Comments on Competing Applications for Additional Acute Care Beds in Wake County

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submitted by

UNC Health Rex Hospital, Inc.

In accordance with N.C. GEN. STAT. § 131E-185(a1)(1), Rex Hospital, Inc. d/b/a UNC Health Rex Hospital (UNC Health Rex) hereby submits the following comments related to competing applications to develop additional acute care beds to meet the need identified in the *2023 State Medical Facilities Plan* (*2023 SMFP*) for 44 additional acute care beds in Wake County. UNC Health Rex's comments on these competing applications include "discussion and argument regarding whether, in light of the material contained in the application and other relevant factual material, the application complies with the relevant review criteria, plans and standards."[1] *See* N.C. GEN. STAT. § 131E-185(a1)(1)(c). To facilitate the Agency's review of these comments, Rex has organized its discussion by issue, noting some of the general Certificate of Need (CON) statutory review criteria and specific regulatory criteria creating the non-conformity on the application. Rex's comments relate to the following applications:

- **Duke Raleigh Hospital (DRAH, Duke), Add 41 acute care beds by converting 29 observation beds to acute beds and developing a new 12-bed inpatient unit, Project ID # J-012412-23**
- **WakeMed North Hospital (WakeMed North), Develop a 5-story tower with 35 acute care beds and 15 observation beds, Project ID # J-012419-23**
- **WakeMed Cary Hospital (WakeMed Cary), Add 9 acute care beds by converting 9 observation beds to acute beds, Project ID # J-012418-23**

Given the number of applications and proposed acute care beds, all the applications cannot be approved. UNC Health Rex's detailed comments include application-specific comments related to each competing application and a comparative analysis relative to its application.

UNC Health Rex has a longstanding demonstrated commitment to developing projects that increase geographic and financial accessibility to healthcare services, feature physician collaboration, and provide cost-effective and efficient patient care services. As detailed in its application, UNC Health Rex believes that the most appropriate way to meet the need for 44 acute care beds in Wake County identified in the *2023 SMFP* is to develop 44 acute care beds at UNC Health Rex Hospital. The UNC Health Rex application is the result of prudent healthcare planning to provide greater access to tertiary acute care beds in Wake County that serve the growing need for specialized medical and surgical care.

[1] UNC Health Rex is providing comments consistent with this statute; as such, none of the comments should be interpreted as an amendment to the applications filed on August 15, 2023 by UNC Health Rex (Project ID # J-012417-23).

ISSUE-SPECIFIC COMMENTS ON DUKE RALEIGH HOSPITAL

Duke's application to expand acute care capacity at the Duke Raleigh campus by converting 29 observation beds to licensed acute beds and adding a new 12-bed nursing unit should not be approved. The Duke application contains multiple errors, omissions, and inconsistencies as well as insufficient responses to the Certificate of Need application form. Please note that relative to each issue, UNC Health Rex has identified the statutory review criteria and specific regulatory criteria and standards creating the non-conformity. The following issues result in areas of non-conformity for the Duke Raleigh application:

1. The Duke application does not sufficiently document project capital costs.

   In its Form F.1a capital cost assumptions (page 118), Duke references Exhibit K.3 for a letter from the project architect documenting the capital costs associated with implementation of the proposed 12 additional acute care beds. The response to Question K.3a also references Exhibit K.3 for documentation from the project architect regarding the project's cost and verification that the project represents the most efficient manner of construction. The exhibits provided by DRAH do not include Exhibit K.3 in the table of contents, nor do they appear to provide any letter from the project architect with the line drawings included in Exhibit K.2. Without this documentation, Duke does not demonstrate that the least costly or most effective alternative was chosen, nor that the proposed construction represents the most reasonable alternative.

   Accordingly, the Duke application is non-conforming with Criteria 4 and 12.

2. The Duke application omits project depreciation expenses.

   Duke fails to provide any depreciation expense for the proposed project. While the assumptions for Form F.3b do not include any assumption for depreciation, the annual depreciation for equipment is $357,143, which starts in the interim years (i.e., prior to development of the proposed project), and thus is based on Duke's 2022 project to add beds. While it is appropriate for Duke to include depreciation for that previously approved project, it is inconsistent and erroneous to omit depreciation for the proposed project, which similarly involves capital costs for both construction and equipment costs. Based on the capital costs for the project, it will generate $417,167 and $214,286 in annual expenses for building depreciation (30 years) and equipment depreciation (seven years), respectively. Thus, Duke has failed to include over $600,000 in expenses for each project year, understating its expenses.

   While Duke does use its system financial statements to demonstrate financial feasibility, Criterion 5 also requires applicants to base their financial projections on reasonable assumptions of costs, which Duke has clearly failed to do.

   As such, the Duke application is non-conforming with Criterion 5. Moreover, its failure to include these expenses means that it cannot be meaningfully compared with the other applications in the comparative analysis.

3. Duke's application fails to sufficiently respond to Section D regarding its proposed reduction of services.

Duke states in Question D.2a on page 55 that its proposed project does not represent a reduction or elimination of services. However, as described in Section C.1 on page 28, the Duke project will convert 29 existing observation beds to licensed acute care beds, with no corresponding development that will maintain the current observation patient capacity. This response is not consistent with previous Duke acute bed applications that involved the conversion of observation beds to licensed acute beds. In its 2022 Wake County acute beds application,[2] Duke stated on page 54 that the proposed project would eliminate 45 observation beds as a result of "deploying space currently used for observation patients for the proposed incremental inpatient bed capacity." The previously approved project then responds to the inquiry under Criterion 3a by explaining how it intends to continue serving patients who had historically been served in the observation beds it was eliminating. In contrast, while the scope of the current Duke application mirrors its 2022 application, there is no explanation for this diverging response to the question in its subsequent application. In fact, while the impact on observation beds is the same, Duke provides opposite responses to Section D.2, stating in the current application that this proposed reduction in observation beds is not a reduction in that service component. By claiming that its project does not represent a reduction or elimination of services, Duke fails to provide an adequate response and does not demonstrate that the needs of its patient population will continue to be met by this reduction in observation bed capacity, nor does Duke address the effect of this reduction on accessibility and the impact on underserved populations in need of care.

Accordingly, the Duke application is non-conforming with Criterion 3a, and should not be approved.

[2] Project ID # J-12263-22

ISSUE-SPECIFIC COMMENTS ON WAKEMED NORTH HOSPITAL

WakeMed North's application to develop a bed tower that will add 35 new acute care beds and 15 observation beds should not be approved. WakeMed's application contains numerous errors, overstatements, and inconsistencies. UNC Health Rex has grouped the errors, overstatements, inconsistencies, and insufficiencies by issue, each of which contributes to WakeMed's non-conformity.

Each of the issues listed above is discussed in turn. Please note that relative to each issue, UNC Health Rex has identified the statutory review criteria and specific regulatory criteria and standards creating the non-conformity.

1. <u>WakeMed provides overstated and unreasonable utilization projections.</u>

   Criterion 3 requires an applicant to "identify the population served by the proposed project, and… demonstrate the need that this population has for the services proposed…"[3] This includes a reasonable projection of volumes for not only the proposed facility, but for all facilities in the applicant's system that provide similar services (in this instance, acute inpatient care services). WakeMed simply fails to provide credible utilization projections for all its existing, approved, and proposed facilities in its application. Form C.1 of WakeMed's application contains multiple inaccuracies and inconsistent information, specifically based upon its calculation of inpatient utilization at WakeMed Raleigh Hospital. This error results in overstated and unreasonable utilization projections for the entire WakeMed system in Form C.1b. An explanation of these inaccuracies follows.

   Failure to account for projected shifts to WakeMed Garner

   According to Assumption 'm' on page 187, WakeMed calculates discharges at the WakeMed Raleigh Campus by starting with an annualized base year of FY 2023 that then increases at an annual growth rate of 1.39 percent, equal to Wake County's projected population compound annual growth rate ("CAGR"). A portion of discharges are then shifted from WakeMed Raleigh to WakeMed North to calculate discharges after shift (Assumptions 'n' and 'o'). However, in its calculations for WakeMed Raleigh, the application fails to include the shift of discharges to its approved acute care facility in Garner, which as a result overstates the discharge volume at the Raleigh campus. In its approved Garner hospital application (Project ID # J-12264-22), WakeMed calculated that over 1,400 discharges at WakeMed Raleigh would shift to its Garner campus in the first project year, increasing to 1,958 discharges in Project Year 3, as shown in the following table:

[3] As defined in North Carolina G.S 131E-183(a)(3).

Table Q-2c

Projected WakeMed Acute Care Bed Utilization with WakeMed Garner

	Projected Status Quo			Projected w/ Garner			Shifted Admissions		
	FY 2027	FY 2028	FY 2029	FY 2027	FY 2028	FY 2029	FY 2027	FY 2028	FY 2029
WakeMed Raleigh Campus									
Admissions*	34,218	34,563	34,911	32,780	32,871	32,953	(1,438)	(1,692)	(1,958)
Patient Days	179,492	181,301	183,127	171,950	172,423	172,857			
ADC (Calculated)	491.8	496.7	501.7	471.1	472.4	473.6			
Acute Care Beds (licensed)**	587	587	587	565	565	565			
ALOS	5.2	5.2	5.2	5.2	5.2	5.2			
% Occupancy (licensed)	**83.8%**	**84.6%**	**85.5%**	**83.4%**	**83.6%**	**83.8%**			

Source: Project ID # 12264-22, p. 192.

In its current application, the total discharges at WakeMed Garner shown in the WakeMed System utilization volume table[4] match the total at the Garner facility shown in its 2022 acute beds application, consistent with the previously approved application. However, completely inconsistent with its prior application, the current application fails to reduce the WakeMed Raleigh Campus discharges to reflect the projected shift to WakeMed Garner. Consequently, WakeMed has double counted these patients which results in significantly overstated volume projections at WakeMed Raleigh Campus, as calculated below.

WakeMed Raleigh Campus Overstated Discharge Volume

	FY 27	***FY 28***	***FY 29***	***FY 30***
Discharge Variance*	1,438	1,692	1,958	1,985
Average Length of Stay	5.76	5.76	5.76	5.76
Patient Days of Care Overstatement	8,283	9,746	11,278	11,433
Overstated Daily Bed Census	22.7	26.7	30.9	31.3

* Source: WakeMed Garner application, p. 192. FY 30 represents FY 29 total increased by population growth rate of 1.39%.

By failing to reduce its patient volume to account for the shift to Garner, or otherwise demonstrate that the volume projected for that campus is generated through another methodology, WakeMed has failed to demonstrate that its projected volume for Garner is reasonable, or it has projected higher utilization at its Raleigh campus, and thereby overstates its need for acute care beds at WakeMed Raleigh and across the system. Indeed, in FY 2030, this error results in an overstated volume totaling 11,433 inpatient days of care, representing an average daily census of more than 31 patients. If this volume is subtracted from WakeMed Raleigh's projected ADC in Table Q-2c above, WakeMed Raleigh has an ADC of 442.7 patients, or 78.3 percent of its licensed bed capacity. Moreover, WakeMed provides financial projections for the entire WakeMed system, which are clearly overstated and unreasonable based on this error.

Use of an unreasonable and unsupported growth rate for WakeMed Raleigh

As another issue, WakeMed fails to demonstrate that its Assumption 'm' regarding discharge growth at the WakeMed Raleigh campus is reasonable. On page 187 of its application WakeMed assumes

[4] WakeMed North application, p. 186.

discharges at WakeMed Raleigh will increase at a CAGR of 1.39 percent, the same rate as projected population growth. In contrast to its WakeMed North Campus and WakeMed Cary Campus methodologies, WakeMed does not provide support for this assumption at the Raleigh Campus; specifically, it fails to document the historical trend in admissions and patient days that would support its projected growth rate. While omitted in its current application, in its approved 2022 WakeMed Garner application, WakeMed provided admissions and patient day utilization trends at the WakeMed Raleigh campus.[5] As shown below, admissions (which are comparable to discharges) at WakeMed's Raleigh Campus have been declining since FY 2019.

Table Q-2a
Historic WakeMed System Inpatient Utilization by Location

	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022 Annualized	FY 2022 CAGR %
WakeMed Raleigh Campus						
Admissions	34,593	35,160	32,870	34,280	32,546	-2.5%
Patient Days	155,086	161,323	155,757	182,787	170,719	1.9%
ADC (Calculated)	425	442	427	501	468	1.9%
Acute Care Beds (licensed)	567	567	567	567	567	
ALOS	4.5	4.6	4.7	5.3	5.2	4.6%
% Occupancy (licensed)	**74.9%**	**78.0%**	**75.3%**	**88.3%**	**82.5%**	

Source: WakeMed Garner application, p. 192.

Given this historical trend of a decline in admissions/discharges, it is not reasonable for WakeMed to simply state, without any reason or support, that discharges at WakeMed Raleigh will now begin to increase. Wake County's population has been growing for many years, yet that has not led to a historical increase in admissions/discharges at the facility; thus, it is unreasonable to expect that future population growth will now correlate to an increase in discharges.

In its 2022 Acute Care Bed Findings[6] for Durham County, the Agency found the Duke University Hospital application (Project ID # J-12211-22) non-conforming with Criterion 3 for not supporting its assumption that discharges would increase despite the historical decline in Duke's discharges. See the 2022 Agency Findings excerpt (pages 15-16) below.

- The applicant projects discharges at DUH based on a projected growth rate that is not reasonable and adequately supported.

  The applicant projects adult and pediatric discharges will increase at a rate of 1.5% each year, and that after an initial increase of 10% in one year, neonatal discharges will increase by 1.5% per year. The applicant states its projections are reasonable because of the historical growth rate of acute care days along with the factors it identified as supporting the need for the proposed project. However, the applicant does not explain in the application as submitted what, if any, correlation exists between an increase in acute care days and an increase in discharges. In Section C, page 34, the applicant states that acute care days between SFY 2016 and SFY 2021 increased by a total of 14% and had a CAGR of 2.6%. However, based on the

[5] Project ID # J-12264-22, p. 190.

[6] https://info.ncdhhs.gov/dhsr/coneed/decisions/2022/sept/findings/2022%20Durham-Caswell%20Acute%20Care%20Bed%20Competitive%20Review.pdf

applicant's License Renewal Applications (LRAs), discharges between SFY 2016 and SFY 2021 decreased by a total of -0.2% and by a CAGR of -0.03%. The applicant does not provide a reasonable basis in the application as submitted for applying a 1.5% growth rate to any of the categories of discharges when its historical growth rate for discharges was essentially flat.

WakeMed's methodology contains this same flaw. Despite historical data that demonstrates a historical decline in admissions/discharges, even given the population growth in Wake County during the same timeframe, WakeMed projects discharges at the WakeMed Raleigh Campus will *increase* from 28,744 in FY 24 to 31,226 in FY 30, based on population growth. This results in 2,482 additional discharges and 14,296 additional patient days from FY 24 to FY 30 that are solely attributable to this unsupported growth rate. Because WakeMed's methodology is based on the growth in discharges, this unreasonable assumption is a fundamental error in the WakeMed application and results in unreasonable projections of patient days and occupancy rates. WakeMed's omission of reasonable utilization projections results in the failure to demonstrate need for its proposed project; therefore, it is non-conforming with Criterion 3. WakeMed also fails to demonstrate that the proposed project is the most effective alternative, and that the project does not represent an unnecessary duplication of services due to the overstatement of bed need and is therefore non-conforming with Criteria 4 and 6.

Unreasonable utilization projections based on ED admissions

In Step 14 of its utilization methodology on page 184, WakeMed estimates the number of Emergency Department (ED) patients that would be admitted as inpatients if there were additional acute care bed capacity. WakeMed converts the number of ED boarding hours to equivalent patient days. The historical ED boarding data at WakeMed North is not provided by the applicant to support its calculation. WakeMed includes another unfounded assumption by asserting that 35 percent of the equivalent patient days will be eligible for inpatient admission. There is no discussion as to why this percentage is reasonable, nor is benchmarking data included that would confirm the accuracy of this figure. These unsupported assumptions augment the inpatient census at WakeMed North by 1,928 patient days in Project Year 3, as shown in the following excerpt from the WakeMed application. This unfounded supplemental volume results in an overstated inpatient average daily census of 5.3 patients in FY 2030 (1,928 patient days ÷ 365 days/year = 5.28).

Table 20: Projected WakeMed North Observation Bed Days

		FY23 Ann	FY24	FY25	FY26	FY27	FY28	FY29	FY30
a	Patient-Equivalent ED Boarding Days	4,901	4,983	5,067	5,152	5,239	5,327	5,417	5,508
b	Acute Inpatient Days						1,865	1,896	1,928
c	Estimated Observation Bed Days		4,983	5,067	5,152	5,239	3,463	3,521	3,580

Source: WakeMed North application, p. 188.

Based on these issues, the WakeMed North application is non-conforming with Criteria 3, 4, 5, and 6, and the performance standards for acute care beds and should not be approved.

2. WakeMed North provides unsupported and inconsistent payor mix for its acute care beds.

WakeMed states that its payor mix for acute care beds is based on its historical payor mix for FY 2023, clarifying this assumption in Section L.3b (page 133) and in the assumptions for Form F.2 (page 195), stating specifically that payor mix is projected to be constant through all three project years. This statement is inaccurate, however, because the payor mix on Form F.2 changes from year to year for all payor classes. As shown in the table below, the projected payor mix in Project Year 3 is not consistent with the historical FY 2023 payor mix, a difference for which WakeMed fails to account or provide any assumptions.

WakeMed North Acute Care Beds Payor Mix – Gross Revenue by Payor

Payor Category	*FY 23*	*FY 23 %*	*FY 30*	*FY 30 %*
Self Pay	$16,466,594	6.4%	$25,883,000	5.9%
Insurance	$80,551,052	31.1%	$155,812,156	35.6%
Medicare	$139,231,954	53.7%	$220,558,554	50.4%
Medicaid	$17,704,005	6.8%	$27,210,333	6.2%
Other	$5,293,193	2.0%	$8,406,444	1.9%
Total	**$259,246,800**	**100.0%**	**$437,870,487**	**100.0%**

Source: Section Q, Form F.2a and F.2b

This clear inconsistency is neither explained nor otherwise supported in the application. It is also concerning that WakeMed is proposing such a significant capital project to expand its inpatient capacity, while projecting to serve a higher percentage of commercial patients and a lower percentage of Medicare and Medicaid patients.

For this reason, the WakeMed North application is non-conforming with Criterion 13(c) and should not be approved.

3. WakeMed's financial projections are unreasonable and unsupported.

WakeMed makes multiple mathematical errors in its Form F.2 income statement summary, as described below, which render its financial projections unreasonable.

The first error is in the calculation of net income for the inpatient beds service at WakeMed North. WakeMed states in its footnote to Form F.2b on page 193 that Net Income is calculated by subtracting Total Operating Costs from Total Net Revenue. However, not all operating costs were subtracted as indicated, and the Net Income figures for Project Years 1 through 3 are overstated by approximately $6 million each year, as summarized in the following table:

WakeMed North Hospital Inpatient Beds Net Income, Project Years 1-3

WakeMed North Hospital Inpatient Beds	*FY 28*	*FY 29*	*FY 30*
Total Net Revenue	$133,598,509	$138,854,229	$144,370,729
Total Operating Costs	$78,273,053	$79,778,915	$81,112,875
Net Income	$55,325,456	$59,075,314	$63,257,855
Net Income as Presented by WakeMed	$61,889,598	$65,311,249	$69,165,582
Overstatement	$6,564,142	$6,235,935	$5,907,727

Source: Form F.2b

The second financial form error concerns WakeMed's inclusion of inconsistent data for its calculation of Gross Revenue. On page 195, WakeMed states that Gross Revenue is calculated for each service component using historical per case averages as the baseline. Given this assumption, one would expect the average charge per discharge to either remain constant or present a regular rate of change in future project years. Neither of these is evident in the WakeMed application. The following table summarizes the average charge per discharge and annual percentage change, beginning with the baseline year and extending through Project Year 3. Rather than following a predictable pattern, there are disparate changes from year to year that are not explained in WakeMed's assumptions. Without a justifiable explanation for these annual variations, the financial projections are unsupported.

WakeMed North Hospital Gross Charges, FY 2022 - FY 2030

	*Discharges**	*Gross Charges***	*Average Charge per Discharge*	*Annual Change*
FY 22	4,826	$218,049,008	$45,182	N/A
FY 23	5,361	$259,246,798	$48,358	+7.0%
FY 24	5,366	$265,950,018	$49,562	+2.5%
FY 25	5,469	$273,415,042	$49,994	+0.9%
FY 26	5,573	$284,172,735	$50,991	+2.0%
FY 27	5,664	$294,608,303	$52,014	+2.0%
FY 28 (PY1)	8,647	$413,711,671	$47,845	-8.0%
FY 29 (PY2)	8,803	$425,501,837	$48,336	+1.0%
FY 30 (PY3)	8,965	$437,870,487	$48,842	+1.0%

*Form C.1a and C.2b
**Form F.2a and F.2b

WakeMed's third error in its financial pro formas follows a similar error in logic. In Forms F.3a and F.3b on pages 196 to 199 of its application, WakeMed calculates operating costs for inpatient beds at WakeMed North Hospital. WakeMed asserts in its assumptions that operating costs for Supplies, Purchased Services, and Central Overhead are based on historical per discharge rates, which one would expect to result in consistent average costs per discharge for the proposed project years, or a consistent progression if there are cost escalations. However, the WakeMed application instead demonstrates inconsistencies in the average supply costs and unpredictable variations from year to year. Like the inconsistencies in gross revenue above, the annual percentage change fluctuates from

year to year and does not reflect a predictable rate of inflation. Pharmacy, Dietary, Laundry, Building & Grounds Maintenance, Utilities, and Rental expenses are all derived from ratios for these initial three expense categories, and therefore are also inconsistent and unreasonable from year to year. These variations are shown in the following table:

WakeMed North Annual Operating Costs for Inpatient Beds, FY 2022 – FY 2030

	*Discharges**	*Supplies***	*Expense Per Discharge*	*Annual Change*	*Purchased Services***	*Expense Per Discharge*	*Annual Change*	*Central Office Overhead***	*Expense Per Discharge*	*Annual Change*
FY 22	4,826	$8,023,414	$1,663		$1,576,764	$327		$738,039	$153	
FY 23	5,361	$9,132,001	$1,703	2.5%	$1,690,950	$315	-3.5%	$792,257	$148	-3.4%
FY 24	5,366	$9,280,907	$1,730	1.5%	$1,737,835	$324	2.7%	$810,951	$151	2.3%
FY 25	5,469	$9,518,468	$1,740	0.6%	$1,833,817	$335	3.5%	$835,745	$153	1.1%
FY 26	5,573	$9,828,055	$1,764	1.3%	$1,921,559	$345	2.8%	$862,826	$155	1.3%
FY 27	5,664	$10,103,273	$1,784	1.1%	$2,002,241	$354	2.5%	$888,381	$157	1.3%
FY 28	8,647	$13,298,272	$1,538	-13.8%	$597,029	$69	-80.5%	$1,222,654	$141	-9.9%
FY 29	8,803	$13,538,185	$1,538	0.0%	$607,800	$69	0.0%	$1,270,682	$144	2.1%
FY 30	8,965	$13,787,326	$1,538	0.0%	$618,986	$69	0.0%	$1,321,189	$147	2.1%

*Form C.1a and C.2b

**Form F.3a and F.3b

The fourth error in WakeMed's financial forms can be found in a comparison of operating cost categories in Form F.3a and F.3b on pages 196 and 197. Several expense items inexplicably decline from the last interim year (FY 27) to PY 1 (FY 28) despite an increase in discharges, patient days, and acute care beds. These sharply reduced values have minimal increases in trailing years (PY 2 and PY 3), but do not return to levels from the interim years before the project is completed. WakeMed does not explain these decreases, nor why the per unit cost drops significantly for operating expenses that typically have a strong correlation with utilization volume. Expenses for Project Years 1 through 3 are understated because of this unexplained and unreasonable decline in expenses. The following table summarizes this unexplained variation in operating costs from the interim year 2027 to the first Project Year:

WakeMed North Hospital Inpatient Beds Operating Costs, Final Interim Year and PY1

Operating Cost Category	*FY 27***	*Discharges**	*FY 27 Cost per Discharge*	*FY 28***	*Discharges**	*FY 28 Cost per Discharge*
Purchased Services	$2,002,241	5,664	$354	$597,029	8,647	$69
Building & Grounds Maintenance	$104,935	5,664	$19	$31,290	8,647	$4
Utilities	$976,329	5,664	$172	$291,122	8,647	$34
Equipment Maintenance	$762,479	5,664	$135	$227,356	8,647	$26
Laundry	$462,495	5,664	$82	$137,907	8,647	$16
Other Expense	$481,072	5,664	$85	$158,673	8,647	$18

*Forms C.1a and C.1b

**Form F.3a and F.3b

This unreasonable decrease in operating costs is readily apparent when comparing the average cost per discharge from FY 27 to FY 28. The costs for all operational categories except Other Expenses are more than five times lower in PY 1 than in the last interim year. While WakeMed North may expect to benefit from some marginal increase in efficiency related to economies of scale, for items with a relatively static unit cost such as laundry and utilities there is no explanation provided as to why the per discharge costs drop so significantly, particularly given the projected increase of 121,000 additional square feet and 50 additional beds (35 licensed and 15 unlicensed)— with which will certainly come higher utilities, higher laundry costs, as well as higher costs overall. The operating costs for the project years are clearly understated.

WakeMed fails to provide reasonable projections for costs and charges and is non-conforming with Criterion 5.

4. <u>WakeMed North Hospital's total facility financials are overstated and unsupported.</u>

In addition to the numerous errors specific to the inpatient acute care revenue and costs, WakeMed does not provide reasonable projections for Total Facility Gross Charges in the first three project years. The increases in total facility revenue are inconsistent with total facility projected volume increases shown in the Section C.3 patient origin tables on page 46. While total patients are projected to increase 14.8 percent from FY 22 to FY 28, Gross Charges spike by 96.4 percent over this period. The average charge increases 71 percent, from $9,932 in FY 22 to $16,992 in FY 28. Even if one assumes the relative percentage of inpatients increases with the expansion of inpatient capacity, this still requires unreasonably aggressive and unsupported growth in Gross Charges. The following table shows the differences in growth of total patients and total gross charges:

WakeMed North Hospital Total Patients and Total Gross Charges, PY 1-3

	*Total Patients**	*Increase Over 2022*	*Gross Charges***	*Increase Over 2022*
FY 22	63,848	N/A	$634,152,604	N/A
FY 28 (PY1)	73,311	14.8%	$1,245,705,658	96.4%
FY 29 (PY2)	75,020	17.5%	$1,264,967,664	99.5%
FY 30 (PY3)	76,768	20.2%	$1,285,441,066	102.7%

*Section C.2b and C.3b

**Form F.2a and F.2b

If the totals for inpatient discharges and inpatient gross charges are excluded to show all other hospital-based services, the increase in average gross charges is significantly higher than the usual and customary charge inflation range of 2 to 3 percent per year:

WakeMed North Hospital Ambulatory Patients and Gross Charges, PY3

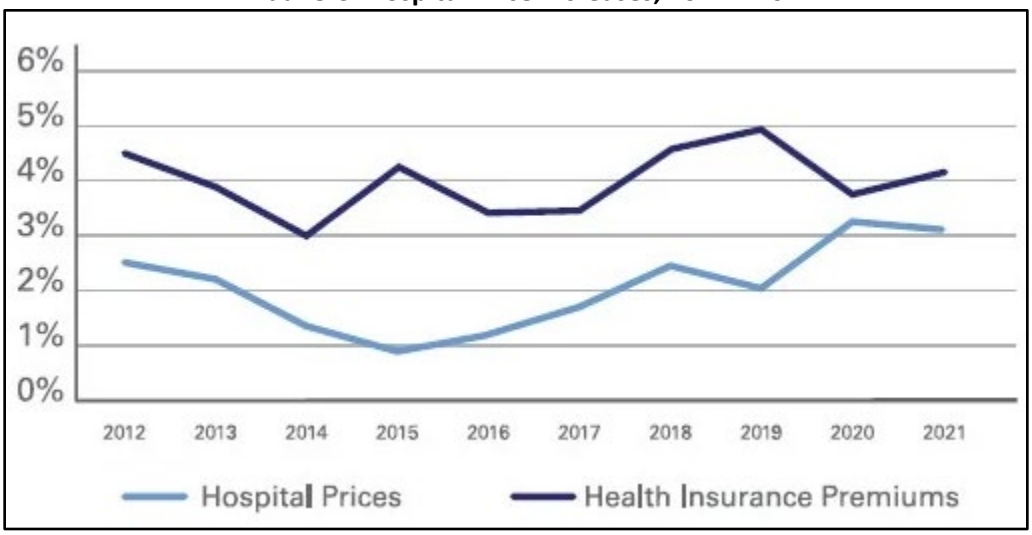
	*Total Ambulatory Patients**	*Ambulatory Gross Charges***	*Average Charge*	*CAGR*
FY 22	59,022	$416,103,596	$7,050	N/A
FY 28 (PY1)	64,664	$831,993,987	$12,866	10.5%

*Section C.2b and C.3b less discharge volumes from Form C.1a and C.1b.

**Form F.2a and F.2b; Total Patient Services Gross Revenue less Inpatient Beds Gross Revenue.

WakeMed states in its total facility assumptions on page 203 that gross revenue uses historical per case averages as a baseline. The average charge for ambulatory services was $7,050 in FY 22. In Project Year 1, this figure increases by 82.5 percent, representing a CAGR of 10.5 percent from FY 22 to FY 28. In contrast, for the period from 2012 to 2021, the average annual increase in U.S. hospital prices ranged from one percent to a maximum of 3.1 percent.

Annual U.S. Hospital Price Increases, 2012 – 2021



Source: Bureau of Labor Statistics, Price Index data, 2012-2021 for Hospitals.

WakeMed fails to explain why its charges increase at such a disproportionately high rate from the baseline year to the first project year. The application thus does not demonstrate a reasonable projection of charges, nor does it provide evidence that the proposed project has a favorable impact on cost-effectiveness due to such aggressive increases in charges.

As such, the WakeMed North application is non-conforming with Criteria 5 and 18a and should not be approved.

ISSUE-SPECIFIC COMMENTS ON WAKEMED CARY HOSPITAL

1. Utilization projections are overstated in the WakeMed application.

Criterion 3 requires an applicant to "identify the population served by the proposed project, and… demonstrate the need that this population has for the services proposed…"[7] This includes a reasonable projection of volumes for not only the proposed facility, but for all facilities in the applicant's system that provide similar services (in this instance, acute inpatient care services). WakeMed simply fails to provide credible utilization projections for all its existing, approved, and proposed facilities in its application. Form C.1 of WakeMed's application contains multiple inaccuracies and inconsistent information, specifically based upon its calculation of inpatient utilization at WakeMed Raleigh Hospital. This error results in overstated and unreasonable utilization projections for the entire WakeMed system in Form C.1b. An explanation of these inaccuracies follows.

Failure to account for projected shifts to WakeMed Garner

According to Assumption 'm' on page 168, WakeMed calculates discharges at the WakeMed Raleigh Campus by starting with an annualized base year of FY 2023 that then increases at an annual growth rate of 1.39 percent, equal to the projected CAGR for Wake County's population. A portion of discharges are then shifted from WakeMed Raleigh to WakeMed North to calculate discharges after the shift (Assumptions 'n' and 'o'). However, in its calculations for WakeMed Raleigh, the application fails to include the shift of discharges to its approved acute care facility in Garner, which as a result overstates the discharge volume at the Raleigh campus. In its approved Garner hospital application (Project ID # J-12264-22), WakeMed calculated that over 1,400 discharges at WakeMed Raleigh would shift to its Garner campus in the first project year, increasing to 1,958 discharges in Project Year 3, as shown in the following table:

Table Q-2c

Projected WakeMed Acute Care Bed Utilization with WakeMed Garner

	Projected Status Quo			Projected w/ Garner			Shifted Admissions		
	FY 2027	FY 2028	FY 2029	FY 2027	FY 2028	FY 2029	FY 2027	FY 2028	FY 2029
WakeMed Raleigh Campus									
Admissions*	34,218	34,563	34,911	32,780	32,871	32,953	(1,438)	(1,692)	(1,958)
Patient Days	179,492	181,301	183,127	171,950	172,423	172,857			
ADC (Calculated)	491.8	496.7	501.7	471.1	472.4	473.6			
Acute Care Beds (licensed)**	587	587	587	565	565	565			
ALOS	5.2	5.2	5.2	5.2	5.2	5.2			
% Occupancy (licensed)	**83.8%**	**84.6%**	**85.5%**	**83.4%**	**83.6%**	**83.8%**			

Source: Project ID # 12264-22, p. 192.

In its current application, the total discharges at WakeMed Garner shown in the WakeMed System utilization volume table[8] match the total at the Garner facility shown in its 2022 acute beds application, consistent with the previously approved application. However, completely inconsistent with its prior application, the current application fails to reduce the WakeMed Raleigh Campus

[7] As defined in North Carolina G.S 131E-183(a)(3).

[8] WakeMed Cary application, p. 167.

discharges to reflect the projected shift to WakeMed Garner. Consequently, WakeMed has double counted these patients which results in significantly overstated volume projections at WakeMed Raleigh Campus, as calculated below.

WakeMed Raleigh Campus Overstated Discharge Volume

	FY 27	*FY 28*	*FY 29*	*FY 30*
Discharge Variance*	1,438	1,692	1,958	1,985
Average Length of Stay	5.76	5.76	5.76	5.76
Patient Days of Care Overstatement	8,283	9,746	11,278	11,433
Overstated Daily Bed Census	22.7	26.7	30.9	31.3

* Source: WakeMed Garner application, p. 192. FY 30 represents FY 29 total increased by population growth rate of 1.39%.

By failing to reduce its patient volume to account for the shift to Garner, or otherwise demonstrate that the volume projected for that campus is generated through another methodology, WakeMed has either failed to demonstrate that its projected volume for Garner is reasonable, or it has projected higher utilization at its Raleigh campus, thereby overstating its need for acute care beds at WakeMed Raleigh and across the system. Indeed, in FY 2030, this error results in an overstated volume totaling 11,433 inpatient days of care, representing an average daily census of more than 31 patients. If this volume is subtracted from WakeMed Raleigh's projected ADC in Table Q-2c above, WakeMed Raleigh has an ADC of 442.7 patients, or 78.3 percent of its licensed bed capacity. Moreover, WakeMed provides financial projections for the entire WakeMed system, which are clearly overstated and unreasonable based on this error.

Use of an unreasonable and unsupported growth rate for WakeMed Raleigh

As another issue, WakeMed fails to demonstrate that its Assumption 'm' regarding discharge growth at the WakeMed Raleigh campus is reasonable. On page 187 of its application WakeMed assumes discharges at WakeMed Raleigh will increase at a CAGR of 1.39 percent, the same rate as projected population growth. In contrast to its WakeMed North Campus and WakeMed Cary Campus methodologies, WakeMed does not provide support for this assumption at the Raleigh Campus; specifically, it fails to document the historical trend in admissions and patient days that would support its projected growth rate. While omitted in its current application, in its approved 2022 WakeMed Garner application, WakeMed provided admissions and patient day utilization trends at the WakeMed Raleigh campus.[9] As shown below, admissions (which are comparable to discharges) at WakeMed's Raleigh Campus have been declining since FY 2019.

[9] Project ID # J-12264-22, p. 190.

Table Q-2a
Historic WakeMed System Inpatient Utilization by Location

	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022 Annualized	FY 2022 CAGR %
WakeMed Raleigh Campus						
Admissions	34,593	35,160	32,870	34,280	32,546	-2.5%
Patient Days	155,086	161,323	155,757	182,787	170,719	1.9%
ADC (Calculated)	425	442	427	501	468	1.9%
Acute Care Beds (licensed)	567	567	567	567	567	
ALOS	4.5	4.6	4.7	5.3	5.2	4.6%
% Occupancy (licensed)	**74.9%**	**78.0%**	**75.3%**	**88.3%**	**82.5%**	

Source: WakeMed Garner application, p. 192.

Given this historical trend of a decline in admissions/discharges, it is not reasonable for WakeMed to simply state, without any reason or support, that discharges at WakeMed Raleigh will now begin to increase. Wake County's population has been growing for many years, yet that has not led to a historical increase in admissions/discharges at the facility; thus, it is unreasonable to expect that future population growth will now correlate to an increase in discharges.

In its 2022 Acute Care Bed Findings[10] for Durham County, the Agency found the Duke University Hospital application (Project ID # J-12211-22) non-conforming with Criterion 3 for not supporting its assumption that discharges would increase despite the historical decline in Duke's discharges. See the 2022 Agency Findings excerpt (pages 15-16) below.

- The applicant projects discharges at DUH based on a projected growth rate that is not reasonable and adequately supported.

  The applicant projects adult and pediatric discharges will increase at a rate of 1.5% each year, and that after an initial increase of 10% in one year, neonatal discharges will increase by 1.5% per year. The applicant states its projections are reasonable because of the historical growth rate of acute care days along with the factors it identified as supporting the need for the proposed project. However, the applicant does not explain in the application as submitted what, if any, correlation exists between an increase in acute care days and an increase in discharges. In Section C, page 34, the applicant states that acute care days between SFY 2016 and SFY 2021 increased by a total of 14% and had a CAGR of 2.6%. However, based on the applicant's License Renewal Applications (LRAs), discharges between SFY 2016 and SFY 2021 decreased by a total of -0.2% and by a CAGR of -0.03%. The applicant does not provide a reasonable basis in the application as submitted for applying a 1.5% growth rate to any of the categories of discharges when its historical growth rate for discharges was essentially flat.

WakeMed's methodology contains this same flaw. Despite historical data that demonstrates a historical decline in admissions/discharges, even given the population growth in Wake County during the same timeframe, WakeMed projects discharges at the WakeMed Raleigh Campus will *increase* from 28,744 in FY 24 to 31,226 in FY 30, based on population growth. This results in 2,482 additional

[10] https://info.ncdhhs.gov/dhsr/coneed/decisions/2022/sept/findings/2022%20Durham-Caswell%20Acute%20Care%20Bed%20Competitive%20Review.pdf

discharges and 14,296 additional patient days from FY 24 to FY 30 that are solely attributable to this unsupported growth rate. Because WakeMed's methodology is based on the growth in discharges, this unreasonable assumption is a fundamental error in the WakeMed application and results in unreasonable projections of patient days and occupancy rates. WakeMed's omission of reasonable utilization projections results in the failure to demonstrate need for its proposed project; therefore, it is non-conforming with Criterion 3. WakeMed also fails to demonstrate that the proposed project is the most effective alternative, and that the project does not represent an unnecessary duplication of services due to the overstatement of bed need and is therefore non-conforming with Criteria 4 and 6.

Accordingly, the WakeMed Cary application is non-conforming with Criteria 3, 4, and 6, and should not be approved.

2. WakeMed Cary provides unsupported and inconsistent payor mix for its acute care beds.

WakeMed states that its payor mix for acute care beds is based on its historical payor mix for FY 2023, clarifying this assumption in Section L.3b (page 118) and in the assumptions for Form F.2 (page 175), stating specifically that payor mix is projected to be constant through all three project years. This statement is inaccurate, however, because the payor mix on Form F.2 changes from year to year for all payor classes. As shown in the table below, the projected payor mix is inconsistent with the historical FY 2023 payor mix, a difference that WakeMed fails to account for or provide any assumptions.

WakeMed Cary Acute Care Beds Payor Mix – Gross Revenue by Payor

	FY 23	*FY 23 %*	*FY 28*	*FY 28 %*
Self Pay	37,336,574	4.4%	38,405,817	4.2%
Insurance	248,464,017	29.5%	305,175,314	33.3%
Medicare	489,058,891	58.1%	503,064,542	54.9%
Medicaid	50,898,289	6.0%	52,355,913	5.7%
Other	16,240,573	1.9%	16,705,669	1.8%
Total	841,998,344	100.0%	915,707,255	100.0%

Source: Section Q, Form F.2a and F.2b

This clear inconsistency is not explained or otherwise supported in the application. It is also concerning that WakeMed is proposing to expand its inpatient capacity while projecting to serve a higher percentage of commercial patients and a lower percentage of Medicare and Medicaid patients.

For this reason, the WakeMed Cary application is non-conforming with Criterion 5 and should not be approved.

3. WakeMed's financial projections are unreasonable and unsupported.

WakeMed commits several financial form errors that are not explained or reasonably supported and that cast doubt on the accuracy of its projections. The first error concerns WakeMed's inclusion of inconsistent data for its calculation of Gross Revenue. On pages 173 to 175, WakeMed states that Gross Revenue is calculated for each service component using historical per discharge averages as the baseline. Given this assumption, one would expect the average charge per discharge to either remain

constant or demonstrate a regular rate of change in future project years. Neither of these is evident in the WakeMed application. The following table summarizes the average charge per discharge beginning with the baseline year and extending through Project Year 3. Rather than following a consistent pattern, there are disparate changes from year to year that are not explained in WakeMed's assumptions. Without a justifiable explanation for these annual variations, the financial projections are unsupported.

WakeMed Cary Hospital Gross Charges, FY 2022 - FY 2030

	*Discharges**	*Gross Charges***	*Average Charge per Discharge*	*Annual Change*
FY 22	12,972	841,998,344	64,909	N/A
FY 23	12,932	846,800,182	65,481	0.9%
FY 24	12,884	815,224,678	63,274	-3.4%
FY 25	12,967	842,437,241	64,968	2.7%
FY 26	13,103	870,721,986	66,452	2.3%
FY 27	12,041	878,516,418	72,960	9.8%
FY 28	12,036	915,707,255	76,081	4.3%

*Form C.1a and C.2b

**Form F.2a and F.2b

WakeMed Cary also provides inconsistent data for its projected operating costs shown on pages 176 to 178 of its application. The application states that Purchased Services, Supplies, and Corporate Support / Allocation are all based on historical per discharge rates. Like gross revenue above, however, the annual change for these initial three expense categories is different from year to year and does not reflect usual and customary assumptions for inflation. The yearly change for these expenses ranges from -1.4 percent to more than 12 percent, with no consistency from one year to the next. Expense assumptions for Pharmacy, Dietary, Laundry, Building & Grounds Maintenance, Utilities, and Rental costs are all derived from ratios for the initial three expenses, and therefore are also inconsistent and unreasonable from year to year. WakeMed provides no explanation for these variations in its assumptions. The following table summarizes the sharp variation in operating costs from FY22 through FY28, the third project year.

WakeMed Cary Annual Operating Costs for Inpatient Beds, FY 2022 – FY 2028

	*Discharges**	*Supplies***	*Expense Per Discharge*	*Annual Change*	*Purchased Services***	*Expense Per Discharge*	*Annual Change*	*Corporate Support***	*Expense Per Discharge*	*Annual Change*
FY 22	12,972	$28,730,080	$2,215	N/A	$1,362,642	$105	N/A	$8,052,124	$621	N/A
FY 23	12,932	$32,154,556	$2,486	12.3%	$1,525,061	$118	12.3%	$8,591,294	$664	7.0%
FY 24	12,884	$31,598,648	$2,453	-1.4%	$1,498,695	$116	-1.4%	$8,668,199	$673	1.3%
FY 25	12,967	$33,325,566	$2,570	4.8%	$1,580,601	$122	4.8%	$9,010,222	$695	3.3%
FY 26	13,103	$35,146,864	$2,682	4.4%	$1,666,984	$127	4.4%	$9,457,067	$722	3.9%
FY 27	12,041	$36,177,740	$3,005	12.0%	$1,715,877	$143	12.0%	$9,720,768	$807	11.9%
FY 28	12,036	$38,463,538	$3,196	6.4%	$1,824,291	$152	6.4%	$10,130,211	$842	4.3%

*Form C.1a and C.2b

**Form F.3a and F.3b

WakeMed thus fails to provide reasonable projections for costs and charges, resulting in the WakeMed Cary application being non-conforming with Criterion 5.

COMPARATIVE ANALYSIS

The UNC Health Rex Hospital (Project ID # J-12417-23), the Duke Raleigh Hospital (Project ID # J-12412-23), the WakeMed Cary Hospital (Project ID # J-12418-23), and the WakeMed North Hospital (Project ID # J-12419-23) applications each propose to develop acute care beds in response to the *2023 SMFP* need determination for Wake County. Given that multiple applicants propose to meet all or part of the need for the 45 additional acute care beds in Wake County, not all can be approved. To determine the comparative factors that are applicable in this review, UNC Health Rex examined recent Agency findings for competitive acute care bed reviews. Based on that examination and the facts and circumstances of the competing applications in this review, UNC Health Rex considered the following comparative factors:

- Conformity with Review Criteria
- Scope of Services
- Geographic Accessibility
- Historical Utilization
- Competition (Patient Access to a New Provider)
- Access by Underserved Groups
    - Projected Medicare
    - Projected Medicaid
- Projected Average Net Revenue per Case
- Projected Average Operating Expense per Case

Rex believes that the factors presented above and discussed in turn below should be used by the Project Analyst in reviewing the competing applications.

Conformity with Applicable Statutory and Regulatory Review Criteria

As discussed in the application-specific comments above, the Duke Raleigh Hospital application and both WakeMed applications are non-conforming with multiple statutory and regulatory review criteria. The Duke Raleigh application is non-conforming with Criteria 3a, 4, 5, and 12. The WakeMed North application is nonconforming with Criteria 3, 4, 5, 6, 13(c), and 18(a). The WakeMed Cary application is nonconforming with Criteria 3, 4, 5, and 6. In contrast, the UNC Health Rex Hospital application conforms with all applicable statutory and regulatory review criteria. Therefore, regarding conformity with statutory and regulatory review criteria, the UNC Health Rex Hospital application is the most effective alternative.

Scope of Services

UNC Health Rex Hospital is a tertiary care hospital, while Duke Raleigh, WakeMed Cary, and WakeMed North are all smaller hospitals that do not offer the same breadth of services nor the scope of subspecialty care that is available to patients at UNC Health Rex Hospital. UNC Health Rex Hospital is therefore the most effective applicant for this factor.

Geographic Accessibility

UNC Health Rex Hospital, Duke Raleigh Hospital, WakeMed Cary Hospital and WakeMed North Hospital each propose to develop the acute care beds in Wake County by adding the acute care beds to their respective

existing facilities in Wake County. Both the UNC Health Rex Hospital application and the Duke Raleigh Hospital application propose adding beds to facilities located in central Wake County. UNC Health Rex Hospital is a tertiary care facility proposing to develop 44 new acute care beds while Duke Raleigh Hospital is a community hospital and proposes to develop 41 new acute care beds at its existing facility. The WakeMed Cary application proposes to develop nine new acute care beds, a small portion of the full *2023 SMFP* need determination of 44 beds, to the existing facility located in western Wake County. WakeMed North Hospital proposes to develop 35 new acute care beds at its campus in North Raleigh located approximately 11 miles from WakeMed Raleigh, an existing tertiary care and trauma hospital. All four applicants will expand capacity at existing campuses that are in the central part of Wake County. Therefore, regarding geographic accessibility, the four applications are equally effective.

Historical Utilization

UNC Health Rex believes it is more appropriate to examine patient census and occupancy rate information for the specific facility that has applied to develop new beds, and not the entire health system in aggregate. Assessing the occupancy data by individual facility is a more accurate indication of the immediate need for beds and which facilities represent the highest priority for additional resources. In the most recent Wake County acute beds review, the Agency considered only total health system patient days and bed capacity, rather than data for individual facilities.[11]

Viewed this way, the historical utilization for the four competing applicants is as follows:

Historical Utilization, Wake County Acute Care Hospitals

Applicant	*Acute Patient Days of Care*	*Average Daily Census*	*Existing and Approved Beds*	*Occupancy Rate*
UNC Health Rex Hospital	134,187	367.6	468	78.6%
Duke Raleigh Hospital	54,279	148.7	186	80.0%
WakeMed Cary Hospital	59,221	162.2	208	78.0%
WakeMed North Hospital	16,969	46.5	61	76.2%

Source: 2023 License Renewal Applications.

Based on the occupancy data for each applicant, Duke Raleigh is the most effective applicant. UNC Health Rex is more effective, and WakeMed's applications are less effective. However, the Duke Raleigh application is non-conforming with Criteria 3a, 4, 5, and 12 and should be disqualified from the comparison. Likewise, the WakeMed North and WakeMed Cary applications are non-conforming with multiple review criteria. Therefore, UNC Health Rex is the most effective applicant for this factor.

Competition (Patient Access to a New Provider)

UNC Health Rex, WakeMed, and DUHS, the operator of Duke Raleigh Hospital, are three existing, mature, and well-established health systems that provide acute care services in Wake County. Further, all four competing applications represent an expansion of existing services at campuses that have operated for a substantial number of years. The scope of each respective project does not include the development of

[11] https://info.ncdhhs.gov/dhsr/coneed/decisions/2023/jan/findings/2022%20Wake%20Acute%20Care%20Bed%20and%20OR%20Review%20Findings.pdf, p. 224.

acute beds for specialty inpatient-based care or inpatient services that are not currently available at the applicant's facility. As such, UNC Health Rex does not believe this factor is conclusive in a comparison of the applicants, and all four applications are equally effective.

Access by Underserved Groups

The following table shows projected acute care bed percentages provided to Medicare and Medicaid recipients in the third project year following completion of the project, based on the information provided in Section L.3(a) of each application.

Medicare and Medicaid Patient Days – Project Year 3

Applicant	*Medicare % of Total*	*Medicaid % of Total*	*Total*
UNC Health Rex Hospital	58.6%	9.9%	68.5%
Duke Raleigh Hospital	60.4%	8.7%	69.1%
WakeMed Cary Hospital	44.8%	6.7%	51.5%
WakeMed North Hospital	50.4%	6.2%	56.6%

Source: Section L.3.a of the respective applications.

On page 86, DUHS states that the projected Medicare payor mix for acute care beds is based on the FY 2023 payor mix and reflects a 3.2 percent adjustment from commercial insurance to Medicare to reflect the anticipated aging of the population. If such a change impacts the percentage of Medicare patients, it is likely to impact all applicants, not just DUHS. UNC Health Rex also notes that the services proposed by the various applicants are significantly different, particularly as UNC Health Rex Hospital is the only tertiary care provider among the applicants. If the Agency believes a comparison is of value, it appears that the DUHS and UNC Health Rex applications are more effective, as the applicants project to serve 69.1 percent and 68.5 percent of patients, respectively, that are Medicare or Medicaid recipients. UNC Health Rex is more effective for serving Medicaid patients, ranking first for the percentage of Medicaid patient days, and second for the percentage of Medicare patient days.

Projected Average Net Revenue per Discharge

The following table shows the projected net revenue per inpatient discharge in the third year of operation based on the information provided in each applicant's pro forma financial statements (Form F.2).

Average Net Revenue per Discharge – Project Year 3

Applicant	*Discharges*	*Net Revenue*	*Average Net Revenue Per Discharge*
UNC Health Rex Hospital	30,072	$122,870,185	$4,086
Duke Raleigh Hospital	12,345	$211,583,381	$17,139
WakeMed Cary Hospital	12,036	$229,832,082	$19,095
WakeMed North Hospital	8,965	$144,370,729	$16,104

Source: Forms C and F.2 of the respective applications.

UNC Health Rex Hospital only includes room and board charges in its revenue calculations. All other charges relating to the patient's inpatient visit are allocated to the applicable department (e.g., surgical services, lab, etc.) The competing applicants in this review include all service categories to calculate inpatient operating revenue. This factor is therefore inconclusive due to the differences in methods of projecting revenue.

Projected Average Operating Expense per Discharge

The following table shows the projected average operating expense per inpatient discharge in the third year of operation for each of the applicants, based on the information provided in applicants' pro forma financial statements (Form F.3).

Average Operating Expense per Discharge – Project Year 3

Applicant	*Discharges*	*Operating Expenses*	*Average Oper Expense Per Disch*
UNC Health Rex Hospital	30,072	$203,846,551	$6,779
Duke Raleigh Hospital	12,345	$309,455,818	$25,067
WakeMed Cary Hospital	12,036	$211,618,368	$17,582
WakeMed North Hospital	8,965	$81,112,875	$9,048

Source: Forms C and F.3 of the respective applications.

UNC Health Rex Hospital only includes room and board charges in its expense calculations. All other expenses relating to the patient's inpatient visit are allocated to the applicable department (e.g., surgical services, lab, etc.) As a result, inpatient services show a net loss. The competing applicants in this review include all service categories for calculating inpatient operating expenses. This factor is therefore inconclusive due to the differences in methods of projected expenses.

Summary of Comparative Analysis

The following table summarizes the comparative analysis for the competing applications.

Comparative Factor	*UNC Health Rex Hospital*	*Duke Raleigh Hospital*	*WakeMed Cary Hospital*	*WakeMed North Hospital*
Conformity with Review Criteria	Yes	No	No	No
Scope of Services	More Effective	Less Effective	Less Effective	Less Effective
Geographic Accessibility	Equally Effective	Equally Effective, But Not Approvable	Equally Effective, But Not Approvable	Equally Effective, But Not Approvable
Historical Utilization	More Effective	Most Effective, But Not Approvable	Less Effective	Less Effective
Competition (Patient Access to a new provider)	Equally Effective	Equally Effective, But Not Approvable	Equally Effective, But Not Approvable	Equally Effective, But Not Approvable
Access by Underserved Groups - Medicare	More Effective	Most Effective, But Not Approvable	Less Effective	Less Effective
Access by Underserved Groups - Medicaid	Most Effective	More Effective, But Not Approvable	Less Effective	Less Effective
Average Net Revenue per Case	Inconclusive	Inconclusive	Inconclusive	Inconclusive
Average Expense per Case	Inconclusive	Inconclusive	Inconclusive	Inconclusive

SUMMARY

In summary, UNC Health Rex believes that its application represents the most effective alternative for 44 additional acute care beds needed in Wake County. UNC Health Rex is also fully conforming to all applicable statutory and regulatory review criteria and is comparatively superior on the relevant factors in this review. As such, the UNC Health Rex application should be approved.

Please note that in no way does UNC Health Rex intend for these comments to change or amend its application filed on August 15, 2023. If the Agency considers any of these comments to be amending the UNC Health Rex application, those responses should not be considered.