

**EXHIBITS FOR NOVANT HEALTH, INC.'S
PETITION TO THE STATE HEALTH COORDINATING COUNCIL
REGARDING POLICY AC-3**

Exhibit	Name
A	Excerpt from 1983 SMFP showing Policy B.5.
B	Excerpts from 1989 SMFP showing Policy B.6.
C	Excerpt from 1990 SMFP showing Policy B.6.
D	Excerpt from 1997 SMFP showing Policy AC-3
E	Excerpt from 1999 SMFP showing Policy AC-3
F	Excerpt from 2001 SMFP showing Policy AC-3
G	Excerpt from draft 2011 SMFP showing Policy AC-3
H	Table 9E from draft 2011 SMFP
I	Findings from Project I.D. No. G-8640-10
J	Comments that Novant filed against Project I.D. No. G-8640-10
K	Excerpt from 2010 SMFP
L	Excerpt from draft 2011 SMFP
M	Excerpt from 2009 SMFP
N	Excerpt from 2008 SMFP
O	Excerpt from CON Application for Project I.D. No. G-8640-10
P	List of Top 20 Procedures in CON Application for Project I.D. No. G-8640-10

**EXHIBIT A TO NOVANT HEALTH'S PETITION
TO THE SHCC REGARDING POLICY AC-3**

according to their size. Some of these hospitals may be experiencing difficulty in competing for patients with nearby larger community hospitals due to their small size, age, or other conditions. A few of these hospitals with low occupancy are located in counties close to large medical centers and some residents apparently are traveling to those large medical centers for care which normally could be provided by local community hospitals.

Reasons for low occupancy and bed need vary with the circumstances of a particular area. In areas where the number of licensed beds considerably exceeds the number of beds projected as needed within the next five years, consideration should be given to alternative or more efficient uses of these beds, including closing them permanently. In other areas, improved utilization of these beds would prevent the need to build additional beds elsewhere. This statement applies to the case involving other hospitals in the same county and to the situation in which patients are going to other counties, particularly large referral centers, for secondary care. A particularly opportune time for reduction of acute care bed capacity, where indicated, may be the time when renovation or replacement of a facility is being considered.

B.5. — SPECIAL CONSIDERATION FOR ACADEMIC MEDICAL
CENTER TEACHING HOSPITALS

A hospital that has been designated an Academic Medical Center Teaching Hospital may receive a special exemption from the State Medical Facilities Plan, if justified. Requests for additional resources made by a formally designated Academic Medical Center Teaching Hospital which are subject to Certificate of Need review will be evaluated in the context of the overall requirements of the academic medical center and in the context of the special characteristics which distinguish the academic medical center teaching hospital from other acute care facilities.

Definition

An academic medical center teaching hospital is defined as a tertiary care facility which serves as the primary site for university-based teaching activities for the health sciences. The hospital associated with such an academic medical center would be engaged in the tripartite mission of education, research, and

patient care. Educational activities would include training programs for various levels of health professional students such as undergraduate, graduate, and professional programs in nursing, allied health, dentistry, pharmacy, health administration and others. Patient care would be offered on a broad spectrum, from primary care (including serving the patient care needs in the local community) to providing highly specialized treatment centers (including serving patients on a statewide, national, and perhaps even international basis). In terms of research, such a facility would serve to facilitate the development of new health care treatment modalities, as well as serving as a vanguard institution in developing new methods of diagnosis, disease prevention and health maintenance. In addition to clinical research, these institutions would be actively engaged in basic research in the health-related sciences and act as testing sites for development and refinement of new medical equipment and pharmaceuticals.

Characteristics of an Academic Medical Center Teaching Hospital

The major characteristics which distinguish the academic medical center teaching hospital from other hospitals is that it possesses all nine of the characteristics listed below:

- (1) The presence of an academic health science center* within close proximity to the hospital and the use of that hospital as a primary teaching site for health professional students.
- (2) The presence of a broad range of health science students at multiple levels of training.
- (3) The existence of broad-based continuing education programs for health professionals.
- (4) The presence of continuous and ongoing research programs, both basic and clinical, directed at the development of new modalities of diagnosis and treatment, disease prevention, health maintenance as well as the development and clinical evaluation of new medical equipment, pharmaceuticals and diagnostic/therapeutic procedures.
- (5) The inclusion of individuals in the hospital's patient population who are being followed for specific research purposes.

*Academic Health Science Center includes a school of medicine and at least one other health professional school or division.

- (6) The presence of state and federally designated centers for the diagnosis and treatment of special conditions such as burns, cancer, trauma, perinatal disease, etc. within the hospital's programs.
- (7) A patient population which reflects treatment of patients referred from extended geographical service areas within and outside the State of North Carolina for the treatment of unique and distinctive clinical conditions that require access to facilities that are uniquely equipped to treat such conditions.
- (8) The provision of a broad spectrum of care ranging from primary to highly specialized levels, across a broad range of clinical specialties and in sufficient volume to meet the educational needs of the hospital's health science students.
- (9) The presence of long-range plans which describes the anticipated future development and growth of the academic health science teaching hospital and its related health science programs.

Special Considerations

The Department of Human Resources in developing its Medical Facilities Plan did not attempt to take into account all of the special needs which may arise in the academic medical center teaching hospital resulting from the unique characteristics they possess which differentiate them from other types of acute care facilities. These characteristics should be taken into consideration in the evaluation of Certificate of Need applications from academic medical center teaching hospitals.

Designation Process

A hospital must be formally designated as an academic medical center teaching hospital by the Health Planning Section within the Division of Facility Services in order for this policy to be applicable. While some hospitals may engage in one or more of the activities described above, a hospital must submit evidence to demonstrate that it possesses all of the characteristics described in Items 1 through 9 in order to be designated as an academic medical center teaching hospital. A hospital desiring

this designation should submit its request along with appropriate evidence to:

Health Planning Section
 Division of Facility Services
 Department of Human Resources
 P.O. Box 12200
 Raleigh, North Carolina 27605-2200

After an application is reviewed, the applicant will be notified about its special designation status as an academic medical center teaching hospital. Once a hospital receives this status, the Certificate of Need Section will recognize this status and may allow for special exemptions from the State Medical Facilities Plan, if justified, for the formerly designated Academic Medical Center Teaching Hospital.

Once a facility receives this special designation, it can continue to maintain this status as long as the facility certifies each year that it continues to possess these characteristics. A statement on the annual licensure application form will be used to continue to monitor this designation. The State Medical Facilities Plan will contain a listing of hospitals which have been designated as academic medical center teaching hospitals.

8.6. — USE OF SWING BEDS

The Department of Human Resources supports the use of swing beds in providing long-term care services in rural acute care hospitals.

According to Public Law 96-499 (The Omnibus Reconciliation Act of 1980), Section 904, (the Swing Bed Provision), certain small rural hospitals may use their inpatient facilities to furnish skilled nursing facility (SNF) services to Medicare and Medicaid beneficiaries and intermediate care facility (ICF) services to Medicaid beneficiaries. The hospital will be reimbursed at rates appropriate for these services, which are generally lower than hospital rates.

Although there has been State legislative action to contain the growth of long-term care beds, there is some evidence to support the need for additional long-term care beds in certain rural areas.

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1989

available bed in a SNF within 5 weekdays, exclusive of holidays and weekends, unless the patient's physician certifies that transfer is not medically appropriate.

A Certificate of Need may not be required if capital expenditures associated with the swing bed service do not exceed \$2 million, annual operating expenses do not exceed \$1 million, and there is no change in bed capacity.

Process for Obtaining Swing Bed Certification

Hospitals interested in pursuing swing bed certification are encouraged to discuss their projected plans with the Division of Medical Assistance regarding reimbursement issues and with the Construction Section in the Division of Facility Services if any physical plant needs are anticipated. To initiate the process of obtaining swing bed certification, a hospital should: (1) submit a letter of intent to the Certificate of Need Section, Division of Facility Services, describing any changes related to the provision of long-term care services, licensed bed capacity and physical plant needs; and (2) submit a written request to the Medicare/Medicaid Certification Section, Division of Facility Services, to be reviewed and surveyed to determine eligibility for swing bed participation. The Medicare/Medicaid Certification Section will coordinate the additional steps that include the request for federal approval.

The North Carolina Medicaid Program reimburses for swing bed services to qualified beneficiaries at the rate of \$57.15 per day for skilled nursing care and \$41.99 per day for intermediate care after a beneficiary has exhausted the days of care for which Medicare provides reimbursement.

In addition, the North Carolina Medicaid Program will reimburse all hospitals, regardless of size, for long-term care services provided to eligible patients who no longer need acute care and are waiting placement for nursing home care. The average rates effective October 1, 1988 are \$61.40 for skilled care and \$46.33 for intermediate care.

POLICY B.6: POLICIES AND PROCEDURES FOR SEEKING SPECIAL CONSIDERATION FOR ACADEMIC MEDICAL CENTER TEACHING HOSPITALS

A hospital may be designated as an Academic Medical Center Teaching Hospital by the Health Resources Development Section. A hospital with this special designation may request a special exemption from the State Medical Facilities Plan. Such a request may be granted if justified. Requests for additional resources made by a formally-designated Academic Medical Center Teaching Hospital which are subject to CON review may be evaluated in the context of the overall requirements of the academic medical center and in the context of the special characteristics which distinguish the Academic Medical Center from other acute care facilities, as described in this section, if the applicant institution submits the application, and justifies the project, in the context of Academic Medical Center Teaching Hospital status.

Definition

An Academic Medical Center Teaching Hospital is defined as a tertiary care facility (the provision of sophisticated technological and support services provided by highly specialized providers) which serves as the primary site for university-based teaching activities for the health sciences. Such a hospital engages in a threefold mission of education, research, and patient care. Educational activities include training programs for various levels of health professional students such as undergraduate, graduate, and professional programs in nursing, allied health, dentistry, pharmacy, health administration and others. Patient care is offered on a broad spectrum, from primary care (including serving the patient care needs in the local community) to providing highly specialized treatment centers (including serving patients on a statewide, national, and perhaps even international basis). In terms of research, such a facility serves to facilitate the development of new health care treatment modalities, and is a vanguard institution in developing new methods of diagnosis, disease prevention and health maintenance. In addition to clinical research, these institutions are actively engaged in basic research in the health-related sciences and act as testing sites for development and refinement of new medical equipment and pharmaceuticals.

Characteristics of an Academic Medical Center Teaching Hospital

The major characteristics which distinguish the Academic Medical Center Teaching Hospital from other hospitals is that it possesses all nine of the characteristics below:

1. The presence of an academic health science center (*Academic health science center includes a school of medicine and at least one other health professional school or division*) within close proximity to the hospital as a primary teaching site for health professional students.
2. The presence of a broad range of health science students at multiple levels of training.
3. The existence of broad-based continuing education programs for health professionals.
4. The presence of continuous and ongoing research programs, both basic and clinical, directed at the development of new modalities of diagnosis and treatment, disease prevention, health maintenance as well as the development and clinical evaluation of new medical equipment, pharmaceuticals and diagnostic/therapeutic procedures.
5. The inclusion of individuals in the hospital's patient population who are being followed for specific research purposes.
6. The presence of state and federally designated centers for the diagnosis and treatment of special conditions such as burns, cancer, trauma, perinatal disease, etc. within the hospital's programs.

7. Patient referrals from extended geographical service areas within and outside the State of North Carolina for the treatment of unique and distinctive clinical conditions that require access to facilities that are uniquely equipped to treat such conditions.
8. The provision of a broad spectrum of care ranging from primary to highly specialized levels, across a broad range of clinical specialties and in sufficient volume to meet the educational needs of the hospital's health science students.
9. The presence of long-range plans which describe the anticipated future development and growth of the academic health science teaching hospital and its related health science programs.

Designation Process

A hospital must be formally designated as an Academic Medical Center Teaching Hospital by the Health Resources Development Section within the Division of Facility Services in order for this policy to be applicable. While some hospitals may engage in one or more of the activities described above, a hospital must submit evidence to demonstrate that it possesses all of the characteristics described in Items 1 through 9 in order to be designated as an Academic Medical Center Teaching Hospital. A hospital desiring this designation should submit its request along with appropriate evidence to:

Health Resources Development Section
Division of Facility Services
Department of Human Resources
701 Barbour Drive
Raleigh, North Carolina 27603

The following have been designated Academic Medical Center Teaching Hospitals:

<u>Name of Hospital</u>	<u>Date of Designation</u>
N.C. Baptist Hospital	February 16, 1983
N.C. Memorial Hospital	August 8, 1983
Duke University Medical Center	July 21, 1983
Pitt County Memorial Hospital	August 8, 1983

Special Considerations in Review of Certificate of Need Application

The Department of Human Resources, in developing the State Medical Facilities Plan, did not take into account all of the special needs which may arise in the Academic Medical Center Teaching Hospital as a result of its unique characteristics. A hospital that has received this special designation may request a special exemption from the State Medical Facilities Plan. When specifically requested by the designated facility, the Certificate of Need Section may, if specifically justified in

the context of its Academic Medical Center Teaching Hospital status, allow for an exemption from the State Medical Facilities Plan. The proponent should demonstrate that the proposed project will fulfill the particular needs of the Academic Medical Center Teaching Hospital without adversely affecting the overall ability of hospitals operating in the same service area to fulfill the needs of the population in that area.

POLICY B.7: COORDINATION OF THE REHABILITATION PROGRAMS OF REGIONAL REHABILITATION CENTERS AND ACUTE CARE HOSPITALS

The Department of Human Resources supports cooperation among rehabilitation service providers, particularly between regional rehabilitation centers and acute care hospitals. Specific areas of recommended cooperation include:

1. Assessment of incidence, prevalence, types and severity of disabling conditions.
2. Estimation of the types and volume of rehabilitation services.
3. Clarification of roles of rehabilitation hospitals and acute care hospitals.
4. Program planning between acute care hospitals and regional rehabilitation centers.
5. Patient referral to and from regional rehabilitation centers.
6. Patient follow-up.
7. Signed agreements between acute care hospitals providing rehabilitation services and the regional rehabilitation centers to undertake cooperative efforts.

POLICY B.8: EXTENSION OF MULTIDISCIPLINARY REHABILITATION TEAM SERVICES

The Department of Human Resources supports extending rehabilitation services by multidisciplinary teams from rehabilitation centers to other service delivery sites, particularly to acute care hospitals and nursing homes. Referral of rehabilitation patients from acute care hospitals to rehabilitation centers is one of the weakest links in the continuum. Initiation of multidisciplinary team services at the acute care level should enhance the patients' rehabilitation at the acute care level, encourage an increased number of and appropriate referrals to rehabilitation centers, as well as improve the quality of programming at all rehabilitation service levels.

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1990

- Have greater than 49 beds and fewer than 100 beds staffed and in operation. Hospitals with 50-99 beds must enter into transfer agreements with each skilled nursing facility (SNF) within their geographic areas and must transfer any swing bed patient to an available bed in a SNF within 5 weekdays, exclusive of holidays and weekends, unless the patient's physician certifies that transfer is not medically appropriate.

A Certificate of Need may not be required if capital expenditures associated with the swing bed service do not exceed \$2 million, annual operating expenses do not exceed \$1 million, and there is no change in bed capacity.

Process for Obtaining Swing Bed Certification

Hospitals interested in pursuing swing bed certification are encouraged to discuss their projected plans with the Division of Medical Assistance regarding reimbursement issues and with the Construction Section in the Division of Facility Services if any physical plant needs are anticipated. To initiate the process of obtaining swing bed certification, a hospital should: (1) submit a letter of intent to the Certificate of Need Section, Division of Facility Services, describing any changes related to the provision of long-term care services, licensed bed capacity and physical plant needs; and (2) submit a written request to the Medicare/Medicaid Certification Section, Division of Facility Services, to be reviewed and surveyed to determine eligibility for swing bed participation. The Medicare/Medicaid Certification Section will coordinate the additional steps that include the request for federal approval.

The North Carolina Medicaid Program reimburses for swing bed services to qualified beneficiaries at the rate of \$60.85 per day for skilled nursing care and \$44.25 per day for intermediate care after a beneficiary has exhausted the days of care for which Medicare provides reimbursement.

In addition, the North Carolina Medicaid Program will reimburse all hospitals, regardless of size, for long-term care services provided to eligible patients who no longer need acute care and are waiting placement for nursing home care. The average rates effective October 1, 1989 are \$69.49 for skilled care and \$52.21 for intermediate care.

POLICY B.6: EXEMPTION FROM PLAN PROVISIONS FOR CERTAIN ACADEMIC MEDICAL CENTER TEACHING HOSPITAL PROJECTS

Some projects for which certificates of need are sought by academic medical center teaching hospitals may qualify for exemption from provisions of the State Medical Facilities Plan. The Health Resources Development Section will designate as an Academic Medical Center Teaching Hospital any facility whose application for such designation demonstrates the following characteristics of the hospital:

1. Serves as a primary teaching site for a school of medicine and at least one other health professional school, providing undergraduate, graduate and postgraduate education.

2. Houses extensive basic medical science and clinical research programs, patients and equipment.
3. Serves the treatment needs of patients from a broad geographic area through multiple medical specialties.

Exemption from the provisions of the State Medical Facilities Plan will be granted to projects submitted by Academic Medical Center Teaching Hospitals designated prior to January 1, 1990 which projects are:

1. Necessary to complement a specified and approved expansion of the number or types of students, residents or faculty, as certified by the head of the relevant associated professional school, and/or
2. Necessary to accommodate patients, staff or equipment for a specified and approved expansion of research activities, as certified by the head of the entity sponsoring the research, and/or
3. Necessary to accommodate changes in requirements of specialty education accrediting bodies as evidenced by copies of documents issued by such bodies.

POLICY B.7: RECONVERSION TO ACUTE CARE

Facilities redistributing beds from acute care bed capacity to rehabilitation or psychiatric use must obtain a certificate of need to convert this capacity back to acute care. Application for such reconversion to acute care of beds converted to psychiatry or rehabilitation after January 1, 1990 shall be evaluated against the hospital's service needs, without regard to the acute care bed need shown in the State Medical Facilities Plan.

C. POLICIES APPLICABLE TO LONG TERM CARE SERVICES

POLICY C.1: PROVISION OF TRANSITIONAL SKILLED NURSING CARE

A certificate of need may be issued to a hospital licensed under North Carolina General Statutes, Chapter 131E, Article 5, to convert up to ten beds or ten percent of its licensed acute care bed capacity, whichever is greater, for use as transitional "short-term skilled nursing care" beds. The certificate of need will remain in force as long as the Department of Human Resources determines that the hospital is meeting the conditions outlined in this Policy.

"Short term skilled nursing care" is defined as transitional skilled nursing care provided to a patient who has been directly discharged from an acute care bed and cannot be immediately placed in a licensed skilled nursing facility. Determination

**EXHIBIT D TO NOVANT HEALTH'S PETITION
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1997

POLICY AC-3: EXEMPTION FROM PLAN PROVISIONS FOR CERTAIN ACADEMIC MEDICAL CENTER TEACHING HOSPITAL PROJECTS

Projects for which certificates of need are sought by academic medical center teaching hospitals may qualify for exemption from the need determinations of this document. The State Medical Facilities Planning Section shall designate as an Academic Medical Center Teaching Hospital any facility whose application for such designation demonstrates the following characteristics of the hospital:

- (A) Serves as a primary teaching site for a school of medicine and at least one other health professional school, providing undergraduate, graduate and postgraduate education.
- (B) Houses extensive basic medical science and clinical research programs, patients and equipment.
- (C) Serves the treatment needs of patients from a broad geographic area through multiple medical specialties.

Exemption from the provisions of need determinations of the State Medical Facilities Plan shall be granted to projects submitted by Academic Medical Center Teaching Hospitals designated prior to January 1, 1990 which projects comply with one of the following conditions:

- (i) Necessary to complement a specified and approved expansion of the number or types of students, residents or faculty, as certified by the head of the relevant associated professional school; or
- (ii) Necessary to accommodate patients, staff or equipment for a specified and approved expansion of research activities, as certified by the head of the entity sponsoring the research; or
- (iii) Necessary to accommodate changes in requirements of specialty education accrediting bodies, as evidenced by copies of documents issued by such bodies.

POLICY AC-4: RECONVERSION TO ACUTE CARE

Facilities redistributing beds from acute care bed capacity to rehabilitation or psychiatric use shall obtain a certificate of need to convert this capacity back to acute care. Application for reconversion of beds converted to psychiatry or rehabilitation back to acute care beds shall be evaluated against the hospital's utilization in relation to the target occupancies shown below without regard to the acute care bed need determinations shown in Chapter 5 of the State Medical Facilities Plan.

<u>Licensed Bed Capacity</u>	<u>Percent Occupancy</u>
1 - 49	65
50 - 99	70
100 - 199	75
200 - 699	80
700 +	81.5

**EXHIBIT E TO NOVANT HEALTH'S PETITION
TO THE SHCC REGARDING POLICY AC-3**

1999

**POLICY AC-3: EXEMPTION FROM PLAN PROVISIONS FOR CERTAIN
ACADEMIC MEDICAL CENTER TEACHING HOSPITAL PROJECTS**

Projects for which certificates of need are sought by academic medical center teaching hospitals may qualify for exemption from the need determinations of this document. The State Medical Facilities Planning Section shall designate as an Academic Medical Center Teaching Hospital any facility whose application for such designation demonstrates the following characteristics of the hospital:

- (A) Serves as a primary teaching site for a school of medicine and at least one other health professional school, providing undergraduate, graduate and postgraduate education.
- (B) Houses extensive basic medical science and clinical research programs, patients and equipment.
- (C) Serves the treatment needs of patients from a broad geographic area through multiple medical specialties.

Exemption from the provisions of need determinations of the State Medical Facilities Plan shall be granted to projects submitted by Academic Medical Center Teaching Hospitals designated prior to January 1, 1990 which projects comply with one of the following conditions:

- (i) Necessary to complement a specified and approved expansion of the number or types of students, residents or faculty, as certified by the head of the relevant associated professional school; or
- (ii) Necessary to accommodate patients, staff or equipment for a specified and approved expansion of research activities, as certified by the head of the entity sponsoring the research; or
- (iii) Necessary to accommodate changes in requirements of specialty education accrediting bodies, as evidenced by copies of documents issued by such bodies.

A project submitted by an Academic Medical Center Teaching Hospital under this Policy that meets one of the above conditions shall also demonstrate that the Academic Medical Center Teaching Hospital's teaching or research need for the proposed project cannot be achieved effectively at any non-Academic Medical Center Teaching Hospital provider which currently offers the service for which the exemption is requested and which is within 20 miles of the Academic Medical Center Teaching Hospital.

Any service, facility or equipment that results from a project submitted under this Policy after January 1, 1999 shall be excluded from the inventory of that service, facility or equipment in the State Medical Facilities Plan.

**EXHIBIT F TO NOVANT HEALTH'S PETITION
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POLICIES APPLICABLE TO GENERAL ACUTE CARE HOSPITALS (AC)

POLICY AC-1: USE OF LICENSED BED CAPACITY DATA FOR PLANNING PURPOSES

For planning purposes the number of licensed beds shall be determined by the Division of Facility Services in accordance with standards found in 10 NCAC 3C - Section .6200 and .6102(d).

Licensed bed capacity of each hospital is used for planning purposes. It is the hospital's responsibility to notify the Division of Facility Services promptly when any of the space allocated to its licensed bed capacity is converted to another use, including purposes not directly related to health care.

POLICY AC-2: UTILIZATION OF ACUTE CARE HOSPITAL BED CAPACITY

Conversion of underutilized hospital space to other needed purposes shall be considered an alternative to new construction. Hospitals falling below utilization targets in Policy AC-4 are assumed to have underutilized space. Any such hospital proposing new construction must clearly and convincingly demonstrate that it is more cost-effective than conversion of existing space.

POLICY AC-3: EXEMPTION FROM PLAN PROVISIONS FOR CERTAIN ACADEMIC MEDICAL CENTER TEACHING HOSPITAL PROJECTS

Projects for which certificates of need are sought by academic medical center teaching hospitals may qualify for exemption from the need determinations of this document. The State Medical Facilities Planning Section shall designate as an Academic Medical Center Teaching Hospital any facility whose application for such designation demonstrates the following characteristics of the hospital:

- (A) Serves as a primary teaching site for a school of medicine and at least one other health professional school, providing undergraduate, graduate and postgraduate education.
- (B) Houses extensive basic medical science and clinical research programs, patients and equipment.
- (C) Serves the treatment needs of patients from a broad geographic area through multiple medical specialties.

Exemption from the provisions of need determinations of the State Medical Facilities Plan shall be granted to projects submitted by Academic Medical Center Teaching Hospitals designated prior to January 1, 1990 which projects comply with one of the following conditions:

- (i) Necessary to complement a specified and approved expansion of the number or types of students, residents or faculty, as certified by the head of the relevant associated professional school; or
- (ii) Necessary to accommodate patients, staff or equipment for a specified and approved expansion of research activities, as certified by the head of the entity sponsoring the research; or
- (iii) Necessary to accommodate changes in requirements of specialty education accrediting bodies, as evidenced by copies of documents issued by such bodies.

A project submitted by an Academic Medical Center Teaching Hospital under this Policy that meets one of the above conditions shall also demonstrate that the Academic Medical Center Teaching Hospital's teaching or research need for the proposed project cannot be achieved effectively at any non-Academic Medical Center Teaching Hospital provider which currently offers the service for which the exemption is requested and which is within 20 miles of the Academic Medical Center Teaching Hospital.

Any health service facility or health service facility bed that results from a project submitted under this Policy after January 1, 1999 shall be excluded from the inventory of that health service facility or health service facility bed in the State Medical Facilities Plan.

POLICY AC-4: RECONVERSION TO ACUTE CARE

Facilities that have redistributed beds from acute care bed capacity to psychiatric, rehabilitation, or nursing care use, shall obtain a certificate of need to convert this capacity back to acute care. Applicants proposing to reconvert psychiatric, rehabilitation, or nursing care beds back to acute care beds shall demonstrate that the hospital's average annual utilization of licensed acute care beds as reported in the most recent licensure renewal application form is equal to or greater than the target occupancies shown below, but shall not be evaluated against the acute care bed need determinations shown in Chapter 5 of the State Medical Facilities Plan.

<u>Licensed Acute Care Bed Capacity</u>	<u>Percent Occupancy</u>
1 - 49	65
50 - 99	70
100 - 199	75
200 - 699	80
700 +	81.5

POLICY AC-5: REPLACEMENT OF ACUTE CARE BED CAPACITY

The evaluation of proposals for either partial or total replacement of acute care beds (i.e., construction of new space for existing acute care beds) shall be evaluated against the utilization of the total number of acute care beds in the applicant's hospital in relation to utilization targets

**EXHIBIT G TO NOVANT HEALTH'S PETITION
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Proposed

2011

State Medical Facilities Plan

North Carolina State Health Coordinating Council • North Carolina Department of Health and Human Services • Division of Health Service Regulation • Medical Facilities Planning Section

IMPORTANT NOTICE: Recommendations for the final 2011 State Medical Facilities Plan will be voted on in October 2010 and may include updated inventories, updated population projections, and other changes resulting from comments and petitions received during the public review period. Statewide revisions to population projections are not anticipated. Please contact the Medical Facilities Planning Section if you have questions.

**CHAPTER 4
STATEMENT OF POLICIES**

Summary of Policy Changes for 2011

Two substantive policy changes have been recommended for incorporation into the North Carolina 2011 State Medical Facilities Plan. **POLICY AC-5: REPLACEMENT OF ACUTE CARE BED CAPACITY** has been revised to include swing bed days when calculating Policy AC-5 target occupancy rates for proposals to replace acute care beds in Critical Access Hospitals.

POLICY GEN-4: ENERGY EFFICIENCY AND SUSTAINABLE BUILDING DESIGN AND CONSTRUCTION is a preliminary energy policy developed in response to the Governor's directive to address more energy efficient and sustainable building design and construction for certificate of need applicants proposing new or replacement health care facilities. Policy Gen-4 will continue to be expanded for future North Carolina State Medical Facility Plans.

Throughout Chapter 4, references to dates have been advanced by one year, as appropriate.

POLICIES APPLICABLE TO ACUTE CARE HOSPITALS (AC)

POLICY AC-1: USE OF LICENSED BED CAPACITY DATA FOR PLANNING PURPOSES

For planning purposes the number of licensed beds shall be determined by the Division of Health Service Regulation in accordance with standards found in 10A NCAC 13B - Section .6200 and Section .3102 (d).

Licensed bed capacity of each hospital is used for planning purposes. It is the hospital's responsibility to notify the Division of Health Service Regulation promptly when any of the space allocated to its licensed bed capacity is converted to another use, including purposes not directly related to health care.

POLICY AC-3: EXEMPTION FROM PLAN PROVISIONS FOR CERTAIN ACADEMIC MEDICAL CENTER TEACHING HOSPITAL PROJECTS

Projects for which certificates of need are sought by academic medical center teaching hospitals may qualify for exemption from the need determinations of this document. The Medical Facilities Planning Section shall designate as an Academic Medical Center Teaching Hospital any facility whose application for such designation demonstrates the following characteristics of the hospital:

1. Serves as a primary teaching site for a school of medicine and at least one other health professional school, providing undergraduate, graduate and postgraduate education.

2. Houses extensive basic medical science and clinical research programs, patients and equipment.
3. Serves the treatment needs of patients from a broad geographic area through multiple medical specialties.

Exemption from the provisions of need determinations of the North Carolina State Medical Facilities Plan shall be granted to projects submitted by Academic Medical Center Teaching Hospitals designated prior to January 1, 1990 provided the projects comply with one of the following conditions:

1. Necessary to complement a specified and approved expansion of the number or types of students, residents or faculty, as certified by the head of the relevant associated professional school; or
2. Necessary to accommodate patients, staff or equipment for a specified and approved expansion of research activities, as certified by the head of the entity sponsoring the research; or
3. Necessary to accommodate changes in requirements of specialty education accrediting bodies, as evidenced by copies of documents issued by such bodies.

A project submitted by an Academic Medical Center Teaching Hospital under this Policy that meets one of the above conditions shall also demonstrate that the Academic Medical Center Teaching Hospital's teaching or research need for the proposed project cannot be achieved effectively at any non-Academic Medical Center Teaching Hospital provider which currently offers the service for which the exemption is requested and which is within 20 miles of the Academic Medical Center Teaching Hospital.

Any health service facility or health service facility bed that results from a project submitted under this Policy after January 1, 1999 shall be excluded from the inventory of that health service facility or health service facility beds in the North Carolina State Medical Facilities Plan.

POLICY AC-4: RECONVERSION TO ACUTE CARE

Facilities that have redistributed beds from acute care bed capacity to psychiatric, rehabilitation, nursing care, or long-term care hospital use, shall obtain a certificate of need to convert this capacity back to acute care. Applicants proposing to reconvert psychiatric, rehabilitation, nursing care, or long-term care hospital beds back to acute care beds shall demonstrate that the hospital's average annual utilization of licensed acute care beds as calculated using the most recent Thomson Reuters Days of Care as provided to the Medical Facilities Planning Section by The Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill, is equal to or greater than the target occupancies shown below, but shall not be evaluated against the acute care bed need determinations shown in

**EXHIBIT H TO NOVANT HEALTH'S PETITION
TO THE SHCC REGARDING POLICY AC-3**

Proposed

2011

State Medical Facilities Plan

North Carolina State Health Coordinating Council • North Carolina Department of Health and Human Services • Division of Health Service Regulation • Medical Facilities Planning Section

IMPORTANT NOTICE: Recommendations for the final 2011 State Medical Facilities Plan will be voted on in October 2010 and may include updated inventories, updated population projections, and other changes resulting from comments and petitions received during the public review period. Statewide revisions to population projections are not anticipated. Please contact the Medical Facilities Planning Section if you have questions.

Table 9E: Hospital and Free-Standing Linear Accelerators and Radiation Oncology Procedures

Facility Name	Service Area #	County	Number of Linear Accelerators	Number of Procedures (ESTVs) 10/1/2008-9/30/2009	Average # of Procedures per Unit
Murphy Medical Center	1	Cherokee	1*	0	0
Harris Regional Hospital	1	Jackson	1	4,338	4,338
NC Radiation Therapy - Franklin	1	Macon	1	633	633
Mission Hospitals (S) (b)	2	Buncombe	3	20,042	6,681
NC Radiation Therapy - Asheville	2	Buncombe	2	7,993	3,997
NC Radiation Therapy - Clyde	2	Haywood	1	4,090	4,090
NC Radiation Therapy - Marion	2	McDowell	1	1,605	1,605
Watauga Hospital	3	Watauga	1	4,169	4,169
Margaret Pardee Memorial Hospital	4	Henderson	1	6,791	6,791
NC Radiation Therapy - Brevard	4	Transylvania	1	2,580	2,580
NC Radiation Therapy - Hendersonville	4	Henderson	1	127	127
Catawba Valley Medical Center	5	Catawba	2	15,372	7,686
Frye Regional Medical Center	5	Catawba	1	689	689
Valdese General Hospital	5	Burke	2	6,325	3,163
Caldwell Memorial Hospital	5	Caldwell	1	2,651	2,651
Cleveland Regional Medical Center	6	Cleveland	1	6,217	6,217
Gaston Memorial Hospital (h)	6	Gaston	3	14,110	4,703
Lincoln Radiation Oncology Associates (s)	6	Lincoln	will be transferred	NR	NR
NC Radiation Therapy - Forest City	6	Rutherford	1	4,951	4,951
Pineville Radiation Therapy Center (n)	7	Mecklenburg	1	6,972	6,972
Carolinas Medical Center (S)	7	Mecklenburg	3**	17,268	5,756
CMC-Union (i)	7	Union	1	7,619	7,619
Mathews Radiation Oncology	7	Mecklenburg	1	11,443	11,443
Presbyterian Hospital	7	Mecklenburg	4	12,688	3,172
University Radiation Oncology	7	Mecklenburg	1	6,271	6,271
Iredell Memorial Hospital	8	Iredell	2	7,197	3,599
Lake Norman Radiation Oncology Center	8	Iredell	1	10,680	10,680
Rowan Regional Medical Center	8	Rowan	1	5,396	5,396
CMC-NorthEast Medical Center	9	Cabarrus	2	12,386	6,193
Stanly Regional Medical Center	9	Stanly	1	3,994	3,994
Forsyth Memorial Hospital	10	Forsyth	4	27,566	6,892
Hugh Chatham Memorial Hospital (d)	10	Surry	1	5,777	5,777
N. C. Baptist Hospitals (S)	10	Forsyth	4	18,597	4,649
Cancer Center of Davidson County (o)	11	Davidson	1	226	226
High Point Regional Health System	12	Guilford	2	8,442	4,221
Morehead Memorial Hospital	12	Rockingham	1	5,811	5,811
Moses Cone Health System	12	Guilford	4	24,654	6,164
Randolph Cancer Center (m)	13	Randolph	1	3,803	3,803
UNC Hospitals (S)	14	Orange	4	25,953	6,488
Alamance Regional Medical Center (j)	15	Alamance	2	9,592	4,796
Duke University Hospital (S)	16	Durham	5	36,721	7,344
Durham Regional Hospital	16	Durham	1	3,924	3,924
Maria Parham Hospital (e)	16	Vance	1	5,444	5,444
FirstHealth Moore Regional	17	Moore	2	18,953	9,477
Scotland Memorial Hospital (l)	17	Scotland	1	4,943	4,943
Cape Fear Valley Medical Center (a)	18	Cumberland	5	18,220	3,644

Table 9E: Hospital and Free-Standing Linear Accelerators and Radiation Oncology Procedures

Facility Name	Service Area #	County	Number of Linear Accelerators	Number of Procedures (ESTVs) 10/1/2008-9/30/2009	Average # of Procedures per Unit
Southeastern Regional Medical Center (v)	18	Robeson	1	7,404	7,404
Sampson Regional Medical Center	18	Sampson	1	2,519	2,519
New Hanover Radiation Oncology	19	New Hanover	2	21,634	10,817
New Hanover Regional Medical Center	19	New Hanover	1	6,954	6,954
South Atlantic Radiation Oncology (c)	19	Brunswick	1	7,640	7,640
Raleigh Hematology Oncology Associates/Cancer Centers of NC (u)	20	Wake	2	11,923	5,962
Duke Raleigh Hospital	20	Wake	1	7,268	7,268
Rex Hospital	20	Wake	4	16,932	4,233
Wake Radiology / Oncology Services	20	Wake	1	4,718	4,718
Rex Healthcare (Smithfield Radiation Oncology)	21	Johnston	1	2,432	2,432
Johnston Memorial Hospital Authority (t)	21	Johnston	1	NR	NR
Lenoir Memorial	22	Lenoir	1	5,860	5,860
Goldsboro Radiation Therapy Services dba Wayne Radiation Oncology Center	22	Wayne	1	4,799	4,799
Carteret General Hospital (g)	23	Carteret	1	119	119
CarolinaEast Medical Center	23	Craven	2	12,036	6,018
Onslow Radiation Oncology	24	Onslow	1	NR	NR
Nash Day Hospital	25	Nash	2	8,491	4,246
Roanoke Valley Cancer Center	25	Halifax	1	3,996	3,996
Wilson Medical Center	25	Wilson	1	5,178	5,178
Beaufort County Hospital	26	Beaufort	1	4,308	4,308
Ahoskie Cancer Center	26	Hertford	1	1,758	1,758
NC Radiation Therapy Management Services (prev Carolina Radiation Medicine, P.A.) (f) (S)	26	Pitt	1	8,228	8,228
ECU Brody School of Medicine (S)	26	Pitt	3	18,786	6,262
Albemarle Hospital	27	Pasquotank	1	5,276	5,276
Alliance Oncology dba Outer Banks Cancer Center	27	Dare	1	2,049	2,049
TOTALS (71 Facilities)			116	593,531	5,117

* Murphy Medical Center stopped operating, and decommissioned, this linear accelerator on May 20, 2009.

** CMC will move one linear accelerator to CMC-Union per CON F-007525-06

(a) Cape Fear Valley Health System received a CON in May 2004 for the fourth linear accelerator, and CON M-008133-08 on 12/18/2009 to retain a linear accelerator, for a total of five, including a CyberKnife.

(b) Mission Hospitals received a CON in September 2004 for a CyberKnife linear accelerator; operational in October 2005.

(c) South Atlantic Radiation Oncology received a CON in August 2005 for a linear accelerator; operational in May 2007.

(d) Hugh Chatham Memorial Hospital became operational in March 2000 with a leased linear accelerator from NC Baptist Hospitals.

(e) Maria Parham Hospital received a CON in July 2001 to lease and install one linear accelerator.

(f) Carolina Radiation Medicine, P.A. became operational in July 1998.

(g) Carteret General Hospital received a no review in June 1999 to replace a linear accelerator and purchase a simulator. Also received a no-review for a replacement linear accelerator in 2009.

(h) Gaston Memorial Hospital received a CON in August 1999 to add one linear accelerator.

Table 9E: Hospital and Free-Standing Linear Accelerators and Radiation Oncology Procedures					
Facility Name	Service Area #	County	Number of Linear Accelerators	Number of Procedures (ESTVs) 10/1/2008-9/30/2009	Average # of Procedures per Unit

footnotes, continued:

- (i) Union Regional Medical Center received a CON in April 2000 to acquire one linear accelerator.
 - (j) Alamance Regional Medical Center received a CON in August 2002 to add one linear accelerator.
 - (k) Forsyth Medical Center received a CON in August 2002 to add one linear accelerator; operational in October 2004.
 - (l) Scotland Memorial Hospital became operational in August 2003.
 - (m) Randolph Cancer Center received a CON in June 2006 for a linear accelerator.
 - (n) Pineville Radiation Therapy Center received a CON in June 2007 for a linear accelerator.
 - (o) Cancer Center of Davidson County, LLC received a CON in July 2007 for a linear accelerator.
 - (p) East Carolina University Brody School of Medicine received a CON in December 2007 to replace an existing linear accelerator with a CyberKnife linear accelerator.
 - (q) UNC Hospitals received a CON in October 2006 to replace an existing linear accelerator with a CyberKnife linear accelerator.
 - (r) Carolinas Medical Center - NorthEast received a CON in February 2006 to acquire a CyberKnife linear accelerator.
 - (s) Lincoln Radiation Oncology Associates received CON 10/27/08 to acquire existing linear accelerator through ownership transfer from Gaston Memorial Hospital, replace the linear accelerator and relocate to Lincoln Radiation Oncology Center.
 - (t) Johnston Memorial Hospital Authority received CON # J-8188-08 on 2/24/09.
 - (u) Raleigh Hematology Oncology Associates, PC d/b/a Cancer Centers of NC received CON #J-007941-07 in July 2009 for a second linear accelerator.
 - (v) Southeastern Regional Medical Center received CON #N-004919-93 on 2/2/94.
- NA - Not Applicable, not in operation for appropriate time frame.
 NR - No report
 S - Has at least one linear accelerator configured for stereotactic radiosurgery

**EXHIBIT I TO NOVANT HEALTH'S PETITION
TO THE SHCC REGARDING POLICY AC-3**

ATTACHMENT - REQUIRED STATE AGENCY FINDINGS

FINDINGS

C = Conforming

CA = Conditional

NC = Nonconforming

NA = Not Applicable

DECISION DATE: June 10, 2010
PROJECT ANALYST: Gebrette Miles
ASSISTANT CHIEF: Martha Frisone

PROJECT I.D. NUMBER: G-8460-10 / North Carolina Baptist Hospital / Construct a new building to house eight operating rooms (seven additional and one relocated), two procedure rooms, one robotic surgery training room, and one simulation operating room / Forsyth County

REVIEW CRITERIA FOR REPLACEMENT INSTITUTIONAL HEALTH SERVICES

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

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

C

North Carolina Baptist Hospital (NCBH) proposes to construct a new building to house eight operating rooms (seven additional operating rooms and one relocated operating room), two procedure rooms, one simulation operating room and one robotic surgery training room. There is no need determination for additional operating rooms in Forsyth County in the 2010 State Medical Facilities Plan. However, NCBH proposes to develop the seven additional operating rooms pursuant to *Policy AC-3: Exemption from Plan Provisions for Certain Academic Medical Center Teaching Hospital Projects* in the 2010 SMFP. Policy AC-3 states,

“Exemption from the provisions of need determinations of the North Carolina State Medical Facilities Plan shall be granted to projects submitted by Academic Medical Center Teaching Hospitals designated prior to January 1, 1990 provided the projects comply with one of the following conditions:

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1. *Necessary to complement a specified and approved expansion of the number or types of students, residents or faculty, as certified by the head of the relevant associated professional school; or*
2. *Necessary to accommodate patients, staff or equipment for a specified and approved expansion of research activities, as certified by the head of the entity sponsoring the research; or*
3. *Necessary to accommodate changes in requirements of specialty education accrediting bodies, as evidenced by copies of documents issued by such bodies.*

A project submitted by an Academic Medical Center Teaching Hospital under this Policy that meets one of the above conditions shall also demonstrate that the Academic Medical Center Teaching Hospital's teaching or research need for the proposed project cannot be achieved effectively at any non-Academic Medical Center Teaching Hospital provider which currently offers the service for which the exemption is requested and which is within 20 miles of the Academic Center Teaching Hospital."

NCBH was designated an Academic Medical Center Teaching Hospital by the Medical Facilities Planning Section on February 17, 1983.

In Exhibit 8, the applicant provides a letter from William B. Applegate, MD, president of Wake Forest University Health Sciences (WFUHS) and Dean of the Wake Forest School of Medicine, which states,

"The purpose of this letter is to certify that the expansion of ambulatory care surgical facilities on the North Carolina Baptist Hospital West Campus proposed in a certificate of need application to be submitted by North Carolina Baptist Hospital on January 15, 2010 is:

'Necessary to complement a specified and approved expansion of the number of types of students, residents, or faculty'

With the support of North Carolina Baptist Hospital, the Wake Forest University School of Medicine and Wake Forest Health Sciences has begun an expansion of the clinical and research faculty within the Division of Surgical Sciences. The expansion is driven by four factors:

- *The increasing specialization of clinical and surgical practices at academic medical centers*

- *The increasing involvement of faculty research, especially clinical trials involving new diagnostic, surgical and therapeutic tools and techniques*
- *The increasing demand for surgical services*
- *The changing paradigms for surgical training*

Over the last three years, we have successfully recruited 36 new clinical faculty within the Division of Surgical Sciences, which has largely contributed to the operating room capacity issues on the NCBH campus. The current number of surgeons practicing within the Division is 113; however, we now project to add a total of 51 faculty in the Division of Surgical Sciences, including 39 clinical FTEs by 2020. It is anticipated that by 2020 there will be a total of 193 surgical faculty within the Division of Surgical Services.

...

The expansion of the ambulatory surgery capacity and facilities on the NCBH West Campus will also allow the Wake Forest University School of Medicine to enhance the training and education of our medical students, faculty and fellows. The simulation and robotics training rooms proposed on the West Campus will simulate high-acuity conditions and utilize scenarios and associated instructor feedback to provide a safe yet lifelike learning environment for students and faculty to acquire essential skills required in surgical care. There is a great need to expand our teaching facilities for our surgical residents and medical students to ensure they have an appropriate environment to practice the fundamental skills of operating outside the clinical field in a laboratory setting where operations can be simulated.

...

The expansion of the surgical capacity on the West Campus proposed in the certificate of need application to be submitted January 15, 2010 is essential to the recruitment and retention of these new faculty as well as our existing faculty. I therefore certify the proposed project as 'Necessary to complement a specified and approved expansion' of the faculty of the Wake Forest University Health Sciences."

NCBH adequately demonstrates that the seven additional ORs are necessary to complement a specified and approved expansion of 39 clinical faculty in the Division of Surgical Sciences. See Criterion (3) for the Agency's analysis and discussion regarding the need for the additional ORs at NCBH.

Regarding NCBH's need to demonstrate that its "teaching or research need for the proposed project cannot be achieved effectively at any non-Academic Medical Center Teaching Hospital provider which currently offers the service for which the exemption is requested and which is

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within 20 miles of the Academic Center Teaching Hospital," in Section III.2, page 64, the applicant states,

"Given the combination of facilities and services required to provide the surgical services, simulation operating rooms, training facilities, equipment, and the fact that the resources are already in place at NCBH, the clinical model the Surgical Services department has developed, and the deep involvement of Wake Forest University researchers, NCBH has concluded that expanding the campus to accommodate the outpatient surgery center on the NCBH campus would benefit our patients and their families, our clinicians, and our researchers far more than establishing the expanded OR and training capacity at another off-campus location. Since all Wake Forest University Faculty provide clinics and have their offices housed on the NCBH campus it would not make sense to relocate services off campus away from where faculty currently practice."

The applicant adequately demonstrates that developing seven additional ORs on the hospital campus would be more effective as the faculty, residents and students will be able to remain on campus rather than have to travel to an offsite location. Therefore, the applicant adequately demonstrates that the teaching need for surgical services cannot be achieved effectively at a non-academic medical center teaching hospital located within 20 miles of NCBH. The proposal is consistent with Policy AC-3 in the 2010 SMFP.

There are no other policies in the 2010 SMFP that are applicable to this review. Therefore, the application is conforming with this criterion.

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

C

North Carolina Baptist Hospital (NCBH) proposes to construct a new 72,300 square foot building on its campus, to be called the West Campus Surgery Center (WCSC). The building will house eight operating rooms (ORs), two procedure rooms, one simulation operating room and one robotic surgery training room. Of the eight proposed ORs, seven will be new (or incremental) ORs and one OR will be relocated from the existing surgical suite in Ardmore Tower. NCBH is currently licensed for 40 ORs (36 shared and four dedicated inpatient). The seven additional ORs and the relocated OR will be dedicated outpatient ORs. Therefore, upon

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completion of the proposed project, NCBH will be licensed for a total of 47 ORs (35 shared, 4 dedicated inpatient and 8 dedicated outpatient).

Population to Be Served

The following table illustrates current patient origin for surgical services provided at NCBH, as reported in Section III.7, pages 75-77:

**2009 NCBH Patient Origin
 Inpatient and Outpatient Surgical Cases
 Performed in the Surgical Suite in Ardmore Tower**

County	% of Total Inpatient and Outpatient Surgical Cases
Caldwell	2%
Catawba	3%
Davidson	7%
Davie	3%
Forsyth	29%
Guilford	10%
Iredell	2%
Randolph	2%
Rockingham	3%
Stokes	3%
Surry	4%
Wilkes	4%
Yadkin	2%
Subtotal*	74%
Other NC Counties	15%
All Other States	11%
Total	100%

*Includes only those counties where the percentage of the total is 2% or greater. All other counties are included in "Other NC Counties."

In Section III.6, page 74, the applicant states,

"Historical patient origin is often the best indicator of future patient origin, and as such the fiscal year 2009 proportions from each county were applied to Project Years 1 and 2"

utilization projections with minor adjustment provided by surgical faculty leadership. NCBH anticipates that any changes to patient origin in the future will be insignificant."

In Section III.6, pages 68-70, the applicant provides the projected patient origin for outpatient surgical cases to be performed in the proposed WCSC.

**Project Year 2 (2014) Patient Origin
 Proposed West Campus Surgery Center
 Percent of Total Surgical Cases Performed in ORs**

County	% of Total Outpatient Surgical Cases Performed in ORs
Catawba	2%
Davidson	6%
Davie	3%
Forsyth	42%
Guilford	10%
Iredell	2%
Randolph	2%
Rockingham	2%
Stokes	4%
Surry	4%
Wilkes	4%
Yadkin	2%
Subtotal*	83%
Other NC Counties	11%
All Other States	6%
Total	100%

*Includes only those counties where the percentage of the total is 2% or greater. All other counties are included in "Other NC Counties."

In Section III.6, pages 73-74, the applicant provides the projected patient origin for the procedures to be performed in the two proposed procedure rooms:

**Project Year 2 (2014) Patient Origin
 Proposed West Campus Surgery Center
 Percent of Total Procedures Performed in Procedure Rooms**

County	% of Total Procedures Performed in Procedure Rooms
Catawba	2%
Davidson	7%
Davie	4%
Forsyth	40%
Guilford	10%
Iredell	2%
Rockingham	2%
Stokes	4%
Surry	4%
Wilkes	3%
Yadkin	4%
Subtotal*	82%
Other NC Counties	10%
All Other States	8%
Total	100%

*Includes only those counties where the percentage of the total is 2% or greater. All other counties are included in "Other NC Counties."

The applicant adequately identified the population proposed to be served.

Need for the Proposed Project

In Section II.1(a), page 12, the applicant states,

"Expansion of outpatient surgical services and the surgical training capabilities will enable NCBH to accomplish the following: 1) provide adequate space to meet the current and projected block scheduling demands for outpatient and inpatient surgeries caused by the current and planned growth in surgical faculty and referrals for surgery; 2) to improve the efficiency and utilization of all NCBH's operating rooms through substantial improvements by expanding ambulatory surgery capacity in the proposed West Campus surgery center; 3) Allow NCBH to continue to recruit and attract new surgical faculty; and 4) enhance research and training abilities

through the addition of an additional simulation OR and new robotics training room."

In Section II.1, page 14, the applicant states,

"As a tertiary, quaternary academic medical center, NCBH is at the forefront of technology and education. NCBH proposes to include an additional simulation OR and a new robotics training room as part of the proposed project. As simulation OR is a requirement by the Council on Graduate Medical Education (GME) as well as an important training tool for existing faculty community surgeons and NCBH's OR nurses.

Wake Forest University School of Medicine has established the Center for Applied Learning, a major new initiative to enhance patient care and safety through immersive learning. The Center utilizes advanced instructional technologies to increase the clinical capacities and skills of health care providers. In addition to the laparoscopic and endoscopic surgical skills training, the Simulation Lab experience includes regularly scheduled sessions and experience in Crew Resource Management in a multidisciplinary environment.

The Center combines faculty expertise from across clinical disciplines and brings together innovative resources for clinical education from a host of diverse training facilities. Among the resources are high-fidelity patient simulation laboratories, a surgery academy, an anatomical training center, a program in medical ultrasound, and standardized patient assessment examination rooms."

In Section III.1(a), page 44, the applicant states,

"The unmet need that prompted the development of the proposed project is the continued and increasing demand for OR block time due to high growth in current and future faculty recruitment of 80+ surgeons at NCBH, the continued increase in the volume of ambulatory surgery and procedures performed at NCBH, and the need to expand training programs for surgical faculty, residents, fellows and nurses."

Furthermore, the applicant states that each of the following factors supports the need for the proposed project:

- *Need in the State Medical Facilities Plan (SMFP)*
- *Need to Accommodate Current and Planned Faculty Growth in Surgical Sciences*
- *Need to Support the Innovations and Research of NCBH as an Academic, Tertiary/Quaternary Hospital*
- *Increase in the Amount of Minimally Invasive Surgical Procedures*

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- *Need to Accommodate Increasing Patient Demand*
- *NCBH Campus—Ardmore Tower—Growth in Demand Exhausts Capacity*
- *Need to Address Capacity Enhancement*

Each factor will be discussed separately below.

Need in the State Medical Facilities Plan (SMFP)

Based on data reported in the 2010 SMFP, the ORs at NCBH are currently operating at full capacity (see chart below). However, in Section III.1(a), page 45, the applicant states that because of the higher acuity patients seen at NCBH, both inpatient and outpatient cases take longer than the average case times of 3.00 hours and 1.50 hours for inpatient and outpatient cases, respectively, used in the 2010 SMFP methodology. In Exhibit 7, the applicant provides data for FY 2005 to FY 2009, which shows that the average case time at NCBH was 3.17 hours for inpatient cases and 1.79 hours for outpatient cases. The applicant states,

“When applying the NCBH average case lengths to the State’s need determination formula, NCBH will be operating at 110% capacity by 2012. These figures suggest NCBH needs four additional ORs by 2012 just to keep pace with Forsyth County population growth alone. Thus, the need for additional ORs included in this application on the NCBH campus is imperative.”

The following chart compares projected OR need in 2012 using the methodology in the 2010 SMFP and projected OR need using the same methodology and assumptions except for substituting NCBH’s five-year average inpatient and outpatient case times. See Section III.1, pages 44-45.

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	NCBH Projected OR Need—Case Length from 2010 SMFP	NCBH Projected OR Need— NCBH Average Five-Year Case Length
Inpatient Cases* (FFY 2008)	13,251	13,251
Inpatient Case Time	3.00	3.12
Total Inpatient Hours	39,753	41,343
Outpatient Cases (FFY 2008)	17,999	17,999
Outpatient Case Time	1.50	1.79
Total Outpatient Case Hours	26,998.50	32,218.21
Total Combined Hours	66,751.50	73,651.33
Growth Factor	5.99	5.99
Projected Hours	70,749.91	77,967.65
Hours per OR per Year	1,872.00	1,872.00
Projected ORs Needed in 2012	37.79	41.65
2010 Adjusted Planning Inventory**	38	38
Projected OR Deficit or Surplus	0	4

*NCBH does not have any dedicated C-Section ORs and only performs a few emergency C-sections in a year (less than 10).

**Two of NCBH's ORs are excluded because NCBH is both a burn and a trauma center.

Need to Accommodate Current and Planned Faculty Growth in Surgical Sciences

In Section III.1(a), page 46, the applicant states,

"In response to population growth in Forsyth County and the patient demands of the 19 county market we serve, NCBH has recruited and employed 36 incremental surgeons in the Division of Surgical Sciences bringing the total surgical faculty to 113 surgeons in just the last three years. (This does not include surgical faculty growth in ER, OB/GYN and Dermatology). As a result we have seen significant growth in inpatient and outpatient surgeries, which has resulted in the number of surgical cases in the last two fiscal years growing by 5.52% for inpatient cases and 5.83% for ambulatory cases.

As previously demonstrated, this increase in faculty has pushed NCBH OR case load to its maximum capacity earlier than anticipated. Wake Forest University Health Sciences (WFUHS) intends to continue to add incremental surgeons to meet patient demands and has recently released surgical faculty projections through 2020. The projections are derived from an annual assessment of faculty recruitment plans and the NCBH strategic facilities plans, which includes the expected addition of clinical faculty over the next ten years. As all surgical practices are located within the Academic Medical Center, all surgical time will be spent on the NCBH campus."

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In Exhibit 8, the applicant provides a letter from William B. Applegate, MD, President, Wake Forest University Health Sciences and Dean of the Wake Forest University School of Medicine, which includes the following chart illustrating the current and projected number of clinical and research faculty in the Division of Surgical Sciences.

Specialty	Current Faculty—Jan 2010			Projected Additional Faculty – 2010 to 2020			Projected Total Faculty—2020		
	Clinical	Research	Total	Clinical	Research	Total	Clinical	Research	Total
Cadiothoracic Surgery	9	1	10	2	0	2	11	1	12
Emergency	23	4	27	6	0	6	29	4	33
General	25	4	29	6	0	6	31	4	35
Hypertension	0	8	8	0	2	2	0	10	10
Neurosurgery	7	4	11	6	4	10	13	8	21
Ophthalmology	16	0	16	4	0	4	20	0	20
ENT	11	1	12	3	1	4	14	2	16
Plastics	6	4	10	3	3	6	9	7	16
Urology	8	3	11	6	2	8	14	5	19
Vascular	8	0	8	3	0	3	11	0	11
Total	113	29	142	39	12	51	152	41	193

As shown in the table above, WFUHS projects to add 39 clinical and 12 research faculty to the Division of Surgical Services over the next 10 years, for a total of 193 clinical and research faculty by 2020, or an increase of 34.5% in clinical faculty and 41.4% in research faculty. The overall increase is 35.9% over the 10-year period. The existing and proposed clinical faculty will perform both inpatient and outpatient surgical procedures in the existing surgical suite in Ardmore Tower and outpatient surgical procedures in the proposed WCSC.

Need to Support the Innovations and Research of NCBH as an Academic, Tertiary/Quaternary Hospital

In Section III.1(a), pages 50-51, the applicant states,

“NCBH’s patients experience a much higher acuity level than other health care providers within the region. In fact, according to the North Carolina Hospital Association, in FFY 2008 NCBH’s acuity level was the second highest amongst the state’s other academic medical centers and statewide.

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<i>Facility</i>	<i>North Carolina Baptist Hospital</i>	<i>Duke University Hospital</i>	<i>Pitt County Memorial Hospital</i>	<i>UNC Hospitals</i>
<i>Case Mix Factor</i>	1.71	1.77	1.66	1.49
<i>Rank Among AMC's</i>	2	1	3	4

**Source: North Carolina Hospital Association*

These high acuity levels provide insight into the type of patients that NCBH treats. In essence, it means that the patients seen at NCBH are sicker on average than any other provider's patient cohort in the state. These patients require more complex [sic] and more health care services. They require subspecialties and treatments that are not offered by most providers. Thus, the needs of these types of patients, and the resulting demand on their providers, such as NCBH, Duke, Pitt, or UNC, are not comparable to other patients and community-based providers within the state."

Furthermore, on page 50, the applicant states,

"The State Health Coordinating Council's (SHCC) Acute Care Committee State Planning methodology does not appropriately account for patient acuity and the longer case times required for higher acuity patients. As previously discussed, the 5 year average inpatient case time is 3.12 and 1.79 for ambulatory cases. Therefore, the State formula does not allow NCBH to accurately reflect its true capacity.

Absent additional capacity, NCBH will find it increasingly difficult to meet the needs of these complex patients referred have [sic] that originate within the service area and beyond. As the only tertiary and academic medical center within western North Carolina, NCBH must be allowed the capacity and capabilities to continue to support this important need and its function as a teaching facility and tertiary, quaternary referral center.

Currently, NCBH experiences significant wait times and/or inconvenient block scheduling with surgeries now scheduled as late as 8:00 p.m. Additional OR capacity will reduce wait times and inconvenient scheduling for patients and surgeons which impacts clinic availability. For high acuity patients in particular, the delay in treating their illness when surgery is part of the plan of care can impact their health and future prognosis. Without the proposed incremental ORs, patient-waiting time will continue to increase."

Increase in the Amount of Minimally Invasive Surgical Procedures

In Section III.1(a), pages 47-48, the applicant states,

"As an academic teaching hospital, NCBH is at the forefront of care delivery and as such will continue to adapt its techniques to both speed the recovery process and to enhance the outcome from surgery itself. In the last several years, NCBH surgeons have received advanced training in techniques such as laparoscopy and robotics. As a result, NCBH surgeons estimate that as much as 20 percent of the current surgeries performed use one of the minimally invasive techniques. Projections suggest that we will continue to see an increase in these laparoscopic and robotic techniques to perform surgeries because of the benefits to the patients: smaller incision, minimization of patient pain, fewer complications and a shorter recovery time. With smaller incisions and shorter recovery surgeries, NCBH expects that many surgical procedures will continue to migrate from the inpatient setting to the outpatient setting.

...

Because of [sic] potential of such surgical interventions and the quality of the outcomes we have also seen an increase in the number of surgeons being trained on this and [sic] equipment and performing these services."

This increase in the number of robotic assisted surgeries has also precipitated the need for the enhanced Robotics Training Institute mentioned earlier in the application. NCBH's goal [sic] is to become a world class multi-specialty surgical program comprised of leading urologic, gynecologic, colorectal, and cardiac physicians dedicated to providing superior patient outcomes through the use of robot assisted laparoscopic technology."

Need to Accommodate Increasing Patient Demand

In Section III.1(a), page 49, the applicant states,

"Between 2009 and 2014, the average annual growth rate is projected to be 1.4%. Currently, 56% of the population who receive surgery are ages 45 and over. Therefore, this trend was taken into consideration in our analysis based on the expectation that the 45-64 and 65 and higher age groups represent the segment of the population that will most likely utilize the ORs proposed in this project...These two cohorts are expected to experience continued growth at a rate of 1.6% for ages 46-64 and 3.3% for those aged 65 and higher between 2009 and 2014. Pediatric information is included in order to provide a complete picture of the age distribution; however, all of the ORs in the proposed project are expected to be utilized by patients ages 18 and older."

NCBH Campus—Ardmore Tower—Growth in Demand Exhausts Capacity

In Section III.1(a), pages 51-52, the applicant states,

“For NCBH’s surgical services, the growth in demand has forced NCBH to extend operating case times well beyond the 7 am to 5 pm weekday period that is strongly preferred by surgeons and their patients. Currently NCBH schedules surgeries from 7 am to 9 pm and schedules six ORs on Saturdays as well. Between FY 2005 and FY 2009, Surgical Services experienced a 25 percent increase in the number of surgical hours. While this increase in hours has provided a temporary solution, it is unworkable in the long term to extend surgery hours from 7:30 am to 11:00 pm, which is currently planned. It should be noted, of NCBH’s 32,129 current operating room cases, about 2,000 cases are now performed on nights and weekends to accommodate the increase in volume.

Currently, wait times can exceed 2-3 hours and there is up to a two month back log for certain types of procedures such as orthopaedics/bone and joint, hip scopes, ophthalmology, and urologic robotics cases. ORs are also open on holidays to accommodate the current backlog of schedule surgeries.

Scheduling surgeries in the evening and on weekends create inconveniences and dissatisfaction for the referring physicians, the surgeons, patients and their families. Moreover, this demand crunch in the surgical suite creates inefficiencies for patient flow, and challenges for finding, training and retaining qualified staff to fill positions ranging from RNs, surgical techs, patient transporters, lab techs and other support personnel.

NCBH’s ability to currently accommodate the growing demand is increasingly challenged. In order to develop and offer adequate capacity, both for the current level of demand and for the anticipated higher levels to come, NCBH has determined that this project is a priority for NCBH.”

Need to Address Capacity Enhancement

In Section III.1(a), page 52, the applicant states,

“A major complicating factor for NCBH is that its 36 shared ORs serve a wide variety of patients, including inpatient, outpatient and elective cases and as a result, patient acuity and risks also vary. As a result, OR cases comingled in our 40 ORs vary from 30 minutes to 8 hours or more, depending on the surgical specialty and patient needs creating challenges for staffing appropriately.

NCBH currently experiences a mix of approximately 42% inpatient surgical cases and 58% outpatient surgical cases. The needs and circumstances of these two groups can be substantially different. For the less complex and lower acuity cases including certain

ophthalmology, orthopedics, ENT, and some plastics, the surgical cases are often less complex and can take less time, NCBH feels a model that would remove these patients from the Ardmore Tower location would allow faculty to utilize ORs and equipment located in Ardmore Tower to more efficiently perform the higher acuity, more complex case."

Need for Additional Procedure Room Capacity

In Section III.1(a), pages 52-53, the applicant states,

"Over the past several decades, the healthcare system and the advent of new technology and innovation has made frequent changes to how various surgical procedures are performed. Currently, some procedures must be performed in an OR (such as open heart), but other procedures (such as sutures or partial knee replacements) do not need to be performed in an OR. Further, there are many patients who need a procedure that could be performed in either an operating room or procedure rooms. The determination about which of those rooms is most appropriate depends on the specific procedure and the circumstantial needs that are specific to an individual patient. The types of individual patient needs is based on medical judgment and include co-morbidities, complications, the patient's age, patient weight, anesthesia needs and other factors.

...

NCBH believes that the benefit of having an adequate supply of procedure rooms is valuable for both the hospital and the community. As previously described, NCBH must create additional surgical services capacity to meet current and future demand. Currently, the NCBH campus does not have any available physical space to develop additional procedure rooms, and therefore, two procedure rooms are service components in the proposed project."

Projected Utilization—ORs

In Section IV, pages 82-84, the applicant provides historical and projected OR through the third fiscal year after completion of the proposed project, as shown in the following table.

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Location	Historical Years		Interim Years			Project Years		
	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
# of Dedicated Inpatient ORs	4	4	4	4	4	4	4	4
# of Inpatient Surgical Cases*	12,743	13,446	14,091	14,683	15,344	16,111	16,917	17,763
# of Shared ORs	36	36	36	36	36	35	35	35
# of Dedicated Outpatient ORs	0	0	0	0	0	8	8	8
# of Outpatient Surgical Cases at NCBH (all locations)	17,654	18,683	19,617	20,598	19,805	20,894	22,043	23,256
Total Surgical Cases	30,397	32,129	33,708	35,281	35,149	37,005	38,960	41,019

*Includes Open Heart and C-Section cases.

NCBH proposes to shift a portion of outpatient surgical cases from the existing surgical suite in Ardmore Tower to the proposed WCSC. In Section III.1(b), page 58, the applicant states,

“Step 6: Calculate the percentage of FY 2009 West Campus volumes to the total outpatient surgical cases for FY 2009, which are presented in Table 13.

<i>Ratio of Low Acuity/Adult Only Ambulatory Cases Divided into Total Ambulatory Cases</i>	
<i>FY 09 NCBH Ambulatory OR Volumes</i>	18,683
<i>FY 09 West Campus Volumes</i>	7,473
<i>FY 09 Percentage</i>	40%

For FY 2009, the criteria test discussed above resulted in [sic] the determination that 40% of NCBH's ambulatory case volumes would be appropriate to shift to West Campus.”

The number of outpatient surgical cases to be performed in the proposed WCSC and in the existing surgical suite in Ardmore Tower in the first three years of the project is illustrated in the following table:

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Location	Project Years		
	FY 2013	FY 2014	FY 2015
# of Outpatient Surgical Cases to be Performed in Existing Surgical Suite in Ardmore Tower	12,536	13,226	13,954
# of Outpatient Surgical Cases to be Performed in the Proposed WCSC	8,358	8,817	9,302
Total # of Outpatient Surgical Cases at NCBH	20,894	22,043	23,256

In Section III.1(b), page 54, the applicant states,

“NCBH engaged in a broad based planning discussions that have evolved over time to address the issues the Division of Surgical Sciences was experiencing as it relates to current OR capacity, block scheduling, the increased number of faculty and planned recruitment efforts. The planning process included a review of historical growth rates for surgical case volumes, assessment of current and future capacity constraints and proposed growth methodologies to project future OR demand. Population growth of our 19-county service area and the growth rates reported in the Pediatric ED and Cancer Center Expansion Certificate of Need applications were considered as well. The projections were vetted through senior leadership and growth rates that reflected all of these variable were developed.”

In Section III.1(b), pages 54-64, the applicant provides the assumptions and methodology used to project OR utilization through the third project year. The applicant first determined the historical growth in inpatient and outpatient surgical case volumes at NCBH from FY 2005 to FY 2009, as shown in the following table:

Year				Growth Rate	IP Growth Rate	OP Growth Rate
	IP	OP	Total			
FY 2005	12,732	15,637	28,009	-	-	-
FY 2006	11,435	16,029	27,464	-1.95%	-7.57%	2.51%
FY 2007	12,428	16,165	28,593	4.11%	8.68%	0.85%
FY 2008	12,743	17,654	30,397	6.31%	2.53%	9.21%
FY 2009	13,446	18,683	32,129	5.70%	5.52%	5.83%
CAGR (compounded annual growth rate)				3.49%	2.10%	4.55%

As shown in the above table, NCBH experienced a 14.7% growth in total surgical cases between FY 2005 and FY 2009, and a compound average growth rate (CAGR) of 3.49%. Inpatient surgical cases grew by 5.77%, resulting in a CAGR of 2.10%. Outpatient surgical cases grew by a larger rate of 19.47%, resulting in a CAGR of 4.55%.

Based on these historical growth rates and the addition of 39 clinical faculty in the Division of Surgical Services (a 34.5% increase in 10 years or approximately 3.5% per year), the applicant assumes inpatient surgical cases will increase 4.5% per year and outpatient surgical cases will increase 5.0% per year in the interim years and 5.0% and 5.5%, respectively, in the project years. In Section III.1(b), pages 55-56, the applicant states,

“Using the historical growth rates along with assumptions for future growth including primarily faculty recruitment, NCBH calculated inpatient and outpatient surgical case volumes for FY 2010 through FY 2015 in the following table utilizing an inpatient growth rate of 5% for the project years and an outpatient growth rate of 5.5% for the project years.

GROWTH RATE		
	Inpatient	Outpatient
<i>Interim Years</i>	4.50%	5.00%
<i>Project Years</i>	5.00%	5.50%

INTERIM YEARS	Inpatient	Outpatient	TOTAL
<i>FY 2010</i>	14,051	19,617	33,668
<i>FY 2011</i>	14,683	20,598	35,281
<i>FY 2012</i>	15,344	19,805	35,149
PROJECT YEARS			
<i>FY 2013</i>	16,111	20,894	37,005
<i>FY 2014</i>	16,917	22,043	38,960
<i>FY 2015</i>	17,763	23,256	41,018

NCBH chose to project future operating room utilization using conservative annual growth rates of 4.5% for inpatient surgeries and 5.0% for outpatient surgeries during the interim years. NCBH's operating rooms maximum capacity of 36,500 cases was taken in consideration when determining the growth rates for the interim years. This capacity calculation is based on the existing block hours, the existing staff, and utilizing NCBH's average case length and an average turnover for all cases. During the three project years, the annual growth rates were increased by 0.50% for both inpatient and outpatient volumes, resulting in a 5.0% increase in surgical cases and an 5.5% increase in outpatient volumes.

Surgical volumes in Davie Certificate of Need (CON ID # G-8078-08) were taken into consideration when developing the project surgical volumes in the proposed project.”

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In Section III.1(b), page 57, the applicant used the above projected growth rates and the methodology for projecting OR need in the 2010 SMFP, to determine the number of ORs needed at NCBH in Project Year 3. The result is shown in the following table:

Year	Inpatient Cases	Inpatient Case Time	Total Inpatient Case Hours	Outpatient Cases	Outpatient Case Time	Total Outpatient Case Hours	Total Combined Hours	Hours per OR per Year	Projected ORs needed in 2015
Interim Years									
FY 2010	14,051	3.0	42,153	19,617	1.5	29,426	71,579	1,872	38.2
FY 2011	14,683	3.0	44,050	20,598	1.5	30,897	74,947	1,872	40.0
FY 2012	15,344	3.0	46,032	20,482	1.5	30,723	76,755	1,872	41.0
Project Years									
FY 2013	16,111	3.0	48,334	20,894	1.5	31,341	79,675	1,872	42.6
FY 2014	16,917	3.0	50,751	22,043	1.5	33,065	83,816	1,872	44.8
FY 2015	17,763	3.0	53,288	23,256	1.5	34,884	88,172	1,872	47.1

The table above shows that NCBH will need a total of 47.1 ORs in 2015, without excluding any ORs for burn and trauma services. NCBH is both a Burn and a Trauma Center. Pursuant to the need methodology in the 2010 SMFP, two ORs would be excluded, one for each service. NCBH currently has 40 ORs. Therefore, NCBH projects a need for seven incremental ORs by Project Year 3.

The applicant determined that 40% of NCBH's outpatient cases would be appropriate to shift to the proposed WCSC. See previous discussion. In Section III.1(b), page 59, the applicant states, "For this projection methodology, the percentage of 40% is assumed to remain constant across all years, FY 2010 through FY 2015."

Based on the applicant's projected total outpatient surgical volumes and the percentage of cases projected to shift to the proposed WCSC, the applicant used the methodology in the 2010 SMFP to determine the number of ORs needed at the proposed WCSC. In Section III.1(b), page 60, the applicant projects the number of ORs needed at WCSC as follows:

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Year	Outpatient Cases	Outpatient Case Time	Total Outpatient Case Hours	Hours per OR per Year	Projected ORs needed in 2015
Interim Year					
FY 2010	7,847	1.5	11,770	1,872	6.3
FY 2011	8,239	1.5	12,359	1,872	6.6
FY 2012	7,922	1.5	11,883	1,872	6.3
Project Years					
FY 2013	8,358	1.5	12,536	1,872	6.7
FY 2014	8,817	1.5	13,226	1,872	7.1
FY 2015	9,302	1.5	13,953	1,872	7.5

As shown in the table above, 8 of the 47.1 ORs are needed in the proposed WCSC. Thus, the applicant proposes to add seven incremental ORs and relocate one shared OR from the existing surgical suite in Ardmore Tower to the proposed WCSC for a total of eight ORs.

Projected Utilization—Procedure Rooms

The applicant states that the proposed WCSC will also address NCBH's need for additional procedure room capacity. In Section III.1(a), page 53, the applicant states,

“NCBH believes that the benefit of having an adequate supply of procedure rooms is valuable for both the hospital and the community. As previously described, NCBH must create additional surgical services capacity to meet current and future demand. Currently, the NCBH campus does not have any available physical space to develop additional procedure rooms, and therefore, two procedure rooms are service components in the proposed project.”

In Section IV, page 85, the applicant provides projected utilization of the proposed procedure rooms in the WCSC, as shown in the following table.

	Project Years		
	FY 2013	FY 2014	FY 2015
# of Procedure Rooms	2	2	2
# of Procedures/Treatments	1,439	1,532	1,632

In Section III.1(b), pages 60-64, the applicant describes the methodology and assumptions used to project utilization of the proposed procedure rooms. The applicant used historical utilization of the three existing procedure rooms in the CompRehab Plaza to project utilization at the proposed WCSC. With the addition of the two proposed procedure rooms, NCBH would have a total of five procedure rooms upon project completion. Procedures are also performed in the six

Interventional Radiology (IR) and five Cardiac Catherization rooms at CompRehab. The applicant states that the procedures performed in these rooms were excluded because only specific procedures can be performed in these rooms, such as cardiac catheterization and IR or angiography procedures, which require specialized equipment. Moreover, the IR procedures are performed by radiologists not surgeons.

In Section III.1(b), page 61, the applicant states that procedures related to pain/physiatry, OB/GYN, plastics, and ENT are performed in the three procedure rooms in the CompRehab Plaza. The applicant reviewed the Top 20 procedures performed in the CompRehab Plaza procedure rooms, as well as NCBH patient records to identify procedures that would be eligible to be performed in a procedure room at the proposed WCSC. On page 61, the applicant states,

"The analysis excluded emergency room patients, all endoscopy patients, all interventional radiology patients, all cardiac cath patients and all patients whose procedure[s] were done in an operating room. The data in the table below indicates that, overall, the number of procedures performed at CompRehab has experienced an overall increase in the number of cases by over 200% in the last five years.

<i>Fiscal Year</i>	<i>Cases Performed in a Procedure Room Volume</i>	<i>% Change from Previous Year</i>
2005	1,032	
2006	1,344	30.23%
2007	1,992	48.21%
2008	2,798	40.46%
2009	3,217	14.97%

The applicant states it assumed volumes would increase 6.5% per year through the third project year. The CAGR between 2005 and 2009 was 32.87%. Furthermore, in Section III.1(b), pages 62-63, the applicant states,

"NCBH believes this 6.5% growth rate is supportable based on the following assumptions:

- Historical growth in cases performed in procedure rooms are expected to continue growing at a slower pace than the preceding five years. The slowdown in growth can be seen in the FY 08 to FY 09 change.*
- NCBH has recruited additional physicians that will continue to contribute to the increase in procedure case volumes at NCBH. NCBH will be adding an additional urologist and a physiatrist in Orthopaedics and Neurosurgery in 2010. Both of these faculty recruits are anticipated to increase the volume of pain*

management procedures and implantable pain devices as well as the number of urologic cases referred for prostate biopsies and other treatment."

The applicant states that projected procedure room volumes will be split between CompRehab and the proposed WCSC, thereby decompressing procedure room volumes at CompRehab. The applicant's methodology and assumptions results in the need for a total of five procedure rooms in Project Year 3, as illustrated in the following table:

Year	# of Procedures	Procedure Room Capacity*	Total # of Procedure Rooms Needed	# of CompRehab Procedures	# of West Campus Surgery Center Procedures	Total Procedure Room Procedures
Historical Years						
FY 2007	1,992	1040	2	1,992	-	1,992
FY 2008	2,798	1040	3	2,798	-	2,798
FY 2009	3,217	1040	3	3,217	-	3,217
Interim Years						
FY 2010	3,410	1040	3	3,426	-	3,426
FY 2011	3,649	1040	4	3,649	-	3,649
FY 2012	3,886	1040	4	3,886	-	3,886
Project Years						
FY 2013	4,139	1040	4	2,700	1,439	4,139
FY 2015	4,408	1040	4	2,876	1,532	4,408
FY 2016	4,694	1040	5	3,062	1,632	4,694

*On page 62, the applicant states, "...for the purposes of this CON application the capacity for each procedure room is determined to be 4 cases per day for 260 days per year, for a total annual capacity of 1,040 cases per procedure room, and a total annual capacity for the three rooms of 3,120."

Need Analysis

Based on projected faculty recruitment to expand teaching, research, and training within the Division of Surgical Sciences at the Wake Forest School of Medicine and the current utilization of NCBH's existing ORs, NCBH does not have the capacity to accommodate the projected increase in surgeons without additional OR capacity. WFUHS projects to hire an additional 39 clinical and 12 research faculty for the Division of Surgical Sciences over the next 10 years, for a total of 193 clinical and research faculty by 2020, or an increase of 34.5% in clinical faculty and 41.4% in research faculty. The overall increase is 35.9% in the Division of Surgical Sciences faculty over the 10-year period. This represents an average increase of 3.9 clinical faculty members per year (39 new clinical faculty / 10 years), or 3.5% per year (34.5% increase in clinical faculty / 10 years = 3.5%). The total complement of existing and proposed ORs in the existing surgical suite in Ardmore Tower and the proposed WCSC will be utilized by the existing and future clinical and research faculty.

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The applicant projects inpatient surgical cases will grow at a rate of 4.5% during the interim years and 5.0% during the project years. Based on historical information provided by the applicant, the CAGR for inpatient surgical cases from FY 2005 to FY 2009 was 2.1%. Information reported on NCBH's license renewal applications (LRAs) from 2005 to 2009 (which uses federal fiscal year data) shows that NCBH performed 11,847 inpatient surgical cases in FFY 2005 and 13,357 inpatient surgical cases in FFY 2009, resulting in a CAGR of 3.0%. Although the projected growth rate for the interim and project years is greater than the CAGR for the past four years, the actual growth rate from FY 2008 to FY 2009 was 5.52%. While the CAGR for outpatient surgical cases was from FY 2005 to FY 2009 was 4.55%, the applicant's projected growth rate of 5.0% and 5.5% for the interim and project years is less than the actual growth in outpatient surgical procedures at NCBH in recent years. Between FY 2007 and FY 2008, outpatient surgical cases grew by 9.21%, and between FY 2008 and FY 2009 by 5.83%. The applicant's assumptions regarding projected growth in surgical cases are reasonable, given current utilization, historical growth and the addition of 39 clinical Division of Surgical Services faculty. The applicant anticipates a 34.5% increase in clinical surgeons by 2020 ($39 / 113 = 0.345$).

Furthermore, NCBH's case length exceeds the case lengths used in the SMFP methodology for projecting OR need, which is 3.0 hours for inpatient cases and 1.5 hours for outpatient cases. The applicant states that NCBH's five year average case length from FY 2005 to FY 2009 was 3.17 for inpatient cases and 1.79 for outpatient cases. However, NCBH's 2010 LRA shows an average case length of 4.17 hours for inpatient cases and 2.13 hours for outpatient cases. This supports the applicant's assumption that patient acuity is a factor driving the need for additional OR capacity at NCBH.

The applicant adequately demonstrates the need to develop seven additional ORs pursuant to Policy AC-3 [See Criterion (1) for discussion] and to relocate one existing shared OR to a new building on campus which will house eight dedicated outpatient ORs, two procedure rooms, a robotic training room and a simulation OR.

In addition to increasing the OR capacity for current and future clinical and research faculty, the proposed WCSC will house a simulation OR and robotics training room. The simulation OR will provide students, nurses and faculty with a variety of training experiences in a real-life setting. The purpose of the robotics training room is to train surgeons interested in laparoscopic surgery and other minimally invasive procedures utilizing the da Vinci Surgical Robot. The applicant adequately demonstrates that co-locating the simulation OR and robotics training room in the same building will support the training needs of surgeons, surgical residents, fellows and medical students, and will also allow for increased operational efficiencies.

In summary, the applicant adequately identified the population to be served and demonstrated the need that the population has for proposal. Therefore, the application is conforming to this criterion.

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

NA

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

CA

In Section III.8, pages 77-79, the applicant describes the alternatives considered. Further, the application is conforming to all other applicable statutory and regulatory review criteria. See Criteria (1) (3), (5), (6), (7), (8), (12), (13), (14), (18a), (20) and the Criteria and Standards for Surgical Services and Operating Rooms, promulgated in 10A NCAC 14C .2100. Therefore, the applicant adequately demonstrated that the proposal is its least costly or most effective alternative and the application is conforming to this criterion and approved subject to the following conditions.

1. North Carolina Baptist Hospital shall materially comply with all representations made in the certificate of need application.
2. North Carolina Baptist Hospital shall develop no more than 7 additional operating rooms pursuant to Policy AC-3 in the 2010 SMFP and relocate 1 existing shared operating room to the new West Campus Surgery Center (licensed as part of the hospital), which shall be utilized for outpatient surgical services. The West Campus Surgery Center shall include no more than 8 operating rooms, 1 robotics training room, a simulation operating room (unlicensed) and 2 procedure rooms.
3. Upon completion of the project, North Carolina Baptist Hospital shall be licensed for a total of no more than 47 operating rooms (35 shared operating rooms, 4 dedicated inpatient operating rooms, and 8 dedicated outpatient operating rooms).
4. North Carolina Baptist Hospital shall not acquire, as part of this project, any equipment that is not included in the project's proposed capital expenditure

in Section VIII of the application or that would otherwise require a certificate of need.

5. **Prior to issuance of the certificate of need, North Carolina Baptist Hospital shall acknowledge acceptance of and agree to comply with all conditions stated herein to the Certificate of Need Section in writing prior to issuance of the certificate of need.**
- (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

In Section VIII, page 108, the applicant projects the total capital expenditure for the project will be \$38,709,009, which includes \$4,008,285 for site preparation costs; \$18,198,034 for construction costs; \$4,331,077 for fixed equipment; \$4,083,446 for movable equipment; \$344,403 for furniture; \$4,067,385 for consulting fees and interest during construction; \$2,220,632 for contingency; and other costs of \$1,455,748. In Section IX, page 113, the applicant projects working capital will not be required since the project is an expansion of existing surgical services. The applicant proposes to finance the capital cost with the accumulated reserves of NCBH. Exhibit 16 contains a letter from the Vice-Treasurer of NCBH, which states,

"North Carolina Baptist Hospital agrees to make available from its accumulated reserves a total of \$38,709,009 for the capital costs incurred in the development of the aforementioned project."

Additionally, Exhibit 17 contains the audited financial statements for North Carolina Baptist Hospital and Affiliates. As of June 30, 2009, NCBH had \$44,061,000 in cash and cash equivalents, \$1,308,427,000 in total assets, and \$714,802,000 in net assets (total assets less total liabilities). The applicant adequately demonstrated the availability of sufficient funds for the capital needs of the project.

In the pro forma revenue and operating cost statements, the applicant projects that the hospital's revenues will exceed operating costs in each of the first three full operating years. See Form B. The applicant also projects that WCSC's revenues will exceed operating costs in each of the first three full operating years. See Form C. The assumptions used by the applicant in preparation of the pro formas are reasonable, including projected utilization. See Criterion (3) for discussion of projected utilization.

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In summary, the applicant adequately demonstrated the availability of funds for the capital needs of the project and that the financial feasibility of the proposal is based upon reasonable assumptions regarding projected revenues and operating costs. Therefore, the application is conforming to this criterion.

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

C

The applicant adequately demonstrated the need to construct a new building on campus to house eight operating rooms (seven incremental operating rooms pursuant to Policy AC-3 and one existing to be relocated), two procedure rooms, one simulation operating room and one robotics training room. See Criterion (3) for discussion. Therefore, the applicant adequately demonstrated the proposed project would not result in unnecessary duplication of existing or approved health service capabilities or facilities, and the application is conforming to this criterion.

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

C

In Section VII, pages 99-100, the applicant provides the current staffing for surgical services at NCBH, as well as the projected staffing for the proposed WCSC. The applicant projects that the WCSC will be staffed with 86.8 full-time equivalent (FTE) positions in the second year of the project. In Section VII.3(a), page 100, the applicant states that none of these positions are new positions. In Section V.4, pages 87-88, the applicant identifies Joseph R. Tobin, M.D., as having expressed interest in serving as the medical director for the WCSC. The applicant demonstrates the availability of adequate health manpower and management personnel to provide the proposed services and is conforming with this criterion.

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

C

In Section II.2(b), the applicant states,

"The West Campus Surgery Center will be operated as a department of NCBH and located on the same campus. The West Campus Surgery Center will include the ancillary

services that are necessary to support the surgical cases and minor procedures that will be performed including Basic Imaging, Pharmacy, Sterile Processing, Post Anesthesia Care, Recovery, Pre-admission Testing and Bio-medical Engineering services. The staffing information in Section VII includes the on-site staff to provide these services. Other support services such as Facility Services and Environmental Services will be provided through the existing NCBH support departments as is done for other existing departments."

In Section VI.9(b), page 95, the applicant states,

"As an academic medical center with a teaching hospital and a regional referral center for tertiary care, NCBH routinely accepts referrals from hospitals across North Carolina."

Exhibit 12 includes copies of letters from WFUHS physicians supporting the proposed WCSC. The applicant adequately demonstrated the availability of the necessary ancillary and support services and that the proposed services would be coordinated with the existing health care system. Therefore, the application is conforming to this criterion.

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

NA

- (10) When applicable, the applicant shall show that the special needs of health maintenance organizations will be fulfilled by the project. Specifically, the applicant shall show that the project accommodates:

- (a) The needs of enrolled members and reasonably anticipated replacement members of the HMO for the health service to be provided by the organization; and

NA

- (b) The availability of replacement 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;

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- (iii) would cost no more than if the services were provided by the HMO; and
- (iv) would be available in a manner which is administratively feasible to the HMO.

NA

(11) Repealed effective July 1, 1987.

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

C

The applicant proposes to construct a new 72,300 square foot building on the hospital campus. The certified estimate of construction costs from the architect, included in Exhibit 21, is consistent with the construction costs reported by the applicant in Section VIII, page 108. In Section XI.6(b), page 124, the applicant estimates construction costs of \$252 per square foot. In Section XI.8, page 125, the applicant describes the methods to be used to maintain efficient energy operations. The applicant adequately demonstrated that the cost, design, and means of construction represent the most reasonable alternative for the proposed project and that the construction project will not unduly increase the costs and charges of providing health services. See Criterion (5) for discussion of costs and charges. Therefore, the application is conforming to this criterion.

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

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

C

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In Section VI.12 and VI.13, pages 96-97, the applicant provides the current payor mix for the entire hospital, surgical services and the existing procedure rooms, as illustrated in the following tables.

NCBH—Entire Facility (includes inpatients)	
Self Pay/Indigent/Charity	5.7%
Commercial	1.5%
Medicare/Medicare Managed Care	39.4%
Medicaid	21.6%
Managed Care	28.8%
Other	3.0%
TOTAL	100.0%

NCBH—Surgical Services (includes inpatients)	
Self Pay/Indigent/Charity	5.5%
Commercial	1.7%
Medicare/Medicare Managed Care	31.6%
Medicaid	17.8%
Managed Care	39.5%
Other	3.9%
TOTAL	100.0%

NCBH—Procedure Rooms	
Self Pay/Indigent/Charity	5.8%
Commercial	0.5%
Medicare/Medicare Managed Care	33.5%
Medicaid	12.4%
Managed Care	42.9%
Other	4.9%
TOTAL	100.0%

The applicant demonstrates that it currently provides adequate access to medically underserved populations, and the application is conforming with this criterion.

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

In Section VI.10(a), page 95, the applicant states that no civil rights access complaints have been filed against NCBH in the last five years. The application is conforming with this criterion.

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

C

In Section VI.14, pages 97-98, the applicant projects the following payor mix for the proposed WCSC in Project Year 2, as illustrated in the following tables.

WCSC—ORs (outpatients only)	
FY 2014	
Self Pay/Indigent/Charity	6.1%
Commercial	0.9%
Medicare/Medicare Managed Care	35.7%
Medicaid	7.7%
Managed Care	46.0%
Other	3.6%
TOTAL	100.0%

WCSC—Procedure Rooms	
FY 2014	
Self Pay/Indigent/Charity	4.4%
Commercial	0.6%
Medicare/Medicare Managed Care	35.5%
Medicaid	12.7%
Managed Care	43.6%
Other	3.2%
TOTAL	100.0%

In the assumptions following the pro formas and a footnote on page 98, NCBH states the projected payor mix for services to be provided in the WCSC is based on historical experience. The applicant demonstrates that medically underserved groups will have adequate access to the proposed services, and the application is conforming with this criterion.

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

C

In Section VI.9(a), page 94, the applicant states,

"Patients have access to surgical services primarily through Wake Forest University physician referrals, community physician referrals, and admissions by physicians who have privileges at the hospital. As a tertiary, quaternary hospital, NCBH also admits and treats patients referred from other facilities. Patients are also admitted and treated through the Emergency Department."

The applicant adequately demonstrated that it offers a range of means by which patients have access to the proposed services. The application is conforming to this criterion.

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

C

In Section V.1(a), page 86, the applicant states,

"As an acute care facility that has been providing services for more than 85 years, NCBH has established relationships with many clinical training programs in the Southeast and continues to provide teaching opportunities for these schools. With the incremental ORs, NCBH will be able to continue to provide training support to the numerous clinical programs utilizing educational opportunities at the hospital by providing more space to accommodate students and new opportunities for learning experiences in an integrated inpatient and outpatient environment."

A list of training programs and affiliates is included in Exhibit 10. NCBH is an "academic medical center teaching hospital," as that term is defined in the 2010 SMFP. Thus, the hospital serves as the primary teaching site for WFUHS and at least one other health professional school. The application is conforming with this criterion.

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

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

on cost-effectiveness, quality, and access to the services proposed, the applicant shall demonstrate that its application is for a service on which competition will not have a favorable impact.

C

The applicant adequately demonstrated that its proposal will have a positive impact upon the cost effectiveness, quality and access to the proposed services. See Criteria (3), (5), (7), (8), (12), (13) and (20). Therefore, the application is conforming to this criterion.

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

C

NCBH is accredited by the Joint Commission and certified for Medicare and Medicaid participation. According to the files in the North Carolina Department of Health and Human Services, Division of Health Service Regulation, Acute and Home Care Licensure and Certification Section, no incidents occurred within the eighteen months immediately preceding the date of this decision, for which any sanctions or penalties related to quality of care were imposed by the State. Therefore, the application is conforming to this criterion.

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

C

NCBH, an "academic medical center teaching hospital," as defined in the 2010 SMFP, proposes to develop seven incremental ORs pursuant to Policy AC-3 in the 2010 SMFP as part of the proposed project. Therefore, the Criteria and Standards for Surgical Services and Operating Rooms, promulgated in 10A NCAC 14C .2100, are applicable to this review. The application is

conforming, to all applicable Criteria and Standards for Surgical Services and Operating Rooms. The specific criteria are discussed below.

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

.2102 INFORMATION REQUIRED OF APPLICANT

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

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

-NA- NCBH proposes to add the seven incremental ORs to its license and locate them on the existing campus. Therefore, this rule is not applicable.

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

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

-C- In Section II.10, page 25, the applicant provides the following information regarding the number of ORs in each licensed facility which NCBH owns a controlling interest in the service area.

**NCBH Owned Facilities
 Current Operating Room Inventory**

Type	NCBH	Davie County Hospital	Lexington Memorial Hospital	Total
Dedicated Open Heart				
Other Dedicated Inpatient	4			4
Shared Inpatient/Outpatient	36	2	4	42
Dedicated Ambulatory Surgical Center				
Dedicated C-Section				
Total	40	2	4	46

(2) *the number and type of operating rooms to be located in each licensed facility which the applicant or a related entity owns a controlling interest in and is located in the service area after completion of the proposed project and all previously approved projects related to these facilities (separately identifying the number of dedicated open heart and dedicated C-Section rooms);*

-C-

In Section II.10, page 26, the applicant provides the following information regarding the number of operating rooms to be located in each licensed facility which NCBH owns a controlling interest in the service area.

**NCBH Owned Facilities
 Projected Operating Room Inventory**

Type	NCBH	Davie County Hospital	Lexington Memorial Hospital	Total
Dedicated Open Heart				
Other Dedicated Inpatient	4			4
Shared Inpatient/Outpatient	35	2	4	41
Dedicated Ambulatory Surgical Center	8			8
Dedicated C-Section				
Total	47	2	4	53

(3) *The number of inpatient surgical cases, excluding trauma cases reported by Level I, II and III trauma centers, cases reported by designated burn intensive care units, and cases performed in dedicated open heart and dedicated C-Section rooms, and the number of outpatient surgical cases performed in the most recent*

12 month period for which data is available, in the operating rooms in each licensed facility listed in response to Subparagraphs (b)(1) and(b)(2) of this Rule:

-C- In Section II.10, page 27, the applicant provides the following information regarding the number of inpatient surgical cases (excludes trauma cases, burn center cases, and cases performed in dedicated open heart and dedicated C-Section rooms) and the number of outpatient surgical cases performed in the most recent 12 month period in the ORs in each licensed facility listed in response to Subparagraphs (b)(1) and(b)(2) of this Rule.

**NCBH Owned Facilities
 Total Inpatient and Outpatient Surgical Cases and
 July 2008 – June 2009**

Type	NCBH	Davie County Hospital	Lexington Memorial Hospital	Total
Inpatient	13,446	8	832	14,286
Outpatient	18,683	119	2,508	21,310
Total	32,129	127	3,340	35,596

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

-C- In Section II.10, pages 27-28, the applicant provides the following information regarding the number of inpatient surgical cases (excludes trauma cases, burn center cases, and cases performed in dedicated open heart and dedicated C-Section rooms) and the number of outpatient surgical cases projected to be performed in each of the first three operating years of the proposed project in the operating rooms in each licensed facility listed in response to Subparagraphs (b)(1) and (b)(2) of this Rule.

**NCBH Owned Facilities
 Total Projected Inpatient Surgical Cases
 FY 2013 – FY 2015**

Type	NCBH	Davie County Hospital*	Lexington Memorial Hospital	Total
Project Year 1 (FY 2013)	16,111	9	866	16,986
Project Year 2 (FY 2014)	16,917	9	874	17,800
Project Year 3 (FY 2015)	17,763	10	883	18,656

*The applicant states the replacement hospital will not offer inpatient services until 2017 (Project I.D. # G-8078-08). Thus, the number of inpatient surgeries are not anticipated to increase until the project is complete and the replacement acute care beds become operational.

**NCBH Owned Facilities
 Total Projected Outpatient Surgical Cases
 FY 2013 – FY 2015**

Type	NCBH	Davie County Hospital	Lexington Memorial Hospital	Total
Project Year 1 (FY 2013)	20,894	2,411	2,651	25,956
Project Year 2 (FY 2014)	22,043	2,508	2,689	27,240
Project Year 3 (FY 2015)	23,256	2,608	2,726	28,590

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

-C- In Section III.1(b), pages 53-64, the applicant provides a detailed description of and documentation to support the assumptions and methodology used in the development of the projections required by this Rule. See Criterion (3) for discussion.

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

-C- In Section II.10, page 28, the applicants states,

"[The] NCBH West Campus Surgery location will operate the same as the NCBH Ardmore Tower location for outpatient surgeries, Monday through Friday from 6:00 am to 6:00 pm."

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

- C- In Section II.10, page 29, the applicant provides the average reimbursement per procedure for the 20 surgical procedures most commonly performed at NCBH during the preceding 12 months. On page 28, the applicant states,

"Current surgical services included inpatients and outpatients, therefore these reimbursement rates included an inpatient stay where necessary. In addition, the reimbursement rates include the preoperative assessment clinic."

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

- C- In Section II.10, page 30, the applicant provides the average reimbursement per procedure for the 20 surgical procedures which the applicant projects will be performed in the proposed WCSC. On page 30, the applicant states,

"These projected rates per case include the per-operative assessment clinic services, the surgery or procedure facility charges, anesthesia used during the surgery or procedure, necessary drugs, supplies and devices and recovery. Surgeon and anesthesiologist professional fees will be billed separately by the providers."

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

- C- In Section II.10, page 31, the applicant states,

"The traditional pre-operative assessment tests such as laboratory procedures and pharmacy medication reconciliations are included in the charge data, however any physician visits or other services incurred by the patients prior to the surgery or procedure are not included."

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

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

(2) the number and type of operating rooms to be located in each affected facility

after completion of the proposed project and all previously approved projects related to these facilities (separately identifying the number of dedicated open heart and dedicated C-Section rooms);

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

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

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

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

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

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

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

-NA-

The applicant does not propose to relocate existing operating rooms between existing licensed facilities in the same service area.

.2102(d)

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

- (1) the single surgical specialty area in which procedures will be performed in the proposed ambulatory surgical facility;*
- (2) a description of the ownership interests of physicians in the proposed ambulatory surgical facility;*
- (3) a commitment that the Medicare allowable amount for self pay and Medicaid surgical cases minus all revenue collected from self-pay and Medicaid surgical cases shall be at least seven percent of the total revenue collected for all surgical cases performed in the proposed facility;*
- (4) for each of the first three full fiscal years of operation, the projected number of self-pay surgical cases;*
- (5) for each of the first three full fiscal years of operation, the projected number of Medicaid surgical cases;*
- (6) for each of the first three full fiscal years of operation, the total projected Medicare allowable amount for the self pay surgical cases to be served in the proposed facility, i.e. provide the projected Medicare allowable amount per self-pay surgical case and multiply that amount by the projected number of self pay surgical cases;*
- (7) for each of the first three full fiscal years of operation, the total projected Medicare allowable amount for the Medicaid surgical cases to be served in the facility, i.e. provide the projected Medicare allowable amount per Medicaid surgical case and multiply that amount by the projected number of Medicaid surgical cases;*
- (8) for each of the first three full fiscal years of operation, the projected revenue to be collected from the projected number of self-pay surgical cases;*
- (9) for each of the first three full fiscal years of operation, the projected revenue to be collected from the projected number of Medicaid surgical cases;*
- (10) for each of the first three full fiscal years of operation, the projected total revenue to be collected for all surgical cases performed in the proposed facility;*
- (11) a commitment to report utilization and payment data for services provided in the proposed ambulatory surgical facility to the statewide data processor, as required by G.S. 131E-214.2;*

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

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

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

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

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

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

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

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

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

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

-NA-

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

.2103 PERFORMANCE STANDARDS

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

-C- In Section II.10, page 32, the applicant states,

"NCBH based the utilization projection of the eight multispecialty surgical operating rooms for West Campus on 5 days per week, 52 weeks a year."

.2103(b) A proposal to establish a new ambulatory surgical facility, to establish a new campus of an existing facility, to establish a new hospital, to increase the number of operating rooms in an existing facility (excluding dedicated C-section operating rooms), to convert a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or to add a specialty to a specialty ambulatory surgical program shall not be approved unless:

(1) the applicant reasonably demonstrates the need for the number of proposed operating rooms in the facility, which is proposed to be developed or expanded, in the third operating year of the project is based on the following formula: $\{[(\text{Number of facility projected inpatient cases, excluding trauma cases reported by Level I or II trauma centers, cases reported by designated burn intensive care units and cases performed in dedicated open heart and C-Section rooms, times 3.0 hours}) \text{ plus } (\text{Number of facilities projected outpatient cases times 1.5 hours}) \text{ plus } (\text{Number of facility's projected outpatient cases times 1.5 hours})] \text{ divided by } 1,872 \text{ hours}\}$ minus the facility's total number of existing and approved operating rooms and operating rooms proposed in another pending application, excluding one operating room for level I or II trauma centers, one operating room for facilities with designated burn intensive care units, and all dedicated open heart and C-section operating rooms. The number of rooms needed is determined as follows:

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

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

*is a negative number or a positive number less than 0.3, the need is zero;
and*

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

(2) the applicant demonstrates conformance of the proposed project to Policy AC-3 in the State Medical Facilities Plan titled "Exemption From Plan Provisions for Certain Academic Medical Center Teaching Hospital Projects."

-C- The applicant demonstrates conformance of the proposed project to Policy AC-3 in the 2010 SMFP. See Criterion (1) for discussion. The applicant also demonstrates the need for the number of ORs proposed for NCBH. See Criterion (3) for discussion.

.2103(c) *A proposal to increase the number of operating rooms (excluding dedicated C-Sections operating rooms) in a service area shall not be approved unless the applicant reasonably demonstrates the need for the number of proposed operating rooms in addition to the rooms in all of the licensed facilities identified in response to 10A NCAC 14C .2102(b)(2) in the third operating year of the proposed project based on the following formula: {[(Number of projected inpatient cases for all the applicant's or related entities' facilities, excluding trauma cases report by Level I or II trauma centers, cases reported by designated burn intensive care units and cases performed in dedicated open heart and C-section rooms, times 3.0 hours) plus (Number of projected outpatient cases for all the applicant's or related entities' times 1.5 hours)] divided by 1,872 hours} minus the total number of existing and approved operating rooms and operating rooms proposed in another pending application, excluding one operating room for Level I or II trauma centers, one operating room for facilities with designated burn intensive care units, and all dedicated open heart and C-section operating rooms in all of the applicant's or related entities' licensed facilities in the service area. The number of rooms needed is determined as follows:*

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

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

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

-NA- NCBH is an academic medical center teaching hospital as that term is defined in the 2010 SMFP. Pursuant to G.S. 131E-183(b), the Agency is not authorized to require NCBH to demonstrate that any facility or service at another hospital is being fully utilized in order to be approved.

.2103(d) *An applicant that has one or more existing or approved dedicated C-section operating rooms and is proposing to develop an additional dedicated C-section operating room in the same facility shall demonstrate that an average of at least 365 C-sections per room were performed in the facility's existing dedicated C-section operating rooms in the previous 12 months and are projected to be performed in the facility's existing, approved and proposed dedicated C-section rooms during the third year of operation following completion of the project.*

-NA- The applicant does not propose to develop an additional dedicated C-section room.

.2103(e) *An applicant proposing to convert a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or to add a specialty to a specialty ambulatory surgical program shall provide documentation to show that each existing ambulatory surgery program in the service area that performs ambulatory surgery in the same specialty area as proposed in the application is currently utilized an average of at least 1,872 hours per operating room per year, excluding dedicated open heart and C-Section operating rooms. The hours utilized per operating room shall be calculated as follows: [(Number of projected inpatient cases, excluding open heart and C-sections performed in dedicated rooms times 3.0 hours) plus (Number of projected outpatient cases times 1.5 hours)] divided by the number of operating rooms, excluding dedicated open heart and C-Section operating rooms.*

- NA- The applicant does not propose to convert a specialty ambulatory surgery program to a multispecialty ambulatory surgery program or to add a specialty to a specialty ambulatory surgical program.
- .2103(f) *An applicant proposing to convert a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or to add a specialty to a specialty ambulatory surgery program shall reasonably demonstrate the need for the conversion in the third operating year of the project based on the following formula: [Total number of projected outpatient cases for all ambulatory surgery programs in the service area times 1.5 hours) divided by 1,872 hours] minus the total number of existing, approved and proposed outpatient or ambulatory surgical operating rooms and shared operating rooms in the service area. The need for the conversion is demonstrated if the difference is a positive number greater than or equal to one, after the number is rounded to the next highest number for fractions of 0.50 or greater.*
- NA- The applicant does not propose to convert a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or to add a specialty to a specialty ambulatory surgical program.
- .2103(g) *The applicant shall document the assumptions and provide data supporting the methodology used for each projection in this Rule.*
- C- In Section III.1(b), pages 53-64, the applicant provides a detailed description of and documentation to support the assumptions and methodology used in the development of the projections required by this Rule. See Criterion (3) for discussion.

.2104 SUPPORT SERVICES

- .2104(a) *An applicant proposing to establish a new ambulatory surgical facility, a new campus of an existing facility, or a new hospital shall provide copies of the written policies and procedures that will be used by the proposed facility for patient referral, transfer, and follow-up.*
- NA- NCBH is proposing to add ORs to its license and locate them on the existing campus. Therefore, this rule is not applicable to this review.
- .2104(b) *An applicant proposing to establish a new ambulatory surgical facility, a new campus of an existing facility, or a new hospital shall provide documentation showing the proximity of the proposed facility to the following services:*
(1) emergency services;
(2) support services;

- (3) ancillary services; and
- (4) public transportation.

-NA- NCBH is proposing to add 7 ORs to its license and locate them on the existing campus. Therefore, this rule is not applicable to this review.

.2105 STAFFING AND STAFF TRAINING

.2105(a) *An applicant proposing to establish a new ambulatory surgical facility, to establish a new campus of an existing facility, to establish a new hospital, to increase the number of operating rooms in a facility, to convert a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or to add a specialty to a specialty ambulatory surgical program shall identify, justify and document the availability of the number of current and proposed staff to be utilized in the following areas:*

- (1) administration;
- (2) pre-operative;
- (3) post-operative;
- (4) operating room; and
- (5) other.

-C- In Sections VII.1 and VII.2, pages 99-100, and Sections VII.6(a) and (b), page 101-102, the applicant provides documentation of the availability of current and proposed staff to be utilized in each of the areas listed in this Rule.

.2105(b) *The applicant shall identify the number of physicians who currently utilize the facility and estimate the number of physicians expected to utilize the facility and the criteria to be used by the facility in extending surgical and anesthesia privileges to medical personnel.*

-C- In Section VII.9(b), page 104, the applicant provides the number of physicians on the NCBH medical staff by specialty. In Section II.10, page 40, the applicant states,

"All of the NCBH medical staff who currently perform surgeries on the NCBH campus will be eligible to perform surgery in the West Campus building."

In Section VII.8(a), page 103, the applicant states,

"Counting fellows and residents as well as faculty, the number of surgeons expected to utilize the West Campus Surgery Center will exceed 42 initially, all of which [sic] perform surgical services."

Additionally, Exhibit 15 contains a copy of NCBH's physician credentialing policies and procedures, which outline the criteria used in extending privileges.

.2105(c) *The applicant shall provide documentation that physicians with privileges to practice in the facility will be active members in good standing at a general acute care hospital within the service area in which the facility is, or will be, located or documentation of contacts the applicant made with hospitals in the service area in an effort to establish staff privileges.*

-C- In Section VII.8(a), page 103, the applicant states,

"Privileges to practice at NCBH are limited to physicians with appointments to the faculty at Wake Forest University School of Medicine whose credentials have been approved by the Executive Committee of the Medical Staff of NCBH."

The applicant states that these physicians are expected to remain in good standing.

.2105(d) *The applicant shall provide documentation that physicians owning the proposed single specialty demonstration facility will meet Emergency Department coverage responsibilities in at least one hospital within the service area, or documentation of contacts the applicant made with hospitals in the service area in an effort to commit its physicians to assume Emergency Department coverage responsibilities.*

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

.2106 FACILITY

.2106(a) *An applicant proposing to establish a licensed ambulatory surgical facility that will be physically located in a physician's or dentist's office or within a general acute care hospital shall demonstrate that reporting and accounting mechanisms exist and can be used to confirm that the licensed ambulatory surgery facility is a separately identifiable entity physically and administratively, and is financially independent and distinct from other operations of the facility in which it is located.*

-NA- The applicant does not propose to establish a licensed ambulatory surgical facility that will be physically located in a physician's or dentist's office or within a general acute care hospital.

- .2106(b) *An applicant proposing a licensed ambulatory surgical facility or a new hospital shall receive accreditation from the Joint Commission for the Accreditation of Healthcare Organizations, the Accreditation Association for Ambulatory Health Care or a comparable accreditation authority within two years of completion of the facility.*
- C- NCBH is already accredited by the Joint Commission.
- .2106(c) *All applicants shall document that the physical environment of the facility to be developed or expanded conforms to the requirements of federal, state, and local regulatory bodies.*
- C- Exhibit 5 contains a letter from HKS, the architects for the proposed project, which documents that the physical environment will conform to the requirements of federal, state, and local regulatory bodies.
- .2106(d) *An applicant proposing to establish a new ambulatory surgical facility, a new campus of an existing facility or a new hospital shall provide a floor plan of the proposed facility identifying the following areas:*
- (1) *receiving/registering area;*
 - (2) *waiting area;*
 - (3) *pre-operative area;*
 - (4) *operating room by type;*
 - (5) *recovery area; and*
 - (6) *observation area.*
- NA- NCBH is proposing to add 7 ORS to its existing license and locate them on the existing campus. Therefore, this rule is not applicable to this review.
- .2106(e) *An applicant proposing to expand by converting a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or by adding a specialty to a specialty ambulatory surgical program that does not propose to add physical space to the existing ambulatory surgical facility shall demonstrate the capability of the existing ambulatory surgical program to provide the following for each additional specialty area:*
- (1) *physicians;*
 - (2) *ancillary services;*
 - (3) *support services;*
 - (4) *medical equipment;*
 - (5) *surgical equipment;*
 - (6) *receiving/registering area;*
 - (7) *clinical support areas;*

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- (8) *medical records;*
- (9) *waiting area;*
- (10) *pre-operative area;*
- (11) *operating rooms by type;*
- (12) *recovery area; and*
- (13) *observation area.*

-NA- The applicant is not proposing to expand by converting a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or by adding a specialty to a specialty ambulatory surgical program.

**EXHIBIT J TO NOVANT HEALTH'S PETITION
TO THE SHCC REGARDING POLICY AC-3**

Original

March 3, 2010
Comments Submitted by Novant Health
Regarding the January 15, 2010
NCBH CON Application for a New \$38 Million
Ambulatory Surgery Center with Seven New ORs
Pursuant to SMFP Policy AC-3
(Project I.D. # G-8460-10)

Received by the
CON Section

03 MAR 2010 03 : 00

***NCBH Does Not Meet the Criteria to Qualify for Special Consideration
and Exemption from the Forsyth County OR Need Determination Under
SMFP Policy AC-3 "Exemption From Plan Provisions for Certain
Academic Medical Center Teaching Hospital Projects"***

Overview

In its January 15, 2010 CON Application, NCBH is seeking the state's approval to add seven new ORs in Forsyth County, even though the 2010 SMFP shows for Forsyth County the need for no new ORs in Forsyth County in Table 6 C of the 2010 SMFP. In fact, the 2010 SMFP in Table 6B shows a projected surplus of 5.52 operating rooms in Forsyth County, more than half of which is associated with ORs that are part of the NCBH/Wake Forest Health Sciences (including the recent acquisition of Plastic Surgery Center of North Carolina) operating room inventory. NCBH/WFU Health Sciences did not address the 2.65 surplus ORs at Plastic Surgery Center of NC in seeking approval for seven new ORs in its 8-OR Ambulatory Surgery Center. NCBH proposes to spend \$38.7 Million to construct a 72,300 Square Foot Ambulatory Surgery Center ("the West Campus Surgery Center") with:

- 8 operating rooms (7 new ORs and 1 relocated OR from NCBH's existing surgical suites)
- 2 procedure rooms
- 1 simulation operating room (to provide a safe and lifelike learning environment for medical students, residents, fellows, nurses, and faculty to acquire essential skills required in clinical care)¹
- 1 robotics training operating room (to train surgeons interested in laparoscopic surgery and other minimally invasive procedures using the DaVinci robot)²
- Sterile Processing in the ASC
- 23 Prep/Recovery Bays plus one patient isolation room
- 10 PACU Bays NCBH .
- 8 Short-Stay Recovery Rooms, including one Isolation Recovery Room

Under the special status afforded only to Academic Medical Centers under SMFP Policy AC-3, the applicant has an especially important burden of showing the need for new ORs in a County where a surplus of existing ORs already exists. SMFP Policy AC-3: "Exemption From Plan Provisions for Certain Academic Medical Center Teaching Hospital Projects" states:

"Projects for which certificates of need are sought by academic medical center teaching hospitals may qualify for exemption from the need determinations of this document. The Medical Facilities Planning Section shall designate as an Academic Medical Teaching

¹ NCBH CON Application page 14.

² NCBH CON Application page 15.

Hospital any facility whose application for such designation demonstrates the following characteristics of the hospital:

- 1. Serves as a primary teaching site for a school of medicine and at least one other health professional school, providing undergraduate, graduate, and postgraduate education.*
- 2. Houses extensive basic medical science and clinical research programs, patients, and equipment.*
- 3. Serves the treatment needs of patients from a broad geographic area through multiple medical specialists.*

Exemption from the provisions of need determinations of the North Carolina State Medical Facilities Plan shall be granted to projects submitted by Academic Medical Center Teaching Hospitals designated prior to January, 1, 1990 provided the projects comply with one of the following conditions:

- 1. Necessary to complement a specified and approved expansion of the number or types of students, residents or faculty, as certified by the head of the relevant associated professional school.*
- 2. Necessary to accommodate patients, staff or equipment for a specified and approved expansion of research activities, as certified by the head of the entity sponsoring the research; or*
- 3. Necessary to accommodate changes in requirements of specialty education accrediting bodies, as evidenced by copies of documents issued by such bodies.*

A project submitted by an Academic Medical Center Teaching Hospital under this policy that meets one of the above conditions shall also demonstrate that the Academic Medical Center Teaching Hospital's teaching or research need for the proposed project cannot be achieved effectively at any non-Academic Medical Center Teaching Hospital provider which currently offers the service for which the exemption is requested and which is within 20 miles of the Academic Medical Center Teaching Hospital." [Emphasis Added]

NCBH Provides Insufficient Documentation and Explanation Needed to Demonstrate Compliance with the SMFP Policy AC-3 Requirement for the Necessity to Support an Expansion of Students, Residents or Faculty

In its CON application for an 8-OR Ambulatory Surgery Center, with seven new ORs, NCBH is seeking to qualify for Policy AC-3 Exemption from SMFP Provisions for New OR Need Determinations in Forsyth County, using Criterion #1 above: "Necessary to complement a specified and approved expansion of the number or types of students, residents or faculty, as certified by the head of the relevant associated professional school."

At pages 66-67 in Section II of the 8-OR ASC CON Application, NCBH briefly addresses the provisions of SMFP Policy AC-3, under which it is seeking an exemption from the finite limits of an OR Need Determination in Forsyth County, where such exemption is only available to Academic Medical Centers. Since SMFP Policy AC-3 grants a unique privilege to a handful of North Carolina hospitals that are Academic Medical Centers, it is imperative that the Academic Medical Center is diligent and thorough in demonstrating compliance with all the requirements of SFMP Policy AC-3 in order to qualify for this exemption, which is a unique exception, available to a chosen few hospitals, in the standard SMFP Need Determination process.

In its Policy AC-3 documentation, NCBH relies on a letter included in CON Application Exhibit #8 from Dr. Applegate, President Wake Forest University Health Sciences & Dean, Wake Forest University School of Medicine. This letter notes as justification for the Policy AC-3 Exemption:

- WFUHS projects to add 39 clinical FTEs to the Division of Surgical Sciences by 2020 (over the next ten years);

The faculty recruiting plan represents the addition of approximately 3.9 FTE clinical staff per year for the Division of Surgical Sciences for each of the next ten years. This seems like a modest and manageable rate of growth in surgical faculty that may also be offset by future retirements of surgical faculty, which were not discussed as part of WFUHS Surgeon Recruiting Plan. However, it is unclear whether the projected 12 additional "research" FTEs in the Division of Surgical Sciences would require access to the proposed operating rooms in the West Campus ASC.³

- 2 of the 39 new Clinical FTEs in the Division of Surgical Sciences are identified as "Cardiothoracic Surgery," so it is unlikely that these surgeons will perform surgical cases in the proposed West Campus 8-OR surgery center.
- 6 of the 39 new Clinical FTEs in the Division of Surgical Sciences are identified as "Emergency"; it is unclear whether these are "emergency" surgeons or whether these 6 FTEs are Emergency Department physicians; if these 6 FTEs are Emergency Room physicians it is very unlikely that they would be performing surgery in the proposed 8-OR West Campus ASC.
- 6 of the 39 new Clinical FTEs in the Division of Surgical Sciences are identified as Neurosurgeons. It is not likely that neurosurgeons would be performing surgical cases on a regular basis in the proposed West Campus 8-OR ASC.

If you assume that fourteen (2 Cardiothoracic Surgery, 6 Emergency, and 6 Neurosurgery) of the 39 Clinical FTEs to be recruited for the Division of Surgical Sciences during the next ten years (2010- 2020) will not use the West Campus Surgery Center ORs, then WFUHS is proposing to add only 25 clinical FTEs to the Division of

³ See the table in Dr. Applegate's letter at page 2. See CON application Exhibit #8 for a copy of this letter.

Surgical Sciences over the next ten years who could be reasonably expected to use the eight ORs at the West Campus surgery center. This represents the modest addition of approximately 2.5 FTE clinical surgical staff per year added to the Division of Surgical Sciences, who would require access to the eight ORs of outpatient surgical capacity proposed at the West Campus ASC.

These 25 FTEs of new clinical surgery FTEs to be recruited to the Division of Surgical Sciences over the next ten years include surgeons specializing in: General Surgery, Ophthalmology, ENT, Plastic Surgery, Urology, and Vascular Surgery. The most recent Medical Group Managers Association "Physician Compensation and Production Survey: Based on 2008 Data" shows that at the 75 Percentile of annual surgical case productivity:

- Each Plastic Surgeon performs 598 surgical cases per year
- Each General Surgeon performs 832 surgical cases per year
- Each Vascular Surgeon performs 685 surgical cases per year
- Each Urological Surgeon performs 2,043 cases per year
- Each ENT Surgeon performs 1,141 cases per year

In total, one each of these five types of surgeons, if working at the highly productive 75th percentile, would generate about 5,300 outpatient surgical cases per year.⁴ The MGMA Table is provided as Attachment 1. Applying the SMFP OR Need Method Weighting Factor of 1.5 Hours Per Outpatient Surgery, would result in 7,949 hours of ambulatory surgery cases per year; dividing this by the SMFP defined capacity for annual OR hours per year per OR of 1,872, shows, at best, a need for only 4 ORs⁵, rather than the 7, for which NCBH is seeking approval. With only 2.5 FTEs of surgeons added on average each year over the next ten years, if those surgeons are going to use only the West Campus surgery center (which seems unlikely), these 2.5 FTE new surgeons might add 2,650 outpatient OR cases per year. These 2,650 outpatient cases would occupy about two ORs during the course of a year⁶, so an initial request for 7 new ORs seems to be overstated for the proposed West Campus ASC. This is not enough outpatient OR case volume to suggest that as many as eight ORs are needed right now.

If these surgeons, functioned at only the MGMA Median Percentile of annual surgical case productivity, due to the added complexity of Academic Medical Center patients as discussed in the NCBH CON application, then the annual cases for the above five surgeon types would total only 3,671. This level of annual outpatient OR volume would utilize the capacity of about 3 outpatient ORs⁷, based on the elements of the SMFP OR Need Method. Again, seven new ORs for the NCBH West Campus ASC, seems excessive at this point in time.

⁴ Calculation: $598 + 832 + 685 + 2,043 + 1,141 = 5,299$ cases per year

⁵ Calculation: $(5,299 \text{ outpt OR cases} \times 1.5 \text{ Hours/Case}) / 1,872 \text{ Hours Per OR Per Year} = 4.2 \text{ ORs}$

⁶ Calculation: 2.5 FTE Surgeons generate half the annual outpatient OR cases that 5 surgeons would = $5,299 / 2 = 2,650$ outpatient OR cases/year. Estimate OR capacity utilized: $(2,650 \text{ outpatient OR cases} \times 1.5 \text{ hours per OR case}) / 1,872 \text{ hours per OR per year} = 2.1 \text{ ORs}$

⁷ Calculation: $(3,671 \text{ outpatient OR cases/year} \times 1.5 \text{ hours per OR case}) / 1,872 \text{ hours per OR per year} = 2.99 \text{ ORs}$

A lesser number of ORs at the proposed ASC would meet the needs in the near-term and would not run the risk of saturating the OR inventory in Forsyth County that already shows a surplus of 5.5 operating rooms in the 2010 SMFP. Also, an affiliate of NCBH, Wake Forest University Health Sciences, has notified the Agency of the exempt acquisition of a 3-OR Plastic Surgery Center in Forsyth County (Plastic Surgery Center of NC), which is licensed for three ORs, 2.65 of which are currently identified in the 2010 SMFP as underutilized ORs. It is puzzling that NCBH did not seek to relocate one or two of these operating rooms to the proposed 8-OR ASC, in order to put them to better, more productive use. In addition, two more operating rooms may well be added to the OR inventory in Forsyth County pursuant to the Triad (Forsyth and Guilford) Need Determination for two new Demonstration Project single specialty ambulatory surgery ORs in the 2010 SMFP. The CON Application deadline for these Demonstration Project ASC ORs is March 15, 2010. Given the above factors, adding seven new ORs to the Forsyth County OR inventory, which are projected to be operational in 2012, would simply compound the surplus of OR capacity in Forsyth County now and for the foreseeable future. Unnecessary Duplication is a statutory Review Criterion⁸ which the Agency will apply in its consideration of NCBH's 8-OR ASC CON application.

NCBH's Application Fails to Discuss the Mandatory SMFP Policy AC-3 Provision Requiring the Academic Medical Center to Show that its Teaching Need for the Project Cannot be Achieved at Any Non-AMC Currently Offering the Service and Located within 20 miles of NCBH

The above criterion, as stated in SMFP Policy AC-3 is a mandatory requirement ("*shall also demonstrate*") which must be discussed by NCBH in its SMFP Policy AC-3 CON Application for the new 8-OR Ambulatory Surgery Center. Neither the CON application narrative nor the CON Application Exhibits provided by NCBH address this requirement. The NCBH application is silent on this point.

The Agency should note that there are other Non-Academic Medical Center providers of ambulatory surgical services within a twenty-mile radius of NCBH. These surgical services providers include:

- Forsyth Medical Center, Winston-Salem, NC (including FMC's Hawthorne Surgery Center, with 6 ORs)
- Medical Park Hospital, Winston-Salem, NC
- Kernersville Medical Center, Kernersville NC (under development and slated to open prior to the 2010 opening date for NCBH's proposed 8-OR ASC)
- Davie County Hospital Replacement Facility, Advance, NC
- Clemmons Medical Center, Clemmons, NC

NCBH's CON application is devoid of any discussion of these options and thus, fails to meet this mandatory requirement to qualify for an SMFP Policy AC-3 exemption from the OR Need Determination in Forsyth County, which is zero new ORs in the 2010

⁸ North Carolina General Statutes Section 131E-183(a)(6).

SMFP. Thus, the Agency should find NCBH non-conforming under CON statutory Review Criterion (1)⁹, which requires the applicant to demonstrate that “the project is consistent with applicable policies [including SMFP Policy AC-3]...in the State Medical Facilities Plan.”

Simulation Operating Room and Robotics Training Operating Room

Novant does not oppose the portion of NCBH’s proposal that seeks approval for one simulation operating room and one robotics training operating room. Novant would note that many area hospital facilities and surgeons already have in use DaVinci robotic surgical technology (to be addresses in the NCBH Robotics Training OR), which is in use today at operating rooms at Forsyth Medical Center, Medical Park Hospital, High Point Regional Medical Center, and Moses Cone Hospital. A few years ago NCBH announced an enhanced clinical training agreement between NCBH and MCH.

⁹North Carolina General Statutes Section 131B-183(a)(6).

NCBH Overstates the Need for Additional Operating Rooms in its Quantitative Need Method in CON Application Section III

Review of NCBH AC-3 OR Need Methodology

1. The following analysis reflects a review of only the need for **total** operating rooms at NCBH. The need methodology for the West Campus Outpatient Surgery Center was not analyzed, only NCBH's total need for ORs.
2. For FFY 2005-FFY 2009, the NCBH annual inpatient surgical growth rate of 0.8% and annual outpatient surgical growth rate of 3.9%, as calculated in the following table, are significantly less than the NCBH reported inpatient surgery growth rate of 5.52% and the outpatient surgery growth rate of 5.83% reflected on page 55; Section III of the Application for 2008 to 2009, based upon a July to June timeframe.

NCBH Annual Surgical Growth

NCBH	FFY 2005	FFY 2006	FFY 2007	FFY 2008	FFY 2009	AGR / FFY 2008 / FFY 2009
Inpatient Cases	11,847	11,900	12,208	13,251	13,357	0.8%
Annual Growth Rate		0.4%	2.6%	8.5%	0.8%	
Ambulatory Cases	15,656	15,842	16,717	17,999	18,693	3.9%
Annual Growth Rate		1.2%	5.5%	7.7%	3.9%	

Source: Table 2; LRAs

NCBH's narrative on CON Application page 55, is addressing the CON Application Question III.1(b), which requires the applicant to "provide statistical data that substantiates the existence of an unmet need for each project component and the proposed services..." This is the most basic threshold which every applicant must demonstrate in its Certificate of Need Application to establish the most fundamental level of "need" for the project: the applicant must first and foremost demonstrate the "quantitative need" for the 8-OR ambulatory surgery center as measured by the Agency under CON Statutory Review Criterion 3 ("Need").¹⁰

Two years of data, such as that used by NCBH on pages 46 and 55 of its application, is not typically enough to establish a trend or a reliable growth rate for use in estimating future surgical cases that justify 8 ORs at the proposed surgery center. It seems that the annual percent growth rates for NCBH OR cases may be overstated, which if applied to base year data would suggest a need for more new ORs than can be supported in the future.

3. The NCBH annual growth rate for the last fiscal year as reported on page 55, Section III of the Application, is inconsistent and overstated when compared to LRA¹¹ data

¹⁰ NCGS Section 131E-183(a)(3).

¹¹ LRA = Annual Hospital Licensure Renewal Application

for the timeframe FFY 2008 to FFY 2009 as shown in the following table. Note that NCBH uses a July to June Fiscal Year in the Application, rather than an October to September Fiscal Year (timeframe in LRAs). The data reported in the 2010 LRA is the most current data available which NCBH elected not to consider in its projections of OR cases to demonstrate the need for its existing ORs and the seven proposed new ASC ORs.

Comparison NCBH Surgical Growth Rates

	Actual One Year Growth Rates 2008-2009	
	LRA Data FFY 2008 and FFY 2009 October 2007 - September 2009	NCBH Reported SFY 2008 and SFY 2009 July 2007 - June 2009 Page 55
Inpatient Cases	0.8%	5.52%
Ambulatory Cases	3.9%	5.83%

Source: Table 2; LRAs and page 55

4. Based upon NCBH's own data reported by NCBH in these two documents the only conclusion to be made is that the rate of inpatient surgical growth dropped precipitously in the last quarter of FFY 2009 (July 1, 2009 - Sept. 30, 2009). Annual growth for the twelve months from July 2008 to June of 2009 was 5.52% which decreased to 0.8% (less than 1%) for the twelve months from October 2008 to September 2009. Likewise, NCBH outpatient surgical growth dropped during the last quarter of FFY2009, from 5.83% for the twelve months from July 2008 to June of 2009, to 3.9% for the twelve months from October 2008 to September 2009. This rapid decrease in growth in only three months was not discussed by NCBH nor was it taken into consideration in the application when determining the projected growth rate used in calculating future surgical utilization to justify the need for all existing and new ORs.
5. The high growth rates utilized by NCBH in Step 3 of its Quantitative Need Method in Section III.1(b) of the application on page 56 were based upon the growth experience of NCBH referenced on page 55. However, the historical growth rates reflected in the NCBH Annual Surgical Growth table included in #2 above, which also are more current growth rates than those presented on page 55 of the Application, reflect a much lower growth rate than that which was used to in the projections.
6. The compound annual growth rates for NCBH as calculated: (a) using the LRA data (see table in #2 above); (b) as reported on page 55 of the application; and (c) those utilized in the projections are reflected in the following table.

**NCBH Reported CAGRs (Compound Annual Growth Rates)
For OR Cases**

	NCBH Reported SFY 2005-SFY2009 July 2004-June2009 Page 55	NCBH Interim Growth Rates Page 56	NCBH Project Year Growth Rates Page 56
Inpatient Cases	2.1%	4.5%	5.0%
Ambulatory Cases	4.55%	5.0%	5.5%

Source: Table 2; 2010 LRA and page 55

7. As shown in the previous table, the 4.5% interim time period inpatient NCBH annual OR case growth rate and the 5.0% Project Year inpatient annual growth rate used in Step 4 on page 57 of the Application is over twice the actual CAGR rate reported by NCBH on page 55. The 5.0% interim period NCBH outpatient OR case annual growth rate and the 5.5% Project Year outpatient annual OR case growth rate used in Step 4 on page 57 of the Application are half of a percent to one percent greater than the actual CAGR rate reported by NCBH on page 55. Both annual OR case growth rates utilized by NCBH in its projections are significantly greater than the more current LRA annual growth rates discussed in #1 above.
8. The projected growth rates utilized in Step 4 of the application on page 57 are contradictory to the most current historical growth rates reported in LRA and the CAGR reflected on 55 of the Application. Overstated growth rates result in overstated utilization. Therefore, the projected need for new operating rooms is overstated.
9. NCBH fails to acknowledge the recent purchase of Plastic Surgery Center of North Carolina by Wake Forest University Health Sciences, which is the teaching/research arm of the organization. North Carolina Baptist Hospital and Wake Forest University Health Sciences are "related entities" as that term is defined in the CON Surgical Services and Operating Room Regulations at 10A NCAC 14C.2101((9))¹². As a result of this recent acquisition, the teaching and research arm of the institution now has three operating rooms which can be utilized for teaching, so it is not clear why seven additional operation rooms, or 10 overall (7 + 3), are needed for teaching at NCBH and Wake Forest Health Sciences. The PSCNC operating rooms are chronically underutilized operating rooms as listed in Chapter 6 of the SMFP and should be relocated to the proposed West Campus ASC, as part of the project.
10. Novant calculated revised number of operating rooms need at NCBH using the LRA 2005-2009 CAGR included in Table 7. The result is a need for only four additional ORs at NCBH when the Plastic Surgery Center of North Carolina (PSCNC) surplus

¹² The definition of "related entity" states: "...or a company that shares common ownership with the applicant (i.e., the applicant [NCBH] and another company [Wake Forest University Health Sciences] are owned by some of the same persons."

of 2.65 out of 3 ORs into consideration. In late 2009 Wake Forest University Health Sciences, a "related entity" and affiliate of NCBH sought and received confirmation from the CON Agency for the CON exemption acquisition of PSCNC. This is shown in the following table and in Table 7. Note that the following projections do not take into consideration any shift in NCBH surgical volume to the new Davie County Hospital, which was described in the Davie County Replacement Hospital CON Application filed in March 2008 by NCBH. This project was approved, a Certificate of Need was issued by the Agency following settlement, which projects the DCH ORs to become operational anytime between now and 2014.

	FFY 2010	FFY 2011	FFY 2012	PY1 FFY 2013	PY2 FFY 2014	PY3 FFY 2015
Inpatient Cases	13,764	14,183	14,615	15,059	15,518	15,990
Annual Growth Rate	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%
Weighted Inpatient Cases NCBH LRA 3.0 hrs/case	41,291	42,548	43,844	45,178	46,554	47,971
Ambulatory Cases	19,540	20,426	21,351	22,319	23,331	24,388
Annual Growth Rate	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%
Weighted Ambulatory Cases at NCBH LRA 1.5 hrs/case	29,310	30,639	32,027	33,479	34,996	36,582
Total Weighted Cases	70,601	73,187	75,871	78,657	81,550	84,553
Licensed ORs needed at 1,872 cases/year	38	39	41	42	44	45
Planning Inventory	38	38	38	38	38	38
Surplus/Deficit	0	-1	-3	-4	-6	-7
NCBH Deficit Less Surplus at PSCNC	3.0	1.7	0.2	-1.3	-2.8	-4.4

- Novant also calculated revised operating room need at NCBH using a weighted population growth rate for 45+ population based upon NCBH discussion on CON Application page 49, Section III and current NCBH surgical patient origin as calculated in the attached Table 8. This methodology results in a need for only 1.5 or 2.0 additional ORs at NCBH (includes PSCNC surplus) as shown in the following table and in the attached Table 6. The result is a need for only four additional ORs at NCBH (taking the PSCNC surplus into consideration) as shown in the following table and in Table 6. Note that the following projections do not take into consideration any shift in surgical volume to the new Davie County Hospital operating rooms, which can open anytime between now and 2014.

	FFY 2010	FFY 2011	FFY 2012	PY1 FFY 2013	PY2 FFY 2014	PY3 FFY 2015
Inpatient Cases	13,695	14,041	14,397	14,761	15,134	15,517
Annual Growth Rate	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%
Weighted Inpatient Cases NCBH LRA 3.0 hrs/case	41,085	42,124	43,190	44,282	45,403	46,551
Ambulatory Cases	19,166	19,651	20,148	20,658	21,180	21,716
Annual Growth Rate	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%
Weighted Ambulatory Cases at 1.5 hrs/case	28,749	29,476	30,222	30,986	31,770	32,574
Total Weighted Cases	69,834	71,600	73,412	75,269	77,173	79,125
Licensed ORs needed at 1,872 cases/year	37	38	39	40	41	42
NCBH Planning Inventory	38	38	38	38	38	38
Surplus/Deficit	0.7	-0.2	-1.2	-2.2	-3.2	-4.3
NCBH Deficit Less Surplus at PSCNC	3.4	2.5	1.5	0.5	-0.5	-1.5

12. NCBH July 2008-June 2009 does not appear to subtract trauma/burn cases but does subtract trauma/burn ORs from planning inventory. This will cause the need for existing and new ORs to be overstated.
13. The 2010 SMFP does not indicate that NCBH's existing operating rooms are currently operating at capacity as suggested on page 44 of the NCBH CON Application. In fact, the 2010 SMFP shows only that NCBH's operating rooms are not projected to be at planning capacity (80% of total capacity) until 2012.
14. Based upon surgical data included in Table 6A of the 2010 SMFP, NCBH and Plastic Surgery Center of NC have a current surplus of 4.5 operating rooms in 2010. Based upon the projected growth rate in the 2010 SMFP, the projected surplus in 2012 for NCBH plus Plastic Surgery Center decreases to 2.0 operating rooms. The proposed additional seven operating rooms in this Application are projected to be operational in July 2012 as reflected in Section XII of the Application, which will result in a combined surplus of 9.0 operating rooms in 2012 if the proposed Application is approved.

Conclusion

In May 2003, NCBH has filed an SMFP Policy AC-3 CON Application that was ultimately successful, for one MRI Scanner and one PET/CT Scanner for placement in the NCBH Cancer Center (CON Project I.D. #G-6816-03). In that case the project involved medical equipment only and capital cost for the MRI scanner was \$3.1 Million and the capital cost for the PET/CT Scanner was \$2.96 Million, for a total of \$6 Million in projects exempt from the SMFP need determinations. By contrast, NCBH's Jan. 15, 2010 CON application, seeks approval to spend \$38 Million for seven new ORs, the relocation of one existing OR, a simulation OR, and a robotics training OR, plus all

associated support space in a 72,600 Square Foot facility. Given the magnitude of the proposed capital expenditure and the large number of new ORs, requested over and above the existing surplus of operating rooms in Forsyth County per the 2010 SMFP OR Need Determination, the Agency should give careful consideration to the scope and capital intensity of this project under the requirements of SMFP Policy AC-3. Seven new ORs in a county that currently has 84 ORs (excluding dedicated c-section ORs) is a substantial, practical increase in operating room capacity (+8%) in a County that has consistently for the past five years of Forsyth County OR 2006-2010 SMPF data shown a surplus of operating rooms ranging from 5.5 to 10.3 ORs¹³. The FFY 2009 OR case data (10/1/2008-9/30/2009) that will populate the 2011 SMFP, will be the first data to reflect the time period when the effects of the economic downturn were in full force and perhaps reflected in hospital volumes, including OR cases. Taken in that context, including the historical pattern some ongoing excess OR capacity in Forsyth County, NCBH's request for seven new ORs is too much, too soon. A less costly project, with a significantly smaller compliment of new ORs and greater relocation of existing ORs seems the more reasonable course at this point in time.

File: NCBH AC-3 OR Application analysis 3 3 2010.FINAL.doc

¹³ Forsyth County OR Surpluses in annual State Medical Facilities Plans, Chapter 6: 2006 SMFP = 8.7 ORs; 2007 SMFP = 8.47 ORs; 2008 SMFP = 10.3 ORs; 2009 SMFP = 8.42 ORs; and 2010 SMFP = 5.5 ORs.

Physician Compensation and Productivity

Table 53: Physician Surgery/Anesthesia Cases (NPP Excluded) (continued)

	Phys	Med Praes	Mean	Std. Dev.	25th %tile	Median	75th %tile	90th %tile
Otolaryngology	208	69	801	649	301	755	1,141	1,478
Otolaryngology: Pediatric	3	3	*	*	*	*	*	*
Management: Nonanesthesia	9	7	*	*	*	*	*	*
Otolaryngology: Anatomical & Clinical	5	1	*	*	*	*	*	*
Otolaryngology: Anatomical	1	1	*	*	*	*	*	*
Otolaryngology: Clinical	0	*	*	*	*	*	*	*
Pediatrics: General	827	100	149	177	48	92	176	332
Pediatrics: Adolescent Medicine	7	3	*	*	*	*	*	*
Pediatrics: Cardiology	6	3	*	*	*	*	*	*
Pediatrics: Child Development	0	*	*	*	*	*	*	*
Pediatrics: Child Development	8	4	*	*	*	*	*	*
Pediatrics: Critical Care/Intensivist	1	1	*	*	*	*	*	*
Pediatrics: Emergency Medicine	4	4	*	*	*	*	*	*
Pediatrics: Endocrinology	6	4	*	*	*	*	*	*
Pediatrics: Gastroenterology	0	*	*	*	*	*	*	*
Pediatrics: Genetics	7	3	*	*	*	8	20	64
Pediatrics: Hematology/Oncology	2	2	*	*	*	6	*	*
Pediatrics: Infectious Disease	26	8	19	20	*	*	*	*
Pediatrics: Neonatal Medicine	2	2	*	*	*	*	*	*
Pediatrics: Nephrology	4	3	*	*	*	*	*	*
Pediatrics: Neurology	6	4	*	*	*	*	724	1,620
Pediatrics: Pulmonology	0	*	*	*	661	58	287	2,304
Pediatrics: Urgent Care	68	33	544	988	1,031	1,748	2,304	2,004
Physical Therapy (Phys Med & Rehab)	62	33	1,762	993	794	236	1,551	2,034
Podiatry: General	40	16	1,012	*	*	*	*	*
Podiatry: Surg-Foot & Ankle	2	2	*	*	*	*	*	*
Podiatry: Surg-Forefoot Only	9	7	*	*	*	*	*	302
Psychiatry: General	3	2	*	*	163	76	135	228
Psychiatry: Child & Adolescent	3	2	180	163	76	146	248	346
Pulmonary Medicine	82	40	176	110	64	132	390	519
Pulmonary Medicine: Critical Care	32	10	224	195	84	3	20	40
Pulmonary Med: Gen & Crit Care	45	11	12	17	1	390	788	1,124
Radiation Oncology	17	7	494	375	170	91	316	650
Radiology: Diagnostic-Invasive	44	12	220	271	34	*	*	1,128
Radiology: Diagnostic-NonInvasive	170	23	543	578	198	398	645	1,128
Radiology: Nuclear Medicine	1	1	543	578	198	398	645	1,128
Rheumatology	104	52	644	342	399	600	832	1,134
Sleep Medicine	3	3	644	342	399	600	763	777
Surgery: General	449	117	580	108	446	634	360	477
Surgery: Bariatric	11	6	300	164	202	265	*	*
Surgery: Cardiovascular	121	33	300	164	202	1,336	1,895	1,998
Surgery: Cardiovascular-Pediatric	0	*	1,249	694	184	274	408	608
Surgery: Colon & Rectal	25	14	346	272	*	*	*	*
Surgery: Neurological	108	35	*	*	*	*	*	*
Surgery: Oncology	9	7	*	*	*	479	683	747
Surgery: Oral	7	2	462	223	257	430	698	1,182
Surgery: Pediatric	10	6	514	491	212	383	678	836
Surgery: Plastic & Reconstruction	65	27	402	240	226	*	*	*
Surgery: Thoracic (primary)	12	8	*	*	*	293	349	1,609
Surgery: Transplant	2	2	412	583	146	485	665	876
Surgery: Trauma	9	9	532	239	358	209	373	477
Surgery: Vascular (primary)	31	29	245	179	102	1,413	2,043	2,432
Urgent Care	71	38	1,427	825	815	*	*	*
Urology	231	68	*	*	*	*	*	*
Urology: Pediatric	298	2	*	*	*	*	*	*
Urology: Pediatric	4	2	*	*	*	*	*	*

Medical Group Management Association®
Compensation and Production Survey: 2009 Guide to the Questionnaire Based on 2008 Data

- 53 Community Mental Health Facility
- 54 Intermediate Care Facility for Mentally Retarded
- 55 Residential Substance Abuse Treatment Facility
- 56 Psychiatric Residential Treatment Center
- 62 Comprehensive Outpatient Rehabilitation Facility
- 63 End-stage Renal Disease Treatment Facility
- 71 State or Local Public Health Clinic
- 72 Rural Health Clinic
- 81 Independent Laboratory

Important: If ambulatory encounters are reported in question 20, respondents must complete question 26.

Question 21 – Hospital encounters

Report the total number of encounters, using the previous definition, with the following CMS place of service codes:

- 21 Inpatient Hospital
- 25 Birthing Center
- 26 Military Treatment Facility
- 51 Inpatient Psychiatric Facility
- 61 Comprehensive Inpatient Rehabilitation Facility

Question 22 – Surgery/anesthesia cases

Report the total surgery/anesthesia cases performed annually by each provider. A surgery/anesthesia case is a case between a provider and a patient where at least one procedure performed is a procedure from the surgery chapter (CPT codes 10021-69979) or anesthesia chapter (CPT codes 00100-01999) of the *Current Procedural Terminology, Fourth Edition*, copyrighted by the American Medical Association (AMA).

Note that the number of cases, not procedures, should be counted since a case may consist of multiple procedures. Surgery/anesthesia cases include cases performed on an inpatient or outpatient basis, regardless of facility or site. For anesthesia care teams or an anesthesiologist who supervises one or more CRNAs, include total care team cases.

Questions 23 and 24 – RVUs

Report the RVUs, as measured by the RBRVS, not weighted by a conversion factor, attributed to all professional services. An RVU is a nonmonetary standard unit of measure that indicates the value of services provided by physicians, nonphysician providers, and other health care professionals. The RVU system is explained in detail in the

November 27, 2007 *Federal Register*, pages 66,222 to 66,578. Addendum B: Relative Value Units (RVUs) and Related Information presents a table of RVUs by CPT code. Your billing system vendor should be able to load these RVUs into your system if you are not yet using RVUs for management analysis. When answering this question, note the following:

- The RVUs published in the November 27, 2007, *Federal Register*, effective for calendar year 2008, should be used; and
- The total RVUs for a given procedure consist of three components:
 - Physician work RVUs;
 - Practice expense (PE) RVUs; and
 - Malpractice RVUs.

Thus, Total RVUs = Physician Work RVUs + Practice Expense RVUs + Malpractice RVUs.

For 2008, there were two different types of practice expense RVUs:

1. Fully implemented nonfacility practice expense RVUs; and
2. Fully implemented facility practice expense RVUs.

* "Nonfacility" refers to RVUs associated with a medical practice that is not affiliated with a hospital and does not utilize a split billing system that itemizes facility (hospital) charges and professional charges. "Nonfacility" also applies to services performed in settings other than a hospital, skilled nursing facility, or ambulatory surgery center. You should report total RVUs in question 23 that are a function of "nonfacility" practice expense RVUs.

"Facility" refers to RVUs associated with a hospital affiliated medical practice that utilizes a split billing fee schedule where facility (hospital) charges and professional charges are billed separately. "Facility" also refers to services performed in a hospital, skilled nursing facility, or ambulatory surgery center. Do not report total RVUs in question 23 that are a function of "facility" practice expense RVUs. If you are a hospital affiliated medical practice that utilizes a split billing fee schedule, you should report your total RVUs in question 23 as if you were a medical practice not affiliated with a hospital.

Table 1: NCBH OR Inventory FFY 2007-FFY 2009

	OR Inventory
Inpatient	4
Shared	36
Ambulatory	0
Total	40
Excluded ORs (Trauma Burn)	-2
OR Planning Inventory	38

Source: 2008-2010 LRAs

Table 2: NCBH OR Utilization and Need FFY 2005 - FFY 2009

	FFY 2005	FFY 2006	FFY 2007	FFY 2008	FFY 2009	CAGR FFY 2005- FFY 2009	CAGR FFY 2008- FFY 2009
Inpatient Cases	11,847	11,900	12,208	13,251	13,357		3.0%
Annual Growth Rate		0.4%	2.6%	8.5%	0.8%		
Weighted Inpatient Cases at 3 hrs/case	35,541	35,700	36,624	39,753	40,071		
Ambulatory Cases	15,656	15,842	16,717	17,999	18,693		4.5%
Annual Growth Rate		1.2%	5.5%	7.7%	3.9%		
Weighted Ambulatory Cases at 1.5 hrs/case	23,484	23,763	25,076	26,999	28,040		
Total Weighted Cases	59,025	59,463	61,700	66,752	68,111		
Planning Inventory	38	38	38	38	38		
Licensed ORs needed at 1.872 cases/year	32	32	33	36	36		
Surplus/Deficit	6	6	5	2	2		

Source: 2006-2010 LRAs

Table 3: NCBH OR Utilization

	FFY 2007	FFY 2008	FFY 2009
Inpatient Cases	12,208	13,251	13,357
Weighted Inpatient Cases	36,624	39,753	40,071
Ambulatory Cases	16,717	17,999	18,693
Weighted Ambulatory Cases	25,076	26,999	28,040
Total Weighted Cases	61,700	66,752	68,111
Licensed ORs needed at 1.872 cases/year	38	38	38
OR Planning Inventory	38	38	38
NCBH Surplus (+) / Deficit (-)	5.0	2.3	1.6

Source: Tables 2; SMFP OR Need Methodology

Table 4: Plastic Surgery Center of NC OR Utilization

	FFY 2007	FFY 2008	FFY 2009	Future Surplus Used in Tables 6,7
Ambulatory Cases	447	411	148	
Weighted Cases at 1.5 hrs/case	670.5	616.5	222	
Ambulatory ORs needed at 1,872 cases/year	0.36	0.33	0.12	
Licensed Ambulatory ORs	3	3	3	
PSCNC Surplus (+) / Deficit (-)	2.64	2.67	2.88	2.75
Combined NCBH and PSCNC Surplus (+) / Deficit (-)	7.68	5.01	4.50	

Source: 2008-2010 LRAs; SMFP OR Need Methodology

Note: On 6/5/2009, CON Section issued Exempt from Review letter approving the acquisition of Plastic Surgery Center of NC, Inc. by Wake Forest Health Sciences

Table 5: NCBH OR Utilization and Projected Need in CON Application

	SEY 2009	SEY 2010	SEY 2011	SEY 2012	PM1 SEY 2013	PM2 SEY 2014	PM3 SEY 2015
Inpatient Cases	13,446	14,051	14,683	15,344	16,111	16,917	17,763
Weighted Inpatient Cases at 3 hrs/case	40,338	42,153	44,049	46,032	48,333	50,751	53,289
Ambulatory Cases	18,683	19,617	20,598	20,482	20,894	22,043	23,256
Weighted Ambulatory Cases at 1.5 hrs/case	28,025	29,426	30,897	30,723	31,341	33,065	34,884
Total Weighted Cases	68,363	71,579	74,946	76,755	79,674	83,816	88,173
Licensed ORs needed at 1,872 cases/year	37	38	40	41	43	45	47
Planning Inventory	38	38	38	38	38	38	38
Surplus/Deficit	1	0	-2	-3	-5	-7	-9

Table 6: Revised Projections NCBH OR Utilization and Projected Need Using 2009-2015 Weighted Population Growth Rate (Table 8)

	Actual		Projected							Weighted Population Growth Rate
	FFY 2007	FFY 2008	FFY 2009	FFY 2010	FFY 2011	FFY 2012	FFY 2013	FFY 2014	FFY 2015	
Inpatient Cases	12,208	13,251	13,357	13,695	14,041	14,397	14,761	15,134	15,517	2.5%
Annual Growth Rate		8.5%	0.8%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	
Weighted Inpatient Cases NCBH LRA 3.0 hrs/case	36,624	39,753	40,071	41,085	42,124	43,190	44,282	45,403	46,551	2.5%
Ambulatory Cases	16,717	17,989	18,693	19,166	19,651	20,148	20,658	21,180	21,716	2.5%
Annual Growth Rate		7.7%	3.9%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	
Weighted Ambulatory Cases at 1.5 hrs/case	25,076	26,999	28,040	28,749	29,476	30,222	30,986	31,770	32,574	2.5%
Total Weighted Cases	61,700	66,752	68,111	69,834	71,600	73,412	75,269	77,173	79,125	2.5%
Licensed ORs needed at 1,872 cases/year	33	36	36	37	38	39	40	41	42	2.5%
NCBH Planning Inventory	38	38	38	38	38	38	38	38	38	2.5%
Surplus/Deficit	5.0	2.3	1.6	0.7	-0.2	-1.2	-2.2	-3.2	-4.3	2.5%
NCBH Deficit Less Surplus at PSCNC	7.8	5.1	4.4	3.4	2.5	1.5	0.5	-0.5	-1.5	2.5%

Table 7: Revised Projections NCBH OR Utilization and Projected Need Using NCBH CAGR 2005-2009

	Actual			Projected							CAGR FY 2005 - FY 2009
	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015		
Inpatient Cases	12,208	13,251	13,357	13,764	14,183	14,615	15,059	15,518	15,990	3.0%	
Annual Growth Rate		8.5%	0.8%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%		
Weighted Inpatient Cases NCBH LRA 3.0 hrs/case	36,624	39,753	40,071	41,291	42,546	43,844	45,178	46,554	47,971	4.5%	
Ambulatory Cases	16,717	17,999	18,693	19,540	20,426	21,351	22,319	23,331	24,388	4.5%	
Annual Growth Rate		7.7%	3.9%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%		
Weighted Ambulatory Cases at NCBH LRA 1.5 hrs/case	25,076	26,999	28,040	29,310	30,639	32,027	33,479	34,996	36,582		
Total Weighted Cases	61,700	66,752	68,111	70,601	73,187	75,871	78,657	81,550	84,553		
Licensed ORs needed at 1,872 cases/year	33	36	36	38	39	41	42	44	45		
Planning Inventory	38	38	38	38	38	38	38	38	38		
Surplus/Deficit	5	2	2	0	-1	-3	-4	-6	-7		
NCBH Deficit Less Surplus at PSCNC	7.8	5.1	4.4	3.0	1.7	0.2	-1.3	-2.8	-4.4		

Table 9: Forsyth County OR Utilization and OR Need FFY 2008 Data - 2010 SMFP

NCH	FSCR/C		EMC		Medical Park		Total
	Inpatient Cases Weighted Inpatient Cases at 3 hrs/case	Inpatient Cases Weighted Inpatient Cases at 3 hrs/case	Inpatient Cases - C- Section Weighted Inpatient Cases at 3 hrs/case	10,361	Inpatient Cases Weighted Inpatient Cases at 3 hrs/case	1,085	
13,357	0	0	31,083	10,361	1,085	24,803	
40,071	0	0	12,676	31,083	3,255	74,409	
18,693	148	148	19,014	12,676	10,531	42,048	
28,040	222	222	50,087	19,014	15,797	69,072	
68,111	222	222	32	50,087	19,052	137,481	
38	3	3	OR Planning Inventory**	32	13	86	
Licensed ORs needed at 1,872 cases/year	0.1	0.1	Licensed ORs needed at 1,872 cases/year	29.8	10.2	73.4	
Surplus/Deficit (-)	1.5	2.9	Surplus/Deficit (-)	5.2	2.8	12.6	

Source: 2010 LRA

*Excludes one trauma and one burn OR

**Excludes two C-Section ORs

Table 9: Forsyth County OR Utilization and OR Need FFY 2008 Data - 2010 SMFP - Combined System OR Surplus

NCH	FSCR/C		EMC		Medical Park		Total
	Inpatient Cases Weighted Inpatient Cases at 3 hrs/case	Inpatient Cases Weighted Inpatient Cases at 3 hrs/case	Inpatient Cases - C- Section Weighted Inpatient Cases at 3 hrs/case	11,446 <th>Inpatient Cases Weighted Inpatient Cases at 3 hrs/case</th> <th>24,803 </th>	Inpatient Cases Weighted Inpatient Cases at 3 hrs/case	24,803	
13,357	0	0	34,338	11,446	2,207	74,408	
40,071	0	0	29,207	34,338	42,048	42,048	
18,841	148	148	34,811	29,207	69,149	69,072	
28,262	222	222	69,149	34,811	137,481	137,481	
68,333	222	222	45	69,149	86	86	
41	3	3	OR Planning Inventory**	45	36.9	73.4	
Licensed ORs needed at 1,872 cases/year	0.1	0.1	Licensed ORs needed at 1,872 cases/year	8.1	8.1	12.6	
Surplus/Deficit (-)	1.5	2.9	Surplus/Deficit (-)	8.1	8.1	12.6	

Source: 2010 LRA

*Excludes one trauma and one burn OR

**Excludes two C-Section ORs

Table 11: Forsyth County OR Utilization and OR Need 2012 - 2010 SMFP

NCHS	PSO/C		FMC		Medical Park		Total
	Inpatient Cases	Weighted Inpatient Cases at 3 hrs/case	Inpatient Cases - C-Section	Weighted Inpatient Cases at 3 hrs/case	Inpatient Cases	Weighted Inpatient Cases at 3 hrs/case	
Inpatient Cases	14,266	0	Inpatient Cases - C-Section	11,068	1,158	Inpatient Cases	26,472
Weighted Inpatient Cases at 3 hrs/case	42,768	0	Weighted Inpatient Cases at 3 hrs/case	33,175	3,474	Weighted Inpatient Cases at 3 hrs/case	79,417
Ambulatory Cases	18,951	156	Ambulatory Cases	13,529	11,240	Ambulatory Cases	44,878
Weighted Ambulatory Cases at 1.5 hrs/case	28,927	237	Weighted Ambulatory Cases at 1.5 hrs/case	20,294	16,860	Weighted Ambulatory Cases at 1.5 hrs/case	87,317
Total Weighted Hours	72,694	237	Total Weighted Hours	53,469	20,334	Total Weighted Hours	146,733
OR Planning Inventory*	38	3	OR Planning Inventory**	32	13	OR Planning Inventory	86
Licensed ORs needed at 1,872 cases/year	38.8	0.1	Licensed ORs needed at 1,872 cases/year	28.6	10.9	Licensed ORs needed at 1,872 cases/year	78.4
Surplus/Deficit (-)	-0.8	2.9	Surplus/Deficit (-)	3.4	2.1	Surplus/Deficit (-)	7.6

Source: 2010 LRA

*Excludes one trauma and one burn OR

**Excludes two C-Section ORs

Table 12: Forsyth County OR Utilization and OR Need 2012 - 2010 SMFP - Combined System OR Surplus

NCHS	PSO/C		FMC		Medical Park		Total
	Inpatient Cases	Weighted Inpatient Cases at 3 hrs/case	Inpatient Cases - C-Section	Weighted Inpatient Cases at 3 hrs/case	Inpatient Cases	Weighted Inpatient Cases at 3 hrs/case	
Inpatient Cases	14,256	12,216	Inpatient Cases	11,068	1,158	Inpatient Cases	26,472
Weighted Inpatient Cases at 3 hrs/case	42,768	36,649	Weighted Inpatient Cases at 3 hrs/case	33,175	3,474	Weighted Inpatient Cases at 3 hrs/case	79,417
Ambulatory Cases	20,109	24,789	Ambulatory Cases	13,529	11,240	Ambulatory Cases	44,878
Weighted Ambulatory Cases at 1.5 hrs/case	30,163	37,153	Weighted Ambulatory Cases at 1.5 hrs/case	20,294	16,860	Weighted Ambulatory Cases at 1.5 hrs/case	87,317
Total Weighted Hours	72,931	73,802	Total Weighted Hours	53,469	20,334	Total Weighted Hours	146,733
OR Planning Inventory*	41	45	OR Planning Inventory**	32	13	OR Planning Inventory	86
Licensed ORs needed at 1,872 cases/year	39.0	39.4	Licensed ORs needed at 1,872 cases/year	28.6	10.9	Licensed ORs needed at 1,872 cases/year	78.4
Surplus/Deficit (-)	2.0	5.5	Surplus/Deficit (-)	3.4	2.1	Surplus/Deficit (-)	7.6

Source: 2010 LRA

*Excludes one trauma and one burn OR

**Excludes two C-Section ORs



North Carolina Department of Health and Human Services
Division of Health Service Regulation
Certificate of Need Section
2704 Mail Service Center • Raleigh, North Carolina 27699-2704

Beverly Hayes Perdue, Governor
Lanier M. Canstler, Secretary

www.ncdhhs.gov/dhsr

Lee Hoffman, Section Chief
Phone: 919-855-3873
Fax: 919-733-8139

June 15, 2009

S. Todd Hemphill
Bode, Call & Stroupe, LLP
3105 Glenwood Avenue, Suite 300
Raleigh, NC 27612

RE: Exempt from Review / Acquisition of Plastic Surgery Center of North Carolina, Inc. by Wake Forest University Health Sciences (WFUHS) / Forsyth County
FID # 953413

Dear Mr. Hemphill:

In response to your letter of May 22, 2009, the above referenced proposal is exempt from certificate of need review in accordance with N.C.G.S. 131E-184(a)(8). Therefore, Wake Forest University Health Sciences (WFUHS) may proceed to acquire the above referenced health service facility without first obtaining a certificate of need. However, you need to contact the Acute and Home Care Licensure and Certification Section of the Division of Health Service Regulation to obtain instructions for changing ownership of the existing facility. Note that pursuant to N.C.G.S. §131E-181(b): "A recipient of a certificate of need, or any person who may subsequently acquire, in any manner whatsoever permitted by law, the service for which that certificate of need was issued, is required to materially comply with the representations made in its application for that certificate of need."

It should be noted that this Agency's position is based solely on the facts represented by you and that any change in facts as represented would require further consideration by this Agency and a separate determination. If you have any questions concerning this matter, please feel free to contact this office.

Sincerely,

Gebrette Miles
Project Analyst

Lee B. Hoffman, Chief
Certificate of Need Section

cc: Acute and Home Care Licensure and Certification Section, DHSR



Location: 701 Harbour Drive • Dorthea Dix Hospital Campus • Raleigh, N.C. 27603
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Received by the
CON Section

May 22, 2009

22 MAY 2009 09:01

Via Hand Delivery

Lee B. Hoffman, Chief
Gebrette Miles, Project Analyst
Certificate of Need Section
Division of Facility Services
701 Barbour Drive
Raleigh, North Carolina 27603

Re: Plastic Surgery Center of North Carolina, Inc. Ambulatory Surgical Facility / Acquisition by
Wake Forest University Health Sciences / Winston-Salem, Forsyth County, North Carolina

Dear Ms. Hoffman and Ms. Miles:

This letter is submitted on behalf of our client, Wake Forest University Health Sciences ("WFUHS"). WFUHS intends to acquire from Plastic Surgery Center of North Carolina, Inc. ("PSCNC"), the ambulatory surgical facility, as that term is defined in G.S. §131E-176(1b), owned by PSCNC (hereinafter, the "Facility"). When the transaction is completed, PSCNC will have no interest in the Facility, and WFUHS will have no interest in PSCNC.

The Facility is located in the lower level of the medical building located at 2901 Maplewood Avenue, Winston-Salem, Forsyth County, North Carolina, and consists of three (3) ambulatory surgery operating rooms and support space, as identified in the 2009 SMFP. The parties have entered into a Purchase Agreement, which provides that the purchase is contingent upon our client obtaining confirmation from the CON Section that it does not need to obtain a certificate of need to acquire the Facility.

The medical office building in which PSCNC is located is owned by John Paul & Associates, LLC ("JPA"). PSCNC leases its space from JPA. WFUHS will enter into a new lease with JPA for the space which constitutes the Facility. WFUHS will not lease any other space in the building and will have no interest in JPA.

Ms. Hoffman
Ms. Miles
May 22, 2009
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By this letter, we are providing notice to the CON Section, pursuant to G.S. §131E-184(a) of this transaction. Because this project involves the acquisition of an interest in an existing health service facility, we believe the acquisition of the Facility is exempt from CON review pursuant to G.S. §131E-184(a)(8). We would appreciate your office reviewing this information and advising us that our analysis is correct and that this acquisition is not subject to CON review.

The parties intend to close on this transaction by no later than the end of June, 2009, so your prompt attention to this request would be very much appreciated. Should you have any questions, please do not hesitate to contact me.

Very truly yours,

BODE, CALL & STROUPE, L.L.P.



S. Todd Hemphill

STH:sh
cc: Brian McGinn

2007/05/22 10:40:00 AM

**EXHIBIT K TO NOVANT HEALTH'S PETITION
TO THE SHCC REGARDING POLICY AC-3**

Table 6A: Operating Room Inventory (Combined Data for Hospitals and Ambulatory Surgical Facilities)
 Case Data for 10/01/07 through 9/30/08 as reported on the 2009 Hospital and Ambulatory Surgical Facility License Renewal Applications.

Counties with one facility shown first, followed by counties with more than one facility.											
Lic #	Facility Name	County	Inpatient Cases (Dedicated C-Section OR Cases Excluded)	Ambulatory Cases	Inpatient ORs	Ambulatory ORs	Shared ORs	Excluded C-Section ORs	Excluded Trauma/Burn ORs	CON Adjustments	CON Adjustments for Dedicated C-Section OR
H0153	Wilkes Regional Medical Center	Wilkes	1,005	1,933	1	0	4	-1	0	0	0
AS0046	Wilkes Regional Medical Center Ambulatory Surgery Facility	Wilkes	0	442	0	1	0	0	0	0	0
	Wilkes Total		1,005	2,375	1	1	4	-1	0	0	0
	Eastern Regional Surgical Center										
AS0005	(X HealthSouth Surgecenter of Wilson)	Wilson	0	1,320	0	4	0	0	0	0	0
H0210	Wilson Medical Center	Wilson	1,759	3,184	1	0	9	-1	0	0	0
AS0007	Wilson OB-GYN	Wilson	0	450	0	1	0	0	0	0	0
	Wilson Total		1,759	4,954	1	5	9	-1	0	0	0
	Grand Total		267,187	657,748	155	284	861	-94	11	51	9

Underutilized Facilities:		
Lic #	Facility Name	County
H0002	Pungo District Hospital	Beaufort
AS0062	Cleveland Ambulatory Services	Cleveland
AS0021	Plastic Surgery Center Of North Carolina	Forsyth
AS0050	Iredell Surgical Center	Iredell
H0193	Highlands-Cashiers Hospital	Macon
AS0098	Same Day Surgery Center at Balaclava	Mecklenburg
AS0010	Chapel Hill Surgical Center	Orange
H0069	Swain County Hospital	Swain
AS0034	Raleigh Plastic Surgery Center	Wake
AS0048	Southern Eye Associates Ophthalmic Surgery Center	Wake
H0160	Blowing Rock Hospital	Watauga
	Eastern Regional Surgical Center	
AS0005	(X HealthSouth Surgecenter of Wilson)	Wilson
AS0007	Wilson OB-GYN	Wilson

OR = Operating Room

Table 6B: Projected Operating Room Need for 2012

A	M	N	O	P	Q	R	S	T	U
Operating Room Service Areas (Multi-County Groupings and Single Counties. Multi-County Groupings First, Followed by Single Counties.)	Number of Inpatient Operating Rooms	Number of Ambulatory Operating Rooms	Number of Shared Operating Rooms	Excluded Dedicated C-Section Rooms	Exclusion of One Operating Room for each Level I and II Trauma Center and Burn Unit	Adjustments: CONs Issued, Settlement Agreements, Previous Need	Adjusted Planning Inventory	Projected Operating Room Deficit or Surplus (Surplus shows as a "+")	Projected Need for New Operating Rooms
Alexander	0	0	2	0	0	0	2	-2.00	0
Alleghany	0	0	2	0	0	0	2	-1.76	0
Anson	0	0	2	0	0	0	2	-1.39	0
Ashe	0	0	2	0	0	0	2	-1.19	0
Avery	0	0	2	0	0	0	2	-1.54	0
Bertie	0	0	2	0	0	0	2	-1.29	0
Bladen	0	0	2	0	0	0	2	-1.21	0
Brunswick	1	0	5	-1	0	1	6	-0.36	0
Burke	1	2	9	-1	0	0	11	-2.59	0
Cabarrus	4	6	17	-2	0	0	25	-0.89	0
Caldwell	1	3	4	-1	0	0	7	-2.33	0
Carteret	1	2	5	-1	0	0	7	-0.98	0
Calawba	3	8	27	-1	0	0	37	-10.13	0
Chatham	0	0	2	0	0	0	2	-1.69	0
Chatham	0	0	2	0	0	0	2	-1.69	0
Cleveland	1	2	8	-1	0	0	10	-0.78	0
Columbus	1	0	4	-1	0	1	5	0.19	0
Dare	1	2	2	-1	0	0	4	-2.19	0
Davidson	1	0	9	-1	0	0	9	-2.23	0
Davie	0	0	2	0	0	0	2	-1.95	0
Duplin	0	0	3	0	0	0	3	-0.74	0
Durham	7	17	48	-2	-1	4	73	-4.98	0
Edgecombe	1	0	5	-1	0	0	5	-2.80	0
Forsyth	9	6	68	-2	-2	4	83	-5.52	0
Franklin	0	0	3	0	0	1	4	-1.19	0
Gaston	5	14	9	-4	0	0	24	-4.52	0
Grenville	0	0	3	0	0	0	3	-0.46	0
Guilford	7	42	47	-1	-1	1	95	-21.20	0
Hamett	0	0	4	0	0	6	10	-5.15	0
Haywood	0	0	7	0	0	0	7	-3.18	0
Henderson	0	0	16	0	0	0	16	-1.87	0
Hertford	1	0	5	-1	0	0	5	-2.35	0
Iredell	3	3	22	-3	0	0	25	-5.37	0
Johnston	1	2	5	-1	0	1	8	-0.39	0
Lee	1	0	5	-1	0	2	7	-3.22	0
Lenoir	1	0	9	-1	0	0	9	-3.46	0
Lincoln	0	0	4	0	0	0	4	-1.17	0
Macon	1	0	4	-1	0	0	4	-2.44	0
Martin	0	0	2	0	0	0	2	-0.82	0
McDowell	1	0	3	-1	0	0	3	-0.77	0
Mecklenburg	23	41	89	-13	-1	0	149	-19.63	0
Mitchell	0	0	3	0	0	0	3	-1.74	0
Montgomery	0	0	2	0	0	0	2	-1.44	0
Nash	1	0	13	-1	0	0	13	-2.95	0
New Hanover	5	16	20	-3	-1	4	41	0.46	0
Onslow	1	4	5	-1	0	0	9	-4.04	0
Orange	6	4	29	-3	-2	4	38	-7.53	0
Pender	0	0	2	0	0	0	2	-1.62	0
Person	0	0	2	0	0	0	2	-1.62	0
Person	1	0	4	-1	0	0	4	-1.45	0
Polk	0	0	3	0	0	0	3	-1.88	0
Randolph	1	0	5	-1	0	2	7	-1.89	0
Richmond	1	0	6	-1	0	0	6	-2.49	0
Robeson	1	0	9	0	0	0	10	-2.66	0
Robeson	1	0	9	0	0	0	9	-3.26	0
Rockingham	1	0	9	-1	0	0	9	-3.26	0
Rowan	2	3	8	-2	0	0	11	-1.87	0
Rutherford	0	0	6	0	0	0	5	-0.91	0

**EXHIBIT L TO NOVANT HEALTH'S PETITION
TO THE SHCC REGARDING POLICY AC-3**

Table 6A: Operating Room Inventory (Combined Data for Hospitals and Ambulatory Surgical Facilities)
 Case Data for 10/01/08 through 9/30/09 as reported on the 2010 Hospital and Ambulatory Surgical Facility License Renewal Applications.

Counties with one facility shown first, followed by counties with more than one facility.											
Lic #	Facility Name	County	Inpatient Cases (Dedicated C-Section OR Cases Excluded)	Ambulatory Cases	Inpatient ORs	Ambulatory ORs	Shared ORs	Excluded C-Section ORs	Excluded Trauma/Burn ORs	CON Adjustments	CON Adjustments for Dedicated C-Section OR
H0153	Wilkes Regional Medical Center	Wilkes	826	2,234	1	0	4	-1	0	0	0
AS0046	Wilkes Regional Medical Center Ambulatory Surgery Facility	Wilkes	0	412	0	1	0	0	0	0	0
	Eastern Regional Surgical Center	Wilkes Total	826	2,646	1	1	4	-1	0	0	0
AS0005	(formerly HealthSouth Surgecenter of Wilson)	Wilson	0	1,453	0	4	0	0	0	0	0
H0210	Wilson Medical Center	Wilson	1,551	2,764	1	0	9	-1	0	0	0
AS0007	Wilson OB-GYN	Wilson	0	400	0	1	0	0	0	0	0
		Wilson Total	1,551	4,617	1	5	9	0	0	0	0
		Grand Total	2,693	8,300	2	6	13	-1	0	0	0

Underutilized Facilities:

Excluded from Need Determinations

H0002	Pittsboro District Hospital Corporation	Beaufort									
AS0062	Waynes Ambulatory Surgery	Wayne									
AS0053	RMS Surgery Center	Dare									
AS0021	North Carolina Plastic Surgery Center of	Forsyth									
AS0051	Frederick Surgical Center	Frederick									
R0024	Agape Medical Center	Macon									
H0193	Johnston-Cashner Hospital	Madison									
AS0019	Chapel Hill Surgical Center	Durham									
H0009	Swain County Hospital	Swain									
AS0024	Richmond Plastic Surgery & Center	Wake									
AS0048	South Wake Associates Orthopedic Surgery Center	Wake									
H0181	Platinum Rock Hospital	Watauga									
AS0046	Wilkes Regional Medical Center Ambulatory Surgery Facility	Wilkes									
AS0005	Surgecenter of Wilson HealthSouth Surgecenter of Wilson	Wilson									
AS0007	Wilson OB-GYN	Wilson									

OR = Operating Room

Table 6B: Projected Operating Room Need for 2013

A	M	H	O	P	Q	R	S	T	U
Operating Room Service Areas (Multi-County Groupings and Single Counties, Multi-County Groupings First, Followed by Single Counties)	Number of Inpatient Operating Rooms	Number of Ambulatory Operating Rooms	Number of Shared Operating Rooms	Excluded Dedicated O-Section Rooms	Exclusion of One Operating Room for each Level I and II Trauma Center and Burn Unit	Adjustments: CONs Issued, Settlement Agreements, Previous Need	Adjusted Planning Inventory	Projected Operating Room Deficit or Surplus (Surplus shows as a "+")	Projected Need for New Operating Rooms
Alamance	2	3	9	-2	0	0	12	-2.45	0
Alexander	0	0	2	0	0	0	2	-1.71	0
Alleghany	0	0	2	0	0	0	2	-1.53	0
Anson	0	0	2	0	0	0	2	-1.22	0
Ashe	0	0	2	0	0	0	2	-1.40	0
Avery	0	0	2	0	0	0	2	-1.35	0
Bertie	0	0	2	0	0	0	2	-1.22	0
Bledsoe	0	0	2	0	0	0	2	-0.62	0
Brunswick	1	0	5	-1	0	0	11	-2.92	0
Burke	1	2	9	-1	0	0	25	-2.27	0
Cabarrus	4	6	17	-2	0	0	7	-2.27	0
Caldwell	1	3	4	-1	0	0	7	-0.72	0
Carteret	1	2	5	-1	0	0	7	-9.73	0
Catawba	3	8	27	-1	0	0	37	-1.68	0
Chatham	0	0	2	0	0	0	2	-1.30	0
Chatham	0	0	8	-1	0	0	10	0.21	1
Cleveland	1	2	4	-1	0	0	5	-0.90	0
Columbus	1	0	2	-1	0	0	2	-2.13	0
Curry	1	0	9	-1	0	0	9	-1.63	0
Dare	1	0	2	0	0	0	3	-1.07	0
Davidson	0	0	3	0	0	0	3	-5.36	0
Davis	0	0	48	-2	-1	4	73	-2.80	0
Duplin	7	17	5	-1	0	0	5	-4.95	0
Durham	1	0	5	-2	-2	4	83	-3.02	0
Edgecombe	9	6	3	0	0	1	4	-5.81	0
Forsyth	0	0	9	-4	0	0	24	-0.33	0
Franklin	5	14	3	0	0	0	3	-26.49	0
Gaston	0	0	47	-1	-1	1	95	-5.20	0
Granville	7	42	4	0	0	6	10	-2.07	0
Guilford	0	0	7	0	0	0	7	-2.47	0
Harnett	0	0	16	0	0	0	16	-2.32	0
Haywood	0	0	5	-1	0	0	5	-6.74	0
Henderson	0	0	22	-3	0	0	26	-0.80	0
Hertford	1	0	5	-1	0	1	8	-2.76	0
Iredell	3	3	5	-1	0	2	7	-3.85	0
Johnston	1	2	5	-1	0	0	9	-1.20	0
Leo	1	0	4	0	0	0	4	0.00	0
Lenoir	0	0	0	0	0	0	0	-0.71	0
Lincoln	0	0	2	0	0	0	2	-1.03	0
Macon	0	0	3	-1	0	0	3	-25.31	0
Martin	0	0	99	-13	-1	-1	151	-1.76	0
McDowell	1	0	3	0	0	0	3	-1.83	0
Mecklenburg	23	44	0	0	0	0	2	-3.15	0
Mitchell	0	0	2	0	0	0	13	-1.04	0
Montgomery	0	0	13	-1	0	0	9	-3.46	0
Montgomery	0	0	20	-3	-1	4	41	-6.75	0
Nash	1	16	5	-1	0	4	38	-1.58	0
New Hanover	5	4	29	-3	-2	4	2	-1.84	0
Onslow	1	4	2	0	0	0	3	-2.42	0
Orange	6	4	5	-1	0	2	7	-3.50	0
Orange	0	0	29	-3	0	0	6	-2.82	0
Pender	0	0	2	0	0	0	10	-4.14	0
Polk	0	0	9	0	0	0	9	0.89	1
Polk	0	0	9	-1	0	0	11	-0.86	0
Randolph	1	0	6	-2	0	0	5		
Richmond	1	0	5	0	0	0	5		
Robeson	1	0	9	0	0	0	9		
Rockingham	1	0	9	-1	0	0	9		
Rockingham	1	0	6	-2	0	0	11		
Rowan	2	3	6	-2	0	0	11		
Rutherford	0	0	5	0	0	0	5		

**EXHIBIT M TO NOVANT HEALTH'S PETITION
TO THE SHCC REGARDING POLICY AC-3**

Table 6A: Operating Room Inventory (Combined Data for Hospitals and Ambulatory Surgical Facilities)
 (Case Data for 10/01/06 through 9/30/07 as reported on the 2008 Hospital and Ambulatory Surgical Facility License Renewal Applications)

Facility Name	County	Inpatient Cases (Dedicated C- Section OR Cases Excluded)	Ambulatory Cases	Inpatient Rooms	Ambulatory Rooms	Shared Rooms	Excluded C-Section Rooms	Excluded Trauma/Burn Rooms	Adjustments for CON Non Dedicated C-Section OR	Adjustments for CON Dedicated C-Section OR
Eastern Regional Surgical Center (X HealthSouth Surgecenter of Wilson)	Wilson	0	882	0	4	0	0	0	0	0
Wilson Medical Center	Wilson	2,075	3,484	1	0	9	-1	0	0	0
Wilson OB-GYN	Wilson	0	413	0	1	0	0	0	0	0
Wilson Total		2,075	4,759	1	5	9	-1	0	0	0
Hoots Memorial Hospital	Yadkin	2	252	0	0	2	0	0	0	0
Yadkin Total		2	252	0	0	2	0	0	0	0
Grand Total		287,754	634,399	151	281	863	-82	-11	51	10

**Underutilized Facilities - Excluded from
Need Determinations**

Facility	County
Pungo District Hospital Corporation	Beaufort
Cleveland Ambulatory Services	Cleveland
Plastic Surgery Center Of North Carolina	Forsyth
Piedmont Surgical Center	Guilford
Iredell Surgical Center	Iredell
Highlands-Cashiers Hospital	Macon
Carolina Center for Specialty Surgery	Mecklenburg
Chapel Hill Surgical Center	Orange
Swain County Hospital	Swain
Raleigh Plastic Surgery Center	Wake
Southern Eye Associates Ophthalmic Surgery	Wake
Blowing Rock Hospital	Watauga
Eastern Regional Surgical Center	Wilson

**EXHIBIT N TO NOVANT HEALTH'S PETITION
TO THE SHCC REGARDING POLICY AC-3**

Table 6A: Operating Room Inventory (Combined Data for Hospitals and Ambulatory Surgical Facilities)
 (Case Data for 10/01/05 through 9/30/06 as reported on the 2007 Hospital and Ambulatory Surgical Facility License Renewal Applications)

Facility Name	County	Inpt.-C-Sec.	Amb. Cases	Inpat. Rms.	Amb. Rms.	Shared Rms.	Exclu. C-Sec.	Exclu. TraiBur	Adj. CON
Maury Medical Center, Inc.	Cherokee	358	1,873	0	0	4	0	0	0
Chowan Hospital	Chowan	614	1,117	0	0	3	0	0	0
Cleveland Ambulatory Services *	Cleveland		1,745		4				0
Cleveland Regional Medical Center	Cleveland	2,295	3,691	1	0	6	-1	-1	0
Eye Surgery Center of Shelby	Cleveland		1,711		2				0
King's Mountain Hospital	Cleveland	271	1,212	0	0	2	0	0	0
Totals for:	Cleveland	2,566	8,389	1	6	8	-1	-1	0
Columbus Regional Healthcare System	Columbus	1,510	3,527	1	0	4	-1	0	0
Columbus Regional Same Day Surgery, LLC	Columbus		0		0				0
Totals for:	Columbus	1,510	3,527	1	0	4	-1	0	1
Craven Regional Medical Center	Craven	3,669	9,527	3	6	8	-1	0	0
Craven Fear Valley Medical Center	Cumberland	7,252	7,040	5	0	13	-3	0	0
Fayetteville Ambulatory Surgery Center	Cumberland		10,372		11				0
Highsmith-Rainey Memorial Hospital	Cumberland	171	2,895	0	0	4	0	0	0
2006 SMFP Need Determination	Cumberland								1
Totals for:	Cumberland	7,423	20,307	5	11	17	-3	0	1
RMS Surgery Center	Dare		2,308		2				0
The Outer Banks Hospital, Inc.	Dare	284	720	1	0	2	-1	0	0
Totals for:	Dare	284	3,028	1	2	2	-1	0	0
Lexington Memorial Hospital	Davidson	1,010	2,820	0	0	4	0	0	0
Thomasville Medical Center	Davidson	792	2,380	1	0	5	-1	0	0
Totals for:	Davidson	1,802	4,970	1	0	9	-1	0	0
Davie County Hospital	Davie	8	62	0	0	2	0	0	0
Duplin General Hospital, Inc.	Duplin	728	1,319	0	0	3	0	0	0
Duke University Hospital	Durham	15,281	18,216	4	8	33	0	-1	4
Durham Regional Hospital	Durham	4,619	3,546	3	0	12	-2	0	0
James E. Davis Ambulatory Surgical Center	Durham		7,575		8				0
North Carolina Specialty Hospital, LLC	Durham	810	4,957	0	0	4	0	0	0
Totals for:	Durham	20,710	33,894	7	16	49	-2	-1	4
Heritage Hospital	Edgecombe	664	1,441	1	0	5	-1	0	0
Forsyth Medical Center	Forsyth	10,153	6,109	5	2	19	-2	0	3
Hawthorne Surgical Center	Forsyth		6,933		4				2
Medical Park Hospital, Inc.	Forsyth	1,170	10,242	0	0	13	0	-1	0
North Carolina Baptist Hospitals, Inc.	Forsyth	11,900	15,842	4	0	36	0	-2	0
Plastic Surgery Center Of North Carolina, Inc. *	Forsyth		328		3				0
Totals for:	Forsyth	23,223	39,454	9	9	68	-2	-2	4

* Chronically underutilized facility; operating rooms in these facilities are excluded from Need Determination calculations.

**EXHIBIT O TO NOVANT HEALTH'S PETITION
TO THE SHCC REGARDING POLICY AC-3**

SURRY	635	766	1401	4%
SWAIN	6	8	14	0%
TRANSYLVANIA	13	11	24	0%
UNION	12	23	35	0%
VANCE	5	2	7	0%
WAKE	40	46	86	0%
WASHINGTON	0	1	1	0%
WATAUGA	151	143	294	1%
WAYNE	8	2	10	0%
WILKES	624	688	1312	4%
WILSON	14	1	15	0%
YADKIN	284	435	719	2%
YANCEY	9	16	25	0%
SUB-TOTAL	11,641	16,850	28,491	89%
SOUTH CAROLINA	152	72	224	1%
TENNESSEE	57	50	107	0%
VIRGINIA	1,210	1,317	2,527	8%
ALL OTHER STATES	386	394	780	2%
GRAND TOTAL	13,446	18,683	32,129	100%

8. Discuss the various alternatives that were considered in development of the proposed project and the reason the alternative chosen is the most effective alternative of those considered.

Several alternatives were considered before NCBH chose to develop the project as proposed. Each of these options will be discussed in turn.

MAINTAIN STATUS QUO

NCBH is Forsyth County's and western North Carolina's only academic medical center and Level I trauma and burn center that offers many highly specialized tertiary services, including open-heart surgery, orthopedics, neurosciences, Level IV neonatal services, inpatient rehabilitation and 34 intensive care beds.

The Ardmore Tower surgical services suite at NCBH is operating at capacity and is heavily focused towards meeting the needs of inpatients. While a significant number of patients receive outpatient surgery on the NCBH campus, there are many times these procedures are delayed due to trauma or emergency patients. NCBH has evaluated the possibility of renovating the surgical suite which has not undergone a significant modernization since the year 2000. Building seven incremental ambulatory ORs and re-

locating one OR from Ardmore Tower to the West Campus will not only allow NCBH to create an attractive, efficient facility geared toward outpatients, but it will also help to alleviate scheduling difficulties and accommodate future faculty growth.

NCBH, as an academic medical center, also receives a substantial number of referrals from other providers. With increasing demand, wait times will only grow longer for referral patients, thus affecting NCBH's ability to provide patient care that in many cases is the only available specialized care in the region or even the state.

When all of the above factors are taken into consideration, NCBH recognizes that it cannot continue to provide the same level of high quality care to its patients without additional surgical capacity. The current and projected utilization alone make it obvious that additional capacity is needed. Other primary factors such as NCBH's patient acuity level and the current and future faculty growth in surgical sciences also demonstrate the need for additional OR capacity.

DEVELOP THE SEVEN OPERATING ROOMS IN ARDMORE TOWER

Consideration was given to building seven incremental ORs in the surgical suite located in and/or adjacent to Ardmore Tower. However, as previously stated there is no space available in surgical services or any adjacent location in Ardmore Tower and it would be more costly and disruptive to renovate hospital space. Therefore, NCBH did not pursue this alternative further.

DEVELOP A FREESTANDING AMBULATORY SURGICAL CENTER

While NCBH considered developing a freestanding ambulatory surgery center, this alternative was quickly rejected because of the integrated nature of the way our faculty treat patients. Further NCBH's patient care model approach is focused on a centralized coordination model that allows patients to receive their physician appointments which include multiple specialists, diagnostic testing and surgery all on the same campus. For example, patients come to the Comprehensive Cancer Center and may receive a comprehensive treatment plan that includes surgery, testing, clinic appointments, chemotherapy and/or radiation therapy treatment that takes place in one location.

Current and projected inpatient and ambulatory surgical demand also adds to the need for additional OR capacity. Locating ORs off-site would not meet the internal OR needs within the NCBH facility nor provide patients with greater access and convenience. In addition, the surgical faculty offices are on the NCBH campus and it is critically important that surgeons be able to practice and hold clinic in the same location. This

options would also not support the mission and needs of the faculty teaching and clinical programs.

For the reasons cited above, this alternative was not pursued.

DEVELOP A WEST CAMPUS SURGERY MODEL

After significant analysis, NCBH leadership determined that developing the West Campus strategy was the best model. This model allows lower risk ambulatory surgery patients to receive their surgery in a convenient campus setting while allowing NCBH to accommodate the faculty growth and training needs by locating the simulation OR and robotics training rooms in the same location. NCBH already owns the West Campus land and the site is large enough to build an efficient, convenient facility with surface parking making it easily accessible to patients and physicians. For these reasons and those discussed in Sections II and III(1) (a.) and (b.), NCBH has chosen to pursue this alternative.

9. (a) **Identify all providers of each service component included in the proposed project located in the service area and provide the utilization at each of these providers during the last full fiscal year prior to submission of this application.**

This question is not applicable to the review of this project, pursuant to N.C. General Statute'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 services 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.

The utilization of NCBH's proposed project is provided in Section IV of this application and related exhibits.

**EXHIBIT P TO NOVANT HEALTH'S PETITION
TO THE SHCC REGARDING POLICY AC-3**

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

OP Principal CPT Procedure Code	OP Principal CPT Procedure Name	FY 2013	FY 2014	FY 2015
66984	CATARACT SURG W/IOL, 1 S	\$ 2,142	\$ 2,194	\$ 2,247
29881	KNEE ARTHROSCOPY/SURGERY	\$ 3,763	\$ 3,853	\$ 3,945
52353	CYSTOURETHROSCOPY W/URETERO AND/OR PYELO; WITH LITHO	\$ 5,698	\$ 5,834	\$ 5,974
58340	CATHETER FOR SIS OR HSG	\$ 871	\$ 892	\$ 914
20680	REMOVAL OF SUPPORT IMPLANT	\$ 2,895	\$ 2,964	\$ 3,035
47562	LAPAROSCOPIC CHOLECYSTECTOMY	\$ 4,952	\$ 5,071	\$ 5,193
52332	CYSTOSCOPY AND TREATMENT	\$ 2,731	\$ 2,796	\$ 2,863
29877	KNEE ARTHROSCOPY/SURGERY	\$ 3,293	\$ 3,372	\$ 3,453
19125	EXCISION OF BREAST LESION	\$ 3,912	\$ 4,006	\$ 4,102
58558	HYSTEROSCOPIC BIOPSY	\$ 2,335	\$ 2,391	\$ 2,449
65730	CORNEAL TRANSPLANT	\$ 5,244	\$ 5,370	\$ 5,499
49505	PRP /HERN INIT REDUC >S	\$ 2,914	\$ 2,984	\$ 3,055
29880	KNEE ARTHROSCOPY/SURGERY	\$ 3,595	\$ 3,681	\$ 3,769
20670	REMOVE SUPERFICIAL WIRE, PIN, ROD	\$ 1,421	\$ 1,455	\$ 1,490
15823	UP BLEPHAROPLAS & FAT HERN	\$ 3,441	\$ 3,523	\$ 3,608
36561	INSERTION OF TUNNELED CVAD, W/SUBQ PORT, 5+Y	\$ 4,069	\$ 4,167	\$ 4,267
69433	CREATE EAR DRUM OPENING	\$ 464	\$ 476	\$ 487
29888	KNEE ARTHROSCOPY/SURGERY	\$ 11,931	\$ 12,218	\$ 12,511
47563	LAPAROSCOPIC CHOLECYSTECTOMY WITH CHOLANGIOGRAPHY	\$ 5,751	\$ 5,889	\$ 6,030
42826	REMOVAL OF TONSILS	\$ 3,470	\$ 3,553	\$ 3,638

These projected rates per case include the pre-operative assessment clinic services, the surgery or procedure facility charges, anesthesia used during the surgery or procedure, necessary drugs, supplies and devices and recovery. Surgeon and anesthesiologist professional fees will be billed separately by the providers.