December 3, 2018

COMMENTS IN OPPOSITION FROM NOVANT HEALTH, INC.

Regarding Atrium Health's
Pineville Medical Center CON Application,
Project I.D. # F-11622-18 for Acute Care Beds in Mecklenburg County

The 2018 SMFP found a need for 50 acute care beds in Mecklenburg County. Two applications were filed for these beds. Novant Health applied to license twelve existing labor/delivery/recover ("LDR") beds as labor/delivery/recovery/postpartum ("LDRP") beds at Novant Health Huntersville Medical Center ("Huntersville") to increase the capacity of its obstetric program quickly and at minimal cost. Atrium applied for 50 beds at Atrium Pineville Medical Center ("Pineville").

Huntersville filed a single application for twelve acute care beds and one shared operating room.[1] Pineville filed separate applications for 50 acute care beds[2] and for one shared use operating room.[3] These comments analyze the Pineville acute care bed application, and compare the Pineville acute care bed application to the acute care bed component of the Huntersville Application. Novant Health compares the operating room component of the Huntersville application to the Pineville operating room application and the other Atrium-sponsored OR applications in separate comments.

These comments will show the Pineville Application is nonconforming with CON policies and criteria. They will further show that in a comparative analysis the Huntersville Application is a more effective alternative than the Pineville Application. Novant Health respectfully urges the Agency to approve the Huntersville Application and deny the Pineville Application. Atrium requests approval to build out 50 private patient rooms in a new bed tower that was exempt from CON review at a project cost of $31.9 million. These 50 proposed new beds are in addition to the fifteen beds for which Pineville was approved under Project I.D. No. F-011361-17 and awarded a CON on June 7, 2018. The award of these fifteen beds brings Pineville's acute care bed inventory to 221 beds. It should be noted that Carolinas Medical Center ("CMC") was also awarded 45 new acute care beds on June 7, 2018 in Project I.D. No. F-011362-17. The award of these 45 beds brings CMC's acute care bed inventory to 1,055 beds. These bed counts are confirmed in the Proposed 2019 State Medical Facilities Plan.[4] If the Pineville Application is approved, Atrium

[1] Huntersville CON Application, Project I.D. No. # F-11624-18
[2] Pineville CON Application, Project I.D. No. # F-11622-18
[3] Pineville CON Application, Project I.D. No. # F-11621-18
[4] Proposed 2019 State Medical Facilities Plan, Chapter 5, Table 5A: Acute Care Bed Need Projections, Column 'D+E'. NOTE: Novant Health has identified discrepancies between the 2019 Draft SMFP counts, Acute and Home

will have been awarded 110 new acute care beds in Mecklenburg County over the course of a year in two consecutive competitive reviews. This is highly unusual and equates to more beds than the entire bed inventory of some hospitals in North Carolina.

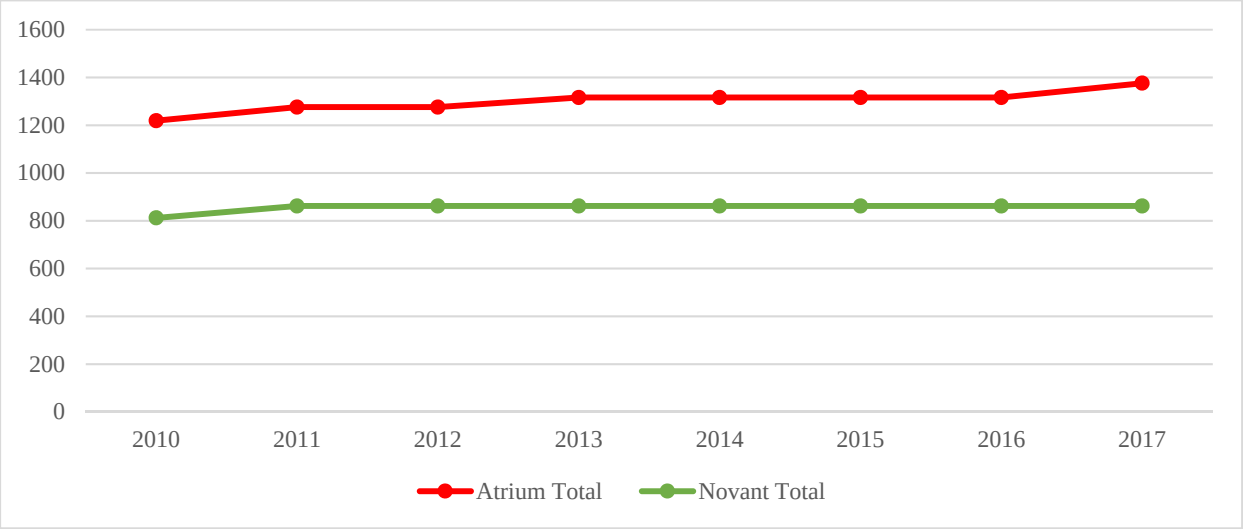
The total Atrium acute care bed inventory in Mecklenburg County is 1,376, compared to the total Novant Health acute care bed inventory in Mecklenburg County of 862.[5] This is a significant disparity in the number of beds under the control of Novant Health as compared to Atrium. The table and chart below demonstrate the market power Atrium has in Mecklenburg County.[6]

Percent of Total Licensed Acute Care Beds in Mecklenburg County

	2010	2011	2012	2013	2014	2015	2016	2017
Atrium	60%	60%	60%	60%	60%	60%	60%	61%
Novant	40%	40%	40%	40%	40%	40%	40%	39%

Source: NC Department of Health and Human Services State Medical Facilities Plan 2012 – Proposed 2019, Chapter 5, Table 5A: Acute Care Bed Need Projections

Total Number of Licensed Acute Care Beds in Mecklenburg County



Source: NC Department of Health and Human Services State Medical Facilities Plan 2012 - Proposed 2019, Chapter 5, Table 5A: Acute Care Bed Need Projections

Care Licensure and Certification Section, and past CON actions that are not material to this comment. We are in the process of resolving the discrepancy with the appropriate agencies.

[5] Proposed 2019 State Medical Facilities Plan, Chapter 5, Table 5A: Acute Care Bed Need Projections, Column 'D+E'. Please note, however, that the 50 beds for Novant Health Mint Hill Medical Center ("NHMHMC") (Project I.D. No. F-7648-06) shown in Column E are not new acute care beds. NHMHMC was established by relocating existing beds. NHMHMC opened on October 1, 2018 with 36 acute care beds; 14 additional acute care beds are allowed to be opened by June 1, 2023.

[6] NOTE: Acute care bed need determination does not include long term acute care or rehabilitation beds.

The last time Novant Health was awarded new beds in a competitive CON review in Mecklenburg County was 2008.[7] Since 2010, Atrium has maintained approximately 60 percent of Mecklenburg's total licensed acute care beds, while Novant Health has consistently hovered around 40 percent. This competitive imbalance will only worsen if the Agency approves Atrium's request. The Agency should therefore approve Novant Health's application for twelve beds and deny the Pineville Application as nonconforming. Improving competitive balance in Mecklenburg County, or not unnecessarily worsening competitive imbalance, will maximize healthcare value by incentivizing high quality care, lowering costs, and expanding patient choice.

Mecklenburg County is North Carolina's largest county by population, and Charlotte is North Carolina's largest city by population.[8] Mecklenburg County needs two strong systems to give patients a choice of where to receive their care, and so payors are not forced to bow to the demands of Atrium. Atrium did not achieve its market share through better quality or lower cost. As has been widely reported in the national press, the United States Department of Justice ("USDOJ") Antitrust Division and the State of North Carolina sued Atrium in federal court in Charlotte in June 2016, alleging that Atrium's anti-steering clauses in its managed care contracts violated Section 1 of the Sherman Antitrust Act. This law prohibits contracts, combinations and conspiracies that unreasonably restrain trade. See 15 U.S.C. § 1. Atrium is alleged to have abused its dominance in the greater Charlotte area to force payors to keep patients within the Atrium system, rather than allowing payors to direct patients to lower cost, higher quality options, such as Novant Health.

After over two years of litigation, a proposed settlement was recently announced. The settlement agreement is attached as Exhibit A to this comment. Two class actions brought by consumers against Atrium are still pending. These class actions are based on the allegations of the USDOJ/State of North Carolina antitrust complaint.[9] The complaints are attached as Exhibit B. Atrium has abused its market power in Mecklenburg County and the Greater Charlotte Area. The Agency should not increase that market power by its CON decisions.

Novant Health respectfully submits that the Pineville Application should be disapproved in its entirety as Pineville has failed to demonstrate the need for 50 new beds in addition to the 15 new beds for which it was recently approved in the 2017 Mecklenburg County Acute Care Bed Review.[10] Awarding 50 beds to Pineville would result in a grand total of 65 new beds awarded to Pineville in one year, which is unnecessary. It would also result in a grand total of 110 new acute care beds awarded to the Atrium system in a year (60 under the 2017 SMFP and 50 under the 2018

[7] In the last 10 years, there were acute care bed reviews in Mecklenburg County in 2008, 2009, 2011, 2013 and 2017. The competitive reviews occurred in 2008, 2013 and 2017. Atrium was the successful applicant in the 2013 and 2017 reviews. The 2017 review resulted in an award of 60 acute care beds to Atrium (45 to CMC Main and 15 to Pineville).

[8] https://www.census.gov/quickfacts/fact/table/charlottecitynorthcarolina,mecklenburgcountynorthcarolina/PST04521

[9] *Benitez v. The Charlotte-Mecklenburg Hospital Authority*, 3:2018cv00095 (WDNC); *DiCesare v. The Charlotte-Mecklenburg Hospital Authority*, 16cvs16404 (Mecklenburg County Superior Court).

[10] Project I.D. No. F-11361-17, CON issued on June 7, 2018.

SMFP), which is extraordinary and excessive. Awarding more beds to Atrium would undermine the proposed antitrust settlement negotiated by the United States and the State of North Carolina by further increasing Atrium's market power. Novant Health respectfully urges the Agency not to undermine the work that the Attorney General of the State of North Carolina has undertaken over the last several years to address Atrium's market power.

However, if the Agency believes that it is in the best interests of the citizens of North Carolina to award all 50 beds, the Agency should approve the 12 beds for which Huntersville has applied, and award Pineville no more than 38 beds. Awarding the 38 beds to Pineville besides the 15 beds for which it received a CON on June 7, 2018 in Project I.D. No. F-011361-17 would give Pineville 53 new beds in a year. These new beds are more than Pineville needs, but limiting the award to Pineville to a maximum of 38 beds allows Novant Health's Huntersville hospital to grow in a reasonable, cost-effective way to meet the needs of its patients.[11]

As explained in these comments, approval of the Pineville application for 50 beds is not possible because the Pineville application is non-conforming with CON Review Criteria (1), (3), (4), (5), (6), (12), and (18a), because it:

- Does not demonstrate that it maximizes healthcare value;
- Does not demonstrate need for its proposed project, and therefore does not demonstrate the financial feasibility of its proposed project;
- Does not demonstrate its proposed project will promote equitable access;
- Does not demonstrate it is the most effective alternative;
- Does not demonstrate its proposed project is not a duplication of existing health services;
- Does not demonstrate that its construction costs are reasonable; and
- Does not demonstrate its proposed project will enhance competition.

Brief Description of Projects

Novant Health Project

The Huntersville Application will license as acute care beds the twelve existing LDR beds in the obstetrics unit as LDRP beds. The beds were originally licensed as LDRP beds and were converted to LDR beds to allow construction of additional postpartum rooms to accommodate growing demand for Huntersville's obstetric services. Demand for Huntersville's obstetric service has

[11] To be absolutely clear, Novant Health is not suggesting that Pineville should be awarded any beds, nor is it suggesting that Pineville has demonstrated the need for 38 beds.

continued to grow to a point that patients and obstetricians must sometimes plan deliveries at other hospitals.[12] Relicensing the twelve LDR beds and LDRP beds will increase the unit's postpartum capacity. The project cost of $701,246 for this element of the application maximizes the healthcare value of the existing physical beds.

Atrium Project

The Pineville Application will construct 50 new patient rooms on the third and fourth floors of Pineville's new CON-exempt bed tower. The project cost will be $31.9 million and the beds will be placed in service in January 2022. This is in addition to the 15 beds for which Pineville was approved on June 7, 2018 at a capital cost of $1,115,000. According to the CON issued for Project I.D. No. F-011361-17, these 15 beds were supposed to be operational on October 1, 2018. Atrium states it planned to finish 22 licensed beds and 14 observation beds on the third floor, but with this application proposes to license the 14 observation beds and license 36 beds on the fourth floor. The 22 beds will be relocated from elsewhere in the hospital and there are no plans how to use the space vacated. No reason is given why the beds must be relocated. Presumably they will continue to be available for use as observation beds and Atrium could request their re-licensure as acute care beds in a future application.

Change of Scope?

Pineville was awarded fifteen acute care beds in 2017 (Project I.D. #F-11361-17, FID #110878). The completion date when the beds were to be in service was October 1, 2018. The Progress Report Atrium filed on October 1, 2018 showed the beds were not in service on that date. (Exhibit E). The Pineville application, filed on October 15, 2018, does not say the beds were in service on that date, but says they would be by November 1, 2018. Atrium says if the beds are in service before the start of the review period for the current application, the current application is not a change in scope. We question whether the current application is a change in scope. If so, the Pineville application is not complete as it omits responses to the additional questions required by a change in scope.

Conformity with CON Statutory Review Criteria

Criterion (1)

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

[12] Huntersville CON Application, project # F-11624-18, Section C, Question 4(a), pp. 35-36

Policy GEN-3 applies to the Pineville Application. The Pineville Application does not comply with Policy GEN-3 because it will not promote safety and quality in the delivery of health care services while promoting equitable access and maximizing health care value for resources expended. In particular, the Pineville Application does not maximize health care value for resources expended. Pineville was awarded 15 beds a few months ago. Pineville has not demonstrated the need for 50 additional beds on top of the 15 it was awarded in June, 2018. Considering Atrium's already massive size, it is not in the best interests of the citizens of North Carolina to award a grand total of 110 new acute care beds in the space of a year to a system facing multiple allegations of anticompetitive behavior from both the government and private parties.

The Agency will maximize healthcare value by approving the Huntersville Application to minimize increasing the imbalance between the number of acute care beds for Novant Health and Atrium in Mecklenburg County. More competition is needed to constrain cost increases. Atrium now has 1,316 acute care beds and Novant Health has 862 acute care beds. While Atrium may argue that it "generated the need," it is not entitled to any additional acute care beds. Rather, it must demonstrate, through reasonable and supported assumptions, that it has a need for more beds. As explained in these comments, the Pineville Application failed to do so. Pineville has not adequately demonstrated the need to develop 50 new acute care beds in Mecklenburg County and therefore does not adequately demonstrate how its projected volumes incorporate the concept of maximum value for resources expended.

Because the 2018 SMFP found a need for 50 acute care beds in Mecklenburg County, the Agency may feel constrained to award all 50 beds. But a need determination in the SMFP does not mean that an application proposing to meet the need must be approved. And it certainly does not mean that the Agency must approve the Pineville Application. If, however, the Agency believes it must award all 50 beds, the Agency can approve the Huntersville Application for 12 beds and the Pineville Application for a maximum of 38 beds.

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

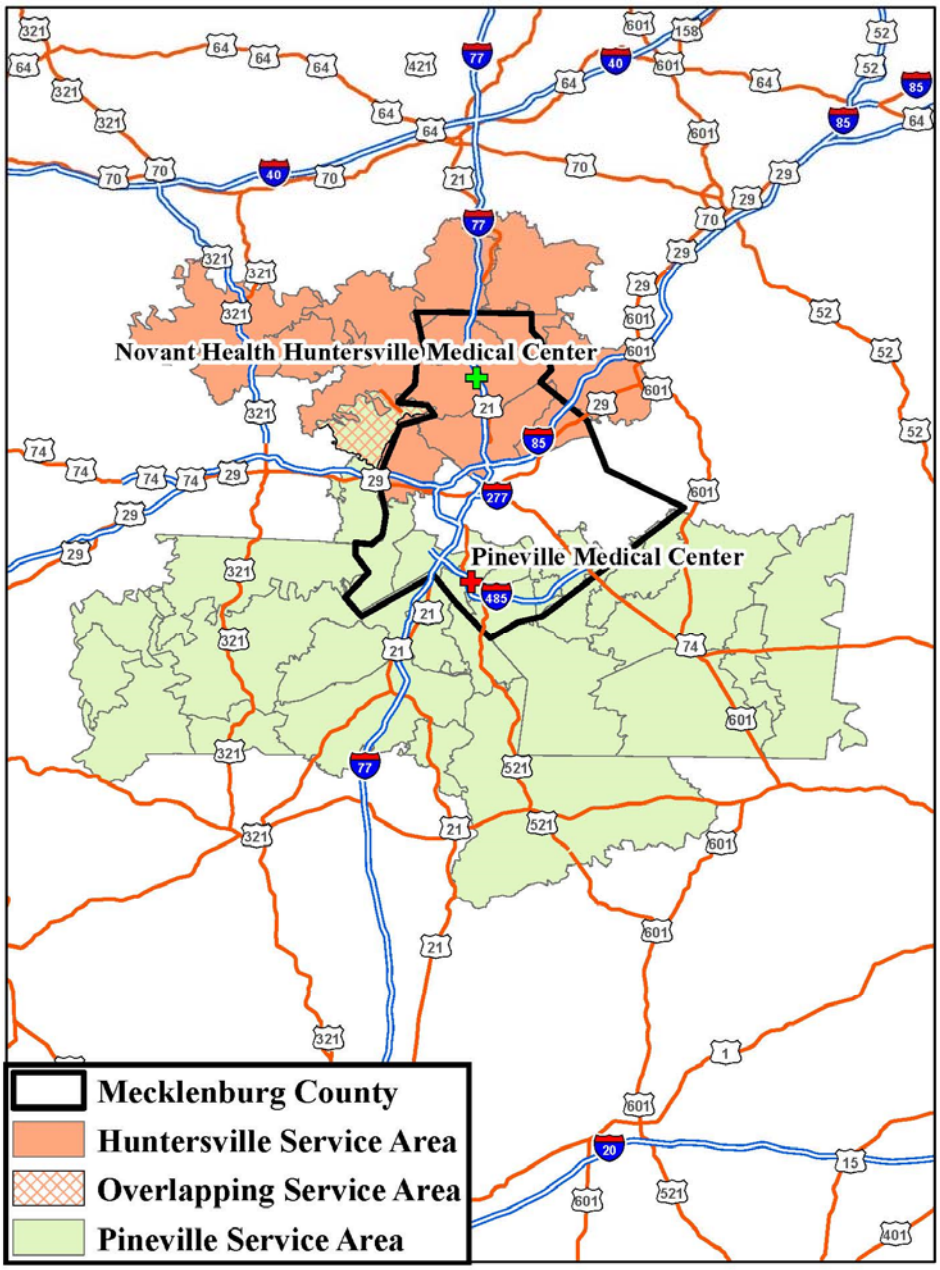
Criterion (3)

Criterion (3): NCGS § 131E-183(a)(3): The applicant shall identify the population to be served by the proposed project, and shall demonstrate the need that this population has for the services proposed and the extent to which all residents of the service area, and, in particular, low income persons, racial and ethnic minorities, women, handicapped persons, the elderly, and other underserved groups likely to have access to the services proposed.

The Pineville Application is nonconforming with this criterion because, in practical terms, all residents of Mecklenburg County will not have geographic access to Pineville's services. The

service area for acute care bed need is Mecklenburg County. The map below shows the institutional service areas for Pineville and Huntersville. Pineville patients reside south of downtown Charlotte. Huntersville patients reside north of downtown Charlotte. Only by approving the Huntersville application will the Agency satisfy this criterion.

Combined Pineville and Huntersville Service Area



The Pineville Application unreasonably assumes its acute care patient days will increase from 2019 to 2024 at a compound annual growth rate of 4.8 percent.[13] This was the 2017-2018 growth rate and shows a declining trend from earlier years, which Novant Health expects to continue. Growth rates at Pineville and all Atrium hospitals in Mecklenburg County and surrounding counties will be lower in future years due to:

1. Reductions in Atrium's ability to abuse its market power in contracts with health plans due to the settlement agreement with the Department of Justice and the State of North Carolina.

2. Novant Health's increased investments beginning in 2015 in primary care practitioners and facilities to balance Atrium's earlier acquisition of physician practices.

3. Exit of many physicians from Atrium employment agreements to join Novant Health Medical Group or to form independent practices able to admit patients to Novant Health facilities.

4. The opening in October 2018 of Novant Health Mint Hill Medical Center (NHMHMC).

Atrium's growth rates and market share in Mecklenburg and Union Counties will be lower in future years due to these factors. This continues a trend as shown in the tables below that began in 2015 that is not reflected in the 2018 SMFP.

Acute Care Patient Days for County Residents

	Mecklenburg County				**Union County**			
System	**2015**	**2016**	**2017**	**2018Q1**	**2015**	**2016**	**2017**	**2018Q1**
Atrium	229,965	240,655	248,940	63,492	46,366	46,657	48,086	12,231
Novant	135,486	133,090	132,491	36,559	23,440	24,679	23,744	7,209
Other	11,855	13,266	13,690	3,649	2,069	2,599	2,387	496
Total	377,306	387,011	395,121	103,700	71,875	73,935	74,217	19,936
Atrium Growth Rate		4.6%	3.4%	2.0%		0.6%	3.1%	1.7%
Atrium Market Share	60.9%	62.2%	63.0%	61.2%	64.5%	63.1%	64.8%	61.4%

*Source: Truven CY Discharge Data *Based on Annualized 2018Q1 Data. Excludes Normal Newborns and Non-Acute Neonates. Excludes LTACH, Rehab, and Behavioral Health Hospitals.*

[13] Pineville CON Application Project # F-11622-18, Form C, Section Q, page 4.

Obstetric Deliveries for County Residents

	Mecklenburg County				Union County			
System	**2015**	**2016**	**2017**	**2018Q1**	**2015**	**2016**	**2017**	**2018Q1**
Atrium	24,444	24,398	25,542	5,584	3,780	3,484	3,420	887
Novant	17,801	17,662	18,789	4,603	2,524	2,805	2,848	739
Other	567	621	465	94	23	31	34	2
Total	42,812	42,681	44,796	10,281	6,327	6,320	6,302	1,628
Atrium Growth Rate		-0.2%	4.7%	-12.6%		-7.8%	-1.8%	3.7%
Atrium Market Share	57.1%	57.2%	57.0%	54.3%	59.7%	55.1%	54.3%	54.5%

*Source: Truven CY Discharge Data *Based on Annualized 2018Q1 Data. Truven*

This trend is due in part to the significant investments Novant Health has made in the Charlotte market in recent years to recruit physicians and advanced nurse practitioners (ANPs) shown in the table below. The number of physicians and ANPs Novant Health employs in the Charlotte market has nearly doubled since 2014, with most of the increase after 2016. The impact of these practitioners on utilization of Novant Health hospitals and surgical facilities will increase in future years. Novant Health plans further increases in the number of employed physicians.

Addition of Providers to Novant Health Medical Staff in the Charlotte Market

Specialty	**2014 Baseline**	**2015 Additions**	**2016 Additions**	**2017 Additions**	**2018 Projected Additions**	**Total Added 2015-2018**
Primary Care	233	28	26	16	23	93
OB/GYN	-	69 (baseline)	20	3	18	41
Pediatrics	62	22	10	15	53	100
Orthopedics	34	0	4	8	8	20
Neurosciences	33	0	0	23	11	34
Cardiology	49	6	9	17	5	37
Oncology	6	1	4	10	24	39
Behavioral Health	21	-2	26	13	9	46
Total	**438**	**55**	**99**	**105**	**151**	**410**

Source: Novant Health Medical Group internal data.

This expansion of the Novant Health employed medical staff has been complemented by development of new clinics and urgent care centers shown in the table below.

New and Expanded Novant Health Outpatient Facilities in the Charlotte Market

Type Facility	Town or Area	Year Opened or Expanded
Pediatrics	Waxhaw	2015
Pediatrics	Arboretum	2015
Urgent Care & Physical Therapy	Midtown/Center City	2016
Primary Care/Midwifery	Langtree	2016
Cancer	Ballantyne	2016
Urgent Care	Quail Corners	2016
Primary Care/Pediatrics	Mint Hill	2016
Orthopedics	Ballantyne	2016
Physical Therapy/EXOS	Huntersville	2016
Neurosurgery	Center City	2016
Pulmonary	Huntersville	2017
Primary Care	Cornelius	2017
Primary Care	South Boulevard	2017
Pediatrics/OB-GYN	South Boulevard	2017
Spine Specialists/Neurology/Pediatrics	Huntersville	2018
Urgent Care & Pulmonary	Harrisburg	2018
Rehab & EXOS	Arboretum	2018
Primary Care	University	2018
Primary Care/HVI	Steele Creek	2018
Primary Care/Urgent Care/OB-GYN/Orthopedics/Physical Therapy	Denver	2018
Psychiatry	Concord	2018
Urgent Care	Huntersville	2018
Pediatrics	Plaza Midwood	2018
Primary Care & Endocrinology	Carmel Road	2018
Primary Care & OB-GYN	Concord	2018
Primary Care/OB-GYN/Pediatrics	Wesley Chapel	2018
Pediatrics	SouthPark	2018
Pediatrics	Highland Creek	2018

Besides outpatient facilities, NHMHMC opened in October 2018. The hospital is in zip code 28215 and the service area consists of four additional zip codes. Besides shifting existing Novant Health

patients to the new facility, Novant Health projected in the application gaining 15 percentage points of market share in zip code 28215 and gaining 10 percentage points of market share in the other service area zip codes. Novant Health continues to see the market share gains as reasonable. The gains will come primarily from Atrium University and Atrium CMC/Mercy. This equals a reduction in Atrium's annual patient days of 3,010 in 2021, NHMHMC's third year of operation.[14]

Two other factors will reduce Atrium's growth rates and market share in Mecklenburg and Union Counties: (1) litigation to reduce Atrium's abuse of its market power; and, (2) dissatisfied physicians leaving Atrium.

The U.S. Department of Justice and State of North Carolina Settlement Agreement, Exhibit A to this comment, should reduce Atrium's ability to abuse its market power in contracts with health plans. Atrium used its market power to restrict health insurers from encouraging consumers to choose non-Atrium providers in the Charlotte market that offer better value. The provider offering better value would likely be Novant Health. With this settlement agreement, health insurers can include both Atrium and Novant Health in their networks and can inform their insureds which system provides the better value based on price or outcomes. Novant Health expects allowing health insurers to steer patients to the higher value provider will decrease Atrium's growth rates and market share. Two class action suits are pending against Atrium whose outcomes may increase Novant Health's ability to compete in the Charlotte market.[15] Suffice it to say that Atrium's historical practice of forcing patients to stay within its system (a practice which has obviously helped its utilization) has been seriously threatened. Therefore, the overly-optimistic growth rates in the Pineville Application that were premised on the challenged conduct are not reasonable.

The Atrium Medical Group has lost many physicians in the last twelve months. Forty-two physicians and two mid-level providers left the Atrium Medical Group to join the Novant Health Medical Group. The table below shows the distribution of thee physicians by specialty

[14] Project I.D. # F-7648-06 Exhibit 20 Table 67 shows the expected impact on Atrium hospitals was 4,210 patient days in project year three. NHMHMC opened in October 2018 with 36 beds, therefore we reduced this impact by 28.3%, or 1,191 days to 3,010.

[15] *Benitez v. The Charlotte-Mecklenburg Hospital Authority*, 3:2018cv00095 (WDNC); *DiCesare v. The Charlotte-Mecklenburg Hospital Authority*, 16cvs16404 (Mecklenburg County Superior Court).

Physicians by Specialty Moving from Atrium Medical Group to Novant Health Medical Group in Last Twelve Months

Specialty	Number
Dermatology	2
Hematology	1
Internal Medicine	2
Neurosurgery	2
Oncology	1
Orthopedics	1
Pediatrics	29
Rheumatology	3
OB/GYN	3
Total	**44**

Source: Novant Health Medical Group internal data.

Charlotte-area physicians are also leaving the Atrium Medical Group to form independent practice groups. In July 2018, a group of 88 physicians in the Mecklenburg Medical Group left to form Tryon Medical Partners and open eight offices around the county. Atrium acquired the Mecklenburg Medical Group in 1993.[16] Other physicians have also chosen to leave Atrium Medical Group for independent practice.[17] These physicians can now practice at Novant Health facilities and Atrium facilities. While the Novant Health Medical Group has normal physician turnover, it has not experienced similar mass departures.

In summary, actions by Novant Health, actions by the U.S. Department of Justice and the North Carolina Attorney General and actions by 100 – 200 Charlotte physicians formerly with Atrium Medical Group will reduce the growth rate and market share of Atrium hospitals and other surgical facilities in Mecklenburg and Union Counties. Assuming a continuation of current or past growth rates is not a reasonable assumption.

Based on these factors and Atrium's declining growth rates and declining market share, Novant Health thinks a growth rate for acute care bed days at Pineville of 3.0% to 3.5% is reasonable. This range includes Pineville's growth rate in 2014. With this growth rate, Pineville cannot add 50 beds and meet the performance standard of 75.2% occupancy in the third project year. See Exhibit C for these calculations.

[16] Atrium will release Mecklenburg Medical Group from contract. Charlotte Business Journal. April 25, 2018. Available at https://www.bizjournals.com/charlotte/news/2018/04/25/atrium-health-will-release-mecklenburg-medical.html

[17] As nearly 100 doctors abandon Atrium, some experts see the start of a trend. The Charlotte Observer. May 25, 2018. Available at https://www.charlotteobserver.com/latest-news/article211322954.html

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

Criterion (4)

Criterion (4) NCGS § 131E-183(a)(4): Where alternative methods of meeting the needs for the proposed project exist, the applicant shall demonstrate that the least costly or most effective alternative has been proposed.

The Pineville Application is nonconforming with this criterion because it does not explain why the applicant cannot reduce construction costs by using the beds it says it will relocate to the third floor of the new bed tower to partially implement the additional 38 or 50 acute care beds. The Pineville Application does not address this alternative. Atrium says it is relocating 22 beds to the third floor of the bed tower from elsewhere in the hospital and there are no plans on how to use the space vacated. It gives no reason the beds must be relocated. It cites no physical deficiencies that prevent continuing use of the 22 patient rooms as acute care beds. Absent this information, there is no reason Atrium cannot reduce project costs by using the 22 patient rooms and reducing the number of patient rooms constructed in the bed tower.

In addition, the Pineville Application is nonconforming with this criterion because the least costly or most effective alternative for Pineville is to utilize the beds it now has, including the 15 beds for which it was approved earlier this year in Project I.D. No. F-011361-17. Pineville need not spend another $31.9 million adding beds that simply happen to be in the SMFP. Pineville can also continue to use observation beds and if necessary, apply for temporary increases in licensed bed capacity. These are no-cost or low-cost options available to the applicant. Pineville failed to consider these options in its application.

Further, since the Pineville Application is not conforming with all the CON criteria, including Criterion (4), it cannot demonstrate that it has chosen the least costly or most effective alternative.

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

Criterion (5)

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

As explained above, the Pineville Application does not demonstrate the need for its proposal. The assumptions used by Pineville in preparation of the financial pro formas are not reasonable and adequately supported because projected utilization is not reasonable. Since projected revenues and expenses are based at least in part on projected utilization, projected revenues and expenses are unreasonable.

For all of the above-stated reasons, plus any additional reasons the Agency may discern as it reviews the Pineville Application, the Pineville Application is non-conforming with Criterion (5) and should be disapproved.

Criterion (6)

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

The Pineville Application is nonconforming with this criterion because the application does not explain why the 22 patient rooms vacated when Atrium relocates the licensed acute care beds to the third floor of the new bed tower cannot be part of the additional acute care beds Atrium seeks in this application. The build out of the fourth floor of the bed tower appears to be an unnecessary duplication of existing patient rooms elsewhere in the hospital.

The Pineville Application is nonconforming with this criterion because it unnecessarily duplicates the capacity provided by approving 15 beds in Project I.D. No. F-011361-17.

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

Criterion (12)

Criterion (12) NCGS § 131E-183(a)(12): Applications involving construction shall demonstrate that the cost. design, and means of construction proposed represent the most reasonable alternative, and that the construction project will not unduly increase the costs of providing health services by the person proposing the construction project or the costs and charges to the public of providing health services by other persons, and that applicable energy savings features have been incorporated into the construction plans.

The Pineville Application proposes construction costs of almost $32 million for beds that are not needed. As stated under the discussion related to Criterion (4), Pineville could save millions of dollars by using the assets it already has, plus the 15 beds for which it was issued a CON in June

2018. The Pineville Application fails to demonstrate that its project will not unduly increase the costs of providing health services or the costs and charges to the public of providing health services.

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

Criterion (18a)

Criterion (18a) NCGS § 131E-183(a)(18a): The applicant shall demonstrate that the effects of the proposed services on competition in the proposed service area, including how any enhanced competition will have a positive impact upon the cost effectiveness, quality, and access to the services proposed; and in the case of applications for services where competition between providers will not have a favorable impact on cost-effectiveness, quality, and access to the services proposed, the applicant shall demonstrate that its application for a services on which competition would not have a favorable impact.

The Pineville Application is nonconforming with this criterion because it fails to demonstrate with any reasonable basis of fact or analysis that approval of the Pineville Application will positively enhance competition in Mecklenburg County or in its hospital service area. The only impact approval of the Pineville Application will have on competition is negative. It will allow Atrium to maintain its market dominance in Mecklenburg County, which is exactly what the USDOJ and State of North Carolina are seeking to counteract in the proposed antitrust settlement.

The Agency decision on additional acute care beds in Mecklenburg County should be to approve the Huntersville Application and to deny the Pineville Application as nonconforming. Atrium is the significantly larger of the two health systems in acute care beds. Even partial approval of the Pineville Application will increase the competitive imbalance, but full approval of the Pineville Application will unnecessarily increase the imbalance more. Please see the data in the comment on Criterion (1) above and the Comparative Analysis below.

For all of the above-stated reasons, plus any additional reasons the Agency may discern as it reviews the Pineville Application, the Pineville Application is non-conforming with Criterion (18a) and should be disapproved.

Acute Care Bed Rules

10A NCAC 14C.3803

(a) ***An applicant proposing to develop new acute care beds shall demonstrate that the projected average daily census (ADC) of the total number of licensed acute care beds proposed to be licensed within the service area, under common ownership with the***

applicant, divided by the total number of those licensed acute care beds is reasonably projected to be at least 66.7 percent when the projected ADC is less than 100 patients, 71.4 percent when the projected ADC is 100 to 200 patients, and 75.2 percent when the projected ADC is greater than 200 patients, in the third operating year following completion of the proposed project or in the year for which the need determination is identified in the State Medical Facilities Plan, whichever is later.

As set forth in Exhibit C to these comments, the Pineville Application does not meet the 75.2% occupancy standard, and should be found non-conforming with this rule.

(b) ***An applicant proposing to develop new acute care beds shall provide all assumptions and data used to develop the projections required in this rule and demonstrate that they support the projected utilization and average daily census.***

Pineville provided the assumptions and data, but as set forth in these comments, and in Exhibit C to these comments, the assumptions Pineville used are not reasonable and supported. Accordingly, the Pineville Application should be found non-conforming with this rule.

Comparative Analysis

The most effective alternative is for the Agency to approve the Huntersville Application and deny the Pineville Application as nonconforming. This section of the comments identifies the factors that make the component of the Huntersville application for acute care beds superior to the Pineville Application for acute care beds.

Conformity with Review Criteria

Huntersville adequately demonstrates its application conforms to all applicable statutory and regulatory review criteria. However, Atrium did not adequately demonstrate that its proposal for 50 acute care beds at Pineville were conforming to Criteria (1), (3), (4), (5), (6), (12) and (18a), and the acute care bed rules. Therefore, the acute care bed component of the Huntersville Application is the more effective alternative in conforming with review criteria.

Competitive Balance in Mecklenburg County

We respectfully submit that Agency decisions that improve the competitive balance between major health systems in the same market are generally in the public interest and those that worsen the competitive balance generally are not. As discussed above, Novant Health has made and is making substantial investments in facilities and practitioners to compete with Atrium to benefit the public. Approval of the Huntersville Application will improve the competitive balance between health

systems in Mecklenburg County. Approval, in whole or in part, of the Pineville Application will worsen the competitive balance.

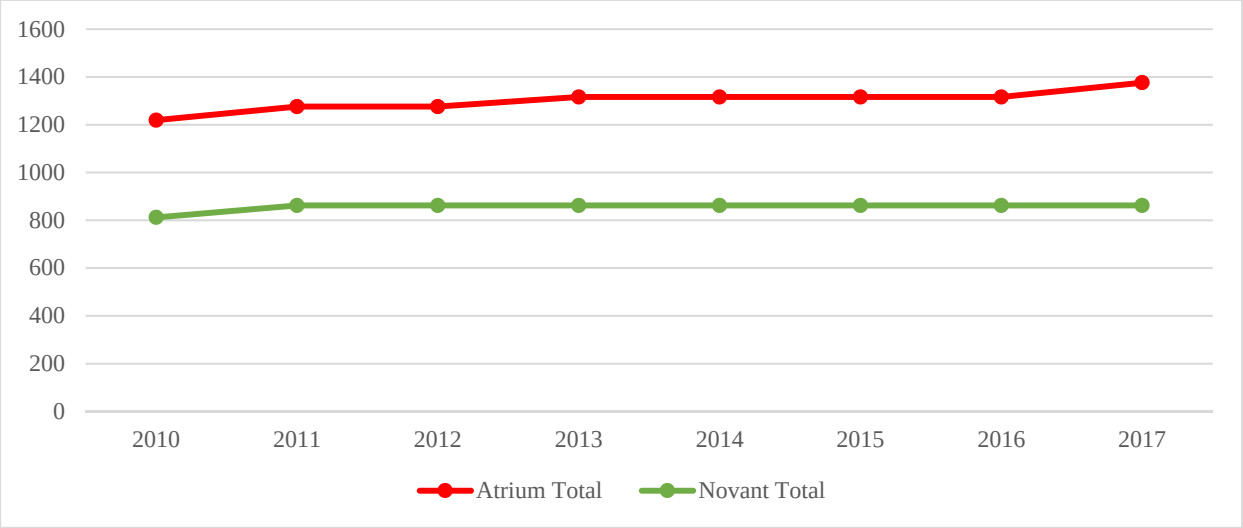
In 2017, the Atrium acute care bed inventory in Mecklenburg County was 1,316 compared to the Novant Health acute care bed inventory in Mecklenburg County is 862.[18] There is a significant disparity in the number of beds under the control of Novant Health as compared to Atrium. The table and chart below demonstrate the market share advantage Atrium has for licensed acute care beds in Mecklenburg county.[19]

Percent of Total Licensed Acute Care Beds in Mecklenburg County

	2010	2011	2012	2013	2014	2015	2016	2017
Atrium	60%	60%	60%	60%	60%	60%	60%	61%
Novant	40%	40%	40%	40%	40%	40%	40%	39%

Source: NC Department of Health and Human Services State Medical Facilities Plan 2012 – Proposed 2019, Chapter 5, Table 5A: Acute Care Bed Need Projections

Total Number of Licensed Acute Care Beds in Mecklenburg County



Source: NC Department of Health and Human Services State Medical Facilities Plan 2012 - Proposed 2019, Chapter 5, Table 5A: Acute Care Bed Need Projections

The Agency has not awarded Novant Health any acute care beds in Mecklenburg County in competitive reviews since 2008. Since 2010, Atrium has had over 60 percent of Mecklenburg's licensed acute care beds, while Novant Health has consistently hovered below 40 percent. This competitive imbalance will only worsen if the Agency approves Atrium's full request. The Agency should therefore approve Novant Health's application for twelve beds and deny the Pineville Application as nonconforming. Improving competitive balance in Mecklenburg county, or not

[18] *Ibid*
[19] NOTE: Acute care bed need determination does not include long term acute care or rehabilitation beds.

unnecessarily worsening competitive balance, will maximize healthcare value by incentivizing high quality care and expanding patient choice.

Mecklenburg County is North Carolina's largest county by population. Mecklenburg County needs two strong systems to give patients a choice of where to receive their care, and payors are not forced to bow to the demands of Atrium. As has been widely reported in the national press, the United States Department of Justice Antitrust Division and the State of North Carolina sued Atrium in federal court in Charlotte in June 2016, alleging that Atrium's anti-steering clauses in its managed care contracts violated Section 1 of the Sherman Antitrust Act. This law prohibits contracts, combinations and conspiracies that unreasonably restrain trade. See 15 U.S.C. § 1. Atrium is alleged to have abused its dominance in the greater Charlotte area to force payors to keep patients within the Atrium system, rather than allowing payors to direct patients to lower cost, higher quality options, such as Novant Health.

After over two years of litigation, a proposed settlement was recently announced. The settlement agreement is attached as Exhibit A to this comment. Two class actions brought by consumers against Atrium are still pending. These class actions are based on the allegations of the USDOJ/State of North Carolina antitrust complaint. The complaints are attached as Exhibit B. Atrium has abused its market power in Mecklenburg County and the Greater Charlotte Area. The Agency should not increase that market power by its CON decisions. Awarding more beds to Atrium would undermine the proposed antitrust settlement by further increasing Atrium's market power. Novant Health respectfully urges the Agency not to undermine the work that the Attorney General of the State of North Carolina has undertaken to address Atrium's market power.

As noted earlier, Atrium was awarded all 60 beds in the 2017 Mecklenburg County Acute Care Bed Review. These CONs were issued in June 2018. Approving Atrium for another 50 beds in the 2018 Mecklenburg County Acute Care Bed Review equals 110 new acute care beds awarded to Atrium over the course of a year. One hundred ten acute care beds is more than the size of many hospitals in North Carolina.[20] A back-to-back award of 110 new acute care beds to Atrium would mean that Atrium has added the equivalent of another good sized community hospital to its vast network of more than 40 hospitals and 900 care locations.[21] Adding more beds to Atrium only increases the disproportion between the two health care systems in Mecklenburg County, which is negative for patients and payors. Greater competition leads to lower costs and higher quality. Adding more beds to the Atrium system increases Atrium's market power, which directly undermines the work of the United States Department of Justice and the State of North Carolina over the last several years to counteract Atrium's market power.

[20] This includes some Novant Health hospitals: Novant Health Medical Park Hospital (22 beds); Novant Health Brunswick Medical Center (74 beds); Novant Health Thomasville Medical Center (101 beds); Novant Health Mint Hill Medical Center (36 beds).
[21] https://atriumhealth.org/about-us.

The Agency has considered competition as a competitive factor before in an acute care bed review. In the 2012 Cumberland-Hoke Acute Care Bed Review, two systems, FirstHealth and Cape Fear Valley, each proposed to develop 28 acute care beds. The Agency considered that Cape Fear controlled the majority of the acute care beds in the service area. The Agency determined that awarding the beds to FirstHealth would enhance competition, and the FirstHealth application was approved. See Exhibit D, page 74. Novant Health respectfully submits that the same analysis should be used here, and the Agency should determine that the Huntersville Application is the most effective alternative with respect to competition.

Geographic Accessibility (Location within Mecklenburg County)

This table identifies the location of the existing and approved acute care beds in Mecklenburg County. The location within Mecklenburg County column is taken from the Agency's 2017 Findings on Acute Care Beds in Mecklenburg County.[22]

Location of Existing/Approved Acute Care Beds - Mecklenburg County

Facility	Existing/(Approved Adjustments) Beds	Location Within Mecklenburg County	City/Town
CMC-Mercy*	196	Downtown	Charlotte
CMC*	814 (+45)	Downtown	Charlotte
NH Presbyterian	567 (-48)	Downtown	Charlotte
NH Orthopedic	64 (-16)	Downtown	Charlotte
CHS University	100	East	Charlotte
NH Mint Hill**		East	Mint Hill
NH Huntersville	91 (+48)	North	Huntersville
CHS Pineville	206 (+15)	South	Pineville
NH Matthews	154	South	Matthews

Source: Proposed 2019 State Medical Facilities Plan, Chapter 5, Table 5A Acute Care Bed Need Projections
**CMC and CMC-Mercy are reported in combination in SMFP so data from 2018 License Renewal Applications was used to determine breakdown.*
*** This facility was still under development when Proposed 2019 SMFP was published. This facility has since opened with 36 licensed beds. 14 beds have the option to be added in 2020 for 50 licensed beds.*

The table below identifies the proposed location of the acute care beds, and total number of beds at the facility following project completion, for each application in this review.

[22] 2017 Mecklenburg County Acute Care Beds Findings, p 133

Location of Proposed Acute Care Beds- Mecklenburg County

Facility	Proposed Beds	Location Within Mecklenburg County	City/Town
CHS Pineville	271	South	Pineville
NHHMC	151	North	Huntersville

Source: Agency Certificate of Need Application Log for November 1, 2018

There are now 375 acute care beds in south Mecklenburg County and only 139 acute care beds in north Mecklenburg County.[23] The Huntersville Application would add 12 licensed beds in the north. The Pineville Application would add 50 beds in the south. The Huntersville Application is the most effective alternative to improve geographic access.

Service to Mecklenburg County Residents

On page 38, the 2018 SMFP defines the service area for acute care bed services as the planning area in which the bed is located. *"An acute care bed's service area is the acute care bed planning area in which the bed is located. The acute care bed planning areas are the single and multicounty groupings shown in Figure 5.1."* Figure 5.1 on page 42 of the 2018 SMFP shows Mecklenburg County as a single-county acute care bed planning area. The service area for this review consists of Mecklenburg County. Facilities may also serve residents of counties not included in their service area. Generally, the application projecting to serve the highest percentage of Mecklenburg County residents is the more effective alternative for this comparative factor. The table below shows the Huntersville Application is more effective than the Pineville Application on this factor.

Service to Mecklenburg County Residents

Applicant	% Mecklenburg County Residents
NH Huntersville	64.8%
CHS Pineville	48.0%

Source: Section C.3(a) (all applications)

As reflected in Pineville's patient origin, Pineville serves a large number of patients from South Carolina. See page 41 of the Pineville Application. There is a great likelihood that many of the 50 beds available in the 2018 Review will be used to serve South Carolina residents. Therefore, the Pineville Application is not the most effective alternative in meeting the need that was established for Mecklenburg County and its residents in the 2018 SMFP.

[23] Source: Proposed 2019 State Medical Facilities Plan, Chapter 5, Table 5A Acute Care Bed Need Projections

Access by Underserved Groups

Projected Charity Care

This table shows each applicant's projected charity care to be provided in the second operating year for each applicant and the percentage of total net revenue. Generally, the application proposing to provide the highest percentage of charity care is the more effective alternative for this comparative factor. Even though NHHMC is a much smaller hospital that Pineville, the table below shows that the Huntersville Application is the most effective alternative for projected charity care percentages.

Charity Care as Percentage of Net Revenue

Applicant	Charity Care	% of Net Revenue
NH Huntersville	$ 40,063,000	12%
CHS Pineville	$ 59,218,000	11%

Source: Form F.3 (all applications)

Projected Access by Medicare Patients

This table compares the percentage of Medicare patients as a percentage of total patients during the second operating year following project completion. Generally, the application proposing the highest percentage of Medicare patients is the more effective alternative for this comparative factor.

Percent of Medicare Patients - Operating Year 2

Applicant	% Medicare Patients Total Facility
NHHMC	39.2%
CHS- Pineville	31.0%

Source: Section L.3(a) (all applications)

Projected Access by Medicaid Patients

This table compares the percentage of Medicaid patients as a percentage of total patients during the second operating year following project completion. Generally, the application proposing the highest percentage of Medicaid patients is the more effective alternative for this comparative factor. For the hospitals as a whole, Pineville is the more effective alternative on this comparative factor.

Percent of Medicaid Patients - Operating Year 2

Applicant	% Medicaid Patients Total Facility
NHHMC	7.7%
CHS- Pineville	16.0%

Source: Section L.3(a) (all applications)

Project Cost per Licensed Bed

The project that can add licensed beds in Mecklenburg County at the lowest project cost is generally the most effective alternative. The acute care bed components of the NHHMC and Pineville applications add licensed beds only and no ancillary services. The Pineville project cost is $31,882,065, or $637,641 per bed. Because the Huntersville Application is licensing existing beds, the project cost for this component of the application is $701,246, or $58,437.17 per licensed bed. The additional patient days of capacity licensing the twelve beds add is 2,093, or the equivalent of four beds at 75% occupancy. Based on the cost of additional capacity, the Huntersville Application project cost is $175,312 per equivalent physical bed added.[24] The Pineville Application builds out one entire floor and one partial floor of a new bed tower. Based on project cost per bed added the Huntersville Application is the more effective alternative.

Timetable for Implementation

The projected opening date for the beds in the Huntersville Application is January 2021, and the projected opening date for the beds in the Pineville Application is January 2022. Accordingly, the Huntersville Application is the more effective alternative with respect to this factor.

Conclusion

The Pineville Application is nonconforming with Criteria (1), (3), (4), (5), (6), (12) and (18(a)), and the acute care bed rules. The Pineville Application is also comparatively inferior to the Huntersville Application. Therefore, the Pineville Application cannot be approved.

The Huntersville Application conforms to all applicable review criteria and rules, and is comparatively superior to the Pineville Application. Therefore, the Huntersville Application should be approved.

[24] Huntersville Application, page 35.

EXHIBIT A

UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF NORTH CAROLINA
CHARLOTTE DIVISION

UNITED STATES OF AMERICA and STATE OF NORTH CAROLINA, *Plaintiffs,* v. THE CHARLOTTE-MECKLENBURG HOSPITAL AUTHORITY d/b/a CAROLINAS HEALTHCARE SYSTEM, *Defendant*.	Case No. 3:16-cv-00311

JOINT STIPULATION AND ORDER
REGARDING THE PROPOSED FINAL JUDGMENT

Plaintiffs, United States of America and State of North Carolina, and Defendant, The Charlotte-Mecklenburg Hospital Authority d/b/a Atrium Health f/k/a Carolinas HealthCare System (collectively, the "Parties"), by and through their attorneys, hereby stipulate, subject to approval and entry by the Court, as follows:

1. A proposed Final Judgment in the form attached hereto as Exhibit 1 may be filed and entered by the Court, upon the motion of any Party or upon the Court's own action, at any time after compliance with the requirements of the Antitrust Procedures and Penalties Act, 15 U.S.C. § 16, ("APPA") and without further notice to any Party or other proceedings, provided that the United States has not withdrawn its consent, which it may do at any time before the entry

of the proposed Final Judgment by serving notice thereof on the Defendant and by filing the notice with the Court.

2. The Defendant agrees to arrange, at its expense, publication as quickly as possible of the newspaper notices required by the APPA, which shall be drafted by the United States in its sole discretion. The publication shall be arranged no later than three (3) business days after Defendant's receipt from the United States of the text of the notice and the identity of the newspapers within which the publication shall be made. The Defendant shall promptly send to the United States (1) confirmation that publication of the newspaper notices has been arranged, and (2) the certification of the publication prepared by the newspaper within which the notices were published.

3. The Defendant agrees to abide by and comply with the provisions of the proposed Final Judgment, pending the Court's entry of the proposed Final Judgment, or until expiration of time for all appeals of any Court ruling declining entry of the proposed Final Judgment, and agrees, from the date of the signing of this Stipulation, to comply with all terms and provisions of the proposed Final Judgment. The United States shall have the full rights and enforcement powers in the proposed Final Judgment as though the same were in full force and effect as a final order of this Court entering the proposed Final Judgment.

4. This Stipulation will apply with equal force and effect to any amended proposed Final Judgment agreed upon in writing by the Parties and submitted to the Court.

5. If (a) the United States has withdrawn its consent, as provided in Paragraph 1 above, or (b) the proposed Final Judgment is not entered pursuant to this Stipulation, the time has expired for all appeals of any Court ruling declining entry of the proposed Final Judgment, and the Court has not otherwise ordered continued compliance with the terms and provisions of the proposed

Final Judgment, then the Parties are released from all further obligations under this Stipulation, and the making of this Stipulation shall be without prejudice to any Party in this or any other proceeding.

6. The Defendant represents that the actions it is required to perform pursuant to the proposed Final Judgment can and will be performed, and that the Defendant will later raise no claim of mistake, hardship or difficulty of compliance as grounds for asking the Court to modify any of the provisions contained therein.

Dated: November 15, 2018

SO ORDERED:

_____
Robert J. Conrad, Jr.
United States District Judge

SO STIPULATED:

FOR PLAINTIFF
UNITED STATES OF AMERICA:

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KARL D. KNUTSEN
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EXHIBIT 1

UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF NORTH CAROLINA
CHARLOTTE DIVISION

UNITED STATES OF AMERICA and STATE OF NORTH CAROLINA, *Plaintiffs,* v. THE CHARLOTTE-MECKLENBURG HOSPITAL AUTHORITY d/b/a CAROLINAS HEALTHCARE SYSTEM, *Defendant*.	Case No. 3:16-cv-00311-RJC-DCK

[PROPOSED] FINAL JUDGMENT

WHEREAS, Plaintiffs, the United States of America and the State of North Carolina (collectively "Plaintiffs"), filed their Complaint on June 9, 2016; Plaintiffs and Defendant The Charlotte-Mecklenburg Hospital Authority d/b/a Atrium Health f/k/a Carolinas HealthCare System (collectively the "Parties"), by their respective attorneys, have consented to the entry of this Final Judgment without trial or adjudication of any issue of fact or law;

AND WHEREAS, this Final Judgment does not constitute any evidence against or admission by any party regarding any issue of fact or law;

AND WHEREAS, the Plaintiffs and Defendant agree to be bound by the provisions of this Final Judgment pending its approval by this Court;

AND WHEREAS, the essence of this Final Judgment is to enjoin Defendant from prohibiting, preventing, or penalizing steering as defined in this Final Judgment;

NOW THEREFORE, before any testimony is taken, without trial or adjudication of any issue of fact or law, and upon consent of the parties, it is ORDERED, ADJUDGED, AND DECREED:

I. JURISDICTION

The Court has jurisdiction over the subject matter of and each of the Parties to this action. The Complaint states a claim upon which relief may be granted against Defendant under Section 1 of the Sherman Act, as amended, 15 U.S.C. § 1.

II. DEFINITIONS

For purposes of this Final Judgment, the following definitions apply:

A. "Benefit Plan" means a specific set of health care benefits and Healthcare Services that is made available to members through a health plan underwritten by an Insurer, a self-funded benefit plan, or Medicare Part C plans. The term "Benefit Plan" does not include workers' compensation programs, Medicare (except Medicare Part C plans), Medicaid, or uninsured discount plans.

B. "Carve-out" means an arrangement by which an Insurer unilaterally removes all or substantially all of a particular Healthcare Service from coverage in a Benefit Plan during the performance of a network-participation agreement.

C. "Center of Excellence" means a feature of a Benefit Plan that designates Providers of certain Healthcare Services based on objective quality or quality-and-price criteria in order to encourage patients to obtain such Healthcare Services from those designated Providers.

D. "Charlotte Area" means Cabarrus, Cleveland, Gaston, Iredell, Lincoln, Mecklenburg, Rowan, Stanly, and Union counties in North Carolina and Chester, Lancaster, and York counties in South Carolina.

E. "Co-Branded Plan" means a Benefit Plan, such as Blue Local with Carolinas HealthCare System, arising from a joint venture, partnership, or a similar formal type of alliance or affiliation beyond that present in broad network agreements involving value-based arrangements between an Insurer and Defendant in any portion of the Charlotte Area whereby both Defendant's and Insurer's brands or logos appear on marketing materials.

F. "Defendant" means The Charlotte-Mecklenburg Hospital Authority d/b/a Atrium Health f/k/a Carolinas HealthCare System, a North Carolina hospital authority with its headquarters in Charlotte, North Carolina; and its directors, commissioners, officers, managers, agents, and employees; its successors and assigns; and any controlled subsidiaries (including Managed Health Resources), divisions, partnerships, and joint ventures, and their directors, commissioners, officers, managers, agents, and employees; and any Person on whose behalf Defendant negotiates contracts with, or consults in the negotiation of contracts with, Insurers. For purposes of this Final Judgment, an entity is controlled by Defendant if Defendant holds 50% or more of the entity's voting securities, has the right to 50% or more of the entity's profits, has the right to 50% or more of the entity's assets on dissolution, or has the contractual power to designate 50% or more of the directors or trustees of the entity. Also for purposes of this Final Judgment, the term "Defendant" excludes MedCost LLC and MedCost Benefits Services LLC, but it does not exclude any Atrium Health director, commissioner, officer, manager, agent, or employee who may also serve as a director, member, officer, manager, agent, or employee of MedCost LLC or MedCost Benefit Services LLC when such director,

commissioner, officer, manager, agent, or employee is acting within the course of his or her duties for Atrium Health. MedCostLLC and MedCost Benefits Services LLC will remain excluded from the definition of "Defendant" as long as Atrium does not acquire any greater ownership interest in these entities than it has at the time that this Final Judgment is lodged with the Court.

G. "Healthcare Provider" or "Provider" means any Person delivering any Healthcare Service.

H. "Healthcare Services" means all inpatient services (*i.e.*, acute-care diagnostic and therapeutic inpatient hospital services), outpatient services (*i.e.*, acute-care diagnostic and therapeutic outpatient services, including but not limited to ambulatory surgery and radiology services), and professional services (*i.e.*, medical services provided by physicians or other licensed medical professionals) to the extent offered by Defendant and within the scope of services covered on an in-network basis pursuant to a contract between Defendant and an Insurer. "Healthcare Services" does not mean management of patient care, such as through population health programs or employee or group wellness programs.

I. "Insurer" means any Person providing commercial health insurance or access to Healthcare Provider networks, including but not limited to managed-care organizations, and rental networks (*i.e.*, entities that lease, rent, or otherwise provide direct or indirect access to a proprietary network of Healthcare Providers), regardless of whether that entity bears any risk or makes any payment relating to the provision of healthcare. The term "Insurer" includes Persons that provide Medicare Part C plans, but does not include Medicare (except Medicare Part C plans), Medicaid, or TRICARE, or entities that otherwise contract on their behalf.

J. "Narrow Network" means a network composed of a significantly limited number of Healthcare Providers that offers a range of Healthcare Services to an Insurer's members for which all Providers that are not included in the network are out of network.

K. "Penalize" or "Penalty" is broader than "prohibit" or "prevent" and is intended to include any contract term or action with the likely effect of significantly restraining steering through Steered Plans or Transparency. In determining whether any contract provision or action "Penalizes" or is a "Penalty," factors that may be considered include: the facts and circumstances relating to the contract provision or action; its economic impact; and the extent to which the contract provision or action has potential or actual procompetitive effects in the Charlotte Area.

L. "Person" means any natural person, corporation, company, partnership, joint venture, firm, association, proprietorship, agency, board, authority, commission, office, or other business or legal entity.

M. "Reference-Based Pricing" means a feature of a Benefit Plan by which an Insurer pays up to a uniformly-applied defined contribution, based on an external price selected by the Insurer, toward covering the full price charged for a Healthcare Service, with the member being required to pay the remainder. For avoidance of doubt, a Benefit Plan with Reference-Based Pricing as a feature may permit an Insurer to pay a portion of this remainder.

N. "Steered Plan" means any Narrow Network Benefit Plan, Tiered Network Benefit Plan, or any Benefit Plan with Reference-Based Pricing or a Center of Excellence as a component.

O. "Tiered Network" means a network of Healthcare Providers for which (i) an Insurer divides the in-network Providers into different sub-groups based on objective price,

access, and/or quality criteria; and (ii) members receive different levels of benefits when they utilize Healthcare Services from Providers in different sub-groups.

P. "Transparency" means communication of any price, cost, quality, or patient experience information directly or indirectly by an Insurer to a client, member, or consumer.

III. APPLICABILITY

This Final Judgment applies to Defendant, as defined above, and all other Persons in active concert with, or participation with, Defendant who receive actual notice of this Final Judgment by personal service or otherwise.

IV. PROHIBITED CONDUCT

A. The contract language reproduced in Exhibit A is void, and Defendant shall not enforce or attempt to enforce it. The contract language reproduced in Exhibit B shall not be used to prohibit, prevent, or penalize Steered Plans or Transparency, but could remain enforceable for protection against Carve-outs. For the Network Participation Agreement between Blue Cross and Blue Shield of North Carolina and Defendant's wholly-owned subsidiary Managed Health Resources, effective January 1, 2014, as amended, Defendant shall exclude from the calculation of total cumulative impact pursuant to Section 6.14 of that agreement any impact to Defendant resulting from Blue Cross and Blue Shield of North Carolina disfavoring Defendant through Transparency or through the use of any Steered Plan.

B. For Healthcare Services in the Charlotte Area, Defendant will not seek or obtain any contract provision which would prohibit, prevent, or penalize Steered Plans or Transparency including:

1. express prohibitions on Steered Plans or Transparency;

2. requirements of prior approval for the introduction of new benefit plans (except in the case of Co-Branded Plans); and

3. requirements that Defendant be included in the most-preferred tier of Benefit Plans (except in the case of Co-Branded Plans). However, notwithstanding this Paragraph IV(B)(3), Defendant may enter into a contract with an Insurer that provides Defendant with the right to participate in the most-preferred tier of a Benefit Plan under the same terms and conditions as any other Charlotte Area Provider, provided that if Defendant declines to participate in the most-preferred tier of that Benefit Plan, then Defendant must participate in that Benefit Plan on terms and conditions that are substantially the same as any terms and conditions of any then-existing broad-network Benefit Plan (*e.g.*, PPO plan) in which Defendant participates with that Insurer. Additionally, notwithstanding Paragraph IV(B)(3), nothing in this Final Judgment prohibits Defendant from obtaining any criteria used by the Insurer to (i) assign Charlotte Area Providers to each tier in any Tiered Network; and/or (ii) designate Charlotte Area Providers as a Center of Excellence.

C. Defendant will not take any actions that penalize, or threaten to penalize, an Insurer for (i) providing (or planning to provide) Transparency, or (ii) designing, offering, expanding, or marketing (or planning to design, offer, expand, or market) a Steered Plan.

V. PERMITTED CONDUCT

A. Defendant may exercise any contractual right it has, provided it does not engage in any Prohibited Conduct as set forth above.

B. For any Co-Branded Plan or Narrow Network in which Defendant is the most-prominently featured Provider, Defendant may restrict steerage within that Co-Branded Plan or Narrow Network. For example, Defendant may restrict an Insurer from including at inception or

later adding other Providers to any (i) Narrow Network in which Defendant is the most-prominently featured Provider, or (ii) any Co-Branded Plan.

C. With regard to information communicated as part of any Transparency effort, nothing in this Final Judgment prohibits Defendant from reviewing its information to be disseminated, provided such review does not delay the dissemination of the information. Furthermore, Defendant may challenge inaccurate information or seek appropriate legal remedies relating to inaccurate information disseminated by third parties. Also, for an Insurer's dissemination of price or cost information (other than communication of an individual consumer's or member's actual or estimated out-of-pocket expense), nothing in the Final Judgment will prevent or impair Defendant from enforcing current or future provisions, including but not limited to confidentiality provisions, that (i) prohibit an Insurer from disseminating price or cost information to Defendant's competitors, other Insurers, or the general public; and/or (ii) require an Insurer to obtain a covenant from any third party that receives such price or cost information that such third party will not disclose that information to Defendant's competitors, another Insurer, the general public, or any other third party lacking a reasonable need to obtain such competitively sensitive information. Defendant may seek all appropriate remedies (including injunctive relief) in the event that dissemination of such information occurs.

VI. REQUIRED CONDUCT

Within fifteen (15) business days of entry of this Final Judgment, Defendant, through its designated counsel, must notify in writing Aetna, Blue Cross and Blue Shield of North Carolina, Cigna, MedCost, and UnitedHealthcare, that:

A. This Final Judgment has been entered (enclosing a copy of this Final Judgment) and that it prohibits Defendant from entering into or enforcing any contract term that would

prohibit, prevent, or penalize Steered Plans or Transparency, or taking any other action that violates this Final Judgment; and

B. For the term of this Final Judgment Defendant waives any right to enforce any provision listed in Exhibit A and further waives the right to enforce any provision listed in Exhibit B to prohibit, prevent, or penalize Steered Plans and Transparency.

VII. COMPLIANCE

A. It shall be the responsibility of the Defendant's designated counsel to undertake the following:

1. within fifteen (15) calendar days of entry of this Final Judgment, provide a copy of this Final Judgment to each of Defendant's commissioners and officers, and to each employee whose job responsibilities include negotiating or approving agreements with Insurers for the purchase of Healthcare Services, including personnel within the Managed Health Resources subsidiary (or any successor organization) of Defendant;

2. distribute in a timely manner a copy of this Final Judgment to any person who succeeds to, or subsequently holds, a position of commissioner, officer, or other position for which the job responsibilities include negotiating or approving agreements with Insurers for the purchase of Healthcare Services, including personnel within the Managed Health Resources subsidiary (or any successor organization) of Defendant; and

3. within sixty (60) calendar days of entry of this Final Judgment, develop and implement procedures necessary to ensure Defendant's compliance with this Final Judgment. Such procedures shall ensure that questions from any of Defendant's commissioners, officers, or employees about this Final Judgment can be answered by counsel (which may be outside counsel) as the need arises. Paragraph 21.1 of the Amended Protective Order Regarding

Confidentiality shall not be interpreted to prohibit outside counsel from answering such questions.

B. For the purposes of determining or securing compliance with this Final Judgment, or any related orders, or determining whether the Final Judgment should be modified or vacated, and subject to any legally-recognized privilege, from time to time authorized representatives of the United States or the State of North Carolina, including agents and consultants retained by the United States or the State of North Carolina, shall, upon written request of an authorized representative of the Assistant Attorney General in charge of the Antitrust Division or the Attorney General for the State of North Carolina, and on reasonable notice to Defendant, be permitted:

1. access during Defendant's office hours to inspect and copy, or at the option of the United States, to require Defendant to provide electronic copies of all books, ledgers, accounts, records, data, and documents in the possession, custody, or control of Defendant, relating to any matters contained in this Final Judgment; and

2. to interview, either informally or on the record, Defendant's officers, employees, or agents, who may have their individual counsel present, regarding such matters. The interviews shall be subject to the reasonable convenience of the interviewee and without restraint or interference by Defendant.

C. Within 270 calendar days of entry of this Final Judgment, Defendant must submit to the United States and the State of North Carolina a written report setting forth its actions to comply with this Final Judgment, specifically describing (1) the status of all negotiations between Managed Health Resources (or any successor organization) and an Insurer relating to contracts that cover Healthcare Services rendered in the Charlotte Area since the entry of the

Final Judgment, and (2) the compliance procedures adopted under Paragraph VII(A)(3) of this Final Judgment.

D. Upon the written request of an authorized representative of the Assistant Attorney General in charge of the Antitrust Division or the Attorney General for the State of North Carolina, Defendant shall submit written reports or responses to written interrogatories, under oath if requested, relating to any of the matters contained in this Final Judgment as may be requested.

E. The United States may share information or documents obtained under Paragraph VII with the State of North Carolina subject to appropriate confidentiality protections. The State of North Carolina shall keep all such information or documents confidential.

F. No information or documents obtained by the means provided in Paragraph VII shall be divulged by the United States or the State of North Carolina to any Person other than an authorized representative of (1) the executive branch of the United States or (2) the Office of the North Carolina Attorney General, except in the course of legal proceedings to which the United States or the State of North Carolina is a party (including grand jury proceedings), for the purpose of securing compliance with this Final Judgment, or as otherwise required by law.

G. If at the time that Defendant furnishes information or documents to the United States or the State of North Carolina, Defendant represents and identifies in writing the material in any such information or documents to which a claim of protection may be asserted under Rule 26(c)(1)(G) of the Federal Rules of Civil Procedure, and Defendant marks each pertinent page of such material, "Subject to claim of protection under Rule 26(c)(1)(G) of the Federal Rules of Civil Procedure," the United States and the State of North Carolina shall give Defendant ten (10)

calendar days' notice prior to divulging such material in any legal proceeding (other than a grand jury proceeding).

H. For the duration of this Final Judgment, Defendant must provide to the United States and the State of North Carolina a copy of each contract and each amendment to a contract that covers Healthcare Services in the Charlotte Area that it negotiates with any Insurer within thirty (30) calendar days of execution of such contract or amendment. Defendant must also notify the United States and the State of North Carolina within thirty (30) calendar days of having reason to believe that a Provider which Defendant controls has a contract with any Insurer with a provision that prohibits, prevents, or penalizes any Steered Plans or Transparency.

VIII. RETENTION OF JURISDICTION

The Court retains jurisdiction to enable any Party to this Final Judgment to apply to the Court at any time for further orders and directions as may be necessary or appropriate to carry out or construe this Final Judgment, to modify any of its provisions, to enforce compliance, and to punish violations of its provisions.

IX. ENFORCEMENT OF FINAL JUDGMENT

A. The United States retains and reserves all rights to enforce the provisions of this Final Judgment, including the right to seek an order of contempt from the Court. Defendant agrees that in any civil contempt action, any motion to show cause, or any similar action brought by the United States regarding an alleged violation of this Final Judgment, the United States may establish a violation of the decree and the appropriateness of any remedy therefor by a preponderance of the evidence, and Defendant waives any argument that a different standard of proof should apply.

B. The Final Judgment should be interpreted to give full effect to the procompetitive purposes of the antitrust laws and to restore all competition Plaintiffs alleged was harmed by the challenged conduct. Defendant agrees that it may be held in contempt of, and that the Court may enforce, any provision of this Final Judgment that, as interpreted by the Court in light of these procompetitive principles and applying ordinary tools of interpretation, is stated specifically and in reasonable detail, whether or not it is clear and unambiguous on its face. In any such interpretation, the terms of this Final Judgment should not be construed against either Party as the drafter.

C. In any enforcement proceeding in which the Court finds that Defendant has violated this Final Judgment, the United States may apply to the Court for a one-time extension of this Final Judgment, together with such other relief as may be appropriate. In connection with any successful effort by the United States to enforce this Final Judgment against Defendant, whether litigated or resolved prior to litigation, Defendant agrees to reimburse the United States for the fees and expenses of its attorneys, as well as any other costs including experts' fees, incurred in connection with that enforcement effort, including in the investigation of the potential violation.

X. EXPIRATION OF FINAL JUDGMENT

Unless the Court grants an extension, this Final Judgment shall expire ten (10) years from the date of its entry, except that after five (5) years from the date of its entry, this Final Judgment may be terminated upon notice by the United States to the Court and Defendant that the continuation of the Final Judgment is no longer necessary or in the public interest.

XI. PUBLIC INTEREST DETERMINATION

Entry of this Final Judgment is in the public interest. The Parties have complied with the requirements of the Antitrust Procedures and Penalties Act, 15 U.S.C. § 16, including making copies available to the public of this Final Judgment, the Competitive Impact Statement, any comments thereon, and the United States' responses to comments. Based upon the record before the Court, which includes the Competitive Impact Statement and any comments and responses to comments filed with the Court, entry of this Final Judgment is in the public interest.

Date: _____

[Court approval subject to procedures of Antitrust Procedures and Penalties Act, 15 U.S.C. § 16]

_____
Robert J. Conrad, Jr.
United States District Judge

Exhibit A

Aetna

Section 2.8 of the Physician Hospital Organization Agreement between and among Aetna Health of the Carolinas, Inc., Aetna Life Insurance Company, Aetna Health Management, LLC, and Defendant states in part:

> "Company may not . . . steer Members away from Participating PHO Providers other than instances where services are not deemed to be clinically appropriate, subject to the terms of Section 4.1.3 of this Agreement."

In addition, Section 2.11 of the above-referenced agreement states in part:

> "Company reserves the right to introduce in new Plans . . . and products during the term of this Agreement and will provide PHO with ninety (90) days written notice of such new Plans, Specialty Programs and products. . . . For purposes under (c) and (d) above, Company commits that Participating PHO Providers will be in-network Participating Providers in Company Plans and products as listed on the Product Participation Schedule. If Company introduces new products or benefit designs in PHO's market that have the effect of placing Participating PHO Providers in a non-preferred position, PHO will have the option to terminate this Agreement in accordance with Section 6.3. Notwithstanding the foregoing, if Company introduces an Aexcel performance network in PHO Provider's service area, all PHO Providers will be placed in the most preferred benefit level. As long as such Plans or products do not directly or indirectly steer Members away from a Participating PHO Provider to an alternative Participating Provider for the same service in the same level of care or same setting, the termination provision would not apply."

Blue Cross and Blue Shield of North Carolina

The Benefit Plan Exhibit to the Network Participation Agreement between Blue Cross and Blue Shield of North Carolina and Defendant (originally effective January 1, 2014), as replaced by the Fifth Amendment, states in part:

> "After meeting and conferring, if parties cannot reach agreement, then, notwithstanding Section 5.1, this Agreement will be considered to be beyond the initial term, and you may terminate this Agreement upon not less than 90 days' prior Written Notice to us, pursuant to Section 5.2."

Cigna

Section II.G.5 of the Managed Care Alliance Agreement between Cigna HealthCare of North Carolina, Inc. and Defendant states in part:

> "All MHR entities as defined in Schedule 1 will be represented in the most preferred benefit level for any and all CIGNA products for all services provided under this Agreement unless CIGNA obtains prior written consent from MHR to exclude any MHR entities from representation in the most preferred benefit level for any CIGNA product. . . . As a MHR Participating Provider, CIGNA will not steer business away from MHR Participating Providers."

Medcost

Section 3.6 of the Participating Physician Hospital Organization agreement between Medcost, LLC and Defendant states in part:

> "Plans shall not directly or indirectly steer patients away from MHR Participating Providers."

UnitedHealthcare

Section 2 of the Hospital Participation Agreement between UnitedHealthcare of North Carolina, Inc. and Defendant states in part:

> "As a Participating Provider, Plan shall not directly or indirectly steer business away from Hospital."

Exhibit B

Cigna

Section II.G.5 of the Managed Care Alliance Agreement between Cigna HealthCare of North Carolina, Inc. and Defendant states in part:

> "CIGNA may not exclude a MHR Participating Provider as a network provider for any product or Covered Service that MHR Participating Provider has the capability to provide except those carve-out services as outlined in Exhibit E attached hereto, unless CIGNA obtains prior written consent from MHR to exclude MHR Participating Provider as a network provider for such Covered Services."

UnitedHealthcare

Section 2 of the Hospital Participation Agreement between UnitedHealthcare of North Carolina, Inc. and Defendant states in part:

> "Plan may not exclude Hospital as a network provider for any Health Service that Hospital is qualified and has the capability to provide and for which Plan and Hospital have established a fee schedule or fixed rate, as applicable, unless mutually agreed to in writing by Plan and Hospital to exclude Hospital as a network provider for such Health Service."

In addition, Section 3.6 of the above-referenced agreement states in part:

> "During the term of this Agreement, including any renewal terms, if Plan creates new or additional products, which product otherwise is or could be a Product Line as defined in this Agreement, Hospital shall be given the opportunity to participate with respect to such new Product Line."

EXHIBIT B

FILED

STATE OF NORTH CAROLINA
COUNTY OF MECKLENBURG

IN THE GENERAL COURT OF JUSTICE
SUPERIOR COURT DIVISION
16 CVS 16404

Christopher DiCesare, individually and on behalf of all others similarly situated,

Plaintiff,

-v-

The Charlotte-Mecklenburg Hospital Authority, d/b/a Carolinas HealthCare System,

Defendant.

COMPLAINT

TABLE OF CONTENTS

Plaintiff Christopher DiCesare, individually and on behalf of a class of similarly situated individuals, hereby states and alleges the following against Defendant Charlotte-Mecklenburg Hospital Authority, d/b/a Carolinas HealthCare System ("Carolinas HealthCare").

I. INTRODUCTION

1. Carolinas HealthCare is the dominant hospital system in the Charlotte area, with yearly revenues exceeding $9 billion. Carolinas HealthCare is the nation's second largest supposedly "public" hospital system. Though Carolinas HealthCare purports to be a nonprofit working in the public interest, Carolinas HealthCare in fact operates in its own interest, leveraging its market power to maximize revenues at the expense of its patients. Carolinas HealthCare generates average annual profits of over $300 million, manages $2 billion in investments, and owns over $1 billion in property. Carolinas HealthCare has expanded aggressively, growing by 50 percent since 2011. After acquiring new practices, Carolinas HealthCare immediately increases the billing rates for the same services those practices offered before. These price increases are often devastating for families struggling to pay for life-saving healthcare. For instance, Carolinas HealthCare overcharges for cancer drugs and refuses to pass along savings from government discount programs to its patients. Last year, the Levine Cancer Institute (owned by Carolinas HealthCare), collected nearly $4,500 per dose of irinotecan, a drug used in the treatment of colon or rectal cancer. The average sales price of that drug was less than $60. Meanwhile, Carolinas HealthCare increased the pay for its CEO (Michael Tarwater) by 26 percent over the previous year, to $6.6 million. Last year, the top 10 executives at Carolinas HealthCare received over $1 million in compensation each.

2. Healthcare costs in the United States are the highest in the world, and increase every year. Spending on healthcare in the United States exceeds $3 trillion per year. Healthcare

costs in the Charlotte area—home to approximately 2.6 million people—are often significantly higher than the national average.

3. This class action challenges a powerful and unlawful tool Carolinas HealthCare uses to charge supracompetitive prices, and to insulate itself from competition that would force prices down. That tool is the use of "anti-steering" provisions, placed in contracts between Carolinas HealthCare and major commercial health insurers. These anti-steering provisions forbid health insurers from offering patients information and financial incentives to use lower cost healthcare services from Carolinas HealthCare's rivals. By design, these "anti-steering" provisions reduced competition and harmed Mr. DiCesare and the class he seeks to represent, increasing health care costs and insurance premiums unlawfully.

4. Carolinas HealthCare's misconduct violates North Carolina law. Mr. DiCesare seeks injunctive relief and damages for violations of Article I, Section 34 of the North Carolina Constitution and North Carolina General Statutes §§ 75-1, 75-1.1, 75-2, and 75-2.1.

II. JURISDICTION AND VENUE

5. Jurisdiction and venue are appropriate in Mecklenburg County, North Carolina, pursuant to Article I, Section 34 of the North Carolina Constitution and North Carolina General Statutes §§ 75-1, 75-1.1, 75-2, and 75-2.1.

6. This Court has subject matter jurisdiction over the claims asserted under North Carolina General Statute § 7A-240.

7. Defendant Carolinas HealthCare is subject to the jurisdiction of this Court under North Carolina General Statute §§ 1-75.3 and 1-75.4 as it is a domestic corporation domiciled within this state, is engaged in substantial activity in North Carolina, and the claimed injuries arise out of its actions that occurred and are occurring within North Carolina.

III. THE PARTIES

8. Plaintiff Christopher DiCesare is a citizen and resident of the State of North Carolina. Mr. DiCesare resides and works in Mecklenburg County. Beginning before 2013 and continuing to the present, Mr. DiCesare has been covered by a PPO health insurance plan offered by Cigna Healthcare of North Carolina, Inc. Mr. DiCesare paid, and continues to pay, premiums to Cigna, and has received medical care from Carolinas HealthCare.

9. Defendant Carolinas HealthCare System is a North Carolina corporation providing healthcare services with its principal place of business in Charlotte. It conducts business primarily through its Carolinas Medical Center, a large general acute-care hospital located in downtown Charlotte. It also operates nine other general acute-care hospitals in the Charlotte area.

IV. CLASS ACTION ALLEGATIONS

10. Mr. DiCesare brings this action on behalf of himself and all others similarly situated (the "Proposed Class"), pursuant to Rule 23 of the North Carolina Rules of Civil Procedure. The Proposed Class is defined as follows:

> All residents and citizens of North Carolina who, from January 1, 2013 to the present, paid premiums to Aetna Health of the Carolinas, Inc., Blue Cross Blue Shield of North Carolina, Cigna Healthcare of North Carolina, Inc., or United Healthcare of North Carolina, Inc., in exchange for coverage under a non-HMO group health insurance plan covering 51 or more persons that included any Carolinas HealthCare System provider in its network. The class includes both natural persons and legal entities who otherwise meet its criteria. Excluded from the Proposed Class are: Carolinas HealthCare, its employees, and any and all judges, justices, and chambers' staff assigned to hear or adjudicate any aspect of this litigation.

11. Based upon the nature of the trade and commerce involved, there are (at least) hundreds of thousands of Proposed Class members. Joinder of all members of the Class therefore is not practicable.

12. The questions of law and fact common to the Proposed Class include but are not limited to:

a. whether Carolinas HealthCare's misconduct violates North Carolina law;

b. whether Carolinas HealthCare has fraudulently concealed its misconduct;

c. whether Carolinas HealthCare, through the misconduct alleged herein, restrained trade, commerce, or competition in the relevant market for general acute care inpatient hospital services in the Charlotte area;

d. whether Mr. DiCesare and the Proposed Class he seeks to represent have suffered antitrust injury and/or have been threatened with antitrust injury;

e. the difference between the premiums Mr. DiCesare and the Proposed Class in fact paid for coverage under a non-HMO group health insurance plan, and the premiums Mr. DiCesare and the Proposed Class would have paid for coverage in the absence of the unlawful acts, contracts, and combinations alleged herein; and

f. the type and measure of damages suffered by Mr. DiCesare and the Proposed Class.

13. These and other questions of law and fact are common to the Proposed Class, and predominate over any questions affecting only individual members of the Proposed Class.

14. Mr. DiCesare's claims are typical of the claims of the Proposed Class.

15. Mr. DiCesare will fairly and adequately represent the interests of the Proposed Class and he has no conflict with the interests of the Proposed Class.

16. Carolinas HealthCare has acted on grounds generally applicable to the Proposed Class, thereby making final injunctive relief appropriate with respect to the Proposed Class as a whole.

17. This class action is superior to the alternatives, if any, for the fair and efficient adjudication of this controversy. There will be no material difficulty in the management of this action as a class action. Prosecution as a class action will eliminate the possibility of repetitive, duplicative, and potentially inconsistent litigation that would waste the resources of the parties and the courts.

V. FACTUAL ALLEGATIONS

A. The Relevant Market For General Acute Care Inpatient Hospital Services In The Charlotte Area

18. A relevant product market is the sale of general acute care inpatient hospital services to insurers ("acute inpatient hospital services"). The market includes sales of such services to insurers' individual, group, fully-insured and self-funded health plans.

19. The relevant market does not include sales of acute inpatient hospital services to government payers, e.g., Medicare (covering the elderly and disabled), Medicaid (covering low-income persons), and TRICARE (covering military personnel and families) because a healthcare provider's negotiations with an insurer are separate from the process used to determine the rates paid by government payers.

20. Acute inpatient hospital services consist of a broad group of medical and surgical diagnostic and treatment services that include a patient's overnight stay in the hospital. Although individual acute inpatient hospital services are not substitutes for each other, insurers typically contract for the various individual acute inpatient hospital services together, and Carolinas HealthCare's steering restrictions have an adverse impact on the sale of all acute inpatient hospital services. Therefore, acute inpatient hospital services are properly grouped together.

21. There are no reasonable substitutes or alternatives to acute inpatient hospital services. Thus, a hypothetical monopolist of acute inpatient hospital services would likely profitably impose a small but significant price increase for those services over a sustained period of time.

22. A relevant geographic market is the Charlotte Combined Statistical Area, as defined by the U.S. Office of Management and Budget, which consists of Cabarrus, Cleveland, Gaston, Iredell, Lincoln, Mecklenburg, Rowan, Stanly, and Union counties in North Carolina, and Chester, Lancaster, and York counties in South Carolina. The Charlotte area has a population of about 2.6 million people.

23. Insurers contract to purchase acute inpatient hospital services from hospitals within the geographic area where their enrollees are likely to require medical care. Such hospitals must be reasonably nearby their enrollees' homes or workplaces. Insurers who seek to sell insurance plans covering individuals in the Charlotte area must include Charlotte area hospitals in their provider networks because people who live and work in the Charlotte area strongly prefer to obtain acute inpatient hospital services in the Charlotte area. Charlotte area consumers have little or no willingness to enroll in an insurance plan that provides no network access to hospitals located in the Charlotte area.

24. Acute inpatient hospital services outside the Charlotte area do not reasonably substitute for such services in the Charlotte are; consequently, competition from providers located outside the Charlotte area would not prevent a hypothetical monopolist provider of acute inpatient hospital services located in Charlotte from profitably imposing small but significant price increases over a sustained period of time.

25. There are significant barriers to entry or expansion in the relevant market. Building facilities capable of competing with Carolinas HealthCare would require large capital costs, acquisition of hospital-size building sites, years to complete adequate physical facilities, the hiring of relevant employees with a broad range of skills, training, and certifications, and overcoming regulatory and licensing hurdles.

26. Accordingly, a relevant market in this action is general acute care inpatient hospital services in the Charlotte area.

B. Carolinas HealthCare Has Long Enjoyed Market Power And Has Charged "Premium To Market" Reimbursement Rates

27. Carolinas HealthCare is the dominant hospital system in the Charlotte area, with approximately a 50 percent share of the relevant market, and annual revenues of approximately $9 billion. From 2011 to 2015, Carolinas HealthCare increased its number of care locations by over 50%, from around 600 to over 900, largely by acquisitions. Thereafter, Carolinas HealthCare leveraged its market power to immediately increase the billing rates for the same services provided by those facilities. Its closest competitor by size is Novant, which owns five general acute care hospitals in the Charlotte area and has less than half of Carolinas HealthCare's revenue. After Novant, the next-largest hospital in the Charlotte area is CaroMont Regional Medical Center, which has less than one tenth of Carolinas HealthCare's revenue.

28. Carolinas HealthCare exerts market power in its dealings with health insurers. Carolinas HealthCare's market power results from its large size, the comprehensive range of healthcare services that it offers, its high market share, and insurers' need to include access to Carolinas HealthCare's hospitals—as well as its other facilities and providers—in at least some of their provider networks in insurance plans that cover people in the Charlotte area. From an insurer's perspective, the ubiquity and scale of Carolinas HealthCare means that smaller

providers such as Novant and CaroMont are not reasonable substitutes for access to Carolinas HealthCare's facilities. Carolinas HealthCare's market power is further evidenced by its ability to profitably charge prices to insurers that are higher than competitive levels across a range of services, and to impose on insurers restrictions that reduce competition.

29. Carolinas HealthCare's market power has enabled it to negotiate high prices (in the form of high "reimbursement rates") for treating insured patients. Carolinas HealthCare has long had a reputation for being a high-priced healthcare provider. In a 2013 presentation, Carolinas HealthCare's internal strategy group bragged that Carolinas HealthCare "has enjoyed years of annual reimbursement rate increases that are premium to the market, with those increases being applied to rates that are also premium to the market." For instance, a major health insurer reports that Carolinas HealthCare demands reimbursement rates that are up to 150 percent more than other hospitals in the Charlotte area for providing the same services.

C. Insurers Sought To Increase Competition And Lower Reimbursement Rates By Providing Financial Incentives To Patients To Use Lower Cost Healthcare Services

30. Steering is a method by which insurers offer consumers of healthcare services options to reduce some of their healthcare expenses. Steering typically occurs when an insurer offers consumers a financial incentive to use a lower-cost provider or lower-cost provider network, in order to lower their healthcare expenses.

31. Insurers want to steer towards lower-cost providers and to offer innovative insurance plans that steer. For years, insurers have tried to negotiate the removal of steering restrictions from their contracts with Carolinas HealthCare, but cannot because of Carolinas HealthCare's market power. In the absence of the steering restrictions, insurers would likely steer consumers to lower-cost providers more than their current contracts with Carolinas HealthCare permit.

32. Steering—and the competition from lower-priced healthcare providers that steering animates—threatened Carolinas HealthCare's high prices and revenues. In 2013, Carolinas HealthCare's internal strategy group surveyed a dozen of Carolinas HealthCare's senior leaders, asking them to list the "biggest risks to [Carolinas HealthCare] revenue streams." Nine of the twelve leaders polled identified the steering of patients away from Carolinas HealthCare as one of the biggest risks to Carolinas HealthCare's revenues.

D. Carolinas HealthCare Eliminated The Competitive Threat By Imposing Anti-Steering Provisions, Increasing Reimbursement Rates, Healthcare Costs, And Insurance Premiums

33. To protect itself against steering that would induce price competition and potentially require Carolinas HealthCare to lower its high prices, Carolinas HealthCare imposed steering restrictions in its contracts with insurers, beginning in approximately 2013. These restrictions impeded, and continue to impede, insurers from providing information and financial incentives to patients to encourage them to use lower-cost but comparable or higher-quality alternative healthcare providers.

34. Tiered networks are a popular type of steering that insurers use in healthcare markets. Typically, insurers using tiered networks place healthcare providers that offer better value healthcare services (lower cost, higher quality) in top tiers. Patients who use top-tier providers pay lower out-of-pocket costs. For example, for a given hypothetical procedure, a patient might be responsible for paying $25,000 in coinsurance at a lower-tier hospital, but only $4,500 in coinsurance to have the same procedure performed at a top-tier hospital, which provides the same procedure at a lower total cost to the insurer and the patient.

35. Narrow-network insurance plans are another popular steering tool. Typically, narrow networks consist of a subset of all the healthcare providers that participate in an insurer's conventional network. A consumer who chooses a narrow-network insurance plan typically pays

lower premiums, and lower out-of-pocket expenses than a conventional broad-network insurance plan, as long as the consumer is willing to choose from the smaller network of providers for his or her healthcare needs.

36. Providers are motivated to have insurers steer towards them, including through an insurer's narrow or tiered network, because of the increased patient volume that accompanies steering. Thus, the ability of insurers to steer gives providers a powerful incentive to be as efficient as possible, maintain low prices, and offer high quality and innovative services. Individuals and employers that provide health insurance to their employees benefit tremendously from this because they can lower their healthcare expenses.

37. Carolinas HealthCare has gained patient volume from insurers steering towards Carolinas HealthCare, and has obtained higher revenues as a result. Carolinas HealthCare encourages insurers to steer patients toward itself by offering health insurers modest concessions on its market-power driven, premium prices.

38. However, Carolinas HealthCare forbids insurers from allowing Carolinas HealthCare's competitors to do the same. Carolinas HealthCare prevents insurers from offering tiered networks that feature hospitals that compete with Carolinas HealthCare in the top tiers, and prevents insurers from offering narrow networks that include only Carolinas HealthCare's competitors. By restricting its competitors from competing for—and benefitting from—steered arrangements, Carolinas HealthCare uses its market power to impede insurers from negotiating lower prices with its competitors and offering lower-premium plans.

39. Carolinas HealthCare also imposes restrictions in its contracts with insurers that impede insurers from providing truthful information to consumers about the value (cost and quality) of Carolinas HealthCare's healthcare services compared to Carolinas HealthCare's

competitors. Carolinas HealthCare's restrictions on insurers' price and quality transparency are an indirect restriction on steering, because they prevent patients from accessing information that would allow them to make healthcare choices based on available price and quality information.

40. Because Carolinas HealthCare's steering restrictions prevent its competitors from attracting more patients through lower prices, Carolinas HealthCare's competitors have less incentive to remain lower priced and to continue to become more efficient. As a result, Carolinas HealthCare's restrictions reduce the competition that Carolinas HealthCare faces in the marketplace. In the instances in which insurers have steered in other markets and in the few instances in which insurers have steered in the Charlotte area despite Carolinas HealthCare's restrictions, insurers have reduced health insurance costs for consumers.

41. Four insurers provide coverage to more than 85 percent of the commercially-insured residents of the Charlotte area. They are: Aetna Health of the Carolinas, Inc., Blue Cross Blue Shield of North Carolina, Cigna Healthcare of North Carolina, Inc., and United Healthcare of North Carolina, Inc.

42. Carolinas HealthCare maintains and enforces steering restrictions in its contracts with all four of these insurers. In some instances, the contract language prohibits steering outright. For example, Carolinas HealthCare secured a contractual obligation from one insurer that it "shall not directly or indirectly steer business away from" Carolinas HealthCare. In other instances, the contract language gives Carolinas HealthCare the right to terminate its agreement with the insurer if the insurer engages in steering, providing Carolinas HealthCare the ability to deny the insurer and its enrollees access to its dominant hospital system unless the steering ends. Although the contractual language that Carolinas HealthCare has imposed varies with each insurer, it consistently creates disincentives that deter insurers from providing to their enrollees

UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF NORTH CAROLINA
CHARLOTTE DIVISION

RAYMOND BENITEZ, individually and on behalf of all others similarly situated, *Plaintiff,* v. THE CHARLOTTE-MECKLENBURG HOSPITAL AUTHORITY, d/b/a CAROLINAS HEALTHCARE SYSTEM, ATRIUM HEALTH, *Defendant.*	Case No. **COMPLAINT** **CLASS ACTION** **JURY TRIAL DEMANDED**

Plaintiff Raymond Benitez, individually, and on behalf of all others similarly situated, for his complaint against Defendant Charlotte-Mecklenburg Hospital Authority, d/b/a Carolinas Healthcare System, Atrium Health ("CHS"), states as follows:

NATURE OF THE ACTION

1. This is an action for restraint of trade seeking classwide damages and injunctive relief under Section One of the Sherman Act and Sections 4 and 16 of the Clayton Act.

2. This matter arises from CHS's abuse of its market dominance through the imposition of unlawful contract restrictions that prohibit commercial health insurers from offering inpatients financial benefits to use less-expensive health care services offered by CHS's competitors. This unlawful restraint of trade is the subject of a separate injunctive action by the United States of America and the State of North Carolina. This related action seeks a remedy for consumers who, as a result of CHS's unlawful conduct, have been forced to pay CHS above-

competitive prices for inpatient services through co-insurance payments and other direct payments.

THE PARTIES

3. Plaintiff Raymond Benitez resides in Charlotte, North Carolina in Mecklenburg County. Between July 4, 2016 and July 10, 2016 he utilized CHS general acute care inpatient hospital services for seven overnight stays. He was insured by Blue Cross Blue Shield of North Carolina and under his policy made a co-insurance payment directly to CHS of $3,440.36.

4. CHS is a North Carolina not-for-profit corporation providing healthcare services with its principal place of business in Charlotte. Its flagship facility is Carolinas Medical Center, a large general acute-care hospital located in downtown Charlotte. It also operates nine other general acute-care hospitals in the Charlotte area. It has done business until recently as Carolinas HealthCare System and now does business as Atrium Health.

JURISDICTION, VENUE, AND INTERSTATE COMMERCE

5. The Court has subject-matter jurisdiction over this action under Section 4 of the Clayton Act, 15 U.S.C. § 15; and Section 16 of the Clayton Act, 15 U.S.C. § 26; and 28 U.S.C. §§ 1331, 1337(a), and 1345.

6. The Court has personal jurisdiction over CHS under Section 12 of the Clayton Act, 15 U.S.C. § 22. CHS maintains its principal place of business and transacts business in this District.

7. Venue is proper under 28 U.S.C. § 1391 and Section 1 of the Clayton Act, 15 U.S.C. § 22. CHS transacts business and resides in this District, and the events giving rise to the claims occurred in this District.

8. CHS engages in interstate commerce and in activities substantially affecting interstate commerce. CHS provides healthcare services for which employers, insurers, and individual patients remit payments across state lines. CHS also purchases supplies and equipment that are shipped across state lines, and it otherwise participates in interstate commerce.

FACTUAL ALLEGATIONS

I. Background

9. CHS is the second largest public health system in the United States. It has what CHS calls 12 million patient "encounters" each year, or "one every three seconds" in the Charlotte area. Many of these involve hospital admissions. More than 50% of all Charlotte inpatient revenues are paid to CHS. Its largest competitor has less than half of CHS's revenues.

10. As this Court has pointed out, the complex world of healthcare is perplexing for consumers and "… [these complexities] present difficulties, frequently to consumers who become limited by who can provide their healthcare and how much it will cost." The free market is the greatest force for efficient, cost-based pricing, and innovation in human history. Just as democracy can thrive only in a free political system unhindered by outside forces, market efficiency and capitalism can survive only if market power is kept in check. Thus, it is imperative to ensure full and fair competition in healthcare markets. Only this keeps the healthcare pricing facing insurance and inpatient consumers at competitive levels and preserves competitive choice. This is the goal of both public and private enforcement of the antitrust laws.

11. CHS's market power has enabled it to negotiate high prices (in the form of high "reimbursement rates") for treating insured patients. CHS has long had a reputation for being a high-priced healthcare provider. In a 2013 presentation, CHS's internal strategy group recognized that CHS "has enjoyed years of annual reimbursement rate increases that are

premium to the market, with those increases being applied to rates that are also premium to the market."

12. Steering is a method by which insurers offer consumers of healthcare services options to reduce some of their healthcare expenses. Steering typically occurs when an insurer offers consumers a financial incentive to use a lower-cost provider or lower-cost provider network, in order to lower their healthcare expenses.

13. Steering – and the competition from lower-priced healthcare providers that steering animates – threatens CHS's high prices and revenues. In 2013, CHS's internal strategy group surveyed a dozen of CHS's senior leaders, asking them to list the "biggest risks to CHS revenue streams." Nine of the twelve leaders polled identified the steering of patients away from CHS as one of the biggest risks to CHS's revenues.

14. To protect itself against steering that would induce price competition and potentially require CHS to lower its high prices, CHS has imposed steering restrictions in its contracts with insurers. These restrictions impede insurers from providing financial incentives to patients to encourage them to consider utilizing lower-cost but comparable or higher quality alternative healthcare providers.

15. The United States of America and the State of North Carolina seek to enjoin CHS from using unlawful contract steering restrictions that prohibit commercial health insurers in the Charlotte area from offering inpatients financial benefits to use less-expensive healthcare services offered by CHS's competitors. These steering restrictions reduce competition resulting in pricing injury to Charlotte area consumers. This related action seeks remedy for the overcharge damages of inpatients paying CHS directly for inpatient services through co-insurance payments or otherwise.

16. Section 5 of the Clayton Act, 15 U.S.C. § 16(a), accords preclusive or prima facie effect in a private damage action to civil and criminal judgments obtained by the United States Department of Justice. This encourages private damage actions relying, in part, on government prosecutions. Thus, public enforcement by the United States Department of Justice, which typically pursues only the most flagrant violations of the antitrust laws, is supplemented by private enforcement enlarging penalties for such violations and deterring future misconduct.

17. Plaintiff relies, in part, on the United States' and the State of North Carolina's thorough assessments of the CHS restraint of trade and their conclusions as to what constitutes the public interest. Plaintiff does not seek consolidation with the government action. However, Plaintiff is prepared to proceed with coordination of discovery should the Court deem that appropriate.

II. Relevant Market

18. The sale of general acute care inpatient hospital services to insurers ("acute inpatient hospital services") is a relevant product market. The market includes sales of such services to insurers' individual, group, fully-insured, and self-funded health plans, as well as to inpatients directly compensating CHS through coinsurance or otherwise.

19. The relevant market does not include sales of acute inpatient hospital services to government payers, e.g., Medicare (covering the elderly and disabled), Medicaid (covering low-income persons), and TRICARE (covering military personnel and families) because a healthcare provider's negotiations with an insurer are separate from the process used to determine the rates paid by government payers.

20. Acute inpatient hospital services consist of a broad group of medical and surgical diagnostic and treatment services that include a patient's overnight stay in the hospital. Although individual acute inpatient hospital services are not substitutes for each other (e.g., obstetrics is

not a substitute for cardiac services), insurers typically contract for the various individual acute inpatient hospital services as a bundle, and CHS's steering restrictions have an adverse impact on the sale of all acute inpatient hospital services. Therefore, acute inpatient hospital services can be aggregated for analytical convenience.

21. There are no reasonable substitutes or alternatives to acute inpatient hospital services. Consequently, a hypothetical monopolist of acute inpatient hospital services would likely profitably impose a small but significant price increase for those services over a sustained period of time.

22. The relevant geographic market is no larger than the Charlotte area. In this Complaint, the Charlotte area means the Charlotte Combined Statistical Area, as defined by the U.S. Office of Management and Budget, which consists of Cabarrus, Cleveland, Gaston, Iredell, Lincoln, Mecklenburg, Rowan, Stanly, and Union counties in North Carolina, and Chester, Lancaster, and York counties in South Carolina. The Charlotte area has a population of about 2.6 million people.

23. Insurers contract to purchase acute inpatient hospital services from hospitals within the geographic area where their enrollees are likely to seek medical care. Such hospitals are typically close to their enrollees' homes or workplaces. Insurers who seek to sell insurance plans to individuals and employers in the Charlotte area must include Charlotte area hospitals in their provider networks because people who live and work in the Charlotte area strongly prefer to obtain acute inpatient hospital services in the Charlotte area. Charlotte area consumers have little or no willingness to enroll in an insurance plan that provides no network access to hospitals located in the Charlotte area.

24. For these reasons, it is not a viable alternative for insurers that sell health insurance plans to consumers in the Charlotte area to purchase acute inpatient hospital services from providers outside the Charlotte area. Consequently, competition from providers of acute inpatient hospital services located outside the Charlotte area would not likely be sufficient to prevent a hypothetical monopolist provider of acute inpatient hospital services located in the Charlotte area from profitably imposing small but significant price increases for those services over a sustained period of time.

III. Market Power

25. CHS – with more than 50% of all Charlotte inpatient revenues – exerts market power in its dealings with commercial health insurers ("insurers"). CHS's market power results from its large size, the comprehensive range of healthcare services that it offers, its high market share, and insurers' need to include access to CHS's hospitals – as well as its other facilities and providers – in at least some of their provider networks in insurance plans that cover people in the Charlotte area. CHS's market power is further evidenced by its ability to profitably charge prices to insurers and inpatients that are higher than competitive levels across a range of services, and to impose on insurers restrictions that reduce competition.

26. CHS's maintenance and enforcement of its steering restrictions lessen competition between CHS and the other providers of acute inpatient hospital services in the Charlotte area that would, in the absence of the restrictions, likely reduce the prices paid for such services by insurers and their inpatient enrollees. Thus, the restrictions help to insulate CHS from competition, by limiting the ability of CHS's competitors to win more commercially-insured business by offering lower prices.

27. Insurers want to steer inpatient enrollees towards lower-cost providers and to offer innovative insurance plans that steer. For years, insurers have tried to negotiate the removal

of steering restrictions from their contracts with CHS, but cannot because of CHS's market power. In the absence of the steering restrictions, insurers would likely steer consumers to lower-cost providers more than their current contracts with CHS presently permit.

IV. Anti-Steering Conduct Restraining Trade

28. CHS restricts steering to help insulate itself from price competition, which enables CHS to maintain high prices to insurers and inpatients and preserve its dominant position, and not for any procompetitive purpose. Indeed, when asked under oath whether CHS should limit the ability of insurers to offer tiered networks or narrow networks that exclude CHS, Carol Lovin, CHS's Chief Strategy Officer, said that CHS should not. And when asked her view about the possibility of eliminating CHS's steering restrictions, she testified, "Would I personally be okay with getting rid of them? Yes, I would." CHS's steering restrictions do not have any procompetitive effects. CHS can seek to avoid losses of revenues and market share from lower cost competitors by competing to offer lower prices and better value than its competitors, rather than imposing rules on insurers that reduce the benefit to its rivals from competing on price.

29. Tiered networks are a popular type of steering that insurers use in healthcare markets. Typically, insurers using tiered networks place healthcare providers that offer better value healthcare services (lower cost, higher quality) in top tiers. Patients who use top-tier providers pay lower out-of-pocket costs. For example, for a procedure costing $10,000, a patient might be responsible for paying $3,600 in co-insurance at a lower-tier hospital, but only $1,800 co-insurance to have the same procedure performed at a top-tier hospital.

30. Narrow-network insurance plans are another popular steering tool. Typically, narrow networks consist of a subset of all the healthcare providers that participate in an insurer's conventional network. A consumer who chooses a narrow-network insurance plan typically pays lower premiums and lower out-of-pocket expenses than a conventional broad-network insurance

plan as long as the consumer is willing to choose from the smaller network of providers for his or her healthcare needs.

31. Providers are motivated to have insurers steer towards them, including through an insurer's narrow or tiered network, because of the increased patient volume that accompanies steering. Thus, the ability of insurers to steer gives providers a powerful incentive to be as efficient as possible, maintain low prices, and offer high quality and innovative services. By doing so, providers induce insurers to steer patient volume to them. Individuals and employers that provide health insurance to their employees benefit tremendously from this because they can lower their healthcare expenses.

32. CHS has gained patient volume from insurers steering towards CHS, and has obtained higher revenues as a result. CHS encourages insurers to steer patients toward itself by offering health insurers modest concessions on its market-power driven, premium prices.

33. However, CHS forbids insurers from allowing CHS's competitors to do the same. CHS prevents insurers from offering tiered networks that feature hospitals that compete with CHS in the top tiers, and prevents insurers from offering narrow networks that include only CHS's competitors. By restricting its competitors from competing for – and benefitting from – steered arrangements, CHS uses its market power to impede insurers from negotiating lower prices with its competitors and offering lower-premium plans.

34. CHS also imposes restrictions in its contracts with insurers that impede insurers from providing truthful information to consumers about the value (cost and quality) of CHS's healthcare services compared to CHS's competitors. CHS's restrictions on insurers' price and quality transparency are an indirect restriction on steering because they prevent inpatients from

accessing information that would allow them to make healthcare choices based on available price and quality information.

35. Because CHS's steering restrictions prevent its competitors from attracting more inpatients through lower prices, CHS's competitors have less incentive to remain lower priced and to continue to become more efficient. As a result, CHS's restrictions reduce the competition that CHS faces in the marketplace. In the instances in which insurers have steered in other markets and in the few instances in which insurers have steered in the Charlotte area despite CHS's restrictions, insurers have reduced health insurance costs for consumers.

36. Four insurers provide coverage to more than 85 percent of the commercially-insured residents of the Charlotte area. They are: Aetna Health of the Carolinas, Inc., Blue Cross Blue Shield of North Carolina, Cigna Healthcare of North Carolina, Inc., and United Healthcare of North Carolina, Inc.

37. CHS maintains and enforces steering restrictions in its contracts with all four of these insurers. In some instances, the contract language prohibits steering outright. For example, CHS secured a contractual obligation from one insurer that it "shall not directly or indirectly steer business away from" CHS. In other instances, the contract language gives CHS the right to terminate its agreement with the insurer if the insurer engages in steering, providing CHS the ability to deny the insurer and its enrollees access to its dominant hospital system unless the steering ends. Although the contractual language that CHS has imposed varies with each insurer, it consistently creates disincentives that deter insurers from providing to their enrollees truthful information about their healthcare options and the benefits of price and quality competition among healthcare providers that the insurers could offer if they had full freedom to steer.

V. Antitrust Injury

38. As a result of this reduced competition due to CHS's steering restrictions, inpatients and employers in the Charlotte area pay higher prices for health insurance coverage, have fewer insurance plans from which to choose, and are denied access to consumer comparison shopping and other cost-saving innovative and more efficient health plans that would be possible if insurers could steer freely.

39. Insurance companies are not the sole source of non-government reimbursement inpatient revenues to CHS. CHS also receives payments directly from Charlotte area inpatient consumers in the form of "co-insurance" payments and other direct payments for expenses not covered by insurance. A co-insurance payment is the percentage of the bill for inpatient medical services paid directly by the insured inpatient consumer, with the rest paid by the insurance company.

40. As a direct result of CHS's anti-competitive conduct, inpatient consumers are forced to pay above-competitive prices for co-insurance and other direct payments to CHS.

CLASS ALLEGATIONS

A. Fed. R. Civ. P. 23(a) Prerequisites

41. Plaintiff ("Class Representative") is a representative of persons residing in the Charlotte Combined Statistical Area making direct payments for general acute care inpatient procedures to the Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas Healthcare System and Atrium Health ("CHS") on or after February 28, 2014. Such persons include inpatients making direct co-insurance payments to CHS as a result of their health plan deductibles or otherwise; or, if no health insurance covers a procedure, direct payments to CHS for all or part of the procedure's costs. Excluded from the class are (a) direct inpatient payments to CHS which are set at a fixed amounts by insurance plan or otherwise regardless of the cost of the CHS

procedure; and (b) the Presiding Judge, employees of this Court, and any appellate judges exercising jurisdiction over these claims as well as employees of that appellate court.

42. Prosecution of the claims of the Class as a class action is appropriate because the prerequisites of Rule 23(a) of the Federal Rules of Civil Procedure are met:

(a) The number of persons in the Class is in the thousands, and the members of the Class are therefore so numerous that joinder of all members of the Class is impracticable. Joinder also is impracticable because of the geographic diversity of the members of the Class, the need to expedite judicial relief, and the Class Representative's lack of knowledge of the identity and addresses of all members of the Class.

(b) There are numerous questions of law and fact arising from the pattern of conspirators' restraint of trade which are common to the members of the Class. These include, but are not limited to, common issues as to (1) whether the Defendant has engaged in restraint of trade; and (2) whether this conduct, taken as a whole, has materially caused antitrust price injury to be inflicted on members of the Class. In addition, there are common issues as to the nature and extent of the injunctive and monetary relief available to the members of the Class.

43. The claims of the Class Representative are typical of the claims of the members of the Class and fairly encompass the claims of the members of the Class. The Class Representative and the members of the Class are similarly or identically harmed by the same systematic and pervasive concerted action.

44. The Class Representative and the Representative's counsel will fairly and adequately protect the interests of the members of the Class. There are no material conflicts between the claims of each Class Representative and the members of the Class that would make

class certification inappropriate. Counsel for the Class will vigorously assert the claims of the Class Representative and the other members of the Class.

B. Federal Rule of Civil Procedure 23(b)(3) Prerequisites

45. In addition, the prosecution of the claims of the Class as a class action pursuant to Rule 23(b)(3) is appropriate because:

(a) Questions of law or fact common to the members of the Class predominate over any questions affecting only its individual members; and

(b) A class action is superior to other methods for the fair and efficient resolution of the controversy.

C. Federal Rule of Civil Procedure 23(b)(2) Prerequisites

46. The prosecution of the claims of the Class as a class action pursuant to Rule 23(b)(2) is appropriate because the conspirators have acted, or refused to act, on grounds generally applicable to the Class, thereby making appropriate final injunctive relief, or corresponding declaratory relief, for the Class as a whole.

CHS'S VIOLATION OF SECTION 1 OF THE SHERMAN ACT

47. Plaintiffs incorporate paragraphs 1 through 46 of this Complaint.

48. CHS has market power in the sale of general acute care inpatient hospital services in the Charlotte area.

49. CHS has and likely will continue to negotiate and enforce contracts containing steering restrictions with insurers in the Charlotte area. The contracts containing the steering restrictions are contracts, combinations, and conspiracies within the meaning of Section 1 of the Sherman Act, 15 U.S.C. § 1.

50. These steering restriction have had, and will likely to continue to have, the following substantial anticompetitive effects in the relevant product and geographic market, among others:

(a) Depriving insurers and their enrolled inpatients of the benefits of a competitive market and competitive pricing for their purchase of acute inpatient hospital services;

(b) Protecting CHS's market power and enabling CHS to maintain at supracompetitive levels the prices for acute inpatient hospital services;

(c) Substantially lessening competition among providers in their sale of acute inpatient hospital services;

(d) Restricting the introduction of innovative insurance products that are designed to achieve lower prices and improved quality for acute inpatient hospital services; and

(e) Reducing consumers' incentives to seek acute inpatient hospital services from more cost-effective providers.

51. Entry or expansion by other hospitals in the Charlotte area has not counteracted the actual and likely competitive harms resulting from CHS's steering restrictions. And in the future, such entry or expansion is unlikely to be rapid enough and sufficient in scope and scale to counteract these harms to competition. Building a hospital with a strong reputation that is capable of attracting physicians and inpatients is difficult, time-consuming, and expensive. Additionally, new facilities and programs, and typically the expansion of existing facilities and programs, are subject to lengthy licensing requirements, and in North Carolina, to certificate-of-need laws.

52. CHS did not devise its strategy of using steering restrictions for any procompetitive purpose. Nor do the steering restrictions have any procompetitive effects. Any arguable benefits of CHS's steering restrictions are outweighed by their actual and likely anticompetitive effects.

53. Inpatient consumers and their insurers have paid above-competitive pricing directly to CHS materially caused by the restraint of trade.

54. The challenged steering restrictions unreasonably restrain trade in violation of Section 1 of the Sherman Act, 15 U.S.C. § 1.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff individually and as a member of the proposed Class alleged prays that:

A. This Court declare that CHS's conduct constitutes a violation of the Sherman Act, 15 U.S.C. § 1, allowing treble damage relief to the proposed Class under Section 4 of the Clayton Act, 15 U.S.C. § 15;

B. This Court permanently enjoin Defendant from continuing the conspiracy and unlawful actions described herein under Section 16 of the Clayton Act, 15 U.S.C. § 26;

C. Plaintiff recover reasonable attorneys' fees and costs as allowed by law;

D. Plaintiff recover pre-judgment and post-judgment interest at the highest rate allowed by law; and

E. Plaintiff be granted such other and further relief as the Court deems just and equitable.

JURY DEMAND

Plaintiff demands a trial by jury.

February 28, 2018

Respectfully submitted,

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truthful information about their healthcare options and the benefits of price and quality competition among healthcare providers that the insurers could offer if they had full freedom to steer.

43. An insurer selling health insurance plans to individuals and employers in the Charlotte area must have Carolinas HealthCare as a participant, in at least some of its provider networks, in order to have a viable health insurance business in the Charlotte area. This gives Carolinas HealthCare the ability to impose steering restrictions in its contracts with insurers. When Carolinas HealthCare negotiates with insurers for Carolinas HealthCare's network participation, Carolinas HealthCare typically negotiates the prices and terms of participation for acute inpatient hospital services and other healthcare services, such as outpatient, ancillary, and physician services, at the same time, including services that are located outside the Charlotte area. As a result, Carolinas HealthCare's anticompetitive steering restrictions typically apply to all the negotiated services.

44. Carolinas HealthCare's steering restrictions lessen competition between Carolinas HealthCare and the other providers of acute inpatient hospital services in the Charlotte area that would, in the absence of the restrictions, likely reduce the prices paid for such services by insurers. Thus, the restrictions help to insulate Carolinas HealthCare from competition, by limiting the ability of Carolinas HealthCare's competitors to win more commercially-insured business by offering lower prices.

45. As a result of this reduced competition due to Carolinas HealthCare's steering restrictions, individuals and employers such as Mr. DiCesare in the Charlotte area pay higher prices for health insurance coverage, have fewer insurance plans from which to choose, and are denied access to consumer comparison shopping and other cost-saving innovative and more

efficient health plans that would be possible if insurers could steer freely. Deprived of the option to benefit from choosing more cost-efficient providers, Charlotte area patients also incur higher out-of-pocket costs for their healthcare.

E. The United States Department of Justice and the Attorney General of North Carolina Filed Suit To Stop Carolinas HealthCare From Imposing "Anti-Steering" Requirements On Commercial Health Insurers

46. On June 9, 2016, the United States Department of Justice ("DOJ") and the Attorney General of North Carolina ("AG") filed suit against Carolinas HealthCare in United States District Court for the Western District of North Carolina. The DOJ and AG complaint alleges substantially the same misconduct as that alleged by Mr. DiCesare here.

47. The DOJ and AG complaint indicates that the DOJ and AG took testimony of relevant witnesses. For instance, the DOJ and AG complaint states that, when asked under oath whether Carolinas HealthCare should limit the ability of insurers to offer tiered networks or narrow networks that exclude Carolinas HealthCare, Carol Lovin, Carolinas HealthCare's Chief Strategy Officer, said that Carolinas HealthCare should not. And when asked her view about the possibility of eliminating Carolinas HealthCare's steering restrictions, she testified, "Would I personally be okay with getting rid of them? Yes, I would." The DOJ and AG allege that this testimony confirms that Carolinas HealthCare's misconduct has no justification.

VI. FIRST CLAIM FOR RELIEF: CONTRACT, COMBINATION, OR CONSPIRACY IN RESTRAINT OF TRADE

48. Mr. DiCesare on behalf of himself and all others similarly situated, realleges and incorporates herein by reference each of the allegations contained in the preceding paragraphs of this Complaint, and further alleges against Carolinas HealthCare as follows.

49. Carolinas HealthCare has and likely will continue to negotiate and enforce contracts containing steering restrictions with insurers in the Charlotte area. The contracts

containing the steering restrictions are contracts, combinations, and conspiracies within the meaning of North Carolina General Statutes §§ 75-1 and 75-2.

50. These steering restrictions have had, and will likely continue to have, the following substantial anticompetitive effects in the relevant product and geographic market, among others:

a. protecting Carolinas HealthCare's market power and enabling Carolinas HealthCare to charge supracompetitive prices for acute inpatient hospital services;

b. substantially lessening competition among providers of acute inpatient hospital services;

c. restricting the introduction of innovative insurance products that are designed to achieve lower prices and improved quality for acute inpatient hospital services;

d. reducing consumers' incentives to seek acute inpatient hospital services from more cost-effective providers;

e. depriving consumers of information about better and less costly health care alternatives; and

f. depriving insurers and their enrollees of the benefits of a competitive market for their purchase of acute inpatient hospital services.

51. Entry or expansion by other hospitals in the Charlotte area has not counteracted the actual and likely competitive harms resulting from Carolinas HealthCare's steering restrictions. And in the future, such entry or expansion is unlikely to be rapid enough and sufficient in scope and scale to counteract these harms to competition. Building a hospital with a strong reputation that is capable of attracting physicians and patients is difficult, time-consuming, and expensive. Additionally, new facilities and programs, and typically the expansion of existing facilities and programs, are subject to lengthy licensing requirements, and in North Carolina, to certificate-of-need laws.

52. Carolinas HealthCare did not devise its strategy of using steering restrictions for any procompetitive purpose. Nor do the steering restrictions have any procompetitive effects. Any arguable benefits of Carolinas HealthCare's steering restrictions are outweighed by their actual and likely anticompetitive effects.

53. The challenged steering restrictions unreasonably restrain trade in violation of North Carolina General Statutes §§ 75-1 and 75-2.

VII. SECOND CLAIM FOR RELIEF: MONOPOLIZATION

54. Mr. DiCesare on behalf of himself and all others similarly situated, realleges and incorporates herein by reference each of the allegations contained in the preceding paragraphs of this Complaint, and further alleges against Carolinas HealthCare as follows.

55. Carolinas HealthCare has monopolized, and continues to monopolize, the relevant market alleged herein in violation of Article I, Section 34 of the North Carolina Constitution and North Carolina General Statutes §§ 75-1.1, 75-2, and 75-2.1.

56. These steering restrictions have had, and will likely continue to have, the following substantial anticompetitive effects in the relevant product and geographic market, among others:

a. protecting Carolinas HealthCare's market power and enabling Carolinas HealthCare to charge supracompetitive prices for acute inpatient hospital services;

b. substantially lessening competition among providers of acute inpatient hospital services;

c. restricting the introduction of innovative insurance products that are designed to achieve lower prices and improved quality for acute inpatient hospital services;

d. reducing consumers' incentives to seek acute inpatient hospital services from more cost-effective providers;

e. depriving consumers of information about better and less costly health care alternatives; and

f. depriving insurers and their enrollees of the benefits of a competitive market for their purchase of acute inpatient hospital services.

57. Entry or expansion by other hospitals in the Charlotte area has not counteracted the actual and likely competitive harms resulting from Carolinas HealthCare's steering restrictions. And in the future, such entry or expansion is unlikely to be rapid enough and sufficient in scope and scale to counteract these harms to competition. Building a hospital with a strong reputation that is capable of attracting physicians and patients is difficult, time-consuming, and expensive. Additionally, new facilities and programs, and typically the expansion of existing facilities and programs, are subject to lengthy licensing requirements, and in North Carolina, to certificate-of-need laws.

58. Carolinas HealthCare did not devise its strategy of using steering restrictions for any procompetitive purpose. Nor do the steering restrictions have any procompetitive effects. Any arguable benefits of Carolinas HealthCare's steering restrictions are outweighed by their actual and likely anticompetitive effects.

59. The challenged steering restrictions unreasonably restrain trade in violation of Article I, Section 34 of the North Carolina Constitution and North Carolina General Statutes §§ 75-1.1, 75-2, and 75-2.1.

PRAYER FOR RELIEF

WHEREFORE, Mr. DiCesare prays that this Court enter judgment on his behalf and that of the Proposed Class by adjudging and decreeing that:

A. This Court certify the Proposed Class and that Mr. DiCesare and the Proposed Class have trial by jury;

B. Carolinas HealthCare has engaged in a trust, contract, combination, or conspiracy in violation of North Carolina General States §§ 75-1 and 75-2, and that Mr. DiCesare and the members of the Proposed Class have been damaged and injured in their business and property as a result of this violation;

C. Carolinas HealthCare has monopolized, and continues to monopolize, the relevant market alleged herein in violation of Article I, Section 34 of the North Carolina Constitution and North Carolina General Statutes §§ 75-1.1, 75-2, and 75-2.1, and that Mr. DiCesare and the members of the Proposed Class have been damaged and injured in their business and property as a result of this violation;

D. Mr. DiCesare and the members of the Proposed Class he represents recover threefold the damages determined to have been sustained by them as a result of Carolinas HealthCare's misconduct, complained of herein, and that judgment be entered against Carolinas HealthCare for the amount so determined;

E. Judgment be entered against Carolinas HealthCare and in favor of Mr. DiCesare and each member of the Proposed Class he represents, for restitution and disgorgement of ill-gotten gains as allowed by law and equity as determined to have been sustained by them, together with the costs of suit, including reasonable attorneys' fees;

F. For prejudgment and post-judgment interest;

G. For injunctive relief, declaring Carolinas HealthCare's misconduct unlawful and enjoining Carolinas HealthCare, its officers, directors, agents, employees, and successors, and all other persons acting or claiming to act on its behalf, directly or indirectly, from seeking, agreeing to, or enforcing any provision in any agreement that prohibits or restricts an insurer from engaging, or attempting to engage, in steering towards any healthcare provider, and enjoining

Carolinas HealthCare from retaliating, or threatening to retaliate, against any insurer for engaging or attempting to engage in steering; and

H. For equitable relief, including a judicial determination of the rights and responsibilities of the parties; and

K. For such other and further relief as the Court may deem just and proper.

Dated: September 9, 2016

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EXHIBIT C

Exhibit C

Pineville Historical Acute Care Bed Utilization

	CY13	CY14	CY15	CY16	CY17	CY18	CAGR 4 Year 2015-2018	CAGR 5 Year 2014-2018	CAGR 6 Year 2013-2018
Days	51,572	55,981	57,815	61,095	65,193	68,295			
CAGR		8.5%	3.3%	5.7%	6.7%	4.8%	5.7%	5.1%	5.8%
ADC	141	153	158	167	179	187			
Beds	206	206	206	206	206	206			

Source: 2013 and 2014 from Project I.D. #F-011361-17 Assumptions and Methodology Pages 2 and 3
Source: 2015 - 2018 from Project I.D. #F-011622-18 Assumptions and Methodology Page 3

Pineville Projected Acute Care Bed Utilization
At 3.00% CAGR

				Y1	Y2	Y3
	CY19	CY20	CY21	CY22	CY23	CY24
Acute Care CAGR	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%
CHS-Pineville Before Shifts	70,344	72,454	74,628	76,867	79,173	81,548
Less Shifts						
Fort Mill			7,276	7,482	7,693	7,910
CHS Union	259	528	806	1,639	2,224	2,829
Total After Shifts	70,085	71,926	66,546	67,746	69,256	70,809
ADC	192.01	197	182	186	190	194
Proposed Beds	221	221	221	271	271	271
Occupancy	86.9%	89.2%	82.5%	68.5%	70.0%	71.6%

Source: Shifts from Project I.D. #F-011622-18 Assumptions and Methodology Pages 5, 6

Pineville Projected Acute Care Bed Utilization
At 3.50% CAGR

				Y1	Y2	Y3
	CY19	CY20	CY21	CY22	CY23	CY24
Acute Care CAGR	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%
CHS-Pineville Before Shifts	70,685	73,159	75,720	78,370	81,113	83,952
Less Shifts						
Fort Mill			7,276	7,482	7,693	7,910
CHS Union	259	528	806	1,639	2,224	2,829
Total After Shifts	70,426	72,631	67,638	69,249	71,196	73,213
ADC	192.95	199	185	190	195	201
Proposed Beds	221	221	221	271	271	271
Occupancy	87.3%	90.0%	83.9%	70.0%	72.0%	74.0%

Source: Shifts from Project I.D. #F-011622-18 Assumptions and Methodology Pages 5, 6

EXHIBIT D

ATTACHMENT - REQUIRED STATE AGENCY FINDINGS

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

DECISION DATE: November 27, 2012
FINDINGS DATE: December 4, 2012

PROJECT ANALYST: Gregory F. Yakaboski
SECTION CHIEF: Craig R. Smith

PROJECT I.D. NUMBER: M-8833-12 / Cumberland County Hospital System, Inc., d/b/a Cape Fear Valley Medical Center/ Add 28 Acute Care Beds at Cape Fear Valley Medical Center on Owen Drive / Cumberland County

N-8838-12 / FirstHealth of the Carolinas, Inc/ Add 28 Acute Care Beds to its approved 8-bed acute care hospital in Hoke County/ Hoke County

REVIEW CRITERIA FOR NEW INSTITUTIONAL HEALTH SERVICES

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

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

NC
CFVMC

C
FHCH

The 2012 State Medical Facilities Plan (SMFP) includes a need determination for 28 additional acute care beds for the Cumberland-Hoke County Acute Bed Service Area. On page 47, the 2012 SMFP states:

"Any qualified applicant may apply for a certificate of need to acquire the needed acute care beds. A person is a qualified applicant if he or she proposes to operate the additional acute care beds in a hospital that will provide:

(1) a 24-hour emergency services department,
(2) inpatient medical services to both surgical and non-surgical patients, and
(3) if proposing a new licensed hospital, medical and surgical services on a daily basis within at least five of the major diagnostic categories as recognized by the Centers for Medicare and Medicaid services (CMS), as follows: … [as listed in the 2012 SFMP]."

Policy GEN-3: Basic Principles is applicable to this review. Policy GEN-3 states:

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

Policy GEN-4: Energy Efficiency and Sustainability for Health Service Facilities is applicable to this review. This policy 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."

Cumberland County Hospital System, Inc., d/b/a Cape Fear Valley Medical Center ("CFVMC") operates a total of 604 beds, including 490 bed hospital at Owen Drive,

Fayetteville ("Owen Drive Campus") and has a certificate of need to develop a 65 bed satellite hospital know as CFV North ("CFV North"), also in Fayetteville, Cumberland County, with a certificate of need issued to a subsidiary, Hoke County Medical Center ("HCMC") to develop a 41 bed hospital in Hoke County. CFVMC proposes to add 28 acute care beds to its existing 490 bed hospital at the Owen Drive Campus, Fayetteville, in Cumberland County. CFVMC operates a 24-hour emergency services department and provides inpatient medical services to both surgical and non-surgical patients. The applicant is not proposing a new licensed hospital. Thus, CFVMC is a qualified applicant.

FirstHealth of the Carolinas, Inc. d/b/a FirstHealth Moore Regional Hospital ("FirstHealth") proposes to add 28 acute care beds to its approved 8-bed hospital (FirstHealth Hoke Community Hospital or **FHCH**) to be developed along US-401 East (Williams Properties) in Raeford in Hoke County. The applicant has approval to develop and operate a 24-hour emergency services department and provide inpatient medical services to both surgical and non-surgical patients at FHCH. The applicant is not proposing a new licensed hospital. Thus, FHCH is a qualified applicant.

CFVMC. proposes to develop 28 acute care beds at CFVMC's Owen Drive Campus in Fayetteville.

Need Determination – CFVMC does not propose to develop more than 28 acute care beds in the Cumberland-Hoke Acute Care Bed Service area. Therefore, the application is conforming to the 2012 need determination for 28-acute care beds in the Cumberland-Hoke Acute Care Bed Service area.

Policy GEN-3 – CFVMC describes how its proposal will promote safety and quality in Section II.7, pages 24-25, Exhibits 13, 14 and 15, Section II.2, pages 20-12, Section II.6, pages 22-24, Exhibits 20, 22 and 35, Section III.2, pages 58-60, Exhibit 38, and Section V.7, page 85. However, the applicant does not adequately demonstrate how its proposal would promote quality of care. See discussion in Criterion (20) which is incorporated hereby as if fully set forth herein. Therefore, the application is nonconforming to Policy GEN-3.

CFVMC describes how its proposal will promote equitable access in Section III.2, pages 57-58, Section V.7, page 86, and Section VI., pages 87-88 and 89. The information provided by the applicant is reasonable, credible and supports the determination that the applicant's proposal will promote equitable access

CFVMC describes how its proposal will maximize health care value for resources expended in Section III.1., pages 38-55, Section III.2, page 57, Section V.7, page 85, Section IV, pages 70-71, Section X, pages 110-112 and Section XIII. The information provided by the applicant is reasonable, credible and supports the determination that the applicant's proposal will maximize health care value for resources expended.

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Policy GEN-4 - CFVMC provides a written statement describing the project's plan to assure improved energy efficiency and water conservation in Section III, pages 60-62, of the application and in Exhibit 10.

In summary, CFVMC is conforming to the need determination in the 2012 SMFP and to Policy GEN-4. However, the applicant is not conforming to Policy GEN-3. Therefore, the application is nonconforming to this criterion

FHCH. FirstHealth proposes to develop 28 acute care beds at their approved 8-bed acute care hospital in Hoke County.

Need Determination – FirstHealth does not propose to develop more than 28 acute care beds in the Cumberland-Hoke Acute Care Bed Service area. Therefore, the application is conforming to the 2012 need determination for 28-acute care beds in the Cumberland-Hoke Acute Care Bed Service area.

Policy GEN-3 – FirstHealth describes how its proposal will promote safety and quality in Section II.7, pages 34-36, Exhibit 8, Section II.2, page 30, Section II.6, page 33, Section III.2, page 84 and Section V.7, pages 120-124. The information provided by the applicant is reasonable, credible and supports the determination that the applicant's proposal will promote safety and quality.

FirstHealth describes how its proposal will promote equitable access in Section III.2, page 84, Section V.7, pages 125-128 and Section VI., pages 131-133. The information provided by the applicant is reasonable, credible and supports the determination that the applicant's proposal will promote equitable access

FirstHealth describes how its proposal will maximize health care value for resources expended in Section III.1., pages 65-82, Section III.2, page 84, Section V.7, pages 120-121 and 128, Section IV, pages 93-108, Section X, pages 164-167 and Section XIII. The information provided by the applicant is reasonable, credible and supports the determination that the applicant's proposal will maximize health care value for resources expended.

FirstHealth adequately demonstrates how its proposal will promote safety and quality, equitable access and maximize healthcare value for resources expended. Therefore, the application is consistent with Policy GEN-3.

Policy GEN-4 - FirstHealth provides a written statement describing the project's plan to assure improved energy efficiency and water conservation in Section III, page 85, and Section X, page 165, of the application.

In summary, the application is conforming to this criterion.

Furthermore, only 28 acute care beds may be approved in this review. Therefore, both of the applications cannot be approved. [See the Comparative Analysis section for the decision

regarding the development of 28 acute care beds in Cumberland-Hoke County Acute Care Bed Service Area].

(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
CFVMC

CA
FHCH

CFVMC. The applicant, CFVMC, operates a hospital with 490 beds at Owen Drive, Fayetteville ("Owen Drive Campus") and has a certificate of need to develop a 65 bed satellite hospital know as CFV North ("CFV North"), also in Fayetteville, Cumberland County, and a certificate of need to develop a 41 bed hospital in Hoke County ("HCMC"). CFVMC proposes to add 28 acute care beds to its existing 490 bed hospital at the Owen Drive Campus, Fayetteville, in Cumberland County. CFVMC operates a 24-hour emergency services department and provides inpatient medical services to both surgical and non-surgical patients. The applicant is not proposing a new licensed hospital. CFVMC proposes to develop 28 new acute care beds at its Owen Drive Campus, Fayetteville, Cumberland County pursuant to a need determination in the 2012 SMFP. If approved, the proposed project will result in 518 acute care beds at CVFMC's Owen Drive Campus and 583 acute care beds overall at CFVMC when the approved 65 acute care beds at CFVMC's satellite hospital, CFV-North, are included. CFVMC-Owen Drive and CFV-North will share the same license. In addition, the applicant owns and operates 66 acute care beds at Highsmith-Rainey Specialty Hospital ("HSRSH") which is located in Fayetteville, Cumberland County. The 66 acute care beds at HSRSH are LTAC beds and are not included in utilization.

Population to be Served

In Section III.5(c), pages 65-66, the applicant provides projected patient origin for CFVMC-Owen Drive Campus first two years of operation following completion of the proposed project as illustrated in the table below (the decrease at CFVMC- Owen Drive reflects the opening of CFV North and HCMC)

CFVMC- Owen Drive Campus Only
Total Projected Inpatient Days of Care by County

County	**FY 2015 PY 1-Days of Care**	**FY 2015 PY 1- Percent of Total**
Cumberland	128,454	73.7%
Bladen	4,492	2.6%
Harnett	10,464	6.0%
Hoke	6,603	3.8%
Robeson	11,955	6.9%
Sampson	6,241	3.6%
Other	6,146	3.5%
Total*	174,357	100.0%

Source: Thomson data included in Exhibit 30, Table 4
*Other reflects all other North Carolina Counties and other States as reflected in Exhibit 30, Table 8 and/or in the patient origin tables included in the CFVMC 2012 LRA included in Exhibit 37.

CFVMC- Owen Drive Campus Only
Total Projected Inpatient Days of Care by County

County	**FY 2016 PY 2- Days of Care**	**FY 2016 PY 2-Percent of Total**
Cumberland	122,080	73.8%
Bladen	4,573	2.8%
Harnett	10,139	6.1%
Hoke	4,670	2.8%
Robeson	11,949	7.2%
Sampson	6,321	3.8%
Other	5,595	3.4%
Total*	165,326	100.0%

Source: Thomson data included in Exhibit 30, Table 4
*Other reflects all other North Carolina Counties and other States as reflected in Exhibit 30, Table 8 and/or in the patient origin tables included in the CFVMC 2012 LRA included in Exhibit 37.

In Section III.5(c), page 67, the applicant provides projected patient origin for both CFVMC-Owen Drive Campus and CFV North for the first two years of operation following completion of the proposed project as illustrated in the table below

CFVMC- Owen Drive Campus plus CFV North
Total Projected Inpatient Days of Care by County

County	**FY 2015 PY 1-Days of Care**	**FY 2015 PY 1- Percent of Total**

Cumberland	128,454	73.7%
Bladen	4,492	2.6%
Harnett	10,464	6.0%
Hoke	6,603	3.8%
Robeson	11,955	6.9%
Sampson	6,241	3.6%
Other	6,146	3.5%
Total*	174,357	100.0%

Source: Thomson data included in Exhibit 30, Table 4
*Other reflects all other North Carolina Counties and other States as reflected in Exhibit 30, Table 8 and/or in the patient origin tables included in the CFVMC 2012 LRA included in Exhibit 37.

CFVMC- Owen Drive Campus plus CFV North
Total Projected Inpatient Days of Care by County

County	**FY 2016 PY 2- Days of Care**	**FY 2016 PY 2-Percent of Total**
Cumberland	122,583	74.1%
Bladen	4,397	2.7%
Harnett	10,242	6.2%
Hoke	4,490	2.7%
Robeson	11,489	6.9%
Sampson	6,109	3.7%
Other	6,016	3.6%
Total*	171,621	100.0%

Source: Thomson data included in Exhibit 30, Table 4
*Other reflects all other North Carolina Counties and other States as reflected in Exhibit 30, Table 8 and/or in the patient origin tables included in the CFVMC 2012 LRA included in Exhibit 37.

In Section III.5(a), page 64, the applicant states

> *"CFVMC serves residents of Cumberland and surrounding counties. The CFVMC Service Area will not change as a result of the proposed project."*

In Section III.5(c), page 66, the applicant states

> *"Projected patient origin for inpatient days of care at CFVMC (including both Owen Drive and CFV North) was calculated based upon the FY 2011 acute care inpatient services patient origin at CFVMC adjusted to reflect the impact of patient volume shifting to HCMC."*

In Section III.5(d), page 67, the applicant states

> *"CFVMC serves residents of Cumberland and surrounding counties. The CFVMC Service Area will not change as a result of the proposed project. The percent of patients by county is expected to shift slightly due to the new community hospitals in north Cumberland County and Hoke County. The patient origin was adjusted to reflect that impact, and is reflected in Exhibit 30, Tables 4, 5, 6 and 8."*

The applicant adequately identified the population proposed to be served.

Need Analysis

In assessing the need for the proposed project, CFVMC states in Section III, pages 38-48, that it looked at the factors summarized below.

"Increase in Acute Care Bed Capacity at CFVMC and CFVHS"

On page 39, CFVMC states *"The proposed addition of 28 acute care beds to the CFVMC campus on Owen Drive will be developed to realize an identified need resulting chiefly from the increase in patients from Cumberland County reflected in the following table.*

Average Daily Census of Patients by County

	2007	2008	2009	2010	2011	Increase in ADC 2007-2011	Increase in ADC 2009-2010
Bladen	11.5	5.3	10.0	10.7	11.9	0.4	0.7
Cumberland	279.2	294.9	305.2	318.6	345.7	66.5	13.4
Harnett	23.7	24.6	25.4	24.3	27.7	4.0	-1.2
Hoke	14.9	17.6	17.;2	16.8	20.7	5.7	-0.4
Moore	0.5	0.5	0.8	0.8	0.6	0.1	0.0
Robeson	27.6	29.7	29.2	29.3	32.0	4.5	0.1
Sampson	14.5	14.8	16.2	15.8	16.6	2.0	-0.4

CFVMC and CFV-North are part of the Cape Fear Valley Health System ("CFVHS"). The applicant also includes a table which illustrates Cape Fear Valley Health System's five acute care bed locations.

Cape Fear Valley Health System Acute Care Bed Capacity- Licensed, Approved and Proposed

	CON Licensed and Approved Acute Care Beds	Proposed Beds	Total Proposed, Licenses and CON approved Bed

			Capacity
Cape Fear Valley Medical Center	490	28	518
Cape Fear Valley Medical Center- CFV North	65	0	65
Hoke Community Medical Center	41	0	41
Bladen County Hospital	48	0	48
Highsmith-Rainey Specialty Hospital (LTACH)	66	0	66
Total System Acute Care Beds	710	28	738

"Need for 28 Additional Acute Care Beds at CFVMC"

On page 40, the applicant identifies the factors that substantiate the unmet need for additional acute care beds at CFVMC-Owen Drive:

- *2012 State Medical Facilities Plan identification of need for 28 acute care beds in the Cumberland/Hoke Service Area;*
- *High Utilization of Inpatient Services at CFVMC;*
- *Population growth in the CFVMC Service Area;*
- *Continued growth and development in Cumberland County*
- *Strong physician support included in Exhibit 23;*
- *Letters of support from the community, schools, businesses, local and state government and other healthcare providers included in Exhibits 24-26.*

"2012 State Medical Facilities Plan Identification of Need for 28 Acute Care Beds in the Cumberland Service Area"

On page 40, the applicant states that CFVMC is the only acute care provider in the SMFP defined service area, thus the need determination was generated by the high utilization and growth of patient days at CFVMC, which therefore substantiates the need for the development of the 28 additional acute care beds at CFVMC.

"High Utilization of Inpatient Services at CFVMC"

On pages 40-43, the applicant provides a series of tables and graphs illustrating the historical acute care beds utilization at CFVMC; acute care patient days; compound annual growth rate ("CAGR") of patient days; average daily census for acute care and emergency department utilization. The applicant states

> *"Development of the proposed 28 acute care beds will help address the increasing demand for acute care beds at CFVMC. … Utilization of operational beds exceeded 80% during the last five years. … CFVHS also has CON approval for 41 additional beds, which are to be developed at Hoke Community Medical Center in Hoke County, and 65 additional beds which are to be developed in northern Cumberland County. If those 106 beds were to be included in CFVMC's acute care bed capacity, utilization of*

total licensed and approved acute care beds would exceed the 78% SMFP planning target for facilities with an ADC of 400 or more patients per day in FY2011, as reflected in Exhibit 30, Table 1. …CFVMC's compound annual growth rate 'CAGR' for inpatient days continues to increase. … Average annual growth rate in patient days at CFVMC exceeded 3.0% annually since 2005, and when comparing the three, four, five and six-year trends, CAGR increased continually to a 4.3% CAGR for the timeframe 2005-2011. … Beginning in March 2011, CFVMC requested and received eight (8) approvals for a temporary increase of 10 percent in licensed acute care bed capacity from the DHSR Licensure Section pursuant to N.C.G.S section 131E-83. … Total occupancy for CFVMC for the first six months of FY2012 was 94.8%. … FY2011 was the busiest year on record in the Emergency Department at CFVMC. ED utilization in FY2012 continues to grow. … Year to date in 2012, Emergency Department admission have increased to over 20% of total emergency visits as reflected in Exhibit 30, Table 18. In addition, date in Exhibit 30, Table 18 reflect the delay patients experience waiting for an acute care bed due to the high utilization of acute care beds at CFVMC."

"Population Growth in CFVMC Service Area"

On pages 43-44, the applicant states that population growth in *"southern Cumberland County, Hoke County, and southern Harnett County has impacted the utilization of CFVMC, and led to the expansion of inpatient beds at CFVMC and the development of Hoke Community Medical Center in Hoke County. … population growth in Cumberland County and in the entire Service Area is projected to be 1.6% annually during the next four years. Growth in Harnett and Hoke Counties continue to be higher at 2.8% and 3.0% respectively."* With respect to the impact of the Base Realignment and Closure Act ("BRAC") the applicant states … *While it is expected that the population will continue to grow; the growth rate will be lower and the growth will occur over a longer time frame."*

"Market Share Analysis"

On pages 44-45, the applicant states

"CFVMC is the only acute care provider in Cumberland County, and provides a large majority of inpatient services to residents of the county. …CFVMC meets the inpatient needs of:

- *86% of the residents of Cumberland County*
- *42.8% of the inpatient needs of the residents of Hoke County*
- *13% of the inpatient needs of the residents of Harnett County*
- *10.7% of the inpatient needs of residents of Robeson County*
- *17.9% of the inpatient needs of residents of Bladen County, and*
- *13% of inpatient needs of the residents of Sampson County.*

… Some of the out-migration from Cumberland County … may be due to the high occupancy levels at CFVMC. .. new acute care beds at CFVMC will provide opportunities including … recapture of market share leaving Cumberland County, and

meeting the inpatient needs of the growing population in southwest Cumberland County and the surrounding area."

"Economic Growth and Development"

On pages 45-48, the applicant states that Cumberland County is the economic growth center of southeastern North Carolina.

"Cumberland County Economic Growth and Development

There is an occupationally balanced, highly productive work force, and ideal geographic position, and a nationally recognized technical education program for new industry training at Fayetteville Technical Community College. … Fayetteville-Cumberland County is an urban center of nearly 500,000 persons, including the service members at Fort Bragg, the 'Home of the 82nd Airborne and Special Operations Force.'. And most recently, the United States Army Forces Command and United States Army Reserve command have moved their headquarters to Fort Bragg. … On June 2,1011, Fayetteville was recognized as the #1 best place for college graduates."

Cumberland County Transportation Development

Completion of the portion of I-295, the Fayetteville Outer Loop, connecting Fort Bragg and I-95 is scheduled to be complete by April 15, 2014.

Cumberland Residential Development

Fayetteville and Cumberland County offer a variety of affordable housing options and styles from which to choose.

On page 48, the applicant states *"The proposed project responds to two to the central purposes of the CON Law: to encourage efficient, cost-effective solutions that maximize existing resources rather than unnecessarily duplicating existing services and to improve access to healthcare services."*

Projected Utilization

In Section IV, page 71, the applicant provides projected utilization of the 28 acute care beds, as illustrated in the table below.

Cape Fear Valley Medical Center- Owen Drive Campus Plus Cape Fear Valley North

Acute Care Beds	Prior Full FY 2010	Last Full FY 2011	Interim Full FY 2012	Interim Full FY 2013	First Full FY 2014	Second Full FY 2015	Third Full FY 2016
# of beds	490	490	490	490	518	583	583
# of Discharges	29,287	31,468	31,918	32,375	32,263	31,782	31,877
# of Patient Days	155,926	170,061	172,494	174,963	174,357	171,621	172,136
Percent	na	9.1%	1.4%	1.4%	<0.3%>	<1.6%>	0.3%

increase in Patient Days							

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The project analyst notes that The 66 beds acute care beds at Highsmith Rainey Specialty Hospital ("HSRSH") are designated as LTACH beds and are not included in the discussion. The applicant describes the assumptions and methodology used to project total patient days in Section III.1(b), pages 48-58, as follows:

1. Determine CFVMC Base Acute Inpatient Days. On page 51, the applicant states that acute inpatient days at CFVMC for FY2011 were 170,061 based on Thomson data and as reflected in the proposed 2013 SMFP.

2. Determine CFVMC Acute Inpatient Day Growth Rate. On page 52, CFVMC states that it considered four different alternatives in determining a growth rate to utilize to project utilization at CFVMC. CFVMC utilized the most conservative growth rate of the four alternatives, *"a 1.43% weighted population growth rate based upon acute inpatient admission patient origin."*

3. Project Future CFVMC Patient Days. On page 52, CFVMC projected patient days for FY2012 to FY2016 utilizing the 1.43% growth rate from Step 2. Patient days were projected prior to any adjustments for volumes shifted to CFV North and HCMC as illustrated in the table below.

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
CFVMC Projected Interim and Future Patient Days (includes volume to be shifted to CFV North and HCMC)	172,494	174,963	177,466	180,005	182,581
Projected Growth Rate (table 7)	1.43%	1.43%	1.43%	1.43%	1.43%
Licensed Bed Capacity (Includes all Licensed, Approved and Proposed Acute Care Beds)	490	490	559	624	624
Occupancy Rate	96.4%	97.8%	87.0%	79.0%	80.2%

*Note- the first three project years for the proposed new 28 acute care beds are FY2014 – FY2016.
**The table above covers all of CFVHS's acute care bed locations in the service area except for those at HSRSH which are excluded.

4. Adjust CFVMC Projected Utilization for Volume Shift to New Community. On page 53, the applicant provided projected acute care patient days for CFVMC-Owen Drive adjusted for volume to be shifted to CFV North and HCMC. CFVMC also discussed how it considered and factored in the potential impact of the new Harnett Health System 50 bed community hospital in Harnett County on CFVMC future utilization. The table below illustrates projected acute care patient days for CFVMC adjusted for CFV North, HCMC and Harnett Health System.

CFVMC – Owen Drive
Projected Acute Care Patient Days

	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016
CFVMC Projected Interim	170,061	172,494	174,963	177,466	180,005	182,581

and Future Patient Days (includes volume to be shifted to CFV North and HCMC)						
CFV North Projected Patient Days					6,296	13,472
HCMC Projected Patient Days				3,110	8,384	10,445
CFVMC Projected Interim and Future Patient Days less volume shifted to CFV North and HCMC)	170,061	172,494	174,963	174,357	165,326	158,664
ADC	465.9	472.6	479.3	477.7	452.9	434.7
Licensed Bed Capacity	490	490	490	518	518	518
Occupancy Rate	95.1%	96.4%	97.8%	92.2%	87.4%	83.9%

On page 53, the applicant states

> *"To adjust for volume to be shifted to CFV North and HCMC, CFVMC utilized projected patient days from the respective approved CON applications. Details and data are included in Exhibit 30, Tables 3,4,5 and 6. CFV North and HCMC patient day projections were converted to CFVMC project years, and subtracted from total days projected in Step 3. … Projected patient days at CFVMC show a decrease from Project Year 1 to Project Year 3 as a result of the opening of CFV North and HCMC, respectively. The patient day volume at CFVMC in PY3, 158,664 acute inpatient days, results in a reasonable utilization rate of 83.9% for the proposed 518 acute care beds, all of which will be operational on October 1, 2013. … CFVMC considered the potential impact of the new Harnett Health System 50 bed community hospital in Harnett County on CFVMC future utilization. As previously discussed CFVMC meets the needs of 13% of total admission from Harnett County. However, these are patients that seek primary care in Cumberland County with Cumberland County physicians and are subsequently referred to Cumberland County hospitals for inpatient care. Therefore, CFVMC does not expect the new Harnett Health System community hospital to impact future utilization."*

Observation Beds. The proposed project includes reducing the number of observation beds at CFVMC from 129 to 88. On page 54, the applicant states

> *"In FY2011 average daily census of all observation beds at CFVMC was 56.3 patients. For the first six months of FY 2012, average daily census in CFVMC observation beds was 64.9 patients. Therefore, the remaining 88 observation beds resulting for the proposed project will be sufficient."*

The following tables illustrate occupancy rate at CFVMC, CFV North and Hoke Community Medical Center with and without the 28 acute care beds. These are the three acute care facilities in the CFVHS that are within the Cumberland-Hoke Acute Care Bed Service Area (not including HSRSH).

Note:

#1) that the first three project years for the proposed 28 acute care beds are FY 2014- FY 2016

#2) the approved 41 acute care beds for Hoke Community Medical Center commence in FY 2014

#3) the approved 65 acute care beds for CFV North commence in FY 2015.

CFVMC, CFV North and Hoke Community Medical Center
Projected Acute Care Inpatient Days

	FY 2011	**FY 2012**	**FY 2013**	**FY 2014 (PY 1)**	**FY 2015 (PY 2)**	**FY 2016 (PY 3)**
CFVMC Projected Interim and Future Patient Days (includes all Cumberland and Hoke County Acute Care Bed Facilities (of CFVHS))	170,061	172,494	174,963	177,466	180,005	182,581
ADC	465.9	472.6	479.3	486.2	493.2	500.2
Licensed Bed Capacity (Includes all Licensed, Approved and proposed acute care beds)	490	490	490	559	624	624
Occupancy Rate (includes the proposed 28 acute care beds)	95.1%	96.4%	97.8%	87.0%	79.0%	80.2%
Same as row 3 less the 28 propose beds	490	490	490	531	596	596
Occupancy Rate (**excludes** the proposed 28 acute care beds)	95.1%	96.4%	97.8%	91.6%	82.7%	83.9%

The following tables illustrate occupancy rate at CFVMC and CFV North which will operate as one licensed facility. The approved 41 acute care beds at Hoke Community Medical Center are not included. Hoke Community Medical Center will be a separately licensed facility. CFVMC and CFV North will share the same license. These are the three acute care facilities in the CFVHS that are within the Cumberland-Hoke Acute Care Bed Service Area (not including HSRSH).

Cape Fear Valley Medical Center- Owen Drive Campus Plus Cape Fear Valley North

Acute Care Beds	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014 (PY 1)***	**FY 2015 (PY 2)***	**FY 2016 (PY 3)**
# of Patient Days	170,061	172,494	174,963	174,357	171,621	172,136
ADC	465.9	472.6	479.3	477.6	470.5	471.6
# of beds (including the proposed 28 beds)	490	490	490	518	583	583

Occupancy Rate with the 28 beds	95.1%	96.4%	97.8%	92.2%	80.7%	80.9%
Same as row 3 less the 28 propose beds	490	490	490	490	555	555
Occupancy Rate without the 28 beds	95.1%	96.4%	97.8%	97.5%	84.7%	89.9%

*Note: In FY 2014 and FY 2015 the # of patient days is less than in FY 2013 because of the "shifting of volume" to the 41 bed acute care hospital Hoke Community.

Projected utilization is based on reasonable, credible and supported assumptions.

In Section VI.2, pages 115-116, the applicant describes in detail the extent medically underserved groups will have access to the proposed acute care beds.

In summary, CFVMC adequately demonstrates the need to develop 28 acute care beds at CFVMC including the extent to which medically underserved groups will have access to the proposed acute care beds. Therefore, the application is conforming this criterion.

FHCH The applicant, FirstHealth of the Carolinas, owns and will develop FHCH in Hoke County and also owns and operates FMRH in Moore County. FirstHealth obtained a certificate of need to relocate 8 existing acute care beds from FMRH to develop FHCH. FirstHealth proposes to add 28 acute care beds to its approved 8-bed acute care hospital in Hoke County (FHCH) pursuant to a need determination in the 2012 SMFP. If approved, the proposed project will result in 36 acute care beds at FHCH.

Population to be Served

In Section III.5(c), page 89, the applicant provides projected patient origin for FHCH for the second year of operation following completion of the proposed project as illustrated in the table below

FHCH-Inpatient Services
County of Patient Origin

County	**FY 2015 PY1- Patients**	**FY 2015 PY1- Percent of Total Patients**
Cumberland	85	6.1%
Hoke	967	69.9%
Robeson	254	18.3%

Scotland	79	5.7%
Total	1,385	100.0%

FHCH- Inpatient Services
County of Patient Origin

County	**FY 2016 PY2- Patients**	**FY 2016 PY2- Percent of Total Patients**
Cumberland	123	6.7%
Hoke	1,242	67.6%
Robeson	364	19.8%
Scotland	107	5.8%
Total	1,836	100.0%

On page 89, the applicant states

> *"It should be noted that the above patient origin is different from the approved 8-bed hospital (Project ID # N-8497-10), as with 28 additional acute care beds, FirstHealth has the opportunity to expand FHCH's service area. … FirstHealth expects its patient origin to be based on the projection methodology and assumptions identified in Section IV. This service area is consistent with the patients who travel to FMRH for acute care services, which are not limited to only specialized care for residents of these counties. FHCH may have patients from outside of the service area receive care at FHCH, but the numbers will be insignificant to both the utilization and the financial feasibility of the project."*

The applicant adequately identified the population proposed to be served. [The 8-bed FHCH proposed 100% of patients would be Hoke County residents.]

Need Analysis

In assessing the need for the proposed project, FirstHealth states in Section III, pages 65-79, that it looked at the factors summarized below.

On page 65, FirstHealth states that

> *"This CON application is being submitted in response to the need determination for twenty-eight acute care beds in Cumberland-Hoke Acute Care Bed Service Area. FirstHealth is approved to relocate eight acute care beds from FMRH in Moore County to FHCH in Hoke County. In this application, FHCH proposes to add 28 more beds for a total of 36. When combined with the 41 beds approved for CFVMC-Hoke, there will be 77 beds within Hoke County."*

"FHCH 4-County Service Area"

On page 67, the applicant states that because of the proposed increased from 8 acute care beds to 36 acute care beds there is an opportunity to increase FHCH's service area to included Hoke, Cumberland, Robeson and Scotland Counties. The applicant states *"These*

four counties have been identified because each has patients that travel through Hoke County to obtain services at FMRH. With the development of FHCH and the services of FirstHealth physicians in Hoke County, specifically at FHCH, FirstHealth believes that many residents from these counties who would travel to FMRH for services will instead receive services at FHCH."

In assessing the need for the proposed project, FHCH states in Section III, pages 65-79, that it looked at the factors summarized below.

"Physician Commitments and Support"

On pages 68-69, the applicant provides a table identifying 45 physicians or medical practices (including specialty) from the service area and their committed annual surgical cases which total 1,455. In addition, the table identified another 9 physicians or medical practices (including specialty) from the service area that did not indicate the number of projected inpatient admissions.

"Service Area Population Growth Trends" [pages 70-72]

"Projected Hoke County Population Growth"

FirstHealth, on page 70, states that it obtained population projections from the North Carolina State Office of Budget and Management (NCSOBM). FirstHealth states

> "*Based on NCOSBM projections Hoke County's population is projected to grow by an additional 27.3 percent from 2010 to 2020. … The elderly population (65+ years old) grew by 36.9 percent from 2000 to 2010, to represent 7.5 percent of Hoke County's total population. NCOSBM projects that the elderly population will be the fastest growing population, increasing by 70.1 percent from 2010 to 2020. … The rapid growth in the 45 to 64 and 65+ population will result in a significant increase in demand for healthcare services including inpatient care. These population groups have higher use rates for acute care services than younger population groups. Thus, the need for an additional acute care beds in Hoke County will increase as a result of both population growth and aging."*

In a table on page 70 the applicant states that the population of Hoke County aged 45-64 will increase from 10,297 in 2010 to 13,056 in 2020 and that the population of Hoke County aged 65+ will increase from 3,557 in 2010 to 6,049 in 2020.

"Overall Service Area Demographics"

On page 71, FirstHealth states that the population of the proposed overall four county service area (Hoke, Cumberland, Robeson and Scotland Counties) service area aged 45-64 will decrease from 128,690 in 2010 to 126,441 in 2020 but the population aged 65+ will increase 34.4% from 55,071 in 2010 to 74,029 in 2020.

The applicant states

> *"Like Hoke County, the rapid growth in 65+ population for the total service area will result in a significant increase in demand for healthcare services including inpatient care. These population groups have higher use rates for acute care services than younger population groups. Thus, the need for an additional acute care beds in Hoke County will increase as a result of both population growth and aging. … It should be noted that although the 65+ age group currently accounts for only 10.1 percent of the overall service area's population in 2010 and 7.5 percent of the Hoke County population, the 65+ age group accounts for over 51.0 percent of projected inpatient admissions at FHCH.."*

"Service Population Growth Trends"

On page 72, the applicant states

> *"NCOSBM projects that Hoke County will have the highest projected population percentage growth increase in North Carolina between 2010 and 2020. Hoke County's population is projected to increase by 27.3 percent, which is nearly three times higher than the North Carolina's projected population increase of 10.9 percent.*
>
> …
>
> *NCOSBM projects that Hoke County will have the second highest projected 65+ population percentage increase in North Carolina between 2010 and 2020. Hoke County's population is projected to increase by 70.1 percent, which is almost double the North Carolina's projected 65+ population growth at 37.9 percent."*

FirstHealth cites both statistics in support of the addition of acute care services.

"Demographic and Health Status Factors Influencing Need for Acute Care Services"

On page 73, FirstHealth, citing to NCSOBM, provides a table illustrating the population diversity of the service area as compared to the state as a whole, see below

	Hoke County	**Cumberland County**	**4-County Service Area**	**NC**
American Indian/ Alaska Native	10.1%	1.7%	12.4%	1.6%
Asian/Pacific Islander	1.5%	2.8%	2.1%	2.4%
African American	33.8%	37.5%	34.1%	21.9%
Two or More Races	4.0%	4.2%	3.6%	1.9%
White	50.6%	53.8%	47.9%	72.3%
Total	100.0%	100.0%	100.0%	100.0%

FirstHealth states "*Approving additional beds* [sic] *for Hoke County is the best way to ensure these underserved groups have access to care."*

On page 74, FirstHealth cites health status factors for FHCH's 4-county service area which *"warrant further efforts to increase accessibility* [sic] *inpatient services."* The health status factors referred to are illustrated in the table below.

	% Uninsured Adults	Population per Primary Physician	% in Fair or Poor Health	Preventable Hospital Stays
Hoke	22%	4,365:1	24%	71
Robeson	25%	1,479:1	27%	103
Scotland	19%	869:1	25%	87
Cumberland	16%	820:1	19%	56

On pages 75-79, the applicant references several programs occurring in Hoke County. FirstHealth states that the comorbidities addressed by the programs are *"likely to cause inpatient and outpatient health care services to remain strong into the future in Hoke County."*

Projected Utilization

In Section IV, page 92, FirstHealth provides projected utilization of 36 acute care beds at FHCH (8 approved and 28 proposed) through the first three years of operation (FY2015 – FY2017) following completion of the proposed project as illustrated in the table below.

	First Full FY	Second Full FY	Third Full FY
	FY 2015	FY 2016	FY 2017
General Acute Care Beds			
Average Length of Stay	4.31	4.31	4.30
# of beds	32	32	32
# of discharges	1,233	1,635	2,046
# of patient days	5,309	7,038	8,771
ICU Beds			
Average Length of Stay	3.70	3.71	3.70
# of beds	4	4	4
# of discharges	152	201	252
# of patient days	564	745	932
Total Acute Care Beds			
Average Length of Stay	4.24	4.23	4.22

# of beds	36	36	36
# of discharges	1,385	1,836	2,298
# of patient days	5,873	7,763	9,703

The applicant describes the assumptions and methodology used to project the number of inpatient days of care to be treated at FHCH for the first three project years in Section IV, pages 93-107, summarized as follows:

Inpatient Days of Care

On page 93, FirstHealth states that it relied on the Thomson North Carolina State Inpatient Database for FY2011 and NCOSBM (May 2012 projections) to generate the data used in the projection methodology.

1. Population Projection. On page 93, FirstHealth identified the population projection for the 4-county service area (Cumberland, Hoke, Robeson and Scotland counties) for 2011-2018.

2. Annual Population Change. On page 93, FirstHealth calculated the annual population change for the 4-county service area for 2011-2018.

3. Identify Number of Patients and Days of Care. On page 94, FirstHealth identified the number of patients and days of care, by all North Carolina hospitals, provided to the residents of the 4-county service area in FY2011 based on the FY2011 Thomson North Carolina State Inpatient Data base. Excluded were patients and days of care related to admissions for chemical dependency (CD), normal newborns, psychiatric, and rehabilitation services.

	Cumberland		**Hoke**		**Robeson**		**Scotland**		**Total**	
	Patients	Days	Patients	Days	Patients	Days	Patients	Days	Patients	Days
All NC Hospitals	27,872	163,628	3,742	19,085	19,988	95,167	5,071	22,927	56,673	300,807

4. Project Number of Admissions 2012 -2018. On page 94, using the volume of patients identified in Step 3 and the annual population change calculated in Step 2 FirstHealth calculated the projected number of acute care admissions from the 4-county service area excluding patients related to chemical dependency (CD), normal newborns, psychiatric, and rehabilitation services for 2012 through 2018.

County	2011	2012	2013	2014	**2015 (PY1)**	**2016 (PY2)**	**2017 (PY3)**	2018
Cumberland	27,872	28,154	28,337	28,489	28,615	28,720	28,808	28,880

Hoke	3,742	3,840	3,938	4,035	4,133	4,231	4,328	4,426
Robeson	19,988	20,014	20,040	20,067	20,093	20,119	20,145	20,171
Scotland	5,071	5,009	4,938	4,866	4,795	4,723	4,652	4,580
Total	56,673	57,017	57,252	57,456	57,635	57,792	57,932	58,057
% Change	na	0.6%	0.4%	0.4%	0.3%	0.3%	0.2%	0.2%

5. Identify number of Patients and Days of Care. On page 95, FirstHealth identified the number of acute care patients and days of care, by all North Carolina hospitals, provided to the residents of the 4-county service area in FY2011 based on the FY2011 Thomson North Carolina State Inpatient Data base. This step differs from Step #3 in that the exclusions were more extensive. Excluded were patients and days of care related to admissions for chemical dependency (CD), normal newborns, psychiatric, and rehabilitation, OB deliveries, neonatology, trauma, open heart, surgical cardiology, neurosurgery, and thoracic surgery.

	Cumberland		**Hoke**		**Robeson**		**Scotland**		**Total**	
	Patients	Days	Patients	Days	Patients	Days	Patients	Days	Patients	Days
All NC Hospitals	21,110	122,394	2,803	14,089	16,157	75,449	4,169	17,255	44,239	229,187

6. Project Number of Admissions 2012 -2018. On page 95, using the volume of patients identified in Step 5 and the annual population change calculated in Step 2 FirstHealth calculated the projected number of acute care admissions from the 4-county service area excluding patients related to chemical dependency (CD), normal newborns, psychiatric, and rehabilitation OB deliveries, neonatology, trauma, open heart, surgical cardiology, neurosurgery, and thoracic surgery for 2012 through 2018. This step differs from Step #4 in that the exclusions were more extensive.

County	2011	2012	2013	2014	**2015 (PY1)**	**2016 (PY2)**	**2017 (PY3)**	2018
Cumberland	21,110	21,324	21,462	21,577	21,673	21,752	21,819	21,874
Hoke	2,803	2,876	2,949	3,023	3,096	3,169	3,242	3,315
Robeson	16,157	16,178	16,199	16,220	16,242	16,263	16,284	16,305
Scotland	4,169	4,118	4,059	4,000	3,942	3,883	3,824	3,766
Total	44,329	44,496	44,670	44,820	44,952	45,067	45,169	45,259
% Change	na	0.4%	0.4%	0.3%	0.3%	0.3%	0.2%	0.2%

7. Identify the Number of Patients and Days of Care by FMRH only. On page 96, FirstHealth identified the number of patients and days of care, by only FMRH, provided in FY2011 to the residents of the 4-county service area based on the FY2011 Thomson North Carolina State Inpatient Data base. Excluded were patients and days of care related to admissions for chemical dependency (CD), normal newborns, psychiatric, and

rehabilitation, OB deliveries, neonatology, trauma, open heart, surgical cardiology, neurosurgery, and thoracic surgery. The services were excluded because they were not planned to be provided at FHCH because of the "*capacity of the hospital, the availability of a medical or surgical specialist, and/or the need for the patient to receive care at a tertiary care facility."* FirstHealth decreased the number of inpatient and inpatient days of care that are available to "shift" to FHCH.

	Cumberland		**Hoke**		**Robeson**		**Scotland**		**Total**	
	Patients	Days	Patients	Days	Patients	Days	Patients	Days	Patients	Days
All NC Hospitals	369	1,360	1,514	6,538	1,091	4,449	629	2,578	3,603	14,925

8. Project Number of Admissions 2012-2018 to FMRH. On page 96, using the volume of patients identified in Step 7 and the annual population change calculated in Step 2 FirstHealth calculated the projected number of admissions to FMRH from the 4-county service area excluding patients related to chemical dependency (CD), normal newborns, psychiatric, and rehabilitation OB deliveries, neonatology, trauma, open heart, surgical cardiology, neurosurgery, and thoracic surgery for 2012 through 2018. This step again "*assumes that admission rates for these types of admissions remain constant throughout the projection period. Further, these projections assume that FMRH's market share for these services remains constant throughout the time period."*

County	2011	2012	2013	2014	**2015 (PY1)**	**2016 (PY2)**	**2017 (PY3)**	2018
Cumberland	369	373	375	377	379	380	381	382
Hoke	1,514	1,554	1,593	1,633	1,672	1,712	1,751	1,791
Robeson	1,091	1,092	1,094	1,095	1,097	1,098	1,100	1,101
Scotland	629	621	612	604	595	586	577	568
Total	3,603	3,640	3,675	3,709	3,742	3,776	3,809	3,842
% Change	na	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%

9. Project Days of Care at FMRH for 2012-2018. On page 97, FirstHealth projected the acute care number of days of care to FMRH from the 4-county service area excluding patients related to chemical dependency (CD), normal newborns, psychiatric, and rehabilitation OB deliveries, neonatology, trauma, open heart, surgical cardiology, neurosurgery, and thoracic surgery for 2012 through 2018. First the applicant calculated the average length of stay (ALOS) for 2012 through 2012, by county by taking the 2011 days of care by county identified in Step 7 and dividing this by patient admissions by

county (also from Step 7). Then, the applicant multiplied the projected number of admissions by county projected in Step 8 by the ALOS calculated in Step 9. This projected acute care number of days of care associated with patient admissions to FMRH form the 4-county service area.

County	**2011**	**ALOS**
Cumberland	1,360	3.7
Hoke	6,538	4.3
Robeson	4,449	4.1
Scotland	2,578	4.1

County	2011	2012	2013	2014	**2015 (PY1)**	**2016 (PY2)**	**2017 (PY3)**	2018
Cumberland	1,360	1,374	1,383	1,390	1,396	1,401	1,406	1,409
Hoke	6,538	6,709	6,880	7,050	7,221	7,392	7,563	7,733
Robeson	4,449	4,455	4,461	4,466	4,472	4,478	4,484	4,490
Scotland	2,578	2,546	2,510	2,474	2,438	2,401	2,365	2,329
Total	14,925	15,084	15,233	15,380	15,527	15,672	15,817	15,960
% Change	na	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%

10. Identify the number of patients and days of care by surgical and medical admission by FMRH for 2011. Using the 2011 patient days of acre identified in Steps 8 and 9, on page 98, FirstHealth classifies the identified number of patients and days provided in 2011 to residents of the 4-county service area by FMRH by medical and surgical admission. Patients and days of care related to chemical dependency (CD), normal newborns, psychiatric, and rehabilitation OB deliveries, neonatology, trauma, open heart, surgical cardiology, neurosurgery, and thoracic surgery were excluded.

11. Project the number of medical and surgical admissions to FMRH for 2012-2018. On page 99, FirstHealth projected the number of surgical and medical admissions to FHRM for 2012 through 2018 from the 4-county service area by multiplying the projected number of admissions by the medical and surgical admission percentages calculated in Step 10. Patients related to admission for chemical dependency (CD), normal newborns, psychiatric, and rehabilitation OB deliveries, neonatology, trauma, open heart, surgical cardiology, neurosurgery, and thoracic surgery were excluded.

FHCH- Surgical Inpatients

12. Project Number of Surgical Inpatients for FHCH. On page 100, FirstHealth projects the "*surgical patient shift*", by percentage, from FMRH to FHCH for the 4-county service area. FirstHealth states "*FirstHealth projected the number of surgical inpatients that would receive care at FHCH, rather than at FMRH. FirstHealth made the assumption that patients seeking care at FirstHealth are more likely to seek care at a closer FirstHealth hospital, especially if their current physician provides services in Hoke County. … Using the experience of its administrative and outreach teams, FirstHealth assumes that 60.0 percent of FMRH patients from Hoke County (excluding patients from the following services chemical dependency (CD), normal newborns, psychiatric, and*

rehabilitation OB deliveries, neonatology, trauma, open heart, surgical cardiology, neurosurgery, and thoracic surgery) who would have travelled to FMRH for care will instead receive care at FHCH; this percentage will ramp-up over a three year period. … FirstHealth also assumes that 40.0 percent of the same medical surgical specialty patients from Cumberland and Robeson counties and 20.0 percent of the same medical surgical specialty patients from Scotland County who would have travelled to FMRH for care will instead receive care at FHCH; again, these percentages will ramp-up over a three year period. … This projected "shift" in existing patients takes into account patient preference and patient acuity. Higher acuity surgical specialties have already been excluded from the need methodology and an additional 40.0 to 80.0 percent of remaining current FMRH patients from the 4-county service area have been identified as not receiving care at FHCH. …"

On page 101, as illustrated in the table below, FirstHealth projects the number of inpatient surgical cases that will "shift" from FMRH to FHCH by multiplying the surgical admission from 2015 through 2017 projected in Step 11 by the patient shift rate projected in Step 12.

Surgical Patients "projected to shift" from FMRH to FHCH

Counties	Surgical Patients	Surgical Patients	Surgical Patients
	2015	**2016**	**2017**
Cumberland	38	58	77
Hoke	89	137	187
Robeson	82	124	165
Scotland	21	31	41
Total	231	350	470

The applicant's projected number of inpatient surgical days of care is illustrated in the table below using the ALOS set forth in Step #10.

Inpatient Surgical Days of Care

	2015	**2016**	**2017**
Cumberland	129	194	259
Hoke	359	552	753
Robeson	337	505	675
Scotland	100	147	194
Total	924	1,398	1,880

FHCH- Medical Inpatients Projected

13. Project Number of Medical Inpatients for FHCH. On page 102, FirstHealth projects the "*medical patient shift*", by percentage, from FMRH to FHCH for the 4-county service area. FirstHealth states "*FirstHealth projected the number of medical inpatients that would receive care at FHCH, rather than at FMRH. FirstHealth made the assumption that patients seeking care at FirstHealth are more likely to seek care at a closer FirstHealth hospital. Using the experience of its administrative and outreach teams, FirstHealth assumes that 60.0 percent of FMRH patients from Hoke County (excluding*

patients from the following services chemical dependency (CD), normal newborns, psychiatric, and rehabilitation OB deliveries, neonatology, trauma, open heart, surgical cardiology, neurosurgery, and thoracic surgery) who would have travelled to FMRH for care will instead receive care at FHCH; this percentage will ramp-up over a three year period. … FirstHealth also assumes that 40.0 percent of the same medical surgical [sic] *specialty patients from Cumberland and Robeson counties and 20.0 percent of the same medical surgical* [sic] *specialty patients from Scotland County who would have travelled to FMRH for care will instead receive care at FHCH; again, these percentages will ramp-up over a three year period. … This projected "shift" in existing patients takes into account patient preference and patient acuity. Higher acuity surgical specialties have already been excluded from the need methodology and an additional 40.0 to 80.0 percent of remaining current FMRH patients from the 4-county service area have been identified as not receiving care at FHCH. …"*

On page 103, as illustrated in the table below, FirstHealth projects the number of inpatient medical cases that will "shift" from FMRH to FHCH by multiplying the medical admission from 2015 through 2017 projected in Step 11 by the patient shift rate projected in Step 13.

Medical Patients "projected to shift" from FMRH to FHCH

Counties	**2015**	**2016**	**2017**
Cumberland	47	66	85
Hoke	481	704	936
Robeson	171	240	309
Scotland	58	76	93
Total	757	1,085	1,423

The applicant's projected number of inpatient medical days of care is illustrated in the table below

Inpatient Medical Days of Care

	2015	**2016**	**2017**
Cumberland	188	265	341
Hoke	2,108	3,082	4,100
Robeson	697	978	1,259
Scotland	216	284	349
Total	3,210	4,608	6,049

FHCH- Inpatient admissions "shifting' from non-FMRH facilities

14. Inpatient admissions "shifting' from non-FMRH facilities. On page 103, FirstHealth states "*In its approved CON application, Project ID# N-8497-10, page 215, FirstHealth's need methodology projected Hoke County Emergency Department inpatient admissions 'shifting' from non-FMRH facilities. FirstHealth assumes a 5.0 increase for the 2014 projection and a 1.0 percent annual increase for 2016 and 2017 and then a 50 percent decrease, as the following table shows*:"

Total Patients

	2012	2013	2014	2015	2016	2017
Previous Need	713	734	756			
% Increase				5.0%	1.0%	1.0%
Potential Need				794	802	810
% Decrease				50.0%	50.0%	50.0%
Total Need				397	401	405

15. Calculate Total Number of Inpatient Cases and Inpatient Days of Care. On page 104, FirstHealth states that it calculated the total number of inpatient cases and inpatient days of care, as illustrated in the tables below, by adding the volumes projected in Steps 12, 13, and 14.

Total Patients

	2015	2016	2017
Cumberland	85	123	162
Hoke	967	1,242	1,528
Robeson	254	364	474
Scotland	79	107	134
Total	1,385	1,836	2,298

Total Days of Care

	2015	2016	2017
Cumberland	317	458	600
Hoke	4,206	5,391	6,627
Robeson	1,034	1,483	1,933
Scotland	316	431	543
Total	5,873	7,763	9,703

16. Daily Census and Occupancy Rate. On page 104, FirstHealth calculated the daily census and occupancy rate of its proposed 36 acute care bed hospital as illustrated in the table below.

	2015	2016	2017
Total days of Care	5,873	7,763	9,703

Days	365	365	365
Daily Census	16.1	21.3	26.6
Beds	36	36	36
Occupancy	44.7%	59.1%	73.8%

17. (Note: the applicant also labeled this step "Step 16" creating two "Step 16's". Calculate the number of ICU days of care and inpatients. On page 105, FirstHealth projected the total ICU days of care and inpatients. As illustrated in the table below, FirstHealth multiplied the total days of care calculated in Step 15 by a percentage or "ICU Rate". To calculate this percentage FirstHealth *"used the medical/surgical ICU days of care as a percentage of total medical/surgical days of care at FirstHealth Moore Regional Hospital (7,058 ICU days of care/ 73,181 days of care = 9.6 percent) as the proxy for FHCH."* The applicant states *"FirstHealth Richmond Memorial Hospital is similar to the proposed expanded FHCH in that both are located in smaller, more rural counties, and both have a smaller number of acute care beds. FirstHealth Richmond Memorial Hospital has 99 acute care beds, and the proposed expanded FHCH would have 36 acute care beds. The percentage of total medical/surgical days of care at FirstHealth Richmond Memorial Hospital that were medical/surgical ICU days of care is over 14.0 percent. FirstHealth could have used this experience as the basis for its projection of ICU days of care and ICU inpatients. … in order to be more conservative in its projections, FirstHealth used the percentage of total medical/surgical days of care at FirstHealth Moore Regional Hospital that were medical/surgical ICU days of care, which was 9.6 percent. ICU patient origin by county is expected to remain consistent with the inpatient origin by county."*

	2015	**2016**	**2017**
Total days of care	5,873	7,763	9,703
ICU Rate	9.6%	9.6%	9.6%
Total ICU Days	564	745	932
Days/Year	365	365	365
Daily Census	1.5	2.0	2.6
ICU Beds	4	4	4
Occupancy	38.6%	51.05	63.8%
ALOS	3.7	3.7	3.7
ICU Patients	152	201	252

18. (Same as Step 17 on page 106) Calculate FHCH's Effective Market Share. On page 106, FirstHealth calculates the effective market share that FHCH would have of inpatient's from its proposed four county service area. The applicant calculates FHCH's market share of patients by dividing the number of patients projected to be treated at FHCH in Step 15, by the total number of patients (excluding chemical dependency (CD), normal newborns, psychiatric, and rehabilitation patients and days of care) identified in Step 4 for the service area in FY 2011. The applicant states *"FirstHealth believes that this is a reasonable means to calculate the effective market share as the calculation does not project an increase in the total number of patients or days of care in the 4-county*

service area, which results in a "higher" market share than would be expected if overall patients and days of care also increased over the next five years."

The applicants' market share calculations are illustrated in the table below

	2015	2016	2017
Cumberland	0.3%	0.4%	0.6%
Hoke	23.4%	29.3%	35.3%
Robeson	1.3%	1.8%	2.4%
Scotland	1.6%	2.3%	2.9%
Total	2.4%	3.2%	4.0%

19. (Same as Step 18 on page 107) Patient Origin of projected FHCH patients. On page 107, FirstHealth calculated the patient origin of projected FHCH patients. The applicant calculated patient origin by dividing the number of patients by county by the total number of patients projected for each year (Step 15) as illustrated in the table below

Total Patients

	2015	2016	2017
Cumberland	85	123	162
Hoke	967	1,242	1,528
Robeson	254	364	474
Scotland	79	107	134
Total	1,385	1,836	2,298

Patient Origin

	2015	2016	2017
Cumberland	6.1%	6.7%	7.0%
Hoke	69.9%	67.6%	66.5%
Robeson	18.3%	19.8%	20.6%
Scotland	5.7%	5.8%	5.8%
Total	100.0%	100.0%	100.0%

Please refer to Exhibit 28 for methodology documents.

Analysis

Rule 10A NCAC 14C .3803 (a) "Performance Standards" states

(a) An applicant proposing to develop new acute care beds shall demonstrate that the projected average daily census (ADC) of the total number of licensed acute care beds proposed to be licensed within the service area, under common ownership with the applicant, divided by the total number of those licensed acute care beds is reasonably projected to be at least 66.7 percent when the projected ADC is less than 100 patients …, in the third operating year following completion of the proposed project or in the year for which the need determination is identified in the State Medical Facilities Plan, whichever is later.

As illustrated in the table below, the Average Daily Census (ADC) in the third project year is 26.58 and the total number of FirstHealth's existing, approved and proposed licensed acute care beds within the Cumberland-Hoke Multi-County Acute Care Bed Service area is 36. The projected ADC in the third operating year following completion of the proposed project is less than 100 patients. 26.58 ADC divided by 36 beds equates to 73.8% which is greater than the 66.7 percent required by this rule.

C	Total Acute Care Patient Days*	9,703
D = C/365	Average Daily Census (FY2017)	26.58
E = D/0.667	# Acute Care Beds Needed at 66.7% Target Occupancy	39.86
F	Total # acute care beds (approved and proposed)	36
G	Acute Care Beds (Surplus)/Deficit	3.86

*From page 92 of the application.

The applicant was reasonable and conservative in projecting total acute care patient days for the third operating year following completion of the proposed project.

The majority of the applicant's projected patient days is derived from "shifting' a portion of its existing market originating from the 4-county service currently receiving service at FMRH to FHCH. However, since FMRH is a tertiary hospital and provides care to patients with higher acuity levels and different services than will be provided at FHCH adjustments have to be made by the applicant to base its projected utilization on the type of cases that are appropriately served at a smaller community hospital.

<u>All North Carolina Hospitals</u>

First, in Steps #1 - #6 the applicant provided both historic and projected data, by each of the 4 counties in the proposed service area, for population, population growth, the number of patients and days of care (both provided and projected to be provided) to residents of the 4 counties by all North Carolina hospitals excluding patients and days of care excluding admissions and days of care for chemical dependency (CD), normal newborns, psychiatric, and rehabilitation, OB deliveries, neonatology, trauma, open heart, surgical cardiology, neurosurgery, and thoracic surgery, services and acuity levels that are not projected to be provided by FHCH. The historical data was "grown" at a reasonable rate. .

<u>FMRH Only</u>

Then the applicant further narrowed the pool for patients and days of care from which cases could reasonably be "shifted" from FMRH to FHCH. Starting with Step #7, page 96, forward, the applicant provided historical and projected data identifying the number of patients and days of care provided just by FMRH to residents of the 4-county service area again excluding admissions and days of care for chemical dependency (CD), normal newborns, psychiatric, and rehabilitation, OB deliveries, neonatology, trauma, open heart, surgical cardiology, neurosurgery, and thoracic surgery. The historical data was "grown" at a reasonable rate.

The average length of stay (ALOS) in Step #9 was based on historical FY2011 data from the 4-county service area.

The applicant further broke down the FY 2011 historical data into surgical and medical inpatient admission and calculated ALOS for both subgroups. (Step #10).

In Steps #12 and #13 the applicant projected "shift rates" for both surgical and medical patients by county. For surgical patients the "shift rates" in the third operating year range from 20% - 60% an 25% - 65% for medical inpatients based on FirstHealth's experience and ramped up over a three year period. By not shifting 100% of the patients originating from the 4-county service area to FHCH the applicant allowed for patient preference, patients with higher acuity (sort of a "double acuity test" since acuity levels were already factored in Step #7 forward.). The "shift rates", considering that they are being applied to existing FirstHealth market share combined with the fact that FHCH will be a new facility, are reasonable and conservative.

In Step #14, the applicant includes those patients which were "new market share", from Hoke County only, as approved in Project ID# N-8497-10 (FHCH). FirstHealth only projected to serve Hoke County residents in the 2010 FHCH application.

The total number of inpatient cases and inpatient days of care was derived in Step #15 by adding the projections found in Steps #12, #13, and #14. Thus, in this application, FirstHealth projected no increase in existing market share, rather a "shifting" of where its existing market share received service. This is a very conservative approach. At this time CFVMC is the only entity with existing acute care beds in the Cumberland-Hoke Multi-County Acute Care Bed Service Area and therefore the only option for patients who which to be treated in the service area. FHCH will be a new facility, located in approximately 3-4 miles from the Cumberland/ Hoke county line and approximately 10 miles from Fayetteville, on the major traffic corridor between Cumberland and Hoke County and, more specifically, the major traffic corridor between the City of Fayetteville and Hoke County. It would not have been unreasonable for FirstHealth to have projected treating some residents of Cumberland County not currently part of FirstHealth's existing market share. On a smaller scale, it also would not have been unreasonable for FirstHealth to project that FHCH would provide service to some of FMRH's existing market share of Moore County residents.
In Step #16 the applicant's analysis in support of using a 9.6 percent for calculating ICU days of care and inpatients is reasonable.

Furthermore, based on Hospital License Renewal Application (LRA) data in 2011 Hoke County generated 3,634 general acute care inpatients who received service in North Carolina. In the table below general acute care inpatients for Hoke County are projected for the years FY2012 – FY2017 based on the County Growth Rate Multiplier in Table 5A of the 2012 SMFP Cumberland/Hoke.

Year	**Growth Rate***	**All Hoke County Acute Care Inpatients**
FY2011	3.6%	3,634
FY2012	3.6%	3,764
FY2013	3.6%	3,900
FY2014	3.6%	4,040
FY2015	3.6%	4,186
FY2016	3.6%	4,336
FY2017	3.6%	4,493

*Source: County Growth Rate Multiplier, Table 5A, page 51, 2012 SMFP.

The table below illustrates the projected number of Hoke County patients in CFVMC's application for its approved 41 acute care bed hospital (HCMC) in Hoke County and the projected number of Hoke County patients in the current FirstHealth application.

Hoke County Patients only.

	FY2014	**FY2015**	**FY2016**	**FY2017**
(A) HCMC (41 beds as approved)	730*	967*	1,163	1,205**
(B) FHCH-2010	734	756		
Subtotal (A+B)	**1,464**	**1,723**		
(C) FHCH- 2012 (36 beds as proposed)		967	1,242	1,528
Subtotal (A+C)		**1,934**	**2,405**	**2,733**

*See page 161- many are OB cases
**Grown at 3.6% County Growth Rate Multiplier, Table 5A, page 51, 2012 SMFP

Thus, for FY2017 HCMC and FHCH combined will account for 60.8% [2,733 / 4493 = .608 or 60.8%] of the general acute care inpatients originating from Hoke County. That leaves 39.2% [100.0% - 60.8% = 39.2%] of the general acute care inpatients from Hoke in FY2017 to go elsewhere (besides FHCH or HCMC) because of acuity issues, patient preference, or for other reasons. Therefore, the proposed project will not adversely affect HCMC in terms of Hoke County patients, there are projected to be enough Hoke County patients to satisfy both the projected utilization of HCMC and FHCH in FY2017.

Projected utilization is based on reasonable, credible and supported assumptions.

Observation Beds

In Project ID #N-8497-10 FHCH was approved for 4 unlicensed observation beds. In this application FHCH proposes to add 4 observation beds for a total of 8. However, there is no demonstration of need for these added unlicensed observation beds. Thus, FHCH shall not add 4 observation beds as conditioned.

In Section VI.2, pages 131-132, the applicant describes in detail how medically underserved groups will have access to the proposed acute care bed.

In summary, FirstHealth adequately demonstrates the need to develop 28 acute care beds at FHCH including the extent to which medically underserved groups will have access to the proposed acute care beds. Therefore, the application is conforming this criterion, subject to conditions #2 and #3.

(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.

NA
Both Applications

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

NC
CFVMC

C
FHCH

CFVMC. In Section III., pages 62-63, the applicant describes the alternatives considered including maintaining the status quo; add 28 new acute care beds to CFV North; Convert Highsmith Rainey Specialty Hospital Back to an Acute Care Hospital; Add a new floor to the Valley Pavilion at CFVMC or Convert Observation Beds at CFVMC.

Maintain Status Quo. On page 62, the applicant states that maintaining the status quo would mean that CFVMC could not provide the level of services necessary to respond to the enormous growth and demand for its services. Thus, this is not a viable option.

Add 28 new acute care beds to CFV North. On page 62, the applicant states that while this option was considered and evaluated it was determined that the CON approved for CFV

North in 2011 was for the correct amount of acute care beds to serve the population in northern Cumberland County.

Convert Highsmith Rainey Specialty Hospital Back to an Acute Care Hospital. On page 62, the applicant states that this option would entail constructing space for, and relocating, the LTACH beds at Highsmith Rainey.

Add a new floor to the Valley Pavilion at CFVMC. On page 62, the applicant states that adding a new patient floor on top of the Valley Pavillion would improve patient flow at CFVMC however, CFVMC determined it was not the most reasonable or cost-effective alternative at this time.

Convert Observation Beds at CFVMC. This involves conversion of existing observation beds and renovation of existing space at three locations at CFVMC. The applicant states on page 63, that it has *"identified 28 existing observation beds that can be renovated and converted with a reasonable capital expenditure. The three units to be converted provided the most effective alternative for conversion at the lowest capital expenditure."* CFVMC found this to be the most effective and lowest cost alternative for the development of the proposed 28 acute care beds.

However, the application is not conforming to all other applicable statutory and regulatory review criteria. See Criteria (1), (18a) and (20). An application must be conforming or conditionally conforming to all review criteria to be an effective alternative. Therefore, the applicant did not adequately demonstrate that its proposal is the least costly or most effective alternative. Thus, the application is nonconforming to this criterion.

FHCH. In Section III.3, pages 86-87, the applicant describes the alternatives considered, including maintaining the status quo; expand FirstHealth Hoke Community Hospital; or a Joint Venture.

- Maintain Status Quo: The applicant states it rejected the status quo alternative for several reasons: 1) fails to address the need determination in the 2012 SMFP for an additional 28 acute care beds in the Cumberland-Hoke acute care bed service area; 2) maintaining the status quo would not allow FHCH to become more accessible through offering more acute care beds, thereby increasing the number of medical and surgical specialties; as well as ICU services. Also, maintaining the status quo would decrease competition and thus lose the opportunity to promote expanded access to services consistent with the objectives of the CON law; 3) by expanding FHCH can become more accessible by offering direct admissions to local physicians and surgeons, which were limited in FHCH's 8-bed approved facility; and 4) maintaining the status quo would prevent FHCH from taking advantage of economies of scale which would result from an expansion in the number of acute care beds and from allowing for equal distribution of acute care beds between the two counties in the service area.

- Expand FirstHealth Hoke Community Hospital: *"After the initial development phase of the FHCH, based on the relocation of existing acute care beds from Moore*

County, future needs for additional acute care beds in Hoke County will be determined by the need methodology included in the SMFP. Currently, the Acute Care Bed need methodology identifies that Hoke County is combined individually with Cumberland and Moore counties in separate two-county acute care bed service areas. Not until a hospital actually operates in Hoke County will the service area be a single county service area. As a result, Hoke County's approved hospitals may increase acute care beds through either of the two-county acute care bed service area need determinations, but future growth of acute care beds in the county will be solely based on the utilization of the two approved hospitals that will operate in Hoke County.

This need determination, based on the previous year's actual data, is included in the current year's SMFP. Add another year for submission and review of the CON application, and another year for design and construction, and it will take up to four years (not including any appeal process) from the year that hospital operations are projected to begin in Hoke County (approximately 2014) before as few as five additional beds can be added.

New beds based on a Hoke County acute care bed service area may not become operational until 2019 or 2020, at the earliest."

- Joint Venture: FirstHealth discussed joint venturing with leadership of other hospitals in the area approximately three years ago. The applicant states "*FirstHealth received no meaningful responses."*

On page 87, the applicant states

"Expanding FHCH under the two-county acute care beds service area need determination is the best means in making FHCH more competitive in comparison to CFVMC (490-beds), CFVMC-North (65-beds), and CFVMC-Hoke (41-beds).

The applicant adequately demonstrated that the proposal is its least costly or most effective alternative to meet the need.

Furthermore, the application is conforming or conditionally conforming to all other statutory and regulatory review criteria, and thus, is approvable. A project that cannot be approved cannot be an effective alternative. The application is conforming to this criterion subject to conditions #2 and #3.

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

C
Both Applications

CFVMC. In Section VIII., page 105, the applicant projects its capital cost for the proposed project to be $3,809,322 allocated as follows:

Construction Contract	
Cost of Materials	$1,183,985
Cost of Labor	$968,715
Other (Design/Constr. Contingency 20%)	$418,000
Miscellaneous Project Costs	
Fixed Equipment	$570,112
Architect & Engineering	$218,510
Legal Fees	$100,000
Other (CON and other Fees)	$50,000
Other (Contingency)	$300,000
Total Capital Cost of Project	**$3,809,322**

In Section VIII.3, page 106, the applicant states the capital cost will be financed with accumulated reserves. In Section IX.1, page 109, the applicant states that the proposed project does not require any start-up or initial operating capital. In Exhibit 4 of the application, the applicant provides a letter from the Chief Financial Officer for Cape Fear Valley Health System, which states

> *"Cape Fear Valley Health System is positioned financially to fund the project cost of $3,809,322 for the above referenced project through operations and/or accumulated cash reserves. The funds are available as reflected in the Cape Fear Valley Health System's 2011 Audited Financial Statements, which are included as part of this Application."*

Exhibit 5 of the application contains audited financial statements for the Cumberland County Hospital System d/b/a Cape Fear Valley Health System for the year ended September 30, 2011, which document that Cape Fear Valley Health System had $60,324,000 million in Cash and Cash Equivalents and $355,506,000 in Net Assets as of September 30, 2011. The applicant adequately demonstrated the availability of funds for the projected capital costs described in the application, as well as other approved hospital projects.

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.

Acute Care Beds	**Project Year 1 10/01/13 - 9/30/14**	**Project Year 2 10/01/14 - 9/30/15**	**Project Year 3 10/01/15 - 9/30/16**
Gross Patient Revenue	$1,354,015	$1,348,080	$1,358,432
Deductions from Gross Patient Revenue	$1,053,197	$1,057,117	$1,063,164
Net Patient Revenue	$311,194	$301,546	$306,063
Total Expenses	$297,836	$297,439	$298,985
Net Income	$13,358	$4,107	$7,078

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 Section X, pages 110-112 and Section XIII, pages 119-126. 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.

FHCH. In Project ID # N-8497-10 the applicant was approved to develop an 8-bed acute care hospital in Hoke County at a capital cost of $34,138,515. In Section VIII., page 159, the applicant projects its capital cost for the proposed project of adding 28 acute care beds to the approved 8-bed acute care hospital to be $17,516,509 for an overall capital cost between the two projects of $51,655,024**.** The capital cost of $17,516,509 is allocated as follows:

Construction Contract	
Cost of Materials (Including Cost of Labor, Site Prep)	$11,279,448
Other (Contingency)	$1,127,945
Miscellaneous Project Costs	
Clinical FFE	$2,694,761
Non-Clinical FFE	$712,694
FFE Inflation and Freight	$249,128
Architect & Engineering	$865,150
Legal Fees/ Market Analysis	$100,000
Permitting	$22,918
Other (Contingency)	$464,465
Total Capital Cost of Project	**$17,516,509**

In Section VIII.3, page 160, the applicant states the capital cost will be financed with accumulated reserves. In Section IX.1, the applicant projects total working capital of $4,488,658 ($388,658 start-up expenses + $4,100,000 initial operating expenses = $4,488,658). In Exhibit 40 of the application, the applicant provides a letter from the Chief Executive Officer for FirstHealth, which states

> *"FirstHealth of the Carolinas, Inc., will provide $17.52 million through Accumulated Reserves (Assets Limited as to use: Internally Designated for Capital Projects) to fund the 28-bed expansion at the FirstHealth Hoke Community Hospital in Hoke County.*

Please accept my assurance that the anticipated $17.52 million will be paid from these designated funds for this project.

FirstHealth of the Carolinas, Inc., will provide $4.5 million through Accumulated Reserves (Current Assets: Cash and Cash Equivalents) to fund the working capital for FirstHealth Hoke Community Hospital in Hoke County.

Please accept my assurance that the anticipated $4.5 million will be paid from these designated funds for this project."

Exhibit 41 of the application contains audited financial statements for FirstHealth for the year ended September 30, 2011, which document that FirstHealth had $316,056,000 million in Assets Limited as to Use: Internally Designated for Capital Projects and $35,824,000 million in Current Assets: Cash and Cash Equivalents as of September 30, 2011. Overall, the applicant had $511,787,000 in Net Assets as of September 30, 2011. The applicant adequately demonstrated the availability of funds for the projected capital costs described in the application, as well as other projects, applications for which were filed at the same time, in Hoke and Moore Counties.

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

FirstHealth Hoke Community Hospital

	Project Year 1	**Project Year 2**	**Project Year 3**
Gross Patient Revenue	$60,773,455	$75,648,355	$91,618,769
Deductions from Gross Patient Revenue	$41,421,878	$51,789,456	$62,626,330
Net Patient Revenue	$19,351,577	$23,858,899	$28,992,439
Total Expenses	$21,024,890	$22,952,596	$25,255,219
Net Income	($1,673,313)	$906,303	$3,737,220

The applicant also projects a positive net income for the entire facility in the second and third 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 Section XIII, pages 176-239, 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.

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

CA
FHCH

CFVMC and FHCH each propose to develop 28 additional acute care beds in the Cumberland Hoke Acute Care Bed Service Area. The 28 bed need determination is identified in the 2012 SMFP. During the review of both applications an issue has been raised concerning potential duplication of facilities in Hoke County, as the approved and proposed hospital projects total 77 acute care beds.

The approval HCMC Project ID #N-8499-10 proposed 41 general acute care beds including 21 medical/surgical beds, 4 ICU beds, and 16 OB beds. The proposed FHCH project includes 28 acute care beds to be added to 8 approved acute care beds for a total of 36 acute care beds. These beds include 32 medical/surgical beds and 4 ICU beds. There is no duplication of OB beds or services in Hoke County, which, in accordance with the SMFP, will become the Hoke Acute Care Service Area upon licensure of at least one of the two new hospitals.

In Section III.5(c), of its approved 41-bed HCMC hospital, CFVMC (the owner of HCMC) provides projected patient origin by program component for HCMC in the second year of operation, which is summarized in the following table:

County	Inpatient Days	Outpatient Visits	Emergency Visits	Surgery Cases
Cumberland	59.5%	70.2%	63.2%	61.0%
Hoke	36.5%	25.5%	32.1%	34.4%
Robeson	4.0%	4.3%	4.7%	4.6%
Total	100.0%	100.0%	100.0%	100.0%

Source: p. 52 of the findings for the 2010 Hoke County Hospitals and Ambulatory Surgery Center Review

Thus, Hoke County patients would utilize 36.5% (3,531 patient days), or 15 beds, of the approved 41 beds [41 x .365 = 14.96 or 15].

In the FHCH application, which amends the original approval for an 8-bed hospital, FHCH proposes that approximately 67.6% of its Year 2 patients (5,391 patient days) would be residents of Hoke County, which is about 25 beds of the 36 proposed [36 x .676 =- 24.3 or 25]. Thus, combined, the approved 41-bed HCMC (CFVMC subsidiary) hospital and proposed 36-bed FHCH (FirstHealth subsidiary) hospital have based a total of 40 beds for Hoke patients. [HCMC = 15 + FHCH = 25 for a total of 40]

Alternatively, based on combining HCMC's and FHCH's projected Hoke County patient days of 8,922 [3,531 HCMC days + 5,391 FHCH days = 8,922 patient days] the average daily census would be 24.4 [8,922 / 365 = 24.44] and the number of acute care beds needed to meet the minimum target occupancy of 66.7% is 36.6 or 37 beds.

The total number of acute care beds (77) proposed by both HCMC (41) and FHCH (36) are to be developed to serve patients from contiguous counties that would be closer to, or more likely to obtain care, at the new Hoke County Hospitals. Notably, in its application, HCMC projects that nearly 60% of its patients would come from Cumberland County which equals 24 of the 41 approved beds.

In comments, provided by CFVMC pursuant to NCGS 131E-185 CFVMC states that Hoke County needs about 50 beds to serve the need of Hoke County residents, adequately and appropriately with the referral of the remaining residents to regional medical centers. [See pages 6-7 of the Comments in Opposition submitted by CFVMS.]

"As shown in the following table… Hoke County does not have a need for more than:

- *48 acute care beds in 2015 (PY1)*
- *49 beds in 2016 (PY 2)*
- *50 acute care beds in 2017 (PY 3)"*

Between the two hospital proposals, 37 beds have been proposed to serve residents of other counties, primarily Cumberland and Robeson. Both the current application and the previously approved applications adequately demonstrate that two flagship hospitals, CFVMC and FMRH, have a history of serving patients from these counties.

CFVMC adequately demonstrates that its proposal would not result in the unnecessary duplication of existing or approved acute care beds in the Cumberland-Hoke Acute Care Bed Service Area based on the following analysis:

1) The State Health Coordinating Council and the Governor determined that 28 new acute care beds will be needed in the Cumberland-Hoke Acute Care Bed Service Area in 2014 in addition to the existing and approved acute care beds located in the service area. See Table 5B on page 58 of the 2012 SMFP.

2) CFVMC adequately demonstrates in its application that the 28 new acute care beds it proposes to develop at CFVMC-Owen Drive in Cumberland County are needed in addition to the existing and approved acute care beds. See Sections III, IV and VI of CFVMC's application.

3) CFVMC's application conforms to this criterion.

FirstHealth adequately demonstrates that its proposal would not result in the unnecessary duplication of existing or approved acute care beds in the Cumberland-Hoke Acute Care Bed Service Area based on the following analysis:

1) The State Health Coordinating Council and the Governor determined that 28 new acute care beds will be needed in the Cumberland-Hoke Acute Care Bed Service Area in 2014 in addition to the existing and approved acute care beds located in the service area. See Table 5B on page 58 of the 2012 SMFP.

2) FirstHealth adequately demonstrates in its application that the 28 new acute care beds it proposes to develop at the approved FHCH in Hoke County are needed in addition to the existing and approved acute care beds. See Sections III, IV and VI of FirstHealth's application.

3) FirstHealth proposed to increase the number of observation beds from 4 to 8 without discussing demonstration of need. Thus, subject to the conditions #2 and #3 not to develop this proposed service, the FirstHealth application conforms with this criterion.

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

C
Both Applications

CFVMC. In Section VII, page 97, the applicant projects a total of 1,066.2 full-time equivalent (FTE) positions at CFVMC, with the proposed 28 acute care beds, in the second full operating year of the proposed project. In Section VII.3, page 98 and VII.6, pages 100-102, the applicant describes its experience and procedures for recruiting and retaining personnel. In Section VII.8, page 102, the applicant identifies Dr. Eugene Wright, as the Chief Medical Officer of CFVHS and Dr. Divyang Patel is identified as the current Chief of Staff at CFVHS. Exhibit 23 contains a letter from Dr. Wright stating that he is *"the Chief Medical Officer of Cape Fear Valley Health System."* Exhibit 23 also contains letters from other physicians expressing their support for the proposed project. In Section V.3, pages 77-82, Section V.4, pages 83-85, and Exhibit 23, the applicant describes efforts to develop relationships with local physicians and physicians who have expressed support for the proposed project. The applicant adequately demonstrates the availability of sufficient health manpower and administrative personnel for the provision of the proposed services. Therefore, the application is conforming to this criterion.

FHCH. In Section VII, page 146, the applicant projects a total of 55.8 FTE positions at FHCH in the second full operating year of the proposed project which shows the administrative, clinical, and support personnel that will be available. In Section VII.3, page 147 and VII.6, pages 148-152, the applicant describes its experience and procedures for recruitment and retention of personnel. Exhibit 21 contains a copy of the Medical Staff Development Plan. In Section V.3, page 117, the applicant identifies John Krahnert, MD., as the Medical Director. Exhibit 32 contains a letter indicating Dr. John Krahnert agreement to serve as the Chief Medical Officer of FHCH. Exhibit 44 also contains letters from other physicians expressing their support of FirstHealth and their willingness to refer patients to FirstHealth. In Section V.3, pages 112-116, and Section V.4, page 118, the applicant both describes efforts to develop relationships with local physicians, other local healthcare providers, and physicians who have expressed support for the proposed project. The applicant adequately demonstrates the availability of sufficient health manpower and management personnel to provide the proposed services. Therefore, the application is conforming to this criterion.

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

C
Both Applications

CFVMC. In Section II.2, pages 20-21, the applicant describes the necessary ancillary and support services for the proposed services that will be provided at the proposed hospital. In Section V.2, page 76, the applicant provides a list of healthcare facilities with which CFVHS currently has transfer agreements. Exhibit 40 contains an example of an existing CFVHS transfer agreement. The applicant adequately demonstrates that the proposed project will be coordinated with the existing health care system and that the necessary ancillary and support services will be available. Therefore, the application is conforming to this criterion.

FHCH. In Section II.2, pages 30-31, the applicant states that the majority of the necessary ancillary and support services for the proposed services will be provided at the proposed hospital, and a few support services will be provided through service agreements with FMRH. In Exhibit 5the applicant provides letters the Chief Executive Officer of FirstHealth of the Carolinas, Inc. documenting provision of pharmaceutical services and that "*the necessary ancillary and support services required to operate an acute care hospital will be provided at FirstHealth Hoke Community Hospital through either hospital staff or provided by FirstHealth corporate services through a Services Agreement.*" The letter from the Chief Executive Officer documents the ancillary and support services that will be provided through a service agreement. In Section V.2, page 110, the applicant states, "*Transfer agreements currently exist between FMRH and the provider facilities listed. FirstHealth will arrange for these agreements to extend to FHCH.*

- *Womack Army Medical Hospital*
- *Scotland Memorial Hospital*
- *UNC Hospitals"*

Exhibit 30 contains copies of correspondence from FirstHealth to arrange transfer agreements with FHCH with the following hospitals

- FirstHealth Moore Regional Hospital
- Cape Fear Valley Medical Center
- Womack Army Medical Hospital
- Scotland Memorial Hospital
- Southeast Regional Medical Center

Exhibit 44 contains approximately 80 letters of physician support for the proposed project. The applicant adequately demonstrates that the proposed project will be coordinated with the existing health care system. The applicant adequately demonstrates that the proposed project will be

coordinated with the existing health care system. Therefore, the application is conforming with 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
Both Applications

(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
Both Applications

(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.

NA
CFVMC

CA
FHCH

FHCH. In CON Project ID# N-8497-10, FHCH was previously approved to construct an 8-bed hospital in Hoke County. The 8-bed hospital is not yet developed. In this application the applicant proposes to construct amend the development described in Project ID # N-8497-10 by adding a 36-bed inpatient wing and convert the approved 8-bed inpatient unit in

the original approval into an 8-bed observation unit. The previously approved inpatient unit was to be 5,560 square feet. In the proposed project the 36-bed inpatient wing will be a total of 25,000 square feet. In Exhibit 42, the architect certifies that the total construction cost for the "*Patient Bed Unit Addition*" is estimated to be $12,407,393. This cost is consistent with the costs reported by the applicant in Section VIII.1, page 159. In Section XI.7, page 173, the applicant states that applicable energy savings features will be incorporated into the plans and lists specific methods that will be incorporated into the design of the facility to maintain energy operations and contain costs of utilities. Exhibit 43 contains a copy of the mechanical, plumbing, and electrical system narratives. The application is conforming to this criterion subject to conditions #2 and #3.

(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
Both Applications

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 Bladen, Cumberland, Harnett, Hoke, Robeson and Scotland counties and statewide.

County	June 2010 Total # of Medicaid Eligibles as % of Total Population *	June 2010 Total # of Medicaid Eligibles Age 21 and older as % of Total Population *	CY 2008-2009 % Uninsured (Estimate by Cecil G. Sheps Center) *
Bladen	25.0%	12.4%	19.4%
Cumberland	18.0%	7.4%	20.3%
Harnett	17.0%	6.2%	20.3%
Hoke	19.0%	6.9%	21.9%
Robeson	31.0%	13.2%	23.9%
Scotland	30.0%	12.9%	21.5%
Statewide	**17.0%**	**6.7%**	**19.7%**

* 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 applicants' 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 following tables show the average inpatient utilization (admissions) for acute general hospitals by payer category for North Carolina and Cumberland County. (The data includes normal newborns.) Hoke County does not have an existing hospital. For North Carolina, data are based on 1,113,423 inpatient admissions. For Cumberland County, data are based on 35,956 inpatient admissions.

North Carolina Hospital Admissions by Payer Category-FY2009

Payer Category	Percent of Total
Commercial/HMO	32.9%
Medicare	36.0%
Medicaid	21.9%
Other	3.1%
Uninsured	6.1%
Total	**100.0%**

Source: Cecil B. Sheps Center for Health Services Research

Cumberland County Hospital Admissions by Payer Category-FY2009

Payer Category	Percent of Total
Commercial/HMO	20.4%
Medicare	35.7%
Medicaid	29.8%
Other-Gov.	8.0
Other	0.2%
Uninsured	6.0%

Total	**100.0%**

Source: Cecil B. Sheps Center for Health Services Research

CFVMC In Section VI.12, page 93, the applicant provides the payer mix during FY2011 for all services provided at CFVMC, as illustrated in the table below.

CFVMC
Last Full Fiscal Year- FY2011

Payer Category	Patient Days as % of Total Utilization
Self Pay/ Indigent/ Charity	4.6%
Medicare/ Medicare Managed Care	51.9%
Medicaid	24.1%
Commercial Insurance	12.3%
Managed Care	4.8%
Other*	2.3%
Total	100.0%

*Payor Mix Category titled "Other" includes all other payors not listed on a separate line and includes payors such as Contract Service and Worker's Comp.

The applicant demonstrates that medically underserved populations currently have adequate access to CFVMC's existing services and is conforming to this criterion.

FHCH. FHCH has not yet been developed. The applicant operates an existing hospital in Moore County (FMRH). In Section VI.12, page 126, of Project ID# N-8843-12, the applicant provides the payer mix during FY2011 for all services provided at FMRH, as shown in the table below.

FMRH
Last Full Fiscal Year 10/1/2010 – 9/30/2011

Payer Category	Patient Days as % of Total Utilization
Self Pay/ Charity/ Other	12.1%
Medicare / Medicare Managed Care	63.1%
Medicaid	7.9%
Commercial Insurance/ Managed Care	16.9%
Total*	100.0%

*May not foot due to rounding.

The applicant demonstrates that medically underserved populations currently have adequate access to FMRH's existing services and 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
Both Applications

CFVMC. Recipients of Hill-Burton funds were required to provide uncompensated care, community service and access by minorities and handicapped persons. In Section VI.11, page 92, the applicant states

"*In October 1985, CFVHS was informed that it had fulfilled all of its Hill-Burton requirements. However, CFVHS continues its admission policy to provide equal access to care without discrimination and without regard to race, color, age, creed, national origin, or source of payment. The Board of Trustees adopted a Charity Care Program, a copy of which is included along with the Admission and Credit/Charity Policy in Exhibit 40."*

In Section VI.10, page 92, the applicant states that one civil rights access complaint against Highsmith Rainey Memorial Hospital was filed with the Office of Civil Rights in August 2007, but the complaint was determined to be unsubstantiated in February 2008.

Also in Section VI.10, page 92, the applicant states

"CFVMC responded swiftly to EMTALA complaints. Follow up surveys conducted by the Acute and Home Care Licensure Section found no deficiencies and recommended compliance with EMTALA. Please see the letters from the Acute and Home Care Licensure Section included in Section 39. Further, as indicated by the letters from CMS included in Exhibit 39, CMS determined that CFVMC's corrective Policies included in Exhibit 41, describes its procedures to assure that patients presenting to CFVMC receive access to healthcare."

FHCH. Recipients of Hill-Burton funds were required to provide uncompensated care, community service and access by minorities and handicapped persons. In Section VI.11, page 141, the applicant states

"In June 1995, FMRH fulfilled its Hill-Burton quota to provide uncompensated care, community service, and access to minorities and handicapped persons under Hill-Burton."

In Section VI.10, page 141, the applicant states that there have not been any civil rights access complaints filed against FirstHealth in the past five years. The application is conforming to this criterion.

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

C

Both Applications

CFVMC. In Section VI.14(a), page 94, the applicant projects the following payer mix for the proposed services in the second full fiscal year of operation (FY2015).

CFVMC
Second Full Fiscal Year- FY2106 (10/1/14 – 9/30/15)
Entire Facility

Payer Category	Patient Days as % of Total Utilization
Self Pay/ Indigent/ Charity	4.5%
Medicare/ Medicare Managed Care	52.1%
Medicaid	24.0%
Commercial Insurance	11.9%
Managed Care	4.6%
Other*	2.9%
Total	100.0%

*Payor Mix Category titled "Other" includes all other payors not listed on a separate line and includes payors such as Contract Service and Worker's Comp.

In Section VI.14, page 94, the applicant states *"Payor mix for the second full fiscal year was based on review of the FY2011 payor mix data from Cape Fear Valley Health System."*

In Section VI.15, pages 94-95, the applicant projects the following payer mix for the proposed services in the second full fiscal year of operation (FY2015).

CFVMC
Second Full Fiscal Year- FY2106 (10/1/14 – 9/30/15)
Inpatient Acute Care Services

Payer Category	Patient Days as % of Total Utilization
Self Pay/ Indigent/ Charity	4.7%
Medicare/ Medicare Managed Care	51.2%
Medicaid	24.6%
Commercial Insurance	12.9%
Managed Care	4.6%
Other*	2.0%
Total	100.0%

*Payor Mix Category titled "Other" includes all other payors not listed on a separate line and includes payors such as Contract Service and Worker's Comp.

On page 95, the applicant states *"Payor mix for Cape Fear Valley Medical Center and proposed additional 28 acute care beds was based on review of the FY2011 payor mix data from Cape Fear Valley Health System Inpatients that included patients from the CFVHS service area and received inpatient acute care services.."*

The applicant demonstrated that the proposed acute care beds will provide adequate access to medically underserved populations. Therefore, the application is conforming with this criterion.

FHCH. In Section VI.14, page 143, the applicant projects the payer mix for the entire facility at FHCH for the second operating year following project completion (FY2016), as shown in the table below.

FHCH
Second Full Fiscal Year- FY2106 (10/1/14 – 9/30/15)
Entire Facility

Payer Category	Patient Days as % of Total Utilization
Self Pay/ Charity	6.6%
Medicare/ Medicare Managed Care	48.2%
Medicaid	12.5%
Commercial Insurance/ Managed Care	26.9%
Other (Specify)	5.8%
Total	100.0%

On page 143, the applicant states *"Overall FHCH payer mix is based on the pro forma financial statements included in Section XIII."*

In Section VI.15, page 144, the applicant projects the payer mix for the proposed inpatient and ICH services at FHCH for the second operating year following project completion (FY2016), as shown in the table below.

FHCH
Second Full Fiscal Year- FY2106 (10/1/14 – 9/30/15)
General IP Services

Payer Category	Patient Days as % of Total Utilization
Self Pay/ Charity	4.9%
Medicare/ Medicare Managed Care	51.0%
Medicaid	10.4%
Commercial Insurance/ Managed Care	26.5%
Other (Specify)	7.2%
Total	100.0%

The applicant states *"FirstHealth assumes no change in payer mix of the service area patients who received care at FMRH in FY2011."* [see page 144.]

FHCH
Second Full Fiscal Year- FY2106 (10/1/14 – 9/30/15)
ICU Services

Payer Category	Patient Days as % of Total Utilization
Self Pay/ Charity	2.2%
Medicare/ Medicare Managed Care	69.8%
Medicaid	10.8%
Commercial Insurance/ Managed Care	15.5%
Other (Specify)	1.7%
Total	100.0%

On page 144, the applicant states, *"FirstHealth assumes no change in payer mix of the service area patients who received care at FMRH in FY2011."*

The applicant demonstrated that the proposed acute care beds will provide adequate access to medically underserved populations. Therefore, 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
Both Applications

CFVMC In Section VI.9, page 91, the applicant describes the range of means by which a person will access their services. The application is conforming to this criterion.

FHCH In Section VI.9, pages 140, the applicant describes the range of means by which a person will access their services. The application is conforming to this criterion.

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

C
Both Applications

CFVMC In Section V.1, pages 72-76, the applicant states that it has extensive relationships with many health professional training programs. On pages 73-74, the applicant provides a

list of institutions with which it has these arrangements. The list of institutions includes: Methodist University; Fayetteville Technical Community College, Central Carolina Community College, Sandhills Community College, Robeson Community College, Sampson Community College and Johnston Community College. The information provided is reasonable and credible and supports a finding of conformity to this criterion.

FHCH In Section V.1, page 109, the applicant states it has extensive relationships with many health professional training programs and that *"FHCH will be available to students in these training programs."* Exhibit 29 contains a list of training programs that FirstHealth has an agreement with and an "*example of a training program affiliation agreement."* The list of training programs includes: Central Carolina Community College; Fayetteville Technical Community College; Hoke County High School; Johnston Community College; Methodist College; Robeson Community College and Sandhills Community College. The information provided is reasonable and credible and supports a finding of conformity to this criterion.

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

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

NC
CFVMC

C
FHCH

There are currently two entities who have existing or approved acute care beds in the Cumberland-Hoke Acute Care Bed Service Area: #1) The Cumberland County Health System, Inc. d/b/a Cape Fear Valley Medical Center; and #2) FirstHealth of the Carolinas, Inc.

The following tables illustrates the location of the existing, approved and proposed acute care beds in the Cumberland-Hoke Acute Care Bed Service Area controlled by The Cumberland County Health System, Inc. d/b/a Cape Fear Valley Medical Center and FirstHealth of the Carolinas, Inc.

#1) The Cumberland County Health System, Inc. d/b/a Cape Fear Valley Medical Center

	Existing Acute Care Beds	Approved Acute Care Beds	Proposed Acute Care Beds	Total
Cumberland County				
CFVMC's- Owen Drive Campus	490	Na	28	518
CFVMC's CFV North Campus	0	65	0	65
Overall Cumberland County Total	490	65	28	583
Hoke County				
Hoke Healthcare, LLC	0	41	0	41
Overall Hoke County Total	0	41	0	41
Overall Cumberland/Hoke County Total	**490**	**106**	**28**	**624**

#2) FirstHealth of the Carolinas, Inc.

	Existing Acute Care Beds	Approved Acute Care Beds	Proposed Acute Care Beds	Total
Cumberland County	0	0	0	0
Hoke County				
FHCH		8	28	**36**

CFVMC. The applicant proposes to develop 28 new acute care beds at CFVMC-Owen Drive Campus for a total of 518 acute care beds at CFVMC's-Owen Drive campus upon project completion. CFVMC also has been approved to develop a second campus with 65 acute care beds, CFV North, in Fayetteville, Cumberland County.

In Section V.7, pages 85-86, the applicant states

"Cost Effectiveness

The proposed project is a logical and responsive approach by Cape Fear Valley Health System, reflecting its continued commitment to its service area. The ability of CFVHS to convert existing space to expeditiously accommodate putting into operation the proposed 28 acute care beds is the most cost efficient means available. In each of the areas identified for inclusion of a portion of the proposed beds, a fully operating patient care unit already exists and all required facility support is in place. The capital expenditure required to renovate the existing units and to expand and improve patient bathrooms for all 28 acute care beds is less expensive than the other options, including new construction and expansion, and can be accomplished in a shorter timeframe.

Quality

The infrastructure for Quality and Patient Safety is well established in each of the areas where the proposed beds will reside and no additional staff or other resources will be required to continue the monitoring and oversight of these functions. The

expanded patient rooms and patient bathrooms on 2 North and 3 North will eliminate shared bathrooms and improve patient quality.

Access

Avoidance for the need to construct new space will result in an improved time line, also, for availability of these beds and will allow them to be used as fully designed/ licensed beds months sooner than other, more costly, approaches."

However, the applicant does not adequately demonstrate that its proposed project would have a positive impact on the quality of the proposed services because: 1) CFVMC has not demonstrated that it has provided quality care in the past (See discussion in Criterion (20) which is incorporated hereby as if fully set forth herein.) Therefore, the application is nonconforming to this criterion.

FHCH. The applicant proposes to develop 28 new acute care beds at the approved FHCH for a total of 36 acute care beds at FHCH upon completion of the proposed project.

In Section V.7, pages 120-129, the applicant describes in detail how the proposed project will foster competition in the proposed service area by promoting the cost effectiveness, quality, and access to services as summarized below.

"*Competitive healthcare markets exist when there is genuine choice for patients in terms of who supplies the care and services they require. Competitive healthcare markets are characterized by various forms of charge and no-charge competition between hospitals who are attempting to increase or protect their market share. FHCH is a true alternative to CFVHS for service area residents who desire a choice in their healthcare provider.*

What are the gains from increased healthcare market competition?

1. *Lower charges to third-party insurers and patients.*
2. *A greater discipline on hospitals to keep costs down.*
3. *Improvements in technology with positive effects on care and outcomes.*
4. *A greater variety of services (giving more choice)*
5. *A faster pace of innovation of care*
6. *Improvements to the quality of care of patients.*
7. *Better performance and quality information available allowing patients to make more informed choices.*
8. *Create jobs.*

The overall impact of increased healthcare competition should be the improvement in the economic and physical welfare of patients."

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 acute care beds. This determination is based on the information in the application and the following analysis:

- The applicant adequately demonstrates the need to develop 28 acute care beds at FHCH and that it is a cost-effective alternative;
- The applicant has and will continue to provide quality services; and
- The applicant has and 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.

NC
CFVMC

C
FHCH

CFVMC. Cape Fear Valley Health System is accredited by the Joint Commission, certified for Medicare and Medicaid participation, and licensed by the North Carolina Department of Health and Human Services. According to the files in the Acute and Home Care Licensure and Certification Section, DHSR, (the state agency) two incidents occurred in November and December 2011 that are within the eighteen months immediately preceding the date of this decision. In both instances complaint investigations were conducted by the state agency on November 29 and 30, and on December 22, 2011, respectively. Both surveys resulted in the identification of an Immediate Jeopardy (IJ) as a consequence of the incidents. The results of these surveys were forwarded to the CMS Regional Office in Atlanta (Region IV). In both instances, the state agency recommended termination of the Medicare provider agreement between CMS and the hospital due to noncompliance with conditions of participation that affected quality of patient care, specifically, 482.12 Governing Body, 482.13 Patient's Rights and 482.23 Nursing Services. CMS began the process of provider termination with the most recent date set for January 19, 2012.

CFVMC negotiated and signed a Systems Improvement Agreement (SIA) with CMS on January 20, 2012 that stayed the effective date of the termination of its Medicare provider agreement. The SIA is analogous to a settlement agreement.

Follow up surveys conducted during the next few months indicated that some of the conditions were in compliance but other conditions were identified as being out of compliance.

Between March 19 and 22, 2012, the Joint Commission conducted an accreditation survey at CFVMC and Cape Fear was reaccredited. Per the Joint Commission

> *Accredited is awarded to a health care organization that is in compliance with all standards at the time of the onsite survey or has successfully addressed requirements for*

improvement in an Evidence of Standards Compliance within 45 or 60 days following the posting of the Accreditation Summary Findings Report.

However, according to CMS, a facility that is accredited does not qualify for deemed status if it has conditions of participation that are out of compliance. The most recent follow-up survey completed by the state agency in August 2012 indicated that no condition level deficiencies were sited for Governing Body, Nursing Services, Quality Assurance, and Infection Control, However, according to a representative for CMS Regional Office in Atlanta, CFVMC will not be in compliance with the conditions of participation of the Medicare Program until it completes a full Medicare and Medicaid Survey with no conditions of participation out of compliance. As of the date of the decision no full validation survey had been conducted.

Therefore, CFVMC is not conforming to this criterion.

FHCH. FirstHealth of the Carolinas, Inc. operates three hospitals in the North Carolina Sandhills: FirstHeath Moore; FirstHealth Richmond; and FirstHealth Montgomery. These FirstHealth of the Carolinas hospitals are certified by CMS for Medicare and Medicaid participation, and licensed by the NC Department of Health and Human Services. According to files in the Acute and Home Care Licensure and Certification Section in the Division of Health Service Regulation, no incidents have occurred at FirstHealth within the eighteen months immediately preceding the date of the decision for which any sanctions or penalties related to quality of care were imposed by the State. Therefore, the application is conforming to this criterion.

(21) Repealed effective July 1, 1987.

(b) The Department is authorized to adopt rules for the review of particular types 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
Both Applications

CVFMC. The applicant proposes to add 28 new acute care beds CFVMC- Owen Drive Campus. The following regulatory review criteria are applicable to this review:

- Criteria and Standards for Acute Care Beds, promulgated in 10A NCAC 14C .3800; and

The application is conforming to all applicable Criteria and Standards. The specific criteria are discussed below.

FirstHealth. The applicant proposes to add 28 acute care beds (24 acute care beds and 4 ICU beds) at the approved 8-bed acute care hospital, FHCH. The following regulatory review criteria are applicable to this review:

- Criteria and Standards for Acute Care Beds, promulgated in 10A NCAC 14C .3800; and
- Criteria and Standards for Intensive Care Services, promulgated in 10A NCAC 14C .1200; and

The application is conforming to all applicable Criteria and Standards. The specific criteria are discussed below.

SECTION .3800 - CRITERIA AND STANDARDS FOR ACUTE CARE BEDS

10A NCAC 14C .3802 INFORMATION REQUIRED OF APPLICANT

(a) An applicant that proposes to develop new acute care beds shall complete the Acute Care Facility/Medical Equipment application form.

-C- **Both Applicants.** Both applicants completed the Acute Care Facility/Medical Equipment application form.

(b) An applicant proposing to develop new acute care beds shall submit the following information:

(1) the number of acute care beds proposed to be licensed and operated following completion of the proposed project;

-C- **CFVMC.** In Section II.8, pages 26-27, the applicant states that it proposes 518 acute care beds to be licensed and operational at CFVMC's Owen Drive Campus upon completion of the proposed project (28 acute care beds) in addition to the existing 490 acute care beds at CFVMC's Owen Drive Campus. Please note that CFVMC has been approved in Project M-8689-11 for a second campus with 65 acute care beds under the same license known as CFV North.

-C- **FHCH.** In Section II.8, page 46, the applicant states that it proposes 36 acute care beds to be licensed and operational at FHCH upon completion of the proposed project (including the 8 acute care beds previously approved to be transferred from FMRH to FHCH.)

(2) documentation that the proposed services shall be provided in conformance with all applicable facility, programmatic, and service specific licensure, certification, and JCAHO accreditation standards;

-C- **CFVMC.** In Section II.8, page 27, and Exhibits 35 and 36, the applicant provides documentation that the services will be provided in conformance with all applicable facility, programmatic, and service specific licensure, certification, and Joint Commission accreditation standards.

-C- **FHCH.** See Section II.8, page 46, and Exhibit 11, the applicant provides documentation that the services will be provided in conformance with all applicable facility, programmatic, and service specific licensure, certification, and Joint Commission accreditation standards.

(3) documentation that the proposed services shall be offered in a physical environment that conforms to the requirements of federal, state, and local regulatory bodies;

-C- **CFVMC.** In Section II.8, page 28, and Exhibits 9 and 10, the applicant provides documentation that the services will be provided in a physical environment that conforms to the requirements of federal, state, and local regulatory bodies.

-C- **FHCH.** See Section II.8, page 46, and Exhibit 12 for the applicant provides documentation that the services will be provided in a physical environment that conforms to the requirements of federal, state, and local regulatory bodies.

(4) if adding new acute care beds to an existing facility, documentation of the number of inpatient days of care provided in the last operating year in the existing licensed acute care beds by medical diagnostic category, as classified by the Centers for Medicare and Medicaid Services according to the list set forth in the applicable State Medical Facilities Plan;

-C- **CFVMC.** In Section II.8, pages 28-29, the applicant documented the number of inpatient days of care provided in the last operating year in the existing licensed acute care beds at Owen Drive by medical diagnostic category, as classified by the Centers for Medicare and Medicaid Services according to the list set forth in the applicable State Medical Facilities. CFVMC states that for October 2010 to September 2011the total inpatient days of care provided was 171,878 excluding normal newborns, rehabilitation, psychiatric and substance abuse.

-NA- **FHCH.** The applicant is not proposing to add new acute care beds to an existing facility. FHCH is an approved 8-bed acute care hospital which has not yet been developed.

(5) the projected number of inpatient days of care to be provided in the total number of licensed acute care beds in the facility, by county of residence, for each of the first three years following completion of the proposed project, including all assumptions, data and methodologies;

-C- **CFVMC.** In Section II.8, pages 29-31, the applicant provides the projected number of inpatient days of care to be provided in the total number of licensed acute care beds in the facility, by county of residence, for each of the first three operating years following completion of the project. In Section III.1(b), pages 48-54, and Exhibit 30, Tables 1-18, the applicant provides the assumptions, data and methodology used for the projections. See Criterion (3) for discussion of the applicants projected utilization regarding the reasonableness of the projections.

CFVMC-Owen Drive Only
Total Projected Inpatient Days of Care by County
Adjusted to Reflect the Impact of CFV North and HCMC
October 1, 2013 – September 30, 2016

	PY1 FY 2014	PY2 FY 2015	PY3 FY 2016
Cumberland	128,454	122,080	116,880
Bladen	4,492	4,573	4,663
Harnett	10,464	10,139	9,741
Hoke	6,603	4,670	3,944
Robeson	11,955	11,949	12,095
Sampson	6,241	6,321	6,406
Other*	6,146	5,595	4,935
Total	174,357	165,326	158,664

Source: Thomson data included in Exhibit 30, Table 4.
*Other reflects all other North Carolina Counties and other States as reflected in Exhibit 30, Table 8 and/or in the patient origin tables included in the CFVMC 2012 LRA included in Exhibit 37.

-C- **FHCH.** In Section II.8, page 47, the applicant provides the projected number of inpatient days of care to be provided in the total number of licensed acute care beds in the facility, by county of residence, for each of the first three operating years following completion of the project. In Section IV, pages 92-107, the applicant provides the assumptions, data and methodology used for the projections. See Criterion (3) for discussion regarding the applicant's projected utilization and the reasonableness of the projections.

County	**FY2015**	**FY2016**	**FY2017**
Cumberland	317	458	600
Hoke	4,206	5,391	6,627
Robeson	1,034	1,483	1,933
Scotland	316	431	543
Total	5,873	7,763	9,703

(6) documentation that the applicant shall be able to communicate with emergency transportation agencies 24 hours per day, 7 days per week;

-C- **CFVMC.** In Section II.8, page 31, and Exhibit 23, the applicant provides documentation that CFV North will be able to communicate with emergency transportation agencies 24 hours per day, 7 days per week.

-C- **FHCH.** In Section II.8, page 47, and Exhibit 9, the applicant provides documentation that the proposed hospital will be able to communicate with emergency transportation agencies 24 hours per day, 7 days per week.

(7) documentation that services in the emergency care department shall be provided 24 hours per day, 7 days per week, including a description of the scope of services to be provided during each shift and the physician and professional staffing that will be responsible for provision of those services;

-C- **CFVMC.** In Section II.8, page 31, and Exhibit 23, the applicant describes the scope of services to be provided in the emergency department and provides documentation that the hospital's emergency department services will be available 24 hours per day, 7 days per week.

-C- **FHCH.** In Section II.8, page 48, the applicant describes the scope of services to be provided in the emergency department and provides documentation that the hospital's emergency department services will be available 24 hours per day, 7 days per week.

(8) copy of written administrative policies that prohibit the exclusion of services to any patient on the basis of age, race, sex, creed, religion, disability or the patient's ability to pay;

-C- **CFVMC.** In Section II.8, page 32, and Exhibits 41-50, the applicant provides written administrative policies documenting that CFVMC will prohibit the exclusion of services to any patient on the basis of age, race, sex, creed, religion, disability or the patient's ability to pay.

-C- **FHCH.** In Section II.8, page 48, and Exhibit 19, the applicant provides written administrative policies documenting that the hospital will prohibit the exclusion of services to any patient on the basis of age, race, sex, creed, religion, disability or the patient's ability to pay.

(9) a written commitment to participate in and comply with conditions of participation in the Medicare and Medicaid programs;

-C- **CFVMC.** In Section II.8, page 32, and Exhibit 36, the applicant provides a written commitment from the COO of CFVHS documenting CFVMC's commitment to participate in and comply with conditions of participation in the Medicare and Medicaid programs.

-C- **FHCH.** In Section II.8, page 48, and Exhibit 20, the applicant provides a written commitment from the Chief Executive Officer of FirstHealth of the Carolinas, Inc. to

participate in and comply with conditions of participation in the Medicare and Medicaid programs.

(10) documentation of the health care services provided by the applicant, and any facility in North Carolina owned or operated by the applicant's parent organization, in each of the last two operating years to Medicare patients, Medicaid patients, and patients who are not able to pay for their care;

-C- **CFVMC** In Section II.1, page 13, the applicant states

"*Cumberland County Hospital System, Inc. ("CCHS") doing business as Cape Fear Valley Medical Center ("CFVMC") is the flag-ship of Cape Fear Valley Health System ("CFVHS"). CFVHS operates a variety of healthcare facilities from its headquarters in Fayetteville, North Carolina, including a tertiary acute care hospital, a long-term acute care hospital, a critical access hospital, an inpatient rehabilitation facility, county emergency medical services, an outpatient psychiatric facility, a detoxification facility, a wellness center, 14 primary care clinics, 16 specialty care clinics, 5 walk-in clinics, and Health Pavilion North, an outpatient complex."*

In Section II.8, page 32, for all CFVHS, the applicant provides a table documenting CFVHS historical payor mix for 2008 – 2011 including Medicare, Medicaid and Self Pay.

	2008	**2009**	**2010**	**2011**
Commercial	15%	14%	14%	12%
Managed Care	9%	8%	7%	5%
Medicaid	17%	20%	19%	24%
Medicare	46%	45%	47%	52%
Other	5%	6%	6%	2%
Self Pay	8%	7%	7%	5%

-C- **FHCH.** In Section II.8, page 49, the applicant provides a table showing the facilities and programs that have provided health care services to Medicare patients, Medicaid patients and patients who are not able to pay for their care in the last two years.

The tables below illustrate the payor mix for FMRH for the last two fiscal years (FY 2010 and FY 2011 from public data sources available to the agency.

FMRH
Full Fiscal Year 2010 and 2011

Payer Category	Patient Days as % of Total Utilization 10/1/09-9/30/10*	Patient Days as % of Total Utilization 10/1/10-9/30/11**
Self Pay/ Charity/ Other	10.0%	12.1%
Medicare / Medicare Managed Care	59.8%	63.1%

Medicaid	8.9%	7.9%
Commercial Insurance/ Managed Care	21.3%	16.9%
Total	100.0%	100.0%

*Source: Findings for Project ID #N-8690-11

**Source: Application for Project ID # N-8843-12, page 126.

FirstHealth-Montgomery
Full Fiscal Year 2010 and 2011

Payer Category	Patient Days as % of Total Utilization 10/1/09-9/30/10	Patient Days as % of Total Utilization 10/1/10-9/30/11
Self Pay/ Charity/ Other	6.0%	8.7%
Medicare / Medicare Managed Care	83.4%	78.7%
Medicaid	2.1%	4.0%
Commercial Insurance/ Managed Care	8.4%	8.7%
Total	100.0%	100.0%

Source: LRA- 2011 & 2012

FirstHealth-Richmond
Full Fiscal Year 2010 and 2011

Payer Category	Patient Days as % of Total Utilization 10/1/09-9/30/10	Patient Days as % of Total Utilization 10/1/10-9/30/11
Self Pay/ Charity/ Other	14.0%	11.9%
Medicare / Medicare Managed Care	55.1%	56.0%
Medicaid	16.9%	17.6%
Commercial Insurance/ Managed Care	13.9%	14.5%
Total	100.0%	100.0%

Source: LRA- 2011 & 2012

FirstHealth Hospice & Palliative Care
Full Fiscal Year 2010 and 2011

Payer Category	Patient Days as % of Total Utilization 10/1/09-9/30/10	Patient Days as % of Total Utilization 10/1/10-9/30/11
Self Pay	1.4%	0.8%
Medicare	92.9%	94.2%
Medicaid	2.2%	2.4%
Private Insurance	3.5%	2.6%
Total	100.0%	100.0%

Source: LRA- 2011 & 2012

(11) documentation of strategies to be used and activities undertaken by the applicant to attract physicians and medical staff who will provide care to patients without regard to their ability to pay; and

-C- **CFVMC.** In Section II.8, page 32, and Exhibits 3 and 41, the applicant provides documentation of strategies to be used and activities undertaken by the applicant to attract physicians and medical staff who will provide care to patients without regard to their ability to pay.

-C- **FHCH.** In Section II.8, page 150, and Exhibits 21 the applicant provides documentation of strategies to be used and activities undertaken by the applicant to attract physicians and medical staff who will provide care to patients without regard to their ability to pay.

(12) documentation that the proposed new acute care beds shall be operated in a hospital that provides inpatient medical services to both surgical and non-surgical patients.

-C- **CFVMC.** In Section II.8, page 33, and Exhibit 36, the applicant provides documentation that the proposed new acute care beds at CFVMC will provide inpatient medical services to both surgical and non-surgical patients.

-C- **FHCH.** In Section II.8, page 50, and Exhibit 22, the applicant provides documentation that the proposed new acute care beds at FHCH will provide inpatient medical services to both surgical and non-surgical patients.

(c) An applicant proposing to develop new acute care beds in a new licensed hospital or on a new campus of an existing hospital shall also submit the following information:

(1) the projected number of inpatient days of care to be provided in the licensed acute care beds in the new hospital or on the new campus, by major diagnostic category as recognized by the Centers for Medicare and Medicaid Services (CMS) according to the list set forth in the applicable State Medical Facilities Plan;

(2) documentation that medical and surgical services shall be provided in the proposed acute care beds on a daily basis within at least five of the major diagnostic categories as recognized by the Centers for Medicare and Medicaid Services (CMS) according to the list set forth in the applicable State Medical Facilities Plan;

(3) copies of written policies and procedures for the provision of care within the new acute care hospital or on the new campus, including but not limited to the following:
(A) the admission and discharge of patients, including discharge planning,
(B) transfer of patients to another hospital,
(C) infection control, and
(D) safety procedures;

(4) documentation that the applicant owns or otherwise has control of the site on which the proposed acute care beds will be located; and

(5) documentation that the proposed site is suitable for development of the facility with regard to water, sewage disposal, site development and zoning requirements; and provide the required procedures for obtaining zoning changes and a special use permit if site is currently not properly zoned; and

(6) correspondence from physicians and other referral sources that documents their willingness to refer or admit patients to the proposed new hospital or new campus.

-NA- Both Applications. Neither application is proposing to develop new acute care beds in a new licensed hospital or on a new campus of an existing hospital shall

10A NCAC 14C .3803 PERFORMANCE STANDARDS

(a) An applicant proposing to develop new acute care beds shall demonstrate that the projected average daily census (ADC) of the total number of licensed acute care beds proposed to be licensed within the service area, under common ownership with the applicant, divided by the total number of those licensed acute care beds is reasonably projected to be at least 66.7 percent when the projected ADC is less than 100 patients, 71.4 percent when the projected ADC is 100 to 200 patients, and 75.2 percent when the projected ADC is greater than 200 patients, in the third operating year following completion of the proposed project or in the year for which the need determination is identified in the State Medical Facilities Plan, whichever is later.

-C- CFVMC. The service area is the Cumberland-Hoke County Acute Care Bed Service Area. The applicant is Cumberland County Hospital System, Inc., d/b/a/ Cape Fear Valley Medical System (CFVMC). As stated above, CFVMC has two campus's, one existing (Owen Drive) and one approved (CFV North). The Owen Drive campus has 490 existing acute care beds and the CFV North campus is approved for 65 acute care beds. Both of CFVMC's campus's are located in Fayetteville, Cumberland County. Hoke Healthcare, LLC, a subsidiary of Cumberland County Hospital System, Inc. d/b/a Cape Fear Valley Health System was approved in Project ID # N-8499-10 to develop 41 acute care beds in Hoke County. The third operating year following completion of the proposed 28 acute care bed project is FY2016. As of FY2016 the 65 acute care beds approved for CFVMC's CFV North campus and the 41 acute care beds approved for Hoke Healthcare, LLC are projected to be licensed.

Therefore, the total existing, approved and proposed acute care beds in the Cumberland-Hoke County Acute Care Bed Service Area under common ownership with the applicant is 624 [490 at CFRVC's Owen Drive Campus + 65 approved for CFVMC's CFV North campus + the proposed 28 for CFVMC's Owen Drive Campus + 41 approved for Hoke Healthcare, LLC.] As illustrated in the table below, the Average Daily Census (ADC) is 500.2 and the total number of existing, approved and proposed acute care beds is 624. The projected ADC in the third operating year following completion of the proposed project is greater than 200 patients. 500.2 ADC divided by 624 beds equates to 80.2% which is greater than 75.2 percent required by this rule.

C	Total Acute Care Patient Days*	182,581
D = C/365	Average Daily Census (FY2016)	500.2
E = D/0.752	# Acute Care Beds Needed at 75.2% Target Occupancy	665.2
F	Total # acute care beds (approved and proposed)	624
G	Acute Care Beds (Surplus)/Deficit	41.2

*From page 50 of the application.

-C- **FHCH.** In Section II.8, page 56, the applicant states "*FirstHealth projects that in the third year of operation, the thirty-six (36) acute care beds at FHCH will operate at 73.8 percent [(9,703 days of care) / (36 beds x 365) x 100 = 73.8%]. This calculation is derived from data in Section IV.* See Criterion (3) for discussion.

As illustrated in the table below, the Average Daily Census (ADC) is 26.58 and the total number of existing, approved and proposed acute care beds is 36. The projected ADC in the third operating year following completion of the proposed project is greater less than 100 patients. 26.58 ADC divided by 36 beds equates to 73.8% which is greater than 66.7 percent required by this rule.

C	Total Acute Care Patient Days*	9,703
D = C/365	Average Daily Census (FY2017)	26.58
E = D/0.667	# Acute Care Beds Needed at 66.7% Target Occupancy	39.86
F	Total # acute care beds (approved and proposed)	36
G	Acute Care Beds (Surplus)/Deficit	3.86

*From page 92 of the application.

(b) An applicant proposing to develop new acute care beds shall provide all assumptions and data used to develop the projections required in this rule and demonstrate that they support the projected inpatient utilization and average daily census.

-C- **CFVMC.** The applicant's assumptions and data used to develop the projections required in this Rule are provided in Section III.1(b), pages 48-54, and Exhibit 30, Tables 1-18. The applicant's assumptions regarding projected inpatient utilization and average daily census are reasonable and credible and support a finding of conformity with this rule. See Criterion (3) for a summary/overview of the assumptions and data used to develop the projections and an analysis of the reasonableness of the projections.

-C- **FHCH.** The applicant's assumptions and data used to develop the projections required in this Rule are provided in Section IV, pages 92-107. The applicant's assumptions regarding projected inpatient utilization and average daily census are reasonable and credible and support a finding of conformity with this rule. See Criterion (3) for summary/overview of the assumptions and data used to develop the projections and an analysis of the reasonableness of the projections.

10A NCAC 14C .3804 SUPPORT SERVICES

(a) An applicant proposing to develop new acute care beds shall document that each of the following items shall be available to the facility 24 hours per day, 7 days per week:

(1) laboratory services including microspecimen chemistry techniques and blood gas determinations;
(2) radiology services;
(3) blood bank services;
(4) pharmacy services;
(5) oxygen and air and suction capability;
(6) electronic physiological monitoring capability;

(7) mechanical ventilatory assistance equipment including airways, manual breathing bag and ventilator/respirator;
(8) endotracheal intubation capability;
(9) cardiac arrest management plan;
(10) patient weighing device for a patient confined to their bed; and
(11) isolation capability;

-C- **CFVMC.** Exhibit 36 contains a letter from the Chief Operating Officer (COO) of CFVHS which states that all of the items listed above will be available 24 hours per day, seven days per week at CFVMC.

-C- **FHCH.** Exhibit 24 contains a letter from the Chief Executive Officer at FirstHealth which states that all of the items listed above will be available 24 hours per day, seven days per week at the hospital.

(b) If any item in Paragraph (a) of this Rule will not be available in the facility 24 hours per day, 7 days per week, the applicant shall document the basis for determining the item is not needed in the facility.

-NA- **CFVMC** In Section II.8, page 36, the applicant states that all of the items in Paragraph (a) of this Rule will be available 24 hours per day, seven days per week.

-NA- **FHCH.** In Section II.8, page 57, and Exhibit 24, the applicant states that all of the items in Paragraph (a) of this Rule will be available 24 hours per day, seven days per week.

(c) If any item in Paragraph (a) of this Rule will be contracted, the applicant shall provide correspondence from the proposed provider of its intent to contract with the applicant.

-NA- **CFVMC.** In Section II.8, page 36, the applicant states that none of the items listed in Paragraph (a) of this Rule will be contracted.

-NA- **FHCH.** In Section II.8, pages 57-58, the applicant states that none of the items listed in Paragraph (a) of this Rule will be contracted.

10A NCAC 14C .3805 STAFFING AND STAFF TRAINING
(a) An applicant proposing to develop new acute care beds shall demonstrate that the proposed staff for the new acute care beds shall comply with licensure requirements set forth in Title 10A NCAC 13B, Licensing of Hospitals.

-C- **CFVMC.** In Section II.8, page 36, and Exhibit 43 the applicant demonstrates that the proposed staff for the new acute care needs will comply with the licensure requirements set forth in Title 10A NCAC 13B, Licensing of Hospitals.

-C- **FHCH.** In Section II.8, page 59, the applicant demonstrates that the proposed staff for the new acute care needs will comply with the licensure requirements set forth in Title 10A NCAC 13B, Licensing of Hospitals.

(b) An applicant proposing to develop new acute care beds shall provide correspondence from the persons who expressed interest in serving as Chief Executive Officer and Chief Nursing Executive of the facility in which the new acute care beds will be located, documenting their willingness to serve in this capacity.

-C- **CFVMC.** In Section II.8, page 36, the applicant identifies the two individuals who will serve as Chief Executive Officer and Chief Nursing Officer. Exhibit 36 contains letters from each individual which documents their willingness to serve in the capacities as required by this rule.

-C- **FHCH.** In Section II.8, page 59, the applicant identifies the two individuals who will serve as Chief Executive Officer and Interim Chief Nurse Officer. Exhibit 25 contains letters from each individual which documents their willingness to serve in the capacities as required by this rule.

(c) An applicant proposing to develop new acute care beds in a new hospital or on a new campus of an existing hospital shall provide a job description and the educational and training requirements for the Chief Executive Officer, Chief Nursing Executive and each department head which is required by licensure rules to be employed in the facility in which the acute care beds will be located.

-NA- **CFVMC**. CFVMC does not propose to develop new acute care beds in a new hospital or on a new campus of an existing hospital

-NA- **FHCH.** FHCH does not propose to develop new acute care beds in a new hospital or on a new campus of an existing hospital

(d) An applicant proposing to develop new acute care beds shall document the availability of admitting physicians who shall admit and care for patients in each of the major diagnostic categories to be served by the applicant.

-C- **CFVMC.** In Section II.8, page 37, Section VII.8.b., pages 102-103, and Exhibits 23 and 36, the applicant provides approximately 230 letters from physicians documenting the availability of admitting physicians who will admit and care for patients in each of the major diagnostic categories to be served at CFVMC.

-C- **FHCH.** In Exhibit 44 the applicant provides approximately 80 letters from physicians documenting the availability of admitting physicians who will admit and care for patients in each of the major diagnostic categories to be served at FHCH.

(e) An applicant proposing to develop new acute care beds shall provide documentation of the availability of support and clinical staff to provide care for patients in each of the major diagnostic categories to be served by the applicant.

-C- **CFVMC.** In Sections VII.1 and VII.8, and Exhibit 36, which includes a letter from the COO of CFVHS, the applicant provides documentation of the availability of

support and clinical staff to provide care for patients in each of the major diagnostic categories to be served at CFVMC.

-C- **FHCH.** See Section II.8, pages 60-63, and Section VII, pages 145-157, the applicant provides documentation of the availability of support and clinical staff to provide care for patients in each of the major diagnostic categories to be served at FHCH.

SECTION .1200 – CRITERIA AND STANDARDS FOR INTENSIVE CARE SERVICES

These rules apply only to FirstHealth, which proposes to develop new intensive care unit (ICU) beds.

10A NCAC 14C .1202 INFORMATION REQUIRED OF APPLICANT

(a) An applicant that proposes new or expanded intensive care services shall use the Acute Care Facility/Medical Equipment application form.

-C- FirstHealth used the Acute Care Facility/Medical Equipment application form.

(b) An applicant proposing new or expanded intensive care services shall submit the following information:

(1) the number of intensive care beds currently operated by the applicant and the number of intensive care beds to be operated following completion of the proposed project;

-C- In Section II.8, page 39, FHCH provides a table showing that FirstHealth currently operates 62 ICU beds: 50 at FMRH and 12 at FRMH. The applicant proposes to develop 4 ICU beds in the new hospital.

(2) documentation of the applicant's experience in treating patients at the facility during the past twelve months, including:

(A) the number of inpatient days of care provided to intensive care patients;

(B) the number of patients initially treated at the facility and referred to other facilities for intensive care services; and

(C) the number of patients initially treated at other facilities and referred to the applicant's facility for intensive care services.

-NA- FHCH is not an existing facility but is approved to develop eight acute care beds as part of Project ID #N-8497-10.

(3) the projected number of patients to be served and inpatient days of care to be provided by county of residence by specialized type of intensive care for each of the first twelve calendar quarters following completion of the proposed project, including all assumptions and methodologies;

-C- In Section II.8, page 40, the applicant provides tables showing the projected number of patients to be served and inpatient days of care to be provided by county of residence for the four proposed ICU beds for each of the first twelve calendar quarters following completion of the proposed project. The applicant’s assumptions and methodology are discussed in Section IV, pages 92-107.

Projected ICU Admissions

County	PY1	PY2	PY3
Cumberland	14	19	24
Hoke	79	104	130
Robeson	43	56	70
Scotland	16	22	27
Total	152	201	252

Projected ICU Patient Days of Care

County	PY1	PY2	PY3
Cumberland	53	71	88
Hoke	292	386	482
Robeson	158	209	261
Scotland	61	80	100
Total	564	745	932

(4) data from actual referral sources or correspondence from the proposed referral sources documenting their intent to refer patients to the applicant's facility;

-C- Exhibit 44 contains copies of 74 letters from physicians documenting their intent to refer patients to the proposed facility.

(5) documentation which demonstrates the applicant's capability to communicate effectively with emergency transportation agencies;

-C- Exhibit 9 contains a copy of a letter documenting FHCH's capability to communicate effectively with emergency transportation agencies.

(6) documentation of written policies and procedures regarding the provision of care within the intensive care unit, which includes the following:
(A) the admission and discharge of patients;
(B) infection control;
(C) safety procedures; and
(D) scope of services.

-C- Exhibit 10 contains copies of the listed ICU policies and procedures.

(7) documentation that the proposed service shall be operated in an area organized as a physically and functionally distinct entity, separate from the rest of the facility, with controlled access;

-C- Exhibit 11 contains a letter documenting that ICU services will be operated in an area organized as a physically and functionally distinct entity, separate from the rest of the facility, with controlled access.

(8) documentation to show that the services shall be offered in a physical environment that conforms to the requirements of federal, state, and local regulatory bodies;

-C- Exhibit 12 contains a letter documenting that the services will be offered in a physical environment that conforms to the requirements of federal, state, and local regulatory bodies.

(9) a floor plan of the proposed area drawn to scale; and

-C- Exhibit 14 contains a floor plan.

(10) documentation of a means for observation by unit staff of all patients in the unit from at least one vantage point.

-C- In Section II.8, page 41, the applicant states, *"Please refer to Exhibit 13 for a floor plan showing observation by unit staff of all patients in the unit from at least one vantage point."*

10A NCAC 14C .1203 PERFORMANCE STANDARDS

(a) The applicant shall demonstrate that the proposed project is capable of meeting the following standards:

(1) the overall average annual occupancy rate of all intensive care beds in the facility, excluding neonatal and pediatric intensive care beds, over the 12 months immediately preceding the submittal of the proposal, shall have been at least 70 percent for facilities with 20 or more intensive care beds, 65 percent for facilities with 10-19 intensive care beds, and 60 percent for facilities with 1-9 intensive care beds; and

-NA- FHCH is not an existing facility but is approved to develop eight acute care beds as part of Project ID #N-8497-10.

(2) the projected occupancy rate for all intensive care beds in the applicant's facility, exclusive of neonatal and pediatric intensive care beds, shall be at least 70 percent for facilities with 20 or more intensive care beds, 65 percent for facilities with 10-19 intensive care beds, and 60 percent for facilities with 1-9 intensive care beds, in the third operating year following the completion of the proposed project.

-C- In Section II.8, page 42, the applicant states FHCH will provide 932 patient days in the proposed 4-bed ICU in the third operating year (FY2017), for a projected occupancy rate of 63.8 percent. See Criterion (3) for discussion.

(b) All assumptions and data supporting the methodology by which the occupancy rates are projected shall be provided.

-C- The applicant's assumptions and data supporting the methodology by which the occupancy rates were determined are provided in Section IV, pages 92-107. See Criterion (3) for discussion.

10A NCAC 14C .1204 SUPPORT SERVICES

(a) An applicant proposing new or additional intensive care services shall document the extent to which the following items are available:

(1) twenty-four hour on-call laboratory services including microspecimen chemistry techniques and blood gas determinations;
(2) twenty-four hour on-call radiology services, including portable radiological equipment;
(3) twenty-four hour blood bank services;
(4) twenty-four hour on-call pharmacy services;
(5) twenty-four hour on-call coverage by respiratory therapy;
(6) oxygen and air and suction capability;
(7) electronic physiological monitoring capability;
(8) mechanical ventilatory assistance equipment including airways, manual breathing bag and ventilator/respirator;
(9) endotracheal intubation capability;
(10) cardiac pacemaker insertion capability;
(11) cardiac arrest management plan;
(12) patient weighing device for bed patients; and
(13) isolation capability.

-C- Exhibit 14 contains a letter from the Chief Executive Officer at FirstHealth documenting FHCH's ability to provide "*all of the previously identified support services.*"

(b) If any item in Subparagraphs (a)(1) - (13) of this Rule will not be available, the applicant shall document the reason why the item is not needed for the provision of the proposed services.

-C- In Section II.8, page 43, the applicant states "*Cardiac pacemaker insertion will be available based on the order of the on-call cardiologist. Either the on-call cardiologist or the Emergency Department physician may insert the cardiac pacemaker. It may also be necessary for the ICU clinical staff to utilize the LifePak for transcutaneous pacing if immediate pacemaker insertion is unavailable and arrangement will be made to transfer the patient as required. This is the same policy utilized at FMRH, which also offers general intensive care beds.*"

10A NCAC 14C .1205 STAFFING AND STAFF TRAINING

The applicant shall demonstrate the ability to meet the following staffing requirements:

(1) nursing care shall be supervised by a qualified registered nurse with specialized training in the care of critically ill patients, cardiovascular monitoring, and life support;

-C- Exhibit 15 contains the job description for ICU registered nurses.

(2) direction of the unit shall be provided by a physician with training, experience and expertise in critical care;

-C- In Section II.8, page 44, the applicant states "*Please refer to Exhibit 15 for the ICU Medical Director Agreement which identifies the required training, experience, and expertise needed to act as a medical director, specifically listed under 3.a.ii.*"

(3) assurance from the medical staff that twenty-four hour medical and surgical on-call coverage is available; and

-C- Exhibit 16 contains a letter from the FirstHealth Chief of Staff indicating that twenty-four hour medical and surgical on-call coverage will be extended to FHCH.

(4) inservice training or continuing education programs shall be provided for the intensive care staff.

-C- Exhibit 17 contains copies of the in-service training and continuing education programs available to the intensive care staff. Exhibit 218 contains a letter from the Chief Executive Officer at FirstHealth documenting that the regulations in 10A NCAC 14C.1205 will be meet at FHCH.

COMPARATIVE ANALYSIS

Pursuant to G.S. 131E-183(a)(1) and the 2012 SMFP, no more than 28 additional acute care beds may be approved for the Cumberland Hoke Multi-County Acute Care Bed Service Area. Because the two applications in this review propose a total of 56 additional acute care beds, both of the applications cannot be approved. Therefore, after considering all of the information in each application and reviewing each application individually against all applicable statutory and regulatory review criteria, the Project Analyst also conducted a comparative analysis of the proposals.

For the reasons set forth below and in the remainder of the findings, the application submitted by FirstHealth is approved and the application submitted by CFVMC is disapproved.

Geographic Accessibility

The 2012 SMFP identifies a need for 28 acute care beds for the Cumberland Hoke Multi-County Acute Care Bed Service Area. The 2012 SMFP need determination does not indicate where in either of those counties the beds should be located. The following table identifies the location of the existing and approved acute care beds in the Cumberland Hoke Multi-County Acute Care Bed Service Area.

CUMBERLAND COUNTY

Facility	Existing/ Approved Acute Care Beds	Location Within the Cumberland Hoke Multi-County Acute Care Bed Service Area	City/Town
CFVMC's Owen Drive Campus	490	Cumberland County- Central	Fayetteville-South
CFVMC's CFV North Campus	65	Cumberland County- North	Fayetteville- North
Cumberland County – Total	**555**		

HOKE COUNTY

Facility	Existing/ Approved Acute Care Beds	Location Within the Cumberland Hoke Multi-County Acute Care Bed Service Area	City/Town
Hoke Community Medical Center	41	Hoke County - Central/East	McLauchlin Township
FHCH	8	Hoke County- Central/East	McLauchlin Township
Hoke County- Total	**49**		

The following tables identifies the location of the acute care beds proposed to be developed in this review.

CUMBERLAND COUNTY

Facility	Proposed Acute Care Beds	Location Within the Cumberland Hoke Multi-County Acute Care Bed Service Area	City/Town
CFVMC's Owen Drive Campus	28	Cumberland County- Central	Fayetteville-South
Cumberland County- Total	28		

HOKE COUNTY

Facility	Proposed Acute Care Beds	Location Within the Cumberland Hoke Multi-County Acute Care Bed Service Area	City/Town
FHCH*	28	Hoke County- Central/East	McLauchlin Township
Hoke County- Total	28		

CFVMC proposes developing the 28 new acute care beds at its Owen Drive Campus in central Cumberland County. FirstHealth proposes developing the 28 new acute care beds on the same site as its approved 8-bed acute care hospital, FHCH, in Hoke County. As illustrated in the table above, there are already 555 existing or approved acute care beds in Cumberland County and only 49 approved acute care beds in Hoke County. Four hundred and ninety (490) of the acute care beds are located in Fayetteville at 1638 Owen Drive, Fayetteville. Sixty Five (65) of the acute care beds are approved to be developed about 12 miles north and slightly west of the 490 beds at 6387 Ramsey Street, Fayetteville. Forty nine (49) of the beds are located at two locations (HCMC and FHCH) in eastern Hoke County due west of CFVMC's Owen Drive Campus a few miles over the Cumberland/Hoke County line on the major transportation corridor (US Highway 401) from Fayetteville to Hoke County.

In FY2016 the population of Hoke County is projected to be 55,471 and the population of Cumberland County is projected to be 337,612. There are currently 49 acute care beds approved for Hoke County and 555 existing or approved acute care beds in Cumberland County. This equates to a ratio of 1 acute care bed to every 1,132 people in Hoke County [55,471 / 49 = 1,132.06] and a ratio of 1 acute care bed to every 608 people in Cumberland County [337,612 / 555 = 608.3]. If the 28 acute care beds are awarded to FHCH this would raise the total number of approved beds in Hoke County to 77 for a ratio of 1 acute care bed to every 720 people in Hoke County [555,471 / 77 = 720.4]. It should be noted that both Hoke County hospitals propose serving significant numbers of residents from contiguous counties, notably Cumberland. With regard to improving geographic access to the proposed services, the FHCH application is determined to be more effective than the CFVMC application.

Access by Underserved Groups

The following tables show the average inpatient utilization (admissions) for acute general hospitals by payer category for North Carolina and Cumberland County. (The data includes normal newborns.) Hoke County does not have an existing hospital. For North Carolina, data are based on 1,113,423 inpatient admissions. For Cumberland County, data are based on 35,956 inpatient admissions.

North Carolina Hospital Admissions by Payer Category-FY2009

Payer Category	Percent of Total
Commercial/HMO	32.9%
Medicare	36.0%
Medicaid	21.9%
Other	3.1%
Uninsured	6.1%
Total	**100.0%**

Source: Cecil B. Sheps Center for Health Services Research

Cumberland County Hospital Admissions by Payer Category-FY2009

Payer Category	Percent of Total
Commercial/HMO	20.4%
Medicare	35.7%
Medicaid	29.8%
Other-Gov.	8.0
Other	0.2%
Uninsured	6.0%
Total	**100.0%**

Source: Cecil B. Sheps Center for Health Services Research

The following table shows each applicant's projected percentage of hospital services to be provided to Medicaid and Medicare Inpatient Acute Care Service recipients in the second year following completion of the project.

Inpatient Acute Care Services

Applicant	Projected Percentage of Services to be Provided to Medicare Recipients	Projected Percentage of Services to be Provided to Medicaid Recipients
CFVMC	51.2%	24.6%
FHCH	51.0%	10.4%

With regard to access by Medicaid recipients, CFVMC projects the higher percentage of total services to be provided to Medicaid recipients and FHCH projects the lowest percentage of total services to be provided to Medicaid recipients. The Project Analyst notes that CFVMC-Owen Drive Campus offers obstetrical services, a service which often has a high percentage of Medicaid recipients. In contrast, obstetrical services will not be offered at FHCH. With regard to access by Medicare recipients both applicants are comparable.

Demonstration of Need

CFVMC adequately demonstrates the need for all components of its proposal based on projected utilization which is based on reasonable, credible and supported assumptions. See Criterion (3) for discussion.

FHCH adequately demonstrates the need for all components of its proposal based on projected utilization which is based on reasonable, credible and supported assumptions. See Criterion (3) for discussion.

Therefore, the applications submitted by CFVMC and FHCH, with regard to demonstration of need for the proposed services, are equally effective alternatives.

Financial Feasibility

CFVMC adequately demonstrated that the financial feasibility of its proposed project is based upon reasonable projections of costs and revenues. See Criterion (5) for discussion.

FHCH adequately demonstrated that the financial feasibility of its proposed project is based upon reasonable projections of costs and revenues. See Criterion (5) for discussion. Therefore, with regard to financial feasibility, the applications submitted by CFVMC and FHCH are equally effective alternatives.

Competition

CFVMC- Cumberland County Hospital System, Inc., d/b/a/ Cape Fear Valley Medical System (CFVMC) and its subsidiaries currently control 596 of the 604 existing or approved acute care beds in the Cumberland-Hoke Multi-County Acute Care Bed Service Area. If CFVMC's proposed project to develop the 28 new acute care beds at CFVMC's Owen Drive Campus is approved Cumberland County Hospital System, Inc. and its subsidiaries will control 624 of the 632 existing or approved acute care beds in the Cumberland-Hoke Multi-County Acute Care Bed Service Area. FirstHealth currently controls 8 of the 604 existing or approved acute care beds in the Cumberland-Hoke Multi-County Acute Care Bed Service Area. If FirstHealth's proposed project to develop the 28 acute care beds at its approved 8 acute care bed hospital, FHCH, in Hoke County FirstHealth will control 36 of the 632 existing or approved acute care beds in the Cumberland-Hoke Multi-County Acute Care Bed Service Area. Therefore, with regard to competition, the application submitted by FirstHealth is the most effective alternative.

Coordination with the Existing HealthCare System

CFVMC and FirstHealth are existing providers with established relationships with physicians and area healthcare providers. Both applications demonstrated that the proposed services would be coordinated with the existing healthcare system. See Criterion (8) for discussion. Therefore, both applications are equally effective alternatives with regard to coordination with the existing health care system.

COMMUNITY SUPPORT

In its application, CFVMC provided in excess of 2,600 letters of support from: 1) physicians; 2) other health care providers; 3) area businesses; 4) local and State government officials; and 5) residents of the proposed service area. See Exhibits 2, 24, 25, 26 and 27. Most

(2,000) of the letters are from Cumberland County ZIP codes associated with Fayetteville [28301, 28303, 28304, 28305, 28306] During the public comment period, the CON Section received 248 additional letters of support from residents of the proposed service area. Community support for HCMC's proposal was also expressed at the public hearing.

In its application, FHCH provided in excess of 1,500 letters and emails of support from: 1) physicians; 2) other health care providers; 3) area businesses and community organizations; 4) local government officials; and 5) residents of the proposed service area. See Exhibits 44, 45 and 46. Most of the letters are from Hoke County (52%) with Cumberland (34%) and Robeson (12%). During the public comment period, the CON Section received additional letters of support from residents of the proposed service area. Community support for FHCH's proposal was also expressed at the public hearing.

Both applications demonstrated that the respective proposals have significant community support. Therefore, both applications are equally effective alternatives with regard to community support.

Revenues

The following table shows the gross revenue per inpatient day for the third operating year for each applicant. Gross revenue and inpatient days are taken from Form B, Form C, and the applications.

Gross Revenue Comparison - Third Year of Operation

Applicant	Gross Revenue	In-Patient Days	Gross Revenue Per In-Patient Day
CFVMC	$3,428,510,000	158,664	$21,608.00
FHCH	$91,618,769	9,703	$9,442.00

As shown in the table above, FHMC projects lower gross revenue per inpatient day than CFVMC in the third full fiscal year of operation. However, CFVMC is a tertiary hospital and FHCH is a community hospital. A tertiary hospital offers more services and handles patients with greater levels of acuity as compared to a community hospital. Due to the differences in the two projects, it is not possible to make conclusive comparisons of the two applications with regard to gross revenue per inpatient day.

The following table shows the net revenue per inpatient day for the third operating year for each applicant. Net revenue and inpatient days are taken from Form B, Form C, and the applications.

Net Revenue Comparison - Third Year of Operation

Applicant	Net Revenue	In-Patient Days	Net Revenue Per

			Patient Day
CFVMC	$826,089,000	158,664	$5,206.00
FHCH	$28,992,439	9,703	$2,987.00

As shown in the table above, FHMC projects lower net revenue per inpatient day than CFVMC in the third full fiscal year of operation. However, CFVMC is a tertiary hospital and FHCH is a community hospital. A tertiary hospital offers more services and handles patients with greater levels of acuity as compared to a community hospital. Due to the differences in the two projects, it is not possible to make conclusive comparisons of the two applications with regard to gross revenue per inpatient day.

Operating Expenses

The following table shows the operating costs (expenses) per inpatient day for the third operating year for each applicant. Operating costs are taken from Form B, Form C, and the applications.

Operating Costs Comparison - Third Year of Operation

Applicant	**Operating Costs**	**In-Patient Days**	**Operating Costs Per In-Patient Day**
CFVMC	$849,307,000	158,664	$5,352.00
FHCH	$25,255,219	9,703	$2,602.00

As shown in the table above, FHMC projects lower operating costs per inpatient day than CFVMC in the third full fiscal year of operation. However, CFVMC is a tertiary hospital and FHCH is a community hospital. A tertiary hospital offers more services and handles patients with greater levels of acuity as compared to a community hospital. Due to the differences in the two projects, it is not possible to make conclusive comparisons of the two applications with regard to operating costs per inpatient day.

Quality

CFVMC has did not adequately demonstrate that it would provide quality care. In contrast, FHCH did adequately demonstrate that it would provide quality care. See discussion in Criterion (20) which is incorporated hereby as if fully set forth herein. Therefore, with regard to quality of care, the application submitted by FHCH is a more effective alternative than the application submitted by CFVMC.

CONCLUSION

Both of the applications are individually conforming to the need determination in the 2012 SMFP for 28 acute care beds in the Cumberland-Hoke Multi-County Acute Care Bed Service Area. However, G.S.131E 183(a)(1) states that the need determination in the SMFP is the determinative limit on the number of acute care beds that can be approved by the Certificate of Need Section. The Certificate of Need Section determined that the application submitted by FirstHealth is the most effective alternative proposed in this review for the development of 28 new acute care beds in the Cumberland-Hoke Multi-County Acute Care Bed Service Area and is approved. The approval of any other application would result in the approval of acute care beds in excess of the need determination in the Cumberland-Hoke Multi-County Acute Care Bed Service Area, and therefore, the competing application of CFVMC is denied. Furthermore, the CON Section determined that the application submitted by CFVMC is not approvable standing alone.

The application submitted by FirstHealth is approved subject to the following conditions:

1. **FirstHealth of the Carolinas, Inc. shall materially comply with all representations made in the certificate of need application, as revised by the conditions of approval.**

2. **FirstHealth of the Carolinas, Inc. shall develop 28 new acute care beds (24 general acute care beds and 4 ICU beds) at FirstHealth Hoke Community Hospital. Upon completion of this project and Project I.D. #N-8497-10 (FHCH 8 bed hospital), FMRH shall be licensed for no more than 36 acute care beds (32 general acute care beds and 4 ICU beds) and 4 observation beds.**

3. **FirstHealth of the Carolinas, Inc. shall not develop any additional observation beds beyond what was approved in Project I.D. #N-8497-10 (FHCH 8 bed hospital).**

4. **FirstHealth of the Carolinas, Inc. 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 that would otherwise require a certificate of need.**

5. **FirstHealth of the Carolinas, Inc. shall acknowledge acceptance of and agree to comply with all conditions stated herein to the Certificate of Need Section, in writing prior to issuance of the certificate of need.**

EXHIBIT E

Atrium Health

October 1, 2018

Ms. Julie Faenza, Project Analyst
Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
N.C. Department of Health & Human Services
809 Ruggles Dr.
Raleigh, NC 27603

Dear Ms. Faenza:

I have attached a copy of Carolinas HealthCare System Pineville's first progress report for developing no more than 15 additional beds for a total of no more than 221 acute care beds (**Project I.D. #F-11361-17, FID #110878**).

Should you have any questions or need additional information, please do not hesitate to call me at 704-446-2070.

Sincerely,

Brighid K Huber

Brighid Huber, Management Associate II
Atrium Health Strategic Services Group

CERTIFICATE OF NEED
PROGRESS REPORT FORM

County:	**Mecklenburg**	Date of Progress Report:	**10/01/18**
Facility:	**Carolinas HealthCare System Pineville**	Facility I.D. #:	**110878**
Project I.D.#:	**F-11361-17**	Effective Date of Certificate:	**06/07/18**

Project Description: **Develop no more than 15 additional acute care beds for a total of no more than 221 acute care beds / Mecklenburg County**

A. Status of the Project

1. Describe in **detail** the **steps taken** to complete the project since the CON was issued or since the last progress report was submitted. **Inadequate responses to this question will result in the certificate holder being asked to redo the progress report.**
   Construction is complete, and documentation has been sent to DHSR for approval.

2. Identify all changes to this project approved after the issuance of the certificate, including:

   a. Cost Overruns and/or Changes of Scope (Include the Project ID #'s);
   b. Material Compliance determinations; and
   c. Declaratory Rulings

3. If the project is not going to be developed exactly as approved (including the previously approved changes identified in #2 above), describe all differences between the project as approved and the project as currently proposed. Such changes include, but are not limited to, changes in the

   a. Site;
   b. Design of the facility;
   c. Number or type of beds to be developed;
   d. Medical equipment to be acquired;
   e. Proposed charges; and
   f. Capital cost of the project.

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

B. Timetable

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

2. **Are you requesting a timetable extension**? [] Yes [X] No If the answer is **yes**, enter your proposed completion dates in the third column of the table below. **Proposed completion dates are contingent upon Agency approval.**

3 Explain **the reason(s) for the delay in development**:

Project Milestones	Projected Completion Date from Certificate	Actual Completion Date	Proposed Completion Date*
	mm/dd/yyyy	mm/dd/yyyy	mm/dd/yyyy
Financing for Project Obtained			
Schematics (i.e., Drawings) Completed	**07/15/2018**	**07/15/2018**	
Land Acquired			
Construction / Renovation Contract(s) Executed	**07/31/2018**	**07/31/2018**	
25% of Construction / Renovation Completed (25% of the cost is in place)	**08/15/2018**	**08/15/2018**	
50% of Construction / Renovation Completed	**08/31/2018**	**08/20/2018**	
75% of Construction / Renovation Completed	**09/15/2018**	**08/31/2018**	
Construction / Renovation Completed	**09/30/2018**	**09/14/2018**	
Equipment Ordered	**08/01/2018**	**08/01/2018**	
Equipment Installed	**09/15/2018**	**09/15/2018**	
Equipment Operational	**09/30/2018**	**09/21/2018**	
Building / Space Occupied	**10/01/2018**		
Licensure Obtained	**10/01/2018**		
Services Offered	**10/01/2018**		
Medicare and / or Medicaid Certification Obtained	**10/01/2018**		
Facility or Service Accredited	**10/01/2018**		
Final Annual Report Due	**01/01/2022**		

*Proposed completion dates are contingent upon Agency approval

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

D. Capital Expenditure

1. What is the total approved capital cost of the project indicated on the certificate of need? **$1,115,000.00**
2. Complete the table below and provide supporting documentation, which may include:
   a. Copies of executed contracts and purchase orders. If you previously provided them, you do not need to provide another copy.

   b. If applicable, copies of the Contractors Application for Payment [AIA G702] with Schedule of Values [AIA G703].

	Capital Expense Since Last Report	Total Cumulative Capital Expenditure
Purchase Price of Land	**$0.00**	**$0.00**
Closing Costs	**$0.00**	**$0.00**
Site Preparation	**$0.00**	**$0.00**
Construction/Renovation Contract(s)	**$2,355.50**	**$2,355.50**
Landscaping	**$0.00**	**$0.00**
Architect / Engineering Fees	**$4,500.00**	**$4,500.00**
Medical Equipment	**$0.00**	**$0.00**
Non-Medical Equipment	**$0.00**	**$0.00**
Furniture	**$0.00**	**$0.00**
Consultant Fees (CON fees, legal fees)	**$310,090.42**	**$310,090.42**
Financing Costs	**$0.00**	**$0.00**
Interest during Construction	**$0.00**	**$0.00**
Other (IS, Security, Internal Allocation)	**$652.66**	**$652.66**
Total Capital Cost	**$317,598.58**	**$317,598.58**

3. What is the projected remaining capital expenditure required to complete the project? **$797,401.42**
4. Will the total actual capital cost of the project exceed 115% of the approved capital expenditure on the certificate of need? If yes, explain the reasons for the difference.
   This project is not expected to exceed 115% of the approved capital expenditure of $1,115,000

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

Signature:	Elizabeth V. Kirkman
Name and Title	**Elizabeth V. Kirkman, Assistant Vice President**
Telephone Number	**704-446-8475**
Email Address	**Elizabeth.Kirkman@atriumhealth.org**