

REQUIRED STATE AGENCY FINDINGS

FINDINGS

C = Conforming

CA = Conforming as Conditioned

NC = Nonconforming

NA = Not Applicable

Decision Date: November 24, 2025

Findings Date: November 24, 2025

Project Analyst: Chalice L. Moore

Co-Signer: Micheala Mitchell

Project ID #: P-12648-25

Facility: Carteret Health Care Surgery Center at Cedar Point

FID #: 250608

County: Carteret

Applicant(s): Carteret Health Care Surgery Center at Cedar Point, LLC

Project: Develop a new ASF by relocating one existing OR from Carteret County General Hospital and developing one procedure room

REVIEW CRITERIA

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.

C

Carteret Health Care Surgery Center at Cedar Point, LLC (hereinafter referred to as “the applicant” or CHCSC-CP). proposes to develop a new ASF by relocating one existing OR from Carteret County General Hospital (CCGH) and developing one procedure room.

Need Determination

The applicant does not propose to develop any beds or services or acquire any medical equipment for which there is a need determination in the 2025 State Medical Facilities Plan (SMFP). Therefore, there are no need determinations applicable to this review.

Policies

There is one policy in the 2025 SMFP which is applicable to this review. *Policy GEN-4: Energy Efficiency and Sustainability for Health Service Facilities*, on page 30 of the 2025 SMFP, states:

“Any person proposing a capital expenditure greater than \$4 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, Certificate of Need 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 is 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.”

The proposed capital expenditure for this project is greater than \$4 million. In Section B, page 25, the applicant describes the project’s plan to improve energy efficiency and conserve water.

Conclusion

The Agency reviewed the:

- Application
- Exhibits to the application
- Information publicly available during the review and used by the Agency

Based on that review, the Agency concludes that the application is conforming to this criterion based on the following:

- The applicant does not propose to develop any beds or services or acquire any medical equipment for which there is a need determination in the 2025 SMFP.
- The applicant adequately demonstrates that the proposal is consistent with Policy GEN-4 because the application includes a written statement describing the project’s plan to assure improved energy efficiency and water conservation.

(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, ... persons [with disabilities], the elderly, and other underserved groups are likely to have access to the services proposed.

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The applicant proposes to develop a new ASF by relocating one existing OR from Carteret County General Hospital and developing one procedure room.

Patient Origin

On page 49, the 2025 SMFP defines the service area for ORs as “...*the single or multicounty grouping shown in Figure 6.1.*” Figure 6.1 on page 55 of the 2025 SMFP shows Carteret County as its own OR service area. Thus, the service area for this project is Carteret County. Facilities may also serve residents of counties not included in their service area.

The Applicant proposes to develop a new licensed and certified freestanding multispecialty ambulatory surgical facility (“ASF”) called Carteret Health Care Surgery Center at Cedar Point (“CHCSC-CP”). The new ASF will have one licensed operating room and one procedure room. Both rooms will be built to accommodate operating room surgical procedures. The operating room license will be transferred from CCGH Hospital license No. H0222 to the proposed new facility; and CCGH will convert the vacated space to a Procedure Room. CCGH Board and Medical staff will develop a policy describing surgical procedures that can be provided in that Procedure Room Initial surgical specialties offered at the ASF will include:

- General Surgery
- Gynecology
- Orthopedic
- Plastic
- Urology
- Vascular
- Pediatric Dental
- General surgeons will also perform GI endoscopy procedures in the licensed operating room.

Carteret Health Care Surgery Center at Cedar Point is not an existing facility but will be developed by relocating one OR from Carteret County General Hospital. The historical patient origin for Carteret County General Hospital for ambulatory/outpatient surgery is shown below.

Carteret County General Hospital Historical Patient Origin Ambulatory Outpatient Surgical FFY 10/01/2023 to 09/30/2024		
County	# of Patients	% of Total
Carteret County	1,469	53.8%
Craven County	393	14.4%
Onslow County	721	26.4%
Other (a)	145	5.3%
Total	2,728	100.0%

Source: Section C, page 29

“Other” includes all other NC counties and other states.

The historical patient origin for Carteret County General Hospital for entire facility is shown below.

Carteret County General Hospital Historical Patient Origin Entire Facility FFY 10/01/2023 to 09/30/2024		
County	# of Patients	% of Total
Carteret County	80,810	68.8%
Craven County	14,841	12.6%
Onslow County	16,179	13.8%
Other (a)	5,563	4.7%
Total	117,393	100.0%

Source: Section C, page 30

“Other” includes all other NC counties and other states.

In Section C, pages 32-34, the applicant provides the projected patient origin for the first three full fiscal years of operation following project completion, as shown in the tables below.

Carteret Health Care Surgery Center at Cedar Point Projected Patient Origin Operating Room FFYs 1-3 (CYs 2028-2030)						
County	FFY 1 10/01/2027 to 09/30/2028		FFY 2 10/01/2028 to 09/30/2029		FFY 3 10/01/2029 to 09/30/2030	
	# of Patients	% of Total	# of Patients	% of Total	# of Patients	% of Total
28511	5	0.4%	6	0.4%	7	0.5%
28512	32	3.1%	44	3.1%	46	3.0%
28516	124	12.0%	170	12.0%	183	12.2%
28520	5	0.5%	7	0.5%	8	0.5%
28524	5	0.5%	7	0.5%	8	0.5%
28528	9	0.9%	12	0.9%	15	1.0%
28531	11	1.0%	14	1.0%	15	1.0%
28532	82	7.9%	112	7.9%	115	7.7%
28539	65	6.3%	89	6.3%	92	6.1%
28553	5	0.5%	6	0.5%	6	0.4%
28555	7	0.7%	10	0.7%	10	0.7%
28557	143	13.8%	196	13.8%	206	13.7%
28570	215	20.8%	295	20.8%	318	21.2%
28575	2	0.2%	3	0.2%	4	0.3%
28577	4	0.3%	5	0.3%	5	0.3%
28579	6	0.6%	8	0.6%	9	0.6%
28581	2	0.2%	3	0.2%	4	0.3%
28582	14	1.4%	19	1.4%	21	1.4%
28584	89	8.6%	122	8.6%	124	8.3%
28589	3	0.3%	4	0.3%	4	0.3%
28594	36	3.5%	49	3.5%	53	3.5%
Other	171	16.5%	234	16.5%	251	16.7%
Total 1	1,034	100.0%	1,417	100.0%	1,501	100.0%

Carteret Health Care Surgery Center at Cedar Point Projected Patient Origin Procedure Room FFYs 1-3 (CYs 2028-2030)						
County	FFY 1 10/01/2027 to 09/30/2028		FFY 2 10/01/2028 to 09/30/2029		FFY 3 10/01/2029 to 09/30/2030	
	# of Patients	% of Total	# of Patients	% of Total	# of Patients	% of Total
28511			1	0.2%	2	0.2%
28512			8	3.2%	26	3.2%
28516			29	11.3%	92	11.3%
28520			1	0.3%	3	0.3%
28524			1	0.4%	3	0.4%
28528			1	0.4%	4	0.4%
28531			3	1.2%	10	1.2%
28532			23	8.9%	73	8.9%
28539			18	7.1%	58	7.1%
28553			2	0.7%	6	0.7%
28555			2	0.8%	7	0.8%
28557			36	14.3%	117	14.3%
28570			48	19.0%	155	19.0%
28575			0	0.1%	1	0.1%
28577			1	1	3	0.4%
28579			1	0.5%	4	0.5%
28581			0	0.1%	1	0.1%
28582			3	1.2%	10	1.2%
28584			26	10.2%	83	10.2%
28589			1	0.2%	2	0.2%
28594			8	3.3%	27	3.3%
Other			40	15.9%	130	15.9%
Total 1			254	100.0%	817	100.0%

Carteret Health Care Surgery Center at Cedar Point Projected Patient Origin Entire Facility FFYs 1-3 (CYs 2028-2030)						
County	FFY 1 10/01/2027 to 09/30/2028		FFY 2 10/01/2028 to 09/30/2029		FFY 3 10/01/2029 to 09/30/2030	
	# of Patients	% of Total	# of Patients	% of Total	# of Patients	% of Total
28511	5	0.4%	7	0.4%	9	0.4%
28512	32	3.1%	52	3.1%	72	3.1%
28516	124	12.0%	199	11.9%	275	11.9%
28520	5	0.5%	8	0.5%	11	0.5%
28524	5	0.5%	8	0.5%	11	0.5%
28528	9	0.9%	14	0.8%	18	0.8%
28531	11	1.0%	17	1.0%	24	1.1%
28532	82	7.9%	135	8.1%	188	8.1%
28539	65	6.3%	107	6.4%	150	6.5%
28553	5	0.5%	8	0.5%	12	0.5%
28555	7	0.7%	12	0.7%	17	0.7%
28557	143	13.8%	232	13.9%	323	13.9%
28570	215	20.8%	343	20.5%	473	20.4%
28575	5	0.2%	4	0.2%	5	0.2%
28577	4	0.3%	6	0.4%	8	0.4%
28579	6	0.6%	9	0.6%	13	0.5%
28581	2	0.2%	4	0.2%	5	0.2%
28582	14	1.4%	22	1.3%	31	1.3%
28584	89	8.6%	148	8.9%	208	9.0%
28589	3	0.3%	4	0.3%	6	0.3%
28594	36	3.5%	58	3.5%	80	3.4%
Other	171	16.5%	275	16.4%	380	16.4%
Total	1,034	100.0%	1,671	100.0%	2,319	100.0%

In Section C, page 31, the applicant provides the assumptions and methodology used to project patient origin. The applicant states projected patient origin is based on CCGH’s outpatient surgical and GI endoscopy patient origin for ZIP Codes identified in the tables, which collectively represent approximately 84 percent of projected operating room and procedure room procedures for the proposed project. The applicant’s assumptions are reasonable and adequately supported based on the following:

- The applicant uses CCGH’s historical outpatient surgical and GI endoscopy patient origin to project future patient origin.
- The applicant assumes that 17% of its patients will be residents from Zip Codes outside of its proposed service area.

Analysis of Need

In Section C, pages 35-45, the applicant explains why the patients it proposes to serve need the proposed services, as summarized below.

- **Continuing Shift of Surgery from Inpatient to Outpatient-** The applicant states that *“Surgical Trends for more than four decades, improvements in anesthesia and surgical techniques have resulted in less invasive procedures and faster patient recovery following surgery. According to data reported to DHSR and included in the 2025 State Medical Facilities Plan, 77 percent of North Carolina surgical procedures were outpatient. This is an increase from the 73 percent in 2019. Because most outpatient surgery can be scheduled ahead of time, national trends also favor freestanding ambulatory surgical settings, that have limited hours, focused surgical types and that can flex schedules to match scheduled demand. These efficiencies permit ambulatory surgery centers to provide care at lower cost. Hospital cases, though a smaller percentage of the total, are also becoming more complex and requiring more surgical time.”* (pages 35-36)
- **Payor and Patient Demand for Low Costs and Charges for Low-Risk Surgical Procedures-** The applicant states that *“Medicare sets the pace for health care reimbursement rates. Hospital rates, even in an outpatient setting, are higher than ambulatory surgery center rates. In 2019, HFMA estimated that ambulatory surgery center payments are about 52 percent of hospital (HOPD) rates, especially if the hospital outpatient surgery is on the hospital main campus. Off-campus HOPDs certified after 2019 receive rates comparable to ambulatory surgery centers, but they represent a very small percentage of HOPD Medicare spending. The applicant further states, “population health” and other initiatives that focus on containing costs of health care services are directing surgical outpatients toward ambulatory surgery centers.”* (pages 36-37)
- **Changes in Healthcare Workforce Availability-** The applicant states that *“Until recently, most Carteret County physicians were self-employed or were members of small single or multi-specialty physician groups. That is changing. Most primary care providers are now hospital employees. Surgeons and specialists are either members of large regional groups like Emerge Ortho or Eastern Radiology Associates, or they are seeking employment in the health care system. The change is driven by complexity of rules, data management and billing systems. When surgeons leave private practice employment, they also surrender ownership relationships with private ambulatory surgical centers.”* (page 38)
- **Control of Ambulatory Surgical Center by CCGH –** The applicant states that *“The one freestanding ambulatory surgery center in Carteret County is a joint venture of a private national company, AmSurg, and local surgeons. The Surgical Center of Morehead City (“SCMC”) has two operating rooms, one GI endoscopy room. It is owned by a joint venture between AmSurg, a national ambulatory surgery company⁸ and local surgeons. CCGH has no ownership relationship with this ASF. SCMC building was constructed in the 1990’s and the joint venture arrangement worked, until recently. Original surgical owners are retiring or leaving their groups and seeking CCGH employment. When they leave, they lose privileges at SCMC. To offer local patients and their surgeons a full range of surgical services, CCGH needs an*

ambulatory surgery center that shares its financial and charity policies and that will accept their patients.” (page 39)

- **Inability to Qualify for the Statutory QUASF Option**– The applicant states that *“CCGH serves permanent residents of four counties, Carteret, Craven, Onslow, and Jones. The service area for the proposed ASF is Carteret and zip codes in Craven, Jones, and Onslow Counties. As detailed in Step 2 of the Utilization methodology in Section Q of this application, national demographer, Claritas predicts the population of all but one of the small zip codes in the proposed service area will grow between 2025 and 2030 at a compound annual growth rate (“CAGR”) of 0.8 percent.” (pages 39-41)*
- **Population Need for Surgical Services**- The applicant states that *“Health and prevention statistics from the North Carolina State Center for Health Statistics indicate that county health providers will see high demand for surgical services and for a provider that will share information about root causes of disease and opportunities for improvement. This sharing is more easily accomplished in a system that has an established case management program and whose mission is community health improvement. Exhibit C.4, page 12 has detailed metrics on community health status and risk factors for service area counties. These estimates are based on The Behavioral Risk Factor Surveillance System (“BRFSS”). BRFSS provides county-level data regarding important health outcomes that indicate need for surgical access in the service area counties. Trends include higher percentage rates of residents with diagnosed obesity, diabetes, heart disease, cancer, and stroke than the state as a whole.” (page 42-45)*
- **Pediatric Dental Surgery in Carteret County**- The applicant states that *“North Carolina hospital licensure regulations prohibit pediatric dentists from directly admitting patients for surgical procedures. Another licensed physician in the hospital must admit the pediatric dental patient and take responsibility for the care. This is cumbersome at best and adds risk that few physicians wish to take. NC ambulatory surgery licensure rules permit dentists to admit patients directly for surgery. Based on experience of the dental only demonstration ambulatory surgery project, about 9 percent of Medicaid children under age 9 have dental issues so complex that they are best treated under general anesthesia¹³. This would be the first surgery location in Carteret County that accommodates pediatric dental patients. One pediatric dentist approached Carteret Health Care requesting ASF time for her patients.” (page 45)*

The information is reasonable and adequately supported for the following reasons:

- The applicant identifies existing constraints that it believes justifies the need to relocate an existing ORs to develop an ASF as surgical trends are shifting from inpatient to outpatient settings.
- The applicant adequately describes how private and government payors now focus on cost containment measures that direct patients toward ambulatory surgical facilities.

- The applicant provides reliable data, makes reasonable statements about the data, and uses reasonable assumptions about the data to demonstrate the projected population growth in the area.
- The applicant identifies a need for pediatric dentistry and other demographics support needs.

Projected Utilization

On Form C.3b in Section Q, the applicant projects utilization for the first three full fiscal years of operation following project completion, as shown in the table below.

Carteret Health Care Surgery Center at Cedar Point, LLC Projected Utilization FFYs 1 – 3 (CYs 2027 – 2030)			
Form C.3b Projected OR and GI Endo Room Utilization upon Project Completion	F: 10/01/2027 to 10/01/2028	F: 10/01/2028 to 10/01/2029	F: 10/01/2029 to 10/01/2030
Operating Rooms - Number of Rooms by Type			
Open Heart ORs			
Dedicated C-Section ORs			
Other Dedicated Inpatient ORs			
Shared ORs			
Dedicated Ambulatory ORs	1	1	1
Total # of ORs	1	1	1
# of Excluded ORs			
Adjusted Planning Inventory	1	1	1
Surgical Cases	Surgical Cases	Surgical Cases	Surgical Cases
# of C-Sections Performed in Dedicated C-Section ORs			
# of Inpatient Surgical Cases			
# of Outpatient Surgical Cases	1,034	1,418	1,502
Total # of Surgical Cases	1,034	1,418	1,502
Case Times			
Inpatient			
Outpatient	1.17	1.17	1.17
Surgical Hours			
Inpatient			
Outpatient	1,210	1,659	1,758
Total Surgical Hours	1,210	1,659	1,758
# of ORs Needed			
Group Assignment	6	6	6
Standard Hours per OR per Year	1312	1312	1312
Total Surgical Hours / Standard Hours per OR per Year	0.92	1.26	1.34
Procedure Rooms			
# of Rooms	1	1	#1
# of Outpatient Cases	-	254	817

In the Utilization Methodology and Assumptions subsection of Section Q, the applicant provides the assumptions and methodology used to project utilization, as summarized below.

Step 1. Identify ASC Service Area ZIP Codes

In Section Q, page 117, the applicant states that “*the proposed ASC will be located in Cedar Point, in western Carteret County. The Applicant defines the service area (“SA”) as all ZIP Codes within Carteret County, along with ZIP Codes 28532 (Craven County), 28539 and*

28584 (Onslow County), and 28555 (Jones County). These ZIP Codes are included based on their close geographic proximity to Cedar Point and historical utilization patterns.”

Step 2. Identify Service Area ZIP Codes Population 2020-2030

In Section Q, page 119, the applicant identifies the service area zip codes population *“by using 2020, 2025, and 2030 population estimates provided by Claritas, a nationally recognized demographic data source. For interim years (2021–2024 and 2026–2029), the Applicant calculates estimates by applying each ZIP Code’s five-year compound annual growth rate (CAGR) to the prior year’s population.”*

The applicant provides detailed ZIP Code-level population estimates and CAGR calculations for the service area between 2020 and 2030.

Step 3. Identify Historic SA Surgical Use Rate

In Section Q, page 121, *“The applicant obtains outpatient surgery discharge data from HIDI for fiscal years 2021 through 2024. For purposes of this methodology, the terms discharges, cases, and patients are used interchangeably and refer to a single outpatient surgical encounter.*

The Applicant calculates the historic outpatient surgery use rate for FY2021 through FY2024 by dividing the number of outpatient surgery patients from the service area by the corresponding service area population for each year from FY2021 through FY2024. The result is multiplied by 1,000 to determine the annual use rate per 1,000 population. This provides a baseline reference for estimating future outpatient surgery use.

Outpatient surgery use rates in the service area steadily trended upward over the four-year period. Specifically, the use rate increased from 77 per 1,000 residents in FY2021 to 84 per 1,000 in FY2024, an increase of 7 per 1,000 population. This trend reflects growing demand for outpatient surgical services, driven by factors such as demographic shifts and increased patient and payor preference for ambulatory settings, as described in Section C.4 of this application.”

The applicant provides a table that demonstrates the calculated annual outpatient surgical use rates for the service area:

SA OP Surgery Use Rate FY2021-2024						
Note	Metric	2021	2022	2023	2024	Net Increase 2021-2024
a	SA OP patients	9,348	9,361	10,277	10,493	1,145
b	SA Population	121,776	122,810	123,857	124,918	3,142
c	SA OP use rate per 1k pop	77	76	83	84	7

Notes:

- a. HIDI Outpatient surgery discharge data
- b. Population identified in Step 2
- c. a / b * 1000

Step 4. Identify SA OP Surgery Need FY2025-2030

In Section Q, page 122, “*The Applicant estimates annual outpatient surgery need in the service area by multiplying the service area population (see Step 2) by the FY2024 outpatient surgery use rate (from Step 3), then dividing by 1,000, as the use rate is defined per 1,000 residents. This calculation yields the projected number of outpatient surgery patients in the service area through FY2030, the third full project year.*

To convert patients into surgical hours, the Applicant multiplies the projected number of outpatient surgery patients by 1.173 hours per case, which represents the average final ambulatory case time for Group 6 (ASCs) as reported in the 2025 State Medical Facilities Plan (SMFP).

The Applicant then divides the total surgical hours by 1,312, the SMFP standard number of annual hours per operating room (“OR”) for ASCs. This provides the number of ORs needed to meet projected outpatient surgery demand in the service area. There are currently seven ORs available in the service area geography. The Applicant subtracts these from the calculated OR need to determine the projected OR surplus or deficit. This analysis indicates a deficit of 2.8 ORs by 2030. “

The applicant provides the calculations by year in the table below.

SA OP Surgery Need and OR Surplus/Deficit FY2025-2030							
Note	Metric	2025	2026	2027	2028	2029	2030
a	SA OP patients	125,993	126,959	127,936	128,923	129,922	130,931
b	SA Population	84	84	84	84	84	84
c	SA OP patients	10,583	10,664	10,746	10,829	10,913	10,998
d	OP Case Time (hours)	1.173	1.173	1.173	1.173	1.173	1.173
e	OP Surgical Hours	12,418	12,513	12,609	12,707	12,805	12,904
f	ASC Standard	1,312	1,312	1,312	1,312	1,312	1,312
g	ORs Needed	9.5	9.5	9.6	9.7	9.8	9.8
h	ORs available in the service area geography	7	7	7	7	7	7
i	Surplus/Deficit	(2.5)	(2.5)	(2.6)	(2.7)	(2.8)	(2.8)

Notes:

- a. Population identified in Step 2
- b. Use rate from Step 3, Table 4, Row c
- c. $a * b / 1000$
- d. 2025 SMFP average final OP case time for Group 6 (ASCs)
- e. $c * d$
- f. SMFP Standard for ASCs (Group 6)
- g. e / f
- h. OR inventory pulled from Table 6B of 2025 SMFP
- i. $g - h$

Step 5. Identify Service Area Counties GI Endoscopy Use Rates

In Section Q, page 124, *“The applicant will provide GI endoscopy procedures as well as surgical cases in the ASC operating room. After careful analysis, the Applicant finds that HIDI data underreport GI endoscopy patient counts. For example, in FY2024 HIDI reported 335 GI outpatient endoscopy cases for CCGH while the LRA and CHC internal data show 414 cases. Therefore, to assess GI endoscopy need in the service area, the Applicant uses FY2023, the most recent available, DHSR patient origin reports which are sourced from LRA data.*

DHSR patient origin data are grouped by county instead of ZIP Code. To estimate a service area GI endoscopy use rate, the Applicant first identifies the use rate for each county in the service area. The Applicant calculates FY2023 county GI endoscopy use rates by dividing the number of GI endoscopy patients from each service area county by the corresponding county populations. The result is multiplied by 1,000 to determine the annual use rate per 1,000 population.”

The applicant provides the FY2023 county-level GI endoscopy use rate calculations in the table below.

GI Endoscopy Use Rate by County of Residence FY2023					
Note	Metric	Carteret	Craven	Jones	Onslow
a	GI endoscopy patients	3,655	8,315	791	9,484
b	Population	70,268	103,605	9,208	213,447
c	Use Rate per 1,000 residents	52	80	86	44

Notes:

- a. DHSR 2024 Report. GI endoscopy Patients: Patient Origin by County of Residence
- b. NC OSBM Population by race, sex, age groups, accessed May 12, 2025
- c. a / b * 1000

Step 6. Estimate Total SA GI Endoscopy Use Rate

In Section Q, page 125, The applicant states that *“To estimate GI endoscopy need in the proposed ASC service area, the Applicant calculates a weighted average FY2023 use rate using DHSR county-level patient origin data. Although the DHSR data reports GI endoscopy use by full county, the Applicant’s service area is defined by ZIP Codes. To calculate a service area use rate, the Applicant groups the included ZIP Codes by county and applies the ZIP Codes’ combined population to weight each county’s use rate.”*

The applicant provides detailed service area GI endoscopy use rate calculations in the table below.

Estimated FY2023 SA GI Endoscopy Use Rate						
Note	Metric	Carteret	Craven	Jones	Onslow	Total Service Area
a	SA ZIPs Population	62,703	22,045	5,376	33,733	123,857
b	% of Service Area	51%	18%	4%	27%	100%
c	Use Rate	52	80	86	44	56

Notes:

- a. SA ZIPs population aggregated by County
- b. a / total SA population (123,857)
- c. Use rate identified in Step 5, Table 6, Row c. Calculation of total SA use rate:
 (Carteret b x c) + (Craven b x c) + (Jones b x c) + (Onslow b x c)

Step 7. Estimate GI Endoscopy Patients FY2023-2030

In Section Q, page 126, *“The applicant estimates GI endoscopy need within the service area by multiplying the service area population (from Step 2) by the FY2023 service area GI endoscopy use rate (from Table 7, Row c), then dividing by 1,000, as the use rate is defined per 1,000 residents. This calculation yields the estimated number of GI endoscopy patients in the service area through FY2030.”*

The applicant provides detailed number of GI endoscopy patients in the service area through FY2030 in the table below.

Estimated FY2023 SA GI Endoscopy Use Rate									
Note	Metric								
a	SA ZIPs Population	123,857	124,918	125,993	126,959	127,936	128,923	129,922	130,931
b	GI endoscopy use rate	56	56	56	56	56	56	56	56
c	SA GI patients	6,991	7,051	7,112	7,167	7,222	7,277	7,334	7,391

Notes:

- a. Population identified in Step 2
- b. Use rate from Step 6, Table 7, Row C
- c. a * b / 1000

Step 8. Identify Historic OP Surgical Cases

In Section Q, page 127, the applicant states, *“To develop a reliable baseline for projecting future utilization of the proposed ASC, the Applicant analyzes historical outpatient surgery case volumes at CCGH from FY2021 through FY2024.”*

Historic case data are obtained from HIDI and reported by ZIP Code. The Applicant calculates FY2024 patient origin percentages for each ZIP Code by dividing the number of cases from that ZIP Code by the total CCGH outpatient surgery cases. Outpatient surgery cases have been increasing year over year.”

The applicant provided a table within the application to demonstrate how they identified historic OP surgical cases. The applicant used the following assumptions:

Step 9. Identify Historic CCGH OP Surgery SA Market Share

In Section Q, page 128, “*The Applicant analyzes FY2021-FY2024 service area outpatient case volumes to estimate CCGH’s current market share of service area patients. Market share is calculated by dividing CCGH outpatient cases by the total outpatient cases from the service area identified in Step 3, Table 4, Row a. CCGH consistently captures around 23 percent of service area outpatient surgery cases.*”

The applicant uses the FY2024 market share as a baseline to forecast future market shares in the table below.

CCGH Market Share of OP Surgical Patients in SA FY2021-2024						
Note	Metric	2021	2022	2023	2024	4-year
a	CCGH SA OP patients	2,090	2,246	2,429	2,478	
b	SA OP patients	9,348	9,361	10,277	10,493	
c	CCGH Market share %	22.4%	24.0%	23.6%	23.6%	23.4%

Notes

- a. Table 9 Total CCGH Service Area cases.
- b. Step 3, Table 4, Row a
- c. a / b

Step 10. Estimate Future OP Surgical Service Area Market Share 2025-2030

In Section Q, page 129, “*The applicant expects its market share to increase when the proposed ASC becomes available. The only freestanding ASC in Carteret County restricts use to physician owners. Moreover, there is no freestanding ASC in the other service area ZIP Codes. The Applicant increases annual market share by 4 percent in the years FY2028, FY2029, and FY2030.*”

The applicant provides projected market share by year in the table below.

CHC Estimated Market Share FY2025-2030							
Note	Metric	2025	2026	2027	2028	2029	2030
a	Previous year share	23.6%	23.6%	23.6%	23.6%	27.6%	31.6%
b	Annual % Increase	0%	0%	0%	4%	4%	4%
c	Expected market share	23.6%	23.6%	23.6%	27.6%	31.6%	35.6%

Notes:

- a. 2025 is Step 9, Table 10, Row c, 2024 CCGH market share; other columns are previous year’s market share.
- b. Increase estimate
- c. a + b

Step 11. Calculate Projected Outpatient Surgical Patients from SA, 2025-2030

In Section Q, page 130, “*The Applicant projects outpatient surgical patients originating from the service area for FY2025 through FY2030 by applying the market share assumptions from Step 10 to the estimated service area outpatient surgical need from Step 4, Table 5, Row c.*”

The applicant provides projected outpatient surgical patients originating from the service area for FY2025 through FY2030 in the table below.

CHC Projected SA OP Surgical Patients FY2025-2030							
Note	Metric	2025	2026	2027	2028	2029	2030
a	SA OP surgical patients	10,583	10,664	10,746	10,746	10,829	10,998
b	Expected market share	23.6%	23.6%	23.6%	27.6%	31.6%	35.6%
c	CHC OP surgical patients	2,499	2,518	2,538	2,991	3,450	3,917

Notes:

- a. Step 4, Table 5, row c
- b. Step 10, Table 11, Row c.
- c. a * b

Step 12. Identify Historic Percent In-Migration for CCGH Surgical Cases

In Section Q, page 131, “*CCGH receives patients from outside the project service area. The most recent available ZIP Code data are for FY2023 and FY2024. The Applicant calculates CCGH surgical in-migration percentage by dividing the cases outside the service area from Step 9 by the total CCGH outpatient surgery cases.*”

The applicant uses these in-migration percentages to calculate a two-year average rate of 15.2 percent, which will be applied to estimate future in-migration cases at CCGH and is demonstrated in the table below.

Historic CCGH OP Surgical in-migration FY2023-2024				
Note	Metric	2023	2024	2-year
a	Total CCGH OP cases	2,843	2,946	2,895
b	In-migration cases	414	468	441
c	In-migration %	14.6%	15.9%	15.2%

2-year average calculation: (2023 value + 2024 value) / 2

Note:

- a. Total CCGH OP cases from Step 8, Table 9
- b. In-migration cases from Step 8, Table 9
- c. b / a

Step 13. Project CHC OP Surgical Utilization 2025-2030

In Section Q, page 132, the applicant states, “*To estimate total outpatient surgical utilization throughout the Carteret Health Care (“CHC”) system, the Applicant adjusts the service area projections from Step 11, Table 12, Row c to include expected cases from outside the service area. As described in Step 12, based on FY2023 and FY2024 data, CCGH’s calculated two-year average in-migration rate for outpatient surgical cases from outside the project service area is 15.2 percent.*”

The applicant’s final projected cases, inclusive of in-migration, are summarized in the table below.

CHC Projected SA OP Surgical Patients FY2025-2030							
Note	Patient Origin	2025	2026	2027	2028	2029	2030
a	Service area (84.8%)	2,499	2,518	2,538	2,991	3,450	3,917
b	in -migration (15.2%)	449	453	456	538	620	704
c	Total (100.0%)	2,949	2,971	2,994	3,528	4,070	4,621

Step 14. Project ASC Surgical Utilization 2028-2030

In Section Q, page 133, “The applicant estimates the number of outpatient surgery cases at the proposed ASC as a function of the net new outpatient surgical cases at CHC. Specifically, the Applicant calculates ASC cases as 75 percent of net new CHC outpatients after FY2024.

The 75 percent estimate is based on Applicant experience and is consistent with estimates of Patients appropriate for ASC as presented in other approved NC ASC applications, as shown in Exhibit C.5, p19. To calculate ASC utilization, the Applicant multiplies the net increase in outpatient surgical volumes over FY2024 levels by 75 percent for each project year. This yields the estimated number of patients who would receive surgical care at the proposed ASC.”

The applicant provides projections for the ASC outpatient surgical patients/cases from FY2025 to FY2030 in the table below.

Projected ASC Surgical Patients FY2028-2030							
Note	Metric	2025	2026	2027	2028	2029	2030
a	Estimated CHC OP surgical cases	2,949	2,971	2,994	3,528	4,070	4,621
b	2024 CCGH OP surgical cases	2,946	2,946	2,946	2,946	2,946	2,946
c	Net increase from 2024	3	25	48	582	1,124	1,675
d	ASC appropriate cases				75%	75%	75%
e	Surgical patients to ASC				437	843	1,256
f	Surgical Patients at CCGH	2,949	2,971	2,994	3,092	3,227	3,365
g	Percent of cases remaining at CCGH	100%	100%	100%	88%	79%	73%
h	ORs available in the service area geography	7	7	7	7	7	7

Notes:

- a. Step 13, Table 14, Row c
- b. 2024 amount identified in Step 8, Table 9
- c. a – b
- d. from provider experience, consistent with other CONs
- e. c * d
- f. a – e
- g. f / a

Step 15. Identify Case Mix and Case Counts by Specialty

In Section Q, page 134, “The Applicant estimates surgical case mix from a combination of CCGH’s historical outpatient surgical case mix and input from physicians expected to provide services at the facility. Thus, while historical volumes at CCGH inform expectations, the projected mix also reflects anticipated growth areas, provider interest, and the types of procedures most appropriate for an ambulatory setting.

The Applicant multiplies the total projected ASC surgical cases from Step 14 by the projected case mix to estimate surgical cases by specialty for each year of the projection period. This generates cases by specialty and supports planning for equipment, staffing, and financial modeling.”

The applicant provides the proposed surgical case mix and cases by specialty through 2030 in the table below.

Specialty	Case Mix			Number of Cases		
	2028	2029	2030	2028	2029	2030
Pediatric Dental	11.5%	5.9%	4.0%	50	50	50
Plastic	0.5%	0.2%	0.2%	2	2	2
Urology	0.5%	1.2%	1.6%	2	10	20
Vascular	2.3%	2.4%	1.6%	10	20	20
General	54.6%	57.8%	59.3%	238	487	745
Gynecology	0.9%	0.9%	0.9%	4	8	12
Orthopedic	29.8%	31.6%	32.4%	130	266	407
Surgical total	100.0%	100.0%	100.0%	437	843	1,256

Number of cases = case mix % * projected annual cases from Step 14, Table 15, Row e

Step 16. Identify CCGH Historic GI Endoscopy Patient Origin

In Section Q, page 135, the applicant states that, “As described in earlier steps, HIDI data underreports GI endoscopy case volumes and does not provide a reliable basis for forecasting future utilization. For this reason, the Applicant relies on data reported in 2024 and 2025 LRA, which includes more complete GI endoscopy volumes. However, LRA patient origin data is reported by county of residence, and the Applicant’s defined service area is based on ZIP Codes.

To estimate the share of GI endoscopy patients originating from the service area, the Applicant analyzes FY2023 and FY2024 ZIP-Code patient origin data from HIDI. For each year, the Applicant divides the number of CCGH GI endoscopy cases from ZIP Codes in the defined service area by total CCGH GI endoscopy cases. This analysis indicates that 84.8 percent of CCGH GI endoscopy patients originated from the service area in FY2023, and 83.0 percent in FY2024.”

The applicant provides FY2023 and FY2024 ZIP-Code patient origin data from HIDI in the table below.

HIDI CCGH GI Endoscopy Cases by ZIP Code FY2023-2024				
Zip	2023 Cases	2024 Cases	2023 Patient origin	2024 Patient origin
28511	3	2	0.7%	0.6%
28512	16	10	3.5%	3.0%
28516	56	42	12.4%	12.5%
28520	1	2	0.2%	0.6%
28524	2	2	0.4%	0.6%
28528	2	4	0.4%	1.2%
28531	7	3	1.5%	0.9%
28532	41	24	9.1%	7.2%
28539	21	19	4.6%	5.7%
28553	4	1	0.9%	0.3%
28555	1	2	0.2%	0.6%
28557	71	45	15.7%	13.4%
28570	92	74	20.3%	22.1%
28575	-	1	0.0%	0.3%
28577	1	1	0.2%	0.3%
28579	2	2	0.4%	0.6%
28581	-	1	0.0%	0.3%
28582	6	5	1.3%	1.5%
28584	47	25	10.4%	7.5%
28589	4	1	0.9%	0.3%
28594	7	12	1.5%	3.6%
Total SA cases	384	278	84.8%	83.0%
In-migration %	69	57	15.2%	17.0%
Total GI Endoscopy cases	453	335	100.0%	100.0%

In-migration = Total CCGH GI Endoscopy cases – Total SA cases

Step 17. Identify Historic CCGH GI Endoscopy SA Market Share

In Section Q, page 137, *“The Applicant uses total GI endoscopy cases reported in the 2024 and 2025 CCGH LRAs to Calculate CCGH’s historic market share in the service area. The Applicant applies percentages calculated from HIDI data in Step 16, Table 17 to the LRA GI case totals to estimate the number of GI endoscopy patients from the defined service area in FY2023 and FY2024.”*

The applicant provides the calculations for CHC Market Share of Estimated GI Endoscopy SA Need FY2025-2030 in the table below.

CHC Market Share of Estimated GI Endoscopy SA Need FY2025-2030							
Note	Metric	2025	2026	2027	2028	2029	2030
a	Previous year share	6.0%	6.0%	8.0%	10.0%	14.0%	17.0%
b	Annual % Increase	0%	2%	2%	4%	3%	3%
c	Expected market share	6.0%	8.0%	10.0%	14.0%	17.0%	20.0%

Notes:

- a. 2025 is Step 17, Table 18, Row e 2024 market share; other columns are prior year expected market share
- b. Increase estimate
- c. a + b

Step 18. Estimate Future GI Endoscopy SA Market Share FY2025-2030

In Section Q, page 138, the applicant states, “*GI Endoscopy is particularly well suited for an ASC. Most procedures are low-risk, and patients prefer the lower associated costs. Thus, the Applicant expects its own market share of GI endoscopy patients to increase when the ASC opens. The Applicant applies annual market share increases of 2 percent in FY2026 and FY2027, 4 percent in FY2028, and 3 percent in FY2029 and FY2030.*”

The applicant provides the calculations for CHC Market Share of Estimated GI Endoscopy SA Need FY2025-2030 in the below.

CHC Market Share of Estimated GI Endoscopy SA Need FY2025-2030							
Note	Patient Origin	2025	2026	2027	2028	2029	2030
a	Previous year share	6.0%	6.0% %	8.0%	10.0%	14.0%	17.0%
b	Annual % Increase	0%	2%	2%	4%	3%	3%
c	Expected market share	6.0%	8.0%	10.0%	14.0%	17.0%	20.0%

Step 19. Calculate Projected CHC GI Endoscopy Patients from SA 2025-2030

In Section Q, page 139, “*The Applicant calculates its projected GI endoscopy patients originating from the service area for FY2025 through FY2030 by applying the projected market shares from Table 19, Row c to the estimated service area GI endoscopy patients from Step 7, Table 8, Row c.*”

The applicant provides the projected market shares by year through 2030 in the table below.

CHC Projected SA OP GI Endoscopy Patients FY2025-2030							
Note	Metric	2025	2026	2027	2028	2029	2030
a	SA GI endoscopy patients	7,112	7,167	7,222	7,277	7,334	7,391
b	CHC market share	6.0%	8.0%	10.0%	14.0%	17.0%	20.0%
c	Expected market share	6.0%	8.0%	10.0%	14.0%	17.0%	20.0%

Step 20. Identify Historic CCGH GI Endoscopy In-Migration

In Section C, page 140, the applicant states, “*CCGH serves GI endoscopy patients from outside the service area. The Applicant identifies an immigration percentage by dividing the in-migration GI endoscopy cases from Step 16, Table 17 by the total CCGH GI endoscopy*

cases for FY2023 and FY2024, the most recent years available. The Applicant uses these in-migration percentages to calculate a two-year average rate of 16.0 percent, which will be applied to estimate future in-migration in the table below.”

CCGH GI Endoscopy In-migration FY2023-2024				
Note	Metric	2023	2024	2-year avg
a	CCGH GI Endoscopy cases	453	335	394
b	In-migration cases	69	57	63
c	In-migration %	15.2%	17.0%	16.0%

Step 21. Project CHC GI Endoscopy Utilization FY2025-2030

In Section Q, page 141, the applicant states *“To estimate total GI endoscopy utilization throughout the CHC system, the Applicant adjusts the service area projections from Table 20, Row c to include cases from outside the service area.*

The Applicant applies the two-year average from Step 20 (16 percent) to each year’s service Area projection. Specifically, volumes are divided by 0.84 (1 –0.16) to calculate total projected utilization inclusive of in-migration. This approach assumes that historic in-migration patterns remain consistent the projection period. Internal CHC data show that most of the in-migration comes from communities just outside the service area. The Applicant expects these communities to experience similar growth.”

CHC GI Endoscopy Patients FY2025-2030							
Note	Patient Origin	2025	2026	2027	2028	2029	2030
a	Service area cases (84%)	426	573	721	1,018	1,246	1,477
b	in-migration cases (16%)	81	109	137	194	237	281
c	Total GI Endoscopy cases(100%)	507	682	859	1,212	1,483	1,759

Step 22. Project ASC GI Endoscopy Utilization FY2028-2030

In Section Q, page 142, the applicant states *“projects ASC GI endoscopy utilization as a percentage of growth in CHC’s GI endoscopy patients. The methodology assumes that all patients at the proposed ASC are net new patients to Carteret Health.*

The Applicant conservatively estimates from its own experience that 85 percent of GI endoscopy cases (patients) are appropriate for an outpatient setting. State data from the DHSR database for FY2022 and FY2023 suggest a higher rate (92 percent)². To calculate ASC utilization, the Applicant multiplies the net increase in GI endoscopy cases after FY2024 by 85 percent.”

The applicant provides the projected the basis for planning facility space, staffing, and financial modeling in the table below.

Projected ASC GI Endoscopy Patients FY2028-2030				
Note	Metric	2028	2029	2030
a	Estimated CHC GI Endoscopy cases	1,212	1,483	1,759
b	2024 CCGH GI Endoscopy cases	509	509	509
c	Net increase from 2024	703	974	1,250
d	ASC appropriate cases	85%	85%	85%
e	GI Endoscopy patients to ASC	597	828	1,062

Step 23. Calculate Operating Rooms Justified

In Section Q, page 143, “*The Applicant forecasts total ASC utilization by converting projected surgical and GI endoscopy cases into operating room hours.*”

The Applicant estimates surgical OR hours by multiplying projected surgical cases by 1.173 hours per case, the average final ambulatory case time for ASCs as published in the SMFP. Similarly, the Applicant multiplies GI endoscopy cases by 0.75 hours per case (45 minutes), based on CCGH experience. The Applicant then sums the surgical and GI endoscopy operating room hours to calculate the total operating room hours required at the ASC.

To determine the number of ORs needed, the Applicant divides total required OR hours by the SMFP standard of 1,312 hours per OR annually for ASCs. Based on this analysis, the Applicant demonstrates a need for 1.7 operating rooms at the proposed ASC.”

The applicant provides the projected OR Need at ASC FY2028-2030 in the table below.

OR Need at ASC FY2028-2030				
Note	Metric	2028	2029	2030
a	Surgical patients	437	843	1,256
b	ASC surgical case time	1.173	1.173	1.173
c	Surgical Hours	512	990	1,474
d	GI endoscopy patients	597	828	1,062
e	GI endoscopy case time	0.75	0.75	0.75
f	GI endoscopy hours	448	621	797
g	Proposed ASC total hours	960	1,611	2,271
h	ASC OR standard	1312	1312	1312
i	ORs needed ASC standard	0.7	1.2	1.7

Step 24. Allocate Cases to Operating Room and Procedure Room

In Section Q, page 144, the applicant states, “*While the projected utilization justifies two operating rooms, the Applicant proposes to relocate one operating room from CCGH and develop one additional procedure room at the proposed ASC. The procedure room will meet the same design and safety standards as the operating room and will be used to accommodate excess surgical cases beyond the licensed operating room's capacity.*”

The applicant provides the projected ASC Operating Room and Procedure Room Cases FY2028-2030 in the table below.

ASC Operating Room and Procedure Room Cases FY2028-2030				
Note	Metric	2028	2029	2030
a	GI endoscopy cases in OR	597	828	1,062
b	GI endoscopy hours	448	621	797
c	OR capacity (hours)	1,312	1,312	1,312
d	Remaining OR hours	864	691	515
e	Total surgical hours	512	990	1,474
f	Surgical hours in OR	512	691	515
g	Surgical hours in PR	-	299	959
h	Surgical case time (hours)	1.173	1.173	1.173
i	Surgical cases in OR	437	589	439
j	Surgical cases in PR	-	254	817
k	Total OR cases	1,034	1,417	1,501

Step 25. Calculate Average OR Case Time

In Section Q, page 146, the applicant states that “*Form C.3b requires use of the Group 6 Ambulatory Surgery case times, 1.173 hours per case. The Applicant completed the form as instructed. However, to determine actual case times, the Applicant calculates the average case time for all operating room procedures by applying a weighted average of surgical and GI endoscopy case times based on the projected share of each case type. This calculation produces a case time that is lower than the standard for Group 6.*”

As shown in in Table 26, surgical cases represent 42 percent in FY2028 & FY2029, and 29 In FY2030 of total operating room cases. These are multiplied by the SMFP average surgical case time of 1.173 hours. GI endoscopy cases, which make up the remaining share, are multiplied by an average case time of 0.75 hours (45 minutes).”

The weighted times are summed to calculate the average OR case time for each year which is provided in the table below.

OR Case Time Calculation FY2028-2030				
Note	Metric	2028	2029	2030
a	Total OR cases	1034	1417	1501
b	OR surgical cases	437	589	439
c	OR GI endoscopy cases	597	828	1062
d	Surgical % of total	42%	42%	29%
e	GI endoscopy % of total	58%	58%	71%
f	Surgical case time	1.173	1.173	1.173
g	GI endoscopy case time	0.75	0.75	0.75
h	OR average case time	0.93	0.93	0.87

Step 26. Identify CCGH Surgical Cases After ASC Opens

In Section Q, page 147, the applicant states, “*For informational purposes, the Applicant projects total CCGH surgery cases during the first three project years of the proposed ASC.*”

The applicant shows anticipated surgical case distribution between CCGH and the proposed

ASC following project implementation from FY2025 through FY2030 provided in the table below.

CCGH OR Utilization FY2025-2030							
Note	Metric	2025	2026	2027	2028	2029	2030
a	Inpatient cases	1108	1108	1108	1108	1108	1108
b	Average inpatient case time	1.82	1.82	1.82	1.82	1.82	1.82
c	Inpatient surgical hours	2013	2013	2013	2013	2013	2013
d	Outpatient cases	2949	2971	2994	3092	3227	3365
e	Average outpatient case time	1.65	1.65	1.65	1.65	1.65	1.65
f	Outpatient surgical hours	4865	4902	4940	5101	5325	5552
g	Total Facility Surgical Hours	6879	6916	6954	7114	7338	7565
h	Number of Shared ORs	5	5	5	4	4	4
i	Hours per OR	1376	1383	1391	1779	1835	1891
j	Hospital Standard	1500	1500	1500	1500	1500	1500
k	ORs Justified	4.6	4.6	4.6	4.7	4.9	5.0

Step 27. Identify Patient Origin for Proposed ASC ORs

In Section Q, pages 149-150, the applicant states that “*projects patient origin for operating room cases at the proposed ASC by applying weighted FY2024 patient origin percentages for surgical and GI endoscopy cases to the projected case mix in each year.*”

Using the projected surgical and GI endoscopy shares of total OR cases from Table 26, Rows d & e, the Applicant multiplies the FY2024 GI endoscopy patient origin percentages by the GI case share, and the FY2024 surgical patient origin percentages by the surgical case share. It then sums the two weighted values to calculate the total projected OR patient origin by ZIP Code in Table 28.”

OR Patient Origin Percentages FY2028-2030					
Zip	2028 OR	2029 OR	2030 OR	2024 GI ENDO	2024 Surgical
28511	0.4%	0.4%	0.5%	0.6%	0.2%
28512	3.1%	3.1%	3.0%	3.0%	3.2%
28516	12.0%	12.0%	12.2%	12.5%	11.3%
28520	0.5%	0.5%	0.5%	0.6%	0.3%
28524	0.5%	0.5%	0.5%	0.6%	0.4%
28528	0.9%	0.9%	1.0%	1.2%	0.4%
28531	1.0%	1.0%	1.0%	0.9%	1.2%
28532	7.9%	7.9%	7.7%	7.2%	8.9%
28539	6.3%	6.3%	6.1%	5.7%	7.1%
28553	0.5%	0.5%	0.4%	0.3%	0.7%
28555	0.7%	0.7%	0.7%	0.6%	0.8%
28557	13.8%	13.8%	13.7%	13.4%	14.3%
28570	20.8%	20.8%	21.2%	22.1%	19.0%
28575	0.2%	0.2%	0.3%	0.3%	0.1%
28577	0.3%	0.3%	0.3%	0.3%	0.4%
28579	0.6%	0.6%	0.6%	0.6%	0.5%
28581	0.2%	0.2%	0.3%	0.3%	0.1%
28582	1.4%	1.4%	1.4%	1.5%	1.2%
28584	8.6%	8.6%	8.3%	7.5%	10.2%
28589	0.3%	0.3%	0.3%	0.3%	0.2%
28594	3.5%	3.5%	3.5%	3.6%	3.3%
Other	16.5%	16.5%	16.7%	17.0%	15.9%
Total	100.0%	100.0%	100.0%	100.0%	100.0%

Step 28. Identify OR Patient Origin Cases by ZIP Codes

In Section Q, page 151, the applicant states that “*The Applicant applies the patient origin percentages calculated in Step 27 to the projected ASC OR cases from Step 24, Table 25, Row k to estimate the number of OR cases by ZIP Code. This calculation is performed for each year and ZIP Code for the years FY2028-2030.*”

The OR Patient Origin: Cases by ZIP Code, FY2028-2030 is provided in the table below.

OR Patient Origin: Cases by ZIP Code, FY2028-2030			
Zip	2028 OR	2029 OR	2030 OR
28511	5	6	7
28512	32	44	46
28516	124	170	183
28520	5	7	8
28524	5	7	8
28528	9	12	15
28531	11	14	15
28532	82	112	115
28539	65	89	92
28553	5	6	6
28555	7	10	10
28557	143	196	206
28570	215	295	318
28575	2	3	4
28577	4	5	5
28579	6	8	9
28581	2	3	4
28582	14	19	21
28584	89	122	124
28589	3	4	4
28594	36	49	53
Other	171	234	251
Total	1034	1417	1501

Step 29. Identify Procedure Room Patient Origin

In Section, Q, page 152, “The Applicant holds procedure room patient origin constant at the FY2024 outpatient surgery patient percentages from Step 8, Table 9. This approach is reasonable because all procedure room cases are surgical, and the distribution of those patients is expected to reflect historic patterns.

To estimate procedure room cases by ZIP Code for FY2029 and FY2030, the Applicant multiplies each ZIP Code’s FY2024 surgical patient origin percentage by the projected procedure room case volumes. No procedure room cases are projected for FY2028. See Table 30 for projected procedure room patient origin by ZIP Code.”

Procedure Room Patient Origin Cases by ZIP Code, FY2028-2030				
Zip	2024 Patent Origin	Cases		
		2028	2029	2030
28511	0.2%	-	1	2
28512	3.2%	-	8	26
28516	11.3%	-	29	92
28520	0.3%	-	1	3
28524	0.4%	-	1	3
28528	0.4%	-	1	4
28531	1.2%	-	3	10
28532	8.9%	-	23	73
28539	7.1%	-	18	58
28553	0.7%	-	2	6
28555	0.8%	-	2	7
28557	14.3%	-	36	117
28570	19.0%	-	48	155
28575	0.1%	-	0	1
28577	0.4%	-	1	3
28579	0.5%	-	1	4
28581	0.1%	-	0	1
28582	1.2%	-	3	10
28584	10.2%	-	26	83
28589	0.2%	-	1	2
28594	3.3%	-	8	27
Other	15.9%	-	40	130
Total	100.0%	-	254	817

Step 30. Identify Entire Facility Patient Origin

In Section Q, page 143, the applicant states, *“The Applicant identifies entire facility patient origin by summing each ZIP Code’s projected operating room cases from Table 29 and procedure room cases from Table 30. For each project year, the Applicant totals the number of cases by ZIP and divides that figure by the total number of cases in that year to calculate patient origin percentages. This produces a single patient origin distribution inclusive of both room types. Table 31 provides the entire facility patient origin by ZIP Code for FY2028 through FY2030.”*

Entire Facility Patient Origin at Proposed ASC FY2028-2030						
	Zip Cases			% of Total		
	2028	2029	2030	2028	2029	2030
28511	5	7	9	0.4%	0.4%	0.4%
28512	32	52	72	3.1%	3.1%	3.1%
28516	124	199	275	12.0%	11.9%	11.9%
28520	5	8	11	0.5%	0.5%	0.5%
28524	5	8	11	0.5%	0.5%	0.5%
28528	9	14	18	0.9%	0.8%	0.8%
28531	11	17	24	1.0%	1.0%	1.1%
28532	82	135	188	7.9%	8.1%	8.1%
28539	65	107	150	6.3%	6.4%	6.5%
28553	5	8	12	0.5%	0.5%	0.5%
28555	7	12	17	0.7%	0.7%	0.7%
28557	143	232	323	13.8%	13.9%	13.9%
28570	215	343	473	20.8%	20.5%	20.4%
28575	2	4	5	0.2%	0.2%	0.2%
28577	4	6	8	0.3%	0.4%	0.4%
28579	6	9	13	0.6%	0.6%	0.5%
28581	2	4	5	0.2%	0.2%	0.2%
28582	14	22	31	1.4%	1.3%	1.3%
28584	89	148	208	8.6%	8.9%	9.0%
28589	3	4	6	0.3%	0.3%	0.3%
28594	36	58	80	3.5%	3.5%	3.4%
Other	171	275	380	16.4%	16.4%	16.4%
Total	1,034	1,671	2,319	100.0%	100.0%	100.0%

Projected utilization is reasonable and adequately supported based on the following:

- The applicant’s projections of outpatient surgical cases are from a combination of CCGH’s historical outpatient surgical case mix and input from physicians expected to provide services at the facility.
- The projected surgical case mix reflects anticipated growth areas, provider interest, and the types of procedures most appropriate for an ambulatory setting.
- The applicant reasonably projects the number of cases that will shift to Carteret Health Care Surgery Center at Cedar Point South based on historical outpatient surgery case volumes at CCGH from FY2021 through FY2024.
- Projected utilization during the third full fiscal year of operation meets the minimum of 1312 surgical cases per year per operating room required in the 2025 SMFP standard of 1,312 hours per OR annually for ASCs.

Access to Medically Underserved Groups

In Section C, page 51, the applicant states:

“CHCSC-CP will take advantage of the policies and procedures set forth by its sole member, CCGH. CCGH accepts patients regardless of gender, gender preference, race, ethnicity, age, or income, it can and does also serve persons with disabilities. See Exhibit C.6 for a copy of its non-discrimination policy. CCGH has Medicare and Medicaid certification and provides services to both sets of beneficiaries..”

In Section C, page 54, the applicant provides the estimated percentage of patients it projects to serve in its third full fiscal year of operation, for each medically underserved group, as shown in the following table.

Medically Underserved Groups	Percentage of Total Patients
Low income persons	7.2%
Racial and ethnic minorities	20.5%
Women	49.2%
Persons with disabilities	17.2%
Persons 65 and older	22.7%
Medicare beneficiaries	37.9%
Medicaid recipients	7%

The applicant adequately describes the extent to which all residents of the service area, including underserved groups, are likely to have access to the proposed services based on the following:

- The applicant provides a statement that it will provide access to the proposed services for underserved groups.
- The applicant provides a copy of the CHCSC-CP non-discrimination policy it will use at Carteret Health Care Surgery Center at Cedar Point in Exhibit C.6.

Conclusion

The Agency reviewed the:

- Application
- Exhibits to the application

Based on that review, the Agency concludes that the application is not conforming to this criterion for all the reasons described above.

- (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, ... persons [with disabilities], and other underserved groups and the elderly to obtain needed health care.

C

The applicant proposes to develop a new ASF by relocating one existing OR from Carteret County General Hospital and developing one procedure room.

In Section D, page 59, the applicant provides a table of the proposed reduction or elimination of operating rooms as illustrated below:

Carteret County General Hospital		
Service Component to be Reduced or Eliminated	Number to be Reduced or Eliminated	Number Remaining
Operating Room	1	4

In Section C, page 59, the applicant explains why it believes the needs of the population presently utilizing the services to be reduced and relocated will be adequately met following completion of the project. The applicant states:

“The 2025 SMFP Table 6B: Projected Operating Room Need for 2027, shows a projected surplus of 0.87 ORs at CCGH by 2027. The move will not affect patient access. Should surgical service demand at CCGH increase, the hospital can serve patients because the space vacated by the relocated operating room will become a procedure room with associated board and medical staff-approved policies for use of that room for surgical cases. This approach is approved by the DHSR Licensure Section in response to the 2014 Kirshbaum ruling. See the Need and Utilization Methodology in Section Q pages 9-13 for forecast surgical demand at CCGH.”

The information is reasonable and adequately supported based on the following:

- The move will not affect patient access.
- There will still be four ORs available for use at CCGH
- The space vacated by the relocated operating room will become a procedure room with associated board and medical staff-approved policies for use of that room for surgical cases.

Access to Medically Underserved Groups

In Section D, page 60, the applicant states:

“...Because CCGH will continue to serve its geographic area population according to its charitable mission and the needs of prescriptions of the SMFP, relocation of one operating room from Morehead City to Cedar Point will have no negative effects on low-income persons, racial and ethnic minorities, or other medically underserved populations.

Because the relocation will give CCGH patients the option of a freestanding ASF that offers medical privileges regardless of ownership, the project will increase access to all residents regardless of payor, gender, or age. Presently, access to the freestanding ASF in Carteret County is restricted to patients of surgeon owners.”

“The applicant projects a conservative shift of surgical cases from CCGH in Morehead City, where the relocated room originates, to the new facility in Cedar Point. According to these projections, the remaining four operating rooms at CCGH will be adequate and appropriate to serve the hospital’s primary service area population according to the thresholds set by the SMFP. See detail in Form D.3 and associated assumptions and methodologies in Section Q of this application.

Because CCGH will continue to serve its geographic area population according to its charitable mission and the needs of prescriptions of the SMFP, relocation of one operating room from Morehead City to Cedar Point will have no negative effects on low-income persons, racial and ethnic minorities, or other medically underserved populations.

Because the relocation will give CCGH patients the option of a freestanding ASF that offers medical privileges regardless of ownership, the project will increase access to all residents regardless of payor, gender, or age. Presently, access to the freestanding ASF in Carteret County is restricted to patients of surgeon owners.

Referral patterns, and patient acceptance policies will remain effectively unchanged, Ensuring that patients—regardless of income level, race, ethnicity, gender, disability status, age, or insurance coverage—can continue to obtain care. More capacity will help reduce wait times.

Patients who rely on Medicare and Medicaid will still find their benefits fully accepted and utilized, and the outpatient-focused design will provide a cost-effective alternative. The new building will be handicap accessible with ample parking, creating a more Accommodating environment for individuals who face mobility or transportation challenges. Patients of CCGH’s surgical services will not see disruption in service.

Overall, the relocation maintains continuity of care while simultaneously improving the patient experience, ensuring that no group’s ability to obtain GI endoscopy services is diminished.

The applicant adequately demonstrates that the needs of medically underserved groups that will continue to use surgical services will be adequately met following completion because the proposed relocation will give CCGH patients the option of a freestanding ASF that offers medical privileges regardless of ownership, the project will increase access to all residents regardless of payor, gender, or age.

Conclusion

The Agency reviewed the:

- Application
- Exhibits to the application

Based on that review, the Agency concludes that the application is conforming to this criterion for the following reasons:

- The applicant adequately demonstrates that the needs of the population currently using the services to be reduced, eliminated or relocated will be adequately met following project completion for all the reasons described above.
- The applicant adequately demonstrates that the project will not adversely impact the ability of underserved groups to access these services following project completion for all the reasons described above.

- (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.

C

The applicant proposes to develop a new ASF by relocating one existing OR from Carteret County General Hospital and developing one procedure room.

In Section E, pages 64-66, the applicant describes the alternatives it considered and explains why each alternative is either more costly or less effective than the alternative proposed in this application to meet the need:

- **Maintain Status Quo** - The applicant states, *“As demonstrated in Section C.4 and in the need methodology in Section Q with Form C, the target geographic area to be served needs additional capacity for freestanding surgical services offered by a provider that reinvests in the community...The deficiency of available, reasonably priced ambulatory surgical care in Carteret County has led to significant outmigration of Carteret County residents. In FY2023, 61 percent of Carteret County residents receiving outpatient surgery did so in a county other than Carteret*
...
The population of Carteret County and communities around western Carteret is growing and aging. Recreation, farming, and shipping industries that dominate the area carry risk factors for injuries that require surgical repair. Combined, these mean that need for ambulatory surgery cases will continue to increase. As noted in Section C.4, access to the one freestanding ASF in Carteret County is limited to physicians who are owners. The status quo would not address the current or future need for freestanding ASF services. Site-Neutral payments have been discussed for a long time but have not yet materialized. CCGH can only offer HOPD surgery and those reimbursement rules are set by CMS with other payers following the CMS pace.” (page 64)
- **Relocate a Different Number of Rooms** – The applicant states, *“ The applicants briefly considered relocating more than one operating room from CCGH. However, after*

evaluating the options, CCGH decided to keep the new ASF focused on procedures that do not require complex equipment. This will enable the proposed ASF to work efficiently and keep its costs within the reimbursement limits. Because ASF cases that have remained at CCGH are largely complex, the methodology in Section Q projects very little shift from CCGH. The shifts will be primarily persons who might have gone to other out-of-county facilities

...

Operating rooms and procedure rooms that can support surgical cases are expensive to build and equip. To keep costs low, CCGH opted to relocate only one operating room. This will support a design that can enable “to follow” cases for physicians and will minimize the size of support spaces

...

The vacated operating room at CCGH will be converted to a procedure room. Per the DHSR Licensure Section response to the 2014 Kirschbaum ruling, some surgical procedures can be performed in a procedure room. This awards a certain level of flexibility to surgical procedures performed at CCGH. It is unlikely that the hospital will feel any strain in scheduling due to the reduction of licensed operating rooms

...

Finally, the proposed new building in which the ASF will be located is bound by certain parameters. As seen in Exhibit K.2, design of the ASF will be efficient for staffing and patient flow. A larger design with more rooms would increase costs unnecessarily with a more complicated design in the space allotted.

...

Carteret Health Care also considered transferring a GI Endoscopy Room from CCGH to the proposed ASF. The large backlog of GI endoscopy procedures made this an appealing option. However, the desire to start small, contain capital costs and conserve resources favored maximum flexibility. In the proposed arrangement, the operating room can be used for GI procedures and surgical procedures. As demand grows, the facility design will support expansion to a third room and CCGH could transfer the GI room to the expansion

...

Based on the surgical case projections for CCGH and proposed design of CHCSC-CP, the Applicant determined relocation of a different number of rooms to be less effective at this time.” (page 65)

- **Develop the ASF at Another Address in Carteret County** – The applicant states, “Although a central location would be more evenly accessible to the serviced area, CCGH campus has no buildable land. Carteret County has a high water table that makes construction of more floors on the current hospital very expensive. The cost of footings required to support high-rise construction is more costly when water tables are high. High water tables also mean more expensive arrangements for water runoff. Thus on-campus is not an option. The hospital campus is hemmed in by railway, other occupants, and public roads.

...

To manage cost effective construction, the applicant must take advantage of existing structures if possible. The building under construction at Carteret Health Care West meets all the construction criteria. The location will be inconvenient for some. However, the inconvenience is offset by the fact that most people do not have outpatient surgery more

than once in a lifetime. Even routine screening endoscopy occurs only once every five years. CCGH chose the existing site as the most effective way to add the service and contain costs.” (page 66)

- **Develop the ASF in a Stand-Alone Building** – The applicant states, *“This alternative is not cost effective. Construction and operating costs benefit from consolidated locations. Putting the proposed ASF in a building that also houses Carteret Medical Group physicians, Seashore Imaging, and a newly proposed Freestanding Emergency Department, will minimize duplicated costs for utility connections, building envelope and operations. Parking and security are much easier to manage on a consolidated site.”* (page 66)

The applicant adequately demonstrates that the alternative proposed in this application is the most effective alternative to meet the need based on the following:

- The applicant provides reasonable information to explain why it believes the proposed project is the most effective alternative.
- The application is conforming to all other statutory and regulatory review criteria. Therefore, the application can be approved.

Conclusion

The Agency reviewed the:

- Application
- Exhibits to the application

Based on that review, the Agency concludes that the application is conforming to this criterion for the reasons stated above. Therefore, the application is approved subject to the following conditions:

1. **Carteret Health Care Surgery Center at Cedar Point, LLC, (hereinafter certificate holder) shall materially comply with all representations made in the certificate of need application.**
2. **Upon completion of the project, Carteret Health Care Surgery Center at Cedar Point shall be licensed for a total of no more than one (1) operating room (OR) and one (1) procedure room.**
3. **Upon completion of this project, the applicant shall take the necessary steps to decertify one (1) OR from the Carteret County General Hospital for a total of four (4) ORs at Carteret County General Hospital.**
4. **Progress Reports:**

- a. Pursuant to G.S. 131E-189(a), the certificate holder shall submit periodic reports on the progress being made to develop the project consistent with the timetable and representations made in the application on the Progress Report form provided by the Healthcare Planning and Certificate of Need Section. The form is available online at: <https://info.ncdhhs.gov/dhsr/coneed/progressreport.html>.
 - b. The certificate holder shall complete all sections of the Progress Report form.
 - c. The certificate holder shall describe in detail all steps taken to develop the project since the last progress report and should include documentation to substantiate each step taken as available.
 - d. The first progress report shall be due on March 1, 2026.
5. The applicant shall develop and implement an Energy Efficiency and Sustainability Plan for the project that conforms to or exceeds energy efficiency and water conservation standards incorporated in the latest editions of the North Carolina State Building Codes.
 6. The certificate holder shall not acquire as part of this project any equipment that is not included in the project's proposed capital expenditures in Section Q of the application and that would otherwise require a certificate of need.
 7. The certificate holder shall execute or commit to a contract for design services for the project no later than two years following the issuance of this certificate of need.
 8. The certificate holder shall acknowledge acceptance of and agree to comply with all conditions stated herein to the Agency in writing prior to issuance of the certificate of need.
- (5) Financial and operational projections for the project shall demonstrate the availability of funds for capital and operating needs as well as the immediate and long-term financial feasibility of the proposal, based upon reasonable projections of the costs of and charges for providing health services by the person proposing the service.

C

The applicant proposes to develop a new ASF by relocating one existing OR from Carteret County General Hospital and developing one procedure room.

Capital and Working Capital Costs

In Section F, and Section Q, Form F.1.a, the applicant projects the total capital cost of the project, as shown in the table below.

Carteret Health Care Surgery Center at Cedar Point, LLC		
	Applicant 1 Carteret Health Care Surgery Center at Cedar Point, LLC	Total
Waste Water System (Allocation)	\$59,095	\$59,095
Site Preparation (Allocation)	\$1,160,958	\$1,160,958
Construction/Renovation Contract(s)	\$8,752,984	\$8,752,984
Landscaping	\$15,519	\$15,519
Architect / Engineering Fees	\$799,084	\$799,084
Medical Equipment	\$3,298,382	\$3,298,382
Non Medical Equipment	\$1,750,597	\$1,750,597
Consultant Fees (CON)	\$50,000	\$50,000
Other (Contingency)	\$1,621,939	\$1,621,939
Total Capital Cost	\$17,508,559	\$17,508,559

In Section Q, immediately following Form F.1.a, the applicant provides the assumptions used to project the capital cost. The applicant adequately demonstrates that the projected capital cost is based on reasonable and adequately supported assumptions based on the following:

- The applicant states the assumptions were based on CHC’s supply chain staff and is provided in Exhibit K.3 development team’s professional experience and analysis.
- The applicant’s costs were based on consulting with East Group and market conditions.
- The applicant provides supporting documentation in Exhibit K.3.

In Section F, page 70, the applicant projects that start-up costs will be \$130,228 and initial operating expenses will be \$116,137 for a total working capital of \$246,365. On page 70, the applicant provides the assumptions and methodology used to project the working capital needs of the project. The applicant adequately demonstrates that the projected working capital needs of the project are based on reasonable and adequately support assumptions based on the following:

- The applicants are projecting a 24-month initial operating period, where available net income is not greater than the total of the monthly fiancé lease payments and depreciation payments. The initial operating costs are projected to be \$246,365.
- The applicant details expenses and revenues during initial operating period as well as the assumptions used to calculate the initial operating costs.

Availability of Funds

Exhibit F.3 contains a letter dated May 29, 2025, from Joanie King, the Chief Financial Officer of Carteret Health states that Carteret Health has sufficient available cash to support the project through the application stage and the operational startup period.

The applicant adequately demonstrates the availability of sufficient funds for the proposed increase in the projected capital cost based on the following:

- The applicant provides a letter from an appropriate company officer confirming the availability of the funding proposed for the capital needs of the project and a commitment to use that funding accordingly.

Financial Feasibility

The applicant provided pro forma financial statements for the first three full fiscal years of operation following project completions. In Forms F.2 and F.3, the applicant projects that revenues will exceed operating expenses in the first three full fiscal years following completion of the project, as shown in the table below:

Carteret Health Care Surgery Center at Cedar Point, LLC Projected Revenues and Operating Expenses upon Project Completion	1st Full FY 10/01/2027 to 10/01/2028	2nd Full FY 10/01/2028 to 10/01/2029	3rd Full FY 10/01/2029 to 10/01/2030
Total Surgical Hours (From Form C.3b)	1,210	1,659	1,758
Total Gross Revenues (Charges)	\$6,392,952	\$11,607,867	\$17,002,409
Total Net Revenue	\$1,724,755	\$3,131,688	\$4,587,082
Average Net Revenue per Case	\$1425	\$1888	\$2609
Total Operating Expenses (Costs)	\$2,460,462	\$3,469,850	\$4,291,693
Average Operating Expense per Case	\$2033	\$2092	\$2441
Net Income	(\$735,707)	(\$338,162)	\$295,390

Source: Section Q, page 90

The assumptions used by the applicant in preparation of the pro forma financial statements are provided in Section Q. The applicant adequately demonstrates that the financial feasibility of the proposal is reasonable, including projected utilization, costs and changes. The discussion regarding projected utilization found in Criterion (3) is incorporated herein by reference.

Conclusion

The Agency reviewed the:

- Application
- Exhibits to the application

Based on that review, the Agency concludes that the application is conforming to this criterion for the following reasons:

- The applicant adequately demonstrates that the capital costs are based on reasonable and adequately supported assumptions for all the reasons described above.
- The applicant adequately demonstrates the availability of sufficient funds for the capital needs of the proposal for all the reasons described above.

The applicant adequately demonstrates sufficient funds for the operating needs of the proposal and that the financial feasibility of the proposal is based upon reasonable projections of revenues and operating expenses for all the reasons described above

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

C

The applicant proposes to develop a new ASF by relocating one existing OR from Carteret County General Hospital and developing one procedure room.

On page 49, the 2025 SMFP defines the service area for ORs as “...the single or multicounty grouping shown in Figure 6.1.” Figure 6.1 on page 53 of the 2025 SMFP shows Carteret County as its own OR service area. Thus, the service area for this project is Carteret County. Facilities may also serve residents of counties not included in their service area.

The following table identifies the existing and approved ORs in Carteret County:

Facilities	OR Planning Inventory
The Surgical Center of Morehead City	2
Carteret General Hospital	5
Total	7

Source: 2025 SMFP, Table 6-B

In Section G, page 77-78, the applicant explains why it believes its proposal would not result in the unnecessary duplication of existing or approved operating room services in Carteret County. The applicant states:

“No Change in Number of Operating Rooms

CHCSC-CP does not propose a net increase in operating rooms. Instead, CCGH, the sole member of CHCSC-CP, will relocate one operating room from the hospital to the proposed ASF. Total inventory of Carteret County operating rooms will not change as a result of this project.

Access Improvements

As described in this application, specifically in Sections C and N, CHCSC-CP’s proposed project will improve geographic and financial access for residents of Carteret County and surrounding communities. This project will be part of CCGH’s commitment to shift the concentration of health care resources from the center of the county to the faster growing western part of the county. Until Carteret Health Care West opens, western Carteret has only a scattering of medical offices and a few urgent care facilities. The only freestanding ambulatory surgery center in Carteret County restricts its schedule to physician owners. This facility will have no such restrictions. Medicare fee schedules determine patient copayments and Medicare fee schedules for

hospital are much higher...

Appropriate Site

CCGH's hospital-based operating rooms are increasingly needed for complex cases. CCGH does not own or have ownership of an ambulatory surgical center. Ambulatory surgery centers are easier for patients who have uncomplicated cases. Parking is near the entrance; registration is adjacent to the service. This will be the only open medical staff surgery center in the service area.

Finally, CHCSC-CP reasonably and adequately demonstrates the need for the OR relocation and proposed ASF. See Section C and Section Q for discussion of the need for the proposed project from both qualitative and quantitative perspectives.

Therefore, CHCSC-CP's proposed new ASF with one relocated operating room and one procedure room will not result in unnecessary duplication of existing or approved health service capabilities or facilities."

The applicant adequately demonstrates that the proposal will not result in an unnecessary duplication of existing or approved services in the service area based on the following:

- The proposal will not result in an increase in ORs in Carteret County.
- The applicant adequately demonstrates that the relocation of one OR from Carteret County General Hospital is needed to expand access to well-utilized hospital-based surgical services.

Conclusion

The Agency reviewed the:

- Application
- Exhibits to the application

Based on that review, the Agency concludes that the application is conforming to this criterion for all the reasons described above.

- (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

The applicant proposes to develop a new ASF by relocating one existing OR from Carteret County General Hospital and developing one procedure room.

In Section Q, Form H, page 128, the applicant provides current and projected full-time equivalent (FTE) staffing for the proposed services, as illustrated in the following table.

Position	Projected FTE		
	1st Full FY	2nd Full FY	3rd Full FY
Registered Nurses - OR	0.8	1.0	1.0
Registered Nurses - Other	0.8	1.0	1.0
RN Coordinator - OR -	-	1.0	1.0
PACU RN	0.5	1.0	2.0
OR Technicians	0.8	1.0	1.0
Clerical Staff	0.8	1.0	1.0
Central Sterile Supply	0.8	1.0	1.0
Materials Management	0.25	0.5	0.5
Business Office	0.5	1.0	1.0
Total	5.25	8.5	9.5

The assumptions and methodology used to project staffing are provided in Section Q, page 163. Adequate operating expenses for the health manpower and management positions proposed by the applicant are budgeted in Form F.3b. In Section H, pages 81-82, the applicant describes the methods used to recruit or fill new positions and its existing training and continuing education programs.

The applicant adequately demonstrates the availability of sufficient health manpower and management personnel to provide the proposed services based on the following:

- The applicant states *“CCGH is a major employer in Carteret County and has historically been able to recruit and retain clinical and non-clinical personnel for its hospital facility and the physician practices and clinics it operates in the county. CCGH offers competitive pay and attractive benefits for recruiting qualified staff. As part of its mission to provide quality healthcare with exceptional compassion and respect, CCGH selects employees who are committed to its "Navigating to Excellence" performance improvement initiative.”*
- The applicant states that *“CCGH traditionally fills positions through continuous recruiting in its Human Resources department. Its techniques include recruitment events¹⁶, recruiting from the pool of professional students who are training at CCGH,¹⁷ networking with professional associations, and third-party recruiters.”*
- The applicant states that *“CCGH is an equal opportunity employer and conducts all human resource practices in compliance with federal, state, and local civil rights and employment legislation. It is the policy of CCGH to consider all applicants for employment equally without bias regarding race, color, religion, sex, national origin, age, disability, veteran’s status, genetic information, sexual*

orientation, or gender identity and to provide employees with an opportunity to progress in the organization consistent with their skills and interests.”

- The applicant states, *“CCGH staff policies establish competency and licensure standards for each staff position; appropriate quality assurance staff review these policies annually for each staff member. CCGH partners with Mayo Clinic in a unique arrangement that provides its clinical staff with direct access to consultation with Mayo specialists on care plans for any patient. CCGH also works with Carteret Community College and with ECU and its medical training programs to provide regular in-service training for its staff.”*

Conclusion

The Agency reviewed the:

- Application
- Exhibits to the application

Based on that review, the Agency concludes that the application is conforming to this criterion for all the reasons described above.

- (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

The applicant proposes to develop a new ASF by relocating one existing OR from Carteret County General Hospital and developing one procedure room.

Ancillary and Support Services

In Section I, pages 84-85, the applicant identifies the necessary ancillary and support services for the proposed services. On page 85, the applicant explains how each ancillary and support service is or will be made available. The applicant adequately demonstrates that the necessary ancillary and support services will be made available based on the following:

- The applicant states that as *“Please see Exhibit I.1 for a letter from Kyle Marek, Managing Member of CHCSC-CP attesting to the provision of ancillary services at the proposed ASF.”*

Coordination

In Section I, page 85, the applicant describes its existing and proposed relationships with other local health care and social service providers. The applicant adequately demonstrates that the

proposed services will be coordinated with the existing health care system based on the following:

- The applicant states that as an existing health care facility in the area it has established relationships with area healthcare providers and social service providers.
- In Exhibit I.2, the applicant provides letters of support from physicians and other providers.

Conclusion

The Agency reviewed the:

- Application
- Exhibits to the application

Based on that review, the Agency concludes that the application is conforming to this criterion for all the reasons described above.

- (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

The applicant does not project to provide the proposed services to a substantial number of persons residing in Health Service Areas (HSAs) that are not adjacent to the HSA in which the services will be offered. Furthermore, the applicant does not project to provide the proposed services to a substantial number of persons residing in other states that are not adjacent to the North Carolina county in which the services will be offered. Therefore Criterion (9) is not applicable to this review.

- (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

The applicant is not an HMO. Therefore, Criterion (10) is not applicable to this review.

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

C

The applicant proposes to develop a new ASF by relocating one existing OR from Carteret County General Hospital and developing one procedure room.

In Section K, page 88, the applicant states that the project involves renovating 9,932 square feet of existing space. Line drawings are provided in Exhibit K.2.

On page 89, the applicant adequately explains how the cost, design and means of construction represent the most reasonable alternative for the proposal based on the following:

- The applicant states *“This project involves leasehold upfits to a physician office building. This will economize on infrastructure and site development costs. The project can be developed with cash and reserves of the Applicant’s member owner, as demonstrated in the letter regarding source of funding in Exhibit F.2, p.2. This will avoid costs associated with debt financing.”*

On page 90, the applicant adequately explains why the proposal will not unduly increase the costs to the applicant for providing the proposed services or the costs and charges to the public for the proposed services based on the following:

- The applicant states, *“The project is sized to meet existing and expected new demand for surgical services. Sections C.4 and Q demonstrate that need and demand in the proposed service area are sufficient to support projected utilization. The proposed ASF will bill Medicare and Medicaid patients and beneficiaries of any policies that are based on Medicare rates at the freestanding ASF rate schedule, which is less than the HOPD schedule.”*

On pages 90-91, the applicant adequately identifies any applicable energy saving features incorporated into the construction / renovation plans based on the following:

- The applicant states, *“CHCSC-CP is committed to being a leader in environmental stewardship in its development and operation of its facility, leading to reduced waste*

being sent to landfills, the conservation of energy and water and a reduction of greenhouse emissions

...

The Applicant agrees to accept a condition requiring it 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.”

In Section B, page 25, the applicant identifies any applicable energy saving features that will be incorporated into the construction plans.

Conclusion

The Agency reviewed the:

- Application
- Exhibits to the application

Based on that review, the Agency concludes that the application is conforming to this criterion for all the reasons described above.

(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 ... persons [with disabilities], which have traditionally experienced difficulties in obtaining equal access to the proposed services, particularly those needs identified in the State Health Plan as deserving of priority. For the purpose of determining the extent to which the proposed service will be accessible, the applicant shall show:

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

C

The applicant is proposing to develop a new facility, therefore, there is no historical payor mix to report. However, the applicant provides the payor mix for a CCGH, the facility where the OR will be relocated from.

Carteret County General Hospital 10/01/2023 to 09/30/2024	
Payor Source	
Self-Pay	1.0%
Charity Care	%
Medicare	41.2%
Medicaid	9.9%
Insurance	35.5%
Workers Compensation 0%	%
TRICARE	%
Other (Champus, Tricare, VA)	12.4%
Total	100.0%

In Section L, page 96, the applicant provides the following comparison.

Carteret County General Hospital Corporation	Last Full FY before Submission of the Application	
	Percentage of Total Patients Served	Percentage of the Population of the Service Area *
Female	54.7%	50.0%
Male	45.3%	50.0%
Unknown		
64 and Younger	57.4%	83.0%
65 and Older	42.6%	17.0%
American Indian	0.3%	1.0%
Asian	0.5%	2.9%
Black or African-American	10.6%	13.9%
Native Hawaiian or Pacific Islander	0.3%	0.0%
White or Caucasian	75.7%	76.1%
Other Race	2.2%	6.1%
Declined / Unavailable	10.3%	

The percentages can be found online using the United States Census Bureau's QuickFacts which is at: <https://www.census.gov/quickfacts/fact/table/US/PST045218>. Just enter in the name of the county.

The Agency reviewed the:

- Application
- Exhibits to the application

Based on that review, the Agency concludes that the applicant adequately documents 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. Therefore, the application is conforming to this criterion.

- (b) Its past performance in meeting its obligation, if any, under any applicable regulations requiring provision of uncompensated care, community service, or access by minorities

and ... persons [with disabilities] to programs receiving federal assistance, including the existence of any civil rights access complaints against the applicant;

C

In Section L, page 96, the applicant states that the facility is not obligated to provide uncompensated care, community service or access by minorities and persons with disabilities, in Section L, pages 96-97, the applicant states:

“As a freestanding ambulatory surgical center, the project will not be obligated under any applicable federal regulations to provide uncompensated care, community service, or access by minorities and persons with disabilities. It will not be subject to EMTALA rules.”

CHCSC-CP’s sole member is CCGH, a community owned hospital. CCGH is in full compliance with CMS certification for Medicare and Medicaid, and by extension in compliance with EMTALA requirements and requirements to be accessible to persons with disabilities.”

In Section L, page 97, the applicant states that during the 18 months immediately preceding the application deadline, no patient civil rights access complaints have been filed against the facility or any similar facilities owned by the applicant or a related entity located in North Carolina.

The Agency reviewed the:

- Application
- Exhibits to the application

Based on that review, the Agency concludes that the applicant adequately documents 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. Therefore, 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

In Section L, page 98, the applicant projects the following payor mix for the proposed services during the third full fiscal year of operation following completion of the project, as shown in the table below.

Payor Category	Percentage of Total Patients Served
Self-Pay	1%
Charity Care	See note
Medicare	37.9%
Medicaid	7%
Insurance	42.1%
Workers Compensation 0%	0%
TRICARE	0%
Other (Champus, Tricare, VA)	12%
Total	100.0%

Source: Section L, page 98.

As shown in the table above, during the third full fiscal year of operation, the applicant projects that 1% of total services will be provided to self-pay patients, 37.9% to Medicare. 0.19% to charity cases and 7% to Medicaid patients.

On page 98, the applicant provides the assumptions and methodology used to project payor mix during the third full fiscal year of operation following completion of the project. The projected payor mix is reasonable and adequately supported. The payor mix is based on the historical payor mix of ambulatory surgical cases from CCGH to payor mix for CHCSC-CP. The projected payor source for surgical cases is consistent with CCGH's historical trends.

The Agency reviewed the:

- Application
- Exhibits to the application

Based on that review, the Agency concludes that the application is conforming to this criterion based on the reasons stated above.

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

C

In Section L, page 100, the applicant adequately describes the range of means by which patients will have access to the proposed services.

The Agency reviewed the:

- Application
- Exhibits to the application

Based on that review, the Agency concludes that 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

The applicant proposes to develop a new ASF by relocating one existing OR from Carteret County General Hospital and developing one procedure room.

In Section M, page 101, the applicant describes the extent to which area health professional training programs in the area will have access to the facility for training purposes. The applicant adequately demonstrates that health professional training programs in the area will have access to the facility for training purposes based on the following:

- The applicant states it will offer the facility as a clinical learning site for students via an existing relationship with Campbell University.
- The applicant states Carteret Health Care Surgery Center will be available for students training in clinical health services. Carteret Health Care Surgery Center is willing to develop a clinical training program in affiliation with any local health professional training programs whose students would benefit from training opportunities in an adult care home setting.
- The applicant states CCGH also maintains a Pharmacy Residency Program. Established in 2012, the program is committed to preparing graduates to work in clinical care.

Conclusion

The Agency reviewed the:

- Application
- Exhibits to the application

Based on that review, the Agency concludes that the application is conforming to this criterion for the reasons stated above.

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

demonstrate that its application is for a service on which competition will not have a favorable impact.

C

The applicant proposes to develop a new ASF by relocating one existing OR from Carteret County General Hospital and developing one procedure room.

On page 49, the 2025 SMFP defines the service area for ORs as “...the single or multicounty grouping shown in Figure 6.1.” Figure 6.1 on page 53 of the 2025 SMFP shows Carteret County as its own OR service area. Thus, the service area for this project is Carteret County. Facilities may also serve residents of counties not included in their service area.

The following table identifies the existing and approved ORs in Carteret County:

Facilities	OR Planning Inventory
The Surgical Center of Morehead City	2
Carteret General Hospital	5
Total	7

Source: 2025 SMFP, Table 6-B

Regarding the expected effects of the proposal on competition in the service area, in Section N, page 103, the applicant states:

“CHCSC-CP will provide an essential alternative in the service area. There is only one freestanding ASF in the four counties touched by the PSA, The Surgical Center of Morehead City. Other surgical centers are hospital-based. While The Surgical Center of Morehead City appears to have capacity for more outpatient surgical procedures (see Table 8 in Section G), it cannot reasonably be expected to capture all cases being shifted out of the three hospitals in the PSA counties. Moreover, that surgery center is privately owned and restricts use to owner physicians.”

Regarding the impact of the proposal on cost effectiveness, in Section N, pages 103-104, the applicant states:

“As discussed in Section C.4, operating rooms in freestanding ASFs are organized for efficiency and are reimbursed less than in hospitals for the same service. Medicare, the benchmark for payment structures, establishes a higher fee rate for the same surgical service when it occurs in a hospital. Section G.2.b of this application provides a brief comparison

...

Consumers of surgical services are becoming more value conscious. Aided by the internet, consumers are better informed and willing to shop for providers that offer lower out-of-pocket costs. Providing additional access to a low-cost, high-quality provider provide residents of the PSA a local option at an ASF that has an open medical staff.”

See also Sections C, F, and Q of the application and any exhibits.

Regarding the impact of the proposal on quality, in Section N, pages 104-107, the applicant states:

“CHCSC-CP plans to seek accreditation by a third party, Accreditation Association for Ambulatory Health Care (“AAAHC”). It will also acquire CMS Medicare and Medicaid certification. Together these third-party overseers will hold CHCSC-CP to outside juried quality standards. See Exhibit N.2 for examples of AAAHC’s quality regulations for ASFs.

Furthermore, CHCSC-CP will take its cues from sole member and management service provider, CCGH, leveraging CCGH’s extensive expertise and track record of high-quality services. The following paragraphs detail CCGH and the Carteret Health Care (CHC) network’s commitment to quality.

CCGH has been providing quality care to Carteret and surrounding counties since 1967. It is an independent not-for-profit 135-bed community hospital and has an extensive history of quality achievements and awards across all service lines.²⁵ All of CCGH’s accreditations, affiliations, and certifications help achieve its mission to “provide Quality Healthcare with exceptional compassion and respect.”

See also Sections C, and O of the application and any exhibits.

Regarding the impact of the proposal on access by medically underserved groups, in Section N, pages 107 and 108, the applicant states:

“...CHCSC-CP will accept both Medicaid and Medicare assignments. Proformas assume that CCGH will continue to have meaningful surgical and GI procedure use by Medicaid beneficiaries. Medicaid use will be proportionately less at the proposed ASF, primarily because use by underinsured persons will be substantially higher than at the hospital. The facility has budgeted for Self-Pay persons who may require discounts. CHCSC-CP has also budgeted for 0.19 percent of patients as full charity by the third full operating year.”

See also Sections L and C of the application and any exhibits.

The applicant adequately describes the expected effects of the proposed services on competition in the service area and adequately demonstrates the proposal would have a positive impact on cost-effectiveness, quality, and access because the applicant adequately demonstrates that:

- 1) The proposal is cost effective because the applicant adequately demonstrated: a) the need the population to be served has for the proposal; b) that the proposal would not result in an unnecessary duplication of existing and approved health services; and c) that projected revenues and operating costs are reasonable.
- 2) Quality care would be provided based on the applicant’s representations about how it will ensure the quality of the proposed services and the applicant’s record of providing quality care in the past.

- 3) Medically underserved groups will have access to the proposed services based on the applicant's representations about access by medically underserved groups and the projected payor mix.

Conclusion

The Agency reviewed the:

- Application
- Exhibits to the application

Based on that review, the Agency concludes that the application is conforming to this criterion based on all the reasons described above.

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

C

In Section Q, Form O, page 109, the applicant states that CHCSC-CP is not an existing ASF. It does not own, operate, or manage any operating rooms or ASFs in the service area. CCGH, CHCSC-CP's sole member, does own and operate five operating rooms in the hospital in Morehead City. Both entities are listed on Form O in Section Q of this application.

In Section O, page 109, the applicant states that, CHCSC-CP is not an existing ASF therefore this is not applicable.

- (21) Repealed effective July 1, 1987.

G.S. 131E-183 (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.

NA

The Criteria and Standards for Surgical Services and Operating Rooms promulgated in 10A NCAC 14C. 2100 are not applicable to this proposed project because the applicant does not propose to add new ORs to the existing OR inventory in Carteret County. Therefore, The Criteria and Standards for Surgical Services and Operating Rooms do not apply to this review.