.

Assuming that RRMC-South's projected Kannapolis discharges are divided according to the population division by county, RRMC-South's total discharges, from page 49, for Rowan and Cabarrus counties in the third project year are as follows:

RRMC-South Defined Service Area Discharges by County – CY2013

Zip Code	*Rowan County*	*Cabarrus County*
28023 – China Grove	377	NA
28088 – Landis	89	NA
28138 – Rockwell	315	NA
28081 – Kannapolis*	280	399
28083 – Kannapolis**	135	439
28025 - Concord	NA	493
28027 - Concord	NA	309
County Total	**1,196**	**1,640**

*Assumes that 41 percent of discharges in 28081 are in Rowan County and remaining in Cabarrus County
**Assumes that 24 percent of discharges in 28083 are in Rowan County and remaining in Cabarrus County

RRMC-South Defined Service Area Discharges by County

	CY 2013	*% of Total SA Discharges*
Cabarrus County	1,640	58%
Rowan County	1,196	42%
Defined Service Area Total	2,836	100%

Note: RRMC-South assumes 10 percent in-migration (315 discharges) from outside the service area which results in total discharges of 3,151 discharges.

RRMC-South does not demonstrate the need for the proposed project. RRMC-South's proposed service area is distinctly different from, and not similar to, Huntersville, Mint Hill, and Kernersville.

On pages 21, 26, 99, and 175, RRMC-South argues that the proposed hospital is needed because the existing population base is similar in size to Huntersville, Kernersville, and Mint Hill, each of which has been approved for a 50-bed hospital.[7] The application suggests that because these other applications have been approved, and this is so similar, the CON Section should readily approve

[7] Please note that the CON Section has never issued an approval of the Huntersville hospital and is on record stating that neither the application nor the supplemental information provided to the Agency met CON review criteria. The N.C. Supreme Court allowed Presbyterian-Huntersville to continue to operate only because the Court considered the CON issues to be moot since that hospital had already been built.

this application. However, RRMC-South's analysis about the similarities fails to compare the areas equally. When compared equally, as shown below, Kannapolis is very different from Huntersville, Kernersville, and Mint Hill.

First, the Kannapolis service area, as proposed, encompasses an existing 457-bed full service acute care facility, CMC-NorthEast. The service areas for Huntersville, Kernersville, and Mint Hill include no other acute care providers.

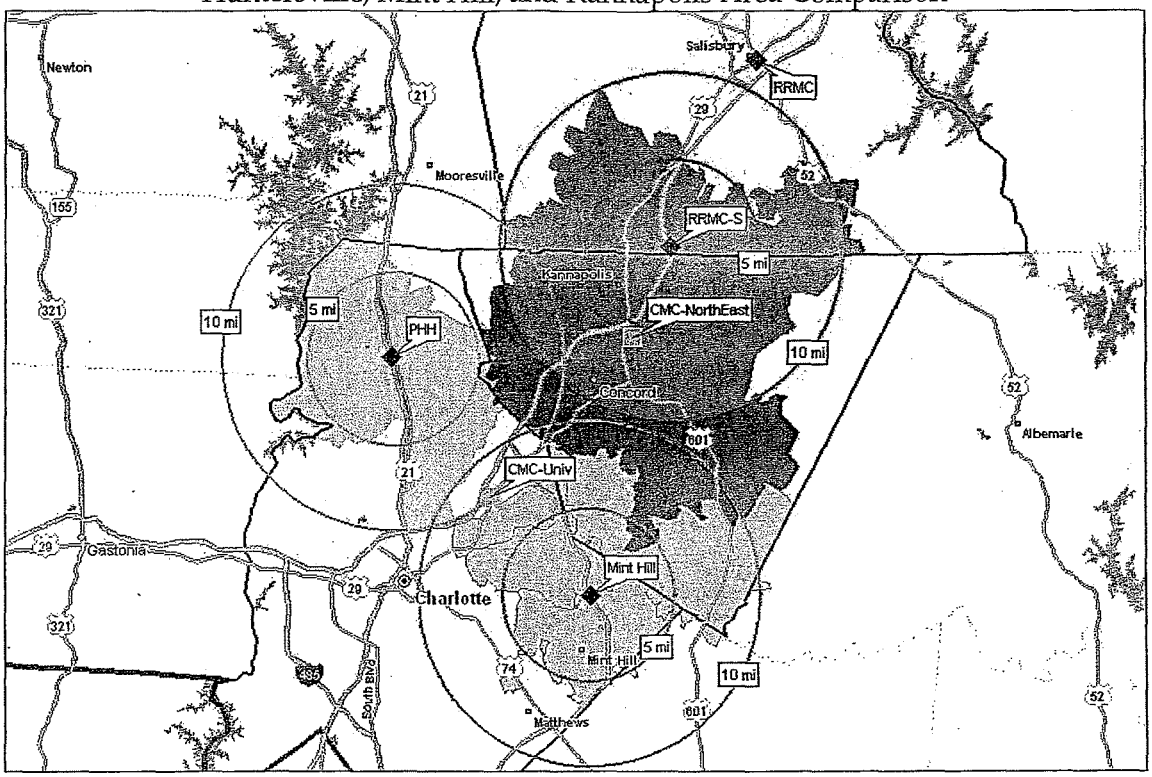
Second, contrary to RRMC-South's statements in the application, the population density surrounding the proposed hospital is much smaller than in the other three locales. On page 99 and elsewhere in the application, RRMC-South states, "the Kannapolis service area has a similar population base to Huntersville in north Mecklenburg County, Mint Hill in eastern Mecklenburg County, and Kernersville in eastern Forsyth County. The population tables below [for the Mint Hill, Greater Kernersville, Huntersville, and Kannapolis service areas] illustrate the similarities in the size of the population base." As the following table demonstrates, the service area definitions presented by RRMC-South hide the fact that the Kannapolis site has the smallest population in its surrounding area.

	Mint Hill	*Kernersville*	*Huntersville*	*Kannapolis*
2007 Population within 10 miles of the hospital site	443,274	262,334	240,232	164,242

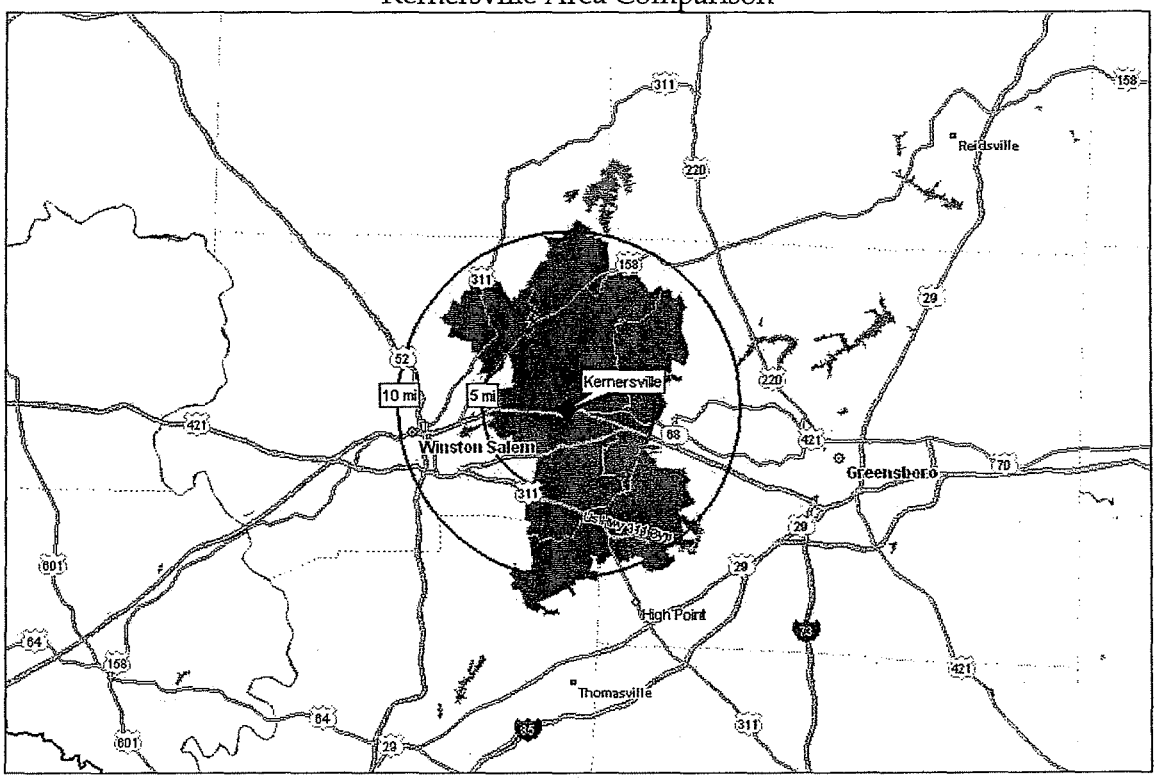
Source: Claritas radius report, included as Exhibit 5.

Third, the geography of the proposed service area is much larger than the service areas for Mint Hill, Kernersville, and Huntersville. In the following maps, circles with 5-mile and 10-mile radii are drawn around each of the hospital sites and compared to the hospital service areas.

Huntersville, Mint Hill, and Kannapolis Area Comparison



Kernersville Area Comparison



As the maps demonstrate, the proposed service area for RRMC-South is considerably larger than other 50-bed hospitals. Much of the proposed service area for RRMC-South falls beyond the 10-mile ring whereas the service areas for the other hospitals fit almost entirely within the 10-mile rings (and in the case of the only existing facility, Huntersville, the service area fits almost entirely within the 5-mile ring). RRMC-South has clearly drawn very different size geographic service areas and claimed that they are the same in order to convince the CON Section that this project is similar to previous 50-bed hospitals.

Another important distinction between the proposed RRMC-South project and the 50-bed hospitals of Huntersville, Kernersville, and Mint Hill is the degree to which the new hospital relies on a shift of patient volume from other hospitals within the parent system. As demonstrated later, RRMC-South is projecting that only 478 discharges will be shifted from RRMC or 15.2 percent of its year three volume. By contrast, Presbyterian-Huntersville, Forsyth Medical Center-Kernersville, and Presbyterian-Mint Hill proposed greater shifts from hospitals within their system.

Discharge Shift from Hospital within System in Project Year 3

	Shift to New Hospital from System Hospitals	*Total New Hospital Volume*	*Percent of Patients Shifted Within System*
Presbyterian-Mint Hill***	2,364	4,293	55.1%
FMC-Kernersville**	1,845	3,364	54.8%
Presbyterian-Huntersville*	862	4,711	18.3%
RRMC-South****	478	3,151	15.2%

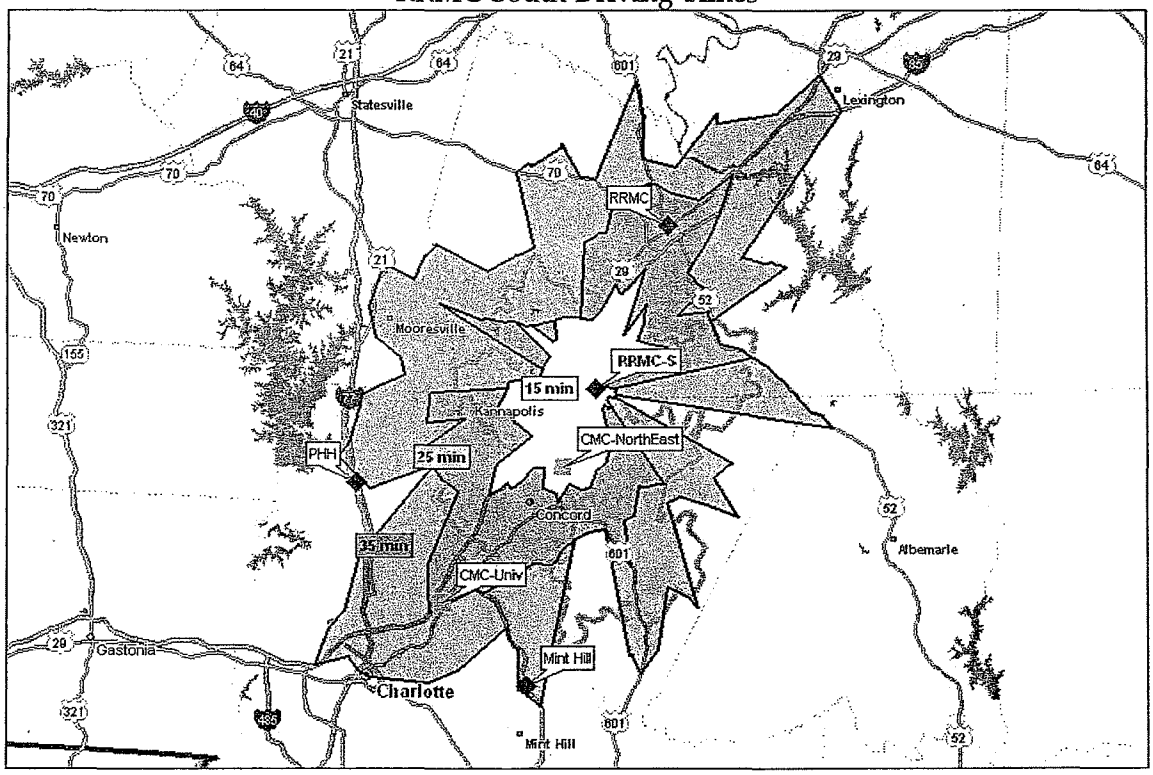
*Presbyterian-Huntersville CON application, Exhibit 17, page 53.
**FMC-Kernersville CON application, Exhibit 20, figures 17, and 36 to 38, impact on inmigration excluded.
***Presbyterian-Mint Hill CON application, page 97, days converted to discharges using ALOS = 3.2 as on page 52.
****RRMC-South application Exhibit 20, Table 25; total hospital volume used instead of service area volume for comparison purposes.

Despite RRMC-South's efforts to demonstrate need by comparing its proposal to recently approved 50-bed hospitals, the above analysis demonstrates that the proposed hospital is very different with regard to access to existing acute care services, population density, and service area size. Therefore, RRMC-South fails to demonstrate the need that the population it has identified in Kannapolis has for the proposed project and is non-conforming with Criterion 3.

RRMC-South does not demonstrate the need for the proposed project. RRMC-South's proposed project is not feasible without significant shifts of market share of Concord residents.

RRMC-South's occupancy is highly dependent upon its market share in the Concord zip codes. However, some residents in the Concord zip codes are as far as 18 miles and 35 minutes away from the proposed site. By comparison, CMC-NorthEast is only 10 miles from all portions of the Kannapolis zip codes and 18 miles from Salisbury and RRMC. The map below shows approximate driving times within the proposed service area, some of which is beyond the 35 minute drive time region of the proposed site.

RRMC-South Driving Times

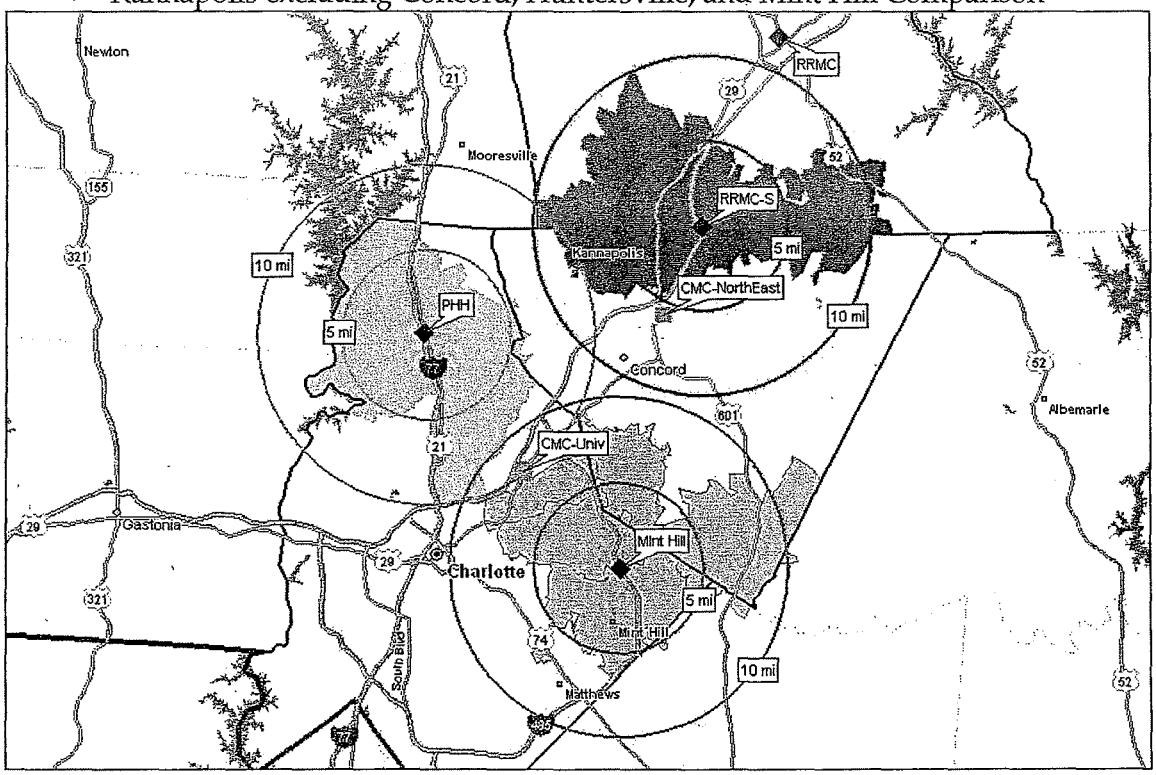


RRMC-South's proposal is directly contradictory to its own rationale for the need to develop the proposed project. Page 25 of the application states, "As a result of the geography of the area, the provision of hospital services to southern Kannapolis is dominated by one hospital, [CMC-NorthEast], which maintains an almost monopolistic position with market share in these immediate zip codes in excess of 75%." Page 30 goes on to state, "RRMC, founded in 1936, has a responsibility to provide hospital services for all of Rowan County. RRMC is located in far north Rowan County in an area of Salisbury that is not easily accessible from the I-85 corridor. The western Salisbury location of RRMC makes it less convenient for residents of the population concentration in the southwestern part of Rowan County to access services at RRMC. The location of RRMC to the population and physicians who practice in southwestern Rowan County and adjacent areas of Cabarrus County present barriers to the use of RRMC. " In essence, RRMC-South is arguing that RRMC's current location (approximately 18 miles from CMC-NorthEast and less than 18 miles from Kannapolis) prohibits the use of its facility by residents of the proposed service

area. (If this is true, then RRMC-South did not propose the most effective alternative for Rowan County, when it spent more than $30 million to construct a bed tower in this inaccessible area of Rowan County). At the same time, RRMC-South argues that residents of Concord, many of whom are 18 miles/35 minutes away from the proposed hospital site (assuming it is not moved farther north) will choose to bypass CMC-NorthEast, the hospital a growing number have used for years, to seek services at RRMC-South, which will be farther away and provide fewer services.

As discussed previously, the proposed service area is significantly larger in terms of geography than those of Huntersville, Mint Hill, and Kernersville hospitals. The map below illustrates that the geography of the RRMC-South service area would be similar to Huntersville, Mint Hill and Kernersville, if it excluded the Concord zip codes.

Kannapolis excluding Concord, Huntersville, and Mint Hill Comparison



However, the RRMC-South project is not feasible if Concord is excluded because the Concord population and the associated increases in RRMC market share are key drivers of the proposed project's utilization. Population of the proposed service area is shown in the table below.

RRMC-South Service Area Population

Zip Code	CY 2007	% of Total
28025 - Concord	49,509	27.9%
28027 - Concord	53,124	29.9%
Concord subtotal	**102,633**	**57.8%**
28081 - Kannapolis	24,732	13.9%
28083 - Kannapolis	22,347	12.6%
Kannapolis subtotal	**47,079**	**26.5%**
28023 - China Grove	13,725	7.7%
28088 - Landis	2,880	1.6%
28138 - Rockwell	11,340	6.4%
Total	**177,657**	**100.0%**

Source: RRMC-South Application page 40.

Nearly 60 percent of the service area population resides in Concord. In contrast, less than 30 percent of the service area population resides in Kannapolis. Without the shift of patients from Concord, the proposed facility would not be sufficiently utilized. As demonstrated in the table below, the proposed project does not achieve target occupancy of 66.7 percent for facilities with an average daily census less than 100 patients without the proposed shift of patients from Concord zip codes.

RRMC-South Project Year 3 Volumes without Concord*

	Including Concord	Excluding Concord	Difference
Service Area Discharges	2,836	2,034	802
Inmigration (10%)	315	226	89
Total Discharges	3,151	2,260	891
ALOS	4.1	4.1	--
Days	12,917	9,266	3,651
Occupancy (50 beds)	***70.8%***	***50.8%***	***20.0%***

* Concord zip codes are 28025 and 28027

As demonstrated in the table below, the proposed project would not support three operating rooms without the Concord population.

RRMC-South Project Year 3 Volumes without Concord*

	Including Concord	*Excluding Concord*	*Difference*
Inpatient Surg.	964	631	333
C-Sections	134	88	46
Outpatient Surg.	2,419	1,617	802
Weighted Procedures w/o C-Sections**	6,122	4,054	2,067
OR Need at Planning Capacity***	3.3	2.2	1.1

* Concord zip codes are 28025 and 28027
**Inpatient surgical cases weighted at 3 hours per case, outpatient surgical at 1.5 hours per case.
***Based upon *SMFP* OR Need Methodology planning capacity target of 1,872 operating hours per year per room

As demonstrated in the table below, the proposed project would perform 4,462 fewer CT procedures without Concord volume.

RRMC-South Project Year 3 Volumes without Concord*

	Including Concord	*Excluding Concord*	*Difference*
Inpatient CT	2,073	1,487	586
Outpatient CT	15,327	11,450	3,876
Total CT	17,400	12,938	4,462

* Concord zip codes are 28025 and 28027

As discussed previously, even if RRMC-South were to achieve its market share projections of Concord zip codes, it would do so at the expense of CMC-NorthEast's utilization and track-record to achieve target occupancy. As the discussion below demonstrates, RRMC-South's service area volume in Project Year 3, if achieved, will be composed largely of discharges shifted from competitor hospitals.

RRMC-South does not demonstrate the need for the proposed project. RRMC-South is projecting to shift 83 percent of its future volume from competitors.

RRMC-South's own projections for the third project year or CY 2013 show that without the development of RRMC-South, RRMC would serve 880 discharges from the defined service area, based on existing market share and projected population growth (from RRMC-South Exhibit 20, Table 25). By contrast, RRMC will only serve 402 discharges if RRMC-South is developed. The difference of 478

discharges is the volume shift projected from RRMC to RRMC-South in Project Year 3.

RRMC Utilization in RRMC-South Defined Service Area CY 2013

	Discharges
Without RRMC-South	880
With RRMC-South	402
Shift to RRMC-South	**478**

Source: RRMC-South application Exhibit 20, Table 25.

RRMC-South is projecting to serve a total of 2,836 discharges from the defined service area in Project Year 3. Of these, 478 discharges are projected to shift from RRMC. Without RRMC-South, the remaining 2,358 patients would otherwise seek care at another facility. Therefore, RRMC-South is projecting that 83 percent of its future volume will be shifted from competitor hospitals.

RRMC-South Utilization in Defined Service Area CY 2013

	Discharges	*% of Total*
Shift from RRMC	478	16.9%
Shift from other facilities	2,358	83.1%
Total	**2,836**	**100.0%**

Source: RRMC-South application Exhibit 20, Table 13.

Even if it was assumed that RRMC-South would capture 100 percent of the new service area growth[8] (highly unlikely), the proposed hospital would be shifting ***at the very least*** 1,292 existing patients, or nearly half of its Project Year 3 defined service area discharges, from competitor hospitals.

	Discharges	*% of Total*
Existing Patient Shift from RRMC	478	16.9%
New service area growth	1,066	37.5%
Existing Patient Shift from Other Facilities	1,292	45.5%
Total	**2,836**	**100.0%**

Based on past experience, CMC-NorthEast believes that the volume shift from competitors could be higher, particularly given the location of the proposed facility and the proposed service area that largely consists of Cabarrus County.

8 As stated in RRMC-South's application, acute discharge growth in the proposed service area, for those DRGs that will be provided at RRMC-South, will be 1,066 discharges, or 7.3 percent, for the time period between FY 2006 and CY 2013.

In the case of Presbyterian-Huntersville, the hospital's CON application on page 53 of Exhibit 17 projected "862 Discharges Lost to PHN [Presbyterian-Huntersville]" from Presbyterian Hospital in the third year of the project. Furthermore, the application argued on page 107 that "the proposed addition of beds in the Huntersville service area, which will be accomplished by the relocation of beds and services from the downtown Charlotte area, not only meets the needs of the residents of Huntersville, but also adequately meets the needs of resident and patients who receive care at Presbyterian Hospital." However, in reality, no volume shifted from Presbyterian Hospital to Huntersville; Presbyterian Hospital's volume from the Huntersville service area increased from 5,385 in 2003 (the year prior to the hospital's opening) to 6,119 in 2005 (the first full year following the hospital's opening). In contrast, even if all new service area growth is attributed to Presbyterian-Huntersville (instead of shared with Presbyterian Hospital), approximately 75 percent of Presbyterian-Huntersville's volume came from competitor hospitals, while additional volume shifted from competitors to Presbyterian Hospital.

Presbyterian-Huntersville Competitive Shift

	2003 Volume	*New Area Growth*	*Competitive Shift*	*2005 Volume*
Presbyterian-Huntersville and Presbyterian Hospital Combined	5,385	608	2,705	8,698
% of Total	**62%**	**7%**	**31%**	**100%**
Presbyterian-Huntersville Only	0	608	1,971	2,579
% of Total	**0%**	**24%**	**76%**	**100%**

Source: Presbyterian-Huntersville analysis conducted by CMC-NorthEast, see Exhibit 6.

As a result of the development of Presbyterian-Huntersville, from 2003 to 2005:

- Presbyterian Hospital/Presbyterian-Huntersville combined gained eight points of share
- Lake Norman Regional Medical Center lost two points of share
- CMC and CMC-University combined lost five points of share
- Occupancy at CMC-University declined by 6.7 points from ***2003 to 2005 alone***; of that 6.2 points is attributable to the 807 discharges lost to Presbyterian Huntersville[9]

9 2006 HLRA (2005 data) occupancy = 45 percent (21,344 days / 130 beds x 365); ALOS = 3.6 (21,344 days / 5898 discharges); 807 discharges equal 2,920 patient days and 6.2 points of occupancy.

Likewise, given the service area proposed, RRMC-South appears to be a market share strategy for Novant/RRMC and will result, even based on projections in its own application, in lower utilization of CMC-NorthEast.

RRMC-South does not demonstrate the need for the proposed project. RRMC-South's application provides no reasonable basis for its projected increases market share.

On page 45 of the application, RRMC-South indicates that inpatient market share will increase, depending on zip code, from 7.5 percentage points to 25 percentage points. In some areas, this represents an increase of more than **3,000 percent** over the current market share experienced by RRMC, as shown in the table below.

RRMC-South Market Share Increases

Zip Code	*City/Town*	*RRMC FFY 2006 Market Share*	*RRMC-South Projected Market Share*	*% Increase Over Current Share*
28023	China Grove	25.1%	33.8%	35%
28025	Concord	0.3%	10.2%	3,300%
28027	Concord	0.3%	7.7%	2,467%
28081	Kannapolis	3.8%	27.3%	618%
28083	Kannapolis	2.2%	26.3%	1,095%
28088	Landis	18.8%	31.3%	66%
28138	Rockwell	44.9%	37.4%	-17%

Source: RRMC-South application, pages 48.

Similarly, page 57 of the application shows that RRMC currently performs a total of 112 surgical procedures (inpatient and outpatient combined) on residents of the proposed service area. However, with the projected increase in market share, RRMC-South projects that it will perform 3,046 surgical cases on residents of the proposed service area in project year 3, an increase of 2,620 percent.

RRMC-South provides no statistical basis for these projected increases and some of its stated beliefs are not correct. For example, on page 45 RRMC-South states that it is closer to portions of each of the seven zip codes than RRMC and competitor hospitals (assuming RRMC-South retains its existing site, which is doubtful given its public promises to southern Rowan County residents). However, an examination of the proposed service area, along with primary highways, suggests that RRMC-South will not be closer to the Concord zip codes than CMC-NorthEast. In fact, given the primary highways, many of these patients would have to drive past CMC-NorthEast to access RRMC-South. Page 45 also states that "Out-migration from Rowan County will decrease and more patients will be treated within the defined service area." However, as discussed

previously, the proposed project is largely dependent on the out-migration of Cabarrus County residents to the RRMC-South facility in Rowan County. Moreover, the discussion under Criterion 18a documents that patients in the area already have a choice of providers, and many are exercising that choice and traveling out of county to receive what they believe to be better care. Page 46 of the application states, "The proposed location convenient to I-85 will result in ease of access to existing population." However, as discussed under Criterion 4, the proposed location, while located in sight of I-85, is not easily accessible from I-85.

RRMC-South does not demonstrate the need for the proposed project. RRMC-South does not demonstrate a need to develop a dedicated C-Section room.

On page 55 of the application, RRMC-South projects that it will perform 134 C-Sections in year 3 of the project (approximately one every three days) and thus needs a dedicated C-Section room. The application also states, "There are no applicable CON utilization criteria standards for c-section ORs in either the SMFP or the Criteria and Standards for Surgical Services." While RRMC-South is correct in that applicable standards do not apply because it is not proposing to add a new C-Section room, but rather to replace/relocate an existing room, the Agency has previously used applicable performance standards in determining whether project components are needed under Criterion 3. In its review of Alamance Regional's outpatient center project (Project ID # G-6827-03), the Agency stated:

> Further, even if current surgical practice patterns at Alamance Regional Medical Center were to be the reasonable estimate of Mebane practice patterns, the rate of utilization at Alamance Regional Medical Center is less than practical utilization. Regarding operating rooms, in Section II.8, the applicant states that Alamance Regional Medical Center has 11 shared operating rooms, 2 dedicated C-Section rooms and 5 endoscopy rooms (3 existing and 2 new rooms, operational since February 2003). According to its 2003 License Renewal Application, Alamance Regional Medical Center reports the following surgical patients served in 2002 in its shared operating rooms and endoscopy rooms:

Alamance Regional Medical Center - Utilization in 2002			
	Surgery Cases	Endoscopy Cases	Total
Ambulatory Cases	6,929	4,393	11,322
Inpatient Cases	2,263	618	2,881
Total Surgical Cases	9,192	5,011	14,203

Source: Alamance Regional Medical Center 2003 License Renewal Application

The above data shows the 11 shared operating rooms at Alamance Regional Medical Center are only performing 3.21 cases per day which is less than practical utilization of 3.5 cases per day (9192 / 260 days/11 operating rooms = 3.21 cases per day) for a shared operating room. The above data shows the 3 existing endoscopy rooms at Alamance Regional Medical Center are only performing 2.58 cases per day which is less than practical utilization of 4.3 cases per day (5011 / 260 days/3 operating rooms = 2.58 cases per day) for an endoscopy room.

The applicant did not adequately demonstrate that its methodology and the resultant projected number of outpatient surgical cases for the primary and secondary markets are reasonable. Therefore, the applicant overestimates the number of surgical procedures to be performed in the proposed relocated operating rooms. Consequently, the applicant did not adequately demonstrate the need to relocate two existing operating rooms and one endoscopy room to Mebane.

The rules in effect at the beginning review date for this application state:

(c) *A proposal to develop an additional operating room to be used as a dedicated C-section operating room shall not be approved unless the applicant documents that the average number of surgical cases per operating room to be performed in each facility owned by the applicant in the proposed service area, is reasonably projected to be at least 2.4 surgical cases per day for each inpatient operating room (excluding dedicated open-heart and dedicated C-section operating rooms), 4.8 surgical cases per day for each outpatient or ambulatory surgical operating room and 3.2 surgical cases per day for each shared operating room during the third of operating following completion of the project.*

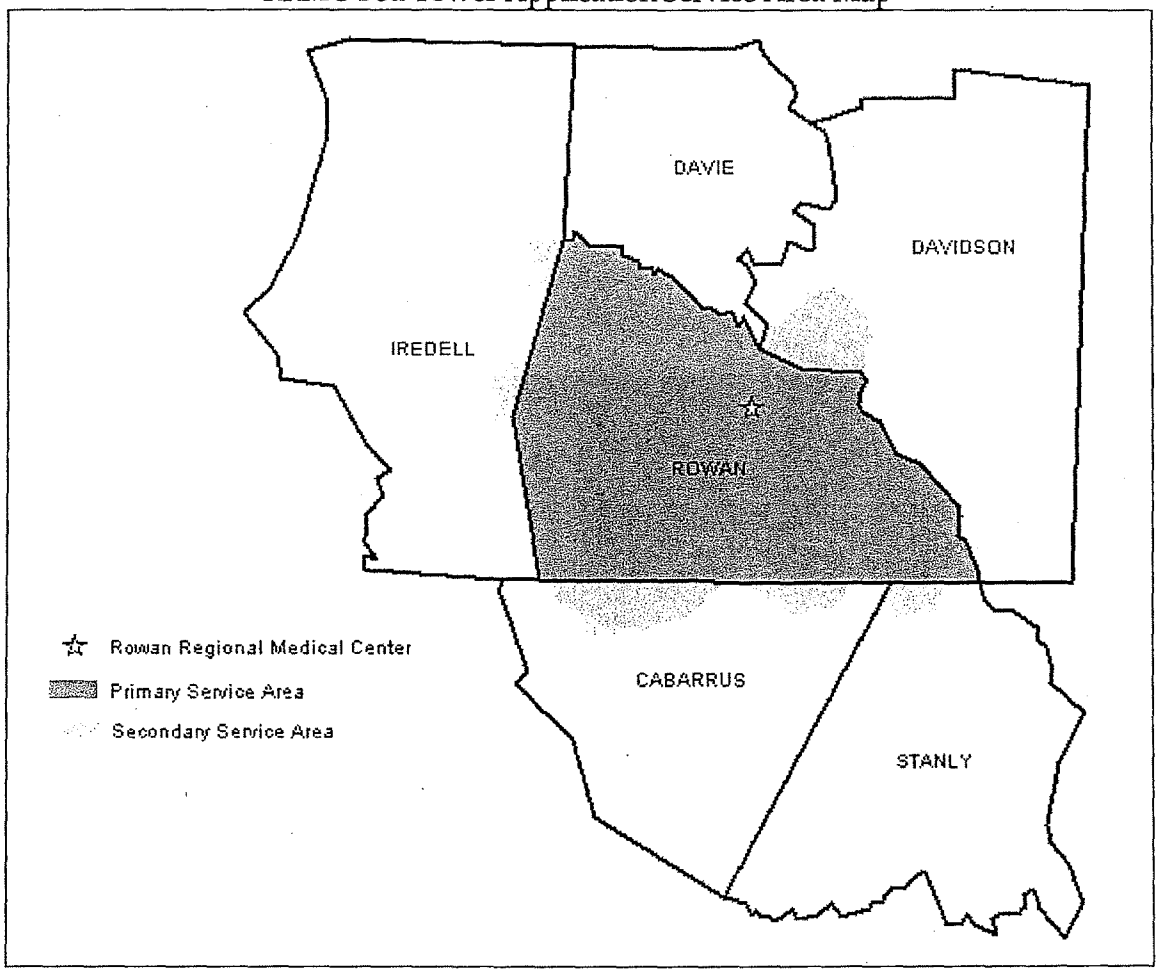
In a recent decision on WakeMed's application to develop inpatient services at its North Raleigh Healthplex (Project ID #J-7843-07), the Agency determined that the application did not demonstrate that it needed to add dedicated C-Section rooms, even with projections of 327 C-Section cases in the third year of its project.

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

RRMC-South fails to demonstrate that the needs of the population presently served by RRMC will be adequately met with the relocation of services to its proposed hospital.

RRMC recently completed a bed tower project on its campus in Salisbury with a project cost of $33.4 million. RRMC filed three CON applications for the bed tower project, the original application (Project ID # F-6687-02) and two cost overrun applications (Project ID # F-6865-03 and Project ID # F-7055-04). According to the most recent application filed on this project, the project was scheduled for completion on May 1, 2006. Therefore, the project is still within the initial three years of completion for which data was provided in its CON application. In its bed tower applications, RRMC proposed to serve Rowan County as its primary service area (see map below).

RRMC Bed Tower Application Service Area Map



Source: RRMC Bed Tower Original Application, Project ID # F-6687-02

On pages 46 and 47 of its original bed tower application, RRMC projected over 85 percent of its patients would originate from Rowan County and less than five percent from Cabarrus.

FY 2007 to FY 2006 RRMC Bed Tower Patient Origin

	Rowan County	*Cabarrus County*
Medical/Surgical	86%	3%
Obstetrics	88%	4%

Source: RRMC Bed Tower CON application, Project ID # F-6687-02

However, as discussed previously, the RRMC-South application proposes to relocate 50 beds, previously demonstrated as needed to serve Rowan patients, to serve a defined service area that consists of 58 percent of patients from Cabarrus County.

According to page 13 of the most recent application filed for the bed tower project, RRMC agreed to reduce its acute care bed capacity in order to meet target occupancy requirements and demonstrate need for the proposed project. With the reduction in bed capacity to 223 beds, RRMC projected to be at 79.8 percent capacity by the end of FY 2008, the third operational year of the project. However, in this application, with no explanation for the difference, RRMC projects to be at only 49 percent occupancy in CY 2008. In addition, there is a significant discrepancy between projected discharges and patient days in the most recent bed tower application and the RRMC-South application, as shown in the table below.

Discrepancy between Projected RRMC Discharges

	2006	*2007***	*2008***
RRMC Bed Tower Application*	14,311	15,051	15,815
RRMC-South Application	8,622	8,636	9,124

*Original RRMC Bed Tower for 2006 and Second RRMC Bed Tower cost overrun used for 2007 and 2008 because Second Bed RRMC Bed Tower does not include 2006 projections.
**2007 indicates FY 2007 for RRMC Bed Tower and CY 2007 for RRMC-South; 2008 indicates FY 2008 for RRMC Bed Tower and CY 2008 for RRMC-South

Discrepancy between Projected RRMC Days

	2006	*2007***	*2008***
RRMC Bed Tower Application*	59,820	61,842	65,001
RRMC-South	37,609	37,669	39,798

*Original RRMC Bed Tower for 2006 and Second RRMC Bed Tower cost overrun used for 2007 and 2008 because Second Bed RRMC Bed Tower does not include 2006 projections.
**2007 indicates FY 2007 for RRMC Bed Tower and CY 2007 for RRMC-South; 2008 indicates FY 2008 for RRMC Bed Tower and CY 2008 for RRMC-South

Thus, the previous applications were approved based on projections that RRMC would require its 223 beds to serve the population in Rowan County. Despite the fact that RRMC is still within the first three years of operation of the bed tower project, it now proposes to move 50 of those beds to serve a geographic area largely based in Cabarrus County – without any discussion or reconciliation of its projections from the 2004 bed tower application.

In its most recent cost overrun application, RRMC projected 65,001 patient days in FY 2008. Based on its RRMC-South application, RRMC has provided the Agency with no information as to why its previously approved projections should be discarded (and in the alternative, if those projections and assumptions were not valid, why the Agency should assume that those in the RRMC-South application are). Based on an assumption that RRMC experiences no growth between its bed tower projected FY 2008 volume and CY 2011, when 50 beds will be transferred to RRMC-South during its first project year, the resulting occupancy at RRMC would be 103 percent.

Discrepancy between Projected RRMC Days

	2006	*2007***	*2008***
RRMC Bed Tower Days*	59,820	61,842	65,001
# of Beds Needed at 71.4% Target Occupancy	230	237	249
% Occupancy of 173 beds	94.7%	97.9%	102.9%

*Original RRMC Bed Tower for 2006 and Second RRMC Bed Tower cost overrun used for 2007 and 2008 because Second Bed RRMC Bed Tower does not include 2006 projections.
**2007 indicates FY 2007 for RRMC Bed Tower and CY 2007 for RRMC-South; 2008 indicates FY 2008 for RRMC Bed Tower and CY 2008 for RRMC-South

The RRMC-South application contradicts the previously approved applications and fails to demonstrate that RRMC will be able to serve the population presently served and that it was approved to serve in Rowan County. Therefore, RRMC-South is non-conforming with Criterion 3a.

In addition, RRMC-South's own projections call into question its ability to serve the patients it is currently serving with the relocation of 50 beds and other services. Pages 86 and 87 of the application provide historical and intervening projections for RRMC; page 89 provides projected volume for RRMC for the first three years RRMC-South is operational. The chart below shows that RRMC is projected to experience a compound annual growth rate (CAGR) in patient days of 4 percent from CY 2006 through CY 2010; however, once RRMC-South opens, RRMC is projected to experience a less than 1 percent CAGR.

Year	RRMC Projected Days	Annual % Increase	CAGR
CY 06	37,693	NA	
CY 07	38,133	1.2%	
CY 08	39,798	4.4%	4.0%
CY 09	41,940	5.4%	
CY 10	44,109	5.2%	
CY 11	44,704	1.3%	
CY 12	45,010	0.7%	0.7%
CY 13	45,316	0.7%	

First, RRMC-South fails to demonstrate that its assumptions for growth between CY 2006 and CY 2010 are based on reasonable assumptions, especially since its inpatient volume has declined at a compound rate of 2.6 percent per year since 2003.

Year	RRMC Acute Days	Annual % Increase	CAGR
FY 03	39,907	NA	
FY 04	38,163	-4.4%	-2.6%
FY 05	36,396	-4.6%	
FY 06	36,819	1.2%	

Second, in the alternative and important under Criterion 3a, RRMC did not demonstrate why its projections of 4 percent compound annual growth through CY 2010 would not continue and that the relocation of 50 beds and other services would not have a negative impact on the patients it currently serves. If RRMC's volume were to continue to grow at the 4 percent rate through CY 2013, the facility would require more than the 173 beds it will have once RRMC-South is operational.

Year	RRMC Revised Projected Days	Annual % Increase	CAGR
CY 06	37,693	NA	
CY 07	38,133	1.2%	
CY 08	39,798	4.4%	4.0%
CY 09	41,940	5.4%	
CY 10	44,109	4.0%	
CY 11	45,877	4.0%	
CY 12	47,716	4.0%	4.0%
CY 13	47,312*	4.0%*	

*Increase of 4% applied to CY 12 volume, resulting in 49,628 days; subtracted 2,316 days shifted to RRMC-South per page 73 of the application.

CY 13 RRMC Revised Patient Days	47,312
CY 13 RRMC Revised ADC	130
CY 13 RRMC Beds Needed at 71.4% Occupancy	182

Thus, RRMC-South has not demonstrated that its projections for RRMC volume are based on reasonable assumptions, nor that the proposed relocation will not have a negative effect on the population it currently serves.

Similarly, RRMC-South has not demonstrated that the transfer of beds from RRMC to the new hospital will not negatively impact its intensive care patients. First, RRMC-South is inconsistent regarding the number of beds that will remain at RRMC. Page 6 of the application states that RRMC's intensive care beds will be reduced from 20 to 18. According to its hospital licensure renewal application, RRMC's 20 existing intensive care beds were operated at 69.8 percent occupancy in FY 2006. According to calculations based on pages 10 and 11 of Exhibit 6 to the application, RRMC's intensive care volume is projected to total 6,144 patient days in 2013 (based on the substantially lower annual growth rate discussed above). With only 18 beds, that would require RRMC to operate at 93.5 percent occupancy in 2013, while the four RRMC-South beds operate at 61.9 percent occupancy. Thus, RRMC failed to demonstrate that it would be able to serve its existing patient population effectively with the transfer of beds to RRMC-South.

In addition to acute and intensive care beds, RRMC-South failed to demonstrate that its development of a nursery at the new hospital would not have a negative impact on existing patients. RRMC-South proposes to provide obstetrical services, thus presumably it proposes to provide neonatal services as defined in 10A NCAC 14C .1401(4) and (11). Its drawings in Exhibit 16 of the application show a nursery; thus, RRMC-South is proposing to develop a new neonatal service. However RRMC-South failed to provide any information regarding the type of neonatal services it would provide, how many bassinets and/or licensed beds it would require to provide these services, and whether or not those bassinets would be transferred from its existing facility. In the event it is relocating bassinets from the existing facility, it failed to demonstrate that the relocation would not negatively impact its existing patient population.

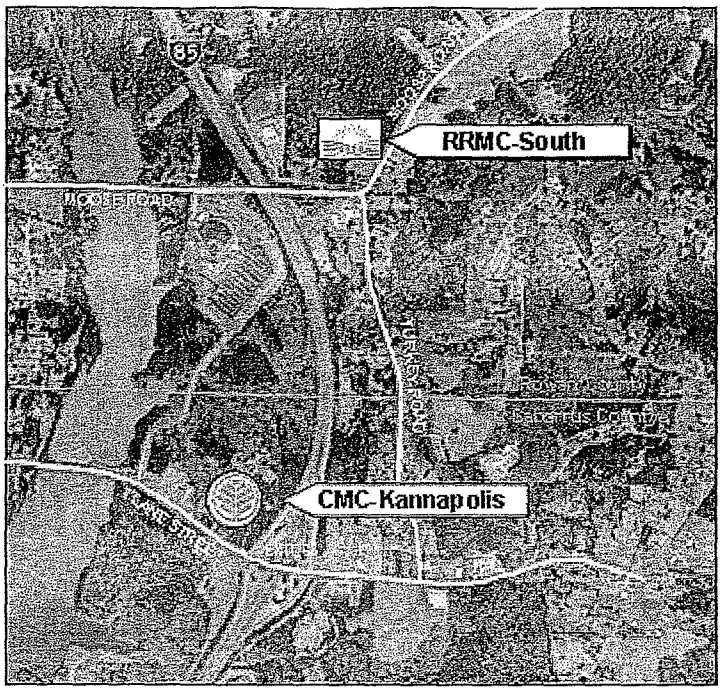
In its findings for the CMC-Lincoln replacement hospital (Project ID #F-7785-07) the Agency found, "However, the application proposes a reduction in post partum beds from 16 to 10, and a reduction in bassinets from 16 to 10. The applicants failed to provide information in response to this criterion for the reductions in beds proposed. Consequently, the application is nonconforming with this criterion." Likewise, the Agency should find RRMC-South nonconforming with Criterion 3a for its failure to demonstrate that reducing its total bed capacity, its intensive care bed capacity, and potentially reducing its nursery capacity, would not have a negative impact on the patients it currently serves.

(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.*

RRMC-South fails to demonstrate that the least costly or most effective alternative has been proposed.

- As discussed under Criterion 18a, RRMC-South is not proposing the least costly alternative in terms of charges to patients and third party payors. All area hospitals, except for RRMC, have lower than charges than RRMC-South is projecting.
- As discussed under Criterion 3, RRMC-South is not proposing the most effective alternative to serve the patient population it claims is its mission—Rowan County. Rather, RRMC-South proposes to develop a facility to serve a majority of patients from Cabarrus County.
- As discussed under Criterion 3 and 6, RRMC-South is not proposing the most effective alternative to serve area residents. RRMC-South has not demonstrated that the proposed project is needed by the population of the service area, that sufficient capacity does not already exist to serve these patients in Salisbury and/or Concord, and that patients do not currently have adequate access to the proposed services.
- As discussed under Criterion 5, RRMC-South is not proposing the most effective alternative for improving the financial position of the larger RRMC. In fact, the development of the proposed project will reduce the financial profitability of the combined facilities.
- As discussed in numerous public forums by area residents and in contrast to its own statements, RRMC-South is not proposing the most effective location for the proposed project. On pages 23 and 46, RRMC-South argues that the proposed site for its hospital is "highly accessible" and "convenient to the I-85." These statements are misleading. While the proposed Moose Road site is adjacent to I-85 North, there is no exit ramp from the interstate in that area. As the map below shows, Moose Road travels over the interstate and thus does not have access.

In order to travel from I-85 northbound to the proposed site of RRMC-South, patients, emergency vehicles, physicians, and visitors would have to exit at Lane Street, the same exit as the proposed site for CMC-Kannapolis, turn on Turkey Road, and then turn on Moose Road. The accessibility of RRMC-South is further compromised by Turkey Road, which has two lanes and curves considerably between Lane Street and Moose Road, as shown in the map below. Clearly, Turkey Road was not built for large emergency vehicles speeding towards a hospital. Visitors traveling from northern destinations on I-85 southbound would take the same route because the nearest exit north of the proposed site is almost six miles away in China Grove.



As noted in many of the articles in Exhibit 1, area residents are not supportive of the proposed location for several reasons. Notably, residents from Landis and China Grove do not believe that the proposed location is situated to serve southern Rowan County. China Grove Mayor Don Bringle said, "If I have to get off at Exit 63, that's Kannapolis. That's not Southern Rowan."[10] The Salisbury Post reports that Landis Alderman Tony Hilton believes that it should be built at the corridor of Interstate 85 and U.S. 29 between China Grove and Landis. He believes the Moose Road site is an isolated area and would not serve the southern Rowan municipalities well.[11] Concern has also been expressed about the viability of the site for institutional services. According to the Independent Tribune, Kannapolis City Council members have questioned RRMC-South representatives about the proposed site, to which RRMC-South responded, "the site does not have utilities and Rowan Regional would not pay to have an interchange [with I-85] built on Moose Road."[12] An earlier report quoted Landis Mayor Mike Mahaley as saying, "We'd like for you to look at somewhere around Daugherty Road. Maybe then we could get an interchange there."[13]

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10 "Rowan Regional makes case for southern Rowan," *Salisbury Post*, October 31, 2007. Attached in Exhibit 1.

11 Ibid.

12 "Health care giants take message straight to Kannapolis residents," *Concord & Kannapolis Independent Tribune*, November 15, 2007. Attached in Exhibit 1.

13 "Landis officials like hospital, not site,"*Concord & Kannapolis Independent Tribune*, November 6, 2007. Attached in Exhibit 1.

(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.*

RRMC-South fails to demonstrate the immediate and long-term financial feasibility of the proposed project.

- RRMC-South proposes to acquire a 64-slice CT scanner for the proposed hospital. Although RRMC-South indicates that this acquisition will be the result of the replacement of an existing CT scanner in China Grove, RRMC-South failed to document that it had previously or simultaneously filed an exemption request with the CON Section. Furthermore, RRMC-South failed to provide sufficient information for the CON Section to conclude that it could acquire a 64-slice CT scanner, construct space, install, and make operational the equipment for less than $2 million.

  In its review of Alamance Regional Medical Center's diagnostic imaging project (Project ID #G-7316-05), the Agency found, "Exhibit 9 of the application identifies proposed costs and financing of the projects to be developed in the new 65,980 square foot building. The applicants indicate there will be a "medical office building" to be developed at a cost of $6,351,452, which they state is "non-reviewable." However, no information was provided in the application regarding this portion of the building. Additionally, the applicants did not provide sufficient information to demonstrate that an exemption has been obtained for costs in the amount of $6,351,452. Thus, the applicants did not demonstrate that all of these costs are properly excluded from the diagnostic and urgent care services project." Similarly, RRMC-South failed to demonstrate that it included all capital costs of the project and the availability of those funds.

- As discussed under Criterion 3, RRMC-South's proposal is heavily predicated on the shift of patients from Concord to Kannapolis, bypassing CMC-NorthEast for care. Without the volume of patients from Concord (which does not include all of the 58 percent of patients projected from other areas of Cabarrus County), the project would not be financially feasible. Based on projected volume, the proposed project will not be feasible until project year 3. As shown under the Criterion 3 discussion, without Concord volume, the project would not achieve target occupancy. Based on its utilization projections in Section IV, page 88, RRMC-South will be just below target occupancy in year one of the project, likely similar to the actual volume it might expect without Concord patients. However, according to the projected income statement for RRMC-South, the facility is expected to lose more than $6.7 million in year one, with inpatient utilization that is just below target occupancy. Thus, without the volume of Concord patients, the proposed project is not financially feasible.

- The financial feasibility is not based on reasonable charges because the outpatient and emergency department (ED) charge per visit is overstated. Per Exhibit 20, Table 26 (1 of 2), the FY 2006 RRMC outpatient and ED visits are shown in the table below, with % of total noted.

FY 2006 RRMC Outpatient and ED Visits

	Visits	*%*
Outpatient	138,699	75.2%
ED	45,619	24.8%
Total	184,318	100.0%

Outpatient gross revenues (which includes ED revenue) for the same period, FY 2006, were $208,139,904 per the Schedules of Net Patient Service Revenue on Page 48 of the RRMC Audited Financial Statements. The calculated blended charge per blended Outpatient and ED Charge Per Visit is as follows for FY 2006:

	FY 2006
Outpatient Gross Revenue	$ 208,139,904
Outpatient and ED Visits	184,318
Blended Charge per Visit	$ 1,129

However, RRMC's blended 2013 outpatient and ED Charge per Visit is $2,678.68, more than double the FY 2006 rate, despite the same blend of outpatient and ED visits, as noted in the table below. A $2,678.68 blended rate in 2013 would require a 13.1 percent *annual* rate increase from FY 2006 to CY 2013. A more reasonable 4.5 percent annual rate increase, the assumption the applicant makes during the projection period, results in a blended rate of only $1,536, as noted in the second table below.

RRMC Projected 2013 per Form B-1a

	Visits	*% of Total Visits (Calculated)*	*Charge per Visit*	*Gross Revenue*
Outpatient	167,123	75.2%	$ 3,029.43	$ 506,288,151
ED	54,968	24.8%	$ 1,612.27	$ 88,623,283
Total (Calculated)	**222,091**	**100.0%**	**$ 2,678.68**	**$ 594,911,434**

	RRMC	*RRMC-South*
FY 2006 Blended Rate Inflated @ 4.5%	$ 1,536	$ 1,536
Blended Rate from Proforma	$ 2,679	$ 2,592
Difference/Overstated Blended Outpatient and ED Charge Per Visit	**$ 1,143**	**$ 1,056**

The overstated outpatient and ED charge assumed by the applicant significantly overstates gross and net revenues for both RRMC and RRMC-South as noted in the table below. For purposes of the net revenue calculation, the percentage revenue deductions per the proformas were assumed.[14] If the proformas were adjusted to reflect reasonable outpatient and ED charges and net revenues, the project would not be financially feasible, as noted in the table below.

	RRMC	*RRMC-South*
2013 Overstated Charge	$1,143	$1,056
2013 Outpatient and ED Visits	222,091	52,711
Overstated Gross Revenue	$253,850,013	$55,662,816
Revenue Deduction % Per Proforma	62.8%	63.6%
Overstated Net Revenue	$94,432,205	$20,261,265

The overstated outpatient revenues are also evident upon review of the historical outpatient revenue compared to the projected volume for RRMC in the projected proformas as recapped in the table below. The applicant assumes a 158.2 percent growth rate over the five year period between FY 2006 and 2013, representing a CAGR of over 20 percent. The increase is even more significant in the RRMC proformas assuming RRMC-South is not developed. The financial proforma assumptions are unreasonable as a result of the foregoing.

14 RRMC-South proforma assumptions state that bad debt and charity care were based on the experience at RRMC and the other contractual percentages were based on the trend of contractual adjustments at RRMC in the service area during the last four years.

Gross Outpatient and ED Revenue

	Per Audited Financials		*Per Application Proformas*		
	FY 2005	*FY 2006*	*2011*	*2012*	*2013*
RRMC – Salisbury (assuming RRMC-S is developed)					
Outpatient Revenue (per Proforma B-1a)			457,358,578	481,210,309	506,288,151
ED Revenue (per Proforma B-1a)			80,058,398	84,233,527	88,623,283
Total RRMC - Salisbury	193,261,295	208,139,904	537,416,976	565,443,836	594,911,434
% Increase		7.7%	158.2%	5.2%	5.2%
CAGR (2006 - 2011)			**20.9%**		
RRMC – Salisbury (assuming RRMC-S is not developed)					
Outpatient Revenue (per Proforma B-1a)			473,679,069	502,087,800	532,163,984
ED Revenue (per Proforma B-1a)			82,915,221	87,888,032	93,152,721
Total RRMC - Salisbury	193,261,295	208,139,904	556,594,290	589,975,832	625,316,705
% Increase		7.7%	167.4%	6.0%	6.0%
CAGR (2006 - 2011)			**21.7%**		

- As discussed under Criterion 7, RRMC-South has failed to include all the FTEs and related salary costs that it proposes in the application. Therefore, it has not demonstrated that the financial feasibility of the project is based upon reasonable costs.
- On page 32 of the application, RRMC-South states, "The development of RRMC-South will improve the overall financial condition of RRMC and will better enable it to perform its charitable mission." However, the financial statements included in the application indicate otherwise. RRMC-South is projected to have an operating margin of 3.40 percent in 2013 (including Concord volume); RRMC is projected to have an operating margin of 3.36 in 2013; and combined, the facilities are expected to have an operating margin of 3.37 percent. However, the projected income statement for RRMC, assuming RRMC-South is not built, indicates an expected operating margin of 3.65 percent in 2013, higher than the operating margin with RRMC-South. Thus, RRMC-South actually will have a negative impact on the financial condition of RRMC, as measured by profitability.

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

RRMC-South fails to demonstrate that the proposed project will not result in unnecessary duplication of existing health service capabilities and facilities.

- Please see discussion under Criterion 1 regarding RRMC-South's inconsistency with Policy AC-5 of the 2007 SMFP, which demonstrates the unnecessary duplication of existing facilities that would result from this project.
- Please see discussion under Criterion 3 regarding RRMC-South's failure to demonstrate need for the proposed project, thereby resulting in unnecessary duplication of existing facilities that would result from this project.
- Please see discussion under Criterion 18a regarding RRMC-South's failure to demonstrate that the project would enhance competition by improving cost-effectiveness, quality, and/or access to services, thereby resulting in unnecessary duplication of existing facilities that would result from this project.
- The applicant's argument that RRMC-South will not adversely impact the utilization of RRMC relies almost exclusively on the assumption that RRMC (Exhibit 20 Table 26 (1 of 2)) will achieve a significant increase in market share during the forecast period, which will offset the shift of patients to RRMC-South. Specifically, this increase in market share equates to 1,868 additional discharges and 8,219 additional patient days, or **an average daily census of 23** in 2012. The applicant's argument that this will be achieved by leveraging existing Novant practices and recruiting additional physicians to existing Novant practices is unreasonable. In fact, Exhibit 8 of the application includes the applicant's list of the 19 Novant physicians currently located in Salisbury, all but four of whom are ***already on staff at RRMC***. It is therefore unreasonable to assume that such a radical increase in discharges is achievable from physicians who are already on staff at RRMC. No data are provided to indicate that additional physicians are needed and it is unclear from what hospital(s) these patients will be redirected, and how these facilities will be impacted.

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

RRMC-South fails to show evidence of the availability of health manpower and management personnel for the provision of services proposed to be provided.

- Page 94 of the application states, "[RRMC-South] will have on-site managers and supervisors for clinical and support departments as follows...Lead Environmental Services; Food and Nutrition; Laboratory...Each of these management and supervisory positions will be linked into their counterpart management structures and departments at RRMC for coordination, consistency, and efficiency." Page 124 of the application (assumptions for staffing chart) states, "12. Staffing for Lab ... are based on comparisons to staffing patterns at Novant's Presbyterian Hospital Huntersville." However, on its staffing chart on pages 119 to 123 of the application, RRMC-South fails

to include any FTEs for on-site managers, supervisors, or any staff for Environmental Services, Food and Nutrition and Laboratory Services.

According to 10A NCAC 13B .3201, a hospital is required to have, "diagnostic and treatment areas to include on-site laboratory and imaging facilities with the capacity to provide immediate response to patient emergencies...nutrition and dietetic services."

According to 10A NCAC 13B .4702(a) and (b), a hospital's nutrition and dietary services "shall be under the full-time direction of a person who is trained or experienced in food services administration or therapeutic diets...The nutrition and dietetic services of the facility shall have at least one dietitian either full-time, part-time, or as consultant."

According to 10A NCAC 13B .4903(2) and (3), a hospital must ensure that "at least one qualified medical technologist is available at all times; and, qualified staff are available to carry out the functions of the laboratory."

According to 10A NCAC 13B .5104, a hospital is required to have, "24-hour a day availability of personnel or supplies and equipment for the cleaning of patient rooms, patient care equipment, and the cleaning of spills."

RRMC-South has failed to demonstrate that is has the necessary manpower to carry out these clinical and support functions required to provide the services it proposes to provide.

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

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

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

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

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

In its application, RRMC-South proposes to provide less care classified as bad debt than RRMC has historically.

	Bad Debt as a Percent of Gross Revenue
RRMC FFY 2006	7.2%
RRMC-South Project Year 1 and 2	6.0%

Source: RRMC-South application, page 107.

RRMC-South provides no explanation for this decrease in bad debt.

In RRMC-South's application, the hospital projects an inpatient payor mix including over 69 percent Medicare/Medicaid patients. These projections, however, are cast into doubt by the past experience of RRMC-South co-applicant, Novant Health at its Presbyterian Huntersville Hospital, which is offered throughout the application as the model for RRMC-South. In the Presbyterian Huntersville CON application, Novant projected a high mix of medically underserved patients and has failed to provide for those patients now that the hospital is in operation, as shown in the table below.

Presbyterian Huntersville Payor Mix: Projected vs. Actual

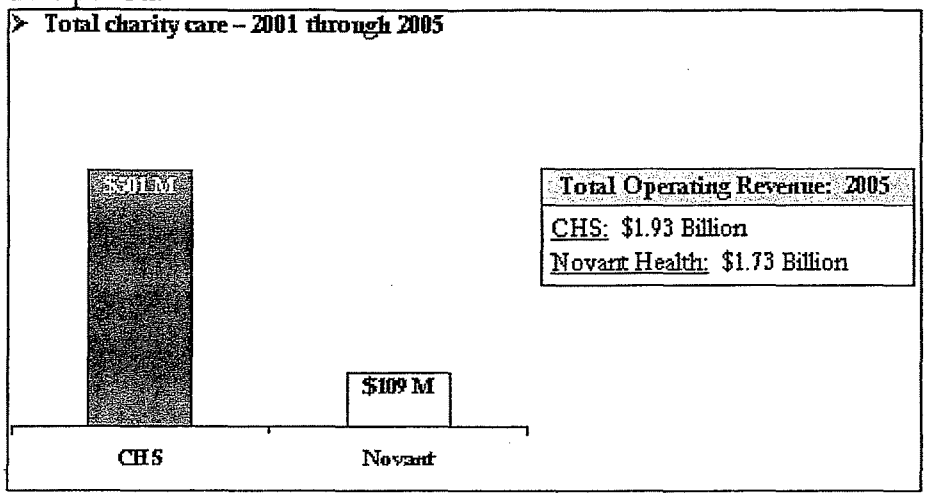
	Proj. FY07	*Actual CY06*	*Actual Q1 2007*
Medicare/Medicaid	52.5%	43.1%	40.9%
Commercial Insurance	43.3%	47.0%	50.2%

Source: Presbyterian Huntersville 2001 CON application F-6495-01; Thomson Solucient.

In contrast, Presbyterian Huntersville has served greater numbers of Commercial patients than projected.

The actual experience of Presbyterian Huntersville is consistent with the record of its parent system, Novant Health. Though both organizations have similar operating revenue—CHS a total of $1.93 billion in 2005 and Novant a total of $1.73 billion—the charity care provisions according to audited financial statements are dramatically different. From 2001

through 2005, CHS provided more than $501 million in charity care, while Novant provided only $109 million in charity care for the same time period.



Source: Audited financial statements.

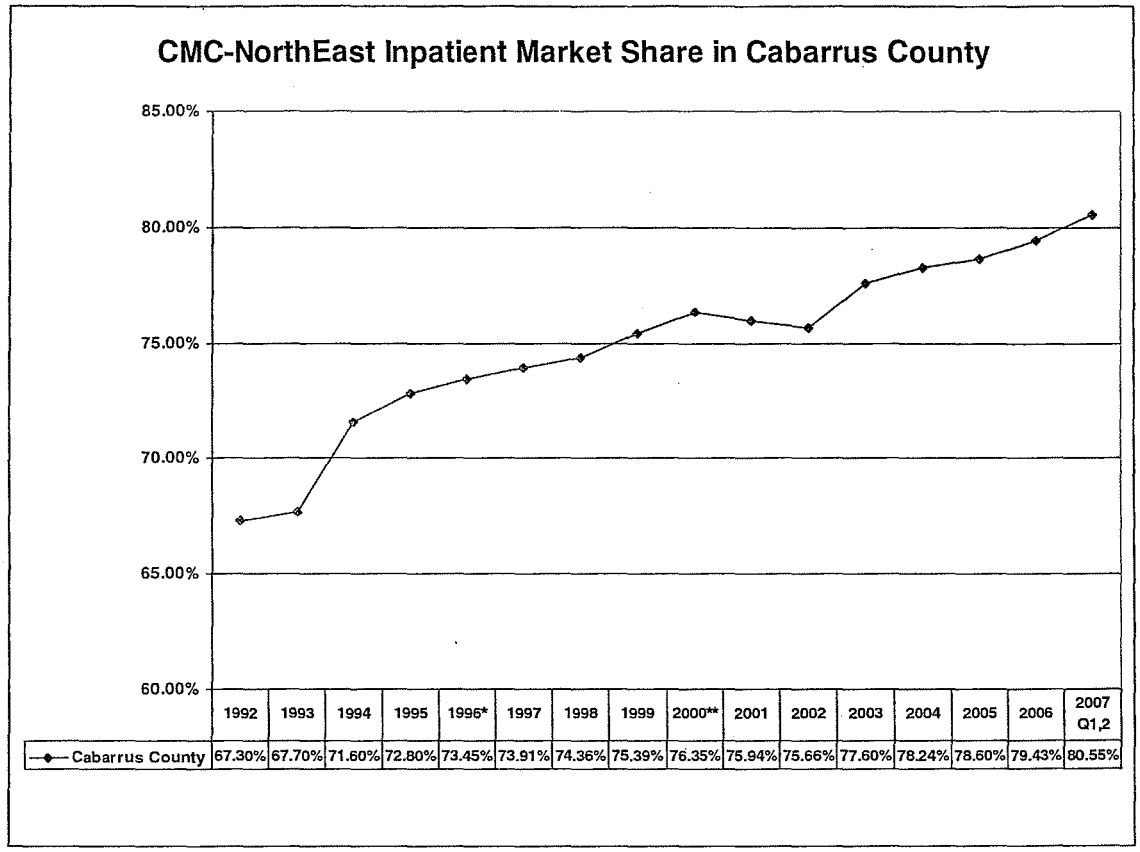
Thus, although RRMC-South's application projects a payor mix that is somewhat similar to RRMC's past experience, the merger of RRMC into Novant Health suggests that its historical mission to serve the medically underserved may be compromised.

(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.*

RRMC-South will not add competition. Competition already exists in the area. CMC-NorthEast does not have a geographic advantage that creates a near monopoly.

In its primary argument for its proposed hospital, RRMC-South contends that CMC-NorthEast has a monopoly in the Concord/Kannapolis area solely owing to its geographic location and that this monopoly needs to be broken by the proposed hospital in order to offer choice to patients and insurers. There is simply no basis in fact for RRMC's assertion that geography is the reason for CMC-NorthEast's success in the proposed service area. CMC-NorthEast has steadily built its share in the Concord/Kannapolis area by offering high clinical quality, a wide breadth of services, and exceptionally satisfying patient experiences.

In the period from 1992 to 2006, CMC-NorthEast's market share in Cabarrus County has grown by over 12 basis points with steady increases nearly every year, as demonstrated in the graph below.



	1992	1993	1994	1995	1996*	1997	1998	1999	2000**	2001	2002	2003	2004	2005	2006	2007 Q1,2
Cabarrus County	67.30%	67.70%	71.60%	72.80%	73.45%	73.91%	74.36%	75.39%	76.35%	75.94%	75.66%	77.60%	78.24%	78.60%	79.43%	80.55%

Source: Solucient Ad Hoc (1996 to 2000); Solucient Polaris (2000 to present)

These data confirm that geography is not a factor in CMC-NorthEast's performance. Its location was the same in 1992, when it had less than 70 percent market share, as it is today, when it has approximately 80 percent market share of Cabarrus County.

Patients have chosen CMC-NorthEast in increasing numbers, not because of geography, but because of numerous service and quality factors, including:

- From 1992 to 2007, CMC-NorthEast staff grew from 1,326 to 3,367.
- From 1992 to 2007, CMC-NorthEast medical staff grew from 108 to 350.
- CMC-NorthEast is currently ranked #1 in North Carolina for cardiac services.
- Since 1992, CMC-NorthEast has added the following clinical services: endocrinology, hematology/oncology, infectious Disease, nephrology, reproductive endocrinology, rheumatology, bariatric Surgery, neurosurgery, surgical oncology, podiatry, reconstructive surgery, neonatology, pediatric dermatology, pediatric endocrinology, pediatric neurology, pediatric

surgery, pediatric urology, perinatology, psychiatry, critical care, and sports medicine.

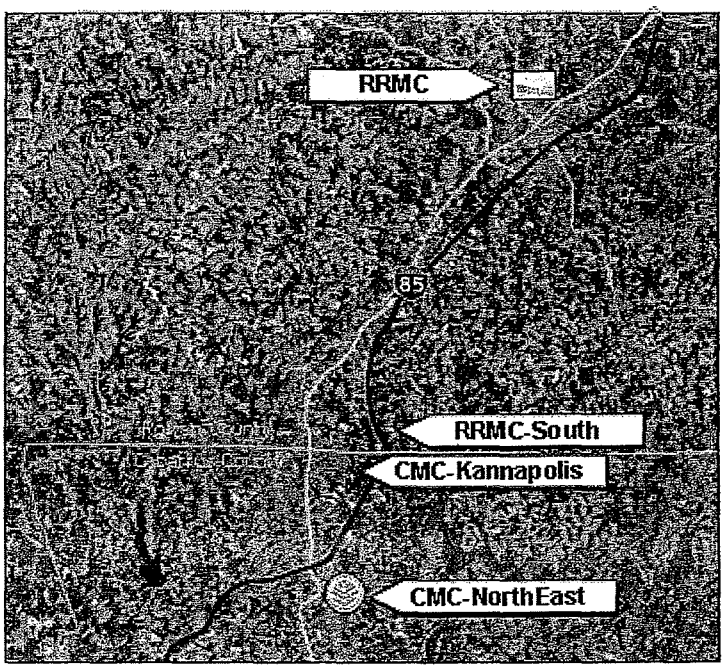
CMC-NorthEast's offerings have been recognized outside of its home county as well. The table below demonstrates CMC-NorthEast's success in serving Rowan County residents, the home of RRMC. RRMC, like CMC-NorthEast, is a sole county provider in a moderately sized county.

Market Share in Rowan County

	2002	2003	2004	2005	2006
CMC-NorthEast	16.4%	16.8%	18.3%	20.1%	22.0%
RRMC	61.9%	61.6%	58.8%	56.6%	55.7%

Source: Thomson Solucient.

Since 2002, CMC-NorthEast has experienced a steady increase in the adjacent Rowan County ***where it is geographically disadvantaged compared to RRMC.*** CMC-NorthEast and RRMC are 18 miles apart.



Perhaps the greatest demonstration of CMC-NorthEast's success is its ability to compete in Salisbury, the location of RRMC. In 2006 (the most recent full-year of data available), RRMC had a 67 percent share of acute discharges from Salisbury zip codes, while CMC-NorthEast had a 14 percent share. Please see the table below for market share trends from 2002 to 2006.

Market Share in Salisbury Zip Codes (28144, 28145, 28146, and 28147)

	2002	2003	2004	2005	2006
CMC-NorthEast	9.8%	9.9%	10.6%	12.9%	14.0%
RRMC	72.7%	72.3%	70.1%	67.6%	67.2%

Note: CMC-NorthEast has increased its market share in each of the Salisbury zip codes.
Source: Thomson Solucient.

Thus, CMC-NorthEast because of its service and capabilities has been able to increase its market share in an area that is 18 miles from its campus. At the same time, RRMC has not been able to achieve any market share gains in Kannapolis, where patients would be able to travel fewer miles to RRMC than those Salisbury patients who are choosing to travel to Concord for care at CMC-NorthEast.

Market Share in Kannapolis Zip Codes (28081, 28082, and 28083)

	2002	2003	2004	2005	2006
CMC-NorthEast	82.5%	82.7%	84.3%	85.6%	85.4%
RRMC	4.7%	4.5%	4.2%	3.6%	3.9%

Note: RRMC has lost market share in each of the Kannapolis zip codes.
Source: Thomson Solucient.

As these market share data demonstrate, CMC-NorthEast has been able to successfully compete in the Salisbury area while RRMC has been less successful in the Kannapolis area. The above comparison is revealing because it removes any geographic advantages; patients can just as easily drive from their homes in Salisbury to Concord as they can drive from Concord to Salisbury. Yet, CMC-NorthEast has proven to be a destination of choice for patients in both areas. CMC-NorthEast's success is not the result of a geographic monopoly, but rather the result of high-quality, compassionate care.

CMC-NorthEast does not have a monopoly in Cabarrus County or Kannapolis. Patients in Salisbury and Kannapolis have a choice in where to seek their care and the discussion above shows that patients have historically exercised that choice. The proposed RRMC-South project will not introduce competition to the service area because competition already exists. RRMC-South simply does not like the results of existing competition in the service area and is seeking to unnecessarily duplicate services as a way of trying to reverse the effects of competition on its facility in Salisbury. Therefore, RRMC-South does not adequately demonstrate that the proposed project will result in enhanced competition and should be found non-conforming with Criterion 18a.

RRMC-South will not add competition with a positive impact on the cost effectiveness, quality and access to services proposed. The approval of the

RRMC-South application will result in unnecessary duplication in this service area and across the state.

In its application, RRMC-South argues that the proposed service area needs a second hospital in order to create competition in the service area because there is only one acute care hospital within a 10 mile radius. If this rationale is accepted and applied across North Carolina, 22 additional hospitals are needed. The proposed service area (excluding the Concord zip codes of 28025 and 28027) has a population of 72,697 in CY 2007 according to the application. There are 36 counties in North Carolina with populations greater than 72,967, and of those, 22 would need an additional hospital because the existing sole county acute inpatient care provider is 10 miles or more from its nearest competitor.

Additional Hospitals Needed under RRMC-South Rationale

County	*2007 Pop.*	*Hospital*	*Nearest Hospital*	*Distance between Hospitals*	*Hospitals Needed*
Lincoln	73,107	CMC - Lincoln	Gaston Mem.	14.54	1
Wilson	78,224	Wilson Med. Ctr.	Nash General	18.26	1
Caldwell	79,940	Caldwell Memorial	Valdese General	12.06	1
Moore	83,933	FirstHealth Moore Reg.	FirstHealth Richmond	25.17	1
Nash	93,088	Nash General	Wilson Med. Ctr.	18.26	1
Craven	96,872	Craven Reg. Med. Ctr.	Beaufort County	30.3	1
Harnett	105,892	Betsy Johnson Reg	Johnston Memorial	21.72	1
Wayne	115,100	Wayne Memorial	Johnston Memorial	22.38	1
Orange	125,046	UNC Hospitals	Duke Hospital	11.90	1
Robeson	130,474	Southeastern Reg.	Bladen County	24.25	1
Rowan	135,931	Rowan Reg. Med. Ctr	Lexington Memorial	13.20	1
Randolph	140,134	Randolph Hospital	Thomasville Med. Ctr.	20.04	1
Alamance	141,466	Alamance Reg. Med. Ctr.	Moses Cone Memorial	15.82	1
Pitt	149,397	Pitt County Mem.	Beaufort County	22.06	1
Johnston	156,887	Johnston Memorial	Betsy Johnson Hosp.	21.72	1
Onslow	163,688	Onslow Memorial	Craven Reg. Med. Ctr.	30.56	1
Cabarrus	163,804	CMC-NorthEast	CMC-University	12.39	1
Union	182,304	CMC - Union	Presbyterian Matthews	14.47	1
New Hanover	188,026	New Hanover Reg. Med. Ctr.	J. Arthur Dosher	21.26	1
Gaston	200,415	Gaston Memorial	Cleveland Reg. Med. Ctr.	11.04	1
Buncombe	226,175	Mission Hospitals	Park Ridge	10.01	1
Cumberland	308,255	Cape Fear Valley Med. Ctr.	Southeastern Reg. Med. Ctr.	30.50	1
Total Hospitals Needed					**22**

Source: Office of State Budget and Management 2007 county populations; *Proposed 2008 State Medical Facilities Plan*; BusinessMAP software for driving distances.

Note: 14 counties had populations greater than 72,697 people, but had more than one hospital within the county: Brunswick, Burke, Catawba, Cleveland, Davidson, Durham, Forsyth, Guilford, Henderson, Iredell, Mecklenburg, Rockingham, Surry, and Wake.

A further examination of the counties where new hospitals would be needed under this rationale shows that seven of the 22 other hospitals have a higher share in their service area than CMC-NorthEast, with service areas defined by the zip codes representing 80 percent of total hospital discharges.

Sole County Provider Service Area Share Ranking

Rank	*Hospital*	*Discharges*	*Service Area Share*
1	Cape Fear Valley Med. Ctr.	22,197	77.5%
2	Southeastern Reg Med Ctr	10,742	69.7%
3	Nash General	10,140	68.2%
4	Wayne Memorial	10,176	67.0%
5	Gaston Memorial	16,929	65.9%
6	Onslow Memorial	6,411	65.3%
7	New Hanover Reg. Med.Ctr.	24,897	63.5%
8	CMC-NorthEast	17,188	63.1%
9	Wilson Memorial	7,040	61.2%
10	Randolph Hospital	5,152	59.0%
11	Alamance Reg. Med. Ctr.	7,944	57.0%
12	Craven Reg. Med. Ctr.	11,810	54.1%
13	Caldwell Memorial	3,711	52.0%
14	Mission Hospitals	28,734	51.6%
15	Johnston Memorial	7,032	49.5%
16	Rowan Reg. Med. Ctr.	6,977	49.0%
17	Betsy Johnson Reg.	5,474	43.8%
18	CMC-Union	7,034	43.4%
19	First Health Moore Reg.	14,166	39.9%
20	CMC-Lincoln	2,977	30.0%
21	Pitt County Mem.	25,584	25.2%
22	UNC Hospitals	24,985	7.9%

Note: Excludes behavioral health and rehabilitation discharges.
Source: Thomson Solucient 2006 data

As this table shows, service area share differs considerably among these facilities, certainly due to the differences in the level/breadth of service, size of service area, and size of medical staff. For example, several are tertiary care facilities while others are smaller, community-based hospitals. The table, however, provides demonstrative evidence that CMC-NorthEast does not have a

monopoly in the service area. Nearly 40 percent of patients in CMC-NorthEast's service area access care elsewhere.

CMC-NorthEast does not believe that competition is lacking among hospitals in North Carolina. Nor, as stated previously, does CMC-NorthEast believe that competition is lacking in the Cabarrus-Rowan/Concord-Kannapolis area. Rather, its dedication to quality service and clinical care has resulted in patients making the choice to seek care at CMC-NorthEast.

Of note is RRMC-South's statement on page xi, "The CMC project is the proverbial camel's nose in the tent. Its intent is to preempt the development of healthcare facilities in SW Rowan County by RRMC or other providers, and to lay the groundwork for a future inpatient facility. The proposed ED is so close to [CMC-NorthEast] that there is no improvement in geographic access to [CMC-NorthEast] services." As demonstrated previously, competition already exists within the proposed service area. Thus, by its own statements, the RRMC-South facility (given its virtually immediate proximity to the proposed CMC-Kannapolis site) does not improve geographic access to hospital services for residents in the service area. Furthermore, it is apparent that RRMC-South is projecting its own intent onto CMC-NorthEast. CMC-NorthEast is proposing a freestanding emergency department in Kannapolis, an area that it currently (and historically) serves. As shown above, based on service and clinical quality ***not*** geography, CMC-NorthEast has been successful in serving Rowan County patients. In contrast, RRMC has not been as successful in serving Rowan County. As a result, it proposes a hospital facility that is located on the Cabarrus County border, projects to serve patients that it is not currently (nor historically) serving, and projects that approximately 58 percent of its defined service area patients will reside in Cabarrus, not Rowan, County.

RRMC-South will not enhance competition with a positive impact on cost effectiveness. RRMC-South proposes higher charges than the very facility it suggests has a monopoly and needs competition.

Throughout its application, and specifically on page vii, RRMC-South contends that its proposed project will "promote lower costs by giving patients and payors the ability to choose between hospitals." However, RRMC-South, RRMC, and Presbyterian Huntersville all have higher than, or comparable charges to, CMC-NorthEast as demonstrated below. Therefore, contrary to its assertions, RRMC-South will not reduce costs in the service area, but will in fact, increase costs by unnecessarily duplicating management and support staff, as well as existing facilities, which are projected to result in higher, not lower, charges for area patients.

In Section X.2.(a).1, RRMC-South reports its projected average charge per inpatient day. RRMC-South's average charge per inpatient discharge can be calculated by multiplying by the projected average length of stay, as shown below.

RRMC-South Projected Average Inpatient Charges

	Charge per Inpatient Day	*ALOS*	*Charge per Discharge*	*CMI**	*Adj. Charge per Discharge*
Project Year 1	$ 4,169	4.1	$ 17,093	0.97	$ 17,545
Project Year 2	$ 4,357	4.1	$ 17,864	0.97	$ 18,335
Project Year 3	$ 4,553	4.1	$ 18,667	0.97	$ 19,157

*RRMC-South CMI assumed to be equal to Presbyterian Huntersville 2006 CMI, as found in Thomson Solucient. See Exhibit 8.
Source: RRMC-South application, Section X.2.(a).1

In order to provide a reasonable comparison, RRMC-South's charges are also adjusted according to its case mix index. RRMC-South's case mix index is assumed to be the same as Presbyterian Huntersville, which is reasonable given the statements in the RRMC-South application about the similarity of services at the two hospitals. The table above shows these calculations.

When RRMC-South's adjusted charges are compared to other hospitals, it is apparent that it will not improve cost-effectiveness. The CY 2006 adjusted charges for each hospital, as provided by Thomson Solucient, were projected forward to CY 2011, RRMC-South's first project year, using a 4.5 percent inflation rate as assumed in the RRMC-South application. The first project year was chosen for comparison because RRMC-South's charges increase at 4.5 percent each year as well, and thus, each project year would show the same comparative results.

CY 2011 Adjusted Charge Comparison

	Adjusted Charge per Discharge
RRMC	$ 18,148
RRMC-South (from above table)	$ 17,545
CMC-NorthEast	$ 15,644
Presbyterian Huntersville	$ 15,552
CMC-University	$ 15,278

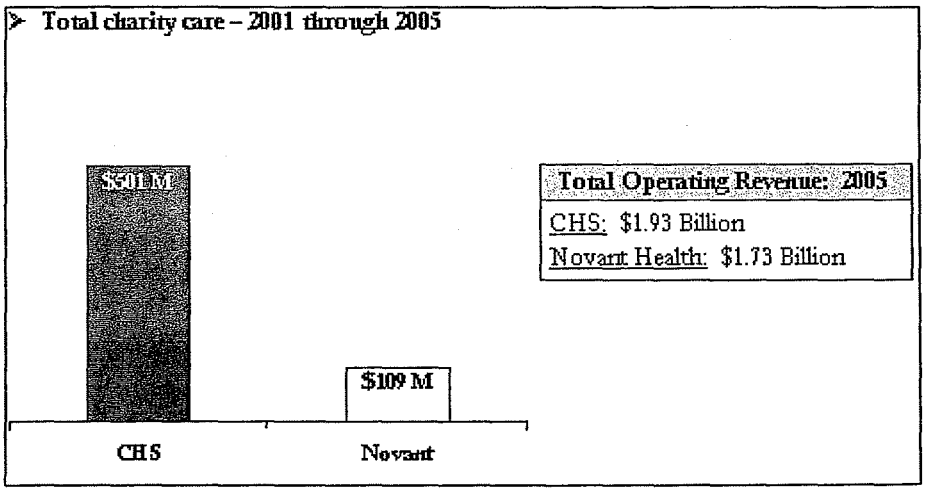
Source: Thomson Solucient. See Exhibit 8.

As the table above demonstrates, RRMC-South is projecting charges 12 percent higher than CMC-NorthEast and higher than Presbyterian Huntersville and CMC-University as well. The only hospital that RRMC-South will offer competition on charges will be its parent hospital, RRMC.

RRMC-South will not enhance competition with a positive impact on economic access. RRMC-South's ultimate parent company, Novant Health,

has a poor track record of service to the underserved, when compared to CMC-NorthEast's parent company, CHS.

As discussed under Criterion 13, RRMC-South's application proposes to provide less care classified as bad debt than RRMC has historically. This fact is important, particularly in light of the poor record of its parent system, Novant Health. Though both organizations have similar operating revenue—CHS a total of $1.93 billion in 2005 and Novant a total of $1.73 billion—the charity care provisions according to audited financial statements are dramatically different. From 2001 through 2005, CHS provided more than $501 million in charity care, while Novant provided only $109 million in charity care for the same time period.



Source: Audited financial statements.

RRMC-South will not enhance competition with a positive impact on access to services or quality. RRMC-South proposes fewer services than readily available in the service area.

RRMC-South's argument that it will provide competition in the service area is undermined by the limited amount services it will be able to offer. CMC-NorthEast currently provides a large breadth and depth of services. By comparison, Presbyterian Huntersville, which RRMC-South frequently refers to as an analog hospital with regard to services offered, offers a limited amount of services.

According to Thomson Solucient data (see attached Exhibit 10), CMC-NorthEast provided inpatient services in 2006 that included 262 DRGS ***not*** provided at Presbyterian Huntersville during the same year. These DRGs represent 44 percent of all 591 DRGs. This disparity in services provides further evidence that RRMC-South will not introduce competition into the service area. Therefore, RRMC-South should be found non-conforming under Criterion 18a.

10A NCAC 14C .1202(b)(3) and (4)

RRMC-South is nonconforming with 10A NCAC 14C .1202(b)(3) and (4), which require an applicant to project the number of intensive care patients and patient days by county of residence. In response to this criterion, RRMC-South projected the number of intensive care patients and patient days by zip code, not by county, with some zip codes splitting between two counties. As discussed previously, assuming RRMC-South's proposed discharges from Kannapolis mirror the Kannapolis population distribution between Rowan and Cabarrus Counties, then more than 50 percent of RRMC-South's patients reside in Cabarrus County, not the county RRMC-South professes that its mission is to serve. Therefore, RRMC-South is non-conforming with this criterion.

10A NCAC 14C .1400

RRMC-South is non-conforming with 10A NCAC 14C .1400. RRMC-South proposes to provide obstetrical services, thus presumably it proposes to provide neonatal services as defined in 10A NCAC 14C .1401(4) and (11). Its drawings in Exhibit 16 of the application show a nursery; thus, RRMC-South is proposing to develop a new neonatal service. However RRMC-South failed to provide any information regarding the type of neonatal services it would provide, how many bassinets and/or licensed beds it would require to provide these services, and whether or not those bassinets would be transferred from its existing facility. RRMC-South failed to respond to any of the required rules of 10A NCAC 14C .1400.

In its review of CMC-Mint Hill's hospital application (Project ID #F-7707-06), the Agency did review the applicant's proposed development of a new hospital (transfer of existing acute care beds) and related neonatal services against the rules of 10A NCAC 14C. 1400. In fact, the Agency found the application non-conforming with two rules: .1405(4) and (5) stating, "However, Exhibit I-11 does not contain copies of policies related to inservice training or continuing education programs. Rather, Exhibit I-11 contains documents showing that CHS has a staff competency evaluation program, which is not the same as an inservice training or a continuing education program.... However, the policy provided in Exhibit I-11 does not address teaching parents how to care for neonatal patients following discharge to home as required by this rule. Rather, Exhibit I-11 contains documents showing that CHS has a staff competency evaluation program." The Agency should therefore find RRMC-South's application non-conforming for failure to demonstrate that its project is conforming with 10A NCAC 14C .1400.

10A NCAC 14C .2300

RRMC-South is non-conforming with 10A NCAC 14C .2300. RRMC-South proposes to acquire a 64-slice CT scanner for the proposed hospital. Although RRMC-South indicates that this acquisition will be the result of the replacement of an existing CT scanner in China Grove, RRMC-South failed to document that it had previously or simultaneously filed an exemption request with the CON Section. Furthermore, RRMC-South failed to provide sufficient information for the CON Section to conclude that it

COMMENTS IN OPPOSITION FROM NOVANT HEALTH, INC.

Regarding Atrium Health's CON Applications Filed October 15, 2019

Attachment 2

ATTACHMENT - REQUIRED STATE AGENCY FINDINGS

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

DECISION DATE:	March 28, 2008
FINDINGS DATE:	April 4, 2008
PROJECT ANALYST:	Carol L. Hutchison
CHIEF:	Lee B. Hoffman

PROJECT I.D. NUMBER: F-7994-07/ Rowan Regional Medical Center (Lessee), Rowan Health Services Corporation, Novant Health Inc. (Lessor), and Rowan Regional Medical Center-South, LLC/ Relocate 50 existing licensed acute care beds from Rowan Regional Medical Center in Salisbury to establish a new separately licensed hospital in Kannapolis / Rowan County

REVIEW CRITERIA FOR NEW INSTITUTIONAL HEALTH SERVICES

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

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

NC

Rowan Regional Medical Center (RRMC) proposes to relocate 50 existing acute care beds to Kannapolis to establish a new separately licensed hospital. The proposal does not result in an increase in the total number of licensed beds, operating rooms or gastrointestinal endoscopy procedure rooms located in Rowan County. Further, the applicants do not propose to acquire any medical equipment or develop any health service facility beds or services for which there is a need determination in the 2007 State Medical Facilities Plan (2007 SMFP). Therefore, there are no need determinations in the 2007 SMFP that are applicable to this proposal.

However, because the applicants propose to construct new space to replace 50 existing acute care beds to be relocated from Salisbury to Kannapolis, Policy

AC-5 is applicable to this review. There are no other policies in the 2007 SMFP that are applicable to this review.

POLICY AC-5: REPLACEMENT OF ACUTE CARE BED CAPACITY states

> *"Proposals for either partial or total replacement of acute care beds (i.e., construction of new space for existing acute care beds) shall be evaluated against the utilization of the total number of acute care beds in the applicant's hospital in relation to the utilization targets found below. In determining utilization of acute care beds, only acute care bed 'days of care' shall be counted. Any hospital proposing replacement of acute care beds must clearly demonstrate the need for maintaining the acute care bed capacity proposed within the application.*

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

According to RRMC's 2008 Hospital License Renewal Application, during Fiscal Year (FY) 2007, the hospital provided 41,207 days of acute care which was an average daily census (ADC) of 112.9 patients (41,207 patient days of care / 365 days = 112.9). Thus, based on the current ADC, the target occupancy for the existing facility is 71.4%. However, RRMC is currently operating at only 50.6% of its licensed 223 acute care bed capacity.

In Section III.1(b), pages 42 and 50, and Exhibit 20, Table 13, the applicants provide projected utilization for the acute care beds to be located at the new facility, Rowan Regional Medical Center-South (RRMC-S) during the first three operating years of the proposed project, as illustrated in the following table.

	TOTAL # OF PROJECTED ACUTE CARE PATIENT DAYS		
	YEAR ONE (2011)	**YEAR TWO (2012)**	**YEAR THREE (2013)**
RRMC-S (50 acute care beds)	8,848	10,861	12,917
Average Daily Census (ADC) [(1)]	24.2	29.8	35.4
% Occupancy [(2)]	48.5%	59.5%	70.8%

Source: Section III.1(b), page 42, Section IV.1, page 88, and Exhibit 20, Table 15.
[(1)]ADC was calculated by dividing projected acute patient days by 365.
[(2)]Occupancy was calculated by dividing ADC by 50.

As shown in the above table, in the third operating year, the applicants project an ADC of 35.4 patients at RRMC-S, which is an occupancy rate of 70.8%. The target occupancy rate for a hospital with an ADC between 1 and 99 is 66.7%. See Section III.1(b), Section IV.1, page 88, and Exhibit 20, Tables 11-15, for the applicants' assumptions and methodology used to project utilization of the acute care beds at RRMC-S.

Additionally, in Section IV, page 89, the applicants provide projected utilization for the total number of acute care beds to be licensed at RRMC after the relocation of beds and services to the new hospital, as illustrated in the following table.

IMPACT ON RRMC WITH RRMC-S	TOTAL # OF PROJECTED ACUTE CARE PATIENT DAYS		
	YEAR ONE CY2011	YEAR TWO CY2012	YEAR THREE CY2013
RRMC (173 acute care beds)	44,704	45,010	45,316
Average Daily Census* - RRMC	122.5	123.3	124.2
% Occupancy** - RRMC	70.8	71.3	71.8

Source: Exhibit 20, Table 26 (2 of 2)
*ADC was calculated by dividing projected acute patient days by 365.
**Occupancy was calculated by dividing ADC by 173.

At the completion of the proposed project, RRMC would be licensed for 173 acute care beds. In Table 26 of the Impact Analysis in Exhibit 20, the applicants project a total of 45,316 acute patient days of care would be provided at RRMC during CY 2013 (Year Three), which is an ADC of 124.2 patients [45,316 / 365 = 124.2] and an occupancy rate of 71.8% (124.2 / 173 = 0.717). The target occupancy rate for a facility with an ADC between 100 and 200 is 71.4%.

However, projected utilization for the two facilities is overstated and is not based on reasonable and supported assumptions. See Criterion (3) for discussion. Therefore, the applicants did not adequately demonstrate that utilization of the licensed general acute care beds at either facility is reasonably projected to exceed target occupancy. Consequently, the applicants did not adequately demonstrate the need to construct new space to replace 50 existing general acute care beds. As a result, the application is not consistent with Policy AC-5 in the 2007 SMFP. Therefore, the application is nonconforming with this criterion.

(2) Repealed effective July 1, 1987.

(3) The applicant shall identify the population to be served by the proposed project, and shall demonstrate the need that this population has for the services proposed, and the

extent to which all residents of the area, and, in particular, low income persons, racial and ethnic minorities, women, handicapped persons, the elderly, and other underserved groups are likely to have access to the services proposed.

NC

Novant Health (Novant) and Rowan Regional Medical Center (RRMC) propose to relocate 50 existing acute care beds from RRMC in Salisbury to establish a new separately licensed hospital, Rowan Regional Medical Center-South (RRMC-S), in Kannapolis. Based on the applicants' representations in Section II.1, pages 17-20, the design schematics in Exhibit 16, and the list of equipment to be acquired provided in Exhibit 18, the applicants propose to offer the following services at RRMC-S:

- 42 general medical-surgical (med/surg) acute care beds to be relocated from RRMC,
- 4 general medical-surgical beds to be relocated from RRMC and converted to 4 intensive care unit (ICU) beds,
- 4 general medical-surgical acute care beds to be relocated from RRMC and converted to LDRP (Labor Delivery Postpartum Recovery) beds,
- 8 unlicensed observation beds [new],
- 3 shared operating rooms (ORs) to be relocated from RRMC,
- 1 dedicated C-Section operating room to be relocated from RRMC,
- 1 GI endoscopy procedure room to be relocated from RRMC,
- a 24 hour Emergency Room (ER), with 12 treatment bays [new],
- laboratory (lab) services, including phlebotomy, blood bank, pathology, chemistry, hematology coagulation, micro urinalysis and accessioning [new],
- pharmacy [new],
- 1 existing CT scanner at the South Rowan Medical Mall in China Grove to be replaced with a 64-slice CT scanner and relocated to the new hospital,
- 1 new combination x-ray/fluoroscopy unit,
- 2 new portable multi-use C-arms and one new portable mini C-arm for use in the ORs, ED and patient rooms,
- 1 new portable nuclear medicine camera,
- mobile MRI service [existing mobile unit],
- 1 new mammography unit, and
- 1 new portable ultrasound (US) unit.

However, it should be noted that the above statements regarding proposed imaging services are inconsistent with the applicants' description of services provided on page 71 of the application. Specifically, on page 71, the applicants propose two combination x-ray/fluoroscopy units and two portable ultrasound units, compared to only one unit each as stated on page 20 of the application.

Additionally, the following diagnostic equipment is listed in Exhibit 18 of the application, but the need for this equipment is not discussed by the applicants in Sections II or III of the application.

- 3 fixed US units
- 1 fixed gamma camera
- 1 fixed x-ray digital unit
- 1 fixed general digital X-ray unit
- 1 mobile mammography unit
- 3 mobile digital x-ray units

Also, in the schematic plan for the facility in Exhibit 18, the applicants include the following service components. However, the need for these components is not discussed by the applicants in Sections II or III of the application.

- 11 unlicensed bassinets
- 20 pre-op rooms in the surgery suite
- 9 recovery rooms in the surgery suite
- 1 rehab gym
- 1 hydro room

Population to be Served

The following table illustrates the historical patient origin for RRMC, as reported by the applicants in Section III.4(a), page 76 of the application.

RRMC Patient Origin
FY2006 Acute Care Admissions

COUNTY	ADMISSIONS	PERCENT OF CASES
Rowan County	8,268	86%
Davidson County	390	4%
Davie County	278	3%
Cabarrus County	266	3%
Other In-Migration	429	4%
Total	9,631	100%

Source: 2007 Hospital License Renewal Application

The following table illustrates the projected patient origin for RRMC-S in the third operating year, as reported by the applicants on page 80 of the application.

ZIP CODE	COUNTY	CITY	RRMC-S PROJECTED DISCHARGES YEAR THREE (2013)	PERCENTAGE OF TOTAL DISCHARGES
28023	Rowan	China Grove	377	12.0%
28025	Cabarrus	Concord	493	15.6%
28027	Cabarrus	Concord	309	9.8%
28081	Rowan/ Cabarrus	Kannapolis	679	21.5%
28083	Rowan/ Cabarrus	Kannapolis	574	18.2%
28088	Rowan	Landis	89	2.8%
28138	Rowan/Cabarrus*	Rockwell	315	10.0%
Inmigration			315	10.0%
Total			3,151	100.0%

*Cabarrus County added by project analyst because zip code 28138 crosses both Cabarrus and Rowan counties.

In Section III.5(a), pages 77-78, the applicants state

"The proposed facility has a service area consisting of seven zip codes: 28023, 28025, 28027, 28081, 28083, 28088 and 28138. The zip codes are the zip codes in which the proposed hospital is located and the surrounding zip codes.

Once the proposed location was determined, actual utilization of hospital inpatient services by residents of the service area was determined by reviewing Solucient data and calculating future need, based on market share and population growth of each zip code in the service area. The resulting projections resulted in the patient origin of the proposed facility." (See Exhibit 20)

The applicants adequately identified the population they propose to serve.

Analysis of Need for the Proposed Project

In Section III.1, pages 38-40, the applicants state that 50 acute care beds are needed in Kannapolis for the following reasons.

"Kannapolis is a growing community of nearly 40,000 people in southern Rowan and northern Cabarrus counties that does not have a community hospital. Residents travel to downtown Charlotte acute care facilities or to other community hospitals in Rowan and Cabarrus counties to receive hospital care, including emergency room services.

For the reasons stated below, this is no longer acceptable; the time has come for Kannapolis to have a community hospital.

…

For consumers in the Kannapolis-Concord area it will create competition in hospital services that will result in improved quality of care, increased patient satisfaction and reduced negotiate rates.

…

The approval and development of the proposed new hospital, RRMC-S, will reduce the geographic market share of CMCN and provide choice for physicians and patients. Since CMCN is part of the Charlotte based Carolinas Medical Center System and the proposed RRMC-S is part of RRMC which is being acquired by Novant, the approval of RRMC-S will provide the residents of the service area balanced access to both major hospital systems.

On page viii of the application, the applicants state

"RRMC has responsibility to provide hospital services for all the people of Rowan County. Salisbury is in the northern part of Rowan County which has not yet begun to experience rapid growth and will not for some years. The only way for a hospital to serve the entire county is to have facilities in the south and the north. It would be bad health planning to relocate the entire hospital and leave the north part of the county without a hospital.

Keeping all RRMC's beds in Salisbury would not permit it to effectively perform its mission for county residents. The growth is in the southern part of the county and RRMC is not well positioned geographically to serve that part of Rowan County. The population in the southwestern part of the county, around Kannapolis does not find Salisbury a convenient location to seek medical care. The physicians who serve this population are located in southern Rowan and adjacent areas in Cabarrus County and today practice at CMCN. Physicians cannot efficiently maintain active staff relationships with CMCN and RRMC because of the distance between them.

Because of geography, CMCN has developed near-monopoly market shares in the Kannapolis – Concord areas. Market shares in these zip codes for basic hospital services are in the 80-90% range. There are currently no other hospitals located close enough to CMCN to permit physicians to be on active staff at two hospitals. Practically speaking,

this deprives patients, their physicians and their health plans a choice of community hospital services."

On page 40, the applicants state

"The proposed Kannapolis service area consists of three zip codes in Rowan County, two zip codes in Cabarrus County. [*Note: For the purposes of this analysis, discharges from all post office zip codes or 'point zip codes' were included in their home zip code. Service area zip code totals include discharges from point zip codes within polgon boundaries. Zip Code 28025 includes 28026. Zip Code 28081 includes 2808]. These are the zip codes in which the hospital will be located and the surrounding zip codes. According to Claritas population data, the 2007 population of the zip codes in the Kannapolis service area was 167,496 persons and the population is projected to increase to 183,019 by 2013.*

…

The table below shows the projected patient days and occupancy rates for RRMC-S in the first three years of operation. Note that RRMC-S's projected occupancy rate will be well over the target occupancy rate required by Policy AC-5 – Replacement of Acute Care Capacity in the 2007 State Medical Facilities Plan. As Kannapolis continues to grow, its future acute health care needs can be met by the development and expansion of RRMC-S."

RRMC-S Projected Inpatient Utilization	***2011***	***2012***	***2013***
Inpatient Discharges	*2,158*	*2,649*	*3,151*
Days (Including ICU)	*8,848*	*10,861*	*12,917*
ALOS	*4.1*	*4.1*	*4.1*
ADC	*24.2*	*29.8*	*35.4*
Med-Surg and ICU Beds	*50*	*50*	*50*
Med-Surg Occupancy	*48.5%*	*59.5%*	*70.8%*
Acute Days (no ICU; no LDRP)	*7,495*	*9,210*	*10,965*
Acute Beds (no ICU; no LDRP)	*42*	*42*	*42*
Acute Care Occupancy	*48.9%*	*60.1%*	*71.5%*
LDRP Days	*733*	*891*	*1,049*
LDRP Beds	*4*	*4*	*4*
LDRP Occupancy	*50.2%*	*61.0%*	*71.8%*
Births	*219*	*387*	*456*
ICU Days	*619*	*760*	*904*
ICU Beds	*4*	*4*	*4*
ICU Occupancy	*42.4%*	*52.1%*	*61.9%*

Source: Section III, page 42 of application

The applicants claim the population of southern Rowan County needs a new 50 bed acute care hospital located on the border between southwestern Rowan County/northern Cabarrus County to best serve all Rowan County residents, and to remedy the dependence of Kannapolis/Concord residents on the hospital located closest to them, which is CMC-NorthEast. CMC-NorthEast is a licensed 447-bed acute care hospital, which is located about 7 miles from the applicants' proposed primary site for their new hospital. According to CMC-NorthEast's 2008 license renewal application (LRA), the hospital reports it is currently operating at approximately 61% of the capacity of its licensed acute care beds (99,425 acute care days / 365 = 272.4 ADC/ 447 = 0.609). However, based on a review of 2006 Solucient data for the hospital (92,686/365/447 = 56.8%), the current occupancy rate of the hospital may be lower than 61%, if 2007 Solucient data is analyzed. Regardless, CMC-NorthEast has existing underutilized capacity to serve the growing population in the proposed service area.

Although the applicants state their intent is to provide services to Rowan County residents whom RRMC cannot adequately serve due to their distance from RRMC, the new hospital's proposed service area will be predominately located in Cabarrus County. For example, approximately 58% of the projected population of the proposed service area resides in two zip codes that are exclusively located in Cabarrus County (28025 and 28027) and another 33% of the population lives in zip codes that span both Cabarrus County and Rowan County. In comparison, as few as 9% of the population resides in the two zip codes that are located exclusively in Rowan County (28088 and 28023). The following table shows population by zip code.

RRMC-S Service Area Population

Zip Code	*County*	*City/Town*	*FY 2007*	*FY 2012*	*% Population By Zip Code*
28023	*Rowan*	*China Grove*	*13,021*	*13,750*	*7.7%*
28025	*Cabarrus*	*Concord*	*41,264*	*49,895*	*27.9%*
28027	*Cabarrus*	*Concord*	*38,716*	*53,758*	*30.0%*
28081	*Rowan/Cabarrus*	*Kannapolis*	*23,039*	*24,818*	*13.9%*
28083	*Rowan/Cabarrus*	*Kannapolis*	*19,924*	*22,464*	*12.6%*
28088	*Rowan*	*Landis*	*2,910*	*2,878*	*1.6%*
28138	*Rowan/Cabarrus**	*Rockwell*	*9,735*	*11,409*	*6.4%*
Total			*148,609*	*178,972*	*100.0%*

Source: Claritas; Exhibit 20, Table 1; *project analyst added Cabarrus County

Zip Code Population Summary

Zip Code	County	City/Town	*% Population By Zip Code*
28023	Rowan	China Grove	7.7%
28088	Rowan	Landis	1.6%
Rowan County Only			**9.3%**
28081	Rowan/Cabarrus	Kannapolis	13.9%
28083	Rowan/Cabarrus	Kannapolis	12.6%
28138	Rowan/Cabarrus	Rockwell	6.4%
Rowan/Cabarrus			**32.9%**
28027	Cabarrus	Concord	27.9%
28025	Cabarrus	Concord	30.0%
Cabarrus County Only			**57.9%**

Additionally, the applicants' service area map shown on page 79 of the application, reveals that the geographic majority of the service area lies in Cabarrus County, below the Rowan County border. On page 78 of the application, the applicants claim

> *"While the service area for the proposed RRMC-S hospital contains seven zip codes, five of which are in Rowan County and two of which are in Cabarrus County, the major anticipated market for RRMC-S in the Cabarrus County zip codes will most likely be the northern portions of these zip codes whose residents are closer to the location of the proposed RRMC-S hospital."*

However, the applicants' statement is misleading. First, the statement suggests the majority of the new hospital's service area lies in Rowan County which is incorrect as discussed above, and secondly, the applicants imply that RRMC-S' zip code population, which it used to project acute care utilization, includes primarily the northern portion of the zip codes in Cabarrus County because those residents would be closer to the new hospital. However, the applicants did not show how they determined the number of patients who reside in only the northern portion of the Cabarrus County zip codes, or how they determined that these patients would choose to be served at the new facility instead of at CMC-NorthEast, given the two facilities would be about 7 miles apart.

Also, as shown in the table above, Rowan County-Only zip codes (9.3%) and those zip codes split between Rowan County and Cabarrus County (32.9%), represent only 42% of RRMC-S' total projected FY2012 service area population. If Cabarrus County residents were subtracted from the shared zip codes (28081, 28083 and 28138), then the percentage of Rowan County residents to be served

by the new hospital would fall far short of 42%. Further, the applicants' service area includes two Concord zip codes (28027 and 28025), that are served by CMC-NorthEast and Gateway Ambulatory Center/Copperfield Diagnostic Imaging Center, both of which are located in zip code 28025. CMC-NorthEast is a tertiary facility, offering significantly more services than will be offered at the new 50-bed hospital in Kannapolis. The applicants do not adequately demonstrate that it is reasonable for any residents of these two zip codes to drive to southern Rowan County for acute care services when there is a larger hospital offering more services located in the same zip codes where they live.

The applicants rely on the population in the Kannapolis and Concord areas to generate inpatient admissions to the new hospital. As shown in the table below, 40% of RRMC-S' inpatient admissions are projected to originate from Kannapolis zip codes 28081 and 28138 (22% + 18% = 40%), and another 26% of total admissions are expected to come from Concord zip codes 28025 and 28027 (10% + 16% = 26%). Further, the applicants identified the source of 10% of "*Other-immigration*" admissions as other areas of North Carolina, which also would include zip codes in Cabarrus County. Therefore, RRMC-S is projected to rely on Kannapolis, Concord and other unidentified areas of North Carolina to provide approximately 76% of the hospital's total inpatient admissions, as well as 84.4% of the total service area's projected population (13.9% + 12.6% + 27.9% + 30% = 84.4%).

Zip Code	County	Project Year 2 (2012)	
		% Population	% of Total Patient Discharges
28023 China Grove	Rowan	7.7%	12%
28088 Landis	Rowan	1.6%	3%
Rowan County Only		9.3%	15%
28081 Kannapolis	Rowan/Cabarrus	13.9%	22%
28083 Kannapolis	Rowan/Cabarrus	12.6%	18%
28138 Rockwell	Rowan/Cabarrus*	6.4%	10%
Rowan/Cabarrus		32.9%	50%
28027 Concord	Cabarrus	27.9%	10%
28025 Concord	Cabarrus	30.0%	16%
Cabarrus County Only		57.9%	26%
Other in-migration			10%
Total		100.0%	100%

*Cabarrus County added by project analyst

In summary, the applicants claim in the above quotes that development of a new 50 bed hospital in Kannapolis is needed to provide hospital services for residents of southern Rowan County. In their statistical analysis of need for the acute care beds, the applicants use Kannapolis and the surrounding Kannapolis service area as if they were synonymous with southern Rowan County. However, the applicants' proposed service area includes more than just areas in southern Rowan

County. As shown in the table above, Kannapolis bridges Rowan and Cabarrus Counties, but the applicants do not provide separate population data and patient discharges for each county in the zip code. Instead, the data is provided as a total for both Rowan and Cabarrus Counties. In addition, the applicants allocate population and patient discharges for Rockwell, as if it were entirely located in Rowan County, although Rockwell is also split between Rowan and Cabarrus Counties. Therefore, the need of the population specifically residing in southern Rowan County is not separately identified by the applicants. For the sake of argument, if the combined Rowan/Cabarrus County population and patient discharges in the table above were divided equally between the two counties, then the projected population for southern Rowan County would be only 26% of the total population [9.3 + (32.9/2 = 16.4) = 25.7%] and patient discharges would be only 40% of total discharges [15 + (50/2 = 25 = 40%], far below the statistical numbers on which the applicants' base the need for a new 50 bed hospital.

Utilization Projections for Proposed Services
On page 43, the applicants state

> *"The applicants used two basic methodologies to project future utilization for the proposed project.*
>
> *1. A Use Rate Methodology*
>
> *Projected Utilization = (Defined Service Area Population x Use Rate x Market Share) + Other In-migration*
> *was used to project:*
>
> - *Acute care inpatient discharges, days, and bed need;*
> - *ICU days and ICU bed need;*
> - *Observation bed days and observation bed need;*
> - *LDRP births, days, and bed need* [*Note: The Use Rate for LDRP projections is the Birth Rate.]*
> - *C-Section procedures and C-Section operating room need;*
> - *Inpatient and outpatient surgical procedures and shared operating room need;*
> - *GI endoscopy procedures and GI endoscopy procedure room need;*
> - *Outpatient visits; and*
> - *Emergency Department visits and emergency treatment rooms need.*
>
> *2. Other ancillary utilization projections were calculated based upon existing ancillary utilization patterns at Presbyterian Healthcare's existing community hospitals: Presbyterian Hospital Matthews*

(PHM) and Presbyterian Hospital Huntersville (PHH). The applicant assumes that projected ancillary utilization at RRMC-S will imitate current ancillary utilization patterns at PHM and PHH since these hospitals not only offer similar services as those to be offered at RRMC-S but also, they are of a similar size and type of location to the proposed RRMC-S."

However, neither of the Novant community hospitals mentioned above is within 7 miles of a large tertiary hospital, as is the case with the proposed new hospital. Therefore, the applicants do not adequately demonstrate that utilization at RRMC-S is reasonably projected to be similar to utilization at these two Novant facilities.

On page 43 of the application, the applicants state their assumptions, as follows:

"Zip Code Population Projections

The proposed RRMC-S service area consists of the zip code where the hospital will be located and surrounding zip codes. Population growth in the defined service area is expected to continue into the next decade. Therefore, population is expected to grow at the same rate through 2013 as reflected in the following table.

Population of Defined Service Area

Zip Code	*County*	*City/Town*	*CY 2007*	*CY 2011*	*CY 2012*	*CY 2013*	*Projected Annual Increase (2007-2013)*
28023	*Rowan*	*China Grove*	*13,527*	*13,725*	*13,775*	*13,825*	*0.4%*
28025	*Cabarrus*	*Concord*	*46,511*	*49,509*	*50,288*	*51,079*	*1.6%*
28027	*Cabarrus*	*Concord*	*48,287*	*53,124*	*54,407*	*55,721*	*2.4%*
28081	*Rowan/Cabarrus*	*Kannapolis*	*24,049*	*24,732*	*24,905*	*25,080*	*0.7%*
28083	*Rowan/Cabarrus*	*Kannapolis*	*21,428*	*22,347*	*22,582*	*22,821*	*1.1%*
28088	*Rowan*	*Landis*	*2,892*	*2,880*	*2,876*	*2,873*	*-0.1%*
28138	*Rowan/ Cabarrus**	*Rockwell*	*10,801*	*11,340*	*11,479*	*11,620*	*1.2%*
Total			*167,496*	*177,655*	*180,313*	*183,019*	*1.5%*

Source: Claritas; Exhibit 20, Table 4
*Cabarrus County added by Project Analyst

Please note that the female population aged 15 to 44 for each zip code in the defined service area was used to project the need for LDRP services. The gender/age-specific population in each zip code will be set out in the detailed LDRP service projections.

Market Share Shift Assumptions

The following assumptions related to the percent market share shift are used in the projections:

1. Percent Market Share Shift from RRMC to RRMC-S

The following percent market share shift from RRMC to RRMC-S was used in all use rate methodologies except in the projection of emergency department visits. Due to the nature of emergency services, a larger percent of market share was shifted from RRMC to RRMC-S.

Percent Market Share Shift from Existing PHS Facilities to RRMC-S

Zip Code	***Percent Market Share Shift***
28023	*55%*
28025	*65%*
28027	*65%*
28081	*60%*
28083	*60%*
28088	*60%*
28138	*50%*

Source: Exhibit 20, Table 11

The following factors were considered important to the determination of the percent of market share, reflected in the previous table, projected to shift from each zip code:

- *New physician offices with easier access will be developed in the future on the RRMC-S campus;*
- *The proposed location of RRMC-S convenient to Interstate I-85 will result in ease of access to the existing population in the defined zip code area.*

2. Market Share Increases Resulting From Proposed Project

RRMC-S expects a market share increase from the current RRMC market shares once RRMC-S becomes operational, as shown in the following table. Projected increases are slightly different for outpatients and ED visits, as described in the detailed projections for these services.

Projected Increase in RRMC-S Market Share

Zip Code	***Projected Market Share Increase***
28023	*20.0%*
28025	*10.0%*
28027	*7.5%*
28081	*25.0%*
28083	*25.0%*
28088	*20.0%*
28138	*15.0%*

Source: Exhibit 20, Table 11

The expected increase in market share of the defined service area is based upon the following factors:

- *Projected population growth in the defined zip code service area is projected to exceed 9% between 2007 and 2013 and many of these people will have no established hospital relationship;*
- *RRMC-S offers an alternative to CMCN for inpatient care in service area;*
- *Many of the residents of 28083, in the home zip code of RRMC-S, will be closer to RRMC-S than other hospitals;*
- *Out-migration from Rowan County will decrease and more patients will be treated within the defined service area as a result of increases in the number of physicians and medical services;*
- *The development of a hospitalist program at RRMC-S will free up primary care and specialist physicians to spend more time in their offices or in operating rooms and/or procedure rooms subsequently enhancing physician recruitment;*
- *RRMC and Novant will work in cooperation to recruit additional physicians and add physicians to Novant's existing network of physicians;*
- *New physician offices with easier access will be developed on the RRMC-S campus; and*
- *The proposed location convenient to the I-85 will result in ease of access to existing population.*

Other In-migration Assumption

While not part of the defined service area, RRMC-S recognizes that patients from other North Carolina counties may chose to travel across service areas to receive services at RRMC-S. As a result, 10.0% of the total projected utilization in each of the project years has been allocated to the category of 'Other In-migration.'"

Medical-Surgical, ICU and Obstetric Beds

The following table illustrates projected utilization of the 50 acute care beds at RRMC-S, as reported by the applicants in Section IV.1, page 88.

RRMC-S
Projected Utilization

	CY 2011	CY 2010	CY 2013
General Med/Surg (42 beds)			
Patient Days	7,495	9,210	10,965
ADC [1]	20.5	25.2	30.0
% Occupancy [2]	48.9%	59.9%	71.5%
Obstetrics (4 LDRP beds)			
Discharges	319	387	456
Average Length of Stay (ALOS)	2.3	2.3	2.3
Patient Days	733	891	1,049
ADC [1]	2.0	2.4	2.9
% Occupancy [2]	50.2%	60.8%	71.8%
ICU (4 beds)			
Patient Days	619	760	904
ADC [1]	1.7	2.1	2.5
% Occupancy [2]	42.4%	51.9%	61.9%
Total (50 beds)			
Discharges	2,158	2,649	3,151
Average Length of Stay (ALOS)	4.1	4.1	4.1
Patient Days	8,848	10,861	12,917
ADC [1]	24.2	29.8	35.4
% Occupancy [2]	48.5%	59.3%	70.8%

Source: Section IV.1, page 88
[1] ADC equals total number of patient days of care divided by 365.
[2] Occupancy equals ADC divided by the number of beds.

As shown in the above table, the applicants project the ADC of the 50 acute care beds at RRMC-S in the third operating year will be 35.4 patients, which is an occupancy rate of 70.8. The applicants provide the assumptions and methodology used to project utilization of the acute care beds on pages 46–54 of the application.

On page 46 of the application, the applicants state

> *"Projected acute care inpatient discharges, days, and bed need were determined as follows:*
>
> *Three Year Average Acute Care Inpatient Discharge Use Rate*
>
> *RRMC-S will be a community hospital. Obstetric services will be provided; cardiac surgery and other tertiary level services will not. To determine total medical/surgical discharges and patient days at RRMC-S the following exclusions were made from the Solucient database of discharges and patient days from the defined service area:*

Solucient Database Exclusions
FFY 2004 -2006

Medical Surgical Exclusions
Mental Health and Drug Abuse DRGs (424-433 and 521-523)
Rehab (462)
Normal Newborns (391)
NICU (385-390)
Diag Cardiac Cath (124, 125)
DRGs with FY2004 Relative Weight > = 2.0 from FFY 2004 Discharges
DRGs with FY2005 Relative Weight > = 2.0 from FFY 2005 Discharges
DRGs with FY2006 Relative Weight > = 2.0 from FFY 2006 Discharges

Source: Exhibit 20, Tables 5, 6, 7, 8

RRMC-S analyzed FFY 2004-2006 zip code level Solucient data to determine the acute care inpatient discharge use rate per 1,000 population. The following table shows the three year average (FFY 2004-2006) acute care inpatient discharge use rate per 1,000 population for each of the seven zip codes in the defined service area.

Three Year Average Acute Care Inpatient Discharge Use Rate

Zip Code	***County***	***City/Town***	***Three Year Average Acute Care Inpatient Discharge Use Rate***
28023	*Rowan*	*China Grove*	*80.6*
28025	*Cabarrus*	*Concord*	*94.7*
28027	*Cabarrus*	*Concord*	*71.7*
28081	*Rowan/Cabarrus*	*Kannapolis*	*99.4*
28083	*Rowan/Cabarrus*	*Kannapolis*	*95.6*
28088	*Rowan*	*Landis*	*98.8*
28138	*Rowan/Cabarrus**	*Rockwell*	*72.4*

Source: Exhibit 20, Table 9
Note: the three year period includes: FFY 2004-FFY 2006
**Project analyst added Cabarrus County*

The three year average acute care inpatient discharge use rate for each zip code was used to determine total acute care inpatient discharges and RRMC market share by zip code in the defined service area for the first three years of the proposed project.

<u>Projected Acute Care Inpatient Market Share in Defined Service Area.</u>

Using the Solucient FFY 2006 inpatient discharge data, the applicant calculated the RRMC acute care inpatient market share for each zip code in the defined service area. The following table shows actual RRMC acute care inpatient discharges, total acute care inpatient discharges, and RRMC acute care inpatient market share for each of the seven zip codes in the defined service area.

RRMC Inpatient Market Share in Defined Service Area
FFY 2006

Zip Code	*County*	*City/Town*	*RRMC Acute Care Discharges*	*Total Acute Care Discharges*	*RRMC Acute Care Inpatient Market Share*
28023	*Rowan*	*China Grove*	*290*	*1,155*	*25.1%*
28025	*Cabarrus*	*Concord*	*13*	*4,423*	*0.3%*
28027	*Cabarrus*	*Concord*	*12*	*3,499*	*0.3%*
28081	*Rowan/Cabarrus*	*Kannapolis*	*91*	*2,424*	*3.8%*
28083	*Rowan/Cabarrus*	*Kannapolis*	*47*	*2,122*	*2.2%*
28088	*Rowan*	*Landis*	*51*	*272*	*18.8%*
28138	*Rowan/Cabarrus**	*Rockwell*	*352*	*784*	*44.9%*

*Source: Solucient; Exhibit 20, Table 11; *Cabarrus County added by Project Analyst*
Note: RRMC Acute Care Inpatient Discharges, Total Acute Care Inpatient Discharges, and RRMC Acute Care Inpatient Market Share reflect the exclusion of medical/surgical categories listed in the table labeled 'Solucient Database Exclusions' above and in Exhibit 20, Tables 5-8.

Actual RRMC acute care inpatient market share was then adjusted to reflect the percent market shift and the projected increase in market share. The following table shows RRMC-S's future acute care inpatient market share of the defined service area.

Projected Acute Care Inpatient Discharge Market Share
Project Year 3

Zip Code	*County[sic] City/Town*	*Current RRMC Market Share*	*Percent Market Share Shift*	*Projected Market Share Increase*	*RRMC-S Market Share PY 3*
		A	*B*	*C*	*D = A*B+C*
28023	*China Grove*	*25.1%*	*55.0%*	*20.0%*	*33.8%*
28025	*Concord*	*0.3%*	*65.0%*	*10.0%*	*10.2%*
28027	*Concord*	*0.3%*	*65.0%*	*7.5%*	*7.7%*
28081	*Kannapolis*	*3.8%*	*60.0%*	*25.0%*	*27.3%*
28083	*Kannapolis*	*2.2%*	*60.0%*	*25.0%*	*26.3%*
28088	*Landis*	*18.8%*	*60.0%*	*20.0%*	*31.3%*
28138	*Rockwell*	*44.9%*	*50.0%*	*15.0%*	*37.4%*

Source: Exhibit 20, Table 11
Note: Project Year 3 begins 1/1/2013

The applicant also assumed that the proposed market share shift will occur gradually over the first three years of operation, realizing 70% of projected market share in Project Year 1, 85% in Project Year 2, and 100% in Project Year 3. The applicant anticipates that a larger portion of the market share shift in the 28025 and 28027 zips will come from residents in the northern part of those zips.

Projected Acute Care Inpatient Discharge Market Share
Project Years 1- 3

Zip Code	***City/Town***	***PY 1 2011***	***PY 2 2012***	***PY 3 2013***
28023	*China Grove*	*23.7%*	*28.7%*	*33.8%*
28025	*Concord*	*7.1%*	*8.7%*	*10.2%*
28027	*Concord*	*5.4%*	*6.6%*	*7.7%*
28081	*Kannapolis*	*19.1%*	*23.2%*	*27.3%*
28083	*Kannapolis*	*18.4%*	*22.4%*	*26.3%*
28088	*Landis*	*21.9%*	*26.6%*	*31.3%*
28138	*Rockwell*	*26.2%*	*31.8%*	*37.4%*
Percent of Project Year 3 Market Share		*70%*	*85%*	*100%*

Source: Exhibit 20, Table 11
Note: Project Year 1 begins 1/1/2011

The projected market share for each zip code was used to determine projected acute care inpatient discharges by zip code in the defined service area for the first three years of the proposed project. RRMC-S also assumed that the proposed market shift will occur over the first three years of operation, realizing 70% of projected market share in Project Year 1, 85% in Project Year 2 and 100% in Project Year 3.

<u>Projected Acute Care Inpatient Discharges in Defined Service Area.</u>

The applicant projected acute care inpatient discharges for the first three years of operation using the following methodology:

Projected Acute Care Inpatient Discharges = (Defined Service Area Population x Three
Year Average Acute Care Inpatient Discharge
Use Rate x Market Share) + 'Other In-migration'

RRMC-S's projected acute care inpatient discharges by zip code are reflected in the following table. Projected 'Other Inmigration' and total discharges also are included.

Projected Acute Care Inpatient Discharges
Project Years 1-3

Zip Code	*City/Town*	*2011*	*2012*	*2013*
28023	*China Grove*	*262*	*319*	*377*
28025	*Concord*	*334*	*412*	*493*
28027	*Concord*	*206*	*256*	*309*
28081	*Kannapolis*	*469*	*574*	*679*
28083	*Kannapolis*	*394*	*483*	*574*
28088	*Landis*	*62*	*75*	*89*
28138	*Rockwell*	*215*	*264*	*315*
Total Acute Care Inpatient Discharges in Defined Service Area		*1,942*	*2,384*	*2,836*
Other In-migration (10%)		*216*	*265*	*315*
Total Acute Care Inpatient Discharges		*2,158*	*2,649*	*3,151*

Source: Exhibit 20, Table 13. Project Year 1 begins on 1/1/2011
Numbers may not sum due to whole unrounded figures used in calculation.

Total projected acute care inpatient discharges reflected in the previous table for calendar years 2011-2013 were used to project total acute care inpatient days for RRMC-S."

Regarding the assumptions in the table above, on page 49, the applicants state

"Projected Acute Care Inpatient Days

FFY 2006 Solucient acute care inpatient discharge and inpatient day data specific to the defined zip code service area was used to determine an average length of stay of 4.1 days. Actual data are included in Exhibit 20, Table 14. Annual total acute care inpatient discharges were multiplied by average length of stay to project acute care utilization at RRMC-S in each of the three project years.

Projected Acute Care Inpatient Days and Bed Need

	PY 1 2011	*PY 2 2012*	*PY 2013*
Total Acute Care Inpatient discharges	*2,158*	*2,649*	*3,151*
Average Length of Stay	*4.1*	*4.1*	*4.1*
Total Inpatient Days	*8,848*	*10,861*	*12,917*
ADC	*24.2*	*29.8*	*35.4*
Acute Care Bed Need @66.7% Occupancy	*36*	*45*	*53*
Proposed Total Acute Care Beds	*50*	*50*	*50*
Occupancy @ 50 Acute Care Beds	*48.5%*	*59.5%*	*70.8%*

Source: Exhibit 20, Table 13. Project Year 1 begins on 1/1/2011

The previous table reflects projected acute care occupancy. The State Medical Facilities Plan Acute Care Bed Need Methodology planning has an occupancy target of 66.7% for facilities with an average daily

census less than 100 patients, which results in an acute care bed need at RRMC-S of 53 acute care beds in calendar year 2013. The proposed 50 acute care bed hospital is projected to achieve an occupancy level of 70.8% in 2013."

On page 72 of the application, the applicants state

" …[P]art of the RRMC-S market share will be a direct shift from RRMC. Additional market share in each zip code will come from other hospitals currently serving patients in this area. For this additional market share, actual loss of inpatient volume from each zip code will be proportional to each hospital's current market share of that zip code, without RRMC. See Exhibit 20 Table 11 for acute care market shares with and without RRMC-S. Exhibit 20 Table 25 shows acute care patient volumes for the service area with and without RRMC-S."

Although the applicants project a shift in market share from RRMC to RRMC-S, the majority of patients projected to shift to RRMC-S will come from CMC-NorthEast in Concord, not RRMC. Specifically, in 2006, CMC-NorthEast served 82.1% of total acute patient discharges from the seven zip code service area, compared to 5.8% served at RRMC, according to FY 2006 market share data in Exhibit 20, Table 11 (1 of 2) of the application. The tables below show CMC-NorthEast's and RRMC's projected patient discharges in 2013 using the applicants' assumptions of market share shift from each hospital to RRMC-S. The applicants then calculate the difference in the numbers of discharges at CMC-NorthEast and RRMC in 2013, assuming their respective market shares remain the same as they were in 2006.

Zip Code	City/Town	2013 Total Projected Patient Discharges by Zip Code	CMC-NorthEast				Diff. in Discharges Due to Market Share Shift
			2013 Market Share	2013 Patient Discharges	2006 Market Share	2013 Patient Discharges	
28023	China Grove	1,114	0.457	509	0.623	694	-185
28025	Concord	4,836	0.80	3,869	0.889	4,299	-430
28027	Concord	3,996	0.747	2,985	0.807	3,225	-240
28081	Kannapolis	2,493	0.65	1,620	0.878	2,189	-569
28083	Kannapolis	2,181	0.671	1,463	0.902	1,967	-504
28088	Landis	284	0.557	158	0.739	210	-52
28138	Rockwell	841	0.305	256	0.420	353	-97
Total		15,745		10,860		12,937	-2077

Zip Code	City/Town	2013 Total Projected Patient Discharges by Zip Code	RRMC				Diff. in Discharges Due to Market Share Shift
			2013 Market Share	Patient Discharges	2006 Market Share	Patient Discharges	
28023	China Grove	1,114	.113	126	0.251	280	-154
28025	Concord	4,836	0.0010	5	0.003	14	-9
28027	Concord	3,996	0.0010	4	0.003	12	-8
28081	Kannapolis	2,493	0.015	37	0.038	95	-58
28083	Kannapolis	2,181	0.0090	20	0.022	48	-28
28088	Landis	284	0.075	21	0.1880	53	-32
28138	Rockwell	841	0.224	188	0.449	378	-190
Total		15,745		401		880	-479

2013 RRMC-S Service Area Discharges	2013 Discharges Shifted From CMC-NorthEast	%	2013 Discharges Shifted From RRMC	%
2,836	2079	73.3	478	16.9%

As shown above, the applicants project RRMC-S will admit 2,836 patients from the seven zip code service area in 2013, of which 2,077 patients or approximately 73% will be shifted from CMC-NorthEast in Concord and 479 patients, or about 17%, will be shifted from RRMC in Salisbury. The applicants state the remaining 280 patients projected to be served at RRMC-S will be shifted from hospitals in Mecklenburg County or other counties. Although the applicants state the amount of their projected increases in market share on pages 45-46 of the application, the applicants provide no statistical basis for how the projected market share increases were determined. Further, the applicants state that a larger portion of the market share in Cabarrus County will come from the northern portions of the zip codes but do not provide any data or projections for the difference in market share within the identified zip codes. In summary, the applicants did not adequately demonstrate that the projections for discharges and acute care patient days for RRMC-S are based on reasonable assumptions.

Further, the applicants do not adequately demonstrate that projected utilization for the 173 beds remaining at RRMC in Salisbury is reasonable. Specifically, the applicants project total discharges to significantly increase at RRMC due to its relationship with Novant. On page 71 of the application, the applicants state

> "*Novant and RRMC are on the path of a merger that is planned to be culminated January 1, 2008. One of the results of the merger will be a strategy to develop additional physician presence in the Salisbury market as a result of leveraging the Novant Presbyterian Medical Group network of physicians and existing RRMC medical staff practices and recruiting additional physicians to established practices in Salisbury.*

An increase in physician supply representing primary care physicians and specialists to meet the needs of persons living in the Salisbury area will reduce patient out-migration and result in more patients using RRMC. The applicant assumes RRMC market shares will increase from five percent in 2008 to twenty-two percent in 2012."

The first table below illustrates the applicants' projected utilization at RRMC based solely on population growth and the assumption that 86% of RRMC's total discharges will be from Rowan County.

RRMC Projected Utilization

	CY 2008	CY 2009	CY 2010	CY 2011	CY 2012	CY 2013
RRMC – Discharges from Rowan	7,483	7,527	7,572	7,617	7,663	7,708
% of Total Discharges from Rowan County	86%	86%	86%	86%	86%	86%
In-migration Discharges	1,206	1,214	1,221	1,228	1,235	1,243
Total Projected RRMC Discharges	8,689	8,741	8,793	8,845	8,898	8,951

Source: Exhibit 20 Table 26 (1)

The applicants also provide a second table to show the impact on the discharges at RRMC projected in the previous tables, assuming additional percentage increases in discharges based on "*Increase Due to Novant*."

RRMC Projected Utilization

	CY 2008	CY 2009	CY 2010	CY 2011	CY 2012	CY 2013
Total Discharges	8,689	8,741	8,793	8,845	8,898	8,951
Increase Due to Novant	5%	10%	15%	20%	21%	22%
Total Discharges with Novant	9,124	9,615	10,112	10,614	10,766	10,920
Additional Discharges	435	874	1,319	1,769	1,868	1,969
Discharges with RRMC-S	9,124	9,615	10,112	10,249	10,319	10,389
ALOS	4.4	4.4	4.4	4.4	4.4	4.4
Total Days of Care	39,798	41,941	44,108	44,704	45,010	45,316
Licensed Beds	223	223	223	173	173	173
Licensed Occupancy	48.9%	51.5%	54.2%	70.8%	71.3%	71.8%

Source: Exhibit 20 Table 26 (2)

The above table shows the applicants project that by 2013, discharges at RRMC will be 22% greater than discharges projected based on population growth alone (10,920/8,951 = 1.219). However, the applicants do not provide adequate evidence to support their assumption that RRMC's total discharges will be greater each year solely due to its relationship with Novant, other than to state they will develop a strategy to increase physician supply. Further, the applicants also did not provide the basis for determining the specific percentage increase in discharges that would be due to Novant, which ranges from 5% more discharges in CY2008 to 22% more discharges in CY2013. Specifically, no information is provided on the number of physicians, their medical specialties, or the number of admissions these physicians would produce that would result in increased

discharges. In addition, the applicants' above projections for growth in utilization at RRMC contradict their statement on page 26 that RRMC is currently underutilized because the population growth in Rowan County is in the south, and "*If the existing licensed acute care beds are not relocated to Kannapolis where the population will use the beds, the beds continue in the state inventory and are not used and remain an underused resource."* Thus, the applicants imply beds at RRMC will continue to be underutilized because they are located in Salisbury. The table below presents historical data from Solucient/Thomson for RRMC which shows utilization of acute care beds in Salisbury.

RRMC
Solucient/Thomson Utilization Data

Year	Acute Care Patient Days	Percent Difference from Previous Year
FY 2002	39,607	
FY 2003	40,406	2.0%
FY 2004	39,401	-2.5%
FY 2005	37,002	-6.1%
FY 2006	36,768	-6.3%
FY 2007	Not Available	Not Available

The applicants state utilization at RRMC in FY2007 is 41,207 acute care days, but Thomson data is not currently available to verify this statement. Regardless, based on 41,207 days of care, the ADC at RRMC would be 114 patients, which would be an occupancy rate of 65.7%, if only 173 beds were currently licensed. However, the applicants propose to shift patients and services from RRMC to RRMC-S, which would reduce utilization and the occupancy rate at RRMC. Thus, the applicants did not adequately demonstrate that the proposed new hospital would not unnecessarily duplicate existing services at RRMC.

On page vii of the application, the applicants state

> *The most important reason to approve this project is because for consumers in the Kannapolis-Concord area it will create constructive competition in hospital services that will result in improved quality of care, increased patient satisfaction and reduced negotiated rates. Approval of this project will give the public these benefits without harming the ability of CMCN to carry out its charitable mission and without harming its financial stability."*

However, the applicants do not provide evidence to support their claim that a new 50-bed hospital would improve quality of care, reduce negotiated rates, and lower costs for service area residents. Neither do the applicants provide evidence that a new hospital would not harm CMC-NorthEast's financial stability or charitable mission, given that the applicants project the occupancy rate of CMC-NorthEast to decrease as a result of the proposed project. See Exhibit 20, Table 28 (2 of 2).

In addition, the applicants state on page 23, "F*urther, in this project RRMC is making the best use of existing resources by shifting not only acute care beds, but also existing licensed operating rooms and an endoscopy room from the underutilized Salisbury location to Kannapolis. Thus, the project responds to one of the central purposes of the CON Law: to encourage efficient, cost-effective solutions that maximize existing resources rather than unnecessarily duplicate existing services."*

However, the proposal to develop 50 acute care beds at RRMC-S would result in shifting medical/surgical patient days of care from CMC-NorthEast which currently serves the proposed service area, and thus, would duplicate services provided by CMC-NorthEast to residents in the service area. The tables below show the impact of shifting acute care market share from CMC-NorthEast and RRMC to RRMC-S in FY2013. As shown in the first table, CMC-NorthEast's acute care market share would decline from 82.2% to 69.0% and RRMC's acute care market share would decline from 5.8% to 3.7%. In the second table below, CMC-NorthEast's loss in market share would be a reduction of 2,079 acute care discharges and RRMC's market share loss would be a reduction of 478 service area acute care discharges.

	Without RRMC-S 2013		**With RRMC-S 2013**	
	CMC-NorthEast	**RRMC**	**CMC-NorthEast**	**RRMC**
Service Area Acute Care (with Exclusions) Discharges	12,941	880	10,862	402
Total Service Area Acute Care Discharges in 2013	15,745	15,745	15,745	15,745
Percent Market Share of Service Area Acute Care Discharges	82.2%	5.8%	69.0%	3.7%

Source: Exhibit 20 Table 25 (1 of 2)

	2013	
	CMC-NorthEast	**RRMC**
Difference in Service Area Acute Care Discharges With RRMC-S	2,079	478
Total Acute Care Discharges (with Exclusions) Projected for RRMC-S	2,836	2,836
Percent of Acute Care Discharges Shifted to RRMC-S	73.3%	16.8%

Source: Exhibit 20 Table 25 (2 of 2)

Further, as shown above, CMC-NorthEast's loss would be a gain in acute care discharges for RRMC-S, or 73.3% (2,079/2,836 = 0.733) of the new hospital's

total service area acute care discharges (2,836). In addition, RRMC's loss in acute care discharges would be a gain of another 16.8% (478/2,836) of acute care discharges for RRMC-S. In Exhibit 20 Table 28 (2 of 2), the applicants project the impact of RRMC-S (and Presbyterian Mint Hill) on CMC-NorthEast's acute care utilization. In CY2013, the applicants project a total of 20,498 discharges, 95,706 days of care and an occupancy rate of 58.7% for CMC-NorthEast's 447 licensed acute care beds. The impact of RRMC-S on CMC-NorthEast will increase from a loss of 2,079 acute care discharges to a loss of 2,492 acute care discharges when deductions are made for the 231 discharges due to the 10% inmigration and 182 discharges due to a shift of patients to the previously approved Presbyterian Hospital in Mint Hill. However, the applicants did not include in these projections of patient discharges the number of obstetric discharges to be shifted from CMC-NorthEast to RRMC-S. Therefore, assuming the same percentage of total RRMC-S obstetric discharges as acute care discharges (73.3%) to be shifted from CMC-NorthEast, the hospital could potentially lose another 301 obstetric discharges (0.733 x 410 obstetric discharge at RRMC-S in 2013 = 301). Assuming an obstetric ALOS of 2.3 days, then CMC-NorthEast would lose another 691 days of care, for a total of 95,015 (95,706 – 691 = 95,015) inpatient days of care projected to be provided at CMC-NorthEast. Based on 95,015 inpatient days of care, CMC-NorthEast would be operating at an occupancy rate of only 58.2% (95,015/365 =260.3/477 = 0.582) in 2013, compared to an occupancy rate of 61% in FY2007.

In summary, the applicants did not adequately demonstrate that projected utilization of the 50 acute care beds at the proposed hospital is based on reasonable and supported assumptions. Further, the applicants failed to demonstrate that CMC-NorthEast, which is located less than 7 miles from the proposed facility, lacks sufficient capacity to meet the needs of the population the applicants propose to serve. Therefore, the applicants did not adequately demonstrate the need to construct a new hospital with 50 acute care beds in southern Rowan County.

Projected ICU Days and Bed Need

The applicants propose to develop four ICU beds. On page 50, the applicants state

> *"Projected ICU beds were determined using total projected inpatient days and FFY 2005 and 2006 ICU utilization data for PHH, included in Exhibit 20, Table 18. 2006 and 2007 Hospital License Renewal Applications show intensive care days at PHH represented 7% of total inpatient days in FFY 2005 and 2006. The following table shows projected ICU patient days and the resulting ICU bed need.*

Projected ICU Patient Days and Bed Need

	PY 1 2011	***PY 2 2012***	***PY 2013***
Total Inpatient Days	*8,848*	*10,861*	*12,917*
Projected ICU Days (7%)	*619*	*760*	*904*
Average Daily Census	*1.7*	*2.1*	*2.5*
ICU Bed Need @60% Occupancy	*3*	*3*	*4*
Proposed Total ICU Beds	*4*	*4*	*4*
Occupancy @4 ICU Beds	*42.4%*	*52.1%*	*61.9%*

Source: Exhibit 20, Table 13
Note: Project Year 1 begins on 1/1/2011

The previous table reflects projected ICU patient days and ICU bed need based upon the State Medical Facilities Plan Acute Care Bed Need Methodology planning occupancy target of 60% for facilities with less than 10 ICU beds, which results in a need at RRMC-S of 4 ICU beds in 2013. The proposed 4 bed ICU unit is projected to achieve an occupancy level of 61.9% in 2013."

The applicants state they calculated the ratio of intensive care patient days to total patient days at Presbyterian Hospital Huntersville (7%) and applied the same ratio to total projected inpatient days at RRMC-S to project ICU days of care and bed need. However, the applicants do not adequately explain why the experience at PHH in Mecklenburg County would be similar to the expected experience at RRMC-S in Kannapolis, which would be only 7 miles from a tertiary hospital. Further, a review of PHH's 2008-2006 License Renewal Applications (LRAs) shows ICU days to total inpatient days was 8.0% in FY2005, 6.3% in FY2006 and 6.5% in FY2007. The table below shows the percent of PHH ICU days to total inpatient days decreased in the past two years to an average of 6.4%. The lower average ratio is a result of excluding the hospital's first fiscal year of operation in FY2005, which included fewer than 365 days of operation.

PHH - Historical ICU Utilization

	FY2007	**FY2006**	**FY2005***
Total Inpatient Days	16,630	14,224	8,616
ICU Days	1,079	898	686
% ICU Days to Total Inpatient Days	6.5%	6.3%	8.0%
Average ICU to Total Inpatient Days FY 2005 – FY 2006	6.9%		
Average ICU to Total Inpatient Days FY 2006 – FY 2007	6.4%		

Source: Presbyterian Hospital Huntersville License Renewal Applications for 2008-2006; * PHH opened on 11/08/04 and operated only 326 days through 9/30/05

Thus, the applicants' 7% ratio of ICU days to total days is unreasonably high and results in overestimating ICU days. Further, the applicants' projection of acute

inpatient days of care is overstated, and thus, projected ICU patient days which are based on a percentage of projected total inpatient days, are also overstated. Therefore, the applicants did not adequately demonstrate that projected utilization of the four ICU beds at CMC-Kannapolis is based on reasonable and supported assumptions. Consequently, the applicants did not adequately demonstrate the need for four ICU beds at CMC-Kannapolis.

Projected Observation Patient Days and Bed Need

The applicants propose to develop eight unlicensed observation beds. On page 51 of the application, the applicants state

> *"Projected observation patient days were determined using total projected inpatient days and FFY2005-2006 observation bed utilization data from PHH. PHH is the only community hospital in the Novant or RRMC system with designated observation beds. FFY 2005 and 2006 observation patient days were equal to 14.9% of total inpatient days at PHH. PHH FFY 2005 and 2006 data from the 2006 and 2007 Hospital LRAs are included in Exhibit 20, Table 16. The following table shows projected observation patient days and the resulting observation bed need.*

Projected Observation Patient Days and Bed Need

	PY 1 2011	***PY 2 2012***	***PY 3 2013***
Total Inpatient Days	*8,848*	*10,861*	*12,917*
Projected Observation Patient Days (14.9%)	*1,319*	*1,619*	*1,925*
Average Daily Census	*3.6*	*4.4*	*5.3*
Observation Bed Need @66.7% Occupancy	*5*	*7*	*8*

Source: Exhibit 20, Table 16
Note: Observation Bed Need calculation = 5.3 ADC/66.7% target occ rate = 8 beds needed
Note: Project Year 1 begins on 1/1/2001

> *The previous table reflects projected observation patient days and bed need based upon the State Medical Facilities Plan Acute Care Bed Need Methodology planning occupancy target of 66.7% for facilities with an average daily census less than 100 patients, which results in a need for 8 observation beds at RRMC-S in CY 2013."*

However, the applicants do not adequately demonstrate why the experience at RRMC-S would be similar to the experience at PHH in Mecklenburg County. See previous discussion. Further, the applicants' projections of acute inpatient days of care are overstated, and thus, projected observation patient days, which are based on a percentage of projected acute inpatient days of care, are also overstated. Therefore, the applicants did not adequately demonstrate that

projected utilization of observation beds at the proposed RRMC-S is based on reasonable and supported assumptions. Consequently, the applicants did not adequately demonstrate the need for eight unlicensed observation beds at the proposed new facility.

Projected LDRP Births, Days, and Bed Need

The applicants propose to develop four labor, delivery, recovery, postpartum (LDRP) beds, which will be licensed as acute care beds. On page 51 of the application, the applicants state

> *"Projected LDRP births, days, and bed need were determined as follows:*
>
> *Projected Female Population Age 15-44 Rowan County and Cabarrus County*
>
> *Claritas population projections for the defined service area were obtained for 2007 and 2012 and interpolated and extrapolated for years 2011 — 2013. Gender/age-specific population data for the defined service area is included in Exhibit 20, Tables 2-4.*
>
> *2006 Birth Rate for Rowan County and Cabarrus County*
>
> *Estimated gender/age-specific 2006 population data from Claritas was used to calculate a 2006 birth rate per 1,000 females, ages 15-44 for Rowan and Cabarrus Counties, respectively. Solucient data for total births from Rowan and Cabarrus County for FFY 2006 are included in Exhibit 20, Table 9. The following table reflects the birth rate used to project obstetric services for the defined service area.*
>
> *The 2006 county specific birth rate for each zip code was used to determine total LDRP cases and RRMC market share by zip code in the defined service area for the first three years of the proposed project. For the two Kannapolis zip codes that fall in both Rowan and Cabarrus Counties, a weighted average of the two counties was used.*

As shown in Exhibit 20, Table 6, the applicants developed birth rates for Cabarrus County, Rowan County, and an average birth rate for both counties, then applied those rates to service area zip codes according to the county in which the zip codes are located. The tables below from Exhibit 20, Table 9 of the application, show the applicants' projected birth rates for each zip code are the same as the calculated birth rates for the entire county, except in those zip codes that bridge both counties.

	FY2006	***FY2006***	***FY2006***
County	***Pop***	***Deliveries***	***Use Rate***
Cabarrus	*32,566*	*2,425*	*74.5*
Rowan	*27,205*	*1,523*	*56.0*
Total	*59,771*	*3,948*	*66.1*

Zip Code	***County***	***City/Town***	***Use Rate***
28023	*Rowan*	*China Grove*	*56.0*
28025	*Cabarrus*	*Concord*	*74.5*
28027	*Cabarrus*	*Concord*	*74.5*
28081	*Rowan/Cabarrus*	*Kannapolis*	*66.1*
28083	*Rowan/Cabarrus*	*Kannapolis*	*66.1*
28088	*Rowan*	*Landis*	*56.0*
28138	*Rowan*	*Rockwell*	*56.0*

As illustrated above, Rowan County showed the lowest birth rate (56.0 births per 1,000 resident women 15-44 years of age), while Cabarrus County's birth rate was higher at 74.5. Therefore, for the zip codes that bridge both counties, the applicants project the birth rate to be 66.1, which they state is a "*weighted" average* of the birth rates for the two counties. However, the birth rates developed by the applicants are based on total births and total population of the entire county, and are not specific to the demographics of the population residing in the applicants' proposed service area, which includes a limited number of zip codes in each county. The applicants did not provide adequate demographic information to demonstrate that the birth rates in these zip codes would be similar to those for the county as a whole.

On page 52, the applicants state

> <u>*Projected LDRP Market Share in the Defined Service Area*</u>
>
> *Using Solucient FFY 2006 obstetric discharge data, included in Exhibit 20, Table 12, the applicants calculated the RRMC market share for obstetric services for each zip code in the defined service area. The following table reflects actual RRMC obstetric discharges, total obstetric discharges, and RRMC market share for each of the seven zip codes in the defined service area.*
>
> *Actual RRMC market share was then adjusted to reflect projected increase in market share. The following table shows RRMC-S's future market share of the defined service area.*

Projected LDRP Discharge Market Share
Project Year 3

Zip Code	*County (sic) City/Town*	*Current RRMC Market Share*	*Percent Market Share Shift*	*Projected Market Share Increase*	*RRMC-S Market Share PY 3*
		A	*B*	*C*	*D = A*B+C*
28023	*China Grove*	*21.4%*	*55.0%*	*20.0%*	*31.8%*
28025	*Concord*	*0.0%*	*65.0%*	*10.0%*	*10.0%*
28027	*Concord*	*0.4%*	*65.0%*	*7.5%*	*7.8%*
28081	*Kannapolis*	*8.0%*	*60.0%*	*25.0%*	*29.8%*
28083	*Kannapolis*	*3.8%*	*60.0%*	*25.0%*	*27.3%*
28088	*Landis*	*29.5%*	*60.0%*	*20.0%*	*37.7%*
28138	*Rockwell*	*31.0%*	*50.0%*	*15.0%*	*30.5%*

Source: Exhibit 20, Table 12

The projected market share for each zip code was used to determine projected obstetric discharges by zip code in the defined service area for the first three years of the proposed project.

Projected LDRP Discharges in the Defined Service Area

RRMC-S projected LDRP discharges for the first three years of operation using the following methodology:

Projected LDRP Discharges = (Defined Service Area Female Population Age 15-44 x
2006 Birth Rate x Market Share) + 'Other In-migration'

RRMC-S projected LDRP discharges by zip code are reflected in the following table. Projected 'Other In-migration' and total LDRP discharges also are included.

Projected LDRP Discharges
Project Years 1-3

Zip Code	*City/Town*	*2011*	*2012*	*2013*
28023	*China Grove*	*33*	*40*	*47*
28025	*Concord*	*52*	*64*	*76*
28027	*Concord*	*44*	*54*	*64*
28081	*Kannapolis*	*68*	*82*	*96*
28083	*Kannapolis*	*55*	*67*	*79*
28088	*Landis*	*8*	*10*	*11*
28138	*Rockwell*	*27*	*33*	*38*
Total LDRP Inpatient Discharges in Defined Service Area		*287*	*349*	*410*
Other In-migration (10%)		*32*	*39*	*46*
Total LDRP Discharges		*319*	*387*	*456*

Source: Exhibit 20, Table 13. Note: Project Year 1 begins on 1/1/2011
Numbers may not sum due to whole unrounded figures used in calculation.

Total projected LDRP discharges reflected in the previous table for CY 2011- 2013 were used to project total LDRP patient days and bed need for RRMC-S.

Projected LDRP Patient Days and Bed Need in the Defined Service Area.

FFY 2006 Solucient LDRP discharge and patient day data specific to the defined zip code service area was used to determine an obstetric average length of stay of 2.3 days. Actual FFY 2006 Solucient data are included in Exhibit 20, Table 14. Projected LDRP discharges were multiplied by average length of stay to project LDRP patient days and determine obstetric bed need as shown in the following table.

Projected LDRP Patient Days and Bed Need

	PY 1 2011	***PY 2 2012***	***PY 2013***
Total LDRP Discharges	*319*	*387*	*456*
Average Length of Stay	*2.3*	*2.3*	*2.3*
Total LDRP Patient Days	*733*	*891*	*1,049*
ADC	*2.0*	*2.4*	*2.9*
LDRP Need @66.7% Occupancy	*3*	*4*	*4*
Proposed LDRP Beds	*4*	*4*	*4*
Occupancy @ 4 LDRP Beds	*50.2%*	*61.0%*	*71.8%*

Source: Exhibit 20, Tables 13, 14
Note: Project Year 1 begins on 1/1/2011

The previous table reflects projected obstetric patient days and bed need based upon the State Medical Facilities Plan Acute Care Bed Need Methodology planning occupancy target of 66.7% for facilities with an average daily census less than 100 patients, which results in a need at RRMC-S for 4 LDRP beds in CY 2013. The proposed 4 LDRP unit is projected to achieve an occupancy level of 71.8% in 2013."

However, the applicants did not provide a statistical basis for how the projected incremental increases in obstetric market share were determined for each zip code area. It should be noted that these increases, which range from 7.5% to 25%, are in addition to the market share to be shifted from RRMC. Also, of the 456 obstetric patients the applicants project to admit in 2013, 67 of them will be shifted from RRMC (see Exhibit 20, Tables 12 & 13), while the other obstetric patients are expected to shift from other existing hospitals, such as CMC-NorthEast, as evidenced by the applicants' significant increases in market share. As shown in Exhibit 20, Table 12 of the application, CMC-NorthEast reported 2,051 obstetric discharges in FY 2006, or 83.4% of all service area obstetric discharges, compared to only 128 obstetric discharges reported by RRMC

which is only 5.2% of all obstetric discharges in the service area. Further, according to CMC-NorthEast's 2008 LRA, the hospital reported 7,294 obstetric days of care in FY2007, which is an ADC of 20 patients (7,294/365 = 19.98 ADC). CMC-NorthEast has 35 obstetric beds, and therefore the occupancy rate for the unit was only 57.1% (20 ADC/ 35 = 0.0571) in FY2007, as shown in the table below. Given CMC-NorthEast's current underutilization of obstetric beds, the projected shift of obstetric patients to RRMC-S would create additional unused capacity of existing obstetric resources.

CMC-NorthEast

	FY2007	FY2006	FY2005
OB (including LDRP) Days	7,294	7,471	7,117
OB (including LDRP) Beds	35	35	32
ADC	20.0	20.5	19.5
% Occupancy of Beds	57.1%	58.5%	60.9%

Source: 2008 – 2006 CMC-NorthEast LRAs

In summary, the applicants did not adequately demonstrate that projected utilization of LDRP beds at the proposed new hospital is based on reasonable and supported assumptions. Further, the applicants failed to demonstrate that the existing LDRP beds at CMC-NorthEast lack sufficient capacity to meet the needs of the population the applicants propose to serve. Therefore, the applicants did not adequately demonstrate the need for obstetric services or four LDRP beds at the proposed new hospital.

Projected New Neonatal Unit

In the applicants' schematic for the new hospital's third floor in Exhibit 16 of the application, the applicants designate a "*Nursery*" that shows eleven potential newborn bassinets. Also, on page 124 the applicants state that staffing will include neonatalogists and neonatal nurse practitioner, which are necessary to provide neonatal services to newborns. Thus, it is apparent the applicants propose to develop a new nursery at RRMC-S. However, the applicants did not discuss or demonstrate the need for eleven bassinets to be developed in the proposed new Level I neonatal unit at RRMC-S. [See 10A NCAC 14C .1400 for additional discussion of failure to demonstrate the need for the proposed neonatal services]. Additionally, as discussed above, the applicants did not adequately demonstrate the need for obstetric services at the new hospital, and consequently the need for a new nursery is also not demonstrated.

Projected C-Section Cases and C-Section Operating Room Need

The applicants propose to relocate to RRMC-S one of RRMC's two existing C-Section operating rooms. On page 55 of the application, the applicants state

"Projected RRMC-S C-Section cases and C-Section operating room need were determined using total projected obstetric cases and the average FFY 2004 - 2006 C-Section rate from PHH and PHM. In FFYs 2004 - 2006 C-Sections represented 29.4% of all births at PHH and PHM. FFY 2004 - 2006 data for PHH and PHM are included in Exhibit 20, Table 17. The following table shows projected C-Section cases.

Projected C-Sections Cases and C-Section Operating Room Need

	PY 1 2011	***PY 2 2012***	***PY 2013***
Total Obstetric Cases (LDRP discharges)	*319*	*387*	*456*
Projected C-section Cases (29.4%)	*94*	*114*	*134*
C-Section Operating Room Need	*1*	*1*	*1*

Source: Exhibit 20, Tables 13, 17
Note: Project year 1 begins on 1/1/2011

The previous table reflects projected C-Section cases and C-Section operating room need in the defined service area. One C-Section operating room is necessary to meet the needs of women unable to have a vaginal delivery. There are no applicable CON utilization standards for C-Section ORs in either the SMFP or the Criteria and Standards for Surgical Services. The proposed C-Section operating room will not be located in the Surgical Services at RRMC-S; it will be located in the LDRP suite."

However, the applicants did not adequately demonstrate the basis for assuming that the C-Section rates at RRMC-S in Rowan County would be similar to those at PHH and PHM in Mecklenburg County. In addition, the projections of obstetric cases were overstated and based on unreasonable assumptions. Thus, projected C-Section cases which are based on a percentage of projected obstetric cases, are also overstated. Further, because the applicants did not adequately demonstrate the need for obstetric services at the new hospital, the applicants did not adequately demonstrate the need for a dedicated C-Section room at RRMC-S.

Projected Surgical Cases and Operating Room Need

The applicants propose to relocate three existing shared operating rooms (ORs) from RRMC to RRMC-S. On page 55 of the application, the applicants state

"Projected surgical cases and shared operating room need were determined as follows:

2006 Inpatient and Outpatient Surgical Use Rates Rowan and Cabarrus County

Inpatient and outpatient surgical cases from Cabarrus and Rowan Counties were aggregated from the 2007 Hospital License Renewal Applications and the 2007 Freestanding Ambulatory Surgery Center Annual Licensure Renewal Applications. County population estimates for 2006 were obtained from Claritas. Inpatient and outpatient surgical use rates in hospitals for FFY 2006 were calculated for Cabarrus and Rowan Counties, respectively, and are shown in the following table.

FFY 2006 Inpatient and Outpatient Surgical Use Rates

Zip Code	*County*	*City/Town*	*Inpatient Surgical Use Rate*	*Outpatient Surgical Use Rate*
28023	*Rowan*	*China Grove*	*32.2*	*85.8*
28025	*Cabarrus*	*Concord*	*32.6*	*78.4*
28027	*Cabarrus*	*Concord*	*32.6*	*78.4*
28081	*Rowan/Cabarrus*	*Kannapolis*	*32.4*	*81.9*
28083	*Rowan/Cabarrus*	*Kannapolis*	*32.4*	*81.9*
28088	*Rowan*	*Landis*	*32.2*	*85.8*
28138	*Rowan/Cabarrus**	*Rockwell*	*32.2*	*85.8*

Source: Exhibit 20, Tables 18 and 19, 2007 Hospital LRAs, 2007 Freestanding ASC LRAs
* Project analyst added Cabarrus County

The county specific surgical use rate for each zip code was used to determine total inpatient and outpatient surgery and RRMC market share in the defined service area for the first three years of the proposed project. For the two Kannapolis zip codes that fall in both Rowan and Cabarrus Counties, a weighted average of the two counties was used.

Projected Surgical Market Share in the Defined Service Area

Using FFY 2006 inpatient and outpatient surgical case data from the RRMC internal Trendstar database, the applicant calculated the RRMC surgical market share for each zip code in the defined service area. Trendstar data are included in Exhibit 20, Tables 18 and 19. The following table shows actual RRMC inpatient and outpatient surgical cases, total inpatient and outpatient surgical cases, and RRMC market share for each of the seven zip codes in the defined service area.

RRMC Surgical Market Share in the Defined Service Area
FFY 2006

Zip Code	*City/Town*	*RRMC Surgical Cases*	*Total Surgical Cases*	*RRMC Market Share*
Inpatient				
28023	*China Grove*	*17*	*433*	*3.9%*
28025	*Concord*	*0*	*1,488*	*0.0%*
28027	*Concord*	*0*	*1,522*	*0.0%*
28081	*Kannapolis*	*1*	*773*	*0.1%*
28083	*Kannapolis*	*0*	*686*	*0.0%*
28088	*Landis*	*3*	*93*	*3.2%*
28138	*Rockwell*	*11*	*342*	*3.2%*
Outpatient				
28023	*China Grove*	*30*	*1,154*	*2.6%*
28025	*Concord*	*2*	*3,575*	*0.1%*
28027	*Concord*	*0*	*3,658*	*0.0%*
28081	*Kannapolis*	*6*	*1,954*	*0.3%*
28083	*Kannapolis*	*1*	*1,733*	*0.1%*
28088	*Landis*	*2*	*249*	*0.8%*
28138	*Rockwell*	*39*	*912*	*4.3%*

Source: RRMC Trendstar Internal Data; Exhibit 20, Tables 18 and 19

Actual RRMC market share was then adjusted to reflect the percent market shift and the projected increase in market share. The following table shows RRMC-S's future market share of the defined service area.

Projected Surgical Market Share
Project Year 3

Zip Code	*City/Town*	*Current RRMC Mkt. Share*	*Percent Market Share Shift*	*Projected Market Share Increase*	*RRMC's Market Share PY 3*
		A	*B*	*C*	*D =A*B+C*
Inpatient					
28023	*China Grove*	*3.9%*	*55%*	*20%*	*22.2%*
28025	*Concord*	*0.0%*	*65%*	*10%*	*10.0%*
28027	*Concord*	*0.0%*	*65%*	*7.5%*	*7.5%*
28081	*Kannapolis*	*0.1%*	*60%*	*25%*	*25.1%*
28083	*Kannapolis*	*0.0%*	*60%*	*25%*	*25.0%*
28088	*Landis*	*3.2%*	*60%*	*20%*	*21.9%*
28138	*Rockwell*	*3.2%*	*50%*	*15%*	*16.6%*
Outpatient					
28023	*China Grove*	*2.6%*	*55%*	*20%*	*21.4%*
28025	*Concord*	*0.1%*	*65%*	*10%*	*10.0%*
28027	*Concord*	*0.0%*	*65%*	*7.5%*	*7.5%*
28081	*Kannapolis*	*0.3%*	*60%*	*25%*	*25.2%*
28083	*Kannapolis*	*0.1%*	*60%*	*25%*	*25.0%*
28088	*Landis*	*0.8%*	*60%*	*20%*	*20.5%*
28138	*Rockwell*	*4.3%*	*50%*	*15%*	*17.1%*

Source: Exhibit 20, Tables 18 and 19

RRMC-S also assumed that the proposed market share shift will occur gradually over the first three years of operation, realizing 70% of projected market share in Project Year 1, 85% in Project Year 2, and 100% in Project Year 3.

RRMC-S Inpatient and Outpatient Surgical Market Share
Project Years 1-3

Zip Code	***City/Town***	***PY 1***	***PY 2***	***PY 3***
Inpatient				
28023	*China Grove*	*15.5%*	*18.8%*	*22.2%*
28025	*Concord*	*7.0%*	*8.5%*	*10.0%*
28027	*Concord*	*5.3%*	*6.4%*	*7.5%*
28081	*Kannapolis*	*17.6%*	*21.3%*	*25.1%*
28083	*Kannapolis*	*17.5%*	*21.3%*	*25.0%*
28088	*Landis*	*15.4%*	*18.6%*	*21.9%*
28138	*Rockwell*	*11.6%*	*14.1%*	*16.6%*
Percent of Project Year 3 Market Share		*70%*	*85%*	*100%*
Outpatient				
28023	*China Grove*	*15.0%*	*18.2%*	*21.4%*
28025	*Concord*	*7.0%*	*8.5%*	*10.0%*
28027	*Concord*	*5.3%*	*6.4%*	*7.5%*
28081	*Kannapolis*	*17.6%*	*21.4%*	*25.2%*
28083	*Kannapolis*	*17.5%*	*21.3%*	*25.0%*
28088	*Landis*	*14.3%*	*17.4%*	*20.5%*
28138	*Rockwell*	*12.0%*	*14.6%*	*17.1%*
Percent of Project Year 3 Market Share		*70%*	*85%*	*100%*

Source: Exhibit 20, Tables 18 and 19
Note: Project Year 1 begins on 1/1/2011

The projected market share for each zip code was used to determine projected inpatient and outpatient surgical cases by zip code in the defined service area for the first three years of the proposed project. RRMC-S also assumed that the proposed market share shift will occur over the first three years of operation, realizing 70% of projected market share in Project Year 1, 85% in Project Year 2 and 100% in Project Year 3.

<u>Projected Surgical Cases in Defined Service Area</u>

RRMC-S projected surgical utilization for the first three years of operation using the following methodology:

Projected Inpatient Surgical Cases = (Defined Service Area Population x Inpatient Surgical Use Rate x Market Share) + 'Other In-migration'

AND

Projected Outpatient Surgical Cases = (Defined Service Area population x Outpatient Surgical Use Rate x Market Share) + 'Other In-migration'

RRMC-S projected surgical cases by zip code are reflected in the Projected in-migration and total surgical cases also are included.

RRMC-S Projected Surgical Cases
Project Year 1-3

Zip Code	***City/Town***	***PY 1 2011***	***PY 2 2012***	***PY 3 2013***
Inpatient Surgical Cases				
28023	*China Grove*	*68*	*83*	*98*
28025	*Concord*	*112*	*138*	*165*
28027	*Concord*	*90*	*112*	*135*
28081	*Kannapolis*	*140*	*171*	*203*
28083	*Kannapolis*	*126*	*155*	*184*
28088**	Landis	*14*	*155*	*20*
28138**	Rockwell	*42*	*17*	*62*
Total Inpatient Surgical Cases In Defined Service Area		*593*	*729*	*868*
Other In-migration (10%)		*66*	*81*	*96*
Total Inpatient Surgical Cases		*659*	*810*	*964*
Outpatient				
28023	*China Grove*	*176*	*215*	*254*
28025	*Concord*	*271*	*334*	*399*
28027	*Concord*	*216*	*269*	*324*
28081	*Kannapolis*	*356*	*435*	*515*
28083	*Kannapolis*	*319*	*391*	*465*
28088**	Landis	*35*	*43*	*51*
28138**	Rockwell	*116*	*143*	*170*
Total Outpatient Surgical Cases In Defined Service Area		*1,489*	*1,830*	*2,178*
Other In-migration (10%)		*165*	*203*	*242*
Total Outpatient Surgical Cases		*1,655*	*2,033*	*2,419*

Source: Exhibit 20, Tables 18 and 19 Note: Project Year 1 begins on 1/1/2011.
Numbers may not sum due to whole unrounded figures used in calculations.
**The applicants omitted these zip codes from the table shown on page 56 of the application, but provided them in Exhibit 20, Tables 18 & 19.

Total projected surgical cases reflected in the previous table for CY 2011-2013 were used to project shared operating rooms need for RRMC-S.

<u>Projected Shared Operating Room Need in the Defined Service Area</u>

Projected inpatient and outpatient surgical cases were used to project shared operating rooms needed at RRMC-S using the case weighting and operating room capacity assumptions used in the State Medical Facilities Plan Operating Room need methodology. The following table reflects the operating rooms needed.

	PY 1 2011	**PY 2 2012**	**PY 3 2013**
Total Inpatient Surgical Cases	659	810	964
C-Sections	94	114	134
Inpatient w/o C-Sections	565	696	830
Total Outpatient Surgical Cases	1,655	2,033	2,419
Weighted Procedures w/o C-Sections	4,178	5,136	6,118
OR Need @ Planning Capacity	2.2	2.7	3.3

Source: Exhibit 20, Tables 18 and 19
Note: Project Year 1 begins on 1/1/2011

The previous table shows projected inpatient and outpatient surgical cases and the resulting shared operating rooms needed based upon the State Medical Facilities Plan Surgical Operating Room Need Methodology, inpatient surgical case weighting of 3.0 hours per case, outpatient surgical case weighting of 1.5 hours per case, and a planning capacity target of 1,872 operating hours per year, which results in a need at RRMC-S for 4 shared surgical operating rooms in CY 2013."

However, the applicants did not provide a statistical basis for how the projected incremental increases in surgical market share were determined for each zip code. It should be noted that these increases, which range from 7.5% to 25%, are in addition to the market share to be shifted from RRMC. Thus, the applicants did not adequately demonstrate that inpatient and outpatient surgery projections for the proposed new hospital are based on reasonable and supported assumptions. Further, the applicants failed to demonstrate that the existing ORs at CMC-NorthEast lack sufficient capacity to meet the needs of the population proposed to be served. As illustrated in the table below, the project analyst determined that CMC-NorthEast's 17 ORs are not fully utilized, because only 14.4 ORs are needed to accommodate the hospital's current inpatient and outpatient surgical utilization, as calculated by the project analyst in the following table:

CMC-NORTHEAST	FFY 2007
Inpatient Surgical Cases	6,412
Open Heart	257
C-Sections	907
Inpatient w/o C-Sections & Open Heart	5,248
Total Outpatient Surgical Cases	7,509
OR hours w/o C-Sections & Open Heart	27,007
Shared ORs	17
OR Need @ Planning Threshold (1,872 hrs/rm)	14.4

Source: CMC-NorthEast 2008 HLRA

In summary, the applicants did not adequately demonstrate the need for three shared ORs at RRMC-S.

Projected GI Endoscopy Procedures and GI Endoscopy Procedure Room Need

The applicants propose to relocate one of four existing GI endoscopy procedure rooms located at RRMC to RRMC-S, the new hospital in Kannapolis. On page 60, the applicants state

> *"Projected GI endoscopy cases, cases per procedure, and GI endoscopy procedure room need were determined as follows:*
>
> *2006 GI Endoscopy Use Rate Rowan and Cabarrus County*
>
> *GI endoscopy cases performed in hospitals and ASCs on residents from Cabarrus and Rowan Counties were aggregated from the 2007 Hospital License Renewal Applications and the 2007 Freestanding Ambulatory Surgery Center Annual Licensure Renewal Applications. County population estimates for 2006 were obtained from Claritas. The GI endoscopy use rate per 1,000 population for FFY 2006 was calculated for Cabarrus and Rowan Counties, respectively, and are reflected in the following table.*

FFY 2006 GI Endoscopy Use Rate

Zip Code	*County*	*City/Town*	*GI Endoscopy Use Rate*
28023	*Rowan*	*China Grove*	*42.9*
28025	*Cabarrus*	*Concord*	*40.6*
28027	*Cabarrus*	*Concord*	*40.6*
28081	*Rowan/Cabarrus*	*Kannapolis*	*41.7*
28083	*Rowan/Cabarrus*	*Kannapolis*	*41.7*
28088	*Rowan*	*Landis*	*42.9*
28138	*Rowan/Cabarrus**	*Rockwell*	*42.9*

Source: Exhibit 20, Table 20, 2007 Hospital LRAs, 2007 Freestanding ASC LRAs

The county specific GI endoscopy use rate was used to determine total GI endoscopy cases and RRMC market share by zip code in the defined service area for the first three years of the proposed project. For the two Kannapolis zip codes that fall in both Rowan and Cabarrus Counties, a weighted average of the two counties was used.

Projected GI Endoscopy Market Share in the Defined Service Area.

Using FFY 2007 GI endoscopy case data from the RRMC internal Trendstar database, the applicant calculated the RRMC market share for each zip code in the defined service area. Trendstar data are included in Exhibit 20, Table 20. The following table shows RRMC GI endoscopy cases, total GI endoscopy cases, and RRMC market share for each of the seven zip codes in the defined service area.

RRMC GI Endoscopy Market Share
Project Year 3

Zip Code	*County*	*Current RRMC Mkt Share*	*Percent Market Share Shift*	*Projected Market Share Increase*	*RRMC-S Market Share PY 3*
		A	*B*	*C*	*D=A*B+C*
28023	*Rowan*	*27.9%*	*55%*	*20%*	*35.4%*
28025	*Cabarrus*	*0.1%*	*65%*	*10%*	*10.1%*
28027	*Cabarrus*	*0.2%*	*65%*	*7.5%*	*7.6%*
28081	*Rowan/Cabarrus*	*2.0%*	*60%*	*25%*	*26.2%*
28083	*Rowan/Cabarrus*	*1.8%*	*60%*	*25%*	*26.1%*
28088	*Rowan*	*16.9%*	*60%*	*20%*	*30.1%*
28138	*Rowan/Cabarrus**	*39.6%*	*50%*	*15%*	*34.8%*

Source: Exhibit 20, Table 20

RRMC-S also assumed that the proposed market share shift will occur gradually over the first three years of operation, realizing 70% of projected market share in Project Year 1, 85% in Project Year 2, and 100% in Project Year 3.

GI Endoscopy Market Share
Project Years 1-3

Zip Code	***City/Town***	***PY 1 2011***	***PY 2 2012***	***PY 3 2013***
28023	*China Grove*	*24.7%*	*30.0%*	*35.4%*
28025	*Concord*	*7.0%*	*8.6%*	*10.1%*
28027	*Concord*	*5.3%*	*6.5%*	*7.6%*
28081	*Kannapolis*	*18.3%*	*22.3%*	*26.2%*
28083	*Kannapolis*	*18.3%*	*22.2%*	*26.1%*
28088	*Landis*	*21.1%*	*25.6%*	*30.1%*
28138	*Rockwell*	*24.4%*	*29.6%*	*34.8%*
Percent of Project Year 3 Market Share		*70%*	*85%*	*100%*

Source: Exhibit 20, Table 20
Note: Project year 1 begins on 1/1/2011

The projected market share for each zip code was used to determine projected GI endoscopy cases by zip code in the defined service area for the first three years of the proposed project.

Projected GI Endoscopy Cases in Defined Service Area

RRMC-S projected GI endoscopy cases for the first three *years of operation using the following methodology:*

Projected GI Endoscopy Cases = (Defined Service Area Population x GI Endoscopy Use Rate x Market Share) + 'Other In-migration.'

RRMC-S projected GI Endoscopy Cases by zip code are reflected in the following table.

Projected 'Other In-migration' and total GI endoscopy cases also are included.

Projected GI Endoscopy Cases
Project Years 1-3

Zip Code	*City/Town*	*PY 1 2011*	*PY 2 2012*	*PY 3 2013*
28023	*China Grove*	*146*	*177*	*210*
28025	*Concord*	*140*	*173*	*207*
28027	*Concord*	*113*	*141*	*170*
28081	*Kannapolis*	*188*	*230*	*273*
28083	*Kannapolis*	*169*	*208*	*247*
28088	*Landis*	*26*	*32*	*37*
28138	*Rockwell*	*118*	*145*	*173*
Total GI Endoscopy Cases in Defined Service Area		*901*	*1,106*	*1,316*
Other In-migration (10%)		*100*	*123*	*146*
Total GI Endoscopy Cases		*1,001*	*1,229*	*1,462*

Source: Exhibit 20, Table 20 Note: Project year 1 begins 1/1/2011
Numbers may not sum due to whole unrounded figures used in calculation.

Total projected GI endoscopy cases reflected in the previous table for CY 2011-2013 were used to project GI endoscopy procedures and GI endoscopy procedure rooms needed for RRMC-S.

Projected GI Endoscopy Procedures and GI Endoscopy Procedure Room Need in the Defined Service Area.

2007 Hospital License Renewal Application GI endoscopy data for RRMC were analyzed to determine that 1.3 GI endoscopy procedures are performed per endoscopy case at RRMC. Projected GI endoscopy cases were multiplied by 1.3 procedures per case to determine projected total GI endoscopy procedures and GI endoscopy procedure room need as shown in the following table.

Projected GI Endoscopy Procedures and GI Endoscopy Procedure Room Need

	PY 1 2011	*PY 2 2012*	*PY 2013*
Total GI Endoscopy Cases	*1,001*	*1,229*	*1,462*
GI Endoscopy Procedures per Case	*1.3*	*1.3*	*1.3*
Total GI Endoscopy Procedures	*1,301*	*1,598*	*1,901*
GI Endoscopy Procedure Rooms Needed @Planning Capacity	*1*	*1*	*1*

Source: Exhibit 20, Tables 20, 2007 RRMC Hospital LRA
Note: Project Year 1 begins on 1/1/2011

The previous table reflects total GI endoscopy procedures, and GI endoscopy procedure room need based upon RRMC-S defined GI endoscopy case weighting of 0.75 hours per case and a planning capacity target of 2,134 cases,

which results in a need at RRMC-S for 1 GI endoscopy procedure room in CY 2013."

However, the applicants did not provide a statistical basis for how the projected incremental increases in GI endoscopy market share were determined for each zip code area. It should be noted that these increases, which range from 7.5% to 25%, are in addition to the market share to be shifted from RRMC. Thus, the applicants did not adequately demonstrate that the numbers of GI endoscopy cases projected to be performed at the new hospital are based on reasonable and supported assumptions. Therefore, the applicants did not adequately demonstrate the need for one GI endoscopy procedure room to be relocated to RRMC-S.

Projected Hospital Outpatient Visits

The applicants did not identify the various services included in the following "*outpatient visits*" projections for RRMC-S. On page 64 of the application, the applicants state

"2005 North Carolina Hospital Outpatient Visit Use Rate

RRMC-S used the North Carolina Hospital Outpatient Visit Use Rate for community hospitals defined by the American Hospital Association to project RRMC-S outpatient visits. Data complied from the AHA Annual Survey are used to calculate state specific utilization rates.

The 2005 North Carolina Outpatient Visit Use Rate was 1,937 visits per 1,000 population as reflected in Exhibit 20, Table 21. RRMC-S used the 2005 North Carolina Outpatient Visit Use Rate to determine total outpatient visits and RRMC market share by zip code in the defined service area for the first three years of the proposed project.

Projected Outpatient Visits in the Defined Service Area

Using FFY 2006 outpatient visit data from the RRMC Internal Trendstar database, the applicant calculated the RRMC market share for each zip code in the defined service area. Trendstar data are included in Exhibit 20, Table 21.

…

Actual RRMC market share was adjusted to reflect the percent market shift and the projected increase in market share. Due to the presence of free standing ambulatory surgery centers as well as hospital outpatient services, more patients in the defined service area have a choice of providers. Therefore the percent increase in market share for outpatient visits was projected at a slightly lower

percent than for other services, as reflected in the following table. The following table shows RRMC-S's future market share of the defined service area.

Projected Outpatient Visit Market Share

Zip Code	*County*	*Current RRMC Mkt Share*	*Percent Market Share Shift*	*Projected Market Share Increase*	*RRMC-S Market Share PY 3*
		A	*B*	*C*	*D=A*B+C*
28023	*Rowan*	*0.9%*	*55%*	*15%*	*15.5%*
28025	*Cabarrus*	*0.0%*	*65%*	*5%*	*5.0%*
28027	*Cabarrus*	*0.0%*	*65%*	*2.5%*	*2.5%*
28081	*Rowan/Cabarrus*	*0.1%*	*60%*	*20%*	*20.0%*
28083	*Rowan/Cabarrus*	*0.0%*	*60%*	*20%*	*20.0%*
28088	*Rowan*	*0.6%*	*60%*	*15%*	*15.4%*
28138	*Rowan/Cabarrus**	*1.1%*	*50%*	*10%*	*10.5%*

Source: Exhibit 20, Table 21.
**Project analyst added Cabarrus County*

RRMC-S also assumed that the proposed market share shift will occur gradually over the first three years of operation, realizing 70% of projected market share in Project Year 1, 85% in Project Year 2, and 1005 in Project Year 3.

…

The projected market share for each zip code was used to determine projected outpatient visits by zip code in the defined service area for the first three years of the proposed project.

<u>Projected Outpatient Visits in the Defined Service Area</u>

RRMC-S projected outpatient visits for the first three years of operation using the following methodology:

Projected Outpatient Visits = (Defined Service Area Population x North Carolina Hospital
Outpatient Visit Use Rate x Market Share) + 'Other In-migration'

RRMC-S projected outpatient visits by zip code in the defined service area are shown in the following table. Projected 'Other In-migration' and total outpatient visits also are included.

Projected Outpatient Visits
Project Years 1-3

Zip Code	*City/Town*	*PY 1 2011*	*PY 2 2012*	*PY 3 2013*
28023	*China Grove*	*2,875*	*3,504*	*4,137*
28025	*Concord*	*3,332*	*4,110*	*4,911*
28027	*Concord*	*1,779*	*2,213*	*2,666*
28081	*Kannapolis*	*6,694*	*8,186*	*9,698*
28083	*Kannapolis*	*6,033*	*7,403*	*8,801*
28088	*Landis*	*601*	*729*	*856*
28138	*Rockwell*	*1,611*	*1,980*	*2,358*
Total Outpatient Visits in Defined Service Area		*22,925*	*28,123*	*33,427*
Other In-migration (10%)		*2,547*	*3,125*	*3,714*
Total Outpatient visits		*25,472*	*31,248*	*37,142*

Source: Exhibit 20, Table 21
Note: Project Year 1 begins 1/1/2011

The previous table reflects total outpatient visits at RRMC-S in the defined service area for the first three years of the proposed project."

However, the applicants did not demonstrate the need for additional outpatient services in the proposed service area relative to existing outpatient services currently offered and those services recently approved or proposed, as indicated in the following table:

Carolinas HealthCare System & CMC-NorthEast	**Novant**	**RRMC**
NorthEast Outpatient Center-Copperfield (existing)	Presbyterian Diagnostic Center at Cabarrus – Concord (proposed)	South Rowan Medical Mall – China Grove (existing)
NorthEast Pavilion –Concord (existing)		
NorthEast Outpatient Rehab Center – Concord (existing)		
Southern Piedmont Imaging – Kannapolis (approved)		
Renaissance Square – Davidson (existing)		
CMC-Kannapolis – Kannapolis (approved)		

The outpatient facilities identified above offer an array of outpatient diagnostic, imaging and physician services to residents of the proposed service area. For example, NorthEast Outpatient Center in Copperfield offers outpatient surgery, endoscopy procedures, pain management, and diagnostic imaging services, including CT, MRI, X-ray, ultrasound, and mammography. NorthEast Pavilion offers outpatient oncology and cardiology diagnostic and treatment services. NorthEast Renaissance Square provides women's health services, diagnostic and imaging services, and internal medicine and pediatric services. CMC-NorthEast operates an outpatient rehabilitation center in

Concord for physical therapy, occupational therapy, speech therapy and other rehab services, and Southern Piedmont Imaging Center was recently approved to provide diagnostic and imaging services to Kannapolis and the surrounding area. Also, RRMC owns South Rowan Medical Mall in China Grove, but the applicants did not provide a description of the outpatient diagnostic imaging services offered at this location. Therefore, given all of the above resources, the applicants failed to demonstrate that there is not sufficient existing or approved capacity in the area to meet the outpatient needs of the population proposed to be served.

Further, the applicants did not provide a statistical basis for how the projected incremental increases in outpatient visits market share were determined for each zip code area. It should be noted that these increases, which range from 2.5% to 20%, are in addition to the market share to be shifted from RRMC. Thus, the applicants did not adequately demonstrate that the projected numbers of outpatient visits to be proposed at the new hospital are based on reasonable and supported assumptions. Therefore, the applicants did not adequately demonstrate the need for all of the outpatient visits proposed to be provided at the new hospital.

Projected Emergency Department Visits and Emergency Treatment Rooms

The applicants propose to develop a new emergency department with 12 treatment bays and two triage rooms. On page 66 of the application, the applicants state

"2005 North Carolina Emergency Department Visit Use Rate

RRMC-S used the North Carolina Emergency Department Visit Use Rate for community hospitals defined by the American Hospital Association (AHA) to project emergency department visits. Data compiled from the AHA Annual Survey are used to calculate state specific utilization rates. The 2005 North Carolina Emergency Department Visit Use Rate was 436 visits per 1,000 population as reflected in Exhibit 20, Table 22. In addition, the 2005 North Carolina Emergency Department Visit Use Rate was increased 1.3% annually to reflect the increasing use of emergency services in North Carolina and nationally.* [*Note: In footnote 19, on page 67 of the application, the applicants reference the *American College of Emergency Physicians, 'The National Report Card on the State of Emergency Medicine' www.myacep.org; The Advisory Board Company, 'Future of EDs,' June 11, 2005; 'A Growing Hole in the Safety Net: Physician Charity Care Declines Again,' Center for Health System Change, www.hschange.org; American College of Physicians-American Society of Internal Medicine, www.medicalreporter.health.org."] The projected North Carolina Emergency Department Visit Use Rate was used to determine total emergency department visits and RRMC market share by zip code in the defined service area for the first three years of the proposed project."*

As shown in the table below, the applicants assumed the ED use rates for Rowan and Cabarrus counties were the same as the North Carolina 2005 ED Use Rate (436.0 ED visits per 1,000 population).

ED Visits by County	***2005 ED Use Rate***
Cabarrus	*436.0*
Rowan	*436.0*
NC	*436.0*

Source: Exhibit 20, Table 22

Next, the applicants increased the state ED use rate by 1.3% annually from 2005 through to Project Year 2013 to project total ED visits by service area zip codes. This resulted in an ED use rate of 471.1 for PY 2011, 477.3 for PY 2012, and 483.5 for PY 2013, and projected total service area ED utilization, as shown in the table below. However, the applicants did not provide their basis for assuming an annual 1.3% increase in the ED use rate.

Zip Code	**County**	**2011**	**2012**	**2013**
ED Use Rate		471.1	477.3	483.5
Projected ED Visits				
28023	Rowan	6,455	6,562	6,672
28025	Cabarrus	23,143	23,813	24,502
28027	Cabarrus	24,730	25,656	26,618
28081	Rowan/Cabarrus	11,611	11,845	12,083
28083	Rowan/Cabarrus	10,473	10,721	10,975
28088	Rowan	1,357	1,374	1,390
28138	Rowan	5,310	5,445	5,583
Total		83,079	85,416	87,822

On page 67, the applicants state

> *"Actual RRMC market share was adjusted to reflect the percent market shift and the projected increase in market share. Due to proximity of the proposed RRMC-S Emergency Department, more patients in the defined service area will choose the closer facility for emergency services. Therefore, the percent market share shift for emergency department visits was projected at a slightly higher percent than for other services… The projected market share increase was projected five percent higher than other services in the two Kannapolis zip codes to reflect this proximity to residents in the service area.*

Projected Emergency Department Visit Market Share
Project Year 3

Zip Code	***County***	***Current RRMC Mkt Share***	***Percent Market Share Shift***	***Projected Market Share Increase***	***RRMC-S Market Share PY 3***
		A	*B*	*C*	*D=A*B+C*
28023	*Rowan*	*1.2%*	*65%*	*20%*	*20.8%*
28025	*Cabarrus*	*0.0%*	*75%*	*10%*	*10.0%*
28027	*Cabarrus*	*0.0%*	*75%*	*7.5%*	*7.5%*
28081	*Rowan/Cabarrus*	*0.1%*	*70%*	*30%*	*30.1%*
28083	*Rowan/Cabarrus*	*0.0%*	*70%*	*30%*	*30.0%*
28088	*Rowan*	*1.3%*	*70%*	*25%*	*25.9%*
28138	*Rowan/Cabarrus**	*1.6%*	*60%*	*15%*	*16.0%*

Source: Exhibit 20, Table 22.
**Project analyst added Cabarrus County*

…RRMC-S also assumed that the proposed market share shift will occur gradually over the first three years of operation, realizing 70% of the projected market share in Project Year 1, 85% in Project Year 2, and 100% in project Year 3.

…

The projected market share for each zip code was used to determine projected emergency department visits by zip code in the defined service area for the first three years of the proposed project.

Projected Emergency Department Visits and Emergency Department Treatment Room Need in the Defined Service Area.

RRMC-S projected emergency department visits for the first three years of operation using the following methodology:

Projected Emergency Department Visits + (Defined Service Area Population x North Carolina Hospital Emergency Department Visit Use Rate x Market Share) + 'Other In-migration'

RRMC-S projected emergency department visits by zip code in the defined service area are reflected in the following table. Projected 'Other In-migration' and total emergency department visits also are included.

Projected Emergency Department Visits
Project Years 1-3

Zip Code	***City/Town***	***PY 1 2011***	***PY 2 2012***	***PY 3 2013***
28023	*China Grove*	*940*	*1,161*	*1,388*
28025	*Concord*	*1,621*	*2,025*	*2,451*
28027	*Concord*	*1,298*	*1,636*	*1,996*
28081	*Kannapolis*	*2,443*	*3,026*	*3,632*
28083	*Kannapolis*	*2,200*	*2,735*	*3,293*
28088	*Landis*	*246*	*302*	*360*
28138	*Rockwell*	*593*	*739*	*891*
Total Emergency Department Visits in Defined Service Area		*9,341*	*11,623*	*14,012*
Other In-migration (10%)		*1,038*	*1,291*	*1,557*
Total Emergency Department visits		*10,379*	*12,914*	*15,569*
Emergency Treatment Rooms Needed @ Planning Capacity		*8*	*10*	*12*

Source: Exhibit 20, Table 22 Note: Project Year 1 begins 1/1/2011
Numbers may not sum due to whole unrounded figures used in calculations

The previous table reflects total emergency department visits, and emergency department treatment rooms needed based upon American College of Emergency Physicians emergency planning capacity of 1,333 Emergency Visits per Treatment Room for Emergency Departments with 20,000 Visits, included in Exhibit 20, Table 23, which results in a need at RRMC-S for 12 emergency treatment rooms in CY 2013."

However, the applicants did not provide documentation to support their assumption that the service area zip code ED use rate would increase 1.3% annually from 2005 to 2013. In addition, the applicants did not provide a statistical basis for how the projected increases in emergency department visits market share were determined for each zip code area. It should be noted that the increases, which range from 7.5% to 30%, are in addition to the market share to be shifted from RRMC. Thus, the applicants did not adequately demonstrate that the projected numbers of emergency department visits at the proposed new hospital are based on reasonable and supported assumptions. Further, on February 27, 2008, CMC-NorthEast (Project I.D. #F-7951-07) was approved for a freestanding emergency department in Kannapolis with 10 treatment rooms to expand the hospital's emergency department capacity. The applicants were aware this application had been filed but did not address the impact of its potential approval on the projected utilization at RRMC-S. In summary, the applicants did not adequately demonstrate the need the persons projected to be served have for the proposed emergency department services.

Projected Ancillary Services Utilization

On page 69 of the application, the applicants state

"Ancillary utilization projections were calculated based upon existing ancillary utilization patterns at Presbyterian Healthcare's existing community hospitals; Presbyterian Hospital Matthews (PHM) and Presbyterian Hospital Huntersville (PHH).

Revelant data was acquired from Hospital License Renewal Applications for the most recent three year timeframe available. FFY 2004 - 2006 for PHM and FFY 2005 and FFY 2006 for PHH. LRA data are included in Exhibit 20, Table 15. Data were averaged to determine the relationship between ancillary volumes and inpatient, outpatient and ED volumes. Inpatient ancillary volumes for RRMC-S were projected using the average percent of total inpatient discharges. Outpatient ancillary volumes were projected using the average percent of total outpatient and ED visits as shown in the following table.

Projected Ancillary Service Utilization: RRMC-S

	PHH & PHM	***Projected Utilization***		
	Average FFY 2004 -2006	***PY 1 2011***	***PY 2 2012***	***PY 3 2012***
MRI*				
Inpatient - % Discharges	*13.0%*	*281*	*344*	*410*
Outpatient - % Outpatient + ED	*4.5%*	*1,623*	*1,999*	*2,386*
Total MRI		*1,904*	*2,344*	*2,796*
CT				
Inpatient - % Discharges	*65.8%*	*1,420*	*1,743*	*2,073*
Outpatient - % Outpatient + ED	*29.1%*	*10,424*	*12,841*	*15,327*
Total CT		*11,845*	*14,584*	*17,400*
Nuclear Medicine				
Inpatient - % Discharges	*16.4%*	*353*	*433*	*515*
Outpatient - % Outpatient + ED	*5.1%*	*1,817*	*2,238*	*2,671*
Total Nuclear Medicine		*2,170*	*2,671*	*3,187*
Mammograms				
Inpatient - % Discharges	*0.0%*	*0*	*0*	*0*
Outpatient - % Outpatient + ED	*6.2%*	*2,237*	*2,756*	*3,290*
Total Mammograms		*2,237*	*2,756*	*3,290*
Other Radiology				
Inpatient - % Discharges	*128.1%*	*2,765*	*3,395*	*4,037*
Outpatient - % Outpatient + ED	*38.2%*	*13,706*	*16,883*	*20,151*
Total Other Radiology		*16,471*	*20,277*	*24,188*
Ultrasound				
Inpatient - % Discharges	*0.13*	*274*	*336*	*400*
Outpatient - % Outpatient + ED	*0.03*	*1,233*	*1,519*	*1,813*
Total Ultrasound		*1,507*	*1,855*	*2,213*
Pharmacy				
Inpatient - % Discharges	*30.21*	*65,190*	*80,023*	*95,176*
Outpatient - % Outpatient + ED	*0.30*	*10,810*	*13,316*	*15,893*
Total Pharmacy		*75,999*	*93,339*	*111,069*
Laboratory				
Inpatient - % Discharges	*34.36*	*74,137*	*91,007*	*108,239*
Outpatient - % Outpatient + ED	*2.82*	*100,930*	*124,328*	*148,392*
Total Laboratory		*175,067*	*215,334*	*256,631*

**MRI utilization was projected using only PHH data as PHH has a mobile MRI as proposed at RRMC-S.*
Source: Exhibit 20, Table 15

The previous table reflects total ancillary services utilization at RRMC-S in the defined service area for the first three years of the proposed project. RRMC-S will include:

- *A full-service laboratory;*
- *A full-service pharmacy;*
- *A new 64-slice CT scanner (to replace an existing CT scanner from RRMC);*

- *Other imaging equipment: Two combination x-ray/fluoroscopy units, two portable ultrasound units, one mammography unit, and one nuclear medicine camera (without coincidence circuitry), and portable chest x-ray units and fluoroscopy units for use in the ED, the ORs, and patient rooms; and*
- *A contract with vendor for mobile MRI scanner service."*

However, it should be noted that the above statements of proposed imaging services are inconsistent with the applicants' description of ancillary services provided on page 20 of the application. Specifically, on page 20, the applicants propose one combination x-ray/fluoroscopy unit and one portable ultrasound unit, compared to two fixed x-ray units and two ultrasound units shown on page 71 of the application. In the equipment list in Exhibit 8 the applicants indicate they propose to acquire two units of fixed x-ray equipment and three units of mobile x-ray equipment. Therefore, the numbers provided on page 20 appear to be typographical errors. However, Exhibit 8 shows the applicants propose to acquire three ultrasound units, rather than two as listed above. Therefore, it appears the applicants propose in Exhibit 8 to acquire more units of ultrasound equipment than they propose are needed on either page 71 or page 20. Also, the applicants did not adequately demonstrate that the numbers of inpatient discharges, outpatient visits and ED visits are based on reasonable assumptions. Therefore, projected ancillary volumes which are based on percentages of inpatient discharges, outpatient visits, and ED visits, are also not reasonable.

Laboratory – The applicants propose to develop a lab at RRMC-S. On pages 69 - 70, the applicants assume the lab at RRMC-S will perform 0.344 procedures for every inpatient discharge and 0.028 procedures for every outpatient and ED visit based on the experience at RRMC. However, since the projected numbers of lab procedures are based on a percentage of projected inpatient discharges, outpatient visits and ED visits, and these projections are overstated and unreasonable, the projected numbers of lab procedures are also unreasonable. See discussion above regarding acute care beds, outpatient visits and ED visits. Therefore, the applicants did not adequately demonstrate the need for the projected number of lab procedures at RRMC-S.

Pharmacy – The applicants propose to develop a new pharmacy at RRMC-S. On pages 69-70, the applicants assume the pharmacy at RRMC-S will dispense 0.302 pharmacy units for every inpatient discharge and 0.003 pharmacy units for every outpatient and ED visit based on the experience at RRMC. However, since the projected numbers of pharmacy units are based on percentages of the projected numbers of inpatient discharges, outpatient visits and ED visits, and these projections are overstated and unreasonable, the projected numbers of pharmacy units are also unreasonable. See discussion above regarding acute care beds,

outpatient visits and ED visits. Therefore, the applicants did not adequately demonstrate the need for the projected number of pharmacy units at RRMC-S.

CT Scanner – The applicants propose to relocate one existing CT scanner from South Rowan Medical Mall to RRMC-S and state they plan to replace it with a new 64-slice CT scanner. The applicants state on pages 69 – 70, that the total number of CT scanners located in Rowan County will not change. The applicants assume the CT scanner at RRMC-S will perform 0.658 CT scans for every inpatient discharge and 0.291 CT scans for every outpatient and ED visit based on the experience at Presbyterian Hospital Matthews and Presbyterian Hospital Huntersville. However, since the projected numbers of CT scans to be performed are based on percentages of the projected numbers of inpatient discharges, outpatient visits and ED visits, and these projections are overstated and unreasonable, the projected numbers of CT scans to be performed are also unreasonable. See discussion above regarding acute care beds, outpatient visits and ED visits. Therefore, the applicants did not adequately demonstrate the need for the CT services proposed to be provided at the proposed RRMC-S campus.

Ultrasound (US) – In Section II.1, page 20, the applicants state that RRMC-S will have one US unit and on page 71, they propose two US units. However, according to the list of equipment to be acquired provided in Exhibit 18, the applicants propose to acquire 3 US units. On pages 69-70, the applicants assume the US equipment at RRMC-S will perform 0.0013 procedures for every inpatient discharge and 0.0003 procedures for every outpatient and ED visit based on the experience at RRMC**.** Based on the above projections if two US units are acquired, the applicants would perform an average of 3.0 procedures per unit per day [2,213 / 2 / 365 = 3.03], but if three US units are acquired, the applicants would perform only 1.0 procedure per unit per day in 2013. In its Presbyterian Hospital Mint Hill application, Project ID #F7648-06, Novant states the capacity of an ultrasound unit is 5.3 US procedures per day. Based on this capacity, the proposed US units would be underutilized. Further, because the projected numbers of US procedures are based on percentages of projected numbers of inpatient discharges, outpatient visits, and ED visits, and these projections are overstated and unreasonable, the projected numbers of US procedures are also unreasonable. See discussion above regarding acute care beds, outpatient visits and ED visits. Therefore, the applicants did not adequately demonstrate the need to acquire two or three ultrasound units to be located at RRMC-S.

Nuclear Medicine Camera – The applicants propose to acquire one new nuclear medicine camera (gamma camera) to be located at RRMC-S, as stated on page 20 of the application. The applicants assume the nuclear medicine camera at RRMC-S will perform 0.164 procedures for every inpatient discharge and 0.051 procedures for every outpatient and ED visit based on the experience at Presbyterian Hospital Matthews and Presbyterian Hospital Huntersville. However, because the projected numbers of nuclear medicine camera procedures

are based on percentages of the projected numbers of inpatient discharges, outpatient visits and ED visits, and these projections are overstated and unreasonable, the projected numbers of nuclear medicine camera procedures to be performed at RRMC-S are also unreasonable. See discussion above regarding acute care beds, outpatient visits, and ED visits. Therefore, the applicants did not adequately demonstrate the need to acquire a nuclear medicine camera to be located at RRMC-S.

Mammography Unit – The applicants propose to acquire one new mammography unit to be located at RRMC-S, on page 20 of the application. The applicants assume the mammography unit at RRMC-S will perform 0.062 procedures for every outpatient and ED visit based on the experience at Presbyterian Hospital Matthews and Presbyterian Hospital Huntersville. However, since the projected numbers of mammography procedures are based on percentages of the projected numbers of outpatient and ED visits, and these projections are unreasonable, the projected numbers of mammography procedures are also unreasonable. See discussion above regarding outpatient and ED visits. Therefore, the applicants did not adequately demonstrate the need to acquire two units of mammography equipment to be located at RRMC-S.

X-ray Equipment – In Section II.1, page 20, the applicants state that they will acquire one combination x-ray/flouroscopy unit, two portable multi-use C-arm and one portable mini C-arm x-ray units for RRMC-S. However, according to the statements on page 71 and the list of equipment to be acquired provided in Exhibit 18, the applicants propose to acquire two fixed digital x-ray units, not one. The applicants assume that the x-ray equipment at RRMC-S will perform 1.281 procedures for every inpatient discharge and 0.382 procedures for every outpatient and ED visit based on the experience at Presbyterian Hospital Matthews and Presbyterian Hospital Huntersville. However, since the projected numbers of x-ray procedures are based on percentages of the projected numbers of inpatient discharges, outpatient visits and ED visits, and these projections are not reasonable, the projected numbers of x-ray procedures are also not reasonable. See discussion above regarding acute care beds, outpatient and ED visits. Therefore, the applicants did not adequately demonstrate the need to acquire the proposed x-ray equipment to be located at RRMC-S.

In summary, the applicants did not adequately demonstrate the need for all of the proposed services. Therefore, the application is nonconforming with this criterion.

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

NC

The applicants propose to relocate the following beds and services from Salisbury to Kannapolis:

- 50 existing acute care beds,
- 3 existing shared ORs,
- 1 dedicated C-Section OR, and
- 1 GI endoscopy procedure room.

In addition, the applicants propose to relocate one CT scanner from China Grove to Kannapolis.

On page 83 of the application, the applicants state

> *"The relocation of 50 acute beds, four OR's (one of which is a dedicated C-section room), one endoscopy procedure room and one CT scanner from RRMC to RRMC-S will not have a negative impact on the patients served at RRMC in terms of changes in services, the impact on costs and charges, or the level of access for medically underserved patients. RRMC will remain a licensed acute care hospital with a capacity of 173 acute care beds, 10 inpatient rehabilitation beds, 15 substance abuse beds, 20 psychiatric beds, 6 unlicensed observation beds, 8 operating rooms (one of which is a C-Section room), 3 endoscopy procedure rooms, and 3 CT scanners. RRMC will continue to operate as a full service hospital and will have ample time to plan between now and January 2011 (the opening date for RRMC-S) for how to re-configure and/or renovate its resources to accomplish this."*

The applicants summarize future acute care bed utilization of RRMC in the table below.

RRMC Projected Utilization

	CY 2008	CY 2009	CY 2010	CY 2011	CY 2012	CY 2013
Total Discharges	8,689	8,741	8,793	8,845	8,898	8,951
Increase Due to Novant	5%	10%	15%	20%	21%	22%
Total Discharges with Novant	9,124	9,615	10,112	10,614	10,766	10,920
Additional Discharges	435	874	1,319	1,769	1,868	1,969
Discharges with RRMC-S	9,124	9,615	10,112	10,249	10,319	10,389
ALOS	4.4	4.4	4.4	4.4	4.4	4.4
Total Days of Care	39,798	41,941	44,108	44,704	45,010	45,316
Licensed Beds	223	223	223	173	173	173
Licensed Occupancy	48.9%	51.5%	54.2%	70.8%	71.3%	71.8%

Source: Exhibit 20 Table 26 (1 & 2)

As shown in the above table, the applicants project that RRMC in Salisbury will provide 45,316 acute care patient days during the third operating year, which is an occupancy rate of 71.8%. Because the applicants' total days of care are overestimated, the occupancy rate of the 173 beds remaining at RRMC will be even lower than 71.8%. Additionally, as reported to the Thomson database, only 36,768 acute days of care were provided at RRMC in FY 2007, which is an ADC of 101 patients. Thus, based on current utilization, 173 beds would be more than adequate to meet the needs of the population presently served. Therefore, the proposed reduction of 50 beds would not affect the ability of the population to be served in Salisbury to continue to receive needed acute care services.

Shared Operating Rooms

RRMC proposes to relocate three existing shared ORs to RRMC-S. The table below shows the number of ORs currently located at RRMC.

RRMC ORs 2006 (Excluding C-Section)

Type of Room	Number of Rooms
Dedicated Ambulatory Surgery (Julian Rd.)	3
Shared Inpatient/Ambulatory (Main Hospital)	8
Total ORs (Excluding C-Section)	11

Source: RRMC 2008 HLRA

Thus, following the relocation of three shared ORs, there would be five shared operating rooms in the hospital and three operating rooms in the ambulatory surgery facility, for a total of eight ORs remaining at RRMC in Salisbury, excluding the dedicated C-Section operating room.

In Exhibit 20, Table 26 (2 of 2), the applicants provide the following projected surgical utilization for RRMC during the first three operating years of RRMC-S.

		Projected Acute Care Utilization Without RRMC-South			*Projected Utilization With RRMC-South*		
	FY2006	***CY 2011***	***CY 2012***	***CY 2013***	***CY 2011***	***CY 2012***	***CY 2013***
Total Discharges	*8,622*	*10,614*	*10,766*	*10,920*	*10,249*	*10,319*	*10,389*
% of Inpatient Discharges	*42.8%*	*42.8%*	*42.8%*	*42.8%*	*42.8%*	*42.8%*	*42.8%*
Inpatient Surgery	*3,686*	*4,538*	*4,603*	*4,668*	*4,381*	*4,411*	*4,441*
% of Discharges	*5.3%*	*5.3%*	*5.3%*	*5.3%*	*5.3%*	*5.3%*	*5.3%*
Outpatient Surgery	*5,514*	*6,788*	*6,885*	*6,984*	*6,554*	*6,599*	*6,644*
% Inpatient Surgery	*149.6%*	*149.6%*	*149.6%*	*149.6%*	*149.6%*	*149.6%*	*149.6%*
Weighted Surgery	*19,329*	*23,795*	*24,136*	*24,481*	*22,975*	*23,133*	*23,290*
Shared ORs needed	*10*	*13*	*13*	*13*	*12*	*12*	*12*

Source: Exhibit 20, Table 26 (1 of 2) and (2 of 2)

Based on the applicants' above calculations, the applicants indicate twelve operating rooms are needed at RRMC. However, RRMC would have only 9 operating rooms, and one of them would be a dedicated C-Section room which cannot be used for any procedures other than C-Sections. Consequently, only eight rooms will be available for general surgical procedures. Thus, given the applicants' above surgical utilization projections, which they claim show a need for 12 ORs, the applicants do not show that eight operating rooms are sufficient to meet the needs of the surgical population it projects to serve at RRMC. Therefore, the applicants failed to demonstrate that the proposed reduction of three shared ORs would not affect the ability of the population it projects to serve in Salisbury to receive needed surgical services.

<u>One Dedicated C-Section OR</u>

The applicants propose to relocate one of two existing C-Section ORs from RRMC in Salisbury to RRMC-S. However, the applicants did not provide the number of C-Section procedures projected to be performed in the one C-Section OR room remaining at RRMC through CY2013. Thus, the applicants failed to demonstrate that one C-Section OR is sufficient to meet the needs of the population they project to serve at RRMC.

<u>One GI Endoscopy Procedure Room</u>

On page 18 of the application, the applicants state

"In addition, the applicant proposes to relocate one existing, licensed GI endoscopy procedure room from RRMC to RRMC-S. Three existing GI endoscopy rooms would remain in place at RRMC. The GI endoscopy room at RRMC-S will be located on the first floor, next to the surgical suite."

However, the applicants did not provide the number of GI endoscopy

procedures projected to be performed at RRMC through CY2013, following the reduction of one GI endoscopy room at this facility. According to RRMC's 2008 LRA, GI endoscopy utilization at RRMC for FY2007 is as follows:

RRMC	FFY 2007
Total GI Endoscopy Cases	2,691
Total GI Endoscopy Procedures	4,717
GI Endoscopy Procedure Rooms Needed @1,500 procedures/room Planning Capacity	3.14

Source: RRMC 2008 HLRA

Thus, based on current utilization, more than 3 GI endoscopy procedure rooms are needed at RRMC. Because the applicants did not provide projected GI endoscopy procedures for RRMC, the applicants failed to provide sufficient information to demonstrate that 3 GI endoscopy procedures rooms are sufficient to meet the needs of the patients projected to utilize RRMC in the future for GI endoscopy services.

One CT Scanner

On pages 14-15 of the application, the applicants state that RRMC currently has seven existing CT scanners: four located at RRMC's main campus in Salisbury, two located at Imaging and Physical Rehabilitation Center in Salisbury, and one located at South Rowan Medical Mall in China Grove. On page 93 of the application, the applicants state

> *"An existing RRMC 4 slice CT scanner located at RRMC's South Rowan Medical Mall in China Grove will be removed from service and replaced with a new 64 slice CT scanner* [sic] *located at RRMC-S. The timing will be during the time of the equipping of the new RRMC-S facility in late 2012."*

On page 14 of the application, the applicants identify only one CT scanner currently located at the South Rowan Medical Mall in China Grove. If the proposal under review were approved, then there would be no CT scanner remaining at the China Grove location. Thus, this proposal represents an elimination of CT services for the population served at the China Grove facility. However, the applicants did not indicate where the patients who currently receive CT services at China Grove will go for services after the only CT scanner at this site is moved to RRMC-S. Therefore, the applicants failed to demonstrate that the needs of the population presently served at the China Grove facility will be adequately met following the relocation of CT services to RRMC-S.

In summary, the application is nonconforming with this criterion.

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

NC

In Section II.5, pages 24-28, the applicants discussed several alternatives they considered prior to submission of this application. However, the application is not conforming to all applicable statutory and regulatory review criteria. See Criteria (1), (3), (3a), (5), (6), (7), (8), (18a) and the criteria and standards in 10A NCAC 14C .1200 and 10A NCAC 14C .1400. The applicants did not adequately demonstrate that their proposal is an effective alternative. Therefore, the application is nonconforming with this criterion and is denied.

(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.

NC

In Section VIII.1, page 133, the applicants project the total capital cost of the project will be $109,207,185 which includes: construction costs of $64,621,536, site costs of $6,835,770, equipment costs of $22,464,296, architect and engineering fees of $2,758,172, and other miscellaneous costs of $12,527,411.

In Section IX, page 149 the applicants project that start up and initial operating expenses will be $14,079,000. In Section VIII.3, page 133 and Section IX, page 149, the applicants state the capital and working capital needs of the project will be financed with the accumulated reserves of RRMC. Exhibit 9 includes a letter signed by the Chief Financial Officer for Novant Health, Inc. which states

"As the Chief Financial Officer for Novant Health, Inc., I have authority to obligate funds from accumulated reserves of Novant Health. I can and will commit Novant's reserves to cover all of the capital costs associated with the CON application to build Rowan Regional Medical Center-South, including the project capital cost of up to $110 million. Novant and Rowan Regional Medical Center-South will enter into a lease agreement,

whereby RRMC-South will make lease payments to Novant in exchange for Novant's commitment to financing the proposed project.

Novant's CY 2006 Balance Sheet from the Novant Health, Inc. audited financial statements indicate that as of year end 2006 Novant had an ending Current Assets balance of $737,170,000 and an ending Longer-term Assets balance of $1,011,287,000 for a total of almost $2 billion dollars in total assets that can be used by Novant for capital expenditures. These balance sheet amounts are available to fund the proposed project. In addition, based on past performance, Novant expects to continue generating capital available for such projects, at a rate of over $200 million annually.

In addition, Novant and Rowan Regional Medical Center-South, LLC reserve the right to consider in the future funding of all or a portion of this project using bond proceeds. Our financial staff will make this determination based on market and economic conditions at the time the capital is required. A letter from Wachovia Securities indicating the appropriateness of this project for tax-exempt bond financing is also included as an Exhibit in the CON application."

Exhibit 9 also contains a letter signed by the Chief Financial Officer for RRMC, which states

"As the Chief Financial Officer for Rowan Regional Medical Center, Inc., I have authority to obligate funds from accumulated reserves of RRMC. I can and will commit RRMC's reserves to cover all of the working capital costs and start-up associated with the CON application to build Rowan Regional Medical Center-South. RRMS has sufficient cash to cover the working capital and start-up cost for the proposed new hospital project in the amount specified in section IX of the CON application. Please see the Current Assets section of the Rowan Regional Medical Center balance sheet contained in Rowan Regional Medical Center's 2006 audited financial statements, which are included as an exhibit in the CON application."

Novant Health also has sufficient cash to cover the working capital needs for the proposed new hospital project in the amount specified in section IX of the CON application. Please see the Current Assets section of the Novant Health Balance sheet contained in Novant Health's 2005 audited financial statements, which are included as an exhibit with our CON application.

I confirm to you that Novant has now and will have available the funds from reserves for the project. This will not impact Novant's ability to

finance CON projects that are approved and not yet operational or currently under CON review."

Exhibit 9 also contains a letter signed by the Managing Director of Wachovia Securities, which states

"You have advised Wachovia Securities ('Wachovia') that Novant Health ('Novant') may finance the above-referenced Project from cash and accumulated reserves, through tax-exempt bond financing (the 'Bond Issue'), or through some combination thereof depending on market conditions at the time funding is required. The borrower would be Novant, a 501(c)(3) private not-for-profit corporation. The debt would be issued under the Novant Master Trust Indenture through the North Carolina Medical Care Commission. We understand that Novant Health, Inc. and Rowan Regional Medical Center will be applying for a Certificate of Need ('CON') on October 15, 2007. The CON will be for a new 50-bed Hospital with Acute, ICU, Labor and Delivery, and Observation Beds, an Emergency Department, Operating Rooms, Imaging, Laboratory, Pathology, and Pharmacy. For purposes of this letter, 'Wachovia' shall include any affiliate thereof.

…

Based upon your financial strength, Wachovia would expect to offer a publicly sold tax-exempt bond issue that would either be insured or issued with Novant's stand-alone ratings. We believe that this funding would result in an investment grade rating for the financing."

Exhibit 9 includes the audited financial statements for Novant. As of December 31, 2006, Novant had $420,107,000 in cash and cash equivalents, $39,464,000 in short-term investments, $712,134,000 in long-term investments, $2,712,843,000 in total assets, and $1,471,095,000 in total net assets (total assets less total liabilities). The applicants adequately demonstrate the availability of sufficient funds for the capital and working capital needs of the project.

In the projected revenue and expense statement, the applicants project that revenues will exceed operating costs at RRMC-S in each of the first three years of operation. The assumptions used by the applicants in preparation of the pro formas are in the Financials Tab of the application. However, the applicants' utilization projections for RRMC-S are unsupported and unreliable. Consequently, costs and revenues that are based on this projected utilization are also not reliable. See Criterion (3) for discussion of projected utilization. Therefore, the applicants did not adequately demonstrate that the financial feasibility of the proposal is based upon reasonable projections

of costs and revenues. Consequently, the application is nonconforming with this criterion.

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

NC

Novant Health (Novant) and Rowan Regional Medical Center (RRMC) propose to develop a new hospital in Kannapolis, Rowan Regional Medical Center-South (RRMC-S), to include 50 beds, 3 shared ORs, and one GI endoscopy procedure room to be relocated from RRMC in Salisbury. The applicants also propose to relocate one CT scanner from the South Rowan Medical Mall in China Grove which will be replaced with a new 64 slice CT scanner. The other equipment and services to be provided in the new hospital will all be new. However, the applicants did not adequately demonstrate the need for all of the services, relocated or new, that they propose to offer in the new hospital in Kannapolis. See Criterion (3) for a description of all proposed services and an analysis of the need for these services. Therefore, the applicants did not adequately demonstrate that the proposal would not result in the unnecessary duplication of existing or approved health service capabilities or facilities. Consequently, the application is nonconforming with this criterion.

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

NC

In Section VII.2, pages 119-123, the applicants provide the projected staffing for RRMC-S for the first three operating years. The applicants project to employ a total of 260.5 full-time equivalent (FTE) positions in Year One, 289.1 FTE positions in Year Two and 322.2 FTE positions in Year Three. The applicants propose 8.0 FTE management positions in the first three operating years. In Section VII.3, page 125, the applicants state

"It is anticipated that RRMC-S staff will be new hires, except for those existing RRMC personnel who may choose to apply for the RRMC-S positions when the jobs are posted. … RRMC has full-time recruiters on staff. Staff recruitment is a continuous effort. Positions have been filled through a combination of advertisements in local newspapers and on the RRMC web site. Periodic job fairs and open houses also help in attracting applicants. Recruitment ads run nationally as well as in the

Charlotte newspapers to fill these positions. Based on past experience, RRMC does not foresee unmanageable difficulty in recruiting these personnel."

In Exhibit 11, the applicants provide letters from physicians who have agreed to act as medical directors for RRMC-S. See also Section II.3. In Section VII.6, page 127, the applicants state

"The support staff … at RRMC-S will report to management at RRMC-S and will also coordinate with their respective departments at RRMC corporate departments as necessary to ensure consistency and quality. Other RRMC support functions will be provided directly to RRMC-S as part of administrative overhead expense and are reflected in the pro forma income statements for RRMC-S."

In the pro forma assumptions, the applicants list corporate overhead attributable to RRMC as billing, human resources, information technology, courier service, general accounting, facility services, materials management, and other. In Section II, pages 23-24 of the application, the applicants state

"The administrative structure for RRMC-S will include an on-site, dedicated management team with linkages to the existing management team and structure at RRMC, where appropriate and necessary. RRMC-S will also have access to RRMC corporate services such as information technology, human resources, finance, and managed care contracting. The expense to RRMC-S for the purchase of these corporate services is included as an expense item ('Corporate Overhead') for RRMC-S in the CON Pro Forma income statement. RRMC-S will not be purchasing services from Novant. See Exhibit 9 for a letter from the RRMC Chief Financial Officer.

The RRMC-S management team will include the following on-site management team members as identified in the responses to the questions in Section VII of this application: Administrator/Vice-President; Director of Nursing; Director of Professional Support Services; and Director of Finance. The RRMC-S Administrator will report to the CEO of RRMC.

RRMC-S will have on-site managers and supervisors for clinical and support departments as follows: Human Resources; Material Management; Nursing Services; ED; Pharmacy Supervisor; Respiratory Therapy; Surgical Services; Clinical Radiology; Patient Access; Lead Environmental Services; Food and Nutrition; Laboratory; Medical Records; Maintenance & Engineering; and Security; Each of these management and supervisory positions will be linked into their counterpart management structures and departments at RRMC for coordination, consistency, and efficiency."

However, the applicants did not demonstrate that all staff needed for provision of neonatal services, as required in 10A NCAC 14C .1405, would be available. Therefore, the applicants did not adequately demonstrate the availability of adequate health manpower and management personnel for the provision of the proposed neonatal services. Therefore, the application is not conforming to this criterion. See 10A NCAC 14C .1405 for detailed discussion.

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

NC

In Section IV.5, pages 93-94; Section II.1, pages 17 through 21; and Section II.3, pages 21 through 24, the applicants describe the ancillary and support services that will be provided at RRMC-S and the services available from RRMC or Novant. On page 109 of the application, the applicants state *"RRMC-S will seek appropriate transfer agreements with area providers, both to receive and send patients, as part of its process of preparing to open as a new acute care hospital. A list of the types of transfer agreements covering RRMC is included in Exhibit 10."* Exhibit 10 contains transfer agreements between RRMC and Lake Norman Regional Medical Center, Brian Center Health and Rehabilitation, The Laurels of Salisbury, The North Carolina Baptist Hospitals, Inc. and with CMC-NorthEast. Exhibit 10 also contains a list of the facilities with which RRMC currently has transfer agreements and a sample agreement. Exhibit 11 contains letters from area physicians supporting the proposal to establish a new site for provision of acute inpatient services in Kannapolis. However, the applicants did not demonstrate that all support services needed for neonatal services, as required in 10A NCAC 14C .1404, would be available. Therefore, the applicants did not adequately demonstrate that all necessary ancillary and support services for provision of Level I neonatal services would be available. Consequently, the application is not conforming to this criterion. See 10A NCAC 14C .1404 for detailed discussion.

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

NA

(10) When applicable, the applicant shall show that the special needs of health maintenance organizations will be fulfilled by the project. Specifically, the applicant shall show that the project accommodates:

(a) The needs of enrolled members and reasonably anticipated new members of the HMO for the health service to be provided by the organization; and

NA

(b) The availability of new health services from non-HMO providers or other HMOs in a reasonable and cost-effective manner which is consistent with the basic method of operation of the HMO. In assessing the availability of these health services from these providers, the applicant shall consider only whether the services from these providers:

(i) would be available under a contract of at least 5 years duration;

(ii) would be available and conveniently accessible through physicians and other health professionals associated with the HMO;

(iii) would cost no more than if the services were provided by the HMO; and

(iv) would be available in a manner which is administratively feasible to the HMO.

NA

(11) Repealed effective July 1, 1987.

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

C

The applicants propose to construct 209,214 square feet of new space to establish a new separately licensed hospital in Kannapolis. In Exhibit 16, the architect certifies that the site work, construction, and contingency costs are projected to be $68,954,306. However, the project capital cost table on page 132 of the application, shows an additional $1,000,000 in site costs (line item 6 *"Other: Utilities to the Site"*) which increases the site,

construction and contingency costs to $69,954,306. In Section XI.7, pages 182-183, the applicants state that applicable energy savings features will be incorporated into the construction plans. The applicants adequately demonstrated that the cost, design and means of construction represent the most reasonable alternative for the project it proposes, and that the construction cost will not unduly increase costs and charges for health services. See Criterion (5) for discussion of costs and charges. The application is conforming to this criterion.

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

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

C

The following table illustrates the current payor mix for all services provided at RRMC during FFY 2006, as reported in Section VI.10, page 110.

RRMC FFY 2006 (10/1/05 – 9/30/06)

PAYOR CATEGORY	***% OF TOTAL PATIENT DAYS / PROCEDURES***
Self Pay / Indigent / Charity	*3.6%*
Medicare	*41.7%*
Medicaid	*14.2%*
Commercial Insurance & Managed Care	*33.9%*
BCBS	*0.8%*
State Employees Health Plan	*3.0%*
Other (other Government & Workers Comp.)	*2.9%*
TOTAL	*100.0%*

Source: Trendstar Internal data for FFY 2006. Note: may not add exactly to 100% due to rounding.

The applicants demonstrated that medically underserved populations currently have adequate access to the services provided at RRMC. Therefore, the application is conforming to this criterion.

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

C

The Acute and Home Care Licensure and Certification Section, DHSR, indicates there have been no civil rights access complaints filed against RRMC within the last five years.

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

C

The following table illustrates the projected payor mix for all of the services to be provided at RRMC-S during Year Two, as reported in Section VI.12, page 115.

RRMC FFY 2012 (10/1/11 – 9/30/12)

PAYOR CATEGORY	***% OF TOTAL PATIENT DAYS / PROCEDURES***
Self Pay / Indigent / Charity	*4.0%*
Medicare	*40.9%*
Medicaid	*13.5%*
Commercial Insurance & Managed Care	32.1%
BCBS	3.2%
State Employees Health Plan	3.1%
Other (other Government & Workers Comp.)	3.3%
TOTAL	*100.0%*

Source: Trendstar Internal data for FFY 2006. Note: may not add exactly to 100% due to rounding.

The applicants adequately demonstrate that medically underserved populations would have adequate access to the proposed services. Therefore, the application is conforming to this criterion.

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

C

See Section VI.7, page 108 of the application, the applicants document the range of means by which patients would have access to the services to be provided at RRMC-S. The information provided is reasonable and credible and supports a finding of conformity with this criterion.

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

C

See Section V.1 and referenced exhibits for documentation that RRMC currently accommodates the clinical needs of health professional training programs in the area and that RRMC-S will do the same. The information provided is reasonable and credible and supports a finding of conformity with this criterion.

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

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

NC

The applicants did not adequately demonstrate that the proposal would have a positive impact upon the cost effectiveness, quality, and access to the proposed services. See Criteria (3), (3a), (5), (6), (7) and (8). Therefore, the application is not conforming to this criterion.

(19) Repealed effective July 1, 1987.

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

C

RRMC is accredited by the Joint Commission of Accreditation of Health Care Organizations and certified for Medicare and Medicaid participation. According to the Acute and Home Care Licensure and Certification Section, DHSR, no incidents occurred at the facility, within the eighteen months immediately preceding the date of this decision, for which any sanctions or penalties related to quality of care were imposed by the State. Therefore, the application is conforming to this criterion.

(21) Repealed effective July 1, 1987.

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

NC

The applicants propose to develop four new ICU beds. Thus, the proposal results in the development of new or expanded intensive care services in Rowan County. The application is not conforming to all applicable Criteria and Standards for Intensive Care Services promulgated in 10A NCAC 14C .1200. The specific criteria are discussed below.

Also, the applicants propose to develop new neonatal services, which include a new Level I nursery with newborn bassinets. The applicants did not provide specific responses in the application to the neonatal rules, although 11 bassinets are shown on the schematic of the new hospitals' proposed third floor. Therefore, the application is not conforming to all applicable Criteria and Standards for Neonatal Services promulgated in 10A NCAC 14C .1400. The specific criteria are discussed below.

SECTION .1200 CRITERIA AND STANDARDS FOR INTENSIVE CARE SERVICES
.1202 INFORMATION REQUIRED OF APPLICANT

.1202(a) This rule states *"An applicant that proposes new or expanded intensive care services shall use the Acute Care Facility/Medical Equipment application form."*

-C- Rowan Regional Medical Center proposes to develop four ICU beds at RRMC-S. Thus, the proposal results in the development of new or expanded intensive care services in Rowan County. The applicants used the Acute Care Facility/Medical Equipment application form.

.1202(b)(1) This rule states *"An applicant proposing new or expanded intensive care services shall also submit the following additional information: (1) the number of intensive care beds currently operated by the applicant and the number of intensive care beds to be operated following completion of the proposed project."*

-C- In Exhibit 20, Table 26 (2 of 2) the applicants provide a table illustrating the current (20) and proposed number (20) of ICU beds operated by the applicants at RRMC in Salisbury. RRMC-S will be licensed for 4 ICU beds.

.1202(b)(2) This rule states *"An applicant proposing new or expanded intensive care services shall also submit the following additional information: … (2) documentation of the applicant's experience in treating patients at the facility during the past twelve months, including: (A) the number of inpatient days of care provided to intensive care patients; (B) the number of patients initially treated at the facility and referred to other facilities for intensive care services; and (C) the number of patients initially treated at other facilities and referred to the applicant's facility for intensive care services."*

-NA- The proposed facility will not be a second campus operated under the license for RRMC, but instead will be a new separately licensed facility. In Exhibit 6, page 2, the applicants state "*Since the RRMC-S campus does not yet exist, it has no historical data*." Therefore, there is no operating experience treating patients at the proposed facility.

.1202(b)(3) This rule states *"An applicant proposing new or expanded intensive care services shall also submit the following additional information: …(3) the number of patients from the proposed service area who are projected to require intensive care services by the patients' county of residence in each of the first 12 quarters of operation, including all assumptions and methodologies."*

-C- In Exhibit 6, pages 3-6, the applicants provided the number of patients from the proposed service area who are projected to require intensive care services by the patients' county of residence in each of the first 12 quarters of operation. The applicants' assumptions and methodologies are provided in Exhibit 6. See Criterion (3) for discussion of reasonableness of projections.

.1202(b)(4) This rule states *"An applicant proposing new or expanded intensive care services shall also submit the following additional information: … (4) the projected number of patients to be served and inpatient days of care to be provided by county of residence by specialized type of intensive care for each of the first twelve calendar quarters following completion of the proposed project, including all assumptions and methodologies."*

-C- The four ICU beds at RRMC-S will all be general med/surg ICU beds. In Exhibit 6, Pages 6 - 8, the applicants provided the number of patients to be served and the number of inpatient days of care to be provided in the four proposed beds by the patients' county of residence in each of the first 12 quarters of operation. The applicants' assumptions and methodology used to project utilization are provided in Section III.1(b), and Exhibit 6. See Criterion (3) for discussion of reasonableness of projections.

.1202(b)(5) This rule states *"An applicant proposing new or expanded intensive care services shall also submit the following additional information: … (5) data from actual referral sources or correspondence from the proposed referral sources documenting their intent to refer patients to the applicant's facility."*

-C- In Exhibit 11, the applicants provide letters from physicians that document their intent to refer patients to RRMC-S.

.1202(b)(6) This rule states *"An applicant proposing new or expanded intensive care services shall also submit the following additional information: … (6) documentation which demonstrates the applicant's capability to communicate effectively with emergency transportation agencies."*

-C- In Section II.8, pages 62-63, the applicants state *"See attachment to this Exhibit regarding the ability of RRMC and*

RRMC-S to communicate effectively with emergency transportation agencies." Exhibit 6 includes a letter from John Pruitt, Senior Vice President and COO of RRMC, which states "*In addition, Rowan Regional Medical Center-South and its Intensive Care Unit will have the ability to communicate effectively with Rowan County EMS, a Critical Care Transport Unit and other rescue units, as needed to support the delivery of appropriate care to ICU patients at Rowan Regional Medical Center-South. Confirmation of the availability of these services is provided in a separate letter which is included as an exhibit with this CON application*." Also see Exhibit 19 for a letter from RRMC's Medical Director of Emergency Medicine and Director of Emergency Services.

.1202(b)(7)(A) This rule states *"An applicant proposing new or expanded intensive care services shall also submit the following additional information: … (7) documentation of written policies and procedures regarding the provision of care within the intensive care unit, which includes, but is not limited to the following: (A) the admission and discharge of patients; (B) infection control; (C) safety procedures; and (D) scope of service."*

-C- Exhibit 6 contains copies of the applicants' policies and procedures for provision of care in the ICU addressing each item in this rule.

.1202(b)(8) This rule states *"An applicant proposing new or expanded intensive care services shall also submit the following additional information: … (8) documentation that the proposed service shall be operated in an area organized as a physically and functionally distinct entity, separate from the rest of the facility, with controlled access."*

-C- Exhibit 16 contains the design schematics for the proposed ICU, which show that the ICU will be operated as a physically and functionally distinct entity in a separate area with controlled access. Also, Exhibit 6 includes a letter from Laura MacFadden, Director of Facilities Planning Design and Construction, Novant Health, which states

> *"A detailed floor plan drawn to scale, of the ICU for the proposed Rowan Regional Medical Center-South, is included in the CON application exhibits. As you can see from the floor plan, the proposed service will be operated*

in an area that is physically and functionally distinct from the rest of the facility, with controlled access. In addition, the drawings illustrate that unit staff can observe all patients in the ICU from at least one vantage point."

.1202(b)(9) This rule states *"An applicant proposing new or expanded intensive care services shall also submit the following additional information: … (9) documentation to show that the services shall be offered in a physical environment that conforms to the requirements of federal, state, and local regulatory bodies."*

-C- Exhibit 6 includes a letter from Laura MacFadden, Director of Facilities Planning Design and Construction, Novant Health, which states

"I will oversee the construction of Rowan Regional Medical Center-South, including the ICU, and will assure that the intensive care services at Rowan Regional Medical Center-South will be offered in a physical environment that conforms to the applicable code requirements of federal, state, and local regulatory bodies."

.1202(b)(10) This rule states *"An applicant proposing new or expanded intensive care services shall also submit the following additional information: … (10) a detailed floor plan of the proposed area drawn to scale."*

-C- See Exhibit 16 for design schematics of the proposed ICU.

.1202(b)(11) This rule states *"An applicant proposing new or expanded intensive care services shall also submit the following additional information: … (11) documentation of a means for observation by unit staff of all patients in the unit from at least one vantage point."*

-C- See Exhibit 16 for design schematics of the proposed ICU and Exhibit 6 for a letter from Laura MacFadden.

.1203 PERFORMANCE STANDARDS

.1203(a)(1) This rule states *"The applicant shall demonstrate that the proposed project is capable of meeting the following*

standards: (a) (1) the overall average annual occupancy rate of all intensive care beds in the facility, excluding neonatal and pediatric intensive care beds, over the 12 months immediately preceding the submittal of the proposal, shall have been at least 70 percent for facilities with 20 or more intensive care beds, 65 percent for facilities with 10-19 intensive care beds, and 60 percent for facilities with 1-9 intensive care beds."

-NA- RRMC-S will be a new separately licensed hospital. Because it does not yet exist, there were no ICU beds operated in the 12 months prior to submittal of the application.

.1203(a)(2) This rule states *"The applicant shall demonstrate that the proposed project is capable of meeting the following standards: (a) … (2) the projected occupancy rate for all intensive care beds in the applicant's facility, exclusive of neonatal and pediatric intensive care beds, shall be at least 70 percent for facilities with 20 or more intensive care beds, 65 percent for facilities with 10-19 intensive care beds, and 60 percent for facilities with 1-9 intensive care beds, in the third operating year following the completion of the proposed project."*

-NC- In Exhibit 6, page 10 and Exhibit 20, Table 13, the applicants project that RRMC-S will provide a total of 904 patient days of care in the four ICU beds which is an occupancy rate of 61.9% [365 x 4 = 1,460; 904 / 1,460 = 0.619]. However, the applicants did not adequately demonstrate that projected utilization of the four ICU beds is based on reasonable and supported assumptions. See Criterion (3) for discussion of reasonableness of assumptions. Therefore, the applicants did not adequately demonstrate that the occupancy rate for the proposed ICU beds would be at least 60% during Year Three as required by this rule.

.1203(b) This rule states *"All assumptions and data supporting the methodology by which the occupancy rates are projected shall be provided."*

-NC- The applicants' assumptions and methodology are provided in Section III.1(b), pages 41 - 50, and Exhibit 20. However, the applicants did not adequately demonstrate that projected utilization of the four ICU beds is based on reasonable assumptions or that data was provided to support the

methodology used to project utilization. See Criterion (3) for additional discussion.

.1204 SUPPORT SERVICES

.1204(a) This rule states *"An applicant proposing new or additional intensive care services shall document the extent to which the following items are available:*

(1) twenty-four hour on-call laboratory services including microspecimen chemistry techniques and blood gas determinations;
(2) twenty-four hour on-call radiology services, including portable radiological equipment;
(3) twenty-four hour blood bank services;
(4) twenty-four hour on-call pharmacy services;
(5) twenty-four hour on-call coverage by respiratory therapy;
(6) oxygen and air and suction capability;
(7) electronic physiological monitoring capability;
(8) mechanical ventilatory assistance equipment including airways, manual breathing bag and ventilatory/respirator;
(9) endotracheal intubation capability;
(10) cardiac pacemaker insertion capability;
(11) cardiac arrest management plan;
(12) patient weighing device for bed patients; and
(13) isolation capability."

-C- Exhibit 6 includes a letter from John C. Pruitt, VPO and COO, Rowan Regional Medical Center documenting the availability of each of the above items.

.1204(b) This rule states *"If any item in Subparagraphs (a)(1) - (13) of this Rule will not be available, the applicant shall document the reason why the item is not needed for the provision of the proposed services."*

-NA- The applicants state in Exhibit 6, page 11 that all of the services listed in this rule will be available at the proposed RRMC-S.

.1205 STAFFING AND STAFF TRAINING

.1205(1) This rule states *"The applicant shall demonstrate the ability to meet the following staffing requirements: (1) nursing care shall be supervised by a qualified registered nurse with specialized training in the care of critically ill patients, cardiovascular monitoring, and life support."*

-C- Exhibit 6 includes a letter from Mary C. Ritchie, MS, RN, BC, CNA, who will have management responsibility for RRMC-S' ICU. Her letter states *"The nursing care in the ICU at Rowan Regional Medical Center-South will be provided by qualified registered nurses with specialized training in the care of critically ill patients, cardiovascular monitoring, and life support."*

.1205(2) This rule states *"The applicant shall demonstrate the ability to meet the following staffing requirements: … (2) direction of the unit shall be provided by a physician with training, experience and expertise in critical care."*

-C- Exhibit 6 includes a letter from Neil Patel, MD, medical director of the ICU at RRMC-S, and his curriculum vitae.

.1205(3) This rule states *"The applicant shall demonstrate the ability to meet the following staffing requirements: … (3) assurance from the medical staff that twenty-four hour medical and surgical on-call coverage is available."*

-C- Exhibit 6 includes a letter from David N. Smith MD, Vice President of Medical Affairs for Rowan Regional Medical Center, stating *"...RRMC will expand its hospitalist physician program to include the provision of 24-hour, in-house coverage at Rowan Regional Medical Center-South, just as the hospitalist physician group currently does at RRMC in Salisbury. When Rowan Regional Medical Center-South becomes operational, it will have medical and surgical on-call coverage 24 hours a day, seven days a week as required by the ICU CON Regulations."*

.1205(4) This rule states *"The applicant shall demonstrate the ability to meet the following staffing requirements: … (4) inservice training or continuing education programs shall be provided for the intensive care staff."*

-C- Exhibit 6 includes a letter from Mary Ritchie, MS, RN, BC, CNA, stating *"In addition, I can confirm that current RRMC*

policies and procedures provide for inservice training and continuing education for ICU staff members at RRMC. …I will work with the Rowan Regional Medical Center-south nursing administration to ensure that the inservice training and continuing education policies and procedures will apply to and be available for the ICU staff members at Rowan Regional Medical Center-South."

SECTION .1400 CRITERIA AND STANDARDS FOR NEONATAL SERVICES

.1402(a) This rule states *"An applicant proposing to develop a new Level I nursery or increase the number of Level II, III or IV neonatal beds shall use the Acute Care Facility/Medical Equipment application form."*

-C- The applicants propose to develop a new Level I nursery on the third floor of the new hospital, as shown in Exhibit 16. The applicants used the Acute Care Facility/Medical Equipment application form.

.1402(b)(1) This rule states *"An applicant proposing to develop a new Level I nursery service or to increase the number of Level II, III or IV neonatal beds shall provide the following additional information: (1) the current number of Level I nursery bassinets, Level II beds, Level III beds and Level IV beds operated by the applicant."*

-NA- RRMC-S currently does not provide neonatal services.

.1402(b)(2) This rule states *"An applicant proposing to develop a new Level I nursery service or to increase the number of Level II, III or IV neonatal beds shall provide the following additional information: … (2) the proposed number of Level I nursery bassinets, Level II beds, Level III beds and Level IV beds to be operated following completion of the proposed project."*

-NC- The applicants did not respond to the neonatal services rules and thus did not state the number of Level I nursery bassinets to be developed. However, it appears from the schematic drawing provided in Exhibit 16 that the applicants propose to develop 11 nursery bassinets.

.1402(b)(3) This rule states *"An applicant proposing to develop a new Level I nursery service or to increase the number of Level II,*

III or IV neonatal beds shall provide the following additional information: … (3) evidence of the applicant's experience in treating the following patients at the facility during the past twelve months, including: (A) the number of obstetrical patients treated at the acute care facility; (B) the number of neonatal patients treated in Level I nursery bassinets, Level II beds, Level III beds and Level IV beds, respectively; (C) the number of inpatient days at the facility provided to obstetrical patients; (D) the number of inpatient days provided in Level II beds, Level III beds and Level IV beds, respectively; (E) the number of high-risk obstetrical patients treated at the applicant's facility and the number of high-risk obstetrical patients referred from the applicant's facility to other facilities or programs; and (F) the number of neonatal patients referred to other facilities for services, identified by required level of neonatal service (i.e. Level II, Level III or Level IV)."

-NA- RRMC-S will be a new separately licensed hospital, and thus, does not currently exist. Therefore, the applicants have no experience treating obstetrical or neonatal patients at RRMC-S.

.1402(b)(4) This rule states *"An applicant proposing to develop a new Level I nursery service or to increase the number of Level II, III or IV neonatal beds shall provide the following additional information: … (4) the projected number of neonatal patients to be served identified by Level I, Level II, Level III and Level IV neonatal services for each of the first three years of operation following the completion of the project, including the methodology and assumptions used for the projections."*

-NC- The applicants did not respond to the neonatal services rules and thus failed to provide the projected number of Level I nursery neonatal patients to be served for each of the first three years of operation following completion of the project. Also, the applicants did not provide a methodology or assumptions for any projections.

.1402(b)(5) This rule states *"An applicant proposing to develop a new Level I nursery service or to increase the number of Level II, III or IV neonatal beds shall provide the following additional information: … (5) the projected number of patient days of care to be provided in Level I bassinets, Level II beds, Level III beds, and Level IV beds, respectively, for each of the first three years of operation following completion of the project,*

including the methodology and assumptions used for the projections."

-NC- The applicants did not respond to the neonatal services rules and thus failed to provide the projected number of Level I nursery neonatal patient days of care to be provided for each of the first three years of operation following completion of the project. Also, the applicants did not provide a methodology or assumptions for any projections.

.1402(b)(6) This rule states *"An applicant proposing to develop a new Level I nursery service or to increase the number of Level II, III or IV neonatal beds shall provide the following additional information: … (6) if proposing to provide Level I or Level II neonatal services, documentation that at least 90 percent of the anticipated patient population is within 30 minutes driving time one-way from the facility."*

-NC- The applicants did not respond to the neonatal services rules and thus failed to document that 90 percent of the anticipated patient population is within 30 minutes driving time one-way from RRMC-S.

.1402(b)(7) This rule states *"An applicant proposing to develop a new Level I nursery service or to increase the number of Level II, III or IV neonatal beds shall provide the following additional information: … (7) if proposing to provide new Level I or Level II neonatal services, documentation of a written plan to transport infants to Level III or Level IV neonatal services as the infant's care requires."*

-C- Exhibit 10 contains copies of the current transfer agreements between RRMC and CMC-NorthEast. These transfer agreements would be applicable to the transfer of neonatal patients to CMC-NorthEast for Level III neonatal services, as well.

.1402(b)(8) This rule states *"An applicant proposing to develop a new Level I nursery service or to increase the number of Level II, III or IV neonatal beds shall provide the following additional information: … (8) evidence that the applicant shall have access to a transport service with at least the following components:*

(A) trained personnel;

(B) transport incubator;
(C) emergency resuscitation equipment;
(D) oxygen supply, monitoring equipment and the means of administration;
(E) portable cardiac and temperature monitors; and
(F) a mechanical ventilator."

-NC- The applicants did not respond to the neonatal services rules and thus failed to document that RRMC-S would have access to a transport service with each component listed above.

.1402(b)(9) This rule states *"An applicant proposing to develop a new Level I nursery service or to increase the number of Level II, III or IV neonatal beds shall provide the following additional information: … (9) documentation that the proposed service shall be operated in an area organized as a physically and functionally distinct entity with controlled access."*

-C- The design schematic provided in Exhibit 16 shows that the proposed neonatal nursery will be located in a separate room with controlled access on the third floor, adjacent to where the applicants propose to locate obstetrical services.

.1402(b)(10) This rule states *"An applicant proposing to develop a new Level I nursery service or to increase the number of Level II, III or IV neonatal beds shall provide the following additional information: … (10) documentation to show that the new or additional Level I, Level II, Level III or Level IV neonatal services shall be offered in a physical environment that conforms to the requirements of federal, state, and local regulatory bodies."*

-C- In Section II, page 33 of the application, the applicants state *"The proposed project will meet all state and federal regulatory and licensure requirements, including OSHA, DFS, and the Rowan County Department of Health. RRMC's facilities are currently in compliance with all applicable regulatory standards."*

.1402(b)(11) This rule states *"An applicant proposing to develop a new Level I nursery service or to increase the number of Level II, III or IV neonatal beds shall provide the following additional information: … (11) a detailed floor plan of the proposed area drawn to scale."*

-C- Exhibit 16 contains a detailed floor plan of the proposed Level I nursery drawn to scale.

.1402(b)(12) This rule states *"An applicant proposing to develop a new Level I nursery service or to increase the number of Level II, III or IV neonatal beds shall provide the following additional information: … (12) documentation of direct or indirect visual observation by unit staff of all patients from one or more vantage points."*

-C- The design schematic provided in Exhibit 16 documents direct or indirect visual observation by unit staff of all neonatal patients from one or more vantage points.

.1402(b)(13) This rule states *"An applicant proposing to develop a new Level I nursery service or to increase the number of Level II, III or IV neonatal beds shall provide the following additional information: … (13) documentation that the floor space allocated to each bed and bassinet shall accommodate equipment and personnel to meet anticipated contingencies."*

-NC- The applicants did not respond to the neonatal services rules and thus failed to provide adequate documentation that the floor space allocated to each bed and bassinet is sufficient to accommodate equipment and personnel to meet anticipated contingencies.

.1402(c) This rule states *"If proposing to provide new Level III or Level IV neonatal services the applicant shall also provide the following information:*

(1) documentation that at least 90 percent of the anticipated patient population is within 90 minutes driving time one-way from the facility, with the exception that there shall be a variance from the 90 percent standard for facilities which demonstrate that they provide very specialized levels of neonatal care to a large and geographically diverse population, or facilities which demonstrate the availability of air ambulance services for neonatal patients;

(2) evidence that existing and approved neonatal services in the applicant's defined neonatal service area are unable to accommodate the applicant's projected need for additional Level III and Level IV services;

(3) an analysis of the proposal's impact on existing Level III and Level IV neonatal services which currently serve patients from the applicant's primary service area;

(4) the availability of high risk OB services at the site of the applicant's planned neonatal service;

(5) copies of written policies which provide for parental participation in the care of their infant, as the infant's condition permits, in order to facilitate family adjustment and continuity of care following discharge; and

(6) copies of written policies and procedures regarding the scope and provision of care within the neonatal service, including but not limited to the following:

(A) the admission and discharge of patients;

(B) infection control;

(C) pertinent safety practices;

(D) the triaging of patients requiring consultations, including the transfer of patients to another facility; and

(E) the protocols for obtaining emergency physician care for a sick infant."

-NA- The applicants do not propose to provide new Level III or Level IV neonatal services.

10A NCAC 14C .1403 PERFORMANCE STANDARDS

.1403(a)(1) This rule states *"An applicant shall demonstrate that the proposed project is capable of meeting the following standards: (1) an applicant proposing new Level I or Level II services, or additional Level II beds shall demonstrate that the occupancy of the applicant's total number of neonatal beds is projected to be at least 50% during the first year of operation and at least 65% during the third year of operation following completion of the proposed project."*

-NC- The applicants did not respond to the neonatal services rules and thus failed to provide utilization projections for the Level I services. Consequently, the applicants failed to document that the occupancy of RRMC-S' total number of neonatal beds is projected to be at least 50% during the first year of operation and at least 65% during the third year of operation following completion of the proposed project.

.1403(a)(2) This rule states *"An applicant shall demonstrate that the proposed project is capable of meeting the following standards: … (2) if an applicant proposes an increase in the number of the facility's existing Level III or Level IV beds, the overall average annual occupancy of the total number of existing Level III and Level IV beds in the facility is at least 75%, over the 12 months immediately preceding the submittal of the proposal."*

-NA- The applicants do not propose an increase in the number of existing Level III or Level IV beds.

.1403(a)(3) This rule states *"An applicant shall demonstrate that the proposed project is capable of meeting the following standards: … (3) if an applicant is proposing to develop new or additional Level III or Level IV beds, the projected occupancy of the total number of Level III and Level IV beds proposed to be operated during the third year of operation of the proposed project shall be at least 75%."*

-NA- The applicants do not propose to develop new or additional Level III or Level IV beds.

.1403(a)(4) This rule states *"An applicant shall demonstrate that the proposed project is capable of meeting the following standards: … (4) The applicant shall document the assumptions and provide data supporting the methodology used for each projection in this rule."*

-NC- The applicants did not respond to the neonatal services rules and thus failed to provide the assumptions and the methodology for any neonatal projections.

.1403(b) This rule states *"If an applicant proposes to develop a new Level III or Level IV service, the applicant shall document that an unmet need exists in the applicant's defined neonatal service area. The need for Level III and Level IV beds shall be computed for the applicant's neonatal service area by:*

(1) identifying the annual number of live births occurring at all hospitals within the proposed neonatal service area, using the latest available data compiled by the State Center for Health Statistics;
(2) identifying the low birth weight rate (percent of live births below 2,500 grams) for the births identified in (1)

of this Paragraph, using the latest available data compiled by the State Center for Health Statistics;

(3) dividing the low birth weight rate identified in (2) of this Paragraph by .08 and subsequently multiplying the resulting quotient by four; and

(4) determining the need for Level III and Level IV beds in the proposed neonatal service area as the product of:

(A) the product derived in (3) of this Paragraph, and

(B) the quotient resulting from the division of the number of live births in the initial year of the determination identified in (1) of this Paragraph by the number 1000."

-NA- The applicants do not propose to develop a new Level III or Level IV neonatal service.

10A NCAC 14C .1404 SUPPORT SERVICES

.1404(a) This rule states *"An applicant proposing to provide new Level I, Level II, Level III or Level IV services shall document that the following items shall be available, unless an item shall not be available, then documentation shall be provided obviating the need for that item:*

(1) competence to manage uncomplicated labor and delivery of normal term newborn;

(2) capability for continuous fetal monitoring;

(3) a continuing education program on resuscitation to enhance competence among all delivery room personnel in the immediate evaluation and resuscitation of the newborn and of the mother;

(4) obstetric services;

(5) anesthesia services;

(6) capability of cesarean section within 30 minutes at any hour of the day; and

(7) twenty-four hour on-call blood bank, radiology, and clinical laboratory services."

-NC- The applicants did not specifically respond to the neonatal services rules, but documented that RRMC-S will offer: obstetric, C-Section, anesthesia, blood bank, radiology and clinical laboratory services. However, the applicants did not document that items (1), (2), and (3) as listed above, would be

available, or alternatively, did not provide information that obviates the need for these items.

.1404(b) This rule states *"An applicant proposing to provide new Level III* [sic] *Level IV services shall document that the following items shall be available, unless any item shall not be available, then documentation shall be provided obviating the need for that item:*

(1) competence to manage labor and delivery of premature newborns and newborns with complications;
(2) twenty-four hour availability of microchemistry hematology and blood gases;
(3) twenty-four hour coverage by respiratory therapy;
(4) twenty-four hour radiology coverage with portable radiographic capability;
(5) oxygen and air and suction capability;
(6) electronic cardiovascular and respiration monitoring capability;
(7) vital sign monitoring equipment which has an alarm system that is operative at all times;
(8) capabilities for endotracheal intubation and mechanical ventilatory assistance;
(9) cardio-respiratory arrest management plan;
(10) isolation capabilities;
(11) social services staff;
(12) occupational or physical therapies with neonatal expertise; and
(13) a registered dietician or nutritionist with training to meet the special needs of neonates."

-NA- The applicants do not propose to provide new Level III or Level IV neonatal services.

(c) This rule states *"An applicant proposing to provide new Level IV services shall document that the following items shall be available, unless any item shall not be available, then documentation shall be provided obviating the need for that item:*

(1) pediatric surgery services;
(2) ophthalmology services;
(3) pediatric neurology services;
(4) pediatric cardiology services;
(5) on-site laboratory facilities;

(6) computed tomography and pediatric cardiac catheterization services;
(7) emergency diagnostic studies available 24 hours per day;
(8) designated social services staff; and
(9) serve as a resource center for the statewide perinatal network."

-NA- The applicants do not propose to provide new Level IV neonatal services.

10A NCAC 14C .1405 STAFFING AND STAFF TRAINING

.1405(1)(a) This rule states *"An applicant shall demonstrate that the following staffing requirements for hospital care of newborn infants shall be met: (1) If proposing to provide new Level I or II services the applicant shall provide documentation to demonstrate that: (a) the nursing care shall be supervised by a registered nurse in charge of perinatal facilities."*

-NC- The applicants did not provide documentation demonstrating that nursing care in the proposed Level I nursery would be supervised by an RN in charge of perinatal facilities as required by this rule.

.1405(1)(b) This rule states *"An applicant shall demonstrate that the following staffing requirements for hospital care of newborn infants shall be met: (1) If proposing to provide new Level I or II services the applicant shall provide documentation to demonstrate that: … (b) a physician is designated to be responsible for neonatal care."*

-NC- The applicants did not adequately document that a physician would be designated to be responsible for Level I neonatal care.

.1405(1)(c) This rule states *"An applicant shall demonstrate that the following staffing requirements for hospital care of newborn infants shall be met: (1) If proposing to provide new Level I or II services the applicant shall provide documentation to demonstrate that: … (c) the medical staff will provide physician coverage to meet the specific needs of patients on a 24 hour basis."*

-NC- The applicants did not adequately document that physician coverage would be provided on a 24 hour basis for the proposed Level I nursery.

.1405(2) This rule states *"If proposing to provide new Level III services the applicant shall provide documentation to demonstrate that:*

(a) the nursing care shall be supervised by a registered nurse;

(b) the service shall be staffed by a pediatrician certified by the American Board of Pediatrics; and

(c) the medical staff will provide physician coverage to meet the specific needs of patients on a 24 hour basis."

-NA- The applicants do not propose to provide new Level III neonatal services.

.1405(3) This rule states *"If proposing to provide new Level IV services the applicant shall provide documentation to demonstrate that:*

(a) the nursing care shall be supervised by a registered nurse with educational preparation and advanced skills for maternal-fetal and neonatal services;

(b) the service shall be staffed by a full-time board certified pediatrician with certification in neonatal medicine; and

(c) the medical staff will provide physician coverage to meet the specific needs of patients on a 24 hour basis."

-NA- The applicants do not propose to provide new Level IV neonatal services.

.1405(4) This rule states *"All applicants shall submit documentation which demonstrates the availability of appropriate inservice training or continuing education programs for neonatal staff."*

-NC- The applicants did not respond to the neonatal services rules and thus failed to document the availability of appropriate inservice training or continuing education programs for neonatal staff.

.1405(5) This rule states *"All applicants shall submit documentation which demonstrates the proficiency and ability of the nursing staff in teaching parents how to care for neonatal patients following discharge to home."*

-NC- The applicants did not submit documentation which demonstrates the proficiency and ability of the nursing staff to teach parents how to care for neonatal patients following discharge to home as required by this rule.

.1405(6) This rule states *"All applicants shall submit documentation to show that the proposed neonatal services will be provided in conformance with the requirements of federal, state and local regulatory bodies."*

-NC- The applicants did not respond to the neonatal services rules and thus failed to document that the proposed neonatal services will be provided in conformance with the requirements of federal, state and local regulatory bodies.