

ATTACHMENT - REQUIRED STATE AGENCY FINDINGS

FINDINGS

C = Conforming

CA = Conditional

NC = Nonconforming

NA = Not Applicable

DECISION DATE: December 20, 2013
FINDINGS DATE: December 20, 2013
PROJECT ANALYST: Celia C. Inman
TEAM LEADER: Lisa Pittman

PROJECT I.D. NUMBER: G-10210-13 / Surgical Center of Greensboro, LLC / Relocate existing ASC within Greensboro to a replacement facility adding two procedure rooms / Guilford 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.

CA

Surgical Center of Greensboro, LLC (SCG) proposes to relocate its existing two-building ambulatory surgical center (ASC) with thirteen operating rooms (ORs) from 1211 Virginia Street and 1101 Carolina Street, Greensboro 27401 to 705 Green Valley Road, Greensboro 27408. SCG also proposes to add two procedure rooms. SCG's major investor/member is NSC Greensboro, LLC (NSCG) which has the same manager/members as SCG. Surgical Care Affiliates (SCA) manages SCG and has more than a five percent owner/membership in NSCG.

The applicant does not propose to develop additional operating rooms or services or acquire equipment for which there is a need determination in the 2013 State Medical Facilities Plan (SMFP). However, Policy GEN-4 is applicable to this project.

Policy GEN-4: Energy Efficiency and Sustainability for Health Service Facilities

Policy GEN-4 states:

“Any person proposing a capital expenditure greater than \$2 million to develop, replace, renovate or add to a health service facility pursuant to G.S. 131E-178 shall include in its certificate of need application a written statement describing the project’s plan to assure improved energy efficiency and water conservation.

In approving a certificate of need proposing an expenditure greater than \$5 million to develop, replace, renovate or add to a health service facility pursuant to G.S. 131E-178, the Certificate of Need Section shall impose a condition requiring the applicant to develop and implement an Energy Efficiency and Sustainability Plan for the project that conforms to or exceeds energy efficiency and water conservation standards incorporated in the latest editions of the North Carolina State Building Codes. The plan must be consistent with the applicant’s representation in the written statement as described in paragraph one of Policy GEN-4.

Any person awarded a certificate of need for a project or an exemption from review pursuant to G.S. 131E-184 are required to submit a plan for energy efficiency and water conservation that conforms to the rules, codes and standards implemented by the Construction Section of the Division of Health Service Regulation. The plan must be consistent with the applicant’s representation in the written statement as described in paragraph one of Policy GEN-4. The plan shall not adversely affect patient or resident health, safety or infection control.”

In Section XI.8, page 149, the applicant addresses improved energy efficiency and containing costs, stating that the construction will be completed using modern energy conservation practices and methods, meeting all requirements of State code and the latest edition of ASHRAE 90.1, the industry standard for energy efficient buildings. The applicant further states:

“If economically viable, additional energy recovery equipment such as heat wheels, runaround coils, or energy recovery units will be installed in the new space.”

In Section III, page 72, the applicant states:

“...SCG understands and agrees to submit a plan for energy efficiency and water conservation that conforms to the rules, codes and standards implemented by the Construction Section of DHHSR. The plan will include a written statement describing the project’s plan to assure improved energy efficiency and water

conservation in a way that does not affect patient or resident health, safety or infection control.”

The application is consistent with Policy GEN-4 and conforming to this criterion, subject to Condition (9) in Criterion (4).

- (2) Repealed effective July 1, 1987.
- (3) The applicant shall identify the population to be served by the proposed project, and shall demonstrate the need that this population has for the services proposed, and the extent to which all residents of the area, and, in particular, low income persons, racial and ethnic minorities, women, handicapped persons, the elderly, and other underserved groups are likely to have access to the services proposed.

C

SCG proposes to relocate all services in its two leased buildings to a new building located at 705 Green Valley Road in Greensboro, approximately 2.5 miles from the existing buildings. The new replacement facility will include the 13 existing, licensed ORs, 24 pre-operation bays, 28 Stage I recovery bays, a Stage II overnight recovery care center with eight recovery bays, four consult rooms, and expanded related support spaces. The applicant also proposes to add two procedure rooms at the new location, which the applicant states will be used primarily for pain management, some ophthalmology, and minor cases, as appropriate. On page 21, the applicant states that current services at SCG include the following surgical specialties:

- Gynecology
- Otolaryngology
- Plastic Surgery
- General Surgery
- Ophthalmology
- Neurosurgery
- Orthopedic Surgery
- Oral Surgery
- Urology
- Vascular Surgery
- General Dentistry
- Physiatry

SCG's 2013 License Renewal Application (LRA) shows the provision of the following surgical specialties:

- Gynecology
- Otolaryngology
- Plastic Surgery
- General Surgery
- Ophthalmology
- Neurosurgery
- Orthopedic Surgery
- Oral Surgery

SCG's 2013 and 2012 LRAs do not list general dentistry, physiatry, urology or vascular surgery as surgical services provided in 2012 or 2011, respectively. SCG's 2011 LRA lists one urology surgical case and 17 GI endoscopy non-surgical cases performed in 2010.

Population to be Served

In Section III.5, page 73, the applicant states:

“Surgical Center of Greensboro’s (SCG) service area will include Guilford, Rockingham, Randolph, and Alamance Counties.”

The following table illustrates patient origin for the fiscal year 2012 ambulatory surgical cases performed at SCG, as reported in Section III.7, page 74 and on SCG’s 2013 LRA:

**SCG Patient Origin
 FFY 2012**

County	# of Surgical Cases	Percent of Total Cases
Guilford	7,732	65.0%
Rockingham	1,230	10.3%
Randolph	975	8.2%
Alamance	556	4.7%
Other	1,409	11.8%
Total	11,902	100.0%

The following table illustrates projected patient origin for ambulatory surgical cases to be performed at the new relocated surgery center, as reported in Section III.6, pages 73-74:

**Projected Patient Origin
 Ambulatory Surgical Cases
 Project Years 1 and 2
 (FY 2016 and FY 2017)**

County	Total Cases		% of Total Ambulatory Surgical Cases	
	FY 2016	FY 2017	FY 2016	FY 2017
Guilford	9,565	10,088	65.0%	65.0%
Rockingham	1,522	1,605	10.3%	10.3%
Randolph	1,206	1,272	8.2%	8.2%
Alamance	688	725	4.7%	4.7%
Other	1,744	1,840	11.8%	11.8%
Total	14,725	15,530	100.0%	100.0%

The applicant states the proposed patient origin is based on historical trends and that it does not expect referral patterns or the service area to change.

The applicant adequately identified the population proposed to be served.

Demonstration of Need

In Section III.1(a), beginning on page 52, the applicant discusses the need for the proposed project, stating:

“The need for the project is based on, but not limited to:

- *Age of buildings*
- *Need for structural design to improve efficiency and patient flow*
- *Consolidation of duplicate functions that are now housed in two separate facilities*
- *Convenient scheduling and access for outpatients*
- *The need to improve operating room efficiency and to treat patients in a more appropriate space*
- *The aging population in the service area and their need for ambulatory surgery.”*

The applicant discusses the buildings’ shortcomings at length, regarding age, efficiency, and access. The applicant states that neither building is energy efficient; and both buildings incur unnecessarily high maintenance costs because of their ages. In addition, the applicant says older buildings can develop problems that can negatively affect patient care: old HVAC and wiring systems can affect air quality and medical equipment function, compromising patient care quality and infection control. On page 53, the applicant states:

“At SCG, increase in demand has also created a need for more treatment space, larger storage spaces, larger waiting rooms and staff preparation and lounge areas, along with space to accommodate equipment and safety procedures for more complex procedures. With expanded internal space requirements, external spaces, including patient and staff parking, must increase.”

On page 54, the applicant states that it is imperative that the facility be both aesthetically appealing to patients and operationally efficient. Currently, Carolina Street patients requiring extended recovery care must be transported across the street to the Virginia Street facility. SCG says this is inconvenient, prolongs patient time at SCG and adds unnecessary ambulance costs to the patient’s bill. Currently, both facilities offer patient registration, waiting area, operating room, recover room, discharge lounges, sterilization, employee lounges and storage. Consolidating services will permit sharing of clinical resources, support staff and medical equipment; and reduce unnecessary duplication of services.

Currently, all patients, both surgical and non-surgical, are treated in SCG’s operating rooms. Operating rooms are outfitted for patient cases needing general anesthesia, are more spacious and have specialized electrical support and more complex air handling than necessary for minor procedures which can be done in procedure rooms. With the option to provide minor and non-surgical cases elsewhere, SCG can use its operating

room capacity for higher acuity cases. The applicant states it needs procedure rooms for current and future patients, based on non-surgical case projections and operational efficiency needs, and patient care accommodation. The applicant says that by adding less expensive procedure rooms, SCG can accommodate more of the longer and complex cases in its operating rooms. On pages 55-56, the applicant states:

“In the replacement facility, operating rooms will have space and infrastructure support for these higher acuity cases. Capacity freed by the procedure rooms will permit SCG to handle more procedures like plastic surgery, high acuity orthopedics, tympanostomies, etc that can be time intensive. Without the additional procedure rooms, SCG service growth opportunities are limited.

In addition, to address patient and provider satisfaction and accommodate payment pressures for productivity, the applicant plans to improve patient processing times. Adding two procedure rooms would permit staff to do parallel processing in each type of room. Parallel processing gives operating rooms and procedure rooms increases [sic] throughput by permitting, in one room, non-operative tasks, such as room cleaning and preparation, while in another, a physician completes a case.”

The applicant states that providing new procedure rooms will permit SCG to treat minor cases outside the operating rooms and open more early start times for patients whose cases truly require an operating room. On page 27, the applicant states;

“With experience, operators have learned that time of case is important for patients. With more space for all cases, SCG can better accommodate patients who need early start times. These include all pediatric cases, because children cannot tolerate a period of NPO (no food)¹ that lasts well into the day. ...

...

For adults, the early start times are important as well. Early start time decreases the length of time adult patients, including elderly and diabetics, are required to remain NPO. Their electrolyte and blood sugar balance issues resemble those of pediatric patients. Also, patients arriving late evening to PACU have required overnight observation to care for nausea or for pain control. An earlier case start would have permitted many of them to return home the same day.”

In conclusion, on page 56, the applicant states:

“... SCG found it more cost-effective and better for patient quality to build a new facility. ... at an available site close to existing facilities, where it can continue to conveniently serve the residents of Guilford County and surrounding communities. Because the expected number of cases will exceed practical

¹ Nil per os

capacity of 13 operating rooms, and many cases can be done safely in less expensive procedure rooms, and because trends in population growth, payor policy, and surgical improvements indicate sustained increase in cases, building two procedure rooms at this time is reasonable.”

Statistical Need

In Section III.1(b), pages 57-67, the applicant discusses the statistical need for the project as related to the growth in ambulatory surgery in North Carolina and SCG’s surgical case growth.

Increase in Ambulatory Surgery Services in North Carolina

On pages 57-59, the applicant discusses the rate of increase in North Carolina ambulatory surgery visits as compared to the population growth rate. The applicants appear to use “cases” and “visits” interchangeably in the methodology. Per the application, using Truven Health Analytics data, the compound annual growth rate (CAGR) of ambulatory surgery visits between 2007 and 2011 (the most recent complete year of analysis) is 4.6% while the CAGR for the population of North Carolina during the same period is only 1.5%. On page 59, the applicant states, “*The growth rate of ambulatory surgery exceeds that of the North Carolina population.*” The applicant discusses the factors contributing to the increase in ambulatory surgery cases, which include improvements in anesthesia, shifts to less invasive techniques, improvements in instrumentation, changes in payor policies and surgeon scheduling convenience.

Need for Operating Rooms at SCG

In Section III.1, page 60, the applicant discusses SCG’s annual surgical case volumes from 2009 through 2012, showing an increase from 10,146 cases to 11,902 cases, a 5.47% compound annual growth rate (CAGR) for that period, as shown in the table below.

SCG Annual Surgical Cases by Specialty

Specialty	2009	2010	2011	2012	CAGR
General Surgery	495	490	556	420	
Neurosurgery	400	4	232	2	
Obstetrics and Gynecology	246	211	181	306	
Ophthalmology	2,212	2,919	3,531	4,154	
Oral Surgery	0	42	95	183	
Orthopedics	4,678	5,135	5,185	5,016	
Otolaryngology	1,787	1,960	1,697	1,557	
Plastic Surgery	325	310	318	264	
Urology	3	1	0	0	
Total	10,146	11,072	11,795	11,902	5.47%

The applicant states that ophthalmology cases increased at a CAGR of 23% and the expectation is that the service will continue to grow as our population grows and ages. The average age for patients to receive cataract surgery is 73 to 75 years old.² SCG states that other cases like plastic surgery and otolaryngology have increased in length of operating room time required. SCG further states that some specialties have decreased in volume due to anomalies of one-time events, the economy and physician attrition. The applicant provides the most recent calendar year data to reinforce the case increase trend shown above, stating:

*“From January 2013 to August 2013, SCG recorded 9,002 surgical cases. Assuming an even distribution over those months, the annual surgical cases for calendar year 2013 could be as many as 13,503 (9002 cases/8 months = 1,125.25 cases/month * 12 months = 13,503). This equates to annual change of 13 percent from 2012 ((13,503-11,902)/11902) and a CAGR of 7.4 percent from 2009 thru 2013.”*

The applicant states that based on the trend data, population statistics and the expectation of future physician stability, a projection of 5.47% annual growth through 2018 is a “conservative metric for predicting future surgical cases at SCG”. The following table from page 61 shows the number of surgical cases forecast by the applicant at an annual increase of 5.47%.

Projected Surgical Cases

2012	2013	2014	2015	2016	2017	2018
Actual	Projected Surgical Cases					
	0.0547	0.0547	0.0547	0.0547	0.0547	0.0547
11,902	12,552	13,238	13,962	14,725	15,530	16,378

The applicant states that it uses the 10A NCAC 14C .2101 standards of 1.5 hours per operating room case to forecast the number of operating room hours needed and 1,872 hours per operating room to calculate the number of operating rooms needed to demonstrate the forecast need for at least 13 operating rooms, as shown in Table III.5, page 62 and below.

	2013	2014	2015	2016	2017	2018
Cases	12,552	13,238	13,962	14,725	15,530	16,378
Hours per Case	1.5	1.5	1.5	1.5	1.5	1.5
Operating Room Hours Required	18,828	19,857	20,943	22,088	23,295	24,567
Hours per Room	1,872	1,872	1,872	1,872	1,872	1,872
Operating Rooms Needed	10.1	10.6	11.2	11.8	12.4	13.1

SCG states that its projection is conservative and makes no adjustment for the longer case times that it anticipates for some specialties.

² <http://www.medicinenet.com/script/main/art.asp?articlekey=53663>

Need for Procedure Rooms at SCG

SCG anticipates needing two procedure rooms for both minor cases that cannot be accommodated in the operating rooms and expected growth in non-surgical cases. The table on page 63 and shown below provides SCG’s historical non-surgical cases, less endoscopy cases, which the applicant says moved to other facilities.

Specialty	2010	2011	2012
Pain Management	3,056	1,383	1,348
GI Endoscopy	17	17	0
YAG Laser	142	294	243
Total Non-Surgical Cases	3,215	1,694	1,591
Less Endoscopy Cases	17	17	0
Total Non-Surgical w/o Endo	3,198	1,677	1,591

The applicant notes that the 3-yr decline in non-surgical cases was temporary and reflects the movement of some pain management and YAG laser cases to private physician practices, a trend which slowed dramatically between 2011 and 2012. Given the nature of these cases and their association with an older population, SCG assumes that non-surgical cases will increase with population growth in the services area and provides data on service area population growth in Section IV. 1, pages 86 and 90, and summarized in the following table.

County	2013	2014	2015	2016	2017	2018
Alamance	154,151	155,272	156,395	157,517	158,639	159,759
Guilford	509,388	516,589	523,788	530,991	538,190	545,391
Randolph	142,646	142,698	142,750	142,801	142,852	142,902
Rockingham	92,494	92,118	91,798	91,524	91,290	91,089
Total	900,692	908,691	916,746	922,833	930,971	939,141
Population Change over Previous Year		7,999	8,055	6,087	8,138	8,170
Percent Change over Previous Year		0.9%	0.9%	0.7%	0.9%	0.9%
CAGR						0.84%

Note: the population totals for 2013-2015 are incorrect. It appears the applicant summed the year into the calculation; thus affecting the percent increase in population for 2016 over 2015. The correct percent change for 2016 is consistent with the other years at 0.9%. Using the correct population totals for the first three years brings the CAGR up to 0.88%. However, the difference is insignificant and results in the applicant’s projection of non-surgical cases being more conservative.

On page 64, the applicant forecasts growth in non-surgical cases using the population CAGR of 0.84%, as follows.

2012	2013	2014	2015	2016	2017	2018
Actual	Projected Non-surgical Cases					
	0.0084	0.0084	0.0084	0.0084	0.0084	0.0084
1,591	1,604	1,618	1,631	1,645	1,659	1,673

The applicant assumes that non-surgical cases require two-thirds the time of an operating room case, thus used one hour per non-surgical case to predict the number of procedure room hours needed and divided that by 1,800 hours per room (9 hours per day, 250 days per year, operating at 80%) to calculate the number of procedure rooms needed.

	2013	2014	2015	2016	2017	2018
Cases	1,604	1,618	1,631	1,645	1,659	1,673
Hours per Case	1	1	1	1	1	1
Procedure Room Hours Required	1,604	1,618	1,631	1,645	1,659	1,673
Hours per Room	1,800	1,800	1,800	1,800	1,800	1,800
Procedure Rooms Needed	0.89	0.90	0.91	0.91	0.92	0.93

Using the applicant’s metrics above, SCG needs one procedure room. On page 65, the applicant states that using the GI Endoscopy standard of 1500 cases per room, the need for procedure rooms at SCG increases to 1.12 rooms by 2018. *“Add to that the 0.1 extra operating room needed from Table III.5, and **the number of procedure rooms needed in 2018 is 1.22.**”*[emphasis added in original]

In Section III.1, page 65, the applicant states the following as reasons to round up to 2.0 rooms:

1. the short supply of ASC operating rooms in the service area combined with increasing copayments and deductibles for private insured and Medicare managed care, which will favor higher future demand for ASC cases than SCG has forecast here,
2. the fact that the facility will operate at this location beyond 2018,
3. one procedure room will be a permanent location for YAG Laser treatments, eliminating the risks associated with moving the equipment between rooms,
4. the ability to move minor cases from the operating rooms to accommodate longer cases, better productivity, parallel processing opportunities, more efficiency in operations and patient scheduling, and the opportunity that increasing operating room capacity creates for earlier start times for more acute surgical cases.

Need for Pre-operating, Stage I and Stage II Recovery Rooms at SCG

SCG projects the need for 24 pre-operating rooms and 28 Stage I recovery rooms based on published facility planning standards recommending one to two pre-operative bed spaces and one to two Stage I recovery bays for every one operating or procedure room.³

On page 65, the applicant states, “*The proposed facility will be within recommended standards.*”

To forecast the need for Stage II recovery beds for 2018, SCG multiplied the average percent of current SCG surgical cases needing Stage II overnight recovery beds (8.5%) by the projected number of surgical cases in 2018 (16,378) for 1,391 Stage II cases when divided by 250 days results in 5.6 $((16,378 \times 8.5\%) / 250 = 5.6)$ Stage II cases per day or 7.4 $(5.6 / 75\% = 7.4)$ Stage II rooms needed at 75% occupancy. The applicant states occupancy of 75% is reasonable for estimating peak load on a small unit of less than 10 beds; and rounding up is reasonable because trends show future increases in cases and building another room later would be unreasonably disruptive. The following table illustrates the applicant’s proposed pre-operating and recovery rooms relative to the number of operating and procedure rooms.

Room / Bay Type	Operating Rooms + Procedure Rooms	Proposed Ratio	Number of Rooms /Bays Required
Pre-operating Room	15	1.60	24
Stage I Recovery Room	15	1.87	28
Stage II Recovery Room for Overnight Surgical Cases	13	0.62	8

On page 67, the applicant further supports the need for its proposed project based on SCG’s need to maintain its successful clinical program, its quality clinical outcomes and its strong financial performance, stating:

“SCG must be prepared to manage its share of the growth in its existing service area, and provide the amenities that make its facility attractive to patients, employees, and medical staff.

With buildings that were designed and built 20 to 30 years ago on tight propertied, SCG cannot achieve these quality standards. New accreditation standards for environment of care emphasize privacy, clear corridors, and add life safety requirements in new facilities.”

Access to Services

In Section VI, pages 103-114, the applicant addresses access to SCG’s services. On page 103, the applicant states:

³ Hayward, Cynthia. SpaceMed Guide: A Space Planning Guide for Healthcare Facilities. 2006. p. 6-8.

“The proposed project will provide access to low income persons, to racial and ethnic minorities, to women, to handicapped persons, to the elderly and to other underserved patients.”

On page 107, the applicant further states:

“SCG does not discriminate on the basis of age, race, national or ethnic origin, disability, sex, income, or ability to pay. ... Patients are admitted and services are rendered in compliance with:

- *Title VI of Civil Rights Act of 1963*
- *Section 504 of Rehabilitation Act of 1973*
- *The Age Discrimination Act of 1975*
- *Americans with Disabilities Act*

For the fiscal year 2012, 37.39 percent of SCG cases were covered by Medicare and 9.1 percent by Medicaid, Self-pay, indigent and charity care. SCG reported \$210,502 in Provision for Doubtful Accounts, which includes Self Pay, Charity and Bad Debt.”

On page 109, the applicant states, *“SCG is easily accessible by these underserved groups and by the remainder of the local population as well. Consistent with SCG’s existing admission, credit and collection policies, SCG will continue to be available to and accessible by any patient having a need for ambulatory surgical services.”* Financial policies are presented in Exhibits 6, 21 and 25.

The applicant demonstrates SCG will continue to provide adequate access to healthcare services to the same population it currently serves, which includes handicapped, elderly, and the underserved groups.

In summary, the applicant adequately identifies the population SCG proposes to serve, adequately demonstrates the need the population has for the proposed relocation and further demonstrates all residents of the area will have adequate access to the proposed services. Therefore, the application is conforming to this criterion.

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

C

The applicant proposes to relocate its two-building ambulatory surgical center to a new replacement facility approximately 2.5 miles from the existing buildings. Both the

existing buildings and the proposed replacement facility are in north Greensboro off of Wendover Avenue with equivalent access to the major highways in the area. Thus, the replacement facility will be geographically accessible to the same population presently served at SCG. In Section VI, pages 103-113, the applicant provides reasons why the relocation and replacement of the ORs will have a positive effect 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. Consequently, the application is conforming to this criterion.

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

CA

In Section III.8, pages 75-78, the applicant describes the alternatives considered:

- Maintain the status quo,
- Renovate one or both of the existing buildings,
- Move to a new location,
- Decrease the number of operating rooms, and
- Not building procedure rooms.

Status Quo

The applicant says status quo is not a viable option from an operational standpoint because continuing to practice in the existing buildings is not cost-effective or efficient. The existing buildings are over 20 years old, have inadequate support space and the infrastructure is becoming antiquated. SCG estimates incurring \$225,000 in excess maintenance expense per year for both buildings combined. On page 75, the applicant states that leaving the facility in separate buildings sustains unnecessary costs: requiring different sets of support staff and equipment that cannot be shared. By combining staff, SCG estimates saving approximately \$300,000 per year in labor costs alone. The applicant further states that limited space and building condition have affected patient satisfaction. On page 76, the applicant states:

“Moving SCG operations to a single, [sic] facility can reduce operating costs associated with duplicated functions like reception, sterilization and processing, and waste management. Savings associated with consolidation can be deployed to increase patient and staff amenities and enhance privacy.”

Renovate Existing Space

Though the applicant considered renovating one or the other of the buildings and expanding to consolidate services, SCG found that consolidation to one of the two sites and bringing the single facility up to all current codes would not only be very costly, it would require taking

that building out of service for a year or more, which would reduce access to the less costly freestanding ambulatory operating rooms in Guilford County. Costs of this approach negated many of the positive aspects of consolidation and would produce a less ideal result. On page 76, the applicant states:

“Using the current locations is undesirable because of operational considerations, construction cost issues, structural and functional compromises, and limitations on future growth. This alternative was rejected.”

Move to a New Location

In Section III.8, page 76, the applicant states that a new, consolidated facility in a new location proves the best alternative with regard to construction, operating cost, and patient and staff quality of life. SCG stated consideration of the following in choosing a new location:

1. distance from current location,
2. proximity to emergency services and hospitals,
3. adequate size to accommodate both facilities' operations, and
4. suitable neighborhood.

The applicant states that meeting the above criteria ensures a new location will still be convenient for patients and staff, and near other medical facilities that can support emergencies.

Decrease the Number of ORs

The option of decreasing the number of ORs was considered by the applicant and found undesirable and unnecessary. The applicant states that decreasing operating rooms would compromise SCG goals of quality and efficient care for patients and limit physicians' and patients' opportunities to schedule cases in a freestanding ambulatory surgery center when demand is increasing.

Not Building Procedure Rooms

On page 77, the applicant states, *“CMS has expanded the scope of procedures it considers appropriate for freestanding ambulatory surgery settings.”* SCG does not have a dedicated room for YAG laser or pain management cases. The applicant states that both the forecast caseload and efficiency of parallel processing, support adding two procedure rooms, one of which will provide a permanent location for the YAG Laser equipment.

The applicant's final argument in support of the proposed project involves managing the quality of air in the surgical center by completing all construction before the facility is occupied for surgery. The applicant says adding the procedure rooms later would increase the construction cost per room and disrupt operations.

The applicant adequately demonstrates that the proposed alternative is the most effective or least costly alternative for the following reasons:

- The relocation of services, from the separate older buildings to a nearby single building, does not change SCG's patient origin of surgical cases or the payor mix. The proposed location is geographically accessible to the same population now served at SCG.
- SCG will provide surgical care to patients more efficiently and effectively because consolidation of all services will:
 - eliminate the need to transport patients between buildings for some services;
 - reduce operating costs associated with duplicated functions like receptions, sterilization and processing, and waste management; and
 - achieve economies of scale and staffing efficiency in recovery, PACU and pre-operation spaces.

Therefore, the applicant adequately demonstrates that the proposal is its least costly or most effective alternative to meet its identified need and the application is conforming to this criterion. Furthermore, the application is conforming to all other statutory and regulatory review criteria, and thus, is approvable. A project that cannot be approved cannot be an effective alternative.

In summary, the applicant adequately demonstrates that its proposal is the least costly or most effective alternative to meet the need. Therefore, the application is conforming to this criterion and approved subject to the following conditions and the condition in Criterion (5).

- 1. Surgical Center of Greensboro, LLC shall materially comply with all representations made in its certificate of need application.**
- 2. Surgical Center of Greensboro, LLC shall relocate 13 operating rooms from two buildings to a single ambulatory surgical center which shall be licensed for no more than 13 dedicated outpatient operating rooms and two procedure room at project completion.**
- 3. Surgical Center of Greensboro, LLC shall construct no more than 13 operating rooms in the replacement facility that meet licensure requirements for an operating room under the ambulatory surgical facility rules.**
- 4. The two procedure rooms shall not be used for procedures that should be performed only in an operating room based on current standards of practice.**
- 5. Procedures performed in the minor procedure rooms shall not be reported for billing purposes as having been performed in an operating**

room and shall not be reported on the facility's license renewal application as procedures performed in an operating room.

- 6. Surgical Center of Greensboro, LLC shall not perform gastrointestinal endoscopy procedures in the procedure rooms.**
 - 7. Surgical Center of Greensboro, LLC shall meet all criteria to maintain accreditation of the ambulatory surgical facility from The Joint Commission, The Accreditation Association of Ambulatory Health Care or a comparable accreditation authority within two years following completion of the facility.**
 - 8. Surgical Center of Greensboro, LLC shall not acquire, as part of this project, any equipment that is not included in the project's proposed capital expenditure in Section VIII of the application or which would otherwise require a certificate of need.**
 - 9. Surgical Center of Greensboro, LLC shall develop and implement an Energy Efficiency and Sustainability Plan for the project that conforms to or exceeds energy efficiency and water conservation standards incorporated in the latest editions of the North Carolina State Building Codes. The plan must be consistent with the applicant's representations in the written statement as described in paragraph one of Policy GEN-4.**
 - 10. Surgical Center of Greensboro, LLC shall acknowledge acceptance of and agree to comply with all conditions stated herein in writing to the Certificate of Need Section prior to the issuance of the certificate of need.**
- (5) Financial and operational projections for the project shall demonstrate the availability of funds for capital and operating needs as well as the immediate and long-term financial feasibility of the proposal, based upon reasonable projections of the costs of and charges for providing health services by the person proposing the service.

CA

In Section VIII.1, pages 131-135, the applicant projects that the total capital cost of the project will be \$22,974,570 as shown in the table below.

Project Capital Costs

Capital Costs	SEBR 715, LLC, Unrelated Developer Lessor Costs	SCG Lessee Costs	Total Costs
Land	\$ 2,000,000		\$ 2,000,000
Site Costs	\$ 1,104,817		\$ 1,104,817
Materials	\$ 12,698,827		\$ 12,698,827
Labor	\$ 571,447		\$ 571,447
Contingency	\$ 1,327,027		\$ 1,327,027
Fixed Equipment		\$ 2,246,544	\$ 2,246,544
Moveable Equipment			\$ -
Furniture		\$ 204,277	\$ 204,277
Landscaping	\$ 120,000		\$ 120,000
Architect/Eng/Legal Fees	\$ 1,126,848	\$ 25,000	\$ 1,151,848
Market Analysis	\$ 8,000		\$ 8,000
Other	\$ 291,946	\$ 95,000	\$ 386,946
Financing	\$ 15,000	\$ 5,500	\$ 20,500
Interest During Construction	\$ 565,043	\$ 89,979	\$ 655,022
Contingency	\$ 212,684	\$ 266,630	\$ 479,314
Total Capital Costs	\$ 20,041,640	\$ 2,932,930	\$ 22,974,570

On page 133, the applicant states that the building is being developed by an unrelated developer, SEBR 715, LLC, and states, *“These costs will be retired by means of a lease. Exhibit 47 contains a copy of the proposed lease. Exhibit 9 contains a letter agreeing to provide the building. The developer is not an applicant for this project.”* On page 136, the applicant states SEBR 715, LLC owns the proposed site and has agreed to contribute the land and a medical office building to SCG upon approval of the proposed project.

Exhibit 8 contains a bank letter from BB&T stating willingness to provide a loan to SEBR 715 for the capital costs in the amount of \$16,041,639.73 for the medical office building. The same exhibit contains a letter from Goldman, Sachs & Co. stating SEBR 715, LLC principles have the assets available for the owner’s equity contribution to funding the capital costs.

Exhibit 48 contains a letter from the architect which states that total estimated construction costs are \$14,597,301, not including land and site costs, which is consistent with the information in Section VIII.

On page 136, the applicant states, *“Surgical Center of Greensboro, LLC will fund the capital costs for equipment and upfits through a bank loan.”* Exhibit 8 contains a First Citizens Bank letter welcoming the opportunity to loan up to \$3.5 million to SCG for capital equipment costs.

In Section IX.1-3, page 139, the applicant states start-up and initial operating expenses required for the project will total \$30,000 and that the source of the working capital will be cash flow from operations. The applicant states, “*SCG will finance the start-up costs through cash flow from operations. Please see Proforma Form B in Tab XIII* “. The applicant does not provide a letter from SCG documenting its intention to finance the start-up with cash from operations. Exhibit 7 contains the Surgical Center of Greensboro’s balance sheet for the period ending July 31, 2013 and income statement for the period ending December 31, 2012. As of July 31, 2013, SCG had cash and temporary investments of \$1,904,391, total current assets of \$5,123,644 and total net assets of \$4,168,929 (total assets – total liabilities). Exhibit 7 also contains the audited consolidated financials for Surgical Care Affiliates for the years ending December 31, 2012 and 2011. As of December 31, 2012, SCA had cash and cash equivalents of \$118,540,000, total current assets of \$264,273,000 and total net assets of \$338,386,000.

The applicant provided pro forma financial statements for the first three years of the project. The applicant projects revenues will exceed operating expenses in each of the first three operating years of the project, as illustrated in the table below.

	First Full FY 2016	Second Full FY	Third Full FY
Projected # of OR Cases	14,726	15,531	16,379
Projected Average Charge OR Cases	\$ 9,855	\$ 10,150	\$ 10,455
Projected # of Procedure Room Cases	1,645	1,659	1,673
Projected Average Charge PR Cases	\$ 4,517	\$ 4,652	\$ 4,792
Projected Total Cases	16,370	17,189	18,051
Projected Average Charge	\$ 9,328	\$ 9,629	\$ 9,939
Gross Patient Revenue	\$ 152,691,897	\$165,506,881	\$179,413,724
Deductions from Gross Patient Revenue	\$ 118,015,221	\$128,602,043	\$140,147,513
Net Patient Revenue	\$ 34,676,676	\$ 36,904,839	\$ 39,266,210
Other Revenue	\$ 1,260	\$ 1,260	\$ 1,260
Total Expenses	\$ 19,349,365	\$ 20,160,902	\$ 21,031,304
Net Income	\$ 15,328,570	\$ 16,745,197	\$ 18,236,166

The applicant also projects a positive net income for the entire facility in each of the first three operating years of the project. The assumptions used by the applicant in preparation of the pro forma financial statements are reasonable, including projected utilization, costs and charges. See the pro forma statements, pages 158-168 for the assumptions regarding costs and charges. See Criterion (3) for discussion regarding projected utilization which is incorporated hereby as if fully set forth herein. The applicant adequately demonstrates that the financial feasibility of the proposal is based upon reasonable projections of costs and charges, and therefore, the application is conforming to this criterion, subject to the following condition:

Prior to issuance of the certificate of need, Surgical Center of Greensboro, LLC shall provide the CON Section with adequate documentation demonstrating SCG's intent to finance the start-up costs through cash flow from operations.

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

C

The applicant adequately demonstrates that the proposal will not result in the unnecessary duplication of existing or approved health service capabilities for the following reasons: First, the applicant does not propose to increase the number of licensed operating rooms, add services, or acquire equipment for which there is a need determination methodology in the 2013 SMFP. Second, the applicant's projected growth rates for surgical and non-surgical cases are reasonable, supported and reliable. Thus, the number of surgical cases and non-surgical procedure cases projected to be performed at the relocated ASC is reasonable. Consequently, the number of ORs and procedure rooms needed appears reasonable. See Criterion (3) for additional discussion regarding need and utilization, which is incorporated hereby as if fully set forth herein. The applicant adequately demonstrates that the relocation of the facility is necessary and the proposed project is its least costly or most effective alternative to meet the stated need. Therefore, the application is conforming to this criterion.

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

C

In Section VII.2, pages 115-118, the applicant provides the current and projected staffing for SCG as illustrated below.

Position	Current FTEs	Proposed 2017 FTEs	Proposed Salary
Health Care Administrators	1.0	1.0	\$ 135,688
RNs	75.5	77.7	\$ 65,763
LPNs	0.5	0.5	\$ 38,134
Nurse Aids/Orderlies/Attendants	3.0	3.0	\$ 30,191
Surgical Techs	12.6	13.2	\$ 39,320
Rad Techs	4.8	3.1	\$ 60,633
Non-health personnel	38.5	38.3	\$ 34,658
Total	135.9	136.8	

The applicant states the new facility will operate Monday through Friday 6:00 am until 5:00 pm or until the last surgery is completed and the patient is recovered and discharged. The recovery center is open Monday from 7:00 am through Saturday at 8:00 am, 24 hours a day, five days a week and eight hours on Saturday. A patient’s stay is limited to less than 24 hours. The applicant expects to achieve economies of scale in staffing by combining the two buildings into one facility. On page 117, the applicant states:

“Consolidating will create staffing efficiency in recovery, PACU, and pre-operation spaces. The proposed additional procedure rooms will each be staffed by a registered nurse and surgical technician. Additional use of flexible part-time pool nurses and other pool staff will cover the proposed procedure rooms, as well as forecast increases in cases.”

Pool staffing is calculated and presented on page 118. In Section VII.3(b), page 119, the applicant discusses the availability of and recruiting of staff. In Section V.3, pages 95-97, the applicant discusses its relationship with local healthcare providers and SCG’s medical staff. SCG identifies John Byers, M.D., as the Medical Director for Surgical Center of Greensboro. Exhibit 10 contains Dr. Byers’ CV. Exhibit 42 contains a letter documenting Dr. Byers’ willingness to continue to serve as medical director. The applicant demonstrates the availability of adequate health manpower and management personnel to provide the proposed services and is conforming with this criterion.

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

C

In Section II.2, pages 23-25, the applicant discusses the necessary ancillary and support services which will be available at the relocated facility and provides a list on page 24 of the services and the associated provider of the service. Exhibit 43 contains a letter from

SCG facility Administrator listing the ancillary and support services currently offered at SCG and documenting that the services will continue to be offered at the relocated facility.

In Section V.1, page 93, the applicant states that SCG has offered its facility as a training site to area nursing and surgical professional training programs. See Exhibit 50 for copies of letters sent to various professional healthcare training programs. In Section V.2(a), page 94, the applicant states that as an existing ASC, it has transfer agreements with the following hospitals: Alamance Regional Medical Center, Cone Health, Randolph Hospital, Rex Hospital, Thomasville Medical Center and Wake Forest Baptist Health. Exhibit 41 contains a copy of SCG's agreement with Moses Cone Memorial Health System. Exhibit 51 contains 50 plus physician support letters.

The applicant adequately demonstrates the availability of the necessary ancillary and support services and that the existing and relocated services will be coordinated with the existing health care system. Therefore, the application is conforming to this criterion.

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

NA

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

NA

- (11) Repealed effective July 1, 1987.
- (12) Applications involving construction shall demonstrate that the cost, design, and means of construction proposed represent the most reasonable alternative, and that the construction project will not unduly increase the costs of providing health services by the person proposing the construction project or the costs and charges to the public of providing

health services by other persons, and that applicable energy saving features have been incorporated into the construction plans.

C

The applicant proposes to lease and upfit a developer constructed 48,002 square foot building for the relocated facility. In Section XI.6 (a), page 148, the applicant provides details of the square footage allocation, as shown in the table below:

	Total Square Footage / New Construction
Entry/Waiting	4,073
Reception/Business Office	3,195
Pre-operative	3,973
Post-operative	10,608
Clinical Support	1,526
Surgical Services Areas	15,575
Staff Support Areas	4,582
General Storage and Utility Areas	4,470
Totals	48,002

The certified estimate of construction costs from the architect, included in Exhibit 48, is consistent with the construction costs reported by the applicant in Section VIII, page 134. In Section XI.6(b), page 148, the applicant estimates construction costs of \$304 per square foot. In Section XI.8, page 149, the applicant describes the methods to be used to maintain efficient energy operations.

The applicant adequately demonstrates that the cost, design, and means of construction represent the most reasonable alternative for the project as proposed and that the construction project will not unduly increase the costs and charges of providing health services. See Criterion (5) for discussion of costs and charges. Therefore, the application is conforming to this criterion.

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

C

In Section VI.12, page 112, the applicant provides the payor mix for SCG for fiscal year 2012, as illustrated in the following table.

SCG FY2012 Payor Mix	
Self Pay/Indigent/Charity	1.6%
Commercial	0.0%
Medicare/Medicare Managed Care	37.4%
Medicaid	7.5%
Managed Care	45.9%
Other	7.6%
TOTAL	100.0%

Source: 2013 LRA

The Division of Medical Assistance (DMA) maintains a website which offers information regarding the number of persons eligible for Medicaid assistance and estimates of the percentage of uninsured for each county in North Carolina. The following table illustrates those percentages for the proposed service area counties and statewide.

	2010 Total # of Medicaid Eligibles as % of Total Population *	2010 Total # of Medicaid Eligibles Age 21 and older as % of Total Population *	2008-2009 % Uninsured (Estimate by Cecil G. Sheps Center) *
Guilford County	15%	5.9%	19.5%
Rockingham County	20%	9.3%	19.0%
Randolph County	19%	7.2%	19.5%
Alamance County	16%	6.2%	21.0%
Statewide	17%	6.7%	19.7%

Source: <http://www.ncdhhs.gov/dma/countyreports/index.htm>

More current data, particularly with regard to the estimated uninsured percentages, was not available.

The majority of Medicaid eligibles are children under the age of 21.

Moreover, the number of persons eligible for Medicaid assistance may be greater than the number of Medicaid eligibles who actually utilize health services. The DMA website includes information regarding dental services which illustrates this point. For dental services only, DMA provides a comparison of the number of persons eligible for dental services with the number actually receiving services. The statewide percentage of persons eligible to receive dental services who actually received dental services was 48.6% for those age 20 and younger and 31.6% for those age 21 and older. Similar information is not provided on the website for other types of services covered by Medicaid. However, it is reasonable to assume that the percentage of those actually receiving other types of health services covered by Medicaid is less than the percentage that is eligible for those services.

The Office of State Budget & Management (OSBM) maintains a website which provides historical and projected population data for each county in North Carolina. In addition, data is available by age, race or gender. However, a direct comparison to the applicant's current payor mix would be of little value. The population data by age, race or gender does not include information on the number of elderly, minorities or women utilizing health services. Furthermore, OSBM's website does not include information on the number of handicapped persons.

The applicant demonstrates that medically underserved populations have adequate access to existing services; 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

In Section VI.11, page 112, the applicant states, "*The applicant has not had any legal obligations to provide uncompensated care.*"

In Section VI.10(a), page 112, the applicant states, "*The applicant and its management company have not received any civil rights complaints.*" The application is conforming with this criterion.

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

C

In Section VI.14, page 114, the applicant states its expectation for the future payor mix to stay the same as the existing payor mix. The applicant projects the following payor mix for the proposed facility in 2017, Project Year 2, as illustrated in the following table.

Surgical Center of Greensboro FY 2017	
Self Pay/Indigent/Charity	1.6%
Commercial Insurance	0.0%
Medicare/Medicare Managed Care	37.4%
Medicaid	7.5%
Managed Care	45.8%
Other	7.6%
TOTAL	100.0%

Totals may not sum due to rounding.

As shown in the table above, the applicants project that 44.9% of all patients will have some or all of their services paid for by Medicare or Medicaid. In Section VI.2, page 103, the applicant states, *“The proposed project will provide access to low income persons, to racial and ethnic minorities, to women, to handicapped persons, to the elderly and to other underserved patients.”* See Exhibits 6 and 21 for copies of financial policies. Exhibit 25 contains a copy of the Financial Orientation and Pre-registration Follow-up. The applicant demonstrates that medically underserved groups will have adequate access to the proposed services, and the application is conforming with this criterion.

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

C

In Section VI.9(a), page 111, the applicant says patients are referred for services by a physician and cannot self-refer for surgery procedures. The applicant further states:

“A patient or the patient’s primary physician can refer the patient to a member of SCG’s medical staff. If that medical staff member deems the patient is in need of a surgery or procedure, then that medical staff member will schedule an admission.”

The applicant adequately demonstrates it will provide a range of means by which a person can access services. 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

In Section V.1, page 93, the applicant states:

“SCG will make its facility available to any and all relevant training programs in the area. This includes registered nursing and surgical technology programs.”

Exhibit 50 contains copies of letters offering SCG as a clinical training site for the following professional training programs: Guilford Technical Community College, University of North Carolina, Greensboro Nursing School, North Carolina A&T State University School of Nursing, Rockingham Community College, Randolph Community College, Alamance Community College, and Forsyth Technical Community College. Therefore, the applicant adequately demonstrates that SCG will accommodate the clinical needs of area health professional training programs. Thus, the application is conforming with this criterion.

- (15) Repealed effective July 1, 1987.
(16) Repealed effective July 1, 1987.
(17) Repealed effective July 1, 1987.
(18) Repealed effective July 1, 1987.
- (18a) The applicant shall demonstrate the expected effects of the proposed services on competition in the proposed service area, including how any enhanced competition will have a positive impact upon the cost effectiveness, quality, and access to the services proposed; and in the case of applications for services where competition between providers will not have a favorable impact on cost-effectiveness, quality, and access to the services proposed, the applicant shall demonstrate that its application is for a service on which competition will not have a favorable impact.

C

The applicant proposes to relocate and consolidate its existing two-building ambulatory surgical facility to a new location. The new building will house the 13 existing operating rooms, 28 Stage I recovery bays, eight Stage II recovery bays, 24 pre-operation bays, four consult rooms, two new procedure rooms and related support space. The applicant does not propose to develop new operating rooms or new services, or acquire equipment for which there is a need determination in the 2013 SMFP.

Per the 2013 SMFP, the following table lists the existing and approved operating room inventory in Guilford County.

Guilford County Operating Room and Endoscopy Room Inventory

Facility	Inpatient	Ambulatory	Shared	CON Adjustments	Total ORs
Premier Surgery Center				2	2
Greensboro Specialty Surgical Center		3			3
Carolina Birth Center		1			1
Surgical Center of Greensboro		13			13
Surgical Eye Center		4			4
High Point Surgery Center		6			6
Piedmont Surgical Center		2			2
High Point Regional Health System	3		9	-1	11
Kindred Hospital-Greensboro			1		1
Cone Health	4	13	37		54
Total	7	42	47	1	97

In Section V.7, pages 99-102, the applicant discusses the impact of the proposed project on competition in the service area as it relates to promoting cost-effectiveness, quality and access. In reference to cost-effectiveness, the applicant states that ambulatory surgery centers have lower charges on average than a hospital based surgery center for the same procedures and patients typically pay less coinsurance for procedure performed in an ASC than for comparable procedures in a hospital setting. On page 101, the applicant states:

“SGC’s [sic] lower charges reflect the efficiency that an ambulatory setting provides, due to higher staff productivity, lower facility costs, scheduling improvements and other economies related to the experienced management company, and the dedicated medical staff.”

The proposed procedure rooms will provide a less costly alternative for clinically appropriate patients.”

With regard to quality, the applicant states the proposed relocation to a combined new facility will be an improvement to the physical and operational environment of SCG, saying,

“It will improve facility operations, which will, in turn, directly impact patient care. ... In addition, the design and available capacity in the new location will promote patient quality of life with more early start times, physician productivity through parallel processing and increase operational efficiency by having all operations in one building.”

The applicant refers to Section III.1(a) for further discussion on the quality of care and patient satisfaction impact of relocating the facility. The applicant addresses access on page 102 in regard to both location and pricing/reimbursement. Exhibit 40 provides pictures of limited parking and storage constraints at the existing buildings. SCG states that in selecting the location, it addressed bus routes, emergency services and support services to determine adequate patient access to each, including convenience for existing patients. The applicant

states that SCG's pricing will make it more attractive to persons who are uninsured and underinsured and that, "*Its practices with regard to Medicaid and charity are, and will continue to be competitive.*" See Exhibits 6 and 21 for financial policies and Exhibit 38 for SCG's non-discrimination policy.

The information provided by the applicant in those sections is reasonable and credible and adequately demonstrates that the expected effects of the proposal on competition in the service area include a positive impact on cost-effectiveness, quality and access to the proposed services. This determination is based on the information in the application and the following analysis:

- The applicant adequately demonstrates the need to relocate and consolidate its ambulatory surgery center and that it is a cost-effective alternative;
- The applicant adequately demonstrates that it will continue to provide quality services; and
- The applicant demonstrates that it will continue to provide adequate access to medically underserved populations.

The application is conforming to this criterion.

- (19) Repealed effective July 1, 1987.
- (20) An applicant already involved in the provision of health services shall provide evidence that quality care has been provided in the past.

C

Per its 2013 License Renewal Application, The Surgical Center of Greensboro is accredited by The Joint Commission and certified for participation in Medicare and Medicaid. According to the files in the Acute and Home Care Licensure and Certification Section, Division of Health Service Regulation, no incidents occurred 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 with this criterion.

- (21) Repealed effective July 1, 1987.
- (b) The Department is authorized to adopt Rules for the review of particular types of applications that will be used in addition to those criteria outlined in subsection (a) of this section and may vary according to the purpose for which a particular review is being conducted or the type of health service reviewed. No such Rule adopted by the Department shall require an academic medical center teaching hospital, as defined by the State Medical Facilities Plan, to demonstrate that any facility or service at another hospital is being appropriately utilized in order for that academic medical center teaching hospital to be approved for the issuance of a certificate of need to develop any similar facility or service.

C

Select rules in The Criteria and Standards for Surgical Services and Operating Rooms, promulgated in 10A NCAC 14C .2100, are applicable to this review. The specific criteria are discussed below.

SECTION .2100 – CRITERIA AND STANDARDS FOR SURGICAL SERVICES AND OPERATING ROOMS

.2102 INFORMATION REQUIRED OF APPLICANT

.2102(a) An applicant proposing to establish a new ambulatory surgical facility, to establish a new campus of an existing facility, to establish a new hospital, to convert a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or to add a specialty to a specialty ambulatory surgical program shall identify each of the following specialty areas that will be provided in the facility:

- (1) gynecology;*
- (2) otolaryngology;*
- (3) plastic surgery;*
- (4) general surgery;*
- (5) ophthalmology;*
- (6) orthopedic;*
- (7) oral surgery; and*
- (8) other specialty area identified by the applicant.*

-NA- The applicant is proposing to build a replacement facility and relocate existing surgical services, including 13 operating rooms.

.2102(b) An applicant proposing to increase the number of operating rooms in a service area, to convert a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or to add a specialty to a specialty ambulatory surgical program shall provide the following information:

(1) the number and type of operating rooms in each licensed facility which the applicant or a related entity owns a controlling interest in and is located in the service area (separately identifying the number of dedicated open heart and dedicated C-Section rooms);

(2) the number and type of operating rooms to be located in each licensed facility which the applicant or a related entity owns a controlling interest in and is located in the service area after completion of the proposed project and all previously approved projects related to these

facilities (separately identifying the number of dedicated open heart and dedicated C-Section rooms);

(3) The number of inpatient surgical cases, excluding trauma cases reported by Level I, II and III trauma centers, cases reported by designated burn intensive care units, and cases performed in dedicated open heart and dedicated C-Section rooms, and the number of outpatient surgical cases performed in the most recent 12 month period for which data is available, in the operating rooms in each licensed facility listed in response to Subparagraphs (b)(1) and(b)(2) of this Rule;

(4) The number of inpatient surgical cases, excluding trauma cases reported by Level I, II and III trauma centers, cases reported by designated burn intensive care units, and cases performed in dedicated open heart and dedicated C-Section rooms, and the number of outpatient surgical cases projected to be performed in each of the first three operating years of the proposed project, in each licensed facility listed in response to Subparagraphs (b)(1) and (b)(2) of this Rule;

(5) A detailed description of and documentation to support the assumptions and methodology used in the development of the projections required by this Rule;

(6) The hours of operation of the proposed operating rooms;

(7) If the applicant is an existing facility, the average reimbursement received per procedure for the 20 surgical procedures most commonly performed in the facility during the preceding 12 months and a list of all services and items included in the reimbursement;

(8) the projected average reimbursement to be received per procedure for the 20 surgical procedures which the applicant projects will be performed most often in the facility and a list of all services and items in the reimbursement; and

(9) identification of providers of pre-operative services and procedures which will not be included in the facility's charge.

-NA- SCG is not proposing to increase the number of operating rooms in a service area, to convert a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or to add a specialty to a specialty ambulatory surgical program.

.2102(c) An applicant proposing to relocate existing or approved operating rooms within the same service area shall provide the following information:

(1) the number and type of existing and approved operating rooms in each facility in which the number of operating rooms will increase or decrease (separately identifying the number of dedicated open heart and dedicated C-Section rooms);

- C - The applicant is licensed to operate 13 dedicated multi-specialty ambulatory surgery operating rooms and proposes to relocate all 13 ORs to one building.

(2) the number and type of operating rooms to be located in each affected facility after completion of the proposed project and all previously approved projects related to these facilities (separately identifying the number of dedicated open heart and dedicated C-Section rooms);

- C- In Section II.10, page 35, the applicant states:

“SCG proposes to relocate its 13 existing multi-specialty operating rooms from its current two-building “ambulatory surgical facility” to a new, consolidated ambulatory surgery facility. No operating rooms will remain in the vacated space.”

(3) the number of inpatient surgical cases, excluding trauma cases reported by Level I, II, or III trauma centers, cases reported by designated burn intensive care units, and cases performed in dedicated open heart and dedicated C-section rooms, and the number of outpatient surgical cases performed in the most recent 12 month period for which data is available, in the operating rooms in each facility listed in response to Subparagraphs (c)(1) and (c)(2) of this Rule;

- C- In Section II, page 36, the applicant provides the number of outpatient surgical cases performed in 2012 at SCG, as reported on its 2013 License Renewal Application: 11,903. No inpatient surgical cases were reported.

(4) the number of inpatient surgical cases, excluding trauma cases reported by level I, II, or III trauma centers, cases reported by designated burn intensive care units and cases performed in dedicated open heart and dedicated C-section rooms, and the number of outpatient surgical cases projected to be performed in each of the first three operating years of the proposed project, in each facility listed in response to Subparagraphs (c)(1) and (c)(2) of this Rule;

- C- On page 36, the applicant provides the number of outpatient surgical cases projected to be performed in each of the first three operating years of the proposed project. SCG does not project performing inpatient surgical cases.

SCG	PY1 FY2016	PY2 FY2017	PY3 FY2018
Outpatient Surgical Cases	14,725	15,530	16,378

See Criterion (3) for discussion regarding projected utilization, which is hereby incorporated as if set forth fully herein.

(5) a detailed description of and documentation to support the assumptions and methodology used in the development of the projections required by this Rule;

- C- The applicant refers to Section IV for documentation to support the assumptions and methodology used in the development of the projections required by this Rule. The assumptions used to project the number of outpatient surgical cases at SCG are reasonable and supported. See Criterion (3) for discussion regarding utilization, which is hereby incorporated as if fully set forth herein. Therefore, the application is conforming to this Rule.

(6) the hours of operation of the facility to be expanded;

- C- In Section II.10, page 37, the applicant states that the hours of operation will remain the same: 6:00 am to 5:00 pm, Monday through Friday, or until the last surgery is completed and the patient is recovered and discharged. The Recovery Care Center is open Monday at 7:00 am until Saturday at 8:00 am, 24 hours a day, five days a week and eight hours on Saturday. The applicant also states that a patient's stay is limited to less than 24 hours.

(7) the average reimbursement received per procedure for the 20 surgical procedures most commonly performed in each affected facility during the preceding 12 months and a list of all services and items included in the reimbursement;

- C- The applicant provides a table with the average reimbursement for the 20 most commonly performed surgical procedures at SCG, during the preceding 12 months, in Exhibit 45. The applicant states that patients receive a separate bill for the contracted services of anesthesia, pathology and laboratory. SCG's charges include all other applicable services, except physician professional fees.

(8) the projected average reimbursement to be received per procedure for the 20 surgical procedures which the applicant projects will be performed most often in the facility to be expanded and a list of all services and items included in the reimbursement; and

-C- In Section II.10, page 37, the applicant states,

“The average reimbursement is expected to change only with inflation and payor policies / negotiations, after the facility is relocated. Please see Exhibit 45 for a table of the 20 surgical procedures most commonly performed at SCG during the preceding 12 months and their average reimbursements. Please see pro forma assumptions in Section XIII for expected average changes in reimbursement. SCG cannot predict what payors will do.”

The applicant further states that patients receive a separate bill for the contracted services of anesthesia, pathology and laboratory. SCG’s charges include all other applicable services, except physician professional fees.

9) identification of providers of pre-operative services and procedures which will not be included in the facility's charge.

-C- In Section II.10, page 38, the applicant states *“Pre-operative anesthesia services are billed separately by Gate City Anesthesia. Greensboro Pathology and Solstas Lab Partners bills patients separately for pathology and laboratory services, respectively. In addition, physician charges are billed separately to the patient by the practicing surgeon.”*

.2102(d) *An applicant proposing to establish a new single specialty separately licensed ambulatory surgical facility pursuant to the demonstration project in the 2010 State Medical Facilities Plan shall provide:*

(1) the single surgical specialty area in which procedures will be performed in the proposed ambulatory surgical facility;

(2) a description of the ownership interests of physicians in the proposed ambulatory surgical facility;

(3) a commitment that the Medicare allowable amount for self pay and Medicaid surgical cases minus all revenue collected from self-pay and Medicaid surgical cases shall be at least seven percent of the total revenue collected for all surgical cases performed in the proposed facility;

(4) for each of the first three full fiscal years of operation, the projected number of self-pay surgical cases;

(5) for each of the first three full fiscal years of operation, the projected number of Medicaid surgical cases;

(6) *for each of the first three full fiscal years of operation, the total projected Medicare allowable amount for the self pay surgical cases to be served in the proposed facility, i.e. provide the projected Medicare allowable amount per self-pay surgical case and multiply that amount by the projected number of self pay surgical cases;*

(7) *for each of the first three full fiscal years of operation, the total projected Medicare allowable amount for the Medicaid surgical cases to be served in the facility, i.e. provide the projected Medicare allowable amount per Medicaid surgical case and multiply that amount by the projected number of Medicaid surgical cases;*

(8) *for each of the first three full fiscal years of operation, the projected revenue to be collected from the projected number of self-pay surgical cases;*

(9) *for each of the first three full fiscal years of operation, the projected revenue to be collected from the projected number of Medicaid surgical cases;*

(10) *for each of the first three full fiscal years of operation, the projected total revenue to be collected for all surgical cases performed in the proposed facility;*

(11) *a commitment to report utilization and payment data for services provided in the proposed ambulatory surgical facility to the statewide data processor, as required by G.S. 131E-214.2;*

(12) *a description of the system the proposed ambulatory surgical facility will use to measure and report patient outcomes for the purpose of monitoring the quality of care provided in the facility;*

(13) *descriptions of currently available patient outcome measures for the surgical specialty to be provided in the proposed facility, if any exist;*

(14) *if patient outcome measures are not currently available for the surgical specialty area, the applicant shall develop its own patient outcome measures to be used for monitoring and reporting the quality of care provided in the proposed facility, and shall provide in its application a description of the measures it developed;*

(15) *a description of the system the proposed ambulatory surgical facility will use to enhance communication and ease data collection, e.g. electronic medical records;*

(16) *a description of the proposed ambulatory surgical facility's open access policy for physicians, if one is proposed;*

(17) *a commitment to provide to the Agency annual reports at the end of each of the first five full years of operation regarding:*

(A) *patient payment data submitted to the statewide data processor as required by G.S. 131E-214.2;*

(B) *patient outcome results for each of the applicant's patient outcome measures;*

(C) *the extent to which the physicians owning the proposed facility maintained their hospital staff privileges and provided Emergency Department coverage, e.g. number of nights each physician is on call at a hospital; and*

(D) *the extent to which the facility is operating in compliance with the representations the applicant made in its application relative to the single specialty ambulatory surgical facility demonstration project in the 2010 State Medical Facilities Plan.*

-NA- The applicant does not propose to establish a new single specialty separately licensed ambulatory surgical facility pursuant to the demonstration project in the 2010 State Medical Facilities Plan.

.2103 PERFORMANCE STANDARDS

.2103(a) *In projecting utilization, the operating rooms shall be considered to be available for use five days per week and 52 weeks per year.*

-C- In Section II.10, page 41, the applicant states that utilization projections are based on all surgical operating rooms being available for use five days per week and 52 weeks per year.

.2103(b) *A proposal to establish a new ambulatory surgical facility, to establish a new campus of an existing facility, to establish a new hospital, to increase the number of operating rooms in an existing facility (excluding dedicated C-section operating rooms), to convert a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or to add a specialty to a specialty ambulatory surgical program shall:*

(1) demonstrate the need for the number of proposed operating rooms in the facility, which is proposed to be developed or expanded, in the third operating year of the project is based on the following formula: {(Number of facility projected inpatient cases, excluding trauma cases

reported by Level I or II trauma centers, cases reported by designated burn intensive care units and cases performed in dedicated open heart and C-Section rooms, times 3.0 hours) plus (Number of facilities projected outpatient cases times 1.5 hours) plus (Number of facility's projected outpatient cases times 1.5 hours)] divided by 1,872 hours} minus the facility's total number of existing and approved operating rooms and operating rooms proposed in another pending application, excluding one operating room for level I or II trauma centers, one operating room for facilities with designated burn intensive care units, and all dedicated open heart and C-section operating rooms or demonstrate conformance of the proposed project to Policy AC-3 in the State Medical Facilities Plan titled "Exemption From Plan Provisions for Certain Academic Medical Center Teaching Hospital Projects;" and

(2) The number of rooms needed is determined as follows:

(A) in a service area which has more than 10 operating rooms, if the difference is a positive number greater than or equal to 0.5, then the need is the next highest whole number for fractions of 0.5 or greater and the next lowest whole number for fractions less than 0.5; and if the difference is a negative number less than 0.5, then the need is zero;

(B) in a service area which has 6 to 10 operating rooms, if the difference is a positive number greater than or equal to 0.3, then the need is the next highest whole number for fractions of 0.3 or greater and the next lowest whole number for fractions less than 0.3, and if the difference is a negative number or a positive number less than 0.3, the need is zero; and

(C) in a service area which has five or fewer operating rooms, if the difference is a positive number greater than or equal to 0.2, then the need is the next highest whole number for fractions of 0.2 or greater and the next lowest whole number for fractions of less than 0.2; and the difference is a negative number or a positive number less than 0.2, the need is zero; or

-NA- The applicant is proposing to build a replacement facility and relocate existing surgical services, including 13 operating rooms.

.2103(c) *A proposal to increase the number of operating rooms (excluding dedicated C-Sections operating rooms) in a service area shall:*

(1) demonstrate the need for the number of proposed operating rooms in addition to the rooms in all of the licensed facilities identified in response

to 10A NCAC 14C .2102(b)(2) in the third operating year of the proposed project based on the following formula: {[(Number of projected inpatient cases for all the applicant's or related entities' facilities, excluding trauma cases report by Level I or II trauma centers, cases reported by designated burn intensive care units and cases performed in dedicated open heart and C-section rooms, times 3.0 hours) plus (Number of projected outpatient cases for all the applicant's or related entities' times 1.5 hours)] divided by 1,872 hours} minus the total number of existing and approved operating rooms and operating rooms proposed in another pending application, excluding one operating room for Level I or II trauma centers, one operating room for facilities with designated burn intensive care units, and all dedicated open heart and C-section operating rooms in all of the applicant's or related entities' licensed facilities in the service area; and

(2) The number of rooms needed is determined as follows:

(A) in a service area which has more than 10 operating rooms, if the difference is a positive number greater than or equal to 0.5, then the need is the next highest whole number for fractions of 0.5 or greater and the next lowest whole number for fractions less than 0.5; and if the difference is a negative number or a positive number less than 0.5, the need is zero;

(B) in a service area which has 6 to 10 operating rooms, if the difference is a positive number greater than or equal to 0.3, then the need is the next highest whole number for fractions of 0.3 or greater and the next lowest whole number for fractions less than 0.3, and if the difference is a negative number or a positive number less than 0.3, the need is zero; and

(C) in a service area which has five or fewer operating rooms, if the difference is a positive number greater than or equal to 0.2, then the need is the next highest whole number for fractions of 0.2 or greater and the next lowest whole number for fractions of less than 0.2; and if the difference is a negative number or a positive number less than 0.2, the need is zero.

-NA- The applicant does not propose to increase the number of operating rooms in the service area.

.2103(d) *An applicant that has one or more existing or approved dedicated C-section operating rooms and is proposing to develop an additional dedicated C-section operating room in the same facility shall demonstrate that an average of at least 365 C-sections per room were performed in the facility's existing dedicated C-section operating rooms in the previous 12*

months and are projected to be performed in the facility's existing, approved and proposed dedicated C-section rooms during the third year of operation following completion of the project.

-NA- The applicant does not have one or more existing or approved dedicated C-section rooms, nor does it propose to develop an additional dedicated C-section room.

.2103(e) *An applicant proposing to convert a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or to add a specialty to a specialty ambulatory surgical program shall:*

(1) provide documentation to show that each existing ambulatory surgery program in the service area that performs ambulatory surgery in the same specialty area as proposed in the application is currently utilized an average of at least 1,872 hours per operating room per year, excluding dedicated open heart and C-Section operating rooms. The hours utilized per operating room shall be calculated as follows: [(Number of projected inpatient cases, excluding open heart and C-sections performed in dedicated rooms times 3.0 hours) plus (Number of projected outpatient cases times 1.5 hours)] divided by the number of operating rooms, excluding dedicated open heart and C-Section operating rooms; and

(2) demonstrate the need in the third operating year of the project based on the following formula: [Total number of projected outpatient cases for all ambulatory surgery programs in the service area times 1.5 hours) divided by 1,872 hours] minus the total number of existing, approved and proposed outpatient or ambulatory surgical operating rooms and shared operating rooms in the service area. The need for the conversion is demonstrated if the difference is a positive number greater than or equal to one, after the number is rounded to the next highest number for fractions of 0.50 or greater.

-NA- SCG is a multispecialty ambulatory surgery center and is not proposing to add a specialty to the program.

.2103(f) *The applicant shall document the assumptions and provide data supporting the methodology used for each projection in this Rule.*

-C- In Sections III.1(b) and IV, the applicant provides a description of the assumptions and methodology used in the development of the projections required by this Rule. See Criterion (3) for discussion of the need which is hereby incorporated as if fully set forth herein. Therefore, the application is conforming to this Rule.

.2104 SUPPORT SERVICES

- .2104(a) An applicant proposing to establish a new ambulatory surgical facility, a new campus of an existing facility, or a new hospital shall provide copies of the written policies and procedures that will be used by the proposed facility for patient referral, transfer, and follow-up.*
- NA- The applicant is proposing to build a replacement facility and relocate existing surgical services, including 13 operating rooms.
- .2104(b) An applicant proposing to establish a new ambulatory surgical facility, a new campus of an existing facility, or a new hospital shall provide documentation showing the proximity of the proposed facility to the following services:*
- (1) emergency services;*
 - (2) support services;*
 - (3) ancillary services; and*
 - (4) public transportation.*
- NA- The applicant is proposing to build a replacement facility and relocate existing surgical services, including 13 operating rooms.

.2105 STAFFING AND STAFF TRAINING

- .2105(a) An applicant proposing to establish a new ambulatory surgical facility, to establish a new campus of an existing facility, to establish a new hospital, to increase the number of operating rooms in a facility, to convert a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or to add a specialty to a specialty ambulatory surgical program shall identify, justify and document the availability of the number of current and proposed staff to be utilized in the following areas:*
- (1) administration;*
 - (2) pre-operative;*
 - (3) post-operative;*
 - (4) operating room; and*
 - (5) other.*
- NA- The applicant is proposing to build a replacement facility and relocate existing surgical services, including 13 operating rooms.
- .2105(b) The applicant shall identify the number of physicians who currently utilize the facility and estimate the number of physicians expected to utilize the facility and the criteria to be used by the facility in extending surgical and anesthesia privileges to medical personnel.*
- C- In Section VII.9(b), page 129, the applicant lists 118 active medical and dental staff utilizing the facility currently and states its expectation that

those physicians will continue in the relocated facility. Exhibit 44 contains a copy of the facility's Delineated Privileges Verification Policy.

- .2105(c) *The applicant shall provide documentation that physicians with privileges to practice in the facility will be active members in good standing at a general acute care hospital within the service area in which the facility is, or will be, located or documentation of contacts the applicant made with hospitals in the service area in an effort to establish staff privileges.*
- C- Exhibit 39 contains a copy of SCG's Medical Staff Bylaws, which require that physicians with privileges to practice at SCG will be active members in good standing at a general acute care hospital within the service area.
- .2105(d) *The applicant shall provide documentation that physicians owning the proposed single specialty demonstration facility will meet Emergency Department coverage responsibilities in at least one hospital within the service area, or documentation of contacts the applicant made with hospitals in the service area in an effort to commit its physicians to assume Emergency Department coverage responsibilities.*
- NA- The applicant does not propose to establish a new single specialty separately licensed ambulatory surgical facility pursuant to the demonstration project in the 2010 State Medical Facilities Plan.

.2106 FACILITY

- .2106(a) *An applicant proposing to establish a licensed ambulatory surgical facility that will be physically located in a physician's or dentist's office or within a general acute care hospital shall demonstrate that reporting and accounting mechanisms exist and can be used to confirm that the licensed ambulatory surgery facility is a separately identifiable entity physically and administratively, and is financially independent and distinct from other operations of the facility in which it is located.*
- NA- The applicant does not propose to establish a licensed ambulatory surgical facility that will be physically located in a physician's or dentist's office or within a general acute care hospital.
- .2106(b) *An applicant proposing a licensed ambulatory surgical facility or a new hospital shall receive accreditation from the Joint Commission for the Accreditation of Healthcare Organizations, the Accreditation Association for Ambulatory Health Care or a comparable accreditation authority within two years of completion of the facility.*
- C- SCG is an existing ambulatory surgical facility and is currently accredited by The Joint Commission. Exhibit 4 contains SCG's Joint Commission

Accreditation. In Section II.10, page 49, the applicant states SCG's intent to continue to undergo regular Joint Commission surveys and to retain its accreditation.

.2106(c) *All applicants shall document that the physical environment of the facility to be developed or expanded conforms to the requirements of federal, state, and local regulatory bodies.*

-C- In Section II.10, page 49, the applicant states, "*The proposed building will be developed to conform to all requirements of federal, state and local regulations. SCG intends to continue to comply with all of these standards after relocation to a new facility.*" The applicant further states that the new ambulatory surgical facility is designed to meet DHSR Construction Section standards, 10A NCAC 13C rules, and 0100-1411 Licensing of Ambulatory Surgical Facilities.

.2106(d) *An applicant proposing to establish a new ambulatory surgical facility, a new campus of an existing facility or a new hospital shall provide a provide a floor plan of the proposed facility identifying the following areas:*

- (1) *receiving/registering area;*
- (2) *waiting area;*
- (3) *pre-operative area;*
- (4) *operating room by type;*
- (5) *recovery area; and*
- (6) *observation area.*

-NA- The applicant does not propose to establish a new ambulatory surgical facility, a new campus of an existing facility or a new hospital. The applicant is proposing to build a replacement facility and relocate existing surgical services, including 13 operating rooms. Exhibit 22 contains copies of the proposed floor plan for the relocated facility, which identifies the specific areas required by this Rule.

.2106(e) *An applicant proposing to expand by converting a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or by adding a specialty to a specialty ambulatory surgical program that does not propose to add physical space to the existing ambulatory surgical facility shall demonstrate the capability of the existing ambulatory surgical program to provide the following for each additional specialty area:*

- (1) *physicians;*
- (2) *ancillary services;*
- (3) *support services;*
- (4) *medical equipment;*
- (5) *surgical equipment;*

- (6) *receiving/registering area;*
- (7) *clinical support areas;*
- (8) *medical records;*
- (9) *waiting area;*
- (10) *pre-operative area;*
- (11) *operating rooms by type;*
- (12) *recovery area; and*
- (13) *observation area.*

-NA- The applicant is proposing to build a replacement facility and relocate existing surgical services, including 13 operating rooms.