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STATE OF NORTH CAROLINA

COUNTY OF DURHAM

IN THE OFFICE OF
ADMINISTRATIVE HEARINGS
22 DHR 02685

Duke University Health System Inc Petitioner, v. NC Department of Health and Human Services, Division of Health Service Regulation, Health Care Planning & Certificate of Need Section Respondent, and University of North Carolina Hospitals at Chapel Hill and University of North Carolina Health Care System. Respondent-Intervenors.	FINAL DECISION

This matter came for hearing before the Honorable Melissa Owens Lassiter, Administrative Law Judge (the "ALJ") on July 6-8, July 11-15, and August 1-3, 2022, in Raleigh, North Carolina to hear Petitioner's contested case petition, filed pursuant to N.C. Gen. Stat. §§ 150B-23 and 131E-188, appealing Respondent's September 21, 2021 Agency decision and Required State Agency Findings, to conditionally approve a Certificate of Need Application by Respondent-Intervenor to construct a new 40 acute care bed, 2 operating room hospital in Durham, North Carolina, and to disapprove Petitioner's competing Certificate of Need Applications to develop 40 acute care beds and 2 operating rooms at Duke University Hospital, its existing facility in Durham, North Carolina.

Having heard all of the evidence presented in the contested case hearing, and considered the testimony, admitted exhibits, the arguments of the parties, and the relevant law, the Undersigned finds by the preponderance of the evidence the following Findings of Fact, enters Conclusions of Law based thereon, and issues this Final Decision pursuant to N.C. Gen. Stat. §§ 150B-34 and 131E-188.

APPEARANCES

For Petitioner Duke University Health System, Inc. ("Duke"):

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For Respondent North Carolina Department of Health and Human Services (the "Department"), Division of Health Service Regulation (the "Division"), Healthcare Planning and Certificate of Need Section (the "Agency"):

Derek L. Hunter
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For Respondent-Intervenors University of North Carolina Hospitals at Chapel Hill and University of North Carolina Health Care System (collectively, "UNC"):

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ISSUES

1. Whether the Agency substantially prejudiced Petitioner Duke's rights by conditionally approving UNC's Certificate of Need application to develop a new hospital with 40 acute care beds and two operating rooms ("ORs") to be known as UNC Hospitals-RTP, located in Research Triangle Park, Durham County, North Carolina, identified as Project I.D. No. J-12065-21 (the "UNC Application") and denying Duke's Certificate of Need application to develop two new ORs at its existing hospital (Duke University Hospital) in Durham County, North Carolina, for a total of no more than 69 ORs upon completion of the proposed project, identified as Project I.D. No. J-12070-21 (the "Duke ORs Application") and Duke's application to develop 40 new acute care beds at its existing

hospital (Duke University Hospital) in Durham County, North Carolina, for a total of no more than 1,102 acute care beds upon completion of the proposed project and two previously approved projects, identified as Project I.D. No. J-12069-21 (the "Duke Beds Application")?

2. Whether the Agency exceeded its authority or jurisdiction, acted erroneously, failed to use proper procedure, acted arbitrarily or capriciously, or failed to act as required by law or rule in conditionally approving the UNC Application and denying the Duke ORs Application and the Duke Beds Application?

APPLICABLE LAW

1. The procedural law applicable to this contested case hearing is the North Carolina Administrative Procedure Act ("APA"), N.C. Gen. Stat. § 150B-1 *et seq.*, to the extent not inconsistent with the Certificate of Need Law, N.C. Gen. Stat. § 131E-175 *et seq*.

2. The substantive law applicable to this contested case is the Certificate of Need ("CON") law, N.C. Gen. Stat. § 131E-175 *et seq*.

3. The administrative regulations applicable to this contested case hearing are the North Carolina Certificate of Need Program Administrative Regulations, 10A N.C.A.C. 14C. 0101 *et seq.*, and the Office of Administrative Hearings Regulations, 26 N.C.A.C. 3 .0101 *et seq*.

PROCEDURAL HISTORY

1. On June 28, 2022, UNC filed a Motion in Limine, arguing that evidence post-dating the Agency decision in this review should be excluded from the contested case hearing under the doctrine set forth in *Britthaven, Inc. v. N.C. Dep't of Human Res.*, 118 N.C. App. 379, 455 S.E.2d 455 (1995), *disc. rev. denied*, 341 N.C. 418, 461 S.E.2d 754 (1995). (Brief in Support of Motion in Limine, June 28, 2022). Following briefing and oral argument at the contested case hearing on July 6, 2022, the ALJ granted UNC's Motion in Limine on July 7, 2022. (Hearing Transcript, Vol. 2, pp. 220-21; *see also* Respondent and Respondent-Intervenors' Joint Proposed Order on Motion in Limine).

2. On July 8, 2022, UNC made a Motion to Exclude Evidence ("Motion to Exclude"), pursuant to Rule 46(a) of the North Carolina Rules of Civil Procedure, relating to zoning and restrictive covenants for the primary site identified in the UNC Application based on the lack of a foundation by Duke that the Agency should have investigated beyond what was contained in the UNC Application and the related Comments and Responses to Comments submitted by the parties. The Agency joined UNC in this Motion

to Exclude on the grounds that such information was not before the Agency in its review. (Order on Respondent-Intervenor's Motion to Exclude Evidence (July 12, 2022)).

3. After oral argument, the Tribunal granted the Motion to Exclude in an Order dated July 12, 2022, precluding the introduction of "evidence related to any suggestion that UNC misrepresented the facts regarding zoning and restrictive covenants in its submissions to the Agency" unless such evidence is "reflected in the Applications, Comments, and Responses to Comments submitted to the Agency during the review." (Order on Respondent-Intervenor's Motion to Exclude Evidence (July 12, 2022)).

4. On July 15, 2022, Duke filed a Stipulation of Voluntary Dismissal Without Prejudice in its contested case, 21 DHR 04525, with the consent of the Agency and UNC for the purpose of initiating a new 270-day deadline by which the ALJ must render a decision. Duke re-filed its petition for contested case hearing that same day, which was assigned docket number 22 DHR 02685.

5. On August 1, 2022, at the close of Duke's case-in-chief, UNC moved for an involuntary dismissal with prejudice pursuant to Rule 41(b) of the North Carolina Rules of Civil Procedure (the "Rule 41(b) Motion"), arguing that under *Britthaven* and *Craven Reg'l Med. Auth. v. N.C. Dep't of Health & Human Servs.*, 176 N.C. App. 46, 58, 625 S.E.2d 837, 845 (2006), Duke failed to provide sufficient evidence to carry its burden, and the Agency's decision is entitled to substantial deference. (Vol. 9, pp. 1555-70). The Agency joined in UNC's Rule 41(b) Motion, arguing that Duke could not prove substantial prejudice in addition to its inability to prove Agency error. (Vol. 9, pp. 1570-80). Duke opposed the Rule 41(b) Motion, arguing that Duke's case in chief raised sufficient questions that merited continuing to hear UNC's evidence. (Vol. 9, pp. 1580-1601). After hearing argument by the Parties, the Tribunal denied the Rule 41(b) Motion. (Vol. 9, p. 1616).

BURDEN OF PROOF

Duke, as the Petitioner in this contested case hearing, bears the burden of showing by the preponderance of the evidence that the Agency substantially prejudiced its rights, and that the Agency acted outside its authority, acted erroneously, acted arbitrarily and capriciously, used improper procedure, or failed to act as required by law or rule when the Agency disapproved the Duke Beds Application and Duke ORs Application and approved the UNC Application. N.C. Gen. Stat § 150B-23(a); *Britthaven, Inc. v. N.C. Dep't of Human Res.*, 118 N.C. App. 379, 382, 455 S.E.2d 455, 459 (1995), *disc. rev. denied*, 341 N.C. 418, 461 S.E.2d 754 (1995).

WITNESSES

For Duke:

1. Gloria Hale (adverse). Team Leader for the Agency.
2. Catharine Cummer. Regulatory Counsel, Strategic Planning for Duke.
3. Karin Sandlin. Principal, Clarity Strategic Services.
4. Scott Levitan. President and CEO, Research Triangle Foundation.
5. Daniel Carter (adverse). Partner, Ascendient.

For UNC:

1. David Meyer. Senior Partner, Keystone Planning Group.
2. Janet Hadar. President, UNC Hospitals.
3. Monte Brown (adverse). Vice President and Secretary for Duke.
4. Daniel Carter. Partner, Ascendient.

EXHIBITS ADMITTED INTO EVIDENCE

Joint Exhibits ("Jt. Ex."):

1-A. Agency File, Tabs 1-4

1-B. Agency File, Tabs 5-6

2. Duke's CON Application (Beds)

3. Duke's CON Application (OR)

4. UNC's CON Application

12. Duke-Durham_0002662 – 4/23/21 Email from Monte Brown to Duke Health Leadership (redacted per ALJ instruction)

13. Duke-Durham_0002663-2683 – Attachment to Ex. 12 – screenshots of UNC primary site

15. Duke-Durham_0002654-2655 – 5/20/21 Minutes of RTF Real Estate Development Committee Meeting

17. Duke-Durham_0000518-519 – 5/30/21 Email from Monte Brown to Vincent Price, Eugene Washington, and William Fulkerson regarding "Heads up on hospital CoN" (redacted per ALJ instruction)

24. Duke's Responses to UNC's 1st Interrogatories and Requests for Production of Documents

25. Duke-Durham_0021396-21399 – 9/3/21 Letter from Vincent Price to Jud Bowman, Chair of the RTF Board of Directors

42. Duke-Durham_0002643 – 4/25/21 Email from Scott Levitan to Scott Selig and Tallman Trask re: UNC Hospitals-RTP

46. 7/12/21 Letter from Levitan to Celia Inman

52. Karin Sandlin CV

53. Duke's CON Application – Green Level Hospital

54. Karin Sandlin Expert Opinion Summary (redacted per ALJ instruction)

55. Duke's Petition for Adjustment to Need Determinations for Additional Acute Care Beds

71. Daniel Carter CV

72. Daniel Carter Expert Report

79. UNC0004364-4366 – 4/14/21 Email from Ziegler to Levitan re: letter of support

91. UNC0000436-438 – 8/3/21 Email from Inman to Martha Waller and Nicki Diamond regarding Levitan's 7/12/21 Letter

96. David Meyer CV

97. David Meyer Expert Report

98. Attachment 1 to Meyer Report – 2021 SMFP Excerpts

100. Attachment 3 to Meyer Report – 2018 Brunswick ASC Material Compliance Relocation

101. Attachment 4 to Meyer Report – Meyer 2018 Orange County Expert Report

102. Attachment 5 to Meyer Report – Meyer 2019 Deposition Testimony in 2018 Orange County Review

103. Attachment 6 to Meyer Report – Maps of Populous Counties

104. Attachment 7 to Meyer Report comprised of:
A. 2020 Forsyth County OR Review Findings

B. 2018 Buncombe County OR Review Findings
C. 2016 Brunswick County OR Findings
D. 2018 Mecklenburg County OR Findings

106. Attachment 9 to Meyer Report – DUHS Arringdon ASC Application

107. Attachment 10 to Meyer Report – DUHS Orange ASC Application

116. Levitan Bio from RTP Website

117. LEV-000000779-780 – 2/11/21 Email from Levitan to RTP Board Members re: Highwoods site for UNC Hospitals-RTP

119. LEV-000000627 – Agenda for 2/11/21 RTP Development Committee Meeting

142. RTP HUB Site Map

146. Sandlin Rebuttal Report (redacted per ALJ instruction)

157. Deposition Transcript of Scott Selig (redacted per ALJ instruction)

Exhibits Admitted by Duke ("Duke Ex.")

200. LEV-000000168 – 7/8/21 Email from Levitan to Lisa Pittman re: UNC Hospitals-RTP

208. CHARTS – from Sandlin First Report – Dep EX 54

210. Attachment 2 to Sandlin Report – 2020 Forsyth Acute Care Beds Review Findings

212. MAPS – from Sandlin Rebuttal Report

213. Duke-Durham_0021353 – CHARTS – Duke Hold Data

215. CHART – DUH Hours on Divert Status (*admitted for illustrative purposes only*)

216. CHART – DUH Historical Acute Days of Care (*admitted for illustrative purposes only*)

217. MAP – Duke University Hospital FY19 Patient Origin (*admitted for illustrative purposes only*)

218. MAP – UNC Hospitals-RTP Projected Acute Inpatient Origin, PY3 (*admitted for illustrative purposes only*)

220. Duke-Durham_0021354 – CHARTS – Duke Transfers

221. Duke-Durham_0021355 – CHARTS – Transfers to DUH from Any UNC-Affiliated Facility by Accepting Service

222. Duke-Durham_0021356 – CHARTS – DUHS Actionable Missed Opportunities by Consulting Service

223. Duke-Durham_0021357 – CHARTS – DUHS Actionable Missed Opportunities, UNC-Affiliated Referring Facility

224. Duke-Durham_0021359 – CHARTS – Avg Accept to Bed Assign

225. Duke-Durham_0021360 – CHARTS – DUH ED Avg. Boarding Census by Service

226. Duke-Durham_0021361 – CHARTS – Median ED LOS

227. CHART – UNC Hospitals-RTP Days of Care (*admitted for illustrative purposes only*)

228. 2018 Wake County OR Review Findings

Exhibits Admitted by UNC ("UNC Ex.")

300. Deposition Transcript of Catharine Cummer, 2018 Orange County Operating Rooms Review (redacted per ALJ instruction)

313. Demonstrative – Map of Durham County with Beds/ORs Count (*admitted for illustrative purposes only*)

314. Demonstrative – Durham Beds Control (*admitted for illustrative purposes only*)

315. Demonstrative – Durham ORs Control (*admitted for illustrative purposes only*)

316. Agency Findings, 2018 Orange County OR Review

317. RTP HUB Flythrough Video (*for illustrative purposes only*)

318. FY 2029 Market Share of Durham County Patient Days (*for illustrative purposes only*)

EXHIBITS ADMITTED UNDER AN OFFER OF PROOF

18. Duke-Durham_0002657-2658 – 5/30/21 Email from Levitan to RTP Development Committee

19. Duke-Durham_0002645 – 5/31/21 Email from Daniel Ennis to Selig

45. Duke-Durham_0002638 – 7/1/21 Email from Brown to Selig re: Levitan issuing "clarifying letter"

68. UNC 0003803-04 – 5/23/21 Email from George re: RTP Development Committee meeting

69. UNC 0003208-09 – 1/26/21 Emails between Runyon and Karageorgiou re: RTP backup option

82. UNC 0003923-24 – 3/26/21 Emails between Ziegler and George re: RTP support

84. UNC 0004278-79 – 4/13/21 Email from Ziegler to Levitan re: letter of support

85. UNC 0003659-61 – 5/6/21 Email from Levitan to George and Ziegler re: Light Industrial versus SRPC text amendment rezoning

88. UNC 0003815-18 – 5/21/21 Email from George to Levitan re: rezoning options

95. UNC 0003891 – 4/8/21 Email between George and Hank Graham re: Levitan and Graham support for UNC Hospitals-RTP

138. LEV-000000762 – 7/8/21 Meeting Minutes for RTP Development Committee

143. LEV-000000055 – 4/25/21 Email between Selig and Levitan re: Trask "venting"

144. UNC-0003831 – 5/13/21 Email from Levitan to George re: Medical Office Building at UNC Hospitals-RTP site

STIPULATED FACTS

In their Joint Prehearing Order, the parties agreed and stipulated to the following undisputed facts:

1. The 2021 State Medical Facilities Plan ("2021 SMFP") identified a need for an additional forty (40) acute care beds in the Durham/Caswell County service area and four (4) operating rooms in the Durham County service area based upon the standard acute care bed and operating room need methodologies, respectively.

2. The 2021 SMFP set the schedule for the filing of any applications pursuant to this need determination as April 15, 2021, and for review of any applications filed pursuant to this need determination to begin on May 1, 2021.

3. On or about April 15, 2021, Duke filed a CON application with the Agency proposing to develop forty additional acute care beds pursuant to the need determination in the 2021 SMFP, to be located at Duke University Hospital in Durham County, identified as Project I.D. No. J-12069-21 (the "Duke Beds Application").

4. On or about April 15, 2021, Duke filed a CON application with the Agency proposing to develop two operating rooms pursuant to the need determination in the 2021 SMFP, to be located at Duke University Hospital in Durham County, identified as Project I.D. No. J-12070-21 (the "Duke ORs Application").

5. On or about April 15, 2021, UNC filed a CON application with the Agency proposing to develop a new hospital with forty acute care beds and two operating rooms ("UNC Hospitals–RTP") pursuant to the need determination in the 2021 SMFP, to be located in the Research Triangle Park ("RTP") in Durham County, identified as Project I.D. No. J-12065-21 (the "UNC Application").

6. Both the Duke and UNC applications were timely submitted, were complete for review, and properly reviewable by the Agency.

7. Pursuant to N.C. Gen. Stat. § 131E-183(a)(1) and the 2021 SMFP, the Agency determined that the approval of one of the applications would result in the denial of the others, and, therefore, a competitive review of the applications was required, and the Parties stipulate that the Agency conducted a competitive review of the applications.

8. On September 21, 2021, the Agency issued its Decision conditionally approving the UNC Application and disapproving both of the Duke Applications.

9. On the same day, the Agency issued its Required State Agency Findings setting forth the bases for its findings and conclusions upon which the Agency based its conditional approval of the UNC Application and the disapproval of the Duke Applications. The Parties stipulate that Agency Decision and Findings at issue in this case were timely issued.

10. On October 21, 2021, Duke timely filed a petition for contested case hearing ("Petition") with the Office of Administrative Hearings ("OAH"), bearing OAH Docket no. 21 DHR 04525, appealing the Agency's disapproval of the Duke Applications and conditional approval of the UNC Application.

11. By Order issued by the Office of Administrative Hearings on November 10, 2021, UNC was, by consent of all parties, granted the right to intervene in 21 DHR 04525 with all the rights of a party.

STIPULATED CONCLUSIONS OF LAW

In their Joint Prehearing Order, the Parties agreed and stipulated to the following Conclusions of Law:

1. The CON Section is part of the North Carolina Department of Health and Human Services, which is charged with the responsibility to administer the Certificate of Need Law, codified in Article 9 of Chapter 131E of the North Carolina General Statutes.

2. The petition for contested case hearing was timely filed by Duke.

3. Duke and UNC are "affected person(s)" under N.C. Gen. Stat. § 131E-188(c).

4. This case is governed by the following law and authorities:

   a. The CON law codified at Chapter 131E, Article 9 of the North Carolina General Statutes;
   b. The North Carolina Administrative Procedure Act codified at Chapter 150B of the North Carolina General Statutes; and
   c. The applicable Agency Rules codified at 10A NCAC 14C .2100, .2300, and .3800.

5. Ms. Karin Sandlin, a witness proffered as an expert by Duke, is accepted by the Office of Administrative Hearings without objection as an expert in:

   a. The field of healthcare planning; and
   b. The preparation and analysis of Certificate of Need applications.

6. Mr. Daniel Carter, a witness proffered as an expert by UNC, is accepted by the Office of Administrative Hearings without objection as an expert in:

   a. The field of healthcare planning; and
   b. The preparation and analysis of Certificate of Need applications.

7. Mr. David Meyer, a witness proffered as an expert by UNC, is accepted by the Office of Administrative Hearings without objection as an expert in:

   a. The field of healthcare planning; and
   b. The preparation and analysis of Certificate of Need applications.

FINDINGS OF FACT

BASED UPON careful consideration of the sworn testimony of the witnesses presented at the hearing, the documents and exhibits received and admitted into evidence, and the entire record in this proceeding, the Undersigned makes the following Findings of Fact after having weighed all of the evidence, assessed the credibility of each witness by considering the appropriate factors for judging the credibility, including but not limited to, the demeanor of the witness, any interests, bias, or prejudice the witness may have, the opportunity of the witness to see, hear, know, or remember the facts or occurrences about which the witness testified, whether the testimony of the witness is reasonable, and whether the testimony is consistent with all other believable evidence in the case:

Parties

1. Petitioner Duke is a North Carolina corporation with its principal place of business in Durham County, North Carolina. Duke operates Duke University Hospital ("DUH"), a tertiary and quaternary referral center and academic medical center teaching hospital. (Jt. Ex. 2, pp. 17, 36; Jt. Ex. 3, p. 17).

2. Respondent Agency is the Healthcare Planning and Certificate of Need Section of the North Carolina Department of Health and Human Services, which is responsible for administering the Certificate of Need Law (the "CON Law"), codified at Article 9 of Chapter 131E of the North Carolina General Statutes.

3. Respondent-Intervenor University of North Carolina Health Care System ("UNC Health") is a state entity established on November 1, 1998, as an affiliated enterprise of the University of North Carolina pursuant to N.C. Gen. Stat. § 116-37. (Jt. Ex. 4, p. 181). It operates numerous facilities throughout the State of North Carolina. Its business address is 101 Manning Drive, Chapel Hill, North Carolina 27514. (Jt. Ex. 4, p. 21).

4. Respondent-Intervenor University of North Carolina Hospitals at Chapel Hill ("UNC Hospitals") is a North Carolina-owned teaching hospital consisting of the North Carolina Memorial Hospital, the North Carolina Children's Hospital, the North Carolina Neurosciences Hospital, the North Carolina Women's Hospital, and the North Carolina Cancer Hospital. (Jt. Ex. 4, p. 181).

Applications at Issue

5. The CON Law establishes a regulatory framework pursuant to which proposals to develop new institutional health services must be reviewed and approved by the Agency prior to development. *See* N.C. Gen. Stat. § 131E-178(a). This includes the

development of acute care beds and ORs, as well as the development of new hospitals. (*See* N.C. Gen. Stat. §§ 131E-176(9c), (13), (16)a., b., and u., and (18c)). The CON Law has multiple purposes, including ensuring quality, access, and value of healthcare for North Carolinians, controlling costs, improving competition, avoiding geographic maldistribution of healthcare assets, and ensuring quality. (Meyer, Vol. 5, pp. 927-30; Jt. Ex. 98; *see also* N.C. Gen. Stat. § 131E-175).

6. The SMFP contains need determinations that set determinative limits on the number of beds, services, or equipment that the Agency can approve in a specified service area for the particular year. (*Id.* § 131E-183(a)(1)). The Agency looks to the distribution of services within a specified service area, not the areas around the service area, in determining the needs within a specified service area. (Meyer, Vol. 6, p. 1365).

7. The 2021 SMFP identified a need for an additional forty acute care beds in the Durham/Caswell County service area and four operating rooms in the Durham County service area based upon the standard acute care bed and operating room need methodologies, respectively. (Prehearing Order, Stip. 7.a; Jt. Ex. 1, pp. 421, 441-42, 1495; Sandlin, Vol. 5, pp. 731-35, 743-44).

8. Despite their non-contiguity, Durham and Caswell counties are paired together in the 2021 SMFP because there is no licensed acute care hospital in Caswell County, and the largest portion of Caswell County residents received inpatient acute care services in Durham County. (Jt. Ex. 1, p. 414; Sandlin, Vol. 5, pp. 739-40).

9. The need determination for acute care beds was generated by Duke's high utilization of beds in the service area; however, any "qualified applicant," as that term is defined in the SMFP, could apply to develop the acute care beds. (Cummer, Vol. 4, p. 619). The State Health Coordinating Council ("SHCC") specified in the 2021 SMFP that "[a]ny person can apply to meet the need, not just the health service facility or facilities that generated the need." (Jt. Ex. 1, pp. 416-17, 428; Hale, Vol. 2, pp. 258-59; Sandlin, Vol. 5, pp. 731-35). Similarly, any applicant could apply to develop the ORs, "not just the health service facility or facilities that generated the need." (Jt. Ex. 1, pp. 464, 1495).

10. The need determinations for acute care beds and ORs in the same year provided an opportunity for the development of a new hospital in Durham County. (Meyer, Vol. 5, pp. 932-933). Before this Review, a new hospital had not been developed in Durham County for over 45 years. (Jt. Ex. 4, p. 52; Carter, Vol. 10, p. 1720).

11. The applications in this review were filed on April 15, 2021, and the review period by the Agency began on May 1, 2021. (Prehearing Order, Stip. 7(c)-(e)). The Duke and UNC Applications were timely submitted, were complete for review, and were properly reviewable by the Agency. (Prehearing Order, Stip. 7(f)). The deadline for submitting written comments in opposition to an application was June 1, 2021, and any

remarks by any member of the public were due on or before June 21, 2021. (Cummer, Vol. 4, p. 641; Jt. Ex. 1, p. 273).

12. Duke applied for all forty acute care beds and two ORs at DUH. Duke also applied for another two ORs at Duke Ambulatory Surgical Center Arringdon ("Duke Arringdon"). UNC applied for all forty acute care beds and two ORs at a proposed new hospital known as UNC Hospitals-RTP ("UNC Hospitals-RTP"). North Carolina Specialty Hospital ("NCSH") applied for all four ORs. (Jt. Ex. 1, 1493-94). Combined, these applications proposed to develop eighty acute care beds and ten ORs, which exceeded the need determinations in the 2021 SMFP. (Jt. Ex. 1, p. 1495).

13. The UNC Application was the only application submitted that proposed to develop an entirely new facility; all other applications submitted, proposed to add assets to an existing facility. (Jt. Ex. 1, pp. 1493-94).

14. Pursuant to N.C. Gen. Stat. § 131E-183(a)(1) and the 2021 SMFP, the Agency determined that the approval of one of the applications would result in the denial of the others, and, therefore, a competitive review of the applications was required. The Agency conducted a competitive review of the applications. (Prehearing Order, Stip. 7(g); Jt. Ex. 1, pp. 1608, 1618; Hale, Vol. 1, pp. 114, 127).

15. On September 21, 2021, the Agency issued its Decision conditionally approving the UNC Application and disapproving both of the Duke Applications. (Prehearing Order, Stip. 7(h); Jt. Ex. 1, pp. 1616, 1629).

16. That same day, the Agency issued its Required State Agency Findings setting forth the bases for its findings and conclusions upon which the Agency based its conditional approval of the UNC Application and the disapproval of the Duke Applications. The Parties stipulate that the Agency Decision and Findings at issue in this case were timely issued. (Prehearing Order, Stip. 7(i)).

17. The Agency further approved the Duke Arringdon Application, awarding Duke two ORs to be located at Duke Arringdon. The Agency also found the NCSH Application to be nonconforming to all statutory and review criteria, leading to the disapproval of its application. (Jt. Ex. 1, p. 1619). NCSH did not appeal this Agency decision, and there has been no appeal of the Agency's approval of the Duke Arringdon Application. Therefore, those applications are not the subject of this Contested Case.

18. The only applications at issue in this case are the UNC Application, the Duke Beds Application, and the Duke ORs Application.

19. On October 21, 2021, Duke timely filed a petition for contested case hearing ("Petition") with the Office of Administrative Hearings ("OAH"), bearing OAH Docket no.

21 DHR 04525, appealing the Agency's disapproval of the Duke Applications and conditional approval of the UNC Application. (Prehearing Order, Stip. 7(j)).

20. By Order issued by the Office of Administrative Hearings on November 10, 2021, UNC was, by consent of all parties, granted the right to intervene in 21 DHR 04525 with all the rights of a party. (Prehearing Order, Stip. 7(k)).

Expert Witnesses

21. Ms. Karin Sandlin is the President of Clarity Strategic Services and has worked in the field of CON and healthcare planning for approximately nineteen years. Prior to Clarity Strategic Services, Ms. Sandlin co-founded Keystone Planning Group, where she worked for approximately fourteen years with David Meyer, another expert in this contested case. (Jt. Ex. 52; Sandlin, Vol. 5, pp. 719-28). Ms. Sandlin assisted Duke as a paid consultant in preparing parts of the Duke ORs Application and Duke's Comments. (Sandlin, Vol. 5, pp. 741, 762; Vol. 6, pp. 956-57). At the hearing, Ms. Sandlin was accepted as an expert in the field of healthcare planning and the preparation and analysis of CON applications. (Sandlin, Vol. 5, p. 728).

22. Ms. Sandlin holds no master's degree or specific education or training in finance. She is not an expert in real estate, land-use, or acute care bed and OR management. Ms. Sandlin has no clinical background or experience of any kind. (Sandlin, Vol. 6, pp. 1083-84). Ms. Sandlin's experience preparing CON applications is primarily related to the non-financial portions of applications, and she has never prepared the financial portions of any Duke application, including the Duke Beds Application and the Duke ORs Application. (Sandlin, Vol. 6, pp. 1085, 1087, 1097).

23. Generally, Ms. Sandlin disagreed with the Agency decision because she opined that UNC should have been found nonconforming with Criterion (3), and consequently nonconforming with Criteria (1), (4), (5), (6), and (18a). (Sandlin, Vol. 6, pp. 1134-35). Furthermore, she disagreed with the Agency's comparative analysis, based on her opinions that UNC could not be the most effective alternative under the conformity with review criteria comparative factor and that Duke should have been found more effective on the geographic accessibility comparative factor. (Sandlin, Vol. 6, pp. 1055-56, 1058).

24. Mr. Daniel Carter is a Partner with Ascendient Healthcare Advisors, where he has provided CON and healthcare planning services for twenty-one years. (Jt. Ex. 71; Carter, Vol. 10, pp. 1658-60, 1671). Mr. Carter has prepared "several hundred" CON applications in his career, including applications for new hospitals, acute care beds, and ORs. He has been accepted as an expert in over a dozen CON cases. (Carter, Vol. 10, pp. 1661-63, 1666-67, 1670-71; Jt. Ex. 71). Mr. Carter led the Ascendient team that assisted UNC in preparing the UNC Application, as well as UNC's Comments and Responses to Comments. (Carter, Vol. 10, pp. 1675-76, 1800; Vol. 11, p. 1969). Mr.

Carter is also an adjunct professor at the UNC Gillings School of Public Health. (Carter, Vol. 1, pp. 1667-69). At the hearing, Mr. Carter was accepted as an expert in the field of healthcare planning and the preparation and analysis of CON applications. (Carter, Vol. 10, p. 1672).

25. Generally, Mr. Carter agreed with the Agency's decision to approve the UNC Application. (Carter, Vol. 10, p. 1674). He opined that the Agency should also have found Duke nonconforming to several review criteria. (*Id.*). Mr. Carter further opined that the Agency should have found Duke not an effective alternative under the Conformity with Review Criteria comparative factor, and equally effective with UNC on the Scope of Services comparative factor for both acute care beds and ORs; however, he ultimately agreed with the Agency's decision. (Carter, Vol. 11, pp. 1884, 1890).

26. Mr. David Meyer is a Senior Partner for Keystone Planning Group who has worked in the field of healthcare planning for twenty-five years. (Jt. Ex. 96; Meyer, Vol. 5, pp. 912-15). Over those years of experience, Mr. Meyer has reviewed thousands of CON applications and Agency findings. (*Id.* at pp. 915-16). Mr. Meyer has served as an expert witness in many previous CON matters, including eleven times testifying in contested case hearings and thirty-one depositions. (*Id.* at pp. 920-21). Mr. Meyer was not involved in preparing any of the applications, comments, or responses to comments in this Review. (*Id.* at p. 922). At the hearing, Mr. Meyer was accepted as an expert in the field of healthcare planning and the preparation and analysis of CON applications. (*Id.* at p. 921).

27. Overall, Mr. Meyer found the Agency's decision consistent with the prior Agency analyses he has seen in his 25-year career and found the Agency's decision to award the beds and ORs in this Review to UNC was correct. (Meyer, Vol. 7, pp. 1335-1336).[1]

Agency Review

Requirements for the CON Review Process

28. Under the CON law, the Agency must conduct its review of CON applications within 90 days, with a possible extension of the review period up to an additional 60 days, making the maximum period within which the Agency can conduct any review 150 days. N.C. Gen. Stat. § 131E-185(a1), (c).

29. Within the review period, the Agency must issue a decision to approve, approve with conditions, or deny a CON application to develop a new institutional health service. *Id.* § 131E-186(a).

[1] Mr. Meyer offered no opinions as to Duke's conformity with the applicable review criteria. (Meyer, Vol. 5, p. 922).

30. Within five business days of issuing its decision, the Agency must then "provide written notice of all the findings and conclusions upon which it based its decision, including the criteria used … in making its decision, to the applicant." *Id.* § 131E-186(b). This written notice of the findings and conclusions upon which the Agency based its decision is known as the Required State Agency Findings.

31. The Agency reviews an application to determine whether the specific application submitted demonstrates conformity with the applicable statutory and regulatory review criteria. *Id.* § 131E-183(a).

32. The Agency conducts a competitive review of applications when two or more applications are submitted to develop the same or similar services and the Agency determines that the approval of one or more of the applications may result in the denial of another application submitted in the same review. (Hale, Vol. 1, pp. 127-28). During a competitive review, the Agency reviews each application independently against the review criteria in the CON Law and any applicable CON regulations. (*Id.* at pp. 207-08). The Agency then conducts a comparative analysis of the applications to determine which application or applications to approve. (*Id.* at p. 208). The Agency can decide which factors to use during the comparative analysis. (*Id.* at p. 128). No statute, regulation, or North Carolina judicial opinion requires the Agency to use any specific factors; instead, the Agency selects the factors based upon the Agency's analysis of which factors are relevant to the particular review. (*Id.*).

33. The Agency's review is limited to the applications, documents submitted during the public comment period, and any publicly available information. (Hale, Vol. 2, pp. 283, 301, 308-09).

Celia Inman

34. Celia Inman was the Project Analyst assigned to the review at issue. (Jt. Ex. 1, p. 1493; Hale, Vol. 1, p. 113).

35. Ms. Inman served as a Project Analyst with the Agency for almost ten years before retiring from the Agency in March 2022. (Hale, Vol. 1, p. 122, Vol. 2, pp. 262-63). Prior to working for the Agency, she was a consultant at a firm that developed CON applications. (*Id.*).

36. Duke failed to either depose or call Ms. Inman as a witness at the hearing. While Ms. Inman was unavailable to be deposed prior to trial, Duke failed to subpoena her as a witness at trial and did not attempt to call her as a witness at trial. (Vol. 3, pp. 340-42).

Gloria Hale

37. During this review, Gloria Hale was a Team Leader for the Agency, responsible for supervising a team of project analysts. (Hale, Vol. 1, pp. 201-02). Ms. Hale usually supervises a team of four project analysts, but at the time of the hearing, she supervised a team of three project analysts due to a vacancy caused by Ms. Inman's retirement. (*Id.* at p. 202). Ms. Hale's supervision of her team involves reviewing the Agency findings and decisions prepared by her team members, the findings and decisions of any other project analysts assigned to her as Co-Signer, and administrative determinations and project monitoring. (*Id.* at pp. 202-03).

38. Ms. Hale has been a Team Leader for over four years. Prior to that, she served as a Project Analyst for the Agency for approximately six years. (*Id.* at p. 108). In her time as a project analyst, Ms. Hale reviewed approximately 25 CON applications annually, or about 150 applications in total. (*Id.* at pp. 203-04).

39. As a Project Analyst, Ms. Inman reported to Ms. Hale. (Hale, Vol. 2, p. 262). In Ms. Hale's opinion, Ms. Inman was "an excellent analyst. Very thorough. Very detailed. Very professional." (*Id.* at p. 263). Based on Ms. Inman's background and experience, Ms. Hale felt confident in the quality of Ms. Inman's work. (*Id.*).

40. Ms. Hale was the Co-Signer for the Agency Findings. The process and responsibilities of a Co-Signer differ from those of the Project Analyst responsible for a review. The Co-Signer reviews draft findings prepared by the Project Analyst along with portions of the applications and public comments and responses provided during the review period. (Hale, Vol. 1, p. 112). Ms. Hale reviewed and considered Duke's comments in her review. (*Id.* at p. 138).

41. Ms. Hale co-signed 58 Agency decisions in 2021 and estimates she has co-signed approximately 240 Agency decisions in her time as a Team Leader, including decisions involving new hospitals. (*Id.* at p. 111).

42. While the Co-Signer has the authority to add or remove comparative factors, Ms. Hale did not feel the need to add or remove any of the comparative factors Ms. Inman selected. (Hale, Vol. 2, p. 252).

43. In reviews for which Ms. Hale serves as a co-signer, Ms. Hale meets with the project analyst to discuss the Agency findings prior to turning the draft findings in for review. (Hale, Vol. 1, p. 124). Ms. Hale met with Ms. Inman to discuss this Review. (*Id.* at pp. 124-25).

The Agency File

44. Ms. Inman prepared the Agency File for this Review. (Jt. Ex. 1, p. 1493; Hale, Vol. 1, pp. 118-19). Ms. Hale does not recall making any changes to the Agency File when she reviewed it prior to co-signing. (Hale, Vol. 1, pp. 118-19).

45. The Agency File in this Review is divided into six sections. (Jt. Ex. 1, Table of Contents).

46. Tab 1 of the Agency File contains correspondence between the Agency and the applicants related to their applications and the review process. (Hale, Vol. 1, pp. 113-14; Jt. Ex. 1, pp. 1-34).

47. Tab 2 of the Agency File contains the Written Comments. (Jt. Ex. 1, pp. 46-265). In this Review, Southpoint Surgery Center, UNC, Duke, and WakeMed Health and Hospitals submitted comments. (Hale, Vol. 1, p. 115).

48. Tab 3 of the Agency File contains Public Hearing Documents. (Jt. Ex. 1, pp. 266-379). This includes the Responses to Written Comments, in which applicants respond to Comments on their application submitted by competitors and other interested parties. (Hale, Vol. 1, p. 115). In this Review, Duke, UNC, and Southpoint Surgery Center provided responses to Comments. (*Id.*).

49. Tab 4 of the Agency File contains Working Papers. (Jt. Ex. 1, pp. 380-1059). The Working Papers include a copy of the applicable CON Law and regulations, the Chapters of the 2021 SMFP pertaining to acute care beds and operating rooms, quality checks for Duke and UNC, and license renewal applications for James E. Davis Ambulatory Surgical Center, DUH, Duke Raleigh Hospital, and Duke Regional Hospital ("Duke Regional"). (*Id.*; Hale, Vol. 1, p. 116).

50. Tab 5 of the Agency File contains Other Agency Findings that the analyst and/or the co-signer utilized in the course of the review. (Jt. Ex. 1, pp. 1060-1490; Hale, Vol. 1, p. 116). The Agency File contains the following Agency Findings: 2018 Duke Arringdon Ambulatory Surgical Center Review, 2017 Durham/Caswell County Acute Care Bed Review, 2018 Durham County Operating Room Review, 2019 Durham County Beds Review, and 2020 Mecklenburg County Acute Care Bed and Operating Room Review. (Jt. Ex. 1, pp. 1060-1490; Hale, Vol. 1, pp. 116-18).

51. Tab 6 of the Agency File contains the Agency Findings in this Review. (Jt. Ex. 1, pp. 1491-1632; Hale, Vol. 1, p. 118).

UNC and the UNC Application

UNC Hospitals

52. UNC Health was established on November 1, 1998, as an affiliated enterprise of the University of North Carolina pursuant to N.C. Gen. Stat. § 116-37. (Jt. Ex. 4, p. 181). It operates numerous facilities throughout the State of North Carolina, including UNC Hospitals based in Chapel Hill. (*Id.*).

53. UNC Health is a widely recognized high quality healthcare provider. (*Id.* at pp. 31-33). UNC Hospitals places an emphasis on equitable access to healthcare, as it is obligated to accept any North Carolina citizen requiring medically necessary treatment, regardless of their race, sex, creed, age, handicap, financial status, or lack of medical insurance. (*Id.* at p. 33).

54. At the time of submission of its application, UNC controlled none of the acute care beds or ORs in Durham County. (*Id.* at p. 37).

55. UNC Health Care System is a not-for-profit, clinically integrated healthcare system owned by the State of North Carolina, comprised of fourteen (14) hospitals across eighteen (18) campuses and a large physician network. It offers a full array of healthcare services ranging from primary care to quaternary care and continuing care services. (Hadar, Vol. 8, pp. 1443-44).

56. Janet Hadar is the President of UNC Hospitals and has over twenty (20) years' experience with the UNC Health Care System. Prior to taking on her administrative role, she worked as a nurse practitioner for a decade. (*Id.* at pp. 1445-46). Her responsibilities as President include overseeing all operational, financial, regulatory, quality and safety operations of the four hospitals under the UNC Hospital license: UNC Hospitals Chapel Hill, UNC Hospitals Hillsborough Campus ("Hillsborough"), Chatham Hospital ("Chatham"), and UNC Hospitals at WakeBrook, as well as 75 clinics, ambulatory surgery centers ("ASCs"), imaging centers, home health and hospice care and durable medical equipment providers. (*Id.* at p. 1447). The new UNC Hospitals-RTP facility will also fall under the responsibilities of Ms. Hadar. (*Id.* at p. 1459).

57. UNC Hospitals-Chapel Hill is an academic medical center offering services including tertiary and quaternary level specialized care including neurosurgery, transplant services and complex cardiac care. It also offers adult medical/surgical services, behavioral health, a women's hospital, and children's hospital. Its mission is to "support the health and well-being of all North Carolinians regardless of their background or ability to pay." Its medical staff consists of physicians who are employed by the School of Medicine at Chapel Hill. (*Id.* at p. 1448-49).

58. In addition to its flagship academic medical center, UNC Hospitals has experience providing care in a community hospital setting such as that at Hillsborough and Chatham. If a patient is seen at one of these locations and requires a higher level of care for a discrete subspecialty, for example, UNC has a seamless transition process in place where a referral is made to UNC Hospitals at Chapel Hill and the patient is transported to ensure they are provided access to the enhanced services needed. (*Id.* at p. 1454).

59. Moreover, the UNC Health Alliance is a clinically integrated network of physicians serving UNC Hospitals. This group provides clinical care across the state along with UNC's nearly 1,000 Physician Network Providers. UNC Hospitals works closely and in collaboration with the UNC Physician Network Providers and the Health Alliance. (*Id.* at pp. 1449-51).

60. In addition to its strong presence of providers, UNC is constantly recruiting subspecialists from every discipline at the UNC Chapel Hill Medical Center and community physicians to serve patients at medical office clinics. (*Id.* at pp. 1450-51).

61. UNC boasts one of the largest graduate medical education training programs in the United States across all medical specialties. The UNC Health Care System offers training programs for physicians, pharmacy, nursing, Allied Health, administrative programs, MBAs, and MHAs. (*Id.* at pp. 1451-52).

62. UNC Hospitals' patient population is comprised of individuals from all 100 North Carolina counties. In addition to providing medical services, UNC Hospitals seeks to provide access to social and community services for its patients. (*Id.* at p. 1453). Approximately twelve (12) percent of that patient population originates from Durham County, even though UNC does not currently operate any hospital facility in Durham County. UNC does have some primary care and physical therapy clinics in Durham County which are staffed by UNC faculty physicians. (*Id.* at p. 1455).

UNC Hospitals-RTP

63. Planning for the UNC Hospitals-RTP began in the fall of 2020 after it was clear there would be a need determination for 40 beds and 4 ORs in Durham County, which provided an opportunity to build a new hospital. Planning involved Ms. Hadar and a large team of strategic planning, real estate and development, clinical and clinical operations leaders, and finance leaders who worked collaboratively over many months to develop the clinical programming proposed in the UNC Application. (*Id.* at pp. 1461-62; Carter, Vol. 10, pp. 1676-77). UNC analyzed data to determine what type of facility was needed in Durham County and determined that there was a need for lower acuity, higher volume services (e.g., appendectomies). (Carter, Vol. 10, pp. 1678-81).

64. Though Ms. Hadar did not draft the UNC Application or any portions thereof, she reviewed parts of the application prior to its filing and otherwise relied upon a team of experts to prepare and finalize the same, just as she delegates other duties in the operation of UNC Hospitals to other individuals with appropriate expertise. (Hadar, Vol. 8, pp. 1462-63, 1466). Ms. Hadar had been involved in many other CON application filings during her tenure at UNC Hospitals, including applications for acute care beds, ORs and imaging services. (*Id.* at p. 1463). Ms. Hadar signed the certification page submitted with the UNC Application, which she understood to acknowledge the accuracy of the content of the same to the best of her knowledge. (*Id.* at p. 1466).

65. UNC intends for UNC Hospitals-RTP to address the expanding needs of a growing population, particularly in southern Durham County, in a cost-effective, accessible environment that does not require patients to navigate a university campus with more than 20,000 students, traffic and paid parking. Specifically, Durham County is becoming one of the most populated counties in North Carolina and is experiencing skyrocketing economic growth and expansion, particularly in the RTP area. There is a clear need for additional services in that part of the Triangle. (*Id.* at p. 1458).

66. Moreover, UNC sought to bring these needed services closer to this growing population by locating the UNC Hospitals-RTP in southern Durham County. The southern Durham County location selected for UNC Hospitals-RTP is easily accessible near Interstate 40, thus providing convenient physical access from the highway. (*Id.* at p. 1458). UNC anticipated the location of UNC-RTP will satisfy consumer demand for medical care closer to their home and ensure that patients do not have to travel farther than necessary to seek such services. (*Id.* at pp. 1456, 1458-59).

67. Based on UNC's experience operating community hospitals at Chatham and Hillsborough, a smaller community hospital setting such as that proposed by UNC Hospitals-RTP is easier to navigate and helps the local community in terms of job creation. It is also more accessible to a potential workforce. This is particularly important for the healthcare industry where organizations are struggling to maintain an adequate workforce, particularly since the onset of the COVID-19 pandemic. (*See id.* at p. 1459).

68. Catharine Cummer, Duke's Regulatory Counsel, also agreed that a smaller, community hospital can offer benefits to patients such as less physical congestion and easier navigation than tertiary/quaternary level facilities or academic medical centers such as Duke University Hospital. (Cummer, Vol. 4, p. 626).

69. Aligning with its determination that there was a need for lower acuity, higher volume services, UNC also decided to focus on women's and OB services, which was a particular need of the population in southern Durham. (Carter, Vol. 10, pp. 1689-90; Hadar, Vol. 8, p. 1502).

70. Based on these discussions and analysis, UNC proposed to develop a new, separately-licensed, 40 acute care bed, 2 OR community hospital in Research Triangle Park in southern Durham County. (Jt. Ex. 4, p. 25; Carter, Vol. 10, pp. 1681-82). The 40 beds would include 32 general medical-surgical beds and eight postpartum beds. (Jt. Ex. 4, p. 37; Carter, Vol. 10, p. 1686). UNC also proposed to develop certain services at UNC Hospitals-RTP that are typically required in a hospital setting but not regulated by the SMFP need determinations: two dedicated C-section operating rooms, unlicensed procedure rooms, 12 emergency department bays, and various imaging and ancillary services. (Jt. Ex. 4, p. 37; Carter, Vol. 10, pp. 1686-89).

71. While "community hospital" is a commonly used term in healthcare, there is no definition of "community hospital" in the CON Law or application form. (Hale, Vol. 3, p. 338; Meyer, Vol. 6, p. 1350, Vol. 7, pp. 1435-36; Carter, Vol. 10, p. 1683). In its Application, UNC defines "community hospital" as "a hospital that provides a wide range of non-tertiary, lower acuity services that are needed in the community." (Jt. Ex. 4, p. 32; *see also* Carter, Vol. 10, pp. 1683-84). Based on this definition, Durham does not have a full-service community hospital, as Duke Regional provides tertiary services despite marketing itself as a community hospital. (Jt. Ex. 4, p. 52; Carter; Vol. 10, pp. 1684-85).

72. In determining what services would be needed to support a community hospital in Durham, UNC also drew from the UNC Health System's recent experience developing community hospitals in the greater Triangle area, including REX Holly Springs and UNC Johnston Hospital in Clayton. (Carter, Vol. 10, pp. 1687-88).

73. UNC Hospitals-RTP project will operate as an extension of UNC Hospitals, as all policies and procedures, training and medical staff will be consistent with both the UNC Hospitals - Chapel Hill and Hillsborough locations. (Hadar, Vol. 8, pp. 1464-65).

UNC Application

74. In this Review, the Agency determined that the UNC Application was conforming with all applicable Review Criteria and Rules and was comparatively superior to the Duke Beds and Duke ORs Applications. (Jt. Ex. 1, pp. 1493-632).

A. Criterion (1)

75. Criterion (1) requires that "[t]he 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." (N.C. Gen. Stat. § 131E-183(a)(1); Jt. Ex. 1, pp. 1494-95).

76. To find an applicant conforming with this Criterion, the Agency analyzes whether the project is consistent with the need determination in the SMFP and whether the project is consistent with the applicable policies in the SMFP. (*Id.*; *see also* Meyer, Vol. 5, pp. 933-34).

77. Here, the Agency first analyzed whether the proposed UNC project was consistent with the need determinations in the 2021 SMFP. (Jt. Ex. 1, p. 1497). The UNC Application did not propose to develop more acute care beds or ORs in the applicable service areas than were determined to be needed in the 2021 SMFP; accordingly, the Agency found the UNC Application was conforming under the need determination aspect of Criterion (1). (*Id.*; Hale, Vol. 2, pp. 210-11).

i. Policies GEN-3 and GEN-4

78. The Agency then analyzed whether the proposed UNC project was consistent with the applicable policies, which included Policy GEN-3: Basic Principles, and Policy GEN-4: Energy Efficiency and Sustainability for Health Service Facilities. With respect to Policy GEN-3, an applicant must "demonstrate how the project will promote safety and quality in the delivery of healthcare services while promoting equitable access and maximizing healthcare value for resources expended." (Jt. Ex. 1, p. 1496; Hale, Vol. 2, p. 211).

79. With respect to Policy GEN-4, an applicant "proposing a capital expenditure greater than $2 million to develop, replace, renovate or add to a health service facility pursuant to G.S. 131E-178" must provide "a written statement describing the project's plan to assure improved energy efficiency and water conservation." (Jt. Ex. 1, p. 1496; Hale, Vol. 2, p. 211). If an applicant "propos[es] an expenditure greater than $5 million to develop, replace, renovate or add to a health service facility pursuant to G.S. 131E-178," the CON must condition approval on the applicant developing and implementing "an Energy Efficiency and Sustainability Plan for the project that conforms to or exceeds energy efficiency and water conservation standards incorporated in the latest editions of the North Carolina State Building Codes." (Jt. Ex. 1, p. 1496; Hale, Vol. 2, pp. 211-12).

80. The Agency found UNC conforming with both policies. For Policy GEN-3, UNC's new hospital would provide access to UNC's high-quality healthcare to its growing number of patients in the area, including the medically underserved. (Jt. Ex. 1, p. 1498; Jt. Ex. 4, pp. 31-35; Hale, Vol. 2, pp. 212-13).

81. For Policy GEN-4, because UNC's Application proposed a project exceeding $5 million, UNC provided a written statement describing UNC's plan to improve energy efficiency and conserve water at the new proposed facility. (Jt. Ex. 1, p. 1498; Jt. Ex. 4, pp. 35-36; Hale, Vol. 2, p. 213).

82. Based on the information provided in the UNC Application, the Agency found UNC conforming to Criterion (1). (Jt. Ex. 1, p. 1498; Hale, Vol. 2, pp. 213-14).

83. Based on his experience with healthcare planning and preparation, and analysis of CON applications, David Meyer agreed with the Agency's analysis of UNC's conformity with Criterion (1), finding it consistent with the Agency's analyses of this Criterion in other findings. (Meyer, Vol. 5, p. 935).

84. On behalf of Duke, Karin Sandlin opined that the only basis for her opinion that the UNC Application was nonconforming with Criterion (1) was her opinion that UNC was nonconforming with Criterion (3) and provided no independent basis for her opinion. (Sandlin, Vol. 6, pp. 1134-35). Thus, she acknowledged that if the UNC Application was properly determined to be conforming with Criterion (3), as the Agency found in this review, then Ms. Sandlin's opinion would be that UNC's application was also conforming with Criterion (1). (*Id.* at p. 1135).

B. Criterion (3)

85. Criterion (3) requires the applicant to "identify the population to be served by the proposed project" and to "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." (N.C. Gen. Stat. § 131E-183(a)(3); Jt. Ex. 1, p. 1502).

86. To find an applicant conforming with this Criterion, the Agency engages in a four-part analysis: (1) the applicant must identify the population to be served, also referred to as the patient origin; (2) the applicant must demonstrate the need of the identified population for the services proposed; (3) the applicant must project the utilization of these services by the identified population in the first three operating years of the project; and (4) the applicant must project the extent to which the projected population, and particularly those in medically underserved groups, have access to the proposed services. (Jt. Ex. 1, p. 1502; Hale, Vol. 2, p. 224; *see also* Meyer, Vol. 5, p. 936). To be found conforming, the information provided by the applicant must be reasonable and adequately supported. (Hale, Vol. 2, pp. 223-24).

i. Patient Origin

87. The first element of Criterion (3) discusses patient origin, which is where the applicant projects patients will come from to utilize the proposed services. (Jt. Ex. 1, p. 1509; Hale, Vol. 2, p. 225). To analyze patient origin, the Agency reviews the information provided by the applicant and determines whether that information is reasonable and adequately supported. (Hale, Vol. 2, pp. 225-26).

88. The UNC Application provided that the patient origin for UNC Hospitals-RTP would include 90 percent Durham County residents, with some in-migration from Wake, Chatham, and Caswell Counties. (Jt. Ex. 4, p. 43; Carter, Vol. 10, pp. 1690-92).

89. To determine its projected patient origin, UNC considered the limited size of the facility and the overwhelming need in Durham County. While UNC could have used a higher percentage of in-migration in its projections, doing so would have been more aggressive, especially given that a small hospital would be less likely to attract patients from outside of the county. (Carter, Vol. 10, pp. 1692-93).

90. Ms. Sandlin acknowledged that her opinions regarding UNC's projected patient origin, in-migration, and patient population were not based on any Duke facilities of similar size, since there are none. She also did not perform any analysis of the patient origin of a hospital of similar size developed by UNC in developing her opinions. (Sandlin, Vol. 7, pp. 1165-66).

91. Daniel Carter, one of UNC's expert witnesses, opined that UNC's 10 percent in-migration assumption was well-supported, reasonable, and conservative. (Carter, Vol. 10, pp. 1695-96). The UNC Application analyzed in-migration at all 116 acute care hospitals in North Carolina to reach its 10 percent in-migration assumption, and it also accounted for UNC Hospitals-RTP's smaller size and densely populated location. (Jt. Ex. 4, pp. 146-47; Carter, Vol. 10, pp. 1693, 1695).

92. Mr. Carter analogized UNC Hospitals-RTP to UNC Johnston Health in Clayton, a 50-bed community hospital which is approximately the same distance from Wake County as UNC Hospitals-RTP would be. At UNC Johnston Health, there is approximately 9 percent in-migration from Wake County despite its proximity. (Carter, Vol. 10, pp. 1693-94).

93. Mr. Carter also noted that had UNC proposed higher in-migration, it would also have the effect of increasing UNC Hospitals-RTP's utilization and the financial feasibility of the project, which would strengthen its application for both Criteria (3) and (5). (*Id.* at p. 1693). Furthermore, he noted that UNC could have supported an assumption of 20 percent or even 30 percent in-migration without going beyond its maximum utilization. (*Id.* at pp. 1694-95).

94. Based upon the information provided in the UNC Application, the Agency determined that UNC adequately identified the patient origin for the population it proposed to serve. (Jt. Ex. 1, p. 1511; Hale, Vol. 2, pp. 226-27).

ii. Demonstration of Need

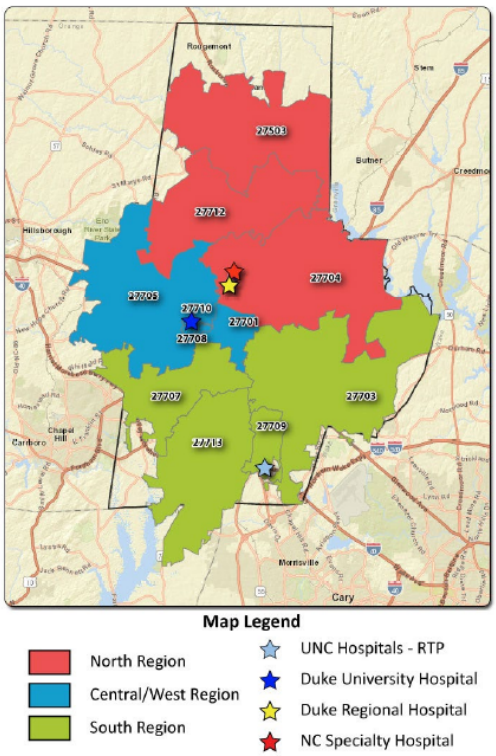
95. The second element of Criterion (3) analyzes whether the applicant demonstrates that the population proposed to be served needs the proposed services. (Jt. Ex. 1, p. 1511; Hale, Vol. 2, p. 231-32). To conduct its analysis of need, the Agency

reviews the information provided by the applicant and assesses whether that information is reasonable and adequately supported. (Hale, Vol. 2, pp. 231-32). This differs from the need determination of Criterion (1), which focuses on the need determination in the SMFP, rather than the needs of patients for the proposed services.

96. UNC provided several reasons why the patients it proposed to serve at UNC Hospitals-RTP needed the proposed services. The Agency determined that UNC's methodology and resulting projections were both reasonable and adequately supported. (Sandlin, Vol. 7, p. 1214).

97. The first reason provided by UNC is the population growth and aging in Durham County. (Jt. Ex. 4, pp. 48-50). UNC noted that Durham County is the sixth most populous county and the third fastest growing county in North Carolina, with the growth rate expected to continue into the next decade. (*Id.* at 48-49). This growth, combined with the aging of the population, demonstrated that there will be more patients needing acute care services. (*Id.* at 49-50; Carter, Vol. 10, pp. 1700-01).

98. The second reason provided by UNC is the need for a new hospital in Durham County. As of the date the applications were submitted, there were no acute care beds in the southernmost zip codes in Durham County, where most of the population and growth exists within the county. (Jt. Ex. 4, pp. 51-55). The UNC Application contained the following map illustrating the location of existing hospitals in Durham County and the proposed UNC Hospitals-RTP location:



(*Id.* at 51; *see also id.* at 53; Carter, Vol. 10, pp. 1710-11).

99. Additionally, UNC demonstrated that its proposed services were needed because (1) there has not been a new hospital opened in Durham County in over 45 years and (2) Durham County lacks a full-service community hospital. (Jt. Ex. 4, pp. 51-52).

100. The UNC Application included a table which displayed UNC's existing market share of certain zip codes within Durham County. This table showed that UNC already has a strong market presence in southern Durham County (including zip codes 27703, 27713, 27707, 27709) despite not having any facilities there. (*Id.* at 54; Carter, Vol. 10, pp. 1711-12).

101. The UNC Application also included a table which displayed the historical population growth by region and zip code within Durham County. This table showed that a majority of the Durham County population lives in the southern zip codes. As of 2020, 165,824 out of 326,262 people live in the southern zip codes. In addition, those southern zip codes are the fastest growing zip codes with a compound annual growth rate ("CAGR") of 2.4% between 2015 and 2020 and expected CAGR of 1.9% between 2020 and 2025. (Jt. Ex. 4, p. 55).

102. In further support of the need for a community hospital in southern Durham County, UNC described the development of roadways and businesses in southern Durham County to emphasize the "sustained growth and development" of southern Durham County that supports the need for UNC Hospitals-RTP. (*Id.* at pp. 56-58; Carter, Vol. 10, pp. 1713-14).

103. While the SMFP never states that there is a need for any hospital, the fact that there is a need for both beds and ORs in the same area offers the potential for a new hospital. Combined with the need for low acuity services in southern Durham County, there is a need for a community hospital in Durham County. (Carter, Vol. 10, pp. 1696-98).

104. UNC examined the entire Durham/Caswell service area when deciding where to locate its hospital. UNC determined that Caswell County was not an ideal location for a hospital due to its relative lack of population and determined that southern Durham County was ideal based on the need in those densely populated zip codes that lacked a hospital. (*Id.* at pp. 1699-702; Jt. Ex. 4, pp. 50-55).

105. A third reason provided by UNC is the need for UNC Hospitals hospital-based services in Durham County. A significant number of patients from Durham County use UNC Health facilities and developing a community hospital closer to them would meet their needs for higher frequency, lower acuity services. (Jt. Ex. 4, pp. 58-60; Carter, Vol. 10, pp. 1714-15).

106. UNC already has physicians in Durham County that are part of UNC Health. UNC is focused on meeting the physician needs in the area and would recruit physicians to meet those needs. (Carter, Vol. 10, pp. 1715-16; *see also* Jt. Ex. 4, pp. 58-59, 382-511). Moreover, UNC Hospitals-RTP would have the same provider number as UNC Hospitals, so the same medical staff that performs surgery in Chapel Hill could do so at UNC Hospitals-RTP. (Carter, Vol. 10, pp. 1716-17; *see also* Jt. Ex. 4, p. 152; Hadar consistent testimony at Vol. 8, pp. 1464-65).

107. UNC already serves a large number of Durham County residents even without having a hospital in Durham County. Moreover, around one-half of patients in a hospital may not need surgery, and the hospitalists that would provide those services at UNC Hospitals could also provide those services at UNC Hospitals-RTP. (Carter, Vol. 10, pp. 1718-19).

108. The UNC Application further supported the need for UNC Hospitals services in Durham County by describing how UNC Hospitals-RTP "represents an exciting opportunity to develop a new hospital facility with innovation as a central design tenet." (Jt. Ex. 4, p. 59). Mr. Carter explained that UNC felt that this opportunity to build a new hospital in Durham County, which had not presented itself for over 40 years, would allow UNC to provide care in a more modern, unique, and innovative way, as it described doing at its other facilities. (Carter, Vol. 10, p. 1720; Jt. Ex. 4, pp. 58-61).

109. The UNC Application provided examples of its "long history of embracing innovation to deliver the highest quality care with the best patient experience." (Jt. Ex. 4, pp. 60-61). In developing this application, administrators of REX Holly Springs and Johnston Health Clayton provided input of lessons learned from the development of these relatively new hospitals that could be incorporated into the development of UNC Hospitals-RTP. (Carter, Vol. 10, pp. 1721-23; Jt. Ex. 4, pp. 60-61).

110. As a fourth supporting reason, UNC explained that UNC Hospitals-RTP meets the need for acute care beds by providing lower acuity community hospital beds in particular, as it projected that convenient, local access to community hospital services was the primary driver of need for additional acute care beds in the service area. (Jt. Ex. 4, pp. 62-69; Carter, Vol. 10, pp. 1723-30).

111. UNC identified certain lower acuity, high volume services as "selected services," and then analyzed Truven data to illustrate how, "despite the growth at existing tertiary and quaternary facilities in Durham, the basis of this growth was the need for lower acuity, community hospital services." (Jt. Ex. 4, p. 65; Carter, Vol. 10, p. 1726).

112. UNC demonstrated that of the existing hospitals in Durham County, Duke Regional is the fastest growing. (Jt. Ex. 4, p. 64; Carter, Vol. 10, p. 1727). UNC then showed that the selected services were experiencing greater growth than other services

in the existing Durham hospitals as a whole, and at DUH and Duke Regional in particular. (Jt. Ex. 4, p. 65; Carter, Vol. 10, pp. 1727-29).

113. UNC further demonstrated that south Durham County residents are seeking lower acuity services more than the central and north regions of Durham County, with over 94 patients daily seeking lower acuity services at existing hospitals. (Jt. Ex. 4, p. 66; Carter, Vol. 10, pp. 1731-33).

114. The UNC Application showed that UNC currently provides the most days of care and experiences the greatest growth for Durham County residents out of all other hospitals except for Duke facilities, and that out of those patients, the highest volume originates from the south region of Durham County. (Jt. Ex. 4, pp. 68-69; Carter, Vol. 10, pp. 1734-36).

115. The UNC Application further showed that UNC Hospitals-RTP meets the need for ORs by providing additional hospital-based ORs, which are well-utilized and provide flexibility and capacity not otherwise available when those ORs are placed in an ambulatory surgical facility. (Jt. Ex. 4, pp. 69-71). Notably, UNC pointed out that while inpatient surgeries have grown at a slower rate than outpatient surgeries statewide, that trend is the opposite in Durham County. (*Id.* at pp. 69-70; Carter, Vol. 10, pp. 1736-37). UNC also indicated that there has been significant growth in outpatient ORs at ASCs, but that hospital-based ORs would provide the flexibility to meet the need for inpatient surgeries while still allowing for outpatient surgeries to be performed as well. (Jt. Ex. 4, pp. 70-71; Carter, Vol. 10, pp. 1737-38).

116. UNC also supported the need for other services at UNC Hospitals-RTP, including observation beds, procedure rooms, C-Section rooms, imaging, laboratory, and other services, which are needed to support the patients to be seen at UNC Hospitals-RTP. (Jt. Ex. 4, p. 71; Carter, Vol. 10, p. 1738).

117. Based on the information UNC provided, the Agency found UNC's analysis of need to be reasonable and adequately supported. (Jt. Ex. 1, pp. 1512; Hale, Vol. 2, pp. 232-34).

a. Duke Green Level

118. At hearing, Duke witnesses opined there was no need for lower acuity, community hospital-based services in Durham County. (*See generally* Cummer, Vol. 6, pp. 958-59; Sandlin, Vol. 6, pp. 999, 1015-16). This rationale is contrary to an application filed by Duke on February 15, 2021, two months before the Applications at issue were filed in this review. In the February 15, 2021 Application, Duke sought to develop a community hospital in southwestern Wake County, known as the Duke Green Level Hospital (the "Green Level Application"), with 40 acute care beds and two operating

rooms—the same size as UNC Hospitals-RTP. (Cummer, Vol. 4, pp. 627-628; Sandlin, Vol. 6, pp. 1102-04; Jt. Ex. 53).

119. The Green Level Application was not subject to a need determination and was therefore non-competitive. (Sandlin, Vol. 6, p. 1103).

120. In the Green Level Application, Duke relied upon the economic growth and development in the area of the proposed hospital as support for its proposed facility. (*Id.* at p. 1105). Duke further relied upon increased access and market opportunities due to the Triangle Expressway infrastructure, as well as the Green Level facility's proximity to RTP, as part of the reason for growth in the area that would support Duke's proposed new Green Level Hospital. (*Id.* at p. 1106).

121. Ms. Sandlin further agreed that generally speaking, when economic growth supports increases in population, that would in turn support the need for additional healthcare facilities. (*Id.* at p. 1107).

122. Much like the benefits espoused by UNC regarding community hospitals, Duke stated in the Green Level Application that "[c]ommunity-based hospitals enable providers to shift lower acuity patient populations out of regional, tertiary and quaternary care centers to effectively decompress[ing] capacity constraints while providing appropriate care in a community-focused facility often closer to home." (Jt. Ex. 53, p. 44; Sandlin, Vol. 6, p. 1108). The Green Level application also noted that it would "provide a more geographically convenient location for many residents, but the proposed 40-bed hospital facility will offer patients a patient-friendly, congenial alternative to DUHS's existing larger tertiary care settings." Ms. Sandlin agreed with the benefits offered by community hospitals. (Jt. Ex. 53, p. 46; Sandlin, Vol. 6, pp. 1109-10.).

123. An additional benefit of community hospital settings relied upon by Duke in its recent Green Level Application was its convenience to patients in terms of traffic and geographic location—another benefit with which Ms. Sandlin agreed. (Jt. Ex. 53, p. 46; Sandlin, Vol. 6, p. 1111).

124. Duke also cited to the benefits that patients would enjoy from enhanced choice in Wake County with the addition of its new community hospital in a new location. (Sandlin, Vol. 6, pp. 1113-14).

iii. Projected Utilization

125. The third element of Criterion (3) evaluates the reasonableness and adequacy of the support for the applicant's projected utilization. (Hale, Vol. 2, p. 235).

126. The Agency does not require applicants to use particular assumptions or methodologies to develop their utilization projections; instead, the assumptions and

methodology used by each applicant must be reasonable and adequately supported. (Cummer, Vol. 4, p. 670; Sandlin, Vol. 6, pp. 1115-16).

127. Ms. Sandlin acknowledged that projected utilization at a facility may not necessarily line up with an applicant's actual experience for various reasons. (Sandlin, Vol. 7, pp. 1193-94).

128. The need methodology and projected utilization for the UNC Application were contained in Form C Utilization – Assumptions and Methodology in Section Q of the application. (Jt. Ex. 4, pp. 141-60). UNC projected utilization for the acute care services, surgical services, and ancillary and support services proposed in its application. (Jt. Ex. 1, pp. 1512-20; Hale, Vol. 2, pp. 236-39).

129. UNC used Truven data as the basis for its utilization projections, which both the Agency witness and expert witnesses agreed is frequently utilized by applicants and is a reliable source of data. (Hale, Tr. pp. 237-38; Meyer, Vol. 5, pp. 941-43; Carter, Vol. 11, pp. 1953-55).

130. At the hearing, Mr. Carter explained in detail the assumptions and methodologies used in the UNC Application. The UNC Application began by describing the service area and emphasizing the focus on Durham County, which "sets the stage for" UNC's focus on Durham County in the methodology. (Jt. Ex. 4, pp. 141-42; Carter, Vol. 10, pp. 1739-40).

a. Selected Services

131. The UNC Application next discussed acute care bed utilization, looking first to all days of care for Durham County residents statewide. (Jt. Ex. 4, p. 142; Carter, Vol. 10, p. 1740). Mr. Carter notes that while many methodologies look no further than this, the UNC Application took the extra step of identifying certain high acuity services that it would exclude from the potential days of care to be provided at UNC Hospitals-RTP, as UNC did not propose to provide high acuity, tertiary and quaternary services at UNC Hospitals-RTP. (Jt. Ex. 4, pp. 142-43; Carter, Vol. 10, pp. 1740-41).

132. The remaining services utilized by UNC were called the Selected Services. (*See* Jt. Ex. 4, p. 143).

133. The decision to exclude certain services was the product of discussions within UNC and the expertise of Mr. Carter. Certain services like cardiac catheterization were excluded because there was no need for a cardiac catheterization unit in the SMFP; other services like neurosurgery could have been included, but given that UNC Hospitals is located nearby, it made sense not to duplicate those services. Moreover, given that UNC Hospitals-RTP is proposed to be a community hospital, UNC prioritized lower-acuity, high-frequency, high-volume cases. (Carter, Vol. 10, pp. 1744-45).

134. UNC decided not to include ICU services at UNC Hospitals-RTP in part based on its recent experience developing community hospitals in Wake and Johnston Counties. Through those facilities, UNC learned that it did not make sense to develop ICU units due to the low volume of patients needing those services compared to the resource-intensive staffing that is required for those beds. (*Id.* at pp. 1763-65).

135. As explained in the UNC Application, the rooms at UNC Hospitals-RTP were designed to be flexible spaces that would be built to standards such that they could provide ICU-level care as needed. (Jt. Ex. 4, p. 38). If UNC Hospitals-RTP learns as it begins operating that more ICU beds are needed, it could decide to make those beds permanent ICU beds, which would not require any additional construction or renovation, or any CON approval. (Carter, Vol. 10, pp. 1761-62, 1765).

136. UNC accomplished the exclusion of high acuity services from its analysis by removing diagnosis related groups ("DRGs") associated with the excluded high acuity services from the dataset. (Carter, Vol. 10, pp. 1741-42, Vol. 11, pp. 1897-98). The exclusion of these services resulted in a 31.1 percent reduction in 2019 days of care for Durham County residents. (Jt. Ex. 4, p. 143; Carter, Vol. 10, pp. 1742-44).

137. While the Agency does not require applicants to exclude services in its methodology, UNC chose to do so to underscore the conservativeness of its projections and to reiterate UNC's intention not to develop a quaternary academic medical center in Durham County. (Carter, Vol. 10, pp. 1742-43).

138. Ms. Sandlin did not conduct any analysis utilizing DRG weights to determine the reasonableness of UNC's projections. (Sandlin, Vol. 7, p. 1222; Carter, Vol. 10, pp. 1767-68). She also opined that there is no specific cutoff or threshold for DRG weights that are associated with ICU level of care. (Sandlin, Vol. 7, p. 1223).

139. Mr. Carter likewise opined that there is no bright-line rule for a DRG weight for ICU services. (Carter, Vol. 10, pp. 1756-58).

140. Mr. Carter even analyzed the data UNC relied upon in its analysis and discovered that had UNC applied a bright-line rule excluding DRG weights of over 3.5, only approximately ten percent of the patient days of care for UNC Hospitals-RTP were over that threshold. (*Id.* at pp. 1759-61).

141. Moreover, those patients without exception had a comorbid condition or major complication that led their condition to progress beyond a 3.5 DRG weight. In those cases, if UNC Hospitals-RTP could not provide the higher level of care needed, they could be transferred to an appropriate facility. (*Id.* at pp. 1760-61).

142. Ultimately, even if there were ICU patients that were not excluded from UNC Hospitals-RTP's selected services patients, the projections in the UNC Application would not be impacted. (*Id.* at p. 1762).

143. Ms. Sandlin created and utilized a Venn diagram as a demonstrative exhibit to show the alleged overlap between UNC's selected services, ICU, post-ICU, and pediatric patients. (Duke Ex. 227). On cross-examination, however, Ms. Sandlin admitted that she did not know what percentage each of the "bubbles" or "circles" on her diagram represented for each service and that her exhibit was not drawn to scale. (Sandlin, Vol. 7, pp. 1218-20). Ms. Sandlin further acknowledged that she did not quantify the numbers or percentage of patients that the diagram was intended to represent. (Sandlin, Vol. 7, p. 1220; Carter, Vol. 10, pp. 1765-67).

144. Regardless of the exclusion of certain high acuity services, UNC Hospitals-RTP will be able to stabilize high acuity patients in an emergency in need of tertiary or quaternary care and transfer them to another hospital that can treat their condition, as it does at its other community hospitals in the greater Triangle area. (Carter, Vol. 10, pp. 1745-46; Hadar, Vol. 8, p. 1454).

b. Methodology

145. Next, UNC projected potential days of care for the selected services in Medicine, Surgery, and Obstetrics through 2029, which is the third project year, using a CAGR based on historical growth rate for those services. (Jt. Ex. 4, pp. 143-44; Carter, Vol. 10, pp. 1746-47). Duke, in its expert testimony, did not criticize UNC's growth rates or methodology included on page 144 of the UNC Application. Mr. Carter opined the growth rates and methodology to be reasonable based on the historical growth rates for Durham County. (Carter, Vol. 10, p. 1747). UNC then showed the potential days of care for Durham County residents for the first three fiscal years of the project. (Jt. Ex. 4, p. 144; Carter, Vol. 10, p. 1747).

146. After that, UNC discussed its market share assumptions for UNC Hospitals-RTP, which is typically analyzed for any new healthcare facility that needs to project a volume of services to be provided. (Carter, Vol. 10, pp. 1747-48). Since UNC already treats many Durham County patients at its existing facilities outside of Durham County, UNC conservatively projected that UNC Hospitals-RTP would serve three-fourths of UNC's existing market share of Durham County residents. (Jt. Ex. 4, p. 145; Carter, Vol. 10, pp. 1748-50). In the third full project year, this results in a 7.7 percent market share of Durham County patient days for the selected services, leaving 92.3 percent of Durham County patient days to be treated at any other facility in the state. (Carter, Vol. 10, pp. 1750-52).

147. After isolating Durham County and narrowing down days of care based on selected services and UNC's market share of Durham County patient days, UNC was

then able to project the patient days by service for Durham County residents, yielding an average daily census ("ADC") of 26.5 patients in the third project year. (Jt. Ex. 4, p. 146; Carter, Vol. 10, pp. 1768-69).

148. The next part of the methodology in the UNC Application demonstrated why the 26.5 ADC was reasonable. UNC noted that its 2019 ADC for Durham County residents for selected services at its existing facilities was 24.4. This highlighted how reasonable and conservative it is to project that UNC Hospitals-RTP would serve only about two more patients per day than UNC currently serves, after UNC Hospitals-RTP is open and operational. (Jt. Ex. 4, p. 146; Carter, Vol. 10, p. 1769). UNC also provided more information about its in-migration assumptions. (Jt. Ex. 4, pp. 146-47; Carter, Vol. 10, pp. 1769-70).

149. UNC further highlighted the conservativeness of its methodology by noting that the amount of patients UNC Hospitals-RTP projects to serve is only part of the projected growth of Durham County residents over the next ten years. (Jt. Ex. 4, p. 148; Carter, Vol. 10, pp. 1770-71). In comparison, the Duke Beds Application proposed to increase patient days by roughly 40,000 in less than ten years. (Jt. Ex. 2, p. 95; Carter, Vol. 10, pp. 1771-72). Based on this observation, Mr. Carter opined that it was not unreasonable for the UNC Application to project to reach 10,700 patient days over a ten-year period of time, especially since UNC already had more patient days for these lower acuity services at hospitals outside of Durham County. (Carter, Vol. 10, pp. 1772-73).

150. In its Comments, Duke claimed that UNC relied on a shift in volume to support its projections. (Jt. Ex. 1, pp. 176-78; Sandlin, Vol. 6, p. 990). UNC responded, however, that this claim was incorrect, because UNC was taking a portion of the new growth in patient days in Durham County. (Jt. Ex. 1, pp. 309-12; Carter, Vol. 10, pp. 1773-75). Regardless, Ms. Sandlin acknowledged that it is reasonable in theory to assume that developing a facility in an area where patients live will cause the existing market share for that provider to increase. (Sandlin, Vol. 6, pp. 1115-16).

151. Ms. Sandlin testified that UNC's projections were unreasonable because the patients that UNC currently treats are going to UNC Hospitals for specialty services. (*Id.* at pp. 994-96). Mr. Carter refuted Ms. Sandlin's testimony, opining that Ms. Sandlin ignored UNC's exclusion of high acuity patients in its methodology. (Carter, Vol. 10, pp. 1775-76). Moreover, Ms. Sandlin acknowledged that she had not done any analysis of the acuity level of services provided to Durham County patients currently seeking care at UNC. (Sandlin, Vol. 7, pp. 1159-60).

152. UNC also projected emergency department ("ED") utilization in its assumptions and methodologies. (Jt. Ex. 4, pp. 149-51; Carter, Vol. 10, pp. 1776-77). A hospital is required to have an emergency department in North Carolina, though there are no statutes or rules that apply to emergency department projections. (Sandlin, Vol. 7, p. 1215; Carter, Vol. 10, pp. 1778-79).

153. UNC's ED utilization projections were not based solely on ED admissions in Durham County; rather, it analyzed all ED admissions of Durham County residents receiving care throughout the state. (Jt. Ex. 4, p. 150; Carter, Vol. 10, pp. 1777-78). As Mr. Carter opined, even if the ED utilization projection methodology was wrong, as a hospital, UNC Hospitals-RTP is required to include an ED, and there is no standard the Agency applies to ED utilization that would cause the UNC Application to not be approvable. (Carter, Vol. 10, pp. 1778-79).

154. UNC began projecting OR utilization by assuming that each surgical inpatient is one surgical inpatient case. (Jt. Ex. 4, pp. 155-56; Carter, Vol. 10, p. 1779). UNC then analyzed projected outpatient cases and concluded that there would be 1.5 outpatient surgeries for every inpatient surgery. (Jt. Ex. 4, p. 155; Carter, Vol. 10, pp. 1779-80).

155. Although Duke's expert witness testified that UNC's OR utilization projections were unreasonable because its acute care beds projections were unreasonable, both of UNC's expert witnesses refuted this testimony. Mr. Carter opined that UNC's OR utilization projections were conservative. The projections showed that some of the surgical cases would need to be performed in procedure rooms based on the relatively small capacity of 2 ORs in UNC's proposal. (Carter, Vol. 10, p. 1781). Mr. Meyer opined that UNC's projections were reasonable, and conservative based on his experience in healthcare planning. (Meyer, Vol. 5, pp. 943-44).

156. UNC similarly projected utilization for imaging and ancillary services, observation beds, procedure rooms, and LDR and C-Section rooms. (Jt. Ex. 4, pp. 151-55, 159-60).

157. Based on the information provided by UNC, the Agency found UNC's projected utilization to be reasonable and adequately supported, because UNC:

(1) used publicly available data to determine Durham County residents' potential days of care for UNC Hospitals-RTP's projected services,

(2) used an historical 2-yr compound annual growth rate ("CAGR") to project days of care going forward, and

(3) based its projected surgical, obstetrics, emergency, imaging/ancillary, and observation bed services on historical Truven data for Durham County residents, relevant historical UNC Hillsborough experience, or UNC Health services for Durham County residents.

(Jt. Ex. 1, p. 1520; Hale, Vol. 2, pp. 239-40).

158. The Agency also found UNC's projection that 90 percent of its patient population would come from Durham County to be reasonable because the southern part of Durham County was highly populated, and any nearby Wake County residents have a number of healthcare and hospital choices in Wake County. (Hale, Vol. 2, p. 317).

iv. Access to Medically Underserved Groups

159. The fourth and final element of Criterion (3) evaluates whether the applicant demonstrates the extent to which residents of the service area are likely to have access to the proposed project, particularly with respect to medically underserved groups. (Jt. Ex. 1, p. 1520). In particular, the Agency looks for reasonable and adequately supported information from the applicant demonstrating an intention to serve medically underserved groups. (Hale, Vol. 2, pp. 240-41).

160. In its Application, UNC indicated its intention to serve medically underserved groups based on its mission to accept any North Carolina citizen requiring medically necessary treatment. (Jt. Ex. 4, pp. 77-78; Meyer, Vol. 5, pp. 937-38). UNC also provided an estimate of the percentage of its total patients that were part of a medically underserved group during the third full fiscal year of the project. (Jt. Ex. 4, p. 78).

161. The Agency found the UNC Application to have adequately described the extent to which the residents of the service area, including underserved groups, are likely to have access to the proposed services. (Jt. Ex. 1, p. 1520; Hale, Vol. 2, p. 241).

162. The Agency ultimately found that the UNC Application was conforming with Criterion (3) because each of the elements of Criterion (3) were reasonable and adequately supported. (Jt. Ex. 1, pp. 1520-21; Hale, Vol. 2, p. 241).

163. At hearing, Mr. Meyer agreed with the Agency's analysis and conclusion that UNC was conforming with Criterion (3). He noted that UNC "described at some length" the need for the proposed services, along with a detailed summary of the utilization projections, which he found to be reasonable and adequately supported. (Meyer, Vol. 5, p. 937, Vol. 7, p. 1266).

164. Mr. Meyer also described that UNC's methodology of projecting its utilization, which projected from its own historical utilization of existing services by Durham area residents, was conservative considering it would also be reasonable to assume that UNC could gain increased market share amongst Durham County residents with a new facility there. (Meyer, Vol. 6, p. 1356). Furthermore, he opined that UNC's projections are sensible since UNC would be gaining a slice of a growing "pie" of Durham County population. (*Id.* at pp. 1356-57).

165. Mr. Meyer further explained that the UNC Application was supported not only in the narrative discussing Criterion (3) but also by the exhibits to the application providing supporting evidence for the need, including over 130 letters of support that spoke to the need for the proposed services and the fact that UNC Hospitals-RTP would "improve access for people in a growing county." (Meyer, Vol. 5, pp. 937, 944).

166. Mr. Meyer observed that the Agency's analysis was consistent with past findings. The Agency reviewed the UNC Application and exhibits, the Comments, and Responses to Comments, and determined the UNC Application was conforming with this Criterion. (*Id.* at pp. 938-39).

167. Duke understood and agreed that the Agency is not required to agree with any comments or portions of comments filed with it by another party and does not always incorporate the comments submitted by Duke against an applicant in a CON review. (Cummer, Vol. 4, pp. 642-43).

168. Moreover, Mr. Meyer explained that there is no single way for an applicant to project utilization in its application. It is typical for competitors to attack an applicant's projections in their Comments. The Agency appropriately considered Duke's Comments while still disagreeing with them and finding the UNC Application conforming. (Meyer, Vol. 5, pp. 939-40, Vol. 7, pp. 1263-66).

C. Criterion (4)

169. Criterion (4) requires that "[w]here 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." (N.C. Gen. Stat. § 131E-183(a)(4); Jt. Ex. 1, p. 1539; Hale, Vol. 2, p. 241; Meyer, Vol. 5, p. 945).

170. UNC considered three alternatives besides developing the project as proposed, including maintaining the status quo, developing the hospital at another location, and developing the hospital with a different number of beds, ORs, or other services. (Jt. Ex. 4, p. 91; Carter, Vol. 10, p. 1783).

171. UNC concluded that maintaining the status quo was not an acceptable alternative because it would leave Durham County without needed geographic distribution of hospital-based services for its growing and aging population. It would also not allow UNC to address the need for its services by Durham County residents closer to where they live. (Jt. Ex. 4, p. 91).

172. UNC similarly concluded that developing the hospital at another location would not be a more effective alternative because the southern region of Durham County is experiencing the greatest growth while also not having a hospital in the region, making it the ideal location for these services. (*Id.* at p. 92; Carter, Vol. 10, pp. 1783-84).

173. Furthermore, UNC also concluded that developing the hospital with a different number of beds and/or services would not be effective, as a smaller facility would not meet the needs of the physicians and their patients. UNC determined that at least 40 beds were needed to meet the need for lower acuity services in the area, and that 2 ORs would be well-utilized at UNC Hospitals-RTP. (Jt. Ex. 4, p. 92).

174. The Agency found UNC conforming with Criterion (4) because UNC provided reasonable information to explain why it believes UNC Hospitals-RTP to be the most effective alternative. (Jt. Ex. 1, pp. 1541-42; Hale, Vol. 2, p. 241).

175. Ms. Sandlin opined that the only basis for her opinion that the UNC Application was nonconforming with Criterion (4) was her opinion that UNC was nonconforming with Criterion (3). (Sandlin, Vol. 6, pp. 1134-35). Thus, if the UNC Application was properly determined to be conforming with Criterion (3), as the Agency found in this review, then Ms. Sandlin's opinion would be that UNC's application was also conforming with Criterion (4). (*Id.* at p. 1135).

176. At the hearing, Mr. Meyer endorsed the Agency's determination that UNC was conforming with Criterion (4). (Meyer, Vol. 5, pp. 945-46). He noted that Duke's only criticism of the UNC Application under Criterion (4) was that it was nonconforming with Criterion (3); however, because the UNC Application conforms with Criterion (3), there is no other argument offered for UNC's nonconformity with this Criterion. (*Id.* at pp. 946-47).

D. Criterion (5)

177. Criterion (5) requires an applicant to provide "[f]inancial and operational projections for the project" that "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." (N.C. Gen. Stat. § 131E-183(a)(5); Jt. Ex. 1, p. 1545; Hale, Vol. 2, p. 242; Carter, Vol. 10, p. 1785).

178. To be conforming with Criterion (5), the applicant must provide information demonstrating projected capital and working capital costs, availability of funds needed for the proposed project, and pro forma financial statements for the first three full fiscal years of the project. (Jt. Ex. 1, pp. 1548-49; Meyer, Vol. 7, pp. 1266-67).

179. The UNC Application demonstrated the financial feasibility of the project as well as the reasonableness of its projections and the costs and charges included in the financial pro formas. (Carter, Vol. 10, pp. 1785-86).

180. The Agency found UNC conforming with Criterion (5). (Jt. Ex. 1, pp. 1549-50; Hale, Vol. 2, p. 242).

181. Ms. Cummer acknowledged that she did not create the content of Duke's Comments regarding UNC's application and Criterion (5), but rather wrote them in the Form included in the Comments after receiving input for the content from Scott Bearrows with DUH's finance department. (Cummer, Vol. 4, pp. 584, 638-39). No other Duke witness, including Mr. Bearrows, testified regarding UNC's application and Criterion (5).

182. Ms. Sandlin reviewed but had no input into Duke's Comments submitted against Criterion (5) of the UNC Application. (Sandlin, Vol. 5, p. 763).

183. Ms. Sandlin opined that the only basis for her opinion that the UNC Application was nonconforming with Criterion (5) was her opinion that UNC was nonconforming with Criterion (3). (Sandlin, Vol. 6, pp. 1134-35). Thus, if the UNC Application was properly determined to be conforming with Criterion 3, as the Agency found in this review, then Ms. Sandlin's opinion would be that UNC's application was also conforming with Criterion (5) (Sandlin, Vol. 6, p. 1135).

184. Duke offered no expert witness testimony concerning its Comments that UNC's payor mix was unreasonable. (*Id.* at p. 1091).

185. Mr. Meyer endorsed the Agency's findings for Criterion (5) and disagreed with Ms. Sandlin's analysis, given that her only reason for finding the UNC Application nonconforming with this Criterion was her belief that the UNC Application was nonconforming with Criterion (3). (Meyer, Vol. 7, pp. 1267-69).

186. Mr. Carter also agreed with the Agency's determination that the UNC Application conformed with this criterion and disagreed with Ms. Sandlin's analysis. (Carter, Vol. 10, pp. 1785-86).

E. Criterion (6)

187. Criterion (6) requires the applicant to "demonstrate that the proposed project will not result in unnecessary duplication of existing or approved health service capabilities or facilities." (N.C. Gen. Stat. § 131E-183(a)(6); Jt. Ex. 1, p. 1556; Hale, Vol. 2, pp. 242-43; Meyer, Vol. 7, p. 1269; Carter, Vol. 10, p. 1786).

188. The UNC Application demonstrated that it will not unnecessarily duplicate existing or approved health service capabilities. First, the need determination itself shows there is a need for more beds and ORs despite existing facilities. Second, UNC Hospitals-RTP would be the first UNC Health inpatient facility in Durham County and the first hospital in the southern region of Durham County. (Jt. Exs. 104 and 105; Carter, Vol. 10, pp. 1786-87).

189. The Agency found UNC conforming with Criterion (6). (Jt. Ex. 1, p. 1559; Hale, Vol. 2, p. 243).

190. Ms. Sandlin opined that the only basis for her opinion that the UNC Application was nonconforming with Criterion (6) was her opinion that UNC was nonconforming with Criterion (3). (Sandlin, Vol. 6, pp. 1134-35). Thus, if the UNC Application was properly determined be conforming with Criterion (3), as the Agency found in this review, then Ms. Sandlin's opinion would be that UNC's application was also conforming with Criterion (6). (*Id.* at p. 1135).

191. Mr. Meyer agreed with the Agency's analysis finding the UNC Application conforming with Criterion (6). He disagreed with Ms. Sandlin's opinion that the UNC Application was nonconforming with Criterion (3), and therefore also disagreed with her related opinion that UNC was nonconforming with Criterion (6). (Meyer, Vol. 7, pp. 1269-71).

192. Mr. Carter also agreed with the Agency's analysis, noting that the rationale provided by UNC in its application is commonly approved by the Agency in other applications. (Carter, Vol. 10, p. 1788).

F. Criterion (7)

193. Criterion (7) provides that 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." (N.C. Gen. Stat. § 131E-183(a)(7); Jt. Ex. 1, p. 1562).

194. The Agency determined that the UNC Application was conforming with Criterion (7). (Jt. Ex. 1, pp. 1563-64).

195. Mr. Carter opined that the Agency properly found UNC conforming with Criterion (7). (Carter, Vol. 10, pp. 1788-89). Duke offered no evidence or testimony to challenge UNC's conformity with Criterion (7) and did not opine that UNC should have been found nonconforming with Criterion (7).

G. Criterion (8)

196. Criterion (8) requires that "[t]he 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." (N.C. Gen. Stat. § 131E-183(a)(8); Jt. Ex. 1, p. 1568).

197. The Agency determined that the UNC Application was conforming with Criterion (8). (Jt. Ex. 1, pp. 1569-70).

198. Mr. Carter opined that the Agency properly found UNC conforming with Criterion (8). (Carter, Vol. 10, pp. 1788-89). Duke offered no evidence or testimony to challenge UNC's conformity with Criterion (8) and did not opine that UNC should have been found nonconforming with Criterion (8).

H. Criterion (12)

199. Criterion (12) states:

> 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.

(N.C. Gen. Stat. § 131E-183(a)(12); Jt. Ex. 1, p. 1573; Hale, Vol. 2, p. 243; Carter, Vol. 10, p. 1789).

200. Analysis of this Criterion contains three elements: (1) whether the cost, design, and means of construction proposed represent the most reasonable alternative; (2) whether the construction project will not unduly increase the cost of providing health services by the person proposing the project; and (3) whether energy-saving features have been incorporated into the construction plans. (*Id.*; Meyer, Vol. 7, pp. 1271-72).

201. The UNC Application satisfied the first element by (1) providing drawings of its site plan and floor plan in Exhibit C.1 and (2) explaining that the proposed construction and layout for the hospital was based on a "configuration that provides the most efficient circulation and throughput for patients and caregivers," based on "best practice methodologies," as well as "relationships and adjacencies to support functions while also preventing unnecessary costs." (Jt. Ex. 4, pp. 112-13, 233-39; Meyer, Vol. 7, p. 1273).

202. UNC satisfied the second element of Criterion (12) by explaining that while the UNC Hospitals-RTP project would be capital intensive, UNC set aside excess revenues to fund the project, such that the project could be completed without increasing costs or charges to the public to help fund it. (Jt. Ex. 4, p. 113). UNC provided a letter from the Chief Financial Officer of UNC Hospitals certifying the availability of accumulated cash reserves to fund the project. (*Id.* at p. 292; Meyer, Vol. 7, pp. 1273-74).

203. Finally, UNC satisfied the third element of Criterion (12) by showing that its proposed hospital would be energy efficient and conserve water, and that UNC would develop and implement an Energy Efficiency and Sustainability Plan. (Jt. Ex. 4, p. 113; Meyer, Vol. 7, p. 1274).

i. Zoning of UNC's Primary Site

204. Because a CON is "valid only for the . . . physical location . . . named in the application," applicants also are required to identify a proposed site for a new facility. (N.C. Gen. Stat. § 131E-181(a); Jt. Ex. 4, p. 114; Meyer, Vol. 7, pp. 1272, 1282). The applicant should specify an address, a parcel number, or intersection of roads. (Meyer, Vol. 7, p. 1272).

205. The primary site for UNC Hospitals-RTP identified in the UNC Application is located in southern Durham County in the Research Triangle Park ("RTP") at the convergence of North Carolina Highway 54 and North Carolina Highway 147, also known as the Triangle Expressway. (Jt. Ex. 4, p. 114). At the time of the filing of the UNC Application, the property, also known as the Highwoods Site, was owned by Highwoods Realty Limited Partnership ("Highwoods"). (*Id.* at 115). UNC provided a Letter of Intent for UNC Health to purchase the property from Highwoods along with its application. (*Id.* at 517-23).

206. The CON Law does not regulate or even mention zoning. (Meyer, Vol. 7, p. 1281). Nonetheless, Section 4(c) of Criterion (12) in the Agency's application form is entitled "Zoning and Special Use Permits." (Hale, Vol. 2, p. 244). This Section requires an applicant to first describe the current zoning at the proposed site, and then, "[i]f the proposed site will require rezoning, describe how the applicant anticipates having it rezoned[.]" (Jt. Ex. 4, p. 115; Hale, Vol. 2, pp. 266-67).

207. The Agency contemplates that a proposed site for a project may not be properly zoned for the proposed project at the time the application is submitted, by asking applicants the questions posed in Section 4(c). (Hale, Vol. 2, pp. 246, 267).

208. The fact that a site identified in an application may need rezoning does not make an application nonconforming with Criterion (12) or non-approvable. (*Id.* at p. 267; Meyer, Vol. 7, pp. 1281-82, Vol. 8, p. 1398). The Agency frequently approves applications that propose projects to be developed on sites that require rezoning before they can be used to develop the proposed services. (Hale, Vol. 2, p. 246; Meyer, Vol. 7, pp. 1277-78). In Mr. Meyer's 25 years of healthcare planning experience, he cannot recall a time when the Agency denied an application due to the fact that a site needed to be rezoned. (Meyer, Vol. 7, p. 1278).

209. Moreover, the Agency is tasked with applying the CON Law and related rules, not with considering an applicant's compliance with other laws like zoning

ordinances. Therefore, the Agency does not review applicable zoning laws or restrictive covenants when it reviews an application. (Hale, Vol. 2, p. 266; *see also Craven Reg'l Med. Auth.*, 176 N.C. App. at 57-58, 625 S.E.2d at 844).

210. Rezoning of sites identified in CON applications typically does not occur until after a CON has been awarded. (Meyer, Vol. 7, p. 1277).

211. According to the UNC Application, UNC's primary proposed site "will require rezoning." UNC noted that it anticipated having the property rezoned:

> The proposed site is located in Research Triangle Park across the street from the Research Triangle Foundations Frontier and HUB RTP developments that have an SRP-C zoning designation. UNC Hospitals currently is working with land use counsel, the property owner, and Research Triangle Foundation management to have the property rezoned to permit hospital use. With the guidance of land use counsel, UNC Hospitals will engage with Durham Planning staff, the Durham Planning Commission, and the Durham Board of County Commissioners to complete the rezoning process. Additionally, UNC Hospitals will, with the cooperation of the Research Triangle Foundation, work with the Research Triangle Park Owners and Tenants Association (O&T) to amend the Research Triangle Park Covenants, Restrictions, and Reservations by resolution to permit hospital use. Please see Exhibit I.2 for a letter of support from the Research Triangle Foundation.

(Jt. Ex. 4, p. 115; Hale, Vol. 2, pp. 268-69).

212. Applicants are not required to submit letters of support with their CON application; however, it is common for CON applicants to do so. (Hale, Vol. 2, p. 260; Carter, Vol. 10, pp. 1790-91). The UNC Application included a letter of support from Scott Levitan, CEO of the Research Triangle Foundation ("RTF"). (Jt. Ex. 4, p. 512). Mr. Levitan's letter indicated that the RTF supported the UNC Application; however, it did not make any reference to the property being rezoned or restrictive covenants being amended. (*Id.*; Hale, Vol. 2, pp. 280-82).

213. UNC was not required to submit the letter of support from Mr. Levitan or anyone else on behalf of RTF to be approvable. (Hale, Vol. 2, pp. 280-81; Carter, Vol. 10, p. 1791).

ii. UNC's Primary Site in the Research Triangle Park

214. The RTP is an approximately 7000-acre university research park located in Durham and Wake Counties, with 5,600 acres, or 80 percent, located in Durham County. (Levitan, Vol. 5, pp. 774, 799-800). There are currently no people living in the RTP. (*Id.* at 897).

215. Scott Levitan is the President and CEO of the Research Triangle Foundation ("RTF"), a position he has held for approximately five years. (*Id.* at 769). In this position, Mr. Levitan reports to the RTF Board, which includes representatives of UNC, Duke, NC State University, and North Carolina Central University. (*Id.* at 773-74).

216. The RTF is a 501(c)(4) entity founded approximately 63 years ago for the purpose of facilitating coordination among UNC, Duke, and NC State University and to enhance the wellbeing of the residents of North Carolina. (*Id.* at 769-70). The RTF administers the activities of the RTP Owners and Tenants Association ("O&T"). (*Id.* at 770). The RTF also owns certain property within the RTP. (*Id.*).

217. There are two types of zoning within the RTP: Science Research Park ("SRP") and Science Research Park – Commercial ("SRP-C"). (*Id.* at 777-78). SRP-C zoning is more lenient than SRP zoning but only covers 101 acres in RTP known as the RTP Hub, which is a mixed-use development intended to serve as a "town center" for RTP. (*Id.* at 780-81). The Hub includes Boxyard, a retail center containing food and retail vendors; Frontier, an innovation campus for startups and emerging companies; residential multi-family apartments; and other businesses not focused on scientific research. (*Id.* at 781, 829-31).

218. There are also restrictive covenants covering RTP that restrict the property to certain uses. (Jt. Ex. 1, pp. 191-255). According to Mr. Levitan, these restrictive covenants do not currently permit the development of a hospital at UNC's primary site. (Levitan, Vol. 5, p. 785).

219. The primary site for UNC Hospitals-RTP is adjacent to the RTP Hub. (*Id.* at 783-84). In the recent past, the RTF allowed a parcel of property adjacent to the RTP Hub to be rezoned from SRP to SRP-C to allow the development of a fire station in Durham County. The RTP also allowed a text amendment to the RTP restrictive covenants to allow a school on a particular parcel in Wake County. (*Id.* at 782-83, 895-96).

220. David Meyer is a 35-year resident of Durham County in addition to his healthcare planning expertise. Mr. Meyer opined that UNC's location adjacent to the RTP Hub made sense from a health planning perspective. He likened UNC Hospitals-RTP to REX Hospital's adjacency to Cameron Village in Raleigh, now known as the Village District, to support the notion that a hospital being adjacent to a multi-use district in the

midst of a highly populated area is sensible. (Meyer, Vol. 7, pp. 1274-76, Vol. 8, pp. 1389-91).

221. Initially, UNC explored purchasing a site owned by Keith Corp. within the RTP, but not adjacent to the RTP Hub, and having the site rezoned to allow UNC to build a hospital there. When approached by Keith Corp. about this proposal, Mr. Levitan was not comfortable setting a precedent of SRP-C zoning in areas other than the Hub; however, Mr. Levitan eventually suggested that UNC approach Highwoods about purchasing its property adjacent to the Hub. (Levitan, Vol. 5, pp. 832, 839-42).

222. Mr. Levitan discussed UNC using the Highwoods Site for its proposed hospital at a February 11, 2021, RTF Development Committee meeting. (Jt. Ex. 119; Levitan, Vol. 5, pp. 843-44). Following that meeting, Mr. Levitan emailed members of the RTF Development Committee who were not affiliated with either Duke or UNC and obtained their approval to continue cooperating with UNC's proposal. (Jt. Ex. 117; Levitan, Vol. 5, pp. 844-49).

223. In particular, RTF Board member Smedes York stated: "I believe this could be positive as it 'anchors' the location without changing the 'sizzle' of the Hub area. We need the 'personality' of Boxyard and other parts of what we have planned. Rex Hospital's previous location was adjacent to Cameron Village which was a positive." (Jt. Ex. 117).

224. To change the zoning of the primary site, UNC would need to seek approval for rezoning from Durham County and would also need to seek approval from the RTP O&T to amend the restrictive covenants. (Levitan, Vol. 5, p. 785, 798). To Mr. Levitan's knowledge, there has never been a healthcare facility like a hospital permitted in the RTP. (*Id.*).

225. Although the ultimate decision to allow the development of UNC Hospitals-RTP on the Highwoods Site is up to the RTP's O&T, Mr. Levitan has already begun the process of running the proposal through the relevant committees for a recommendation to the RTP's O&T. UNC's proposal was first brought before the RTF Development Committee. Mr. Levitan believed he "had the imprimatur of the Development Committee to continue conversations in support of the hospital application on the part of the foundation…." (*Id.* at 796-97). Based on this direction from the Development Committee, Mr. Levitan cooperated with UNC in its efforts to build a hospital within the RTP. (Jt. Exs. 15, 42; Levitan, Vol. 5, pp. 837-38).

226. Mr. Levitan did not discuss his letter of support with the RTF Board or Development Committee before signing it, as he is frequently asked to sign letters of support and does not generally bring those to the RTF Board or other committees for review. (Levitan, Vol. 5, p. 799).

227. Mr. Levitan gave conflicting testimony about whether he was aware Duke might be applying for the same need determined assets in Durham County as UNC. (*Compare* Levitan, Vol. 5, pp. 786-87 *with* pp. 822-23). Despite Mr. Levitan's apparent confusion, this Tribunal finds that Mr. Levitan appears to have been aware that Duke may have a conflicting interest with UNC's proposed hospital, based on his February 11, 2021 email to certain members of the RTF Development Committee. In this email, Mr. Levitan noted he was "[k]eeping conflicted folks out of the conversation"—i.e., people who were affiliated with either Duke or UNC—and sought their approval to recommend the Highwoods site to UNC. (*See* Jt. Ex. 119).

228. Mr. Levitan's Letter of Support indicated that the RTF supported UNC's Application; however, it did not make any reference to the property being rezoned or restrictive covenants being amended. (*Id.*; Hale, Vol. 2, pp. 280-82). At the time the letter was submitted, Mr. Levitan understood the letter would be used "as support for UNC's certificate of need application for a hospital in RTP." (Levitan, Vol. 5, pp. 790-92).

229. UNC reasonably believed its statements regarding the zoning of the primary site were accurate at the time UNC submitted its Application. In an email to Scott Selig and Tallman Trask, Levitan stated, "I think Duke is going to need to pursue its interests in this matter, but based on the direction from the DevComm meeting, we have cooperated with this initiative." (Jt. Ex. 42; Hale, Vol. 2, pp. 283-287). Similarly, in a May 20, 2021 meeting of the RTF Development Committee, the meeting minutes reflected that at a prior meeting, that "committee suggested to UNC that they could pursue extending the SRP-C zoning across the street if Highwoods was interested in selling their land." (Jt. Ex. 15; Hale, Vol. 2, pp. 287-88).

230. The Agency's Team Leader Ms. Hale did not review any documents prior to the Agency decision that suggested UNC would not be able to have the primary site rezoned or the restrictive covenants amended. (Hale, Vol. 2, p. 291).

231. On or about May 13, 2021, the Triangle Business Journal published an article discussing UNC's proposed new hospital in the RTP. (Jt. Ex. 130; Levitan, Vol. 5, p. 808). Following the publication of this article, Mr. Levitan was asked by the RTF Executive Committee to clarify his letter of support. (Levitan, Vol. 5, pp. 804, 816). The Executive Committee gave Mr. Levitan the language to include in his second letter verbatim. (Levitan, Vol. 5, pp. 808, 813-14, 827-28).

232. At the hearing and at his deposition, Mr. Levitan used the terms "clarify," "rescind," and "withdraw" interchangeably to mean the same thing. (Levitan, Vol. 5, p. 816). Given the text of the July 12, 2021 Letter and Mr. Levitan's testimony, the July 12, 2021 Letter was a clarification of the RTF's position on the UNC Application, rather than a rescission or withdrawal of support.

233. After the RTF Executive Committee decided a clarifying letter should be sent to the Agency, Mr. Levitan sent an email to the Agency stating that his letter of support, which he described as "an outdated correspondence" was included in the UNC Application. In that email, Mr. Levitan asked to speak with either Ms. Inman or Lisa Pittman, the Agency's Assistant Chief of Certificate of Need, regarding "the process and deadlines for submitting comment on UNC Health's application." (Duke Ex. 200; Hale, Vol. 3, pp. 332-33; Levitan, Vol. 5, pp. 810, 812-13).

234. Mr. Levitan subsequently spoke with Ms. Inman, who informed him that the deadline for submitting public comments to the CON Section had passed. Ms. Inman told Mr. Levitan he could still submit a letter and that she would "make every effort" to ensure it was seen by the CON Section. (Levitan, Vol. 5, p. 810).

235. After speaking with Ms. Inman, Mr. Levitan sent his second letter, dated July 12, 2021 to the Agency. (Jt. Ex. 46). Mr. Levitan submitted his July 12, 2021 letter to the Agency after the end of the public comment period in this Review. (Hale, Vol. 2, pp. 283, 308-09, 336). Mr. Levitan stated in the July 12, 2021 Letter, in relevant part, that he was "writing to clarify [his] prior letter dated 13 April 2021," and that "[u]ntil a certificate of need has been awarded and any appeals to the determination of the Healthcare Planning and Certificate of Need Section have been exhausted, RTF will not consider a zoning change for the proposed site in RTP." (Jt. Ex. 46; Levitan, Vol. 5, pp. 818-19).

236. In a September 3, 2021, letter to Jud Bowman, Chairman of the RTF Board, Vincent Price, President of Duke University, characterized Duke's position on the July 12, 2021 Letter as follows:

> [Mr. Levitan] then sent a follow up letter on July 12th to the State CON analyst stating that the Foundation would not consider a zoning change until after the CON determination and any appeals. This second letter is also deeply troubling. It did not withdraw the endorsement by RTF of UNC's application. It continued to support placing a hospital within the RTP. It was also provided outside the prescribed public comment period, so cannot by law be considered by the State; thus, its purpose is unclear to me.

(Jt. Ex. 25).

237. Though the Agency received Mr. Levitan's July 12, 2021 Letter, the Agency did not consider Mr. Levitan's second letter, and did not include the letter as part of the Agency File because the letter was submitted after the end of the public comment period. (Jt. Ex. 91; Hale, Vol. 1, pp. 177-78, 308-09, 336, 339). Mr. Levitan advised the RTF Executive Committee that he had submitted the clarifying letter and that it was submitted outside the public comment period. (Levitan, Vol. 5, pp. 814-15).

238. At the hearing, Mr. Levitan opined that UNC's description on page 115 of the UNC Application regarding the zoning of the primary site was accurate. (*Id.* at pp. 833-38).

iii. Issues Raised by Duke Regarding UNC's Proposed Sites

239. Duke's Comments raised issues regarding UNC's primary site and pointed to UNC's statement that rezoning was needed. Duke indicated that "the rezoning will require not only Durham County approval but also compliance with the applicable covenants and restrictions affecting Research Triangle Park to which the site is subject," and attached the RTP restrictive covenants to its comments. (Jt. Ex. 1, pp. 185, 191-255).

240. Duke had no knowledge or factual basis to support its comments regarding the UNC Application's primary site or conformity with Criterion (12).

241. Duke provided no expert testimony in support of its contention that the UNC Application was nonconforming with Criterion 12. (Sandlin, Vol. 6, p. 955).

242. Catharine Cummer was the only fact witness Duke called in its case. Ms. Cummer serves dual roles as regulatory counsel and in strategic planning for Duke and has primary responsibility for ensuring the preparation of all CON applications submitted by Duke. (Cummer, Vol. 3, pp. 410-11). Ms. Cummer was not tendered or accepted as an expert witness in this case. Ms. Cummer has never been qualified as an expert witness in any kind of case. She has no expertise in finance, is not a clinician and has never served as a healthcare or certificate of need consultant. Ms. Cummer has never been employed as a project analyst or in any other capacity by the Agency. She has never served on the SHCC or its subcommittees. (Cummer, Vol. 4, pp. 579-82). Ms. Cummer is not on the Real Estate Development Committee or any other committee of the RTF Board. She is not a member of the RTF Board of Directors. (*Id.* at p. 647).

243. Duke included multiple pages of comments regarding the primary and alternative sites proposed by UNC and its conformity with Criterion 12. Duke also included a copy of the RTP Restrictive Covenants in its Comments against the UNC Application. (*Id.* at pp. 638-39; Jt. Ex. 1, pp. 191-255). Ms. Cummer was sent a copy of the RTP Restrictive Covenants from Dr. Monte Brown. (Cummer, Vol. 4, p. 645).

244. Duke relied heavily upon its Comments filed against the UNC project as a purported basis for alleging Agency error in this matter and argued that the Agency failed to appropriately consider its Comments, in particular those comments regarding Criterion 12. In its Comments, Duke alleged:

> Notably, the Board [Research Triangle Foundation Board] has historically denied all rezoning applications to allow for health care facilities. In fact,

> DUHS is informed and believes that UNC has previously asked for permission to put a healthcare facility on the RTP campus itself, which was denied.

(Jt. Ex. 1, p. 185).

245. Ms. Cummer was primarily responsible for the preparation of the Duke Comments regarding Criterion (12). On cross-examination, contrary to the above Comment, Ms. Cummer admitted she had no personal knowledge regarding any prior applications for rezoning related to healthcare facilities at the RTP and had no personal knowledge regarding what other applications, if any, had been submitted by UNC to the RTP. (Cummer, Vol. 4, pp. 646-49).

246. Instead, Ms. Cummer relied upon a discussion with Scott Selig, Vice President of Real Estate and Capital Assets for Duke University and a designated member of the Real Estate Development Committee of the RTF, for the factual basis of Duke's contentions in its Comments to the Agency. (Cummer, Vol. 4, pp. 646-47).

247. On cross-examination, Ms. Cummer's testimony was impeached by the following deposition testimony of Mr. Selig:

Question:	Okay. Well, regardless of who prepared it, there's a statement in here, right here it says, 'Notably, the board has historically denied all rezoning applications to allow for healthcare facilities.' Is that accurate?
Answer:	I have no idea.
Question:	Okay. Can you recall a time when the RTF board has denied rezoning for a healthcare facility?
Answer:	No.
Question:	Okay. The following sentence says, 'In fact, UNC has previously asked for permission to put a facility on the RTP campus itself, which was denied.' Is that accurate?
Answer:	I have no idea.
Question:	Do you know anything about UNC asking permission to put a facility on the RTP campus itself being denied?
Answer:	No.

(Jt. Ex. 157, p. 140; Cummer, Vol. 4, pp. 646-51). After such impeachment, Ms. Cummer agreed that she would defer to Mr. Selig's personal knowledge of such questions

regarding the history of the RTF and any submissions, approvals or denials made for zoning. (Cummer, Vol. 4, p. 652).

248. Ms. Cummer then testified that Dr. Monte Brown, Vice President of Administration for the Duke University Health System, had provided her with the factual basis for those representations made by Duke to the Agency. However, on cross-examination, Ms. Cummer's testimony was impeached with the following deposition testimony of Dr. Brown:

> Question: And with respect to the primary site in the RTP, why do you say that was not a viable site?
> Answer: Because we had always been told, the entire time I was here at Duke, that you can't put healthcare in the RTP.
> Question: Who had told you that?
> Answer: I don't know. It's kind of folklore. Scott [Selig], Tallman [Trask], my predecessor, we had always stayed out of it.

(Jt. Ex. 147, p. 39; Cummer, Vol. 4, p. 654). Ms. Cummer acknowledged that she did not speak with any other persons regarding the content of this section of the Comments. (Cummer, Vol. 4, p. 655).

249. At hearing, Dr. Brown could not recall the factual basis supporting Duke's contention in this regard. (Brown, Vol. 10, pp. 1630, 1634).

250. Despite Duke's comments opposing the proposed site for UNC Hospitals-RTP, Dr. Brown sent an email communication to other Duke representatives calling the UNC primary location a "prime location." (Jt. Ex. 12). Dr. Brown also sent an email stating that "DUHS honored the RTP rules and has purchased land at Page Road and Green Level Road to accomplish its goals outside the RTP. Had the RTP allowed for medical, we likely would have chosen differently." (Jt. Ex. 17).

251. Dr. Brown acknowledged he made no investigation or inquiry whether the zoning for the primary site proposed by UNC could be modified by the Durham County zoning authorities. (Brown, Vol. 10, p. 1633).

252. The unrefuted factual testimony from UNC established that there was no factual basis supporting Duke's contention that UNC had previously sought permission to put a healthcare facility on the RTP campus and was denied. In its Response to Comments, UNC disputed Duke's statements regarding UNC's primary site as UNC was "not aware of the Research Triangle Foundation Board purportedly historically denying all rezoning applications to allow for healthcare facilities[,]" nor was UNC "aware of any situation in which it asked for permission to put a healthcare facility on campus." (Jt. Ex. 1, p. 320). Ms. Hadar testified unequivocally, that UNC has *not* previously sought to put

a facility on the RTP campus prior to the UNC Hospitals-RTP Application. (Hadar, Vol. 8, p. 1467).

253. Moreover, Ms. Hale's testimony established that a project analyst may, but is not required to, research information outside of the application to understand what is contained in an application. (Hale, Vol. 1, p. 193). Ms. Hale was aware of the Agency doing such additional research in one other review—the 2016 Wake County MRI Review. (Hale, Vol. 1, pp. 194-97). While zoning ordinances, real estate deeds, and restrictive covenants may be public documents that the Agency could locate and review, the Agency was not required to do so and did not feel the need to do so with respect to UNC's primary site. (Hale, Vol. 1, pp. 197-98, Vol. 2, pp. 300-01). Further, the Agency does not request additional information from applicants who are involved in a competitive review. (Hale, Vol. 2, pp. 277-78).

iv. The Alternate Site Identified in the UNC Application

254. UNC also identified an alternate site for its proposed new hospital. (Jt. Ex. 4, p. 114, n. 30). The alternate site is located along Highway 70 in Durham County and would not require any rezoning. (*Id.* at 515-16). The alternate site is also close to power, water, and sewer services. (*Id.* at 516).

255. Duke raised concerns about UNC's alternate site in its Comments alleging the following: "However, that site has even more fundamental obstacles to development than the primary site. . . . The bigger issue, however, is that the alternate site will be rendered unavailable for the proposed use by a NCDOT highway project in planning stages. . . ." (Jt. Ex. 1, p. 186). For that reason, Duke took the position in its Comments that UNC's alternate site is not a viable possible location for UNC Hospitals-RTP. (Cummer, Vol. 4, p. 661).

256. By letter dated September 3, 2021, during the Agency's review of the UNC and Duke Applications, Dr. Vincent Price, President of Duke University, sent a four-page letter to the Chair of the Board of Directors for the Research Triangle Foundation, Jud Bowman ("Dr. Price Letter"). (Jt. Ex. 25). In his letter, Dr. Price aired several grievances regarding the UNC Hospitals-RTP project, its proposed primary site in the RTP, and the support letters from Mr. Levitan regarding the same. Dr. Price's Letter represented to the RTF that:

> It seems to me that the only cure for this highly concerning matter is for the Board to recuse itself going forward from any decision that relates to the CON application or eventual award, regardless of who is successful in the CON process. Note that UNC's application does include an alternate site that does not require RTF action that does not require RTF rezoning.

(*Id.* at 3).

257. Thus, while the Comments filed by Duke represent that the alternate site is "not viable," the Dr. Price letter to the RTF makes no reference to Duke's public position on the alternate site and implies that the alternate site is viable.

258. Duke attempted to distinguish its position in these two documents by claiming that it was merely pointing out that UNC had represented the alternate location to be viable and that the "alternate site has nothing to do with the Research Triangle Park or Research Triangle Foundation, so there would be nothing for the board to do as to the viability or not of an alternate site." (Cummer, Vol. 4, p. 668). Dr. Brown confirmed in his testimony that he did not discuss whether this representation by Dr. Price was inconsistent with the representations in Duke's Comments. (Brown, Vol. 10, p. 1645). Though it could cite no factual support for the same, Duke continued to stand by its Comments in Opposition. (*Id.* at 1652). Nonetheless, this answer did not explain why Dr. Price addressed UNC's alternate site at all if its existence was not relevant to the RTF.

259. Ms. Cummer, the author of the Comments, also reviewed and provided comments on a draft of Dr. Price's Letter prior to it being sent to the RTF (Cummer, Vol. 4, p. 666), and was therefore aware of the inconsistent representations made by Duke to the Agency regarding the alternate site and those made to the RTF regarding the same.

260. At hearing, Dr. Brown acknowledged that he provided the information in Duke's Comments about the proposed NCDOT highway project on UNC's alternate site. Yet, he also conceded that he did not investigate whether (1) the proposed alternate site had actually been acquired for the highway project or (2) whether there were any restrictions on what UNC could do with the alternate site property if it had not been acquired by NC DOT or if UNC had acquired the property. (Brown, Vol. 10, pp. 1635-36). Dr. Brown also testified that UNC admitted, in its application, that a highway project was planned for its alternate site. (*Id.* at p. 1635).

261. However, Mr. Carter clarified that the UNC Application provided information about the alternate site but did not speculate "as to the future of that parcel of land or how it may be used other than for a proposed hospital." (Carter, Vol. 10, p. 1792).

v. UNC Can Make a Material Compliance Request if it Ultimately Cannot Develop a Hospital at its Primary Site

262. A material compliance request is a letter to the Agency stating why the applicant cannot proceed with the project exactly as described in its application. (Hale, Vol. 2, pp. 247, 276-77; Meyer, Vol. 7, p. 1283). The applicant would include in its request the reasons why they could not develop the project at the site and identify an alternate site for the Agency to consider as a location for the assets awarded in the CON. (Hale, Vol. 2, pp. 247-48; Meyer, Vol. 7, p. 1283). Through this process, a modification in plans

can be deemed by the Agency to be in "material compliance" with the representations in the approved application.

263. The Agency routinely approves material compliance requests and has approved material compliance requests to develop projects at alternate sites. (Hale, Vol. 2, p. 248; Cummer, Vol. 4, pp. 680-81; Meyer, Vol. 7, p. 1283). For example, in 2018, Mr. Meyer assisted an ASC in making a material compliance request to the Agency seeking to develop its ASC in a location within Brunswick County at a different site. The Agency approved this request. (Jt. Ex. 100; Meyer, Vol. 7, pp. 1284-85).

264. Regardless of whether UNC develops UNC Hospitals-RTP at the primary site, UNC would be able to submit a material compliance request to the Agency to approve a new location for the facility. UNC could make a similar request if it ultimately was unable to have the primary site rezoned appropriately. (Meyer, Vol. 7, pp. 1285-86).

265. Notably, Duke itself experienced issues with a site identified in a 2018 CON application for ORs in Orange County. (*Id.* at p. 1286). The 2018 Orange County OR Review was a competitive review in which Duke and UNC both applied for 2 ORs in Orange County. (Cummer, Vol. 4, p. 681). The Agency ultimately awarded the CON to Duke, and UNC challenged this award in a contested case. (*Id.* at p. 681-82). Duke engaged Keystone Planning, Mr. Meyer's company, to develop Duke's application, and later serve as an expert witness, in that review. (Meyer, Vol. 7, pp. 1286-87).

266. In that review, Duke had leased a location on Sage Road, which location was approved by the Agency. However, during the course of the Agency's review of the application, Duke identified certain remediation and code issues that it believed made it financially more favorable for the project to be developed at a different location. In response, Duke determined that it could make a successful request for a material compliance determination to change the location. (Cummer, Vol. 4, pp. 685-88; Meyer, Vol. 7, pp. 1286-87).

267. Duke did not inform the Agency during the course of the review that it had identified potential issues with its proposed site. (Cummer, Vol. 4, p. 691). Because the original site was still available to Duke during the course of the review, the "information in the application that the site was available was correct." (*Id.* at p. 693). According to Ms. Cummer, "[s]o unless an[d] until we were interested in seeking a different site or doing anything else, there was nothing to inform the agency of." (*Id.*)

268. In both his expert report and deposition testimony in the 2018 Orange County OR Review, Mr. Meyer emphasized that the issues with Duke's ASC site in its CON application were immaterial, as Duke could submit a material compliance request, which the Agency routinely approves. (Jt. Exs. 101, 102; Meyer, Vol. 7, pp. 1287-89).

269. Ms. Cummer also cited to an occasion when Duke previously withdrew a CON application after learning it had relied upon incorrect and overstated data. She explained that the data error was so significant that it made the application infeasible as presented. (*Id.* at pp. 697-98).

270. Mr. Meyer's opinion concerning UNC's conformity with Criterion (12) and the ability of an approved applicant to submit a material compliance request in the event of site issues is consistent between this Review on behalf of UNC and the 2018 Orange County OR Review on behalf of Duke. (*Id.*).

271. Mr. Carter agreed with the Agency's conclusion that the UNC Application was conforming with Criterion (12), as UNC provided all information requested by the Agency for this Criterion. (Carter, Vol. 10, p. 1790). Mr. Carter opined that the Agency's analysis of this Criterion was consistent with the way the Agency has analyzed Criterion (12) in previous reviews. (*Id.* at 1792). Mr. Carter also opined that the specific location of UNC Hospitals-RTP was not material to UNC's demonstration of need for this project, but rather the location of the facility within the southern region of Durham. (Carter, Vol. 11, pp. 1982-83).

272. Ms. Sandlin offered no opinions with respect to UNC's conformity with Criterion (12). (Sandlin, Vol. 6, p. 955; *see also* Jt. Exs. 54, 146).

273. The Agency considered Duke's Comments in its analysis of UNC's conformity with Criterion (12). In its analysis of Criterion (12), the Agency noted "there is some question as to whether or not the first site can be rezoned for a hospital" and indicated it had reviewed Duke's Comments. (Jt. Ex. 1, pp. 1575-76; Meyer, Vol. 7, pp. 1280-81, Vol. 8, pp. 1393-94). The Agency was aware that the site has not yet been rezoned and that Duke questioned the possibility of rezoning the site. (*Id.*).

274. Ultimately, the Agency found that UNC had adequately explained its proposed project and its plans for accomplishing the required rezoning, such that it was conforming with Criterion (12). (Jt. Ex. 1, pp. 1575-76; Hale, Vol. 2, pp. 274-75).

I. Criterion (13)

275. Criterion (13)(c) requires an applicant to demonstrate 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." (N.C. Gen. Stat. § 131E-183(a)(13)(c); Jt. Ex. 1, p. 1582).

276. The Agency determined that the UNC Application was conforming with Criterion (13)(c). (Jt. Ex. 1, pp. 1582-84).

277. Duke offered no evidence or testimony to challenge UNC's conformity with Criterion (13)(c) and did not opine that UNC should have been found nonconforming with Criterion (13)(c).

278. Criterion (13)(d) requires 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." (N.C. Gen. Stat. § 131E-183(a)(13)(c); Jt. Ex. 1, pp. 1585-86).

279. The Agency determined that the UNC Application was conforming with Criterion (13)(d). (Jt. Ex. 1, pp. 1587-88).

280. Duke offered no evidence or testimony to challenge UNC's conformity with Criterion (13)(d) and did not opine that UNC should have been found nonconforming with Criterion (13)(d).

281. The Agency determined that the remaining subsections of Criterion (13) were not applicable to this review. (*Id.* at pp. 1578, 1581).

J. Criterion (14)

282. Criterion (14) provides that the "applicant shall demonstrate that the proposed health services accommodate the clinical needs of health professional training programs in the area, as applicable." (N.C. Gen. Stat. § 131E-183(a)(14); Jt. Ex. 1, p. 1589).

283. The Agency determined that the UNC Application was conforming with Criterion (14). (Jt. Ex. 1, pp. 1589-90).

284. Mr. Carter provided testimony that UNC was properly found conforming with Criterion (14). (Carter, Vol. 10, p. 1793). Duke offered no evidence or testimony to challenge UNC's conformity with Criterion (14) and did not opine that UNC should have been found nonconforming with Criterion (14).

K. Criterion (18a)

285. Criterion (18a) requires an applicant to

> 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.

(N.C. Gen. Stat. § 131E-183(a)(18a); Jt. Ex. 1, p. 1591; Carter, Vol. 10, p. 1795).

286. To find an application conforming with this Criterion, the Agency analyzes the effect the application would have on competition, if any, and whether it would have a positive or negative impact. (*Id.*; Hale, Vol. 2, pp. 249-50). This analysis differs from the Agency's analysis of the Competition/Patient Access to New Provider comparative factor discussed further herein, as it only looks at each applicant's effect on competition standing alone, rather than in comparison to other applicants. (Meyer, Vol. 8, p. 1408; Carter, Vol. 11, pp. 1987-89).

287. The UNC Application explained that it would enhance competition by introducing another choice of hospital within Durham County and that this competition would be cost effective, improve quality by introducing a new high quality healthcare provider in the county, and improve access by medically underserved groups through UNC's mandate to accept all citizens requiring medically necessary treatment as a state-owned hospital system. (Jt. Ex. 4, pp. 126-29; Carter, Vol. 10, pp. 1797-99).

288. The Agency found the UNC Application conforming with Criterion (18a) because UNC adequately described the positive effects UNC Hospitals-RTP would have on competition in the service area. (Jt. Ex. 1, p. 1596; Hale, Vol. 2, pp. 249-50).

289. Ms. Sandlin opined that the only basis for her opinion that the UNC Application was nonconforming with Criterion (18a) was her opinion that UNC was nonconforming with Criterion (3) and provided no independent basis for her opinion. (Sandlin, Vol. 6, pp. 1134-35). Thus, she acknowledged that if the UNC Application was properly determined to be conforming with Criterion (3), as the Agency found in this review, then Ms. Sandlin's opinion would be that UNC's application was also conforming with Criterion (18a). (*Id.* at p. 1135).

290. Mr. Meyer opined that the Agency correctly analyzed this Criterion. Mr. Meyer noted that this is an important Criterion because it goes directly to the basic principles of quality, access, and value that are the foundation of the 2021 SMFP. (Meyer, Vol. 7, p. 1290).

291. Mr. Meyer agreed with the Agency's finding that UNC was conforming with this Criterion. Moreover, he disagreed with Ms. Sandlin's opinion that the UNC Application was nonconforming with Criterion (18a) because it was nonconforming with Criteria (3) and (5). (*Id.* at pp. 1290-91).

292. Mr. Carter agreed that the Agency appropriately analyzed this Criterion consistently with its prior analyses. (Carter, Vol. 10, p. 1796, 1799).

L. Criterion (20)

293. Criterion (20) provides that "an applicant already involved in the provision of health services shall provide evidence that quality care has been provided in the past." (N.C. Gen. Stat. § 131E-183(a)(20); Jt. Ex. 1, p. 1601).

294. The Agency determined that the UNC Application was conforming with Criterion (20). (Jt. Ex. 1, pp.1601-02).

295. Mr. Carter agreed that the Agency properly found UNC conforming with Criterion (20). (Carter, Vol. 10, p. 1794). Duke offered no evidence or testimony to challenge UNC's conformity with Criterion (20) and did not opine that UNC should have been found nonconforming with Criterion (20).

M. Performance Standards

296. In addition to the statutory review criteria, the Agency also analyzed applications for their conformity with certain performance standards adopted by the Agency pursuant to N.C. Gen. Stat. § 131E-183(b). (Jt. Ex. 1, p. 1603; Meyer, Vol. 7, p. 1291). There were three sets of administrative rules applicable to the UNC Application in this Review. (Meyer, Vol. 7, pp. 1291-92).

i. Section .2100 Criteria and Standards for Surgical Services and Operating Rooms

297. The Performance Standards at 10A NCAC 14C .2103 require an "applicant proposing to increase the number of operating rooms (excluding dedicated C-section operating rooms) in a service area" to:

> [d]emonstrate the need for the number of proposed operating rooms in addition to the existing and approved operating rooms in the applicant's health system in the applicant's third full fiscal year following completion of the proposed project based on the Operating Room Need Methodology set forth in the 2018 State Medical Facilities Plan. The applicant is not required to use the population growth factor.

(*Id.* .2103(a)). The applicant must also "document the assumptions and provide data supporting the methodology used for each projection in this Rule." (*Id.* .2103(b)).

298. The Agency found UNC conforming with the performance standards for operating rooms because it "project[ed] sufficient surgical cases and hours to demonstrate the need for two additional ORs in the Durham County service area in the third full fiscal year following completion of the proposed project based on the Operating Room Need Methodology in the 2021 SMFP." (Jt. Ex. 1, p. 1604; Hale, Vol. 2, p. 251). The Agency incorporated its discussion regarding Criterion (3) into its discussion of this performance standard. (*Id.*).

299. Aside from Ms. Sandlin's rebuttal report (Jt. Ex. 146), Duke offered no evidence or testimony to challenge UNC's conformity with this performance standard and did not contend that UNC should have been found nonconforming with this performance standard. Ms. Sandlin opined that the only basis for her opinion that the UNC Application was nonconforming with this performance standard was her opinion that UNC was nonconforming with Criterion (3) and provided no independent basis for her opinion. (Jt. Ex. 146, p. 10).

300. Mr. Meyer opined that the Agency correctly analyzed this performance standard and properly found UNC conforming. (Meyer, Vol. 7, pp. 1292-93).

301. Mr. Carter agreed with the Agency finding UNC conforming to this performance standard. (Carter, Vol. 10, p. 1794).

ii. Section .2300 Criteria and Standards for Computed Tomography Equipment

302. The Performance Standards at 10A NCAC 14C .2303 requires an "applicant proposing to acquire a CT scanner" to demonstrate:

> (1) [e]ach fixed or mobile CT scanner to be acquired shall be projected to perform 5,100 HECT units annually in the third year of operation of the proposed equipment;
> (2) [e]ach existing fixed or mobile CT scanner which the applicant or a related entity owns a controlling interest in and is located in the applicant's CT service area shall have performed at least 5,100 HECT units in the 12-month period prior to submittal of the application; and
> (3) [e]ach existing and approved fixed or mobile CT scanner which the applicant or a related entity owns a controlling interest in and is located in the applicant's CT service area shall be projected to perform 5,100 HECT units annually in the third year of operation of the proposed equipment.

(Id.).[2]

[2] 10A NCAC 14C .2303 was repealed effective January 1, 2022 but was in effect at the time the Agency conducted this Review.

303. The Agency found UNC conforming with the performance standards for CT equipment because UNC projected to perform 11,530 HECT units in the third year of operation, more than twice what was required under .2300(a)(1). (Jt. Ex. 1, p. 1605; Hale, Vol. 2, p. 251; Meyer, Vol. 7, p. 1293). Moreover, the UNC Application was conforming with these performance standards because it did not have any existing CT equipment in the service area. (*Id.*).

304. Aside from Ms. Sandlin's rebuttal report (Jt. Ex. 146), Duke offered no evidence or testimony to challenge UNC's conformity with this performance standard and did not assert that UNC should have been found nonconforming with this performance standard. Ms. Sandlin opined that the only basis for her opinion that the UNC Application was nonconforming with this performance standard was her opinion that UNC was nonconforming with Criterion (3) and provided no independent basis for her opinion. (Jt. Ex. 146, p. 10).

305. Mr. Meyer opined that the Agency correctly analyzed this performance standard and properly found UNC conforming. (Meyer, Vol. 7, pp. 1293-94).

306. Mr. Carter agreed with the Agency finding UNC conforming to this performance standard. (Carter, Vol. 10, p. 1794).

iii. Section .3800 Criteria and Standards for Acute Care Beds

307. The Performance Standards at 10A NCAC 14C .3803 require an "applicant proposing to develop new acute care beds" to:

> [d]emonstrate that the projected average daily census (ADC) of the total number of licensed acute care beds proposed to be licensed within the service area, under common ownership with the applicant, divided by the total number of those licensed acute care beds is reasonably projected to be at least 66.7 percent when the projected ADC is less than 100 patients, 71.4 percent when the projected ADC is 100 to 200 patients, and 75.2 percent when the projected ADC is greater than 200 patients, in the third operating year following completion of the proposed project or in the year for which the need determination is identified in the State Medical Facilities Plan, whichever is later.

(*Id.* .3803(a)). An applicant must also "provide all assumptions and data used to develop the projections required in this rule and demonstrate that they support the projected inpatient utilization and average daily census." (*Id.* .3803(b)).

308. The Agency found UNC conforming with the performance standards for acute care beds because UNC "adequately demonstrate[d] that the projected utilization of the total number of licensed acute care beds proposed to be licensed within the service

area and which are owned by UNC Hospitals is reasonably projected to be at least 66.7 percent by the end of the third operating year following completion of the proposed project." (Jt. Ex. 1, p. 1606; Hale Vol. 2, pp. 251-52; Meyer, Vol. 7, p. 1294). The Agency incorporated its discussion regarding Criterion (3) into its discussion of this performance standard. (*Id.*).

309. Aside from Ms. Sandlin's rebuttal report (Jt. Ex. 146), Duke offered no evidence or testimony to challenge UNC's conformity with this performance standard and did not opine that UNC should have been found nonconforming with this performance standard. Ms. Sandlin opined that the only basis for her opinion that the UNC Application was nonconforming with this performance standard was her opinion that UNC was nonconforming with Criterion (3) and provided no independent basis for her opinion. (Jt. Ex. 146, p. 10).

310. Mr. Meyer opined that the Agency correctly analyzed this performance standard and properly found UNC conforming. (Meyer, Vol. 7, p. 1294).

311. Mr. Carter agreed with the Agency finding UNC conforming to this performance standard. (Carter, Vol. 10, p. 1794).

Duke and the Duke Beds and ORs Applications

Distribution of Existing Acute Care Bed and ORs in Durham County

312. All of the existing hospitals in Durham County are located in the City of Durham in the central part of the County, within five (5) miles of each other. (Cummer, Vol. 4, pp. 617, 619-20; Sandlin, Vol. 7, p. 1196; Jt. Ex. 1, p. 1609). There are no hospitals located south of the City of Durham in Durham County (Cummer, Vol. 4, p. 620; Hadar, Vol. 8, p. 1461), and no acute care beds in south Durham County. (Sandlin, Vol. 7, p. 1196).

313. As of the filing of its application, Duke owned or operated 1,364 of the existing 1,388 existing and approved acute care beds in Durham County, or 98.3%. (Jt. Ex. 1, p. 157; Cummer, Vol. 4, pp. 587-88). Duke Regional's acute care beds are considered to be assets of the Duke Health System under the SMFP's bed need methodology. (Cummer, Vol. 4, p. 631; Jt. Ex. 1, pp. 1610, 1622; Meyer, Vol. 5, p. 933).

314. At the time the Applications were filed in this case, there were 93 total existing and approved ORs in Durham County, 87 or approximately 94 percent of which were owned and/or operated by Duke. (Jt. Ex. 1, p. 454; Cummer, Vol. 4, p. 588). Of Duke's 87 ORs, 66 were located at DUH, 4 at Duke Arringdon, 4 at Davis Ambulatory Surgical Center and 13 at Duke Regional. (*Id.*) Thus, Duke owns or operates all but six existing and approved ORs in Durham County. (Cummer, Vol. 4, p. 589). Of the 87 ORs

in the Duke University Health System, there are still two ORs from a 2018 CON review that have not yet been developed or operationalized by Duke. (*Id.* at p. 620).

315. Notably, Duke Regional had a projected surplus of thirty-nine (39) acute care beds in the 2021 SMFP. (Cummer, Vol. 4, pp. 629-30; Jt. Ex. 1, p. 421). In fact, there has been a surplus of beds at Duke Regional for the last several years. (Cummer, Vol. 4, p. 630).

316. Nevertheless, Duke did not consider the possibility of relocating beds from Duke Regional to Duke University Hospital in order to alleviate any purported capacity constraints at DUH. (Cummer, Vol. 4, pp. 633-34). Duke is, however, familiar with the process for relocating assets within its system to different locations or different facilities. (Sandlin, Vol. 7, p. 1170).

317. Duke Regional offers tertiary level care services, including open heart surgery, for example, and some of its service offerings overlap with those of Duke University Hospital. (Cummer, Vol. 4, pp. 625-26).

Duke Applications

318. Ms. Cummer believes that Duke University Hospital/Duke University Health System has applied for all the need determinations that have arisen in Durham County for acute care beds or ORs during Ms. Cummer's ten years at Duke. (Cummer, Vol. 4, pp. 590, 615-16).

319. When Duke filed its application in the need determinations at issue in this case, 960 acute care beds were licensed and operational at Duke University Hospital, plus an additional 102 approved acute care beds. Of those additional 102 beds approved from prior projects, 88 were recently put into service and licensed, and fourteen were still in development and not projected to open until around the end of 2022. (Jt. Ex. 2, p. 29; Cummer, Vol. 3, pp. 445-46). In recent reviews, Duke was also approved to develop additional ORs in 2018, which resulted in an additional two ORs and three procedure rooms through settlement. (Jt. Ex. 3, p. 28).

320. Within Durham County, Duke operates DUH, a tertiary and quaternary referral center and academic medical center teaching hospital, and Duke Regional, a full-service tertiary hospital. (Jt. Ex. 2, p. 36; Jt. Ex. 4, p. 52). Duke describes Duke Regional as a community hospital. (Cummer, Vol. 4, p. 419).

321. Quaternary and tertiary hospitals are specialized facilities that offer higher acuity services compared to community hospitals. (Carter, Vol. 1, p. 1684).

322. Duke proposed adding 40 acute care beds and 2 ORs at Duke North Pavilion, part of DUH's facility, for a total of 1102 licensed beds and 69 ORs at DUH. (Jt. Ex. 2, p. 29; Jt. Ex. 3, p. 28).

323. Duke proposed to complete its beds project and have the acute care beds in service by 1 July 2025, only one year before UNC proposed to complete the UNC Hospitals-RTP facility and have those acute care beds operational. (Jt. Ex. 2, p. 90; Cummer, Vol. 4, pp. 614-15). Similarly, Duke proposed to complete its ORs project and have the two ORs in service by January 1, 2025, only one-and-one-half years before UNC proposed to complete the UNC Hospitals-RTP facility and have those ORs operational. (Jt. Ex. 3, p. 95; Cummer, Vol. 4, p. 615).

324. Dr. William Fulkerson, Executive Vice President of Duke University Health System, Inc. signed the certification page for both the Duke Beds and ORs Applications. (Jt. Ex. 2, p. 4; Jt. Ex. 3, p. 4). However, Duke presented no evidence to demonstrate that Dr. Fulkerson ever reviewed either of the Duke applications. While Ms. Cummer made the Duke Applications available to Dr. Fulkerson, she was unaware that he reviewed the Applications. Neither did Dr. Fulkerson ask Ms. Cummer any questions regarding the Applications. (Cummer, Vol. 4, pp. 673-75).

Analysis of the Duke Beds and Duke ORs Applications

325. At the hearing, UNC presented evidence regarding the Agency's analysis of the Duke Beds and ORs Applications' conformity with the statutory and regulatory review criteria.

326. Mr. Carter reviewed the Duke Applications, drafted a portion of UNC's Comments, and ultimately finalized UNC's Comments that were submitted to the Agency. At hearing, Mr. Carter described and explained UNC's Comments about the Duke Applications. (Carter, Vol. 10, p. 1800).

327. Ms. Sandlin was not involved in the preparation of the Duke Beds Application, and she did not verify the tables or numerical portions of the Duke Beds Application. (Sandlin, Vol. 6, pp. 1095-96).

328. Ms. Sandlin offered no opinions that the Agency made any errors in its representations concerning the Duke Beds Application or Duke ORs Application in the Agency Findings. (Sandlin, Vol 7, p. 1212).

A. Criterion (3) – Beds Application

329. The first issue UNC identified in its Comments was Duke's alleged failure to identify the population to be served under Criterion (3) due to inconsistencies between representations and data in the Duke Applications. (Carter, Vol. 10, pp. 1801-02).

330. Mr. Carter opined that the Duke Beds and ORs Applications "presented to the Agency a different patient population . . . that they projected to serve for the same services." (*Id.* at p. 1801). Based on this inconsistency between the Duke Applications, in Mr. Carter's opinion "there's no way to know which of the two, indeed either, is the accurate one." (*Id.*). Furthermore, the Duke Beds Application provided inconsistent information regarding the specific population to be served by the acute care beds. (*Id.* at p. 1802).

331. The Duke Applications both projected patient origin for DUH for the first three project years (2026-2028). (*Compare* Jt. Ex. 2, p. 33 *with* Jt. Ex. 3, p. 32). In the Duke Beds Application, the total population to be served in the third full fiscal year of the project is 1,493,237 patients, compared to 1,538,613 patients in the Duke ORs Application. (Jt. Ex. 2, p. 33; Jt. Ex. 3, p. 32; *see also* Jt. Ex. 1, pp. 111-12; Carter, Vol. 10, pp. 1803-04).[3]

332. Mr. Carter opined that Duke's inconsistency in total population projections between applications matters because (1) the Agency requires all applicants to provide accurate data and (2) the Agency relies on these numbers in its comparative review, including in the Scope of Services comparative factor. (Carter, Vol. 10, pp. 1804-05; *see also* Jt. Ex. 1, p. 1609).

333. There is a similar inconsistency elsewhere in the Duke Applications for the specific acute care beds proposed to be developed pursuant to the need determination in the 2021 SMFP. In the Duke Beds Application, Duke projects 42,330 patients to be served in inpatient beds at DUH in the third full fiscal year of the project. However, later Duke projects to serve only 40,788 in that same third full fiscal year of the project. (*Compare* Jt. Ex. 2, p. 32 *with* Jt. Ex. 2, p. 94; *see also* Jt. Ex. 1, p. 113; Carter, Vol. 10, pp. 1805-06).

334. In its Response to Comments, Duke stated that the table projecting utilization of inpatient beds in the first three fiscal years of the project on page 94 of the Duke Beds Application was correct, and that the projection on page 32 of the Duke Beds Application was incorrect. (Jt. Ex. 1, p. 357; Carter, Vol. 10, p. 1806). Mr. Carter opined that this was an admission by Duke that they failed to demonstrate the patient population they proposed to serve. (Carter, Vol. 10, pp. 1806-07). Mr. Carter opined that these inconsistencies are "clearly more than just a rounding error" or "typo for one year." (*Id.* at p. 1807). Mr. Carter further opined that this inconsistency in patient population causes the Duke Applications to be nonconforming with Criterion (3). (*Id.* at pp. 1809-10).

[3] The page numbers cited herein are the Bates-labeled pages from the filed exhibits.

335. The second issue UNC identified in its Comments was that Duke failed to demonstrate the reasonableness of its projections. (Jt. Ex. 1, p. 114; Carter, Vol. 10, p. 1810).

336. In the Duke Beds Application, Duke explained that "[d]ue to the impacts of COVID-19, DUH experienced declines in inpatient discharges in FY20 and FY21 compared to FY 2019," and therefore Duke projected that FY22 inpatient discharges would return to FY19 utilization levels. (Jt. Ex. 1, p. 116; Carter, Vol. 10, pp. 1810-11).

337. Mr. Carter did not quarrel with Duke's adjustment for COVID-19 in this regard; however, Mr. Carter found certain aspects of Duke's methodology inconsistent with this assumption. First, Duke claimed that it would apply a 1.5 percent and 1.0 percent CAGR for adult and pediatric inpatient discharges, respectively, which it claims was "conservative" compared to its 3.0 percent and 1.8 percent rate from FY17-19. (Jt. Ex. 1, p. 114; Carter, Vol. 10, p. 1811). However, Mr. Carter noted that Duke did not provide the calculations supporting this historical growth rate. (Carter, Vol. 10, pp. 1811-14; *see also* Jt. Ex. 2, pp. 94-95).

338. Second, and more troubling to Mr. Carter, Duke did not adjust its average length of stay to pre-COVID figures. (Carter, Vol. 10, pp. 1814-15). Based on data provided by Duke, Mr. Carter observed that DUH's average length of stay grew from 7.0 days in 2019 to 7.6 days in 2021, a growth of 7.7 percent. (*Id.*; Jt. Ex. 1, p. 114).

339. Mr. Carter reported that this overstatement in average length of stay results in an overstatement in the Duke Beds Application of projected acute care days at DUH of 23,123. (Carter, Vol. 10, pp. 1815-16). Mr. Carter calculated that without this overstatement, DUH would be able to serve the number of patient days they will have with approximately 84 *fewer* beds. (*Id.* at pp. 1816-18; Jt. Ex. 1, pp. 114-15).

340. Mr. Carter opined that even assuming Duke was not wrong to use its COVID-era average length of stay, awarding the 40 acute care beds in this Review to Duke would not make a material difference in its occupancy rate. (Carter, Vol. 10, pp. 1820-21).

341. Duke contended the demand and need determination was driven by Duke's specialized and quaternary services. While Duke repeatedly discussed its span of such services, it provided no evidence in its application or testimony to support this conclusion. (Cummer, Vol. 3, p. 471). Duke did not discuss any analysis of what services were driving the need for additional beds in Durham County. (Carter, Vol. 10, p. 1699; *see also* Jt. Ex. 2, pp. 33-38). Neither did Duke analyze the need based on level of acuity. (Carter, Vol. 10, p. 1729). Instead, Duke proposed to use the beds as general medical-surgical beds rather than for ICU or any other particular services. (*Id.* at pp. 1729-1730).

i. Duke's Petition to Eliminate a 67 Bed Need Determination in the 2022 SMFP

342. In July 2021, during the Agency's review of the subject Applications, Duke submitted a petition to the SHCC (the "Petition") seeking to eliminate a need determination for an additional 67 acute care beds that at the time, was proposed to be included in the 2022 SMFP. (Jt. Ex. 55; Cummer, Vol. 4, pp. 592-93). In support of its Petition, Duke stated:

> Based on its existing and historical volume and capacity as well as the additional capacity under development or review in the service area, Duke University Hospital (DUH), whose utilization is the sole engine of need for additional acute care bed capacity in the [*sic*] Durham County, believes that additional capacity is needed for Wake County patients, and that any additional bed need determinations in Durham County should be deferred.

(Jt. Ex. 55, p. 2). In so doing, Duke cited to its existing and historical volume as support for its Petition to eliminate another need for acute care beds in Durham County.

343. Duke represented to the SHCC that of the 130 acute care beds awarded in Durham County in the last five years, 124 were awarded to DUH and 6 to North Carolina Specialty Hospital "NCSH"). Of those 130 beds, DUH licensed and implemented 22 beds in 2019. An additional 88 beds were licensed effective 21 June 2021 and are now in the process of being put into service. (Cummer, Vol. 4, pp. 601-02). The remaining 20 awarded beds, 14 at DUH and 6 at NCSU, remain in development and have not been placed into service at the time of Duke's Petition for the 2022 SMFP. Duke concluded:

> Accordingly, there is significant capacity [108 acute care beds] that is either only recently put into service or is still in development. In addition to this new capacity, there is a pending review of applications to develop another 40 beds in the service area pursuant to the 2021 SMFP need determination. . . . **DUH would accordingly propose the elimination or deferral of any additional need determination in Durham County until the resulting utilization trends with this additional capacity are known.**

(Jt. Ex. 55, p. 2; Cummer, Vol. 4, pp. 601-02; Emphasis added).

344. Duke further represented that "adding to the inventory may lead to the unnecessary duplication of existing and approved services at least until the effects of the additional capacity are known." (Jt. Ex. 55, p. 4; Cummer, Vol. 4, pp. 603-04).

345. Though Duke attempted to explain the Petition as being relevant to the Triangle market as a whole, Ms. Cummer acknowledged that the "Triangle" is not a service area in the SMFP and need determinations are not calculated based on combining acute care bed services areas into regions like the Triangle. Rather, Wake County is its own service area for acute care beds, as is the Durham/Caswell service area. (Cummer, Vol. 4, pp. 595-96).

346. While Ms. Cummer attempted to portray Duke's Petition as "substituting" need determinations in one county for another, she acknowledged there is no requirement that a petition propose to substitute need determinations and Duke could have instead asked that the SHCC add a need determination in Wake County for additional acute care beds. (*Id.* at pp. 597-98, 608).

347. Duke further acknowledged that despite its representations to the Agency in the Duke Beds Application and its testimony at the hearing, Duke did not include any discussion about its purported lack of capacity or capacity constraints or operational challenges at DUH—cited in support of the Duke Beds Application—in the Petition seeking to eliminate the opportunity for additional acute care bed capacity in Durham County. (*Id.* at pp. 606-07, 610).

B. Criterion (3) – ORs Application

348. Mr. Carter also expressed opinions regarding Criterion (3) as it relates to the Duke ORs Application. First, Mr. Carter noted that the inconsistencies between the Duke Beds and ORs Applications regarding patient origin for DUH equates to a failure by Duke to identify the population to be served as required by Criterion (3). (Carter, Vol. 10, pp. 1821-22; Jt. Ex. 1, pp. 119-20).

349. Second, Mr. Carter opined that the utilization projections in the Duke ORs Application were unreasonable. (Carter, Vol. 10, p. 1822). Duke chose to annualize its FY2020 surgical cases based on eight months of data: July 2019 through February 2020. (Jt. Ex. 1, p. 120; Carter, Vol. 10, pp. 1824-25). Mr. Carter observed that this was not reasonable because (1) impacts from COVID-19 began in March 2020, and (2) Duke had the data for the full FY2020 when it submitted the Duke ORs Application and therefore, did not need to annualize FY2020 surgical cases based on eight months of data. (Carter, Vol. 10, pp. 1823-24; *see also* Carter, Vol. 11, pp. 1958-61).

350. As a result of this annualization of FY2020 surgical cases, the Duke ORs Application had an inflated growth rate of 1.7 percent for inpatient cases, 2.9 percent for outpatient cases, or a combined growth rate of 2.4 percent. This is higher than DUH's historical growth rate. (Carter, Vol. 10, pp. 1825-26; Jt. Ex. 1, p. 121).

351. Mr. Carter clarified that Duke had reported its FY2020 data to Truven and on its license renewal application prior to filing the Duke ORs Application. (Carter, Vol. 10, p. 1827).

352. Mr. Carter opined that while he could not speak to Duke's specific intent in failing to use the actual FY2020 data, the result of using inflated data was inflated projections. (Carter, Vol. 10, pp. 1827-28). Comparing the annualized FY2020 surgical cases used in the Duke ORs Application to the actual FY2020 surgical cases, Duke actually had 9.5% fewer surgical cases, or 6,845 cases less, than the annualized FY2020 data. (Carter, Vol. 10, pp. 1828-29; Jt. Ex. 1, p. 122).

353. Due to these inflated figures, Mr. Carter opined that Duke was not conforming with either Criterion (3) or the performance standards in this Review. (Carter, Vol. 10, pp. 1829-30).

354. Mr. Carter also disagreed with Duke's statements in its application that its OR volume had recovered since COVID, noting that annualized data from April through September 2020 revealed Duke's surgical cases to be 22 percent below its annualized FY2020 volume. (Carter, Vol. 10, pp. 1830-31; Jt. Ex. 1, pp. 123-24).

i. Duke's Proposal to Replace Three Procedure Rooms with Two ORs

355. Procedure rooms are unregulated rooms where non-surgical, minor-surgical, and potentially major-surgical procedures can be performed, depending upon how the room is designed and upfit with equipment. At the time of the Duke ORs Application, Duke had two ORs and three procedure rooms that had been approved but were not operational yet. (Sandlin, Vol. 6, pp. 1100-01). In the Duke ORs Application, Duke proposed to replace the three approved procedure rooms with two ORs and a storage room. (Jt. Ex. 1, pp. 127-29; Carter, Vol. 11, pp. 1857-58).

356. Mr. Carter opined that Duke failed to demonstrate why the 3 previously-approved procedure rooms would be insufficient to perform Duke's projected surgical cases going forward. Moreover, Duke proposed to actually downsize their capacity from 3 procedure rooms to 2 ORs. (Carter, Vol. 11, p. 1859). Based on this, Mr. Carter opined that Duke failed to demonstrate need for the ORs as required by Criterion (3), failed to demonstrate the reasonableness of its project and conformity with Policy GEN-3 as required by Criterion (1), and failed to demonstrate that its project was based on reasonable assumptions as required by Criterion (12). (*Id.* at pp. 1859-60).

357. Mr. Carter supported his opinion by noting that the Agency found the Southpoint Surgery Center application to develop ORs for surgical cases nonconforming because it proposed to shift cases that would be performed in procedure rooms to operating rooms—the same thing Duke proposes here. (*Id.* at pp. 1860-61).

358. Mr. Carter elaborated that Duke's proposal to change the scope of its previously-approved project was not itself problematic. Instead, Duke's error was in failing to demonstrate why it needed operating rooms instead of procedure rooms. (*Id.* at pp. 1861-62). Mr. Carter noted that the ORs Duke proposed to develop were located in dedicated ambulatory surgical space, not shared operating rooms with inpatient surgeries. Yet, Duke failed to demonstrate why the procedure rooms could not be just as effective or adequate as the ORs to perform ambulatory surgeries going forward. As a result, Duke failed to demonstrate why they needed to develop operating rooms in place of the procedure rooms to perform those particular cases. (*Id.* at pp. 1862-1863).

359. Based on his observations and opinions, Mr. Carter concluded that the Agency erred in finding the Duke Beds and ORs Applications conforming with Criteria (1), (3), (6), (12), and (18a). (*Id.* at pp. 1864-67).

C. Criterion (5) – Beds Application

360. In UNC's Comments, UNC noted that the Duke Beds Application shows two different columns of data on a table of historical and interim revenues and net income with different financial results for FY2023. (Jt. Ex. 1, p. 116; Jt. Ex. 2, p. 99; Carter, Vol. 11, pp. 1839-41). Duke explained in its Response to Comments that this was merely a typo, and that the last column on page 99 of the Duke Beds Application should have ended with 6/30/2024. (Jt. Ex. 1, pp. 359, 370; Carter, Vol. 11, pp. 1842-43). Mr. Carter did not opine that this typo caused Duke to be nonconforming with Criterion (5). (Carter, Vol. 11, pp. 1842-43).

361. Mr. Carter did opine, however, that Duke did not provide projected net revenues upon project completion for the third full project year, ending June 30, 2028, despite providing projected operating costs for the third full project year. (*Compare* Jt. Ex. 2, p. 100 *with* Jt. Ex. 2, pp. 103-04; *see also* Carter, Vol. 11, pp. 1843-45).

362. Mr. Carter opined that Duke's failure to provide projected net revenues for the third full project year means it did not provide all the information requested on the application form, making the Duke Beds Application nonconforming with Criterion (5) in his opinion. (Carter, Vol. 11, pp. 1845-46).

363. More importantly, Mr. Carter explained that as a result of this missing information, Duke loses money on the proposed acute care beds in all three project years. While this is not disqualifying on its own, Mr. Carter noted that the absence of projected revenues in the third project year means that Duke did not demonstrate that it had sufficient income to offset the losses projected for the third project year. (*Id.* at pp. 1846-48).

364. In its Response to Comments, Duke acknowledged its error, but stated that Duke's ability to offset the losses are adequately supported by the systemwide audited

financial statements and the documentation of financial commitment to the project by Duke's Chief Financial Officer. (Jt. Ex. 1, p. 359).

365. Mr. Carter responded that the Agency could not rely on Duke's assets in reserves because Duke has many capital-intensive projects going on in Durham County and elsewhere, and while he does not know if Duke would use those accumulated reserves by the last project year, the Agency likewise does not know, and it was Duke's obligation to provide this information in its applications. (Carter, Vol. 11, pp. 1922-24). Mr. Carter opined that the Agency would be committing error by treating applicants unequally if it allowed Duke to still be found conforming despite omitting information requested in the application form. (*Id.* at pp. 1848-49, 1919-21).

366. The Agency findings stated that Duke's "Form F.2b incorrectly shows the project years as FY2025, FY2026, and FY2027, respectively." (Jt. Ex. 1, p. 1551). However, Mr. Carter opined that based on his observations and Duke's Response to Comments, the Agency was incorrect, and Duke actually omitted the FY2028 projected revenues. (Carter, Vol. 11, pp. 1850-52).

D. Criterion (5) – ORs Application

367. Mr. Carter opined that the Duke ORs Application suffers from the same issue regarding Criterion (5) as the Duke Beds Application, because the system income statement is identical to what was included in the Duke Beds Application. (Carter, Vol. 11, pp. 1852-55; Jt. Ex. 3, pp. 132-33, 136-37, 142).

368. Based on these shared errors, Mr. Carter also opined that the Duke ORs Application was nonconforming with Criterion (5), and that the Agency erred in finding the Duke ORs Application conforming with this Criterion. (Carter, Vol. 11, pp. 1855-56).

369. Duke's expert witness Ms. Sandlin did not prepare Duke's Response to Comments under Criterion 5 and offered no independent opinions on the Response to UNC's Comments. (Sandlin, Vol. 6, pp. 1092-93).

E. Criterion (9)

370. Criterion (9) requires:

> 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.

(Jt. Ex. 1, p. 1573).

371. The Agency found this Criterion was inapplicable in this Review because:

> None of the applications include projections to provide the proposed services to a substantial number of persons residing in Health Service Areas (HSAs) that are not adjacent to the HSA in which the services will be offered. [or] include projections to provide the proposed services to a substantial number of persons residing in other states that are not adjacent to the North Carolina County in which the services will be offered.

(*Id.*).

372. At hearing, Ms. Hale acknowledged that there is no statutory or regulatory definition of the term "substantial portion of the project's services" in this context, and the Agency does not have a threshold percentage it uses to determine what is "substantial." (Hale, Vol. 2, pp. 263-264).

373. In Mr. Carter's opinion, it is "concerning" that the Agency lacks a definition for "substantial" in this context. (Id. at pp. 1530-31).

374. In the Duke Beds and ORs Applications, Duke projected that approximately one-third of adult inpatients would come from areas besides Durham County or adjacent HSAs. (Jt. Ex. 2, p. 71; Jt. Ex. 3, p. 74; Hale, Vol. 2, pp. 264-265; Carter, Vol. 8, p. 1526).

375. Duke acknowledged approximately one-third of its total patient origin for acute care services accounts for a significant portion of its patient origin. (Cummer, Vol. 4, p. 622). Similarly, Duke acknowledged that less than one-fourth of its total patient population accounts for a substantial and significant portion of Duke's patient population. (*Id.* at p. 623).

376. While Mr. Carter noted that he had not seen agency findings within the last 20 years that found an applicant nonconforming with Criterion (9), he also noted that there are very few facilities that have the high patient origin percentage from outside their HSA or adjacent HSAs as Duke. (Carter, Vol. 8, p. 1528). For that reason, Carter opined that the Agency should have analyzed this Criterion for the Duke Applications and found Duke nonconforming. (Carter, Vol. 8, pp. 1525-26; Jt. Ex. 72, pp. 1, 5).

377. Mr. Carter also noted that in the 2008 Carteret County Adult Care Home Beds Review, the Agency analyzed Criterion (9), and the applicant provided much more detailed information explaining why it needed to serve patient population outside of the HSA or adjacent HSAs based on the facility's mission to serve merchant mariners based on a trust providing financial support for the facility. (*Id.* at pp. 1526-28; *see also* Jt. Ex. 73).

Duke's Substantial Prejudice

378. When the applications at issue were submitted, Duke operated 1,364 of the 1,388 existing and approved acute care beds in the Durham/Caswell service area, or 98%. (Jt. Ex. 1B, pp. 1609-10).

379. The Agency's approval of the UNC Hospitals-RTP Application to develop 40 acute care beds would result in Duke operating 1,364 of the 1,428 existing and approved acute care beds in the Durham/Caswell service area, or 96%, and UNC would operate 2.8%. (Jt. Ex. 1B, p. 1610).

380. When the applications at issue in this case were submitted, Duke operated 87 of the 93 existing and approved operating rooms in Durham County, or 94%. (Jt. Ex. 1B, pp. 1620, 1622).

381. The Agency's approval of the UNC Hospitals-RTP Application to develop 2 operating rooms (and the Duke Arringdon application to develop 2 operating rooms) would result in Duke operating 89 of the 97 existing and approved operating rooms in Durham County, or 92%, and UNC would operate 2.1%.

382. As noted above, after submission of the applications at issue, but prior to the Agency's decision, Duke submitted a Petition to the SHCC in July 2021 requesting the SHCC eliminate the need determination for 67 additional acute care beds in the Durham/Caswell service area that was proposed to be included in the 2022 SMFP. (Jt. Ex. 55, p. 1; Cummer, Vol. 4, pp. 592-93). In that Petition, Duke stated:

> Based on its existing and historical volume and capacity as well as the additional capacity under development or review in the service area, Duke University Hospital (DUH), whose utilization is the sole engine of need for additional acute care bed capacity in Durham County, believes that additional capacity is needed for Wake County patients, and that any additional bed need determinations in Durham County should be deferred.

(Jt. Ex. 55, p. 2; Cummer, Vol. 4, p. 597).

383. At hearing, Ms. Cummer credibly testified that in Duke's Petition to the SHCC, Duke was presenting an alternative way for the SHCC to "increase bed capacity for Wake County without being concerned about a proliferation of bed capacity in the Triangle (Durham, Orange, and Wake counties collectively) more broadly." That is, Duke's suggestion was not "intended as a standalone petition to decrease the need for bed capacity in Durham/Caswell County." Instead, it was a "packaged proposal to address bed need through the Triangle, given that the Triangle is a region that tends to have patients that aren't strictly bound by the counties from which they seek healthcare." (Cummer, Vol.4, pp. 594-595).

384. "Bed capacity management' at Duke is the process of ensuring there are physical operational beds available to accommodate necessary patient flow. "Patient flow" is the term for moving patients through their care encounter at Duke, from admission through procedures to a bed, if the individual is admitted as an inpatient, and then ultimately to discharge. It's physically moving patients through the hospital to get the care they need. (Cummer, Vol. 4, pp. 535-36)

385. Limited bed capacity impacts or limits Duke's ability to accept admissions that are not emergent, to accept transfers from other facilities, to move individuals from the emergency department into a bed, and to move individuals undergoing inpatient surgical procedures from the operating room into a bed following a procedure to receive inpatient care. (Cummer, Vol. 4, p. 536)

386. Lack of bed capacity impacts inpatient surgeries as the patient, after surgery, must remain in the post-acute care unit ("PACU") if there isn't an available bed in the unit, he/she needs. That is, the patient must remain in the PACU until there is a licensed inpatient bed available. If the PACU becomes full, then other surgeries are delayed because a surgery cannot start until there is space in the PACU to move other patients following their surgeries. (Cummer, Vol. 4, pp. 537-38)

387. Lack of bed capacity also impacts staff morale and affects overtime. Regarding surgery, delays in surgery starts due to bed limitations have caused significant staff dissatisfaction at Duke within the operating room environment. The delays cause increases in the length of workdays and are not predictable. This in turn increases staff stress and morale. (Cummer, Vol. 4, p. 542)

388. An OR hold is the time a patient spends in the OR in a hold designation to when they leave the OR. A patient may be in a hold designation if they are waiting for a surgery to start or waiting in the OR after surgery for an available spot in the PACU. From April 2021 to March 2022, there were over 2,600 patients at Duke who had experienced an OR hold. In addition, from April 2021 to March 2022, there were 9,900 patients at Duke who experienced a hold in the PACU. (Cummer, Vol. 4, pp. 547-555) (Duke Ex. 213).

389. Annually, Duke receives approximately 10,000-12,000 transfer requests. From April 2021 to March 2022, there were 3,517 patients who were eligible for transfer from other facilities; that is, determined to be clinically appropriate for transfer and would benefit from transfer but whom Duke University Hospital was not able to admit because of capacity constraints. 344 of the 3,517 patients were transfers from UNC facilities. (Cummer, Vol. 4, pp. 555-64) (Duke Ex. 222 and 223).

390. Duke measures the time in hours between when a patient is accepted from transfer to when a bed is assigned to that patient and calls this measurement an "Average

Accept to Bed Assign." Over the past five years, excluding a slight dip in 2020 due to the COVID pandemic, there has been a steady increase in the "Average Accept to Bed Assign" time at Duke. This increase is attributed to capacity constraints at Duke. (Cummer, Vol. 4, pp. 564-67) (Duke Ex. 224).

391. "Boarding census" means the average number of patients at any point in time who have been on a boarding status in the emergency department for two or more hours. This represents the average daily census of patients at Duke who wait in the Emergency Department for two or more hours after the decision to admit the patient has been made.

392. From April 2021 to March 2022, Duke experienced an increase in the number of patients who have to remain in the ED after a decision to admit is made because the patient is waiting for an available bed. The increase in average boarding census impacts the length of stay for patients who are waiting for an inpatient bed but also correlates to a longer length of stay for ED patients who are only seeking care in the ED and are not being admitted. (Cummer, Vol. 4, pp. 567-73) (Duke Ex. 225 and 226).

393. At hearing, UNC stipulated that Duke was substantially prejudiced by the denial of its competitive application by virtue of Duke's status as an applicant in a competitive review seeking approval for assets limited by a need determination in the SMFP.

394. The Agency did not stipulate to Duke's alleged substantial prejudice.

395. The evidence described above proved that the denial of Dukes' Applications for acute care beds and operating rooms has a significant impact on Duke's operations because the denial restricts Duke's capacity to provide services.

Comparative Analyses

396. The Agency conducts a Comparative Analysis of the applications in a competitive CON review to determine which of the applications will be awarded the need determined assets. (Jt. Ex. 1, pp. 1608, 1618; Hale, Vol. 1, pp. 114, 127; Meyer, Vol. 7, pp. 1295-96).

397. The Agency conducted two comparative analyses in this Review: one for applications seeking to develop ORs, and one for applications seeking to develop acute care beds. (*Id.*).

398. There is no statute or rule requiring the Agency to use particular comparative factors in a competitive review. (Hale, Vol. 1, pp. 128-30). Ms. Sandlin agreed that the Agency has the discretion to choose those factors that it utilizes in a comparative analysis for a competitive review. (Sandlin, Vol. 6, p. 1136).

399. The Project Analyst for a particular review selects the competitive factors he or she will use, which is drawn from a list of suggested comparative factors along with comparative factors recently used in similar reviews. (Hale, Vol. 1, pp. 128-30). Ms. Inman selected the comparative factors to be used in this Review. (Hale, Vol. 1, pp. 128-30, Vol. 2, p. 252).

400. In this review, the Agency utilized each of the comparative factors included by Duke in its Comments in its Agency Findings. (Cummer, Vol. 4, p. 636).

401. As the Co-Signer, Ms. Hale also had the authority to add or remove comparative factors used in this Review; however, she did not do so after Ms. Inman initially selected the factors that were used in this Review. (Hale, Vol. 2, p. 252).

402. The Agency used the same comparative factors for both the bed applications and the OR applications. (Jt. Ex. 1, pp. 1615, 1626). Mr. Meyer opined that the Agency selected appropriate comparative factors to be used in this Review. (Meyer, Vol. 7, p. 1296). Duke's expert, Ms. Sandlin, agreed that the Agency selected appropriate comparative factors in this analysis. (Sandlin, Vol. 6, p. 1054).

403. The eleven comparative factors used in the beds and ORs comparative analyses include:

a. Conformity with Review Criteria
b. Scope of Services
c. Geographic Accessibility
d. Historical Utilization
e. Competition/Access to New Provider
f. Access by Service Area Residents
g. Access by Underserved Groups: Projected Charity Care
h. Access by Underserved Groups: Projected Medicare
i. Access by Underserved Groups: Projected Medicaid
j. Projected Average Net Revenue per Case
k. Projected Average Operating Expense per Case

(Jt. Ex. 1, pp. 1615, 1628). The ORs comparative analysis also analyzed a twelfth factor, Patient Access to Lower Cost Surgical Services. (*Id.* at p. 1628).

404. The comparative factors used by the Agency in this Review were identical to the comparative factors analyzed by Duke in its Comments. (*Compare* Jt. Ex. 1, pp. 1615, 1628 *with* Jt. Ex. 1, pp. 155, 163; *see also* Hale, Vol. 2, pp. 279-80; Meyer, Vol. 7, p. 1296).

405. The Agency determined both the UNC Application and the Duke ORs Application were less effective under this factor. This factor therefore was not determinative of whether the Agency awarded the ORs to UNC or Duke. (Jt. Ex. 1, p. 1621; *see also* Carter, Vol. 11, p. 1887).

406. To determine the approved application, the Agency analyzes which of the applicants are more effective as to each comparative factor, and then tallies the number of comparative factors for which each applicant was more effective. The applicant with the greatest number of factors for which it is "more effective" is the approved applicant. (Hale, Vol. 1, pp. 131-32). The comparative factors are typically not weighted. (*Id.* at p. 131).

A. Conformity with Review Criteria

407. The Agency utilized the comparative factor of Conformity with Review Criteria in its comparative review of the UNC and Duke Applications. (Jt. Ex. 1, pp. 1608, 1618).

408. For this comparative factor, any application that conforms to all applicable review criteria is deemed "equally effective" or "more effective," and any application that does not conform to all applicable review criteria is deemed "less effective." (*See Id.* at pp. 1609, 1619).

409. The Agency found the UNC Application and both Duke Applications conforming with the applicable review criteria, and thus, equally effective under this comparative factor. (*Id.* at pp. 1609, 1619).

410. Ms. Sandlin opined that Duke should have been found comparatively superior due to alleged non-conformities in the UNC Application to certain review criteria. In contrast, Mr. Meyer agreed that the UNC Application was conforming with the review criteria, and therefore equally effective under this factor. Mr. Meyer did not issue an opinion whether Duke was conforming with the review criteria. (Sandlin, Vol. 6, pp. 1055-56; Meyer, Vol. 7, pp. 1297-98, 1330).

411. Mr. Carter disagreed with the Agency's analysis of this comparative factor only to the extent it found Duke conforming with the applicable review criteria. (Carter, Vol. 11, pp. 1868, 1885). Mr. Carter noted that he agreed that the Agency ultimately reached the correct conclusion in its comparative analysis for acute care beds, but he disagreed with the Agency's analysis of certain comparative factors. (*Id.* at pp. 1867-68).

B. Scope of Services

412. The Agency utilized the comparative factor of Scope of Services in its comparative review of the UNC and Duke Applications and found "[g]enerally, the

application proposing to provide the greatest scope of services is the more effective alternative…." (Jt. Ex. 1, pp. 1609, 1619).

413. Ms. Sandlin opined that the Agency properly found the Duke Beds Application to be comparatively superior to the UNC Application because UNC will offer a more limited scope of services than what is available at DUH. (Sandlin, Vol. 6, p. 1057).

414. In contrast, Mr. Carter opined that the Agency erred in the acute care beds comparative analysis by comparing the scope of services provided at DUH as a whole to those provided at UNC Hospitals-RTP as a whole, rather than the scope of services to be provided by the acute care beds at issue. (Carter, Vol. 11, pp. 1869-70, 1873-74).

415. In analyzing this factor in the acute care beds comparative analysis, the Agency compared the scope of services for the facilities as a whole. In other words, the Agency compared the services provided at DUH as a whole to those provided at UNC Hospitals-RTP as a whole. (Jt. Ex. 1, p. 1609; Hale, Vol. 2, pp. 292-93; Carter, Vol. 11, pp. 1869-70).

416. However, in analyzing this factor in the ORs comparative analysis, the Agency compared the proposed surgical services rather than the services provided by the facility as a whole. (Jt. Ex. 1, p. 1619; Hale, Vol. 2, p. 293; Carter, Vol. 11, p. 1870).

417. In the 2017 Durham County Acute Care Bed Review, the Agency utilized a comparative factor entitled "Patient Access to Broad Range of Medical and Surgical Specialties," which is similar to the Scope of Services comparative factor analyzed in this Review. (Jt. Ex. 1, p. 1160; Carter, Vol. 11, pp. 1870-71). In that review, the Agency compared the services proposed to be provided by the beds, rather than the facilities as a whole, resulting in the relatively small, specialized North Carolina Specialty Hospital being found "comparable" to DUH. The Agency included the findings for the 2017 Durham County Acute Bed Review findings in the Agency File in this Review. (Jt. Ex. 1, p. 1160; Carter, Vol. 11, pp. 1871-73).

418. Mr. Carter opined that had the Agency consistently interpreted this comparative factor to focus on the acute care beds, rather than the facilities as a whole, the UNC Application should have been found equally effective, and the factor should not have weighed in favor of Duke or UNC. (Carter, Vol. 11, pp. 1873-74).

419. While Mr. Carter disagreed with the Agency's analysis of this comparative factor for acute care beds, he agreed with the Agency's analysis of this comparative factor for ORs, as it properly compared the services to be provided by the applicants and found UNC and Duke equally effective alternatives. (*Id.* at pp. 1885-86).

C. Geographic Accessibility

420. The Agency utilized the comparative factor of Geographic Accessibility in its comparative analysis of the UNC and Duke Applications. (Jt. Ex. 1, pp. 1609, 1619).

421. In analyzing this comparative factor, the Agency looked at where each applicant proposes to place the proposed services. (Meyer, Vol. 7, p. 1299). An application placing the services at issue in a location where there are not any such services is deemed the more effective alternative under this factor. (Jt. Ex. 1, p. 253; Carter, Vol. 11, pp. 1874-75).

422. Ms. Sandlin opined that the Agency erred in its analysis of this comparative factor as having geographic dispersal of these need determined assets is not critical because Durham has less land mass than other counties in North Carolina. (Sandlin, Vol. 6, pp. 1058-67).

423. Mr. Meyer opined that this factor is important because it is related to access, a foundational principle of the CON Law. The CON Law seeks to avoid geographic maldistribution of services, and North Carolina has a "compelling interest in helping to ensure that all North Carolinians have access to … healthcare services[.]" (Meyer, Vol. 7, p. 1299).

424. In the acute care beds review, the Agency noted there were 1,388 existing and approved acute care beds in the Durham/Caswell County service area, all of which are located in the central area of Durham County, illustrated by the following table:

Facility	Total AC Beds	Address	Location
Duke University Hospital	1,048	2301 Erwin Rd, Durham 27710	Central Durham County
Duke Regional Hospital	316	3643 N. Roxboro Rd, Durham 27704	Central Durham County
North Carolina Specialty Hospital	24	3916 Ben Franklin Blvd, Durham 27704	Central Durham County

(Jt. Ex. 1, p. 1609; *see also* Meyer, Vol. 7, p. 1300).

425. Similarly, in the ORs review, the Agency noted that there were 93 existing and approved ORs in Durham County, the vast majority of which were concentrated in the central area of Durham County, illustrated by the following table:

Facility	Type	Durham SA OR System	Total ORs	Address	Location
NCSH	Existing Hospital	NCSH	4	3916 Ben Franklin Blvd, Durham 27704	Central Durham County
DUH	Existing Hospital	Duke	66	2301 Erwin Rd, Durham 27710	Central Durham County
DRH	Existing Hospital	Duke	13	3643 N. Roxboro Rd, Durham 27704	Central Durham County
DASC	Existing ASF	Duke	4	2400 Pratt St, Durham 27710	Central Durham County
Arringdon	Existing ASF	Duke	4	5601 Arringdon Park Dr, Morrisville 27560	South Durham, near I540 at I40
SSC	Approved ASF	NCSH	2	7810 NC Hwy 751, Durham 27713	South Durham, near Hwy 147
UNC-RTP	Proposed Hospital	UNC	2	Parcels in Research Triangle Park 27709	South Durham, just below I40

(Jt. Ex. 1, p. 1620).

426. For both the acute care beds and ORs comparative analyses, the Agency determined that the UNC Application was the more effective alternative, and Duke's Applications were the less effective alternatives for geographic accessibility. (Jt. Ex. 1, pp. 1609, 1620; Hale, Vol. 1, p. 188).

427. UNC proposed placing the acute care beds in this Review in the southern area of Durham County, where there were no existing acute care beds, while Duke proposed placing additional beds at DUH where there were already over one thousand existing or approved acute care beds. (Jt. Ex. 1, p. 1609; Hale, Vol. 1, p. 188). The Agency also found UNC Hospitals-RTP, Duke Arringdon, and Southpoint Surgery Center to be more effective because they "propose to develop ORs in South Durham County where there are currently only six of 93 existing/approved Durham County ORs[,]" as opposed to the Duke ORs Application which proposed placing additional ORs at DUH where there were already sixty-six existing and approved ORs. (Jt. Ex. 1, p. 1620).

428. Mr. Meyer agreed with the Agency's analysis of this comparative factor. (Meyer, Vol. 7, pp. 1299-1300, 1330-31). In the beds analysis, the existing facilities in Durham are concentrated in the center of the county. (Jt. Ex. 97, p. 11; Meyer, Vol. 7, p. 1301). Mr. Meyer analyzed the locations of hospitals in certain populous counties in North Carolina, including Wake, Mecklenburg, Guilford, and Forsyth counties, all of which have hospitals in the perimeter of the county and generally have good geographic dispersal of hospitals. (Jt. Ex. 103; Meyer, Vol. 7, pp. 1302-1305). His analysis showed that compared to these highly populated counties, Durham County as another highly populated county, "does not have an acute care hospital that's located anywhere but in the center of the county," (Meyer, Vol. 7, p. 1305).

429. Similarly, both Mr. Meyer and Mr. Carter observed that both the UNC Application and the Duke Arringdon application proposed to place ORs in south Durham County, and both were deemed the more effective alternative as to this comparative factor, which they agree was the correct decision. (Meyer, Vol. 7, pp. 1330-31; Carter, Vol. 11, pp. 1886-87).

430. While Durham County has relatively small land mass compared to other counties, Durham County is the third most densely populated county in the state, and such density leads to traffic congestion that can make geographic dispersion of healthcare facilities more important. (Meyer, Vol. 7, pp. 1306-07, 1309-10).

431. Ms. Sandlin produced two maps showing different amounts of population density in Durham County. In Sandlin's initial expert report, the map showing population density illustrated that UNC Hospitals-RTP would be located in a densely-populated area of the county where there are no existing hospitals. (Jt. Ex. 54, p. 12; Meyer, Vol. 7, p. 1309). However, in Sandlin's rebuttal report, the map showing population density illustrated there is no population in the zip code where UNC Hospitals-RTP would be located, but still showed that the surrounding zip codes are densely populated. (Jt. Ex. 212; Meyer, Vol. 7, pp. 1307-09).[4]

432. Mr. Meyer opined that despite the lack of population in UNC Hospitals-RTP's zip code, UNC's primary site is easily accessible by "the largest, most significant traffic arteries in that part of the county" such that residents in densely-populated southern Durham County would have easy access. (Meyer, Vol. 7, pp. 1308-09).

433. Mr. Carter likewise explained that the UNC Application illustrated that UNC Hospitals-RTP is located along prominent roadways in addition to being located near the heavily populated southern Durham zip codes. (Carter, Vol. 10, p. 1703; *see also* Jt. Ex. 4, pp. 51-58).

434. Ms. Sandlin also opined that UNC Hospitals-RTP is not near a majority of Durham County zip codes and that this does not improve geographic access for the majority of the service area zip codes. (Sandlin, Vol. 6, p. 1061).

435. In contradiction, Mr. Meyer noted that it is more important for a healthcare facility to be proximate to more people, rather than more zip codes. (Meyer, Vol. 7, p. 1310). The zip codes in southern Durham County which are near UNC Hospitals-RTP "comprise more than half of the population of Durham County." (Jt. Ex. 4, p. 55; Meyer, Vol. 7, p. 1310; Sandlin, Vol. 7, pp. 1205-06).

436. When looking at population rather than zip codes, UNC Hospitals-RTP was proximate to over half of the population of Durham County. (Meyer, Vol. 7, p. 1311-12).

437. Mr. Carter added that UNC Hospitals-RTP's primary site is "on the border of RTP" and is "near where a lot of people live." (Carter, Vol. 11, pp. 1904-05). He further opined that UNC Hospitals-RTP's location being in the southern region of Durham County

[4] Similarly, there is no population in the zip code that comprises DUH. (Jt. Ex. 4, p. 242; Sandlin, Vol. 7, p. 1201; Carter, Vol. 11, p. 1903).

improves access by providing another option for those residents. While some of those residents may still choose one of the existing facilities, they have another option that may be closer to where they live. (Carter, Vol. 10, p. 1733). Furthermore, compared to DUH, UNC Hospitals-RTP would be easier to find parking and navigate as a smaller facility. (*Id.* at pp. 1733-34).

438. The fact that DUH may be closer to some residents in Caswell County and northern Durham County does not change the Agency's analysis that UNC Hospitals-RTP enhances geographic accessibility. In Mr. Meyer's opinion:

> [R]esidents of northern Durham County are not going to be disadvantaged by this proposal. They will continue to have the same access to any of those existing acute care hospitals that they do currently. This doesn't take away from their access.

(Meyer, Vol. 7, pp. 1313-14). Instead, UNC's proposal "enhances access for south Durham County residents," which is where the greatest need exists for these services due to the population growth in that area. (*Id.* at p. 1314).

439. As a small hospital, "the intent is not to serve each and every patient within Durham County," because UNC Hospitals-RTP does not "have the capacity to do that." (Carter, Vol. 10, pp. 1703-04).

440. Ms. Sandlin testified that the Agency's analysis of this comparative factor was inconsistent with the way the Agency analyzed it in prior reviews. (Sandlin, Vol. 6, pp. 1045-46).

441. Mr. Meyer disagreed with Ms. Sandlin of the Agency's prior reviews. While he interpreted Ms. Sandlin's testimony as opining that the Agency needs to analyze geographic accessibility based on municipalities, Mr. Meyer noted that there is no rule requiring that. Moreover, analyzing geographic accessibility based on municipalities is impractical in Durham County, where there is only one incorporated municipality, the City of Durham. (Meyer, Vol. 7, pp. 1314-15). More importantly, the geographic accessibility comparative factor should look at where people live compared to the existing and proposed services. (*Id.* at 1315-16).

442. Likewise, Mr. Carter disagreed with Ms. Sandlin. In his opinion, the 2020 Forsyth Acute Care Beds Review mentioned by Ms. Sandlin was an inapt comparison, where the existing hospitals were more dispersed than the existing facilities within Durham that are contained in a five-mile radius. (Carter, Vol. 11, p. 1877)

443. Ms. Sandlin testified that UNC's analysis splitting Durham into different regions based on zip codes "seemed manufactured and illogical." (Sandlin, Vol. 6, p. 1017).

444. However, Ms. Sandlin's testimony ignores the fact that Duke itself, assisted by Keystone Planning while Ms. Sandlin was still with that company, analyzed geographic accessibility in this same "manufactured" manner in its 2018 application to develop the Duke Arringdon facility. In its 2018 application, Duke described the same four zip codes (27703, 27709, 27707 and 27713) as "South Durham" that UNC described as south Durham in its application in this Review. (*Compare* Jt. Ex. 106, p. 30 *with* Jt. Ex. 4, p. 54; *see also* Meyer, Vol. 7, pp. 1317-18; Sandlin, Vol. 6, pp. 1120-22).

445. Mr. Carter explained the process by which UNC determined to split Durham County into regions and concluded that UNC divided Durham County into three regions by zip codes so it could analyze where in the county a new hospital should be located, which the SMFP does not discuss in any detail. (Carter, Vol. 10, pp. 1704-06). Mr. Carter further opined that not all patients within the City of Durham were equally served by the existing hospitals due to the lack of available facilities in southern Durham. In other words, "there aren't enough facilities to serve residents in Durham County notwithstanding the fact that the municipality of Durham may go well into the southern part of the county." (*Id.* at p. 1708).

446. Ultimately, Mr. Meyer agreed with the Agency's analysis of this comparative factor, describing it as "an easy call for the Agency." (Meyer, Vol. 7, p. 1318).

447. Mr. Carter agreed that the Agency was correct in determining the UNC was the more effective alternative, and that it was consistent with other findings he has seen. (Carter, Vol. 11, pp. 1874, 1886). Mr. Carter further opined that he did not believe "the Agency's analysis or conclusions would have been any different if UNC had proposed a different site really anywhere else in the county that was not within five miles of another hospital." (*Id.* at p. 1877).

D. Historical Utilization

448. The Agency utilized the Historical Utilization comparative factor in its comparative analysis of the UNC and Duke Applications. (Jt. Ex. 1, pp. 1610, 1622). In this analysis, the Agency noted that "[g]enerally, the applicant with the higher historical utilization is the more effective alternative with regard to this comparative analysis factor." (*Id.*).

449. The Agency found this factor to be inconclusive in both reviews. In the acute care beds review, the Agency noted that because UNC Hospitals-RTP was not an existing facility, it did not have any historical utilization, and a comparison of historical utilization therefore "could not be effectively evaluated." (*Id.* at p. 1610).

450. Ms. Sandlin disagreed with the Agency's determination with respect to historical utilization in the comparative analysis and opined that the Agency should have

found the Duke Beds Application and the UNC Application could be compared by comparing DUH and UNC Hospitals-Chapel Hill, located in Orange County. (Sandlin, Vol. 6, pp. 1067-1068).

451. However, Ms. Sandlin acknowledged on cross-examination, that she had never seen a decision from the Agency where the Agency compared healthcare systems or components of health services where those services were not located within the same service area, as she had opined. In all cases, the Agency has compared an applicant's historical utilization for the service requested only within the same service area that is under review. (*Id.* at pp. 1146-47).

452. Mr. Carter disagreed with Ms. Sandlin, noting that the service areas set by the SHCC in the SMFP is determinative of where the Agency should focus its analysis. (Carter, Vol. 11, p. 1878). Mr. Carter had not seen the Agency look outside the SMFP-defined service area to compare the historical utilization of applicants. (*Id.* at p. 1879).

453. Moreover, Mr. Carter indicated that if the Agency were to look to UNC's facilities in other counties, it would also need to include facilities in Wake County as well, which raises questions of what other facilities should be included and whether that would be fair to the applicants, especially since UNC has facilities throughout the state. (*Id.* at pp. 1878-79). Ultimately, Mr. Carter agreed with the Agency's analysis of this comparative factor. (*Id.* at pp. 1878, 1887).

E. Competition (Patient Access to a New or Alternative Provider)

454. The Agency also utilized the Competition (Patient Access to a New or Alternative Provider) comparative factor in its comparative analysis of the UNC and Duke Applications. (Jt. Ex. 1, pp. 1610, 1622). Ms. Sandlin opined that the Agency's analysis of competition as a comparative factor was consistent with past Agency reviews and the analysis contained in Duke's Comments. She further noted that assuming UNC was conforming with all review criteria as determined by the Agency, then UNC would be appropriately deemed the comparatively superior applicant in this review, as determined by the Agency. (Sandlin, Vol. 6, p. 1150).

455. Mr. Meyer explained that this is an important comparative factor because the CON Law "encourages competition" to benefit consumers by encouraging providers to provide better services than their competitors. (Meyer, Vol. 7, p. 1319).

456. In this analysis, the Agency noted that "[g]enerally, the application proposing to increase competition and patient access to a new or alternative provider in the service area is the more effective alternative with regard to this comparative factor." (Jt. Ex. 1, p. 1622; *see also* Meyer, Vol. 7, p. 1322). The Agency's analysis of this factor did not examine competition for the services proposed to be offered by the applicants, but

rather, examined competition for the need determined assets, i.e., the beds and ORs at issue in this Review. (Hale, Vol. 2, pp. 310-13).

457. In analyzing this factor in the acute care beds review, the Agency noted that Duke "controls 1,364 of the 1,388 acute care beds in Durham County, or 98 percent." DUH alone "controls 75.5 percent of the acute care beds in Durham County." (Jt. Ex. 1, p. 1610; *see also* Meyer, Vol. 5, p. 933). If approved, Duke would control 98.3 percent of the acute care beds in Durham County, with "1,088 of the 1,428 existing and approved acute care beds in Durham County, or 76.2 percent" at DUH alone. (*Id.*). This is a "near monopoly" control of beds in Durham County. (Meyer, Vol. 7, p. 1320).

458. Similarly, Duke controls 87 of the 93 ORs in Durham County, or 93.5 percent. If all applications were approved as proposed, Duke would control 91 of 103 existing and approved ORs, or 88.3 percent. (Jt. Ex. 1, p. 1623; *see also* Meyer, Vol. 5, pp. 933, 1331-32).

459. Even with UNC being awarded the 40 beds and 2 ORs in this review, Duke still controls over 90 percent of the beds and ORs in Durham County. (Hale, Vol. 2, pp. 294-96).

460. Accordingly, the Agency found that UNC was the most effective alternative in both the beds and ORs reviews as it was a new entrant to the market providing patients with access to a new or alternative provider. (Jt. Ex. 1, pp. 1610, 1623; Hale, Vol. 1, pp. 190-91).

461. At the hearing, Ms. Hale agreed that when Ms. Inman selected the competition comparative factor, Ms. Inman was aware that UNC was a new entrant to the market and that Duke was an existing provider in the market. Ms. Hale agreed that Ms. Inman would have known that UNC would be the more effective alternative under this factor. Ms. Hale also agreed that UNC and Duke each would have won one comparative factor in this Review without the selection of this comparative factor. (Hale, Vol. 1, pp. 191-92).

462. Ms. Hale was not aware of any competitive review where competition or access to a new or alternative provider was not one of the comparative factors chosen by the Agency. (Hale, Vol. 2, p. 255).

463. Mr. Meyer agreed with the Agency's analysis of this comparative factor, noting that it was an "easy call for the Agency to determine that UNC was the more effective alternative as to competition." (Meyer, Vol. 7, p. 1327).

464. Mr. Meyer pointed out that in the 2018 Orange County OR Review, Duke proposed a new ASC in Orange County in which UNC was the only provider of surgical services. (*Id.* at pp. 1332-34; *see also* Jt. Ex. 107). In Duke's application in that review, which Keystone Planning prepared, Duke claimed that its proposed new ASC would "promote competition in the Orange County service area[,]" which "is healthy for providers

as it spurs continuous quality improvement and serves as motivation for seeking maximum cost-effectiveness, and local residents will have access to an alternative ASC provider conveniently located in Orange County." (Jt. Ex. 107, p. 23; Meyer, Vol. 7, p. 1334).

465. Similar to Agency's analysis in the current Review, the Agency in the 2018 Orange County Review found Duke to be the more effective alternative for the competition comparative factor because it was "introducing a new provider of surgical services located in Orange County." (UNC Ex. 316, p. 78; Meyer, Vol. 7, pp. 1334-35).

466. In Mr. Meyer's experience, "the Agency finds the newer alternative provider to be more effective as to competition." (Meyer, Vol. 7, p. 1322).

467. Mr. Meyer also discussed four recent competitive reviews in which the Agency found the new provider to be the more effective alternative for the Competition/Patient Access to New Provider comparative factor, consistent with the Agency's analysis in this Review. Those four competitive reviews include: (1) the 2020 Forsyth County OR Review; (2) the 2018 Buncombe County OR Review; (3) the 2016 Brunswick County OR Review; and (4) the 2018 Mecklenburg County acute care beds and OR review. (*Id.* at pp. 1322-26; Jt. Exs. 104A, 104B, 104C, and 104D).

468. Mr. Carter agreed with the Agency's analysis of this comparative factor that UNC would better enhance competition by providing patient access to a new provider in the service area. In his experience, the Agency did not simply "rubber stamp" UNC's comparative superiority under this factor, but rather performed a proper analysis of the percentage of control or percentage of market share held by Duke versus UNC within the Durham/Caswell area. (Carter, Vol. 11, pp. 1880-81, 1888-89). Mr. Carter opined that percentage of control or percentage of market share is perfectly appropriate for an analysis in competition. (Carter, Vol. 11, pp. 1880-81)

F. Access by Service Area Residents

469. The Agency also utilized the Access by Service Area Residents comparative factor in its comparative analysis of the UNC and Duke Applications. (Jt. Ex. 1, pp. 1610, 1623). In its analysis of this factor for acute care beds applicants, the Agency noted:

> Generally, the application projecting to serve the highest percentage of Durham and Caswell County residents is the more effective alternative with regard to this comparative factor since the need determination is for 40 additional acute care beds to be located in the Durham/Caswell County service area.

(*Id.* at 1610-11; Hale, Vol. 1, p. 189).

470. Similarly, the Agency noted in its analysis of this factor for OR applicants that "[g]enerally, the application projecting to serve the highest percentage of Durham County residents is the more effective alternative with regard to this comparative factor since the need determination is for four additional ORs to be located in Durham County." (Jt. Ex. 1, p. 1623).

471. Regarding acute care beds, the Agency found that "a comparison of access by service area residents cannot be effectively evaluated" because the proposals by Duke to place beds at DUH, "a full-service tertiary and quaternary care hospital with specialists serving patients from all over North Carolina" as opposed to placing beds at UNC Hospitals-RTP, "a small, community hospital in south Durham County," "are different types of facilities and offer a different scope of services." (*Id.* at p. 1611; Hale, Vol. 1, pp. 189-90).

472. Similarly, the Agency found with respect to ORs, the UNC Application projects its utilization to be comprised of 90 percent Durham County residents, "the highest percentage of Durham County residents during the third full fiscal year of operation following project completion," compared to just 21.8 percent Durham County residents in Duke's proposal. (Jt. Ex. 1, p. 1623 (See table of percentages of Durham County residents served by each proposal.)) Nonetheless, the Agency concluded this factor was "inconclusive" because the:

> [D]ifferences in the acuity level of patients at each facility, the level of care (community hospital, quaternary care hospital, ASF, etc.) at each facility, and the number and types of surgical services vs. all patient services proposed by each of the facilities, may impact the averages shown in the table above.

(*Id.*).

473. While Mr. Carter ultimately agreed with the Agency's analysis of this factor, he noted that had the Agency drawn a conclusion here, the UNC Application would have been the more effective alternative. (Carter, Vol. 11, pp. 1882, 1888).

G. Access by Underserved Groups: Projected Charity Care

474. The Agency also utilized the Access by Underserved Groups: Projected Charity Care comparative factor in its comparative analysis of the UNC and Duke Applications. (Jt. Ex. 1, pp. 1611, 1624). In its analysis of that factor, the Agency found, "[g]enerally, the application projecting to provide the most charity care is the more effective alternative with regard to this comparative factor." (*Id.*).

475. The UNC Application and Duke Beds Application used different definitions of "charity care" in their applications. Duke defined "charity care" as "free or discounted

care provided to persons in medical need who are unable to financially afford to pay for their care, and who do not qualify for public or private assistance." (*Id.* at 1611; Jt. Ex. 2, p. 80). UNC defined "charity care" as "the difference between projected gross revenue and projected net revenue for self-pay patients." (Jt. Ex. 1, p. 1612; Jt. Ex. 4, p. 163).

476. Based on their chosen definitions of charity care, Duke and UNC projected the following charity care in the third full fiscal year following project completion for acute care beds:

Projected Charity Care Inpatient Services – 3rd Full FY			
Applicant	Total Charity Care	Average Charity Care per Discharge	% of Gross Revenue
Duke University Hospital *	$117,155,479	$2,872	3.2%
UNC Hospitals-RTP	$10,493,509	$4,689	8.7%

Sources: Forms C and F.2 for each applicant
*Adult inpatient services

(Jt. Ex. 1, p. 1611). As noted above, a comparison of the applicants showed that UNC projected higher average charity care per discharge and as a percentage of gross revenue than Duke. (*Id.*).

477. Analyzing this factor for acute care beds applications, the Agency could not determine which applicant was more effective due to the different definitions of charity care in these applications. In addition, the differences in acuity level and level of care in each proposal made "any comparison of little value." (*Id.* at p. 1612).

478. For ORs, Duke projected charity care of 3.3 percent of its gross surgical revenue, while UNC projected charity care across its entire facility as 12.1 percent. (Jt. Ex. 1, p. 1624).

479. Similarly, for ORs, the Agency found it difficult to compare the Duke OR Application and UNC Application due to differences in the applicant's financial pro formas. As with its analysis for acute care beds, the differences in acuity level and level of care in each proposal made the analysis "inconclusive." (Jt. Ex. 1, p. 1624).

480. Duke offered no evidence or testimony to challenge the Agency's analysis of this comparative factor. (Sandlin, Vol. 6, pp. 1071-72).

H. Access by Underserved Groups: Projected Medicare

481. The Agency also utilized the Access by Underserved Groups: Projected Medicare in its comparative analysis of the UNC and Duke Applications. (Jt. Ex. 1, pp. 1612, 1624). In its analysis, the Agency noted: "[g]enerally, the application projecting the highest Medicare revenue is the more effective alternative with regard to this comparative

factor to the extent the Medicare revenue represents the number of Medicare patients served." (*Id.*).

482. Duke and UNC projected the following Medicare revenues in the third full fiscal year following project completion for acute care beds:

Projected Medicare Revenue – 3rd Full FY			
Applicant	**Total Medicare Rev.**	**Av. Medicare Rev./Discharge**	**% of Gross Rcv.**
Duke University Hospital *	$ 1,930,001,447	$ 47,318	52.9%
UNC Hospitals-RTP	$ 60,881,892	$ 27,204	50.7%

Sources: Forms C and F.2 for each applicant
*Adult inpatient services

(*Id.* at p. 1612).

483. Analyzing this factor for acute care beds, similar to its analysis for Projected Charity Care, the Agency could not determine which applicant was more effective due to the different presentations of pro forma financial statements in these applications. Nonetheless, the differences in acuity level and level of care in the proposals made "any comparison of little value." (*Id.* at p. 1613).

484. Similarly, for ORs, the Agency found it difficult to compare the Duke OR Application and UNC Application due to differences in the applicant's financial pro formas. As with its analysis for acute care beds, the differences in acuity level and level of care in the proposals made the analysis "inconclusive." (*Id.* at p. 1624).

485. Duke offered no evidence or testimony to challenge the Agency's analysis of this comparative factor. (Sandlin, Vol. 6, pp. 1071-72).

I. Access by Underserved Groups: Projected Medicaid

486. The Agency also utilized the Access by Underserved Groups: Projected Medicaid in its comparative analysis of the UNC and Duke Applications. (Jt. Ex. 1, pp. 1612, 1625). In its analysis, the Agency noted: "[g]enerally, the application projecting the highest Medicaid revenue is the more effective alternative with regard to this comparative factor to the extent the Medicaid revenue represents the number of Medicaid patients served." (*Id.*).

487. Duke and UNC projected the following Medicare revenues in the third full fiscal year following project completion for acute care beds:

Projected Medicaid Revenue – 3rd Full FY			
Applicant	Total Medicaid Rev.	Av. Medicaid Rev./Discharge	% of Gross Rev.
Duke University Hospital *	$ 396,406,070	$ 9,719	10.9%
UNC Hospitals-RTP	$ 18,865,906	$ 8,430	15.7%

Sources: Forms C and F.2 for each applicant

*Adult inpatient services

(*Id.* at p. 1613). UNC projected a higher projected Medicaid revenue as percentage of gross revenue than Duke, which projected a higher average Medicaid revenue per discharge compared to UNC. (*Id.*).

488. Analyzing this factor for acute care beds, similar to its analysis for Projected Charity Care and Medicare, the Agency could not determine which applicant was more effective due to the different presentations of pro forma financial statements in these applications. Furthermore, the differences in acuity level and level of care in the proposals made "any comparison of little value." (*Id.* at p. 1613).

489. For ORs, Duke projected Medicaid Revenue in the third full fiscal year following project completion as 14.54 percent, while UNC projected Medicaid revenue as 14.2 percent of gross facility revenue. (*Id.* at p. 1625).

490. Similarly, for ORs, the Agency found it difficult to compare the Duke OR Application and UNC Application due to differences in the applicants' financial pro formas. As with its analysis for acute care beds, the differences in acuity level and level of care in the proposals made the analysis "inconclusive." (*Id.* at p. 1626).

491. Duke offered no evidence or testimony to challenge the Agency's analysis of this comparative factor. (Sandlin, Vol. 6, pp. 1071-72).

J. Projected Average Net Revenue per Patient/Surgical Case

492. The Agency utilized the Projected Average Net Revenue per Patient (or Surgical Case/Patient) in its comparative analysis of the UNC and Duke Applications. (Jt. Ex. 1, pp. 1613, 1626). In its analysis, the Agency noted: "[g]enerally, the application projecting the lowest average net revenue per patient is the more effective alternative with regard to this comparative factor to the extent the average reflects a lower cost to the patient or third-party payor." (*Id.*; *see also* Meyer, Vol. 7, p. 1239).

493. Duke and UNC projected the following average net revenue per patient in the third full fiscal year following project completion for acute care beds:

Projected Average Net Revenue per Discharge – 3rd Full FY			
Applicant	Total # of Discharges	Net Revenue	Average Net Revenue / Discharge
Duke University Hospital *	40,788	$1,152,860,372	$28,265
UNC Hospitals-RTP	2,238	$ 47,304,485	$21,137

Sources: Forms C and F.2 for each applicant

*Adult inpatient services

(Jt. Ex. 1, p. 1613). UNC projected lower average net revenue per discharge than Duke in the third full fiscal year following project completion. (*Id.*; Meyer, Vol. 7, pp. 1328-1329; Carter, Vol. 11, p. 1883).

494. The Agency determined for both acute care beds and ORs that it could not make a valid comparison between the UNC and Duke Applications due to differences in presentation of pro forma financial statements. It also noted that comparison would be "of little value" or "inconclusive" due to differences in acuity and level of care at each facility. (Jt. Ex. 1, pp. 1613, 1626).

495. Mr. Carter agreed with the Agency's analysis, but noted that had the Agency reached a conclusion, UNC would have been deemed more effective as to this comparative factor. (Carter, Vol. 11, pp. 1883, 1889).

496. Duke offered no evidence or testimony to challenge the Agency's analysis of this comparative factor. (Sandlin, Vol. 6, pp. 1072-73).

K. Projected Average Operating Expense per Patient/Surgical Case

497. The last factor the Agency analyzed in its comparison of the UNC and Duke Applications was the Projected Average Operating Expense per Patient (or Surgical Case/Patient for ORs). (Jt. Ex. 1, pp. 1613, 1626). In its analysis, the Agency noted: "[g]enerally, the application projecting the lowest average operating expense per patient is the more effective alternative with regard to this comparative factor to the extent it reflects a more cost-effective service which could also result in lower costs to the patient or third-party payor." (*Id.* at pp. 1615, 1627).

498. Duke and UNC projected the following average net revenue per patient in the third full fiscal year following project completion for acute care beds:

Projected Operating Expense per Discharge – 3rd Full FY			
Applicant	Total # of Discharges	Operating Expense	Average Operating Expense / Discharge
Duke University Hospital *	40,788	$1,510,709,079	$37,038
UNC Hospitals-RTP	2,238	$ 42,521,459	$19,000

Sources: Forms C and F.2 for each applicant

*Adult inpatient services

(*Id.* at p. 1614). UNC projected lower operating expense per discharge than Duke in the third full fiscal year following project completion. (*Id.*; Meyer, Vol. 7, p. 1329).

499. The Agency determined for both acute care beds and ORs that it could not make a valid comparison between the UNC and Duke Applications due to differences in presentation of pro forma financial statements. It also noted that comparison would be "of little value" or "inconclusive" due to differences in acuity and level of care at each facility. (Jt. Ex. 1, pp. 1614, 1627).

500. Both Mr. Meyer and Mr. Carter agreed with the Agency decision. (Meyer, Vol. 7, p. 1329; Carter, Vol. 11, pp. 1883, 1889).

501. Duke offered no evidence or testimony to challenge the Agency's analysis of this comparative factor. (Sandlin, Vol. 6, pp. 1073).

L. Conclusion of Comparative Analysis

502. The Agency ultimately concluded that, for acute care beds, UNC was a more effective alternative for two comparative factors (Geographic Accessibility and Competition/Access to New Provider) and Duke was a more effective alternative for one comparative factor (Scope of Services). (Jt. Ex. 1, p. 1615). Based on the fact that UNC was a more effective alternative for more comparative factors, the Agency approved the UNC Application for 40 acute care beds. (*Id.* at pp. 1615-16).

503. For ORs, the Agency ultimately concluded that UNC was the more effective alternative for three comparative factors (Scope of Services, Geographic Accessibility, and Competition/Access to New Provider) and Duke was the more effective alternative for one comparative factor (Scope of Services). (Jt. Ex. 1, p. 1628).

504. Based on the fact that UNC was a more effective alternative for more comparative factors, the Agency approved the UNC Application for 2 ORs. (Jt. Ex. 1, pp. 1628-29; Hale, Vol. 2, pp. 256-57).

505. Likewise, the Agency found that Duke Arringdon was more effective for two comparative factors (Geographic Accessibility and Patient Access to Lower Cost Surgical Services), leading the Agency to approve the Duke Arringdon application for 2 ORs. (*Id.*).

506. Ms. Hale, the only Agency witness called at the hearing, affirmed the Agency's findings with respect to UNC's conformity with the review criteria and the UNC Application's comparative superiority to the Duke Beds and ORs Applications. (Hale, Vol. 2, pp. 260-61).

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Undersigned Administrative Law Judge makes the following Conclusions of Law:

General Conclusions of Law

1. The Office of Administrative Hearings has jurisdiction over the parties and the subject matter of this action. All parties have been correctly designated, and there is no question as to misjoinder or nonjoinder of parties.

2. The parties received proper notice of the hearing in this matter as required by N.C. Gen. Stat. § 150B-23.

3. To the extent certain portions of the foregoing Findings of Fact constitute mixed issues of law and fact, such Findings of Fact shall be deemed incorporated herein by reference as Conclusions of Law. Similarly, to the extent that some of these Conclusions of Law are Findings of Fact, they should be so considered without regard to the given label. *Charlotte v. Heath*, 226 N.C. 750, 755, 40 S.E.2d 600, 604 (1946); *Peters v. Pennington*, 210 N.C. App. 1, 15, 707 S.E.2d 724, 735 (2011).

4. A court "need not make findings as to every fact which arises from the evidence and need only find those facts which are material to the settlement of the dispute." *Brewington v. N.C. Dep't of Public Safety, State Bureau of Investigation*, 254 N.C. App. 1, 23, 802 S.E.2d 115, 131 (2017).

5. N.C. Gen. Stat. § 131E-188(a) provides for administrative review of an Agency decision to issue, deny or withdraw a certificate of need. *Presbyterian Hosp. v. N.C. Dep't of Health & Human Servs.*, 177 N.C. App. 780, 783, 630 S.E.2d 213, 215 (2006); *Britthaven*, 118 N.C. App. at 382, 455 S.E.2d at 459 ("The subject matter of a contested case hearing by the ALJ is an agency decision.").

6. The subject matter of this contested case is the Agency's decision to disapprove the Duke Beds and ORs Applications and to approve the UNC Application.

7. When considering the Agency decision in a contested CON case, the Tribunal is limited to a review of the information presented or available to the Agency at the time of the review. *See, e.g., Britthaven,* 118 N.C. App at 382, 455 S.E.2d at 459; *In Re Wake Kidney Clinic, P.A.*, 85 N.C. App. 639, 643, 355 S.E.2d 788, 791 (1987) ("The hearing officer is properly limited to consideration of evidence which was before the Section when making its initial decision, but the hearing officer is not limited to that part of the evidence before it that the Section actually relied upon in making its decision."); *Dialysis Care of N.C., LLC, v. N.C. Dep't of Health & Human Servs.*, 137 N.C. App. 638, 647-48, 529 S.E.2d 257, 262, *aff'd*, 353 N.C. 258, 538 S.E.2d 566 (2000) ("The hearing officer (ALJ) is properly limited to consideration of evidence which was before the CON Section when making its initial decision.").

8. "The fundamental purpose of [CON law] is to limit the construction of health care facilities in North Carolina to those that are needed by the public and that can be operated efficiently and economically for its benefit." *See* N.C. Gen. Stat. §§ 131E-182, 131E-283*; see also In re Humana Hosp. Corp. v. N.C. Dep't of Hum. Res.*, 81 N.C. App. 628, 345 S.E.2d 235 (1986).

9. To obtain a CON for a proposed project, a CON application must satisfy all of the review criteria set forth in N.C. Gen. Stat. § 131E-183(a). If an application fails to conform with any one of these criteria, then the applicant is not entitled to a CON for the proposed project as a matter of law. *See Presbyterian-Orthopedic Hospital v. N.C. Dept. of Human Resources,* 122 N.C. App. 529, 534-35, 470 S.E.2d 831, 834 (1996) (holding that "an application must comply with all review criteria" and that failure to comply with one review criteria supports entry of summary judgment against the applicant).

10. CON applications must be based on the individual circumstances of the applicant and the service area proposed; hence, there is no single, universal, objective standard that can be applied by the CON Section in its reviews to determine whether an applicant's projections are reasonable or supported.

11. Under N.C. Gen. Stat. § 131E-183(a), the Agency "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."

12. In a competitive review, the Agency may conduct a comparison of the applications to determine which applicant should be awarded the CON. *Britthaven,* 118 N.C. App. at 385-86, 455 S.E.2d at 461. In conducting a comparative analysis, the Agency may include other "findings and conclusions upon which it based its decision." *Id.* at 385, 455 S.E.2d at 461 (quoting N.C. Gen. Stat. § 131E-186(b)). "Those additional findings and conclusions give the Agency the opportunity to explain why it finds one applicant preferable to another on a comparative basis." (*Id).*

13. When there are competing applications, the Agency must initially review each application individually to determine if the application conforms with the review criteria, without regard to the competing applications. *Britthaven v. N.C. Dep't of Hum. Res.*, 188 N.C. App. 379, 385, 455 S.E.2d 455, 460-61 (1995). Only after completing its initial review does the Agency conduct a comparative analysis to determine which of the competing applications should be approved. (*Id).*

Burden of Proof

14. Pursuant to N.C. Gen. Stat. § 150B-23(a), in a contested case hearing, "the ALJ is to determine whether the petitioner has met its burden in showing that the agency substantially prejudiced petitioner's rights, and that the agency acted outside its authority, acted erroneously, acted arbitrarily and capriciously, used improper procedure, or failed to act as required by law or rule." *Britthaven*, 118 N.C. App. at 382, 455 S.E.2d at 459.

15. Duke contends that the Agency erred in finding UNC conforming with Criteria (1), (3), (4), (5), (6), and (18a) and the performance standards at 10A NCAC 14C .2103(a)-(b), .2303(1), and .3803(a)-(b), and in finding the UNC Application comparatively superior to the Duke Beds and ORs Applications.

16. Duke has the burden of proof as to all issues presented to the Tribunal regarding the Agency's approval of the UNC Application and the disapproval of the Duke Application. *See Southland Amusements and Vending, Inc. v. Rourk,* 143 N.C. App. 88, 94, 545 S.E.2d 254, 257 (2001); *Britthaven, Inc. v. North Carolina Dept. of Human Resources, Div. of Facility Svcs.*, 118 N.C. App. 379, 455 S.E.2d 455, 459, *disc. rev. denied,* 341 N.C. 418, 461 S.E.2d 754 (1995).

17. Duke has the burden of proof to "establish the facts required by G.S. 150B-23(a) by a preponderance of the evidence." N.C. Gen. Stat. § 150B-29(a).

18. Although UNC did not appeal the Agency's decision, UNC contends that the Agency erred in finding the Duke Beds Application conforming with Criteria (1), (3), (4), (5), (6), (9), and (18a) and the performance standards for acute care beds, and in finding the Duke ORs Application conforming with Criteria (1), (3), (4), (5), (6), (9), (12), and (18a) and the performance standards for ORs. UNC has the burden of proof on the issues of whether the Agency erred in finding the Duke Beds and ORs Applications conforming with the statutory and regulatory review criteria.

Deference to Agency

19. Under N.C.G.S. § 150B-34(a), the Undersigned must "make a final decision or order that contains findings of fact and conclusions of law" and "shall decide the case based upon the preponderance of the evidence, giving due regard to the demonstrated

knowledge and expertise of the agency with respect to facts and inferences within the specialized knowledge of the agency."

20. "It is well settled that when a Tribunal reviews an agency's interpretation of a statute it administers, the Tribunal should defer to the agency's interpretation of the statute ... as long as the agency's interpretation is reasonable and based on a permissible construction of the statute." *Craven Reg'l Med. Auth.*, 176 N.C. App. at 58, 625 S.E.2d at 844 (internal quotation omitted); *see also Blue Ridge Healthcare Hosps. Inc. v. N. Carolina Dep't of Health & Human Servs.*, 255 N.C. App. 451, 459-60, 808 S.E.2d 271, 276-77 (2017). Thus, the issue is not whether the Agency could have come to a different decision, but whether the decision it reached was within the bounds of reason.

21. An ALJ sitting in review of an Agency decision must not substitute its interpretation of the law which the Agency is charged with enforcing, so long as "the Agency's interpretation is reasonable and based on a permissible construction of the statute." *Craven Regional Medical Authority v. N.C. HHS,* 176 N.C. App. 46, 58, 625 S.E.2d 837, 844 (2006) (*internal citation omitted*); *and accord, Good Hope Health Sys., L.L.C. v. N.C. HHS*, 189 N.C. App. 534, 544, 659 S.E.2d 456, 463 (N.C. Ct. App. 2008*), aff'd sub nom. Good Hope Health Sys., L.L.C. v. N.C. HHS,* 362 N.C. 504, 666 S.E.2d 749 (2008).

22. Although there is a presumption that an administrative agency has properly performed its official duties, the presumption can be rebutted by showing the Agency exceeded its authority or jurisdiction, acted erroneously, failed to use proper procedure, acted arbitrarily or capriciously, or failed to act as required by law or rule. *See E. Carolina Internal Med. V. N.C. Dep't of Health & Hum. Servs.*, 211 N.C. App. 397, 411, 710 S.E.2d 245, 255 (2011).

23. "Administrative agency decisions may be reversed as arbitrary and capricious if they are … 'whimsical' in the sense that they indicate a lack of fair and careful consideration or fail to indicate any course of reasoning and the exercise of judgment…." *Craven Reg'l Med. Auth.*, 176 N.C. App. at 52, 625 S.E.2d at 841 (*quoting Blalock v. N.C. Dep't of Health & Human Servs.*, 143 N.C. App. 470, 475, 546 S.E.2d 177, 181 (2001)).

24. "[C]ourts will not defer to an agency's interpretation of a statute that is an impermissible construction of the statute." *AH N. Carolina Owner LLC v. N.C. Dep't of Health & Hum. Servs.*, 240 N.C. App. 92, 771 S.E.2d 537 (2015). The inability of the Agency to articulate a coherent rationale for the interpretation of a law that goes "because I said so" signals that the Agency's interpretation of the law should not be afforded deference. (*See AH N. Carolina Owner LLC v. N.C. Dep't of Health & Hum. Servs.,* 240 N.C. App. 92, 113, 771 S.E.2d 537, 551 (2015)).

25. There are no set of circumstances where the courts will "follow an administrative interpretation in direct conflict with the clear intent and purpose of the act

under consideration." *High Rock Lake Partners, LLC v. N.C. Dep't of Transp.,* 366 N.C. 315, 319, 735 S.E.2d 300, 303 (2012). The Agency errs when it fails to perform its duty of enforcing the CON criteria. "[T]he Agency may not metaphorically shrug its shoulders and say, 'that is someone else's problem, or 'we rely on other people to make that call.'" *Id.* If an applicant omits information necessary to demonstrate conformity with a criterion that raises an issue, the Agency should do its duty in asking the hard questions and receiving properly supported and provable assurances. *See id.*

26. "The cardinal principle of statutory construction is that the intent of the legislature is controlling. In ascertaining the legislative intent, courts should consider the language of the statute, the spirit of the statute, and what is seeks to accomplish." AH *N.C. Owner LLC v. N.C. Dep't of Health & Hum. Servs.,* 240 N.C. App. 92, 110, 771 S.E.2d 537, 548 (2015) (*citing State ex rel. Utils. Comm'n v. Pub. Staff,* 309 N.C. 195, 210, 306 S.E.2d 435, 443-44 (1983)).

Substantial Prejudice to Duke's Rights

27. Substantial prejudice is an element of a petitioner's claim separate and apart from whether the Agency made an error in its evaluation of a petitioner's application. *Surgical Care Affiliates, LLC v. N.C. Dep't of Health & Human Servs.*, 235 N.C. App. 620, 628, 762 S.E.2d 468, 473-74 (2014) (citing *Britthaven, Inc. v. N.C. Dep't of Human Res.*, 118 N.C. App. 379, 382, 455 S.E.2d 455, 459 (1995).

28. A party seeking to show prejudice must "provide specific evidence of harm resulting from the award of the CON to [a competitor] that went beyond any harm that necessarily resulted from additional . . . competition[.]" *Novant Health, Inc. v. N.C. Dep't of Health & Human Servs*., 223 N.C. App. 362, 734 S.E.2d 138 (2012).

29. The harm required to establish substantial prejudice cannot be conjectural or hypothetical, but must be "concrete, particularized, and 'actual' or imminent." *Surgical Care Affiliates, LLC v. N.C. Dep't of Health & Human Servs.*, 235 N.C. App. 620, 631, 762 S.E.2d 468, 476 (2014).

30. The North Carolina Court of Appeals "has previously held in multiple cases that a petitioner's mere status as a denied competitive CON applicant alone is insufficient to establish substantial prejudice as a matter of law." *Bio-Medical Applications of N. Carolina v. N.C. Dep't of Health & Human Servs*., 282 N.C. App. 413, 871 S.E.2d 555 (2022) (internal quotations omitted).

31. In this case, UNC stipulated that by virtue of Duke's status as an applicant in a competitive review seeking approval for assets limited by a need determination in the SMFP, Duke has met its burden of demonstrating that the Agency substantially prejudiced its rights in denying the Duke Beds and ORs Applications and instead awarding the CONs at issue to UNC.

32. The undisputed evidence showed that Duke is a tertiary and quaternary care hospital with national recognition for the specialty services that it offers to its patients. Duke's expansive origin of its patient population generated the need for additional acute care beds and operating rooms in the 2021 SMFP.

33. Duke demonstrated by a preponderance of the evidence that it will suffer an injury in fact as a result of the Agency's decision. The denial of its Applications will significantly impact Duke's operations, limit its capacity and its ability to meet patients' needs, limit Duke's ability to increase acute care bed and operating room capacity, lead to delays in surgeries, surgery starts, staff dissatisfaction, and staffing shortages, impact Duke's ability to accept transfer patients, increase wait times, boarding times, and length of stay in the Emergency Department.

34. Duke's July 2021 petition requesting the SHCC eliminate the need determination for additional acute care bed capacity in the Durham/Caswell service area for the proposed 2022 SMFP does not significantly undermine the injury in fact Duke demonstrated it will suffer as a result of the Agency's decision.

35. Duke met its burden of demonstrating by a preponderance of the evidence that the Agency substantially prejudiced its rights in denying Duke's Applications for a CON for forty acute care beds and two operating rooms and instead awarding the CON to UNC.

Statutory Criterion

36. An application cannot be approved if it is not conforming to all review criteria. N.C. Gen. Stat. § 131E-183(a).

37. In accordance with Criterion (1), an applicant must demonstrate that its proposed project is:

> 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.

N.C. Gen. Stat. § 131E-183(a)(1); (Jt. Ex. 1, p. 1521).

38. Policies GEN-3 and GEN-4 are applicable to the UNC Application. Policy GEN-3 requires an applicant to "demonstrate how the project will promote safety and quality in the delivery of healthcare services while promoting equitable access and maximizing healthcare value for resources expended." (Jt. Ex. 1, p. 1496). Policy GEN-4 requires an applicant "proposing a capital expenditure greater than $2 million to develop,

replace, renovate or add to a health service facility pursuant to G.S. 131E-178" to provide "a written statement describing the project's plan to assure improved energy efficiency and water conservation." (*Id.*). If an applicant "propos[es] an expenditure greater than $5 million to develop, replace, renovate or add to a health service facility pursuant to G.S. 131E-178," the CON must condition approval on the applicant developing and implementing "an Energy Efficiency and Sustainability Plan for the project that conforms to or exceeds energy efficiency and water conservation standards incorporated in the latest editions of the North Carolina State Building Codes." (*Id.*).

39. UNC adequately demonstrated the need for the proposed UNC Hospitals-RTP project. UNC also demonstrated that the utilization projected for all service lines proposed in the UNC Application is based on reasonable and adequately supported assumptions. Therefore, the UNC Application adequately demonstrated that the proposal would maximize healthcare value.

40. UNC also adequately demonstrated that it had a plan to assure improved energy efficiency and water conservation.

41. Duke offered no evidence of UNC's nonconformity with Criterion (1) other than its alleged nonconformity with Criterion (3). As described further herein, the Undersigned concludes that the Agency did not err in determining that the UNC Application was conforming with Criterion (3).

42. Substantial evidence in the record supports the Agency's determination that the UNC Application was conforming with Criterion (1).

43. The Agency did not err in determining that the UNC Application was conforming with Criterion (1).

44. Criterion (3) requires an applicant to

> identify the population to be served by the proposed project, and [] 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.

N.C. Gen. Stat. § 131E-183(a)(3).

45. To conform with Criterion (3), an applicant's projected patient origin, demonstration of need, and projected utilization must be reasonable and adequately supported.

46. The Agency correctly determined that UNC's projected patient origin for UNC Hospitals-RTP, including 90 percent Durham County residents and its conservative 10 percent in-migration assumption, was reasonable and adequately supported.

47. The Agency also correctly determined that UNC's demonstration of need for UNC Hospitals-RTP based on the population growth and aging of the population in Durham County, the need for a new hospital in Durham County (particularly the southern area), the need for UNC-Hospitals' hospital-based services in Durham County, and the need for acute care beds (especially community hospital beds) and ORs in Durham County, was reasonable and adequately supported.

48. The Agency further correctly determined that UNC's projected utilization for all service components at UNC Hospitals-RTP was reasonable and adequately supported.

49. Substantial evidence in the record of this case supports the Agency's determination that the UNC Application was conforming with Criterion (3).

50. The Agency did not err in determining that the UNC Application was conforming with Criterion (3).

51. Criterion (4) provides that "[w]here 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." N.C. Gen. Stat. § 131E-183(a)(4).

52. The Agency correctly determined that UNC adequately analyzed the alternatives to its proposal and reasonably determined them to be less effective alternatives to the UNC Hospitals-RTP proposal.

53. Duke offered no evidence of UNC's nonconformity with Criterion (4) other than its alleged nonconformity with Criterion (3). As described above, the Undersigned concluded that the Agency did not err in determining that the UNC Application was conforming with Criterion (3).

54. Substantial evidence in the record supports the Agency's determination that the UNC Application was conforming with Criterion (4).

55. The Agency did not err in determining that the UNC Application was conforming with Criterion (4).

56. Criterion (5) requires that

> 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.

N.C. Gen. Stat. § 131E-183(a)(5).

57. The Agency correctly determined that UNC demonstrated the financial feasibility of UNC Hospitals-RTP and that the projections, costs, and charges included in its financial pro formas were reasonable and adequately supported.

58. Duke offered no evidence of UNC's nonconformity with Criterion (5) other than its alleged nonconformity with Criterion (3). As described above, the Undersigned concludes that the Agency did not err in determining that the UNC Application was conforming with Criterion (3).

59. Substantial evidence in the record supports the Agency's determination that the UNC Application was conforming with Criterion (5).

60. The Agency did not err in determining that the UNC Application was conforming with Criterion (5).

61. Criterion (6) requires an applicant to "demonstrate that the proposed project will not result in unnecessary duplication of existing or approved health service capabilities or facilities." N.C. Gen. Stat. § 131E-183(a)(6).

62. The Agency correctly determined that UNC adequately demonstrated that UNC Hospitals-RTP would not unnecessarily duplicate existing or approved facilities based on the need determination in the 2021 SMFP and UNC's analysis of the need for the acute care beds and ORs in addition to the existing and approved assets.

63. Duke offered no evidence of UNC's nonconformity with Criterion (6) other than its alleged nonconformity with Criterion (3). As described above, the Undersigned concludes that the Agency did not err in determining that the UNC Application was conforming with Criterion (3).

64. Substantial evidence in the whole record of this case supports the Agency's determination that the UNC Application was conforming with Criterion (6).

65. The Agency did not err in determining that the UNC Application was conforming with Criterion (6).

66. Criterion (7) requires that 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." N.C. Gen. Stat. § 131E-183(a)(7).

67. The evidence in the whole record of this case supports the Agency's determination that the UNC Application was conforming with Criterion (7).

68. The Agency did not err in determining that the UNC Application was conforming with Criterion (7).

69. Criterion (8) requires that "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." N.C. Gen. Stat. § 131E-183(a)(8).

70. The evidence in the record supports the Agency's determination that the UNC Application was conforming with Criterion (8).

71. The Agency did not err in determining that the UNC Application was conforming with Criterion (8).

72. Criterion (12) requires that:

> 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.

N.C. Gen. Stat. § 131E-183(a)(12).

73. The Agency correctly determined that the UNC Application identified a proposed site and adequately demonstrated that the cost, design, and means of construction of UNC Hospitals-RTP represent the most reasonable alternative, will not unduly increase the cost of service to the public, and incorporates energy saving features.

74. UNC provided adequate information requested by the Agency in the application related to Criterion (12), including describing how it anticipated having the property rezoned.

75. The Agency reasonably assessed potential zoning and restrictive covenant issues with the primary site for UNC Hospitals-RTP and correctly determined that the UNC Application was conforming with Criterion (12) nonetheless. Moreover, the Agency did not err in not seeking additional information regarding the zoning and restrictive covenants at the primary site. "There is no provision in N.C. Gen. Stat. § 131E-183, nor Chapter 131E, which permits the Agency to independently assess whether the applicant is conforming to other statutes." (Hale, Vol. 2, p. 266; *see also Craven Reg'l Med. Auth.*, 176 N.C. App. at 58, 625 S.E.2d at 844). Therefore, the Agency did not err in not engaging in further analysis of the zoning or restrictive covenants beyond what was contained in the Agency findings.

76. The letter of support from Mr. Levitan was not necessary to the approval of the UNC Application; nonetheless, Mr. Levitan's support letter was consistent with UNC's representations in the UNC Application and its Responses to Comments.

77. The Agency was correct to exclude Mr. Levitan's clarifying letter of July 12, 2021 from the Agency File because it was submitted after the end of the public comment period. Had the Agency considered that letter and used it as a basis to deny the UNC Application, it would have been reversible error.

78. Mr. Levitan's clarifying July 12, 2021 Letter did not state that the RTF would deny any efforts to rezone the primary site; instead, it simply noted that the RTF would not take action until a CON has been awarded and any appeals exhausted. (Jt. Ex. 46; *see also* Jt. Ex. 25). Thus, had the Agency considered the July 12, 2021 Letter, the Agency would have been incorrect to use it as a basis for UNC's nonconformity with Criterion (12).

79. While Duke raised questions about UNC's alternate site, Duke presented no competent evidence as to the unavailability of that site. Neither Ms. Cummer nor Dr. Brown are qualified as an expert in real estate, condemnation, or highway construction. Their testimony suggesting UNC could not develop a hospital at the alternate site is unreliable, and the undersigned gives it no weight.

80. If UNC is ultimately unable to develop a hospital at the UNC Hospitals-RTP primary site due to zoning or restrictive covenant issues, UNC may submit a material compliance request for another suitable site, consistent with prior Agency decisions approving alternate sites following issuance of a CON. (*See* N.C. Gen. Stat. § 131E-181; Hale, Vol. 2, p. 248; Meyer, Vol. 7, pp. 1283-89; Jt. Exs. 100-102). The Agency has the discretion to evaluate any request to develop the proposed hospital at a different location and determine whether such project would be in material compliance with UNC's representations in the UNC Application. N.C. Gen. Stat. § 131E-189(b).

81. Substantial evidence in the record supports the Agency's determination that the UNC Application was conforming with Criterion (12).

82. The Agency did not err in determining that the UNC Application was conforming with Criterion (12).

83. Criterion (13)(c) requires the applicant to demonstrate 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 serve." N.C. Gen. Stat. § 131E-183(a)(13)(c).

84. The evidence in the whole record of this case supports the Agency's determination that the UNC Application was conforming with Criterion (13)(c).

85. The Agency did not err in determining that the UNC Application was conforming with Criterion (13)(c).

86. Criterion (13)(d) requires 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." N.C. Gen. Stat. § 131E-183(a)(13)(d).

87. The evidence in the whole record of this case supports the Agency's determination that the UNC Application was conforming with Criterion (13)(d).

88. The Agency did not err in determining that the UNC Application was conforming with Criterion (13)(d).

89. Criterion (14) provides that the "applicant shall demonstrate that the proposed health services accommodate the clinical needs of health professional training programs in the area, as applicable." N.C. Gen. Stat. § 131E-183(a)(14).

90. The evidence in the record supports the Agency's determination that the UNC Application was conforming with Criterion (14).

91. The Agency did not err in determining that the UNC Application was conforming with Criterion (14).

92. Criterion (18a) requires an applicant to

> 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.

N.C. Gen. Stat. § 131E-183(a)(18a).

93. The Agency correctly determined that UNC demonstrated that its proposal would improve cost-effectiveness, quality, and access.

94. Duke offered no evidence of UNC's nonconformity with Criterion (18a) other than its alleged nonconformity with Criterion (3). As described above, the Undersigned concludes that the Agency did not err in determining that the UNC Application was conforming with Criterion (3).

95. Substantial evidence in the record supports the Agency's determination that the UNC Application was conforming with Criterion (18a).

96. The Agency did not err in determining that the UNC Application was conforming with Criterion (18a).

97. Criterion (20) requires that "an applicant already involved in the provision of health services shall provide evidence that quality care has been provided in the past." (N.C. Gen. Stat. § 131E-183(a)(20)).

98. The evidence in the whole record of this case supports the Agency's determination that the UNC Application was conforming with Criterion (20).

99. The Agency did not err in determining that the UNC Application was conforming with Criterion (20).

100. 10A NCAC 14C .2103(a) and (b) require an applicant proposing to increase the number of ORs (excluding dedicated C-section ORs) to demonstrate the need for the number of proposed ORs, in addition to the existing and approved ORs in the applicant's health system during the third full fiscal year following completion of the project and to document the assumptions and to provide data underlying the methodology used for each projection under the performance standard.

101. The Agency correctly determined that UNC demonstrated the need for the 2 ORs in its proposal and that its supporting assumptions and methodology were reasonable and adequately supported.

102. Duke offered no evidence of UNC's nonconformity with 10 NCAC 14C .2103(a) and (b) other than its alleged nonconformity with Criterion (3). As described

above, the Undersigned concludes that the Agency did not err in determining that the UNC Application was conforming with Criterion (3).

103. Substantial evidence in the record supports the Agency's determination that the UNC Application was conforming with 10A NCAC 14C .2103(a) and (b).

104. The Agency did not err in determining that the UNC Application was conforming with 10A NCAC 14C .2103(a) and (b).

105. The performance standards at 10A NCAC 14C. 2303(1) and (3) require an applicant proposing to develop a CT scanner to demonstrate that the new CT scanner and that any existing CT scanners in the service area in which the applicant or a related party has a controlling interest shall perform 5,100 HECT units annually in the third year of operation of the proposed equipment.

106. The Agency correctly determined that UNC demonstrated the need for the CT equipment in its proposal and that its supporting assumptions and methodology were reasonable and adequately supported.

107. Duke offered no evidence of UNC's nonconformity with 10A NCAC 14C .2303(1) and (3) other than its alleged nonconformity with Criterion (3). As described further above, the Undersigned concludes that the Agency did not err in determining that the UNC Application was conforming with Criterion (3).

108. Substantial evidence in the whole record of this case supports the Agency's determination that the UNC Application was conforming with 10A NCAC 14C .2303(1) and (3).

109. The Agency did not err in determining that the UNC Application was conforming with 10A NCAC 14C .2303(1) and (3).

110. 10A NCAC 14C .3803(a) and (b) require applicants proposing to develop new acute care beds to demonstrate that the projected ADC of the total number of licensed acute care beds proposed to be licensed within the service area under common ownership with the applicant meets certain thresholds in the third operating year following completion of the proposed project and to provide reasonable and adequately supported assumptions for those projections.

111. The Agency correctly determined that UNC demonstrated the need for the 40 acute care beds in its proposal and that its supporting assumptions and methodology were reasonable and adequately supported.

112. Duke offered no evidence of UNC's nonconformity with 10A NCAC 14C .3803(a) and (b) other than its alleged nonconformity with Criterion (3). As described

above, the Undersigned concludes that the Agency did not err in determining that the UNC Application was conforming with Criterion (3).

113. Substantial evidence in the record supports the Agency's determination that the UNC Application was conforming with 10A NCAC 14C .3803(a) and (b).

114. The Agency did not err in determining that the UNC Application was conforming with 10A NCAC 14C .3803(a) and (b).

115. The Agency properly found the UNC Application was conforming with statutory review criteria (1), (3), (4), (5), (6), (7), (8), (12), (13), (14), (18a), and (20) and the regulatory review criteria at 10A NCAC 14C .2103(a) and (b), .2303(1), and .3803(a) and (b).

116. The Agency did not exceed its authority or jurisdiction; act erroneously; fail to use proper procedure; act arbitrarily or capriciously; or fail to act as required by law or rule in determining that the UNC Application was conforming with statutory review criteria (1), (3), (4), (5), (6), (7), (8), (12), (13), (14), (18a) and (20) and the regulatory review criteria at 10A NCAC 14C .2103(a) and (b), .2303(1), and .3803(a) and (b).

Comparative Analysis

117. In a competitive review, the Agency "may conduct a comparison of the applications to determine which applicant should be awarded the CON." *Craven Reg'l Med. Auth.*, 176 N.C. App. at 58, 625 S.E.2d at 845 (citing *Britthaven*, 118 N.C. App. at 385-86, 455 S.E.2d at 461). "There is no statute or rule which requires the Agency to utilize certain comparative factors." (*Id).*

118. The Agency has discretion to select comparative factors which it determines are appropriate for each review. *Raleigh Radiology LLC v. N.C. Dep't of Health & Hum. Servs., Div. of Health Serv. Regul., Health Care Plan. & Certificate of Need*, 266 N.C. App. 504, 508-09, 833 S.E.2d 15, 20 (2019) (citing *Craven Reg'l Med. Auth.*, 176 N.C. App. at 58, 625 S.E.2d at 845. It would be reversible error for the Undersigned to add comparative factors that the Agency did not use in its comparative analysis here. (*Id.* at 510, 833 S.E.2d at 21).

119. The comparative factors used by the Agency for the comparative analysis of both the OR and acute care beds applications in this Review were appropriate.

120. There is no statute, rule, or case which compels the Agency to rank the applications being compared under a comparative factor. It is within the Agency's discretion to determine which applicant is the more effective alternative and then to determine which applicants are the less effective alternative.

121. The Agency was correct in finding that the UNC Application was an equally effective alternative with respect to the comparative factor of conformity with review criteria.

122. Although UNC presented competent evidence regarding Agency error for the scope of services comparative factor, the Agency did not err in finding Duke comparatively superior for that comparative factor.

123. The Agency was correct in finding that the UNC Application was a more effective alternative as to the comparative factor of geographic accessibility. Prior to this review, all of the approved and existing acute care beds, and the vast majority of existing and approved ORs, were located within a five-mile radius in central Durham County. The proposed UNC Hospitals-RTP location will improve access to healthcare services to the growing, dense population of southern Durham County where there are no existing or approved acute care hospitals in a physically and geographically accessible location. The Agency's analysis of this comparative factor was consistent with prior reviews.

124. While UNC may not be closer to some Durham County residents than DUH, UNC adequately supported the need for UNC Hospitals-RTP in southern Durham County and will support the growing population of southern Durham County which currently lacks a hospital.

125. The Agency did not err in its analysis of the historical utilization comparative factor. The Agency's analysis properly looked to historical utilization within the service area defined by the 2021 SMFP, and correctly concluded that it could not effectively evaluate this comparative factor due to the lack of history for UNC Hospitals-RTP as a new facility.

126. The Agency did not err in its analysis of the competition comparative factor, which was consistent with its prior analyses of this comparative factor. Duke has well over 90 percent control of the beds and ORs in Durham County. Awarding Duke more beds and ORs in a service area where it owns or controls nearly all of those assets will not further competition. UNC Hospitals-RTP increases competition in the service area, which is a benefit for patients and providers alike, and aligns with the goals of the CON Law to improve cost, quality, and access in healthcare.

127. Duke argued that the Agency should engage in a balancing test regarding this comparative factor. The ALJ declines to do so for two reasons.

a. First, "deference must be given to the agency's decision where it chooses between two reasonable alternatives," and "[i]t would be improper for this Tribunal to substitute our judgment for the Agency's decision where there is substantial evidence in the record to support its findings." (*Craven Reg'l Med. Auth.*, 176 N.C. App. at 59, 625 S.E.2d at 845.)

b. Second, the Court of Appeals has considered similar logic and declined to adopt it. In *Craven*, the Court noted the Craven Regional Medical Authority's apparent argument that it should operate all three of the MRI scanners in a service area because it "would somehow foster competition rather than if a competitor operated one of the MRI scanners." (*Id.* at 57, 625 S.E.2d at 844). The Court further characterized this argument as one suggesting that "giving it a monopoly in the service area would increase competition." (*Id).* The Court of Appeals "decline[d] to adopt this incongruous line of reasoning," and the Undersigned likewise declines to adopt Duke's similar line of reasoning here.

128. The Tribunal further finds persuasive that in its Comments, Duke selected this comparative factor, and every other comparative factor analyzed by the Agency in this comparative analysis. (Jt. Ex. 1, pp. 157-58, 168). Duke also noted in its Comments that the analysis engaged by the Agency provides that "[g]enerally, the application proposing to increase competition in the service area is the more effective alternative regarding this comparative factor." (*Id.*).

129. The Agency did not err in its analysis of the access by service area residents comparative factor. UNC ordinarily would have been found more effective under this comparative factor, as it projected to serve 90 percent Durham residents in the UNC Application, much more than Duke's projections. However, the Agency correctly used its discretion to determine it could not effectively compare these proposals under this factor based on the differences in the levels of acuity and care provided by a community hospital as opposed to a quaternary academic medical center teaching hospital.

130. The UNC Application was comparatively superior to the Duke Beds Application on the following factors: Geographic Accessibility and Competition. The UNC Application was equally effective with the Duke Beds Application on the following comparative factor: Conformity with Review Criteria.

131. The UNC Application was comparatively superior to the Duke ORs Application on the following factors: Geographic Accessibility and Competition. The UNC Application was equally effective with the Duke ORs Application on the following comparative factors: Conformity with Review Criteria and Scope of Services.

132. The Agency did not err in its analysis of the access by underserved groups comparative factors. The Agency appropriately determined it could not effectively compare the Duke Applications and UNC Application based on differences in their financial pro formas along with the differences in levels of acuity and care at each hospital.

133. The Agency did not err in its analysis of the projected net revenue per patient comparative factor. UNC ordinarily would have been found more effective under this comparative factor, as it projected a lower average net revenue per patient than Duke.

However, the Agency correctly used its discretion to determine it could not effectively compare the Duke Applications and UNC Application based on differences in their financial pro formas along with the differences in levels of acuity and care at each hospital.

134. The Agency did not err in its analysis of the projected average operating expense per patient comparative factor. UNC ordinarily would have been found more effective under this comparative factor, as it projected a lower average operating expense per patient than Duke. However, the Agency correctly used its discretion to determine it could not effectively compare the Duke Applications and UNC Application based on differences in their financial pro formas along with the differences in levels of acuity and care at each hospital.

135. The UNC Application was comparatively superior to the Duke Beds Application and the Duke ORs Application.

136. The Agency did not err in determining that the UNC Application was comparatively superior to the Duke Beds Application and Duke ORs Application in the comparative analyses for both the ORs and acute care beds applications.

137. The Agency did not exceed its authority or jurisdiction; act erroneously, fail to use proper procedure; act arbitrarily or capriciously; or fail to act as required by law or rule in determining that the UNC Application was comparatively superior to the Duke Beds Application and Duke ORs Application and in approving the UNC Application.

138. There is sufficient evidence in the record to properly and lawfully support the Conclusions of Law cited above.

139. Duke failed to meet its burden of proving by a preponderance of the evidence that the Agency erred in finding the UNC Application comparatively superior to the Duke Beds Application and Duke ORs Application and in approving the UNC Application.

140. Because the undersigned has determined the Agency properly found the UNC Application conforming with the review criteria and properly found the UNC Application comparatively superior to the Duke Applications and therefore approved the UNC Application, the undersigned need not and does not rule on whether the Agency erred in finding the Duke Applications conforming with the review criteria.

FINAL DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the preponderance of the evidence and having given due regard to the demonstrated knowledge and expertise of the Agency with respect to the facts and inferences within the specialized knowledge of the Agency, the Undersigned hereby **ORDERS**:

1. The Agency's decision that the UNC Application, Project I.D. No. J-12065-21, is conforming with all applicable Review Criteria and Performance Standards is hereby AFFIRMED.

2. The Agency's decision that the UNC Application was the more effective alternative as compared to the Duke Beds Application and Duke ORs Application is hereby AFFIRMED

3. The Agency's decision to approve the UNC Application and award the Certificates of Need in this Review to UNC is hereby AFFIRMED. The Agency is directed to issue the CON in this Review to UNC.

NOTICE OF APPEAL

Under the provisions of North Carolina General Statute § 131E-188(b): "Any affected person who was a party in a contested case hearing shall be entitled to judicial review of all or any portion of any final decision in the following manner. The appeal shall be to the Court of Appeals as provided in G.S. 7A-29(a). The procedure for the appeal shall be as provided by the rules of appellate procedure. The appeal of the final decision shall be taken within 30 days of the receipt of the written notice of final decision and notice of appeal shall be filed with the Office of Administrative Hearings and served on the Department [North Carolina Department of Health and Human Services] and all other affected persons who were parties to the contested hearing."

Under N.C. Gen. Stat. § 131E-188(b1): "Before filing an appeal of a final decision granting a certificate of need, the affected person shall deposit a bond with the Clerk of the Court of Appeals. The bond requirements of this subsection shall not apply to any appeal filed by the Department."

In conformity with the Office of Administrative Hearings' Rule 26 NCAC 03 .0102 and the Rules of Civil Procedure, N.C. Gen. Stat. 1A-1, Article 2, this Final Decision was served on the parties the date it was placed in the mail or served via electronic service as indicated on the Certificate of Service attached to this Final Decision.

This the 9th day of December, 2022.

Melissa Owens Lassiter
Administrative Law Judge

CERTIFICATE OF SERVICE

The undersigned certifies that, on the date shown below, the Office of Administrative Hearings sent the foregoing document to the persons named below at the addresses shown below, by electronic service as defined in 26 NCAC 03 .0501(4), or by placing a copy thereof, enclosed in a wrapper addressed to the person to be served, into the custody of the North Carolina Mail Service Center who subsequently will place the foregoing document into an official depository of the United States Postal Service.

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This the 9th day of December, 2022.

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